Oklahoma Health Care Authority

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

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Executive Summary

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

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

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

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

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

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

Executive Summary

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

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

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

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

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

Introduction

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

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

Background

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

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

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

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

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

Background

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

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

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

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

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

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

Background

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

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

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

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

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

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

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

Noteworthy Activity 2013

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

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

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

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

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

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

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

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

Noteworthy Activity 2014

- Effective January 1, 2014, SoonerPlan's full scope pregnancy benefits Federal Poverty Level (FPL) income limit decreased to 133 percent from 185 percent.

- On January 1, 2014, the OHCA implemented a requirement for conducting a Behavioral Health screening for all SoonerCare members ages 5 and older who are enrolled in a PCMH.

- Medicaid Management Information System (MMIS) reprocurement project implemented two major projects in January 1, 2014. The Secure Provider Portal and Rules Engine Enhancement. Secure Provider Portal is a workflow system for SoonerCare providers. The rules engine enhancement reduces the number of suspended claims by systematically processing some of the claim based on the rules confirmed by the policy department and implementation into the rules engine

- In accordance with the Improper Payments Information Act of 2002, federal agencies review Medicaid and CHIP programs for improper payments every three years; this is known as the PERM program. The OHCA achieved the lowest Payment Error Rate Measurement (PERM) of 0.28 for SoonerCare among 17 states in a federal comprehensive review.

- Proposed rule changes were implemented in 2014 to align the IO program with Special Terms and Condition of the 1115 Demonstration. The revision removed children from the Individual Plan (IP) while retaining children on the ESI plan. Limits were set on adult IP enrollment to person household income at or below 100 percent of FPL.

- During the summer of 2014 the OHCA initiated a Pharmacy Lock-in program to assist providers on monitoring potential abuse or inappropriate utilization of controlled Rx medications by SoonerCare members.

- On July 1, 2014 the OHCA excluded individuals with creditable coverage from SoonerCare Choice program. TEFRA children affected by this change are able to continue their coverage through the SC program.

- On July 1, 2014 the OHCA approved ending the Perinatal Dental (PDEN) program. (The State determined that of the members who qualified, very few members utilized the service.)

Noteworthy Activity 2014

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

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

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

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

Noteworthy Activity 2015

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

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

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

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

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

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

Noteworthy Activity 2015

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

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

Methods

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

Demonstration Objectives:

Major objectives of the SoonerCare waiver program are:

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

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

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

Evaluation of Health Access Networks

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

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

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

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

Waiver Evaluation Results

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

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

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

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

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

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

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

Hypothesis 1A Results:

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

Hypothesis 1B Results:

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

Hypothesis 1C Results:

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

Hypothesis 2: PCP Visits

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

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

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

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

Hypothesis 3: PCP Enrollments

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

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

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

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

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

Hypothesis 3 Results:

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

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

Hypothesis 4: PCP Capacity Available

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

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

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

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

Hypothesis 4A Results:

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

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

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

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

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

Hypothesis 4B Results:

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

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

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

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

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

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

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

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

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

Hypothesis 5 Results:

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

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

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

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

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

Hypothesis 6: Eligible Member Enrollments in Medical Home

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

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

Hypothesis 6 Results:

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

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

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

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

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

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

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

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

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

C. Decrease overall ER use for HAN members.

Hypothesis 7 Results:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Hypothesis 8 Results:

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

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

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

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

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

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

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

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

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

Hypothesis 9a(A) Results:

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

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

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

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

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

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

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

SFY 2013 PCP visits and HMP members:

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

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

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

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

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

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

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

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

Hypothesis 9b Results:

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

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

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

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

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

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

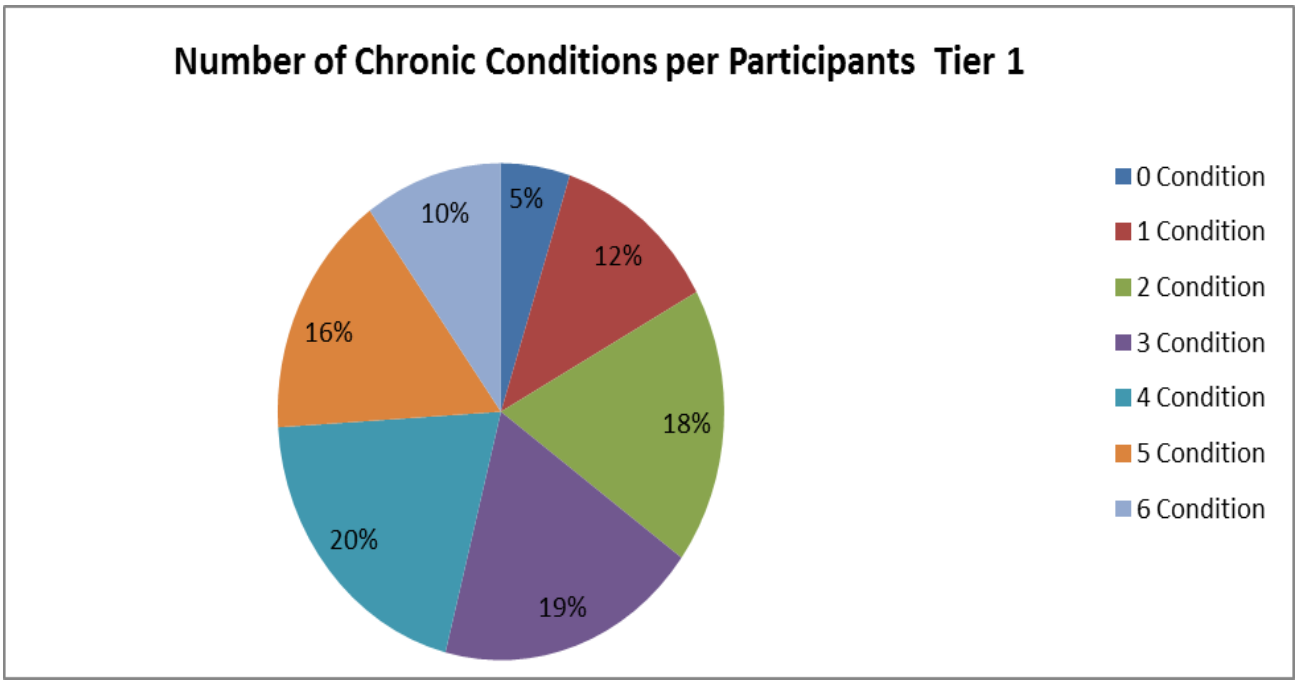
HMP Preventive Measures-Practice Facilitation Members vs. Comparison Group	Comparison Group Compliance Rate
Adult Access to Preventive/Ambulatory Care	84.7%

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

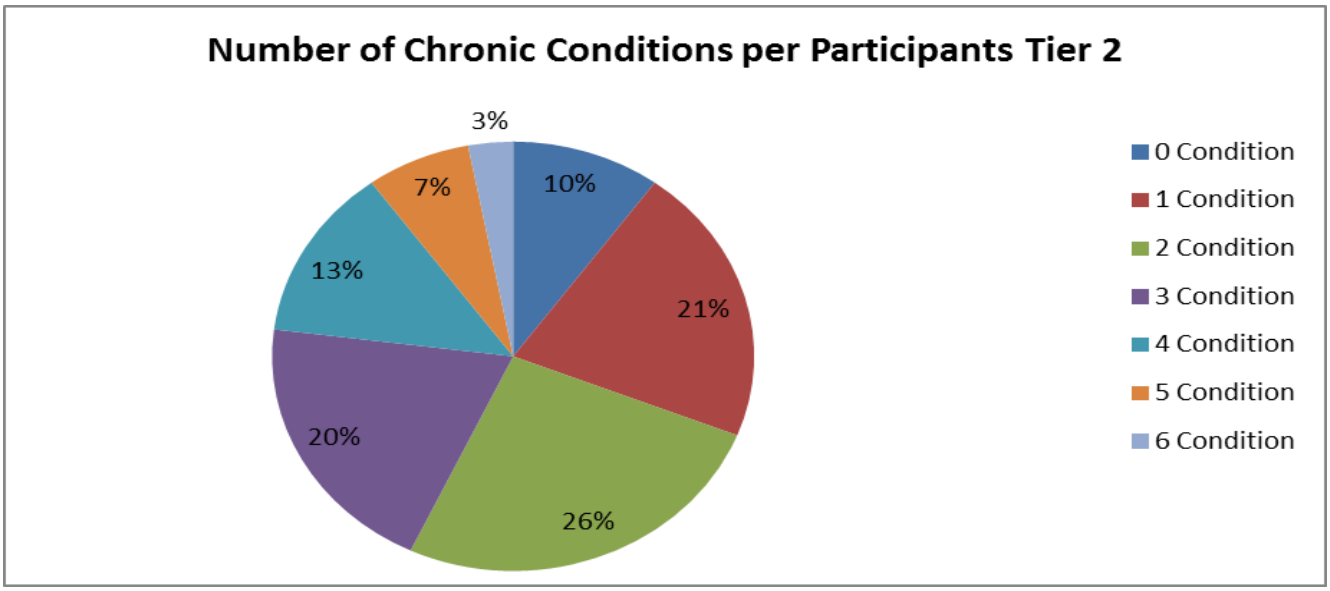
This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #2, and #2 of CMS's Three Part Aim.

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

Hypothesis 9c Results:

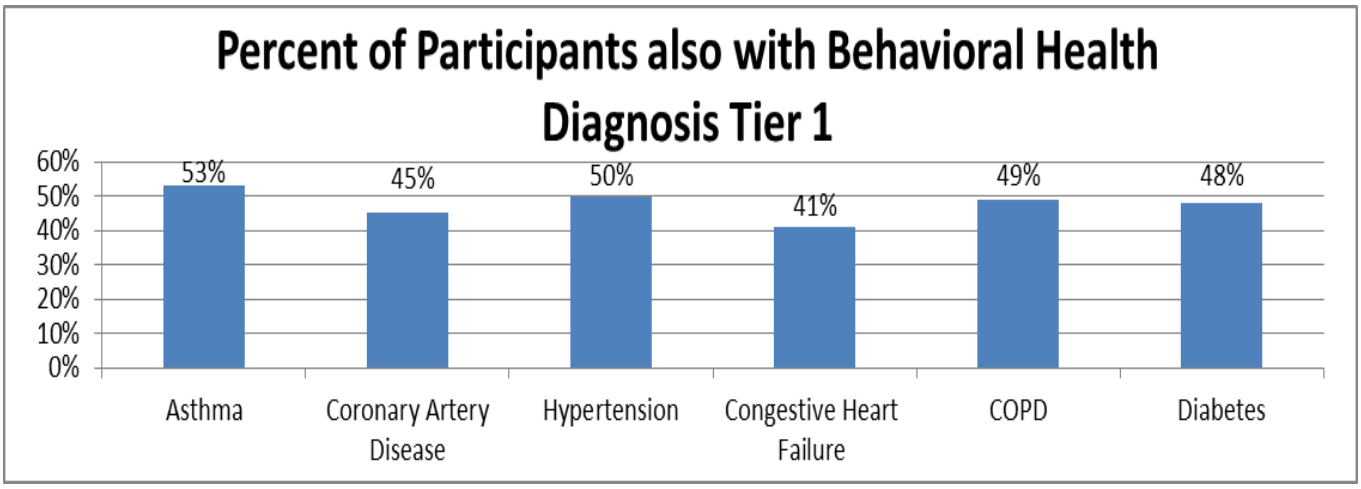


SFY2013 Results:

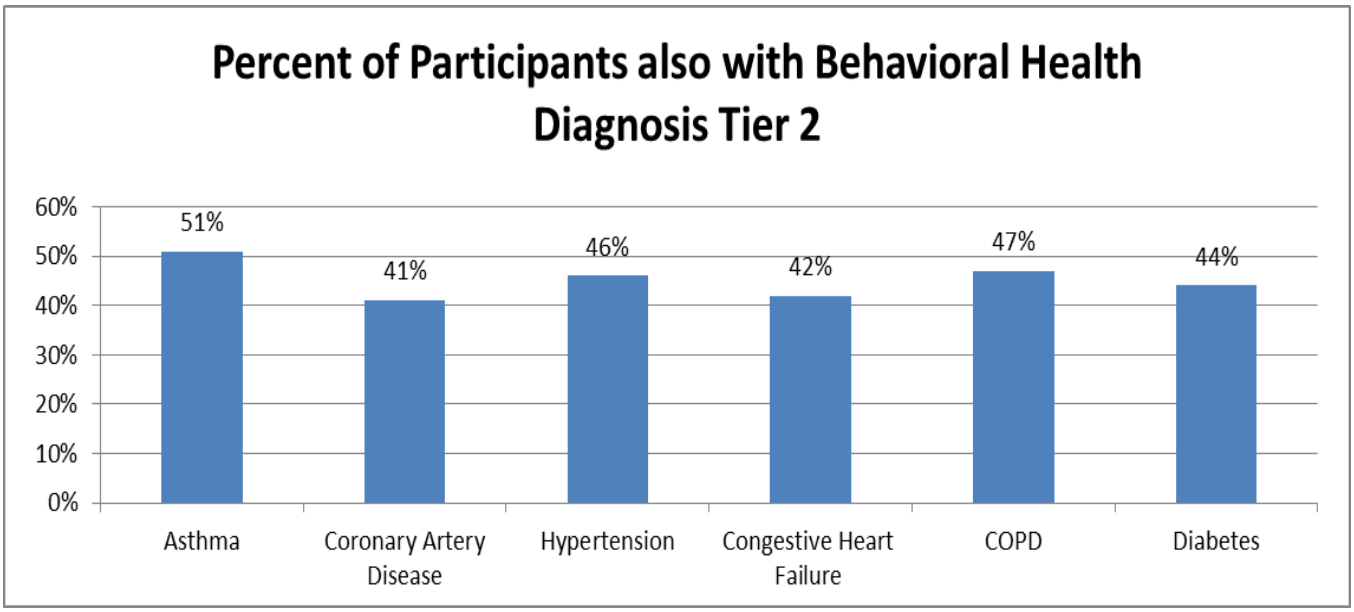


SFY2013 Results:

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



SFY2013 Results:



SFY2013 Results:

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

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

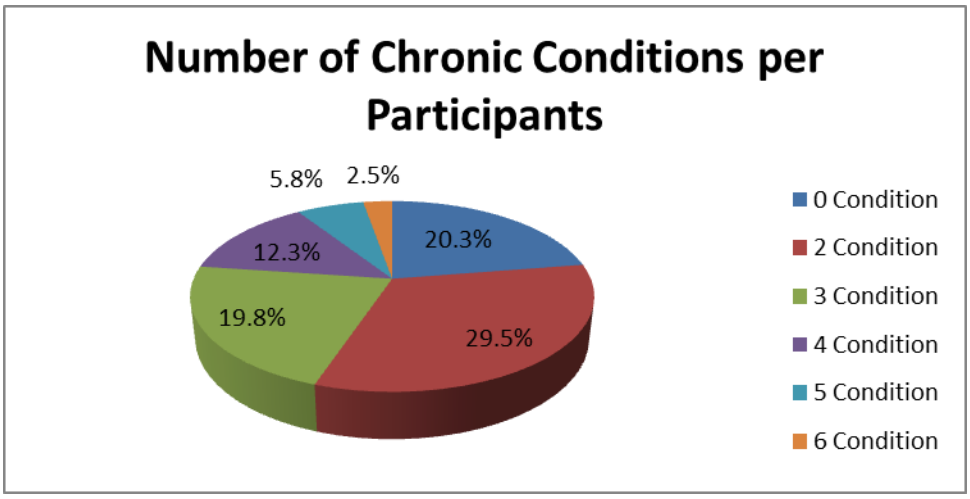
The Health Management Program (HMP) transitioned to Phase II of the program, Next Generation HMP, in July 2013. Phase II of the program embeds health coaches into the practices for face-to-face care management. The OHCA noted in earlier reporting the baseline data for this measure would begin SFY 2013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

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

[7] CDC Website

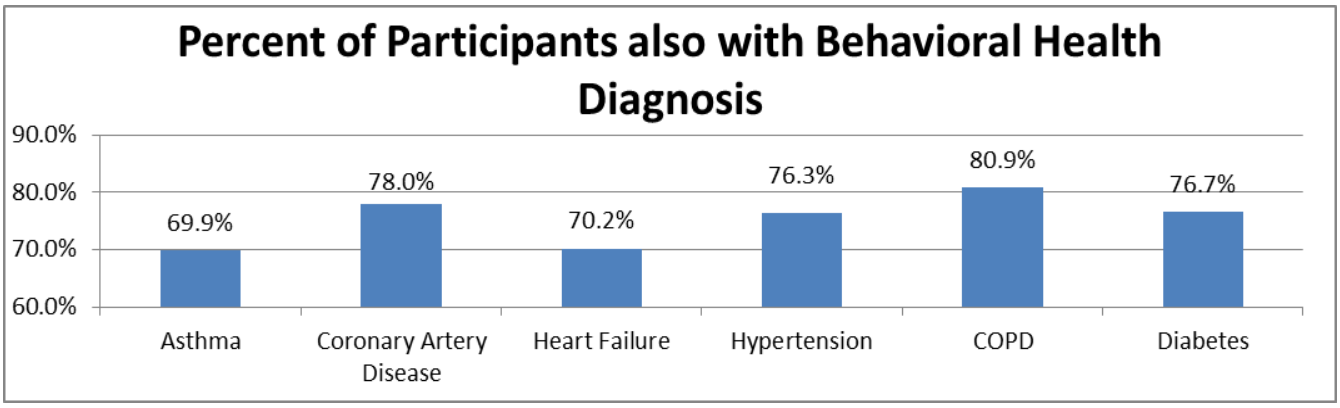
was to provide health coaching at any given time to as many as 7,500 members at around 46 enrolled practices, but the actual numbers found during the PHPG evaluation was closer to 5,000. Program participants are treated for numerous chronic and acute physical conditions. PHPG found that 80 percent of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

SFY2014 Results:



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

SFY2014 Results:



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

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

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

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

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

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

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

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

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

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

SFY2013 Results:

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

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

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

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

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

SFY2014 Results:

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

SFY2015 Results:

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

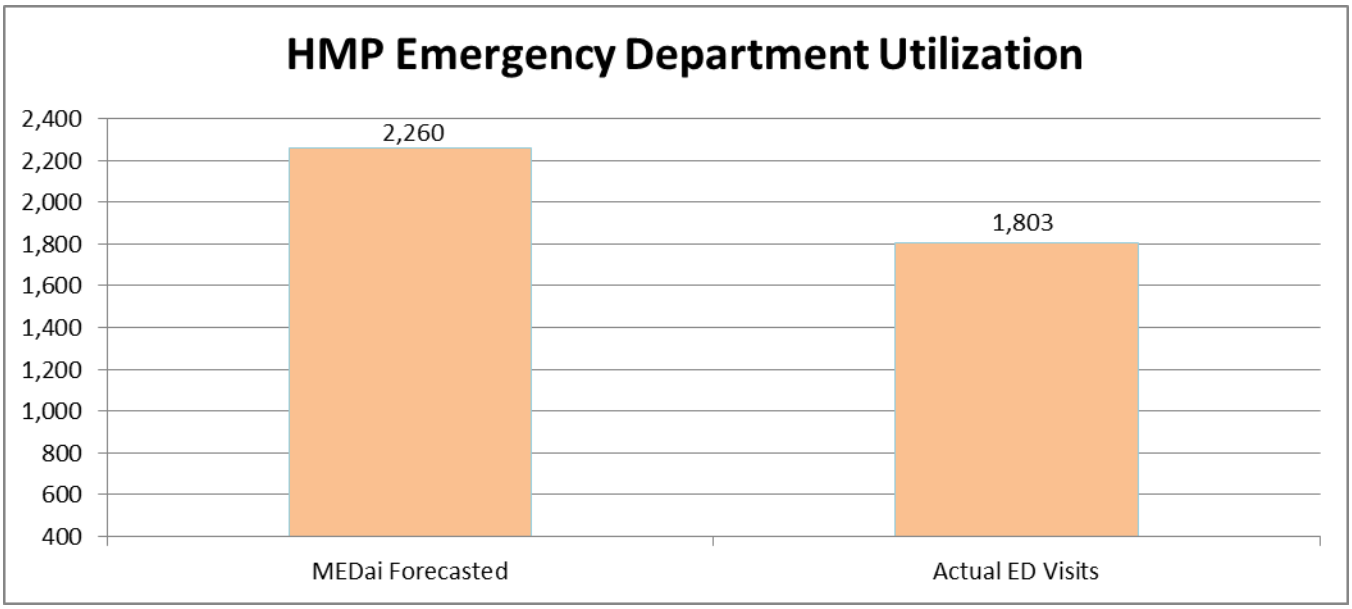
Hypothesis 9e: Health Management Program (HMP); Impact on Cost/Utilization of Care

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

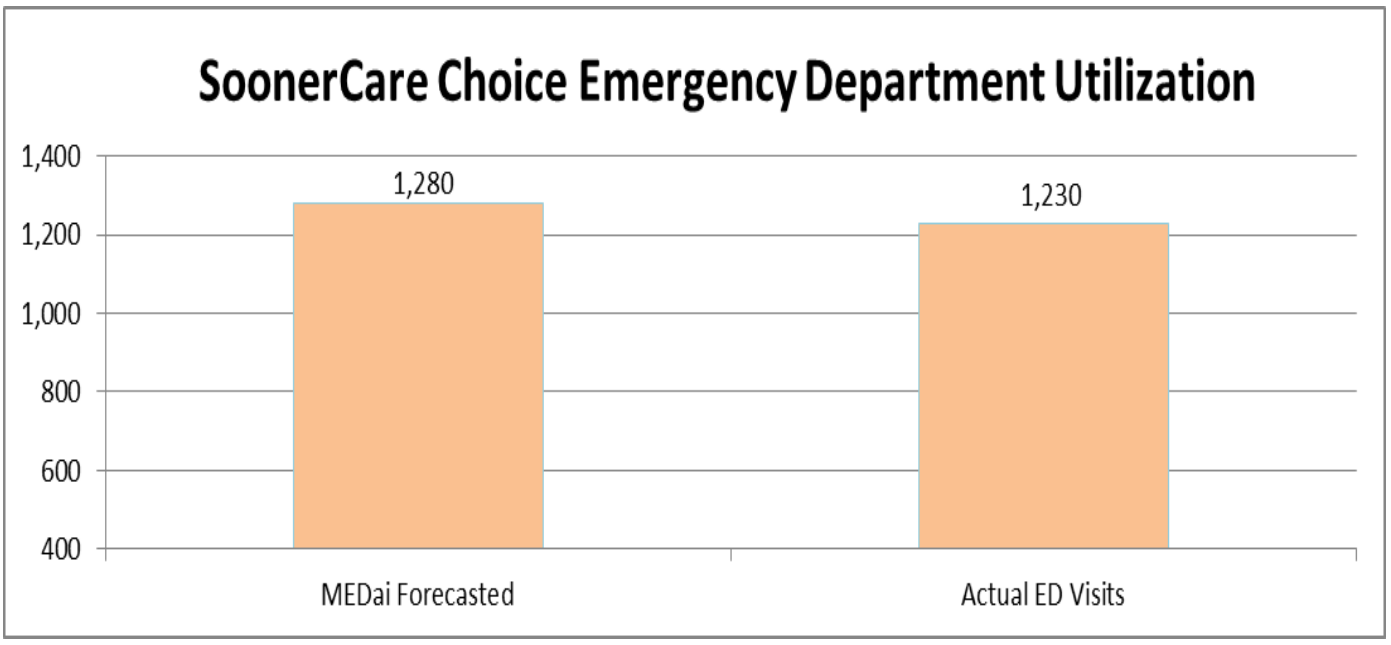
Hypothesis 9e Results:

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

SFY2014 Results



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



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

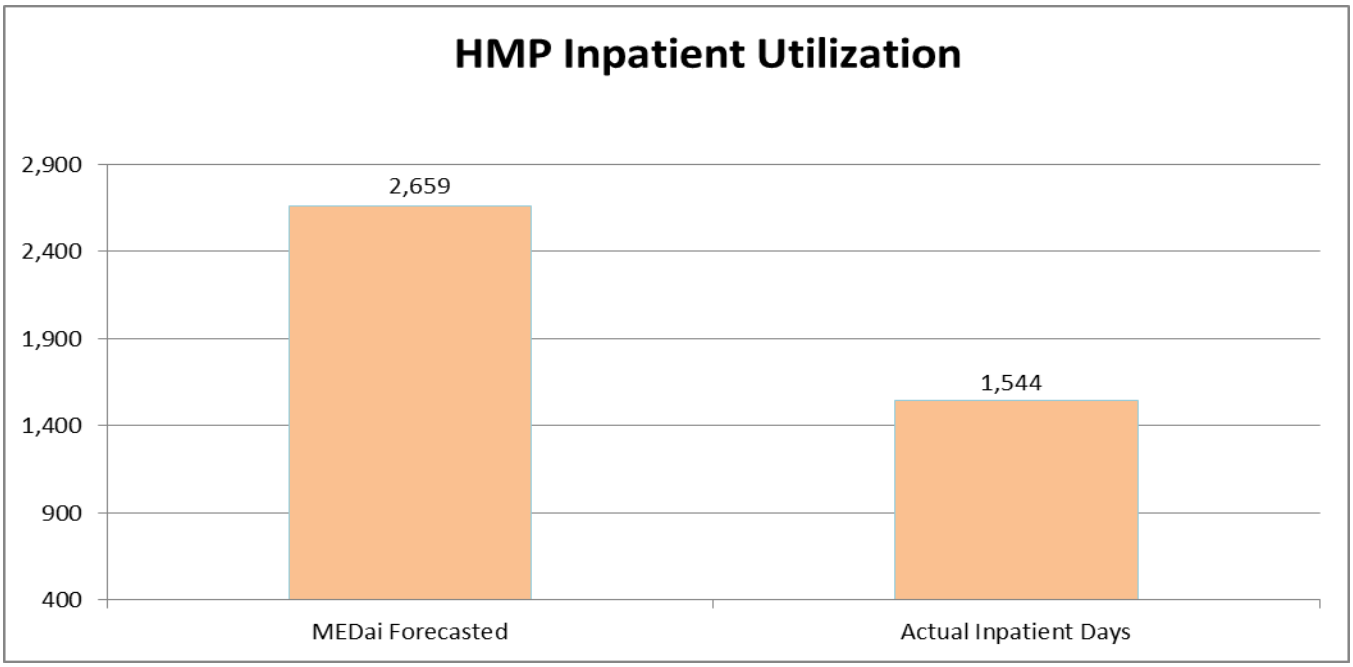
Hypothesis 9f: Health Management Program (HMP); Impact on Cost/Utilization of Care

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

Hypothesis 9f Results:

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

SFY2014 Results

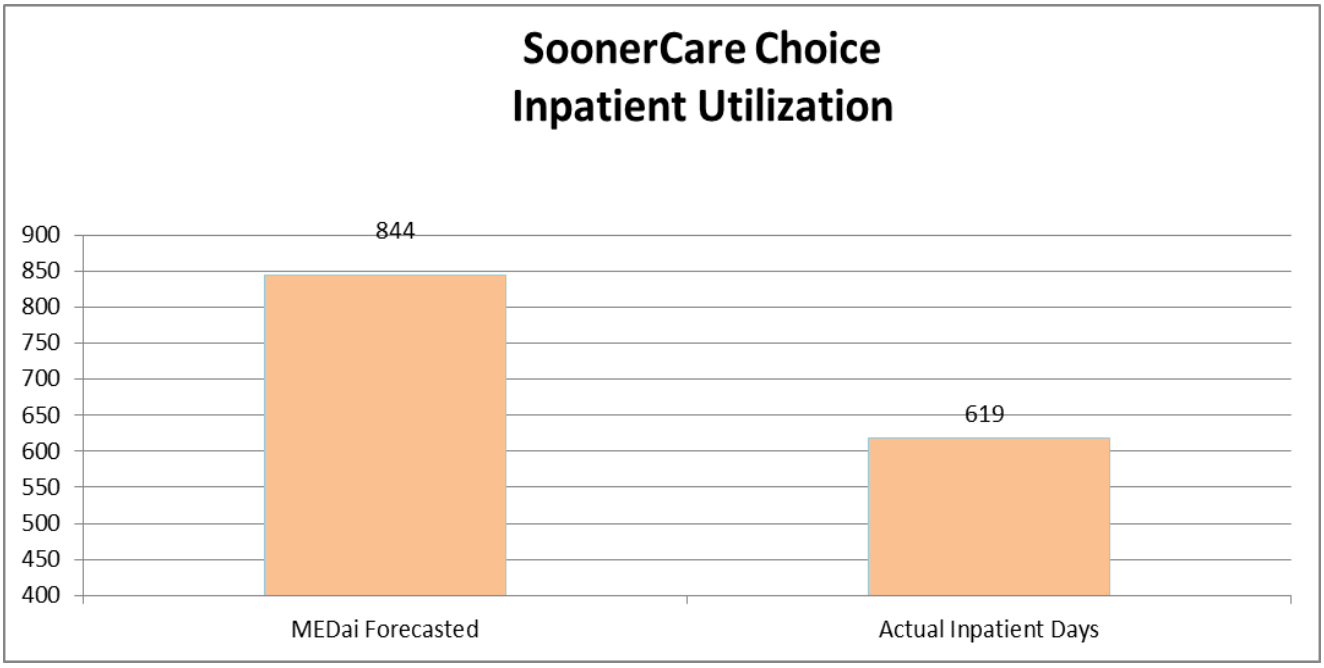


MEDai forecasted that SoonerCare HMP participants as a group would incur 2,659 inpatient days per 1,000 participants in the first 12 months of engagement. The actual rate was 1,544 or 58 percent of forecast. This demonstrated member receiving nurse care management services in the HMP were successfully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

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

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

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



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

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

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

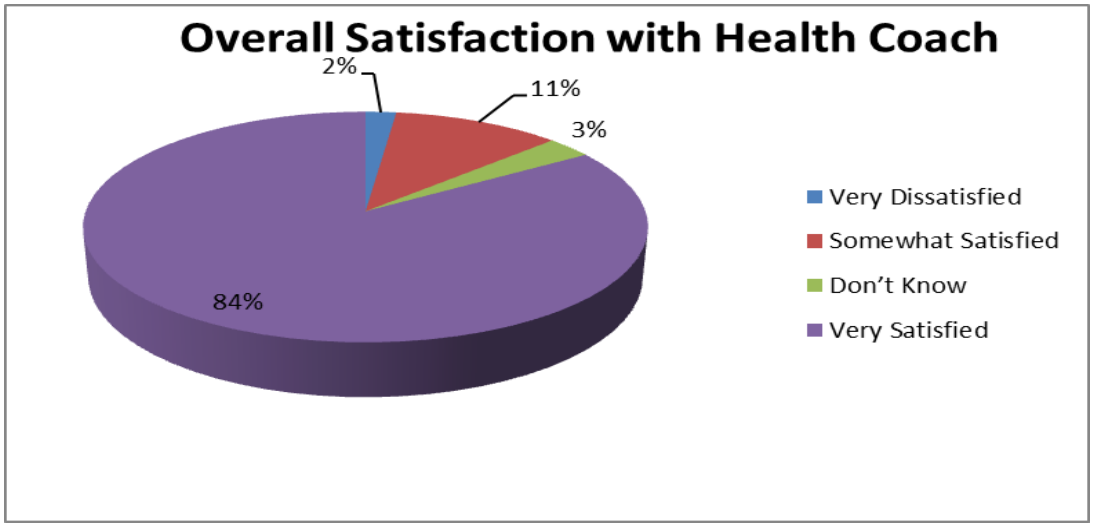
Hypothesis 9g: Health Management Program (HMP); Impact on Satisfaction/Experience with Care

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

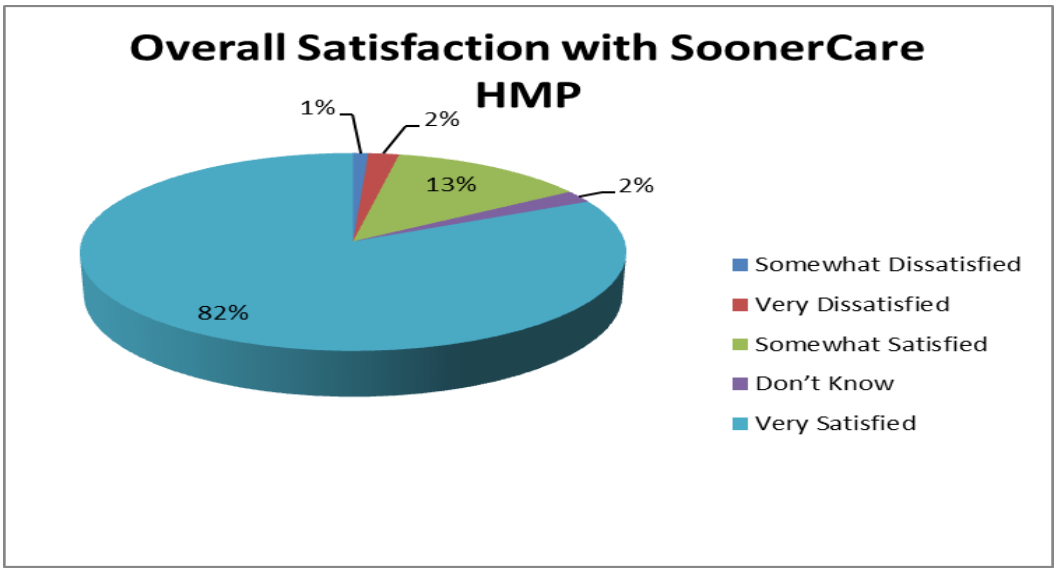
Hypothesis 9g Results:

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

SFY2014 Results



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



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

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

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

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

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

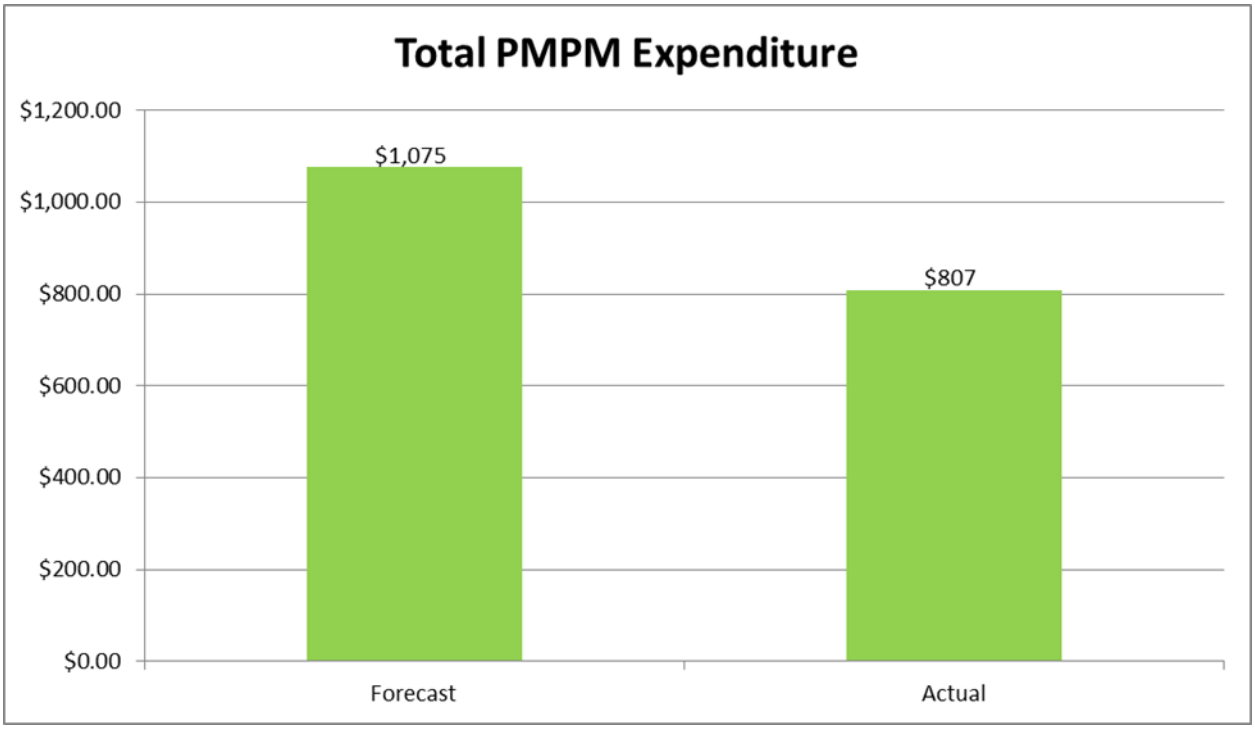
Hypothesis 9h Results:

SFY2014 Results:

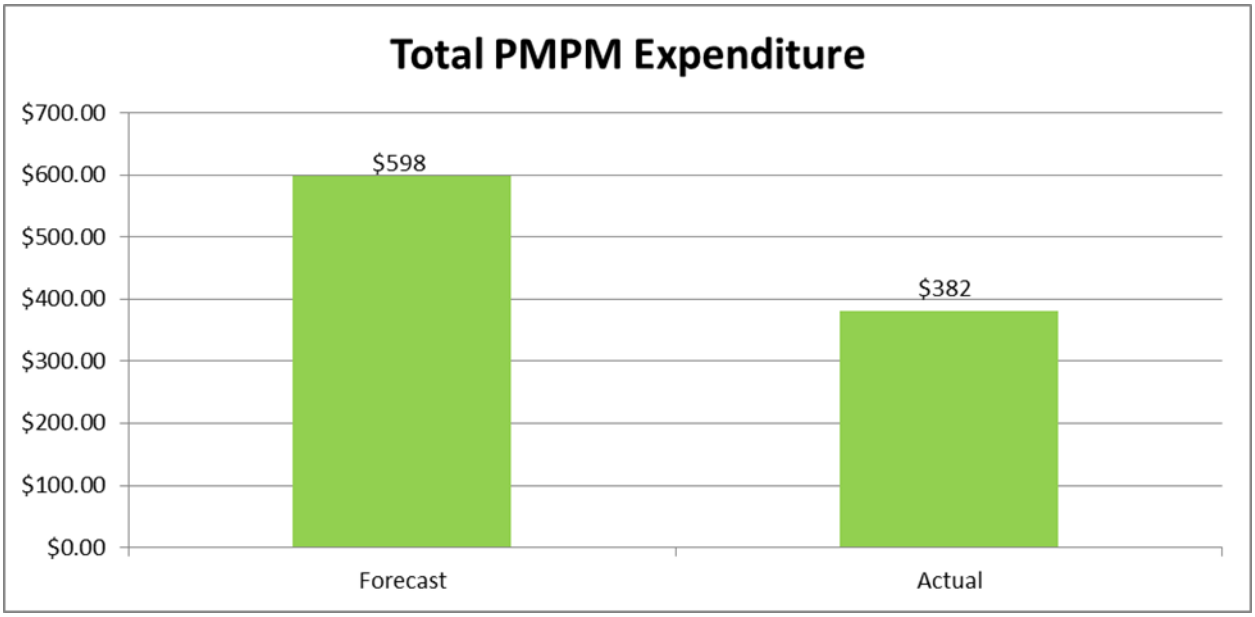
In accordance with OHCA's 2013-2015 Evaluation Design, this hypothesis relates to Phase II of the HMP program. The HMP program transitioned to Phase II of the program in July 2013. Phase II of the program embeds health coaches into the practices for face-to-face care management.

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

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



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



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

Hypothesis 10 – Retroactive Eligibility

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

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

Hypothesis 10 Results:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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

Attachments

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

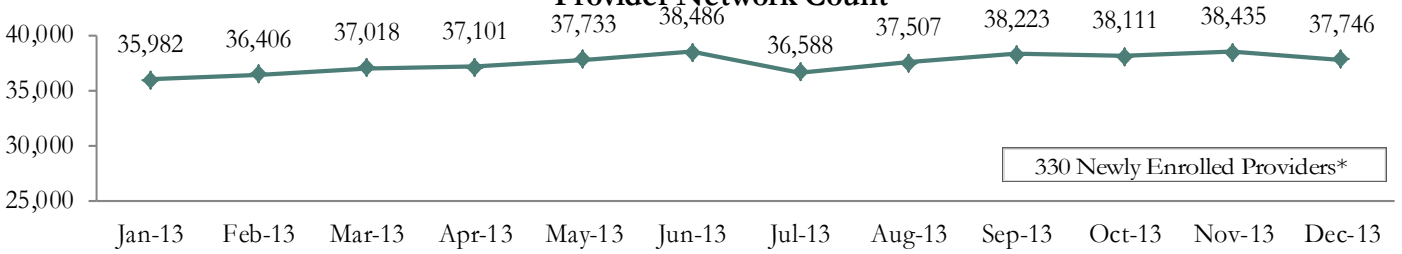
Provider Fast Facts

December 2013

Effective July 2012, the methodology for counting providers has changed to count provider network. Previous counts include group practice and its members; the current count will include members only. **Provider Network** is providers who are contracted to provide health care services by locations, programs, types, and specialties. Providers are being counted multiple times if they have multiple locations, programs, types, and/or specialties. The term "contracted" is defined as a provider that was enrolled with Oklahoma SoonerCare within the reporting period, it does not necessarily indicate participation.

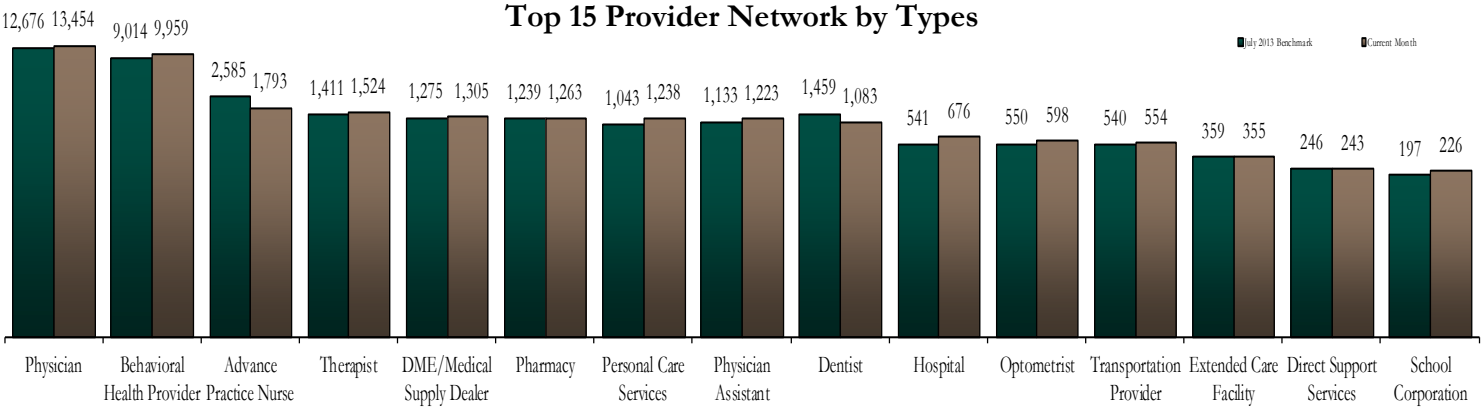
OHCA is currently in a provider contract renewal period. Some of the totals below may indicate a decrease in the provider counts due to this process. This occurrence is typical during all renewal periods.

Provider Network Count



* The data is based on the new provider IDs added to the system during the reporting month. The effective date of the contract may or may not be in that month.

Top 15 Provider Network by Types



Primary Care Provider (PCP) Capacities

SoonerCare Program	Total Capacity	% of Capacity Used
SoonerCare Choice	1,149,541	45.46%
SoonerCare Choice I/T/U	99,400	19.00%
Insure Oklahoma IP	423,972	1.14%

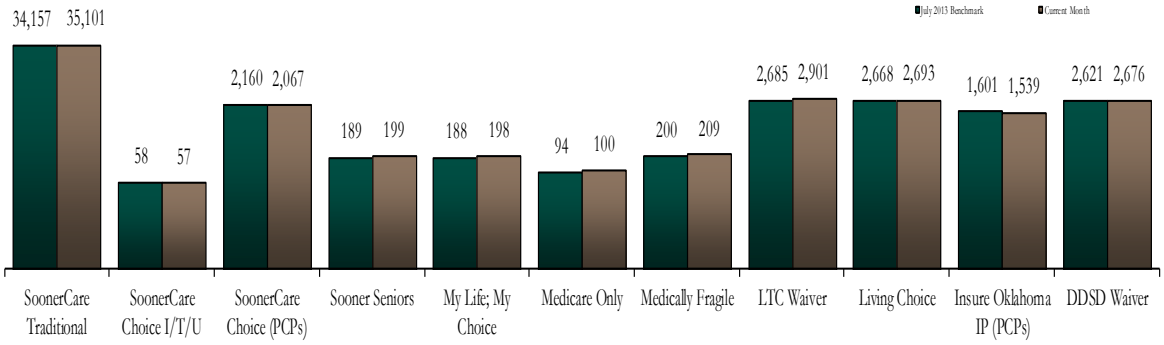
Total Capacity represents the maximum number of members that PCPs request to have assigned within OHCA's limit. Panels on hold status are excluded from the capacity calculation. The facility's panels such as group practice, FQHC (Federally Qualified Health Clinic), RHC (Rural Health Clinic), and other clinics are included.

Patient-Centered Medical Home (PCMH) Enrollment by Tier

Payment Tier Code	Count
Tier 1	521
Tier 2	234
Tier 3	126

These counts were computed using a different method than indicated elsewhere on the report and are not comparable to any other figures. Non-participating PCMH are excluded.

Provider Network by Program



Acronyms

DDSD - Developmental Disabilities Services Division

DME - Durable Medical Equipment

IP - Individual Plan

I/T/U - Indian Health Service/ Tribal/Urban Indian

LTC - Long-Term Care

PCMH - Patient-Centered Medical Home

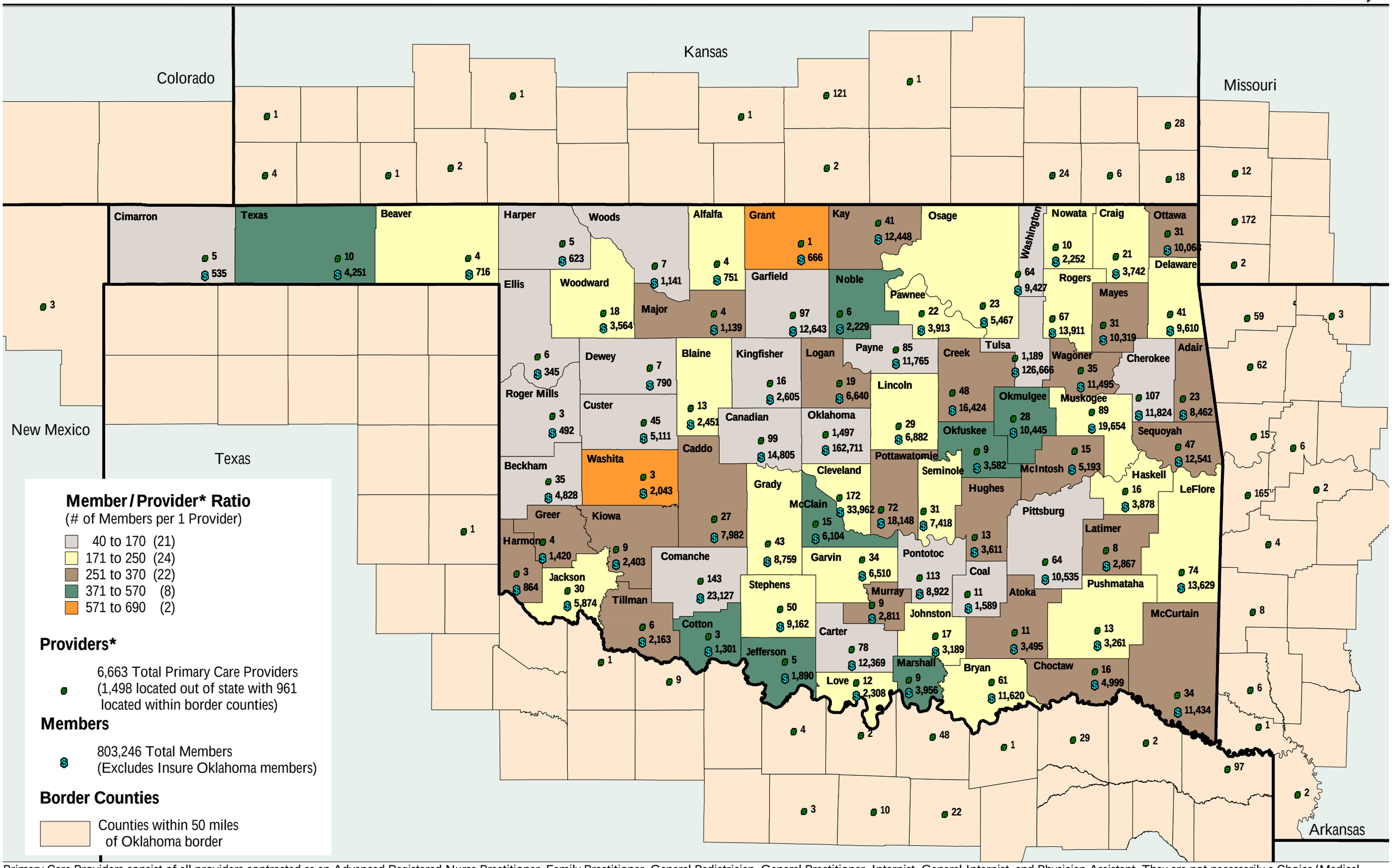
PCP - Primary Care Provider

1/13/2014

SoonerCare Member to Provider* Ratio

December 2013

oklahoma health care authority



Member / Provider* Ratio

(# of Members per 1 Provider)

- 40 to 170 (21)
- 171 to 250 (24)
- 251 to 370 (22)
- 371 to 570 (8)
- 571 to 690 (2)

Providers*

6,663 Total Primary Care Providers
(1,498 located out of state with 961 located within border counties)

Members

803,246 Total Members
(Excludes Insure Oklahoma members)

Border Counties

Counties within 50 miles of Oklahoma border

Primary Care Providers consist of all providers contracted as an Advanced Registered Nurse Practitioner, Family Practitioner, General Pediatrician, General Practitioner, Internist, General Internist, and Physician Assistant. They are not necessarily a Choice / Medical Home Provider. Data is valid as of the report date and is subject to change.

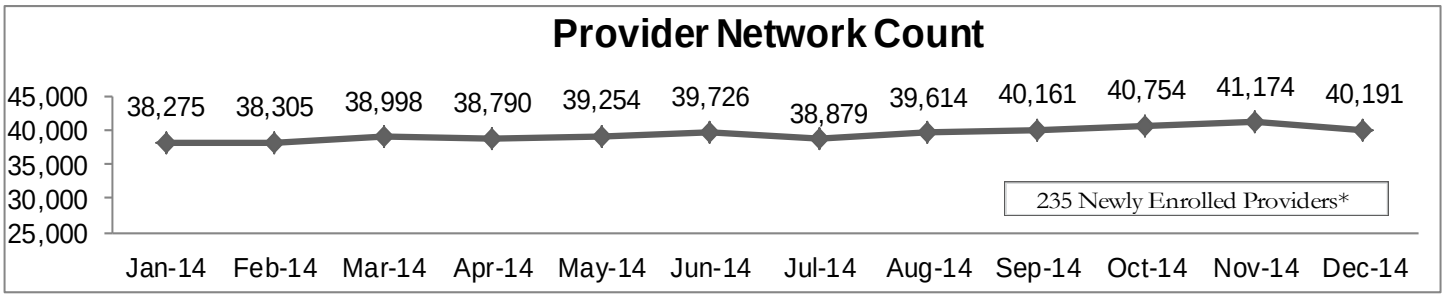
* Provider Network is define on previous page.

01 / 13 / 2014

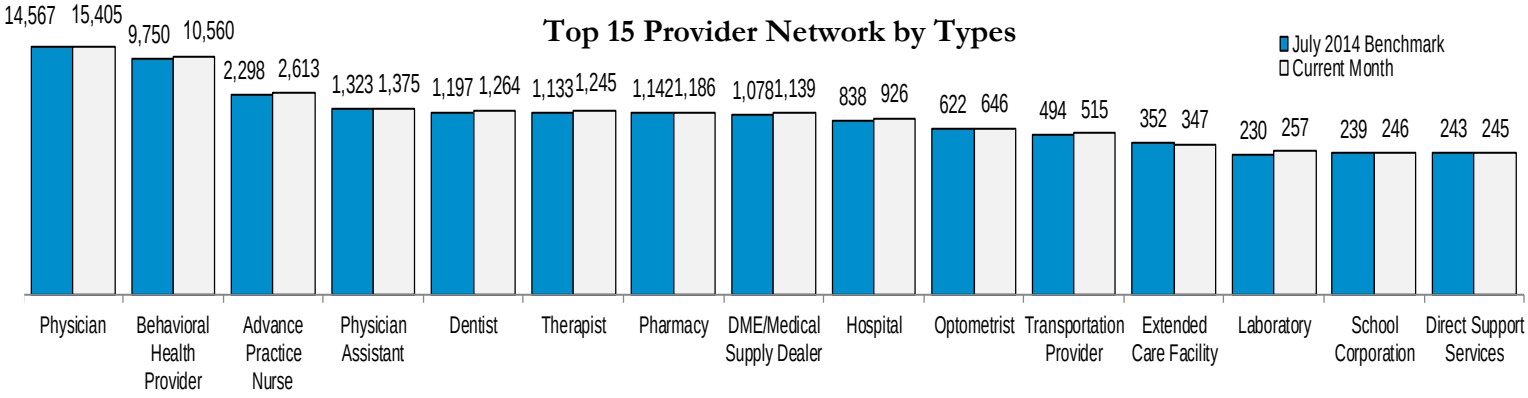
Provider Fast Facts
December 2014

Effective July 2012, the methodology for counting providers has changed to count provider network. Previous counts include group practice and its members; the current count will include members only. **Provider Network** is providers who are contracted to provide health care services by locations, programs, types, and specialties. Providers are being counted multiple times if they have multiple locations, programs, types, and/or specialties. The term "contracted" is defined as a provider that was enrolled with Oklahoma SoonerCare within the reporting period, it does not necessarily indicate participation.

OHCA is currently in a provider contract renewal period. Some of the totals below may indicate a decrease in the provider counts due to this process. This occurrence is typical during all renewal periods.



* The data is based on the new provider IDs added to the system during the reporting month. The effective date of the contract may or may not be in that month.



Primary Care Provider (PCP) Capacities

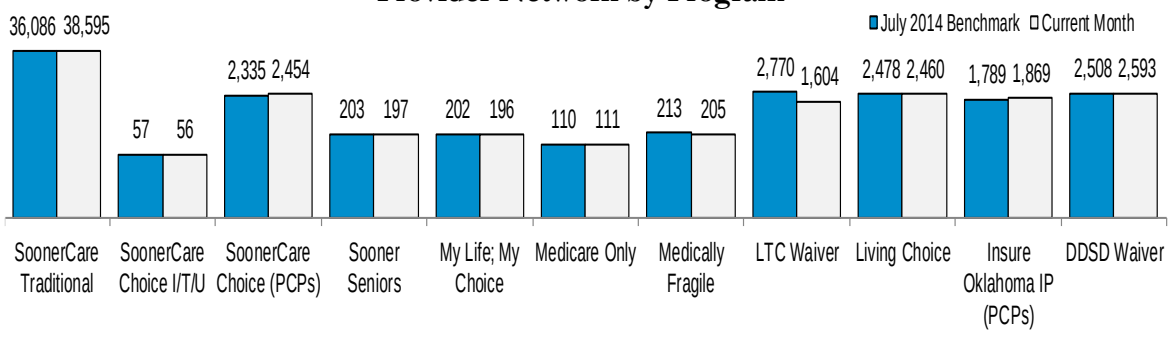
SoonerCare Program	Total Capacity	% of Capacity Used
SoonerCare Choice	1,155,455	43.50%
SoonerCare Choice I/T/U	98,400	19.65%
Insure Oklahoma IP	430,118	1.03%

Total Capacity represents the maximum number of members that PCPs request to have assigned within OHCA's limit. Panels on hold status are excluded from the capacity calculation. The facility's panels such as group practice, FQHC (Federally Qualified Health Clinic), RHC (Rural Health Clinic), and other clinics are included.

Patient-Centered Medical Home (PCMH) Enrollment by Tier

Payment Tier Code	Count
Tier 1	498
Tier 2	222
Tier 3	178

These counts were computed using a different method than indicated elsewhere on the report and are not comparable to any other figures. Non-participating PCMH are excluded.



Acronyms

DDSD - Developmental Disabilities Services Division

DME - Durable Medical Equipment

IP - Individual Plan

I/T/U - Indian Health Service/Tribal/ Urban Indian

LTC - Long-Term Care

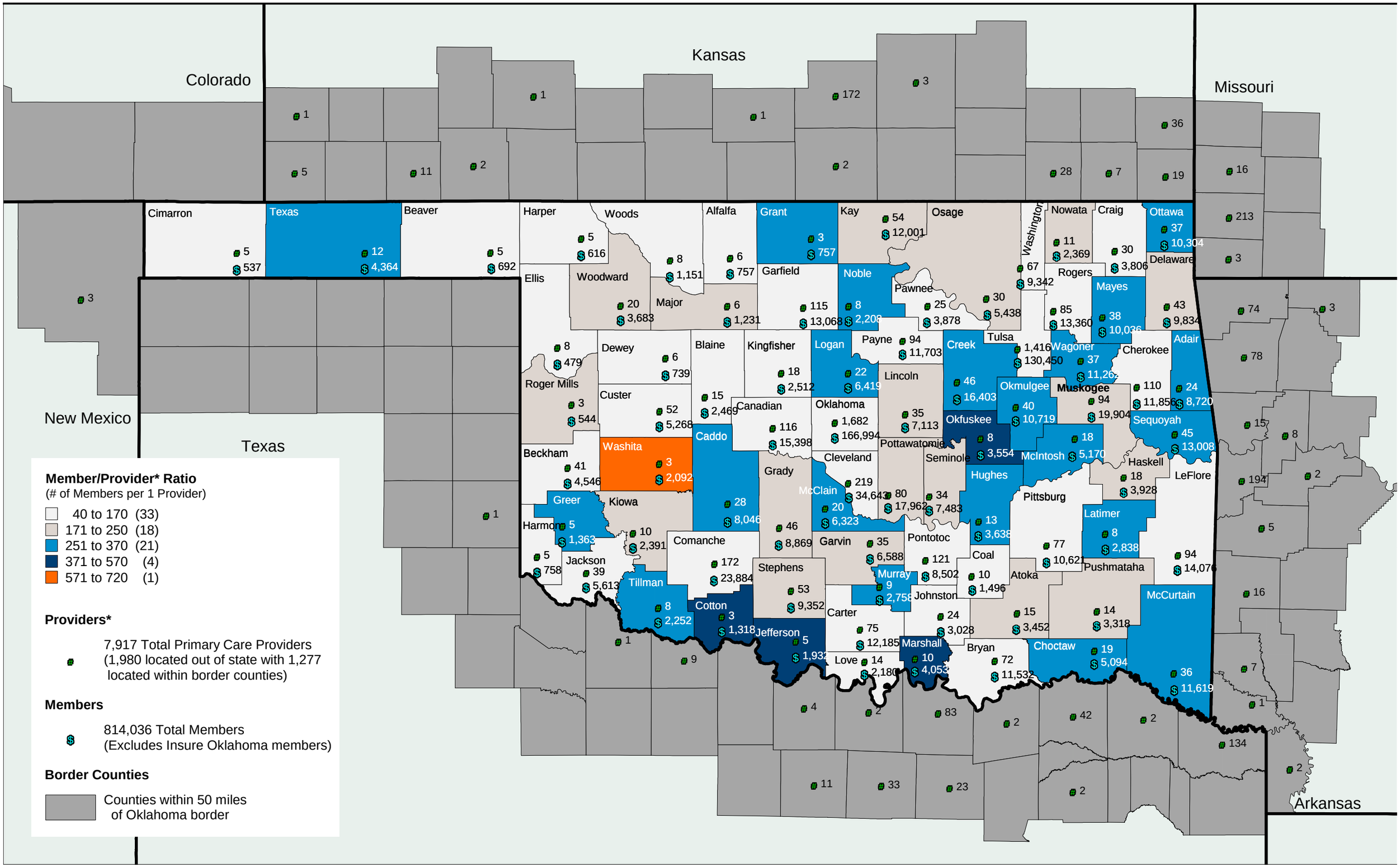
PCMH - Patient-Centered Medical Home

PCP - Primary Care Provider

1/13/2015

SoonerCare Member to Provider* Ratio
December 2014

Oklahoma Health Care Authority



Member/Provider* Ratio
(# of Members per 1 Provider)

- 40 to 170 (33)
- 171 to 250 (18)
- 251 to 370 (21)
- 371 to 570 (4)
- 571 to 720 (1)

Providers*

7,917 Total Primary Care Providers
(1,980 located out of state with 1,277 located within border counties)

Members

814,036 Total Members
(Excludes Insure Oklahoma members)

Border Counties

Counties within 50 miles of Oklahoma border

Primary Care Providers consist of all providers contracted as an Advanced Registered Nurse Practitioner, Family Practitioner, General Pediatrician, General Practitioner, Internist, General Internist, and Physician Assistant. They are not necessarily a Choice/Medical Home Provider. Data is valid as of the report date and is subject to change.

* Provider Network is define on previous page.

01/13/2015

Provider Fast Facts
December 2015

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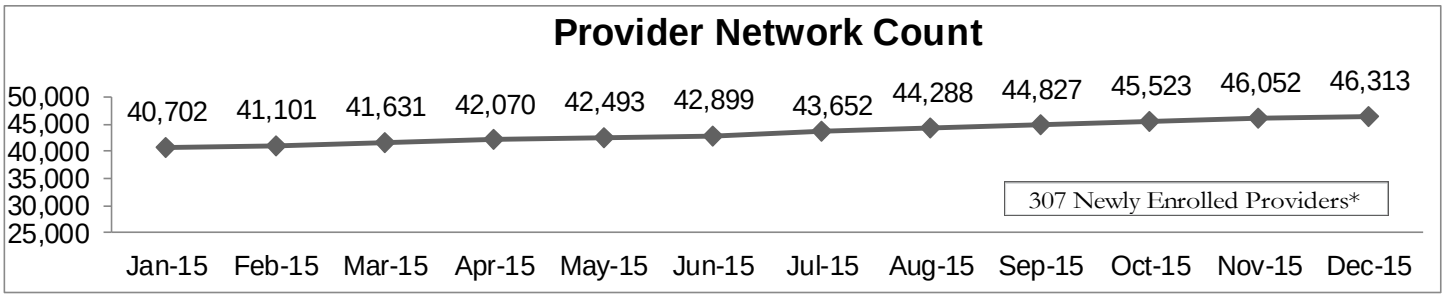

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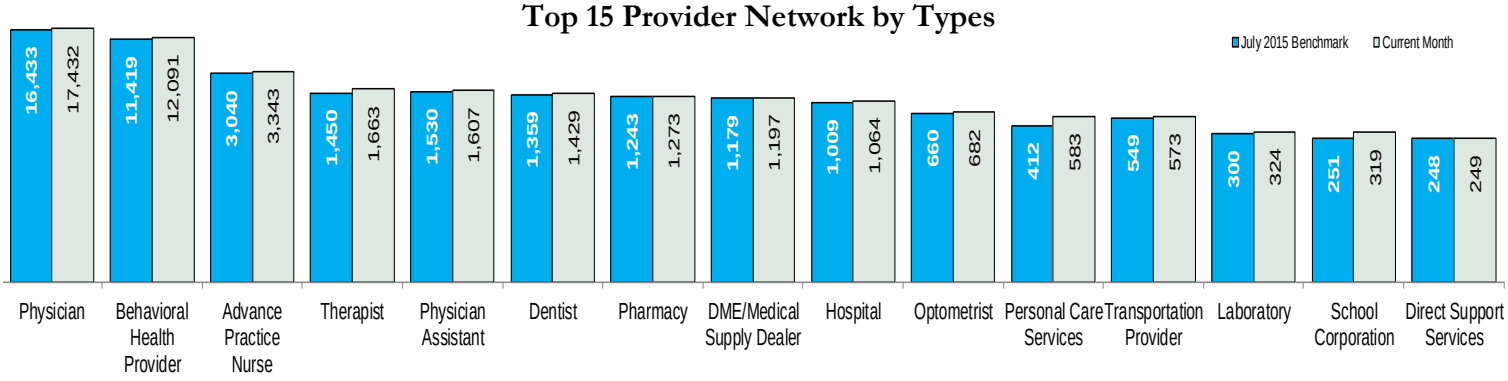
Top 15 Provider Network by Types



Primary Care Provider (PCP) Capacities

SoonerCare Program	Total Capacity	% of Capacity Used
SoonerCare Choice	1,146,767	41.23%
SoonerCare Choice I/T/U	96,999	16.78%
Insure Oklahoma IP	449,850	0.86%

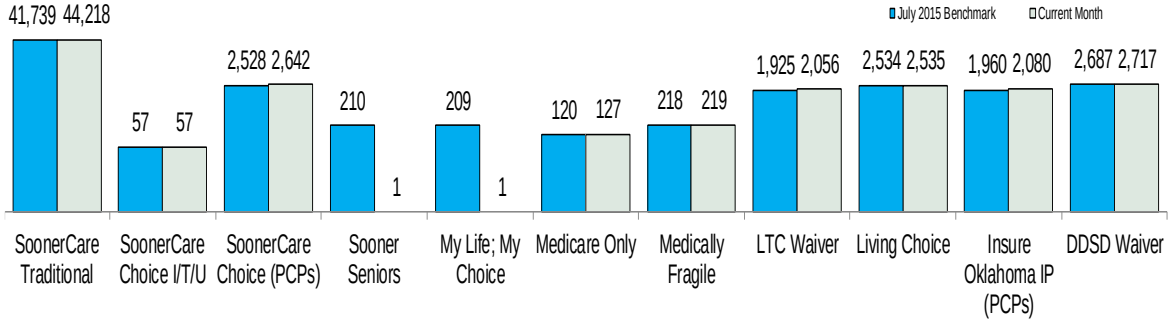
Total Capacity represents the maximum number of members that PCPs request to have assigned within OHCA's limit. Panels on hold status are excluded from the capacity calculation. The facility's panels such as group practice, FQHC (Federally Qualified Health Clinic), RHC (Rural Health Clinic), and other clinics are included.

Patient-Centered Medical Home (PCMH) Enrollment by Tier

Payment Tier Code	Count
Tier 1	497
Tier 2	235
Tier 3	195

These counts were computed using a different method than indicated elsewhere on the report and are not comparable to any other figures. Non-participating PCMH are excluded.

Provider Network by Program



Note: Sooner Seniors and My Life; My Choice waivers sunset in Dec 2015, eliminating the category for providers.

Acronyms

DDSD - Developmental Disabilities Services Division

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PCMH - Patient-Centered Medical Home

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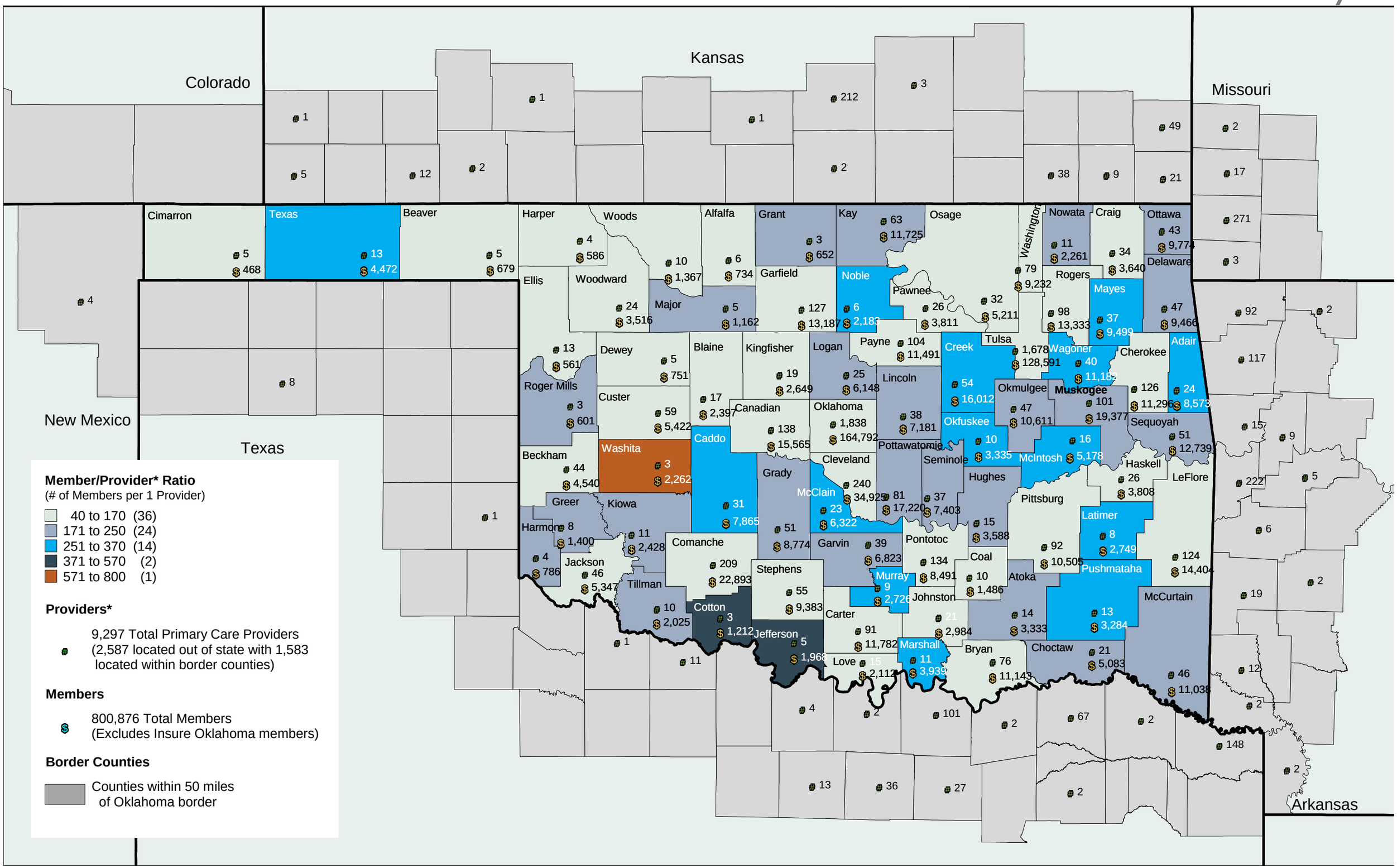
1/14/2016

SoonerCare Member to Provider* Ratio
December 2015

Oklahoma HealthCare Authority



Member/Provider* Ratio
(# of Members per 1 Provider)

- 40 to 170 (36)
- 171 to 250 (24)
- 251 to 370 (14)
- 371 to 570 (2)
- 571 to 800 (1)

Providers*

9,297 Total Primary Care Providers
(2,587 located out of state with 1,583 located within border counties)

Members

800,876 Total Members
(Excludes Insure Oklahoma members)

Border Counties

Counties within 50 miles of Oklahoma border

Primary Care Providers consist of all providers contracted as an Certified Registered Nurse Practitioner, Family Practitioner, General Pediatrician, General Practitioner, Internist, General Internist, and Physician Assistant. They are not necessarily a Choice/Medical Home Provider. Count is based on Provider Network which is defined on previous page. Data is valid as of the report date and is subject to change.

01/14/2016