Oklahoma Health Care Authority

SoonerCare Choice and Insure Oklahoma §1115(a) Demonstration 11-W-0048/6

Application for Extension of the Demonstration, 2013 – 2015

Submitted to the Centers for Medicare and Medicaid Services

December 30, 2011

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Request for Extension and Amendment of the Demonstration

The SoonerCare 1115(a) Research and Demonstration Waiver is currently approved through December 31, 2012. Oklahoma requests an extension of the program for the period January 1, 2013 to December 31, 2015. Oklahoma is aware that the SoonerCare / Insure Oklahoma waiver will need to be amended in order to bring the program into compliance with provisions of the Patient Protection and Affordable Care Act (PPACA) that take effect in 2014. At this time, the State is requesting renewal of this waiver in its present form, pending instructions from State leadership on the direction Oklahoma intends to take with regard to health reform. The Oklahoma Health Care Authority (OHCA) plans to request appropriate amendments to the waiver after receiving proper guidance. OHCA is also requesting that approval of the Health Access Network (HAN) program be maintained as a pilot from 2013 to 2015. The State is not at present requesting authorization to implement the HANs statewide.

The State requests that one amendment be made to the waiver for the extension period; it is specific to the Insure Oklahoma (IO) Individual Plan (IP) program. The State requests that the adult outpatient behavioral health benefit for IO IP be limited to 48 visits per year. This change will match the adult benefit with the children's benefit, which is already limited to 48 outpatient behavioral health visits per year.[1]

[1] See Appendix A for documentation related to the amendment request.

Program Objectives

Narrative Summary of the Demonstration Project

The Oklahoma SoonerCare Demonstration program manages care for enrollees statewide and offers coverage to expansion populations who would otherwise be ineligible for medical assistance.

Care is managed through a Primary Care Case Management (PCCM) system that provides each member with a medical home of his or her choice. Enrolled primary care providers (PCPs) are paid monthly care coordination fees for each member on their panels in amounts that vary depending on the level of medical home services provided and the mix of adults and children the provider accepts. Providers are also eligible for performance incentive payments when they meet certain quality improvement goals defined by the State.

Outside of care coordination, all other services provided in the medical home as well as by specialists, hospitals or other providers are reimbursed on a fee-for-service basis. Members are required to get referrals from their PCPs for most services provided outside of the medical home, but may receive primary care services from any provider enrolled as a Choice PCP, without a referral, limited to a maximum of 4 visits per month. Visits to the medical home PCP are unlimited. Members also actively choose their medical homes: they are no longer automatically enrolled with a PCP, they can change PCPs with no delay in the enrollment effective date, and there is no limit on the number of times a member can change PCPs. These features of the medical home delivery system give members greater access to primary care and incentivize PCPs to proactively care for the members assigned to their panels.

Members of the Temporary Assistance for Needy Families (TANF)-related populations and the Aged, Blind and Disabled (ABD) populations are eligible for SoonerCare Choice with some exceptions. SoonerCare benefits are Title XIX State Plan benefits, with the exception of the Insure Oklahoma Employer Sponsored Insurance (ESI) and the Insure Oklahoma Individual Plan (IP).

Coverage is authorized to be expanded to disabled children through TEFRA and to working and unemployed adults, their children, college students and foster parents through Insure Oklahoma, a public/private partnership for subsidizing health insurance premiums. Members receiving coverage through Insure Oklahoma are otherwise ineligible for Medicaid. Eligible adults are receiving unemployment benefits, are disabled and working, or are working for a small employer with fewer than 250 employees.

Major objectives of the SoonerCare Waiver program are:

- To improve access to preventive and primary care services,
- To provide each member with a medical home,
- To integrate IHS beneficiaries and providers into the SoonerCare delivery system,
- To expand access to affordable health insurance for low-income working adults and their spouses,
- To effectively and efficiently purchase appropriate care for members, and
- To optimize quality of care through effective care management.

Objectives at the Time the Demonstration was Proposed

The SoonerCare Demonstration was first implemented in 1995 under a 1915(b) waiver. Since then, the program has changed from Managed Care Organizations (MCOs) in urban areas to a statewide partially capitated PCCM model, to the current patient-centered medical home model of service delivery.[2] The objectives that apply to the current model were outlined in the State's renewal request for the 2010-2012 extension period as follows:

[2] See Appendix B for a detailed history of the Demonstration and its amendments.

- Improve access to preventive and primary care services;
- Increase the number of participating primary care providers, and overall primary care capacity, in both urban and rural areas;
- Provide active, comprehensive care management to beneficiaries with complex and/or exceptional health care needs;
- Integrate IHS beneficiaries and providers into the SoonerCare delivery system; and
- Expand access to affordable health insurance for low income adults in the work force and their spouses.

Access to Care

Under the Demonstration program, Healthcare Effectiveness Data and Information Set (HEDIS®) results for the access to PCP / ambulatory health care measure have improved in every age range from 2008 to 2009.[3]

Provider Enrollments

The number of PCPs enrolled as medical homes has increased from a baseline of 1,409 in December 2008 to 1,576 PCPs as of September 2011. Overall capacity declined from the baseline in December 2008 (1,373,058) in 2009, but has since increased by 2.05% from 1,039,583 in January 2010 to 1,060,883 as of September 2011.

Care Management

In January 2010, the Demonstration provided care management through OHCA nurse care managers to 3,018 members, at a rate of 6.82 per 1,000 SoonerCare members. As of September 2011, 2,239 members are receiving care management through OHCA, at a rate of 5.02 per 1,000 SoonerCare members. Another 118 members are receiving care management through the OU Sooner HAN, raising the total to 2,447, at a rate of 5.48 per 1,000 members.

Integration of IHS Beneficiaries and Providers

In December 2009, 62,826 IHS members were enrolled in SoonerCare Choice, of whom 12,866 or 20.48% were enrolled with an I/T/U PCP. I/T/U capacity at that time was 116,150. As of September 2011, IHS membership has expanded to 70,586 people, of whom 13,718 or 19.43% are enrolled with an I/T/U PCP. I/T/U capacity is now lower, at 113,150 as of September 2011, but is still significantly higher than the number of IHS members.

Expansion of Access to Affordable Health Insurance

Access to health insurance for adults and children ineligible for SoonerCare is provided through the Insure Oklahoma program. Insure Oklahoma enrollments (combined for Employer Sponsored Insurance, ESI, and Individual Plan, IP) were 28,958 in December 2009. Enrollments increased by 11.05% to 32,159 in September 2011.

[3] HEDIS data are not yet available for 2010.

Special Terms and Conditions

1. Compliance with Federal Non-Discrimination Statutes

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

2. Compliance with Medicaid and CHIP Law, Regulation, and Policy including protections for Indians pursuant to section 5006 of ARRA (2009)

The State complies with all Medicaid and CHIP program requirements in law, regulation and policy statement that are not expressly waived or identified as not applicable in the waiver and expenditure authority documents received from the Centers for Medicare and Medicaid Services (CMS), including protections for Indians pursuant to Section 5006 of the American Recovery and Reinvestment Act of 2009.

3. Compliance with Changes in Medicaid and CHIP Law, Regulation, and Policy

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

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

If a change in Federal law, regulation or policy results in a change in Federal financial participation (FFP) for expenditures made under the SoonerCare Demonstration, the State submits modified budget neutrality and allotment neutrality agreements for CMS approval. The State recognizes that the modified agreements referred to in this paragraph do not involve changes to trend rates for the budget neutrality agreement, and that modified agreements take effect on the date the relevant change is implemented. Changes that require state legislation take effect the day the state law becomes effective or the last effective day required by the Federal law.

5. State Plan Amendments

State Plan Amendments are submitted if changes to the Demonstration affect populations eligible through the Medicaid or CHIP State Plans.

6. Changes Subject to the Amendment Process

The State does not implement changes related to eligibility, enrollment, benefits, cost sharing, sources of non-Federal share of funding, budget neutrality or other comparable program elements without submission of amendment requests 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

Amendment requests are submitted to CMS no later than 120 days prior to the planned implementation date, and are not implemented until approved. Amendment requests include all required elements for Federal review.

8. Extension of the Demonstration

The State is submitting its extension request no later than 12 months prior to the expiration date of the Demonstration, December 31, 2012, including all required supporting documentation.

9. Demonstration Phase-Out

In the event that the State elects to suspend or terminate the Demonstration in whole or in part, the State will promptly notify CMS in writing and will submit a phase-out plan to CMS at least six months prior to initiating phase-out activities. Such a plan will not be shorter than six months unless quicker action is

necessitated by emergent circumstances. The State understands that FFP upon suspension or termination will be limited to normal closeout costs, including services and administrative costs of disenrolling participants.

10. 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.

11. Enrollment Limitation during Demonstration Phase-Out

In the event that the State elects to suspend, terminate or not renew the Demonstration, the State will not enroll individuals who would not be eligible for Medicaid under the current State Plan in the final six months, unless CMS extends the Demonstration. If CMS notifies the State in writing that the Demonstration will not be renewed, enrollment will be suspended.

12. Finding of Non-Compliance

The State understands its rights to challenge a CMS finding that the State materially failed to comply with the terms of the Demonstration.

13. 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.

14. 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.

15. Public Notice, Tribal Consultation, and Consultation with Interested Parties

Documentation of compliance with these requirements is provided in the section titled "Public Notice".

16. 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.

17. Federal Funds Participation

The State understands that Federal matching funds for expenditures under this Demonstration will not be made available to the State until the effective date identified in the Demonstration approval letter.

18. Eligibility

The State maintains the eligibility rules outlined in the Special Terms and Conditions (STC) and is not requesting any changes to the populations eligible to participate in the Demonstration.

19. Eligibility Exclusions

The State maintains the eligibility exclusion rules outlined in the STC and is not requesting any changes to the populations not eligible to participate in the Demonstration.

20. TEFRA Children

The State maintains the rules for eligibility in the TEFRA category and is not requesting any changes in the definition of the population or their eligibility for the Demonstration.

21. TEFRA Children Retroactive Eligibility

The waiver of retroactive eligibility does not apply to TEFRA children. Their parents or guardians choose an appropriate PCP/Case Manager. The State is not requesting any changes to these rules.

22. Enrollment Cap

The State maintains an enrollment cap of 3,000 on full-time college students enrolled in Insure Oklahoma. As of September 2011, 114 college students are enrolled in ESI and 353 are enrolled in IP, for a total of 467. The State received authorization for a waiting list for IO from CMS and understands that the State must notify CMS a minimum of 60 days prior to implementing a waiting list. A waiting list is not in place at present.

23. SoonerCare Benefits

This paragraph does not apply to IO ESI or IP. SoonerCare Choice benefits are Title XIX State Plan benefits, with one difference. The State Plan limits physician visits (including specialty visits) to four per month, whereas the waiver package allows unlimited physician visits with the member's PCP as medically necessary. The State is not requesting any changes to SoonerCare benefits.

24. Insure OK: Premium Assistance Employer Coverage

The State maintains the definitions and eligibility rules given in this paragraph of the STC, and is not requesting any changes.

25. Insure OK: Premium Assistance Employer Coverage Qualified Health Plan Benefits

The State maintains the required criteria for qualified health plans as defined in this section of the STC. All IO ESI health plans are approved by the Oklahoma Insurance Department for the Oklahoma market. The State is not requesting any changes to the maximum allowed copay amounts defined in paragraph 29 of the STC.

26. Insure OK: Premium Assistance Individual Plan (Insure Oklahoma)

The State maintains the rules outlined in the STC with regard to eligibility criteria, the application process, the premium schedule, delinquent premium payments, the repayment process, waiver of premiums in cases of hardship and reenrollment. The State is not requesting changes to these elements of the program.

27. Premium Assistance Individual Plan (Insure Oklahoma) Benefits

The State currently maintains the benefit package with the limitations listed in the STC. The State is requesting addition of a limitation: regarding the Service Outpatient Behavioral Health visits, the State requests a limit of 48 visits per year.

28. SoonerCare and Insure Oklahoma Cost Sharing

Under the SoonerCare program, pregnant women, children (including TEFRA children) 18 years or younger, 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 currently maintains co-pays assessed under the Insure Oklahoma Individual Plan program at the maximum levels listed in the STC. The State understands that the State may lower the co-pays at any time by notifying CMS in writing at least 30 days prior to the effective date. Annual out-of-pocket cost sharing does not exceed five percent of a family's gross income.

29. Premium Assistance Employer Coverage Co-Payments and Deductibles

The State continues to require the limitations on cost sharing for Qualified Health Plans offered through IO ESI and is not requesting any changes in the limitations.

30. Premium Assistance Employer Coverage Plan Premiums

The State maintains all rules regarding premiums charged, reimbursements for out-of-pocket costs in excess of five percent of annual gross household income, and the schedule of premium assistance outlined in this section of the STC. The State is not requesting any changes to these elements of the program.

31. Premium Assistance Individual Plan Premiums

The State maintains all rules established in this paragraph with regard to IP premiums and is not requesting any changes.

32. Access and Service Delivery

The State maintains all requirements and definitions for PCP/CMs available to members and is not requesting any changes to this paragraph.

33. Care Coordination Fees

The State maintains the schedule of monthly care coordination fees dependent upon medical home tier and the composition of the PCP's panel outlined in this section of the STC. The State is not requesting any changes to the care coordination fees. 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.

34. Other Medical Services

It continues to be the case that other than monthly care coordination fees and non-emergency transportation (which is paid through a capitated contract), all other medical services are provided through the State's Fee-For-Service system. The State is not requesting any changes to this arrangement.

35. Health Access Networks

The State is currently piloting three Health Access Networks (HANs). The State is not requesting authorization to expand the HAN element of the Demonstration beyond the current maximum of four pilots. The State maintains all other definitions, rules and requirements for the HANs outlined in this paragraph and is not requesting any changes in this area. 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 requirement 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.

36. Provider Performance

The State maintains the incentive payment for performance program outlined in this paragraph and is not requesting that any changes be made to it.

37. Services for American Indians

Eligible American Indian SoonerCare members continue to enroll with I/T/U clinics as their PCP/CMs. This enrollment is voluntary. The I/T/U providers enrolled as SoonerCare PCPs receive the care coordination fees established in paragraph 33 and are eligible for the incentive payments established in paragraph 36. The State is not requesting any changes to this paragraph.

38. Contracts

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

39. TEFRA Children

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

40. Health Management Program Defined

The State is not requesting any changes to the definition of the Health Management Program (HMP) or the reporting requirements outlined in this paragraph of the STC. The State reports on the HMP in the Quarterly Report, which is submitted no later than 60 days after the last day of each calendar quarter.

41. Health Management Program Services

The State maintains the services provided through the HMP as defined in this paragraph and is not requesting that any changes be made. The State understands the requirement to notify CMS 60 days prior to any change in these services and recognizes that a revised budget neutrality assessment must accompany such a notification.

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

The State monitors and publishes the aggregate costs for ESI as compared with IP, the average monthly premium assistance contributions in both plans, the annual total cost PMPM for ESI members and the total PMPM costs for IP members.[4]

43. 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, summarizes the total statewide employer contribution level and monitors changes in covered benefits and cost-sharing requirements of employer-sponsored plans, documenting any trends noted.[5]

44. General Financial Requirements

See Section 6 of this Renewal Application, Compliance with the Budget Neutrality Cap.

45. Reporting Requirements Related to Budget Neutrality

See Section 6 of this Renewal Application, Compliance with the Budget Neutrality Cap.

46. Monthly Calls

The State participates in the monthly calls with CMS outlined in this paragraph of the STC.

47. Quarterly Operational Reports

The State submits operational reports on the Demonstration to CMS in the format specified in Attachment A of the STC every quarter, no later than 60 days following the end of the quarter. The reports include all elements listed in this section of the STC.

48. Annual Report

The State submits the annual report specified in this paragraph in a format that combines the report with the quarterly report referred to in paragraph 47. The State submits the report within 60 days following the last quarter of the calendar year, and no later than 120 days after the close of the year.

49. Title XXI Enrollment Reporting

The State complies with Title XXI enrollment reporting requirements.

50. Quarterly Expenditure Reports

See Section 6 of this Renewal Application, Compliance with the Budget Neutrality Cap.

51. Reporting Expenditures Under the Demonstration

See Section 6 of this Renewal Application, Compliance with the Budget Neutrality Cap.

[4] See Appendix C.

[5] See Appendix C.

52. Reporting Member Months

See Section 6 of this Renewal Application, Compliance with the Budget Neutrality Cap.

53. Standard Medicaid Funding Process

See Section 6 of this Renewal Application, Compliance with the Budget Neutrality Cap.

54. Extent of Federal Financial Participation for the Demonstration

See Section 6 of this Renewal Application, Compliance with the Budget Neutrality Cap.

55. Sources of Non-Federal Share

See Section 6 of this Renewal Application, Compliance with the Budget Neutrality Cap. The State submits certifications of financial matters quarterly through the CMS-64.

56. State Certification of Funding Conditions

See Section 6 of this Renewal Application, Compliance with the Budget Neutrality Cap. The State submits certifications of financial matters quarterly through the CMS-64.

57. Monitoring the Demonstration

The State provides CMS with information requested in order to allow CMS to effectively monitor the Demonstration.

58. Quarterly Expenditure Reports

See Section 6 of this Renewal Application, Compliance with the Budget Neutrality Cap. The State submits certifications of financial matters quarterly through the CMS-64.

59. Claiming Period

See Section 6 of this Renewal Application, Compliance with the Budget Neutrality Cap. The State submits certifications of financial matters quarterly through the CMS-64.

60. Limitation on Title XXI Funding

See Section 6 of this Renewal Application, Compliance with the Budget Neutrality Cap. The State submits certifications of financial matters quarterly through the CMS-64.

61. Limit on Title XIX Funding

See Section 6 of this Renewal Application, Compliance with the Budget Neutrality Cap. The State submits certifications of financial matters quarterly through the CMS-64.

62. Risk

See Section 6 of this Renewal Application, Compliance with the Budget Neutrality Cap. The State submits certifications of financial matters quarterly through the CMS-64.

63. Demonstration Populations Subject to the Budget Neutrality Agreement

See Section 6 of this Renewal Application, Compliance with the Budget Neutrality Cap. The State submits certifications of financial matters quarterly through the CMS-64.

64. Budget Neutrality Expenditure Limit

See Section 6 of this Renewal Application, Compliance with the Budget Neutrality Cap. The State submits certifications of financial matters quarterly through the CMS-64.

65. Enforcement of Budget Neutrality

See Section 6 of this Renewal Application, Compliance with the Budget Neutrality Cap.

66. Exceeding Budget Neutrality

See Section 6 of this Renewal Application, Compliance with the Budget Neutrality Cap.

67. Submission of Draft Evaluation Design

See Section 7 of this Renewal Application, Draft of Evaluation Status and Findings.

68. Evaluation of Health Access Networks

See Section 7 of this Renewal Application, Draft of Evaluation Status and Findings.

69. Interim Evaluation Reports

See Section 7 of this Renewal Application, Draft of Evaluation Status and Findings.

70. Final Evaluation Plan and Implementation

See Section 7 of this Renewal Application, Draft of Evaluation Status and Findings.

71. Cooperation with CMS Evaluators

The State will fully cooperate with any CMS evaluation of the Demonstration.

Waiver and Expenditure Authorities

The State requests the following waiver and expenditure authorities for the 2013-2015 extension period.

Waiver Authorities Applicable to SoonerCare Populations

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

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

Freedom of Choice; Section 1902(a)(23)

To enable the State to restrict beneficiaries' freedom of choice of providers.

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.

Counting Income and Comparability of Eligibility; Section 1902(a)(17)

To permit the State to exclude parental income in determining eligibility for disabled children eligible in the TEFRA category.

Waiver Authorities Applicable to Expansion Demonstration Populations 5, 6, and 8[6]

Comparability; Section 1902(a)(10)(B) and 1902(a)(17)

To permit the State to provide different benefit packages to different populations in the Insure Oklahoma program. Benefits (i.e., amount, duration, and scope) may vary by individual based on eligibility category.

Cost-Sharing Requirements; Section 1902(a)(14) insofar as it incorporates Section 1916

To permit the State to impose premiums, deductibles, cost sharing, and similar charges that exceed the statutory limitations to populations in the Insure Oklahoma program.

Freedom of Choice; Section 1902(a)(23)

To permit the State to restrict the choice of provider for beneficiaries eligible under the Insure Oklahoma program.

Retroactive Eligibility; Section 1902(a)(34)

To enable the State to waive retroactive eligibility for Demonstration participants.

Waiver Authorities Applicable to Expansion Demonstration Population 8

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services; Section 1902(a)(43)

To exempt the State from furnishing or arranging for EPSDT services for full-time college students ages 19 to 22 who have income not to exceed 250 percent of the FPL.

Expenditure Authorities

Demonstration Population 5

Expenditures for expanded coverage for individuals who are "Non-Disabled Low Income Workers" 19-64 years of age who work for a qualifying employer, are self-employed, or unemployed, and have income above the Medicaid standard, but no more than 250 percent of the Federal poverty level (FPL), and their spouses, and who are not Medicaid eligible. This includes foster parents and employees of not-for-profit organizations.

[6] See Appendix B for definitions of Demonstration populations.

Demonstration Population 6

Expenditures for expanded coverage for individuals who are "Working Disabled Adults" 19-64 years of age who work for a qualifying employer, are self-employed, or unemployed (and seeking work), who have income up to 250 percent of the FPL and are not Medicaid eligible. This includes foster parents and employees of not-for-profit organizations.

Demonstration Population 8

Expenditures for expanded coverage for no more than 3,000 individuals at any one time who are full-time college students ages 19 to 22 who have income not to exceed 250 percent of the FPL, who have no creditable health insurance coverage, and are not Medicaid eligible.

Demonstration Expenses 1

Expenditures for Per Member Per Month payments made to the Health Access Networks.

Demonstration Expenses 2

Expenditures for reimbursing out-of-pocket costs in excess of five percent of annual gross income for individuals enrolled in the Premium Assistance Program and in the Individual Plan, in a manner and to the extent defined by the State and approved by CMS.

Demonstration Expenses 3

Expenditures for otherwise non-covered costs related to the Health Management Program.

Evidence of Beneficiary Satisfaction

Oklahoma hires contractors to conduct and analyze member satisfaction surveys: the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and the ECHO® Behavioral Health Survey, both of which are conducted separately for adults and children in alternating years. The most recent ECHO® surveys are the 2010 report for children, which reviews data collected in 2009, and the 2009 report for adults, which reviews data collected in 2008. The most recent CAHPS® surveys are the 2010 report for adults, which reviews data collected in 2009, and the 2011 report for children, which reviews data gathered from January through May of 2011. The 2011 CAHPS® for children is the only study that covers data gathered during the 2010-2012 extension period.[7]

CAHPS®

Both adult and child ratings on all measures have generally improved over the course of the Demonstration, other than slight declines on the child survey in 2011 for care coordination; the percent reporting that it is usually or always easy to get the care, tests, and treatment they think they need; and the percent ranking the health plan 8-10 on a scale of 1 to 10. The percent reporting that they have a personal doctor on the child survey increased from 84.65% in 2009 to 87.10% in 2011. The most substantial increase was in the percent reporting that it is usually or always easy to get appointments with specialists; it rose from 70.95% in 2009 to 81.10% in 2011 on the child survey.

ECHO®

The ECHO® Behavioral Health Survey gives results for two global measures in addition to the individual questions. SoonerCare's scores on those two measures are displayed in Appendix D. Analysts of the survey data found that none of the differences in either the adult or child survey were statistically significant.

Analysts of the Children's ECHO® 2010 Survey found overall that

> Comparing the SFY 2008 survey and the SFY 2010 survey, results indicated relatively high levels of satisfaction holding steady across an array of 21 quality measures. Although the majority of the differences were not statistically significant, many of the quality measures showed slight improvements. These results continue to reflect a positive upward trend occurring in regards to member satisfaction with the behavioral health services for children.

Analysts of the Adult's ECHO® 2009 Survey found overall that

> Comparing the SFY 2007 survey and the SFY 2009 survey, results indicate relatively high levels of satisfaction holding steady across an array of 11 quality measures. One measure showed statistically significant differences between SFY 2007 and SFY 2009. The composite measure "Information about Treatment Options" had a significant increase of members from SFY 2007 to SFY 2009 who indicated they were informed of alternative treatment options.

Insure Oklahoma ESI and IP Member Satisfaction Surveys

The Primary Care Health Policy Division of the University of Oklahoma Department of Family and Preventive Medicine prepared a report on member experience in the Insure Oklahoma ESI and IP programs in 2011.

The OU researchers' primary findings for both ESI and IP were that member satisfaction overall is high for both programs. Their recommendations for ESI include, "costs were the most challenging issue for ESI members"; "employers said they would like more materials available explaining the IO program for employees"; and "[d]ental and vision benefits were requested by ESI members." Primary recommendations for the IP program are that "IP members reported they were least satisfied with the application and renewal process … [s]treamlining the process, especially with regard to renewal, might be investigated"; "[l]ike ESI members, IP members requested access to dental and vision benefits"; and "[s]ome IP members had challenges finding PCPs who accepted their insurance within a reasonable distance from their homes …

[7] See Appendix D for detailed survey results over time.

[o]utreach efforts aimed at attracting physicians to participate as providers for the IP plan could benefit both IP members and the physicians."

PCMH Provider Survey

The Primary Care Health Policy Division of the OU Health Sciences Center also completed a survey and report titled "The Patient-Centered Medical Home Model of Care: A Survey of SoonerCare-Contracted Primary Care Providers" in March 2010. Researchers mailed the survey to all 755 practice locations of providers enrolled as SoonerCare Choice PCPs; the response rate was 20.6%. A detailed summary of survey results is provided in Appendix D.

The Discussion portion of the report notes that

> Visits by the QA Review Teams were very useful. Respondents who were called on and assisted by OHCA QA Review Teams were more likely to feel that OHCA had been helpful and supportive during the transition from the previous reimbursement system to the PCMH tiered system. … Although many of the PCPs responding to this survey agreed that the Patient-Centered Medical Home was the best model of care for their patients, there is still a great deal of work to be done to increase the tier status of SoonerCare PCPs, which in turn increases access, continuity, and coordination of care for patients. Support – financial, technical and personal – will be essential as the PCMH model grows in Oklahoma.

Quality

Quality Initiatives

OHCA recently issued the SFY 2010 report "Minding Our P's and Q's: The OHCA Performance and Quality Report". The report documents quality initiatives, reviews, programs and performance trends. Its findings are summarized here, and the report is available for download from the OHCA website.

Pregnancy Outreach Program

- Outreach letters sent: 16,463
- Return calls generated by letters: 7,194
- Response rate: 43.70%
- Members referred to Care Management for high-risk pregnancy evaluation: 624

Health Management Program

- Number of Tier 1 members who received face-to-face case management: 889
- Number of Tier 2 members who received telephonic case management: 3,824
- Providers who received practice facilitation: 63
- Members served by providers who received facilitation: 85,000
- Savings credited to the program through SFY 2010: $5.2 million

Reducing Disparities at the Practice Site

- Number of practices participating: 10
- Focus population of the program: racially and ethnically diverse members with diabetes
- Provider improvement in performance rates on diabetic measures: aggregate improvement of up to 13%

Provider Profiles

- Child health checkups performed: 1,850 profiles sent to providers
- Cervical cancer screenings received: 749 profiles sent to providers
- Mammograms received: 292 profiles sent to providers
- Ratio of ER visits to office visits: 477 profiles sent to providers

SoonerQuit: Prenatal Tobacco Cessation Initiative

- Number of OB providers who received practice facilitation focused on tobacco cessation: 6

SoonerEnroll Outreach and Enrollment Initiative

- Number of community partners engaged in outreach, enrollment and retention of children: more than 500

Patient Centered Medical Home Provider Reviews

- Visits made to providers to educate on PCMH medical home requirements: 557
- On-site provider reviews performed: 137

PCP Compliance with 24-Hour Access Requirement

- Number of provider contacts made after hours to ensure member access to appropriate services: 1,914
- Percentage of PCPs providing after-hours access: 81%

Dental Audits

- Practices audited: 93
- Total audits performed: 124

Medical Record Review

- Inpatient hospital admission cases randomly selected for retrospective review: 10,429
- Outpatient observation cases randomly selected for retrospective review: 353

Quality Studies and Reports

HEDIS® Measures

Quality Assurance staff are currently reviewing procedures for collection and analysis of HEDIS® measures; as a result, 2010 data are not yet available in a form that can be compared with that of previous years. The table of results from 2001 to 2009 shows that there was no significant decrease on any quality measure, and that the program's performance on 18 measures increased significantly in 2009.

HEDIS Measures[8]	*2001*	*2002*	*2003*	*2004*	*2005*	*2006*	*2007*	*2008*	*2009*
Annual Dental Visit (Combined rate <21 years) (ADV)	41.6%	46.6% ↑	51.2% ↑	53.6% ↑	56.6% ↑	56.3%	57.2% ↑	59.7% ↑	62.1% ↑
Breast Cancer Screening (BCS)	N/A	N/A	29.8%	29.2%	31.9%	33.8%	35.1%	38.3% ↑	43.0% ↑
Cervical Cancer Screening (CCS)	N/A	N/A	32.6%	34.5% ↑	43.5% ↑	↓ 42.0%	43.7% ↑	44.4%	46.6% ↑
Child Health Checkups in first 15 months (1 or more visits) (W15)	87.6%	91.4% ↑	92.6%	91.6%	95.2% ↑	96.5% ↑	96.8%	97.3%*** ↑	97.4%
Child Health Checkups 3-6 yrs (1 or more visits) (W34)	35.3%	40.1% ↑	47.3% ↑	48.6%	54.7% ↑	56.7% ↑	57.1%	60.0%*** ↑	64.9% ↑
Child Health Checkups adolescent (1 or more visits) (AWC)	N/A	N/A	23.7%	23.8%	25.9% ↑	26.4%	28.6% ↑	32.1%*** ↑	40.1% ↑
Children's Access to PCP (CAP) (at least one PCP visit): 12-24 months	88.1%	89.5% ↑	90.8% ↑	91.4%	91.6%	94.3% ↑	94.1%	94.1%	96.2% ↑
Children's Access to PCP (CAP) (at least one PCP visit): 25 months - 6 yrs	74.1%	77.0% ↑	79.3% ↑	↓ 78.2%	78.7%	81.2% ↑	81.4%	83.1% ↑	86.9% ↑
Children's Access to PCP (CAP) (at least one PCP visit): 7-11 yrs	76.7%	79.0% ↑	79.2%	77.3%	81.5% ↑	↓ 80.4%	80.8%	82.7% ↑	87.6% ↑
Children's Access to PCP (CAP) (at least one PCP visit): 12-19 yrs	N/A	N/A	77.4%	77.0%	81.7% ↑	↓ 79.8%	80.1%	81.4% ↑	85.8% ↑
Adult Access to Preventive/Amb Health Services (AAP): 20-44 yrs	68.4%	68.8%	69.8%	71.6% ↑	72.0%	74.9% ↑	75.6%	78.4% ↑	83.3% ↑
Adult Access to Preventive/Amb Health Services (AAP): 45-64 yrs	80.3%	81.5%	81.3%	81.8%	82.8%	84.2% ↑	85.2% ↑	86.8% ↑	89.7% ↑
Comprehensive Diabetes Care (CDC): HbA1C Screening	N/A	N/A	44.4%	49.2% ↑	64.1% ↑	62.0%	63.3%	66.5% ↑	71.3% ↑

[8] * May not be trendable to previous year because of extensive changes in prescription lists used in the measures.
** No valid statistical comparison to previous year because of changes in the measure's technical specifications.
*** Includes data from Indian Health Service.
ASM measure age groupings changed.
Note: SoonerCare Choice 2001-2003; SoonerCare 2004-2005; SoonerCare Choice 2006-2009
Last update: January 24, 2011

HEDIS Measures[8]	*2001*	*2002*	*2003*	*2004*	*2005*	*2006*	*2007*	*2008*	*2009*
CDC: LDL-C Screening	N/A	N/A	34.7%	39.4% ↑	43.9% ↑	55.8%**	55.2%	60.4% ↑	65.7% ↑
CDC: Eye Exam Screening for diabetic retinopathy	N/A	N/A	14.1%	20.7%	27.7% ↑	↓ 25.4%	26.3%	26.9%	30.2% ↑
CDC: Nephropathy Screening (or evidence of nephropathy)	N/A	N/A	40.9%	45.3% ↑	49.9% ↑	79.5%**	78.1%	79.1%	80.3%
Appropriate Medications for Asthma (ASM): 5-9 yrs ***(5-11 yrs CY2009)***	N/A	N/A	72.1%	73.9%	89.8%**	↓ 86.2%	89.7% ↑	90.3%	87.8%****
Appropriate Medications for Asthma (ASM): 10-17 yrs ***(12-50 yrs CY2009)***	N/A	N/A	65.7%	64.2%	82.7%**	83.3%	86.1% ↑	86.7%	76.2%****
Appropriate Medications for Asthma (ASM): 18-56 yrs	N/A	N/A	44.7%	48.6%	63.1%**	59.7%	65.4% ↑	63.5%	NA
Appropriate Treatment for Children with URI (URI)	N/A	N/A	N/A	N/A	N/A	64.3%	66.0% ↑	65.3%	67.2% ↑
Appropriate Testing for Children with Pharyngitis (CWP)	N/A	N/A	N/A	N/A	N/A	N/A	20.9%	20.8%	24.7% ↑
Lead Screening in Children (LSC)	N/A	N/A	N/A	N/A	N/A	N/A	34.4%	38.7% ↑	41.8% ↑
Cholesterol Management for Patients with Cardiovascular Conditions (CMC) (LDL-C screening)	N/A	N/A	N/A	N/A	N/A	35.6%	34.1%	33.7%	40.8% ↑

↑: Significant increase from previous year
↓: Significant decrease from previous year

SoonerCare External Quality Review Organization Report, 2010

SoonerCare's External Quality Review Organization (EQRO) issued the following findings in the major areas of assessment for State Fiscal Year 2010:

Domain	*Finding*
Quality Assessment and Performance Improvement (QAPI) Program	Full Compliance
Enrollee Rights	Full Compliance
Health Services Delivery	Full Compliance
Delegation	Full Compliance

Under domain 1, QAPI program, the EQRO found that

Findings of Quality studies impacted agency policy and procedure decisions.

The agency makes QAPI studies available to the public via its website.

Agency QA/QI staff completed 277 on-site provider reviews in SFY 2009, the dental unit reviewed 118 practices, and the EQRO reviewed thousands of inpatient hospital admissions.

Administrative data is sound, reliable and valid.

SoonerCare meets requirements for a policy-making body that oversees the QA program and for communication and collaboration between the policy-making body and other areas of the organization.

Under domain 2, enrollee rights, the EQRO found that

The agency ensures compliance with laws on enrollees rights with regard to discrimination, confidentiality, right to privacy and accessibility.

SoonerCare ensures that each member has the option to select a PCP who is accepting new members, and monitors member access to their assigned PCPs.

The agency makes information needed to file complaints or grievances or request an appeal or fair hearing readily available to members.

The agency received and investigated 4,289 member complaints in SFY 2009 (representing less than 1% of enrollees).

Under domain 3, health services delivery, the EQRO found that

The agency monitors access to a selection of PCPs; availability of appointment times with specialists; geographic accessibility of PCPs; and availability of PCPs based on hours of operation, timely appointments and after-hours access.

The Patient Advice Line ensures that members have access to medical advice 24 hours a day, seven days a week.

SoonerCare provides each member with a medical home, ensuring enrollment with a PCP whose contract lists responsibilities for coordinating care.

The agency communicates frequently with providers through a variety of media, keeping them updated on member benefits and program procedures.

The agency has processes in place for provider termination; the procedures and appeal process are included in provider contracts.

Under domain 4, delegation, the EQRO found that

The agency only delegates operational functions, not services, to other organizations.

Delegated operations are monitored through reports and audits.

Overall, the EQRO found that the SoonerCare program met standards on all 122 quality measures.

SoonerCare HMP Evaluation, 2010

This evaluation of the SoonerCare Health Management Program (HMP) assessed both OHCA administration of the program and the performance of the HMP vendor, the Iowa Foundation for Medical Care (IFMC). Evaluators concluded that

The SoonerCare HMP completed its second full year of operations with a well-defined structure and processes for conducting nurse care management and practice facilitation/provider education. Participants, both members and providers, are very satisfied with the program and their decision to enroll. Quality-of-care measures and cost indicators are moving in a positive direction. The program demonstrated net savings of $5.2 million across its two components and, if current trend lines continue, should achieve even greater savings in the next year.

Emergency Room Utilization QAPI Study, 2010

The ER utilization study was completed in 2010, reviewing data from State Fiscal Year (SFY) 2009. It focused on provider characteristics to determine whether they contributed to the likelihood that providers were in the top or bottom 15% for high or low ER utilization by members on their panels. The study found that

Pediatricians were less likely to have high risk-adjusted ER utilization than family physicians.

Rural health centers (RHCs), either free-standing or hospital-based, were more likely to have high ER utilization, compared to family physicians.

Providers with higher percentages of Native American members were more likely to have high ER utilization than providers with lower percentages of Native American patients on their panels.

Providers with higher percentages of African American members were more likely to have high ER utilization than providers with lower percentages of African American patients on their panels.

Comprehensive Diabetes Care QAPI Study, 2010

The most recent diabetes quality study was completed in 2010, reviewing data from calendar year 2008. The study analyzes 10 HEDIS® measures of diabetes care services. The study found that comparing results for 2007 and 2008, the nine measures that are comparable showed improvement; of those, three of the changes were statistically significant. It also found that "although the number of Hispanic members was small, Hispanics had the highest compliance rates for six of the 10 measures."

Behavioral Health QAPI Study, 2010

This study analyzes behavioral health data for SFY 2009 to determine frequencies of follow-up care and recidivism/readmission for members under 21 who received inpatient behavioral health services during the study period. The study found that the proportion of members receiving follow-up care within 30 days increased with age. However, after discharge from a Residential Treatment Center (RTC), members aged 18-20 were significantly less likely than all other age groups to receive follow-up services. A higher proportion of members living in urban areas received follow-up care than members living in rural areas (62.7% versus 56.6%).

The results also indicated that "members in the 18 to 20 years age group were significantly more likely to return to inpatient acute care within 30 days of discharge and composed almost half (49.4%) of inpatient acute recidivism… Females (47.1%) were significantly more likely to access follow-up care after a discharge from an acute inpatient behavioral health setting than males (41%)." Members enrolled in Sooner Care Choice were less likely to have an acute readmission within 30 days than members enrolled in fee-for-service Title XIX coverage.

Breast and Cervical Cancer QAPI Study, SFY 2009

The most recent QAPI study of the Breast and Cervical Cancer program (Oklahoma Cares) was completed in 2009, reviewing data from the period July 1, 2007 to June 30, 2008. The study examines paid claims, and finds that "BCC members are receiving the types of treatment for cancer listed by the CDC."

Early Preterm Birth Outcomes QAPI Study, 2009

The most recent QAPI study of early preterm birth outcomes was completed in 2009, reviewing data for CY 2007. Findings are based on delivery records for 33 infants born to 29 mothers in 4 hospitals; because of the low response rate to the 140 requests for records, the results are not generalizable. Case studies indicated that "appropriate prophylactic and reactive procedures were used for these babies."

Child Health Checkups QAPI Study, 2009

Other than regular annual reports of HEDIS® results for Choice members, the most recent study of utilization of child health checkups was completed in 2009, reviewing data for CY 2007. The study covered well-child visits, or Early and Periodic Screening, Diagnosis and Treatment (EPSDT) visits, for four age groups: 0 to 15 months, 3 to 6 years, 7 to 11 years and 12 to 21 years. The expectation incorporated in the study is that children 0 to 15 months should have six visits in the study period, and members aged 3 to 21 should have one visit in the period.

The study found that SoonerCare child health checkup rates were lower than the national Medicaid means for all age groups for the same time period, and that the difference was statistically significant. It also found that SoonerCare rates for members aged 0 to 15 months having at least 1, 2 or 3 visits were consistent with the national Medicaid mean, whereas those having 4, 5 or 6 visits were lower than the national Medicaid mean by a statistically significant margin.

Compliance with the Budget Neutrality Cap

As of June 2011, the State has $2.2 billion in savings over the life of the Demonstration. Actuarial analysis of the Demonstration, including the amendment requested with this extension, projects that the State will maintain compliance with the budget neutrality cap through 2015. It is projected that the State will have $3.2 billion in savings by the end of 2015.

This section contains updated enrollment and expenditure projections for the SoonerCare program through the upcoming 2013 - 2015 extension period. The exhibits[9] incorporate full-year enrollment and expenditure data through calendar year 2010 (demonstration year 15). Data for 2011 is annualized based on actual enrollment and expenditures for the first nine months of the year.

Projections for 2012 – 2015 are based on Medicaid Eligibility Group (MEG) specific assumptions, as described in detail throughout the section. These include adjustments for the expected impact of the 2014 Medicaid expansion on the TANF, Insure Oklahoma and College Student MEGs.

Budget Neutrality Data for Individual MEGs

The SoonerCare program includes four traditional MEGs that, in combination, provide the "without waiver" expenditure estimates for calculation of the budget neutrality cap. They are TANF-Urban, TANF-Rural, ABD-Urban and ABD-Rural.

The "with waiver" expenditure estimates include three expansion populations: Insure Oklahoma Low Income Workers and Spouses ("Insure Oklahoma"), TEFRA Children and College Students. State and Federal expenditures for these MEGs are funded with waiver savings.

Traditional MEGs

Budget neutrality exhibits for the four traditional MEGs are presented in the Appendix. Each exhibit includes enrollment, expenditure and budget neutrality data. Expenditures consist of both paid claims and non-claim medical expenses.

The exhibits include actual enrollment and expenditure data through calendar year 2010. Calendar year 2011 enrollment and expenditures are estimated by annualizing actual data for the first nine months of the year.

Calendar year 2012 – 2015 member months for each MEG are projected based on the historical member month growth trend, as shown in exhibit 1 in Appendix E, with a one-time adjustment to the TANF-Urban and TANF-Rural MEGs to account for the expected impact of the Affordable Care Act (ACA) Medicaid expansion.

The State is not at present requesting that persons newly eligible for Medicaid under ACA be added to the waiver, so that adult population is not included in the budget neutrality analysis. However, the OHCA estimates that approximately 50,000 persons eligible but not enrolled under current rules will enroll in 2014 as the result of ACA-related outreach. The 2014 TANF-Urban and TANF-Rural member months have been adjusted to include these new member months (prorated between the two MEGs based on 2011 enrollment).

Calendar year 2012 – 2015 per member per month (PMPM) expenditures are trended forward using the currently approved waiver trend factors of 5.13 percent for the TANF MEGs and 5.20 percent for the ABD MEGs, as shown in exhibit 2 in the Appendix.

[9] See Appendix E for the budget neutrality exhibits, including historical and projected data.

Budget neutrality data for the traditional MEGs is presented in exhibits 3 – 6. Exhibit 3 (TANF-Urban MEG) includes data for the nominal $5.00 PMPM Health Access Network (HAN) payments within the Actual/Projected expenditure amounts[10].

Expansion MEGs

Budget neutrality data for the three expansion populations is presented in exhibits 7 – 9. Member month and expenditure data has been prepared using the same methodology as for the traditional MEGs, subject to the adjustments described below.

The Insure Oklahoma and College Student MEGs have been adjusted to account for the expected impact of the ACA Medicaid expansion in 2014. The average FPL of Insure Oklahoma members is approximately 135 percent, or nearly equal to the ACA eligibility threshold. The Insure Oklahoma and College Student MEGs have been reduced by 50 percent in 2014 on the assumption that this portion of the membership will become eligible for Medicaid.

The Insure Oklahoma MEG has also been adjusted to account for a proposed benefit change. The OHCA is proposing to set Insure Oklahoma adult Individual Plan benefits for behavioral health outpatient visits at a maximum of 48 per year, to align with the benefit for children enrolled in the program. The estimated impact of the change in 2012, based on annualized and trended 2011 data, is ($99,692). Projected expenditures in 2012 and beyond have been adjusted to account for the proposed change.

All MEGs

Exhibit 10 provides updated aggregate budget neutrality projections through calendar year 2015. As the exhibit illustrates, the SoonerCare demonstration is projected to continue generating savings throughout the remainder of the current waiver period and during the three-year extension.

Standard CMS Financial Management Questions

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

1. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, DRG, DSH, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other), including the Federal and non-Federal share (NFS)?

   Answer: Yes, SoonerCare providers retain 100% of the payments.

   a. Do any providers (including managed care organizations [MCOs], prepaid inpatient health plans [PIHPs] and prepaid ambulatory health plans [PAHPs]) participate in such activities as intergovernmental transfers (IGTs) or certified public expenditure (CPE) payments, or is any portion of any payment returned to the State, local governmental entity, or any other intermediary organization?

      Answer: Yes, some providers participate in IGTs. Nothing is returned to the state.

   b. If providers are required to return any portion of any payment, 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: N/A

[10] HAN $5.00 PMPM payments in 2010 totaled $745,520. HAN $5.00 PMPM payments in 2011 are estimated to be $1,823,225, based on nine months of actual data. HAN PMPM payments in 2012 - 2015 are included in the total projected expenditure amounts and trended at the same annual rate as other TANF-Urban expenditures.

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

    a. Please describe how the NFS of each type of Medicaid payment (normal per diem, DRG, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other) is funded.

    Answer: The NFS of the medical home care coordination payments and HAN payments are funded from appropriations from the legislature to the Medicaid agency. The NFS for Insure OK is funded by tobacco tax. The NSF payments to Academic medical centers are funded through IGTs from appropriations from the legislature.

    b. Please describe whether the NFS comes from appropriations from the legislature to the Medicaid agency, through IGT agreements, CPEs, provider taxes, or any other mechanism used by the State to provide NFS. 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: Appropriations from the legislature to the Medicaid agency and through IGTs from: OU and OSU Medical Schools and the Physician Manpower Training Commission for the GME Payments.

    c. Please provide an estimate of total expenditures and NFS amounts for each type of Medicaid payment.

Type	*Total*	*NFS*
Care Coordination fees & SoonerExcel Payments*	$28,887,142	$10,357,485
HAN Payments*	$3,300,000	$1,183,215
GME Payments*	$62,729,093	$22,491,516

*The above are annual estimates based on the SFY 2012 Budget.

    d. If any of the NFS 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.

    e. 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 is in accordance with 42 CFR 433.51(b).

    Answer: N/A

    f. For any payment funded by CPEs or IGTs, please provide the following: a complete list of the names of entities transferring or certifying funds; the operational nature of the entity (state, county, city, other); the total amounts transferred or certified by each entity; clarify whether the certifying or transferring entity has general taxing authority; and whether the certifying or transferring entity received appropriations (identify level of appropriations).

        - OU and OSU Medical schools and the Physician Manpower Training Commission
        - State Medical schools and State Commission
        - $22,491,516
        - No general taxing authority
        - 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 = $4,500,000 (Budgeted Amount, Annual Average payment for last two years of $3.6 million)

a. Please provide a detailed description of the methodology used by the State to estimate the upper payment limit for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated).

   Answer: These hospital classes are not applicable for this amendment.

b. Does any governmental provider or contractor receive payments (normal per diem, DRG, fee schedule, global payments, supplemental payments, enhanced payments, other) that, in the aggregate, exceed its reasonable costs of providing services?

   Answer: No

c. In the case of MCOs, PIHPs, PAHPs, are there any actual or potential payments which supplement or otherwise exceed the amount certified as actuarially sound as required under 42 CFR 438.6(c)? (These payments could be for such things as incentive arrangements with contractors, risk sharing mechanisms such as stop-loss limits or risk corridors, or direct payments to providers such as DSH hospitals, academic medical centers, or FQHCs.)

   Answer: No

d. If so, how do these arrangements comply with the limits on payments in §438.6(c)(5) and §438.60 of the regulations?

   Answer: N/A

e. If payments exceed the cost of services (as defined above), does the State recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?
   Answer: N/A

Draft of Evaluation Status and Findings

Summary of Evaluation Results to Date

Table 0.1: Hypotheses and Current Findings

Hypothesis	*Do current outcomes of the Demonstration confirm the hypothesis?*
1. Access to primary care: rates will be maintained and/or improved for well-child and adolescent visits	Unknown; data is not yet available
2. Access to primary care providers: percentage of children and adults with at least one visit to a PCP will increase by 4 percentage points from 2010 to 2012	Unknown; data is not yet available
3. Access to dental care: the percentage of members aged 3 to 21 with at least one visit to a dentist will increase	Unknown; data is not yet available
4.A.1 The number of Choice PCPs will be maintained or will increase	Yes
4.A.2 The capacity of Choice PCPs will be maintained or will increase	No
4.B.1 The proportion of IHS members whose PCP is an I/T/U provider will increase	No
4.B.2 I/T/U provider capacity will be maintained	No
4.C Members will continue to have access to age-appropriate PCPs within 45 miles/minutes	Yes
5. Implementation of HANs will allow the OHCA Care Management Unit to identify an additional population to enroll in agency care management	Yes
6. At least 500 children will be enrolled in the Title XXI State Plan for stand-alone CHIP children	Yes
7.A The HAN will improve member access to all levels of care	Unknown; data is not yet available
7.B The HAN will enhance the quality and coordination of services	Unknown; data is not yet available
7.C The HAN will reduce inappropriate utilization and costs	Unknown; data is not yet available
7.D The HAN will increase the number of participating PCPs using electronic medical record systems	No, because all PCPs who joined already had EMRs

Hypothesis One

This hypothesis posits that the number of members who have regular visits with their primary care providers is a measure of how much access members have to primary care. One of the objectives of the medical home model of primary care delivery is improvement of access to regular primary care. The

measure predicts that as a result of the waiver, rates will be maintained and/or improved for well-child and adolescent visits over the duration of the waiver extension period (2010-2012).

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

HEDIS® data are not yet available for 2010. The medical home model was implemented in January 2009, however, so initial effects of the waiver's primary care model can be seen in 2009 data.

Table 1. 1: Percentage of Child and Adolescent Members with at least One Checkup Per Year

Age cohort	*2001*	*2002*	*2003*	*2004*	*2005*	*2006*	*2007*	*2008*	*2009*
0-15 months	87.6%	91.4%	92.6%	91.6%	95.2%	96.5%	96.8%	97.3%	97.4%
3-6 years	35.3%	40.1%	47.3%	48.6%	54.7%	56.7%	57.1%	60.0%	64.9%
12-19 years	N/A	N/A	23.7%	23.8%	25.9%	26.4%	28.6%	32.1%	40.1%

This hypothesis specifies that checkup rates for children aged 0 to 15 months will be maintained at or above 95%. The rate reached 95% in 2005, and has increased yearly since then. The slight increase in 2009 is not statistically significant.

The checkup rate for children aged 3 to 6 years is to increase by 4 percentage points over the extension period, 2010-2012, which would be an average of 1.33 percentage points per year. Data for the extension period is not yet available. The rate increased by at least 4 percentage points in 2002, 2003, 2005, and 2009. The increase in the rate was statistically significant in 2002, 2003, 2005, 2006, 2008 and 2009. The average yearly increase from 2002 to 2009 is 3.7%. If the average from 2002 to 2009 is maintained over the extension period, the total increase from 2010 to 2012 would be 11.1%, well over the hypothesized amount.

The evaluation measures hypothesize that the checkup rate for adolescents will also increase by 4 percentage points over the period from 2010 to 2012, which is an average of 1.33 percentage points per year. Data for the adolescent rate is only available from 2003 to 2009. Increases were statistically significant in 2005, 2007, 2008 and 2009. The rate only increased by more than 4 percentage points in 2009, when it increased by 8 percentage points. The average yearly increase before the implementation of medical homes in 2009 was 1.68 per year, which would be 5.04 over a 3-year period. The average including 2009 is 2.73, which would be 8.2 points over a 3-year period.

The total number of children and adolescents whose visit rates are included in this analysis (the number who had maximum one break in eligibility of no more than 45 days during the year) for 2009 is 193,269; for 2008, it is 172,199. Compare those totals with the total unduplicated number of children enrolled for the state fiscal year, given in the OHCA Annual Report (although this total includes infants): 519,880 for SFY 2008, 531,410 for SFY 2009, and 561,974 for SFY 2010.

Although data for the extension period 2010-2012 is not yet available, analysis of the data from 2001 to 2009 shows that, in the absence of a significant negative effect on access to primary care, child and adolescent checkup rates should meet the terms specified in the hypothesis.

Hypothesis Two

This hypothesis postulates that children's and adolescents' rate of access to primary care providers will increase by 4 percentage points over the life of the extension, and that adults' rate of access to preventive/ambulatory health care services will increase by 4 percentage points over the life of the

extension, 2010-2012. Access is determined in accordance with HEDIS® guidelines: a member with at least one paid claim or encounter with a primary care provider in a 12-month period is determined to have access to primary care. Only members who were enrolled for 11 or 12 months of the data year who did not have gaps in enrollment of more than 45 days during the year are included in the population for whom the access rate is determined. The adult rate excludes claims for inpatient procedures, hospitalizations, emergency room visits and visits primarily related to mental health and/or chemical dependency.

Table 2.1: Percentage of Children and Adults with at least One Primary Care Visit

Age cohort	*2001*	*2002*	*2003*	*2004*	*2005*	*2006*	*2007*	*2008*	*2009*
12-24 months	88.1%	89.5%	90.8%	91.4%	91.6%	94.3%	94.1%	94.1%	96.2%
25 months-6 years	74.1%	77.0%	79.3%	78.2%	78.7%	81.2%	81.4%	83.1%	86.9%
7-11 years	76.7%	79.0%	79.2%	77.3%	81.5%	80.4%	80.8%	82.7%	87.6%
12-19 years	N/A	N/A	77.4%	77.0%	81.7%	79.8%	80.1%	81.4%	85.8%
20-44 years	68.4%	68.8%	69.8%	71.6%	72.0%	74.9%	75.6%	78.4%	83.3%
45-64 years	80.3%	81.5%	81.3%	81.8%	82.8%	84.2%	85.2%	86.8%	89.7%

All increases in access rates for all age cohorts in 2009 were statistically significant.

Table 2.2 Average yearly percentage point increase by age cohort

	12-24 months	*25 months-6 years*	*7-11 years*	*12-19 years*	*20-44 years*	*45-64 years*
Avg yearly percentage increase 2002-2008	0.86%	1.29%	0.86%	0.80%	1.43%	0.93%
Avg yearly percentage increase 2002-2009	1.01%	1.60%	1.36%	1.40%	1.86%	1.18%

The average yearly increase from 2010 to 2012 called for in the evaluation hypothesis is 1.33%. Only the age cohort of 20-44 years met that average increase for the period from 2002-2008. When the increases in access rates in 2009 are included in the average, children 7-11 years old, adolescents 12-19 years old and adults 20-44 years old all met the average increase in access rates. If those averages, weighted toward the 2009 increases, continue in the 2010 to 2012 extension period, the second hypothesis criteria will be met.

Hypothesis Three

This hypothesis postulates that the dental visit rate of members ages 3 to 21 will continue to improve over the extension period 2010-2012. The member population included is those members who were enrolled in SoonerCare Choice for 11 out of 12 months of the year with no more than one gap in enrollment of up to 45 days. Whether the member had at least one dental visit during the year is determined according to HEDIS® guidelines using paid claims and encounters. The baseline comparison is the 2009 dental visit rate. Given that none of the HEDIS® measures are available for 2010, it is not yet possible to report on the first year of the Demonstration extension.

Table 3.1: Percentage of Members Ages 3-21 with at least One Dental Visit

	2001	*2002*	*2003*	*2004*	*2005*	*2006*	*2007*	*2008*	*2009*
Percentage	41.6%	46.6%	51.2%	53.6%	56.6%	56.3%	57.2%	59.7%	62.1%

Dental visit rates increased every year from 2001 to 2009 except for 2006, when a 0.3% decrease was recorded. The increase was statistically significant in 2002, 2003, 2004, 2005, 2007, 2008 and 2009. Provided that program or external factors for years 2010-2012 do not adversely affect members' access to dental care, this pattern is likely to continue, meeting the criteria of the hypothesis.

Hypothesis Four

This hypothesis postulates that the number of primary care providers enrolled as SoonerCare Choice PCPs and their available capacity will equal or exceed the number and capacity of Choice PCPs recorded when the medical home model was implemented in January 2009 over the duration of the extension period from 2010 to 2012. It also specifies that the proportion of SoonerCare IHS members whose PCP is an Indian Health Service/Tribal/Urban Indian Clinic (I/T/U) will increase, and I/T/U provider capacity will be maintained over the life of the waiver extension period. It further postulates that members will continue to have access to age-appropriate PCPs within the waiver-mandated travel time/distance radius of 45 miles or 45 minutes during the 2010-2012 extension period.

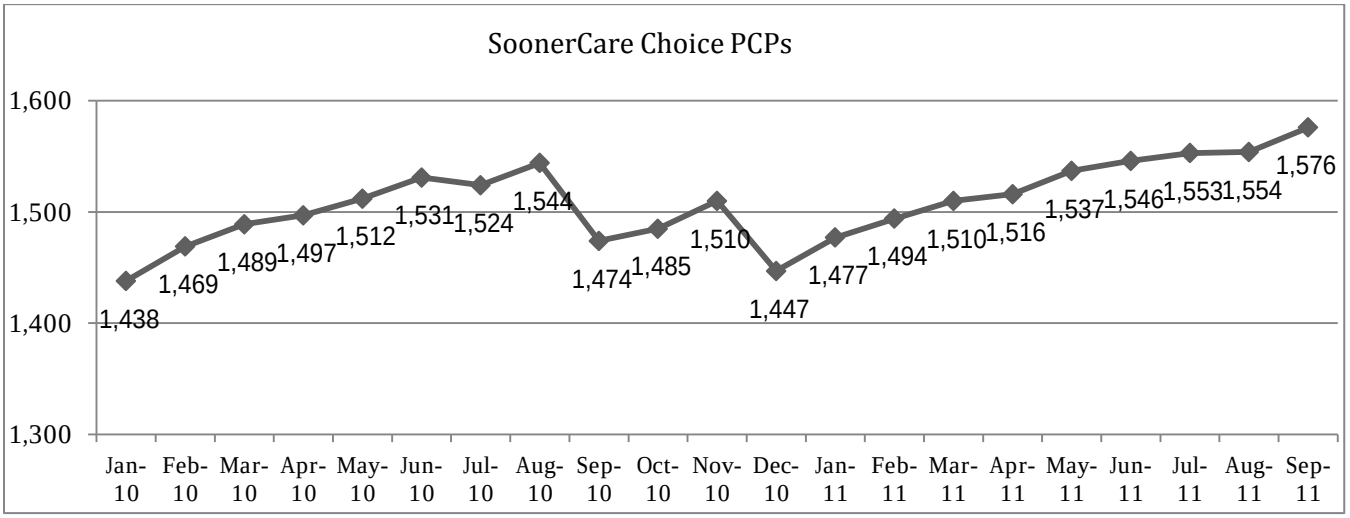
Table 4.1 Comparison of Baseline and Current PCP Capacities

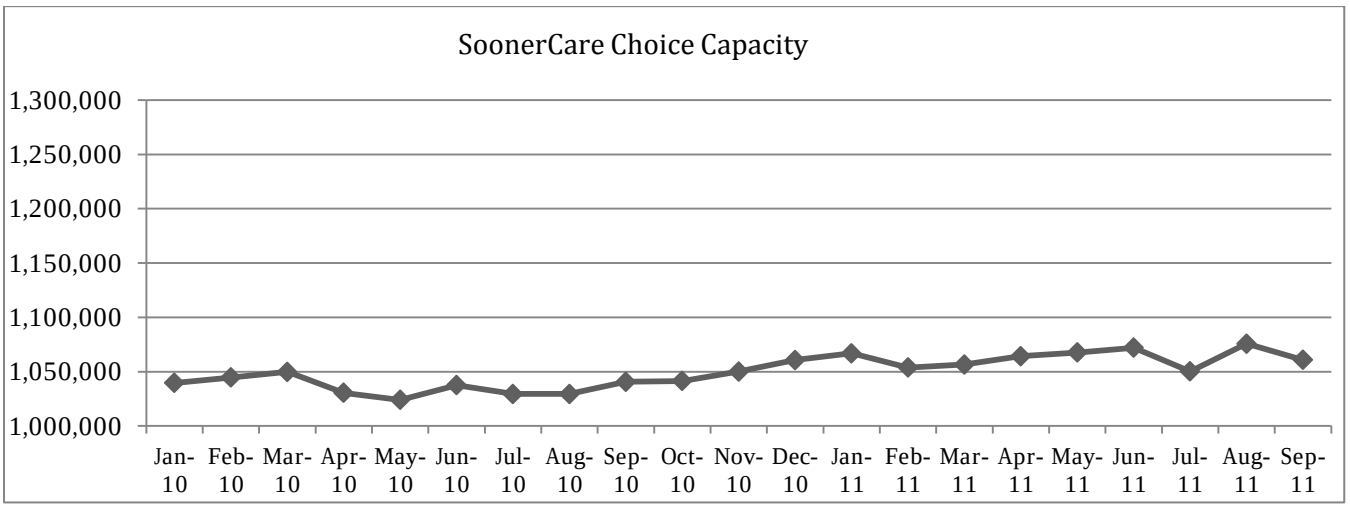
Hypothesis Measure	*Baseline data*	*September 2011 data*
Number of Choice PCPs enrolled	1,409	1,576
Capacity of Choice PCPs	1,373,058	1,060,883
Average number of members per PCP	289.15	283.18
Proportion of IHS members with I/T/U PCP	20.48%	19.43%
I/T/U Provider Capacity	116,150	113,150
Percentage of Members with a PCP within 45 miles/minutes	100%	100%

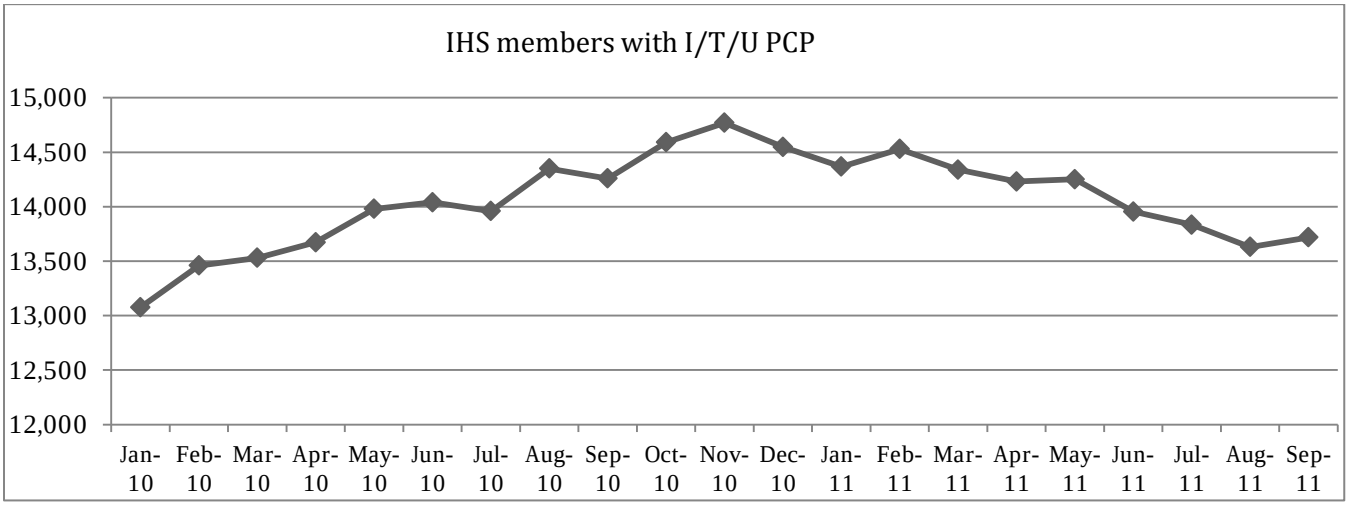
The number of Choice PCPs enrolled has increased by 167 providers. The PCP capacity, however, decreased by a quarter of a million lives the month the medical home model was implemented, to 1,113,577 in January 2009, and has not recovered. Capacity after implementation decreased further to 1,039,583 at the beginning of the extension period, January 2010, and has since increased slightly over the last year and a half, although it has yet to recover to January 2009 levels. PCP declared capacity is currently 312,175 lives under the capacity recorded in December 2008. Although capacity has decreased, the percentage of capacity used is only 40.45% in September 2011. Additionally, the average number of members per PCP has decreased by 2% from the December 2008 baseline.

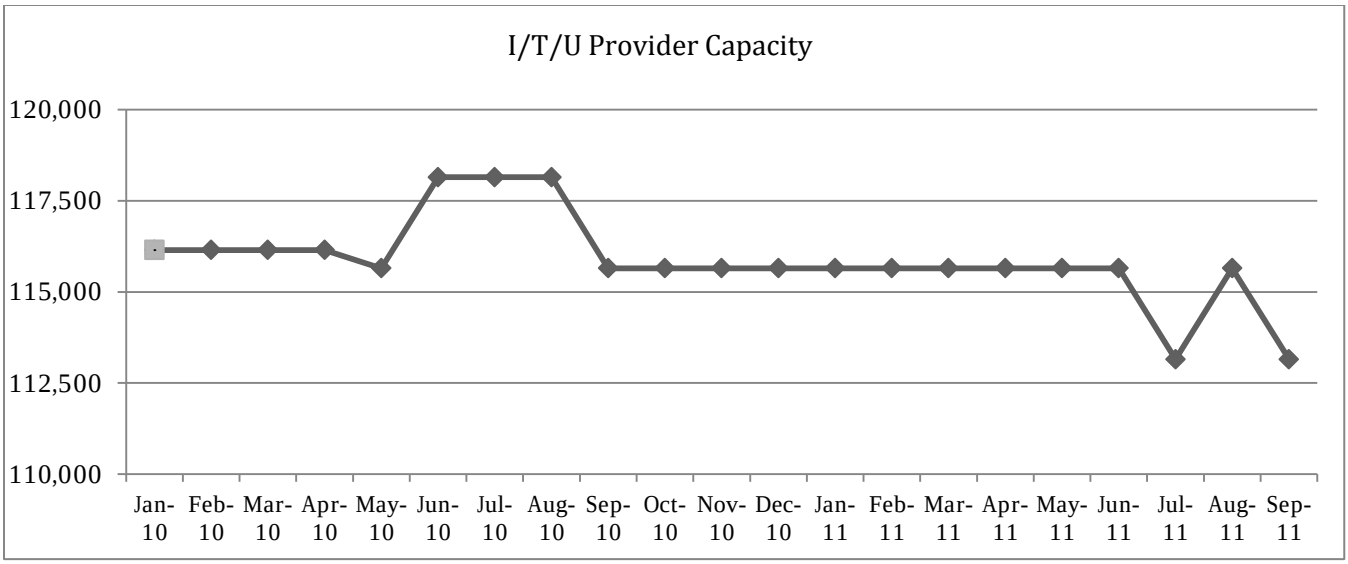
Although SoonerCare Choice continues to attract primary care providers, the PCPs enrolled are accepting fewer SoonerCare patients on their panels than they were before the implementation of the patient-centered medical home model of service delivery. Overall, the available capacity of primary care providers has declined since 2008, so the outcomes of the Demonstration do not meet expectations for this hypothesis. It is worth noting, however, that the nominal decrease in capacity does not appear to have negatively impacted member access to primary or preventive care. Program staff have reason to believe that prior to implementation of the medical home model in January 2009, PCPs were declaring a larger capacity than they could reasonably serve. For that reason, the agency does not consider the results of this hypothesis, when weighed against other program performance measures, to be reason for concern.

The proportion of IHS members with an I/T/U PCP has decreased slightly, by 1.05 percentage points. I/T/U provider capacity has decreased by 3,000 lives over the first 21 months of the Demonstration extension period.



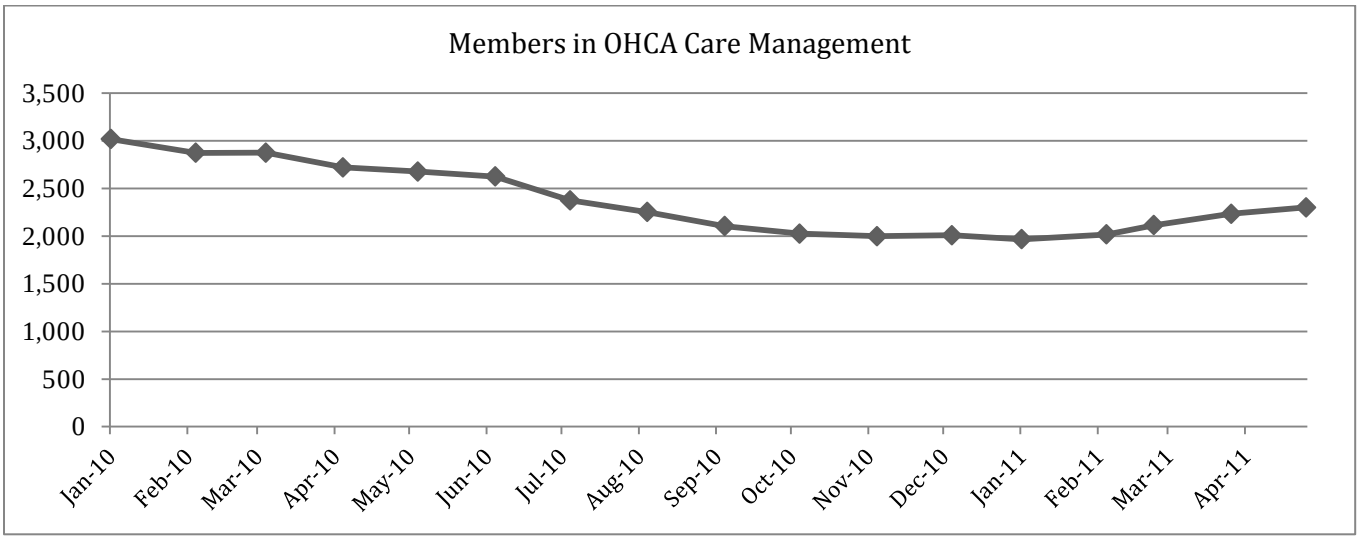






Hypothesis Five

This hypothesis predicts that as members transition to the Health Access Network(s) (HAN) for care management, the OHCA Care Management Unit will be able to identify new populations to receive care management services through the agency. At present, only one HAN, the OU Sooner HAN out of Tulsa, has been operating for long enough to collect meaningful data. The hypothesis does not specify numbers or proportions of members, but notes that the agency will track the number of Choice members under active care management, the rate per 1,000 of Choice members under active care management, the number of members transitioned to HAN care management, and the identification and introduction of a new population to be enrolled in OHCA care management.



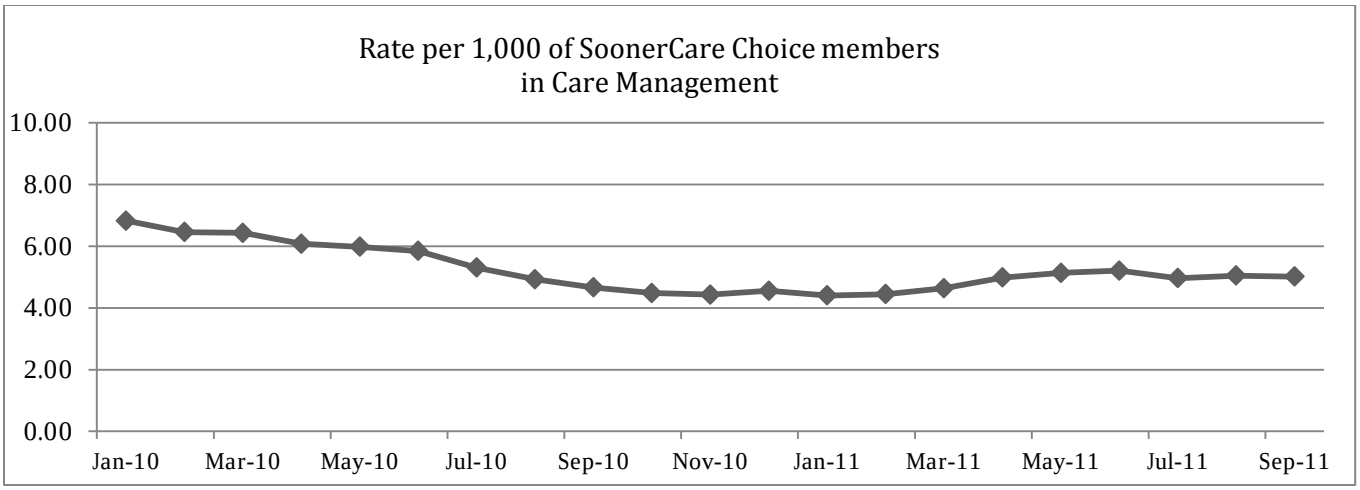


Table 5.3 Populations Transitioned to OU Sooner HAN Care Management

Populations Transitioned	*Oct-Dec 2010*	*Jan-Mar 2011*	*Apr-June 2011*	*July–Sept 2011*	*Total Transitioned*
High Risk OB	23	25	28	38	114
Hemophilia	7	1	0	0	8
ER Utilization[11]	222	170	251	318	961
Pharmacy Lock-in[12]	39	15	19	8	81
OK Cares (BCC)	19	12	10	15	56
Total	310	223	308	379	1,220

Two new populations have been identified to be enrolled in OHCA Care Management: infants receiving Synagis therapy and pregnant women who live in the ten rural counties with the highest fetal infant mortality rates (FIMR).

Hypothesis Six

This hypothesis predicts that at least 500 children will be enrolled in the Title XXI CHIP Stand-Alone (186-200% FPL) eligibility group over the duration of the extension period, 2010-2012. As of September 2011, that goal has been exceeded with 565 children enrolled.

Hypothesis Seven

This hypothesis postulates that the HAN pilot program will improve access to care for members, quality and coordination of health care and use of electronic medical record systems (EMR) for participating providers. The Partnership for a Healthy Canadian County and Oklahoma State University (OSU) HANs began enrolling members in July and September, 2011, respectively; data is not yet available to measure their performance. The measures used as indicators of success in these areas include the number and type of specialty providers participating, the number of PCPs participating by tier, the time that elapses between a PCP referral and a specialty transaction within the network, clinical measures for quality improvement and coordination (from MEDai profiles), costs for each HAN given by MEDai profiles and MMIS paid warrants, and the number of HAN PCPs adding EMR capabilities. At present, sufficient data for most measures are only available for the OU Sooner HAN. Data for assessment of quality of care and cost avoidance measures are not yet available.

[11] This is the number of outreach letters the HAN has sent; not all of the members respond or are engaged in active care management. These members are also co-managed by OHCA.

[12] These members are currently care managed by their PCPs in place of the HAN.

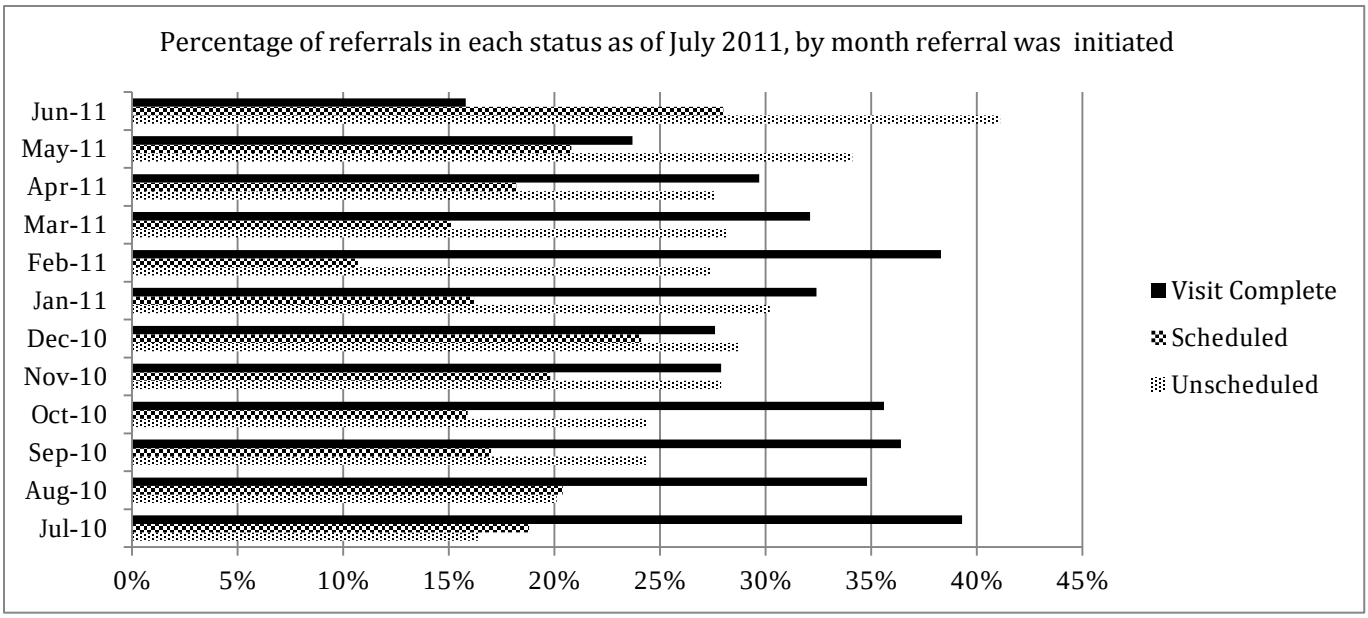
Provider Participation

OU Sooner HAN	*As of July, 2010*	*As of Feb, 2011*	*As of Aug, 2011*
PCPs	4	9	12
Members Enrolled	24,967	28,085	31,365
Specialists	N/A	N/A	689

Medical Home / PCP Participation by Tier (as of August 2011; no PCPs have changed tiers since they began participating in the HAN)

Tier 1	3
Tier 2	2
Tier 3	4
FQHC (no other tier)	3

Care Coordination: Referrals to Specialists



These data begin with the month the OU Sooner HAN was initiated; as a result, there is no baseline for the participating PCPs to use to establish a difference in time-to-visit-completion as a result of enrollment in the HAN. The more detailed status for referrals initiated in July 2010 after one year can be compared with the status of referrals initiated in December 2010 after 6 months:

Referral Status	*1 year status (initiated July 2010): number*	*1 year status: percentage*	*6 month status (initiated Dec 2010): number*	*6 month status: percentage*
Pending appointment	322	16.4%	449	28.7%
Scheduled	369	18.8%	377	24.1%
Consult in Progress	6	0.3%	4	0.3%
Visit Occurred: Report Pending	47	2.4%	68	4.3%

Referral Status	*1 year status (initiated July 2010): number*	*1 year status: percentage*	*6 month status (initiated Dec 2010): number*	*6 month status: percentage*
Visit Occurred: Complete	770	39.3%	432	27.6%
Cancelled	446	22.8%	236	15.1%
Total	1,960	100%	1,566	100%

EMR Capabilities

All PCPs participating in the OU Sooner HAN had already implemented Electronic Medical Records at the time of their enrollment in the HAN.

Quality of Care and Cost Avoidance

Data is not yet available for this performance measure.

Plans for Evaluation Activities 2013 – 2015

The State plans to continue its focus on access to and quality of care provided under the Demonstration in its selection of program evaluation measures and hypotheses for the extension period. Agency staff housed in the Waiver Development and Reporting unit are responsible for evaluating the Demonstration program through analysis of administrative data provided by various units within the agency. In the interest of conserving state resources, the agency does not at present plan to undertake an evaluation that would involve scientific methods or surveys, other than consideration of such studies conducted by the agency for other purposes. In developing these evaluation measures, the State is mindful of recommendations listed in recent Proposed Rules issued by CMS on waiver transparency and access measures in relation to changes in provider rates. Where possible, the State will aim to streamline data collection and analysis activities to meet various reporting and evaluation requirements. The evaluation measures listed below may change, therefore, depending on the final rules.

Hypothesis 1: Child Health Checkup Rates

Providing access to primary and preventive care is one of the primary functions of the Demonstration program. If the administrative structure, medical home incentives and outreach initiatives function as expected, rates for well-child and adolescent visits should be maintained or improved over the extension period 2013-2015.

Hypothesis 2: PCP Visits

In addition to tracking well-child visits in the first hypothesis, the agency tracks the rate of members who have one or more visits with a primary care provider in a year as a measure of access to primary care in accordance with HEDIS® guidelines. The rates are grouped by age cohort: 12 to 24 months, 25 months to 6 years, 7 to 11 years, 12 to 19 years, 20 to 44 years and 45 to 64 years.

Hypothesis 3: Dental Visits

Dental visit rates should also improve for members aged 3 to 21.

Hypothesis 4: PCP Enrollments

SoonerCare Choice is designed to provide incentives to primary care practitioners that encourage them to enroll as medical home PCPs; if the program functions as designed, the number of PCPs enrolled should increase.

Hypothesis 5: PCP Capacity Available

In order for members to have adequate access to PCPs, the primary care providers enrolled as Choice medical homes must be willing to accept adequate numbers of SoonerCare members. If the Demonstration performs well in this area, the percentage of PCPs' declared SoonerCare capacity that remains available to members should not decrease significantly.

Hypothesis 6: Integration of I/T/U Providers

As I/T/U providers continue to be better integrated into the medical home model, it is reasonable to expect that the percentage of Native American members who are enrolled with an I/T/U PCP will increase.

Hypothesis 7: Eligible Member Enrollments in Medical Homes

A *sine qua non* of the program is that members need to be enrolled with a PCP in order to access services through the medical home delivery model. If the Demonstration performs as designed, the number of members eligible for enrollment in Choice who are not enrolled with a PCP should decrease.

Hypothesis 8: Access to Care Call Volumes

This hypothesis looks at two types of call volumes. One is calls to OHCA's Patient Advice Line, which is staffed by nurses and offers medical advice after hours. The other is calls to the SoonerCare Helpline that indicate that a member is having difficulty getting access to primary or specialty care and has called OHCA for assistance.

Given that Choice PCPs are required to offer 24/7 access to care, it is reasonable to expect that the number of calls to the Patient Advice Line, controlling for differences in enrollment numbers, should decrease with time, provided that PCPs are offering access to care that effectively replaces that offered by the Patient Advice Line.

As the medical home model develops in primary care offices across the state, provided the SoonerCare network of PCPs and specialists remains strong, member calls for assistance with matters like getting an appointment within the timeframe perceived necessary by the member should decrease.

Hypothesis 9: Continuity of Care

While it is important that members be able to move between providers to find the most suitable medical home, the medical home model also presumes that continuity of care can best be achieved with continuity of the relationship with one's PCP. Long-term stability of enrollment on a doctor's panel also suggests that the member is satisfied with care received in the medical home. As the medical home model develops and matures, the number of members enrolled with more than one PCP during a month should decrease.

Hypothesis 10: Impact of Health Access Networks on Quality of Care

As the HANs in operation continue to develop, their impact on the quality of care received by members enrolled with participating PCPs should increase. Provider profiles that capture key quality performance measures can be tracked for PCPs participating in the HAN, and should indicate improvement over the Demonstration extension period. The number of HAN-affiliated PCPs using Electronic Medical Records in their practices should also increase.

Hypothesis 11: Impact of Health Access Networks on Effectiveness of Care

A key assumption underlying the HAN model is that better networks and better coordination and management of care lead to reduced medical expenses. As the HANs continue their operations, expenditures per member per month for members enrolled with PCPs participating in the HAN should decrease.

Documentation of Compliance with Public Notice Requirements

In compliance with public notice requirements, OHCA has provided meaningful notice of the state's intent to renew the SoonerCare Demonstration to the Native American Tribes and to the general public. The notice included explanation of the amendment the State is requesting be made to the Demonstration.

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.

- OHCA published an announcement in the five major newspapers in the state (*The Daily Oklahoman* on Nov 23, 2011; the *Tulsa World* on Nov 23, 2011; the *Norman Transcript* on Nov 23, 2011; the *Lawton Constitution* on Nov 23, 2011; and the *Broken Arrow Ledger* on Nov 25, 2011), directing interested parties to consult the application online or to request it from OHCA.
- OHCA posted the draft of the renewal application on the agency's public website, www.okhca.org. A prominent scrolling banner at the top of the home page provided a link to the page where visitors can download the application document and submit comments to the agency electronically.
- OHCA sent notice of the renewal to the tribes on October 15, 2011, and discussed the renewal application with the tribes at the Tribal Consultation Meeting held at OHCA on November 1, 2011.
- OHCA discussed the renewal at two public hearings: at a meeting of the Medical Advisory Committee on November 16, 2011 and at a meeting of the Board of the OHCA on December 8, 2011. Both meetings' times and locations are published beforehand in accordance with Oklahoma's Open Meeting Act.

Comments Received

At the Tribal Consultation Meeting on November 1, 2011, a representative of the Chickasaw Nation commented that she would appreciate more information on the medical home model. A representative of the Kickapoo Nation concurred that more educational material would be helpful. The representative of the Chickasaw Nation also noted, regarding Demonstration evaluation results, that the percentage of Native American members enrolled with an I/T/U PCP (about 20%) sounded low to her; she said that the agency might want to work on improving outreach to Native American members. Dana Miller, OHCA Director of Indian Health, will address both comments.

At the Medical Advisory Committee meeting on November 16, 2011, a committee member inquired regarding the amendment limiting adult outpatient behavioral health visits to 48; the member asked who would pay for visits beyond 48 in a year. The OHCA representative responded that visits over 48 in a calendar year would not be covered services. A committee member representing the Oklahoma Department of Mental Health and Substance Abuse Services commented that 48 is a reasonable number of visits.

At the OHCA Board Meeting on December 8, 2011, State Representative Mark McCullough referred to page twenty-seven of this renewal application and inquired whether there is a conflict between the data showing that Choice PCP capacity had decreased while enrollments had increased. The State Medicaid Director explained that the capacity data do not represent the number of members enrolled with PCPs; rather, they represent the maximum number of SoonerCare members participating PCPs declare that they can serve. Representative McCullough also inquired about when the State received authorization to provide coverage for unemployed adults and college students, and about the legal authorities behind changes in Native American cost-sharing. The Waiver Coordinator explained the Federal mandate behind changes in Native American cost-sharing requirements and gave information on State legislation and Federal approvals for the Insure Oklahoma program.

Only two comments were received through the online form; neither were relevant to the renewal, and both appear to have been generated by other websites without the involvement of a person. OHCA did not receive any other comments apart from those summarized above.

References

APS Healthcare. "Behavioral Health Quality Assessment and Performance Improvement (QAPI) Study: Executive Summary." Oklahoma City, 2010.

APS Healthcare. "Breast and Cervical Cancer Quality Assessment and Performance Improvement (QAPI) Study." Oklahoma City, 2009.

APS Healthcare. "CAHPS Adult Health Survey for SoonerCare Choice." Oklahoma City, 2010.

APS Healthcare. "CAHPS Child Health Survey for SoonerCare Choice." Oklahoma City, 2009.

APS Healthcare. "Comprehensive Diabetes Care Study: SoonerCare Choice Quality Assessment and Performance Improvement (QAPI) Study." Oklahoma City, 2010.

APS Healthcare. "Early Preterm Birth Outcomes Quality Assessment and Performance Improvement (QAPI) Study." Oklahoma City, 2009.

APS Healthcare. "ECHO Adult Behavioral Health Survey for SoonerCare Choice." Oklahoma City, 2009.

APS Healthcare. "ECHO Child Behavioral Health Survey for SoonerCare Choice." Oklahoma City, 2010.

APS Healthcare. "Emergency Room Utilization Study: SoonerCare Choice Quality Assessment and Performance Improvement (QAPI) Study." Oklahoma City, 2010.

APS Healthcare. "Oklahoma Health Care Authority External Quality Review Report." Oklahoma City, 2010.

APS Healthcare. "SoonerCare Quality Assessment and Performance Improvement (QAPI) Study: Child Health Checkups." Oklahoma City, 2009.

Oklahoma Foundation for Medical Quality. "SoonerCare Choice Final Technical Report of CAHPS Survey Findings: Medicaid Adult Survey." Oklahoma City, 2006.

Oklahoma Health Care Authority. "Minding Our P'S and Q's: The OHCA Performance and Quality Report July 2009-June 2010." Oklahoma City, 2011.

Pacific Health Policy Group. "SoonerCare HMP Evaluation - SFY 2010." 2011.

Primary Care Health Policy Division. "Insure Oklahoma: Member Experience with the Insure Oklahoma Employer-Sponsored and Individual Health Insurance Plans." Department of Family & Preventive Medicine, University of Oklahoma Health Sciences Center, Oklahoma City, 2011.

Primary Care Health Policy Division. "The Patient-Centered Medical Home Model of Care: A Survey of SoonerCare-Contracted Primary Care Providers." Department of Family and Preventive Medicine, University of Oklahoma Health Sciences Center, Oklahoma City, OK, 2010.

Sooner Health Access Network. "Sooner Health Access Network: Annual Report For Period July 1, 2010 to June 30, 2011." 2011.

The Myers Group. "CAHPS 2007 Medicaid Child Survey: Final Report." Snellville, GA, 2007.

The Myers Group. "CAHPS 2008 Medicaid Adult Survey: Final Report." Snellville, GA, 2008.

The Myers Group. "CAHPS 2011 Medicaid Child Survey: Final Report." Duluth, GA, 2011.

Appendix A: Amendment Request Documentation

Amendment Request

The State requests that benefit limitations in the Insure Oklahoma Individual Plan be revised to limit coverage of outpatient behavioral health visits to 48 per year. At present, children's outpatient behavioral health visits are limited to 48 per year, while adults' visits are unlimited. This amendment will revise the adult benefit to match the children's benefit.

Public Process

The State included this amendment request in all public notice materials and processes documented for the renewal of the waiver. See the section of the renewal application titled "Documentation of Compliance with Public Notice Requirements".

Impact on Budget Neutrality

The amendment is projected to produce nominal additional savings. See the section of the renewal application titled "Compliance with the Budget Neutrality Cap" and Appendix E.

CHIP Allotment Neutrality Worksheet

This requirement is not applicable to the amendment requested.

Impact on Beneficiaries

Utilization of Adult Outpatient Behavioral Health Visits, IO IP, by Calendar Year

Year	*Member Count*	*Total Cost of All Visits*	*Average Cost / Recipient*
2007	32	$9,136.79	$285.52
2008	269	$45,478.31	$169.06
2009	719	$178,319.84	$248.01
2010	1,287	$458,168.56	$356.00
2011 (through Sept)	1,076	$421,688.93	$391.90

Utilization of Outpatient Behavioral Health Visits by Members Who had More than 48 Visits per Calendar Year

Year	*Member Count*	*Total Cost of All Visits*	*Average Cost/Recipient*
2009	2	$12,085.14	$6,042.57
2010	15	$84,980.52	$5,665.37
2011 (through Sept)	14	$71,099.04	$5,078.50

Cost of Outpatient Behavioral Health Visits Received over 48 per Calendar Year

Year	*Member Count*	*Total Cost of Visits Exceeding 48*	*Average Cost/Recipient of Visits Exceeding 48*
2009	2	$6,125.00	$3,062.50
2010	15	$34,253.60	$2,283.57
2011 (through Sept)	14	$28,875.25	$2,062.52

Using 2010 as the most recent year for which complete data is available, it can be expected that about 1.2% of all members who utilize the outpatient behavioral health visit benefit will be affected by the amendment if it is approved. The total savings can be expected to be about $99,692 in 2012. Please see the budget

neutrality exhibits in Appendix E for projections of the effect of the amendment on budget neutrality for the waiver.

Evaluation Design

This Amendment does not require any modification of the Demonstration evaluation design, and will not have an impact on Demonstration evaluation results.

Appendix B: The History of the Waiver

January 1995	SoonerCare Demonstration approved.
August 1995	The State implements a fully capitated managed care organization (MCO) model in urban areas.
October 12, 1995	Authority granted to waive retroactive eligibility.
July 1996	The State implements a primary care case management (PCCM) partial capitation model in rural areas.
December 31, 2003	The State terminates the MCO program and transitions managed care enrollees to the PCCM model statewide.
January 1, 2004	Renewal approved effective January 1, 2004 through December 31, 2006.
September 30, 2005	HIFA amendment approved to provide insurance coverage to adults employed by small employers and working disabled adults.
September 30, 2005	TEFRA amendment approved to expand coverage to eligible disabled children.
January 1, 2007	Renewal approved effective January 1, 2007 through December 31, 2009.
January 3, 2009	Amendment approved to change the service delivery model from a partially capitated payment to an exclusive Primary Care Case Management (PCCM) model. Medical home implemented.
January 3, 2009	Amendment approved to add an expansion population to Insure Oklahoma for full-time college students aged 19 to 22 not to exceed 200% FPL, capped at 3,000 members.
January 3, 2009	Amendment approved to expand the size of employers eligible to participate in Insure Oklahoma from 50 employees to 250 employees.
January 3, 2009	Amendment approved to expand the description of qualified PCPs to permit County Health Departments to serve as medical homes for members who choose these providers.
January 3, 2009	Amendment approved to include an option for voluntary enrollment of children in State or Tribal custody in the Demonstration.
January 3, 2009	Amendment approved to implement SoonerExcel incentive payments for PCPs to build upon the EPSDT and Fourth DTaP Bonus program.
January 3, 2009	Amendment approved to amend cost sharing requirements for the Insure Oklahoma Program and to add a $1 co-pay for non-pregnant adults in SoonerCare.
January 1, 2010	Renewal approved effective January 1, 2010 to December 31, 2012.
January 1, 2010	Amendment approved to implement Health Access Network (HAN) pilot program.
January 1, 2010	Amendment approved to expand eligibility under Insure Oklahoma for non-disabled working adults and their spouses, disabled working adults, and full-time college students, from 200% FPL up to and including 250% FPL.
January 1, 2010	Amendment approved to add a new eligibility group under Insure Oklahoma for foster parents up to and including 250% FPL.
January 1, 2010	Amendment approved to add a new eligibility group under Insure Oklahoma for employees of not-for-profit businesses having fewer than 500 employees, up to and including 250% FPL.

August 1, 2011 Amendment approved to eliminate the $10 co-pay for the initial prenatal visit under Insure Oklahoma, Individual Plan.

Demonstration Eligibility Groups

1 TANF-Urban

Includes low-income families, pregnant women and children, and women who are eligible under the Breast and Cervical Cancer Treatment Program, receiving health care services in the designated Central, Northeast, and Southwest urban areas of the State.

2 TANF-Rural

Includes low-income families, pregnant women and children, and women who are eligible under the Breast and Cervical Cancer Treatment Program, receiving health care services in the rural areas of the State.

3 ABD-Urban

Includes the Aged, Blind and Disabled receiving health care services in the designated Central, Northeast, and Southwest urban areas of the State.

4 ABD-Rural

Includes the Aged, Blind and Disabled receiving health care services in the rural areas of the State.

5 Non-Disabled Working Adults

Includes non-disabled low income workers and their spouses with household incomes no greater than 250 percent of the FPL.

6 Working Disabled Adults

Includes low income working disabled adults with household incomes no greater than 250 percent of the FPL.

7 TEFRA Children

Includes children defined in paragraph 20 of the Special Terms and Conditions.

8 Full-Time College Students

Includes full-time college students ages 19-22 up to and including 250 percent of the FPL (limited to 3,000 individuals at any given time).

9 CHIP Medicaid Expansion Children

Includes infants under age 1, children ages 1-5, and children ages 6-18.

10 Foster Parents

Includes working foster parents with household incomes no greater than 250 percent of the FPL. The spouse of a working employee can be covered.

11 Not-for-Profit Employees

Includes employees and spouses of not-for-profit businesses with 500 or fewer employees with household incomes no greater than 250 percent of the FPL.

12 HAN Expenditures

Includes PMPM expenditures made to the HANs.

Appendix C: Insure Oklahoma Monitoring

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

Quarter	*ESI Average Premium Contribution*	*IP Average Cost PMPM*
July – Sept 2007	$231.22	$175.39
Oct – Dec 2007	$227.94	$214.55
Jan – Mar 2008	$230.70	$288.31
Apr – June 2008	$227.96	$267.36
July – Sept 2008	$236.10	$286.77
Oct – Dec 2008	$238.16	$328.33
Jan – Mar 2009	$242.83	$279.51
Apr – June 2009	$244.93	$311.93
July – Sept 2009	$246.79	$321.44
Oct – Dec 2009	$251.13	$337.94
Jan – Mar 2010	$256.00	$315.60
Apr – June 2010	$259.27	$310.78
July – Sept 2010	$265.43	$324.83
Oct – Dec 2010	$270.31	$313.10
Jan – Mar 2011	$274.79	$317.70
Apr – June 2011	$278.31	$336.43
July – Sept 2011	$281.30	$339.03

ESI Mean Premium Contribution PMPM: $250.77

IP Mean Cost PMPM: $298.18

Total Costs PMPM for ESI and IP Members, Including Reimbursements of Out-of-Pocket Expenses over 5% of Gross Income

Year	*Total Cost PMPM, ESI*	*Total Cost PMPM, IP*
2007	$230.55	$199.60
2008	$234.82	$298.70
2009	$248.40	$317.40
2010	$265.57	$316.28
2011 (through Sept)	$285.30	$331.50

ESI Mean PMPM Total Cost 2007 – 2011: $252.93

IP Mean PMPM Total Cost 2007 – 2011: $292.69

Contributions by Employers Pre- and Post-Participation in ESI

Total annual employer premiums pre-implementation: $155,431,255

Total annual employer premiums post-implementation: $167,442,237

Total annual amount paid by employers toward subsidized employees' premiums: $51,020,236

Total Statewide Employer Contributions Per Year

Year	*Total Employer Contribution*
2007	$1,110,129.95
2008	$6,371,915.40
2009	$11,303,340.57
2010	$15,092,287.60
2011 (through Sept)	$11,836,870.73

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. Staff have not noted any trends in health plan changes.

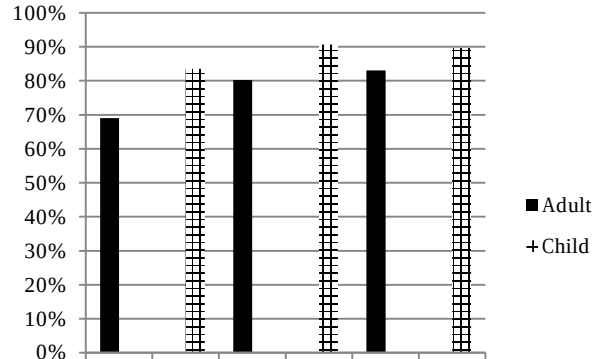
Appendix D: Beneficiary Satisfaction Survey Results

CAHPS®

The following table summarizes the major findings of the 2011 survey by health plan evaluation area.

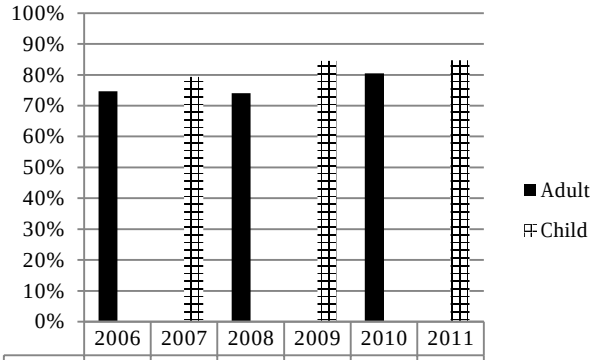
Evaluation Area	*2011 Score*	*Significantly different from 2010 NCBD benchmark?*	*Significantly different from 2009 score?*	*Percentile Ranking of 2011 Score*
Rating of Health Plan	78.4% rate Choice 8, 9, or 10 on scale of 1-10	No	No (82.3%)	16th
Getting Needed Care	80%	No	No (76.8%)	28th
Customer Service	80.1%	No	No (75.3%)	31st
Rating of Health Care	78.1% rate health care received 8, 9, or 10	No	No (74.5%)	< 10th
Getting Care Quickly	87.1%	No	No (87.6%)	25th
How Well Doctors Communicate	91.6% "always" or "usually" satisfied	No	No (88.8%)	24th
Shared Decision Making	68.3% feel doctors discussed options and asked their opinion	No	No (66.4%)	47th
Health Promotion and Education	64.1% feel doctors discussed specific ways to prevent illness	No	No (61.2%)	52nd
Coordination of Care	71.9% feel doctor was "always" or "usually" informed and up-to-date about their care	No	No (79.1%)	10th
Rating of Personal Doctor	82.2%	No	No (80.3%)	< 10th
Rating of Specialist	84.7%	No	No (75.0%)	80th

Percent reporting that it is usually or always easy to get urgently needed care right away



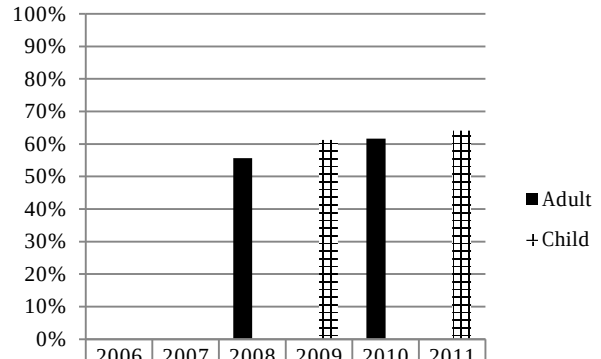
	2006	2007	2008	2009	2010	2011
Adult	69.00%		80.20%		83.06%	
Child		83.50%		90.71%		89.60%

Percent reporting that it is usually or always easy to get non-urgent care when it is needed



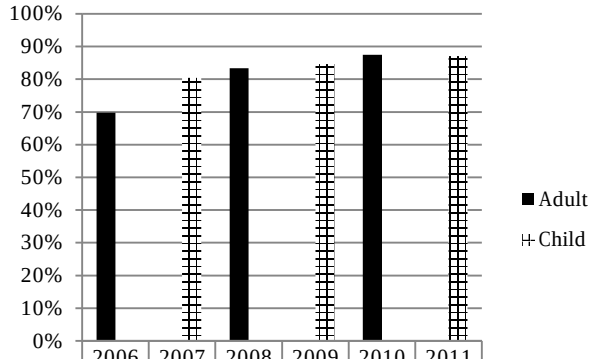
	2006	2007	2008	2009	2010	2011
Adult	74.70%		74.00%		80.47%	
Child		79.30%		84.56%		84.70%

Percent reporting that their doctors usually or always discuss ways to prevent illness



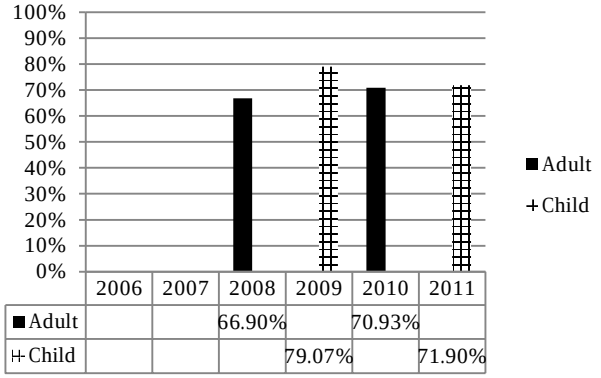
	2006	2007	2008	2009	2010	2011
Adult			55.60%		61.60%	
Child				61.25%		64.10%

Percent reporting that they have a personal doctor



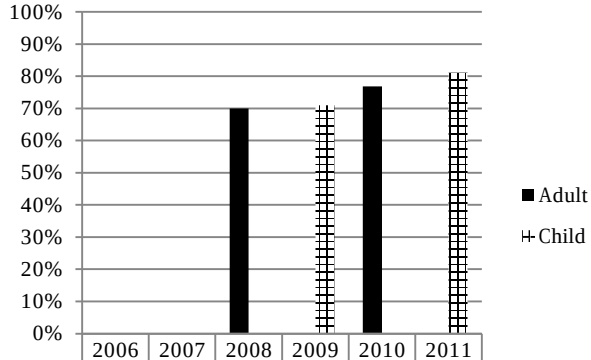
	2006	2007	2008	2009	2010	2011
Adult	69.80%		83.40%		87.50%	
Child		80.40%		84.65%		87.10%

Percent reporting that their personal doctor usually or always seemed informed about visits to other providers (general care coordination)

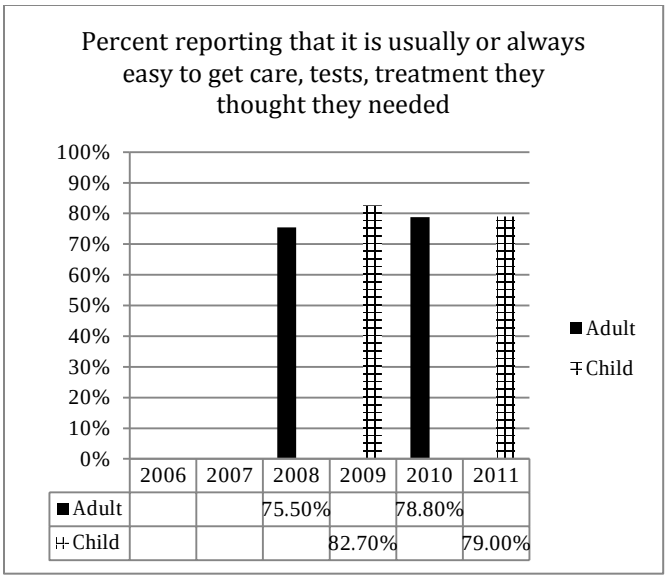


	2006	2007	2008	2009	2010	2011
Adult			66.90%		70.93%	
Child				79.07%		71.90%

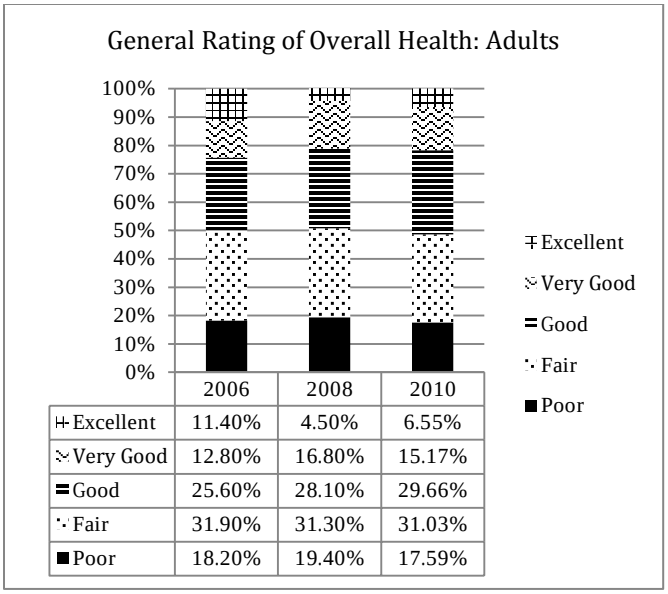
Percent reporting that it is usually or always easy to get appointments with specialists



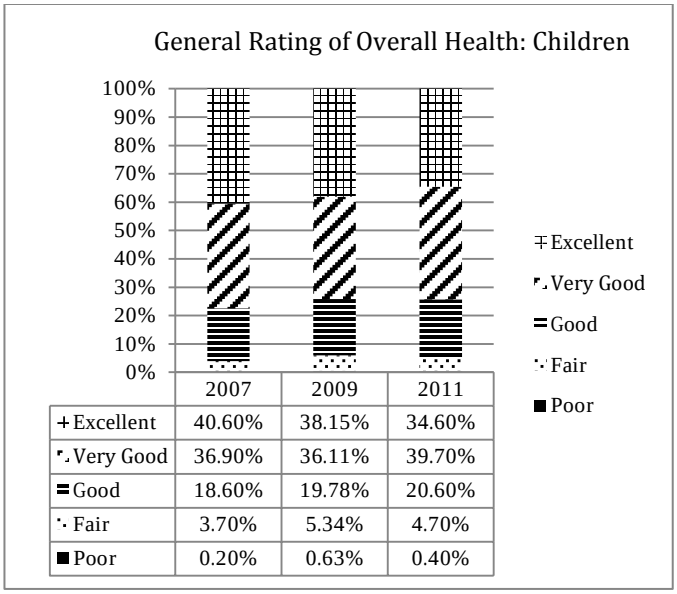
	2006	2007	2008	2009	2010	2011
Adult			70.00%		76.84%	
Child				70.95%		81.10%



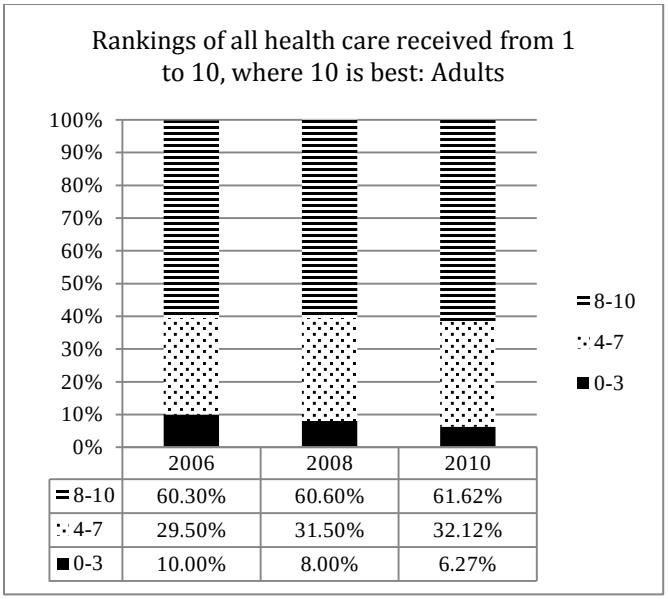
	2006	2007	2008	2009	2010	2011
Adult			75.50%		78.80%	
Child				82.70%		79.00%



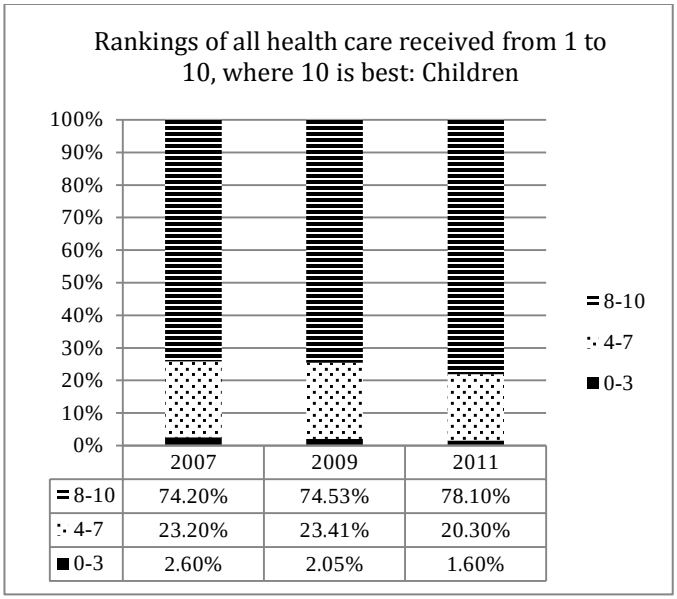
	2006	2008	2010
Excellent	11.40%	4.50%	6.55%
Very Good	12.80%	16.80%	15.17%
Good	25.60%	28.10%	29.66%
Fair	31.90%	31.30%	31.03%
Poor	18.20%	19.40%	17.59%



	2007	2009	2011
Excellent	40.60%	38.15%	34.60%
Very Good	36.90%	36.11%	39.70%
Good	18.60%	19.78%	20.60%
Fair	3.70%	5.34%	4.70%
Poor	0.20%	0.63%	0.40%

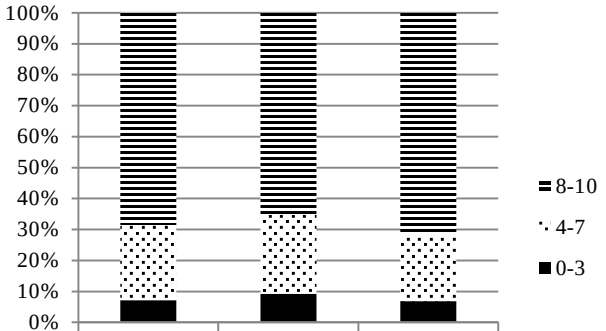


	2006	2008	2010
8-10	60.30%	60.60%	61.62%
4-7	29.50%	31.50%	32.12%
0-3	10.00%	8.00%	6.27%



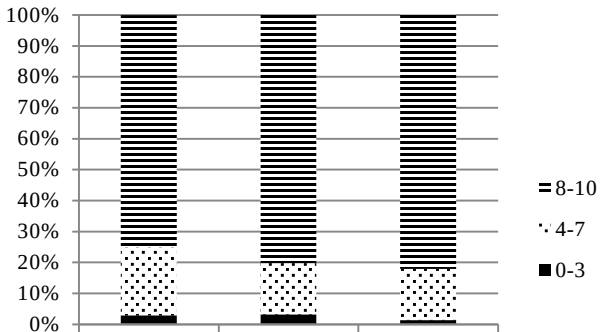
	2007	2009	2011
8-10	74.20%	74.53%	78.10%
4-7	23.20%	23.41%	20.30%
0-3	2.60%	2.05%	1.60%

Rankings of personal doctors from 1 to 10, where 10 is best: Adults



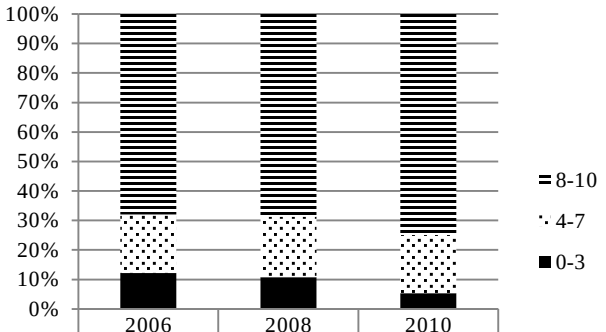
	2006	2008	2010
8-10	68.60%	65.10%	71.77%
4-7	24.30%	25.70%	21.37%
0-3	7.20%	9.20%	6.85%

Rankings of personal doctors from 1 to 10, where 10 is best: Children



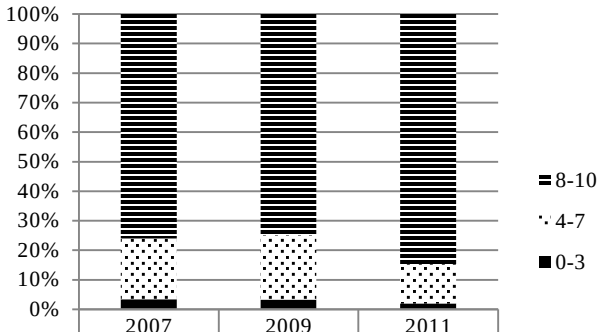
	2007	2009	2011
8-10	75.10%	80.26%	82.20%
4-7	21.90%	16.51%	16.60%
0-3	2.90%	3.23%	1.30%

Rankings of specialists from 1 to 10, where 10 is best: Adults



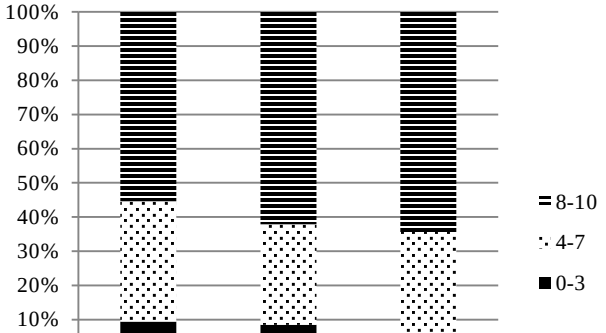
	2006	2008	2010
8-10	68.10%	68.80%	74.90%
4-7	19.90%	20.50%	19.84%
0-3	12.10%	10.70%	5.25%

Rankings of specialists from 1 to 10, where 10 is best: Children



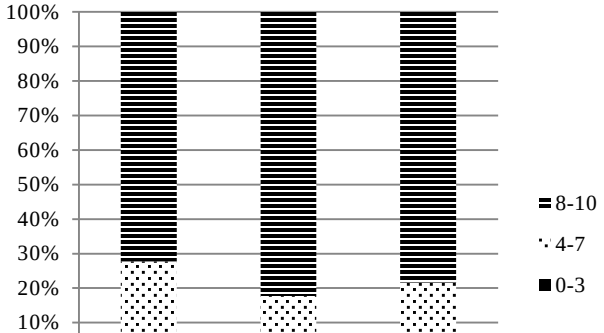
	2007	2009	2011
8-10	76.10%	75.00%	84.70%
4-7	20.50%	21.76%	13.30%
0-3	3.40%	3.23%	2.00%

Rankings of the health plan from 1 to 10, where 10 is best: Adults



	2006	2008	2010
8-10	55.40%	62.10%	64.32%
4-7	35.20%	29.40%	30.57%
0-3	9.40%	8.50%	5.10%

Rankings of the health plan from 1 to 10, where 10 is best: Children



	2007	2009	2011
8-10	72.30%	82.33%	78.40%
4-7	25.10%	17.04%	20.70%
0-3	2.60%	0.64%	0.90%

ECHO®

Children

Measure	*2008*	*2010*
Overall rating of treatment received in the last 12 months on a scale of 1 to 10	7.83	7.84
Overall rating of health plan for counseling or treatment on a scale of 1 to 10	8.19	8.20

Adults

Measure	*2007*	*2009*
Overall rating of treatment received in the last 12 months on a scale of 1 to 10; responses were recoded with 0-6=1; 7-8=2 & 9-10=3	2.10	2.11 [7.40 on 1-10 scale]
Overall rating of health plan for counseling or treatment on a scale of 1 to 10; responses were recoded with 0-6=1; 7-8=2 & 9-10=3	No comparable data available	2.19 [7.72 on 1-10 scale]

Insure Oklahoma ESI and IP Member Satisfaction Surveys

Measure	*ESI*	*IP*
Uninsured before beginning coverage through IO	44%	74%
"Very Satisfied" or "Okay" with current health plan	93%	94%
Have used health care services under the plan	88%	92%
"Very Satisfied" or "Okay" with application and renewal process	89%	86%
"Very Satisfied" or "Okay" with costs and out-of-pocket expenses	84%	97%
"Very Satisfied" or "Okay" with benefits and coverage	91%	96%
"Very Satisfied" or "Okay" with customer service	89%	93%
"Very Satisfied" or "Okay" with ability to locate a PCP	94%	93%
"Very Satisfied" or "Okay" with referral process	68%	81%
"Very Satisfied" or "Okay" with pharmacy/prescription drug benefits	87%	93%

PCMH Provider Survey

PCMH Tiers of responding providers

Tier	*Self-Reported Tier*	*Actual Tier*	*Choice PCP Tier proportions at time of survey (Oct 2009)*
1	49%	56%	65%
2	43%	38%	30%
3	8%	6%	5%

As these data indicate, providers tended to self-report a higher tier than their actual tier; tier 2 and tier 3 providers were also slightly over-represented among PCPs responding to the survey.[13]

Responses to key measures related to quality and the relationship between PCPs and members

Survey Question	*Result*	*Interpretation/Notes*
Rate your familiarity with the PCMH model	Not familiar: 6% Somewhat familiar: 24% Familiar: 28% Knowledgeable: 30% Very knowledgeable: 12%	Responses fell mostly in the mid-range between somewhat familiar and knowledgeable. (mean = 3.18 out of 5; SEM = .09)
What would incentivize PCP to advance tier status	Higher pay: 33% No interest: 13% Less red tape: 12% Don't know: 12% More PCPs: 10% OHCA help: 9% Patient effort: 7% EHR: 4%	25% of respondents had either no interest in advancing their tier or didn't know what to do. 33% asked for higher pay.
What might incentivize patients to take more responsibility for their health.	Regulatory changes: 37%[14] Pt education/responsibility: 24% Rewards: 17% Don't know: 13% Good PCP/pt relationship: 9%	Two categories that emerged were unique and interesting: good PCP/pt relationship and rewards for meeting health milestones or responsibility. Most were frustrated, however, with 'no shows' and the inability to penalize for inappropriate use of health care services (e.g., ER); they didn't know of anything that would help.
Willingness to communicate, provide certain medical services via e-mail.	Not willing: 39% Willing: 43% Very willing: 18%	Some respondents reported being hesitant about providing medical services via e-mail.
If willing to provide e-mail services, what should the reimbursement be?	Mean: $36.56 Range: $5-$100 Mode: $25 Median: $30	Comments indicated that many felt both e-mail and phone services should be coded and billed like an office visit.

[13] The report notes that some respondents indicated that they did not know what a tier was and 15 did not answer the question.

[14] "37% of PCPs felt that only regulatory changes to allow them to dismiss patients or charge co-pays would incentivize SoonerCare patients to become more accountable for their health."

Survey Question	*Result*	*Interpretation/Notes*
EHR in your practice? If no, do you plan to implement?	Yes: 48% No: 52% By 2011: 38% By 2015: 32% No plans: 30%	48% of respondents had an EHR in place. Approximately 1/3 had no plans to implement. Some reasons given were: loss of productivity, cost, too close to retirement.
If no plans to implement an EHR, would financial assistance change your mind?	Unlikely: 19% Somewhat likely: 36% Very likely: 45%	Financial aid would impact respondents' decision regarding an EHR to a great degree.
Additional comments.	E-mail: 29% Provider issues: 26% Patient issues: 18% Positive remarks: 13% EHR: 7% Support/education: 7%	Most remarks had to do with provider issues related to advancing tier status (e.g. 24/7 coverage) and providing services using e-mail.

Appendix E: Budget Neutrality Exhibits

Exhibit 1: Enrollment Trends for Traditional MEGs

MEG	2007	2008	2009	2010	2011 (Annualized)	Annual Trend	Trending Years
TANF - Urban	2,808,278	2,772,622	3,029,870	3,333,170	3,320,081	4.27%	*2007 - 2011*
TANF - Rural	2,130,548	2,078,460	2,246,021	2,429,264	2,414,579	3.18%	*2007 - 2011*
ABD - Urban	268,332	283,834	301,034	327,267	344,304	6.43%	*2007 - 2011*
ABD - Rural	244,220	251,088	262,857	278,093	285,347	3.97%	*2007 - 2011*
Insure OK	38,417	139,822	172,704	392,155	388,776	-0.86%	*2010 - 2011*
TEFRA	1,813	2,515	3,299	4,018	4,443	10.57%	*2010 - 2011*
College Students	-	-	873	3,972	5,348	34.64%	*2010 - 2011*

Exhibit 2: PMPM Expenditure Trends by MEG

MEG	Factor
TANF-U	1.0513
TANF-R	1.0513
ABD-U	1.0520
ABD-R	1.0520
INSURE OK	1.0513
TEFRA	1.0520
College Students	1.0513

Exhibit 3: Budget Neutrality for TANF-Urban MEG

DY	CY	Member Months	Budget Neutrality Limit PMPM	Budget Neutrality Limit Aggregate	Actual/Projected Expenditures PMPM	Actual/Projected Expenditures Aggregate	Savings/ (Deficit)	Cumulative Savings/ (Deficit)
1	1996	1,248,591	$121.60	$151,828,666	$109.06	$136,166,854	$15,661,812	$15,661,812
2	1997	1,201,538	$129.52	$155,618,588	$121.58	$146,088,131	$9,530,457	$25,192,268
3	1998	1,299,675	$137.95	$179,287,128	$118.62	$154,165,878	$25,121,250	$50,313,518
4	1999	1,489,962	$146.93	$218,917,218	$120.93	$180,176,146	$38,741,072	$89,054,590
5	2000	1,575,250	$156.49	$246,515,710	$142.38	$224,278,709	$22,237,001	$111,291,592
6	2001	1,988,010	$166.68	$331,363,038	$156.92	$311,964,540	$19,398,498	$130,690,090
7	2002	2,159,002	$177.53	$383,291,270	$156.45	$337,784,795	$45,506,475	$176,196,565
8	2003	2,319,441	$189.09	$438,580,782	$163.84	$380,021,639	$58,559,143	$234,755,708
9	2004	2,426,341	$201.40	$488,661,911	$136.62	$331,495,295	$157,166,616	$391,922,324
10	2005	2,528,654	$214.51	$542,420,938	$141.17	$356,967,558	$185,453,380	$577,375,704
11	2006	2,643,157	$228.47	$603,893,538	$213.25	$563,645,768	$40,247,770	$617,623,474
12	2007	2,808,278	$240.19	$674,520,293	$204.58	$574,528,973	$99,991,320	$717,614,794

DY	CY	Member Months	Budget Neutrality Limit PMPM	Budget Neutrality Limit Aggregate	Actual/Projected Expenditures PMPM	Actual/Projected Expenditures Aggregate	Savings/ (Deficit)	Cumulative Savings/ (Deficit)
13	2008	2,772,622	$252.51	$700,119,625	$237.41	$658,239,328	$41,880,297	$759,495,092
14	2009	3,029,870	$265.47	$804,339,589	$249.71	$756,593,334	$47,746,255	$807,241,346
15	2010	3,333,170	$279.09	$930,249,786	$235.05	$783,461,815	$146,787,971	$954,029,317
16	2011 (est)	3,320,081	$293.42	$974,178,265	$259.23	$860,668,761	$113,509,504	$1,067,538,821
17	2012 (proj)	3,461,991	$308.46	$1,067,885,608	$272.53	$943,495,560	$124,390,048	$1,191,928,868
18	2013 (proj)	3,609,965	$324.28	$1,170,654,002	$286.51	$1,034,293,229	$136,360,773	$1,328,289,641
19	2014 (proj)	4,111,635	$340.92	$1,401,737,650	$301.21	$1,238,459,663	$163,277,988	$1,491,567,629
20	2015 (proj)	4,287,377	$358.41	$1,536,634,428	$316.66	$1,357,643,318	$178,991,110	$1,670,558,739

Exhibit 4: Budget Neutrality for TANF-Rural MEG

DY	CY	Member Months	Budget Neutrality Limit PMPM	Budget Neutrality Limit Aggregate	Actual/Projected Expenditures PMPM	Actual/Projected Expenditures Aggregate	Savings/ (Deficit)	Cumulative Savings/ (Deficit)
1	1996	1,088,941	$123.34	$134,309,983	$103.62	$112,839,567	$21,470,416	$21,470,416
2	1997	1,081,206	$131.37	$142,037,420	$125.66	$135,865,141	$6,172,279	$27,642,695
3	1998	1,250,830	$139.92	$175,018,115	$119.50	$149,478,153	$25,539,962	$53,182,657
4	1999	1,510,946	$149.03	$225,177,007	$110.12	$166,390,827	$58,786,180	$111,968,837
5	2000	1,522,229	$158.73	$241,627,007	$129.42	$197,013,558	$44,613,449	$156,582,286
6	2001	1,915,864	$169.07	$323,907,157	$130.46	$249,934,052	$73,973,105	$230,555,391
7	2002	2,014,674	$180.07	$362,786,430	$134.34	$270,655,613	$92,130,817	$322,686,208
8	2003	1,941,227	$191.79	$372,317,080	$141.26	$274,223,683	$98,093,397	$420,779,605
9	2004	1,984,722	$204.28	$405,440,105	$148.84	$295,405,508	$110,034,597	$530,814,202
10	2005	2,015,932	$217.58	$438,624,903	$159.74	$322,029,698	$116,595,205	$647,409,407
11	2006	2,036,491	$231.74	$471,943,801	$190.64	$388,233,608	$83,710,193	$731,119,599
12	2007	2,130,548	$243.63	$519,065,409	$195.93	$417,441,217	$101,624,192	$832,743,791
13	2008	2,078,460	$256.13	$532,352,258	$208.78	$433,930,837	$98,421,421	$931,165,212
14	2009	2,246,021	$269.27	$604,780,677	$220.17	$494,500,234	$110,280,443	$1,041,445,655
15	2010	2,429,264	$283.08	$687,678,542	$213.62	$518,943,390	$168,735,152	$1,210,180,807
16	2011 (est)	2,414,579	$297.61	$718,602,757	$223.69	$540,119,553	$178,483,204	$1,388,664,010
17	2012 (proj)	2,491,316	$312.87	$779,458,129	$235.17	$585,873,795	$193,584,334	$1,582,248,344
18	2013 (proj)	2,570,493	$328.92	$845,487,057	$247.23	$635,503,939	$209,983,119	$1,792,231,463

DY	CY	Member Months	Budget Neutrality Limit PMPM	Budget Neutrality Limit Aggregate	Actual/Projected Expenditures PMPM	Actual/Projected Expenditures Aggregate	Savings/ (Deficit)	Cumulative Savings/ (Deficit)
19	2014 (proj)	2,904,815	$345.79	$1,004,467,284	$259.91	$755,000,222	$249,467,063	$2,041,698,525
20	2015 (proj)	2,997,133	$363.53	$1,089,557,037	$273.25	$818,957,289	$270,599,748	$2,312,298,273

Exhibit 5: Budget Neutrality for ABD-Urban MEG

DY	CY	Member Months	Budget Neutrality Limit PMPM	Budget Neutrality Limit Aggregate	Actual/Projected Expenditures PMPM	Actual/Projected Expenditures Aggregate	Savings/ (Deficit)	Cumulative Savings/ (Deficit)
1	1996							
2	1997							
3	1998							
4	1999	96,785	$536.14	$51,889,826	$408.54	$39,540,909	$12,348,917	$12,348,917
5	2000	190,315	$567.55	$108,013,756	$441.30	$83,985,855	$24,027,901	$36,376,818
6	2001	279,689	$600.81	$168,040,252	$363.42	$101,645,621	$66,394,631	$102,771,450
7	2002	306,526	$636.02	$194,956,243	$402.14	$123,267,004	$71,689,239	$174,460,688
8	2003	233,742	$673.29	$157,375,990	$578.12	$135,130,199	$22,245,791	$196,706,479
9	2004	244,590	$712.74	$174,330,070	$488.80	$119,555,202	$54,774,868	$251,481,347
10	2005	255,066	$754.51	$192,450,068	$668.41	$170,487,473	$21,962,595	$273,443,942
11	2006	259,473	$798.73	$207,247,624	$854.61	$221,748,359	($14,500,734)	$258,943,208
12	2007	268,332	$840.26	$225,468,646	$887.41	$238,121,801	($12,653,155)	$246,290,053
13	2008	283,834	$883.96	$250,898,901	$954.33	$270,870,487	($19,971,585)	$226,318,468
14	2009	301,034	$929.92	$279,937,423	$1,003.30	$302,026,585	($22,089,162)	$204,229,306
15	2010	327,267	$978.28	$320,157,269	$960.49	$314,336,505	$5,820,764	$210,050,070
16	2011 (est)	344,304	$1,029.15	$354,339,003	$926.94	$319,148,246	$35,190,758	$245,240,828
17	2012 (proj)	366,446	$1,082.66	$396,736,447	$975.14	$357,335,037	$39,401,410	$284,642,238
18	2013 (proj)	390,011	$1,138.96	$444,206,838	$1,025.85	$400,090,963	$44,115,875	$328,758,113
19	2014 (proj)	415,092	$1,198.19	$497,357,166	$1,079.19	$447,962,729	$49,394,437	$378,152,550
20	2015 (proj)	441,786	$1,260.49	$556,867,047	$1,135.31	$501,562,457	$55,304,590	$433,457,140

Exhibit 6: Budget Neutrality for ABD-Rural MEG

DY	CY	Member Months	Budget Neutrality Limit PMPM	Budget Neutrality Limit Aggregate	Actual/Projected Expenditures PMPM	Actual/Projected Expenditures Aggregate	Savings/ (Deficit)	Cumulative Savings/ (Deficit)
1	1996							

DY	CY	Member Months	Budget Neutrality Limit PMPM	Budget Neutrality Limit Aggregate	Actual/Projected Expenditures PMPM	Actual/Projected Expenditures Aggregate	Savings/ (Deficit)	Cumulative Savings/ (Deficit)
2	1997							
3	1998							
4	1999	103,533	$427.26	$44,235,510	$387.69	$40,139,140	$4,096,370	$4,096,370
5	2000	209,188	$452.30	$94,615,196	$416.00	$87,022,957	$7,592,239	$11,688,609
6	2001	329,747	$478.80	$157,883,545	$332.70	$109,707,133	$48,176,412	$59,865,020
7	2002	343,627	$506.86	$174,170,735	$350.27	$120,361,978	$53,808,757	$113,673,778
8	2003	222,348	$536.56	$119,303,455	$516.96	$114,944,808	$4,358,647	$118,032,425
9	2004	231,151	$568.00	$131,294,780	$598.48	$138,339,043	($7,044,263)	$110,988,163
10	2005	238,426	$601.29	$143,363,035	$637.30	$151,950,033	($8,586,998)	$102,401,165
11	2006	241,661	$636.52	$153,823,267	$793.03	$191,644,245	($37,820,978)	$64,580,187
12	2007	244,220	$669.62	$163,534,596	$834.57	$203,819,591	($40,284,995)	$24,295,192
13	2008	251,088	$704.44	$176,876,491	$871.89	$218,920,190	($42,043,699)	($17,748,507)
14	2009	262,857	$741.07	$194,795,734	$930.09	$244,480,177	($49,684,443)	($67,432,950)
15	2010	278,093	$779.61	$216,803,202	$943.46	$262,368,307	($45,565,105)	($112,998,055)
16	2011 (est)	285,347	$820.15	$234,026,037	$962.04	$274,514,325	($40,488,288)	($153,486,343)
17	2012 (proj)	296,668	$862.79	$255,963,366	$1,012.06	$300,246,979	($44,283,613)	($197,769,956)
18	2013 (proj)	308,439	$907.66	$279,957,074	$1,064.69	$328,391,782	($48,434,707)	($246,204,663)
19	2014 (proj)	320,676	$954.86	$306,199,925	$1,120.06	$359,174,846	($52,974,921)	($299,179,584)
20	2015 (proj)	333,399	$1,004.51	$334,902,751	$1,178.30	$392,843,479	($57,940,728)	($357,120,312)

Exhibit 7: Budget Neutrality for Insure Oklahoma MEG

DY	CY	Member Months	Budget Neutrality Limit PMPM	Budget Neutrality Limit Aggregate	Actual/Projected Expenditures PMPM	Actual/Projected Expenditures Aggregate	Savings/ (Deficit)	Cumulative Savings/ (Deficit)
1	1996							
2	1997							
3	1998							
4	1999							
5	2000							
6	2001							
7	2002							
8	2003							
9	2004							

DY	CY	Member Months	Budget Neutrality Limit PMPM	Budget Neutrality Limit Aggregate	Actual/Projected Expenditures PMPM	Actual/Projected Expenditures Aggregate	Savings/ (Deficit)	Cumulative Savings/ (Deficit)
10	2005							
11	2006	9,744			$198.81	$1,937,239	($1,937,239)	($1,937,239)
12	2007	38,417			$204.54	$7,857,841	($7,857,841)	($9,795,080)
13	2008	139,822			$239.62	$33,504,032	($33,504,032)	($43,299,112)
14	2009	172,704			$437.93	$75,632,880	($75,632,880)	($118,931,992)
15	2010	392,155			$285.37	$111,910,574	($111,910,574)	($230,842,565)
16	2011 (est)	388,776			$313.25	$121,785,792	($121,785,792)	($352,628,357)
17	2012 (proj)	385,426			$329.07	$126,830,512	($126,830,512)	($479,458,869)
18	2013 (proj)	382,105			$345.95	$132,188,021	($132,188,021)	($611,646,890)
19	2014 (proj)	189,406			$363.69	$68,885,920	($68,885,920)	($680,532,810)
20	2015 (proj)	187,774			$382.35	$71,795,763	($71,795,763)	($752,328,573)

Exhibit 8: Budget Neutrality for TEFRA Children MEG

DY	CY	Member Months	Budget Neutrality Limit PMPM	Budget Neutrality Limit Aggregate	Actual/Projected Expenditures PMPM	Actual/Projected Expenditures Aggregate	Savings/ (Deficit)	Cumulative Savings/ (Deficit)
1	1996							
2	1997							
3	1998							
4	1999							
5	2000							
6	2001							
7	2002							
8	2003							
9	2004							
10	2005							
11	2006	931			$943.85	$878,723	($878,723)	($878,723)
12	2007	1,813			$1,055.94	$1,914,416	($1,914,416)	($2,793,139)
13	2008	2,515			$914.81	$2,300,739	($2,300,739)	($5,093,878)
14	2009	3,299			$1,393.11	$4,595,878	($4,595,878)	($9,689,756)
15	2010	4,018			$1,127.92	$4,532,001	($4,532,001)	($14,221,757)
16	2011 (est)	4,443			$933.61	$4,147,729	($4,147,729)	($18,369,486)

DY	CY	Member Months	Budget Neutrality Limit PMPM	Budget Neutrality Limit Aggregate	Actual/Projected Expenditures PMPM	Actual/Projected Expenditures Aggregate	Savings/ (Deficit)	Cumulative Savings/ (Deficit)
17	2012 (proj)	4,912			$982.16	$4,824,584	($4,824,584)	($23,194,070)
18	2013 (proj)	5,431			$1,033.23	$5,611,893	($5,611,893)	($28,805,963)
19	2014 (proj)	6,005			$1,086.96	$6,527,681	($6,527,681)	($35,333,644)
20	2015 (proj)	6,640			$1,143.48	$7,592,914	($7,592,914)	($42,926,558)

Exhibit 9: Budget Neutrality for College Student MEG

DY	CY	Member Months	Budget Neutrality Limit PMPM	Budget Neutrality Limit Aggregate	Actual/Projected Expenditures PMPM	Actual/Projected Expenditures Aggregate	Savings/ (Deficit)	Cumulative Savings/ (Deficit)
1	1996							
2	1997							
3	1998							
4	1999							
5	2000							
6	2001							
7	2002							
8	2003							
9	2004							
10	2005							
11	2006							
12	2007							
13	2008							
14	2009	873			$65.14	$56,867	($56,867)	($56,867)
15	2010	3,972			$150.85	$599,168	($599,168)	($656,035)
16	2011 (est)	5,348			$147.77	$790,285	($790,285)	($1,446,320)
17	2012 (proj)	7,201			$155.35	$1,118,646	($1,118,646)	($2,564,966)
18	2013 (proj)	9,695			$163.32	$1,583,439	($1,583,439)	($4,148,405)
19	2014 (proj)	6,527			$171.70	$1,120,677	($1,120,677)	($5,269,082)
20	2015 (proj)	8,788			$180.51	$1,586,314	($1,586,314)	($6,855,396)

Exhibit 10: Revised Budget Neutrality

DY	CY	Member Months	Budget Neutrality Limit PMPM	Budget Neutrality Limit Aggregate	Actual/Projected Expenditures PMPM	Actual/Projected Expenditures Aggregate	Savings/ (Deficit)	Cumulative Savings/ (Deficit)
1	1996	2,337,532	$122.41	$286,138,649	$106.53	$249,006,421	$37,132,228	$37,132,228
2	1997	2,282,744	$130.39	$297,656,008	$123.52	$281,953,272	$15,702,736	$52,834,964
3	1998	2,550,505	$138.92	$354,305,243	$119.05	$303,644,031	$50,661,212	$103,496,175
4	1999	3,201,226	$168.75	$540,219,561	$133.15	$426,247,022	$113,972,539	$217,468,714
5	2000	3,496,982	$197.53	$690,771,669	$169.37	$592,301,079	$98,470,590	$315,939,304
6	2001	4,513,310	$217.40	$981,193,992	$171.33	$773,251,346	$207,942,646	$523,881,951
7	2002	4,823,829	$231.19	$1,115,204,678	$176.64	$852,069,390	$263,135,288	$787,017,239
8	2003	4,716,758	$230.58	$1,087,577,307	$191.72	$904,320,329	$183,256,978	$970,274,217
9	2004	4,886,804	$245.50	$1,199,726,867	$181.06	$884,795,048	$314,931,819	$1,285,206,036
10	2005	5,038,078	$261.38	$1,316,858,944	$198.77	$1,001,434,762	$315,424,182	$1,600,630,217
11	2006	5,180,782	$277.35	$1,436,908,230	$264.07	$1,368,087,941	$68,820,289	$1,669,450,506
12	2007	5,451,378	$290.31	$1,582,588,944	$264.83	$1,443,683,838	$138,905,106	$1,808,355,612
13	2008	5,386,004	$308.25	$1,660,247,275	$300.36	$1,617,765,613	$42,481,662	$1,850,837,275
14	2009	5,839,782	$322.59	$1,883,853,423	$321.57	$1,877,885,955	$5,967,468	$1,856,804,742
15	2010	6,367,794	$338.40	$2,154,888,798	$313.48	$1,996,151,759	$158,737,039	$2,015,541,782
16	2011 (est)	6,364,311	$358.43	$2,281,146,062	$333.29	$2,121,174,691	$159,971,372	$2,175,513,153
17	2012 (proj)	6,616,420	$377.85	$2,500,043,549	$350.60	$2,319,725,113	$180,318,436	$2,355,831,589
18	2013 (proj)	6,878,908	$398.36	$2,740,304,972	$368.90	$2,537,663,266	$202,641,706	$2,558,473,295
19	2014 (proj)	7,752,218	$414.04	$3,209,762,026	$371.14	$2,877,131,736	$332,630,289	$2,891,103,584
20	2015 (proj)	8,059,695	$436.49	$3,517,961,262	$391.08	$3,151,981,534	$365,979,728	$3,257,083,313