DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

July 31, 2026

Melissa Miller, Medicaid Director
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

Dear Ms. Melissa Miller:

In accordance with 42 CFR 438.6(c), the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving Oklahoma's submission of a proposal for a state directed payment (SDP) under Medicaid managed care plan contract(s). The proposal was received by CMS on June 20, 2025, and a final revised preprint was received on March 26, 2026. The proposal has a control name of OK_Fee_IPH.OPH1_Renewal_20250701-20260630**.**

CMS has completed our review of the following Medicaid managed care SDP(s):

- Uniform increase for inpatient and outpatient hospital services for rating periods covering July 1, 2025 through June 30, 2026, incorporated in the capitation rates through a separate payment term amount up to $1,087,525,595.

This letter satisfies the regulatory requirement in 42 CFR 438.6(c)(2) for SDPs described in 42 CFR 438.6(c)(1). This letter pertains only to the actions identified above and does not apply to other actions currently under CMS's review. This letter does not constitute approval of any specific Medicaid financing mechanism used to support the non-federal share of expenditures associated with these actions. All relevant federal laws and regulations apply. CMS reserves its authority to enforce requirements in the Social Security Act and the applicable implementing regulations.

Based on CMS's preliminary determination, this SDP proposal likely qualifies for the temporary grandfathering period in section 71116(b) of the Working Families Tax Cut (WFTC) legislation (Public Law 119-21). CMS acknowledges that this determination is preliminary in nature and policies will be finalized as part of notice and comment rulemaking. CMS will enforce all federal requirements, including section 71116, and CMS's assessment may be revised if further information is identified that alters the initial assessment.

Until the phase down required by section 71116 begins, the total dollar amount of a grandfathered SDP (as specified in item 4 of the current SDP preprint form) cannot increase and a state cannot increase this total dollar amount under any change or revision to the grandfathered SDP, including an amendment to the SDP, or subsequent renewal of this SDP for a future rating period. For rating periods beginning on or after January 1, 2028, grandfathered SDPs must comply with the specified phase down requirements.

The state is required to submit contract action(s) and related capitation rates that include all SDPs, including those that do not require written prior approval as specified in 42 CFR 438.6(c)(2)(i). Additionally, all SDPs must be addressed in the applicable rate certifications.

CMS recommends that states share this letter and the preprint(s) with the certifying actuary. Documentation of all SDPs must be included in the initial rate certification as outlined in Section I, Item 4, Subsection D, of the Medicaid Managed Care Rate Development Guide. The state and its actuary must ensure all documentation outlined in the Medicaid Managed Care Rate Development Guide is included in the initial rate certification. Failure to provide all required documentation in the rate certification will cause delays in CMS review.

Approval of this SDP proposal for the applicable rating period does not preclude CMS from requesting additional materials from the state, revision to the SDP proposal design, or any other modifications to the proposal for this rating period or future rating periods, if CMS determines that such modifications are required for the state to meet relevant federal requirements.

If you have any questions concerning this letter, please contact StateDirectedPayment@cms.hhs.gov.

Sincerely,

JOHN F. GILES JR -S

Digitally signed by JOHN F. GILES JR -S
Date: 2026.07.31 11:57:33 -04'00'

John Giles
Director, Managed Care Group
Center for Medicaid and CHIP Services

Section 438.6(c) Preprint

42 C.F.R. § 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts (i.e., state directed payments). 42 C.F.R. § 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract. Under 42 C.F.R. § 438.6(c)(2)(ii), contract arrangements that direct an MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in 42 C.F.R. § 438.6(c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D). Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).

Submit all state directed payment preprints for prior approval to: StateDirectedPayment@cms.hhs.gov.

SECTION I: DATE AND TIMING INFORMATION

1. Identify the State's managed care contract rating period(s) for which this payment arrangement will apply (for example, July 1, 2020 through June 30, 2021):

   July 1, 2025 - June 30, 2026

2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2021). *Note, this should be the start of the contract rating period unless this payment arrangement will begin during the rating period.* July 1, 2025

3. Identify the managed care program(s) to which this payment arrangement will apply:

   SoonerSelect Health Program & SoonerSelect Children's Specialty Program

4. Identify the estimated **total dollar amount** (federal and non-federal dollars) of this state directed payment: $1,087,525,595

   a. Identify the estimated federal share of this state directed payment: $826,519,452

   b. Identify the estimated non-federal share of this state directed payment: $261,006,143

   Please note, the estimated total dollar amount and the estimated federal share should be described for the rating period in Question 1. If the State is seeking a multi-year approval (which is only an option for VBP/DSR payment arrangements (42 C.F.R. § 438.6(c)(1)(i)-(ii))), States should provide the estimates per rating period. For amendments, states should include the change from the total and federal share estimated in the previously approved preprint.

5. Is this the initial submission the State is seeking approval under 42 C.F.R. § 438.6(c) for this state directed payment arrangement? ☐ Yes ☒ No

6. If this is not the initial submission for this state directed payment, please indicate if:

a. ☐ The State is seeking approval of an amendment to an already approved state directed payment.

b. ☒ The State is seeking approval for a renewal of a state directed payment for a new rating period.

i. If the State is seeking approval of a renewal, please indicate the rating periods for which previous approvals have been granted:

April 1, 2024 - June 30, 2025

c. Please identify the types of changes in this state directed payment that differ from what was previously approved.

☐ Payment Type Change
☐ Provider Type Change
☐ Quality Metric(s) / Benchmark(s) Change
☒ Other; please describe:

This SDP was initially approved by CMS for the April 1, 2024, through June 30, 2025, contract rating period. The following changes have been made for the SFY 2026 rating period: 1) Developed separate uniform dollar and perc

☐ No changes from previously approved preprint other than rating period(s).

7. ☒ Please use the checkbox to provide an assurance that, in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(F), the payment arrangement is not renewed automatically.

SECTION II: TYPE OF STATE DIRECTED PAYMENT

8. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., utilization of services by managed care enrollees, meet or exceed a performance benchmark on provider quality metrics).

The Oklahoma Health Care Authority (OHCA) will require each managed care organization (MCO) to make directed payments to qualifying SHOPP-eligible hospitals. For each combination of service type (inpatient or outpatient), class of SHOPP-eligible hospitals, and managed care program, OHCA calculated a fixed payment pool and interim uniform dollar increase per managed care plan discharge (for inpatient services) or interim uniform percentage increase to base managed care plan payments (for outpatient services) such that total modeled managed care plan payments (including base and directed payments) are equal to 90% of the commercial payment equivalent.

Quarterly interim payments will initially be made to each eligible hospital based on modeled managed care plan discharges and base payments and interim uniform dollar and percentage increase amounts. At the conclusion of the contract period and after the contract period encounter data is sufficiently complete, OHCA will perform a reconciliation based on actual in-network managed care plan discharges and base payments for the July 2025 through June 2026 contract period. Under this reconciliation, OHCA will:
- Calculate a final uniform dollar increase per discharge (for inpatient services) and final uniform percentage increase (for outpatient services) in order to pay the total fixed payment pool amount for each combination of service type, class of SHOPP-eligible hospitals, and managed care program, such that total final payments are equal to $1,087,525,595.
- Calculate final directed payments for each hospital by multiplying the hospital's contract period discharges by the applicable final uniform dollar increase per discharge (for inpatient services) and by multiplying the hospital's contract period base managed care plan payments by the applicable final uniform percentage increase (for outpatient services).

Any differences in final vs. interim directed payments will be settled with each hospital through recoupment of payments (if the final payment amount is less than the sum of the four quarterly interim payments) or an additional payment (if the final payment is more than the sum of the four quarterly interim payments).

a. ☒ Please use the checkbox to provide an assurance that CMS has approved the federal authority for the Medicaid services linked to the services associated with the SDP (i.e., Medicaid State plan, 1115(a) demonstration, 1915(c) waiver, etc.).

b. Please also provide a link to, or submit a copy of, the authority document(s) with initial submissions and at any time the authority document(s) has been renewed/revised/updated.

Oklahoma's currently approved State Plan is available at: https://oklahoma.gov/content/dam/ok/en/okhca/docs/research/title-xix-state-plans/2025/State%20Plan%2005.01.2025.pdf

CMS approved Oklahoma's request for an amendment to the 1915(b) waiver for the managed care program, OK-0001.R00.01, titled SoonerSelect, effective March 1, 2024.

9. Please select the general type of state directed payment arrangement the State is seeking prior approval to implement. (Check all that apply and address the underlying questions for each category selected.)

a. ☐ **VALUE-BASED PAYMENTS / DELIVERY SYSTEM REFORM:** In accordance with 42 C.F.R. § 438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

If checked, please answer all questions in Subsection IIA.

b. ☒ **FEE SCHEDULE REQUIREMENTS:** In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(B) through (D), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. **[Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).]**

If checked, please answer all questions in Subsection IIB.

SUBSECTION IIA: VALUE-BASED PAYMENTS (VBP) / DELIVERY SYSTEM REFORM (DSR):

This section must be completed for all state directed payments that are VBP or DSR. This section does not need to be completed for state directed payments that are fee schedule requirements.

10. Please check the type of VBP/DSR State directed payment the State is seeking prior approval for. *Check all that apply; if none are checked, proceed to Section III.*

☐ Quality Payment/Pay for Performance (Category 2 APM, or similar)
☐ Bundled Payment/Episode-Based Payment (Category 3 APM, or similar)
☐ Population-Based Payment/Accountable Care Organization (Category 4 APM, or similar)
☐ Multi-Payer Delivery System Reform
☐ Medicaid-Specific Delivery System Reform
☐ Performance Improvement Initiative
☐ Other Value-Based Purchasing Model

11. Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services. If "other" was checked above, identify the payment model. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., meet or exceed a performance benchmark on provider quality metrics).

12. In Table 1 below, identify the measure(s), baseline statistics, and targets that the State will tie to provider performance under this payment arrangement (provider performance measures). Please complete all boxes in the row. To the extent practicable, CMS encourages states to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures when applicable. If the state needs more space, please use Addendum Table 1.A and check this box: ☐

TABLE 1: Payment Arrangement Provider Performance Measures

Measure Name and NQF # (if applicable)	**Measure Steward/ Developer**[1]	**Baseline**[2] **Year**	**Baseline**[2] **Statistic**	**Performance Measurement Period**[3]	**Performance Target**	**Notes**[4]
Example: Percent of High-Risk Residents with Pressure Ulcers – Long Stay	*CMS*	*CY 2018*	*9.23%*	*Year 2*	*8%*	*Example notes*
a.						
b.						
c.						
d.						
e.						

1. Baseline data must be added after the first year of the payment arrangement
2. If state-developed, list State name for Steward/Developer.
3. If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement that performance on the measure will trigger payment.
4. If the State is using an established measure and will deviate from the measure steward's measure specifications, please describe here. Additionally, if a state-specific measure will be used, please define the numerator and denominator here.

13. For the measures listed in Table 1 above, please provide the following information:

a. Please describe the methodology used to set the performance targets for each measure.

b. If multiple provider performance measures are involved in the payment arrangement, discuss if the provider must meet the performance target on each measure to receive payment or can providers receive a portion of the payment if they meet the performance target on some but not all measures?

c. For state-developed measures, please briefly describe how the measure was developed?

14. Is the State seeking a multi-year approval of the state directed payment arrangement?
☐ Yes ☐ No

a. If this payment arrangement is designed to be a multi-year effort, denote the State's managed care contract rating period(s) the State is seeking approval for.

b. If this payment arrangement is designed to be a multi-year effort and the State is **NOT** requesting a multi-year approval, describe how this application's payment arrangement fits into the larger multi-year effort and identify which year of the effort is addressed in this application.

15. Use the checkboxes below to make the following assurances:

a. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(A), the state directed payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified below) providing services under the contract related to the reform or improvement initiative.

b. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.

c. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(C), the payment arrangement does not set the amount or frequency of the expenditures.

d. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES:

This section must be completed for all state directed payments that are fee schedule requirements. This section does not need to be completed for state directed payments that are VBP or DSR.

16. Please check the type of state directed payment for which the State is seeking prior approval. *Check all that apply; if none are checked, proceed to Section III.*

a. ☐ Minimum Fee Schedule for providers that provide a particular service under the contract *using rates other than State plan approved rates* [1] (42 C.F.R. § 438.6(c)(1)(iii)(B))

b. ☐ Maximum Fee Schedule (42 C.F.R. § 438.6(c)(1)(iii)(D))

c. ☒ Uniform Dollar or Percentage Increase (42 C.F.R. § 438.6(c)(1)(iii)(C))

[1] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

17. If the State is seeking prior approval of a fee schedule (options a or b in Question 16):

- **a.** Check the basis for the fee schedule selected above.
  - **i.** ☐ The State is proposing to use a fee schedule based on the **State-plan approved rates** as defined in 42 C.F.R. § 438.6(a). [2]
  - **ii.** ☐ The State is proposing to use a fee schedule based on the **Medicare or Medicare-equivalent rate**.
  - **iii.** ☐ The State is proposing to use a fee schedule based on an **alternative fee schedule established by the State**.
    1. If the State is proposing an alternative fee schedule, please describe the alternative fee schedule (e.g., 80% of Medicaid State-plan approved rate)
- **b.** Explain how the state determined this fee schedule requirement to be reasonable and appropriate.

18. If using a maximum fee schedule (option b in Question 16), please answer the following additional questions:

- **a.** ☐ Use the checkbox to provide the following assurance: In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.
- **b.** Describe the process for plans and providers to request an exemption if they are under contract obligations that result in the need to pay more than the maximum fee schedule.
- **c.** Indicate the number of exemptions to the requirement:
  - **i.** Expected in this contract rating period (estimate)
  - **ii.** Granted in past years of this payment arrangement
- **d.** Describe how such exemptions will be considered in rate development.

[2] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

19. If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:

a. Will the state require plans to pay a ☐ uniform dollar amount **or** a ☒ uniform percentage increase? (*Please select only one.*)

b. What is the magnitude of the increase (e.g., $4 per claim or 3% increase per claim?)

For the SoonerSelect Health Program, the inpatient uniform dollar increase per discharge is $13,905.94 for eligible CAHs (prior to limiting payments based on billed charges as described in response to Question 21), $9,102.96 for eligible non-CAH

c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).

Interim quarterly payments will be made by the managed care plans to qualifying SHOPP-eligible hospitals based on modeled managed care plan discharges and payments for the hospitals. At the conclusion of the contract period and after the contract period encounter data is sufficiently complete, OHCA will perform a reconciliation based on actual in-network managed care plan discharges and payments for the July 2025 through June 2026 contract period.

d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract

The Oklahoma Legislature mandated SHOPP directed payments to 90% of commercial equivalent payments to establish adequate reimbursement levels necessary to ensure compliance with network adequacy requirements and continued access to hospital services for Oklahoma's Medicaid population in all areas (both urban and rural) of the State.

SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

20. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), identify the class or classes of providers that will participate in this payment arrangement by answering the following questions:

a. Please indicate which general class of providers would be affected by the state directed payment (check all that apply):

- ☒ inpatient hospital service
- ☒ outpatient hospital service
- ☐ professional services at an academic medical center
- ☐ primary care services
- ☐ specialty physician services
- ☐ nursing facility services
- ☐ HCBS/personal care services
- ☐ behavioral health inpatient services
- ☐ behavioral health outpatient services
- ☐ dental services
- ☐ Other:

b. Please define the provider class(es) (if further narrowed from the general classes indicated above).

Consistent with the SHOPP Act, qualifying SHOPP-eligible hospitals are separated into the following two provider classes for the purposes of calculating uniform dollar (for inpatient services) and percentage (for outpatient services) increases:
- Critical access hospitals (CAHs)
- All other (non-CAH) hospitals

The state has further broken out a separate class of non-CAH hospitals with lengths of stay equal to or greater than 35 days.

c. Provide a justification for the provider class defined in Question 20b (e.g., the provider class is defined in the State Plan.) If the provider class is defined in the State Plan, please provide a link to or attach the applicable State Plan pages to the preprint submission. Provider classes cannot be defined to only include providers that provide intergovernmental transfers.

Hospitals eligible to receive payments under this arrangement are consistent with the Supplemental Hospital Offset Payment Program (SHOPP) Act, which OHCA has been utilizing for purposes of the existing SHOPP program for over 10 years.

https://legiscan.com/OK/text/SB1396/id/2587480/Oklahoma-2022-SB1396-Enrolled.pdf

Hospitals eligible to receive payments under this arrangement are all Oklahoma hospitals except the following:
1. A hospital that is owned or operated by the state or a state agency, the federal government, a federally recognized Indian tribe, or the Indian Health Service.
2. A hospital that provides more than fifty percent (50%) of its inpatient days under a contract with a state agency other than OHCA
3. A hospital that specializes in any one of the following: treatment of a neurological injury, treatment of cancer, treatment of cardiovascular disease, obstetrical or childbirth services, surgical care, except that this exemption shall not apply to any hospital located in a city of less than five hundred thousand (500,000) population and for which the majority of inpatient days are for back, neck, or spine surgery;
4. A hospital that is certified by the Centers for Medicare and Medicaid Services (CMS) as a long-term acute care hospital or as a Children's Hospital.

21. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract.

The uniform dollar (for inpatient services) and percentage (for outpatient services) increases are the same for all hospitals within a given class.

For the Critical Access Hospital class of providers, payments are also uniformly limited such that total modeled inpatient or outpatient managed care plan payments (including base and directed payments) for each CAH do not exceed modeled billed charges.

22. For the services where payment is affected by the state directed payment, how will the state directed payment interact with the negotiated rate(s) between the plan and the provider? Will the state directed payment:

a. ☐ Replace the negotiated rate(s) between the plan(s) and provider(s).

b. ☐ Limit but not replace the negotiated rate(s) between the plans(s) and provider(s).

c. ☒ Require a payment be made in addition to the negotiated rate(s) between the plan(s) and provider(s).

23. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22), please provide an analysis in Table 2 showing the impact of the state directed payment on payment levels for each provider class. This provider payment analysis should be completed distinctly for each service type (e.g., inpatient hospital services, outpatient hospital services, etc.).

This should include an estimate of the base reimbursement rate the managed care plans pay to these providers as a percent of Medicare, or some other standardized measure, and the effect the increase from the state directed payment will have on total payment. *Ex: The average base payment level from plans to providers is 80% of Medicare and this SDP is expected to increase the total payment level from 80% to 100% of Medicare.*

If the state needs more space, please use Addendum 2.A and check this box: ☒

TABLE 2: Provider Payment Analysis

Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs
Ex: Rural Inpatient Hospital Services	*80%*	*20%*	*N/A*	*N/A*	*100%*
a. See Addendum					
b.					
c.					
d.					
e.					
f.					
g.					

24. Please indicate if the data provided in Table 2 above is in terms of a percentage of:

a. ☐ Medicare payment/cost

b. ☐ State-plan approved rates as defined in 42 C.F.R. § 438.6(a) *(Please note, this rate cannot include supplemental payments.)*

c. ☒ Other; Please define: Average Commercial Rate (ACR)

25. Does the State also require plans to pay any other state directed payments for providers eligible for the provider class described in Question 20b? ☒ Yes ☐ No

If yes, please provide information requested under the column "Other State Directed Payments" in Table 2.

26. Does the State also require plans to pay pass-through payments as defined in 42 C.F.R. § 438.6(a) to any of the providers eligible for any of the provider class(es) described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column "Pass-Through Payments" in Table 2.

27. Please describe the data sources and methodology used for the analysis provided in response to Question 23.

The analysis provided in response to Question 23 is based on the following data sources:

--Oklahoma Medicaid program FFS claims data for inpatient and outpatient hospital services with last dates of service between April 1, 2023, and March 31, 2024. The data set has been limited to services for members with an aid category and health program indicating eligibility for managed care. The data set has been further adjusted to account for assumed disenrollment following the end of the continuous coverage requirement, the assumed managed care enrollment rate for voluntary populations, retroactive eligibility periods, managed care enrollment waiting periods, and adjustments for new facilities to account for expected changes in claims volume. Claims with coordination of benefits (COB) payments, including Medicare crossover claims, are also removed from the data set.

--Commercial allowed-to-billed benchmarks for Oklahoma hospitals providing services to Oklahoma residents. These benchmarks are based on commercial group claims experience for inpatient and outpatient hospital services incurred from January 2023 through December 2023 in Milliman's Consolidated Health Cost Guidelines™ (HCG) Sources Database (CHSD) to develop these benchmarks by service category and geographic area.

--Commercial-to-Medicare allowed benchmarks for the state of Oklahoma by service category. Market average reimbursement benchmarks are based on commercial group claims experience for inpatient and outpatient hospital services from the Milliman Consolidated Health Cost Guidelines™ (HCG) Sources Database (CHSD) and the IBM® MarketScan® Research Databases.

The Oklahoma Medicaid program claims data was processed through the Milliman Health Cost Guidelines™ (HCG) Grouper to assign Milliman service categorizations, consolidate interim claims, and validate the completeness and validity of relevant data fields. For services provided by non-CAH hospitals, commercial payment equivalents were estimated by applying the commercial allowed-to-billed benchmarks to billed charges in the Medicaid data. For services provided by CAH hospitals, Medicare reimbursement was estimated as 101% of cost by applying cost-to-charge ratios to billed charges in the Medicaid data. Commercial payment equivalents were then estimated by applying the commercial-to-Medicare benchmarks to the estimated Medicare reimbursement.

Unit price trend assumptions were applied to the Medicaid paid, and billed, and cost amounts included in the analysis to project values for the July 1, 2025 through June 30, 2026 managed care contract period. The commercial allowed-to-billed benchmarks and commercial-to-Medicare allowed benchmarks are based on actual payment data and have not been trended. Similarly, estimated commercial equivalent payments (which were developed based on application of these ratios to the adjusted Medicaid data) have not been trended.

Comparison average Medicaid and commercial rates were then calculated by dividing total Medicaid base payments, state directed payments, and commercial equivalent payments by Medicaid discharges (for inpatient services) and Medicaid claim lines (for outpatient services). Finally, average Medicaid rates were expressed as a percentage of average commercial rates.

28. Please describe the State's process for determining how the proposed state directed payment was appropriate and reasonable.

The Oklahoma Legislature mandated SHOPP directed payments to 90% of commercial equivalent payments to establish adequate reimbursement levels necessary to ensure compliance with network adequacy requirements and continued access to hospital services for Oklahoma's Medicaid population in all areas (both urban and rural) of the State.

In compliance with this mandate, this directed payment provides uniform dollar and percentage increases to each class of qualifying SHOPP-eligible hospitals such that total modeled managed care plan payments (including base and directed payments) are equal to 90% of the average commercial rate. For the Critical Access Hospital class of providers, payments are also uniformly limited such that total modeled inpatient or outpatient managed care plan payments (including base and directed payments) for each CAH do not exceed modeled billed charges.

SECTION IV: INCORPORATION INTO MANAGED CARE CONTRACTS

29. States must adequately describe the contractual obligation for the state directed payment in the state's contract with the managed care plan(s) in accordance with 42 C.F.R. § 438.6(c). Has the state already submitted all contract action(s) to implement this state directed payment? ☒ Yes ☐ No

a. If yes:

i. What is/are the state-assigned identifier(s) of the contract actions provided to CMS?

Aetna: 8079004725, Oklahoma Complete Health: 8079004726, Humana: 8079004727, Oklahoma Complete Health Children's Specialty: 8079004728

ii. Please indicate where (page or section) the state directed payment is captured in the contract action(s).

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b. If no, please estimate when the state will be submitting the contract actions for review.

SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

Note: Provide responses to the questions below for the first rating period if seeking approval for multi-year approval.

30. Has/Have the actuarial rate certification(s) for the rating period for which this state directed payment applies been submitted to CMS? ☒ Yes ☐ No

a. If no, please estimate when the state will be submitting the actuarial rate certification(s) for review.

b. If yes, provide the following information in the table below for each of the actuarial rate certification review(s) that will include this state directed payment.

Table 3: Actuarial Rate Certification(s)

Control Name Provided by CMS (List each actuarial rate certification separately)	Date Submitted to CMS	Does the certification incorporate the SDP?	If so, indicate where the state directed payment is captured in the certification (page or section)
i. Oklahoma_SoonerSelect Medical_20250701-20260630_Certification_20250630	06/30/2025	Yes	Page 32+
ii. Oklahoma_SoonerSelect Children's Specialty_20250701-20260630_Certification_20250630	06/30/2025	Yes	Page 35+
iii.			
iv.			
v.			

Please note, states and actuaries should consult the most recent [Medicaid Managed Care Rate Development Guide](#) for how to document state directed payments in actuarial rate certification(s). The actuary's certification must contain all of the information outlined; if all required documentation is not included, review of the certification will likely be delayed.)

c. If not currently captured in the State's actuarial certification submitted to CMS, note that the regulations at 42 C.F.R. § 438.7(b)(6) requires that all state directed payments are documented in the State's actuarial rate certification(s). CMS will not be able to approve the related contract action(s) until the rate certification(s) has/have been amended to account for all state directed payments. Please provide an estimate of when the State plans to submit an amendment to capture this information.

The state anticipates the certification will be submitted prior to June 30, 2025, which will include this state directed payment.

31. Describe how the State will/has incorporated this state directed payment arrangement in the applicable actuarial rate certification(s) (please select one of the options below):

a. ☐ An adjustment applied in the development of the monthly base capitation rates paid to plans.

b. ☒ Separate payment term(s) which are captured in the applicable rate certification(s) but paid separately to the plans from the monthly base capitation rates paid to plans.

c. ☐ Other, please describe:

32. States should incorporate state directed payment arrangements into actuarial rate certification(s) as an adjustment applied in the development of the monthly base capitation rates paid to plans as this approach is consistent with the rate development requirements described in 42 C.F.R. § 438.5 and consistent with the nature of risk-based managed care. For state directed payments that are incorporated in another manner, particularly through separate payment terms, provide additional justification as to why this is necessary and what precludes the state from incorporating as an adjustment applied in the development of the monthly base capitation rates paid to managed care plans.

OHCA is attempting to preserve the existing SHOPP payment timing (consistent with the Medicaid FFS state plan amendments approved by CMS) that have historically been successful in Oklahoma to the greatest extent possible. It is also our understanding that this is an approach CMS has approved in other states.

33. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with 42 C.F.R. § 438.4, the standards specified in 42 C.F.R. § 438.5, and generally accepted actuarial principles and practices.

SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

34. Describe the source of the non-federal share of the payment arrangement. Check all that apply:

a. ☐State general revenue

b. ☐Intergovernmental transfers (IGTs) from a State or local government entity

c. ☒Health Care-Related Provider tax(es) / assessment(s)

d. ☐Provider donation(s)

e. ☐Other, specify:

35. For any payment funded by **IGTs (option b in Question 34)**,

a. Provide the following (respond to each column for all entities transferring funds). If the state needs more space, please use Addendum Table 4.A and check this box: ☐

Table 4: IGT Transferring Entities

Name of Entities transferring funds (enter each on a separate line)	Operational nature of the Transferring Entity (State, County, City, Other)	Total Amounts Transferred by This Entity	Does the Transferring Entity have General Taxing Authority? (Yes or No)	Did the Transferring Entity receive appropriations? If not, put N/A. If yes, identify the level of appropriations	Is the Transferring Entity eligible for payment under this state directed payment? (Yes or No)
i.					
ii.					
iii.					
iv.					
v.					
vi.					
vii.					
viii.					
ix.					
x.					

b. ☐ Use the checkbox to provide an assurance that no state directed payments made under this payment arrangement funded by IGTs are dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

c. Provide information or documentation regarding any written agreements that exist between the State and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement. This should include any written agreements that may exist with healthcare providers to support and finance the non-federal share of the payment arrangement. Submit a copy of any written agreements described above.

36. For any state directed payments funded by **provider taxes/assessments (option c in Question 34)**,

a. Provide the following (respond to each column for all entries). If there are more entries than space in the table, please provide an attachment with the information requested in the table.

Table 5: Health Care-Related Provider Tax/Assessment(s)

Name of the Health Care-Related Provider Tax / Assessment (enter each on a separate line)	Identify the permissible class for this tax / assessment	Is the tax / assessment broad-based?	Is the tax / assessment uniform?	Is the tax / assessment under the 6% indirect hold harmless limit?	If not under the 6% indirect hold harmless limit, does it pass the "75/75" test?	Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the tax payer?
i. Supplemental Hospital Offset Payment Program fee	Inpatient Hospital Services/ Outpatient Hospital Services	No	Yes	Yes		No
ii.						
iii.						
iv.						
v.						

b. If the state has any waiver(s) of the broad-based and/or uniform requirements for any of the health care-related provider taxes/assessments, list the waiver(s) and its current status:

Table 6: Health Care-Related Provider Tax/Assessment Waivers

Name of the Health Care-Related Provider Tax/Assessment Waiver (enter each on a separate line)	Submission Date	Current Status (Under Review, Approved)	Approval Date
i. Supplemental Hospital Offset Payment Program fee	7/26/2011	Approved	01/17/2012
ii.			
iii.			
iv.			
v.			

37. For any state directed payments funded by **provider donations (option d in Question 34)**, please answer the following questions:

a. Is the donation bona-fide? ☐ Yes ☐ No

b. Does it contain a hold harmless arrangement to return all or any part of the donation to the donating entity, a related entity, or other provider furnishing the same health care items or services as the donating entity within the class?
☐ Yes ☐ No

38. ☒ **For all state directed payment arrangements**, use the checkbox to provide an assurance that in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

39. ☒ Use the checkbox below to make the following assurance, "In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340."

40. Consistent with 42 C.F.R. § 438.340(d), States must post the final quality strategy online beginning July 1, 2018. Please provide:

- **a.** A hyperlink to State's most recent quality strategy: https://oklahoma.gov/content/dam/ok/en/okhca/docs/about/soonerselect/_20230906-OHCA%20Sooner
- **b.** The effective date of quality strategy. September 6, 2023

41. If the State is currently updating the quality strategy, please submit a draft version, and provide:

- **a.** A target date for submission of the revised quality strategy (month and year): Sep-26
- **b.** Note any potential changes that might be made to the goals and objectives.
  N/A

Note: The State should submit the final version to CMS as soon as it is finalized. To be in compliance with 42 C.F.R. § 438.340(c)(2) the quality strategy must be updated no less than once every 3-years.

42. To obtain written approval of this payment arrangement, a State must demonstrate that each state directed payment arrangement expects to advance at least one of the goals and objectives in the quality strategy. In the Table 7 below, identify the goal(s) and objective(s), as they appear in the Quality Strategy (include page numbers), this payment arrangement is expected to advance. If additional rows are required, please attach.

Table 7: Payment Arrangement Quality Strategy Goals and Objectives

Goal(s)	Objective(s)	Quality strategy page
Example: Improve care coordination for enrollees with behavioral health conditions	*Example: Increase the number of managed care patients receiving follow-up behavior health counseling by 15%*	*5*
a. Improve behavioral & chronic condition management	Improve diabetes management: Reduce Preventable Hospital Admissions - Diabetes Short-Term Complications admits per 100K member months by 2%. (PQI-01-AD). Measurement year 2024 (reporting year 2025) will eventually serve as the baseline for Managed Care. Performance targets for required Quality Measures will be set annually based on evaluation of performance for the most recently reported year.	2023 Quality Strategy p. 7 Goal 2 & Objective 2.2; pp. 7 Performance Measures; p. 32 Appendix A Performance Measure Tables
b. Improve behavioral & chronic condition management	Improve asthma management (Younger Adults): Reduce admits per 100K member months by 2% for Asthma Admissions in Younger Adults (PQI15-AD). Measurement year 2024 (reporting year 2025) will eventually serve as the baseline for Managed Care. Performance targets for required Quality Measures will be set annually based on evaluation of performance for the most recently reported year.	2023 Quality Strategy p. 7 Goal 2 & Objective 2.3; pp. 7 Performance Measures; p. 32 Appendix A Performance Measure Tables
c. Improve behavioral & chronic condition management	Improve asthma management (Older Adults): Reduce Preventable Hospital Admissions - COPD or Asthma in Older Adults admits per 100K member months by 2%. (PQI 05-AD). Measurement year 2024 (reporting year 2025) will eventually serve as the baseline for Managed Care. Performance targets for required Quality Measures will be set annually based on evaluation of performance for the most recently reported year.	2023 Quality Strategy p. 7 Goal 2 & Objective 2.3; pp. 7 Performance Measures; p. 32 Appendix A Performance Measure Tables
d.		

43. Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Table 7. If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and in terms of that of the multi-year payment arrangement.

OHCA's overarching goals for this directed payment arrangement are to 1) improve the health outcomes for Medicaid members and the State as a whole, 2) ensure budget predictability, and 3) ensure a sustainable delivery system consistent with Governor Stitt's plan to transform Oklahoma into a Top Ten state in health outcomes. To optimize success, OHCA will use the balanced framework of the Quadruple Aim. The Institute for Healthcare Improvement (IHI) described the Triple Aim as the goal of population health activities in general; one of the goals of Triple Aim refers to the improving health outcomes for the population.

To achieve improved health outcomes for the population, OHCA has transitioned Oklahoma to a Medicaid Managed Care program in a way that advances high-value care, improves population health, engages and supports enrollees and providers, and establishes a sustainable program with predictable costs. As OHCA transitioned to a Managed Care delivery system, it is has finalized an updated managed care quality strategy.

The State believes this payment arrangement will advance the goals described above, especially in vulnerable rural and underserved areas, by reducing the financial hardship facing many hospitals at risk of closure.

The State plans to monitor hospital performance of stated quality measures, acknowledge performance and use high performers to identify best practices for other hospitals statewide. Access to care will be vital for successful transformation to a managed care delivery system. The state plans to closely monitor each MCO's hospital network on an annual basis prior to and following each program year. Since directed payments are only available to in-network providers, we anticipate that the program will continue to provide an incentive for providers to remain contracted with or begin new contracts with MCOs.

44. Please complete the following questions regarding having an evaluation plan to measure the degree to which the payment arrangement advances at least one of the goals and objectives of the State's quality strategy. To the extent practicable, CMS encourages States to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures, when applicable.

a. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(D), use the checkbox to assure the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340, and that the evaluation conducted will be *specific* to this payment arrangement. *Note:* States have flexibility in how the evaluation is conducted and may leverage existing resources, such as their 1115 demonstration evaluation if this payment arrangement is tied to an 1115 demonstration or their External Quality Review validation activities, as long as those evaluation or validation activities are *specific* to this payment arrangement and its impacts on health care quality and outcomes.

b. Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 42. For each measure the State intends to use in the evaluation of this payment arrangement, provide in Table 8 below: 1) the baseline year, 2) the baseline statistics, and 3) the performance targets the State will use to track the impact of this payment arrangement on the State's goals and objectives. Please attach the State's evaluation plan for this payment arrangement.

TABLE 8: Evaluation Measures, Baseline and Performance Targets

Measure Name and NQF # (if applicable)	**Baseline Year**	**Baseline Statistic**	**Performance Target**	**Notes[1]**
Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF # 0039	*CY 2019*	*34%*	*Increase the percentage of adults 18–64 years of age who report receiving an influenza vaccination by 1 percentage point per year*	*Example notes*
i. See addendum				
ii.				
iii.				
iv.				

1. If the State will deviate from the measure specification, please describe here. If a State-specific measure will be used, please define the numerator and denominator here. Additionally, describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

c. If this is any year other than year 1 of a multi-year effort, describe (or attach) prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. Evaluation findings must include 1) historical data; 2) prior year(s) results data; 3) a description of the evaluation methodology; and 4) baseline and performance target information from the prior year(s) preprint(s) where applicable. If full evaluation findings from prior year(s) are not available, provide partial year(s) findings and an anticipated date for when CMS may expect to receive the full evaluation findings.

CY2023 measurement data for the PCR and PQI measures are reported. Given that the implementation of Oklahoma's Medicaid managed care delivery went live on April 1, 2024, we are reporting CY2023 basis for the purposes of evaluating the impact of this directed payment on the goals and objectives of our managed care quality strategy.

Section 438.6(c) Preprint Addendum Tables

Overview

This addendum to the Section 438.6(c) preprint file allows States to add rows to the eight tables in the preprint: Please use this workbook if States need additional rows than what is provided in the preprint. States may also use the Workbook Tables 1.A. - 8.A. in lieu of completing Tables 1 - 8 in the preprint.

Directions

States should only submit the tables they populate to CMS; please do not submit the entire workbook unless the State inputs data into all addendum Tables 1.A - 8.A. For example, if the State only needs extra rows to complete Table 1.A, please delete Tabs 2.A - 8.A

CMS requests States submit the addendum tables with the preprint in this Excel format; please do not merge and re-PDF the preprint.

Addendum Table Organization

The addendum tables are organized by tab. Within the tables, States will find data elements with specific drop-downs that CMS has pre-selected to standardize data provided by States in the preprint.

Table 1.A	Payment Arrangement Provider Performance Measures
Table 2.A	Provider Payment Analyses
Table 3.A	Actuarial Rate Certification(s)
Table 4.A	IGT Transferring Entities
Table 5.A	Health Care-Related Provider Tax/Assessment(s)
Table 6.A	Health Care-Related Provider Tax/Assessment Waivers
Table 7.A	Payment Arrangement Quality Strategy Goals and Objectives
Table 8.A	Evaluation Measures, Baseline and Performance Targets

Identifying Information	Column1
State/Territory (Select from dropdown menu):	Oklahoma

PREPRINT SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS
ADDENDUM TABLE 8.A. EVALUATION MEASURES, BASELINE AND PERFORMANCE TARGETS

Directions

8. Use Table 8.A below to add each measure the State intends to use in the evaluation of this payment arrangement, including (1) the baseline year, (2) the baseline statistics, and (3) the performance targets the State will use to track the impact of this payment arrangement on the State's goals and objectives. States may also use Table 8.A in lieu of completing Table 8 in the preprint. Input data only in beige cells in columns B - F.

States should only submit the tables they populate to CMS; please do not submit the entire workbook unless the State inputs data into Tables 1.A - 8.A. For example, if the State only needs extra rows to complete Table 8 in the preprint, please delete Tabs 1.A - 7.A. CMS requests States submit the addendum tables with the preprint in this Excel format; please do not merge and re-PDF the preprint.

TABLE 8.A: Evaluation Measures, Baseline and Performance Targets

Column1	Measure Name and NQF # (if applicable)	Baseline Year	Baseline Statistic	Updated Baseline Year	Updated Baseline Statistic	Performance Target	Notes
Data Format	**Free text**	**Free text**	**Percentage (00.0%)**	**Free text**	**Percentage (00.0%)**	**Percentage (00.0%)**	**Free text. If the State will deviate from the measure specification, please describe here. If the State is using a state-specific measure, please define the numerator and denominator here. In addition, describe any planned data or measure stratifications (for example, age, race, or ethnicity) the State will use to evaluate the payment arrangement**
Example:	*Flu Vaccinations for Adults Ages 19 - 64 (FVA-AD); NQF # 0039*	*CY 2019*	*34.0%*			*34.0%*	
	Plan All-Cause Readmissions (PCR-AD): NQF #1768	CY 2021	4.7% observed rate; 11.8% expected rate; 0.4002 O/E Ratio	CY 2023	5.4% observed rate; 8.7% expected rate; 0.6130 O/E Ratio	Reduce observed / expected ratio by 2%	CMS specifications for this measure were adhered to with the only deviations as follows: All inpatient claims for admissions and readmissions were only from SHOPP identified providers. Readmissions could be to any SHOPP identified provider. Outliers were determined from only SHOPP identified providers. **Although Year 1 State Directed Payment Program (SDP) data (CY 2024) is currently unavailable, the pre-print has been updated with the most recent data (CY 2023) available to OHCA. The Plan-All-Cause Readmission observed rate for CY 2023 is slightly higher than the 2021 rate. This could be due to a number of factors such as the declaration of Public Health Emergency and the expansion of Medicaid in Oklahoma. Adding the updated baseline data provides 2 data points preceeding the implementation of the SDP Program. This will facilitate program evaluation once CY 2024 data becomes available and will allow comparison of pre and post implementation data. Improving this measure remains one of the main goals of OHCA's Medicaid Managed Care program.**
	Preventable Hospital Admissions - Diabetes Short-Term Complications Admission Rate (PQI-01-AD)	CY 2021	35.649 admits per 100K member months	CY 2023	34.435 admits per 100K member months	Reduce admits per 100K member months by 2%	CMS specifications for this measure were followed. Based on all members age 18+ that had a claim to any of the SHOPP identified providers in CY 2021. **Although the Year 1 State Directed Payment Program (SDP) data (CY 2024) is currently unavailable, the pre-print has been updated with the most recent data (CY 2023) available to OHCA. Adding the updated baseline data provides 2 data points preceeding the implementation of the SDP Program. This will facilitate program evaluation once CY 2024 data becomes available and will allow comparison of pre and post implementation data. Improving this measure remains one of the main goals of OHCA's Medicaid Managed Care program.**
	Preventable Hospital Admissions - COPD or Asthma in Older Adults Admission Rate (PQI 05-AD)	CY 2021	31.997 admits per 100k member months	CY 2023	23.186 admits per 100k member months	Reduce admits per 100K member months by 2%	CMS specifications for this measure were followed. Based on all members age 18+ that had a claim to any of the SHOPP identified providers in CY 2021. **Although the Year 1 State Directed Payment Program (SDP) data (CY 2024) is currently unavailable, the pre-print has been updated with the most recent data (CY 2023) available to OHCA. The COPD or Asthma in Older Adult Admission Rate for CY 2023 is slightly lower than the 2021 rate. This could be due to the decrease in COVID-19 cases from CY 2021 to CY 2023. Adding the updated baseline data provides 2 data points preceeding the implementation of the SDP Program. This will facilitate program evaluation once CY 2024 data becomes available and will allow comparison of pre and post implementation data. Improving this measure remains one of the main goals of OHCA's Medicaid Managed Care program.**
	Preventable Hospital Admissions - Heart Failure (PQI 08-AD)	CY 2021	78.906 admits per 100K member months	CY 2023	65.729 admits per 100K member months	Reduce admits per 100K member months by 2%	CMS specifications for this measure were followed. Based on all members age 18+ that had a claim to any of the SHOPP identified providers in CY 2021. **Although the Year 1 State Directed Payment Program (SDP) data (CY 2024) is currently unavailable, the pre-print has been updated with the most recent data (CY 2023) available to OHCA. Adding the updated baseline data provides 2 data points preceeding the implementation of the SDP Program. This will facilitate program evaluation once CY 2024 data becomes available and will allow comparison of pre and post implementation data. Improving this measure remains one of the main goals of OHCA's Medicaid Managed Care program.**
	Asthma in Younger Adults Admission Rate (PQI15-AD)	CY 2021	6.565 admits per 100K member months	CY 2023	5.295 admits per 100K member months	Reduce admits per 100K member months by 2%	CMS specifications for this measure were followed. Based on all members age 18+ that had a claim to any of the SHOPP identified providers in CY 2021. **Although the Year 1 State Directed Payment Program (SDP) data (CY 2024) is currently unavailable, the pre-print has been updated with the most recent data (CY 2023) available to OHCA. Adding the updated baseline data provides 2 data points preceeding the implementation of the SDP Program. This will facilitate program evaluation once CY 2024 data becomes available and will allow comparison of pre and post implementation data. Improving this measure remains one of the main goals of OHCA's Medicaid Managed Care program.**