

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

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

## Facesheet

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

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

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

**Type of request.** This is an:

- initial request for new waiver. All sections are filled.
- amendment request for existing waiver, which modifies Section/Part
  - Replacement pages are attached for specific Section/Part being amended (note: the State may, at its discretion, submit two versions of the replacement pages: one with changes to the old language highlighted (to assist CMS review), and one version with changes made, i.e. not highlighted, to actually go into the permanent copy of the waiver).
  - Document is replaced in full, with changes highlighted

renewal request

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

Section A is  replaced in full  
 carried over from previous waiver period. The State:

- assures there are no changes in the Program Description from the previous waiver period.
- assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.

Section B is  replaced in full  
 carried over from previous waiver period. The State:

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

**Effective Dates:** This waiver/**renewal**/amendment is requested for a period of 2 years; **effective July 1, 2026**, and ending **June 30, 2028**. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)

**State Contact:** The State contact person for this waiver is Melissa Miller and can be reached by telephone at **(405) 693-8260**, or e-mail at **Melissa.Miller@okhca.org**. (Please list for each program)

## **Section A: Program Description**

### **Part I: Program Overview**

#### **Tribal consultation**

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

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

- **Meeting #1 – regularly scheduled tribal consultation: July 7, 2020**
- **Meeting #2 – tribal policy workgroup: July 21, 2020**
- **Meeting #3– tribal policy workgroup: July 30, 2020**
- **Meeting #4 – regularly scheduled tribal consultation: September 1, 2020**
- **Meeting #5– tribal policy workgroup: October 8, 2020**
- **Meeting #6– regularly scheduled tribal consultation: November 3, 2020**
- **Meeting #7– regularly scheduled annual tribal meeting: November 14, 2020**
- **Meeting #8– regularly scheduled tribal consultation: January 5, 2021**
- **Meeting #9 – regularly scheduled tribal consultation: June 8, 2022**
- **Meeting #10 – regularly scheduled tribal consultation: November 1, 2022**
- **Meeting #11 – regularly scheduled tribal consultation: January 3, 2023**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The State proposed to amend the SoonerSelect choice period and clarify the populations included and excluded from the waiver and presented this revision during the regularly scheduled tribal consultation held on November 5, 2024. One comment was received requesting clarification regarding the proposed change and its potential impact on the tribal population OHCA provided clarification regarding the amendment.

The State proposed to amend the cost effectiveness information and presented this revision during the regularly scheduled tribal consultation held on July 1, 2025. No comments were received from tribal partners.

In advance of the State's first 1915(b) waiver renewal request for the SoonerSelect program, OHCA conducted formal tribal consultation on January 6, 2026, offering both in-person and teleconference participation. The consultation was well attended, with 102 stakeholders participating. During the meeting, OHCA provided an overview of the upcoming 1915(b) waiver renewal, including anticipated technical and administrative updates as well as revisions to monitoring and oversight requirements. No questions or concerns were raised regarding the 1915(b) waiver renewal.

### **Program History**

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

The Oklahoma Health Care Authority (OHCA) is the single state agency responsible for administering Oklahoma's Medicaid program, SoonerCare, that serves over 1 million Oklahomans, by connecting individuals with a comprehensive array of medical, behavioral health, dental, and non-emergency medical transportation services. In 2022, Oklahoma issued three Request for Proposals (RFPs), in alignment with 56 O.S. 4002.3a, the Ensuring Access to Medicaid Act, to operationalize SoonerSelect. As outlined in the RFPs, Oklahoma sought to transition the State's Medicaid fee-for-service program to a comprehensive managed care program, for the following populations:

- Children;
- Pregnant women;
- Deemed newborns;
- Parent and caretaker relatives;
- Expansion adults;
- Former foster care children;

- Juvenile justice involved children;
- Foster care children; and
- Children receiving adoption assistance.

American Indian/Alaska Native members were considered a voluntary enrollment population and had the choice to opt into SoonerSelect.

The overall goals of the SoonerSelect program include:

- Improving health outcomes for Medicaid members and the State as a whole;
- Ensuring budget predictability through shared risk and accountability;
- Ensuring access to care, quality measures, and member satisfaction;
- Ensuring efficient and cost-effective administrative systems and structures; and
- Ensuring a sustainable delivery system that is a provider-led effort and that is operated and managed by providers to the maximum extent possible.

On February 1, 2024, OHCA launched the first of 3 managed care programs, SoonerSelect Dental. Two dental prepaid ambulatory health plans (PAHPs) were selected through a competitive bidding process to administer comprehensive dental benefits to eligible members, DentaQuest and Liberty Dental Plan of Oklahoma.

Shortly thereafter, the SoonerSelect and SoonerSelect Children's Specialty Program were launched on April 1, 2024. Three managed care organizations (MCOs) were selected through the competitive bidding process to administer medical benefits to eligible members enrolled in the SoonerSelect program, Aetna Better Health of Oklahoma, Humana Healthy Horizons in Oklahoma, and Oklahoma Complete Health, Inc. Oklahoma Complete Health, Inc was also the single plan selected to administer the SoonerSelect Children's Specialty Program which provides comprehensive medical services for children in foster care, former foster care children, juvenile justice involved children and children receiving adoption assistance.

In December of 2023, OHCA issued an additional RFP for an end-to-end platform that ingests managed care plan report submissions and provides real-time data analysis results through dashboarding and other reporting methodologies. Through the competitive bidding process, a contract was awarded to Accenture for the implementation of the Managed Care Insights Tool. Implementation efforts were launched in January 2025, with a planned go-live date of May 1, 2026. OHCA is actively collaborating with the SoonerSelect MCOs and PAHPs, Gainwell (Oklahoma's Medicaid Managed Care Information systems vendor), and Accenture to complete design and testing prior to go-live. In the interim, OHCA is monitoring and reviewing all MCO and PAHP reporting through internal processes and procedures.

**Additionally, between May 1-June 13, 2025, Oklahoma initiated its first open enrollment period for all three (3) SoonerSelect programs, offering the opportunity for members to make plan changes ahead of the second year of the program. Plan changes requested during the open enrollment period took effect on July 1, 2025. OHCA's choice counselors were available to provide unbiased choice counseling to help members feel informed about plan options and the selection process.**

## A. Statutory Authority

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

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

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

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

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

- a. \_\_\_ **Section 1902(a)(1)** - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.
- b. \_\_\_ **Section 1902(a)(10)(B)** - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program.
- c. X **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM.  
  
With the exception of voluntary populations, namely AI/AN populations, enrollees will be mandatorily enrolled into an MCO for medical services and a PAHP for dental services.
- d. \_\_\_ **Section 1902(a)(4)** - To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here).
- e. \_\_\_ **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.

## B. Delivery Systems

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

a.  **MCO**: Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.

b.  **PIHP**: Prepaid Inpatient Health Plan means an entity that:  
provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.

The PIHP is paid on a risk basis.

The PIHP is paid on a non-risk basis.

c.  **PAHP**: Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. This includes capitated PCCMs.

The PAHP is paid on a risk basis.

The PAHP is paid on a non-risk basis.

d.  **PCCM**: A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis. Note: a capitated PCCM is a PAHP.

e.  **Fee-for-service (FFS) selective contracting**: A system under which the State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards. Reimbursement is:

the same as stipulated in the state plan

is different than stipulated in the state plan (please describe)

f.  **Other**: (Please provide a brief narrative description of the model.)

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

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

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

### 1. Assurances.

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

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

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

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

### 3. Rural Exception.

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

### 4. 1915(b)(4) Selective Contracting

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

**D. Geographic Areas Served by the Waiver**

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

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

**Less than Statewide**

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

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

## E. Populations Included in Waiver

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

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

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

Mandatory enrollment  
 Voluntary enrollment

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

Mandatory enrollment  
 Voluntary enrollment

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

Mandatory enrollment  
 Voluntary enrollment

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

Mandatory enrollment  
 Voluntary enrollment

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

Mandatory enrollment  
 Voluntary enrollment

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

Mandatory enrollment  
 Voluntary enrollment

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

Mandatory enrollment  
 Voluntary enrollment

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

Mandatory enrollment  
 Voluntary enrollment

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

Mandatory enrollment  
 Voluntary enrollment

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

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

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

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

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

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

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

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

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

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

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

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

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

**Other** (Please define):

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

**Individuals enrolled in the Medicare Savings Program.**

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

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

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

**Undocumented persons eligible for Emergency Services only in accordance**

**with 42 C.F.R. § 435.139.**

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

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

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

## F. Services

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

### 1. Assurances.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

#### **5. EPSDT Requirements.**

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

#### **6. 1915(b)(3) Services.**

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

#### **7. Self-referrals.**

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

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

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

## Section A: Program Description

### Part II: Access

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

#### A. Timely Access Standards

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

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

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

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

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

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

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

1.  PCPs (please describe):

2.  Specialists (please describe):

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

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

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

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

1. \_\_\_ PCPs (please describe):
2. \_\_\_ Specialists (please describe):
3. \_\_\_ Ancillary providers (please describe):

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

d. \_\_\_ **Other Access Standards** (please describe)

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

## B. Capacity Standards

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

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

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

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

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

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

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

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

<b>Providers</b>	<b># Before Waiver</b>	<b># In Current Waiver</b>	<b># Expected in Renewal</b>
Family Practitioners			
Internists			
General Practitioners			
OB/GYN and GYN			
FQHCs			
RHCs			
Nurse Practitioners			
Nurse Midwives			
Indian Health Service Clinics			
Additional Types of Provider to be in PCCM			

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

- e. \_\_\_ The State ensures adequate **geographic distribution** of PCCMs. Please describe the State's standard.
- f. \_\_\_ **PCP: Enrollee Ratio.** The State establishes standards for PCP to enrollee ratios. Please calculate and list below the expected average PCP/Enrollee ratio for each area or county of the program, and then provide a statewide average. Please note any changes that will occur due to the use of physician extenders.

<i>Area(City/County/Region)</i>	<i>PCCM-to-Enrollee Ratio</i>
<i>Statewide Average: (e.g. 1:500 and 1:1,000)</i>	

- g. \_\_\_ **Other capacity standards** (please describe):

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

## C. Coordination and Continuity of Care Standards

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

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

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

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

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

The following items are required.

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

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

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

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

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

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

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

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

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

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

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

## **LIBERTY**

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

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

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

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

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

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

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

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

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

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

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

### **DentaQuest**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## Section A: Program Description

### Part III: Quality

#### 1. Assurances for MCO or PIHP programs.

X The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 in so far as these regulations are applicable.

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

X The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

X Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. The State assures CMS that this **quality strategy** was initially submitted to the CMS Regional Office on **September 6, 2023**.

X The State assures CMS that it complies with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, **external quality review** of the outcomes and timeliness of, and access to the services delivered under each MCO/PIHP contract. Note: EQR for PIHPs is required beginning March 2004. Please provide the information below (modify chart as necessary):

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

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

				strategy, including advising on a quality rating system for program MCOs.
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*\*KFMC is under contract to conduct the four mandatory EQR-related activities for MCOs and PAHPs. In addition to conducting the mandatory activities, KFMC will also conduct the optional activity of validating plans' encounter data. .*

**2. Assurances For PAHP program.**

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

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

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

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

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

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

1. \_\_\_ Provide education and informal mailings to beneficiaries and PCCMs;

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

3. \_\_\_ Request PCCM's response to identified problems;

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

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

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

1. \_\_\_ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).
2. \_\_\_ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.
3. \_\_\_ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process

that updates information obtained through the following (check all that apply):

Initial credentialing

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

The utilization management system.

The complaint and appeals system.

Enrollee surveys.

Other (Please describe).

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

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

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

5.  Other (please describe).

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

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

## Section A: Program Description

### Part IV: Program Operations

#### A. Marketing

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

##### 1. Assurances

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

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

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

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

##### 2. Details

###### a. **Scope of Marketing**

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

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

**The State permits marketing by MCO/PAHPs via:**

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

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

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

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

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

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

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

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

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

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

## B. Information to Potential Enrollees and Enrollees

### 1. Assurances.

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

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

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

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

### 2. Details.

#### a. Non-English Languages

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

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

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

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

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

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

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

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

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

#### **b. Potential Enrollee Information**

Information is distributed to potential enrollees by:

State  
 contractor (please specify) **Maximus**

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

#### **c. Enrollee Information**

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

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

## C. Enrollment and Disenrollment

### 1. Assurances.

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

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

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

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

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

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

### b. **Administration of Enrollment Process.**

State staff conducts the enrollment process.

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

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

Broker name: Maximus

Please list the functions that the contractor will perform:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**d. Disenrollment:**

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

- i. \_\_\_ Enrollee submits request to State.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## **D. Enrollee rights.**

### **1. Assurances.**

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

## E. Grievance System

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

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

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

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

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

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

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

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

### **3. Details for MCO or PIHP programs.**

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

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

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

b. **Timeframes**

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

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

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

c. **Special Needs**

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

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

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

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

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

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

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

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

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

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

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

**The PAHP shall:**

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

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

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

**Grievances**

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

### **Appeals**

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

### **State Fair Hearings**

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

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

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

### **Grievances**

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

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

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

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

### **Appeals**

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

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

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

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

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

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

Specify the time frame set by the State for this process

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

\_\_\_\_ Other (please explain):

## **F. Program Integrity**

### **1. Assurances.**

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

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

### **2. Assurances For MCO or PIHP programs**

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

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

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

## Section B: Monitoring Plan

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

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

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

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

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

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

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

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

## **I. Summary Chart of Monitoring Activities**

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

Please note:

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

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

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

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



## II. Details of Monitoring Activities

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

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

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

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

NCQA

JCAHO

AAAHC

Other (please describe)

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

### ***Applicable Programs***

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

### ***Personnel Responsible***

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

### ***Detailed Description of Activity***

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

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

***Frequency of Use***

The EQR is performed annually.

***How the Activity will be Applied to the Areas being Monitored***

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

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

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

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

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

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

***Applicable Programs***

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

***Personnel Responsible***

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

***Detailed Description of Activity***

MCOs/PAHP contractors must be accredited by an HHS-recognized Accrediting Entity within 18 months of Operations Start Date (Contract Section 1.4.2 – all versions).

Additionally, MCO contractors must also earn National Committee for Quality Assurance (NCQA) Health Outcomes Accreditation, formerly known as Health Equity Accreditation, within two (2) years of Operations Start Date. (Contract Section 1.4.2 – all versions).

***Frequency of Use***

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

Evidence of NCQA Health Outcomes Accreditation must be provided within 2 years of Operations Start Date and at time of accreditation renewal.

***How the Activity will be Applied to the Areas being Monitored***

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

- Marketing – MCO/PAHP policies/procedures and marketing practices will be evaluated for adherence to federal standards.
- Program Integrity – MCO/PAHP policies/procedures and program integrity audits will be evaluated for sufficiency and to ensure appropriate follow-up actions are taken when findings occur.

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

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

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

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

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

***Applicable Programs***

MCO and PAHP

***Personnel Responsible***

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

***Detailed Description of Activity***

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

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

***Frequency of Use***

Surveys must be conducted annually, with findings due to the OHCA no later than August 1<sup>st</sup> of each year. Survey data may be included in MCO and PAHP scorecards posted by the OHCA to the agency website.

***How the Activity will be Applied to the Areas being Monitored***

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

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

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

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

The OHCA will be developing and implementing a Medicaid Managed Care Quality Rating System, in accordance with 42 C.F.R. § 438.334.

Additionally, OHCA has developed a SoonerSelect Scorecard in accordance with Oklahoma statute 56 O.S. § 4002.11 to evaluate quarterly and annual performance metrics of all MCO/PAHP contractors participating in the SoonerSelect Program. As part of the SoonerSelect Scorecard, the OHCA compares each MCO/PAHP contractor on an array of measures, one of which is Enrollee satisfaction. The scorecard is compiled quarterly and will consist of the information obtained during the prior quarter where appropriate. (Survey data and quality metrics will be updated annually in the quarter for which it becomes available.)

- d.   X   Data Analysis (non-claims)

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

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

***DISENROLLMENT REQUESTS BY ENROLLEE – FROM PLAN***

***Applicable Programs***

MCO and PAHP

***Personnel Responsible***

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

***Detailed Description of Activity***

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

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

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

### ***Frequency of Use***

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

### ***How the Activity will be Applied to the Areas being Monitored***

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

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

The rate of disenrollment requests can provide an early indication of access/network adequacy and/or quality-of-care issues. This information can be used by the OHCA to identify necessary corrective actions or performance improvement project opportunities at the individual contractor and/or program levels.

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

#### ***Applicable Programs***

MCO and PAHP

#### ***Personnel Responsible***

MCOs/PAHPs are responsible for processing enrollee requests to change assigned Primary Care Providers (PCPs) or Primary Care Dentists (PCDs) in accordance with contractual requirements and for submitting required non-claims operational reports to the OHCA. OHCA is responsible for reviewing, analyzing and applying PCP and PCD change data for compliance oversight and program monitoring.

#### ***Detailed Description of Activity***

The OHCA monitors requests to change PCP and PCD assignments and disenrollment activity through analysis of non-claims operational data, including enrollment and provider assignment information, grievance and appeals data, and required contractor reports related to enrollee services.

This monitoring focuses on identifying the volume, frequency, and reasons for enrollee requests to change PCP or PCD assignments, including requests associated with access concerns, provider availability, communication issues, or dissatisfaction with care. Grievance and appeals data are reviewed

to identify access-related complaints or concerns that may be associated with PCP or PCD assignment changes.

OHCA analyzes these data to identify trends at the contractor and program level and to distinguish routine enrollee choice from patterns that may indicate access barriers, provider capacity issues, or network instability.

### ***Frequency of Use***

PCP and PCD change data are reviewed on an ongoing basis through routine analysis of required non-claims reports and enrollment information submitted in accordance with the SoonerSelect Reporting manual and contract. Focused reviews may be conducted as warranted based on identified trends, complaint patterns, or other risk indicators.

### ***How the Activity will be Applied to the Areas being Monitored***

PCP and PCD change data are applied to OHCA's evaluation of MCO/PAHP performance related to enrollee choice, primary care capacity, continuity of care, provider assignment practices, and timely access to services.

OHCA uses this information to assess whether enrollee requests reflect routine choice or indicate systemic issues such as difficulty accessing care, limited provider availability, or recurring concerns with specific providers or service areas. Findings inform routine oversight activities, targeted technical assistance, or additional monitoring when patterns suggest potential access or compliance concerns.

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

Analysis of PCP and PCD change patterns provides insight into member experience and access to primary care services. Elevated rates of PCP or PCD changes, repeated changes by the same enrollees, or clustering of requests within specific plans, geographic areas, or provider types may indicate access barriers, continuity of care concerns, or network management issues.

This information supports OHCA's ability to identify emerging risks related to primary care access and network stability and to take appropriate oversight actions when warranted.

## ***GRIEVANCE AND APPEALS DATA***

### ***Applicable Programs***

MCO and PAHP

### ***Personnel Responsible***

MCOs/PAHPs are responsible for submitting grievance and appeals summary reports in accordance with contractual and reporting manual requirements. The OHCA is responsible for reviewing, analyzing, and applying grievance and appeals data for compliance oversight and program monitoring.

### ***Detailed Description of Activity***

OHCA monitors grievance and appeals activity to assess member experience and contractor performance related to access to care, coverage and authorization practices, coordination and continuity of care, and quality of care.

Grievance and appeal reports are reviewed to evaluate the volume, nature, and resolution of enrollee grievances, including those related to difficulty obtaining appointments, access to primary or specialty care providers, after-hours access, provider availability, and other access related concerns. Appeals data are reviewed to assess the volume, timeliness, reasons for appeal, overturn rates, and escalation to State Fair Hearings-

This approach allows OHCA to identify access-related issues regardless of whether they involve formal authorization decisions, provider availability, or administrative barriers within the contractor's delivery system.

### ***Frequency of Use***

Grievance and appeals data are reviewed on an ongoing basis through routine analysis of required summary reports submitted in accordance with the SoonerSelect Reporting Manual. Focused reviews may be conducted as warranted based on identified trends, compliant patterns, or other risk indicators.

### ***How the Activity will be Applied to the Areas being Monitored***

Grievance and appeals data will be applied, at a minimum, to the OHCA's evaluation of MCO/PAHP performance related to timely access to care, primary and specialty provider capacity, coordination and continuity of care, coverage and authorization processes, and quality-of-care.

OHCA reviews trends at both the plan and program level to identify recurring access barriers, including difficulties securing timely appointments, limited provider availability, or other systemic issues affecting enrollee access to services. Findings inform routine oversight activities and enforcement actions, including the development and monitoring of corrective action plans when warranted.

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

Analysis of grievance and appeals volume, reasons, resolution outcomes, and trends provide actionable insight into enrollee access and quality-of-care issues that may not be apparent through claims data alone. Grievances related to appointment availability, provider access, or service delays may indicate network adequacy concerns or operational barriers within the managed care delivery system.

Appeal trends, including overturn rates at the plan and State Fair Hearing levels, provide additional insight into the appropriateness of coverage and authorization practices. Collectively, these data support OHCA's ability to identify emerging risks, assess contractor compliance with access and quality requirements, and determine when corrective action or performance improvement activities are necessary.

The OHCA has established contractual performance standards for timely resolution of grievances and appeals. Contractors are required to resolve at least 98 percent of grievances and appeals within 30 days of receipt and 100 percent within 60 days of receipt. Enrollees must receive written notice of resolution within three calendar days of case resolution.

Failure to meet performance standards or to address identified access-related issues may result in enforcement actions, including the imposition of liquidated damages and/or corrective action plans, in accordance with contractual requirements.

### ***PCP/PCD TERMINATION RATES AND REASONS***

#### ***Applicable Programs***

MCO and PAHP

#### ***Personnel Responsible***

MCOs/PAHPs are responsible for submitting network provider enrollment, disenrollment, and termination reports to the OHCA in accordance with contractual and SoonerSelect Reporting Manual requirements. OHCA is responsible for reviewing, analyzing, and applying termination data for compliance oversight and program monitoring.

#### ***Detailed Description of Activity***

OHCA monitors Primary Care Provider (PCP) and Primary Care Dentist (PCD) termination rates and reasons through review of network provider enrollment, disenrollment, and terminations reports submitted by MCOs

and PAHPs. These reports identify the volume of PCP and PCD terminations and categorize the reasons for termination, including provider-initiated and plan-initiated terminations.

Termination data are analyzed to assess the stability of the primary care network and to identify trends that may affect enrollee access to services. OHCA reviews termination patterns over time and across contractors to detect potential systemic issues related to provider network management, contractor operational practices, or market conditions.

When appropriate, OHCA may request additional information or clarification from the contractor to better understand the circumstances contributing to provider terminations.

### ***Frequency of Use***

PCP and PCD termination data are reviewed on an ongoing basis through routine analysis of required non-claims reports submitted in accordance with the SoonerSelect Reporting Manual. Focused or comparative reviews may be conducted as warranted based on identified trends, significant changes in termination rates, or other risk indicators.

### ***How the Activity will be Applied to the Areas being Monitored***

PCP and PCD termination rate data are applied, at a minimum, to the OHCA's evaluation of MCO/PAHP performance related to primary care capacity, network adequacy, continuity of care, provider selection, and quality-of-care.

OHCA uses termination trends to assess whether changes in the primary care network may result in disruptions to enrollee-provider relationships, reduced access to services, or increased administrative burden for enrollees. Findings inform routine oversight activities and may prompt targeted reviews, technical assistance, or corrective action when termination patterns suggest potential access or compliance concerns.

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

Analysis of PCP and PCD disenrollment and termination rate trends provides insight into the stability and sufficiency of the primary care network. Elevated termination rates, concentration of terminations within specific geographic areas, or recurring termination reasons may indicate underlying issues such as network management challenges, contractor-provider relationship concerns, or operational barriers affecting provider participation.

This information supports OHCA’s ability to identify emerging risks to network adequacy and access to care and to take appropriate oversight actions, including the imposition of liquidated damages and/or corrective action plans, in accordance with contractual requirements when warranted.

### ***OTHER DATA ANALYSIS (NON-CLAIMS)***

#### ***Applicable Programs***

MCO and PAHP

#### ***Personnel Responsible***

MCOs/PAHPs are responsible for submitting mandatory non-claims operational reports to the OHCA in accordance with contractual requirements and the SoonerSelect Reporting Manual. OHCA is responsible for reviewing, analyzing, and applying these data to support ongoing compliance oversight and program monitoring.

#### ***Detailed Description of Activity***

In addition to specific non-claims monitoring activities described elsewhere in this Monitoring Plan, OHCA conducts analysis of a broader set of required operational reports submitted by MCOs/PAHPs. These reports provide information related to program operations, access to services, enrollee experience, network development, care delivery, and quality improvement activities.

OHCA reviews these reports to identify trends, anomalies, or emerging risks that may affect program performance, enrollee access, or quality-of-care. Analysis is conducted at both the contractor and program level and is used to supplement and contextualize findings from other monitoring activities, including grievance and appeals review, enrollment and disenrollment analysis, and network oversight.

When potential concerns are identified, OHCA may request additional information, conduct focused reviews, or engage contractors through routine oversight processes to further assess and address identified issues.

#### ***Types of Reports Reviewed***

The operational reports reviewed under this activity include, but are not limited to:

- Covered benefits reports;
- Medical management reports;

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

Additional details regarding specific reports are described elsewhere in this Monitoring Plan, as applicable.

***Frequency of Use***

The frequency varies by report and is defined in the SoonerSelect Reporting Manual. Reports are reviewed on an ongoing basis, with focused or comparative analysis conducted as warranted based on identified trends, emerging risks, or findings from other monitoring activities.

***How the Activity will be Applied to the Areas being Monitored***

Non-claims operational reports are applied to OHCA’s evaluation of MCO/PAHP performance across multiple monitoring domains including:

- Coverage and authorization practices- through covered benefits, provider services, and medical management reports.
- Timely access and network capacity- through medical management and provider network development reports.
- Continuity and coordination of care- through care management, population health, and transition of care reports.
- Quality-of-Care- through quality improvement and care management reports.
- Enrollment, disenrollment, and information to beneficiaries- through enrollee services reports.
- Choice and access for AI/AN enrollees- through AI/AN population and IHCP reports-

- Program integrity- through program integrity reports.

Findings from these reports inform routine oversight discussions, technical assistance, and enforcement actions, including the imposition of liquidated damages and/or corrective action plans, in accordance with contractual requirements when warranted.

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

Analysis of non-claims operational reports provides OHCA with a comprehensive, system-level view of managed care program performance that complements claims-based monitoring and targeted oversight activities. Review of trends across report types allows OHCA to identify potential access barriers, operational inefficiencies, quality-of-care concerns, or compliance risks that may not be evident through a single data source.

This information supports OHCA’s risk-based oversight approach by enabling early identification of issues, prioritization of monitoring resources, and timely intervention to promote compliance with contractual and regulatory requirements.

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

***Applicable Programs***

MCO and PAHP

***Personnel Responsible***

Oklahoma Lifeline Vendor Network, OHCA and MCOs/PAHPs.

***Detailed Description of Activity***

MCO contractors must use the Oklahoma 24-hour 988 mental health lifeline vendor network for provision of telephonic behavioral health crisis services. The 988 Lifeline serves as a statewide access point for behavioral health crisis response and triage, including assessment of immediate risk, crisis de-escalation, coordination with mobile crisis or emergency response when indicated, and connection to ongoing supports.

The OHCA maintains a toll-free compliance hotline for reporting potential fraud, waste, and abuse. MCOs and PAHP contractors must publicize the hotline to Enrollees and must also operate their own toll-free hotline for the same purpose. OHCA utilizes compliance hotline intake and call tracking

to support program integrity monitoring, including identification of potential fraud, waste, and abuse trends, and to ensure appropriate referral, documentation, and follow-up occurs.

***Frequency of Use***

The 988 lifeline operates 24 hours a day, seven days a week.

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

***How the Activity will be Applied to the Areas being Monitored***

Data regarding calls to the 988 lifeline is provided by the contracted vendor and is shared directly with the MCOs. This data supports timely care coordination and required follow-ups by the MCOs. CEs share relevant information with SoonerSelect Operations. As applicable, 988 utilization information supports monitoring of behavioral health access and quality-of-care concerns, including the need for timely crisis response and follow-up engagement with members after crisis contact.

Compliance hotline data is sent to SoonerSelect Operations, for appropriate follow-up and tracking. Monitoring focuses on call volume and final disposition by plan. This monitoring supports OHCA's evaluation of MCO/PAHP performance related to program integrity, compliance, and responsiveness to issues reported through enrollee and provider channels, including ensuring appropriate referral pathways and resolution activity are completed.

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

Data regarding calls to the mental health life line will provide information on potential behavioral health access or quality-of-care issues within MCOs. This includes identification of trends that may indicate gaps in access to crisis services, outpatient behavioral health services, or care coordination needs following crisis events.

Compliance hotline data will be used to identify potential program integrity concerns within individual MCOs/PAHPs. Call dispositions and trends may provide early indicators of recurring concerns, provider or enrollee complaints requiring escalation, or areas requiring additional oversight, technical assistance, or targeted review.

- f. X Focused Studies (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they

do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service).

***Applicable Programs***

MCO and PAHP

***Personnel Responsible***

OHCA EQRO and MCOs/PAHPs.

***Detailed Description of Activity***

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

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

***Frequency of Use***

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

***How the Activity will be Applied to the Areas being Monitored***

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

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

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

- g.   **X**   Geographic mapping of provider network

***Applicable Programs***

MCO and PAHP

***Personnel Responsible***

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

***Detailed Description of Activity***

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

***Frequency of Use***

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

***How the Activity will be Applied to the Areas being Monitored***

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

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

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

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

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

This information also can be used by the OHCA to identify performance improvement project opportunities (e.g., use of alternative care delivery

methods/modes in rural areas lacking specialty providers) at the individual contractor and/or program levels.

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

***Applicable Programs***

MCO and PAHP

***Personnel Responsible***

Independent evaluator personnel under contract to the OHCA.

***Detailed Description of Activity***

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

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

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

***Frequency of Use***

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

***How the Activity will be Applied to the Areas being Monitored***

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

- **Enroll/Disenroll** – The assessment will examine enrollment and disenrollment trends to document performance at the MCO/PAHP and program levels.
- **Information to Beneficiaries** – The assessment will examine MCO/PAHP and OHCA communications for clarity and accuracy, and will review grievance data to identify trends/issues related to communication.
- **Grievance** – The assessment will examine grievance volume and trends, by grievance type, to identify issues at the MCO/PAHP and program levels.
- **Timely Access** – The assessment will examine access and grievance reports and trends, as well as CAHPS data, to evaluate performance at the MCO/PAHP and program levels.
- **PCP/Specialty Capacity** – The assessment will examine PCP/specialist and grievance reports and trends, as well as CAHPS data, to evaluate performance at the MCO/PAHP and program levels.
- **Coordination/Continuity** – The assessment will examine medical management reports and trends, HEDIS/encounter, CAHPS and provider survey data, to evaluate performance at the MCO/PAHP and program levels.
- **Coverage/Authorization** - The assessment will examine medical management and grievance reports and trends, as well as CAHPS and provider survey data, to evaluate performance at the MCO/PAHP and program levels.
- **Provider Selection** – The assessment will examine PCP/specialist and grievance reports and trends, as well as CAHPS data, to evaluate performance at the MCO/PAHP and program levels.
- **Quality-of-Care** – The assessment will examine quality improvement reports and trends, HEDIS/encounter, CAHPS and provider survey data, to evaluate performance at the MCO/PAHP and program levels.

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

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

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

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

***Applicable Programs***

MCO and PAHP

***Personnel Responsible***

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

***Detailed Description of Activity***

The OHCA is committed to improving health outcomes for its Medicaid beneficiaries. MCO and PAHP contractors submit race and ethnicity data as a part of a quality measures report. The OHCA analyzes race and ethnicity data to identify opportunities to improve the health status of beneficiaries.

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

The cultural competency plan must include guidelines for evaluating health status and monitoring outcomes in membership and service quality, especially about specific population groups. The plan must address how a contractor will identify and develop intervention strategies for high-risk health conditions found in certain population groups, including AI/AN Enrollees, among other activities.

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

MCO and PAHP contractors also must maintain population health (formerly known as health equity) representatives who are actively involved in improvement initiatives to improve health outcomes by obtaining input from Enrollees and from providers of direct services which are intended to reduce adverse health outcomes among Enrollees, determining the root cause of inequities, developing targeted interventions and measures, and collecting and analyzing data to track progress in population health improvement efforts.

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

Health Outcomes accreditation directly addresses improvement in beneficiaries health status. Accredited contractors must demonstrate they have the capacity and processes for using data to identify and address improvement opportunities in quality of care, including unmet social needs, to support better health outcomes.

### ***Frequency of Use***

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

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

### ***How the Activity will be Applied to the Areas being Monitored***

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

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

will be reviewed to identify any disparity across racial or ethnic groups.

- Quality-of-Care – MCO quality improvement reports, HEDIS and CAHPS data (if reportable by racial/ethnic category) will be reviewed to identify opportunities for improvement in health outcomes across racial or ethnic groups.

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

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

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

***Applicable Programs***

MCO and PAHP

***Personnel Responsible***

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

***Detailed Description of Activity***

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

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

***Frequency of Use***

MCO and PAHP contractors must submit network adequacy data in accordance with SoonerSelect Reporting Manual requirements.

The EQRO review will occur annually.

***How the Activity will be Applied to the Areas being Monitored***

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

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

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

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

- k.    Ombudsman  
(Not a component of the monitoring plan.)
- l.   X On-site review

***Applicable Programs***

MCO and PAHP

***Personnel Responsible***

OHCA and EQRO staff.

***Detailed Description of Activity***

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

The scope of the review will include:

- Administration (e.g., staffing and resources, delegation);

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

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

***Frequency of Use***

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

***How the Activity will be Applied to the Areas being Monitored***

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

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

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

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

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

m.   X   Performance Improvement projects [**Required** for MCO/PIHP]

  X   Clinical

  X   Non-clinical

***Applicable Programs***

MCO and PAHP

***Personnel Responsible***

MCOs/PAHPs and OHCA EQRO.

***Detailed Description of Activity***

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

MCO contractors are required to obtain approval for at least three PIPs in the first year of implementation. Initially, contractors must propose, for the OHCA's approval, one non-clinical and two clinical PIPs; one clinical PIP that addresses physical health and one that addresses behavioral health. PAHP contractors are required to obtain approval for two PIPs in the first year of implementation, one clinical and one non-clinical. PIPs should carryover from year-to-year when appropriate. MCO/PAHP contractors are not required to submit new PIPs if the PIPs carried over from the prior year still met the minimum number of PIPS required. In subsequent years, PIP topics may be identified by CMS, the contractor, or the OHCA. All PIPs are subject to final approval by OHCA.

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

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

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

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

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

#### ***Frequency of Use***

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

#### ***How the Activity will be Applied to the Areas being Monitored***

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

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

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

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

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

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

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

### ***Applicable Programs***

MCO and PAHP

### ***Personnel Responsible***

The OHCA is responsible for establishment of performance measures. MCOs/PAHP’s are responsible for collection and reporting results. The OHCA EQRO validates performance measure results.

### ***Detailed Description of Activity***

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

the SoonerSelect program and include target performance rates that will increase annually.

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

***SOONERSELECT MCO***

<b>Performance Measure</b>	<b>Measure Set/Source</b>
1. Childhood Immunization Status (CIS-CH) Combination Three	CMS Child Core Set
2. Well-Child Visits in the First 30 Months of Life (W30-CH)	CMS Child Core Set
3. Screening for Depression and Follow-up Plan: Ages 12-17 (CDF-CH) (CMS #672)	CMS Child Core Set
4. Child and Adolescent Well-Child Visits (WCV-CH)	CMS Child Core Set
5. Prenatal and Postpartum Care: Under Age 21 (PPC2-CH) (PPC02-CH)	CMS Child Core Set
6. Prenatal and Postpartum Care: Age 21 and Older (PPC2-AD) (PPC02-AD)	CMS Adult Core Set
7. Controlling High Blood Pressure (CBP-AD)	CMS Adult Core Set
8. Adults' Access to Preventative/Ambulatory Health Services (AAP) measure	HEDIS
9. Follow-up after Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)	CMS Child Core Set
10. Follow-up after Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)	CMS Adult Core Set
11. Glycemic Status Assessment for Patients with Diabetes (GSD-AD)	CMS Adult Core Set
12. Plan All-Cause Readmissions (PCR-AD)	CMS Adult Core Set

***SOONERSELECT CHILDREN'S SPECIALTY PROGRAM***

<b>Performance Measure</b>	<b>Measure Set/Source</b>
13. Childhood Immunization Status (CIS-CH) Combination Three (3)	CMS Child Core Set
14. Well-Child Visits in the First 30 Months of Life (W30-CH)	CMS Child Core Set
15. Screening for Depressing and Follow-Up Plan: Ages 12-17 (CDF-CH) (CMS #672)	CMS Child Core Set

<b>Performance Measure</b>	<b>Measure Set/Source</b>
16. Developmental Screening in the First Three Years of Life (DEV-CH) (CMIT#1003)	CMS Child Core Set
17. Child and Adolescent Well-Care Visits (WCV-CH)	CMS Child Core Set
18. Prenatal and Postpartum Care: Under Age 21 (PPC2-CH) (PPC02-CH)	CMS Child Core Set
19. Prenatal and Postpartum Care: Age 21 and Older (PPC2-AD) (PPC02-AD)	CMS Adult Core Set
20. Follow-up after Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)	CMS Child Core Set
21. Follow-up after Emergency Department Visit for Alcohol and other Drug Abuse and Dependence: Ages 13 to 17 (FUA-CH)	CMS Child Core Set
22. Follow-up after Emergency Department Visit for Mental Illness: Ages 6 to 17 (FUM-CH)	CMS Child Core Set
23. Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)	CMS Child Core Set
24. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	CMS Child Core Set

***SOONERSELECT DENTAL***

<b>Performance Measure</b>	<b>Measure Set/Source</b>
25. Oral Evaluation, Dental Services (OEV-CH)	CMS Child Core Set
26. Topical Fluoride for Children (TFL-CH)	CMS Child Core Set
27. Sealant Receipt on Permanent First Molars (SFM-CH)	CMS Child Core Set
28. Periodontal Evaluation in Adults with Periodontitis	Dental Quality Alliance (DQA) (ADA)

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

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

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

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

Additionally, OHCA will monitor all measures not listed above that are contained within the CMS Adult and Child core sets.

### ***Frequency of Use***

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

### ***How the Activity will be Applied to the Areas being Monitored***

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

- Timely Access – Will be monitored, at a minimum, through evaluation of measures 2, 4, 5, 17, 18, and 19.
- Coordination/Continuity – Will be monitored, at a minimum, through evaluation of measures 9, 10, 11, 20, 21, 27, and 28.
- Quality-of-Care – Will be monitored, at a minimum, through evaluation of measures 1, 6, 12, 13, 14, 16, 24, 25, and 26.

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

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

The OHCA will be applying a quality performance withhold, starting in the second year of the program. MCO and PAHP contractors will have the opportunity to earn back withhold amounts by meeting or exceeding performance thresholds.

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

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

***Applicable Programs***

MCO and PAHP

***Personnel Responsible***

MCOs and PAHPs.

***Detailed Description of Activity***

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

***Frequency of Use***

MCO and PAHP contractors must submit an updated listing at the frequency outlined in the SoonerSelect Reporting manual.

Beginning in May 2026, MCO and PAHP contractors will begin submitting monthly provider network interface files that will be ingested into the States' new monitoring and oversight tool, Managed Care Insights (MCI). The frequency of this submission may be reviewed and updated post MCI-implementation based on the needs of the State.

***How the Activity will be Applied to the Areas being Monitored***

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

- Choice – MCO/PAHP provider reports will be reviewed to verify beneficiaries have an adequate choice of providers across plans. Reports provide timely insight into network composition and potential emerging issues.
- PCP/PCD/Specialist Capacity – MCO/PAHP provider reports will be reviewed to identify any potential barriers to primary or specialty care access, including provider availability and distribution.
- Provider Selection – MCO/PAHP provider reports will be reviewed to identify any potential barriers to offering members a choice of providers in accordance with contract requirements.

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

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

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

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

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

q.   X   Provider Self-report data

  X   Survey of providers

\_\_\_ Focus groups

***Applicable Programs***

MCO and PAHP

***Personnel Responsible***

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

***Detailed Description of Activity***

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

survey instrument. The approved survey instrument will include six domains:

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

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

### ***Frequency of Use***

Contractors must report survey results annually.

### ***How the Activity will be Applied to the Areas being Monitored***

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

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

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

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

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

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

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

***Applicable Programs***

MCO

***Personnel Responsible***

MCOs

***Detailed Description of Activity***

OHCA monitors compliance with 24 hours/7 days a week Primary Care Provider (PCP) availability requirements through a combination of contractual oversight, network adequacy monitoring, and operational data review. While MCOs are responsible for ensuring that contracted PCPs maintain after-hours access in accordance with contract requirements, OHCA verifies compliance by reviewing multiple data sources that reflect members’ ability to access primary care services outside of standard business hours.

These monitoring activities include but are not limited to: review of MCO policies and procedures related to after-hours coverage, analysis of network data, review of member grievances and appeals related to access to care; analysis of utilization data for indicators of inappropriate emergency department use; and evaluation of issues identified through provider, member, or stakeholder communications.

### *Frequency of Use*

Monitoring 24 hours/7 days a week PCP availability occurs on an ongoing basis through routine review of operational data, grievance and appeal submissions, and network information. Policy and procedure assessments or targeted data requests are conducted annually and more frequently as indicated by identified risks, trends, or complaints.

### *How the Activity will be Applied to the Areas being Monitored*

This activity is applied to assess whether members enrolled in SoonerSelect have appropriate access to primary care services outside of standard business hours as required by federal and state regulations and contractual standards.

Data sources are reviewed to identify patterns or indicators that suggest barriers to after-hours access, such as repeated member complaints, elevated emergency department utilization for non-emergent conditions, or gaps in documented provider coverage arrangements. Findings are used to evaluate MCO compliance, inform oversight discussions, and guide enforcement actions, including the development and monitoring of corrective action plans when necessary.

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

By leveraging multiple data sources rather than a single reporting mechanism, this activity provides a comprehensive view of after-hours PCP access across the provider network. Grievances and appeals offer direct insight into member experience accessing care; network and provider data demonstrate whether contractual coverage requirements are documented and maintained; and utilization data may reveal indicators of access challenges.

Collectively, these data points allow OHCA to identify trends, validate MCO compliance, and detect potential access issues that may not be evident through self-reported CE attestations alone.

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

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

### ***MEDICAL MANAGEMENT REPORTS***

### ***Applicable Programs***

MCO and PAHP

### ***Personnel Responsible***

MCOs/PAHPs

### ***Detailed Description of Activity***

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

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

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

### ***Frequency of Use***

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

### ***How the Activity will be Applied to the Areas being Monitored***

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

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

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

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

## ***EMERGENCY ROOM UTILIZATION***

### ***Applicable Programs***

MCO

### ***Personnel Responsible***

MCOs through submission of mandatory operational reports.

### ***Detailed Description of Activity***

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

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

- Enrollee outreach (telephonic or mail);
- Appointment assistance with PCP or specialist;
- Enrollee education; and
- Referral to care management.

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

### ***Frequency of Use***

Contractors must submit results every six months.

### ***How the Activity will be Applied to the Areas being Monitored***

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

- Coordination/Continuity – The OHCA will review emergency room data to verify appropriate follow-up with frequent users of this setting.

- Quality-of-Care – The OHCA will review emergency room utilization data to identify potential access and quality-of-care issues driving utilization.

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

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

***EPSDT COMPLIANCE***

***Applicable Programs***

MCO and PAHP

***Personnel Responsible***

MCOs/PAHPs and OHCA EQRO

***Detailed Description of Activity***

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

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

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

***Frequency of Use***

The EQRO will submit findings annually.

***How the Activity will be Applied to the Areas being Monitored***

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

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

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

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

t.   X   Other: (please describe)

***MARKETING PLAN***

***Applicable Programs***

MCO and PAHP

***Personnel Responsible***

MCOs/PAHPs

***Detailed Description of Activity***

MCO and PAHP contractors must submit marketing plans demonstrating compliance with OHCA and federal regulations as part of readiness review activities, as well as the marketing component of employee training materials. Contractors also must submit documentation of marketing activities for OHCA review. Marketing materials intended for distribution must be submitted to OHCA for review and approval in accordance with the SoonerSelect Reporting Manual.

***Frequency of Use***

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

***How the Activity will be Applied to the Areas being Monitored***

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

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

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

***PROGRAM INTEGRITY REPORTS***

***Applicable Programs***

MCO and PAHP

***Personnel Responsible***

MCOs/PAHPs

***Detailed Description of Activity***

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

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

***Frequency of Use***

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

### ***How the Activity will be Applied to the Areas being Monitored***

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

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

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

## ***ENROLLEE SERVICE REPORTS***

### ***Applicable Programs***

MCO and PAHP

### ***Personnel Responsible***

MCOs/PAHPs through submission of mandatory operational reports.

### ***Detailed Description of Activity***

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

- Enrollees in Care Management – Report documenting new, closed and total cases assigned to care management;
- Social Determinants of Health - Monitoring of Enrollee referrals to social services and MCO and PAHP contractor partnerships with community-based organizations; and
- Value-Added Benefits – Report documenting all Value-Added benefits offered by the contractor and Enrollee utilization rates for each.

The OHCA requires MCO contractors to report on additional Enrollee services, beyond the monitoring activities previously described. The additional reports include, but are not limited to:

- Health Risk Screening – Report documenting timely completion of Health Risk Screenings of new Enrollees;

- Health Risk Screening Unreachable Enrollees – Report documenting Enrollees the contractor was unable to reach to complete the Health Risk Screening, including name, number of outreach attempts, type(s) of attempts and Enrollee’s contact information;
- Comprehensive Assessment and Reassessment – Report documenting timely completion of comprehensive assessments in accordance with the contractor’s risk stratification level framework;
- Care Management Activities – Report documenting assignment to a care manager, caseload, contacts and success;
- Care Plan – Monitoring of care plan initiation, revision, completion, review, and reduction; and
- NEMT Utilization – Report documenting the number of trips requested, approved, denied, provided, and no shows.

***Frequency of Use***

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

***How the Activity will be Applied to the Areas being Monitored***

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

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

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

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

## Section C: Monitoring Results

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

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

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

This is a renewal request.

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

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

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

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

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

**Strategy:** a. Accreditation for Non-duplication

**Confirmation it was conducted as described:**

Yes

No. Please explain:

**Summary of results:** Regarding nonduplication as it relates to accreditation results, the EQRO planned to incorporate nonduplication using the MCO/PAHP accreditation results starting in review year 2026, as the MCOs/PAHPs were not required to be accredited until after EQRO activities had already been implemented in 2024 and 2025. Regarding nonduplication as it relates to HEDIS-certified audits and the submission of measures to NCQA, the EQRO incorporated applicable NCQA final audit results for HEDIS measures into its validation activity in 2025. Nonduplication was not applicable to every MCO and PAHP, as not all MCOs and PAHPs submitted measures to NCQA in 2025. Plans are not required to submit HEDIS measure results to NCQA until 2026, as measurement year 2025 represents the first year in which a complete 12 months of data could be captured.

**Problems identified:** Strategy was partially implemented due to timing of accreditations and submissions of performance measures for NCQA audits. Nonduplication will be fully implemented for applicable EQR activities in 2026.

**Corrective action (plan/provider level):** No corrective action required.

**Program change (system-wide level):** Not applicable.

**Strategy:** b. Accreditation for Participation

**Confirmation it was conducted as described:**

Yes

No. Please explain:

**Summary of results:** Pursuant to Section 1.4.2: Accreditation of the SoonerSelect contracts, MCOs and PAHPs were required to be accredited by an Accrediting Entity identified by 45 C.F.R. § 156.275 within eighteen (18) months of operations start date. The operations start date for the SoonerSelect Dental was 2/1/2024; the operations start date for the SoonerSelect medical and the Children’s Specialty Program was 4/1/2024.

All PAHPs submitted certificates for full Dental Plan Accreditation through the Utilization Review Accreditation Commissions (URAC), including both Dental Plan 7.4 Accreditation Program for 2022-2025 and Dental Plan 8.0 Accreditation Program for 2025-2028. The specific dates covered by each certificate are individualized to each PAHP. OHCA validates URAC accreditation using the URAC accreditations directory here: <https://www.urac.org/directory/accreditations/>

All MCOs submitted certificates for full Health Plan Accreditation through the National Committee for Quality Assurance (NCQA) for 2025-2028. The specific dates covered by each certificate are individualized to each MCO. OHCA validates each MCO’s NCQA accreditation using the NCQA health plan report card search feature here: <https://reportcards.ncqa.org/health-plans>.

Additionally, all MCOs are actively engaging in NCQA’s Health Outcomes Accreditation survey activities and are on target to achieve the required Health Outcomes Accreditation within two years of operations start date (i.e., by 3/31/2026). OHCA monitors MCO progress toward this required accreditation as per the instructions outlined in the applicable SoonerSelect Reporting Manuals.

In accordance with 42 CFR § 438.332, OHCA publishes the accreditation status of each MCO and PAHP on the State’s website at the following link: [Accreditation](#).

**Problems identified:** One PAHP’s URAC certificate did not list individual locations covered by the accreditation. OHCA is currently working with the PAHP to obtain documentation from URAC confirming their Oklahoma location is covered by the accreditation.

**Corrective action (plan/provider level):** No corrective action required.

**Program change (system-wide level):** Not applicable.

**Strategy:** c. Consumer Self-Report data (CAHPS®)

**Confirmation it was conducted as described:**

Yes  
 No. Please explain:

**Summary of results:** The SoonerSelect contracts required all MCOs and PAHPs to utilize a single survey vendor to administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey. OHCA selected Press Ganey as the single survey administrator. OHCA reserves the right to change the single survey vendor in future contract years and/or waiver periods to meet the needs of the State and SoonerSelect program.

MCOs submitted Health Plan Survey results to the CAHPS® Database Submission system through the Agency for Healthcare Research and Quality (AHRQ). Additionally, OHCA’s Quality division held quarterly meetings with key MCO and PAHP staff, where CAHPS® results were discussed in depth and opportunities for improvement were highlighted for each MCO and PHAP.

Selected key measures from the CAHPS® Patient Experience Surveys are posted on the public facing website as part of the state’s SoonerSelect Scorecards. Scorecards are published quarterly, and historical versions of the scorecard are maintained on the OHCA public website for comparison purposes.

**Problems identified:** OHCA required that MCO and PAHP contractors submit CAHPS® Health Plans surveys for the adult population, the Title XXI (CHIP) population and Title XIX population. Oklahoma has an expansion CHIP program and 2 contractors (one MCO and one PAHP) had difficulty with the enrollment files identifying CHIP members. That

problem was addressed through targeted technical assistance and education; OHCA does not anticipate that being a problem in future years.

**Corrective action (plan/provider level):** One PAHP was unable to successfully contract in time with the required single survey vendor and requested a separate vendor be utilized. After review, OHCA was able to approve the additional requested vendor for the initial year. The PAHP is transitioning to the required single survey vendor beginning in the second year.

**Program change (system-wide level):** Not applicable.

**Strategy:** d. Data Analysis – Denial of referral requests

**Confirmation it was conducted as described:**

Yes

No. Please explain: During the reporting period, OHCA did not conduct monitoring of denials of referral requests. Under the SoonerSelect program's open-access managed care model, MCOs do not require PCP-to-specialist referrals as a condition of coverage or payment. Because referral authorization is not a plan-controlled function, there are no contractor-issued referrals denials to monitor. Specialty access is monitored through alternative mechanisms, including grievance and appeals data, enrollment and disenrollment trends, and provider network monitoring activities, as described in Section B: Monitoring Plan.

**Summary of results:** Not applicable. The program does not generate referral denial data because contractor authorization of PCP-to-specialist referrals is not required.

**Problems identified:** Not applicable.

**Corrective action (plan/provider level):** Not applicable.

**Program change (system-wide level):** OHCA updated its Monitoring Plan to remove this monitoring activity and clarify oversight responsibilities consistent with the program's open-access model. No changes to enrollee access standards or contractor obligations were made.

**Strategy:** d. Data Analysis – Disenrollment requests by Enrollee (from plan)

**Confirmation it was conducted as described:**

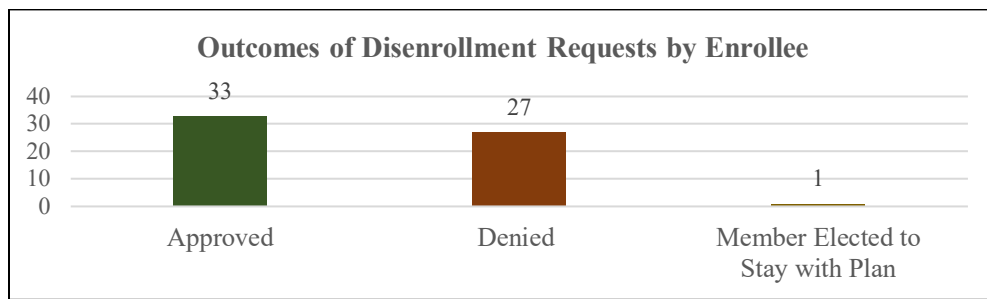
Yes

No. Please explain:

**Summary of results:** OHCA reviewed enrollment and disenrollment data maintained in MMIS and contractor-submitted reports to monitor enrollee-initiated plan changes during the initial 90-day period, annual open enrollment, and lock-in periods requiring good-cause review.

Review of disenrollment requests showed that, following initial implementation, requests are now limited and appropriately aligned with allowable good-cause criteria. Current trends reflect stabilized disenrollment activity and accurate reporting by MCOs/PAHPs. Between October 2024 and January 2026, OHCA received 61 total disenrollment requests through applicable reporting processes, 33 of which were approved because they met the good-cause criteria outlined with the SoonerSelect contract.

OHCA uses the state’s MMIS to systematically track disenrollment requests and plan changes by MCO/PAHP and for the overall program, including requests occurring during the first 90 days of enrollment and during the open enrollment period. This tracking supports ongoing oversight and compliance monitoring consistent with waiver reporting requirements.



**Problems identified:** During the initial phase of implementation, OHCA identified instances of disenrollment requests submitted by MCOs/PAHPs that did not meet good-cause requirements. OHCA implemented direct training and education for MCOs/PAHPs, including the distribution of a standardized disenrollment guidance manual to clarify allowable disenrollment reasons and procedural expectations. These actions effectively resolved the issue of submission of inappropriate disenrollment requests, and MCOs/PAHPs are now consistently applying correct disenrollment criteria and reporting processes.

**Corrective action (plan/provider level):** No corrective action is required. Where clarification was needed regarding disenrollment reporting or documentation, OHCA addressed this through routine oversight communication.

**Program change (system-wide level):** Not applicable.

**Strategy:** d. Data Analysis – Disenrollment requests by enrollee (from PCP within plan)

**Confirmation it was conducted as described:**

- Yes
- No. Please explain:

**Summary of results:** OHCA reviewed enrollee-initiated PCP and PCD assignment changes through analysis of enrollment data, contractor reports, and grievance information. Monitoring supported identification of provider assignment trends and member experience considerations. No systemic concerns regarding primary care access were identified.

**Problems identified:** No systemic deficiencies were identified. PCP/PCD change activity reflected routine enrollee choice and did not demonstrate patterns of widespread access disruption.

**Corrective action (plan/provider level):** No corrective actions were required. Isolated issues were addressed through routine oversight engagement with the applicable contractor.

**Program change (system-wide level):** No Applicable.

**Strategy:** d. Data Analysis – Grievances and appeals data

**Confirmation it was conducted as described:**

Yes  
 No. Please explain:

**Summary of results:** During the first waiver period, OHCA monitored grievances and appeals across all MCOs and PAHPs using the required reporting submission (*Member Notice of Adverse Benefit Determination, Grievances, Appeals and State Fair Hearing Monthly Report*). This report includes data elements related to grievances and appeals, including the date of the complaint and the date the notice was issued/sent, as well as the appeal deadline. OHCA uses this data to assess timeliness and compliance with applicable member notice and appeal requirements and to identify anomalies or reporting errors requiring follow-up.

**Grievances, Appeals, and State Fair Hearings (Previous Waiver Period)**

Contractor	Grievances Filed	Appeals Filed	State Fair Hearings
MCOs	4,764	6,262	32
PAHPs	712	2,130	7
<b>Totals</b>	<b>5,476</b>	<b>8,392</b>	<b>39</b>

**Problems identified:** No systemic issues were identified. OHCA did identify intermittent data validation and reporting discrepancies (e.g., incomplete fields, inconsistent dates, or misclassification of appeal categories), which required follow-up with contractors for clarification and/or corrected resubmissions.

**Corrective action (plan/provider level):** No corrective actions were required. When data validation and reporting discrepancies were identified, OHCA engaged the applicable MCO and/or PAHP through standard oversight processes to ensure timely resolution and continued compliance.

**Program change (system-wide level):** Not applicable.

**Strategy:** d. Data Analysis – PCP termination rates and reasons

**Confirmation it was conducted as described:**

Yes

No. Please explain:

**Summary of results:** OHCA reviewed network provider enrollment, disenrollment, and termination reports to assess PCP and PCD termination volume and reasons. Monitoring supported evaluation of primary care network stability and continuity of care. No systemic network instability trends were identified during the reporting period.

**Problems identified:** No systemic primary care network instability or access deficiencies were identified during the reporting period. However, OHCA identified contractor-specific compliance issues related to untimely notification of provider termination/disenrollment to OHCA, as required under contractual reporting standards. The issue involved adherence to reporting timelines and did not result in identified disruptions to enrollee access to primary care services.

**Corrective action (plan/provider level):** No corrective actions were required related to primary care network instability or access deficiencies during the reporting period. However, OHCA issued a Notice of Findings and assessed Liquidated Damages (LDs) to contractors for failure to provide timely notification of provider termination/disenrollment to OHCA, as required under contractual reporting standards. This enforcement action was related to compliance with reporting and notification requirements and did not reflect systemic primary care access disruption. OHCA monitored the contractor’s subsequent compliance with notification requirements through routine oversight processes.

**Program change (system-wide level):** Not applicable.

**Strategy:** d. Data Analysis – Other data analysis (non-claims)

**Confirmation it was conducted as described:**

Yes

No. Please explain:

**Summary of results:** OHCA reviewed additional non-claims operational reports, including covered benefits, medical management, care management and population health, transition of care, quality improvement, enrollee services, provider network development, provider services, AI/AN and IHCP reporting and program integrity submissions. Analysis supported a risk-based oversight approach and provided ongoing visibility into plan performance and operational compliance. Reviews of this data did not identify systemic program-wide deficiencies affecting enrollee or quality of care. Monitoring activities

supported identification of contractor-specific reporting compliance issues, which were addressed through established oversight and enforcement mechanisms.

**Problems identified:** No systemic program-wide deficiencies were identified through review of non-claims operational reports during the reporting period. However, OHCA identified contractor-specific compliance issues related to reporting accuracy, completeness, and/or timeliness across certain required operational reports within this monitoring category. These issues involved adherence to contractual reporting standards and did not reflect systemic access or quality-of-care failures.

**Corrective action (plan/provider level):** No formal corrective actions were required at the program level as a result of non-claims operational data monitoring. Where reporting deficiencies were identified, OHCA addressed them through appropriate enforcement mechanisms in accordance with contractual requirements. This included issuance of Notice of Findings and assessment of Liquidated Damages when warranted for failure to meet reporting, documentation or timeliness standards. OHCA monitored contractor compliance following enforcement action through routine oversight processes to ensure sustained adherence to reporting requirements.

**Program change (system-wide level):** OHCA refined its Monitoring Plan during the reporting period to clarify alignment between documented monitoring strategies and operational oversight activities, including removal of activities not applicable to the program's open-access model and strengthening of access-related monitoring language.

**Strategy:** e. Enrollee Hotlines operated by State

Confirmation it was conducted as described:

Yes

No. Please explain:

**Summary of results:** During the first waiver period, OHCA monitored enrollee and compliance hotline activity across all MCOs and PAHPs. Call data was tracked by plan and final disposition, consistent with approved waiver language. OHCA also ensured the contracted vendor (Solari) shared 988 mental health lifeline call data directly with MCO contractors. Call data regarding the 988 lifeline is provided by the contracted vendor and is shared directly with MCO contractors to support timely care coordination and required follow up activities.

**Problems identified:** No systemic issues were identified through review of enrollee or compliance hotline data during the first waiver period.

**Corrective action (plan/provider level):** No corrective action required.

**Program change (system-wide level):** Not applicable.

**Strategy:** f. Focused studies

**Confirmation it was conducted as described:**

Yes

No. Please explain:

**Summary of results:** As part of its monitoring and oversight framework, the State conducted multiple focused studies in collaboration with the MCOs to evaluate discrete aspects of service delivery, including a comprehensive review of MCO behavioral health claims processing and MCO/PAHP claims timeliness (i.e., the percentage of claims processed in accordance with contractual standards).

The focused study for MCO behavioral health claims processing was conducted in 2 phases. The first phase focused on MCO supplied claims data between August 1, 2024, through October 31, 2024, which evaluated multiple components of each MCO's claims processing system, including benefits configuration and claim denial logic, to assess whether systems were appropriately configured in accordance with waiver and State Plan requirements. MCOs were required to prepare an action plan to address deficiencies. A second review, conducted for the period of July 1, 2025, through September 30, 2025, leveraged supplemental data supplied by the MCOs to assess the implementation of system corrections addressing previously identified issues from phase one, and to identify any remaining gaps requiring further oversight or corrective action. Review results indicate that the MCOs have resolved several system issues identified in the State's 2024 analysis; however, some issues remain outstanding, which will be addressed with each MCO.

In addition, the State conducted a comprehensive claims timeliness focused study for the SoonerSelect Dental program, reviewing claims with service dates from February 1, 2024, through February 28, 2025, to assess PAHP compliance with applicable claims processing timeliness standards. PAHPs provided supplemental claims data and files, in addition to the encounters data contained within the States' MMIS to conduct the assessment. Review results indicate that during the first year of implementation, one PAHP did not meet the contractual requirement to adjudicate ninety percent (90%) of clean claims within fourteen (14) days of receipt for three months and did not meet the requirement to adjudicate ninety-nine percent (99%) of clean claims within ninety (90) days of receipt for four months. The second PAHP did not meet the fourteen (14)-day adjudication standard for two months but met the ninety (90)-day adjudication standard throughout the review period. The State is finalizing the formal results of this focused study for distribution to the PAHPs. However, for calendar year 2025, which was not included in the focused study period, OHCA monitored PAHP claims timeliness through monthly reporting. Results from this ongoing monitoring demonstrate improved alignment with contractual requirements for both PAHPs, indicating that some of the claims processing delays identified during the focused study period were associated with early implementation challenges. A similar focused study is currently underway for MCOs, evaluating claims timeliness during the initial year of program implementation. The State anticipates finalizing this review results during the upcoming waiver period and will distribute formal results to the MCOs upon completion.

**Problems identified:** The results of the MCO behavioral health claims review indicate new issues have appeared in the past year that will require further investigation (e.g., timeliness-related denials, global claim reprocessing).

**Corrective action (plan/provider level):** OHCA will coordinate with the Oklahoma Department of Mental Health and Substance Abuse Services to implement system-wide improvements to MCO behavioral health claims processing, with the goal of ensuring consistent application of requirements.

**Program change (system-wide level):** Not applicable.

**Strategy:** g. Geographic mapping of provider network

**Confirmation it was conducted as described:**

Yes

No. Please explain: Per the SoonerSelect contract, MCOs/PAHPs were required to submit distance-based geo-access reports only, and OHCA's monitoring reflects the data submitted. As the program continues, OHCA may consider including travel time standards as a future monitoring tool.

**Summary of results:** Pursuant to the 'Time and Distance and Appointment Access Standards' section of the SoonerSelect contract, MCOs and PAHPs submitted geo-access reports and maps in accordance with the reporting manual's required cadence.

Under the SoonerSelect contract, MCOs/PAHPs submitted geo-access reports containing distance-based analysis of provider networks. OHCA reviewed these reports to assess compliance with distance standards for primary care providers (PCP), primary care dentists (PCD), mental health, substance use disorder, specialists (as designated by the State) adult and pediatric, pediatric dental, pharmacy, and hospital providers. Monitoring was therefore conducted using the distance data only, as MCOs/PHAPs were not required to submit travel-time information during the review period.

For every geo-access report and map submitted by an MCO or PAHP, OHCA reviewed the reported network across each provider type including PCP, PCD, mental health, substance use disorder, specialists (as designated by the State) adult and pediatric, pediatric dental, and hospital providers on a county-level basis and for pharmacy providers on a zip-code level basis to confirm compliance with distance standards. For each county, OHCA reviewed whether ninety percent (90%) of enrollees in the county were within the specified distance standards as defined in the SoonerSelect contract. This threshold was determined to be sufficient to verify adequate provider choice and selection for enrollees across MCOs/PAHPs. OHCA responded to each submitted geo-access report with any questions on the submitted data and a table of all counties and/or zip codes that were not currently within distance standards.

OHCA maintained a reported network across report submissions. When an MCO or PAHP reported a loss of network adequacy (falling below the 90% threshold), OHCA requested

an explanation of contributing factors and the steps the MCO/PAHP was taking to confirm continued enrollee access.

For all counties and/or zip codes across provider types where an MCO or PAHP reported being unable to meet distance standards, MCOs and PAHPs were required to submit a network adequacy exception request including justification and steps to confirm continued enrollee access. OHCA reviewed each exception request and compared it to available providers and the networks of other MCOs/PAHPs. Preliminary denials were issued when available providers had not been contracted. MCOs and PAHPs were given an opportunity to respond with additional justification or a description of ongoing contracting efforts.

**Problems identified:** During the review of reported networks or network adequacy exception requests, OHCA identified instances where MCOs/PAHPs did not provide sufficient justifications for unmet standards or significant changes in their network.

**Corrective action (plan/provider level):** OHCA responded using several measures to confirm future compliance, including:

- More frequent reporting on deficient areas;
- Levying liquidated damages when justifications for unmet standards were insufficient; and
- Providing targeted training and education on expectations for building and maintaining adequate networks that support enrollee choice.

These measures improved the sufficiency and consistency of MCO/PAHP responses and supported comprehensive network monitoring.

**Program change (system-wide level):** Not applicable.

**Strategy:** h. Independent Assessment of program impact, access, quality, and cost-effectiveness

**Confirmation it was conducted as described:**

Yes  
 No. Please explain:

**Summary of results:** OHCA retained the Pacific Health Policy Group (PHPG) to conduct the SoonerSelect independent assessment. The independent assessment covered three domains: beneficiary access to care, quality of care, and cost effectiveness.

The beneficiary access to care domain focused on:

- Access monitoring and analysis,
- Enrollment information,
- Education and customer service,
- Provider capacity,
- Enrollee access to urgent/emergency care,
- Travel and waiting times for primary care and specialty care, and
- Referrals.

The quality of care domain focused on:

- State quality monitoring and External Quality Review Organization (EQRO) reports,
- Clinical review of utilization patterns,
- Grievances and appeals,
- Beneficiary, provider and subcontractor satisfaction,
- Quality improvement measures, and
- Assessment (i.e., health risk screening and assessments) and care management.

The cost effectiveness domain focused on:

- Core cost effectiveness approaches (i.e., calculating the cost-effectiveness of the managed care program), comparing trended “without waiver” costs to “with waiver” costs; reviewing State oversight and monitoring activities related to rate setting and cost effectiveness; and reviewing sources of expenditure changes, including changes in utilization and enrollment, and
- Additional cost effectiveness approaches, including analysis of possible cost shifting from capitated services to fee-for-service utilization for American Indian/Alaska Native enrollees, who have the option to receive services from IHS/tribal providers and whether CMS and the State are paying CEs/PAHPs appropriately for services

The independent assessment used both quantitative and qualitative techniques to assess program performance within the three domains. The quantitative component employed time-series methods to characterize differences over the life of the waiver for enrollees and subpopulations. Qualitative methods were employed to measure enrollee and provider perceptions and satisfaction, and to gather information on State and contracted entity (CE) administrative activities.

The independent assessment leveraged existing data sources to assess performance within the three domains, including CAHPS surveys, EQRO reports, CE submitted regulatory reports as outlined in the SoonerSelect contracts and SoonerSelect Reporting Manuals, CMS Managed Care Annual Program Reports (MCPARs), and other state reports posted to the OHCA’s public website at [www.oklahoma.gov/ohca](http://www.oklahoma.gov/ohca). Additional data was collected as needed, through enrollee telephone surveys, stakeholder interviews, and claims/encounter data.

A copy of the completed independent assessment is included with the States’ waiver renewal application as Attachment 1.

**Problems identified:** No problems identified.

**Corrective action (plan/provider level):** No corrective action required.

**Program change (system-wide level):** Not applicable.

**Strategy:** i. Measurement of any disparities by racial or ethnic groups

**Confirmation it was conducted as described:**

Yes

No. Please explain:

**Summary of results:** Quality metrics that evaluate variance in outcomes by racial or ethnic groups were limited in the first year to Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan results.

All three MCOs are actively engaging in National Committee for Quality Assurance (NCQA) Health Outcomes Accreditation survey activities and are on target to achieve the required Health Outcomes Accreditation within two years of operations start date (i.e., by 3/31/2026). OHCA monitors MCO progress toward this required accreditation as per the instructions outlined in the applicable SoonerSelect Reporting Manuals. All MCOs and PAHP contractors submitted cultural competency plans prior to managed care implementation go-live. Each competency plan contains approximately 15 standards focusing on areas like assessing members' linguistics needs, collecting race, ethnicity and demographic data and using data to drive improvement of population health outcomes, identifying and developing interventions strategies for high-risk conditions in specific cultural groups etc. All plans conduct health risk assessment screenings and use the information to improve quality of services provided to beneficiaries. MCO and PAHPs collect enrollee identified race, ethnicity and social determinants of health data in HEDIS and CAHPS reporting which reported to OHCA using various quality reports. On a frequent basis, MCOs & PAHPs report key staff personnel to the state and the EQRO and update as staff changes occur. All MCOs and PAHPs have tribal liaisons who support health improvement strategies being implemented to address the health needs of tribal members.

**Problems identified:** Almost all quality measures the MCOs and PHAPs report on where data is available on racial and ethnic groups, including Healthcare Effectiveness Data and Information Set (HEDIS) and the Centers for Medicare and Medicaid Services (CMS) core set measures, were hampered by continuous eligibility requirements for members in measurement year (MY) 2024. The MCOs and PAHPs report measures based on a calendar year, yet they did not begin operations until February 2024 and April 2024, respectively. As a result, most members did not meet the minimum eligibility requirements. This was a known problem, and the limitation will not be an issue for future reporting years.

**Corrective action (plan/provider level):** The plans will have MY 2025 as a full calendar year for quality measures reporting thereby negating the eligibility requirement issues that arose with the partial measurement year in 2024.

**Program change (system-wide level):** Not applicable.

**Strategy:** j. Network adequacy assurance submitted by plan

**Confirmation it was conducted as described:**

X Yes  
\_\_\_ No. Please explain:

**Summary of results:** MCOs and PAHPs submitted network adequacy assurances and related data in line with the cadence established in the SoonerSelect Reporting Manual. OHCA reviewed each submission to assess whether the plans demonstrate sufficient provider capacity and network coverage across primary care providers (PCP), primary care dentists (PCD), mental health, substance use disorder, specialists (as designated by the State) adult and pediatric, pediatric dental, pharmacy, and hospital provider types.

Consistent with the process applied to geo-access monitoring, OHCA evaluated each plan's reported network adequacy on a county- or zip-code level basis and reviewed whether the plan met the minimum access standards defined in their contract. OHCA provided written feedback to each MCO/PAHP, including questions on the reported data and identification of areas where the plan did not meet network adequacy requirements.

For any provider types of geographic areas where a plan reported being unable to meet standards, OHCA required the MCO/PAHP to submit a network adequacy exception request that included a justification and the steps the plan was taking to confirm continued enrollee access. OHCA reviewed these exception requests by assessing the plan's provider list and comparing it to available providers and to the networks reported by other plans. OHCA issued preliminary denials in instances where providers were available but not contracted, and allowed plans to submit supplemental justification describing contracting challenges or planned actions to address gaps. OHCA maintained a record of network changes across submissions and requested explanations when an MCO/PAHP reported a loss of adequacy in areas where they had previously met standards.

In addition, the EQRO completed its annual validation of network adequacy for the review period, and its findings were incorporated into OHCA's overall assessment of provider capacity and geographic coverage.

**Problems identified:** During the review of network adequacy assurances and exception requests, OHCA identified issues including insufficient justification provided by MCOs/PAHPs when they did not meet access standards.

Additionally, the EQRO's annual validation activities resulted in the following recommendations for Network Adequacy Quality Improvement:

- OHCA should continue to work with the MCOs and PAHPs to improve the completeness of the provider directory files.
- MCOs and PAHPs should strive to populate the Accommodations for Persons with Disabilities directory field.
- MCOs and PAHPs should ensure that the technical specifications for the network adequacy report are unambiguous to allow for better interrater reliability and to limit the potential for misinterpretation.
- MCOs and PAHPs should work together, and with OHCA, to ensure that providers and locations are counted consistently among all MCOs and PAHPs. This would

allow for a more accurate comparison between each of the MCO's and PAHP's networks.

**Corrective action (plan/provider level):** To support compliance and improve reporting quality, OHCA required the following actions from MCOs/PAHPs:

- Liquidated damages in cases where plans did not provide sufficient justification for unmet standards; and
- Additional technical assistance and training for MCOs/PAHPs on expectations for establishing and maintaining adequate networks.

These actions improved the completeness and quality of MCO/PAHP responses over time.

**Program change (system-wide level):** Not applicable.

**Strategy:** 1. On-site review

**Confirmation it was conducted as described:**

Yes  
 No. Please explain:

**Summary of results:** In accordance with 42 C.F.R. § 438.66, OHCA conducted a readiness review of all MCO and PAHP contractors prior to the program operational start date. Readiness reviews assessed each MCO and PAHP contractor's ability and capacity to perform satisfactorily in the following functional areas: administration, enrollment-related functions, member services, provider and provider network, coverage, quality and utilization management, care coordination and population health, grievance and appeals, program integrity, information technology, finance, and general terms and conditions. OHCA's approach to readiness reviews included an initial desk review of submitted materials (namely contractor policies and procedures), followed by onsite interviews and demonstrations of systems and processes, which took place between March and November of 2023. Follow-up on-site reviews were completed between January and March of 2024 to reassess requirements that were determined to be incomplete or in progress at the time of the initial on-site readiness review.

All MCO and PAHP contractors successfully completed OHCA's readiness review process, and assurances, in accordance with 42 C.F.R. § 438.66(d)(4), were submitted to CMS that each contractor demonstrated satisfactorily their ability to perform the requirements outlined in the SoonerSelect contract, in accordance with both federal and state laws.

OHCA continues to monitor all MCO and PAHP operations through the ongoing submission of updated policies and procedures, as well as through mandatory operational reports as specified in the applicable SoonerSelect Reporting Manuals.

**Problems identified:** No problems identified.

**Corrective action (plan/provider level):** No corrective action required.

**Program change (system-wide level):** Not applicable.

**Strategy:** m. Performance Improvement Projects

**Confirmation it was conducted as described:**

Yes

No. Please explain:

**Summary of results:** Both MCOs and PAHPs are required to design and implement Performance Improvement Projects (PIPs). Of the sixteen (16) PIPs that are required of the MCOs and PAHPs, fifteen (15) have been approved and implemented and one (1) is pending approval.

Each PAHPs must implement 2 PIPs, a clinical PIP aimed at improving member health outcomes and a non-clinical PIP aimed at improving health related social needs. Proposed and approved clinical PAHP PIPs include:

- *Preventive Services for Children:* Improving rates of any of the following measures - oral evaluation, topical fluoride varnish and/or sealant receipt on permanent first molar.
- *Visits by 1st Birthday:* Increasing the percentage of SoonerSelect enrollees receiving a dental visit by their first birthday.

Proposed and approved non-clinical PAHP PIPs include:

- *Transportation Support:* Improving access to care through transportation appointment scheduling and transportation assistance.
- *Oral Health Literacy:* Improving oral health outcomes among adult tribal populations

Similarly, all MCOs are required to implement three (3) PIPs, which must incorporate a physical health PIP, a behavioral health PIP, and a non-clinical PIP. Proposed and approved physical health PIPs include:

- *Childhood Immunization Status Combo 3:* Improving immunization rates for enrollees in rural areas of the state. (Medical PIP)
- *Comprehensive Diabetes Care (Hemoglobin HbA1c Control for Patients with Diabetes):* Improve Glycemic Status Assessment for Patients with Diabetes (GSD). (Medical PIP)
- *Improve Performance of the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (HEDIS Measure):* Improving performance on the HEDIS measure. (Medical and CSP PIP)

Proposed and approved behavioral health PIPs include:

- *Improve the Rate of Follow-up Care for Children Prescribed ADHD Medication:* Improving the initiation and continuation sub measures. (Medical PIP)
- *30-Day Follow-up After Hospitalization for Mental Illness for Enrollees 6 years and Older:* Improving performance on the quality measure. (Medical PIP)

- *7-Day Follow-up After Hospitalization for Mental Illness for Enrollees 6 years and Older: Improving performance on the quality measure. (Medical and CSP PIP)*

Proposed and approved non-clinical PIPs include:

- *Improving Social Determinate of Health Assessment and Referral in Plan Members: Identifying and meeting enrollees' health related social needs. (Medical PIP)*
- *Social Needs Screening and Intervention: Increasing health-related social needs (HRSN) screenings for enrollees and ensuring referrals for positive screens within 30 days. (Medical PIP)*
- *Increase Case Management Support for Foster Care: Reducing the utilization of higher levels of care among youth in foster care. (CSP specific PIP)*

One MCO has not received approval for their non-clinical PIP (i.e., *Notification of Pregnancy: Improving prenatal and postpartum visits and connecting high risk members to care management to improve outcomes*). The state is currently working with the MCO to strengthen its proposed interventions for approval and implementation.

Both MCOs and PAHPs are required to submit annual reports on PIP progress and activity, with due dates driven by the start date of interventions for each PIP. OHCA anticipates MCOs and PAHPs will submit these reports when due.

OHCA anticipates that most MCOs and PAHPs will submit annual PIP reports as a part of the EQRO process in calendar year 2026.

**Problems identified:** MCOs and PAHPs struggled to design meaningful and potentially impactful PIPs. It took an average of 12 months across both MCOs and PAHPs to get approval for their PIPs.

**Corrective action (plan/provider level):** The state created a process consisting of PIP draft reviews and feedback meetings to discuss how proposed PIP designs could be strengthened. MCOs and PAHPs were then given the opportunity to incorporate feedback into their proposed PIPs and resubmit them for review.

**Program change (system-wide level):** Not applicable

**Strategy:** n. Performance measures

**Confirmation it was conducted as described:**

Yes

No. Please explain:

**Summary of results:** Quality metrics were limited in the first year to Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan results and provider surveys.

**Problems identified:** Almost all quality metrics the MCOs and PAHPs report on where data is available, including Healthcare Effectiveness Data and Information Set (HEDIS) and the Centers for Medicare and Medicaid Services (CMS) measures, were hampered by continuous eligibility requirements for members. The MCOs and PAHPs report measures based on a calendar year, yet they did not begin operations until February 2024 or April 2024, respectively. As a result, no members met the minimum eligibility requirements. This was a known problem, and the limitation will not be an issue for future reporting years.

**Corrective action (plan/provider level):** No corrective actions required.

**Program change (system-wide level):** Not applicable.

**Strategy:** o. Periodic comparison of numbers and types of Medicaid providers before and after waiver

**Confirmation it was conducted as described:**

Yes  
 No. Please explain:

**Summary of results:** MCOs and PAHPs submitted provider listings in accordance with the SoonerSelect Reporting Manual. Each submission had information including the provider's location, provider type and specialty type, and an indicator identifying whether the provider was a primary care provider (PCP)/primary care dentist (PCD). OHCA reviewed all submissions to assess provider capacity and to track changes in the number and types of participating providers over time.

Consistent with the approach used for network adequacy monitoring, OHCA evaluated provider counts at both the plan and program level, reviewing changes across PCP, PCD, mental health, substance use disorder, specialists (as designated by the State) adult and pediatric, pediatric dental, pharmacy, and hospital provider types. The frequency of these submissions allowed OHCA to identify early changes in provider availability, including increases or decreases in specific provider types, shifts in geographic distribution, or opportunities for MCOs/PAHPs to contract with available providers.

OHCA reviewed trends in provider participation across reporting cycles and monitored changes in areas where provider availability had previously met standards. When decreases in provider counts or changes in geographic distribution were identified, OHCA asked MCOs/PAHPs to provide clarification regarding the cause of the changes and the steps the plan was taking to confirm continued enrollee access.

**Problems identified:** No systemic issues were identified in the submission of participating providers.

**Corrective action (plan/provider level):** No corrective action required.

**Program change (system-wide level):** Not applicable.

**Strategy:** p. Profile utilization by provider caseload (looking for outliers)

**Confirmation it was conducted as described:**

Yes  
 No. Please explain:

**Summary of results:** The MCOs/PAHPs reported in their Quality Assurance and Performance Improvement (QAPI) Plans that profiling was initially limited due to being a new market, but they have started the initial functions of provider profiling. These include developing processes to ensure delivery of report cards and necessary training available for reporting platforms. Additionally, MCOs/PAHPs are providing education to providers, focusing on providers that are underperforming in selected metrics. Those efforts include direct engagement to support workflow improvement, delivery of gaps in care lists to properly identify patients who have unmet needs, and provider education in how metrics are met, coding opportunities, and data support. Further development is planned for future years.

**Problems identified:** No problems identified.

**Corrective action (plan/provider level):** No corrective action required.

**Program change (system-wide level):** Not applicable.

**Strategy:** q. Provider self-report data

**Confirmation it was conducted as described:**

Yes  
 No. Please explain:

**Summary of results:** OHCA collaborated with the MCO and PAHP contractors to develop a set of uniform questions for the provider satisfaction survey. The final survey included 41 questions for MCOs and 29 questions PAHPs, and covered all six domains as outlined in Section B. All MCOs and PAHPs conducted their provider surveys through 3<sup>rd</sup> party survey vendors. All three MCOs used the same vendor and both PAHPs also used the same vendor.

Each MCO and PAHP contractor is required to submit the results of its annual provider satisfaction survey to OHCA in accordance with the requirements outlined in the SoonerSelect Reporting Manual. As a part of the submission, each MCO and PAHP contractor must also develop and submit an action plan detailing efforts they will undertake to improve provider experience and/or satisfaction, based on the survey results.

Both of the PAHPs had a response rate of at least 24%. The PAHPs scored high in overall satisfaction and in addressing social determinants of health. However, the survey revealed

opportunities for improvement with language and interpreter services and the appeals process.

Across all MCOs, the provider satisfaction survey response rate ranged from 7.5% to 13.2%. MCOs performed relatively well in overall satisfaction and in their likelihood to be recommended by the providers. The main areas of opportunity for the MCOs were related to Pharmacy, Network, and Coordination of Care.

Oklahoma Statute (56 O.S. § 4002.11) requires OHCA to create a scorecard that compares each MCO and separately compares each PAHP. One of the required elements of the scorecard is provider satisfaction survey results. Scorecards are published quarterly and available on OHCA's public website here: <https://oklahoma.gov/ohca/soonerselect/scorecards.html>.

**Problems identified:** Getting the PAHPs to contract with a single vendor for survey administration was a challenge. However, it is believed this will not be an issue in the future as the contracts are already in place.

**Corrective action (plan/provider level):** No corrective action required.

**Program change (system-wide level):** Not applicable.

**Strategy:** r. Test 24 hours/7 days a week PCP availability

**Confirmation it was conducted as described:**

Yes  
 No. Please explain: During the reporting period, the specified monitoring activity previously described was not conducted as originally outlined. OHCA transitioned away from direct availability testing and instead relied on alternative oversight mechanisms, including review of contractor policies and procedures, grievance and appeals data, network monitoring activities, and enrollee feedback processes to assess compliance with after-hours access requirements. OHCA is reviewing and updating its monitoring approach to ensure alignment between documented monitoring strategies and operational oversight activities.

**Summary of results:** Through review of grievance and appeals data, enrollee complaints, and network monitoring activities during the reporting period, OHCA did not identify systemic program-wide deficiencies related to after-hours PCP access. Routine oversight discussions with contractors included reinforcement of contractual requirements related to 24 hours/7 days availability and coverage arrangements.

**Problems identified:** No systemic program-wide deficiencies related to 24 hours/7 days PCP availability were identified during the reporting period. Any isolated access concerns identified through grievances or complaints were addressed through routine oversight communication with the applicable contractor.

**Corrective action (plan/provider level):** No corrective actions were required at the plan or provider-level. Where individual access concerns were identified, OHCA addressed them through routine oversight communication and technical assistance with the applicable contractor.

**Program change (system-wide level):** Not applicable.

**Strategy:** s. Utilization review (e.g. ER, non-authorization specialists requests)

**Confirmation it was conducted as described:**

Yes

No. Please explain:

**Summary of results:** MCOs and PAHPs submitted required emergency department (ED) utilization reports (MCOs only), utilization management reports, and out-of-state services reports in accordance with the reporting cadences established in the SoonerSelect Reporting Manuals. OHCA reviewed utilization reports, including but not limited to data on inpatient admissions, readmissions, ER utilization, and drug utilization, as a part of ongoing monitoring activities to assess utilization patterns and to identify potential concerns related to access to care, service delivery, and quality-of-care.

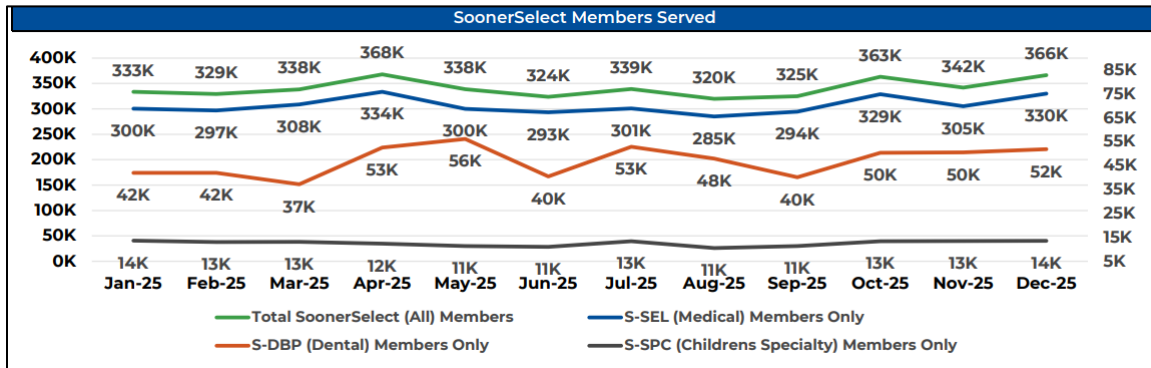
During the initial waiver implementation period, OHCA engaged with MCOs and PAHPs to promote consistent interpretation of reporting requirements and greater uniformity in data submission across contractors. OHCA provided targeted technical assistance to individual MCOs and PAHPs to review reporting expectations and identify opportunities to improve data completeness, accuracy, and consistency. Based on findings from these monitoring activities, OHCA refined reporting templates and documentation to reflect lessons learned and to further standardize reporting requirements for MCOs and PAHPs.

As part of its monitoring of out-of-state services, OHCA's Care Coordination Services (CCS) unit provided structured training and technical guidance to MCOs and PAHPs regarding applicable policies, procedures, and documentation standards. This training reinforced requirements that documentation must include that medically necessary services were not available within Oklahoma, consistent with State statute and each MCO's and PAHP's prior authorization and approval processes for out-of-state care.

In addition to contractor-submitted reports, OHCA's Office of Data Governance and Analytics conducts ongoing monitoring through the production monthly SoonerSelect metrics. These metrics integrate enrollment data with MCO- and PAHP-submitted encounter data to evaluate trends in enrollment, utilization, and expenditures. Expenditure metrics are calculated based on paid MCO and PAHP encounters [e.g., provider claims] and payment date, rather than date of service, and are used to support continuous monitoring of program performance and identification of emerging trends.

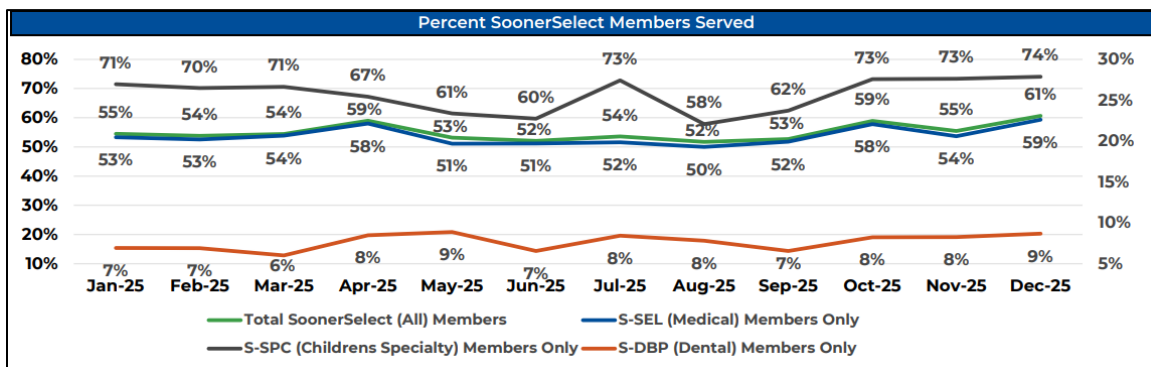
The following examples illustrate selected metrics routinely reviewed by OHCA as part of its oversight activities:

### SoonerSelect Members Served for Calendar Year 2025



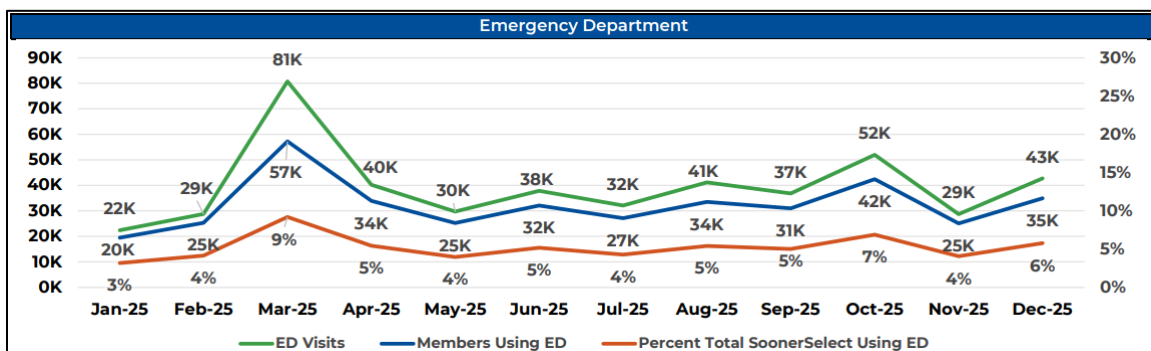
Note: Member enrollment is based on any point in time and any length of time enrolled during the respective month.

### Percent of SoonerSelect Members Served for Calendar Year 2025



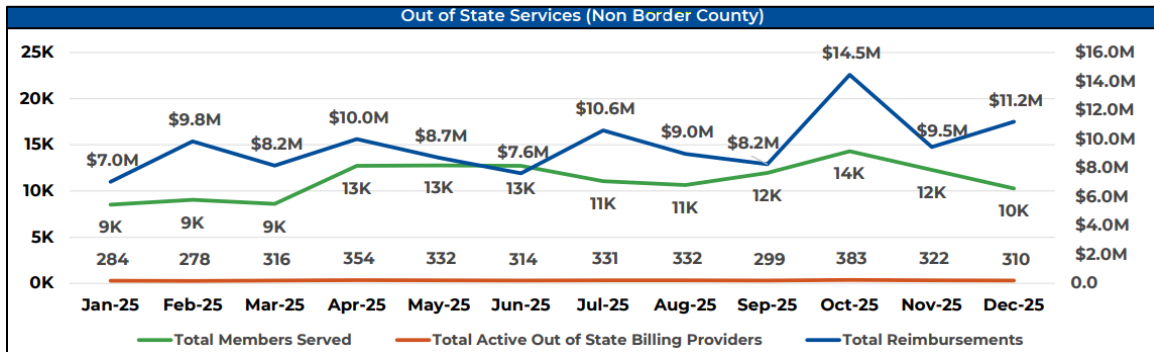
Note: Member enrollment is based on any point in time and any length of time enrolled during the respective month.

### Emergency Department Utilization for Calendar Year 2025



Note: Emergency department claims are calculated using paid facility claims based on paid dates with revenue codes between 450 and 459. The spike in data for March of 2025 represents a large submission of MCO encounters, and not a spike in utilization for the individual month.

### Out-of-State Service Utilization for Calendar Year 2025



Note: Out of state services are calculated using paid claims based on paid dates. Billing providers (service location addresses) are filtered to only include those not in Oklahoma, and address type is service.

In addition to monitoring utilization, OHCA contracts with KFMC Health Improvement Partners (KFMC), as the External Quality Review Organization (EQRO), to annually assess MCO and PAHP compliance with OHCA and the Centers for Medicare & Medicaid Services (CMS) Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements. MCOs have provided SoonerSelect managed care services since April 2024 and PAHPs have provided SoonerSelect managed care services since February 2024.

KFMC and OHCA discussed and determined the scope of review for the first year of managed care implementation. KFMC’s objective was to conduct a desk review to assess adherence to the SoonerSelect EPSDT contract requirements, and the quality of notification and education provided to EPSDT-eligible enrollees and participating providers. A targeted case review included an examination of the appropriateness and timeliness of determinations regarding medical necessity and assessed the MCOs and PAHPs handling of specific prior authorization denials and appeals. Each MCO and PAHP was presented with a document describing the process, compliance results, recommendations and suggested enhancement for quality improvement.

Future reviews will include assessing how each MCO and PAHP is operationalizing the EPSDT-related contract language in practice.

**Problems identified:** For EPSDT compliance review, two (2) of the MCOs/PAHPs met all contractual requirements. The other four (4) MCOs/PAHPs had at least one contractual requirement that was not met or was only partially met. Future EPSDT compliance reports will detail how each MCO/PAHP closed the gap on the items that were identified that did not meet contractual requirements.

**Corrective action (plan/provider level):** No corrective action required.

**Program change (system-wide level):** On May 1, 2026, OHCA will implement a new monitoring and oversight platform, Managed Care Insights (MCI), to enhance visibility into MCO and PAHP- submitted reports. MCI will ingest MCO- and PAHP-submitted regulatory reporting, in addition to encounters, provider network, and prior authorization data, and generate standardized analytic dashboards and visualizations to support proactive

monitoring and trend analysis. MCOs and PAHPs will have access to MCI to facilitate self-monitoring and early identification of utilization patterns.

**Strategy:** t. Other – Marketing Plan

**Confirmation it was conducted as described:**

Yes

No. Please explain:

**Summary of results:** During the first waiver period, OHCA reviewed marketing plans, marketing materials, social media calendars, and media releases from all MCOs and PAHPs. The MCOs and PAHPs successfully made all corrective revisions prior to publication, as requested. OHCA is not aware of any materials produced that did not follow the pre-approved protocols and channels.

**Problems identified:** No problems identified.

**Corrective action (plan/provider level):** No corrective action required.

**Program change (system-wide level):** Not applicable

**Strategy:** t. Other – Program Integrity Reports

**Confirmation it was conducted as described:**

Yes

No. Please explain:

**Summary of results:** OHCA monitored contractor submission of required Program Integrity reports in accordance with the SoonerSelect Reporting Manual. Reports reviewed included Service Delivery Verification submissions (*including Evidence of Benefits outreach and enrollee response resolution*), Overpayments (*recoveries of overpayments*), and Investigations Opened (*program integrity investigations initiated and referrals to the State, as applicable*).

Program Integrity staff reviewed submitted reports for completeness and trends and conducted follow-up reviews as appropriate. During the first waiver period, OHCA Program Integrity staff reviewed contractor submissions, including the Claims Activity and Payment Accuracy Report (*contractor claims activity and payment accuracy reporting*), which was used to support oversight of claims payment timeliness and identification of potential payment integrity concerns for follow-up, as needed.

In addition to monitoring required report submissions, OHCA Program Integrity staff provided ongoing technical assistance and oversight. This included monthly Program Integrity meetings with contractors to discuss audit situations, emerging trends, and scenarios with potential cross-contractor impact, as well as monthly open office hours to provide additional guidance.

**Problems identified:** No problems identified.

**Corrective action (plan/provider level):** No corrective action required.

**Program change (system-wide level):** Not applicable.

**Strategy:** t. Other – Enrollee Services Reports

**Confirmation it was conducted as described:**

Yes

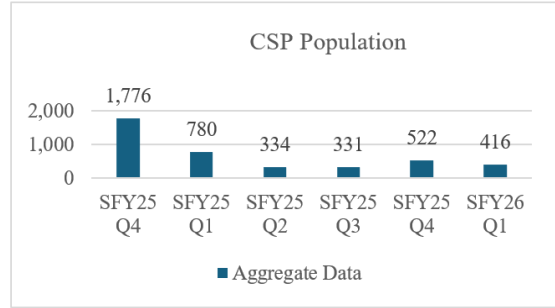
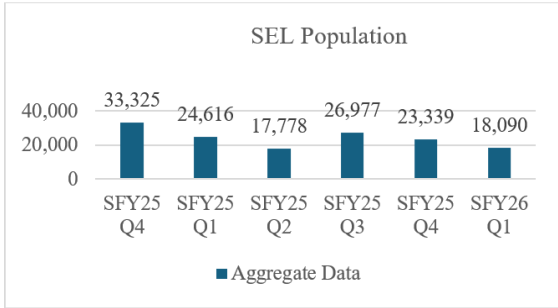
No. Please explain:

**Summary of results:** As a part of pre-implementation activities, OHCA Care Coordination Services (CCS) leaders met with MCOs and PAHP contractors to educate their leadership and care coordinators on SoonerCare and SoonerSelect policies. These educational efforts continued through late fall of 2024. OHCA and the MCO and PAHP contractors collaborated to ensure that, per section 1.9.5.4, Care Managers received initial and ongoing training relevant to the SoonerSelect population. OHCA shared developed scopes of work, processes, and procedures to assist MCO and PAHP contractors in further developing their own curricula, ensuring all Care Managers were equipped to uphold policy requirements.

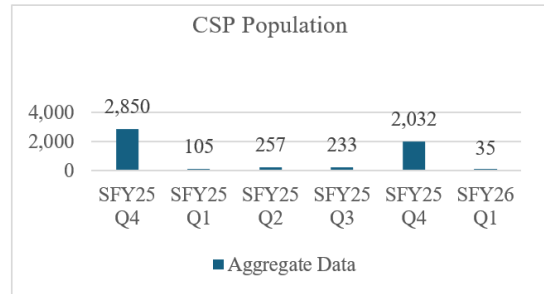
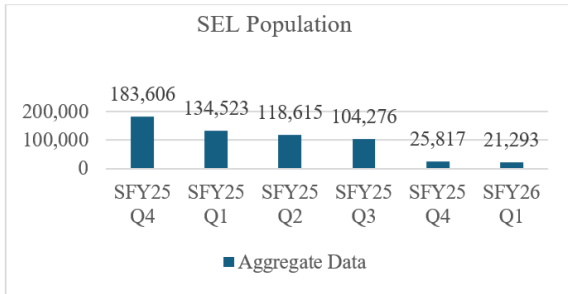
As part of Enrollee Case Management and coordinating and documenting cases assigned to case managers, OHCA and MCO and PAHP contractors have committed to ensuring continuity of care for enrollees transitioning between the SoonerCare (FFS) and SoonerSelect programs. OHCA executed a comprehensive 'warm hand-off' strategy for complex care members and monitored enrollee referrals to social services and behavioral health services. Beginning two weeks prior to launch, CCS staffed over 2,000 unique cases across Behavioral Health, Chronic Care Management, and Social Service Coordination. Through this process, OHCA ensured that critical clinical data and Social Determinants of Health (SDOH) insights transitioned seamlessly to the MCO and PAHP contractors. To date, these warm hand-offs continue for enrollees with complex needs that may impact their health journey.

Foundational to care coordination is understanding the health needs of the population being served. In accordance with 42 C.F.R. § 438.208(b)(3) each MCO was required to demonstrate a good faith effort to perform a Health Risk Screening (HRS) on all new enrollees following contractual timeline requirements and making subsequent attempts if the initial contact was unsuccessful. For the SoonerSelect medical program (SEL), from April 2024 to September 2025, there were 144,125 successful Health Risk Assessment Screenings. For SoonerSelect CSP during the same period, there were 5,559 successful Health Risk Assessment Screenings completed.

**Successful Health Risk Assessment Surveys for SEL and CSP Populations from  
April 2024 through December 2025**

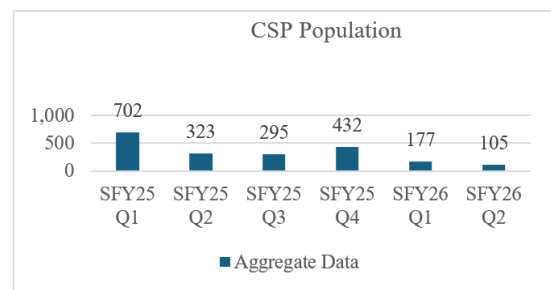
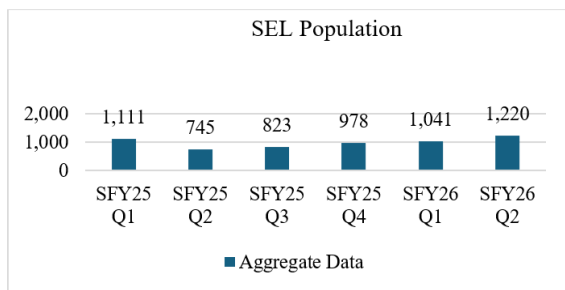


### Unsuccessful Health Risk Assessment Surveys for SEL and CSP Populations from April 2024 through December 2025

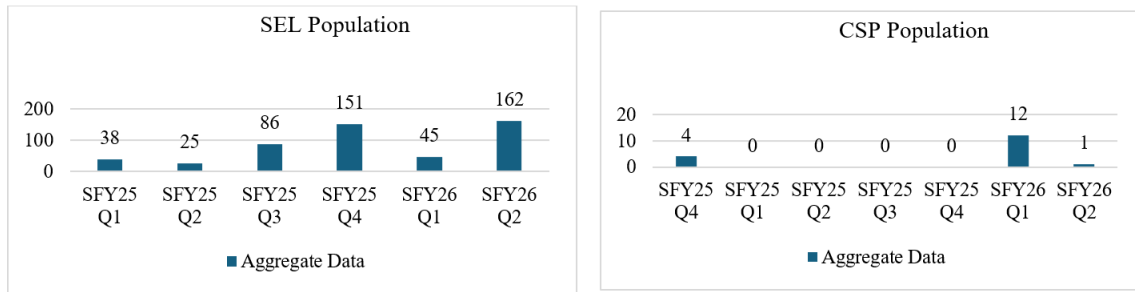


After completing the HRS, some enrollee's care rise to the level (as defined in each MCO's Risk Stratification Framework) to be offered a Comprehensive Assessment. This assessment is a deep-dive evaluation of the enrollee's total health and life situation, and serves as a mechanism to evaluate enrollees identified as having special health care needs or a requirement for Long-Term Services and Supports (LTSS). This process identifies ongoing conditions that require a specific course of treatment or regular care monitoring. Between April 2024 to December 2025, in the SoonerSelect medical program, there were 7,246 successful Comprehensive Assessments. For SoonerSelect CSP during the same period, there were 2,220 successful Comprehensive Assessments. For the entire reporting period from April 2024 to December 2025 the SoonerSelect Medical population received 495 reassessments and the SoonerSelect CSP population received 17.

### Successful Comprehensive Assessments Completed for SEL and CSP Populations from April 2024 through December 2025



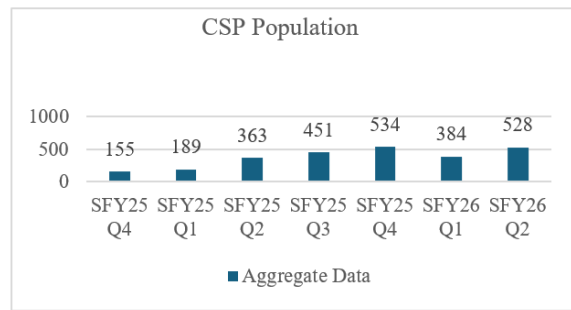
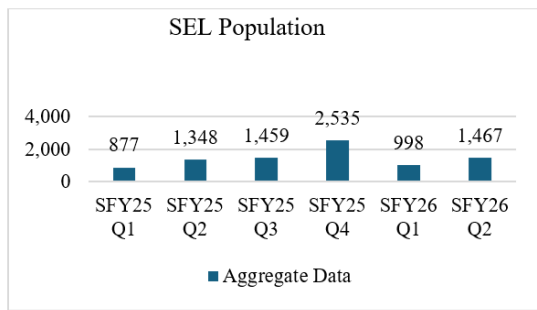
## Successful Comprehensive Reassessments Completed for SEL and CSP Populations from April 2024 through December 2025



As stated, transitions of care and care coordination/continuity are of importance to both OHCA and the MCOs as they are key indicators of the success of the enrollee’s journey along the continuum of care. One area of particular concern is the transition of care from an inpatient setting to a home environment. This is a vital component of healthcare delivery because they represent a high-risk period where the continuity of medical care is most likely to fail. Successfully managed transitions are essential for reducing preventable hospital readmissions, which otherwise lead to a "churn" effect that is both costly to the system and detrimental to patient recovery. Central to this process is medication reconciliation; without a structured hand-off, patients are at a high risk for adverse drug events caused by conflicting prescriptions. Furthermore, these transitions shift the burden of care from 24/7 clinical supervision to the patient or their family, making "teach-back" education and self-management support critical to ensuring safety.

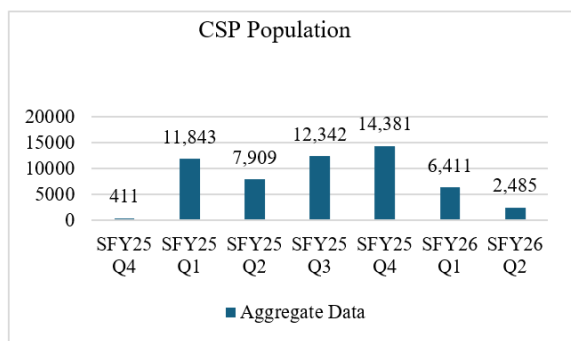
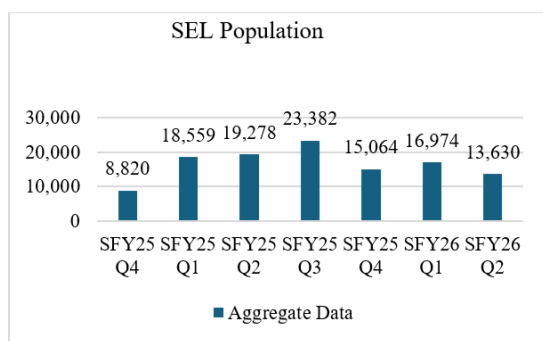
Additionally, a robust transition plan must account for Social Determinants of Health (SDOH), addressing environmental hazards or transportation barriers that might otherwise impede a patient’s ability to follow through with their recovery plan and follow-up appointments. MCOs submit monthly transitions of care reports, which are reviewed and validated for accuracy and completeness. A portion of the reporting requirements are for MCOs to report all enrollees who experienced an inpatient to residential setting discharge. For the entire reporting period from April 2024 to December 2025 the SoonerSelect medical population completed 15,254 transitions of care from an inpatient to residential setting and the SoonerSelect CSP population completed 2,604 transitions of care from an inpatient to residential setting.

### Enrollee Transitions of Care From An Inpatient To A Residential Setting Completed for SEL and CSP Populations from April 2024 through December 2025



Enrollees being served through a comprehensive care coordination and care management experience a more integrated, proactive, and person-centered healthcare journey. By moving away from reactive "crisis-based" care, care coordination allows for early intervention and consistent monitoring of chronic conditions, which leads to improved clinical outcomes and a reduction in avoidable emergency room visits. Beyond clinical benefits, care management serves as an essential bridge for health literacy, empowering members with the navigation support and self-management tools necessary to successfully move through a complex medical system. This holistic approach is particularly vital for those with co-occurring physical and behavioral health needs, ensuring that treatment plans are synchronized and comprehensive. Furthermore, by identifying and addressing social determinants of health—such as food insecurity or housing instability—care managers mitigate the non-medical barriers that often impede health progress. Ultimately, care coordination ensures that members are not navigating their health journey alone, providing a dedicated point of contact to coordinate services, reconcile medications, and ensure every aspect of the member's well-being is addressed.

### Total SoonerSelect Enrollees in Care Coordination Services Completed for SEL and CSP Populations from April 2024 through December 2025



Finally, the provision of non-emergency medical transportation (NEMT) is monitored to ensure SoonerSelect medical and CSP members have transportation assistance to medical services and treatments. Access to NEMT services provides a vital lifeline for members who may otherwise lack reliable transportation. When transportation barriers are removed, members have the means to actively participate in the overall healthcare through the attainment of medically necessary services to address ongoing chronic conditions as well

as attend to their primary and preventive health care needs. MCO contractors submit monthly NEMT utilization reports that focus on the number of trips requested, approved, denied, provided, and the number of trips resulting in a no show.

For calendar year 2024 (April 1, 2024-December 31, 2024), SoonerSelect medical MCO contractors received 220,557 requests for NEMT trips, of which 219,419 were approved and 1,338 were denied. Of the requested trips, SoonerSelect medical MCOs provided 146,978 trips; 11,204 trips resulted in member no shows. For the same period, the SoonerSelect CSP MCO contractor received 4,436 requests for NEMT trips, of which 4,426 were approved and 10 were denied. Of the requested trips, the SoonerSelect CSP MCO provided 3,976 trips; 24 trips resulted in member no shows.

For calendar year 2025 (January 1, 2025-December 31, 2025), SoonerSelect Medical MCO contractors received 302,882 requests for NEMT trips, of which 295,093 were approved and 5,175 were denied. Of the requested trips, SoonerSelect medical MCOs provided 206,682 trips; 12,798 trips resulted in no shows. For the same period, the SoonerSelect CSP MCO contractor received 5,620 requests for NEMT trips, of which 5,588 were approved and 32 were denied. Of the requested trips, the SoonerSelect CSP MCO provided 4,501 trips; 115 trips resulted in no-shows.

Lastly, social determinants of health and value-added benefits are also tracked and monitored through report analysis. OHCA Quality receives three reports namely, a value-added benefits plan (VAB Plan), a value-added utilization report (VAB Utilization Report) and the social determinants of health report (SDOH Report). The VAB Plan is submitted prior to the start of the new plan contract year. This allows the VABs to be reviewed and discussed with MCOs and PAHPs. When MCOs and PAHPs also want to make changes to approved VABs during the contract year, they submit a VAB Plan showing the updates requested which once again is reviewed and approved by OHCA subject matter experts (SMEs). The SDOH Report is a quarterly report submitted by the MCOs and PAHPs which details enrollee referrals for health-related social needs. Analysis of the report over a 20-month period shows that food insecurity, housing needs, utilities and transportation were enrollees' top needs for the medical and CSP population. For the PAHPs, transportation and food insecurity were the top needs that emerged over the same period. Data from the SDOH report is used to provide guidance to MCOs and PAHPs as they design their VABs. **Problems identified:** An opportunity for improvement in the upcoming waiver period will be in the area of Reassessments, understanding how each CE defines 'reassessment', and ensuring that each CE is accurately reporting reassessments and intervention in accordance with the SoonerSelect contract.

An additional opportunity for improvement in the upcoming waiver period will be to increase monitoring and oversight of NEMT services through the collection of additional measures to create a more comprehensive review of NEMT service utilization. During the initial waiver period, MCO contractors reported on additional NEMT service utilization metrics beyond those outlined above; however, reporting for some additional measures was stopped to allow OHCA additional time to work with MCO contractors and their NEMT vendor to understand what data metrics were available to report on that would allow OHCA to more appropriately monitor access to care.

**Corrective action (plan/provider level):** No corrective action required.

**Program change (system-wide level):** Moving forward, OHCA and the CEs will be working towards bi-directional exchange of care coordination information to include health risk assessments, comprehensive assessments, and prior authorizations. The bidirectional exchange of information serves as the operational backbone of Oklahoma’s care coordination strategy. By facilitating the real-time flow of clinical data, ADT alerts, and social screening results between OHCA, our contracted CEs, and the provider network, we ensure that care is never delivered in a vacuum. This data transparency allows for more accurate risk stratification, reduces the likelihood of duplicative testing, and ensures that transition-of-care protocols—such as the over 2,000 warm hand-offs conducted at launch—are supported by a comprehensive, up-to-date medical record for every enrollee.

## Section D – Cost-Effectiveness

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

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

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

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

### Part I: State Completion Section

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

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

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

**A. Assurances**

- a. [Required] Through the submission of this waiver, the State assures CMS:
  - The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
  - The State assures CMS that the actual waiver costs will be less than or equal to or the State’s waiver cost projection.
  - Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.
  - Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
  - The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
  - The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State’s submitted CMS-64 forms.
- b. Name of Medicaid Financial Officer making these assurances: **Josh Richards.**
- c. Telephone Number: **(405) 522-7759**
- d. E-mail: **Josh.Richards@okhca.org**
- e. The State is choosing to report waiver expenditures based on   **X**   date of payment.  
       date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

#### **E. Appendix D1 – Member Months**

Please mark all that apply.

For Initial Waivers only:

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

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

**Member Month Summary**

<b>MEG</b>	<b>Base Year (CY22) Member Months</b>	<b>Projected P1 Member Months</b>	<b>Projected P2 Member Months</b>
TANF and Related: Child and Adult	7,344,085	4,187,489	4,682,994
CHIP	1,493,649	560,058	739,861
Expansion	3,697,122	1,853,412	1,986,797
<b>Total</b>	<b>12,534,856</b>	<b>6,600,959</b>	<b>7,409,652</b>

For Conversion or Renewal Waivers:

- a. X [Required] Population in the base year and R1 and R2 data is the population under the waiver.
- b. X For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period.*
- c. X [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:  
**Member months projections are based on actual enrollment for the two most recent quarters (July 1, 2025 – December 31, 2025).**

**Enrollment projections include a modest quarterly trend factor of .5 percent.**

- d. X [Required] Explain any other variance in eligible member months from BY/R1 to P2: **R2 member months were trended by a quarterly rate of .5 percent to develop P2 enrollment projections.**
- e. X [Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period:

**Time periods are as follows:**

<b>R1</b>	<b>SFY25</b>	<b>July 1, 2024 – June 30, 2025</b>
<b>R2</b>	<b>SFY26 (First Half)</b>	<b>July 1, 2025 – December 31, 2025</b>
<b>P1</b>	<b>SFY27</b>	<b>July 1, 2026 – June 30, 2027</b>
<b>P2</b>	<b>SFY28</b>	<b>July 1, 2027 – June 30, 2028.</b>

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

For Initial Waivers:

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

For Conversion or Renewal Waivers:

- a. X [Required] Explain if different services are included in the Actual Waiver Cost from the previous period in **Appendix D3** than for the upcoming waiver period in **Appendix D5**. Explain the differences here and how the adjustments were made on **Appendix D5**:

**N/A-The same services are included in previous and upcoming waiver periods.**

- b. X [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account: **Individuals who are enrolled in SoonerSelect may also participate in the State’s 1115 IMD Demonstration; CMS and the OHCA developed reporting processes to ensure that program expenditures are not double-counted.**

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

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

**The table below provides a summary of actual and projected pmpm administrative costs.**

	TANF and Related: Child and Adult	CHIP	Expansion
R2 (Actual) Administrative Costs (First half of SFY26, July 1, 2025 – December 31, 2025)	\$42,847,662	\$10,818,587	\$33,415,062
R2 (Actual) Member Months	2,353,358	356,373	981,108
R2 (Actual) Administrative Cost PMPM	\$18.21	\$30.36	\$34.06
Trend Factor (President’s Budget annual trend of 4.8 percent x 18 months)	7.3 percent	7.3 percent	7.3 percent
P1 (Projected) Administrative Cost PMPM	\$19.53	\$32.57	\$36.54

For Initial Waivers:

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

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

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

**H. Appendix D3 – Actual Waiver Cost**

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

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

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

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

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

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

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

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

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

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

premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.

Basis and Method:

1. \_\_\_ The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.

2. X The State provides stop/loss protection (please describe):

**The State has established a Medical Loss Ratio (MLR) risk corridor to ensure MCOs maintain at least a targeted Medical Loss Ratio, but also to offer stop/loss protection.**

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

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

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

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

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

i. Document the criteria for awarding the incentive payments.

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

**Current Initial Waiver Adjustments in the preprint**

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

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

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

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

please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

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

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

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

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

Others:

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

1.  The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.
  
2.  An adjustment was necessary. The adjustment(s) is(are) listed and described below:
  - i.  The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.  
 For each change, please report the following:
    - A.  The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment \_\_\_\_\_
    - B.  The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment \_\_\_\_\_
    - C.  Determine adjustment based on currently approved SPA. PMPM size of adjustment \_\_\_\_\_
    - D.  Determine adjustment for Medicare Part D dual eligibles.**
    - E.  Other (please describe): \_\_\_\_\_
  
  - ii.  The State has projected no externally driven managed care rate increases/decreases in the managed care rates.
  
  - iii.  Changes brought about by legal action (please describe):  
 For each change, please report the following:
    - A.  The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment \_\_\_\_\_
    - B.  The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment \_\_\_\_\_
    - C.  Determine adjustment based on currently approved SPA. PMPM size of adjustment \_\_\_\_\_
    - D.  Other (please describe): \_\_\_\_\_
  
  - iv.  Changes in legislation (please describe):  
 For each change, please report the following:
    - A.  The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment \_\_\_\_\_
    - B.  The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment \_\_\_\_\_
    - C.  Determine adjustment based on currently approved SPA. PMPM size of adjustment \_\_\_\_\_
    - D.  Other (please describe): \_\_\_\_\_

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

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

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

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

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

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

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

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

- e. State Plan Service trend

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

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

- 1. List the State Plan trend rate by MEG from **Section D.I.I.a.** \_\_\_\_\_
- 2. List the Incentive trend rate by MEG if different from **Section D.I.I.a** \_\_\_\_\_
- 3. Explain any differences:

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

1. \_\_\_ We assure CMS that GME payments are included from base year data.
2. \_\_\_ We assure CMS that GME payments are included from the base year data using an adjustment. (Please describe adjustment.)
3. \_\_\_ Other (please describe):

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

1. \_\_\_ GME adjustment was made.
  - i. \_\_\_ GME rates or payment method changed in the period between the end of the BY and the beginning of P1 (please describe).
  - ii. \_\_\_ GME rates or payment method is projected to change in the period between the beginning of P1 and the end of P2 (please describe).
2. \_\_\_ No adjustment was necessary and no change is anticipated.

*Method:*

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

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

1. \_\_\_ Payments outside of the MMIS were made. Those payments include (please describe):
2. \_\_\_ Recoupments outside of the MMIS were made. Those recoupments include (please describe):
3. \_\_\_ The State had no recoupments/payments outside of the MMIS.

- h. Copayments Adjustment:** This adjustment accounts for any copayments that are collected under the FFS program but will not be collected in the waiver program.

States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program.

*Basis and Method:*

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

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

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

*Method:*

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

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

*Basis and method:*

1. \_\_\_ No adjustment was necessary
2. \_\_\_ Base Year costs were cut with post-pay recoveries already deducted from the database.
3. \_\_\_ State collects TPL on behalf of MCO/PIHP/PAHP enrollees
4. \_\_\_ The State made this adjustment: \*
  - i. \_\_\_ Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs/PIHPs/PAHPs. Please account for this adjustment in **Appendix D5.**
  - ii. \_\_\_ Other (please describe):

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

*Basis and Method:*

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

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

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

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

1. \_\_\_ This adjustment is not necessary as there are no voluntary populations in the waiver program.
2. \_\_\_ This adjustment was made:
  - a. \_\_\_ Potential Selection bias was measured in the following manner:
  - b. \_\_\_ The base year costs were adjusted in the following manner:

- m. FQHC and RHC Cost-Settlement Adjustment:** Base Year costs should not include cost-settlement or supplemental payments made to FQHCs/RHCs. The

Base Year costs should reflect fee-for-service payments for services provided at these sites, which will be built into the capitated rates.

1. \_\_\_ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the Base Year costs. Payments for services provided at FQHCs/RHCs are reflected in the following manner:
2. \_\_\_ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the base year data using an adjustment.
3. \_\_\_ ***We assure CMS that Medicare Part D coverage has been accounted for in the FQHC/RHC adjustment.***
4. \_\_\_ Other (please describe):

### **Special Note section:**

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

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

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

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

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

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

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

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

- o. PCCM Case Management Fees (Initial PCCM waivers only)** – The State must add the case management fees that will be claimed by the State under new PCCM waivers. There should be sufficient savings under the waiver to offset these fees.
1. \_\_\_ The new PCCM case management fees will be accounted for with an adjustment on Appendix D5.
  2. \_\_\_ This adjustment is not necessary as this is not an initial PCCM waiver in the waiver program.
  3. \_\_\_ This adjustment was made in the following manner:
- p. Other adjustments:** Federal law, regulation, or policy change: If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State’s FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
- Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
- For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
1. \_\_\_ No adjustment was made.
  2. \_\_\_ This adjustment was made (Please describe) This adjustment must be mathematically accounted for in **Appendix D5**.

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

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

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

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

- a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.

1.   X   [Required, if the State’s BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (*i.e., trending from 1999 to present*) The actual trend rate used is: **the President’s Budget annual trend rate (4.8 percent)**. Please document how that trend was calculated:

**The OHCA applied the President’s Budget trend rate for the period from R2 to P1. The President’s Budget trend rate is consistent with most recently observed pmpm trends (R1 v R2).**

2.   X   [Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) (*i.e., trending from present into the future*).

i.      State historical cost increases. Please indicate the years on which the rates are based: base years \_\_\_\_\_ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State’s cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

ii.   X   National or regional factors that are predictive of this waiver’s future costs. Please indicate the services and indicators used: **President’s Budget (4.8 percent)**. In addition, please indicate how this factor was determined to be predictive of this waiver’s future costs. Finally, please note and explain if the State’s cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM. **The President’s Budget trend rate was applied as a generally recognized basis for estimating waiver cost trends.**

3. \_\_\_\_\_ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2.
- i. Please indicate the years on which the utilization rate was based (if calculated separately only).
  - ii. Please document how the utilization did not duplicate separate cost increase trends.

b. \_\_\_\_\_ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** These adjustments should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend. If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.* The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in Cost increase or pricing (+/-)
- Graduate Medical Education (GME) Changes - This adjustment accounts for changes in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments from the capitation rates. However, GME payments must be included in cost-effectiveness calculations.
- Copayment Changes - This adjustment accounts for changes from R2 to P1 in any copayments that are collected under the FFS program, but not collected in the MCO/PIHP/PAHP capitated program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.

1.  The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.
  
2.  An adjustment was necessary and is listed and described below:
  - i.  The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.  
 For each change, please report the following:
    - A.  The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment \_\_\_\_\_
    - B.  The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment \_\_\_\_\_
    - C.  Determine adjustment based on currently approved SPA. PMPM size of adjustment \_\_\_\_\_
    - D.  **Determine adjustment for Medicare Part D dual eligibles.**
    - E.  Other (please describe): \_\_\_\_\_
  - ii.  The State has projected no externally driven managed care rate increases/decreases in the managed care rates.
  - iii.  The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain: \_\_\_\_\_
  - iv.  Changes brought about by legal action (please describe): \_\_\_\_\_  
 For each change, please report the following:
    - A.  The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment \_\_\_\_\_
    - B.  The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment \_\_\_\_\_
    - C.  Determine adjustment based on currently approved SPA. PMPM size of adjustment \_\_\_\_\_
    - D.  Other (please describe): \_\_\_\_\_
  - v.  Changes in legislation (please describe): \_\_\_\_\_  
 For each change, please report the following:
    - A.  The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment \_\_\_\_\_
    - B.  The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment \_\_\_\_\_
    - C.  Determine adjustment based on currently approved SPA. PMPM size of adjustment \_\_\_\_\_
    - D.  Other (please describe): \_\_\_\_\_
  - vi.  Other (please describe): \_\_\_\_\_

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

c. **Administrative Cost Adjustment:** This adjustment accounts for changes in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the managed care program then the State needs to estimate the impact of that adjustment.

- 1.  No adjustment was necessary and no change is anticipated.
- 2. \_\_\_ An administrative adjustment was made.
  - i. \_\_\_ Administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:
  - ii. \_\_\_ Cost increases were accounted for.
    - A. \_\_\_ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
    - B. \_\_\_ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
    - C. \_\_\_ State Historical State Administrative Inflation. The actual trend rate used is: \_\_\_\_\_. Please document how that trend was calculated:
    - D. \_\_\_ Other (please describe): \_\_\_\_\_
  - iii. \_\_\_ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.
    - A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base

years \_\_\_\_\_ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.J.a.** above \_\_\_\_\_.

**d. 1915(b)(3) Trend Adjustment:** The State must document the amount of 1915(b)(3) services in the R1/R2/BY Section D.I.H.a above. The R1/R2/BY already includes the actual trend for the 1915(b)(3) services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the R2/BY and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1. \_\_\_\_ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1 to trend BY or R2 to P1] The State is using the actual State historical trend to project past data to the current time period (*i.e., trending from 1999 to present*). The actual documented trend is: \_\_\_\_\_. Please provide documentation.

2. \_\_\_\_ [Required, when the State's BY or R2 is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (*i.e., trending from present into the future*), the State must use the lower of State historical 1915(b)(3) trend or the State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

i. State historical 1915(b)(3) trend rates

1. Please indicate the years on which the rates are based: base years \_\_\_\_\_

2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):

ii. State Plan Service Trend

1. Please indicate the State Plan Service trend rate from **Section D.I.J.a.** above \_\_\_\_\_.

**e. Incentives (not in capitated payment) Trend Adjustment: Trend is limited to the rate for State Plan services.**

1. List the State Plan trend rate by MEG from Section D.I.J.a \_\_\_\_\_

2. List the Incentive trend rate by MEG if different from Section D.I.J.a. \_\_\_\_\_

3. Explain any differences:

f. **Other Adjustments** including but not limited to federal government changes. (Please describe):

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - ◆ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - ◆ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
- **Pharmacy Rebate Factor Adjustment (Conversion Waivers Only)\*:** Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

*Basis and Method:*

1. \_\_\_ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population *which includes accounting for Part D dual eligibles*. Please account for this adjustment in **Appendix D5**.
2. \_\_\_ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS *or Part D for the dual eligibles*.
3. \_\_\_ Other (please describe):
4. \_\_\_ No adjustment was made.
5. \_\_\_ This adjustment was made (Please describe). This adjustment must be mathematically accounted for in **Appendix D5**.

### **K. Appendix D5 – Waiver Cost Projection**

The State should complete these appendices and include explanations of all adjustments in **Section D.I.I and D.I.J** above.

### **L. Appendix D6 – RO Targets**

The State should complete these appendices and include explanations of all trends in enrollment in **Section D.I.E.** above.

### **M. Appendix D7 - Summary**

a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.

1. Please explain caseload changes contributing to the overall annualized rate of change in **Appendix D7 Column I**. This response should be consistent with or the same as the answer given by the State in **Section D.I.E.c & d**:

**A quarterly caseload trend of .5 percent was applied.**

2. Please explain unit cost changes contributing to the overall annualized rate of change in **Appendix D7 Column I**. This response should be consistent with or the same as the answer given by the State in the State's explanation of cost increase given in **Section D.I.I and D.I.J**:

**The President's Budget annual trend rate of 4.8 percent was applied, intended to account for increases in unit costs and utilization.**

3. Please explain utilization changes contributing to the overall annualized rate of change in **Appendix D7 Column I**. This response should be consistent with or the same as the answer given by the State in the State's explanation of utilization given in **Section D.I.I and D.I.J**:

**The President's Budget annual trend rate of 4.8 percent was applied, intended to account for increases in unit costs and utilization.**

Please note any other principal factors contributing to the overall annualized rate of change in **Appendix D7 Column I**. N/A

### **Part II: Appendices D.1-7**

Please see attached OK 1915b Waiver Cost Effectiveness Excel spreadsheets.