Oklahoma Health Care Authority

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

Application for Extension of the Demonstration, 01/01/19-12/31/21

Submitted to the Centers for Medicare and Medicaid Services

December 29, 2017

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I. HISTORICAL NARRATIVE SUMMARY

Demonstration Background

In 1993, the State of Oklahoma was in the process of reforming the Medicaid program in order to improve access to care, quality of care, and cost effectiveness. During the 1993 legislative session, Oklahoma State leadership passed legislation[1] that directed the Oklahoma Health Care Authority (OHCA), as the state entity designated by law, to assume the responsibilities for the preparation and development for converting the present delivery of the Oklahoma Medicaid Program to a managed care system.

The OHCA worked collaboratively with state leadership, providers and stakeholders to propose a program that was innovative and unique to Oklahoma. The Oklahoma SoonerCare Choice demonstration was approved by the Health Care Financing Administration in January 1995 under a 1915(b) managed care waiver. The managed care program was subsumed under a Section 1115(a) Research and Demonstration Waiver on January1, 1996. The SoonerCare Choice program began as a partially-capitated, primary care case management (PCCM) pilot program in four rural areas of Oklahoma and, in 1997 became a statewide program for all rural areas. In contrast, the SoonerCare Plus program was offered as a fully-capitated managed care program in urban areas of the state, and relied on contracted managed care organizations as providers. While the program initially enrolled children, pregnant women and Temporary Assistance for Needy Families (TANF) populations, over the years, the success of the program led state leadership to enlarge the program to serve the Aged, Blind and Disabled, as well as additional populations. In December 2003, the fully capitated managed care program, SoonerCare Plus was ended, and in January 2004, SoonerCare Choice PCCM was expanded statewide as the single managed care delivery system, for both urban and rural areas.

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

In the current SoonerCare Choice medical home model, members actively choose their medical home from a network of contracted SoonerCare providers. Members can change PCPs with no delay in the enrollment effective date. SoonerCare Choice providers are paid monthly care coordination payments for each member they provide services to 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.

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

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

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

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

In accordance with Title 56 of the Oklahoma Statutes, the 1115(a) demonstration also serves individuals not qualified for SoonerCare Choice, but who qualify for the Insure Oklahoma program. The Insure Oklahoma program, enabled by State Legislation in April 2004, includes the Employer Sponsored Insurance (ESI) program and the Individual Plan (IP). Refer to Appendix A to review a list of Insure Oklahoma populations. Individuals in ESI receive assistance with payment for their premiums based on the Insure Oklahoma qualifying health plan[2] they choose. The employers also contribute a portion of premiums. Individuals who do not qualify for ESI may qualify for IP. Individuals who qualify for the IP program receive premium assistance and cost sharing for benefits that meet the essential health benefit requirements that would be applicable to alternative benefit plans under federal regulations found in 42 Code of Federal Regulations (CFR) Section 440.347.

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

Objectives Approved for the 2016 - 2018 Demonstration

The OHCA's objectives for the SoonerCare Choice demonstration are representative of the goals of the agency and the state. The OHCA was approved by the Centers for Medicare & Medicaid Services (CMS) for a one year extension for 2017 on November 30, 2016 and for the following objectives for the 2016 - 2018 extension period. The OHCA is currently pending approval for the final demonstration year.

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

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

Evaluation of 2016 - 2018 Objective Measures

In order to ensure that the OHCA is successfully meeting the stated objectives, the agency evaluates the SoonerCare Choice program through evaluation measures that assess each of the waiver objectives. The OHCA's progress in meeting the 2016 - 2018 objectives are detailed in section ***VI Demonstration Evaluation*** of this document with data to date of December 2016. An overview of each waiver objective is listed below.

Waiver Objective 1: Access to Care (Hypos 1, 2, 4 & 5)

Through the Healthcare Effectiveness Data and Information Set (HEDIS®) and the Consumer Assessment of Health Plan Surveys (CAHPS®), the OHCA's SoonerCare Choice program has shown effectiveness in providing access to care. The most recent outcomes of the HEDIS® and CAHPS® surveys are from June 2017. The information is updated on an annual basis.

Waiver Objective 2: Medical Home (Hypos 3 & 4)

The OHCA continues to increase the number of SoonerCare providers and to ensure that each member has a medical home. The number of SoonerCare contracted providers has continued to increase since the January 2013 baseline year in accordance with our monthly Fast Fact reports through the OHCA. In July 2016 there were 2,701 SoonerCare Choice PCPs. There are a total of 2,770 SoonerCare Choice PCPs as of May 2017.

Waiver Objective 3: Integration of IHS Beneficiaries and Providers (Hypo 6)

The OHCA continues to integrate Indian health members and providers into the SoonerCare Choice program. As of December 2016, the ratio of Native American SoonerCare members with an Indian Health Services, Tribal facilities and/or Urban Indian Clinics (I/T/U) PCP with SoonerCare Choice, and those Native American SoonerCare members with an I/T/U PCP only was 8:2.

Wavier Objective 4: Providing Access to Affordable Health Insurance (Hypos 3 & 5)

The OHCA believes that the number of Insure Oklahoma PCPs will continue to be maintained throughout the 2018 extension period. The 2016 CAHPS ® survey indicates satisfactory responses for scheduling an appointment as soon as needed for the majority of both the Adult and Child survey respondents surveyed. In July 2016 there were 2,129 Insure Oklahoma IP PCPs. There are a total of 2,204 Insure Oklahoma IP PCPs as of May 2017.

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

The OHCA provides comprehensive care management to individuals with chronic conditions in the Health Management Program (HMP), as well as individuals with complex health care needs in the Health Access Network (HAN) pilot program. The HMP program continues to utilize nurse care management for individuals engaged in the program and practice facilitation for practices that care for SoonerCare Choice members. Both programs continue to show significant improvements. To review the evaluation measures in their entirety, refer to Section VI *Demonstration Evaluation*

Demonstration Hypotheses

The state will test the demonstration hypotheses listed in Section XIV, Evaluation of the Demonstration, of the Special Terms and Conditions (STC).

Proposed Objectives for the 2019 - 2021 Extension

The State proposes to continue the main objectives for the 2019 - 2021 extension.

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

II. REQUESTED CHANGES FOR THE 2019 - 2021 DEMONSTRATION

The SoonerCare Choice and Insure Oklahoma § 1115(a) Research and Demonstration Waiver is currently approved through December 31, 2017. The final 2018 demonstration year is pending CMS approval. Oklahoma is aware that the SoonerCare/Insure Oklahoma Demonstration Waiver will need to be amended in order to include any provision of changes to the program(s) as noted within the demonstration waiver renewal. Oklahoma requests a renewal of the waiver program(s) for the period of January 1, 2019 through December 31, 2021 at this time with one amended change:

The OHCA wishes to remove the pilot status of the Health Access Networks (HAN) to allow the possibility of "statewideness". The number one item listed on the waiver list of the approval package, Statewideness in accordance with Section 1902(a)(1), will also be removed from the waiver list in the demonstration for this renewal period.

III. 2019-2021 WAIVER LIST, EXPENDITURE AUTHORITIES AND COMPLIANCE WITH SPECIAL TERMS AND CONDITIONS

The State requests the following waiver list and expenditure authorities for the 2019 - 2021 renewal of the demonstration. 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 2018 SoonerCare Choice demonstration with the below change to reflect the possibility of statewideness for the HANs.

~~*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~~. 1. *Freedom of Choice Section 1902(a) (23)(A)*

To enable the state to restrict beneficiaries' freedom of choice of care management providers and to use selective contracting that limits freedom of choice of certain provider groups to the extent that the selective contracting is consistent with beneficiary

access to quality services. No waiver of freedom of choice is authorized for family planning providers.

~~3.~~ 2. *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 2019 - 2021 demonstration renewal.

1. *Demonstration Population 5.*
   Expenditures for health benefits coverage for individuals who are "Non-Disabled Low- Income Workers" ages 19-64 years old, who work for a qualifying employer, and have no more than 200 percent of the federal poverty level (FPL) and their spouses.

2. *Demonstration Population 6.*
   Expenditures for health benefit coverage for individuals who are "Working Disabled Adults ages 19-64 years of age, who work for a qualifying employer and have income up to 200 percent of the FPL.

3. *Demonstration Population 8.*
   Expenditures for health benefit coverage for no more than 3,000 individuals at any one time who are full-time college students ages 19-22 and have income 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 benefit coverage for foster parents who work for a qualified employer and their spouses with household incomes no greater than 200 percent of the FPL.

5. *Demonstration Population 11.*
   Expenditures for health benefit coverage for individuals who are employees and their 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 benefit coverage for individuals who are "Non-Disabled Low- Income Workers" 19-64 years of age, whose employer elects not to participate in the Premium Assistance Employer Coverage Plan, as well as those who are self-employed or unemployed (and seeking work) and who have income up to 100 percent of the FPL and their spouses.

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

who have income up to 100 percent of the FPL.

8. *Demonstration Population 14.*
   Expenditures for health benefit coverage for no more than 3,000 individuals at any one time who are full-time college students ages 19-22 and have income 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 Population15.*
   Expenditures for health benefit coverage for individuals who are working foster parents, whose employer elects not to participate in the Premium Assistance Employer Coverage Plan and their spouses, who have household incomes no greater than 100 percent of the FPL.

10. *Demonstration Population16.*
    Expenditures for health benefit coverage for individuals who are employees and their 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 the 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.

Title XIX Requirements Not Applicable to the Demonstration Expenditure Authorities

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

1. *Comparability; Section 1902(a)(10)(B) and 1902(a)(17)*
   To permit the State to provide different benefit packages to individuals in demonstration populations 5, 6, 8, 10 and 11 who are enrolled in the Premium Assistance Employer Coverage Plan that may vary by individual.

2. *Cost Sharing Requirements; Section 1902(a)(14) insofar as it incorporates Section 1916*
   To permit the State to impose premiums, deductions, cost sharing and similar charges that exceed the statutory limitations to individuals in populations 5, 6, 8, 10 and 11 who are enrolled in the Premium Assistance Employer Coverage Plan.

3. *Freedom of Choice; Section 1902(a)(23)(A)*
   To permit the State to restrict the choice of provider for beneficiaries qualified under populations 5, 6, 8, 10 and 11 enrolled in the Premium Assistance Employer Coverage Plan. No waiver of freedom of choice is authorized for family planning providers.

4. *Retroactive Eligibility; Section 1902(a)(34)*
   To enable the State to not provide retroactive eligibility for demonstration participants in populations 5, 6, 8, 10, 11, 12, 13, 14, 15 and 16.

5. *Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services; Section 1902(a)(4)(B); 1902(a)(10)(A); and 1902(a)(43)*
   To exempt the State from furnishing or arranging for EPSDT services for full-time college students age 19 through age 22 who are defined in populations 8, 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 non-emergency transportation benefits to individuals in populations 12, 13, 14, 15 and 16 enrolled in the Insure Oklahoma Premium Assistance Individual Plan

Compliance with Special Terms and Conditions

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

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

3. *Compliance with Changes in Medicaid and CHIP Law, Regulation and Policy (e.g. CHIPRA)*
   Within the timeframes specified by law, regulation or policy statement, the State brings the Demonstration into compliance with changes in Federal and State law, regulations or policy that affect the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision change is expressly waived or identified as not applicable to the Demonstration.

4. *Impact on Demonstration of Changes in Federal Law, Regulation and Policy.*
   a) If change in federal law, regulation or policy results in a change in Federal Financial

Participation (FFP) for expenditures made under the Demonstration, the State submits modified budget neutrality and allotment neutrality agreements for CMS approval. The State recognizes that the modified agreements referred to in this subparagraph do not involve changes to trend rates for the budget neutrality agreement, and that modified agreements take effect on the date the relevant change (s) is implemented.

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

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

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

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

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

   b. The State submits this application as documentation of compliance with the transparency requirements in 42 CFR section 431.412 and the required supporting documentation outlined in (i)-(vii) of this section, as well as the public notice requirements outlined in paragraph 16 of STCs.

9. *Demonstration Phase-Out.*
The State agrees to promptly notify CMS in writing and submit a phase-out plan to CMS at least six months prior to initiating phase-out activities. The State agrees to comply with all phase-out requirements set forth in (a)-(d) of this section.

10. *Expiring Demonstration Authority.*
In the event that CMS elects to expire demonstration authority prior to the Demonstration's expiration date, the State agrees to submit a demonstration Transition and Expiration Plan to

CMS at least six months prior to the Demonstration authority's expiration date. The State agrees to include in the Expiration Plan, the requirements as outlined in (a)-(d) of this section.

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

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

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

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

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

16. *Public Notice, Tribal Consultation, and Consultation with Interested Parties.*
The State complies with the State Notice Procedures set forth in 59 Federal Register 49249, as well as the tribal consultation requirements pursuant to Section 1902(a) (73) of the Act as amended by Section 5006(e) of the American Recovery and Reinvestment Act of 2009. The State also complies with the tribal consultation requirements contained in the State's approved State Plan. The State submits evidence to CMS regarding solicitation of advice from federally recognized Indian tribes, Indian health programs and Urban Indian Organizations prior to submission of any waiver proposal, amendment or renewal of the Demonstration. Documentation of compliance with these requirements is provided in Section VII of this application, *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 of this application, *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 13-0018 S10).

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

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

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

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

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

25. Eligibility Conditions for Full-Time College Students, Populations 8 and 14.
The State complies with the requirements of the income eligibility documentation. The State maintains an enrollment cap of 3,000 full-time college students for the Insure Oklahoma program. The State received authorization for a waiting list from CMS on April 25, 2011. As of May 2017, there are 118 students enrolled in ESI and 164 students enrolled in IP for a total of 282 college students currently enrolled in the Insure Oklahoma program. A waiting list is currently not in place. The State does not expect to implement a waiting list for the 2019 - 2021 demonstration renewal, but understands that a minimum of 60-day notifications to CMS is required prior to implementing a waiting list.

26. SoonerCare Benefits.

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

27. SoonerCare Cost Sharing.

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

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

28. Insure Oklahoma: Premium Assistance Employer Coverage.

The State maintains all other definitions, eligibility rules for premium assistance employer coverage, as well as the employer requirements outlined in (a)-(f) of this section.

29. Insure Oklahoma: Premium Assistance Employer Coverage IO Qualifying Plans.

The State maintains the required criteria for the Insure Oklahoma qualified health plans as defined in Oklahoma Administrative Code 317:45-5-1. All Insure Oklahoma employer sponsored insurance health plans are approved by the Oklahoma Insurance Department. The State is not requesting any changes to qualified health plans at this time. The maximum allowed copayment amounts continue to comply with paragraph 33 of the STCs.

30. Insure Oklahoma: Premium Assistance Individual Plan.

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

31. Premium Assistance Individual Plan (Insure Oklahoma) Benefit.

The State maintains the Individual Plan benefit package. The benefit package meets the essential health benefit requirements that would be applicable to alternative benefit plans under federal regulations found in 42 CFR Section 440.347. In the future, the State agrees to submit all changes covered and non-covered services and benefits to CMS for prior approval.

32. Insure Oklahoma Cost Sharing.

The State agrees to not exceed the cost sharing amounts for the Employer Sponsored

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

33. Premium Assistance Employer Coverage Copayments and Deductibles.

The State maintains that Insure Oklahoma ESI copayments continue to be the copayments required by the enrollee's specific health plan, as defined in paragraph 29 of the STCs. The State also maintains the copayment and deductible requirements as outlined in (a)-(d) of this section.

34. Premium Assistance Employer Coverage Plan Premiums.

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

35. Premium Assistance Individual Plan Premiums.

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

36. Compliance with Managed Care Regulations.

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

37. Access and Service Delivery.

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

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

38. Care Coordination Payments.

The State maintains the definition for the monthly care coordination payments, the monthly schedule of care coordination payments, the changes to monthly care coordination payments and the monthly care management payments as outlined in (a) – (d). The State understands the

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

requirement to notify CMS at least 60 days prior to changing the fees paid to PCPs and to include a revised budget neutrality assessment with such a notification.

39. Other Medical Services.

It continues to be the case that all other SoonerCare Choice benefits, (with the exception of non-emergency transportation and PACE, which are paid through a capitated contract) are paid through the State's FFS system. The State is not requesting any changes to this arrangement.

40. Health Access Networks.

The State understands that it may ~~pilot up to four~~ allow for the possibility of Health Access Networks (HANs) statewide. 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 Choice PCPs receive the care coordination payments as outlined in paragraph 38. The State maintains that Oklahoma's I/T/Us must have a SoonerCare Choice American Indian PCCM contract. All of the OHCA's I/T/U SoonerCare providers have a SoonerCare Choice 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, as defined in paragraph 23, outlined in this paragraph and is not requesting that any changes be made.

45. Health Management Program Defined.

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

46. Health Management Program Services.

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

47. Changes to the HMP Program.

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

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

The State monitors the aggregate costs for the Insure Oklahoma ESI and IP programs. On a quarterly basis, the State compares the average monthly premium assistance contribution per employer and the coverage for enrollees, to the cost per member per month of the Individual Plan population. On an annual basis, the State calculates the total cost per enrollee per month for individuals receiving subsidies under the ESI program, including reimbursement made to enrollees whose out-of-pocket costs exceed their income stop loss threshold (five percent of income). The State compares the cost to the 'per enrollee per month' cost of individuals enrolled in the Individual Plan. Documentation of compliance with these requirements is provided in Appendix C, Insure Oklahoma Monitoring.

49. Monitoring Employer Sponsored Insurance.

The State monitors the aggregate level of contributions made by participating employers, requires that participating employers report annually their total contributions for employees, prepares an aggregate analysis across all participating employers summarizing the total statewide employer contribution and monitors changes in covered benefits and cost-sharing requirements of employer-sponsored health plans and documents any trends. Documentation of compliance with these requirements is provided in Appendix C, *Insure Oklahoma Monitoring*.

50. General Financial Requirements.

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

51. Reporting Requirements Related to Budget Neutrality.

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

52. Monthly Calls.

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

53. Quarterly Operational Reports.

The State submits quarterly operational reports on the Demonstration to CMS in the format specified in Attachment A of the STCs, no later than 60 days following the end of the quarter.

The reports include all of the following elements outlined in (a)-(e) of this section of the STCs.

54. Annual Report.

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

55. Title XXI Enrollment Reporting.

The State complies with Title XXI enrollment reporting requirements.

56. Quarterly Expenditure Reports.

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

57. Reporting Expenditures Under the Demonstration

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

58. Reporting Member Months.

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

59. Standard Medicaid Funding Process.

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

60. Extent of Federal Financial Participation for the Demonstration.

The State understands CMS's provision of FFP for applicable federal matching rates for the

Demonstration, as outlined in (a)-(d) of this section. Refer to Section V of this document and attachments one and two for compliance with budget neutrality.

61. Sources of Non-Federal Share.

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

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

62. State Certification of Funding Conditions

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

63.Monitoring the Demonstration.

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

64. Quarterly Expenditure Reports.

The State complies with submission of reports quarterly under this demonstration expenditure through the MBES/CBES, following routine CMS-64.21 reporting instructions as outlined in Section 2115 and 2500 of the State Medicaid Manual. The State submits all Title XXI expenditures through the CMS- 64.21U and/or the CMS-64.21UP. Refer to Section V of this document and attachments one and two for compliance with budget neutrality.

65. Claiming Period.

The State complies with the claiming period requirements outlined in this section (a) – (b). Refer to Section V of this document and attachments one and two for compliance with budget neutrality.

66. Limitation on Title XXI Funding.

The State understands that there is a limit on the amount of federal Title XXI funds that the State may receive for demonstration expenditures during the demonstration period. The State also understands that no further enhanced federal matching funds will be available for costs of the Demonstration if the State expends its available allotment. If Title XXI funds are

exhausted, the State agrees to continue to provide coverage to Medicaid expansion children Demonstration Population 9 through Title XIX funds until further Title XXI funds become available. Refer to Section V of this document and attachments one and two of this document for compliance with budget neutrality.

67. Limit on Title XIX Funding.

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

68. Risk.

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

69. Demonstration Populations Subject to the Budget Neutrality Agreement.

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

70. Budget Neutrality Expenditure Limit.

The State complies with the method used to calculate the budget neutrality expenditure limit, as outlined in (a)-(b) of this section. Refer to Section V of this document and attachment one and two of this document for compliance with budget neutrality.

71. Enforcement of Budget Neutrality.

The State agrees to submit a corrective action plan to CMS if the State exceeds the calculated cumulative budget neutrality expenditure limit. Refer to Section V of this document and attachments one and two for compliance with budget neutrality.

72. Exceeding Budget Neutrality.

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

73. Submission of Draft Evaluation Design.

The State submits to CMS a draft Evaluation Design no later than 120 days after the award of the Demonstration. The State agrees to include in the draft Evaluation Design the requirements set forth in (a)-(g) of this section. Refer to Section VI of this document for the Evaluation Design findings from 2016 - 2018. To review the final Evaluation Design, refer to attachment three.

74. Identify the Evaluator.

The State identifies in the Evaluation Design the agency or contractor who will conduct the Evaluation report. The state will have 120 days after the award of the demonstration to submit a draft evaluation plan and identify the evaluators at that time.

75. Demonstration Hypotheses.

The State tests the demonstration hypotheses that are approved by the State and CMS. Refer to Section VI of this document for the Evaluation Design findings from 2016 - 2018.

The OHCA proposes the 2019 - 2021 demonstration hypotheses to remain the same at this time. The state will have 120 days after the award of the demonstration to submit a draft evaluation plan if any changes should occur.

Hypothesis 1: Child Health Checkup Rates. The rate for age-appropriate well-child and adolescent visits will be maintained between the extension period of 2019 - 2021.

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 be maintained as a measure of access to primary care in accordance with HEDIS® guidelines between 2019 - 2021.

Hypothesis 3: PCP Enrollments. The number of SoonerCare Choice primary care practitioners enrolled as medical home PCPs will be maintained at or above the baseline between 2019 - 2021.

Hypothesis 3b: PCP Enrollments Insure Oklahoma. The number of Insure Oklahoma practitioners enrolled as PCPs will be maintained at or above the baseline between 2019 - 2021.

Hypothesis 4: PCP Capacity. There will be adequate PCP capacity to meet the health care needs of SoonerCare members between 2019 - 2021.

Hypothesis 5: PCP Availability. There will be adequate PCP availability to meet the health care needs of the SoonerCare members with Children's Health Insurance Program (CHIP) eligibility between 2019 - 2021. As perceived by the member, the time it takes for the member to schedule an appointment will be maintained as compared to the baseline data between 2019 - 2021.

Hypothesis 6: Integration of I/T/U Providers. The percentage of Native American 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 (PCCM) contract will be maintained between 2019 - 2021 waiver period.

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 2019 - 2021.

Hypothesis 8: Impact of Health Access Networks on Effectiveness of Care. 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 2019 - 2021.

Hypothesis 9a-h: Health Management Program (HMP). Health outcomes for chronic diseases will improve between 2019 - 2021 as a result of participation in the HMP. Total expenditures for members enrolled in HMP will decrease.

76. Evaluation of Health Access Networks.

The State submits to CMS a draft Evaluation Design for the Health Access Network pilot program as required under paragraph 73. Within the Evaluation Design, the State includes the requirements set forth in (a)-(d) of this section. Refer to Section VI of this document for the Evaluation Design findings from 2016 - 2018.

For the 2019 – 2021 demonstration renewal, the OHCA proposes the HAN hypothesis remain the same at this time. The state will have 120 days after the award of the demonstration to submit a draft evaluation plan if any changes should occur.

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

77. Evaluation of the Health Management Program.

The State submits to CMS a draft Evaluation Design for the Health Management Program as required under paragraph 73. Within the Evaluation Design, the State includes the requirements set forth in (a)–(h) of this section. Refer to Section VI of this document for the Evaluation Design findings from 2016 - 2018.

The OHCA proposes the HMP hypotheses for the 2019 – 2021 demonstration renewal to remain the same at this time. The state will have 120 days after the award of the demonstration to submit a draft evaluation plan if any changes should occur.

78. Evaluation of Eligibility and Enrollment Systems.

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

79. Interim Evaluation Reports.

The State submits to CMS an interim evaluation report in the event that the State requests to extend the Demonstration beyond the current approval period. Refer to Section VI of this document for the most recent submission 2015 - 2016 Evaluation Design findings. CMS has allowed this to be used for the remaining 2017 - 2018 demonstration years.

80. Final Evaluation Plan and Implementation.

The State provides the final Evaluation Design to CMS within 60 days of receiving CMS's comments. The State agrees to implement the Evaluation Design and include progress reports within the SoonerCare Quarterly Reports. The State also submits to CMS a draft Evaluation of the

Demonstration 120 days after the expiration of the current Demonstration. The State agrees to provide a final Evaluation of the Demonstration to CMS within 60 days of receiving CMS's comments. The State agrees to include in the Evaluation the requirements set forth in (a)-(g) of this section.

The OHCA will report on the progress of hypotheses within each Quarterly report as it relates to progress of each evaluation measure. The annual report will provide progress to date of all measures.

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

IV. QUALITY

Quality Assurance Monitoring

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

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

The outcome conclusion of the child and adult survey is noted in Appendix D. Please see attachments four, four (a) and five for full detailed information.

Quality Initiatives

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

SoonerRide

The SoonerRide program was developed in order to assist SoonerCare members with transportation to and from medically necessary appointments. The Oklahoma Health Care Authority partners with LogistiCare Solutions LLC to provide non-emergency transportation to and from medical appointments.

During 2016, the SoonerRide program provided approximately 779,638 trips for SoonerCare Choice and other OHCA covered program members within the 77 counties of the state.

Throughout SFY2016 member satisfaction surveys were conducted on a quarterly basis. Members ranked the SoonerRide program as excellent, good, fair or poor. The survey revealed very positive results during each quarter of 2016. Ninety-two percent of respondents gave the program a positive rating of either excellent, good or fair the first quarter. The respondents gave the program 91 percent, 84 percent and 89 percent of a positive rating the remaining three quarters.

Access Survey

The OHCA requires that providers give members 24-hour access and ensure that members receive appropriate and timely services. Provider services staff place calls to providers after 5:00 pm and report the type of access available. Provider representatives also educate providers in need of improving after-hours access to comply with contractual standards.

2016 Access Survey	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec
Number of Providers Called	905	900	884	876
Percent of Providers with 24-hr Access on Initial Survey	93%	93%	94%	92%
Percent of Providers Educated for Compliance	7%	7%	6%	8%

Medical Home Audits

The OHCA's Quality Assurance Compliance department conducts an on-location evaluation of medical home requirements for contracted providers. The division has worked to continue to refine their process to better serve the providers and assist them in becoming successful Patient Centered Medical Home (PCMH) providers to our eligible Medicaid members. The unit reports it has been rather successful at going out to audit PCMH providers within 12 to 18 months of their effective PCMH contract date.

Calendar YEAR	# 1st time audited providers/clinics (total	Average days from contract effective date to date of 1st (audit) compliance review	Compliance review done <18 months from contract effective date	Compliance review done 18> months from contract effective date	# of those first time audited who PASSED all required measures of audit
2010	295	533	166	129	75 of the 295
2011	287 of 315	781	61	226	118 of the 287
2012	167 of 281	729	83	84	56 of the 167
2013	69 of 319	572	45	24	32 of the 69
2014	120 of 412	920	42	78	37 of the 120
2015	112 of 313	823	54	58	46 of the 112
2016	150 of 255	727	95	55	11 of the 150
Never audited Panel Size >100	X	X	8	12	X

Calendar YEAR	# 1st time audited providers/clinics (total	Average days from contract effective date to date of 1st (audit) compliance review	Compliance review done <18 months from contract effective date	Compliance review done 18> months from contract effective date	# of those first time audited who PASSED all required measures of audit
Never audited Panel Size <100	X	X	6	17	X

Prior process 2010 to October 2015:

- Many locations had a second audit 1 year later, any time they failed any portion of the medical home measures.
- The process was to repeat audits in 1 – 3 years (pass or fail).
- Audits were not done on those locations which had a panel of 75 or less. It is difficult to pull claims and get 10 viable members to do a medical record review.

Changes and current process, since transition October 2015:

- Target all providers who have never before had an audit, including those with smaller panel sizes.

Legislative Impacts

On May 31, 2017 Governor Mary Fallin signed the appropriation request for state fiscal year 2018. The State continues to have a revenue failure however, the current level of appropriations are not expected to have a negative impact on the OHCA or the demonstration. The OHCA however did not receive additional funding needed for implementation of an independent contractor for the Managed Care model for the aged, blind and disabled (ABD) populations. The OHCA cancelled its Request For Proposal (RFP) asking private companies to manage the ABD members. The OHCA has determined that the cancellation of the Request For Proposal (RFP) for the aged, blind and disabled (ABD) population is in the best interest of the State due to the appropriation request for this model not receiving funding.

HEDIS ® Quality Measures

The OHCA's Quality Assurance department began compiling the data in 2010. The services were contracted out to Pacific Health Policy Group (PHPG) in 2013. PHPG recalculated the 2013 rates and changed the methodology, which meant that some of the rates may not be comparable to previous years' rates. The table below indicates HEDIS ® year measures using the new methodology. (Attachment 12)

HEDIS® Measures 2013-2016	HEDIS® 2013	HEDIS® 2014	HEDIS® 2015	HEDIS® 2016
Annual Dental Visit				
Aged 2-3 years	40.4%	39.5%	Not Available	Not Available

HEDIS® Measures 2013-2016	HEDIS® 2013	HEDIS® 2014	HEDIS® 2015	HEDIS® 2016
Aged 4-6 years	65.7%	63.4%	Not Available	Not Available
Aged 7-10 years	70.9%	68.8%	Not Available	Not Available
Aged 11-14 years	68.7%	66.9%	Not Available	Not Available
Aged 15-18 years	62.0%	59.9%	Not Available	Not Available
Aged 19-21 years	40.6%	38.2%	Not Available	Not Available
Children and Adolescents' Access to PCP				
Aged 25 months – 6 years	90.2%	89.0%	89.6%	89.8%
Aged 7-11 years	92.2%	90.9%	91.8%	92.1%
Aged 12-19 years	92.8%	92.7%	92.9%	92.8%
Adults' Access to Preventive/Ambulatory Health				
Aged 20-44 years	83.4%	82.4%	81.0%	80.3%
Aged 45-64 years	89.8%	89.9%	90.1%	90.0%
Aged 65+ years	83.5%	78.2%	77.4%	77.5%
Well-Child Visits				
Aged <15 months 6+ visits	59.65%	55.8%	68.5%	68.1%
Aged 3-6 years 1+ visits	57.60%	58.5%	57.1%	56.7%
Appropriate Medications for the Treatment of Asthma				
Aged 5-11 years	91.5%	89.7%	90.2%	90.3%
Aged 12-18 years	86.4%	82.6%	82.5%	82.3%
Aged 19-50 years	63.2%	61.7%	61.9%	62.0%
Aged 51-64 years	67.3%	62.5%	61.8%	62.0%
Comprehensive Diabetes Care (Aged 8-75 years)				
Hemoglobin A1C Testing	71.56%	71.9%	72.1%	72.2%

HEDIS® Measures 2013-2016	HEDIS® 2013	HEDIS® 2014	HEDIS® 2015	HEDIS® 2016
Eye Exam (Retinal)	32.00%	26.3%	27.3%	27.6%
LDL-C Screen	63.08%	63.4%	63.9%	64.2%
Medical Attention for Nephropathy	58.71%	53.4%	52.4%	52.5%
Screening Rates				
Lead Screening in Children (by 2 years of age)	48.24%	47.6%	Not Available	Not Available
Appropriate Treatment for Children with URI (aged 3 months to 18 years)	73.08%	72.5%	Not Available	Not Available
Appropriate Testing for Children with Pharyngitis (aged 2 to 18 years)	53.21%	51.6%	Not Available	Not Available
Breast Cancer Screening (aged 42-74 years)	36.51%	36.5%	38.5%	39.0%
Chlamydia Screening in Women (CHL) (aged 16-24 years)	49.3%	48.0%	56.8%	57.2%
Cervical Cancer Screening (aged 21-64 years)	46.0%	47.5%	37.7%	41.2%
Cholesterol Management for Patients with Cardiovascular Conditions (aged 18-75)	49.9%	45.2%	Not Available	Not Available

Program Integrity

In accordance with the Improper Payments Information Act of 2002, federal agencies review Medicaid and CHIP programs for improper payments every three years, this is known as the Payment Error Rate Measurement (PERM) program. The consistent application of eligibility rules also has enabled Oklahoma to achieve one of the lowest processing error rates in the nation. Under the federal PERM initiative, states must audit the accuracy of their eligibility processes every three years. In 2015, the most recent audit, Oklahoma's error rate was 3.82 percent versus the national average of 5.70 percent. To continue ensuring proper payments, the OHCA annually conducts a payment accuracy review. This review is similar to the PERM initiative review.

V. BUDGET NEUTRALITY

Compliance with Budget Neutrality Cap

As of December 2016, the State has $2.82 billion savings over the life of the Demonstration. Actuarial analysis of the Demonstration projections indicate that the State will maintain compliance with the budget neutrality cap through 2021. It is projected that the state will have $3.64 billion in savings by the end of 2021. To review the Budget Neutrality in its entirety, refer to Attachments one and two.

Standard CMS Financial Management Questions

1. Section 1903(a)(1) provides that federal matching funds are only available for expenditures made by states for services under the approved State Plan.
    a. Do providers receive and retain the total Medicaid expenditures claimed by the State(includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local government entity or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or Percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e. general fund, medical services account, etc.)

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

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of care and services available under the plan.
    a. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded.

    Answer: The non-federal share (NFS) of the medical home care coordination payments and HAN payments are funded by appropriations from the legislature to the Medicaid Agency. The NFS for Insure Oklahoma is funded by tobacco tax. The NFS payments to academic medical centers are funded through Intergovernmental Transfers (IGTs) from appropriations from the legislature.

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

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

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

    Answer: Funds are appropriated to University of Oklahoma (OU) and Oklahoma State University (OSU) Medical Schools, Physician Manpower Training Commission for the

Graduate Medical Education (GME) payments and the Tobacco Settlement Endowment Trust

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

Type	Total	NFS
Care Coordination fees	$29,227,899	$11,632,704
HAN Payments[4]	$3,000,000	$1,194,000
GME Payments	$106,969,897	$42,574,019
Insure Oklahoma	$85,617,321	$34,075,694

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

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

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

Answer: Not applicable.

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

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

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

iii. The total amounts transferred or certified by each entity:
Answer: $42,574,019

iv. Clarify whether the certifying or transferring entity has general taxing authority:
Answer: No general taxing authority

v. Whether the certifying or transferring entity receives appropriations (identify level of appropriations):
Answer: Yes, they receive appropriations.

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy and quality of care. Section 1903(a)(1) provides for federal financial participation to states for

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

expenditures for services under an approved State Plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

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

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

   Answer: The upper payment limit demonstration is not applicable.

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

Answer: No

VI. DEMONSTRATION EVALUATION

Demonstration Evaluation Introduction

This portion of the application has three sections. The Program Evaluation portion provides current reports related to SoonerCare Choice, the Health Management Program, and statewide insurance and access. A summary of the 2015-2016 evaluation findings is also included. CMS has allowed this to be used for the remaining 2017 -2018 demonstration years. The Hypotheses proposed for 2019 - 2021 are requested to remain the same at this time until approval of this demonstration. Further review of the evaluation design will occur and a draft evaluation design will be submitted 120days upon CMS waiver approval.

Program Evaluation

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

Access Monitoring Review Plan 2016

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

report, the State addresses access to care by measuring the following enrollee needs, the ability of care and providers; and the utilization of services.

Access:

- Per the OHCA Annual Report, in 2015, the OHCA provided coverage to approximately 1.02 million unduplicated enrolled beneficiaries, or 26 percent of the state's citizens.
- Provider contracts, provider networks and beneficiary access to primary care services remain stable in spite of the significant rate decreases of July 2014 and January 2016.

Quality:

- The outcomes of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey indicate satisfaction with services from children and adults of SoonerCare.
- Oklahoma measures and monitors indicators of healthcare access to ensure that its Medicaid beneficiaries have access to care that is comparable to the general population.
- In accordance with 42 CFR 447.203, the Oklahoma Health Care Authority developed an access review monitoring plan for the defined service categories provided under a Fee-for-Service arrangement.

Cost Effectiveness:

- Per the OHCA Annual Report, total expenditures for the SoonerCare program in State Fiscal Year 2015 were approximately $5.1 billion.
- SoonerCare is the largest payer of health care services in terms of covered lives in the state.

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

Health Management Program Evaluation

The OHCA's evaluator for the HMP program, the Pacific Health Policy Group (PHPG), collaborated with Telligen to conduct the SoonerCare HMP's annual evaluation for SFY 2015. During SFY 2014, the OHCA and Telligen executed a contract amendment to modify and expand operations starting in SFY 2015. The amendment included three components: intervention quality enhancement; chronic pain and opioid drug utilization initiative and staff increase. OHCA received the final SFY 2015 report in July 2016. Results were noted in the 2018 waiver extension. The OHCA anticipates it will receive the next HMP evaluation report July 2017.

Evaluation Findings from the 2016 - 2017 Hypotheses

Hypotheses	Do the outcomes of the 2016 Demonstration confirm the hypotheses?
1A. Child Health checkup rates for children 0 to15 months old will be maintained at or above 95 percent over the life of the extension period.	Yes
1B. Child Health checkup rates for children 3 through 6 years old will increase by one percentage point over the life of the extension period.	No. The OHCA will continue to track this data associated with this hypothesis over the extension period.
1C. Adolescent child health checkup rates will maintain over the life of the extension period.	Yes
2. The rate of adult members who have one or more preventative health visits with a primary care provider in a year will improve by one percentage point as a measure of access to primary care in accordance with HEDIS guidelines between 2015-2016.	Yes. SoonerCare Choice adults ages 45-64 met the measure. Although, SoonerCare Choice adults ages 20 – 44 did not met the measure. The OHCA will continue to track the data associated with the 20-44 age group over the extension period.
3. The number of SoonerCare primary care practitioners enrolled as medical home PCPs will maintain at or above the baseline data between 2015-2016.	Yes
4. There will be adequate PCP capacity to meet the health care needs of the SoonerCare members between 2015 - 2016. Also, as perceived by the member, the time it takes to schedule an appointment should improve between 2015 - 2016. The available capacity will equal or exceed the baseline capacity data over the duration of the waiver extension period.	Yes
5. There will be adequate PCP capacity to meet the health care needs of the SoonerCare members with Children's Health Insurance Program (CHIP) eligibility between 2015 - 2016. Also, as perceived by the member, the time it takes to schedule an appointment should improve between 2015 - 2016. As perceived by the member, the time it takes for the member to schedule an appointment should exceed the baseline data between 2015 - 2016.	Yes

Hypotheses	Do the outcomes of the 2016 Demonstration confirm the hypotheses?
6. The percentage of American Indian members who are enrolled with an Indian Health Services, Tribal, or Urban Indian Clinic (I/T/U) with a SoonerCare Choice American Indian primary care case management contract will improve during the 2015 - 2016 waiver period.	No – The OHCA has not yet met this measure. The OHCA will continue to track this data associated with this hypothesis over the extension period.
7A. Key quality performance measures, asthma and Emergency Room (ER) utilization, tracked for PCPs participating in the HANs will improve between 2015-2016. Decrease asthma related ER visits for HAN members with an Asthma diagnosis identified in the medical record.	Yes
7B. Key quality performance measures, asthma and Emergency Room (ER) utilization, tracked for PCPs participating in the HANs will improve between 2015-2016. Decrease 90-day readmissions for related asthma conditions for HAN members with an Asthma diagnosis identified in their medical record.	Yes
7C. Key quality performance measures, asthma and Emergency Room (ER) utilization, tracked for PCPs participating in the HANs will improve between 2015-2016. Decrease overall ER use for HAN members.	Yes
8. Average per member per month expenditures for members belonging to a HAN affiliated PCP will continue to be less than those members enrolled with non-Han affiliated PCPs during the period of 2015-2016.	Yes
9a. The implementation of phase two of the SoonerCare HMP, including introduction of physician office-based Health Coaches for nurse care managed members and closer alignment of nurse care management and practice facilitation will maintain enrollment and active participation in the program.	Yes
9b. The incorporation of Health Coaches	Yes

Hypotheses	Do the outcomes of the 2016 Demonstration confirm the hypotheses?
into primary care practices will result in increased PCP contact with nurse care managed members for preventive/ambulatory care.	
9c. The implementation of phase two of the SoonerCare HMP, including introduction of physician office-based Health Coaches for nurse care managed members and closer alignment of nurse care management and practice facilitation will improve the process for identifying qualified members and result in an increase in average complexity of need within the nurse care managed population.	Yes
9d. Health Coaches will improve quality measures for members who are engaged.	Yes
9e. Nurse care managed members will utilize the emergency room at a lower rate than forecasted without nurse care management intervention.	Yes
9f. Nurse care managed members will have fewer hospital admissions than forecasted without nurse care management intervention.	Yes
9g. Nurse care managed members will report high levels of satisfaction with their care.	Yes
9h. Total and PMPM expenditures for members enrolled in HMP will be lower than would have occurred absent their participation in nurse care management.	Yes

The OHCA reports the most current data and analysis for the SoonerCare Choice program's hypotheses. The data for hypotheses one and two are taken from the Quality of Care in the Sooner Care Program report – Reporting Year 2016 Measurement year 2015. The hypotheses for 9b- 9h, are taken from SoonerCare Health Management Program Evaluation SFY 2015.

Hypothesis 1- Child Health Checkup Rates: This hypothesis directly relates to SoonerCare Choice waiver objective #1 and #2 of CMS's Three Part Aim.
The rate age-appropriate well-child and adolescent visits will improve between 2015-2016.

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

extension period.

Well-Child Adolescent	Baseline HEDIS ® 2014 SCY2013	Baseline HEDIS ® 2015 SCY2014	Baseline HEDIS ® 2016 SCY2015
0-15months	96.3%	94.3%	96.4%
3-6 years	58.5%	57.1%	56.7%
12-21 years	21.8%	22.1%	22.4%

Hypothesis 1A Results:
This hypothesis specifies that checkup rates for children 0 to 15 months will be maintained at or above 95 percent over the course of the extension period.

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

Hypothesis 1B Results:
In accordance with the hypothesis, the checkup rates for children ages 3 to 6 years will increase by one percentage point over the extension period 2015-2016.

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

Hypothesis 1C Results:
The evaluation measure hypothesizes that the checkup rate for adolescents' ages 12 to 21 years will maintain over the life of the extension period.
Adolescent ages 12 to 21 years of age saw a slight increase in health checkup rates for HEDIS® year 2016. There was a .3 percent increase in health checkup rates from HEDIS® year 2014 to HEDIS® year 2015. For HEDIS® year 2015 to HEDIS® 2016 there was an increase of .3 percent in health checkups for this population.

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.

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

Hypothesis 2 Results:
This hypothesis suggests that adults' rate of access to primary care providers will improve by one percentage point as a measure of access to primary care in accordance with HEDIS® guidelines between 2015-2016.

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

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

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

Number of SoonerCare Choice PCPs	Baseline Dec - 13	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
	2,067	2,663	2,588	2,613	2,637	2,659	2,661	2,701	2,738	2,759	2,655	2,681	2,689

Hypothesis 3 Results:

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

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

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

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

Hypothesis 3b Results:

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

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

There will be adequate PCP capacity to meet the health care needs of the SoonerCare members between 2015-2016. Also, as perceived by the member, the time it takes to schedule an appointment should improve between 2015-2016. The available capacity will equal or exceed the baseline capacity data over the duration of the waiver extension period.

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

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

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

Hypothesis 5 - PCP Availability: This hypothesis directly relates to SoonerCare Choice waiver objectives #1, #2 and #1 of CMS's Three Part Aim.

There will be adequate PCP capacity to meet the health care needs of the SoonerCare members with Children's Health Insurance Program (CHIP) eligibility between2015 - 2016. Also, as perceived by the member, the time it takes to schedule an appointment should improve between 2015 - 2016. As perceived by the member, the time it takes for the member to schedule an appointment should exceed the baseline data between 2015 - 2016.

CAHPS® Adult Survey Results	Baseline Data: 2013 CAHPS® Survey Response	2014 CAHPS® Survey Response	2015 CAHPS® Survey Response	2016 CAHPS® Survey Response
Positive Responses from The Survey Question: *"In the last 6 months, how often did you get an appointment for a check- up or routine care at a doctor's office or clinic as soon as you needed?"*	80% Responded "Usually" or "Always"	82% Responded "Usually" or "Always"	87% Responded "Usually" or "Always	82% Responded "Usually" or "Always

CAHPS® Child Survey Results	Baseline Data: 2013 CAHPS® Survey Respon	2014 CAHPS® Survey Response	2015 CAHPS® Survey Response	2016 CAHPS® Survey Response
Positive Responses from the Survey Question: *"In the last 6 months, when you made an appointment for a check-up or routine care for your child at a doctor's office or clinic, how often did you get an appointment as soon as your child needed?"*	90% Responded "Usually" or "Always"	91% Responded "Usually" or "Always"	93% Responded "Usually" or "Always"	92% Responded "Usually" or "Always"

Hypothesis 5 Results:

This hypothesis theorizes that the member's response to the time it takes to schedule an appointment should exceed the baseline data. The OHCA's contracted External Quality Review Organization (EQRO) Morpace, conducted the Consumer Assessment of Healthcare Providers & Systems (CAHPS®) survey for the period 2016. Results from the CAHPS® survey indicate that the majority of survey respondents for both the Adult and Child surveys had satisfactory responses for scheduling an appointment as soon as needed. In review of the adult respondents, 82 percent felt satisfied in the time it took to schedule an appointment with their PCP, while 92 percent of child survey respondents

indicated they were "Usually" or "Always" satisfied. More than 800 combined adult and child survey respondents had a positive response about the time it takes to get an appointment with their PCP; the OHCA saw an increase in the number of positive responses in SFY16 for both the adult and children composite responses compared to the baseline data. The OHCA believes that the survey responses will continue to improve throughout the 2017 extension period.

Hypothesis 6 - Integration of Indian Health Services, Tribal Clinics, and Urban Indian Clinic Providers: This hypothesis directly relates to SoonerCare Choice waiver objective #4 and #1 of CMS's Three Part Aim:

The percentage of American Indian members who are enrolled with an Indian Health Services, Tribal, or Urban Indian Clinic (I/T/U) with a SoonerCare Choice American Indian primary care case management contract will improve during the 2015 - 2016 waiver period.

	Baseline Dec 2013	16-Jan	16-Feb	16-Mar	16-Apr	16-May	16-Jun	16-Jul	16-Aug	16-Sep	16-Oct	16-Nov	16-Dec
Total AI/AN Members with SC Choice and I/T/U PCP	94,142	81,240	82,544	82,935	82,273	82,721	84,465	87,237	87,512	88,750	88,737	90,001	90,232
AI/AN Members with I/T/U PCP	21,165	12,702	13,016	12,767	12,501	12,464	12,725	14,406	12,969	13,293	13,590	13,856	13,885
Percent of AI/AN Members with I/T/U PCP	22.48%	15.64%	15.77%	15.39%	15.19%	15.07%	15.07%	16.51%	14.82%	14.98%	15.31%	15.40%	15.39%
Percent of American Indian members in SC Choice	77.52%	84.36%	84.23%	84.61%	84.81%	84.93%	84.93%	83.49%	85.18%	85.02%	84.69%	84.60%	84.61%
I/T/U Capacity	99,400	96,999	96,999	96,466	99,499	99,499	99,499	99,499	99,499	99,499	99,499	99,499	99,499

Hypothesis 6 Results:
This hypothesis postulates that the percentage of American Indian members who are enrolled with an I/T/U with a SoonerCare American Indian primary care case management contract will improve during the extension period. The proportion of

American Indian members with an I/T/U PCP has decreased 7.09 percentage points when comparing December 2013 to December 2016. At this time, the OHCA expects the percentage of IHS members who are enrolled with an I/T/U PCP will continue to be maintained throughout the extension period. The OHCA has not yet met the measure; the OHCA will continue to track the data associated with this hypothesis over the extension period to monitor for significant changes in rates for these eligibility groups.

Hypothesis 7 – Impact of Health Access Networks on Quality of Care: This hypothesis directly relates to the SoonerCare Choice waiver objective #3 and #2 of CMS' Three Part Aim:

Key quality performance measures, asthma and Emergency Room (ER) utilization, tracked for PCPs participating in the HANs will improve between 2015–2016.

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

Hypothesis 7 Results:

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

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

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

A. 2016 Asthma Related ER Visits	HAN members with an Asthma diagnosis in their medical record	All HAN members with ER visit in a calendar year	Percent of HAN members with an Asthma diagnosis who visited the ER
OU Sooner HAN	4,987	59,643	8%
PHCC HAN	42	2,679	2%
OSU Network HAN	412	6,767	6%

Hypothesis 7B Results: The HANs are on track in decreasing 90-day re-admissions for HAN members with asthma. In comparing 2015 to 2016 each network had a decrease. The OU Sooner HAN had a 3 percent decrease and the PHCC HAN had a 22 percent decrease. Although the OSU HAN Network had limited opportunity to intervene with certain newly enrolled PCPs and members in 2016, resulting in a three percent increase in readmissions in comparison to 2015, the Network is confident it will see fewer asthma readmissions in 2017.

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

B. 2016 90-Day Re-admissions for HAN members with Asthma	HAN members with Asthma who were Re-admitted to the Hospital 90-days after previous asthma-related hospitalization	HAN members with Asthma identified in their medical record and having at least one inpatient stay related to Asthma	Percent of HAN members with Asthma who had a 90-Day re-admission for Asthma related Condition(s)
OU Sooner HAN	17	268	6%
PHCC HAN	0	2	0%
OSU Network HAN	5	80	6%

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

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

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

Hypothesis 8 - Impact of Health Access Networks on Effectiveness of Care: This hypothesis directly relates to SoonerCare Choice waiver objective #3 and #3 of CMS's Three Part Aim. Reducing costs associated with the provision of health care services to SoonerCare beneficiaries served by the HANs.

Reducing costs associated with the provision of health care services to SoonerCare beneficiaries served by the HANs. Average per member per month expenditures for members belonging to a HAN affiliated PCP will continue to be less than those members enrolled with non-HAN affiliated PCPs during the period of 2015-2016.

Hypothesis 8 Results:

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

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

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

Hypothesis 9a - Health Management Program (HMP) Impact on Enrollment Figures: This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #3 and #1 of CMS's Three Part Aim.

The implementation of Phase two of the SoonerCare HMP, including introduction of physician office-based Health Coaches for nurse care managed members and closer alignment of nurse care management and practice facilitation, the HMP has maintained enrollment and active participation in the program.

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

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

SoonerCare Choice Members in an active HMP practice	
Jan-16	75,258
Feb-16	70,689
Mar-16	70,228
Apr-16	75,066
May-16	74,168
Jun-16	75,816
Jul-16	72,417
Aug-16	71,757
Sep-16	71,058
Oct-16	79,129
Nov-16	81,923

SoonerCare Choice Members in an active HMP practice	
Dec-16	80,985

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

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

The incorporation of Health Coaches into primary care practices will result in increased PCP contact with nurse care managed members for preventive/ambulatory care.

Hypothesis 9b Results:
The HMP measures access to care for health coaching participants and members aligned with a practice facilitation provider through the following three clinical measures:

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

The compliance rate is the percentage of participants engaged in health coaching or members aligned with a practice facilitation provider that meets the measure criteria. The comparison group is the general SoonerCare population.

Measures for Members Engaged in Health Coaching	SFY2014		SFY2015	
	Percent Compliant	Comparison Group - Compliance Rate	Percent Compliant	Comparison Group Compliance Rate
1. Adult Access to Preventive/Ambulatory Care	96.30%	84.70%	96.10%	84.10%
2. Child Access to PCP	98.40%	91.20%	98.70%	91.70%
3. Adult BMI	14.30%	N/A	14.20%	10.70%

In SFY 2014, the comparison group for the percentage of members 20 years and older that had an ambulatory or preventive care visit during the measurement year had an 84.7 percent compliance rate and the Health Coach Participants group had a 96.3 percent compliance rate. The compliance rate for the health coaching population exceeded the comparison group rate on the two measures having a comparison group percentage. The difference was statistically significant in both cases.

In SFY 15, the comparison group for the percentage of members 20 years and older that had an ambulatory or preventive care visit during the measurement year had an 84.1 percent compliance rate and the Health Coach Participants group had a 96.1 percent compliance rate. The compliance rate for the health coaching population exceeded the comparison group rate on all there measures. The difference was statistically significant for all three.

The same three measures are utilized to determine access to care for members aligned with a practice facilitation provider.

Measures for Members Aligned with a Practice Facilitation Provider	SFY2014		SFY2015	
	Percent Compliant	Comparison Group - Compliance Rate	Percent Compliant	Comparison Group Compliance Rate
1. Adult Access to Preventive/Ambulatory Care	96.50%	84.70%	96.60%	84.10%
2. Child Access to PCP	98.90%	91.20%	99.10%	91.70%
3. Adult BMI	9.20%	N/A	9.00%	10.70%

In SFY 2014, the comparison group for the percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year had an 84.7 percent compliance rate and the Health Coach Participants group had a 96.5 percent compliance rate.
The compliance rate for the members aligned with a practice facilitation provider exceeded the comparison group rate on the two measures having a comparison group percentage. The difference was statistically significant in both cases.

In SFY 15, the comparison group for the percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year had an 84.1 percent compliance

rate and the members aligned with a practice facilitation provider had a 96.6 percent compliance rate. The compliance rate for the members aligned with a practice facilitation provider exceeded the comparison group rate on two of the three measures and the difference was statistically significant in both cases.

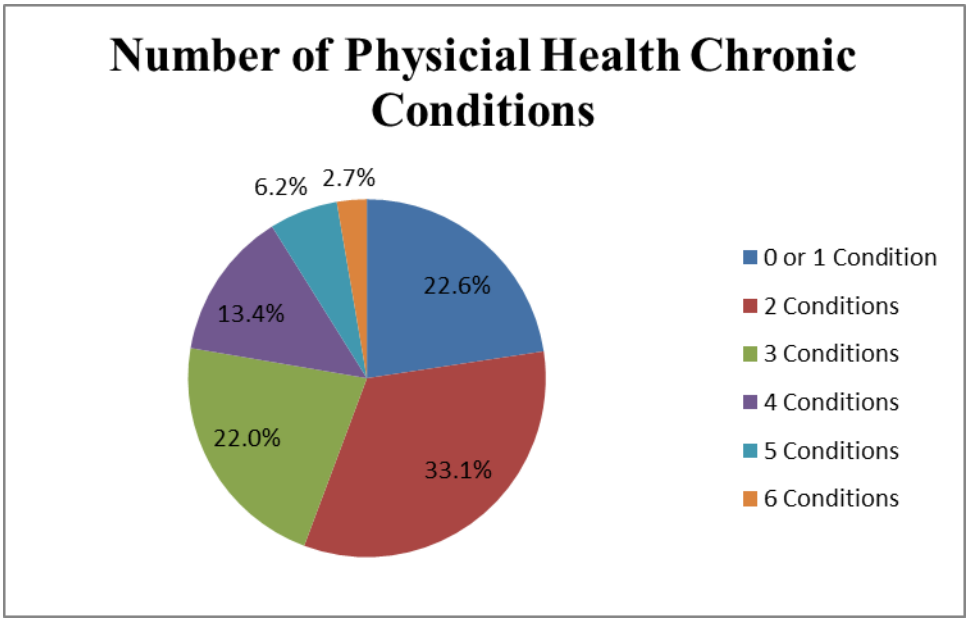
The above findings suggest that the health coaching and practice facilitation are both having a positive impact on access to care.

Hypothesis 9c - Health Management Program (HMP); Impact on Identifying Appropriate Target Population: This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #2, and #2 of CMS's Three Part Aim.

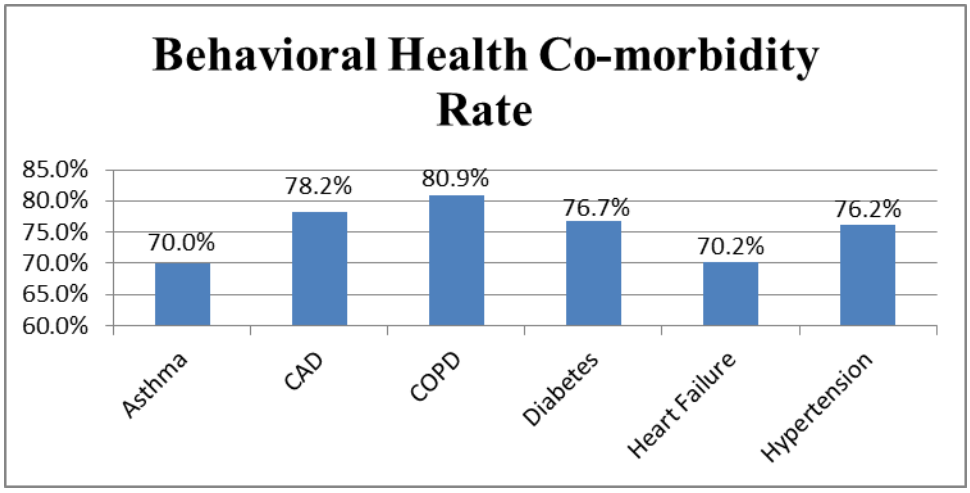
The implementation of phase two of the SoonerCare HMP, including introduction of physician office-based Health Coaches for nurse care managed members and closer alignment of nurse care management and practice facilitation will improve the process for identifying qualified members and result in an increase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

Hypothesis 9c Results:

The SoonerCare HMPs' focus on holistic care rather than management of a single disease is appropriate given the prevalence of co-morbidities in the participating population. Independent research conducted by Pacific Health Policy Group (PHPG) examined the number of physical chronic conditions per participant and found that nearly 80 percent in SFY 2015 had at least two of the six high priority chronic physical conditions (asthma, COPD, coronary artery disease, diabetes, heart failure and hypertension) as demonstrated in the chart below. The SFY 2015 distribution was very similar to the distribution in SFY 2014.



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



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

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

Hypothesis 9d Results:

In SFY 2015 the health coaching participant compliance rate exceeded the comparison group rate on 12 of 17 measures for which there was a comparison group percentage (70.6 percent). The difference was statistically significant for 10 of the 12 measures (83.3 percent).

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

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

HMP Health Coaching Members' Compliance Rates	SFY 2014	SFY 2015
	Percent Compliant	Percent Compliant
Asthma	**SFY2014**	**SFY 2015**
Use of Appropriate Medications for People with Asthma	95.3%	93.5%
Medication Management for People with Asthma - 50 Percent	68.3%	68.2%
Medication Management for People with Asthma - 75 Percent	26.8%	27.3%
Cardiovascular Disease	**SFY2014**	**SFY 2015**
Persistence of Beta Blocker Treatment after Heart Attack	50.0%	46.2%
LDL-C Screening	76.0%	76.8%
COPD	**SFY2014**	**SFY 2015**
Use of Spirometry Testing in the Assessment/Diagnosis of COPD	31.5%	31.8%
Pharmacotherapy Management of COPD Exacerbation-14 days	49.5%	50.4%
Pharmacotherapy Management of COPD Exacerbation-30 days	73.9%	76.5%
Diabetes	**SFY2014**	**SFY 2015**
LDL-C Screening	77.0%	78.3%
Retinal Eye Exam	37.8%	38.1%
HbA1c Test	86.7%	87.2%
Medical Attention for Nephropathy	77.1%	77.0%
ACE/ARB Therapy	66.8%	66.5%
Hypertension	**SFY2014**	**SFY 2015**
LDL-C Screening	67.3%	67.8%
ACE/ARB Therapy	66.5%	65.8%
Diuretics	45.1%	44.9%
Annual Monitoring for Patients Prescribed ACE/ARB or Diuretics	84.2%	83.7%
Mental Health	**SFY2014**	**SFY 2015**
Follow-up after Hospitalization for Mental Illness – Seven Days	34.8%	34.3%
Follow-up after Hospitalization for Mental Illness – 30 Days	67.4%	67.2%
Prevention	**SFY2014**	**SFY 2015**
Adult Access to Preventive/Ambulatory Care	96.3%	96.1%
Child Access to PCP	98.4%	98.7%
Adult BMI	14.3%	14.2%

The practice facilitation participant compliance rate exceeded the comparison group rate on eight of 17 measures for which there was a comparison group percentage (47.1 percent). The difference was statistically significant for five of the eight measures (62.5 percent). Conversely, the comparison group achieved a higher rate on nine of the 17 measures (52.9 percent), including five for which the difference was statistically significant (55.6 percent). The practice facilitation participant compliance rate improved on 14 of 22 measures (63.6 percent) from SFY 2014 to SFY 2015, although typically by small amounts. Eight of 22 measures (36.4 percent) experienced a slight decline from SFY 2014 to SFY 2015. The most impressive results, relative to the comparison group, were observed for participants with diabetes and mental illness, and with respect to access to preventive care.

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

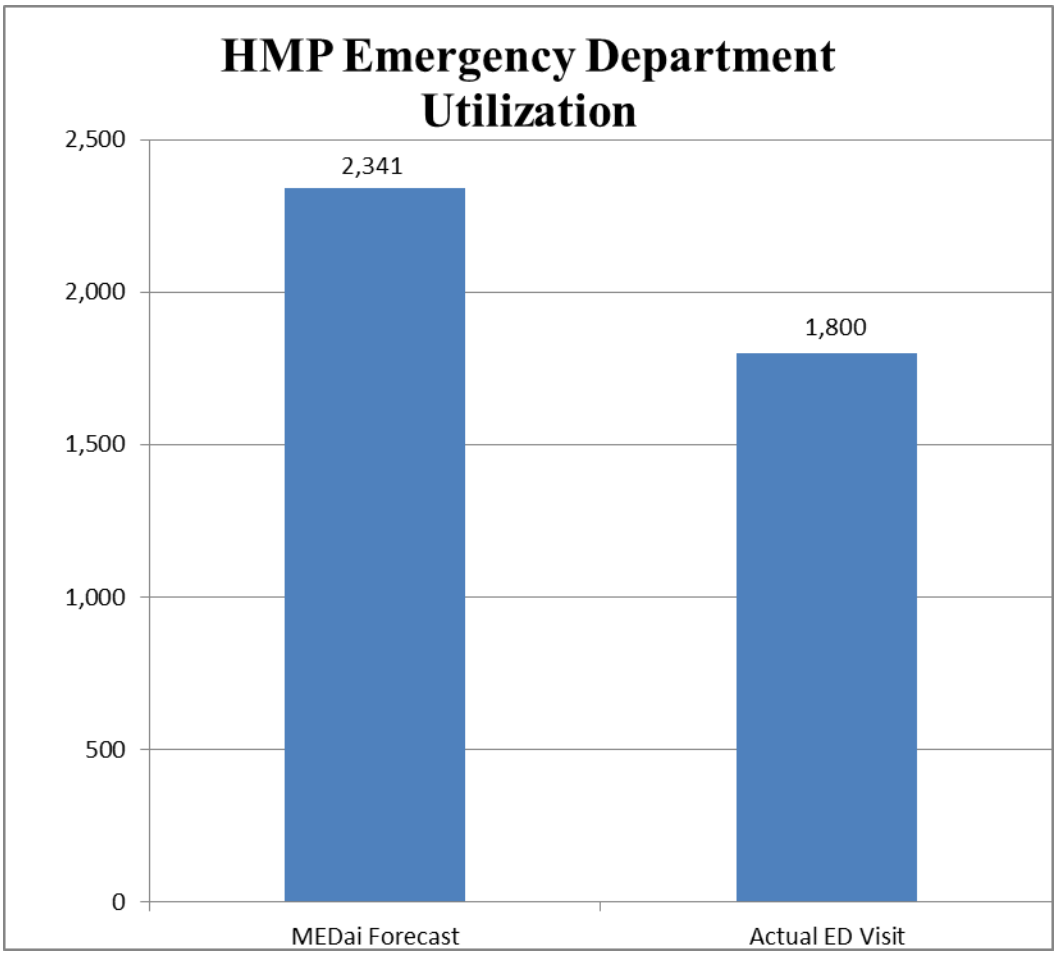
Hypothesis 9e – Health Management Program (HMP); Impact on Cost/Utilization of Care: This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #1, and #2 of CMS's Three Part Aim.

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

Hypothesis 9e Results:

Health coaching, if effective, should have an observable impact on participant service utilization and expenditures. Practice facilitation, like health coaching, should demonstrate its effectiveness through an observable impact on member service utilization and expenditures. Improvement in quality of care should yield better outcomes in the form of fewer emergency department visits and hospitalizations, and lower acute care costs. Most potential SoonerCare HMP participants are identified based on MEDai data, which includes a 12-month forecast of emergency department visits, hospitalizations and total expenditures. MEDai's advanced predictive modeling, as opposed to extrapolating historical trends, accounts for participants' risk factors and recent clinical experience. The resulting forecasts serve as an accurate depiction of what participant utilization would have been like in the absence of health coaching. They serve as benchmarks against which each member's actual utilization and expenditures, post HMP enrollment, can be compared.

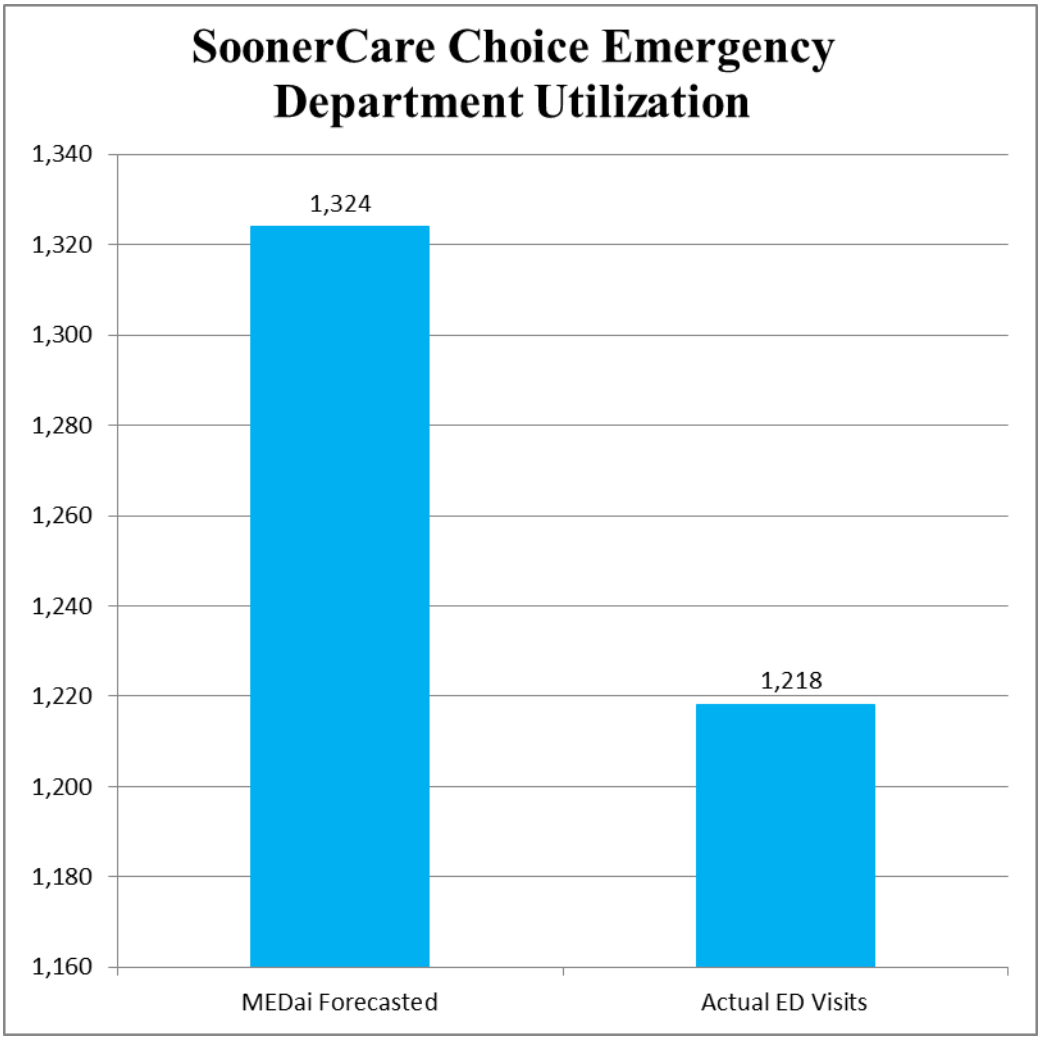
In SFY 2015 MEDai forecasted that HMP health coaching participants as a group would incur 2,341 emergency department visits per 1,000 participants in the first 12 months of engagement. The actual rate was 1,800 or 77 percent of forecast.



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

PHPG conducted the practice facilitation utilization and expenditure evaluation by comparing the actual claims experience of members aligned with Patient Centered Medical Home (PCMH) practice facilitation providers to MEDai forecasts. To be included in the analysis, members had to have been aligned with a PCMH provider who underwent practice facilitation. They also had to have been seen by a PCMH provider at least once following their own PCMH provider's initiation into practice facilitation. Members participating in the health coaching portion of the SoonerCare HMP were excluded from the analysis. This was done to avoid double counting the impact of the program.

In SFY 2015, MEDai projected members aligned with a practice facilitation provider in total would incur 1,324 emergency department visits per 1,000 over the 12-month forecast period. The actual rate was 1,218, or 92 percent of forecast.



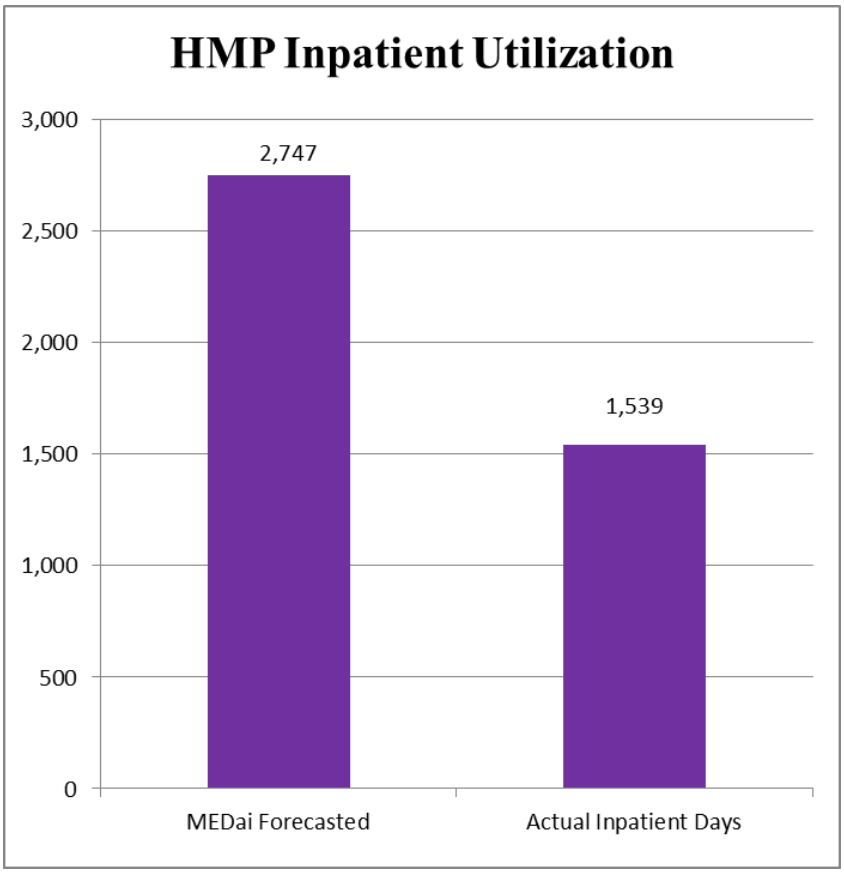
Hypothesis 9f – Health Management Program (HMP); Impact on Cost/Utilization of Care: This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #1 and #2 of CMS's Three Part Aim. Nurse care managed members will have fewer hospital admissions than forecasted without nurse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

Hypothesis 9f Results:

Health coaching, if effective, should have an observable impact on participant service utilization and expenditures. Improvement in quality of care should yield better outcomes in the form of fewer emergency department visits and hospitalizations, and lower acute care costs. Most potential SoonerCare HMP participants are identified based on MEDai data, which includes a 12-month forecast of emergency department visits, hospitalizations and total expenditures. MEDai's advanced predictive modeling, as opposed to extrapolating historical trends, account for participants' risk factors and recent clinical experience. The resulting forecasts serve as an accurate depiction of what participant utilization would have been like in the absence of health coaching. They serve as benchmarks against which each member's actual utilization and expenditures, post HMP enrollment,

can be compared.

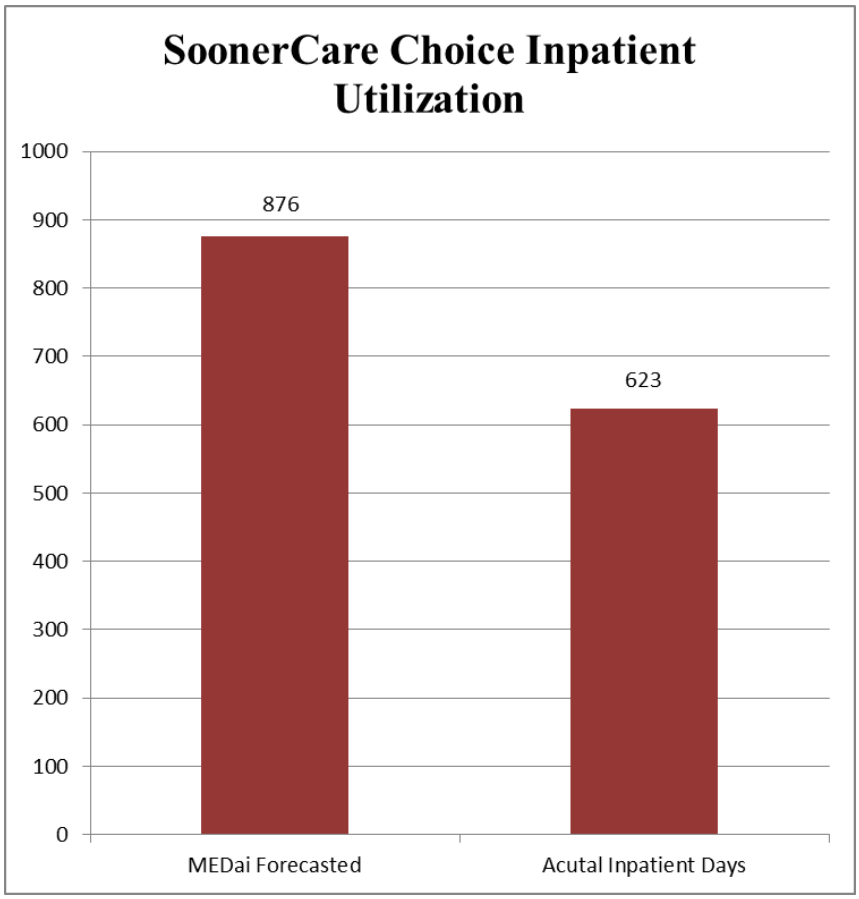
In SFY 2015, MEDai forecasted that SoonerCare HMP participants as a group would incur 2,747 inpatient days per 1,000 participants in the first 12 months of engagement. The actual rate was 1,539, or 56 percent of forecast.



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

PHPG conducted the practice facilitation utilization and expenditure evaluation by comparing the actual claims experience of members aligned with Patient Centered Medical Home (PCMH) practice facilitation providers to MEDai forecasts. To be included in the analysis, members had to have been aligned with a PCMH provider who underwent practice facilitation. They also had to have been seen by a PCMH provider at least once following their own PCMH provider's initiation into practice facilitation. Members participating in the health coaching portion of the SoonerCare HMP were excluded from the analysis. This was done to avoid double counting the impact of the program.

In SFY 2015, MEDai projected members aligned with a practice facilitation provider in total would incur 876 inpatient days per 1,000 over the 12-month forecast period. The actual rate was 623, or 71 percent of forecast.



The OHCA will continue to monitor the program for the impact of reducing medical cost of the population served.

Hypothesis 9g - Health Management Program (HMP); Impact on Satisfaction /Experience with Care: This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #3, and #2 of CMS's Three Part Aim.

Nurse care managed members will report higher levels of satisfaction with their care.

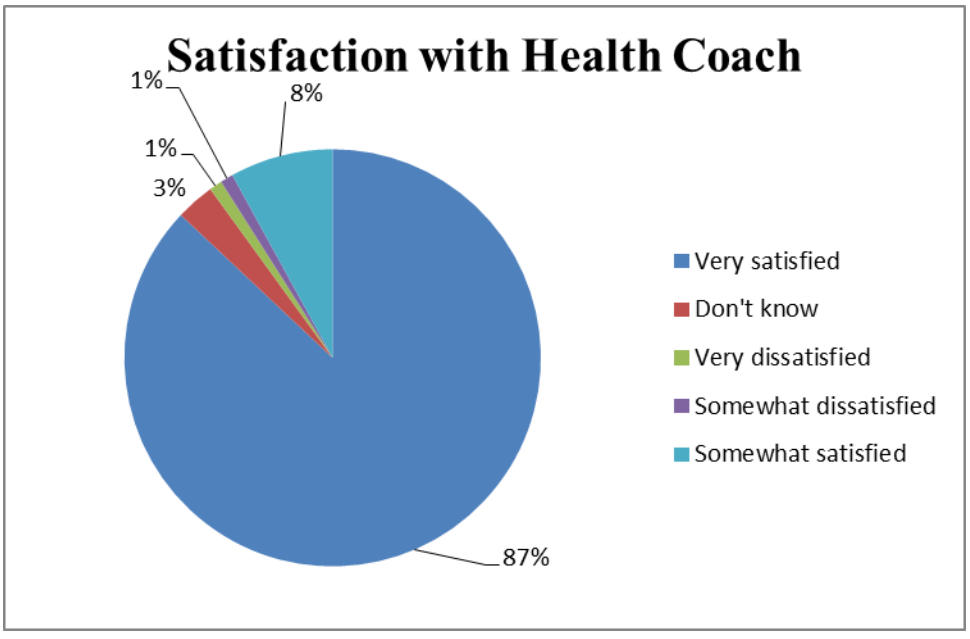
Hypothesis 9g Results:
Member satisfaction is a key component of SoonerCare HMP performance. If members are satisfied with their experience and value its worth, they are likely to remain engaged and focused on improving their self-management skills and adopting a healthier lifestyle.

Conversely, if members do not see a lasting value to the experience, they are likely to lose interest and lack the necessary motivation to follow coaching recommendations.

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

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

Respondents were asked to rate their satisfaction with each "yes" activity. The overwhelming majority reported being very satisfied with the help they received, with the portion ranging from 91 to 94 percent, depending on the item. This attitude carried over to the members' overall satisfaction with their health coaches; 87 percent reported being very satisfied. Results for the follow-up survey were closely aligned to the initial survey.
Survey respondents reported very high levels of satisfaction with the SoonerCare HMP overall, consistent with their opinion of the health coach, who serves as their point of contact with the program. Eighty-seven percent of initial survey respondents and 90 percent of follow-up survey respondents stated they were very satisfied. Nearly all respondents (93 percent of initial survey and 97 percent of follow-up survey) said they would recommend the program to a friend with health care needs like theirs.



The OHCA will continue to track and trend this hypothesis over the extension period to monitor for significant changes in results.

Hypothesis 9h - Health Management Program (HMP); Impact of HMP on Effectiveness of Care: This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #1, and #3 of CMS's Three Part Aim.

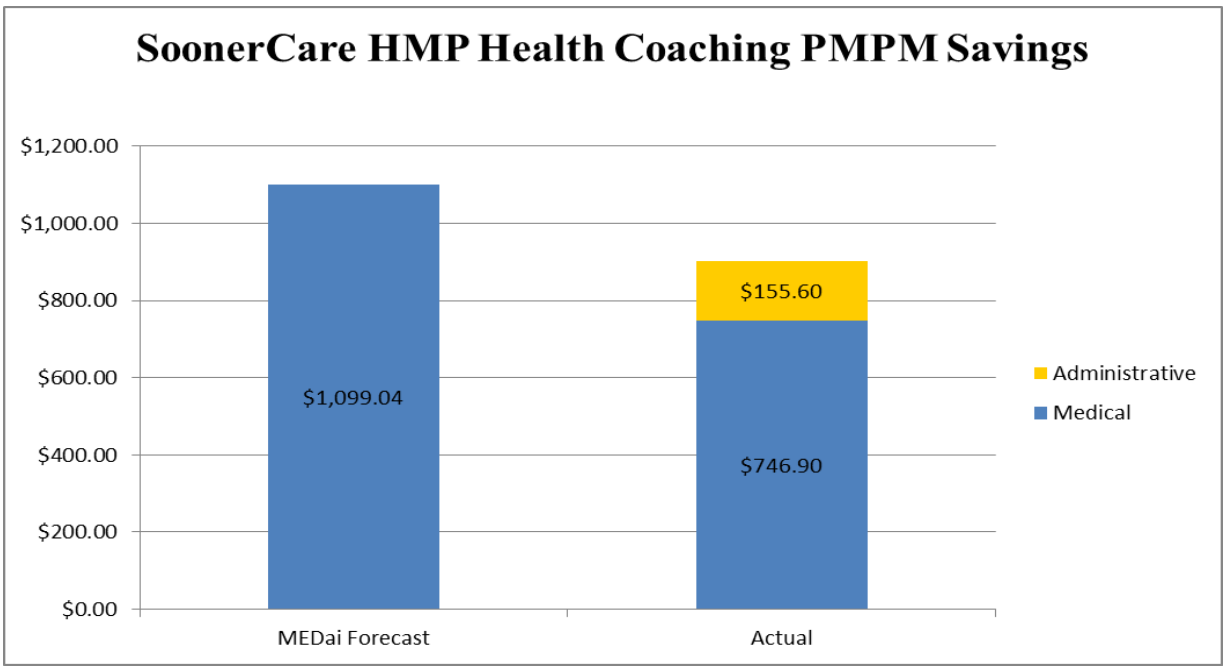
Total and PMPM expenditures for members enrolled in HMP will be lower than would have occurred absent their participation in nurse care management.

Hypothesis 9h Results:
The value of the SoonerCare HMP is measurable on multiple axes, including participant satisfaction and change in behavior, quality of care, improvement in service utilization and overall impact on medical expenditures. The last criterion is arguably the most important, as progress in other areas ultimately result in medical expenditures remaining below the level that would have occurred absent the program.

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

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

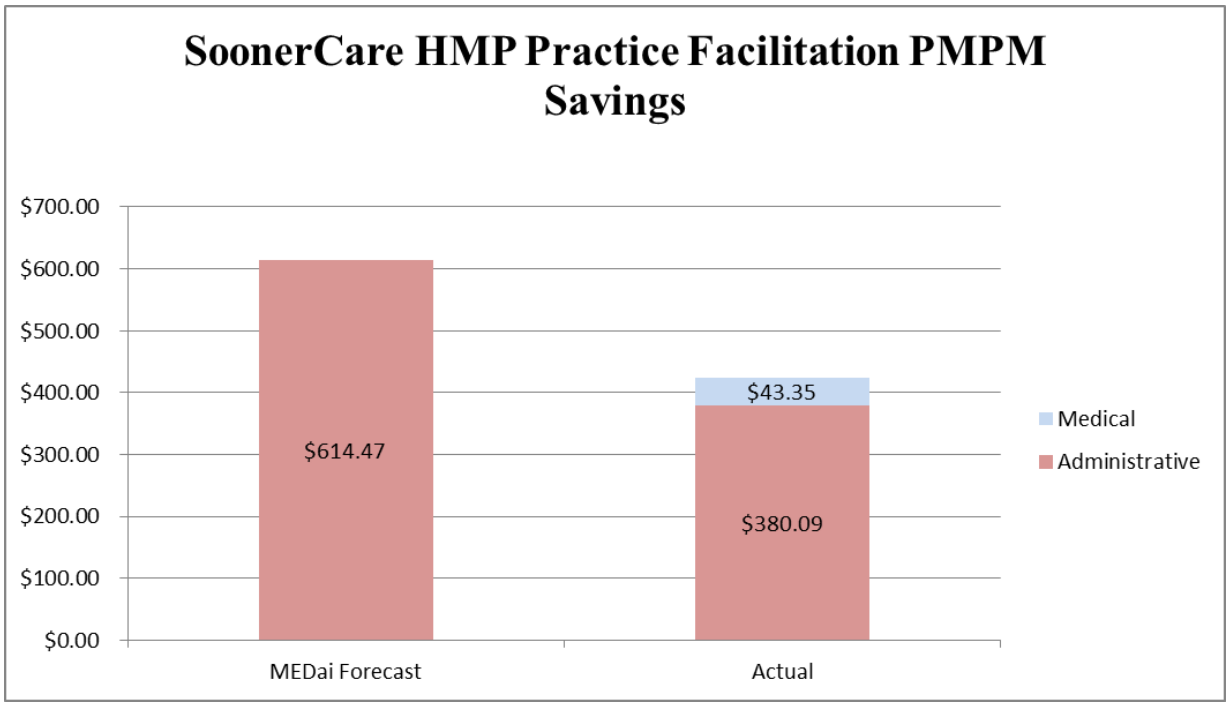
The SoonerCare HMP health coaching participants as a group were forecasted to incur average medical costs of $1,099.04. Their actual average PMPM medical costs were $746.90. With the addition of $155.60 in average PMPM administrative expenses, total actual costs were $902.50. Medical expenses accounted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



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

PHPG performed a cost effectiveness test by comparing forecasted costs to actual costs during SFY2014 and SFY2015, inclusive of SoonerCare HMP practice facilitation administrative expenses.

SoonerCare HMP members aligned with a practice facilitation provider and included in the expenditure analysis were forecasted to incur average medical costs of $614.47. Their actual average PMPM medical costs were $380.09. With the addition of $43.35 in average PMPM administrative expenses, total actual costs were $423.44. Medical expenses accounted for 90 percent of the total and administrative expenses for the other 10 percent. Overall, net SoonerCare HMP practice facilitation-related PMPM expenses were 61.9 percent of forecast.



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

Proposed 2019 - 2021 SoonerCare Choice and Insure Oklahoma Hypotheses

The OHCA is requesting that these remain the same as the 2016 - 2018 approved hypotheses submitted at this time with the noted adjustments. The state understands it will have 120 days after the award of the demonstration to submit a draft evaluation plan and identify any changes and updates at that time.

Hypothesis 1 – Child Health Checkup Rates.

The rate for age-appropriate well-child and adolescent visits will be maintained between the extension period of 2019 - 2021.

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 be maintained as a measure of access to primary care in accordance with HEDIS® guidelines between 2019 - 2021.

Hypothesis 3 – PCP Enrollments.

The number of SoonerCare primary care practitioners enrolled as medical home PCPs will be maintained at or above the baseline data between 2019 - 2021.

Hypothesis 3b: PCP Enrollments Insure Oklahoma.

The number of Insure Oklahoma practitioners enrolled as PCPs will be maintained at or above the baseline data between 2 0 1 9 - 2021

Hypothesis 4 – PCP Capacity Available.

There will be adequate PCP capacity to meet the health care needs of SoonerCare members between 2019 - 2021.

Hypothesis 5 – PCP Availability.

There will be adequate PCP availability to meet the health care needs of the SoonerCare members with Children's Health Insurance Program (CHIP) eligibility between 2019 - 2021. Also, as perceived by the member, the time it takes to schedule an appointment will be maintained between 2019 - 2021. As perceived by the member, the time it takes for the member to schedule an appointment will be maintained as compared to the baseline data between 2019 - 2021.

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

The percent of American Indian/Alaskan Native 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 be maintained during the 2019 - 2021 waiver period.

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

Key quality performance measures, asthma and Emergency Room (ER) utilization, tracked for PCPs participating in the HANs will improve between 2019 - 2021.

Hypothesis 8 – Impact of Health Access Networks on Effectiveness of Care.

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 2019 - 2021.

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

Health outcomes for chronic diseases will improve between 2019 - 2021 as a result of participation in the HMP. Total expenditures for members enrolled in HMP will decrease.

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

(b) The incorporation of Health Coaches into primary care practices will result in increased PCP

contact with nurse care managed members for preventive/ambulatory care.

(c) The implementation of phase two of the SoonerCare HMP, including introduction of physician office- based Health Coaches for nurse care managed members and closer alignment of nurse care management and practice facilitation will improve the process for identifying qualified members and result in an increase in average complexity of need within the nurse care managed population.
(d) Health Coaches will improve quality measures for members who are engaged.
(e) Nurse care managed members will utilize the emergency room at a lower rate than forecasted without nurse care management intervention
(f) Nurse care managed members will have fewer hospital admissions than forecasted without nurse care management intervention.
(g) Nurse care managed members will report high levels of satisfaction with their care.
(h) Total and PMPM expenditures for members enrolled in HMP will be lower than would have occurred absent their participation in nurse care management

VII. PUBLIC NOTICE PROCESS

Post Award Forum

In accordance with STC #17, the OHCA scheduled the Post Award Forum for September 21, 2017, for the 2017 extension period in order to afford the public an opportunity to provide meaningful comment on the progress of the demonstration. There were no oral or written comments from this meeting. The presentation for the post award and public meetings can be found in attachment 6 and 6a

Public Meetings

In accordance with 42 CFR Section 431.408, the OHCA held two public meetings. Notification of the public notice can be found in attachment seven.

On July 11, 2017, the first public meeting located at the University Health Science Center, was held at The Children's Health Group (TCHG) meeting. Several comments were received and a response was provided for each of the commenters.

On September 21, 2017, the state conducted it second public meeting at the Oklahoma Health Care Authority during the Medical Advisory Committee (MAC) Meeting in Oklahoma City, OK. There were no comments from this meeting.

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.

The OHCA made use of the methods listed below to inform the public of the State's intent to renew the Demonstration, inform of its post award forum and to solicit feedback from the public. All dates reflected are 2017. Please reference the comments list Attachment eight.

July 6 • **Newspaper notification:** To announce meeting location(s) and intent to request an extension in the newspapers of widest circulation in each city with a population of 100,000, or more persons. (Attachment nine)

July 10 • **OHCA Banners:** Place a banner and renewal request document on the OHCA public site for a public comment period to run through September 22, 2017. (Attachment 10 and 10a)

July 11 • **1st Public meeting Child Health Workgroup:** Regarding renewal request for the 2019 – 2021 demonstration waiver and any modification. (Attachment 11)

July 11 • **Tribal Consultation:** Regarding renewal request for the 2019 – 2021 demonstration waiver and any modification. (Attachment 13)

September 21 • **2nd Public meeting Medical Advisory Meeting (MAC):** Regarding renewal request for the 2019 – 2021 demonstration waiver and any modification. Post Award Forum for public comment on progress of demonstration. (Attachment 6a)

September 30 • The OHCA Comment Period ends: Regarding renewal request for the 2019– 2021 demonstration waiver and any modification.

November 1 • Receive Cover Letter from Governor's Office for Renewal. (Attachment 14)

December 29 • Submit Renewal Application to CMS.

APPENDICES

Appendix A: 2019 - 2021 SoonerCare Choice and Insure Oklahoma Eligibility Chart

Mandatory State Plan Groups	FPL and/or Other Qualifying Criteria	Applicable Waivers and CNOMs (Waiver List summary)	Demonstration Population (STC# 57)
Pregnant women and infants under age 1 1902(a)(10)(A)(i)(IV)	Up to and including 133% FPL	Freedom of Choice, Retroactive Eligibility	Populations 1,2,3,4
Children 1-5 1902(a)(10)(A)(i)(VI)	Up to and including 133% FPL	As Above	Populations 1,2,3,4

Mandatory State Plan Groups	FPL and/or Other Qualifying Criteria	Applicable Waivers and CNOMs (Waiver List summary)	Demonstration Population (STC# 57)
Children 6-18 1902(a)(10)(A)(i)(VII)	Up to and including 133%	As Above	Populations 1,2,3,4
IV-E Foster Care or Adoption Assistance Children	Automatic Medicaid 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~~ 1916(b)members	SSI for unearned income and earned income limit is the 1916(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 state is claiming title XXI funding	As Above	Population 9
Children 1-5 through CHIP Medicaid expansion	Above 133% - 185% FPL and for whom the state is claiming title XXI funding	As Above	Population 9

Mandatory State Plan Groups	FPL and/or Other Qualifying Criteria	Applicable Waivers and CNOMs (Waiver List summary)	Demonstration Population (STC# 57)
Children 6-18 through CHIP Medicaid expansion	Above 133% - 185% FPL and for whom the state is claiming title XXI funding	As Above	Populations 9
Non-IV-E foster care children under age 21 in State or Tribal custody	AFDC limits as of 7/16/1996	As above	Populations 1,2,3,4
Aged, Blind and Disabled	From SSI up to and including 100% FPL	Freedom of Choice	Populations 1,2,3,4
Eligible but not receiving cash assistance	Up to SSI limit	Freedom of Choice	Populations 1,2,3,4
Individuals receiving only optional State supplements	100% SSI FBR + $41 (SSP)	Freedom of Choice	Populations 1,2,3,4
Breast and Cervical Cancer Prevention and Treatment	Up to and including 185% FPL	Freedom of Choice, Counting Income and Comparability of Eligibility	Populations 1,2,3,4
TEFRA Children (under 19 years of age) without creditable health care insurance coverage	Must be disabled according to SSA definition, with gross personal income at or below 200% FPL, and for whom the state is claiming title XXI funding.	Freedom of Choice, Counting Income and Comparability of Eligibility	Population 7

Demonstration Expansion Groups	**FPL and/or Other Qualifying Criteria**	**Applicable Waivers and CNOMs (See Waiver List Summary)**	**Demonstration Population (See Paragraph 57)**
Non-Disabled Low Income Workers and Spouse (ages 19-64) (Employer Sponsored Plan)	Up to and including 200% FPL, who work for an eligible employer with 200 or fewer employees. Spouses who do not work are also eligible to enroll on their working spouse's coverage.	Comparability, Cost Sharing Requirements, Freedom of Choice	Population 5
Working Disabled Adults (ages 19-64) (Employer Sponsored Plan)	Up to and including 200% FPL, who are ineligible for Medicaid due to employment earnings and who otherwise, except for earned income, would be eligible to receive Supplemental Security Income (SSI) benefits. No limit on employer size.	As Above	Population 6
Full-time College Students (ages 19-22) (Employer Sponsored Plan)	Full time college students with FPL not to exceed 200% (limited to 3,000 participants), who have no creditable health insurance coverage, work for a qualifying employer.	As Above	Population 8
Foster Parents (ages 19-64) (Employer Sponsored Plan)	Up to and including 200% FPL, who work full-time or part-time for an eligible employer. Spouses who do not work are also eligible to enroll on their working spouse's coverage. No limit on employer size.	As Above	Population 10

Demonstration Expansion Groups	**FPL and/or Other Qualifying Criteria**	**Applicable Waivers and CNOMs (See Waiver List Summary)**	**Demonstration Population (See Paragraph 57)**
Qualified Employees of Not-for-profit Businesses (ages 19-64) (Employer Sponsored Plan)	Up to and including 200% FPL, who work for an eligible employer with access to an ESI with 500 or fewer employees. Spouses who do not work are also eligible to enroll on their working spouse's coverage.	As Above	Population 11
Non-Disabled Low Income Workers and Spouse (ages 19-64) (Individual Plan)	Effective through 12/31/13 individuals up to and including 200% FPL, who are self-employed, or unemployed. Spouses who do not work are also eligible to enroll on their spouse's coverage. Effective 1/1/14, this population will be covered to 100% of the FPL.	Retroactive Eligibility, Assurance of Transportation	Population 12
Working Disabled Adults (ages 19-64) (Individual Plan)	Effective through 12/31/13 individuals up to and including 200% FPL, who are ineligible for Medicaid due to employment earnings, and who otherwise, except for earned income, would be eligible to receive Supplemental Security Income (SSI) benefits. Effective 1/1/14, this population will be covered to 100% of the FPL.	As Above	Population 13

Demonstration Expansion Groups	**FPL and/or Other Qualifying Criteria**	**Applicable Waivers and CNOMs (See Waiver List Summary)**	**Demonstration Population (See Paragraph 57)**
Full-time College Students (ages 19-22) (Individual Plan)	Effective through 12/31/13 full time college students with FPL not to exceed 200% (limited to 3,000 participants) and who do not have access to employer sponsored insurance or creditable insurance coverage. Effective 1/1/14, this population will be covered to 100% of the FPL.	As Above	Population 14
Foster Parents (ages 19-64) (Individual Plan)	Effective through 12/31/13 individuals up to and including 200% FPL, who work full-time or part-time. Spouses who do not work are also eligible to enroll on their working spouse's coverage. Effective 1/1/14, this population will be covered to 100% of the FPL.	As Above	Population 15
Qualified Employees of Not-for-profit Businesses (ages 19-64) (Individual Plan)	Effective through 12/31/13 individuals up to and including 200% FPL, who work for a not-for-profit with 500 or fewer employees. Spouses who do not work are also eligible to enroll on their working spouse's coverage. Effective 1/1/14, this population will be covered to 100% of FPL.	As Above	Population 16

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

Demonstration Expansion Groups	Authority	FPL and/or Other Qualifying Criteria
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.
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[5], 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[5] program and transitions managed care enrollees to the SoonerCare Choice primary care case management model statewide.
January 1, 2004	CMS approved extending the program from January 1, 2004 through December 31, 2006.
January 2005	CMS approved the Breast and Cervical Cancer population for SoonerCare Choice.
September 30, 2005	CMS approved adding coverage for TEFRA children.
December 21, 2006	CMS approved extending the program from January 1, 2007 through December 31, 2009.
January 3, 2009	a) CMS approved changing the service delivery model from a Prepaid Ambulatory Health Plan (PAHP) to an exclusive Primary Care Case Management (PCCM) model. The patient-centered medical home was implemented. b) CMS approved expanding the description of qualified PCPs to permit County Health Departments to serve as medical homes for members who choose those providers. c) CMS approved the option for the voluntary enrollment of children in State or Tribal custody in the Demonstration.

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

Appendix B: A Historical Timeline of the SoonerCare Choice Program	
	d) CMS approved the SoonerExcel incentive payment program for PCPs to build upon the EPSDT and fourth DTaP Bonus program. e) CMS approved adding $1 copay for non-pregnant adults in SoonerCare.
December 30, 2009	a) CMS approved extending the program from January 1, 2010 to December 31, 2012. b) CMS approved the Health Access Network (HAN) pilot program.
December 31, 2012	a) CMS approved extending the program from January 1, 2013 to December 31, 2015. b) CMS approved removal of the waiver authority that allowed the State to exclude parental income in determining eligibility for children with disabilities who are qualified for the TEFRA category because the State has this authority under the State Plan. c) CMS approved the Health Management Program, as reflected in Section VII to rename nurse care managers as health coaches and to increase face-to-face care management by embedding health coaches within physician practices with the highest concentration of members with chronic illnesses.
July 23, 2013	CMS approved the early adoption of the Systems Simplification Implementation.
September 6, 2013	a) CMS approved adding the mandatory Title XXI Targeted Low-Income Child eligibility group for children ages 0-18. b) CMS approved adding to the SoonerCare Eligibility Exclusions list individuals in the Former Foster Care group and pregnant women with incomes between 134 percent and 185 percent FPL. c) CMS approved referencing the calculation of Modified Adjusted Gross Income (MAGI) for determination of SoonerCare eligibility.
August 13, 2014	CMS approved removal of individuals with other creditable health insurance coverage from the SoonerCare Choice demonstration. Other technical changes were made to clarify language in the STCs.
July 9, 2015	CMS approved extending the program from January 1, 2016 to December 31, 2016.
January 2016	The SoonerCare Pain Management program was implemented.
June 29, 2016	Leon Bragg, DDS, Chief Dental Officer for the OHCA was recognized by Delta Dental of Oklahoma for his service as President of the Medicaid Medicare Children's Health Insurance Program (CHIP) Services Dental Association (MSDA).
July 11, 2016	Text4Baby (T4b) enrolled its 1 millionth participant the largest mobile health initiative in the nation.
August 22, 2016	Dr. Mike Herndon named Chief Medical Officer of the Oklahoma Health Care Authority.
August 29, 2016	Nico Gomez announced he was stepping down as Chief Executive Officer of the Oklahoma Health Care Authority. His last day was September 30, 2016.
September 9, 2016	State Medicaid Director Becky Pasternik-Ikard accepted position of Chief Executive Officer of the Oklahoma Health Care Authority.
November 30, 2016	The Oklahoma Office of Management and Enterprise Services (OMES) released the RFP for SoonerHealth+, The fully capitated, statewide model of care coordinated that is being developed for Oklahoma Medicaid's ABD population.

Appendix B: A Historical Timeline of the SoonerCare Choice Program	
	CMS approved extending the program from January 1, 2017 to December 31, 2017.
December 12, 2016	The Oklahoma Health Care Authority (OHCA) comes in at number ten of Workplace Dynamic's "Top Workplaces," a list of the best places to work in Oklahoma. The OHCA was included, for the second year in a row.
May 25, 2017	The chairman of the Oklahoma Health Care Authority board, Charles 'Ed' McFall, has been named Rural Health Advocate of the Year by the Rural Health Association of Oklahoma.
June 17, 2017	The Oklahoma Health Care Authority cancelled the Request for Proposal (RFP) for SoonerHealth+, the fully capitated, statewide model of care coordination for Oklahoma Medicaid's aged, blind and disabled (ABD) population.

Appendix B: A Historical Timeline of the Insure Oklahoma Program	
August 2001	President Bush approved the Health Insurance Flexibility and Accountability waiver policy.
April 20, 2004	State legislators pass Senate Bill 1546 authorizing OHCA to develop an assistance program for employees of small businesses (25 or fewer) and individuals to purchase state-sponsored health plans under the state Medicaid program.
September 30, 2005	CMS approved OHCA's Health Insurance Flexibility and Accountability waiver amendment providing insurance coverage to adults employed by small employers and working disabled adults. Originally named the Oklahoma Employers/Employees Partnership for Insurance Coverage (O-EPIC), the program was included in the 1115(a) SoonerCare Choice Research and Demonstration waiver.
December 21, 2006	CMS approved increasing the Insure Oklahoma ESI employer size to 50 or fewer employees.
February 21, 2007	Oklahoma Senate passes Senate bill 424, the All Kids Act.
March 1, 2007	CMS approved the Insure Oklahoma IP program, which was created to serve those individuals who did not have access to ESI coverage.
January 3, 2009	a) CMS approved increasing the Insure Oklahoma ESI employer size to 250 or fewer employees. b) CMS approved the Insure Oklahoma eligibility group of full-time college students ages 19 to 22 up to 200 percent of the FPL,
	with a cap of 3,000 members. c) CMS approved amending cost sharing requirements for the Insure Oklahoma program.
June 22, 2009	CMS approved the Title XXI stand-alone CHIP State Plan amendment for children in the Insure Oklahoma program with incomes from 186 percent to 300 percent FPL.
December 30, 2009	a) CMS approved to expand eligibility under the Insure Oklahoma program for non- disabled working adults and their spouses, disabled wording adults and full-time college students, from 200 percent FPL up to and including 250 percent FPL. b) CMS approved the Insure Oklahoma eligibility group of foster parents up to 250 percent of the FPL. c) CMS approved the Insure Oklahoma eligibility group of employees

Appendix B: A Historical Timeline of the Insure Oklahoma Program	
	of not-for-profit businesses having fewer than 500 employees, up to and including 250 percent of the FPL.
August 1, 2011	CMS approved elimination of the $10 copay for the initial prenatal visit under the Insure Oklahoma Individual Plan program.
December 31, 2012	a) CMS reduced the financial eligibility under the Insure Oklahoma program for all populations from up to and including 250 percent FPL to up to and including 200 percent FPL. While OHCA continues to have authority up to 250 percent FPL, this programmatic change indicates the current FPL utilization. b) CMS approved limiting the adult outpatient behavioral health benefit in the Insure Oklahoma Individual Plan program by limiting the number of visits to 48 per year consistent with the limitation for behavioral health visits for children. This benefit is limited to individual licensed behavioral health professionals (LBHPs).
September 6, 2013	a) CMS approved eligibility under the Insure Oklahoma program for populations qualified for the Individual Plan from up to and including 200 percent FPL to be reduced to up to and including 100 percent FPL. New demonstration populations were separately defined for the Individual Plan coverage populations. The new demonstration populations were added to the Expenditure Authorities and the Demonstration Expansion Groups in the eligibility chart. CMS approved extending the ESI and IP programs through December 31, 2014. b) CMS approved deleting the Individual Plan benefits and cost-sharing charts from the Special Terms and Conditions in order to add language to reference the State changing the benefits and cost sharing for the Insure Oklahoma Individual Plan in order to align with federal regulations.
June 27, 2014	CMS approved extending the Insure Oklahoma program through December 31, 2015.
July 9, 2015	CMS approved extending the program from January 1, 2016 to December 31, 2016.
March 2016	Insure Oklahoma completed its online enrollment systems project
March 4, 2016	The Oklahoma Health Care Authority submitted an amendment to the 1115 demonstration waiver known as Insure Oklahoma Program known as Sponsor's Choice.
November 30, 2016	CMS approved extending the program from January 1, 2017 to December 31, 2017.

Appendix C: Insure Oklahoma Monitoring

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

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

Quarter	ESI Monthly Average	IP Average Cost PMPM
Jan-Mar 2008	$228.74	$283.97
Apr-Jun 2008	$229.21	$273.04
Jul-Sep 2008	$234.35	$290.24
Oct-Dec 2008	$236.91	$328.70
Jan-Mar 2009	$240.07	$278.30
Apr-Jun 2009	$244.32	$311.81
Jul-Sep 2009	$246.23	$321.29
Oct-Dec 2009	$249.63	$339.70
Jan-Mar 2010	$254.34	$313.84
Apr-Jun 2010	$257.48	$309.93
Jul-Sep 2010	$260.57	$325.33
Oct-Dec 2010	$270.44	$313.32
Jan-Mar 2011	$273.20	$318.01
Apr-June 2011	$277.39	$336.42
Jul-Sep 2011	$280.06	$337.36
Oct-Dec 2011	$281.78	$352.93
Jan-Mar 2012	$285.85	$325.56
Apr-Jun 2012	$286.12	$357.86
Jul-Sep 2012	$285.55	$338.17
Oct-Dec 2012	$288.47	$331.11
Jan-Mar 2013	$287.29	$346.71
Apr-Jun 2013	$289.40	$336.85
Jul-Sep 2013	$293.11	$364.26
Oct-Dec 2013	$298.93	$408.05
Jan-Mar 2014	$299.71	$621.16
Apr-Jun 2014	$292.21	$480.66
Jul-Sep 2014	$295.84	$443.06
Oct-Dec 2014	$297.94	$450.62
Jan-Mar 2015	$302.81	$419.92
Apr-Jun 2015	$307.08	$460.93
Jul-Sep 2015	$311.68	$473.49
Oct-Dec 2015	$313.51	$438.17
Jan-Mar 2016	$325.46	$549.72
Apr-Jun 2016	Unavailable	$422.25
Jul-Sep 2016	$340.52	$418.84
Oct-Dec 2016	$336.26	$373.43
Jan-Mar 2017	$357.16	$393.49

ESI Average PMPM Total Cost for 2016: $344.08 (OHCA separates the employee, spouse, student and dependent categories). The OHCA was also missing data for the second quarter (April – June) for this calendar year. ESI PMPM 2017 three month average $357.16

IP Average PMPM Total Cost for 2016: $ 441.06 IP PMPM 2017 three month averages: $393.49

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

Contributions by Employers Pre- and Post- Participation in ESI Total annual employer premiums pre-implementation: $13,636,335

Total annual amount paid by employers toward subsidized employees' premiums 2016: $14,650,644.10. For 2017 the total amount is for the first quarter of 2017 $4,323,321.23.

Total Costs PMPM for ESI and IP Members Including Reimbursements of Out-of-Pocket Expenses over Five Percent of Gross Income. The first quarter of 2017 will be represented in this chart due to timing of data available.

Year	Total Average Cost PMPM, ESI	Total Average Cost
2008	$234.82	$299.62
2009	$248.40	$317.69
2010	$265.57	$315.97
2011	$287.01	$336.76
2012	$294.16	$337.91
2013	$302.91	$363.34
2014	$305.26	$501.55
2015	$318.53	$447.69
2016	$346.05	$419.60
2017 (three month average)	$366.49	$393.25

This table includes total cost of out of pocket expenses of all eligible member and employer expenses prior to meeting their 5 percent threshold. The numbers in this table were reconfigured due to a refinement in methodology in 2016. The first quarter of 2017 will be represented in this chart due to timing of data available.

Year	Total Employer Contribution
2008	$6,371,915.40
2009	$11,303,340.57
2010	$15,092,287.60
2011	$15,749,806.23
2012	$14,900,847.59
2013	$14,051,782.26
2014	$12,251,882.15
2015	$13,248,870,.04
2016	$14,650,644.10
2017 (three months of reporting)	$4,323,321.23

ESI Health Plan Monitoring

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

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

Year	Survey	Time Period of Data Collected	EQRO
2016	2016 Child CAHPS® Medicaid Survey 5.0H	February 2015 to June 2016	Telligen / Morpace
2016	2016 Adult CAHPS® Medicaid Survey 5.0H	February 2015 to June 2016	Telligen / Morpace
2017	2017 Child CAHPS® Medicaid Survey 5.0H	February 2016 to June 2017	Telligen / Morpace
2017	2017Adult CAHPS® Medicaid Survey 5.0H	Data will not be available until 2018	

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

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

CAHPS® Child Survey (CHIP) Key Measure	2014 Summary Rate	2015 Summary Rate	2016 Summary Rate	2017 Summary Rate
Getting Needed Care	89%	85%	89%	81%
Getting Care Quickly	92%	92%	93%	92%
How Well Doctors	97%	96%	97%	96%
Customer Service	88%	86%	86%	91%
Shared Decision Making	Not Applicable	78%	78%	80%
Rating of Health Care	85%	87%	88%	84%
Rating of Personal Doctor	88%	89%	89%	88%
Rating of Specialist	89%	88%	83%	81%
Rating of Health Plan	86%	87%	86%	87%

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

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

For comprehensive CAHPS® survey results, please visit Studies and Evaluations under the Member Satisfaction Surveys of the OHCA Data and Reports website.