Alternative Benefit Plan

State Name: Oklahoma Attachment 3.1-L- [ ] OMB Control Number: 0938-1148

Transmittal Number: OK - 25 - 0003

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:

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

Managed Care Options

Managed Care Assurance

- [x] 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.

MCO: Managed Care Organization

The managed care delivery system is the same as an already approved managed care program. [ ]

- [ ] 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. ☐

MCO service delivery is provided on less than a statewide basis. ☐

MCO Participation Exclusions

Individuals are excluded from MCO participation in the Alternative Benefit Plan: Yes

Select all that apply:

- ☐ Individuals with other medical insurance.
- ☐ Individuals eligible for less than three months.
- ☐ Individuals in a retroactive period of Medicaid eligibility.
- ☒ Other:

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:

Expansion adults will be mandatorily enrolled with a medical MCE; however, American Indian/Alaskan Native (AI/AN) expansion adults will have the option to voluntarily enroll in the SoonerSelect Medical program through an opt-in process.

Expansion adults will have thirty (30) days to select a medical MCE prior to the start of coverage under the SoonerSelect Medical program. Subsequent to program implementation, expansion adults will have an opportunity to select a medical MCE on their application. Expansion adults who do not make an election within the allowed timeframe will automatically assigned to a medical MCE.

Expansion adults who apply within the first (1st) day of the month through the fifteenth (15th) day of the month will be enrolled effective the first (1st) day of the following month. Expansion adults who select or are assigned to a medical MCE on the sixteenth (16th) day of the month through the last day of the month will be enrolled effective on the first day of the second following month.

Expansion adults may change their assigned medical MCE within ninety (90) days of enrollment or ninety (90) days within receiving notification of enrollment, whichever is later and may also change their medical MCE during the annual open enrollment period.

A medical MCE 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 discrimination on the basis of race, color or national origin, sex, sexual orientation, gender identity, or disability. A medical MCE 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.

Individuals during a period of presumptive eligibility are excluded from MCO enrollment.

Individuals 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) are excluded from MCO enrollment.

Populations excluded from this ABP and MCO enrollment include: Medicare dual eligible individuals; Individuals enrolled in the Medicare Savings Program; individuals determined eligible for Medicaid on the basis of age, blindness, or disability; Medicaid beneficiaries who reside in nursing facilities(NF) or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), with the exception of beneficiaries with a pending level of care determination; participants of a in Home and Community Base Services (HCBS) Waiver program; individuals infected with tuberculosis eligible for tuberculosis-related services under 42 C.F.R 435.21; individuals determined eligible for SoonerCare on the basis of needing treatment for breast or cervical cancer under 42 C.F.R. 435.213; 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, and individuals enrolled in the SoonerPlan program.

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Additional Information: MCO (Optional)

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 primary care case management (PCCM) consistent with applicable managed care requirements (42 CFR Part 438, section 1903(m) of the Social Security Act, and section 1932 of the Social Security Act).

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

One or more of the Alternative Benefit Plan benefits or services will be provided apart from the PAHP. Yes

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			Remove

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

PAHP Participation Exclusions

Alternative Benefit Plan

Individuals are excluded from PAHP participation in the Alternative Benefit Plan: Yes

Select all that apply:

- ☐ Individuals with other medical insurance.
- ☐ Individuals eligible for less than three months.
- ☐ Individuals in a retroactive period of Medicaid eligibility.
- ☒ Other:

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:

Expansion adults will be mandatorily enrolled with a dental PAHP; however, American Indian/Alaskan Native (AI/AN) expansion adults will have the option to voluntarily enroll in the SoonerSelect Dental program through an opt-in process.

Expansion adults will have thirty (30) days to select a dental PAHP prior to the start of coverage under the SoonerSelect Dental program. Subsequent to program implementation, expansion adults will have an opportunity to select a CE on their application. Expansion adults who do not make an election within the allowed timeframe will automatically assigned to a dental PAHP.

Expansion adults who apply within the first (1st) day of the month through the fifteenth (15th) day of the month will be enrolled effective the first (1st) day of the following month. Expansion adults who select or are assigned to a dental PAHP on the sixteenth (16th) day of the month through the last day of the month will be enrolled effective on the first day of the second following month.

Expansion adults may change their assigned dental PAHP within ninety (90) days of enrollment or ninety (90) days within receiving notification of enrollment, whichever is later and may also change their dental PAHP during the annual open enrollment period.

A dental PAHP 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 discrimination on the basis of race, color or national origin, sex, sexual orientation, gender identity, or disability. A dental PAHP 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.

Individuals during a period of presumptive eligibility are excluded from PAHP enrollment.

Individuals 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) are excluded from PAHP enrollment.

Populations excluded from this ABP and PAHP enrollment include: Medicare dual eligible individuals; individuals enrolled in the Medicare Savings Program; individuals determined eligible for Medicaid on the basis of age, blindness, or disability; Medicaid beneficiaries who reside in nursing facilities (NF) or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), with the exception of beneficiaries with a pending level of care determination; participants of a in Home and Community Base Services (HCBS) Waiver program; individuals infected with tuberculosis eligible for tuberculosis-related services under 42 C.F.R 435.21; individuals determined eligible for SoonerCare on the basis of needing treatment for breast or cervical cancer under 42 C.F.R. 435.213; 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, and individuals enrolled in the SoonerPlan program.

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Additional Information: PAHP (Optional)

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

PCCM: Primary Care Case Management

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

☐ The Alternative Benefit Plan will be provided through primary care case management (PCCM) consistent with applicable managed care requirements (42 CFR Part 438, section 1903(m) of the Social Security Act, and section 1932 of the Social Security Act).

PCCM Procurement or Selection Method

Indicate the method used to select PCCMs:

- ○ Competitive procurement method (RFP, RFA).
- ○ Other procurement/selection method.

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

Other PCCM-Based Service Delivery System Characteristics

One or more of the Alternative Benefit Plan benefits or services will be provided apart from the PCCM. ☐

PCCM service delivery is provided on less than a statewide basis. ☐

PCCM Payments

Specify how payment for services is handled:

- ○ Per member/per month case management fee paid to PCCM provider.
- ○ Other:

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

Alternative Benefit Plan

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.

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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