2022
SOONERCARE DEMONSTRATION
11-W-00048/6
§1115(a) ANNUAL REPORT

JAN 1, 2022-Dec 31, 2022 | SUBMITTED MARCH 31, 2023

OKLAHOMA HEALTH CARE AUTHORITY

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Table of Contents

I. INTRODUCTION

The Oklahoma Health Care Authority is the single state agency that administers the SoonerCare Choice and Insure Oklahoma programs under Section 1115(a) demonstration waiver. The waiver was originally approved in January 1996. In August 2018, the waiver was approved for the period of Aug. 31, 2018, through Dec. 31, 2023. Below is a timeline of waiver approvals beginning with the 2013 demonstration period.

Demonstration Period	Approved by CMS
Jan. 1, 2013–Dec. 31, 2015	Dec. 31, 2012
Jan. 1, 2016–Dec. 31, 2016	July 9, 2015
Jan. 1, 2017–Dec. 31, 2017	Nov. 30, 2016
Jan. 1, 2018–Dec. 31, 2018	Dec. 29, 2017
Aug. 31, 2018–Dec. 31, 2023	Aug. 31, 2018

Oklahoma's SoonerCare Choice program operates under an enhanced primary care case management delivery system to serve qualified populations statewide. OHCA contracts directly with primary care providers to serve as patient-centered medical homes. The SoonerCare Choice program promotes the goals of providing accessible, high quality and cost-effective care to SoonerCare Choice members. In addition, the 1115(a) research and demonstration waiver provides the authority for the Insure Oklahoma program, which provides premium assistance to qualifying Oklahomans.

In accordance with the special terms and conditions of the waiver, OHCA is required to submit an annual progress report to the Centers for Medicare & Medicaid Services. Under Section XI. MONITORING, STC 56. annual reports are due no later than 60 calendar days following the end of each demonstration period. The reports will include all required elements as per 42 CFR 431.428. The monitoring reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed or evolve and be provided in a structured manner that supports federal tracking and analysis.

II. OPERATIONAL UPDATES

Policy or Administrative Difficulties

OHCA did not experience any policy or administrative difficulties with the operation of the 1115 demonstration during the evaluation period.

Key Challenges

Waiver Requests	Date of Submission	Status of Request
SoonerCare Choice Community Engagement waiver amendment	12/7/2018	On hold
Insure Oklahoma Employer-Sponsored Insurance (ESI) amendment	11/16/2020	Approved 1/31/2022
Insure Oklahoma phase-out plan	11/16/2020	Approved 1/31/2022
Enrollment of the Expansion Adult Group and Former Foster Care Group under the SoonerCare Demonstration, Waiver or Retroactive Eligibility for the Expansion Adult Group and implementation of SoonerSelect (MCO)	2/19/2021	On hold
1115 SoonerCare Choice Demonstration Renewal Application	12/28/2022	Pending CMS

Public Health Emergency

With the declaration of a public health emergency (PHE) due to the COVID-19 pandemic, OHCA agency staff, contractors and partners remain as a remote workforce while maintaining essential operations to serve SoonerCare members and providers. Further, OHCA continued to exercise the provision in STC 30.e. to waive premiums for members participating in the Insure Oklahoma Individual Plan due to extreme financial hardship.

OHCA received approval on March 24, 2020, for a Section 1135 waiver to provide flexibility to waive or modify certain requirements to support SoonerCare members and providers. These measures remain in place and will continue while the emergency declaration is in effect.

The Consolidated Appropriations Act (CAA) funding bill passed in late December 2022 decoupled the continuous enrollment requirement from the PHE and set a hard end date of March 31, 2023, for continuous enrollment of the PHE-protected group. The agency initiated the unwinding period with redeterminations beginning on April 1, 2023.

Adult Medicaid Expansion

Due to the passing of State Question (SQ) 802, a new state constitution article was added to expand Medicaid in Oklahoma no later than July 1, 2021; therefore, OHCA submitted an 1115 waiver amendment and phase-out plan to sunset the Insure Oklahoma Individual Plan (IP) program and to move members within the Employer-Sponsored Insurance (ESI) plan with incomes at or below 133% FPL (plus any applicable income disregards) to Medicaid coverage provided under Title XIX. All phase-out activities were completed as of June 30, 2021, and CMS provided the state with approved STCs on Jan. 31, 2022; however, the agency has not ended the program due to maintenance of effort (MOE) requirements during the PHE. Upon the expiration of the PHE declaration, fully sunsetting the IO IP program will occur.

Payments for Excellence

In January 2022, OHCA revised the metrics being utilized for the state's Payments for Excellence program referenced in paragraph 43 of the STCs with the intent of targeting behaviors that will ensure healthier outcomes for SoonerCare members. CMS provided direction that the state did not need a waiver amendment to modify the types of provider practice behaviors incentivized. The retired metrics include breast and cervical cancer screenings, EPSDT and inpatient admissions. The new metrics are emergency department utilization, behavioral health screening, diabetic control, and obesity. Incentive payments will reward high-achieving practices relative to all PCMH providers and those that make significant improvements in performance.

In November 2021, PCMH providers received a provider scorecard to highlight baseline data for the two existing measures that continued into 2022: emergency department utilization and behavioral health screening. Providers will receive scorecards quarterly throughout the year.

Payments and provider scorecards for the first quarter of 2022 will be provided in July. These scorecards demonstrate providers' performance on all four incentive measures, as well as how they performed compared to their peers.

Delivery Model Transformation

Oklahoma Senate Bill (SB) 1337 directs the agency to obtain federal authority to add a new health care delivery model transforming the Medicaid program by prioritizing health outcomes for SoonerCare members, seeking to improve SoonerCare member satisfaction, moving the state toward a value-based payment system, containing costs by investing in preventive and primary care, and increasing cost predictability to the state. The legislation directs OHCA to award no less than three capitated contracts for medical, one contract for the Children's Specialty Plan, and no less than two capitated contracts for dental managed care programs. SB 1337 directs OHCA to award at least one urban region contract to a provider-led entity if it otherwise meets all the Request for

Proposal (RFP) requirements and agrees to expand to statewide coverage within five years. Populations transitioning into new delivery reform program(s) include: pregnant women, children, deemed newborns, parent-caretaker relatives, and the expansion population for services related to physical health, dental, behavioral health, and prescription drug services. The Children's Specialty Plan will serve children in foster care, juvenile justice-involved children, and children receiving adoption assistance. The American Indian/Alaska Native population is considered voluntary and will have the option of receiving services through a managed care contracted entity or through the current fee-for-service program operated by OHCA.

The agency is working toward an implementation date of April 1, 2024, contingent upon CMS review and approval, and the state is actively working with consultants to achieve the aggressive timeline.

The SoonerSelect Dental RFP was released on Sept. 1, 2022, with a proposal submission deadline of October 31. Bids were reviewed, oral presentations were conducted, and recommendations were made to executive staff. Notice of award is scheduled for early January 2023.

The SoonerSelect Medical RFP was released on Nov. 10, 2022, with a proposal submission deadline of Feb. 8, 2023.

1115 Research and Demonstration Waiver Renewal

During June 2022, the state began work with the contracted external evaluator, Pacific Health Policy Group (PHPG), for the current 1115 SoonerCare Choice Demonstration waiver to renew the demonstration, without amendment, from Jan. 1, 2024, through Dec. 31, 2028, as it is set to end on Dec. 31, 2023.

The agency submitted its renewal application to CMS on Dec. 29, 2022, requesting a five-year renewal from Jan. 1, 2024, through Dec. 28, 2028.

Key Achievements

Adult Medicaid Expansion

Since the agency began enrollment for newly eligible adults on June 1, 2021, with an effective date of July 1, 2021, for qualified individuals, there were 354,394 adult expansion members as of December 2022.

Issues or Complaints

There were no new issues or complaints during the reporting period. Actions taken by the agency based on recommendations made by the Member Advisory Task Force can be found in the Member Satisfaction portion of this report.

Lawsuits or Legal Actions

There were no new lawsuits related to the 1115 Research and Demonstration Waiver filed during the reporting period.

Unusual or Unanticipated Trends

Neither SoonerCare nor Insure Oklahoma experienced any unanticipated trends in 2022.

Legislative Updates

In 2022, 2,332 bills were newly filed, and 2,531 bills were carried over from 2021. In total, the 58th legislative regular session resulted in 5,846 bills being filed with 1,121 being signed into law as of Sine Die on May 27, 2022.

Signed Legislation Affecting the Agency	Budget Impact Bills
SB 1337 codifies the system design for a transformed Medicaid program, which prioritizes access and quality health outcomes for SoonerCare members and creates preferential scoring opportunities for Oklahoma provider-led entities to partner with OHCA as contracted entities under this new model. Under the law, contracted entities can include accountable care organizations, provider-led entities, commercial plans and/or dental benefit managers.	SB 1396 makes several adjustments to the supplemental hospital offset payment program and the Health Care Authority's regulations regarding SHOPP.
SB 1467 requires the Health Care Authority to conduct an annual review of all medications and forms of treatment for sickle cell disease to determine if such treatments are adequately covered by Medicaid, with a report to the House and Senate.	SB 1661 establishes standards for nonstate government owned medical facilities within the Medicaid supplement program.
SB 1369 creates the Office of the State Coordinator for Health Information Exchange within the Health Care Authority and requires health care entities to report data to said office.	SB 1040 includes the SFY 23 budget agreement. The OHCA received a 9.7% increase in appropriations for FY 23.
SB 1323 allows self-funded and self-insured health care plans which are recognized by the Insurance Department and meet certain standards to qualify under the Medicaid Premium Assistance Program.	SB 1074 contained OHCA's budget limits and directives for replacing funding no longer available, maintaining and enhancing programs, and implementing an enhanced payment for certain intermediate care facilities for individuals with intellectual disabilities.
HB 2322 provides updates to Medicaid coverage to bring it in line with the Ensuring Access to Medicaid Act;	

Public Forums

The following public forums were held during 2022:

1. July 19, 2022
   SoonerSelect Dental
   Virtual
   26 attendees
   0 questions/comments received
2. July 26, 2022
   SoonerSelect Dental
   In person – Oklahoma City MetroTech
   95 attendees
   50 questions/comments received
3. Aug. 31, 2022
   SoonerSelect Medical
   In person – Oklahoma City MetroTech
   412 attendees
   87 questions/comments received
4. Sept. 29, 2022
   SoonerSelect Medical
   Virtual
   582 attendees
   63 questions/comments received
5. Oct. 5, 2022

SoonerSelect Medical
Virtual
478 attendees
23 questions received

6. Nov. 15, 2022
   Public hearing – waiver renewal application request
   Virtual
   3 attendees
   1 comment received
7. November 17, 2022
   Public hearing – waiver renewal application request
   Virtual
   0 attendees
   0 comments received

The Provider Engagement department conducted webinars held in January, March, May, July and August 2022 regarding the Payments for Excellence program and other Patient-Centered Medical Home updates.

Tribal Consultation

Tribal consultation serves as a venue for discussion between OHCA and tribal governments on proposed SoonerCare policy changes, State Plan Amendments, waiver amendments and updates that may impact the agency or tribal partners. All tribal clinics, hospitals, Urban Indian health facilities, Indian Health Services agencies, stakeholders, and tribal leaders are invited to attend.

Six routine and one ad-hoc virtual and on-site tribal consultation meetings were held in 2022. OHCA staff presented 57 proposed policy changes inclusive of state rules, SPAs, and waiver amendments. Topics at the tribal consultation meetings included, but were not limited, to:

- HIV taskforce updates.
- RHC and FQHC visit limitation revisions.
- Removing PCMH panel limits.
- OHCA comprehensive quality strategy.
- 2022 OMB rate increase.
- SB 1337 SoonerSelect.
- Statewide Health Information Exchange.
- Public health emergency unwinding.

Member Advisory Task Force

The Member Advisory Task Force provides a structured process focused on consumer engagement, dialogue and leadership in the identification of program issues and solutions. MATF is used to inform stakeholders of agency policy and program decisions and allows opportunities for ongoing feedback on program improvements from the members' perspective.

MATF met seven times in 2022 and the following items were discussed:

- Community partners.
- Quality care form, including how to file a complaint or provide feedback about care received.
- Public health emergency.
- SoonerCare member portal and application changes.
- Non-emergency transportation (SoonerRide).
- New benefits including donor human breast milk and doula services.

During this evaluation period, the public website was updated to include additional education on program guidelines and the application process including resources required. Agency Partner

training curriculum is updated as needed and trainings are added as gaps are identified.

Public Comments Received in Post-Award Forum

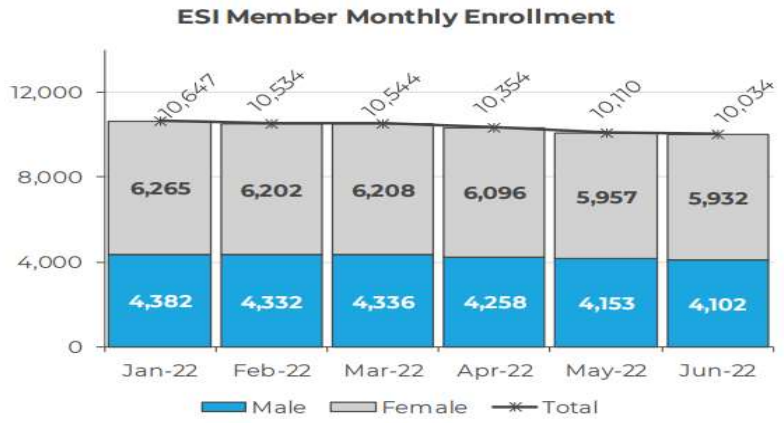
The state conducted the 2022 post-award forum during this reporting period. One commenter asked if this was related to Managed Care. The state responded that this renewal was not related to Managed Care.

III. PERFORMANCE METRICS

Impact of Coverage

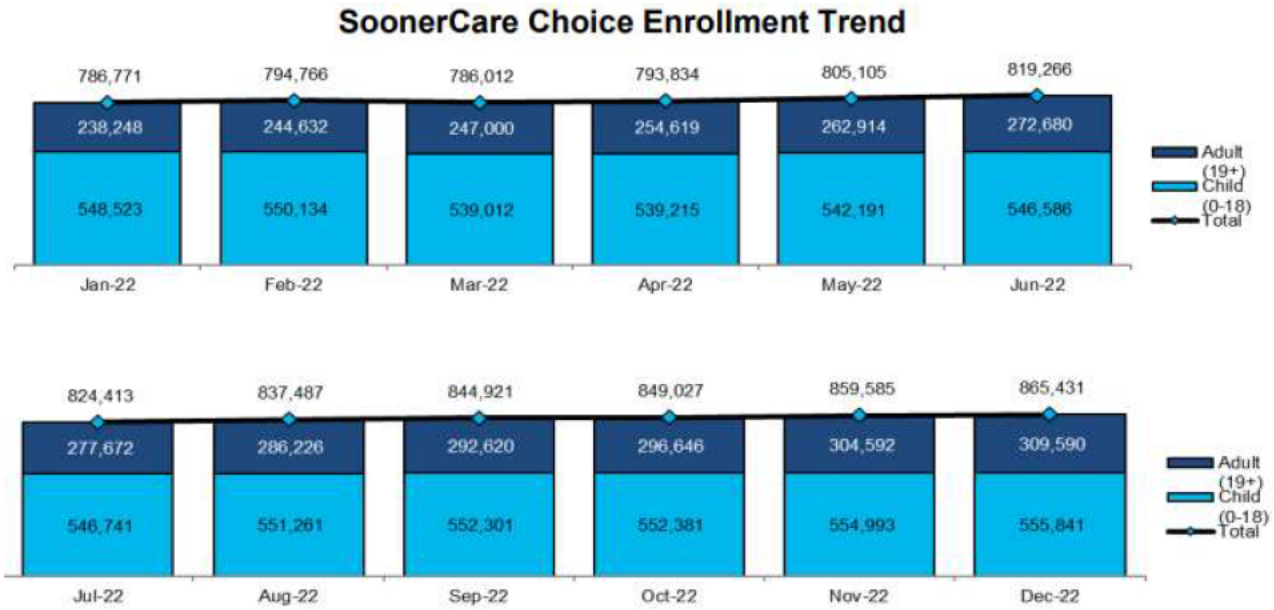
The Insure Oklahoma program authorized under the waiver to provide premium assistance since 2005 has proven to be a successful means of covering individuals who are not otherwise eligible for Medicaid. With the approval of adult Medicaid expansion, OHCA submitted an 1115 waiver amendment and phase-out plan to sunset the Insure Oklahoma Individual Plan (IP) program and to move members within the Employer-Sponsored Insurance (ESI) plan with incomes at or below 133% FPL (plus any applicable income disregards) to Medicaid coverage provided under Title XIX. All phase-out activities were completed as of June 30, 2021. It is worth noting that although the agency received approval from CMS to sunset the IO IP program, the agency hasn't termed the program due to MOE requirements during the PHE. Upon the expiration of the PHE declaration, fully sunsetting the IO IP program will occur.

Enrollment for the ESI program is shown in the graph below for the period of January through June and July through December 2022.

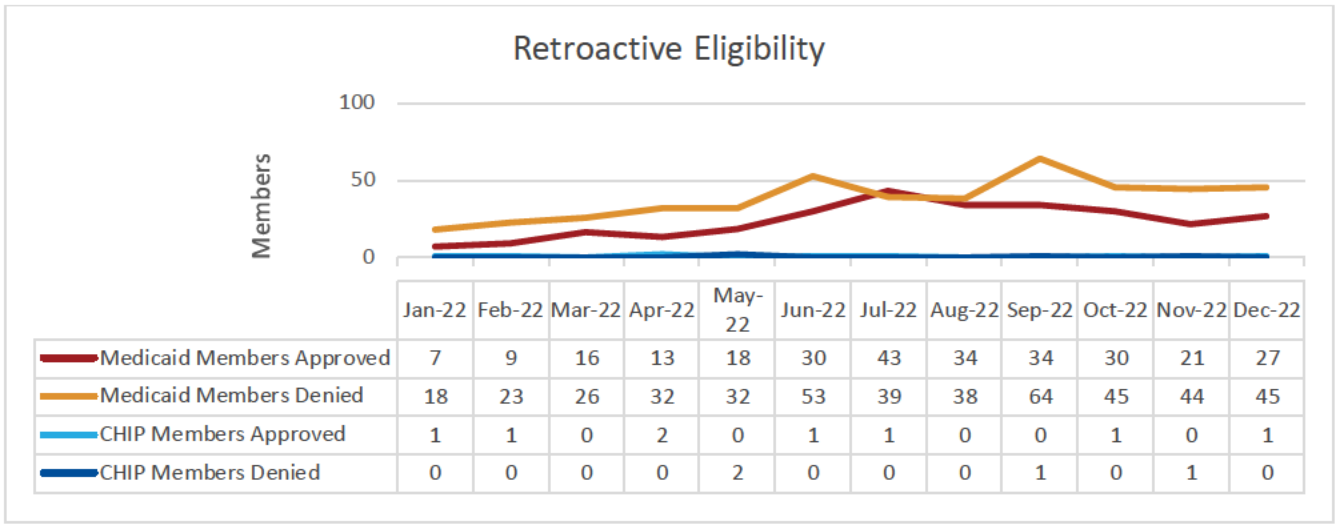


Eligibility and Coverage

SoonerCare Choice and its patient-centered medical home managed care delivery system cover the majority of eligible members. Enrollment in SoonerCare Choice continues to increase each month and is up 34% since June 2021 (644,160 enrollment) following the implementation of adult Medicaid expansion on July 1, 2021. During the public health emergency, eligibility is continual without closures unless the member dies, moves out of state, or requests the termination.



OHCA completed its work to add retroactive eligibility as required in the waiver for pregnant women and children. Implementation occurred in May 2020.



	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Medicaid Members Approved	7	9	16	13	18	30	43	34	34	30	21	27
Medicaid Members Denied	18	23	26	32	32	53	39	38	64	45	44	45
CHIP Members Approved	1	1	0	2	0	1	1	0	0	1	0	1
CHIP Members Denied	0	0	0	0	2	0	0	0	1	0	1	0

Access, Quality and Outcomes

Quantitative Data

In September 2022, the CMS report on MAGI Application Processing Time was released. It analyzes the length of time it took state Medicaid and CHIP agencies to conduct final determinations for individuals who submitted applications during January through March 2022. According to the report, OHCA processed 100% of the nearly 59,000 applications received in less than 24 hours

during the reporting timeframe. Real-time eligibility decisions allow SoonerCare members to access quality health care services.

In December 2022, CMS released 2022 Payment Error Rate Measurement (PERM) results which measure how accurately Medicaid programs determine eligibility and process claims. Oklahoma's PERM error rate for determining eligibility was 1.95%, which was the second lowest rate in the nation and significantly below the national average of 15.62%. The claims processing error rate for 2022 was 0%, the lowest payment error rate in the history of OHCA.

As of December 2022, there are over 354,000 adult Medicaid expansion members. The table below shows the top 10 categories of utilization based on reimbursement.

Top 10 Categories of Service by Spend	
Prescribed Drugs Services	Adult Behavioral Health Services
Inpatient Services	Dental Services
Outpatient Services	Psychiatric Services
Physician Services	Transportation Services
Clinic Services	Laboratory Services

As noted in the SoonerCare 1115 Interim Evaluation report, access to primary care rates among children and adolescents in HAN care management were higher than the comparison group by a statistically significant amount (see table). This was true for adult access to preventive/ambulatory services with the HAN care managed rate at 95% and the comparison group rate at 83%.

HAN (Care Managed) – Children & Adolescents' Access to PCP – 12 Months to 19 Years				
	2019	2020	2021	3-Year Pooled
HAN (Care Managed)	99.0%	95.8%	93.5%	96.1%
Comparison Group	93.2%	89.4%	86.4%	89.7%
Difference	5.8%‡	6.4%‡	7.1%‡	6.4%‡
‡ HAN rate differs from comparison group rate by a statistically significant amount (95% confidence level)				

Likewise, children and adolescents participating in the Health Management Program (HMP) had higher access to primary care rates than the comparison group by a statically significant amount (see table). This was true for adult access to preventive/ambulatory services with the HMP participant rate at 94% and the comparison group rate at 85%.

HMP – Children's & Adolescents' Access to PCP – 12 Months to 19 Years				
	2019	2020	2021	3-Year Pooled
HMP	98.3%	99.2%	98.0%	98.5%
Comparison Group	93.5%	90.5%	83.4%	89.1%
Difference	4.8%‡	8.7%‡	14.6%‡	9.4%‡
‡ HMP rate differs from comparison group rate by a statistically significant amount (95% confidence level)				

Through provider education and nurse care management for members with or at risk for chronic conditions, the OHCA Health Management Program demonstrated $.67 in medical savings for every $1 spent in CY 2019 and 2020 (utilizing comparison group methodology).

The value-based purchasing component of the Health Management Program (HMP) contract is a 5% monthly withhold that can be earned back each year by meeting one or more of the performance targets. Measures include two diabetes HEDIS measures: emergency department visit rates and the number of inpatient days. Health coaches educate members about adherence to clinical guidelines for preventive care and for treatment of chronic conditions. In SFY 22, results indicate that health coaching participant compliance rate exceeded that of the comparison group on all four measures by a statistically significant amount.

Case Studies

- In 2020, a 24-year-old member with a diagnosis of hemophilia had 6 ED visits, 4 inpatient stays and total cost of nearly $4 million. The member was enrolled with a chronic care nurse care manager who collaborated with an interdisciplinary team including specialty providers, specialty pharmacy and a community representative with the pharmacy to work with the member on establishing a manageable and appropriate treatment plan. In 2022, the member is managing the condition with medication and routine outpatient care. The member had a decrease of 86% in cost, no ED visits or inpatient stays and has an improved quality of life.
- A 52-year-old member was engaged in the Health Management Program in February 2021. During the initial call, the member requested a behavioral health counselor in addition to needing assistance with resources and medical needs. A referral was made for a behavioral health and the member is now working with a psychiatrist and receiving proper medication management. In August 2021, the member identified the need to work on diabetes control. Through collaboration with the health coach on keeping a food diary, portion control and basic carbohydrate education, the member's A1c dropped from 7.0 to 5.5 over the following 10 months.
- A 59-year-old member was engaged in the Health Management Program in July 2021. The member has multiple health conditions such as anxiety, depression, COPD, diabetes, chronic pain, and hypertension. The member reported being confused with navigating health care and reported a lack of understanding processes and guidance from the provider. The member reported financial barriers with obtaining medications and struggled to take medications as prescribed. A resource navigator with the HMP provided assistance, but the member was easily confused and not successful in utilizing supports put in place. The navigator engaged the PCP for a full medication review and 90-day prescriptions. The navigator compared out-of-pocket expenses at local pharmacies and called the pharmacy to assist in establishing a rotating supply schedule for the member. In January 2022, the navigator spoke with the member who reported successfully obtaining all prescriptions without financial barriers and was following the schedule established with the navigator's assistance.

- A HAN community partner accepts used bicycles and refurbishes them for free giveaway bike events around the holidays. This year, they were overwhelmed with donations and had bikes left after all requests were filled. The HAN was able to notify their members, and several were able to obtain a new bike. Again in the spring, they found themselves with an abundance of bikes and they sponsored a community event to give them away. Additional HAN members were able to take advantage of this opportunity and received a bike.

Member Satisfaction Surveys, Grievances and Appeals

Member Satisfaction

Members of the MATF have expressed the need for and made recommendations for non-pharmaceutical alternatives for treating pain. As of January 2022, chiropractic care and physical therapy in a non-hospital-based setting (for adults) became effective. Adults 21 years and older have access to 12 chiropractor visits per year with a diagnosis of spinal pain and approved prior authorization. OHCA extended physical therapy services to include non-hospital-based settings for a diagnosis of spinal pain. There was no change to existing coverage of physical therapy services provided in an outpatient hospital facility.

Changes to the SoonerCare member portal and application were made due to recommendations by the MATF. The changes included adding a link from the "Apply for Benefits" page to go directly to an application that included instructions on how to apply.

PHPG conducted member surveys for participants in the HANs and HMP. Below is a sample of or respondent comments:

- "(My care manager) always seems to know when to call me. I would be lost without her calls to help [calm] me down. I have been through a lot and still am and her calls save me. She also helped me to get kids' furniture for my grandbabies I am now raising. I bless (her) and SoonerCare and hope I have both 'til I die."
- "(My health coach) has helped me so much, especially during COVID. I'm a single mom of three and can't always afford food; she sent me information on food pantries and helped me get my medications approved."
- "SoonerCare only gives six punches of prescriptions a month and I have more than that. I was doing without some of my meds until my health coach set me up on 90-day supplies, now I get all of them! She also helped me write up a budget to help me keep track of my money."
- "(My health coach) helped me at my lowest point in life. He never rushes me and I can tell he truly cares. He has helped me track down my medical records for a specialist. I have memory issues and he has been such a help. I told the other health coach that called that I am putting (my regular health coach) in my will."

Grievances and Appeals

The table below provides the number of grievances (appeals) filed by category for the SoonerCare program during the reporting period. Cases not counted as granted or denied are pending or have been closed for reasons other than a decision (settled, withdrawn, not filed timely, etc.). All cases are heard and, at minimum, provided an initial decision within 90 days, absent agreement of the parties to continue the case.

SoonerCare Grievances (January to December 2022)

	Filed	Granted	Denied
SoonerCare Eligibility	68	2	8
Dental	60	0	13
Prior Authorization	120	2	15
Private Duty Nursing	217	8	34
Misc. (unpaid claims, etc.)	28	9	8
All Other	2	0	0
Total:	495	21	78

The number of grievances/appeals related to private duty nursing increased significantly during this reporting period. In March 2020, OHCA worked to clarify federal guidance related to the COVID-19 public health emergency and suspended reductions or denials of existing private duty nursing service authorizations. Subsequent guidance provided within the Interim Final Rule with request for comments (CMS-9912-IFC) published on Nov. 6, 2020, indicated during the public health emergency states may apply service authorization criteria to determine the amount, duration, or scope of a beneficiary's benefits under the state's plan.

Effective April 1, 2022, OHCA reinstituted standard medical review practices pertaining to all private duty nursing authorizations. Normal appeal rights apply to any adverse determination regarding private duty nursing benefits.

IV. BUDGET NEUTRALITY AND FINANCIAL REPORTING

Budget Neutrality Model

Pursuant to STC 54. Monitoring Reports, item iii. and according to 42 CFR 431.428, the state's monitoring reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every monitoring report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of the state's STCs, including the submission of corrected budget neutrality data upon request.

Section 1115(a) Medicaid demonstration waivers must be budget neutral; the programs under the demonstration shall not cost the federal government more than what would have otherwise been spent absent the demonstration.

The state submitted the budget neutrality workbook for 2022 through the PMDA portal on Aug. 18, 2022, and Feb. 21, 2023. Of note, budget neutrality figures remain similar to previous submissions, however, there has been an increase in overall SoonerCare enrollment numbers due to continuing eligibility during the public health emergency.

V. EVALUATION ACTIVITIES AND INTERIM FINDINGS

On Sept. 26, 2019, CMS approved the state's evaluation design. Per 42 CFR 431.428 1115(a), monitoring reports must document any results of the demonstration to date per the evaluation hypotheses and include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

SoonerCare 1115 Evaluation Activities

The state's independent evaluator, Pacific Health Policy Group (PHPG), produced an interim evaluation report in December 2022. The report documented evaluation findings for calendar years 2019-2021 and was submitted to CMS along with the agency's waiver renewal application.

The interim report adhered to the CMS-approved evaluation design and examined SoonerCare performance against demonstration goals. The evaluation, through a series of hypotheses, measured the impact of the SoonerCare Health Access Networks (HANs), the SoonerCare Health

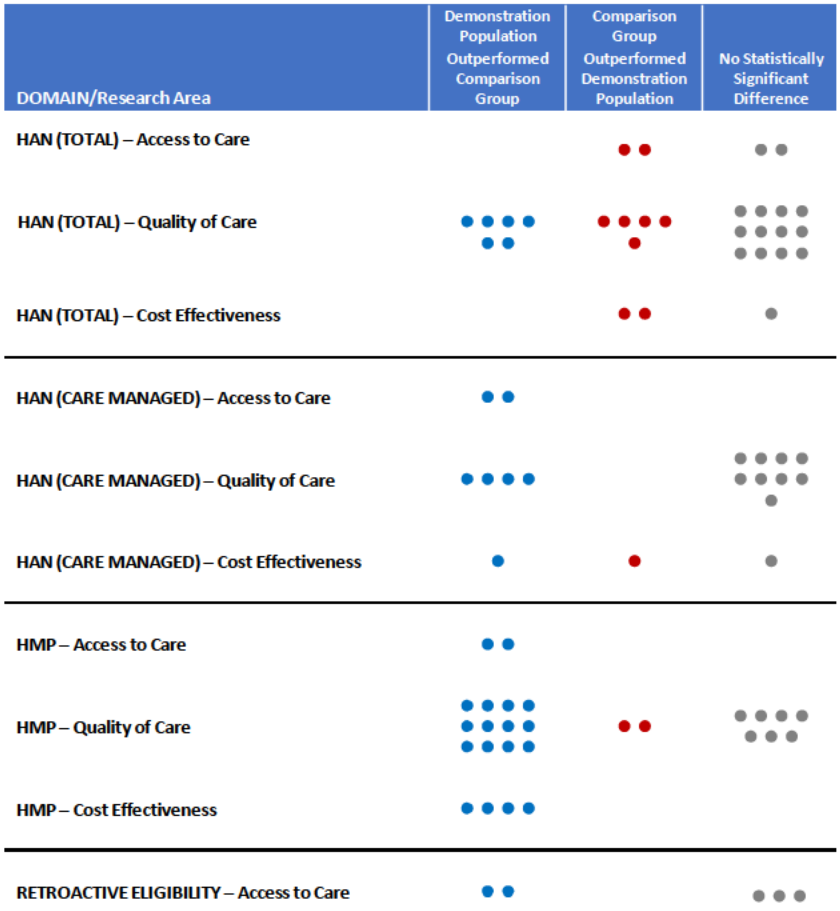
Management Program (HMP) and the waiver of retroactive eligibility (for certain MEGs) on access, quality and cost effectiveness.

The evaluation included a combination of HEDIS®, CAHPS survey, claims-derived, and qualitative measures. There were a total of 86 measures as summarized in the table below.

Hypothesis Area	Demonstration Population			
Measure Count by Type	HAN (Total Population)	HAN (Care Managed Subgroup)	HMP	Retroactive Eligibility
Accessible Care				
HEDIS Preventive Care Measures	*2 measures*	*2 measures*		
CAHPS Survey Access Measures	*2 measures*		*2 measures*	*3 measures*
Other (Qualitative) Measures			*1 measure*	*2 measures*
High Quality Care				
HEDIS Chronic Care Measures	*17 measures*	*13 measures*	*14 measures*	
CAHPS Survey Quality of Care Measures	*6 measures*		*4 measures*	
Other (Qualitative) Measures	*4 measures*	*1 measure*	*3 measures*	
Cost Effective Care				
Utilization Measures (Paid Claims Analysis)	*2 measures*	*2 measures*	*3 measures*	
Per Member Per Month Expenditure Measure	*1 measure*	*1 measure*	*1 measure*	

The evaluation relied on a comparison group methodology for 77 of the 86 measures. The HMP and HAN populations were measured against "unmanaged" beneficiaries selected using a matching scheme that took into account relevant demographic characteristics. The population subject to the waiver of retroactive eligibility was compared to beneficiaries not subject to the waiver.

Overall, the interim evaluation found that the demonstration population outperformed the comparison group on 33 of 45 measures for which there was a statistically significant difference, as summarized in the table below.



PHPG is currently documenting calendar year 2022 evaluation findings for inclusion in the SoonerCare summative evaluation report to be submitted to CMS within 18 months of expiration of the current waiver period in December 2023. The table below summarizes current evaluation activities.

Waiver Component	Progress Summary
Health Access Networks	
Impact on Costs – The implementation and expansion of the HANs will reduce costs associated with the provision of health care services to SoonerCare beneficiaries served by the HANs.	PHPG will be obtaining an eligibility file and paid claims extract for calendar year 2022 in April 2023. The extract will be used to calculate ER visit rates, hospital admission rates and PMPM expenditures for HAN beneficiaries (general and care managed) and a comparison group of beneficiaries not enrolled in a HAN or the SoonerCare Health Management Program. The comparison will be selected using Coarsened Exact Matching (CEM), in accordance with guidance provided by CMS.

Impact on Access – The implementation and expansion of the HANs will improve access to and the availability of health care services to SoonerCare beneficiaries served by the HANs.	The independent evaluator using the claims extract described above to evaluate access through HEDIS® child and adult preventive care measures. The evaluation includes the same comparison group methodology as described above. The OHCA provides PHPG with annual adult and child CAHPS survey data from its CAHPS vendor. The vendor's files contain de-identified member-level data, with HAN-affiliated respondents flagged within the database. PHPG will request the latest CAHPS data in July 2023, to document HAN member responses to access-to-care questions, as well as responses from a comparison group consisting of the non-HAN population.
Impact on Quality of Care – The implementation and expansion of the HANs will improve the quality and coordination of health care services to SoonerCare beneficiaries served by the HANs, including specifically populations at greatest risk (e.g., those with multiple chronic illnesses).	The independent evaluator using the claims extract described above to evaluate access through HEDIS® child and adult preventive care measures. The evaluation includes the same comparison group methodology as described above. PHPG will be conducting surveys of HAN-affiliated beneficiaries who have been enrolled in care management, to document satisfaction with the assistance received, including with respect to social determinants of health. PHPG also will be surveying HAN-affiliated providers who have received HAN practice support, to document satisfaction with the assistance received. The surveys will be conducted in Spring 2023. (Although the surveys will occur this year, many of the activities addressed will have occurred in 2022.)
Health Management Program	
Impact on Enrollment Figures – The implementation of the third generation HMP, including health coaches and practice facilitation, will result in an increase in enrollment, as compared to baseline.	The HMP contractor routinely provides updated rosters to the independent evaluator. The evaluator uses the rosters to track new enrollments, disenrollments and continuing participants on a monthly basis.
Impact on Access to Care – Incorporating health coaches into primary care practices will result in increased contact with HMP beneficiaries by the PCP (measured through claims encounter data), as compared to baseline, when care management occurred (exclusively) via telephonic or face-to-face contact with a nurse care manager.	The evaluator is using the paid claims extract described above to document the average number of PCMH visits incurred by HMP participants.

Impact on Identifying Appropriate Target Population – The implementation of the third generation HMP, including geographic expansion and introduction of additional health coaching modalities, will result in an increase in the average risk profile of newly enrolled members (based on the average number of chronic conditions) as the program becomes available to qualified members who do not currently have access to the HMP.	The evaluator is using the paid claims extract described above to document the average number of chronic conditions among HMP participants and percentage of participants with a physical/behavioral health comorbidity.
Impact on Health Outcomes – Use of disease registry functions by the health coach will improve the quality of care delivered to beneficiaries, as measured by changes in performance on the initial set of Health Care Quality Measures for Medicaid-Eligible Adults or CHIPRA Core Set of Children's Healthcare Quality Measures.	The evaluator is using the claims extract described above to evaluate health outcomes using HEDIS® chronic care measures for Asthma, CAD, COPD, Diabetes, Hypertension, Mental Health, and pain management. The evaluator also is conducting surveys of HMP-participating PCMH providers and members, to document satisfaction with HMP practice support activities (provider surveys) and HMP quality-of-care management, including assistance with social determinants of health (member surveys). Both surveys are being conducted on a continuous basis. In 2019-2022, the evaluator completed approximately 2,508 initial and 1,228 follow-up surveys. The beneficiary survey also included the CAHPS question set addressed above for the HAN population. PHPG is evaluating HMP beneficiary responses against the same comparison group universe as used in the HAN analysis.
Impact on Cost/Utilization of Care - ER – Beneficiaries using HMP services will have fewer ER visits, compared to beneficiaries not receiving HMP services (as measured through claims data).	The evaluator is calculating ER cost/utilization for 2022 by applying the same methodology for HMP participants as described above for HAN-affiliated beneficiaries.
Impact on Cost/Utilization of Care – Hospital – Beneficiaries using HMP services will have fewer admissions and readmissions to hospitals, compared to beneficiaries not receiving HMP services (as measured through claims data).	The evaluator is in the process of calculating hospital cost/utilization for 2022 by applying the same methodology for HMP participants as described above for HAN-affiliated beneficiaries.
Impact on Satisfaction/Experience with Care – Beneficiaries using HMP services will have higher satisfaction, compared to beneficiaries not receiving HMP services (as measured through survey data employing CAHPS questions).	The beneficiary survey also included the CAHPS question set addressed above for the HAN population. PHPG is evaluating HMP beneficiary responses against the same comparison group universe as used in the HAN analysis.

Impact on Effectiveness of Care – Total and per member per month expenditures for members enrolled in HMP will be lower than would have occurred absent their participation in nurse care management.	The evaluator is calculating PMPM expenditures for 2022 by applying the same methodology for HMP participants as described above for HAN-affiliated beneficiaries.
Insure Oklahoma	
The evaluation will support the hypothesis that Insure Oklahoma is improving access to care for low-income Oklahomans not eligible for Medicaid, as measured by the number of individuals enrolled in Insure Oklahoma.	OHCA produces monthly reports of Insure Oklahoma member enrollment. The evaluator is using the reports to document program enrollment trends.
The evaluation will support the hypothesis that Insure Oklahoma is improving access to care for low-income Oklahomans not eligible for Medicaid, as measured by the number of employers participating in the ESI portion of Insure Oklahoma.	OHCA produces monthly reports of Insure Oklahoma employer counts. The evaluator is using the reports to document employer participation trends.
The evaluation will support the hypothesis that Insure Oklahoma is improving access to care for low-income Oklahomans not eligible for Medicaid, as measured by the number of primary care providers participating in the Individual Plan portion of Insure Oklahoma.	OHCA produces monthly reports of Insure Oklahoma primary care provider counts. The evaluator is using the reports to document PCP participation trends.
Waiver of Retroactive Eligibility	
Impact on Access to Care – Eliminating retroactive eligibility will increase the likelihood of enrollment and enrollment continuity.	The evaluator is using the eligibility extract described above to calculate quarterly enrollment of members subject to the waiver and a comparison group of members not subject to the waiver. The comparison group is being selected using CEM. Note that this analysis will be affected by the extension of eligibility for covered populations during the COVID-19 public health emergency.
Impact on Quality of Care – Health Status at Enrollment – Eliminating retroactive eligibility will increase enrollment of eligible people when they are healthy relative to those eligible people who have the option of retroactive eligibility.	The evaluator drafted a health status survey in accordance with CMS technical assistance/guidance and is conducting the survey by telephone on members subject to the waiver and a comparison group of members not subject to the waiver. The survey is conducted at time of enrollment (baseline) and at 12, 18 and 24-months post-enrollment. The populations subject to the retroactive eligibility waiver were modified in the current Demonstration period and OHCA implemented the modifications in the spring of 2020. The evaluator began baseline surveys in August 2020. Follow-up surveys commenced in August 2021, starting with members who received baseline surveys in August 2020.

Impact on Quality of Care – Health Outcomes – Through greater continuity of coverage, health outcomes will be better for those subject to retroactive eligibility waivers compared to other Medicaid beneficiaries who have access to retroactive eligibility.	Self-reported health outcomes are being evaluated using the survey process described above.

VI. ATTACHMENTS

None

VII. STATE CONTACT

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Kevin Corbett
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[redacted]

VIII. DATE SUBMITTED TO CMS

March 22, 2023