Medicaid Premiums and Cost Sharing

State Name: Oklahoma

OMB Control Number: 0938-1148

Transmittal Number: OK - 14 - 0014

Cost Sharing Requirements G1

1916
1916A
42 CFR 447.50 through 447.57 (excluding 447.55)

The state charges cost sharing (deductibles, co-insurance or co-payments) to individuals covered under Medicaid. Yes

☑ The state assures that it administers cost sharing in accordance with sections 1916 and 1916A of the Social Security Act and 42 CFR 447.50 through 447.57.

General Provisions

☑ The cost sharing amounts established by the state for services are always less than the amount the agency pays for the service.

■ No provider may deny services to an eligible individual on account of the individual's inability to pay cost sharing, except as elected by the state in accordance with 42 CFR 447.52(e)(1).

■ The process used by the state to inform providers whether cost sharing for a specific item or service may be imposed on a beneficiary and whether the provider may require the beneficiary to pay the cost sharing charge, as a condition for receiving the item or service, is (check all that apply):

☒ The state includes an indicator in the Medicaid Management Information System (MMIS)

☐ The state includes an indicator in the Eligibility and Enrollment System

☒ The state includes an indicator in the Eligibility Verification System

☐ The state includes an indicator on the Medicaid card, which the beneficiary presents to the provider

☐ Other process

■ Contracts with managed care organizations (MCOs) provide that any cost-sharing charges the MCO imposes on Medicaid enrollees are in accordance with the cost sharing specified in the state plan and the requirements set forth in 42 CFR 447.50 through 447.57.

Cost Sharing for Non-Emergency Services Provided in a Hospital Emergency Department

The state imposes cost sharing for non-emergency services provided in a hospital emergency department. No

Cost Sharing for Drugs

The state charges cost sharing for drugs. Yes

The state has established differential cost sharing for preferred and non-preferred drugs. No

■ All drugs will be considered preferred drugs.

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Beneficiary and Public Notice Requirements

☑ Consistent with 42 CFR 447.57, the state makes available a public schedule describing current cost sharing requirements in a manner that ensures that affected applicants, beneficiaries and providers are likely to have access to the notice. Prior to submitting a SPA which establishes or substantially modifies existing cost sharing amounts or policies, the state provides the public with advance notice of the SPA, specifying the amount of cost sharing and who is subject to the charges, and provides reasonable opportunity for stakeholder comment. Documentation demonstrating that the notice requirements have been met are submitted with the SPA. The state also provides opportunity for additional public notice if cost sharing is substantially modified during the SPA approval process.

Other Relevant Information

When changes to cost sharing are made and to meet the notice requirements to alert providers of changes in cost sharing policy, the State will initiate a notice process that is consistent with the process described in 42 CFR 447.205, which is used to inform providers and the public of any payment rate changes. This process will inform providers of any changes in Statewide method or standards for setting payment rates. To engage stakeholders, State Plan amendments and/or changes in policy are presented at regularly scheduled, bi-monthly Tribal Consultations and the proposed SPA page, noting the changes in red-line, are posted for a 30-day public review period on the Agency's website. Significant changes in rates and methodology are considered by the State Plan Rate Committee as well as the OHCA Board of Directors. In accordance with 42 CFR 447.57, member letter OHCA 2014-03 regarding the changes in co-pays was sent to all SoonerCare members and the current cost sharing public schedule is available on the Agency's public website at http://okhca.org/benefitcomparison.

PRA Disclosure Statement

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Medicaid Premiums and Cost Sharing

State Name: Oklahoma

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Cost Sharing Amounts - Categorically Needy Individuals

G2a

State: Oklahoma
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1916
1916A
42 CFR 447.52 through 54

The state charges cost sharing to all categorically needy (Mandatory Coverage and Options for Coverage) individuals. Yes

Services or Items with the Same Cost Sharing Amount for All Incomes

Add	Service or Item	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	Inpatient Hospital Services	10.00	$	Day	Up to $75.00 maximum	Remove
Add	Outpatient Hospital Services	4.00	$	Visit		Remove
Add	Organized Outpatient Clinic Services	4.00	$	Visit		Remove
Add	Ambulatory Surgery Services	4.00	$	Visit		Remove
Add	Physician Services	4.00	$	Visit		Remove
Add	Physician Assistant/ Anesthesiologist Assistant	4.00	$	Visit		Remove
Add	Advanced Practice Nurse Services	4.00	$	Visit		Remove
Add	Optometrist Services	4.00	$	Visit		Remove
Add	Durable Medical Equipment Services	4.00	$	Item	Blood glucose testing supplies & insulin syringes have $0 copay (effective 9.1.15).	Remove
Add	Home Health Agency Services	4.00	$	Visit		Remove
Add	Rural Health Clinic (RHC) Services	4.00	$	Visit		Remove
Add	Federally Qualified Health Center (FQHC) Services	4.00	$	Visit		Remove
Add	Medicare Part B Crossover Claims	1.00	$	Visit		Remove
Add	Behavioral health and substance abuse services - inpatient	10.00	$	Day	Up to $75.00 maximum	Remove
Add	Behavioral health and substance abuse services - outpatient	3.00	$	Visit		Remove

Add	Service or Item	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	Laboratory and X-ray Services	4.00	$	Visit		Remove
Add	Prescription Drugs	4.00	$	Prescription	Limited to the drug benefit under the state plan. Tobacco cessation products have $0 copay (effective 09/01/15). Prenatal vitamins have $0 copay. Birth control has a $0 copay. Naloxone have $0 copay (effective 11/01/17).	Remove
Add	Preferred generic drugs for HCBS waiver members	0.00	$	Prescription	HCBS waiver members incur tiered copays for prescription drugs through an additional benefit that is supplied through the 1915(c) HCBS waivers.	Remove
Add	Prescription Drugs drug valued between $0 - $10.00 for HCBS waiver members	0.65	$	Prescription	HCBS waiver members incur tiered copays for prescription drugs through an additional benefit that is supplied through the 1915(c) HCBS waivers.	Remove
Add	Prescription Drugs drug valued between $10.01 - $25.00 for HCBS waiver members	1.20	$	Prescription	HCBS waiver members incur tiered copays for prescription drugs through an additional benefit that is supplied through the 1915(c) HCBS waivers.	Remove
Add	Prescription Drugs drug valued between $25.01 - $50.00 for HCBS waiver members	2.40	$	Prescription	HCBS waiver members incur tiered copays for prescription drugs through an additional benefit that is supplied through the 1915(c) HCBS waivers.	Remove
Add	Prescription Drugs drug valued at $50.01 or more for HCBS waiver members	3.50	$	Prescription	HCBS waiver members incur tiered copays for prescription drugs through an additional benefit that is supplied through the 1915(c) HCBS waivers.	Remove

Services or Items with Cost Sharing Amounts that Vary by Income

Service or Item:

Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

Add	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add							Remove

Add Service or Item

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Cost Sharing for Non-preferred Drugs Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-preferred drugs (entered above), answer the following question:

The state charges cost sharing for non-preferred drugs to otherwise exempt individuals.

Cost Sharing for Non-emergency Services Provided in the Hospital Emergency Department Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-emergency services provided in the hospital emergency department (entered above), answer the following question:

The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals. ☐

PRA Disclosure Statement

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V.20181119

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Medicaid Premiums and Cost Sharing

State Name: Oklahoma

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Cost Sharing Amounts - Medically Needy Individuals	G2b
1916 1916A 42 CFR 447.52 through 54	
The state charges cost sharing to all medically needy individuals.	No

PRA Disclosure Statement

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V.20181119

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State Name: Oklahoma

OMB Control Number: 0938-1148

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Cost Sharing Amounts - Targeting	G2c
1916 1916A 42 CFR 447.52 through 54	
The state targets cost sharing to a specific group or groups of individuals.	No

PRA Disclosure Statement

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Medicaid Premiums and Cost Sharing

State Name: Oklahoma

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Cost Sharing Limitations

G3

State: Oklahoma
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42 CFR 447.56
1916
1916A

☑ The state administers cost sharing in accordance with the limitations described at 42 CFR 447.56, and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act, as follows:

Exemptions

Groups of Individuals - Mandatory Exemptions

The state may not impose cost sharing upon the following groups of individuals:

■ Individuals ages 1 and older, and under age 18 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118).

■ Infants under age 1 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118), whose income does not exceed the higher of:

- ■ 133% FPL; and
- ■ If applicable, the percent FPL described in section 1902(l)(2)(A)(iv) of the Act, up to 185 percent.

■ Disabled or blind individuals under age 18 eligible for the following eligibility groups:

- ■ SSI Beneficiaries (42 CFR 435.120).
- ■ Blind and Disabled Individuals in 209(b) States (42 CFR 435.121).
- ■ Individuals Receiving Mandatory State Supplements (42 CFR 435.130).

■ Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age.

■ Disabled children eligible for Medicaid under the Family Opportunity Act (1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act).

■ Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends, except for cost sharing for services specified in the state plan as not pregnancy-related.

■ Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.

■ An individual receiving hospice care, as defined in section 1905(o) of the Act.

■ Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services.

■ Individuals who are receiving Medicaid because of the state's election to extend coverage to the Certain Individuals Needing Treatment for Breast or Cervical Cancer eligibility group (42 CFR 435.213).

Medicaid Premiums and Cost Sharing

Groups of Individuals - Optional Exemptions

The state may elect to exempt the following groups of individuals from cost sharing:

The state elects to exempt individuals under age 19, 20 or 21, or any reasonable category of individuals 18 years of age or over. Yes

Indicate below the age of the exemption:

- ○ Under age 19
- ○ Under age 20
- ◉ Under age 21
- ○ Other reasonable category

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The state elects to exempt individuals whose medical assistance for services furnished in a home and community-based setting is reduced by amounts reflecting available income other than required for personal needs. No

Services - Mandatory Exemptions

The state may not impose cost sharing for the following services:

- ■ Emergency services as defined at section 1932(b)(2) of the Act and 42 CFR 438.114(a).
- ■ Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and pharmaceuticals for which the state claims or could claim federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies.
- ■ Preventive services, at a minimum the services specified at 42 CFR 457.520, provided to children under 18 years of age regardless of family income, which reflect the well-baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics.
- ■ Pregnancy-related services, including those defined at 42 CFR 440.210(a)(2) and 440.250(p), and counseling and drugs for cessation of tobacco use. All services provided to pregnant women will be considered pregnancy-related, except those services specificially identified in the state plan as not being related to pregnancy.
- ■ Provider-preventable services as defined in 42 CFR 447.26(b).

Enforceability of Exemptions

The procedures for implementing and enforcing the exemptions from cost sharing contained in 42 CFR 447.56 are (check all that apply):

- ■ To identify that American Indians/Alaskan Natives (AI/AN) are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services in accordance with 42 CFR 447.56(a)(1)(x), the state uses the following procedures:
  - ☒ The state accepts self-attestation
  - ☒ The state runs periodic claims reviews
  - ☐ The state obtains an Active or Previous User Letter or other Indian Health Services (IHS) document
  - ☒ The Eligibility and Enrollment and MMIS systems flag exempt recipients

☐ Other procedure

Additional description of procedures used is provided below (optional):

The State undertakes the following processes to ensure individuals who meet cost sharing exemptions as per 42 CFR 447.56(a)(1)(x) are not assessed cost sharing:
• An automatic, periodic claims review which examines members' claims to verify if they have incurred a paid claim from an Indian Health facility or contracted health services provider. When applicable, the information is loaded into MMIS to ensure no cost sharing is applied.

• The Agency's accepts self-attestation in accordance with 42 CFR 447.56(a)(1)(x) in the following way:
- From September 1, 2019 to June 30, 2020, the State will accept verbal self-attestation (i.e., via telephone) for individuals who meet the requirements for cost sharing exemptions as per the federal regulation noted above during the interim period while the State makes necessary changes to the online application for self-attestation cost sharing exemptions. Individuals will need to verbally respond “yes” when asked if they are AI/AN and must also respond “yes” when asked if they are eligible to receive, is currently receiving, or has ever received an item or service furnished by an Indian health care provider or through referral under contract health services. In order to be exempt from cost sharing, there must be an affirmative answer to both questions from the individual(s). The State accepts verbal self-attestation at face value based on the aforementioned process and will not conduct or require any other verification. The verbal self-attestation mirrors the self-attestation process that the online application will apply beginning July 1, 2020.
- Beginning July 1, 2020, the online SoonerCare application will ask the applicant(s) whether they are AI/AN; if the applicant(s) responds "yes", a follow-up question will require an answer as to whether the applicant(s) is eligible to receive, is currently receiving, or has ever received an item or service furnished by an Indian health care provider or through referral under contract health services. If the applicant(s) responds "yes" to the second question, the applicant(s) will be exempt from all cost sharing. In order to be exempt from cost sharing, there must be an affirmative answer to both questions from the applicant(s). The State accepts self-attestation at face value based on the aforementioned process and will not conduct or require any other verification.

■ To identify all other individuals exempt from cost sharing, the state uses the following procedures (check all that apply):

☒ The MMIS system flags recipients who are exempt

☐ The Eligibility and Enrollment System flags recipients who are exempt

☐ The Medicaid card indicates if beneficiary is exempt

☐ The Eligibility Verification System notifies providers when a beneficiary is exempt

☐ Other procedure

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Additional description of procedures used is provided below (optional):

MMIS is programmed not to deduct copayments from claims for Medicaid recipients and services that are exempt from cost sharing as identified in 42 CFR 447.56(a).

Payments to Providers

☑ The state reduces the payment it makes to a provider by the amount of a beneficiary's cost sharing obligation, regardless of whether the provider has collected the payment or waived the cost sharing, except as provided under 42 CFR 447.56(c).

Payments to Managed Care Organizations

The state contracts with one or more managed care organizations to deliver services under Medicaid. No

Aggregate Limits

☑ Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household do not exceed an aggregate limit of 5 percent of the family's income applied on a quarterly or monthly basis.

■ The percentage of family income used for the aggregate limit is:

- ◉ 5%
- ○ 4%
- ○ 3%
- ○ 2%
- ○ 1%
- ○ Other: [ ] %

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■ The state calculates family income for the purpose of the aggregate limit on the following basis:

- ○ Quarterly
- ◉ Monthly

The state has a process to track each family's incurred premiums and cost sharing through a mechanism that does not rely on beneficiary documentation. Yes

■ Describe the mechanism by which the state tracks each family's incurred premiums and cost sharing (check all that apply):

☒ As claims are submitted for dates of services within the family's current monthly or quarterly cap period, the state applies the incurred cost sharing for that service to the family's aggregate limit. Once the family reaches the aggregate limit, based on incurred cost sharing and any applicable premiums, the state notifies the family and providers that the family has reached their aggregate limit for the current monthly or quarterly cap period, and are no longer subject to premiums or cost sharing.

☐ Managed care organization(s) track each family's incurred cost sharing, as follows:

☒ Other process:

The agency considers all cost sharing to be paid by the beneficiary in the calculation of whether a beneficiary has incurred out-of-pocket expenses up to the family's aggregate limit. The State's MMIS calculates family income for the purpose of the aggregate limit on a monthly basis. To accommodate households in different delivery systems (i.e., ABD and TANF combined families; MCO and PCCM or different forms of managed care combined families; managed care and fee-for-service combined families), cost sharing is tracked for each beneficiary and a report is provided to Agency staff to analyze and ensure the beneficiary out-of-pocket expenses do not exceed the family's aggregate limit.

☑ Describe how the state informs beneficiaries and providers of the beneficiaries' aggregate family limit and notifies beneficiaries and providers when a beneficiary has incurred premiums and cost sharing up to the aggregate family limit and individual family members are no longer subject to premiums or cost sharing for the remainder of the family's current monthly or quarterly cap period:

The Agency informs beneficiaries of their aggregate household cost sharing cap amount upon eligibility determination via a member letter or a secure e-message. A separate notification will be issued to beneficiaries when they have incurred premiums and cost sharing up to the aggregate family limit and are no longer subject to premiums or cost-sharing on a monthly basis. Beneficiaries of households in different delivery systems (i.e., ABD and TANF combined families; MCO and PCCM or different forms of managed care combined families; managed care and fee-for-service combined families) are informed via a member letter or a secure e-message of their aggregate household cost sharing cap amount as well as when they have incurred premiums and cost sharing up to the aggregate family limit and are no longer subject to premiums or cost sharing during any monthly cap period.

Providers have access to a secure electronic portal which allows them to determine if a member is subject to a copay. When individual family members are no longer subject to cost sharing for the remainder of the family's monthly cap period, the secure electronic portal will reflect that the member should not be charged a copay prompting the provider to notify the member. A zero dollar copay is indicated for those members/services not subject to cost sharing.

The state has a documented appeals process for families that believe they have incurred premiums or cost sharing over the aggregate limit for the current monthly or quarterly cap period. Yes

Describe the appeals process used:

Members can appeal the calculation of the aggregate cap; members are also notified of appeal rights at the initial eligibility determination and upon redetermination of the member's eligibility. Members may contact the SoonerCare Helpline at 1-800-987-7767. A representative will review the Member Cost Sharing information in the MMIS to be able to determine the amount of cost sharing that has been processed in the current review period and verify if the member has made over payments in cost sharing. Member Services and Provider Services Representatives educate providers to refund members who have overpaid cost sharing. Members have the right to appeal the decision through the official OHCA member appeals process as per Oklahoma Administrative Code (OAC): 317:2-1-2.

☑ Describe the process used to reimburse beneficiaries and/or providers if the family is identified as paying over the aggregate limit for the month/quarter:

The MMIS system tracks cost sharing expenditures incurred across household members and re-sets at the beginning of each month. Systematic tracking of cost sharing occurs in real time as claims are adjudicated in MMIS. Providers have access through a secure electronic portal to information that the member should not be charged a copay. Further, if the member is identified as paying over the aggregate limit for the month, the provider will issue reimbursement to the member. If the State is responsible for reimbursement to the provider, the State will re-process the claim with provider and notify provider to reimburse the member.

☑ Describe the process for beneficiaries to request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium:

Members can request a reassessment of their 5% aggregate cap when they update information regarding their change in circumstances at any time using Oklahoma's online application or they can call the SoonerCare Helpline to have a representative update their information.

The state imposes additional aggregate limits, consistent with 42 CFR 447.56(f)(5). No

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Oklahoma

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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