Mary Fallin
Office of the Governor
State of Oklahoma

September 28, 2016

Patricia Hansen, Project Officer
Centers for Medicare and Medicaid Services
Division of State Demonstrations and Waivers
7500 Security Blvd., Mail Stop S2-0l-16
Baltimore, MD 21244-1850

RE: Two Year Renewal Application for SoonerCare
Demonstration for January 1, 2017 to December 31, 2018

Waiver No. 11-W-00048/6

Dear Ms. Hansen:

This letter accompanies the Oklahoma Health Care Authority's (OHCA) renewal application for two additional years of the three year waiver renewal cycle for the SoonerCare §1115(a) Research and Demonstration Waiver (Demonstration) for January 1, 2017 to December 31, 2018. The state assures its compliance with transparency and public notice requirements as evidenced by the documentation in the renewal application.

The current approval of the waiver is for January 1, 2016 through December 31, 2016. This one year approval was based on additional information requested by The Centers for Medicare and Medicaid Services (CMS) about limitations on specialty visits in the SoonerCare Choice program. The OHCA subsequently provided documentation to CMS that demonstrated the limitations do not have a negative impact on sufficiency or access to care for SoonerCare Choice members.

Pursuant to providing the satisfactory information and documentation of the requested information, the State respectfully requests continuation of the Demonstration with the SoonerCare Choice and Insure Oklahoma programs in their present form including maintaining the current waiver list and expenditure authorities, while sustaining budget neutrality for the 2017 – 2018 years. The waiver evaluation hypotheses will be updated to reflect the additional years of the waiver. The evaluation design will remain as previously approved by CMS in the current extension with modification to the dates.

If you have any questions, please contact Rebecca Pasternik-Ikard, State Medicaid Director, at (405) 522-7208, or Tywanda Cox, Chief of Federal and State Policy, at (405) 522-7153.

Sincerely,

Mary Fallin
Governor

Oklahoma Health Care Authority

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

Application for Extension of the Demonstration, 2017 – 2018

Submitted to the Centers for Medicare and Medicaid Services

TBD, 2016*

Public Comment Version, August 26, 2016

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

Table of Contents

I. HISTORICAL NARRATIVE SUMMARY 3
Demonstration Background 3
Objectives Approved for the 2013-2015 Demonstration 4
Evaluation of 2013-2015 Objective Measures 4
Objectives Approved for the 2016 Demonstration 6
Proposed Objectives for the 2017-2018 Extension 6
II. Requested Changes for the 2017-2018 Demonstration 7
III. 2017-2018 WAIVER LIST, EXPENDITURE AUTHORITIES AND COMPLIANCE WITH SPECIAL TERMS AND CONDITIONS 8
Waiver List 8
Expenditure Authorities 8
Compliance with Special Terms and Conditions 10
IV. QUALITY 21
Quality Assurance Monitoring 21
Quality Initiatives 22
HEDIS® Quality Measures 23
Program Integrity 25
V. BUDGET NEUTRALITY 25
Compliance with Budget Neutrality Cap 25
Standard CMS Financial Management Questions 25
VI. DEMONSTRATION EVALUATION 28
Demonstration Evaluation Introduction 28
Program Evaluation 28
Evaluation Findings from the 2013-2015 Hypotheses 30
Proposed 2017-2018 SoonerCare Choice and Insure Oklahoma Hypotheses 52
VII. PUBLIC NOTICE PROCESS 53
Post Award Forum 53
Documentation of Compliance with Public Notice Requirements 54
APPENDICES 54
Appendix A: 2017-2018 SoonerCare Choice and Insure Oklahoma Eligibility Chart 54
Appendix B: A Historical Timeline of the SoonerCare Choice Program 57
Appendix C: Insure Oklahoma Monitoring 60
Appendix D: Recent Quality Assurance Monitoring for the SoonerCare Choice Program 62
Appendix E: CAHPS® Medicaid Adult and Child Member Satisfaction Survey Results 62

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I. HISTORICAL NARRATIVE SUMMARY

Demonstration Background

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

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

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

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

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

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

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

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

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

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

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

Objectives Approved for the 2013-2015 Demonstration

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

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

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

Evaluation of 2013-2015 Objective Measures

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

Waiver Objective 1: Access to Care

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

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

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

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

Waiver Objective 2: Provider Enrollments

OHCA continues to increase the number of SoonerCare providers and to ensure that each member has a medical home.

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

Waiver Objective 3: Care Management

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

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

Waiver Objective 4: Integration of IHS Beneficiaries and Providers

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

Waiver Objective 5: Providing Access to Affordable Health Insurance

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

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

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Objectives Approved for the 2016 Demonstration

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

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

Demonstration Hypotheses:

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

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

Proposed Objectives for the 2017-2018 Extension

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

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

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II. Requested Changes for the 2017-2018 Demonstration

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

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

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

Waiver List

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

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

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

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

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

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

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

Expenditure Authorities

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

1. Demonstration Population 5.

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

2. Demonstration Population 6.

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

3. Demonstration Population 8.

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

4. Demonstration Population 10.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21. Demonstration Eligibility.

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

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

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

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

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

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

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

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

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

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

30. Insure Oklahoma: Premium Assistance Individual Plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

56. Quarterly Expenditure Reports.

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

57. Reporting Expenditures Under the Demonstration.

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

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

58. Reporting Member Months.

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

59. Standard Medicaid Funding Process.

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

60. Extent of Federal Financial Participation for the Demonstration.

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

61. Sources of Non-Federal Share.

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

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

62. State Certification of Funding Conditions.

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

63. Monitoring the Demonstration.

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

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

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

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

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

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

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

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

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

72. Exceeding Budget Neutrality.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

78. Evaluation of Eligibility and Enrollment Systems.

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

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

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

79. Interim Evaluation Reports.

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

80. Final Evaluation Plan and Implementation.

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

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

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

IV. QUALITY

Quality Assurance Monitoring

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

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

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

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

Quality Initiatives

Community Relations

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

Fetal Infant Mortality Rate (FIMR) Initiative

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

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

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

Interconception Care (ICC) Initiative

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

- Number of prenatal women enrolled in ICC: 724

Medical Home Audits

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

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

Member Outreach Letters

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

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

PCP Compliance with 24-Hour Access Requirement

The data below is from SFY 2015.

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

DRAFT

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

HEDIS® Quality Measures

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

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

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

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

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Program Integrity

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

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

V. BUDGET NEUTRALITY

Compliance with Budget Neutrality Cap

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

Standard CMS Financial Management Questions

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

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

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

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

DRAFT

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

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

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

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

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

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

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

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

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

Answer: Not applicable.

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

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

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

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

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

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

Answer: No general taxing authority

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

Answer: Yes, they receive appropriations.

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

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

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

Answer: The upper payment limit demonstration is not applicable.

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

Answer: No

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VI. DEMONSTRATION EVALUATION

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

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

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

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

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

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

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

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

Cost Effectiveness:

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

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

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

Health Management Program Evaluation

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

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

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

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

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

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

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

2013 Oklahoma Health Care Insurance and Access Survey

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

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

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

Evaluation Findings from the 2013-2015 Hypotheses

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

DRAFT

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

DRAFT

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

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

DRAFT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Hypothesis 4.A Results:

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

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

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

Hypothesis 4.B Results

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

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

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

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

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

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

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

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

Hypothesis 5 Results:

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

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

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

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

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

DRAFT

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

Hypothesis 6 Results:

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

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

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

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

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

Hypothesis 7 Results:

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

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

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

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

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

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

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

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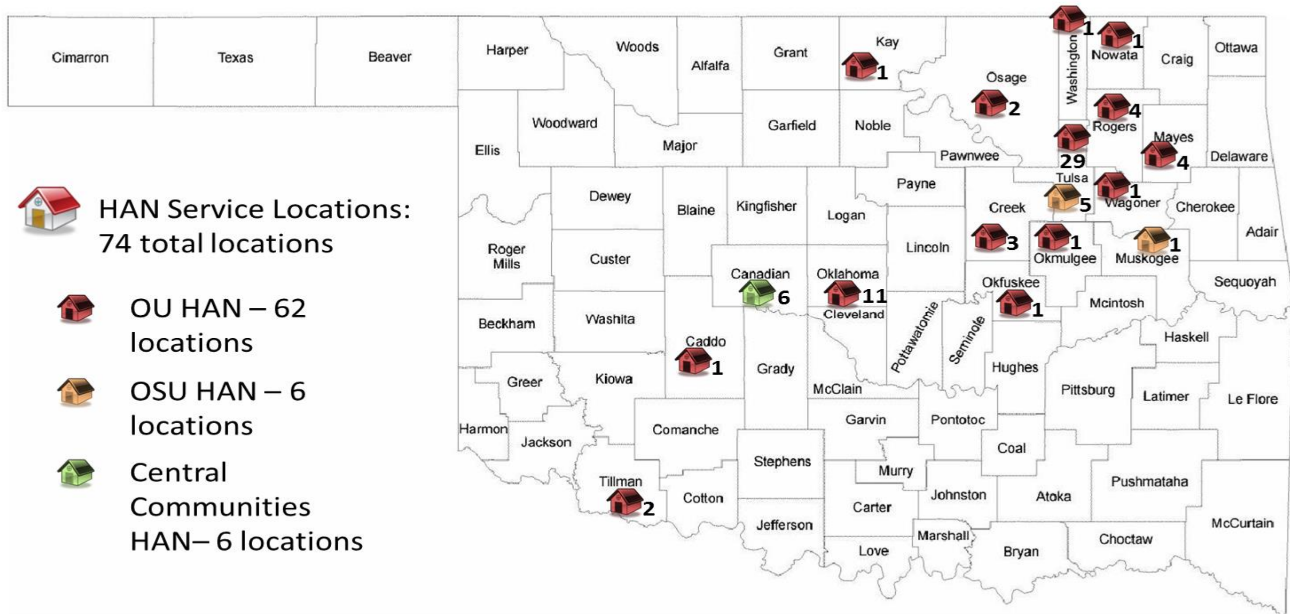
b. Improving access to and the availability of health care services: All three HAN programs provide services to members at multiple provider locations with numerous primary care providers, specialty providers and community resources. Currently, there are 74 HAN locations throughout the State.



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Hypothesis 9a(A) Results:

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

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

Hypothesis 9a(B) Results:

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

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

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

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

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

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

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

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

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

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

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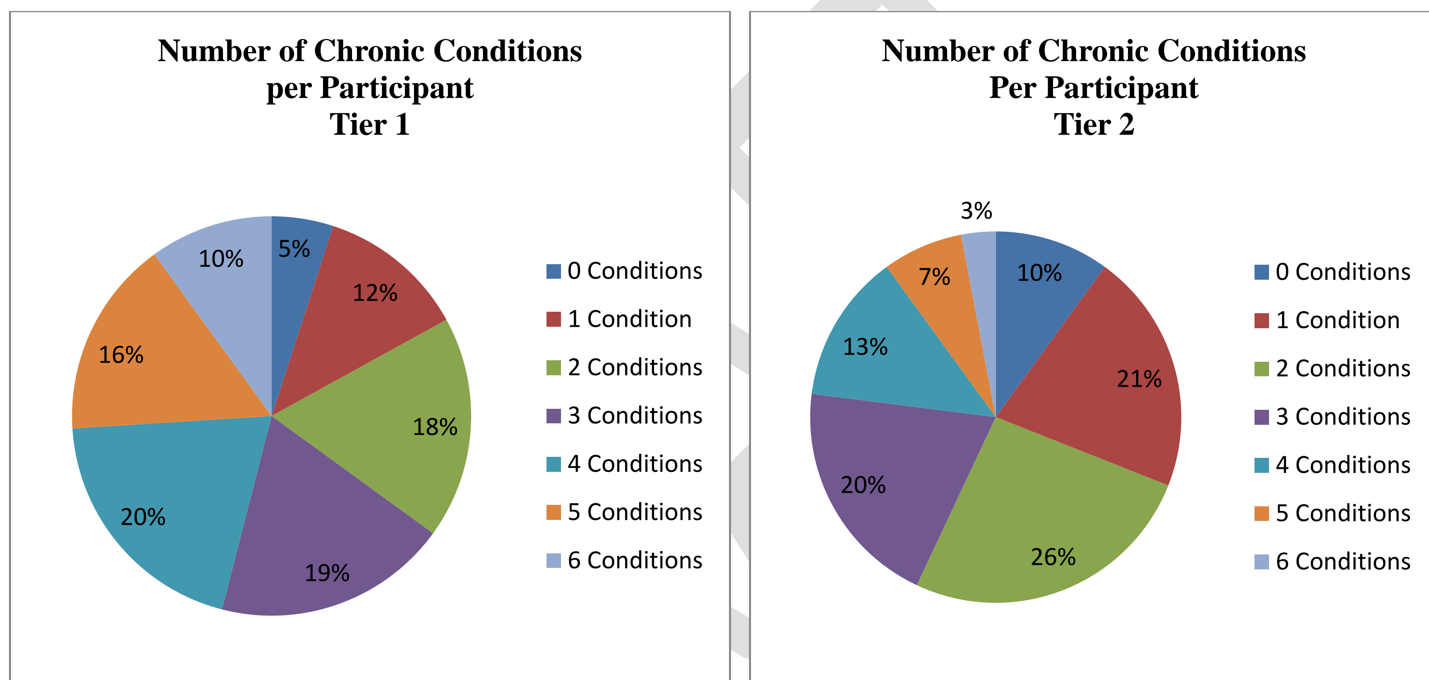
The implementation of Phase II of the SoonerCare HMP, including introduction of physician office-based Health Coaches for nurse care managed members and closer alignment of nurse care management and practice facilitation will improve the process for identifying qualified members and result in an increase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

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

Hypothesis 9c(A) Results:

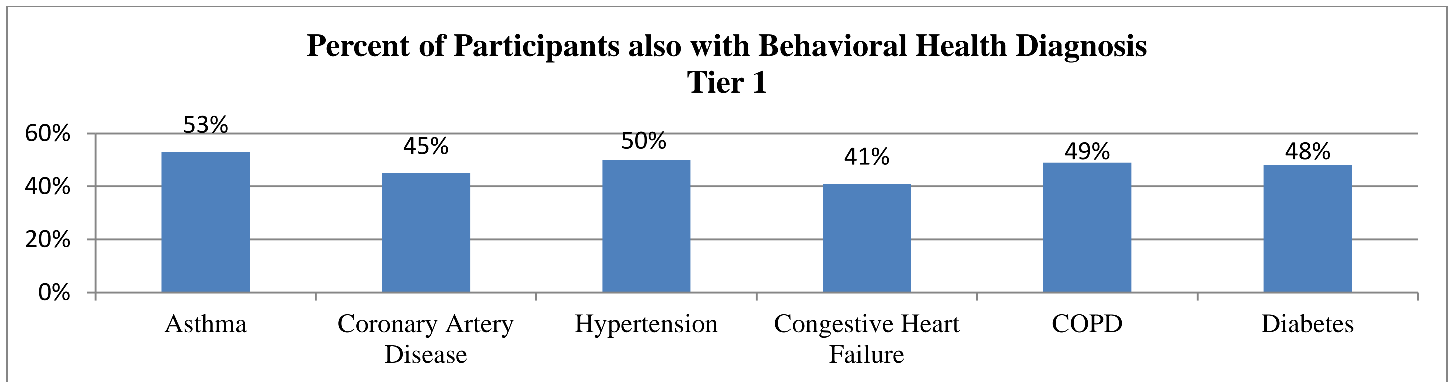


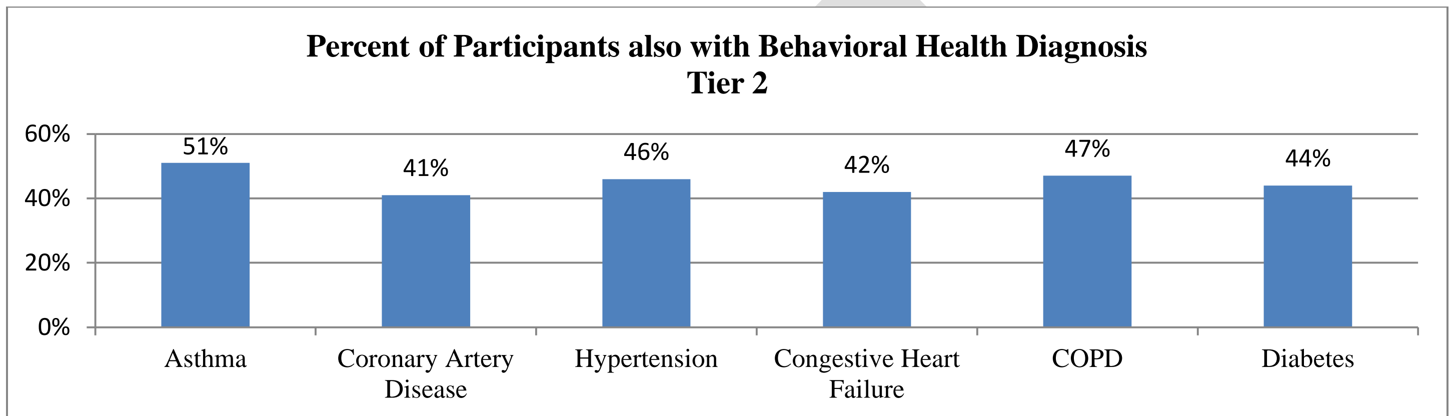
This measure indicates the number of members in nurse care management with multiple chronic conditions. In accordance with PHPG's SFY 2013 HMP Evaluation, 83 percent of Tier 1 (highest acuity) participants had at least two of the six most frequently observed chronic physical conditions, as shown in the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

Hypothesis 9c(B) Results:

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

Hypothesis 9c(C) Results:





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

Hypothesis 9c(D) Results:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Hypothesis 10 Results[11]:

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

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

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

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

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

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

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

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

a) Eligibility determinations: Refer to Hypothesis 10A.

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

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

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

e) Individuals disenrolled: Refer to Hypothesis 10C.

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

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

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

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Proposed 2017-2018 SoonerCare Choice and Insure Oklahoma Hypotheses

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

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

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

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

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

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

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

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

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

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

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

VII. PUBLIC NOTICE PROCESS

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

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

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

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

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

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

Documentation of Compliance with Public Notice Requirements

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

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

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

APPENDICES

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

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

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

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

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

Appendix B: A Historical Timeline of the SoonerCare Choice Program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A Historical Timeline of the Insure Oklahoma Program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix C: Insure Oklahoma Monitoring

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

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

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

ESI Average Premium Contribution PMPM YTD: $275.01

IP Average Cost PMPM YTD: $343.53

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

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

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

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

Contributions by Employers Pre- and Post- Participation in ESI

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

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

Total Statewide Employer Contributions Per Year

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

ESI Health Plan Monitoring

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

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

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

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

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

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

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

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Oklahoma Health Care Authority

SoonerCare Demonstration 11-W-00048/6
§1115(a) Evaluation Design (2013-2015)

Demonstration Year: 20 (01/01/2015 – 12/31/2015)
Federal Fiscal Year Quarter: 3/2016 (01/15 – 12/15)

Submitted
April 26, 2016

Table of Contents

Executive Summary 2
Background 5
Noteworthy Activity 2013 8
Noteworthy Activity 2014 9
Methods 13
Waiver Evaluation Results 15
Conclusion 54
Attachments 55

Executive Summary

The history of the SoonerCare and Insure Oklahoma 1115 SoonerCare Choice Waiver Demonstration consists of an evolution of programs and services to insure the citizens of Oklahoma receive the appropriate health care. The demonstration over time continues to work to provide an array of quality care. This is seen in the programs accomplishments, services offered with approaches to statewide coverage and population accessibility. The Oklahoma Health Care Authority (OHCA) has renewed the SoonerCare Choice waiver program to continue improvements in access to care, quality and cost effectiveness. The waiver has three primary programs operated under the waiver; Health Management Program (HMP), Health Access Networks (HAN) and Insure Oklahoma (IO) programs.

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

The OHCA worked collaboratively with state leadership, providers and stakeholders to propose a program that was unique to Oklahoma. The Oklahoma SoonerCare Choice demonstration was approved by the Health Care financing Administration in January 1995 under a 1915(b) managed care waiver. In 1995, the OHCA implemented a fully capitated managed care model SoonerCare Plus to operate in the largest metropolitan areas in Oklahoma City, Tulsa and Lawton.

In 1996, the SoonerCare Choice program was available in rural areas as a partially-capitated primary care case management (PCCM) program. The OHCA has continued this model of care throughout the term of the waiver. The OHCA contracts directly with primary care providers throughout the state to provide basic health care services. The primary care providers (PCPs) receive a monthly care coordination payment for each enrolled beneficiary, based upon the services provided at the medical home. This practice helps members have access to care and care coordination of services.

At the end of 2003, the OHCA ended the SoonerCare Plus program and replaced it with SoonerCare Choice in Oklahoma City, Tulsa and Lawton. SoonerCare Choice became the health care delivery system for individuals in Oklahoma's SoonerCare managed care program.

In 2004, SoonerCare Choice was expanded statewide as the single managed care delivery system for urban and rural areas.

Executive Summary

The Insure Oklahoma program offers premium assistance to working adults who would not be eligible for SoonerCare. The IO program went live in 2005. Two pathways are open to individuals seeking premium assistance. The first is through the employer, if the employer qualifies for Insure Oklahoma and chooses to participate. Individuals receiving premium assistance for Employer Sponsored Insurance (ESI) must pay a portion of the premium and must enroll in a qualified health plan offered by their employer.

The second pathway to eligibility is through the Individual Plan (IP), which is directly administered by OHCA and uses the SoonerCare provider network. In 2007, the IP program went live and open coverage to persons who met the Insure Oklahoma eligibility criteria and who were self-employed, unemployed or working disabled and do not have access to ESI.

In 2005, the Health Insurance Flexibility and Accountability (HIFA) amendment was approved to provide insurance to adults employed by small employers and working disabled adults. The Tax Equity and Fiscal Responsibility (TEFRA) amendment was approved to expand coverage to eligible disabled children.

As required by the special terms and conditions of the SoonerCare Choice demonstration program, the OHCA must complete an evaluation of the SoonerCare Choice demonstration at the close of each renewal period. The purpose of this evaluation is to determine the effectiveness of the SoonerCare Choice waiver for the renewal period from 2013-2015. This evaluation includes a history of the SoonerCare Choice waiver program, noteworthy activities during each year of the renewal period and the extent to which the SoonerCare Choice and Insure Oklahoma program have achieved their goals and objectives.

The results of the evaluation conclude that the program has met the waiver goals and objectives stated in the approved evaluation design for the renewal period of 2013-2015. The hypotheses were proven in most measures except for those noted within evaluation measures documented in this closeout. The state will continue to monitor the upcoming evaluation period or has made changes to said evaluation hypothesis. Notations are also made in the areas that reflect methodology changes in reporting that may have impacted outcomes to measures.

Introduction

The SoonerCare Demonstration was initially approved in January 1995. The demonstration operates under a Primary Care Case Management (PCCM) model in which the Oklahoma Health Care Authority (OHCA) contracts directly with primary care providers throughout the state to provide basic health care services. The primary care providers (PCPs) receive a monthly care coordination payment and fee-for-service payments for each enrolled beneficiary, based upon the services provided at the medical home.

The demonstration provides for a modification of the service delivery system for family and child populations and some aged and disabled populations. The benefits for individuals affected by or eligible only under SoonerCare, with the exception of individuals enrolled in the Insure Oklahoma Premium Assistance Employer Coverage and the Premium Assistance Individual Plan, are state plan benefits.

Background

In 1993, The State of Oklahoma was in the process of reforming the Medicaid program in order to improve access to care, quality of care and cost effectiveness. Federal law required every state to designate a single agency to administer its Medicaid program. In Oklahoma, state leadership passed legislation that named the Oklahoma Health Care Authority (OHCA) as the single-state agency to administer the Medicaid program, as well as convert the SoonerCare program to a managed care system.

In 1995, OHCA worked in collaboration with state leadership, providers and stakeholder to propose a program that was exclusive to Oklahoma. The Oklahoma SoonerCare Choice demonstration was approved by the Health Care Financing Administration under a 1915(b) managed care waiver. The capitated managed care model was called SoonerCare Plus and it operated in the largest metropolitan areas in the state, Oklahoma City, Tulsa and Lawton.

In 1996, the managed care program was included under Section 1115(a) research and demonstration waiver. The SoonerCare Choice program began as a partially-capitated, primary care case management pilot program in four rural areas of Oklahoma. The initial 1115(a) waiver has been extended for a three-year period beginning in January 2001- 2003 and as a result of multiple request thereafter, the demonstration continues through December 31, 2016.

In October 1996, the SoonerCare Choice program was available in rural areas as a partially-capitated Primary Care Case Management (PCCM) program.

In 1997, Senate Bill (SB) 639 was passed to allow coverage for families whose income was up to 185 percent of the Federal Poverty Level (FPL). The SoonerCare Choice program became a statewide program for all rural areas. The SoonerCare Plus program was offered in urban areas of the state and relied on contracted managed care organization (MCO) as providers. While the program initially enrolled children, pregnant women and Temporary Assistance for Needy Families (TANF) populations, over the years the success of the program has led state leadership to expand the program to serve the Aged, Blind and Disabled populations as well as additional populations.

Background

In 1998, approximately 13,000 Oklahomans qualified for SoonerCare as "medically needy", an option under the SoonerCare program. Oklahoma provided short-term medical coverage for individuals who did not meet other income or need criteria but who have such high medical costs that their incomes, in effect, are reduced to an established eligibility level. Before becoming eligible for assistance, a person must actually incur medical bills and "spend down" his or her resources to an established minimum level.

From 1999 to 2000 enrollment of the Aged, Blind or Disabled (ABD) populations into the SoonerCare Plus program began (about 32,000 individuals) in both urban and rural areas. ABD members were served by the same HMOs (urban) or primary care providers (rural) as the Aid to Families with Dependent Children (AFDC) – related population, but had an enhanced benefit package that stresses case management of special needs.

At the end of 2003, the OHCA ended the SoonerCare Plus program and replaced it with SoonerCare Choice in all three metropolitan areas. SoonerCare Choice is the health care delivery system for individuals served in Oklahoma's managed care system.

In 2004, SoonerCare Choice was expanded statewide as the single managed care delivery system for both urban and rural areas.

In 2004, State legislators approved Senate Bill 1546, which authorized the OHCA to develop a program to assist employees of small businesses with either a portion of their private health plan premiums or the purchase of a state-sponsored health plan operated under the SoonerCare program. Additionally, State legislators passed Senate Bill 610, which gave the OHCA the authority to apply for a premium assistance waiver.

In 2005, the SoonerCare program was awarded a Health Insurance Flexibility and Accountability (HIFA) waiver amendment. The OHCA was authorized to operate a premium assistance program for qualifying low-income adults with incomes above Medicaid limits, up to 200 percent of Federal Poverty Level (FPL). The Insure Oklahoma program was also known as the Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC). The Oklahoma Health Care Authority used money dedicated from the Tobacco Tax funds to assist with healthcare coverage for persons meeting income qualifications. There are currently two programs operating under the Insure Oklahoma program which is Employer-Sponsored Insurance (ESI) and the Individual Plan Insurance (IP).

Background

In 2005, the ESI program was implemented for small businesses. It gives employers the option to purchase commercial employer-sponsored insurance state approved healthcare coverage for their employees and families.

In 2005, the Oklahoma Cares program was implements. The Oklahoma Care program requires women to be screened for breast or cervical cancer under the Breast and Cervical Cancer Early Detection program (BCCEDP). Qualifications for this program are abnormal screening results or a cancerous or precancerous condition. This program, also known as Oklahoma Cares, is a partnership of the Oklahoma State Department of Health (OSDH), the Oklahoma Department of Human Services (DHS), the Cherokee Nation, The Kaw Nation and the Oklahoma Health Care Authority.

In 2005, the SoonerPlan program went live. The SoonerPlan program is Oklahoma's family planning program for women and men who are not enrolled in traditional SoonerCare services.

In 2005, the Tax Equity and Fiscal Responsibility Act (TEFRA) went live. TEFRA is a program for children with physical or mental disabilities whom are not qualified for Supplemental Security Income benefits because of their parent's income, but are able to qualify for SoonerCare benefits if they meet the TEFRA requirements.

In 2007, the IP program was implemented for individuals 19 to 64 years of age that are: low-income; working adults; self-employed, temporarily unemployed; and/or a college student. Individuals with the IP plan are not qualified for coverage with the ESI program

In 2009, OHCA implemented the Patient Centered Medical Home (PCMH) in order to provide each member with a Primary Care Provider (PCP), also known as Medical Home. In the current SoonerCare Choice Medical Home model, members actively choose their Medical Home from a network of contracted SoonerCare providers.

Indian Health Services (IHS)/Tribal-clinics and hospitals and Urban health facilities (I/T/U) providers can serve as PCPs for American Indian members in the SoonerCare Choice program. I/T/U providers receive a care coordination payment and are paid fee-for-service for all services they provide. By allowing I/T/U providers to serve as PCPs, American Indian SoonerCare Choice members can access culturally appropriate care.

Noteworthy Activity 2013

- Governor Fallin appointed members to the Blue Ribbon Panel to address a growing waitlist for individuals with disabilities that were waiting on services with the Developmental Disabilities Service (DDS) unit of Oklahoma Department of Human Services (OKDHS). Waitlisted individuals include children in the TEFRA program. This program is important because the TEFRA option allows children who qualify for institutional services to be cared for in their homes.

- OHCA initiated the Cesarean Section (C-section) Quality Initiative in January 2011, in an attempt to lower the primary C-section rate performed without medical indication. Through the Cesarean Section Quality Initiative, OHCA successfully lowered the primary C-section rate from 20.3 in state fiscal year (SFY) 2009 to 16.9 in SFY 2013.

- For SFY 2013, aggregate savings for the Health Management Program (HMP) stood at nearly $182 million, even after factoring in administrative costs. From a return on investment perspective, the SoonerCare HMP has generated more than six dollars in medical savings for every dollar in administrative expenditures.

- Eighty-eight percent of SoonerCare applications in 2013 were completed using an online application. As the year progressed, the use of online enrollment applications continued to increase.

- The Electronic Health Records (EHR) incentive program had a 24 percent increase in the number of qualified professionals and hospitals who received incentive payments. An overall total of $96 million in incentive payments was paid out in 2013.

- In May of 2013, the OHCA participated in Quality Team Day – hosted by the State of Oklahoma, and received a Governor's Commendation for Excellence award for the following projects: TSET Partnership to Support the Oklahoma Tobacco Helpline; Oklahoma Durable Medical Equipment Reuse Program; and the Medically Fragile Waiver Program.

- Oklahoma's Governor announced a one-year extension (January 1, 2014 - December 31, 2014) of the Insure Oklahoma program following successful negotiations with the federal government.

- Budget neutrality calculations for 2013 denoted state savings of some $560 million dollars, with an overall cumulative savings of $3 billion over the life of the demonstration.

Noteworthy Activity 2014

- Effective January 1, 2014, SoonerPlan's full scope pregnancy benefits Federal Poverty Level (FPL) income limit decreased to 133 percent from 185 percent.
- On January 1, 2014, the OHCA implemented a requirement for conducting a Behavioral Health screening for all SoonerCare members ages 5 and older who are enrolled in a PCMH.
- Medicaid Management Information System (MMIS) reprocurement project implemented two major projects in January 1, 2014. The Secure Provider Portal and Rules Engine Enhancement. Secure Provider Portal is a workflow system for SoonerCare providers. The rules engine enhancement reduces the number of suspended claims by systematically processing some of the claim based on the rules confirmed by the policy department and implementation into the rules engine
- In accordance with the Improper Payments Information Act of 2002, federal agencies review Medicaid and CHIP programs for improper payments every three years; this is known as the PERM program. The OHCA achieved the lowest Payment Error Rate Measurement (PERM) of 0.28 for SoonerCare among 17 states in a federal comprehensive review.
- Proposed rule changes were implemented in 2014 to align the IO program with Special Terms and Condition of the 1115 Demonstration. The revision removed children from the Individual Plan (IP) while retaining children on the ESI plan. Limits were set on adult IP enrollment to person household income at or below 100 percent of FPL.
- During the summer of 2014 the OHCA initiated a Pharmacy Lock-in program to assist providers on monitoring potential abuse or inappropriate utilization of controlled Rx medications by SoonerCare members.
- On July 1, 2014 the OHCA excluded individuals with creditable coverage from SoonerCare Choice program. TEFRA children affected by this change are able to continue their coverage through the SC program.
- On July 1, 2014 the OHCA approved ending the Perinatal Dental (PDEN) program. (The State determined that of the members who qualified, very few members utilized the service.)

Noteworthy Activity 2014

- On August 13, 2014, an independent report on the SoonerCare C-section Initiative shows a decrease in medically unnecessary C-section rate from 1.81 percent to 1.43 percent.

- On September 1, 2014 SoonerCare removed prior authorization requirements and co-pays from the seven FDA-approved tobacco cessation products.

- On November 1, 2014, the OHCA started communication process known as "going green". This allowed the use or electronic mail (email); electronic data interchange (EDI) and the secure Provider Portal to communicate with providers regarding provider letters, contract changes, renewals, newsletters and other business.

- On November 3, 2014, the OHCA began enforcing the first step in its initiative to lower the number of short-acting opioid pain relievers reimbursed by OHCA for SoonerCare members.

Noteworthy Activity 2015

- The Insure Oklahoma program celebrated its 10th Anniversary Campaign. Governor Mary Fallin declared March 23-27, 2015 "Insure Oklahoma Week". The campaign included a news release, which was distributed statewide. In addition, state leaders and Insure Oklahoma employers participated in a social media campaign by providing video messages and testimonials. The campaign demonstrated the value of the program, impact on the lives of Oklahomans and supported awareness by reaching nearly 8,000 Oklahomans who had connections to small businesses though Facebook, Twitter and other social media outlets.

- In April 2015, pursuant to House Bill 1566, The Oklahoma Health Care Authority initiated the process required to issue a Request for Proposal for care coordination model for the Age, Blind and Disabled populations.

- In June 2015, Leon Bragg, DDS, Chief Dental Officer for the Oklahoma Health Care Authority was named President of the Medicaid-CHIP State Dental Association during their Annual Conference in Washington, D.C. The national organization serves to develop and promote evidence-based Medicaid/Children's Health Insurance Program (CHIP) oral health best practices and policies. Dr. Bragg has served the organization as vice-president since 2013. In February 2004, Dr. Bragg became the OHCA's first full-time dentist. As Chief Dental Officer, he has helped develop program policy for dental care for SoonerCare members, established benefits standards for quality and assisted with utilization review for the program. Dr. Bragg also serves as a liaison between the state agency and its dental providers.

- The Oklahoma Health Care Authority received the Blue Pencil and Gold Screen Award for outstanding performance in the mobile communication category for Text4Baby enrollment in Oklahoma. The award was presented by the National Association of Government Communicators (NAGC) at the Awards Banquet held on June 3, 2015.

- In August 2015 the Insure Oklahoma program partnered with Oklahoma City based advertising agency, Staplegun Design. As a result of this partnership, a statewide broadcast, digital and print campaign was launched. This launch included social media, radio, television, digital and outdoor advertising. As part of the radio and television media outreach Insure Oklahoma conducted radio interviews with stations across the state of Oklahoma such as: KJMZ in Lawton, KTUZ in OKC and KOKC in Oklahoma City. This portion of the campaign concluded on September 2015

- In August 2015 the Oklahoma Health Care Authority held its Annual Strategic Planning Conference.

Noteworthy Activity 2015

- In September 2015, State leadership and the Oklahoma Health Care Authority announced that Insure Oklahoma program is increasing its employer size limit from 99 to 250 employees. A new e –newsletter was also launched for insurance agents who assist their clients with enrolling in the Employer-Sponsored Insurance option.

- In November 2015, the Oklahoma Health Care Authority selected a care coordination model for Aged, Blind and Disabled populations.

Methods

The evaluation design includes a review of the waiver objectives and related performance measures. The performance measures were indicated in each of the individual hypothesis as to how the data would be collected. CMS's three part aim is pointed out for each of the hypothesis. The objectives specific to hypothesis for the Health Management Pilot Program are also designated.

Demonstration Objectives:

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 Indian health Service (IHS) eligible beneficiaries and IHS and tribal providers into the SoonerCare delivery system;
- To expand access to affordable health insurance for low-income working adults and their spouses; and
- To optimize quality of care through effective care management.

CMS' Three Part Aim is also included for reference below for the SoonerCare Choice program hypotheses.

- Improving access to and experience of care;
- Improving quality of health care; and
- Decreasing per capita costs.

Evaluation of Health Access Networks

Incorporate the use of baseline data collected by the HAN and include an analysis of the HANs effectiveness in

- Reducing costs associated with the provision of health care services to SoonerCare beneficiaries served by the HAN;
- Improving access to and the availability of health care services to SoonerCare beneficiaries served by the HAN;

- Improving the quality and coordination of health care services to SoonerCare beneficiaries served by the HAN with specific focus on the populations at greatest risk including those with multiple chronic illnesses; and,

- Enhancing the state's patient-centered medical home program through an evaluation of PCP profiles that incorporates a review of utilization, disease guideline compliance, and cost.

Waiver Evaluation Results

The information which follows summarizes the results of the 2013-2015 evaluation of OHCA's success in meeting the waiver program objectives.

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

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

A. child health checkup rates for children 0-15 months old will be maintained at or above 95 percent over the life of the extension period

B. Child health checkup rates for children 3 through 6 years old increases by three percentage points over the life of the extension period.

C. Adolescent child health checkup rates will increase by three percentage points over the life of the extension period.

Well-Child Adolescent Visits	HEDIS 2010 CY 2009	HEDIS 2011 CY 2010	HEDIS 2012 CY 2011	HEDIS 2013 CY 2012	HEDIS 2014 CY 2013	HEDIS 2015 CY2014
0-15 months.1+visit	95.4%	98.3%	98.3%	95.7%	96.3%	94.3%
3-6 years	61.9%	59.8%	57.4%	59.9%	58.5%	57.1%
12-21 years	37.1%	33.5%	34.5%	22.5%	21.8%	22.1%

Hypothesis 1A Results:

This hypothesis specifies that checkup rates for children 0 to 15 months will be maintained at or above 95 percent over the course of the extension period. The OHCA met this measure in HEDIS® year 2012 when the percentage of child visits was at 98.3 percent. The OHCA has maintained at or above this rate through consecutive years as evidenced by HEDIS® data in year 2013 (95.7 percent), and through HEDIS® year 2014 (96.3 percent). In HEDSI® Year 2015 the child checkup rate fell below 95 percent rate to 94.3%. The overall average of the three years indicates the OHCA is meeting the measure with around a 95.43 percent average of the three years. The OHCA will continue to track and monitor this group during the 2016 extension period to ensure meeting this over time.

Hypothesis 1B Results:

In accordance with the hypothesis, the checkup rates for children ages 3 to 6 years are to increase by 3 percentage points over the extension period, 2013-2015, which would be an average of 1 percentage point per year. During HEDIS year 2013, children ages 3-6 years of age saw a 2.5 percent increase compared to HEDIS year 2012. In HEDIS year 2014, children ages 3-6 years of age saw a 1.4 percent increase. Children ages 3-6 years have seen a 1.4 percent decrease in health checkup rates during HEDIS® year 2015. Over the three year period, there was only a total of less than one percentage total decrease in this population group. In order to meet this measure, the OHCA will continue to track and monitor this group during the 2016 extension period.

Hypothesis 1C Results:

The evaluation measure hypothesizes that the checkup rate for adolescent's ages 12 to 21 years will also increase 3 percentage points over the period from 2013-2015, which is an average of 1 percentage point per year. Adolescents' ages 12-21 years have had a .4 percent decrease in health checkup rates from HEDIS® year 2013, to HEDIS® year 2015. The OHCA's analysis indicates that there is an adverse relationship between increasing age of the child and screening/participation rates. The percentage has slightly decreased over the term of the evaluation period. In order to meet this measure, the OHCA will continue to track and monitor the 12-21 age group during the 2016 extension period.

Hypothesis 2: PCP Visits

This hypothesis directly relates to SoonerCare waiver objective #1 # 1 of CMS's Three Part Aim.

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

SoonerCare adults ages 20-44 and 45-64 have not yet achieved the three-percentage point increase for the 2013-2015 extension periods. There seems to be no clear reason for why the numbers trend up and down for ages 20-44 and 45-64. The OHCA will continue to track and monitor this group during the 2016 extension period.

Access to PCP/ Ambulatory Health Care HEDIS Measures	HEDIS 2012 CY2011	HEDIS 2013 CY2012	HEDIS 2014 CY2013	HEDIS 2015 CY2014
20-44 years	83.1%	83.4%	82.4%	81.0%
45-64 years	91.0 %	89.8%	89.9%	90.1%

Hypothesis 3: PCP Enrollments

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

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

PCP Enrollment 2013	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
Number of SoonerCare Choice PCPs[1]	1,952	1,973	2,008	2,069	2,083	2,111	2,160	2,199	2,223	2,232	2,217	2,067

PCP Enrollment 2014	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
Number of SoonerCare Choice PCPs[2]	2,119	2,141	2,192	2,225	2,231	2,252	2,335	2,361	2,376	2,393	2,431	2,454

PCP Enrollment 2015	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
Number of SoonerCare Choice PCPs[3]	2,461	2,442	2,445	2,465	2,487	2,501	2,528	2,550	2,572	2,625	2,630	2,642

Hypothesis 3 Results:

This hypothesis measures the State's access to care by tracking the number of SoonerCare primary care providers enrolled as medical home PCPs. The OHCA exceeded the baseline data during 2013 and has continued to exceed the baseline through the end of 2015 by 37 percent. The OHCA believes that the number of Choice PCPs will continue to be maintained during the next demonstration period.

[1] SoonerCare Member to Provider Ratio 2013 (Attachment #1)
[2] SoonerCare Member to Provider Ratio 2014 (Attachment #2)
[3] SoonerCare Member to Provider Ratio 2015 (Attachment #3)

Hypothesis 4: PCP Capacity Available

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

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

A. The available capacity will equal or exceed the baseline capacity data over the duration of the waiver extension period.

B. As perceived by the member, the time it takes for the member to schedule an appointment should exceed the baseline data between 2013-2015.

Hypothesis 4A Results:

Hypothesis 4A 2013	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
Monthly SoonerCare Choice Enrollment	533,998	538,256	515,200	537,037	537,293	539,670	540,164	544,939	548,679	553,455	554,336	555,436
A1. Number of PCPs	1,952	1,973	2,008	2,069	2,083	2,111	2,160	2,199	2,223	2,232	2,217	2,067
A2. Choice PCP capacity	1,111,522	1,125,722	1,135,495	1,147,625	1,151,772	1,139,130	1,144,405	1,143,135	1,147,141	1,167,336	973,431	1,149,541
A3. Average members per PCP[4]	273.56	272.81	256.57	259.56	257.94	255.56	250.08	247.81	246.82	247.96	250.04	268.72

Hypothesis 4A 2014	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
Monthly SoonerCare Choice Enrollment	565,117	574,530	583,231	565,329	566,248	560,887	531,147	537,443	538,008	540,592	541,261	539,647
A1. Number of PCPs	2,119	2,141	2,192	2,225	2,231	2,252	2,335	2,361	2,376	2,393	2,431	2,454
A2. Choice PCP capacity	1,133,841	1,161,533	1,161,708	1,717,008	1,177,033	1,177,398	1,175,263	1,176,743	1,101,570	1,146,905	1,149,565	1,155,455
A3. Average members per PCP[5]	266.69	268.35	266.07	254.08	253.81	249.06	227.47	227.63	226.43	225.91	222.65	219.91

[4] SoonerCare Member to Provider Ratio 2013 (Attachment #1)
[5] SoonerCare Member to Provider Ratio 2014 (Attachment #2)

Hypothesis 4A 2015	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Monthly SoonerCare Choice Enrollment	541,627	545,710	546,156	544,782	548,190	548,162	549,267	545,102	540,708	534,780	531,672	528,202
A1. Number of PCPs	2,461	2,442	2,445	2,465	2,487	2,501	2,528	2,550	2,572	2,625	2,630	2,642
A2. Choice PCP capacity	1,143,025	1,148,302	1,124,592	1,163,692	1,176,882	1,151,757	1,168,177	1,155,567	1,098,018	1,148,563	1,134,697	1,146,767
A3. Average members per PCP[6]	220.08	223.47	223.38	221.01	220.42	219.18	217.27	213.77	210.23	203.73	202.16	199.93

This hypothesis postulates that OHCA will equal or exceed the baseline capacity data (1,092,850; average of 279 members per PCP) over the duration of the extension period. The OHCA exceeded the baseline capacity in the beginning of 2013 and continued to exceed it through the end of 2015. The number of SoonerCare Choice PCP providers increased steadily over the course of renewal period. In 2013 there was a seven percent increase from the number of providers in December 2012, the baseline year. Likewise, there was a 27 percent increase and a 37 percent increase in 2014 and 2015 respectively. The increased capacity resulted in an average ratio of members per PCP of 268 in 2013, 219 in 2014 and 199 in 2015.

Hypothesis 4B Results:

CAHPS® **Adult** Survey Results	**Baseline Data: SFY 2012 CAHPS® Survey Response**	**SFY 2013 CAHPS® Survey Response**	**SFY 2014 CAHPS® Survey Response**	**SFY 2015 CAHPS® Survey Response**
Positive Responses from the Survey Questions: ‘in the last 6 months, how often did you get an appointment for a checkup or routine care at a doctor’s office or clinic as soon as you needed?	85% Responded “Usually” or “Always”	80% Responded “Usually” or “Always”	82% Responded “Usually” or “Always”	87% Responded “Usually” or “Always”
CAHPS® **Child** Survey Results	**Baseline Data: SFY 2012 CAHPS® Survey Response**	**SFY 2013 CAHPS® Survey Response**	**SFY 2014 CAHPS® Survey Response**	**SFY 2015 CAHPS® Survey Response**
Positive Responses from the Survey Questions: ‘in the last 6 months, how often did you get an appointment for a checkup or routine care at a doctor’s office or clinic as soon as you needed?	91% Responded “Usually” or “Always”	90% Responded “Usually” or “Always”	91% Responded “Usually” or “Always”	93% Responded “Usually” or “Always”

This hypothesis posits that the member’s response to the time it takes to schedule an appointment should exceed the baseline data. OHCA’s contracted External Quality Review Organization

[6] SoonerCare Member to Provider Ratio 2015 (Attachment #3)

(EQRO) Morpace, conducted the CAHPS® survey for the period renewal period. Results from the CAHPS® survey indicate that the majority of survey respondents for both the Adult and Child surveys had satisfactory responses for scheduling an appointment as soon as needed. An average of eighty-three percent of the adult survey respondents felt satisfied in the time it took to schedule an appointment with their PCP over the renewal period, and there was an average of ninety-one percent of child survey respondents that indicated they were "Usually" or "Always" satisfied during the 2013-2015 renewal.

While more than three-quarters of survey respondents had a positive response about the time it takes to get an appointment with their PCP; the OHCA saw a decrease in the number of positive responses in 2013 for both the adult and children composite responses, compared to the baseline data. The OHCA saw a slight increase in positive responses in 2014 compared to the 2013 data, but still lower than the 2012 baseline. For 2015, compared to the 2012 baseline data, there was a two percent increase in the adult composite response and two percent increase for the child composite response.

Hypothesis 5: Integration of Indian Health Services, Tribal Clinics, and Urban Indian Clinic Providers

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

The percentage of American Indian members who are enrolled with an Indian Health Services, Tribal or Urban Indian Clinic (I/T/U) with a SoonerCare Choice American Indian primary care case management contract will increase nine percentage points during the 2013-2015 extension period (this is three percentage points each year).

This hypothesis postulates that the percentage of American Indian members who are enrolled with an I/T/U with a SoonerCare American Indian primary care case management contract will increase nine percentage points from the 2012 baseline amount, during the extension period of 2013-2015.

Hypothesis 5 Results:

2013 I/T/U Providers	Dec 2012 Base line	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Total AI/AN Members with SoonerCare Choice and I/T/U PCP	86,465	84,196	84,355	84,745	87,491	91,606	86,207	87,858	87,786	90,190	90,468	92,755	94,142
IHS Members with I/T/U PCP	18,195	17,165	17,570	17,541	20,718	20,167	20,418	19,645	19,664	20,005	19,953	20,116	21,165
Percent of IHS Members with I/T/U PCP	21.04%	20.39%	20.83%	20.70%	23.68%	22.01%	23.68%	22.36%	22.40%	22.18%	22.06%	21.69%	22.48%
I/T/U Capacity	124,400	124,400	101,900	101,900	101,900	102,900	101,900	101,900	101,900	96,900	99,400	99,400	99,400

2014 I/T/U Providers	Dec 2012 Base line	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Total AI/AN Members with SoonerCare Choice and I/T/U PCP	86,465	95,221	96,503	98,547	93,557	94,133	93,997	88,970	89,123	89,762	90,814	91,350	90,336
IHS Members with I/T/U PCP	18,195	21,838	22,579	22,658	20,803	21,480	21,699	21,908	22,387	22,035	22,339	22,558	21,901

2014 I/T/U Providers	**Dec 2012 Base line**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Percent of IHS Members with I/T/U PCP	21.04%	22.93%	23.40%	22.99%	22.24%	22.82%	23.08%	24.62%	25.12%	24.55%	24.60%	24.69%	24.24%
I/T/U Capacity	124,400	99,400	99,400	99,900	99,900	99,900	99,900	99,900	99,900	98,400	98,400	98,400	98,400

2015 I/T/U Providers	**Dec 2012 Base line**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Total AI/AN Members with SoonerCare Choice and I/T/U PCP	86,465	90,240	89,578	89,850	88,881	90,379	92,412	89,991	87,306	85,070	83,181	84,364	83,360
IHS Members with I/T/U PCP	18,195	15,270	15,286	15,196	14,913	15,143	15,224	15,109	14,583	14,263	13,904	13,916	13,777
Percent of IHS Members with I/T/U PCP	21.04%	24.54%	24.72%	24.08%	24.46%	24.49%	24.61%	24.52%	24.25%	24.27%	24.22%	24.08%	24.18%
I/T/U Capacity	124,400	100,900	100,900	100,900	100,900	100.900	100,900	100,900	98,400	98,400	98,499	96,999	96,999

The proportion of American Indian members with an I/T/U PCP increased 1.7 percentage points when comparing December 2013 to December 2014 and 3.5 percentage points when comparing December 2013 to December 2015. There was an increase of 3.1 percentage points of American Indian members who are enrolled with an I/T/U PCP when comparing the December 2012 baseline to December 2015. The OHCA believes that the number American Indian members utilizing a PCP will continue to be maintained during the next renewal period.

Hypothesis 6: Eligible Member Enrollments in Medical Home

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

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

Hypothesis 6 Results:

Productivity Categories 2013	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
PCP Total Enrollments-Completed	1,584	1,260	562	717	738	661	635	788	402	538	127	333
Total Unduplicated Claims	3,503	3,229	640	1,642	546	492	648	639	447	759	642	501
Percentage	45.22%	39.02%	87.81%	43.67%	135.16%	134.35%	97.99%	123.32%	89.93%	70.88%	19.78%	66.47%

Productivity Categories 2014	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
PCP Total Enrollments-Completed	292	501	316	342	383	531	559	686	861	641	444	503
Total Unduplicated Claims	848	558	550	727	890	955	1,341	1,718	1,737	924	956	836
Percentage	34.43%	89.78%	57.45%	47.04%	43.03%	55.60%	41.69%	39.93%	49.57%	69.37%	46.44%	60.17%

Productivity Categories 2015	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
PCP Total Enrollments-Completed	409	541	540	473	607	479	483	400	566	511	560	456
Total Unduplicated Claims	1,150	1,018	885	911	738	850	850	756	1,106	1,110	938	678
Percentage	35.57%	53.14%	61.02%	51.92%	82.25%	56.35	56.82%	52.91%	51.18%	46.04%	59.70%	67.26%

The OHCA's Primary Care Claims Analysis Report is a monthly report that includes every SoonerCare Choice qualified member with a claim who does not have an established PCP. In January of 2013 the percentage of members aligned with a PCP was 45.2% and grew to 66.4 % by the end of the year, a 21.2% improvement. In January of 2014 the percentage of members aligned with a PCP was 34.4% and grew to 60.1% by the end of the year, a 25.8% improvement. In January of 2015 the percentage of members aligned with a PCP was 35.5% and grew to 67.2% by the end of the year, a 31.7% improvement. The OHCA has successfully met this measure as the OHCA continually increased the number of SoonerCare Choice eligible members who have an established PCP throughout each of the past three demonstration years.

Hypothesis 7: Impact of Health Access Networks on Quality of Care

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

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

A. Decrease asthma-related ER visits for HAN members with an asthma diagnosis identified in their medical record.

B. Decrease 90-day readmissions for related asthma conditions for HAN members with an asthma diagnosis identified in their medical record.

C. Decrease overall ER use for HAN members.

Hypothesis 7 Results:

A. **2013** Asthma-Related ER Visits	HAN members with an Asthma diagnosis in their medical record	All HAN Members with ER visit in a calendar year	**Percent of HAN members with an Asthma diagnosis who visited the ER**
OU Sooner HAN	2,588	31,364	**8%**
PHCC HAN	86	839	**10%**
OSU Network HAN	628	3,057	**21%**

B. **2013** 90-Day Re-admissions for HAN Members with Asthma	HAN Members with Asthma who were Re-admitted to the Hospital 90 Days after Previous Asthma-Related Hospitalization	HAN members with Asthma identified in their medical record and having at least one inpatient stay related to Asthma	**Percent of HAN Members with Asthma who had a 90-Day Re-admission for Related Asthma Condition(s)**
OU Sooner HAN	16	26	**62%**
PHCC HAN	0	7	**0%**
OSU Network HAN	6	80	**8%**

C. **2013** ER Use for HAN Members	Total number of ER visits for HAN Members	Total Number of HAN members	**Percent of ER Use for HAN Members**
OU Sooner HAN	31,364	238,208	**13%**
PHCC HAN	2,153	5,192	**41%**
OSU Network HAN	9,873	29,528	**33%**

A. **2014** Asthma-Related ER Visits	HAN members with an Asthma diagnosis in their medical record	All HAN Members with ER visit in a calendar year	**Percent of HAN members with an Asthma diagnosis who visited the ER**
OU Sooner HAN	3,950	58,055	**7%**
PHCC HAN	72	885	**8%**
OSU Network HAN	415	4,548	**9%**

B. **2014** 90-Day Re-admissions for HAN Members with Asthma	HAN Members with Asthma who were Re-admitted to the Hospital 90 Days after Previous Asthma-Related Hospitalization	HAN members with Asthma identified in their medical record and having at least one inpatient stay related to Asthma	**Percent of HAN Members with Asthma who had a 90-Day Re-admission for Related Asthma Condition(s)**
OU Sooner HAN	29	504	**6%**
PHCC HAN	0	4	**0%**
OSU Network HAN	2	66	**3%**

C. **2014** ER Use for HAN Members	Total number of ER visits for HAN Members	Total Number of HAN members	**Percent of ER Use for HAN Members**
OU Sooner HAN	58,055	124,421	**47%**
PHCC HAN	1,938	5,273	**37%**
OSU Network HAN	10,073	61,405	**16%**

A. **2015** Asthma-Related ER Visits	HAN members with an Asthma diagnosis in their medical record	All HAN Members with ER visit in a calendar year	**Percent of HAN members with an Asthma diagnosis who visited the ER**
OU Sooner HAN	5,888	64,958	**9%**
PHCC HAN	41	858	**5%**
OSU Network HAN	560	7,390	**8%**

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

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

The health access networks continue to move forward with reporting under the refined methodology established in 2013 (calendar year 2013 will be the baseline for the health access networks). The OHCA will continue to track hypothesis 7 over the demonstration period to monitor for significant changes in results.

Hypothesis 8: Impact of Health Access Networks on Effectiveness of Care

This hypothesis directly relates to SoonerCare Choice waiver objective #3 and #3 of CMS's Three Part Aim.

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

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

Hypothesis 8 Results:

SFY 2013 PMPM	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Avg.
HAN Members	$280.35	$303.82	$285.38	$309.49	$298.32	$283.84	$324.19	$278.91	$298.39	$305.92	$296.58	$274.13	$294.94
Non HAN Members	$292.90	$324.93	$291.95	$327.93	$308.13	$296.22	$369.75	$305.06	$321.47	$323.94	$324.52	$277.06	$313.66

SFY 2014 PMPM	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Avg.
HAN Members	$295.86	$316.43	$295.77	$304.31	$282.98	$262.24	$312.61	$273.60	$289.47	$298.97	$292.06	$268.83	$291.09
Non HAN Members	$371.12	$293.59	$286.47	$391.41	$298.06	$261.84	$317.51	$267.06	$293.95	$408.11	$288.34	$274.17	$312.64

SFY 2015 PMPM	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Avg.
HAN Members	$274.53	$274.34	$274.70	$283.50	$249.48	$276.98	$297.24	$271.75	$283.64	$282.14	$260.49	$261.19	$274.16
Non HAN Members	$307.30	$302.33	$308.02	$318.93	$268.47	$309.24	$332.12	$297.22	$312.00	$318.22	$277.06	$284.21	$302.93

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

This hypothesis indicates that the average per member per month (PMPM) expenditure for HAN members will be less than the PMPM expenditure for Non-HAN members. The SFY 2015 PMPM average for HAN members was $274.16 while the PMPM average for Non-HAN members was $302.93. Per member per month expenditures, continue to be lower for SoonerCare Choice members enrolled with a HAN PCP, than for SoonerCare Choice members who are not enrolled with a HAN PCP. The OHCA expects this trend to continue.

Hypothesis 9A: Health Management Program (HMP) Impact on Enrollment Figures

This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #3, and #1 of CMS's Three Part Aim.

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

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

Hypothesis 9a(A) Results:

SoonerCare HMP Part A	Engaged in Nurse Care Management
July 2013	184
August 2013	511
September 2013	1,132
October 2013	1,952
November 2013	2,737
December 2013	3,083

SoonerCare HMP Part A	Engaged in Nurse Care Management
January 2014	3,674
February 2014	4,329
March 2014	5,040
April 2014	5,621
May 2014	5,493
June 2014	5,360
July 2014	5,057
August 2014	4,900
September 2014	4,745
October 2014	4,628
November 2014	4,544
December 2014	4,370

SoonerCare HMP Part A	Engaged in Nurse Care Management
January 2015	4,153
February 2015	3,997
March 2015	4,023
April 2015	4,113
May 2015	4,170
June 2015	4,298
July 2015	4,531
August 2015	4,574
September 2015	4,644
October 2015	4,499
November 2015	4,532
December 2015	4,526

The Health Management Program (HMP) transitioned to Phase II of the program, Next Generation HMP, in July 2013. Phase II of the program embeds health coaches into the practices for face-to-face care management. For this measure, The OHCA provides the baseline data for SFY 2013.

This hypothesis posits that the percentage of SoonerCare members identified as qualified for nurse care management, who enroll and are actively engaged, will increase as compared to the baseline data. In July 2013, the methodology for identifying and reporting members eligible for and engaged in the HMP changed due to programmatic and contractual changes. The OHCA is confident in the accuracy of the number of members engaged and in the total number of members assigned to HMP practices. However, the methodology used to count the number of members eligible for the HMP did not capture the total eligible population and the data is not available retrospectively.

Hypothesis 9a(B) Results**:**

SFY Baseline Data	Eligible	Engaged	**Percentage**
SFY 2013	11,343	3,252	**28.66%**

SFY 2013 PCP visits and HMP members:

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

SFY 2013Actively Engaged HMP Members Aligned with a Health Coach	Total SoonerCare Members Assigned to Panel of Practices with Health Coaches	Individuals Qualified for the HMP Program	Number of HMP Members Actively Engaged in Nurse Care Management	Percentage of HMP Members Aligned with a Health Coach who are Actively Engaged in Nurse Care Management
Members	29,723	5,684	3,083	10.4%

SFY 2014 Actively Engaged HMP Members Aligned with a Health Coach	Total SoonerCare Members Assigned to Panel of Practices with Health Coaches	Individuals Qualified for the HMP Program	Number of HMP Members Actively Engaged in Nurse Care Management	Percentage of HMP Members Aligned with a Health Coach who are Actively Engaged in Nurse Care Management
Members	71,621	Not Available	4,526	6.32%

Note: not all SoonerCare Choice members are considered eligible for HMP. They must meet the HMP criteria with having (or be at risk for) a identified chronic illness etc.

The results show the total number of eligible SoonerCare members assigned to a panel of Practices with Health Coaches and the number of HMP members actively engaged in nurse care management. In addition, this chart shows the percentage of HMP members aligned with health coaches who are actively engaged in nurse care management.

Hypothesis 9b: Health Management Program (HMP); Impact on Access to Care

This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #4, and #1 of CMS's Three Part Aim.

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

Hypothesis 9b Results:

The Health Management Program (HMP) transitioned to Phase II of the program, Next Generation HMP, in July 2013. Phase II of the program embeds health coaches into the practices for face-to-face care management. For this measure, OHCA provides the baseline data for SFY 2013, as the OHCA is still accumulating data for Phase II of the HMP program.

The PHPG conducted an over-the-telephone HMP member survey for SFY 2013. The survey included the question: "Not including trips to the ER, how many times have you seen a health care provider in the past 12 months." Of the 3,924 members who were interviewed for the survey, 99 percent of members (3,921) gave a response.

For SFY2013, half (50 percent) of survey respondents indicated that they visited their PCP 10 or more times within 12 months. Comparatively only 0.8 percent of survey respondents indicated that they did not see their PCP at all over twelve months. As health coaches were embedded into practices beginning in July 2013, OHCA postulates that more members will report increased visits with their PCPs.

SFY2014 (engaged group) Results: The methodology has changed to now report the compliance of health coached participants 20 years of age and older who had an ambulatory/preventive care visit during this measurement year. The outcome of the participants measured (3,617 of 3,757), yielded 96.3 percent of members having contact with primary care physicians. The incorporation of Health Coaches into primary care practices will result in increased PCP contact with nurse care managed members, versus baseline for two successive years and a comparison group of eligible but not enrolled members.

SFY2013 (baseline group) Results: As a result of the changes made to the HMP, members engaged in telephonic nurse care management were transitioned to the Chronic Care Unit (CCU) which is part of the OHCA's Population Care Management (PCM) department. These members were not included in the annual HMP evaluation and therefore, we do not have results for this measure. The OHCA will continue to monitor the care of members in this department.

SFY2014 (comparison group) Results: The comparison group is the general SoonerCare population. The compliance rate of participants 20 years of age and older who had an ambulatory/preventive care visit during the measurement year was 84.7 percent. Hypothesis language has been updated to report this measure going forward, these numbers will be used as the baseline. The OHCA will continue to monitor the impact of this measure on members.

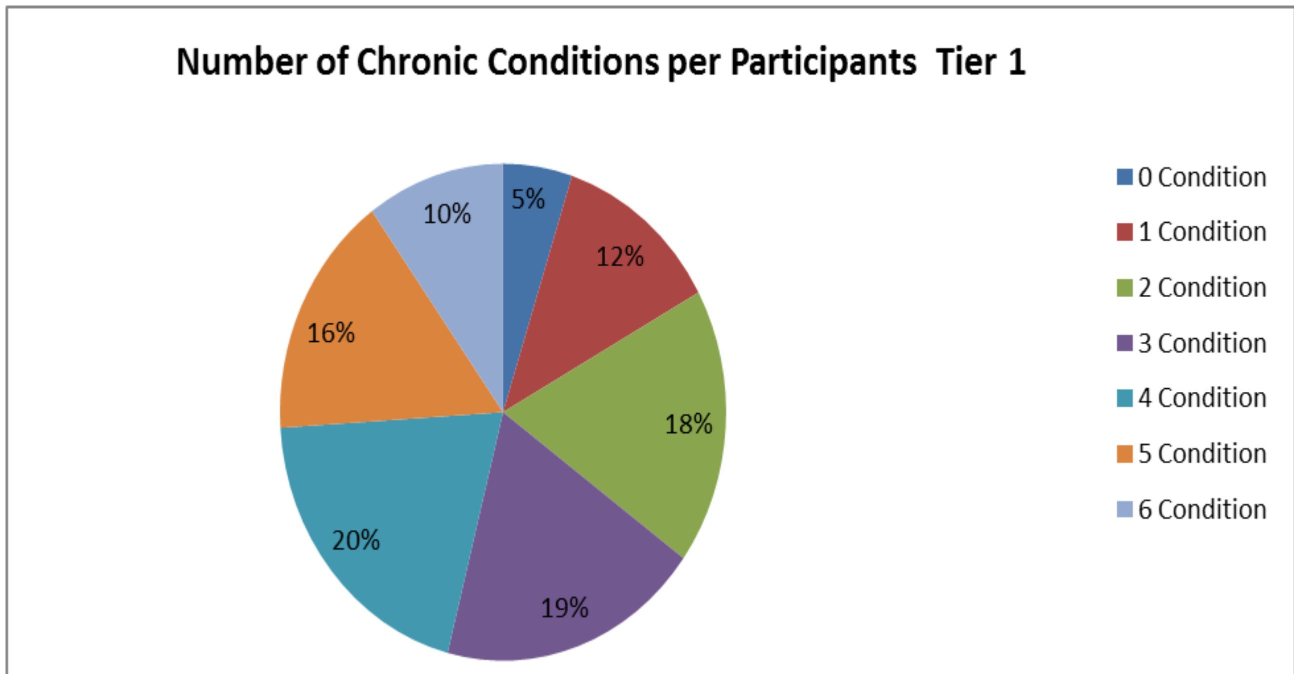
HMP Preventive Measures-Practice Facilitation Members vs. Comparison Group	Comparison Group Compliance Rate
Adult Access to Preventive/Ambulatory Care	84.7%

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

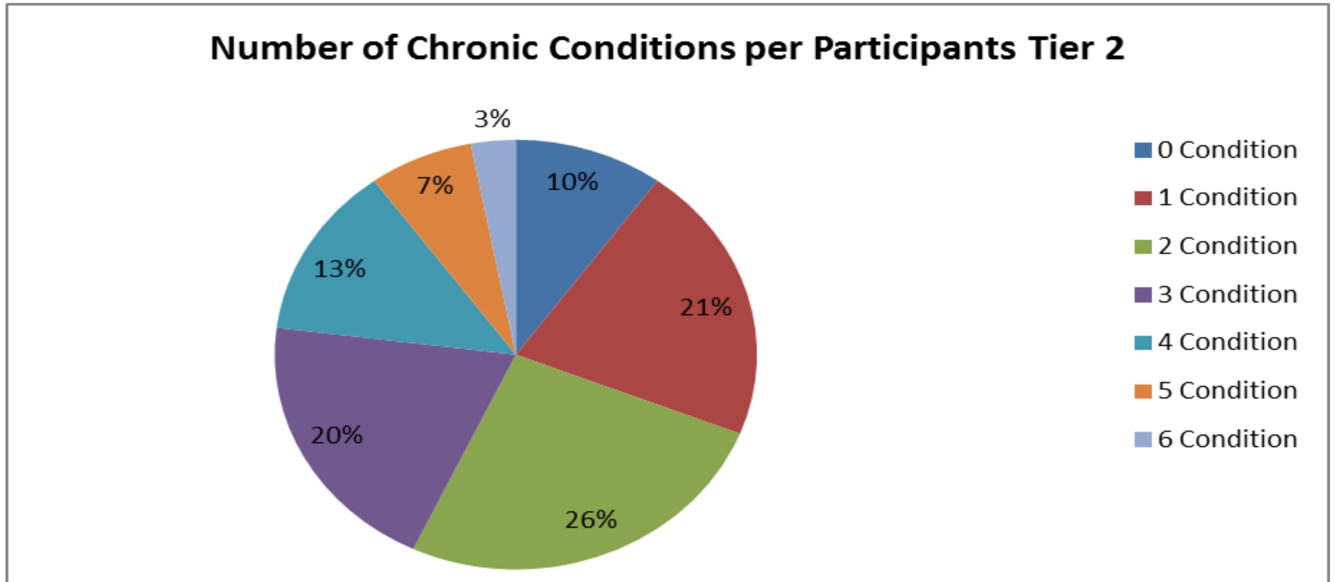
This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #2, and #2 of CMS's Three Part Aim.

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

Hypothesis 9c Results:

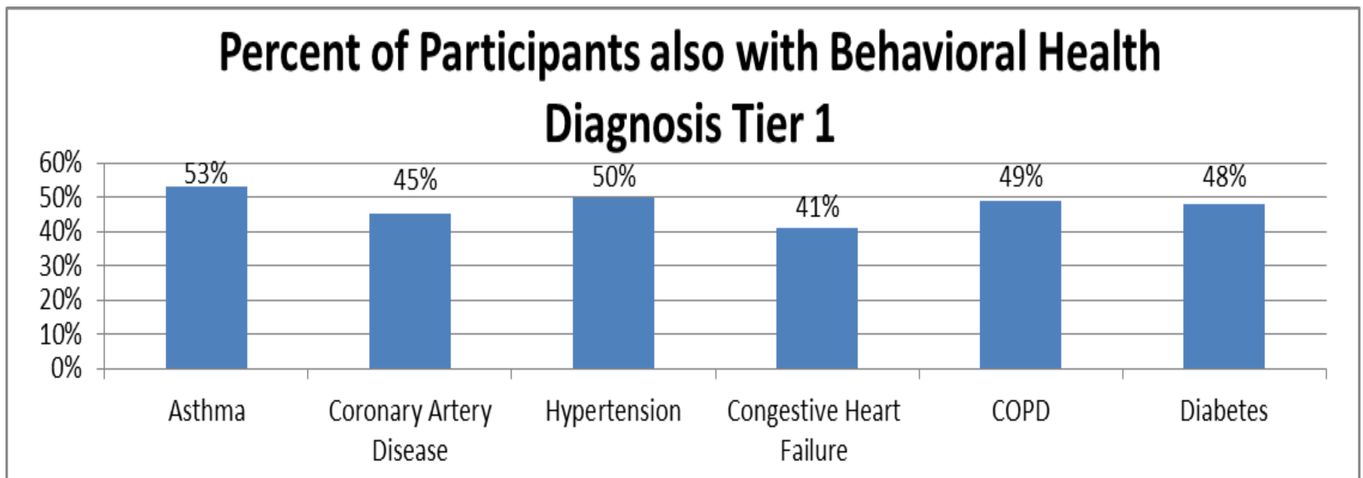


SFY2013 Results:

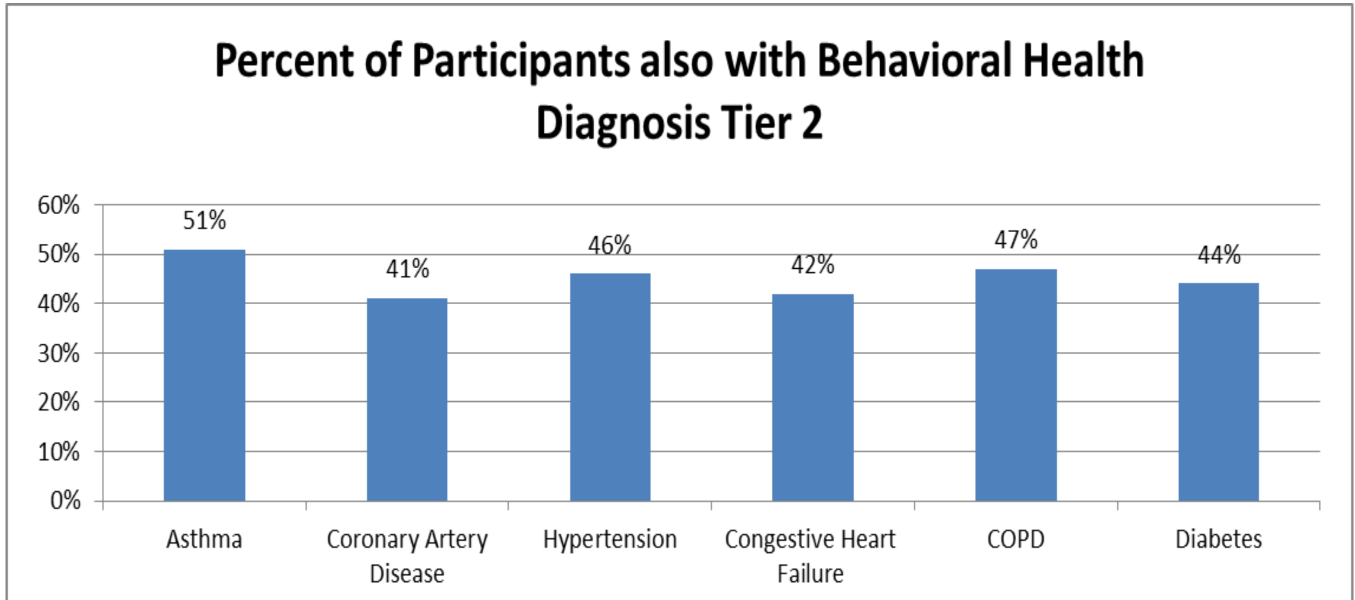


SFY2013 Results:

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



SFY2013 Results:



SFY2013 Results:

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

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

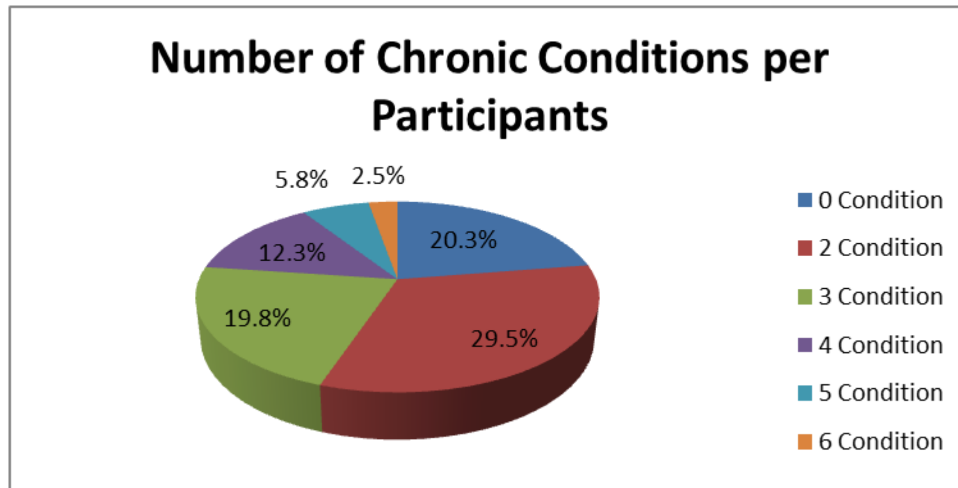
The Health Management Program (HMP) transitioned to Phase II of the program, Next Generation HMP, in July 2013. Phase II of the program embeds health coaches into the practices for face-to-face care management. The OHCA noted in earlier reporting the baseline data for this measure would begin SFY 2013 to allow the OHCA time to accumulate data for Phase II of the HMP program.

Chronic diseases are the leading cause of death and disability in the United States according to the Centers for Disease Control and Prevention in 2012. One in four adults had two or more chronic health conditions. [7]In Oklahoma, the CDC estimates that the total expenditures related to treating selected major chronic conditions will surpass $8.0 billion in 2015. The OHCA's goal

[7] CDC Website

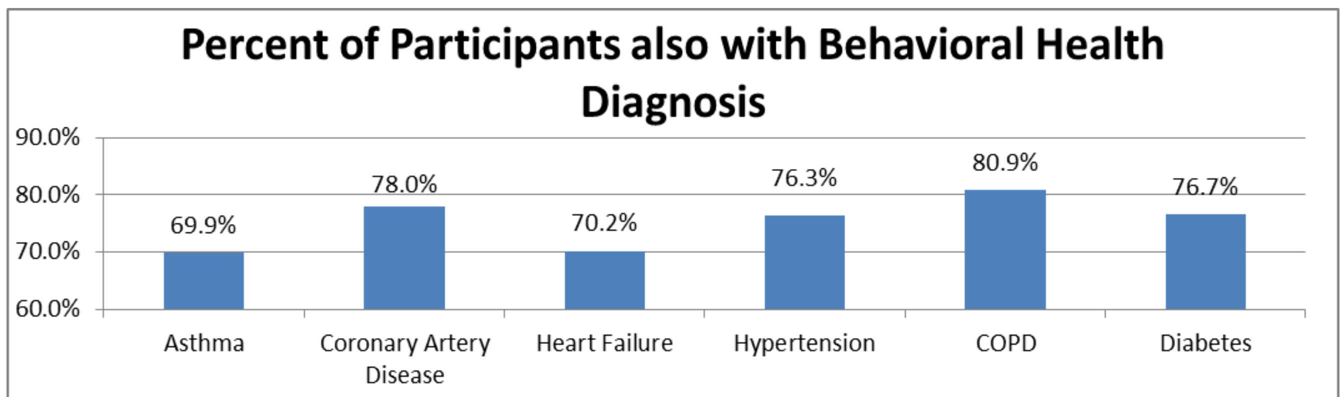
was to provide health coaching at any given time to as many as 7,500 members at around 46 enrolled practices, but the actual numbers found during the PHPG evaluation was closer to 5,000. Program participants are treated for numerous chronic and acute physical conditions. PHPG found that 80 percent of participants had at least 2 chronic physical conditions.

SFY2014 Results:



The SoonerCare HMPs focus on holistic care rather than management of a single disease is appropriate given the prevalence of co-morbidities in the participating population. Independent research group PHPG examined the number of physical chronic conditions per participant in the health management program during this time and found that nearly 80 percent have at least two of six high priority chronic physical conditions (asthma, COPD, coronary artery disease, diabetes, heart failure and hypertension)[8] as demonstrated in the table above.

SFY2014 Results:



[8] These conditions are used by MEDai as part of its calculation of chronic impact scores.

Nearly 75 percent of the participant of the HMP population also has both a physical and behavioral health condition. Among the six physical health conditions, the co-morbidity prevalence ranges from approximately 81 percent in cases of persons with COPD which is the highest to 70 percent among person with asthma noted as the lowest.

The Chronic impact score total for engaged members = 350,230/4,526 (number of engaged members as of Dec 2015). Engaged members had an Average chronic impact score of 77.37.

SFY2015: The data results necessary to provide outcomes for hypothesis 9c are reported in the claims analysis portion of the annual evaluation report, which will not be available until June 30, 2016.

Hypothesis 9d: Health Management Program (HMP); Impact on Health Outcomes

This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #5, and #2 of CMS's Three Part Aim.

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

HMP Members' Compliance Rates with CareMeasures ™ Clinical Measures	SFY2013 Percent Compliant
Asthma – Percent of patients 5 to 40 with a diagnosis of asthma who were evaluated during at least one office visit within 12 months for the frequency of daytime and nocturnal asthma symptoms	85.9%
Asthma – Percent of patients 5 to 40 with a diagnosis of mild, moderate or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment	100.0%
Chronic Obstructive Pulmonary Disease – Spirometry Evaluation	81.0%
Chronic Obstructive Pulmonary Disease – Bronchodilator Therapy	91.7%
Diabetes Mellitus – Percent of patients 18 to 75 with DM receiving one or more A1c test(s) per year	87.1%
Diabetes Mellitus – Percent of patients 18 to 75 with DM who had most recent hemoglobin A1c less than 9 percent	67.0%
Diabetes Mellitus – Percent of patients 18 to 75 with DM who had most recent blood pressure in control (<140/80 mmHg)	71.7%
Diabetes Mellitus – Percent of patients 18 to 75 with DM receiving at least one lipid profile (or all component tests)	69.1%
Diabetes Mellitus – Percent of patients 18 to 75 with DM with most recent LDL-C < 130 mg/dI	53.1%
Diabetes Mellitus – Percent of patients 18 to 75 with DM who received urine protein screening or medical attention for nephropathy during at least one office visit within 12 months	59.0%

Diabetes Mellitus – Percent of patients 18 to 75 with diagnosis of DM who had dilated eye exam	49.2%
Diabetes Mellitus – Percent of patients 18 to 75 with DM who had a foot exam	64.2%
Hypertension – Percent of patients with blood pressure measurement recorded among all patient visits for patients 18 and older with diagnosed HTN	98.8%
Hypertension – Percent of patients 18 and older who had a diagnosis of HTN and whose blood pressure was adequately controlled (< 140/90 mmHg) during the measurement year	69.4%
	SFY2013
Members' Compliance Rates with CareMeasures™ Clinical Measures	**Percent Compliant**
Prevention – Percent of women 50 to 69 who had a mammogram to screen for breast cancer within 24 months	39.4%
Prevention – Percent of patients 50 to 80 who received the appropriate colorectal cancer screening	20.0%
Prevention – Percent of patients 18 and older who received an influenza vaccination during the measurement period	37.1%
Prevention – Percent of patients 18 and older who have ever received a pneumococcal vaccine	12.5%
Prevention – Percent of patients identified as tobacco users who received cessation intervention during the measurement period	20.0%
Prevention – BMI and follow-up documented	90.7%
Tobacco Cessation – Percent of patients 10 and older where inquiry about tobacco use was recorded	60.6%
Tobacco Cessation – Percent of patients 10 and older who use tobacco where act of assessing the patient’s readiness to quit tobacco use was recorded	75.7%
Tobacco Cessation – Percent of patients 10 and older who use tobacco where the act of advising the patient to quit tobacco use was recorded	95.5%
Tobacco Cessation – Percent of patients 10 and older who use tobacco where assistance with developing a behavioral quit plan was provided	77.8%

Tobacco Cessation – Percent of patients 18 and older who use tobacco where medication use was recommended to aid their quit plan	65.0%
Tobacco Cessation – Percent of patients 10 and older who use tobacco who were provided motivational treatment to quit tobacco use	40.9%
Tobacco Cessation – Percent of patients 10 and older who use tobacco, and who are ready to quit using tobacco, where a follow up was scheduled	25.5%
Tobacco Cessation – Percent of patients 10 and older who were former tobacco users where assistance with relapse prevention was provided	N/A

SFY2013 Results:

The nurse care managed participant compliance rate exceeded the comparison group rate on 16 of the 21 diagnosis-specific measures. The difference was statistically significant for 11 of the 16, suggesting that the program is continuing to have a positive effect on quality of care. The most impressive results, relative to the comparison group, were observed for the participant with chronic obstructive pulmonary disease, congestive heart failure, diabetes and hypertension.

HMP Members' Compliance Rates with CareMeasures ™ Clinical Measures changed from Nurse Care Management to Health Coach for SFY2014.

HMP Members' Compliance Rates with CareMeasures ™ Clinical Measures	SFY2014 Percent Compliant
Asthma	
Use of appropriate medications for people with Asthma	95.3%
Medication management for people with Asthma - 50 percent	68.3%
Medication management for people with Asthma - 75 percent	26.8%
Cardiovascular Disease	
Persistence of beta blocker treatment after heart attack	50.0%
LDL-C screening	76.0%
COPD	
Use of spirometry testing in the assessment/diagnosis of COPD	31.5%

Pharmacotherapy management of COPD exacerbation - 14 days	49.5%
Pharmacotherapy management of COPD exacerbation - 30 days	73.9%
Diabetes	
LDL-C Test	77.0%
Retinal Eye Exam	37.8%
HbA1c Test	86.7%
Medical attention for nephropathy	77.1%
ACE/ARB Therapy	66.8%
Hypertension	
LDL-C Test	67.3%
ACE/ARB Therapy	66.5%
Diuretics	45.1%
Annual monitoring for patients prescribed ACE/ARB or diuretics	84.2%
Mental Health	
Follow-up after hospitalization for mental illness - seven days	34.8%
Follow-up after hospitalization for mental illness - 30 days	67.4%
Prevention	

Adult Access to preventive/ambulatory care	96.3%
Child access to PCP	98.4%
Adult BMI	14.3%

SFY2014 Results:

The health coaching participant compliance rate exceeded the comparison group rate on 11 of 18 measures for which there was comparison group percentage. The difference was statistically significant for nine of the 11, suggesting that the program is having a positive effect on quality of care, although there is room for continued improvement. The most impressive results, relative to comparison group, were observed for participants with diabetes and mental illness, and with respect to access to preventive care.

SFY2015 Results:

The contract to evaluate the HMP was renewed in 2014, which resulted in the timeline for report deliverables being altered. Annual evaluation reports are now due to OHCA by June 30th of each year to evaluate the work performed during fiscal year. The SFY 2015 data necessary to provide outcomes for this will not be available until June 30, 2016.

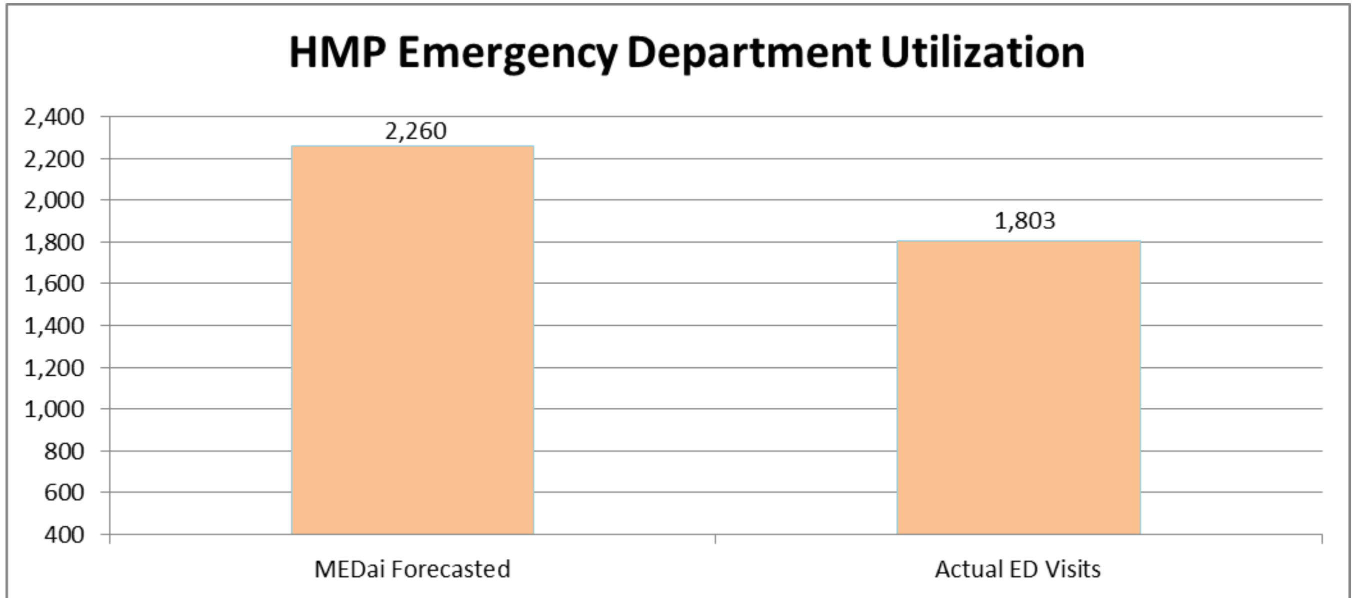
Hypothesis 9e: Health Management Program (HMP); Impact on Cost/Utilization of Care

This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #1, and #2 of CMS's Three Part Aim.

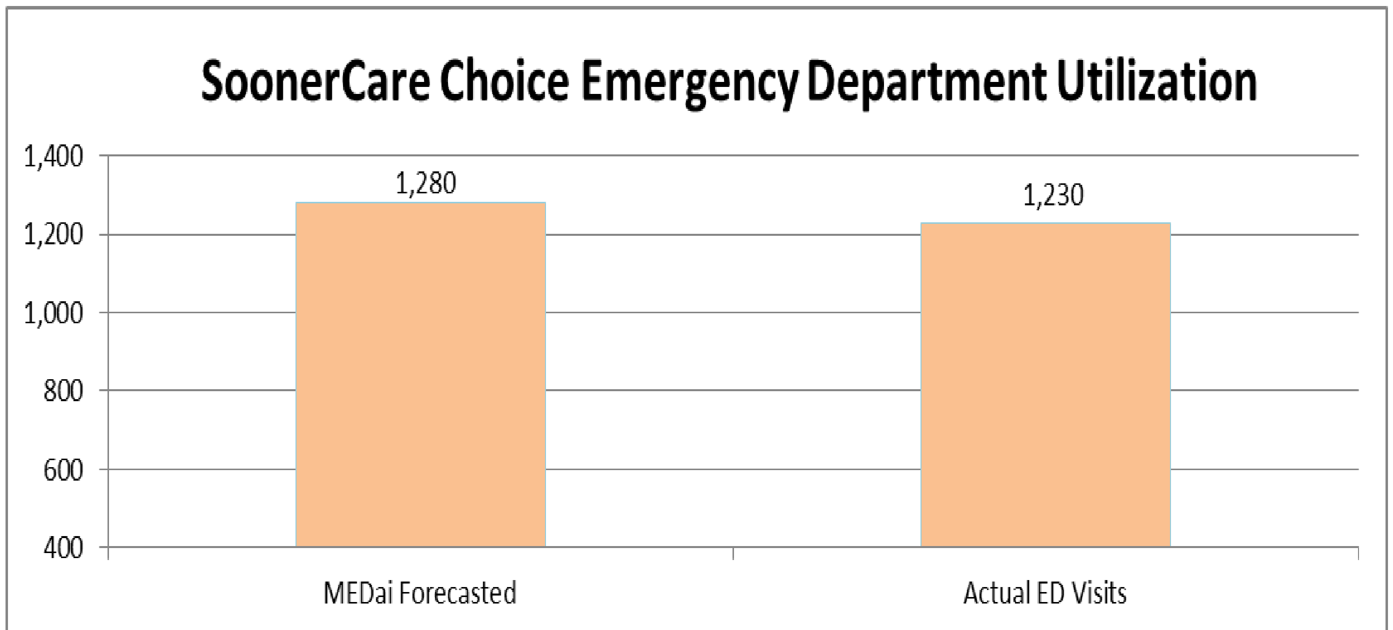
Hypothesis 9e Results:

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

SFY2014 Results



MEDai forecasted that SoonerCare HMP participants as a group would incur 2,260 emergency department visits per 1,000 participants in the first 12 months of engagement. The actual rate was 1,803 or 80 percent of forecast.



MEDai projected members with a chronic illness in the comparison group would incur 1,280 emergency department visits per 1,000 over the 12-month forecast period. The actual rate was 1,230 or 96 percent of forecast.

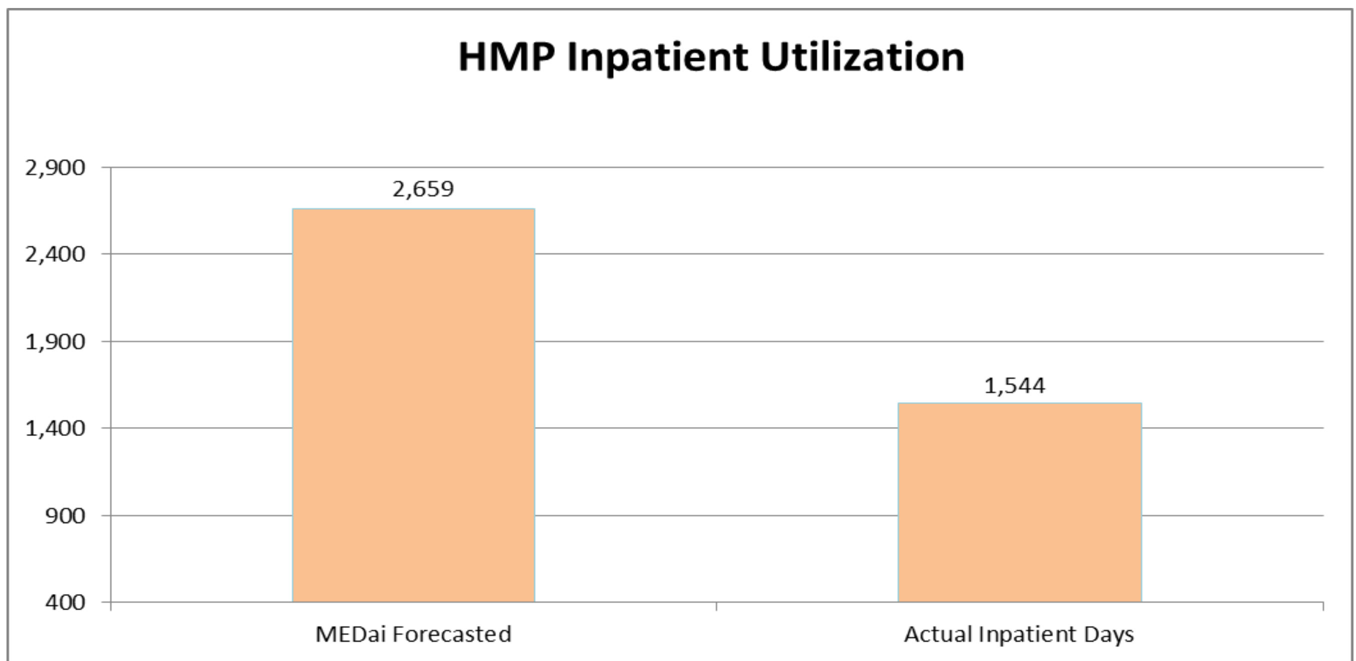
Hypothesis 9f: Health Management Program (HMP); Impact on Cost/Utilization of Care

This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #1, and #2 of CMS's Three Part Aim.

Hypothesis 9f Results:

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

SFY2014 Results

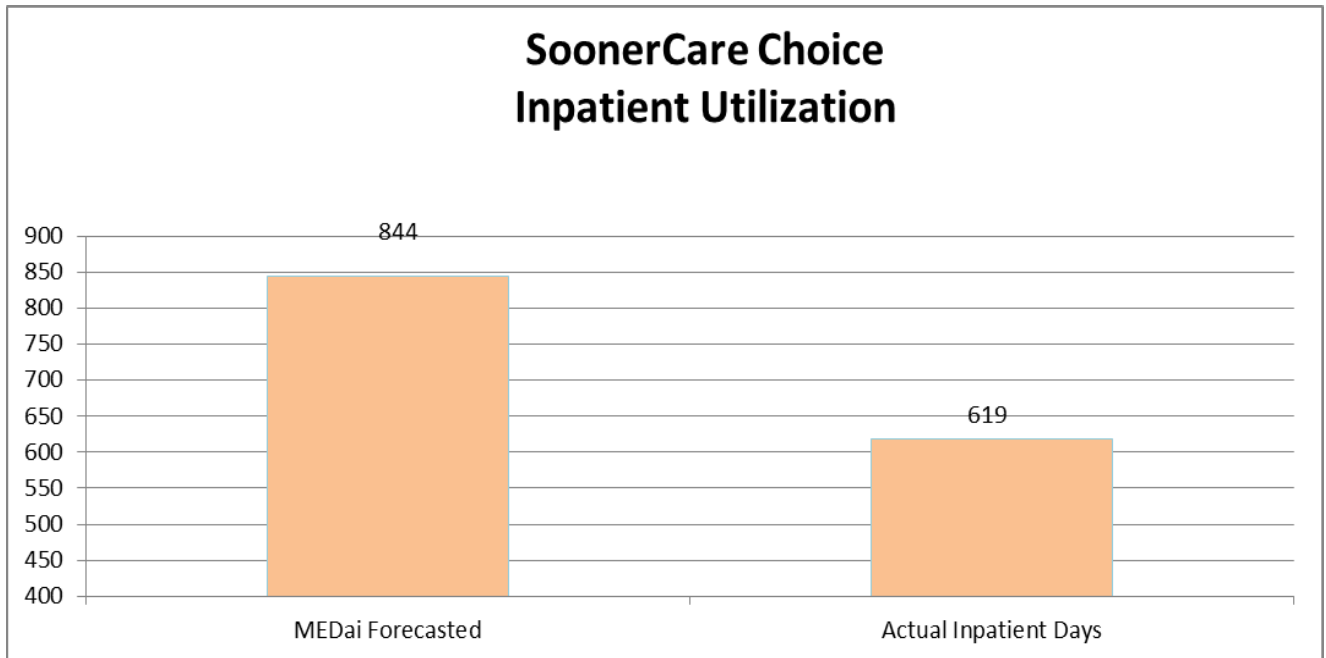


MEDai forecasted that SoonerCare HMP participants as a group would incur 2,659 inpatient days per 1,000 participants in the first 12 months of engagement. The actual rate was 1,544 or 58 percent of forecast. This demonstrated member receiving nurse care management services in the HMP were successfully impacted with fewer hospitalizations over the reporting period.

Hospital readmissions data tracking was not completed on health coached members during this reporting period. The HMP staff however, continuously monitors hospital discharge data to identify members engaged in health coaching to a recent discharge. One of the health coaches' roles are to assess individual needs and provide appropriate follow-up. The HMP recognized as a result of this work, the need to enhance health coaching services for this identified population.

The HMP is adding transitional care health coaches that will specialize in successfully transitioning members from an inpatient hospitalization back into community and receiving outpatient services as needed to avoid re-hospitalizations. Core functions of these coaches will

include intense follow-up, assessments and ongoing monitoring in the weeks post discharge. The OHCA will continue to monitor this work of the HMP over time.



The HMP elected to measure members who were in a Practice Facilitation practice but not health coached as a comparison group. MEDai projected members in the comparison group would incur 844 inpatients days per 1,000 over the 12-month forecast period. The actual rate was 619, or 73 percent of the forecast group. This demonstrated that the nurse care managed group with 58 percent of the forecast group was lower than the comparison group. The HMP posit that the HMP will continue to work to help improve health outcomes while reducing hospital cost.

Hospital readmissions data tracking was not completed on health coached members during this reporting period. The HMP staff however, continuously monitors hospital discharge data to identify members engaged in health coaching to a recent discharge. One of the health coaches' roles are to assess individual needs and provide appropriate follow-up. The HMP recognized as a result of this work, the need to enhance health coaching services for this identified population.

The HMP is adding transitional care health coaches that will specialize in successfully transitioning members from an inpatient hospitalization back into community and receiving outpatient services as needed to avoid re-hospitalizations. Core functions of these coaches will include intense follow-up, assessments and ongoing monitoring in the weeks post discharge. This phase of heath coaching is still in the planning and development phase, but the HMP continues discussions with its vendor Telligen on when this process will begin. The OHCA will continue to monitor this work of the HMP over time.

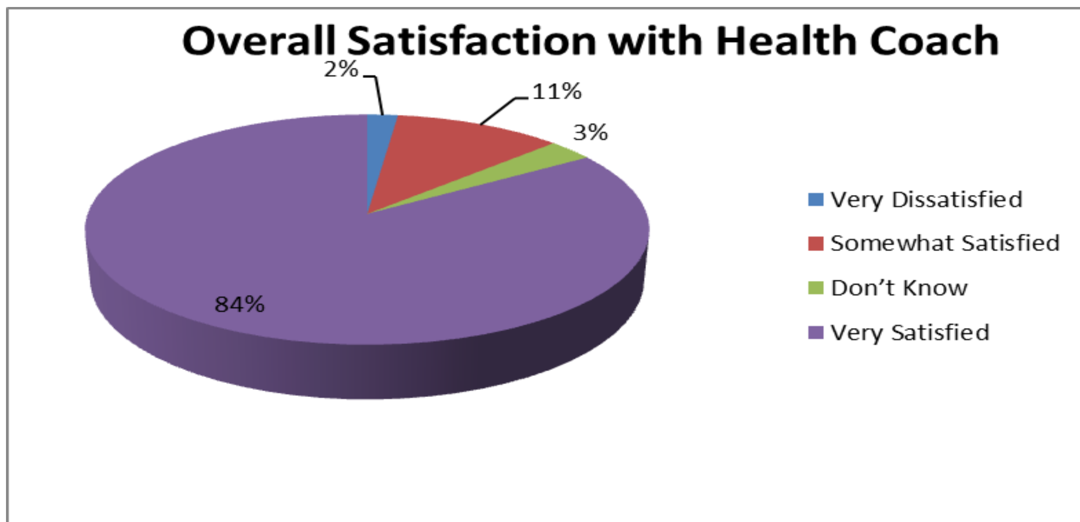
Hypothesis 9g: Health Management Program (HMP); Impact on Satisfaction/Experience with Care

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

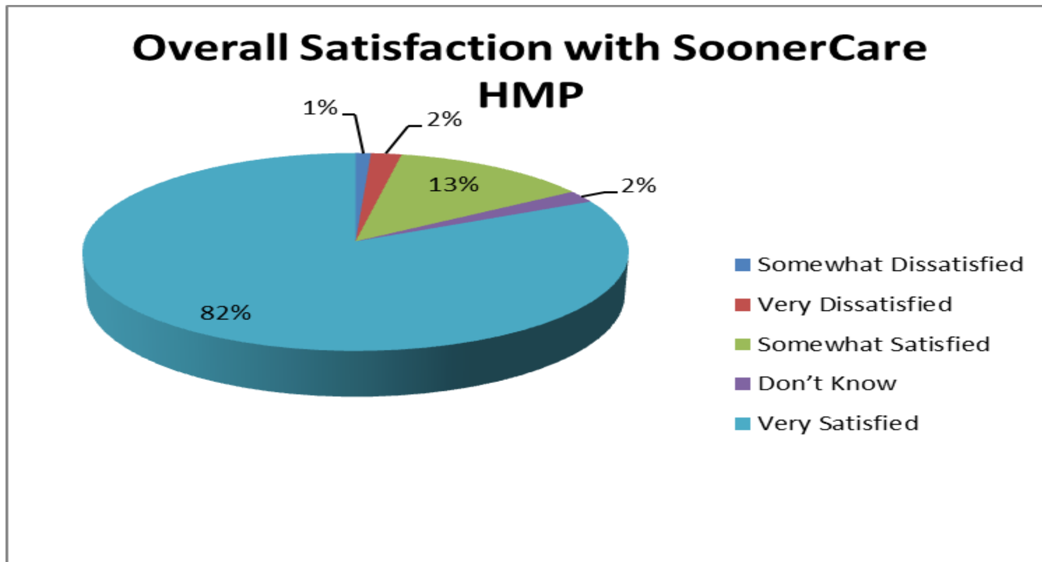
Hypothesis 9g Results:

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

SFY2014 Results



Regardless of their status, members were overwhelmingly positive about the role of the health coach, with 84 percent stating that their coach had been "very satisfied" to them in achieving their goal and eleven percent stating that their coach had been "somewhat satisfied". This attitude carried over to members' overall satisfaction with their health coaches, which was again very high.



Survey respondents reported very high levels of satisfaction with the SoonerCare HMP overall, consistent with their opinion of the health coach, who serves as the face of the program. Nearly all respondents around 82 percent of the persons surveyed, as stated in the HMP annual report said they would recommend the program to a friend with health care needs like theirs.

Efforts were made to gather information for the survey for comparison group. There were limited responses from members that were discharged from this program or previous program to analyze. The overall outcome appears to show participants experienced satisfaction with HMP.

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

This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #1, and #3 of CMS's Three Part Aim.

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

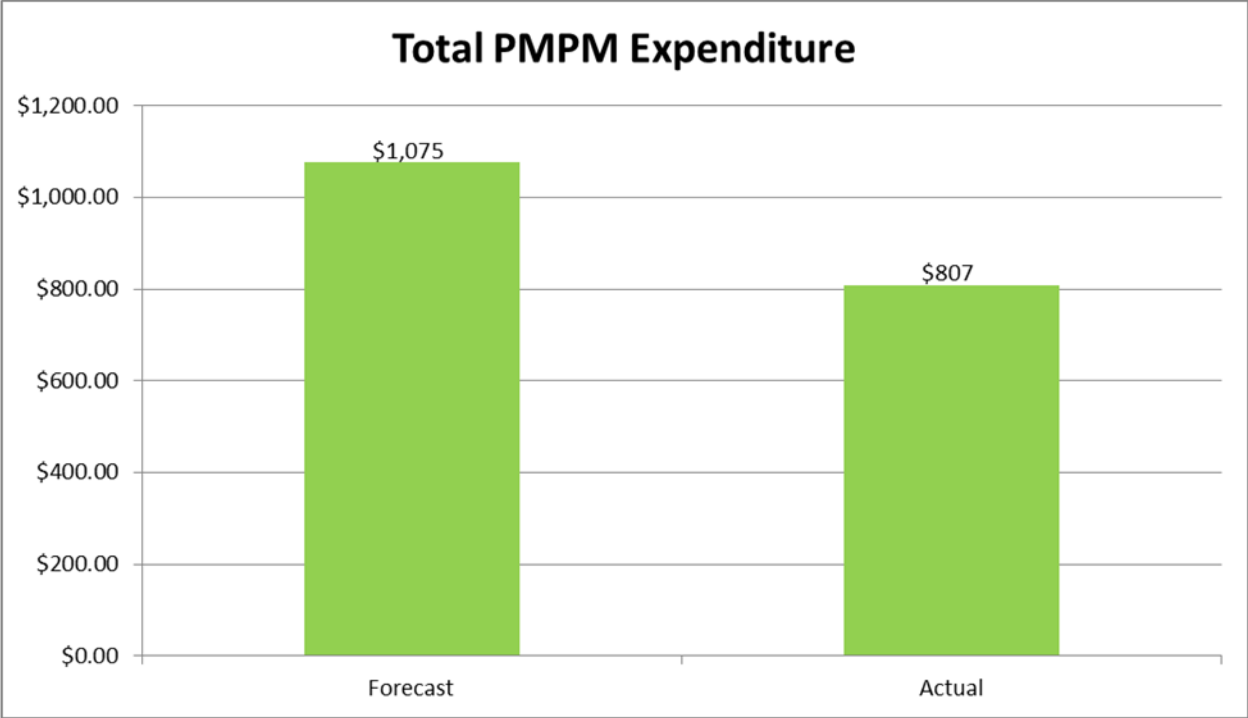
Hypothesis 9h Results:

SFY2014 Results:

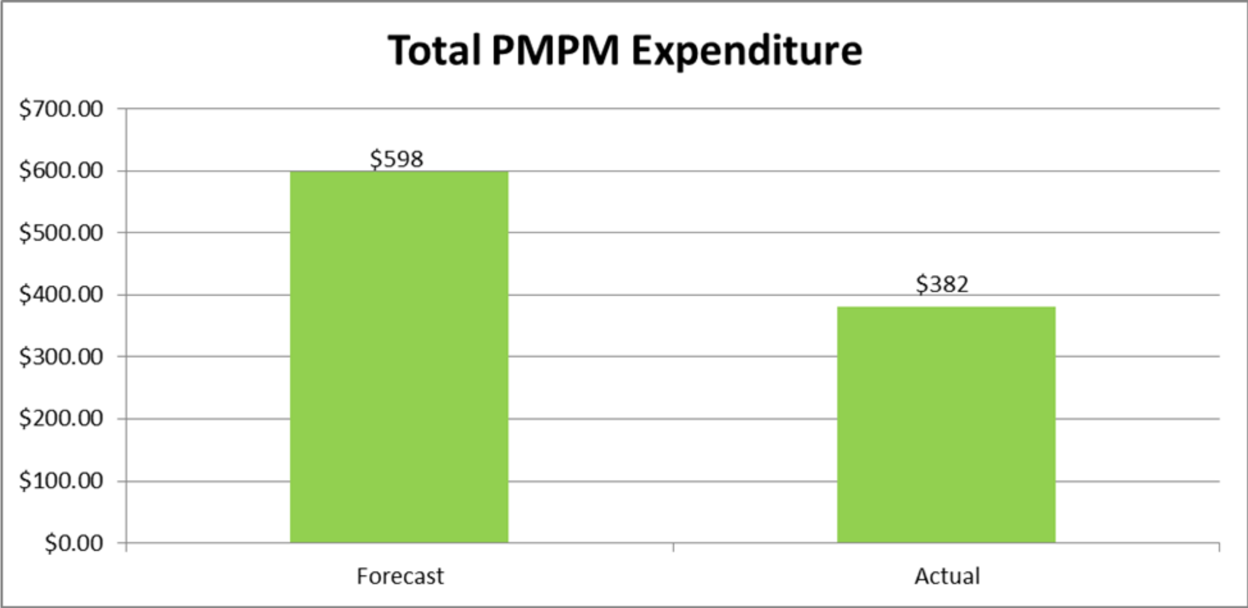
In accordance with OHCA's 2013-2015 Evaluation Design, this hypothesis relates to Phase II of the HMP program. The HMP program transitioned to Phase II of the program in July 2013. Phase II of the program embeds health coaches into the practices for face-to-face care management.

HMP Nurse Care Management PMPM for All Members	1 to 12 Months after First contact with Provider	13 to 24 Months after First contact with Provider	25 to 36 Months after First contact with Provider	37 to 48 Months after First contact with Provider	Any
MEDai Forecasted PMPM Expenditures	$607	$609	$635	$675	$629
Actual PMPM Expenditures	$609	$520	$556	$613	$580
Percent of Forecast	100.40%	85.40%	87.40%	90.80%	92.20%

The PMPM expenditures for all HMP members during the first 12 months after first contact with a provider were equivalent with the forecasted cost. PMPM expenditures, however, averaged 14 percent below forecast for the three remaining evaluation periods. Overall, PMPM savings averaged $49 through SFY 2013. Additionally, The HMP program achieved aggregate savings in excess of $124 million, which is approximately 15 percent of total forecasted medical claims costs. For the baseline year, the OHCA saw a savings in both PMPM costs and total expenditures in the HMP program, compared to MEDai's forecasted costs without the program. The OHCA expects to continue to see cost savings with the HMP program.



The PHPG documented total PMPM medical expenditures for all SoonerCare HMP participants as a group and compared actual medical expenditures to forecasted expenditures for the first 12 months of engagement. MEDai forecasted that the participant population would incur an average of $1,075 in PMPM expenditures in the first 12 months of engagement. The actual amount was $807, or 75 percent of forecast. The HMP continues to demonstrate savings over the course of the program.



MEDai projected that members in total would incur an average of $598 in PMPM expenditures over the 12-month forecast period. The actual amount was $382, or 64 percent of the forecast. At the category-of-service level, expenditures increased for all services except behavioral health. Behavioral health demonstrated a three percentage decrease. The overall percentage of change in PMPM expenditures was a total increase of 11 percent. The OHCA will continue to monitor the program for impact of the reducing medical cost of the population served.

Hypothesis 10 – Retroactive Eligibility

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

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

Hypothesis 10 Results:

A. Eligibility Determinations	October 2013	November 2013	December 2013
MAGI Determination – Qualified	55,242	46,735	86,447
Determined Qualified – Direct or Transfer Application	22,664	18,295	28,624
Determined Qualified at Annual Renewal	32,578	28,440	57,823

B. Individuals Determined Not Qualified	October 2013	November 2013	December 2013
Ineligibility Established	11,830	10,107	20,171
Inadequate Documentation	804	848	842

C. Individuals Disenrolled	October 2013	November 2013	December 2013
Determined Not Qualified at Application (new applicant)	4,950	4,339	7,097
Determined Not Qualified at Annual Renewal (current member)	7,684	6,616	13,916

A. Eligibility Determinations 2014	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
MAGI Determination – Qualified	41,552	34,213	84,648	76,312	71,282	63,087	59,587	57,891	55,168	70,525	46,218	50,859
Determined Qualified – Direct or Transfer Application	18,672	13,915	31,073	31,311	32,391	30,153	28,982	27,287	26,598	29,750	22,745	24,028
Determined Qualified at Annual Renewal	22,880	20,298	53,575	45,001	38,891	32,934	30,605	30,604	28,570	40,775	23,473	26,831

B. Individuals Determined Not Qualified 2014	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Ineligibility Established	10,852	9,519	25,013	22,202	20,017	15,954	19,339	18.664	16,499	24,137	15,213	12,652
Inadequate Documentation	822	545	1,385	1,833	1,971	1,652	2,149	2,325	2,231	2,790	2,900	2,313

C. Individuals Disenrolled 2014	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Determined Not Qualified at Application (new applicant)	5,230	3,896	10,936	10,743	10,264	8,821	9,465	8,845	7,921	9,983	8,713	7,318
Determined Not Qualified at Annual Renewal (current member)	6,444	6,168	15,462	13,292	11,724	8,785	9,874	9,819	8,578	14,154	9,400	7,647

This hypothesis postulates that the OHCA will ensure seamless coverage between Medicaid and the Marketplace after federal changes are effectuated. The OHCA went live with outbound (State to Hub) account transfers on January 23, 2014. The outbound account transfer includes all

individuals who are found not qualified for full-benefit Medicaid. Between October 1, 2013 and January 23, 2014, the OHCA had approximately 90,000 applications queued up for the outbound account transfer.

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

Eligibility Determinations 2015	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Modified Adjusted Gross Income Determination Qualified	80,534	71,233	72,535	69,071	62,014	39,909	48,315	56,105	55,916	55,662	52,094	60,879
Determined Qualified Direct or Transfer Application	34,519	32,960	35,616	35,825	32,501	21,248	25,238	28,832	27,901	28,156	26,689	28,996
Determination at Annual Renewal	46,015	38,273	36,919	33,246	29,513	18,661	23,077	27,273	28,015	27,506	25,405	31,883

Individuals Determined Not Qualified 2015	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
Ineligibility Established	23,677	18,648	18,707	19,747	17,413	8,639	13,102	14,779	15,531	15,144	13,309	14,751
Inadequate Documentation	3,632	2,671	4,374	4,086	2,953	4,036	4,831	4,439	4,771	5,342	3,808	4,409

Individuals Disenrolled 2015	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
Determined Not Qualified at Application (new applicant)	12,095	10,394	11,815	12,598	10,951	6,759	9,212	10,058	10,177	10,462	8,971	9,239
Determined Not Qualified at Annual Renewal (current member)	15,214	10,925	11,266	11,235	9,415	5,916	8,721	9,160	10,125	10,024	8,146	9,921

Account Transfers 2014	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Total Transfer Account Received (Inbound)	0	12,308	6,575	3,967	1,961	970	824	752	642	583	2,405	5,450
Total Transfer Account Sent (Outbound)	14,285	8,395	55,898	32,274	34,346	30,143	31,144	32,280	29,802	36,516	38,077	30,312

Account Transfers 2015	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Total Transfer Account Received (Inbound)	3,674	4,373	1,515	1,996	3,135	1,790	1,458	1,176	1,146	1,111	4,741	6,271
Total Transfer Account Sent (Outbound)	39,429	36,477	37,086	42,409	34,877	34,619	48,399	52,219	59,540	54,732	45,010	42,628

This hypothesis postulates that the OHCA will ensure seamless coverage between Medicaid and the Federally Facilitated Marketplace after federal changes are effectuated. The outbound account transfer includes all individuals who do not qualify for Medicaid benefits. In 2015, OHCA transferred approximately 527,425 applications to the Hub. The Hub verifies applicant information used to determine eligibility for enrollment in qualified health plans and insurance affordability programs.

Conclusion

The goal of the evaluation was to determine the effectiveness of the SoonerCare Choice and Insure Oklahoma waiver for the extension period from 2013-2015. The results from this evaluation shows that the 1115 demonstration is meeting its goals and objectives with respect to child health check-up rates, PCP visits, I/T/U capacity, HANs and HMP. OHCA will continue to monitor, track and trend these measures over the next demonstration period for changes in results for these groups.

Attachments

1. SoonerCare Member to Provider Ratio 2013
2. SoonerCare Member to Provider Ratio 2014
3. SoonerCare Member to Provider Ratio2015

Creative Minds. Intelligent Solutions.

2015 CAHPS® Adult Medicaid Member Satisfaction Survey Executive Summary

Oklahoma Health Care Authority

June 2015

This document was developed through funding provided by the grant program outlined under the Catalog of Federal Domestic Assistance Number 93.609 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. However, these contents do not necessarily represent the policy or views of the U.S. Department of Health and Human Services, and you should not assume endorsement by the Federal Government.

Table of Contents

Oklahoma Health Care Authority

Executive Summary 3

Background and Protocol 3

Disposition Summary. 4

Summary of Key Measures 5

Scoring for NCQA Accreditation 6

Comparison to Quality Compass® 7

Key Driver Analysis 8

Demographics 15

HEDIS® Measures 19

Flu Vaccinations for Adults Ages 18-64 20

Medical Assistance with Smoking and Tobacco Use Cessation. 21

Aspirin Use and Discussion. 24

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Executive Summary
Background and Protocol

Background

- CAHPS® measures health care consumers' satisfaction with the quality of care and customer service provided by their health plan. Plans which are collecting HEDIS® (Healthcare Effectiveness Data and Information Set) data for NCQA accreditation are required to field the CAHPS® survey among their eligible populations.

Protocol

- For CAHPS® results to be considered in HEDIS® results, the CAHPS® 5.0H survey must be fielded by an NCQA (National Committee for Quality Assurance)-certified survey vendor using an NCQA-approved protocol of administration in order to ensure that results are collected in a standardized way and can be compared across plans. Standard NCQA protocols for administering CAHPS® 5.0H include a mixed-mode mail/telephone protocol and a mail-only protocol.
- Oklahoma Health Care Authority chose the mail/telephone protocol. This protocol included mailing a questionnaire with a cover letter. For those selected members who did not respond to the first questionnaire, a second questionnaire with a cover letter encouraging participation was sent. Thank you/reminder postcards were mailed after each survey mailing. If a selected member still did not respond to the questionnaires, at least four telephone calls were made to complete the survey using trained telephone interviewers.
- NCQA originally designed this protocol with the goal of achieving a total response rate of at least 45%. The average of response rates for all Adult Medicaid plans reporting to NCQA in 2014 was 29%, consistent with the 2013 average.
- In February, 1823 Oklahoma Health Care Authority members were randomly selected to participate in the 2015 CAHPS® 5.0H Adult Medicaid Survey. This report is compiled from the responses of the 426 Oklahoma Health Care Authority members who responded to the survey (24% response rate).

Executive Summary

Disposition Summary

- A response rate is calculated for those members who were eligible and able to respond. According to NCQA protocol, ineligible members include those who are deceased, do not meet eligible criteria, have a language barrier, or are either mentally or physically incapacitated. Non-responders include those members who have refused to participate in the survey, could not be reached due to a bad address or telephone number, or members that reached a maximum attempt threshold and were unable to be contacted during the survey time period.
- The table below shows the total number of members in the sample that fell into each of the various disposition categories.

Oklahoma Health Care Authority
2015 Disposition Summary

Ineligible	Number
Deceased (M20/T20)	3
Does not meet criteria (M21/T21)	22
Language barrier (M22/T22)	0
Mentally/physically incapacitated (M24/T24)	2
Total Ineligible	**27**

Non-response	Number
Bad address/phone (M23/T23)	110
Refusal (M32/T32)	0
Maximum attempts made (M33/T33)	1260
Total Non-response	**1370**

- Ineligible surveys are subtracted from the sample size when computing a response rate (see below):

$$\frac{\textit{Completed mail and telephone surveys}}{\textit{Sample size - Ineligible surveys}} = \textit{Response Rate}$$

- Using the final figures from Oklahoma Health Care Authority's Adult Medicaid survey, the numerator and denominator used to compute the response rate are presented below:

$$\frac{\textit{Mail completes (268) + Phone completes (158)}}{\textit{Total Sample (1823) - Total Ineligible (27)}} = \frac{426}{1796} = \textit{Response Rate} = \textbf{24\%}$$

Executive Summary

Summary of Key Measures

Oklahoma HealthCare Authority

- For purposes of reporting the CAHPS® results in HEDIS® (Healthcare Effectiveness Data and Information Set) and for scoring for health plan accreditation, the National Committee for Quality Assurance (NCQA) uses 5 composite measures and four rating questions from the survey.
- Each of the composite measures is the average of 2 - 4 questions on the survey, depending on the measure, while each rating score is based on a single question. CAHPS® scores are most commonly shown using Summary Rate scores (percentage of positive responses).

Oklahoma Health Care Authority			
	Trended Data		
Composite Measures	**2013**	**2014**	**2015**
Getting Care Quickly	79%	82%	86%
Shared Decision Making	NT	NT	77%
How Well Doctors Communicate	87%	90%	90%
Getting Needed Care	80%	82%	85%
Customer Service	90%	82%	92%
Overall Rating Measures			
Health Care	64%	68%	72%
Personal Doctor	71%	79% ↑	80%
Specialist	75%	83%	78%
Health Plan	61%	73% ↑	73%
HEDIS® Measures			
Flu Vaccinations***	NA	45%	46%
Advising Smokers and Tobacco Users to Quit*	76%	75%	74%
Discussing Cessation Medications*	45%	48%	49%
Discussing Cessation Strategies*	42%	44%	46%
Aspirin Use**	NR	NR	NR
Discussing Aspirin Risks and Benefits**	NR	NR	NR
Health Promotion & Education	70%	71%	71%
Coordination of Care	77%	83%	79%
Sample Size	*1350*	*1350*	*1823*
# of Completes	*414*	*309*	*426*
Response Rate	*32%*	*23%*	*24%*

Legend: ↑/↓ Statistically higher/lower compared to prior year results.
NA=Data not available NT=Data not trendable NR=Data not reportable

*Measure is reported using a Rolling Average Methodology. The score shown is the reportable score for the corresponding year.
**Measure is reported using a Rolling Average Methodology and is not reportable in 2015.
***New measure in 2014. This is a single year measure.

Executive Summary

Scoring for NCQA Accreditation

Oklahoma HealthCare Authority

				2015 NCQA National Accreditation Comparisons*					
				Below 25th Nat'l	25th Nat'l	50th Nat'l	75th Nat'l	90th Nat'l	
			Accreditation Points	***0.29***	***0.58***	***0.98***	***1.27***	***1.44***	
Composite Scores	**Unadjusted**	**Approximate Percentile Threshold**							***Approximate Score***
Getting Care Quickly	**2.522**	90th			2.37	2.42	2.46	2.50	***1.44***
How Well Doctors Communicate	**2.636**	75th			2.48	2.54	2.58	2.64	***1.27***
Getting Needed Care	**2.465**	90th			2.31	2.37	2.42	2.46	***1.44***
Customer Service	**2.625**	90th			2.48	2.54	2.58	2.61	***1.44***
Overall Ratings Scores									
Q13 Health Care	**2.347**	50th			2.28	2.34	2.38	2.43	***0.98***
Q23 Personal Doctor	**2.497**	25th			2.43	2.50	2.53	2.57	***0.58***
Q27 Specialist	**2.533**	50th			2.48	2.51	2.56	2.59	***0.98***
			Accreditation Points	***0.58***	***1.16***	***1.96***	***2.54***	***2.89***	
Q35 Health Plan	**2.381**	25th			2.35	2.43	2.49	2.54	***1.16***
								Estimated Overall CAHPS® Score:	**9.29**

NOTE: NCQA begins their calculation with an unadjusted raw score showing six digits after the decimal and then compares the adjusted score to their benchmarks and thresholds (also calculated to the sixth decimal place). For 2015, this is the first year NCQA is no longer using an adjusted score. This report displays accreditation points and scores with only two digits after the decimal. Therefore, the estimated overall CAHPS® score may differ from the sum of the individual scores due to rounding and could differ slightly from official scores provided by NCQA. The CAHPS® measures account for 13 points towards accreditation.

*Data Source: **NCQA Memorandum of January 30, 2015**. Subject: 2015 Accreditation Benchmarks and Thresholds.

*** Not reportable due to insufficient sample size.

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Executive Summary

Comparison to Quality Compass®

Oklahoma Health Care Authority

Composite Scores	Oklahoma Health Care Authority	2014 Quality Compass® Comparisons*						
		5th Nat'l	10th Nat'l	25th Nat'l	50th Nat'l	75th Nat'l	90th Nat'l	95th Nat'l
		%	%	%	%	%	%	%
Getting Care Quickly *(% Always and Usually)*	**86.32%**	**74.01**	**75.26**	**78.39**	**81.75**	**83.75**	**85.52**	**86.98**
Shared Decision Making *(% Yes)*	**77.23%**	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**
How Well Doctors Communicate *(% Always and Usually)*	**89.55%**	**85.40**	**86.17**	**88.16**	**89.76**	**91.11**	**92.42**	**93.07**
Getting Needed Care *(% Always and Usually)*	**84.69%**	**71.65**	**74.70**	**77.47**	**80.90**	**84.27**	**85.59**	**86.45**
Customer Service *(% Always and Usually)*	**91.60%**	**80.66**	**81.85**	**84.45**	**87.05**	**88.64**	**90.28**	**91.32**
Overall Ratings Scores								
Q13 Health Care (% 8, 9, and 10)	**72.34%**	**63.40**	**64.32**	**68.54**	**71.53**	**74.06**	**76.95**	**78.57**
Q23 Personal Doctor (% 8, 9, and 10)	**79.82%**	**72.50**	**74.37**	**76.45**	**78.82**	**80.97**	**83.10**	**84.65**
Q27 Specialist (% 8, 9, and 10)	**78.26%**	**73.43**	**75.89**	**78.64**	**80.61**	**82.47**	**85.31**	**86.14**
Q35 Health Plan (% 8, 9, and 10)	**72.73%**	**63.54**	**66.57**	**71.37**	**75.52**	**78.77**	**81.49**	**82.82**

NA=Comparison data not available from NCQA

*Data Source: 2014 Quality Compass®. Scores above based on 147 plans who qualified and chose to publicly report their scores.

- = Plan score falls below 5th Percentile
- = Plan score falls on 5th or below 10th Percentile
- = Plan score falls on 10th or below 25th Percentile
- = Plan score falls on 25th or below 50th Percentile
- = Plan score falls on 50th or below 75th Percentile
- = Plan score falls on 75th or below 90th Percentile
- = Plan score falls on 90th or below 95th Percentile
- = Plan score falls on or above 95th Percentile

Executive Summary
Key Driver Recommendations

Oklahoma Health Care Authority

A Key Driver Analysis is conducted to understand the impact that different aspects of plan service and provider care have on members' overall satisfaction with their health plan, their personal doctor, their specialist, and health care in general. Two specific scores are assessed both individually and in relation to each other. These are:

1. The relative importance of the individual issues (Correlation to overall measures).
2. The current levels of performance on each issue (Percentile group from Quality Compass®).

The key drivers for the health plan and health care are shown below:

High Priority for Improvement (High correlation/Relatively low performance)	
Health Plan	**Health Care**
None	Q19 - Show Respect for What You Had to Say Q18 - Listen Carefully to You

Continue to Target Efforts (High correlation/Relatively high performance)	
Health Plan	**Health Care**
Q31 - Got Information or Help Needed Q32 - Treated You with Courtesy and Respect Q14 - Easy to Get Care Believed Necessary	Q14 - Easy to Get Care Believed Necessary Q17 - Explain Things in a Way You Could Understand Q20 - Spend Enough Time with You Q6 - Getting Appointment as Soon as Needed

Executive Summary

Key Driver Analysis – Health Plan

Q35. Rating of Health Plan

Item	Correlation	Sample Size	Health Plan's Score	Plan's Percentile Range
Q31. Got Information or Help Needed	0.54	101	87.13%	95th
Q32. Treated You with Courtesy and Respect	0.43	102	96.08%	95th
Q14. Easy to Get Care Believed Necessary	0.39	327	86.54%	75th
Q18. Listen Carefully to You	0.31	306	88.89%	**25th**
Q19. Show Respect for What You Had to Say	0.31	307	89.90%	**25th**
Q20. Spend Enough Time with You	0.30	306	88.56%	50th
Q25. Easy to Get Appointment with Specialist	0.27	198	82.83%	75th
Q4. Getting Care as Soon as Needed	0.27	230	85.22%	50th
Q17. Explain Things in a Way You Could Understand	0.26	306	90.85%	50th
Q11. Discussed Reasons Not to Take Medicine	0.22	174	67.24%	NA
Q6. Getting Appointment as Soon as Needed	0.21	326	87.42%	95th
Q12. Asked Preference for Medicine	0.15	171	74.27%	**25th**
Q10. Discussed Reasons to Take Medicine	0.14	173	90.17%	NA

Axis: 0.0, 0.5, 1.0

Use caution when reviewing scores with sample sizes less than 25.

"Health Plan's Score" is the percent of respondents that answered "Always", "Usually"; "Yes"

High Priority for Improvement
(High Correlation/
Lower Quality Compass® Group)

None

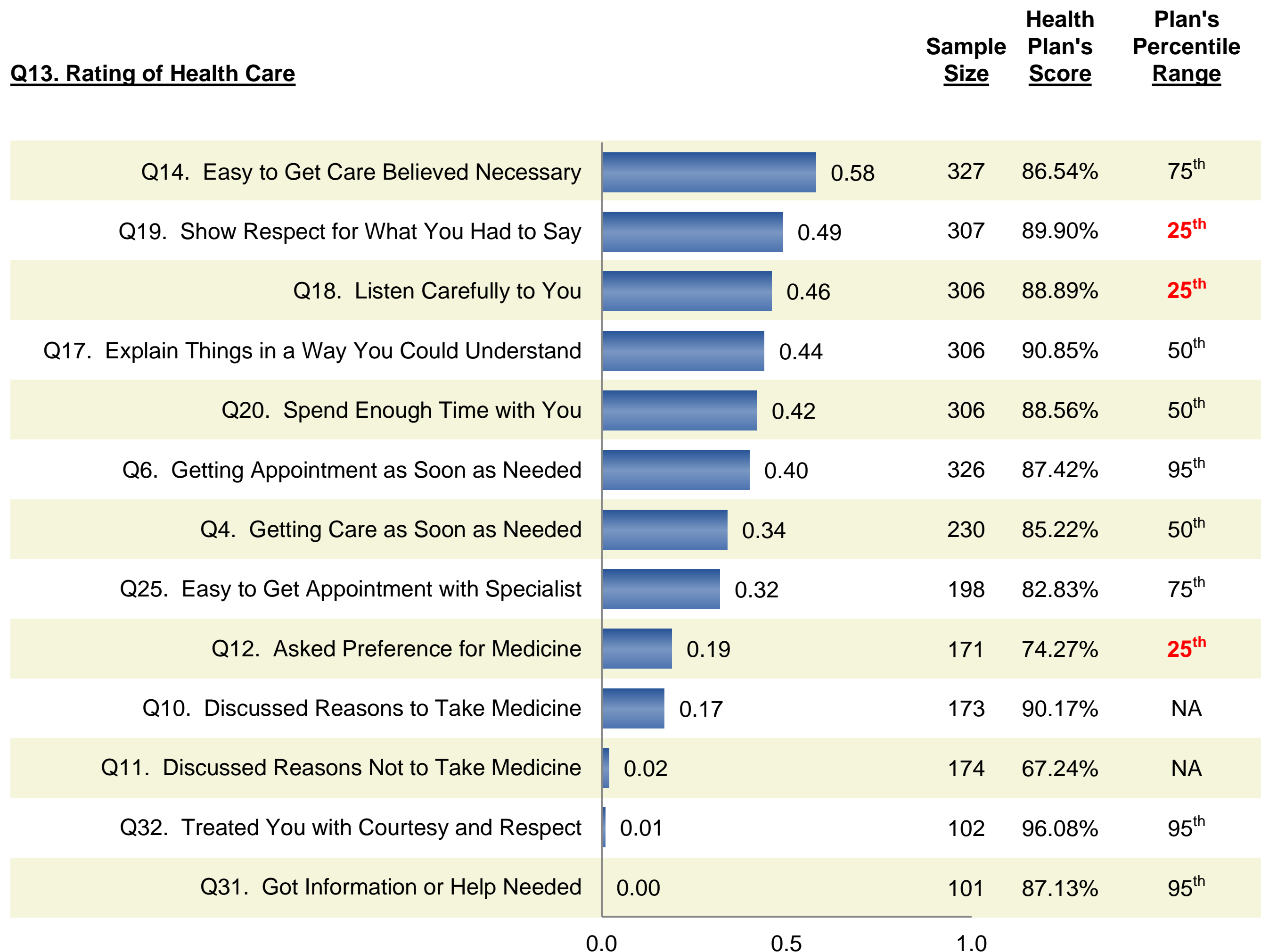
Continue to Target Efforts
(High Correlation/
Higher Quality Compass® Group)

Q31 - Got Information or Help Needed
Q32 - Treated You with Courtesy and Respect
Q14 - Easy to Get Care Believed Necessary

Legend:
95th = Plan score falls on or above 95th Percentile
90th = Plan score falls on 90th or below 95th Percentile
75th = Plan score falls on 75th or below 90th Percentile
50th = Plan score falls on 50th or below 75th Percentile
25th = Plan score falls on 25th or below 50th Percentile
10th = Plan score falls on 10th or below 25th Percentile
5th = Plan score falls on 5th or below 10th Percentile
Below 5th = Plan score falls below 5th Percentile

Executive Summary

Key Driver Analysis – Health Care



Q13. Rating of Health Care	Correlation	Sample Size	Health Plan's Score	Plan's Percentile Range
Q14. Easy to Get Care Believed Necessary	0.58	327	86.54%	75th
Q19. Show Respect for What You Had to Say	0.49	307	89.90%	25th
Q18. Listen Carefully to You	0.46	306	88.89%	25th
Q17. Explain Things in a Way You Could Understand	0.44	306	90.85%	50th
Q20. Spend Enough Time with You	0.42	306	88.56%	50th
Q6. Getting Appointment as Soon as Needed	0.40	326	87.42%	95th
Q4. Getting Care as Soon as Needed	0.34	230	85.22%	50th
Q25. Easy to Get Appointment with Specialist	0.32	198	82.83%	75th
Q12. Asked Preference for Medicine	0.19	171	74.27%	25th
Q10. Discussed Reasons to Take Medicine	0.17	173	90.17%	NA
Q11. Discussed Reasons Not to Take Medicine	0.02	174	67.24%	NA
Q32. Treated You with Courtesy and Respect	0.01	102	96.08%	95th
Q31. Got Information or Help Needed	0.00	101	87.13%	95th

Use caution when reviewing scores with sample sizes less than 25.
"Health Plan's Score" is the percent of respondents that answered "Always", "Usually"; "Yes"

High Priority for Improvement
(High Correlation/
Lower Quality Compass® Group)

Q19 - Show Respect for What You Had to Say
Q18 - Listen Carefully to You

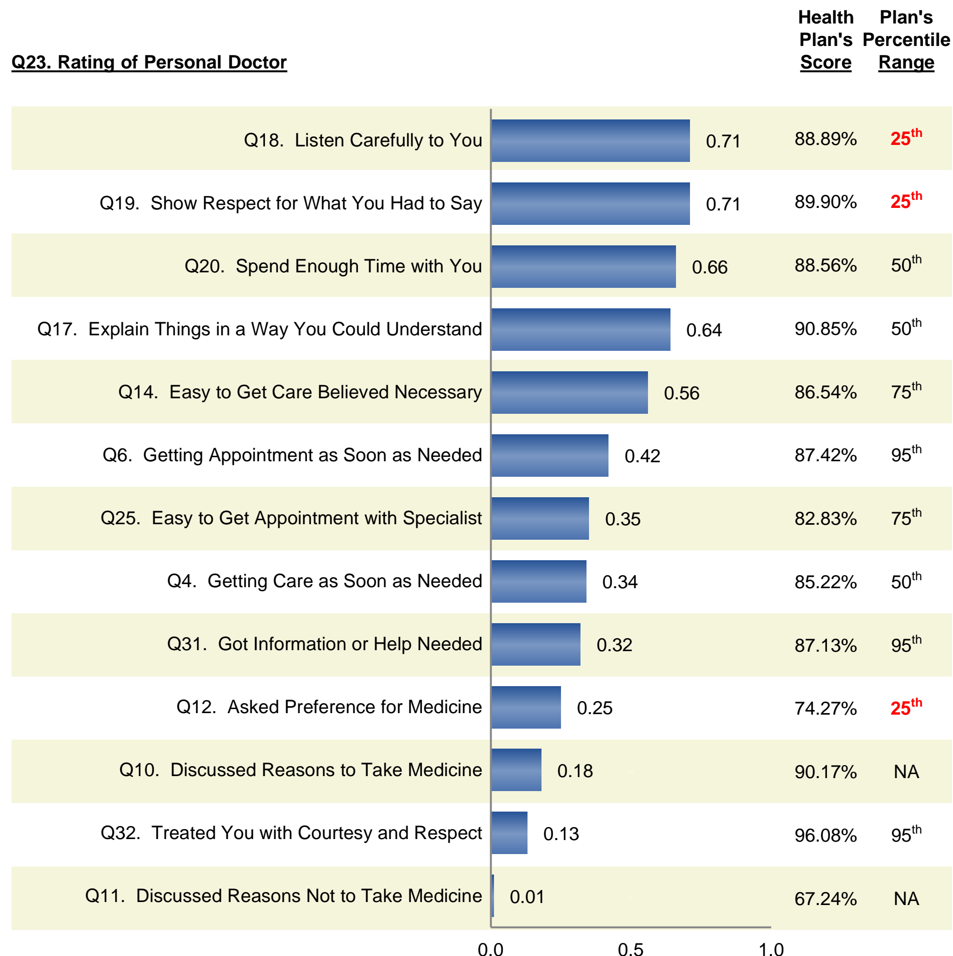
Continue to Target Efforts
(High Correlation/
Higher Quality Compass® Group)

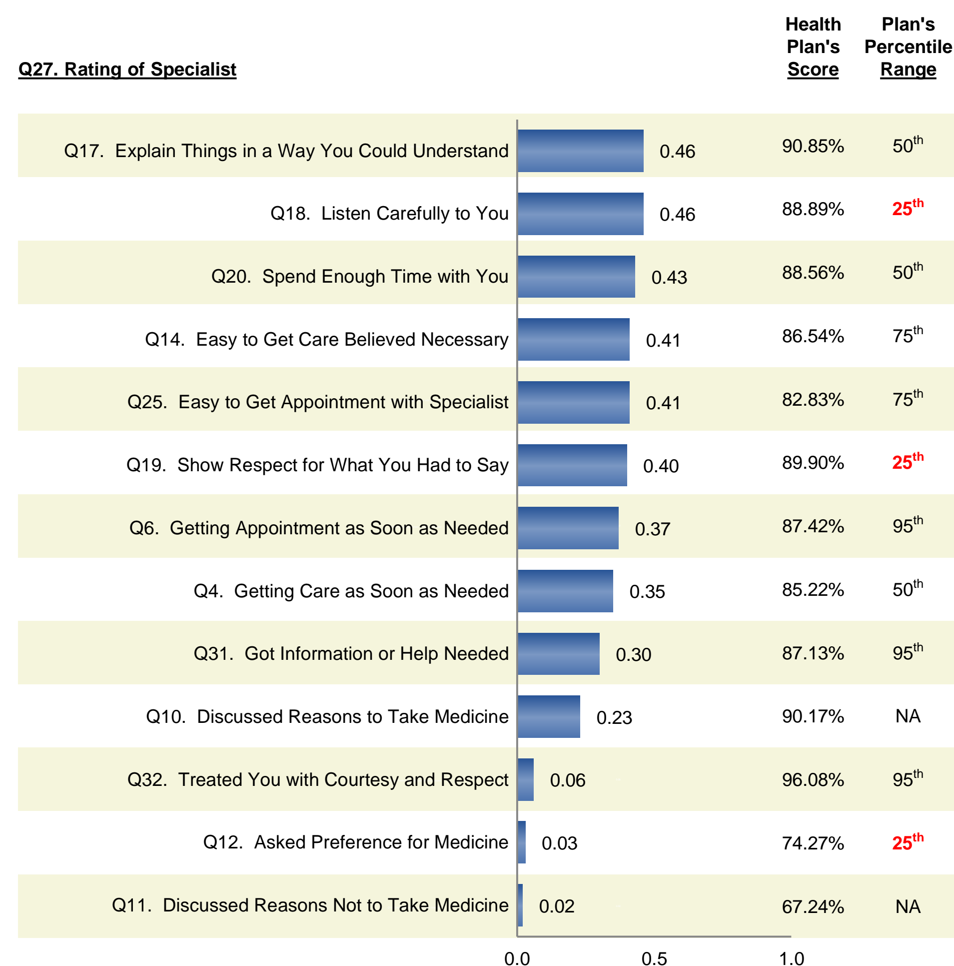
Q14 - Easy to Get Care Believed Necessary
Q17 - Explain Things in a Way You Could Understand
Q20 - Spend Enough Time with You
Q6 - Getting Appointment as Soon as Needed

Legend:
95th = Plan score falls on or above 95th Percentile
90th = Plan score falls on 90th or below 95th Percentile
75th = Plan score falls on 75th or below 90th Percentile
50th = Plan score falls on 50th or below 75th Percentile
25th = Plan score falls on 25th or below 50th Percentile
10th = Plan score falls on 10th or below 25th Percentile
5th = Plan score falls on 5th or below 10th Percentile
Below 5th = Plan score falls below 5th Percentile

Executive Summary

Key Driver Analysis – Doctor and Specialist





"Health Plan's Score" is the percent of respondents that answered "Always", "Usually"; "Yes"

Executive Summary

Action Plans for Improving CAHPS® Scores

Morpace has consulted with numerous clients on ways to improve CAHPS® scores. Even though each health plan is unique and faces different challenges, many of the improvement strategies discussed on the next few pages can be applied by most plans with appropriate modifications.

In addition to the strategies suggested below, we suggest reviewing AHRQ's CAHPS® Improvement Guide, an online resource located on the Agency for Healthcare Research and Quality website at:

www.cahps.ahrq.gov/quality-improvement/index.html

Getting Needed Care

- Ease of obtaining appointment with specialist
  - Review panel of specialists to assure that there are an adequate number of specialists and that they are disbursed geographically to meet the needs of your members.
  - Conduct an Access to Care survey with either or both of 2 audiences: physician's office and/or among members.
  - Conduct a CG-CAHPS survey including specialists in the sample to identify the specialists with whom members are having a problem obtaining an appointment.
  - Include supplemental questions on the CAHPS® survey to determine whether the difficulty is in obtaining the initial consult or subsequent appointments.
  - Include a supplemental question on the CAHPS® survey to determine with which type of specialist members have difficulty making an appointment.
  - Utilize Provider Relations staff to question PCP office staff when making a regular visit to determine with which types of specialists they have the most problems scheduling appointments.
  - Develop materials to promote your specialist network and encourage the PCPs to develop new referral patterns that align with the network.

Getting Needed Care

- Ease of obtaining care, tests, or treatment you needed through your health plan
  - Include a supplemental question on the CAHPS® survey to identify the type of care, test or treatment for which the member has a problem obtaining.
  - Review complaints received by Customer Service regarding inability to receive care, tests or treatments.
  - Evaluate pre-certification, authorization, and appeals processes. Of even more importance is to evaluate the manner in which the policies and procedures are delivered to the member, whether the delivery of the information is directly to the member or through their provider. Members may be hearing that they cannot receive the care, tests, or treatment, but are not hearing why.
  - When care or treatment is denied, care should be taken to ensure that the message is understood by both the provider and the member.

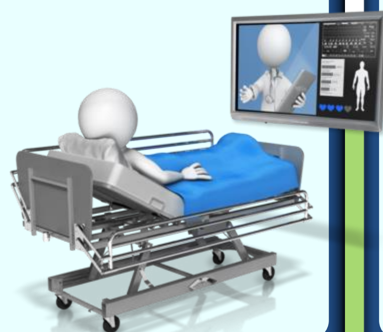
Executive Summary

Action Plans for Improving CAHPS® Scores (cont'd)

Oklahoma Health Care Authority

Getting Care Quickly

- Obtaining care for urgent care (illness, injury or condition that needed care right away) as soon as you needed
- Obtaining an appointment for routine care/check-ups
  - Conduct a CG-CAHPS survey to identify offices with scheduling issues.
  - Conduct an Access to Care Study
    - Calls to physician office - unblinded
    - Calls to physician office – blinded (Secret Shopper)
    - Calls to members with recent claims
    - Desk audit by provider relations staff
  - Develop seminars for physicians' office staff that could include telephone skills (answering, placing a person on hold, taking messages from patients, dealing with irate patients over the phone, etc.) as well as scheduling advice. Use this time to obtain feedback concerning what issues members have shared with the office staff concerning interactions with the plan.
    - These seminars could be offered early morning, lunch times or evenings so as to be convenient for the office staff. Most physicians would be appreciative of having this type of training for their staff as they do not have the time or talents to train their employees in customer service and practice management.



How Well Doctors Communicate

- Doctor explained things in a way that was easy to understand
- Doctor listened carefully
- Doctor showed respect for what member had to say
- Doctor spent enough time with member
  - Conduct a CG-CAHPS survey to identify lower performing physicians for whom improvement plans should be developed.
  - Conduct focus group of members to identify examples of behaviors identified in the questions. Video the groups to show physicians how patients characterize excellent and poor physician performance.
  - Include supplemental questions from the Item Set for Addressing Health Literacy to better identify communication issues.
  - Develop "Questions Checklists" on specific diseases to be used by members when speaking to doctors. Have these available in office waiting rooms.
  - Offer in-service programs with CMEs for physicians on improving communication with patients. This could be couched in terms of motivating patients to comply with medication regimens or to incorporate healthy life-style habits. Research has shown that such small changes as having physicians sit down instead of stand when talking with a patient leads the patient to think that the doctor has spent more time with them.
  - Provide the physicians with patient education materials, which the physician will then give to the patient. These materials could reinforce that the physician has heard the concerns of the patient or that they are interested in the well-being of the patient. The materials might also speak to a healthy habit that the physician wants the patient to adopt, thereby reinforcing the communication and increasing the chances for compliance.
  - Provide communication tips in the provider newsletters. Often, these are better accepted if presented as a testimonial from a patient.

Executive Summary

Action Plans for Improving CAHPS® Scores (cont'd)

Oklahoma HealthCare Authority

Shared Decision Making

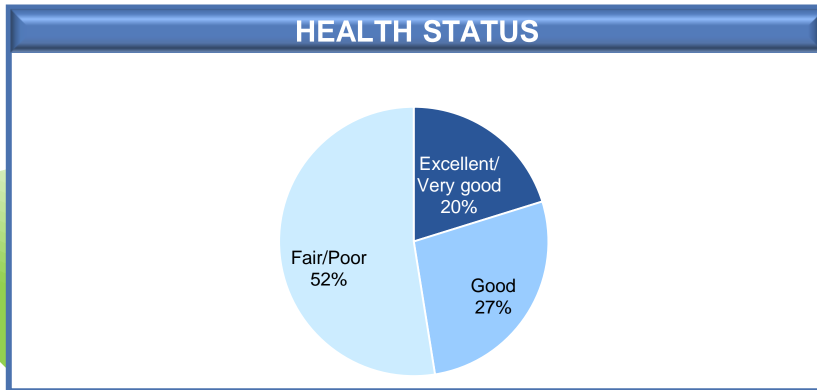
- Doctor talked about reasons you might want to take a medicine
- Doctor talked about reasons you might not want to take a medicine
- Doctor asked you what you thought was best
  - Conduct a CG-CAHPS survey and include the Shared Decision Making Composite as supplemental questions.
  - Develop patient education materials on common medicines described for your members explaining pros and cons of each medicine. Examples: asthma medications, high blood pressure medications, statins.
  - Develop audio recordings and/or videos of patient/doctor dialogues/vignettes on common medications. Distribute to provider panel via podcast or other method.

Health Plan Customer Service

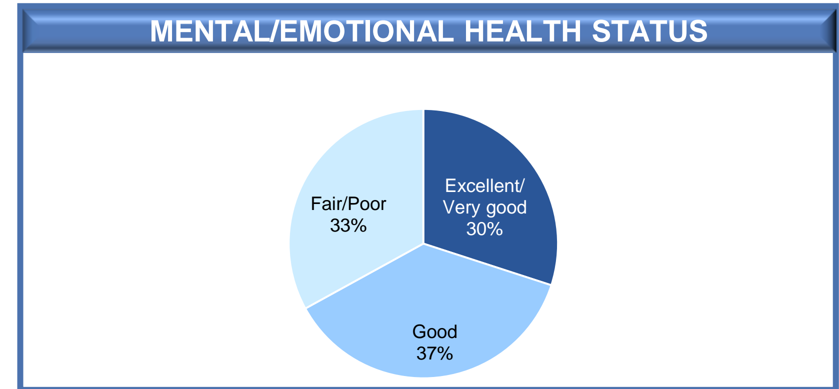
- Customer service gave the information or help needed
- Customer service treated member with courtesy and respect
  - Conduct Call Center Satisfaction Survey. Implement a short IVR survey to members within days of their calling customer service to explore/assess their recent experience.
  - At the end of each Customer Service call, have your representative enter/post the reason for the call. At the end of a month, synthesize the information to discern the major reasons for a call. Have the customer service representatives and other appropriate staff discuss ways to address the reason for the majority of the calls and design interventions so that the reason for the call no longer exists.

Executive Summary
Demographics

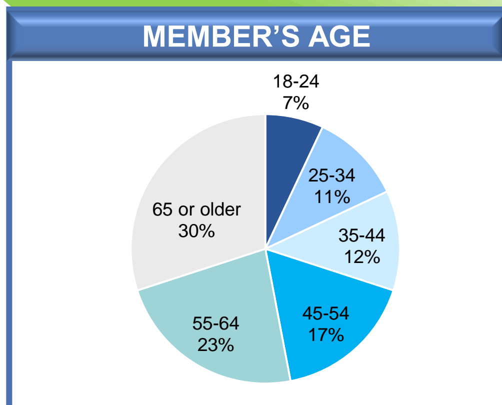
HEALTH STATUS



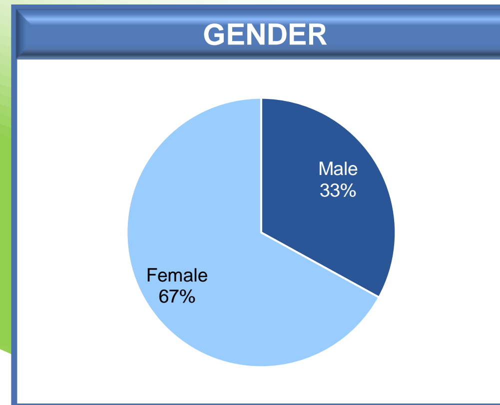
MENTAL/EMOTIONAL HEALTH STATUS



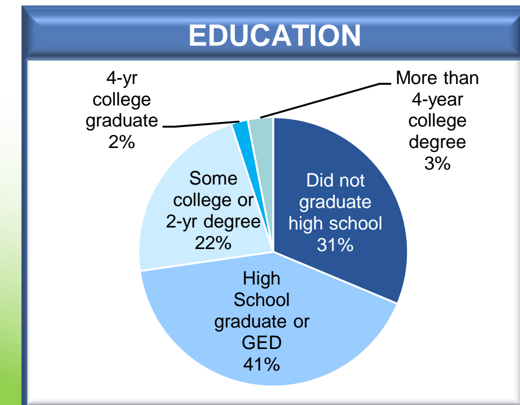
MEMBER'S AGE



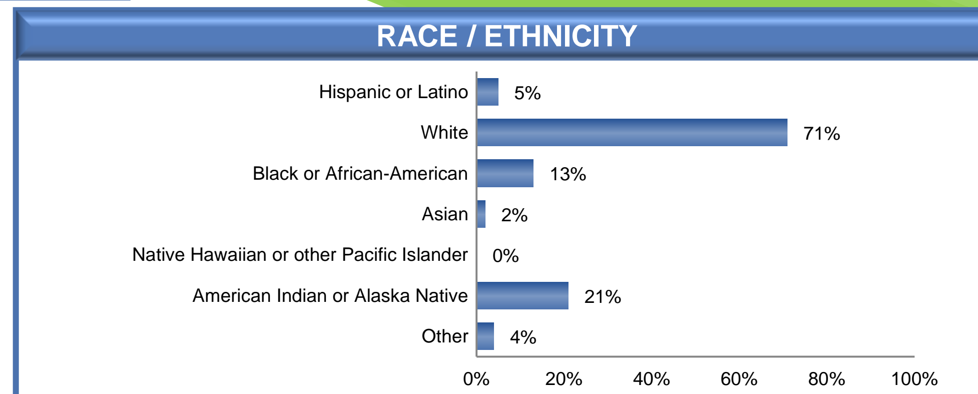
GENDER



EDUCATION



RACE / ETHNICITY



Data shown are self reported.

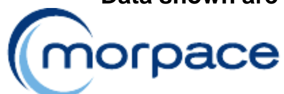
Executive Summary

Demographics

Oklahoma HealthCare Authority

	2013	2014	2015	2014 Quality Compass®
Q36. Health Status				
Excellent/Very good	25%	24%	20%	34%
Good	27%	30%	27%	32%
Fair/Poor	48%	46%	52%	34%
Q37. Mental/Emotional Health Status				
Excellent/Very good	32%	35%	30%	43%
Good	28%	26%	37%	28%
Fair/Poor	40%	39%	33%	30%
Q52. Member's Age				
18 to 24	18%	18%	7%	17%
25 to 34	21%	15%	11%	21%
35 to 44	15%	16%	12%	18%
45 to 54	24%	25%	17%	19%
55 to 64	21%	24%	23%	20%
65 or older	1%	2%	30%	5%
Q53. Gender				
Male	32%	32%	33%	33%
Female	68%	68%	67%	67%
Q54. Education				
Did not graduate high school	32%	30%	31%	27%
High school graduate or GED	46%	46%	41%	38%
Some college or 2-year degree	19%	20%	22%	28%
4-year college graduate	2%	3%	2%	5%
More than 4-year college degree	1%	1%	3%	2%
Q55/56. Race/Ethnicity				
Hispanic or Latino	6%	7%	5%	16%
White	74%	71%	71%	53%
Black or African-American	15%	14%	13%	24%
Asian	1%	1%	2%	4%
Native Hawaiian or other Pacific Islander	0%	1%	0%	2%
American Indian or Alaska Native	18%	18%	21%	4%
Other	5%	6%	4%	9%

Data shown are self reported.



Executive Summary

General Knowledge about Demographic Differences

Oklahoma Health Care Authority

The commentary below is based on generally recognized industry knowledge per various published sources:

Age	Older respondents tend to be more satisfied than younger respondents.
Health Status	People who rate their health status as 'Excellent' or 'Very good' tend to be more satisfied than people who rate their health status lower.
Education	More educated respondents tend to be less satisfied.
Race and ethnicity effects are independent of education and income. Lower income generally predicts lower satisfaction with coverage and care.	
Race	Whites give the highest ratings to both rating and composite questions. In general, Asian/Pacific Islanders and American Indian/Alaska Natives give the lowest ratings. Growing evidence that lower satisfaction ratings from Asian Americans are partially attributable to cultural differences in their response tendencies. Therefore, their lower scores might not reflect an accurate comparison of their experience with health care.
Ethnicity	Hispanics tend to give lower ratings than non-Hispanics. Non-English speaking Hispanics tend to give lower ratings than English-speaking Hispanics.

Note: If a health plan's population differs from Quality Compass® in any of the demographic groups, these differences could account for the plan's score when compared to Quality Compass®. For example, if a plan's population rates themselves in better health than the Quality Compass® population, this could impact a plan's score positively. Conversely, if a plan's population rates themselves in poorer health than the Quality Compass® population, the plan's scores could be negatively impacted.

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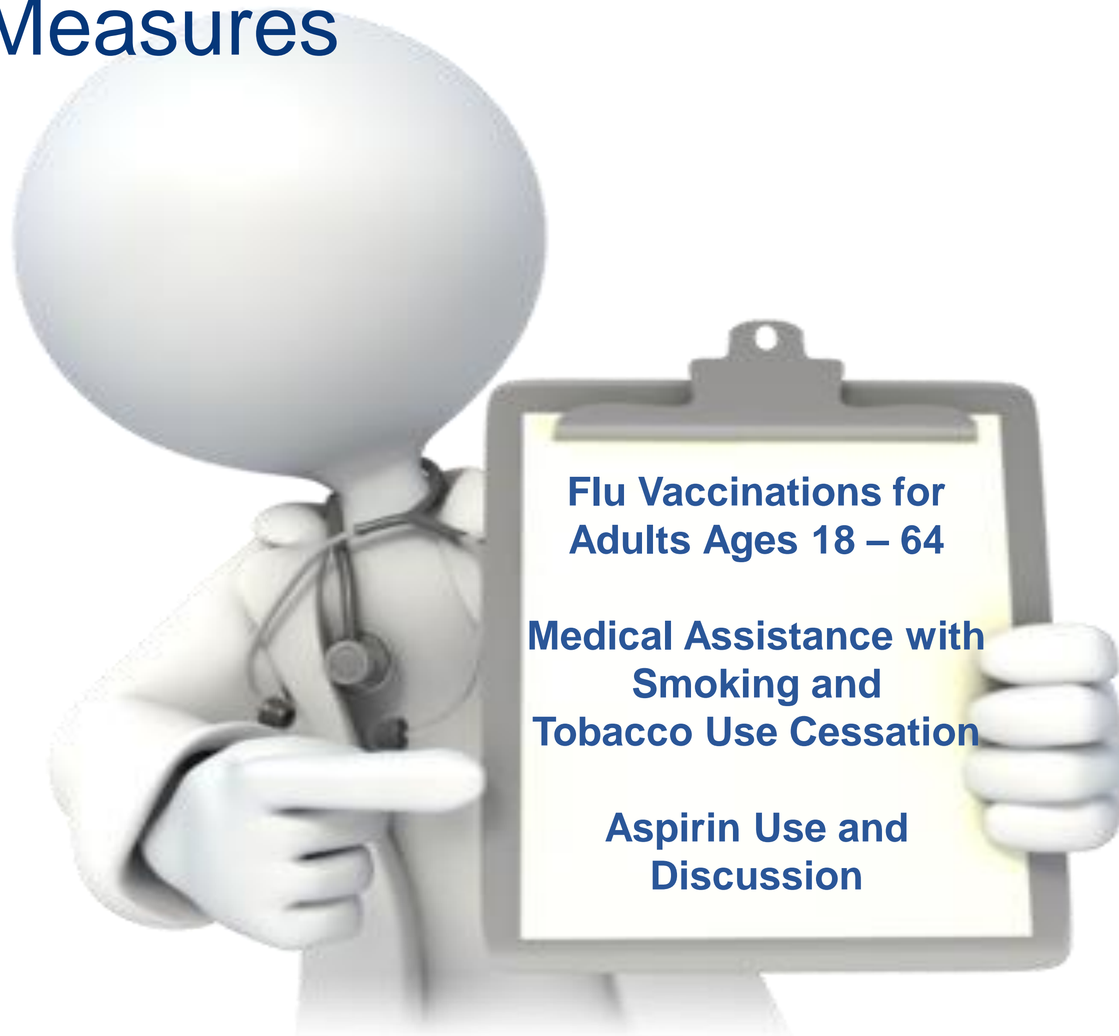
Executive Summary

Composite & Rating Scores by Demographics

	Age				Race				Ethnicity		Educational Level		Health Status		
Demographic	**18-24**	**25-34**	**35-44**	**45+**	**Caucasian**	**African American**	**Asian**	**All other**	**Hispanic**	**Non-Hispanic**	**HS Grad or Less**	**Some College+**	**Excellent/ Very Good**	**Good**	**Fair/ Poor**
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
Sample size	(n=29)	(n=47)	(n=50)	(n=286)	(n=303)	(n=57)	(n=8)	(n=102)	(n=20)	(n=380)	(n=298)	(n=114)	(n=83)	(n=112)	(n=213)
Composites *(% Always/Usually)*															
Getting Care Quickly	83	75	86	87	89F	78	42	88	66	88	85	91	83	86	88
Shared Decision Making *(% Yes)*	89	73	87	77	77	77	0	79	100	76	80	70	69	80	78
How Well Doctors Communicate	92	87	87	90	89	92	67	90	73	91	91	87	86	90	91
Getting Needed Care	92	75	83	85	85	84	40	86	73	85	85	85	84	86	84
Customer Service	100	81	97	91	91	100	100	93	75	93	91	96	92	86	94
Ratings *(% 8,9,10)*															
Personal Doctor	95	71	73	80	79	78	80	81	72	80	80	80	88	78	78
Specialist	100	73	95	76	80	70	0	77	71	79	79	75	86	82	75
Health Care	79	61	71	73	72	64	100	74	77	72	75L	64	83O	80O	65
Health Plan	72	57	80B	74B	70	79	88	72	65	73	74	70	80O	79O	67

Significance is noted by UPPERCASE letters for columns significantly HIGHER at 95% confidence level

HEDIS® Measures



Flu Vaccinations for Adults Ages 18 – 64

- In 2014, the Flu Vaccinations for Adults Ages 18-64 Measure (FVA) was added to the Medicaid product line.
- The Flu Vaccinations for Adults Ages 18-64 Measure is designed to report the percent of members:
  - who are between the ages of 18-64 as of July 1st of the measurement year
  - who were continuously enrolled during the measurement year, and
  - who received an influenza vaccination or flu spray between July of the measurement year and the date on which the survey was completed
- Results for this measure are calculated using data collected during the measurement year.
- All members in the sample are asked to answer this question but only the members that meet the age criteria will be included in the results for this measure. Below are the 2015 Reported Results. See Technical Notes for Accreditation Scoring.

	2015 Reported Results*
Q38. Have you had either a flu shot or flu spray in the nose since July 1, 2014?	
Members that meet age criteria (results are not reportable if less than 100)	289
Members that meet age criteria and received a flu vaccination	134
Flu Vaccinations for Adults Rate	***46%***

2014 Quality Compass®							
Mean	5th	10th	25th	50th	75th	90th	95th
NA	NA	NA	NA	NA	NA	NA	NA

** The 2015 Reported Result is calculated using results collected during the measurement year. There must be a total of 100 or more respondents eligible for calculation in the measurement year for the rate to be reportable. This is a second year measure and became eligible for public reporting in 2015.*

Medical Assistance with Smoking & Tobacco Use Cessation
Advising Smokers and Tobacco Users to Quit

- In 2010, the Medical Assistance with Smoking Cessation measure was revised and is now called the Medical Assistance with Smoking and Tobacco Use Cessation (MSC) measure. The scope of the measure was expanded to include smokeless tobacco use and revised the question response choices. This measure consists of the following components that assess different facets of providing medical assistance with smoking and tobacco use cessation:
  - Advising Smokers and Tobacco Users to Quit
  - Discussing Cessation Medications
  - Discussing Cessation Strategies
- Criteria for inclusion in this measure are members who are at least 18 years old, who were either current smokers, tobacco users, or recent quitters, who were seen by an MCO practitioner during the measurement year, and who received advice on quitting smoking/tobacco use.

Q40. Advising Smokers and Tobacco Users to Quit	2014	2015	2015 Reported Results*
Members that meet criteria (results are not reportable if less than 100)	147	148	295
Members that meet criteria and were advised to quit smoking or using tobacco	108	110	218
Advising Smokers and Tobacco Users to Quit Rate	***73%***	***74%***	***74%***

2014 Quality Compass®							
Mean	5th	10th	25th	50th	75th	90th	95th
75.84	66.33	68.94	73.58	76.80	79.32	81.42	83.22

Plan score falls on 25th or below 50th Percentile

**The Reported Results are calculated using a rolling average methodology, using results collected during two consecutive years of data collection. The Reported Results were calculated for the first time in 2011.*

Medical Assistance with Smoking & Tobacco Use Cessation

Discussing Cessation Medications

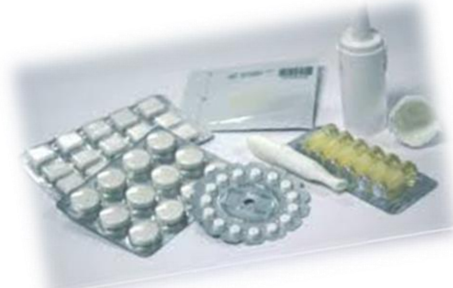
Oklahoma HealthCare Authority

- Criteria for inclusion in this measure are members who are at least 18 years old, who were either current smokers, tobacco users, or recent quitters, who were seen by an MCO practitioner during the measurement year, and who discussed smoking/tobacco use cessation medications.

	2014	2015	2015 Reported Results*
Q41. Discussing Cessation Medications			
Members that meet criteria (results are not reportable if less than 100)	145	146	291
Members that meet criteria and discussed medications to quit smoking or using tobacco	74	69	143
Discussing Cessation Medications Rate	***51%***	***47%***	***49%***

2014 Quality Compass®							
Mean	5th	10th	25th	50th	75th	90th	95th
46.63	33.74	37.61	41.40	45.87	51.68	57.11	60.00

Plan score falls on 50th or below 75th Percentile



**The Reported Results are calculated using a rolling average methodology, using results collected during two consecutive years of data collection. The Reported Results were calculated for the first time in 2011.*

Oklahoma HealthCare Authority

Medical Assistance with Smoking & Tobacco Use Cessation
Discussing Cessation Strategies

- Criteria for inclusion in this measure are members who are at least 18 years old, who were either current smokers, tobacco users, or recent quitters, who were seen by an MCO practitioner during the measurement year, and who discussed smoking/tobacco use cessation medications or strategies with their doctor.

Q42. Discussing Cessation Strategies	2014	2015	2015 Reported Results*
Members that meet criteria (results are not reportable if less than 100)	145	149	294
Members that meet criteria and discussed methods & strategies to quit smoking or using tobacco	68	66	134
Discussing Cessation Strategies Rate	***47%***	***44%***	***46%***

2014 Quality Compass®							
Mean	5th	10th	25th	50th	75th	90th	95th
41.88	31.43	33.70	37.91	41.57	45.27	50.89	53.24

Plan score falls on 75th or below 90th Percentile

**The Reported Results are calculated using a rolling average methodology, using results collected during two consecutive years of data collection. The Reported Results were calculated for the first time in 2011.*

Aspirin Use and Discussion (ASP)

- In 2010, Aspirin Use and Discussion (ASP) was added to assess different facets of managing aspirin use for the primary prevention of cardiovascular disease.
- This measure is not yet approved to be publicly reported for Adult Medicaid plans. The Aspirin results are calculated using a rolling average methodology, using results collected during two consecutive years of data collection.
- Criteria for inclusion in the Aspirin Use measure are:
  - Women 56-79 years of age with at least two risk factors for cardiovascular disease
  - Men 46-65 years of age with at least one risk factor for cardiovascular disease
  - Men 66-79 years of age, regardless of risk factors
- Criteria for the Discussing Aspirin Risks/Benefits measure are:
  - Women 56-79 years of age
  - Men 46-79 years of age

	2014	2015	2015 Rolling Average Results*
Q43. Aspirin Use			
Members that meet criteria (results are not reportable in 2015)	23	44	67
Members that meet criteria and use aspirin for preventative measures	11	21	32
Aspirin Use Rate	***48%***	***48%***	***48%***
Q45. Discussing Aspirin Risks and Benefits			
Members that meet criteria (results are not reportable in 2015)	43	87	130
Members that meet criteria and provider discussed risks/benefits of aspirin use for preventative measures	20	46	66
Discussing Aspirin Risks and Benefits Rate	***47%***	***53%***	***51%***

**The Reported Results are calculated using a rolling average methodology, using results collected during two consecutive years of data collection. The Rolling Average was calculated for the first time in 2011 and is not yet approved for public reporting.*

2015 Adult Medicaid CAHPS® Results
Oklahoma Health Care Authority

Legend:

	Never / Sometimes	Usually	Always	% Always/ Usually or %Yes	Summary Mean (1-3)	*Sample Size*
Getting Care Quickly	14	20	66	**86**	**2.52**	***(360)***
Getting care as soon as needed	15	16	69	85	2.54	*(230)*
Getting appointment as soon as needed	13	25	63	87	2.50	*(326)*
Shared Decision Making (% No, Yes)	23		77	**77**	**NA**	***(174)***
Discussed reasons to take medicine	10		90	90	NA	*(173)*
Discussed reasons not to take medicine	33		67	67	NA	*(174)*
Asked preference for medicine	26		74	74	NA	*(171)*
How Well Doctors Communicate	10	16	74	**90**	**2.64**	***(308)***
Explain things in a way you could understand	9	17	74	91	2.65	*(306)*
Listen carefully to you	11	16	73	89	2.62	*(306)*
Show respect for what you had to say	10	13	77	90	2.67	*(307)*
Spend enough time with you	11	16	72	89	2.61	*(306)*
Getting Needed Care	15	23	62	**85**	**2.47**	***(346)***
Easy to get care believed necessary	13	25	61	87	2.48	*(327)*
Easy to get appointment with specialist	17	21	62	83	2.45	*(198)*
Customer Service	8	21	71	**92**	**2.63**	***(104)***
Got information or help needed	13	24	63	87	2.51	*(101)*
Treated you with courtesy and respect	4	18	78	96	2.75	*(102)*
Other Measures						
Health Promotion and Education (% No, Yes)	29		71	71	2.42	*(325)*
Coordination of Care	21	23	55	79	2.34	*(206)*

Legend:

Ratings	0-3	4-5	6-7	8-10	% 8-10	Summary Mean	Sample Size
Health Care	4	9	16	72	72	2.35	*(329)*
Personal Doctor	4	7	10	80	80	2.50	*(342)*
Specialist	4	4	14	78	78	2.53	*(184)*
Health Plan	3	11	14	73	73	2.38	*(396)*

Percents may not add to 100% due to rounding

NA = Means are not calculated for the Shared Decision Making composite.

Plan Comparison to 2014 Adult Medicaid Quality Compass®

Oklahoma Health Care Authority

Adult Medicaid Survey Questions	Oklahoma Health Care Authority 2015	Percentile	2014 Adult Medicaid Quality Compass® Mean	5th	10th	25th	50th	75th	90th	95th
Getting Care Quickly *(% Always/Usually)*	**86.32**	**90th**	81.00	74.01	75.26	78.39	81.75	83.75	85.52	86.98
Q4 Getting care as soon as needed	85.22	50th	82.74	75.00	76.29	80.09	83.33	86.14	87.58	88.44
Q6 Getting appointment as soon as needed	87.42	95th	79.30	71.25	72.40	76.80	79.79	82.85	84.65	85.95
Shared Decision Making *(% Yes)*	**77.23**	**NA**	NA	NA	NA	NA	NA	NA	NA	NA
Q10 Discussed reasons to take medicine	90.17	NA	NA	NA	NA	NA	NA	NA	NA	NA
Q11 Discussed reasons not to take medicine	67.24	NA	NA	NA	NA	NA	NA	NA	NA	NA
Q12 Asked preference for medicine	74.27	25th	76.41	70.00	71.77	73.25	76.43	79.12	81.82	82.61
How Well Doctors Communicate *(% Always/Usually)*	**89.55**	**25th**	89.49	85.40	86.17	88.16	89.76	91.11	92.42	93.07
Q17 Explain things in a way you could understand	90.85	50th	89.86	85.64	86.45	88.04	90.25	91.71	93.15	94.50
Q18 Listen carefully to you	88.89	25th	89.94	84.97	86.47	88.15	90.17	91.78	93.33	94.50
Q19 Show respect for what you had to say	89.90	25th	91.38	87.25	88.42	89.83	91.30	93.02	94.19	94.85
Q20 Spend enough time with you	88.56	50th	86.80	81.82	82.91	84.70	87.20	88.71	90.13	90.98
Getting Needed Care *(% Always/Usually)*	**84.69**	**75th**	80.45	71.65	74.70	77.47	80.90	84.27	85.59	86.45
Q14 Easy to get care believed necessary	86.54	75th	82.47	74.43	76.30	79.28	83.15	85.87	87.94	89.58
Q25 Easy to get appointment with specialist	82.83	75th	78.67	68.90	71.01	75.39	79.19	82.28	85.08	86.13
Customer Service *(% Always/Usually)*	**91.60**	**95th**	86.51	80.66	81.85	84.45	87.05	88.64	90.28	91.32
Q31 Got information or help needed	87.13	95th	80.32	72.40	74.36	77.24	81.01	83.39	85.52	87.13
Q32 Treated you with courtesy and respect	96.08	95th	92.70	88.19	88.98	91.29	93.02	94.61	95.74	96.08
Q13 Rating of Health Care *(% 8, 9, 10)*	72.34	50th	71.26	63.40	64.32	68.54	71.53	74.06	76.95	78.57
Q23 Rating of Personal Doctor *(% 8, 9, 10)*	79.82	50th	78.75	72.50	74.37	76.45	78.82	80.97	83.10	84.65
Q27 Rating of Specialist *(% 8, 9, 10)*	78.26	10th	80.42	73.43	75.89	78.64	80.61	82.47	85.31	86.14
Q35 Rating of Health Plan *(% 8, 9, 10)*	72.73	25th	74.67	63.54	66.57	71.37	75.52	78.77	81.49	82.82
Q8 Health Promotion and Education *(% Yes)*	70.77	25th	71.64	65.99	66.97	69.01	71.93	74.07	76.23	76.92
Q22 Coordination of Care *(% Always/Usually)*	78.64	25th	79.24	72.49	73.18	76.62	79.67	82.04	85.19	85.99
HEDIS® Measures										
Q38 Flu (Ages 18-64)	46.37	NA	NA	NA	NA	NA	NA	NA	NA	NA
Q40 Advising Smokers and Tobacco Users to Quit*	73.90	25th	75.84	66.33	68.94	73.58	76.80	79.32	81.42	83.22
Q41 Discussing Cessation Medications*	49.14	50th	46.63	33.74	37.61	41.40	45.87	51.68	57.11	60.00
Q42 Discussing Cessation Strategies*	45.58	75th	41.88	31.43	33.70	37.91	41.57	45.27	50.89	53.24
Q43 Aspirin Use*	47.76	NA	NA	NA	NA	NA	NA	NA	NA	NA
Q45 Discussing Aspirin Risks and Benefits*	50.77	NA	NA	NA	NA	NA	NA	NA	NA	NA

* Calculated using a rolling average
NA = Comparison data not available from NCQA.
The 2014 Adult Medicaid Quality Compass® consists of 147 plans who publicly and non-publicly reported their scores (All Lines of Business excluding PPOs).

Legend
- = Plan score falls on or above 95th Percentile
- = Plan score falls on 90th or below 95th Percentile
- = Plan score falls on 75th or below 90th Percentile
- = Plan score falls on 50th or below 75th Percentile
- = Plan score falls on 25th or below 50th Percentile
- = Plan score falls on 10th or below 25th Percentile
- = Plan score falls on 5th or below 10th Percentile
- = Plan score falls below 5th Percentile

Adult Medicaid Historical Trending
Oklahoma Health Care Authority

Adult Medicaid Survey Questions	Oklahoma Health Care Authority							
	2013		2014		2015		Sig Testing	
	Summary Rate	Sample Size	Summary Rate	Sample Size	Summary Rate	Sample Size	2013 to 2014	2014 to 2015
Getting Care Quickly *(% Always/Usually)*	**79.4**	**341**	**82.3**	**258**	**86.3**	**360**	**NS**	**NS**
Q4 Getting care as soon as needed	78.3	198	82.3	158	85.2	230	NS	NS
Q6 Getting appointment as soon as needed	80.5	307	82.4	227	87.4	326	NS	NS
Shared Decision Making** *(% Yes)*	**NT**	**NT**	**NT**	**NT**	**77.2**	**174**	**NC**	**NC**
Q10 Discussed reasons to take medicine**	NT	NT	NT	NT	90.2	173	NC	NC
Q11 Discussed reasons not to take medicine**	NT	NT	NT	NT	67.2	174	NC	NC
Q12 Asked preference for medicine	70.3	175	70.4	135	74.3	171	NS	NS
How Well Doctors Communicate *(% Always/Usually)*	**87.1**	**287**	**89.9**	**206**	**89.6**	**308**	**NS**	**NS**
Q17 Explain things in a way you could understand	88.4	285	90.7	205	90.9	306	NS	NS
Q18 Listen carefully to you	87.5	287	90.3	206	88.9	306	NS	NS
Q19 Show respect for what you had to say	88.4	284	90.3	206	89.9	307	NS	NS
Q20 Spend enough time with you	84.2	285	88.4	206	88.6	306	NS	NS
Getting Needed Care *(% Always/Usually)*	**80.0**	**341**	**82.1**	**256**	**84.7**	**346**	**NS**	**NS**
Q14 Easy to get care believed necessary	80.6	329	81.3	251	86.5	327	NS	NS
Q25 Easy to get appointment with specialist	79.4	170	83.0	135	82.8	198	NS	NS
Customer Service *(% Always/Usually)*	**90.3**	**104**	**82.2**	**80**	**91.6**	**104**	**NS**	**NS**
Q31 Got information or help needed	89.4	104	77.2	79	87.1	101	-	NS
Q32 Treated you with courtesy and respect	91.3	103	87.2	78	96.1	102	NS	+
Q13 **Rating of Health Care** *(% 8, 9, 10)*	64.0	328	68.4	253	72.3	329	NS	NS
Q23 **Rating of Personal Doctor** *(% 8, 9, 10)*	70.7	328	79.0	247	79.8	342	+	NS
Q27 **Rating of Specialist** *(% 8, 9, 10)*	74.5	157	82.5	126	78.3	184	NS	NS
Q35 **Rating of Health Plan** *(% 8, 9, 10)*	61.3	388	73.1	290	72.7	396	+	NS
Q8 Health Promotion and Education *(% Yes)*	70.1	328	70.9	251	70.8	325	NS	NS
Q22 Coordination of Care *(% Always/Usually)*	77.1	166	82.9	123	78.6	206	NS	NS
HEDIS® Measures								
Q38 Flu (Ages 18-64)***	NA	NA	44.6	280	46.4	289	NC	NS
Q40 Advising Smokers and Tobacco Users to Quit*	76.3	169	75.0	316	73.9	295	NS	NS
Q41 Discussing Cessation Medications*	45.2	168	47.9	313	49.1	291	NS	NS
Q42 Discussing Cessation Strategies*	41.7	168	44.1	313	45.6	294	NS	NS
Q43 Aspirin Use*	36.4	22	42.2	45	47.8	67	NS	NS
Q45 Discussing Aspirin Risks and Benefits*	41.8	55	43.9	98	50.8	130	NS	NS

* Calculated using a rolling average
** Question wording and response choices changed in 2015.
*** New measure in 2014. This is a single year measure.
NA= Data not available
NT= Not trendable
NC= Not comparable

Legend

+ = Results significantly higher than prior year's results
NS = No significant difference between the two years
- = Results significantly lower than prior year's results

2015 Adult Medicaid Demographic Profile - Age
Oklahoma Health Care Authority

	Adult Medicaid Survey Questions	Oklahoma Health Care Authority					
		Total (%)	18-24 (%)	25-34 (%)	35-44 (%)	45+ (%)	High/Low Diff (%)
	Sample Size	(n=426)	(n=29)	(n=47)	(n=50)	(n=286)	
	Getting Care Quickly *(% Always/Usually)*	**86**	**83**	**75**	**86**	**87**	**12**
Q4	Getting care as soon as needed	85	82	72	86	86	14
Q6	Getting appointment as soon as needed	87	85	78	86	88	10
	Shared Decision Making *(% Yes)*	**77**	**89**	**73**	**87**	**77**	**16**
Q10	Discussed reasons to take medicine	90	100	88	92	90	12
Q11	Discussed reasons not to take medicine	67	67	65	85	66	20
Q12	Asked preference for medicine	74	100	65	85	74	35
	How Well Doctors Communicate *(% Always/Usually)*	**90**	**92**	**87**	**87**	**90**	**5**
Q17	Explain things in a way you could understand	91	88	92	94	91	6
Q18	Listen carefully to you	89	94	92	88	88	6
Q19	Show respect for what you had to say	90	94	79	84	91	15
Q20	Spend enough time with you	89	94	83	81	90	13
	Getting Needed Care *(% Always/Usually)*	**85**	**92**	**75**	**83**	**85**	**17**
Q14	Easy to get care believed necessary	87	83	84	86	87	4
Q25	Easy to get appointment with specialist	83	100	67	79	84	33
	Customer Service *(% Always/Usually)*	**92**	**100**	**81**	**97**	**91**	**19**
Q31	Got information or help needed	87	100	75	95	86	25
Q32	Treated you with courtesy and respect	96	100	88	100	95	12
Q13	**Rating of Health Care** *(% 8, 9, 10)*	**72**	**79**	**61**	**71**	**73**	**18**
Q23	**Rating of Personal Doctor** *(% 8, 9, 10)*	**80**	**95**	**71**	**73**	**80**	**24**
Q27	**Rating of Specialist** *(% 8, 9, 10)*	**78**	**100**	**73**	**95**	**76**	**27**
Q35	**Rating of Health Plan** *(% 8, 9, 10)*	**73**	**72**	**57**	**80**	**74**	**23**
Q8	Health Promotion and Education *(% Yes)*	71	63	52	74	74	22
Q22	Coordination of Care *(% Always/Usually)*	79	90	61	84	79	29
HEDIS® Measures							
Q38	Flu (Ages 18-64)	46	22	36	30	58	36
Q40	Advising Smokers and Tobacco Users to Quit*	74	57	68	71	79	22
Q41	Discussing Cessation Medications*	49	22	42	52	54	32
Q42	Discussing Cessation Strategies*	46	22	43	50	49	28
Q43	Aspirin Use*	48	0	0	0	48	48
Q45	Discussing Aspirin Risks and Benefits*	51	0	0	0	52	52

* Calculated using a rolling average

"High/Low Diff" is the percentage point difference between the largest and smallest score across the demographic group for that specific measure.

"High/Low Diff" column may not be exact due to rounding.

Use caution when reviewing scores with sample sizes less than 20.

2015 Adult Medicaid Demographic Profile - Race (1 of 2)

Oklahoma Health Care Authority

	Adult Medicaid Survey Questions	Oklahoma Health Care Authority					
		Total (%)	Caucasian (%)	African American (%)	Asian (%)	All other (%)	High/Low Diff (%)
	Sample Size	(n=426)	(n=303)	(n=57)	(n=8)	(n=102)	
	Getting Care Quickly *(% Always/Usually)*	**86**	**89**	**78**	**42**	**88**	**47**
Q4	Getting care as soon as needed	85	88	73	0	86	88
Q6	Getting appointment as soon as needed	87	89	82	83	90	8
	Shared Decision Making *(% Yes)*	**77**	**77**	**77**	**0**	**79**	**79**
Q10	Discussed reasons to take medicine	90	89	90	0	88	90
Q11	Discussed reasons not to take medicine	67	66	70	0	71	71
Q12	Asked preference for medicine	74	75	70	0	78	78
	How Well Doctors Communicate *(% Always/Usually)*	**90**	**89**	**92**	**67**	**90**	**25**
Q17	Explain things in a way you could understand	91	92	93	67	94	27
Q18	Listen carefully to you	89	87	95	67	88	28
Q19	Show respect for what you had to say	90	90	88	67	91	24
Q20	Spend enough time with you	89	88	93	67	88	26
	Getting Needed Care *(% Always/Usually)*	**85**	**85**	**84**	**40**	**86**	**46**
Q14	Easy to get care believed necessary	87	87	83	80	88	8
Q25	Easy to get appointment with specialist	83	83	85	0	85	85
	Customer Service *(% Always/Usually)*	**92**	**91**	**100**	**100**	**93**	**9**
Q31	Got information or help needed	87	86	100	100	90	14
Q32	Treated you with courtesy and respect	96	95	100	100	95	5
Q13	**Rating of Health Care** *(% 8, 9, 10)*	**72**	**72**	**64**	**100**	**74**	**36**
Q23	**Rating of Personal Doctor** *(% 8, 9, 10)*	**80**	**79**	**78**	**80**	**81**	**3**
Q27	**Rating of Specialist** *(% 8, 9, 10)*	**78**	**80**	**70**	**0**	**77**	**80**
Q35	**Rating of Health Plan** *(% 8, 9, 10)*	**73**	**70**	**79**	**88**	**72**	**18**
Q8	Health Promotion and Education *(% Yes)*	71	70	66	20	79	59
Q22	Coordination of Care *(% Always/Usually)*	79	78	79	100	82	22
	HEDIS® Measures						
Q38	Flu (Ages 18-64)	46	45	58	33	39	25
Q40	Advising Smokers and Tobacco Users to Quit*	74	73	68	0	80	80
Q41	Discussing Cessation Medications*	49	47	53	0	54	54
Q42	Discussing Cessation Strategies*	46	42	56	0	48	56
Q43	Aspirin Use*	48	48	36	100	47	64
Q45	Discussing Aspirin Risks and Benefits*	51	52	44	0	65	65

* Calculated using a rolling average
"High/Low Diff" is the percentage point difference between the largest and smallest score across the demographic group for that specific measure.
"High/Low Diff" column may not be exact due to rounding.
Use caution when reviewing scores with sample sizes less than 20.

2015 Adult Medicaid Demographic Profile - Race (2 of 2)

Oklahoma Health Care Authority

	Adult Medicaid Survey Questions	Oklahoma Health Care Authority			
		Total (%)	Caucasian (%)	Non-Caucasian (%)	High/Low Diff (%)
	Sample Size	(n=426)	(n=303)	(n=106)	
	Getting Care Quickly *(% Always/Usually)*	**86**	**89**	**81**	**8**
Q4	Getting care as soon as needed	85	88	78	10
Q6	Getting appointment as soon as needed	87	89	85	4
	Shared Decision Making *(% Yes)*	**77**	**77**	**80**	**3**
Q10	Discussed reasons to take medicine	90	89	92	3
Q11	Discussed reasons not to take medicine	67	66	75	9
Q12	Asked preference for medicine	74	75	74	1
	How Well Doctors Communicate *(% Always/Usually)*	**90**	**89**	**91**	**2**
Q17	Explain things in a way you could understand	91	92	92	0
Q18	Listen carefully to you	89	87	93	6
Q19	Show respect for what you had to say	90	90	89	1
Q20	Spend enough time with you	89	88	91	3
	Getting Needed Care *(% Always/Usually)*	**85**	**85**	**85**	**0**
Q14	Easy to get care believed necessary	87	87	85	2
Q25	Easy to get appointment with specialist	83	83	84	1
	Customer Service *(% Always/Usually)*	**92**	**91**	**98**	**7**
Q31	Got information or help needed	87	86	96	10
Q32	Treated you with courtesy and respect	96	95	100	5
Q13	**Rating of Health Care** *(% 8, 9, 10)*	**72**	**72**	**72**	**0**
Q23	**Rating of Personal Doctor** *(% 8, 9, 10)*	**80**	**79**	**82**	**3**
Q27	**Rating of Specialist** *(% 8, 9, 10)*	**78**	**80**	**73**	**7**
Q35	**Rating of Health Plan** *(% 8, 9, 10)*	**73**	**70**	**80**	**10**
Q8	Health Promotion and Education *(% Yes)*	71	70	73	3
Q22	Coordination of Care *(% Always/Usually)*	79	78	85	7
HEDIS® Measures					
Q38	Flu (Ages 18-64)	46	45	51	6
Q40	Advising Smokers and Tobacco Users to Quit*	74	73	77	4
Q41	Discussing Cessation Medications*	49	47	54	7
Q42	Discussing Cessation Strategies*	46	42	54	12
Q43	Aspirin Use*	48	48	45	3
Q45	Discussing Aspirin Risks and Benefits*	51	52	47	5

* Calculated using a rolling average

"High/Low Diff" is the percentage point difference between the largest and smallest score across the demographic group for that specific measure.

"High/Low Diff" column may not be exact due to rounding.

Use caution when reviewing scores with sample sizes less than 20.

2015 Adult Medicaid Demographic Profile - Ethnicity
Oklahoma Health Care Authority

	Adult Medicaid Survey Questions	Oklahoma Health Care Authority			
		Total (%)	Hispanic (%)	Non-Hispanic (%)	High/Low Diff (%)
	Sample Size	(n=426)	(n=20)	(n=380)	
	Getting Care Quickly *(% Always/Usually)*	**86**	**66**	**88**	**22**
Q4	Getting care as soon as needed	85	71	86	15
Q6	Getting appointment as soon as needed	87	62	90	28
	Shared Decision Making *(% Yes)*	**77**	**100**	**76**	**24**
Q10	Discussed reasons to take medicine	90	100	90	10
Q11	Discussed reasons not to take medicine	67	100	66	34
Q12	Asked preference for medicine	74	100	73	27
	How Well Doctors Communicate *(% Always/Usually)*	**90**	**73**	**91**	**18**
Q17	Explain things in a way you could understand	91	73	92	19
Q18	Listen carefully to you	89	73	90	17
Q19	Show respect for what you had to say	90	80	91	11
Q20	Spend enough time with you	89	67	91	24
	Getting Needed Care *(% Always/Usually)*	**85**	**73**	**85**	**12**
Q14	Easy to get care believed necessary	87	79	87	8
Q25	Easy to get appointment with specialist	83	67	84	17
	Customer Service *(% Always/Usually)*	**92**	**75**	**93**	**18**
Q31	Got information or help needed	87	67	89	22
Q32	Treated you with courtesy and respect	96	83	98	15
Q13	**Rating of Health Care** *(% 8, 9, 10)*	**72**	**77**	**72**	**5**
Q23	**Rating of Personal Doctor** *(% 8, 9, 10)*	**80**	**72**	**80**	**8**
Q27	**Rating of Specialist** *(% 8, 9, 10)*	**78**	**71**	**79**	**8**
Q35	**Rating of Health Plan** *(% 8, 9, 10)*	**73**	**65**	**73**	**8**
Q8	Health Promotion and Education *(% Yes)*	71	43	72	29
Q22	Coordination of Care *(% Always/Usually)*	79	60	80	20
	HEDIS® Measures				
Q38	Flu (Ages 18-64)	46	20	47	27
Q40	Advising Smokers and Tobacco Users to Quit*	74	83	74	9
Q41	Discussing Cessation Medications*	49	67	49	18
Q42	Discussing Cessation Strategies*	46	50	45	5
Q43	Aspirin Use*	48	0	45	45
Q45	Discussing Aspirin Risks and Benefits*	51	25	52	27

* Calculated using a rolling average
"High/Low Diff" is the percentage point difference between the largest and smallest score across the demographic group for that specific measure.
"High/Low Diff" column may not be exact due to rounding.

Use caution when reviewing scores with sample sizes less than 20.

2015 Adult Medicaid Demographic Profile - Education

Oklahoma Health Care Authority

	Adult Medicaid Survey Questions	Oklahoma Health Care Authority Total (%)	HS grad or less (%)	Some college or more (%)	High/Low Diff (%)
	Sample Size	(n=426)	(n=298)	(n=114)	
	Getting Care Quickly *(% Always/Usually)*	**86**	**85**	**91**	**6**
Q4	Getting care as soon as needed	85	83	91	8
Q6	Getting appointment as soon as needed	87	86	90	4
	Shared Decision Making *(% Yes)*	**77**	**80**	**70**	**10**
Q10	Discussed reasons to take medicine	90	91	89	2
Q11	Discussed reasons not to take medicine	67	68	62	6
Q12	Asked preference for medicine	74	81	58	23
	How Well Doctors Communicate *(% Always/Usually)*	**90**	**91**	**87**	**4**
Q17	Explain things in a way you could understand	91	92	88	4
Q18	Listen carefully to you	89	90	88	2
Q19	Show respect for what you had to say	90	92	85	7
Q20	Spend enough time with you	89	90	86	4
	Getting Needed Care *(% Always/Usually)*	**85**	**85**	**85**	**0**
Q14	Easy to get care believed necessary	87	87	84	3
Q25	Easy to get appointment with specialist	83	82	85	3
	Customer Service *(% Always/Usually)*	**92**	**91**	**96**	**5**
Q31	Got information or help needed	87	87	91	4
Q32	Treated you with courtesy and respect	96	96	100	4
Q13	**Rating of Health Care** *(% 8, 9, 10)*	**72**	**75**	**64**	**11**
Q23	**Rating of Personal Doctor** *(% 8, 9, 10)*	**80**	**80**	**80**	**0**
Q27	**Rating of Specialist** *(% 8, 9, 10)*	**78**	**79**	**75**	**4**
Q35	**Rating of Health Plan** *(% 8, 9, 10)*	**73**	**74**	**70**	**4**
Q8	Health Promotion and Education *(% Yes)*	71	73	64	9
Q22	Coordination of Care *(% Always/Usually)*	79	81	75	6
	HEDIS® Measures				
Q38	Flu (Ages 18-64)	46	44	50	6
Q40	Advising Smokers and Tobacco Users to Quit*	74	75	74	1
Q41	Discussing Cessation Medications*	49	53	37	16
Q42	Discussing Cessation Strategies*	46	47	43	4
Q43	Aspirin Use*	48	48	47	1
Q45	Discussing Aspirin Risks and Benefits*	51	51	50	1

* Calculated using a rolling average
"High/Low Diff" is the percentage point difference between the largest and smallest score across the demographic group for that specific measure.
"High/Low Diff" column may not be exact due to rounding.
Use caution when reviewing scores with sample sizes less than 20.

2015 Adult Medicaid Demographic Profile - Health Status
Oklahoma Health Care Authority

Adult Medicaid Survey Questions		Oklahoma Health Care Authority Total (%)	Excellent/ Very Good (%)	Good (%)	Fair/ Poor (%)	High/Low Diff (%)
	Sample Size	(n=426)	(n=83)	(n=112)	(n=213)	
	Getting Care Quickly *(% Always/Usually)*	**86**	**83**	**86**	**88**	**5**
Q4	Getting care as soon as needed	85	80	88	86	8
Q6	Getting appointment as soon as needed	87	86	84	89	5
	Shared Decision Making *(% Yes)*	**77**	**69**	**80**	**78**	**11**
Q10	Discussed reasons to take medicine	90	79	91	91	12
Q11	Discussed reasons not to take medicine	67	68	70	67	3
Q12	Asked preference for medicine	74	61	78	75	17
	How Well Doctors Communicate *(% Always/Usually)*	**90**	**86**	**90**	**91**	**5**
Q17	Explain things in a way you could understand	91	87	91	92	5
Q18	Listen carefully to you	89	87	90	89	3
Q19	Show respect for what you had to say	90	83	92	91	9
Q20	Spend enough time with you	89	87	89	89	2
	Getting Needed Care *(% Always/Usually)*	**85**	**84**	**86**	**84**	**2**
Q14	Easy to get care believed necessary	87	88	87	86	2
Q25	Easy to get appointment with specialist	83	80	85	82	5
	Customer Service *(% Always/Usually)*	**92**	**92**	**86**	**94**	**8**
Q31	Got information or help needed	87	89	79	90	11
Q32	Treated you with courtesy and respect	96	95	93	98	5
Q13	**Rating of Health Care** *(% 8, 9, 10)*	**72**	**83**	**80**	**65**	**18**
Q23	**Rating of Personal Doctor** *(% 8, 9, 10)*	**80**	**88**	**78**	**78**	**10**
Q27	**Rating of Specialist** *(% 8, 9, 10)*	**78**	**86**	**82**	**75**	**11**
Q35	**Rating of Health Plan** *(% 8, 9, 10)*	**73**	**80**	**79**	**67**	**13**
Q8	Health Promotion and Education *(% Yes)*	71	57	72	76	19
Q22	Coordination of Care *(% Always/Usually)*	79	72	74	83	11
HEDIS® Measures						
Q38	Flu (Ages 18-64)	46	37	42	51	14
Q40	Advising Smokers and Tobacco Users to Quit*	74	66	71	77	11
Q41	Discussing Cessation Medications*	49	43	44	54	11
Q42	Discussing Cessation Strategies*	46	45	41	49	8
Q43	Aspirin Use*	48	33	43	55	22
Q45	Discussing Aspirin Risks and Benefits*	51	32	50	58	26

* Calculated using a rolling average

"High/Low Diff" is the percentage point difference between the largest and smallest score across the demographic group for that specific measure.

"High/Low Diff" column may not be exact due to rounding.

Use caution when reviewing scores with sample sizes less than 20.

TECHNICAL NOTES – Adult Medicaid

Aspirin Use and Discussion (ASP)
A HEDIS Measure, Aspirin Use and Discussion (ASP), was added in 2010 to assess different facets of managing aspirin use for the primary prevention of cardiovascular disease. The ASP results are calculated using a rolling average methodology, with results collected during two consecutive years of data collection. The rolling average was calculated for the first time in 2011. Aspirin Use was approved for public reporting in 2012. Discussing Aspirin Risks and Benefits will not be publicly reported in HEDIS 2015.
.

Criteria for inclusion in the Aspirin Use measure are:

- Women 56-79 years of age with at least two risk factors for cardiovascular disease
- Men 46-65 years of age with at least one risk factor for cardiovascular disease
- Men 66-79 years of age, regardless of risk factors

Criteria for Discussing Aspirin Risks/Benefits are:

- Women 56-79 years of age
- Men 46-79 years of age

The Cardiovascular disease risk factors include:

- Current smoker or tobacco user
- High cholesterol
- High blood pressure
- Parent or sibling who had a heart attack before 60 years of age

Because the measure assesses aspirin use for the primary prevention of cardiovascular disease, members with cardiovascular disease are excluded. This includes members with a history of:

- Heart attack
- Angina or coronary heart disease
- Stroke
- Diabetes or high blood sugar

In order to calculate the results, Gender-Dependent Age Band Eligibility Flags are established for each member in the CAHPS 5.0H Adult Survey sample frame data file. These flags identify members eligible for the Aspirin Use and Discussion measures (see below).

Dependent Age Band Eligibility Flags
1 = Female age 55 or younger as of December 31 of the measurement year
2 = Female age 56–79 as of December 31 of the measurement year
3 = Female age 80 or older as of December 31 of the measurement year
4 = Male age 45 or younger as of December 31 of the measurement year
5 = Male age 46-65 as of December 31 of the measurement year
6 = Male age 66–79 as of December 31 of the measurement year
7 = Male age 80 or older as of December 31 of the measurement year

The following table illustrates the questions and responses included in the Aspirin Use and Discussion measures.

Commercial	Medicaid	Question	Response Choices
Q46	Q39	Do you now smoke cigarettes or use tobacco every day, some days, or not at all?	• Every day • Some days • Not at all • Don't know
Q50	Q43	Do you take aspirin daily or every other day?	• Yes • No • Don't know
Q51	Q44	Do you have a health problem or take medication that makes taking aspirin unsafe for you?	• Yes • No • Don't know
Q52	Q45	Has a doctor or health provider ever discussed with you the risks and benefits of aspirin to prevent heart attack or stroke?	• Yes • No
Q53	Q46	Are you aware that you have any of the following conditions? Mark one or more.	• High cholesterol • High blood pressure • Parent or sibling with heart attack before the age of 60
Q54	Q47	Has a doctor ever told you that you have any of the following conditions? Mark one or more.	• A heart attack • Angina or coronary heart disease • A stroke • Any kind of diabetes or high blood sugar

Calculation of Aspirin Use and Discussion:

The Aspirin Use and Discussion measures are calculated using a rolling average methodology. See *Rolling Average* for an explanation of how a rolling average is calculated.

ASPIRIN USE	
Denominator	The number of members who responded to the survey and indicated that they did not have a health problem or take medication that makes taking aspirin unsafe, did not have an exclusion and who are: • Women 56-79 with at least two risk factors for cardiovascular disease • Men 46-65 with at least one risk factor for cardiovascular disease • Men 66-79
Eligible gender-dependent age bands	Only members with Gender-Dependent Age Band Eligibility Flags of 2, 5, and 6 are included in the denominator. • Members with a **Gender-Dependent Age Band Eligibility Flag = 2** must have at least two cardiovascular risk factors • Members with a **Gender-Dependent Age Band Eligibility Flag = 5** must have at least one cardiovascular risk factor • Members with a **Gender-Dependent Age Band Eligibility Flag = 6** are included, regardless of the number of cardiovascular risk factors
Summing cardiovascular risk factors	Each response choice below indicates a cardiovascular risk factor. Sum the responses by member to calculate the total number of risk factors for that member. Q39 = “Every day” or “Some days” Q46 = “High cholesterol” Q46 = “High blood pressure” Q46 = “Parent or sibling with heart attack before the age of 60*
Exclusions	Any response to Q47 indicates a cardiovascular disease exclusion. Exclude any member who selected *any* response choice for Q47: “A heart attack” or “Angina or coronary heart disease” or “A stroke” or “Any kind of diabetes or high blood sugar.”
Aspirin Use questions	Response choices must be as follows to be included in the denominator: Q43 = “Yes” or “No” Q44 = “No”
Numerator	The number of members in the denominator who indicated that they currently take aspirin daily or every other day. Member response choice must be as follows to be included in the numerator: Q43 = Yes

DISCUSSING ASPIRIN RISKS AND BENEFITS	
Denominator	The number of respondents who are Women 56-79 and Men 46-79 years of age.
Eligible gender-dependent age bands	Only members with Gender-Dependent Age Band Eligibility Flags of 2, 5, and 6 are included in the denominator.
Aspirin discussion question	Response choices must be as follows to be included in the denominator: Q45 = "Yes" or "No"
Numerator	The number of members in the denominator who indicated that their doctor or other provider discussed the risks and benefits of aspirin use to prevent heart attack or stroke. Member response choice must be as follows to be included in the numerator: Q45 = "Yes"

SOURCE: Page 33-37, Volume 3 HEDIS® 2015 Specifications for Survey Measures

Composites

Composite scores are used to both facilitate aggregation of information from multiple specific questions and to enhance the communication of this important information to consumers.

The composites are:

Getting Care Quickly
Shared Decision Making
How Well Doctors Communicate
Getting Needed Care
Customer Service

In 2007 one composite was deleted (Courteous and Helpful Office Staff) and one was added (Shared Decision Making). In 2008 the Customer Service composite was reduced from 3 questions to 2 questions.

In 2013, the questions in the Shared Decision Making composite were changed; highlighting decisions on prescriptions rather than decisions about health care in general. These changes impacted trending for this composite and the individual measures. For HEDIS 2015, NCQA revised the Shared Decision Making composite. Question language and response options have been revised from a four-point scale (Not at all/A little/Some/A lot) to a two-point scale (Yes/No). This composite will not be trendable to 2014 data. See Page N for new wording of these questions.

In addition, in 2013, both questions in Getting Needed Care were modified. Also, the placement of the question regarding ease of getting care, tests and treatment through your health plan (Q27) was changed and is now Q14 and the reference to "through the health plan" was removed from the question. While these changes were not expected to impact trending, the National Mean for Q14 increased from 77.02% in 2012 to 82.54% in 2013.

The Composite Summary Rate is used in reporting to Quality Compass® and the Three-Point Score is used in NCQA accreditation. See *Summary Rate Scoring* and *Scoring for NCQA Accreditation* for an explanation of how the scores are calculated.

See Page N for a listing of each of the questions in the composites, the response choices, and how each response is scored.

Composite Mean

The composite mean that is calculated for Composite Measures is a mean of the individual means that make up that composite.

For example, the measure "Getting Care Quickly" comprises two individual measures:
Q4 - How often did you get care as soon as you thought you needed?
Q6 - How often did you get an appointment for a check-up or routine at a doctor's office or clinic as soon as you thought you needed?

To calculate a composite mean or composite percent, first calculate the individual means or percents for Q4 and Q6. For example, if the individual means or percents are:

Mean for Q4 = 1.9	Percent for Q4 = 84%
Mean for Q6 = 2.2	Percent for Q6 = 88%

Then, calculate the mean of those means:

Composite Mean = (1.9 + 2.2) / 2 = 2.05
Composite Percent = (84% + 88%)/2 = 86%

Note that each question within a composite is weighted equally, regardless of the number of members responding to each or to the relative importance of one question to another.

Correlation

The Pearson Product Moment Correlation (called Pearson correlation for short) is used in the Key Driver Analysis. Correlation is a measure of direction and degree of linear relationship between two variables. A correlation coefficient is a numerical index of that relationship. The closer the correlation coefficient is to 1.0, the stronger the correlation between the two variables.

Demographics

To allow for better statistical comparison of the demographic segments, Morpace has collapsed some of NCQA's response categories in the standard cross tabulations.

CAHPS® Segments	Morpace Segments
AGE	
18 – 24	18 – 34
25 – 34	
35 – 44	35 – 54
44 – 54	
55 – 64	55 +
65 – 74	
75 or older	
EDUCATION	
8th grade or less	High school or less
Some high school	
High school graduate/GED	
Some college/2-year degree	Some college or more
4-year college degree	
More than 4-year college degree	
RACE /ETHNICITY	
White	White
Black/African-American	Black/African-American
Asian	All Other
Native Hawaiian/Pacific Islander	
American Indian/Alaska Native	
Other	
HEALTH STATUS	
Excellent	Excellent – Very Good
Very Good	
Good	Good
Fair	Fair - Poor
Poor	

Flu Vaccinations for Adults Ages 18 – 64 (FVA)

This measure was added to the Adult Medicaid Survey in 2014. This measure will be reportable in 2015.

The health plan assigns a *Flu Vaccinations for Adults Ages 18 – 64* Eligibility Flag for each member in the adult survey sample frame data file. An eligible member receives a designation of "1" meaning that the member was born on or between July 2, 1949, and July 1, 1996.

Only one question is included in the measure:
Q38: Have you had either a flu shot or flu spray in the nose since July 1, 2014?

Calculations of Flu Vaccinations for Adults Ages 18 - 64
Denominator: Number of members with an "Eligible" flag that responded "Yes" or "No" to Q38.
Numerator: Number of members in the denominator who responded "Yes" to Q38.

Health plans must achieve a denominator of at least 100 responses to obtain a reportable result. If the denominator is less than 100, NCQA assigns a measure result of NA.

History of CAHPS®

The CAHPS® 5.0H surveys are a set of standardized surveys that assess health plan member satisfaction with the experience of care. In October 1995, the Agency of Healthcare Research and Quality (AHRQ) began the CAHPS® initiative with researchers from Harvard Medical School, RAND, and Research Triangle Institute, Inc. The first survey data from the CAHPS® 2.0H survey was reported to NCQA in 1998.

In 2002, a CAHPS® Instrument Panel was convened to reevaluate and update the CAHPS® 2.0H Surveys. The Panel evaluated consumer feedback, performed analyses on CAHPS® results, and conducted cognitive testing on proposed revisions. The outcome of the CAHPS® Instrument Panel was the revised set of surveys, CAHPS® 3.0H. The HEDIS® versions of the CAHPS® surveys were also updated to be consistent with the CAHPS® 3.0H surveys. In 2007, AHRQ replaced the CAHPS® 3.0H Adult Survey with the CAHPS® Health Plan Survey 4.0H.

In 2013, AHRQ replaced the CAHPS® 4.0H Adult Survey with the CAHPS® Health Plan Survey 5.0H as part of its Ambulatory CAHPS® initiative.

The overarching goal of the CAHPS® 5.0H survey is to obtain information that is not available from any other source - the person receiving care. The major objectives of the 2015 CAHPS® 5.0H Adult Medicaid Survey are to:

- Measure satisfaction levels, health plan use, health and socio-demographic characteristics of members
- Identify factors that affect the level of satisfaction
- Provide a tool that can be used by plan management to identify opportunities for quality improvement
- Provide plans with data for HEDIS® and NCQA accreditation

Key Driver Analysis

A Key Driver Analysis was conducted to understand the relationship between different aspects of plan service and provider care and member overall satisfaction with their health plan, their personal doctor, their specialist, and health care in general. Two specific scores are assessed both individually and in relation to each other. These are:

1) The relative importance of the individual issues (or attributes).
   Pearson correlation scores are calculated for the 13 individual ratings (potential drivers) in relation to ratings of the overall experience with the health plan, doctor, specialist, and health care. The correlation coefficients are then used to establish the relative importance of each driver - the higher the correlation, the more important the driver.

2) Relationship to 50th percentile for Quality Compass®
   Attributes are noted as to whether their score is above or below the 50th percentile. Those below the 50th percentile are noted as an area for improvement, if their correlation is high. Those above the 50th percentile are noted as an area of strength, if their correlation is high. Quality Compass® 2014 is used for this report.

   How to Read the Key Driver Analysis Charts:

   The bar charts on the key driver pages depict the correlation scores of the individual attributes to each of the four overall measures. Directly to the right of each correlation score is the plan's score and the percentile group in which the health plan's score falls.

   The higher the correlation score, the more impact the individual attribute has on the overall score. That is, if you modify behavior to improve the rating of the individual issue, the overall score is also likely to improve.

   The higher the Quality Compass® percentile group, the more members are satisfied with the attribute. Conversely, the lower the Quality Compass® percentile group, the fewer members are satisfied with the attribute. Attributes with scores below the 50th percentile are considered to be high priority for improvement.

   How to interpret…

Higher correlation/Lower Quality Compass® Percentile Group	**HIGH PRIORITY FOR IMPROVEMENT**. The attribute is a driver of the overall measure and the plan's score is below the 50th percentile when compared to plans reporting to Quality Compass®. If performance can be

	improved on this attribute, members will be more satisfied, and the overall measure should reflect this.
Higher correlation/Higher Quality Compass® Percentile Group	**CONTINUE TO TARGET EFFORTS**. It is critical to continue to target efforts in this area. The majority of members are satisfied with the performance, and the attribute is clearly related to the overall measure.
Lower correlation	**LOW PRIORITY**. While satisfaction of these attributes varies, these attributes are lower in importance to the overall measure. Monitor performance and consider possible action based on cost benefit analysis.

Margin of Error

The results presented in this report are obtained from a sample of the members of each plan; therefore, the estimates presented have a margin of error that should be considered.

The following table shows the approximate margin of error for different combinations of sample sizes and the estimated proportions, using a 95% confidence level.

95% Confidence Interval for Sample Proportions Margin of Error						
		Observed Proportion				
		90% | 10%	80% | 20%	70% | 30%	60% | 40%	50%
Number of Valid Responses	100	±5.9%	±7.8%	±9.0%	±9.6%	±9.8%
	200	±4.2%	±5.5%	±6.4%	±6.8%	±6.9%
	300	±3.4%	±4.5%	±5.2%	±5.5%	±5.7%
	400	±2.9%	±3.9%	±4.5%	±4.8%	±4.9%
	500	±2.6%	±3.5%	±4.0%	±4.3%	±4.4%

Examples of how to use this table:

Assume that a plan obtains a rating of 50% for a given measure and the number of valid responses is 500. In this case we are 95% confident that the unknown population rating is between 45.6% and 54.4% (50%± 4.4%).

Assume that a plan obtains a rating of 70% for a given measure and the number of valid responses is 300. In this case we 95% confident that the unknown population rating is between 64.8% and 75.2% (70%± 5.2%).

Medical Assistance with Smoking Cessation and Tobacco Use Cessation (MSC)

The Medical Assistance with Smoking Cessation was revised in the 2010 survey and is now called the Medical Assistance with Smoking and Tobacco Use Cessation (MSC). The scope of the measure was expanded to include smokeless tobacco use and to include the smokers and tobacco users who were not seen by a health plan practitioner during the measurement year. The question response choices were also revised. This measure now consists of the following components that assess different facets of providing medical assistance with smoking and tobacco use cessation:

- Advising Smokers and Tobacco Users to Quit
- Discussing Cessation Medications
- Discussing Cessation Strategies

Calculating the results of these three measures is described in detail on pages 38-42 of HEDIS® Volume 3. Questions 39, 40, 41 and 42 are included in the calculation. The example here focuses on "Advising Smokers to Quit". The Advising Smokers and Tobacco Users to Quit rate includes members (18+ years of age) that are current smokers or tobacco users and who received advice to quit during the measurement year.

Responses must follow the path below to qualify for inclusion in the denominator of the calculation.

Q39 = “Everyday” or “Some Days”
Q40 = “”Never” or “Sometimes” or “Usually” or “Always”

To qualify for inclusion in the numerator, the member response choices must be “Sometimes”, “Usually” or “Always” to Q40.

Note: The calculations for the other two sub-measures, “Discussing Cessation Medications” and “Discussing Cessation Strategies” use the same logic as above. However, Q40 is changed to Q41 for Discussing Cessation Medication, and Q41 is changed to Q42 for Discussing Cessation Strategies.

This measure is reported using a rolling average methodology, using results collected during two consecutive years of data collection. The reported results were calculated and publicly reported for the first time in 2011.

Overall Rating of Health Plan – National Results

The Overall Rating of Health Plan measure increased 1 percentage point since the previous year, now at its highest level. This measure remains comparatively low compared to other CAHPS® ratings and composites.

CAHPS® 3.0H/4.0H/5.0H Overall Rating of Health Plan 2000-2013	
Year	Mean
2000	-
2001	51.4
2002	69.3
2003	69.9
2004	71.2
2005	71.9
2006	70.1
2007	70.7
2008	72.7
2009	70.7
2010	72.4
2011	73.5
2012	73.5
2013	74.7

SOURCE: The State of Health Care Quality 2014.

Percentiles

Percentiles displayed in this report are those provided in Quality Compass®. A percentile is a value on a scale of one hundred that indicates the percent of the distribution that is equal to or below it. For example, if a plan’s score falls in the 75th percentile compared to Quality Compass®, that means 75% of plans represented in Quality Compass® have a score that is equal to or lower than it. Conversely, 25% of the plans in Quality Compass® have a higher score.

Quality Compass® 2014

The Quality Compass® database is compiled from performance data and member satisfaction information from 147 health plans who publicly reported their data to Quality Compass®.

Rating Questions

Responders are asked to rate four items (personal physician, specialist, health care received and overall experience with the health plan) from 0 to 10 with 0 being the worst and 10 being the best. The order in which these questions are asked in the survey changed in 2007.

Response Rate

Response rates are calculated according to the following NCQA method:

$$\text{Final Response Rate} = \frac{\text{Completed surveys}}{\text{Plan's total eligible sample*}}$$

*Total eligible sample = Entire random sample – Ineligible

Ineligible are: deceased, does not meet eligible population criteria, language barrier, mentally or physically incapacitated.

A survey is included in the analysis if the member answers one or more survey questions and indicates that they meet the eligible population criteria. SOURCE: *Pages 63-64, Volume 3 HEDIS® 2015 Specifications for Survey Measures*

NCQA Average Response Rate Trend for Adult Medicaid Surveys

2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
34%	33%	34%	34%	32%	29%	29%	30%	31%	32%	29%	26%	29%	29%

SOURCE: 2015 NCQA Vendor Training Materials – October 2014

Rolling Average

The rolling average methodology is used for several survey measures:

- Advising Smokers to Quit
- Aspirin Use and Discussion
- Discussing Cessation Medications
- Discussing Cessation Strategies

Rolling average methodology allows the health plan up to two consecutive years of data collection to obtain a denominator (eligible sample size) sufficient to calculate results for a measure. Rolling average results are calculated using data reported for the current year and, when available, data reported for the prior year.

The denominator (eligible sample size) must be at least one hundred over two years in order to have a result calculated. If the denominator (eligible sample size) over the course of two years is less than one hundred, NCQA assigns a measure result of ‘Not Applicable’. In this report, Morpace has identified these as ‘NR’ or ‘Not Reportable’.

If the denominator (eligible sample size) over the course of two years is at least one hundred, the rate is calculated based on the following formula:

Rate = (Year 1 numerator + Year 2 numerator) / (Year 1 denominator + Year 2 denominator)

Sampling Criteria

The sample frame includes all current Medicaid health care members at the time the sample is drawn who are age 18 years and older as of December 31 of the reporting year. Members must have been continuously enrolled in the health plan for the 6 months of the reporting year (allowing for no more than one gap of up to 45 days). The reporting year for the 2015 CAHPS® 5.0H surveys is January 1, 2014 to December 31, 2014.

For each survey Morpace drew a random sample of enrollees making sure that only one adult per household would be sampled. In 2015, NCQA required all plans to draw a base sample of 1,350 members.

Scoring for NCQA Accreditation

The NCQA accreditation survey is based on 100 points with 33% of the results accounted for by HEDIS® measures and HEDIS®/CAHPS® 5.0H survey results. The HEDIS®/CAHPS® 5.0H survey results account for 13 of the 100 points.

Step 1: Convert responses to their score value.
At the member level, the member's response is recoded using a scale of 1-3 according to the following table.

CAHPS 5.0H Results	Scoring Scale Based on Responses		
Getting Needed Care (2 questions) Getting Care Quickly (2 questions) How Well Doctors Communicate (4 questions) Customer Service (2 questions)	Never or Sometimes Usually Always	= = =	1 2 3
Rating of Health Care Rating of Personal Doctor Rating of Specialist Rating of Health Plan	0, 1, 2, 3, 4, 5, 6 7, 8 9, 10	= = =	1 2 3

Step 2: Calculate the mean for all members' responses. For the composite measures, perform this calculation for each of the questions in the composite.

Step 3: Calculate the mean of the means for questions in that composite. The result of these calculations is the mean.

The CAHPS® survey represents a possible 13 points toward NCQA accreditation. Points are earned toward NCQA accreditation by comparing the adjusted mean for each of the measures to the NCQA national benchmark (the 90th percentile of national results) and to national thresholds (the 75th, 50th, 25th percentiles, and below the 25th percentile) for the same measure. NCQA does not publish the exact scores used in accreditation (calculated to the sixth decimal point). Therefore, Morpace cannot calculate the precise accreditation score. However, by adding up the individual composite and rating scores, an estimate of the overall accreditation score can be obtained.

For a composite's score to be counted toward accreditation, an average of 100 responses for all questions within the composite must be obtained. If an average of 100 responses is not obtained, that measure is not counted and denoted with an "N/A". The scoring is adjusted based on the number of reported measures according to the chart on the next page. If less than four of the measures qualify, no points are awarded from the survey.

NCQA Scoring for all Composite Scores and Overall Ratings, except Overall Rating of Health Plan

Number of Applicable Measures

Percentile	9	8	7	6	5	4
90th	1.444	1.625	1.857	2.167	2.600	3.250
75th	1.271	1.430	1.634	1.907	2.288	2.860
50th	0.982	1.105	1.263	1.473	1.768	2.210
25th	0.578	0.650	0.743	0.867	1.040	1.300
0	0.289	0.325	0.371	0.433	0.520	0.650

NCQA Scoring for Overall Rating of Health Plan only

Number of Applicable Measures

Percentile	9	8	7	6	5	4
90th	2.888	3.250	3.714	4.334	5.200	6.500
75th	2.542	2.860	3.268	3.814	4.576	5.720
50th	1.964	2.210	2.526	2.946	3.536	4.420
25th	1.156	1.300	1.486	1.734	2.080	2.600
0	0.578	0.650	0.742	0.866	1.040	1.300

Specialty Calculation

The measure below is calculated by combining the results of two individual questions. The calculations are described briefly below.

Forms Easy to Fill Out
For this measure, questions 33 and 34 are used. A member who was not given any forms to fill out by their health plan in the last 6 months is coded as “Always” at Q34.

Statistical Testing

Statistical testing has been conducted in various places. A 0.05 level of significance is used in performing tests of *differences.* For example, when testing for a difference in the population percent for 2014 and the population percent for 2015, a 0.05 level of significance would mean there is a 0.05 chance that a significant difference would be found even if there were no difference in the population.

The notation of “up arrow” reflects the conclusion of significant *increase* which would be found if a significance test had been conducted for the hypothesis that the population percent for 2015 was *greater than* the population percent for 2014 (with a 0.025 level of significance). The notation of “down arrow” reflects the conclusion of significant *decrease* which would be found if a significance test had been conducted for the hypothesis that the population percent for 2015 was *less than* the population percent for 2014 (with a 0.025 level of significance).

Summary Rate Scoring

Summary rate scores are those scores used in comparing scores to Quality Compass® and in presenting data to the public. Summary Rates are calculated in the following manner:

CAHPS® 5.0H Measures	Response = Summary Rate
Shared Decision Making (3 questions)	Yes
Getting Care Quickly (2 questions) How Well Doctors Communicate (4 questions) Getting Needed Care (2 questions) Customer Service (2 questions)	Usually and Always
Rating of Personal Doctor Rating of Specialist Seen Most Often Rating of All Health Care Received Rating of Health Plan	8, 9, 10

Survey Administration Protocol

NCQA has approved two options for survey administration of the CAHPS® 5.0H survey: a 5-wave mail-only methodology or a mixed methodology (mail and telephone), which includes a 4-wave mail (two questionnaire mailings and two reminder postcards) with telephone follow-up of at least 3 attempts.

Mixed Methodology Tasks	Time Frame
First questionnaire and cover letter sent to the member.	0 days
A postcard reminder is sent to non-responders 4-10 days after the 1st questionnaire.	4-10 days
A second questionnaire with replacement cover letter is sent to non-responders approximately 35 days after the mailing of the first questionnaire.	35 days
A second postcard reminder is sent to non-responders 4 to 10 days after mailing the second questionnaire.	39 – 45 days
Telephone calls by CATI are conducted for non-responders approximately 21 days after the mailing of the second questionnaire.	56 days
Telephone contact is made to all non-responders such that at least 3 calls are attempted at different times of day, on different days and in different weeks.	56 – 70 days
Telephone follow-up is completed approximately 14 days after initiation.	70 days

Mail-Only Methodology Tasks	Time Frame
First questionnaire and cover letter sent to the member.	0 days
A postcard reminder is sent to non-responders 4-10 days after the 1st questionnaire.	4-10 days
A second questionnaire with replacement cover letter is sent to non-responders approximately 35 days after the mailing of the first questionnaire.	35 days
A second postcard reminder is sent to non-responders 4 to 10 days after mailing the second questionnaire.	39-45 days
A third questionnaire and cover letter is sent to non-responders approximately 25 days after mailing the second questionnaire.	60 days
Allow 21 days for the third questionnaire to be returned by the member.	81 days

SOURCE: Pages 59-60, Volume 3 HEDIS® 2015 Specifications for Survey Measures

The actual timeline followed for the 2015 survey was:

2/6	First questionnaire with cover letter sent to sample.
2/13	Postcard reminder sent to sample.
3/13	Second questionnaire and cover letter sent to non-responders.
3/20	Second postcard reminder sent to non-responders.
4/6 – 5/3	Contacted all non-responders via telephone – Up to 4 attempts were made at different times of the day, different days of the week, and in different weeks.

The text of the mailing pieces and the CATI (Computer Assisted Telephone Interviewing) script are prescribed by NCQA.

Composites, Attributes and Rating Questions for CAHPS® 5.0H
Response Choices and Scoring Options

Composites and Questions	Response Choices	Summary Rate	Three-Point
Getting Care Quickly			
Q4 - In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? Q6 - In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctors' office or clinic as soon as you thought you needed?	Never/Sometimes		1
	Usually	Summary Rate	2
	Always		3
Shared Decision Making – *Questions and response categories changed in 2015 – Not trendable*			
Q10 – Did you and a doctor or other health provider talk about the reasons you might want to take a medicine? Q11 – Did you and a doctor or other health provider talk about the reasons you might not want to take a medicine? Q12 – When you talked about starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you?	Yes	Summary Rate	NA
	No		NA
How Well Doctors Communicate			
Q17 – In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand? Q18 - In the last 6 months, how often did your personal doctor listen carefully to you? Q19 - In the last 6 months, how often did your personal doctor show respect for what you had to say? Q20 - In the last 6 months, how often did your personal doctor spend enough time with you?	Never/Sometimes		1
	Usually	Summary Rate	2
	Always		3
Getting Needed Care			
Q14 - In the last 6 months, how often was it easy to get the care, tests or treatment you needed? Q25 - In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?	Never/Sometimes		1
	Usually	Summary Rate	2
	Always		3
Customer Service			
Q31 - In the last 6 months, how often did the health plan's customer service give you the information or help you needed? Q32 - In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?	Never/Sometimes		1
	Usually	Summary Rate	2
	Always		3

Creative Minds. Intelligent Solutions.

2015 CAHPS® Child Medicaid Member Satisfaction Survey Executive Summary

Oklahoma Health Care Authority (CHIP)

June 2015

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Table of Contents

Oklahoma HealthCare Authority

Executive Summary 3

- Background and Protocol 3
- Disposition Summary. 4
- Summary of Key Measures 5
- Scoring for NCQA Accreditation 6
- Comparison to Quality Compass®. 7
- Key Driver Analysis 8
- Demographics 15

Executive Summary
Background and Protocol

Oklahoma HealthCare Authority

Background

- CAHPS® measures health care consumers' satisfaction with the quality of care and customer service provided by their health plan. Plans which are collecting HEDIS® (Healthcare Effectiveness Data and Information Set) data for NCQA accreditation are required to field the CAHPS® survey among their eligible populations.

Protocol

- For CAHPS® results to be considered in HEDIS® results, the CAHPS® 5.0H survey must be fielded by an NCQA (National Committee for Quality Assurance)-certified survey vendor using an NCQA-approved protocol of administration in order to ensure that results are collected in a standardized way and can be compared across plans. Standard NCQA protocols for administering CAHPS® 5.0H include a mixed-mode mail/telephone protocol and a mail-only protocol.
- Oklahoma Health Care Authority (CHIP) chose the mail/telephone protocol. This protocol included mailing a questionnaire with a cover letter. For those selected members who did not respond to the first questionnaire, a second questionnaire with a cover letter encouraging participation was sent. Thank you/reminder postcards were mailed after each survey mailing. If a selected member still did not respond to the questionnaires, at least four telephone calls were made to complete the survey using trained telephone interviewers.
- NCQA originally designed this protocol with the goal of achieving a total response rate of at least 45%. In 2014, the average response rate for all Child Medicaid plans reporting to NCQA was 28%, which is lower than the 2013 average (29%).
- In February, 1980 Oklahoma Health Care Authority (CHIP) members were randomly selected to participate in the 2015 CAHPS® 5.0H Child Medicaid Survey. This report is compiled from the responses of the 500 Oklahoma Health Care Authority (CHIP) members who responded to the survey (25% response rate).

Executive Summary

Disposition Summary

- A response rate is calculated for those members who were eligible and able to respond. According to NCQA protocol, ineligible members include those who are deceased, do not meet eligible criteria, have a language barrier, or are either mentally or physically incapacitated. Non-responders include those members who have refused to participate in the survey, could not be reached due to a bad address or telephone number, or members that reached a maximum attempt threshold and were unable to be contacted during the survey time period.
- The table below shows the total number of members in the sample that fell into each of the various disposition categories.

Oklahoma Health Care Authority (CHIP)
2015 Disposition Summary

Ineligible	Number
Deceased (M20/T20)	0
Does not meet criteria (M21/T21)	14
Language barrier (M22/T22)	0
Mentally/physically incapacitated (M24/T24)	0
Total Ineligible	**14**

Non-response	Number
Bad address/phone (M23/T23)	77
Refusal (M32/T32)	1
Maximum attempts made (M33/T33)	1388
Total Non-response	**1466**

- Ineligible surveys are subtracted from the sample size when computing a response rate (see below):

$$\frac{\textit{Completed mail and telephone surveys}}{\textit{Sample size - Ineligible surveys}} = \textit{Response Rate}$$

- Using the final figures from Oklahoma Health Care Authority (CHIP)'s Child Medicaid survey, the numerator and denominator used to compute the response rate are presented below:

$$\frac{\textit{Mail completes (268)} + \textit{Phone completes (232)}}{\textit{Total Sample (1980)} - \textit{Total Ineligible (14)}} = \frac{500}{1966} = \textit{Response Rate} = \mathbf{25\%}$$

Executive Summary

Summary of Key Measures

- For purposes of reporting the CAHPS® results, the National Committee for Quality Assurance (NCQA) uses 5 composite measures and four rating questions from the survey.
- Each of the composite measures is the average of 2 - 4 questions on the survey, depending on the measure, while each rating score is based on a single question. CAHPS® scores are most commonly shown using Summary Rate scores (percentage of positive responses).

Oklahoma Health Care Authority (CHIP)			
		Trended Data	
Composite Measures	**2013**	**2014**	**2015**
Getting Care Quickly	93%	92%	92%
Shared Decision Making	NT	NT	78%
How Well Doctors Communicate	93%	97%	96%
Getting Needed Care	89%	89%	85%
Customer Service	84%	88%	86%
Overall Rating Measures			
Health Care	82%	85%	87%
Personal Doctor	85%	88%	89%
Specialist	89%	89%	88%
Health Plan	84%	86%	86%
Health Promotion & Education	68%	69%	67%
Coordination of Care	77%	82%	86%
Sample Size	*1650*	*1650*	*1980*
# of Completes	*549*	*357*	*500*
Response Rate	*34%*	*22%*	*25%*

Legend: ↑/↓ Statistically higher/lower compared to prior year results.
NT= Data not trendable

Executive Summary

Scoring for NCQA Accreditation

Composite Scores	Unadjusted	Approximate Percentile Threshold		Below 25th Nat'l	25th Nat'l	50th Nat'l	75th Nat'l	90th Nat'l	Approximate Score
				2015 NCQA National Accreditation Comparisons*					
			Accreditation Points	***0.33***	***0.65***	***1.11***	***1.43***	***1.63***	
Getting Care Quickly	**2.657**	50th			2.54	2.61	2.66	2.69	***1.11***
How Well Doctors Communicate	**2.786**	90th			2.63	2.68	2.72	2.75	***1.63***
Getting Needed Care	**2.451**	25th			2.42	2.47	2.53	2.58	***0.65***
Customer Service	**2.513**	25th			2.50	2.53	2.58	2.63	***0.65***
Overall Ratings Scores									
Q13 Health Care	**2.587**	75th			2.49	2.52	2.57	2.59	***1.43***
Q26 Personal Doctor	**2.683**	75th			2.58	2.62	2.65	2.69	***1.43***
Q30 Specialist***	**0.000**	NA			2.53	2.59	2.62	2.66	***NA***
			Accreditation Points	***0.65***	***1.30***	***2.21***	***2.86***	***3.25***	
Q36 Health Plan	**2.622**	75th			2.51	2.57	2.62	2.67	***2.86***
								Estimated Overall CAHPS® Score:	**9.76**

NOTE: NCQA begins their calculation with an unadjusted raw score showing six digits after the decimal and then compares the adjusted score to their benchmarks and thresholds (also calculated to the sixth decimal place). For 2015, this is the first year NCQA is no longer using an adjusted score. This report displays accreditation points and scores with only two digits after the decimal. Therefore, the estimated overall CAHPS® score may differ from the sum of the individual scores due to rounding and could differ slightly from official scores provided by NCQA. The CAHPS® measures account for 13 points towards accreditation.

*Data Source: **NCQA Memorandum of January 30, 2015**. Subject: 2015 Accreditation Benchmarks and Thresholds.

*** Not reportable due to insufficient sample size.

Executive Summary

Comparison to Quality Compass®

Oklahoma Health Care Authority

	Oklahoma Health Care Authority (CHIP)	2014 Child Medicaid Quality Compass® Comparisons*						
		5th Nat'l	10th Nat'l	25th Nat'l	50th Nat'l	75th Nat'l	90th Nat'l	95th Nat'l
Composite Scores		%	%	%	%	%	%	%
Getting Care Quickly *(% Always and Usually)*	**92.19%**	**80.19**	**83.34**	**87.67**	**90.59**	**92.45**	**93.81**	**94.04**
Shared Decision Making *(% Yes)*	**78.29%**	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**
How Well Doctors Communicate *(% Always and Usually)*	**95.65%**	**88.40**	**89.71**	**91.96**	**93.25**	**94.67**	**95.61**	**95.96**
Getting Needed Care *(% Always and Usually)*	**85.41%**	**77.49**	**79.05**	**82.62**	**85.44**	**87.90**	**90.71**	**91.28**
Customer Service *(% Always and Usually)*	**86.32%**	**83.24**	**84.38**	**85.98**	**88.13**	**89.91**	**91.03**	**91.91**
Overall Ratings Scores								
Q13 Health Care (% 8, 9, and 10)	**87.47%**	**79.64**	**80.94**	**82.63**	**84.70**	**86.65**	**88.85**	**89.67**
Q26 Personal Doctor (% 8, 9, and 10)	**88.73%**	**83.17**	**84.38**	**85.89**	**87.84**	**89.43**	**90.93**	**91.46**
Q30 Specialist (% 8, 9, and 10)	**87.88%**	**78.66**	**80.69**	**83.06**	**85.01**	**87.36**	**89.50**	**91.52**
Q36 Health Plan (% 8, 9, and 10)	**86.40%**	**77.60**	**78.63**	**81.85**	**84.83**	**87.45**	**88.66**	**91.28**

NA = Comparison data not available from NCQA.

*Data Source: 2014 Child Medicaid Quality Compass®. Scores above based on 94 plans who qualified and chose to publicly report their scores.

- = Plan score falls below 5th Percentile
- = Plan score falls on 5th or below 10th Percentile
- = Plan score falls on 10th or below 25th Percentile
- = Plan score falls on 25th or below 50th Percentile
- = Plan score falls on 50th or below 75th Percentile
- = Plan score falls on 75th or below 90th Percentile
- = Plan score falls on 90th or below 95th Percentile
- = Plan score falls on or above 95th Percentile

Executive Summary
Key Driver Recommendations

A Key Driver Analysis is conducted to understand the impact that different aspects of plan service and provider care have on members' overall satisfaction with their health plan, their personal doctor, their specialist, and health care in general. Two specific scores are assessed both individually and in relation to each other. These are:

1. The relative importance of the individual issues (Correlation to overall measures).
2. The current levels of performance on each issue (Percentile group from Quality Compass®)

The key drivers for the health plan and health care are shown below:

High Priority for Improvement (High correlation/Relatively low performance)	
Health Plan Q33 - Treated You with Courtesy and Respect Q14 - Easy to Get Care Believed Necessary for Child	**Health Care** Q14 - Easy to Get Care Believed Necessary for Child Q18 - Listen Carefully to You
Continue to Target Efforts (High correlation/Relatively high performance)	
Health Plan None	**Health Care** Q22 - Spend Enough Time with Child

Executive Summary

Key Driver Analysis – Health Plan

Q36. Rating of Health Plan

Question	Correlation	Sample Size	Health Plan's Score	Plan's Percentile Range
Q33. Treated You with Courtesy and Respect	0.34	117	91.45%	10th
Q14. Easy to Get Care Believed Necessary for Child	0.32	375	89.33%	25th
Q18. Listen Carefully to You	0.27	323	94.74%	25th
Q4. Getting Care for Child as Soon as Needed	0.27	209	91.87%	50th
Q12. Asked Preference for Medicine	0.25	127	71.65%	5th
Q28. Easy to Get Appointment for Child with Specialist	0.25	108	81.48%	25th
Q32. Got Information or Help Needed	0.20	117	81.20%	25th
Q22. Spend Enough Time with Child	0.19	319	94.67%	95th
Q6. Getting Appointment for Child as Soon as Needed	0.19	321	92.52%	75th
Q19. Show Respect for What You Had to Say	0.17	322	96.58%	50th
Q17. Explain Things in a Way You Could Understand	0.16	323	96.59%	90th
Q11. Discussed Reasons Not to Take Medicine	0.12	128	70.31%	NA
Q10. Discussed Reasons to Take Medicine	0.01	127	92.91%	NA

Chart axis: 0.0, 0.5, 1.0

Use caution when reviewing scores with sample sizes less than 25.

"Health Plan's Score" is the percent of respondents that answered "Always", "Usually"; "Yes".

High Priority for Improvement
(High Correlation/
Lower Quality Compass® Group

Q33 - Treated You with Courtesy and Respect

Q14 - Easy to Get Care Believed Necessary for Child

Continue to Target Efforts
(High Correlation/
Higher Quality Compass® Group

None

Legend:
95th = Plan score falls on or above 95th Percentile
90th = Plan score falls on 90th or below 95th Percentile
75th = Plan score falls on 75th or below 90th Percentile
50th = Plan score falls on 50th or below 75th Percentile
25th = Plan score falls on 25th or below 50th Percentile
10th = Plan score falls on 10th or below 25th Percentile
5th = Plan score falls on 5th or below 10th Percentile
Below 5th = Plan score falls below 5th Percentile

Executive Summary

Key Driver Analysis – Health Care

Q13. Rating of Health Care

Question	Correlation	Sample Size	Health Plan's Score	Plan's Percentile Range
Q14. Easy to Get Care Believed Necessary for Child	0.45	375	89.33%	**25th**
Q18. Listen Carefully to You	0.41	323	94.74%	**25th**
Q22. Spend Enough Time with Child	0.39	319	94.67%	95th
Q19. Show Respect for What You Had to Say	0.34	322	96.58%	50th
Q6. Getting Appointment for Child as Soon as Needed	0.34	321	92.52%	75th
Q17. Explain Things in a Way You Could Understand	0.33	323	96.59%	90th
Q12. Asked Preference for Medicine	0.32	127	71.65%	**5th**
Q4. Getting Care for Child as Soon as Needed	0.32	209	91.87%	50th
Q33. Treated You with Courtesy and Respect	0.25	117	91.45%	**10th**
Q10. Discussed Reasons to Take Medicine	0.19	127	92.91%	NA
Q11. Discussed Reasons Not to Take Medicine	0.17	128	70.31%	NA
Q28. Easy to Get Appointment for Child with Specialist	0.16	108	81.48%	**25th**
Q32. Got Information or Help Needed	0.12	117	81.20%	**25th**

Axis: 0.0, 0.5, 1.0

Use caution when reviewing scores with sample sizes less than 25.

"Health Plan's Score" is the percent of respondents that answered "Always", "Usually"; "Yes".

High Priority for Improvement
(High Correlation/
Lower Quality Compass® Group

Q14 - Easy to Get Care Believed Necessary for Child

Q18 - Listen Carefully to You

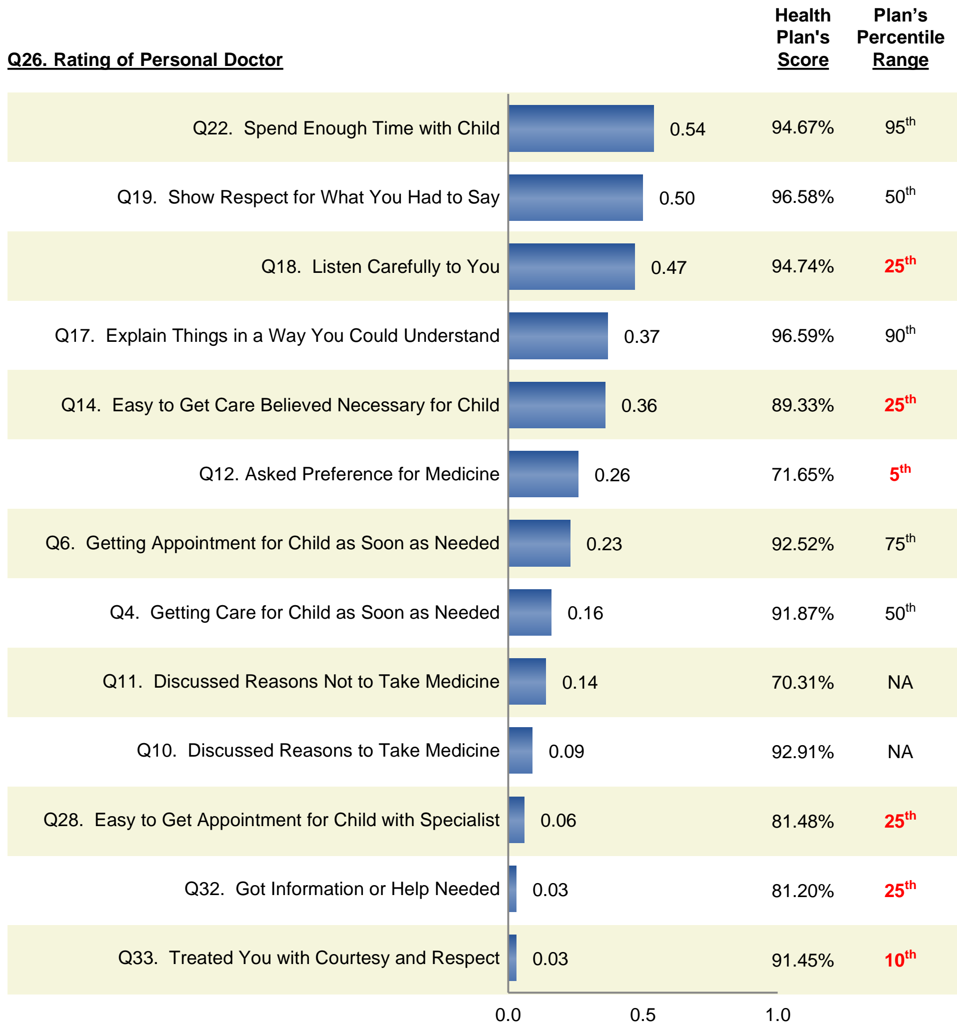
Continue to Target Efforts
(High Correlation/
Higher Quality Compass® Group

Q22 - Spend Enough Time with Child

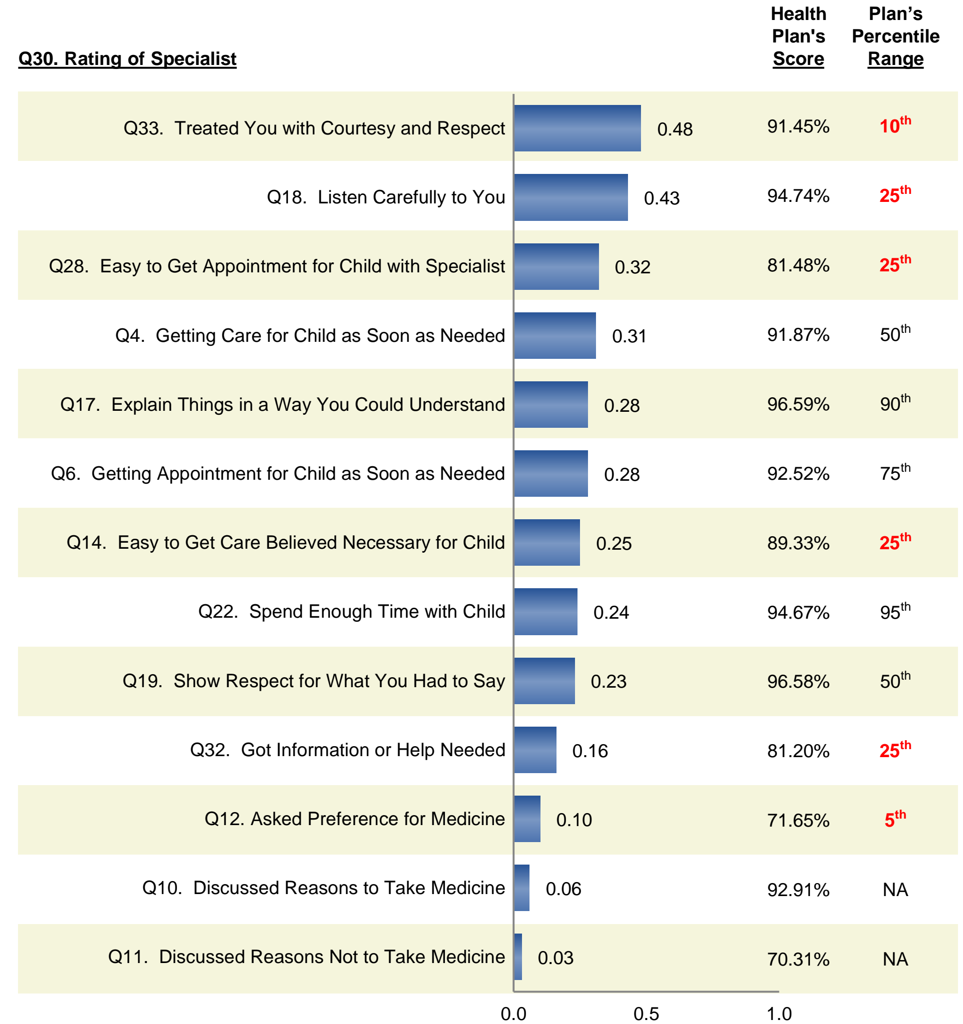
Legend:
- 95th = Plan score falls on or above 95th Percentile
- 90th = Plan score falls on 90th or below 95th Percentile
- 75th = Plan score falls on 75th or below 90th Percentile
- 50th = Plan score falls on 50th or below 75th Percentile
- 25th = Plan score falls on 25th or below 50th Percentile
- 10th = Plan score falls on 10th or below 25th Percentile
- 5th = Plan score falls on 5th or below 10th Percentile
- Below 5th = Plan score falls below 5th Percentile

Executive Summary

Key Driver Analysis – Doctor and Specialist



Q26. Rating of Personal Doctor	Key Driver	Health Plan's Score	Plan's Percentile Range
Q22. Spend Enough Time with Child	0.54	94.67%	95th
Q19. Show Respect for What You Had to Say	0.50	96.58%	50th
Q18. Listen Carefully to You	0.47	94.74%	25th
Q17. Explain Things in a Way You Could Understand	0.37	96.59%	90th
Q14. Easy to Get Care Believed Necessary for Child	0.36	89.33%	25th
Q12. Asked Preference for Medicine	0.26	71.65%	5th
Q6. Getting Appointment for Child as Soon as Needed	0.23	92.52%	75th
Q4. Getting Care for Child as Soon as Needed	0.16	91.87%	50th
Q11. Discussed Reasons Not to Take Medicine	0.14	70.31%	NA
Q10. Discussed Reasons to Take Medicine	0.09	92.91%	NA
Q28. Easy to Get Appointment for Child with Specialist	0.06	81.48%	25th
Q32. Got Information or Help Needed	0.03	81.20%	25th
Q33. Treated You with Courtesy and Respect	0.03	91.45%	10th



Q30. Rating of Specialist	Key Driver	Health Plan's Score	Plan's Percentile Range
Q33. Treated You with Courtesy and Respect	0.48	91.45%	10th
Q18. Listen Carefully to You	0.43	94.74%	25th
Q28. Easy to Get Appointment for Child with Specialist	0.32	81.48%	25th
Q4. Getting Care for Child as Soon as Needed	0.31	91.87%	50th
Q17. Explain Things in a Way You Could Understand	0.28	96.59%	90th
Q6. Getting Appointment for Child as Soon as Needed	0.28	92.52%	75th
Q14. Easy to Get Care Believed Necessary for Child	0.25	89.33%	25th
Q22. Spend Enough Time with Child	0.24	94.67%	95th
Q19. Show Respect for What You Had to Say	0.23	96.58%	50th
Q32. Got Information or Help Needed	0.16	81.20%	25th
Q12. Asked Preference for Medicine	0.10	71.65%	5th
Q10. Discussed Reasons to Take Medicine	0.06	92.91%	NA
Q11. Discussed Reasons Not to Take Medicine	0.03	70.31%	NA

"Health Plan's Score" is the percent of respondents that answered "Always", "Usually"; "Yes".

Executive Summary

Action Plans for Improving CAHPS® Scores

Morpace has consulted with numerous clients on ways to improve CAHPS® scores. Even though each health plan is unique and faces different challenges, many of the improvement strategies discussed on the next few pages can be applied by most plans with appropriate modifications.

In addition to the strategies suggested below, we suggest reviewing AHRQ's CAHPS® Improvement Guide, an online resource located on the Agency for Healthcare Research and Quality website at:

www.cahps.ahrq.gov/quality-improvement/index.html

Getting Needed Care

- Ease of obtaining appointment with specialist
  - Review panel of specialists to assure that there are an adequate number of specialists and that they are disbursed geographically to meet the needs of your members.
  - Conduct an Access to Care survey with either or both of 2 audiences: physician's office and/or among members.
  - Conduct a CG-CAHPS survey including specialists in the sample to identify the specialists with whom members are having a problem obtaining an appointment.
  - Include supplemental questions on the CAHPS® survey to determine whether the difficulty is in obtaining the initial consult or subsequent appointments.
  - Include a supplemental question on the CAHPS® survey to determine with which type of specialist members have difficulty making an appointment.
  - Utilize Provider Relations staff to question PCP office staff when making a regular visit to determine with which types of specialists they have the most problems scheduling appointments.
  - Develop materials to promote your specialist network and encourage the PCPs to develop new referral patterns that align with the network.

Getting Needed Care

- Ease of obtaining care, tests, or treatment you needed through your health plan
  - Include a supplemental question on the CAHPS® survey to identify the type of care, test or treatment for which the member has a problem obtaining.
  - Review complaints received by Customer Service regarding inability to receive care, tests or treatments.
  - Evaluate pre-certification, authorization, and appeals processes. Of even more importance is to evaluate the manner in which the policies and procedures are delivered to the member, whether the delivery of the information is directly to the member or through their provider. Members may be hearing that they cannot receive the care, tests, or treatment, but are not hearing why.
  - When care or treatment is denied, care should be taken to ensure that the message is understood by both the provider and the member.

Executive Summary

Action Plans for Improving CAHPS® Scores (cont'd)

Getting Care Quickly

- Obtaining care for urgent care (illness, injury or condition that needed care right away) as soon as you needed
- Obtaining an appointment for routine care/check-ups
  - Conduct a CG-CAHPS survey to identify offices with scheduling issues.
  - Conduct an Access to Care Study
    - Calls to physician office - unblinded
    - Calls to physician office – blinded (Secret Shopper)
    - Calls to members with recent claims
    - Desk audit by provider relations staff
  - Develop seminars for physicians' office staff that could include telephone skills (answering, placing a person on hold, taking messages from patients, dealing with irate patients over the phone, etc.) as well as scheduling advice. Use this time to obtain feedback concerning what issues members have shared with the office staff concerning interactions with the plan.
    - These seminars could be offered early morning, lunch times or evenings so as to be convenient for the office staff. Most physicians would be appreciative of having this type of training for their staff as they do not have the time or talents to train their employees in customer service and practice management.

How Well Doctors Communicate

- Doctor explained things in a way that was easy to understand
- Doctor listened carefully
- Doctor showed respect for what member had to say
- Doctor spent enough time with member
  - Conduct a CG-CAHPS survey to identify lower performing physicians for whom improvement plans should be developed.
  - Conduct focus group of members to identify examples of behaviors identified in the questions. Video the groups to show physicians how patients characterize excellent and poor physician performance.
  - Include supplemental questions from the Item Set for Addressing Health Literacy to better identify communication issues.
  - Develop "Questions Checklists" on specific diseases to be used by members when speaking to doctors. Have these available in office waiting rooms.
  - Offer in-service programs with CMEs for physicians on improving communication with patients. This could be couched in terms of motivating patients to comply with medication regimens or to incorporate healthy life-style habits. Research has shown that such small changes as having physicians sit down instead of stand when talking with a patient leads the patient to think that the doctor has spent more time with them.
  - Provide the physicians with patient education materials, which the physician will then give to the patient. These materials could reinforce that the physician has heard the concerns of the patient or that they are interested in the well-being of the patient. The materials might also speak to a healthy habit that the physician wants the patient to adopt, thereby reinforcing the communication and increasing the chances for compliance.
  - Provide communication tips in the provider newsletters. Often, these are better accepted if presented as a testimonial from a patient.

Executive Summary

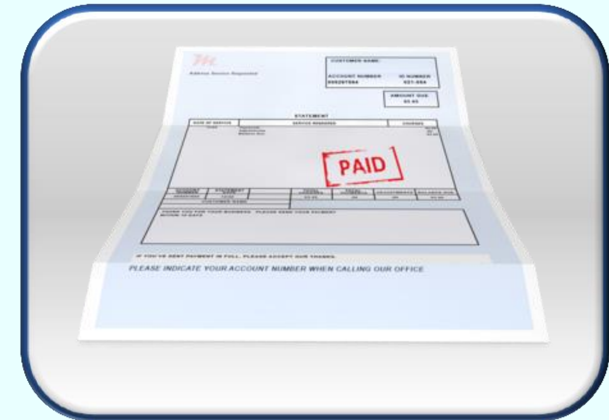
Action Plans for Improving CAHPS® Scores (cont'd)

Shared Decision Making

- Doctor talked about reasons you might want to take a medicine
- Doctor talked about reasons you might not want to take a medicine
- Doctor asked you what you thought was best
  - Conduct a CG-CAHPS survey and include the Shared Decision Making Composite as supplemental questions.
  - Develop patient education materials on common medicines described for your members explaining pros and cons of each medicine. Examples: asthma medications, high blood pressure medications, statins.
  - Develop audio recordings and/or videos of patient/doctor dialogues/vignettes on common medications. Distribute to provider panel via podcast or other method.

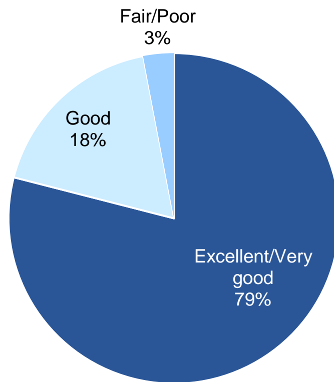
Health Plan Customer Service

- Customer service gave the information or help needed
- Customer service treated member with courtesy and respect
  - Conduct Call Center Satisfaction Survey. Implement a short IVR survey to members within days of their calling customer service to explore/assess their recent experience.
  - At the end of each Customer Service call, have your representative enter/post the reason for the call. At the end of a month, synthesize the information to discern the major reasons for a call. Have the customer service representatives and other appropriate staff discuss ways to address the reason for the majority of the calls and design interventions so that the reason for the call no longer exists.

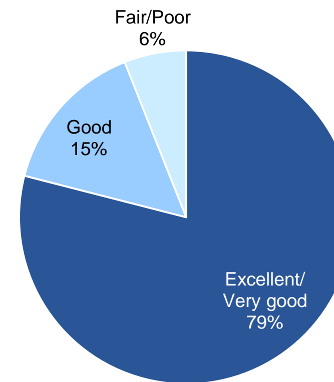


Executive Summary
Demographics

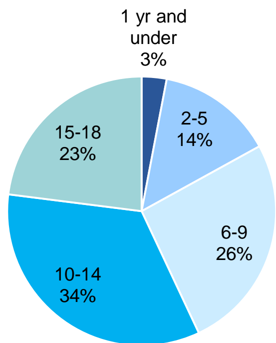
CHILD'S HEALTH STATUS



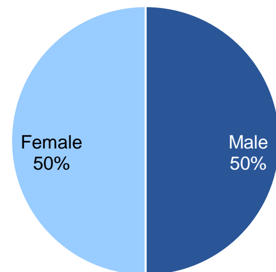
CHILD'S MENTAL/EMOTIONAL HEALTH STATUS



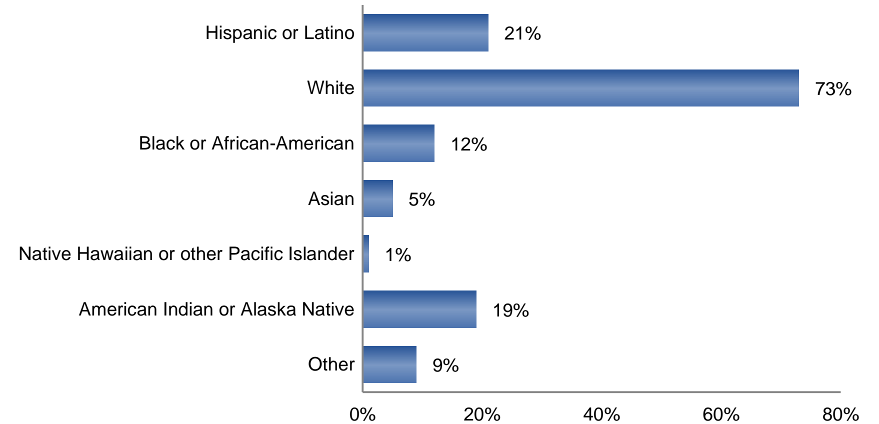
CHILD'S AGE



CHILD'S GENDER



CHILD'S RACE / ETHNICITY



Data shown are self reported.

Executive Summary

Child Demographics

Oklahoma HealthCare Authority

	2013	2014	2015	2014 Quality Compass®
Q37. Child's Health Status				
Excellent/Very good	80%	77%	79%	76%
Good	17%	20%	18%	19%
Fair/Poor	3%	3%	3%	4%
Q38. Child's Mental/Emotional Health Status				
Excellent/Very good	79%	77%	79%	75%
Good	16%	16%	15%	17%
Fair/Poor	5%	7%	6%	9%
Q39. Child's Age				
1 yr and under	2%	1%	3%	NA
2-5	15%	11%	14%	NA
6-9	27%	24%	26%	NA
10-14	33%	39%	34%	NA
15-18	23%	26%	23%	NA
Q40. Child's Gender				
Male	52%	54%	50%	52%
Female	48%	46%	50%	48%
Q41/42. Child's Race/Ethnicity				
Hispanic or Latino	21%	17%	21%	30%
White	68%	71%	73%	46%
Black or African-American	11%	9%	12%	21%
Asian	5%	3%	5%	5%
Native Hawaiian or other Pacific Islander	1%	2%	1%	1%
American Indian or Alaska Native	22%	23%	19%	2%
Other	10%	6%	9%	11%

Data shown are self reported.
NA = Data not available

Executive Summary

Respondent Demographics

	2013	2014	2015	2014 Quality Compass®
Q7. Number of Times Going to Doctor's Office/Clinic for Care				
None	23%	23%	23%	25%
1 time	26%	26%	30%	26%
2 times	24%	21%	24%	22%
3 times	13%	14%	13%	13%
4 times	6%	7%	5%	6%
5-9 times	6%	8%	4%	6%
10 or more times	1%	2%	1%	2%
Q16. Number of Times Visited Personal Doctor to Get Care				
None	22%	24%	23%	21%
1 time	31%	30%	36%	32%
2 times	23%	21%	21%	23%
3 times	13%	13%	11%	12%
4 times	4%	6%	5%	6%
5-9 times	5%	6%	4%	6%
10 or more times	1%	1%	1%	1%
Q43. Respondent's Age				
Under 18	5%	7%	3%	7%
18 to 24	5%	1%	3%	8%
25 to 34	35%	27%	33%	33%
35 to 44	33%	41%	38%	30%
45 to 54	18%	17%	14%	14%
55 to 64	4%	7%	6%	5%
65 or older	1%	1%	1%	2%
Q44. Respondent's Gender				
Male	12%	15%	16%	12%
Female	88%	85%	84%	88%
Q45. Respondent's Education				
Did not graduate high school	15%	14%	15%	22%
High school graduate or GED	34%	34%	30%	34%
Some college or 2-year degree	37%	36%	40%	32%
4-year college graduate	10%	11%	10%	8%
More than 4-year college degree	5%	5%	5%	4%

Data shown are self reported.

Executive Summary

General Knowledge about Demographic Differences

The commentary below is based on generally recognized industry knowledge per various published sources:

Age	Older respondents tend to be more satisfied than younger respondents.
Health Status	People who rate their health status as 'Excellent' or 'Very good' tend to be more satisfied than people who rate their health status lower.
Education	More educated respondents tend to be less satisfied.
Race and ethnicity effects are independent of education and income. Lower income generally predicts lower satisfaction with coverage and care.	
Race	Whites give the highest ratings to both rating and composite questions. In general, Asian/Pacific Islanders and American Indian/Alaska Natives give the lowest ratings. Growing evidence that lower satisfaction ratings from Asian Americans are partially attributable to cultural differences in their response tendencies. Therefore, their lower scores might not reflect an accurate comparison of their experience with health care.
Ethnicity	Hispanics tend to give lower ratings than non-Hispanics. Non-English speaking Hispanics tend to give lower ratings than English-speaking Hispanics.

Note: If a health plan's population differs from Quality Compass® in any of the demographic groups, these differences could account for the plan's score when compared to Quality Compass®. For example, if a plan's population rates themselves in better health than the Quality Compass® population, this could impact a plan's score positively. Conversely, if a plan's population rates themselves in poorer health than the Quality Compass® population, the plan's scores could be negatively impacted.

Executive Summary
Composite & Rating Scores by Demographics

Demographic	Child's Age					Child's Race				Child's Ethnicity		Respondent's Educational Level		Child's Health Status		
	1 yr and under	2-5 yrs	6-9 yrs	10-14 yrs	15-18 yrs	Caucasian	African American	Asian	All other	Hispanic	Non-Hispanic	HS Grad or Less	Some College+	Excellent/ Very Good	Good	Fair/ Poor
Sample size	(n=15)	(n=69)	(n=127)	(n=161)	(n=108)	(n=367)	(n=59)	(n=24)	(n=137)	(n=103)	(n=382)	(n=224)	(n=266)	(n=385)	(n=89)	(n=14)
Composites *(% Always/Usually)*																
Getting Care Quickly	88	95	92	90	94	94	90	74	94	90	93	92	93	94	88	100
Shared Decision Making *(% Yes)*	81	82	78	82	71	80	73	89	79	71	80	70	85	76	91	60
How Well Doctors Communicate	96	93	97	96	97	96	94	85	96	91	97	94	97	96	95	95
Getting Needed Care	97	88	86	83	85	89	74	76	87	89	85	84	86	86	84	79
Customer Service	80	90	77	88	89	86	81	78	91	84	86	89	84	85	88	100
Ratings *(% 8,9,10)*																
Personal Doctor	86	83	90	91	90	88	87	87	84	91	88	89	88	89	86	92
Specialist	100	94	71	90	93	91	77	100	88	100	87	89	88	88	88	83
Health Care	93	85	92	84	91	89	80	82	85	93	86	89	88	89	81	100
Health Plan	93	86	87	86	87	86	83	79	88	92	85	87	86	88	80	93

2015 Child Medicaid CAHPS® Results
Oklahoma Health Care Authority (CHIP)

Legend:

Measure	Never / Sometimes	Usually	Always	% Always / Usually or % Yes	Summary Mean (1-3)	*Sample Size*
Getting Care Quickly	8	19	74	**92**	**2.66**	*(389)*
Getting care for child as soon as needed	8	13	78	92	2.70	*(209)*
Getting appointment for child as soon as needed	7	24	69	93	2.61	*(321)*
Shared Decision Making (% No, Yes)	22		78	**78**	**NA**	*(128)*
Discussed reasons to take medicine	7		93	93	NA	*(127)*
Discussed reasons not to take medicine	30		70	70	NA	*(128)*
Asked preference for medicine	28		72	72	NA	*(127)*
How Well Doctors Communicate	4	13	83	**96**	**2.79**	*(323)*
Explain things in a way you could understand	3	11	86	97	2.83	*(323)*
Listen carefully to you	5	12	83	95	2.77	*(323)*
Show respect for what you had to say	3	9	88	97	2.85	*(322)*
Spend enough time with child	5	19	75	95	2.70	*(319)*
Getting Needed Care	15	26	60	**85**	**2.45**	*(390)*
Easy to get care believed necessary for child	11	24	66	89	2.55	*(375)*
Easy to get appointment for child with specialist	19	28	54	81	2.35	*(108)*
Customer Service	14	21	65	**86**	**2.51**	*(117)*
Got information or help needed	19	27	55	81	2.36	*(117)*
Treated you with courtesy and respect	9	16	75	91	2.67	*(117)*
Other Measures						
Health Promotion and Education (% No, Yes)	33		67	67	2.35	*(371)*
Coordination of Care	14	26	60	86	2.47	*(146)*

Legend:

Ratings	0-3	4-5	6-7	8-10	% 8-10	Summary Mean	*Sample Size*
Health Care	1	2	9	87	87	2.59	*(375)*
Personal Doctor	0	3	8	89	89	2.68	*(426)*
Specialist	3	7	2	88	88	2.65	*(99)*
Health Plan	1	4	9	86	86	2.62	*(500)*

Percents may not add to 100% due to rounding

NA = Means are not calculated for the Shared Decision Making composite.

Plan Comparison to 2014 Child Medicaid Quality Compass®
Oklahoma Health Care Authority (CHIP)

Child Medicaid Survey Questions	Oklahoma Health Care Authority (CHIP) 2015	Percentile	2014 Child Medicaid Quality Compass® Mean	5th	10th	25th	50th	75th	90th	95th
Getting Care Quickly *(% Always/Usually)*	**92.19**	**50th**	89.46	80.19	83.34	87.67	90.59	92.45	93.81	94.04
Q4 **Getting care for child as soon as needed**	91.87	50th	90.66	82.24	84.04	88.61	91.60	93.96	95.62	96.00
Q6 **Getting appointment for child as soon as needed**	92.52	75th	88.35	78.69	82.02	86.29	89.20	91.73	93.04	93.90
Shared Decision Making *(% Yes)*	**78.29**	**NA**	NA	NA	NA	NA	NA	NA	NA	NA
Q10 **Discussed reasons to take medicine**	92.91	NA	NA	NA	NA	NA	NA	NA	NA	NA
Q11 **Discussed reasons not to take medicine**	70.31	NA	NA	NA	NA	NA	NA	NA	NA	NA
Q12 **Asked preference for medicine**	71.65	5th	77.23	70.18	71.88	74.53	77.17	80.42	82.21	83.89
How Well Doctors Communicate *(% Always/Usually)*	**95.65**	**90th**	92.98	88.40	89.71	91.96	93.25	94.67	95.61	95.96
Q17 **Explain things in a way you could understand**	96.59	90th	93.54	88.84	90.42	91.68	93.86	95.63	96.35	97.10
Q18 **Listen carefully to you**	94.74	25th	94.48	90.52	91.88	93.57	94.86	95.88	96.50	97.30
Q19 **Show respect for what you had to say**	96.58	50th	95.61	92.95	93.77	94.68	95.87	96.64	97.61	97.88
Q22 **Spend enough time with child**	94.67	95th	88.29	80.90	82.71	86.45	88.66	91.24	92.38	93.30
Getting Needed Care *(% Always/Usually)*	**85.41**	**25th**	84.97	77.49	79.05	82.62	85.44	87.90	90.71	91.28
Q14 **Easy to get care believed necessary for child**	89.33	25th	89.54	82.10	84.14	87.94	90.09	92.38	93.57	94.41
Q28 **Easy to get appointment for child with specialist**	81.48	25th	81.89	74.68	75.52	78.52	82.51	84.52	88.89	89.57
Customer Service *(% Always/Usually)*	**86.32**	**25th**	87.89	83.24	84.38	85.98	88.13	89.91	91.03	91.91
Q32 **Got information or help needed**	81.20	25th	82.55	76.78	77.45	79.93	82.84	85.37	86.89	88.12
Q33 **Treated you with courtesy and respect**	91.45	10th	93.22	89.29	90.32	91.71	93.44	94.86	95.83	96.47
Q13 **Rating of Health Care** *(% 8, 9, 10)*	87.47	75th	84.70	79.64	80.94	82.63	84.70	86.65	88.85	89.67
Q26 **Rating of Personal Doctor** *(% 8, 9, 10)*	88.73	50th	87.63	83.17	84.38	85.89	87.84	89.43	90.93	91.46
Q30 **Rating of Specialist** *(% 8, 9, 10)*	87.88	75th	85.02	78.66	80.69	83.06	85.01	87.36	89.50	91.52
Q36 **Rating of Health Plan** *(% 8, 9, 10)*	86.40	50th	84.49	77.60	78.63	81.85	84.83	87.45	88.66	91.28
Q8 **Health Promotion and Education** *(% Yes)*	67.39	5th	71.74	65.33	67.66	69.19	71.48	74.62	76.50	77.82
Q25 **Coordination of Care** *(% Always/Usually)*	86.30	75th	81.03	73.56	75.44	77.60	81.82	84.12	86.31	87.65

NA = Comparison data not available from NCQA

The 2014 Child Medicaid Quality Compass® consists of 94 plans who publicly and non-publicly reported their scores (All Lines of Business excluding PPOs).

Legend
- = Plan score falls on or above 95th Percentile
- = Plan score falls on 90th or below 95th Percentile
- = Plan score falls on 75th or below 90th Percentile
- = Plan score falls on 50th or below 75th Percentile
- = Plan score falls on 25th or below 50th Percentile
- = Plan score falls on 10th or below 25th Percentile
- = Plan score falls on 5th or below 10th Percentile
- = Plan score falls below 5th Percentile

Child Medicaid Historical Trending
Oklahoma Health Care Authority (CHIP)

	Child Medicaid Survey Questions	Oklahoma Health Care Authority (CHIP)							
		2013		2014		2015		Sig Testing	
		Summary Rate	Sample Size	Summary Rate	Sample Size	Summary Rate	Sample Size	2013 to 2014	2014 to 2015
	Getting Care Quickly *(% Always/Usually)*	**92.7**	**408**	**92.1**	**268**	**92.2**	**389**	**NS**	**NS**
Q4	Getting care for child as soon as needed	95.6	229	93.8	128	91.9	209	NS	NS
Q6	Getting appointment for child as soon as needed	89.9	345	90.5	242	92.5	321	NS	NS
	Shared Decision Making** *(% Yes)*	**NT**	**NT**	**NT**	**NT**	**78.3**	**128**	**NC**	**NC**
Q10	Discussed reasons to take medicine**	NT	NT	NT	NT	92.9	127	NC	NC
Q11	Discussed reasons not to take medicine**	NT	NT	NT	NT	70.3	128	NC	NC
Q12	Asked preference for medicine	68.3	123	75.0	92	71.7	127	NS	NS
	How Well Doctors Communicate *(% Always/Usually)*	**93.3**	**367**	**96.6**	**242**	**95.7**	**323**	**NS**	**NS**
Q17	Explain things in a way you could understand	94.0	365	95.0	240	96.6	323	NS	NS
Q18	Listen carefully to you	94.0	367	97.5	241	94.7	323	+	NS
Q19	Show respect for what you had to say	95.4	367	97.9	242	96.6	322	NS	NS
Q22	Spend enough time with child	89.9	366	95.9	241	94.7	319	+	NS
	Getting Needed Care *(% Always/Usually)*	**88.7**	**418**	**89.0**	**266**	**85.4**	**390**	**NS**	**NS**
Q14	Easy to get care believed necessary for child	90.1	415	91.6	262	89.3	375	NS	NS
Q28	Easy to get appointment for child with specialist	87.3	79	86.5	74	81.5	108	NS	NS
	Customer Service *(% Always/Usually)*	**83.8**	**133**	**88.1**	**80**	**86.3**	**117**	**NS**	**NS**
Q32	Got information or help needed	79.7	133	85.0	80	81.2	117	NS	NS
Q33	Treated you with courtesy and respect	88.0	133	91.3	80	91.5	117	NS	NS
Q13	**Rating of Health Care** *(% 8, 9, 10)*	**82.0**	**411**	**85.1**	**261**	**87.5**	**375**	**NS**	**NS**
Q26	**Rating of Personal Doctor** *(% 8, 9, 10)*	**85.2**	**473**	**88.3**	**325**	**88.7**	**426**	**NS**	**NS**
Q30	**Rating of Specialist** *(% 8, 9, 10)*	**89.3**	**75**	**88.7**	**71**	**87.9**	**99**	**NS**	**NS**
Q36	**Rating of Health Plan** *(% 8, 9, 10)*	**84.1**	**533**	**86.2**	**347**	**86.4**	**500**	**NS**	**NS**
Q8	Health Promotion and Education *(% Yes)*	68.5	412	69.2	260	67.4	371	NS	NS
Q25	Coordination of Care *(% Always/Usually)*	76.8	142	81.7	104	86.3	146	NS	NS

** Question wording and response choices changed in 2015.
NT= Not trendable
NC= Not comparable

Legend
+ = Results significantly higher than prior year's results
NS = No significant difference between the two years
- = Results significantly lower than prior year's results

2015 Child Medicaid Demographic Profile - Child's Age

Oklahoma Health Care Authority (CHIP)

Child Medicaid Survey Questions	Total (%)	1 Yr and Less (%)	2 - 5 (%)	6 - 9 (%)	10 - 14 (%)	15 - 18 (%)	High/ Low Diff (%)
	Oklahoma Health Care Authority (CHIP)						
Sample Size	(n=500)	(n=15)	(n=69)	(n=127)	(n=161)	(n=108)	
Getting Care Quickly *(% Always/Usually)*	**92**	**88**	**95**	**92**	**90**	**94**	**7**
Q4 Getting care for child as soon as needed	92	75	95	93	91	93	20
Q6 Getting appointment for child as soon as needed	93	100	96	90	89	96	11
Shared Decision Making *(% Yes)*	**78**	**81**	**82**	**78**	**82**	**71**	**11**
Q10 Discussed reasons to take medicine	93	100	100	90	90	96	10
Q11 Discussed reasons not to take medicine	70	57	76	70	77	62	20
Q12 Asked preference for medicine	72	86	71	73	79	56	30
How Well Doctors Communicate *(% Always/Usually)*	**96**	**96**	**93**	**97**	**96**	**97**	**4**
Q17 Explain things in a way you could understand	97	100	98	96	96	97	4
Q18 Listen carefully to you	95	93	90	96	94	99	9
Q19 Show respect for what you had to say	97	100	92	99	97	97	8
Q22 Spend enough time with child	95	93	92	96	95	94	4
Getting Needed Care *(% Always/Usually)*	**85**	**97**	**88**	**86**	**83**	**85**	**14**
Q14 Easy to get care believed necessary for child	89	93	93	94	85	90	9
Q28 Easy to get appointment for child with specialist	81	100	83	79	81	80	21
Customer Service *(% Always/Usually)*	**86**	**80**	**90**	**77**	**88**	**89**	**13**
Q32 Got information or help needed	81	80	86	65	85	84	21
Q33 Treated you with courtesy and respect	91	80	95	88	90	95	15
Q13 **Rating of Health Care** *(% 8, 9, 10)*	**87**	**93**	**85**	**92**	**84**	**91**	**9**
Q26 **Rating of Personal Doctor** *(% 8, 9, 10)*	**89**	**86**	**83**	**90**	**91**	**90**	**8**
Q30 **Rating of Specialist** *(% 8, 9, 10)*	**88**	**100**	**94**	**71**	**90**	**93**	**29**
Q36 **Rating of Health Plan** *(% 8, 9, 10)*	**86**	**93**	**86**	**87**	**86**	**87**	**7**
Q8 **Health Promotion and Education** *(% Yes)*	67	67	77	62	68	69	15
Q25 **Coordination of Care** *(% Always/Usually)*	86	100	82	89	82	88	18

"High/Low Diff" is the percentage point difference between the largest and smallest score across the demographic categories for that specific measure.

"High/Low Diff" column may not be exact due to rounding.

Use caution when reviewing scores with sample sizes less than 20.

2015 Child Medicaid Demographic Profile - Child's Race (1 of 2)

Oklahoma Health Care Authority (CHIP)

	Oklahoma Health Care Authority (CHIP)					
Child Medicaid Survey Questions	Total (%)	Caucasian (%)	African American (%)	Asian (%)	All other (%)	High/Low Diff (%)
Sample Size	(n=500)	(n=367)	(n=59)	(n=24)	(n=137)	
Getting Care Quickly *(% Always/Usually)*	**92**	**94**	**90**	**74**	**94**	**20**
Q4 Getting care for child as soon as needed	92	94	90	63	95	32
Q6 Getting appointment for child as soon as needed	93	94	90	86	92	8
Shared Decision Making *(% Yes)*	**78**	**80**	**73**	**89**	**79**	**16**
Q10 Discussed reasons to take medicine	93	94	100	100	93	7
Q11 Discussed reasons not to take medicine	70	73	75	67	72	8
Q12 Asked preference for medicine	72	74	45	100	71	55
How Well Doctors Communicate *(% Always/Usually)*	**96**	**96**	**94**	**85**	**96**	**11**
Q17 Explain things in a way you could understand	97	98	100	70	98	30
Q18 Listen carefully to you	95	96	87	90	93	9
Q19 Show respect for what you had to say	97	97	97	90	97	7
Q22 Spend enough time with child	95	95	90	90	97	7
Getting Needed Care *(% Always/Usually)*	**85**	**89**	**74**	**76**	**87**	**15**
Q14 Easy to get care believed necessary for child	89	91	85	76	91	15
Q28 Easy to get appointment for child with specialist	81	86	63	75	83	23
Customer Service *(% Always/Usually)*	**86**	**86**	**81**	**78**	**91**	**13**
Q32 Got information or help needed	81	83	75	67	85	18
Q33 Treated you with courtesy and respect	91	88	88	89	97	9
Q13 **Rating of Health Care** *(% 8, 9, 10)*	**87**	**89**	**80**	**82**	**85**	**9**
Q26 **Rating of Personal Doctor** *(% 8, 9, 10)*	**89**	**88**	**87**	**87**	**84**	**4**
Q30 **Rating of Specialist** *(% 8, 9, 10)*	**88**	**91**	**77**	**100**	**88**	**23**
Q36 **Rating of Health Plan** *(% 8, 9, 10)*	**86**	**86**	**83**	**79**	**88**	**9**
Q8 **Health Promotion and Education** *(% Yes)*	67	68	80	63	67	17
Q25 **Coordination of Care** *(% Always/Usually)*	86	86	86	71	96	25

"High/Low Diff" is the percentage point difference between the largest and smallest score across the demographic categories for that specific measure.
"High/Low Diff" column may not be exact due to rounding.
Use caution when reviewing scores with sample sizes less than 20.

2015 Child Medicaid Demographic Profile - Child's Race (2 of 2)

Oklahoma Health Care Authority (CHIP)

		Oklahoma Health Care Authority (CHIP)			
	Child Medicaid Survey Questions	Total (%)	Caucasian (%)	Non-Caucasian (%)	High/Low Diff (%)
	Sample Size	(n=500)	(n=367)	(n=119)	
	Getting Care Quickly *(% Always/Usually)*	**92**	**94**	**86**	**8**
Q4	Getting care for child as soon as needed	92	94	82	12
Q6	Getting appointment for child as soon as needed	93	94	90	4
	Shared Decision Making *(% Yes)*	**78**	**80**	**75**	**5**
Q10	Discussed reasons to take medicine	93	94	93	1
Q11	Discussed reasons not to take medicine	70	73	64	9
Q12	Asked preference for medicine	72	74	67	7
	How Well Doctors Communicate *(% Always/Usually)*	**96**	**96**	**94**	**2**
Q17	Explain things in a way you could understand	97	98	94	4
Q18	Listen carefully to you	95	96	90	6
Q19	Show respect for what you had to say	97	97	97	0
Q22	Spend enough time with child	95	95	94	1
	Getting Needed Care *(% Always/Usually)*	**85**	**89**	**72**	**17**
Q14	Easy to get care believed necessary for child	89	91	83	8
Q28	Easy to get appointment for child with specialist	81	86	62	24
	Customer Service *(% Always/Usually)*	**86**	**86**	**88**	**2**
Q32	Got information or help needed	81	83	79	4
Q33	Treated you with courtesy and respect	91	88	97	9
Q13	**Rating of Health Care** *(% 8, 9, 10)*	**87**	**89**	**83**	**6**
Q26	**Rating of Personal Doctor** *(% 8, 9, 10)*	**89**	**88**	**89**	**1**
Q30	**Rating of Specialist** *(% 8, 9, 10)*	**88**	**91**	**80**	**11**
Q36	**Rating of Health Plan** *(% 8, 9, 10)*	**86**	**86**	**86**	**0**
Q8	Health Promotion and Education *(% Yes)*	67	68	67	1
Q25	Coordination of Care *(% Always/Usually)*	86	86	88	2

"High/Low Diff" is the percentage point difference between the largest and smallest score across the demographic categories for that specific measure.

"High/Low Diff" column may not be exact due to rounding.

Use caution when reviewing scores with sample sizes less than 20.

2015 Child Medicaid Demographic Profile - Child's Ethnicity
Oklahoma Health Care Authority (CHIP)

Child Medicaid Survey Questions	Oklahoma Health Care Authority (CHIP) Total (%)	Hispanic (%)	Non-Hispanic (%)	High/Low Diff (%)
Sample Size	(n=500)	(n=103)	(n=382)	
Getting Care Quickly *(% Always/Usually)*	**92**	**90**	**93**	**3**
Q4 Getting care for child as soon as needed	92	91	92	1
Q6 Getting appointment for child as soon as needed	93	89	94	5
Shared Decision Making *(% Yes)*	**78**	**71**	**80**	**9**
Q10 Discussed reasons to take medicine	93	86	96	10
Q11 Discussed reasons not to take medicine	70	71	71	0
Q12 Asked preference for medicine	72	57	75	18
How Well Doctors Communicate *(% Always/Usually)*	**96**	**91**	**97**	**6**
Q17 Explain things in a way you could understand	97	92	98	6
Q18 Listen carefully to you	95	89	96	7
Q19 Show respect for what you had to say	97	92	98	6
Q22 Spend enough time with child	95	90	96	6
Getting Needed Care *(% Always/Usually)*	**85**	**89**	**85**	**4**
Q14 Easy to get care believed necessary for child	89	85	90	5
Q28 Easy to get appointment for child with specialist	81	93	79	14
Customer Service *(% Always/Usually)*	**86**	**84**	**86**	**2**
Q32 Got information or help needed	81	79	81	2
Q33 Treated you with courtesy and respect	91	90	92	2
Q13 **Rating of Health Care** *(% 8, 9, 10)*	**87**	**93**	**86**	**7**
Q26 **Rating of Personal Doctor** *(% 8, 9, 10)*	**89**	**91**	**88**	**3**
Q30 **Rating of Specialist** *(% 8, 9, 10)*	**88**	**100**	**87**	**13**
Q36 **Rating of Health Plan** *(% 8, 9, 10)*	**86**	**92**	**85**	**7**
Q8 Health Promotion and Education *(% Yes)*	67	64	68	4
Q25 Coordination of Care *(% Always/Usually)*	86	81	87	6

"High/Low Diff" is the percentage point difference between the largest and smallest score across the demographic categories for that specific measure.
"High/Low Diff" column may not be exact due to rounding.
Use caution when reviewing scores with sample sizes less than 20.

2015 Child Medicaid Demographic Profile - Respondent's Education
Oklahoma Health Care Authority (CHIP)

Child Medicaid Survey Questions	Oklahoma Health Care Authority (CHIP) Total (%)	HS grad or less (%)	Some college or more (%)	High/Low Diff (%)
Sample Size	(n=500)	(n=224)	(n=266)	
Getting Care Quickly *(% Always/Usually)*	**92**	**92**	**93**	**1**
Q4 Getting care for child as soon as needed	92	91	92	1
Q6 Getting appointment for child as soon as needed	93	92	93	1
Shared Decision Making *(% Yes)*	**78**	**70**	**85**	**15**
Q10 Discussed reasons to take medicine	93	92	95	3
Q11 Discussed reasons not to take medicine	70	53	83	30
Q12 Asked preference for medicine	72	65	78	13
How Well Doctors Communicate *(% Always/Usually)*	**96**	**94**	**97**	**3**
Q17 Explain things in a way you could understand	97	94	99	5
Q18 Listen carefully to you	95	93	96	3
Q19 Show respect for what you had to say	97	96	97	1
Q22 Spend enough time with child	95	92	97	5
Getting Needed Care *(% Always/Usually)*	**85**	**84**	**86**	**2**
Q14 Easy to get care believed necessary for child	89	84	93	9
Q28 Easy to get appointment for child with specialist	81	84	79	5
Customer Service *(% Always/Usually)*	**86**	**89**	**84**	**5**
Q32 Got information or help needed	81	85	76	9
Q33 Treated you with courtesy and respect	91	92	91	1
Q13 **Rating of Health Care** *(% 8, 9, 10)*	**87**	**89**	**88**	**1**
Q26 **Rating of Personal Doctor** *(% 8, 9, 10)*	**89**	**89**	**88**	**1**
Q30 **Rating of Specialist** *(% 8, 9, 10)*	**88**	**89**	**88**	**1**
Q36 **Rating of Health Plan** *(% 8, 9, 10)*	**86**	**87**	**86**	**1**
Q8 Health Promotion and Education *(% Yes)*	67	64	70	6
Q25 Coordination of Care (*% Always/Usually*)	86	81	89	8

"High/Low Diff" is the percentage point difference between the largest and smallest score across the demographic categories for that specific measure.
"High/Low Diff" column may not be exact due to rounding.
Use caution when reviewing scores with sample sizes less than 20.

2015 Child Medicaid Demographic Profile - Child's Health Status
Oklahoma Health Care Authority (CHIP)

	Child Medicaid Survey Questions	Oklahoma Health Care Authority (CHIP) Total (%)	Excellent/ Very Good (%)	Good (%)	Fair/ Poor (%)	High/Low Diff (%)
	Sample Size	(n=500)	(n=385)	(n=89)	(n=14)	
	Getting Care Quickly *(% Always/Usually)*	**92**	**94**	**88**	**100**	**12**
Q4	Getting care for child as soon as needed	92	93	86	100	14
Q6	Getting appointment for child as soon as needed	93	94	89	100	11
	Shared Decision Making *(% Yes)*	**78**	**76**	**91**	**60**	**31**
Q10	Discussed reasons to take medicine	93	93	100	60	40
Q11	Discussed reasons not to take medicine	70	67	85	60	25
Q12	Asked preference for medicine	72	67	88	60	28
	How Well Doctors Communicate *(% Always/Usually)*	**96**	**96**	**95**	**95**	**1**
Q17	Explain things in a way you could understand	97	97	92	100	8
Q18	Listen carefully to you	95	95	98	82	16
Q19	Show respect for what you had to say	97	96	96	100	4
Q22	Spend enough time with child	95	95	92	100	8
	Getting Needed Care *(% Always/Usually)*	**85**	**86**	**84**	**79**	**7**
Q14	Easy to get care believed necessary for child	89	90	87	91	4
Q28	Easy to get appointment for child with specialist	81	82	82	67	15
	Customer Service *(% Always/Usually)*	**86**	**85**	**88**	**100**	**15**
Q32	Got information or help needed	81	79	85	100	21
Q33	Treated you with courtesy and respect	91	91	92	100	9
Q13	**Rating of Health Care** *(% 8, 9, 10)*	**87**	**89**	**81**	**100**	**19**
Q26	**Rating of Personal Doctor** *(% 8, 9, 10)*	**89**	**89**	**86**	**92**	**6**
Q30	**Rating of Specialist** *(% 8, 9, 10)*	**88**	**88**	**88**	**83**	**5**
Q36	**Rating of Health Plan** *(% 8, 9, 10)*	**86**	**88**	**80**	**93**	**13**
Q8	Health Promotion and Education *(% Yes)*	67	64	78	91	27
Q25	Coordination of Care *(% Always/Usually)*	86	86	86	86	0

"High/Low Diff" is the percentage point difference between the largest and smallest score across the demographic categories for that specific measure.

"High/Low Diff" column may not be exact due to rounding.

Use caution when reviewing scores with sample sizes less than 20.

TECHNICAL NOTES–Child Medicaid Survey

Composites

Composite scores are used to both facilitate aggregation of information from multiple specific questions and to enhance the communication of this important information to consumers.

The composites are:

- Getting Care Quickly
- Shared Decision Making
- How Well Doctors Communicate
- Getting Needed Care
- Customer Service

In 2009 one composite was deleted (Courteous and Helpful Office Staff) and one was added (Shared Decision Making).

In 2013, the questions in the Shared Decision Making composite were changed; highlighting decisions on prescriptions rather than decisions about health care in general. These changes impacted trending for this composite and the individual measures. For HEDIS 2015, NCQA revised the Shared Decision Making composite. Question language and response options have been revised from a four-point scale (Not at all/A little/Some/A lot) to a two-point scale (Yes/No). This composite will not be trendable to 2014 data. See page I for new wording of these questions.

In addition, in 2013, both questions in Getting Needed Care were modified. Also, the placement of the question regarding ease of getting care, tests and treatment through your health plan (Q27) was changed and is now Q14 and the reference to "through the health plan" was removed from the question.

The Composite Summary Rate is used in reporting to Quality Compass® and the Three-Point Score is used in NCQA accreditation. See *Summary Rate Scoring* for an explanation of how the scores are calculated.

See Page I for a listing of each of the questions in the composites, the response choices, and how each response is scored.

Composite Mean

The composite mean that is calculated for Composite Measures is a mean of the individual means that make up that composite.

For example, the measure "Getting Care Quickly" comprises two individual measures:
Q4 - How often did your child get care as soon as you thought he or she needed?
Q6 - How often did your child get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you thought your child needed?

To calculate a composite mean or composite percent, first calculate the individual means or percents for Q4 and Q6. For example, if the individual means or percents are:

Mean for Q4 = 1.9
Mean for Q6 = 2.2
Percent for Q4 = 84%
Percent for Q6 = 88%

Then, calculate the mean of those means or percents:

Composite Mean = (1.9 + 2.2) / 2 = 2.05
Composite Percent = (84% + 88%)/2 = 86%

Note that each question within a composite is weighted equally, regardless of the number of members responding to each question or to the relative importance of one question to another.

Correlation

The Pearson Product Moment Correlation (called Pearson correlation for short) is used in the Key Driver Analysis. Correlation is a measure of direction and degree of linear relationship between two variables. A correlation coefficient is a numerical index of that relationship. The closer the correlation coefficient is to 1.0, the stronger the correlation between the two variables.

Demographics

To allow for better statistical comparison of the demographic segments in the cross tabulations, Morpace has collapsed some of NCQA's response categories in the standard cross tabulations.

<table>
<tr><th>CAHPS® Segments</th><th>Morpace Segments</th></tr>
<tr><td colspan="2">AGE</td></tr>
<tr><td>Less than 1 year</td><td>1 year and less</td></tr>
<tr><td rowspan="4">X years old (write in)</td><td>2-5 years</td></tr>
<tr><td>6-9 years</td></tr>
<tr><td>10-14 years</td></tr>
<tr><td>15-18 years</td></tr>
<tr><td colspan="2">CHILD'S RACE</td></tr>
<tr><td>White</td><td>White</td></tr>
<tr><td>Black/African-American</td><td>Black/African-American</td></tr>
<tr><td>Asian</td><td rowspan="4">All Other</td></tr>
<tr><td>Native Hawaiian/Pacific Islander</td></tr>
<tr><td>American Indian/Alaska Native</td></tr>
<tr><td>Other</td></tr>
<tr><td colspan="2">CHILD'S HEALTH STATUS</td></tr>
<tr><td>Excellent</td><td rowspan="2">Excellent - Very Good</td></tr>
<tr><td>Very Good</td></tr>
<tr><td>Good</td><td>Good</td></tr>
<tr><td>Fair</td><td rowspan="2">Fair - Poor</td></tr>
<tr><td>Poor</td></tr>
</table>

History of CAHPS®

The CAHPS® 5.0H surveys are a set of standardized surveys that assess health plan member satisfaction with the experience of care. In October 1995, the Agency of Healthcare Research and Quality (AHRQ) began the CAHPS® initiative with researchers from Harvard Medical School, RAND, and Research Triangle Institute, Inc. The first survey data from the CAHPS® 2.0H survey was reported to NCQA in 1998.

In 2002, a CAHPS® Instrument Panel was convened to reevaluate and update the CAHPS® 2.0H Surveys. The Panel evaluated consumer feedback, performed analyses on CAHPS® results, and conducted cognitive testing on proposed revisions. The outcome of the CAHPS® Instrument Panel was the revised set of surveys, CAHPS® 3.0H. The HEDIS® versions of the CAHPS® surveys were also updated to be consistent with the CAHPS® 3.0H surveys. In 2009, AHRQ replaced the CAHPS® 3.0H Child Survey with the CAHPS® Health Plan Survey 4.0H.

In 2013, AHRQ replaced the CAHPS® Health Plan Survey 4.0H with the CAHPS® Health Plan Survey 5.0H as part of its Ambulatory CAHPS® initiative.

The overarching goal of the CAHPS® 5.0H survey is to obtain information that is not available from any other source - the person receiving care.

The major objectives of the 2015 CAHPS® 5.0H Child Medicaid Survey are to:

- Measure satisfaction levels, health plan use, health and socio-demographic characteristics of members
- Identify factors that affect the level of satisfaction
- Provide a tool that can be used by plan management to identify opportunities for quality improvement
- Provide plans with data for HEDIS® and NCQA accreditation

Key Driver Analysis

A Key Driver Analysis was conducted to understand the relationship between different aspects of plan service and provider care and the overall satisfaction of a parent or guardian with their child's health plan, their child's personal doctor, their child's specialist, and their child's health care in general. Two specific scores are assessed both individually and in relation to each other. These are:

1) The relative importance of the individual issues (or attributes).
   Pearson correlation scores are calculated for the 13 individual ratings (potential drivers) in relation to ratings of the overall experience with the health plan, doctor, specialist, and health care. The correlation coefficients are then used to establish the relative importance of each driver - the higher the correlation, the more important the driver.

2) The relationship to 50th Percentile of Quality Compass®.
   Attributes are noted as to whether their score is above or below the 50th percentile. Those below the 50th percentile are noted as an area for improvement, if their correlation is high. Those above the 50th percentile are noted as an area of strength, if their correlation is high. Quality Compass® 2014 is used for this report.

How to Read the Key Driver Analysis Charts:
The bar charts on the key driver pages depict the correlation scores of the individual attributes to each of the four overall measures. Directly to the right of each correlation score is the plan's score and the percentile group in which the health plan's score falls.

The higher the correlation score, the more impact the individual attribute has on the overall score. That is, if you modify behavior to improve the rating of the individual issue, the overall score is also likely to improve.

The higher the Quality Compass percentile group, the more members are satisfied with the attribute. Conversely, the lower Quality Compass® percentile group, the fewer members are satisfied with the attribute. Attributes with scores below 50th percentile are considered to be high priority for improvement.

How to interpret…

Higher correlation/Lower Quality Compass® Percentile Group	**HIGH PRIORITY FOR IMPROVEMENT**. The attribute is a driver of the overall measure and the plan's score is below the 50th percentile when compared to plans reporting to Quality Compass®. If performance can be improved on this attribute, members will be more satisfied, and the overall measure should reflect this.
Higher correlation/ Higher Quality Compass® Percentile Group	**CONTINUE TO TARGET EFFORTS**. It is critical to continue to target efforts in this area. The majority of members are satisfied with the performance, and the attribute is clearly related to the overall measure.
Lower correlation	**LOW PRIORITY**. While satisfaction of these attributes vary, these attributes are lower in importance to the overall measure. Monitor performance and consider possible action based on cost benefit analysis.

Margin of Error

The results presented in this report are obtained from a sample of the members of each plan; therefore, the estimates presented have a margin of error that should be considered.

The following table shows the approximate margin of error for different combinations of sample sizes and the estimated proportions, using a 95% confidence level.

95% Confidence Interval for Sample Proportions Margin of Error						
		Observed Proportion				
		90% | 10%	80% | 20%	70% | 30%	60% | 40%	50%
Number of Valid Responses	100	±5.9%	±7.8%	±9.0%	±9.6%	±9.8%
	200	±4.2%	±5.5%	±6.4%	±6.8%	±6.9%
	300	±3.4%	±4.5%	±5.2%	±5.5%	±5.7%
	400	±2.9%	±3.9%	±4.5%	±4.8%	±4.9%
	500	±2.6%	±3.5%	±4.0%	±4.3%	±4.4%

Example of how to use this table:

Assume that a plan obtains a rating of 50% for a given measure and the number of valid responses is 500. In this case we are 95% confident that the unknown population rating is between 45.6% and 54.4% (50%± 4.4%).

Assume that a plan obtains a rating of 70% for a given measure and the number of valid responses is 300. In this case we are 95% confident that the unknown population rating is between 64.8% and 75.2% (70%± 5.2%).

Percentiles

Percentiles displayed in this report are those provided in Quality Compass®. A percentile is a value on a scale of one hundred that indicates the percent of the distribution that is equal to or below it. For example, if a plan's score falls in the 75th percentile compared to the Quality Compass® that means 75% of plans represented in the Quality Compass® have a score that is equal to or lower than it. Conversely, 25% of the plans in the Quality Compass® have a higher score.

Quality Compass® 2014

The Quality Compass® for the Child Medicaid database is compiled from performance data and member satisfaction information from 94 Child Medicaid health plans who publicly reported their data to Quality Compass®.

Rating Questions

Responders are asked to rate four items (child's personal physician, child's specialist, child's health care received, and overall experience with child's health plan) from 0 to 10 with 0 being the worst and 10 being the best.

Response Rate

Response rates are calculated according to the following NCQA method:

$$\text{Final Response Rate} = \frac{\text{Completed surveys}}{\text{Plan's total eligible sample*}}$$

*Total eligible sample = Entire random sample – Ineligible

Ineligible are: deceased, does not meet eligible population criteria, language barrier, mentally or physically incapacitated.

A survey is included in the analysis if the member answers one or more survey question and indicates that they meet the eligible population criteria.

SOURCE: Pages 63-64, Volume 3 HEDIS® 2015 Specifications for Survey Measures

Sampling Criteria

The sample frame includes all current Medicaid health care members at the time the sample is drawn who are age 17 years and younger as of December 31 of the reporting year. Members must have been continuously enrolled in the health plan for the 6 months of the reporting year (allowing for no more than one gap of up to 45 days). The reporting year for the 2015 CAHPS® 5.0H surveys is January 1, 2014 to December 31, 2014.

For each survey Morpace drew a random sample of enrollees making sure that only one child per household would be sampled. In 2015, NCQA required all plans to draw a base sample of 1,650 members.

Scoring for NCQA Accreditation

The NCQA accreditation survey is based on 100 points with 33% of the results accounted for by HEDIS® measures and HEDIS®/CAHPS® 5.0H survey results. The HEDIS®/CAHPS® 5.0H survey results account for 13 of the 100 points. NCQA will calculate the Scoring for Accreditation on the General Population sample (also referred as the “CAHPS sample”).

Step 1: Convert responses to their score value.
At the member level, the member’s response is recoded using a scale of 1-3 according to the following table.

CAHPS 5.0H Results	Scoring Scale Based on Responses		
Getting Needed Care (2 questions) Getting Care Quickly (2 questions) How Well Doctors Communicate (4 questions) Customer Service (2 questions)	Never or Sometimes Usually Always	= = =	1 2 3
Rating of Health Care Rating of Personal Doctor Rating of Specialist Rating of Health Plan	0, 1, 2, 3, 4, 5, 6 7, 8 9, 10	= = =	1 2 3

Step 2: Calculate the mean for all members’ responses. For the composite measures, perform this calculation for each of the questions in the composite.

Step 3: Calculate the mean of the means for questions in that composite. The result of these calculations is the mean.

The CAHPS® survey represents a possible 13 points toward NCQA accreditation. Points are earned toward NCQA accreditation by comparing the adjusted mean for each of the measures to the NCQA national benchmark (the 90th percentile of national results) and to national thresholds (the 75th, 50th, 25th percentiles, and below the 25th percentile) for the same measure. NCQA does not publish the exact scores used in accreditation (calculated to the sixth decimal point). Therefore, Morpace cannot calculate the precise accreditation score. However, by adding up the individual composite and rating scores, an estimate of the overall accreditation score can be obtained.

For a composite’s score to be counted toward accreditation, an average of 100 responses for all questions within the composite must be obtained. If an average of 100 responses is not obtained, that measure is not counted and denoted with an “N/A”. The scoring is adjusted based on the number of reported measures according to the chart on the next page. If less than four of the measures qualify, no points are awarded from the survey.

NCQA Scoring for all Composite Scores and Overall Ratings, except Overall Rating of Health Plan

Number of Applicable Measures

Percentile	9	8	7	6	5	4
90th	1.444	1.625	1.857	2.167	2.600	3.250
75th	1.271	1.430	1.634	1.907	2.288	2.860
50th	0.982	1.105	1.263	1.473	1.768	2.210
25th	0.578	0.650	0.743	0.867	1.040	1.300
0	0.289	0.325	0.371	0.433	0.520	0.650

NCQA Scoring for Overall Rating of Health Plan only

Number of Applicable Measures

Percentile	9	8	7	6	5	4
90th	2.888	3.250	3.714	4.334	5.200	6.500
75th	2.542	2.860	3.268	3.814	4.576	5.720
50th	1.964	2.210	2.526	2.946	3.536	4.420
25th	1.156	1.300	1.486	1.734	2.080	2.600
0	0.578	0.650	0.742	0.866	1.040	1.300

Specialty Calculation

This measure is calculated by combining the results of two individual questions. The calculations are described briefly below.

Forms Easy to Fill Out
For this measure, questions 34 and 35 are used. A member who was not given any forms to fill out by their health plan in the last 6 months is coded as "Always" at Q35.

Statistical Testing

Statistical testing has been conducted in various places in the report. A 0.05 level of significance is used in performing tests of *differences.* For example, when testing for a difference in the population percent for 2014 and the population percent for 2015, a 0.05 level of significance would mean there is a 0.05 chance that a significant difference would be found even if there were no difference in the population.

The notation of "up arrow" reflects the conclusion of significant *increase* which would be found if a significance test had been conducted for the hypothesis that the population percent for 2015 was *greater than* the population percent for 2014 (with a 0.025 level of significance). The notation of "down arrow" reflects the conclusion of significant *decrease* which would be found if a significance test had been conducted for the hypothesis that the population percent for 2015 was *less than* the population percent for 2014 (with a 0.025 level of significance).

Summary Rate Scoring

Summary rate scores are those scores used in comparing scores to Quality Compass® and in presenting data to the public. Summary Rates are calculated in the following manner:

CAHPS® 5.0H Measures	Response = Summary Rate
Shared Decision Making (3 questions)	Yes
Getting Care Quickly (2 questions) How Well Doctors Communicate (4 questions) Getting Needed Care (2 questions) Customer Service (2 questions)	Usually and Always
Rating of Personal Doctor Rating of Specialist Seen Most Often Rating of All Health Care Received Rating of Health Plan	8, 9, 10

Survey Administration Protocol and Timeline

NCQA has approved two options for survey administration of the CAHPS 5.0H survey: a 5-wave mail-only methodology or a mixed methodology (mail and telephone), which includes a 4-wave mail (two questionnaire mailings and two reminder postcards) with telephone follow-up of at least 3 attempts.

Mixed Methodology Tasks	Time Frame
First questionnaire and cover letter sent to the member.	0 days
A postcard reminder is sent to non-responders 4-10 days after the 1st questionnaire.	4-10 days
A second questionnaire with replacement cover letter is sent to non-responders approximately 35 days after the mailing of the first questionnaire.	35 days
A second postcard reminder is sent to non-responders 4 to 10 days after mailing the second questionnaire.	39 – 45 days
Telephone calls by CATI are conducted for non-responders approximately 21 days after the mailing of the second questionnaire.	56 days
Telephone contact is made to all non-responders such that at least 3 calls are attempted at different times of day, on different days and in different weeks.	56 – 70 days
Telephone follow-up is completed approximately 14 days after initiation.	70 days

Mail-Only Methodology Tasks	Time Frame
First questionnaire and cover letter sent to the member.	0 days
A postcard reminder is sent to non-responders 4-10 days after the 1st questionnaire.	4-10 days
A second questionnaire with replacement cover letter is sent to non-responders approximately 35 days after the mailing of the first questionnaire.	35 days
A second postcard reminder is sent to non-responders 4 to 10 days after mailing the second questionnaire.	39-45 days
A third questionnaire and cover letter is sent to non-responders approximately 25 days after mailing the second questionnaire.	60 days
Allow 21 days for the third questionnaire to be returned by the member.	81 days

SOURCE: Pages 59-60, Volume 3 HEDIS® 2015 Specifications for Survey Measures

The actual timeline followed for the 2015 survey was:

2/6	First questionnaire with cover letter sent to sample.
2/13	Postcard reminder sent to sample.
3/13	Second questionnaire and cover letter sent to non-responders.
3/20	Second postcard reminder sent to non-responders.
4/6 – 5/3	Contacted all non-responders via telephone – Up to 4 attempts were made at different times of the day, different days of the week, and in different weeks.

The text of the mailing pieces and the CATI (Computer Assisted Telephone Interviewing) script are prescribed by NCQA.

Composites, Attributes and Rating Questions for CAHPS® 5.0H
Response Choices and Scoring Options

Composites and Questions	Response Choices	Summary Rate	Three-Point
Getting Care Quickly			
Q4 - In the last 6 months, when your child needed care right away, how often did your child get care as soon as you thought you needed? Q6 - In the last 6 months, when you made an appointment for a check-up or routine care for your child at a doctors' office or clinic, how often did you get an appointment as soon as your child needed? ***Rewording of question in 2013***	Never/Sometimes		1
	Usually	Summary Rate	2
	Always		3
Shared Decision Making – *Questions and response categories changed in 2015 – Not trendable*			
Q10 – Did you and a doctor or other health provider talk about the reasons you might want your child to take a medicine? Q11 – Did you and a doctor or other health provider talk about the reasons you might not want your child to take a medicine? Q12 - When you talked about your child starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for your child?	Yes	Summary Rate	NA
	No		NA
How Well Doctors Communicate			
Q17 – In the last 6 months, how often did your child's personal doctor explain things about your child's health in a way that was easy to understand? Q18 - In the last 6 months, how often did your child's personal doctor listen carefully to you? Q19 - In the last 6 months, how often did your child's personal doctor show respect for what you had to say? Q22 - In the last 6 months, how often did your child's personal doctor spend enough time with your child?	Never/Sometimes		1
	Usually	Summary Rate	2
	Always		3
Getting Needed Care - – *Question wording changed in 2013*			
Q14 - In the last 6 months, how often was it easy to get the care, tests or treatment your child needed? Q28 - In the last 6 months, how often did you get an appointment for your child to see a specialist as soon as you needed?	Never/Sometimes		1
	Usually	Summary Rate	2
	Always		3
Customer Service			
Q32 - In the last 6 months, how often did the customer service at your child's health plan give you the information or help you needed? Q33 - In the last 6 months, how often did your customer service staff at your child's health plan treat you with courtesy and respect?	Never/Sometimes		1
	Usually	Summary Rate	2
	Always		3

Oklahoma Health Care Authority

2015-2016 Evaluation Design for the SoonerCare §1115(a) Waiver Demonstration 11-W-00048/6

November 9, 2015

I. OVERVIEW

The Oklahoma Health Care Authority (OHCA), Oklahoma's single-state Medicaid agency, administers the 1115(a) SoonerCare Choice Research and Demonstration waiver. The waiver is currently in its twentieth year of operations and has been renewed by the Centers for Medicare and Medicaid Services (CMS) seven times.

OHCA recently received CMS's approval for the 2015 - 2016 demonstration extension period on July 9, 2015, with the State acknowledging the approval of the renewal application and the Special Terms and Conditions (STC) on August 6, 2015.

The State operates the SoonerCare Choice program as a means to address Oklahoman's health care needs by providing quality care, as well as increasing access to care. OHCA identifies five objectives for the Choice demonstration in which to support program goals. The SoonerCare Choice program objectives include:

- To 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;
- To optimize quality of care through effective care management;
- To integrate Indian Health Service (IHS) qualified members and IHS and tribal providers into the SoonerCare delivery system;
- To provide access to affordable health insurance for qualified low-income working adults, their spouses and college students.

In accordance with section XIV of the STC, OHCA proposes this SoonerCare Choice Evaluation Design for the 2015 - 2016 extension period to outline the hypotheses and reporting methodologies the State will use to evaluate the demonstration as it relates to the program's objectives, as well as CMS's Three-Part Aim.

II. OVERVIEW OF SOONERCARE CHOICE PROGRAM

SoonerCare Choice

The SoonerCare Choice demonstration operates under a Primary Care Case Management (PCCM) model in which the OHCA contracts directly with primary care providers throughout the state who serve as Primary Care Medical Homes (PCMH) for SoonerCare Choice members. PCMHs are paid monthly care coordination payments for each member on their panels. Payments vary depending on the PCMH tier level services provided and the mix of adults and children on the provider's panel. Providers may qualify for performance incentive payments when certain quality improvement goals, defined by the State, are met. Aside from care coordination, all other services provided in the medical home or by specialists, hospitals, or other providers, are reimbursed on a fee-for-service basis.

The SoonerCare Choice demonstration serves children in mandatory state plan groups, pregnant women and Aged, Blind and Disabled (ABD) members as well as, state plan populations including 1931 low-income families, IV-E foster care or adoption assistance children; the latter with voluntary enrollment. In accordance with Senate Bill 741, OHCA serves individuals in need of breast or cervical cancer treatment and children with disabilities in accordance with the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). The SoonerCare Choice program currently serves approximately 540,000[1] members.

Insure Oklahoma Premium Assistance Program

The OHCA operates the Insure Oklahoma premium assistance program under the 1115(a) SoonerCare Choice Research and Demonstration waiver. The Insure Oklahoma program provides two avenues for individuals to receive premium assistance – the Employer Sponsored Insurance (ESI) and the Individual Plan (IP) programs. Individuals in ESI enroll in an Insure Oklahoma private health plan and pay up to 15 percent of the premium, with costs also divided among the employee and the state and federal governments. Individuals in the IP program are responsible for health plan premiums up to four percent of their monthly gross household income[2].

The Insure Oklahoma program serves non-disabled, low-income working adults, and their spouses, who work for an employer with 250 or fewer employees; working disabled adults, and their spouses (ages 19-64); foster parents, and their spouses; qualified employees of not-for-profit businesses, and their spouses, who work for an employer with 500 or fewer employees; full-time college students (ages 19-22); and (dependent children of parents in the Insure Oklahoma program). The Insure Oklahoma program currently serves 13,518[3] individuals enrolled in the ESI program and 3,920[3] individuals enrolled in the IP program for a total of 17,438[3] individuals.

[1] September 2015, SoonerCare Choice Fast Facts.
[2] In accordance with Oklahoma Administrative Code 317:45-9-4 & 317:45-11-24, American Indians providing documentation of ethnicity are exempt from premium payments.
[3] October 2015, Insure Oklahoma Fast Facts.

Health Access Networks (HANs)

OHCA has three health access network pilot programs under the 1115(a) SoonerCare Choice Research and Demonstration waiver – the University of Oklahoma (OU) Sooner HAN, the Partnership for a Healthy Canadian County (PHCC) HAN, and the Oklahoma State University (OSU) Network HAN. Each HAN is a non-profit, administrative entity that works with affiliated providers to coordinate and improve the quality of care provided to SoonerCare Choice members. Health Access Networks receive a nominal $5 per member per month payment (PMPM).

The HANs offer care management and care coordination to SoonerCare Choice members with complex health care needs and co-manage individuals enrolled in the Health Management Program. The HANs also work to establish new initiatives to address complex medical, social and behavioral health issues. An asthma specific protocol as defined by evidence based guidelines, is one initiative that has been implemented by the HANs to assist members who have uncontrolled asthma to move to controlled status. The OU Sooner HAN, the PHCC HAN and the OSU HAN currently serves approximately 103,030[4] individuals, 3,380[4] individuals, and 13,112[4] respectively.

Health Management Program (HMP)

The Health Management Program (HMP) is a statewide program under the 1115(a) SoonerCare Choice Research and Demonstration waiver developed to manage SoonerCare Choice members most at-risk for chronic disease and other adverse health care concerns. The program is administered by the OHCA and is managed by a vendor obtained through competitive bid.

The SoonerCare HMP serves SoonerCare Choice beneficiaries ages 4 through 63 with chronic illness who are at highest risk for adverse outcomes and increased health care expenditures. The chronic illness for which the program provides care coordination includes, but is not limited to asthma, chronic obstructive pulmonary disease, congestive heart failure, diabetes, and renal disease.

The SoonerCare HMP program refocused their efforts after a process of examining the program to see if the program could be enhanced to better benefit the members and the providers. They moved from telephonic case management and decided to centralize the nurse care management services in the physician practices. The new generation of HMP would work closely with the practice staff to provide coaching services to members and practice facilitation to the providers. The telephonic members were offered an opportunity to work on the Chronic Care Unit (CCU) operated directly by the OHCA.

Through embedded health coaches into the Primary Care Practices (PCP) practices, the HMP program is able to assist members to become more invested in their health outcomes and improve self-management of chronic disease. Health coaches coordinate closely with the providers on health-related goals, as well as allow providers to easily refer members to the health coaches. With health coaches embedded in PCP practices more one-on-one care management is possible.

[4] Oklahoma Medicaid Management Information System data as of October 2015.

In addition to embedded health coaches, the HMP program also incorporates Practice Facilitation in each HMP participating practice. A Practice facilitator (PF) is assigned to each practice participating in the program. Some of the essential functions and core components of the PFs include; Practice Facilitator and Health Coach Integration, Foundation Intervention and Academic Detailing. Practice facilitators have health coach training and certification. Additionally, PFs work with the health coaches to coordinate efforts within the practices. There are four tiers of practice facilitation: Tier 1 practices need full practice facilitation services before deployment of a health coach; Tier 2 practices have received prior practice facilitation but require additional training before deployment of a health coach; Tier 3 practices have received full practice facilitation, are high-functioning practices and are ready for deployment of a health coach. Tier 4 is for a High-functioning practice, but the practice still requests inclusion in academic detailing and other educational services.

III. EVALUATION DESIGN PLAN

Since the program's inception, OHCA has provided a set of waiver objectives for the demonstration that establish the purpose and the goals of the SoonerCare Choice program. The following Evaluation Design waiver objectives refer back to the still-relevant goals from the program's inception, as well as taking into consideration the program's populations and goals for the 2015 - 2016 extension period, and CMS's three-part aim.

2015 - 2016 SoonerCare Choice Waiver Objectives:

1. To improve access to preventive and primary care services;
2. Increase the number of participating primary care providers, and overall primary care capacity, in both urban and rural areas;
3. To optimize quality of care through effective care management;
4. To integrate Indian Health Service (IHS) qualified members and IHS and tribal providers into the SoonerCare delivery system;
5. To provide access to affordable health insurance for qualified low-income working adults, their spouses and college students.

CMS's Three Part Aim:

1. Improving access to and experience of care;
2. Improving quality of health care; and
3. Decreasing per capita costs.

All data reported will be based on the entire universe of SoonerCare Choice members being evaluated within each hypothesis, unless a sample of the larger population is specified.

Each of the hypotheses targets a SoonerCare initiative for which there is no parallel initiative whose effect must be isolated as part of the analysis. Therefore, OHCA did not deem it necessary to develop specific steps to isolate the effects of the SoonerCare program from others in the state.

OHCA and the state's External Quality Review Organization will be responsible for evaluation and reporting on the hypotheses. OHCA will report interim evaluation findings and hypothesis data in the quarterly operational reports.

In accordance with the Special Terms and Conditions, the State will submit to CMS a draft evaluation plan 120 days after the award of the 2015 - 2016 extension.

Hypothesis 1
Hypothesis 1: Child Health Checkup Rates *This hypothesis directly relates to SoonerCare Choice waiver objective #1 and #2 of CMS's Three Part Aim.* The rate for age-appropriate well-child and adolescent visits will improve between 2015 - 2016. A. Child health checkup rates for children 0 to 15 months old will be maintained at or above 95 percent over the life of the extension period. B. Child health checkup rates for children 3 through 6 years old will increase by one percentage point over the life of the extension period. C. Adolescent child health checkup rates will maintain over the life of the extension period.
Research Methodology: The visit rates will be calculated separately for each of the age cohorts (0 to 15 months, 3 to 6 years, and 12 to 21 years) in accordance with each year's HEDIS® guidelines, using administrative data (paid claims and encounters).
Population Studied: SoonerCare Choice members ages 0 to 15 months, 3 to 6 years, and 12 to 21 years.
Numerators: A. The number of SoonerCare Choice members ages 0-15 months old during the measurement year and who received one or more well-child visits with a primary care provider during their first 15 months of life. B. The number of SoonerCare Choice members who were three, four, five, or six years of age during the calendar year and who received one or more well-child visits with a primary care provider during the calendar year. C. The number of SoonerCare Choice members who were twelve to twenty-one years of age during the calendar year and who were due to receive one or more well-child visits with a primary care provider during the calendar year. The following primary care provider types are recognized under SoonerCare Choice: - Physicians - Family Medicine Practitioner - General Practitioner - General Pediatrician - General Internist - Clinics - EPSDT Clinic - Family Planning Clinic - FQHC/RHC - Medical Clinic - Nurse Practitioner Clinic - Pediatric Clinic - Other - Family Nurse Practitioner - Other Nurse Practitioner - Pediatric Nurse Practitioner - Physician Assistant

Hypothesis 1
Denominators: A. Number of children enrolled in SoonerCare Choice continuously from their date-of-birth (DOB) + 31 days to their DOB + 15 months, allowing for a gap of one month, and who are enrolled in SoonerCare on their "anchor date" (DOB + 15 months). B. Number of children enrolled in SoonerCare Choice for 11 or 12 months in the measurement year, including on the anchor date (December 31 of measurement year), with no more than one gap in enrollment of up to 45 days during the continuous enrollment period. C. Number of adolescents enrolled in SoonerCare Choice for 11 or 12 months in the measurement year, including on the anchor date (December 31 of measurement year), with no more than one gap in enrollment of up to 45 days during the continuous enrollment period.
Data Source: Oklahoma Medicaid Management Information System.
Baseline Data: Demonstration year 2013 well-child visit rate.
Reporting Frequency: OHCA compiles HEDIS® data on a calendar year basis and reports data six to nine months after the close of the calendar year.
Statistical Analysis OHCA will determine whether a change (increase or decrease) from one year to the following year is statistically significant. The HEDIS® data will be analyzed using a statistical procedure called the test of two independent proportions, or a z-test. The z-test determines the value of the number of standard deviations between the two proportions.

Hypothesis 2
Hypothesis 2: PCP Visits *This hypothesis directly relates to SoonerCare Choice waiver objective #1 and #2 of CMS's Three Part Aim.* The rate of adult members who have one or more preventive health visits with a primary care provider in a year will improve by one percentage point as a measure of access to primary care in accordance with HEDIS® guidelines between 2015 - 2016.
Research Methodology: Health visits will be calculated separately for each of the age cohorts (20-44 years and 45-64 years) in accordance with HEDIS® guidelines, using administrative data (paid claims and encounters).
Population Studied: SoonerCare Choice members ages 20-44 years and 45-64 years.
Numerator: The number of SoonerCare Choice members ages 20 years through 44 years and 45 years through 64 years continuously enrolled during the measurement year that have had one or more preventive health visits during the year. The only exclusions will be for inpatient procedures, hospitalizations, emergency room visits, and visits primarily related to mental health and/or chemical dependency. The following primary care provider types are recognized under SoonerCare Choice: - Physicians - Family Medicine Practitioner - General Practitioner - General Pediatrician - General Internist - Clinics - EPSDT Clinic - Family Planning Clinic - FQHC/RHC - Medical Clinic - Nurse Practitioner Clinic - Pediatric Clinic - Other - Family Nurse Practitioner - Other Nurse Practitioner - Pediatric Nurse Practitioner - Physician Assistant
Denominator: The number of adults ages 20 through 44 and 45 through 64 enrolled in SoonerCare Choice for 11 or 12 months of the calendar year, including on the "anchor date" (December 31 of the calendar year), with no more than one gap in enrollment of up to 45 days during the continuous enrollment period.
Data Source: Oklahoma Medicaid Management Information System.
Baseline Data: Demonstration year 2013 preventive health access rate for adult age cohorts.
Reporting Frequency: OHCA compiles HEDIS® data on a calendar year basis and reports data six to nine months after the close of the calendar year.
Statistical Analysis: OHCA will determine whether a change (increase or decrease) from one year to the following year is statistically significant. The HEDIS® data will be analyzed using a statistical procedure called the test of two independent proportions, or a z-test. The z-test determines the value of the number of standard deviations between the two proportions.

Hypothesis 3
Hypothesis 3: PCP Enrollments *This hypothesis directly relates to SoonerCare Choice waiver objective #2 and #1 of CMS's Three Part Aim.* The number of SoonerCare primary care practitioners enrolled as medical home PCPs will maintain at or above the baseline data between 2015 - 2016.
Research Methodology: SoonerCare Choice PCPs are calculated by counting the number of service locations of individual providers who are contracted as Choice PCPs and the number of members of group practices that are contracted as Choice PCPs.
Population Studied: Contracted SoonerCare Choice PCPs.
Data Source: Provider Fast Facts
Baseline Data: Demonstration year 2013. (December 2013 – 2,067)
Reporting Frequency: The OHCA Reporting and Statistics unit compiles the Provider Fast Facts on a monthly basis.

Hypothesis 3b
Hypothesis 3b: PCP Enrollments Insure Oklahoma *This hypothesis directly relates to SoonerCare Choice waiver objective #2 and #1 of CMS's Three Part Aim.* The number of Insure Oklahoma practitioners enrolled as PCPs will maintain at or above the baseline data between 2015 - 2016.
Research Methodology: Insure Oklahoma PCPs are calculated by counting the number of service locations of individual providers who are contracted as Insure Oklahoma PCPs and the number of members of group practices that are contracted as Insure Oklahoma PCPs.
Population Studied: Contracted Insure Oklahoma PCPs.
Data Source: Oklahoma Medicaid Management Information System.
Baseline Data: Demonstration year 2013. (January-March 2013 – 1,514)
Reporting Frequency: The OHCA Reporting and Statistics unit compiles the data report from the Oklahoma Medicaid Management Information System on a quarterly basis.

Hypothesis 4
Hypothesis 4: PCP Capacity Available *This hypothesis directly relates to SoonerCare Choice waiver objectives #1 and #2, and #1 of CMS's Three Part Aim.* There will be adequate PCP capacity to meet the health care needs of the SoonerCare members between 2015 - 2016. Also, as perceived by the member, the time it takes to schedule an appointment should improve between 2015 - 2016. The available capacity will equal or exceed the baseline capacity data over the duration of the waiver extension period.
Research Methodology: Capacity will be calculated in terms of total capacity and the average number of SoonerCare Choice members per PCP.
Population Studied: SoonerCare Choice members.
Numerators: The total number of SoonerCare Choice members in each measurement month.
Denominators: The total contracted capacity across SoonerCare Choice PCPs, as recorded in the provider subsystem of the Medicaid Management Information System.
Data Resources: The total contracted capacity, as recorded in the Medicaid Management Information System, as derived from PCP contract data; and the average number of members per PCP, calculated by dividing the total number of members in the measurement month by the total number of contracted PCPs in that same month.
Data Sources: Oklahoma Medicaid Management Information System.
Baseline Data: December 2013 total contracted capacity (1,149,541) and average members per PCP (268.72).
Reporting Frequency: The OHCA Reporting and Statistics unit compiles the Provider Fast Facts on a monthly basis.
Statistical Analysis: The data will be analyzed using a statistical procedure called the test of two independent proportions, or a z-test. The z-test determines the value of the number of standard deviations between the two proportions.

Hypothesis 5
Hypothesis 5: PCP Availability *This hypothesis directly relates to SoonerCare Choice waiver objectives #1 and #2, and #1 of CMS's Three Part Aim.* There will be adequate PCP capacity to meet the health care needs of the SoonerCare members with Children's Health Insurance Program (CHIP) eligibility between 2015 - 2016. Also, as perceived by the member, the time it takes to schedule an appointment should improve between 2015 - 2016. As perceived by the member, the time it takes for the member to schedule an appointment should exceed the baseline data between 2015 - 2016.
Research Methodology: The member's perception of timeliness to schedule an appointment will be calculated using OHCA's External Quality Review contractor who will conduct a CAHPS® member survey, and include a question relating to the time it takes to schedule an appointment.
Population Studied: A. SoonerCare Choice members. B. A sample group from the SoonerCare Choice population, who meet certain eligibility criteria.
Numerators: The total number of qualified members who give a positive response to the CAHPS® survey question relating to the time it takes to schedule an appointment.
Denominators: The total number of qualified members who complete the CAHPS® survey question relating to the time it takes to schedule an appointment.
Data Resources: Survey responses collected through mail and telephone will be systematically entered into a central database. Once the survey collection period ends, the statistical analysis software SAS® will be used with the CAHPS® Analysis Program to complete the necessary cleaning and preparation of the data as well as the analysis. The survey responses will be recorded in order to perform the necessary calculations using assigned numeric values from the CAHPS® Survey and Reporting Kit.
Data Sources: A. Oklahoma Medicaid Management Information System. B. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0 Medicaid Adult or Child Member Satisfaction Surveys
Baseline Data: CAHPS® survey, July 2013
Reporting Frequency: A. The OHCA receives the data quarterly, no later than 90 days after close of the measurement period. B. The CAHPS® survey is reported annually on a state fiscal year basis.

Hypothesis 5
Statistical Analysis: OHCA's vendor for the CAHPS® member survey will determine whether a change (increase or decrease) from one year to the following year is statistically significant. The data will be analyzed using a statistical procedure called the test of two independent proportions, or a z-test. The z-test determines the value of the number of standard deviations between the two proportions.

Hypothesis 6
<u>Hypothesis 6</u>: Integration of Indian Health Services, Tribal Clinics, and Urban Indian Clinic Providers *This hypothesis directly relates to SoonerCare Choice waiver objective #4, and #1 of CMS's Three Part Aim.* The percentage of American Indian members who are enrolled with an Indian Health Services, Tribal, or Urban Indian Clinic (I/T/U) with a SoonerCare Choice American Indian primary care case management contract will improve during the 2015 - 2016 waiver period.
<u>Research Methodology</u>: The American Indian SoonerCare Choice enrollment percentage will be calculated based on PCP assignment data.
<u>Population Studied</u>: American Indian SoonerCare Choice members who are enrolled with an Indian Health Services, Tribal or Urban Indian Clinic (I/T/U) with a SoonerCare American Indian primary care case management contract.
<u>Numerator</u>: The total number of SoonerCare Indian Health Services enrollees in December of each measurement year who have an I/T/U PCP.
<u>Denominator</u>: The total number of SoonerCare Indian Health Service's enrollees in December of each measurement year.
<u>Data Resource</u>: The total I/T/U contracted capacity, as recorded in the MMIS from PCP contract data. The member PCP alignment data, as recorded in the eligibility subsystem of the MMIS.
<u>Data Source</u>: Oklahoma Medicaid Management Information System.
<u>Baseline Data</u>: Total contracted I/T/U capacity in December 2013 (99,400) and percentage of SoonerCare IHS enrollees with an I/T/U PCP in December 2013 (22.48 percent).
<u>Reporting Frequency</u>: The OHCA Reporting and Statistics unit compiles the Provider Fast Facts on a monthly basis as well as data report from the Oklahoma Medicaid Management Information System on a quarterly basis.

Hypothesis 7
Hypothesis 7: Impact of Health Access Networks on Quality of Care *This hypothesis directly relates to SoonerCare Choice waiver objective #3 and #2 of CMS's Three Part Aim.* Key quality performance measures, asthma and Emergency Room (ER) utilization, tracked for PCPs participating in the HANs will improve between 2013-2015. A. Decrease asthma-related ER visits for HAN members with an asthma diagnosis identified in their medical record. B. Decrease 90-day readmissions for related asthma conditions for HAN members with an asthma diagnosis identified in their medical record. C. Decrease overall ER use for HAN members.
Research Methodology: A. ER visits will be reviewed to identify ER visits related to an asthma diagnosis and compared to HAN members with asthma identified as a problem in their medical records. ER visits for unrelated illnesses will not be included in the measure. B. Readmissions that occurred within 90 days of first admission will be reviewed to identify readmissions related to an asthma diagnosis and compared to HAN members with asthma identified as a problem in their medical records. Readmissions for unrelated illnesses will not be included in the measure. C. ER visits will be reviewed for all HAN members regardless of reason.
Population Studied: Members in the HAN.
Numerator: A. Total number of ER visits by HAN members with asthma identified in their problem list for an asthma-related diagnosis. B. Total number of HAN members with asthma identified in their problem list who were readmitted to the hospital for an asthma-related illness within 90 days of a previous asthma-related hospitalization. C. Total number of ER visits for HAN members.
Denominator: A. All HAN members with an asthma diagnosis identified in their medical record. B. All HAN members with an asthma diagnosis identified in their medical record and having at least one inpatient stay related to asthma. C. All HAN members.
Data Resource: Claims data as recorded in the claims subsystem of the Medicaid Management Information System. Patient data recorded in electronic medical records, community Health Information Exchange (HIE), medical record or self-report by providers.
Data Source: Oklahoma Medicaid Management Information System. Provider electronic medical record, medical record, HIE, and self-report by providers in absence of access to EMR or HIE.
Baseline Data: A. The number of ER visits for HAN members continuously enrolled in the HAN for at least 90 days with a related diagnosis of asthma for CY2013 will serve as the numerator for baseline

Hypothesis 7
data. The number of ER visits for HAN members continuously enrolled in the HAN for at least 90 days for CY2013 will serve as the denominator for baseline data. B. The number of HAN members continuously enrolled in the HAN for at least 90 days with asthma identified in their problem list who were readmitted to the hospital for an asthma related illness within 90 days of a previous asthma related hospitalization for CY 2013 will serve as the numerator for baseline data. The number of HAN members continuously enrolled in the HAN for at least 90 days with an asthma diagnosis identified in their medical record and having at least one inpatient stay related to asthma for CY 2013 will serve as the denominator for baseline data. C. The number of ER Visits for any cause for HAN members continuously enrolled in the HAN for at least 90 days for CY 2013 will serve as the numerator for baseline data. The number of ER Visits for any cause for HAN members continuously enrolled in the HAN for at least 90 days for CY 2013 will serve as the denominator for baseline data.
Reporting Frequency: The HANs will perform and submit quarterly data during each calendar year as well as evaluate results annually.

In addition to the hypothesis, the HANs will include in their annual report an analysis of the HANs effectiveness in:

- Improving access to and the availability of health care services to SoonerCare beneficiaries served by the HAN;
- Improving the quality and coordination of health care services to SoonerCare beneficiaries served by the HAN with specific focus on the populations at greatest risk including those with multiple chronic illnesses; and
- Enhancing the state's patient-centered medical home program through an evaluation of PCP profiles that incorporates a review of utilization, disease guideline compliance, and cost.

Hypothesis 8
Hypothesis 8: Impact of Health Access Networks on Effectiveness of Care *This hypothesis directly relates to SoonerCare Choice waiver objective #3 and #3 of CMS's Three Part Aim.* Reducing costs associated with the provision of health care services to SoonerCare beneficiaries served by the HANs. Average per member per month expenditures for members belonging to a HAN affiliated PCP will continue to be less than those members enrolled with non-HAN affiliated PCPs during the period of 2013-2015.
Research Methodology: A PMPM comparison will be calculated between Choice members' whose PCPs are in a HAN and those members PCPs who do not participate in a HAN.
Population Studied: SoonerCare Choice members' whose PCPs are in a HAN and SoonerCare Choice members PCPs not participating in a HAN.
Numerator: A. The monthly total of paid claims, care coordination payments, HAN network payments, and Sooner Excel payments for members whose PCPs belong to a HAN. B. The monthly total of paid claims, care coordination payments, and Sooner Excel payments for members whose PCPs do not belong to a HAN.
Denominator: A. Member months for all PCPs in a HAN. B. Member months for all PCPs not in a HAN.
Data Source: Oklahoma Medicaid Management Information System.
Baseline Data: PMPM comparison for SFY 2012.
Reporting Frequency: Completed on a yearly basis three to four months after the end of each state fiscal year.

Evaluation of the Health Management Program

OHCA discusses the goals, objectives, and specific hypotheses that are being tested through the Health Management (HMP) program.

OHCA and the HMP contractor will partner together to evaluate the effectiveness of the HMP program as it relates to the HMP program goals and CMS's three-part aim.

2016 HMP program Objectives:

- Improving health outcomes and reducing medical costs of the population served;
- Reducing the incidence and severity of chronic disease in the member population;
- Encouraging and enabling members to better manage their own health;
- Improving the effectiveness of providers in caring for members with chronic disease or at risk for such disease; and
- Having the ability to provide services to providers and members in any area of the state, urban or rural.

CMS's Three Part Aim:

- Improving access to and experience of care;
- Improving quality of health care; and
- Decreasing per capita costs.

Hypothesis 9a
Hypothesis 9a: Health Management Program (HMP); Impact on Enrollment Figures *This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #3, and #1 of CMS's Three Part Aim.* The implementation of phase two of the SoonerCare HMP, including introduction of physician office-based Health Coaches for nurse care managed members and closer alignment of nurse care management and practice facilitation will maintain enrollment and active participation in the program.
Research Methodology: The number for population item A will be calculated using data provided by the program contractor (Telligen) on the number of members identified as engaged in nurse care management. The number for population item B will be calculated using data provided by overall PCP assignment data provided by the OHCA.
Population Studied: A. SoonerCare Choice members identified as engaged in nurse care management. B. SoonerCare Choice members whose PCP has undergone practice facilitation.
Population Studied: The number of members actively engaged in nurse care management.
Data Resource: SoonerCare HMP contractor (Telligen) and OHCA.
Data Source: Monthly rosters denoting PCP panel assignment and members engaged in nurse care management.
Baseline Data: Participation data for SFY2013 (Phase II of the SoonerCare HMP began).
Reporting Frequency: Telligen will submit monthly reports to the OHCA and the OHCA will prepare quarterly PCP assignment reports.

Hypothesis 9b
Hypothesis 9b: Health Management Program (HMP); Impact on Access to Care *This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #2, and #1 of CMS's Three Part Aim.* The incorporation of Health Coaches into primary care practices will result in increased PCP contact with nurse care managed members for preventive/ambulatory care.
Research Methodology: The contact rates will be calculated through analysis of visit activity, as derived from paid claims data, for members identified by the program contractor (Telligen) as engaged in nurse care management.
Population Studied: SoonerCare Choice members who receive nurse care management.
Numerator: SoonerCare Choice members who receive nurse care management and are 20 years old and older who had an ambulatory or preventive care visit during the measurement year.
Denominator: SoonerCare Choice members who receive nurse care management and are 20 years old and older.
Data Resource: SoonerCare HMP contractor (Telligen) and MMIS contractor (HP).
Data Source: Monthly roster of members engaged in nurse care management. Monthly paid claims extract.
Baseline Data: SoonerCare Choice members who receive nurse care management and are 20 years old and older who had an ambulatory or preventive care visit in SFY14.
Reporting Frequency: Telligen will submit monthly reports to the OHCA. The Telligen reports and paid claims extracts will be provided to the SoonerCare HMP independent evaluator. Findings will be presented in the annual progress report prepared by the evaluator.

Hypothesis 9c
<u>Hypothesis 9c</u>: Health Management Program (HMP); Impact on Identifying Appropriate Target Population *This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #2, and #2 of CMS's Three Part Aim.* The implementation of phase two of the SoonerCare HMP, including introduction of physician office-based Health Coaches for nurse care managed members and closer alignment of nurse care management and practice facilitation will improve the process for identifying qualified members and result in an increase in average complexity of need within the nurse care managed population.
<u>Research Methodology</u>: The type and number of physical and behavioral health chronic conditions for engaged members will be analyzed using diagnosis codes from paid claims data.
<u>Population Studied</u>: SoonerCare Choice members in nurse care management.
<u>Numerator</u>: A. Number of members engaged in nurse care management at any time in a 12-month period with 2, 3, 4, etc. chronic physical health conditions. B. Number of members engaged in nurse care management at any time in a 12-month period with at least one chronic physical health condition and one behavioral health condition.
<u>Denominator</u>: A. Total members engaged in nurse care management for the 12-month period. B. Total members engaged in nurse care management for the 12-month period.
<u>Data Resource</u>: SoonerCare HMP contractor (Telligen) and MMIS contractor (HP).
<u>Data Source</u>: Monthly rosters denoting members engaged in nurse care management and monthly paid claims extracts.
<u>Baseline Data</u>: Same metrics for nurse care managed population in SFY2013.
<u>Reporting Frequency</u>: Telligen will submit monthly reports to the OHCA. The Telligen reports and paid claims extracts will be provided to the SoonerCare HMP independent evaluator. Findings will be presented in the annual progress report prepared by the evaluator.

Hypothesis 9d
<u>Hypothesis 9d</u>: Health Management Program (HMP); Impact on Health Outcomes *This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #1, and #2 of CMS's Three Part Aim.* Health Coaches will improve quality measures for members who are engaged.
<u>Research Methodology</u>: The percentage of engaged members documented as compliant on diagnosis-specific quality measures and preventive health measures will be analyzed and trended over time. Measures will be derived from the Initial Set of Health Care Quality Measures for Medicaid-Qualified Adults and CHIPRA Core Set of Children's Healthcare Quality Measures.
<u>Population Studied</u>: SoonerCare Choice members who receive nurse care management.
<u>Numerator</u>: Sum of measures across all reporting practices documented as compliant on each quality measure (separate analysis for each measure).
<u>Denominator</u>: Sum of members across all reporting practices.
<u>Data Resource</u>: SoonerCare HMP contractor (Telligen), MEDai and MMIS contractor (HP).
<u>Data Source</u>: Monthly extract from claims data.
<u>Baseline Data</u>: Same metrics for nurse care managed population in SFY2013 for measures reported that year. SFY2014 metrics for new measures.
<u>Reporting Frequency</u>: Telligen will submit monthly reports to the OHCA. The Telligen reports, MEDai and MMIS data runs will be provided to the SoonerCare HMP independent evaluator. Findings will be presented in the annual progress report prepared by the evaluator.

Hypothesis 9e
Hypothesis 9e: Health Management Program (HMP); Impact on Cost/Utilization of Care *This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #1, and #2 of CMS's Three Part Aim.* Nurse care managed members will utilize the emergency room at a lower rate than forecasted without nurse care management intervention
Research Methodology: Emergency room utilization rates will be calculated through analysis of paid claims data as reported on a per 1,000 member basis.
Population Studied: SoonerCare Choice members who receive nurse care management (actual vs. forecasted).
Numerator: Total emergency room visits over a 12-month period for members engaged in nurse care management for at least a 3-month continuous period within the 12 months, starting in SFY2014 (actual).
Denominator: Total emergency room visits over a 12-month period for members engaged in nurse care management for at least a 3 month continuous period within the 12 months. Starting in SFY 2014 (forecasted).
Data Resource: SoonerCare HMP contractor (Telligen), MEDai and MMIS contractor (HP).
Data Source: Monthly rosters of members engaged in nurse care management. Monthly paid claims extract and MEDai data runs.
Baseline Data: Emergency room visit rate per 1,000 engaged members (actual vs. forecasted) group members in SFY2014.
Reporting Frequency: Telligen will submit monthly reports to the OHCA. The Telligen reports, MEDai and MMIS data runs will be provided to the SoonerCare HMP independent evaluator. Findings will be presented in the annual progress report prepared by the evaluator.

Hypothesis 9f
<u>Hypothesis 9f</u>: Health Management Program (HMP); Impact on Cost/Utilization of Care *This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #1, and #2 of CMS's Three Part Aim.* Nurse care managed members will have fewer hospital admissions than forecasted without nurse care management intervention.
<u>Research Methodology</u>: Hospital admission rates will be calculated through analysis of paid claims data and reported on a per 1,000 member basis.
<u>Population Studied</u>: SoonerCare Choice members who receive nurse care management (forecasted vs. actual).
<u>Numerator</u>: Total hospital admissions in a 12-month period for members engaged in nurse care management for at least a 3-month continuous period within the 12 months, starting in SFY2015 (actual).
<u>Denominator</u>: Total hospital admissions in a 12-month period for members engaged in nurse care management for at least a 3-month continuous period within the 12 months, starting in SFY 2014 (forecasted).
<u>Data Resource</u>: SoonerCare HMP contractor (Telligen), MEDai and MMIS contractor (HP).
<u>Data Source</u>: Monthly rosters of members engaged in nurse care management. Monthly paid claims extract and MEDai data runs.
<u>Baseline Data</u>: Hospital admission rate per 1,000 engaged members (actual vs. forecasted) in SFY2014.
<u>Reporting Frequency</u>: Telligen will submit monthly reports to the OHCA. The Telligen reports, MEDai and MMIS data runs will be provided to the SoonerCare HMP independent evaluator. Findings will be presented in the annual progress report prepared by the evaluator.

Hypothesis 9g
Hypothesis 9g: Health Management Program (HMP); Impact on Satisfaction/Experience with Care *This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #3, and #2 of CMS's Three Part Aim.* Nurse care managed members will report high levels of satisfaction with their care.
Research Methodology: Nurse care managed members will be surveyed regarding their satisfaction with their personal provider and overall health care. The survey will include validated questions derived from the CAHPS® instrument.
Population Studied: SoonerCare Choice members who receive nurse care management.
Numerator: Nurse care managed members surveyed in a 12-month period and reporting positive satisfaction levels.
Denominator: Total nurse care managed members surveyed in a 12-month period.
Data Resource: SoonerCare HMP contractor (Telligen) and independent evaluator.
Data Source: Monthly rosters denoting members engaged in nurse care management. Survey data collected by independent evaluator.
Baseline Data: Satisfaction rates for engaged members SFY2014.
Reporting Frequency: Telligen will provide monthly rosters to the independent evaluator for use in contacting survey respondents. Findings will be presented in the annual progress report prepared by the evaluator.

Hypothesis 9h
Hypothesis 9h: Health Management Program (HMP); Impact of HMP on Effectiveness of Care *This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #1, and #3 of CMS's Three Part Aim.* Total and PMPM expenditures for members enrolled in HMP will be lower than would have occurred absent their participation in nurse care management.
Research Methodology: Actual expenditures for nurse care managed members will be calculated and compared to forecasted expenditures as derived through MEDai predictive modeling software. In order to measure the program's true cost effectiveness, the actual expenditures will include both paid claims and administrative expenses (vendor payments and OHCA salary/overhead expenses) associated with the nurse care management portion of the HMP.
Population Studied: SoonerCare Choice members who receive nurse care management (actual vs. forecasted).
Numerator: Total and PMPM expenditures incurred over a 12-month period by members engaged in nurse care management for at least a 3-month continuous period within the 12 months, starting in SFY2014 (actual).
Denominator: Total and PMPM projected health expenditures in the initial 12-month period for nurse care managed members, as calculated by MEDai predictive modeling software (forecasted).
Data Source: Monthly rosters of members engaged in nurse care management. Monthly MEDai expenditure forecasts for the same population. Monthly paid claims extract. Vendor payment and OHCA administrative expense data.
Baseline Data: Total projected health expenditures in the initial 12-month period for nurse care managed members.
Reporting Frequency: Telligen will submit monthly reports to the OHCA. The Telligen reports, MEDai data runs and paid claims extracts will be provided to the SoonerCare HMP independent evaluator. Findings will be presented in the annual progress report prepared by the evaluator.

Summary of July 2016 update to Oklahoma SoonerCare Budget Neutrality

Sponsor's Choice MEG

The SoonerCare budget neutrality submission has been updated to include the Insure OK Sponsor's Choice Insurance (SCI) MEG. A new MEG tab has been added as Exhibit 16. The subsequent tabs have been renumbered accordingly (former Exhibit 16 is now Exhibit 17, former Exhibit 17 is now Exhibit 18, etc.).

The SCI enrollment projection assumes 10,000 members will join by December 2017 and 50,000 by December 2018. The 50,000 figure is the OHCA's estimate of the total number eligible to enroll. The model assumes enrollment will begin in January 2017 with 833 members and will increase by 833 members per month, through December 2017. Enrollment in 2018 will increase by 3,333 members per month, reaching 50,000 in December 2018.

The PMPM value for the SCI MEG has been set equal to the PMPM rate for the closest equivalent MEG, IOK Non-Disabled Working Adults and Spouses covered through Employer-Sponsored Insurance (NDWA-ESI).

Costs associated with the new MEG have been incorporated into the aggregate expenditure exhibit as an offset to waiver savings.

Provider Rate Reduction

The SoonerCare budget neutrality forecast has been updated to account for the projected impact of a three percent across-the-board reduction in provider payment rates that took effect on January 1, 2016. The rate reduction applies to traditional Medicaid MEGs only; Insure OK, HAN and HMP MEGs are not affected.

The rate reduction calculations can be found in Exhibits 3 (TANF-U), 4 (TANF-R), 5 (ABD-U), 6 (ABD-R) and 11 (TEFRA). The reductions also affect the summary budget neutrality forecast shown in Exhibit 24 (All).

Completion of CY 2015 Data

DY20 (CY 2015) member months and expenditures have been updated on all applicable exhibits to include a full year of historical data (previous iteration was annualized based on nine months of data).

SOONERCARE 1115 BUDGET NEUTRALITY TREND FACTORS

July 2016 Notes/Updates:
- OMB trend factors used for 2016 - 2018 PMPM expenditure projections

MEG Enrollment Trend Calculation

MEG	2010	2011	2012	2013	2014	2015	Annual Trend	Trending Years
TANF - Urban	3,333,170	3,357,000	3,620,263	3,741,817	4,001,208	4,101,736	4.24%	*2010 - 2015*
TANF - Rural	2,429,264	2,433,324	2,565,123	2,618,683	2,745,120	2,807,836	2.94%	*2010 - 2015*
ABD - Urban	327,267	344,575	348,935	360,205	365,630	362,810	2.08%	*2010 - 2015*
ABD - Rural	278,093	285,113	285,622	290,965	291,806	287,250	0.65%	*2010 - 2015*
NDWA - ESI							0.73%	*See IOK_ESI-IP Tab*
NDWA - IP							-16.69%	*See IOK_ESI-IP Tab*
WDA	90	114	66	42	-	-	-100.00%	*2010 - 2015*
TEFRA	4,018	4,514	4,978	5,326	6,148	6,771	11.00%	*2010 - 2015*
College - ESI							-3.81%	*See IOK_ESI-IP Tab*
College - IP							0.56%	*See IOK_ESI-IP Tab*

PMPM Trend Factors

MEG	Factor
TANF-U	1.0440
TANF-R	1.0440
ABD-U	1.0420
ABD-R	1.0420
NDWA	1.0440
WDA	1.0420
TEFRA	1.0420
College Students	1.0440

SOONERCARE BUDGET NEUTRALITY
HISTORICAL AND PROJECTED MEMBER MONTHS AND EXPENDITURES - *BY MEG*

TANF URBAN MEG

July 2016 Notes/Updates:
- MEG-specific actual expenditures not available for 1996 - 2003
- Historical expenditures reflect C-Report amounts
- 2016 projected PMPM expenditures reduced by 3 percent in cell G30 to reflect provider payment rate reduction effective 1/1/16
- Adjustment for HAN expenditures in cells H24 - H27 (dollars removed to eliminate doublecount in 2010 - 2013 data; no doublecount in 2014-2015 data)
- GME expenditures added to cells G28 - G30 to align with C-Report guidelines; expenditures were originally reported on GME line 1D, rather than TANF-U line 18A
- Historical HMP expenditures added to cells H27 - H29
- Projected PMPM HMP expenditures added to cells G30 - G32

Comparison with HAN expenditures included in, and HMP expenditures excluded from, TANF-U amounts

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)	TANF-U with HAN and without HMP	Difference (C Report minus BN table)	Cumulative Deviation by Renewal Period
				PMPM	Aggregate	PMPM	Aggregate					
Historical	1	1996	1,248,591	$ 121.60	$ 151,828,666							
	2	1997	1,201,538	$ 129.52	$ 155,618,588							
	3	1998	1,299,675	$ 137.95	$ 179,287,128							
	4	1999	1,489,962	$ 146.93	$ 218,917,218							
	5	2000	1,575,250	$ 156.49	$ 246,515,710							
	6	2001	1,988,010	$ 166.68	$ 331,363,038							
	7	2002	2,159,002	$ 177.53	$ 383,291,270							
	8	2003	2,319,441	$ 189.09	$ 438,580,782							
	9	2004	2,426,341	$ 201.40	$ 488,661,911	$ 136.70	$ 331,669,473	$ 156,992,438	$ 156,992,438	$ 331,669,473	$ (331,669,473)	
	10	2005	2,528,654	$ 214.51	$ 542,420,938	$ 188.11	$ 475,653,511	$ 66,767,427	$ 223,759,865	$ 475,653,511	$ (475,653,511)	
	11	2006	2,643,157	$ 228.47	$ 603,893,538	$ 213.25	$ 563,645,766	$ 40,247,772	$ 264,007,637	$ 563,645,766	$ (563,645,766)	
	12	2007	2,808,278	$ 240.19	$ 674,520,293	$ 217.74	$ 611,465,158	$ 63,055,135	$ 327,062,772	$ 611,465,158	$ (611,465,158)	
	13	2008	2,772,622	$ 252.51	$ 700,119,625	$ 237.40	$ 658,219,711	$ 41,899,914	$ 368,962,686	$ 658,219,711	$ (658,219,711)	
	14	2009	3,029,870	$ 265.47	$ 804,339,589	$ 249.71	$ 756,593,334	$ 47,746,255	$ 416,708,941	$ 756,593,334	$ (756,593,334)	
	15	2010	3,333,170	$ 279.09	$ 930,249,786	$ 234.68	$ 782,242,482	$ 148,007,304	$ 564,716,244	$ 782,988,002	$ (782,988,002)	
	16	2011	3,357,000	$ 293.41	$ 984,968,363	$ 252.31	$ 847,000,007	$ 137,968,356	$ 702,684,600	$ 849,144,497	$ (849,144,497)	
	17	2012	3,620,263	$ 308.46	$ 1,116,703,111	$ 251.66	$ 911,062,393	$ 205,640,718	$ 908,325,319	$ 913,775,678	$ (913,775,678)	
Current	18	2013	3,741,817	$ 322.03	$ 1,204,977,329	$ 260.87	$ 976,119,115	$ 228,858,214	$ 1,137,183,532	$ 978,052,044	$ (978,052,044)	$ (6,921,207,174)
	19	2014	4,001,208	$ 336.20	$ 1,345,206,130	$ 254.89	$ 1,019,875,339	$ 325,330,791	$ 1,462,514,323			
	20	2015	4,101,736	$ 350.99	$ 1,439,668,319	$ 264.45	$ 1,084,707,551	$ 354,960,768	$ 1,817,475,091			
Extension	21	2016 (proj)	4,275,528	$ 366.44	$ 1,566,724,471	$ 268.76	$ 1,149,110,893	$ 417,613,578	$ 2,235,088,669			
	22	2017 (proj)	4,456,684	$ 382.56	$ 1,704,963,844	$ 281.55	$ 1,254,761,717	$ 450,202,127	$ 2,685,290,796			
	23	2018 (proj)	4,645,515	$ 399.40	$ 1,855,400,718	$ 294.88	$ 1,369,892,310	$ 485,508,408	$ 3,170,799,204			

See Exhibit 24 (Aggregate)

SOONERCARE BUDGET NEUTRALITY
HISTORICAL AND PROJECTED MEMBER MONTHS AND EXPENDITURES - *BY MEG*

TANF RURAL MEG

July 2016 Notes/Updates:
- MEG-specific actual expenditures not available for 1996 - 2003
- Historical expenditures reflect C-Report amounts
- 2016 projected PMPM expenditures reduced by 3 percent in cell G30 to reflect provider rate reduction effective 1/1/16
- Historical HMP expenditures added to cells H27 - H29
- Projected PMPM HMP expenditures added to cells G30 - G32

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Historical and Current	1	1996	1,088,941	$ 123.34	$ 134,309,983				
	2	1997	1,081,206	$ 131.37	$ 142,037,420				
	3	1998	1,250,830	$ 139.92	$ 175,018,115				
	4	1999	1,510,946	$ 149.03	$ 225,177,007		*See Exhibit 24 (Aggregate)*		
	5	2000	1,522,229	$ 158.73	$ 241,627,007				
	6	2001	1,915,864	$ 169.07	$ 323,907,157				
	7	2002	2,014,674	$ 180.07	$ 362,786,430				
	8	2003	1,941,227	$ 191.79	$ 372,317,080				
	9	2004	1,984,722	$ 204.28	$ 405,440,105	$ 149.19	$ 296,093,830	$ 109,346,275	$ 109,346,275
	10	2005	2,015,932	$ 217.58	$ 438,624,903	$ 159.74	$ 322,029,702	$ 116,595,201	$ 225,941,475
	11	2006	2,036,491	$ 231.74	$ 471,943,801	$ 190.64	$ 388,233,610	$ 83,710,191	$ 309,651,667
	12	2007	2,130,548	$ 243.63	$ 519,065,409	$ 195.93	$ 417,441,223	$ 101,624,186	$ 411,275,853
	13	2008	2,078,460	$ 256.13	$ 532,352,258	$ 208.78	$ 433,930,540	$ 98,421,718	$ 509,697,571
	14	2009	2,246,021	$ 269.27	$ 604,780,677	$ 220.17	$ 494,500,235	$ 110,280,442	$ 619,978,012
	15	2010	2,429,264	$ 283.08	$ 687,678,542	$ 213.70	$ 519,126,643	$ 168,551,899	$ 788,529,911
	16	2011	2,433,324	$ 297.60	$ 724,164,719	$ 224.38	$ 545,999,493	$ 178,165,226	$ 966,695,137
	17	2012	2,565,123	$ 312.87	$ 802,550,338	$ 230.22	$ 590,533,873	$ 212,016,465	$ 1,178,711,602
	18	2013	2,618,683	$ 326.64	$ 855,366,615	$ 230.12	$ 602,610,415	$ 252,756,200	$ 1,431,467,803
	19	2014	2,745,120	$ 341.01	$ 936,113,371	$ 229.99	$ 631,345,478	$ 304,767,893	$ 1,736,235,696
	20	2015	2,807,836	$ 356.01	$ 999,617,694	$ 210.86	$ 592,057,993	$ 407,559,702	$ 2,143,795,398
Extension	21	2016 (proj)	2,890,355	$ 371.67	$ 1,074,258,133	$ 214.49	$ 619,962,204	$ 454,295,929	$ 2,598,091,326
	22	2017 (proj)	2,975,299	$ 388.02	$ 1,154,485,689	$ 224.89	$ 669,105,727	$ 485,379,962	$ 3,083,471,288
	23	2018 (proj)	3,062,739	$ 405.10	$ 1,240,704,785	$ 235.73	$ 721,987,938	$ 518,716,847	$ 3,602,188,136

Comparison with HMP expenditures excluded from TANF-R amounts

DY	TANF-R without HMP	Difference (C Report minus BN table)	Cumulative Deviation by Renewal Period
1			
2			
3			
4			
5			
6			
7			
8			
9	$ 296,093,830	$ (296,093,830)	
10	$ 322,029,702	$ (322,029,702)	
11	$ 388,233,610	$ (388,233,610)	
12	$ 417,441,223	$ (417,441,223)	
13	$ 433,930,540	$ (433,930,540)	
14	$ 494,500,235	$ (494,500,235)	
15	$ 519,126,643	$ (519,126,643)	
16	$ 545,999,493	$ (545,999,493)	
17	$ 590,533,873	$ (590,533,873)	
18	$ 600,427,955	$ (600,427,955)	$ (2,256,087,964)
19			
20			
21			
22			
23			

SOONERCARE BUDGET NEUTRALITY
HISTORICAL AND PROJECTED MEMBER MONTHS AND EXPENDITURES - *BY MEG*

ABD URBAN MEG

July 2016 Notes/Updates:
- MEG-specific actual expenditures not available for 1996 - 2003
- Historical expenditures reflect C-Report amounts
- 2016 projected PMPM expenditures reduced by 3 percent in cell G30 to reflect provider payment rate reduction effective 1/1/16
- Historical HMP expenditures added to cells H27 - H29
- Projected PMPM HMP expenditures added to cells G30 - G32

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Historical and Current	1	1996							
	2	1997							
	3	1998							
	4	1999	96,785	$ 536.14	$ 51,889,826				
	5	2000	190,315	$ 567.55	$ 108,013,756		See Exhibit 24 (Aggregate)		
	6	2001	279,689	$ 600.81	$ 168,040,252				
	7	2002	306,526	$ 636.02	$ 194,956,243				
	8	2003	233,742	$ 673.29	$ 157,375,990				
	9	2004	244,590	$ 712.74	$ 174,330,070	$ 489.16	$ 119,644,174	$ 54,685,896	$ 54,685,896
	10	2005	255,066	$ 754.51	$ 192,450,068	$ 668.41	$ 170,487,472	$ 21,962,596	$ 76,648,492
	11	2006	259,473	$ 798.73	$ 207,247,624	$ 858.00	$ 222,627,081	$ (15,379,457)	$ 61,269,036
	12	2007	268,332	$ 840.26	$ 225,468,646	$ 894.55	$ 240,036,203	$ (14,567,557)	$ 46,701,479
	13	2008	283,834	$ 883.96	$ 250,898,901	$ 962.43	$ 273,171,226	$ (22,272,325)	$ 24,429,154
	14	2009	301,034	$ 929.92	$ 279,937,423	$ 1,003.30	$ 302,026,587	$ (22,089,164)	$ 2,339,990
	15	2010	327,267	$ 978.28	$ 320,157,269	$ 960.84	$ 314,450,856	$ 5,706,413	$ 8,046,403
	16	2011	344,575	$ 1,029.15	$ 354,617,902	$ 931.12	$ 320,839,827	$ 33,778,075	$ 41,824,478
	17	2012	348,935	$ 1,082.66	$ 377,778,436	$ 932.40	$ 325,345,676	$ 52,432,760	$ 94,257,239
	18	2013	360,205	$ 1,128.13	$ 406,358,067	$ 974.58	$ 351,048,325	$ 55,309,742	$ 149,566,981
	19	2014	365,630	$ 1,175.51	$ 429,801,721	$ 1,055.90	$ 386,068,587	$ 43,733,135	$ 193,300,115
	20	2015	362,810	$ 1,224.89	$ 444,402,341	$ 1,089.26	$ 395,192,726	$ 49,209,615	$ 242,509,730
Extension	21	2016 (proj)	370,369	$ 1,276.34	$ 472,716,798	$ 1,101.91	$ 408,115,006	$ 64,601,792	$ 307,111,523
	22	2017 (proj)	$ 378,086	$ 1,329.95	$ 502,833,451	$ 1,149.15	$ 434,477,249	$ 68,356,202	$ 375,467,725
	23	2018 (proj)	$ 385,963	$ 1,385.80	$ 534,868,827	$ 1,198.37	$ 462,524,659	$ 72,344,168	$ 447,811,893

Comparison with HMP expenditures excluded from ABD-U amounts

DY	ABD-U without HMP	Difference (C Report minus BN table)	Cumulative Deviation by Renewal Period
1			
2			
3			
4			
5			
6			
7			
8			
9	$ 119,644,174	$ (119,644,174)	
10	$ 170,487,472	$ (170,487,472)	
11	$ 222,627,081	$ (222,627,081)	
12	$ 240,036,203	$ (240,036,203)	
13	$ 273,171,226	$ (273,171,226)	
14	$ 302,026,587	$ (302,026,587)	
15	$ 314,450,856	$ (314,450,856)	
16	$ 320,839,827	$ (320,839,827)	
17	$ 325,345,676	$ (325,345,676)	
18	$ 350,748,123	$ (350,748,123)	$(1,311,384,482)
19			
20			
21			
22			
23			

SOONERCARE BUDGET NEUTRALITY
HISTORICAL AND PROJECTED MEMBER MONTHS AND EXPENDITURES - *BY MEG*

ABD RURAL MEG

July 2016 Notes/Updates:
- MEG-specific actual expenditures not available for 1996 - 2003
- Historical expenditures reflect C-Report amounts
- 2016 projected PMPM expenditures reduced by 3 percent in cell G30 to reflect provider payment rate reduction effective 1/1/16
- Historical HMP expenditures added to cells H27 - H29
- Projected PMPM HMP expenditures added to cells G30 - G32

Comparison with HMP expenditures excluded from ABD-U amounts

				Budget Neutrality Limit		Actual/Projected Expenditures						
	DY	CY	Member Months	PMPM	Aggregate	PMPM	Aggregate	Savings/ (Deficit)	Cumulative Savings/ (Deficit)	ABD-R without HMP	Difference (C Report minus BN table)	Cumulative Deviation by Renewal Period
Historical and Current	1	1996										
	2	1997										
	3	1998										
	4	1999	103,533	$ 427.26	$ 44,235,510							
	5	2000	209,188	$ 452.30	$ 94,615,196							
	6	2001	329,747	$ 478.80	$ 157,883,545		*See Exhibit 24 (Aggregate)*					
	7	2002	343,627	$ 506.86	$ 174,170,735							
	8	2003	222,348	$ 536.56	$ 119,303,455							
	9	2004	231,151	$ 568.00	$ 131,294,780	$ 599.10	$ 138,481,478	$ (7,186,698)	$ (7,186,698)	$ 138,481,478	$ (138,481,478)	
	10	2005	238,426	$ 601.29	$ 143,363,035	$ 639.45	$ 152,460,934	$ (9,097,899)	$ (16,284,596)	$ 152,460,934	$ (152,460,934)	
	11	2006	241,661	$ 636.52	$ 153,823,267	$ 793.03	$ 191,644,246	$ (37,820,979)	$ (54,105,575)	$ 191,644,246	$ (191,644,246)	
	12	2007	244,220	$ 669.62	$ 163,534,596	$ 834.57	$ 203,819,587	$ (40,284,991)	$ (94,390,566)	$ 203,819,587	$ (203,819,587)	
	13	2008	251,088	$ 704.44	$ 176,876,491	$ 871.89	$ 218,920,196	$ (42,043,705)	$ (136,434,272)	$ 218,920,196	$ (218,920,196)	
	14	2009	262,857	$ 741.07	$ 194,795,734	$ 930.09	$ 244,480,172	$ (49,684,438)	$ (186,118,709)	$ 244,480,172	$ (244,480,172)	
	15	2010	278,093	$ 779.61	$ 216,803,202	$ 943.82	$ 262,470,486	$ (45,667,284)	$ (231,785,993)	$ 262,470,486	$ (262,470,486)	
	16	2011	285,113	$ 820.15	$ 233,834,396	$ 958.77	$ 273,358,100	$ (39,523,704)	$ (271,309,697)	$ 273,358,100	$ (273,358,100)	
	17	2012	285,622	$ 862.79	$ 246,432,947	$ 938.53	$ 268,063,880	$ (21,630,933)	$ (292,940,630)	$ 268,063,880	$ (268,063,880)	
	18	2013	290,965	$ 899.03	$ 261,586,264	$ 970.21	$ 282,298,187	$ (20,711,923)	$ (313,652,553)	$ 282,055,691	$ (282,055,691)	$(1,085,948,157)
	19	2014	291,806	$ 936.79	$ 273,360,943	$ 1,011.24	$ 295,085,785	$ (21,724,842)	$ (335,377,395)			
	20	2015	287,250	$ 976.14	$ 280,396,215	$ 1,031.19	$ 296,210,205	$ (15,813,990)	$ (351,191,386)			
Extension	21	2016 (proj)	289,117	$ 1,019.09	$ 294,636,518	$ 1,043.23	$ 301,615,423	$ (6,978,905)	$ (358,170,290)			
	22	2017 (proj)	290,997	$ 1,061.89	$ 309,006,979	$ 1,088.00	$ 316,604,387	$ (7,597,408)	$ (365,767,698)			
	23	2018 (proj)	292,888	$ 1,106.49	$ 324,078,338	$ 1,134.65	$ 332,324,788	$ (8,246,450)	$ (374,014,148)			

SOONERCARE BUDGET NEUTRALITY
HISTORICAL AND PROJECTED MEMBER MONTHS AND EXPENDITURES - *BY MEG*

July 2016 Notes/Updates:
- Historical expenditures reflect C-Report amounts
- Adjustment for College Student (CS) expenditures in cells H23 - H27 (dollars removed to eliminate doublecount)

NON-DISABLED WORKING ADULTS MEG - ESI & IP

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Historical and Current	1	1996							
	2	1997							
	3	1998							
	4	1999							
	5	2000							
	6	2001							
	7	2002							
	8	2003							
	9	2004							
	10	2005							
	11	2006	9,744			$ 198.81	$ 1,937,239	$ (1,937,239)	$ (1,937,239)
	12	2007	38,417			$ 204.54	$ 7,857,843	$ (7,857,843)	$ (9,795,082)
	13	2008	139,822			$ 239.38	$ 33,470,013	$ (33,470,013)	$ (43,265,095)
	14	2009	172,594			$ 437.73	$ 75,549,419	$ (75,549,419)	$ (118,814,514)
	15	2010	392,065			$ 284.10	$ 111,386,167	$ (111,386,167)	$ (230,200,681)
	16	2011	392,772			$ 314.00	$ 123,330,328	$ (123,330,328)	$ (353,531,009)
	17	2012	391,031			$ 309.32	$ 120,952,327	$ (120,952,327)	$ (474,483,336)
	18	2013	388,005			$ 297.14	$ 115,291,324	$ (115,291,324)	$ (589,774,660)
	19	2014							
	20	2015							
Extension	21	2016 (proj)							
	22	2017 (proj)							
	23	2018 (proj)							

See Exhibit 8 for ESI 2014 and later
See Exhibit 17 for IP 2014 and later

SOONERCARE BUDGET NEUTRALITY
HISTORICAL AND PROJECTED MEMBER MONTHS AND EXPENDITURES - *BY MEG*

NON-DISABLED WORKING ADULTS MEG - ESI PROJECTIONS

July 2016 Notes/Updates:
- 2014 expenditure data includes C-report adjustments in order to align with C-report values, resulting in a low PMPM value for that year. PMPM trending is based on OMB rate for TANF-U and is unaffected by inclusion of the adjusted data

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Historical and Current	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							
	15	2010							
	16	2011							
	17	2012							
	18	2013							
	19	2014	273,146			$ 72.50	$ 19,802,018	$ (19,802,018)	$ (379,039,071)
	20	2015	158,543			$ 277.93	$ 44,063,972	$ (44,063,972)	$ (423,103,043)
Extension	21	2016 (proj)	159,699			$ 290.16	$ 46,338,191	$ (46,338,191)	$ (469,441,234)
	22	2017 (proj)	160,863			$ 302.93	$ 48,729,786	$ (48,729,786)	$ (518,171,021)
	23	2018 (proj)	162,036			$ 316.26	$ 51,244,816	$ (51,244,816)	$ (569,415,837)

SOONERCARE BUDGET NEUTRALITY
HISTORICAL AND PROJECTED MEMBER MONTHS AND EXPENDITURES - *BY MEG*

July 2016 Notes/Updates:
- Historical expenditures reflect C-Report amounts

WORKING DISABLED ADULTS MEG - ESI & IP

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Historical and Current	1	1996							
	2	1997							
	3	1998							
	4	1999							
	5	2000							
	6	2001							
	7	2002							
	8	2003							
	9	2004							
	10	2005							
	11	2006	-				$ -	$ -	$ -
	12	2007	-				$ 24	$ (24)	$ (24)
	13	2008	-				$ 34,024	$ (34,024)	$ (34,048)
	14	2009	110			$ 1,175.11	$ 129,262	$ (129,262)	$ (163,310)
	15	2010	90			$ 1,517.03	$ 136,533	$ (136,533)	$ (299,843)
	16	2011	114			$ 907.56	$ 103,462	$ (103,462)	$ (403,305)
	17	2012	66			$ 1,429.38	$ 94,339	$ (94,339)	$ (497,644)
	18	2013	42			$ 1,243.31	$ 52,219	$ (52,219)	$ (549,863)
	19	2014							
	20	2015							
Extension	21	2016 (proj)							
	22	2017 (proj)							
	23	2018 (proj)							

See Exhibit 10 for ESI 2014 and later
See Exhibit 18 for IP 2014 and later

SOONERCARE BUDGET NEUTRALITY
HISTORICAL AND PROJECTED MEMBER MONTHS AND EXPENDITURES - *BY MEG*

WORKING DISABLED ADULTS MEG - ESI PROJECTIONS

July 2016 Notes/Updates:
- Historical WDA enrollment has been exclusively in the IP MEG; cumulative saving/deficit amounts therefore are depicted in the WDA IP MEG
- The OHCA continues to project no enrollment in this MEG for 2016 - 2018 and has requested that it be removed (continuing to show pending CMS approval)

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Historical and Current	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							
	15	2010							
	16	2011							
	17	2012							
	18	2013							
	19	2014							
	20	2015	-			$ -	$ -	$ -	$ -
Extension	21	2016 (proj)	-			$ -	$ -	$ -	$ -
	22	2017 (proj)	-			$ -	$ -	$ -	$ -
	23	2018 (proj)	-			$ -	$ -	$ -	$ -

SOONERCARE BUDGET NEUTRALITY
HISTORICAL AND PROJECTED MEMBER MONTHS AND EXPENDITURES - *BY MEG*

July 2016 Notes/Updates:
- 2016 projected PMPM expenditures reduced by 3 percent in cell G30 to reflect provider payment rate reduction
- Historical expenditures reflect C-Report amounts

TEFRA CHILDREN MEG

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Historical and Current	1	1996							
	2	1997							
	3	1998							
	4	1999							
	5	2000							
	6	2001							
	7	2002							
	8	2003							
	9	2004							
	10	2005					$ 5,427	$ (5,427)	$ (5,427)
	11	2006	931			$ 943.85	$ 878,723	$ (878,723)	$ (884,150)
	12	2007	1,813			$ 1,055.94	$ 1,914,413	$ (1,914,413)	$ (2,798,563)
	13	2008	2,515			$ 914.81	$ 2,300,738	$ (2,300,738)	$ (5,099,301)
	14	2009	3,299			$ 1,393.11	$ 4,595,873	$ (4,595,873)	$ (9,695,174)
	15	2010	4,018			$ 1,128.02	$ 4,532,385	$ (4,532,385)	$ (14,227,559)
	16	2011	4,514			$ 1,007.97	$ 4,549,994	$ (4,549,994)	$ (18,777,553)
	17	2012	4,978			$ 1,209.69	$ 6,021,818	$ (6,021,818)	$ (24,799,371)
	18	2013	5,326			$ 1,038.85	$ 5,532,926	$ (5,532,926)	$ (30,332,297)
	19	2014	6,148			$ 1,018.70	$ 6,262,962	$ (6,262,962)	$ (36,595,259)
	20	2015	6,771			$ 1,061.48	$ 5,999,400	$ (5,999,400)	$ (42,594,659)
Extension	21	2016 (proj)	7,516			$ 1,072.88	$ 8,063,702	$ (8,063,702)	$ (50,658,362)
	22	2017 (proj)	8,343			$ 1,117.95	$ 9,326,759	$ (9,326,759)	$ (59,985,121)
	23	2018 (proj)	9,261			$ 1,164.90	$ 10,787,656	$ (10,787,656)	$ (70,772,777)

SOONERCARE BUDGET NEUTRALITY
HISTORICAL AND PROJECTED MEMBER MONTHS AND EXPENDITURES - *BY MEG*

July 2016 Notes/Updates:
- Historical expenditures reflect C-Report amounts

FULL TIME COLLEGE STUDENT MEG - ESI & IP

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Historical and Current	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	5,493			$ 147.65	$ 811,060	$ (811,060)	$ (1,467,095)
	17	2012	6,724			$ 162.45	$ 1,092,335	$ (1,092,335)	$ (2,559,430)
	18	2013	5,630			$ 191.36	$ 1,077,362	$ (1,077,362)	$ (3,636,792)
	19	2014							
	20	2015							
Extension	21	2016 (proj)							
	22	2017 (proj)							
	23	2018 (proj)							

See Exhibit 13 for ESI 2014 and later
See Exhibit 19 for IP 2014 and later

SOONERCARE BUDGET NEUTRALITY
HISTORICAL AND PROJECTED MEMBER MONTHS AND EXPENDITURES - *BY MEG*

July 2016 Notes/Updates:
- Historical expenditures reflect C-Report amounts

FULL TIME COLLEGE STUDENT MEG - ESI PROJECTIONS

				Budget Neutrality Limit		Actual/Projected Expenditures			
	DY	CY	Member Months	PMPM	Aggregate	PMPM	Aggregate	Savings/ (Deficit)	Cumulative Savings/ (Deficit)
Historical and Current	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							
	15	2010							
	16	2011							
	17	2012							
	18	2013							
	19	2014	3,182			$ 74.14	$ 235,903	$ (235,903)	$ (1,853,302)
	20	2015	1,217			$ 251.98	$ 306,659	$ (306,659)	$ (2,159,961)
Extension	21	2016 (proj)	1,171			$ 263.07	$ 307,956	$ (307,956)	$ (2,467,917)
	22	2017 (proj)	1,126			$ 274.64	$ 309,258	$ (309,258)	$ (2,777,175)
	23	2018 (proj)	1,083			$ 286.73	$ 310,566	$ (310,566)	$ (3,087,741)

SOONERCARE BUDGET NEUTRALITY
HISTORICAL AND PROJECTED MEMBER MONTHS AND EXPENDITURES - *BY MEG*

FOSTER PARENT MEG - ESI PROJECTIONS

July 2016 Notes/Updates:
- The OHCA projects no enrollment in this MEG for 2016 - 2018

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Historical and Current	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							
	15	2010							
	16	2011							
	17	2012							
	18	2013							
	19	2014							
	20	2015							
Extension	21	2016 (proj)							
	22	2017 (proj)							
	23	2018 (proj)							

SOONERCARE BUDGET NEUTRALITY
HISTORICAL AND PROJECTED MEMBER MONTHS AND EXPENDITURES - *BY MEG*

EMPLOYEES OF NON-PROFIT ORGANIZATIONS MEG - ESI PROJECTIONS

July 2016 Notes/Updates:
- The OHCA projects no enrollment in this MEG for 2016 - 2018

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Historical and Current	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							
	15	2010							
	16	2011							
	17	2012							
	18	2013							
	19	2014							
	20	2015							
Extension	21	2016 (proj)							
	22	2017 (proj)							
	23	2018 (proj)							

SOONERCARE BUDGET NEUTRALITY
HISTORICAL AND PROJECTED MEMBER MONTHS AND EXPENDITURES - *BY MEG*

SPONSOR'S CHOICE INSURANCE PROJECTIONS

July 2016 Notes/Updates:
- Enrollment member month projections based on enrollment of 10,000 members in December 2017 and 50,000 members in December 2018
- PMPM projections set equal to NDWA-ESI MEG

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Historical	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							
	15	2010							
	16	2011							
	17	2012							
	18	2013							
	19	2014							
	20	2015							
Extension	21	2016 (proj)							
	22	2017 (proj)	65,000			#REF!	#REF!	#REF!	#REF!
	23	2018 (proj)	380,000			$ 316.26	$ 120,177,084	$ (120,177,084)	#REF!

SOONERCARE BUDGET NEUTRALITY
HISTORICAL AND PROJECTED MEMBER MONTHS AND EXPENDITURES - *BY MEG*

NON-DISABLED WORKING ADULTS MEG - IP PROJECTIONS

July 2016 Notes/Updates:
- 2014 expenditure data includes C-report adjustments in order to align with C-report values, resulting in a high PMPM value. PMPM trending is based on OMB rate for TANF-U and is unaffected by inclusion of the adjusted data

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Historical and Current	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							
	15	2010							
	16	2011							
	17	2012							
	18	2013							
	19	2014	12,712			$ 4,478.15	$ 56,926,254	$ (56,926,254)	$ (287,463,861)
	20	2015	48,088			$ 588.04	$ 28,277,714	$ (28,277,714)	$ (315,741,575)
Extension	21	2016 (proj)	40,062			$ 613.91	$ 24,594,710	$ (24,594,710)	$ (340,336,285)
	22	2017 (proj)	33,376			$ 640.93	$ 21,391,396	$ (21,391,396)	$ (361,727,681)
	23	2018 (proj)	27,805			$ 669.13	$ 18,605,294	$ (18,605,294)	$ (380,332,975)

SOONERCARE BUDGET NEUTRALITY
HISTORICAL AND PROJECTED MEMBER MONTHS AND EXPENDITURES - *BY MEG*

WORKING DISABLED ADULTS MEG - IP PROJECTIONS

July 2016 Notes/Updates:
-The OHCA projects no increase in enrollment in this MEG for 2016 - 2018; projected member months equate to one enrollee
- Historical WDA enrollment has been exclusively in the IP MEG; cumulative saving/deficit amounts therefore are depicted below

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Historical and Current	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							
	15	2010							
	16	2011							
	17	2012							
	18	2013							
	19	2014	4			$ 1,560.75	$ 6,243	$ (6,243)	$ (556,106)
	20	2015	11			$ 4,187.27	$ 46,060	$ (46,060)	$ (602,166)
Extension	21	2016 (proj)	12			$ 4,363.14	$ 52,358	$ (52,358)	$ (654,524)
	22	2017 (proj)	12			$ 4,546.39	$ 54,557	$ (54,557)	$ (709,080)
	23	2018 (proj)	12			$ 4,737.34	$ 56,848	$ (56,848)	$ (765,928)

SOONERCARE BUDGET NEUTRALITY
HISTORICAL AND PROJECTED MEMBER MONTHS AND EXPENDITURES - *BY MEG*

July 2016 Notes/Updates:
- Historical expenditures reflect C-Report amounts

FULL TIME COLLEGE STUDENT MEG - IP PROJECTIONS

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Historical and Current	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							
	15	2010							
	16	2011							
	17	2012							
	18	2013							
	19	2014	-			#DIV/0!	$ 293,200	$ (293,200)	$ (2,312,593)
	20	2015	2,126			$ 180.09	$ 382,877	$ (382,877)	$ (2,695,470)
Extension	21	2016 (proj)	2,138			$ -	$ -	$ -	$ (2,695,470)
	22	2017 (proj)	2,150			$ -	$ -	$ -	$ (2,695,470)
	23	2018 (proj)	2,162			$ -	$ -	$ -	$ (2,695,470)

SOONERCARE BUDGET NEUTRALITY
HISTORICAL AND PROJECTED MEMBER MONTHS AND EXPENDITURES - *BY MEG*

FOSTER PARENT MEG - IP PROJECTIONS

July 2016 Notes/Updates:
- The OHCA projects no enrollment in this MEG for 2016 - 2018

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Historical and Current	1	1996							
	2	1997							
	3	1998							
	4	1999							
	5	2000							
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	11	2006							
	12	2007							
	13	2008							
	14	2009							
	15	2010							
	16	2011							
	17	2012							
	18	2013							
	19	2014							
	20	2015							
Extension	21	2016 (proj)							
	22	2017 (proj)							
	23	2018 (proj)							

SOONERCARE BUDGET NEUTRALITY
HISTORICAL AND PROJECTED MEMBER MONTHS AND EXPENDITURES - *BY MEG*

July 2016 Notes/Updates:
- The OHCA projects no enrollment in this MEG for 2016 - 2018

EMPLOYEES OF NON-PROFIT ORGANIZATIONS MEG - IP PROJECTIONS

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Historical and Current	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							
	15	2010							
	16	2011							
	17	2012							
	18	2013							
	19	2014							
	20	2015							
Extension	21	2016 (proj)							
	22	2017 (proj)							
	23	2018 (proj)							

SOONERCARE BUDGET NEUTRALITY
HISTORICAL AND PROJECTED MEMBER MONTHS AND EXPENDITURES - *BY MEG*

July 2016 Notes/Updates:
- Historical expenditures reflect C-Report amounts
- Member months trended at TANF-U growth rate

HAN MEG

	DY	CY	Client Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Historical and Current	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							
	15	2010 (6 mos)	149,104			$ 5.00	$ 745,520	$ (745,520)	$ (745,520)
	16	2011	428,898			$ 5.00	$ 2,144,490	$ (2,144,490)	$ (2,890,010)
	17	2012	542,657			$ 5.00	$ 2,713,285	$ (2,713,285)	$ (5,603,295)
	18	2013	1,010,286			$ 5.00	$ 5,051,430	$ (5,051,430)	$ (10,654,725)
	19	2014	1,396,342			$ 5.00	$ 6,981,710	$ (6,981,710)	$ (17,636,435)
	20	2015	1,455,505			$ 5.00	$ 7,133,940	$ (7,133,940)	$ (24,770,375)
Extension	21	2016 (proj)	1,517,176			$ 5.00	$ 7,585,879	$ (7,585,879)	$ (32,356,254)
	22	2017 (proj)	1,581,459			$ 5.00	$ 7,907,295	$ (7,907,295)	$ (40,263,549)
	23	2018 (proj)	1,648,466			$ 5.00	$ 8,242,330	$ (8,242,330)	$ (48,505,879)

SOONERCARE BUDGET NEUTRALITY

HEALTH MANAGEMENT PROGRAM (HMP) EXPENDITURES - DISTRIBUTION BY MEG

July 2016 Notes/Updates:
- Medical match claiming for all HMP contract expenditures began in January 2013
- 2014 expenditure data includes C-Report adjustments in order to align with C-report data, resulting in a larger than historical value in cell M28
- 2015 MM and expenditures are actual for 3 quarters (annualized)
- Expenditures trended at 3 percent rate (corresponds to current contract)
- Expenditures distributed across traditional MEGs based on client months (HMP participants are drawn from all four MEGs)
- Expenditures are included within aggregate waiver expenditure amounts on traditional MEG worksheets

			Traditional MEG Client Months					HMP Expenditures (Prorated across MEGs based on Client Months)				
	DY	CY	TANF-U	TANF-R	ABD-U	ABD-R	Total Client Months	TANF-U	TANF-R	ABD-U	ABD-R	Total Expenditures
Historical and Current	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										
	15	2010										
	16	2011										
	17	2012										
	18	2013	3,741,817	2,618,683	360,205	290,965	7,011,670	$ 3,118,501	$ 2,182,460	$ 300,202	$ 242,496	$ 5,843,658
	19	2014	4,001,208	2,745,120	365,630	291,806	7,403,764	$ 8,334,149	$ 5,717,833	$ 761,574	$ 607,805	$15,421,361
	20	2015	4,101,736	2,807,836	362,810	287,250	7,559,632	$ 3,959,816	$ 2,710,685	$ 350,257	$ 277,311	$ 7,298,068
Extension	21	2016 (proj)	4,275,528	2,890,355	370,369	289,117	7,825,369	$ 4,107,051	$ 2,776,460	$ 355,775	$ 277,725	$ 7,517,010
	22	2017 (proj)	4,456,684	2,975,299	378,086	290,997	8,101,064	$ 4,259,436	$ 2,843,615	$ 361,352	$ 278,117	$ 7,742,520
	23	2018 (proj)	4,645,515	3,062,739	385,963	292,888	8,387,105	$ 4,417,142	$ 2,912,175	$ 366,989	$ 278,490	$ 7,974,796

SOONERCARE BUDGET NEUTRALITY
HISTORICAL AND PROJECTED MEMBER MONTHS AND EXPENDITURES - *BY MEG*

SOONERCARE CHOICE - AGGREGATE (ALL MEGS)

July 2016 Notes/Updates:
- Member months are for traditional MEGs only (used to calculate budget neutrality limit)

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Historical and Current	1	1996	2,337,532	$ 122.41	$ 286,138,649	$ 170.69	$ 398,999,423	$ (112,860,774)	$ (112,860,774)
	2	1997	2,282,744	$ 130.39	$ 297,656,008	$ 134.54	$ 307,126,525	$ (9,470,517)	$ (122,331,291)
	3	1998	2,550,505	$ 138.92	$ 354,305,243	$ 106.62	$ 271,927,279	$ 82,377,964	$ (39,953,328)
	4	1999	3,201,226	$ 168.75	$ 540,219,561	$ 144.65	$ 463,050,620	$ 77,168,941	$ 37,215,613
	5	2000	3,496,982	$ 197.53	$ 690,771,669	$ 171.75	$ 600,600,099	$ 90,171,570	$ 127,387,183
	6	2001	4,513,310	$ 217.40	$ 981,193,992	$ 129.19	$ 583,054,043	$ 398,139,949	$ 525,527,133
	7	2002	4,823,829	$ 231.19	$ 1,115,204,678	$ 176.23	$ 850,117,611	$ 265,087,067	$ 790,614,200
	8	2003	4,716,758	$ 230.58	$ 1,087,577,307	$ 194.45	$ 917,157,855	$ 170,419,452	$ 961,033,652
	9	2004	4,886,804	$ 245.50	$ 1,199,726,867	$ 181.28	$ 885,888,955	$ 313,837,912	$ 1,274,871,564
	10	2005	5,038,078	$ 261.38	$ 1,316,858,944	$ 222.43	$ 1,120,637,046	$ 196,221,898	$ 1,471,093,461
	11	2006	5,180,782	$ 277.35	$ 1,436,908,230	$ 264.24	$ 1,368,966,665	$ 67,941,565	$ 1,539,035,027
	12	2007	5,451,378	$ 290.31	$ 1,582,588,944	$ 271.96	$ 1,482,534,451	$ 100,054,493	$ 1,639,089,520
	13	2008	5,386,004	$ 308.25	$ 1,660,247,275	$ 300.79	$ 1,620,046,448	$ 40,200,827	$ 1,679,290,347
	14	2009	5,839,782	$ 322.59	$ 1,883,853,423	$ 321.58	$ 1,877,931,749	$ 5,921,674	$ 1,685,212,021
	15	2010	6,367,794	$ 338.40	$ 2,154,888,798	$ 313.40	$ 1,995,690,240	$ 159,198,558	$ 1,844,410,579
	16	2011	6,420,012	$ 357.88	$ 2,297,585,380	$ 329.93	$ 2,118,136,761	$ 179,448,619	$ 2,023,859,198
	17	2012	6,819,943	$ 372.95	$ 2,543,464,833	$ 326.38	$ 2,225,879,926	$ 317,584,907	$ 2,341,444,105
	18	2013	7,011,670	$ 389.11	$ 2,728,288,274	$ 333.60	$ 2,339,081,302	$ 389,206,972	$ 2,730,651,077
	19	2014	7,403,764	$ 403.10	$ 2,984,482,165	$ 327.25	$ 2,422,883,479	$ 561,598,686	$ 3,292,249,763
	20	2015	7,559,632	$ 418.55	$ 3,164,084,569	$ 324.67	$ 2,454,379,096	$ 709,705,473	$ 4,001,955,236
Extension	21	2016 (proj)	7,825,369	$ 435.55	$ 3,408,335,921	$ 327.88	$ 2,565,746,322	$ 842,589,599	$ 4,844,544,835
	22	2017 (proj)	8,101,064	$ 453.19	$ 3,671,289,963	#REF!	#REF!	#REF!	#REF!
	23	2018 (proj)	8,387,105	$ 471.56	$ 3,955,052,668	$ 369.16	$ 3,096,154,289	$ 858,898,379	#REF!

JOEL NICO GOMEZ
CHIEF EXECUTIVE OFFICER

MARY FALLIN
GOVERNOR

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

2017-2018 SoonerCare Choice and Insure Oklahoma 1115(a) Demonstration Waiver
PUBLIC COMMENT April 1, 2016 – June 3, 2016

Commenter Name: Anonymous

DATE	COMMENT SOURCE	COMMENT	RESPONSE
Saturday, April 02, 2016 1:43PM	**From:** OHCAWebApps@okhca.org	We are two providers in primary care and because of the 25% reduction in payments along with last years 9.9% we cannot accept this proposal and further more our doors will close forever.......this really helps recruit providers doesn't it, NO!!	The OHCA appreciates your comments. The agency does not take these cuts lightly and understand that the 25% reduction will mean difficult decisions for providers. The specific posting that you responded to was to inform the public at large that the agency is submitting a request to the Centers for Medicaid and Medicare Services (CMS) requesting a 2 year extension to the existing SoonerCare waiver. We will be happy to forward your comments for the 25% rate cut posting to the appropriate staff for response. Thank you. Sherris

April 19, 2016
OHCA's SoonerCare Extension Renewal Application 2017 -2018 &
Post Award Forum Summary
of
Presentation and Comments

State staff presented at the Oklahoma Perinatal Quality Improvement Collaborative on April 19, 2016, affording the public an opportunity to provide meaningful comment on the progress of SoonerCare and Insure Oklahoma, as authorized in the State's 1115 demonstration waiver. It was presented that the SoonerCare serves 580,000 people per month through managed care and was recently awarded a renewal by CMS through December 31, 2016.

SoonerCare Choice provides services through the patient-centered medical home. It was demonstrated that SoonerCare Choice houses the health management program which improves quality outcomes by embedding health coaches and certain practice facilitators, and assisting with chronic conditions, accordingly. It was further detailed that the health management program reduces costs, visits to the emergency room, and hospitalizations. Additonally, the State's health access networks were described as facilitating specialty care, thus, improving care coordination. The State also recognized the Insure Oklahoma premium assistance programs, the employer sponsored insurance plan offered to supplement the employer relationship with their employees as well as the individual plan. Finally, it was presented that the State is working to acquire a two year waiver extension and is currently seeking public comment via the Oklahoma Health Care Authority's website through June 3, 2016.

There was one comment regarding how the Oklahoma Health Care Authority shares updates and member stories through the news media, stating it was noteworthy to communicate that the SoonerCare Demonstration serves 580,000 members per month. Ed Long, OHCA Chief Communications Officer, replied that the agency shares member stories which will have a positive impact on Oklahomans through multiple social media platforms. He particularly invited those in attendance to look on YouTube for the young member spotlight that features a young man who can hear any classical musical excerpt once and play it back correctly entirely from memory. This SoonerCare member is a young man who has autism, and his family is extremely grateful for the health care services that he receives through SoonerCare. SoonerCare and Insure Oklahoma are active presence on Facebook, Twitter and YouTube.

The State also explained the public notice process and how it provides the agency an opportunity to share public meeting dates regarding the waiver renewal with cities in Oklahoma which have 10,000 residents or more.

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2017-2018 SoonerCare Choice and Insure Oklahoma 1115(a) Demonstration Waiver Update

The Oklahoma Health Care Authority Reporting unit is seeking comments from the public regarding the current SoonerCare Choice and Insure Oklahoma 1115(a) Demonstration Waiver on an update to the demonstration for an extension through 2017-2018.

Please view the full original SoonerCare Renewal application here: SoonerCare Renewal Application. Please submit all comments by close of business, **June 3, 2016**, via the comment box below. The OHCA will respond in writing to any feedback received during the comment period. Thank you for your participation in the process.

Also, an overview of the feedback received will be discussed in the public meetings mentioned below. Input from meeting participants will also be summarized and submitted to the Centers for Medicare and Medicaid Services.

April 19, 2016 5:00p.m.
OPQIC Oklahoma Perinatal Quality Improvement Collaborative Meeting,
Stephenson Cancer Center
Fifth Floor Conference Room
Oklahoma City, OK 73104.

Videoconferencing is also available for this meeting:

- OU College of Medicine, Tulsa;
- Northwestern Oklahoma State University, Enid;
- Eastern Oklahoma State University, Wilburton and
- Stillwater Medical Center.

May 19, 2016 at 1:00p.m.
Medical Advisory Committee Meeting
Ed McFall Boardroom
Oklahoma Health Care Authority
4345 N. Lincoln Blvd, Oklahoma City, Ok.

125%