Oklahoma Health Care Authority

SoonerCare Choice and Insure Oklahoma §1115(a) Demonstration 11-W-00048/6

Application for Extension of the Demonstration, 2017 – 2018

Submitted to the Centers for Medicare and Medicaid Services

TBD, 2016*

Public Comment Version, August 26, 2016

*Updated from the original 2016-2018 extension request that was submitted to CMS on December 29, 2014

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I. HISTORICAL NARRATIVE SUMMARY

Demonstration Background

In 1993, the State of Oklahoma was in the process of reforming the Medicaid program in order to improve access to care quality of care and cost effectiveness. During the 1993 legislative session, Oklahoma state leadership passed legislation[1] that directed the Oklahoma Health Care Authority (OHCA) as the single-state agency to administer the Medicaid program, SoonerCare, as well as convert the program to a managed care system.

OHCA worked collaboratively with state leadership, providers and stakeholders to propose a program that was innovative and unique to Oklahoma. The Oklahoma SoonerCare Choice demonstration was approved by the Health Care financing Administration in January 1995 under a 1915(b) managed care waiver. The managed care program was subsumed under a Section 1115(a) research and demonstration waiver on January 1, 1996. The SoonerCare Choice program began as a partially-capitated, primary care case management pilot program in four rural areas of Oklahoma and, in 1997, became a statewide program for all rural areas. In contrast, the SoonerCare Plus program was offered in urban areas of the state, and relied on contracted managed care organizations as providers. While the program initially enrolled children, pregnant women and Temporary Assistance for Needy Families (TANF) populations, over the years the success of the program has led state leadership to enlarge the program to serve the Aged, Blind and Disabled, as well as additional populations. In 2004, SoonerCare Choice was expanded statewide as the single managed care delivery system for both urban and rural areas.

In addition to the primary care case management delivery system, in January 2009, OHCA implemented the patient-centered medical home in order to furnish each member with a primary care provider (PCP), otherwise known as a medical home. OHCA continues to use this model today.

In the current SoonerCare Choice medical home model, members actively choose their medical home from a network of contracted SoonerCare providers, and members can change PCPs with no delay in the enrollment effective date. SoonerCare Choice providers are paid monthly care coordination payments for each member on their panel in amounts that vary depending on the level of medical home services provided and the mix of adults and children the provider accepts. Providers also qualify for performance incentive payments when they meet certain quality improvement goals defined by the State.

Outside of care coordination, all other services provided in the medical home, as well as by specialists, hospitals or other providers, are reimbursed on a fee-for-service basis. Members receive primary care services from their medical home PCP without a referral. For certain specialty services provided outside of the medical home, members are required to obtain a referral from their PCP.

SoonerCare Choice members receive SoonerCare benefits, which are State Plan benefits. The SoonerCare benefits plan does provide the enhanced benefit of unlimited physician visits (as medically necessary with the PCP) as compared to the State Plan, which limits physician services to four visits per month, including specialty visits.

The SoonerCare Choice demonstration serves individuals who qualify for the Mandatory and Optional State Plan groups. Refer to Appendix A for a list of the SoonerCare Choice eligibility groups.

In accordance with Title 56 of the Oklahoma Statutes, the 1115(a) demonstration also serves individuals not qualified for SoonerCare Choice, but who qualify for the Insure Oklahoma program. The Insure Oklahoma

[1] Title 63, §63-5009 of the Oklahoma Statutes.

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program, enabled by the State Legislature in April 2004, includes the Employer Sponsored Insurance (ESI) program and the Individual Plan (IP). Refer to Appendix A to review a list of Insure Oklahoma populations. Individuals in ESI receive assistance with payment for their premiums based on the Insure Oklahoma qualifying health plan[2] that they choose. The employers also contribute a portion of premiums. Individuals who do not qualify for ESI may qualify for IP. Individuals who qualify for the IP program receive premium assistance and cost sharing for benefits that meet the essential health benefit requirements that would be applicable to alternative benefit plans under federal regulations found in 42 Code of Federal Regulation (CFR) Section 440.347.

Refer to Appendix B for a detailed history of the SoonerCare Choice and Insure Oklahoma programs and the corresponding program amendments.

Objectives Approved for the 2013-2015 Demonstration

OHCA's objectives for the SoonerCare Choice demonstration are representative of the goals of the agency and the State. OHCA was approved by the Centers for Medicare & Medicaid Services (CMS) on December 31, 2012, for the following objectives for the 2013-2015 extension period:

- Waiver Objective 1: Improving access to preventive and primary care services; a
- Waiver Objective 2: To provide each member with a medical home. (Increasing the number of participating primary care providers, and overall primary care capacity in both urban and rural areas);
- Waiver Objective 3: Providing active, comprehensive care management and providers into the SoonerCare delivery system; and
- Waiver Objective 4: Integrate Indian Health Services' members and providers into the SoonerCare delivery system; and

Waiver Objective 5: Expanding access to affordable health insurance for low-income adults in the workforce, their spouses and college students.

Evaluation of 2013-2015 Objective Measures

In order to ensure that OHCA is successfully meeting the stated objectives, the agency evaluates the SoonerCare Choice program through evaluation measures that assess each of the waiver objectives. OHCA's progress in meeting the 2013-2015 objectives are outlined below:

Waiver Objective 1: Access to Care

Through the Healthcare Effectiveness Data and Information Set (HEDIS®) and the Consumer Assessment of Health Plan Surveys (CAHPS®), OHCA's SoonerCare Choice program has shown effectiveness in providing access to care. Results from HEDIS® and CAHPS® surveys indicate:

- The percentage of children ages 0-15 months that have at least one or more checkups each year has maintained between 97 and 98 percent since HEDIS® year 2011.
- More than half of children ages 3-6 years old have at least one or more checkups each year.
- A little more than 30 percent of adolescents' ages 12-19 years old have at least one or more checkups each year. OHCA is currently working on outreach efforts for this age group in order to inform providers, school administrators and parents of the importance of child health checkups.

[2] Insure Oklahoma qualified health plan requirements can be found at Oklahoma Administrative Code 317:45-5-1.

- The percentage of adults' ages 20-44 years with at least one or more PCP visits per year has maintained at or above 80 percent since HEDIS® year 2009.
- A little more than 90 percent of adults' ages 45-64 years old have at least one or more PCP visits a year.
- Some 82 percent of adult CAHPS® survey respondents indicated that they are "Usually" or "Always" satisfied with the time it takes to get an appointment with their PCP, while 91 percent of child CAHPS® survey respondents indicated their satisfaction with appointment times.

Waiver Objective 2: Provider Enrollments
OHCA continues to increase the number of SoonerCare providers and to ensure that each member has a medical home.

- The number of SoonerCare contracted providers has increased 17 percent since December 2012.
- As of June 2014, SoonerCare Choice PCP capacity is at 42 percent, allowing 58 percent capacity for additional members.
- Since January 2013, OHCA has aligned 57 percent of SoonerCare Choice members who were not aligned with a PCP to a provider.

Waiver Objective 3: Care Management
OHCA provides comprehensive care management to individuals with chronic conditions in the Health Management Program (HMP), as well as individuals with complex health care needs in the Health Access Network (HAN) pilot program.

- Since the beginning of Phase II of the HMP, OHCA has increased the number of individuals engaged in nurse care managed by 291 percent.
- In SFY 2013, of nearly 4,000 HMP members who were surveyed, 50 percent of HMP members indicated that they had visited their PCP 10 or more times within 12 months. Some 92 percent had visited their PCP one or more times within the year.
- Aggregate savings for the HMP's nurse care management and practice facilitation stood at nearly $182 million by the end of SFY 2013.
- As of June 2014, some 118,100 SoonerCare Choice members with complex health care needs are receiving care management through one of the Demonstration's three pilot HANs.
- The per member per month expenditure differences for HAN members to non-HAN members ranges from a $2.93 difference up to a $45.56 difference.

Waiver Objective 4: Integration of IHS Beneficiaries and Providers
OHCA continues to integrate Indian health members and providers into the SoonerCare Choice program. As of June 2014, nearly 77 percent of Native American SoonerCare members have a SoonerCare Choice PCP, while 23 percent of Native American SoonerCare members have an I/T/U PCP.

Waiver Objective 5: Providing Access to Affordable Health Insurance
OHCA provides secure transfer access of information to and from the federally facilitated marketplace (FFM) for individuals who apply. OHCA began outbound account transfers to the federal hub on January 23, 2014, and was able to receive account transfers from the federal hub effective February 12, 2014. As of June 2014, OHCA transferred some 64,489 applications to the federal hub and OHCA has received nearly 3,000 applications from the hub.

To review the evaluation measures in their entirety, refer to Section VI, *Demonstration Evaluation.*

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Objectives Approved for the 2016 Demonstration

OHCA's objectives for the SoonerCare Choice demonstration are representative of the goals of the agency and the State. OHCA was approved by the Centers for Medicare & Medicaid Services (CMS) on July 9, 2015 for the following objectives for the 2016 extension period:

- Waiver Objective 1: To improve access to preventive and primary care services;
- Waiver Objective 2: To provide each member with a medical home;
- Wavier Objective 3: To integrate Indian health Service (IHS) eligible beneficiaries and IHS and tribal providers into the SoonerCare delivery system;
- Waiver Objective 4: To expand access to affordable health insurance for low-income working adults and their spouses; and
- Waiver Objective 5: To optimize quality of care through effective care management

Demonstration Hypotheses:

The state will test the demonstration hypotheses listed in Section XIV, Evaluation of the Demonstration, including:

- Hypothesis 1: Child Health Checkup Rates. The rate for age-appropriate well-child and adolescent visits will improve between 2015-2016.
- Hypothesis 7: Impact of Health Access Networks on Quality of Care. Key quality performance measures tracked for PCPs participating in the HANs will improve between 2015-2016.
- Hypothesis 8: Impact of Health Access Networks on Effectiveness of Care. Average per member per month expenditures will decrease for members enrolled with PCPs participating in the HANs between 2015- 2016.
- Hypothesis 9: Health Management Program (HMP). Health outcomes for chronic diseases will improve between 2015-2016 as a result of participation in the HMP. Total expenditures for members enrolled in HMP will decrease.

Proposed Objectives for the 2017-2018 Extension

The State proposes to continue the main objectives for the 2017-2018 extension, while adjusting them slightly to better link the objectives to the evaluation measures.

- Waiver Objective 1: To improve access to preventive and primary care services;
- Waiver Objective 2: To provide each member with a medical home;
- Wavier Objective 3: To integrate Indian health Service (IHS) eligible beneficiaries and IHS and tribal providers into the SoonerCare delivery system;
- Waiver Objective 4: To expand access to affordable health insurance for low-income working adults and their spouses; and
- Waiver Objective 5: To optimize quality of care through effective care management

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II. Requested Changes for the 2017-2018 Demonstration

The SoonerCare Choice and Insure Oklahoma §1115(a) Research and Demonstration Waiver is currently approved through December 31, 2016. Oklahoma requests an extension of the program for the period January 1, 2017 to December 31, 2018. At this time, the State is requesting renewal of this waiver in its present form.

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III. 2017-2018 WAIVER LIST, EXPENDITURE AUTHORITIES AND COMPLIANCE WITH SPECIAL TERMS AND CONDITIONS

The State requests the following waiver list and expenditure authorities for the 2017-2018 extension period. Additionally, the State complies with the current Special Terms and Conditions (STCs).

Waiver List

The State requests the following Waiver List as approved in the 2016 SoonerCare Choice demonstration.

1. Statewideness/Uniformity; Section 1902(a)(1)

To enable the State to provide Health Access Networks (HANs) only in certain geographical areas of the State.

2. Freedom of Choice; Section 1902(a)(23)(A)

To enable the State to restrict beneficiaries' freedom of choice of care management providers and to use selective contracting that limits freedom of choice of certain provider groups to the extent that the selective contracting is consistent with member access to quality services. The freedom of choice waiver is not authorized for family planning providers.

3. Retroactive Eligibility; Section 1902(a)(34)

To enable the State to waive retroactive eligibility for demonstration participants, with the exception of Tax Equity and Fiscal Responsibility Act (TEFRA) and Aged, Blind and Disabled populations.

Expenditure Authorities

The State requests the following Expenditure Authorities for the 2017-2018 demonstration extension.

1. Demonstration Population 5.

Expenditures for health benefits coverage for individuals who are "Non-Disabled Low-Income Workers" age 19-64 years who work for a qualifying employer and have no more than 200 percent of the federal poverty level (FPL), and their spouses.

2. Demonstration Population 6.

Expenditures for health benefits coverage for individuals who are "Working Disabled Adults" 19-64 years of age who work for a qualifying employer and have income up to 200 percent of the FPL.

3. Demonstration Population 8.

Expenditures for health benefits coverage for no more than 3,000 individuals at any one time who are full-time college students age 19 through age 22 and have income not to exceed 200 percent of the FPL, who have no creditable health insurance coverage and work for a qualifying employer.

4. Demonstration Population 10.

Expenditures for health benefits coverage for foster parents who work for a qualified employer and their spouses with household incomes no greater than 200 percent of the FPL.

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5. Demonstration Population 11.
Expenditures for health benefits coverage for individuals who are employees and spouses of not-for-profit businesses with 500 or fewer employees, work for a qualifying employer and with household incomes no greater than 200 percent of the FPL.

6. Demonstration Population 12.
Expenditures for health benefits coverage for individuals who are "Non-Disabled Low-Income Workers" age 19-64 years whose employer elects not to participate in the Premium Assistance Employer Coverage Plan, who are self-employed or unemployed and have up to 100 percent of the FPL, and their spouses.

7. Demonstration Population 13.
Expenditures for health benefits coverage for individuals who are "Working Disabled Adults" 19-64 years of age whose employer elects not to participate in the Premium Assistance Employer Coverage Plan, as well as those who are self-employed, or unemployed (and seeking work) and who have income up to 100 percent of the FPL.

8. Demonstration Population 14.
Expenditures for health benefits coverage for no more than 3,000 individuals at any one time who are full-time college students age 19 through age 22 and have income not to exceed 100 percent of the FPL, who have no creditable health insurance coverage, and do not have access to the Premium Assistance Employer Coverage Plan.

9. Demonstration Population 15.
Expenditures for health benefits coverage for individuals who are working foster parents, whose employer elects not to participate in the Premium Assistance Employer Coverage Plan and their spouses with household incomes no greater than 100 percent of the FPL.

10. Demonstration Population 16.
Expenditures for health benefits coverage for individuals who are employees and spouses of not-for-profit businesses with 500 or fewer employees with household incomes no greater than 100 percent of the FPL, and do not have access to the Premium Assistance Employer Coverage Plan.

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

12. Premium Assistance Beneficiary Reimbursement.
Expenditures for reimbursement of costs incurred by individuals enrolled in the Premium Assistance Employer Coverage Plan and in the Premium Assistance Individual Plan that are in excess of five percent of annual gross family income.

13. Health Management Program.
Expenditures for otherwise non-covered costs to provide health coaches and practice facilitation services through the Health Management Program.

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Title XIX Requirements Not Applicable to the Demonstration Expenditure Authorities for Demonstration Populations: 5, 6, 8, 10, 11, 12, 13, 14, 15 and 16.

1. Comparability; Section 1902(a)(10)(B) and 1902(a)(17)
To permit the State to provide different benefit packages to individuals in demonstration populations 5, 8, 10 and 11who are enrolled in the Premium Assistance Employer Coverage Plan that may vary by individual.

2. Cost Sharing Requirements; Section 1902(a)(14) insofar as it incorporates Section 1916
To permit the State to impose premiums, deductions, cost sharing and similar charges that exceed the statutory limitations to individuals in populations 5, 8, 10 and 11 who are enrolled in the Premium Assistance Employer Coverage Plan.

3. Freedom of Choice; Section 1902(a)(23)(A)
To permit the State to restrict the choice of provider for beneficiaries qualified under populations 5, 8, 10 and 11 enrolled in the Premium Assistance Employer Coverage Plan. No waiver of freedom of choice is authorized for family planning providers.

4. Retroactive Eligibility; Section 1902(a)(34)
To enable the State to not provide retroactive eligibility for demonstration participants in populations 5, 8, 10, 11, 12, 13, 14, 15 and 16.

5. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services; Section 1902(a)(4)(B); 1902(a)(10)(A); and 1902(a)(43)
To exempt the State from furnishing or arranging for EPSDT services for full-time college students age 19 through age 22 who are defined in populations 8, 13 and 14.

6. Assurance of Transportation; Sections 1902(a)(4); and 1902(a)(19); 42 CFR 431.53
To permit the State not to provide transportation benefits to individuals in populations 12, 13, 14, 15 and 16 enrolled in the Insure Oklahoma Premium Assistance Individual Plan.

Compliance with Special Terms and Conditions

1. Compliance with Federal Non-Discrimination Statutes.
The State complies with all applicable state and federal statutes relating to non-discrimination, including but not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 and the Age of Discrimination Act of 1975.

2. Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation and Policy Including Protections for Indians Pursuant to Section 5006 of ARRA (2009).
The State complies with all Medicaid and CHIP program requirements in law, regulation and policy statement that are not expressly waived or identified as not applicable in the waiver and expenditure authority documents received from the Centers for Medicare and Medicaid Services (CMS), including protections for Indians pursuant to Section 5006 of the American Recovery and Reinvestment Act of 2009.

3. Compliance with Changes in Medicaid and CHIP Law, Regulation and Policy.
Within the timeframes specified by law, regulation or policy statement, the State brings the Demonstration into compliance with changes in federal and State law, regulation or policy that affects the Medicaid or CHIP programs, unless the provision changed is expressly waived or identified as not applicable to the Demonstration.

4. Impact on Demonstration of Changes in Federal Law, Regulation and Policy.

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a) If a change in federal law, regulation or policy results in a change in Federal Financial Participation (FFP) for expenditures made under the Demonstration, the State submits modified budget neutrality and allotment neutrality agreements for CMS approval. The State recognizes that the modified agreements referred to in this paragraph do not involve changes to trend rates for the budget neutrality agreement, and that modified agreements take effect on the date the relevant change(s) is implemented.

b) The State complies that mandated changes in federal law that require state legislation will take effect the day the State law becomes effective or the last effective day required by the federal law.

5. State Plan Amendments.
The State submits State Plan amendments if changes to the Demonstration affect populations qualified through the Medicaid or CHIP State Plans.

6. Changes Subject to the Amendment Process.
The State agrees to not implement changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality or other comparable program elements without submission of an amendment request and receipt of prior approval by CMS. Amendments are not retroactive, and the State recognizes that FFP is not available for changes to the Demonstration that have not been approved through the proper amendment process.

7. Amendment Process.
The State submits amendment requests to CMS no later than 120 days prior to the planned implementation date and the requests are not implemented until receipt of CMS approval. Amendment requests include all required elements, as outlined in (a)-(e) of this section, for CMS review.

8. Extension of the Demonstration.
a) The State submits its extension request per CMS guidance.

b) The State submits this application as documentation of compliance with the transparency requirements in 42 CFR Section 431.412 and the required supporting documentation outlined in (i)-(vii) of this section, as well as the public notice requirements, which can be found in Section VII of this document.

9. Demonstration Phase-Out.
In the event that the State elects to suspend or terminate the Demonstration in whole or in part, the State agrees to promptly notify CMS in writing and submit a phase-out plan to CMS at least six months prior to initiating phase-out activities. The State agrees to comply with all phase-out requirements set forth in (a)-(d) of this section.

10. Expiring Demonstration Authority.
In the event that CMS elects to expire demonstration authority prior to the Demonstration's expiration date, the State agrees to submit a demonstration Transition and Expiration Plan to CMS at least six months prior to the Demonstration authority's expiration date. The State agrees to include the in the Expiration Plan, the requirements as outlined in (a)-(d) of this section.

11. CMS Right to Terminate or Suspend.
The State understands that CMS may suspend or terminate the Demonstration in whole or in part whenever it determines, after a hearing that the State has materially failed to comply with the terms of the Demonstration.

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12. Federal Financial Participation.
The State understands that federal financial funds for Medicaid expenditures will not be available until the effective date of the demonstration approval letter.

13. Finding of Non-Compliance.
The State understands its right to challenge a CMS finding that the State materially failed to comply with the terms of the Demonstration.

14. Withdrawal of Waiver or Expenditure Authority.
The State understands that CMS reserves the right to withdraw waiver or expenditure authorities and that the State may request a hearing prior to the effective date to challenge CMS's determination that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of Title XIX and/or Title XXI.

15. Adequacy of Infrastructure.
The State ensures the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach and enrollment; maintenance of eligibility systems; compliance with cost sharing requirements and reporting on financial and other demonstration components.

16. Public Notice, Tribal Consultation, and Consultation with Interested Parties.
The State complies with the State Notice Procedures set forth in 59 Federal Register 49249, as well as the tribal consultation requirements pursuant to Section 1902(a)(73) of the Act as amended by Section 5006(e) of the American Recovery and Reinvestment Act of 2009. The State also complies with the tribal consultation requirements contained in the State's approved State Plan. The State submits evidence to CMS regarding solicitation of advice from federally recognized Indian tribes, Indian health programs and Urban Indian Organizations prior to submission of any waiver proposal, amendment or renewal of the Demonstration. Documentation of compliance with these requirements is provided in Section VII, *Public Notice*.

17. Post Award Forum.
The State complies with the requirement to afford the public an opportunity to provide comment on the progress of the Demonstration through a Post Award Forum. Documentation of compliance with these requirements is provided in Section VII, *Public Notice*.

18. Compliance with Managed Care Regulations.
The State complies with all managed care regulations at 42 CFR section 438 et.seq. that are applicable to the Demonstration.

19. Use of Modified Adjusted Gross Income (MAGI) Based Methodologies for Demonstration Groups.
The State derives the SoonerCare Choice Mandatory and Optional State Plan groups' eligibility from the Medicaid State Plan, which are subject to all applicable Medicaid laws and regulations, except as expressly waived in the Demonstration. The State understands that Medicaid State Plan amendments apply to the eligibility standards and methodologies for the Mandatory and Optional SoonerCare Choice State Plan groups. This includes the conversion to MAGI for the SoonerCare Choice population on October 1, 2013 (State Plan 13-018 S10).

20. State Plan Populations Affected.
The Demonstration includes Title XIX and Title XXI populations. The State maintains the Mandatory and Optional State Plan groups outlined in the Special Terms and Conditions. The State does not request any changes. Refer to Appendix A, *SoonerCare Choice and Insure Oklahoma Eligibility Chart*.

21. Demonstration Eligibility.

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The State maintains the eligibility groups in the Individual Plan program as outlined in the Special Terms and Conditions. The State does not request any changes.

22. Eligibility Exclusions.
The State maintains the eligibility exclusion rules outlined in the STCs and is not requesting any changes to the populations not qualified to participate in the Demonstration.

23. TEFRA Children, Population 7.
The State maintains the rules for eligibility in the TEFRA category and is not requesting any changes in the definition of the population or the eligibility for the Demonstration.

24. TEFRA Children Retroactive Eligibility.
The State agrees that the waiver of retroactive eligibility does not apply to TEFRA children. TEFRA parents or guardians choose an appropriate PCP/case manager. The State is not requesting any changes to these rules.

25. Eligibility Conditions for Full-Time College Students, Populations 8 and 14
a) The State complies with the requirements of the income eligibility documentation.
b) The State maintains an enrollment cap of 3,000 full-time college students for the Insure Oklahoma program. The State received authorization for a waiting list from CMS on April 25, 2011. As of August 2016, however, there are 105 students enrolled in ESI and 177 students enrolled in IP for a total of 280 college students currently enrolled in the Insure Oklahoma program. A waiting list is currently not in place and, at this time, the State does not expect to implement a waiting list for the 2017-2018 extension period.

26. SoonerCare Benefits.
The State agrees that SoonerCare Choice benefits are Title XIX State Plan benefits with one exception. The SoonerCare Choice waiver package allows unlimited, medically necessary PCP visits and up to four specialty visits per month. The State is not requesting any changes to the SoonerCare benefits. Insure Oklahoma Employer Sponsored Insurance benefits can be found under Section VI, STC #29 of the STCs. Insure Oklahoma Individual Plan benefits can be found under Section VI, STC #31.

27. SoonerCare Cost Sharing.
The State agrees that under the current SoonerCare program, American Indians with an I/T/U provider, pregnant women, children (including TEFRA children) up to and including age 18, individuals in the Breast and Cervical Cancer program, emergency room services and family planning services are not subject to cost sharing. Cost sharing for non-pregnant adults enrolled in SoonerCare is the same as the cost sharing assessed under the Title XIX State Plan. That State is not requesting any changes to cost sharing.

Insure Oklahoma premium assistance benefits and cost sharing is referred to in Section VI of the STCs.

28. Insure Oklahoma: Premium Assistance Employer Coverage.
The State maintains all other definitions, eligibility rules for premium assistance employer coverage, as well as the employer requirements outlined in (a)-(f) of this section.

29. Insure Oklahoma: Premium Assistance Employer Coverage IO Qualifying Plans.
The State maintains the required criteria for the Insure Oklahoma qualified health plans as defined in Oklahoma Administrative Code 317:45-5-1. All Insure Oklahoma employer sponsored insurance health plans are approved by the Oklahoma Insurance Department. The State is not requesting any changes to the maximum allowed copay amounts at this time, and continues to comply with STC #33.

30. Insure Oklahoma: Premium Assistance Individual Plan.

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The State complies with the Insure Oklahoma Individual Plan definition and eligibility criteria. The State also maintains the Individual Plan benefits, under STC #31. Additionally, the State is not requesting any changes to the process requirements, as outlined in (a)-(f) of this section.

31. Premium Assistance Individual Plan (Insure Oklahoma) Benefit.
The State maintains the Individual Plan benefit package. The benefit package meets the essential health benefit requirements that would be applicable to alternative benefit plans under federal regulations found in 42 CFR Section 440.347. In the future, the State agrees to submit any changes to the benefit package to CMS for prior approval.

32. Insure Oklahoma Cost Sharing.
The State agrees to not exceed the cost sharing amounts for the Employer Sponsored Insurance program, as outlined in Section VI, STC #33 and #34. For the Individual Plan, the State agrees to not exceed cost sharing amounts as defined under federal regulation 42 CFR Section 447. One exception to this is that the State maintains a $30 copay for emergency services, unless the individual is admitted to the hospital. The State understands that copays may be lowered at any time by notifying CMS in writing at least 30 days prior to the effective date. The State also maintains the annual out-of-pocket cost sharing to not exceed five percent of a family's gross income.

33. Premium Assistance Employer Coverage Copayments and Deductibles.
The State maintains that Insure Oklahoma ESI copays continue to be the copays required by the enrollee's specific health plan, as defined in STC #29. The State also maintains the copay and deductible requirements as outlined in (a)-(d) of this section.

34. Premium Assistance Employer Coverage Plan Premiums.
The State maintains that individuals and families participating in employer coverage be responsible for up to 15 percent of the total health insurance premium not to exceed three percent out of the five percent annual gross household income cap. The State maintains the reimbursement and premium responsibilities as outlined in (a)-(b) of this section.

35. Premium Assistance Individual Plan Premiums.
The State maintains the Individual Plan premiums as imposed in (a)-(d) of this section.

36. Compliance with Managed Care Regulations.
The State complies with all managed care regulations at 42 CFR Section 438 et. seq. that are applicable to the Demonstration.

37. Access and Service Delivery.
The State maintains the access and service delivery language as outlined in this section. In accordance with the provider type chart, the State adds the following underlined language to the "Medical Resident" requirement, in order to comply with current OHCA rules[3] and business practices.

Medical Resident: <u>Must be licensed by the State in which s/he practices.</u> Must be at least at the Post Graduate 2 level and may serve as a PCP/CM only within his/her continuity clinic setting. Must work under the supervision of a licensed attending physician.

38. Care Coordination Payments.
The State maintains the definition for the monthly care coordination payments, the monthly schedule of care coordination payments, the changes to monthly care coordination payments and the monthly care management payments.

[3] Oklahoma Administrative Code 317:25-7-5.

39. Other Medical Services.
It continues to be the case all other SoonerCare Choice benefits, (with the exception of non-emergency transportation and PACE, which are paid though a capitated contract) are paid through the State's FFS system.

40. Health Access Networks.
The State understands that it may pilot up to four Health Access Networks (HANs). The State maintains all other definitions, rules and requirements for the HANs as outlined in this section inclusive of care management /care coordination responsibilities. The State understands that duplicative payments for services offered under the State Plan are not to be made to HANs. The State also recognizes the requirements to notify CMS 60 days prior to any change to the HAN PMPM payment and to include a revised budget neutrality assessment with the notification.

41. Provider Performance.
The State maintains incentive payments for the performance program, SoonerExcel, outlined in this paragraph and maintains a 60-day CMS notice requirement if the State wishes to make changes.

42. Services for American Indians.
The State agrees that qualified American Indian SoonerCare Choice members may continue to enroll with I/T/Us as their PCP. This enrollment is voluntary. I/T/U providers enrolled as SoonerCare PCPs receive the care coordination payments established in STC #38. The State maintains that Oklahoma's I/T/Us must have a SoonerCare American Indian PCCM contract.

All of OHCA's I/T/U SoonerCare providers have a SoonerCare American Indian PCCM contract.

43. Contracts.
The State understands that procurement and subsequent final contracts that implement selective contracting by the State with any provider group must be approved by CMS prior to implementation. The State maintains existing contracts with Federally Qualified Health Centers.

44. TEFRA Children.
The State maintains the arrangements for service delivery for TEFRA children outlined in this paragraph and is not requesting that any changes be made.

45. Health Management Program Defined.
The State complies with the definition and eligibility requirements outlined for the Health Management program. The State reports on the HMP in the Quarterly Reports, which are submitted no later than 60 days after the last day of each calendar quarter.

46. Health Management Program Services.
The State continues health coaching and practice facilitation services for HMP members, as defined in (a)-(b) of this section. The State is not requesting that any changes be made.

47. Changes to the HMP Program.
The State submits notification to CMS 60 days prior to any change in HMP services, as well as a revised budget neutrality assessment. The State is not requesting that any changes be made.

48. Monitoring Aggregate Costs for Eligibles in the Premium Assistance Program.

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a) The State monitors the aggregate costs for the Insure Oklahoma ESI program and the cost for the Individual Plan. On a quarterly basis, the State compares the average monthly premium assistance contribution per employer coverage enrollee to the cost per member per month of the Individual Plan population.

b) On an annual basis, the State calculates the total cost per enrollee per month for individuals receiving subsidies under the Employer Sponsored Insurance program, including reimbursement made to enrollees whose out-of-pocket costs exceed their income stop loss threshold (or five percent income). The State compares the cost to the 'per enrollee per month' cost of individuals enrolled in the Individual Plan. Documentation of compliance with these requirements is provided in Appendix C, *Insure Oklahoma Monitoring.*

49. Monitoring Employer Sponsored Insurance.
a) The State monitors the aggregate level of contributions made by participating employers both pre- and post-implementation of premium assistance.

b) The State requires that participating employers report annually their total contributions for employees. The State prepares an aggregate analysis across all participating employers summarizing the total statewide employer contribution.

c) The State monitors changes in covered benefits and cost-sharing requirements of employer-sponsored health plans and documents any trends.
Documentation of compliance with these requirements is provided in Appendix C, *Insure Oklahoma Monitoring*.

50. General Financial Requirements.
The State complies with all General Financial Requirements under Title XIX, set forth in the STCs, Section XI, as well as the General Financial Requirements under Title XXI, set forth in the STCs, Section XII. Refer to Section V of this document for compliance with budget neutrality.

51. Reporting Requirements Related to Budget Neutrality.
The State complies with all reporting requirements for Monitoring Budget Neutrality, set forth in the STCs, Section XIII. Refer to Section V of this document for compliance with budget neutrality.

52. Monthly Calls.
The State participates in monthly calls with CMS as outlined in this section.

53. Quarterly Operational Reports.
The State submits to CMS quarterly operational reports for the Demonstration in the format specified in Attachment A of the STCs, no later than 60 days following the end of the quarter. The reports include all of the following elements outlined in (a)-(e) of this section.

54. Annual Report.
The State submits a draft Annual Report to CMS within 120 days after the close of each demonstration year; the State submits the final Annual Report to CMS 30 days after receiving comments from CMS. The State includes in the report the requirements set forth in this section.

55. Title XXI Enrollment Reporting.
The State complies with Title XXI enrollment reporting requirements.

56. Quarterly Expenditure Reports.

The State complies with the quarterly expenditure report requirements outlined in this section. Refer to Section V of this document and attachments six and seven for compliance with budget neutrality.

57. Reporting Expenditures Under the Demonstration.
The State reports demonstration expenditures through the SoonerCare and CHIP program budget and Expenditure System, following routine CMS-64 reporting instructions. The State complies with all reporting expenditure requirements outlined in (a)-(j) of this section. Refer to Section V of this document for compliance with the Budget Neutrality Cap.

The State complies with all other reporting expenditure requirements outlined in (a)-(j) of this section. Refer to Section V of this document and attachment six and seven for compliance with budget neutrality.

58. Reporting Member Months.
The State complies with the member months reporting requirements, as outlined in (a)-(d) of this section.
Refer to Section V of this document for compliance with the Budget Neutrality Cap.

59. Standard Medicaid Funding Process.
The State reports to CMS matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure agreement, and separately reports these expenditures by quarter for each federal fiscal year on the CMS-37 form for the Medical Assistance Payments and state and local administration costs. The State submits to CMS the CMS-64 quality Medicaid expenditure report 30 days after the end of each quarter. Refer to Section V of this document and attachment six and seven for compliance with budget neutrality.

60. Extent of Federal Financial Participation for the Demonstration.
The State understands CMS's provision of FFP for applicable federal matching rates for the Demonstration, as outlined in (a)-(d) of this section. Refer to Section V of this document and attachment six and seven for compliance with budget neutrality.

61. Sources of Non-Federal Share.
The State certifies that the matching non-federal share of funds for the Demonstration is state/local monies. The State also certifies that such funds shall not be used as the match for any other federal grant or contract except as permitted by law. The State certifies that all sources of non-federal funding is compliant with Section 1903(w) of the Act and applicable regulations, and is subject to CMS approval. In addition, the State complies with the requirements set forth in (a)-(b) of this section. The State submits certifications of financial matters quarterly through the CMS-64. Refer to Section V of this document and attachment six and seven for compliance with budget neutrality.

The State also agrees that health care providers must retain 100 percent of the reimbursement amounts claimed by the State as demonstration expenditures. The State understands that no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the State government to return and/or redirect any portion of the Medicaid payments.

62. State Certification of Funding Conditions.
The State complies with the non-federal share requirements of demonstration expenditures, as outlined in (a)-(d) of this section. Refer to Section V of this document and attachment six and seven for compliance with budget neutrality.

63. Monitoring the Demonstration.

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The State provides CMS all requested information in a timely manner in order to effectively monitor the Demonstration.

64. Quarterly Expenditure Reports.
The State reports quarterly demonstration expenditures through the MBES/CBES, following routine CMS-64.21 reporting instructions as outlined in Section 2115 and 2500 of the State Medicaid Manual. The State submits all Title XXI expenditures through the CMS-64.21U and/or the CMS-64.21UP. Refer to Section V of this document and attachment six and seven for compliance with budget neutrality.

65. Claiming Period.
The State complies with the claiming period requirements outlined in this section. Refer to Section V of this document and attachment six and seven for compliance with budget neutrality.

66. Limitation on Title XXI Funding.
The State understands that there is a limit on the amount of federal Title XXI funds that they may receive for demonstration expenditures during the demonstration period. The State also understands that no further enhanced federal matching funds will be available for costs of the Demonstration if the State expends its available allotment. If Title XXI funds are exhausted, the State agrees to continue to provide coverage to Medicaid expansion children (Demonstration Population 8) through Title XIX funds until further Title XXI funds become available. Refer to Section V and attachment six and seven of this document for compliance with budget neutrality.

67. Limit on Title XIX Funding.
The State understands that there is a limit on the amount of Title XIX funds that the State may receive for selected Medicaid expenditures during the period of approval for the Demonstration. Refer to Section V of this document for compliance with budget neutrality.

68. Risk.
The State understands that they are at risk for the per capita cost for demonstration enrollees under the budget neutrality agreement. The State understands, however, that they are not at risk for the number of demonstration enrollees in each of the groups, as well as for changing economic conditions, which might impact enrollment levels. Refer to Section V of this document for compliance with budget neutrality.

69. Demonstration Populations Subject to the Budget Neutrality Agreement.
The State agrees that the demonstration populations outlined in (a)-(e) of this section are subject to the budget neutrality agreement and are incorporated into the demonstration eligibility groups used to calculate budget neutrality. Refer to Section V of this document for compliance with budget neutrality.

70. Budget Neutrality Expenditure Limit.
The State complies with the method used to calculate the budget neutrality expenditure limit, as outlined in (a)-(b) of this section. Refer to Section V and attachment six and seven of this document for compliance with budget neutrality.

71. Enforcement of Budget Neutrality.
The State agrees to submit a corrective action plan to CMS if the State exceeds the calculated cumulative budget neutrality expenditure limit. Refer to Section V of this document and attachment six and seven for compliance with budget neutrality.

72. Exceeding Budget Neutrality.

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The State agrees that if the budget neutrality limit has been exceeded at the end of the demonstration period, the State will return all excess federal funds to CMS. Refer to Section V of this document and attachment six and seven for compliance with budget neutrality.

73. Submission of Draft Evaluation Design.
The State submits to CMS a draft Evaluation Design no later than 120 days after the award of the Demonstration. The State agrees to include in the draft Evaluation Design the requirements set forth in (a)-(g) of this section.

OHCA submitted to CMS the proposed SoonerCare Choice 2015-2016 Evaluation Design on November 9, 2015 and submitted the final document to CMS on March 3, 2016. To review the final Evaluation Design, refer to Attachment one.

74. Identify the Evaluator.
The State identifies in the Evaluation Design the agency or contractor who will conduct the Evaluation report.

The State identified the 2015-2016 evaluator(s) for the SoonerCare Choice Evaluation report within the proposed 2015-2016 Evaluation Design that was submitted to CMS on November 9, 2015, and again on March 3, 2016 when OHCA submitted the final document to CMS.

75. Demonstration Hypotheses.
The State tests the demonstration hypotheses that are approved by the State and CMS.

OHCA submitted the proposed SoonerCare Choice demonstration hypotheses in the 2015-2016 Evaluation Design submitted to CMS on November 9, 2015, and submitted the final document to CMS on March 3, 2016. For the 2013 -2015 findings from the Evaluation Design, refer to Section VI of this document.

OHCA proposes the 2017-2018 demonstration hypotheses to remain the same as those proposed for the 2015 - 2016 Evaluation Design submission.

76. Evaluation of Health Access Networks.
The State submits to CMS a draft Evaluation Design for the Health Access Network pilot program as required under STC #73. Within the Evaluation Design, the State also includes the requirements set forth in (a)-(d) of this section.

OHCA submitted the HAN Evaluation Design, as well as the HAN reporting requirements outlined in (a)-(d) of this section in the 2015-2016 SoonerCare Choice Evaluation Design, which was submitted to CMS on November 9, 2015, and again on March 3, 2016, when OHCA submitted the final document to CMS. Refer to Section VI of this document for the 2013-2015 Evaluation Design findings.

For the 2017-2018 demonstration extension, OHCA would like to retain the changes that were included in the submission of the 2015 - 2016 Evaluation Design which included an analysis of the HANs effectiveness in:

a. Improving access to health care services to SoonerCare members served by the HANs;
b. Improving coordination of health care services through health information technology; and
c. Enhancing the State's patient-centered medical home program.

77. Evaluation of the Health Management Program.
The State submits to CMS a draft Evaluation Design for the Health Management Program. The State includes the requirements set forth in this section.

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The State included an Evaluation Design of the 2015-2016 HMP hypotheses listed under Section XIV, STC #77(a)-(h) in the SoonerCare Choice Evaluation Design submitted to CMS on November 9, 2015, and again on March 3, 2016 when OHCA submitted the final document to CMS. Refer to Section VI of this document for the 2013-2015 Evaluation Design findings.

OHCA proposes the following HMP hypotheses for the 2017-2018 demonstration extension.

a) *Impact on Enrollment Figures.* The implementation of phase two of the SoonerCare HMP, including introduction of physician office-based Health Coaches for nurse care managed members and closer alignment of nurse care management and practice facilitation will maintain enrollment and active participation in the program.

b) *Impact on Access to Care.* The incorporation of Health Coaches into primary care practices will result in increased PCP contact with nurse care managed members for preventive/ambulatory care.

c) *Impact on Identifying Appropriate Target Population.* The implementation of phase two of the SoonerCare HMP, including introduction of physician office-based Health Coaches for nurse care managed members and closer alignment of nurse care management and practice facilitation will improve the process for identifying qualified members and result in an increase in average complexity of need within the nurse care managed population.

d) *Impact on Health Outcomes.* Health Coaches will improve quality measures for members who are engaged.

e) *Impact on Cost/Utilization of Care.* Nurse care managed members will utilize the emergency room at a lower rate than forecasted without nurse care management intervention

f) *Impact on Cost/Utilization of Care.* Nurse care managed members will have fewer hospital admissions than forecasted without nurse care management intervention.

g) *Impact on Satisfaction/Experience with Care.* Nurse care managed members will report high levels of satisfaction with their care.

h) *Impact of HMP on Effectiveness of Care.* Total and PMPM expenditures for members enrolled in HMP will be lower than would have occurred absent their participation in nurse care management.

78. Evaluation of Eligibility and Enrollment Systems.
OHCA evaluates the State's eligibility and enrollment system, as indicated in (a)-(g) of this section, during an interim evaluation report, which documents the State's systems performance between Medicaid, CHIP and the FFM.

This requirement corresponds to the 2013-2015 demonstration Hypothesis 10. Documentation of compliance with this requirement can be found in Section VI of this document.

For the 2017-2018 extension period, OHCA removes the (a)-(g) systems reporting requirements. These requirements are a duplicative effort as OHCA is already reporting performance indicators to CMS on a monthly basis through the Socrata reporting system.

79. Interim Evaluation Reports.
The State submits to CMS an interim evaluation report in the event that the State requests to extend the Demonstration beyond the current approval period. Refer to Section VI of this document for the current 2017-2018 Evaluation Design findings.

80. Final Evaluation Plan and Implementation.

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The State provides the final Evaluation Design to CMS within 60 days of receiving CMS's comments. The State agrees to implement the Evaluation Design and include progress reports within the SoonerCare Quarterly Reports. The State also submits to CMS a draft Evaluation of the Demonstration 120 days after the expiration of the current Demonstration. The State agrees to provide a final Evaluation of the Demonstration to CMS within 60 days of receiving CMS's comments. The State agrees to include in the Evaluation the requirements set forth in (a)-(g) of this section.

OHCA submitted to CMS the proposed 2015-2016 SoonerCare Choice Evaluation Design on November 9, 2015, and again as a final report on March 3, 2016, after receipt of CMS's comments. OHCA also reports one or more hypotheses within each Quarterly report. In addition, OHCA submitted to CMS a proposed Evaluation report of the 2013-2015 Demonstration on April 26, 2015. OHCA received no comments from CMS.

81. Cooperation with CMS Evaluators.
The State agrees to fully cooperate with CMS, or an independent evaluator of CMS, for the evaluation of the Demonstration.

IV. QUALITY

Quality Assurance Monitoring

OHCA continues to provide program integrity through monitoring of the Demonstration. In January 2011, OHCA issued a Request for Proposal (RFP) for the provision of External Quality Review, and Behavioral Health Utilization Management for the SoonerCare Choice program. OHCA awarded the contract to Telligen in June 2011. During this extension period, Telligen worked with an outside contractor, Morpace, to conduct the Consumer Assessment of Health Plan Surveys (CAHPS®) for adults and children in 2013 and 2014, as well as an Experience of Care and Health Outcomes (ECHO®) Behavioral Health Survey for adults in 2013 and for children in 2014. Refer to Appendix D to review a list of recent quality assurance monitoring for the SoonerCare Choice program.

CAHPS® Member Surveys

OHCA's External Quality Review Organization (EQRO), Telligen, contracted with an outside vendor, Morpace to conduct the State Fiscal Year (SFY) 2015 *CAHPS® Adult Medicaid Member Satisfaction Surveys*, and SFY 2015 *CAHPS® Child Medicaid with Child Chronic Condition (CCC) Member Satisfaction Surveys*. OHCA received these reports in June 2015. The objective of the surveys is to capture accurate and complete information about consumer-reported experiences with SoonerCare Choice by:

- Measuring satisfaction levels, health plan use, health and socio-demographic characteristics of members;
- Identifying factors that affect the level of satisfaction;
- Providing a tool that can be used by plan management to identify opportunities for quality improvement; and
- Providing plans with data for HEDIS® and National Committee for Quality Assurance (NCQA) accreditation.

The conclusion of significant *increase* which would be found if a significance test had been conducted for the hypothesis that the population percent for 2015 was *greater than* the population percent for 2014 (with a 0.025 level of significance). The conclusion of significant *decrease* which would be found if a significance test had been conducted for the hypothesis that the population percent for 2015 was *less than* the population percent for 2014 (with a 0.025 level of significance).Additionally, the SFY 2015 CAHPS® adult and child surveys did yield OHCA's desired response rates. Please see attachment two and three for more detail information.

Quality Initiatives

Community Relations

OHCA has more than 538 public, private and nonprofit entities within Oklahoma's 77 counties who are considered OHCA community partners. Community partners are engaged in outreach, enrollment and retention of SoonerCare children.

Fetal Infant Mortality Rate (FIMR) Initiative

OHCA's case management unit identifies the top ten rural counties in Oklahoma with the highest infant mortality rate. Case management staff provides outreach to the prenatal women, ages 18 and older, within these ten counties for the duration of their pregnancy through their infants' first birthday. The data below is from SFY 2015.

- Number of prenatal women being monitored through their pregnancy: 1,378
- Number of moms receiving newborn education: 1,568

The State's infant mortality rate[4] has dropped from 8.6 in 2007 to 6.8 in 2013, a 1.8 percent decrease. The State can attribute the improvement in rate to the State's numerous infant mortality initiatives, such as FIMR.

Interconception Care (ICC) Initiative

The ICC outreach is for pregnant women ages 13 to 18 who have been identified in the 13FIMR counties who can remain in active care management until one year post delivery. The data below is from SFY 2015.

- Number of prenatal women enrolled in ICC: 724

Medical Home Audits

OHCA's Quality Assurance Compliance department conducts an on-location evaluation of medical home requirements for contracted providers. As of 2015, the OHCA review team updated terminology with "quality review" to now say "passed compliance". This means those who PASSED every component of the review would be 162 of the 397

- SFY 2014 – 361 medical home audits conducted; 97.5% passed quality review.
- SFY 2015 - 40.8% pass all PCMH components
- SFY 2016 64 of 260 passed all components 24.6%

Member Outreach Letters

OHCA's Member Services unit sends outreach letters to assist specific SoonerCare members, such as high ER utilizers with four or more visits to the ER, and pregnant women. Members receiving letters may call the SoonerCare helpline and ask for the appropriate "outreach representative" to receive information about their medical home and the particular benefits education they need. The data below is from SFY 2014.

- Prenatal Outreach or "Pat Letters" mailed: 14,637
- Prenatal Outreach or "Pat Letters" average response rate: 26%
- Households with Newborns Outreach or "Jean Letters" mailed: 29,793
- Households with Newborns Outreach or "Jean Letters" average response rate: 11%
- High ER Utilization Outreach or "Ethel Letters" mailed: 5,192
- High ER Utilization Outreach or "Ethel Letters" average response rate: 20%

PCP Compliance with 24-Hour Access Requirement

The data below is from SFY 2015.

[4] The infant mortality rate is the number of infant deaths per 1,000 live births.

- Average number of providers called each quarter: 907
- Average percentage of PCPs providing after-hours access each quarter: 94%

HEDIS® Quality Measures

Previous to 2010, OHCA used a contractor, APS Healthcare, to produce the State's HEDIS® measures. Beginning in 2010, however, OHCA's Quality Assurance department began compiling the data. The table below indicates that in HEDIS® year 2013, 14 measures had a statistically significant increase from the previous year, while only 4 measures indicated a significant decrease.

HEDIS® Measures 2010-2013[5]	HEDIS® 2010	HEDIS® 2011	HEDIS® 2012	HEDIS® 2013
Annual Dental Visit				
Aged 2-3 years	37.8%	39.3% ↑	41.0% ↑	40.9%
Aged 4-6 years	63.5%	64.6% ↑	67.2% ↑	66.6%
Aged 7-10 years	69.0%	70.5% ↑	72.6% ↑	72.3%
Aged 11-14 years	66.1%	68.3% ↑	70.3% ↑	70.2%
Aged 15-18 years	58.8%	61.2% ↑	62.9% ↑	63.1%
Aged 19-21 years	42.6%	43.2%	↓ 40.2%	40.0%
Children and Adolescents' Access to PCP				
Aged 12-24 months	97.8%	↓ 97.2%	↓ 96.6%	97.0% ↑
Aged 25 months – 6 years	89.1%	↓ 88.4%	90.1% ↑	90.6% ↑
Aged 7-11 years	89.9%	90.9% ↑	91.7% ↑	92.4% ↑
Aged 12-19 years	88.8%	89.9% ↑	91.6% ↑	92.8% ↑
Adults' Access to Preventive/Ambulatory Health Services				
Aged 20-44 years	83.6%	84.2% ↑	↓ 83.1%	82.8%
Aged 45-64 years	90.9%	91.1%	91.0%	90.8%
Aged 65+ years	92.6%	↓ 92.1%	92.2%	92.4%
Well-Child Visits				
Aged <15 months 1+ visits	95.4%	98.3% ↑	98.3%	↓ 97.3%
Aged <15 months 6+ visits	48.8%	59.0% ↑	58.6%	59.6% ↑
Aged 3-6 years 1+ visits	61.9%	↓ 59.8%	↓ 57.4%	57.6%

[5] ↑: Significant increase from previous year; ↓: Significant decrease from previous year.

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HEDIS® Measures 2010-2013[5]	HEDIS® 2010	HEDIS® 2011	HEDIS® 2012	HEDIS® 2013
Aged 12-21 years 1+ visits	37.1%	↓ 33.5%	34.5% ↑	↓ 31.6%
Medications for the Treatment of Asthma				
Aged 5-11 years	90.9%	90.6%	Not Available	Not Available
Aged 12-50 years	83.1%	81.9%	Not Available	Not Available
	HEDIS® 2010	HEDIS® 2011	HEDIS® 2012	HEDIS® 2013
Appropriate Medications for the Treatment of Asthma (Change in HEDIS® 2012)				
Aged 5-11 years	Not Available	Not Available	90.3%	94.0% ↑
Aged 12-18 years	Not Available	Not Available	85.2%	95.2% ↑
Aged 19-50 years	Not Available	Not Available	60.4%	68.9% ↑
Aged 51-64 years	Not Available	Not Available	56.9%	74.1%
Comprehensive Diabetes Care (Aged 18-75 years)				
Hemoglobin A1C Testing	71.0%	71.1%	70.5%	71.5% ↑
Eye Exam (Retinal)	32.8%	↓ 31.8%	31.8%	32.0%
LDL-C Screen	63.6%	62.9%	62.0%	63.1% ↑
Medical Attention for Nephropathy	54.4%	55.9% ↑	56.8%	58.7% ↑
Screening Rates				
Lead Screening in Children (by 2 years of age)	43.5%	44.5% ↑	44.7%	48.2% ↑
Appropriate Treatment for Children with URI (aged 3 months to 18 years)	67.7%	69.5% ↑	↓ 66.8%	73.1% ↑
Appropriate Testing for Children with Pharyngitis (aged 2 to 18 years)	38.8%	44.8% ↑	49.1% ↑	53.2% ↑
Breast Cancer Screening (aged 40-69 years)	41.1%	41.3%	↓ 36.9%	36.5%
Chlamydia Screening in Women (CHL) (aged 16-24 years)	Not Available	Not Available	49.1%	↓ 46.8%
Cervical Cancer Screening (aged 21-64 years)	44.2%	47.2% ↑	↓ 42.5%	↓ 41.0%
Cholesterol Management for Patients with Cardiovascular Conditions (aged 18-75)	69.5%	69.9%	68.6%	68.2%

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Program Integrity

In accordance with the Improper Payments Information Act of 2002, federal agencies review Medicaid and CHIP programs for improper payments every three years; this is known as the Payment Error Rate Measurement (PERM) program. The consistent application of eligibility rules also has enabled Oklahoma to achieve one of the lowest processing error rates in the nation. Under the federal Payment Error Rate Measurement (PERM) initiative, states must audit the accuracy of their eligibility processes every three years. In 2009, prior to online enrollment, Oklahoma's error rate was 1.24 percent. In 2012, the most recent audit, Oklahoma's error rate was 0.28 percent, versus the national average of 5.7 percent.

To continue ensuring proper payments, OHCA annually conducts a payment accuracy review; this review is similar to the PERM initiative review.

V. BUDGET NEUTRALITY

Compliance with Budget Neutrality Cap

As of December 2015, the State has $4.0 billion in savings over the life of the Demonstration. Actuarial analysis of the Demonstration projects that the State will maintain compliance with the budget neutrality cap through 2018. It is projected that the State will have $6.6 billion in savings by the end of 2018. To review the Budget Neutrality in its entirety, refer to Attachment six and seven.

Standard CMS Financial Management Questions

1. Section 1903(a)(1) provides that federal matching funds are only available for expenditures made by states for services under the approved State Plan.

> a. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e. general fund, medical services account, etc.)
>
> *Answer: Yes, SoonerCare providers retain 100 percent of the payments.*

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of care and services available under the plan.

> a. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded.
>
> *Answer:*
> *The non-federal share (NFS) of the medical home care coordination payments and HAN payments are funded from appropriations from the legislature to the Medicaid agency. The NFS for Insure Oklahoma is funded by tobacco tax. The NFS payments to academic medical centers are funded through Intergovernmental Transfers (IGTs) from appropriations from the legislature.*

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b. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes or any other mechanism used by the State to provide state share.

Answer: The state share is from appropriations from the legislature to the Medicaid agency and through IGTs.

c. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated.

Answer: Funds are appropriated to OU and OSU Medical Schools, Physician Manpower Training Commission for the Graduate Medical Education (GME) payments and the Oklahoma Tobacco Settlement Endowment Trust.

d. Please provide an estimate of total expenditure and state share amounts for each type of Medicaid payment.

Type	Total	NFS
Care Coordination fees and SoonerExcel Payments	$27,973,231	$10,820,745
HAN Payments Payments[6]	$6,359,145	$24592,459,876
GME Payments[7]	$101,679,897	$39,332,326
Insure Oklahoma Oklahoma[7]	$85,853,212	$33,210,169

e. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds.

Answer: The State receives the transferred amounts prior to making the payments.

f. If CPEs are used, please describe the methodology used by the State to verify that the total expenditures being certified are eligible for federal matching funds in accordance with 42 CFR 433.51(b).

Answer: Not applicable.

g. For any payment funded by CPEs or IGTs, please provide the following:

i. A complete list of the names of entities transferring or certifying funds:
Answer: OU and OSU medical schools and Physician Manpower Training Commission

ii. The operational nature of the entity (state, county, city, other):
Answer: State medical schools and State Commission

iii. The total amounts transferred or certified by each entity:
Answer: $39,332,326

[6] Numbers are estimates based on the SFY 2016 budget and FFY 2016 FMAP (.623175).

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iv. Clarify whether the certifying or transferring entity has general taxing authority:

Answer: No general taxing authority

v. Whether the certifying or transferring entity receives appropriations (identify level of appropriations):

Answer: Yes, they receive appropriations.

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy and quality of care. Section 1903(a)(1) provides for federal financial participation to states for expenditures for services under an approved State Plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

Answer: Supplemental payments include SoonerExcel bonus payments to medical homes. Total amount budgeted annually $3,000,000 with annual average payment for last two years of $2.84 million.

4. Please provide a detailed description of the methodology used by the State to estimate the upper payment limit (UPL) for each class of providers (state owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e. applicable to the current rate year) UPL demonstration.

Answer: The upper payment limit demonstration is not applicable.

5. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the federal share of the excess to CMS on the quarterly expenditures report?

Answer: No

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VI. DEMONSTRATION EVALUATION

Demonstration Evaluation Introduction

This portion of the application has three sections. The Program Evaluation portion provides current reports related to SoonerCare Choice, the Health Management Program, and Statewide insurance and access. A summary of the 2013 -2015 evaluation findings is also included, followed by the details of the report. Finally the Hypotheses proposed for 2017 – 2018 are included for review.

Program Evaluation

OHCA uses multiple contractors to evaluate the SoonerCare program. OHCA uses an independent, outside contractor, Pacific Health Policy Group (PHPG), to evaluate the SoonerCare Choice program and the Health Management Program. PHPG uses paid claims data, member and provider survey results and OHCA's enrollment and expenditure data to evaluate the programs' effectiveness in access, quality of care and cost savings.

OHCA contracted with another independent contractor, Leavitt Partners, in 2013, after Oklahoma's Governor announced a possible 'Oklahoma Plan,' aimed at focusing on improving the health of Oklahoma citizens; lowering the frequency of preventable illnesses and improving access to quality and affordable care. Leavitt Partners evaluated the current SoonerCare Choice and Insure Oklahoma programs and made recommendations "on how to optimize access and quality of health care in the State."

Finally, OHCA contracted with the State Health Access Data Assistance Center (SHADAC) to review the overall health insurance climate in Oklahoma and the role of SoonerCare in the State.

SoonerCare Choice Program Evaluation by PHPG

OHCA contracts with PHPG to evaluate the SoonerCare Choice program. PHPG evaluated the SoonerCare Choice program for the period 2009 through 2014[7]. The evaluation report focuses on the program's effectiveness in program access, quality and cost effectiveness goals.

PHPG's primary findings for the SoonerCare Choice program indicate, "The SoonerCare Choice program continued to demonstrate improved performance with respect to quality and access from 2009-2014." Below includes some highlights from PHPG's evaluation findings:

Access:

- The OHCA processes over 20,000 applications for SoonerCare Choice every month.
- In SFY 2014, all but two percent of applications were filed online directly by applicants or with the assistance of one of the OHCA's partner agencies.
- The online enrollment system has significantly reduced application processing times

Quality:

- The OHCA tracks preventive and diagnostic service delivery for SoonerCare Choice through "Healthcare Effectiveness Data and Information Set" (HEDIS®) measures.
- The OHCA recently began a quality improvement initiative under the auspices of an Adult Medicaid Quality Grant to increase cervical screening rates through a combination of provider training and member outreach activities.
- In response, the OHCA launched the SoonerQuit initiative in 2010 with the goal of reducing tobacco use among SoonerCare Choice members

Cost Effectiveness:

[7] The report includes some data for 2014, which is notated in the report.

- Total medical spending for SoonerCare (all aid categories), inclusive of spending attributable to eligibility growth, increased at an average annual rate of 4.5 percent from 2010 – 2013. This was below the national average of 5.7 percent
- Controlling for eligibility growth, SoonerCare Choice PMPM medical expenditure growth was significantly below the national rate."

To review the SoonerCare Choice Program PHPG Evaluation report in its entirety, refer to OHCA public website at www.okhca.org and view *SoonerCare Choice Program Independent Evaluation State Fiscal Year 2014 by PHPG.*

Health Management Program Evaluation
OHCA's evaluator for the HMP program, the Pacific Health Policy Group (PHPG), collaborated with Telligen to conduct the SoonerCare HMP's annual evaluation for SFY 2014; OHCA received the report in August 2015.

PHPG collected data for the evaluation through a variety of methods. These included an audit of Telligen, analysis of paid claims data and surveys/in-depth interview of nurse care management and practice facilitation participants.

Nearly all of the respondents (98 percent) indicated that their health coach asked questions about health problems or concerns, and the great majority stated their coach also provided answers and instructions for taking care of their health problems or concerns (84 percent) and answered questions about their health (79 percent). A majority (59 percent) reported that their health coach reviewed and helped with management of medications and 45 percent stated that their coach helped them to talk to and work with their regular doctor and his/her staff.

Respondents were asked to rate their satisfaction with each "yes" activity. The overwhelming majority reported being very satisfied with the help they received, with the portion ranging from 85 to 96 percent, depending on the item. This attitude carried over to the members' overall satisfaction with their health coaches; 84 percent reported being very satisfied.

Health coaching employs motivational interviewing to identify lifestyle changes that members would like to make. Once identified, it is the health coach's responsibility to collaborate with the member in developing an action plan with goals to be pursued by the member with his/her coach's assistance.
Seventy-seven percent of survey respondents confirmed that their health coach asked them what change in their life would make the biggest difference in their health. Eighty-six percent of this subset (or 67 percent of total) stated that they actually selected an area to make a change.

The SoonerCare HMP health coaching component registered net savings of approximately $3.4 million. This was a noteworthy outcome given the relatively short enrollment tenure of many participants. It also is noteworthy given the inclusion in health coaching of "at risk" members referred by providers. These members have lower projected costs, and therefore lower documentable savings under the MEDai methodology, even though by intervening at an early stage, the health coach may help to avert significant future health costs.

To review the HMP Evaluation report in its entirety, go to the OHCA public website at www.okhca.org and view *SoonerCare Health Management State Fiscal Year 2014 Evaluation.*

2013 Oklahoma Health Care Insurance and Access Survey
OHCA contracted with the State Health Access Data Assistance Center (SHADAC) to provide information such as health insurance coverage among adults and children in Oklahoma, descriptions of those with and without

health insurance coverage, change over time in coverage rates and the characteristics of insured and uninsured populations. SHADAC conducted telephone interview surveys within the following timeframes: March through June 2004, July through September 2008 and January through April 2013. In 2004, SHADAC completed 5,847 telephone interviews (44.0 percent response rate); in 2008, SHADAC completed 5,729 telephone interviews (15.6 percent response rate); and in 2013, SHADAC completed 6,270 telephone interviews (31.4 percent response rate).

Results from the surveys indicate that the rate of uninsurance in the state of Oklahoma increased 2.3 percentage points from 2008 (16.4 percent) to 2013 (18.7 percent), but only increased 0.6 percentage points from 2004 (18.1 percent) to 2013 (18.7) percent. Results also indicate that in 2013, 35.7 percent of Oklahomans had coverage through a public insurance program, such as Medicare or Medicaid. Additionally, only 4.5 percent of state residents had insurance through a self-purchased plan in 2013, and this rate remained unchanged from 2008. To review a summary of the survey findings in its entirety, please visit our www.okhca.org website for Studies and Evaluations.

Evaluation Findings from the 2013-2015 Hypotheses

Hypothesis	**Do 2015 Outcomes of the Demonstration Confirm the Hypothesis?**
1A. Child Health checkup rates for children 0 to 15 months old will be maintained at or above 95 percent over the life of the extension period.	No – The OHCA has not yet met this measure. The OHCA will continue to track this data associated with this hypothesis over the extension period.
1B. Child Health checkup rates for children 3 through 6 years old will increase by three percentage points over the life of the extension period.	No – The OHCA has not yet met this measure. The OHCA will continue to track this data associated with this hypothesis over the extension period.
1C. Adolescent child health checkup rates will increase by three percentage points over the life of the extension period.	No – The OHCA has not yet met this measure. The OHCA will continue to track this data associated with this hypothesis over the extension period.
2. The rate of adult members who have one or more preventative health visits with a primary care provider in a year will improve by three percentage points as a measure of access to primary care in accordance with HEDIS guidelines between 2013-2015.	No – The OHCA has not yet met this measure. The OHCA will continue to track this data associated with this hypothesis over the extension period.
3. The number of SoonerCare primary care practitioners enrolled as medical home PCPs will maintain at or above the baseline data between 2013-2015.	Yes
4A. There will be adequate PCP capacity to meet the health care needs of the SoonerCare members between 2015-2015. The available capacity will equal or exceed the baseline data over duration of the waiver extension period.	Yes
4B. There will be adequate PCP capacity to meet the health care needs of the SoonerCare	Yes

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Hypothesis	Do 2015 Outcomes of the Demonstration Confirm the Hypothesis?
members between 2013-2015. As perceived by the member. The time it takes for the member to schedule an appointment should exceed the baseline data between 2013-2015.	
5. The percentage of American Indian members who are enrolled with an Indian Health Services, Tribal or Urban Indian Clinic (I/T/U) with a SoonerCare Choice American Indian primary care case management contract will increase nine percentage points during the 2013-2015 extension period (this is three percentage points each year).	No – The OHCA has not yet met this measure. The OHCA will continue to track this data associated with this hypothesis over the extension period.
6. The proportion of members eligible for SoonerCare Choice who do not have an established PCP will decrease within 90 days of the primary care claims analysis report.	Yes
7A. key quality performance measures, asthma and Emergency Room (ER) utilization, tracked for PCPs participating in the HANs will improve between 2013-2015. Decrease asthma related ER visits for HAN members with an Asthma diagnosis identified in the medical record.	The health access networks continue to move forward with reporting under the refined methodology established in 2013. The OHCA will continue to track and trend hypothesis 7 over the extension period to monitor for significant changes in results.
7B. Key quality performance measures, asthma and Emergency Room (ER) utilization, tracked for PCPs participating in the HANs will improve between 2013-2015. Decrease 90-day readmissions for related asthma conditions for HAN members with an Asthma diagnosis identified in their medical record.	The health access networks continue to move forward with reporting under the refined methodology established in 2013. The OHCA will continue to track and trend hypothesis 7 over the extension period to monitor for significant changes in results.
7C. Key quality performance measures, asthma and Emergency Room (ER) utilization, tracked for PCPs participating in the HANs will improve between 2013-2015. Decrease overall ER use for HAN members.	The health access networks continue to move forward with reporting under the refined methodology established in 2013. The OHCA will continue to track and trend hypothesis 7 over the extension period to monitor for significant changes in results.
8. Average per member per month expenditures for members belonging to a HAN affiliated PCP will continue to be less than those members enrolled with non-Han affiliated PCPs during the period of 2013-2015.	Yes
9a(A). The percentage of SoonerCare members identified as qualified for nurse care management, who enroll and are actively engaged, will increase as compared to baseline.	No – The OHCA has not yet met this measure. The OHCA will continue to track data associated with this hypothesis over the extension period.

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Hypothesis	Do 2015 Outcomes of the Demonstration Confirm the Hypothesis?
9a(B). The percentage of members actively engaged in nurse care management in relation to the providers' total SoonerCare Choice panel.	No – The OHCA has not yet met this measure. The OHCA will continue to track data associated with this hypothesis over the extension period.
9b. The incorporation of Health Coaches into primary care practices will result in increased PCP contact with nurse care managed members, versus baseline for two successive years and a comparison group of eligible but not enrolled members.	Pending – It is not clear if the HMP has met this measure at this time. HMP has updated this hypothesis with revised data and will provide the OHCA with updated SFY2015 data after the reporting time period of this evaluation.
9c(A). The implementation of Phase II of the SoonerCare HMP, including introduction of physician office-based Health Coaches for nurse care managed members and closer alignment of nurse care management and practice facilitation, will improve the process for identifying qualified members and result in an increase in average complexity of need within the nurse care managed population. Number of members engaged in nurse care management with two or more chronic conditions.	Pending – It is not clear if the HMP has met this measure at this time. HMP will provide the OHCA with updated SFY2015 data after the reporting time period of this evaluation.
9c(B). The implementation of Phase II of the SoonerCare HMP, including introduction of physician office-based Health Coaches for nurse care managed members and closer alignment of nurse care management and practice facilitation, will improve the process for identifying eligible members and result in an increase in average complexity of need within the nurse care managed population. Sum of chronic conditions across all members engaged at any time in a 12-month period.	Pending – It is not clear if the HMP has met this measure at this time. HMP will provide the OHCA with updated SFY2015 data after the reporting time period of this evaluation.
9c(C). The implementation of Phase II of the SoonerCare HMP, including introduction of physician office-based Health Coaches for nurse care managed members and closer alignment of nurse care management and practice facilitation, will improve the process for identifying eligible members and result in an increase in average complexity of need within the nurse care managed population. Number of members engaged in nurse care management at any time in a 12-month period.	Pending – It is not clear if the HMP has met this measure at this time. HMP will provide the OHCA with updated SFY 2015data after the reporting time period of this evaluation.
9c(D). The implementation of Phase II of the	Pending – It is not clear if the HMP has met

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Hypothesis	Do 2015 Outcomes of the Demonstration Confirm the Hypothesis?
SoonerCare HMP, including introduction of physician office-based Health Coaches for nurse care managed members and closer alignment of nurse care management and practice facilitation, will improve the process for identifying eligible members and result in an increase in average complexity of need within the nurse care managed population. Sum of chronic impact scores across all members engaged at any time in a 12 month period.	this measure at this time. HMP will provide the OHCA with updated SFY2015 data after the reporting time period of this evaluation.
9d. The use of a disease registry by Health Coaches will improve the quality of care for nurse care managed members.	Pending – It is not clear if the HMP has met this measure at this time. HMP will provide the OHCA with updated SFY2015 data after the reporting time period of this evaluation.
9e. Nurse care managed members will utilize the emergency room at a lower rate than members in a comparison group comprised of eligible but not enrolled members.	Pending – It is not clear if the HMP has met this measure at this time. HMP will provide the OHCA with updated SFY2015 data after the reporting time period of this evaluation.
9f. Nurse care managed members will have fewer hospital admissions and readmissions than members in a comparison group comprised of eligible but not enrolled members.	Pending – It is not clear if the HMP has met this measure at this time. HMP will provide the OHCA with updated SFY2015 data after the reporting time period of this evaluation.
9g. Nurse care managed members will report higher levels of satisfaction with their care than in a comparison group comprised of eligible but not engaged members.	Pending – It is not clear if the HMP has met this measure at this time. HMP will provide the OHCA with updated SFY2015 data after the reporting time period of this evaluation.
9h. Total and per member per month expenditures for members enrolled in HMP will be lower than would have occurred absent their participation in nurse care management.	Pending – It is not clear if the HMP has met this measure at this time. HMP will provide the OHCA with updated SFY2015 data after the reporting time period of this evaluation.
10. The state's systems performance will ensure seamless coverage between Medicaid and the Marketplace after changes outlined in the Affordable Care Act effectuated.	Yes

OHCA reports the most current data and analysis for the SoonerCare Choice program's hypotheses. Refer to page 3 to reference the 2013-2015 waiver objectives.

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Hypothesis 1 – This hypothesis directly relates to SoonerCare Choice waiver objective #1 and #1 of CMS's Three Part Aim:

The rate of age-appropriate well-child and adolescent visits will improve between 2013-2015.

> *A. Child health checkup rates for children 0 to 15 months old will be maintained at or above 95 percent over the life of the extension period.*
> *B. Child health checkup rates for children 3 through 6 years old will increase by three percentage points over the life of the extension period.*
> *C. Adolescent child health checkup rates will increase by three percentage points over the life of the extension period.*

This hypothesis posits that the number of members who have regular visits with their primary care providers is a measure of how much access members have to primary care. One of the objectives of the medical home model of primary care delivery is improvement of access to regular primary care. The measure predicts that as a result of the waiver, rates will be maintained and/or improved for well-child and adolescent visits over the duration of the waiver extension period (2013-2015).

The data used is administrative, derived from paid claims and encounters, following HEDIS® measure guidelines. The members in the measurement group are divided by age cohorts (0-15 months, 3-6 years and adolescents 12-19 years) and are limited to those who were enrolled in SoonerCare for 11 or 12 months of the measurement year allowing for a maximum gap in enrollment of 45 days.

The medical home model was implemented in January 2009, so initial effects of the waiver's primary care model began in HEDIS® year 2010 data.

Percentage of Child and Adolescent Members with at Least One Checkup Per Year[8]	CY2009 HEDIS® 2010[9]	CY2010 HEDIS® 2011	CY2011 HEDIS® 2012	CY2012 HEDIS® 2013
0-15 months	95.4%	98.3%	98.3%	97.3%
3-6 years	61.9%	59.8%	57.4%	57.6%
12-19 years	37.1%	33.5%	34.5%	31.6%

Hypothesis 1.A Results:
This hypothesis specifies that checkup rates for children 0-15 months will be maintained at or above 95 percent over the course of the extension period. OHCA met this measure in HEDIS® year 2010 when the percentage of child visits was at 95.4 percent. OHCA has maintained at or above this rate through the baseline data in HEDIS® year 2012 (98.3 percent), and through HEDIS® year 2013 (97.3 percent). OHCA expects to maintain above 95 percent throughout the rest of the extension period.

Hypothesis 1.B Results:
In accordance with the hypothesis, the checkup rates for children ages 3-6 years are to increase by 3 percentage points over the extension period, 2013-2015, which would be an average of 1 percentage point per year. Children ages 3-6 years have seen a slight 0.2 percent increase in health checkup rates during HEDIS® year 2013. OHCA continues to monitor this group during the 2013-2015 extension period.

[8] Data shaded in light gray represents data that has had a statistically significant increase from the previous year. Data shaded in the darker gray represents data that has had a statistically significant decrease from the previous year.
[9] OHCA started producing HEDIS® data internally using a different formula; thus, recalculating 2009 data. In previous years, HEDIS® data was produced by a Quality Improvement Organization contractor.

Hypothesis 1.C Results:
The evaluation measure hypothesizes that the checkup rate for adolescent's ages 12-21 years will also increase 3 percentage points over the extension period, 2013-2015, which is an average of 1 percentage point per year. Adolescents ages 12-21 years have had a 2.9 percent decrease in health checkup rates from HEDIS® year 2012, to HEDIS® year 2013. OHCA analysis indicates that there is an inverse relationship between the increasing age of the child and screening/participation rates.

OHCA is in the process of improving adolescent well visits through a number of outreach initiatives. OHCA is in the process of partnering with the Child Study Center at the University of Oklahoma for analysis and recommendations on how to improve checkup rates for this age group. In addition, OHCA has been working with the University of Oklahoma Department of Family Medicine on provider education in residency practices to increase well visits. OHCA has also provided outreach to schools to alert them to the Child Health Checkup guide that can be ordered and distributed to students. Finally, OHCA is exploring the possibility of implementing an advisory board or focus group of teens to provide information on effective outreach methods.

OHCA continues to monitor this group during the 2013-2015 extension period.

Hypothesis 2 – This hypothesis directly relates to SoonerCare Choice waiver objective #1 and #1 of CMS's Three Part Aim:

The rate of adult members who have one or more preventive health visits with a primary care provider in a year will improve by three percentage points as a measure of access to primary care in accordance with HEDIS® guidelines between 2013-2015.

Access to primary care providers is determined in accordance with HEDIS® guidelines: a member with at least one paid claim or encounter with a primary care provider in a 12-month period is determined to have access to primary care. Only members who were enrolled for 11 or 12 months of the data year who did not have gaps in enrollment of more than 45 days during the year are included in the population for whom the access rate is determined. The adult rate excludes claims for inpatient procedures, hospitalizations, emergency room visits and visits primarily related to mental health and/or chemical dependency.

Access to PCP/Ambulatory Health Care: HEDIS® Measures for Adults[8]	CY2009 HEDIS® 2010[9]	CY2010 HEDIS® 2011	CY2011 HEDIS® 2012	CY2012 HEDIS® 2013
20-44 years	83.6%	84.2%	83.1%	82.8%
45-64 years	90.9%	91.1%	91.0%	90.8%

Hypothesis 2 Results:
This hypothesis postulates that adults' rate of access to primary care providers will improve by three percentage points over the life of the extension, 2013-2015. SoonerCare adults ages 20-44 and 45-64 have not yet attained a three percentage point increase over the 2013-2015 extension period. For HEDIS® year 2013, adults' ages 20-44 years with access to a PCP or ambulatory health care decreased 0.3 percentage points from HEDIS® year 2012, while adults ages 45-64 with access to a PCP or ambulatory health care decreased 0.2 percentage points from HEDIS® year 2012 to HEDIS® year 2013. OHCA continues to trend the adult access rates over the extension period to monitor for significant changes in rates for these age groups.
Hypothesis 3 – This hypothesis directly relates to SoonerCare Choice waiver objective #2 and #1 of CMS's Three Part Aim:

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The number of SoonerCare primary care practitioners enrolled as medical home PCPs will maintain at or above the baseline data (1,932) providers between 2013-2015.

PCP Enrollments	Dec 2012	Jan 2013	Feb 2013	Mar 2013	Apr 2013	May 2013	June 2013	July 2013	Aug 2013	Sept 2013	Oct 2013	Nov 2013	Dec 2013
Number of SoonerCare Choice PCPs	1,932	1,952	1,973	2,008	2,069	2,083	2,111	2,160	2,199	2,223	2,232	2,217	2,067
	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	June 2014							
	2,119	2,141	2,192	2,225	2,231	2,252							

Hypothesis 3 Results:
This hypothesis measures the State's access to care by tracking the number of SoonerCare primary care providers enrolled as medical home PCPs. OHCA exceeded the baseline data during the first quarter of 2013 and has continued to exceed the baseline in 2014. By the end of June 2014, OHCA had 2,252 PCPs contracted as medical home PCPs, which is a 17 percent increase from the December 2012 baseline data. OHCA believes that the number of SoonerCare Choice PCPs will continue to increase throughout the extension period.

Hypothesis 4 – This hypothesis directly relates to SoonerCare Choice waiver objectives #1 and #2, and #1 of CMS's Three Part Aim:

There will be adequate PCP capacity to meet the health care needs of the SoonerCare members between 2013-2015. Also, as perceived by the member, the time it takes to schedule an appointment should improve between 2013-2015.

> *A. The available capacity will equal or exceed the baseline capacity data over the duration of the waiver extension period.*
> *B. As perceived by the member, the time it takes for the member to schedule an appointment should exceed the baseline data between 2013-2015.*

Hypothesis 4.A Results:

SoonerCare Choice PCP Capacity	Baseline Data December 2012	PCP Capacity December 2013	PCP Capacity June 2014
Number of SoonerCare Choice PCPs	1,932	2,067	2,252
SoonerCare Choice PCP Capacity	1,092,850	1,149,541	1,177,398
Average Members per PCP	279.11	268.72	249.06

This hypothesis postulates that OHCA will equal or exceed the baseline capacity data (1,092,850) over the duration of the extension period. OHCA exceeded the baseline capacity at the end of December 2013 and has continued to exceed it through the second quarter of 2014. As of June 2014, OHCA's contracted providers were able to serve an additional 84,548 SoonerCare Choice members from December 2012, which is an eight percent increase. From the total number (1,177,398) of members providers are able to serve, the percentage of capacity used is 42 percent, which leaves 58 percent of capacity available to serve additional members.

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OHCA staff conducted a SoonerCare Provider Capacity Analysis report in early 2014. To review the report in its entirety, please reference our www.ohca.org public website.

Hypothesis 4.B Results

CAHPS® Adult Survey Results	Baseline Data: SFY 2012 CAHPS® Survey Response	SFY 2013 CAHPS® Survey Response	SFY 2014 CAHPS® Survey Response
Positive Responses from the Survey Question: *"In the last 6 months, how often did you get an appointment for a checkup or routine care at a doctor's office or clinic as soon as you needed?"*	89% Responded "Usually" or "Always"	80% Responded "Usually" or "Always"	82% Responded "Usually" or "Always"

CAHPS® Child Survey Results	Baseline Data: SFY 2012 CAHPS® Survey Response	SFY 2013 CAHPS® Survey Response	SFY 2014 CAHPS® Survey Response
Positive Responses from the Survey Question: *"In the last 6 months, when you made an appointment for a checkup or routine care for your child at a doctor's office or clinic, how often did you get an appointment as soon as your child needed?"*	93% Responded "Usually" or "Always"	90% Responded "Usually" or "Always"	91% Responded "Usually" or "Always"

This hypothesis posits that the member's response to the time it takes to schedule an appointment should exceed the baseline data. OHCA's contracted External Quality Review Organization (EQRO) Telligen, contracted with an outside vendor, Morpace, to conduct the CAHPS® survey for State Fiscal Year (SFY) 2013 and 2014. Results from the surveys indicate that the majority of survey respondents for both the adult and child surveys had satisfactory responses for scheduling an appointment as soon as needed. Eighty and eighty-two percent of the adult survey respondents felt satisfied in the time it took to schedule an appointment with their PCP, while ninety and ninety-one percent of child survey respondents indicated they were "Usually" or "Always" satisfied.

While the majority of survey respondents had a positive response about the time it takes to get an appointment with their PCP, OHCA saw a decrease in these positive responses in 2013. Compared to the 2012 baseline data, there was a 9 percent decrease in the 2013 adult composite response and a slight 3 percent decrease for the 2013 child composite response. OHCA believes the decrease can be attributed to an updated version (5.0H) of the member surveys with modifications to questions and new survey goals. The survey question for this hypothesis, for example, was reworded from CAHPS® survey 2012 to CAHPS® survey 2013.

Hypothesis 5 – This hypothesis directly relates to SoonerCare Choice waiver objective #4, and #1 of CMS's Three Part Aim:

The percentage of American Indian members who are enrolled with an Indian Health Services, Tribal or Urban Indian Clinic (I/T/U) with a SoonerCare Choice American Indian primary care case management contract will

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increase nine percentage points during the 2013-2015 extension period (this is three percentage points each year).

I/T/U Providers	Total American Indian /Alaska Native Members with SoonerCare Choice and I/T/U PCP	IHS Members with I/T/U PCP	Percent of IHS Members with I/T/U PCP	I/T/U Capacity
Baseline Data Dec 2012	**86,465**	**18,195**	**21.04%**	**124,400**
Jan 2013	84,196	17,165	20.39%	124,400[10]
Feb 2013	84,355	17,570	20.83%	101,900
Mar 2013	84,745	17,541	20.70%	101,900
Apr 2013	87,491	20,718	23.68%	101,900
May 2013	91,606	20,167	22.01%	102,900
June 2013	86,207	20,418	23.68%	101,900
July 2013	87,858	19,645	22.36%	101,900
Aug 2013	87,786	19,664	22.40%	101,900
Sept 2013	90,190	20,005	22.18%	96,900
Oct 2013	90,468	19,953	22.06%	99,400
Nov 2013	92,755	20,116	21.69%	99,400
Dec 2013	94,125	21,165	22.48%	99,400
Jan 2014	95,221	21,838	22.93%	99,400
Feb 2014	96,503	22,579	23.40%	99,400
Mar 2014	98,547	22,658	22.99%	99,900
Apr 2014	93,557	20,803	22.24%	99,900
May 2014	94,133	21,480	22.82%	99,900
June 2014	93,997	21,699	23.08%	99,900

Hypothesis 5 Results:
This hypothesis postulates that the percentage of American Indian members who are enrolled with an I/T/U PCP with a SoonerCare American Indian primary care case management contract will increase nine percentage points during the extension period. The proportion of American Indian members with an I/T/U PCP has increased 2.04 percentage points when comparing June 2014 to December 2012. At this time, OHCA expects the increase of American Indian members with an I/T/U PCP to continue. In order to meet this measure, OHCA will continue to monitor this group during the 2013-2015 extension period.

Hypothesis 6 – This hypothesis directly relates to SoonerCare Choice waiver objective #1 and #2, and #1 of CMS's Three Part Aim:

The proportion of members qualified for SoonerCare Choice who do not have an established PCP will decrease within 90 days of the primary care claims analysis report.

Percentage of Members Aligned with a PCP	Primary Care Claims Analysis Report – Members with Claims with no Selected PCP	Total Number of Members OHCA Aligned with a PCP	**Percentage**

[10] During contract renewals for I/T/U providers in February 2013, maximum capacities were implemented across the board. This resulted in a reduction of overall capacity for this network, but really made the I/T/U provider capacities consistent with the rest of the SoonerCare Choice program. This change did not result in any members being removed from their I/T/U provider. These contractors, in fact, provide services for any American Indian who presents at their facility.

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Percentage of Members Aligned with a PCP	Primary Care Claims Analysis Report – Members with Claims with no Selected PCP	Total Number of Members OHCA Aligned with a PCP	**Percentage**
Jan 2013	3,503	1,584	**45.2%**
Feb 2013	3,229	1,260	**39.0%**
Mar 2013	640	562	**87.8%**
Apr 2013	1,642	717	**43.7%**
May 2013	546	738	**135.2%**
June 2013	492	661	**134.4%**
July 2013	648	635	**98.0%**
Aug 2013	639	788	**123.3%**
Sept 2013	447	402	**89.9%**
Oct 2013	759	538	**70.9%**
Nov 2013	642	127	**19.8%**
Dec 2013	501	333	**66.5%**
Jan 2014	848	292	**34.4%**
Feb 2014	558	501	**89.8%**
Mar 2014	550	316	**57.5%**
Apr 2014	727	342	**47.0%**
May 2014	890	383	**43.0%**
June 2014	955	176	**18.4%**

Hypothesis 6 Results:
OHCA's Primary Care Claims Analysis Report is a monthly report that includes every SoonerCare Choice qualified member with one or more claims who does not have an established PCP. In January 2013, for example, the Primary Care Claims Analysis Report indicated that 3,503 SoonerCare Choice qualified members had one or more claims, but were not aligned with a PCP. In June 2014, approximately 955 SoonerCare Choice qualified members with claims were not aligned with a PCP.

Once OHCA receives the report, staff aligns the qualified members with a PCP. As indicated in the chart, of the 3,503 SoonerCare Choice members who were not aligned with a PCP in January 2013, OHCA staff successfully aligned 1,584 members within 90 days of receiving the Primary Care Claims Analysis Report. Of the 4,500 members in 2014 who were not aligned with a PCP, OHCA staff has aligned 44 percent of those members with a PCP within 90 days of receiving the Primary Care Claims Analysis Report. OHCA has successfully met this measure as OHCA staff has decreased the number of SoonerCare Choice qualified members who do not have an established PCP.

Hypothesis 7 – This hypothesis directly relates to SoonerCare Choice waiver objective #3 and #2 of CMS's Three Part Aim:

Key quality performance measures, asthma and Emergency Room (ER) utilization, tracked for PCPs participating in the HANs will improve between 2013-2015.

> *A. Decrease asthma-related ER visits for HAN members with an asthma diagnosis identified in their medical record.*
> *B. Decrease 90-day readmissions for related asthma conditions for HAN members with an asthma diagnosis identified in their medical record.*
> *C. Decrease overall ER use for HAN members.*

Hypothesis 7 Results:

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For calendar year 2013, OHCA collected the first-year baseline data for this hypothesis. OHCA will be able to provide analysis on the data as more data becomes available.

A. Asthma-Related ER Visits	All HAN Members with Asthma	Total Number of ER Visits by HAN Members with Asthma	Percent of HAN Members with Asthma who Visited the ER
OU Sooner HAN	31,364	2,588	8%
PHCC HAN	839	86	10%
OSU Network HAN	1,903	317	17%

B. 90-Day Readmissions for HAN Members with Asthma	HAN Members with Asthma with at least One Inpatient Stay Related to Asthma	HAN Members with Asthma who were Readmitted to the Hospital 90 Days after Previous Asthma-Related Hospitalization	Percent of HAN Members with Asthma who had a 9-Day Readmission for Related Asthma Condition(s)
OU Sooner HAN	26	16	62%
PHCC HAN	7	0	0%
OSU Network HAN	30	2	7%

C. ER Use for HAN Members	Total HAN Members	ER Visits for HAN Members	Percent of ER Use for HAN Members
OU Sooner HAN	238,208	31,364	13%
PHCC HAN	5,192	2,153	41%
OSU Network HAN	14,764	9,048	61%

In accordance with STC #76, which relates to Hypothesis 7, OHCA provides an analysis of the HANs effectiveness in reducing costs, improving access to care, improving quality and coordination of services and enhancing the SoonerCare Choice medical home.

a. Reducing costs: OHCA had indicated to CMS an expectation that per member per month cost will decrease for members enrolled with a HAN. PMPM expenditures have decreased for members enrolled with PCPs participating in the HANs. The results show lower costs for HAN members that are enrolled with a medical home compared to those members not affiliated with a HAN.

HAN Per Member Per Month Dates of Service for SFY 2013	July 2012	Aug 2012	Sept 2012	Oct 2012	Nov 2012	Dec 2012	Jan 2013	Feb 2013	Mar 2013	Apr 2013	May 2013	June 2013
HAN Members	$280.35	$303.82	$285.38	$309.49	$298.32	$283.84	$324.19	$278.91	$298.39	$305.92	$296.58	$274.13
Non-HAN Members	$292.90	$324.93	$291.95	$327.93	$308.13	$296.22	$369.75	$305.06	$321.47	$323.94	$324.52	$277.06

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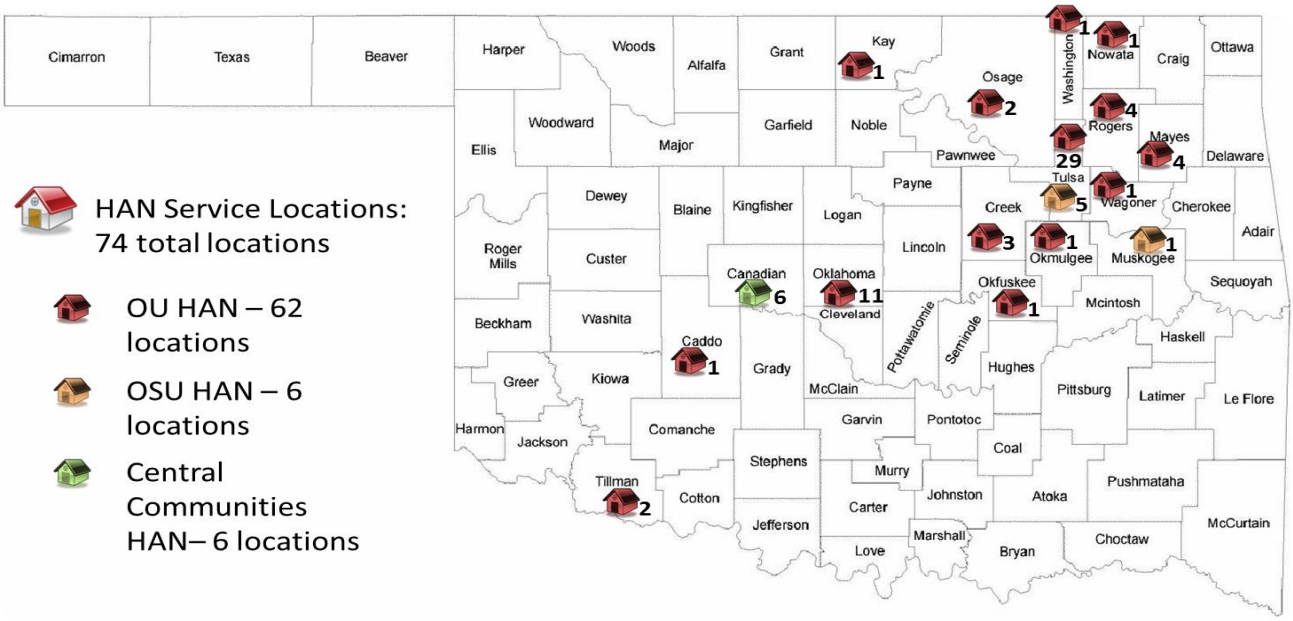
b. Improving access to and the availability of health care services: All three HAN programs provide services to members at multiple provider locations with numerous primary care providers, specialty providers and community resources. Currently, there are 74 HAN locations throughout the State.



c. Improving the quality and coordination of health care services: All three HAN programs combined have care managed some 2,866 members during SFY 2013 and SFY 2014. The HANs focus on initiatives to improve primary care effectiveness, reduce ER use and raise provider efficiency. The HANs utilize a care management structure process, including member assessment, education and care coordination.

Over the course of SFY 2013 and 2014, the HANs have been working with management of each provider service location in achieving Patient Centered Medical Home (PCMH) tier advancement. Tier advancement not only provides additional reimbursement to the provider, but also increase the level of services provided to HAN members.

During SFY 2014, CMS approved OHCA's request that the care coordination for members with complex health care needs be directed by the HAN or Health Management Program, whichever is determined to be most appropriate for the member.

d. Enhancing the state's patient-centered medical home program: Although OHCA is not utilizing MEDai, the HANs are making use of other forms of technology such as Doc2Doc, electronic medical records and electronic health records.

The OU HAN Doc2Doc staff has completed 131 site visits with providers who utilize Doc2Doc. These visits include revising the system, sharing of data/reports and completing training opportunities. The OU HAN facilitated the creation of the first interface between a HAN provider's electronic medical record and Doc2Doc. The interface has allowed for better tracking of referrals and reporting capabilities.

The OU HAN staff has completed over 180 formal training sessions with staff and providers using the tool. This includes trainings held with providers in the Central Communities HAN.

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Central Communities has made substantial gains, while efforts to achieve full implementation are ongoing. Central Communities continues to work with the Doc2Doc team leader from the OU HAN who has provided training at four of their PCP practices. Although Central Communities has not fully implemented Doc2Doc, they have 21 practices that utilize EMRs.

The OSU HAN has completed the implementation of HER for the OSU Physician clinics. The EHR will allow the PCPs to identify, monitor and provide early intervention strategies for their members.

Within the HAN, the OSU Health Information Technology team has been engaged in conversations with MyHealth Access Network to work toward the implementation of Doc2Doc for all OSU Physician clinics. Health information technology and MyHealth will work with Doc2Doc to automate the creation of referrals by developing an interface so the physicians can continues to order referrals using the EHR.

To review the annual HAN reports in their entirety, please visit our public website at www.okhca.org.

Hypothesis 8 – This hypothesis directly relates to SoonerCare Choice waiver objective #3 and #3 of CMS's Three Part Aim:

Reducing costs associated with the provision of health care services to SoonerCare beneficiaries served by the HANs.

A. Average per member per month expenditures for members belonging to a HAN-affiliated PCP will continue to be less than those members enrolled with non-HAN affiliated PCPs during the period of 2013-2015.

HAN Per Member Per Month Dates of Service for SFY 2013	July 2012	Aug 2012	Sept 2012	Oct 2012	Nov 2012	Dec 2012	Jan 2013	Feb 2013	Mar 2013	Apr 2013	May 2013	June 2013
HAN Members	$280.35	$303.82	$285.38	$309.49	$298.32	$283.84	$324.19	$278.91	$298.39	$305.92	$296.58	$274.13
Non-HAN Members	$292.90	$324.93	$291.95	$327.93	$308.13	$296.22	$369.75	$305.06	$321.47	$323.94	$324.52	$277.06

Hypothesis 8 Results:
This hypothesis postulates that the average per member per month (PMPM) expenditure for HAN members will be less than the PMPM expenditure for non-HAN members. From the beginning of SFY 2013 until the end of SFY 2013, OHCA has met this measure each month. The PMPM expenditure differences for HAN members to non-HAN members ranges from a $2.93 difference up to a $45.56 difference. Per member per month expenditures continue to be lower for SoonerCare members enrolled with a HAN PCP than for SoonerCare members who are not enrolled with a HAN PCP. OHCA expects this trend to continue.
Hypothesis 9a – This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP Objective #3 and #1 of CMS's Three Part Aim:

The implementation of Phase II of the SoonerCare HMP, including introduction of physician office-based Health Coaches for nurse care managed members and closer alignment of nurse care management and practice facilitation, will yield increased enrollment and active participation (engagement) in the program.

A. The percentage of SoonerCare members identified as qualified for nurse care management, who enroll and are actively engaged, will increase as compared to baseline.
B. The percentage of members actively engaged in nurse care management in relation to the providers' total SoonerCare Choice panel.

Hypothesis 9a(A) Results:

SoonerCare HMP Members in Nurse Care Management	Qualified for Nurse Care Management	Engaged in Nurse Care Management	Percentage of Individuals Engaged in Nurse Care Management
July 2013	848	184	21.70%
Aug 2013	1,574	511	32.47%
Sept 2013	2,653	1,132	42.67%
Oct 2013	3,849	1,952	50.71%
Nov 2013	4,968	2,737	55.09%
Dec 2013	5,684	3,083	54.24%
Jan 2014	7,573	3,674	48.51%
Feb 2014	9,207	4,329	47.02%
Mar 2014	12,043	5,040	41.85%
Apr 2014	15,243	5,621	36.88%
May 2014	16,326	5,493	33.65%
June 2014	17,242	5,360	31.09%
SFY 2013 Baseline Data	3,252	8,091	40.19%

This hypothesis posits that the percentage of SoonerCare members identified as qualified for nurse care management, who enroll and are actively engaged, will increase as compared to the baseline data. At the beginning of Phase II (July 2013), Next Generation HMP, 21.7 percent of HMP individuals were actively engaged in nurse care management. This is 18.49 percent lower than the SFY 2013 baseline data. OHCA met or exceeded the baseline measure, however, during the period of September 2013 through March 2014. In the second quarter of 2014, several clinics were added to the HMP causing an increase in the number of individuals qualified for the program. OHCA expects that as the number of clinics being added to the program slows down, the number of individuals engaged in the program will begin to catch up and stabilize the percent engaged.

Hypothesis 9a(B) Results:

Actively Engaged HMP Members Aligned with a Health Coach	Total SoonerCare Members Assigned to Panels of Practices with Health Coaches	Individuals Qualified for the HMP Program	Number of HMP Members Actively Engaged in Nurse Care Management	Percentage of HMP Members Aligned with a Health Coach who are Actively Engaged in Nurse Care Management
January 2014	29,723	5,684	3,083	10%
September 2014	53,241	17,242	5,360	10%

This hypothesis measures the percentage of members actively engaged in nurse care management in relation to the providers' total SoonerCare Choice panel. Approximately 53,241 individuals are assigned to panels of practices that have embedded health coaches. Of those individuals, some 17,242 individuals qualify for the HMP program. Individuals who qualify for the HMP program include individuals who meet HMP criteria – they have chronic illness and are at highest risk for adverse outcomes and increased health care expenditures. Overall, approximately ten percent of SoonerCare members assigned to panels of practices with health coaches

are HMP members who are actively engaged in nurse care management. OHCA uses this as the baseline data for this measure.

As noted in Hypothesis 9a(A), in the second quarter of 2014, several clinics were added to the HMP causing an increase in the number of individuals qualified for the program. OHCA expects that as the number of clinics being added to the program slows down, the number of individuals engaged in the program will begin to catch up and stabilize the percent engaged.

Hypothesis 9b – This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #4 and #1 of CMS's Three Part Aim:

The incorporation of Health Coaches into primary care practices will result in increased PCP contact with nurse care managed members, versus baseline for two successive years and a comparison group of qualified but not enrolled members.

Self-Reported Number of PCP Visits In 12 Months for HMP Members	
Number of Visits to PCP	Number of Members
0	31 (0.8%)
1	47 (1.2%)
2	128 (3.3%)
3	204 (5.2%)
4	381 (9.7%)
5	249 (6.4%)
6	299 (7.6%)
7	115 (2.9%)
8	163 (4.2%)
9	60 (1.5%)
10 or more	1,970 (50.2%)
Unsure	274 (7.0%)

Hypothesis 9b Results:
The Health Management Program (HMP) transitioned to Phase II of the program, Next Generation HMP, in July 2013. Phase II of the program embeds health coaches into the practices for face-to-face care management. For this measure, OHCA provides the baseline data for SFY 2013, as OHCA is still accumulating data for Phase II of the HMP program. OHCA's contracted HMP evaluator, Pacific Health Policy Group (PHPG), conducts the evaluation of the program on a SFY basis; therefore, comparison data for Phase II of the HMP program will be provided to OHCA in early 2015. Refer to Attachment one, OHCA's 2013-2015 Evaluation Design Close out.

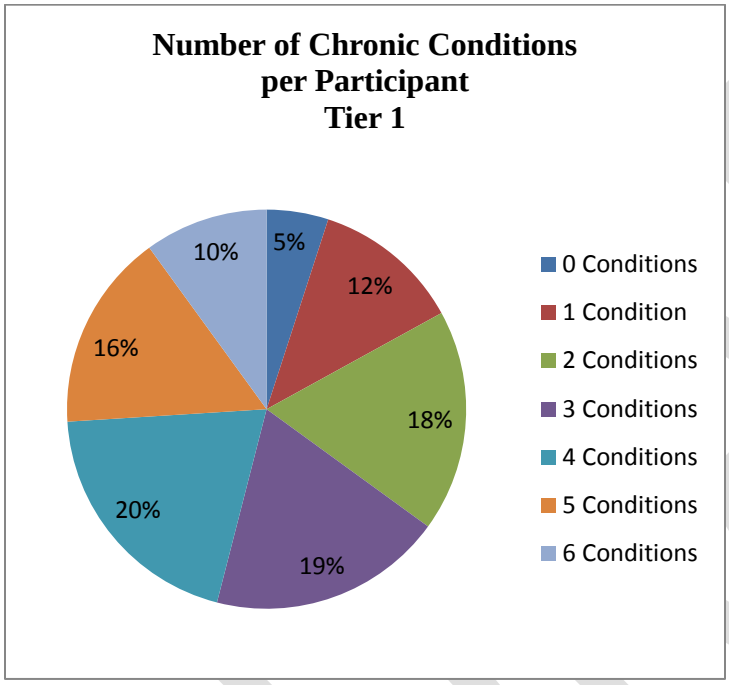
PHPG conducted an over-the-telephone HMP member survey for SFY 2013. The survey included the question: "*Not including trips to the ER, how many times have you seen a health care provider in the past 12 months?"* Of the 3,924 members who were interviewed for the survey, 99 percent of members (3,921), gave a response. For SFY 2013, half (50 percent) of survey respondents indicated that they visited their PCP 10 or more times within 12 months. Comparatively, only 0.8 percent of survey respondents indicated that they did not see their PCP at all over twelve months. As health coaches were embedded into practices beginning in July 2013, OHCA postulates that more members will report increased visits with their PCPs.

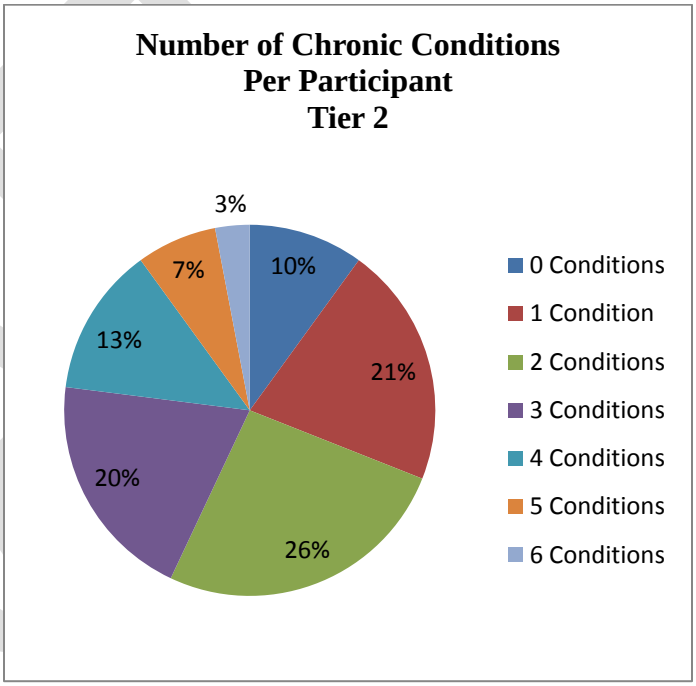
Hypothesis 9c – This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #2 and #2 of CMS's Three Part Aim:

The implementation of Phase II of the SoonerCare HMP, including introduction of physician office-based Health Coaches for nurse care managed members and closer alignment of nurse care management and practice facilitation will improve the process for identifying qualified members and result in an increase in average complexity of need within the nurse care managed population.

For Hypothesis 9c, the HMP transitioned to Phase II of the program, Next Generation HMP, in July 2013. Phase II of the program embeds health coaches into the practices for face-to-face care management. For this measure, OHCA provides the baseline data for SFY 2013, as OHCA is still accumulating data for Phase II of the HMP program. OHCA's contracted HMP evaluator, Pacific Health Policy Group (PHPG), conducts the evaluation of the program on a SFY basis; therefore, comparison data for Phase II of the HMP program will be provided to OHCA in early 2015, as noted in OHCA's 2013-2015 Evaluation Design.

Hypothesis 9c(A) Results:



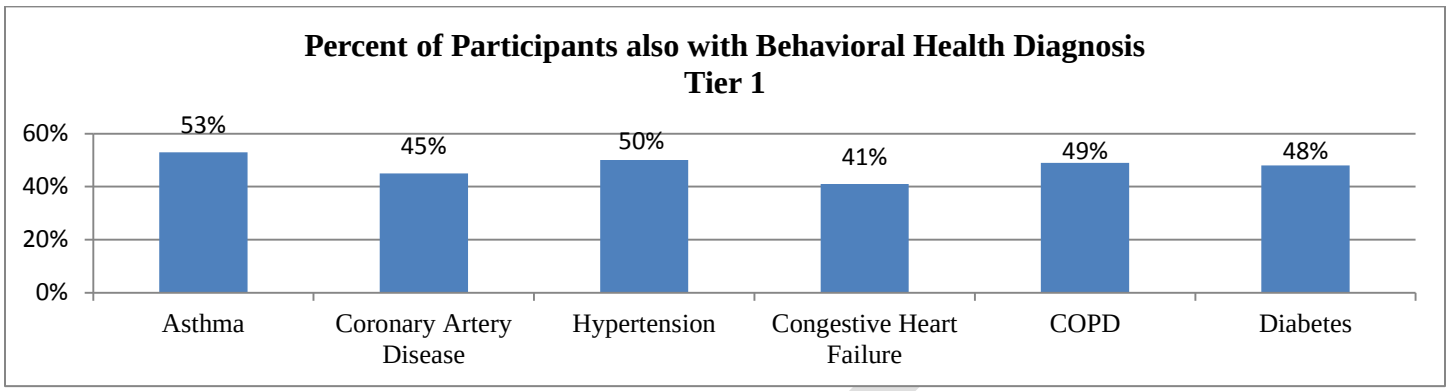


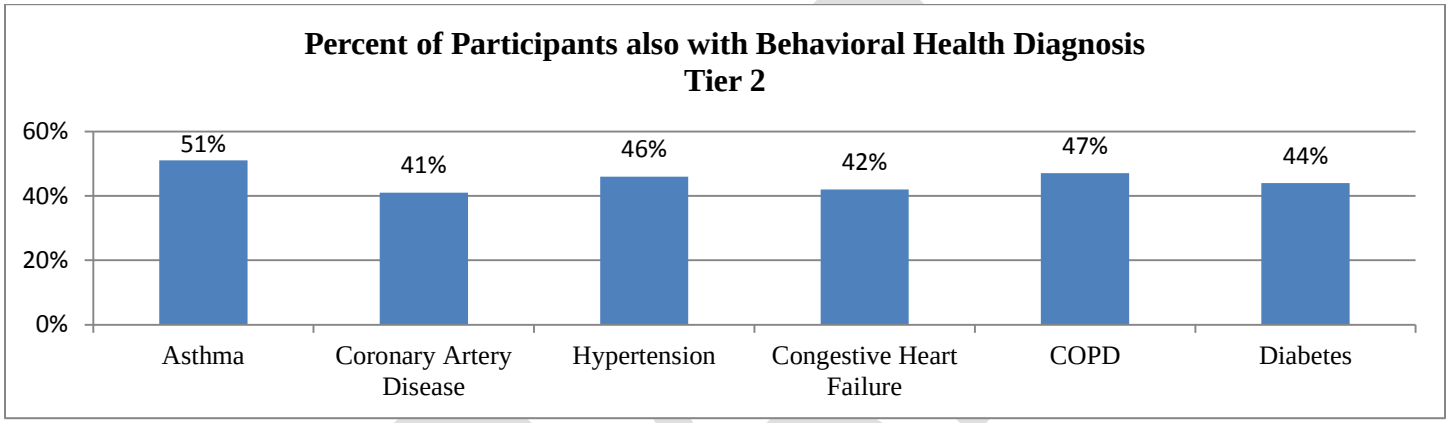
This measure indicates the number of members in nurse care management with multiple chronic conditions. In accordance with PHPG's SFY 2013 HMP Evaluation, 83 percent of Tier 1 (highest acuity) participants had at least two of the six most frequently observed chronic physical conditions, as shown in the chart above. Comparatively, a lower percentage, 69 percent, of Tier 2 participants had two or more co-morbidities, as shown in the chart above. With the implementation of health coaches, OHCA continues to take a holistic approach to care rather than just managing a single disease.

Hypothesis 9c(B) Results:

This measure provides the sum of chronic conditions across all members engaged at any time within a 12-month period. In accordance with PHPG's SFY 2013 HMP Annual Evaluation, seven different chronic conditions for HMP members are tracked with some 21 diagnosis-specific measures related to the chronic conditions.

Hypothesis 9c(C) Results:





This measure provides the number of HMP members with a chronic condition and at least one behavioral health condition. PHPG's HMP Evaluation report indicates that nearly 50 percent of the Tier 1 population had a chronic condition with at least one behavioral health co-morbidity. Tier 2 participants were somewhat less likely to have chronic and behavioral health co-morbidity, although the rate was still significant at an average of 45 percent.

Hypothesis 9c(D) Results:

Chronic Impact Score for HMP Members	Data for SFY 2013
Number of HMP Members	5,566
Chronic Impact Score Sum	537,235.55
Average Chronic Impact Score	96.52

This measure provides the sum of chronic impact scores across all HMP members engaged at any time in a 12-month period. For SFY 2013, the average chronic impact score was 96.52. As HMP members' health gets better and they are transitioned off the program, OHCA will continue to bring new members into the program; therefore, OHCA expects for the chronic impact score to stay relatively high.

Hypothesis 9d – This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #5 and #2 of CMS's Three Part Aim:

The use of a disease registry by Health Coaches will improve the quality of care for nurse care managed members.

HMP Members' Compliance Rates with CareMeasures™ Clinical Measures	June 2012 – Percent Compliant	June 2013 – Percent Compliant
Asthma – Percent of patients 5 to 40 with a diagnosis of asthma who were evaluated during at least one office visit within 12 months for the frequency of daytime and nocturnal asthma symptoms	61.4%	85.9%
Asthma – Percent of patients 5 to 40 with a diagnosis of mild, moderate or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment	100.0%	100.0%
Chronic Obstructive Pulmonary Disease – Spirometry Evaluation	44.3%	81.0%
Chronic Obstructive Pulmonary Disease – Bronchodilator Therapy	91.7%	91.7%
Diabetes Mellitus – Percent of patients 18 to 75 with DM receiving one or more A1c test(s) per year	79.6%	87.1%
Diabetes Mellitus – Percent of patients 18 to 75 with DM who had most recent hemoglobin A1c less than 9 percent	59.5%	67.0%
Diabetes Mellitus – Percent of patients 18 to 75 with DM who had most recent blood pressure in control (<140/80 mmHg)	67.8%	71.7%
Diabetes Mellitus – Percent of patients 18 to 75 with DM receiving at least one lipid profile (or all component tests)	62.7%	69.1%
Diabetes Mellitus – Percent of patients 18 to 75 with DM with most recent LDL-C < 130 mg/dI	47.1%	53.1%
Diabetes Mellitus – Percent of patients 18 to 75 with DM who received urine protein screening or medical attention for nephropathy during at least one office visit within 12 months	52.7%	59.0%
Diabetes Mellitus – Percent of patients 18 to 75 with diagnosis of DM who had dilated eye exam	37.7%	49.2%
Diabetes Mellitus – Percent of patients 18 to 75 with DM who had a foot exam	52.4%	64.2%
Hypertension – Percent of patients with blood pressure measurement recorded among all patient visits for patients 18 and older with diagnosed HTN	98.6%	98.8%
Hypertension – Percent of patients 18 and older who had a diagnosis of HTN and whose blood pressure was adequately controlled (< 140/90 mmHg) during the measurement year	66.2%	69.4%
Prevention – Percent of women 50 to 69 who had a mammogram to screen for breast cancer within 24 months	34.0%	39.4%

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HMP Members' Compliance Rates with CareMeasures™ Clinical Measures	June 2012 – Percent Compliant	June 2013 – Percent Compliant
Prevention – Percent of patients 50 to 80 who received the appropriate colorectal cancer screening	19.2%	20.0%
Prevention – Percent of patients 18 and older who received an influenza vaccination during the measurement period	13.4%	37.1%
Prevention – Percent of patients 18 and older who have ever received a pneumococcal vaccine	8.3%	12.5%
Prevention – Percent of patients identified as tobacco users who received cessation intervention during the measurement period	3.8%	20.0%
Prevention – BMI and follow-up documented	49.4%	90.7%
Tobacco Cessation – Percent of patients 10 and older where inquiry about tobacco use was recorded	63.9%	60.6%
Tobacco Cessation – Percent of patients 10 and older who use tobacco where act of assessing the patient's readiness to quit tobacco use was recorded	51.5%	75.7%
Tobacco Cessation – Percent of patients 10 and older who use tobacco where the act of advising the patient to quit tobacco use was recorded	59.6%	95.5%
Tobacco Cessation – Percent of patients 10 and older who use tobacco where assistance with developing a behavioral quit plan was provided	70.4%	77.8%
Tobacco Cessation – Percent of patients 18 and older who use tobacco where medication use was recommended to aid their quit plan	37.0%	65.0%
Tobacco Cessation – Percent of patients 10 and older who use tobacco who were provided motivational treatment to quit tobacco use	61.1%	40.9%
Tobacco Cessation – Percent of patients 10 and older who use tobacco, and who are ready to quit using tobacco, where a follow up was scheduled	18.5%	25.5%
Tobacco Cessation – Percent of patients 10 and older who were former tobacco users where assistance with relapse prevention was provided	28.6%	N/A

Hypothesis 9d Results:

The Health Management Program (HMP) transitioned to Phase II of the program, Next Generation HMP, in July 2013. Phase II of the program embeds health coaches into the practices for face-to-face care management. For this measure, OHCA provides the baseline data for SFY 2013, as OHCA is still accumulating data for Phase II of the HMP program. OHCA's contracted HMP evaluator, Pacific Health Policy Group (PHPG), conducts the evaluation of the program on a SFY basis; therefore, comparison data for Phase II of the HMP program will be provided to OHCA in early 2015.

As indicated in the HMP Fifth Annual Evaluation report, OHCA's HMP contractor, Telligen, generates monthly reports on the number of patients entered into the registry that are compliant and meet the CareMeasures™ clinical measures. Of the 28 measures, 82 percent (23 out of 28) of the findings showed improvement in the number of members compliant from SFY 2012 to SY 2013; seven percent (2 out of 28) of the measures stayed the same and seven percent (2 out of 28) decreased. One of the measures did not have data for SFY 2013. The use of the CareMeasures™ disease registry helps evaluate how many members comply with the CareMeasures™ clinical measures and which areas the nurse care managers/health coaches need to improve.

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Hypothesis 9e – This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #1 and #2 of CMS's Three Part Aim:

Nurse care managed members will utilize the emergency room at a lower rate than members in a comparison group comprised of qualified but not enrolled members.

Hypothesis 9e Results:
In accordance with OHCA's 2013-2015 Evaluation Design, this hypothesis relates to Phase II of the HMP program. The HMP program transitioned to Phase II of the program in July 2013. Phase II of the program embeds health coaches into the practices for face-to-face care management. OHCA's contracted HMP evaluator, PHPG, conducts the evaluation and data necessary to measure this hypothesis. The evaluation and data is collected on a state fiscal year (SFY) basis; therefore, SFY 2014 data for this hypothesis will be available in early 2015.

Hypothesis 9f – This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #1 and #2 of CMS's Three Part Aim:

Nurse care managed members will have fewer hospital admissions and readmissions than members in a comparison group comprised of qualified but not enrolled members.

Hypothesis 9f Results:
In accordance with OHCA's 2013-2015 Evaluation Design, this hypothesis relates to Phase II of the HMP program. The HMP program transitioned to Phase II of the program in July 2013. Phase II of the program embeds health coaches into the practices for face-to-face care management. OHCA's contracted HMP evaluator, PHPG, conducts the evaluation and data necessary to measure this hypothesis. The evaluation and data is collected on a state fiscal year (SFY) basis; therefore, SFY 2014 data for this hypothesis will be available in early 2015.

Hypothesis 9g – This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #3 and #2 of CMS's Three Part Aim.

Nurse care managed members will report higher levels of satisfaction with their care than members in a comparison group comprised of qualified but not engaged members.

Hypothesis 9g Results:
In accordance with OHCA's 2013-2015 Evaluation Design, this hypothesis relates to Phase II of the HMP program. The HMP program transitioned to Phase II of the program in July 2013. Phase II of the program embeds health coaches into the practices for face-to-face care management. OHCA's contracted HMP evaluator, PHPG, conducts the evaluation and data necessary to measure this hypothesis. The evaluation and data is collected on a state fiscal year (SFY) basis; therefore, SFY 2014 data for this hypothesis will be available in early 2015.

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Hypothesis 9h – This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #1 and #3 of CMS's Three Part Aim:

Total and PMPM expenditures for members enrolled in HMP will be lower than would have occurred absent their participation in nurse care management.

HMP Nurse Care Management PMPM for All Members	1 to 12 Months after First Contact with Provider	13 to 24 Months after First Contact with Provider	25 to 36 Months after First Contact with Provider	37 to 48 Months after First Contact with Provider	Any
MEDai Forecasted PMPM Expenditures	$607	$609	$635	$675	$629
Actual PMPM Expenditures	$609	$520	$556	$613	$580
Percent of Forecast	100.4%	85.4%	87.4%	90.8%	92.2%

Hypothesis 9h Results:
In accordance with OHCA's 2013-2015 Evaluation Design, this hypothesis relates to Phase II of the HMP program. The HMP program transitioned to Phase II of the program in July 2013. Phase II of the program embeds health coaches into the practices for face-to-face care management. For this measure, OHCA provides the baseline data for SFY 2013, as OHCA is still accumulating data for Phase II of the HMP program. OHCA's contracted HMP evaluator, PHPG, conducts the evaluation and data necessary to measure this hypothesis. The evaluation and data is collected on a state fiscal year (SFY) basis; therefore, SFY 2014 data for this hypothesis will be available in early 2015.

PMPM expenditures for all HMP members during the first 12 months after first contact with a provider were equivalent with the forecasted cost. PMPM expenditures, however, averaged 14 percent below forecast for the three remaining evaluation periods. Overall, PMPM savings averaged $49 through SFY 2013. Overall, the HMP program achieved an aggregate savings in excess of $182 million. The nurse care management portion of the program achieved an aggregate savings of $124 million, or approximately 15 percent of the total forecasted medical claims costs. The practice facilitation portion of the program yielded an aggregate savings of $58 million, or 6.4 percent as measured against total forecasted medical claims costs.

For the baseline year, OHCA saw a savings in both PMPM costs and total expenditures in the HMP program, compared to MEDai's forecasted costs without the program. OHCA expects to continue to see cost savings with the HMP program.

Hypothesis 10 – This hypothesis directly relates to SoonerCare Choice waiver objective #5 and #1 of CMS's Three Part Aim:

The State's systems performance will ensure seamless coverage between Medicaid and the FFM after changes outlined in the Affordable Care Act are effectuated.

Hypothesis 10 Results[11]*:*

A. Eligibility Determinations	Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	June 2014
MAGI Determination – Qualified	55,242	46,735	86,447	41,552	34,213	84,648	76,312	71,282	63,087

[11] OHCA began collecting systems data on October 1, 2013, at the onset of open enrollment for the federally facilitated marketplace.

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A. Eligibility Determinations	Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	June 2014
Determined Qualified – Direct or Transfer Application	22,664	18,295	28,624	18,672	13,915	31,073	31,311	32,391	30,153
Determined Qualified at Annual Renewal	32,578	28,440	57,823	22,880	20,298	53,575	45,001	38,891	32,934

B. Individuals Determined Not Qualified	Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	June 2014
Ineligibility Established	11,830	10,107	20,171	10,852	9,519	25,013	22,202	20,017	15,954
Inadequate Documentation	804	848	842	822	545	1,385	1,833	1,971	1,652

C. Individuals Disenrolled	Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	June 2014
Determined Not Qualified at Application (New Applicant)	4,950	4,339	7,097	5,230	3,896	10,936	10,743	10,264	8,821
Determined Not Qualified at Annual Renewal (current member)	7,684	6,616	13,916	6,444	6,168	15,462	13,292	11,724	8,785

This hypothesis postulates that the OHCA will ensure seamless coverage between Medicaid and the FFM after federal changes are effectuated. OHCA went live with outbound (State to hub) account transfers on January 23, 2014. The outbound account transfer includes all individuals who are found not qualified for full-benefit Medicaid. Between October 1, 2013 and January 23, 2014, OHCA had some 90,000 applications queued up for the first outbound account transfer. As of June 2014, OHCA transferred some 64,489 applications to the federal hub.

Inbound (hub to State) account transfers had a go-live date of February 12, 2014. This includes all individuals who apply through the federally facilitated marketplace who are assessed as 'potentially qualified' for full-benefit Medicaid. Approximately 20,000 applications were queued to be sent to OHCA for the first transfer between October 1, 2013 and February 12, 2014. As of June 2014, OHCA received nearly 3,000 applications from the hub.

In accordance with STC #78, which relates to Hypothesis 10, OHCA provides the following data from the State's online enrollment and eligibility system.

a) Eligibility determinations: Refer to Hypothesis 10A.

b) Individuals determined not-qualified: Refer to Hypothesis 10B.

c) Due to Oklahoma's real-time online eligibility system, the average application processing time is less than 24 hours for MAGI populations. The average application processing time for non-MAGI populations is less than 30 days.

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d) Due to Oklahoma's real-time online eligibility system, the average application processing time is less than 24 hours for MAGI populations. The average application processing time for non-MAGI populations is less than 30 days.

e) Individuals disenrolled: Refer to Hypothesis 10C.

f) From October 2013 to June 2014, OHCA has termed from SoonerCare Choice an estimated eight percent of individuals a month, with an average estimate of 92 percent of individuals continuing the next month.

SoonerCare Choice Churn Rates	Continuing Enrollees	Percent Continuing	New Enrollees	Terminated Enrollees	Percent Terminated	Total Current Enrollees
Oct 2013	471,473	97%	68,940	58,144	12%	486,413
Nov 2013	448,523	89%	57,561	37,890	7%	506,084
Dec 2013	480,723	93%	35,655	25,361	5%	516,378
Jan 2014	482,600	91%	47,786	33,778	6%	530,386
Feb 2014	499,471	94%	31,284	30,915	6%	530,755
March 2014	515,939	93%	40,538	14,816	3%	556,477
April 2014	478,602	90%	55,328	77,875	15%	533,930
May 2014	487,200	91%	48,756	46,730	9%	535,956
June 2014	503,796	94%	33,094	32,160	6%	536,890

g) OHCA went live with outbound (State to hub) account transfers on January 3, 2014. As of June 2014, OHCA transferred some 64,489 applications to the federal hub. Inbound (hub to State) account transfers had a go-live date of February 12, 2014. As of June 2014, OHCA received nearly 3,000 applications from the hub.

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Proposed 2017-2018 SoonerCare Choice and Insure Oklahoma Hypotheses

The OHCA is requesting that these remain the same as the 2015 -2016 approved hypotheses.

Hypothesis 1 – Child health checkup rates.
The rate for age-appropriate well-child and adolescent visits will improve between 2016-2018.

Hypothesis 2 – PCP visits.
The rate of adult members who have one or more preventive health visits with a primary care provider in a year will improve as a measure of access to primary care in accordance with HEDIS® guidelines between 2016-2018.

Hypothesis 3 – PCP enrollments.
The number of SoonerCare Choice primary care practitioners enrolled as medical home PCPs will increase between 2016-2018.

Hypothesis 4 – PCP capacity available.
There will be adequate PCP capacity to meet the health care needs of the SoonerCare members between 2016-2018.

Hypothesis 5 – PCP availability.
As perceived by the member, the time it takes for the member to schedule an appointment should exceed the baseline data.

Hypothesis 6 – Integration of I/T/U providers.
The percentage of Native American members who are enrolled with IHS, Tribal or Urban Indian Clinics with a SoonerCare American Indian PCCM contract will increase between 2016-2018.

Hypothesis 7 – Impact of health access networks on quality of care.
Key quality performance measures tracked for PCPs participating in the HANs will improve between 2016-2018.

Hypothesis 8 – Impact of health access networks on effectiveness of care.
Average per member per month expenditures will decrease for members enrolled with PCPs participating in the HANs between 2016-2018.

Hypothesis 9 – Health Management Program (HMP).
Health outcomes for chronic diseases will improve between 2016-2018 as a result of participation in the HMP. Total expenditures for members enrolled in HMP will decrease. Refer to STC #77 to review the proposed HMP hypotheses.

Hypothesis 10 – Impact on satisfaction/experience with care for the Insure Oklahoma program.
Members in the Insure Oklahoma program will have a higher satisfaction rate with their health care plans and exceed the baseline data.

VII. PUBLIC NOTICE PROCESS

Post Award Forum
In accordance with STC #17, OHCA held one Post Award Forum for the 2015 -2016 extension period in order to afford the public with an opportunity to provide meaningful comment on the progress of the demonstration extension.

May 26, 2016 –OHCA held the forum six months after CMS approved the 2013-2015 demonstration extension. The meeting was held at the Oklahoma Health Care Authority in Oklahoma City; the meeting included teleconferencing by the go to meeting feature. The meeting time and location was published beforehand in accordance with Oklahoma's Open Meeting Act.

Comments
One comment was provided in the form of a verbal request by those in attendance of how to be more involved in the decision making process and offer input. An email response was provided as follow up after the meeting in addition to the discussion.

Agency response: The Oklahoma Health Care Authority (OHCA) appreciates your attendance Thursday, May 26, 2016, at the 2016 Post Award Forum meeting. Part of our public notice process is to follow up on questions and comments to us by the attendees. As mentioned in the discussion, you requested information on how your agency could be more involved with ensuring that the agency is aware of the significance of the services you provide and your ability to have greater input.

During the forum, the OHCA Waiver Development & Reporting Coordinator provided education on the 1115 waiver authority, the use of medical homes and the programs within the 1115 authority, as well as discussed the benefits, services and main program goals of the SoonerCare Choice program. The Coordinator also explained

the process by which the OHCA evaluates the Demonstration, and the modifications to the Demonstration for the 2016-2018 extension periods, as outlined in Section II of the STCs.

Documentation of Compliance with Public Notice Requirements

In compliance with public notice requirements of the agency and regulations at 42 CFR §431.408, the OHCA provided meaningful notice of the State's intent to renew the SoonerCare demonstration to the Native American Tribes and to the general public.

OHCA made use of the methods listed below to inform the public of the State's intent to renew the Demonstration and to solicit feedback from the public. All dates reflected are 2016.

March 17	• CMS determined that the state must to go through a public notice process prior to gaining the two year extension for 2017 – 2018 1115 Demonstration Waiver
March 29	• Intent to request an extension posted to OHCA Banners (60 day Post) Attachment 9
April 1 – June 3	• Post Draft Renewal Application on OHCA website (60 day Post) Attachment 15; for comment see Attachment 10
April 8	• Posting of intent to request an extension in the newspapers of widest circulation in each city with a population of 100,000, or more persons. (60 day post) Attachment 11
April 19	• First Public Notice Meeting Oklahoma Perinatal Quality Improvement Collaborative Presentation Attachment 12 & 12a
May 3	• Tribal Consultation Attachment 14 & 14a
May 19	• Second Public Notice Meeting, Medical Advisory Committee (MAC) Presentation Attachment 13
June 3	• OHCA Comment Period Ends
July 15	• Receive Cover Letter from Governor's Office for Renewal
July 20	• Submit Renewal Application to CMS
August 26	• OHCA Posts Revised Renewal Application For 30-day Public Comment

APPENDICES

Mandatory State Plan Groups	FPL and/or Other Qualifying Criteria	Applicable Waivers and CNOMs (Waiver List summary)	Demonstration Population (STC# 57)
Pregnant women and infants under age 1 1902(a)(10)(A)(i)(IV)	Up to and including 133 % FPL	Freedom of Choice, Retroactive Eligibility	Populations 1,2,3,4

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Children 1-5 1902(a)(10)(A)(i)(VI)	Up to and including 133 % FPL	As Above	Populations 1,2,3,4
Children 6-18 1902(a)(10)(A)(i)(VII)	Up to and including 133% FPL*	As Above	Populations 1,2,3,4
IV-E Foster Care or Adoption Assistance Children	Automatic Medicaid eligibility	As Above	Populations 1,2,3,4
1931 low-income families	73% of the AFDC standard of need.	As above	Populations 1,2,3,4
SSI recipients	Up to SSI limit	Freedom of Choice	Populations 1,2,3,4
Pickle amendment	Up to SSI limit	Freedom of Choice	Populations 1,2,3,4
Early widows/widowers	Up to SSI limit	Freedom of Choice	Populations 1,2,3,4
Disabled Adult Children (DACs)	Up to SSI limit	Freedom of Choice	Populations 1,2,3,4
1619(b)	SSI for unearned income and earned income limit is the 1619(b) threshold amount for Disabled SSI members, as updated annually by the SSA.	Freedom of Choice	Populations 1,2,3,4
Targeted Low-Income Child	Up to and including 185% FPL	As Above	Population 9
Infants under age 1 through CHIP Medicaid expansion	Above 133% - 185% FPL and for whom the	As Above	Population 9
Children 1-5 through CHIP Medicaid expansion	Above 133% - 185% FPL and for whom the	As Above	Population 9
Children 6-18 through CHIP Medicaid expansion	Above 133% - 185% FPL and for whom the	As Above	Populations 9
Non-IV-E foster care children under age 21 in State or Tribal	AFDC limits as of 7/16/1996	As above	Populations 1,2,3,4
Aged, Blind and Disabled	From SSI up to and including 100% FPL	Freedom of Choice	Populations 1,2,3,4
Eligible but not receiving cash assistance	Up to SSI limit	Freedom of Choice	Populations 1,2,3,4

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Individuals receiving only optional State supplements	100% SSI FBR + $41 (SSP)	Freedom of Choice	Populations 1,2,3,4
Breast and Cervical Cancer Prevention and Treatment	Up to and including 185% FPL	Freedom of Choice, Counting Income and Comparability of Eligibility	Populations 1,2,3,4
Optional State Plan Groups	**FPL and/or Other Qualifying Criteria**	**Applicable Waivers and CNOMs (Waiver List summary)**	**Demonstration Population (STC# 57)**
TEFRA Children (under 19 years of age) without	Must be disabled according to	Freedom of Choice, Counting Income and Comparability of Eligibility	Population 7

Demonstration Expansion Groups	Authority	FPL and/or Other Qualifying Criteria
Non-Disabled Low-Income Workers and Spouse (ages 19-64) (Employer Sponsored Plan)	Oklahoma Senate Bill 1546	Up to and including 200 percent FPL, who work for a qualified employer with 200 or fewer employees. Spouses who do not work are also qualified to enroll on their working spouse's coverage.
Full-Time College Students (ages 19-22) (Employer Sponsored Plan)	Oklahoma House Bill 2842	Full-time college students with FPL not to exceed 200 percent (limited to 3,000 participants), who have no creditable health insurance coverage, work for a qualifying employer.
Foster Parents (ages 19-64) (Employer Sponsored Plan)	Oklahoma House Bill 2713	Up to and including 200 percent FPL, who work full-time or part-time for a qualified employer. Spouses who do not work are also qualified to enroll on their working spouse's coverage. No limit on employer size.
Qualified Employees of Not-for-Profit Businesses (ages 19-64) (Employer Sponsored Plan)	Oklahoma Senate Bill 1404	Up to and including 200 percent FPL, who work for a qualified employer with access to an ESI with 500 or fewer employees. Spouses who do not work are also qualified to enroll on their working spouse's coverage.
Non-Disabled Low-Income Workers and Spouse (ages 19-64) (Individual Plan)	Oklahoma Senate Bill 1546	Individuals up to and including 100 percent FPL, who are self-employed, or unemployed. Spouses who do not work are also qualified to enroll on their spouse's coverage.
Working Disabled Adults (ages 19-64) (Individual Plan)	Oklahoma Senate Bill 1546	Individuals up to and including 100 percent FPL, who are not qualified for Medicaid due to employment earnings, and who otherwise, except for earned income, would be qualified to receive Supplemental Security Income (SSI)

Demonstration Expansion Groups	Authority	FPL and/or Other Qualifying Criteria
		benefits.
Full-Time College Students (ages 19-22) (Individual Plan)	Oklahoma House Bill 2842	Full-time college students with FPL not to exceed 100 percent FPL (limited to 3,000 participants), who do not have access to employer sponsored insurance and do not have creditable insurance coverage.
Foster Parents (ages 19-64) (Individual Plan)	Oklahoma House Bill 2713	Individuals up to and including 200 percent FPL, who work full-time or part-time. Spouses who do not work are also qualified to enroll on their working spouse's coverage.
Qualified Employees of Not-for-Profit Businesses (ages 19-64) (Individual Plan)	Oklahoma Senate Bill 1404	Individuals up to and including 200 percent FPL, who work for a not-for-profit with 500 or fewer employees. Spouses who do not work are also qualified

Appendix B: A Historical Timeline of the SoonerCare Choice Program

- July 1, 1993 State leadership passes Title 63 of the Oklahoma Statute directing the Oklahoma Health Care Authority as the single-state Medicaid agency, and to convert the Medicaid program to managed care.

- January 1995 The Health Care Financing Administration approved operating SoonerCare under a Section 1915(b) managed care waiver.

- January 1, 1996 The SoonerCare program is subsumed under a Section 1115(a) demonstration waiver.

- July 1996 The State implements SoonerCare Choice, a partially capitated model for specific rural areas of the State utilizing primary care case management, and SoonerCare Plus, a capitated model in urban areas utilizing fee-for-service.

- 1997 The SoonerCare Choice program is taken statewide in rural areas.

- December 31, 2002 The State terminates the SoonerCare Plus[12] program and transitions managed care enrollees to the SoonerCare Choice primary care case management model statewide.

- January 1, 2004 CMS approved extending the program from January 1, 2004 through December 31, 2006.

- January 2005 CMS approved the Breast and Cervical Cancer population for SoonerCare Choice.

- September 30, 2005 CMS approved adding coverage for TEFRA children.

- December 21, 2006 CMS approved extending the program from January 1, 2007 through December 31, 2009.

[12] The SoonerCare Plus program contracted with health maintenance organizations for individuals in urban communities.

- January 3, 2009 CMS approved changing the service delivery model from a Prepaid Ambulatory Health Plan (PAHP) to an exclusive Primary Care Case Management (PCCM) model. The patient-centered medical home was implemented.

  - CMS approved expanding the description of qualified PCPs to permit County Health Departments to serve as medical homes for members who choose those providers.

  - CMS approved the option for the voluntary enrollment of children in State or Tribal custody in the Demonstration.

  - CMS approved the SoonerExcel incentive payment program for PCPs to build upon the EPSDT and Fourth DTaP Bonus program.

  - CMS approved adding $1 copay for non-pregnant adults in SoonerCare.

- December 30, 2009 CMS approved extending the program from January 1, 2010 to December 31, 2012.

  - CMS approved the Health Access Network (HAN) pilot program.

- December 31, 2012 CMS approved extending the program from January 1, 2013 to December 31, 2015.

  - CMS approved removal of the waiver authority that allowed the State to exclude parental income in determining eligibility for children with disabilities who are qualified for the TEFRA category because the State has this authority under the State Plan.

  - CMS approved the Health Management Program, as reflected in Section VII to rename nurse care managers as health coaches and to increase face-to-face care management by embedding health coaches within physician practices with the highest concentration of members with chronic illnesses.

- July 23, 2013 CMS approved the early adoption of the Systems Simplification Implementation.

- September 6, 2013 CMS approved adding the mandatory Title XXI Targeted Low-Income Child eligibility group for children ages 0-18.

  - CMS approved adding to the SoonerCare Eligibility Exclusions list individuals in the Former Foster Care group and pregnant women with incomes between 134 percent and 185 percent FPL.

  - CMS approved referencing the calculation of Modified Adjusted Gross Income (MAGI) for determination of SoonerCare eligibility.

- August 13, 2014 CMS approved removal of individuals with other creditable health insurance coverage from the SoonerCare Choice demonstration. Other technical changes were made to clarify language in the STCs.

- July 9, 2015 CMS approved extending the program from January 1, 2016 to December 31, 2016

A Historical Timeline of the Insure Oklahoma Program

- August 2001 President Bush approved the Health Insurance Flexibility and Accountability waiver policy.

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- April 2004 State legislators pass Senate Bill 1546 authorizing OHCA to develop an assistance program for employees of small businesses (25 or fewer) and individuals to purchase state-sponsored health plans under the state Medicaid program.

- September 30, 2005 CMS approved OHCA's Health Insurance Flexibility and Accountability waiver amendment providing insurance coverage to adults employed by small employers and working disabled adults. Originally named the Oklahoma Employers/Employees Partnership for Insurance Coverage (O-EPIC), the program was included in the 1115(a) SoonerCare Choice Research and Demonstration waiver.

- December 21, 2006 CMS approved increasing the Insure Oklahoma ESI employer size to 50 or fewer employees.

- February 21, 2007 Oklahoma Senate passes Senate bill 424, the All Kids Act.

- March 1, 2007 CMS approved the Insure Oklahoma IP program, which was created to serve those individuals who did not have access to ESI coverage.

- January 3, 2009 CMS approved increasing the Insure Oklahoma ESI employer size to 250 or fewer employees.

    - CMS approved the Insure Oklahoma eligibility group of full-time college students ages 19 to 22 up to 200 percent of the FPL, with a cap of 3,000 members.

    - CMS approved amending cost sharing requirements for the Insure Oklahoma program.

- June 22, 2009 CMS approved the Title XXI stand-alone CHIP State Plan amendment for children in the Insure Oklahoma program with incomes from 186 percent to 300 percent FPL.

- December 30, 2009 CMS approved to expand eligibility under the Insure Oklahoma program for non-disabled working adults and their spouses, disabled wording adults and full-time college students, from 200 percent FPL up to and including 250 percent FPL.

    - CMS approved the Insure Oklahoma eligibility group of foster parents up to 250 percent of the FPL.

    - CMS approved the Insure Oklahoma eligibility group of employees of not-for-profit businesses having fewer than 500 employees, up to and including 250 percent of the FPL.

- August 1, 2011 CMS approved elimination of the $10 copay for the initial prenatal visit under the Insure Oklahoma Individual Plan program.

- December 31, 2012 CMS reduced the financial eligibility under the Insure Oklahoma program for all populations from up to and including 250 percent FPL to up to and including 200 percent FPL. While OHCA continues to have authority up to 250 percent FPL, this programmatic change indicates the current FPL utilization.

    - CMS approved limiting the adult outpatient behavioral health benefit in the Insure Oklahoma Individual Plan program by limiting the number of visits to 48 per year consistent with the limitation for behavioral health visits for children. This benefit is limited to individual licensed behavioral health professionals (LBHPs).

- September 6, 2013 CMS approved eligibility under the Insure Oklahoma program for populations qualified for the Individual Plan from up to and including 200 percent FPL to be reduced to up to

and including 100 percent FPL. New demonstration populations were separately defined for the Individual Plan coverage populations. The new demonstration populations were added to the Expenditure Authorities and the Demonstration Expansion Groups in the eligibility chart. CMS approved extending the ESI and IP programs through December 31, 2014.

- CMS approved deleting the Individual Plan benefits and cost-sharing charts from the Special Terms and Conditions in order to add language to reference the State changing the benefits and cost sharing for the Insure Oklahoma Individual Plan in order to align with federal regulations.

- June 27, 2014 CMS approved extending the Insure Oklahoma program through December 31, 2015.

- July 9, 2015 CMS approved extending the program from January 1, 2016 to December 31, 2016

Appendix C: Insure Oklahoma Monitoring

Average Monthly Premium Assistance Contribution per ESI Member and Cost PMPM for IP Member

Quarter	ESI Monthly Average Premium Contribution	IP Average Cost PMPM
Jan-March 2008	$228.74	$283.97
April-June 2008	$229.21	$273.04
July-Sept 2008	$234.35	$290.24
Oct-Dec 2008	$236.91	$328.70
Jan-March 2009	$240.07	$278.30
April-June 2009	$244.32	$311.81
July-Sept 2009	$246.23	$321.29
Oct-Dec 2009	$249.63	$339.70
Jan-March 2010	$254.34	$313.84
April-June 2010	$257.48	$309.93
July-Sept 2010	$260.57	$325.36
Oct-Dec 2010	$270.44	$313.32
Jan-March 2011	$273.20	$318.01
April-June 2011	$277.39	$336.42
July-Sept 2011	$280.06	$337.36
Oct-Dec 2011	$281.78	$352.93
Jan-March 2012	$285.85	$325.56
April-June 2012	$286.12	$357.86
July-Sept 2012	$285.55	$338.17
Oct-Dec 2012	$288.47	$331.11
Jan-March 2013	$287.29	$346.71
April-June 2013	$289.40	$336.85
July-Sept 2013	$293.11	$364.26
Oct-Dec 2013	$298.93	$408.05
Jan-March 2014	$299.71	$621.16
Apr-June 2014	$292.21	$480.67
July-Sept 2014	$295.84	$443.06
Oct-Dec 2014	$297.94	$450.62
Jan-March 2015	$302.81	$281.06
Apr-June 2015	$307.08	$281.56

Quarter	ESI Monthly Average Premium Contribution	IP Average Cost PMPM
July-Sept 2015	$311.68	$289.20
Oct-Dec 2015	$313.51	$302.81

ESI Average Premium Contribution PMPM YTD: $275.01

IP Average Cost PMPM YTD: $343.53

Total Costs PMPM for ESI and IP Members Including Reimbursements of Out-of-Pocket Expenses over Five Percent of Gross Income

Year	Total Cost PMPM, ESI	Total Cost PMPM, IP
2008	$310.13	$366.61
2009	$321.48	$394.50
2010	$342.15	$401.96
2011	$367.92	$422.54
2012	$376.86	$422.86
2013	$388.02	$440.88
2014	$1,185.70	$1995.51
2015	$1,235.08	$1,793.52

ESI Average PMPM Total Cost for 2014: $296.43
IP Average PMPM Total Cost for 2014: $498.88

*In 2015 the cost was broken down by category of employee, spouse, college student and dependent.
ESI Average PMPM Total Cost for 2015: $308.77
IP Average PMPM Total Cost for 2015: $448.13

Contributions by Employers Pre- and Post- Participation in ESI

Total annual employer premiums pre-implementation: $13,636,335

Total annual amount paid by employers toward subsidized employees' premiums 2015: $44,938,437.09

Total Statewide Employer Contributions Per Year

Year	Total Employer Contribution
2008	$6,371,915.40
2009	$11,303,340.57
2010	$15,092,287.60
2011	$15,749,806.23
2012	$14,900,847.59
2013	$14,051,782.26
2014	$9,748,407.00
2015	$11,435,955.06

ESI Health Plan Monitoring

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Insure Oklahoma program staff monitor ESI qualified health plans as they are submitted for each year and ensure that the benefits covered and cost-sharing requirements meet OHCA rules and standards. Due to federal mandates, staff has noted that newer health plans have more expenses that accumulate toward the out-of-pocket maximums. Some of the older plans' costs, such as copays, do not apply to out-of-pocket, while in newer plans they do.

Appendix D: Recent Quality Assurance Monitoring for the SoonerCare Choice Program

Year	Survey	Time Period of Data Collected	EQRO
2015	Adult CAHPS® Member Survey 5.0H	July 2014to June 2015	Telligen
2015	Child CAHPS® Member Survey 5.0H	July 2014 to June 2015	Telligen
2014	Adult CAHPS® Member Survey 5.0H	July 2013 to June 2014	Telligen
2014	Child CAHPS® Member Survey 5.0H	July 2013 to June 2014	Telligen
2014	Child ECHO® Behavioral Health Member Survey	July 2013 to June 2014	Telligen

Appendix E: CAHPS® Medicaid Adult and Child Member Satisfaction Survey Results

CAHPS® Adult Survey Reporting Measures	2014 Summary Rate	2013 Summary Rate	2012 Summary Rate	2010 Summary Rate	2008 Summary Rate
Getting Needed Care	82.12%	79.98%	80.58%	77.82%	72.76%
Getting Care Quickly	82.33%	79.37%	82.47%	81.76%	77.12%
How Well Doctors Communicate	89.92%	87.12%	84.93%	84.22%	80.39%
Customer Service	82.20%	90.34%	80.56%	78.21%	78.09%
Shared Decision Making[13]	49.95%	47.81%	57.95%	52.50%	52.67%
Rating of Health Care	68.38%	64.02%	66.12%	61.62%	60.56%
Rating of Personal Doctor	78.95%	70.73%	75.80%	71.77%	65.06%
Rating of Specialist	82.54%	74.52%	79.08%	74.90%	68.75%
Rating of Health Plan	73.10%	61.34%	68.41%	64.32%	62.09%

CAHPS® Child Survey Reporting Measures	2014 Summary Rate	2013 Summary Rate	2012 Summary Rate	2010 Summary Rate	2008 Summary Rate
Getting Needed Care	89.04%	88.73%	85.75%	80.04%	76.82%
Getting Care Quickly	92.12%	92.74%	92.70%	87.13%	87.64%
How Well Doctors Communicate	96.57%	93.31%	93.09%	91.55%	88.76%
Customer Service	88.13%	83.84%	75.65%	80.14%	75.28%
Shared Decision Making[13]	59.75%	52.45%	74.82%	68.31%	66.43%
Rating of Health Care	85.06%	82.00%	85.15%	78.13%	74.54%
Rating of Personal Doctor	88.31%	85.20%	84.32%	82.17%	80.27%
Rating of Specialist	88.73%	89.33%	83.49%	84.69%	75.00%
Rating of Health Plan	86.17%	84.05%	83.85%	78.40%	82.32%

[13] The questions in the composite, *Shared Decision Making,* were changed in 2013 to highlight decisions on prescriptions rather than decisions about health care management. These changes impacted trending for this composite and the individual measure.

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