DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

August 28, 2026

Melissa Miller
Medicaid Director and Deputy Chief of Staff
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

Dear Director Miller:

The Centers for Medicare & Medicaid Services (CMS) is approving Oklahoma's request to renew its Medicaid section 1115(a) demonstration entitled "SoonerCare" (Project Number 11-W-00048/6), in accordance with section 1115(a) of the Social Security Act (the Act). This approval is effective January 1, 2027 through December 31, 2031, upon which date, unless renewed or otherwise temporarily extended, all authorities granted to operate this demonstration will expire.

CMS has determined that the SoonerCare demonstration is likely to assist in promoting the objectives of the Medicaid statute by enabling the state to provide medical assistance and improve the health of communities and populations through the Insure Oklahoma Employer Sponsored Insurance (IO-ESI) program, the Health Access Networks (HAN), and the Health Management Program (HMP).

CMS's approval of this section 1115(a) demonstration is subject to the limitations specified in the attached waiver and expenditure authorities, special terms and conditions (STCs), and any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The state may deviate from the Medicaid state plan requirements only to the extent those requirements have been specifically listed not applicable to expenditures under the demonstration.

Program Integrity

States are responsible for following all applicable federal law and regulations when they claim and use federal Medicaid funds and must fully comply with all applicable Medicaid statutes and regulations under a section 1115 demonstration, except where specific provisions have been expressly waived or identified as not applicable for that demonstration. This obligation includes all requirements in title XIX of the Act and implementing regulations governing provider screening and enrollment activities, pre- and post-payment review claiming, payment methodologies and rate-setting, utilization controls, and program integrity including processes to identify, investigate, and refer suspected fraud, and methods to receive complaints and identify questionable practices. States must maintain effective systems and safeguards to prevent, detect, and address any fraud, waste, or abuse (FWA) in the delivery of and payment for Medicaid services, including referrals to law enforcement when appropriate.

States should have heightened monitoring and oversight mechanisms in place featuring robust internal controls to identify and remediate all vulnerabilities (including, but not limited to, FWA and beneficiary access issues) inherent in service areas approved as part of a demonstration. At any time, CMS may request that the state provide a plan detailing the state's systems and safeguards to prevent, detect, and address any FWA relative to this demonstration. Failure to meet program integrity obligations under federal statutes and regulations or under the terms and conditions of this demonstration approval may result in compliance actions or other enforcement measures that could include requirements to develop and implement corrective action plans, withholdings, deferrals, disallowances, and termination of demonstration authority.

Extent and Scope of Demonstration Renewal

The SoonerCare demonstration encompasses a variety of authorities to allow that state to maximize consistent access to coverage. This approval includes continued authority for premium assistance for the IO-ESI demonstration populations and evolution of the HMP and HAN. This approval includes the following changes to the STCs from the previous demonstration approval: technical corrections to reflect the phase-out plan for Insure Oklahoma Individual Plan (IO IP) and the previously approved state plan changes to postpartum coverage and income limits for the pregnancy-related eligibility group; updates to reflect current CMS policy on budget neutrality and carryforward savings; and alignment of demonstration eligibility with state plan changes to effectuate a managed care delivery system in the state, known as SoonerSelect.

Clarifying minimum essential coverage designation

Section 1902(xx)(9)(A)(i)(II)(aa) of the Act and 42 CFR 435.551 define applicable individuals to include certain individuals who are not eligible for or enrolled in the state plan adult group and who are otherwise eligible to enroll or are enrolled in a demonstration project under section 1115(a)(2) of the Act that provides coverage that meets minimum essential coverage (MEC). As part of its work related to implementation of section 1902(xx), CMS is reviewing currently authorized section 1115 demonstrations that provide eligibility for medical assistance under section 1115(a)(2) expenditure authority and making MEC determinations applicable to each population. CMS is also reviewing previous MEC determinations to ensure they are up to date. In some instances, coverage for a population using 1115(a)(2) demonstration expenditure authority was previously designated as MEC but no longer meets the standards described in section 5000A(f)(1)(A) of the Internal Revenue Code due to changes to the demonstration.

As part of this effort, CMS determined that individuals who are eligible for and enrolled in coverage under the section 1115(a)(2) expenditure authority for the Employer-Sponsored Health Insurance population in the SoonerCare demonstration do not receive MEC from the expenditure authority as the expenditure authority only provides premium/cost-sharing assistance. Therefore, in the STCs, CMS is adding a new STC that indicates that the Employer-Sponsored Health Insurance population does not receive MEC through the SoonerCare demonstration.

Budget Neutrality

This demonstration project is extended using CMS's current approach to determining budget neutrality as described in CMS SMDL #24-003.[1] However, CMS acknowledges that section 71118 of subchapter C of chapter 1 of subtitle B of title VII of Public Law 119-21 the Working Families Tax Cuts (WFTC) legislation adds a new subsection (g) to section 1115 of the Act with budget neutrality requirements that will apply beginning January 1, 2027 to CMS approvals of section 1115 Medicaid demonstration project applications, renewals, or amendments.[2] CMS has released additional guidance in CMS SMDL #26-003[3] on June 11, 2026 about the section 1115(g) requirements

Under SMDL #24-003, as a condition of demonstration approval, demonstrations must be "budget neutral," meaning the federal costs of the state's Medicaid program with the demonstration cannot exceed what the federal government's Medicaid costs likely would have been in that state absent the demonstration.[4] The demonstration renewal is projected to be budget neutral to the federal government. In practice, budget neutrality generally means that the total computable (i.e., both state and federal) costs for approved demonstration expenditures are limited to a certain amount for the demonstration approval period. This limit is called the budget neutrality expenditure limit and is based on a projection of the Medicaid expenditures that could have occurred absent the demonstration (the "without waiver" [WOW] costs). The state will be held to the budget neutrality monitoring and general financial requirements as outlined in the STCs.

Rebasing Without Waiver Baselines
Under this demonstration, for existing Medicaid Expenditure Groups (MEGs) that were implemented, CMS calculated the WOW baseline by using a weighted average of the state's historical WOW per-member-per-month (PMPM) baseline and its recent actual PMPM costs. The projected demonstration expenditures associated with each MEG in the WOW baseline (except MEGs with aggregate cost limits) have been trended forward using the President's Budget trend rate to determine the maximum expenditure authority for the new approval period. Using the President's Budget trend rate aligns the demonstration trend rate with federal budgeting principles and assumptions.

Hypothetical Budget Neutrality Treatment
Under its current approach to budget neutrality, CMS generally treats expenditures for populations or services which could have otherwise been covered via the Medicaid state plan, or other title XIX authority, such as a section 1915 waiver, as "hypothetical" for the purposes of budget neutrality. In these cases, CMS adjusts budget neutrality to account for the spending which the state could have hypothetically provided through the Medicaid state plan or other title

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[1] https://www.medicaid.gov/federal-policy-guidance/downloads/smd24003.pdf
[2] https://www.congress.gov/bill/119th-congress/house-bill/1/text
[3] https://www.medicaid.gov/federal-policy-guidance/downloads/smd26003.pdf
[4] https://www.medicaid.gov/medicaid/section-1115-demonstrations/budget-neutrality/index.html

XIX authority. CMS does not, however, currently allow for budget neutrality savings accrual as a result of including hypothetical populations or services in section 1115 demonstration projects. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies a separate, independent budget neutrality "supplemental test" for hypothetical expenditures. These supplemental budget neutrality tests subject the hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, during negotiations. If the state's "with waiver" (WW) hypothetical spending exceeds the supplemental test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending with savings elsewhere in the demonstration or to refund the FFP to CMS.

The Employer-Sponsored Health Insurance MEG will be treated as hypothetical for budget neutrality purposes. For that MEG, CMS calculated the WOW baseline (which refers to the projected expenditures that could have occurred absent the demonstration and which is the basis for the budget neutrality expenditure limit for each approval period). The projected demonstration expenditures associated with each of these MEGs in the WOW baseline have been trended forward using the President's Budget trend rate to determine the maximum expenditure authority for the new approval period. Using the President's Budget trend rate aligns the demonstration trend rate with federal budgeting principles and assumptions.

With Waiver Only Budget Neutrality
The state's expenditures for the Aged, Blind, and Disabled, Temporary Assistance for Needy Families, HAN expenditures, and HMP expenditures MEGs are costs related to waivers for state plan populations or costs not otherwise matchable that require budget neutrality "savings" to offset the expenditures.

Mid-Course Correction
CMS has also updated its approach to mid-course corrections to budget neutrality calculations in this demonstration approval to provide flexibility and stability for the state over the life of a demonstration. This update identifies, in the STCs, a list of circumstances under which a state's baseline may be adjusted based on actual expenditure data to accommodate circumstances that are either out of the state's control (for example, if expensive new drugs that the state is required to cover enter the market); and/or the effect is not a condition or consequence of the demonstration (for example, unexpected costs due to a public health emergency); and/or the new expenditure (while not a new demonstration-covered service or population that would require the state to propose an amendment to the demonstration) is likely to further strengthen access to care (for example, a legislated increase in provider rates). CMS also explains in the STCs what data and other information the state should submit to support a potentially approvable request for an adjustment. CMS considers this a more rational, transparent, and standardized approach to permitting budget neutrality modifications during the course of a demonstration.

Monitoring and Evaluation

Consistent with the demonstration STCs, the state submitted with the renewal application its Interim Evaluation Report[5] for the prior demonstration approval period, and included the time period of January 1, 2019 through December 31, 2021.

[5] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ok-soonercare-interim-eval-rprt.pdf

The demonstration renewal aims to continue meeting the health care needs of participants by improving access to preventative and primary care services, ensuring medical home availability for eligible beneficiaries, expanding access to affordable health insurance for low-income working adults and their spouses, and improving quality of care through effective case management. The state expects to achieve these goals through two beneficiary-centered initiatives: the HAN and HMP, which offer enhanced care coordination to beneficiaries with complex care needs or chronic health conditions. The demonstration also seeks to integrate Indian Health Service (IHS) eligible beneficiaries and IHS and tribal providers into the SoonerCare delivery system and includes a waiver of retroactive eligibility for a portion of the SoonerCare population.

Based on available data in the state's Interim Evaluation Report, which includes the time period of January 1, 2019 through December 31, 2021, CMS determined that the demonstration made important advances toward the demonstration's goals for beneficiaries enrolled in SoonerCare.[6]

The demonstration's performance varied across program components; however, evaluation findings generally indicate that targeted care coordination interventions were associated with improvements in access to care, quality of care, and cost effectiveness for participating beneficiaries. Evaluation findings were strongest for beneficiaries receiving enhanced care coordination services, particularly within the HMP population and the HAN Care Managed subgroup. HMP populations outperformed the comparison group[7] across access, quality, and cost measures — including higher rates of preventive care access (94% vs. 85%), better chronic disease management for diabetes (79% of HMP populations with diabetes received HbA1c testing compared to 69% in the comparison group) and hypertension (63% vs. 56%), lower rates of high-dose opioid (4% vs. 5%) and concurrent opioid/benzodiazepine use (11% vs. 13%), meaningfully lower per member per month expenditures ($619 vs. $767), and lower emergency department utilization and hospital admission rates. Similarly, the HAN Care Managed subgroup, which received enhanced support for complex or chronic health needs, outperformed its comparison group on preventive access and select diabetes quality measures and had lower per member per month expenditures ($627 vs. $692). These results were statistically significant in the three-year pooled analysis and generally consistent across individual years despite disruptions from the COVID-19 public health emergency.

Results for the broader HAN total population were more mixed and generally less conclusive than those observed for HMP participants. There was no strong evidence that this population had better outcomes than the comparison group across measures related to access to care, quality of care, or cost effectiveness. Findings related to the retroactive eligibility waiver were more limited. The population subject to the retroactive eligibility waiver had more favorable results than the comparison group for two measures of self-reported health, but there were no statistically significant differences in emergency department or hospital utilization.

[6] Due to the temporary extensions, the state's summative evaluation report has not yet been due.
[7] Findings were assessed by comparing demonstration participants to a matched comparison group of SoonerCare members not enrolled in either the HAN or HMP programs.

Based on the progress made to date and the need for additional evidence, the renewal provides the state an opportunity to continue building on and assessing these policies. To ensure transparency towards continued progress on more of the demonstration goals and to address the identified areas for improvement, the state is required under this renewal to continue conducting systematic monitoring and robust evaluation of the demonstration. In collaboration with CMS, the state must undertake demonstration monitoring, including reporting of relevant metrics data and narrative details describing progress with implementation of all components of the demonstration.

Additionally, the state is required to conduct an evaluation of the demonstration which includes the temporary extension approval period. The evaluation supports a comprehensive assessment of whether the demonstration components are effective in producing the desired outcomes for its beneficiaries and providers, as well as the state's overall Medicaid program. The demonstration evaluation must also outline and address well-crafted hypotheses and research questions for all key demonstration policy components, as described in the STCs.

Consideration of Public Comments

CMS posted the application on Medicaid.gov for a 30-day federal public comment period from January 5, 2023, to February 4, 2023. CMS received five comments, one in support of the demonstration and four that shared concerns, from various individuals, research institutions, and advocacy organizations. The one commenter expressed support for the demonstration's continued inclusion of the Patient-Center Medical Home (PCMH) since 2009 and indicated interest in implementation of an Indian PCMH that Oklahoma Health Care Authority created in consultation with the IHS and tribes. The state does not need authority from CMS to establish an Indian PCMH as long as it complies with the terms described in the STCs, and the state has indicated they are continuing to work on developing one. Additionally, nothing precludes SoonerCare Choice providers from being tribal providers as well.

All four commenters who expressed concerns with this renewal application wrote about the retroactive eligibility waiver. All four commenters argued that the waiver does not meet section 1115 criteria and does not further the goals of Medicaid. CMS notes that the state is expected to continue evaluating the waiver of retroactive eligibility policy, with particular focus on its effects on enrollment, enrollment continuity, enrollment when people are healthy, and health status. In addition, the state must evaluate the waiver's impact on beneficiary financial outcomes, including medical debt, as well as any barriers to timely renewal for affected individuals, in order to build additional evidence regarding the effects of the policy and its role in promoting the objectives of Medicaid.

After careful review of the public comments submitted during the federal comment period and information received from the state public comment period, CMS has concluded that renewing the SoonerCare demonstration is likely to promote the objectives of Medicaid.

Other Information

CMS' approval of this demonstration renewal is conditioned upon compliance with the enclosed set of waiver and expenditure authorities and the STCs defining the nature, character, and extent of anticipated federal involvement in the demonstration. The award is subject to CMS receiving written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this approval letter. Your project officer is Alicia Bazell, who is available to answer any questions concerning this demonstration renewal, and her 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, Maryland 21244-1850
Email: alicia.bazell@cms.hhs.gov

If you have any questions regarding this approval, please contact Sarah Aker, Acting Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at Sarah.Aker@cms.hhs.gov.

Sincerely,

Dan Brillman
Deputy Administrator, CMS
Director, Center for Medicaid and CHIP Services

Enclosure

cc: Stacey Steiner, State Lead, Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITY

NUMBER: 11-W-00048/6

TITLE: SoonerCare

AWARDEE: Oklahoma Health Care Authority (OHCA)

Under the authority of section 1115(a)(1) of the Social Security Act ("the Act"), the following waivers are granted to enable Oklahoma (referred to herein as the state) to operate the Oklahoma SoonerCare Medicaid section 1115 demonstration. These waivers are effective beginning January 1, 2027 through December 31, 2031 and are limited to the extent necessary to achieve the objectives described below. These waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs) set forth in the accompanying document.

As discussed in the Centers for Medicare & Medicaid Services' (CMS) approval letter, the Secretary of Health and Human Services has determined that the Oklahoma SoonerCare section 1115 demonstration, including the granting of the waivers described below, is likely to assist in promoting the objectives of title XIX of the Act.

Except as provide below with respect to expenditure authority, all requirements of the Medicaid program expressed in law, regulation, and policy statements, not expressly waived in this list, shall apply to the demonstration project for the period beginning January 1, 2027 through December 31, 2031.

1. Freedom of Choice Section 1902(a)(23)(A)

To enable the state to restrict beneficiaries' freedom of choice of care management providers, and to use selective contracting that limits freedom of choice of certain provider groups to the extent that the selective contracting is consistent with beneficiary access to quality services. No waiver of freedom of choice is authorized for family planning providers.

2. Retroactive Eligibility Section 1902(a)(34)

To enable the state to waive retroactive eligibility for state plan eligible populations. The waiver of retroactive eligibility does not apply to pregnant women (and during the period of postpartum eligibility beginning on the last day of the pregnancy), children described in section 1902(l)(4) of the Act, the Tax Equity and Fiscal Responsibility Act (TEFRA) and Aged, Blind, and Disabled populations.

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: 11-W-00048/6

TITLE: SoonerCare

AWARDEE: Oklahoma Health Care Authority

Under the authority of section 1115(a)(2) of the Social Security Act ("the Act"), expenditures made by Oklahoma for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period from January 1, 2027 through December 31, 2031, unless otherwise specified, be regarded as expenditures under the state's title XIX plan, except those specified below as not applicable to these expenditure authorities.

The following expenditure authorities and the provisions specified as "not applicable" may only be implemented consistent with the approved Special Terms and Conditions (STC) and shall enable Oklahoma to operate the above-identified section 1115(a) demonstration.

1. **Employer-Sponsored Health Insurance Population.** Expenditures for premium and cost sharing assistance for non-state plan eligible individuals who work for a qualifying employer and have income no more than 200 percent of the federal poverty level (FPL), and their spouses. These individuals include:
   a. Non-disabled low-income workers from age 19 up to and including age 64 years.
   b. Working disabled adults age 19 up to and including age 64 years.
   c. No more than 3,000 full-time college students age 19 up to and include age 22 years, who have no minimum essential coverage, and whose parent(s)/guardian(s), who claim the individual as a dependent, work for a qualifying employer.
   d. Foster parents
   e. Employees and spouses of not-for-profit businesses with 500 or fewer employees.

2. **Health Access Networks Expenditures.** Expenditures for Per Member Per Month payments made to the Health Access Networks for case management activities.

3. **Health Management Program.** Expenditures for otherwise non-covered costs to provide services authorized through the Health Management Program as described in these STCs.

Title XIX Requirements Not Applicable to the Demonstration Expenditure Authorities

Not Applicable to the Employer-Sponsored Health Insurance population

1. Comparability	**Section 1902(a)(10)(B) and 1902(a)(17)**

To permit the state to provide different benefit packages to individuals in the Employer-Sponsored Health Insurance population who are enrolled in the Premium Assistance Employer Coverage Plan that may vary by individual.

2. Cost Sharing Requirements	**Section 1902(a)(14) insofar as it incorporates Section 1916**

To permit the state to impose premiums, deductibles, cost sharing, and similar charges that exceed the statutory limitations for individuals in the Employer-Sponsored Health Insurance population who are enrolled in the Premium Assistance Employer Coverage Plan.

3. Freedom of Choice	**Section 1902(a)(23)(A)**

To permit the state to restrict the choice of provider for beneficiaries eligible in the Employer-Sponsored Health Insurance population enrolled in the Premium Assistance Employer Coverage Plan. No waiver of freedom of choice is authorized for family planning providers.

4. Retroactive Eligibility	**Section 1902(a)(34)**

To enable the state to not provide retroactive eligibility for demonstration participants in the Employer-Sponsored Health Insurance population.

5. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	**Section 1902(a)(4)(B); 1902(a)(10)(A); and 1902(a)(43)**

To exempt the state from furnishing or arranging for EPSDT services for individuals in the Employer-Sponsored Health Insurance population who are age 19 through age 22.

6. Assurance of Transportation	**Sections 1902(a)(4) and 1902(a)(19) 42 CFR 431.53**

To permit the state not to provide non-emergency transportation benefits to individuals in the Employer-Sponsored Health Insurance population enrolled in Insure Oklahoma.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00048/6**

TITLE: **SoonerCare**

AWARDEE: **Oklahoma Health Care Authority**

I. PREFACE

The following are the Special Terms and Conditions (STC) for the "SoonerCare" section 1115(a) Medicaid demonstration (hereinafter "demonstration"), to enable Oklahoma, (hereinafter "state") to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Social Security Act (Act), and expenditure authorities authorizing federal matching of the demonstration costs not otherwise matchable, which are separately enumerated. The STCs set forth conditions and limitations on those waivers and expenditure authorities, and describe in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS related to the demonstration. These STCs neither grant additional waivers or expenditure authorities, nor expand upon those separately granted.

The STCs related to the programs for those populations affected by the demonstration are effective from January 1, 2027 through December 31, 2031, unless otherwise specified.

The STCs have been arranged into the following subject areas:

I	Preface
II	Program Description
III	General Program Requirements
IV	Eligibility
V	SoonerCare Benefits and Cost Sharing
VI	Insure Oklahoma Premium Assistance Benefits and Cost Sharing
VII	SoonerCare Delivery Systems (other than Insure Oklahoma)
VIII	Health Management Program
IX	Monitoring and Reporting Requirements
X	Evaluation of the Demonstration
XI	General Financial Requirements
XII	Monitoring Budget Neutrality for the Demonstration
XIII	Schedule of Deliverables for the Demonstration Period

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

Attachment A	Evaluation Design [Reserved]

II. PROGRAM DESCRIPTION

The SoonerCare Demonstration was initially approved in January 1995. The demonstration operated under a Primary Care Case Management (PCCM) model in which the Oklahoma Health Care Authority (OHCA) contracted directly with primary care providers throughout the state to provide basic health care services. The primary care providers (PCPs) received a monthly care coordination payment for each enrolled beneficiary, based upon the services provided at the medical home.

The demonstration provided for a modification of the service delivery system for eligible populations. The benefits for individuals affected by or eligible only under SoonerCare, with the exception of individuals enrolled in the Insure Oklahoma Premium Assistance Employer Coverage, were state plan benefits. Building on this foundation, the demonstration renewal aims to continue meeting the health care needs of participants by improving access to preventative and primary care services, ensuring medical home availability for eligible beneficiaries, expanding access to affordable health insurance for low-income working adults and their spouses, and improving quality of care through effective case management.

Historical Context of Demonstration Renewals and Amendments:

At the program's inception in 1995, the "SoonerCare" demonstration covered Medicaid state plan populations of AFDC (TANF) and related children and adults, including pregnant women up to the minimum federal poverty level (FPL) standards as defined by state law. The original SoonerCare populations were separated into Urban and Rural Eligibility Groups (EGs). The Urban EG included three catchment areas: Central (Oklahoma City and surrounding areas), Northeast (Tulsa and surrounding areas) and Southwest (Lawton and surrounding areas). The Rural EG included the rest of the state. The original SoonerCare demonstration also granted authority for the state to mandatorily enroll non-Medicare Aged, Blind and Disabled (ABD) beneficiaries into managed care. Over the years since then, the state has revised the populations covered by the demonstration by adding additional populations and/or changing the requirements for eligibility for existing populations. The state has extended their demonstration multiple times since 1995.

In more recent history, on August 31, 2018, CMS approved a five-year renewal of the SoonerCare demonstration, with the following changes: technical corrections to make numbering and grammatical updates; removal of the authority to waive retroactive eligibility for pregnant women and children under 19; and expenditure authority for one year of phase-down expenditures for the state's medical education program.

On November 1, 2019, CMS approved two amendments to the SoonerCare demonstration making changes to its Health Management Program (HMP) and Health Access Networks

(HANs). The amendments provided the HMP with more options for data analytics to identify beneficiaries for HMP services beyond the current HMP predictive modeling software to include Medicaid Management Information System (MMIS) claims, health information exchange information, provider referrals, and other sources; modified the "services" language under the HMP to further define health coaching and practice facilitation; newly incorporated emerging interventions such as health navigation, performance improvement projects, and assistance with transitions of care. The amendment also modified language in the STCs that described the HAN's duties. The previous language, originally written in 2010, related to ensuring patient access to all levels of care, including 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 reflected that the HAN program was no longer a pilot program and had been evaluated by the state with results showing that the HAN reduced cost and improved access and quality for beneficiaries. As such, the language requiring the HANs to submit development plans to the state, and to offer core components of EHR, was removed. Remaining language continued to describe the HAN program 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.

On January 31, 2022, CMS approved an amendment to modify the STCs to update the Insure Oklahoma Individual Plan benefits to be equivalent to the state's approved Alternative Benefit Package (ABP) for the state plan adult group as of July 1, 2021. This amendment also approved the phase-out plan for the Insure Oklahoma (IO) Individual Plan (IP). Upon the expiration of the COVID-19 public health emergency (PHE), the state determined eligibility for those individuals in the IO IP who had incomes over 133 percent FPL who Oklahoma had maintained enrollment in the demonstration on the basis of section 6008(b)(3) of the Families First Coronavirus Response Act (FFCRA) (the "continuous coverage" provision), but for the continuous coverage provision, would have been terminated due to excess income. Upon the expiration of the PHE, the state reviewed the eligibility of those individuals above the 133 percent FPL threshold and made appropriate assessments towards coverage.

On March 23, 2023, CMS approved Oklahoma's State Plan Amendment (SPA) OK-22-0042 to adopt the 12-month postpartum coverage option authorized under Section 1902(e)(16) of the Social Security Act, and to increase the income limit for the mandatory pregnancy-related eligibility group to 205 percent of the FPL. The SPA was approved with an effective date of January 1, 2023. Under the terms of STC 5 of the demonstration and in alignment with approved SPA OK-22-0042, effective January 1, 2023, the income limit for the mandatory pregnancy-related eligibility group incorporated into the SoonerCare demonstration was increased to 205 percent of the FPL, and the state began providing 12-month postpartum coverage.

Recent Actions and Status:

On November 1, 2023, on November 7, 2024, and on December 18, 2025, CMS approved a one-year temporary extension of the SoonerCare demonstration, with no changes, through December 31, 2024, December 31, 2025, and December 31, 2026, respectively.

On August 28, 2026, CMS approved a five-year renewal of the SoonerCare demonstration, effective January 1, 2027, with the following changes: technical corrections to reflect the phase-out plan for IO IP and state plan changes to postpartum coverage and income limits for the pregnancy-related eligibility group; updates to reflect current CMS policy on budget neutrality and carryforward savings; and alignment of demonstration eligibility with state plan changes to effectuate a managed care delivery system in the state, known as SoonerSelect.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).

2. **Compliance with Medicaid and Child Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in federal law, regulation, and policy statement not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
    a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change, as well as a modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for budget neutrality agreements are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 7) as a result of the change in FFP.
    b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of federal law, the changes must take effect on the day such

state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

5. **State Plan Amendments.** The state will not be required to submit title XIX or title XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plan governs.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below, except as provided in STC 3.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to, failure by the state to submit required elements of a viable amendment request as found in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

   a. An explanation of the public process used by the state, consistent with the requirements of STC 12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

   b. A detailed description of the amendment, including the impact on beneficiaries, with sufficient supporting documentation;

   c. A data analysis worksheet which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

d. An up-to-date CHIP allotment neutrality worksheet, if necessary;

e. The state must provide updates to existing demonstration reporting, quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

8. **Renewal of the Demonstration**. States that intend to request a renewal of the demonstration must submit an application to CMS from the Governor of the state in accordance with the requirements of 42 CFR 431.412(c). States that do not intend to request a renewal of the demonstration beyond the period authorized in these STCs must submit phase-out plan consistent with the requirements of STC 9.

9. **Demonstration Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements:

   a. Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into a revised transition and phase-out plan.

   b. Transition and Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct redeterminations of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.

   c. Transition and Phase-out Plan Approval: The state must obtain CMS's approval of the transition and phase-out plan prior to implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS's approval of the transition and phase-out plan.

d. Transition and Phase-out Procedures: The state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to making a determination of ineligibility as required under 42 CFR 35.916(f)(1). For individuals determined ineligible for Medicaid and CHIP, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e). The state must comply with all applicable advance notice requirements and fair hearing rights described at 42 CFR 431, Subpart E. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230.

e. Exemption from Public Notice Procedures 42 CFR 431.416(g): CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. Enrollment Limitation during Demonstration Phase-out: If the state elects to suspend, terminate, or not extend this demonstration during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP must be limited to normal closeout costs associated with termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling participants.

10. **Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and/or title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authorities, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling participants.

11. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

12. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state

must comply with the state notice procedures as required in 42 CFR 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved state plan, when any program changes to the demonstration, either through amendment as set out in STC 7 or renewal, are proposed by the state.

13. **Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration, including administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

14. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, MCOs, and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

15. **Common Rule Exception.** The state must ensure that the only involvement of human subjects in research activities which may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs; procedures for obtaining Medicaid benefits or services; possible changes in or alternatives to Medicaid or CHIP programs and procedures; or possible changes in methods or levels of payments for Medicaid benefits or services. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(d)(5).

IV. ELIGIBILITY

16. **Use of Modified Adjusted Gross Income (MAGI) Based Methodologies For Demonstration Groups.** Mandatory and optional state plan groups described below derive their eligibility through the Medicaid State Plan and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid State Plan, except as expressly waived in this demonstration and as described in these STCs. Any Medicaid State Plan Amendments to the eligibility standards and methodologies for these eligibility groups will apply to this demonstration. These state plan eligible beneficiaries are included in the demonstration so

they can use the managed care network and access the additional benefits that are not included in the state plan.

17. **State Plan Populations Affected.** Title XIX state plan populations are affected by the demonstration as described in the waiver authorities and STCs 28 through 38. A member of any mandatory or optional State Plan group that is also a SoonerSelect voluntary member and chooses to opt out of managed care will be eligible for the demonstration.

18. **Demonstration Eligibility.** The demonstration includes individuals described in the expenditure authorities and enrolled in the Premium Assistance Employer Coverage Plan who receive a premium assistance benefit.

19. **Eligibility Exclusions.** The following persons are excluded from the SoonerCare demonstration expenditure authorities:
    a. Individuals dually eligible for Medicare and Medicaid;
    b. Individuals residing in an institution or nursing home;
    c. Individuals receiving home and community-based waiver services;
    d. Individuals infected with tuberculosis covered under 1902(a)(10)(A)(ii)(XII) and 1902(z)(1);
    e. Individuals covered by a SoonerSelect Managed Care Organization;
    f. Individuals in the Former Foster Care group;
    g. Individuals with other creditable coverage; and
    h. Individuals eligible only for emergency services under section 1903(v)(3) of the Act.

20. **Eligibility Conditions for Full-Time College Students under the Employer-Sponsored Health Insurance population.**
    a. Income eligibility Documentation. Applicants must complete the Free Application for Federal Student Aid (FAFSA) as a component of their application. Parental income will not be considered in the state's eligibility determination if the FAFSA or the university's financial aid office verifies that the college student is financially independent. Parental income will be considered in the eligibility determination if the college student is deemed by the college or university to be a dependent. An eligible full-time college student can be enrolled in no other creditable health coverage as defined by section 2701(c) of the Public Health Service Act, whether provided by their parents, their college/university, or their employer.
    b. Enrollment Cap. There is an enrollment cap of 3,000, at any given time, on full-time college students. The state must notify CMS 60 days prior to implementing a waiting list for individuals covered under Insure Oklahoma. This notification must include a plan for how the waiting list will be implemented. To insure resources are available statewide, the state will be divided into six regions with each region eligible to receive a population density, pro-rata share of funding. Any employer or individual already approved for the Premium Assistance Plan may continue to re-enroll not subject to the waiting list. The state will provide written notification to CMS at least 15 days before re-opening enrollment of the demonstration.

V. SOONERCARE BENEFITS AND COST SHARING

21. SoonerCare Benefits. All demonstration participants, except those receiving Insure Oklahoma benefits, receive SoonerCare Choice benefits. Benefits for Insure Oklahoma Premium Assistance Employer Coverage enrollees are limited to premium assistance and cost sharing reductions, as described in section VI.

22. SoonerCare Cost Sharing. Under the SoonerCare demonstration, cost-sharing does not differ from what is allowable under the state plan. Cost sharing for individuals who would otherwise not be eligible under the state plan is described in Section VI, which describes Insure Oklahoma premium assistance benefits and cost sharing.

VI. INSURE OKLAHOMA PREMIUM ASSISTANCE BENEFITS AND COST SHARING

23. Insure OK: Premium Assistance Employer Coverage. Premium Assistance Employer Coverage provides qualifying low-income non-disabled workers and their spouses, working foster parents, disabled workers, and full-time college students ages 19-22 up to and including 200 percent of the FPL (subject to any enrollment caps), with premium assistance coverage if they are employed by a qualifying employer. In order for an employer to participate in the Premium Assistance Employer Coverage program the employer must:

a. Have no more than 250 employees or have no more than 500 employees if the business is not-for-profit (however, working foster parents and working college students participating in the program may enroll in Premium Assistance Employer Coverage regardless of the size of their employer);

b. Have a business that is physically located in Oklahoma;

c. Be currently offering or intending to offer within 90 calendar days an Insure Oklahoma qualifying plan, as outlined in STC 24;

d. Offer the Insure Oklahoma qualifying plan coverage to employees in accordance with Oklahoma Small Business Statutes, Oklahoma Department of Insurance, and all other regulatory agencies; and,

e. Contribute a minimum 25 percent of the eligible employee monthly health plan premium for non-disabled workers, disabled workers, and employed college students.

The state may impose an enrollment cap on populations covered under Insure Oklahoma, including the non-disabled low-income workers and spouses and working disabled, in order to remain within state funding limits.

24. Insure OK: Premium Assistance Employer Coverage IO Qualifying Plans. An Insure Oklahoma qualifying plan is a health plan that meets the definition of a Qualified Health Plan as defined in Oklahoma Administrative Code 317:45-5-1 for the purposes of Insure Oklahoma. Qualifying health plans must also be approved by the Oklahoma Insurance Department for participation in the Oklahoma market. If the health plan requires co-pays or deductibles, amounts cannot exceed the limits outlined in STC 25.

25. **Premium Assistance Employer Coverage Co-Payments and Deductibles.** For individuals participating in Insure Oklahoma Premium Assistance Employer Coverage, co-pays will be those required by the enrollee's specific health plan, as defined in STC 24, subject to the following limitations:

    a. The maximum amount of all cost sharing (co-pays, deductibles and premiums) cannot exceed five percent of a family's total income.

26. **Premium Assistance Employer Coverage Plan Premiums and Other Out-of-Pocket Costs.** Individuals/families participating in Employer Coverage Programs will be responsible for up to 15 percent of the total health insurance premium not to exceed 3 percent out of the 5 percent annual gross household income cap.

    a. The state will provide reimbursement for out-of-pocket costs incurred by the household in excess of the 5 percent annual gross household income cap for individuals (or their eligible Insure Oklahoma spouse) enrolled in Premium Assistance Employer Coverage. A medical expense must be for an allowed and covered service by the health plan to be eligible for reimbursement. The state calculates the 5 percent threshold for each enrollee on a monthly basis and applies the premiums paid by the enrollee toward the 5 percent cap. The state also records co-payments made by the enrollee based upon documentation submitted by the enrollee. Reimbursement is provided by the state once the 5 percent cap is met.

27. **Minimum Essential Coverage (MEC).** The Oklahoma SoonerCare demonstration includes coverage of only premium and cost-sharing assistance for the Employer Sponsored Insurance population, as described in STC 23 Insure OK: Premium Assistance Employer Coverage. Consequently, this coverage available to this population through the demonstration is not recognized as Minimum Essential Coverage (MEC) with respect to enrollees, consistent with the guidance set forth in the State Health Official Letter #14-002, issued by CMS on November 7, 2014.

VII. SOONERCARE DELIVERY SYSTEMS (OTHER THAN INSURE OKLAHOMA)

28. **Description of Managed Care Program.** Under the terms of this demonstration, the state authorizes the Health Management Program (HMP) program to provide case management services to SoonerCare beneficiaries.

29. **Compliance with Managed Care Regulations.** The state, its PCCM program, and any subcontracted entity delegated to perform activities under the managed care contract must

comply with the managed care regulations published at 42 CFR part 438, except as expressly waived or specified as not applicable to an expenditure authority in these STCs.

30. **Access and Service Delivery.** With the exception of individuals receiving benefits through Insure Oklahoma or through SoonerSelect, all SoonerCare Choice beneficiaries select or are assigned a PCP/CM responsible for furnishing primary and preventive services and making medically necessary referrals. For purposes of determining the member's choice of PCP, the most recent selection received by the OHCA determines the PCP with which the member is enrolled, as long as capacity is available. If capacity is not available or the member does not choose, the member is assigned to a PCP according to the assignment mechanism as defined by the OHCA. A member, who is eligible for SoonerCare Choice but is not assigned, may request enrollment with a PCP by contacting the SoonerCare Helpline. Members may also request a change to their PCP by contacting the SoonerCare Helpline.

PCP/CMs must belong to one of the provider types listed below.

Provider	Required Qualifications
Primary Care Physician	Engaged in Family Medicine, General Internal Medicine, General Pediatrics or General Practice; may be board certified or board eligible; or meet all Federal employment requirements, be employed by the Federal Government and practice primary care in an Indian Health Services (IHS) facility.
Specialist Physician	At discretion of OHCA CEO, based on consideration of percentage of primary care services delivered in physician's practice, the availability of primary care physicians in the geographic area, the extent to which the physician has historically served Medicaid and his/her medical education and training.
Advanced Practice Nurse	Must be licensed by the state in which s/he practices and have prescriptive authority; or meet all Federal employment requirements, be employed by the Federal Government and practice in an IHS facility.
Physician's Assistant	Must be licensed by the state in which s/he practices; or meet all Federal employment requirements, be employed by the Federal government and practice primary care in an IHS facility.
Medical Resident	The resident has obtained a medical license or a special license for training from the appropriate regulatory state medical board; and has the appropriate contract on file with the OHCA to render services within the scope of their licensure.
Health Department Clinics	Beneficiaries would be served by one of 68 county health departments or the two city-county health departments in Oklahoma City and Tulsa.

31. **Care Coordination Payments.**

a. <u>Monthly Care Coordination Payments Defined.</u> PCPs receive a monthly care coordination payment for each enrolled beneficiary, based upon the services provided at the medical home. In return, they are responsible for providing or otherwise assuring the provision of medically necessary primary care and case management services and for making specialty care referrals. There are three tiers of Medical Homes: Entry Level Medical Home, Advanced Medical Home (Tier 2), and Optimal Medical Home (Tier 3). The contracted PCP must meet certain requirements to qualify for payments in each tier. Payments are also stratified according to the PCP panel composition; children only, children and adults, or adults only. PCPs are also responsible for providing 24-hour/7-day telephone coverage for their beneficiaries.

b. <u>Monthly Care Management Payments.</u> In addition to the monthly care coordination payments described above, the state also makes monthly care management payments to PCPs and IHS, tribal or Urban Indian Clinic (ITU) PCPs participating in the SoonerCare program. Care management payments are paid per member, per month based on the age and eligibility category of the member.

32. **Other Medical Services.** All other SoonerCare benefits (with the exception of non-emergency transportation and PACE, which are paid through a capitated contract) are paid through the state's FFS or managed care systems.

33. **Health Access Networks.** The state may implement Health Access Networks (HANs) statewide. HANs are non-profit, administrative entities that will work with providers to coordinate and improve the quality of care for SoonerCare beneficiaries. Networks will receive a nominal Per Member per Month (PMPM) payment. This PMPM payment will be made in addition to the care coordination payment paid to PCPs as outlined in STC 31. HANs are not eligible for the care coordination payment outlined in STC 31. The state must not make duplicative payments to the HANs for Medicaid services covered under the Medicaid state plan.

34. **Provider Performance.** The state may provide additional incentive payments, through the state's Payments for Excellence program, to contracted providers to recognize outstanding performance. Incentive payments will be based on provider practice behavior that may include EPSDT screens, DTaP immunizations, Inpatient Admitting and Visits, Breast and Cervical Cancer Screenings, Behavioral Health Screens, and Emergency Department Utilization. The state certifies that incentive payments will not exceed five percent of the total FFS payments for those services provided or authorized by the PCP for the period covered.

    The state furnishes the Provider Performance Payments for Excellence Program to the Indian Health Service, Tribal, and Urban Health Clinics for American Indians, and the Insure Oklahoma Network.

35. **Services for American Indians.** Eligible SoonerCare beneficiaries, with the exception of Insure Oklahoma beneficiaries, may elect to enroll with an IHS, tribal or urban Indian clinic

as their PCP/Care Manager. This voluntary enrollment links American Indian members with these providers for primary care/case management services. The providers receive the care coordination payment paid to PCPs as outlined in STC 31. All of Oklahoma's IHS, tribal, or urban Indian clinics must have a SoonerCare American Indian PCCM contract.

36. **Contracts.** Procurement and the subsequent final contracts developed to implement selective contracting by the state with any provider group shall be subject to CMS approval prior to implementation. Existing contracts with Federally Qualified Health Centers shall continue in force.

VIII. HEALTH MANAGEMENT PROGRAM

37. **Health Management Program Defined.** The SoonerCare Health Management Program (HMP) is a voluntary program offered statewide and serves certain SoonerCare Choice beneficiaries. SoonerCare Choice beneficiaries for whom HMP services may be appropriate (HMP beneficiaries) are identified based on data analysis that includes but is not limited to claims in the state's Medicaid Management Information System (MMIS), Health Information Exchange information, provider referral, and other sources as determined by the state.

38. **Health Management Program Services.** The HMP services are designed by the HMP vendor and approved by OHCA. The HMP vendor's activities may include services delivered directly to SoonerCare Choice beneficiaries or activities in connection with health care providers that are designed to benefit SoonerCare Choice beneficiaries.

    SoonerCare beneficiaries may remain in the HMP until the maximum benefit has been achieved, as determined by OHCA. The maximum benefit is determined individually for each beneficiary served by the HMP, and considers diagnoses, goals, and progress achieved.

IX. MONITORING AND REPORTING REQUIREMENTS

39. **Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

    The following process will be used: 1) 30 calendar days after the deliverable was due if the state has not submitted a written request to CMS for approval of a renewal as described in subsection (b) below; or 2) 30 calendar days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non–compliant submissions of required deliverable(s).

b. For each deliverable, the state may submit to CMS a written request for a renewal to submit the required deliverable. The renewal request must explain the reason why the required deliverable was not submitted, the steps the state has taken to address such issue, and the state's anticipated date of submission. Should CMS agree in writing to the state's request, a corresponding renewal of the deferral process described below can be provided. CMS may agree to a corrective action plan as an interim step before applying the deferral, if corrective action is proposed in the state's written renewal request.

c. If CMS agrees to an interim corrective process in accordance with subsection (b), and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) that meets the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

d. If the CMS deferral process has been initiated for state non–compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.

As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations, and other deliverables will be considered by CMS in reviewing any application for a renewal, amendment, or for a new demonstration.

40. **Submission of Post-Approval Deliverables.** The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs, unless CMS and the state mutually agree to another timeline.

41. **Compliance with Federal Systems Updates**. As federal systems continue to evolve and incorporate additional section 1115 demonstration reporting and analytics functions, the state will work with CMS to:

    a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

    b. Ensure all section 1115 demonstration, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and

c. Submit deliverables to the appropriate system as directed by CMS.

42. **Monitoring Reports**. The state must submit one Annual Monitoring Report each demonstration year (DY) that is due no later than 180 calendar days following the end of the DY. The state must submit a revised Annual Monitoring Report within 60 calendar days after receipt of CMS's comments, if any. CMS might increase the frequency of monitoring reporting if CMS determines that doing so would be appropriate. CMS will make on-going determinations about reporting frequency under the demonstration by assessing the risk that the state might materially fail to comply with the terms of the approved demonstration during its implementation and/or the risk that the state might implement the demonstration in a manner unlikely to achieve the statutory purposes of Medicaid. See 42 CFR 431.420(d)(1)-(2).

The Annual Monitoring Report will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Annual Monitoring Report must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve and must be provided in a structured manner that supports federal tracking and analysis.

a. Operational Updates. Per 42 CFR 431.428, the Annual Monitoring Report must document any policy or administrative difficulties in operating the demonstration. The Annual Monitoring Report must provide sufficient information to document key operational and other challenges, underlying causes of challenges, and how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Annual Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. Performance Metrics. The performance metrics will provide data to demonstrate the state's progress towards meeting the demonstration's goals and any applicable milestones. Per 42 CFR 431.428, the Annual Monitoring Report must document the impact of the demonstration on beneficiaries' outcomes of care, quality and overall cost of care, and access to care, as applicable. This should also include the results of beneficiary satisfaction or experience of care surveys, if conducted, as well as grievances and appeals. The Annual Monitoring Report must provide detailed information about deviations from CMS's applicable metrics technical specifications, relevant methodology, plans for phasing in metrics, and data or reporting issues for applicable metrics, in alignment with CMS guidance and technical assistance.

The state and CMS will work collaboratively to finalize the list of metrics to be reported on in the Annual Monitoring Report. The demonstration's monitoring metrics must cover categories to include, but not be limited to, eligibility, utilization of services, quality of care and health outcomes, and grievances and appeals. The state must report these metrics for all demonstration populations. The state is expected to report applicable monitoring metrics to cover the waiver of retroactive eligibility policy, including unpaid medical bills. Demonstration monitoring reporting does not duplicate or replace reporting requirements for other authorities, such as Home and Community Based Services and Managed Care authorities.

The reporting of these monitoring metrics may also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, or geography) and by demonstration component, as appropriate. Subpopulation reporting can support identifying any gaps in quality of care and health outcomes, and help track whether the demonstration's initiatives help improve outcomes for the state's Medicaid population.

c. **Evaluation Activities and Interim Findings.** Per 42 CFR 431.428, the Annual Monitoring Report must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

43. **Corrective Action Plan Related to Monitoring**. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A state corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10. CMS might withdraw an authority, as described in STC 10, if metrics indicate substantial and sustained directional change inconsistent with the state's demonstration goals and desired directionality, and the state has not implemented corrective action, and the circumstances described in STC 10, are met. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

44. **Close-Out Report**. Within 120 calendar days after the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

i. The Close-Out Report must comply with the most current guidance from CMS.

ii. In consultation with CMS, and per guidance from CMS, the state will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without renewal along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval period, in agreement with CMS, the evaluation requirement may be satisfied through the Interim or Summative Evaluation Reports stipulated in STCs 53 and 54, respectively.

iii. The state will present to and participate in a discussion with CMS on the Close–Out Report.

iv. The state must take into consideration CMS's comments for incorporation into the final Close-Out Report.

v. A revised Close-Out Report is due to CMS no later than 30 calendar days after receipt of CMS's comments.

vi. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 39.

45. **Monitoring Calls**. CMS will convene, no less frequently than quarterly, monitoring calls with the state.

i. The purpose of these calls is to discuss ongoing demonstration operations and implementation which align with the state's demonstration monitoring reports, including (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, eligibility and access, and progress on evaluation activities.

ii. These calls will follow the structure of and focus on the topics in the Annual Monitoring Report.

iii. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

iv. The state and CMS will jointly develop the agenda for the calls.

46. **Post Award Forum**. Pursuant to 42 CFR 431.420(c), within six months of the demonstration's implementation and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 calendar days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent Annual Monitoring Report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the public comments in the Annual Monitoring Report associated with the year in which the forum was held.

X. EVALUATION OF THE DEMONSTRATION

47. **Cooperation with Federal Evaluators and Learning Collaborative.** As required under 42

CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required under 42 CFR 431.420(f). This may also include the state's participation – including representation from the state's contractors, independent evaluators, and organizations associated with the demonstration operations, as applicable – in a federal learning collaborative aimed at cross-state technical assistance, and identification of lessons learned and best practices for demonstration measurement, data development, implementation, monitoring and evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 39.

48. **Independent Evaluator.** The state must use an independent entity (herein referred to as the Independent Evaluator) to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The Independent Evaluator must sign an agreement to conduct the demonstration evaluation in an independent manner in accordance with the CMS-approved Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

49. **Evaluation Design.** The state must submit, for CMS comment and approval, an Evaluation Design with implementation timeline no later than 180 calendar days after the approval of the demonstration. The Evaluation Design must be developed in accordance with the STCs and any applicable CMS evaluation guidance and technical assistance for the demonstration's policy components. The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi- experimental methods like difference-in-differences and interrupted time series, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations.

    The state is strongly encouraged to use the expertise of the Independent Evaluator in the development of the Evaluation Design. The Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STCs 53 and 54.

    For any amendment to the demonstration, the state will be required to update the approved Evaluation Design to accommodate the amendment component, unless otherwise agreed upon by the state and CMS. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. The amendment components of the Evaluation Design must also be reflected in the state's Interim and Summative Evaluation Reports, described below.

50. **Evaluation Design Approval and Updates**. The state must submit a revised Evaluation Design within 60 calendar days after receipt of CMS's comments, if any. Upon CMS approval of the Evaluation Design, the document will be posted to Medicaid.gov. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within 30 calendar days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation progress in each Annual Monitoring Report. Once CMS approves the Evaluation Design, if the state wishes to make changes and the changes are substantial in scope, the state must submit a revised Evaluation Design to CMS for approval; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in an Annual Monitoring Report.

51. **Evaluation Questions and Hypotheses.** Consistent with the STCs and applicable CMS guidance, the evaluation deliverables must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding of the demonstration's impact and its effectiveness in achieving the demonstration's goals.

    The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must study outcomes, such as eligibility and various measures of access, utilization, costs, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance for the demonstration policy components. The evaluation is expected to use applicable demonstration monitoring and other data on the provision of and beneficiary utilization of demonstration and other applicable services. Proposed measures should be selected from nationally recognized sources and national measures sets, where possible. Measures sets could include the Consumer Assessment of Health Care Providers and Systems (CAHPS), the Medicaid and CHIP Core Sets of Health Care Quality measures, commonly referred to as the Child and Adult Core Sets, the Behavioral Risk Factor Surveillance System (BRFSS) survey, or measures endorsed by National Quality Forum (NQF).

    The state must develop robust evaluation questions and hypotheses related to each demonstration initiative, and per applicable CMS guidance. The state must also collect necessary data to accommodate CMS's evaluation expectations to assess the effects of the waiver retroactive eligibility on beneficiaries and providers, for example, by examining outcomes such as timely enrollment and renewal, enrollment continuity, as well as beneficiary financial status, including changes in incidence of medical debt, and provider uncompensated care costs.

    As part of its evaluation efforts, the state must also conduct an overall demonstration cost assessment to include, but not be limited to, administrative costs of demonstration implementation and operation and Medicaid health services expenditures. In addition, the state must use findings from hypothesis tests aligned with other demonstration goals and cost analyses to assess the demonstration's effects on the fiscal sustainability of the state's Medicaid program.

CMS underscores the importance of the state undertaking a well-designed beneficiary survey or interviews to assess, for instance, beneficiary understanding of the demonstration policy components and beneficiary experiences with access to and quality of care. To better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of—and barriers to—implementation, the state is strongly encouraged to undertake a robust process/implementation evaluation. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

Finally, the state may collect data to support analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, or geography). Such stratified data analyses can provide a fuller understanding of gaps in access to and quality of care and health outcomes, as well as help inform how the demonstration's various policies support improving outcomes.

52. **Evaluation Budget.** A budget for the evaluations must be provided with the Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluations such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the designs are not sufficiently developed, or if the estimates appear to be excessive.

53. **Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). The draft Interim Evaluation Report must be developed in alignment with the approved Evaluation Design, and in accordance with the requirements outlined in these STCs and applicable CMS guidance.

    a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved Evaluation Design.

    b. For demonstration authority or any component within the demonstration that expires prior to the overall demonstration's expiration date, and depending on the timeline of the expiration/phase-out, the Interim Evaluation Report must include an evaluation of the authority, to be collaboratively determined by CMS and the state.

    c. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted, or one year prior to the end of the demonstration, whichever is sooner. When applying for a renewal of the demonstration, the Interim Evaluation Report should be posted to the state's website with the application for public comment. If the state does not request a renewal for the demonstration, the Interim Evaluation Report is due one year prior to the end of the demonstration. For demonstration phase-outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

d. The state must submit a revised Interim Evaluation Report 60 calendar days after receiving CMS comments on the draft Interim Evaluation Report, if any.

e. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's Medicaid website within 30 calendar days.

54. **Summative Evaluation Report.** The state must submit the draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be developed in alignment with the approved Evaluation Design, and in accordance with the requirements outlined in these STCs and applicable CMS guidance.

   a. The state must submit a revised Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft Summative Evaluation Report, if any.

   b. Once approved by CMS, the state must post the final Summative Evaluation Report to the state's Medicaid website within 30 calendar days.

55. **Corrective Action Plan Related to Evaluation.** If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of a renewal process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

56. **State Presentations for CMS.** CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation Report, or the Summative Evaluation Report.

57. **Public Access.** The state shall post the final documents (e.g., Annual Monitoring Report, Close-Out Report, Evaluation Design, Interim Evaluation Report, and Summative Evaluation

Report) on the state's Medicaid website within 30 calendar days of approval by CMS.

58. **Additional Publications and Presentations**. For a period of 12 months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given 30 calendar days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews.

XI. GENERAL FINANCIAL REQUIREMENTS

59. **Allowable Expenditures.** This demonstration project is approved for authorized demonstration expenditures applicable to services rendered and for costs incurred during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.

60. **Standard Medicaid Funding Process.** The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

61. **Sources of Non-Federal Share.** As a condition of demonstration approval, the state certifies that its funds that make up the non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.

a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.

b. If CMS determines that any funding sources are not consistent with applicable federal statutes or regulations, the state must address CMS's concerns within the time frames allotted by CMS.

c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

62. State Certification of Funding Conditions. As a condition of demonstration approval, the state certifies that the following conditions for non-federal share financing of demonstration expenditures have been met:

a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the state must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with section 1903(w) of the Act and applicable implementing regulations.

b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state identifies those costs eligible for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. The federal financial participation paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c).

c. The state may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.

d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third parties to return and/or redirect to the state any portion of the Medicaid payments in a manner inconsistent with the requirements in section 1903(w) of the Act and its implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

e. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

63. **Financial Integrity for Managed Care Delivery Systems.** As a condition of demonstration approval, the state attests to the following, as applicable:

   a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR 438.6(b)(2), 438.6(c), 438.6(d), 438.60, and 438.74.

   b. For non-risk-based PIHPs and PAHPs, arrangements comply with the upper payment limits specified in 42 CFR 447.362, and if payments exceed the cost of services, the state will recoup the excess and return the federal share of the excess to CMS.

64. **Requirements for Health Care-Related Taxes and Provider Donations.** As a condition of demonstration approval, the state attests to the following, as applicable:

   a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).

   b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).

   c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR 433.72.

   d. The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Act and 42 CFR 433.68(f).

   e. All provider-related donations as defined by 42 CFR 433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Social Security Act, 42 CFR 433.66, and 42 CFR

433.54.

65. **State Monitoring of Non-federal Share.** If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than 60 days after demonstration approval. This deliverable is subject to the deferral as described in STC 39. This report must include:

    a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state, or other entities relating to each locality tax or payments received that are funded by the locality tax;

    b. Number of providers in each locality of the taxing entities for each locality tax;

    c. Whether or not all providers in the locality will be paying the assessment for each locality tax;

    d. The assessment rate that the providers will be paying for each locality tax;

    e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;

    f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;

    g. The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR 433.68(f); and

    h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under section 1903(w) of the Act.

66. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures, subject to the budget neutrality expenditure limits described in the STCs in section XII:

    a. Administrative costs, including those associated with the administration of the demonstration;

    b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan;

    c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration renewal period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third-party liability; and

d. Net premiums and net medical assistance expenditures for persons enrolled in the Insure Oklahoma Program.

67. **Program Integrity.** The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

68. **Medicaid Expenditure Groups.** Medicaid Expenditure Groups (MEG) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Table 1: Master MEG Chart

MEG	Which BN Test Applies?	WOW Per Capita	WOW Aggre gate	WW	Brief Description
ABD-Urban	Main	X		X	Expenditures for aged, blind, and disabled individuals enrolled in the demo for the purposes of utilizing the HAN and HMP, receiving services in the designated Central, Northeast, and Southwest urban areas of the state.
ABD-Rural	Main	X		X	Expenditures for aged, blind, and disabled individuals enrolled in the demo for the purposes of utilizing the HAN and HMP, receiving services in the rural areas of the state.
TANF-Urban	Main	X		X	Expenditures for TANF individuals enrolled in the demo for the purposes of utilizing the HAN and HMP, receiving services in the designated Central, Northeast, and Southwest urban areas of the state.
TANF-Rural	Main	X		X	Expenditures for TANF individuals enrolled in the demo for the purposes of utilizing the HAN and HMP, receiving services in the rural area of the state.

Table 1: Master MEG Chart					
MEG	**Which BN Test Applies?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
Employer-Sponsored Health Insurance	Hypo	X		X	Employer-sponsored health insurance populations work for qualifying employers and have incomes no greater than 200 percent of the FPL. This population includes non-disabled low-income workers and their spouses, low income working disabled adults and their spouses, no more than 3,000 full-time college students ages 19 through 22, foster parents, and employees and spouses of not-for-profit businesses with 500 or fewer employees.
HAN Expenditures	Main			X	PMPM Expenditures made to the HANs.
HMP Expenditures	Main			X	Operational and other expenditures to provide health coaches and practice facilitation services through the Health Management Program and for individuals not covered under managed care (e.g. AI/AN populations).

BN – budget neutrality; MEG – Medicaid expenditure group; WOW – without waiver; WW – with waiver

69. **Reporting Expenditures Under the Demonstration.** The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00048/6). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number renewal). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

    a. **Cost Settlements**. The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b (in lieu of lines 9 or 10c), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

b. **Premiums and Cost Sharing Collected by the State.** The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by demonstration year on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.

c. **Pharmacy Rebates.** Because pharmacy rebates are not included in the base expenditures used to determine the budget neutrality expenditure limit, pharmacy rebates are not included for calculating net expenditures subject to budget neutrality. The state will report pharmacy rebates on form CMS-64.9 BASE, and not allocate them to any form 64.9 or 64.9P WAIVER.

d. **Administrative Costs.** The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the MEG Charts and in the STCs in section XIV, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

e. **Member Months.** Using the Budget Neutrality Monitoring Tool, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months per person, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

f. **Budget Neutrality Specifications Manual.** The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 2: MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 or 64.10 Line(s) to Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**Meg Start Date**	**Meg End Date**
ABD-Urban	Expenditures for aged, blind, and disabled individuals enrolled in the demo for the purposes of utilizing the HAN and HMP, receiving services in the designated Central, Northeast, and Southwest urban areas of the state.				MAP	Y	01/01/2027	12/31/2031
ABD-Rural	Expenditures for aged, blind, and disabled individuals enrolled in the demo for the purposes of utilizing the HAN and HMP, receiving services in the rural areas of the				MAP	Y	01/01/2027	12/31/2031

	state.							
TANF-Urban	Expenditures for TANF individuals enrolled in the demo for the purposes of utilizing the HAN and HMP, receiving services in the designated Central, Northeast, and Southwest urban areas of the state.				MAP	Y	01/01/2027	12/31/2031
TANF-Rural	Expenditures for TANF individuals enrolled in the demo for the purposes of utilizing the HAN and HMP, receiving services in the rural area of the state.				MAP	Y	01/01/2027	12/31/2031
Employer-Sponsored Health Insurance	Employer-sponsored health insurance populations work for qualifying employers and have incomes no greater than 200 percent of the FPL. This population includes non-		Follow standard CMS-64.9 Category of Service Definitions		MAP	Y	01/01/2027	12/31/2031

	disabled low income workers and their spouses, low income working disabled adults and their spouses, no more than 3,000 full-time college students ages 19 through 22, foster parents, and employees and spouses of not-for-profit businesses with 500 or fewer employees.							
HAN Expenditures	PMPM Expenditures made to the HANs.				MAP	Y	01/01 /2027	12/3 1/20 31
HMP Expenditures	Expenditures to provide health coaches and practice facilitation services through the Health Management Program.				MAP	Y	01/01 /2027	12/3 1/20 31

70. **Demonstration Years.** Demonstration Years (DY) for this demonstration are defined in the table below.

Demonstration Years		
Demonstration Year 32	January 1, 2027 to December 31, 2027	12 months
Demonstration Year 33	January 1, 2028 to December 31, 2028	12 months

Demonstration Year 34	January 1, 2029 to December 31, 2029	12 months
Demonstration Year 35	January 1, 2030 to December 31, 2030	12 months
Demonstration Year 36	January 1, 2031 to December 31, 2031	12 months

71. **Budget Neutrality Monitoring Tool.** The state must provide CMS with annual budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the performance metrics database and analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing the demonstration's actual expenditures to the budget neutrality expenditure limits described in section XII. CMS will provide technical assistance, upon request.[1]

72. **Claiming Period.** The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

73. **Future Adjustments to Budget Neutrality.** CMS reserves the right to adjust the budget neutrality expenditure limit:

    a. To be consistent with enforcement of laws and policy statements, including regulations and guidance, regarding impermissible provider payments, health care related taxes, or other payments. CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

    b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified

[1] Per 42 CFR 431.420(a)(2), states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and 431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and states agree to use the tool as a condition of demonstration approval.

agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

c. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

74. **Budget Neutrality Mid-Course Correction Adjustment Request.** No more than once per demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

a. **Contents of Request and Process**. In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 74(c). If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. After acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 7. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

b. **Types of Allowable Changes.** Adjustments will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:

    a. Provider rate increases that are anticipated to further strengthen access to care;

b. CMS or State technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;

c. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;

d. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;

e. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;

f. High cost innovative medical treatments that states are required to cover; or,

g. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.

c. **Budget Neutrality Update.** The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:

i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and

ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

XII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

75. Limit on Title XIX Funding. The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit consists of a Main Budget Neutrality Test and one Hypothetical Budget Neutrality Test, as described below. CMS's assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

76. Risk. The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 1, the Master MEG Chart, and Table 2, the MEG Detail for Expenditure and Member Month Reporting. Oklahoma shall be at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions, however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

77. **Calculation of the Budget Neutrality Limits and How They Are Applied.** To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

78. **Main Budget Neutrality Test.** The Main Budget Neutrality Test allows the state to show that approval of the demonstration has not resulted in Medicaid costs to the federal government that are greater than what the federal government's Medicaid costs would likely have been absent the demonstration, and that federal Medicaid "savings" have been achieved sufficient to offset the additional projected federal costs resulting from expenditure authority. The table below identifies the MEGs that are used for the Main Budget Neutrality Test. MEGs designated as "WOW Only" or "Both" are components used to calculate the budget neutrality expenditure limit. MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against the budget neutrality expenditure limit. In addition, any expenditures in excess of the limit from Hypothetical Budget Neutrality Test counts as expenditures under the Main Budget Neutrality Test. The Composite Federal Share for this test is calculated based on all MEGs indicated as "Both."

Table 3: Main Budget Neutrality Test								
MEG	PC or Agg *	WOW Only, WW Only, or BOTH	Trend Rate	DY 32	DY 33	DY 34	DY 35	DY 36
TANF-Urban	PC	Both	4.8%	$ 938.40	$ 983.44	$ 1,030.65	$ 1,080.12	$ 1,131.97
TANF-Rural	PC	Both	5.1%	$ 1,397.49	$ 1,468.76	$ 1,543.67	$ 1,622.40	$ 1,705.14
ABD-Urban	PC	Both	4.8%	$ 1,241.24	$ 1,300.82	$ 1,363.26	$ 1,428.70	$ 1,497.28
ABD-Rural	PC	Both	2.8%	$ 1,512.89	$ 1,555.25	$ 1,598.80	$ 1,643.57	$ 1,689.59
HAN Expenditures	Agg	WW only	5.3%	$ 5,537,849	$ 5,831,355	$ 6,140,417	$ 6,465,859	$ 6,808,550
HMP Expenditures	Agg	WW only	5.3%	$ 16,755,436	$ 17,643,474	$ 18,578,578	$ 19,563,243	$ 20,600,095

*PC = Per Capita, Agg = Aggregate. The PMPM costs above are net of premiums paid by demonstration eligibles.

79. **Hypothetical Budget Neutrality.** When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be "hypothetical," such that the expenditures are treated as if the state could have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical

spending exceeds the Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

80. **Hypothetical Budget Neutrality Test 1**: Employer-Sponsored Health Insurance. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 1 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 4: Hypothetical Budget Neutrality Test 1

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 32	DY 33	DY 34	DY 35	DY 36
Employer-Sponsored Health Insurance	PC	Both	5.1%	$ 478.75	$ 503.17	$ 528.83	$ 555.80	$ 584.15

81. **Composite Federal Share.** The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

82. **Exceeding Budget Neutrality.** CMS will enforce the budget neutrality agreement over the demonstration period, which extends from January 1, 2027 through December 31, 2031. The Main Budget Neutrality Test for this demonstration period may incorporate carry forward savings, that is, net savings from up to 10 years of the immediately prior demonstration approval period(s) January 1, 2027 through December 31, 2031. If at the end of the demonstration approval period the Main Budget Neutrality Test or the Hypothetical Budget

Neutrality Test has been exceeded, the excess federal funds will be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

83. **Budget Neutrality Savings Cap.** The amount of savings available for use by the state during this demonstration period will be limited to the lower of these two amounts: 1) the savings amount the state has available in the current demonstration period, including carry-forward savings as described in STC 82, or 2) 15 percent of the state's projected total Medicaid expenditures in aggregate for this demonstration period. This projection will be determined by taking the state's total Medicaid spending amount in its most recent year with completed data and trending it forward by the President's Budget trend rate for this demonstration period. Fifteen percent of the state's total projected Medicaid expenditures for this demonstration period is $8,484,439,899.

84. **Corrective Action Plan.** If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Budget Neutrality Test Corrective Action Plan Calculation		
Demonstration Year	**Cumulative Target Definition**	**Percentage**
DY 32	Cumulative budget neutrality limit plus:	2.0 percent
DY 32 through DY 33	Cumulative budget neutrality limit plus:	1.5 percent
DY 33 through DY 34	Cumulative budget neutrality limit plus:	1.0 percent
DY 34 through DY 35	Cumulative budget neutrality limit plus:	0.5 percent
DY 35 through DY 36	Cumulative budget neutrality limit plus:	0.0 percent

XIII. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION

Deliverable	Timeline	STC Reference
Evaluation Design	No later than 180 calendar days after approval of the demonstration. Revised no later than 60 days after receipt of CMS comments.	STCs 49 and 50

Interim Evaluation Report	One year prior to the end of the demonstration period, or when the renewal application is submitted, whichever is sooner. Revised no later than 60 calendar days after receipt of CMS comments.	STC 53
Summative Evaluation Report	No later than 18 months after the end of the demonstration period. Revised no later than 60 calendar days after receipt of CMS comments.	STC 54
Annual Monitoring Report	No later than 180 calendar days after the end of each demonstration year.	STC 42

Attachment A: Evaluation Design [Reserved]