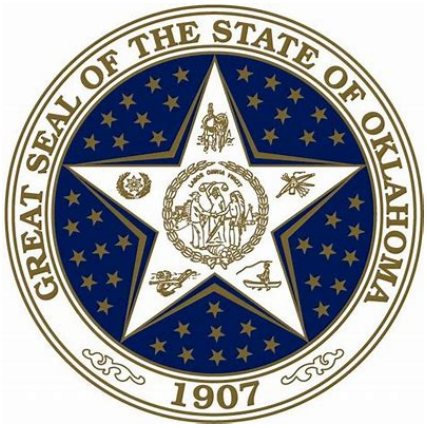
Oklahoma Health Care Authority



Evaluation Design for the SoonerCare §1115(a) Waiver Demonstration 11-W-00048/6

December 28, 2018

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A. GENERAL BACKGROUND INFORMATION

Medicaid is the largest health provider in the state of Oklahoma. In State Fiscal Year (SFY) 2018, the program provided coverage to over 860,000 Oklahomans, out of a total population of approximately four million (22 percent). In calendar year 2016 (the most recent year available), the program covered 30,490 births out of a statewide total of 52,607 (58 percent).

The Oklahoma Health Care Authority (OHCA), Oklahoma's Single-State Agency for Medicaid, administers SoonerCare, the State's Section 1115(a) Research and Demonstration waiver, which includes SoonerCare Choice managed care and Insure Oklahoma (11-W-00048/6). The Demonstration was originally approved to begin operations in January 1996. The OHCA received approval in August 2018 of its latest renewal application, for the period August 31, 2018 – December 31, 2023.

1. Demonstration Goal

The OHCA's overarching goal for the SoonerCare Choice program is to address the health care needs of Oklahomans through provision of high quality, accessible and cost-effective care.

In accordance with Section XV of the SoonerCare Special Terms and Conditions (STCs), the OHCA proposes this Evaluation Design for the August 31, 2018 – December 31, 2023 extension period. The design has been developed and is organized in accordance with CMS guidance, as outlined in STC Attachment A.

The OHCA will amend the Evaluation Design as waiver amendments are approved over the life of the demonstration, to ensure it continues to align with program policies and initiatives.

2. Description of the Demonstration

The SoonerCare Demonstration was implemented in 1996 to address concerns regarding access and quality of care in a fiscally prudent manner. In the period leading-up to the Demonstration, the State experienced an economic downturn and was forced to reduce benefits and provider reimbursement to meet its obligations under Title XIX.

The OHCA was established to oversee the program's transition to managed care and implement and administer the SoonerCare Demonstration. The program initially included children in mandatory state plan groups, pregnant women and 1931 low income families who were enrolled in managed care organizations (MCOs) in three metropolitan areas (Oklahoma City, Tulsa and Lawton) and a primary care case management (PCCM) model in the remainder of the State. In its original design, the PCCM model included a

partial capitation payment to cover primary care services and office-based laboratory and radiology services.

The Demonstration has evolved and expanded significantly over the years. The program's covered populations and major components are described below. They include the core SoonerCare Choice program, Insure Oklahoma, Health Access Networks and Health Management Program.

Covered Populations (Populations Impacted by the Demonstration)

The Demonstration today covers children in mandatory state plan groups, pregnant women and Aged, Blind and Disabled (ABD) members who are not dually-eligible and not receiving long term care, as well as 1931 low-income families and IV-E foster care or adoption assistance children, the latter with voluntary enrollment. In accordance with Oklahoma Senate Bill 741, the OHCA serves individuals in need of breast or cervical cancer treatment and children with disabilities in accordance with the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

In September 2018, SoonerCare Choice program enrollment stood at 533,775. (Total Medicaid enrollment was 862,259, including 299,200 SoonerCare Traditional members, such as dual eligibles and long-term care recipients, and 29,284 SoonerPlan family planning members.)

SoonerCare Choice (Core Program)

The Demonstration operates statewide under an enhanced PCCM model in which the OHCA contracts directly with primary care providers to serve as patient centered medical homes (PCMH) for SoonerCare Choice members. PCMH providers receive monthly care coordination payments for each member on their panels.

Payments vary depending on the PCMH provider's tier level and the mix of children and adults on the provider's panel. Providers also can qualify for performance incentive payments by meeting one or more OHCA-defined quality improvement targets. Aside from care coordination, all services furnished in the medical home and by other providers (specialists, hospitals etc.) are reimbursed fee-for-service.

Insure Oklahoma Premium Assistance Program

The OHCA operates the Insure Oklahoma premium assistance program under the authority of the SoonerCare waiver. Insure Oklahoma offers two ways for individuals to receive premium assistance: Employer Sponsored Insurance (ESI) and Individual Plan (IP) programs.

Individuals in ESI enroll in an Insure Oklahoma-participating private health plan and pay up to 15 percent of the premium. The remaining premium cost is shared between the individual's employer and the state and federal governments.

Individuals in the IP program, other than American Indians, are responsible for health plan premiums up to four percent of their monthly gross household income. In accordance with Oklahoma Administrative Code 317:45-9-4 and 317:45-11-24, American Indians providing documentation of tribal citizenship are exempt from premium payments.

In September 2018, Insure Oklahoma enrollment totaled 18,997. This included 13,711 ESI members and 5,285 IP members.

Health Access Networks

The OHCA has contracted with three Health Access Networks (HANs) under the Demonstration: University of Oklahoma (OU) Sooner HAN; Partnership for Healthy Central Communities (PHCC) HAN; and Oklahoma State University (OSU) HAN. Each HAN is a non-profit, administrative entity that works with affiliated providers to coordinate and improve the quality of care provided to SoonerCare Choice members. The HANs receive a nominal $5.00 per member per month (PMPM) payment.

The HANs offer care management and care coordination to SoonerCare Choice members with complex health care needs who are enrolled with affiliated PCMH providers. The HANs also work to establish new initiatives to address complex medical, social and behavioral health issues. For example, the HANs have implemented evidence-based protocols for care management of Aged, Blind and Disabled (ABD) members with, or at risk for, complex/chronic health conditions, as well as TANF and related members with asthma and diabetes, among other conditions. In calendar year 2017, OU Sooner HAN served approximately 176,000 members, OSU HAN served approximately 23,000 members and PHCC HAN served approximately 3,500 members.

Under prior Demonstration periods, the HANs operated as a pilot program with limited geographic coverage. STC 40, which addresses HAN operations, no longer classifies the HANs as a pilot and permits the HANs to expand statewide. (The OHCA will be requesting that CMS update the corresponding STC 84, which addresses evaluation of the HANs and still refers to the program as a pilot.)

Health Management Program

The SoonerCare Health Management Program (HMP) is a statewide initiative under the Demonstration developed to offer care management to SoonerCare Choice members most at-risk for chronic disease and other adverse health events. The program is administered by the OHCA and is managed by a vendor selected through a competitive procurement.

The SoonerCare HMP serves SoonerCare Choice beneficiaries ages four through 63 who have one or more chronic illnesses and are at high risk for adverse outcomes and increased health care expenditures. The program is holistic, rather than disease-specific, but prominent conditions of members in the program include asthma, cardiovascular disease, chronic obstructive pulmonary disorder, diabetes, heart failure and hypertension.

The program was implemented in 2008 and has evolved over time. During its first five years, individuals were stratified into two levels of care, with the highest-risk segment placed in "Tier 1" and the remainder in "Tier 2." Prospective participants were contacted and "enrolled" in their appropriate tier. After enrollment, participants were "engaged" through initiation of care management activities. Tier 1 participants received face-to-face nurse care management while Tier 2 participants received telephonic nurse care management. The OHCA sought to provide services at any given time to about 1,000 members in Tier 1 and about 4,000 members in Tier 2.

As the contractual period for the first generation SoonerCare HMP was nearing its end, the OHCA began the process of examining how the program could be enhanced for the benefit of both members and providers. The OHCA observed that a significant amount of the nurse care managers' time was being spent on outreach and scheduling activities, particularly for Tier 1 participants. The OHCA also observed that nurse care managers tended to work in isolation from primary care providers, although coordination did improve somewhat in the program's later years, as documented in provider survey results.

To enhance member identification and participation, as well as coordination with primary care providers, the OHCA elected to replace centralized nurse care management services with registered nurse health coaches embedded at primary care practice sites. The health coaches would work closely with practice staff and provide coaching services to participating members. Health coaches could either be dedicated to a single practice with one or more providers or shared between multiple practice sites within a geographic area. This change took effect with implementation of the second generation SoonerCare HMP in 2013.

In addition to health coaching, the SoonerCare HMP incorporates Practice Facilitation into each location with an embedded health coach. A practice facilitator nurse assesses the office's existing processes related to care of patients with chronic conditions. The practice facilitator then undertakes education and academic detailing appropriate to the office's needs before deployment of the health coach.

In 2014, the OHCA authorized its vendor to resume telephonic case management (health coaching) and, in limited cases, care coordination in members' homes. Telephonic health coaches would focus their efforts on engaging new members, actively pursuing members needing assistance with care transitions and serving high risk members not assigned to a primary care provider with an embedded coach. The majority of health coaching would continue to occur through the embedded health coaches at provider offices.

The OHCA also authorized its vendor to hire practice facilitators and substance use resource specialists dedicated to improving the effectiveness of providers caring for members with chronic pain and opioid drug use. The new staff would assist providers with implementation of a chronic pain management toolkit and principles of proper prescribing. These staff members work both with offices that have an embedded health coach and offices that do not.

The OHCA is in the process of re-procuring SoonerCare HMP vendor services for a contract to take effect in July 2019. The OHCA will require the vendor to do the following under the new contract:

- Implement an assessment and person-centered care planning process that aligns with processes used by the HANs and internal OHCA care management staff;
- Employ a risk stratification methodology to identify the appropriate mode and frequency of health coaching, based on each member's needs and goals; and
- Integrate pain management into general health coaching and practice facilitation activities, as part of promoting whole person care; and
- Expand practice facilitation by offering it to interested providers who may be unable to host an embedded health coach.

The OHCA is aligning SoonerCare HMP, HAN and internal care management activities to ensure all SoonerCare Choice members have access to this level of support, regardless of their location or PCMH provider. This is part of a broader strategy under the SoonerCare Demonstration to advance managed care principles and a statewide Quality Improvement Program (QIP) through delivery and financing models other than traditional risk-based managed care organizations.

The evaluation design presented includes questions and hypotheses related to the two major SoonerCare Choice care management systems: HANs and SoonerCare HMP. The design includes access, quality and health outcome measures relevant to each system.

Retroactive Eligibility

The evaluation design also addresses another important feature of the Demonstration, namely the impact of the OHCA's waiver of a retroactive eligibility period for a portion of the SoonerCare population. As described in the STCs, by waiving retroactive eligibility, the Demonstration tests the efficacy of measures designed to encourage eligible individuals to enroll earlier, to maintain health insurance coverage even while healthy, and to obtain preventive health care. Under the current STCs, the OHCA is permitted to waive retroactive eligibility for members other than pregnant women and children under age 19.

B. EVALUATION QUESTIONS AND HYPOTHESES

1. Quantifiable Targets for Improvement

The SoonerCare Demonstration's goals focus on improving access and quality of care, while controlling costs. The Demonstration seeks to accomplish these goals through advancement of managed care principles, including enhanced primary care and effective care management of members with, or at risk for, complex/chronic conditions. The Demonstration Special Terms and Conditions include questions and hypotheses selected to evaluate the program's performance in the three goal areas.

The OHCA has identified measures for each of the evaluation questions and hypotheses that can be expressed as numerical values and can be tracked on a longitudinal basis. The OHCA's target will be to document improvement in the trendline, either upward or downward, depending on the specific measure.

A subset of the measures (e.g., HEDIS®) have national benchmarks. The OHCA also will evaluate SoonerCare outcomes against these national benchmarks, where available. The target will be to exceed the applicable national benchmark value (e.g., median rate for Medicaid managed care, in the case of HEDIS measures).

2. Driver Diagrams

The Driver Diagrams presented below (Exhibits 1 and 2) illustrate the relationship between the OHCA's overall goals for SoonerCare Choice and the primary and secondary drivers for achieving these goals.

As depicted in the diagrams, the HAN and HMP initiatives serve as the platforms, or primary drivers, for achieving Demonstration aims with respect to access/quality (Exhibit 1) and cost effectiveness (Exhibit 2). Both initiatives are supported by secondary drivers related to changes in preventive/primary care access, utilization of emergency room and inpatient services and provider payment systems.

Exhibit 1 - SoonerCare Choice Driver Diagram (Access & Quality)

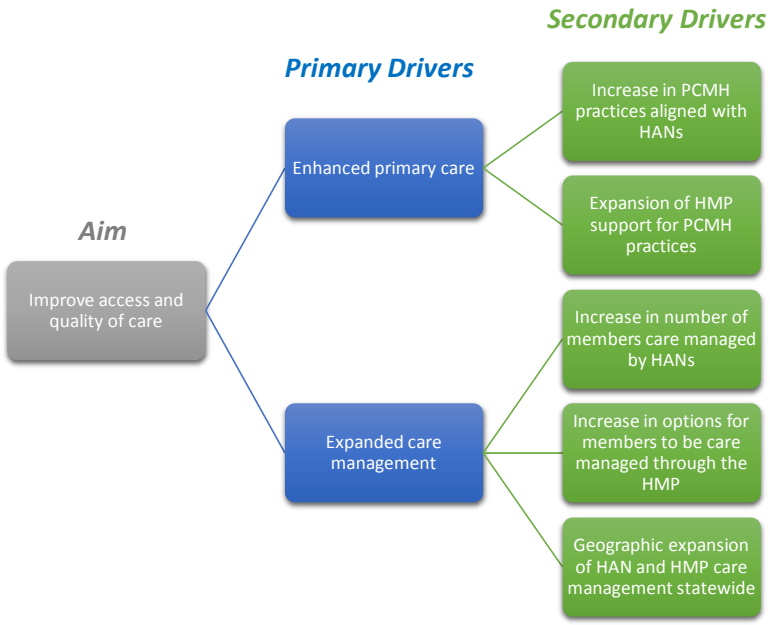
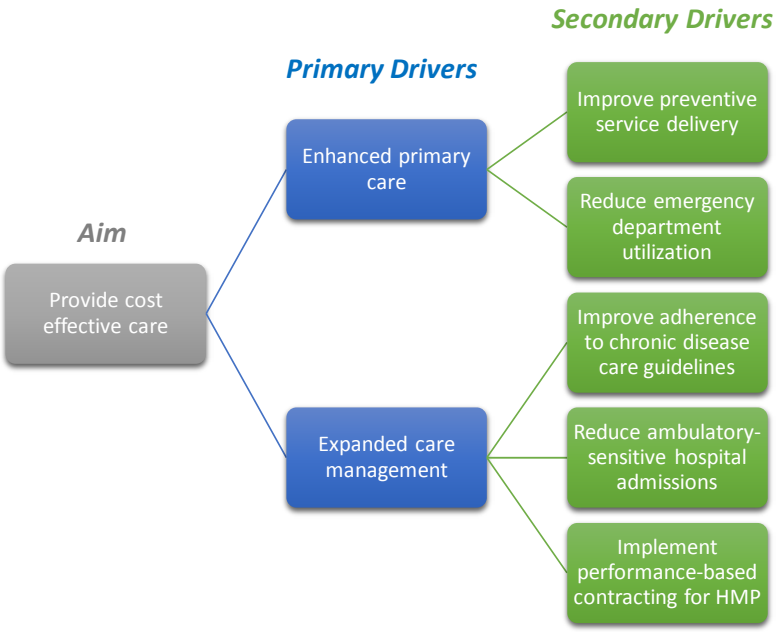


Exhibit 2 - SoonerCare Choice Driver Diagram (Cost Effectiveness)



3. Demonstration Hypotheses

The Demonstration will be evaluated through testing of hypotheses related to the HANs, HMP, Insure Oklahoma program and waiver of retroactive eligibility. Specifically:

1. Evaluation of Health Access Networks

    a. *Impact on Costs:* The implementation and expansion of the HANs will reduce costs associated with the provision of health care services to SoonerCare beneficiaries served by the HANs;

    b. *Impact on Access:* The implementation and expansion of the HANs will improve access to and the availability of health care services to SoonerCare beneficiaries served by the HANs;

    c. *Impact on Quality and Coordination:* The implementation and expansion of the HANs will improve the quality and coordination of health care services to SoonerCare beneficiaries served by the HANs, with specific focus on the populations at greatest risk, including those with multiple chronic illnesses; and

    d. *Impact on PCMH Program:* The implementation and expansion of the HANs will enhance the State's Patient Centered Medical Home program through an evaluation of PCP profiles that incorporates a review of utilization, disease guideline compliance and cost.

2. Evaluation of the Health Management Program

    a. *Impact on Enrollment Figures:* The implementation of the third generation HMP, including health coaches and practice facilitation, will result in an increase in enrollment, as compared to baseline;

    b. *Impact on Access to Care:* Incorporating health coaches into primary care practices will result in increased contact with HMP beneficiaries by the PCP (measured through claims encounter data), as compared to baseline, when care management occurred (exclusively) via telephonic or face-to-face contact with a nurse care manager;

    c. *Impact on Identifying Appropriate Target Population:* The implementation of the third generation HMP, including health coaches and practice facilitation, will result in a change in the characteristics of the beneficiary population enrolled in the HMP (as measured through population characteristics, including disease burden and co-morbidity obtained through claims and algorithms), as compared to baseline;

d. *Impact on Health Outcomes:* Use of disease registry functions by the health coach will improve the quality of care delivered to beneficiaries, as measured by changes in performance on the initial set of Health Care Quality Measures for Medicaid-Eligible Adults or CHIPRA Core Set of Children's Healthcare Quality Measures;

e. *Impact on Cost/Utilization of Care - ER:* Beneficiaries using HMP services will have fewer ER visits, as compared to beneficiaries not receiving HMP services (as measured through claims data);

f. *Impact on Cost/Utilization of Care - Hospital:* Beneficiaries using HMP services will have fewer (admissions and) readmissions to hospitals, as compared to beneficiaries not receiving HMP services (as measured through claims data);

g. *Impact on Satisfaction/Experience with Care:* Beneficiaries using HMP services will have higher satisfaction compared to beneficiaries not receiving HMP services (as measured through CAHPS® survey data); and

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

3. Evaluation of Insure Oklahoma: The evaluation will support the hypothesis that Insure Oklahoma is improving access to care for low-income Oklahomans not eligible for Medicaid, as measured by:

    a. The number of individuals enrolled in Insure Oklahoma
    b. The number of employers participating in the ESI portion of Insure Oklahoma
    c. The number of primary care providers participating in the Individual Plan portion of Insure Oklahoma

4. Evaluation of Eligibility and Enrollment Systems: The evaluation will support the hypothesis that the waiver of retroactive eligibility is an appropriate feature of the program, as measured by:

    a. The number of eligibility determinations made, broken down by type, such as application, transfer and redetermination
    b. The number of individuals determined ineligible, broken down by procedural versus eligibility reasons;
    c. The average application processing times, broken down by type, such as application, transfer and redetermination;
    d. The rate of timely eligibility determinations, broken down by those completed within five days, 10 days and 30 days;

e. The number of individuals disenrolled, broken down by procedural versus eligibility reasons;
f. The internal churn rate, i.e., the number of disenrolled beneficiaries re-enrolling within six months; and
g. The accurate transfer rate, i.e., the number of individuals transferred to Medicaid, CHIP or the Exchange, as applicable, who are determined eligible by the agency.

Alignment of Demonstration Goals and Hypotheses

The OHCA's overarching goals for SoonerCare Choice are to provide accessible, high quality and cost-effective care to SoonerCare Choice beneficiaries. The evaluation questions to be answered by testing Demonstration hypotheses align closely with these goals, as illustrated in Exhibit 3 below.

Exhibit 3 – Alignment of Goals and Hypotheses

Goal	Demonstration Component	Hypothesis/Evaluation Question(s)
Accessible Care	Health Access Network	Will the implementation and expansion of the HANs improve access to and the availability of health care services to SoonerCare beneficiaries served by the HANs?
Accessible Care	Health Management Program	Will the implementation of the third generation HMP, including health coaches and practice facilitation, result in an increase in enrollment, as compared to baseline? Will incorporating health coaches into primary care practices result in increased contact with HMP beneficiaries by the PCP (measured through claims encounter data), as compared to baseline, when care management occurred (exclusively) via telephonic or face-to-face contact with a nurse care manager?

Goal	Demonstration Component	Hypothesis/Evaluation Question(s)
Accessible Care	Insure Oklahoma	Will the evaluation support the hypothesis that Insure Oklahoma is improving access to care for low-income Oklahomans not eligible for Medicaid?
Accessible Care	Waiver of Retroactive Eligibility	Will the evaluation support the hypothesis that the waiver of retroactive eligibility (for a portion of the SoonerCare population) is an appropriate feature of the program?
High Quality Care	Health Access Networks	Will the implementation and expansion of the HANs improve the quality and coordination of health care services to SoonerCare beneficiaries served by the HANs, including specifically populations at greatest risk (e.g., those with multiple chronic illnesses)? Will the implementation and expansion of the HANs enhance the State's Patient Centered Medical Home program? Will beneficiaries enrolled with a HAN PCMH provider have higher satisfaction compared to beneficiaries enrolled with a non-HAN PCMH (as measured through CAHPS survey data)?
High Quality Care	Health Management Program	Will the implementation of the third generation HMP result in a change in the characteristics of the beneficiary population (e.g., disease burden and co-morbidity) enrolled in the HMP, as compared to baseline? Will the use of disease registry functions by the Health Coach (along with other coaching activities) improve the quality of care delivered to beneficiaries, as

Goal	Demonstration Component	Hypothesis/Evaluation Question(s)
		measured by changes in performance on the initial set of Health Care Quality Measures for Medicaid-Eligible Adults or CHIPRA Core Set of Children's Healthcare Quality Measures? Will beneficiaries who are enrolled in the HMP report that the program has contributed to an improvement in quality of care and health status? Will providers who are participating in the HMP report that the program has improved the quality of their care management?
Cost Effectiveness	Health Access Networks	Will the implementation and expansion of the HANs reduce cost associated with provision of health care services to SoonerCare beneficiaries served by the HANs?
Cost Effectiveness	Health Management Program	Will ER and hospital utilization for members enrolled in the HMP be lower than would have occurred absent their participation? Will total and per member per month expenditures for members enrolled in the HMP be lower than would have occurred absent their participation?

Promotion of Title XIX Objectives

The Affordable Care Act (ACA) included provisions for Medicaid related to quality of care and delivery systems. Specifically, the ACA anticipates that, "improvements will be made in the quality of care and the manner in which that care is delivered, while at the same time reducing costs."[1]

[1] Medicaid.gov

The SoonerCare Demonstration promotes these ideals through the overarching goals of providing accessible, high quality and cost-effective care to SoonerCare Choice beneficiaries. The evaluation methodology presented in the next section is designed to measure the Demonstration's performance in achieving these goals.

C. METHODOLOGY

The SoonerCare Choice evaluation is designed to measure the Demonstration's performance in achieving program goals, while also providing actionable information for improving the program in the future. The proposed methodology is outlined in detail below.

1. Evaluation Design (Overview)

The evaluation will use a combination of analytical techniques, as determined by best available data and the presence or absence of a valid comparison group. The evaluation will employ nationally-validated measures (e.g., HEDIS and CAHPS) where appropriate and State-specific measures where a national measure does not exist (e.g., data on enrollment or PCMH status and member surveys tailored to assess specific HAN and HMP care management activities). Nationally-validated measures that are part of the CMS Scorecard will be given priority for measure selection.

As discussed below, the evaluation will include a comparison group for a portion of the analysis. It will not include a pre/post comparison but will use data analytics/predictive modeling to assess performance against what was forecast to occur absent any intervention.

2. Target and Comparison Populations

The SoonerCare Choice target populations are HAN and HMP members. The two populations do not overlap; the OHCA reviews enrollment data monthly to identify and resolve any instances of members being co-enrolled in both programs.

The evaluation is structured to isolate, as much as possible, the discrete impact of the HAN and HMP initiatives with respect to access, quality and cost effectiveness. This will be accomplished by stratifying SoonerCare Choice members into three population segments for applicable measures: members enrolled with a SoonerCare HAN PCMH; members enrolled in the SoonerCare HMP; and all other SoonerCare Choice members (comparison group).

The HAN and HMP programs are expanding statewide and have sufficient enrollment to be evaluated in isolation. The OHCA estimates that the HMP population in 2019 will be approximately 10,000 members, while the HAN population will be approximately 200,000 members. The residual comparison group will exceed 300,000 members.

The HAN population closely resembles the comparison group population in terms of demographics. HAN members are primarily non-disabled children, pregnant women, parents and members with disabilities who are not eligible for Medicare. (High risk

pregnant women receive care management directly from the OHCA, regardless of HAN status, and therefore are not a focus of the HAN evaluation.)

The HMP population consists primarily of adults and has a higher percentage of ABD members than the comparison group population. The differences will be addressed through stratification of the three populations by aid category (ABD or TANF), age cohort and health condition(s).

The evaluation will encompass the entire universe of members, with the exception of member surveys (CAHPS and program-specific surveys). These will be conducted on a randomly-selected representative sample of HAN and HMP members.

Comparison Group Method

All SoonerCare Choice members should have access to preventive services through their PCMH, regardless of their status in terms of HAN or HMP enrollment. The comparison group method therefore will be used for calculation of HEDIS rates across the three populations. This will include both population-wide preventive measures and preventive care measures specific to various chronic health condition measures.

The comparison group method also will be used for evaluating CAHPS ratings among HAN, HMP and comparison group members with respect to access to care. The OHCA's CAHPS vendor is able to stratify CAHPS results for these two populations, although not for the HMP population. The evaluator will include CAHPS-validated questions in the targeted HMP member survey to obtain equivalent data for the HMP population.

Predictive Modeling Method

The SoonerCare HAN population is passively enrolled in the program based on the member's selection of a HAN-affiliated PCMH provider. This typically occurs at time of enrollment in Medicaid. A pre/post enrollment analysis therefore would be impractical for most HAN members.

However, the OHCA uses data analytics/predictive modeling to identify SoonerCare Choice members with, or at risk for chronic conditions who would benefit from care management. The OHCA currently employs MEDai as its predictive modeler, although this may change in the future.

The OHCA provides the predictive modeling data to its HMP and HAN contractors, for use in identifying members for enrollment in health coaching/care management. The predictive model presents forecasted hospital and ER utilization and total health care expenditures at the member level.

The predictive modeler eliminates the need to stratify or otherwise account for population differences between HAN/HMP members and a comparison group population. The OHCA therefore proposes to use the predictive modeling output and to evaluate actual utilization and cost against what was forecast to have occurred absent care management for members enrolled in the two programs.

Qualitative Research

Contractual requirements for the HAN and HMP contractors are being aligned in 2019 to ensure that HAN members enrolled in care management receive comparable assistance to their counterparts enrolled in the HMP. This includes both clinical care management and assistance with social determinants of health.

The evaluation will assess member satisfaction with care management, and the member's perception of its impact on health status, through targeted surveys. The survey samples will be randomly drawn from the care managed population in each of the two programs.

Insure Oklahoma Evaluation

The evaluation of Insure Oklahoma is distinct from other portions of the design and is based on tracking beneficiary, employer and provider participation rates over time. It does not require use of comparison groups, predictive modeling or qualitative research to attain reliable findings.

Eligibility and Enrollment System Analysis

The evaluation of the waiver of retroactive eligibility for a portion of the SoonerCare Choice population also is distinct from the other portions of the design. The OHCA's enrollment system includes the data elements necessary to evaluate six of the seven components specified in the SoonerCare Choice STCs.

The exception is the accurate transfer rate of individuals who are determined ineligible by the agency and are referred to the Exchange. Oklahoma's Exchange is operated by the federal government and the State does not have access to data on the disposition of individuals who apply for coverage through the Exchange.

3. Evaluation Period

The HAN and HMP programs are undergoing expansion and enhancement, as described in Section A. Therefore, although the OHCA's Independent Evaluator already is tracking a portion of the evaluation measures for the renewal period, the OHCA proposes to treat 2019 as a base year. Program performance in 2020 – 2023 will be assessed against performance in 2019[2].

The OHCA's Independent Evaluator will produce findings on a state fiscal year (July to June), rather than calendar year basis for all measures except HEDIS. The OHCA believes this is the most appropriate time period, as it aligns with HMP and HAN contract cycles.

[2] The waiver renewal period begins August 31, 2018. The independent evaluator will present data for the final four months of 2018, along with the 2019 base data, where appropriate. The 2018 partial year data will be informational, with 2019 serving as the formal base year period.

The OHCA currently is conducting a procurement to select a vendor to administer the third generation Health Management Program. The new contract will take effect on July 1, 2019 (SFY 2020) and will include provisions for expanding the program statewide.

The OHCA also will be revising contracts with the HANs to address statewide expansion and adoption of enhanced care management activities. The new HAN contracts also are anticipated to take effect on July 1, 2019.

HEDIS measures will be calculated on a calendar year basis, in accordance with HEDIS specifications, with calendar year 2019 serving as the baseline reporting year (2018 results). (Calculating "HEDIS-like" values on state fiscal year cycle would require generating results twice per year, since the calendar year measures would still be necessary for meeting CMS scorecard reporting requirements.)

Exhibit 4 summarizes the overall evaluation and measurement periods.

Exhibit 4 – Demonstration Years & Measurement Periods

Measures	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
Non-HEDIS	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024
HEDIS	CY 2018[3]	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023

4. Evaluation Measures

The proposed evaluation measures are listed below, by evaluation component and hypothesis/question. Detailed specifications for each measure are presented in Exhibit 5, immediately following the list.

Evaluation of Health Access Networks – Access to Care

Hypothesis/Question: Will the implementation and expansion of the HANs improve access to and the availability of health care services to SoonerCare beneficiaries served by the HANs?

HAN access and availability will be evaluated through the following measures:

- Child and adolescent access to PCPs – 12 months to 19 years
- Adult access to preventive/ambulatory health services
- Getting needed care – children and adults
- Rating of health care – children and adults

[3] 2019 Reporting cycle for 2018 values

- Rating of health plan – children and adults
- Rating of personal doctor – children and adults

Evaluation of Health Access Networks – Quality of Care

Hypothesis/Question: Will the implementation and expansion of the HANs improve the quality and coordination of health care services to SoonerCare beneficiaries served by the HANs, including specifically populations at greatest risk (e.g., those with multiple chronic illnesses)?

HAN quality and coordination will be evaluated through the following measures:

- Number of members engaged in care management
- Asthma measures
    - Use of appropriate medications for people with asthma
    - Medication management for people with asthma – 75 percent
- Cardiovascular (CAD and heart failure) measures
    - Persistence of beta-blocker treatment after a heart attack
    - Cholesterol management for patients with cardiovascular conditions – LDL-C test
- COPD measures
    - Use of spirometry testing in the assessment and diagnosis of COPD
    - Pharmacotherapy management of COPD exacerbation – 14 days
    - Pharmacotherapy management of COPD exacerbation – 30 days
- Diabetes measures
    - Percentage of members who had LDL-C test
    - Percentage of members who had retinal eye exam performed
    - Percentage of members who had Hemoglobin A1c (HbA1c) testing
    - Percentage of members who received medical attention for nephropathy
    - Percentage of members prescribed angiotensin converting enzyme inhibitors or angiotensin receptor blockers (ACE/ARB therapy)
- Hypertension measures
    - Percentage of members who had LDL-C test
    - Percentage of members prescribed ACE/ARB therapy
    - Percentage of members prescribed diuretics
    - Percentage of members prescribed ACE/ARB therapy or diuretics with annual medication monitoring
- Mental Health measures
    - Follow-up after hospitalization for mental illness – 7 days
    - Follow-up after hospitalization for mental illness – 30 days
- Social Determinants of Health
    - Member satisfaction with SDOH assistance (targeted member survey)
    - Impact of assistance on member self-reported health status (targeted member survey)

Hypothesis/Question: Will the implementation and expansion of the HANs enhance the State's Patient Centered Medical Home program through an evaluation of PCP profiles that incorporates a review of utilization, disease guideline compliance and cost?

HAN performance with respect to enhancement of the PCMH program will be evaluated through the following measures:

- Number and percentage of HAN-affiliated PCMH providers who have attained the highest level of OHCA accreditation
- PCMH provider satisfaction with HAN practice support activities
- PCHM provider adoption of chronic care disease guidelines
- Emergency room utilization
- Per member per month costs

PCMH patient compliance with HEDIS chronic disease measures for asthma, CAD, COPD, diabetes and hypertension (measures identified for preceding hypothesis/question) will also be included in the evaluation of this hypothesis/question, as higher compliance rates would be driven by PCMH activities.

Evaluation of Health Access Networks – Cost Effectiveness

Hypothesis/Question: Will the implementation and expansion of the HANs reduce cost associated with provision of health care services to SoonerCare beneficiaries served by the HANs?

HAN cost effectiveness will be evaluated through the following measures:

- Emergency room utilization – actual versus forecast for care managed members
- Hospital admissions – actual versus forecast for care managed members
- Per member per month costs – actual versus forecast for care managed members

Evaluation of Health Management Program – Access to Care

Hypothesis/Question: Will the implementation of the third generation HMP, including health coaches and practice facilitation, result in an increase in enrollment, as compared to baseline?

HMP enrollment will be evaluated through the following measure:

- Number of members engaged in health coaching for a minimum of three months in a 12-month period

Hypothesis/Question: Will incorporating health coaches into primary care practices result in increased contact with HMP beneficiaries by the PCP (measured through claims encounter data), as compared to baseline, when care management occurred (exclusively) via telephonic or face-to-face contact with a nurse care manager?

HMP contacts will be evaluated through the following measure:

- PCMH contacts (total and average number per engaged member)

Evaluation of Health Management Program – Quality of Care

Hypothesis/Question: Will the implementation of the third generation HMP, including health coaches and practice facilitation, result in a change in the characteristics of the beneficiary population enrolled in the HMP (as measured through population characteristics, including disease burden and co-morbidity obtained through claims and algorithms)?

HMP beneficiary population characteristics will be evaluated through the following measures:

- Average number of chronic conditions
- Percentage of members with physical/behavioral health co-morbidities
- Average risk score, as calculated through data analytics
- Average care gap score, as calculated through data analytics

Hypothesis/Question: Will the use of disease registry functions by the Health Coach (along with other coaching activities) improve the quality of care delivered to beneficiaries, as measured by changes in performance on the initial set of Health Care Quality Measures for Medicaid-Eligible Adults or CHIPRA Core Set of Children's Healthcare Quality Measures?

HMP quality of care will be evaluated through the following measures:

- Asthma measures
    - Use of appropriate medications for people with asthma
    - Medication management for people with asthma – 75 percent
    - COPD or asthma in older adults admission rate
    - Asthma in younger adults admission rate
- Cardiovascular (CAD and heart failure) measures
    - Persistence of beta-blocker treatment after a heart attack
    - Cholesterol management for patients with cardiovascular conditions – LDL-C test
    - Heart failure admission rate
- COPD measures
    - Use of spirometry testing in the assessment and diagnosis of COPD
    - Pharmacotherapy management of COPD exacerbation – 14 days

    - Pharmacotherapy management of COPD exacerbation – 30 days
- Diabetes measures
    - Percentage of members who had LDL-C test
    - Percentage of members who had retinal eye exam performed
    - Percentage of members who had Hemoglobin A1c (HbA1c) testing
    - Percentage of members who received medical attention for nephropathy
    - Percentage of members prescribed angiotensin converting enzyme inhibitors or angiotensin receptor blockers (ACE/ARB therapy)
    - Diabetes short-term complications admission rate
- Hypertension measures
    - Percentage of members who had LDL-C test
    - Percentage of members prescribed ACE/ARB therapy
    - Percentage of members prescribed diuretics
    - Percentage of members prescribed ACE/ARB therapy or diuretics with annual medication monitoring
- Mental Health measures
    - Follow-up after hospitalization for mental illness – 7 days
    - Follow-up after hospitalization for mental illness – 30 days
- Opioid measures
    - Use of opioids at high dosage in persons without cancer
    - Concurrent use of opioids and benzodiazepines
- Social Determinants of Health
    - Member awareness and use of available SDOH assistance (targeted member survey)
    - Member satisfaction with SDOH assistance (targeted member survey)

Hypothesis/Question: Will beneficiaries using HMP services have higher satisfaction compared to beneficiaries not receiving HMP services (as measured through CAHPS survey data)?

HMP performance with respect to member (beneficiary) satisfaction will be evaluated through the following measures:

- Getting needed care – children and adults
- Rating of health care – children and adults
- Rating of health plan – children and adults
- Rating of personal doctor – children and adults

Evaluation of Health Management Program – Cost Effectiveness

Hypothesis/Question: Will beneficiaries using HMP services have fewer ER visits as compared to beneficiaries not receiving HMP services (as measured through claims data)?

HMP effectiveness in reducing ER utilization will be evaluated through the following measures:

- Emergency room utilization – HMP members versus comparison group
- Emergency room utilization – actual versus forecast for care managed members

Hypothesis/Question: Will beneficiaries using HMP services have fewer (admissions and) readmissions as compared to beneficiaries not receiving HMP services (as measured through claims data)?

HMP effectiveness in reducing hospital utilization will be evaluated through the following measures:

- Hospital admissions and readmissions – HMP members versus comparison group
- Hospital admissions and readmissions – actual versus forecast for care managed members

Hypothesis/Question: Will total and per member per month expenditures for members enrolled in HMP be lower than what would have occurred absent their participation?

HMP cost effectiveness will be evaluated through the following measures:

- Per member per month costs – HMP members versus comparison group
- Per member per month costs – actual versus forecast for care managed members

Evaluation of Insure Oklahoma – Access to Care

Hypothesis/Question: Will the evaluation support the hypothesis that Insure Oklahoma is improving access to care for low-income Oklahomans not eligible for Medicaid?

Insure Oklahoma will be evaluated through the following measures:

- The number of individuals enrolled in Insure Oklahoma
- The number of employers participating in the ESI portion of Insure Oklahoma
- The number of primary care providers participating in the Individual Plan portion of Insure Oklahoma

Evaluation of Retroactive Eligibility Waiver – Access to Care

Hypothesis/Question: Will the evaluation support the hypothesis that the waiver of retroactive eligibility (for a portion of the SoonerCare population) is an appropriate feature of the program?

The waiver of retroactivity eligibility will be evaluated through the following measures:

- The number of eligibility determinations made, broken down by type
- The number of individuals determined ineligible, broken down by procedural versus eligibility reasons
- The average application processing times, broken down by type
- The rate of timely eligibility determinations, broken down by those completed within five days, 10 days and 30 days
- The number of individuals disenrolled, broken down by procedural versus eligibility reasons
- The internal churn rate, i.e., the number of disenrolled beneficiaries re-enrolling within six months
- Accurate transfer rate, i.e., the number of individuals transferred to Medicaid, CHIP or the Exchange, as applicable, who are determined eligible by the agency

Exhibit 5 – Evaluation Measures

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
Evaluation of Health Access Networks – Access to Care							
1	Will the implementation and expansion of the HANs improve access to and the availability of health care services to SoonerCare beneficiaries served by the HANs?	Child and adolescent access to PCPs – 12 months to 19 years	Members within age cohort enrolled with a HAN-affiliated PCMH	In accordance with HEDIS specifications (administrative data only)	SoonerCare Choice members within age cohort not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	t-test
2		Adult access to preventive/ ambulatory health services	Members within age cohort enrolled with a HAN-affiliated PCMH	In accordance with HEDIS specifications (administrative data only)	SoonerCare Choice members within age cohort not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	t-test
3		Getting needed care – children and adults	Adult members enrolled with a HAN-affiliated PCMH Child members enrolled with a HAN-affiliated PCMH	In accordance with CAHPS specifications	SoonerCare Choice adult members not enrolled with a HAN-affiliated PCMH SoonerCare Choice child members not enrolled with a HAN-affiliated PCMH	Source - CAHPS survey data file Steward – CAHPS	t-test
4		Rating of health plan – children and adults	Adult members enrolled with a HAN-affiliated PCMH Child members enrolled with a HAN-affiliated PCMH	In accordance with CAHPS specifications	SoonerCare Choice adult members not enrolled with a HAN-affiliated PCMH SoonerCare Choice child members not enrolled with a HAN-affiliated PCMH	Source - CAHPS survey data file Steward – CAHPS	t-test

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
5		Rating of personal doctor – children and adults	Adult members enrolled with a HAN-affiliated PCMH Child members enrolled with a HAN-affiliated PCMH	In accordance with CAHPS specifications	SoonerCare Choice adult members not enrolled with a HAN-affiliated PCMH SoonerCare Choice child members not enrolled with a HAN-affiliated PCMH	Source - CAHPS survey data file Steward – CAHPS	t-test
Evaluation of Health Access Networks – Quality of Care							
6	Will the implementation and expansion of the HANs improve the quality and coordination of health care services to SoonerCare beneficiaries served by the HANs, including specifically populations at greatest risk (e.g., those with multiple chronic illnesses)?	Number of members engaged in care management	Total unduplicated members engaged in care management at any point during year Unduplicated members with multiple chronic illnesses engaged in care management at any point during the year	Numerators – members engaged in care management (total and population with multiple chronic conditions Denominators – all members (total and population with multiple chronic conditions)	N/A	Source - HAN care management databases Steward - HANs	Time series
7		Asthma – use of appropriate medications for people with asthma	HAN members with asthma	In accordance with HEDIS specifications	SoonerCare Choice members with asthma not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	t-test
8		Asthma – Medication management for people with asthma – 75 percent	HAN members with asthma	In accordance with HEDIS specifications	SoonerCare Choice members with asthma not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	t-test

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
		CAD – Persistent beta-blocker treatment after a heart attack	HAN members with CAD and heart failure	In accordance with HEDIS specifications	SoonerCare Choice members with CAD/heart failure not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	t-test
9		CAD – Cholesterol management for patients with cardiovascular conditions – LDL-C test	HAN members with CAD and heart failure	In accordance with HEDIS specifications	SoonerCare Choice members with CAD/heart failure not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	t-test
10		COPD – Use of spirometry testing in the assessment and diagnosis of COPD	HAN members with COPD	In accordance with HEDIS specifications	SoonerCare Choice members with CAD/heart failure not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	t-test
11		COPD – pharmacotherapy management of COPD exacerbation – 14 days	HAN members with COPD	In accordance with HEDIS specifications	SoonerCare Choice members with COPD not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	t-test
12		COPD – pharmacotherapy management of COPD exacerbation – 30 days	HAN members with COPD	In accordance with HEDIS specifications	SoonerCare Choice members with COPD not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	t-test

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
13		Diabetes – Percentage of members who had LDL-C test	HAN members with diabetes	In accordance with HEDIS specifications	SoonerCare Choice members with diabetes not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	t-test
14		Diabetes – percentage of members who had retinal eye exam performed	HAN members with diabetes	In accordance with HEDIS specifications	SoonerCare Choice members with diabetes not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	t-test
15		Diabetes – percentage of members who had HbA1c testing	HAN members with diabetes	In accordance with HEDIS specifications	SoonerCare Choice members with diabetes not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	t-test
16		Diabetes - Percentage of members who received medical attention for nephropathy	HAN members with diabetes	In accordance with HEDIS specifications	SoonerCare Choice members with diabetes not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	t-test
17		Diabetes - Percentage of members prescribed ACE/ARB therapy	HAN members with diabetes	In accordance with HEDIS specifications	SoonerCare Choice members with diabetes not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	t-test
18		Hypertension – Percentage of members who had LDL-C test	HAN members with hypertension	In accordance with HEDIS specifications	SoonerCare Choice members with hypertension not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	t-test

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
19		Hypertension – Percentage of members prescribed ACE/ARB therapy	HAN members with hypertension	In accordance with HEDIS specifications	SoonerCare Choice members with hypertension not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	t-test
20		Hypertension – Percentage of members prescribed diuretics	HAN members with hypertension	In accordance with HEDIS specifications	SoonerCare Choice members with hypertension not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	t-test
21		Hypertension – Percentage of members prescribed ACE/ARB therapy or diuretics with annual medication monitoring	HAN members with hypertension	In accordance with HEDIS specifications	SoonerCare Choice members with hypertension not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	t-test
22		Mental Health – Follow-up after hospitalization for mental illness – 7 days	HAN members hospitalized for mental illness	In accordance with HEDIS specifications	SoonerCare Choice members hospitalized for mental illness not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	t-test
23		Mental Health – Follow-up after hospitalization for mental illness – 30 days	HAN members hospitalized for mental illness	In accordance with HEDIS specifications	SoonerCare Choice members hospitalized for mental illness not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	t-test

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
24		SDOH – Member satisfaction	Randomly selected sample of HAN members receiving assistance with SDOH as part of care management	Numerator – Members reporting satisfaction Denominator – All respondents	N/A	Source - HAN care management databases for sample Steward - SoonerCare Independent Evaluator for survey data	Descriptive statistics
25	Will the implementation and expansion of the HANs enhance the State's PCMH program through an evaluation of PCP profiles that incorporates a review of utilization, disease guideline compliance and cost? *(Note: HEDIS chronic disease measures from preceding hypothesis/question also will be included in evaluation of this hypothesis/question,*	Number and percentage of HAN-affiliated PCMH providers who have attained the highest level of OHCA accreditation	HAN-affiliated PCMH providers	Numerator – PCMH providers with Level 3 accreditation (or highest level under any future redesign of PCMH tiers) Denominator – All HAN-aligned PCMH providers	PCMH providers not aligned with a HAN	Source – MMIS Steward – OHCA	t-test
26		PCMH provider satisfaction with HAN practice support activities	Randomly selected sample of HAN-affiliated PCMH providers	Numerator – Providers reporting satisfaction Denominator – All respondents	N/A	Source – MMIS for provider sample Steward – SoonerCare Independent Evaluator for survey data	Descriptive statistics

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
27	*as PCMH providers drive member compliance.)*	PCMH provider adoption of chronic care disease guidelines (self-reported)	Randomly selected sample of HAN-affiliated PCMH providers	Numerator – Providers reporting compliance by disease state Denominator – All respondents	N/A	Source – MMIS for provider sample Steward – SoonerCare Independent Evaluator for survey data	Descriptive statistics
28		Emergency room utilization	SoonerCare Choice HAN members	Numerator – ED visits Denominator – total member months	SoonerCare Choice members not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source – MMIS Steward – OHCA	t-test
29		Evaluation of Health Access Networks – Quality of Care	SoonerCare Choice HAN members	Numerator – total expenditures (paid claims and PCMH case management fees) Denominator – total member months	SoonerCare Choice members not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source – MMIS Steward – OHCA	t-test
Evaluation of Health Access Networks – Cost Effectiveness							
30	Will the implementation and expansion of the HANs reduce cost associated with provision of health care services to SoonerCare beneficiaries served by the HANs?	Emergency room utilization – actual versus forecasted	SoonerCare Choice HAN members engaged in care management	Numerator – ED visits Denominator – total participants	Actual utilization will be compared to forecasted utilization, as determined by data analytics/predictive modeling	Source – MMIS for claims data; DXC Technology Services for predictive modeler Steward – DXC Technology Services for predictive modeler	Meese-Rogoff test

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
31		Hospital admissions – actual versus forecasted	SoonerCare Choice HAN members engaged in care management	Numerator – Hospital admissions Denominator – total participants	Actual utilization will be compared to forecasted utilization, as determined by data analytics/predictive modeling	Source – MMIS for claims data; DXC Technology Services for predictive modeler Steward – DXC Technology Services for predictive modeler	Meese-Rogoff test
32		PMPM expenditures – actual versus forecasted	SoonerCare Choice HAN members engaged in care management	Numerator – (paid claims and PCMH case management fees) Denominator – total member months	Actual expenditures will be compared to forecasted expenditures, as determined by data analytics/predictive modeling	Source – MMIS for claims data; DXC Technology Services for predictive modeler Steward – DXC Technology Services for predictive modeler	Meese-Rogoff test

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
Evaluation of Health Management Program – Access to Care							
33	Will the implementation of the third generation HMP, including health coaches and practice facilitation, result in an increase in enrollment, as compared to baseline?	Number of members engaged in health coaching	SoonerCare HMP members engaged in health coaching (minimum of three months), by coaching method	N/A	N/A	Source – HMP contractor database Steward – HMP contractor	Time series
34	Will incorporating health coaches into primary care practices result in increased contact with HMP beneficiaries by the PCP (measured through claims encounter data), as compared to baseline, when care management occurred (exclusively) via telephonic or face-to-face contact with a nurse care manager?	Number of PCP contacts (total and per member engaged in health coaching)	SoonerCare HMP members engaged in health coaching (minimum of three months), by coaching method	Numerator - Member contacts (visits) with PCMH, by coaching method Denominator – Member months, by coaching method	Members receiving health coaching in PCMH offices will be compared to members receiving field-based and telephonic health coaching	Source – MMIS; HMP contractor database Steward – OHCA for claims; HMP contractor for member assignments	t-test

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
Evaluation of Health Management Program – Quality of Care							
35	Will the implementation of the third generation HMP, including health coaches and practice facilitation, result in a change in the characteristics of the beneficiary population enrolled in the HMP (as measured through population characteristics, including disease burden and co-morbidity obtained through claims and algorithms)?	Average number of chronic conditions	SoonerCare members enrolled in the HMP, by coaching method	Numerator – Number of chronic conditions Denominator – Number of members	Members receiving health coaching in PCMH offices will be compared to members receiving field-based and telephonic health coaching	Source – MMIS; HMP contractor database Steward – OHCA for claims; HMP contractor for member assignments	t-test
36		Percentage of members with physical/behavioral health co-morbidities	SoonerCare members enrolled in the HMP, by coaching method	Numerator – Number of members with at least one chronic physical and one behavioral health condition Denominator – Number of members	Members receiving health coaching in PCMH offices will be compared to members receiving field-based and telephonic health coaching	Source – MMIS; HMP contractor database Steward – OHCA for claims; HMP contractor for member assignments	t-test
37		Average risk score	SoonerCare members enrolled in the HMP, by coaching method	Numerator – Total risk score value, using data analytics/predictive modeler (currently MEDai) Denominator – Number of members	Members receiving health coaching in PCMH offices will be compared to members receiving field-based and telephonic health coaching	Source – MMIS for claims data; DXC Technology Services for predictive modeler Steward – DXC Technology Services for predictive modeler	t-test

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
38		Average care gap score	SoonerCare members enrolled in the HMP, by coaching method	Numerator – Total care gap score value, using data analytics/predictive modeler (currently MEDai) Denominator – Number of members	Members receiving health coaching in PCMH offices will be compared to members receiving field-based and telephonic health coaching	Source – MMIS for claims data; DXC Technology Services for predictive modeler Steward – DXC Technology Services for predictive modeler	t-test
39	Will the use of disease registry functions by the Health Coach (along with other coaching activities) improve the quality of care delivered to beneficiaries, as measured by changes in performance on the initial set of Health Care Quality Measures for Medicaid-Eligible Adults or CHIPRA Core Set of Children's Healthcare Quality Measures?	Asthma – use of appropriate medications for people with asthma	HMP members with asthma	In accordance with HEDIS specifications	SoonerCare Choice members with asthma not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	t-test
40		Asthma – Medication management for people with asthma – 75 percent	HMP members with asthma	In accordance with HEDIS specifications	SoonerCare Choice members with asthma not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	t-test
41		Asthma - COPD or asthma in older adults admission rate	HMP members with asthma or COPD	In accordance with AHRQ specifications	SoonerCare Choice members with COPD or asthma not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - AHRQ	t-test
42		Asthma – Asthma in younger adults admission rate	HMP members with asthma	In accordance with AHRQ specifications	SoonerCare Choice members with asthma not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - AHRQ	t-test

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
43		CAD – Persistent beta-blocker treatment after a heart attack	HMP members with CAD and heart failure	In accordance with HEDIS specifications	SoonerCare Choice members with CAD/heart failure not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	t-test
44		CAD – Cholesterol management for patients with cardiovascular conditions – LDL-C test	HMP members with CAD and heart failure	In accordance with HEDIS specifications	SoonerCare Choice members with CAD/heart failure not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	t-test
45		CAD – Heart failure admission rate	HMP members with heart failure	In accordance with AHRQ specifications	SoonerCare Choice members with heart failure not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - AHRQ	t-test
46		COPD – Use of spirometry testing in the assessment and diagnosis of COPD	HMP members with COPD	In accordance with HEDIS specifications	SoonerCare Choice members with CAD/heart failure not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	t-test
47		COPD – pharmacotherapy management of COPD exacerbation – 14 days	HMP members with COPD	In accordance with HEDIS specifications	SoonerCare Choice members with COPD not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	t-test

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
48		COPD – pharmacotherapy management of COPD exacerbation – 30 days	HMP members with COPD	In accordance with HEDIS specifications	SoonerCare Choice members with COPD not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	t-test
49		Diabetes – Percentage of members who had LDL-C test	HMP members with diabetes	In accordance with HEDIS specifications	SoonerCare Choice members with diabetes not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	t-test
50		Diabetes – percentage of members who had retinal eye exam performed	HMP members with diabetes	In accordance with HEDIS specifications	SoonerCare Choice members with diabetes not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	t-test
51		Diabetes – percentage of members who had HbA1c testing	HMP members with diabetes	In accordance with HEDIS specifications	SoonerCare Choice members with diabetes not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	t-test
52		Diabetes - Percentage of members who received medical attention for nephropathy	HMP members with diabetes	In accordance with HEDIS specifications	SoonerCare Choice members with diabetes not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	t-test
53		Diabetes - Percentage of members prescribed ACE/ARB therapy	HMP members with diabetes	In accordance with HEDIS specifications	SoonerCare Choice members with diabetes not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	t-test

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
54		Diabetes – Diabetes short-term complications admission rate	HMP members with diabetes	In accordance with AHRQ specifications	SoonerCare Choice members with diabetes not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - AHRQ	t-test
55		Hypertension – Percentage of members who had LDL-C test	HMP members with hypertension	In accordance with HEDIS specifications	SoonerCare Choice members with hypertension not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	t-test
56		Hypertension – Percentage of members prescribed ACE/ARB therapy	HMP members with hypertension	In accordance with HEDIS specifications	SoonerCare Choice members with hypertension not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	t-test
57		Hypertension – Percentage of members prescribed diuretics	HMP members with hypertension	In accordance with HEDIS specifications	SoonerCare Choice members with hypertension not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	t-test
58		Hypertension – Percentage of members prescribed ACE/ARB therapy or diuretics with annual medication monitoring	HMP members with hypertension	In accordance with HEDIS specifications	SoonerCare Choice members with hypertension not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	t-test

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
59		Mental Health – Follow-up after hospitalization for mental illness – 7 days	HMP members hospitalized for mental illness	In accordance with HEDIS specifications	SoonerCare Choice members hospitalized for mental illness not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	t-test
60		Mental Health – Follow-up after hospitalization for mental illness – 30 days	HMP members hospitalized for mental illness	In accordance with HEDIS specifications	SoonerCare Choice members hospitalized for mental illness not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	t-test
61		Opioid – Use of opioids at high dosage in persons without cancer	HMP members prescribed opioids (through Medicaid)	In accordance with PQA specifications	SoonerCare Choice members prescribed opioids not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - PQA	t-test
62		Opioid – Concurrent use of opioids and benzodiazepines	HMP members prescribed opioids (through Medicaid)	In accordance with PQA specifications	SoonerCare Choice members prescribed opioids not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - PQA	t-test
63		SDOH – Member awareness of SDOH available assistance	Randomly selected sample of HMP members enrolled in HMP	Numerators – Members reporting awareness and use of SDOH assistance available through HMP Denominator – All respondents	N/A	Source - HAN care management databases for sample Steward - SoonerCare Independent Evaluator for survey data	Descriptive statistics

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
64		SDOH – Member satisfaction with SDOH available assistance	Randomly selected sample of HMP members enrolled in HMP	Numerator – Members reporting satisfaction with SDOH assistance Denominator – All respondents reporting use of assistance	N/A	Source - HAN care management databases for sample Steward - SoonerCare Independent Evaluator for survey data	Descriptive statistics
65	Will beneficiaries using HMP services have higher satisfaction compared to beneficiaries not receiving HMP services (as measured through CAHPS survey data)?	Rating of health care – children and adults	Adult HMP members Child HMP members	In accordance with CAHPS specifications	SoonerCare Choice adult members not enrolled with a HAN-affiliated PCMH SoonerCare Choice child members not enrolled with a HAN-affiliated PCMH	Source – SoonerCare Independent Evaluator survey data file Steward – CAHPS	t-test
66		Getting needed care – children and adults	Adult HMP members Child HMP members	In accordance with CAHPS specifications	SoonerCare Choice adult members not enrolled with a HAN-affiliated PCMH SoonerCare Choice child members not enrolled with a HAN-affiliated PCMH	Source – SoonerCare Independent Evaluator survey data file Steward – CAHPS	t-test

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
67		Rating of health plan – children and adults	Adult HMP members Child HMP members	In accordance with CAHPS specifications	SoonerCare Choice adult members not enrolled with a HAN-affiliated PCMH SoonerCare Choice child members not enrolled with a HAN-affiliated PCMH	Source - SoonerCare Independent Evaluator Steward – CAHPS	t-test
68		Rating of personal doctor – children and adults	Adult HMP members Child HMP members	In accordance with CAHPS specifications	SoonerCare Choice adult members not enrolled with a HAN-affiliated PCMH SoonerCare Choice child members not enrolled with a HAN-affiliated PCMH	Source - SoonerCare Independent Evaluator data file Steward – CAHPS	t-test
Evaluation of Health Management Program – Cost Effectiveness							
69	Will beneficiaries using HMP services have fewer ER visits as compared to beneficiaries not receiving HMP services (as measured through claims data)?	ER utilization – HMP members versus comparison group	SoonerCare HMP members (minimum of three months)	Numerator – ED visits Denominator – total participants	SoonerCare Choice members not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source – MMIS Steward – Independent Evaluator	t-test
70		ER utilization – actual versus forecast for care managed members	SoonerCare HMP members (minimum of three months)	Numerator – ED visits Denominator – total participants	Actual utilization will be compared to forecasted utilization, as determined by data analytics/predictive modeling	Source – MMIS for claims data; DXC Technology Services for predictive modeler Steward – DXC Technology Services for predictive modeler	Meese-Rogoff test

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
71	Will beneficiaries using HMP services have fewer (admissions and) readmissions as compared to beneficiaries not receiving HMP services (as measured through claims data)?	Hospital admissions – HMP members versus comparison group Hospital readmissions (30 days) – HMP members versus comparison group	SoonerCare HMP members (minimum of three months) SoonerCare HMP members with at least one hospitalization	Numerator – Admissions Denominator – total participants Numerator – Unique members with readmissions within 30 days following an admission Denominator- total members with admissions in 30-day period	SoonerCare Choice members not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source – MMIS Steward – SoonerCare Independent Evaluator	t-test
72		Hospital admissions – actual versus forecast for care managed members Hospital readmissions (30 days) – actual versus forecast for care managed members	SoonerCare HMP members (minimum of three months) SoonerCare HMP members with at least one hospitalization	Numerator – Hospital admissions Denominator – total participants Numerator – Unique members with readmissions within 30 days following an admission Denominator- total members with admissions in 30-day period	Actual utilization will be compared to forecasted utilization, as determined by data analytics/predictive modeling	Source – MMIS for claims data; DXC Technology Services for predictive modeler Steward – DXC Technology Services for predictive modeler	Meese-Rogoff test

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
73	Will total and per member per month expenditures for members enrolled in HMP be lower than would have occurred absent their participation?	PMPM costs – HMP members versus comparison group	SoonerCare HMP members (minimum of three months)	Numerator – total expenditures (paid claims) and program administrative costs (vendor payments and agency direct/overhead expenses) Denominator – member months	SoonerCare Choice members not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP (claim costs only)	Source – MMIS Steward – SoonerCare Independent Evaluator	t-test
74		PMPM costs – actual versus forecast for care managed members	SoonerCare HMP members (minimum of three months)	Numerator – total expenditures (paid claims) and program administrative costs (vendor payments and agency direct/overhead expenses) Denominator – total member months	Actual expenditures will be compared to forecasted expenditures (claims costs only), as determined by data analytics/predictive modeling	Source – MMIS for claims data; DXC Technology Services for predictive modeler Steward – DXC Technology Services for predictive modeler	Meese-Rogoff test

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
Evaluation of Insure Oklahoma – Access to Care							
75	Will the evaluation support the hypothesis that Insure Oklahoma is improving access to care for low-income Oklahomans not eligible for Medicaid?	The number of individuals enrolled in Insure Oklahoma	Insure Oklahoma beneficiaries, both ESI and Individual Plan	N/A	N/A	Source – OHCA eligibility system Steward – OHCA	Descriptive statistics
76		The number of employers participating in the ESI portion of Insure Oklahoma	Employers participating in the ESI portion of the program	N/A	N/A	Source – Insure Oklahoma Steward – OHCA	Descriptive statistics
77		The number of primary care providers participating in the Individual Plan portion of Insure Oklahoma	Primary care providers (PCMH providers) participating in the Individual Plan network	N/A	N/A	Source – MMIS Steward – OHCA	Descriptive statistics

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
Evaluation of Retroactive Eligibility – Access to Care							
78	Will the evaluation support the hypothesis that the waiver of retroactive eligibility (for a portion of the SoonerCare population) is an appropriate feature of the program?	The number of eligibility determinations made, broken down by type	Applicants 19 and older, excluding pregnant women	Numerator – eligibility determinations by type Denominator – total applications	N/A	Source – OHCA eligibility system Steward - OHCA	Descriptive statistics
79		The number of individuals determined ineligible, broken down by procedural versus eligibility reasons	Applicants 19 and older, excluding pregnant women	Numerator – ineligibility disposition, by type Denominator – total ineligible applicants	N/A	Source – OHCA eligibility system Steward - OHCA	Descriptive statistics
80		The average application processing times, broken down by type	Applicants 19 and older, excluding pregnant women	Numerator – processing time per applicant, by type Denominator – total applicants	N/A	Source – OHCA eligibility system Steward - OHCA	Descriptive statistics
81		The rate of timely eligibility determinations, broken down by those completed within five days, 10 days and 30 days	Applicants 19 and older, excluding pregnant women	Numerator – eligibility determinations by days to disposition Denominator – total applicants	N/A	Source – OHCA eligibility system Steward - OHCA	Descriptive statistics
82		The number of individuals disenrolled, broken down by procedural versus eligibility reasons	Members 19 and older, excluding pregnant women	Numerator – disenrollments by reason Denominator – total disenrollments	N/A	Source – OHCA eligibility system Steward - OHCA	Descriptive statistics

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
83		The internal churn rate, i.e., the number of disenrolled beneficiaries re-enrolling within six months	Disenrolled members 19 and older, excluding pregnant women	Numerator – members disenrolled and re-enrolled within six months Denominator – total disenrollments	N/A	Source – OHCA eligibility system Steward - OHCA	Descriptive statistics
84		Accurate transfer rate, i.e., the number of individuals transferred to Medicaid, CHIP or the Exchange, as applicable, who are determined eligible by the agency	Applicants referred/ transferred to the Exchange	Numerator – applicants transferred and subsequently enrolled in SoonerCare (within three months) Denominator – total applicants referred/transferred to the Exchange	N/A	Source – OHCA eligibility system Steward - OHCA	Descriptive statistics

Evaluation Measures – Additional Considerations

The OHCA has taken into account the additional considerations for evaluation measures outlined in Attachment A of the Special Terms and Conditions. Specifically:

- *Process and Outcome Measures* – The proposed measure list contains assessments of both process (e.g., HEDIS measures) and outcomes (e.g., utilization and cost measures) to evaluate the effectiveness of the demonstration.

- *Qualitative Analysis* – The evaluation will include qualitative findings in the form of beneficiary and PCMH provider survey data. The beneficiary surveys will include CAHPS-validated questions and will be conducted on a randomly-selected sample of the target population(s). PCMH provider surveys also will be conducted on a randomly-selected sample of the target population. Survey questions will be tested on a small number of providers for clarity and reliability before the survey is finalized and fielded on a larger scale.

- *Benchmarking and Comparisons to National and State Standards* – HEDIS, AHRQ, PQA and CAHPS measures will be compared to national Medicaid managed care benchmarks, where available.

- *Use of CMS Core Set Measures* – Core set measures are included in the evaluation.

- *Use of Nationally-Recognized Metrics* – Nationally-recognized metrics are included in the evaluation.

- *Opportunities for Improving Quality of Care, Health Outcomes and Cost Effectiveness* – The evaluation measure set addresses quality, outcomes and cost effectiveness, consistent with demonstration goals and areas identified for improvement through the OHCA's Quality Improvement Program and CMS scorecard data.

5. Data Sources

The evaluation will include primary data collection by the Independent Evaluator in the form of targeted beneficiary and provider surveys. CAHPS-validated questions will be used for targeted beneficiary surveys, where applicable.

Beneficiary and provider surveys will be conducted by telephone, although providers will be given the option of completing and returning hard copies of the surveys. The OHCA's Independent Evaluator has conducted beneficiary and provider surveys for over a decade using this methodology and has achieved high response rates with both survey groups.

Targeted beneficiary surveys for HAN and HMP members receiving care management will be scheduled using the engagement date as the anchor point, with surveys for six months post-engagement. Provider surveys will be conducted on a rolling basis throughout the year.

The OHCA will share copies of the targeted surveys with CMS prior to their use.

6. Analytic Methods

Statistical Tests

Exhibit 5 presents the statistical tests to be undertaken for each measure. When possible, inferential statistics, such as t-tests, will be used to test the hypotheses by examining whether the Demonstration outcomes are different from the outcomes of a comparison group. The Independent Evaluator will test whether these outcome measures meet the assumptions of parametric analyses (e.g., t-tests). If these measures do not meet the assumptions of parametric tests, non-parametric tests will be used instead. The traditionally accepted risk of error ($p < 0.05$) will be used for all comparisons.

When a comparison group is not available, the Independent Evaluator will leverage change in outcome measures over time to determine whether the Demonstration has achieved the hypothesized outcomes. For measures with predictive modeling data available, the Meese-Rogoff test will be used to compare the actual Demonstration outcomes to the forecasted outcomes had the demonstration not occurred. Otherwise, if predictive modeling data is not available, time series analysis will be used.

In addition, descriptive statistics will be used to describe the basic features of the data along with the measures that do not have a comparison group, measurement across time, or forecasted data (e.g., satisfaction).

Isolating Effects of the Demonstration

The SoonerCare Choice program operates under managed care principles, with PCMH providers, Health Access Networks and the Health Management Program performing key managed care functions. SoonerCare Choice members are not co-enrolled in the HAN and HMP, making these programs unique in their composition.

The evaluation is designed to isolate the effects of the HANs and HMP from other activities through creation of a comparison group comprised of members not enrolled in either program (but still enrolled with a non-HAN affiliated PCMH). As presented in Exhibit 5, results for the comparison group will be generated wherever applicable.

The demographics of the HAN and comparison group populations are very similar, reflecting the large number of beneficiaries (200,000 HAN members and 300,000 or more comparison group members). The HANs also are well-represented in both urban and rural portions of the State.

The demographics of the HMP population skew older than the comparison group and include more ABD beneficiaries as a percentage of the total enrollment. The specifications for HEDIS measures should minimize differences in the evaluation populations but other measures will be stratified by age and aid category, as appropriate, to achieve greater accuracy in findings.

Propensity Score Matching and Difference in Differences

The Independent Evaluator will examine the profiles of the HAN, HMP and comparison group populations to determine if Propensity Score Matching, or, in the case of time series analysis, a Difference in Differences analysis is necessary to account for variation across the Demonstration populations and comparison group. If the Independent Evaluator determines that there are important differences between the populations and advises that such tests are necessary, they will be conducted as a robustness check in addition to the t-tests and time series analyses.

Sensitivity Testing

The data analytics used for predictive modeling is expected to provide a standard error along with the forecast values. The Independent Evaluator will explore using the standard error output to perform sensitivity analyses for predictive model measures.

D. METHODOLOGICAL LIMITATIONS

The SoonerCare Choice evaluation has been designed to yield accurate and actionable findings but does have methodological limitations, most of which are inherent to the Section 1115 demonstrations. These include:

- *Lack of true experimental control groups* – The evaluation design includes a comparison group that serves as a reasonable proxy for the two target populations. However, it is not a true experimental control group.

- *Reliance on administrative data* – HEDIS measures account for a significant portion of the evaluation measure set. The OHCA calculates HEDIS rates using administrative data, which limits the accuracy of measures that require a hybrid method to capture fully beneficiary/provider activity. The OHCA has accounted for this limitation by selecting measures that can be calculated accurately using administrative data.

- *Lack of access to Exchange data* – The evaluation of the waiver of retroactive eligibility includes a question related to the accuracy of OHCA transfers/referrals of ineligible applicants to the Exchange. The OHCA and its Independent Evaluator will not have access to information on the disposition of these individuals, making it difficult to assess the appropriateness of the transfer. As a best alternative, the OHCA will track the number of referred applicants who re-apply and qualify for Medicaid or CHIP within 90 days. Since the applicants' circumstances may have changed in the interim (e.g., income may have fallen), this will likely overstate the rate of inaccurate referrals but should represent a reasonable proxy.

E. SPECIAL METHODOLOGICAL CONSIDERATIONS

The SoonerCare Demonstration meets many of the "special methodological considerations" criteria outlined by CMS in Attachment A. The demonstration is long-standing (2019 is DY 24) and has demonstrated its success in prior evaluations.

However, the Special Terms and Conditions addressed this limitation by focusing on two program components that are changing. The HAN and HMP both are expanding and adopting enhanced care management processes, with the intent of improving access, quality and cost-effectiveness. The evaluation will examine the performance of the programs across all three domains, while treating the remainder of the program as a statewide comparison group.

ATTACHMENTS

1. Independent Evaluator

The OHCA procures evaluation services through a qualification RFP process, in which potential contractors furnish information on their qualifications, along with references through which the OHCA can verify past performance. The OHCA has signed a task order with one of these contractors, The Pacific Health Policy Group (PHPG), to perform the independent evaluation.

The OHCA selected PHPG because the firm has performed multiple independent evaluations of SoonerCare Choice program components over the past decade, including the first and second generation SoonerCare HMP and the Health Access Networks. PHPG's evaluations included use of comparison groups where applicable, consistent with the methodology outlined for the SoonerCare Choice evaluation.

PHPG also serves as the OHCA's contractor for calculation of core measures for reporting to CMS. The firm therefore is knowledgeable about the OHCA MMIS and the process for generating HEDIS rates using OHCA administrative data.

In addition to its evaluation work in Oklahoma, PHPG serves as the Independent Evaluator of the Vermont Global Commitment to Health Section 1115 demonstration and the New Mexico Centennial Care Section 1115 demonstration (the latter under a subcontract to, and in partnership with, Deloitte Consulting).

The OHCA's Policy and Quality Improvement functions will oversee PHPG activities throughout the evaluation, to ensure it is conducted in accordance with the evaluation design. The OHCA will schedule regular meetings with PHPG's Project Manager/Principal Investigator to receive updates on the evaluation and address any issues that arise with respect to data collection and clarity/accuracy of findings.

PHPG has signed a "No Conflict of Interest" declaration covering the evaluation. A scanned image of the document is included on the next page.

PHPG

The Pacific Health Policy Group

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December 18, 2018

Catina Baker
Senior Research Analyst
Oklahoma Health Care Authority
4345 North Lincoln Boulevard
Oklahoma City, Oklahoma 73105

Dear Ms. Baker:

The purpose of this letter is to affirm that the Pacific Health Policy Group (PHPG) has no conflict of interest with respect to serving as a independent evaluator of the SoonerCare Choice Section 1115a waiver program.

Very truly yours,

The Pacific Health Policy Group

Andrew Cohen, Director

2. Evaluation Budget

The proposed evaluation budget is presented below.

EVALUATION AREA/TASK	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5
HAN Evaluation					
CAHPS survey					
Analysis of HAN beneficiary responses	$ 7,500	$ 7,500	$ 7,500	$ 7,500	$ 7,500
SDOH beneficiary targeted survey					
Creation of survey instrument	$ 3,000	$ -	$ -	$ -	$ -
Data collection	$ 22,500	$ 22,500	$ 22,500	$ 22,500	$ 22,500
Analysis of HAN SDOH beneficiary responses	$ 7,500	$ 7,500	$ 7,500	$ 7,500	$ 7,500
HAN PCMH targeted survey					
Creation of survey instrument	$ 6,000	$ -	$ -	$ -	$ -
Data collection	$ 30,000	$ 30,000	$ 30,000	$ 30,000	$ 30,000
Analysis of HAN PCMH responses	$ 7,500	$ 7,500	$ 7,500	$ 7,500	$ 7,500
Claims/utilization analysis					
Creation and testing of paid claims extract	$ 30,000	$ 30,000	$ 30,000	$ 30,000	$ 30,000
Creation of eligibility file, stratified by HAN, HMP and other	$ 15,000	$ 15,000	$ 15,000	$ 15,000	$ 15,000
Analysis of paid claims for HEDIS/utilization measures	$ 105,000	$ 105,000	$ 105,000	$ 105,000	$ 105,000
HMP Evaluation					
HMP beneficiary targeted survey					
Creation of survey instrument	$ 3,000	$ -	$ -	$ -	$ -
Data collection	$ 45,000	$ 45,000	$ 45,000	$ 45,000	$ 45,000
Analysis of HMP beneficiary responses	$ 15,000	$ 15,000	$ 15,000	$ 15,000	$ 15,000
Claims/utilization analysis					
Creation and testing of paid claims extract	$ 30,000	$ 30,000	$ 30,000	$ 30,000	$ 30,000
Creation of eligibility file, stratified by HAN, HMP and other	$ 15,000	$ 15,000	$ 15,000	$ 15,000	$ 15,000
Analysis of paid claims for HEDIS/utilization measures	$ 105,000	$ 105,000	$ 105,000	$ 105,000	$ 105,000
Waiver of Retroactive Eligibility Evaluation					
Creation of monthly eligibility file extracts	$ 9,000	$ 9,000	$ 9,000	$ 9,000	$ 9,000
Analysis of eligibility measures	$ 15,000	$ 15,000	$ 15,000	$ 15,000	$ 15,000
Evaluation Reports					
Annual/Interim Reports (Interim in Year 4, in lieu of Annual)	$ -	$ 37,500	$ 37,500	$ 37,500	$ 52,500
Final Summative Report (included in Year 5)	$ -	$ -	$ -	$ -	$ -
TOTAL	**$ 471,000**	**$ 496,500**	**$ 496,500**	**$ 496,500**	**$ 511,500**

3. Timeline and Major Milestones (Calendar Years)

ACTIVITY/MILESTONE	2019 (DY 24)				2020 (DY 25)				2021 (DY 26)				2022 (DY 27)				2023 (DY 28)				2024				2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Health Access Network Evaluation																												
Development of targeted surveys (for CMS review)																												
Targeted survey data collection																												
CAHPS survey data collection																												
Survey data analysis																												
Paid claims data collection and prep for non-HEDIS measures																												
Paid claims analysis - non-HEDIS measures																												
Paid claims data collection and prep for HEDIS measures																												
Paid claims analysis - HEDIS measures																												
Health Management Program Evaluation																												
Development of targeted surveys (for CMS review)																												
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Paid claims data collection and prep for HEDIS measures																												
Paid claims analysis - HEDIS measures																												
Retroactive Eligibility Waiver Evaluation																												
Collection and prep of eligibility data																												
Eligibility data analysis																												
Reporting																												
Submission of draft semi-annual reports for CMS review																												
Submission of draft annual reports for CMS review																												
Submission of draft interim report for CMS review																												
Submission of draft summative report for CMS review																												