Alternative Benefit Plan

State Name: Oklahoma

Attachment 3.1-L-

OMB Control Number: 0938-1148

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Service Delivery Systems — ABP8

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

- ☒ Managed care.
  - ☒ Managed Care Organizations (MCO).
  - ☐ Prepaid Inpatient Health Plans (PIHP).
  - ☒ Prepaid Ambulatory Health Plans (PAHP).
  - ☒ Primary Care Case Management (PCCM).
- ☒ Fee-for-service.
- ☐ Other service delivery system.

Managed Care Options

Managed Care Assurance

☑ The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

The State engaged stakeholders as part of its planning process for the new managed care delivery system, SoonerSelect. The agency conducted formal tribal consultation during the bi-monthly meetings on July 7, 2020, September 1, 2020, November 3, 2020, and January 5, 2021. The transition to a managed care organization (MCO) delivery system was further discussed at the annual tribal consultation meeting on November 12, 2020 and during tribal MCO workgroup meetings on July 21, 2020, July 30, 2020, and October 8, 2020.

The Alternative Benefit Plan (ABP) for expansion adults was discussed as it is the benefit service array within the RFP and/or model contract.

On July 16, 2020, OHCA issued a Request For Information (RFI) to solicit input and recommendations on the design of SoonerSelect. The benefits described under the ABP were included within the RFP and/or model contract. Extensive feedback was received from a broad array of stakeholders including provider associations, community organizations, advocacy groups, and MCOs.

The RFI invited respondents to offer recommendations in key areas, inclusive of benefits provided through MCOs, and the OHCA worked to incorporate into the SoonerSelect and SoonerSelect Dental RFPs numerous recommendations that came from the RFI responses such as encouraging MCOs to offer in lieu of services and flexibility in value-added benefits to meet member needs.

The State's RFPs were drafted in accordance with state procurement policies and the SoonerSelect MCO RFP was released on the State's public website on November 13, 2020 with opportunities for managed care entities to submit bids through December 15, 2020.

The SoonerSelect Dental RFP was available on the OHCA public website from October 15, 2020 through December 15, 2020.

The OHCA began a 30-day public notice process on February 19, 2021 and concluded the process on March 21, 2021. The public notice was posted on the OHCA's website on February 19, 2021. A copy of the public notice and instructions about the public comment process is available at oklahoma.gov/ohca/policies-and-rules/public-notices.

MCO: Managed Care Organization

The managed care delivery system is the same as an already approved managed care program. No

☑ The Alternative Benefit Plan will be provided through a managed care organization (MCO) consistent with applicable managed care requirements (42 CFR Part 438, and sections 1903(m), 1932 and 1937 of the Social Security Act).

MCO Procurement or Selection Method

Indicate the method used to select MCOs:

◉ Competitive procurement method (RFP, RFA).

○ Other procurement/selection method.

Describe the method used by the state/territory to procure or select the MCOs:

Other MCO-Based Service Delivery System Characteristics

One or more of the Alternative Benefit Plan benefits or services will be provided apart from the managed care organization. No

MCO service delivery is provided on less than a statewide basis. No

MCO Participation Exclusions

Individuals are excluded from MCO participation in the Alternative Benefit Plan: No

General MCO Participation Requirements

Indicate if participation in the managed care is mandatory or voluntary:

◉ Mandatory participation.

○ Voluntary participation. Indicate the method for effectuating enrollment:

Describe method of enrollment in MCOs:

Mandatory Enrollment. For mandatory enrollment populations, the State does not use a passive enrollment process. If a member does not make an active choice of MCO during the period allowed, the member will be enrolled into an MCO by the State's default system according to the State's auto-assignment protocols. MCO mandatory populations include:
- Expansion Adults;
- Parents and Caretaker Relatives;
- Pregnant Women;
- Deemed Newborns;
- Children;
- All other populations requiring mandatory coverage pursuant to 42 CFR Subpart B, unless otherwise covered by SoonerCare;
- Foster Care Children (FC);
- Certain children in the Custody of OJA (JJ);
- Former Foster Care (FFC), if the Eligible does not opt out or make a different selection during the initial selection;
- Children with an open prevention service case (PSC) through CWS, if the Eligible does not opt out or make a different selection

during the initial selection; and
- Children Receiving Adoption Assistance (AA), if the Eligible does not opt out or make a different selection during the initial selection.

Populations excluded from mandatory enrollment include American Indian/Alaskan Native (AI/AN) members.

Excluded populations from the MCO include:
- Dual Eligible Individuals;
- Individuals enrolled in the Medicare Savings Program, including Qualified Medicare Beneficiaries (QMB), Specified Low Income Medicare Beneficiaries (SLMB), Qualified Disabled Workers (QDW) and Qualified Individuals (QI);
- Persons with a nursing facility or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID) level of care, with the exception of individuals with a pending level of care determination;
- Individuals during a period of presumptive eligibility;
- Individuals infected with tuberculosis eligible for tuberculosis-related services under 42 C.F.R. § 435.215;
- Individuals determined eligible for SoonerCare on the basis of needing treatment for breast or cervical cancer under 42 C.F.R. § 435.213;
- Individuals enrolled in a §1915(c) Waiver;
- 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 State Plan;
- Coverage of pregnancy-related services under Title XXI for the benefit of unborn children, as allowed by 42 C.F.R. § 457.10; and
- Individuals determined eligible for Medicaid on the basis of age, blindness, or disability.

Default enrollment. Beneficiaries already enrolled in an MCO are given priority to continue that enrollment if the MCO does not have capacity to accept all those seeking enrollment. Default enrollment processes seek to preserve existing provider-beneficiary relationships and relationships with providers that have traditionally served Medicaid beneficiaries. However, if this approach is not immediately available, the State will distribute beneficiaries equitably among MCOs, will not arbitrarily exclude any MCO, and may consider additional criteria to conduct the default enrollment process. Potential enrollees that do not select an MCO during the period allowed by the State are subject to the State's default enrollment process, which only includes MCOs that are not subject to intermediate sanctions and have capacity to enroll beneficiaries.

Voluntary Enrollment. For voluntary populations, the State provides an enrollment choice period during which potential enrollees may make an active choice of delivery system and, if appropriate, choice of MCO before enrollment is effectuated. The State does not engage in passive enrollment. If the potential enrollee does not make an active choice during the period allowed by the State, the potential enrollee will continue to receive services through the FFS delivery system. MCO voluntary populations include AI/AN individuals who are determined eligible for a SoonerCare population may voluntarily enroll through an opt-in process.

Auto-Assignment. OHCA's MMIS processes auto-assignment for its various managed care programs. Applicants may choose an MCO from OHCA's "selection module" or by stating the choice on the SoonerCare application. Applicants who are eligible to choose an MCO and fail to make an election will be assigned to the MCO that is due next to receive an auto assignment taking into account quality weighted assignment factors. Once assigned to an initial MCO, the member shall have 90 calendar days to request a transfer to another MCO; otherwise, changes may be made at the next open enrollment.

Non-Discrimination. An MCO may not refuse an assignment or seek to disenroll an enrollee or otherwise discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and may not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin, sex, sexual orientation, gender identity, or disability. An MCO may not discriminate against an enrollee in enrollment, disenrollment, or re-enrollment on the basis of expectations that the individual will require frequent or high-cost care, or on the basis of health status or need for health care services or due to an adverse change in the individual's health.

Additional Information: MCO (Optional)

Alternative Benefit Plan

Provide any additional details regarding this service delivery system (optional):

PAHP: Prepaid Ambulatory Health Plan

The managed care delivery system is the same as an already approved managed care program. No

☑ The Alternative Benefit Plan will be provided through a prepaid ambulatory health plan (PAHP) consistent with applicable managed care requirements (42 CFR Part 438, and section 1937 of the Social Security Act).

◉ PAHPs are paid on a risk basis.

○ PAHPs are paid on a non-risk basis.

PAHP Procurement or Selection Method

Indicate the method used to select PAHPs:

◉ Competitive procurement method (RFP, RFA).

○ Other procurement/selection method.

Describe the method used by the state/territory to procure or select the PAHPs:

Other PAHP-Based Service Delivery System Characteristics

List the benefits or services that will be provided apart from the PAHP, and explain how they will be provided. Add as many rows as needed.

Add	Benefit/service	Description of how the benefit/service will be provided	Remove
Add	Medical services	Provided via MCOs apart from the PAHP	Remove

PAHP service delivery is provided on less than a statewide basis. No

PAHP Participation Exclusions

Individuals are excluded from PAHP participation in the Alternative Benefit Plan: No

General PAHP Participation Requirements

Indicate if participation in the managed care is mandatory or voluntary:

◉ Mandatory participation.

○ Voluntary participation. Indicate the method for effectuating enrollment:

Describe method of enrollment in PAHPs:

Mandatory Enrollment. For mandatory enrollment populations, the State does not use a passive enrollment process. If a member does not make an active choice of dental benefit manager (DBM) during the period allowed, the member will be enrolled into a DBM by the State's default system according to the State's auto-assignment protocols. PAHP mandatory populations include:
- Expansion Adults;
- Parents and Caretaker Relatives;
- Pregnant Women;

- Deemed Newborns;
- Children;
- All other populations requiring mandatory coverage pursuant to 42 CFR Subpart B, unless otherwise covered by SoonerCare;
- Foster Care Children (FC);
- Certain children in the Custody of OJA (JJ);
- Former Foster Care (FFC), if the Eligible does not opt out or make a different selection during the initial selection;
- Children with an open prevention service case (PSC) through CWS, if the Eligible does not opt out or make a different selection during the initial selection; and
- Children Receiving Adoption Assistance (AA), if the Eligible does not opt out or make a different selection during the initial selection.

Populations excluded from mandatory enrollment include American Indian/Alaskan Native (AI/AN) members.

Excluded populations from the PAHP include:
- Dual Eligible Individuals;
- Individuals enrolled in the Medicare Savings Program, including Qualified Medicare Beneficiaries (QMB), Specified Low Income Medicare Beneficiaries (SLMB), Qualified Disabled Workers (QDW) and Qualified Individuals (QI);
- Persons with a nursing facility or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) level of care, with the exception of individuals with a pending level of care determination;
- Individuals during a period of presumptive eligibility;
- Individuals infected with tuberculosis eligible for tuberculosis-related services under 42 C.F.R. § 435.215;
- Individuals determined eligible for SoonerCare on the basis of needing treatment for breast or cervical cancer under 42 C.F.R. § 435.213;
- Individuals enrolled in a §1915(c) Waiver;
- 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 State Plan;
- Coverage of pregnancy-related Services under Title XXI for the benefit of unborn children, as allowed by 42 C.F.R. § 457.10; and
- Individuals determined eligible for Medicaid on the basis of age, blindness, or disability.

Default enrollment. Beneficiaries already enrolled in a DBM are given priority to continue that enrollment if the PAHP does not have capacity to accept all those seeking enrollment. Default enrollment processes seek to preserve existing provider-beneficiary relationships and relationships with providers that have traditionally served Medicaid beneficiaries. However, if this approach is not immediately available, the State will distribute beneficiaries equitably among DBMs, will not arbitrarily exclude any DBM, and may consider additional criteria to conduct the default enrollment process. Potential enrollees that do not select a DBM during the period allowed by the State are subject to the State's default enrollment process, which only includes DBMs that are not subject to intermediate sanctions and have capacity to enroll beneficiaries.

Voluntary Enrollment. For voluntary populations, the State provides an enrollment choice period during which potential enrollees may make an active choice of delivery system and, if appropriate, choice of DBM before enrollment is effectuated. The State does not engage in passive enrollment. If the potential enrollee does not make an active choice during the period allowed by the State, the potential enrollee will continue to receive services through the FFS delivery system. PAHP voluntary populations include AI/AN individuals who are determined eligible for a SoonerCare population may voluntarily enroll through an opt-in process.

Auto-Assignment. OHCA's MMIS processes auto-assignment for its various managed care programs. Applicants may choose a DBM from OHCA's "selection module" or by stating the choice on the SoonerCare application. Applicants who are eligible to choose a DBM and fail to make an election will be assigned to the DBM that is due next to receive an auto assignment taking into account quality weighted assignment factors. Once assigned to an initial DBM, the member shall have 90 calendar days to request a transfer to another DBM; otherwise, changes may be made at the next open enrollment.

Non-Discrimination. A DBM may not refuse an assignment or seek to disenroll an enrollee or otherwise discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and may not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin, sex, sexual orientation, gender identity, or disability. A DBM may not discriminate against an enrollee in enrollment, disenrollment, or re-

enrollment on the basis of expectations that the individual will require frequent or high-cost care, or on the basis of health status or need for health care services or due to an adverse change in the individual's health.

Additional Information: PAHP (Optional)

Provide any additional details regarding this service delivery system (optional):

State is seeking to establish a PAHP to provide dental services only via a DBM. Medical services will be provided by MCOs apart from the dental services provided by the DBM.

PCCM: Primary Care Case Management

The PCCM delivery system is the same as an already approved PCCM program. Yes

The PCCM program is operating under (select one):

- ○ Section 1915(b) managed care waiver.
- ○ Section 1932(a) mandatory managed care state plan amendment.
- ◉ Section 1115 demonstration.
- ○ Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS: Oct 12, 1995

Describe program below:

The demonstration operates under a Primary Care Case Management (PCCM) model in which the State contracts directly with primary care providers throughout the state to provide basic health care services. The primary care providers (PCPs) receive a monthly care coordination payment for each enrolled beneficiary, based upon the services provided at the medical home. The demonstration provides for a modification of the service delivery system for family and child populations and some aged and disabled populations. The benefits for individuals affected by or eligible only under SoonerCare, with the exception of individuals enrolled in the Insure Oklahoma Premium Assistance Employer Coverage, are state plan benefits.

Additional Information: PCCM (Optional)

Provide any additional details regarding this service delivery system (optional):

Fee-For-Service Options

Indicate whether the state/territory offers traditional fee-for-service and/or services managed under an administrative services organization:

- ◉ Traditional state-managed fee-for-service
- ○ Services managed under an administrative services organization (ASO) arrangement

Please describe this fee-for-service delivery system, including any bundled payment arrangements, pay for performance, fee-for-service care management models/non-risk, contractual incentives as well as the population served via this delivery system.

All services provided under the ABP are provided under the Medicaid State Plan and are paid in the same manner as those services provided in the Medicaid state plan, Attachment 4.19.

Additional Information: Fee-For-Service (Optional)

Provide any additional details regarding this service delivery system (optional):

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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