# Oklahoma Health Care Authority

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

Application for Extension of the Demonstration, 01/01/18-12/31/18

Submitted to the Centers for Medicare and Medicaid Services

August 1, 2017

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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 state entity designated by law, to assume the responsibilities for the preparation and development for converting the present delivery of the Oklahoma Medicaid Program to a managed care system.

The 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 January1, 1996. The SoonerCare Choice program began as a partially-capitated, primary care case management (PCCM) 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 as a fully-capitated managed care program 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 led state leadership to enlarge the program to serve the Aged, Blind and Disabled, as well as additional populations. In December 2003, the fully capitated managed care program, SoonerCare Plus was ended, and in January 2004, SoonerCare Choice PCCM was expanded statewide as the single managed care delivery system, for both urban and rural areas.

In addition to the PCCM 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 "Medical Home". The 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. 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 specialist, 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.

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

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 for adults.

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 program, enabled by State Legislation 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] 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 Regulations (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 2016-2017 Demonstration

The OHCA's objectives for the SoonerCare Choice demonstration are representative of the goals of the agency and the state. The OHCA was approved by the Centers for Medicare & Medicaid Services (CMS) on November 30, 2016, for the following objectives for the 2016-2017 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;
- Waiver Objective 3: To integrate Indian Health Services (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

Evaluation of 2016-2017 Objective Measures

In order to ensure that the OHCA is successfully meeting the stated objectives, the agency evaluates the SoonerCare Choice program through evaluation measures that assess each of the waiver objectives. The OHCA's progress in meeting the 2016-2017 objectives are outlined below.

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

*Waiver Objective 1: Access to Care (Hypos 1, 2, 4 & 5)*
Through the Healthcare Effectiveness Data and Information Set (HEDIS®) and the Consumer Assessment of Health Plan Surveys (CAHPS®), the 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 0-15months that had at least one or more checkups each year has maintained consistently above 90 percent since HEDIS® year 2011.
- More than 50 percent of children ages 3-6 years old had at least one or more checkups each year.
- Adolescents' ages 12-19 years old have maintained their percentage of health checkup rates. Although Oklahoma remains below the national average, there was an increase of 0.3 percent in health checkups for this population for HEDIS® year 2015 to HEDIS® 2016.
- The percentage of adults ages 20-44 years old who had at least one or more PCP visits per year has historically maintained at or above 80 percent since HEDIS® 2009, but, saw a slight decrease of 2.1 percent in HEDIS® year 2016.
- Adults ages 45- 64 years old who had at least one or more PCP visits a year saw a 0.1 percent increase and continues to maintain at a little more than 90 percent in HEDIS® year 2016.
- Some 82 percent of adults CAHPS® survey respondents indicated that they are "Usually" or "Always" satisfied with the time it takes to get an appointment with their PCP, while 92 percent of child CAHPS® survey respondents indicated their satisfaction with appointment times.

*Waiver Objective 2: Medical Home (Hypos 3 & 4)*
The 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 continued to increase. The OHCA began tracking Insure Oklahoma PCP providers which totaled 2,196 by December 2016 which has increased 45 percent since the January 2013 baseline total of 1,514.
- SoonerCare Choice PCP providers increased to 2,689 contracted providers as of December 2016. This is a capacity increase of 30 percent from the baseline year of December 2013. The average member per PCP continues to fluctuate.

*Waiver Objective 3: Integration of IHS Beneficiaries and Providers (Hypo 6)*
The OHCA continues to integrate Indian health members and providers into the SoonerCare Choice program.

- As of December 2016, nearly 85 percent of Native American SoonerCare members had an I/T/U PCP with SoonerCare Choice, while 15 percent of Native American SoonerCare members have an I/T/U PCP only.

Wavier Objective 4: Providing Access to Affordable Health Insurance (Hypos 3 & 5)
The OHCA believes that the number of Insure Oklahoma PCPs will continue to be maintained throughout the 2016 extension period. There was a total 2,196.

- The 2016 CAHPS ® survey indicate the majority of survey respondents for both the Adult and Child surveys had satisfactory responses for scheduling and appointment as soon as needed.

*Waiver Objective 5: Care Management (Hypos 7, 8 & 9)*
The 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.

- The OHCA has increased the number of individuals engaged in nurse care management in an active HMP practice that have undergone practice facilitation by seven percent as of December 2016.
- In SFY 2015, the comparison group which is the General SoonerCare population had an 84.1 percent compliance rate and the Health Coach Participant group had a 96.1 percent compliance rate which indicates members visited their PCP more times within 12 months.
- Nearly 75 percent of the participant population also has both a physical and behavioral health condition. The HMP staff was able to identify members to participate in the program. The health coaching participant compliance rate improved in 10 of 22 measures (45.5 percent increase) from SFY2014 to SFY2015, although typically by small amounts.
- As of June 2016, some 117,750 SoonerCare Choice members with complex health care needs are receiving care management through one of the Demonstration's three pilot HANs.
- In SFY 2016, the Per Member Per Month (PMPM) average for HAN members was $285.30 while the PMPM average for non-HAN members was $313.33 PMPM. Expenditures continue to be lower for SoonerCare Choice members enrolled with a HAN PCP, than for SoonerCare Choice members who are not enrolled with a HAN PCP.

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

<u>Demonstration Hypotheses</u>
The state will test the demonstration hypotheses listed in Section XIV, Evaluation of the Demonstration

<u>Proposed Objectives for the 2018 Extension</u>
The State proposes to continue the main objectives for the 2018 extension.

- Waiver Objective 1: To improve access to preventive and primary care services;

- Waiver Objective 2: To provide each member with a medical home;
- Waiver Objective 3: To integrate Indian Health Services (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

## II. REQUESTED CHANGES FOR THE 2018 DEMONSTRATION

The SoonerCare Choice and Insure Oklahoma § 1115(a) Research and Demonstration Waiver is currently approved through December 31, 2017. Oklahoma is aware that the SoonerCare/Insure Oklahoma Demonstration Waiver will need to be amended in order to include the provision of changes to the program (s) noted within the waiver extension. Oklahoma requests an extension of the program for the period of January 1, 2018 through December 31, 2018. At this time the state is requesting extension of this wavier with the following amended changes:

The State requests amendment to the expenditure authority and special terms and conditions to the waiver for the extension period to add the following program.

**Work Force Development Supplemental Payments to State Teaching Universities**
The OHCA makes supplemental payments to state teaching universities to grow and improve the healthcare workforce in the state of Oklahoma. These payments offer longitudinal options for training, development and placement of critical healthcare workers that offer flexible components that can be easily adapted to address specific healthcare needs that achieve certain goals. State universities can receive payments for programs that reach defined metrics such as percentage of graduating medical students entering residency programs in Oklahoma, number of medical students in qualified training programs, percentage of registered nurse students with clinical experience to Medicaid patients in a Medicaid contracted hospital/facility and percentage of licensed physical therapist in Oklahoma five (5) years post- graduation. This list of metrics is not exhaustive but serves as an example of required metrics for payments. The federal estimated impact is $115,000,000.

**History:**
Oklahoma has poor rankings in many health indicators. According to the Commonwealth Fund (December 2015), Oklahoma ranked in the bottom quartile for Access & Affordability ($50^{th}$), Prevention & Treatment ($48^{th}$), Avoidable Hospital Use & Cost ($46^{th}$), Healthy Living ($46^{th}$) and Equity ($49^{th}$). These statistics are alarming and indicative of the need for a plan of action to improve the overall health within the state which has a 20% Medicaid health insurance coverage of non-elderly 0-64 population (source Kaiser Foundation 2015).

In late 2016, Governor Mary Fallin, appointed a committee to address both workforce development and health improvement through a request to the National Governors Association for a program called "Connecting Medicaid and Health Workforce: How

States Can Use Medicaid Funds to Address Workforce Needs in Rural and Other Underserved Areas." The program was selected for technical assistance support through the National Governors Association Center for Best Practices.

The committee identified the following recommendations for addressing two critically important issues of workforce development and health improvement.

- Improve funding to Training Institutions;
- Improve data collection and analysis related to workforce demand and critical shortages;
- Develop a collaborative program with communities to recruit and retain physicians and other health professionals across the state; and
- Engage in research to identify the critical success factors required to stabilize health care entities, sustain physicians and health care workers in communities, and enable care systems to effectively address the health needs of our citizens.

The committee concluded that the state is currently experiencing a serious physician workforce shortage and it is likely only to get worse without some type of intervention. The fact that Oklahoma is not alone in a physician shortage, as it is a national problem, affects the ability of Oklahoma to retain physicians who are targeted by the recruitment efforts of other states across the country. Stabilizing and improving the physician pipeline is absolutely imperative for both patients' wellbeing and insurers (Medicare and Medicaid) needs for access.

In addition, Oklahoma has high percentages of unfilled health professions as indicated in an excerpt of the Oklahoma's Critical Occupation for Ecosystems table below.

| **2017 Oklahoma[3] Health Professions** | | | |
|---|---|---|---|
| **Description** | **2016 Jobs** | **Openings** | **Percentage of Unfilled Positions** |
| Surgeons | 626 | 265 | 42% |
| Physicians (D.O. M.D.) & Surgeons, All Other | 3,387 | 1,301 | 38% |
| Physical Therapists | 1,795 | 1,144 | 64% |
| Registered Nurses | 27,577 | 10,577 | 38% |
| Nurse Practitioners | 1,104 | 625 | 57% |

**Solution:**

The OHCA makes payments, under Section 1115(a) authority, to teaching universities to recruit, train and retain medical professionals to address the healthcare workforce shortage in Oklahoma. Specifically, Oklahoma has two primary physician training institutions, the University of Oklahoma and Oklahoma State University, which provide the vast majority of training to medical students, residents and fellows in both primary care and sub-specialty

[3] Source: Oklahoma Works, 2016.

medical care. These two institutions, as well as other academic institutions, are also working to address the workforce needs of the state with training of health profession workers such as registered nurses, advanced practice registered nurses, and physical therapists.

**Eligibility Participation:**

To be eligible to participate in the program schools must: (1) be a four year public university, (2) request funding for students enrolled in academic programs that result in licensure eligibility for the following healthcare workers: physician (D.O. & M.D.), registered nurse, advanced practice registered nurse or physical therapist, (3) provide an intergovernmental transfer (IGT) for the non-federal share, and (4) meet or exceed defined metrics for payment. Eligible programs must provide face to face onsite classes resulting in 100% online programs being prohibited from participation.

**Payment Metrics:**

**Workforce Development for Physicians**

- Number of medical students in qualified training programs
- Percentage of graduating medical students entering residency programs in Oklahoma
- Percentage of graduates of Oklahoma post graduate training (residency/fellowship) programs who remain in Oklahoma two years
- Percentage of graduates of Oklahoma post graduate training (residency/fellowship) who remain in Oklahoma 5 years with an active Medicaid contract
- Number of critical specialty graduates of an Oklahoma public universities in an accredited residency/fellowship program including, but not limited to, Psychiatrist, Neurologist, Dermatologist, Rheumatologist, Hepatologist

**Workforce Development for Registered Nurses (RN)**

- Total number of full-time enrolled equivalent RN students
- Percentage of RN students with clinical rotation experience in Medicaid contracted facilities
- Percentage of RN graduates from an Oklahoma public university who are licensed RNs in Oklahoma 2 years post-graduation.

**Workforce Development for Advanced Practice Registered Nurse (APRN)**

- Total number of full-time enrolled equivalent APRN students
- Percentage of APRN students with clinical rotation experience in Medicaid contracted facilities
- Percentage of graduates from an Oklahoma public university who are licensed APRNs in Oklahoma 2 years post-graduation.
- Percentage of APRN graduates from an Oklahoma public university who have an active Medicaid contract 2 years post-graduation.

**Workforce Development for Physical Therapist (PT)**

- Total number of full-time enrolled equivalent PT students
- Percentage of PT students with clinical rotation experience in Medicaid contracted facilities
- Percentage of graduates from an Oklahoma public university who are licensed PT in

Oklahoma 2 years post-graduation.

- Percentage of PT graduates from an Oklahoma public university who have an active Medicaid contract 2 years post-graduation.

**Workforce Development for Resident Rural Scholarship**

- Scholarships are paid to enrolled students in an accredited Oklahoma Family Practice/Family Medicine Program and agreement to match with an approved rural community and spend one month during the 3rd year of residency on elective rotation in the selected community and return to the community upon completion of residency training, one month for each month the loan was received.

**Workforce Development for Nursing Student Assistance Loan Program**

- Loans are made to Registered Nurses and Advanced Practice Registered Nurses who are unconditionally enrolled as a student in a four-year public university program, a legal resident of Oklahoma and a United States citizen. Loans are forgiven if the nurse fulfills work obligation of one year for each year of financial assistance at an approved health institution.

**Workforce Development for Physician Loan Program**

- Loans are made to provide financial assistance to the primary care physician in setting up a practice in a selected community in Oklahoma, in exchange for a service obligation to a rural community with a population of 10,000 or less.

**Workforce Development for Loan Repayment Program**

- Educational loan repayment assistance is made to Oklahoma licensed primary care physicians who agree to establish a practice in a community located in Oklahoma to provide medical care and services to Oklahoma citizens in rural and underserved areas with special emphasis to Medicaid members as authorized by the Oklahoma Health Care Authority. Participating physicians must agree to a minimum of two years practice in rural or underserved areas.

**Workforce Development for Resident Retention**

- Assistance is provided for resident salaries to assist with retention and faculty to promote and support the retention and training of primary care physicians for the state of Oklahoma. Payment assistance is made to pay a portion the salaries of individuals in residency programs in Oklahoma. Qualified expenditures will also include a percentage of the total amount of salary and benefits paid by each qualifying health training program for faculty and support staff and other indirect cost of running the residency program at qualifying employers.

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

The State requests the following waiver list and expenditure authorities for the 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 2017 SoonerCare Choice demonstration.

*1. Statewideness/Uniformity Section 902(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 beneficiary access to quality services. No waiver of freedom of choice is 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 2018 demonstration extension.

1. *Demonstration Population 5.*
   Expenditures for health benefits coverage for individuals who are "Non-Disabled Low-Income Workers" ages 19-64 years old, who work for a qualifying employer, and have income up to 200 percent of the federal poverty level (FPL) and their spouses.

2. *Demonstration Population 6.*
   Expenditures for health benefit coverage for individuals who are "Working Disabled Adults ages 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 benefit coverage for no more than 3,000 individuals at any one time who are full-time college students ages 19-22 and have income up to 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 benefit coverage for foster parents who work for a qualified employer and their spouses with household incomes up to 200 percent of the FPL.

5. *Demonstration Population 11.*
   Expenditures for health benefit 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 up to 200 percent of the FPL.

6. *Demonstration Population 12.*
   Expenditures for health benefit coverage for individuals who are "Non-Disabled Low-Income Workers" 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 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 benefit coverage for no more than 3,000 individuals at any one time who are full-time college students ages 19-22 and have income up to 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 Population15.*
   Expenditures for health benefit coverage for individuals who are working foster parents, whose employer elects not to participate in the Premium Assistance Employer Coverage Plan and their spouses, who have household incomes up to 100 percent of the FPL.

10. *Demonstration Population16.*
    Expenditures for health benefit coverage for individuals who are employees and spouses of not-for-profit businesses with 500 or fewer employees with household incomes up to 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 the excess of five percent of annual gross family income.

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

14. *Work Force Development Supplemental Payments to State Teaching Universities.*
    Expenditures for reimbursement to state teaching universities to grow and improve the healthcare workforce in Oklahoma.

**Title XIX Requirements Not Applicable to the Demonstration Expenditure Authorities**

**Not applicable to Demonstration Populations: 5,6,8,10,11,12,13,14, 15, and16.**

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 5,6, 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, 6, 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, 6,8, 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, 6, 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

<u>Compliance with Special Terms and Conditions</u>

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 American 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.*
   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 wavier and expenditure authority documents received from the Centers for Medicare and Medicaid Services (CMS) of which these terms and conditions are a part, including protections for Indians pursuant to Section 5006 of the American Recovery Reinvestment Act of 2009.

3. *Compliance with Changes in Medicaid and CHIP Law, Regulation and Policy (e.g. CHIPRA)*

Within the timeframes specified by law, regulation or policy statement, the State brings the Demonstration into compliance with changes in Federal and State law, regulations or policy that affect the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision change is expressly waived or identified as not applicable to the Demonstration.

4. *Impact on Demonstration of Changes in Federal Law, Regulation and Policy.*
   a) If 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 subparagraph 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 with mandated changes in federal law that requires state legislation. Any mandatory changes 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 outlined in paragraph 16 of STCs.

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 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.

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' 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.*
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 13-0018 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. Refer to Appendix A, *SoonerCare Choice and Insure Oklahoma Eligibility Chart*. The State does not request any changes.

*21. Demonstration Eligibility.*
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*

The State complies with the requirements of the income eligibility documentation. 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 December 2016, there are 114 students enrolled in ESI and 187 students enrolled in IP for a total of 301 college students currently enrolled in the Insure Oklahoma program. A waiting list is currently not in place. The State does not expect to implement a waiting list for the 2018 extension period but understands that a minimum of 60-day notifications to CMS is required prior to implementing a waiting list.

*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 in paragraph 29, of the STCs. Insure Oklahoma Individual Plan benefits can be found in paragraph 31 of the STCs.

*27. SoonerCare Cost Sharing*

The State agrees that under the current SoonerCare program, American Indians with an I/T/U provider, pregnant women, and 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. The 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 copayment amounts at this time, and continues to comply with paragraph 33 of the STCs.

*30. Insure Oklahoma: Premium Assistance Individual Plan.*

The State complies with the Insure Oklahoma Individual Plan definition and eligibility criteria. The State also maintains the Individual Plan benefits, under

paragraph 31 of the STCs. 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 all changes covered and non-covered services and benefits 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 paragraphs 33 and 34 of the STCs. 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 copayment for emergency services, unless the individual is admitted to the hospital. The State understands that copayments 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 copayments continue to be the copayments required by the enrollee's specific health plan, as defined in paragraph 29 of the STCs. The State also maintains the copayment 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 will 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[4] and business practices.

**Medical Resident:** Must be licensed by the State in which s/he practices**.** Must be at least at the Post Graduate 2 level and may serve as a PCP/CM only within his/her continuity clinic setting and 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 as outlined in (a) – (d). The State understands the requirement to notify CMS at least 60 days prior to changing the fees paid to PCPs and to include a revised budget neutrality assessment with such a notification.

*39. Other Medical Services.*

It continues to be the case that 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. The State is not requesting any changes to this arrangement.

*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 as outlined in paragraph 38. The State maintains that Oklahoma's I/T/Us must have a SoonerCare American Indian PCCM contract. All of the OHCA's I/T/U SoonerCare providers have a SoonerCare American Indian PCCM contract.

43. *Contracts.*

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

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, as defined in paragraph 23, 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 maintains the services provided through the HMP as defined in this paragraph, in (a)-(b) of this section. The State is not requesting that any changes be made.

*47. Changes to the HMP Program.*

The State understands that it must submit notification to CMS 60 days prior to any requested change in HMP services, as well as submit a revised budget neutrality assessment. The State is not requesting that any changes be made.

*48. Monitoring Aggregate Costs for Eligible in the Premium Assistance Program.*

The State monitors the aggregate costs for the Insure Oklahoma ESI and IP programs. 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. On an annual basis, the State calculates the total cost per enrollee per month for individuals receiving subsidies under the ESI 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.*

The State monitors the aggregate level of contributions made by participating employers, requires that participating employers report annually their total contributions for employees, prepares an aggregate analysis across all participating employers summarizing the total statewide employer contribution and 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 Section XII of the STCs. 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, as set forth in Section XIII of the STCs. 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 paragraph of the STCs.

*53. Quarterly Operational Reports.*

The State submits quarterly operational reports on the Demonstration to CMS 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 of the STCs

*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 paragraph.

*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 one and two 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 and attachments one and two for compliance with the Budget Neutrality Cap.

*58. Reporting Member Months.*

The State complies with the member months reporting requirements, as outlined in (a)-(d) of this paragraph. Refer to Section V of this document for compliance with

the Budget Neutrality.

*59. Standard Medicaid Funding Process.*

The State reports to CMS its best estimate of 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 attachments one and two 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 attachments one and two 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 are 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 are compliant with Section 1903(w) of the Act and applicable regulations are subject to CMS approval. In addition, the State complies with the requirements set forth in (a)-(b) of this paragraph. The State submits certifications of financial matters quarterly through the CMS-64. Refer to Section V of this document and attachments one and two 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 attachments one and two for compliance with budget neutrality.

*63. Monitoring the Demonstration.*

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

*64. Quarterly Expenditure Reports.*

The State complies with submission of reports quarterly under this demonstration expenditure 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 attachments one and two for compliance with budget neutrality.

*65. Claiming Period.*

The State complies with the claiming period requirements outlined in this section (a) – (b). Refer to Section V of this document and attachments one and two 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 9) through Title XIX funds until further Title XXI funds become available. Refer to Section V of this document and attachments one and two 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 of this document and attachment one and two 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 attachments one and two for compliance with budget neutrality.

*72. Exceeding Budget Neutrality*

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 attachments one and two 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.

The OHCA submitted to CMS the proposed SoonerCare Choice 2015-2016 Evaluation Design on November 9, 2015 and submitted the final document to CMS on (December 15, 2016) which included the extension for the 2017 demonstration year. To review the final Evaluation Design, refer to attachment three.

*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 2016-2017 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 (December 15, 2016) when the OHCA submitted the final document to CMS which included the extension for the 2017 demonstration year.

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*75. Demonstration Hypotheses.*

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

The OHCA submitted the proposed SoonerCare Choice demonstration hypotheses in the 2015-2016 Evaluation Design submitted to CMS on November 9, 20015, and submitted the final document to CMS on (December 15, 2016) which included the extension for the 2017 demonstration year. For the 2015-2016 findings from the Evaluation Design, refer to Section VI of this document.

The OHCA proposes the 2018 demonstration hypotheses to remain the same as those proposed for the 2016-2017 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 paragraph 73. Within the Evaluation Design, the State includes the requirements set forth in (a)-(d) of this section.

The OHCA submitted the draft HAN Evaluation Design with the HAN reporting requirements outlined in (a)-(d) of this section within the 2015-2016 SoonerCare Choice Evaluation Design, which was submitted to CMS on November 9, 2015, and submitted the final document to CMS on (December 15, 2016), Refer to Section VI of this document for the Evaluation Design findings.

For the 2018 demonstration extension, the OHCA would like to retain the changes that were included in the submission of the 2016 - 2017 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 as required under paragraph 73. Within the Evaluation Design, the State includes the requirements set forth in (a)–(h) of this section.

The OHCA submitted the draft HMP Evaluation Design with the HMP hypothesis listed within the 2015-2016 SoonerCare Choice Evaluation Design, which was submitted to CMS on November 9, 2015, and submitted the final document to CMS on (December 15, 2016), Refer to Section VI of this document for the Evaluation Design findings.

The OHCA proposes the HMP hypotheses for the 2018 demonstration extension to remain the same.

*78. Evaluation of Eligibility and Enrollment Systems.*

The 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 Exchange.

*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 2015-2016 Evaluation Design findings.

*80. Final Evaluation Plan and Implementation.*

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.

The OHCA submitted to CMS the proposed 2015-2016 SoonerCare Choice Evaluation Design on November 9, 2015, and again as a final report on (December 15, 2016), after receipt of CMS's comments. The OHCA will report on the progress of two or more hypotheses within each Quarterly report as it relates to progress of each evaluation measure.

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

The OHCA continues to provide program integrity through monitoring of the Demonstration. The OHCA continues to contract with Telligen who works with an outside contractor, Morpace, to conduct the Consumer Assessment of Health Plan Surveys (CAHPS®) for adults and children in 2016. Refer to Appendix D to review a list of recent quality assurance monitoring for the SoonerCare Choice Program.

*CAHPS® Member Surveys*

The OHCA is contracted with an outside vendor Telligen who works with, Morpace to conduct the State Fiscal Year (SFY) 2016 *CAHPS® Adult Medicaid Member Services Satisfaction Surveys, and SFY 2016 CAHPS® Child Medicaid with Child Chronic Condition (CCC) Member Satisfaction Surveys.* The OHCA received these reports in June 2016. The objective of the survey is to capture accurate and complete information about consumer-reported experiences with SoonerCare Choice by:

- Measuring satisfaction levels, health plan 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 outcome conclusion of the child and adult survey is noted in Appendix D please see attachments four and five for full detailed information.

Quality Initiatives

Community Relations

The office of Health Promotion expanded the SoonerQuit Engagement Grant in 2016. There are two branches of the grant with SoonerQuit, Health Promotion and SoonerQuit Provider Engagement. The OHCA partnered with Oklahoma's Tobacco Settlement Endowment Trust (TSET) fund and the Oklahoma State Department of Health (OSDH) to administer the Provider Engagement program.

In 2016, the SoonerQuit Provider Engagement program utilized practice facilitation to educate providers on tobacco cessation best practice methodology in 24 clinics. Sixty-six providers participated in the program in 2016.

The OHCA has more than 589 public, private and nonprofit entities within Oklahoma's 77 counties who are considered OHCA's community partners. Community partners are engaged in outreach, enrollment and retention activities for SoonerCare eligible and enrolled children.

TEFRA

The Governor appointed members to the Blue Ribbon Panel for Developmental Disabilities in response to the significant number of Oklahoma's men, women and children with intellectual disabilities that were on a waiting list for services. Before its finalization, the Blue Ribbon Panel commissioned an Executive Council, which was formed to improve the range and quality of services accessible to Oklahomans with developmental disabilities. There are four objectives that have been created by the Council:

- Provide for the regular, periodic dissemination of information about resources to individuals on the wavier services request list;
- Develop and implement resources training programs that are designed both for state employees to employ at the point of intake and for families and self -advocates to access;
- Improve the ease-of-use and prominence of information on state agency websites concerning resources of a uniform disability information web portal; and
- Analyze how to best prioritize the waiver services request list.

During 2016, the Executive Council initiated and continues to work towards implementation of a web portal to provide a streamlined application, allowing users to access multiple state systems without having to enter information multiple times. It will also be used to coordinate supports and services, and provide prescreening for Medicaid applicants.

Applied Behavior Analysis

According to the Centers for Disease Control, one in 68 children has an autism spectrum diagnosis (ASD), higher than previous years[5]. House Bill 2962 (HB 2962), passed during the 2nd regular session of the 55th Legislature, authored by Representative Jason Nelson and Senator AJ Griffin, directed the Oklahoma Health Care Authority (OHCA) and partnering state agencies Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), Oklahoma State Department of Education (OSDE), and the Oklahoma State Department of Health (OSDH) to study and prepare a report concentrating on the use of applied behavior analysis therapy treatment for children with ASD within the state's Medicaid program. The data referenced throughout the final report includes information from SFY2010 through SFY2016.

The report took into account various states' cost analysis of services to this population. Variance exists with a probability of new members being added for services, which are not

[5] Centers for Disease Control and Prevention (March 27, 2014); Autism Spectrum Disorder

counted in the State of Oklahoma final calculation in addition to other limitations inclusive of provider access and funding. Since ABA therapy is individualized and a clinical cannot uniformly apply the interventions to all persons with an ASD diagnosis, an assumption of 10 percent of the population was applied; however, the percentage of members with ASD that could benefit from ABA therapy is undeterminable. To review the report in its entirety, please visit 2016 - HB 2962 Legislative Report 2016 HB 2962 Legislative Report (located under Studies and Evaluations)

*Medical Home Audits*

The OHCA's Quality Assurance Compliance department conducts an on-location evaluation of medical home requirements for contracted providers. As of CY 2016, the OHCA review team conducted 258 reviews with "quality review "to determine success of "pass compliance" This means those who PASSED every component of the review would be 162 of the 397. Below are the findings of the review:

Total compliance reviews performed = 258

- Tier ONE: 115, of these 18 were FQHC facilities
- Tier TWO: 50, of these 6 were FQHC facilities
- Tier THREE: 60, of these 3 were FQHC facilities

Primary Audit- Non-Compliant = 225

- Tier ONE: 100, of these 17 were FQHC facilities (99 with a score + & 1 invalid = 100)
- Tier TWO: 44, of these 4 were FQHC facilities
- Tier THREE: 56, of these 3 were FQHC facilities with one being invalid and two failed.

Primary Audit-PASSED ALL = 19

- Tier ONE: 10
- Tier TWO: 6
- Tier THREE: 3

Corrective Action Plan Audit – Follow-ups = 14(these are medical record reviews only and validation for those who failed a primary audit and would like to have their PCMH contract reinstate and out of the corrective action plan status)

- Provider with Panel (PWP) status: (scored at Tier ONE requirements) = 5, this allows the provider to continue to provide care coordination for these members and offer referrals, but at this time cannot accept new membership. This happens after receiving a score on medical records audit below 75 percent. This status allows the provider to work at Tier ONE for the next 12 months and receive education from the OHCA provider services unit to help with reinstatement of a higher tier level.
- Tier ONE: 5, of which 1 was an FQHC facility
- Tier TWO: 2 both were FQHC/RHC facilities
- Tier THREE: 1

INVALID Audit: This means that the contact was active, but the records were not valid to determine compliance.

- Tier ONE: Invalid Record
- FQHC Tier THREE: Invalid records
- (41%) which is 107 of the 258 audits, had at least one previous compliance review
- (59%) which is 151 of the 258 audits was first time compliance reviews.

*PCP Compliance with 24-Hour Access Requirements*
The OHCA requires providers give member 24-hour access and ensure members receive appropriate and timely services. The data below is from CY 2016.

- Average number of providers called each quarter: 892
- Average percentage of PCPs providing after-hours access each quarter: 93%
- Percent of Providers Educated for compliance: 7%

HEDIS ® Quality Measures

The OHCA's Quality Assurance department began compiling the data in 2010. The services were contracted out to Pacific Health Policy Group (PHPG) in 2013. PHPG recalculated the 2013 rates and changed the methodology, which meant that some of the rates may not be comparable to previous years' rates. The table below indicates that HEDIS ® year measures using the new methodology.

| HEDIS® Measures 2013-2016[5] | HEDIS® 2013 | HEDIS® 2014 | HEDIS® 2015 | HEDIS® 2016 |
|---|---|---|---|---|
| Annual Dental Visit | | | | |
| Aged 2-3 years | 40..4% | 39.5% | Not Available | Not Available |
| Aged 4-6 years | 67.k7% | 63.4% | Not Available | Not Available |
| Aged 7-10 years | 70.9% | 68.8% | Not Available | Not Available |
| Aged 11-14 years | 68.7% | 66.9% | Not Available | Not Available |
| Aged 15-18 years | 62.0% | 59.9% | Not Available | Not Available |
| Aged 19-21 years | 40.6% | 38.2% | Not Available | Not Available |
| Children and Adolescents' Access to PCP | | | | |
| Aged 12-24 months | 96.3% | 96.2% | 96.1% | 96.1% |
| Aged 25 months – 6 years | 90.2% | 89.0% | 87.6% | 89.6% |
| Aged 7-11 years | 92.2% | 90.9% | 91.8% | 91.8% |
| Aged 12-19 years | 92.8% | 92.7% | 92.9% | 92.9% |
| Adults' Access to Preventive/Ambulatory Health | | | | |
| Aged 20-44 years | 83.4% | 82.4% | 81.0% | 80.3% |
| Aged 45-64 years | 89.8% | 89.9% | 90.1% | 90.0% |
| Aged 65+ years | 83.5% | 78.2% | 77.4% | 77.4% |
| Well-Child Visits | | | | |

| | | | | |
|---|---|---|---|---|
| Aged <15 months 1+ visits | 97.3% | 96.3% | 94.3% | 96.4% |
| Aged <15 months 6+ visits | 59.6% | 55.8% | 68.5% | 68.1% |
| Aged 3-6 years 1+ visits | 57.6% | 58.5% | 57.1% | 56.7% |

| HEDIS® Measures 2013-2016 | HEDIS® | HEDIS® 2014 | HEDIS® 2015 | HEDIS® 2016 |
|---|---|---|---|---|
| Appropriate Medications for the Treatment of Asthma (Change in | | | | |
| Aged 5-11 years | 91.5% | 89.7% | 90.2% | 90.3% |
| Aged 12-18 years | 86.4% | 82.6% | 82.5% | 82.3% |
| Aged 19-50 years | 63.2% | 61.7% | 61.9% | 62.0% |
| Aged 51-64 years | 67.3% | 62.5% | 61.8% | 62.0% |
| Comprehensive Diabetes Care (Aged | | | | |
| Hemoglobin A1C Testing | 71.6% | 71.9% | 72.1% | 72.2% |
| Eye Exam (Retinal) | 32.0% | 26.3% | 27.3% | 27.6% |
| LDL-C Screen | 63.1% | 63.4% | 63.9% | 64.2% |
| Medical Attention for Nephropathy | 58.7% | 53.4% | 52.4% | 52.5% |
| Screening Rates | | | | |
| Lead Screening in Children (by 2 years of | 48.2% | 47.6% | Not Available | Not Available |
| Appropriate Treatment for Children with URI (aged 3 months to 18 years) | 73.1% | 72.5% | Not Available | Not Available |
| Appropriate Testing for Children with Pharyngitis (aged 2 to 18 years) | 53.2% | 51.6% | Not Available | Not Available |
| Breast Cancer Screening (aged 42-74 years) | 36.5% | Not Available | Not Available | Not Available |
| Chlamydia Screening in Women (CHL) (aged 16-24 years) | 49.3% | 48.0% | 56.8% | 57.2% |
| Cervical Cancer Screening (aged 21-64 years) | 46.0% | 47.5% | 37.7% | 41.2% |
| Cholesterol Management for Patients with Cardiovascular Conditions (aged 18-75) | 49.9% | 45.2% | Not Available | Not Available |

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 PERM initiative, states must audit the accuracy of their eligibility processes every three years. In 2015, the most recent audit, Oklahoma's error rate was 3.82% versus the national average of 5.70%. To continue ensuring proper payments, the 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 2016, the State has $5.6 billion savings over the life of the Demonstration. Actuarial analysis of the Demonstration projects indicates that the State will maintain compliance with the budget neutrality cap through 2018. It is projected that the state will have 3.75 billion in savings by the end of 2018. To review the Budget Neutrality in its entirety, refer to Attachments one and two.

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 government 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 (NFS) of the medical home care coordination payments and HAN payments are funded by 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.*

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, manpower Training Commission for the Graduate Education (GME) payments and the 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 | $29,227,899 | $11,632,704 |
| HAN Payments[6] | $3,000,000 | $1,194,000 |
| GME Payments | $106,969,897 | $42,574,019 |
| Insure Oklahoma | $85,617,321 | $34,075,694 |

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*

[6] Numbers are estimates based on the SFY 2017 budget and SFY Blended 2017 FMAP (60.20%).

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: $42,574,019*

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.*

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*

## 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 2015-2016 evaluation findings is also included, followed by the details of the report. Finally, the Hypotheses proposed for 2018 are requested to remain the same as those for the 2016-2017 requested demonstration term year.

Program Evaluation

The OHCA uses multiple contractors to evaluate the SoonerCare program. The 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.

*Access Monitoring Review Plan 2016*

On November 2, 2015, CMS issued the final rule with comment period: Methods for Assuring Access to Covered Medical Services (CMS-2328-FC). The final rule requires states to develop an Access Monitoring Review Plan (AMRP) which includes an analysis of access to covered services under their Fee-For-Service (FFS) programs, consistent with section 1902(a)(30)(A) of the Social Security Act. Certain categories of services will be reviewed every three years and additional services will be reviewed and monitored as states reduce (or restructure) provider payment rates. Through this report, the State addresses access to care by measuring the following enrollee needs, the ability of care and providers; and the utilization of services.

Access:

- The OHCA continues to have a service capacity for the 1 million Oklahomans that it serves. This is about 26 percent of the state's population.

- Provider contracts, provider networks and beneficiary access to primary care services remain stable in spite of the significant rate decreases of July 2014 and January 2016.

Quality:

- The outcomes of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey indicate satisfaction with services from children and adults of SoonerCare.

- Services under state plan are available to beneficiaries to the extent that those are available to the general population.
- In accordance with 42 CFR 447.203, the Oklahoma Health Care Authority developed an access review monitoring plan for the defined service categories provided under a Fee-for-Service arrangement.

Cost Effectiveness:

- Per the OHCA Annual Report, total expenditures for the SoonerCare program in State Fiscal Year 2015 were approximately $5.1 billion.

To review the Access Monitoring Review Plan 2016 report in its entirety, refer to the OHCA public website at 2016 Access Monitoring Review Plan and view *Access Monitoring Review Plan 2016 under Studies and Evaluations.*

*Health Management Program Evaluation*

The 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 2015; During SFY 2014, the OHCA and Telligen executed a contract amendment to modify

and expand operations starting in SFY 2015. The amendment included three components: intervention quality enhancement; chronic pain and opioid drug utilization initiative and staff increase. OHCA received the report in July 2016

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 initial survey respondents (99 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 (91 percent); answered questions about their health (88 percent); and helped with management of medications (77 percent). Over 30 percent stated that their nurse helped to identify changes in health that might be an early sign of a problem and 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. Except for one activity4, the overwhelming majority reported being very satisfied with the help they received, with the portion ranging from 91 to 94 percent, depending on the item. This attitude carried over to the members' overall satisfaction with their health coaches; 87 percent reported being very satisfied. Results for the follow-up survey were closely aligned to the initial survey.

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-six percent of initial survey respondents confirmed that their health coach asked them what change in their life would make the biggest difference in their health. Eighty-four percent of this subset (or 63 percent of total) stated that they actually selected an area to make a change.

PHPG examined the program's return on investment (ROI) through SFY 2015, by comparing health coaching and practice facilitation administrative expenditures to medical savings. Both program components have achieved a positive ROI, with the program as a whole generating net savings of $41.2 million and a return on investment of 249 percent. Put another way, the second generation SoonerCare HMP generated nearly $2.50 in net medical savings for every dollar in administrative expenditures.

To review the HMP Evaluation report in its entirety, go to the OHCA public website at 2016 - SoonerCare Health Management Program Evaluation SFY 2015 and view *SoonerCare Health Management State Fiscal Year 2015 Evaluation under Studies and Evaluations*

Evaluation Findings from the 2016 - 2017 Hypotheses

| **Hypotheses** | **Do the outcomes of the 2016 Demonstration confirm the hypotheses?** |
|---|---|
| 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. | Yes |
| 1B. Child Health checkup rates for children 3 through 6 years old will increase by one percentage point over the life of the extension period. | No. The OHCA will continue to track this data associated with this hypothesis over the extension period. |
| 1C. Adolescent child health checkup rates will maintain over the life of the extension period. | Yes |
| 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 one percentage point as a measure of access to primary care in accordance with HEDIS guidelines between 2015-2016. | No. 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 2015-2016. | Yes |
| 3b. The number of Insure Oklahoma practitioners enrolled as PCPs will maintain at or above the baseline data between 2015 - 2016. | Yes |
| 4. There will be adequate PCP capacity to meet the health care needs of the SoonerCare members between 2015 - 2016. Also, as perceived by the member, the time it takes to schedule an appointment should improve between 2015 - 2016. The available capacity will equal or exceed the baseline capacity data over the duration of the waiver extension period. | Yes |

| Hypotheses | Do the outcomes of the 2016 Demonstration confirm the hypotheses? |
|---|---|
| 5. There will be adequate PCP capacity to meet the health care needs of the SoonerCare members with Children's Health Insurance Program (CHIP) eligibility between 2015 - 2016. Also, as perceived by the member, the time it takes to schedule an appointment should improve between 2015 - 2016. As perceived by the member, the time it takes for the member to schedule an appointment should | Yes |
| 6. 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 improve during the 2015 - 2016 waiver 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. |
| 7A. Key quality performance measures, asthma and Emergency Room (ER) utilization, tracked for PCPs participating in the HANs will improve between 2015-2016. Decrease asthma related ER visits for HAN members with an Asthma diagnosis identified in the medical record. | Yes |
| 7B. Key quality performance measures, asthma and Emergency Room (ER) utilization, tracked for PCPs participating in the HANs will improve between 2015-2016. Decrease 90-day readmissions for related asthma conditions for HAN members with an Asthma diagnosis identified in their medical record. | Yes |
| 7C. Key quality performance measures, asthma and Emergency Room (ER) utilization, tracked for PCPs participating in the HANs will improve between 2015-2016. Decrease overall ER use for HAN members. | Yes |

| | |
|---|---|
| 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 2015-2016. | Yes |
| 9a. 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. | Yes |
| 9b. The incorporation of Health Coaches into primary care practices will result in increased PCP contact with nurse care managed members for preventive/ambulatory care. | Yes |
| 9c. 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. | Yes |
| 9d. Health Coaches will improve quality measures for members who are engaged. | Yes |
| 9e. Nurse care managed members will utilize the emergency room at a lower rate than forecasted without nurse care management intervention. | Yes |
| 9f. Nurse care managed members will have fewer hospital admissions than forecasted without nurse care management intervention. | Yes |
| 9g. Nurse care managed members will report high levels of satisfaction with their care. | Yes |
| 9h. Total and PMPM expenditures for members enrolled in HMP will be lower than would have occurred absent their participation in nurse care management. | Yes |

The OHCA reports the most current data and analysis for the SoonerCare Choice program's

hypotheses. The data for hypotheses one and two, as well as 9b- 9h, are taken from the PHPG (2016) Reporting Year 2015 Measurement Year 2014 Quality of Care in the SoonerCare Program Report.

**Hypothesis 1-** Child Health Checkup Rates: This hypothesis directly relates to SoonerCare Choice waiver objective #1 and #2 of CMS's Three Part Aim.

The rate age-appropriate well-child and adolescent visits will improve between 2015-2016.

A. Child health check-up 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 one percentage points over the life of the extension period.
C. Adolescent child health checkup rates will maintain over the life of the extension period.

| Well-Child Adolescent Visits | Baseline HEDIS® 2014 CY2013 | Baseline HEDIS® 2015 CY2014 | Baseline HEDIS® 2016 CY2015 |
|---|---|---|---|
| 0-15 months.1+visit | 96.3% | 94.3% | 96.4% |
| 3-6 years | 58.5% | 57.1% | 56.7% |
| 12-21 years | 21.8% | 22.1% | 22.4% |

*Hypothesis 1A Results:*

This hypothesis specifies that checkup rates for children 0 to 15 months will be maintained at or above 95 percent over the course of the extension period.

Children 0 to 15 months old saw an increase in child checkup rates for HEDIS® year 2016. In HEDIS® year 2015 the child checkup rate fell slightly below 95 percent to 94.3 percent. The data shows that the child health checkup rates fluctuate throughout the years, but has maintained above 90 percent consistently. In HEDIS® year 2016 OHCA met the measure when the percentage of child visits increased to 96.4 percent. The OHCA will continue to monitor this group during the 2017 extension period.

*Hypothesis 1B Results:*

In accordance with the hypothesis, the checkup rates for children ages 3 to 6 years will increase by one percentage point over the extension period 2015-2016.

Children 3 to 6 years old saw a 1.8 percent decrease in child health checkup rates from HEDIS® year 2014 to HEDIS® year 2016. For HEDIS® year 2015 to HEDIS® year 2016 there was a .4 percent decrease in health checkups for this population. The OHCA has not yet met the measure; the OHCA will continue to track the measure over the extension period to monitor for significant changes in rates for this age group during the 2017 extension period.

*Hypothesis 1C Results:*

The evaluation measure hypothesizes that the checkup rate for adolescent's ages 12 to 21 years will maintain over the life of the extension period.

Adolescent's ages 12 to 21 years of age saw a slight increase in health checkup rates for HEDIS® year 2016. There was a .3 percent increase in health checkup rates from HEDIS® year 2014 to HEDIS® year 2015. For HEDIS® year 2015 to HEDIS® 2016 there was an increase of .3 percent in health checkups for this population. The adolescents ages 12 to 21 have maintained their percentage for health checkup rates. The OHCA will continue to monitor this group during the 2017 extension period.

PCP Visits: This hypothesis directly relates to SoonerCare Choice waiver objective #1 and #2 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 one percentage point as a measure of access to primary care in accordance with HEDIS® guidelines between 2015-2016.

| Access to PCP/Ambulatory HealthCare: HEDIS® Measures | Baseline HEDIS® 2014 CY2013 | HEDIS® 2015 CY2014 | HEDIS® 2016 CY2015 |
|---|---|---|---|
| 20-44 years | 82.4% | 81.0% | 80.3% |
| 45-64 years | 89.9% | 90.1% | 90.0% |

*Hypothesis 2 Results:*

This hypothesis suggests that adults' rate of access to primary care providers will improve by one percentage point as a measure of access to primary care in accordance with HEDIS® guidelines between 2015-2016.

SoonerCare adults ages 20 to 44 saw a 2.1 percent decrease with access to PCP or ambulatory health care in HEDIS® year 2016 compared to HEDIS® year 2014. SoonerCare adults ages 45 to 64 saw a .1 percent increase with access to PCP or ambulatory health care in HEDIS® year 2016 compared to HEDIS® year 2014. The OHCA has not yet met the measure; the OHCA will continue to track the adult access rates over the extension period to monitor for significant changes in rates for these age groups.

Hypothesis 3 - PCP Enrollments: This hypothesis directly relates to SoonerCare Choice waiver objective #2 and #1 of CMS's Three Part Aim:

The number of SoonerCare primary care practitioners enrolled as medical home PCPs will maintain at or above the baseline data (2,067 providers) between 2015-2016.

| | Baseline Dec 2013 | Jan '16 | Feb '16 | Mar '16 | Apr '16 | May '16 | Jun '16 | Jul '16 | Aug '16 | Sep '16 | Oct '16 | Nov '16 | Dec '16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of SoonerCare Choice PCPs | 2,067 | 2,663 | 2,588 | 2,613 | 2,637 | 2,659 | 2,661 | 2,701 | 2,738 | 2,759 | 2,655 | 2,681 | 2,689 |

*Hypothesis 3 Results:*

This hypothesis measures the State's access to care by tracking the number of SoonerCare primary care providers (PCP) enrolled as medical home PCPs. The OHCA exceeded the baseline data during the first month of 2016 and has continued to exceed baseline. The OHCA exceeded the baseline data by 30 percent at the end of 2016. The OHCA believes that the number of Choice PCPs will continue to be maintained throughout the 2017extension period.

**Hypothesis 3b** - PCP Enrollments Insure Oklahoma: This hypothesis directly relates to SoonerCare Choice waiver objective #2 and #1 of CMS's Three Part Aim:

The number of Insure Oklahoma practitioners enrolled as PCPs will maintain at or above the baseline data between 2015-2016.

| 2016 PCP Enrollments | Baseline Jan-Mar 2013 | Jan-Mar 2016 | Apr-Jun 2016 | Jul-Sep 2016 | Oct-Dec 2016 |
|---|---|---|---|---|---|
| Number of SoonerCare Choice PCPs | 1,514 | 2,149 | 2,127 | 2,216 | 2,196 |

*Hypothesis 3b Results:*

This hypothesis tracks the number of Insure Oklahoma primary care providers (PCP) enrolled as PCPs. The OHCA exceeded the baseline data during the first month of 2016 and has continued to exceed baseline. The OHCA exceeded the baseline data by 45 percent at the beginning of 2016. The OHCA believes that the number of Insure Oklahoma PCPs will continue to be maintained throughout the 2017 extension period

Hypothesis 4 - PCP Capacity Available: This hypothesis directly relates to SoonerCare Choice waiver objectives #1, #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 2015-2016. Also, as perceived by the member, the time it takes to schedule an appointment should improve between 2015-2016. The available capacity will equal or exceed the baseline capacity data over the duration of the waiver extension period.

| SoonerCare Choice PCP Capacity | PCP Capacity December 2013 | PCP Capacity December 2014 | PCP Capacity December 2015 | PCP Capacity December 2016 |
|---|---|---|---|---|

| SoonerCare Choice PCP Capacity | PCP Capacity December 2013 | PCP Capacity December 2014 | PCP Capacity December 2015 | PCP Capacity December 2016 |
|---|---|---|---|---|
| SoonerCare Choice Enrollment | 555,436 | 539,647 | 528,202 | 549,184 |
| Number of SoonerCare Choice PCPs | 2,067 | 2,454 | 2,642 | 2,689 |
| SoonerCare Choice PCP Capacity | 1,149,541 | 1,155,455 | 1,146,767 | 1,176,817 |
| Average Members per PCP | 268.72 | 219.91 | 199.93 | 204.23 |

*Hypothesis 4 Results:*
This hypothesis suggests that OHCA will equal or exceed the baseline capacity data (1,149,541; average of 269 members per PCP) over the duration of the extension period. The OHCA exceeded the baseline capacity in the beginning of 2016

Additionally, the number of SoonerCare Choice PCP providers has increased over the course of the year. There are 2,689 contracted SoonerCare Choice providers who serve SoonerCare members as of December 2016. This is a 30 percent increase from the number of providers in December 2013 the baseline year. In 2016, SoonerCare Choice providers served an average of 204 members per provider. As the number of SoonerCare Choice PCPs increases, the average members per PCP fluctuate. The OHCA believes that the available capacity will equal or exceed the baseline capacity over the duration of the 2017 extension period.

**Hypothesis 5** - PCP Availability: This hypothesis directly relates to SoonerCare Choice waiver objectives #1, #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 with Children's Health Insurance Program (CHIP) eligibility between 2015 - 2016. Also, as perceived by the member, the time it takes to schedule an appointment should improve between 2015 - 2016. As perceived by the member, the time it takes for the member to schedule an appointment should exceed the baseline data between 2015 - 2016.

| CAHPS® Adult Survey Results | Baseline Data: 2013 CAHPS® Survey Response | 2014 CAHPS® Survey Response | 2015 CAHPS® Survey Response | 2016 CAHPS® Survey Response |
|---|---|---|---|---|
| Positive Responses from the Survey | 80% | 82% | 87% | 82% |

| CAHPS® Adult Survey Results | Baseline Data: 2013 CAHPS® Survey Response | 2014 CAHPS® Survey Response | 2015 CAHPS® Survey Response | 2016 CAHPS® Survey Response |
|---|---|---|---|---|
| Question: *"In the last 6 months, how often did you get an appointment for a check- up or routine care at a doctor's office or clinic as soon as you needed?"* | Responded "Usually" or "Always" | Responded "Usually" or "Always" | Responded "Usually" or "Always | Responded "Usually" or "Always |

| CAHPS® Child Survey Results | Baseline Data: 2013 CAHPS® Survey Response | 2014 CAHPS® Survey Response | 2015 CAHPS® Survey Response | 2016 CAHPS® Survey Response |
|---|---|---|---|---|
| Positive Responses from the Survey Question: *"In the last 6 months, when you made an appointment for a check-up 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?"* | 90% Responded "Usually" or "Always" | 91% Responded "Usually" or "Always" | 93% Responded "Usually" or "Always" | 92% Responded "Usually" or "Always" |

*Hypothesis 5 Results:*

This hypothesis theorizes that the member's response to the time it takes to schedule an appointment should exceed the baseline data. The OHCA's contracted External Quality Review Organization (EQRO) Morpace, conducted the Consumer Assessment of Healthcare Providers & Systems (CAHPS®) survey for the period 2016. Results from the CAHPS® survey 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. In review of the adult respondents, 82 percent felt satisfied in the time it took to schedule an appointment with their PCP, while 92 percent of child survey respondents indicated they were "Usually" or "Always" satisfied more than 800 combined adult and child survey respondents that had a positive response about the time it takes to get an appointment with their PCP; the OHCA saw an increase in the number of positive responses in SFY16 for both the adult and children composite responses compared to

the baseline data. The OHCA believes that the survey responses will continue to improve throughout the 2017 extension period.

**Hypothesis 6** - Integration of Indian Health Services, Tribal Clinics, and Urban Indian Clinic Providers: 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 improve during the 2015 - 2016 waiver period.

| | Base line Dec 2013 | Jan 2016 | Feb 2016 | Mar 2016 | Apr 2016 | May 2016 | Jun 2016 | Jul 2016 | Aug 2016 | Sep 2016 | Oct 2016 | Nov 2016 | Dec 2016 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total AI/AN Members with SC Choice and I/T/U PCP | 94,142 | 81,240 | 82,544 | 82,935 | 82,273 | 82,721 | 84,465 | 87,237 | 87,512 | 88,750 | 88,737 | 90,001 | 90,232 |
| IHS Members with I/T/U PCP | 21,165 | 12,702 | 13,016 | 12,767 | 12,501 | 12,464 | 12,725 | 14,406 | 12,969 | 13,293 | 13,590 | 13,856 | 13,885 |
| Percent of IHS Members with I/T/U PCP | 22.48% | 15.64% | 15.77% | 15.39% | 15.19% | 15.07% | 15.07% | 16.51% | 14.82% | 14.98% | 15.31% | 15.40% | 15.39% |
| Percent of American Indian members with I/T/U PCP and Choice | 77.52% | 84.36% | 84.23% | 84.61% | 84.81% | 84.93% | 84.93% | 83.49% | 85.18% | 85.02% | 84.69% | 84.60% | 84.61% |
| I/T/U Capacity | 99,400 | 96,999 | 96,999 | 96,466 | 99,499 | 99,499 | 99,499 | 99,499 | 99,499 | 99,499 | 99,499 | 99,499 | 99,499 |

*Hypothesis 6 Results:*

This hypothesis postulates that the percentage of American Indian members who are enrolled with an I/T/U with a SoonerCare American Indian primary care case management contract will improve during the extension period. The proportion of American Indian members with an I/T/U PCP has decreased 7.09 percentage points when comparing December 2013 to December 2016. At this time, the OHCA expects the percentage of HIS members who are enrolled with an I/T/U PCP will continue to be maintained throughout the extension period. The OHCA has not yet met the measure; the OHCA will continue to track the data associated with this hypothesis over the extension period to monitor for significant changes in rates for these age groups.

**Hypothesis 7 –** Impact of Health Access Networks on Quality of Care: This hypothesis directly relates to the SoonerCare Choice waiver objective #3 and #2 of CMS' Three Part Aim:
Key quality performance measures, asthma and Emergency Room (ER) utilization, tracked for PCPs participating in the HANs will improve between 2015–2016.

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:*

This hypothesis posits that the percentage of HAN members with asthma who visit the ER will decrease, 90-day readmission for asthma conditions will decrease and percent of ER use for HAN members will decrease.

*Hypothesis 7A Results:* The health access networks continue to move forward with reporting. The HANs are on track in decreasing percent asthma related ER visits. In comparing 2015 to 2016 each network had a decrease. The OU Sooner HAN had a 1 percent decrease, the PHCC HAN had a 3 percent decrease and the OSU Network HAN had a 2 percent decrease.

| A. **2015** Asthma Related ER Visits | HAN members with an Asthma diagnosis in their medical record | All HAN members with ER visit in a calendar year | Percent of HAN members with an Asthma diagnosis who visited the ER |
|---|---|---|---|
| OU Sooner HAN | 5,888 | 64,958 | 9% |
| PHCC HAN | 41 | 858 | 5% |
| OSU Network HAN | 560 | 7,390 | 8% |
| A. **2016** Asthma Related ER Visits | HAN members with an Asthma diagnosis in their medical record | All HAN members with ER visit in a calendar year | Percent of HAN members with an Asthma diagnosis who visited the ER |
| OU Sooner HAN | 4,987 | 59,643 | 8% |
| PHCC HAN | 42 | 2,679 | 2% |
| OSU Network HAN | 412 | 6,767 | 6% |

*Hypothesis 7B Results:* The HANs are on track in decreasing 90-day re-admissions for HAN members with asthma. In comparing 2015 to 2016 each network had a decrease. The OU Sooner HAN had a 3 percent decrease and the PHCC HAN had a 22 percent. Although the OSU HAN Network had an increase in enrollment; therefore a three percent increase in re-admissions resulted in comparison to the previous year 2015.

| B. **2015** 90-Day Re-admissions for HAN members with Asthma | HAN members with Asthma who were Re- admitted to the Hospital 90-days after previous asthma-related hospitalization | HAN members with Asthma identified in their medical record and having at least one inpatient stay related to Asthma | Percent of HAN members with Asthma who had a 90-Day re-admission for Asthma related Condition(s) |
|---|---|---|---|
| OU Sooner HAN | 44 | 469 | 9% |
| PHCC HAN | 2 | 9 | 22% |
| OSU Network HAN | 2 | 71 | 3% |

*Hypothesis 7C Results:* The HANs are on track in decreasing ER use for HAN members. In comparing 2015 to 2016 each network had a decrease. The OU Sooner HAN had a 6 percent decrease, the PHCC HAN had a 36 percent decrease and the OSU Network HAN had a 9 percent decrease.

| C. **2015** ER Use for HAN Members | Total number of ER visits for HAN members | Total number of HAN members | Percent of ER Use for HAN Members |
|---|---|---|---|
| OU Sooner HAN | 64,958 | 136,679 | 48% |
| PHCC HAN | 2,256 | 5,137 | 44% |
| OSU Network HAN | 9,937 | 57,895 | 17% |

| C. **2016** ER Use for HAN Members | Total number of ER visits for HAN members | Total number of HAN members | Percent of ER Use for HAN Members |
|---|---|---|---|
| OU Sooner HAN | 59,643 | 143,032 | 42% |
| PHCC HAN | 1,397 | 16,441 | 8% |
| OSU Network HAN | 5,339 | 68,385 | 8% |

The health access networks continue to move forward with reporting. The OSU HAN Network had an increase in enrollment; therefore an increase in re-admission resulted in comparison to the previous year 2015. The HANs are on track in decreasing percent of ER utilization, 90-day re-admission for asthma conditions and HAN members with asthma who visit the ER.

**Hypothesis 8 -** Impact of Health Access Networks on Effectiveness of Care: 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.

Reducing costs associated with the provision of health care services to SoonerCare beneficiaries served by the HANs. 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 2015-2016.

*Hypothesis 8 Results:*

This hypothesis indicates that the average per member per month (PMPM) expenditure for HAN members will be less than the PMPM expenditure for Non-HAN members. In SFY 2016, the PMPM average for HAN members was $285.30 while the PMPM average for non-HAN members was $313.33. Per member per month expenditures, continue to be lower for SoonerCare Choice members enrolled with a HAN PCP, than for SoonerCare Choice members who are not enrolled with a HAN PCP.

The OHCA has met the measure and expects this trend to continue. The evaluation design gathers the data for this hypothesis on a state fiscal year basis. In order to allow for claims lag data to be reported, the analysis of the information is done in conjunction with the evaluation design reporting frequency within three to four month window following the state fiscal year. The information reported in the hypothesis is the most current available.

| HAN PMP SFY 2016 | **Jul '15** | **Aug '15** | **Sep '15** | **Oct '15** | **Nov '15** | **Dec '15** | **Jan '16** | **Feb '16** | **Mar '16** | **Apr '16** | **May '16** | **Jun '16** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| HAN Members | $262.02 | $272.14 | $276.49 | $295.14 | $279.74 | $273.40 | $292.92 | $307.84 | $311.22 | $286.52 | $286.16 | $282.66 |
| Non-HAN Members | $300.11 | $308.40 | $308.49 | $320.62 | $302.99 | $306.00 | $325.82 | $335.40 | $342.86 | $313.22 | $306.21 | $293.45 |

OHCA has retained the Pacific Health Policy Group (PHPG) to conduct an independent evaluation of the SoonerCare HMP. PHPG is evaluating the program's impact on participants and the health care system as a whole. The information in hypotheses 9b – 9h are taken from the PHPG (2016) evaluation in totality. For additional information on the HMP program, please refer to attachment VI HMP SoonerCare Health Management Program Evaluation SFY2015.

**Hypothesis 9a -** Health Management Program (HMP) Impact on Enrollment Figures: 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 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, the HMP has maintained enrollment and active participation in the program.

*Hypothesis 9a Results:* The results show the total number of HMP members actively engaged in nurse care management and it shows the number of SoonerCare Choice members in an active HMP practice that have undergone practice facilitation.

| SoonerCare HMP Members in Nurse Care Management | Engaged in Nurse Care Management |
|---|---|

| | |
|---|---|
| Jan-16 | 4,595 |
| Feb-16 | 4,792 |
| Mar-16 | 4,999 |
| Apr-16 | 5,020 |
| May-16 | 4,766 |
| Jun-16 | 4,544 |
| Jul-16 | 4,300 |
| Aug-16 | 3,968 |
| Sep-16 | 3,771 |
| Oct-16 | 3,580 |
| Nov-16 | 3,300 |
| Dec-16 | 3,147 |

| SoonerCare HMP Members in Nurse Care Management | Engaged in Nurse Care Management |
|---|---|
| Jan-16 | 4,595 |
| Feb-16 | 4,792 |
| Mar-16 | 4,999 |
| Apr-16 | 5,020 |
| May-16 | 4,766 |
| Jun-16 | 4,544 |
| Jul-16 | 4,300 |
| Aug-16 | 3,968 |
| Sep-16 | 3,771 |
| Oct-16 | 3,580 |
| Nov-16 | 3,300 |
| Dec-16 | 3,147 |

The OHCA will continue to track and trend this hypothesis over the extension period to monitor for significant changes in results. The results show the total number of HMP members actively engaged in nurse care management and it shows the number of SoonerCare Choice members in an active HMP practice that have undergone practice facilitation.

**Hypothesis 9b** - Health Management Program (HMP); Impact on Access to Care: This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #2 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 for preventive/ambulatory care.

*Hypothesis 9b Results:*
The Comparison group is comprised of SoonerCare members who were determined to be eligible for the SoonerCare HMP but who declined the opportunity to enroll ("eligible but not engaged").

The comparison group is the general SoonerCare population. The compliance rate of participants 20 years of age and older who had an ambulatory/preventive care visit during the measurement year. The quality of preventive care for health coaching participants was evaluated through three clinical measures:

- Adult Access to Preventive/Ambulatory Care: Percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year;
- Child Access to PCP: Percentage of children 12 months to 19 years old who visited a primary care practitioner (PCP) during the measurement year, or if seven years or older, in the measurement year or year prior; and
- Adult BMI: Percentage of adults 18 to 75 years old who had an outpatient visit where his/her BMI was documented, either during the measurement year or year prior to the measurement year. In SFY14, the comparison group which is the general SoonerCare population had an 84.7 percent compliance rate and the Health Coach Participants group had a 96.5 percent compliance rate. The compliance rate for the health coaching population exceeded the comparison group rate on the two measures having a comparison group percentage. The difference was statistically significant in both cases.

The practice facilitation population compliance rate exceeded the comparison group rate on eight of 18 measures for which there was a comparison group percentage. The difference was statistically significant for six of the eight. However, the comparison group performed slightly better by achieving a higher rate on 10 of the 18 measures, including six for which the difference was statistically significant.

| HMP Preventive Measures-Practice Group **SFY14** | Comparison Group Compliance Rate | Health Coaching Participants Compliance Rate |
|---|---|---|
| Adult Access to Preventive/Ambulatory Care | 84.7% | 96.5% |

The compliance rate for the practice facilitation population exceeded the comparison group rate on two of the three measures having a comparison group percentage. The difference was statistically significant in both cases. In SFY15, the comparison group which is the general SoonerCare population had an 84.1 percent compliance rate and the Health Coach Participants group had a 96.1 percent compliance rate. The practice facilitation participant compliance rate exceeded the comparison group rate on eight of 17 measures for which there was a comparison group percentage (47.1 percent). The difference was statistically significant for five of the eight measures (62.5 percent). Conversely, the comparison group achieved a higher rate on nine of the 17 measures (52.9 percent), including five for which the difference was statistically

significant (55.6 percent).

The practice facilitation participant compliance rate improved on 14 of 22 measures (63.6 percent) from SFY 2014 to SFY 2015, although typically by small amounts. Eight of 22 measures (36.4 percent) experienced a slight decline from SFY 2014 to SFY 2015. The most impressive results, relative to the comparison group, were observed for participants with diabetes and mental illness, and with respect to access to preventive care.

Similar to the health coaching quality outcomes, the above findings suggest that practice facilitation is having a positive impact on the quality of care for program participants. The long term benefit to participants will continue to be measured through the quality of care longitudinal analysis and through the utilization and expenditure analysis.

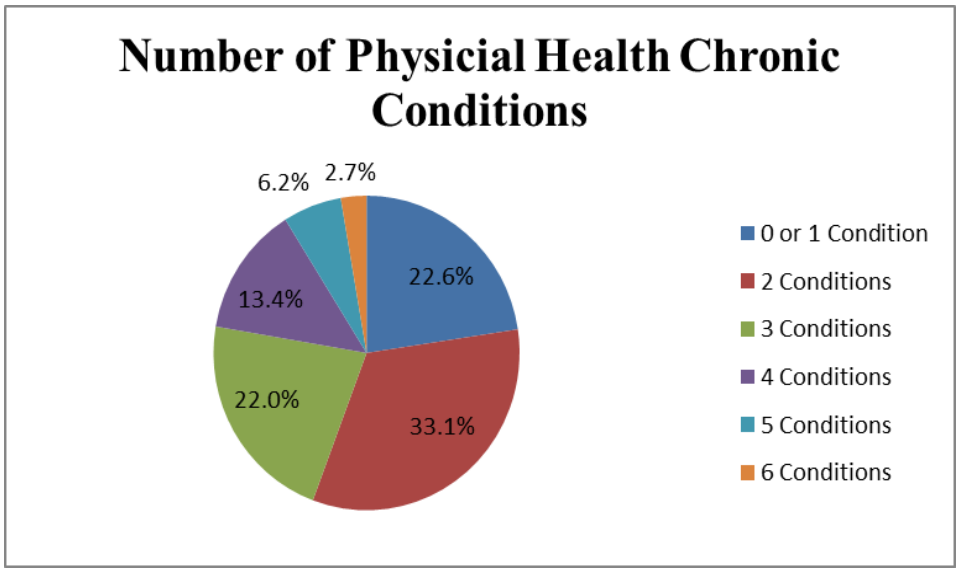
| HMP Preventive Measures-Practice Group **SFY15** | Comparison Group Compliance Rate | Health Coaching Participants Compliance Rate |
|---|---|---|
| Adult Access to Preventive/Ambulatory Care | 84.1% | 96.1% |

**Hypothesis 9c** - Health Management Program (HMP); Impact on Identifying Appropriate Target Population: 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 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.

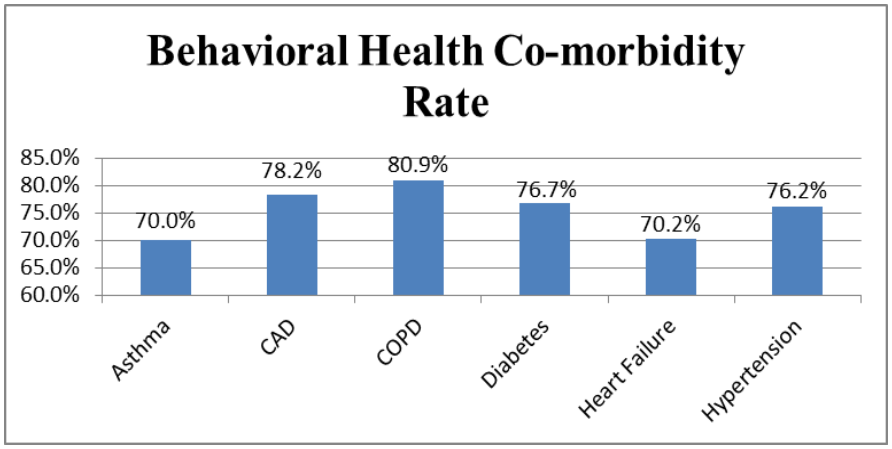
*Hypothesis 9c Results:*

The SoonerCare HMPs focus on holistic care rather than management of a single disease is appropriate given the prevalence of co-morbidities in the participating population. Independent research group Pacific Health Policy examined the number of physical chronic conditions per participant and found that nearly 80 percent in SFY 2015 had at least two of six high priority chronic physical conditions (asthma, COPD, coronary artery disease, diabetes, heart failure and hypertension) as demonstrated in the table above. The SFY 2015 distribution was very similar to the distribution in SFY




Nearly 75 percent of the participant population also has both a physical and behavioral health condition. Among the six priority physical health conditions, the co-morbidity prevalence in SFY 2015 ranged from approximately 81 percent in the case of persons with COPD to 70 percent among persons with asthma. The percentage distributions were almost unchanged from SFY 2014.

Overall, health coaching participants demonstrate the characteristics expected of a population that could benefit from care management. Most have two or more chronic physical health conditions, often coupled with serious acute conditions. The population also has significant behavioral health needs that can complicate adherence to guidelines for self-management of physical health conditions and maintaining a healthy lifestyle.




**Hypothesis 9d** - Health Management Program (HMP); Impact on Health Outcomes: This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #1, and #2 of CMS's Three Part Aim. Health coaches will improve quality measures for members who

are engaged.

*Hypothesis 9d Results:*

The health coaching participant compliance rate exceeded the comparison group rate on 12 of 17 measures for which there was a comparison group percentage (70.6 percent). The difference was statistically significant for 10 of the 12 measures (83.3 percent). Conversely, the comparison group achieved a higher rate on five of the 17 measures (29.4 percent), including three for which the difference was statistically significant (60 percent). The health coaching participant compliance rate improved on 10 of 22 measures (45.5 percent) from SFY 2014 to SFY 2015, although typically by small amounts. Twelve of 22 measures (54.5 percent) experienced a slight decline from SFY 2014 to SFY 2015. The most impressive results, relative to the comparison group, were observed for participants with diabetes and mental illness, and with respect to access to preventive care.

While it is still early in the evaluation process, the above findings suggest that health coaching is having a positive impact on the quality of care for program participants. The long term benefit to participants will continue to be measured through the quality of care longitudinal analysis and through the utilization and expenditure analysis.

| **HMP Members' Compliance Rates with Care Measures ™ Clinical Measures** | **SFY 2014** | **SFY 2015** |
|---|---|---|
| | **Percent Compliant** | **Percent Compliant** |
| **Asthma** | | |
| Use of appropriate medications for people with Asthma | 95.3% | 93.50% |
| Medication management for people with Asthma - 50 percent | 68.3% | 68.20% |
| Medication management for people with Asthma - 75 percent | 26.8% | 27.30% |
| **Cardiovascular Disease** | | |
| Persistence of beta blocker treatment after | 50.0% | 46.20% |
| **HMP Members' Compliance Rates with** | SFY 2014 | SFY 2015 |
| heart attack | | |
| LDL-C screening | 76.0% | 76.80% |
| **COPD** | | |
| Use of spirometry testing in the | 31.5% | 31.80% |
| Pharmacotherapy management of COPD | 49.5% | 20.40% |
| | SFY 2014 | SFY 2015 |
| Pharmacotherapy management of COPD | 73.9% | 76.50% |
| **Diabetes** | | |
| LDL-C Test | 77.0% | 78.30% |
| Retinal Eye Exam | 37.8% | 38.10% |
| HbA1c Test | 86.7% | 87.20% |
| Medical attention for nephropathy | 77.1% | 77.00% |
| ACE/ARB Therapy | 66.8% | 66.50% |
| **Hypertension** | | |

| | | |
|---|---|---|
| LDL-C Test | 67.3% | 67.80% |
| ACE/ARB Therapy | 66.5% | 65.80% |
| Diuretics | 45.1% | 44.90% |
| Annual monitoring for patients prescribed | 84.2% | 83.70% |
| **Mental Health** | | |
| Follow-up after hospitalization for mental | 34.8% | 34.30% |
| Follow-up after hospitalization for mental | 67.4% | 67.20% |
| **Prevention** | | |
| Adult Access to preventive/ambulatory care | 96.3% | 96.10% |
| Child access to PCP | 98.4% | 98.70% |
| **Adult BMI** | 14.3% | 14.20% |

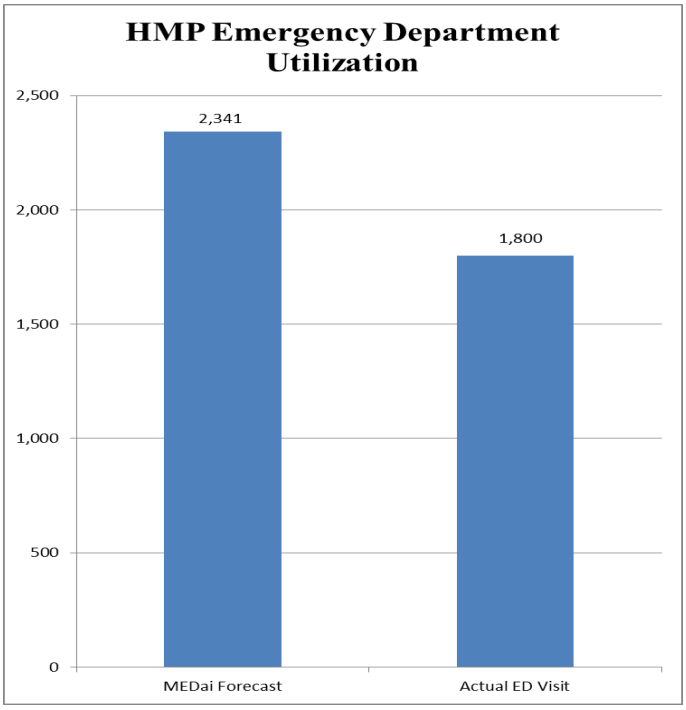
**Hypothesis 9e –** Health Management Program (HMP); Impact on Cost/Utilization of Care: This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #1, and #2 of CMS's Three Part Aim.

Nurse care managed members will utilize the emergency room at a lower rate than forecasted without nurse care management intervention.

*Hypothesis 9e Results:*
MEDai forecasted that SoonerCare HMP participants as a group would incur 2,341 emergency department visits per 1,000 participants in the first 12 months of engagement. The actual rate was 1,800 or 77 percent of forecast. Health coaching, if effective, should have an observable impact on participant service utilization and expenditures.

Improvement in quality of care should yield better outcomes in the form of fewer emergency department visits and hospitalizations, and lower acute care costs. Most potential SoonerCare HMP participants are identified based on MEDai data, which includes a 12-month forecast of emergency department visits, hospitalizations and total expenditures. MEDai's advanced predictive modeling, as opposed to extrapolating historical trends, accounts for participants' risk factors and recent clinical experience.

Members also can be identified and referred to the program by providers with embedded health coaches at their sites. This includes members whose MEDai scores are relatively low, but are determined by the provider and health coach to be "at risk" based on the individual's total profile.

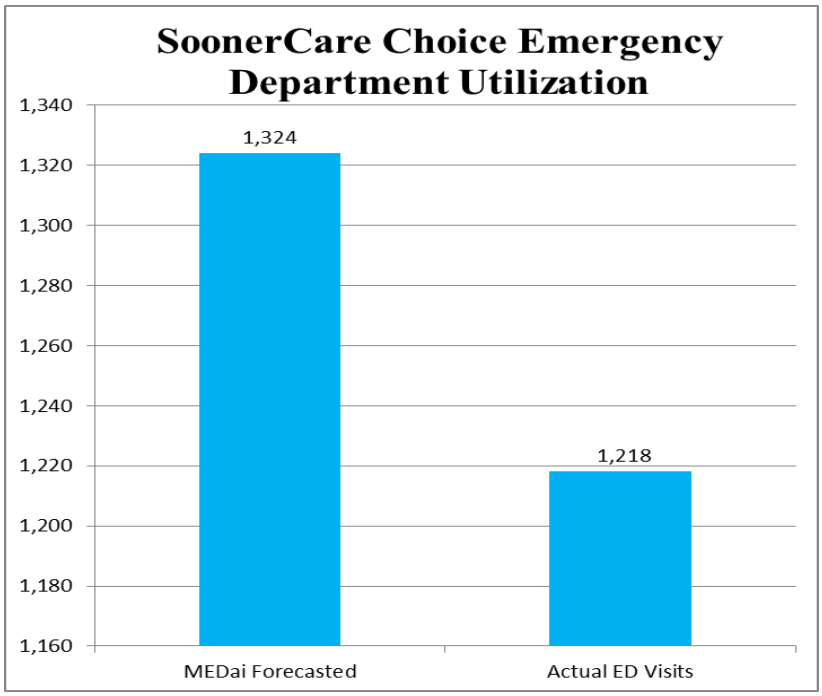



The PHPG conducted the utilization and expenditure evaluation by comparing participants' actual claims experience to MEDai forecasts absent health coaching" MEDai projected members in total would incur 1,324 emergency department visits per 1,000 over the 12-month forecast period. The actual rate was 1,218, or 92 percent of forecast.

Practice facilitation, like health coaching, should demonstrate its effectiveness through an observable impact on member service utilization and expenditures. Improvement in quality of care should yield better outcomes in the form of fewer emergency department visits and hospitalizations, and lower acute care costs.

PHPG conducted the practice facilitation utilization and expenditure evaluation by comparing the actual claims experience of members aligned with Patient Centered Medical Home (PCMH) practice facilitation providers to MEDai forecasts. The practice facilitation dataset was developed from the complete Medicaid claims and eligibility extract provided by the OHCA.

To be included in the analysis, members had to have been aligned with a PCMH provider who underwent practice facilitation. They also had to have been seen by a PCMH provider at least once following their own PCMH provider's initiation into practice facilitation. Members participating in the health coaching portion of the SoonerCare HMP were excluded from the analysis. This was done to avoid double counting the impact of the program.

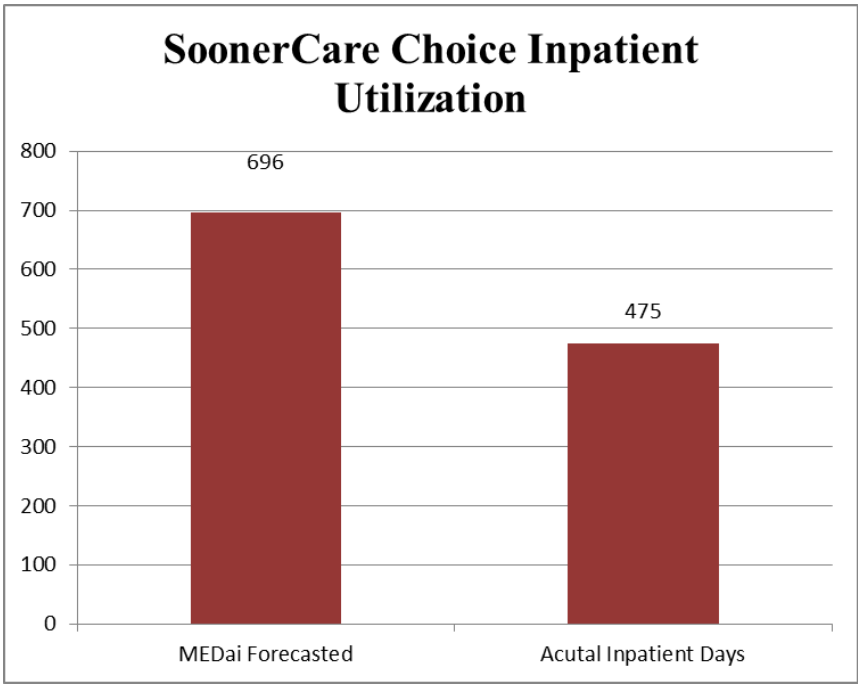



**Hypothesis 9f** – Health Management Program (HMP); Impact on Cost/Utilization of Care: This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #1 and #2 of CMS's Three Part Aim. Nurse care managed members will have fewer hospital admissions than forecasted without nurse care management intervention.

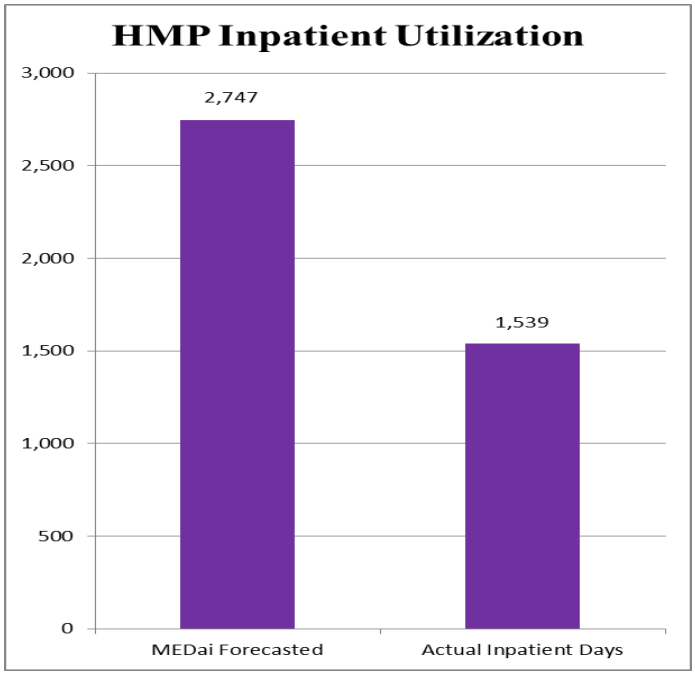
*Hypothesis 9f Results:*

Health coaching, if effective, should have an observable impact on participant service utilization and expenditures. Improvement in quality of care should yield better outcomes in the form of fewer emergency department visits and hospitalizations, and lower acute care costs.

Members also can be identified and referred to the program by providers with embedded health coaches at their sites. This includes members whose MEDai scores are relatively low, but are determined to be "at risk" based on the individual's total profile.




MEDai forecasted that SoonerCare HMP participants as a group would incur 2,747 inpatient days per 1,000 participants in the first 12 months of engagement. The actual rate was 1,539 or 56 percent of forecast PHPG conducted the utilization and expenditure evaluation by comparing participants' actual claims experience to MEDai forecasts absent health coaching. MEDai projected members in the "all others" group would incur 696 inpatient days per 1,000 over the 12 month forecast period. The actual rate was 475, or 68 percent of forecast.



PHPG conducted the practice facilitation utilization and expenditure evaluation by comparing the actual claims experience of members aligned with PCMH practice facilitation providers to MEDai forecasts.

The practice facilitation dataset was developed from the complete Medicaid claims and eligibility extract provided by the OHCA.

To be included in the analysis, members had to have been aligned with a PCMH provider who underwent practice facilitation. They also had to have been seen by a PCMH provider at least once following their own PCMH provider's initiation into practice facilitation. Members participating in the health coaching portion of the SoonerCare HMP were excluded from the analysis. The OHCA will continue to monitor the program for the impact of reducing medical cost of the population served.

**Hypothesis 9g -** Health Management Program (HMP); Impact on Satisfaction /Experience with Care: 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.
*Hypothesis 9g Results:*

Member satisfaction is a key component of SoonerCare HMP performance. If members are satisfied with their experience and value its worth, they are likely to remain engaged and focused on improving their self-management skills and adopting a healthier lifestyle. Conversely, if members do not see a lasting value to the experience, they are likely to lose interest and lack the necessary motivation to follow coaching recommendations[7].

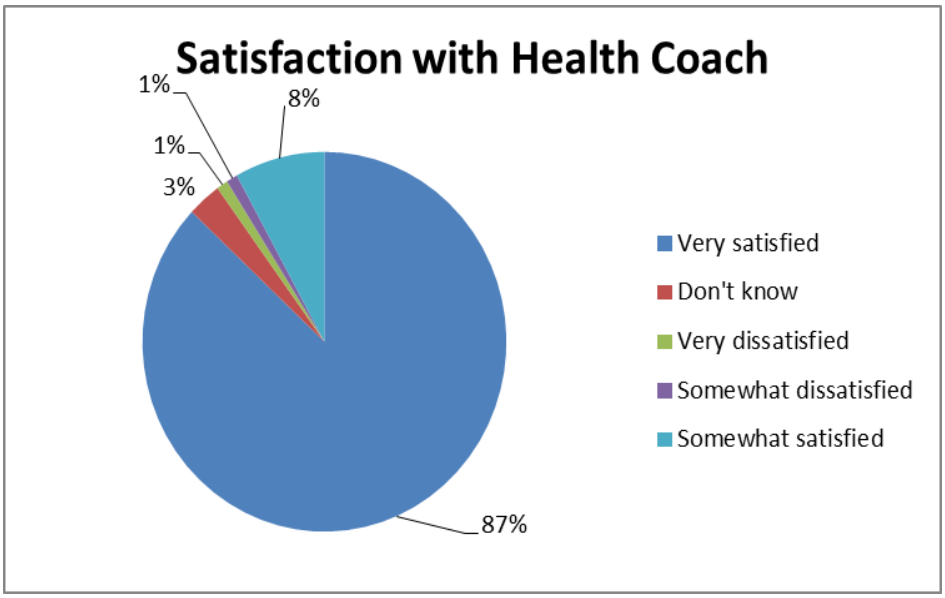
PHPG completed 758 initial surveys with SoonerCare HMP participants, as well as 133 six-month follow-up surveys with participants who previously completed an initial survey. The purpose of the follow-up survey was to identify changes in attitudes and health status over time.

Health coaches are expected to help participants build their self-management skills and improve their health through a variety of activities. Respondents were read a list of activities and asked, for each, whether it had occurred and, if so, how satisfied they were with the interaction or help they received.

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 91 to 94 percent, depending on the item. This attitude carried over to the members' overall satisfaction with their health coaches; 87 percent reported being very satisfied. Results for the follow-up survey were closely aligned to the initial survey.

[7] Data has been updated since last reporting period

Survey respondents reported very high levels of satisfaction with the SoonerCare HMP overall, consistent with their opinion of the health coach, who serves as their point of contact with the program. Eighty-seven percent of initial survey respondents and 90 percent of follow-up survey respondents stated they were very satisfied. Nearly all respondents (93 percent of initial survey and 97 percent of follow-up survey) said they would recommend the program to a friend with health care needs like theirs. The OHCA will continue to track and trend this hypothesis over the extension period to monitor for significant changes in results.




**Hypothesis 9h -** Health Management Program (HMP); Impact of HMP on Effectiveness of Care: 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.

*Hypothesis 9h Results:*

The value of the SoonerCare HMP is measurable on multiple axes, including participant satisfaction and change in behavior, quality of care, improvement in service utilization and overall impact on medical expenditures. The last criterion is arguably the most important, as progress in other areas ultimately result in medical expenditures remaining below the level that would have occurred absent the program.

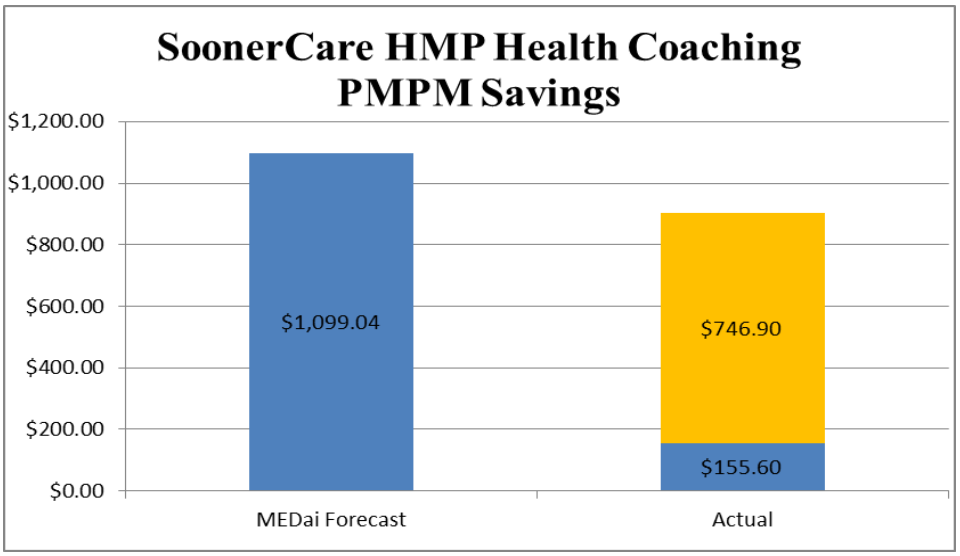
PHPG examined the program's return on investment (ROI) through SFY 2015, by comparing health coaching and practice facilitation administrative expenditures to medical savings.

Both program components have achieved a positive ROI, with the program as a whole generating net savings of $41.2 million and a return on investment of 249 percent. Put another way, the second generation SoonerCare HMP generated nearly $2.50 in net medical savings for

every dollar in administrative expenditures.

PHPG performed a cost effectiveness test by comparing forecasted costs to actual costs during SFY 2014 and SFY 2015, inclusive of SoonerCare HMP health coaching administrative expenses.
The SoonerCare HMP health coaching participants as a group were forecasted to incur average medical costs of $1,099.04. Their actual average PMPM medical costs were $746.90. With the addition of $155.60 in average PMPM administrative expenses, total actual costs were $902.50. Medical expenses accounted for 83 percent of the total and administrative expenses for the other 17 percent. Overall, SoonerCare HMP health coaching participant PMPM expenses, inclusive of administrative costs were 82.1 percent of forecast.

On an aggregate basis, the health coaching portion of the SoonerCare HMP achieved net savings during its initial 24 months of operation (July 2013 through June 2015) of nearly $12.8 million, up from only $3.4 million in its first 12. These results appear in line with the nurse care management component of the first generation SoonerCare HMP, which generated cumulative net savings of $5.5 million through its initial 17 months of operation (February 2008 implementation through June 2009) and $14.9 million in cumulative net savings through its initial 29 months of operation (February 2008 through June 2010).

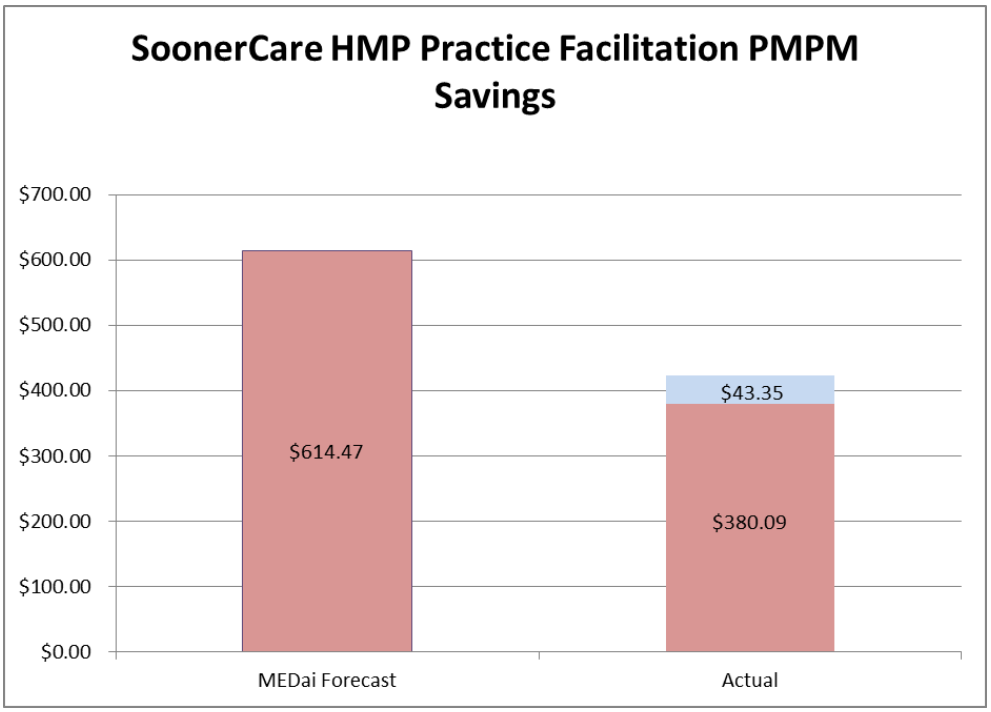



PHPG performed a cost effectiveness test by comparing forecasted costs to actual costs during SFY 2014 and SFY 2015, inclusive of SoonerCare HMP practice facilitation administrative expenses.

SoonerCare HMP members aligned with a practice facilitation provider and included in the expenditure analysis were forecasted to incur average medical costs of $614.47. Their actual average PMPM medical costs were $380.09. With the addition of $43.35 in average PMPM administrative expenses, total actual costs were $423.44. Medical expenses accounted for 90

percent of the total and administrative expenses for the other 10 percent. Overall, net SoonerCare HMP practice facilitation-related PMPM expenses were 61.9 percent of forecast.

On an aggregate basis, the practice facilitation portion of the SoonerCare HMP achieved net savings in excess of $28.4 million. These net savings compare favorably to the practice facilitation component of the first generation SoonerCare HMP, which generated cumulative net savings of $3.5 million through its initial 17 months of operation (February 2008 implementation through June 2009) and $19.2 million in cumulative net savings through its initial 29 months of operation (February 2008 through June 2010). The OHCA will continue to track and trend this hypothesis over the extension period to monitor for significant changes in results.




Proposed 2018 SoonerCare Choice and Insure Oklahoma Hypotheses

The OHCA is requesting that these remain the same as the 2017 approved hypotheses submitted (December 15, 2016)

*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- 2017.

*Hypothesis 3 – PCP Enrollments.*

The number of SoonerCare primary care practitioners enrolled as medical home PCPs will maintain at or above the baseline data between 2016-2018.

*Hypothesis 3b: PCP Enrollments Insure Oklahoma.*

The number of Insure Oklahoma practitioners enrolled as PCPs will maintain at or above the baseline data 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. Also, as perceived by the member, the time it takes to schedule an appointment should improve between 2016-2018.

*Hypothesis 5 – PCP Availability.*

There will be adequate PCP capacity to meet the health care needs of the SoonerCare members with Children's Health Insurance Program (CHIP) eligibility between 2016-2018. Also, as perceived by the member, the time it takes to schedule an appointment should improve between 2016 - 2018.

*Hypothesis 6 - Integration of Indian Health Services, Tribal Clinics, and Urban Indian Clinic Providers.*

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 improve during the 2016-2018 waiver period.

*Hypothesis 7 – Impact of Health Access Networks on Quality of Care.*

Key quality performance measures, asthma and Emergency Room (ER) utilization, 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 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 2016-2018.

*Hypothesis 9 – Health Management Program (HMP). Impact on Enrollment Figures*

Health outcomes for chronic diseases will improve between 2017-2018 as a result of participation in the HMP. Total expenditures for members enrolled in HMP will decrease.

(a) 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) 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) 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) Health Coaches will improve quality measures for members who are engaged.

(e) Nurse care managed members will utilize the emergency room at a lower rate than forecasted without nurse care management intervention

(f) Nurse care managed members will have fewer hospital admissions than forecasted without nurse care management intervention.

(g) Nurse care managed members will report high levels of satisfaction with their care.

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

## VII. PUBLIC NOTICE PROCESS

Post Award Forum

In accordance with STC #17, OHCA has the Post Award Forum scheduled for September 20, 2017 for the 2017 extension period in order to afford the public an opportunity to provide meaningful comment on the progress of the demonstration. Any oral or written comments will be provided to CMS accordingly.

Public Meetings

In accordance with 42 CFR Section 431.408, OHCA held three public meetings to inform the public of constant and consistent transparency and feedback for the public regarding the waiver. Two of the public meetings are to be considered as part of the requirements for the public notice process for the 2018 demonstration extension.

The OHCA held a public meeting on April 11, 2017; five months after CMS approved the 2017 demonstration extension[8]. 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[9]. During the forum/ public meeting, 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 on the Demonstration for the 2016-2017 extension periods as outlined in Section II of the STCs. Due to posting requirements, the agency counted this as a public meeting for informational purposes for the public.

[8] Refer to attachments 15 and 16 for The Children's Health Group Quarterly Meeting agenda and SoonerCare Choice Insure Oklahoma Post Award Forum PowerPoint for April 2017.

[9] Refer to attachment 17 for the Post Award Forum Newspaper Publication Notice April 2017.

Comments during this meeting included:

1. 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.

   The OHCA responded: An email response was provided The Oklahoma Health Care Authority (OHCA) appreciates your attendance, April 11, 2017, at the 2017 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.

On May 18, 2017, the state conducted it first public meeting at the Oklahoma Health Care Authority during the Medical Advisory Committee (MAC) Meeting in Oklahoma City, OK. The State provided updated information of its plan to submit an extension application for the SoonerCare Choice and Insure Oklahoma 1115(a) waiver to the Centers for Medicare and Medicaid Services (CMS) for the period January 1 2018, to December 31, 2018. The State also introduced Supplemental Payment Methodology information regarding Workforce Development for Teaching Universities during this meeting. The state reported anticipation to make application August 1, 2017.

Comments during this meeting included:

1. One of the MAC members asked if the Physicians Manpower organization had been involved with the development of the matrix for the Work Force development of the 2018 extension.
   The OHCA responded: "Yes."
2. Would the extension request be impacted with the status of the Aged Blinded & Disabled (ABD)
   The OHCA responded: This was an extension request to continue the waiver without including ABD or without ABD being impacted. If we were to do anything that would impact the ABD, we would have to amend the demonstration to add a new program.

On May 25, 2017 the State conducted its second meeting at the Cleveland County Health Department in Norman, OK during the Child Health Workgroup. Information regarding programs covered under the demonstration waiver inclusive of the Health Management Program, Health Access Networks and Workforce Development for Teaching Universities was discussed. It was mentioned that the state has introduced Supplemental Payment Methodology information regarding Workforce Development for Teaching Universities in the 2018 extension request during this meeting. The extension application requires approval from our federal partners, CMS, to continue services provided under the 1115(a) demonstration waiver. This information was also explained during this meeting.

Comments during this meeting included:

1. Since the current administration, has it caused the State to have any problems with getting authority to operate Medicaid or waivers described today?

The OHCA responded: The State has always utilized transparence and seeks public comment on any changes that are made to any policy and/or waiver decisions before proceeding. Our federal partners have supported the authority to continue to process demonstration waiver request this way.

.

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 2017.

May 17 • **Newspaper notification** to announce meeting location(s) intent to request an extension in the newspapers of widest circulation in each city with a population of 100,000, or more persons.

May 18 **OHCA Banners** Place on OHCA public site for public comment period 30-day requirement we will have 60 day period to run through July 26, 2017 (refer to attachment seven.

May 18 • **1st Public meeting Medical Advisory Meeting (MAC):** regarding modifications Workforce Development supplemental payments to Waiver.

May 23 • **Tribal Consultation:** regarding modifications Workforce development supplemental payments.

May 24 • **2nd Public meeting Child Health Workgroup:** regarding modifications Workforce Development supplemental payments to Waiver. (Attachment nineteen)

June 26 • OHCA Comment Period ends: regarding modifications Workforce Development to Waiver

July 17 • Receive Cover Letter from Governor's Office for Renewal

By August 1 • Submit Renewal Application to CMS

## APPENDICES

**Appendix A:** 2018 SoonerCare Choice and Insure Oklahoma Eligibility Chart

| 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 |
| 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 | As Above | Populations 1,2,3,4 |
| IV-E Foster Care or Adoption Assistance Children | Automatic Medicaid | 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~~ 1916(b) | SSI for unearned income and earned income limit is the ~~1619~~ 1916(b) threshold amount for Disabled SSI members, as updated annually by the SSA. | Freedom of Choice | Populations 1,2,3,4 |

| Mandatory State Plan Groups | FPL and/or Other Qualifying Criteria | Applicable Waivers and CNOMs (Waiver List summary) | Demonstration Population (STC# 57) |
|---|---|---|---|
| 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 |
| 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 |
| 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 |
| 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 |

| 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 |
| 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 [10] 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 |
| January 3, 2009 | a) 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<br>b) CMS approved expanding the description of qualified PCPs to permit County Health Departments to serve as medical homes for members who choose those providers.<br>c) CMS approved the option for the voluntary enrollment of children in State or Tribal custody in the Demonstration.<br>d) CMS approved the SoonerExcel incentive payment program for |

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

| **Appendix B**: A Historical Timeline of the SoonerCare Choice Program | |
|---|---|
| | PCPs to build upon the EPSDT and Fourth DTaP Bonus program.<br>e) CMS approved adding $1 copay for non-pregnant adults in SoonerCare. |
| December 30, 2009 | a) CMS approved extending the program from January 1, 2010 to December 31, 2012.<br>b) CMS approved the Health Access Network (HAN) pilot program. |
| December 31, 2012 | a) CMS approved extending the program from January 1, 2013 to December 31, 2015.<br>b) 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.<br>c) 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 | a) CMS approved adding the mandatory Title XXI Targeted Low-Income Child eligibility group for children ages 0-18.<br>b) 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.<br>c) 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 |
| January 2016 | The SoonerCare Pain Management program was implemented |
| June 29, 2016 | Leon Bragg, DDS, Chief Dental Officer for the OHCA was recognized by Delta Dental of Oklahoma for his service as President of the Medicaid Medicare Children's Health Insurance Program (CHIP) Services Dental Association (MSDA) |
| July 11, 2016 | Text4Baby (T4b) enrolled its 1 millionth participant the largest mobile health initiative in the nation |
| August 22, 2016 | Dr. Mike Herndon named Chief Medical Officer of the Oklahoma Health Care Authority. |
| August 29, 2016 | Nico Gomez announced he was stepping down as Chief Executive Officer of the Oklahoma Health Care Authority. His last day was September 30, 2016. |

| **Appendix B**: A Historical Timeline of the SoonerCare Choice Program | |
|---|---|
| September 9, 2016 | State Medicaid Director Becky Pasternik-Ikard accepted position of Chief<br>Executive Officer of the Oklahoma Health Care Authority |
| November 30, 2016 | The Oklahoma Office of Management and Enterprise Services (OMES) released the RFP for SoonerHealth+, The fully capitated, statewide model of care coordinated that is being developed for Oklahoma Medicaid's ABD population.<br><br>CMS approved extending the program from January 1, 2017 to December 31, 2017 |
| December 12, 2016 | The Oklahoma Health Care Authority (OHCA) comes in at number ten of Workplace Dynamic's "Top Workplaces," a list of the best places to work in Oklahoma. The OHCA was included, for the second year in a row. |

| **A Historical Timeline of the Insure Oklahoma Program** | |
|---|---|
| August 2001 | President Bush approved the Health Insurance Flexibility and Accountability waiver policy. |
| April 20, 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 | a) CMS approved increasing the Insure Oklahoma ESI employer size to 250 or fewer employees.<br>b) 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.<br>c) 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 | a) 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.<br>b) CMS approved the Insure Oklahoma eligibility group of foster parents up to 250 percent of the FPL.<br>c) 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 | a) 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.<br>b) 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 | a) 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.<br>b) 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 |
| March 2016 | Insure Oklahoma completed its online enrollment systems project |
| March 4, 2016 | The Oklahoma Health Care Authority submitted an amendment to the 1115 demonstration waiver known as Insure Oklahoma Program known as Sponsor's Choice. |

| | |
|---|---|
| November 30, 2016 | CMS approved extending the program from January 1, 2017 to December 31, 2017 |

**Appendix C:** Insure Oklahoma Monitoring

The OHCA began work on a new system migration for online enrollment of the IO program which includes the enrollment numbers for Insure Oklahoma. Therefore, none of the Insure Oklahoma table data was reported during the first quarter of the 2016 year.

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 | $325.33 |
| 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 | $480.66 |
| July-Sept 2014 | $295.84 | $443.06 |
| Oct-Dec 2014 | $297.94 | $450.62 |
| Jan-March 2015 | $302.81 | $419.92 |

| | | |
|---|---|---|
| Apr-June 2015 | $307.08 | $460.93 |
| July-Sept 2015 | $311.68 | $473.49 |
| Oct-Dec 2015 | $313.51 | $438.17 |
| Jan-March 2016 | Unavailable | Unavailable[11] |
| Apr-June 2016 | Unavailable | Unavailable |
| July-Sept 2016 | $340.52 | Unavailable |
| Oct-Dec 2016 | $336.26 | $373.43 |

SI Average PMPM Total Cost for 2016: $308.68 (OHCA separates the employee, spouse, student and dependent categories).

IP Average PMPM Total Cost for 2016: $ 441.06

In 2016 The Oklahoma Health Care Authority switched to an online system for enrollment of providers and members. This created a delay in the way in which numbers were gathered for the reporting documentation for accuracy. This was reported each month to CMS and the methodology changed around May 2016 moving forward. The numbers may appear inconsistent from previous years for this reason.

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 2016: $14,650,644.10

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

| Year | Total Average Cost PMPM, ESI | Total Average Cost |
|---|---|---|
| 2008 | $234.82 | $299.62 |
| 2009 | $248.40 | $317.69 |
| 2010 | $265.57 | $315.97 |
| 2011 | $287.01 | $336.76 |
| 2012 | $294.16 | $337.91 |
| 2013 | $302.91 | $363.34 |
| 2014 | $305.26 | $501.55 |
| 2015 | $318.53 | $447.69 |
| 2016 | $346.05 | $419.60 |

This table includes total cost of out of pocket expenses of all eligible member and employer expenses prior to meeting their 5 percent threshold. The numbers in this table were reconfigured due to a refinement in methodology in 2016.

[11] Due to delays in the enrollment migration these numbers were not reported in the quarter indicated.

| 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 | $12,251,882.15 |
| 2015 | $13,248,870,.04 |
| 2016 | $14,650,644.10 |

ESI Health Plan Monitoring

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 |
|---|---|---|---|
| 2016 | 2016 Child CAHPS® Medicaid Survey 5.0H | February 2015 to June 2016 | Telligen / Morpace |
| 2016 | 2016 Adult CAHPS® Medicaid Survey 5.0H | February 2015 to June 2016 | Telligen / Morpace |

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

The OHCA annually conducts the Consumer Assessment of Health Provider and Systems (CAHPS) survey designed for children. The sample is from members enrolled via the Children's Health Insurance Program (CHIP) for his survey.

| CAHPS® Child Survey (CHIP) 2016 Key Measure | 2014 Summary Rate | 2015 Summary Rate | 2016 Summary Rate |
|---|---|---|---|
| Getting Needed Care | 89% | 85% | 89% |
| Getting Care Quickly | 92% | 92% | 93% |
| How Well Doctors Communicate | 97% | 96% | 97% |
| Customer Service | 88% | 86% | 86% |
| Shared Decision Making | Not Applicable | 78% | 78% |
| Rating of Health Care | 85% | 87% | 88% |
| Rating of Personal Doctor | 88% | 89% | 89% |
| Rating of Specialist | 89% | 88% | 83% |
| Rating of Health Plan | 86% | 87% | 86% |

CAHPS® adult member satisfaction survey shows improvement compared to SFY 2015, SoonerCare Adult member satisfaction rates held steady or increased slightly in all key measures other than Rating of Specialist.

| CAHPS® Adult Survey 2016 Key Measure | 2014 Summary Rate | 2015 Summary Rate | 2016 Summary Rate |
|---|---|---|---|
| Getting Needed Care | 82% | 85% | 85% |
| Getting Care Quickly | 82% | 82% | 84% |
| How Well Doctors Communicate | 90% | 90% | 91% |
| Customer Service | 82% | 92% | 87% |
| Shared Decision Making | Not Applicable | 77% | 77% |
| Rating of Health Care | 68% | 72% | 74% |
| Rating of Personal Doctor | 79% | 80% | 81% |
| Rating of Specialist | 83% | 78% | 83% |
| Rating of Health Plan | 73% | 73% | 67% |

For comprehensive CAHPS® survey results, please CAHPS visit under Member Satisfaction Surveys.