Oklahoma Application Certification Statement - Section 1115(a) Extension

This document, together with the supporting documentation outlined below, constitutes Oklahoma's application to the Centers for Medicare & Medicaid Services (CMS) to extend the section 1115(a) demonstration titled, "SoonerCare" (Project Number 11-W00048/6) for a period of 5 years pursuant to section 1115(a) of the Social Security Act.

Type of Request (*select one only*):

___X___ Section 1115(a) extension with no program changes

This constitutes the state's application to the Centers for Medicare & Medicaid Services (CMS) to extend its demonstration without any programmatic changes. The state is requesting to extend approval of the demonstration subject to the same Special Terms and Conditions (STCs), waivers, and expenditure authorities currently in effect for the period August 31, 2018 through December 31, 2023.

The state is submitting the following items that are necessary to ensure that the demonstration is operating in accordance with the objectives of title XIX and/or title XXI as originally approved. The state's application will only be considered complete for purposes of initiating federal review and federal-level public notice when the state provides the information as requested in the below appendices.

- **Appendix A:** A historical narrative summary of the demonstration project, which includes the objectives set forth at the time the demonstration was approved, evidence of how these objectives have or have not been met, and the future goals of the program.
- **Appendix B:** Budget/allotment neutrality assessment, and projections for the projected extension period. The state will present an analysis of budget/allotment neutrality for the current demonstration approval period, including status of budget/allotment neutrality to date based on the most recent expenditure and member month data, and projections through the end of the current approval that incorporate the latest data. CMS will also review the state's Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) expenditure reports to ensure that the demonstration has not exceeded the federal expenditure limits established for the demonstration. The state's actual expenditures incurred over the period from initial approval through the current expiration date, together with the projected costs for the requested extension period, must comply with CMS budget/allotment neutrality requirements outlined in the STCs.
- **Appendix C:** Interim evaluation of the overall impact of the demonstration that includes evaluation activities and findings to date, in addition to plans for evaluation activities over the requested extension period. The interim evaluation should provide CMS with a clear analysis of the state's achievement in obtaining the outcomes expected as a direct effect of the demonstration program. The state's interim evaluation must meet all of the requirements outlined in the STCs.

- **Appendix D:** Summaries of External Quality Review Organization (EQRO) reports, managed care organization and state quality assurance monitoring, and any other documentation of the quality of and access to care provided under the demonstration.
- **Appendix E:** Documentation of the state's compliance with the public notice process set forth in 42 CFR 431.408 and 431.420.

_____ **Section 1115(a) extension with minor program changes**

This constitutes the state's application to the Centers for Medicare & Medicaid Services (CMS) to extend its demonstration with minor demonstration program changes. In combination with completing the Section 1115 Extension Template, the state may also choose to submit a redline version of its approved Special Terms and Conditions (STCs) to identify how it proposes to revise its demonstration agreement with CMS.
With the exception of the proposed changes outlined in this application, the state is requesting CMS to extend approval of the demonstration subject to the same STCs, waivers, and expenditure authorities currently in effect for the period [insert current demo period].

The state's application will only be considered complete for purposes of initiating federal review and federal-level public notice when the state provides the information requested in Appendices A through E above, along with the Section 1115 Extension Template identifying the program changes being requested for the extension period. Please list all enclosures that accompany this document constituting the state's whole submission.

1. Section 1115 Extension Template
2. [List Enclosure]
3. [List Enclosure]
4. [List Enclosure]

The state attests that it has abided by all provisions of the approved STCs and will continuously operate the demonstration in accordance with the requirements outlined in the STCs.

Signature: [redacted] **Date:** 12/15/2022

CMS will notify the state no later than 15 days of submitting its application of whether we determine the state's application meets the requirements for a streamlined federal review. The state will have an opportunity to modify its application submission if CMS determines it does not meet these requirements. If CMS reviews the state's submission and determines that any proposed changes significantly alter the original objectives and goals of the existing demonstration as approved, CMS has the discretion to process this application full scope pursuant to regular statutory timeframes for an extension or as an application for a new demonstration.

SOONERCARE SECTION 1115 EXTENSION

APPENDIX A

SoonerCare Historical Narrative Summary

Introduction

The Oklahoma Medicaid program in the early 1990's was experiencing significant financial and service accessibility problems. Budgetary shortfalls had forced the State to reduce hospital, physician, and prescription drug coverage for adults. At the same time, access to primary and specialty care in rural areas, where providers are relatively sparse, was deteriorating in the face of declining physician participation.

In response, the Oklahoma Legislature during its 1993 session enacted comprehensive reforms through two statutes: House Bill (HB) 1573 and Senate Bill (SB) 76. HB 1573 created the Oklahoma Health Care Authority (OHCA) and established it as Oklahoma's new Single State Agency (SSA) for Medicaid. SB 73 authorized the conversion of the state's fee-for-service Medicaid program to a managed system of care and directed the OHCA to seek all necessary federal approvals for the conversion. The two bills were codified in Title 63 of Oklahoma Statutes (Public Health and Safety).

The OHCA submitted an application to the Health Care Financing Administration (HCFA) on December 1, 1994 for approval of "SoonerCare", to be operated as a Demonstration program under Section 1115 of the Social Security Act (SSA). The OHCA also submitted a 1915(b) managed care waiver application for operation of SoonerCare pending approval of the Section 1115 Demonstration, at which time the 1915(b) program would be subsumed under the Demonstration.

The objectives for SoonerCare outlined in the state's original application included[1]:

- Improving access to preventive services, primary care and early prenatal care for Oklahoma's Title XIX population.

- Ensuring that every Title XIX beneficiary is able to choose a primary care provider who will serve as his or her family physician and be responsible for providing all basic medical services.

- Building managed care capacity in Oklahoma's rural communities, and testing various alternatives for creating this capacity in order to identify the most effective model(s).

[1] Application to the Department of Health and Human Services for the Development of SoonerCare, December 1994, pp 2 – 3.

- More closely aligning rural providers with their urban counterparts, so that rural Title XIX beneficiaries are better able to obtain access to needed specialty/referral services.

- Enhancing the ability of rural communities to retain existing providers and attract new ones.

- Instilling a greater degree of budget predictability into Oklahoma's Title XIX program, by moving from a fee-for-service system to one based on the concept of pre-payment.

The SoonerCare application requested authority to phase-in enrollment of all Title XIX populations, beginning with non-disabled children, TANF and TANF-related beneficiaries ("Parent and Caretaker" Medicaid Eligibility Group (MEG)) and pregnant women. This initial population would be followed by Aged, Blind and Disabled (ABD) beneficiaries not eligible for Medicare and not enrolled in the Medicaid long term care program. Medicaid-Medicare dual eligibles and beneficiaries eligible for long term care services (dual eligibles and others) would be enrolled last.

The Section 1915(b) waiver was approved by HCFA in January 1995 and implemented in April 1995. The SoonerCare Section 1115 Demonstration was approved for implementation in April 1996.

SoonerCare began with the Title XIX populations designated for inclusion at program start-up. The non-dual eligible, non-long term care ABD population was added in 1998. The OHCA subsequently decided not to move forward with enrollment of the dual eligible and long-term care populations.

The original SoonerCare Demonstration ran from April 1996 to December 2000. The Demonstration has been renewed or extended by HCFA and later CMS seven times (see Exhibit 1). The current Demonstration cycle began on August 30, 2018 and runs through December 31, 2023.

Exhibit 1 - SoonerCare Demonstration – Initial and Renewal Periods

Demo Year	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*12*	*13*	*14*	*15*	*16*	*17*	*18*	*19*	*20*	*21*	*22*	*23*	*24*	*25*	*26*	*27*	*28*
Calendar Year	96	97	98	99	00	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Initial																												
Renewal 1																												
Renewal 2																												
Renewal 3																												
Renewal 4																												
Renewal 5																												
Renewal 6																												
Renewal 7																												
Renewal 8																												

SoonerCare Demonstration – 1996 to 2003

The SoonerCare Demonstration began as two distinct delivery models: SoonerCare Plus and SoonerCare Choice. (Beneficiaries outside of the Demonstration were enrolled in SoonerCare Traditional, the OHCA's fee-for-service system.)

The SoonerCare Plus program operated as a comprehensive risk-based managed care model in the state's three largest metropolitan areas of Lawton, Oklahoma City and Tulsa. The SoonerCare Choice program began as a partial risk-based primary care case management (PCCM) program in four rural counties in 1996 before expanding to the rest of rural Oklahoma in 1997[2].

The Oklahoma managed care environment was relatively immature in the program's early years. The OHCA faced ongoing challenges attracting a sufficient number of licensed health plans to ensure price competition and beneficiary choice in the metropolitan areas.

In 2003, the OHCA discontinued SoonerCare Plus and expanded the SoonerCare Choice model statewide. The OHCA also modified the SoonerCare Choice model by transitioning to payment of a per member per month (PMPM) age-adjusted case management fee coupled with fee-for-service payment of medical claims.

SoonerCare Demonstration – 2004 to 2018

<u>New Demonstration Populations</u>

The Oklahoma Legislature in 2004 passed SB 1546, authorizing the OHCA to develop a subsidized insurance program for qualifying employees and spouses of participating small businesses, as well as other qualifying low-income adults not eligible for Medicaid. The program, originally known as O-EPIC and later as Insure Oklahoma (the name used in the remainder of this application), was approved by CMS as a Health Insurance Flexibility and Affordability (HIFA) waiver amendment in September 2005.

Insure Oklahoma (IO) included two participation tracks: Employer Sponsored Insurance (IO-ESI) and Individual Plan (IO-IP). Under IO-ESI, the OHCA pays a portion of the health insurance premium for qualifying employees at participating small businesses.

Individuals in IO-ESI enroll into an Insure Oklahoma-participating private health plan through their employer and pay up to 15 percent of the premium. The remaining premium cost is shared between the individual's employer and the state and federal governments. The individual's premium share is capped at three percent of household income; total cost sharing is capped at five percent of household income.

[2] SoonerCare Choice providers were capitated for office visits and office-based lab and radiology services. SoonerCare Choice formally was designated as a Prepaid Ambulatory Health Plan until 2009, when it was reclassified as a PCCM model.

Under IO-IP, qualifying individuals in the workforce unable to access coverage through an employer paid a premium to the OHCA, subject to a cap equal to five percent of their gross household income. The individuals were enrolled directly into the SoonerCare program and served by the same network of providers as other SoonerCare beneficiaries. The IO-IP model was discontinued concurrent with Oklahoma's Medicaid expansion, as discussed later in the narrative.

During the current waiver cycle (and prior to Medicaid expansion), the program was open to Oklahomans with household incomes up to 200 percent of the federal poverty level, who worked at an eligible business enrolled in IO-ESI, or Oklahomans making between 48 percent and 100 percent of the federal poverty level who were unemployed, working disabled or had qualifying income.

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

The OHCA also added new Title XIX MEGs to the Demonstration in 2005. These included the Breast and Cervical Cancer (BCC) MEG and Tax Equity and Fiscal Responsibility Act (TEFRA) children.

SoonerCare Health Management Program

Under the Oklahoma Medicaid Reform Act of 2006 (HB2 842), the Oklahoma Legislature directed the OHCA to develop and implement a management program for persons with chronic diseases including (for example): asthma, chronic obstructive pulmonary disease and diabetes. The program would address the health needs of chronically ill SoonerCare members[3] while reducing unnecessary medical expenditures at a time of significant fiscal constraints.

In response, the OHCA in 2008 developed the SoonerCare Health Management Program (HMP), to be operated under the Demonstration. The SoonerCare HMP offers care management to SoonerCare Choice members most at-risk for chronic disease and other adverse health events. It also offers practice support to participating primary care providers.

The program is administered by the OHCA and is managed by a vendor selected through a competitive procurement. The program is authorized to operate statewide.

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

[3] Member and beneficiary are used interchangeably in the document.

The SoonerCare HMP, when implemented, stratified members into two levels of care, with the highest-risk segment placed in "Tier 1" and the remainder in "Tier 2." Tier 1 participants received face-to-face nurse care management while Tier 2 participants received telephonic nurse care management. The OHCA sought to provide services at any given time to about 1,000 members in Tier 1 and about 4,000 members in Tier 2.

Selected participating providers received practice facilitation through the SoonerCare HMP.

Practice facilitators collaborated with providers and office staff to improve the quality-of-care through implementation of enhanced disease management and improved patient tracking and reporting systems.

Patient Centered Medical Homes

In January 2009, the OHCA enhanced the existing PCCM system through introduction of a Patient Centered Medical Home (PCMH) model for SoonerCare Choice beneficiaries. Under this model, beneficiaries actively choose a medical home from a network of contracted primary care providers. (PCMH contracts are offered to all Medicaid-enrolled primary care providers.)

There are three PCMH participation levels, or "tiers": entry level, advanced and optimal. All three tiers include standards for care management, quality improvement and access, with the standards becoming more stringent in the higher tiers. For example, entry level medical homes must provide at least 20 hours of office time per week, while advanced medical homes must offer at least 30 hours and optimal medical homes must offer at least 30 hours plus four hours of evening or weekend availability.

Medical homes are paid monthly care coordination payments for each beneficiary on their panel. The payments vary by practice type (children only, adults only or children and adults) and tier. In 2022, the fees ranged from $3.63 to $8.82 per member per month (see Exhibit 2 below). (Tribal and FQHC providers receive distinct payments that are not age- or tier-based.) Providers also are eligible to receive "SoonerExcel" payments for meeting pre-defined quality targets.

Exhibit 2 - PCMH Payments by Practice Type and Tier (PMPM)

Practice Type	Entry Level	Advanced	Optimal
Adults Only	$5.08	$6.63	$8.82
Children and Adults	$4.39	$5.73	$7.61
Children Only	$3.63	$4.73	$6.28

Health Access Networks

In 2010, the OHCA expanded the PCMH model by introducing Health Access Networks (HANs). The HANs are non-profit, administrative entities that work with affiliated PCMH

providers to coordinate and improve the quality of care provided to SoonerCare Choice members.

The HANs employ care managers to provide telephonic and in-person care management and care coordination to SoonerCare Choice members with complex health care needs who are enrolled with affiliated PCMH providers. The HANs also work to establish new initiatives to address complex medical, social and behavioral health issues. For example, the HANs have implemented evidence-based protocols for care management of ABD members with, or at risk for, complex/chronic health conditions, as well as TANF and related members with asthma and diabetes, among other conditions.

The OHCA contracts with three HANs: University of Oklahoma (OU) Sooner HAN; Partnership for Healthy Central Communities (PHCC) HAN; and Oklahoma State University (OSU) HAN. The HANs began operations in 2010 with combined enrollment of approximately 25,000.

SoonerCare Demonstration – 2018 to Present

Medicaid Expansion

On June 30, 2020, Oklahoma voters approved State Question 802, which directed the state to expand Medicaid eligibility to adults ages 19-64 whose income is 138 percent (133 percent with a five percent disregard) of the federal poverty level or lower. The OHCA began enrollment of beneficiaries into adult expansion MEG in June 2021, for effective dates of July 1.

The adult expansion MEG was added to the program through a State Plan Amendment. The OHCA also submitted a proposed waiver amendment to CMS to permit enrollment of the expansion population into the SoonerCare Demonstration. CMS approved the amendment in September 2021, at which time expansion beneficiaries became eligible to select a medical home for their primary care.

The expansion largely subsumed the Insure Oklahoma program. The IO-IP portion of the program had an income limit of 100 percent of FPL, while the IO-ESI portion had an income limit of 200 percent of FPL. The OHCA restricted eligibility for the IO-ESI benefit to qualifying individuals with incomes between 139 and 200 percent of FPL.

The OHCA implemented the phase-out of the IO-IP program concurrent with implementation of the expansion, although the IO-IP program still includes members whose eligibility is based on PHE Maintenance-of-Effort requirements. (Authority to operate IO-IP remains in the SoonerCare STCs and will be removed upon expiration of the PHE.)

Evolution of the SoonerCare Health Management Program

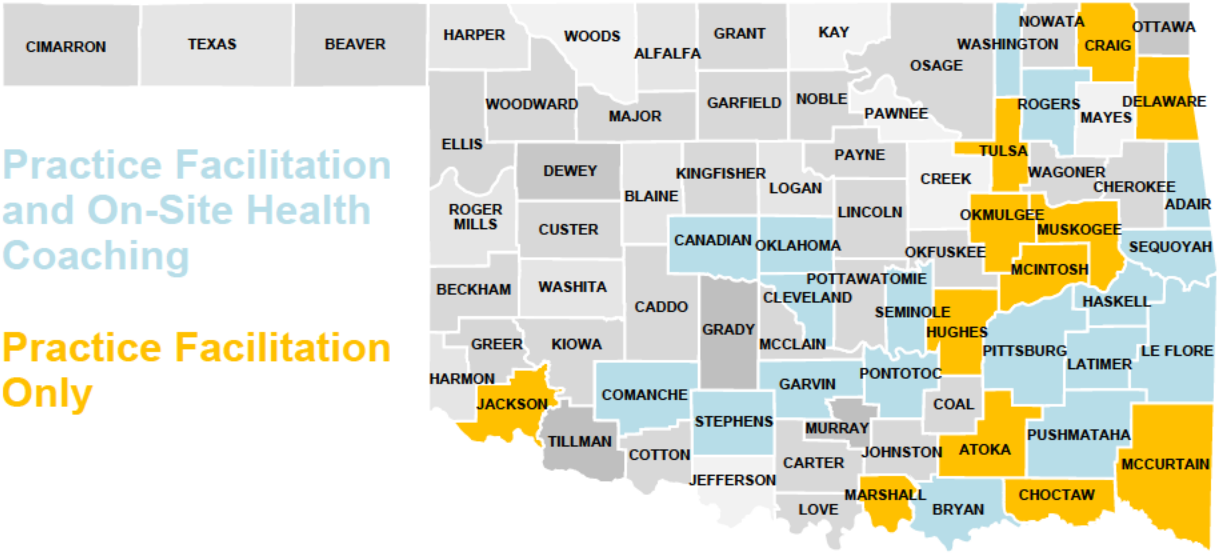
The SoonerCare HMP has evolved and expanded over time. To enhance member identification and participation, as well as coordination with primary care providers, the OHCA elected to

replace centralized nurse care management services with registered nurse health coaches embedded at primary care practice sites. The health coaches work closely with practice staff and provide coaching services to participating members using evidence-based concepts such as motivational interviewing and member-driven action planning principles to impart changes in behaviors that impact chronic disease care. (The SoonerCare HMP continues to offer telephonic and field-based care management to beneficiaries not aligned with a participating provider.)

The OHCA also expanded the SoonerCare HMP to include practice facilitators and substance use disorder resource specialists dedicated to improving the effectiveness of providers caring for members with chronic pain and opioid drug use. These staff assist providers with implementation of a chronic pain management toolkit and principles of proper prescribing.

In August 2022, the program had practice facilitators and onsite health coaches jointly assisting practices in 18 counties. The program had practice facilitators without onsite health coaches working in an additional nine counties (Exhibit 3 below). Note that many counties had multiple practice facilitation/health coaching sites. (Counties with telephonic-only participants are not shaded.)

Exhibit 3 – Counties with One or More Health Coaching/General Practice Facilitation Sites



Evolution of the Patient Centered Medical Home Model

In June 2022, there were 870 PCMH providers statewide, with a total contracted capacity to serve 1.5 million members. SoonerCare Choice beneficiaries in total accounted for only 48 percent of the contracted PCMH capacity throughout the state leaving ample room for further growth.

The OHCA redesigned the SoonerExcel portion of the PCMH model in 2022, to place a greater emphasis on state health priorities. The OHCA updated the SoonerExcel component of the program through adoption of four measurement areas:

- Risk-adjusted emergency department visit rate, using the Johns Hopkins Adjusted Clinical Group Case-Mix System
- Behavioral health needs screening rate
- Diabetic control rate (combination of patients with poor control of blood sugar, as identified through HbA1c testing and hospital admission rate for short-term complications associated with diabetes)
- Obesity management (combination of rate of BMI measurement, nutrition counseling and exercise counseling)

The OHCA also introduced an online quarterly provider "scorecard" showing each medical home its performance that quarter and its SoonerExcel payments earned that quarter (if any). PCMH providers are ranked against their peers and earn payments for placing in the top grouping for a given measure. (See Exhibit 4 - sample scorecard on the following two pages.)

PRV-1020-I (v1.0)

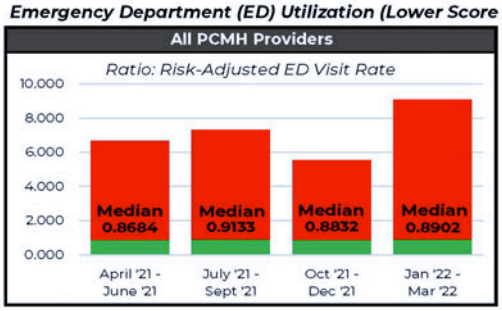
July 21, 2022

OKLAHOMA
Health Care Authority

Patient-Centered Medical Home (PCMH) Performance Summary

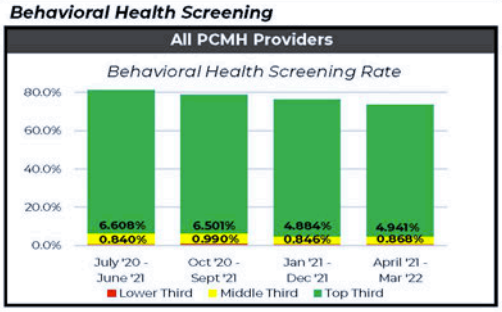
Provider Name *Provider Name Here* *Provider Number Here*

Emergency Department (ED) Utilization (Lower Score is Better)



Your Practice				
Reporting Period (Quarterly)	April '21 - June '21	July '21 - Sept '21	Oct '21 - Dec '21	Jan '22 - Mar '22
Results	0.6560	0.5324	0.6296	0.6063
Performance	Meets	Meets	Meets	Meets
Improvement to Next Cohort?	*No Data Available*	No	No	No

Behavioral Health Screening



Your Practice				
Reporting Period (Rolling Average)	July '20 - June '21	Oct '20 - Sept '21	Jan '21 - Dec '21	April '21 - Mar '22
Results	0.164%	0.337%	0.563%	0.529%
Performance	Low Performer	Low Performer	Low Performer	Low Performer
Improvement to Next Cohort?	*No Data Available*	No	No	No

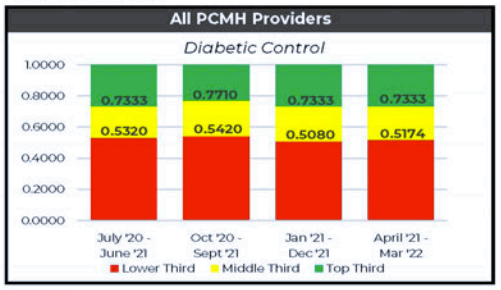
July 21, 2022

OKLAHOMA
Health Care Authority

Patient-Centered Medical Home (PCMH) Performance Summary

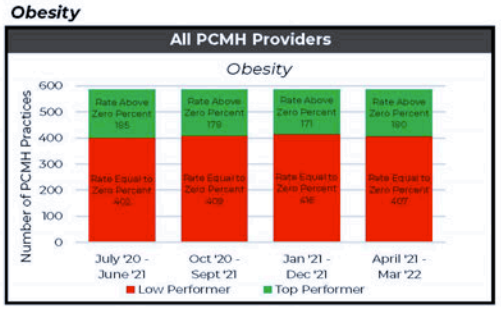
Provider Name *Provider Name Here*

Diabetic Control



Your Practice				
Reporting Period (Rolling Average)	July '20 - June '21	Oct '20 - Sept '21	Jan '21 - Dec '21	April '21 - Mar '22
Results	0.5647	0.3500	0.4571	0.5176
Performance	Middle Performer	Low Performer	Low Performer	Middle Performer
Improvement to Next Cohort?	*No Data Available*	No	No	Yes

Obesity



Your Practice				
Reporting Period (Rolling Average)	July '20 - June '21	Oct '20 - Sept '21	Jan '21 - Dec '21	April '21 - Mar '22
Results	0.000%	0.000%	1.149%	0.000%
Performance	Low Performer	Low Performer	Top Performer	Low Performer
Improvement to Next Cohort?	*No Data Available*	No	Yes	No

Exhibit 4 - SoonerExcel Scorecard (Sample) – page3

Patient-Centered Medical Home (PCMH) Payment Summary

Provider Name *Provider Name Here*

Please look for incentive payments on your July 20, 2022 remit. This payment is not patient specific and will be found on the financial transaction page under non-claim specific payouts.

Performance Payment				
Reporting Period:	**April '21 - June '21**	**July '21 - Sept '21**	**Oct '21 - Dec '21**	**Jan '22 - Mar '22**
ED Utilization:				$387.00
Behavioral Health:				$0.00
Diabetic Control:				$265.96
Obesity:				$0.00
Quarterly Total:				**$652.95**

Improver Bonus Payment				
Reporting Period:	**April '21 - June '21**	**July '21 - Sept '21**	**Oct '21 - Dec '21**	**Jan '22 - Mar '22**
ED Utilization:				$0.00
Behavioral Health:				$0.00
Diabetic Control:				$1,251.21
Obesity:				$0.00
Quarterly Total:				**$1,251.21**

Combined Total Performance and Improver Bonus Payment for Current Reporting Period:	**$1,904.16**

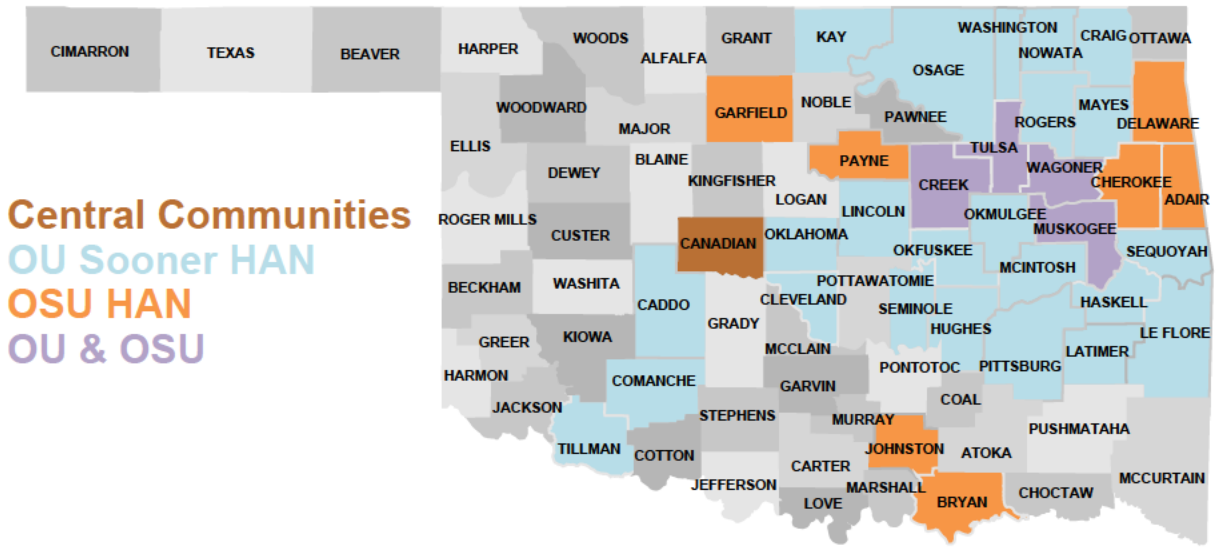
SoonerExcel incentive payments are dependent on the types of members you see and services provided. They are calculated on a quarterly basis; please look for your next communication in October, 2022 . The incentive payment methodology can be found on our public website at https://oklahoma.gov/ohca under the "Provider" section by selecting the Patient-Centered Medical Home link. If you have questions or require additional information please contact scorecards@okhca.org.

Growth of SoonerCare Health Access Networks

The OHCA has collaborated continuously with the three SoonerCare HANs to expand their geographic footprint and enrollment. Total HAN enrollment currently exceeds 300,000 beneficiaries.

The HANs are affiliated with practices in 34 of Oklahoma's 77 counties (See Exhibit 5 below). (The PCMH program operates in all 77 counties.)

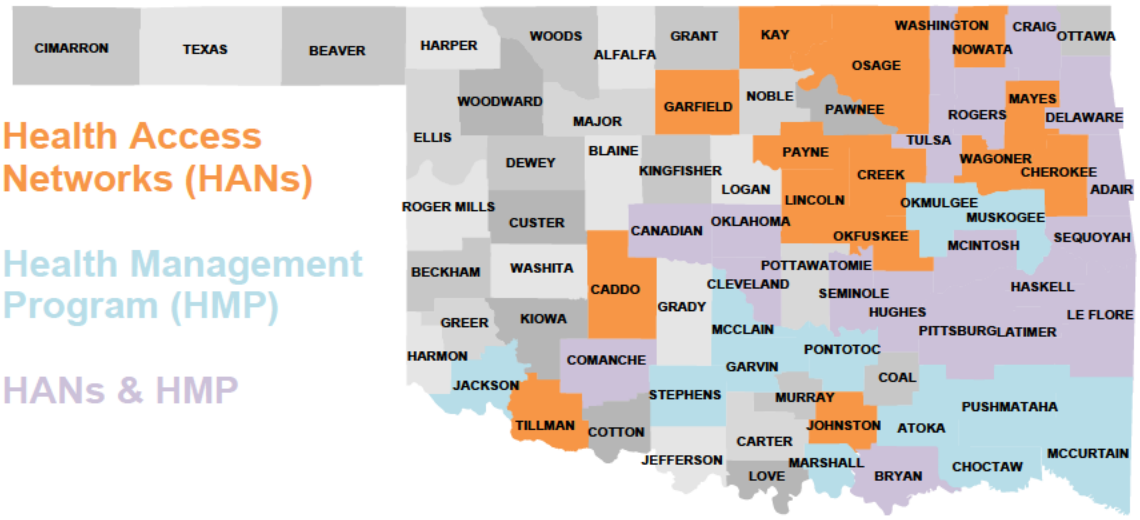
Exhibit 5 –SoonerCare HAN Counties in 2022



The SoonerCare HMP and Health Access Networks have overlapping geographic footprints, although they serve discrete populations (i.e., members are not co-enrolled). Together, they offer care management and/or practice facilitation in 46 counties to SoonerCare members with or at risk for complex/chronic health conditions (see Exhibit 6 on the following page)[4].

[4] The OHCA also operates an internal Chronic Care Unit (CCU) within its Population Care Management Department. The CCU provides telephonic care management to approximately 1,000 SoonerCare members at any point in time, including members with Hepatitis-C, Hemophilia, Sickle Cell Disease. The CCU also serves members with complex/chronic conditions who reside outside the SoonerCare HAN service area and are not enrolled in the SoonerCare HMP.

Exhibit 6 – SoonerCare HMP and HAN Counties 2022



Summary Exhibit of Major Events

Exhibit 7 below presents a summary of major events in the history of the Demonstration. The first part addresses SoonerCare Choice; the second part addresses Insure Oklahoma.

Exhibit 7 – Major Events – SoonerCare Choice & Insure Oklahoma

Historical Timeline of the SoonerCare Choice Program	
July 1, 1993	State leadership passes Title 63 of the Oklahoma Statute directing the Oklahoma Health Care Authority as the single state Medicaid agency, and to convert the Medicaid program to managed care.
January 1995	The Health Care Financing Administration approves operating SoonerCare under a Section 1915(b) managed care waiver.
July 1996	The State implements SoonerCare Choice, a partially capitated model for specific rural areas of the State utilizing primary care case management, and SoonerCare Plus[5], a capitated model in urban areas utilizing fee-for-service.
1997	The SoonerCare Choice program is taken statewide in rural areas.
December 31, 2002	The State terminates the SoonerCare Plus[5] program and transitions managed care enrollees to the SoonerCare Choice primary care case management model statewide.

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

Historical Timeline of the SoonerCare Choice Program	
January 1, 2004	CMS approves extending the program from January 1, 2004 through December 31, 2006.
January 2005	CMS approves the Breast and Cervical Cancer population for SoonerCare Choice.
September 30, 2005	CMS approves adding coverage for TEFRA children.
December 21, 2006	CMS approves extending the program from January 1, 2007 through December 31, 2009.
January 3, 2009	a) CMS approves changing the service delivery model from a Prepaid Ambulatory Health Plan (PAHP) to an exclusive Primary Care Case Management (PCCM) model. The patient-centered medical home was implemented. b) CMS approves expanding the description of qualified PCPs to permit County Health Departments to serve as medical homes for members who choose those providers. c) CMS approves the option for the voluntary enrollment of children in State or Tribal custody in the Demonstration. d) CMS approves the SoonerExcel incentive payment program for PCPs to build upon the EPSDT and fourth DTaP Bonus program. e) CMS approves adding $1 copay for non-pregnant adults in SoonerCare.
December 30, 2009	a) CMS approves extending the program from January 1, 2010 to December 31, 2012. b) CMS approves the Health Access Network (HAN) pilot program.
December 31, 2012	a) CMS approves extending the program from January 1, 2013 to December 31, 2015. b) CMS approves removal of the waiver authority that allowed the State to exclude parental income in determining eligibility for children with disabilities who are qualified for the TEFRA category because the State has this authority under the State Plan. c) CMS approves the Health Management Program, as reflected in Section VII to rename nurse care managers as health coaches and to increase face-to-face care management by embedding health coaches within physician practices with the highest concentration of members with chronic illnesses.
July 23, 2013	CMS approves the early adoption of the Systems Simplification Implementation.
September 6, 2013	a) CMS approves adding the mandatory Title XXI Targeted Low-Income Child eligibility group for children ages 0-18.

Historical Timeline of the SoonerCare Choice Program	
	b) CMS approves adding to the SoonerCare Eligibility Exclusions list individuals in the Former Foster Care group and pregnant women with incomes between 134 percent and 185 percent FPL. c) CMS approves referencing the calculation of Modified Adjusted Gross Income (MAGI) for determination of SoonerCare eligibility.
August 13, 2014	CMS approves removal of individuals with other creditable health insurance coverage from the SoonerCare Choice demonstration. Other technical changes were made to clarify language in the STCs.
July 9, 2015	CMS approves extending the program from January 1, 2016 to December 31, 2016.
January 2016	The SoonerCare Pain Management program was implemented.
June 29, 2016	Leon Bragg, DDS, Chief Dental Officer for the OHCA was recognized by Delta Dental of Oklahoma for his service as President of the Medicaid Medicare Children's Health Insurance Program (CHIP) Services Dental Association (MSDA).
July 11, 2016	Text4Baby (T4b) enrolled its 1 millionth participant the largest mobile health initiative in the nation.
August 22, 2016	Dr. Mike Herndon named Chief Medical Officer of the Oklahoma Health Care Authority.
September 9, 2016	State Medicaid Director Becky Pasternik-Ikard accepts position of Chief Executive Officer of the Oklahoma Health Care Authority.
November 30, 2016	The Oklahoma Office of Management and Enterprise Services (OMES) releases the RFP for SoonerHealth+, the fully capitated, statewide model for Oklahoma Medicaid's ABD population. CMS approves extending the program from January 1, 2017 to December 31, 2017.
December 12, 2016	The Oklahoma Health Care Authority (OHCA) comes in at number ten of Workplace Dynamic's "Top Workplaces," a list of the best places to work in Oklahoma. The OHCA was included, for the second year in a row.
May 25, 2017	The chairman of the Oklahoma Health Care Authority board, Charles 'Ed' McFall, has been named Rural Health Advocate of the Year by the Rural Health Association of Oklahoma.
June 17, 2017	The Oklahoma Health Care Authority cancels the Request for Proposal (RFP) for SoonerHealth+.
December 29, 2017	The Oklahoma Health Care Authority submits an application to renew the SoonerCare Demonstration. (CMS extends the existing authority pending approval of the renewal.)

Historical Timeline of the SoonerCare Choice Program	
August 31, 2018	CMS approves extending the program from August 31, 2018 to December 31, 2023.
May 2020	Kevin Corbett is confirmed formally by the Oklahoma Senate to serve as OHCA CEO, after being named to the position in the fall of 2019.
July 1, 2019	The Oklahoma Health Care Authority executes a new Value-based contract for continued operation and expansion of the Health Management Program
March 24, 2020	CMS approves Oklahoma's initial Section 1135 waiver applications, granting flexibilities for operating under the COVID-19 Public Health Emergency.
June 30, 2020	Oklahoma voters approves State Question 802, which directs the State to expand Medicaid eligibility to adults ages 19-64 whose income is 138 percent (133 percent with a five percent disregard) of the federal poverty level or lower.
October 15, 2020	The Oklahoma Health Care Authority issues RFPs to contract with risk-based medical and dental Managed Care Entities (MCEs) to serve the non-ABD population under a program to be known as SoonerSelect.
June 1, 2021	The Oklahoma Supreme Court halts implementation SoonerSelect in the absence of clear legislative authority for its implementation.
July 1, 2021	New Adult expansion MEG becomes effective. The OHCA begins the transition of Medicaid-eligible Insure Oklahoma beneficiaries into the program.
September 2021	CMS approves amendment to the Demonstration allowing enrollment of New Adult expansion MEG into SoonerCare Choice.
May 2022	The OHCA announces that SoonerCare will transition to a risk-based model with SoonerSelect medical and dental MCE contracts following passage by the Legislature of SB 1337, which codifies the system design for a transformed Medicaid program.
July 2022	The Oklahoma Health Care Authority implements PCMH performance scorecards as part of broader quality improvement strategy to make Oklahoma a "top ten" state on key health indicators.
September 1, 2022	The Oklahoma Health Care Authority issues an RFP to contract with dental MCEs under SoonerSelect.

Historical Timeline of the SoonerCare Choice Program	
August 2001	President Bush approves the Health Insurance Flexibility and Accountability waiver policy.
April 20, 2004	State legislators pass Senate Bill 1546 authorizing OHCA to develop an assistance program for employees of small businesses (25 or fewer) and individuals to purchase state-sponsored health plans under the state Medicaid program.
September 30, 2005	CMS approves OHCA's Health Insurance Flexibility and Accountability waiver amendment providing insurance coverage to adults employed by small employers and working disabled adults. Originally named the Oklahoma Employers/Employees Partnership for Insurance Coverage (O-EPIC), the program was included in the 1115(a) SoonerCare Choice Research and Demonstration waiver.
December 21, 2006	CMS approves increasing the Insure Oklahoma ESI employer size to 50 or fewer employees.
February 21, 2007	Oklahoma Senate passes Senate bill 424, the All Kids Act.
March 1, 2007	CMS approves the Insure Oklahoma IP program, which was created to serve those individuals who did not have access to ESI coverage.
January 3, 2009	a) CMS approves increasing the Insure Oklahoma ESI employer size to 250 or fewer employees. b) CMS approves the Insure Oklahoma eligibility group of full-time college students ages 19 to 22 up to 200 percent of the FPL, with a cap of 3,000 members. c) CMS approves amending cost sharing requirements for the Insure Oklahoma program.
June 22, 2009	CMS approves the Title XXI stand-alone CHIP State Plan amendment for children in the Insure Oklahoma program with incomes from 186 percent to 300 percent FPL.
December 30, 2009	a) CMS approves to expand eligibility under the Insure Oklahoma program for non- disabled working adults and their spouses, disabled wording adults and full-time college students, from 200 percent FPL up to and including 250 percent FPL. b) CMS approves the Insure Oklahoma eligibility group of foster parents up to 250 percent of the FPL. c) CMS approves the Insure Oklahoma eligibility group of employees of not-for-profit businesses having fewer than 500 employees, up to and including 250 percent of the FPL.
August 1, 2011	CMS approves elimination of the $10 copay for the initial prenatal visit under the Insure Oklahoma Individual Plan program.
December 31, 2012	a) CMS reduces the financial eligibility under the Insure Oklahoma program for all populations from up to and including 250 percent

Historical Timeline of the SoonerCare Choice Program	
	FPL to up to and including 200 percent FPL. While OHCA continues to have authority up to 250 percent FPL, this programmatic change indicates the current FPL utilization. b) CMS approves limiting the adult outpatient behavioral health benefit in the Insure Oklahoma Individual Plan program by limiting the number of visits to 48 per year consistent with the limitation for behavioral health visits for children. This benefit is limited to individual licensed behavioral health professionals (LBHPs).
September 6, 2013	a) CMS approves eligibility under the Insure Oklahoma program for populations qualified for the Individual Plan from up to and including 200 percent FPL to be reduced to up to and including 100 percent FPL. New demonstration populations were separately defined for the Individual Plan coverage populations. The new demonstration populations were added to the Expenditure Authorities and the Demonstration Expansion Groups in the eligibility chart. CMS approved extending the ESI and IP programs through December 31, 2014. b) CMS approves deleting the Individual Plan benefits and cost-sharing charts from the Special Terms and Conditions in order to add language to reference the State changing the benefits and cost sharing for the Insure Oklahoma Individual Plan in order to align with federal regulations.
June 27, 2014	CMS approves extending the Insure Oklahoma program through December 31, 2015.
July 9, 2015	CMS approves extending the program from January 1, 2016 to December 31, 2016.
March 2016	Insure Oklahoma completes its online enrollment systems project
March 4, 2016	The Oklahoma Health Care Authority submits an amendment to the 1115 demonstration waiver known as Insure Oklahoma Program known as Sponsor's Choice.
November 30, 2016	CMS approves extending the program from January 1, 2017 to December 31, 2017.
December 29, 2017	The Oklahoma Health Care Authority submits an application to renew Insure Oklahoma. (CMS extends the existing authority pending approval of the renewal.)
August 31, 2018	CMS approves extending the program from August 31, 2018 to December 31, 2023.
September 3, 2020	The Oklahoma Health Care Authority announces that, as Oklahoma adds the expansion adult population, the ESI program will be revised to cover individuals with qualifying income from 138 to 200% of the federal poverty level starting July 1, 2021 and that IP members will be moved into the new expansion population.

Historical Timeline of the SoonerCare Choice Program	
July 1, 2022	The Oklahoma Health Care Authority begins to transition the IP population and Medicaid-eligible ESI members into the new Adult Expansion MEG.

Demonstration Objectives and Performance

Demonstration Objectives

The OHCA's application for the current Demonstration period included five objectives:

1. Improve access to preventive and primary care services;
2. Provide each member with a medical home;
3. Integrate Indian Health Services (IHS) eligible beneficiaries and IHS and tribal providers into the SoonerCare delivery system;
4. Expand access to affordable health insurance for low-income working adults and their spouses; and
5. Optimize quality of care through effective care management.

The CMS-approved evaluation design for the SoonerCare Demonstration examines the performance of the SoonerCare HMP and SoonerCare HANs against objectives number 1 and 5. Select data from the interim evaluation of the current Demonstration period's first three years (calendar years 2019 – 2021) is presented below. The full interim evaluation is included as Appendix C of the renewal application.

Objectives 2 through 4 are addressed using program operational data. Summary findings also are presented below.

The SoonerCare Demonstration interim evaluation period overlapped significantly with the COVID-19 Public Health Emergency, which began in March 2019. This should be considered when reviewing findings for the three-year period.

Performance in Meeting Objectives

Objective 1 – Improve Access to Preventive and Primary Care Services

Access to preventive and primary care services for SoonerCare HMP and SoonerCare HAN members was evaluated through two Healthcare Effectiveness Data and Information Set (HEDIS®) measures: Adult Access to Preventive/Ambulatory Health Services (AAP) and Child and Adolescent Access to PCPs – 12 months to 19 years (CAP).

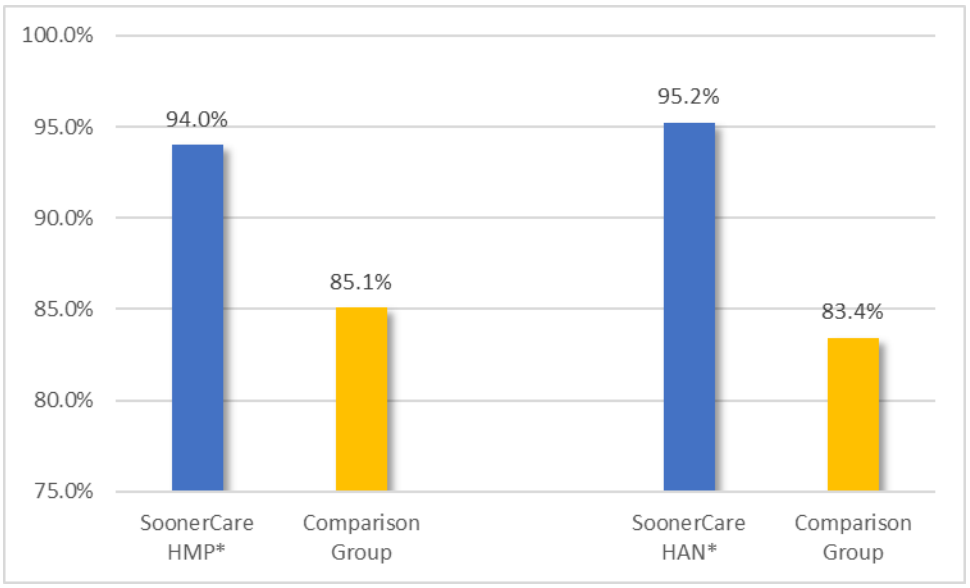
The two Demonstration populations were evaluated against discrete SoonerCare Choice comparison groups. The comparison groups were selected using a statistical "matching" process and are comprised of non-care managed members with similar demographic characteristics.

Exhibit 8 below presents three-year pooled (average) rates for the AAP HEDIS measure. Statistically significant differences at a 95 percent confidence level are noted. The SoonerCare HAN results are for the subset of HAN members enrolled in care management.

The SoonerCare HMP compliance rate was 8.1 percentage points higher than the comparison group compliance rate across the three years; the difference was statistically significant. The

SoonerCare HAN compliance rate was 11.8 percentage points higher than the comparison group rate across the three years; the difference again was statistically significant.

Exhibit 8 - Adult Access to Preventive/Ambulatory Services (2019 – 2021 Pooled Average)



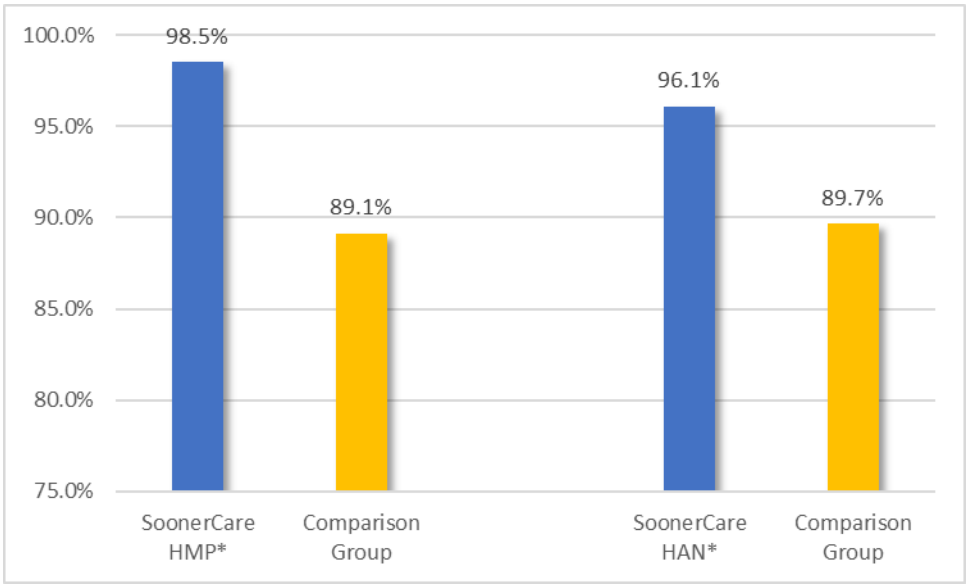
Note: Y-axis does not begin at zero.

* Denotes statistically significant difference between HMP or HAN and comparison group

Exhibit 9 on the following page presents three-year pooled (average) rates for the CAP HEDIS measure. Statistically significant differences at a 95 percent confidence level again are noted.

The SoonerCare HMP compliance rate was 9.4 percentage points higher than the comparison group compliance rate across the three years; the difference was statistically significant. The SoonerCare HAN compliance rate was 6.4 percentage points higher than the comparison group rate across the three years; the difference again was statistically significant.

Exhibit 9 - Child/Adolescent Access to PCPs (2019 – 2021 Pooled Average)



Note: Y-axis does not begin at zero.

* Denotes statistically significant difference between HMP or HAN and comparison group

Access to care also was evaluated using Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey data collected during the interim evaluation period. SoonerCare HMP and HAN adult and child beneficiary survey results were analyzed against discrete comparison groups. The HAN data was for all HAN-affiliated beneficiaries, including respondents who did not receive care management.

Exhibit 10 on the following page presents findings for the adult CAHPS "Getting Needed Care" composite measure. The exhibit shows the percentage of adult respondents who reported they "always" or "usually" were able to get necessary care, tests or treatment and (if applicable) an appointment with specialists as soon as needed.

The adult SoonerCare HMP, HAN and comparison group rates all demonstrated high levels of satisfaction with getting needed care. The differences between HMP/HAN and respective comparison groups were not statistically significant.

Exhibit 10 - CAHPS Getting Needed Care Composite Measure - Adults

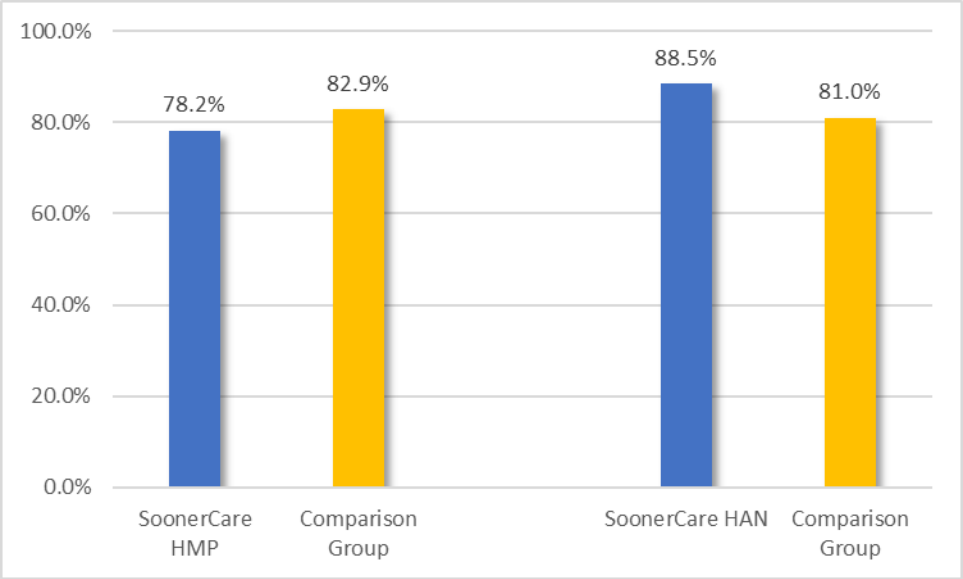
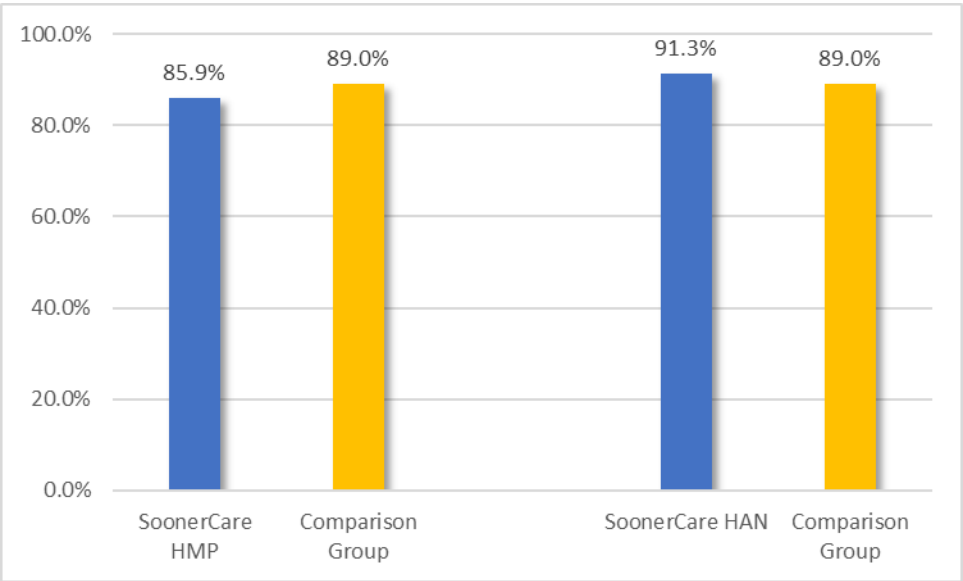


Exhibit 11 below presents findings for the child CAHPS "Getting Needed Care" composite measure. The exhibit shows the percentage of respondents who reported they "always" or "usually" were able to get necessary care, tests or treatment and (if applicable) an appointment with specialists as soon as needed for their child.

The child SoonerCare HMP, HAN and comparison group rates also all demonstrated high levels of satisfaction with getting needed care. The differences between HMP/HAN and respective comparison groups again were not statistically significant.

Exhibit 11 - CAHPS Getting Needed Care Composite Measure - Children

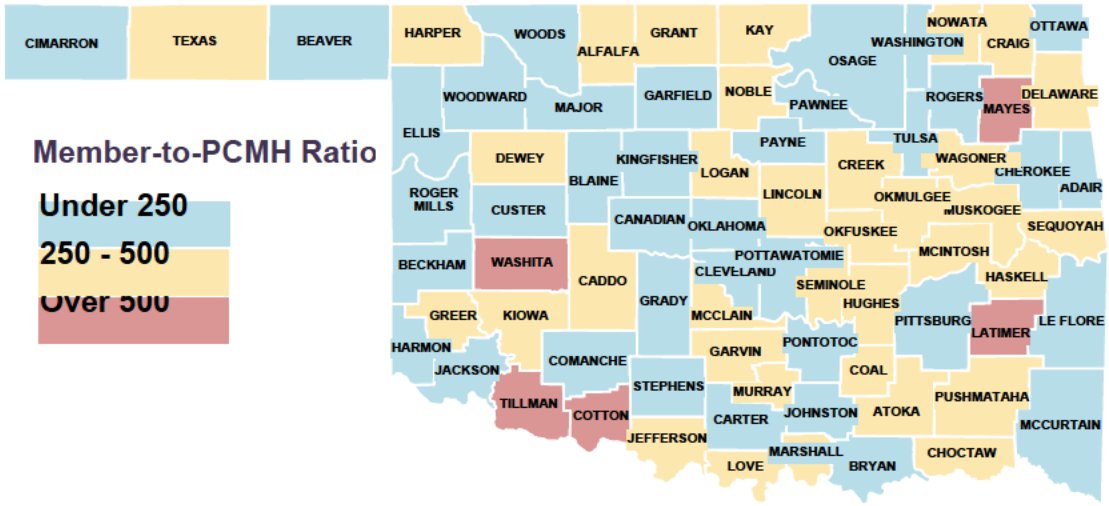


Objective 2 – Provide Each Member with a Medical Home

Every SoonerCare Choice member is offered the opportunity to select a Patient Centered Medical Home at time of enrollment or any time thereafter. (Members also can change PCMH providers monthly.) The OHCA continuously works to expand PCMH capacity, both in terms of the number of participating providers and overall contracted capacity (panel size).

Exhibit 12 below presents member-to-PCMH ratios for June 2022. The OHCA contracts with providers in every county and has total contracted capacity to serve 1.5 million members through medical homes; actual enrollment is approximately 745,000. As the map illustrates, the SoonerCare Choice member-to-PCP ratio is below 500 in all but five of the state's 77 counties.

Exhibit 12 - SoonerCare PCMH Capacity



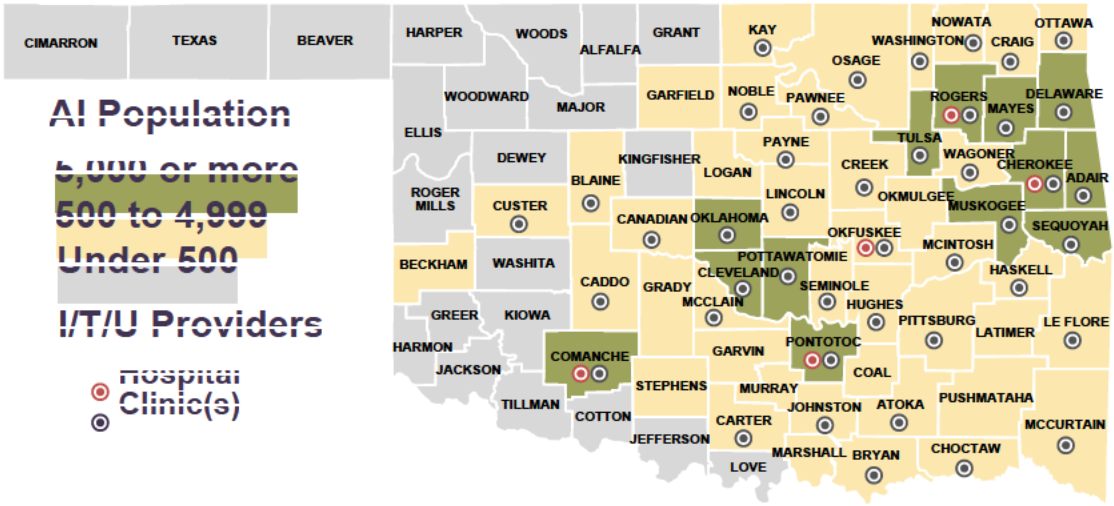
Objective 3 – Integrate IHS Eligible Beneficiaries and IHS and Tribal Providers into…System

The OHCA actively partners with the tribal provider system to integrate American Indian beneficiaries and the IHS/Tribal/Urban Indian delivery system into SoonerCare Choice. The OHCA collaborates with its I/T/U partners through regular tribal consultation meetings and educates SoonerCare Choice American Indian beneficiaries about the availability of I/T/U Patient Centered Medical Homes.

In June 2022, the OHCA was contracted with 70 I/T/U clinics and eight hospitals and had contracted capacity to serve over 240,000 American Indian beneficiaries through I/T/U medical homes; actual enrollment was approximately 62,000.

Exhibit 13 below displays the location of I/T/U clinics and hospitals. The exhibit also shows American Indian enrollees by county.

Exhibit 13 - SoonerCare I/T/U Providers



Objective 4 – Expand Access to Affordable Health Insurance…

As discussed earlier, Oklahoma expanded Medicaid coverage in July 2021 to adults ages 19-64 whose income is 138 percent (133 percent with a five percent disregard) of the federal poverty level or lower.

In 2019, prior to the expansion, over 570,000 Oklahomans were uninsured[6]. The uninsured rate stood at 14 percent, second highest in the nation after Texas.

In August 2022, approximately 300,000 beneficiaries were enrolled in the adult expansion MEG. Although not all of these individuals lacked coverage prior to their enrollment, the expansion greatly facilitated access to affordable health insurance among lower income adults across the state.

Objective 5 – Optimize Quality of Care through Effective Care Management

The SoonerCare HMP and SoonerCare HAN programs offer care management to members with, or at risk for, complex and chronic health conditions. The impact of care management was evaluated through analysis of HEDIS measures related to conditions treated through the two programs.

[6] Source: US Census Bureau

Diabetes and hypertension are the two most common chronic conditions in the care managed population. Diabetes quality of care was evaluated through four HEDIS measures:

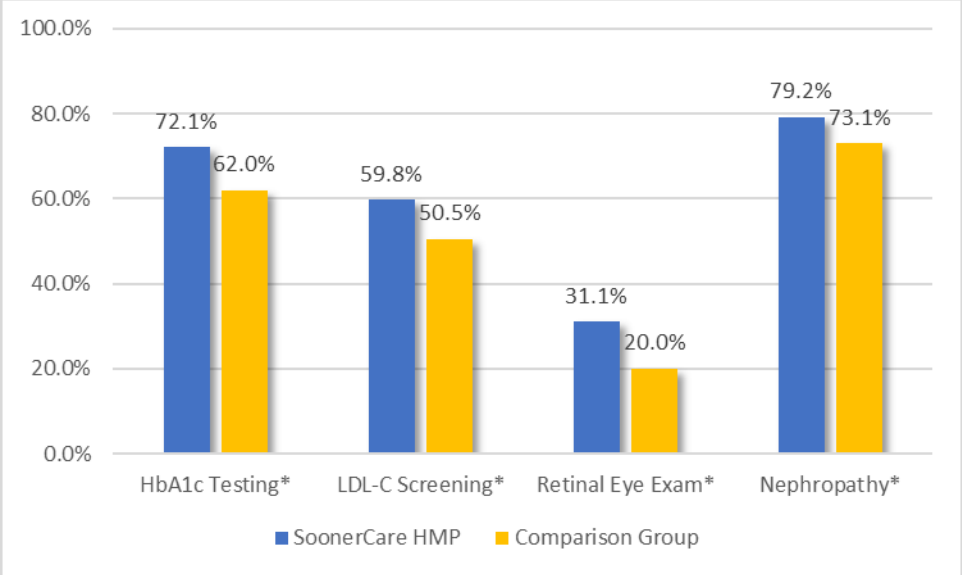
- Hemoglobin A1c (HbA1c) testing rate
- LDL-C (cholesterol level) testing rate
- Retinal eye exam rate
- Medical attention for nephropathy (kidney disease) rate

The two Demonstration populations again were evaluated against discrete SoonerCare Choice comparison groups. The comparison groups were selected using a statistical "matching" process and are comprised of non-care managed members with similar demographic characteristics.

Exhibit 14 below and Exhibit 15 on the following page present three-year pooled (average) rates for the diabetes measures. Statistically significant differences at a 95 percent confidence level are noted. The SoonerCare HAN results are for the subset of HAN members enrolled in care management.

The SoonerCare HMP compliance rate was higher than the comparison group compliance rate across the three years and across all four measures. The difference was statistically significant for every measure.

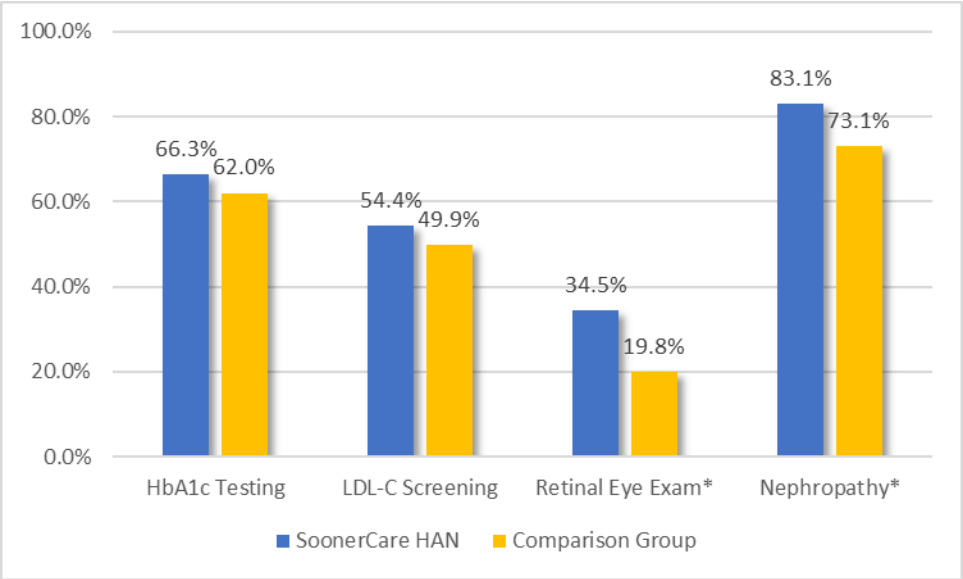
Exhibit 14 - SoonerCare HMP Diabetes Measures (2019 – 2021 Pooled Average)



* Denotes statistically significant difference between HMP and comparison group

The SoonerCare HAN compliance rate also was higher than the comparison group compliance rate across the three years and across all four measures. The difference was statistically significant for two of the four measures.

Exhibit 15 - SoonerCare HAN Diabetes Measures (2019 – 2021 Pooled Average)



* Denotes statistically significant difference between HAN and comparison group

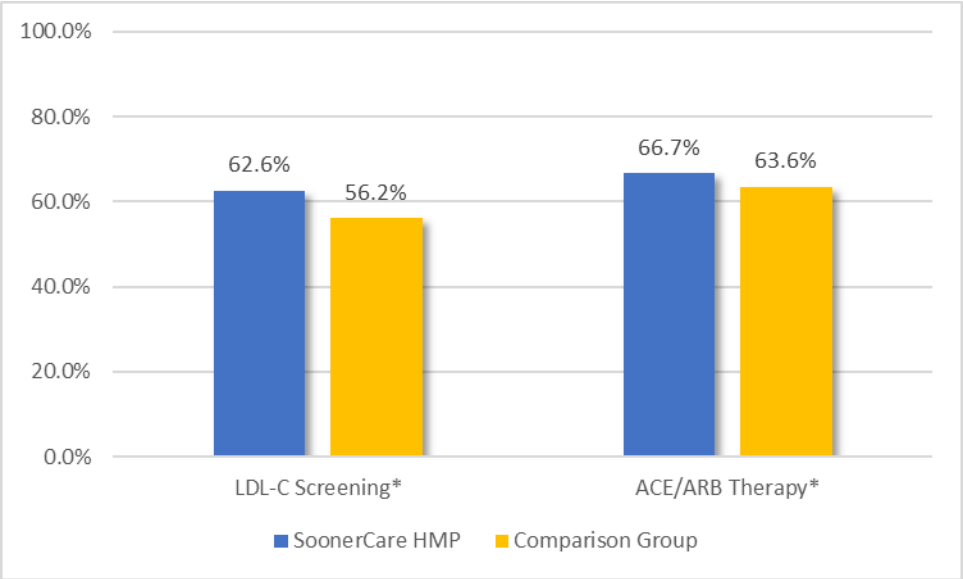
Hypertension quality of care was evaluated through two HEDIS measures:

- LDL-C (cholesterol level) testing rate
- Angiotensin-converting enzyme (ACE) inhibitors and angiotensin II receptor blocker (ARB) therapy rate

Exhibits 16 and 17 on the following page present three-year pooled (average) rates for the SoonerCare HMP diabetes measures. Statistically significant differences at a 95 percent confidence level are noted.

The SoonerCare HMP compliance rate was higher than the comparison group compliance rate across the three years and across both measures. The difference was statistically significant for measures.

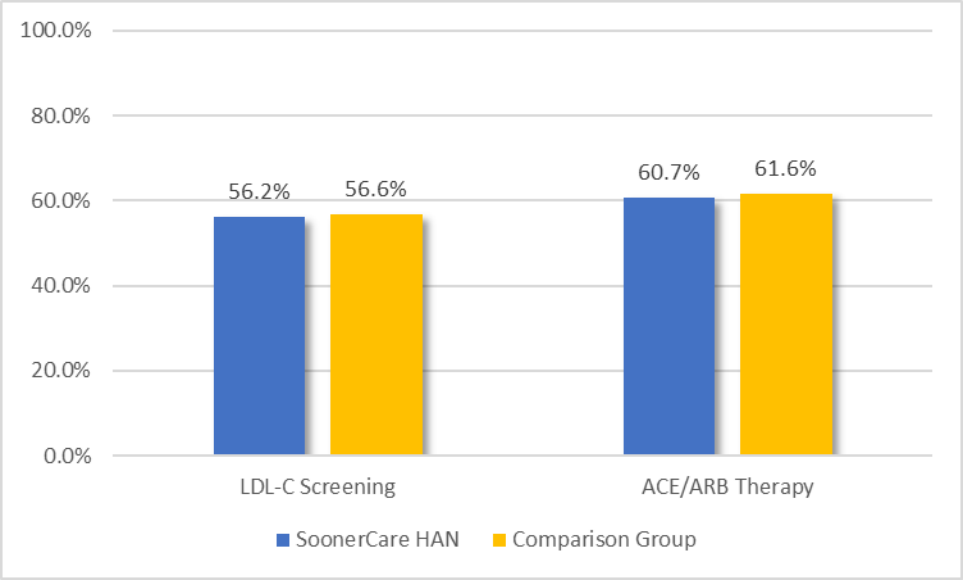
Exhibit 16 - SoonerCare HMP Hypertension Measures (2019 – 2021 Pooled Average)



* Denotes statistically significant difference between HAN and comparison group

The SoonerCare HAN and comparison group compliance rates were nearly identical for both measures. The differences were not statistically significant but were over 56 percent for LDL-C screening and over 60 percent for ACE/ARB therapy.

Exhibit 17 - SoonerCare HAN Hypertension Measures (2019 – 2021 Pooled Average)



The care management responsibilities of SoonerCare HMP and SoonerCare HAN extend beyond clinical services to include social determinants of health (SDOH). This is in recognition that SDOH-related barriers to care can impact beneficiary access to services and health status.

The quality of SDOH interventions was evaluated through surveys of SoonerCare HMP and HAN members. Members reported receiving a variety of assistance, including with respect to housing, utilities, food insecurity, transportation, child care and clothing needs.

Respondents in both programs reported high satisfaction levels with the assistance they received. Eight-five percent of SoonerCare HMP members and 93 percent of SoonerCare HAN members reported being "very satisfied" with the help provided by their Health Coach (HMP) or Nurse/Care Manager (HAN).

Respondents were asked to describe the impact of the assistance outside the format of the structured survey. A representative sample of quotes is provided below:

> *"(My health coach) filled out and sent in my HUD application for me. I am computer illiterate so she just did it herself and I am so thankful." – SoonerCare HMP member*
>
> *"The lady who calls has literally saved my life. If I didn't have her to talk to, I probably would have killed myself by now. She is helping me get section 8 housing and transportation. She also had my medication delivered to me when I could not get to the pharmacy and was panicking. She is an angel." – SoonerCare HMP member*
>
> *"(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. I would always have trouble with getting them approved before she got involved. She also suggested that I see a rheumatologist for my anemia problem and helped me get an appointment." – SoonerCare HMP member*
>
> *"(My health coaches) have been amazing especially during this quarantine. I was unable to get my mental health help and I was in a real bad place mentally. (They) would call me and let me get it all out and helped me get my head straight. (They) also helped me work with my doctor to finally get my arm pain checked out. They have been wonderful." – SoonerCare HMP member*
>
> *"She is very pleasant to talk to. She doesn't just help me with my medical problems but listens to me for as long as I need about everything. I really enjoy having her call and look forward to it." – SoonerCare HMP member*
>
> *"My son's nurse got me into the program after talking to me. I have extreme anxiety about leaving the house. (She) and my own nurse have helped me by encouraging me, very patiently, to leave the house to go to my doctor appointments. She helped me find a therapist for my problem too. She also told me who to contact to get a scooter. I would not have left the house to go to any appointments if it wasn't for (them). I owe them so much." – SoonerCare HMP member*

"(My care manager) is everything to me. She is my light. She uplifts me every time we talk. She helps me maneuver through the health care and insurance process. I have a head injury and have a hard time thinking sometimes. She helps me understand my medical problems. She goes above and beyond like once my car died and no one would help me. (She) came out to my trailer, took my dead battery and went and got a new one then put it in. That meant so much to me." – SoonerCare HAN member

"(My care manager) is like a sister to me. I felt like I was falling apart before I started talking to her. She helped me get through my anxiety about my gastric bypass surgery. She also worked with a mental health doctor to get extra help for me. She has also brought me food."– SoonerCare HAN member

"(My care manager) always seems to know when to call me. I would be lost without her calls to help 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 them both until I die." – SoonerCare HAN member

Objectives for Renewal Period

The OHCA proposes to continue progress toward achieving the five objectives from the current waiver period.

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

Appendix B

Budget Neutrality Methodology

Introduction

The State of Oklahoma seeks to extend the Demonstration without any changes to the current approved budget neutrality methodology. This extension request does not contemplate any changes to program eligibility, benefits or program financing that would require modifications to the existing model.

The budget neutrality model presented as part of this extension is based on actual and projected expenditures for the current waiver period, as calculated in the CMS Budget Neutrality workbook. The CMS Budget Neutrality workbook has been updated with actual enrollment and expenditures through June 2022 (the most recent Budget Neutrality submission by the State). The workbook therefore reflects actual enrollment and expenditures through June 2022 (one-half of Demonstration Year 27) and projected enrollment and expenditures through the end of the current Demonstration period (December 31, 2023).

The State's budget neutrality approach is presented in the following two sections:

- Status of Budget Neutrality for the Current Demonstration Period
- Budget Neutrality Approach for the Extension Period

Status of Budget Neutrality for the Current Demonstration Period

Actual program enrollment as reported by the OHCA to CMS through June of 2022 is presented in Exhibit 1, below. Annual enrollment trend rates also are presented in the exhibit.

Exhibit 1 – Actual Program Enrollment: Current Demonstration Period

Demonstration Year	23	24	25	26	27 (First Half)	Annual Trend:
Calendar Year	2019	2018	2020	2021	2022 (First Half)	DY 23-26
MEG						
TANF-Urban	4,131,606	4,130,599	4,564,648	5,148,963	2,655,853	7.61%
TANF-Rural	2,717,342	2,669,177	2,971,077	3,360,641	1,710,387	7.34%
ABD-Urban	378,835	374,453	373,689	397,322	203,027	1.60%
ABD-Rural	289,801	278,491	280,859	281,049	139,134	-1.02%
Total Member Months	**7,517,584**	**7,452,720**	**8,190,273**	**9,187,975**	**4,708,401**	

Actual program expenditures for the current Demonstration are presented in Exhibit 2. Demonstration expenditures include both expenditures for traditional Medicaid populations by Medicaid Eligibility Group (MEG) as well as expenditures for populations and initiatives (Waiver Groups) authorized under Section 1115 waiver authority.

Exhibit 2 – Actual Program Expenditures: Current Demonstration Period

Demonstration Year	23	24	25	26	27 (First Half)
Calendar Year	2019	2018	2020	2021	2022 (First Half)
MEG					
TANF-Urban	$ 807,177,426	$ 892,743,565	$ 959,908,774	$ 1,091,752,849	$ 575,114,197
TANF-Rural	$ 620,389,523	$ 642,381,366	$ 687,024,970	$ 785,891,976	$ 413,559,430
ABD-Urban	$ 439,698,547	$ 473,031,006	$ 495,875,963	$ 487,328,835	$ 249,809,609
ABD-Rural	$ 337,361,416	$ 362,590,612	$ 357,916,031	$ 368,145,856	$ 173,599,583
CHIP Medicaid Expansion Children Urban	$ -	$ -	$ -	$ -	$ -
CHIP Medicaid Expansion Children Rural	$ -	$ -	$ -	$ -	$ -
Subtotal: MEGS	*$ 2,204,626,912*	*$ 2,370,746,549*	*$ 2,500,725,738*	*$ 2,733,119,516*	*$ 1,412,082,819*
Waiver Group					
Non-Disabled Working Adults ESI	$ 58,392,924	$ 55,060,585	$ 56,506,565	$ 52,478,252	$ 20,930,337
Working Disabled Adults ESI	$ -	$ -	$ -	$ -	$ -
TEFRA Children	$ 7,123,897	$ 9,059,365	$ 10,881,447	$ 11,759,641	$ 6,642,154
Full-Time College Students ESI	$ 450,306	$ 460,889	$ 535,853	$ 581,061	$ 213,201
Non-Disabled Working Adults IP	$ 37,146,874	$ 41,345,641	$ 57,488,530	$ 57,064,642	$ 267,263
Full-Time College Students IP	$ 643,932	$ 444,908	$ 898,250	$ 1,033,274	$ 2,660
HAN Expenditures	$ 9,868,155	$ 10,671,780	$ 12,376,510	$ 13,925,370	$ 7,172,621
HMP Expenditures	$ 10,651,907	$ 10,176,586	$ 10,614,480	$ 11,326,722	$ 4,519,951
Medical Education Programs	$ -	$ 107,687,388	$ -	$ -	$ -
Subtotal: Waiver Groups	*$ 124,277,995*	*$ 234,907,142*	*$ 149,301,635*	*$ 148,168,962*	*$ 39,748,187*
Total Expenditures	**$ 2,328,904,907**	**$ 2,605,653,691**	**$ 2,650,027,373**	**$ 2,881,288,478**	**$ 1,451,831,006**

Projected expenditures absent the Demonstration are presented in Exhibit 3 on the following page.

Projected expenditures absent the Demonstration are based on the Per Member Per Month (PMPM) limits by MEG for the current Demonstration period. The PMPM limits are multiplied by member months to determine the total projected expenditures by MEG.

Exhibit 3 – Projected Expenditures Without Waiver: Current Demonstration Period

Demonstration Year		23	24	25	26	27	28	Total
Calender Year		2018	2019	2020	2021	2022	2023	
Medicaid Per Capita								
TANF-Urban	Total	$ 1,637,520,722	$ 1,699,328,429	$ 1,949,241,635	$ 2,282,329,339	$ 2,076,234,837	$ 2,214,595,770	$11,859,250,732
	PMPM	$ 396.34	$ 411.40	$ 427.03	$ 443.26	$ 460.10	$ 477 58	
	Member Months	4,131,606	4,130,599	4,564,648	5,148,963	4,512,573	4,637,120	
TANF-Rural	Total	$ 1,092,371,484	$ 1,113,767,487	$ 1,286,862,581	$ 1,510,910,587	$ 1,315,059,727	$ 1,388,637,230	$ 7,707,609,096
	PMPM	$ 402.00	$ 417.27	$ 433.13	$ 449.59	$ 466.67	$ 484.40	
	Member Months	2,717,342	2,669,177	2,971,077	3,360,641	2,817,965	2,866,716	
ABD-Urban	Total	$ 518,962,278	$ 531,427,442	$ 549,434,937	$ 605,212,790	$ 574,076,617	$ 590,817,839	$ 3,369,931,903
	PMPM	$ 1,369.89	$ 1,419.21	$ 1,470.30	$ 1,523.23	$ 1,578 07	$ 1,634 88	
	Member Months	378,835	374,453	373,689	397,322	363,784	361,383	
ABD-Rural	Total	$ 316,981,436	$ 315,574,862	$ 329,714,423	$ 341,814,604	$ 345,675,737	$ 355,756,173	$ 2,005,517,234
	PMPM	$ 1,093.79	$ 1,133.16	$ 1,173.95	$ 1,216.21	$ 1,259 99	$ 1,305 35	
	Member Months	289,801	278,491	280,859	281,049	274,348	272,537	
TOTAL		**$ 3,565,835,920**	**$ 3,660,098,219**	**$ 4,115,253,576**	**$ 4,740,267,321**	**$ 4,311,046,917**	**$ 4,549,807,012**	**$24,942,308,965**

Exhibit 4 presents actual and projected expenditures for the current Demonstration period. Expenditures are based on actual experience through the first half of Demonstration Year 27 (June 30, 2022) and projected expenditures for the second half of Demonstration Year 27 and Demonstration Year 28 (CY23).

Exhibit 4 – Actual and Projected Expenditures with Waiver: Current Demonstration Period

Demonstration Year	23	24	25	26	27	28	Total
Calender Year	2018	2019	2020	2021	2022	2023	
Medicaid Per Capita							
TANF-Urban	$ 807,177,426	$ 892,743,565	$ 959,908,774	$ 1,091,752,849	$ 1,135,789,935	$ 1,196,217,455	$ 6,083,590,004
TANF-Rural	$ 620,389,523	$ 642,381,366	$ 687,024,970	$ 785,891,976	$ 805,500,323	$ 827,825,745	$ 4,369,013,903
ABD-Urban	$ 439,698,547	$ 473,031,006	$ 495,875,963	$ 487,328,835	$ 503,886,887	$ 522,985,051	$ 2,922,806,289
ABD-Rural	$ 337,361,416	$ 362,590,612	$ 357,916,031	$ 368,145,856	$ 371,632,429	$ 407,788,306	$ 2,205,434,649
Medicaid Aggregate - WW only							
Non-Disabled Working Adults ESI	$ 58,392,924	$ 55,060,585	$ 56,506,565	$ 52,478,252	$ 41,860,674	$ 43,943,493	$ 308,242,493
TEFRA Children	$ 7,123,897	$ 9,059,365	$ 10,881,447	$ 11,759,641	$ 13,006,498	$ 14,194,006	$ 66,024,854
Full-Time College Students ESI	$ 450,306	$ 460,889	$ 535,853	$ 581,061	$ 486,945	$ 512,344	$ 3,027,398
Non-Disabled Working Adults IP	$ 37,146,874	$ 41,345,641	$ 57,488,530	$ 57,064,642	$ 534,526	$ 561,122	$ 194,141,335
Full-Time College Students IP	$ 643,932	$ 444,908	$ 898,250	$ 1,033,274	$ 5,320	$ 5,585	$ 3,031,269
HAN Expenditures	$ 9,868,155	$ 10,671,780	$ 12,376,510	$ 13,925,370	$ 13,032,736	$ 12,043,707	$ 71,918,258
HMP Expenditures	$ 10,651,907	$ 10,176,586	$ 10,614,480	$ 11,326,722	$ 11,240,202	$ 14,248,007	$ 68,257,904
Medical Education Programs	$ -	$ 107,687,388	$ -	$ -	$ -	$ -	$ 107,687,388
TOTAL	**$ 2,328,904,907**	**$ 2,605,653,691**	**$ 2,650,027,373**	**$ 2,881,288,478**	**$ 2,896,976,473**	**$ 3,040,324,821**	**$16,403,175,742**

Exhibit 5 on the following page provides a summary of waiver savings for the current Demonstration period. Estimated savings are adjusted in accordance with the CMS waiver savings phase-down methodology. As indicated in the exhibit, the estimated budget neutrality surplus at the end of the current Demonstration period is approximately $1.23 Billion.

Exhibit 5 – Budget Neutrality Summary: Current Demonstration Period

Demonstration Year		23	24	25	26	27	28	Total
Calender Year		2018	2019	2020	2021	2022	2023	
Medicaid Per Capita								
	Savings Phase-Down							
TANF-Urban	Without Waiver	$ 1,637,520,722	$ 1,699,328,429	$ 1,949,241,635	$ 2,282,329,339	$ 2,076,234,837	$ 2,214,595,770	$11,859,250,732
	With Waiver	$ 807,177,426	$ 892,743,565	$ 959,908,774	$ 1,091,752,849	$ 1,135,789,935	$ 1,196,217,455	$ 6,083,590,004
Difference		$ 830,343,296	$ 806,584,864	$ 989,332,861	$ 1,190,576,490	$ 940,444,903	$ 1,018,378,314	$ 5,775,660,729
Phase-Down Percentage		25%	25%	25%	25%	25%	25%	
Savings Reduction		$ 622,757,472	$ 604,938,648	$ 741,999,646	$ 892,932,368	$ 705,333,677	$ 763,783,736	$ 4,331,745,546
	Savings Phase-Down							
TANF-Rural	Without Waiver	$ 1,092,371,484	$ 1,113,767,487	$ 1,286,862,581	$ 1,510,910,587	$ 1,315,059,727	$ 1,388,637,230	$ 7,707,609,096
	With Waiver	$ 620,389,523	$ 642,381,366	$ 687,024,970	$ 785,891,976	$ 805,500,323	$ 827,825,745	$ 4,369,013,903
Difference		$ 471,981,961	$ 471,386,121	$ 599,837,611	$ 725,018,611	$ 509,559,404	$ 560,811,485	$ 3,338,595,193
Phase-Down Percentage		25%	25%	25%	25%	25%	25%	
Savings Reduction		$ 353,986,471	$ 353,539,591	$ 449,878,208	$ 543,763,958	$ 382,169,553	$ 420,608,614	$ 2,503,946,395
	Savings Phase-Down							
ABD-Urban	Without Waiver	$ 518,962,278	$ 531,427,442	$ 549,434,937	$ 605,212,790	$ 574,076,617	$ 590,817,839	$ 3,369,931,903
	With Waiver	$ 439,698,547	$ 473,031,006	$ 495,875,963	$ 487,328,835	$ 503,886,887	$ 522,985,051	$ 2,922,806,289
Difference		$ 79,263,731	$ 58,396,436	$ 53,558,974	$ 117,883,955	$ 70,189,730	$ 67,832,788	$ 447,125,614
Phase-Down Percentage		25%	25%	25%	25%	25%	25%	
Savings Reduction		$ 59,447,798	$ 43,797,327	$ 40,169,230	$ 88,412,966	$ 52,642,297	$ 50,874,591	$ 335,344,211
	Savings Phase-Down							
ABD-Rural	Without Waiver	$ 316,981,436	$ 315,574,862	$ 329,714,423	$ 341,814,604	$ 345,675,737	$ 355,756,173	$ 2,005,517,234
	With Waiver	$ 337,361,416	$ 362,590,612	$ 357,916,031	$ 368,145,856	$ 371,632,429	$ 407,788,306	$ 2,205,434,649
Difference		$ (20,379,980)	$ (47,015,750)	$ (28,201,608)	$ (26,331,252)	$ (25,956,692)	$ (52,032,133)	$ (199,917,415)
Phase-Down Percentage		25%	25%	25%	25%	25%	25%	
Savings Reduction		$ -	$ -	$ -	$ -	$ -	$ -	
Total Reduction		*$ 1,036,191,741*	*$ 1,002,275,565*	*$ 1,232,047,085*	*$ 1,525,109,292*	*$ 1,140,145,528*	*$ 1,235,266,941*	*$ 7,171,036,152*
BASE VARIANCE		$ 200,739,272	$ 52,168,963	$ 233,179,119	$ 333,869,550	$ 231,475,380	$ 181,502,110	$ 1,232,934,393
Cumulative Budget Neutrality Limit (CBNL)		$ 2,529,644,179	$ 5,187,466,833	$ 8,070,673,324	$ 11,285,831,353	$ 14,456,732,742	$ 17,771,272,813	
Actual Cumulative Variance (Positive = Overspending)		$ (200,739,272)	$ (252,908,235)	$ (486,087,353)	$ (819,956,904)	$ (1,051,432,283)	$ (1,232,934,393)	

Budget Neutrality Approach for the Extension Period

Projected Enrollment

Projected enrollment for the renewal period is based on historical enrollment and resulting trend rates. Program enrollment under the Demonstration was impacted by Oklahoma's Medicaid expansion.

The average annual growth rates for the TANF-Urban and TANF-Rural MEGs are 7.61 percent and 7.34 percent, respectively. Enrollment trends for the TANF MEGs were adjusted to address the impact of the Medicaid expansion on TANF enrollment. The adjustment was made by calculating a blended trend rate based on traditional and expansion population discrete trend rates and the portion of total enrollment represented by each group.

Exhibit 6 on the following page presents a summary of the TANF trend rate adjustment.

Exhibit 6 – Projected Program Enrollment: Renewal Period

MEG	Annual Trend Rate: DY23-26	Trend Rate Net of Expansion DY 23-26	Expansion Enrollment Percentage	Expansion Trend Rate	Adjusted Trend Rate
TANF-Urban	7.61%	2.70%	13.09%	6.00%	3.13%
TANF-Rural	7.34%	2.43%	13.09%	6.00%	2.90%

Exhibit 7 presents projected annual enrollment estimates by MEG for the Demonstration renewal period.

Exhibit 7 – Projected Program Enrollment: Renewal Period

Demonstration Year	Enrollment Trend Factor	29	30	31	32	33
Calendar Year		2024	2025	2026	2027	2028
MEG						
TANF-Urban	3.13%	4,782,187	4,931,793	5,086,078	5,245,191	5,409,281
TANF-Rural	2.90%	2,949,881	3,035,458	3,123,518	3,214,133	3,307,376
ABD-Urban	1.60%	367,168	373,046	379,018	385,086	391,251
ABD-Rural	-1.02%	269,765	267,022	264,306	261,618	258,958
Total Member Months		**8,369,002**	**8,607,319**	**8,852,921**	**9,106,028**	**9,366,865**

Projected Per Member, Per Month (PMPM) Expenditures Without the Demonstration

The budget neutrality model for the renewal period is based on continuation of the PMPM limits established under the current Demonstration. Development of updated "without waiver" PMPM limits based on more recent claims experience was determined not to be feasible due to the Public Health Emergency's impact on program expenditures and utilization.

Exhibit 8 on the following page provides a summary of annual PMPM expenditures for Oklahoma's Medicaid program. As indicated in the exhibit, PMPM expenditures have declined since the onset of the Public Health Emergency as the result of disruptions in the service delivery system following imposition of lockdown rules in March 2020. These disruptions continued into 2021 and the first half of 2022. They are not expected to persist, however, into the next Demonstration period, by which time the Public Health Emergency is expected to have ended.

Exhibit 8 – Impact of Public Health Emergency on Per Member Per Month (PMPM) Expenditures

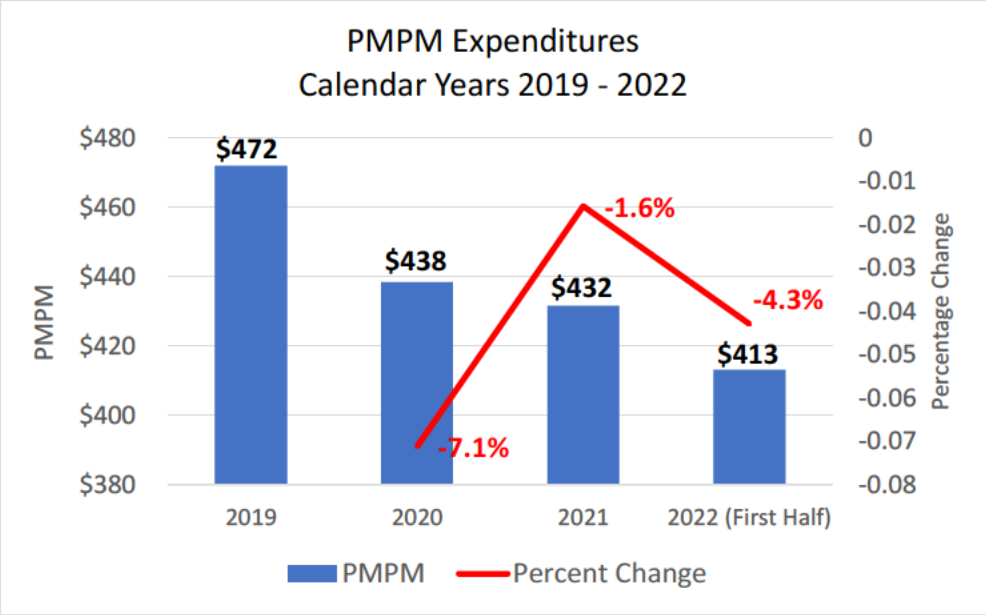


Exhibit 9 provides a summary of the impact of the Public Health Emergency on utilization. The average annual number of claims per member has declined each year since 2019. Between Calendar Year 2019 and the first half of Calendar Year 2022, the average number of claims per member has declined by approximately 27 percent.

Exhibit 9 – Impact of Public Health Emergency on Utilization

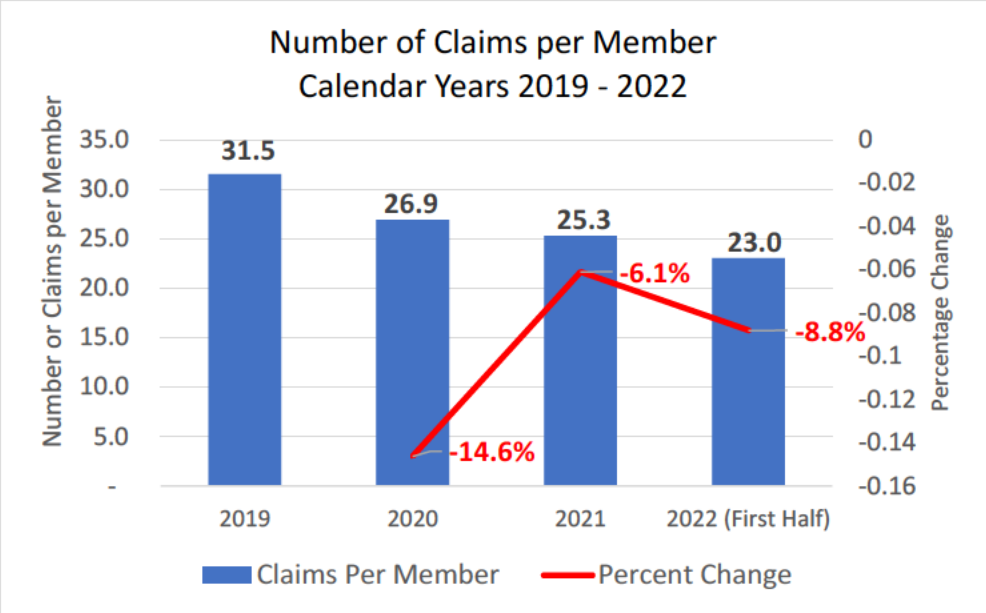


Exhibit 10 presents the PMPM limits that were applied to develop the "without waiver" expenditure projections. The limits reflect a continuation of the current Demonstration PMPM limits, trended annually by the rates presented in the exhibit.

Exhibit 10 – Projected Per Member Per Month (PMPM) Expenditures Without the Waiver: Renewal Period

Demonstration Year	PMPM Trend	29	30	31	32	33
Calendar Year	Factor	2024	2025	2026	2027	2028
MEG						
TANF-Urban	4.80%	$ 495.73	$ 514.57	$ 534.12	$ 554.42	$ 575.48
TANF-Rural	4.80%	$ 502.81	$ 521.91	$ 541.75	$ 562.33	$ 583.70
ABD-Urban	4.80%	$ 1,693.74	$ 1,754.71	$ 1,817.88	$ 1,883.32	$ 1,951.12
ABD-Rural	4.80%	$ 1,352.34	$ 1,401.03	$ 1,451.46	$ 1,503.72	$ 1,557.85

Projected Expenditures without the Demonstration

Projected "without waiver" expenditures are the product of projected enrollment and the PMPM limit established for each MEG. Exhibit 11 provides a summary of enrollment and expenditures without the waiver.

Exhibit 11 – Projected Expenditures Without the Waiver: Renewal Period

Demonstration Year		29	30	31	32	33	Total
Calender Year		2024	2025	2026	2027	2028	
Medicaid Per Capita							
TANF-Urban	Total	$ 2,393,503,043	$ 2,586,863,435	$ 2,795,844,546	$ 3,021,708,305	$ 3,265,818,586	$ 14,063,737,916
	PMPM	$ 500.50	$ 524.53	$ 549.71	$ 576.09	$ 603.74	
	Member Months	4,782,187	4,931,793	5,086,078	5,245,191	5,409,281	
TANF-Rural	Total	$ 1,497,510,465	$ 1,614,919,681	$ 1,741,534,124	$ 1,878,075,511	$ 2,025,322,143	$ 8,757,361,923
	PMPM	$ 507.65	$ 532.02	$ 557 56	$ 584.32	$ 612.37	
	Member Months	$ 2,949,881	$ 3,035,458	$ 3,123,518	$ 3,214,133	$ 3,307,376	
ABD-Urban	Total	$ 629,089,430	$ 669,840,151	$ 713,230,595	$ 759,431,755	$ 808,625,702	$ 3,580,217,634
	PMPM	$ 1,713.35	$ 1,795.60	$ 1,881.78	$ 1,972.11	$ 2,066.77	
	Member Months	$ 367,168	$ 373,046	$ 379,018	$ 385,086	$ 391,251	
ABD-Rural	Total	$ 369,040,856	$ 382,821,617	$ 397,116,980	$ 411,946,162	$ 427,329,097	$ 1,988,254,712
	PMPM	$ 1,368.01	$ 1,433.67	$ 1,502.49	$ 1,574.61	$ 1,650.19	
	Member Months	$ 269,765	$ 267,022	$ 264,306	$ 261,618	$ 258,958	
TOTAL		**$ 4,889,143,794**	**$ 5,254,444,884**	**$ 5,647,726,245**	**$ 6,071,161,733**	**$ 6,527,095,529**	**$ 28,389,572,185**

Projected Expenditures with Demonstration

Projected "with waiver" expenditures are based on actual and projected expenditures during the current Demonstration period. Exhibit 12 on the following page provides a summary of projected expenditures for the renewal period.

Exhibit 12 – Expenditures with the Waiver: Renewal Period

Demonstration Year	29	30	31	32	33	Total
Calender Year	2024	2025	2026	2027	2028	
Medicaid Per Capita						
TANF-Urban	$ 1,292,854,506	$ 1,397,298,431	$ 1,510,179,914	$ 1,632,180,585	$ 1,764,037,145	$ 7,596,550,582
TANF-Rural	$ 822,355,956	$ 846,553,087	$ 987,533,902	$ 1,170,635,016	$ 1,028,717,828	$ 4,855,795,788
ABD-Urban	$ 556,862,616	$ 592,934,679	$ 631,343,393	$ 672,240,120	$ 715,786,027	$ 3,169,166,835
ABD-Rural	$ 423,015,978	$ 438,812,283	$ 455,198,456	$ 472,196,522	$ 489,829,332	$ 2,279,052,571
Medicaid Aggregate - WW only						
Non-Disabled Working Adults ESI	$ 46,129,945	$ 48,425,186	$ 50,834,629	$ 53,363,957	$ 56,019,133	$ 254,772,851
TEFRA Children	$ 16,292,302	$ 18,700,789	$ 21,465,321	$ 24,638,534	$ 28,280,842	$ 109,377,789
Full-Time College Students ESI	$ 539,068	$ 567,186	$ 596,770	$ 627,898	$ 660,649	$ 2,991,570
Non-Disabled Working Adults IP	$ 589,041	$ 618,349	$ 649,116	$ 681,413	$ 715,318	$ 3,253,237
Full-Time College Students IP	$ 5,863	$ 6,154	$ 6,460	$ 6,782	$ 7,119	$ 32,379
HAN Expenditures	$ 12,533,288	$ 13,042,771	$ 13,572,964	$ 14,124,711	$ 14,698,885	$ 67,972,619
HMP Expenditures	$ 15,101,479	$ 16,006,074	$ 16,964,856	$ 17,981,070	$ 19,058,156	$ 85,111,634
Medical Education Programs	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	**$ 3,186,280,042**	**$ 3,372,964,990**	**$ 3,688,345,781**	**$ 4,058,676,607**	**$ 4,117,810,435**	**$18,424,077,855**

Budget Neutrality Summary with Savings Phase Down

Exhibit 13 on the following page presents a comparison of "with waiver" and "without waiver" expenditures. The savings phase-down methodology has been applied in the table.

The summary does not include carry-forward of savings from prior Demonstration periods. The final model may incorporate these savings, based on CMS guidance.

Demonstration savings for the renewal period, not including the potential carry-forward of savings from prior Demonstration periods, are expected to equal approximately $1.88 Billion.

Exhibit 13 – Budget Neutrality Summary: Renewal Period

Demonstration Year		29	30	31	32	33	Total
Calender Year		2024	2025	2026	2027	2028	
Medicaid Per Capita							
	Savings Phase-Down						
TANF-Urban	Without Waiver	$ 2,393,503,043	$ 2,586,863,435	$ 2,795,844,546	$ 3,021,708,305	$ 3,265,818,586	$14,063,737,916
	With Waiver	$ 1,292,854,506	$ 1,397,298,431	$ 1,510,179,914	$ 1,632,180,585	$ 1,764,037,145	$ 7,596,550,582
Difference		$ 1,100,648,537	$ 1,189,565,003	$ 1,285,664,632	$ 1,389,527,720	$ 1,501,781,441	$ 6,467,187,334
Phase-Down Percentage		25%	25%	25%	25%	25%	
Savings Reduction		$ 825,486,403	$ 892,173,752	$ 964,248,474	$ 1,042,145,790	$ 1,126,336,081	$ 4,850,390,500
	Savings Phase-Down						
TANF-Rural	Without Waiver	$ 1,497,510,465	$ 1,614,919,681	$ 1,741,534,124	$ 1,878,075,511	$ 2,025,322,143	$ 8,757,361,923
	With Waiver	$ 822,355,956	$ 846,553,087	$ 987,533,902	$ 1,170,635,016	$ 1,028,717,828	$ 4,855,795,788
Difference		$ 675,154,509	$ 768,366,594	$ 754,000,222	$ 707,440,495	$ 996,604,315	$ 3,901,566,135
Phase-Down Percentage		25%	25%	25%	25%	25%	
Savings Reduction		$ 506,365,881	$ 576,274,946	$ 565,500,167	$ 530,580,371	$ 747,453,236	$ 2,926,174,601
	Savings Phase-Down						
ABD-Urban	Without Waiver	$ 629,089,430	$ 669,840,151	$ 713,230,595	$ 759,431,755	$ 808,625,702	$ 3,580,217,634
	With Waiver	$ 556,862,616	$ 592,934,679	$ 631,343,393	$ 672,240,120	$ 715,786,027	$ 3,169,166,835
Difference		$ 72,226,814	$ 76,905,473	$ 81,887,202	$ 87,191,635	$ 92,839,675	$ 411,050,799
Phase-Down Percentage		25%	25%	25%	25%	25%	
Savings Reduction		$ 54,170,110	$ 57,679,105	$ 61,415,402	$ 65,393,726	$ 69,629,756	$ 308,288,099
	Savings Phase-Down						
ABD-Rural	Without Waiver	$ 369,040,856	$ 382,821,617	$ 397,116,980	$ 411,946,162	$ 427,329,097	$ 1,988,254,712
	With Waiver	$ 423,015,978	$ 438,812,283	$ 455,198,456	$ 472,196,522	$ 489,829,332	$ 2,279,052,571
Difference		$ (53,975,122)	$ (55,990,666)	$ (58,081,476)	$ (60,250,360)	$ (62,500,235)	$ (290,797,859)
Phase-Down Percentage		25%	25%	25%	25%	25%	
Savings Reduction		$ -	$ -	$ -	$ -	$ -	
Total Reduction		*$ 1,386,022,395*	*$ 1,526,127,803*	*$ 1,591,164,043*	*$ 1,638,119,888*	*$ 1,943,419,073*	*$ 8,084,853,201*
BASE VARIANCE		$ 316,841,357	$ 355,352,092	$ 368,216,421	$ 374,365,239	$ 465,866,021	$ 1,880,641,129
Cumulative Budget Neutrality Limit (CBNL)		$ 3,503,121,399	$ 5,384,601,293	$ 8,070,673,324	$11,285,831,353	$14,456,732,742	
Actual Cumulative Variance (Positive = Overspending)		$ (316,841,357)	$ (672,193,449)	$ (1,040,409,870)	$ (1,414,775,108)	$ (1,880,641,129)	

Appendix C

Draft Interim Evaluation
(also submitted to CMS within PMDA on 12/28/22)

SoonerCare Section 1115 Waiver Evaluation

INTERIM EVALUATION
DEMONSTRATION YEARS 24 – 26 (CY 2019 – 2021)

Prepared by the Pacific Health Policy Group for:

State of Oklahoma
Oklahoma Health Care Authority

DECEMBER 2022

INDEPENDENT EVALUATION

The independent evaluation of the SoonerCare Demonstration was conducted by The Pacific Health Policy Group (PHPG). PHPG is solely responsible for the analysis and findings presented in this report.

PHPG wishes to acknowledge the cooperation of the Oklahoma Health Care Authority in obtaining the necessary data for completion of the evaluation. PHPG also wishes to acknowledge the contributions of the OHCA's (CAHPS®) surveyor, Health Management Program vendor and Health Access Networks in providing data for the evaluation.

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COMMONLY-USED ABBREVIATIONS & ACRONYMS

ABD	Aged, Blind, Disabled
AHRQ	Agency for Healthcare Quality and Research
BRFSS	Behavioral Risk Factor Surveillance System
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CEM	Coarsened Exact Matching
CMS	Centers for Medicare and Medicaid Services
FPL	Federal Poverty Level
HAN	Health Access Network
HMP	Health Management Program
IO	Insure Oklahoma
IO-ESI	Insure Oklahoma – Employer Sponsored Insurance
IO-IP	Insure Oklahoma – Individual Plan
ITS	Interrupted Time Series
MCO	Managed Care Organization
MEG	Medicaid Eligibility Group
MMIS	Medicaid Management Information System
NCQA	National Committee for Quality Assurance
NHIS	National Health Interview Survey
OHCA	Oklahoma Health Care Authority
OSU	Oklahoma State University
OU	Oklahoma, University of
PCCM	Primary Care Case Management
PCMH	Patient Centered Medical Home
PCP	Primary Care Provider
PHCC	Partnership for Healthy Central Communities
PHE	Public Health Emergency
PMPM	Per Member Per Month
SDOH	Social Determinants of Health

A. EXECUTIVE SUMMARY

Introduction

Medicaid is the largest health insurer in the state of Oklahoma. In December 2021, the program provided coverage to over 1,175,000 Oklahomans, out of a total population of approximately four million (29 percent). In 2020 (the most recent year available), the program covered approximately 28,000 births out of 50,000 statewide (56 percent).

The Oklahoma Health Care Authority (OHCA), Oklahoma's Single State Agency for Medicaid, administers SoonerCare, the State's Section 1115(a) Research and Demonstration waiver (11-W-00048/6). The Demonstration originally was approved to begin operations in January 1996 and has continued through multiple renewal periods. The findings presented in this interim evaluation report are for Demonstration Years 24 – 26 (January 1, 2019 – December 31, 2021).

SoonerCare Choice Program

The OHCA's overarching goals for the SoonerCare Choice program are to meet the health care needs of Oklahomans through provision of high quality, accessible and cost-effective care. During the evaluation period, the OHCA sought to achieve these goals through two beneficiary-centered initiatives: Health Access Networks (HANs) and the SoonerCare Health Management Program (HMP).

The Demonstration operates statewide under an enhanced Primary Care Case Management (PCCM) model in which the OHCA contracts directly with primary care providers to serve as patient centered medical homes (PCMHs) for SoonerCare Choice members. These providers serve as the foundation for both the HAN and HMP initiatives.

SoonerCare Health Access Networks

SoonerCare Health Access Networks are non-profit, administrative entities that work with affiliated providers to coordinate and improve the quality of care provided to SoonerCare Choice members. The HANs employ care managers to provide telephonic and in-person care management and care coordination to SoonerCare Choice members with complex health care needs who are enrolled with affiliated PCMH providers. The HANs also work to establish new initiatives to address complex medical, social and behavioral health issues. For example, the HANs have implemented evidence-based protocols for care management of ABD members with, or at risk for, complex/chronic health conditions, as well as TANF and related members with asthma and diabetes, among other conditions.

The OHCA contracts with three HANs: University of Oklahoma (OU) Sooner HAN; Partnership for Healthy Central Communities (PHCC) HAN; and Oklahoma State University (OSU) HAN. The HANs began operations in 2010 with combined enrollment of approximately 25,000. In December 2021, enrollment exceeded 300,000.

SoonerCare Health Management Program

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

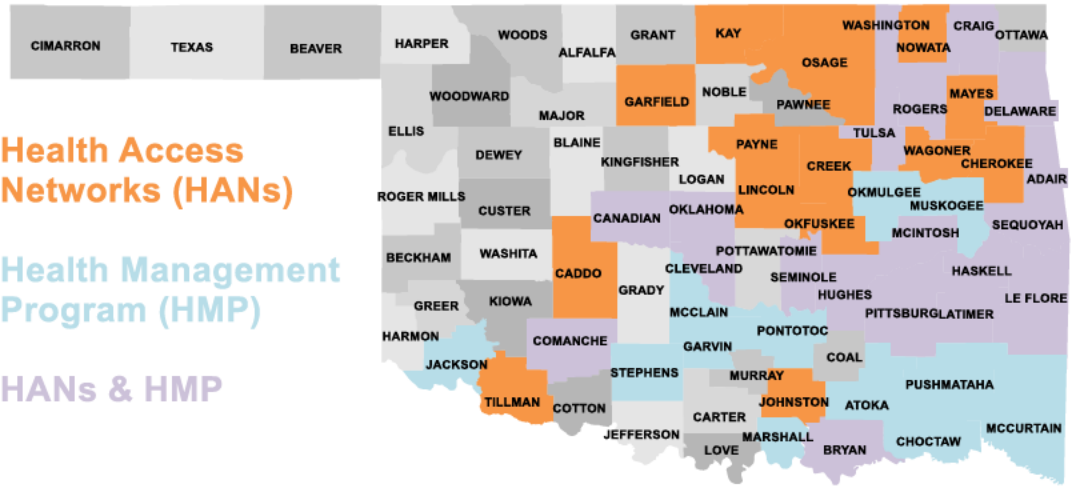
The SoonerCare HMP serves SoonerCare Choice beneficiaries ages four through 63 who have one or more chronic illnesses and are at high risk for adverse outcomes and increased health care expenditures. The program is holistic, rather than disease-specific, but prominent conditions of members in the program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

The SoonerCare HMP was implemented in 2008 and has evolved over time. Under its current model, registered nurse health coaches are embedded at primary care practice sites, where they work closely with practice staff and provide care coordination and health education to participating members. Some health coaches are dedicated to a single practice with one or more providers while others are shared between multiple practice sites within a geographic area. A smaller portion of SoonerCare HMP beneficiaries receive telephonic or in-home health coaching. Enrollment fluctuated during the current Demonstration period, rising from 4,864 in 2019 to 7,152 in 2020 before dropping back to 6,292 in 2021.

HAN and HMP Service Areas

Exhibit ES-1 below identifies the counties with one or more HAN-affiliated PCMH providers in December 2021, as well as counties in which one or more HMP health coaches was embedded in a PCMH practice. Forty-five out of 77 counties had one or both programs in operation and serving beneficiaries at the conclusion of the three-year waiver period. (Map does not depict counties with telephonic-only HMP beneficiaries; PCMH program operates in all 77 counties.)

Exhibit ES-1 – HAN and HMP Counties (December 2021)



Retroactive Eligibility

The SoonerCare Demonstration also includes a waiver of retroactive eligibility for a portion of the SoonerCare population. The waiver has been a component of SoonerCare since the program's inception. At the start of the current Demonstration period, the population subject to the waiver was reduced, with several Medicaid Eligibility Groups (MEGs) becoming newly-eligible for retroactive coverage, leaving the Parent/Caretaker MEG as the primary group still subject to the waiver.

Evaluation Scope and Methodology

Hypotheses and Measures

The SoonerCare evaluation was organized around a series of hypotheses related to the OHCA's goals for the Demonstration. The hypotheses were tested through analysis of over 80 discrete performance measures (some with multiple components).

The evaluation was structured to isolate, as much as possible, the discrete impact of the HAN and HMP initiatives on program access, quality and cost effectiveness. This was accomplished by stratifying SoonerCare Choice members into three population segments for applicable measures: members enrolled with a SoonerCare HAN PCMH; members enrolled in the SoonerCare HMP; and other SoonerCare Choice members (comparison group). Similarly, for the retroactive eligibility portion of the evaluation, members were stratified into two groups: those subject to the waiver and those receiving retroactive coverage.

Comparison group members were identified using a statistical technique known as coarsened exact matching (CEM). The CEM analysis controlled for age, gender, aid category (Aged, Blind or Disabled and other), place of residence (urban or rural) and (where applicable) health status.

The evaluation used a combination of analytical techniques, as determined by best available data and the presence or absence of a valid comparison group. The evaluation employed nationally-validated measures where appropriate, including: Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey data. The HEDIS data set included population-level preventive care measures, as well as measures specific to five prevalent chronic conditions among HMP members and the portion of HAN membership receiving care management: asthma, coronary artery disease, chronic obstructive pulmonary disease, diabetes and hypertension. The HEDIS data set also included several behavioral health measures.

The evaluation used State-specific measures where a national measure did not exist (e.g., data on enrollment or PCMH status). HEDIS measures were calculated using administrative (paid claims) data extracted from the OHCA's Medicaid Management Information System (MMIS).

Exhibit ES-2 on the following page summarizes key evaluation hypotheses and measures by evaluation domain.

Exhibit ES-2 - HAN Access to Care Measures – Overview

Hypothesis Area / Measure Count by Type	Demonstration Population			
	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*[1]
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*	

[1] Retroactive eligibility survey included questions from several nationally-validated instruments, including CAHPS.

COVID-19 Public Health Emergency

The COVID-19 Public Health Emergency substantially disrupted health care utilization patterns during two of the three years addressed in the interim evaluation. The use of treatment and comparison groups for the majority of measures helps to mitigate the impact of the PHE on findings, to the extent both populations were exposed to the same disruptions in care (e.g., unavailability of office appointments for routine care needs).

The suspension of Most Title XIX disenrollments during the PHE directly affected the portion of the retroactive eligibility evaluation related to enrollment continuity. Descriptive statistics are provided in the interim evaluation but no conclusions can be drawn for the period falling under the PHE.

Medicaid Expansion

On June 30, 2020, Oklahoma voters passed State Question 802, to expand Medicaid eligibility no later than July 1, 2021 to adults ages 19-64 whose income is 138 percent (133 percent with a five percent disregard) of the federal poverty level or lower. The OHCA established a new Adult Medicaid Eligibility Group and began to accept applications in June 2021 for an enrollment effective date of July 1, 2021. The expansion population was added to SoonerCare Choice in September 2021 through an amendment to the Demonstration.

The majority of evaluation measures report findings on an annualized basis and exclude beneficiaries who fail to meet continuous enrollment requirements. The expansion population therefore is not represented in the interim evaluation but will be a component of the summative evaluation.

Evaluation Findings

Comparison Group Measures

Findings are presented below for the subset of measures evaluated using the comparison group methodology (Quantitative Measures). Results were calculated for each of the individual years of the evaluation and also were pooled to present a three-year average. The difference in results for "treatment" (HMP, HAN or persons subject to the retroactive eligibility waiver) and comparison groups then were tested for statistical significance ($p<0.05$). Three-year pooled results served as the basis for findings.

Health Access Networks

Exhibit ES-3 below summarizes results for the SoonerCare HAN population in total. As it illustrates, the population in total was not favorably differentiated from the comparison group. This outcome was not surprising, as the great majority of the HAN population receives the same level of care management as other SoonerCare Choice members; both groups rely on their PCMH provider for primary care and specialist referrals. Although the HANs receive a monthly capitation for all members, the OHCA's expectation is that the funds will be targeted to care management of members with complex/chronic conditions.

Exhibit ES-3 - HAN (Total) Members versus Comparison Group

DOMAIN/Research Area	Demonstration Population Outperformed Comparison Group	Comparison Group Outperformed Demonstration Population	No Statistically Significant Difference
HAN (TOTAL) – Access to Care			
HAN (TOTAL) – Quality of Care			
HAN (TOTAL) – Cost Effectiveness			

To isolate the impact of the HANs on members with the greatest needs, PHPG obtained records of the subset receiving care management during the Demonstration period. This averaged about 4,000 members per year. The same measures were evaluated, except in cases where the population size was too small to produce reliable results.

Exhibit ES-4 below summarizes results for the SoonerCare HAN Care Managed population. The Care Managed population showed more favorable differentiation from its comparison group than did the HAN population in total[2].

[2] Each "treatment" group is matched to a unique comparison group. That is, the HAN total comparison group is not identical to the HAN Care Managed comparison group.

Exhibit ES-4 - HAN (Care Managed) Members versus Comparison Group

DOMAIN/Research Area	Demonstration Population Outperformed Comparison Group	Comparison Group Outperformed Demonstration Population	No Statistically Significant Difference
HAN (CARE MANAGED) – Access to Care	● ●		
HAN (CARE MANAGED) – Quality of Care	● ● ● ●		● ● ● ● ● ● ● ● ●
HAN (CARE MANAGED) – Cost Effectiveness	●	●	●

Health Management Program

Exhibit ES-5 below summarizes results for the SoonerCare HMP population. As it illustrates, the population was favorably differentiated from the comparison group on a majority of measures.

Exhibit ES-5 - HMP Members versus Comparison Group

DOMAIN/Research Area	Demonstration Population Outperformed Comparison Group	Comparison Group Outperformed Demonstration Population	No Statistically Significant Difference
HMP – Access to Care	● ●		
HMP – Quality of Care	● ● ● ● ● ● ● ● ● ● ● ●	● ●	● ● ● ● ● ● ●
HMP – Cost Effectiveness	● ● ● ●		

Retroactive Eligibility

Exhibit ES-6 below summarizes results for the population subject to the retroactive eligibility waiver. As it illustrates, the population was favorably differentiated from the comparison group on both quantitative measures for which there was a statistically significant difference.

Exhibit ES-6 – Retroactive Eligibility Waiver Members versus Comparison Group

DOMAIN/Research Area	Demonstration Population Outperformed Comparison Group	Comparison Group Outperformed Demonstration Population	No Statistically Significant Difference
RETROACTIVE ELIGIBILITY – Access to Care	● ●		● ● ●

Additional Analyses

The Demonstration populations were stratified into urban and rural subgroups for measures with sufficient data to support a substate analysis. No pattern was observed; for some measures the urban subgroup outperformed the rural subgroup and for others the rural subgroup outperformed the urban.

The SoonerCare HAN and HMP programs existed in the prior three-year Demonstration period, and a subset of measures also was evaluated for the prior period, making available data for a six-year trend analysis. As with the urban/rural analysis, no consistent pattern was observed; some measures showed an upward trend while others either were flat or trended downward.

National data is available for a subset of HEDIS and CAHPS measures. Demonstration population results were compared to national benchmarks, defined as the 50th percentile of reporting states. In all instances, the SoonerCare rate exceeded the benchmark rate. (Caution: the benchmark population characteristics were not matched to Demonstration members to minimize differences in the populations. The data is presented in the body of the report for informational purposes only.)

Summative Evaluation

The interim evaluation presents results for the first three years of the five-year Demonstration period. A portion of the three years overlapped with the COVID-19 PHE. Results should be treated as preliminary and subject to anomalies introduced by the PHE.

Findings for the summative evaluation will be reported following completion of the five-year Demonstration. The summative evaluation results will offer a more complete profile of the Demonstration's performance with respect to advancing the OHCA's goal of offering accessible, high quality and cost-effective care.

B. GENERAL BACKGROUND INFORMATION

Medicaid is the largest health insurer in the state of Oklahoma. In December 2021, the program provided coverage to over 1,175,000 Oklahomans, out of a total population of approximately four million (29 percent). In 2020 (the most recent year available), the program covered approximately 28,000 births out of 50,000 statewide (56 percent)[3].

The Oklahoma Health Care Authority (OHCA), Oklahoma's Single State Agency for Medicaid, administers SoonerCare, the State's Section 1115(a) Research and Demonstration waiver (11-W-00048/6). The Demonstration originally was approved to begin operations in January 1996 and has continued through multiple renewal periods. The findings presented in this interim evaluation report are for Demonstration Years 24 – 26 (January 1, 2019 – December 31, 2021).

1. *Demonstration Goals and Issues to Address*

The OHCA's overarching goals for the SoonerCare Demonstration are to meet the health care needs of Oklahomans through provision of high quality, accessible and cost-effective care.

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

Access and quality-of-care both suffered, as the number of participating providers declined and beneficiaries were forced to seek primary care in emergency rooms or, in the case of adults, forego care altogether due to benefit limits. The program also lacked any formal care management structure, leaving beneficiaries with chronic conditions to navigate the health care system on their own.

The State responded to this crisis through creation of a new Medicaid agency, the Oklahoma Health Care Authority (OHCA) and through development of the SoonerCare program under Section 1115 Demonstration authority. As described in more detail below, SoonerCare operates as a managed care system by contracting with Patient Centered Medical Homes (PCMH) and arranging for care management of high risk/high need members through Health Access Networks (HANs) and the SoonerCare Health Management Program (HMP).

[3] Source for Medicaid enrollment and births is the Oklahoma Health Care Authority. Source for total population and births is US Census Bureau.

2. Demonstration Name and Timeframe

The SoonerCare Demonstration (Project Number 11-W-0048/6) was approved originally for a five-year period commencing on January 1, 1996[4]. The Demonstration has received multiple extensions since expiration of the original five-year authority.

On August 31, 2018, CMS granted a 64-month extension for the period August 31, 2018 – December 31, 2023. The OHCA is requesting another extension of the Demonstration, to begin on January 1, 2024.

In accordance with Section 1115 Demonstration Special Terms and Conditions, states requesting an extension must submit an Interim Evaluation of the program along with the extension application. This report constitutes the SoonerCare Interim Evaluation and addresses the first three years of the current extension period, from January 1, 2019 – December 31, 2021.

(Although the current extension formally began on August 31, 2018, many of the evaluation measures, such as those using Healthcare Effectiveness and Data Information Set (HEDIS®) specifications, are calculated on a calendar year basis. Data and findings for the months of September 2018 – December 2018 already were included in the Summative Evaluation report for the prior Demonstration period.)

3. Description of the Demonstration

The OHCA was established to oversee the program's transition to managed care and implement and administer the SoonerCare Demonstration. The program initially included children in mandatory Medicaid State Plan Medicaid Eligibility Groups (MEGs), pregnant women and Section 1931[5] low-income families. SoonerCare members were enrolled in "SoonerCare Plus" risk-based managed care organizations (MCOs) in the State's three largest metropolitan areas (Oklahoma City, Tulsa and Lawton), while members in the remainder of the State were enrolled in a primary care case management (PCCM) model. In its original design, the "SoonerCare Choice" PCCM model included a partial capitation payment to cover primary care services and office-based laboratory and radiology services.

The Oklahoma managed care environment was relatively immature in the program's early years. The OHCA faced ongoing challenges attracting a sufficient number of licensed health plans to ensure price competition and beneficiary choice in the metropolitan areas. In 2003, the OHCA discontinued SoonerCare Plus and expanded the SoonerCare Choice model statewide. The OHCA also modified the SoonerCare Choice model by transitioning to payment of a per member per

[4] The Demonstration's formal name is "SoonerCare". However, Oklahoma uses the same title for its entire Medicaid program. To distinguish the populations, the Demonstration managed care model also is known as "SoonerCare Choice", while Medicaid beneficiaries not enrolled in managed care are referred to as "SoonerCare Traditional" and "SoonerPlan" (family planning benefits-only population).

[5] Refers to Section 1931 of the Social Security Act, which was added through the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and created a new category of Medicaid eligibility for low-income parents. It requires states to cover at least those parents with incomes below 1996 state Aid to Families with Dependent Children (AFDC) income thresholds, regardless of whether they receive cash assistance.

month (PMPM) age-adjusted case management fee coupled with fee-for-service payment of medical claims.

The Demonstration has continued to evolve and expand significantly over the years. The program's covered populations and major components during the current evaluation period are described below. They include the core SoonerCare Choice program, Insure Oklahoma, Health Access Networks and the SoonerCare Health Management Program.

Covered Populations (Populations Impacted by the Demonstration)

SoonerCare Choice

At the outset of the evaluation period, the SoonerCare Demonstration covered children in mandatory state plan groups, pregnant women and Aged, Blind and Disabled (ABD) members who are not dually-eligible and not receiving long term care, as well as 1931 low-income families and IV-E Foster Care or Adoption Assistance children, the latter with voluntary enrollment. In accordance with Oklahoma Senate Bill 741, the OHCA also serves individuals in need of breast or cervical cancer treatment and children with disabilities addressed under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

The Demonstration operates statewide under an enhanced Primary Care Case Management (PCCM) model in which the OHCA contracts directly with primary care providers to serve as patient centered medical homes for Title XIX SoonerCare Choice members. Patient centered medical home (PCMH) providers receive monthly care coordination payments for each beneficiary on their panels[6].

SoonerCare beneficiaries are not required to select a PCMH as a condition of eligibility. Beneficiaries are counted as part of SoonerCare Choice if and when they enroll with a PCMH.

Insure Oklahoma Premium Assistance Program

The Oklahoma Legislature in 2004 passed SB 1546, authorizing the OHCA to develop a subsidized insurance program for qualifying employees of participating small businesses, and their spouses, as well as other qualifying low-income adults not eligible for Medicaid. The program, originally known as O-EPIC and later as Insure Oklahoma (IO), was approved by CMS as a Health Insurance Flexibility and Affordability (HIFA) waiver amendment in September 2005.

IO includes two participation tracks: Employer Sponsored Insurance (IO-ESI) and Individual Plan (IO-IP). Under IO-ESI, the OHCA pays a portion of the health insurance premium for qualifying employees at participating small businesses.

During 2019 and 2020, the program was open to qualifying Oklahomans with household incomes up to 200 percent of the federal poverty level, who worked at an eligible business enrolled in IO-ESI, and Oklahomans making between 48 percent and 100 percent of the federal poverty level who were unemployed, working disabled or had qualifying income (O-IP population).

[6] The terms "member" and "beneficiary" are used interchangeably throughout the report.

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

Medicaid Expansion (July 2021)

On June 30, 2020, Oklahoma voters passed State Question 802, to expand Medicaid eligibility no later than July 1, 2021 to adults ages 19-64 whose income is 138 percent (133 percent with a five percent disregard) of the federal poverty level or lower. The OHCA established a new Adult Medicaid Eligibility Group and began to accept applications in June 2021 for an enrollment effective date of July 1, 2021.

The OHCA also transitioned automatically to Medicaid those Insure Oklahoma enrollees who qualified for Medicaid under the expansion[7]. The transition included all IO-IP enrollees and the portion of the IO-ESI population with incomes below 138 percent of FPL. Insure Oklahoma continues to provide coverage to persons with incomes between 138 and 200 percent of FPL enrolled in the IO-ESI portion of the program[8].

The expansion population was added to SoonerCare Choice in September 2021 through an amendment to the Demonstration. Like other SoonerCare beneficiaries, expansion beneficiaries are not required to select a PCMH as a condition of eligibility. Beneficiaries are counted as part of SoonerCare Choice if and when they enroll with a PCMH.

The majority of evaluation measures report findings on an annualized basis and exclude beneficiaries who fail to meet continuous enrollment requirements. The evaluation population therefore is not represented in the interim evaluation but will be a component of the summative evaluation.

COVID-19 Public Health Emergency (March 2020)

The COVID-19 pandemic was declared a national public health emergency (PHE) on March 13, 2020. In response, Congress on March 18, 2020 enacted HR 6201, the Families First Coronavirus Response Act, which the President signed into law on the same day.

Section 6008 of the Act provided for a temporary increase in the Medicaid Federal Medical Assistance Percentage (FMAP). The higher FMAP was contingent on the suspension of involuntary disenrollment from Medicaid under most circumstances, until the end of the emergency.

[7] IO members who are eligible for Medicaid solely due to the suspension of disenrollments under the COVID-19 PHE remain in the IO program pending cessation of the PHE.

[8] The approved evaluation design includes a domain for Insure Oklahoma, with three enrollment-related measures. The formal evaluation measures are omitted from the report, in recognition of the program's planned discontinuation. Enrollment data instead is included in this section for informational purposes only.

This provision had a significant impact on Medicaid enrollment nationally, including in Oklahoma, which received its initial Section 1135 waiver application[9] on March 24, 2020. It also had implications for the retroactive eligibility component of the SoonerCare Demonstration evaluation, as discussed in Section F (Results).

Title XIX Populations not Covered under the Demonstration

The SoonerCare Demonstration covers the majority of Oklahoma Medicaid beneficiaries but does not encompass the entire program. There are two non-Demonstration categories: SoonerCare Traditional and SoonerPlan. The SoonerCare Traditional population includes Medicare-Medicaid beneficiaries, long-term care beneficiaries and several smaller MEGs; it also includes persons eligible for the Demonstration who have not enrolled with a PCMH. SoonerPlan includes persons receiving family planning services only.

Enrollment Trends

Oklahoma Medicaid enrollment grew substantially during the period covered by the evaluation, both as a result of the Medicaid expansion and the suspension of most involuntary disenrollments during the COVID-19 PHE. Overall, the SoonerCare Choice population grew in size from 525,486 in January 2019 to 775,077 in December 2021 (47.5 percent increase).

The IO population grew from 18,754 in January 2019 to a peak of 40,867 in June 2021, before implementation of Medicaid expansion. IO enrollment in December 2021 was down to 10,576.

Exhibit B – 1 on the following page depicts monthly enrollment for the SoonerCare Choice and IO populations from January 2019 to December 2021[10].

[9] This waiver type is being used by CMS to grant states flexibilities in responding to the PHE.
[10] Source for Exhibits B-1 and B-2: OHCA monthly enrollment reports. https://oklahoma.gov/ohca/research/fast-facts-archives.html

Exhibit B-1 – SoonerCare Choice and Insure Oklahoma Population Monthly Enrollment

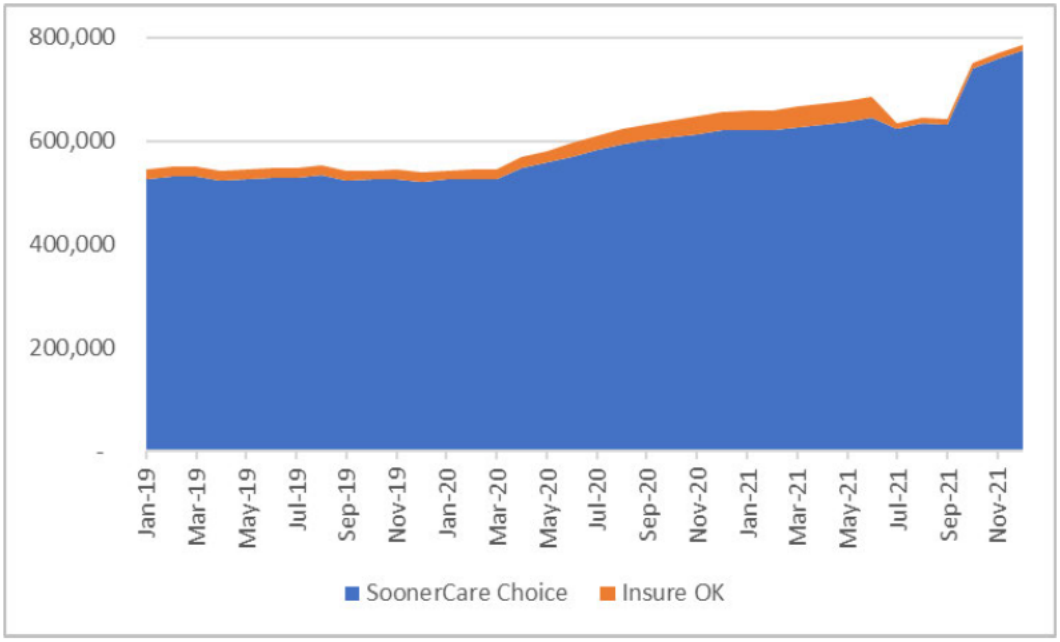


Exhibit B – 2 below presents enrollment numbers and percentages for the total SoonerCare program (all MEGs) in January 2019 and December 2021. The SoonerCare Traditional population includes Medicare-Medicaid dual eligible beneficiaries, long term care recipients and several smaller MEGs. It also includes persons who are eligible to select a PCMH but who have not yet done so.[11]

Exhibit B-2 – Enrollment Distribution – All SoonerCare

Population	January 2019 Enrollment	Percent of Total	December 2021 Enrollment	Percent of Total
SoonerCare Choice	525,486	67.7%	775,077	65.9%
Insure Oklahoma	18,754	2.4%	10,576	0.9%
Sub-Total Managed Care	*544,240*	*69.1%*	*785,653*	*66.8%*
SoonerCare Traditional	231,784	29.9%	390,014	33.2%
Total	**776,024**	**100.0%**	**1,175,667**	**100.0%**

There were 231,046 Medicaid expansion beneficiaries in December 2021. They are included within the SoonerCare Choice and SoonerCare Traditional categories, based on their PCMH status.

[11] Oklahoma also offers a family planning-only benefit to qualifying post-partum women ("SoonerPlan program"). Enrollment is not included in the exhibit.

SoonerCare Service Delivery and Care Management Models

The SoonerCare Demonstration offers all beneficiaries the opportunity to select a medical home for primary care and management of other medical and social needs. A portion of these medical homes are aligned with Health Access Networks (HANs) that provide practice support and care management to certain beneficiaries with, or at risk for, complex/chronic health conditions.

The OHCA also operates the SoonerCare Health Management Program, which provides care management to certain beneficiaries with, or at risk for, complex/chronic health conditions whose medical homes are not aligned with a HAN.

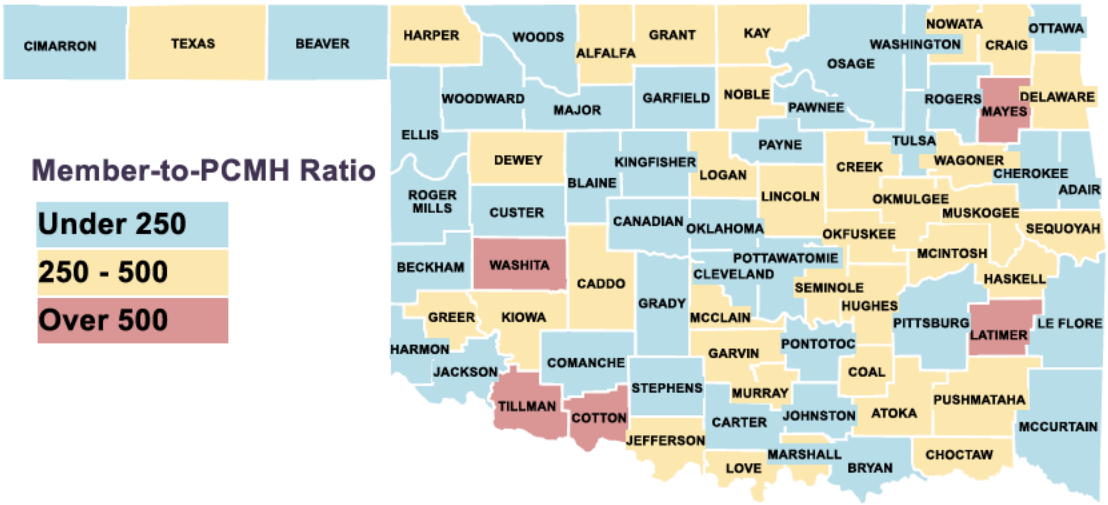
The Demonstration delivery models are described in more detail below.

Patient Centered Medical Homes

In January 2009, the OHCA enhanced the existing PCCM system through introduction of a Patient Centered Medical Home model for SoonerCare Choice beneficiaries. Under this model, beneficiaries actively choose a medical home from a network of contracted primary care providers. (PCMH contracts are offered to all Medicaid-enrolled primary care providers.)

In most counties, there is at least one PCMH provider for every 500 beneficiaries. Exhibit B – 3 below presents Member-to-PCMH ratios by county as of June 2022.

Exhibit B-3 – Member-to-PCMH Ratios by County



There are three PCMH participation levels, or "tiers": entry level, advanced and optimal. All three tiers include standards for care management, quality improvement and access, with the standards becoming more stringent in the higher tiers. For example, entry level medical homes must provide at least 20 hours of office time per week, while advanced medical homes must offer at least 30 hours and optimal medical homes must offer at least 30 hours plus four hours of evening or weekend availability.

Medical homes are paid monthly care coordination payments for each beneficiary on their panel. The payments vary by practice type (children only, adults only or children and adults) and tier. In 2022, the fees ranged from $3.63 to $8.82 per member per month (see Exhibit B-4 below). (Tribal and FQHC providers receive distinct payments that are not age- or tier-based.) Providers also are eligible to receive "SoonerExcel" payments for meeting pre-defined quality targets.

Exhibit B-4 - PCMH Payments by Practice Type and Tier (PMPM)

Practice Type	Entry Level	Advanced	Optimal
Adults Only	$5.08	$6.63	$8.82
Children and Adults	$4.39	$5.73	$7.61
Children Only	$3.63	$4.73	$6.28

Health Access Networks

SoonerCare Health Access Networks are non-profit, administrative entities that work with affiliated providers to coordinate and improve the quality of care provided to SoonerCare Choice members. The HANs receive a nominal $5.00 per member per month (PMPM) payment[12].

The SoonerCare Special Terms and Conditions specify that each HAN must:

- Be organized for the purpose of restructuring and improving the access, quality, and continuity of care to SoonerCare beneficiaries;
- Ensure patients access to all levels of care, including primary, outpatient, specialty, certain ancillary services, and acute inpatient care, within a community or across a broad spectrum of providers across a service region or the State;
- Submit a development plan to the State detailing how the network will reduce costs associated with the provision of health care services to SoonerCare enrollees, improve access to health care services, and enhance the quality and coordination of health care services to SoonerCare beneficiaries;
- Offer core components of electronic medical records, improved access to specialty care, telemedicine, and expanded quality improvement strategies; and,
- Offer care management/care coordination to persons with complex health care needs as specified in the state-HAN provider agreement.

[12] The HANs pay a portion of the state match, and are capped on the number of beneficiaries for which they can be paid the fee, making the average effective payment less than $5.00.

Most SoonerCare HAN members receive care coordination, if needed, through their HAN-affiliated PCMH provider. In this respect, they do not differ from other members enrolled with a non-HAN PCMH.

The HANs each employ care managers (primarily registered nurses) to assist members with, or at risk for complex or chronic health care needs, such as asthma or diabetes. Candidates for care management may be identified through analysis of paid claims data, electronic health record reviews or provider referrals. Care management can be telephonic or in-person and can encompass both clinical and social service needs.

The OHCA contracts with three HANs: University of Oklahoma (OU) Sooner HAN; Partnership for Healthy Central Communities (PHCC) HAN; and Oklahoma State University (OSU) HAN. The HANs began operations in 2010 with combined enrollment of approximately 25,000. In December 2021, enrollment exceeded 300,000.

The two larger HANs are affiliated with universities and originated in Tulsa. They both gradually expanded geographically during the waiver period by adding new practices outside of their initial service areas. Most of the expansion was to the east and south. Central Communities is a grassroots organization based in Canadian County, which is to the west of Oklahoma City. Exhibit B-5 below presents HAN service areas by county.

Exhibit B-5 – HAN Service Areas by County

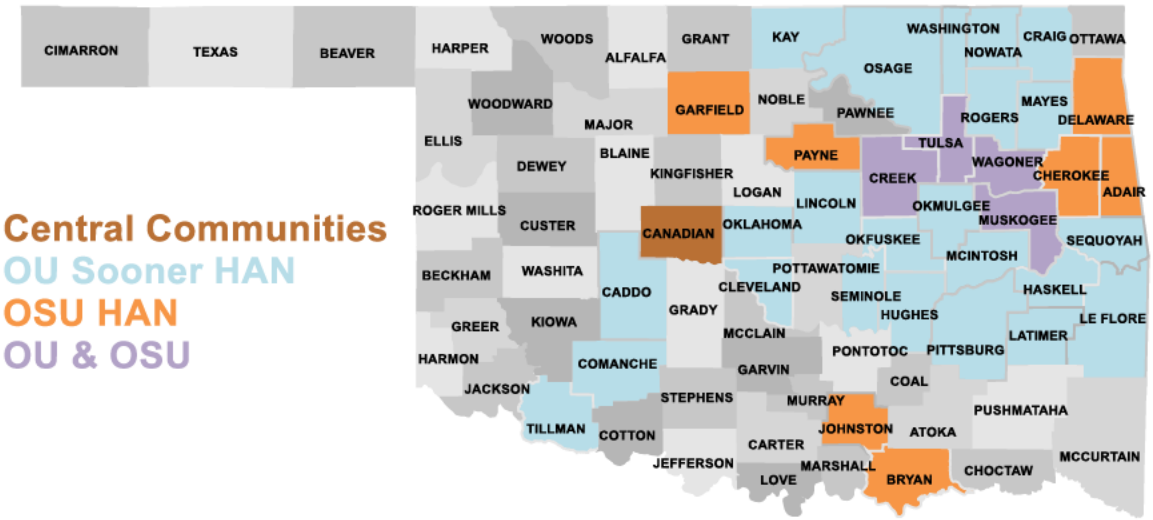


Exhibit B-6 on the following page presents total HAN enrollment by year, as well as enrollment for the cohort receiving care management. (Some members received care management across two or more years.)

Exhibit B-6 – HAN Enrollment by Year[13]

Enrollment Type	2019	2020	2021
Total	156,853	194,805	312,855
Care Managed	3,037	3,511	4,192

SoonerCare Health Management Program

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

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

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

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

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

[13] Combined enrollment for all three HANs. Count reflects members enrolled for the entire calendar year.

In addition to health coaching, the SoonerCare HMP incorporates Practice Facilitation into each location with an embedded health coach. A practice facilitator nurse assesses the office's existing processes related to care of patients with chronic conditions. The practice facilitator then undertakes education and academic detailing appropriate to the office's needs before deployment of the health coach. Practice facilitators also in some cases provide assistance to practices without embedded health coaches.

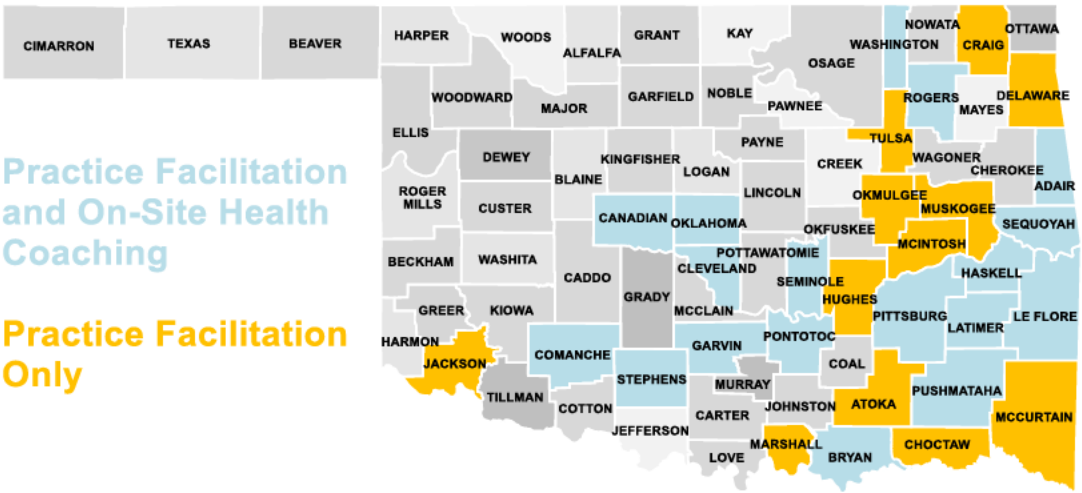
In 2014, the OHCA authorized its vendor to resume telephonic case management (health coaching) and, in limited cases, care coordination in members' homes. Telephonic health coaches would focus their efforts on engaging new members, actively pursuing members needing assistance with care transitions and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

The OHCA also implemented a Pain Management program within HMP in 2015. The OHCA authorized its vendor to hire practice facilitators and substance use resource specialists dedicated to improving the effectiveness of providers caring for members with chronic pain and opioid drug use. The Pain Management staff assist providers with implementation of a chronic pain management toolkit and principles of proper prescribing. These staff members work both with offices that have an embedded health coach and offices that do not.

In 2019, the OHCA entered into a new five-year contract with the HMP vendor. The contract promoted value-based purchasing concepts through payment withholds to be earned back by meeting quality-related performance benchmarks. The contract also allowed for program expansion under all three health coaching modalities.

Exhibit B-7 below identifies the counties with SoonerCare HMP office-embedded health coaches, practice facilitators or both. (Counties with telephonic-only care management are not highlighted.)

Exhibit B-7 – HMP On-Site Health Coaches and Practice Facilitators by County

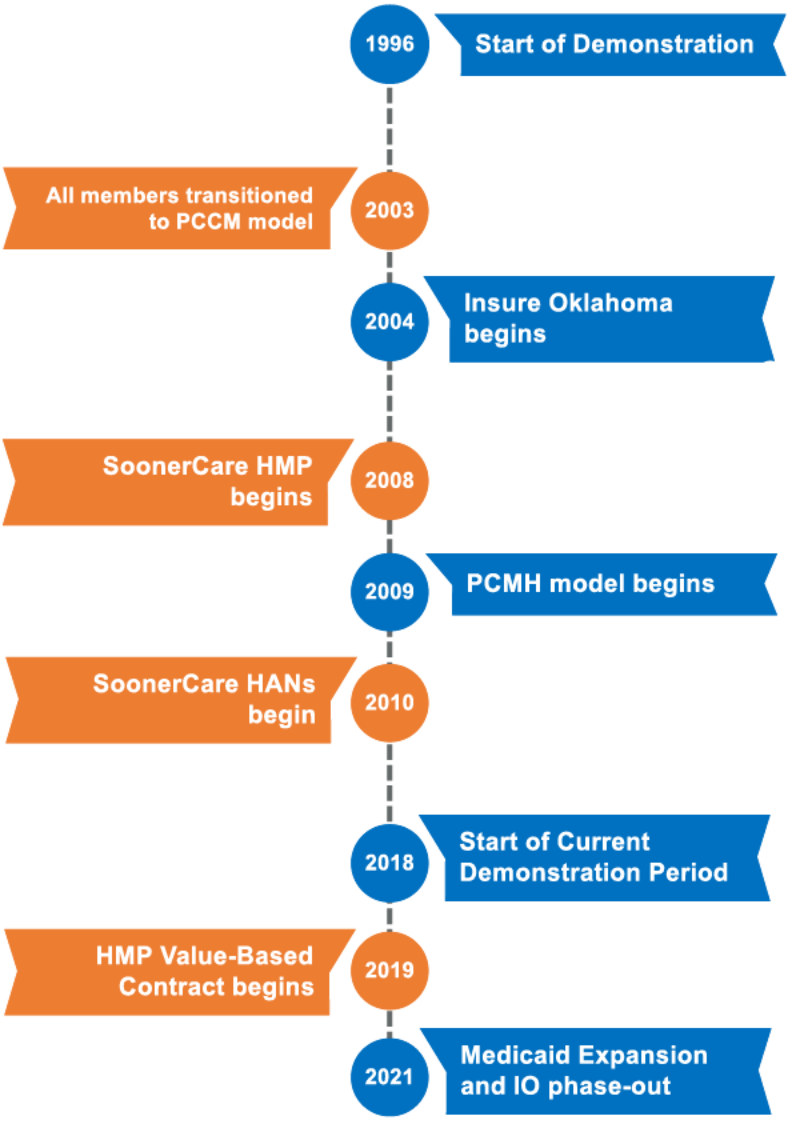


SoonerCare HMP enrollment fluctuated during the current Demonstration period. Enrollment in 2019 was 4,864. It grew to 7,152 in 2020 before dropping to 6,292 in 2021[14]. (Some members received care management across two or more years.)

Summary of Major Events

Exhibit B – 8 below presents a timeline summarizing major events affecting enrollment and service delivery during the Demonstration.

Exhibit B-8 – SoonerCare Milestones



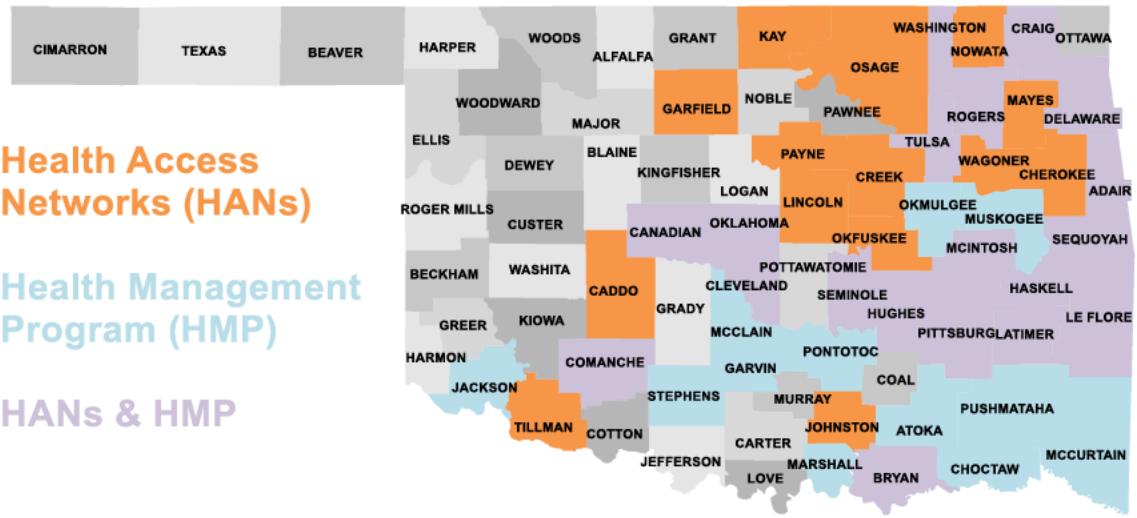
[14] Count of members enrolled in SoonerCare for the entire year and in SoonerCare HMP for at least three months of the year.

Alignment of Care Management Initiatives

The OHCA's objective is to align PCMH, HAN, SoonerCare HMP and internal care management activities, such that all SoonerCare Choice members with complex/chronic conditions have access to care management. This is part of a broader strategy under the SoonerCare Demonstration to advance managed care principles and a statewide Quality Improvement Program through complementary initiatives.

Exhibit B-9 below identifies the counties in which the SoonerCare HMP, SoonerCare HAN or both programs operate. The SoonerCare HMP also provides telephonic care management to SoonerCare Choice members in other counties throughout the State.

Exhibit B-9 – SoonerCare HAN and HMP Operations, by County



The evaluation includes questions and hypotheses related to the two major SoonerCare Choice care management systems. The evaluation design incorporates access, quality, health outcome and cost effectiveness measures relevant to each system.

As discussed further in the methodology section, the evaluation relies primarily on analysis of SoonerCare HMP and SoonerCare HAN performance against a comparison group selected from the non-HMP/non-HAN SoonerCare Choice population.

The SoonerCare HAN analysis presents results both for the HAN population at large ("HAN total") and the cohort receiving care management ("HAN Care Managed"). The HAN Care Managed subgroup is broken-out because the HAN total population is undifferentiated in its model-of-care from the non-HAN population.

Retroactive Eligibility

The SoonerCare Demonstration also includes a waiver of retroactive eligibility for a portion of the SoonerCare population. The waiver has been a component of SoonerCare since the Demonstration's inception.

At the start of the current Demonstration period, the population subject to the waiver was reduced, with several groups becoming newly-eligible for retroactive coverage. Exhibit B-10 below identifies the status of populations subject to the waiver in the prior and current Demonstration periods. In the current period, no children or pregnant women are subject to the retroactive eligibility waiver.

Exhibit B-10 – Demonstration Retroactive Eligibility Waiver Populations

Population	Subject to Waiver in Prior Demonstration Period	Subject to Waiver in Current Demonstration Period
Pregnant women and infants under 1 1902(a)(10)(A)(i)(IV)	*Yes*	*No*
Children 1 – 5 1902(a)(10)(A)(i)(VI)	*Yes*	*No*
Children 6 – 18 1902(a)(10)(A)(i)(VII)	*Yes*	*No*
IV-E Foster Care or Adoption Assistance children	*Yes*	*No*
1931 low-income families	*Yes*	*Yes*
Targeted low-income child	*Yes*	*No*
Infants under age 1 through CHIP Medicaid expansion	*Yes*	*No*
Children 1 – 5 through CHIP Medicaid expansion	*Yes*	*No*
Children 6 – 18 through CHIP Medicaid expansion	*Yes*	*No*
Non-IV-E foster care children under age 21 in State or tribal custody	*Yes*	*No*
Non-disabled low-income workers and spouses ages 19 – 64 (IO IP)	*Yes*	*Yes*
Working disabled adults ages 19 – 64 (IO IP)	*Yes*	*Yes*
Full-time college students ages 19 – 22 (IO IP)	*Yes*	*Yes*
Foster parents ages 19 – 64 (IO IP)	*Yes*	*Yes*
Qualified employees of not-for-profit businesses ages 19 – 64 (IO IP)	*Yes*	*Yes*

The retroactive eligibility evaluation also uses the comparison group method to evaluate the waiver's impact on enrollment patterns and health outcomes.

4. Changes to the Demonstration

The principal change to the Demonstration during the current period occurred through the expansion of Medicaid to adults ages 19-64 whose income is 138 percent (133 percent with a five percent disregard) of the federal poverty level or lower. The expansion resulted in substantial growth to the Medicaid program.

Enrollment into the expansion MEG began in July 2021, six months prior to the end of the three-year period addressed in the interim evaluation. Expansion beneficiaries were offered the opportunity to select a PCMH provider under SoonerCare Choice starting in September 2021.

The majority of the measures in the evaluation design specify that an individual must be enrolled continuously for longer than six months to be included in the analysis. Except where noted in the report, the expansion population is not a component of the evaluation.

The summative evaluation report will include two complete years of data for the expansion population. The analysis will be stratified, as appropriate, to identify any differences between the expansion and traditional Medicaid populations.

5. Population Groups Impacted by the Demonstration

The Demonstration includes the majority of Oklahoma's Medicaid/CHIP population[15]. In addition to the groups identified in Exhibit B-10, the Demonstration includes the populations presented below in Exhibit B-11. These populations received retroactive eligibility during the period covered in the evaluation.

As discussed, the expansion population is excluded from the interim evaluation, except where noted, due to its short period of enrollment.

Exhibit B-11 – Other Demonstration Populations

Population	FPL and/or other Qualifying Criteria
SSI recipients	Up to SSI limit
Pickle amendment	Up to SSI limit
Early widows/widowers	Up to SSI limit
Disabled adult children (DACs)	Up to SSI limit
1619(b) population	SSI for unearned income and income limit
Aged, blind and disabled	From SSI up to and including 100% FPL
Eligible but not receiving cash assistance	Up to SSI limit
Individuals receiving only optional State supplements	100% SSI FBR + $41 (SSP)
Breast and cervical cancer prevention and treatment	Up to and including 185% FPL
TEFRA children under 19 years of age without creditable coverage	Disabled according to SSA definition, with gross personal income at or below 200% FPL
New Adult Group (Medicaid Expansion)	Adults ages 19-64 whose income is 138 percent (133 percent with a five percent disregard) of the federal poverty level or lower

[15] The major exclusions are residents of long term care facilities, 1915c waiver recipients, persons dually-eligible for Medicare/Medicaid and persons receiving less than full Title XIX benefits.

C. EVALUATION QUESTIONS AND HYPOTHESES

1. *Quantifiable Targets for Improvement*

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

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

The Driver Diagrams presented on the following page in Exhibits C-1 and C-2 illustrate the relationship between the OHCA's overall goals for SoonerCare Choice and the primary and secondary drivers for achieving these goals.

As depicted in the diagrams, the SoonerCare HAN and HMP care management programs serve as the platforms, or primary drivers, for achieving Demonstration aims with respect to access/quality (Exhibit C-1) and cost effectiveness (Exhibit C-2).

Both programs are supported by secondary drivers related to changes in preventive/primary care access, utilization of emergency room and inpatient services, provider payment systems and enrollment continuity (for beneficiaries who are subject to the retroactive eligibility waiver).

Exhibit C-1 – Driver Diagram (Access and Quality)

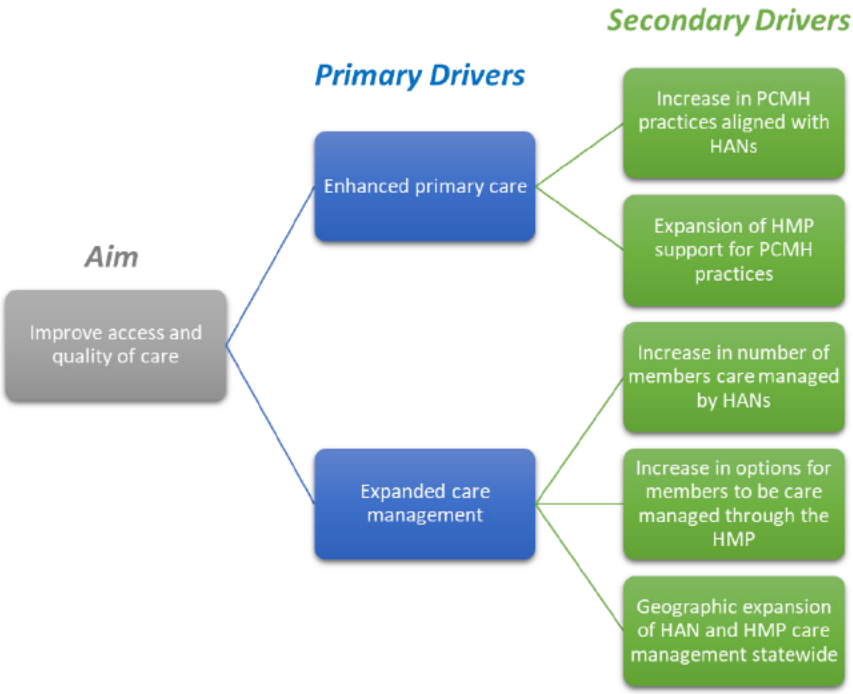
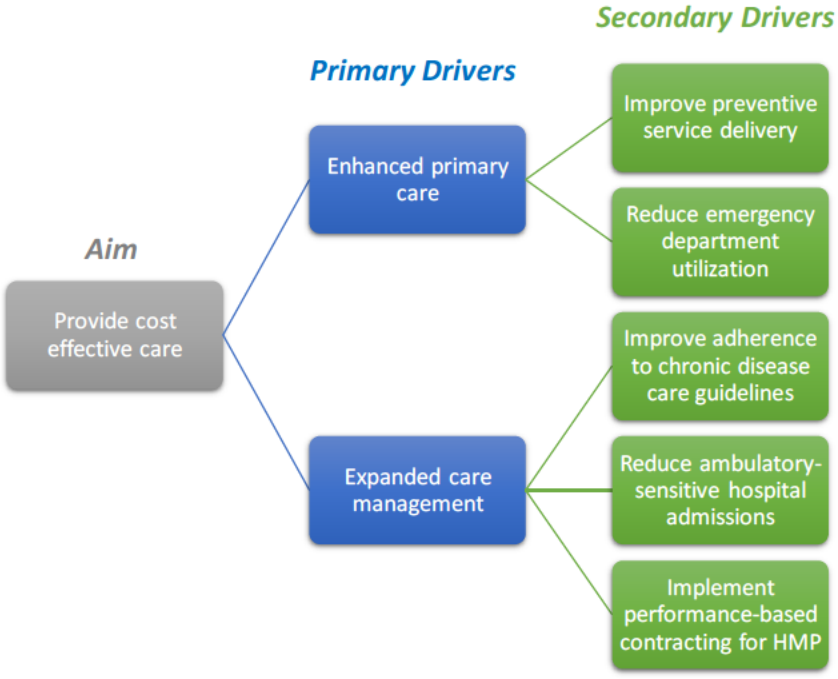


Exhibit C-2 – Driver Diagram (Cost Effectiveness)



2. Demonstration Hypotheses

The Demonstration was evaluated through testing of hypotheses related to the HANs, HMP and waiver of retroactive eligibility. Specifically:

1. Evaluation of Health Access Networks

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

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

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

    d. *Impact on PCMH Program:* The implementation and expansion of the HANs will enhance the State's Patient Centered Medical Home program by making HAN care management support and practice enhancement available to more providers, as documented through an evaluation of PCP profiles that incorporates a review of utilization, disease guideline compliance and cost.

2. Evaluation of the Health Management Program

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

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

    c. *Impact on Identifying Appropriate Target Population:* The implementation of the HMP, including health coaches and practice facilitation, will result in a change in the characteristics of the beneficiary population enrolled in the HMP (as measured through claims data to identify characteristics such as disease burden and co-morbidity) compared to baseline[16];

[16] The wording of this hypothesis was retained from earlier evaluation periods and refers to the HMP's transition to practice-embedded health coaches. This transition happened several years prior the period being evaluated in

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

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

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

g. *Impact on Satisfaction/Experience with Care:* Beneficiaries using HMP services will have high satisfaction and will attribute improvement in health status (if applicable) to the HMP[17]; and

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

3. Evaluation of Retroactive Eligibility Waiver: The evaluation will support the hypothesis that the waiver of retroactive eligibility is an appropriate feature of the program, as measured by:

a. *Impact on Access to Care:* Eliminating retroactive eligibility will increase the likelihood of enrollment and enrollment continuity;

b. *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; and

c. *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.

this report. PHPG focused on the appropriateness of the enrolled population over the three years but did not seek to do a look-back to the original HMP population, which was enrolled in 2008-2009.

[17] The SoonerCare STCs state, "Beneficiaries using HMP services will have higher satisfaction compared to beneficiaries not receiving HMP services (as measured through CAHPS survey data)." The OHCA's CAHPS surveyor is not able to identify HMP members within the larger survey universe. PHPG therefore added evaluation-designated CAHPS survey questions to its targeted survey instrument to collect data for this hypothesis.

Alignment of Demonstration Goals and Hypotheses

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

Exhibit C-3 – Alignment of Goals and Hypotheses

Goal	Demonstration Component	Hypothesis/Research Question(s)
Health Access Networks		
Accessible Care	Health Access Network	Will the implementation and expansion of the HANs improve access to and the availability of health care services to SoonerCare beneficiaries served by the HANs?
High Quality Care	Health Access Networks	Will the implementation and expansion of the HANs improve the quality and coordination of health care services to SoonerCare beneficiaries served by the HANs, including those with one or more chronic illnesses? Will the implementation and expansion of the HANs enhance the State's Patient Centered Medical Home program by making HAN care management support and practice enhancement available to more providers (as documented through an evaluation of PCP profiles that incorporates a review of utilization, disease guideline compliance and cost)? Will beneficiaries enrolled with a HAN PCMH provider have higher satisfaction, compared to beneficiaries enrolled with a non-HAN PCMH (as measured through Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data)?

Goal	Demonstration Component	Hypothesis/Research Question(s)
Cost Effectiveness	Health Access Networks	Will the implementation and expansion of the HANs reduce cost associated with provision of health care services to SoonerCare beneficiaries served by the HANs?
Health Management Program		
Accessible Care	Health Management Program	Will implementation of the HMP, including health coaches and practice facilitation, result in an increase in enrollment, as compared to baseline? Will incorporating health coaches into primary care practices result in increased contact with HMP beneficiaries by the PCP (measured through claims encounter data), as compared to baseline, when care management occurred (exclusively) via telephonic or face-to-face contact with a nurse care manager?
High Quality Care	Health Management Program	Will implementation of the HMP result in a change in the characteristics of the beneficiary population enrolled in the HMP (as measured through population characteristics, including disease burden and co-morbidity obtained through claims and algorithms) compared to baseline? Will the use of disease registry functions by the health coach (along with other coaching activities) improve the quality of care delivered to beneficiaries, as measured by changes in performance on the initial set of Health Care Quality Measures for Medicaid-Eligible Adults or CHIPRA Core Set of Children's Healthcare Quality Measures? Will beneficiaries using HMP services have high satisfaction and attribute improvement in health status (if applicable) to the HMP?

Goal	Demonstration Component	Hypothesis/Research Question(s)
Cost Effectiveness	Health Management Program	Will ER and hospital utilization for members enrolled in the HMP be lower than would have occurred absent their participation? Will per member per month health expenditures for members enrolled in the HMP be lower than would have occurred absent their participation?
Waiver of Retroactive Eligibility		
Accessible Care	Enrollment	Do eligible people subject to retroactive eligibility waivers enroll in Medicaid at the same rate as other eligible people who have access to retroactive eligibility? Do eligible people subject to retroactive eligibility waivers continue enrollment at the same rate as other eligible people who have access to retroactive eligibility? Do eligible people subject to retroactive eligibility waivers who disenroll have shorter enrollment gaps than eligible people who have access to retroactive eligibility?
High Quality Care	Health Status	Do newly-enrolled beneficiaries subject to retroactive eligibility waivers have higher self-assessed health status than eligible people who have access to retroactive eligibility? Do eligible people subject to retroactive eligibility waivers have better health outcomes than eligible people who have access to retroactive eligibility?

Promotion of Title XIX Objectives

The Affordable Care Act (ACA) included provisions for Medicaid related to quality of care and delivery systems. Specifically, the ACA anticipates that, "improvements will be made in the quality of care and the manner in which that care is delivered, while at the same time reducing costs."[18]

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

[18] https://www.medicaid.gov/about-us/program-history/index.html

D. EVALUATION METHODOLOGY

1. *Evaluation Design*

Overview

The SoonerCare Choice evaluation was conducted in accordance with an evaluation design approved by CMS in November 2019. A copy of the final approved design measure set is included as Appendix 1[19].

The OHCA and evaluator (PHPG) relied on CMS guidance for developing robust research methods, intended to isolate the impact of the Demonstration on covered populations. The retroactive eligibility component of the design adhered to specific guidance released by CMS for use by states with retroactive eligibility waivers, to ensure comparability of findings across Demonstrations.

The purpose of the evaluation was to establish whether a causal relationship exists between enrollment in one of the SoonerCare Choice care management programs and between SoonerCare eligibility policy and outcomes related to access, quality and cost effectiveness. The evaluation design sought to establish or rule out such a relationship through a mixed methods approach. This included comparing outcomes between the "treatment" group and a counterfactual in the form of a comparison group chosen to match the treatment group on demographic and health status characteristics. It also included time series analysis, descriptive statistics and qualitative data collection to support quantitative findings.

The SoonerCare Choice evaluation uses best available data, including nationally-validated measures developed by HEDIS and the Agency for Healthcare Research and Quality (AHRQ). It also includes nationally-validated survey questions from the Consumer Assessment of Healthcare Providers and Systems (CAHPS), Behavioral Risk Factor Surveillance System (BRFSS) and National Health Interview Survey (NHIS). The evaluation uses State-specific measures where a national measure does not exist.

A portion of the HEDIS measure set also is part of CMS' schedule of Core Set Measures for children and adults. CMS publishes an annual report of Core Set Measure data for reporting states and identifies the median (50th percentile) rate across states for each measure. PHPG included the 50th percentile rate for the published 2020 measure set, where available, as a point of comparison to the Oklahoma data.

States use varying methods to collect Core Set data (i.e., analysis of administrative (paid claims)-only versus a "hybrid" combination of administrative and medical record data); the demographic make-up of states also differ significantly. Caution therefore should be exercised when comparing

[19] The narrative portion of the approved design is largely replicated in Sections B – D and so is not presented again in the Appendix. The full evaluation design document is available as a component of the Demonstration Special Terms and Conditions posted on the OHCA website at OK SoonerCare 1115 Demo STCs 1.31.22.pdf (oklahoma.gov)

national and Oklahoma rates. The comparison is presented for informational purposes only and not as a formal component of the evaluation.

The National Committee for Quality Assurance (NCQA) publishes national Medicaid Quality Compass scores (rates) for CAHPS measures, using data provided by reporting Medicaid health plan products. Where available, PHPG compared SoonerCare CAHPS findings to the Medicaid Quality Compass scores, using the NCQA 2021 Medicaid health plan Quality Compass dataset, as presented by the OHCA's CAHPS survey vendor in its published reports. PHPG selected the median (50th percentile) as the comparison benchmark.

Caution also should be exercised when reviewing benchmark data as Core Set and CAHPS benchmark population characteristics were not matched to the OHCA groups. The data again is presented for informational purposes only.

CMS Guidance for Enhancement of Approved Evaluation Design

The SoonerCare Choice evaluation design for the current Demonstration period was approved by CMS before development of the summative evaluation report for the prior Demonstration period (2016 – 2018). CMS granted the OHCA's request for its evaluator to use the updated design for 2016 – 2018 summative evaluation to the extent practicable.

The 2019 – 2023 evaluation design included the same three domains (SoonerCare HAN, SoonerCare HMP and retroactive eligibility) but contained a more comprehensive set of measures than in the originally-approved design for the earlier period. It also incorporated statistical techniques favored by CMS for ensuring analytical rigor.

As part of its subsequent review of the 2016 – 2018 summative evaluation report, CMS made recommendations for modifying and enhancing the evaluation methodology prior to its application to the current Demonstration period. The OHCA and its evaluator incorporated the recommendations into the design whenever feasible. This included modifying the approach for evaluating treatment and comparison group characteristics and adding geographic stratification (urban/rural) to the statewide-level analysis. The full set of CMS recommendations are included behind the approved design document in Appendix 1 and are referred to, as applicable, in the body of the report.

Treatment of Retired HEDIS Measures

The approved evaluation design included several HEDIS measures that subsequently were retired by the HEDIS steward, NCQA. In circumstances where NCQA identified a replacement measure, the replacement has been used where feasible. These measures are noted in the report.

Retired measures for which NCQA continued to provide the necessary supporting data specifications are included in the interim evaluation but may be discontinued prior to the summative evaluation if the supporting specifications are no longer available.

Other Deviations from Approved Evaluation Design

PHPG omitted the Insure Oklahoma evaluation domain from Section F (Results) in view of the program's substantial transition to the Medicaid expansion MEG. The enrollment data instead is included in Section B (General Background Information) of the report.

PHPG modified a portion of the retroactive eligibility waiver to account for the suspension of most disenrollments during the PHE. PHPG also modified a small number of measures for which better data was available than called for in the evaluation design.

The SoonerCare HMP evaluation included an Interrupted Time Series analysis to assess the impact of a new vendor contract, with enhanced health coaching requirements, on member outcomes. The PHE disrupted the vendor's ability to utilize fully all health coaching modalities (i.e., in-office and in-home coaching). PHPG did not conduct the ITS portion of the evaluation but did complete the treatment-comparison group component.

Similarly, the retroactive eligibility evaluation included an ITS analysis for populations subject to the waiver before 2020 and covered for retroactive expenses starting in 2020[20]. The suspension of most disenrollments under the PHE prevented PHPG from performing the ITS analysis.

All of the measure-specific deviations are noted where they occur within Section F (Results). The deviations also are summarized in a table at the end of Appendix 1.

COVID-19 Public Health Emergency

In August 2020, CMS released a technical assistance document addressing implications of the COVID-19 PHE on Section 1115 demonstration evaluations. The OHCA and PHPG reviewed the guidance and incorporated it into the evaluation as applicable.

The technical assistance document addresses changes in billing codes resulting from expansion of telehealth services during the PHE. Oklahoma already permitted telehealth visits prior to the PHE and, while telehealth activity increased significantly, the billing codes included in the analysis of service utilization and expenditures did not change.

The document provides options to states with respect to selecting an evaluation base year, if the original base year fell into the PHE period. The SoonerCare interim evaluation covers calendar years 2019 – 2021. The COVID-19 PHE began in March 2020, leaving calendar year 2019 unaffected by the pandemic. (Although calendar year 2019 serves as a base year for the current Demonstration period, trended data for calendar years 2016 – 2018 also is presented for measures that were evaluated in the prior Demonstration period.)

The document addresses challenges in assessing and interpreting trends that include the period affected by the PHE. As recommended by CMS, the evaluation report discusses the implications of the COVID-19 PHE where applicable to findings.

[20] The revised standards were included in the STCs for 2019 – 2023 but the changes were not implemented in the MMIS until 2020.

2. Target and Comparison Populations

SoonerCare HAN and HMP Component of Evaluation

The Demonstration evaluation target populations are SoonerCare HAN (total and Care Managed subgroup) and HMP members. With very few exceptions, the two populations do not overlap; the OHCA reviews enrollment data monthly to identify and resolve any instances of members being co-enrolled in both programs.

The evaluation was structured to isolate, as much as possible, the discrete impact of the HAN and HMP initiatives with respect to access, quality and cost effectiveness. This was accomplished by stratifying SoonerCare Choice members into the following population segments for applicable measures: members enrolled with a SoonerCare HAN PCMH (both total and Care Managed); members enrolled in the SoonerCare HMP; and SoonerCare Choice members not enrolled in either program or in any other SoonerCare program offering care management[21] (unmanaged comparison group).

All of the populations were sufficient in size to be evaluated in isolation. The HAN total population averaged 221,500 members; the HAN Care Managed subset averaged 3,580 members per year; the HMP population averaged 6,100 members per year. The comparison group exceeded 300,000 members in each year of the evaluation.

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

The SoonerCare HAN Care Managed and HMP populations include a higher percentage of adults and persons eligible due to Aged, Blind or Disabled (ABD) status[22] than the comparison group population. Coarsened exact matching was used to account for differences between the care managed populations and the comparison group. (See below and Methodology section for more detail on the comparison group method and matching process.)

The evaluation encompassed the entire universe of SoonerCare Choice members, with the exception of certain member surveys (CAHPS and program-specific surveys). These were conducted on a randomly-selected representative sample of SoonerCare HAN, HMP and comparison group members. (For other member surveys, attempts were made to contact 100 percent of the population. See Member Survey Methods below for more detail.)

[21] Excluded populations consisted of SoonerCare Choice members enrolled in the OHCA's internal care management program known as the "Chronic Care Unit" (CCU), which serves a similar population to the SoonerCare HMP and is open to members without access to the HMP, and SoonerCare Choice members enrolled with a PCMH provider who received practice facilitation through the HMP and had an embedded health coach. These beneficiaries were excluded on the presumption that their PCMH practice benefited from instruction on enhanced care management techniques which may have been applied to their treatment.

[22] The SoonerCare Choice Demonstration does not include persons dually eligible for Medicare and Medicaid. The ABD population enrolled in the Demonstration is Medicaid only.

Comparison Group Method

All SoonerCare Choice members should have access to preventive services through their PCMH, regardless of whether they receive additional care management through the SoonerCare HAN or HMP. An in-state comparison group method therefore was used for calculation of HEDIS rates across the three populations. This included both population-wide preventive measures and preventive care measures specific to various chronic health conditions.

The comparison group method also was used for evaluating CAHPS ratings among the three populations, with some limitations. The OHCA and its CAHPS vendor were able to stratify survey results between respondents affiliated with a HAN PCMH and all others. The evaluation of CAHPS results for the HAN portion of the evaluation was conducted at this population level, rather than for the subset of HAN members receiving care management.

The OHCA and its CAHPS vendor were not able to identify SoonerCare HMP survey respondents, if any. PHPG included a subset of CAHPS survey questions on its targeted survey of SoonerCare HMP members and evaluated the responses against the same comparison group used for the HAN evaluation. Findings should be interpreted with caution given the possible inclusion of SoonerCare HMP members in the broader CAHPS survey universe[23].

Finally, the comparison group method was used to evaluate the cost effectiveness of the HAN and HMP models versus the population not enrolled in either program. This included evaluation of inpatient hospital utilization, ER utilization and per member per month expenditures.

Member Survey Methods

The evaluation assessed member satisfaction with access to care and care management, including the member's perception of care management's impact on health status, through a combination of CAHPS and targeted surveys.

The OHCA's CAHPS contractor surveyed a random sample of SoonerCare Choice beneficiaries; the contractor and OHCA identified SoonerCare HAN respondents within the response universe and provided beneficiary de-identified data to PHPG for the evaluation.

PHPG attempted to conduct a baseline telephone survey on 100 percent of newly-enrolled HMP participants and a six-month follow-up survey on 100 percent of baseline respondents.

PHPG conducted a targeted telephone survey of SoonerCare HAN Care Managed members to document their satisfaction with HAN activities related to social determinants of health (SDOH). Each of the HANs furnished PHPG with a database of members who had received care management during the current evaluation period. PHPG used database filters and key word searches of care manager notes to identify members with SDOH needs. PHPG attempted to contact 100 percent of these members to complete the survey.

[23] SoonerCare HMP members comprise less than two percent of the SoonerCare Choice population. Their representation in the survey universe was considered unlikely to more than a handful of respondents.

PHPG also conducted a targeted telephone/mail survey of HAN-affiliated PCMH providers to document their satisfaction with HAN activities related to practice enhancement. PHPG attempted to contact 100 percent of the providers identified by the HANs as having received practice enhancement assistance, either specific to care management of patients with complex/chronic health conditions or raising their PCMH tier assignment to a higher level. Due to the low sample size and response rate, the survey results should be treated as qualitative in nature.

In addition, PHPG conducted a targeted baseline telephone survey of a random sample of newly-enrolled SoonerCare Choice beneficiaries subject to the waiver of retroactive eligibility and a comparison group not subject to the waiver. PHPG attempts to reach 100 percent of baseline survey respondents for follow-up surveys conducted at regular intervals (twelve-months, eighteen-months and twenty-four months). The survey tracks changes in respondent physical and behavioral health status, in accordance with the methodology recommended by CMS in its document: Appendix to Eligibility & Coverage Evaluation Guidance: Retroactive Eligibility Waivers.

Retroactive Eligibility Waiver Component of Evaluation

The evaluation of the waiver of retroactive eligibility is distinct from the other portions of the design. As noted, the approved evaluation design incorporated measures recommended by CMS to all states with retroactive eligibility waivers.

In addition to the survey measures discussed above, the approved design contains a series of measures related to enrollment tenure and coverage gaps, for which members subject to the waiver of retroactive eligibility are to be evaluated against a comparison group of members not subject to the waiver. The design also includes an interrupted time series analysis of members subject to the waiver prior to the current Demonstration period but no longer subject to the waiver as of March 2019.

The emergence of the COVID-19 PHE and resultant suspension of most eligibility-related disenrollments in early 2020 eliminated the normal enrollment churn experienced by Medicaid programs. Enrollment statistics for both populations (treatment and comparison groups) are included in the report but no conclusions are offered based on the trend lines. PHPG will report findings for the post-PHE period in accordance with the evaluation design in the summative evaluation report.

Building upon and Expanding Earlier Demonstration Evaluation Findings

The SoonerCare model in the current period is a continuation of the model in place during the prior Demonstration period (calendar years 2016 – 2018). As discussed earlier, the approved evaluation design for the current Demonstration period also was used, to the extent practicable, for the evaluation of the prior period. However, the approved design was modified and enhanced in accordance with CMS recommendations, following completion of the Summative evaluation report for the prior period.

The modifications included refinements to the initial paid claims extract from the OHCA Medicaid Management Information System, to ensure the universe included only beneficiaries eligible for

SoonerCare Choice[24], as well as a change to the matching methodology used for selection of comparison groups. In addition, the HAN portion of the evaluation was expanded to include a targeted analysis of the HAN Care Managed subgroup, to better isolate the impact of the HAN program on the enrolled population. The prior period evaluation examined only the HAN population in total[25].

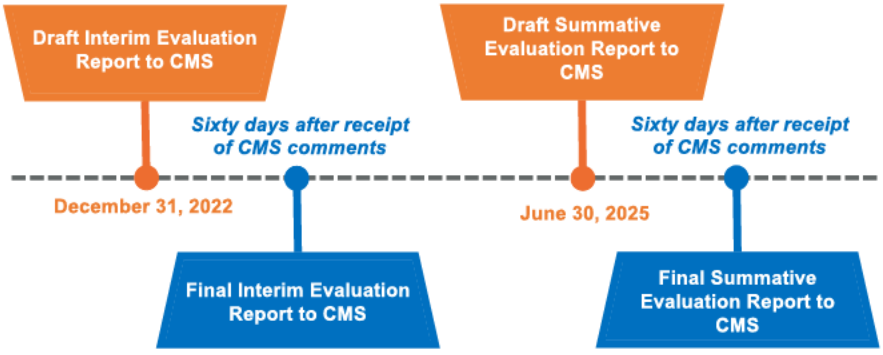
These changes made it necessary to use calendar year 2019 as the base year for the evaluation. However, the SoonerCare HMP population was evaluated in both Demonstration periods using many of the same measures. Where available, trended data for the SoonerCare HMP program is presented for the entire six-year period of calendar years 2016 – 2021[26].

3. Evaluation Period

The Demonstration period addressed in the interim evaluation is calendar years 2019 – 2021. This also served as the default time period for evaluation measures, with calendar year 2019 serving as the base year. The summative evaluation report will address calendar years 2019 – 2023 and will be issued in accordance with Demonstration Special Terms and Conditions.

Exhibit D-1 below presents a deliverable schedule for the interim and summative evaluation reports.

Exhibit D-1 – Evaluation Deliverable Schedule



[24] The paid claims/eligibility extract for the 2016 – 2018 evaluation included all beneficiaries with a "Title XIX" designation who belonged to one of the Demonstration MEGs. The 2019 – 2021 extract excluded beneficiaries who lacked a secondary "SoonerCare Choice" designation (a separate field in the MMIS). PHPG applied the additional filter in consultation with the OHCA to ensure the data universe erred on the side of only containing beneficiaries who were enrolled in SoonerCare Choice.

[25] The HAN Care Managed subgroup also is included within the analysis of the HAN total population. The subgroup represents approximately two percent of the total.

[26] PHPG examined six-year trend lines on a measure-by-measure basis and excluded this data for any measures that appeared to be affected by the refinement of the claims/eligibility extract and matching methods between Demonstration periods. These were isolated within the CAD and COPD measures and, in approximately all cases, showed a greater than expected improvement from 2018 to 2019.

Evaluation Measures

Demonstration evaluation measures are listed below, by evaluation component and hypothesis/question. Exhibits D-2 through D-8 present the measures and their sources (e.g., HEDIS or CAHPS), as applicable. Appendix 1 (approved evaluation design) contains detailed specifications for each measure.

Evaluation of Health Access Networks – Access to Care

HAN performance in improving access to care was evaluated through the research question and measures presented below in Exhibit D-2.

Exhibit D-2 – HAN Access to Care Measures

Hypothesis/Research Question(s)	Measures	Source
Will the implementation and expansion of the HANs improve access to and the availability of health care services to SoonerCare beneficiaries served by the HANs?	• Children and adolescents' access to PCPs – 12 months to 19 years	HEDIS
	• Adults' access to preventive/ambulatory health services	HEDIS
	• Getting needed care – children and adults	CAHPS

Evaluation of Health Access Networks – Quality of Care

HAN performance in improving quality of care was evaluated through the research questions and measures presented below in Exhibit D-3.

Exhibit D-3 – HAN Quality of Care Measures

Hypothesis/Research Question(s)	Measures	Source
Will the implementation and expansion of the HANs improve the quality and coordination of health care services to SoonerCare beneficiaries served by the HANs, including those with one or more chronic illnesses?	• Number of HAN members engaged in care management • Asthma measures ○ Asthma medication ratio-5 to 18[27] ○ Asthma medication ratio-19 to 64 • Cardiovascular measures ○ Persistence of beta-blocker treatment after a heart attack ○ Cholesterol management for patients with cardiovascular conditions – LDL-C test • COPD measures ○ Use of spirometry testing in the assessment and diagnosis of COPD ○ Pharmacotherapy management of COPD exacerbation – 14 days ○ Pharmacotherapy management of COPD exacerbation – 30 days • Diabetes measures[28] ○ Percentage of members who had LDL-C test ○ Percentage of members who had retinal eye exam performed ○ Percentage of members who had Hemoglobin A1c (HbA1c) testing ○ Percentage of members who received medical attention for nephropathy	OHCA HEDIS (all remaining measures, except as noted)

[27] The approved evaluation design included two Asthma HEDIS measures which have been retired: Use of appropriate medications for people with asthma and medication management for people with asthma – 75 percent. PHPG replaced these measures with a successor measure, asthma medication ratio.
[28] The approved evaluation design included an additional Diabetes measure that has been retired: Percentage of members prescribed angiotensin converting enzyme inhibitors or angiotensin receptor blockers (ACE/ARB therapy).

Hypothesis/Research Question(s)	Measures	Source

Will the implementation and expansion of the HANs improve the quality and coordination of health care services to SoonerCare beneficiaries served by the HANs, including those with one or more chronic illnesses? *Continued*	• Hypertension measures[29]
	  ○ Percentage of members who had LDL-C test
	  ○ Percentage of members prescribed ACE/ARB therapy
	  ○ Percentage of members prescribed diuretics
	• Mental Health measures[30]
	  ○ Follow-up after hospitalization for mental illness – 7 days
	  ○ Follow-up after hospitalization for mental illness – 30 days	

Will the implementation and expansion of the HANs enhance the State's Patient Centered Medical Home program by making HAN care management support and practice enhancement available to more providers, as documented through an evaluation of PCP profiles that incorporates a review of utilization, disease guideline compliance and cost?	• Number and percentage of HAN-affiliated members aligned with a PCMH who has attained the highest level of OHCA accreditation[31,32]	OHCA

[29] The approved evaluation design included an additional Hypertension measure that has been retired: Percentage of members prescribed ACE/ARB therapy or diuretics with annual medication monitoring.
[30] Measures are "HEDIS-like", as the HEDIS specifications are based on counts of discharges and not unique member counts and the 1115 evaluation is based on a unique member count of those members with discharges, to accommodate minimum HAN and HMP enrollment tenures.
[31] The SoonerCare STCs use the term "accreditation". The OHCA typically uses the term "tier designation" to distinguish SoonerCare PCMH standards from those of national accrediting bodies. The two terms are used interchangeably in the report.
[32] The 2019 – 2023 evaluation design approved by CMS (and adopted by the OHCA to the extent practical for the 2016 – 2018 evaluation) defined this measure using PCMH counts by tier, rather than beneficiary counts. However, the largest HAN provides care primarily through university clinics and reports its network data at the clinic, rather than practitioner level. Beneficiary counts were selected as a more accurate measure.

Hypothesis/Research Question(s)	Measures	Source
Will beneficiaries enrolled with a HAN PCMH provider have higher satisfaction, compared to beneficiaries enrolled with a non-HAN PCMH?	• Rating of health care – children and adults • Rating of health plan – children and adults • Rating of personal doctor – children and adults	CAHPS (first three measures)
	• Rating of assistance with SDOH	PHPG targeted survey

Evaluation of Health Access Networks – Cost Effectiveness

HAN cost effectiveness was evaluated through the research question and measures presented below in Exhibit D-4.

Exhibit D-4 – HAN Cost Effectiveness Measures

Hypothesis/Research Question(s)	Measures	Source
Will the implementation and expansion of the HANs reduce cost associated with provision of health care services to SoonerCare beneficiaries served by the HANs?	• Emergency room utilization • Hospital admissions • Per member per month health expenditures	OHCA (MMIS)

Evaluation of Health Management Program – Access to Care

HMP performance in improving access to care was evaluated through the research questions and measures presented in Exhibit D-5.

Exhibit D-5 – HMP Access to Care Measures

Hypothesis/Research Question(s)	Measures	Source
Will the implementation of the HMP, including health coaches and practice facilitation, result in an increase in enrollment, as compared to baseline?	• Number of HMP beneficiaries engaged in health coaching	OHCA
Will incorporating health coaches into primary care practices result in increased contact with HMP beneficiaries by the PCP (measured through claims encounter data), as compared to baseline, when care management occurred (exclusively) via telephonic or face-to-face contact with a nurse care manager?	• Children and adolescents' access to PCPs – 12 months to 19 years • Adults' access to preventive/ambulatory health services[33]	HEDIS

[33] The approved evaluation design included a simple measure of PCMH contacts. PHPG replaced this measure with the two HEDIS preventive care measures in order to maximize use of validated measures and to align with the HAN Access to Care evaluation.

Evaluation of Health Management Program – Quality of Care

HMP performance in improving quality of care was evaluated through the research questions and measures presented below in Exhibit D-6.

Exhibit D-6 – HMP Quality of Care Measures

Hypothesis/Research Question(s)	Measures	Source
Will the implementation of the HMP result in a change in characteristics of the beneficiary population enrolled in the HMP (as measured through population characteristics, including disease burden and co-morbidity obtained through claims and algorithms) as compared to baseline?	• Number of chronic conditions • Percentage of members with physical/behavioral health co-morbidities	OHCA (MMIS)

Will the use of disease registry functions by the health coach (along with other coaching activities) improve the quality of care delivered to beneficiaries, as measured by changes in performance on the initial set of Health Care Quality Measures for Medicaid-Eligible Adults or CHIPRA Core Set of Children's Healthcare Quality Measures?[34]	• Asthma measures
	  ○ Asthma medication ratio-5 to 18[35]
	  ○ Asthma medication ratio-19 to 64
	• Cardiovascular (CAD and heart failure) measures
	  ○ Persistence of beta-blocker treatment after a heart attack
	  ○ Cholesterol management for patients with cardiovascular conditions – LDL-C test
		HEDIS (all measures, except as noted)

[34] The approved evaluation included four Agency for Healthcare Research and Quality (AHRQ) hospital utilization measures (COPD or asthma in older adults admission rate; asthma in younger adults' admission rate; heart failure admission rate; and diabetes short-term complications admission rate). PHPG determined there were too few cases to evaluate reliably and excluded the measures from the analysis. PHPG will re-examine the measures for the summative evaluation.

[35] The approved evaluation design included two Asthma HEDIS measures which have been retired: Use of appropriate medications for people with asthma and medication management for people with asthma – 75 percent. PHPG replaced these measures with a successor measure, asthma medication ratio.

Hypothesis/Research Question(s)	Measures	Source
Will the use of disease registry functions by the health coach (along with other coaching activities) improve the quality of care delivered to beneficiaries, as measured by changes in performance on the initial set of Health Care Quality Measures for Medicaid-Eligible Adults or CHIPRA Core Set of Children's Healthcare Quality Measures? *continued*	• COPD measures ○ Use of spirometry testing in the assessment and diagnosis of COPD ○ Pharmacotherapy management of COPD exacerbation – 14 days ○ Pharmacotherapy management of COPD exacerbation – 30 days • Diabetes measures[36] ○ Percentage of members who had LDL-C test ○ Percentage of members who had retinal eye exam performed ○ Percentage of members who had Hemoglobin A1c (HbA1c) testing ○ Percentage of members who received medical attention for nephropathy • Hypertension measures[37] ○ Percentage of members who had LDL-C test ○ Percentage of members prescribed ACE/ARB therapy ○ Percentage of members prescribed diuretics • Mental Health measures ○ Follow-up after hospitalization for mental illness – 7 days ○ Follow-up after hospitalization for mental illness – 30 days • Opioid measures ○ Use of opioids at high dosage in persons without cancer ○ Concurrent use of opioids and benzodiazepines	

[36] The approved evaluation design included an additional Diabetes measure that has been retired: Percentage of members prescribed angiotensin converting enzyme inhibitors or angiotensin receptor blockers (ACE/ARB therapy).

[37] The approved evaluation design included an additional Hypertension measure that has been retired: Percentage of members prescribed ACE/ARB therapy or diuretics with annual medication monitoring.

Hypothesis/Research Question(s)	Measures	Source

Will the use of disease registry functions by the health coach (along with other coaching activities) improve the quality of care delivered to beneficiaries, as measured by changes in performance on the initial set of Health Care Quality Measures for Medicaid-Eligible Adults or CHIPRA Core Set of Children's Healthcare Quality Measures? *continued*	• Social Determinants of Health
	  ○ Member awareness and use of available SDOH assistance (targeted member survey)
	  ○ Member satisfaction with SDOH assistance (targeted member survey)
		PHPG (targeted survey)

Will beneficiaries using HMP services have high satisfaction and attribute improvement in health status (if applicable) to the HMP?	• Overall satisfaction with health coach • Overall satisfaction with HMP • Change in health status (self-reported) • Contribution of HMP to improved health status (if applicable)	PHPG (targeted survey)

Evaluation of Health Management Program – Cost Effectiveness

HMP cost effectiveness was evaluated through the research questions and measures presented below in Exhibit D-7.

Exhibit D-7 – HMP Cost Effectiveness Measures

Hypothesis/Research Question(s)	Measures	Source
Will beneficiaries using HMP services have fewer ER visits compared to beneficiaries not receiving HMP services?	• Emergency room utilization	OHCA (MMIS)
Will beneficiaries using HMP services have fewer (admissions and) readmissions compared to beneficiaries not receiving HMP services?	• Hospital admission rate • Hospital readmission rate	OHCA (MMIS)
Will per member per month expenditures health for members enrolled in HMP be lower than would have occurred absent their participation?	• Per member per month expenditures[38]	OHCA (MMIS)

[38] The approved evaluation design included an additional step to calculate total expenditures inclusive of HMP administrative expenses. Telligen health coach FTE costs are reported to the OHCA but the health coaches perform a variety of tasks. In addition to direct care management, the health coaches also are responsible for supporting the practices in which they are embedded and for providing short term assistance to patients referred by the PCMH provider but not enrolled formally into the program. Health coaches also have administrative, documentation and reporting duties. PHPG will collaborate with the OHCA and vendor for the summative evaluation report to isolate direct care management activities/costs and activities/costs of other personnel supporting the health coaches (e.g., resource specialists) to allow for an accurate accounting of relevant administrative expenses.

Evaluation of Retroactive Eligibility Waiver

The appropriateness of the waiver of retroactive eligibility and its impact on beneficiary enrollment patterns and health status was evaluated through the research question and measures presented below in Exhibit D-8.

Exhibit D-8 – Retroactive Eligibility Waiver Appropriateness

Hypothesis/Research Question(s)	Measures	Source
Do eligible people subject to the retroactive eligibility waivers enroll in Medicaid at the same rate as other eligible people who have access to retroactive eligibility?[39]	• The number of individuals enrolled in Medicaid by eligibility group, by quarter • The number of new enrollees in Medicaid by eligibility group, by quarter • Probability of remaining enrolled in Medicaid for 12-, 18- 24-consecutive months, by eligibility group • Number of months with Medicaid coverage (average tenure)	OHCA (eligibility system)
Do beneficiaries subject to retroactive eligibility waivers who disenroll from Medicaid have shorter enrollment gaps than other beneficiaries who have access to retroactive eligibility?	• Possibility of re-enrolling in Medicaid after a gap in coverage of six months • Number of months without Medicaid coverage, up to six months	OHCA (eligibility system)
Do newly-enrolled beneficiaries subject to a waiver of retroactive eligibility have higher self-assessed health status than other newly-enrolled beneficiaries who have access to retroactive eligibility?	• Beneficiary self-reported health status; reported prior year utilization	PHPG (targeted survey)

[39] The approved evaluation design included a measure of the probability of completing the renewal process, by eligibility group. PHPG was unable to obtain data for this measure for the interim evaluation. If data becomes available it will be included in the summative evaluation report.

Hypothesis/Research Question(s)	Measures	Source
Do beneficiaries subject to the retroactive eligibility waiver have better health outcomes than other beneficiaries who have access to retroactive eligibility?	• Beneficiary self-reported health status; healthy days • Change in physical and mental health status, measured at baseline and at 12, 18 and 24 months	PHPG (targeted survey)

4. Data Sources

The SoonerCare evaluation was conducted using a variety of data sources, including eligibility/paid claims data and beneficiary and provider survey data.

Eligibility and Paid Claims Data

PHPG analysts were granted access to the OHCA MMIS and worked directly with eligibility and paid claims data for calculation of HEDIS rates, utilization trends and PMPM health expenditures. PHPG has worked within the OHCA MMIS for over a decade and performs routine quality checks to validate the completeness of the claims data, including comparison of month-to-month variance in expenditures by category-of-service, to identify and research potential data gaps. PHPG uses data smoothing and similar techniques to close gaps, if necessary.

PHPG also accounts for incurred but not received (IBNR) claims when performing utilization and expenditure calculations. The paid claims data for calendar years 2019 – 2021 was extracted in July 2022, making it unnecessary to apply claims completion factors to the data in this instance.

CAHPS Survey

The evaluation included CAHPS 5.0H survey data collected by the OHCA's contracted CAHPS surveyor, which uses a combined, mail/telephone/internet protocol to maximize response rates. The OHCA and surveyor furnished PHPG with respondent de-identified child and adult CAHPS data; the data included flags for respondents whose PCMH providers were affiliated with a HAN.

PHPG used the data to evaluate beneficiary responses to CAHPS questions, stratified by HAN enrollment status. Although the CAHPS surveyor conducted the surveys, PHPG was solely responsible for calculating and reporting the stratified results.

The most recently-published child and adult SoonerCare CAHPS reports, as well as archived reports, are posted on the OHCA's website[40]. The reports describe the surveyor's methodology in greater detail and provide complete survey findings.

Targeted Surveys

PHPG also conducted targeted surveys of beneficiaries and providers to capture data for evaluation measures in the SoonerCare HAN, SoonerCare HMP and retroactive eligibility components of the evaluation. The survey instrument used for the retroactive eligibility component of the evaluation included nationally-validated questions from CAHPS, BRFSS and NHIS, as recommended by CMS in its evaluation design guidance. PHPG's survey unit conducted all surveys by telephone, although providers also were given the option of completing and returning hard copies of the surveys.

[40] http://www.okhca.org/research.aspx?id=87

5. Analytic Methods

Overview

The evaluation data analysis consists of both exploratory and descriptive strategies and incorporates univariate, bi-variate, and multi-variate techniques. The analysis applied statistical and/or logical techniques to describe, summarize, and compare data within the State and across time.

Descriptive statistics are used to illustrate the basic features of the data and what they depict, and to provide simple summaries about the sample and the measures. They also are used to provide summaries about members and their outcomes.

An exploratory data analysis was employed to compare many variables in the search for organized patterns. Data was analyzed as rates, proportions, frequencies, and measures of central tendency, and/or qualitatively analyzed for themes. Where available, results are compared to national benchmarks for informational purposes only.

As appropriate, analytic methods included t-test, ANOVA, and coarsened exact matching with weighted t-test. These methods were used for comparing sample and population proportions and means against each other, specifically where one group had received treatment/intervention and another had not. (See below for additional detail on the coarsened exact matching procedure.)

T-tests and ANOVA are appropriate when granular (member-level) data is not available, but population-level proportions, means and standard deviations are, the outcome variable is continuous, and the objective is to determine whether the proportion or mean of a certain outcome variable of interest is significantly different between two or more groups. T-tests allow for comparison of proportions or means between two groups whereas ANOVA allows this to be done for more than two groups.

The analysis was performed both at a statewide level and stratified into urban and rural subgroups, subject to sample size limitations. The urban subgroup consists of the counties comprising the greater Oklahoma City, Tulsa, and Lawton metropolitan areas; the rural subgroup consists of the remainder of the State.

The traditionally accepted significance level ($p \leq 0.05$) was used for all comparisons.

Coarsened Exact Matching

Coarsened exact matching applies the concept that multiple covariates (e.g., gender, age) and specific characteristics (e.g., urban versus rural or presence/absence of a medical condition such as asthma or diabetes) may be salient covariates for determining health outcomes.

The analysis universe includes various archetypes of individuals with combinations of properties (e.g., female, under age 18, urban). The relative frequency of a particular archetype will vary

between the treatment and potential comparison group populations. To match and normalize the two populations more effectively, bins or coarsened values are constructed (e.g., coarsening into age cohorts, such as under21 – 30, 31 – 40 etc.) and used for the matching step.

Final weights then are determined by assigning a weight of 0 to all unmatched (comparison group and treatment) observations and a weight of 1 to all matched treatment observations. Matched comparison observations are given a positive weight (either fractional or greater than or equal to 1) such that the bin/archetype distribution of the comparison group (matched observations) can match that of the treatment group (matched observations).

The formula is as follows:

$$weight = \frac{\frac{treatment_n}{comparison_n}}{\frac{comparison_{total}}{treatment_{total}}}$$

Where:

> *$Treatment_{total}$ and $Comparison_{total}$ represent the total number of matched observations in the treatment and comparison groups, respectively; and*
>
> *Treatment and comparison represent the number of matched $treatment_n$ and $comparison_n$ groups, respectively, that belong to archetype (or bin) n (i.e., a specific combination/bin of attributes).*

The weight value is later applied in the t-test to ensure, when comparing the sample means, that the observations are appropriately weighted.

Controlling for Member Characteristics

The design relies on measures that by nature include participants with attributes that are highly correlated. For example, many measures focus on a specific diagnosis, medication, age band or treatment condition. The inclusion and exclusion criteria for each measure limits the variability of beneficiary characteristics that are observed in the data.

As part of the analysis, and based on the viability of the sample size, the evaluation controls for the following member demographic characteristics: age, gender, urban/rural status, aid category code and, for a subset of measures, claims history (prior year cost), using the following covariates for coarsened exact matching to produce weights:

$$Group \sim Age + Gender + Urban/Rural + ABD_{year} + ClaimsHistory_{year}$$

For geography (urban/rural), members were classified using the same parameters as for geographic stratification. The urban subgroup consisted of the counties comprising the greater Oklahoma City, Tulsa, and Lawton metropolitan areas; the rural subgroup consisted of the remainder of the State.

For aid category, members were classified either as Aged, Blind or Disabled (ABD) without Medicare or non-ABD (all others).

Claims history was included as a variable for HAN Care Managed and HMP utilization and expenditure measures, to better approximate the characteristics of these two populations. This was done by replicating the method used to identify candidates for care management. Both programs use data analytics that rely on claims history as a basis for selecting candidates for enrollment. Matching was performed on the basis of actual recruitment into care management and on prior year claim costs, with members in the 95th percentile identified as care management candidates. (Health status/claims history was not considered for HEDIS measures because HEDIS specifications serve an equivalent purpose at the diagnosis code level.)

Survey Samples

The sample size for the CAHPS survey was determined by the OHCA's CAHPS survey vendor. For all non-CAHPS beneficiary surveys, a repeated measures power analysis was used to determine the appropriate sample size. Effect size estimates used in the power calculation were based on the effect size of prior surveys of a similar nature conducted in the State by PHPG. The attrition rate of the same surveys from prior periods also was used to estimate the necessary sample size.

Isolating Effects of the Demonstration

The SoonerCare Choice Demonstration operates under managed care principles, with PCMH providers, SoonerCare HANs and the HMP performing key managed care functions. SoonerCare Choice members are not co-enrolled for care management in the HAN and HMP, making the populations within these programs unique in their composition.

The evaluation is designed to isolate the effects of the SoonerCare HANs and HMP from other activities through creation of a comparison group comprised of members not enrolled in either program (but still enrolled with a non-HAN affiliated PCMH).

6. Other Additions

None.

E. METHODOLOGICAL LIMITATIONS

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

- *Lack of true experimental control groups* – The evaluation design includes a comparison group that serves as a reasonable proxy for the two target populations. However, it is not a true experimental control group. PHPG used coarsened exact matching, as feasible, to maximize the validity of the comparison group for the evaluation.

- *SoonerCare HMP child/adolescent HEDIS measures* – The SoonerCare HMP beneficiary population is significantly older than the general SoonerCare population; fewer than 10 percent of HMP beneficiaries are children/adolescents versus 65 percent of the general population. The small universe of HMP beneficiaries under the age of 21 posed challenges when calculating rates for diagnosis-specific pediatric measures. PHPG identified the affected measures within the body of the report.

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

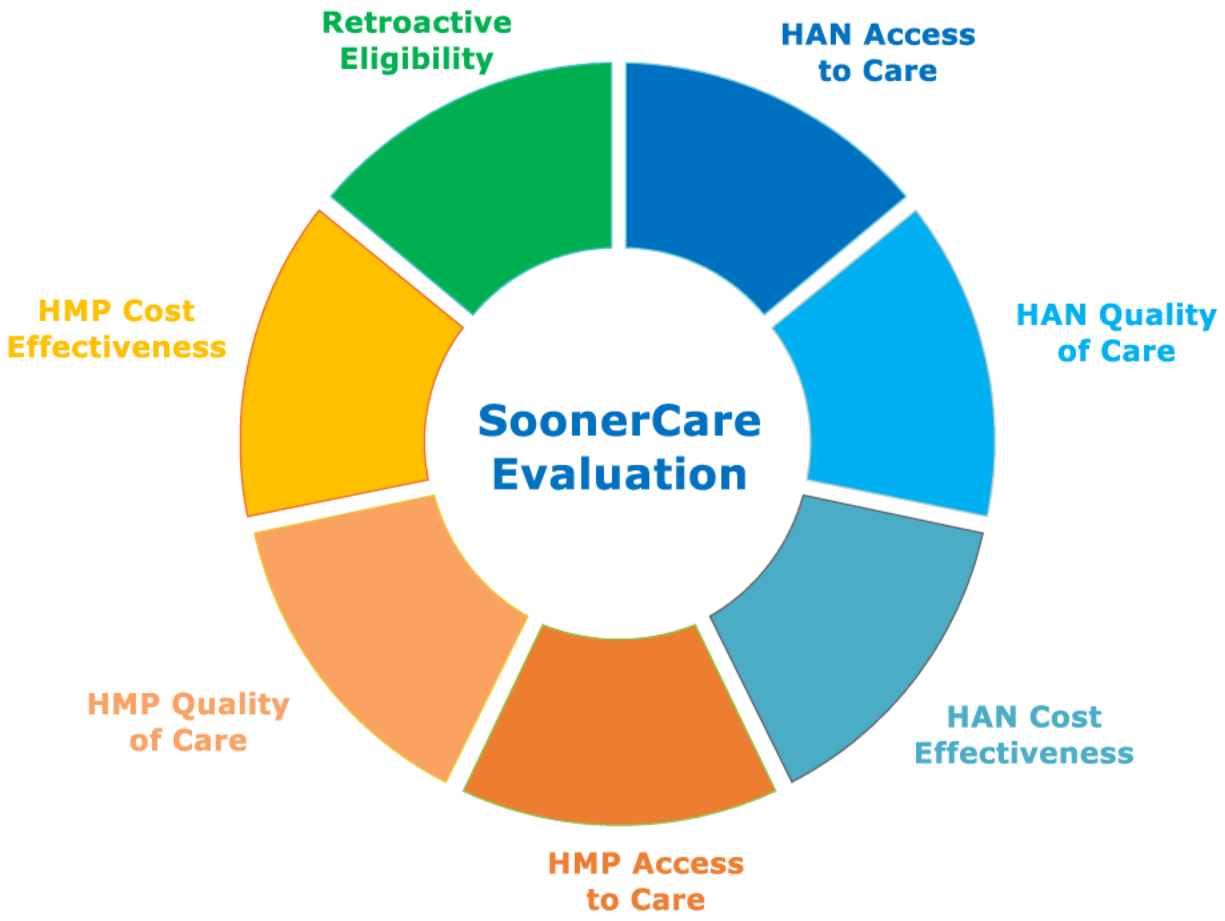
Caution should be exercised when interpreting results. The evaluation examined initiatives (HAN and HMP) and policies (retroactive eligibility) that were implemented prior to 2019. The findings, while descriptive, should not be interpreted as causal evidence for the impact of this Demonstration.

The evaluation also includes a large number of statistical significance tests. In any such test, there is the potential for a "false positive" finding; the large number of tests raises the possibility that one or more findings is due to chance.

In addition to these inherent limitations, the presence of the COVID-19 Public Health Emergency substantially disrupted health care utilization patterns during two of the three years addressed in the interim evaluation. The use of treatment and comparison groups for the majority of measures helps to mitigate the impact of the PHE on findings, to the extent both populations were exposed to the same disruptions in care (e.g., unavailability of office appointments for routine care needs).

The suspension of Most Title XIX disenrollments during the PHE directly affected the portion of the retroactive eligibility evaluation related to enrollment continuity. Descriptive statistics are provided in the interim evaluation but no conclusions can be drawn for the period falling under the PHE.

F. Results



Introduction

The results of the SoonerCare Choice evaluation are organized by hypothesis/research question. Findings are presented for each measure pertaining to a hypothesis/research question, followed by summary results across all measures. Supporting data for statistical analyses are included in report appendices, as noted within the narrative.

The SoonerCare HAN portion of the evaluation includes findings for the total HAN-aligned population ("HAN total") and, where available, for the subset of HAN members enrolled in care management ("HAN Care Managed"). The distinction is important, as the HAN total population is largely undifferentiated from the non-HAN population. Both groups receive primary care and referral services through their PCMH provider; the sole point of difference is the provider's status as affiliated or not affiliated with a SoonerCare HAN. The HAN Care Managed population is

differentiated in that its members receive additional support with clinical and social service needs through enrollment with a SoonerCare HAN care manager, usually a registered nurse.

The SoonerCare HAN and HMP evaluations present statewide data for all measures. The evaluations also stratify results into urban and rural geographic subgroups, where possible.

The majority of the SoonerCare HAN and HMP measures are reported for each of three years of the evaluation. The individual year results also are pooled to present a three-year average. Statistical significance for the three-year average results were calculated through application of Fisher's Combined Probability Test.

Caution should be exercised when reviewing individual year results and year-over-year changes, particularly with respect to chronic care HEDIS measures, where substantial variance may in part be an artifact of small treatment group population sizes. This applies in particular to the HAN Care Managed and HMP populations. The three-year pooled data is the most robust test of statistical significance between treatment and comparison group populations.

Conversely, a small number of population-level measures, such as for HEDIS preventive care, are susceptible to findings of statistical significance despite small absolute differences in rates between the treatment and comparison group. This applies in particular to the HAN total population and its comparison group.

A portion of the SoonerCare HAN and HMP measures also were evaluated in the previous Demonstration period (calendar years 2016 – 2018). Six-year trend lines for the treatment group are presented where available[41]. Comparison group trendlines are not included due to a change in the matching methodology from the previous period[42].

National benchmarks exist for a portion of the SoonerCare HAN and HMP HEDIS and CAHPS measures. These are presented where available. The HEDIS benchmark is the 50th percentile rate of the CMS 2020 Core Measure Set. The CAHPS benchmark is the 50th percentile rate among Medicaid health plans as reported in the NCQA 2021 Medicaid health plan Quality Compass dataset. Benchmark population characteristics were not matched to the treatment groups; the data is presented for informational purposes only.

The COVID-19 PHE overlapped with two of the three years of the evaluation. Caution should be exercised when reviewing findings due to the PHE's disruptive effect on the health care delivery system.

[41] See footnote 25.

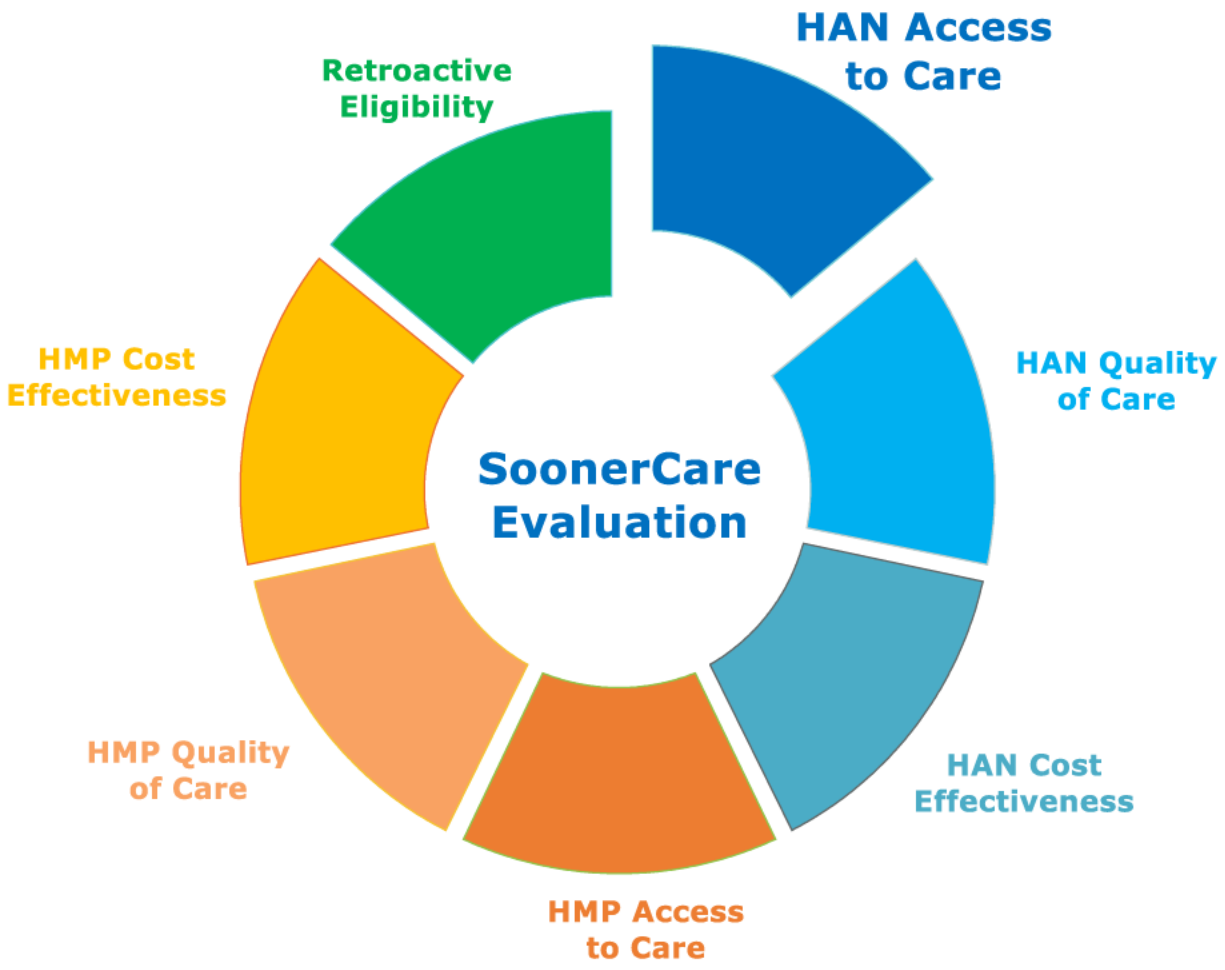
[42] Propensity Score Matching was used for the 2106 – 2018 evaluation. Coarsened Exact Matching was used for the 2019 – 2021 evaluation.

Supporting Appendices

Supporting data for narrative findings is included in a series of report appendices. Exhibit F-1 below identifies the contents within each appendix. The appendices specific to each analysis are identified again at the start of the individual results sections.

Exhibit F-1 – Supporting Appendices for Results

Appendix	Applies to	Contents
Appendix 2	HAN Analysis	CEM covariate balance tables (pre- and post-matching) for HEDIS, utilization and expenditure measures (2019 – 2021)
Appendix 3	HAN Analysis	Statistical significance test results (p<.005) for HEDIS, utilization and expenditure measures (2019 – 2021 and three-year pooled data)
Appendix 4	HAN Analysis	CEM covariate balance tables (pre- and post-matching) for CAHPS measures
Appendix 5	HAN Analysis	Statistical significance test results for CAHPS measures (HAN and comparison group)
Appendix 6	HAN Analysis	HAN member SDOH targeted survey instrument (HAN and comparison group)
Appendix 7	HAN Analysis	HAN-aligned PCMH targeted survey instrument
Appendix 8	HMP Analysis	CEM covariate balance tables (pre- and post-matching) for CAHPS measures (HMP and comparison group)
Appendix 9	HMP Analysis	Statistical significance test results for CAHPS measures (HMP and comparison group)
Appendix 10	HMP Analysis	CEM covariate balance tables (pre- and post-matching) for HEDIS, utilization and expenditure measures (2019 – 2021)
Appendix 11	HMP Analysis	Statistical significance test results (p<.005) for HEDIS, utilization and expenditure measures (2019 – 2021 and three-year pooled data)
Appendix 12	HMP Analysis	HMP member targeted survey instrument (SDOH section only)
Appendix 13	Retroactive Eligibility Analysis	Retroactive eligibility analysis survey instrument
Appendix 14	Retroactive Eligibility Analysis	CEM covariate balance tables (pre- and post-matching) for survey measures
Appendix 15	Retroactive Eligibility Analysis	Statistical significance test results for retroactive survey measures (population subject to waiver and comparison group)


HAN Access to Care
HAN Quality of Care
HAN Cost Effectiveness
HMP Access to Care
HMP Quality of Care
HMP Cost Effectiveness
Retroactive Eligibility
SoonerCare Evaluation

1. SoonerCare HAN Access to Care

Overview

The research question for this evaluation component asks: Will the implementation and expansion of the HANs improve access to and the availability of health care services to SoonerCare beneficiaries served by the HANs?

The OHCA, through its contracts with SoonerCare Health Access Networks, requires the HANs to promote improved access to care as part of advancing broader principles of managed care. The OHCA monitors HAN contractual compliance through a quarterly reporting process under which the HANs provide documentation on staffing and updates on activities related to improving access and quality of care. The HANs also submit annual reports summarizing the prior year's activities.

The required access activities include, among others:

- Ensuring access to physical health specialty care for beneficiaries with a HAN-affiliated PCMH;
- Ensuring behavioral health network adequacy and availability; and
- Generating care gap lists for the HAN and/or PCMH to use in identifying beneficiaries who are due for a primary care visit or are potential candidates for care management based on underlying health needs.

HAN Access to Care Measures

Exhibit F-2 on the following page presents the HAN access to care measures and identifies:

- Data sources
- Subgroups evaluated (if any)
- Presence or absence of a national benchmark
- Presence or absence of comparative data from the prior Demonstration period

Supporting Appendices

Appendix 2 contains CEM covariate balance tables for HEDIS measures. Appendix 3 contains statistical significance test results for HEDIS measures. Appendix 4 contains CEM covariate balance tables for CAHPS measures. Appendix 5 contains statistical significance tests results for CAHPS measures.

Exhibit F-2 - HAN Access to Care Measures - Overview

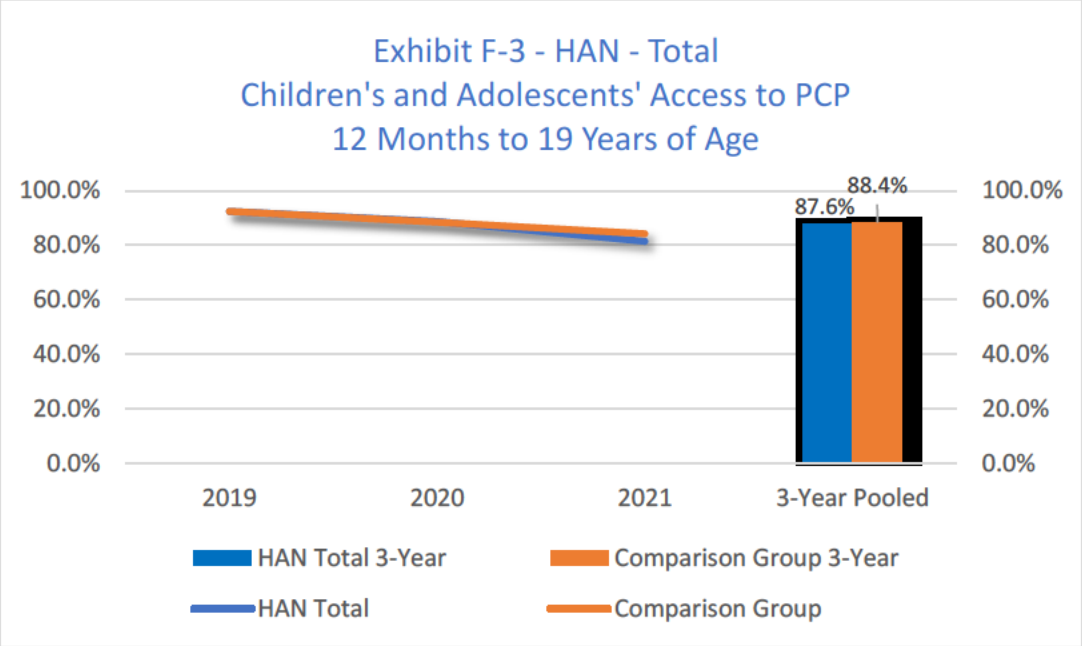
Measures	Source	HAN Care Managed Subgroup	Geographic Subgroups	National Benchmark	Prior Period Data
Children and adolescents' access to PCPs – 12 months to 19 years Percentage of beneficiaries 12 months to 19 years of age who had a visit with a PCP during the measurement year.	HEDIS	***Yes***	***Yes***	No	No[43]
Adults' access to preventive/ambulatory health services Percentage of beneficiaries 20 years of age and older who had an ambulatory or preventive care visit in the measurement year.	HEDIS	***Yes***	***Yes***	No	***Yes***
Getting Needed Care – children and adults Percentage of beneficiaries (adults and parents/caretakers of children) who reported "always" getting needed care. "Getting Needed Care" is a composite measure consisting of two questions, the first of which asks about getting necessary care, tests or treatment[44] and the second of which asks about getting appointments with specialists as soon as needed[45]. The composite is a simple average of the individual measure percentages.	CAHPS	No	No	***Yes***	***Yes***

[43] Consolidated measure for 12 months to 19 years introduced for the HAN portion of the evaluation in current period. Prior period reported multiple age cohorts.
[44] In the last 6 months, how often was it easy to get the care, tests, or treatment you (your child) needed?
[45] In the last 6 months, how often did you (your child) get an appointment to see a specialist as soon as you needed?

Children and Adolescents' Access to PCPs – 12 Months to 19 Years

Findings – HAN Total Population

Approximately 88 percent of HAN total members and comparison group members were compliant on this measure across the three years (Exhibit F-3). The compliance rate for both populations declined from 2019 to 2021.



The difference between the HAN beneficiary and comparison group compliance rates was statistically significant in each of the individual years. It also was statistically significant for the three-year pooled data (Exhibit F-4)[46].

Exhibit F-4 – HAN (Total) – Children's & Adolescents' Access to PCP – 12 Months to 19 Years

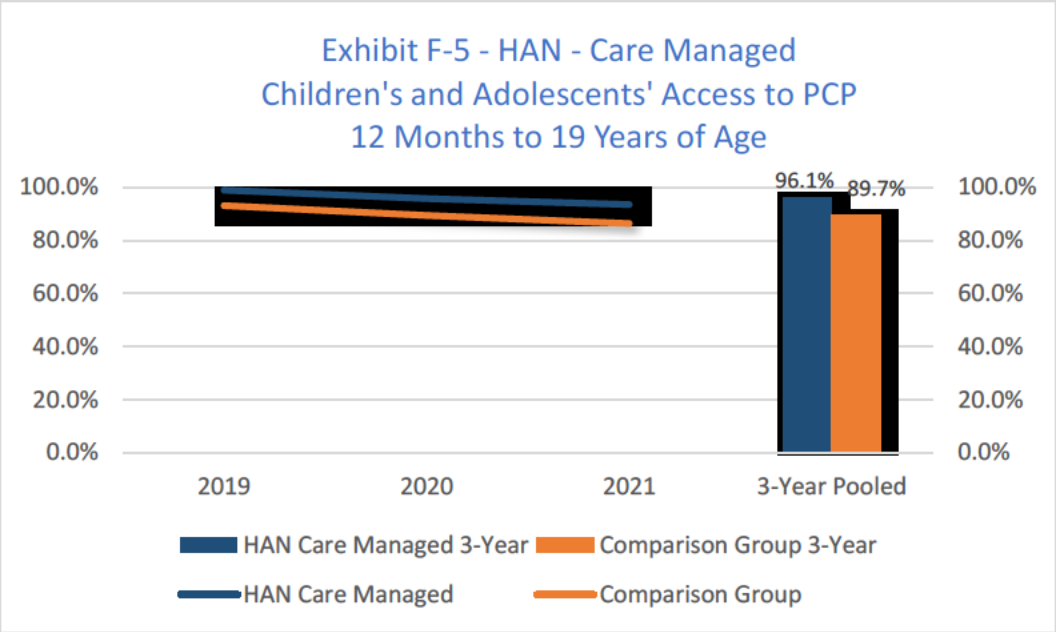
	2019	2020	2021	3-Year Pooled
HAN (Total)	92.5%	88.7%	81.5%	87.6%
Comparison Group	92.4%	88.5%	84.3%	88.4%
Difference	0.1%‡	0.2%‡	(3.8%)‡	(0.8%)‡

‡ HAN rate differs from comparison group rate by a statistically significant amount (95% confidence level)

[46] The finding of statistical significance despite the small percentage difference is an artifact of the large population sizes for both groups.

Findings – HAN Care Managed Population

Approximately 96 percent of HAN Care Managed members and 90 percent of comparison group members were compliant on this measure across the three years (Exhibit F-5). The compliance rate for both populations declined from 2019 to 2021.



The difference between the HAN Care Managed and comparison group compliance rates was statistically significant in each of the individual years. It also was statistically significant for the three-year pooled data (Exhibit F-6).

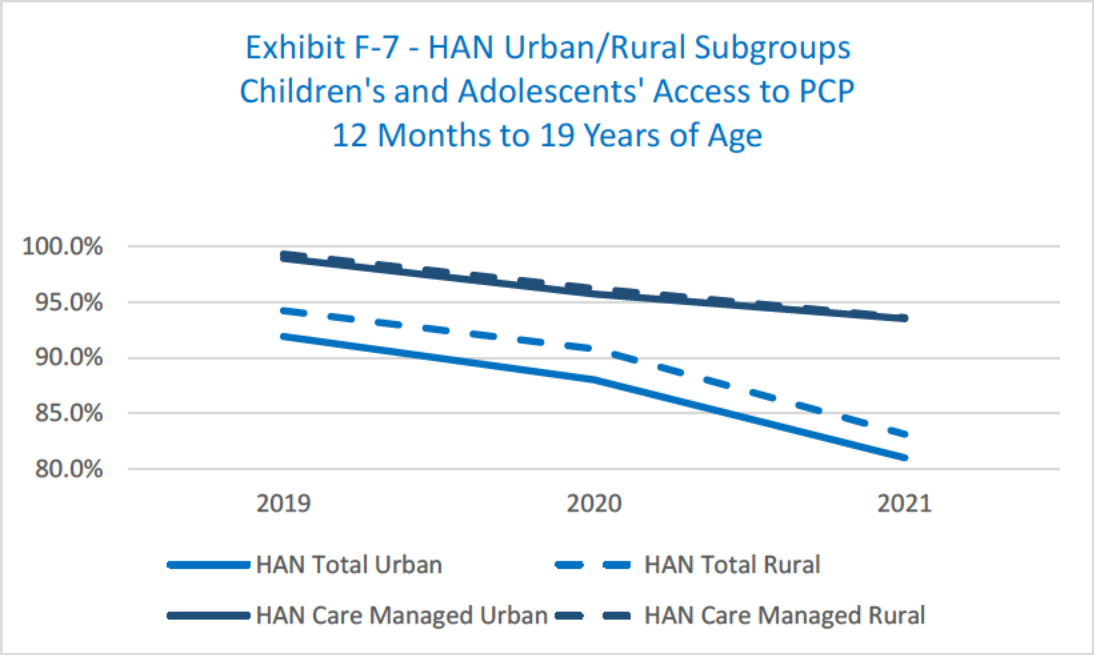
Exhibit F-6 – HAN (Care Managed) – Children & Adolescents' Access to PCP – 12 Months to 19 Years

	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)

Findings – HAN Total and Care Managed Populations – Urban and Rural Subgroups

The HAN total rural subgroup compliance rate was slightly higher than the urban subgroup rate; both trended downward from 2019 to 2021. The HAN Care Managed urban and rural subgroup compliance rates were very similar; both also trended downward (Exhibit F-7).



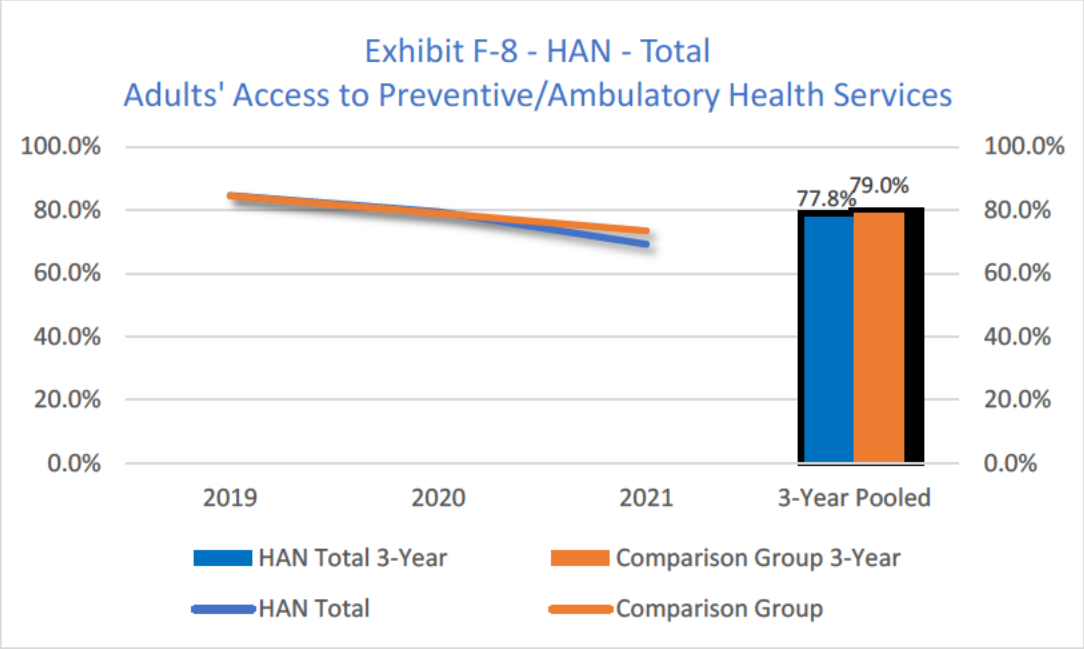
Note: Y-axis does not begin at 0.

	Subgroup	2019	2020	2021
HAN (Total)	**Urban**	91.9%	88.0%	81.0%
	Rural	94.2%	90.8%	83.1%
HAN (Care Managed)	**Urban**	98.9%	95.7%	93.5%
	Rural	99.3%	96.2%	93.6%

Adults' Access to Preventive/Ambulatory Health Services

Findings – HAN Total Population

Approximately 78 percent of HAN total members and 79 percent of comparison group members were compliant on this measure across the three years (Exhibit F-8). The compliance rate for both populations declined from 2019 to 2021.



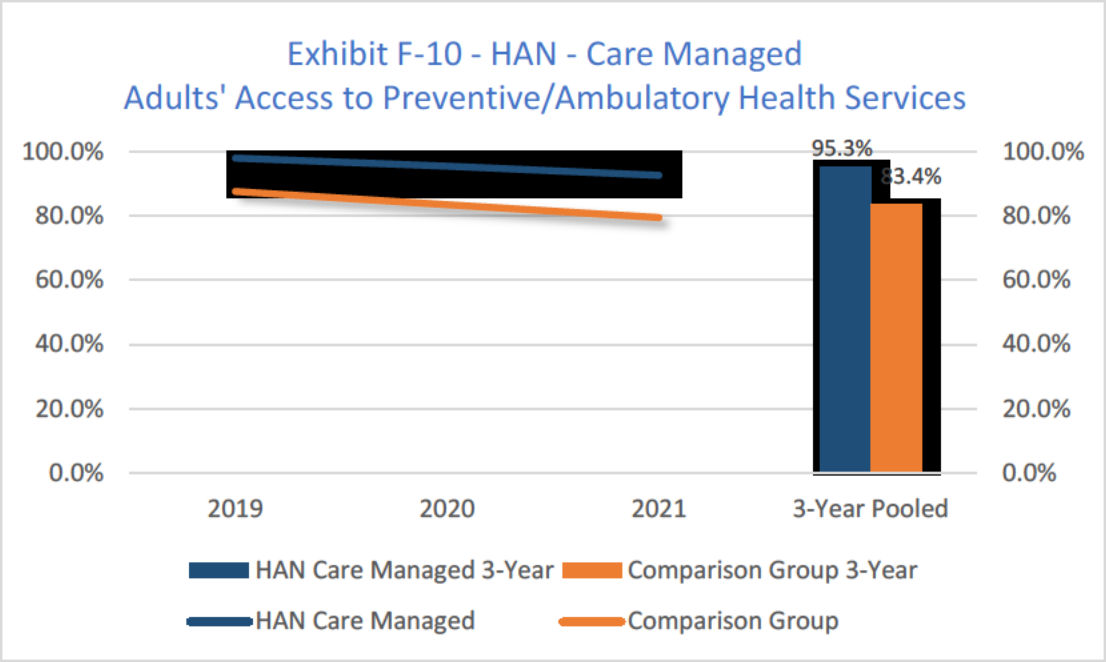
The difference between the HAN total and comparison group compliance rates was statistically significant in each of the individual years. It also was statistically significant for the three-year pooled data (Exhibit F-9)[47].

Exhibit F-9 – HAN (Total) – Adults' Access to Preventive/Ambulatory Health Services				
	2019	2020	2021	3-Year Pooled
HAN (Total)	84.6%	79.5%	69.3%	77.8%
Comparison Group	84.5%	79.1%	73.5%	79.0%
Difference	0.1%‡	0.4%‡	(4.2%)‡	(1.2%)‡
‡ HAN rate differs from comparison group rate by a statistically significant amount (95% confidence level)				

[47] The finding of statistical significance despite the small percentage difference is an artifact of the large population sizes for both groups.

Findings – HAN Care Managed Population

Approximately 95 percent of HAN Care Managed members and 83 percent of comparison group members were compliant on this measure across the three years (Exhibit F-10). The compliance rate for both populations declined from 2019 to 2021.



The difference between the HAN Care Managed and comparison group compliance rates was statistically significant in each of the individual years. It also was statistically significant for the three-year pooled data (Exhibit F-11).

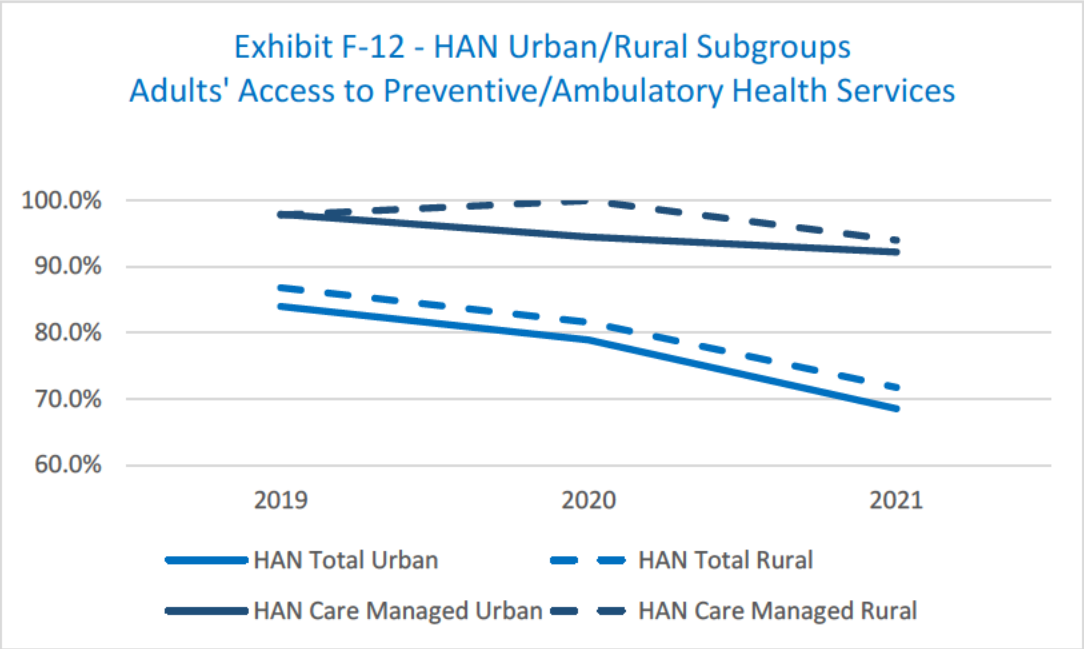
Exhibit F-11 – HAN (Care Managed) – Adults' Access to Preventive/ Ambulatory Health Services

	2019	2020	2021	3-Year Pooled
HAN (Care Managed)	97.9%	95.4%	92.5%	95.3%
Comparison Group	87.5%	83.4%	79.4%	83.4%
Difference	10.4‡	12.0%‡	13.1%‡	11.9%‡

‡ HAN rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HAN Total and Care Managed Populations – Urban and Rural Subgroups

The HAN total urban and rural subgroups recorded similar compliance rates; both trended downward from 2019 to 2021. The HAN Care Managed urban and rural subgroups also recorded similar compliance rates and also trended downward, with the exception of the rural subgroup rate from 2019 to 2020 (Exhibit F-12).

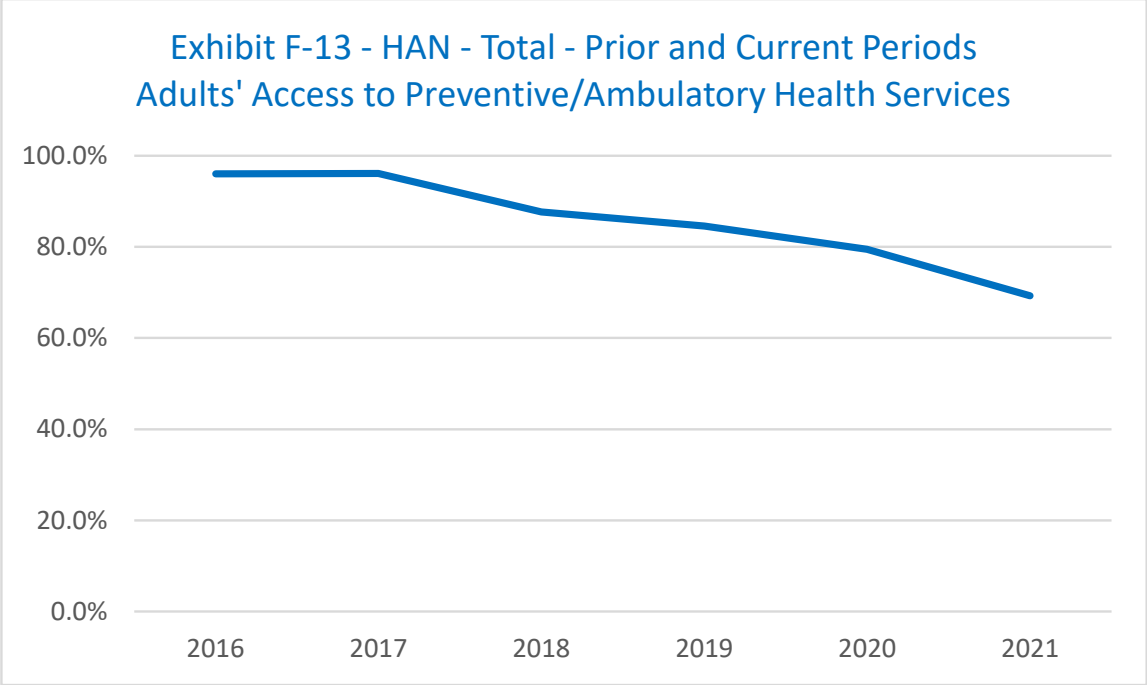


Note: Y-axis does not begin at 0.

	Subgroup	2019	2020	2021
HAN (Total)	**Urban**	84.0%	78.9%	68.5%
	Rural	86.8%	81.6%	71.7%
HAN (Care Managed)	**Urban**	97.9%	94.5%	92.2%
	Rural	97.8%	100.0%	94.0%

Findings – HAN Total Population – Comparison to Prior Waiver Period

This measure also was evaluated for the HAN total population in the prior waiver period (2016 to 2018). The compliance rate declined from 96 percent in 2016 to approximately 69 percent in 2021 (Exhibit F-13). (Note that 2020 and 2021 include the period affected by the COVID-19 PHE.)

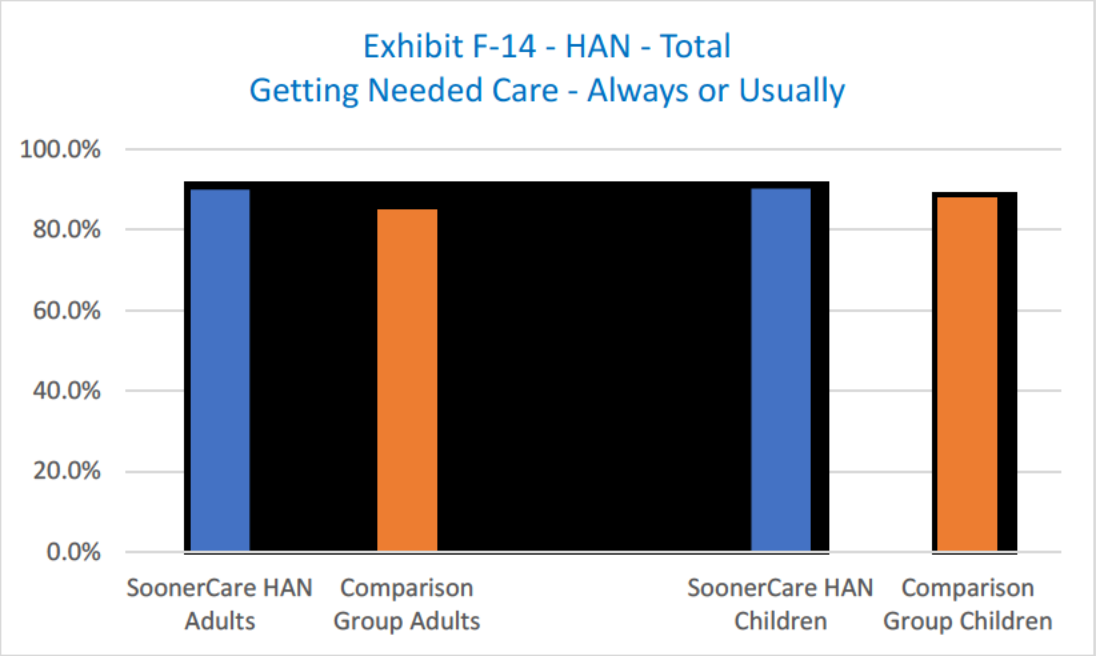


	2016	2017	2018	2019	2020	2021
HAN (Total)	96.0%	96.1%	87.7%	84.6%	79.5%	69.3%

Getting Needed Care – Children and Adults

Findings – HAN Total Population

Ninety percent of HAN adult members and approximately 85 percent of comparison group adult members reported always or usually being able to get needed care[48]. Approximately 90 percent of parents/caretakers of HAN child members and 88 percent of comparison group parents/caretakers reported always or usually being able to get needed care for their children (Exhibit F-14).



The difference between the HAN total and comparison group rates was not statistically significant for either group (Exhibit F-15).

Exhibit F-15 – HAN (Total) – Getting Needed Care – Percent Responding Always or Usually		
	Adults	Children
HAN (Total)	90.0%	90.2%
Comparison Group	85.1%	87.8%
Difference	4.9%	2.4%
‡ HAN rate differs from comparison group rate by a statistically significant amount (95% confidence level)		

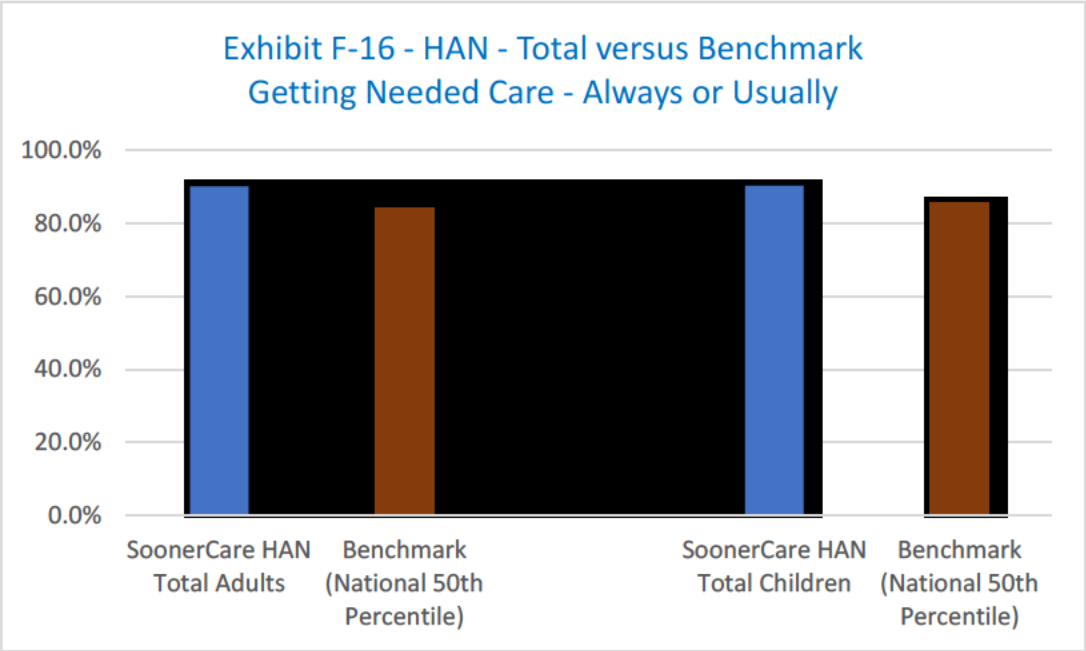
[48] Composite measure (simple average) of two CAHPS survey questions: In the last six months, how often was it easy to get the care, tests or treatment you (your child) needed? In the last 6 months, how often did you (your child) get an appointment to see a specialist as soon as you needed?

Findings – HAN Total Population and National Benchmark

The rate for SoonerCare HAN adults exceeded the 2021 national benchmark rate by approximately six percentage points.

The rate for SoonerCare HAN children exceeded the 2021 national benchmark rate by approximately five percentage points (Exhibit F-16).

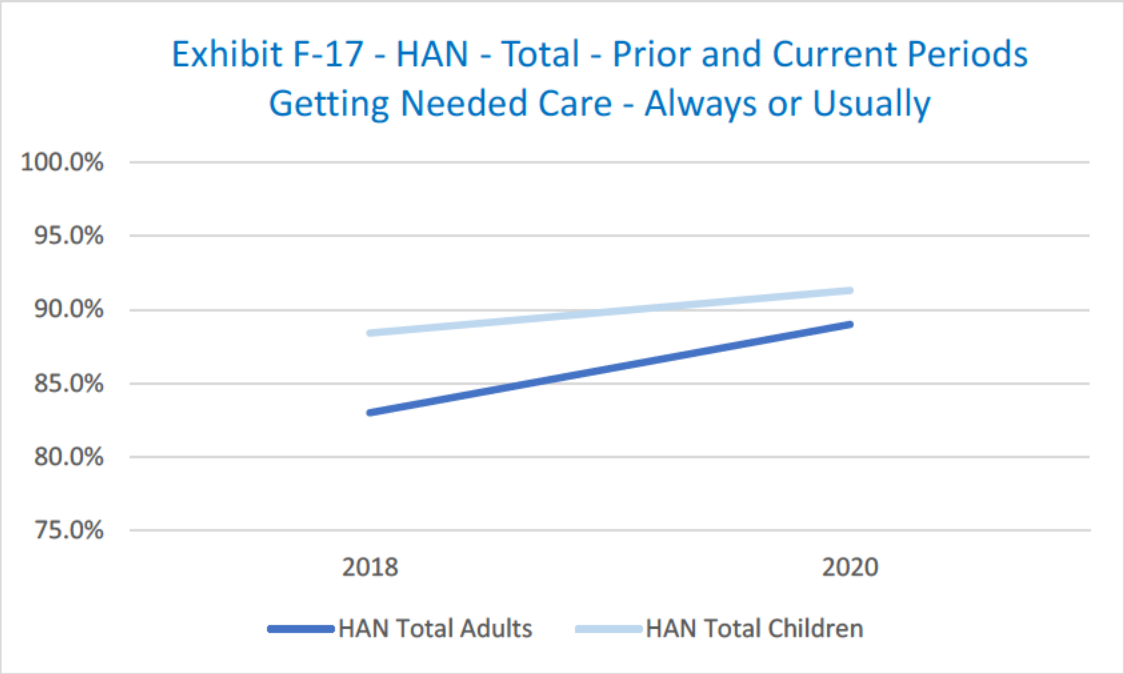
(Caution: the benchmark population characteristics were not matched to the OHCA groups to minimize differences in the populations. The data is presented for informational purposes only.)



	HAN Adult	Benchmark	HAN Child	Benchmark
HAN (Total)	96.0%	96.1%	84.6%	79.5%

Findings – HAN Total Population – Comparison to Prior Waiver Period

This measure also was calculated for the HAN total population in the 2018 CAHPS survey period. The percentage responding always or usually increased by nine percentage points among adults and approximately three percentage points among parents/caretakers of children (Exhibit F-17).



Note: Y-axis does not begin at 0.

	HAN Adult 2018	HAN Adult 2020	HAN Child 2018	HAN Child 2020
HAN (Total)	83.0%	89.0%	88.4%	91.3%

HAN Access to Care – Summary

The SoonerCare HAN total and comparison group populations differed by a statistically significant amount on the two HEDIS preventive care measures, with the comparison group outperforming the HAN beneficiary population. The 2019 to 2021 trend for both measures was downward.

The SoonerCare HAN Care Managed member and comparison group populations also differed by a statistically significant amount on the two HEDIS preventive care measures, with the HAN population outperforming the comparison group. The 2019 to 2021 trend for both measures again was downward.

There was no statistically significant difference between the SoonerCare HAN total member and comparison group populations with respect to the CAHPS Getting Needed Care measure (Exhibit F-18).

Exhibit F-18 – HAN Access to Care Measures – Summary

Measures	HAN Total versus Comparison Group	HAN 2019-2021 Trend	HAN Care Managed versus Comparison Group	HAN Care Managed 2019 – 2021 Trend
Children and adolescents' access to PCPs – 12 months to 19 years	✦	▼	✦	▼
Adults' access to preventive/ambulatory health services	✦	▼	✦	▼
Getting needed care – children	✦			
Getting needed care – adults	✦			

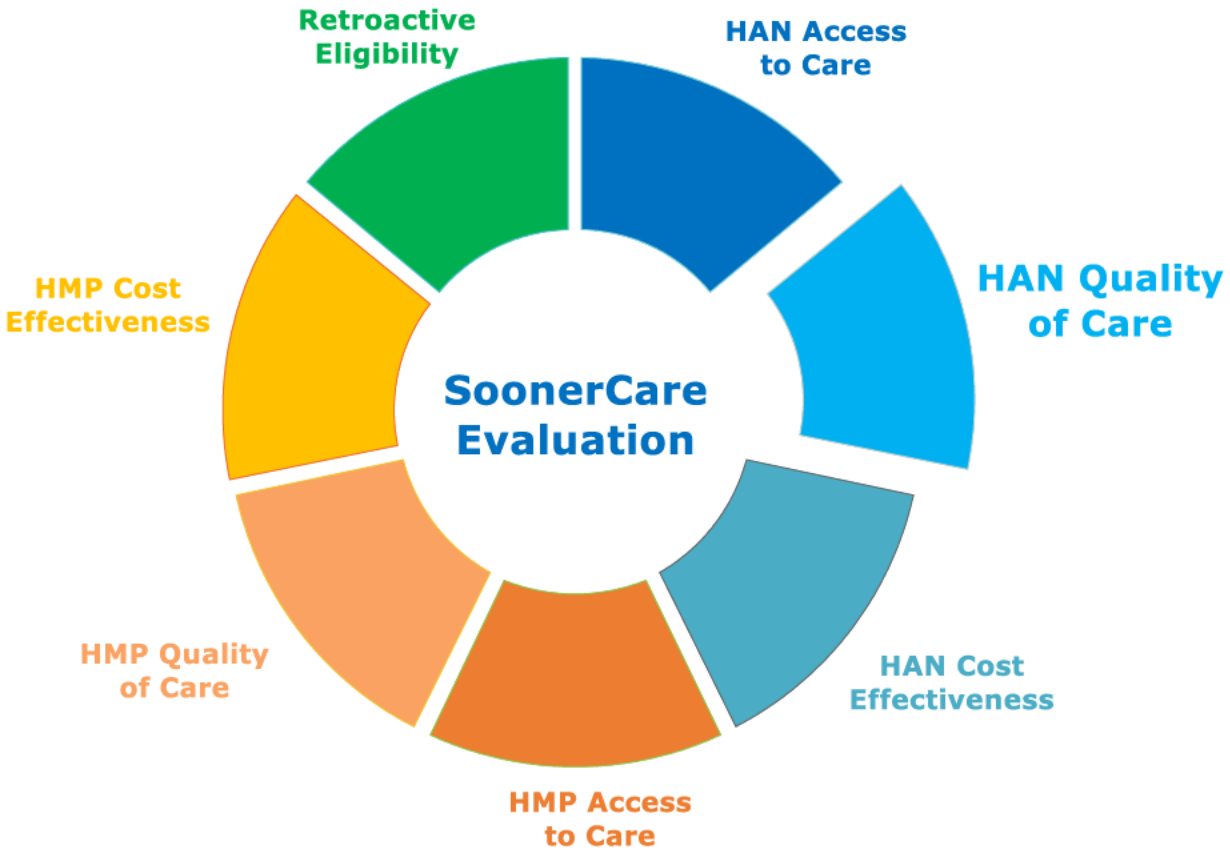
✦ HAN exceeds comparison group by a statistically significant amount (3-year pooled)

✦ No statistically significant difference (3-year pooled)

✦ Comparison group exceeds HAN by a statistically significant amount (3-year pooled)

▲ 2019 – 2021 trend is upward

▼ 2019 – 2021 trend is downward


Retroactive Eligibility
HAN Access to Care
HAN Quality of Care
HAN Cost Effectiveness
HMP Access to Care
HMP Quality of Care
HMP Cost Effectiveness
SoonerCare Evaluation

2. HAN Quality of Care

Overview

The OHCA, through its contracts with SoonerCare Health Access Networks, requires the HANs to promote improved quality of care by assisting affiliated PCMH providers to obtain higher levels of accreditation[49] and by undertaking care coordination/management of beneficiaries' "complex health care needs". The complex health care needs population includes individuals who are frequent users of the emergency room, individuals enrolled in the Medicaid pharmacy lock-in program and others with targeted chronic conditions, such as asthma and diabetes, and/or social service needs presenting potential barriers to care (social determinants of health).

Care management is defined to encompass outreach, follow-up and education to members and affiliated providers. Required activities include, among others:

- Providing education and care management to beneficiaries who are frequent users of the emergency room;
- Providing care coordination and care management to beneficiaries with complex/chronic conditions, such as persons with asthma or diabetes;
- Undertaking care management initiatives to improve health outcomes for targeted populations; and
- Establishing multi-disciplinary care management teams and engaging affiliated PCMH providers in discharge planning and care management initiatives.

HAN Quality of Care Measures

Exhibit F-19 on the following page presents the HAN access to care measures and identifies:

- Data sources
- Subgroups evaluated (if any)
- Presence or absence of a national benchmark
- Presence or absence of comparative data from the prior Demonstration period

Supporting Appendices

Appendix 2 contains CEM covariate balance tables for HEDIS measures. Appendix 3 contains statistical significance test results for HEDIS measures. Appendix 4 contains CEM covariate balance tables for CAHPS measures. Appendix 5 contains statistical significance tests results for CAHPS measures. Appendix 6 contains the HAN member SDOH targeted survey instrument. Appendix 7 contains the HAN-aligned PCMH targeted survey instrument.

[49] As described earlier, the SoonerCare PCMH program includes three tiers with escalating participation requirements related to access (e.g., office hours) and patient care management (e.g., contacting patients after an emergency room visit): 1 – Entry; 2 – Advanced; and 3- Optimal.

Exhibit F-19 - Quality of Care Measures - Overview

Measures	Source	HAN Care Managed Subgroup	Geographic Subgroups	National Benchmark	Prior Period Data
Number of HAN beneficiaries engaged in care management Number of HAN members engaged in care management at any point during the measurement year.	OHCA	***Yes***	No	No	No
Asthma – Medication Ratio Percentage of members ages 5 to 18 and 19 to 64 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medication of 0.50 or greater during the measurement year.	HEDIS	***Yes***	***Yes***	***Yes***	***Yes***
Cardiovascular – Persistence of Beta Blocker Treatment after a Heart Attack Percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.	HEDIS	***Yes***	***Yes***	No	No
Cardiovascular – Cholesterol Management for Patients with Cardiovascular Conditions – LDL-C Test Percentage of members 18 to 75 years of age with cardiovascular disease who had an LDL-C test during the measurement year.	HEDIS	***Yes***	***Yes***	No	No
COPD – Use of Spirometry Testing in the Assessment and Diagnosis of COPD Percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.	HEDIS	***Yes***	***Yes***	No	No

Measures	Source	HAN Care Managed Subgroup	Geographic Subgroups	National Benchmark	Prior Period Data
COPD – Pharmacotherapy Management of COPD Exacerbation – 14 Days and 30 Days Percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or emergency room visit on or between January 1 to November 30 of the measurement year and who were dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event and within 30 days of the event.	HEDIS	***Yes***	***Yes***	No	No
Diabetes – Percentage of Members who had LDL-C Test Percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who had LDL-C performed.	HEDIS	***Yes***	***Yes***	No	***Yes***
Diabetes – Percentage of Members who had Retinal Eye Exam Performed Percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who had retinal eye exam performed.	HEDIS	***Yes***	***Yes***	No	***Yes***
Diabetes - Percentage of Members who had Hemoglobin A1c (HbA1c) Testing Percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who had Hemoglobin A1c (HbA1c) testing performed.	HEDIS	***Yes***	***Yes***	No	***Yes***
Diabetes - Percentage of Members who Received Medical Attention for Nephropathy Percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who received medical attention for nephropathy.	HEDIS	***Yes***	***Yes***	No	***Yes***
Hypertension – Percentage of Members who had LDL-C Test Percentage of members 18 years of age and older with hypertension who had an LDL-C test performed.	HEDIS	***Yes***	***Yes***	No	***Yes***

Measures	Source	HAN Care Managed Subgroup	Geographic Subgroups	National Benchmark	Prior Period Data
Hypertension – Percentage of Members Prescribed ACE/ARB Therapy Percentage of members 18 years of age and older with hypertension who were prescribed angiotensin converting enzyme inhibitors or angiotensin receptor blockers (ACE/ARB therapy).	HEDIS	***Yes***	***Yes***	No	***Yes***
Mental Health – Follow-up after Hospitalization for Mental Illness – 7 Days and 30 Days Percentage of members 6 to 20 years of age and 21 years and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within seven days after discharge and within 30 days after discharge.	HEDIS-like[50]	No[51]	***Yes***	***Yes***	***Yes***
Rating of Assistance with SDOH – Children and Adults Rating of importance of help and satisfaction, among HAN members receiving assistance with social determinants of health (SDOH)	PHPG Targeted Survey	***Yes***	No	No	No
Rating of Healthcare – Children and Adults Rating of health care (or child's health care) in the last six months, using a scale from 0 to 10, where "0" represented the worst possible health care and "10" the best possible health care.	CAHPS	No	No	***Yes***	***Yes***

[50] Measures are "HEDIS-like", as the HEDIS specifications are based on counts of discharges and not unique member counts and the 1115 evaluation is based on a unique member count of those members with discharges, to accommodate minimum HAN and HMP enrollment tenures.
[51] Insufficient population size to perform 7-day or 30-day analysis.

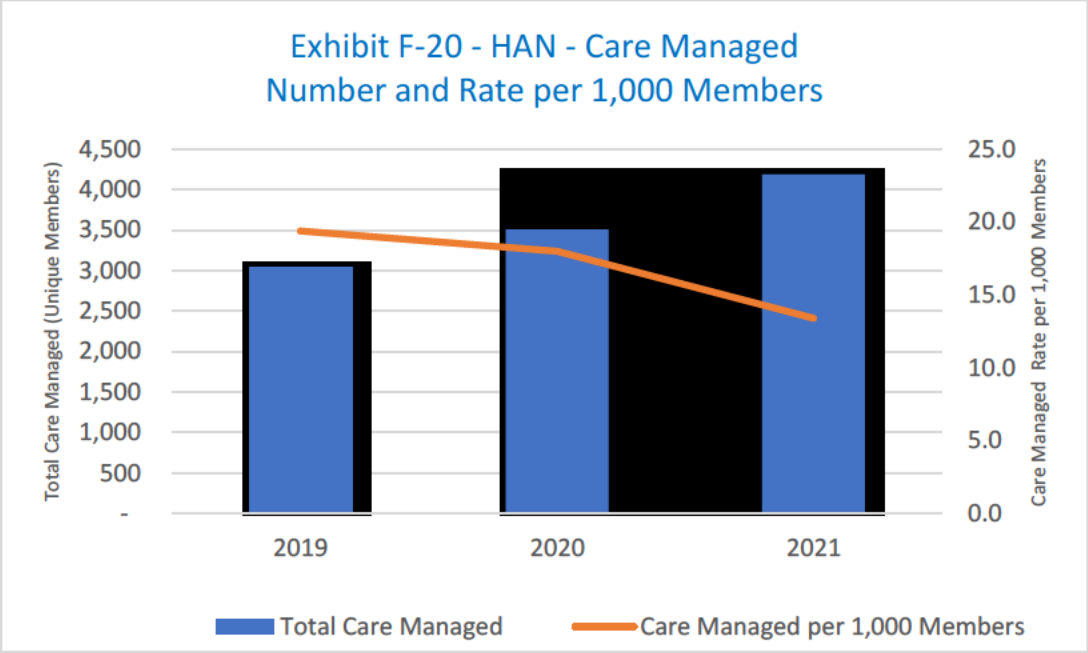
Measures	Source	HAN Care Managed Subgroup	Geographic Subgroups	National Benchmark	Prior Period Data
Rating of Health Plan – Children and Adults Rating of health plan (or child's health plan) in the last six months, using a scale from 0 to 10, where "0" represented the worst possible health plan and "10" the best possible health plan.	CAHPS	No	No	***Yes***	***Yes***
Rating of Personal Doctor – Children and Adults Rating of personal doctor (or child's personal doctor) in the last six months, using a scale from 0 to 10, where "0" represented the worst possible doctor and "10" the best possible doctor.	CAHPS	No	No	***Yes***	***Yes***
PCMH Accreditation Number and percentage of HAN-affiliated members aligned with a PCMH who has attained the highest level of OHCA accreditation[52].	OHCA MMIS	No	No	No	***Yes***
PCMH Provider Satisfaction – Practice Support Provider satisfaction with HAN practice support activities	PHPG Targeted Survey	No	No	No	No
PCMH Provider Satisfaction – Chronic Disease Guidelines PCMH provider adoption of chronic care disease guidelines (self-reported)	PHPG Targeted Survey	No	No	No	No

[52] The approved evaluation design description is for a simple count of providers by tier. The results instead are being reported based on HAN membership within each tier, to more accurately measure the relative importance of each tier within the HAN structure. (Practices in higher tiers, on average, are larger and serve more members.)

Number of HAN Beneficiaries Engaged in Care Management

Findings – HAN Care Managed Population

The absolute number of SoonerCare HAN members engaged in care management increased from 2019 to 2021, while the rate per 1,000 members declined. Total HAN enrollment approximately doubled during the three-year period, which contributed to the decline in rate per 1,000 members (Exhibit F-20).

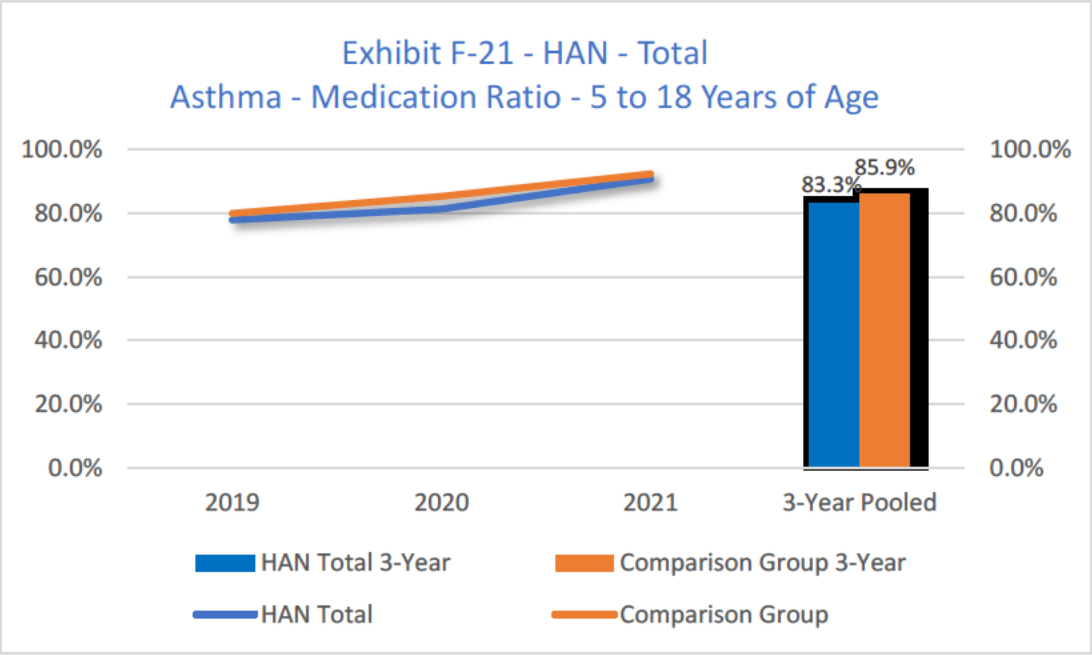


	2019	2020	2021
Total Care Managed	3,037	3,511	4,192
Care Managed per 1,000 Members	19.4	18.0	13.4

Asthma – Medication Ratio – Ages 5 to 18

Findings – HAN Total Population

Approximately 83 percent of HAN total members and 86 percent of comparison group members were compliant on this measure across the three years (Exhibit F-21). The compliance rate for both populations rose from 2019 to 2021.



The difference between the HAN total and comparison group compliance rates was statistically significant in each of the individual years. It also was statistically significant for the three-year pooled data (Exhibit F-22).

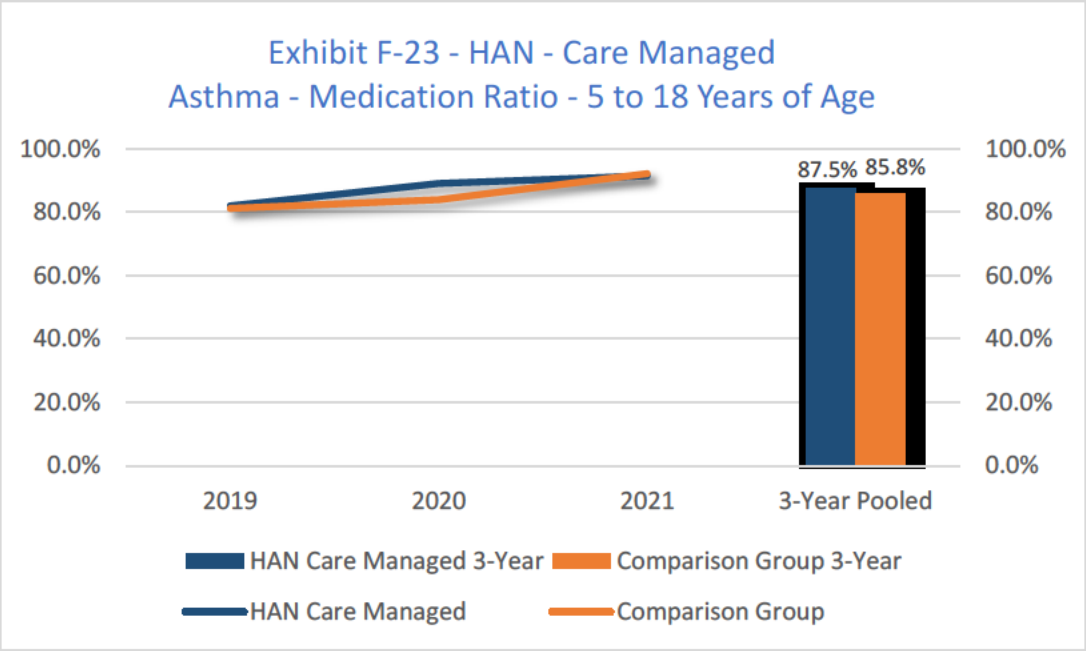
Exhibit F-22 – HAN (Total) – Asthma – Medication Ratio – 5 to 18 Years of Age

	2019	2020	2021	3-Year Pooled
HAN (Total)	77.9%	81.3%	90.8%	83.3%
Comparison Group	80.0%	85.3%	92.4%	85.9%
Difference	(2.1%)‡	(4.0%)‡	(1.6%)‡	(2.6%)‡

‡ HAN rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HAN Care Managed Population

Approximately 88 percent of HAN Care Managed members and approximately 86 percent of comparison group members were compliant on this measure across the three years (Exhibit F-23). The compliance rate for both populations rose from 2019 to 2021.



The difference between the HAN Care Managed and comparison group compliance rates was not statistically significant in any of the individual years. It also was not statistically significant for the three-year pooled data (Exhibit F-24).

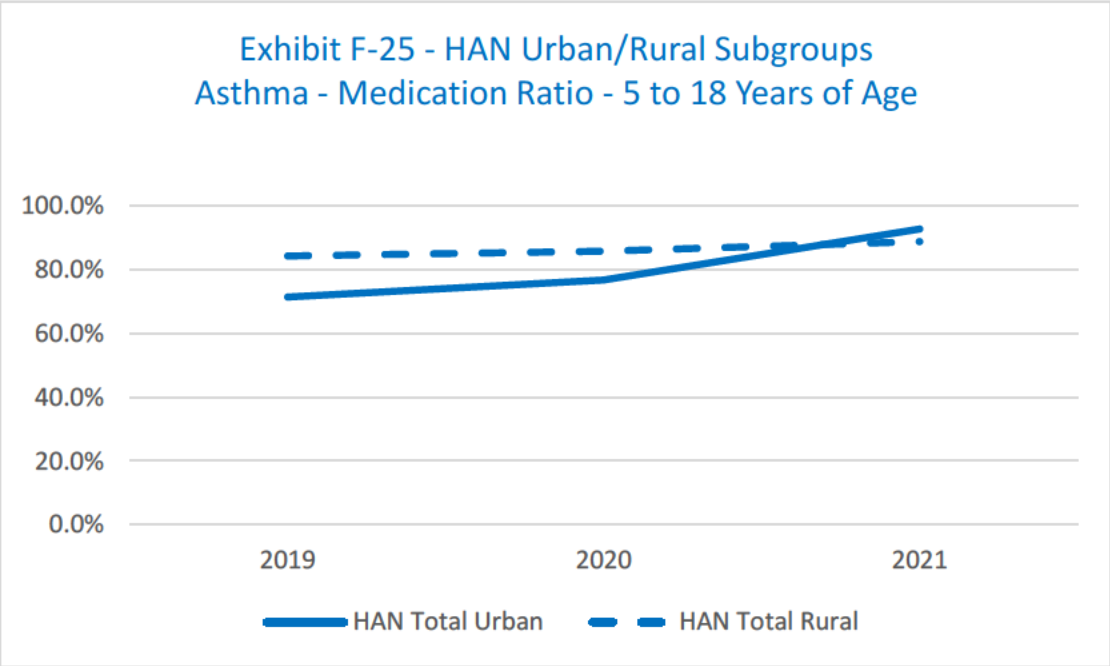
Exhibit F-24 – HAN (Care Managed) – Asthma – Medication Ratio – 5 to 18 Years of Age

	2019	2020	2021	3-Year Pooled
HAN (Care Managed)	82.0%	89.1%	91.5%	87.5%
Comparison Group	81.1%	84.0%	92.2%	85.8%
Difference	0.9%	5.1%	(0.7%)	1.7%

‡ HAN rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HAN Total and Care Managed Populations – Urban and Rural Subgroups

The HAN total rural subgroup rate exceeded the urban rate in 2019 and 2020, while the urban subgroup rate exceeded the rural rate in 2021. Both subgroups trended upward from 201 to 2021 (Exhibit F-25).



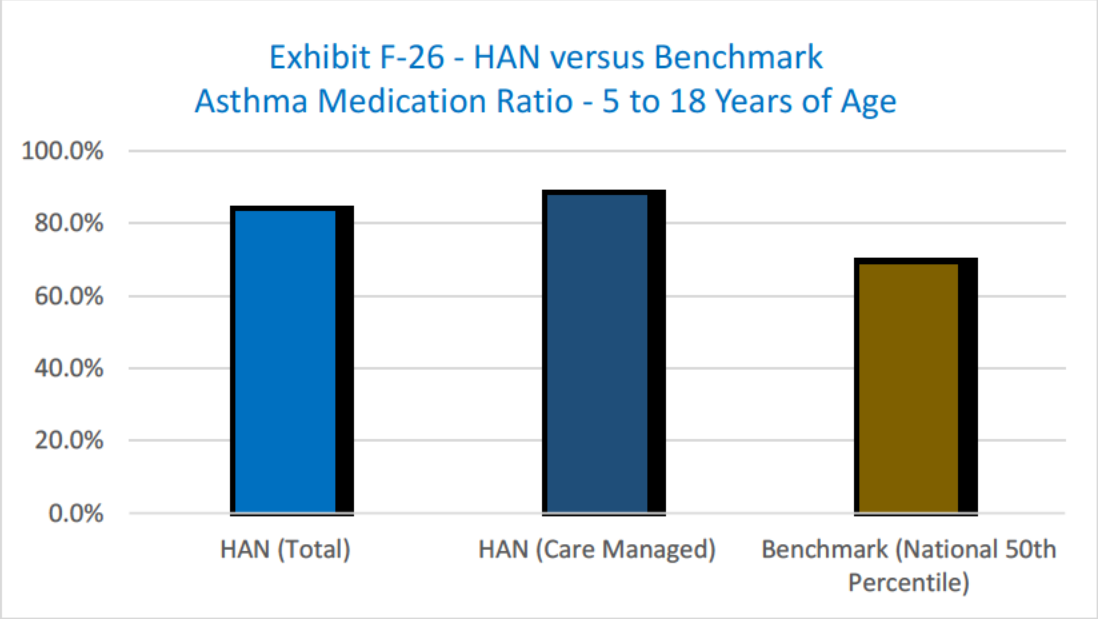
	Subgroup	2019	2020	2021
HAN (Total)	**Urban**	71.5%	76.8%	92.8%
	Rural	84.3%	85.8%	88.8%

The HAN Care Managed urban and rural subgroups were not sufficient in size to produce reliable trendlines.

Findings – HAN Total and Care Managed Populations and National Benchmark

The three-year pooled rate for the SoonerCare HAN total population exceeded the national benchmark rate by approximately 15 percentage points. The three-year pooled rate for the SoonerCare HAN Care Managed population exceeded the national benchmark rate by approximately 19 percentage points (Exhibit F-26).

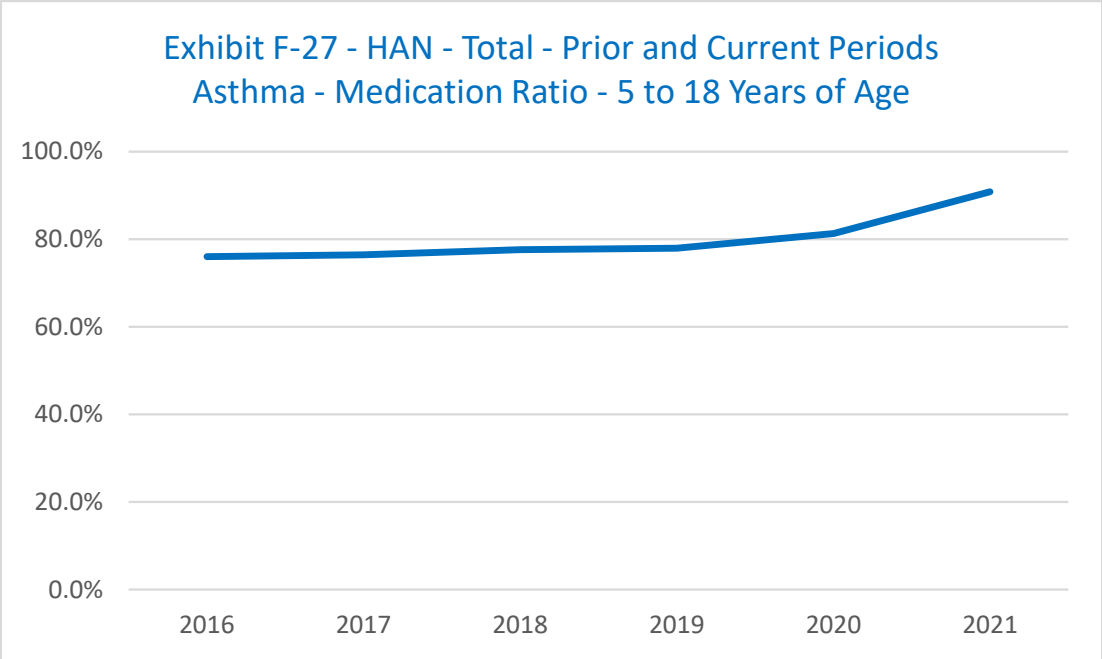
(Caution: the benchmark population characteristics were not matched to the OHCA groups to minimize differences in the populations. The data is presented for informational purposes only.)



	HAN Total	HAN Care Managed	Benchmark
Compliance Rate	83.3%	87.5%	68.6%

Findings – HAN Total Population – Comparison to Prior Waiver Period

This measure also was evaluated for the HAN total population in the prior waiver period (2016 to 2018). The compliance rate rose from 76 percent 2016 to approximately 91 percent in 2021 (Exhibit F-27).

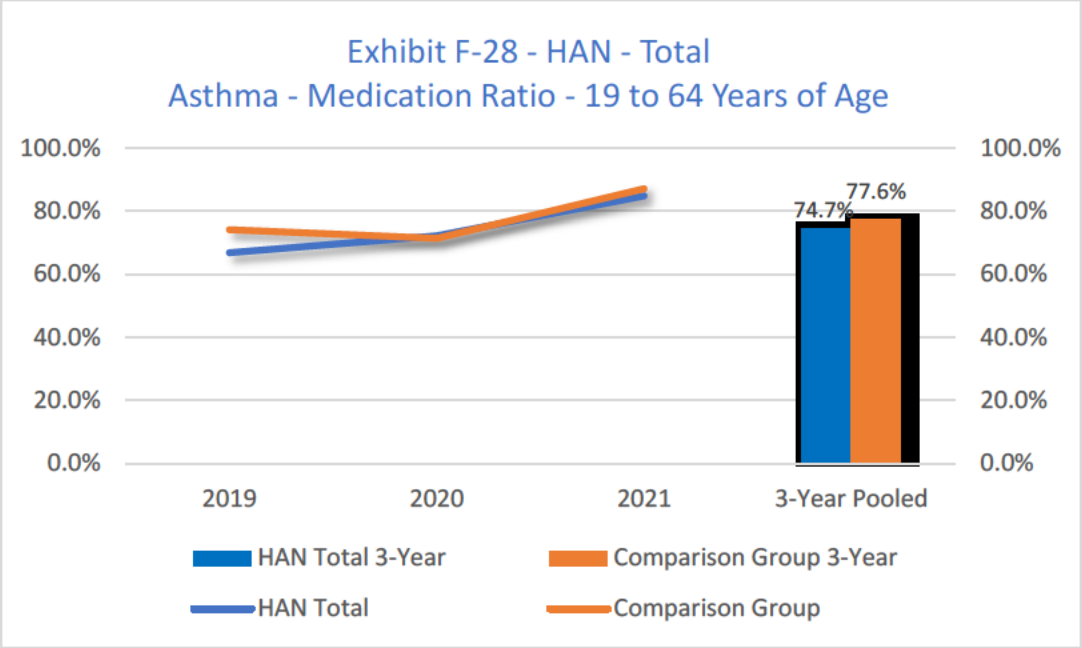


	2016	2017	2018	2019	2020	2021
HAN (Total)	76.0%	76.4%	77.6%	77.9%	81.3%	90.8%

Asthma – Medication Ratio – Ages 19 to 64

Findings – HAN Total Population

Approximately 75 percent of HAN total members and approximately 78 percent of comparison group members were compliant on this measure across the three years (Exhibit F-28). The compliance rate for the HAN total population rose from 2019 to 2021. The compliance rate for the comparison group declined from 2019 to 2020 and rose from 2020 to 2021.



The difference between the HAN total and comparison group compliance rates was statistically significant in 2019 and 2021. It also was statistically significant for the three-year pooled data (Exhibit F-29).

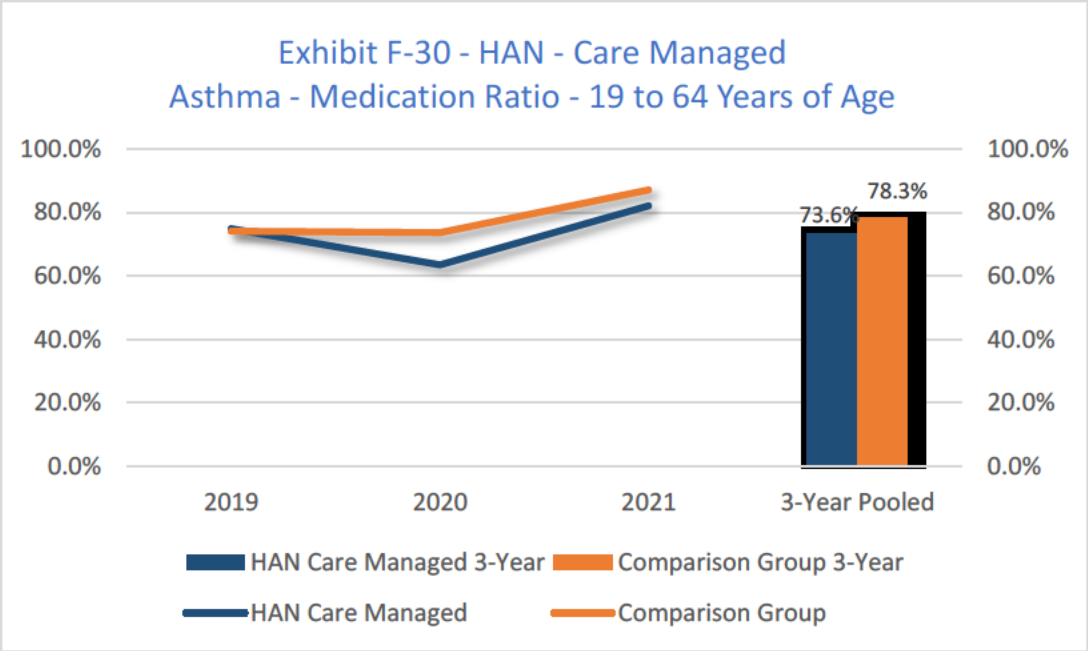
Exhibit F-29 – HAN (Total) – Asthma – Medication Ratio – 19 to 64 Years of Age

	2019	2020	2021	3-Year Pooled
HAN (Total)	66.9%	72.2%	84.9%	74.7%
Comparison Group	74.1%	71.4%	87.2%	77.6%
Difference	(7.2%)‡	0.8%	(2.3%)‡	(2.9%)‡

‡ HAN rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HAN Care Managed Population

Approximately 74 percent of HAN Care Managed members and 78 percent of comparison group members were compliant on this measure across the three years (Exhibit F-30.) The compliance rate for both populations declined from 2019 to 2020 and rose from 2020 to 2021.



The difference between the HAN Care Managed and comparison group compliance rates was not statistically significant in any of the individual years. It also was not statistically significant for the three-year pooled data (Exhibit F-31).

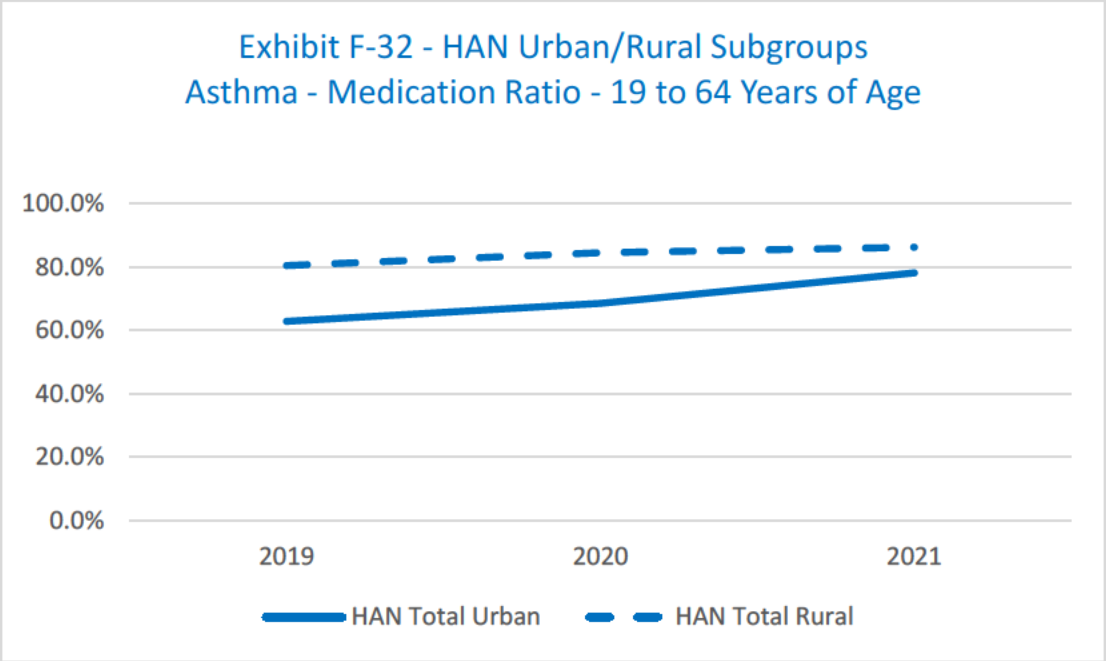
Exhibit F-31 – HAN (Care Managed) – Asthma – Medication Ratio – 19 to 64 Years of Age

	2019	2020	2021	3-Year Pooled
HAN (Care Managed)	75.0%	63.6%	82.1%	73.6%
Comparison Group	74.0%	73.9%	87.1%	78.3%
Difference	1.0%	(10.3%)	(5.0%)	(4.7%)

‡ HAN rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HAN Total and Care Managed Populations – Urban and Rural Subgroups

The HAN total rural subgroup rate exceeded the urban rate in all three years. The compliance rate for both subgroups trended upward from 2019 to 2021 (Exhibit F-32).



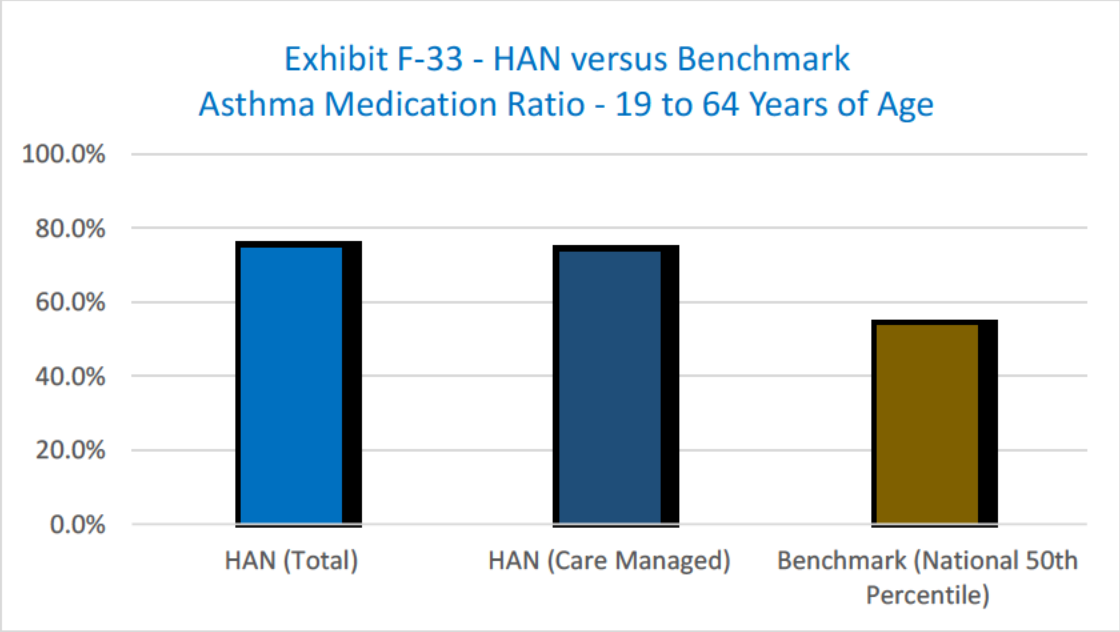
	Subgroup	2019	2020	2021
HAN (Total)	**Urban**	62.9%	68.5%	78.1%
	Rural	80.5%	84.6%	86.3%

The HAN Care Managed urban and rural subgroups were not sufficient in size to produce reliable trendlines.

Findings – HAN Total and Care Managed Populations and National Benchmark

The three-year pooled rate for the SoonerCare HAN total population exceeded the national benchmark rate by 21 percentage points. The three-year pooled rate for the SoonerCare HAN Care Managed population exceeded the national benchmark rate by approximately 20 percentage points (Exhibit F-33).

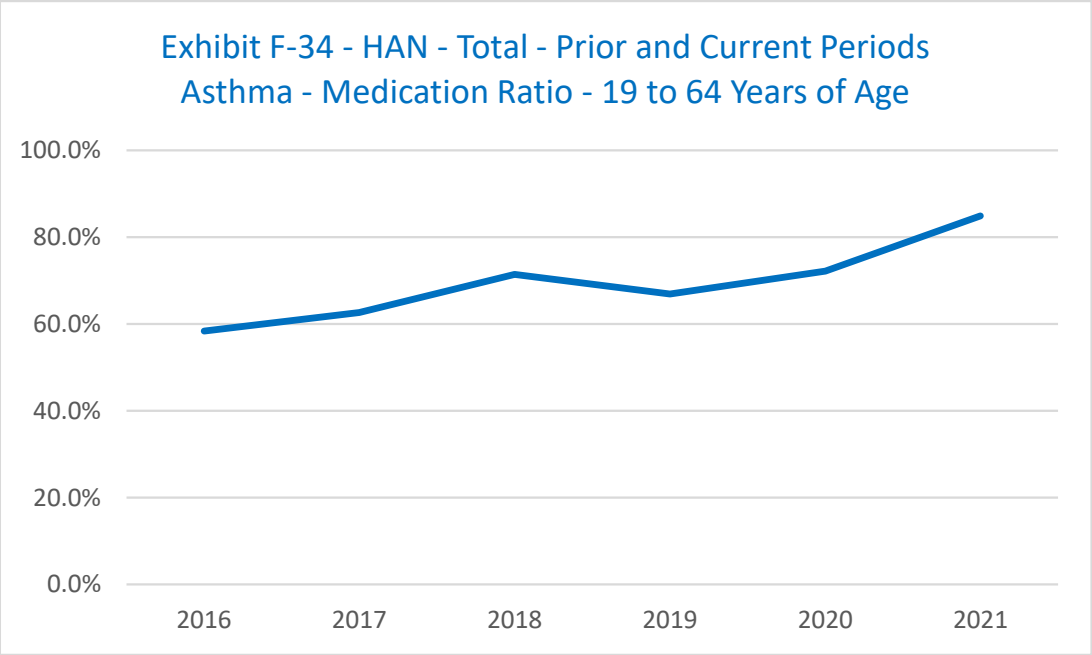
(Caution: the benchmark population characteristics were not matched to the OHCA groups to minimize differences in the populations. The data is presented for informational purposes only.)



	HAN Total	HAN Care Managed	Benchmark
Compliance Rate	74.7%	73.6%	53.7%

Findings – HAN Total Population – Comparison to Prior Waiver Period

This measure also was evaluated for the HAN total population in the prior waiver period (2016 to 2018). The compliance rate rose from approximately 58 percent in 2016 to 85 percent in 2021 (Exhibit F-34).

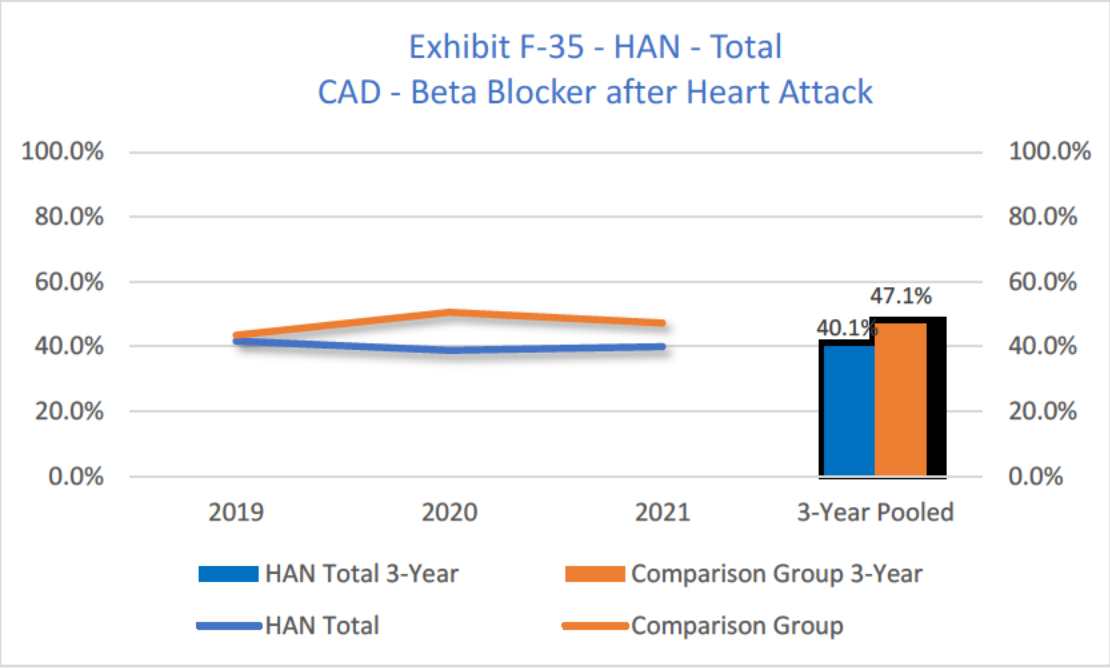


	2016	2017	2018	2019	2020	2021
HAN (Total)	58.4%	62.6%	71.4%	66.9%	72.2%	84.9%

Coronary Artery Disease – Persistent Beta Blocker Treatment after a Heart Attack

Findings – HAN Total Population

Approximately 40 percent of HAN total members and 47 percent of comparison group members were compliant on this measure across the three years (Exhibit F-35). The compliance rate for the HAN population was stable from 2019 to 2021. The compliance rate for the comparison group rose from 2019 to 2020 before declining slightly from 2020 to 2021.



The difference between the HAN total and comparison group compliance rates was statistically significant in 2020 and 2021. It also was statistically significant for the three-year pooled data (Exhibit F-36).

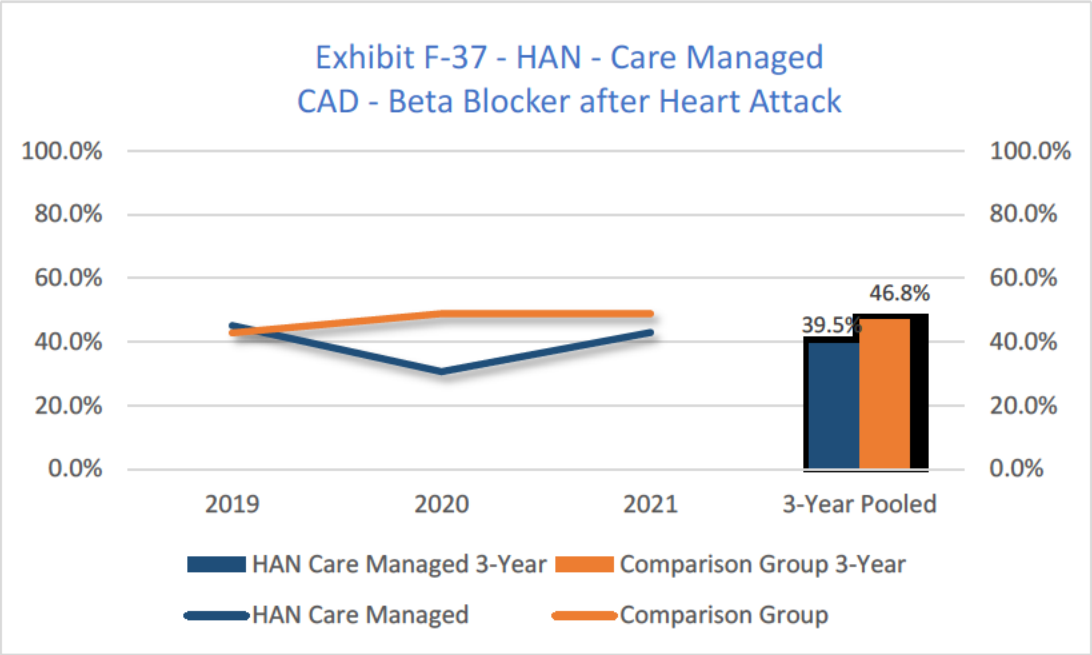
Exhibit F-36 – HAN (Total) – CAD – Beta Blocker after Heart Attack

	2019	2020	2021	3-Year Pooled
HAN (Total)	41.7%	38.8%	39.9%	40.1%
Comparison Group	43.5%	50.5%	47.2%	47.1%
Difference	(1.8%)	(11.7%)‡	(7.3%)‡	(7.0%)‡

‡ HAN rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HAN Care Managed Population

Approximately 39 percent of HAN Care Managed members and approximately 46 percent of comparison group members were compliant on this measure across the three years (Exhibit F-37). The compliance rate for HAN members declined from 2019 to 2020 before rising again from 2020 to 2021. The compliance rate for the comparison group rose from 2019 to 2020 and was unchanged from 2020 to 2021.



The difference between the HAN Care Managed and comparison group compliance rates was statistically significant in 2020. It was not statistically significant for the three-year pooled data (Exhibit F-38).

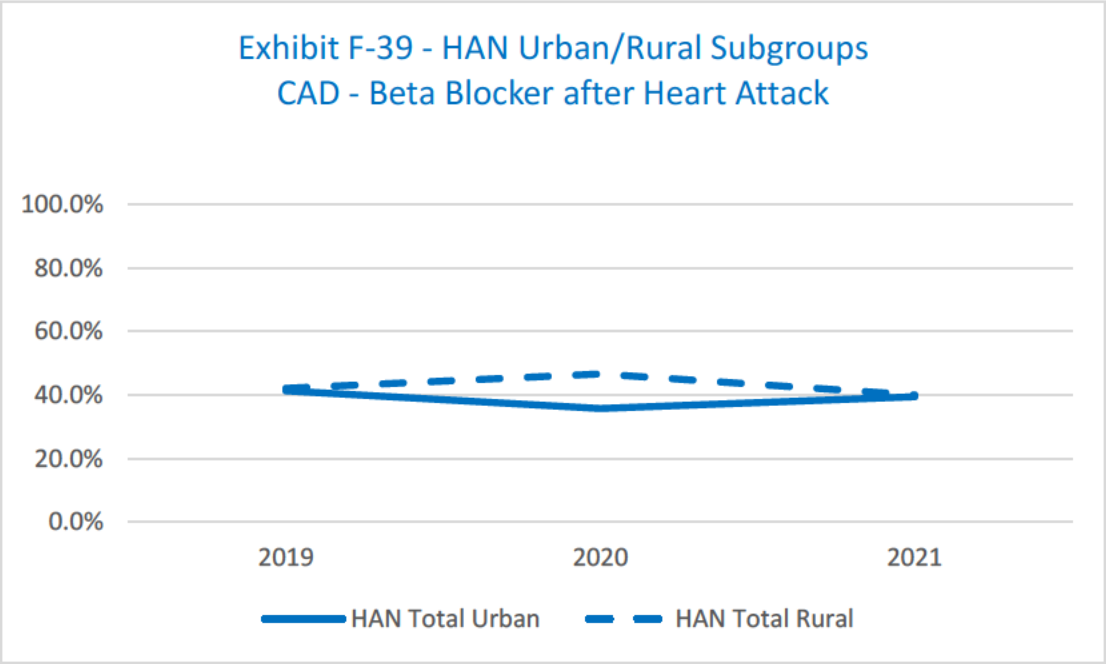
Exhibit F-38 – HAN (Care Managed) – CAD – Beta Blocker after Heart Attack

	2019	2020	2021	3-Year Pooled
HAN (Care Managed)	45.1%	30.6%	42.9%	39.5%
Comparison Group	42.8%	48.8%	48.8%	46.8%
Difference	2.3%	(18.2%)‡	(5.9%)	(7.3%)

‡ HAN rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HAN Total and Care Managed Populations – Urban and Rural Subgroups

The HAN total rural subgroup rate exceeded the urban rate in 2020; the two subgroups had nearly equal rates in 2019 and 2021. The rural subgroup rate trended upward from 2019 to 2020 and downward from 2020 to 2021; the urban subgroup rate trended slightly downward from 2019 to 2020 and slightly upward from 2020 to 2021 (Exhibit F-39).



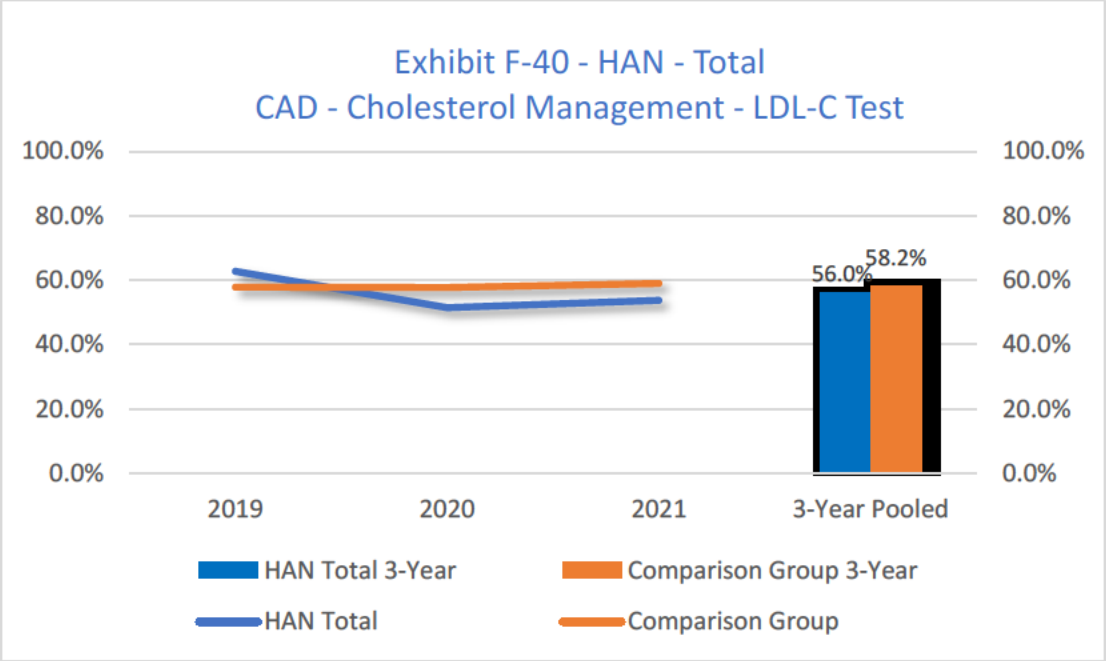
	Subgroup	2019	2020	2021
HAN (Total)	**Urban**	41.3%	35.8%	39.5%
	Rural	42.1%	46.7%	40.0%

The HAN Care Managed urban and rural subgroups were not sufficient in size to produce reliable trendlines.

Coronary Artery Disease – Cholesterol Management – LDL-C Test

Findings – HAN Total Population

Fifty-six percent of HAN total members and approximately 58 percent of comparison group members were compliant on this measure across the three years (Exhibit F-40). The compliance rate for the HAN population declined from 2019 to 2020 before rising again from 2020 to 2021. The compliance rate for the comparison group was stable across the three years.



The difference between the HAN total and comparison group compliance rates was statistically significant in 2021. It was not statistically significant for the three-year pooled data (Exhibit F-41).

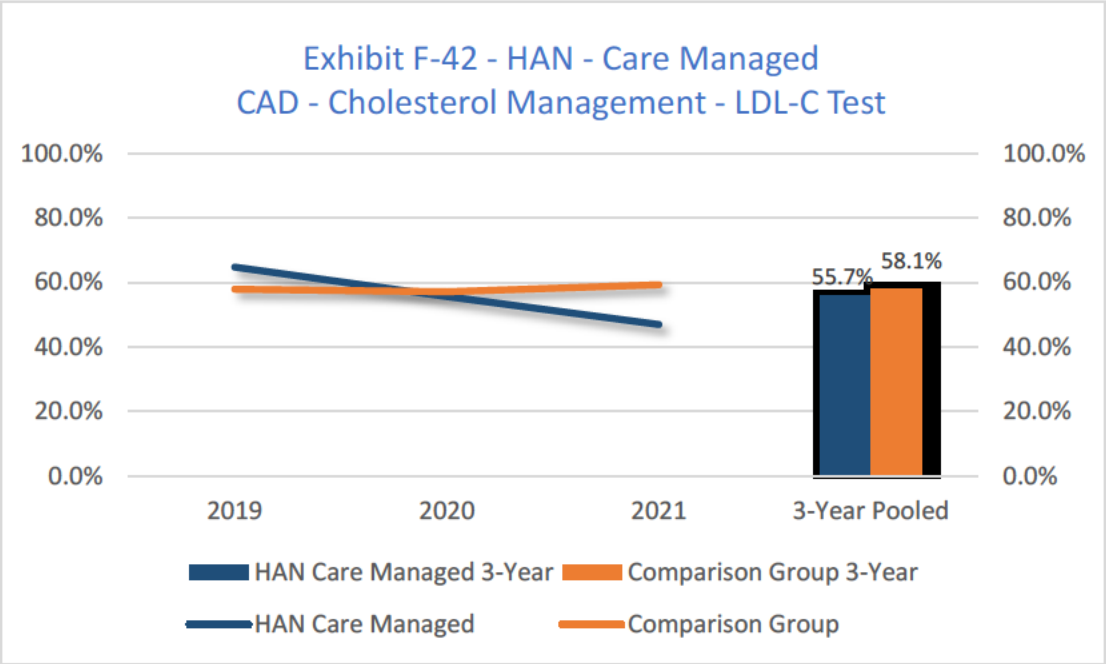
Exhibit F-41 – HAN (Total) – CAD – Cholesterol Management – LDL-C Test

	2019	2020	2021	3-Year Pooled
HAN (Total)	62.8%	51.5%	53.7%	56.0%
Comparison Group	57.9%	57.7%	59.0%	58.2%
Difference	4.9%	(6.2%)	(5.3%)‡	(2.2%)

‡ HAN rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HAN Care Managed Population

Approximately 56 percent of HAN Care Managed members and 58 percent of comparison group members were compliant on this measure across the three years (Exhibit F-42). The compliance rate for HAN members declined from 2019 to 2021. The compliance rate for the comparison group declined slightly from 2019 to 2020 before rising again from 2020 to 2021.



The difference between the HAN Care Managed and comparison group compliance rates was not statistically significant in any of the individual years. It also was not statistically significant for the three-year pooled data (Exhibit F-43).

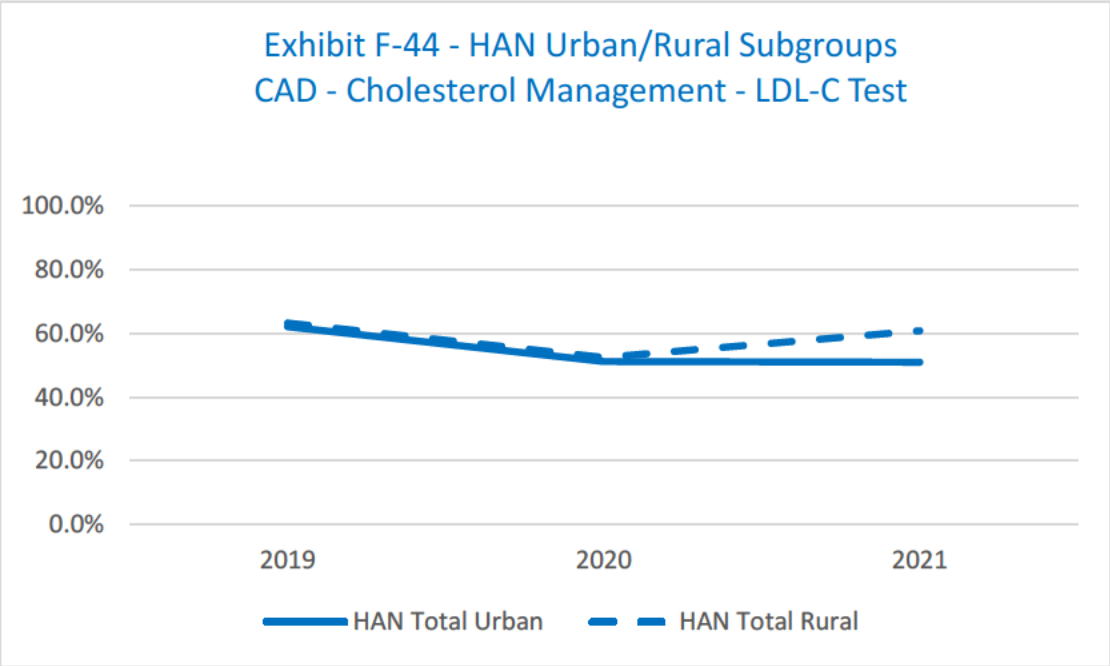
Exhibit F-43 – HAN (Care Managed) – CAD – Cholesterol Management – LDL-C Test

	2019	2020	2021	3-Year Pooled
HAN (Care Managed)	64.7%	55.6%	46.9%	55.7%
Comparison Group	57.9%	57.1%	59.2%	58.1%
Difference	6.8%	(1.5%)	(12.3%)	(2.4%)

‡ HAN rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HAN Total and Care Managed Populations – Urban and Rural Subgroups

The HAN total urban and rural subgroups had nearly equal rates in 2019 and 2020; the rural rate exceeded the urban rate in 2021. The rural subgroup rate trended downward from 2019 to 2020 and upward from 2020 to 2021; the urban subgroup rate trended downward from 2019 to 2020 and was nearly unchanged from 2020 to 2021 (Exhibit F-44).



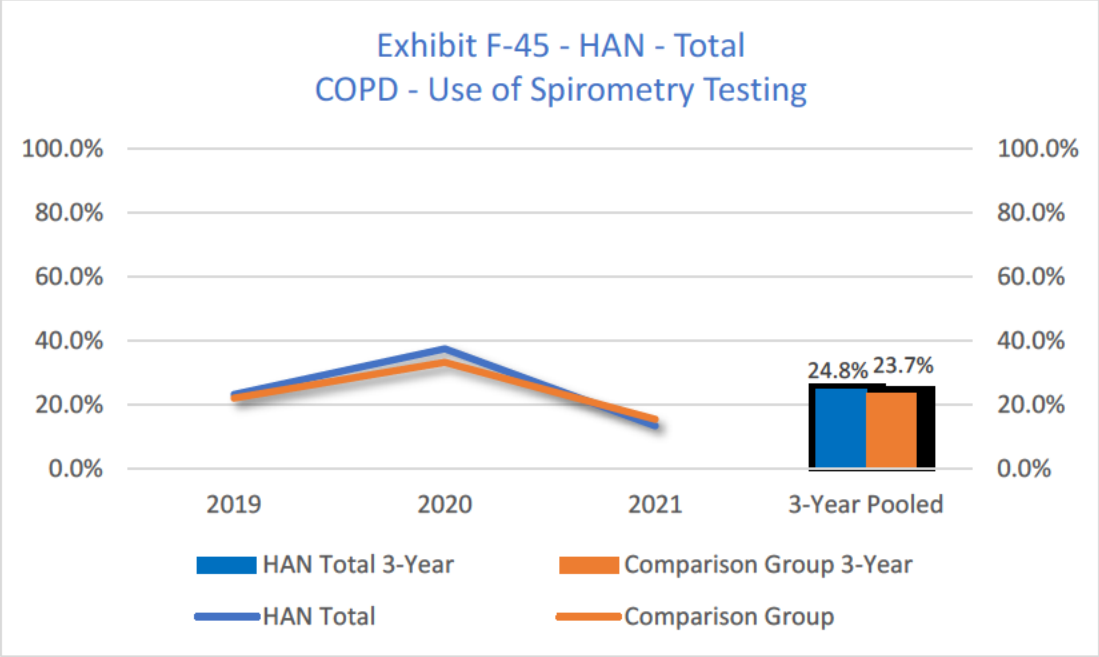
	Subgroup	2019	2020	2021
HAN (Total)	**Urban**	62.1%	51.2%	50.9%
	Rural	63.2%	52.4%	60.8%

The HAN Care Managed urban and rural subgroups were not sufficient in size to produce reliable trendlines.

Chronic Obstructive Pulmonary Disease – Use of Spirometry Testing

Findings – HAN Total Population

Approximately 25 percent of HAN total members and 24 percent of comparison group members were compliant on this measure across the three years (Exhibit F-45). The compliance rate for both populations rose from 2019 to 2020 before declining from 2020 to 2021.



The difference between the HAN total and comparison group compliance rates was statistically significant in 2020. It was not statistically significant for the three-year pooled data (Exhibit F-46).

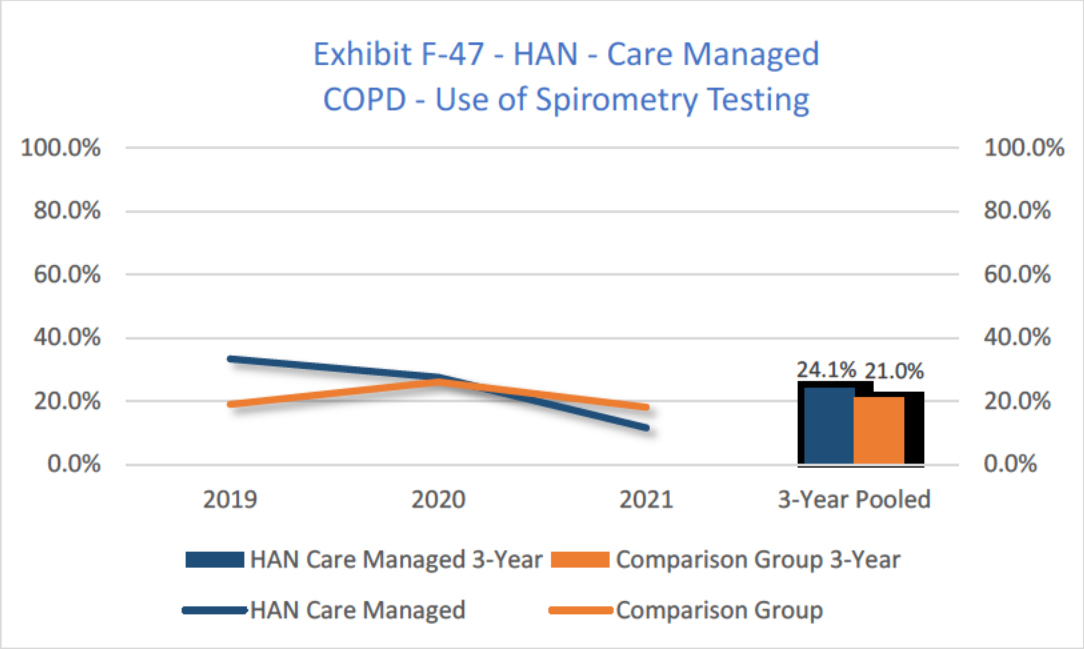
Exhibit F-46 – HAN (Total) – COPD – Use of Spirometry Testing

	2019	2020	2021	3-Year Pooled
HAN (Total)	23.3%	37.5%	13.5%	24.8%
Comparison Group	22.2%	33.3%	15.5%	23.7%
Difference	1.1%	4.2%‡	(2.0%)	1.1%

‡ HAN rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HAN Care Managed Population

Approximately 24 percent of HAN Care Managed members and 21 percent of comparison group members were compliant on this measure across the three years (Exhibit F-47). The compliance rate for HAN members declined from 2019 to 2021. The compliance rate for the comparison group rose from 2019 to 2020 before declining from 2020 to 2021.



The difference between the HAN Care Managed and comparison group compliance rates was not statistically significant in any of the individual years. It also was not statistically significant for the three-year pooled data (Exhibit F-48).

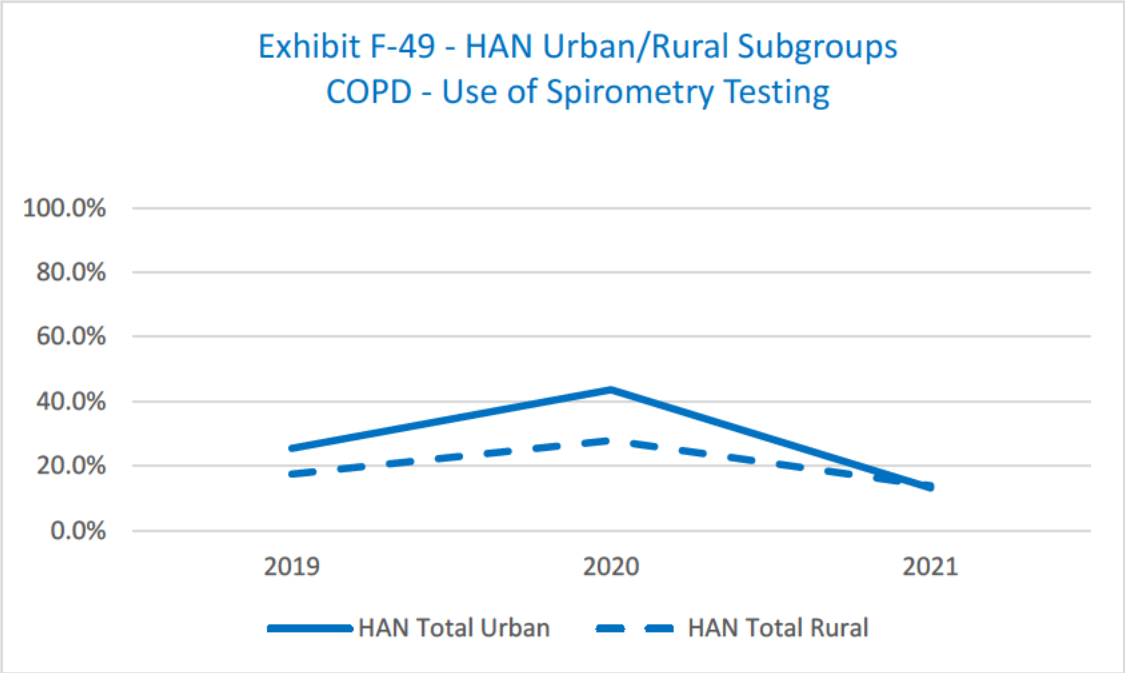
Exhibit F-48 – HAN (Care Managed) – COPD – Use of Spirometry Testing

	2019	2020	2021	3-Year Pooled
HAN (Care Managed)	33.3%	27.5%	11.6%	24.1%
Comparison Group	19.0%	26.0%	18.1%	21.0%
Difference	14.3%	1.5%	(6.5%)	3.1%

‡ HAN rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HAN Total and Care Managed Populations – Urban and Rural Subgroups

The HAN total urban subgroup rate exceeded the rural rate in 2019 and 2020; the two subgroups had nearly equal rates in 2021. The rates for both subgroups trended upward from 2019 to 2020 and downward from 2020 to 2021 (Exhibit F-49).



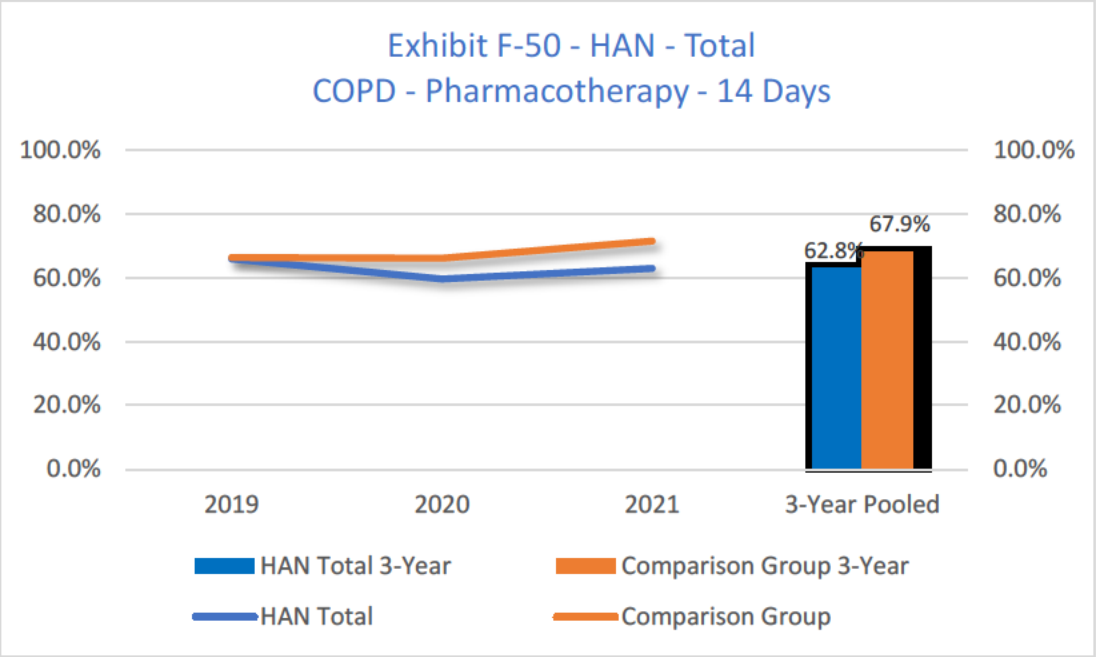
	Subgroup	2019	2020	2021
HAN (Total)	**Urban**	25.4%	43.6%	13.1%
	Rural	17.4%	27.9%	13.9%

The HAN Care Managed urban and rural subgroups were not sufficient in size to produce reliable trendlines.

Chronic Obstructive Pulmonary Disease – Pharmacotherapy Management of Exacerbation – 14 Days

Findings – HAN Total Population

Approximately 63 percent of HAN total members and 68 percent of comparison group members were compliant on this measure across the three years (Exhibit F-50). The compliance rate for the HAN total population declined from 2019 to 2020 before rising again from 2020 to 2021. The compliance rate for the comparison group was stable from 2019 to 2020 and rose from 2020 to 2021.



The difference between the HAN total and comparison group compliance rates was statistically significant in 2021. It also was statistically significant for the three-year pooled data (Exhibit F-51).

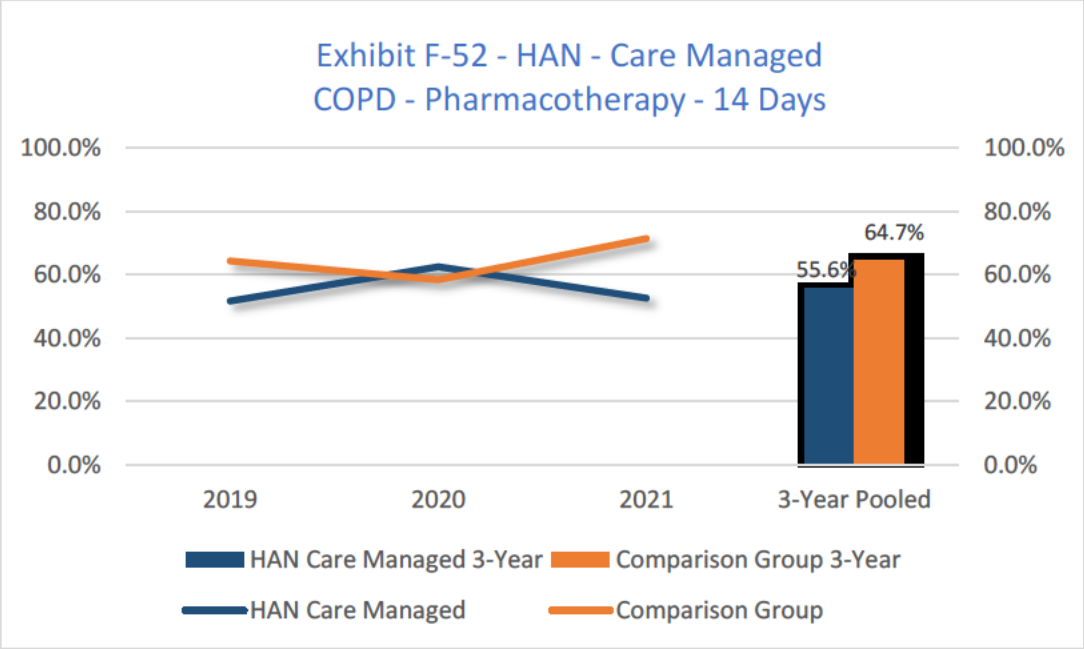
Exhibit F-51 – HAN (Total) – COPD – Pharmacotherapy – 14 Days

	2019	2020	2021	3-Year Pooled
HAN (Total)	65.8%	59.6%	62.9%	62.8%
Comparison Group	66.3%	66.1%	71.4%	67.9%
Difference	(0.5%)	(6.5%)	(8.5%)‡	(5.1%)‡

‡ HAN rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HAN Care Managed Population

Approximately 56 percent of HAN Care Managed members and 65 percent of comparison group members were compliant on this measure across the three years (Exhibit F-52). The compliance rate for HAN members rose from 2019 to 2020 before declining from 2021 to 2021. Conversely, the compliance rate for the comparison group declined from 2019 to 2020 before rising from 2020 to 2021.



The difference between the HAN Care Managed and comparison group compliance rates was statistically significant in 2021. It was not statistically significant for the three-year pooled data (Exhibit F-53).

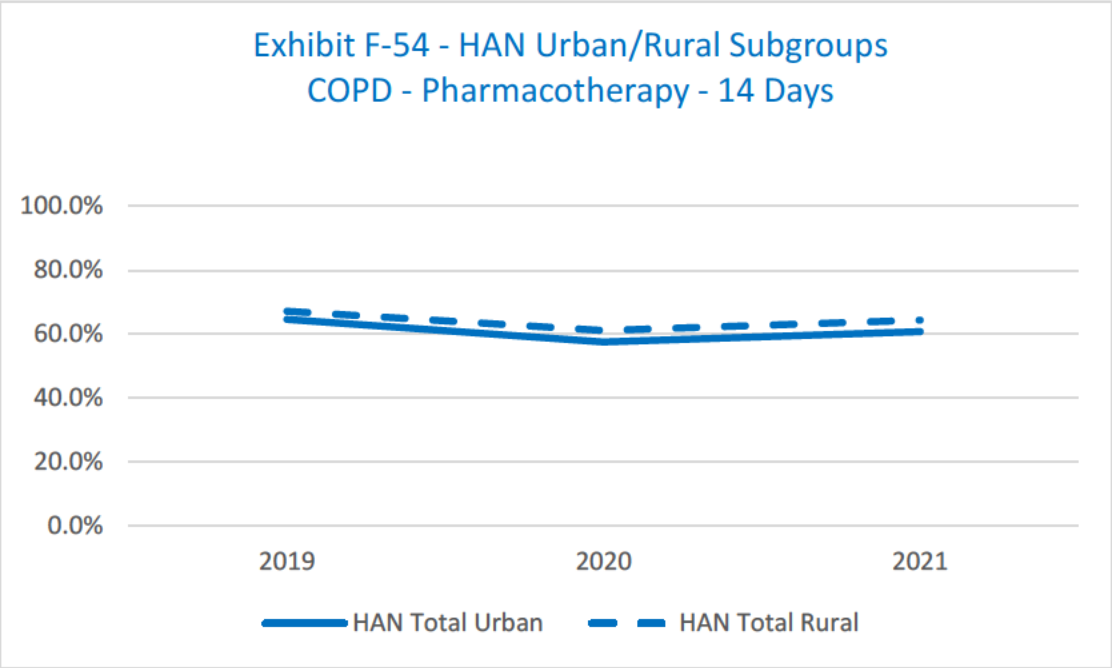
Exhibit F-53 – HAN (Care Managed) – COPD – Pharmacotherapy – 14 Days

	2019	2020	2021	3-Year Pooled
HAN (Care Managed)	51.7%	62.5%	52.6%	55.6%
Comparison Group	64.4%	58.4%	71.4%	64.7%
Difference	(12.7%)	4.1%	(18.8%)‡	(9.1%)

‡ HAN rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HAN Total and Care Managed Populations – Urban and Rural Subgroups

The HAN total rural subgroup rate exceeded the urban subgroup rate from 2019 to 2021. The rates for both subgroups trended downward from 2019 to 2020 and rose again from 2020 to 2021 (ExhibitF-54).



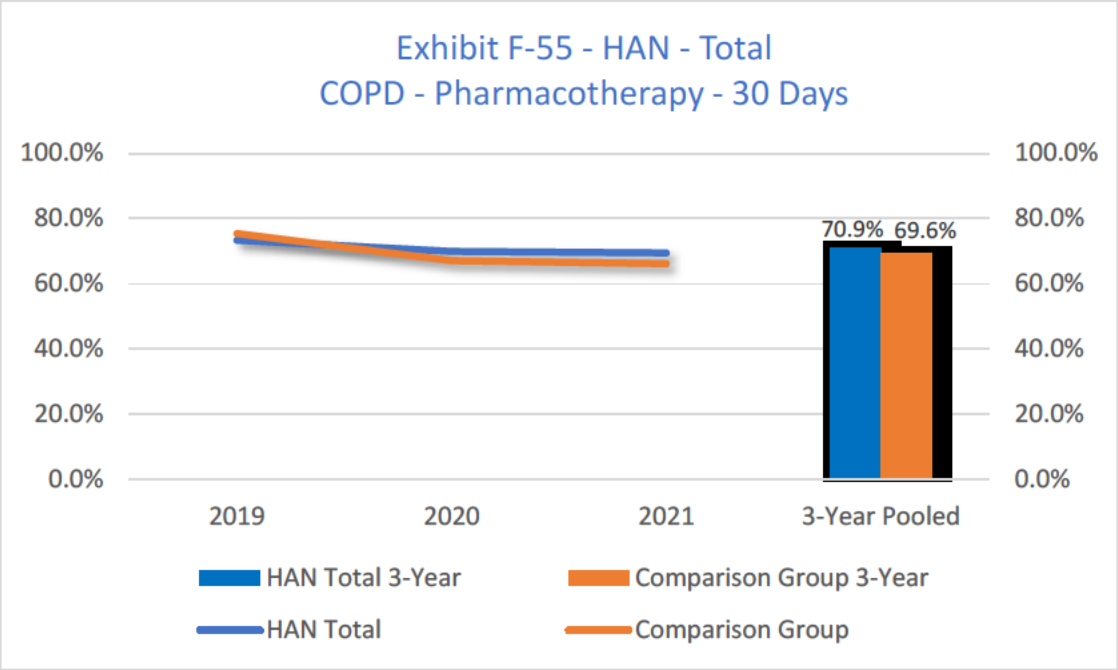
	Subgroup	2019	2020	2021
HAN (Total)	**Urban**	64.6%	57.5%	60.8%
	Rural	67.2%	61.1%	64.4%

The HAN Care Managed urban and rural subgroups were not sufficient in size to produce reliable trendlines.

Chronic Obstructive Pulmonary Disease – Pharmacotherapy Management of Exacerbation – 30 Days

Findings – HAN Total Population

Approximately 71 percent of HAN total members and 70 percent of comparison group members were compliant on this measure across the three years (Exhibit F-55). The compliance rate for both populations declined from 2019 to 2021.

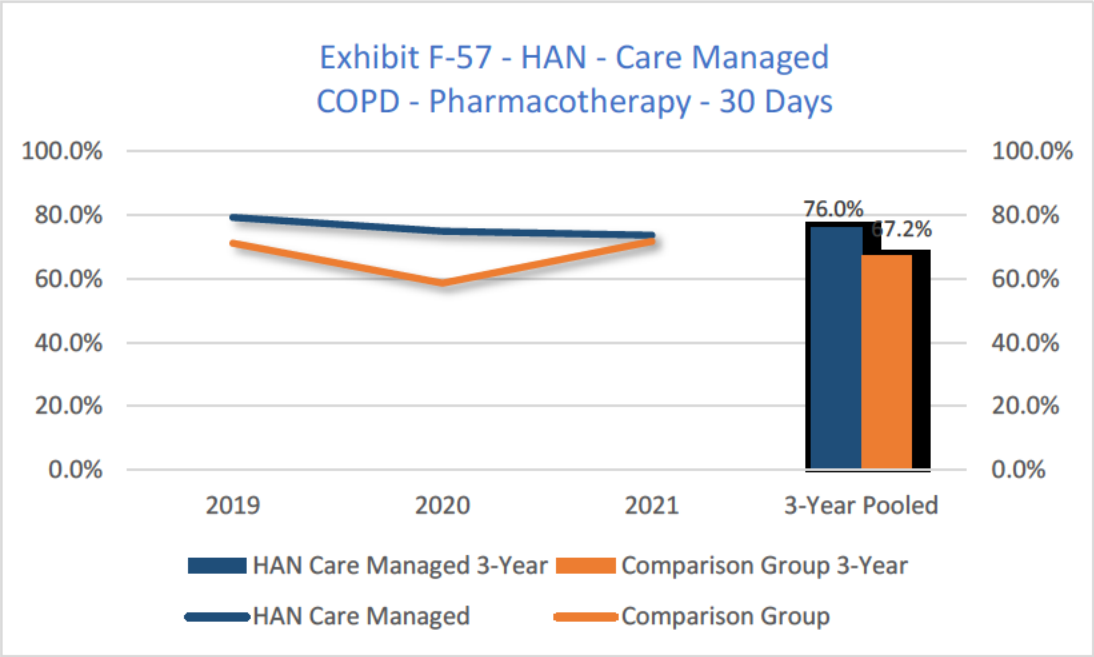


The difference between the HAN total and comparison group compliance rates was not statistically significant in any of the individual years. It also was not statistically significant for the three-year pooled data (Exhibit F-56).

Exhibit F-56 – HAN (Total) – COPD – Pharmacotherapy – 30 Days				
	2019	2020	2021	3-Year Pooled
HAN (Total)	73.4%	69.9%	69.5%	70.9%
Comparison Group	75.4%	67.1%	66.2%	69.6%
Difference	(2.0%)	2.8%	3.3%	1.3%
‡ HAN rate differs from comparison group rate by a statistically significant amount (95% confidence level)				

Findings – HAN Care Managed Population

Seventy-six percent of HAN Care Managed members and approximately 67 percent of comparison group members were compliant on this measure across the three years (Exhibit F-57). The compliance rate for HAN members declined from 2019 to 2021. The compliance rate for the comparison group declined from 2019 to 2020 before rising from 2020 to 2021.

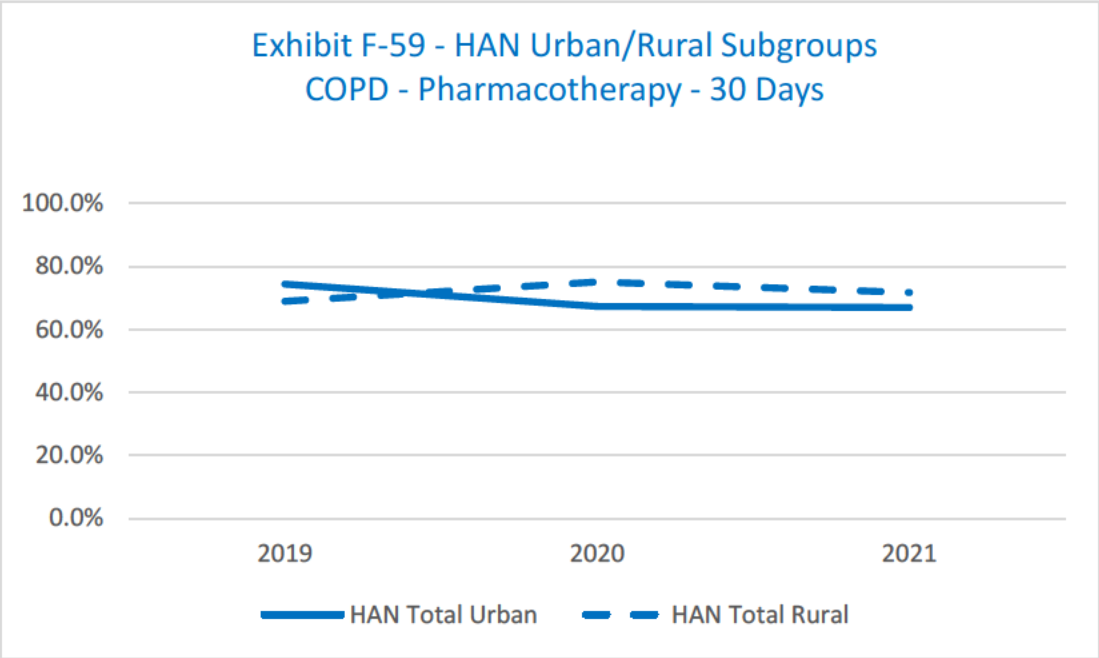


The difference between the HAN Care Managed and comparison group compliance rates was not statistically significant in any individual year. It was not statistically significant for the three-year pooled data (Exhibit F-58).

Exhibit F-58 – HAN (Care Managed) – COPD – Pharmacotherapy – 30 Days				
	2019	2020	2021	3-Year Pooled
HAN (Care Managed)	79.3%	75.0%	73.7%	76.0%
Comparison Group	71.2%	58.6%	71.8%	67.2%
Difference	8.1%	16.4%	1.9%	8.8%
‡ HAN rate differs from comparison group rate by a statistically significant amount (95% confidence level)				

Findings – HAN Total and Care Managed Populations – Urban and Rural Subgroups

The HAN total urban subgroup rate exceeded the rural subgroup rate in 2019; the rural subgroup rate exceeded the urban rate in 2020 and 2021. The urban subgroup rate trended downward from 2019 to 2021. The rural subgroup rate rose from 2019 to 2020 before declining from 2020 to 2021 (Exhibit F-59).



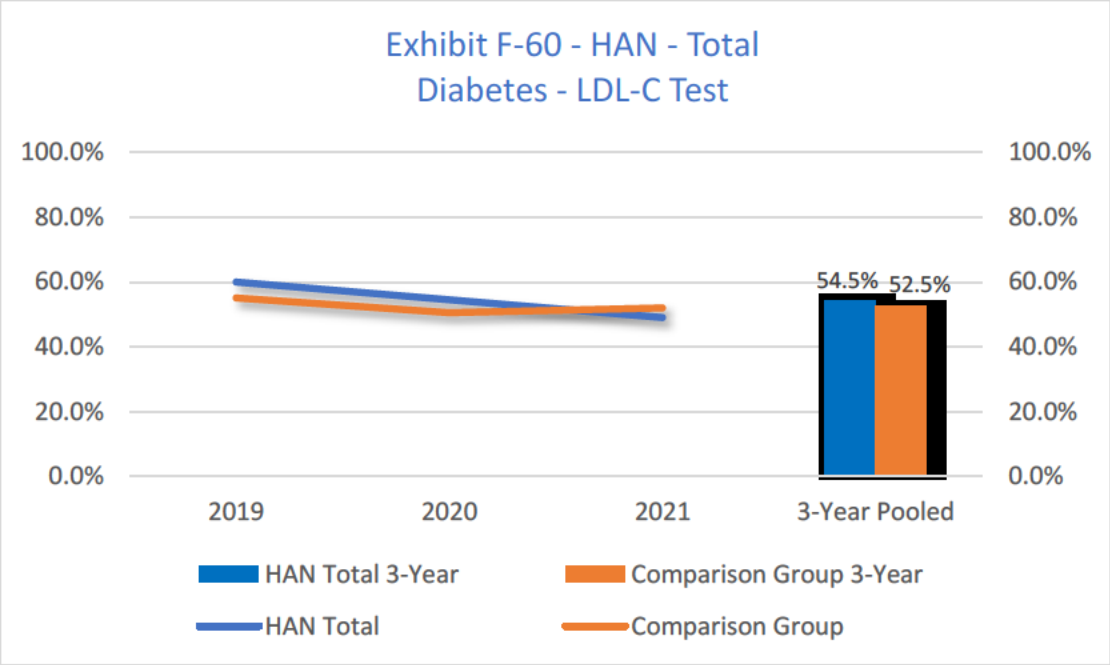
	Subgroup	2019	2020	2021
HAN (Total)	**Urban**	74.4%	67.3%	66.9%
	Rural	68.9%	75.0%	71.7%

The HAN Care Managed urban and rural subgroups were not sufficient in size to produce reliable trendlines.

Diabetes – LDL-C Test

Findings – HAN Total Population

Approximately 55 percent of HAN total members and 53 percent of comparison group members were compliant on this measure across the three years (Exhibit F-60). The compliance rate for the HAN total population declined from 2019 to 2021. The compliance rate for the comparison group declined from 2019 to 2020 before rising again from 2020 to 2021.

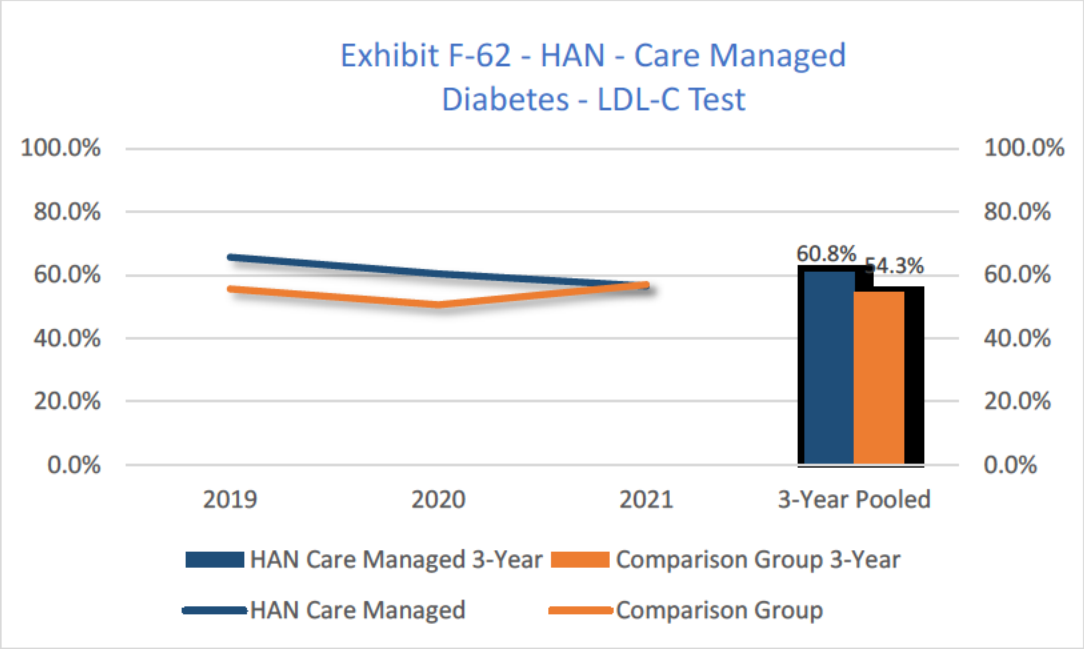


The difference between the HAN total and comparison group compliance rates was statistically significant in each of the individual years. It also was statistically significant for the three-year pooled data (Exhibit F-61).

Exhibit F-61 – HAN (Total) – Diabetes – LDL-C Test				
	2019	2020	2021	3-Year Pooled
HAN (Total)	60.0%	54.5%	49.1%	54.5%
Comparison Group	55.1%	50.5%	52.0%	52.5%
Difference	4.9%‡	4.0%‡	(2.9%)‡	2.0%‡
‡ HAN rate differs from comparison group rate by a statistically significant amount (95% confidence level)				

Findings – HAN Care Managed Population

Approximately 61 percent of HAN Care Managed members and 54 percent of comparison group members were compliant on this measure across the three years (Exhibit F-62). The compliance rate for the HAN Care Managed population declined from 2019 to 2021. The compliance rate for the comparison group declined from 2019 to 2020 before rising again from 2020 to 2021.



The difference between the HAN Care Managed and comparison group compliance rates was statistically significant in 2019 and 2020. It also was statistically significant for the three-year pooled data (Exhibit F-63).

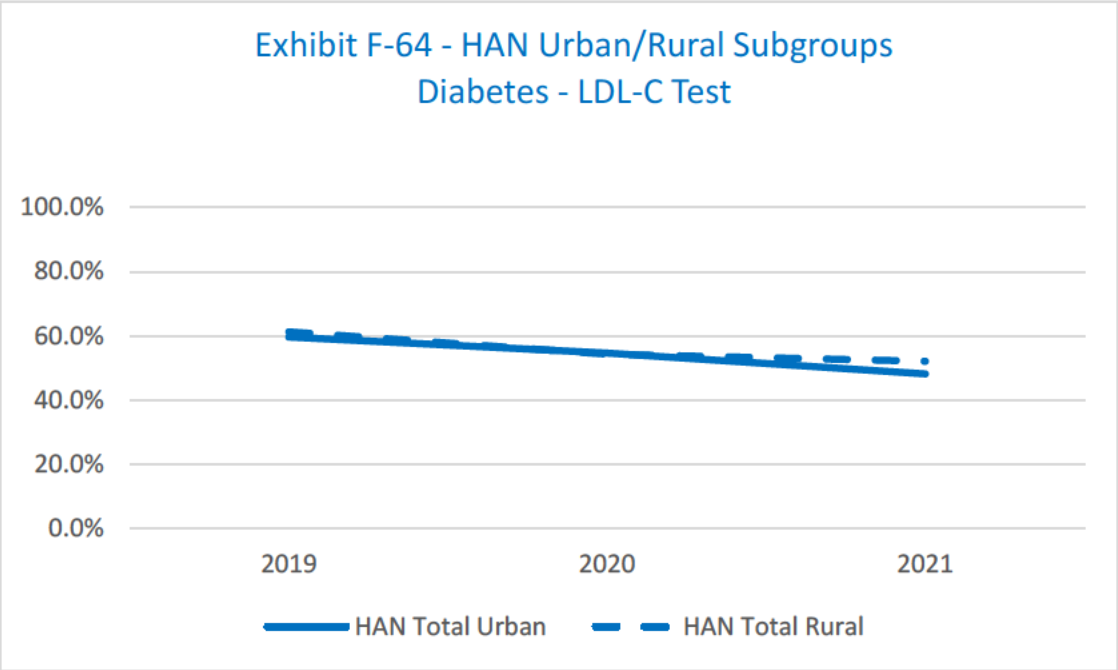
Exhibit F-63 – HAN (Care Managed) – Diabetes – LDL-C Test

	2019	2020	2021	3-Year Pooled
HAN (Care Managed)	65.6%	60.4%	56.5%	60.8%
Comparison Group	55.6%	50.5%	56.9%	54.3%
Difference	10.0%‡	9.9%‡	(0.4%)	6.3%‡

‡ HAN rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HAN Total and Care Managed Populations – Urban and Rural Subgroups

The HAN total urban and rural subgroups had nearly equal rates in 2019 and 2020; the HAN rural subgroup rate exceeded the urban rate in 2021. The rates for both subgroups declined from 2019 to 2021 (Exhibit F-64).

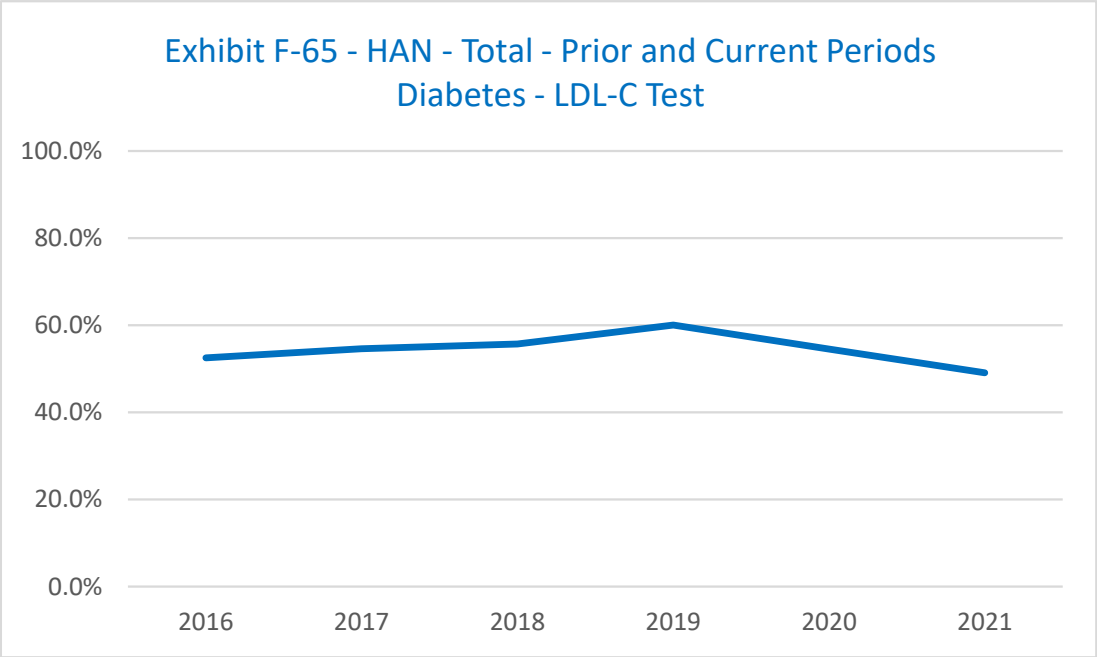


	Subgroup	2019	2020	2021
HAN (Total)	**Urban**	59.6%	54.7%	48.1%
	Rural	61.3%	54.3%	52.1%

The HAN Care Managed urban and rural subgroups were not sufficient in size to produce reliable trendlines.

Findings – HAN Total Population – Comparison to Prior Waiver Period

This measure also was evaluated for the HAN total population in the prior waiver period (2016 to 2018). The compliance rate rose from approximately 53 percent in 2016 to 60 percent in 2019, before declining to 49 percent in 2021 (Exhibit F-65).

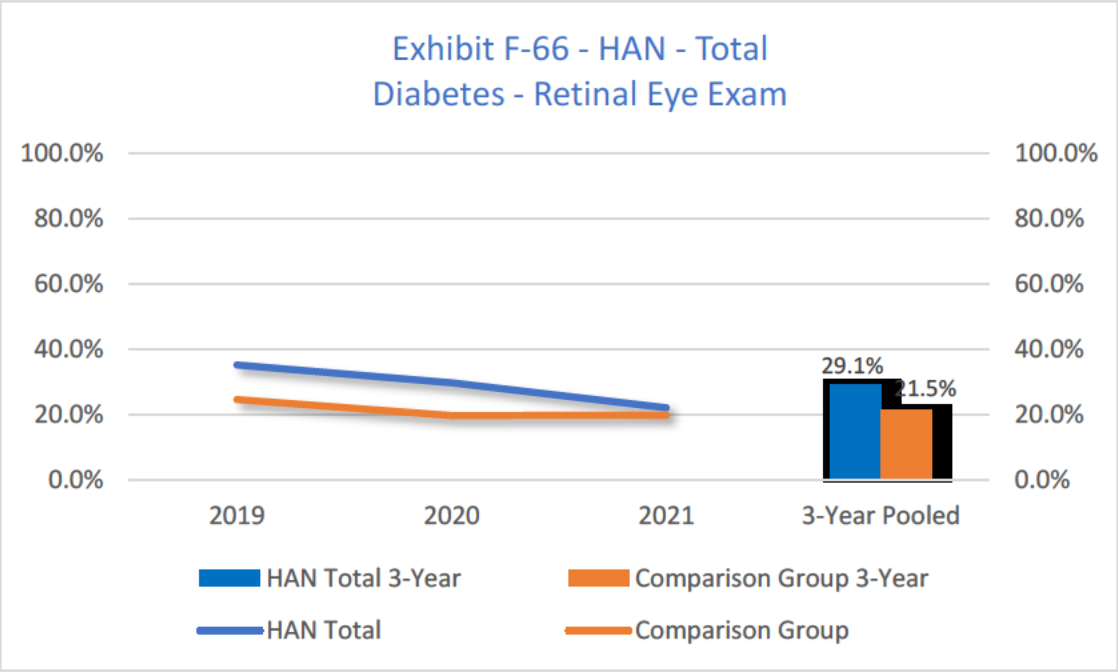


	2016	2017	2018	2019	2020	2021
HAN (Total)	52.5%	54.6%	55.7%	60.0%	54.5%	49.1%

Diabetes – Retinal Eye Exam

Findings – HAN Total Population

Approximately 29 percent of HAN total members and 22 percent of comparison group members were compliant on this measure across the three years (Exhibit F-66). The compliance rate for both populations declined from 2019 to 2021.



The difference between the HAN total and comparison group compliance rates was statistically significant in each of the individual years. It also was statistically significant for the three-year pooled data (Exhibit F-67).

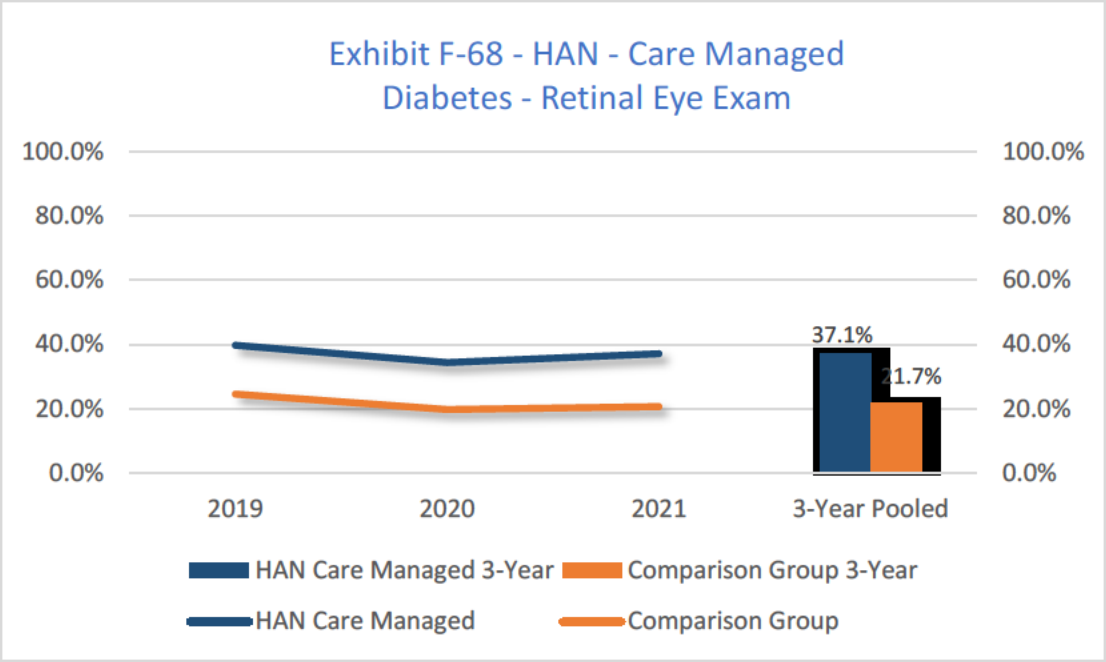
Exhibit F-67 – HAN (Total) – Diabetes – Retinal Eye Exam

	2019	2020	2021	3-Year Pooled
HAN (Total)	35.3%	29.8%	22.2%	29.1%
Comparison Group	24.7%	19.8%	19.9%	21.5%
Difference	10.6%‡	10.0%‡	2.3%‡	7.6%‡

‡ HAN rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HAN Care Managed Population

Approximately 37 percent of HAN Care Managed members and 22 percent of comparison group members were compliant on this measure across the three years (Exhibit F-68). The compliance rate for both populations declined from 2019 to 2020 before rising again from 2020 to 2021.



The difference between the HAN Care Managed and comparison group compliance rates was statistically significant in each of the individual years. It also was statistically significant for the three-year pooled data (Exhibit F-69).

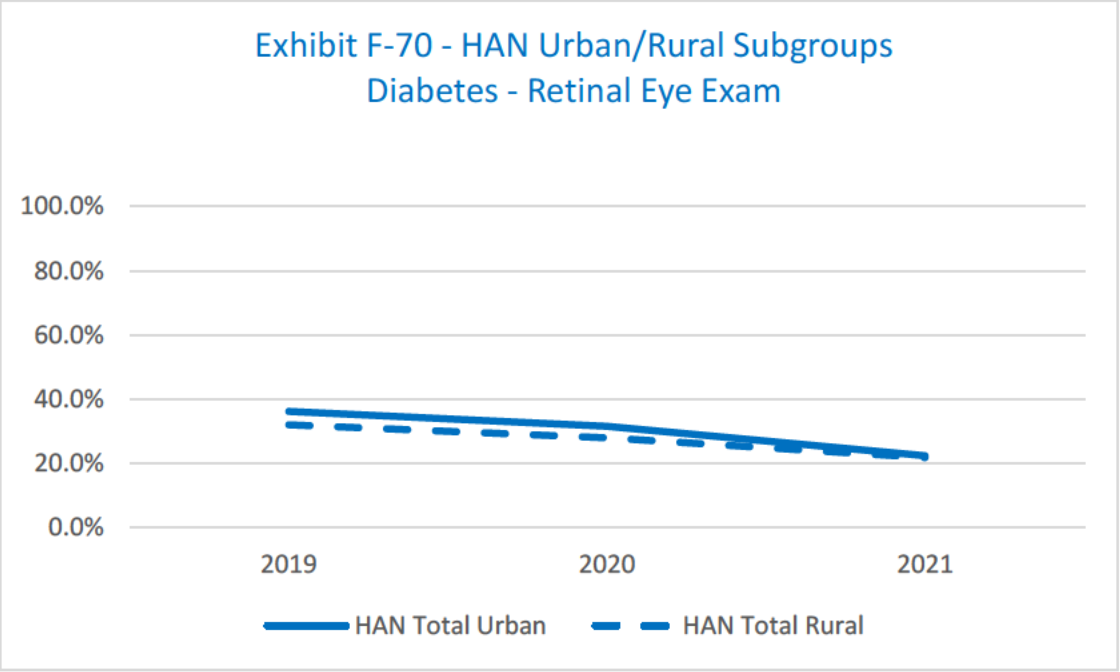
Exhibit F-69 – HAN (Care Managed) – Diabetes – Retinal Eye Exam

	2019	2020	2021	3-Year Pooled
HAN (Care Managed)	39.7%	34.4%	37.1%	37.1%
Comparison Group	24.5%	19.8%	20.7%	21.7%
Difference	15.2%‡	14.6%‡	16.4%‡	15.4%‡

‡ HAN rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HAN Total and Care Managed Populations – Urban and Rural Subgroups

The HAN total urban subgroup rate exceeded the rural subgroup rate across the three years. The rates for both subgroups declined from 2019 to 2021 (Exhibit F-70).

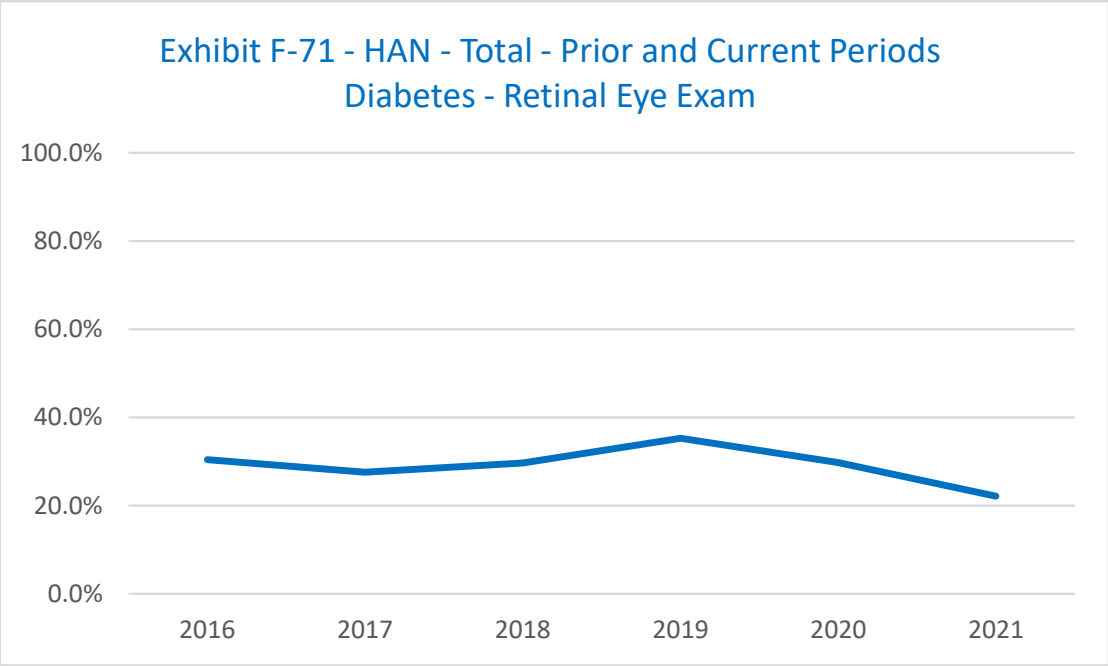


	Subgroup	2019	2020	2021
HAN (Total)	**Urban**	36.2%	31.6%	22.4%
	Rural	32.1%	28.0%	21.8%

The HAN Care Managed urban and rural subgroups were not sufficient in size to produce reliable trendlines.

Findings – HAN Total Population – Comparison to Prior Waiver Period

This measure also was evaluated for the HAN total population in the prior waiver period (2016 to 2018). The compliance rate rose from approximately 30 percent in 2016 to 35 percent in 2019, before declining to 22 percent in 2021 (Exhibit F-71).

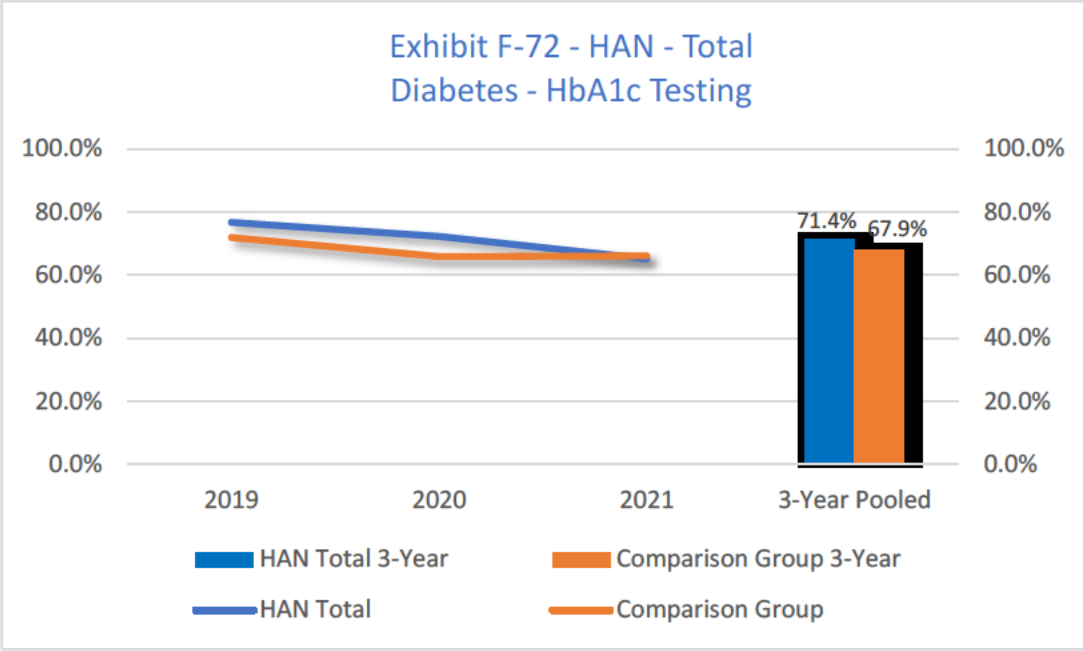


	2016	2017	2018	2019	2020	2021
HAN (Total)	30.4%	27.6%	29.7%	35.3%	29.8%	22.2%

Diabetes – HbA1c Testing

Findings – HAN Total Population

Approximately 71 percent of HAN total members and 68 percent of comparison group members were compliant on this measure across the three years (Exhibit F-72). The compliance rate for both populations declined from 2019 to 2021.

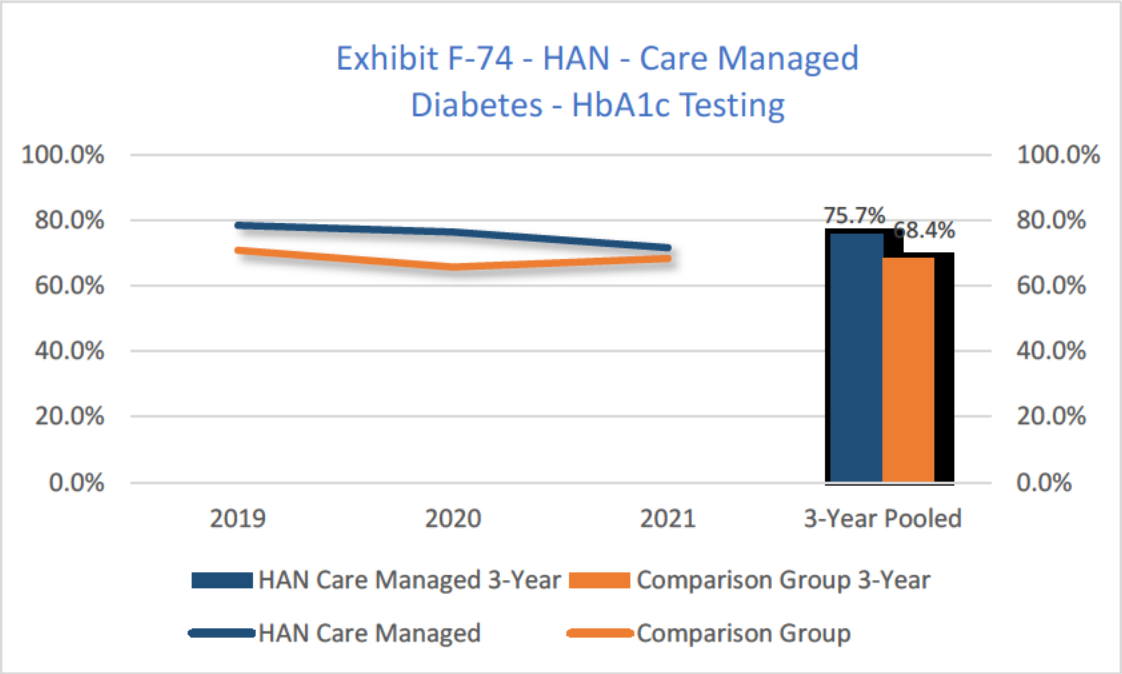


The difference between the HAN total and comparison group compliance rates was statistically significant in 2019 and 2020. It also was statistically significant for the three-year pooled data (Exhibit F-73).

Exhibit F-73 – HAN (Total) – Diabetes – HbA1c Testing				
	2019	2020	2021	3-Year Pooled
HAN (Total)	76.7%	72.2%	65.2%	71.4%
Comparison Group	71.9%	65.8%	66.0%	67.9%
Difference	4.8%‡	6.4%‡	(0.8%)	3.5%‡
‡ HAN rate differs from comparison group rate by a statistically significant amount (95% confidence level)				

Findings – HAN Care Managed Population

Approximately 76 percent of HAN Care Managed members and 68 percent of comparison group members were compliant on this measure across the three years (Exhibit F-74). The compliance rate for the HAN total population declined from 2019 to 2021. The compliance rate for the comparison group population declined from 2019 to 2020 before rising again from 2020 to 2021.



The difference between the HAN Care Managed and comparison group compliance rates was statistically significant in 2019 and 2020. It also was statistically significant for the three-year pooled data (Exhibit F-75).

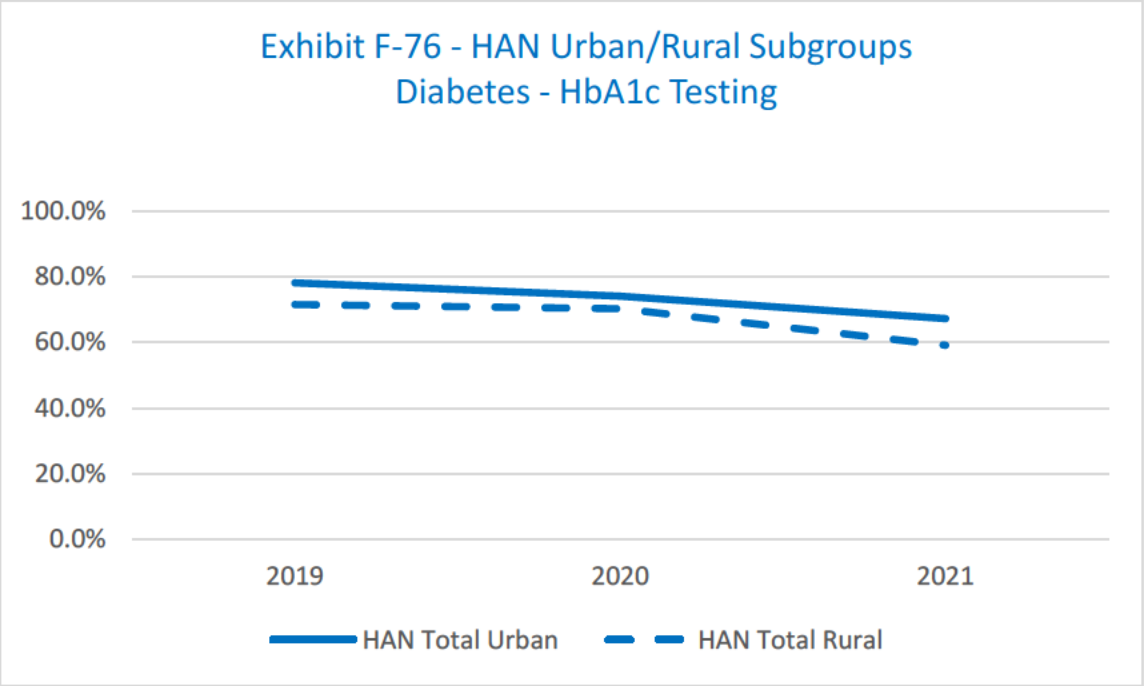
Exhibit F-75 – HAN (Care Managed) – Diabetes – HbA1c Testing

	2019	2020	2021	3-Year Pooled
HAN (Care Managed)	78.6%	76.6%	71.8%	75.7%
Comparison Group	71.0%	65.8%	68.4%	68.4%
Difference	7.6%‡	10.8%‡	3.4%	7.3%‡

‡ HAN rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HAN Total and Care Managed Populations – Urban and Rural Subgroups

The HAN total urban subgroup rate exceeded the rural subgroup rate across the three years. The rates for both subgroups declined from 2019 to 2021 (Exhibit F-76).

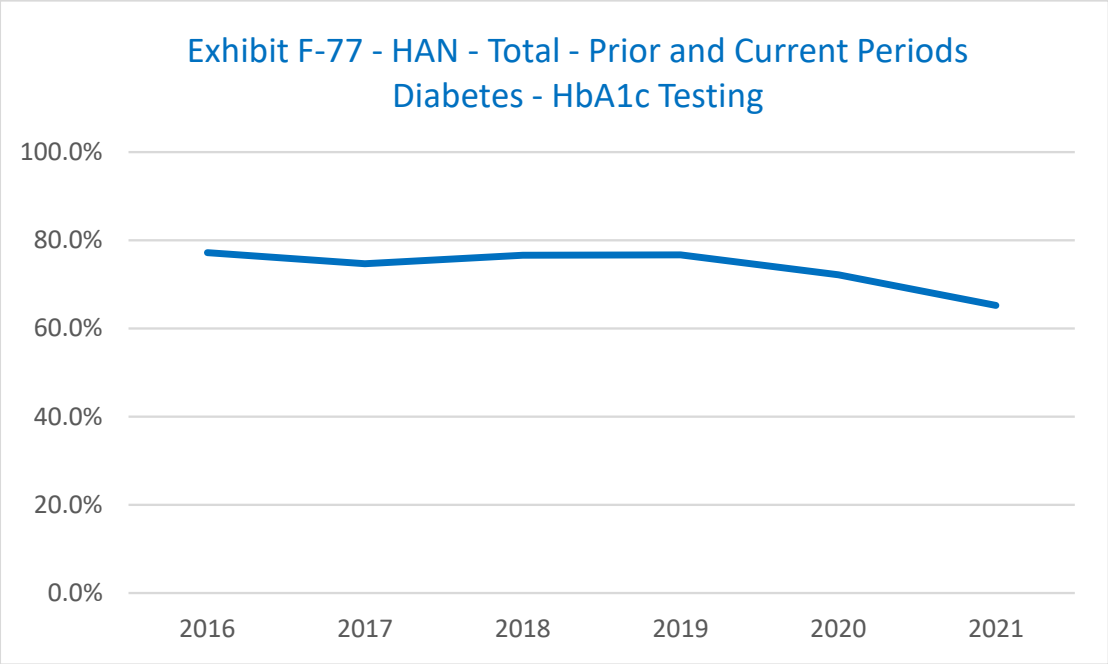


	Subgroup	2019	2020	2021
HAN (Total)	**Urban**	78.2%	74.2%	67.3%
	Rural	71.6%	70.3%	59.2%

The HAN Care Managed urban and rural subgroups were not sufficient in size to produce reliable trendlines.

Findings – HAN Total Population – Comparison to Prior Waiver Period

This measure also was evaluated for the HAN total population in the prior waiver period (2016 to 2018). The compliance rate declined from approximately 77 percent in 2016 to 65 percent in 2021 (Exhibit F-77).

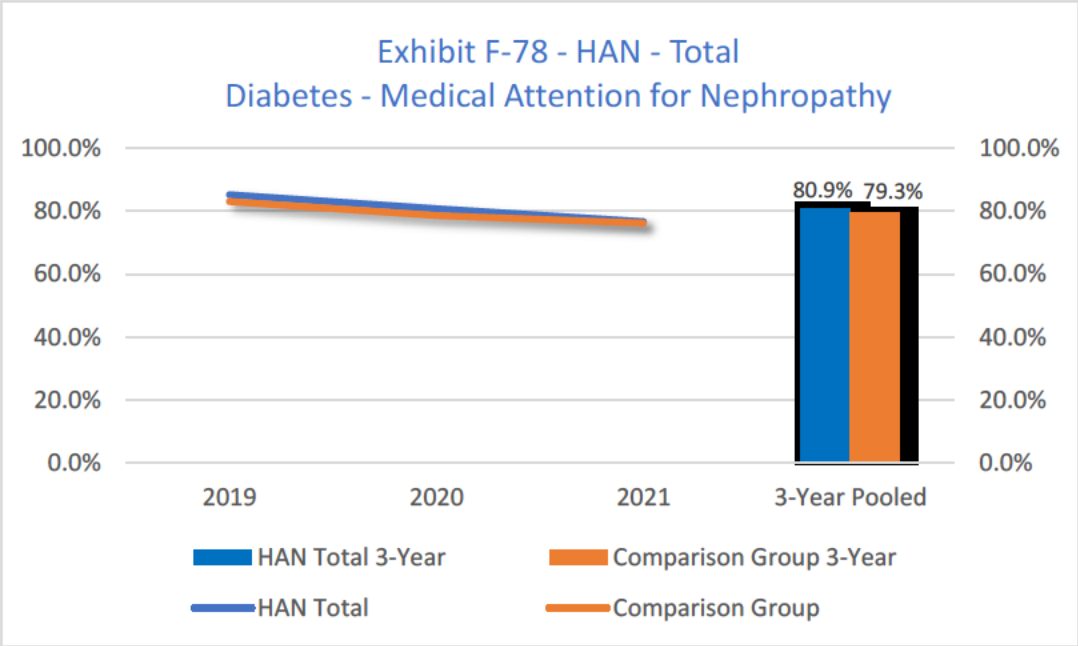


	2016	2017	2018	2019	2020	2021
HAN (Total)	77.2%	74.7%	76.6%	76.7%	72.2%	65.2%

Diabetes – Medical Attention for Nephropathy

Findings – HAN Total Population

Approximately 81 percent of HAN total members and 79 percent of comparison group members were compliant on this measure across the three years (Exhibit F-78). The compliance rate for both populations declined from 2019 to 2021.



The difference between the HAN total and comparison group compliance rates was statistically significant in 2019 and 2020. It also was statistically significant for the three-year pooled data (Exhibit F-79).

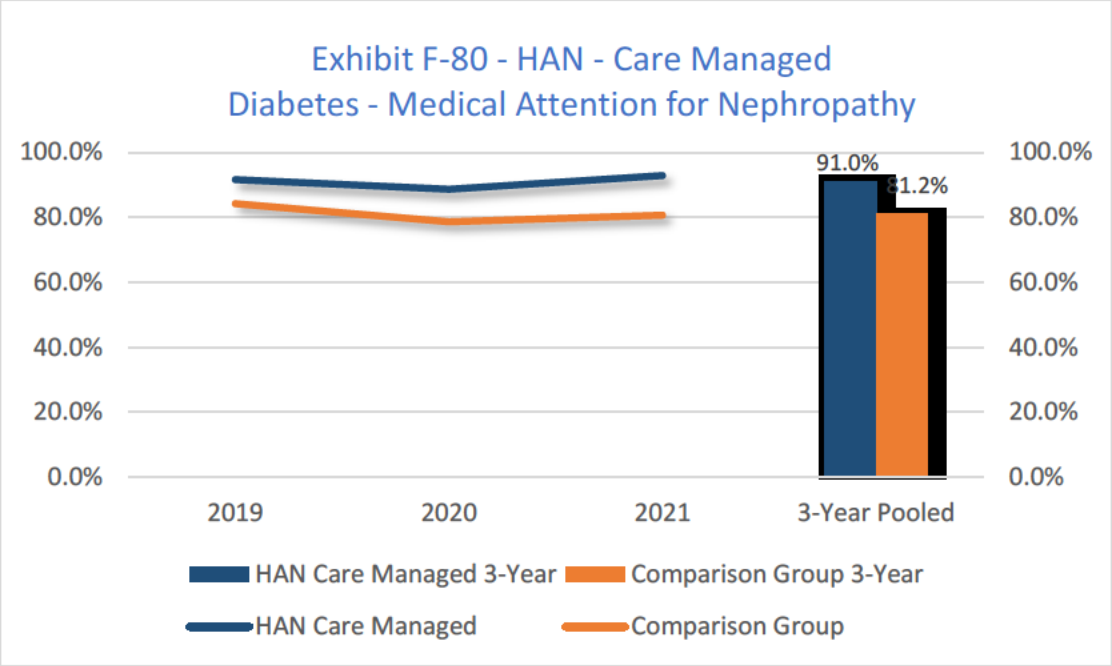
Exhibit F-79 – HAN (Total) – Diabetes – Medical Attention for Nephropathy

	2019	2020	2021	3-Year Pooled
HAN (Total)	85.2%	80.8%	76.7%	80.9%
Comparison Group	83.1%	78.6%	76.2%	79.3%
Difference	2.1%‡	2.2%‡	0.5%	1.6%‡

‡ HAN rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HAN Care Managed Population

Ninety-one percent of HAN Care Managed members and approximately 81 percent of comparison group members were compliant on this measure across the three years (Exhibit F-80). The compliance rate for both populations declined from 2019 to 2020 before rising again from 2020 to 2021.



The difference between the HAN Care Managed and comparison group compliance rates was statistically significant in each of the individual years. It also was statistically significant for the three-year pooled data (Exhibit F-81).

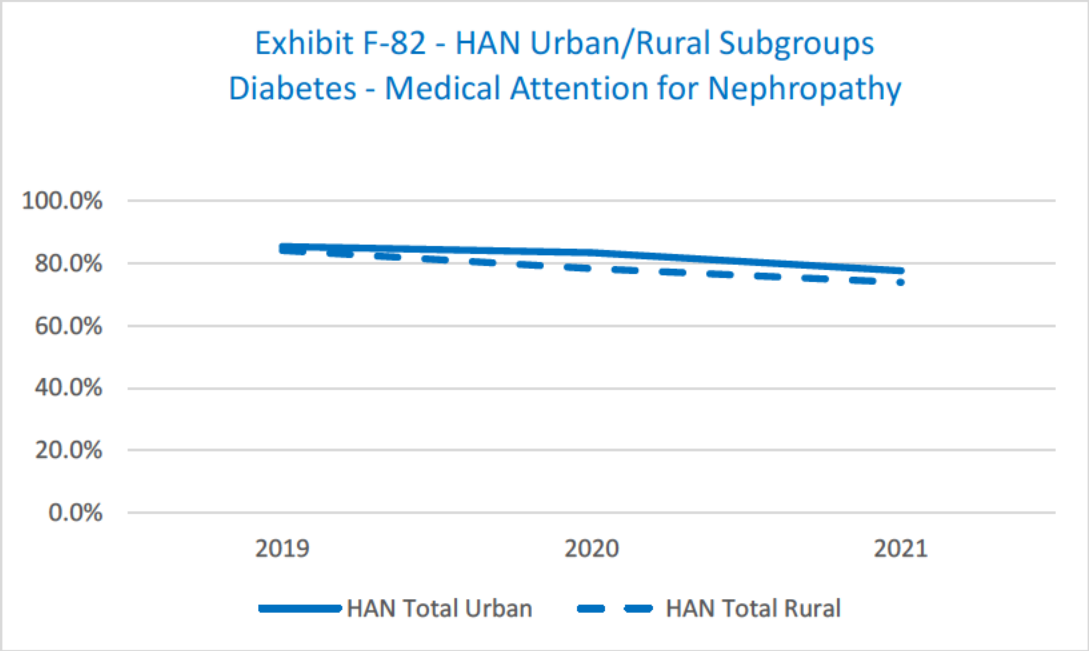
Exhibit F-81 – HAN (Care Managed) – Diabetes – Medical Attention for Nephropathy

	2019	2020	2021	3-Year Pooled
HAN (Care Managed)	91.6%	88.6%	92.9%	91.0%
Comparison Group	84.2%	78.6%	80.7%	81.2%
Difference	7.4%‡	10.0%‡	12.2%‡	9.8%‡

‡ HAN rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HAN Total and Care Managed Populations – Urban and Rural Subgroups

The HAN total urban subgroup rate exceeded the rural subgroup rate across the three years. The rates for both subgroups declined from 2019 to 2021 (Exhibit F-82).

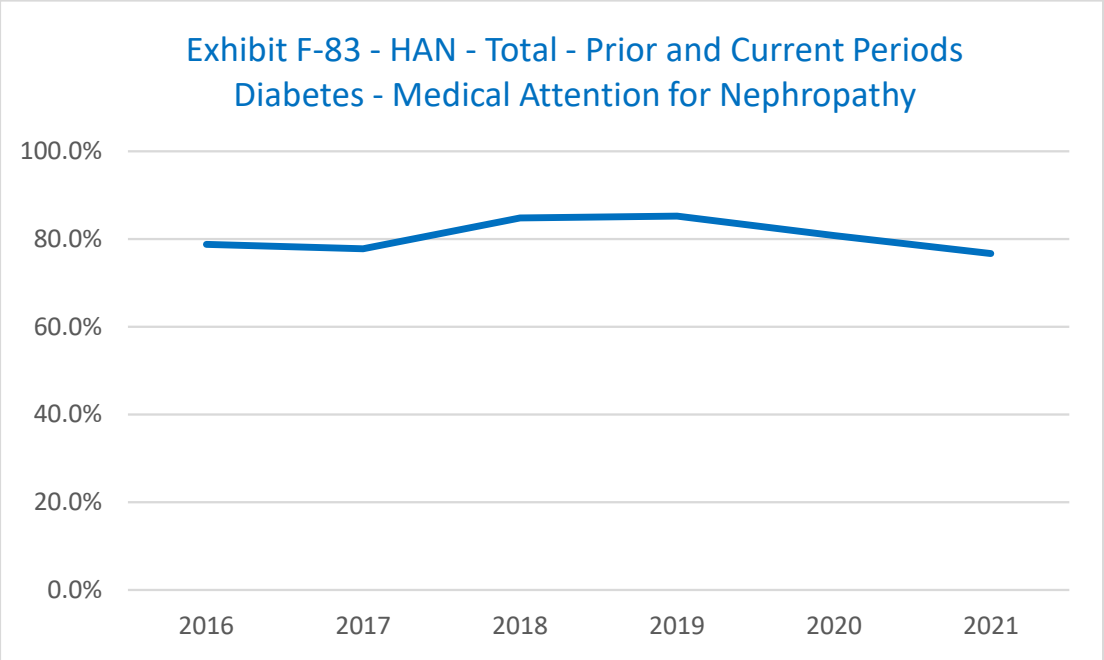


	Subgroup	2019	2020	2021
HAN (Total)	**Urban**	85.4%	83.4%	77.6%
	Rural	84.1%	78.3%	73.9%

The HAN Care Managed urban and rural subgroups were not sufficient in size to produce reliable trendlines.

Findings – HAN Total Population – Comparison to Prior Waiver Period

This measure also was evaluated for the HAN total population in the prior waiver period (2016 to 2018). The compliance rate rose from approximately 79 percent in 2016 to 85 percent in 2019, before declining to 77 percent in 2021 (Exhibit F-83).

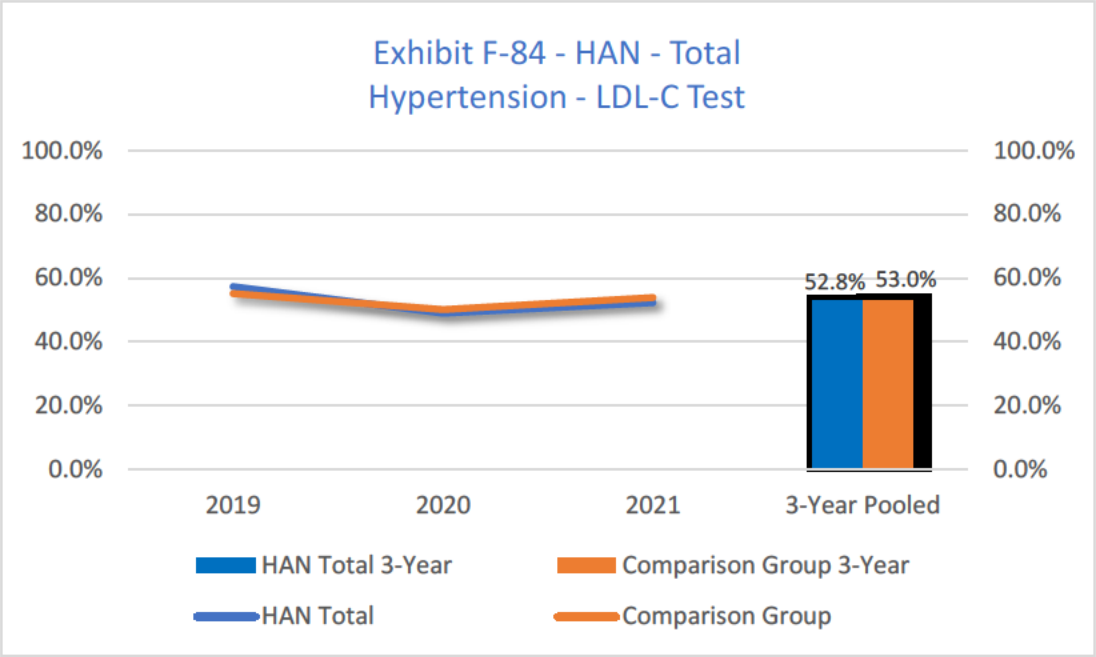


	2016	2017	2018	2019	2020	2021
HAN (Total)	78.8%	77.8%	84.8%	85.2%	80.8%	76.7%

Hypertension – LDL-C Test

Findings – HAN Total Population

Approximately 53 percent of HAN total members and 53 percent of comparison group members were compliant on this measure across the three years (Exhibit F-84). The compliance rate for both populations declined from 2019 to 2020 before rising again from 2020 to 2021.



The difference between the HAN total and comparison group compliance rates was statistically significant in 2019 and 2021. It was not statistically significant for the three-year pooled data (Exhibit F-85).

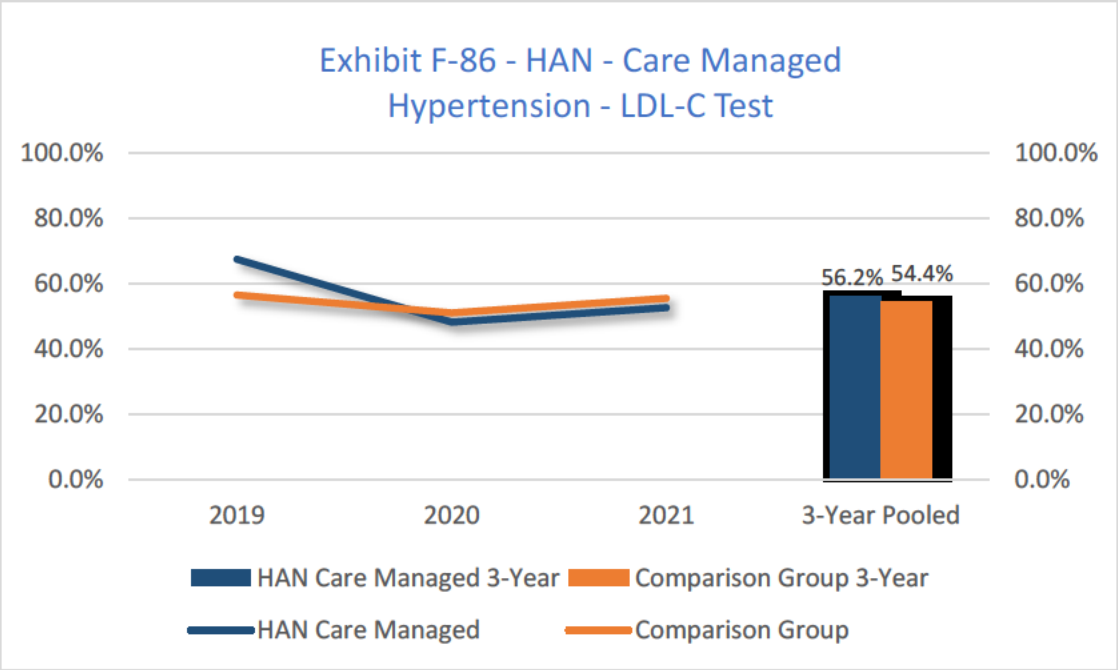
Exhibit F-85 – HAN (Total) – Hypertension – LDL-C Test

	2019	2020	2021	3-Year Pooled
HAN (Total)	57.3%	48.9%	52.3%	52.8%
Comparison Group	55.1%	50.1%	53.8%	53.0%
Difference	2.2%‡	(1.2%)	(1.5%)‡	(0.2%)

‡ HAN rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HAN Care Managed Population

Approximately 56 percent of HAN Care Managed members and 54 percent of comparison group members were compliant on this measure across the three years (Exhibit F-86). The compliance rate for both populations declined from 2019 to 2020 before rising again from 2020 to 2021.



The difference between the HAN Care Managed and comparison group compliance rates was statistically significant in 2019. It was not statistically significant for the three-year pooled data (Exhibit F-87).

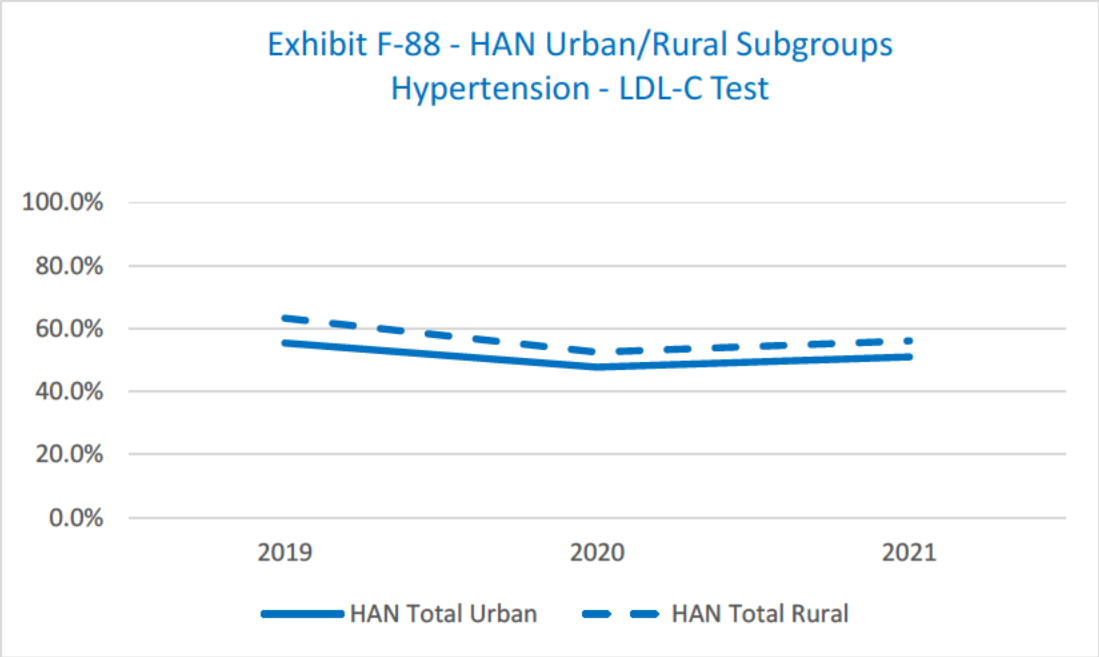
Exhibit F-87 – HAN (Care Managed) – Hypertension – LDL-C Test

	2019	2020	2021	3-Year Pooled
HAN (Care Managed)	67.5%	48.3%	52.7%	56.2%
Comparison Group	56.6%	51.1%	55.6%	54.4%
Difference	9.9%‡	(2.8%)	(2.9%)	1.8%

‡ HAN rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HAN Total and Care Managed Populations – Urban and Rural Subgroups

The HAN total rural subgroup rate exceeded the urban subgroup rate across the three years. The rates for both subgroups declined from 2019 to 2020 and rose from 2020 to 2021 (Exhibit F-88).

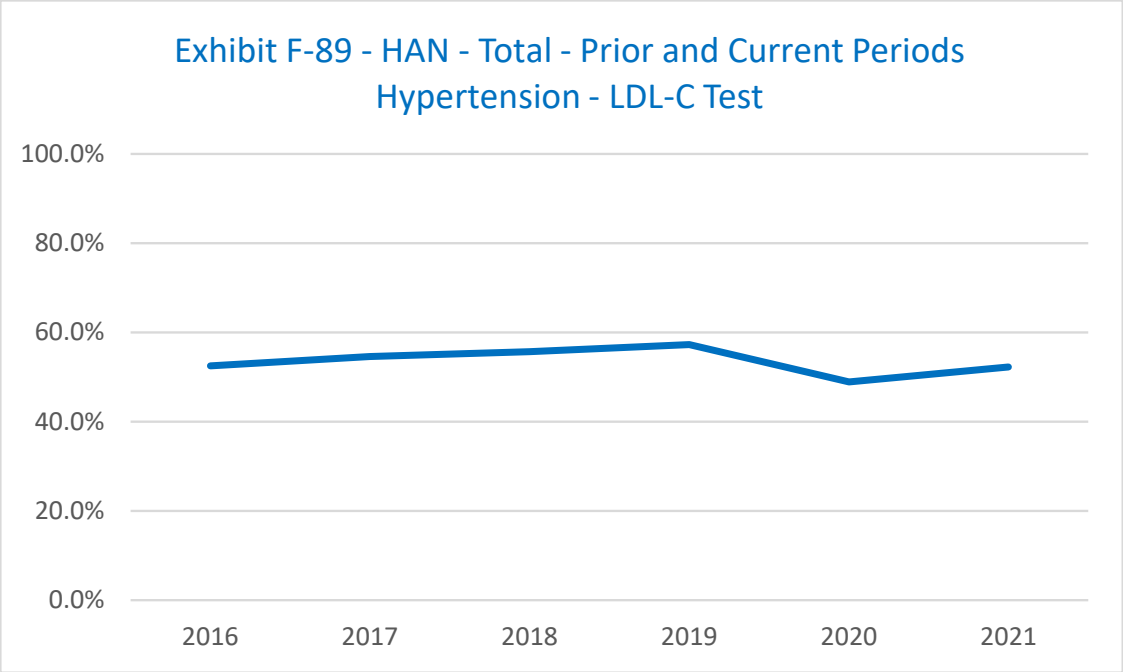


	Subgroup	2019	2020	2021
HAN (Total)	**Urban**	55.5%	47.8%	51.0%
	Rural	63.3%	52.6%	56.1%

The HAN Care Managed urban and rural subgroups were not sufficient in size to produce reliable trendlines.

Findings – HAN Total Population – Comparison to Prior Waiver Period

This measure also was evaluated for the HAN total population in the prior waiver period (2016 to 2018). The compliance rate rose from approximately 53 percent in 2016 to 57 percent in 2019, before declining to 49 percent in 2021 and rising again to 52 percent in 2021 (Exhibit F-89).

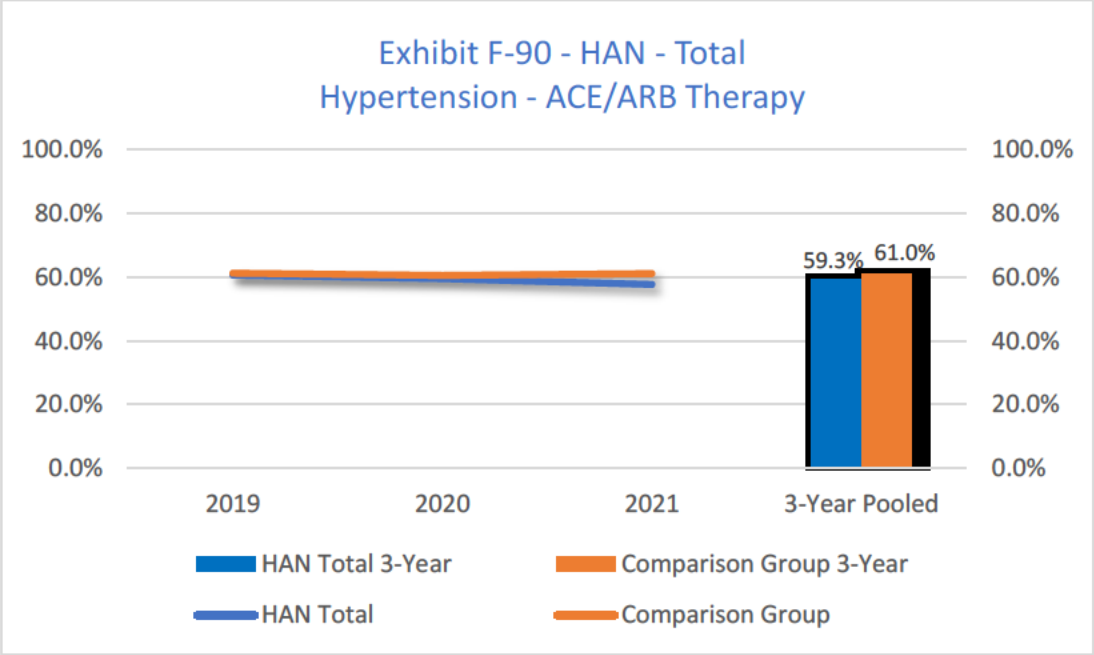


	2016	2017	2018	2019	2020	2021
HAN (Total)	52.5%	54.6%	55.7%	57.3%	48.9%	52.3%

Hypertension – ACE/ARB Therapy

Findings – HAN Total Population

Approximately 59 percent of HAN total members and 61 percent of comparison group members were compliant on this measure across the three years (Exhibit F-90). The compliance rate for the HAN total population declined slightly from 2019 to 2021. The compliance rate for the comparison group declined slightly from 2019 to 2020 before rising slightly again from 2020 to 2021.

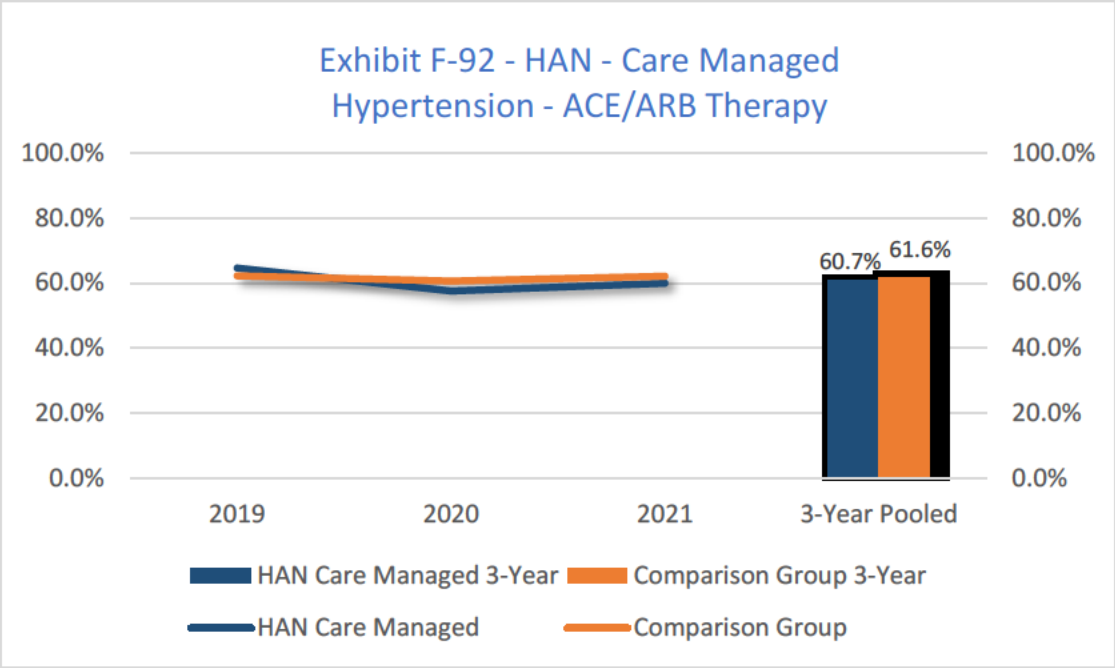


The difference between the HAN total and comparison group compliance rates was statistically significant in 2021. It also was statistically significant for the three-year pooled data (Exhibit F-91).

Exhibit F-91 – HAN (Total) – Hypertension – ACE/ARB Therapy				
	2019	2020	2021	3-Year Pooled
HAN (Total)	60.7%	59.5%	57.7%	59.3%
Comparison Group	61.3%	60.6%	61.1%	61.0%
Difference	(0.6%)	(1.1%)	(3.4%)‡	(1.7%)‡
‡ HAN rate differs from comparison group rate by a statistically significant amount (95% confidence level)				

Findings – HAN Care Managed Population

Approximately 61 percent of HAN Care Managed members and 62 percent of comparison group members were compliant on this measure across the three years (Exhibit F-92). The compliance rate for both populations declined from 2019 to 2020 before rising again from 2020 to 2021.



The difference between the HAN Care Managed and comparison group compliance rates was not statistically significant in any of the individual years. It also was not statistically significant for the three-year pooled data (Exhibit F-93).

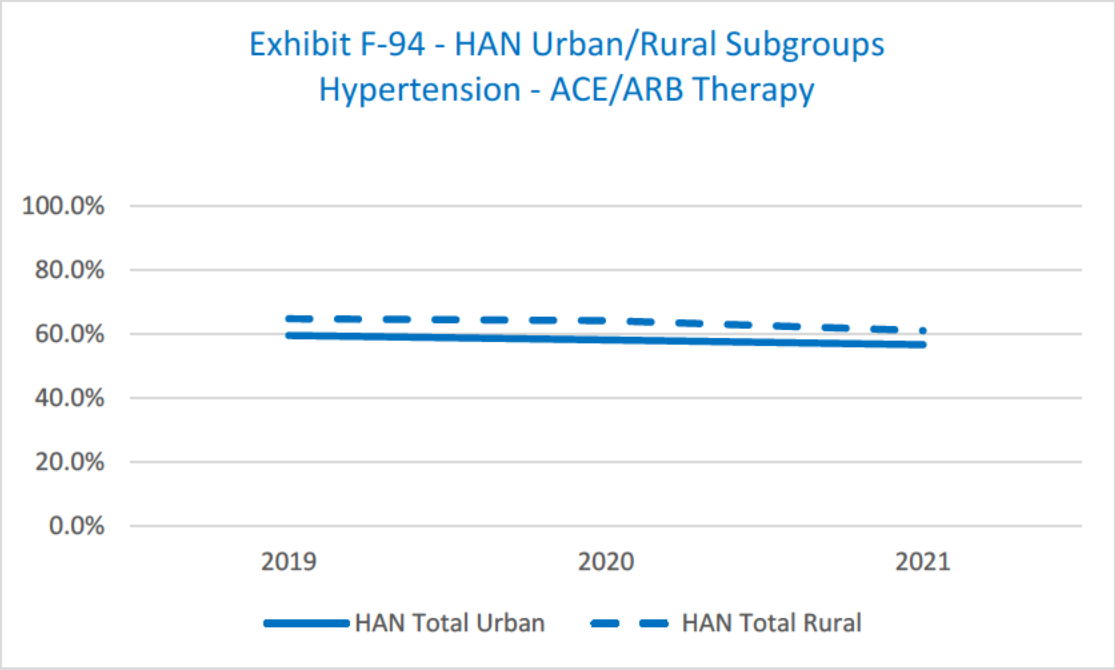
Exhibit F-93 – HAN (Care Managed) – Hypertension – ACE/ARB Therapy

	2019	2020	2021	3-Year Pooled
HAN (Care Managed)	64.6%	57.5%	59.9%	60.7%
Comparison Group	62.2%	60.6%	62.1%	61.6%
Difference	2.4%	(3.1%)	(2.2%)	(0.9%)

‡ HAN rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HAN Total and Care Managed Populations – Urban and Rural Subgroups

The HAN total rural subgroup rate exceeded the urban subgroup rate across the three years. The rates for both subgroups declined slightly from 2019 to 2021 (Exhibit F-94).

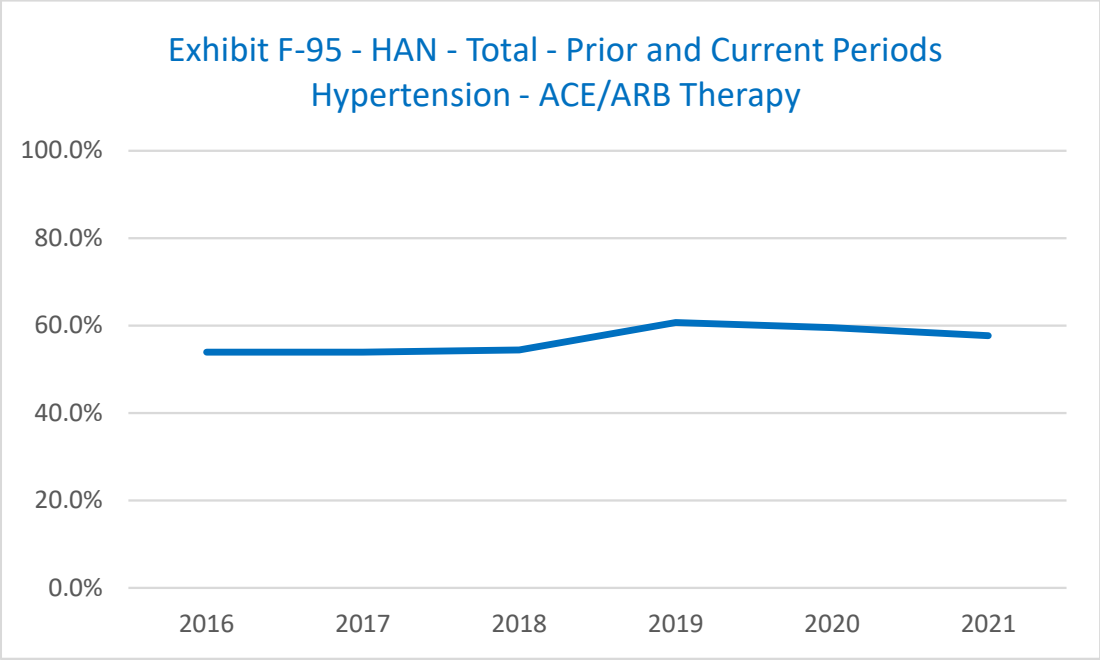


	Subgroup	2019	2020	2021
HAN (Total)	**Urban**	59.5%	58.1%	56.6%
	Rural	64.7%	64.2%	61.0%

The HAN Care Managed urban and rural subgroups were not sufficient in size to produce reliable trendlines.

Findings – HAN Total Population – Comparison to Prior Waiver Period

This measure also was evaluated for the HAN total population in the prior waiver period (2016 to 2018). The compliance rate rose from approximately 54 percent in 2016 to 61 percent in 2019, before declining to 58 percent in 2021 (Exhibit F-95).

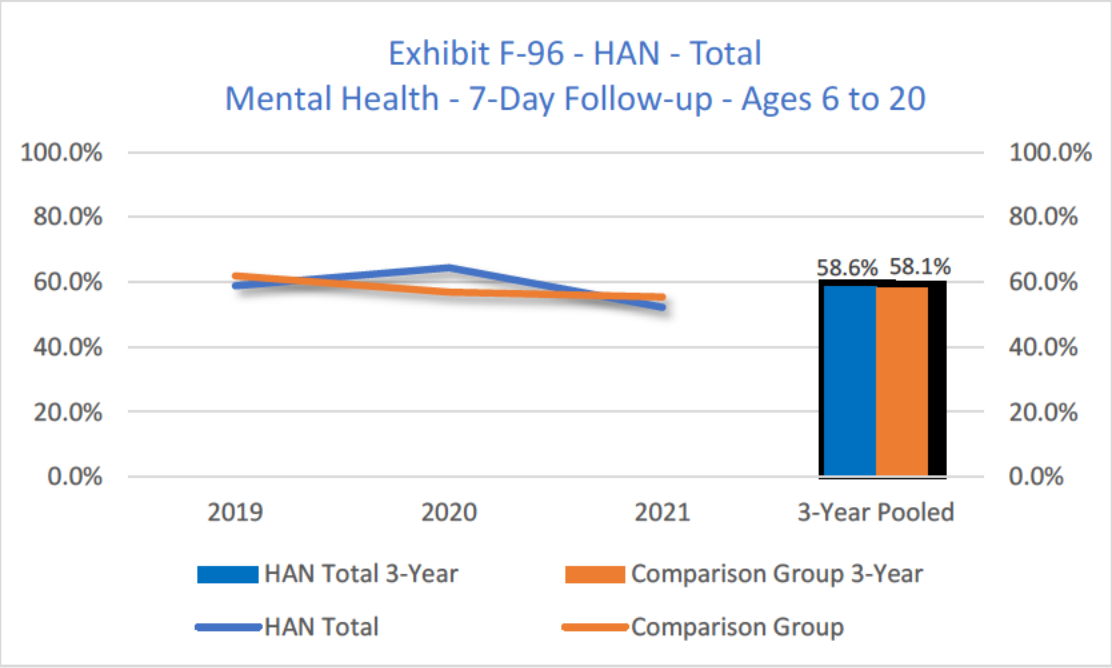


	2016	2017	2018	2019	2020	2021
HAN (Total)	53.9%	53.9%	54.4%	60.7%	59.5%	57.7%

Mental Health – Follow-up after Hospitalization for Mental Illness – 7 Days – Ages 6 to 20

Findings – HAN Total Population

Approximately 59 percent of HAN total members and 58 percent of comparison group members were compliant on this measure across the three years (Exhibit F-96). The compliance rate for the HAN total population rose from 2019 to 2020, before declining from 2020 to 2021. The compliance rate for the comparison group declined from 2019 to 2021.



The difference between the HAN total and comparison group compliance rates was statistically significant in 2020. It was not statistically significant for the three-year pooled data (Exhibit F-97).

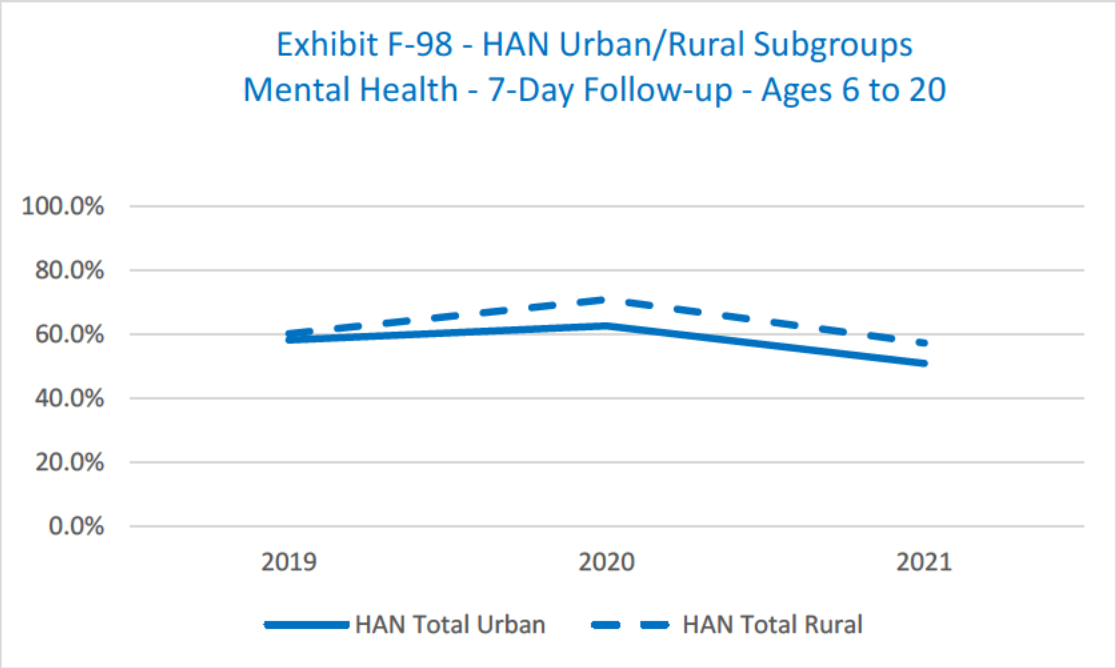
Exhibit F-97 – HAN (Total) – Mental Health – 7-Day Follow-up – Ages 6 to 20

	2019	2020	2021	3-Year Pooled
HAN (Total)	58.9%	64.5%	52.3%	58.6%
Comparison Group	62.0%	56.9%	55.5%	58.1%
Difference	(3.1%)	12.4%‡	(3.2%)	0.5%

‡ HAN rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HAN Total and Care Managed Populations – Urban and Rural Subgroups

The HAN total rural subgroup rate exceeded the urban subgroup rate in 2020 and 2021. The rates for both subgroups rose from 2019 to 2021 and declined from 2019 to 2021 (Exhibit F-98).



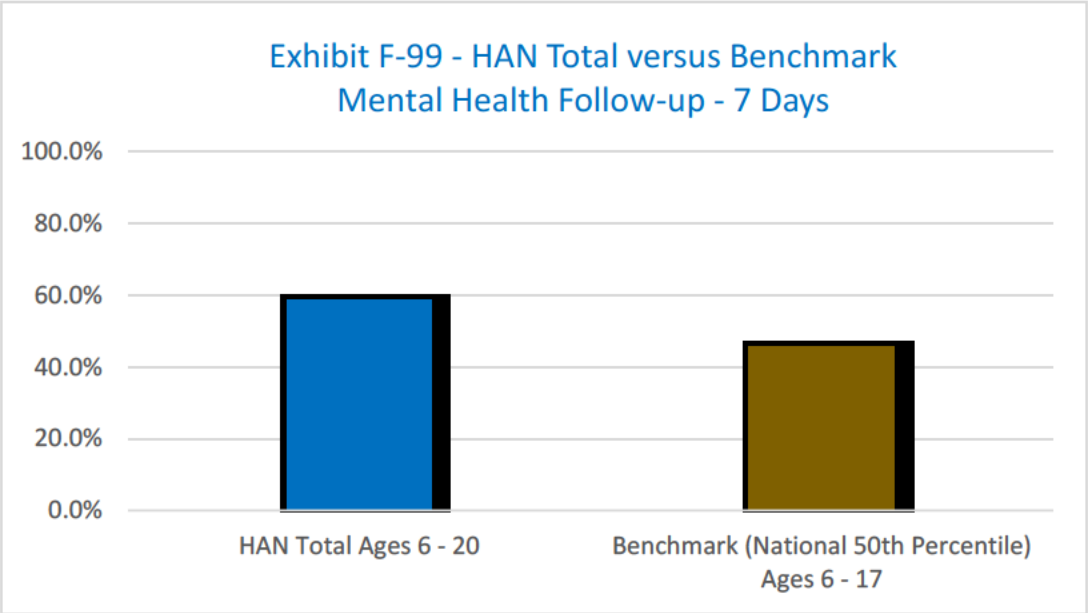
	Subgroup	2019	2020	2021
HAN (Total)	**Urban**	58.2%	62.6%	50.9%
	Rural	60.2%	70.9%	57.3%

Findings – HAN Total Population and National Benchmark

The HAN and national benchmark measures differed slightly with respect to age ranges. The HAN population includes ages 6 to 20 while the national benchmark includes ages 6 to 17.

The three-year pooled rate for the SoonerCare HAN total population exceeded the national benchmark rate by 13 percentage points (Exhibit F-99).

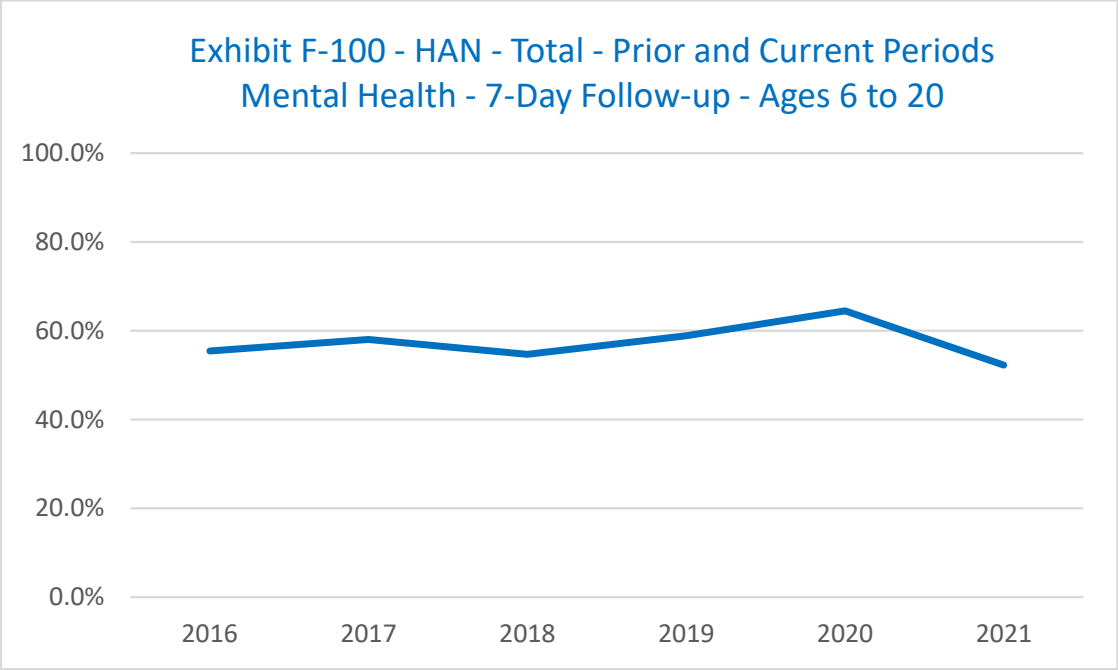
(Caution: the benchmark population characteristics were not matched to the OHCA groups to minimize differences in the populations. The data is presented for informational purposes only.)



	HAN Total	Benchmark
Compliance Rate	58.6%	45.6%

Findings – HAN Total Population – Comparison to Prior Waiver Period

This measure also was evaluated for the HAN total population in the prior waiver period (2016 to 2018). The compliance rate rose from approximately 55 percent in 2016 to 65 percent in 2020, before declining to 52 percent in 2021 (Exhibit F-100).

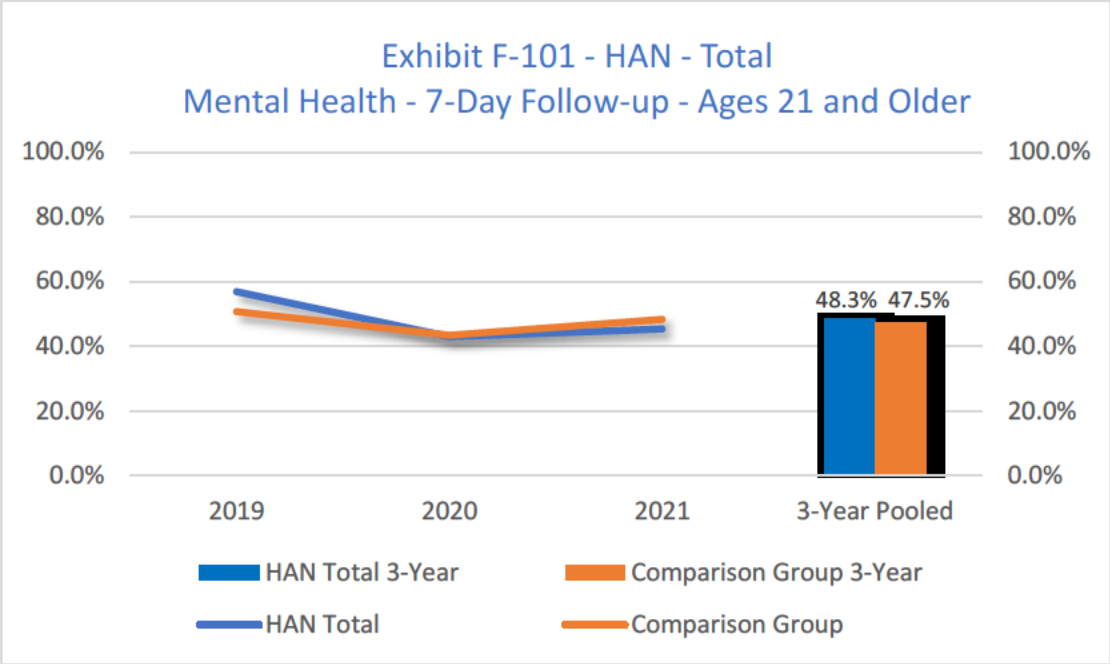


	2016	2017	2018	2019	2020	2021
HAN (Total)	55.4%	58.0%	54.7%	58.9%	64.5%	52.3%

Mental Health – Follow-up after Hospitalization for Mental Illness – 7 Days – Ages 21 and Older

Findings – HAN Total Population

Approximately 48 percent of HAN total members and 48 percent of comparison group members were compliant on this measure across the three years (Exhibit F-101). The compliance rate for both populations declined from 2019 to 2020 before rising again from 2020 to 2021.



The difference between the HAN total and comparison group compliance rates was not statistically significant in any of the individual years. It also was not statistically significant for the three-year pooled data (Exhibit F-102).

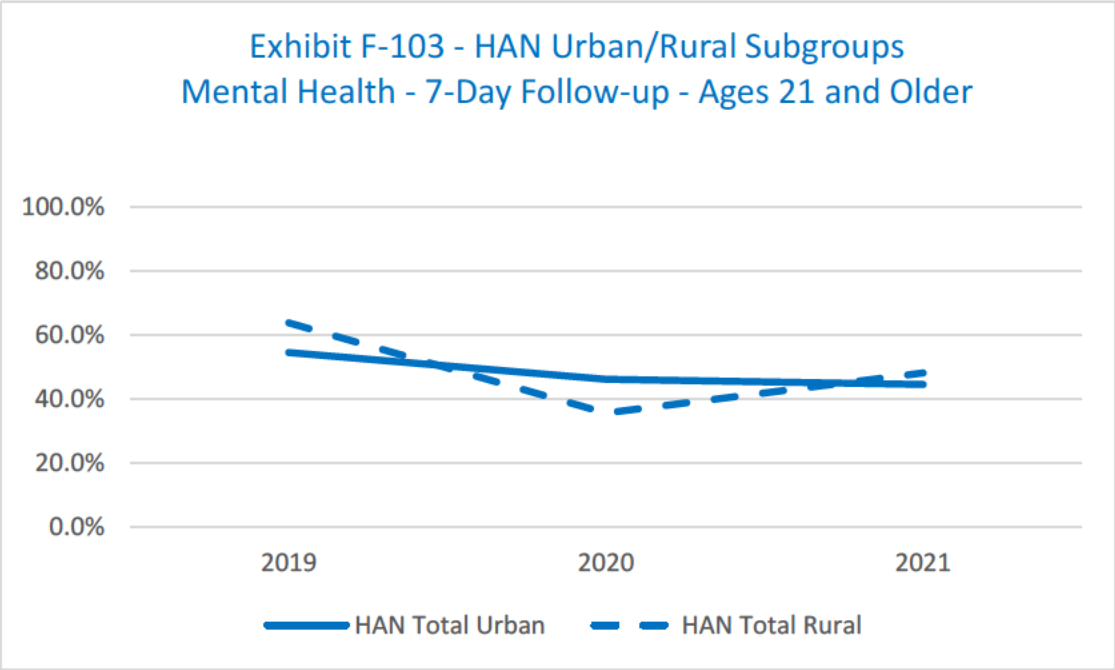
Exhibit F-102 – HAN (Total) – Mental Health – 7-Day Follow-up – Ages 21 and Older

	2019	2020	2021	3-Year Pooled
HAN (Total)	56.8%	42.9%	45.3%	48.3%
Comparison Group	50.7%	43.4%	48.3%	47.5%
Difference	6.1%	(0.5%)	2.0%	0.8%

‡ HAN rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HAN Total and Care Managed Populations – Urban and Rural Subgroups

The HAN total rural subgroup rate exceeded the urban subgroup rate in 2019 and 2021; the urban subgroup rate exceeded the rural subgroup rate in 2020. The urban subgroup rate declined from 2019 to 2021 while the rural subgroup rate declined from 2019 to 2020 and rose again from 2020 to 2021 (Exhibit F-103)[53].



	Subgroup	2019	2020	2021
HAN (Total)	**Urban**	54.6%	46.3%	44.7%
	Rural	63.9%	35.7%	48.3%

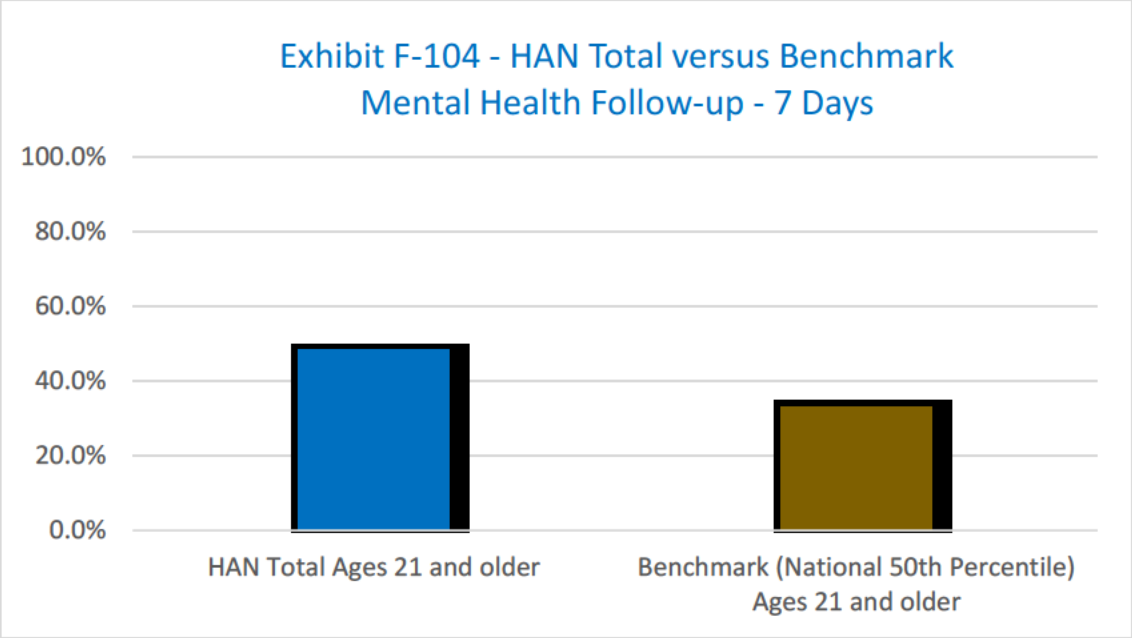
[53] See cautionary note in Introduction to Section F regarding year-over-year variance in measures with small denominators. HAN rural population denominator for this measure was less than 100 in each of the three years.

Findings – HAN Total Population and National Benchmark

The HAN and national benchmark measures differed slightly with respect to age ranges. The HAN population includes ages 21 and older while the national benchmark includes ages 18 and older.

The three-year pooled rate for the SoonerCare HAN total population exceeded the national benchmark rate by approximately 15 percentage points (Exhibit F-104).

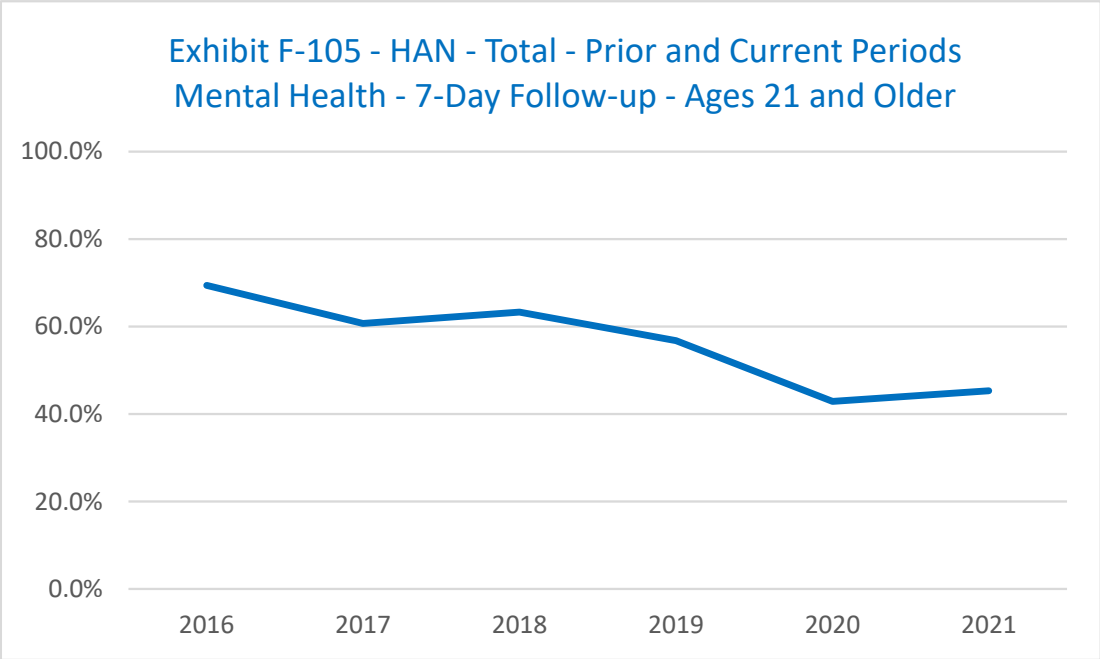
(Caution: the benchmark population characteristics were not matched to the OHCA groups to minimize differences in the populations. The data is presented for informational purposes only.)



	HAN Total	Benchmark
Compliance Rate	48.3%	33.1%

Findings – HAN Total Population – Comparison to Prior Waiver Period

This measure also was evaluated for the HAN total population in the prior waiver period (2016 to 2018). The compliance rate declined gradually from approximately 69 percent in 2016 to 43 percent in 2020 and rising again slightly to 45 percent in 2021 (Exhibit F-105).

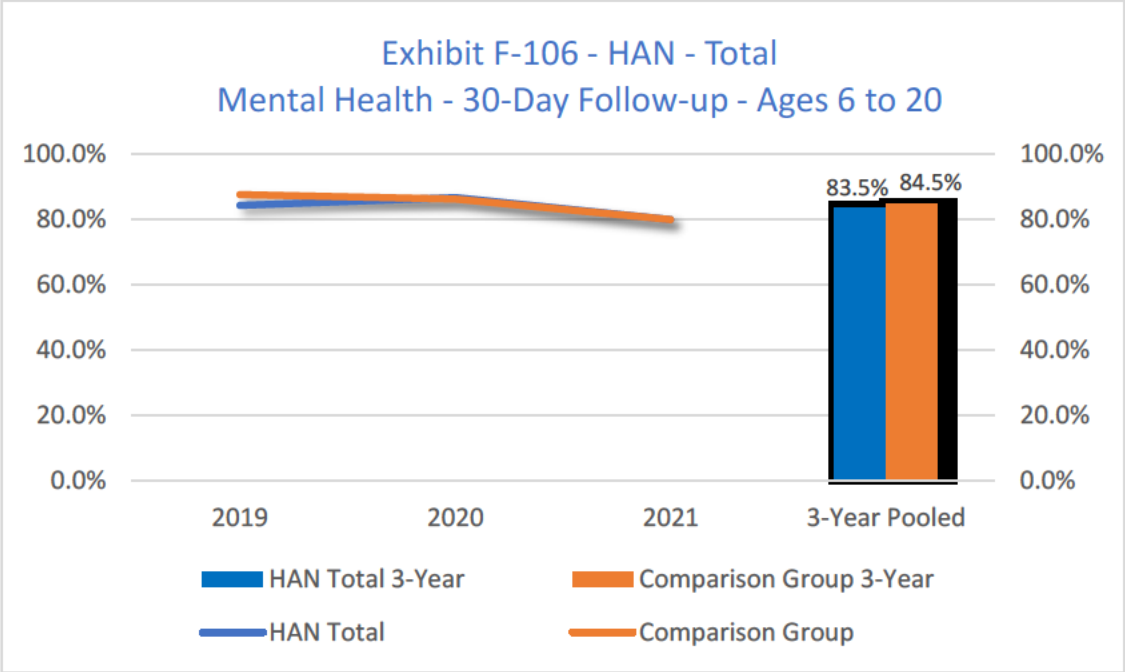


	2016	2017	2018	2019	2020	2021
HAN (Total)	69.4%	60.7%	63.3%	56.8%	42.9%	45.3%

Mental Health – Follow-up after Hospitalization for Mental Illness – 30 Days – Ages 6 to 20

Findings – HAN Total Population

Approximately 84 percent of HAN total members and 85 percent of comparison group members were compliant on this measure across the three years (Exhibit F-106). The compliance rate for the HAN total population rose from 2019 to 2020, before declining from 2020 to 2021. The compliance rate for the comparison group declined from 2019 to 2021.



The difference between the HAN total and comparison group compliance rates was statistically significant in 2019. It was not statistically significant for the three-year pooled data (Exhibit F-107).

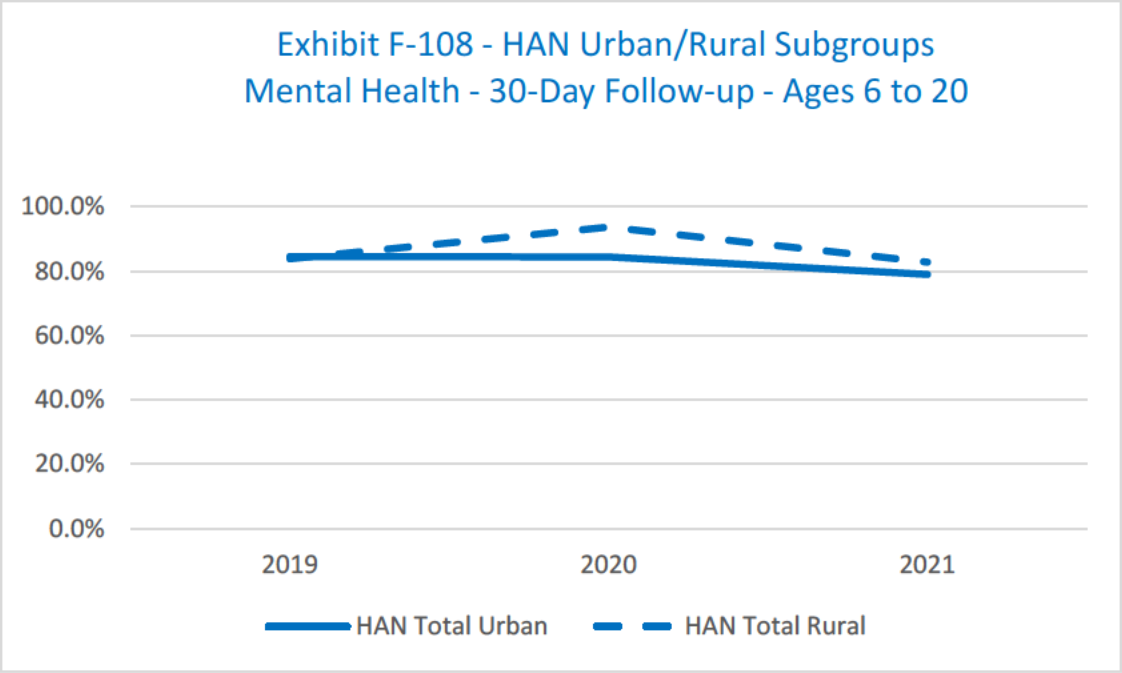
Exhibit F-107 – HAN (Total) – Mental Health – 30-Day Follow-up – Ages 6 to 20

	2019	2020	2021	3-Year Pooled
HAN (Total)	84.2%	86.6%	79.8%	83.5%
Comparison Group	87.5%	86.1%	79.9%	84.5%
Difference	(3.3%)‡	0.5%	(0.1%)	(1.0%)

‡ HAN rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HAN Total and Care Managed Populations – Urban and Rural Subgroups

The HAN total rural subgroup rate exceeded the urban subgroup rate in 2020 and 2021. The rates for both subgroups rose from 2019 to 2021 and declined from 2019 to 2021 (Exhibit F-108).



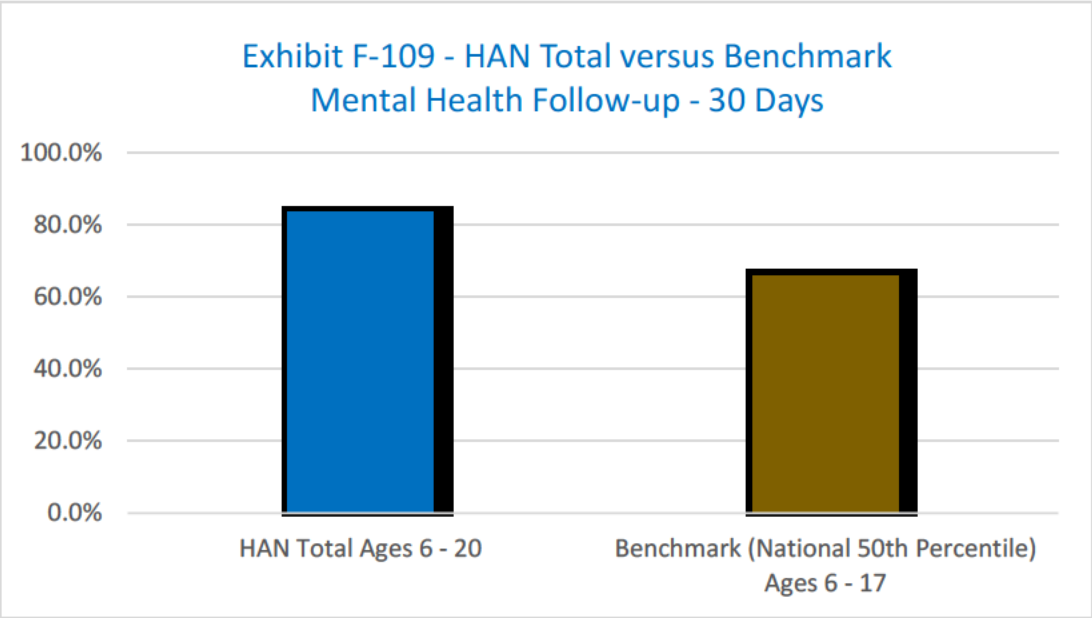
	Subgroup	2019	2020	2021
HAN (Total)	**Urban**	84.5%	84.4%	79.0%
	Rural	83.9%	93.7%	82.8%

Findings – HAN Total Population and National Benchmark

The HAN and national benchmark measures differed slightly with respect to age ranges. The HAN population includes ages 6 to 20 while the national benchmark includes ages 6 to 17.

The three-year pooled rate for the SoonerCare HAN total population exceeded the national benchmark rate by approximately 17 percentage points (Exhibit F-109).

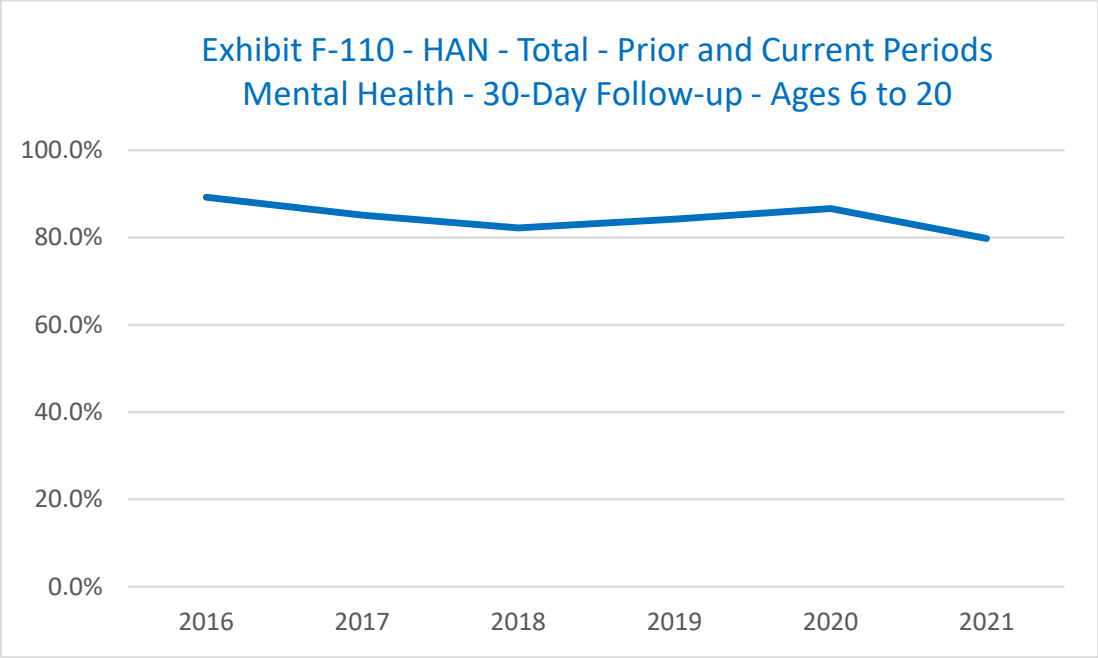
(Caution: the benchmark population characteristics were not matched to the OHCA groups to minimize differences in the populations. The data is presented for informational purposes only.)



	HAN Total	Benchmark
Compliance Rate	83.5%	66.0%

Findings – HAN Total Population – Comparison to Prior Waiver Period

This measure also was evaluated for the HAN total population in the prior waiver period (2016 to 2018). The compliance rate declined from approximately 89 percent in 2016 to 82 percent in 2018, before rising to 87 percent in 2020 and declining again to 80 percent in 2021 (Exhibit F-110).

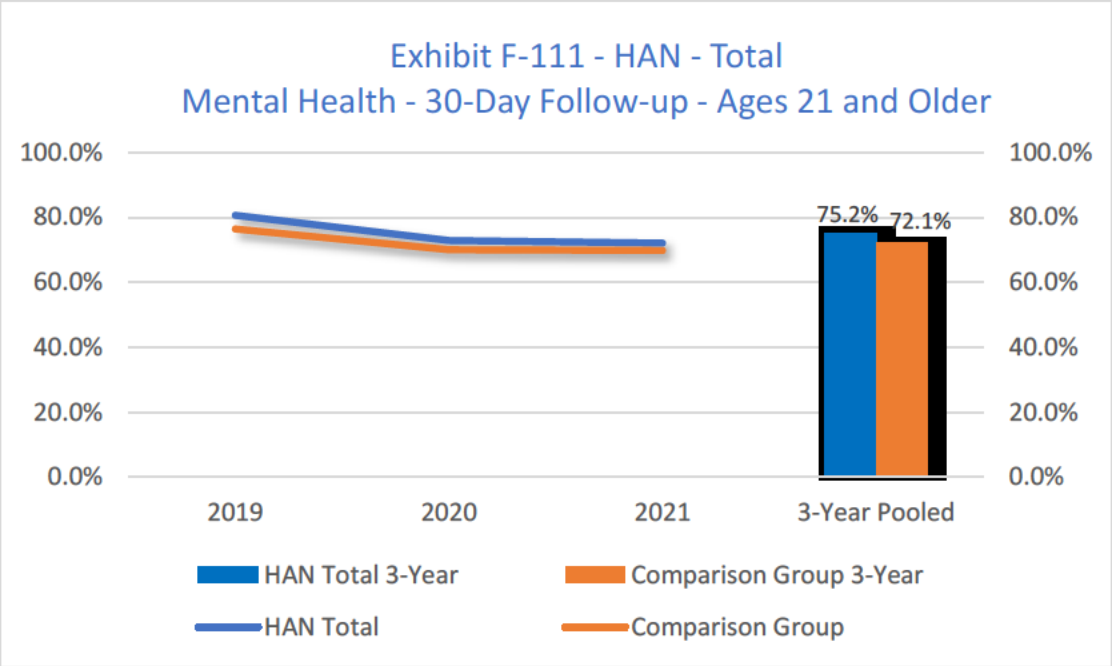


	2016	2017	2018	2019	2020	2021
HAN (Total)	89.2%	85.1%	82.2%	84.2%	86.6%	79.8%

Mental Health – Follow-up after Hospitalization for Mental Illness – 30 Days – Ages 21 and Older

Findings – HAN Total Population

Approximately 75 percent of HAN total members and approximately 72 percent of comparison group members were compliant on this measure across the three years (Exhibit F-111). The compliance rate for both populations declined from 2019 to 2021.



The difference between the HAN total and comparison group compliance rates was not statistically significant in any of the individual years. It also was not statistically significant for the three-year pooled data (Exhibit F-112).

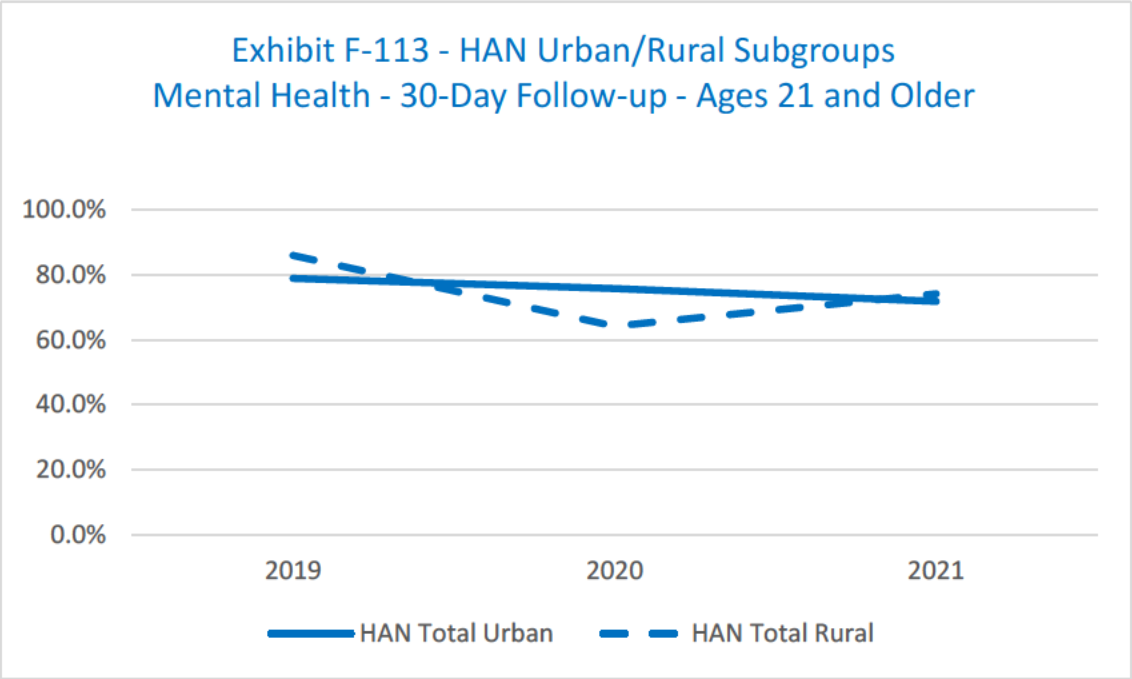
Exhibit F-112 – HAN (Total) – Mental Health – 30-Day Follow-up – Ages 21 and Older

	2019	2020	2021	3-Year Pooled
HAN (Total)	80.6%	72.9%	72.1%	75.2%
Comparison Group	76.4%	70.1%	69.8%	72.1%
Difference	4.2%	2.8%	2.3%	3.1%

‡ HAN rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HAN Total and Care Managed Populations – Urban and Rural Subgroups

The HAN total rural subgroup rate exceeded the urban subgroup rate in 2019 and 2021; the urban subgroup rate exceeded the rural subgroup rate in 2020. The urban subgroup rate declined from 2019 to 2021 while the rural subgroup rate declined from 2019 to 2020 and rose again from 2020 to 2021 (Exhibit F-113).



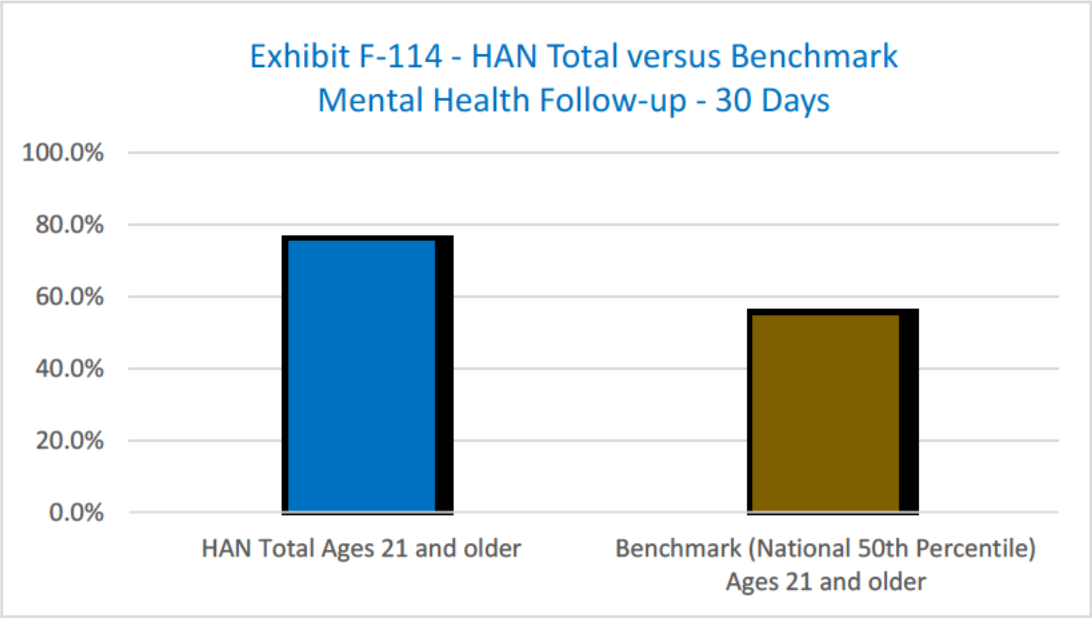
	Subgroup	2019	2020	2021
HAN (Total)	**Urban**	79.0%	75.9%	71.9%
	Rural	86.1%	64.3%	74.2%

Findings – HAN Total Population and National Benchmark

The HAN and national benchmark measures differed slightly with respect to age ranges. The HAN population includes ages 21 and older while the national benchmark includes ages 18 and older.

The three-year pooled rate for the SoonerCare HAN total population exceeded the national benchmark rate by approximately 21 percentage points (Exhibit F-114).

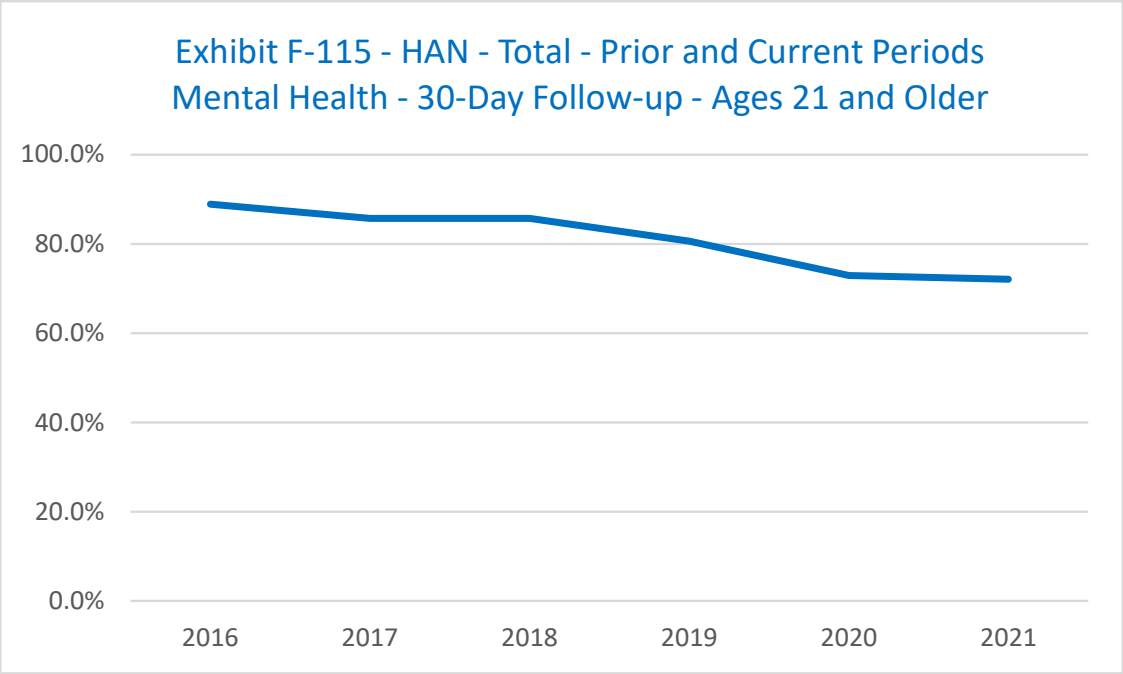
(Caution: the benchmark population characteristics were not matched to the OHCA groups to minimize differences in the populations. The data is presented for informational purposes only.)



	HAN Total	Benchmark
Compliance Rate	75.2%	54.7%

Findings – HAN Total Population – Comparison to Prior Waiver Period

This measure also was evaluated for the HAN total population in the prior waiver period (2016 to 2018). The compliance rate declined gradually from approximately 89 percent in 2016 to 72 percent in 2021 (Exhibit F-115).



	2016	2017	2018	2019	2020	2021
HAN (Total)	88.9%	85.7%	85.7%	80.6%	72.9%	72.1%

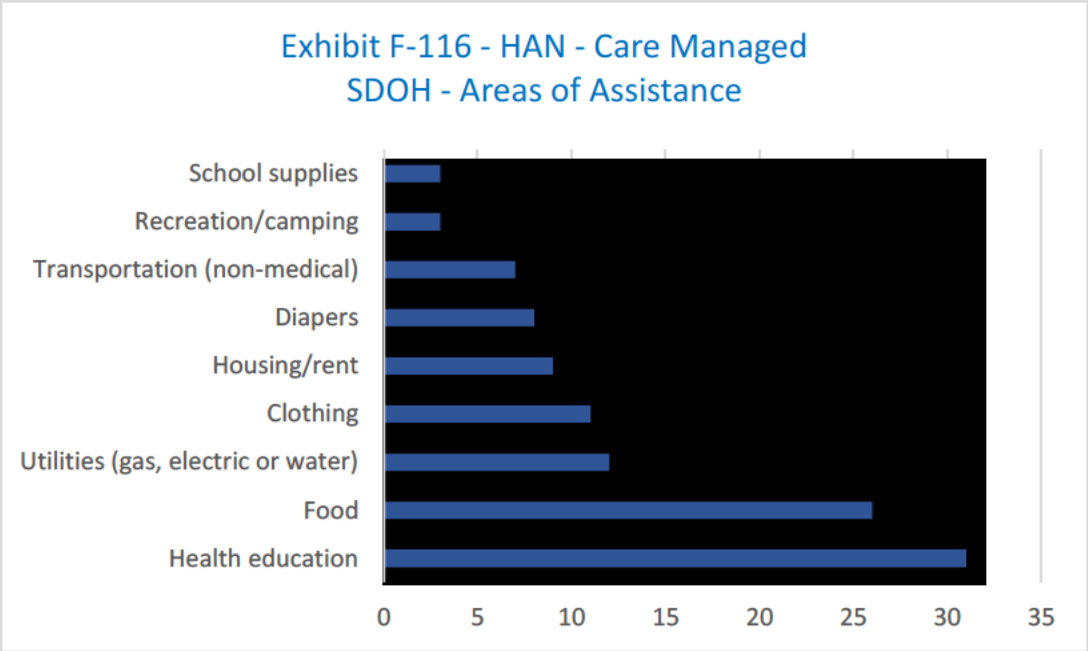
HAN Quality of Care – Social Determinants of Health

A stratified sample of SoonerCare HAN members was surveyed concerning social determinants of health (SDOH). PHPG surveyed 125 care managed members whose profile included an indicator that the HAN had provided assistance with SDOH in 2021. The survey inquired about the nature of the assistance, its importance to the member in addressing social service needs and/or reducing barriers to care and the member's satisfaction with help provided. Appendix 6 contains a copy of the survey instrument.

Although a structured survey instrument was used, the findings should be considered qualitative due to the sample selection method. Findings are not necessarily representative of the entire SoonerCare HAN population.

Findings – HAN Care Managed Population – Nature of Assistance

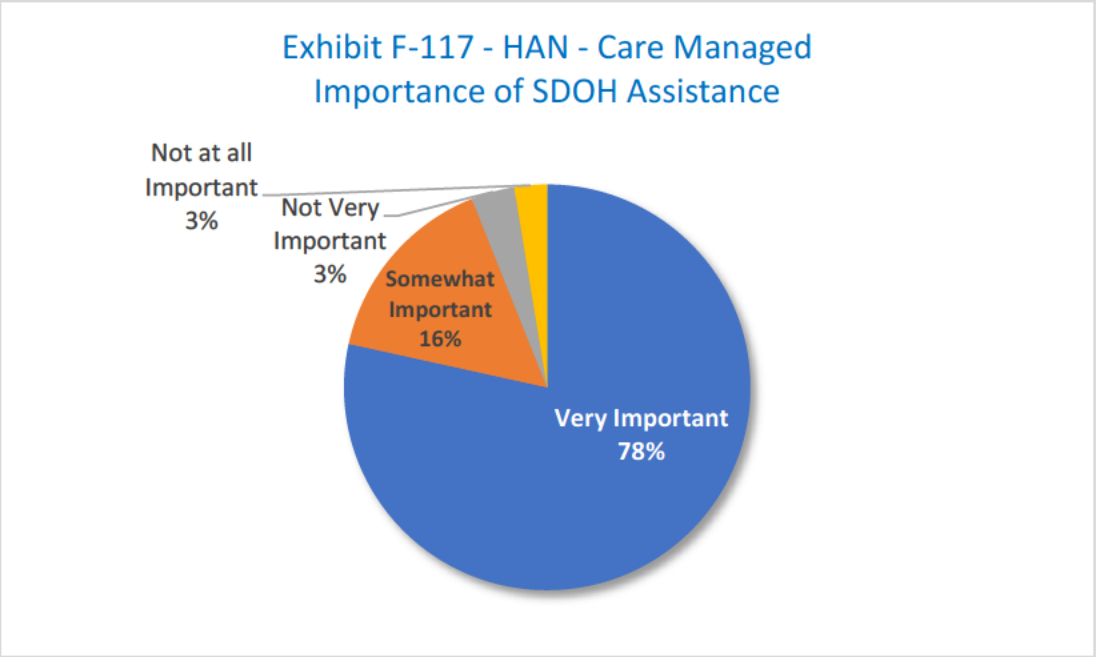
Respondents reported receiving assistance with a variety of SDOH-related needs (multiple responses per member were permitted). The most common areas cited were health education and help resolving food insecurity, followed by assistance with utilities, clothing and housing/rent (Exhibit F-116)[54].



[54] Areas mentioned by fewer than three respondents not shown on chart.

Findings – HAN Care Managed Population – Importance and Satisfaction

Respondents were asked to rate the importance of the help they received. Ninety-four percent rated the help as either very or somewhat important (Exhibit F-117).



Respondents also were asked to rate their satisfaction with the help received. All but one respondent gave a rating of very satisfied; the remaining respondent gave a rating of somewhat satisfied.

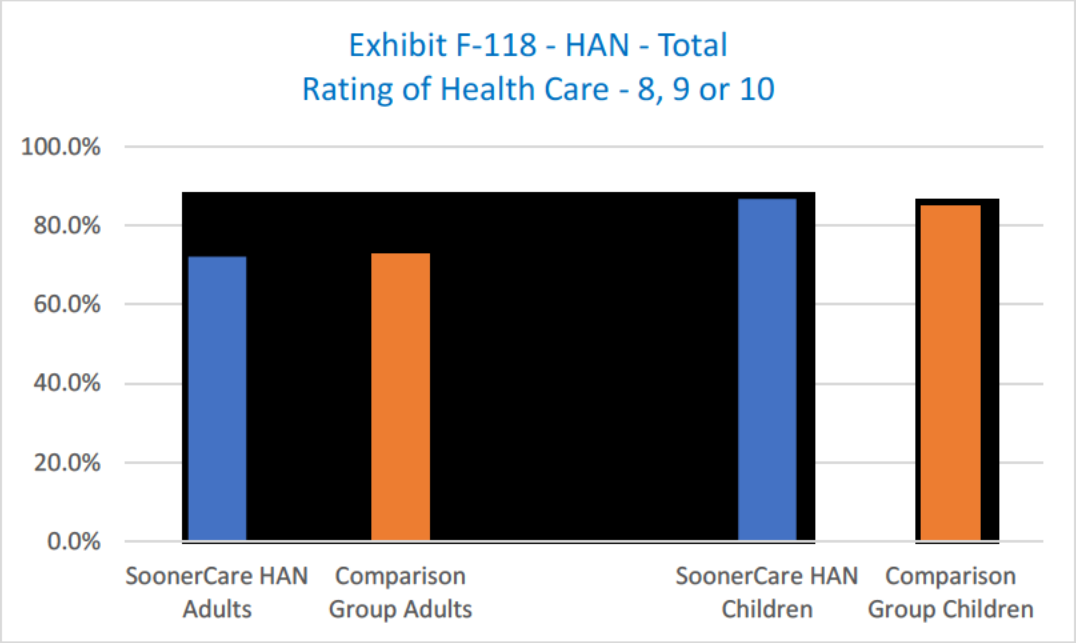
In addition to providing responses to the structured survey questions, respondents were invited to describe their experience in their own words. A representative sample of respondent comments is provided below.

> *"(My care manager) is everything to me. She is my light. She uplifts me every time we talk. She helps me maneuver through the health care and insurance process. She goes above and beyond like once my car died and no one would help me. (She) came out to my trailer, took my dead battery and went and got a new one then put it in. That meant so much to me."*
>
> *"(My care manager) is like a sister to me. I felt like I was falling apart before I started talking to her. She helped me get through my anxiety about my surgery. She has also brought me food. "*
>
> *"(My care manager) always seems to know when to call me. I would be lost without her calls to help 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 them both 'til I die."*

Rating of Health Care – Children and Adults

Findings – HAN Total Population

Seventy-two percent of HAN adult members and approximately 73 percent of comparison group adult members rated their health care as 8, 9 or 10 on a scale of 0 (worst health care possible) to 10 (best health care possible)[55]. Approximately 87 percent of parents/caretakers of HAN child members and 85 percent of comparison group parents/caretakers rated their health care as 8, 9 or 10 (Exhibit F-118).



The difference between the HAN total and comparison group compliance rates was not statistically significant for either group (Exhibit F-119).

Exhibit F-119 – HAN (Total) – Rating of Health Care– Percent Rating 8, 9 or 10

	Adults	Children
HAN (Total)	72.0%	86.7%
Comparison Group	72.8%	85.1%
Difference	(0.8%)	1.6%

‡ HAN rate differs from comparison group rate by a statistically significant amount (95% confidence level)

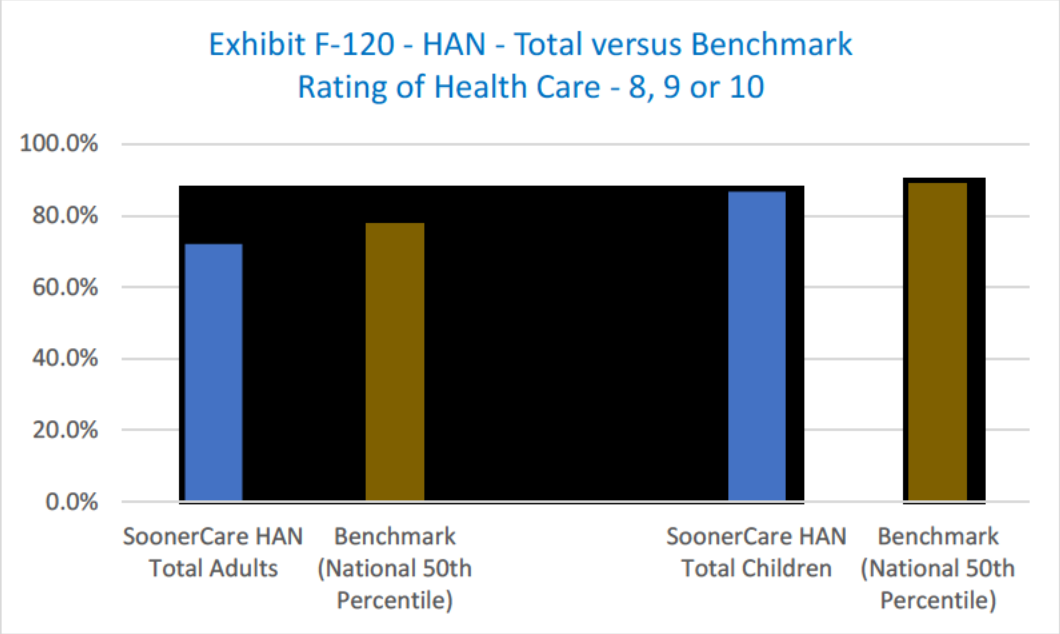
[55] CAHPS question: Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your (your child's) health care in the last six months?

Findings – HAN Total Population and National Benchmark

The 2021 national benchmark rate for adults exceeded the SoonerCare HAN adult rate by approximately six percentage points (Exhibit F-120).

The 2021 national benchmark rate for children exceeded the SoonerCare HAN children rate by approximately two percentage points.

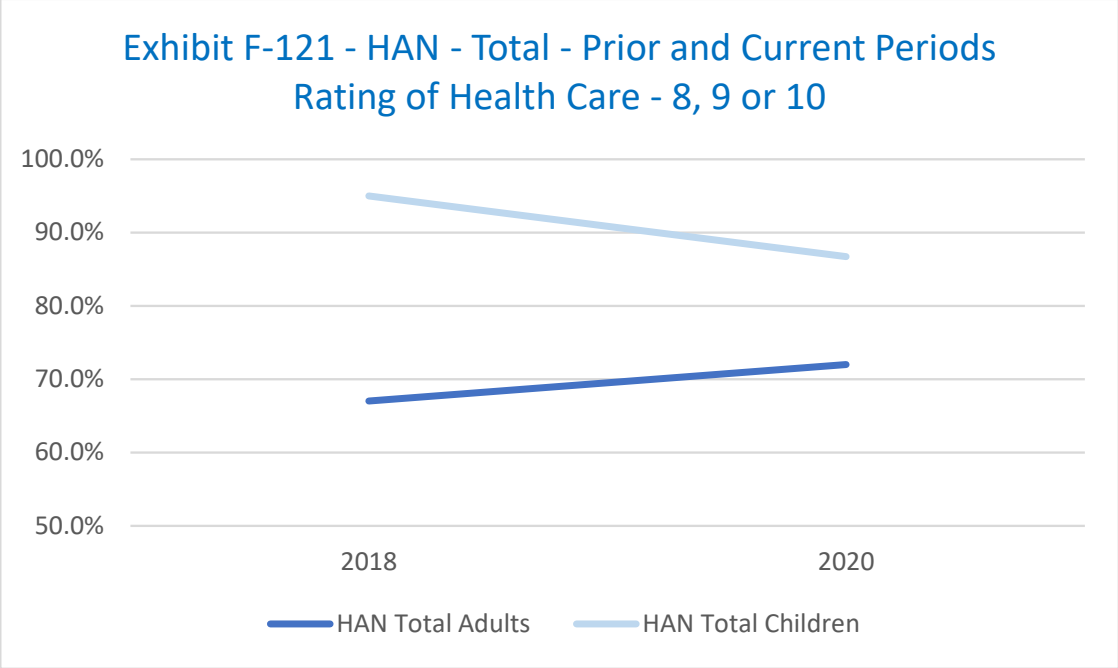
(Caution: the benchmark population characteristics were not matched to the OHCA groups to minimize differences in the populations. The data is presented for informational purposes only.)



	HAN Adult	Benchmark	HAN Child	Benchmark
HAN (Total)	72.0%	77.7%	86.7%	88.8%

Findings – HAN Total Population – Comparison to Prior Waiver Period

This measure also was calculated for the HAN total population in the 2018 CAHPS survey period. The percentage rating their health care 8, 9 or 10 increased five percentage points among adults and declined approximately eight percentage points among parents/caretakers of children (Exhibit F-121).



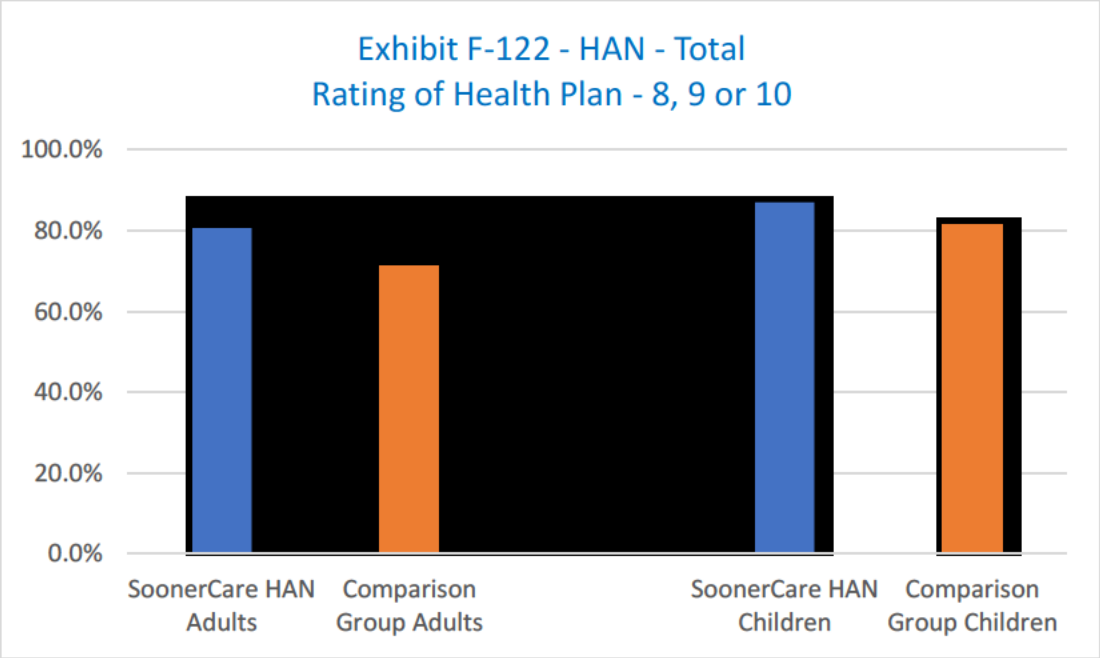
Note: Y-axis does not begin at 0.

	HAN Adult 2018	HAN Adult 2020	HAN Child 2018	HAN Child 2020
HAN (Total)	67.0%	72.0%	95.0%	86.7%

Rating of Health Plan – Children and Adults

Findings – HAN Total Population

Approximately 80 percent of HAN adult members and approximately 71 percent of comparison group adult members rated their health plan (SoonerCare) as 8, 9 or 10 on a scale of 0 (worst health plan possible) to 10 (best health plan possible)[56]. Eighty-seven percent of parents/caretakers of HAN child members and approximately 81 percent of comparison group parents/caretakers rated their health plan as 8, 9 or 10 (Exhibit F-122).



The difference between the adult HAN total and comparison group compliance rates was not statistically significant; the difference between parents/caretakers of HAN child members and comparison group parents/caretakers was statistically significant (Exhibit F-123).

Exhibit F-123 – HAN (Total) – Rating of Health Plan – Percent Rating 8, 9 or 10

	Adults	Children
HAN (Total)	80.6%	87.0%
Comparison Group	71.3%	81.6%
Difference	9.3%	5.4%‡

‡ HAN rate differs from comparison group rate by a statistically significant amount (95% confidence level)

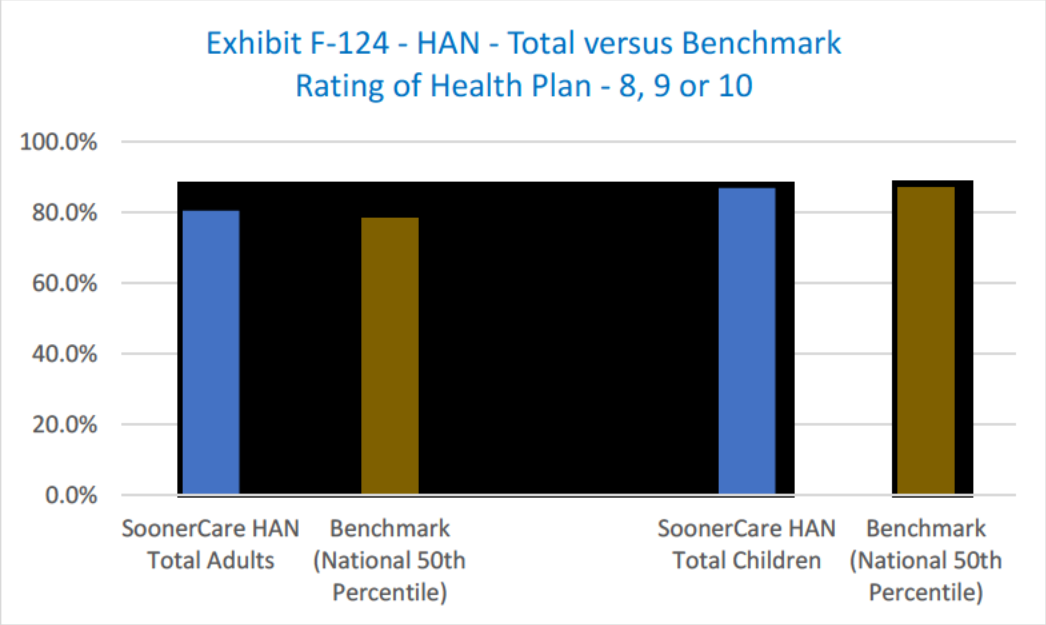
[56] CAHPS question: Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your (your child's) health plan?

Findings – HAN Total Population and National Benchmark

The rate for SoonerCare HAN adults exceeded the 2021 national benchmark rate by two percentage points (F-124).

The 2021 national benchmark rate for children exceeded the SoonerCare HAN children rate by less than one percentage point.

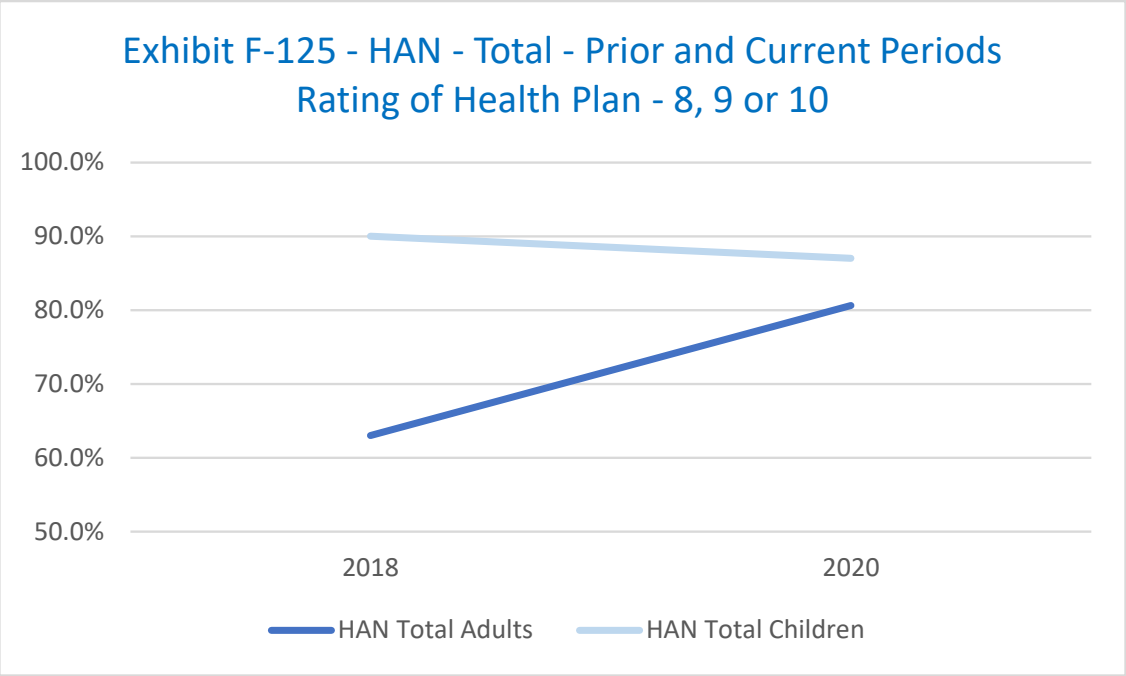
(Caution: the benchmark population characteristics were not matched to the OHCA groups to minimize differences in the populations. The data is presented for informational purposes only.)



	HAN Adult	Benchmark	HAN Child	Benchmark
HAN (Total)	80.6%	78.6%	87.0%	87.2%

Findings – HAN Total Population – Comparison to Prior Waiver Period

This measure also was calculated for the HAN total population in the 2018 CAHPS survey period. The percentage rating their health plan 8, 9 or 10 increased 18 percentage points among adults and declined three percentage points among parents/caretakers of children (Exhibit F-125).



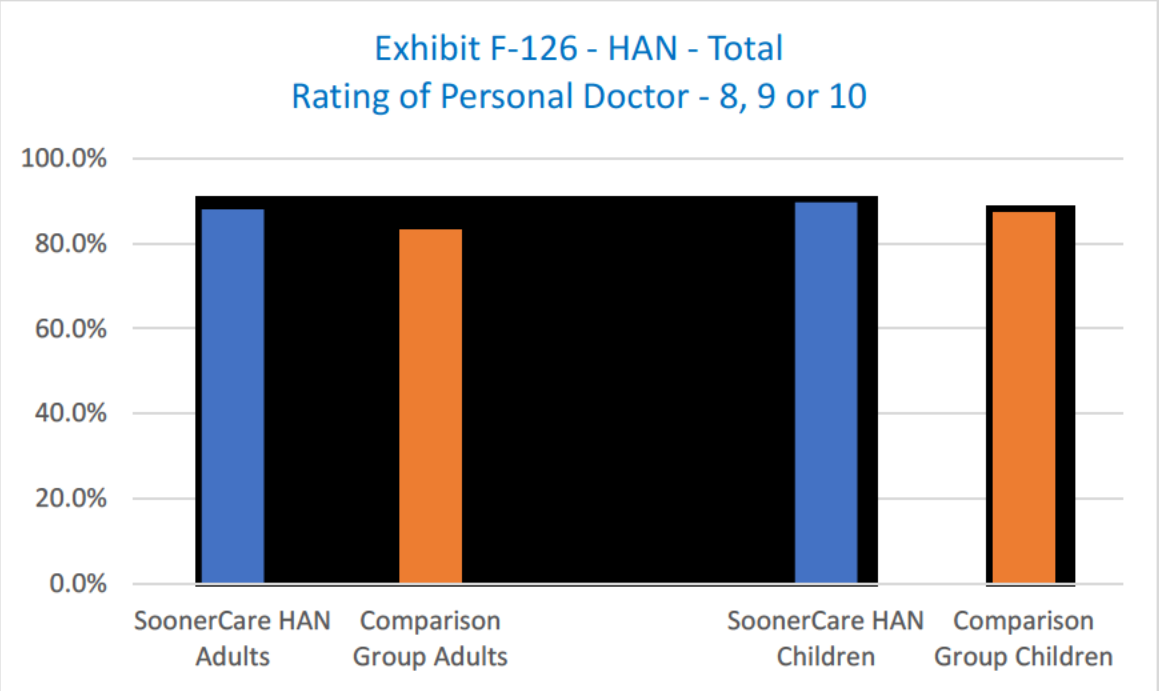
Note: Y-axis does not begin at 0.

	HAN Adult 2018	HAN Adult 2020	HAN Child 2018	HAN Child 2020
HAN (Total)	63.0%	80.6%	90.0%	87.0%

Rating of Personal Doctor – Children and Adults

Findings – HAN Total Population

Eighty-eight percent of HAN adult members and approximately 83 percent of comparison group adult members rated their personal doctor as 8, 9 or 10 on a scale of 0 (worst doctor possible) to 10 (best doctor possible)[57]. Approximately 90 percent of parents/caretakers of HAN child members and 87 percent of comparison group parents/caretakers rated their personal doctor as 8, 9 or 10 (Exhibit F-126).



The difference between the HAN total and comparison group compliance rates was not statistically significant for either group (Exhibit F-127).

Exhibit F-127 – HAN (Total) – Rating of Personal Doctor – Percent Rating 8, 9 or 10

	Adults	Children
HAN (Total)	88.0%	89.6%
Comparison Group	83.3%	87.3%
Difference	6.7%	2.3%‡

‡ HAN rate differs from comparison group rate by a statistically significant amount (95% confidence level)

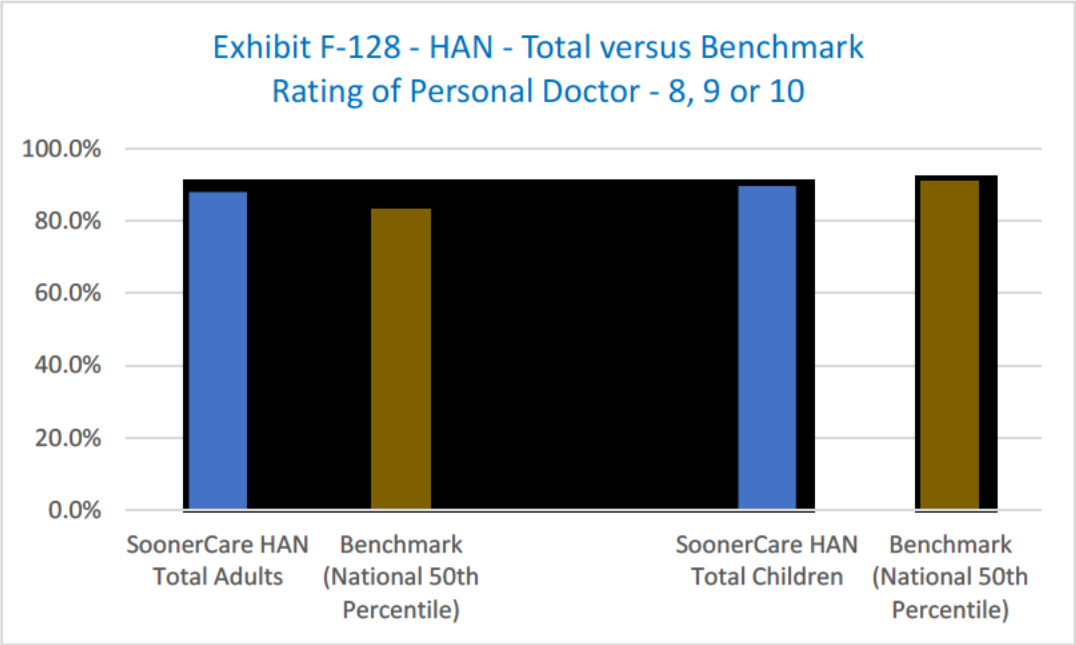
[57] CAHPS question: Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your (your child's) personal doctor?

Findings – HAN Total Population and National Benchmark

The rate for SoonerCare HAN adults exceeded the 2021 national benchmark rate by approximately five percentage points (Exhibit F-128).

The 2021 national benchmark rate for children exceeded the SoonerCare HAN children rate by approximately one percentage point.

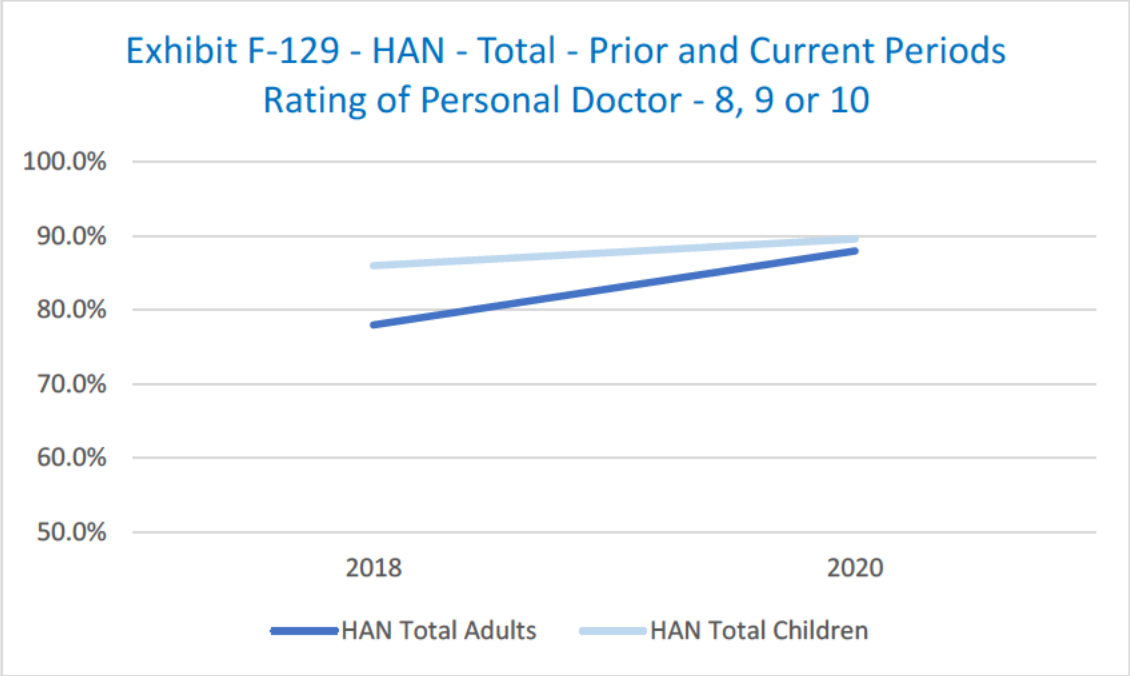
(Caution: the benchmark population characteristics were not matched to the OHCA groups to minimize differences in the populations. The data is presented for informational purposes only.)



	HAN Adult	Benchmark	HAN Child	Benchmark
HAN (Total)	88.0%	83.1%	89.6%	90.6%

Findings – HAN Total Population – Comparison to Prior Waiver Period

This measure also was calculated for the HAN total population in the 2018 CAHPS survey period. The percentage rating their personal doctor 8, 9 or 10 increased 10 percentage points among adults and approximately four percentage points among parents/caretakers of children (Exhibit F-129).



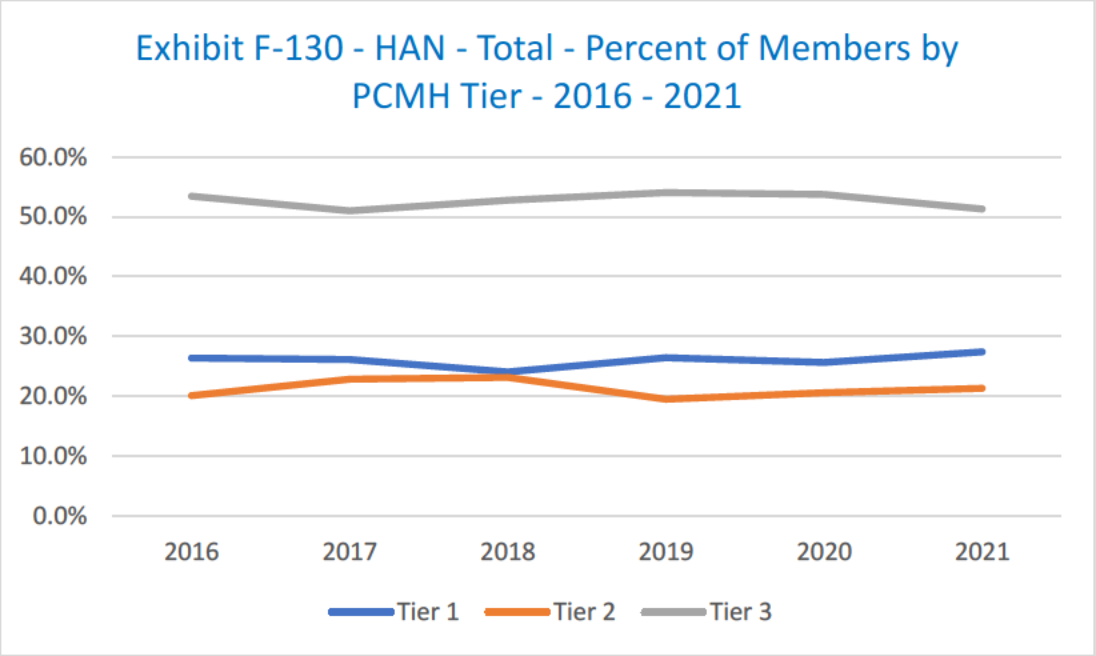
Note: Y-axis does not begin at 0.

	HAN Adult 2018	HAN Adult 2020	HAN Child 2018	HAN Child 2020
HAN (Total)	78.0%	88.0%	86.0%	89.6%

HAN Quality of Care – Members Served within Each PCMH Tier

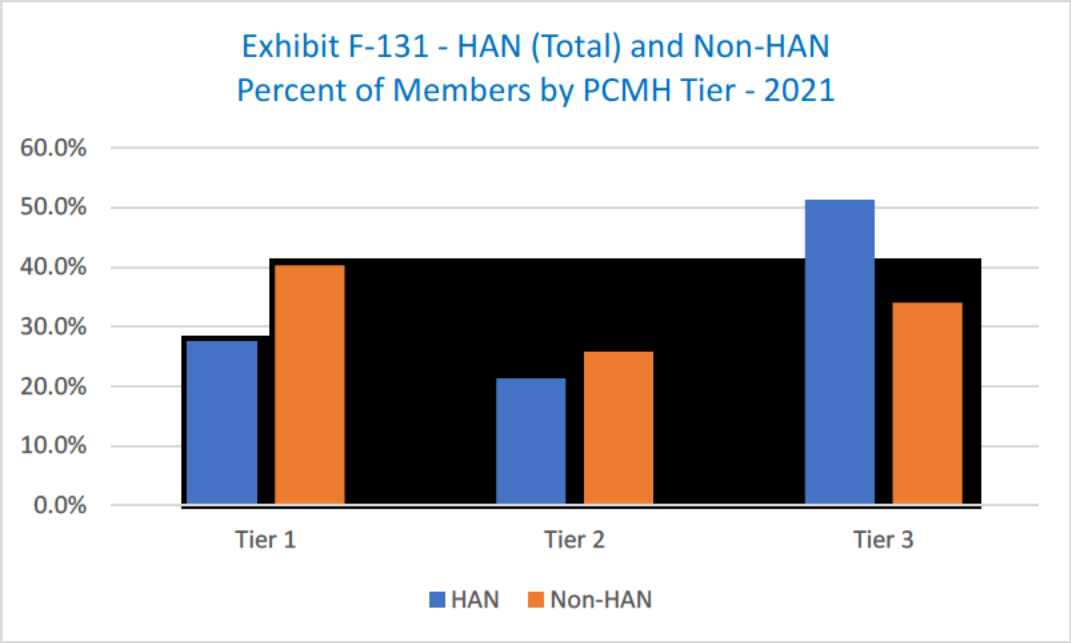
Findings – HAN Total Population

The percentage of members enrolled with a Tier 3 practice remained relatively constant, both during the current waiver period (2019 – 2021) and the prior period (2016 – 2018). The percentage enrolled with a Tier 1 or Tier 2 practice also remained constant (Exhibit F-130).



HAN (Total) – Percent of Members by PCMH Tier						
PCMH Tier	2016	2017	2018	2019	2020	2021
Tier 1 (Entry)	26.4%	26.1%	24.1%	26.4%	25.7%	27.4%
Tier 2 (Advanced)	20.1%	22.9%	23.2%	19.5%	20.6%	21.3%
Tier 3 (Optimal)	53.5%	51.0%	52.7%	54.1%	53.7%	51.3%

Although the portion of HAN members enrolled with a Tier 3 practice has been stable, it is substantially higher than for the non-HAN population, while the portion enrolled with a Tier 1 provider is substantially lower (Exhibit F-131).



HAN (Total) and Non-HAN – Percent of Members by PCMH Tier (2021)		
PCMH Tier	HAN	Non-HAN
Tier 1 (Entry)	27.4%	40.3%
Tier 2 (Advanced)	21.3%	25.8%
Tier 3 (Optimal)	51.3%	34.0%

HAN Quality of Care – PCMH Satisfaction

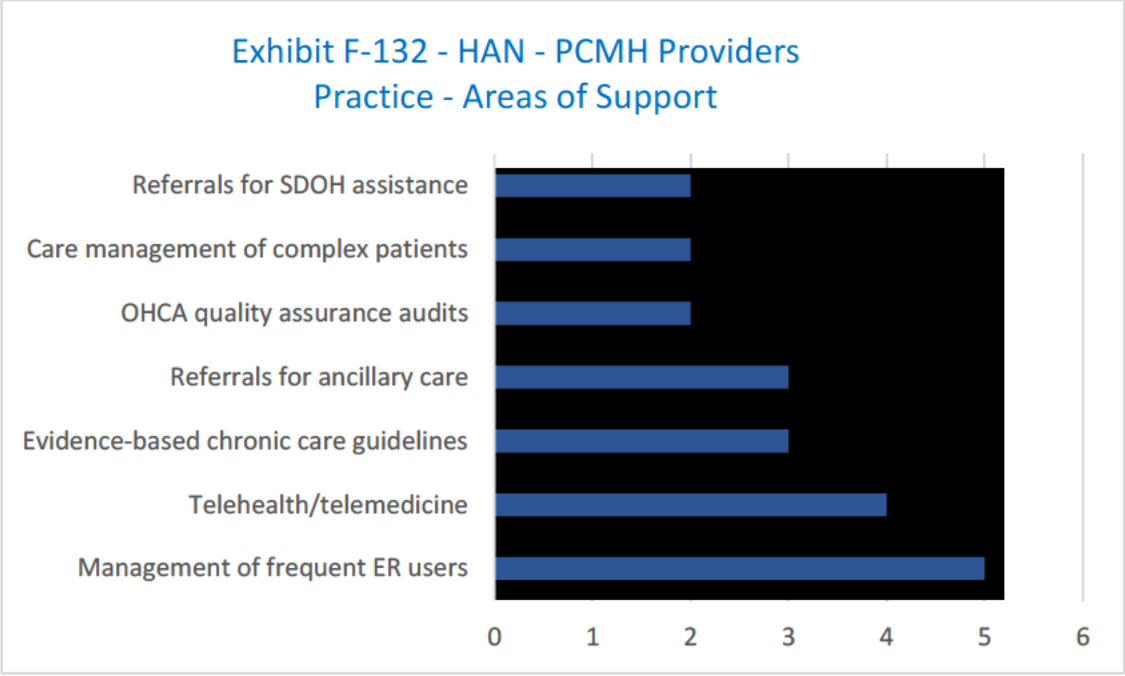
The SoonerCare HANs provided lists of PCMH practices that received assistance in 2021 to raise their Medicaid tier level (and associated case management fee) and/or to incorporate chronic care disease guidelines into their practices. The HANs identified 11 sites as candidates to be surveyed.

PHPG was able to survey six of the 11 sites. The survey inquired about the type of support the practice had received and its satisfaction both with the specific activities performed and with HAN support in general. Appendix 7 includes a copy of the survey.

Although a structured survey instrument was used, the findings should be considered qualitative due to the sample selection method and size.

Findings – HAN Care Managed Population – Nature of Support Activities

Respondents reported receiving support with patient care management, quality assurance and adoption of telehealth/telemedicine (multiple responses per member were permitted). No respondents specifically reported being assisted to achieve a higher level of tier support, although OHCA quality assurance audits are a component of maintaining or raising a provider's tier level (Exhibit F-132).



Findings – HAN Care Managed Population – PCMH Provider Satisfaction

Five of the six respondents reported being very satisfied both with the specific support activities and the HAN's overall level of support. One respondent reported being somewhat satisfied in both areas. No respondents reported being dissatisfied.

HAN Quality of Care – Summary

The SoonerCare HAN total and comparison group populations differed by a statistically significant amount on 10 of 17 HEDIS or HEDIS-like quality-of-care measures, with the HAN total population outperforming the comparison group on six measures and the comparison group outperforming the HAN total population on four. All of but one of the measures trended downward from 2019 to 2021.

The SoonerCare HAN Care Managed member and comparison group populations differed by a statistically significant amount on four of 11 HEDIS measures, with the SoonerCare HAN Care Managed population outperforming the comparison group on all four measures. Four of the measures trended upward from 2019 to 2021; the remaining seven trended downward.

The SoonerCare HAN total and comparison group populations differed by a statistically significant amount on two of six CAHPS measures, with the SoonerCare HAN population outperforming the comparison group on both measures (Exhibit F-133). (See bottom of exhibit for legend.)

Exhibit F-133 – HAN Quality of Care Measures – Summary

Measures	HAN Total versus Comparison Group	HAN Total 2019 – 2021 Trend	HAN Care Managed versus Comparison Group	HAN Care Managed 2019 – 2021 Trend
Number of HAN beneficiaries engaged in care management				▲
Asthma – Medication Ratio – Ages 5 to 18	✦	▲	✦	▲
Asthma – Medication Ratio – Ages 19 to 64	✦	▲	✦	▲
Cardiovascular – Persistence of Beta Blocker Treatment after a Heart Attack	✦	▼	✦	▼
Cardiovascular – LDL-C Test	✦	▼	✦	▼
COPD – Use of Spirometry Testing	✦	▼	✦	▼
COPD – Pharmacotherapy Management of COPD Exacerbation – 14 Days	✦	▼	✦	▲

Measures	HAN Total versus Comparison Group	HAN Total 2019 – 2021 Trend	HAN Care Managed versus Comparison Group	HAN Care Managed 2019 – 2021 Trend
COPD – Pharmacotherapy Management of COPD Exacerbation – 30 Days	✦	▼	✦	▼
Diabetes – Percentage of Members who had LDL-C Test	✦	▼	✦	▼
Diabetes – Percentage of Members who had Retinal Eye Exam Performed	✦	▼	✦	▼
Diabetes – Percentage of Members who had HbA1c Testing	✦	▼	✦	▼
Diabetes – Percentage who Received Medical Attention for Nephropathy	✦	▼	✦	▲
Hypertension – Percentage of Members who had LDL-C Test	✦	▼	✦	▼
Hypertension – Percentage of Members Prescribed ACE/ARB Therapy	✦	▼	✦	▼
Mental Health – Follow-up after Hospitalization – 7 Days – Ages 6 to 20	✦	▼		
Mental Health – Follow-up after Hospitalization – 7 Days – Ages 21 and Older	✦	▼		
Mental Health – Follow-up after Hospitalization – 30 Days – Ages 6 to 20	✦	▼		
Mental Health – Follow-up after Hospitalization – 30 Days – Ages 21 and Older	✦	▼		
SDOH Assistance		*Qualitative Measure*		
Rating of Health Care – Adults	✦			

Measures	HAN Total versus Comparison Group	HAN Total 2019 – 2021 Trend	HAN Care Managed versus Comparison Group	HAN Care Managed 2019 – 2021 Trend
Rating of Health Care – Children				
Rating of Health Plan – Adults				
Rating of Health Plan – Children				
Rating of Personal Doctor – Adults				
Rating of Personal Doctor - Children				
PCMH accreditation – members by tier		*Qualitative Measure*		
PCMH Provider satisfaction – practice support activities		*Qualitative Measure*		
PCMH provider satisfaction – chronic disease guidelines		*Qualitative Measure*		

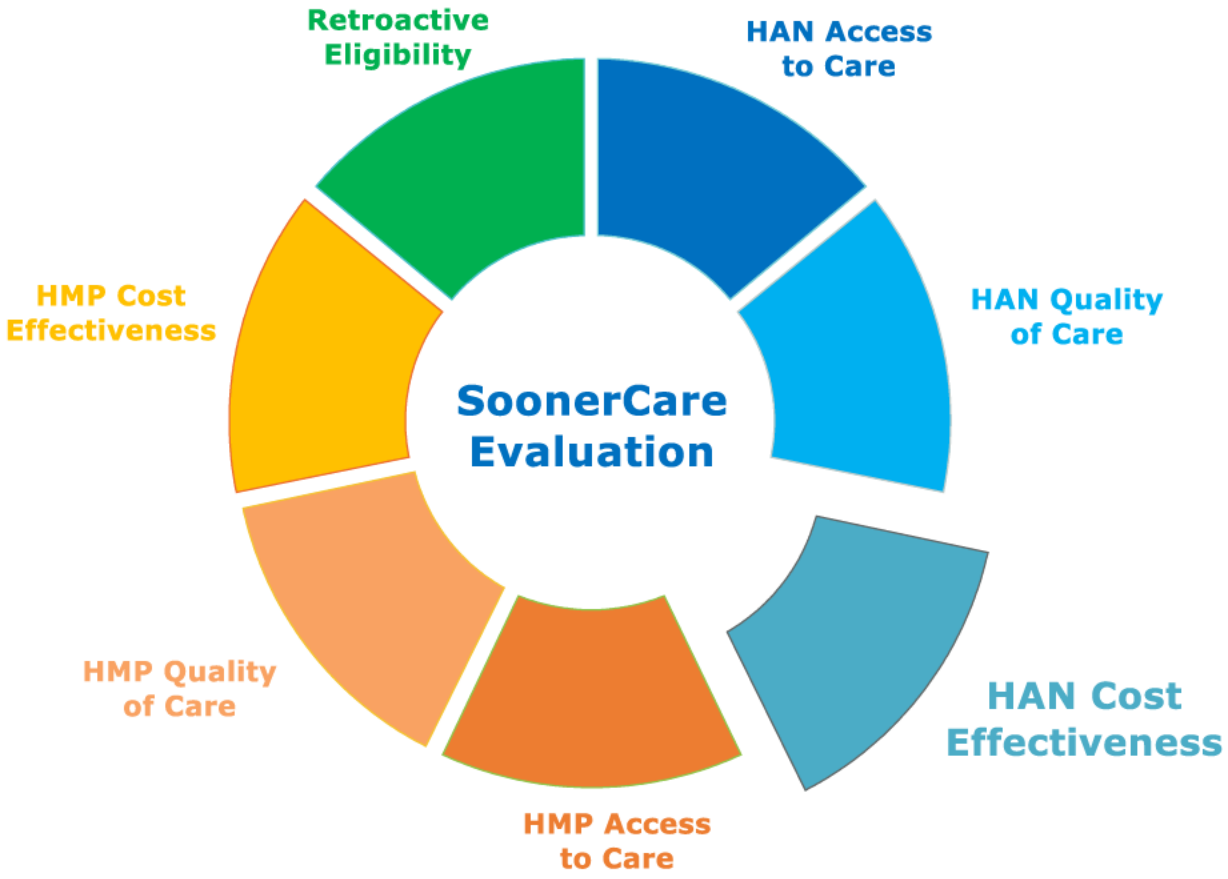
 HAN exceeds comparison group by a statistically significant amount (3-year pooled)

 No statistically significant difference (3-year pooled)

 Comparison group exceeds HAN by a statistically significant amount (3-year pooled)

 2019 – 2021 trend is upward

 2019 – 2021 trend is downward


Retroactive Eligibility
HAN Access to Care
HAN Quality of Care
HAN Cost Effectiveness
HMP Access to Care
HMP Quality of Care
HMP Cost Effectiveness
SoonerCare Evaluation

3. HAN Cost Effectiveness

Overview

HAN activities related to improving access and quality, if effective, should have an observable impact on beneficiary service utilization and expenditures. Improvement in quality of care should yield better outcomes in the form of fewer emergency room visits and hospitalizations, and lower acute care costs.

HAN Cost Effectiveness Measures

F-134 on the following page presents the HAN cost effectiveness measures and identifies:

- Data sources
- Subgroups evaluated (if any)
- Presence or absence of a national benchmark
- Presence or absence of comparative data from the prior Demonstration period

Supporting Appendices

Appendix 2 contains CEM covariate balance tables for utilization and expenditure measures. Appendix 3 contains statistical significance test results for utilization and expenditure measures.

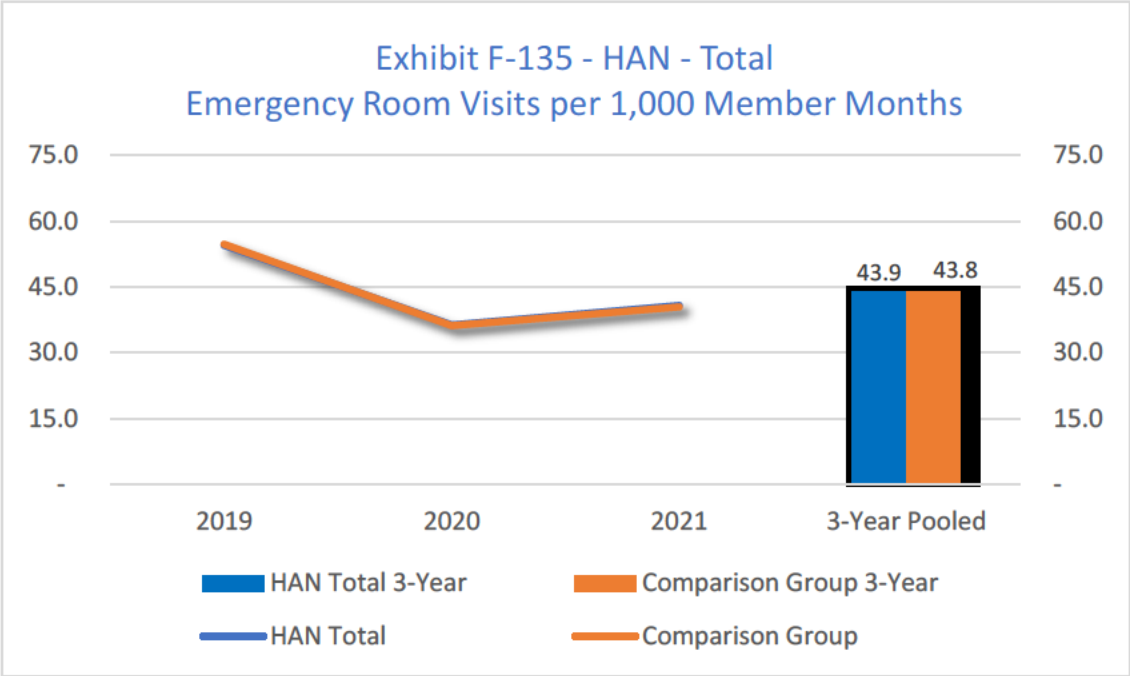
Exhibit F-134 - HAN Cost Effectiveness Measures - Overview

Measures	Source	HAN Care Managed Subgroup	Geographic Subgroups	National Benchmark	Prior Period Data
Emergency Room Utilization Emergency room visits per 1,000 member months.	MMIS (claims)	***Yes***	***Yes***	No	***Yes***
Hospital Admissions Acute care hospital admissions per 100,000 member months.	MMIS (claims)	***Yes***	***Yes***	No	***Yes***
PMPM Expenditures Average per member per month expenditures (all services).	MMIS (claims)	***Yes***	***Yes***	No	***Yes***

Emergency Room Visits per 1,000 Member Months

Findings – HAN Total Population

HAN total and comparison group members each averaged approximately 44 emergency room visits per 1,000 member months across the three years (Exhibit F-135). The visit rate for both populations declined from 2019 to 2020 and rose again from 2020 to 2021.



Note: Lower rate is better

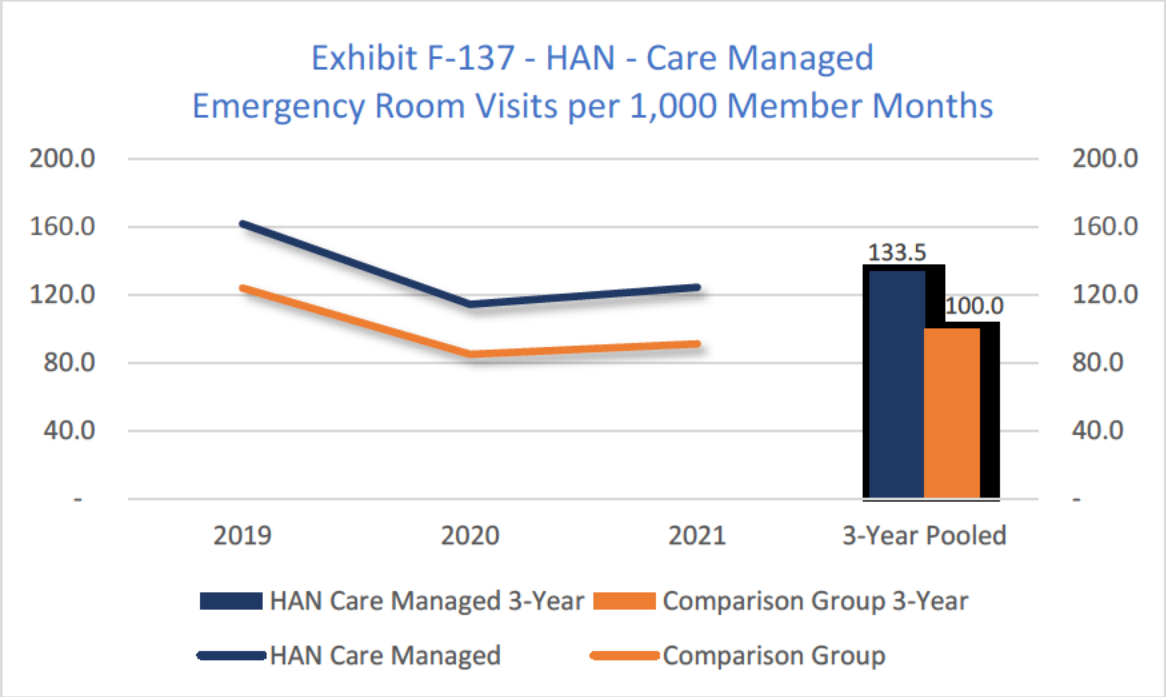
The difference between the HAN total and comparison group compliance rates was statistically significant in each of the individual years. It was not statistically significant for the three-year pooled data (Exhibit F-136)[58].

Exhibit F-136 – HAN (Total) – Emergency Room Visits per 1,000 Member Months				
	2019	2020	2021	3-Year Pooled
HAN (Total)	54.5	36.4	40.8	43.9
Comparison Group	54.8	36.2	40.5	43.8
Difference	(0.3) ǂ	0.2ǂ	0.3ǂ	0.1
ǂ HMP rate differs from comparison group rate by a statistically significant amount (95% confidence level)				

[58] The finding of statistical significance for the individual years, despite the small absolute difference, is an artifact of the large population sizes for both groups. The three-year pooled rate, when taken to the third decimal place, was 43.895 for the HAN total population and 43.833 for the comparison group.

Findings – HAN Care Managed Population

HAN Care Managed members averaged approximately 134 emergency room visits per 1,000 member months and comparison group members averaged 100 visits per 1,000 member months across the three years (Exhibit F-137). The visit rate for both populations declined from 2019 to 2020 and rose again from 2020 to 2021.



Note: Lower rate is better

The difference between the HAN Care Managed and comparison group compliance rates was statistically significant in each of the individual years. It also was statistically significant for the three-year pooled data (Exhibit F-138).

Exhibit F-138 – HAN (Care Managed) – Emergency Room Visits per 1,000 Member Months

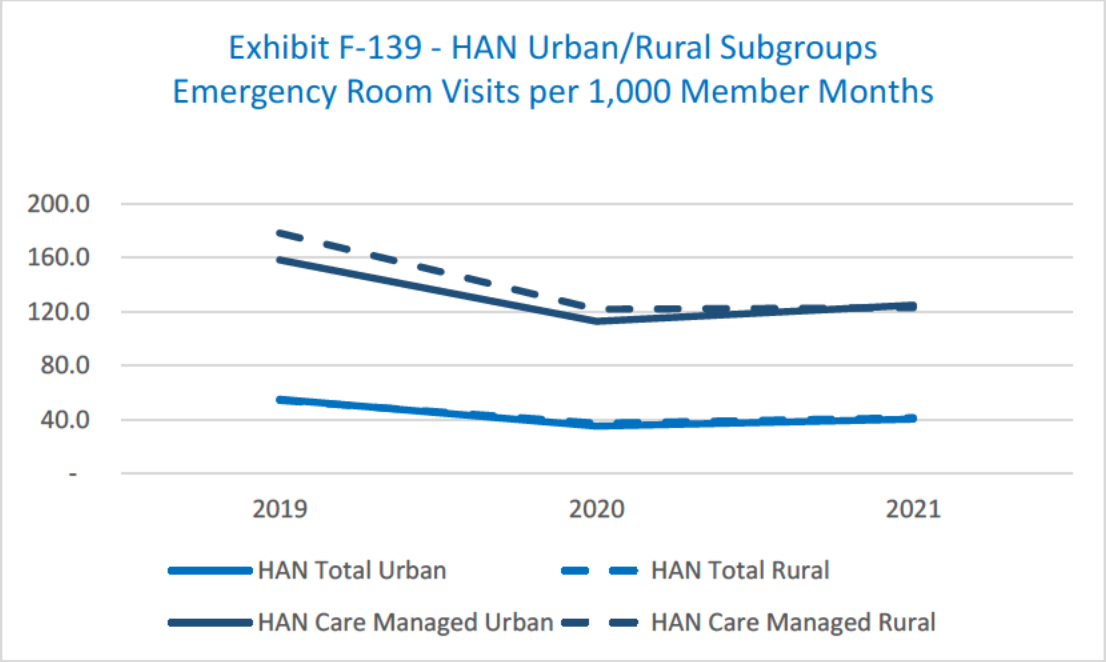
	2019	2020	2021	3-Year Pooled
HAN (Care Managed)	161.8	114.3	124.4	133.5
Comparison Group	124.0	84.8	91.1	100.0
Difference	37.8 ‡	29.5‡	33.3‡	33.5‡

‡ HMP rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HAN Total and Care Managed Populations – Urban and Rural Subgroups

The HAN total urban and rural subgroups recorded similar compliance rates; both trended subgroups downward from 2019 to 2020 and rose again from 2020 to 2021.

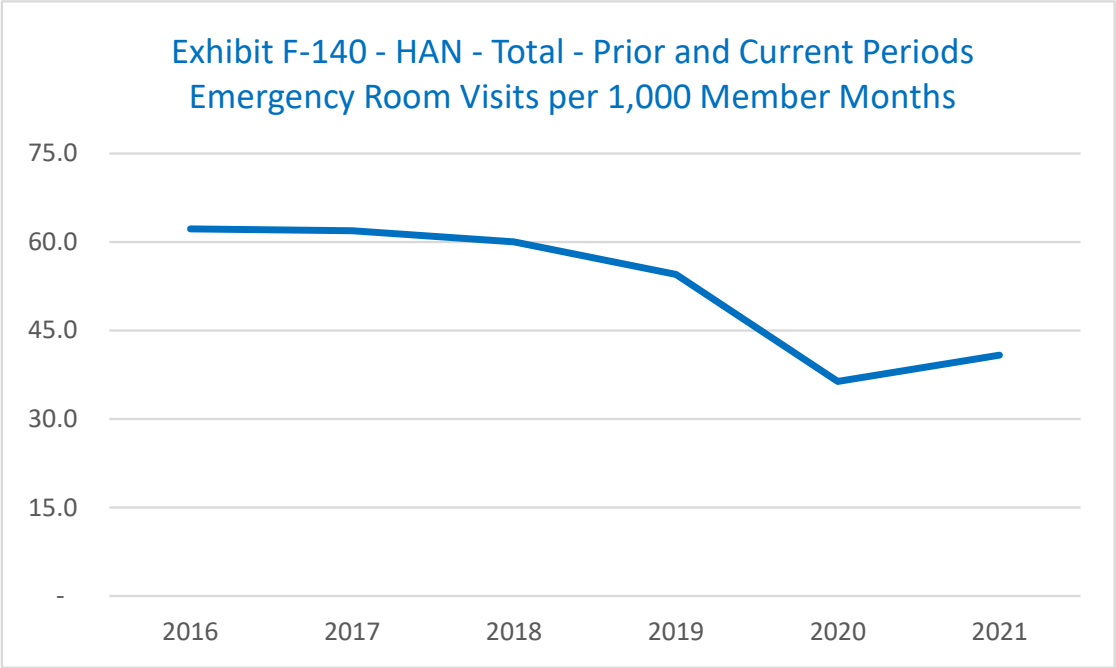
The HAN Care Managed rural subgroup recorded a higher rate than the urban subgroup in 2019 and 2020; the rates were nearly equal in 2021. Both subgroups trended downward from 2019 to 2020 and rose again from 2020 to 2021 (Exhibit F-139).



	Subgroup	2019	2020	2021
HAN (Total)	**Urban**	55.0	35.3	40.5
	Rural	54.3	37.4	41.5
HAN (Care Managed)	**Urban**	158.2	112.9	124.9
	Rural	178.1	121.8	123.0

Findings – HAN Total Population – Comparison to Prior Waiver Period

This measure also was evaluated for the HAN total population in the prior waiver period (2016 to 2018). The emergency room visit rate declined gradually from approximately 62 visits per 1,000 member months in 2016 to 36 visits per 1,000 member months in 2020, before rising partially again to 41 visits per 1,000 member months in 2021 (Exhibit F-140).

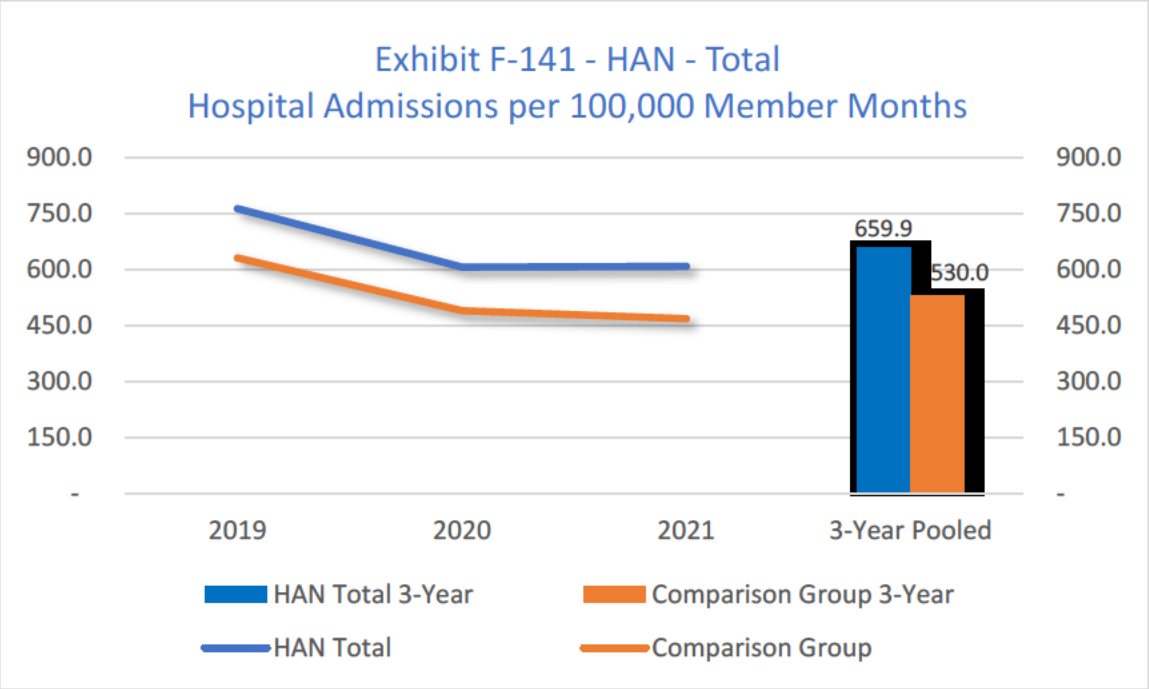


	2016	2017	2018	2019	2020	2021
HAN (Total)	62.2	61.9	60.0	54.5	36.4	40.8

Hospital Admissions per 100,000 Member Months

Findings – HAN Total Population

HAN total members averaged approximately 660 hospital admissions per 100,000 member months and comparison group members 530 admissions per 100,000 member months across the three years (Exhibit F-141). The admission rate for both populations declined from 2019 to 2020; it remained approximately unchanged from 2020 to 2021 for the HAN total population and declined further for the comparison group population.



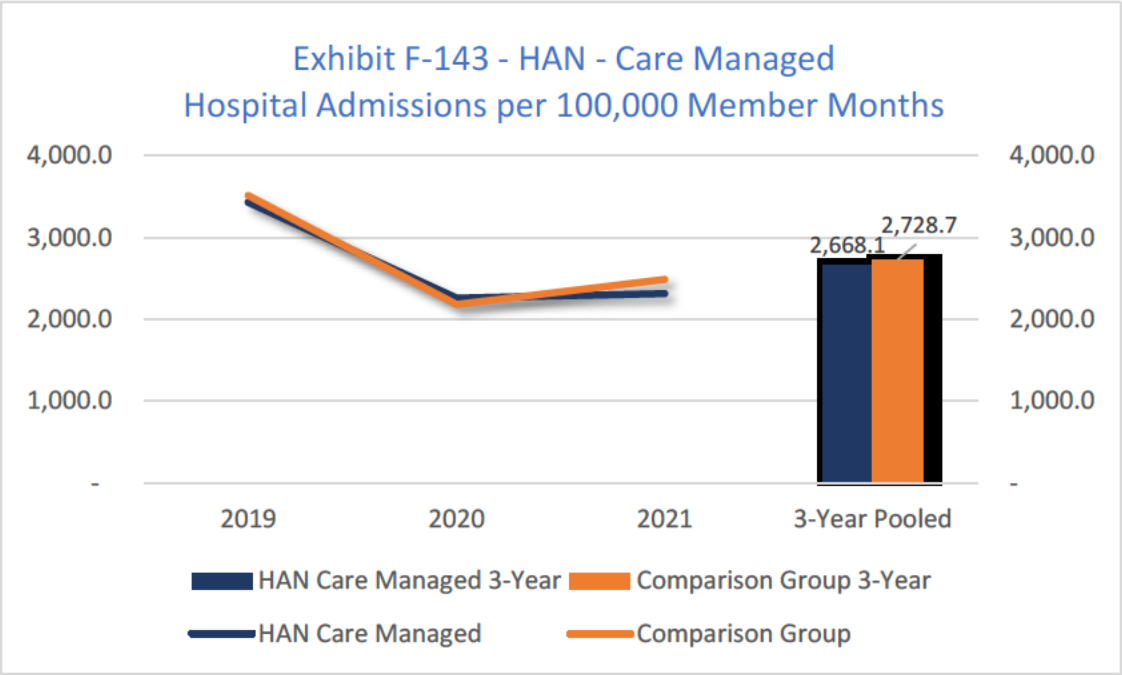
Note: Lower rate is better

The difference between the HAN total and comparison group compliance rates was statistically significant in each of the individual years. It also was statistically significant for the three-year pooled data (Exhibit F-142).

Exhibit F-142 – HAN (Total) – Hospital Admissions per 100,000 Member Months				
	2019	2020	2021	3-Year Pooled
HAN (Total)	764.4	606.6	608.8	659.9
Comparison Group	632.0	489.8	468.1	530.0
Difference	**132.4 ‡**	**117.8‡**	**140.7‡**	**129.9‡**
‡ HMP rate differs from comparison group rate by a statistically significant amount (95% confidence level)				

Findings – HAN Care Managed Population

HAN Care Managed members averaged approximately 2,668 hospital admissions per 100,000 member months and comparison group members averaged approximately 2,729 admissions per 100,000 member months across the three years (Exhibit F-143). The admission rate for both populations declined from 2019 to 2020 and rose again from 2020 to 2021.



Note: Lower rate is better

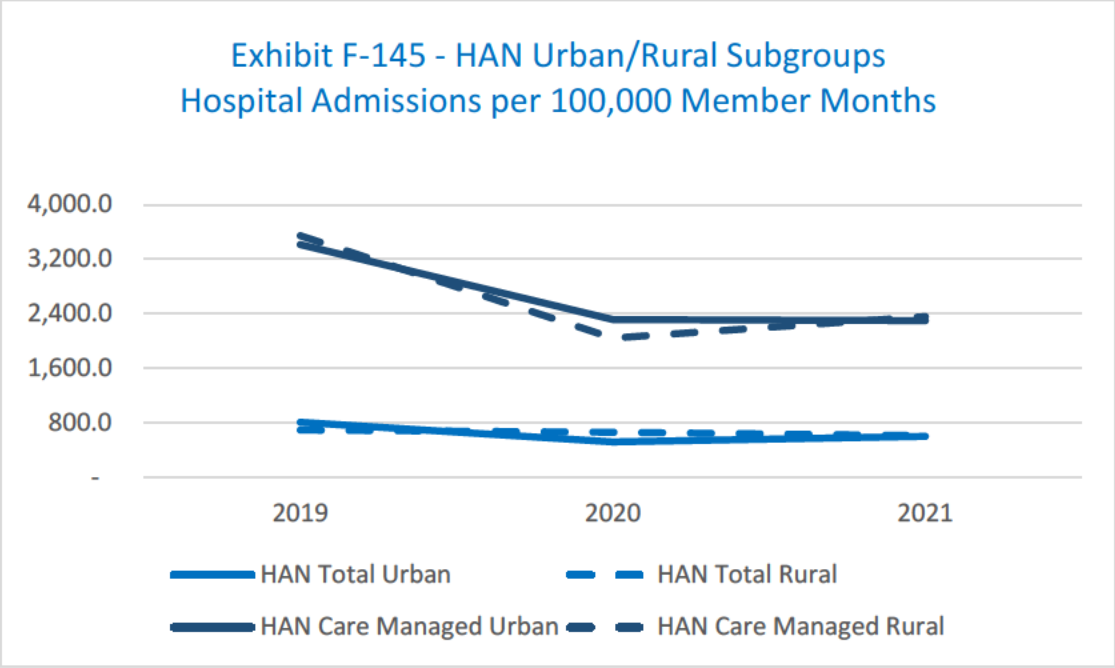
The difference between the HAN Care Managed and comparison group compliance rates was not statistically significant in any of the individual years. It also was not statistically significant for the three-year pooled data (Exhibit F-144) .

Exhibit F-144 – HAN (Care Managed) – Hospital Admissions per 100,000 Member Months				
	2019	2020	2021	3-Year Pooled
HAN (Care Managed)	3,431.4	2,260.1	2,312.8	2,668.1
Comparison Group	3,515.0	2,182.8	2,488.2	2,728.7
Difference	(83.6)	77.3	(175.4)	(60.6)
‡ HMP rate differs from comparison group rate by a statistically significant amount (95% confidence level)				

Findings – HAN Total and Care Managed Populations – Urban and Rural Subgroups

The HAN total urban subgroup recorded a higher rate than the rural subgroup in 2019 and a lower rate in 2020; the 2021 rates were nearly equal. The urban subgroup trended downward from 2019 to 2020 and rose again from 2020 to 2021; the rural subgroup trended downward from 2019 to 2021.

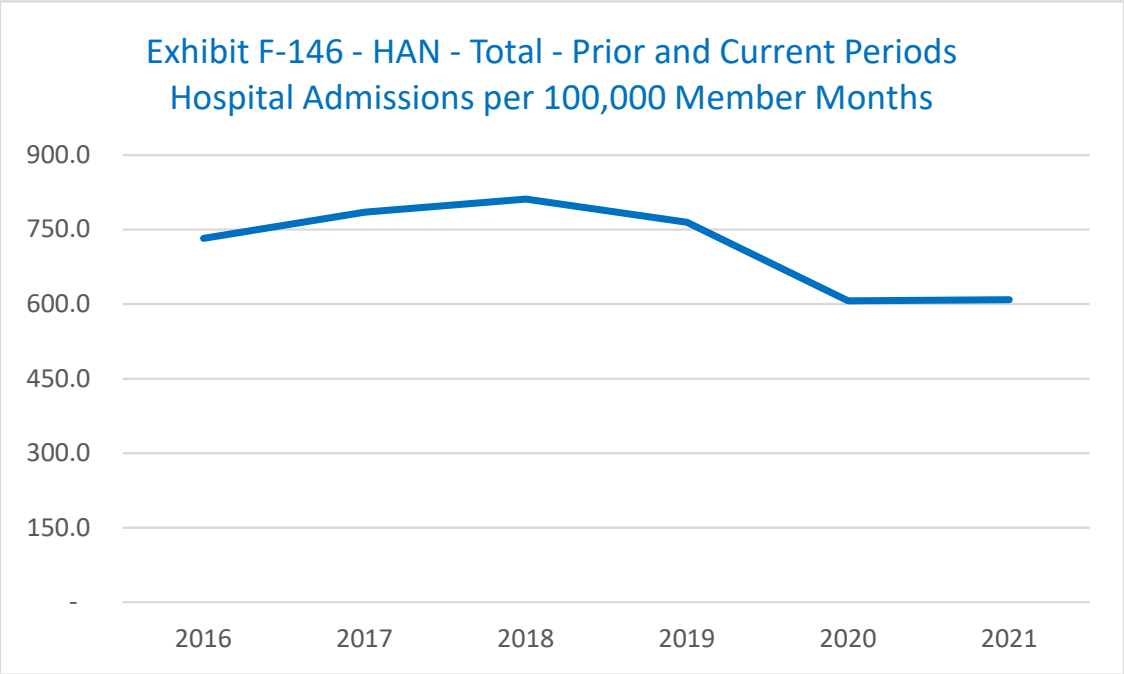
The HAN Care Managed urban subgroup recorded a lower rate in 2019 and 2021 and a higher rate in 2020. The urban subgroup trended downward from 2019 to 2020 and was approximately flat from 2020 to 2021. The rural subgroup also trended downward from 2019 to 2020 and rose again from 2020 to 2021 (Exhibit F-145).



	Subgroup	2019	2020	2021
HAN (Total)	**Urban**	809.2	518.0	602.0
	Rural	694.4	633.3	613.1
HAN (Care Managed)	**Urban**	3,416.5	2,317.4	2,297.8
	Rural	3,548.8	2,043.0	2,357.8

Findings – HAN Total Population – Comparison to Prior Waiver Period

This measure also was evaluated for the HAN total population in the prior waiver period (2016 to 2018). The hospital admission rate rose from approximately 733 admissions per 100,000 member months in 2016 to 811 admissions per 100,000 member months in 2018, before declining to 609 admissions per 100,000 member months in 2021 (Exhibit F-146).

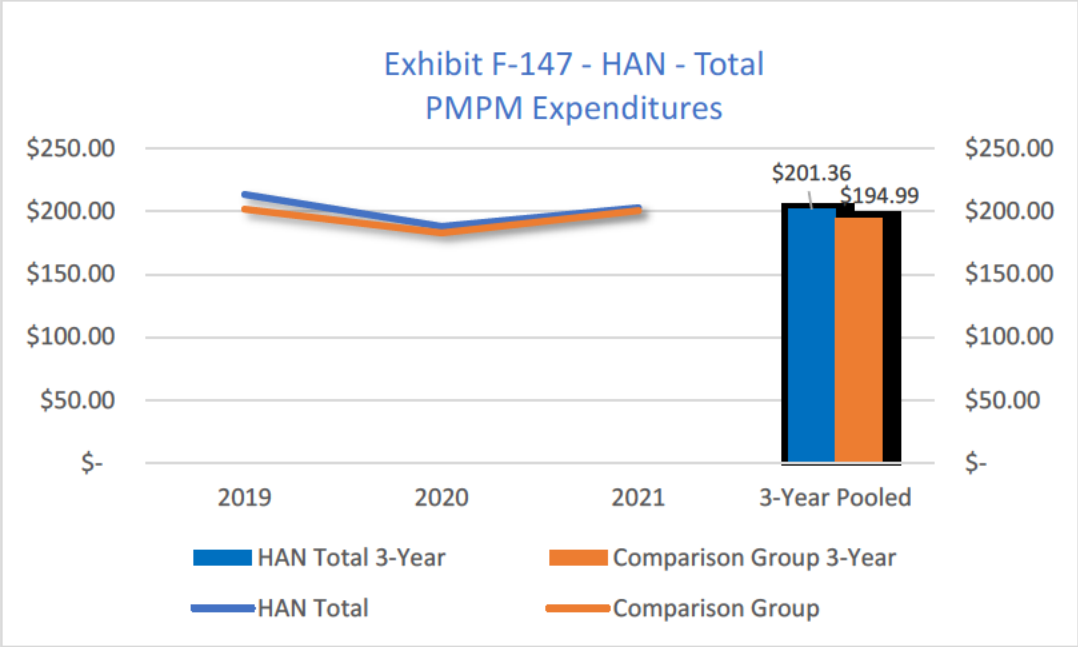


	2016	2017	2018	2019	2020	2021
HAN (Total)	732.6	785.0	811.2	764.4	606.6	608.8

Per Member Per Month (PMPM) Expenditures

Findings – HAN Total Population

HAN total member expenditures averaged approximately $201 PMPM and comparison group member expenditures averaged approximately $195 PMPM across the three years (Exhibit F-147). Average expenditures for both populations declined from 2019 to 2020 and rose again from 2020 to 2021.



Note: Lower rate is better

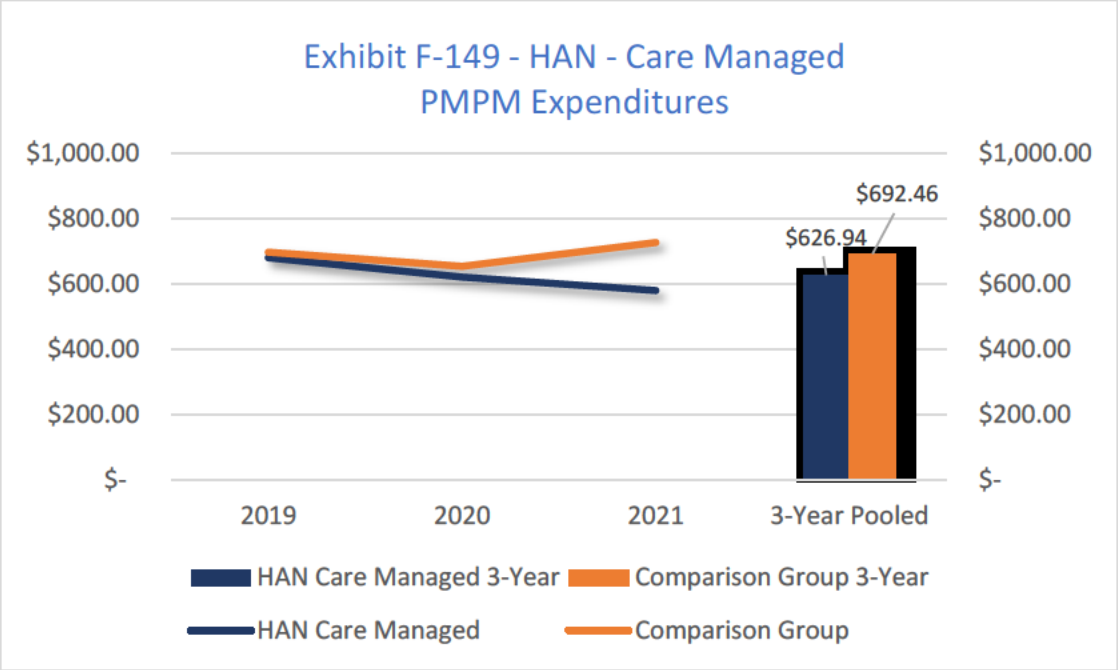
The difference between the HAN total and comparison group compliance rates was statistically significant in each of the individual years. It also was statistically significant for the three-year pooled data (Exhibit F-148)[59].

Exhibit F-148 – HAN (Total) – PMPM Expenditures				
	2019	2020	2021	3-Year Pooled
HAN (Total)	$213.32	$187.94	$202.83	$201.36
Comparison Group	$201.62	$182.75	$200.60	$194.99
Difference	$11.70‡	$5.19‡	$2.23‡	$6.37‡
‡ HMP rate differs from comparison group rate by a statistically significant amount (95% confidence level)				

[59] The finding of statistical significance despite the small absolute difference is an artifact of the large population sizes for both groups.

Findings – HAN Care Managed Population

HAN Care Managed member expenditures averaged approximately $627 PMPM and comparison group member expenditures averaged approximately $692 PMPM across the three years (Exhibit F-149). Average expenditures for the HAN Care Managed population declined from 2019 to 2021. Average expenditures for the comparison group declined from 2019 to 2020 and rose again from 2020 to 2021.



Note: Lower rate is better

The difference between the HAN Care Managed and comparison group compliance rates was statistically significant in 2021. It also was statistically significant for the three-year pooled data (Exhibit F-150).

Exhibit F-150 – HAN (Care Managed) – PMPM Expenditures

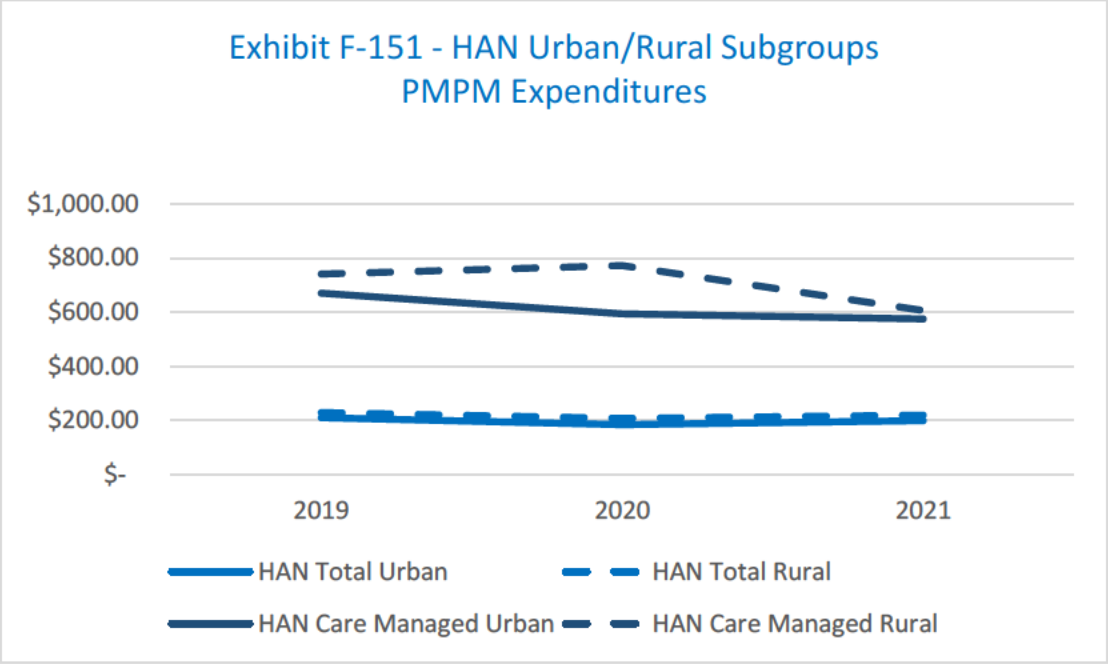
	2019	2020	2021	3-Year Pooled
HAN (Care Managed)	$680.44	$620.76	$579.62	$626.94
Comparison Group	$697.17	$653.91	$726.29	$692.46
Difference	($16.73)	($33.15)	($146.67)‡	($65.52)‡

‡ HMP rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HAN Total and Care Managed Populations – Urban and Rural Subgroups

The HAN total rural subgroup recorded a higher rate than the urban subgroup across the three years. Both subgroups trended downward from 2019 to 2020 and rose again from 2020 to 2021.

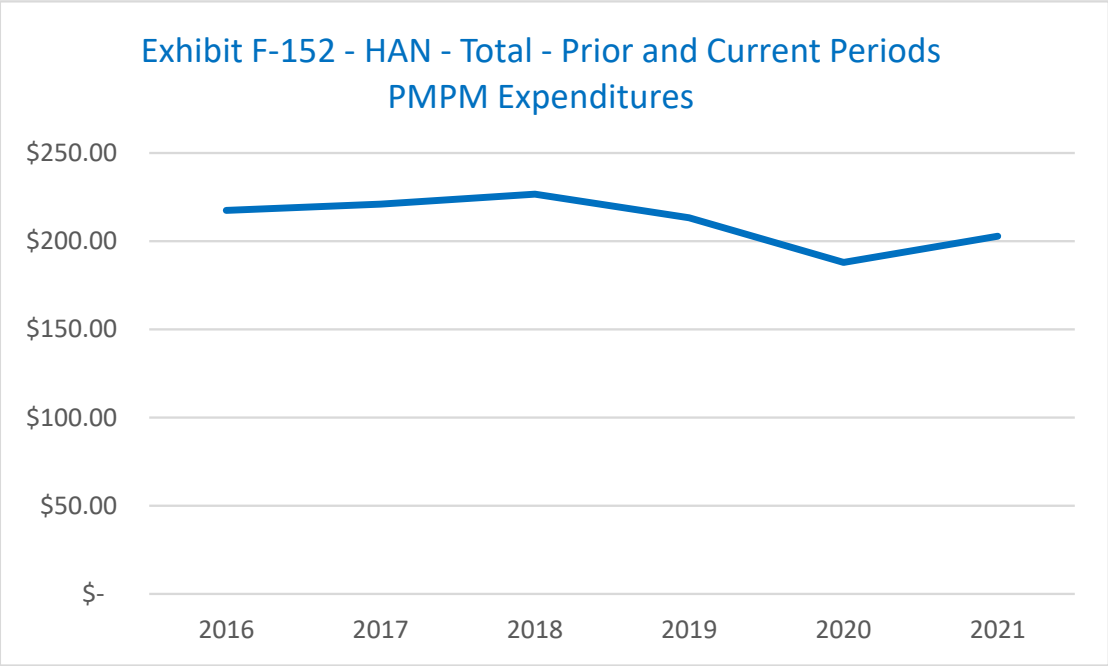
The HAN Care Managed rural subgroup also recorded a higher rate than the urban subgroup across the three years. The urban subgroup trended downward from 2019 to 2021; the rural subgroup rose from 2019 to 2020 and declined from 2020 to 2021 (Exhibit F-151).



	Subgroup	2019	2020	2021
HAN (Total)	**Urban**	$210.55	$184.43	$199.67
	Rural	$229.01	$207.81	$219.96
HAN (Care Managed)	**Urban**	$669.77	$594.03	$574.87
	Rural	$740.90	$772.21	$606.53

Findings – HAN Total Population – Comparison to Prior Waiver Period

This measure also was evaluated for the HAN total population in the prior waiver period (2016 to 2018). Average PMPM expenditures rose from approximately $217 PMPM in 2016 to $227 PMPM in 2018, before declining to $188 PMPM in 2020 (first year of Public Health Emergency) and rising partially again to $203 PMPM in 2021 (Exhibit F-152).



	2016	2017	2018	2019	2020	2021
HAN (Total)	$217.33	$220.97	$226.69	$213.32	$187.94	$202.83

HAN Cost Effectiveness – Summary

The SoonerCare HAN total and comparison group populations differed by a statistically significant amount on the three cost effectiveness measures, with the comparison group outperforming the HAN total population. All three of the measures trended downward from 2019 to 2021 (lower rate is better).

The SoonerCare HAN Care Managed member and comparison group populations differed by a statistically significant amount on two of the three cost effectiveness measures, with each outperforming the other on one. All three of the measures trended downward from 2019 to 2021 (Exhibit F-153).

Exhibit F-153 – HAN Cost Effectiveness – Summary

Measures	HAN Total versus Comparison Group	HAN Total 2019 – 2021 Trend	HAN Care Managed versus Comparison Group	HAN Care Managed 2019 – 2021 Trend
Emergency Room Visits per 1,000 Member Months	✦	▼	✦	▼
Hospital Admissions per 100,000 Member Months	✦	▼	✦	▼
PMPM Expenditures	✦	▼	✦	▼

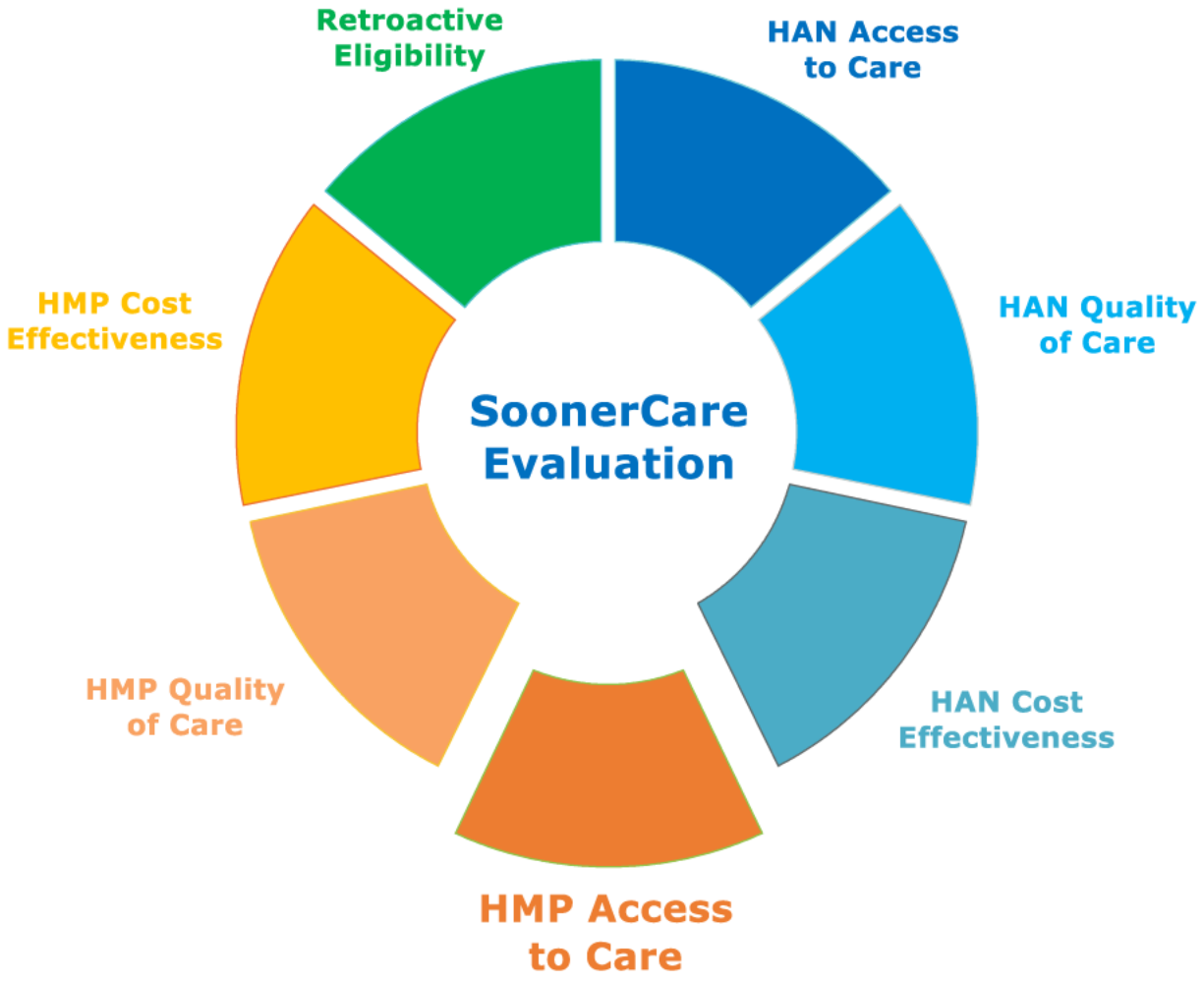
✦ HAN exceeds comparison group by a statistically significant amount (3-year pooled)

✦ No statistically significant difference (3-year pooled)

✦ Comparison group exceeds HAN by a statistically significant amount (3-year pooled)

▲ 2019 - 2021 trend is upward (higher trend is worse)

▼ 2019 – 2021 trend is downward (lower trend is better)


Retroactive Eligibility
HAN Access to Care
HAN Quality of Care
HAN Cost Effectiveness
HMP Access to Care
HMP Quality of Care
HMP Cost Effectiveness
SoonerCare Evaluation

4. HMP Access to Care

Overview

The OHCA contracted with the SoonerCare HMP vendor (Telligen) to offer practice facilitation in holistic chronic care management to participating providers. The OHCA also required its vendor to assess and identify beneficiaries with, or at risk for chronic conditions who would benefit from holistic care management. (Beneficiaries aligned with an HMP-participating practice.)

The OHCA established a target number of beneficiaries to be care managed during a contract year and specified that the majority of care management was to occur at the PCMH office. This was to improve the frequency of beneficiary interactions with the care manager and PCMH, and associated access to care.

HMP Access to Care Measures

Exhibit F-154 on the following page presents the HMP access to care measures and identifies:

- Data sources
- Subgroups evaluated (if any)
- Presence or absence of a national benchmark
- Presence or absence of comparative data from the prior Demonstration period[60]

Supporting Appendices

Appendix 8 contains CEM covariate balance tables for CAHPS measures. Appendix 9 contains statistical significance tests results for CAHPS measures.

[60] The approved evaluation design included an Interrupted Time Series (ITS) analysis for a subset of HMP access, quality and cost measures, using the 2016 – 2018 time period as baseline. PHPG concluded that the ITS could not be performed for the interim evaluation due to insufficient data points and the disruptive effects of the COVID-19 PHE on the HMP vendor's implementation of enhanced coaching modalities. The efficacy of the ITS analysis will be reconsidered for the summative evaluation.

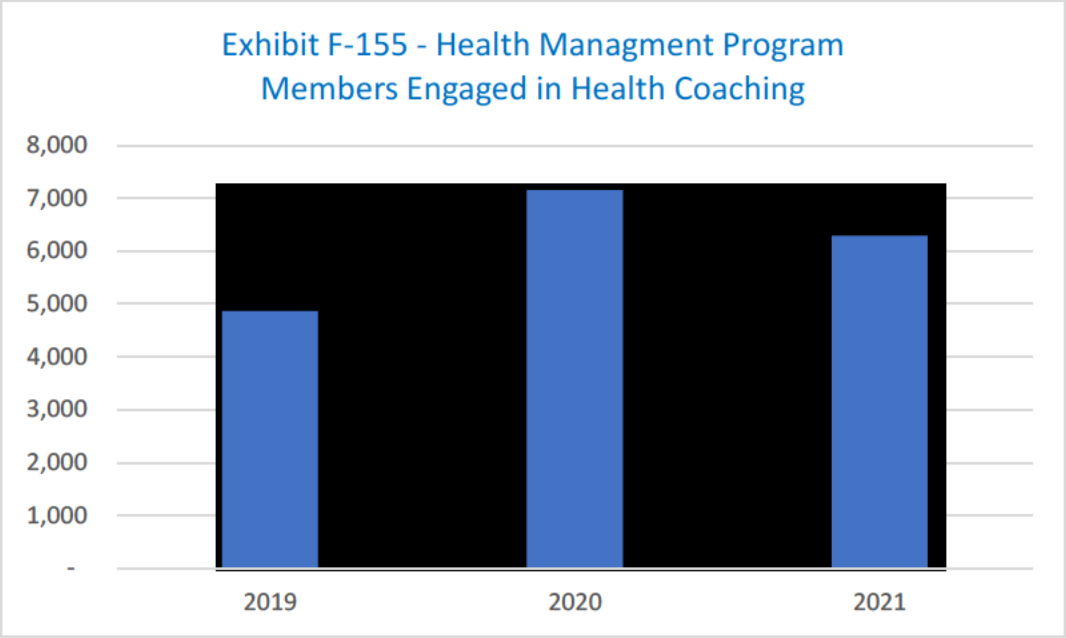
Exhibit F-154 - HMP Access to Care Measures - Overview

Measures	Source	Geographic Subgroups	National Benchmark	Prior Period Data
Number of HAN beneficiaries engaged in care management Number of HAN members engaged in care management at any point during the measurement year.	OHCA	No	No	No
Children and adolescents' access to PCPs – 12 months to 19 years Percentage of beneficiaries 12 months to 19 years of age who had a visit with a PCP during the measurement year.	HEDIS	***Yes***	No	***Yes***
Adults' access to preventive/ambulatory health services Percentage of beneficiaries 20 years of age and older who had an ambulatory or preventive care visit in the measurement year.	HEDIS	***Yes***	No	No

Number of HMP Members Engaged in Health Coaching

Findings

Telligen proposed to serve 6,000 beneficiaries each year under the contract that took effect in 2019. Telligen provided health coaching to 4,864 unduplicated beneficiaries in 2019, 7,152 in 2020 and 6,292 in 2021[61]. Although these are not point-in-time caseloads, average tenure each year was close to 12 months (Exhibit F-155).



Hypertension and diabetes were the most common of the major chronic diagnoses across the three years, although approximately 35 percent of members had none of the five conditions (Exhibit F-156).

Exhibit F-156 – HMP – Health Coaching Diagnoses (Percent of Total)[62]

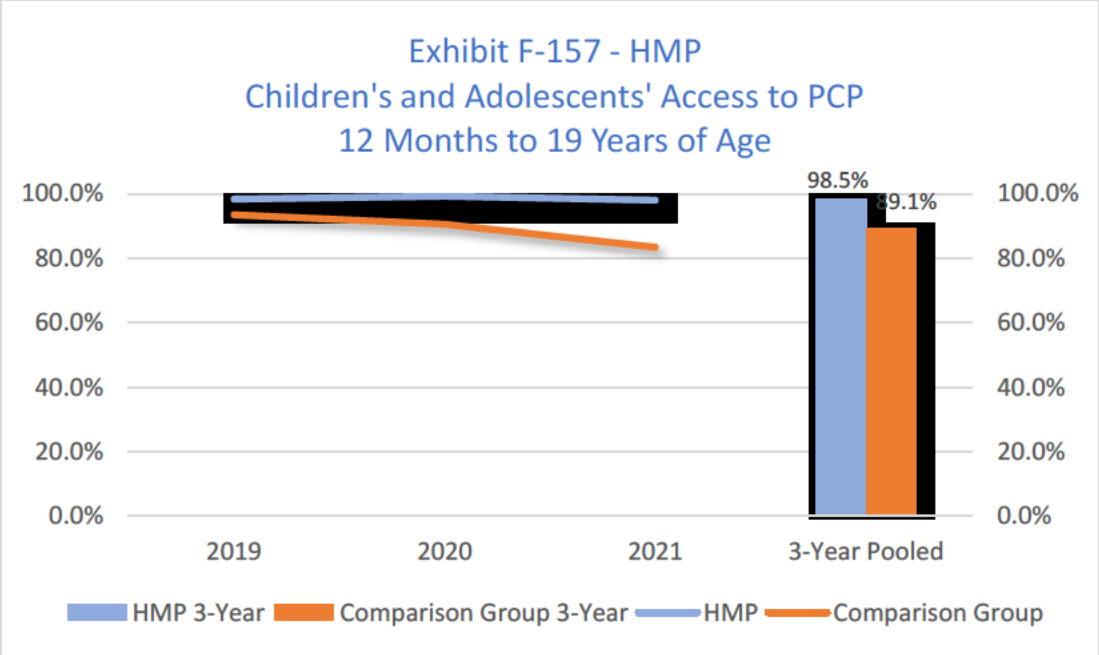
	2019	2020	2021	3-Year Average
Asthma	5.6%	5.4%	6.2%	5.7%
CAD	12.7%	8.7%	9.2%	10.0%
COPD	11.8%	8.5%	9.5%	9.6%
Diabetes	36.6%	31.8%	32.7%	33.4%
Hypertension	53.5%	49.4%	45.4%	49.1%
Other	28.1%	36.8%	37.7%	34.8%

[61] The lower enrollment in 2019 was at least partially due to Telligen's decision not to automatically re-enroll all members at the time of the new contract. Telligen took several months to re-assess the health coaching population and to enroll new participants in place of those found no longer to need assistance.
[62] Beneficiaries can be in multiple categories; "other" includes those not appearing in any of the defined categories.

Children and Adolescents' Access to PCPs – 12 Months to 19 Years

Findings – HMP Population

Approximately 98 percent of HMP members and 89 percent of comparison group members were compliant on this measure across the three years (Exhibit F-157). The compliance rate for the HMP population was stable from 2019 to 2021 while the comparison group rate declined.



The difference between the HMP and comparison group compliance rates was statistically significant in each of the individual years. It also was statistically significant for the three-year pooled data (Exhibit F-158).

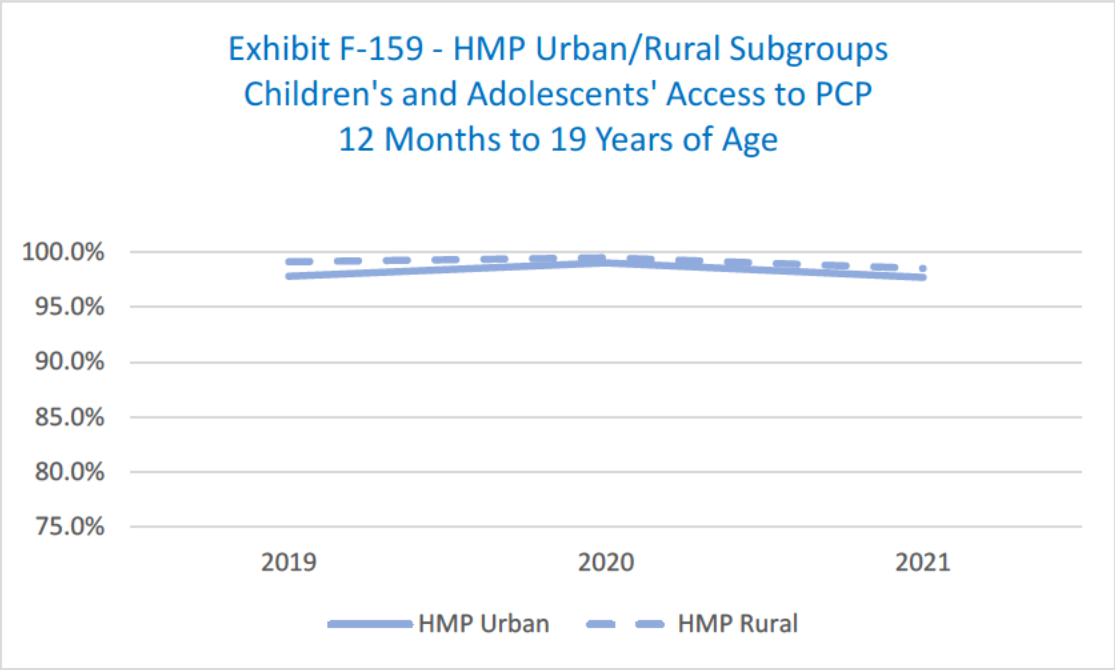
Exhibit F-158 – HMP – Children's & Adolescents' Access to PCP – 12 Months to 19 Years

	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)

Findings – HMP and Care Managed Populations – Urban and Rural Subgroups

The HMP urban and rural subgroups recorded similar compliance rates, with both remaining above 97 percent across the three years (Exhibit F-159).

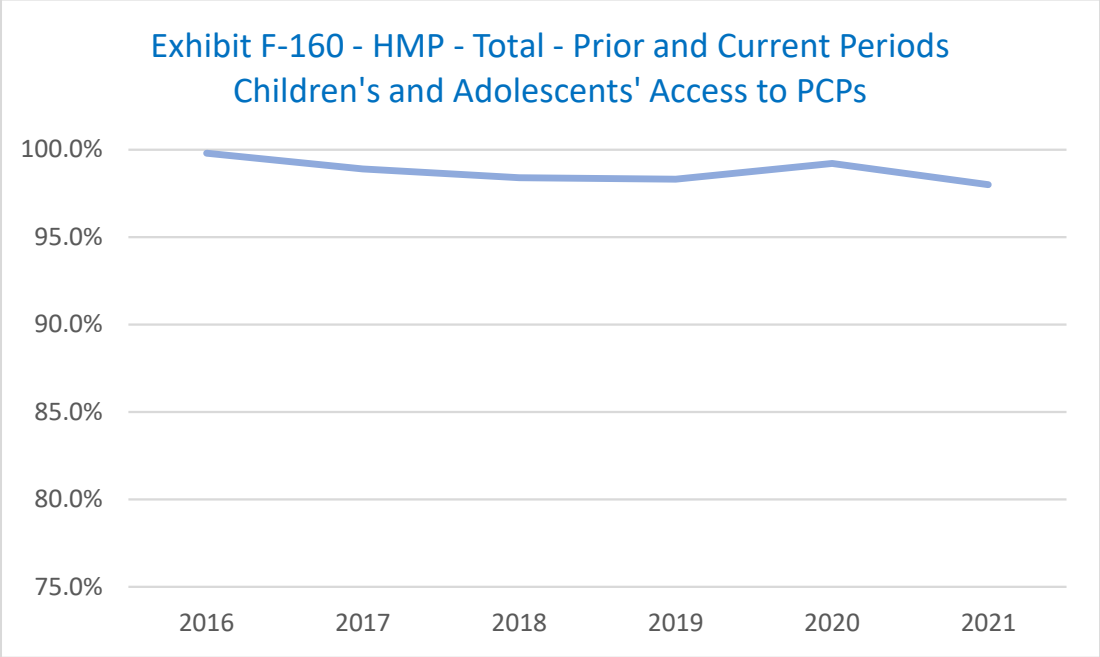


Note: Y-axis does not begin at 0.

	Subgroup	2019	2020	2021
Compliance Rate	**Urban**	97.8%	99.0%	97.7%
	Rural	99.1%	99.5%	98.5%

Findings – HMP Population – Comparison to Prior Waiver Period

This measure also was evaluated for the HMP population in the prior waiver period (2016 to 2018). The compliance rate consistently remained at 98 percent or higher from 2016 to 2021 (Exhibit F-160).



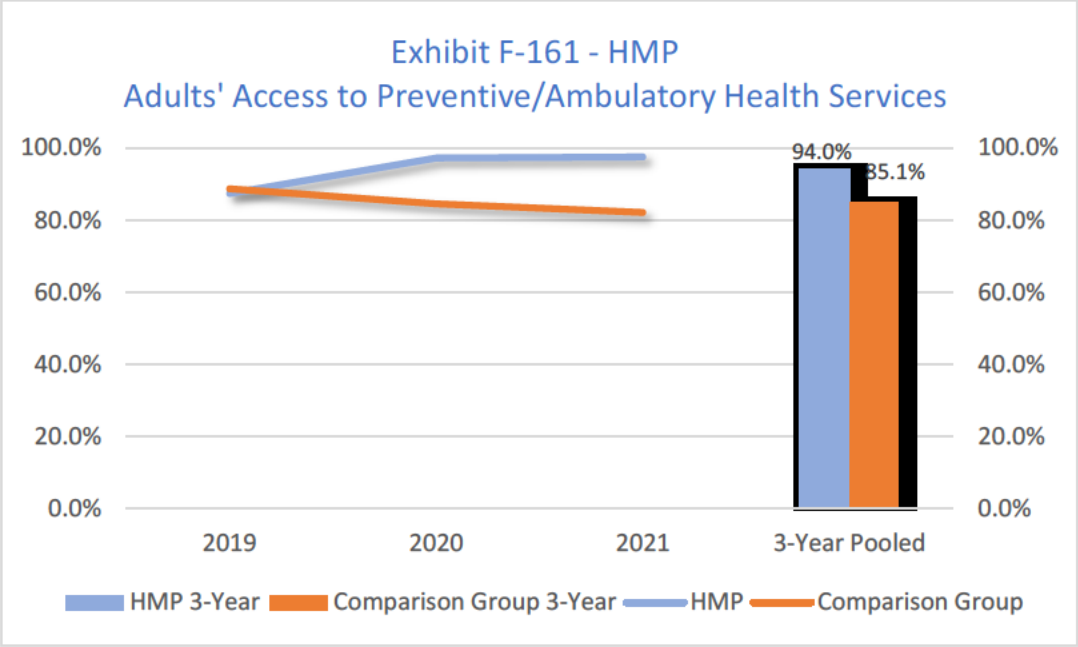
Note: Y-axis does not begin at 0.

	2016	2017	2018	2019	2020	2021
Compliance Rate	99.8%	98.9%	98.4%	98.3%	99.2%	98.0%

Adults' Access to Preventive/Ambulatory Health Services

Findings – HMP Population

Ninety-four percent of HMP members and approximately 85 percent of comparison group members were compliant on this measure across the three years (Exhibit F-161). The compliance rate for the HMP population rose from 2019 to 2021 while the compliance rate for the comparison group declined.



The difference between the HMP and comparison group compliance rates was statistically significant in each of the individual years. It also was statistically significant for the three-year pooled data (Exhibit F-162).

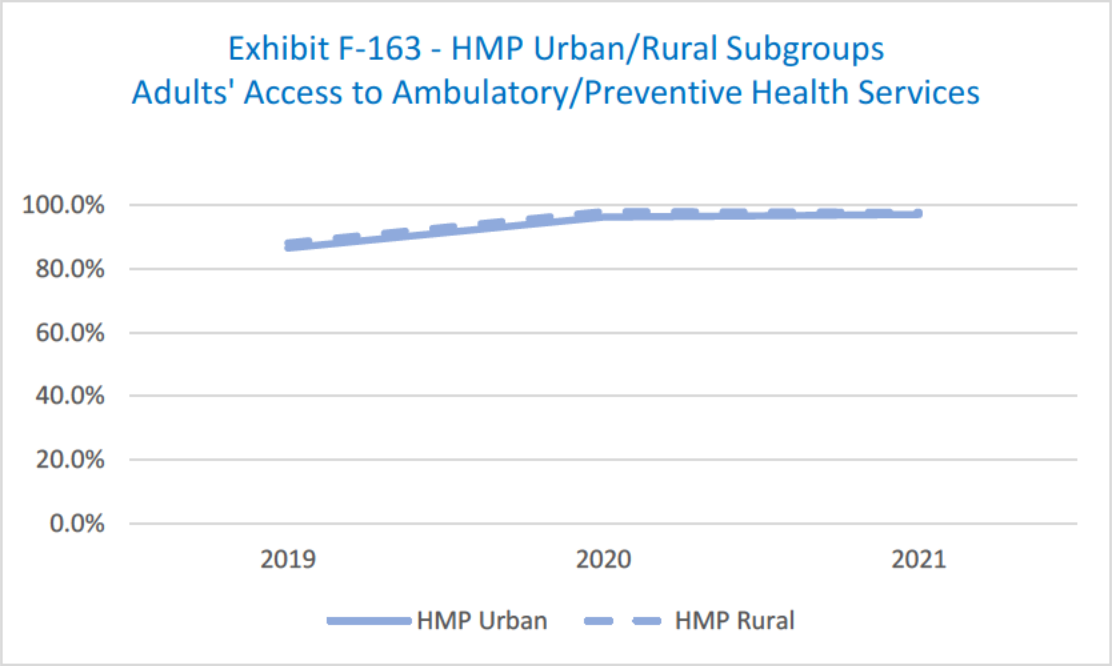
Exhibit F-162– HMP – Adults' Access to Preventive/Ambulatory Health Services

	2019	2020	2021	3-Year Pooled
HMP	87.4%	97.2%	97.5%	94.0%
Comparison Group	88.7%	84.5%	82.1%	85.1%
Difference	(1.3%)‡	12.7%‡	15.4‡	8.9%‡

‡ HMP rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HMP and Care Managed Populations – Urban and Rural Subgroups

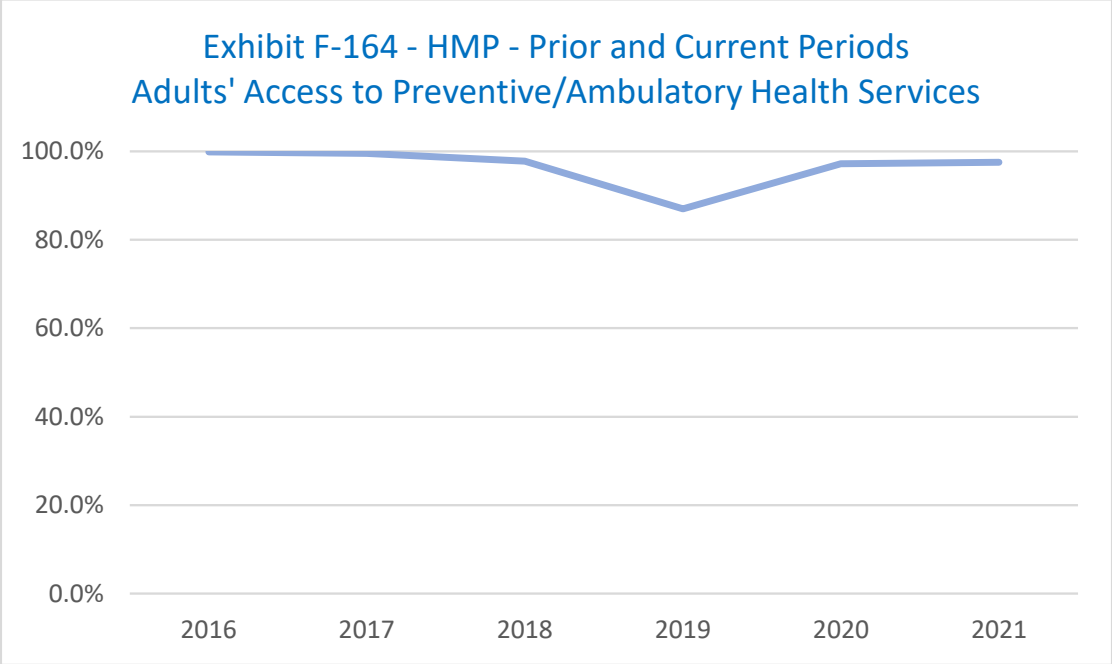
The HMP urban and rural subgroups recorded similar compliance rates; both trended upward from 2019 to 2021. (Exhibit F-163).



	Subgroup	2019	2020	2021
Compliance Rate	**Urban**	86.5%	96.2%	97.1%
	Rural	88.1%	98.0%	97.8%

Findings – HMP Population – Comparison to Prior Waiver Period

This measure also was evaluated for the HMP population in the prior waiver period (2016 to 2018). The compliance rate remained above 97 percent in every year except one[63] from 2016 to 2021 (Exhibit F-164).



	2016	2017	2018	2019	2020	2021
Compliance Rate	99.9%	99.5%	97.8%	87.0%	97.2%	97.5%

[63] 2019 was a transitional year, with a new Telligen contract taking effect in July. Although all members included in the measure met the HEDIS continuous enrollment standard, a larger proportion than in other years were enrolled in the HMP for only part of the year. (See also footnote 64.)

HMP Access to Care – Summary

The SoonerCare HAN total member and comparison group populations differed by a statistically significant amount on the two HEDIS preventive care measures, with the comparison group outperforming the HAN beneficiary population. The 2019 to 2021 trend for both measures was downward.

The SoonerCare HAN Care Managed member and comparison group populations also differed by a statistically significant amount on the two HEDIS preventive care measures, with the HAN population outperforming the comparison group. The 2019 to 2021 trend for both measures again was downward.

There was no statistically significant difference between the SoonerCare HAN total member and comparison group populations with respect to the CAHPS Getting Needed Care measure (Exhibit F-165).

Exhibit F-165 – HMP Access to Care Measures – Summary

Measures	HMP versus Comparison Group	HMP 2019 – 2021 Trend
Number of members engaged in health coaching		▲
Children and adolescents' access to PCPs – 12 months to 19 years	✦	▼
Adults' access to preventive/ambulatory health services	✦	▲

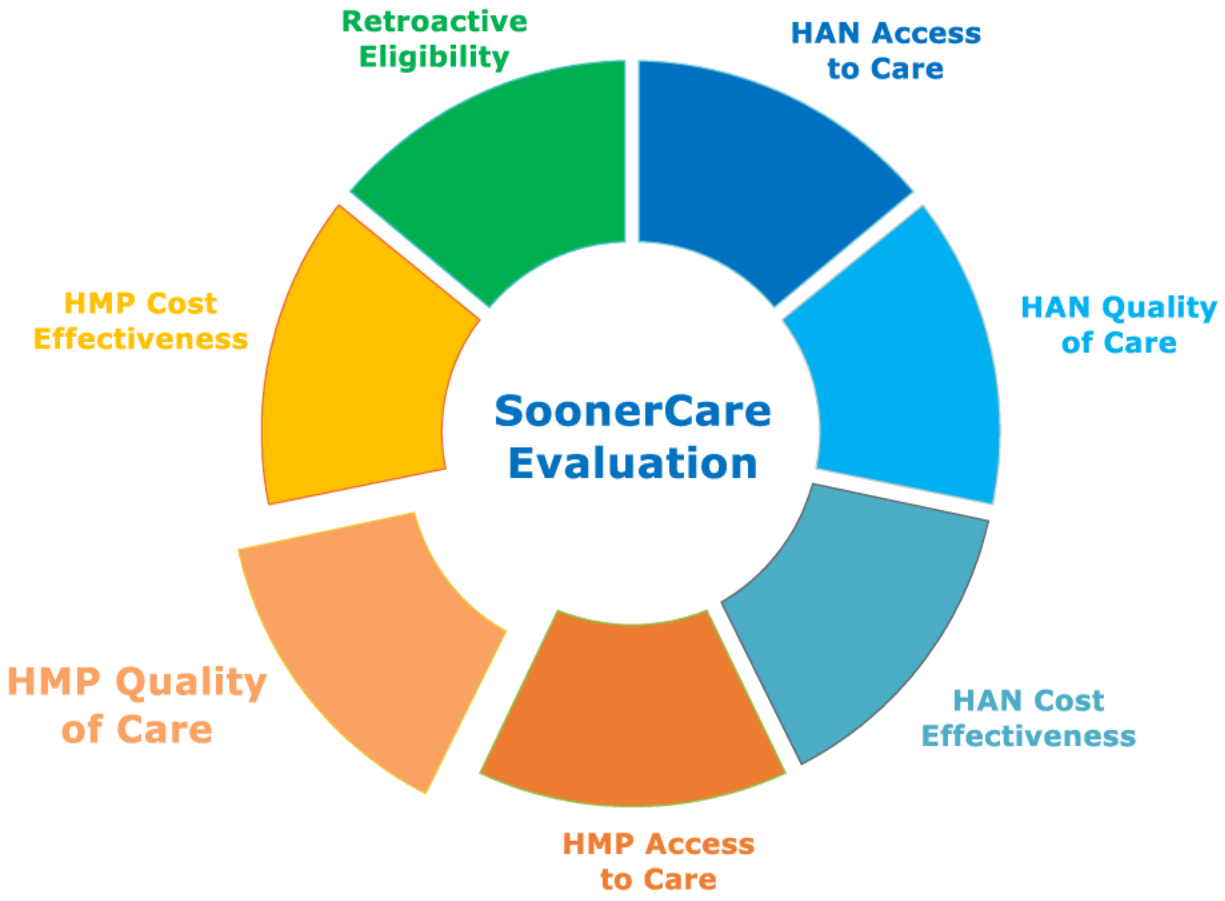
✦ HMP exceeds comparison group by a statistically significant amount (3-year pooled)

✦ No statistically significant difference (3-year pooled)

✦ Comparison group exceeds HMP by a statistically significant amount (3-year pooled)

▲ 2019 – 2021 trend is upward

▼ 2019 – 2021 trend is downward


Retroactive Eligibility
HAN Access to Care
HAN Quality of Care
HAN Cost Effectiveness
HMP Access to Care
HMP Quality of Care
HMP Cost Effectiveness
SoonerCare Evaluation

5. HMP Quality of Care

Overview

The SoonerCare HMP uses a combination of data analytics and physician referrals to identify appropriate candidates for health coaching. The program targets persons with multiple physical health conditions (often with behavioral health co-morbidities) who can benefit from holistic care management.

Health coaches employ motivational interviewing and other techniques to engage beneficiaries in better managing their chronic health conditions and adopting healthier lifestyles. Health coaches provide education on the importance of preventive care specific to the beneficiary's condition (e.g., retinal eye exams and HbA1c tests for diabetics) and for general good health (e.g., proper diet and exercise). Coaches also assist beneficiaries in communicating with their PCMH provider and scheduling appointments with specialists and behavioral health providers.

Health coaches make themselves available to beneficiaries by telephone, as well as at the physician's office, in the case of practice-embedded coaches. The SoonerCare HMP vendor also operates a telephonic resource center, through which beneficiaries (or their health coaches) can obtain assistance addressing social service needs (social determinants of health) that could present barriers to care (e.g., food or housing insecurity).

HMP Quality of Care Measures

Exhibit F-166 on the following page presents the HMP quality of care measures and identifies:

- Data sources
- Subgroups evaluated (if any)
- Presence or absence of a national benchmark
- Presence or absence of comparative data from the prior Demonstration period

Supporting Appendices

Appendix 8 contains CEM covariate balance tables for CAHPS measures. Appendix 9 contains statistical significance tests results for CAHPS measures. Appendix 10 contains CEM covariate balance tables for HEDIS measures. Appendix 11 contains statistical significance test results for HEDIS measures. Appendix 12 contains the SDOH component of the HMP member targeted survey instrument.

Exhibit F-166 - Quality of Care Measures - Overview[64]

Measures	Source	Geographic Subgroups	National Benchmark	Prior Period Data
Chronic conditions Average number of physical health chronic conditions among HMP members.	MMIS	No	No	No
Physical/behavioral health co-morbidities Percentage of members with co-occurring chronic physical health and behavioral health conditions	MMIS	No	No	No
Asthma – Medication Ratio Percentage of members ages 5 to 18 and 19 to 64 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medication of 0.50 or greater during the measurement year.	HEDIS	***Yes***[65]	***Yes***	***Yes***
Cardiovascular – Persistence of Beta Blocker Treatment after a Heart Attack Percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.	HEDIS	***Yes***	No	No
Cardiovascular – Cholesterol Management for Patients with Cardiovascular Conditions – LDL-C Test Percentage of members 18 to 75 years of age with cardiovascular disease who had an LDL-C test during the measurement year.	HEDIS	***Yes***	No	No
COPD – Use of Spirometry Testing in the Assessment and Diagnosis of COPD Percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.	HEDIS	***Yes***	No	No

[64] The approved evaluation design includes follow-up for hospitalization after mental illness, as well as measures for asthma, CAD and diabetes admission rates for treatment of short-term complications. The HMP case count was determined to be too small to produce reliable findings. The measures will be re-examined for possible inclusion in the summative evaluation report.

[65] 19 – 64 age cohort only. Insufficient case count in 5 – 18 age cohort for reliable results.

Measures	Source	Geographic Subgroups	National Benchmark	Prior Period Data
COPD – Pharmacotherapy Management of COPD Exacerbation – 14 Days and 30 Days Percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or emergency room visit on or between January 1 to November 30 of the measurement year and who were dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event and within 30 days of the event.	HEDIS	***Yes***	No	No
Diabetes – Percentage of Members who had LDL-C Test Percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who had LDL-C performed.	HEDIS	***Yes***	No	***Yes***
Diabetes – Percentage of Members who had Retinal Eye Exam Performed Percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who had retinal eye exam performed.	HEDIS	***Yes***	No	***Yes***
Diabetes - Percentage of Members who had Hemoglobin A1c (HbA1c) Testing Percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who had Hemoglobin A1c (HbA1c) testing performed.	HEDIS	***Yes***	No	***Yes***
Diabetes - Percentage of Members who Received Medical Attention for Nephropathy Percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who received medical attention for nephropathy.	HEDIS	***Yes***	No	***Yes***
Hypertension – Percentage of Members who had LDL-C Test Percentage of members 18 years of age and older with hypertension who had an LDL-C test performed.	HEDIS	***Yes***	No	***Yes***
Hypertension – Percentage of Members Prescribed ACE/ARB Therapy Percentage of members 18 years of age and older with hypertension who were prescribed angiotensin converting enzyme inhibitors or angiotensin receptor blockers (ACE/ARB therapy).	HEDIS	***Yes***	No	***Yes***

Measures	Source	Geographic Subgroups	National Benchmark	Prior Period Data
Opioids – Use of Opioids at High Dosage Percentage of members without cancer using prescribed opioids at high dosage.	HEDIS	***Yes***	***Yes***	No
Opioids – Concurrent use of Opioids and Benzodiazepines Percentage of members concurrently using prescribes opioids and benzodiazepines.	HEDIS	***Yes***	***Yes***	No
Rating of Assistance with SDOH Member awareness of the availability of help with SDOH and satisfaction, among HAN members receiving assistance.	PHPG Targeted Survey	No	No	No
Getting Needed Care – children and adults Percentage of beneficiaries (adults and parents/caretakers of children) who reported "always" getting needed care. "Getting Needed Care" is a composite measure consisting of two questions, the first of which asks about getting necessary care, tests or treatment[66] and the second of which asks about getting appointments with specialists as soon as needed[67]. The composite is a simple average of the individual measure percentages.	CAHPS	No	***Yes***	No
Rating of Healthcare – Children and Adults[68] Rating of health care (or child's health care) in the last six months, using a scale from 0 to 10, where "0" represented the worst possible health care and "10" the best possible health care.	CAHPS	No	***Yes***	No
Rating of Health Plan – Children and Adults Rating of health plan (or child's health plan) in the last six months, using a scale from 0 to 10, where "0" represented the worst possible health plan and "10" the best possible health plan.	CAHPS	No	***Yes***	No

[66] In the last 6 months, how often was it easy to get the care, tests, or treatment you (your child) needed?
[67] In the last 6 months, how often did you (your child) get an appointment to see a specialist as soon as you needed?
[68] The approved evaluation design includes the CAHPS Rating of Personal Doctor question. The determination was made not to survey SoonerCare HMP members on this item because the program has no role in the member's selection of a PCMH provider.

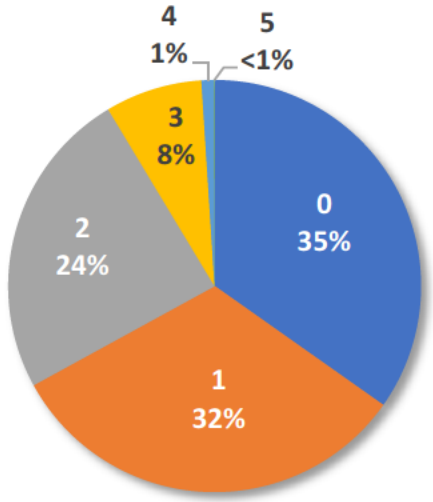
Average Number of Chronic Conditions

Findings – HMP Population

The SoonerCare HMP is designed to be holistic and not diagnosis-driven. However, five chronic physical health conditions are prevalent in the member population: asthma, coronary artery disease, chronic obstructive pulmonary disease, diabetes and hypertension.

On average, from 2019 – 2021, approximately 65 percent of SoonerCare HMP members had one or more of the prevalent conditions (Exhibit F-167).

Exhibit F-167 - Health Management Program
Number of Chronic Conditions



The percentage having one or more of the prevalent chronic conditions declined from 2019 to 2021 (Exhibit F-168).

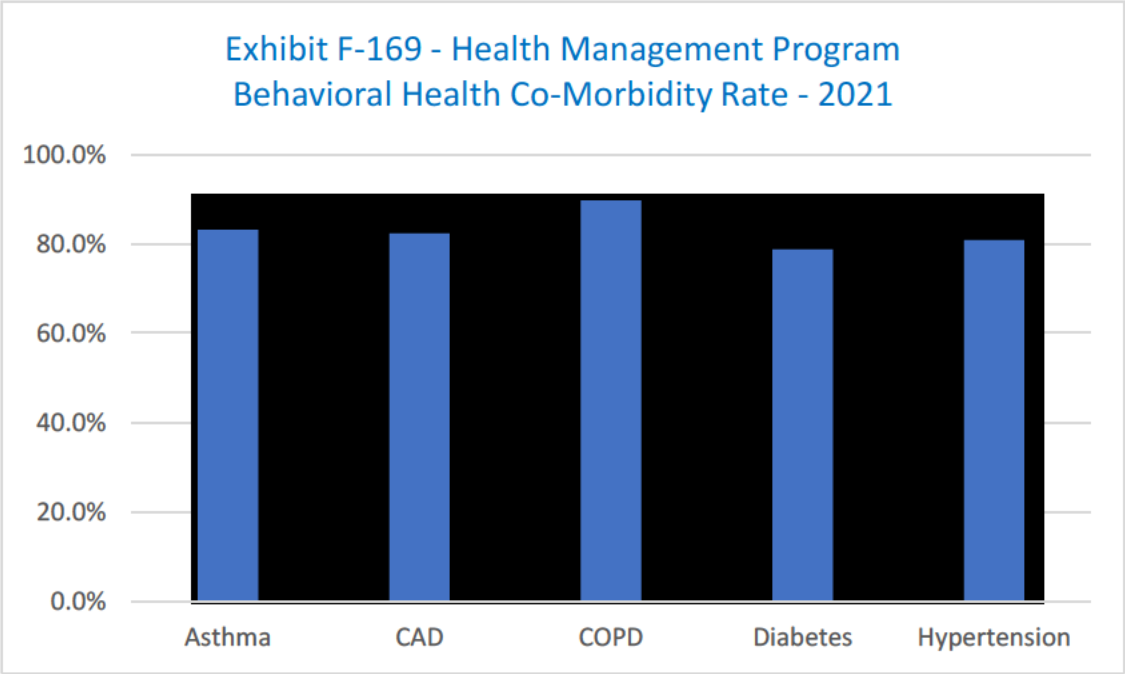
Exhibit F-168 – HMP – Number of Chronic Conditions per Member

	2019	2020	2021	3-Year Average
0 conditions (of the five)	28.1%	36.8%	37.7%	34.8%
1 condition	35.1%	31.3%	31.0%	32.2%
2 conditions	26.9%	23.9%	22.9%	24.4%
3 conditions	8.7%	7.1%	7.3%	7.6%
4 conditions	1.1%	0.8%	1.0%	0.9%
5 conditions	0.1%	0.1%	0.1%	0.1%
1 or more conditions	71.9%	63.2%	62.3%	65.2%

Percentage of Members with Physical and Behavioral Health Co-Morbidities

Findings – HMP Population

A significant majority of the HMP members with one or more of the prevalent chronic physical health conditions had a behavioral health co-morbidity. The portion ranged from approximately 79 percent for members with diabetes to 90 percent for members with COPD. Common co-morbidities included psychosis and major depression (Exhibit F-169).



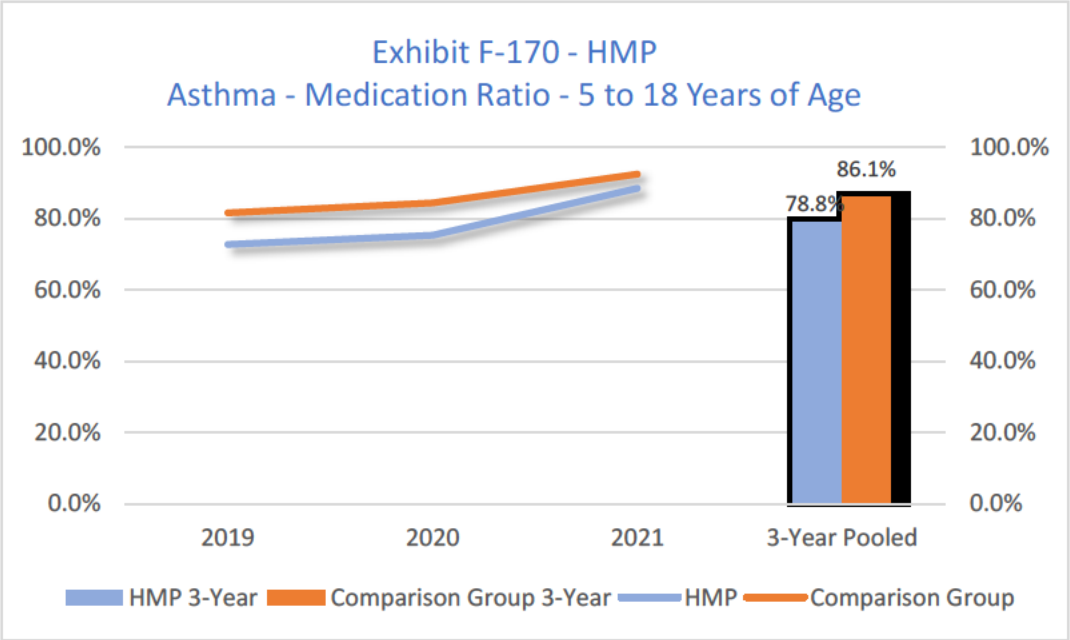
Asthma	CAD	COPD	Diabetes	Hypertension
83.1%	82.3%	89.8%	78.8%	80.0%

Behavioral health conditions were prevalent throughout the SoonerCare HMP population in 2021; 79.9 percent had a diagnosis with or without a co-morbidity, versus 29.2 percent for the total SoonerCare Choice population.

Asthma – Medication Ratio – Ages 5 to 18

Findings – HMP Population

Approximately 79 percent of HMP members and 86 percent of comparison group members were compliant on this measure across the three years (Exhibit F-170). The compliance rate for both populations rose from 2019 to 2021.



The difference between the HMP and comparison group compliance rates was statistically significant in 2020. It also was statistically significant for the three-year pooled data (Exhibit F-171).

Exhibit F-171 – HMP – Asthma – Medication Ratio – 5 to 18 Years of Age

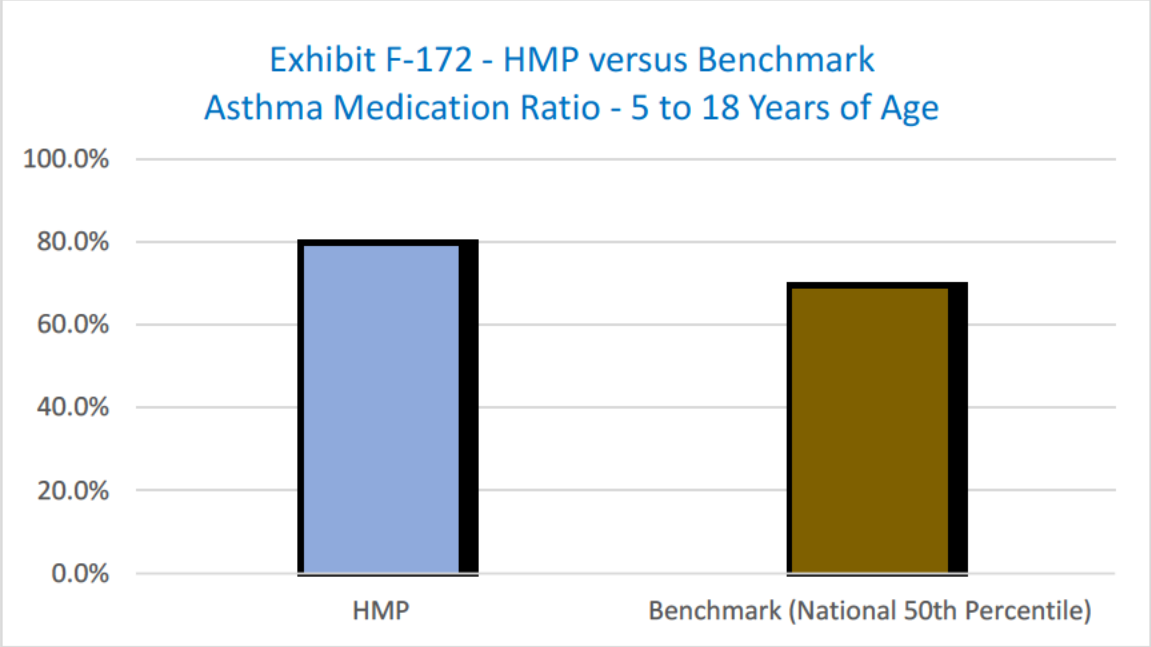
	2019	2020	2021	3-Year Pooled
HMP	72.7%	75.3%	88.4%	78.8%
Comparison Group	81.5%	84.3%	92.4%	86.1%
Difference	(8.8%)	(9.0%)‡	(4.0%)	(7.3%)‡

‡ HMP rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HMP and National Benchmark

The three-year pooled rate for the SoonerCare HMP population exceeded the national benchmark rate by approximately 10 percentage points (Exhibit F-172).

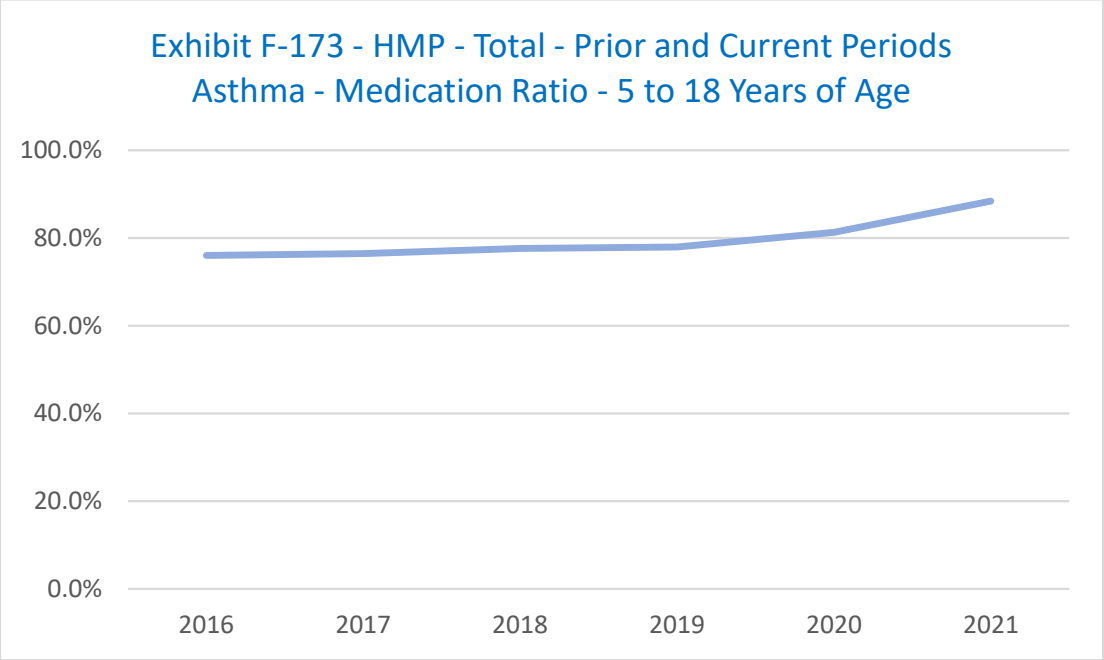
(Caution: the benchmark population characteristics were not matched to the OHCA groups to minimize differences in the populations. The data is presented for informational purposes only.)



	HMP	Benchmark
Compliance Rate	78.8%	68.6%

Findings – HMP Population – Comparison to Prior Waiver Period

This measure also was evaluated for the HMP population in the prior waiver period (2016 to 2018). The compliance rate rose from 76 percent 2016 to approximately 88 percent in 2021 (Exhibit F-173).

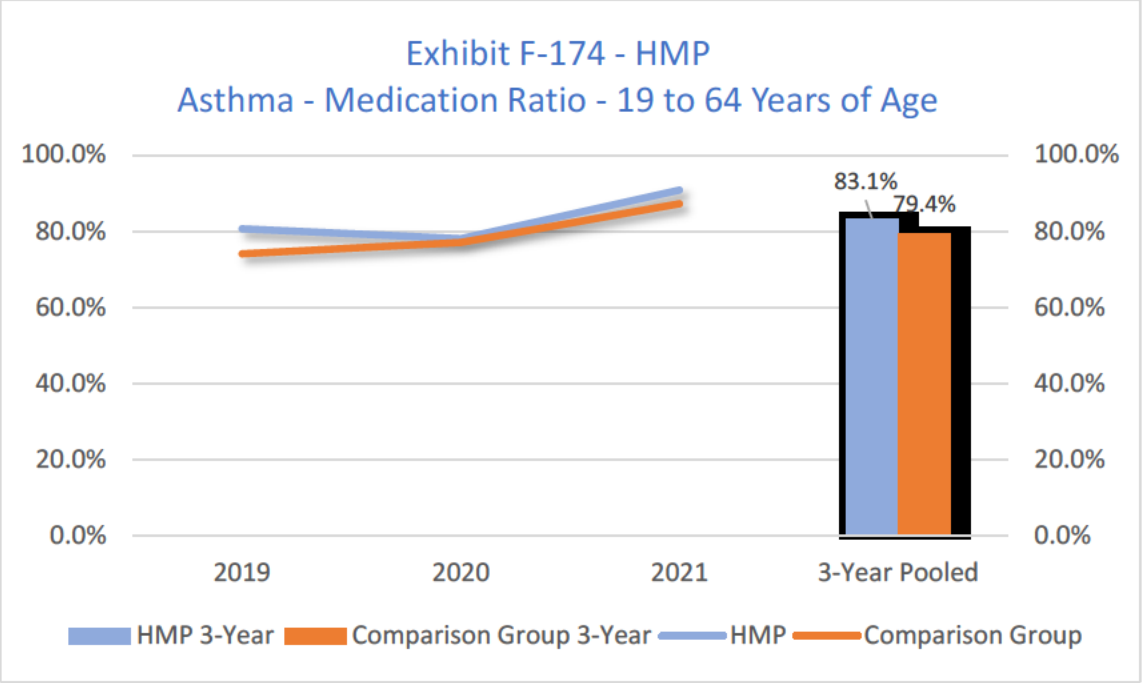


	2016	2017	2018	2019	2020	2021
Compliance Rate	76.0%	76.4%	77.6%	77.9%	81.3%	88.4%

Asthma – Medication Ratio – Ages 19 to 64

Findings – HMP Population

Approximately 83 percent of HMP members and 79 percent of comparison group members were compliant on this measure across the three years (Exhibit F-174). The compliance rate for both populations declined slightly from 2019 to 2020 and rose from 2020 to 2021.

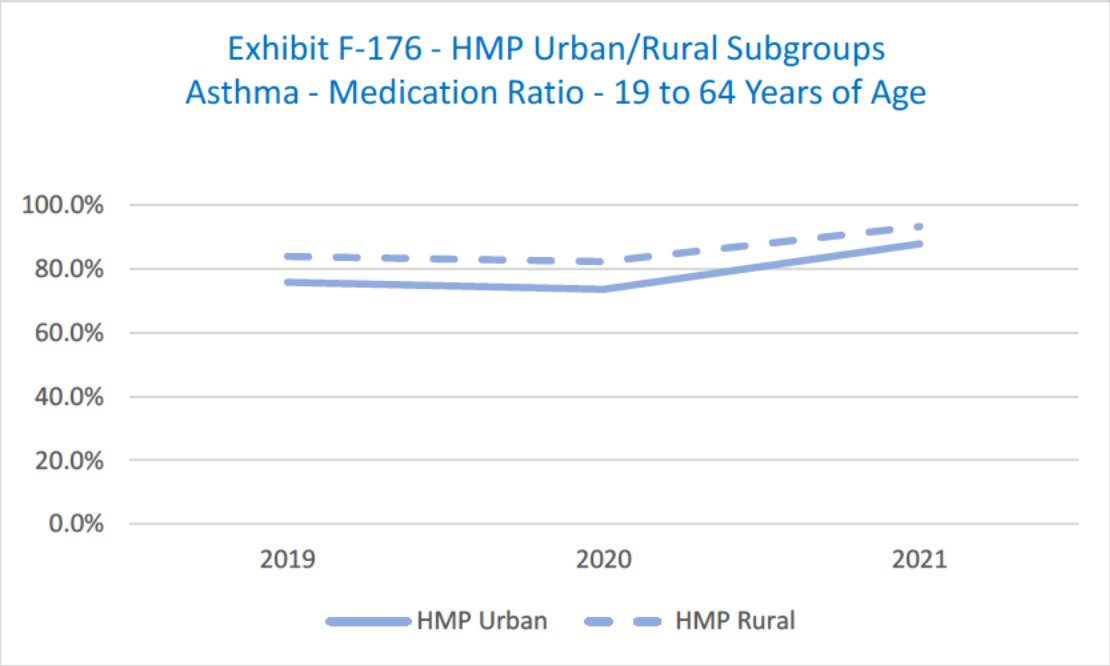


The difference between the HMP and comparison group compliance rates was statistically significant in 2019. It also was statistically significant for the three-year pooled data (Exhibit F-175).

Exhibit F-175 – HMP – Asthma – Medication Ratio – 19 to 64 Years of Age				
	2019	2020	2021	3-Year Pooled
HMP	80.6%	78.0%	90.8%	83.1%
Comparison Group	74.1%	77.0%	87.2%	79.4%
Difference	6.5%‡	1.0%	3.6%	3.7%‡
‡ HMP rate differs from comparison group rate by a statistically significant amount (95% confidence level)				

Findings – HMP and Care Managed Populations – Urban and Rural Subgroups

The HMP rural subgroup rate exceeded the urban rate in all three years. The compliance rate for both subgroups trended slightly downward from 2019 to 2020 and upward from 2020 to 2021 (Exhibit F-176).

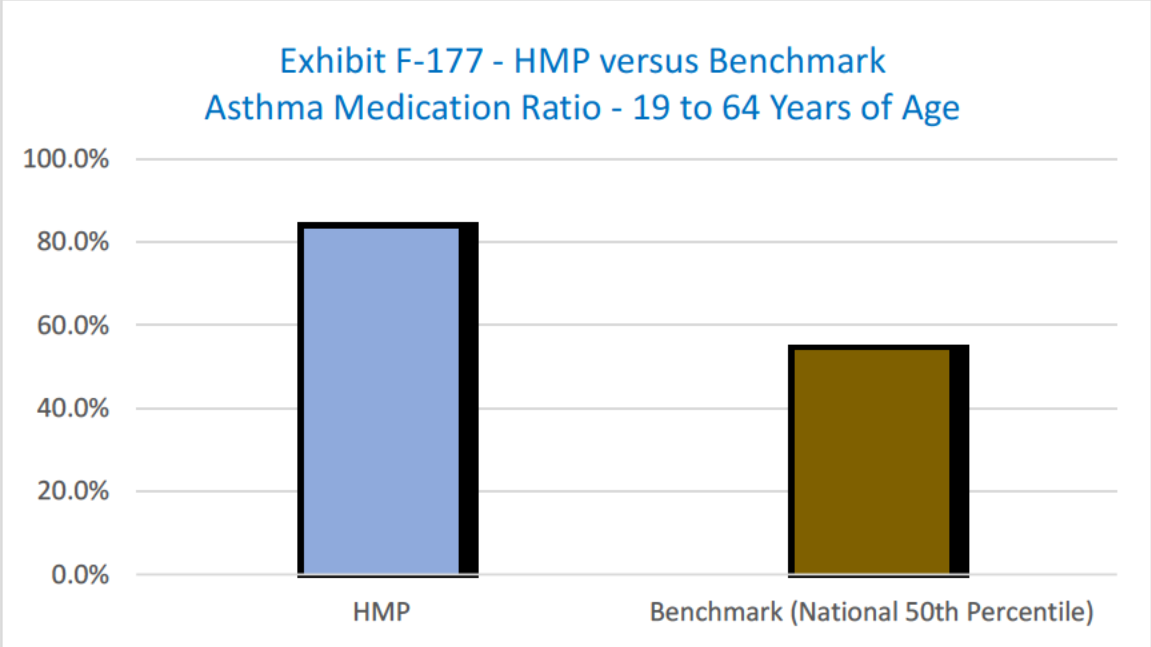


	Subgroup	2019	2020	2021
Compliance Rate	**Urban**	75.8%	73.6%	87.9%
	Rural	84.0%	82.4%	93.4%

Findings – HMP and Care Managed Populations and National Benchmark

The three-year pooled rate for the SoonerCare HMP population exceeded the national benchmark rate by approximately 29 percentage points (Exhibit F-177).

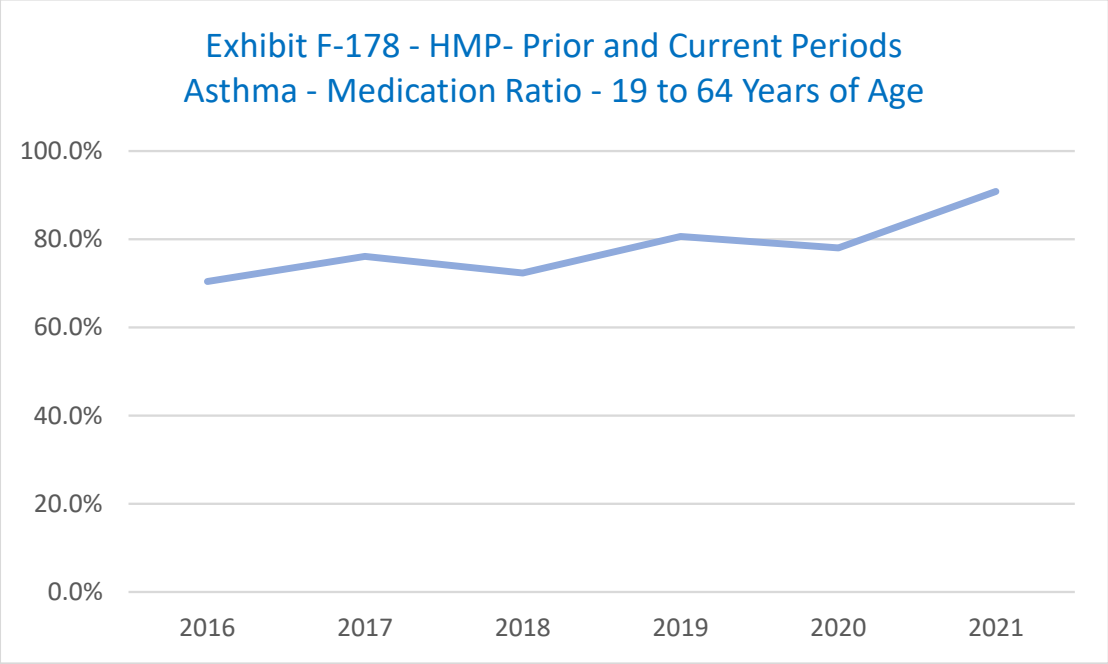
(Caution: the benchmark population characteristics were not matched to the OHCA groups to minimize differences in the populations. The data is presented for informational purposes only.)



	HMP	Benchmark
Compliance Rate	83.1%	53.7%

Findings – HMP Population – Comparison to Prior Waiver Period

This measure also was evaluated for the HMP population in the prior waiver period (2016 to 2018). The compliance rate rose from 70 approximately percent in 2016 to 91 percent in 2021 (Exhibit F-178).

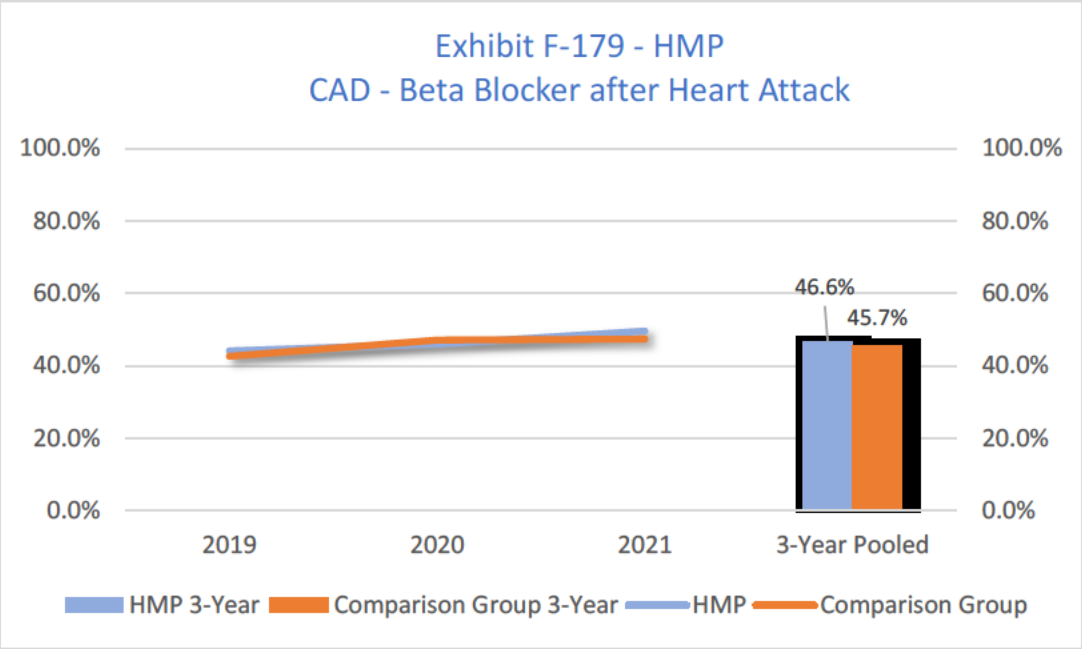


	2016	2017	2018	2019	2020	2021
Compliance Rate	70.4%	76.1%	72.3%	80.6%	78.0%	90.8%

Coronary Artery Disease – Persistent Beta Blocker Treatment after a Heart Attack

Findings – HMP Population

Approximately 47 percent of HMP members and 46 percent of comparison group members were compliant on this measure across the three years (Exhibit F-179). The compliance rate rose for both populations from 2019 to 2021.



The difference between the HMP and comparison group compliance rates was not statistically significant in any of the individual years. It also was not statistically significant for the three-year pooled data (Exhibit F-180).

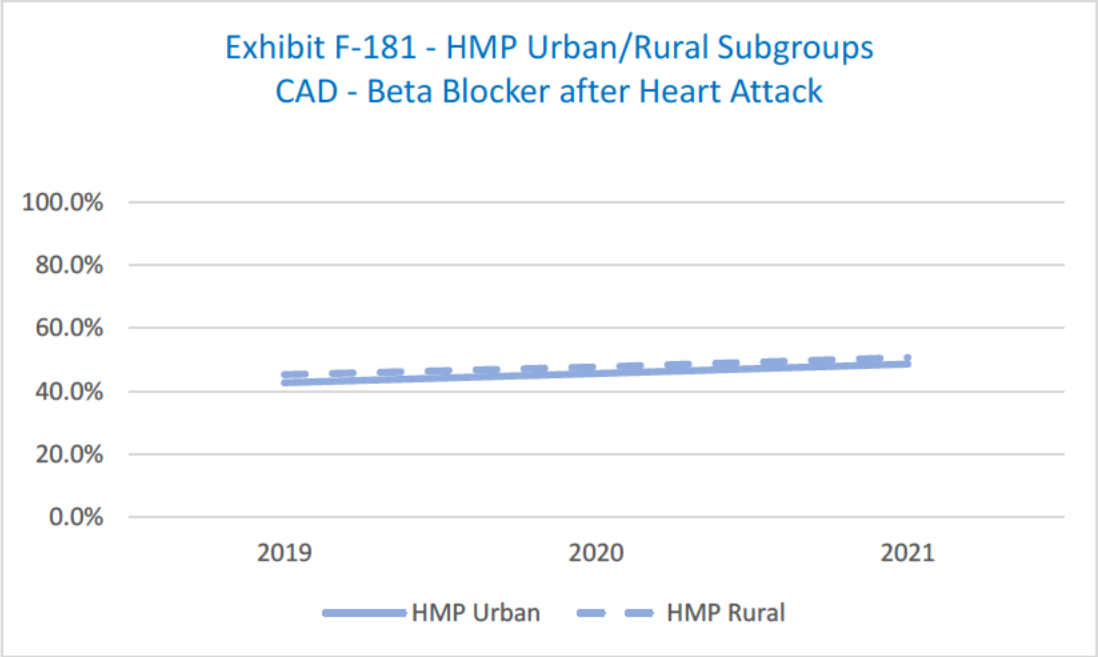
Exhibit F-180 – HMP – CAD – Beta Blocker after Heart Attack

	2019	2020	2021	3-Year Pooled
HMP	44.1%	46.0%	49.6%	46.6%
Comparison Group	42.6%	47.1%	47.4%	45.7%
Difference	1.5%	(1.1%)	2.2%	0.9%

‡ HMP rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HMP and Care Managed Populations – Urban and Rural Subgroups

The HMP rural subgroup had a slightly higher compliance rate than the urban subgroup across the three years. The compliance rate for both subgroups trended upward from 2019 to 2021 (Exhibit F-181).

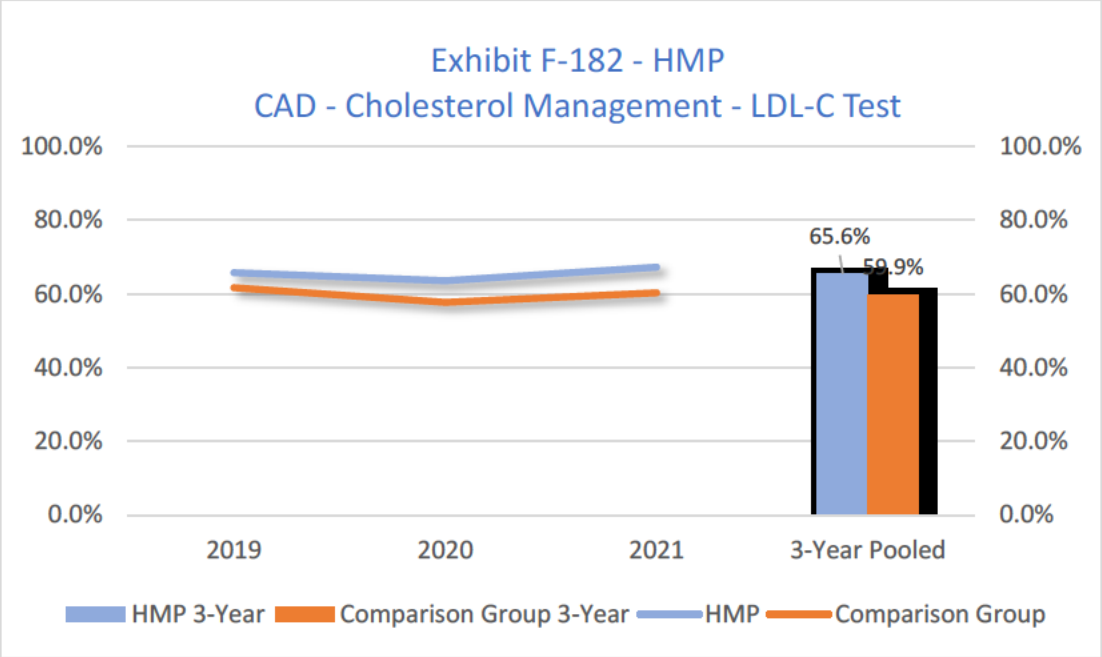


	Subgroup	2019	2020	2021
Compliance Rate	**Urban**	42.7%	45.6%	48.6%
	Rural	45.3%	47.7%	50.7%

Coronary Artery Disease – Cholesterol Management – LDL-C Test

Findings – HMP Population

Approximately 66 percent of HMP members and 60 percent of comparison group members were compliant on this measure across the three years (Exhibit F-182). The compliance rate for both populations declined from 2019 to 2020 before rising again from 2020 to 2021.



The difference between the HMP and comparison group compliance rates was statistically significant in 2020 and 2021. It also was statistically significant for the three-year pooled data (Exhibit F-183).

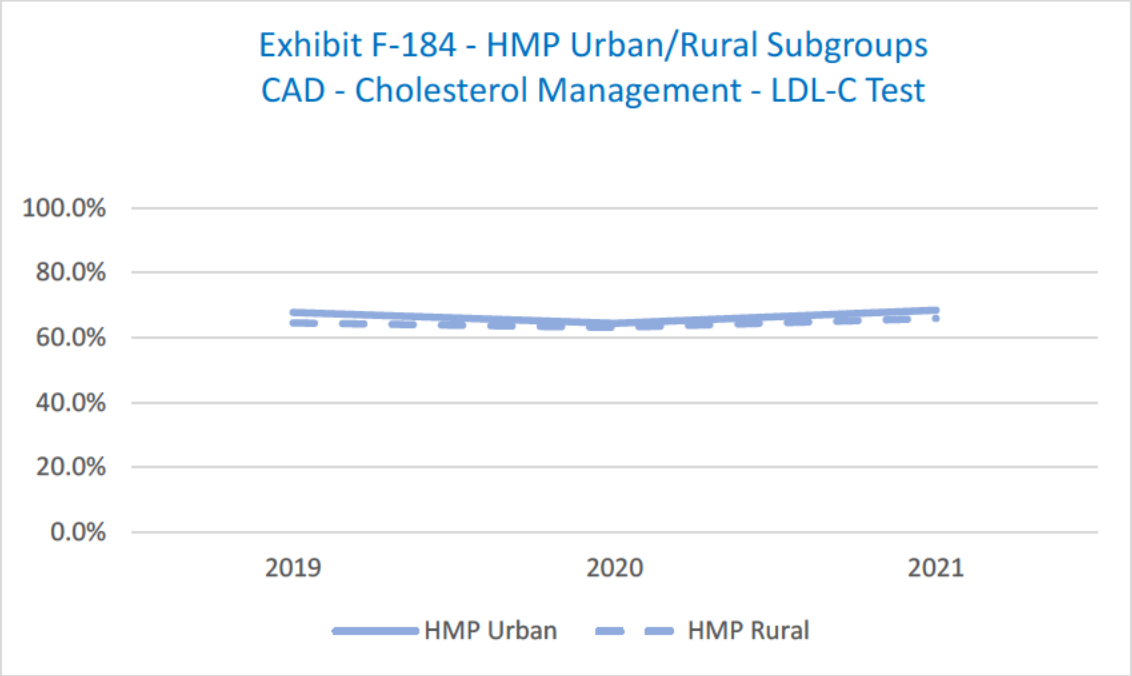
Exhibit F-183 – HMP – CAD – Cholesterol Management – LDL-C Test

	2019	2020	2021	3-Year Pooled
HMP	65.8%	63.6%	67.3%	65.6%
Comparison Group	61.7%	57.7%	60.3%	59.9%
Difference	4.1%	5.9%‡	7.0%‡	6.6%‡

‡ HMP rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HMP and Care Managed Populations – Urban and Rural Subgroups

The HMP urban subgroup compliance rate exceeded the rural subgroup rate across the three years. The compliance rate for both subgroups trended downward from 2019 to 2020 and upward from 2019 to 2021 (Exhibit F-184).

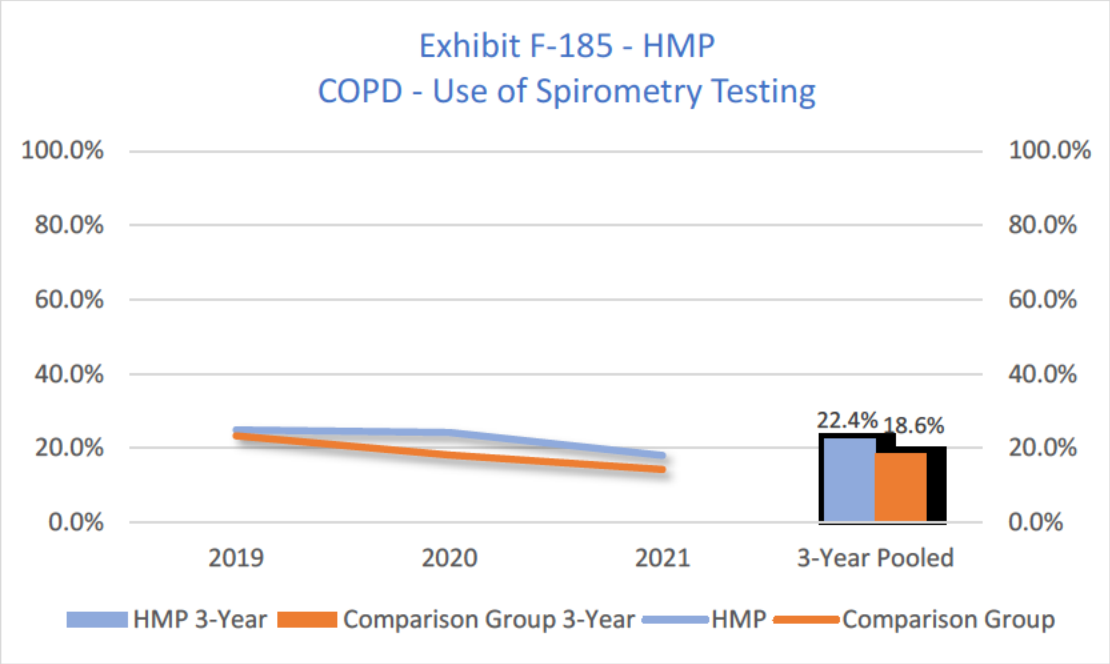


	Subgroup	2019	2020	2021
Compliance Rate	**Urban**	67.8%	64.4%	68.4%
	Rural	64.5%	63.1%	65.9%

Chronic Obstructive Pulmonary Disease – Use of Spirometry Testing

Findings – HMP Population

Approximately 22 percent of HMP members and 19 percent of comparison group members were compliant on this measure across the three years (Exhibit F-185). The compliance rate for both populations declined from 2019 to 2021.



The difference between the HMP and comparison group compliance rates was statistically significant in 2020. It also was statistically significant for the three-year pooled data (Exhibit F-186).

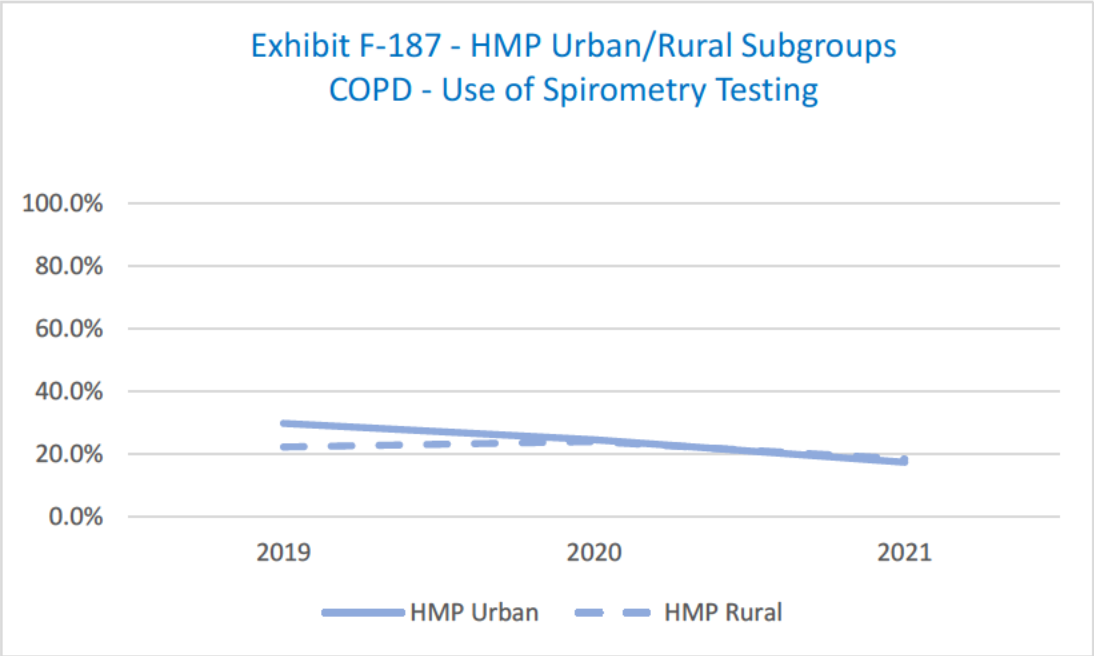
Exhibit F-186 – HMP – COPD – Use of Spirometry Testing

	2019	2020	2021	3-Year Pooled
HMP	24.9%	24.2%	18.1%	22.4%
Comparison Group	23.3%	18.2%	14.3%	18.6%
Difference	1.6%	6.0%‡	3.8%	3.8%‡

‡ HMP rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HMP and Care Managed Populations – Urban and Rural Subgroups

The HMP urban subgroup rate exceeded the rural rate in 2019 and 2020; the rural subgroup rate exceeded the urban rate in 2021. The rate for the urban subgroup trended downward from 2019 to 2021; the rate for the rural subgroup trended upward from 2019 to 2020 and downward from 2020 to 2021 (Exhibit F-187).

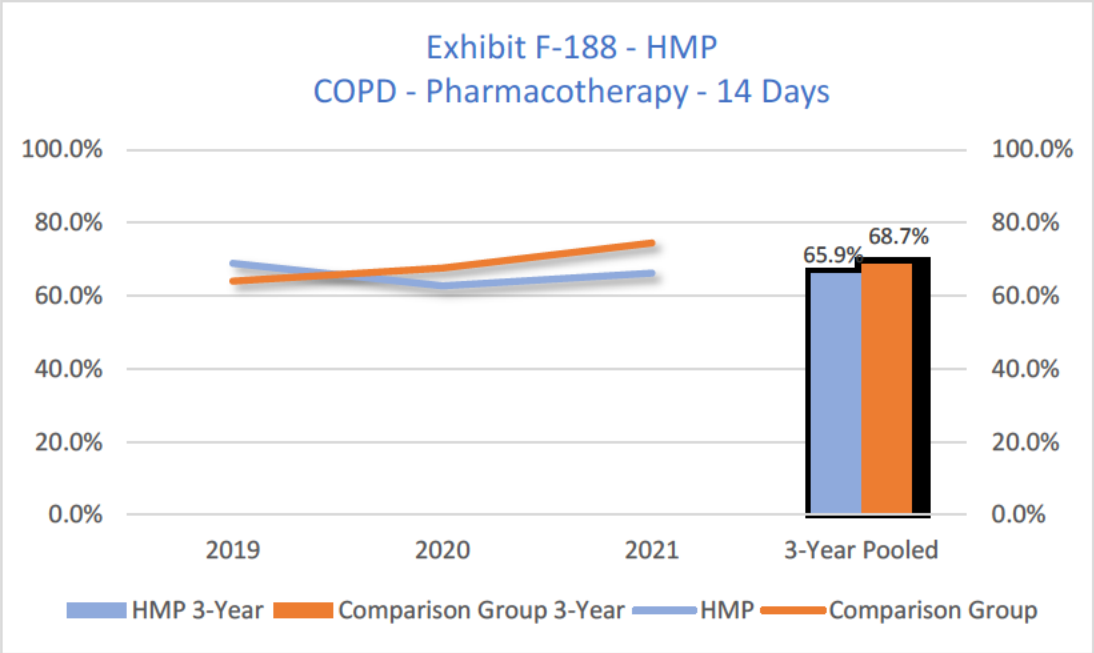


	Subgroup	2019	2020	2021
Compliance Rate	**Urban**	29.9%	24.6%	17.4%
	Rural	22.3%	24.0%	18.5%

Chronic Obstructive Pulmonary Disease – Pharmacotherapy Management of Exacerbation – 14 Days

Findings – HMP Population

Approximately 66 percent of HMP members and 69 percent of comparison group members were compliant on this measure across the three years (Exhibit F-188). The compliance rate for the HMP population declined from 2019 to 2020 before rising again from 2020 to 2021. The compliance rate for the comparison group rose from 2019 to 2021.



The difference between the HMP and comparison group compliance rates was statistically significant in 2021. It was not statistically significant for the three-year pooled data (Exhibit F-189).

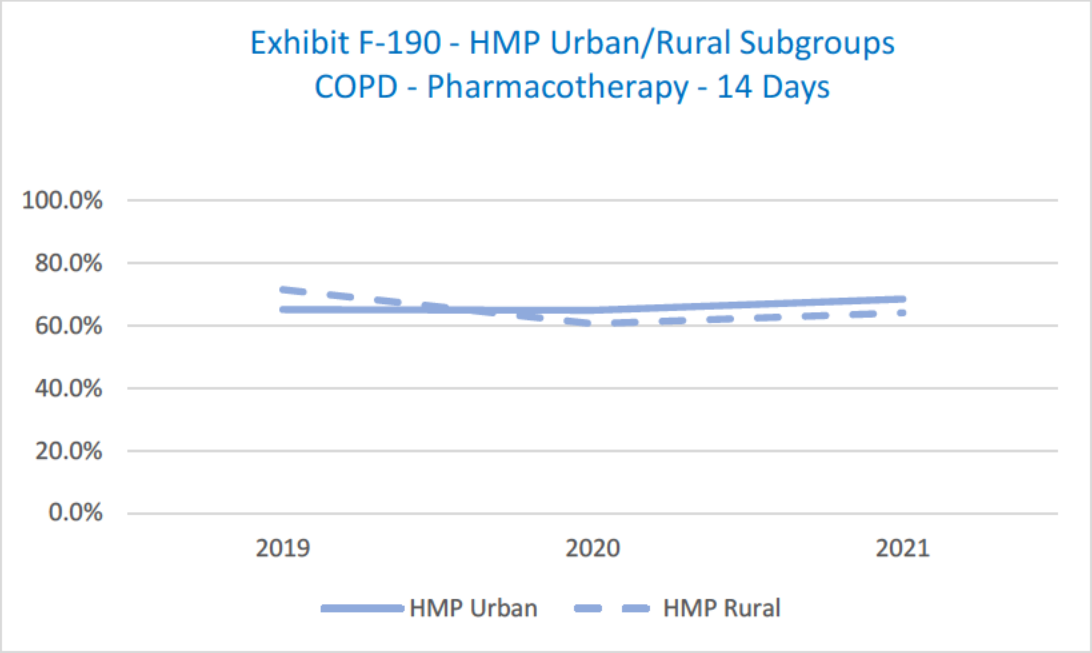
Exhibit F-189 – HMP – COPD – Pharmacotherapy – 14 Days

	2019	2020	2021	3-Year Pooled
HMP	68.9%	62.7%	66.2%	65.9%
Comparison Group	64.0%	67.6%	74.5%	68.7%
Difference	4.9%	(4.9%)	(8.3%)‡	(2.8%)

‡ HMP rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HMP and Care Managed Populations – Urban and Rural Subgroups

The HMP rural subgroup had a higher compliance rate than the urban subgroup in 2019; the urban subgroup had a higher rate in 2020 and 2021. The rates for both groups trended downward from 2019 to 2020 and trended upward from 2020 to 2021 (Exhibit F-190).

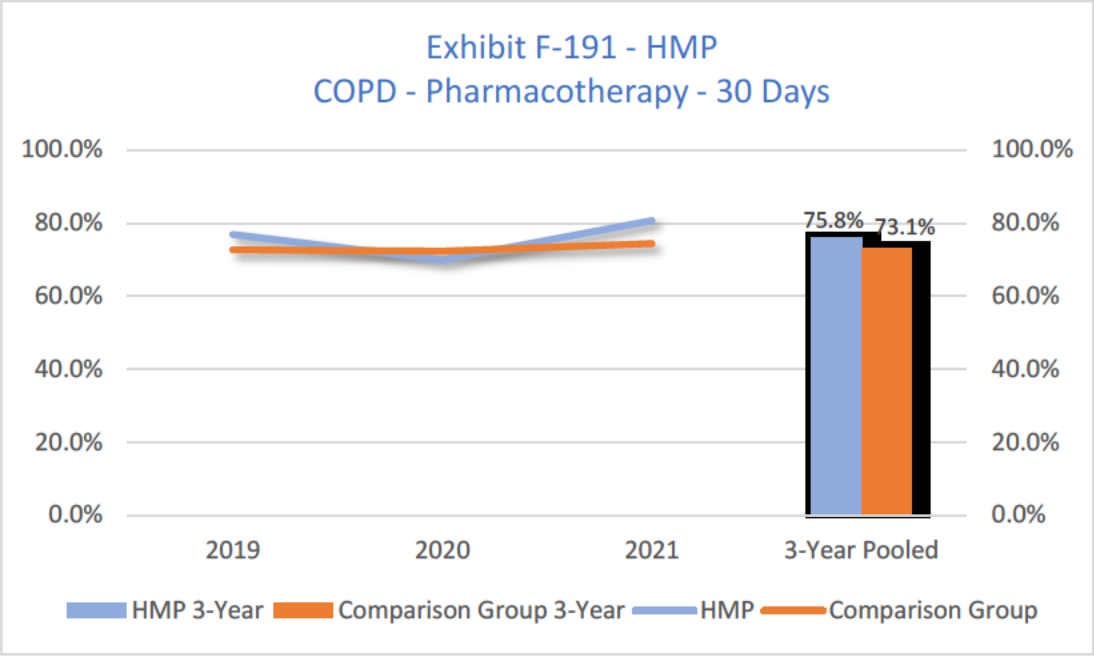


	Subgroup	2019	2020	2021
Compliance Rate	**Urban**	65.1%	64.9%	68.4%
	Rural	71.5%	60.5%	64.0%

Chronic Obstructive Pulmonary Disease – Pharmacotherapy Management of Exacerbation – 30 Days

Findings – HMP Population

Approximately 76 percent of HMP members and 73 percent of comparison group members were compliant on this measure across the three years (Exhibit F-191). The compliance rate for both populations declined from 2019 to 2020 and rose again from 2020 to 2021.



The difference between the HMP and comparison group compliance rates was not statistically significant in any of the individual years. It also was not statistically significant for the three-year pooled data (Exhibit F-192).

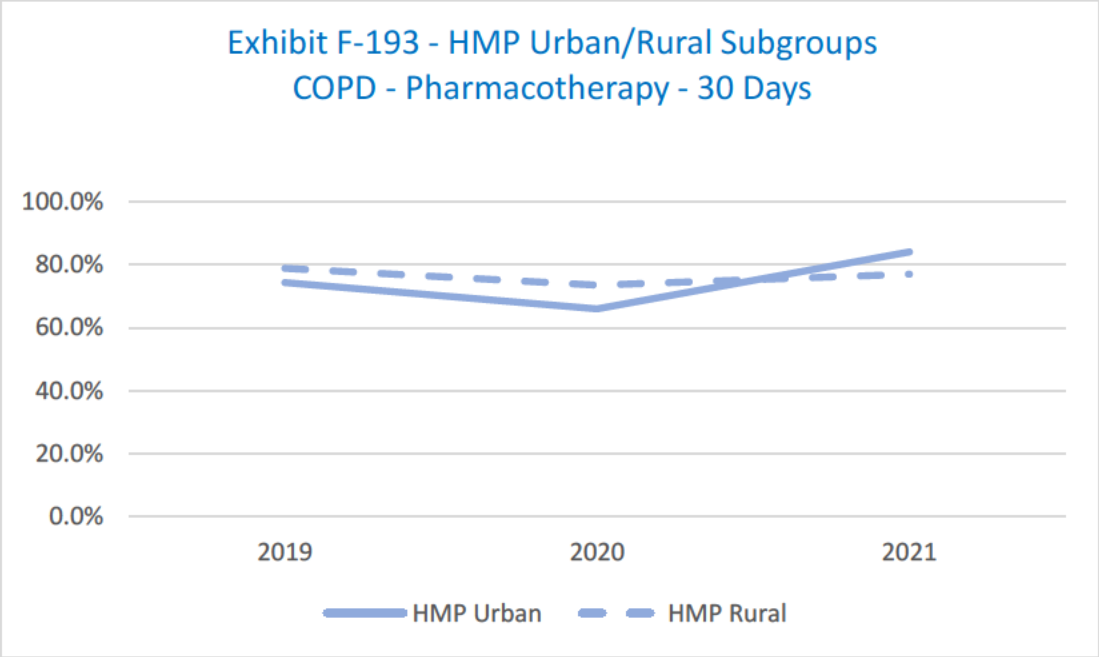
Exhibit F-192 – HMP – COPD – Pharmacotherapy – 30 Days

	2019	2020	2021	3-Year Pooled
HMP	76.8%	69.9%	80.6%	75.8%
Comparison Group	72.7%	72.3%	74.4%	73.1%
Difference	4.9%	(2.4%)	6.2%	2.7%

‡ HMP rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HMP and Care Managed Populations – Urban and Rural Subgroups

The HMP rural subgroup had a higher compliance rate than the urban subgroup in 2019 and 2020; the urban subgroup had a higher rate in 2021. The rates for both groups trended downward from 2019 to 2020 and trended upward from 2020 to 2021 (Exhibit F-193).

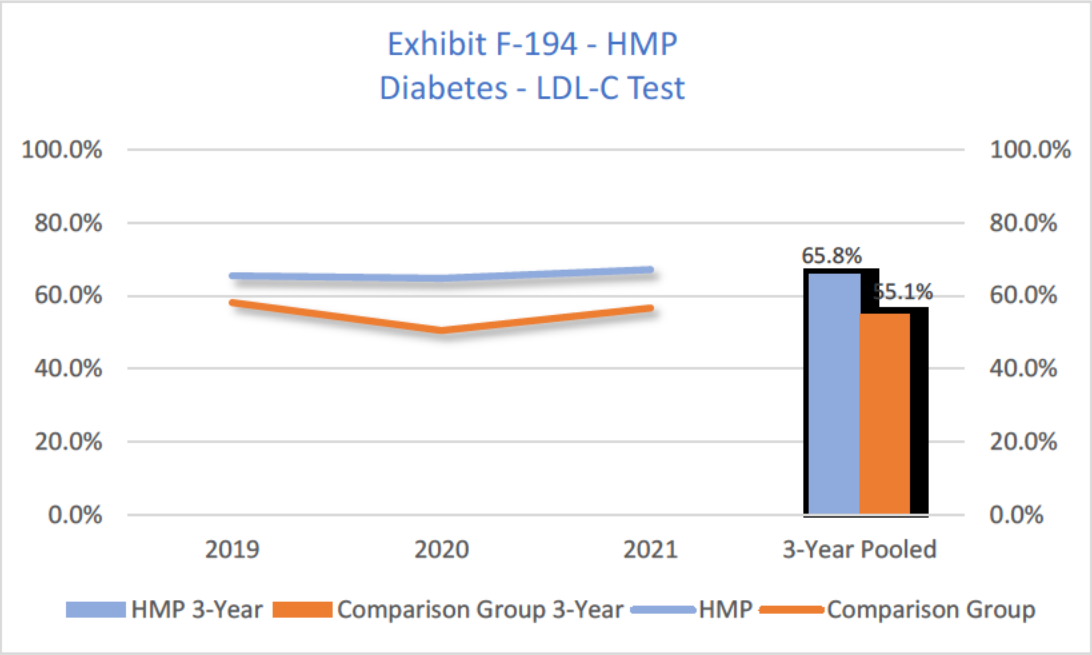


	Subgroup	2019	2020	2021
Compliance Rate	**Urban**	74.4%	66.0%	84.1%
	Rural	78.9%	73.5%	77.0%

Diabetes – LDL-C Test

Findings – HMP Population

Approximately 66 percent of HMP members and 55 percent of comparison group members were compliant on this measure across the three years (Exhibit F-194). The compliance rate for both populations declined from 2019 to 2020 before rising again from 2020 to 2021.



The difference between the HMP and comparison group compliance rates was statistically significant in each of the individual years. It also was statistically significant for the three-year pooled data (Exhibit F-195).

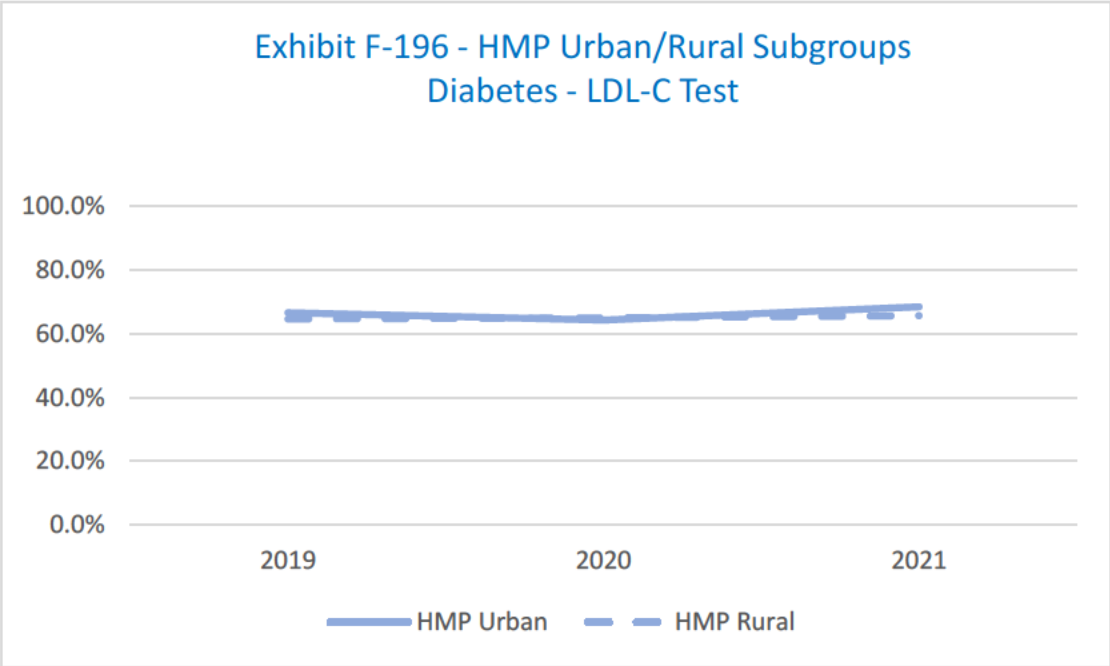
Exhibit F-195 – HMP – Diabetes – LDL-C Test

	2019	2020	2021	3-Year Pooled
HMP	65.5%	64.8%	67.2%	65.8%
Comparison Group	58.1%	50.5%	56.7%	55.1%
Difference	7.4%‡	14.3%‡	10.5%‡	10.7%‡

‡ HMP rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HMP and Care Managed Populations – Urban and Rural Subgroups

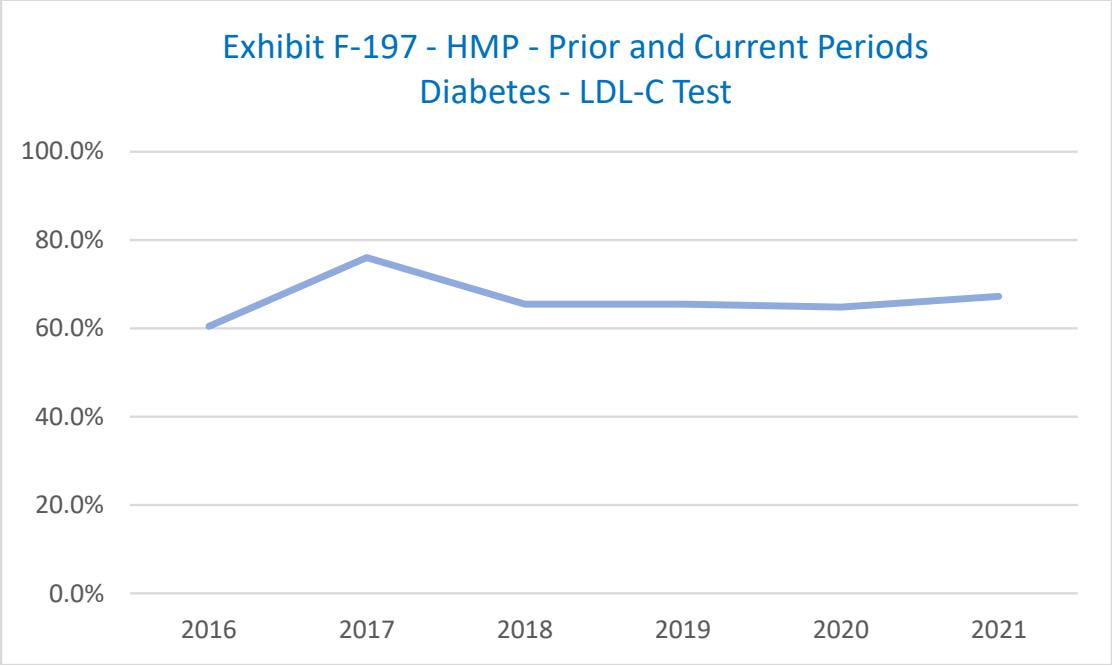
The HMP urban subgroup compliance rate exceeded the rural subgroup rate in 2019 and 2021; the rural subgroup rate exceeded the urban subgroup rate in 2020. The urban subgroup rate trended slightly downward from 2019 to 2020 and upward from 2020 to 2021; the rural subgroup rate trended slightly upward from 2019 to 2021 (Exhibit F-196).



	Subgroup	2019	2020	2021
Compliance Rate	**Urban**	66.7%	64.4%	68.5%
	Rural	64.7%	65.1%	65.8%

Findings – HMP Population – Comparison to Prior Waiver Period

This measure also was evaluated for the HMP population in the prior waiver period (2016 to 2018). The compliance rate rose from approximately 61 percent in 2016 to 76 percent in 2017, before declining to 66 percent in 2018 and rising again to 67 percent in 2021 (Exhibit F-197).

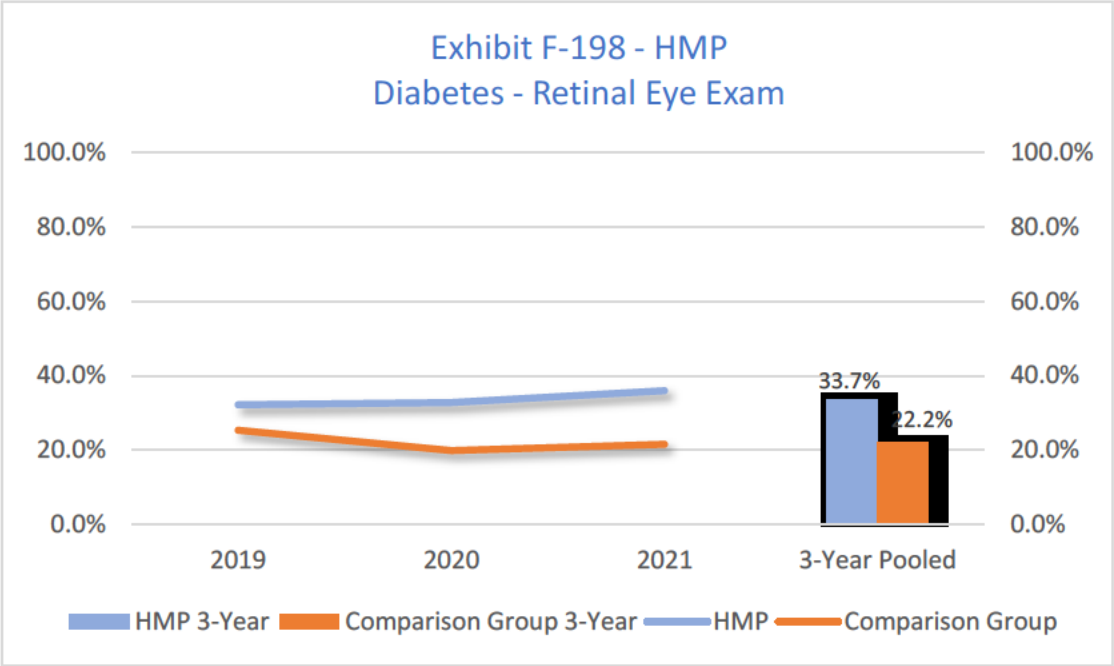


	2016	2017	2018	2019	2020	2021
Compliance Rate	60.5%	76.0%	65.5%	65.5%	64.8%	67.2%

Diabetes – Retinal Eye Exam

Findings – HMP Population

Approximately 34 percent of HMP members and 22 percent of comparison group members were compliant on this measure across the three years (Exhibit F-198). The compliance rate for the HMP population rose from 2019 to 2021; the compliance rate for the comparison group declined from 2019 to 2020 before rising again from 2020 to 2021.



The difference between the HMP and comparison group compliance rates was statistically significant in each of the individual years. It also was statistically significant for the three-year pooled data (Exhibit F-199).

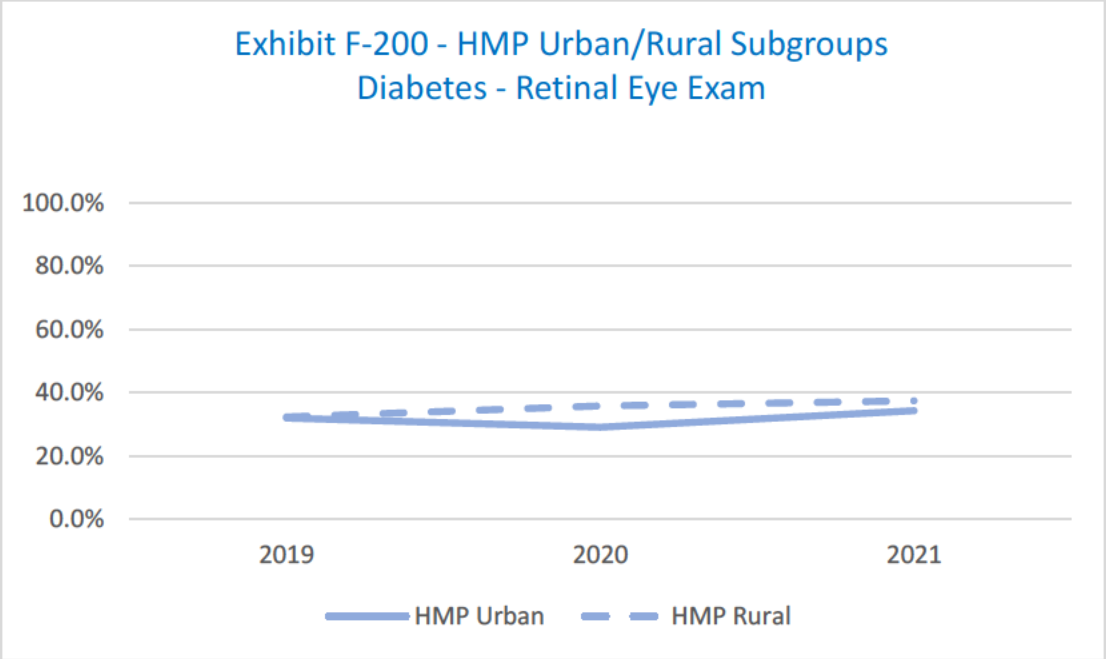
Exhibit F-199 – HMP – Diabetes – Retinal Eye Exam

	2019	2020	2021	3-Year Pooled
HMP	32.2%	32.8%	36.0%	33.7%
Comparison Group	25.3%	19.8%	21.5%	22.2%
Difference	6.9%‡	13.0%‡	14.5%‡	11.5%‡

‡ HMP rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HMP and Care Managed Populations – Urban and Rural Subgroups

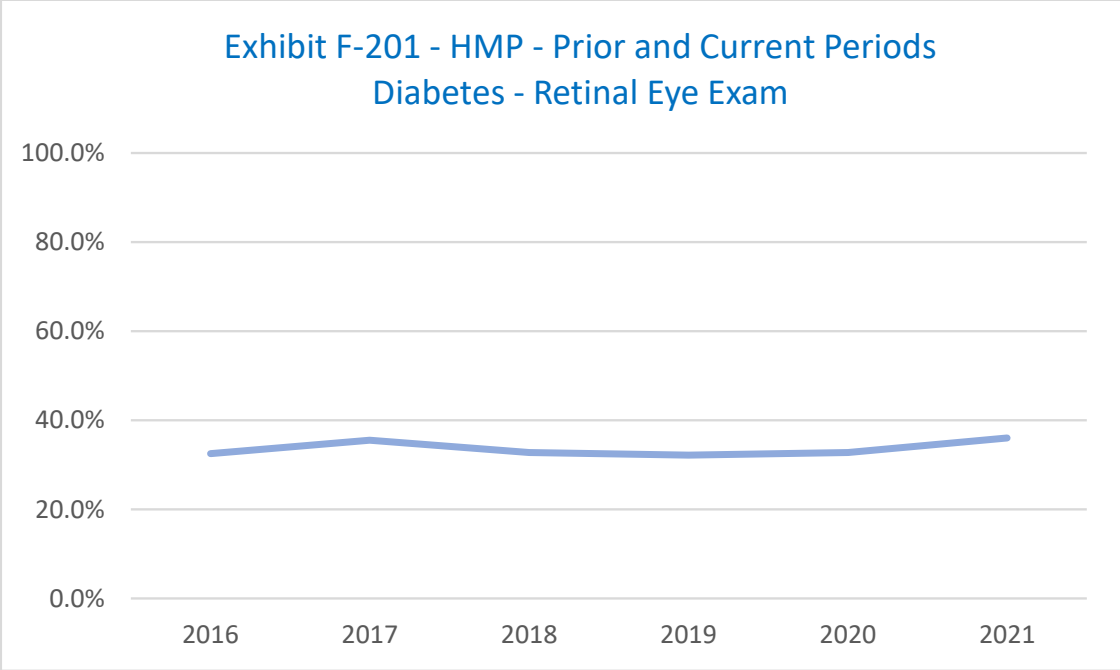
The HMP rural subgroup rate exceeded the urban subgroup rate across the three years. The rural subgroup trended upward from 2019 to 2021. The urban subgroup trended downward from 2019 to 2021 before rising again from 2020 to 2021 (Exhibit F-200).



	Subgroup	2019	2020	2021
Compliance Rate	**Urban**	32.0%	29.1%	34.4%
	Rural	32.4%	35.9%	37.5%

Findings – HMP Population – Comparison to Prior Waiver Period

This measure also was evaluated for the HMP population in the prior waiver period (2016 to 2018). The compliance rate rose from approximately 33 percent in 2016 to 36 percent in 2021 (Exhibit F-201).

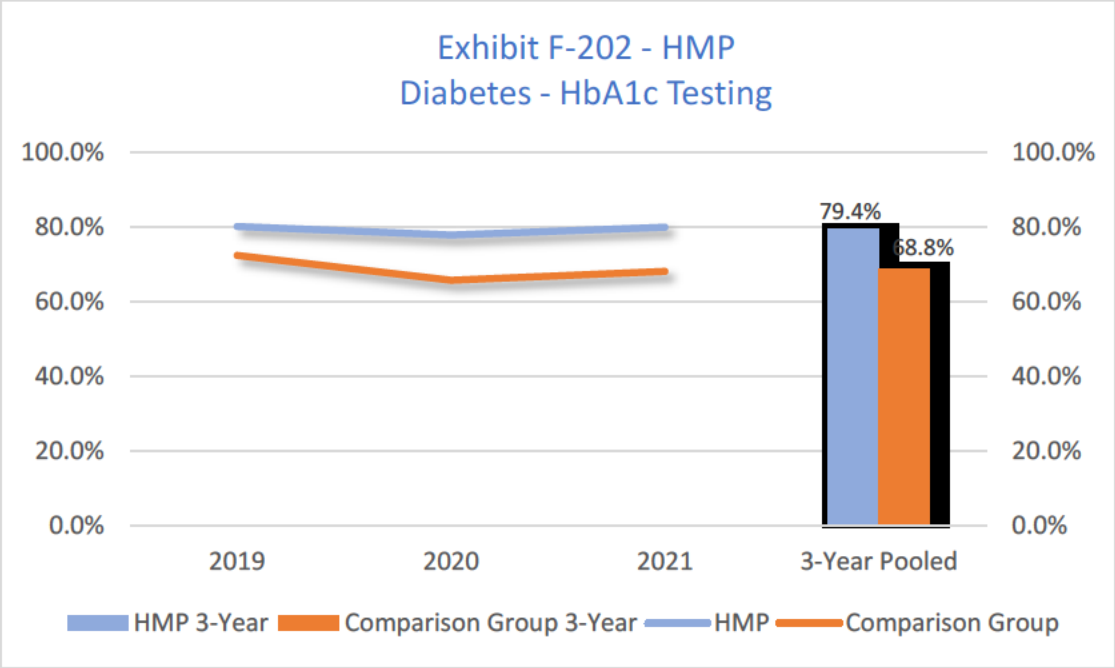


	2016	2017	2018	2019	2020	2021
Compliance Rate	32.5%	35.5%	32.8 %	32.2%	32.8%	36.0%

Diabetes – HbA1c Testing

Findings – HMP Population

Approximately 79 percent of HMP members and 69 percent of comparison group members were compliant on this measure across the three years (Exhibit F-202). The compliance rate for both populations declined from 2019 to 2020 before rising again from 2020 to 2021.



The difference between the HMP and comparison group compliance rates was statistically significant in each of the individual years. It also was statistically significant for the three-year pooled data (Exhibit F-203).

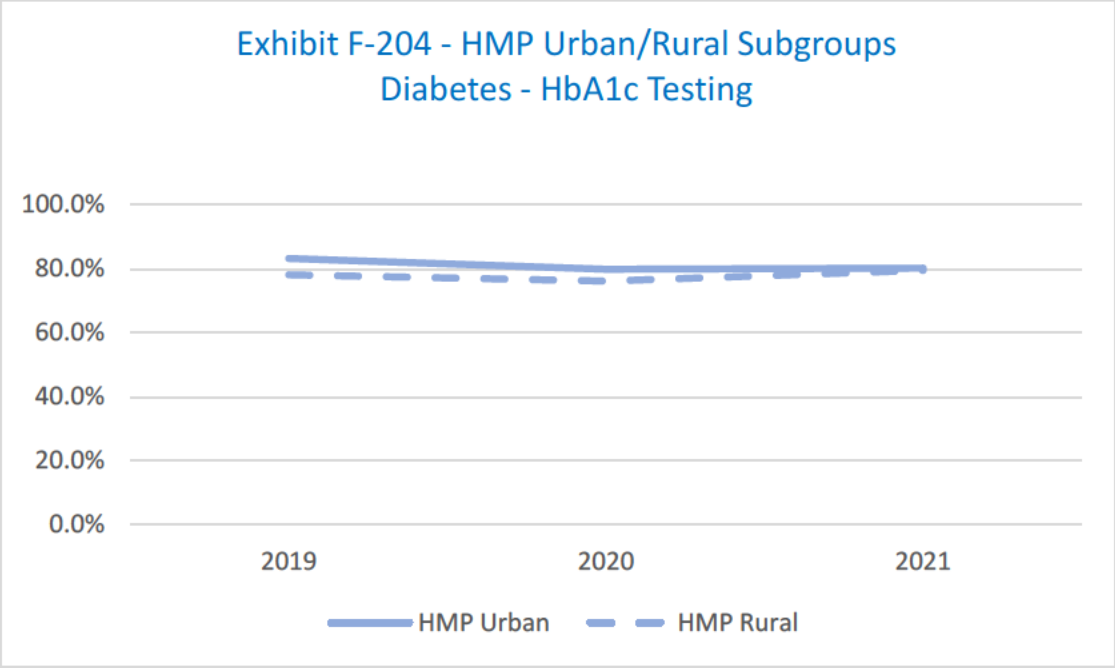
Exhibit F-203 – HMP – Diabetes – HbA1c Testing

	2019	2020	2021	3-Year Pooled
HMP	80.2%	77.9%	80.0%	79.4%
Comparison Group	72.5%	65.8%	68.2%	68.8%
Difference	7.7%‡	12.1%‡	11.8%‡	10.6%‡

‡ HMP rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HMP and Care Managed Populations – Urban and Rural Subgroups

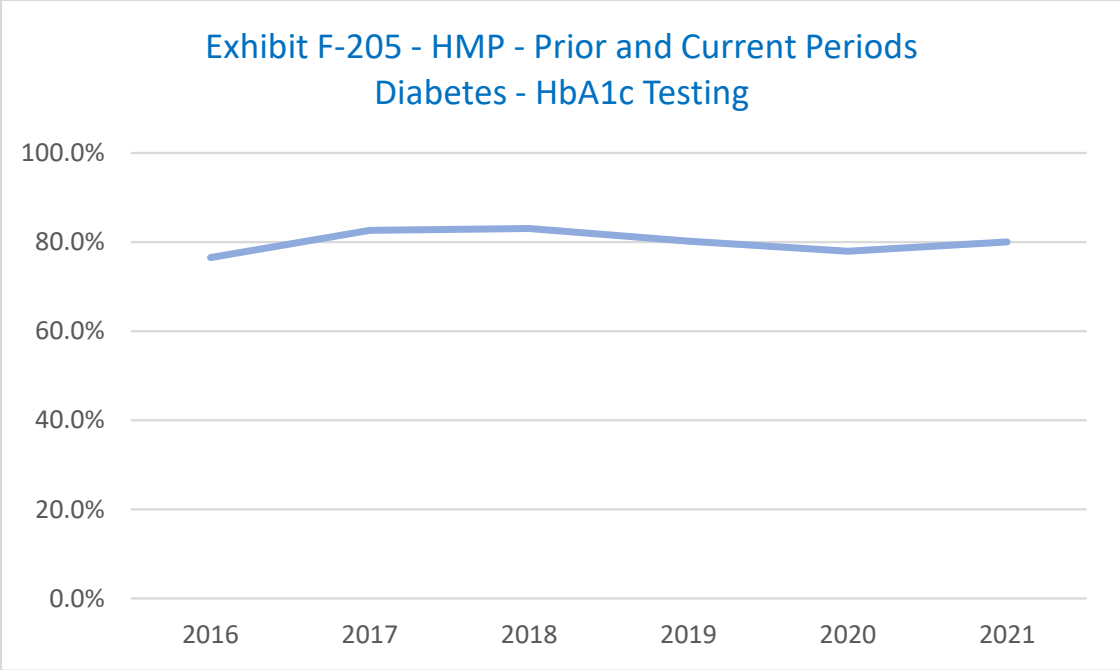
The HMP urban subgroup rate exceeded the rural subgroup rate across the three years. The compliance rate for both subgroups trended downward from 2019 to 2020 and trended upward from 2020 to 2021 (Exhibit F-204).



	Subgroup	2019	2020	2021
Compliance Rate	**Urban**	83.3%	79.9%	80.3%
	Rural	78.2%	76.2%	79.6%

Findings – HMP Population – Comparison to Prior Waiver Period

This measure also was evaluated for the HMP population in the prior waiver period (2016 to 2018). The compliance rate rose from approximately 77 percent in 2016 to 83 percent in 2018, before declining to 78 percent and rising again to 80 percent in 2021 (Exhibit F-205).

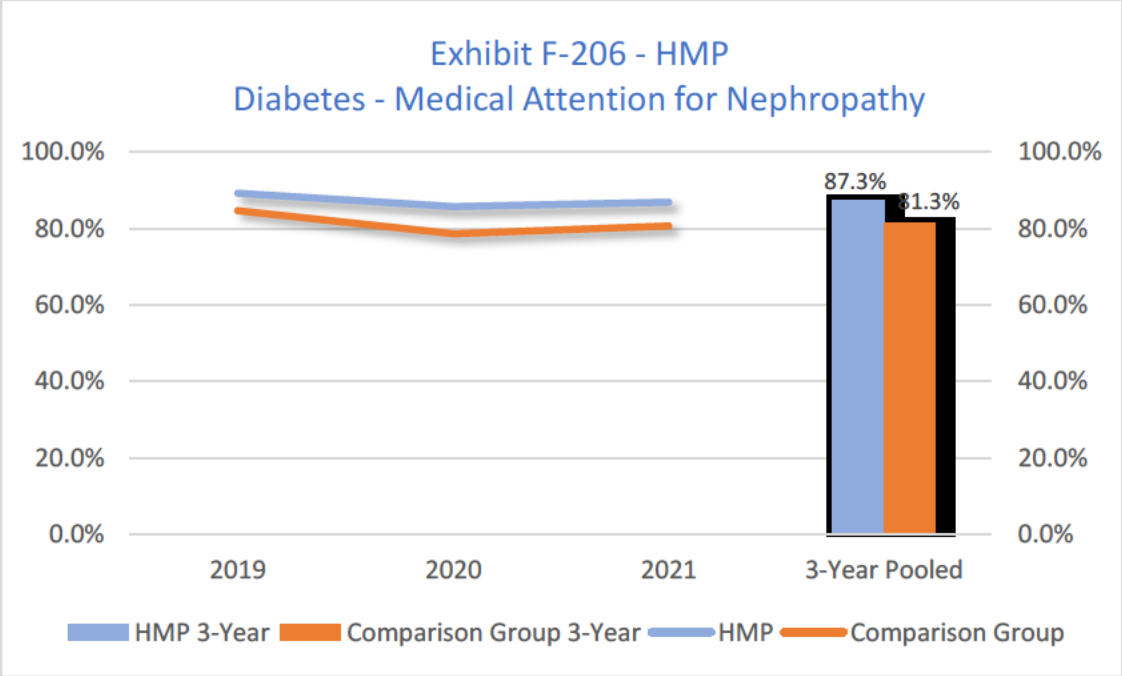


	2016	2017	2018	2019	2020	2021
Compliance Rate	76.5%	82.6%	83.0 %	80.2%	77.9%	80.0%

Diabetes – Medical Attention for Nephropathy

Findings – HMP Population

Approximately 87 percent of HMP members and 81 percent of comparison group members were compliant on this measure across the three years (Exhibit F-206). The compliance rate for both populations declined from 2019 to 2020 before rising again from 2020 to 2021.



The difference between the HMP and comparison group compliance rates was statistically significant in each of the individual years. It also was statistically significant for the three-year pooled data (Exhibit F-207).

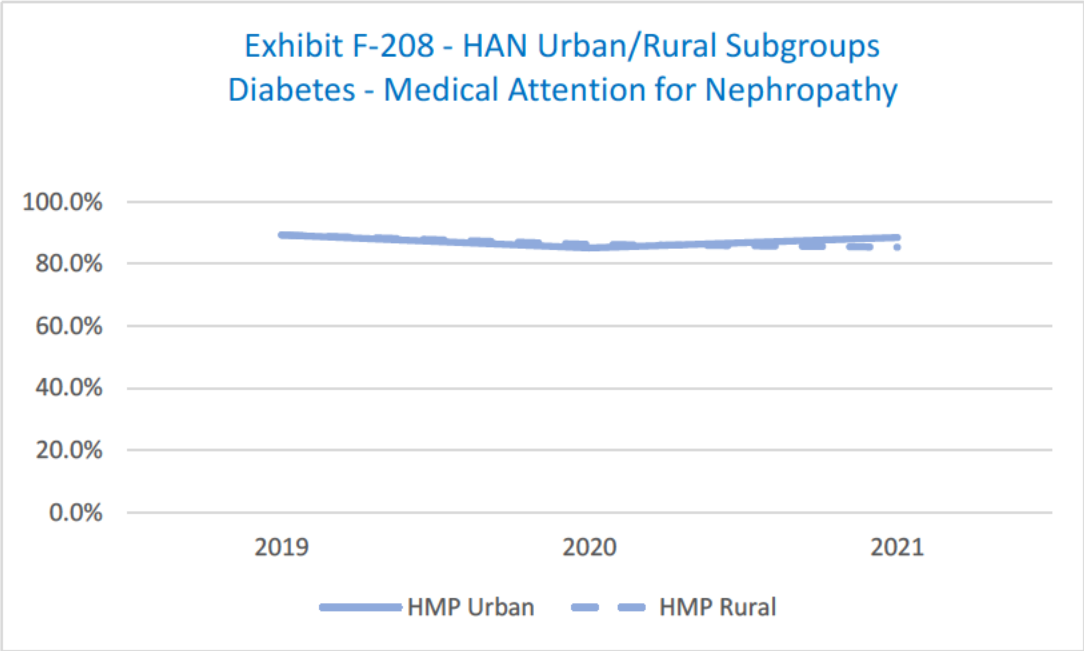
Exhibit F-207 – HMP – Diabetes – Medical Attention for Nephropathy

	2019	2020	2021	3-Year Pooled
HMP	89.3%	85.8%	86.9%	87.3%
Comparison Group	84.7%	78.6%	80.7%	81.3%
Difference	4.6%‡	7.2%‡	6.2%‡	6.0%‡

‡ HMP rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HMP and Care Managed Populations – Urban and Rural Subgroups

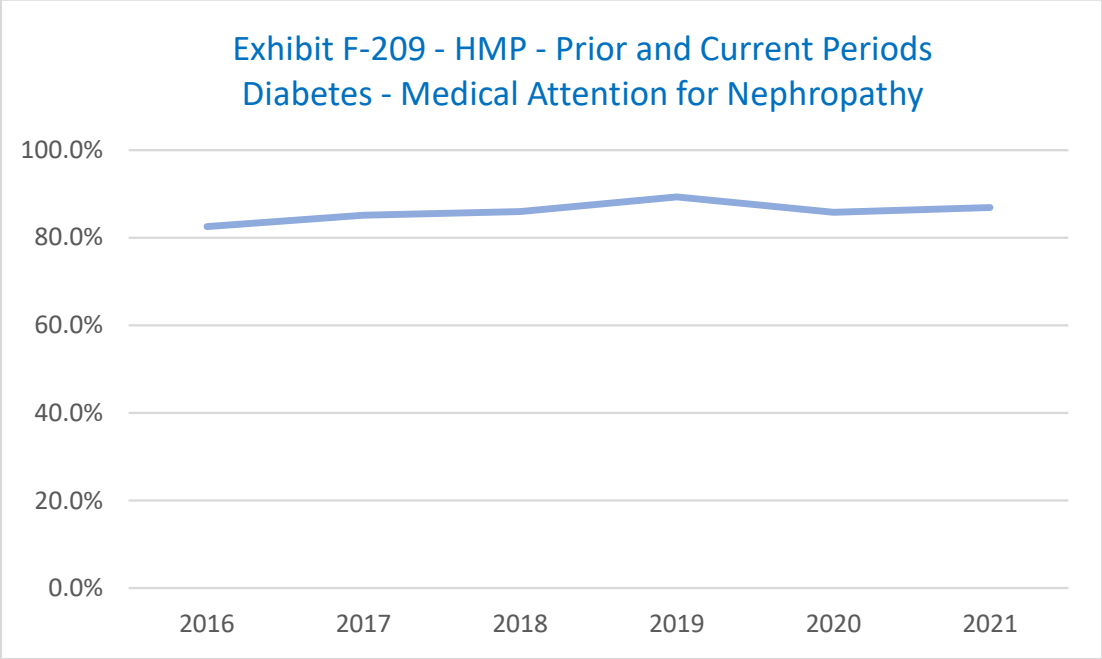
The HMP urban and rural subgroups had identical compliance rates in 2019; the rural subgroup rate was slightly higher in 2020 and the urban subgroup rate was higher in 2021. The urban subgroup rate trended downward from 2019 to 2020 and trended upward from 2020 to 2021. The rural subgroup rate trended downward from 2019 to 2021 (Exhibit F-208).



	Subgroup	2019	2020	2021
Compliance Rate	**Urban**	89.3%	85.1%	88.5%
	Rural	89.3%	86.3%	85.1%

Findings – HMP Population – Comparison to Prior Waiver Period

This measure also was evaluated for the HMP population in the prior waiver period (2016 to 2018). The compliance rate rose from approximately 83 percent in 2016 to 89 percent in 2019, before declining to 86 percent in 2020 and rising again slightly to 87 percent in 2021 (Exhibit F-209).

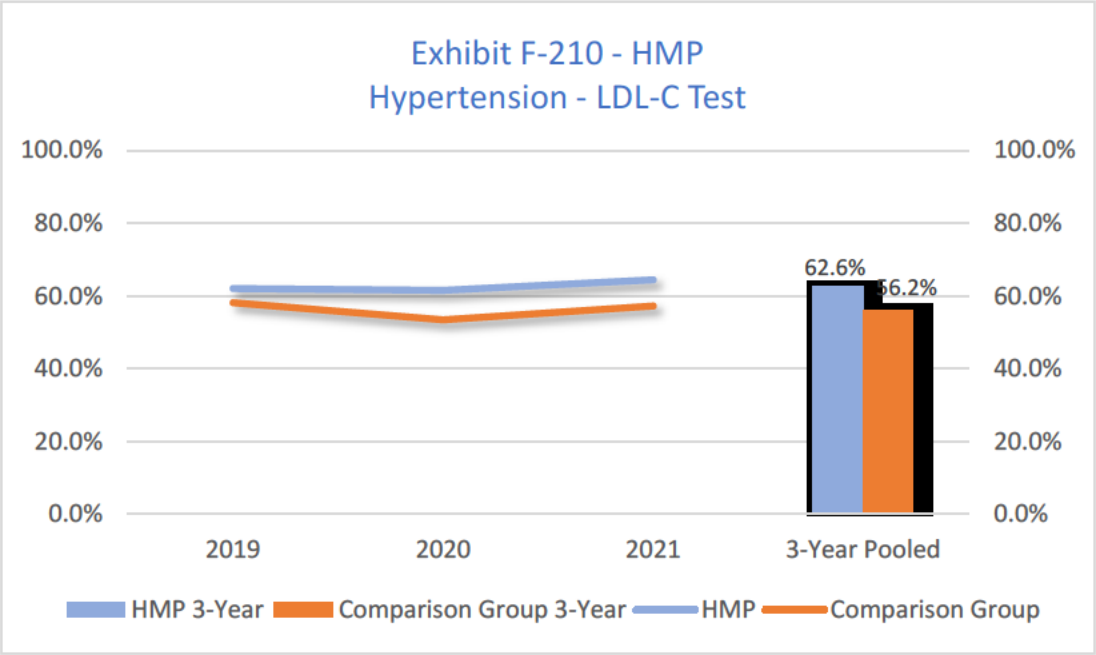


	2016	2017	2018	2019	2020	2021
Compliance Rate	82.5%	85.1%	86.0%	89.3%	85.8%	86.9%

Hypertension – LDL-C Test

Findings – HMP Population

Approximately 63 percent of HMP members and 56 percent of comparison group members were compliant on this measure across the three years (Exhibit F-210). The compliance rate for both populations declined from 2019 to 2020 before rising again from 2020 to 2021.



The difference between the HMP and comparison group compliance rates was statistically significant in each of the individual years. It also was statistically significant for the three-year pooled data (Exhibit F-211).

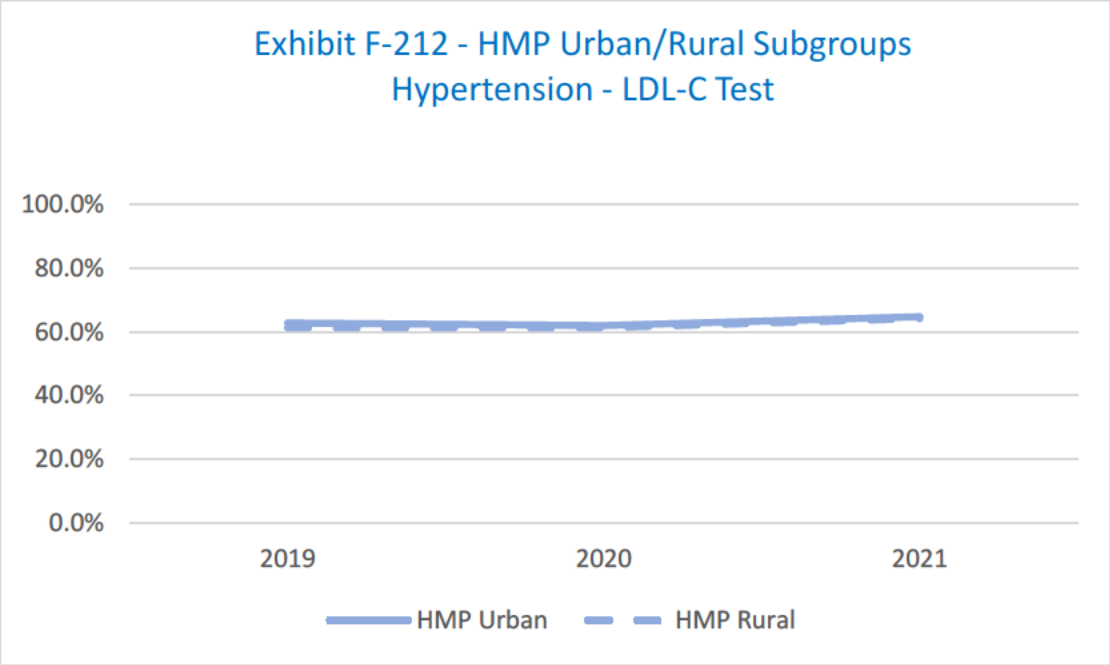
Exhibit F-211 – HMP – Hypertension – LDL-C Test

	2019	2020	2021	3-Year Pooled
HMP	62.0%	61.5%	64.4%	62.6%
Comparison Group	58.1%	53.4%	57.2%	56.2%
Difference	3.9%‡	8.1%	7.2%‡	6.4%‡

‡ HMP rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HMP and Care Managed Populations – Urban and Rural Subgroups

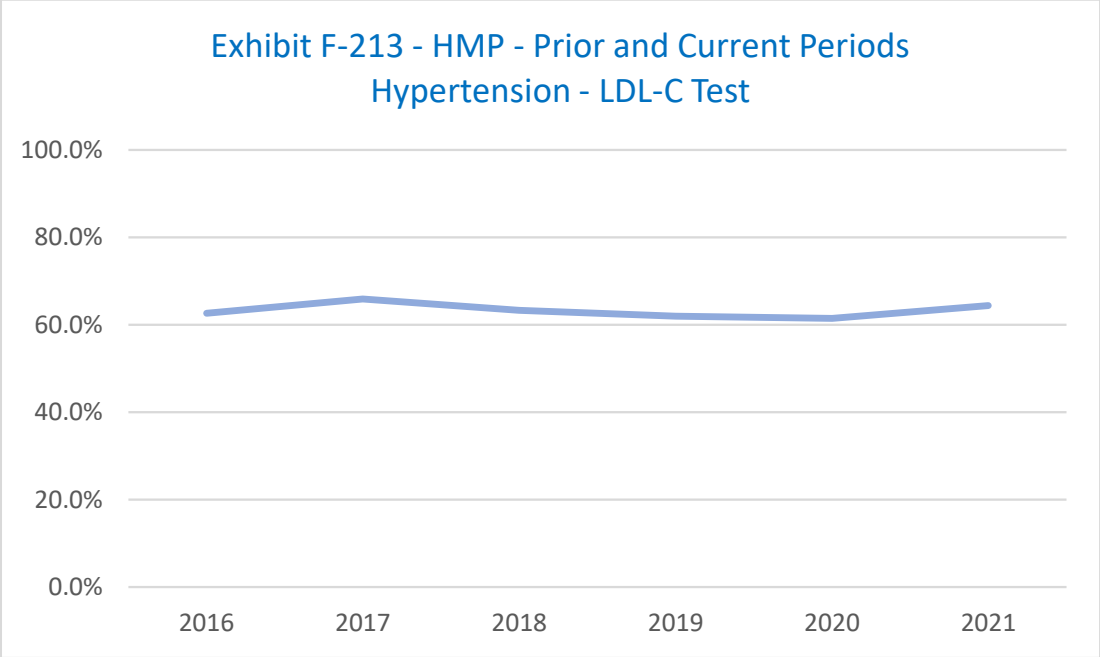
The HMP urban and rural subgroup rates were similar across the three years. The rate for the urban subgroup trended downward from 2019 to 2020 before trending upward from 2020 to 2021. The rate for the rural subgroup trended upward from 2019 to 2021 (Exhibit F-212).



	Subgroup	2019	2020	2021
Compliance Rate	**Urban**	62.8%	61.9%	64.7%
	Rural	61.3%	61.3%	64.1%

Findings – HMP Population – Comparison to Prior Waiver Period

This measure also was evaluated for the HMP population in the prior waiver period (2016 to 2018). The compliance rate rose from approximately 63 percent in 2016 to 66 percent in 2017, before declining gradually over several years and rising again to 64 percent in 2021 (Exhibit F-213).

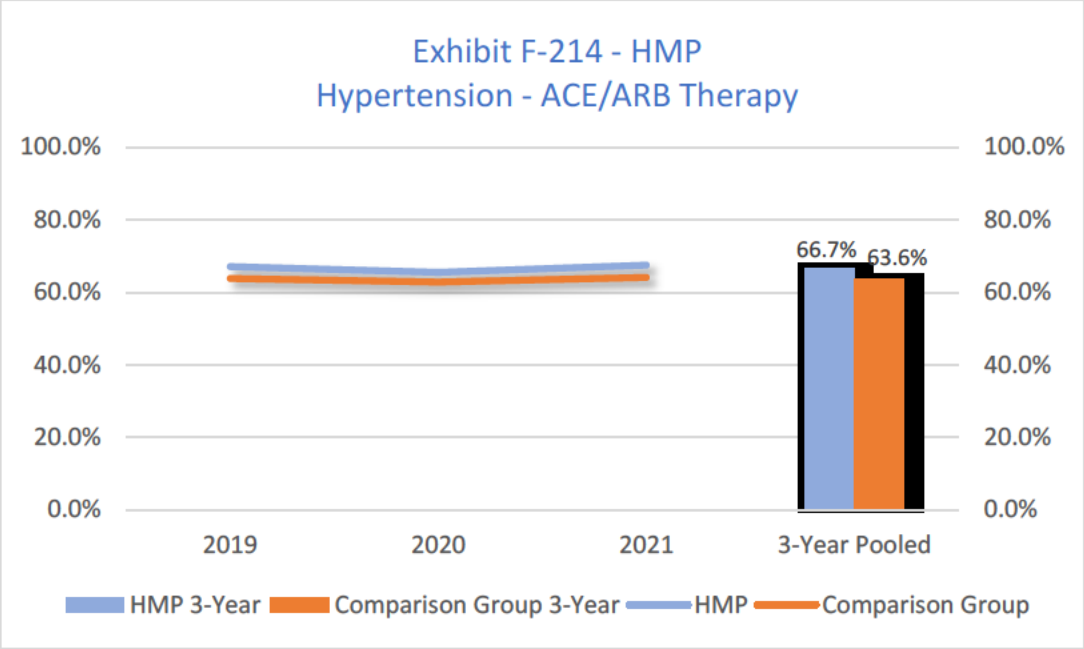


	2016	2017	2018	2019	2020	2021
Compliance Rate	62.6%	65.9%	63.3%	62.0%	61.5%	64.4%

Hypertension – ACE/ARB Therapy

Findings – HMP Population

Approximately 67 percent of HMP members and 64 percent of comparison group members were compliant on this measure across the three years (Exhibit F-214). The compliance rate for both populations declined slightly from 2019 to 2020 before rising again from 2020 to 2021.

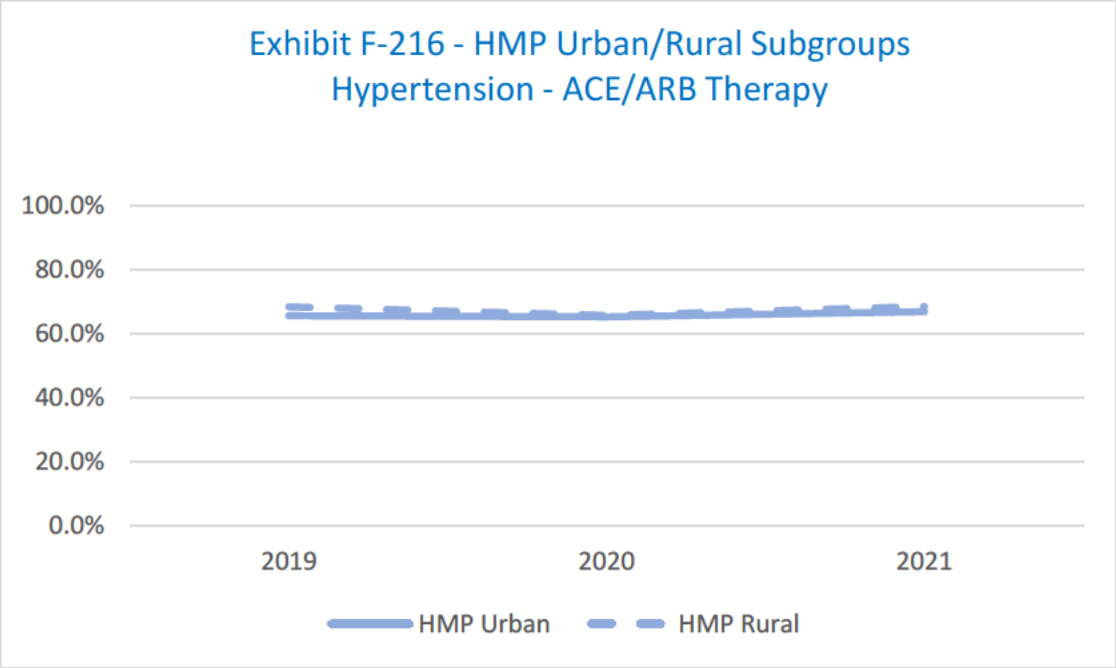


The difference between the HMP and comparison group compliance rates was statistically significant in each of the individual years. It also was statistically significant for the three-year pooled data (Exhibit F-215).

Exhibit F-215 – HMP – Hypertension – ACE/ARB Therapy				
	2019	2020	2021	3-Year Pooled
HMP	67.1%	65.5%	67.5%	66.7%
Comparison Group	63.8%	62.8%	64.1%	63.6%
Difference	6.3%‡	2.7%‡	3.4%‡	4.1%‡
‡ HMP rate differs from comparison group rate by a statistically significant amount (95% confidence level)				

Findings – HMP and Care Managed Populations – Urban and Rural Subgroups

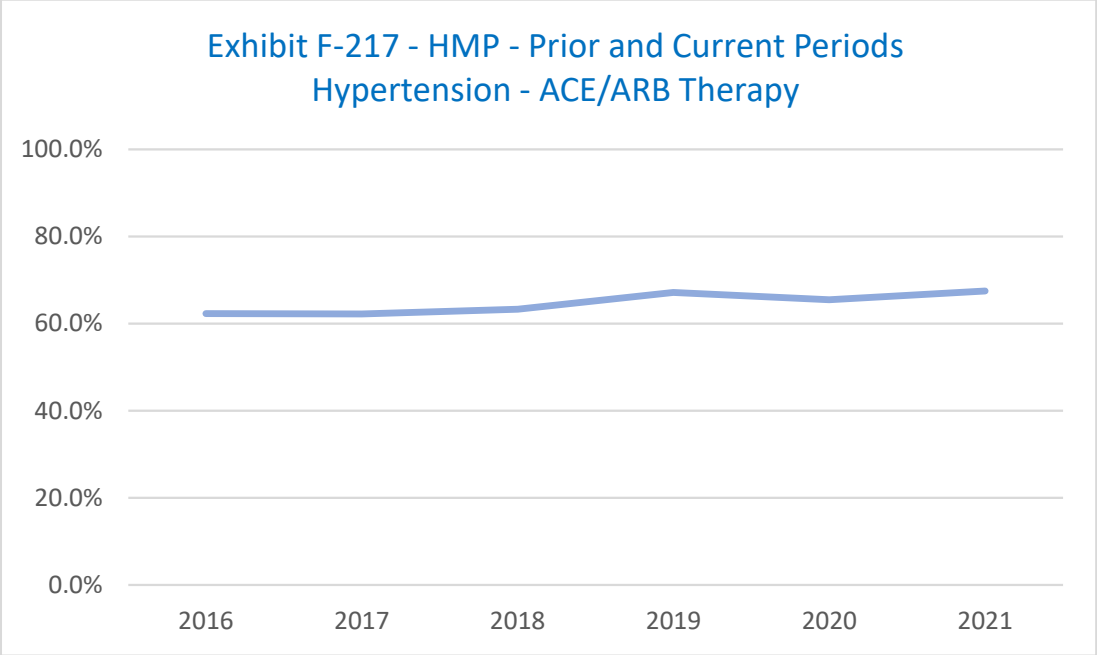
The HMP rural subgroup rate exceeded the urban subgroup rate across the three years. The rates for both groups trended downward slightly from 2019 to 2020 before trending upward from 2020 to 2021 (Exhibit F-216).



	Subgroup	2019	2020	2021
Compliance Rate	**Urban**	65.5%	65.2%	66.8%
	Rural	68.3%	65.7%	68.4%

Findings – HMP Population – Comparison to Prior Waiver Period

This measure also was evaluated for the HMP population in the prior waiver period (2016 to 2018). The compliance rate rose from approximately 62 percent in 2016 to 67 percent in 2019, before declining slightly to 66 percent in 2020 and rising again to 68 percent in 2021 (Exhibit F-217).

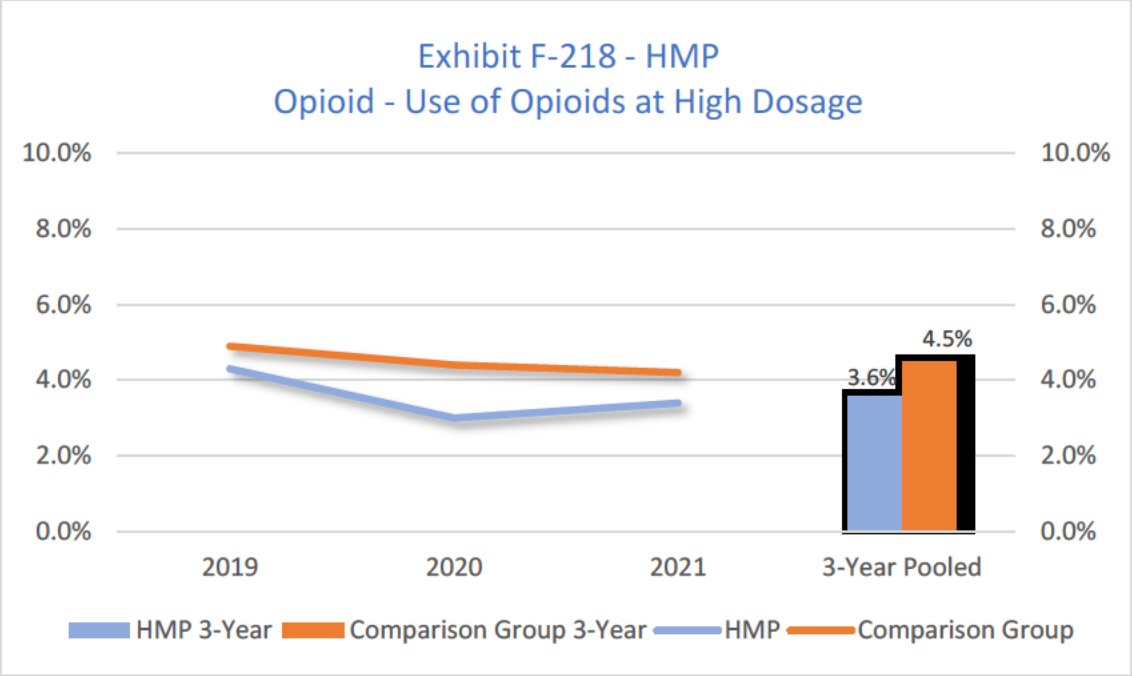


	2016	2017	2018	2019	2020	2021
Compliance Rate	62.3%	62.2%	63.3%	67.1%	65.5%	67.5%

Opioid – Use of Opioids at High Dosage

Findings – HMP Population

Approximately four percent of HMP members and five percent of comparison group members were positive for this measure (users of prescription opioids at high dosage) across the three years (Exhibit F-218). The HMP population rate declined from 2019 to 2020 before rising again from 2020 to 2021. The comparison group rate declined from 2019 to 2021.



Note: Lower rate is better

The difference between the HMP and comparison group compliance rates was statistically significant in 2020. It also was statistically significant for the three-year pooled data (Exhibit F-219).

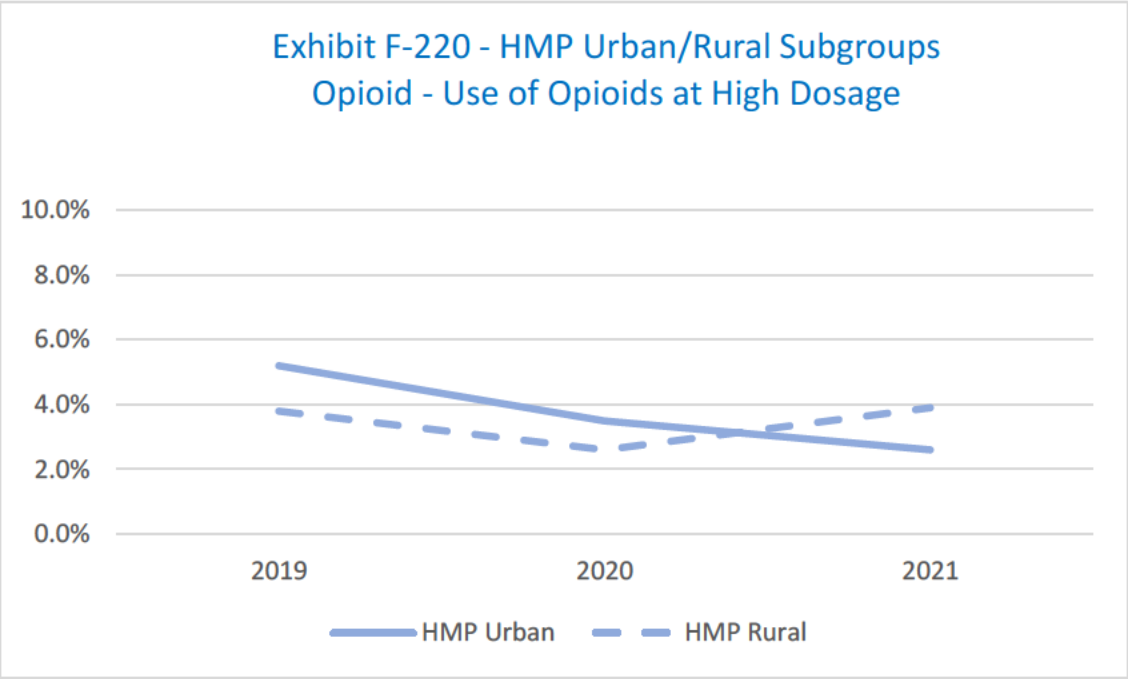
Exhibit F-219 – HMP – Opioid – Use of Opioids at High Dosage

	2019	2020	2021	3-Year Pooled
HMP	4.3%	3.0%	3.4%	3.6%
Comparison Group	4.9%	4.4%	4.2%	4.5%
Difference	(0.6%)	(1.4%)‡	(0.8%)	(0.9%)‡

‡ HMP rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HMP and Care Managed Populations – Urban and Rural Subgroups

The HMP urban subgroup rate exceeded the rural subgroup rate in 2019 and 2020 and was lower than the rural subgroup rate in 2021. The rate for the urban subgroup trended downward from 2019 to 2021. The rate for the rural subgroup trended downward from 2019 to 2020 and upward from 2020 to 2021 (Exhibit F-220).



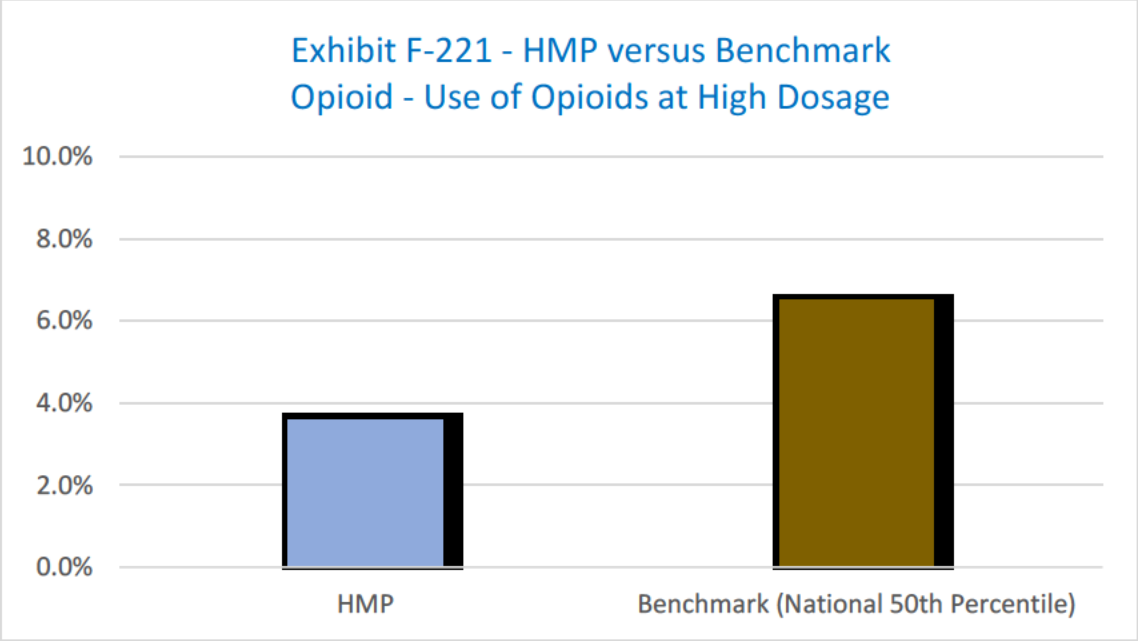
Note: Lower rate is better

	Subgroup	2019	2020	2021
Compliance Rate	**Urban**	5.2%	3.5%	2.6%
	Rural	3.8%	2.6%	3.9%

Findings – HMP and National Benchmark

The three-year pooled rate for the SoonerCare HMP population was 33 percentage points lower than the national benchmark rate (Exhibit F-221).

(Caution: the benchmark population characteristics were not matched to the OHCA groups to minimize differences in the populations. The data is presented for informational purposes only.)



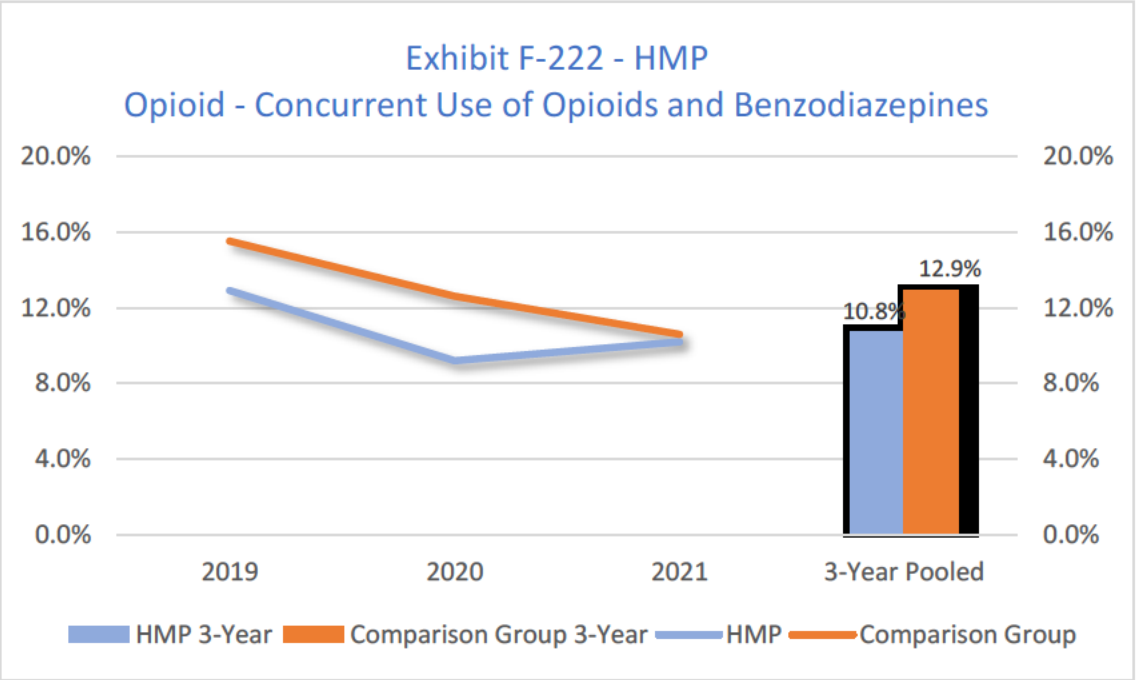
Note: Lower rate is better

	HMP	Benchmark
Compliance Rate	3.6%	6.5%

Opioid – Concurrent Use of Opioids and Benzodiazepines

Findings – HMP Population

Approximately 11 percent of HMP members and 13 percent of comparison group members were positive for this measure (concurrent users of prescription opioids and benzodiazepines) across the three years (Exhibit F-222). The HMP population rate declined from 2019 to 2020 before rising again from 2020 to 2021. The comparison group rate declined from 2019 to 2021.



Note: Lower rate is better

The difference between the HMP and comparison group compliance rates was statistically significant in 2019 and 2020. It also was statistically significant for the three-year pooled data (Exhibit F-223).

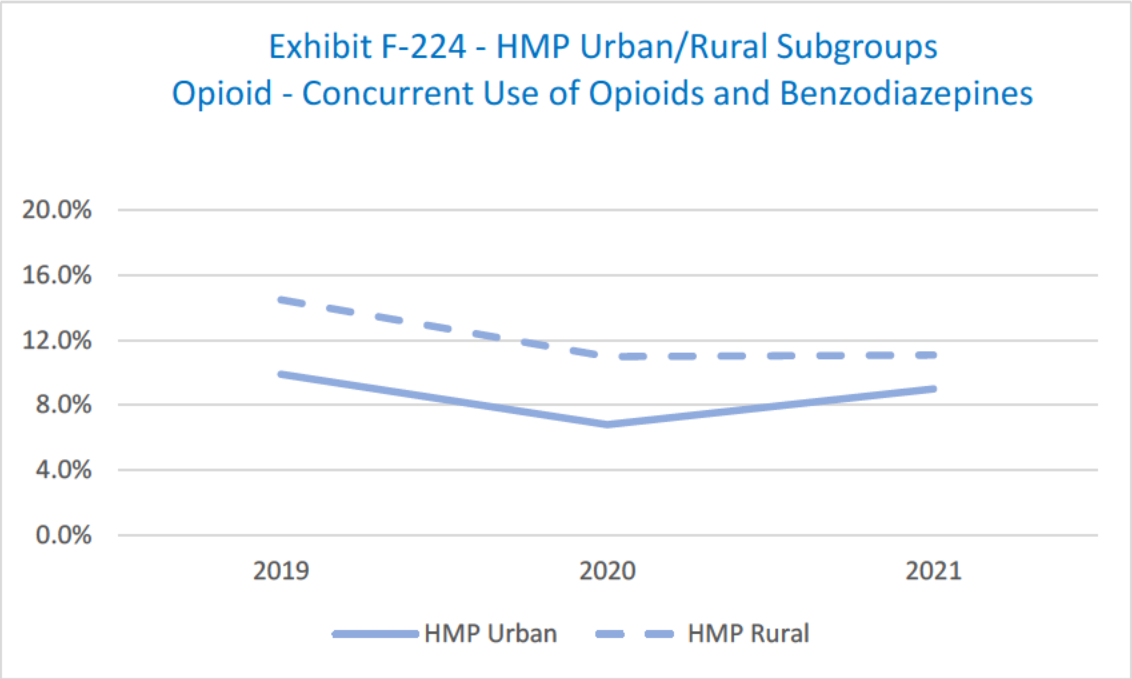
Exhibit F-223 – HMP – Opioid – Concurrent Use of Opioids and Benzodiazepines

	2019	2020	2021	3-Year Pooled
HMP	12.9%	9.2%	10.2%	10.8%
Comparison Group	15.5%	12.6%	10.6%	12.9%
Difference	(2.6%)‡	(3.4%)‡	(0.4%)	(2.1%)‡

‡ HMP rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HMP and Care Managed Populations – Urban and Rural Subgroups

The HMP rural subgroup rate exceeded the urban subgroup rate across all three years. The rate for the rural subgroup trended downward from 2019 to 2020 and was stable from 2020 to 2021. The rate for the urban subgroup trended downward from 2019 to 2020 and upward from 2020 to 2021 (Exhibit F-224).



Note: Lower rate is better

	Subgroup	2019	2020	2021
Compliance Rate	**Urban**	9.9%	6.8%	9.0%
	Rural	14.5%	11.0%	11.1%

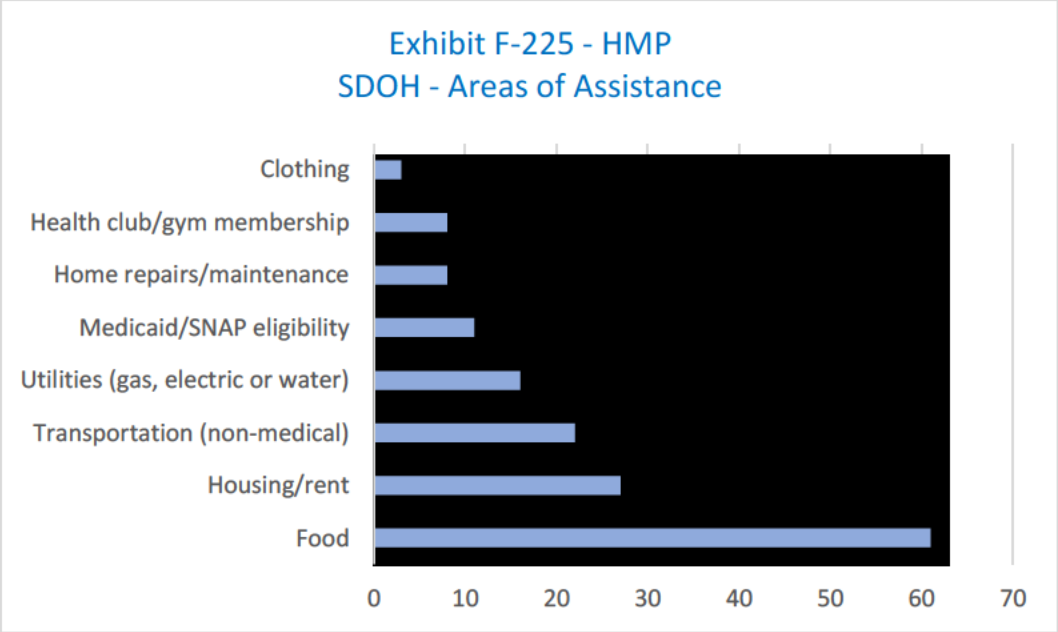
HMP Quality of Care – Social Determinants of Health

PHPG attempts to conduct a telephone survey with all SoonerCare HMP members at time of enrollment (baseline) and again six months later (follow-up). The survey includes questions concerning social determinants of health (SDOH). PHPG conducted 1,936 baseline surveys and 923 follow-up surveys from 2019 to 2021. Both surveys inquired about awareness of available assistance with SDOH through the SoonerCare HMP, use rates among those aware and satisfaction among those receiving assistance (asked in terms of how helpful the assistance was). Appendix 8 contains a copy of the survey instrument SDOH section.

Findings – Awareness and Use of SDOH Assistance

Fifty-six percent of baseline respondents and sixty-five percent of follow-up respondents were aware that the SoonerCare HMP offers assistance with SDOH, either through the member's health coach or a SoonerCare HMP Community Resource Specialist. Among those aware, 17 percent of baseline respondents reported receiving assistance from their Health Coach and/or a SoonerCare HMP Community Resource Specialist; 14 percent of follow-up respondents reported receiving assistance in the preceding six months.

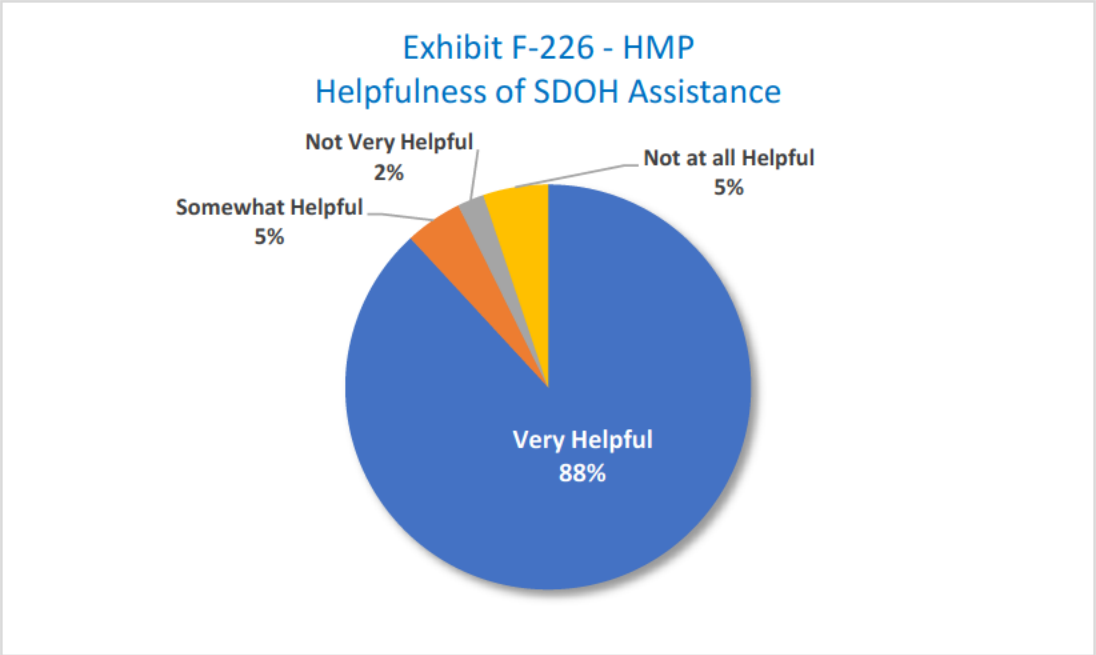
Respondents reported receiving assistance with a variety of SDOH-related needs (multiple responses per member were permitted). The most common areas cited were help resolving food insecurity, housing/rent and transportation (Exhibit F-225)[69].



[69] Areas mentioned by fewer than three respondents not shown on chart.

Findings – Satisfaction (Helpfulness)

Respondents were asked to rate the helpfulness of the assistance they received. Ninety-three percent rated it as very or somewhat helpful (Exhibit F-226).



In addition to providing responses to the structured survey questions, respondents were invited to describe their experience in their own words. A representative sample of respondent comments is provided below.

> *"(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."*
>
> *"(My health coach) filled out and sent in my HUD application for me. I am computer illiterate so she just did it herself and I am so thankful."*
>
> *"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."*
>
> *"I am computer illiterate. My nurse prints out helpful things for my health and sends them to me. She also helped get me dentures and glasses."*
>
> *"(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!"*

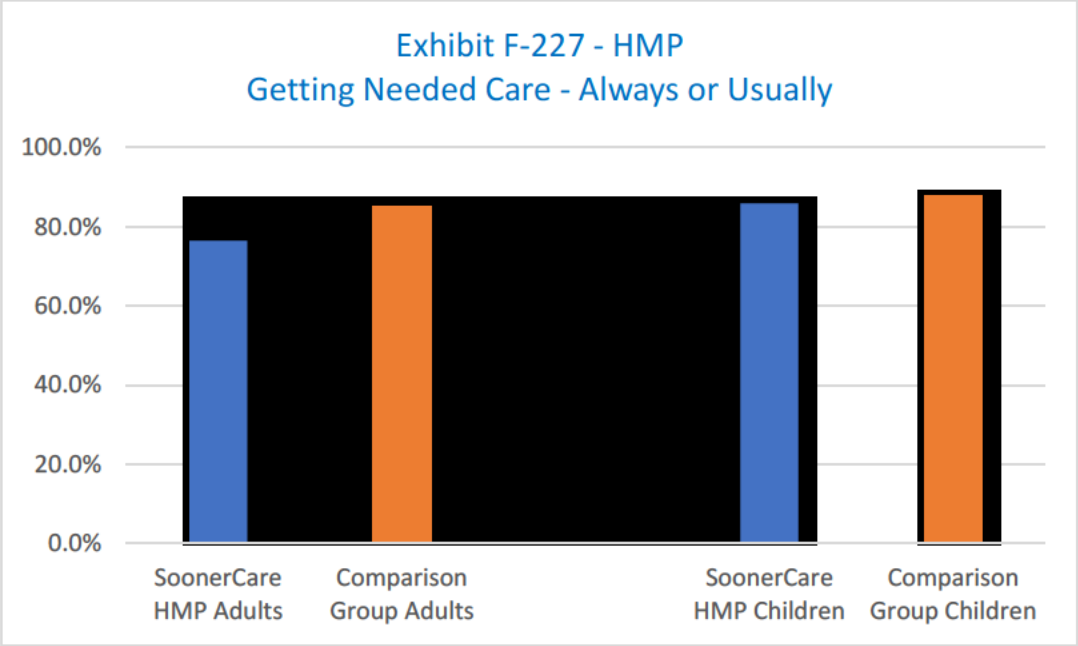
"(My health coach) not only helped me get glasses and stop smoking but she is so easy to talk to. She is always upbeat and happy. I can text her, call her or email her and she always answers quickly."

"The lady who calls has literally saved my life. If I didn't have her to talk to, I probably would have killed myself by now. She is helping me get section 8 housing and transportation. She also had my medication delivered to me when I could not get to the pharmacy and was panicking. She is an angel."

Getting Needed Care – Children and Adults

Findings – HMP Population

Approximately 77 percent of HMP adult members and 86 percent of comparison group adult members reported always or usually being able to get needed care[70]. Approximately 86 percent of parents/caretakers of HAN child members and 88 percent of comparison group parents/caretakers reported always or usually being able to get needed care for their children (Exhibit F-227).



The difference between the HMP and comparison group compliance rates was statistically significant for adults (Exhibit F-228).

Exhibit F-228 – HMP – Getting Needed Care – Percent Responding Always or Usually		
	Adults	Children
HMP	76.5%	85.9%
Comparison Group	85.1%	87.8%
Difference	(9.6%)‡	(1.9%)
‡ HMP rate differs from comparison group rate by a statistically significant amount (95% confidence level)		

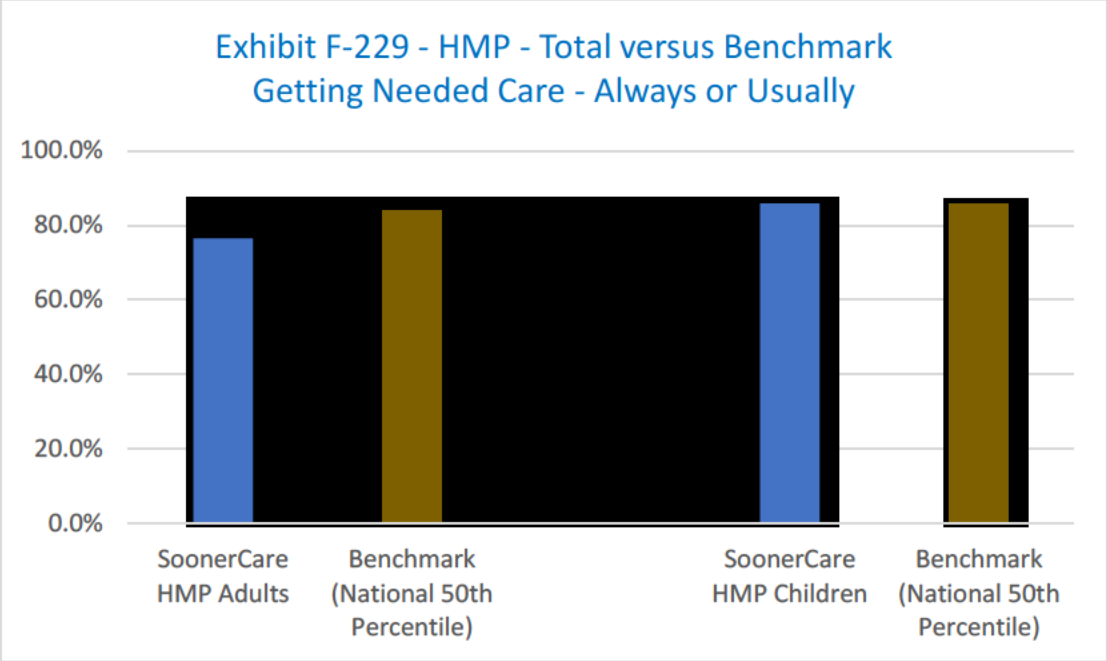
[70] CAHPS question: In the last six months, how often was it easy to get the care, tests or treatment you (your child) needed?

Findings – HMP Population and National Benchmark

The 2021 national benchmark rate for adults exceeded the rate for SoonerCare HMP by approximately eight percentage points (Exhibit F-229).

The rate for SoonerCare HMP children exceeded the 2021 national benchmark rate by less than one percentage point.

(Caution: the benchmark population characteristics were not matched to the OHCA groups to minimize differences in the populations. The data is presented for informational purposes only.)

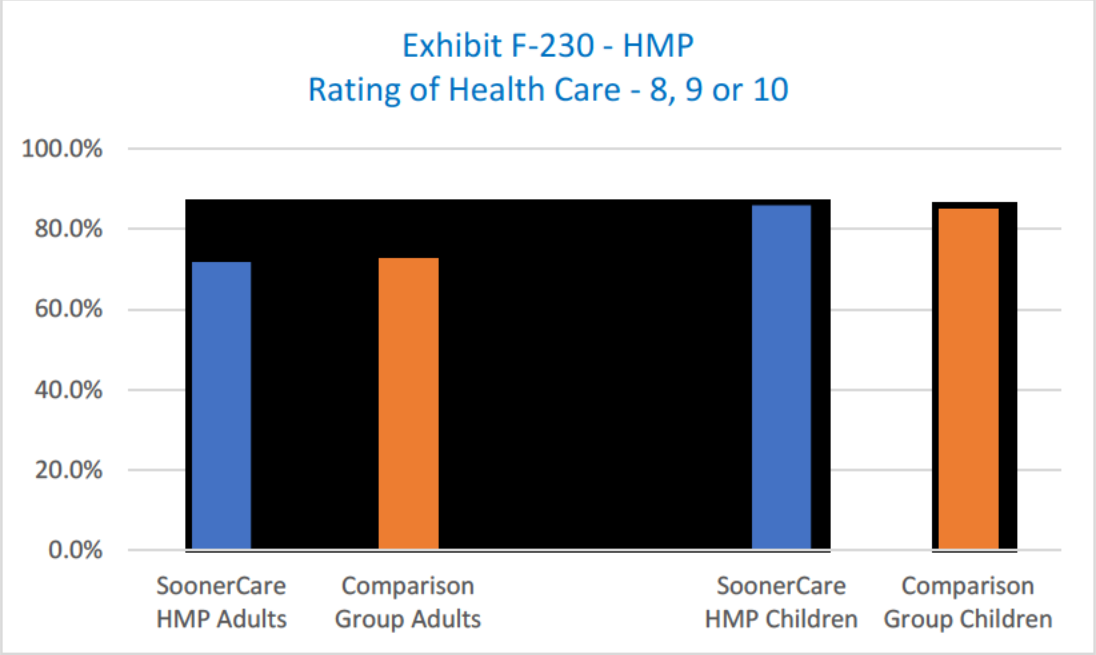


	HMP Adult	Benchmark	HMP Child	Benchmark
Response	76.5%	84.1%	85.9%	85.7%

Rating of Health Care – Children and Adults

Findings – HMP Population

Approximately 72 percent of both HMP adult and comparison group members rated their health care as 8, 9 or 10 on a scale of 0 (worst health care possible) to 10 (best health care possible)[71]. Approximately 86 percent of parents/caretakers of HMP child members and 85 percent of comparison group parents/caretakers rated their health care as 8, 9 or 10 (Exhibit F-230).



The difference between the HMP and comparison group compliance rates was not statistically significant for either group (Exhibit F-231).

Exhibit F-231 – HMP – Rating of Health Care– Percent Rating 8, 9 or 10		
	Adults	Children
HMP	71.8%	85.9%[72]
Comparison Group	72.8%	85.1%
Difference	(1.0%)	0.8%
‡ HMP rate differs from comparison group rate by a statistically significant amount (95% confidence level)		

[71] CAHPS question: Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your (your child's) health care in the last six months?

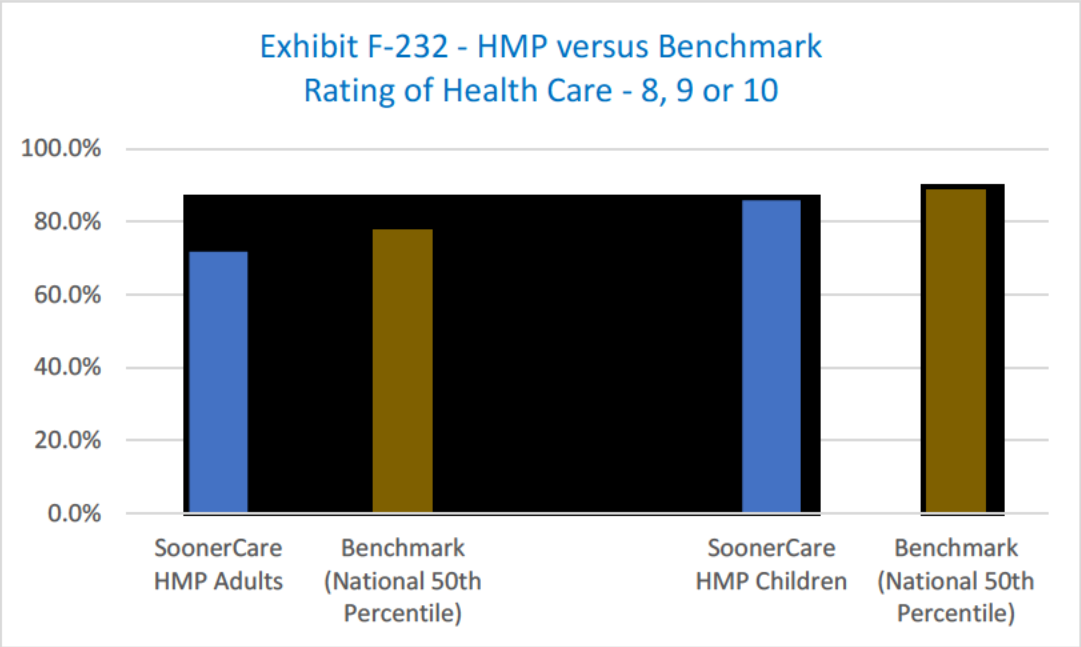
[72] Percentage for HMP children on this measure coincidentally matches percentage on previous measure.

Findings – HMP Population and National Benchmark

The 2021 national benchmark rate for adults exceeded the SoonerCare HMP adult rate by approximately six percentage points (Exhibit F-232).

The 2021 national benchmark rate for children exceeded the SoonerCare HMP children rate by approximately three percentage points.

(Caution: the benchmark population characteristics were not matched to the OHCA groups to minimize differences in the populations. The data is presented for informational purposes only.)

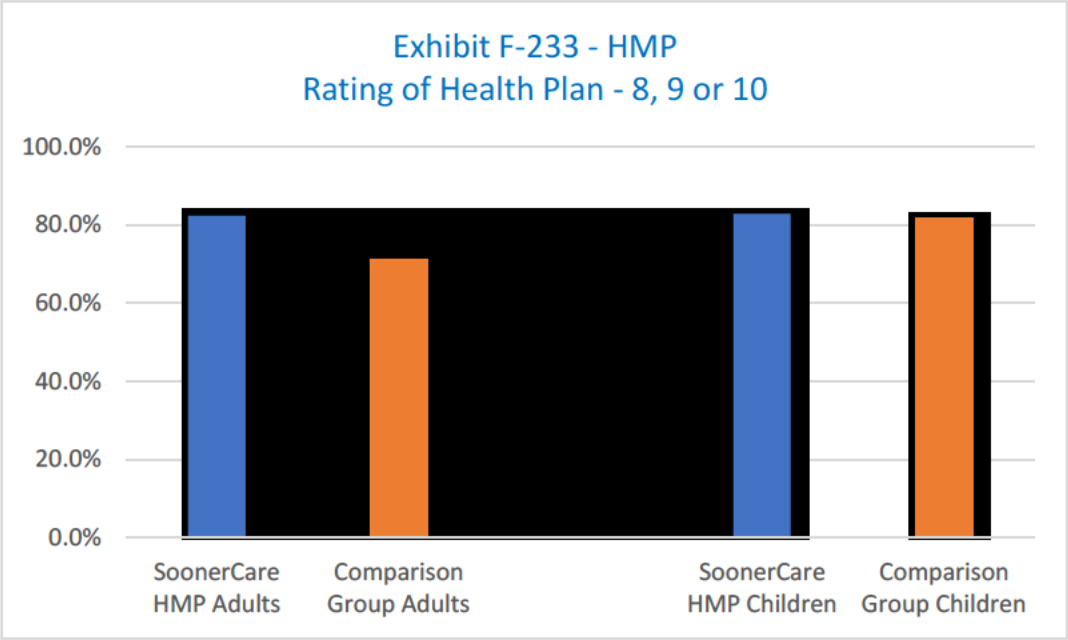


	HMP Adult	Benchmark	HMP Child	Benchmark
Response	71.8%	77.7%	85.9%	88.8%

Rating of Health Plan – Children and Adults

Findings – HMP Population

Approximately 82 percent of HMP adult members and approximately 71 percent of comparison group adult members rated their health plan (SoonerCare) as 8, 9 or 10 on a scale of 0 (worst health plan possible) to 10 (best health plan possible)[73]. Approximately 82 percent of parents/caretakers of HMP child members and approximately 81 percent of comparison group parents/caretakers rated their health plan as 8, 9 or 10 (Exhibit F-233).



The difference between the adult HMP total and comparison group compliance rates was statistically significant (Exhibit F-234).

Exhibit F-234 – HMP – Rating of Health Plan – Percent Rating 8, 9 or 10		
	Adults	Children
HMP	82.3%	82.8%
Comparison Group	71.3%	81.6%
Difference	11.0%‡	1.2%
‡ HMP rate differs from comparison group rate by a statistically significant amount (95% confidence level)		

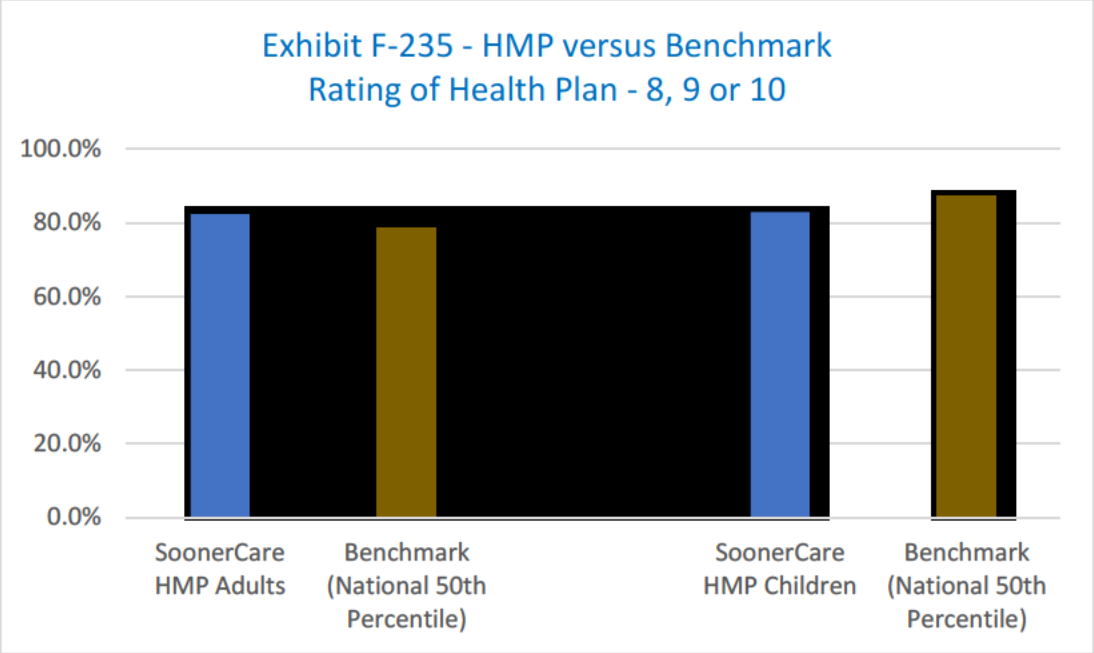
[73] CAHPS question: Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your (your child's) health plan?

Findings – HMP Population and National Benchmark

The rate for SoonerCare HMP adults exceeded the 2021 national benchmark rate by approximately four percentage points (Exhibit F-235).

The 2021 national benchmark rate for children exceeded the SoonerCare HMP children rate by approximately four percentage points.

(Caution: the benchmark population characteristics were not matched to the OHCA groups to minimize differences in the populations. The data is presented for informational purposes only.)



	HMP Adult	Benchmark	HMP Child	Benchmark
Response	82.3%	78.6%	82.8%	87.2%

Exhibit F-236 – HMP Quality of Care Measures – Summary

Measures	HMP versus Comparison Group	HMP 2019 – 2021 Trend
Average number of chronic conditions	*Qualitative Measure*	
Physical/behavioral health co-morbidities	*Qualitative Measure*	
Asthma – Medication Ratio – Ages 5 to 18	✦	▲
Asthma – Medication Ratio – Ages 19 to 64	✦	▲
Cardiovascular – Persistence of Beta Blocker Treatment after a Heart Attack	✦	▲
Cardiovascular – LDL-C Test	✦	▲
COPD – Use of Spirometry Testing	✦	▼
COPD – Pharmacotherapy Management of COPD Exacerbation – 14 Days	✦	▼
COPD – Pharmacotherapy Management of COPD Exacerbation – 30 Days	✦	▲
Diabetes – Percentage of Members who had LDL-C Test	✦	▲
Diabetes – Percentage of Members who had Retinal Eye Exam Performed	✦	▲
Diabetes – Percentage of Members who had HbA1c Testing	✦	▼
Diabetes – Percentage who Received Medical Attention for Nephropathy	✦	▼

Measures	HMP versus Comparison Group	HMP 2019 – 2021 Trend
Hypertension – Percentage of Members who had LDL-C Test	✦	▲
Hypertension – Percentage of Members Prescribed ACE/ARB Therapy	✦	▲
Opioids – Use of Opioids at High Dosage	✦	▼
Opioids – Concurrent Use of Opioids and Benzodiazepines	✦	▼
SDOH Assistance	*Qualitative Measure*	
Getting Needed Health Care – Adults	✦	
Getting Needed Health Care - Children	✦	
Rating of Health Care – Adults	✦	
Rating of Health Care – Children	✦	
Rating of Health Plan – Adults	✦	
Rating of Health Plan – Children	✦	

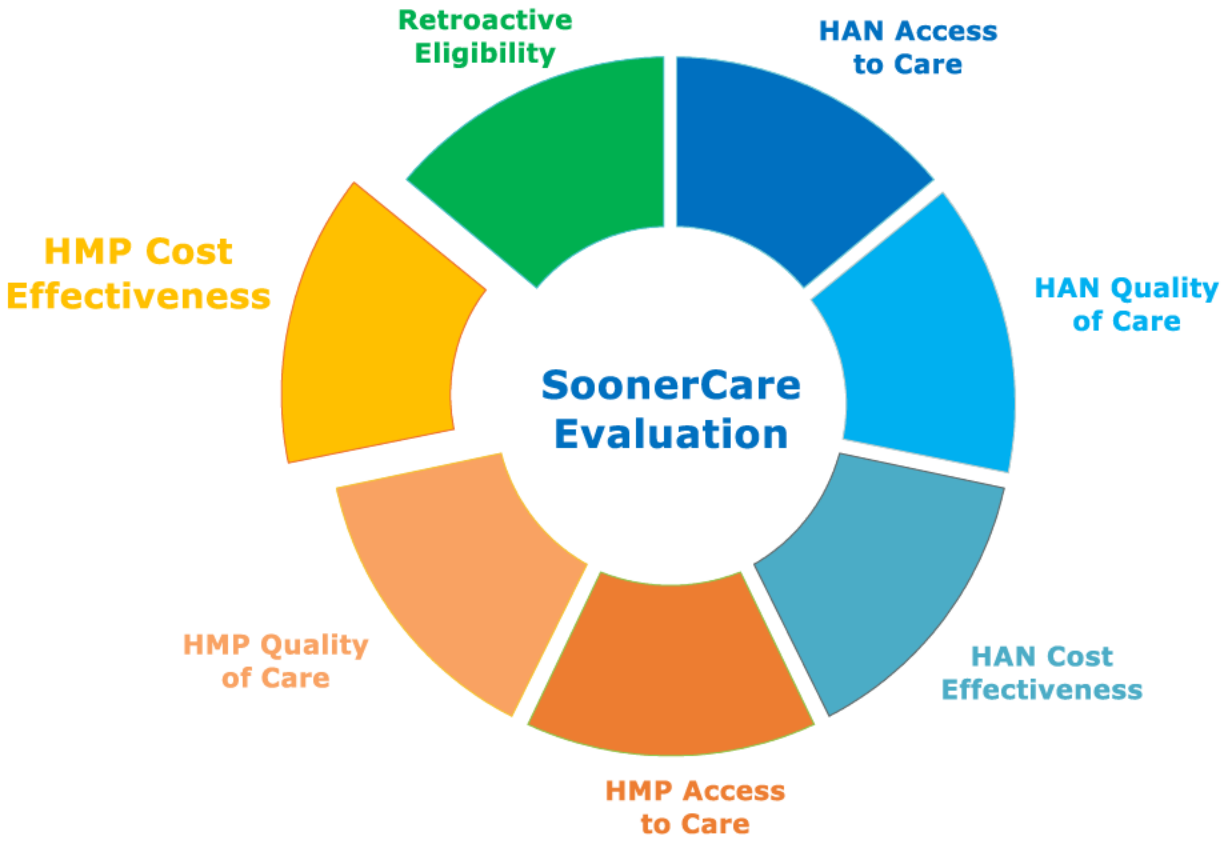
✦ HMP exceeds comparison group by a statistically significant amount (3-year pooled)

✦ No statistically significant difference (3-year pooled)

✦ Comparison group exceeds HMP by a statistically significant amount (3-year pooled)

▲ 2019 – 2021 trend is upward / ▼ trend is downward (opioid measures)

▼ 2019 – 2021 trend is downward (non-opioid measures)


Retroactive Eligibility
HAN Access to Care
HAN Quality of Care
HAN Cost Effectiveness
HMP Access to Care
HMP Quality of Care
HMP Cost Effectiveness
SoonerCare Evaluation

6. HMP Cost Effectiveness

Overview

SoonerCare HMP activities related to improving access and quality, if effective, should have an observable impact on beneficiary service utilization and expenditures. Improvement in quality of care should yield better outcomes in the form of fewer emergency room visits and hospitalizations, and lower acute care costs.

HMP Cost Effectiveness Measures

Exhibit F-237 on the following page presents the HMP cost effectiveness measures and identifies:

- Data sources
- Subgroups evaluated (if any)
- Presence or absence of a national benchmark
- Presence or absence of comparative data from the prior Demonstration period

Supporting Appendices

Appendix 10 contains CEM covariate balance tables for utilization and expenditure measures. Appendix 11 contains statistical significance test results for utilization and expenditure measures.

Exhibit F-237 - HMP Cost Effectiveness Measures - Overview

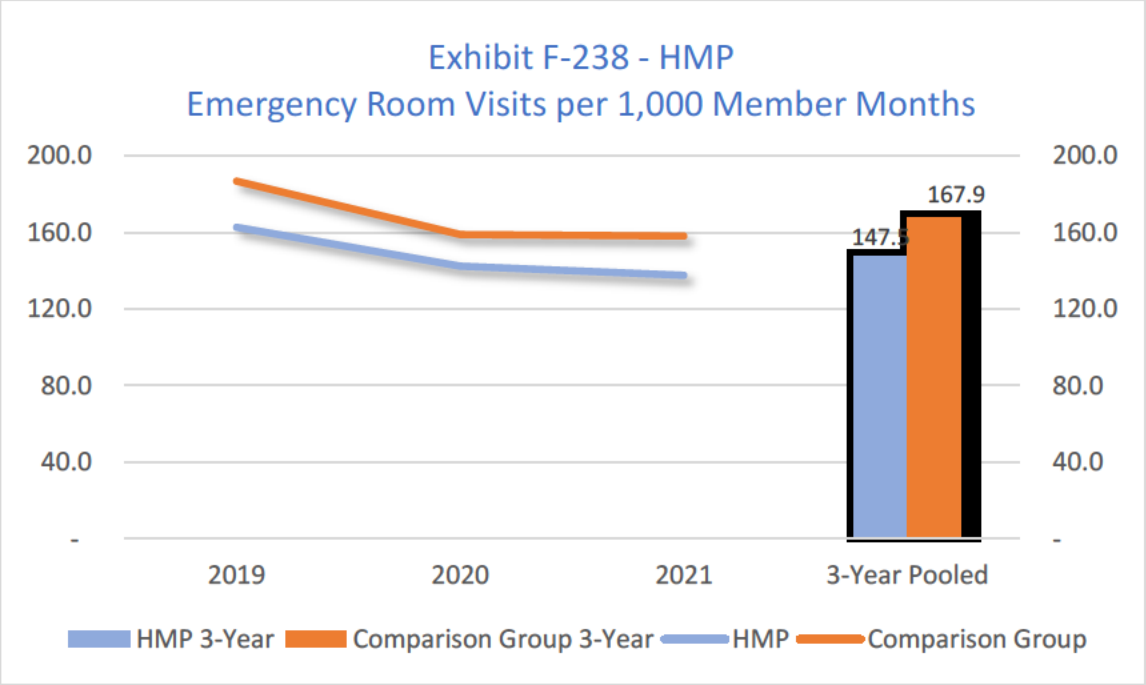
Measures	Source	Geographic Subgroups	National Benchmark	Prior Period Data[74]
Emergency Room Utilization Emergency room visits per 1,000 member months.	MMIS (claims)	***Yes***	No	No
Hospital Admissions Acute care hospital admissions per 100,000 member months.	MMIS (claims)	***Yes***	No	No
Hospital Readmissions Acute care hospital 30-day readmission rate (all causes).	MMIS (claims)	***Yes***	No	No
PMPM Expenditures Average per member per month expenditures (all services).	MMIS (claims)	***Yes***	No	No

[74] The member acuity component of the matching criteria used for selection of a comparison group was modified from the prior evaluation period, to better align HMP and comparison group populations. PHPG determined it would be inappropriate to show a six-year trend line. (The trends in all cases are favorable as compared to the 2016 - 2018 period, but the degree of change suggests that at least a portion of the improvement is due to the refined matching method.)

Emergency Room Visits per 1,000 Member Months

Findings – HMP Population

HMP members averaged approximately 148 emergency room visits per 1,000 member months and comparison group members averaged 168 visits per 1,000 member months across the three years (Exhibit F-238). The visit rate for both populations declined from 2019 to 2021.



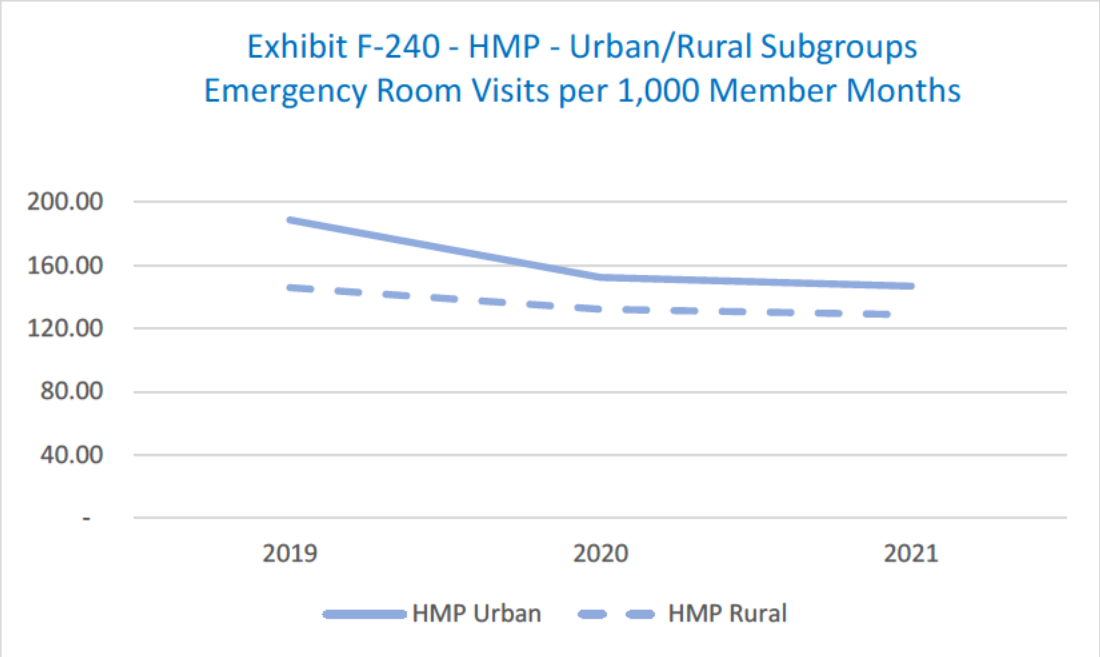
Note: Lower rate is better

The difference between the HMP and comparison group compliance rates was statistically significant in each of the individual years. It also was statistically significant for the three-year pooled data (Exhibit F-239).

Exhibit F-239 – HMP – Emergency Room Visits per 1,000 Member Months				
	2019	2020	2021	3-Year Pooled
HMP	162.7	142.4	137.5	147.5
Comparison Group	186.8	158.9	158.0	167.9
Difference	(24.1)‡	(16.5)‡	(20.5%)‡	(20.4) ‡
‡ HMP rate differs from comparison group rate by a statistically significant amount (95% confidence level)				

Findings – HMP Population – Urban and Rural Subgroups

The HMP urban subgroup rate exceeded the rural subgroup rate across the three years. The rate for both subgroups rate declined from 2019 to 2021 (Exhibit F-240).

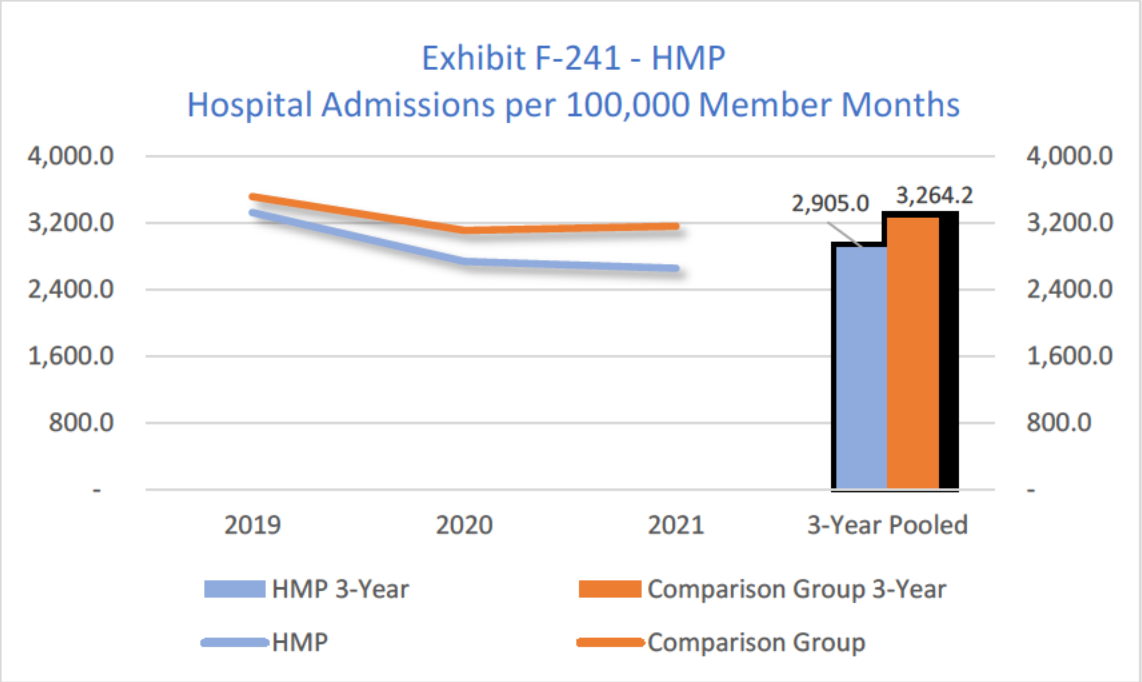


	Subgroup	2019	2020	2021
Visit Rate	**Urban**	188.7	152.5	146.8
	Rural	145.9	132.3	128.8

Hospital Admissions per 100,000 Member Months

Findings – HMP Population

HMP members averaged 2,905 hospital admissions per 100,000 member months and comparison group members averaged approximately 3,264 admissions per 100,000 member months across the three years (Exhibit F-241). The admission rate for the HMP population declined from 2019 to 2021. The admission rate for the comparison group population declined from 2019 to 2020 before rising slightly from 2020 to 2021.



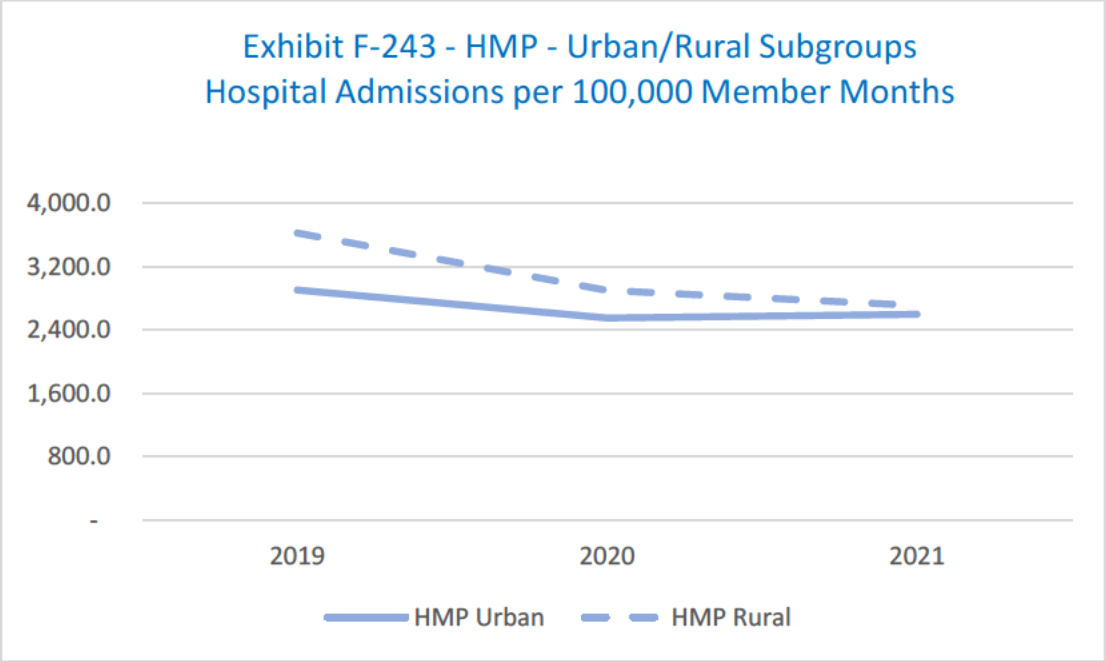
Note: Lower rate is better

The difference between the HMP and comparison group compliance rates was statistically significant in 2020 and 2021. It also was statistically significant for the three-year pooled data (Exhibit F-242).

Exhibit F-242 – HMP – Hospital Admissions per 100,000 Member Months				
	2019	2020	2021	3-Year Pooled
HMP	3,324.3	2,736.2	2,654.5	2,905.0
Comparison Group	3,518.2	3,112.8	3,161.5	3,264.2
Difference	(193.9) ‡	(376.6)‡	(507.0)‡	(359.2)‡
‡ HMP rate differs from comparison group rate by a statistically significant amount (95% confidence level)				

Findings – HMP Population – Urban and Rural Subgroups

The HMP rural subgroup rate exceeded the urban subgroup rate across all three years. The rural subgroup rate declined from 2019 to 2021 while the urban subgroup rate declined from 2019 to 2020 and rose slightly again from 2020 to 2021 (Exhibit F-243).

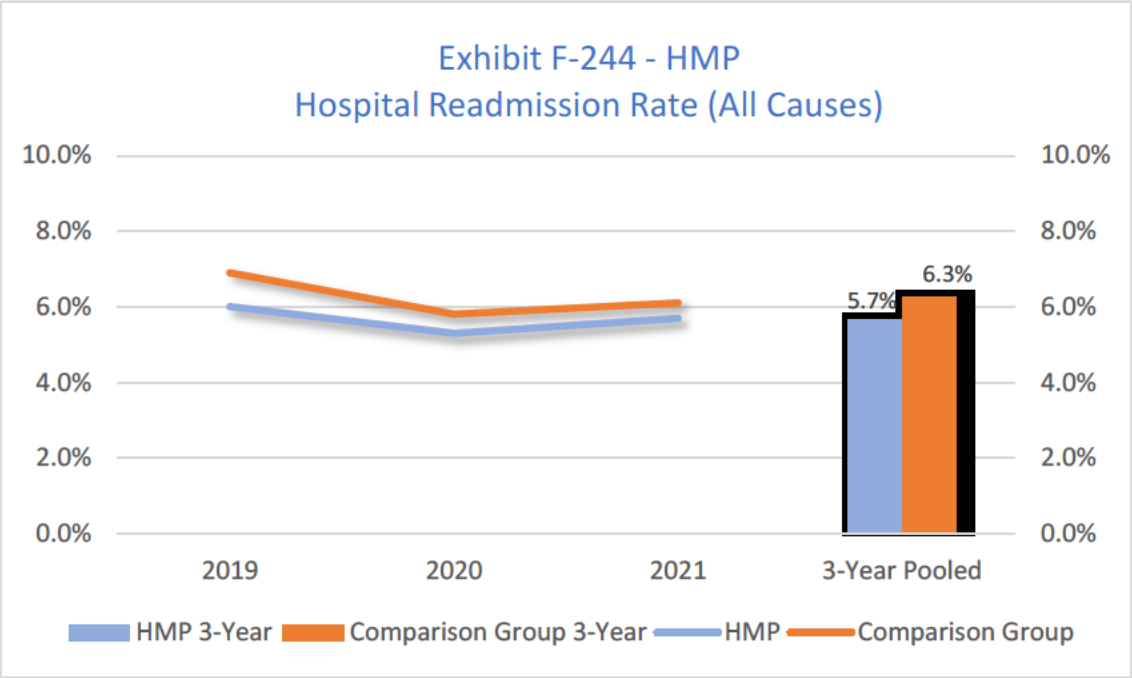


	Subgroup	2019	2020	2021
Admission Rate	**Urban**	2,902.4	2,550.8	2,599.5
	Rural	3,623.2	2,900.4	2,710.0

Hospital 30-Day Readmission Rate (All Causes)

Findings – HMP Population

HMP and comparison group members both had an average 30-day hospital readmission rate of approximately six percent across the three years (Exhibit F-244). The readmission rate for both populations declined from 2019 to 2020 before rising again from 2020 to 2021.



Note: Lower rate is better

The difference between the HMP and comparison group compliance rates was not statistically significant in any of the individual years. However, it was statistically significant for the three-year pooled data (Exhibit F-245).

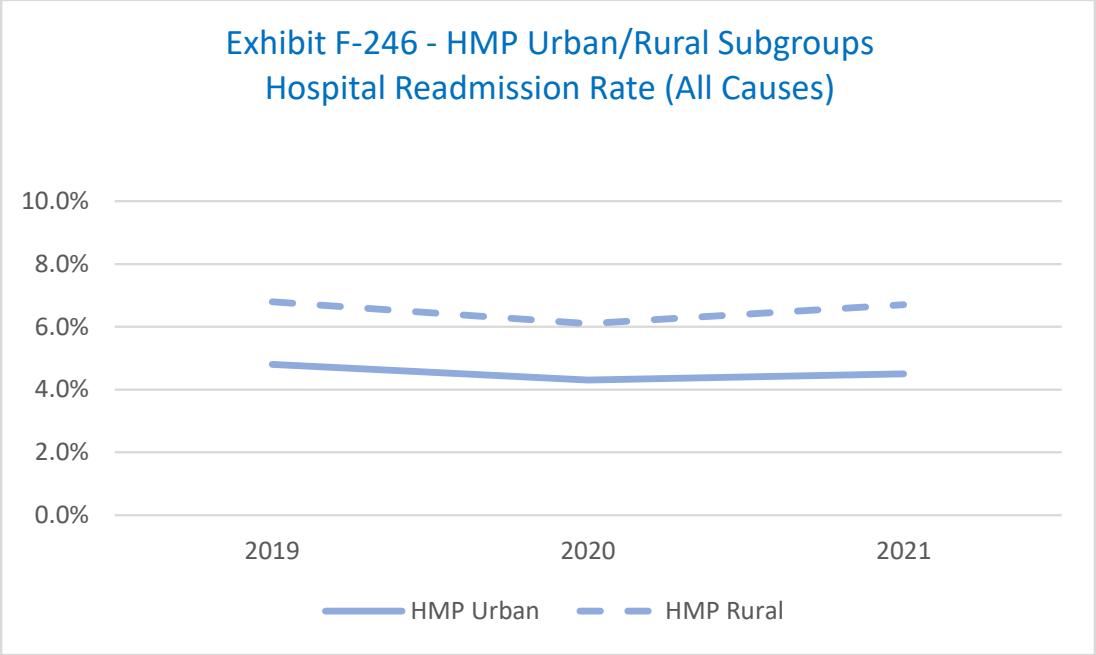
Exhibit F-245 – HMP – Hospital 30-Day Readmission Rate

	2019	2020	2021	3-Year Pooled
HMP	6.0%	5.3%	5.7%	5.7%
Comparison Group	6.9%	5.8%	6.1%	6.3%
Difference	(0.9%)	(0.5%)	(0.4%)	(0.6%)‡

‡ HMP rate differs from comparison group rate by a statistically significant amount (95% confidence level)

Findings – HMP Population – Urban and Rural Subgroups

The HMP rural subgroup rate exceeded the urban subgroup rate across all three years. The rate for both subgroups declined from 2019 to 2020 and rose again from 2020 to 2021 (Exhibit F-246).

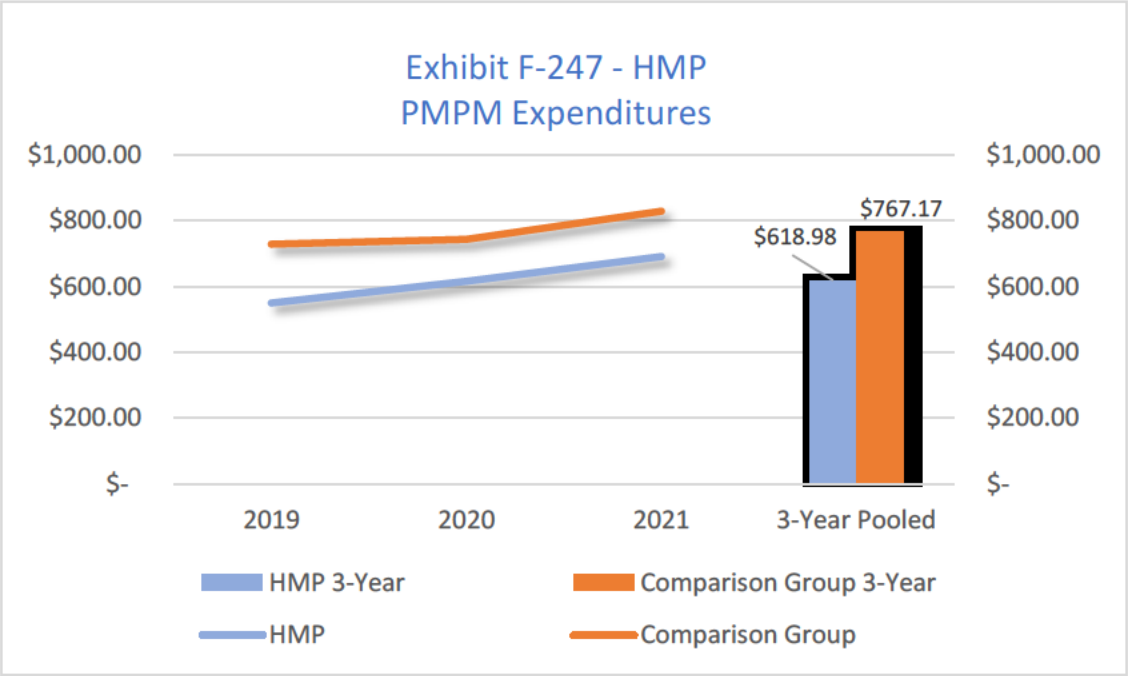


	Subgroup	2019	2020	2021
Readmission Rate	**Urban**	4.8%	4.3%	4.5%
	Rural	6.8%	6.1%	6.7%

Per Member Per Month (PMPM) Expenditures

Findings – HMP Population

HMP member expenditures averaged approximately $619 PMPM and comparison group member expenditures averaged $767 PMPM across the three years (Exhibit F-247). Average expenditures for both populations rose from 2019 to 2021.



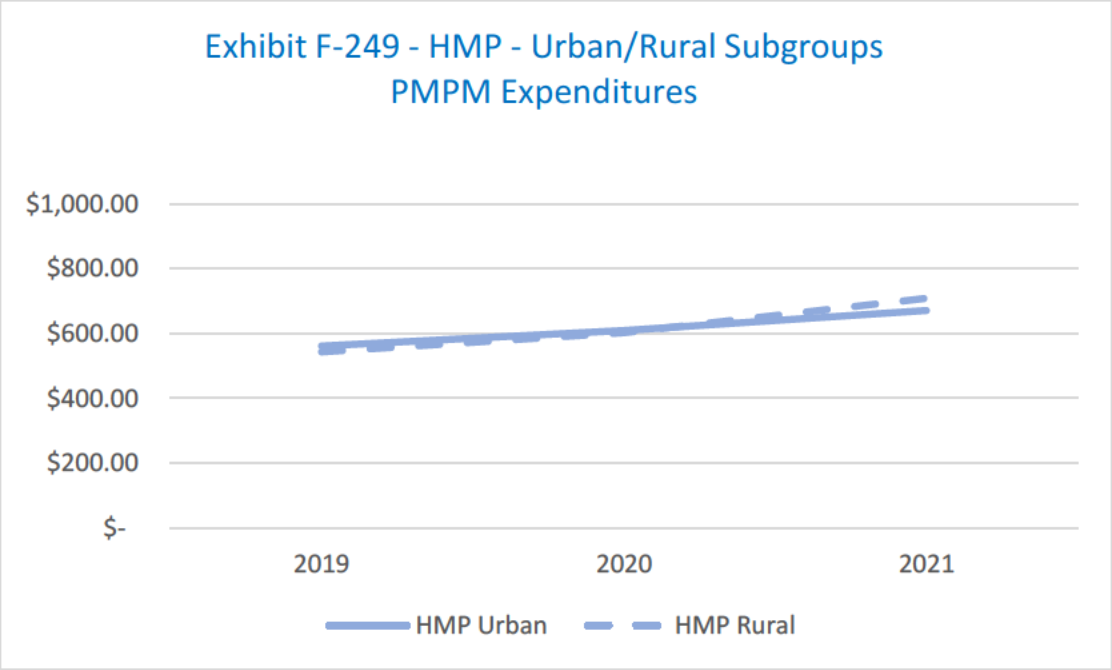
Note: Lower rate is better

The difference between the HMP and comparison group compliance rates was statistically significant in each of the individual years. It also was statistically significant for the three-year pooled data (Exhibit F-248).

Exhibit F-248 – HMP – PMPM Expenditures				
	2019	2020	2021	3-Year Pooled
HMP	$550.09	$616.09	$690.77	$618.98
Comparison Group	$728.57	$743.48	$829.46	$767.17
Difference	($178.48)‡	($127.39)‡	($138.69)‡	($148.19)‡
‡ HMP rate differs from comparison group rate by a statistically significant amount (95% confidence level)				

Findings – HMP and Care Managed Populations – Urban and Rural Subgroups

HMP urban subgroup member expenditures slightly exceeded rural subgroup expenditures in 2019 and 2020, while rural subgroup expenditures exceeded urban subgroup expenditures in 2021. PMPM expenditures rose for both subgroups from 2019 to 2021 (Exhibit F-249).



	Subgroup	2019	2020	2021
PMPM	**Urban**	$561.89	$610.33	$671.66
	Rural	$543.58	$603.28	$709.55

HMP Cost Effectiveness – Summary

The SoonerCare HMP and comparison group populations differed by a statistically significant amount on the four cost effectiveness measures, with the HMP population outperforming the comparison group (Exhibit F-250). Three of the four measures trended downward from 2019 to 2021 (lower rate is better).

Exhibit F-250 – HMP Cost Effectiveness – Summary

Measures	HMP versus Comparison Group	HMP 2019 – 2021 Trend
Emergency Room Visits per 1,000 Member Months	✦	▼
Hospital Admissions per 100,000 Member Months	✦	▼
Hospital 30-Day Readmission Rate	✦	▼
PMPM Expenditures	✦	▲

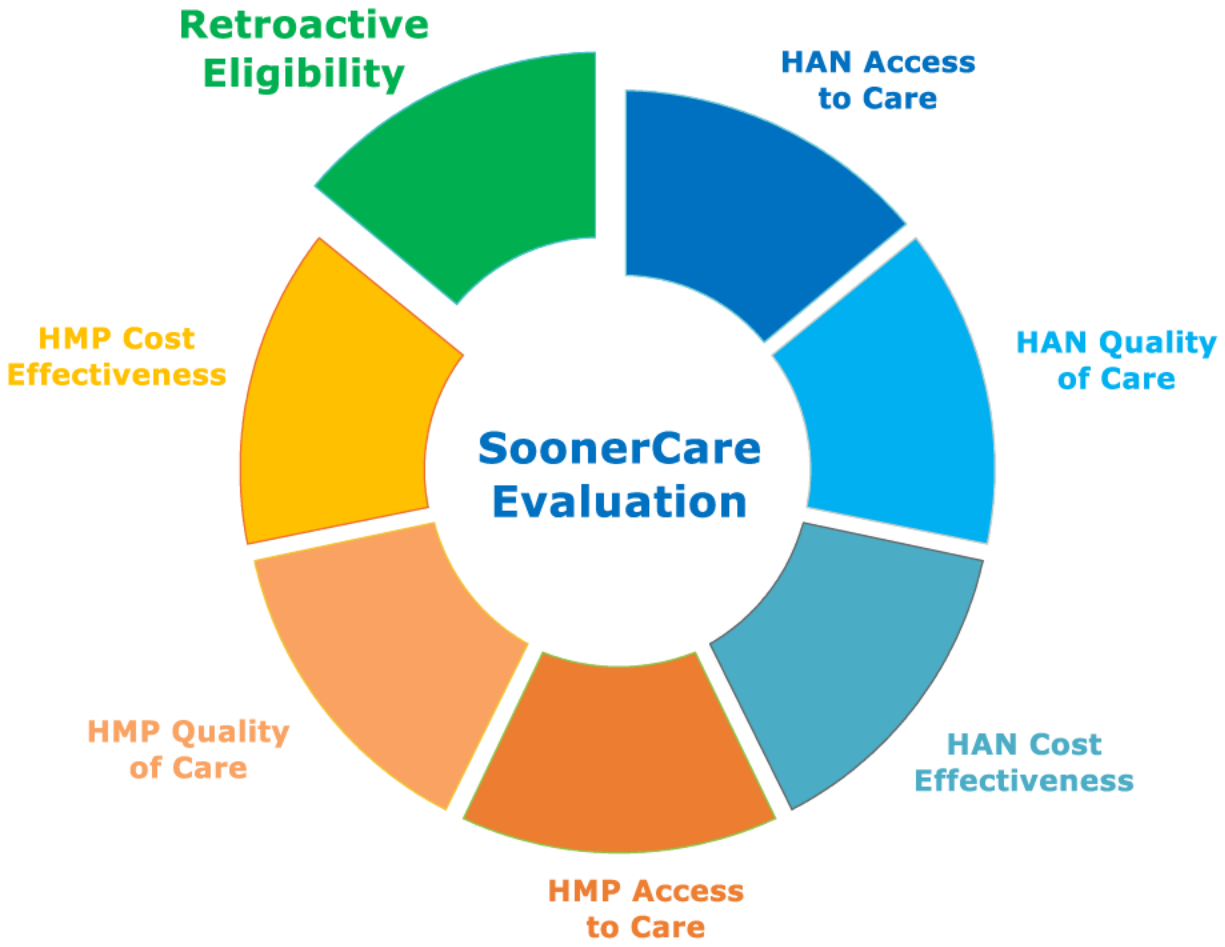
✦ HMP exceeds comparison group by a statistically significant amount (3-year pooled)

✦ No statistically significant difference (3-year pooled)

✦ Comparison group exceeds HMP by a statistically significant amount (3-year pooled)

▲ 2019 - 2021 trend is upward (higher trend is worse)

▼ 2019 – 2021 trend is downward (lower trend is better)


Retroactive Eligibility
HAN Access to Care
HAN Quality of Care
HAN Cost Effectiveness
HMP Access to Care
HMP Quality of Care
HMP Cost Effectiveness
SoonerCare Evaluation

7. Retroactive Eligibility Waiver

Overview

The SoonerCare Demonstration during the evaluation period included a waiver of retroactive eligibility for the parent/caretaker MEG and Insure Oklahoma beneficiaries[75]. (Exhibit B-10 presents detailed information on populations covered under the waiver and populations exempted from it[76].) The retroactive eligibility waiver evaluation examines whether being subject to the waiver encourages eligible individuals to enroll earlier, to maintain health insurance coverage even while healthy, and to obtain preventive health care.

In March 2020, Oklahoma received a Section 1135 waiver, granting flexibilities for operating under the COVID-19 Public Health Emergency. As a condition of the waiver, Oklahoma agreed to a maintenance of effort in the form of continued eligibility for most SoonerCare members who otherwise would have lost eligibility absent the PHE.

The preservation of eligibility in the absence of timely re-certifications removed a key variable from the evaluation, which primarily relies on testing treatment group behaviors against a comparison group of members not subject to the waiver. In the absence of such data, the evaluation presents enrollment counts and survey findings but does not offer conclusions about the waiver's impact. The summative evaluation report will include findings for the post-PHE period in accordance with the approved design.

Retroactive Eligibility Waiver Measures

Exhibit F-251 on the following page presents the retroactive eligibility waiver measures and identifies:

- Data sources
- Subgroups evaluated (if any)
- Presence or absence of a national benchmark
- Presence or absence of comparative data from the prior Demonstration period

Supporting Appendices

Appendix 13 contains the retroactive eligibility targeted survey instrument. Appendix 14 contains CEM covariate balance tables for survey measures. Appendix 15 contains statistical significance tests results for survey measures.

[75] Although the current demonstration period began on August 31, 2018, the MEGs subject to the retroactive eligibility waiver under current STCs took effect in March 2020, approximately concurrent with the PHE.
[76] The waiver applies only to adult beneficiaries in the affected MEGs. Accordingly, evaluation results are for adult beneficiaries only.

Exhibit F-251 - Retroactive Eligibility Waiver Measures - Overview

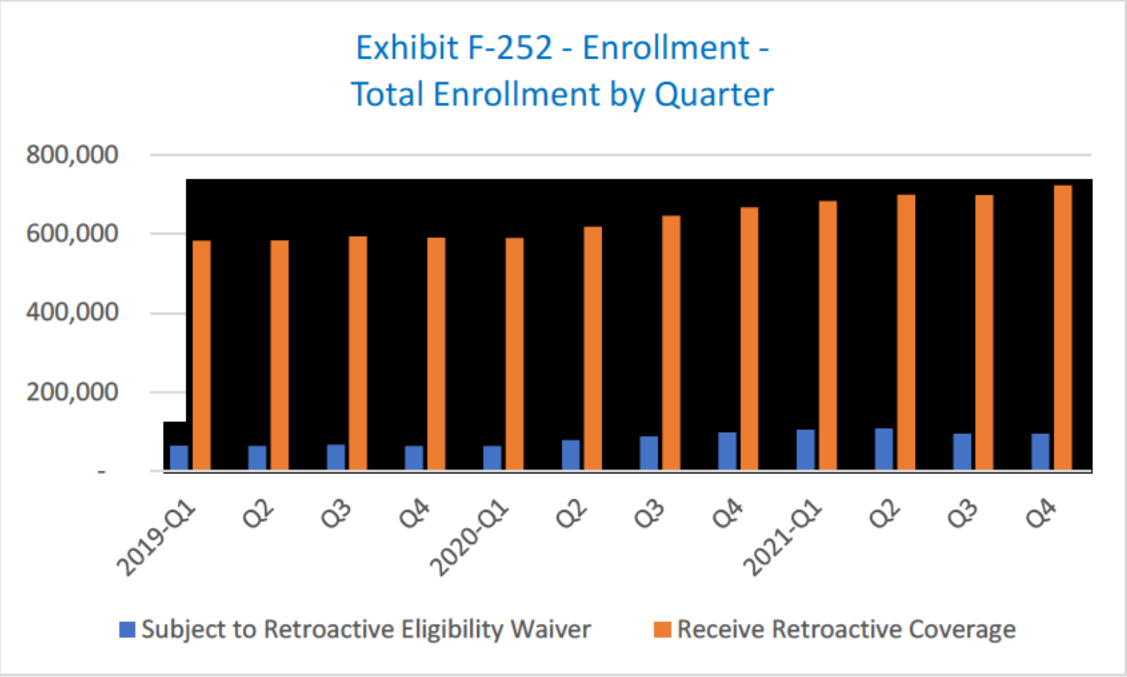
Measures[77]	Source	Geographic Subgroups	National Benchmark	Prior Period Data[78]
Total Enrollment Trend Number of individuals (adults) enrolled in Medicaid, by eligibility group, by quarter.	MMIS	No	No	No
New Enrollment Trend Number of new enrollees (adults) in Medicaid, by eligibility group, by quarter.	MMIS	No	No	No
Beneficiary Health Status – Self-Reported Beneficiary self-reported health status, measured at baseline and at 12, 18 and 24 months[79].	PHPG Targeted Survey	No	No	No
Beneficiary Health Status – Utilization Beneficiary self-reported emergency department and hospital utilization in the past 12 months.	PHPG Targeted Survey	No	No	No
Beneficiary Health Status – Not Healthy Days Beneficiary self-reported not healthy days out of the past 30 days, both physical and mental health.	PHPG Targeted Survey	No	No	No

[77] The approved evaluation design also includes several measures related to renewal timeliness and enrollment tenure (see Appendix #, measures 74 – 78). These measures were not evaluated, due to the impact of the PHE-related suspension of disenrollments on the recertification process. They will be included in the summative evaluation report for the post-PHE period.
[78] The evaluation design for the retroactive eligibility waiver, and the affected MEGs, differed in the prior demonstration period.
[79] Interim evaluation includes results for baseline surveys. The summative evaluation report also will include results for follow-up surveys.

Enrollment - Total Enrollment Trend

Total enrollment for SoonerCare beneficiaries subject to the retroactive eligibility waiver increased from 65,400 (rounded) in the first quarter of 2019 to 95,100 in the fourth quarter of 2021, a 42 percent change (Exhibit F-252). The growth began in the second quarter of 2020, concurrent with suspension of disenrollments under the PHE and accelerated in the fourth quarter of 2021, following implementation of Medicaid expansion[80].

Total enrollment for SoonerCare beneficiaries eligible for retroactive coverage also grew, increasing from 582,400 in the first quarter of 2019 to 721,900 in the fourth quarter of 2021, a 24 percent change. As with the population subject to the retroactive eligibility waiver, the growth began in the second quarter of 2020, concurrent with the start of the PHE.



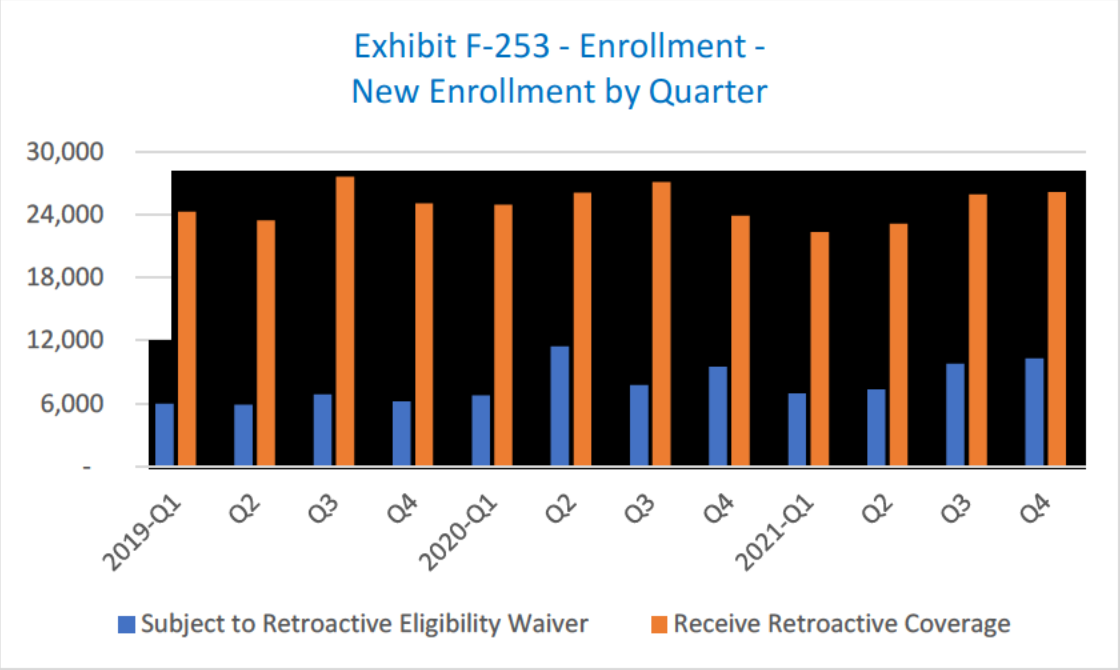
Total Enrollment by Quarter (in thousands)													
	2009				2020				2021				
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	% Change
Subject to Waiver	64.5	64.3	66.4	64.3	64.2	79.0	88.0	98.0	104.4	108.7	95.5	95.1	47.4%
Receive Coverage	582.4	583.3	592.6	590.2	589.1	617.2	645.3	666.1	682.7	698.8	698.0	721.9	23.9%
Total	646.9	647.6	659.0	654.5	653.3	696.2	733.3	764.1	787.1	807.5	793.5	817.0	26.3%

[80] The drop in enrollment in quarters 3 and 4 of 2021 coincides with implementation of Medicaid expansion. The portion of the Parent/Caretaker MEG ineligible for Medicaid except for the PHE, but eligible under the expansion, was transitioned to the new MEG starting in July 2021. Expansion beneficiaries, who became eligible for SoonerCare Choice in September 2021, are not depicted in the exhibit pending the OHCA's decision as to whether to extend the retroactive eligibility waiver to this population (subject to CMS approval).

Enrollment – New Enrollment Trend[81]

New enrollments for SoonerCare beneficiaries subject to the retroactive eligibility waiver fluctuated across the three years but averaged approximately 7,900 (rounded) per quarter (Exhibit F-253).

Total enrollment for SoonerCare beneficiaries eligible for retroactive coverage also fluctuated, averaging approximately 25,000 per quarter.



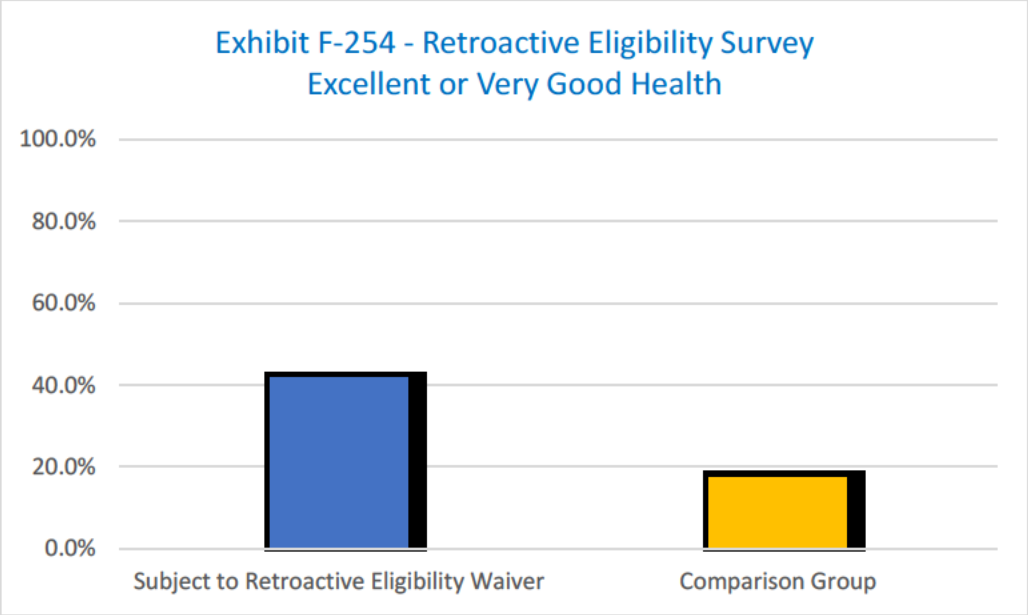
New Enrollment by Quarter (in thousands)													
	2019				2020				2021				
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Average
Subject to Waiver	6.0	5.9	6.9	6.2	6.8	11.5	7.8	9.5	7.0	7.4	9.8	10.3	7.9
Receive Coverage	24.3	23.4	27.6	25.1	24.9	26.1	27.1	23.9	22.3	23.1	25.9	26.1	25.0
Total	30.3	29.3	34.5	31.3	31.7	37.6	34.9	33.4	29.3	30.5	35.7	36.4	32.9

[81] New enrollment counts exclude beneficiaries who were enrolled (and subsequently disenrolled) at any point in the twelve months prior to their new enrollment period.

Beneficiary Health Status – Self-Reported

Findings – Baseline Survey

Approximately 42 percent of members subject to the retroactive eligibility waiver reported being in excellent or very good health at the time of the baseline survey[82]. Approximately 17 percent of the comparison group population reported being in excellent or very good health (Exhibit F-254 (The comparison group includes aged, blind and disabled members, among others.)



The difference between the retroactive eligibility waiver and comparison group populations was statistically significant among respondents reporting their health status as fair or good (Exhibit F-255).

Exhibit F-255– Retroactive Eligibility Survey – Self-Reported Health Status

	Poor	Fair	Good	Very Good	Excellent
Subject to Waiver	5.4%	16.2%	36.6%	29.9%	11.9%
Comparison Group	13.9%	51.6%	17.0%	13.0%	4.5%
Difference	(8.5%)	(35.4%)‡	19.6%‡	16.9%	7.4%

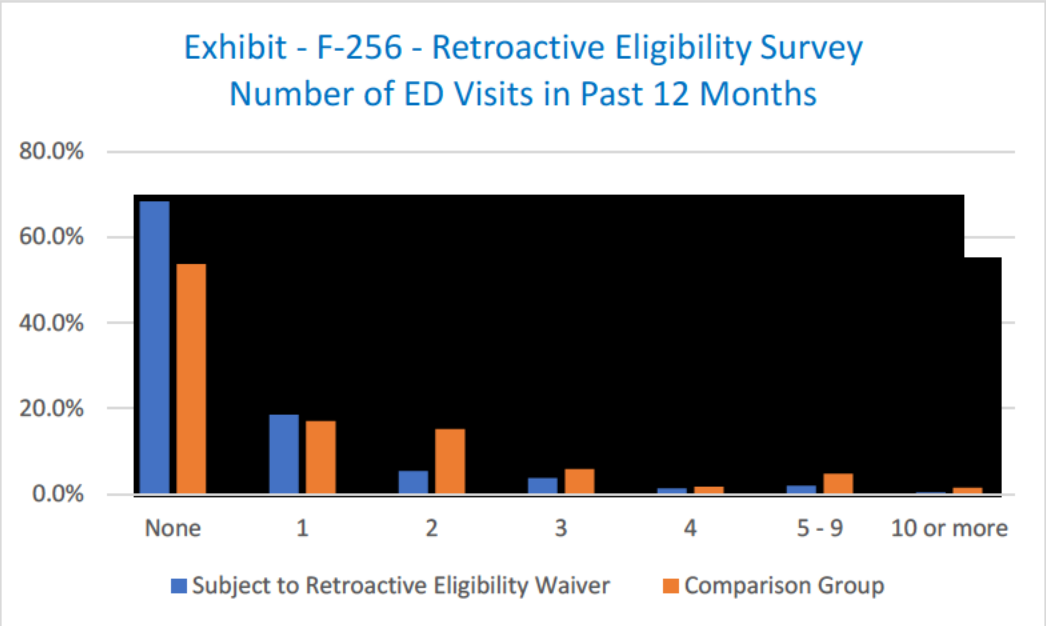
‡ Retroactive eligibility waiver group differs from comparison group by a statistically significant amount

[82] Survey question: How would you say that in general your health is – excellent, very good, good, fair or poor? (Question source – BRFSS 2018 survey.)

Beneficiary Health Status – Utilization – Emergency Department

Findings – Baseline Survey

Approximately 68 percent of members subject to the retroactive eligibility waiver reported having no ED visits in the past twelve months, while approximately 32 percent reported having one or more visits[83]. The percentages for the comparison group were approximately 54 percent with no visits and 47 percent with one or more visits (Exhibit F-256). (Baseline surveys are conducted during the first 30 days of SoonerCare enrollment; at least 11 of the 12 months therefore pre-dates SoonerCare coverage.)



The difference between the retroactive eligibility waiver and comparison group populations was not statistically significant for any of the individual ED visit counts (Exhibit F-257).

Exhibit F-257 – Retroactive Eligibility Survey – ED Visits in Past 12 Months

	None	1	2	3	4	5 – 9	10+
Subject to Waiver	68.4%	18.6%	5.4%	3.8%	1.3%	2.0%	0.4%
Comparison Group	53.7%	17.1%	15.3%	5.9%	1.7%	4.7%	1.5%
Difference	14.7%	1.5%	(9.9%)	(2.1%)	(0.4%)	(2.7%)	(1.1%)

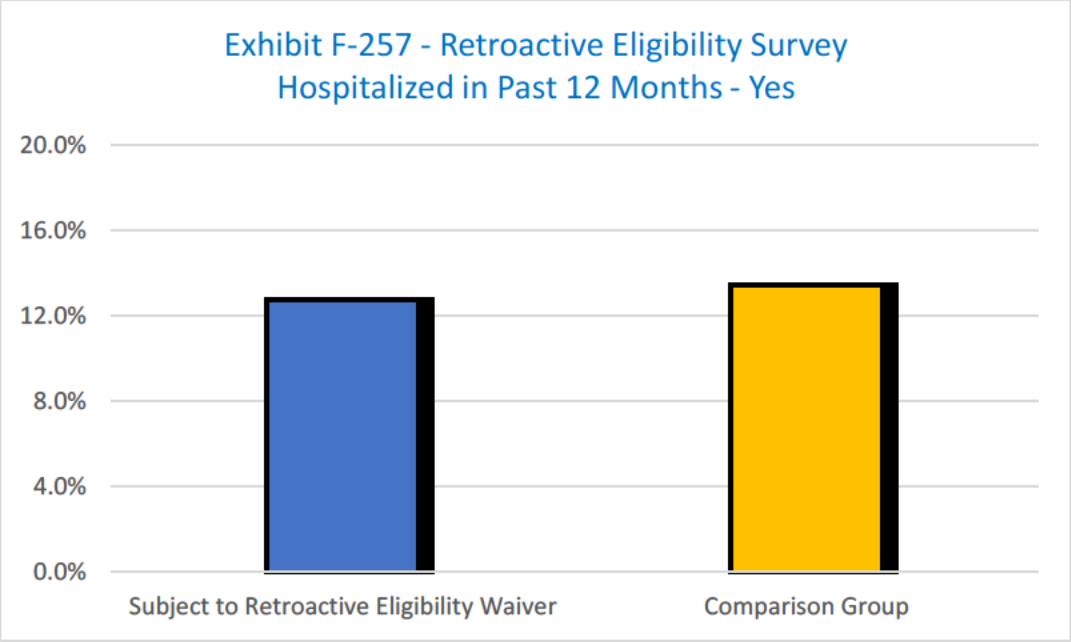
‡ Retroactive eligibility waiver group differs from comparison group by a statistically significant amount

[83] Survey question: In the last 12 months, how many times did you go to an emergency room to get care for yourself? (Question source – CAHPS 5.0 Adult Health Plan survey.)

Beneficiary Health Status – Utilization – Hospitalization

Findings – Baseline Survey

Approximately 13 percent of both members subject to the retroactive eligibility and members in the comparison group population reported having been hospitalized in the past 12 months[84] (Exhibit F-257). (Baseline surveys are conducted during the first 30 days of SoonerCare enrollment; at least 11 of the 12 months therefore pre-dates SoonerCare coverage.)



The difference between the retroactive eligibility waiver and comparison group populations was not statistically significant (Exhibit F-258).

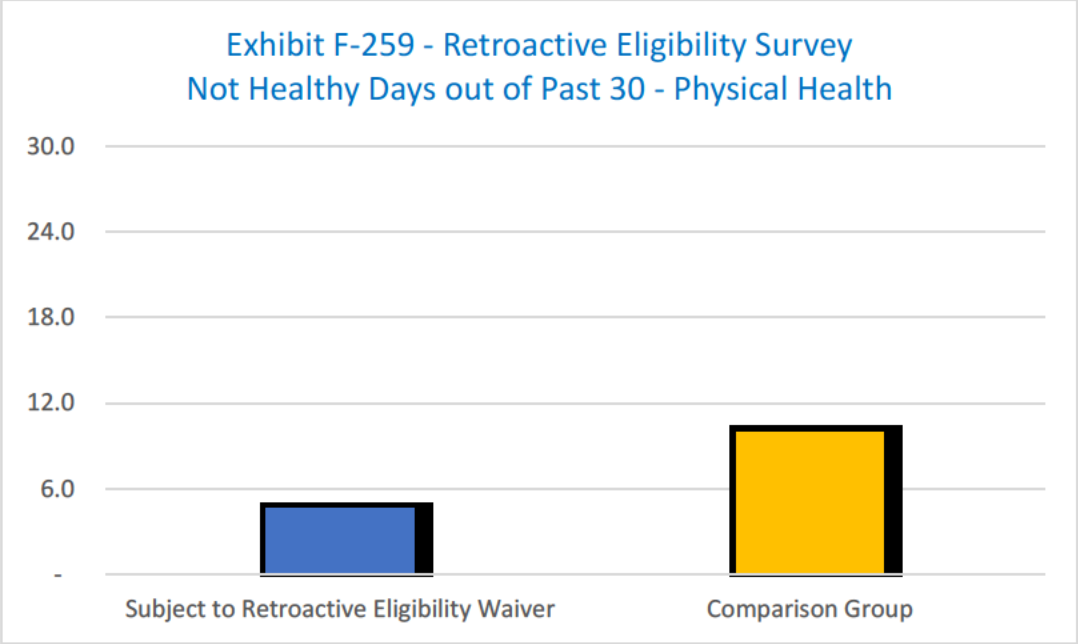
Exhibit F-258 – Retroactive Eligibility Survey – Hospitalized in Past 12 Months		
	Yes	No
Subject to Waiver	12.6 %	87.4%
Comparison Group	13.3%	86.7%
Difference	(0.7%)	
‡ Retroactive eligibility waiver group differs from comparison group by a statistically significant amount		

[84] Survey question: Have you been hospitalized overnight in the past 12 months? Do not include an overnight stay in the emergency room (Question source: FHOSPYR, NHIS Draft 2018 – Family.)

Beneficiary Health Status – Not Healthy Days – Physical Health

Findings – Baseline Survey

Members subject to the retroactive eligibility reported having approximately five days out of the past 30 in which their physical health was not good. Members of the comparison group population reported having approximately 10 days out of the past 30 in which their physical health was not good[85] (Exhibit F-259).



Note: Lower count is better

The difference between the retroactive eligibility waiver and comparison group populations was statistically significant (Exhibit F-260).

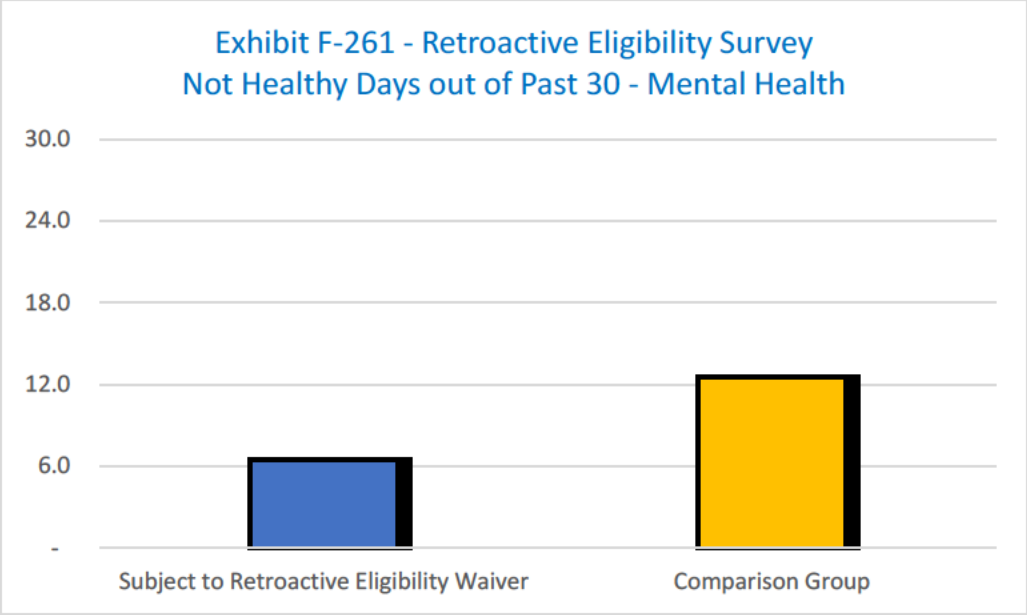
Exhibit F-260 – Retroactive Eligibility Survey – Not Healthy Days out of Past 30 Days (Physical Health)		
	Not Healthy	Healthy (Imputed)
Subject to Waiver	4.6	25.4
Comparison Group	10.0	20.0
Difference	(5.4) ǂ	
ǂ Retroactive eligibility waiver group differs from comparison group by a statistically significant amount		

[85] Survey question: Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good? (Question source: BRFSS 2018 survey.)

Beneficiary Health Status – Not Healthy Days – Mental Health

Findings – Baseline Survey

Members subject to the retroactive eligibility reported having approximately six days out of the past 30 in which their physical health was not good. Members of the comparison group population reported having approximately 12 days out of the past 30 in which their physical health was not good[86] (Exhibit F-261).



Note: Lower count is better

The difference between the retroactive eligibility waiver and comparison group populations was statistically significant (Exhibit F-262).

Exhibit F-262 – Retroactive Eligibility Survey – Not Healthy Days out of Past 30 Days (Mental Health)		
	Not Healthy	Healthy (Imputed)
Subject to Waiver	6.2	23.8
Comparison Group	12.3	17.7
Difference	(6.1) ǂ	
ǂ Retroactive eligibility waiver group differs from comparison group by a statistically significant amount		

[86] Survey question: Now thinking about your mental health, which includes stress, depression and problems with emotions, for how many days during the past 30 days was your mental health not good? (Question source: BRFSS 2018 survey.)

Exhibit F-263 – Retroactive Eligibility Waiver – Summary

Measures	Retroactive Eligibility Waiver versus Comparison Group	Baseline to Follow-up Trend
Total Enrollment Trend	*Qualitative Measure*	
New Enrollment Trend	*Qualitative Measure*	
Beneficiary Health Status – Excellent or Very Good	✦	–
Beneficiary Health Status – ED Utilization	✦	–
Beneficiary Health Status – Hospital Utilization	✦	–
Beneficiary Health Status – Not Healthy Days (Physical Health)	✦	–
Beneficiary Health Status – Not Healthy Days (Mental Health)	✦	–

✦ Population subject to retroactive eligibility waiver exceeds comparison group by a statistically significant amount (baseline)

✦ No statistically significant difference (baseline)

✦ Comparison group exceeds population subject to retroactive eligibility waiver by a statistically significant amount (baseline)

– Trend from baseline to follow-up survey periods will be reported in summative evaluation

G. Conclusions

The SoonerCare Demonstration evaluation examines the impact of the Health Access Networks and Health Management Program on access, quality and cost. It also examines the impact of the retroactive eligibility waiver on beneficiary enrollment patterns and health status.

The interim evaluation includes data for only the first three years of the five-year Demonstration, making tentative any conclusions drawn from the analysis. The evaluation also overlapped with the COVID-19 PHE, which disrupted patterns-of-care in Oklahoma and throughout the nation.

Exhibit G-1 on the following page presents summary findings by evaluation domain and research area. The exhibit documents the number of quantitative measures for which the Demonstration populations (HAN – total, HAN – care managed, HMP and persons subject to the retroactive eligibility waiver) differed from their respective comparison groups by a statistically significant amount.

The HMP population registered the greatest net positive results, outperforming the comparison group on 18 of 20 measures for which there was a statistically significant difference. Seven measures showed no statistically significant difference.

The HAN Care Managed population also showed net positive results, outperforming the comparison group on seven of eight measures for which there was a statistically significant difference. Eight measures showed no statistically significant difference.

The HAN Total population showed mixed results, outperforming the comparison group on six of 16 measures for which there was a statistically significant difference. Fourteen measures showed no statistically significant difference.

The population subject to the retroactive eligibility waiver outperformed the comparison group on both measures for which there was a statistically significant difference. Three measures showed no statistically significant difference.

Exhibit – G-1 - Demonstration Populations versus Comparison Groups – Summary

DOMAIN/Research Area	Demonstration Population Outperformed Comparison Group	Comparison Group Outperformed Demonstration Population	No Statistically Significant Difference
HAN (TOTAL) – Access to Care		● ●	● ●
HAN (TOTAL) – Quality of Care	● ● ● ● ● ●	● ● ● ● ●	● ● ● ● ● ● ● ● ● ● ● ●
HAN (TOTAL) – Cost Effectiveness		● ●	●
HAN (CARE MANAGED) – Access to Care	● ●		
HAN (CARE MANAGED) – Quality of Care	● ● ● ●		● ● ● ● ● ● ● ●
HAN (CARE MANAGED) – Cost Effectiveness	●	●	●
HMP – Access to Care	● ●		
HMP – Quality of Care	● ● ● ● ● ● ● ● ● ● ● ●	● ●	● ● ● ● ● ● ●
HMP – Cost Effectiveness	● ● ● ●		
RETROACTIVE ELIGIBILITY – Health Status	● ●		● ● ●

● One measure (Demonstration population outperformed comparison group)

● One measure (comparison group outperformed Demonstration population)

● One measure (no difference)

H. Interpretations & Policy Limitations/Interactions with other State Initiatives

The majority of state Medicaid programs have transitioned to managed care by enrolling at least a portion of their populations into capitated health plans. Health plan contracts typically encompass most or all covered medical services, and in many instances also include behavioral health. The contracts also require health plans to assess their members' medical, behavioral health (if applicable) and social service needs, develop care plans and provide care management in accordance with care plan goals and interventions.

Oklahoma is one of a minority of states that has elected to implement managed care through a non-traditional model. After terminating its capitated program in 2004, the OHCA began a years-long transition to the SoonerCare Choice program in place during the waiver evaluation period.

SoonerCare Choice seeks to achieve the same access, quality and cost effectiveness objectives common to capitated programs but to do so in a more targeted fashion. The OHCA contracts with the SoonerCare HANs and SoonerCare HMP vendor to offer practice enhancement to affiliated PCMH providers and provide care management to high-risk beneficiaries.

Medicaid benefits continue to be paid on a fee-for-service basis and the majority of SoonerCare Demonstration beneficiaries, who are healthy children and pregnant women, receive any needed care coordination through their PCMH provider and/or prenatal care provider.

The OHCA is preparing to transition the non-ABD portion of the SoonerCare Choice population back into risk based managed care, with a target implementation date of October 2023. This will coincide with the completion of the current five-year Demonstration period and will present the opportunity to evaluate the impact of the transition on the non-ABD population, while continuing to monitor outcomes for the residual population remaining in the non-traditional model.

Contracting with capitated health plans is a proven strategy for implementing managed care. At the same time, the current SoonerCare Demonstration model offers another option for states to consider when implementing or expanding managed care in areas where a capitated program may be difficult to establish, such as rural/frontier counties.

I. Lessons Learned & Recommendations

It is premature to draw lessons or make recommendations during the interim evaluation stage, particularly given the still unknown full impact of the COVID-19 PHE.

The summative evaluation report will address lessons learned and recommendations based on a complete five-year analysis, the final portion of which is expected to lie outside of the PHE window.

J. Appendices

Supporting appendices for the evaluation design and results section are presented, starting on the following page.

Appendix	Applies to	Contents
Appendix 1	All Sections	Approved evaluation design, CMS recommendations for enhanced evaluation and listing of deviations from approved design
Appendix 2	HAN Analysis	CEM covariate balance tables (pre- and post-matching) for HEDIS, utilization and expenditure measures (2019 – 2021)
Appendix 3	HAN Analysis	Statistical significance test results (p<.005) for HEDIS, utilization and expenditure measures (2019 – 2021 and three-year pooled data)
Appendix 4	HAN Analysis	CEM covariate balance tables (pre- and post-matching) for CAHPS measures
Appendix 5	HAN Analysis	Statistical significance test results for CAHPS measures (HAN and comparison group)
Appendix 6	HAN Analysis	HAN member SDOH targeted survey instrument (HAN and comparison group)
Appendix 7	HAN Analysis	HAN-aligned PCMH targeted survey instrument
Appendix 8	HMP Analysis	CEM covariate balance tables (pre- and post-matching) for CAHPS measures (HMP and comparison group)
Appendix 9	HMP Analysis	Statistical significance test results for CAHPS measures (HMP and comparison group)
Appendix 10	HMP Analysis	CEM covariate balance tables (pre- and post-matching) for HEDIS, utilization and expenditure measures (2019 – 2021)
Appendix 11	HMP Analysis	Statistical significance test results (p<.005) for HEDIS, utilization and expenditure measures (2019 – 2021 and three-year pooled data)
Appendix 12	HMP Analysis	HMP member targeted survey instrument (SDOH section only)
Appendix 13	Retroactive Eligibility	Retroactive eligibility analysis survey instrument
Appendix 14	Retroactive Eligibility	CEM covariate balance tables (pre- and post-matching) for survey measures
Appendix 15	Retroactive Eligibility	Statistical significance test results for retroactive survey measures (population subject to waiver and comparison group)

1. Approved Evaluation Design Measure Set and Related

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

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
4		Rating of health plan – children and adults	Adult members enrolled with a HAN-affiliated PCMH Child members enrolled with a HAN-affiliated PCMH	In accordance with CAHPS specifications	SoonerCare Choice adult members not enrolled with a HAN-affiliated PCMH SoonerCare Choice child members not enrolled with a HAN-affiliated PCMH	Source - CAHPS survey data file Steward – CAHPS	T-tests Regression with propensity score matching
5		Rating of personal doctor – children and adults	Adult members enrolled with a HAN-affiliated PCMH Child members enrolled with a HAN-affiliated PCMH	In accordance with CAHPS specifications	SoonerCare Choice adult members not enrolled with a HAN-affiliated PCMH SoonerCare Choice child members not enrolled with a HAN-affiliated PCMH	Source - CAHPS survey data file Steward – CAHPS	T-tests Regression with propensity score matching
Evaluation of Health Access Networks – Quality of Care							
6	Will the implementation and expansion of the HANs improve the quality and coordination of health care services to SoonerCare beneficiaries served by the HANs, including specifically populations at greatest risk (e.g.,	Number of members engaged in care management	Total unduplicated members engaged in care management at any point during year Unduplicated members with multiple chronic illnesses engaged in care management at any point during the year	Numerators – members engaged in care management (total and population with multiple chronic conditions Denominators – all members (total and population with multiple chronic conditions)	N/A	Source - HAN care management databases Steward - HANs	Time series

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
7	those with multiple chronic illnesses)?	Asthma – use of appropriate medications for people with asthma	HAN members with asthma	In accordance with HEDIS specifications	SoonerCare Choice members with asthma not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching
8		Asthma – Medication management for people with asthma – 75 percent	HAN members with asthma	In accordance with HEDIS specifications	SoonerCare Choice members with asthma not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching
9		CAD – Persistent beta-blocker treatment after a heart attack	HAN members with CAD and heart failure	In accordance with HEDIS specifications	SoonerCare Choice members with CAD/heart failure not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching
10		CAD – Cholesterol management for patients with cardiovascular conditions – LDL-C test	HAN members with CAD and heart failure	In accordance with HEDIS specifications	SoonerCare Choice members with CAD/heart failure not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
11		COPD – Use of spirometry testing in the assessment and diagnosis of COPD	HAN members with COPD	In accordance with HEDIS specifications	SoonerCare Choice members with COPD not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching
12		COPD – pharmacotherapy management of COPD exacerbation – 14 days	HAN members with COPD	In accordance with HEDIS specifications	SoonerCare Choice members with COPD not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching
13		COPD – pharmacotherapy management of COPD exacerbation – 30 days	HAN members with COPD	In accordance with HEDIS specifications	SoonerCare Choice members with COPD not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching
14		Diabetes – Percentage of members who had LDL-C test	HAN members with diabetes	In accordance with HEDIS specifications	SoonerCare Choice members with diabetes not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching

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

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
19		Hypertension – Percentage of members who had LDL-C test	HAN members with hypertension	In accordance with HEDIS specifications	SoonerCare Choice members with hypertension not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching
20		Hypertension – Percentage of members prescribed ACE/ARB therapy	HAN members with hypertension	In accordance with HEDIS specifications	SoonerCare Choice members with hypertension not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching
21		Hypertension – Percentage of members prescribed diuretics	HAN members with hypertension	In accordance with HEDIS specifications	SoonerCare Choice members with hypertension not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching
22		Hypertension – Percentage of members prescribed ACE/ARB therapy or diuretics with annual medication monitoring	HAN members with hypertension	In accordance with HEDIS specifications	SoonerCare Choice members with hypertension not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
23		Mental Health – Follow-up after hospitalization for mental illness – 7 days	HAN members hospitalized for mental illness	In accordance with HEDIS specifications	SoonerCare Choice members hospitalized for mental illness not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching
24		Mental Health – Follow-up after hospitalization for mental illness – 30 days	HAN members hospitalized for mental illness	In accordance with HEDIS specifications	SoonerCare Choice members hospitalized for mental illness not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching
25		SDOH – Member satisfaction	Randomly selected sample of HAN members receiving assistance with SDOH as part of care management	Numerator – Members reporting satisfaction Denominator – All respondents	N/A	Source - HAN care management databases for sample Steward - SoonerCare Independent Evaluator for survey data	Descriptive statistics

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
26	Will the implementation and expansion of the HANs enhance the State's PCMH program by making HAN care management and support available to more providers, as documented through an evaluation of PCP profiles that incorporates a review of utilization, disease guideline compliance and cost? *(Note: HEDIS chronic disease measures from preceding hypothesis/question also will be included in evaluation of this hypothesis/question, as PCMH providers drive member compliance.)*	Number and percentage of HAN-affiliated PCMH providers who have attained the highest level of OHCA accreditation	HAN-affiliated PCMH providers	Numerator – PCMH providers with Tier 3 accreditation (or highest level under any future redesign of PCMH tiers) Denominator – All HAN-aligned PCMH providers	PCMH providers not aligned with a HAN	Source – MMIS Steward – OHCA	Time series
27		PCMH provider satisfaction with HAN practice support activities	Randomly selected sample of HAN-affiliated PCMH providers	Numerator – Providers reporting satisfaction Denominator – All respondents	N/A	Source – MMIS for provider sample Steward – SoonerCare Independent Evaluator for survey data	Descriptive statistics
28		PCMH provider adoption of chronic care disease guidelines (self-reported)	Randomly selected sample of HAN-affiliated PCMH providers	Numerator – Providers reporting compliance by disease state Denominator – All respondents	N/A	Source – MMIS for provider sample Steward – SoonerCare Independent Evaluator for survey data	Descriptive statistics

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
Evaluation of Health Access Networks – Cost Effectiveness							
29	Will the implementation and expansion of the HANs reduce cost associated with provision of health care services to SoonerCare beneficiaries served by the HANs?	Emergency room utilization	SoonerCare Choice HAN members	Numerator – ED visits Denominator – total member months	SoonerCare Choice members not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source – MMIS Steward – OHCA	T-tests Regression with propensity score matching
30		Hospital admissions	SoonerCare Choice HAN members	Numerator – IP admissions Denominator – total member months	SoonerCare Choice members not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP PCMH and not enrolled in the HMP	Source – MMIS Steward – OHCA	T-tests Regression with propensity score matching
31		Evaluation of Health Access Networks – PMPM Expenditures	SoonerCare Choice HAN members	Numerator – total expenditures (paid claims and PCMH case management fees) Denominator – total member months	SoonerCare Choice members not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source – MMIS Steward – OHCA	T-tests Regression with propensity score matching
Evaluation of Health Management Program – Access to Care							

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

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
34	Will implementation of the third generation HMP 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?	Average number of chronic conditions	SoonerCare members enrolled in the HMP, by coaching method	Numerator – Number of chronic conditions Denominator – Number of members	HMP beneficiaries enrolled in second generation HMP	Source – MMIS; HMP contractor database Steward – OHCA for claims; HMP contractor for member assignments	Interrupted time series
35		Percentage of members with physical/behavioral health co-morbidities	SoonerCare members enrolled in the HMP, by coaching method	Numerator – Number of members with at least one chronic physical and one behavioral health condition Denominator – Number of members	HMP beneficiaries enrolled in second generation HMP	Source – MMIS; HMP contractor database Steward – OHCA for claims; HMP contractor for member assignments	Interrupted time series
36	Will the use of disease registry functions by the health coach (along with other coaching activities) improve the quality of care delivered to beneficiaries, as measured by changes in performance on the	Asthma – use of appropriate medications for people with asthma	HMP members with asthma	In accordance with HEDIS specifications	SoonerCare Choice members with asthma not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching Interrupted time series

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
37	initial set of Health Care Quality Measures for Medicaid-Eligible Adults or CHIPRA Core Set of Children's Healthcare Quality Measures?	Asthma – Medication management for people with asthma – 75 percent	HMP members with asthma	In accordance with HEDIS specifications	SoonerCare Choice members with asthma not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching Interrupted time series
38		Asthma - COPD or asthma in older adults admission rate	HMP members with asthma or COPD	In accordance with AHRQ specifications	SoonerCare Choice members with COPD or asthma not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source - MMIS Steward - AHRQ	T-tests Regression with propensity score matching Interrupted time series
39		Asthma – Asthma in younger adults admission rate	HMP members with asthma	In accordance with AHRQ specifications	SoonerCare Choice members with COPD or asthma not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source - MMIS Steward - AHRQ	T-tests Regression with propensity score matching Interrupted time series

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
40		CAD – Persistent beta-blocker treatment after a heart attack	HMP members with CAD and heart failure	In accordance with HEDIS specifications	SoonerCare Choice members with CAD not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching Interrupted time series
41		CAD – Cholesterol management for patients with cardiovascular conditions – LDL-C test	HMP members with CAD and heart failure	In accordance with HEDIS specifications	SoonerCare Choice members with CAD not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching Interrupted time series
42		CAD – Heart failure admission rate	HMP members with heart failure	In accordance with AHRQ specifications	SoonerCare Choice members with CAD not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source - MMIS Steward - AHRQ	T-tests Regression with propensity score matching Interrupted time series

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
43		COPD – Use of spirometry testing in the assessment and diagnosis of COPD	HMP members with COPD	In accordance with HEDIS specifications	SoonerCare Choice members with COPD or asthma not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching Interrupted time series
44		COPD – pharmacotherapy management of COPD exacerbation – 14 days	HMP members with COPD	In accordance with HEDIS specifications	SoonerCare Choice members with COPD or asthma not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching Interrupted time series
45		COPD – pharmacotherapy management of COPD exacerbation – 30 days	HMP members with COPD	In accordance with HEDIS specifications	SoonerCare Choice members with COPD or asthma not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching Interrupted time series

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
46		Diabetes – Percentage of members who had LDL-C test	HMP members with diabetes	In accordance with HEDIS specifications	SoonerCare Choice members with diabetes not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching Interrupted time series
47		Diabetes – percentage of members who had retinal eye exam performed	HMP members with diabetes	In accordance with HEDIS specifications	SoonerCare Choice members with diabetes not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching Interrupted time series
48		Diabetes – percentage of members who had HbA1c testing	HMP members with diabetes	In accordance with HEDIS specifications	SoonerCare Choice members with diabetes not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching Interrupted time series

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
49		Diabetes - Percentage of members who received medical attention for nephropathy	HMP members with diabetes	In accordance with HEDIS specifications	SoonerCare Choice members with diabetes not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching Interrupted time series
50		Diabetes - Percentage of members prescribed ACE/ARB therapy	HMP members with diabetes	In accordance with HEDIS specifications	SoonerCare Choice members with diabetes not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching Interrupted time series
51		Diabetes – Diabetes short-term complications admission rate	HMP members with diabetes	In accordance with AHRQ specifications	SoonerCare Choice members with diabetes not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source - MMIS Steward - AHRQ	T-tests Regression with propensity score matching Interrupted time series

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
52		Hypertension – Percentage of members who had LDL-C test	HMP members with hypertension	In accordance with HEDIS specifications	SoonerCare Choice members with hypertension not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching Interrupted time series
53		Hypertension – Percentage of members prescribed ACE/ARB therapy	HMP members with hypertension	In accordance with HEDIS specifications	SoonerCare Choice members with hypertension not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching Interrupted time series
54		Hypertension – Percentage of members prescribed diuretics	HMP members with hypertension	In accordance with HEDIS specifications	SoonerCare Choice members with hypertension not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching Interrupted time series

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
55		Hypertension – Percentage of members prescribed ACE/ARB therapy or diuretics with annual medication monitoring	HMP members with hypertension	In accordance with HEDIS specifications	SoonerCare Choice members with hypertension not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching Interrupted time series
56		Mental Health – Follow-up after hospitalization for mental illness – 7 days	HMP members hospitalized for mental illness	In accordance with HEDIS specifications	SoonerCare Choice members hospitalized for mental illness not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching Interrupted time series
57		Mental Health – Follow-up after hospitalization for mental illness – 30 days	HMP members hospitalized for mental illness	In accordance with HEDIS specifications	SoonerCare Choice members hospitalized for mental illness not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching Interrupted time series

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
					HMP beneficiaries enrolled in second generation HMP		
58		Opioid – Use of opioids at high dosage in persons without cancer	HMP members prescribed opioids (through Medicaid)	In accordance with PQA specifications	SoonerCare Choice members prescribed opioids not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source - MMIS Steward - PQA	T-tests Regression with propensity score matching Interrupted time series
59		Opioid – Concurrent use of opioids and benzodiazepines	HMP members prescribed opioids (through Medicaid)	In accordance with PQA specifications	SoonerCare Choice members prescribed opioids and benzodiazepines not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source - MMIS Steward - PQA	T-tests Regression with propensity score matching Interrupted time series

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
60		SDOH – Member awareness of SDOH available assistance	Randomly selected sample of HMP members enrolled in HMP	Numerators – Members reporting awareness and use of SDOH assistance available through HMP Denominator – All respondents	N/A	Source – SoonerCare Independent Evaluator survey data file Steward - SoonerCare Independent Evaluator for survey data	Descriptive statistics
61		SDOH – Member satisfaction with SDOH available assistance	Randomly selected sample of HMP members enrolled in HMP	Numerator – Members reporting satisfaction with SDOH assistance Denominator – All respondents reporting use of assistance	N/A	Source – SoonerCare Independent Evaluator survey data file Steward - SoonerCare Independent Evaluator for survey data	Descriptive statistics
62	Will beneficiaries using HMP services have higher satisfaction compared to beneficiaries not receiving HMP services (as measured through CAHPS survey questions)?	Rating of health care – children and adults	Adult HMP members Child HMP members	In accordance with CAHPS specifications	SoonerCare Choice adult members not enrolled with a HAN-affiliated PCMH SoonerCare Choice child members not enrolled with a HAN-affiliated PCMH	Source – SoonerCare Independent Evaluator survey data file Steward – CAHPS	T-tests Regression with propensity score matching

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
63		Getting needed care – children and adults	Adult HMP members Child HMP members	In accordance with CAHPS specifications	SoonerCare Choice adult members not enrolled with a HAN-affiliated PCMH SoonerCare Choice child members not enrolled with a HAN-affiliated PCMH	Source – SoonerCare Independent Evaluator survey data file Steward – CAHPS	T-tests Regression with propensity score matching
64		Rating of health plan – children and adults	Adult HMP members Child HMP members	In accordance with CAHPS specifications	SoonerCare Choice adult members not enrolled with a HAN-affiliated PCMH SoonerCare Choice child members not enrolled with a HAN-affiliated PCMH	Source - SoonerCare Independent Evaluator Steward – CAHPS	T-tests Regression with propensity score matching
65		Rating of personal doctor – children and adults	Adult HMP members Child HMP members	In accordance with CAHPS specifications	SoonerCare Choice adult members not enrolled with a HAN-affiliated PCMH SoonerCare Choice child members not enrolled with a HAN-affiliated PCMH	Source - SoonerCare Independent Evaluator data file Steward – CAHPS	T-tests Regression with propensity score matching

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
Evaluation of Health Management Program – Cost Effectiveness							
66	Will beneficiaries using HMP services have fewer ER visits as compared to beneficiaries not receiving HMP services (as measured through claims data)?	ER utilization – HMP members versus comparison group	SoonerCare HMP members (minimum of three months)	Numerator – ED visits Denominator – total participants	SoonerCare Choice members not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source – MMIS Steward – Independent Evaluator	T-tests Regression with propensity score matching Interrupted time series
67	Will beneficiaries using HMP services have fewer (admissions and) readmissions as compared to beneficiaries not receiving HMP services (as measured through claims data)?	Hospital admissions – HMP members versus comparison group Hospital readmissions (30 days) – HMP members versus comparison group	SoonerCare HMP members (minimum of three months) SoonerCare HMP members with at least one hospitalization	Numerator – Admissions Denominator – total participants Numerator – Unique members with readmissions within 30 days following an admission Denominator- total members with admissions in 30-day period	SoonerCare Choice members not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source – MMIS Steward – SoonerCare Independent Evaluator	T-tests Regression with propensity score matching Interrupted time series

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
68	Will total and per member per month expenditures for members enrolled in HMP be lower than would have occurred absent their participation?	PMPM costs – HMP members versus comparison group	SoonerCare HMP members (minimum of three months)	Numerator – total expenditures (paid claims) and program administrative costs (vendor payments and agency direct/overhead expenses) Denominator – member months	SoonerCare Choice members not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source – MMIS Steward – SoonerCare Independent Evaluator	T-tests Regression with propensity score matching Interrupted time series
Evaluation of Insure Oklahoma – Access to Care							
69	Will the evaluation support the hypothesis that Insure Oklahoma is improving access to care for low-income Oklahomans not eligible for Medicaid?	The number of individuals enrolled in Insure Oklahoma	Insure Oklahoma beneficiaries, both ESI and Individual Plan	N/A	N/A	Source – OHCA eligibility system Steward – OHCA	Descriptive statistics
70		The number of employers participating in the ESI portion of Insure Oklahoma	Employers participating in the ESI portion of the program	N/A	N/A	Source – Insure Oklahoma Steward – OHCA	Descriptive statistics

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
71		The number of primary care providers participating in the Individual Plan portion of Insure Oklahoma	Primary care providers (PCMH providers) participating in the Individual Plan network	N/A	N/A	Source – MMIS Steward – OHCA	Descriptive statistics
Evaluation of Retroactive Eligibility – Access to Care							
72	Do eligible people subject to retroactive eligibility waivers enroll in Medicaid at the same rate as other eligible people who have access to retroactive eligibility?	The number of individuals enrolled in Medicaid by eligibility group, by quarter	Beneficiaries subject to retroactive eligibility waiver Beneficiaries newly covered by retroactive eligibility (non-disabled children under age 19 and pregnant women)	N/A	Non-pregnant adults covered by retroactive eligibility waiver Beneficiaries previously subject to retroactive eligibility waiver	Source – OHCA eligibility system Steward - OHCA	Regression with propensity score matching Interrupted time series

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
73		The number of new enrollees in Medicaid by eligibility group, by quarter	Beneficiaries subject to retroactive eligibility waiver Beneficiaries newly covered by retroactive eligibility (non-disabled children under age 19 and pregnant women)	N/A	Non-pregnant adults covered by retroactive eligibility waiver Beneficiaries previously subject to retroactive eligibility waiver	Source – OHCA eligibility system Steward - OHCA	Regression with propensity score matching Interrupted time series
74	What is the likelihood of enrollment continuity for those subject to a retroactive eligibility waiver compared to other Medicaid beneficiaries who have access to retroactive eligibility?	Probability of completing the renewal (recertification) process, by eligibility group	Beneficiaries subject to retroactive eligibility waiver Beneficiaries newly covered by retroactive eligibility (non-disabled children under age 19 and pregnant women)	N/A	Non-pregnant adults covered by retroactive eligibility waiver Beneficiaries previously subject to retroactive eligibility waiver	Source – OHCA eligibility system Steward - OHCA	Regression with propensity score matching Interrupted time series

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
75		Probability of remaining enrolled in Medicaid for 12-, 18- 24- consecutive months, by eligibility group	Beneficiaries subject to retroactive eligibility waiver Beneficiaries newly covered by retroactive eligibility (non-disabled children under age 19 and pregnant women)	N/A	Non-pregnant adults covered by retroactive eligibility waiver Beneficiaries previously subject to retroactive eligibility waiver	Source – OHCA eligibility system Steward - OHCA	Regression with propensity score matching Interrupted time series
76		Number of months with Medicaid coverage (average tenure) (1-12)	Beneficiaries subject to retroactive eligibility waiver Beneficiaries newly covered by retroactive eligibility (non-disabled children under age 19 and pregnant women)	N/A	Non-pregnant adults covered by retroactive eligibility waiver Beneficiaries previously subject to retroactive eligibility waiver	Source – OHCA eligibility system Steward - OHCA	Regression with propensity score matching Interrupted time series

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
77	Do beneficiaries subject to retroactive eligibility waivers who disenroll from Medicaid have shorter enrollment gaps than other beneficiaries who have access to retroactive eligibility?	Probability of re-enrolling in Medicaid after a gap in coverage of six months	Beneficiaries subject to retroactive eligibility waiver Beneficiaries newly covered by retroactive eligibility (non-disabled children under age 19 and pregnant women)	N/A	Non-pregnant adults covered by retroactive eligibility waiver Beneficiaries previously subject to retroactive eligibility waiver	Source – OHCA eligibility system Steward - OHCA	Regression with propensity score matching Interrupted time series
78		Number of months without Medicaid coverage, up to six months	Beneficiaries subject to retroactive eligibility waiver Beneficiaries newly covered by retroactive eligibility (non-disabled children under age 19 and pregnant women)	N/A	Non-pregnant adults covered by retroactive eligibility waiver Beneficiaries previously subject to retroactive eligibility waiver	Source – OHCA eligibility system Steward - OHCA	Regression with propensity score matching Interrupted time series

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
Evaluation of Retroactive Eligibility – Quality of Care							
79	Do newly-enrolled beneficiaries subject to a waiver of retroactive eligibility have higher self-assessed health status than other newly enrolled beneficiaries who have access to retroactive eligibility?	Beneficiary self-reported health status; reported prior year utilization	Beneficiaries subject to retroactive eligibility waiver	N/A	Non-pregnant adults covered by retroactive eligibility waiver	Source – SoonerCare Independent Evaluator survey data file Steward - SoonerCare Independent Evaluator for survey data	Descriptive regression model (due to lack of baseline data; waiver is ongoing from prior period)
80	Do beneficiaries subject to the retroactive eligibility waiver have better health outcomes than other beneficiaries who have access to retroactive eligibility?	Beneficiary self-reported health status; healthy days	Beneficiaries subject to retroactive eligibility waiver	N/A	Non-pregnant adults covered by retroactive eligibility waiver	Source – SoonerCare Independent Evaluator survey data file Steward - SoonerCare Independent Evaluator for survey data	Regression with propensity score matching

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
81		Change in physical and mental health status, measured at baseline and at 12, 18 and 24 months	Beneficiaries subject to retroactive eligibility waiver	N/A	Non-pregnant adults covered by retroactive eligibility waiver	Source – SoonerCare Independent Evaluator survey data file Steward - SoonerCare Independent Evaluator for survey data	Regression model of change in self-reported health status among Medicaid beneficiaries initially enrolled and subject to waiver

Oklahoma SoonerCare Section 1115 Demonstration

CMS COMMENTS ON THE SUMMATIVE EVALUATION REPORT FOR THE PERIOD ENDING DECEMBER 31, 2018

September 29, 2020

I. Introduction

The Centers for Medicare & Medicaid Services (CMS) has reviewed Oklahoma's summative evaluation report, titled "SoonerCare Section 1115 Waiver Evaluation: Demonstration Years 21 – 23 (CY 2016 – 2018)," dated June 2020. The report evaluates Oklahoma's SoonerCare section 1115 demonstration for the demonstration period of January 1, 2016 through December 31, 2018. CMS compared the summative evaluation report to the demonstration special terms and conditions (STC)[87] and the evaluation design from the state[88].

The demonstration contains the following policies:

- SoonerCare Health Access Networks (HANs), which offer care management and care coordination to SoonerCare Choice members with complex health care needs who are enrolled with affiliated primary care medical home (PCMH) providers. HANs expanded to additional counties between 2016 and 2018, but the policy was otherwise unchanged from the previous demonstration period.

- SoonerCare Health Management Program (HMP), an initiative under the demonstration developed to offer care management to SoonerCare Choice members most at risk for chronic disease and other adverse health events. During the 2016–2018 period, HMP was unchanged from the previous demonstration period.

- The state continued to waive retroactive eligibility for most SoonerCare Choice beneficiaries but did not apply it to those eligible due to the Tax Equity and Fiscal Responsibility Act (TEFRA) or Aged, Blind or Disabled (ABD) status. During the 2016–2018 period, the retroactive eligibility waiver was unchanged from the previous demonstration period.

The goals of the demonstration are to improve enrollee health care access and quality and to increase cost-effectiveness.

CMS has identified strengths and weaknesses of the analyses contained in the summative evaluation report. The strengths of the evaluation are that the state uses a mix of claims and primary survey data and employs propensity score matching to select an in-state comparison

[87] Three sets of STCs cover the 2016–2018 demonstration period: https://www medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ok/soonercare/ok-soonercare-2015-ext-appvl-07092015.pdf; https://www medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ok/soonercare/ok-soonercare-tech-crrctns-amdmnt-rqst-11302016.pdf; and https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ok/soonercare/ok-soonercare-renewal-12292017.pdf.

[88] Evaluation Design available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ok/soonercare/ok-soonercare-draft-eval-design-20181228.pdf.

group among Oklahoma beneficiaries not enrolled in HAN or HMP. The state also uses well-defined outcome measures that are appropriate for the research questions. CMS has several recommendations for improving the methods, their description, and presentation of the results (Section II). CMS has also identified a number of opportunities to strengthen the evaluation of the demonstration period August 31, 2018 through December 31, 2023[89] (Section III). Upon CMS's review of this evaluation report, CMS also has identified a few areas where the state could consider certain minor amendments to the approved evaluation design for this period, dated June 2019. These updates within the approved design framework will strengthen future evaluation efforts, including the interim and summative evaluation reports. The state is not required to resubmit the evaluation design for these suggested modifications, but should accommodate those adjustments in evaluation of the ongoing demonstration approval period. In accordance with STC 88 of the STCs for the January 1 to December 31, 2018 approval period, CMS anticipates receiving a revised summative evaluation report from the state within 60 days after it receives CMS comments.

II. Recommendations for improvements to the summative evaluation report

The OHCA appreciates CMS' recommendations for improving the summative evaluation report. We have worked with our independent evaluator to incorporate the recommendations in the manner described below.

1. **Provide more details about the propensity score matching process used to select the comparison groups and other analytic methods.**

The report describes the beneficiary characteristics that are included in the matching process but does not provide any comparison of summary statistics for the intervention and comparison groups. The state should consider adding balance tables that display mean beneficiary characteristics for treatment and comparison group, before and after matching. The balance tables would help persuade the reader that the treatment and comparison groups are observably similar after matching. In addition, the state should describe the matching algorithm in more detail, for example, whether the evaluator used matching with or without replacement and which distance measure was used for matching. The summative evaluation report also mentions "peer grouping" on page 50 but does not explain elsewhere what this is. If this references a specific statistical method, the state should describe it in more detail.

The matching process description has been expanded in the report methodology section to address the elements identified by CMS. (Nearest neighbor PSM without replacement was utilized.) Report Appendix 2 also now contains balance table data depicting mean beneficiary characteristics (treatment and comparison group) and standardized difference. (Post-matching data is presented to allow readers to assess the similarity of treatment and comparison groups.) The "peer grouping" reference has been removed.

2. **Describe the results only in terms of statistically significant findings when assessing whether the data supports each hypothesis.**

[89] The STCs for 2019–2023 can be found at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ok/soonercare/ok-soonercare-demo-appvl-20180831.pdf.

In the section describing the hypothesis that HANs would improve beneficiary access on page 152 of the summative evaluation report, the state notes that, "The SoonerCare HAN and comparison group rates did not differ by a statistically significant amount on the majority of measures, and this typically would argue against a conclusion that the evaluation supported the hypothesis. However, the compliance and satisfaction rates were very high in absolute terms, and also relative to the national benchmark." The state then uses this to argue that HANs improved access to care, a conclusion that is not supported by the data. The state should revise this statement to reflect the fact that no conclusion about the impact of HANs on beneficiary access can be drawn, given lack of statistically significant findings.

The report has been revised to clarify that no conclusion about the impact of HANs on beneficiary access can be drawn from the evaluation measures, given the lack of statistically significant findings.

The discussion of absolute compliance/satisfaction rates, and performance against national benchmarks, has been retained as it is relevant to Oklahoma policymakers when assessing the Oklahoma Medicaid program in its entirety. However, the language has been revised to clarify why the information is provided. The report also has been revised to include cautionary language regarding differences in the Oklahoma waiver and national benchmark populations. This language appears throughout the report whenever benchmark data is presented or discussed.

3. Add a disclaimer that results should not be interpreted as causal.

Because the demonstration continued the same policies during the 2016–2018 period that existed before 2016, the state cannot use an evaluation design that supports causal inferences about the effects of demonstration policies, such as difference-in-differences. Therefore, the findings in the summative evaluation report should not be interpreted as causal evidence for the impacts of this demonstration. The state does not claim causality in its interpretation of the findings but should add an explicit reference to the descriptive nature of the results.

As noted above, the evaluation report did not claim causality. Per CMS' request, an explicit reference to the descriptive nature of the results has been added both to the executive summary and methodological limitations section of the report.

4. Consider pooling three years of data, 2016–2018, and reporting results for the pooled sample as the main results.

The state should consider reporting only results from the pooled three-year period in the main text of the report and relegate the results for each individual year to an appendix. The evaluation report currently assesses many outcomes (at least 68) up to three times (2016, 2017, and 2018) each. The state nicely organizes the outcomes by demonstration policy and hypothesis, and then summarizes the high-level findings at the conclusion of each section of results, but the results could be more concisely presented using a pooled sample. Although it is interesting to see trends over three years in some cases, most are flat or display no strong trendline, and therefore reporting results for separate years is not very informative. Pooling multiple years of data would also increase statistical power.

The revised report contains pooled three-year rates for all HEDIS measures, as well as all utilization and cost measures. (The individual year-over-year rates are still available in Appendix 2 of the report.)

5. Correct for multiple comparison tests.

The state currently presents a large number of statistical tests (greater than 200) without noting any kind of statistical correction to account for the risk of false discoveries. Without adjustment for multiple comparisons, this means that several of the findings are likely statistically significant purely by chance.[90] Pooling the three years will reduce the number of hypothesis tests significantly, but the state should also account for multiple comparisons by using correction methods to decrease the likelihood of a false positive.[4]

The revised evaluation report adopts CMS' recommendation of using pooling to reduce the number of discrete hypothesis tests. The state's independent evaluator did not make additional statistical corrections but did include a cautionary note for readers concerning false positives both in the executive summary and methodological limitations section of the report.

6. Consider dropping the comparison to Core Set benchmarks when comparison groups are available.

The Core Set comparison group is very different from the HAN and HMP populations and inferior to the in-state matched comparison group because the state cannot match or regression-adjust the Core Set comparison to make it more similar to the demonstration population. The median value is an interesting benchmark that could be included in the tables for context, but it should not be used as evidence that the demonstration did or did not meet its goals, especially when an in-state comparison group is available.

As noted previously, the national benchmark data is of interest to Oklahoma policymakers when evaluating the relative performance of the state's Medicaid program. (Oklahoma has been a

[90] See the discussion of multiple comparisons here: https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/causal-inference.pdf.

strong supporter of the CMS Scorecard initiative for this same reason.) However, the report has been revised to include cautionary language regarding differences in the Oklahoma waiver and national benchmark populations. This language appears throughout the report whenever benchmark data is presented or discussed.

7. For each demonstration component, provide a concise, high-level summary of relevant results from previous evaluation reports to place analyses in context.

CMS requests that the state add a high-level summary of key evaluation results and their implications, including results from earlier reports. Given that the HAN, HMP, and retroactive eligibility waiver components have been ongoing and largely unchanged for many years, the state should summarize the findings from the previous evaluations alongside new results. This summary should incorporate the level of confidence the evaluators place in different sets of prior results.

The evaluation design used for 2016 – 2018 is based on the latest CMS guidance and differs greatly in comprehensiveness and statistical rigor from earlier evaluations. Going forward, it will be possible to make comparisons across waiver periods for the majority of measures contained in this report.

The retroactive eligibility waiver similarly has changed in terms of covered populations over time. For the current waiver cycle, the OHCA is adopting the design guidelines issued by CMS for such waivers.

Although it would be problematic to link this evaluation formally to prior evaluations, the revised report contains a new appendix with data from the most recent HAN and HMP evaluations pre-dating the 2016 – 2018 evaluation period. The prior period data is compared to corresponding data for the 2016 – 2018 evaluation, where applicable, and summary findings are presented. A link to the section of the OHCA website holding the prior period evaluation reports also is included.

8. Correct minor errors and typos.

There are two minor issues that the state should correct:

a) (p. 26) Exhibit 8a appears to have a typo. The aim is listed as "provide cost effective care" when it should be "improve access and quality." There may also be changes required for the primary and secondary drivers, which look quite similar for both Exhibits 8a and 8b.

b) (p. 84) In exhibit 48, "Tier 2" is listed twice. One of these should likely be "Tier 1."

Corrections made. (Note – primary and secondary drivers in Exhibits 8a and 8b intentionally overlap. The drivers contribute to all three Demonstration aims.)

III. Considerations for future demonstration evaluations

We concur with both of CMS' recommendations below and will work to incorporate them into the next cycle.

9. The state should consider using multiple matching approaches to assess the sensitivity of the results to each set of matching assumptions.

In addition to propensity score matching, the state should consider using another matching algorithm, such as coarsened exact matching, especially if the evaluators continue to use a small number of covariates that can be expressed as categorical variables. Coarsened exact matching and similar techniques are preferred to propensity score matching in cases where there are few matching variables and should be at least considered as a sensitivity check.

10. The state should consider additional variables for the matching process.

Currently, the state uses a small number of demographic characteristics to match demonstration and comparison beneficiaries, but there are more covariates available in Medicaid eligibility and claims data, and in other data sets that can be linked by geographic area such as county or zip code. The state should consider all or some of the following to improve the match quality:

- Beneficiary level: Medicaid eligibility category, beneficiary race, a risk adjustment score such as the Chronic Illness and Disability Payment System (CDPS), chronic condition indicators, and length of continuous Medicaid enrollment.
- Provider practice level: academic affiliation, hospital system affiliation or independent practice, and practice size.
- County, zip code, or Census block group level: median income, poverty rate, education level.

Deviations from Approved Design Measure Set

Measure Reference Number	Population	Measure Description	Notes
7	HAN	Asthma – use of appropriate medications for people with asthma	Measure was retired. Replaced with successor measure – asthma medication ratio
8	HAN	Asthma – medication management for people with asthma – 75 percent	Measure was retired. Replaced with successor measure – asthma medication ratio
18	HAN	Diabetes – percentage of members prescribed ACE/ARB therapy	Measure was retired. No replacement
22	HAN	Hypertension – percentage of members prescribed ACE/ARB therapy or diuretics with annual medication monitoring	Measure was retired. No replacement
26	HAN	Number and percentage of HAN-affiliated PCMH providers who have attained the highest level of OHCA accreditation	Measure calculated based on counts of beneficiaries aligned with PCMH providers at each tier level, rather than PCMH provider counts
33	HMP	Number of PCP contacts (total and per member engaged in health coaching)	Replaced with two HEDIS preventive/ambulatory care measures – child and adolescent access to PCPs – 12 months to 19 years and adult access to preventive/ambulatory health services
36	HMP	Asthma – use of appropriate medications for people with asthma	Measure was retired. Replaced with successor measure – asthma medication ratio
37	HMP	Asthma – medication management for people with asthma – 75 percent	Measure was retired. Replaced with successor measure – asthma medication ratio
38	HMP	Asthma – COPD or asthma in older adults admission rate	Measure was not reported due to sample size concerns. Will be re-examined for summative evaluation
39	HMP	Asthma – asthma in younger adults admission rate	Measure was not reported due to sample size concerns. Will be re-examined for summative evaluation

Measure Reference Number	Population	Measure Description	Notes
42	HMP	CAD – heart failure admission rate	Measure was not reported due to sample size concerns. Will be re-examined for summative evaluation
50	HMP	Diabetes – percentage of members prescribed ACE/ARB therapy	Measure was retired. No replacement
51	HMP	Diabetes – short term complications admission rate	Measure was not reported due to sample size concerns. Will be re-examined for summative evaluation
55	HMP	Hypertension – percentage of members prescribed ACE/ARB therapy or diuretics with annual medication monitoring	Measure was retired. No replacement
56	HMP	Mental Health – follow-up after hospitalization for mental illness – 7 days	Measure was not reported due to sample size concerns. Will be re-examined for summative evaluation
57	HMP	Mental Health – follow-up after hospitalization for mental illness – 30 days	Measure was not reported due to sample size concerns. Will be re-examined for summative evaluation
65	HMP	Rating of personal doctor – children and adults	Measure (survey question) was not asked, as HMP does not influence choice of doctor
69	Insure OK	Number of individuals enrolled in Insure OK	Enrollment data included in Background section of report. Measure not reported in Results due to phase-out of majority of program following eligibility expansion
70	Insure OK	Number of employers participating in the ESI portion of Insure OK	Participation data included in Background section of report. Measure not reported in Results due to phase-out of majority of program following eligibility expansion
71	Insure OK	PCPs participating in the Individual Plan portion of Insure OK	Not evaluated

Measure Reference Number	Population	Measure Description	Notes
74	Retroactive Eligibility	Probability of completing the renewal (recertification) process, by eligibility group	Data not available for interim evaluation. Will be included in summative evaluation if obtainable
75	Retroactive Eligibility	Probability of remaining enrolled in Medicaid for 12-, 18-, 12-consecutive months, by eligibility group	Not evaluated due to suspension of most disenrollments under PHE. Will be evaluated for post-PHE period and included in summative evaluation report
76	Retroactive Eligibility	Number of months with Medicaid coverage (average tenure)	Not evaluated due to suspension of most disenrollments under PHE. Will be evaluated for post-PHE period and included in summative evaluation report
77	Retroactive Eligibility	Probability of re-enrolling in Medicaid after a gap in coverage of six months	Not evaluated due to suspension of most disenrollments under PHE. Will be evaluated for post-PHE period and included in summative evaluation report
78	Retroactive Eligibility	Number of months without Medicaid coverage, up to six months	Not evaluated due to suspension of most disenrollments under PHE. Will be evaluated for post-PHE period and included in summative evaluation report

2. HAN CEM Covariate Balance Tables (Pre- and Post-Matching) 2019 - 2021

HEALTH ACCESS NETWORKS - TOTAL - STATEWIDE	2019 All Data (pre-balancing)			2019 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	**HAN General Mean**	**Comparison Mean**	**Standardized Difference**	**HAN General Mean**	**Comparison Mean**	**Standardized Difference**
HEDIS Measures						
Asthma - Medication Ratio - 5 to 18 years						
Age	10.902	11.073	-0.044	10.902	12.290	0.000
Gender (0 = male; 1 = female)	0.487	0.493	-0.011	0.487	0.487	0.000
Urban/Rural (0 = urban; 1 = rural)	0.230	0.581	-0.835	0.230	0.230	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.046	0.038	0.039	0.046	0.046	0.000
Asthma - Medication Ratio - 19 to 64 years						
Age	38.623	38.670	-0.004	38.623	38.621	0.000
Sex (0 = male; 1 = female)	0.702	0.689	0.030	0.702	0.702	0.000
Urban/Rural (0 = urban; 1 = rural)	0.235	0.600	-0.860	0.235	0.235	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.440	0.428	0.024	0.440	0.440	0.000
CAD - Persistent Beta-Blocker Treatment after a Heart Attack						
Age	54.160	54.758	-0.071	54.489	54.514	-0.003
Sex (0 = male; 1 = female)	0.446	0.526	-0.160	0.450	0.450	0.000
Urban/Rural (0 = urban; 1 = rural)	0.241	0.620	-0.888	0.239	0.239	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.850	0.831	0.053	0.855	0.855	0.000
CAD - Cholesterol Management - LDL-C Test	*Same population as CAD Beta Blocker*			*Same population as CAD Beta Blocker*		
Age	54.160	54.758	-0.071	54.489	54.514	-0.003
Sex (0 = male; 1 = female)	0.446	0.526	-0.160	0.450	0.450	0.000
Urban/Rural (0 = urban; 1 = rural)	0.241	0.620	-0.888	0.239	0.239	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.850	0.831	0.053	0.855	0.855	0.000

HEALTH ACCESS NETWORKS - TOTAL - STATEWIDE	2019 All Data (pre-balancing)			2019 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	**HAN General Mean**	**Comparison Mean**	**Standardized Difference**	**HAN General Mean**	**Comparison Mean**	**Standardized Difference**
HEDIS Measures						
COPD - Use of Spirometry Testing						
Age	43.993	46.804	-0.151	44.343	44.392	-0.003
Sex (0 = male; 1 = female)	0.622	0.626	-0.008	0.623	0.623	0.000
Urban/Rural (0 = urban; 1 = rural)	0.246	0.648	-0.934	0.244	0.244	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.648	0.656	-0.016	0.648	0.648	0.000
COPD - Pharmacotherapy Management of Exacerbation - 14 days						
Age	54.674	52.715	0.224	55.023	54.987	0.004
Sex (0 = male; 1 = female)	0.639	0.684	-0.093	0.653	0.653	0.000
Urban/Rural (0 = urban; 1 = rural)	0.274	0.630	-0.797	0.275	0.275	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.878	0.837	0.127	0.901	0.901	0.000
COPD - Pharmacotherapy Management of Exacerbation - 30 days	*Same population as 14 days*			*Same population as 14 days*		
Age	54.674	52.715	0.224	55.023	54.987	0.004
Sex (0 = male; 1 = female)	0.639	0.684	-0.093	0.653	0.653	0.000
Urban/Rural (0 = urban; 1 = rural)	0.274	0.630	-0.797	0.275	0.275	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.878	0.837	0.127	0.901	0.901	0.000
Diabetes - Members who had LDL-C Test						
Age	47.353	47.676	-0.027	47.411	47.359	0.004
Sex (0 = male; 1 = female)	0.653	0.652	0.002	0.654	0.654	0.000
Urban/Rural (0 = urban; 1 = rural)	0.237	0.617	-0.895	0.238	0.238	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.667	0.688	-0.046	0.669	0.669	0.000
Diabetes - Retinal Eye Exam	*Same population as LDL-C*			*Same population as LDL-C*		
Age	47.353	47.676	-0.027	47.411	47.359	0.004
Sex (0 = male; 1 = female)	0.653	0.652	0.002	0.654	0.654	0.000
Urban/Rural (0 = urban; 1 = rural)	0.237	0.617	-0.895	0.238	0.238	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.667	0.688	-0.046	0.669	0.669	0.000

HEALTH ACCESS NETWORKS - TOTAL - STATEWIDE	2019 All Data (pre-balancing)			2019 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	**HAN General Mean**	**Comparison Mean**	**Standardized Difference**	**HAN General Mean**	**Comparison Mean**	**Standardized Difference**
HEDIS Measures						
Diabetes - HbA1c Testing	*Same population as LDL-C*			*Same population as LDL-C*		
Age	47.353	47.676	-0.027	47.411	47.359	0.004
Sex (0 = male; 1 = female)	0.653	0.652	0.002	0.654	0.654	0.000
Urban/Rural (0 = urban; 1 = rural)	0.237	0.617	-0.895	0.238	0.238	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.667	0.688	-0.046	0.669	0.669	0.000
Diabetes - Medical Attention for Nephropathy	*Same population as LDL-C*			*Same population as LDL-C*		
Age	47.353	47.676	-0.027	47.411	47.359	0.004
Sex (0 = male; 1 = female)	0.653	0.652	0.002	0.654	0.654	0.000
Urban/Rural (0 = urban; 1 = rural)	0.237	0.617	-0.895	0.238	0.238	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.667	0.688	-0.046	0.669	0.669	0.000
Hypertension - LDL-C Test						
Age	49.262	49.071	0.017	49.245	49.247	0.000
Sex (0 = male; 1 = female)	0.623	0.612	0.023	0.623	0.623	0.000
Urban/Rural (0 = urban; 1 = rural)	0.231	0.607	-0.892	0.231	0.231	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.689	0.684	0.010	0.688	0.688	0.000
Hypertension - ACE/ARB Therapy	*Same population as LDL-C*			*Same population as LDL-C*		
Age	49.262	49.071	0.017	49.245	49.247	0.000
Sex (0 = male; 1 = female)	0.623	0.612	0.023	0.623	0.623	0.000
Urban/Rural (0 = urban; 1 = rural)	0.231	0.607	-0.892	0.231	0.231	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.689	0.684	0.010	0.688	0.688	0.000
Mental Health - Follow-up after Hospitalization - 7 days - 6 to 20						
Age	13.662	14.213	-0.178	13.687	13.719	-0.010
Sex (0 = male; 1 = female)	0.527	0.558	-0.061	0.527	0.527	0.000
Urban/Rural (0 = urban; 1 = rural)	0.254	0.518	-0.607	0.255	0.255	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.150	0.145	0.015	0.141	0.141	0.000

HEALTH ACCESS NETWORKS - TOTAL - STATEWIDE	2019 All Data (pre-balancing)			2019 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	**HAN General Mean**	**Comparison Mean**	**Standardized Difference**	**HAN General Mean**	**Comparison Mean**	**Standardized Difference**
HEDIS Measures						
Mental Health - Follow-up after Hospitalization - 7 days - 21 and older						
Age	41.437	41.238	0.017	41.413	41.335	0.007
Sex (0 = male; 1 = female)	0.665	0.653	0.024	0.677	0.677	0.000
Urban/Rural (0 = urban; 1 = rural)	0.234	0.452	-0.513	0.232	0.232	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.741	0.694	0.107	0.755	0.755	0.000
Mental Health - Follow-up after Hospitalization - 30 days - 6 to 20	*Same population as 7 days - 6 to 20*			*Same population as 7 days - 6 to 20*		
Age	13.662	14.213	-0.178	13.687	13.719	-0.010
Sex (0 = male; 1 = female)	0.527	0.558	-0.061	0.527	0.527	0.000
Urban/Rural (0 = urban; 1 = rural)	0.254	0.518	-0.607	0.255	0.255	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.150	0.145	0.015	0.141	0.141	0.000
Mental Health - Follow-up after Hospitalization - 30 days - 21 and older	*Same population as 7 days - 21 and older*			*Same population as 7 days - 21 and older*		
Age	41.437	41.238	0.017	41.413	41.335	0.007
Sex (0 = male; 1 = female)	0.665	0.653	0.024	0.677	0.677	0.000
Urban/Rural (0 = urban; 1 = rural)	0.234	0.452	-0.513	0.232	0.232	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.741	0.694	0.107	0.755	0.755	0.000
Child and Adolescents' Access to PCP - 12 months to 19 years						
Age	8.777	9.025	-0.049	8.777	8.777	0.000
Sex (0 = male; 1 = female)	0.487	0.492	-0.010	0.487	0.487	0.000
Urban/Rural (0 = urban; 1 = rural)	0.232	0.576	-0.816	0.232	0.232	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.039	0.033	0.031	0.039	0.039	0.000
Adults' Access to Preventive/Ambulatory Health Services						
Age	39.736	39.761	-0.002	39.731	39.742	-0.001
Sex (0 = male; 1 = female)	0.708	0.694	0.032	0.708	0.708	0.000
Urban/Rural (0 = urban; 1 = rural)	0.235	0.598	-0.857	0.235	0.235	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.453	0.441	0.024	0.453	0.453	0.000

HEALTH ACCESS NETWORKS - TOTAL - STATEWIDE	2019 All Data (pre-balancing)			2019 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	**HAN General Mean**	**Comparison Mean**	**Standardized Difference**	**HAN General Mean**	**Comparison Mean**	**Standardized Difference**
Utilization/Expenditure Measures						
Emergency Room Visits (per 1,000 member months) - All						
Age	12.656	13.419	-0.066	12.642	12.653	0.000
Sex	0.508	0.518	-0.019	0.508	0.508	0.000
Urban/Rural	0.224	0.564	-0.816	0.224	0.224	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.097	0.098	-0.002	0.097	0.097	0.000
Hospital Admissions (per 100,000 member months) - All	*Same population as ER visits*			*Same population as ER visits*		
Age	12.656	13.419	-0.066	12.642	12.653	0.000
Sex	0.508	0.518	-0.019	0.508	0.508	0.000
Urban/Rural	0.224	0.564	-0.816	0.224	0.224	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.097	0.098	-0.002	0.097	0.097	0.000
Per Member Per Month Expenditures - All	*Same population as ER visits*			*Same population as ER visits*		
Age	12.656	13.419	-0.066	12.642	12.653	0.000
Sex	0.508	0.518	-0.019	0.508	0.508	0.000
Urban/Rural	0.224	0.564	-0.816	0.224	0.224	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.097	0.098	-0.002	0.097	0.097	0.000

HEALTH ACCESS NETWORKS - TOTAL - STATEWIDE	2020 All Data (pre-balancing)			2020 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	**HAN General Mean**	**Comparison Mean**	**Standardized Difference**	**HAN General Mean**	**Comparison Mean**	**Standardized Difference**
HEDIS Measures						
Asthma - Medication Ratio - 5 to 18 years						
Age	10.949	11.139	-0.048	10.949	10.949	0.000
Gender (0 = male; 1 = female)	0.487	0.492	-0.010	0.487	0.487	0.000
Urban/Rural (0 = urban; 1 = rural)	0.224	0.576	-0.845	0.224	0.224	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.042	0.034	0.039	0.042	0.042	0.000
Asthma - Medication Ratio - 19 to 64 years						
Age	34.995	35.222	-0.018	34.995	34.987	0.001
Sex (0 = male; 1 = female)	0.707	0.699	0.016	0.707	0.707	0.000
Urban/Rural (0 = urban; 1 = rural)	0.240	0.580	-0.798	0.240	0.240	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.309	0.285	0.052	0.309	0.309	0.000
CAD - Persistent Beta-Blocker Treatment after a Heart Attack						
Age	54.331	55.551	-0.139	54.651	54.751	-0.006
Sex (0 = male; 1 = female)	0.484	0.509	-0.050	0.488	0.488	0.000
Urban/Rural (0 = urban; 1 = rural)	0.290	0.623	-0.734	0.291	0.291	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.814	0.824	-0.025	0.817	0.817	0.000
CAD - Cholesterol Management - LDL-C Test	*Same population as CAD Beta Blocker*			*Same population as CAD Beta Blocker*		
Age	54.331	55.551	-0.139	54.651	54.751	-0.006
Sex (0 = male; 1 = female)	0.484	0.509	-0.050	0.488	0.488	0.000
Urban/Rural (0 = urban; 1 = rural)	0.290	0.623	-0.734	0.291	0.291	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.814	0.824	-0.025	0.817	0.817	0.000

HEALTH ACCESS NETWORKS - TOTAL - STATEWIDE	2020 All Data (pre-balancing)			2020 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	**HAN General Mean**	**Comparison Mean**	**Standardized Difference**	**HAN General Mean**	**Comparison Mean**	**Standardized Difference**
HEDIS Measures						
COPD - Use of Spirometry Testing						
Age	27.767	37.031	-0.405	27.804	27.815	-0.001
Sex (0 = male; 1 = female)	0.502	0.553	-0.102	0.504	0.504	0.000
Urban/Rural (0 = urban; 1 = rural)	0.239	0.611	-0.874	0.241	0.241	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.401	0.527	-0.257	0.397	0.397	0.000
COPD - Pharmacotherapy Management of Exacerbation - 14 days						
Age	52.310	53.066	-0.075	53.719	53.871	-0.015
Sex (0 = male; 1 = female)	0.652	0.645	0.015	0.685	0.685	0.000
Urban/Rural (0 = urban; 1 = rural)	0.228	0.585	-0.851	0.233	0.233	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.798	0.821	-0.058	0.815	0.815	0.000
COPD - Pharmacotherapy Management of Exacerbation - 30 days	*Same population as 14 days*			*Same population as 14 days*		
Age	52.310	53.066	-0.075	53.719	53.871	-0.015
Sex (0 = male; 1 = female)	0.652	0.645	0.015	0.685	0.685	0.000
Urban/Rural (0 = urban; 1 = rural)	0.228	0.585	-0.851	0.233	0.233	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.798	0.821	-0.058	0.815	0.815	0.000
Diabetes - Members who had LDL-C Test						
Age	46.382	46.351	0.003	46.420	46.398	0.002
Sex (0 = male; 1 = female)	0.659	0.667	-0.017	0.660	0.660	0.000
Urban/Rural (0 = urban; 1 = rural)	0.244	0.597	-0.821	0.245	0.245	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.601	0.586	0.030	0.602	0.602	0.000
Diabetes - Retinal Eye Exam	*Same population as LDL-C*			*Same population as LDL-C*		
Age	46.382	46.351	0.003	46.420	46.398	0.002
Sex (0 = male; 1 = female)	0.659	0.667	-0.017	0.660	0.660	0.000
Urban/Rural (0 = urban; 1 = rural)	0.244	0.597	-0.821	0.245	0.245	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.601	0.586	0.030	0.602	0.602	0.000

HEALTH ACCESS NETWORKS - TOTAL - STATEWIDE	2020 All Data (pre-balancing)			2020 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	**HAN General Mean**	**Comparison Mean**	**Standardized Difference**	**HAN General Mean**	**Comparison Mean**	**Standardized Difference**
HEDIS Measures						
Diabetes - HbA1c Testing	*Same population as LDL-C*			*Same population as LDL-C*		
Age	46.382	46.351	0.003	46.420	46.398	0.002
Sex (0 = male; 1 = female)	0.659	0.667	-0.017	0.660	0.660	0.000
Urban/Rural (0 = urban; 1 = rural)	0.244	0.597	-0.821	0.245	0.245	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.601	0.586	0.030	0.602	0.602	0.000
Diabetes - Medical Attention for Nephropathy	*Same population as LDL-C*			*Same population as LDL-C*		
Age	46.382	46.351	0.003	46.420	46.398	0.002
Sex (0 = male; 1 = female)	0.659	0.667	-0.017	0.660	0.660	0.000
Urban/Rural (0 = urban; 1 = rural)	0.244	0.597	-0.821	0.245	0.245	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.601	0.586	0.030	0.602	0.602	0.000
Hypertension - LDL-C Test						
Age	48.229	47.621	0.053	48.221	48.226	0.000
Sex (0 = male; 1 = female)	0.630	0.624	0.013	0.630	0.630	0.000
Urban/Rural (0 = urban; 1 = rural)	0.236	0.588	-0.830	0.236	0.236	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.620	0.584	0.075	0.620	0.620	0.000
Hypertension - ACE/ARB Therapy	*Same population as LDL-C*			*Same population as LDL-C*		
Age	48.229	47.621	0.053	48.221	48.226	0.000
Sex (0 = male; 1 = female)	0.630	0.624	0.013	0.630	0.630	0.000
Urban/Rural (0 = urban; 1 = rural)	0.236	0.588	-0.830	0.236	0.236	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.620	0.584	0.075	0.620	0.620	0.000
Mental Health - Follow-up after Hospitalization - 7 days - 6 to 20						
Age	14.221	14.713	-0.163	14.334	14.332	0.001
Sex (0 = male; 1 = female)	0.593	0.597	-0.008	0.608	0.608	0.000
Urban/Rural (0 = urban; 1 = rural)	0.255	0.570	-0.723	0.262	0.262	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.130	0.115	0.047	0.097	0.097	0.000

HEALTH ACCESS NETWORKS - TOTAL - STATEWIDE	2020 All Data (pre-balancing)			2020 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	**HAN General Mean**	**Comparison Mean**	**Standardized Difference**	**HAN General Mean**	**Comparison Mean**	**Standardized Difference**
HEDIS Measures						
Mental Health - Follow-up after Hospitalization - 7 days - 21 and older						
Age	41.840	38.969	0.206	41.400	41.203	0.014
Sex (0 = male; 1 = female)	0.733	0.620	0.256	0.757	0.757	0.000
Urban/Rural (0 = urban; 1 = rural)	0.267	0.519	-0.572	0.229	0.229	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.653	0.659	-0.012	0.657	0.657	0.000
Mental Health - Follow-up after Hospitalization - 30 days - 6 to 20	*Same population as 7 days - 6 to 20*			*Same population as 7 days - 6 to 20*		
Age	14.221	14.713	-0.163	14.334	14.332	0.001
Sex (0 = male; 1 = female)	0.593	0.597	-0.008	0.608	0.608	0.000
Urban/Rural (0 = urban; 1 = rural)	0.255	0.570	-0.723	0.262	0.262	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.130	0.115	0.047	0.097	0.097	0.000
Mental Health - Follow-up after Hospitalization - 30 days - 21 and older	*Same population as 7 days - 21 and older*			*Same population as 7 days - 21 and older*		
Age	41.840	38.969	0.206	41.400	41.203	0.014
Sex (0 = male; 1 = female)	0.733	0.620	0.256	0.757	0.757	0.000
Urban/Rural (0 = urban; 1 = rural)	0.267	0.519	-0.572	0.229	0.229	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.653	0.659	-0.012	0.657	0.657	0.000
Child and Adolescents' Access to PCP - 12 months to 19 years						
Age	8.938	9.254	-0.060	8.938	8.938	0.000
Sex (0 = male; 1 = female)	0.487	0.493	-0.012	0.487	0.487	0.000
Urban/Rural (0 = urban; 1 = rural)	0.225	0.574	-0.835	0.225	0.225	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.035	0.029	0.033	0.035	0.035	0.000
Adults' Access to Preventive/Ambulatory Health Services						
Age	37.833	37.771	0.005	37.832	37.845	-0.011
Sex (0 = male; 1 = female)	0.739	0.725	0.031	0.739	0.739	0.000
Urban/Rural (0 = urban; 1 = rural)	0.240	0.578	-0.792	0.240	0.240	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.351	0.320	0.066	0.351	0.351	0.000

HEALTH ACCESS NETWORKS - TOTAL - STATEWIDE	2020 All Data (pre-balancing)			2020 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	**HAN General Mean**	**Comparison Mean**	**Standardized Difference**	**HAN General Mean**	**Comparison Mean**	**Standardized Difference**
Utilization/Expenditure Measures						
Emergency Room Visits (per 1,000 member months) - All						
Age	12.444	13.515	-0.098	12.430	12.446	-0.001
Sex	0.509	0.519	-0.019	0.509	0.509	0.000
Urban/Rural	0.222	0.574	-0.848	0.222	0.222	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.084	0.087	-0.010	0.084	0.084	0.000
Hospital Admissions (per 100,000 member months) - All	*Same population as ER visits*			*Same population as ER visits*		
Age	12.444	13.515	-0.098	12.430	12.446	-0.001
Sex	0.509	0.519	-0.019	0.509	0.509	0.000
Urban/Rural	0.222	0.574	-0.848	0.222	0.222	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.084	0.087	-0.010	0.084	0.084	0.000
Per Member Per Month Expenditures - All	*Same population as ER visits*			*Same population as ER visits*		
Age	12.444	13.515	-0.098	12.430	12.446	-0.001
Sex	0.509	0.519	-0.019	0.509	0.509	0.000
Urban/Rural	0.222	0.574	-0.848	0.222	0.222	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.084	0.087	-0.010	0.084	0.084	0.000

HEALTH ACCESS NETWORKS - TOTAL - STATEWIDE	2021 All Data (pre-balancing)			2021 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	**HAN General Mean**	**Comparison Mean**	**Standardized Difference**	**HAN General Mean**	**Comparison Mean**	**Standardized Difference**
HEDIS Measures						
Asthma - Medication Ratio - 5 to 18 years						
Age	11.077	11.257	-0.045	11.077	11.077	0.000
Gender (0 = male; 1 = female)	0.487	0.491	-0.008	0.487	0.487	0.000
Urban/Rural (0 = urban; 1 = rural)	0.232	0.589	-0.846	0.232	0.232	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.037	0.029	0.042	0.037	0.037	0.000
Asthma - Medication Ratio - 19 to 64 years						
Age	33.535	33.357	0.014	33.535	33.462	0.006
Sex (0 = male; 1 = female)	0.671	0.688	-0.035	0.671	0.671	0.000
Urban/Rural (0 = urban; 1 = rural)	0.245	0.594	-0.811	0.245	0.245	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.137	0.233	-0.276	0.137	0.137	0.000
CAD - Persistent Beta-Blocker Treatment after a Heart Attack						
Age	55.207	55.940	-0.085	55.244	55.524	-0.001
Sex (0 = male; 1 = female)	0.499	0.501	-0.005	0.501	0.501	0.000
Urban/Rural (0 = urban; 1 = rural)	0.232	0.622	-0.923	0.238	0.238	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.814	0.824	-0.025	0.817	0.817	0.000
CAD - Cholesterol Management - LDL-C Test	*Same population as CAD Beta Blocker*			*Same population as CAD Beta Blocker*		
Age	55.207	55.940	-0.085	55.244	55.524	-0.001
Sex (0 = male; 1 = female)	0.499	0.501	-0.005	0.501	0.501	0.000
Urban/Rural (0 = urban; 1 = rural)	0.232	0.622	-0.923	0.238	0.238	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.814	0.824	-0.025	0.817	0.817	0.000

HEALTH ACCESS NETWORKS - TOTAL - STATEWIDE	2021 All Data (pre-balancing)			2021 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	**HAN General Mean**	**Comparison Mean**	**Standardized Difference**	**HAN General Mean**	**Comparison Mean**	**Standardized Difference**
HEDIS Measures						
COPD - Use of Spirometry Testing						
Age	54.876	53.918	0.135	54.822	54.713	0.015
Sex (0 = male; 1 = female)	0.614	0.629	-0.030	0.614	0.614	0.000
Urban/Rural (0 = urban; 1 = rural)	0.280	0.671	-0.871	0.280	0.280	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.401	0.527	-0.257	0.397	0.397	0.000
COPD - Pharmacotherapy Management of Exacerbation - 14 days						
Age	55.812	56.097	-0.041	55.975	55.952	0.003
Sex (0 = male; 1 = female)	0.633	0.659	-0.056	0.690	0.690	0.000
Urban/Rural (0 = urban; 1 = rural)	0.269	0.633	-0.820	0.285	0.285	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.798	0.821	-0.058	0.815	0.815	0.000
COPD - Pharmacotherapy Management of Exacerbation - 30 days	*Same population as 14 days*			*Same population as 14 days*		
Age	55.812	56.097	-0.041	55.975	55.952	0.003
Sex (0 = male; 1 = female)	0.633	0.659	-0.056	0.690	0.690	0.000
Urban/Rural (0 = urban; 1 = rural)	0.269	0.633	-0.820	0.285	0.285	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.798	0.821	-0.058	0.815	0.815	0.000
Diabetes - Members who had LDL-C Test						
Age	46.478	46.105	0.030	46.462	46.443	0.002
Sex (0 = male; 1 = female)	0.657	0.677	-0.041	0.657	0.657	0.000
Urban/Rural (0 = urban; 1 = rural)	0.260	0.618	-0.815	0.260	0.260	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.601	0.586	0.030	0.602	0.602	0.000
Diabetes - Retinal Eye Exam	*Same population as LDL-C*			*Same population as LDL-C*		
Age	46.478	46.105	0.030	46.462	46.443	0.002
Sex (0 = male; 1 = female)	0.657	0.677	-0.041	0.657	0.657	0.000
Urban/Rural (0 = urban; 1 = rural)	0.260	0.618	-0.815	0.260	0.260	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.601	0.586	0.030	0.602	0.602	0.000

HEALTH ACCESS NETWORKS - TOTAL - STATEWIDE	2021 All Data (pre-balancing)			2021 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	**HAN General Mean**	**Comparison Mean**	**Standardized Difference**	**HAN General Mean**	**Comparison Mean**	**Standardized Difference**
HEDIS Measures						
Diabetes - HbA1c Testing	*Same population as LDL-C*			*Same population as LDL-C*		
Age	46.478	46.105	0.030	46.462	46.443	0.002
Sex (0 = male; 1 = female)	0.657	0.677	-0.041	0.657	0.657	0.000
Urban/Rural (0 = urban; 1 = rural)	0.260	0.618	-0.815	0.260	0.260	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.601	0.586	0.030	0.602	0.602	0.000
Diabetes - Medical Attention for Nephropathy	*Same population as LDL-C*			*Same population as LDL-C*		
Age	46.478	46.105	0.030	46.462	46.443	0.002
Sex (0 = male; 1 = female)	0.657	0.677	-0.041	0.657	0.657	0.000
Urban/Rural (0 = urban; 1 = rural)	0.260	0.618	-0.815	0.260	0.260	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.601	0.586	0.030	0.602	0.602	0.000
Hypertension - LDL-C Test						
Age	48.794	48.613	0.016	48.787	48.740	0.004
Sex (0 = male; 1 = female)	0.639	0.617	0.046	0.639	0.639	0.000
Urban/Rural (0 = urban; 1 = rural)	0.246	0.610	-0.847	0.246	0.246	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.620	0.584	0.075	0.620	0.620	0.000
Hypertension - ACE/ARB Therapy	*Same population as LDL-C*			*Same population as LDL-C*		
Age	48.794	48.613	0.016	48.787	48.740	0.004
Sex (0 = male; 1 = female)	0.639	0.617	0.046	0.639	0.639	0.000
Urban/Rural (0 = urban; 1 = rural)	0.246	0.610	-0.847	0.246	0.246	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.620	0.584	0.075	0.620	0.620	0.000
Mental Health - Follow-up after Hospitalization - 7 days - 6 to 20						
Age	15.045	15.235	-0.064	15.165	15.148	0.006
Sex (0 = male; 1 = female)	0.655	0.612	0.091	0.655	0.655	0.000
Urban/Rural (0 = urban; 1 = rural)	0.250	0.565	-0.728	0.251	0.251	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.111	0.069	0.134	0.093	0.093	0.000

HEALTH ACCESS NETWORKS - TOTAL - STATEWIDE	2021 All Data (pre-balancing)			2021 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	HAN General Mean	Comparison Mean	Standardized Difference	HAN General Mean	Comparison Mean	Standardized Difference
HEDIS Measures						
Mental Health - Follow-up after Hospitalization - 7 days - 21 and older						
Age	38.102	38.785	-0.057	37.364	37.461	-0.008
Sex (0 = male; 1 = female)	0.656	0.667	-0.024	0.672	0.672	0.000
Urban/Rural (0 = urban; 1 = rural)	0.175	0.515	-0.895	0.178	0.178	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.432	0.590	-0.318	0.455	0.455	0.000
Mental Health - Follow-up after Hospitalization - 30 days - 6 to 20	*Same population as 7 days - 6 to 20*			*Same population as 7 days - 6 to 20*		
Age	15.045	15.235	-0.064	15.165	15.148	0.006
Sex (0 = male; 1 = female)	0.655	0.612	0.091	0.655	0.655	0.000
Urban/Rural (0 = urban; 1 = rural)	0.250	0.565	-0.728	0.251	0.251	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.111	0.069	0.134	0.093	0.093	0.000
Mental Health - Follow-up after Hospitalization - 30 days - 21 and older	*Same population as 7 days - 21 and older*			*Same population as 7 days - 21 and older*		
Age	38.102	38.785	-0.057	37.364	37.461	-0.008
Sex (0 = male; 1 = female)	0.656	0.667	-0.024	0.672	0.672	0.000
Urban/Rural (0 = urban; 1 = rural)	0.175	0.515	-0.895	0.178	0.178	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.432	0.590	-0.318	0.455	0.455	0.000
Child and Adolescents' Access to PCP - 12 months to 19 years						
Age	9.623	9.832	-0.039	9.623	9.623	0.000
Sex (0 = male; 1 = female)	0.488	0.492	-0.008	0.488	0.488	0.000
Urban/Rural (0 = urban; 1 = rural)	0.235	0.587	-0.831	0.235	0.235	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.035	0.029	0.033	0.035	0.035	0.000
Adults' Access to Preventive/Ambulatory Health Services						
Age	36.201	37.063	-0.071	36.196	36.198	0.000
Sex (0 = male; 1 = female)	0.697	0.729	-0.069	0.697	0.697	0.000
Urban/Rural (0 = urban; 1 = rural)	0.246	0.594	-0.807	0.246	0.246	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.351	0.320	0.066	0.351	0.351	0.000

HEALTH ACCESS NETWORKS - TOTAL - STATEWIDE	2021 All Data (pre-balancing)			2021 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	**HAN General Mean**	**Comparison Mean**	**Standardized Difference**	**HAN General Mean**	**Comparison Mean**	**Standardized Difference**
Utilization/Expenditure Measures						
Emergency Room Visits (per 1,000 member months) - All						
Age	12.830	13.992	-0.108	12.817	12.827	-0.001
Sex	0.513	0.524	-0.023	0.513	0.513	0.000
Urban/Rural	0.225	0.588	-0.869	0.225	0.225	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.078	0.078	-0.001	0.077	0.077	0.000
Hospital Admissions (per 100,000 member months) - All	*Same population as ER visits*			*Same population as ER visits*		
Age	12.830	13.992	-0.108	12.817	12.827	-0.001
Sex	0.513	0.524	-0.023	0.513	0.513	0.000
Urban/Rural	0.225	0.588	-0.869	0.225	0.225	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.078	0.078	-0.001	0.077	0.077	0.000
Per Member Per Month Expenditures - All	*Same population as ER visits*			*Same population as ER visits*		
Age	12.830	13.992	-0.108	12.817	12.827	-0.001
Sex	0.513	0.524	-0.023	0.513	0.513	0.000
Urban/Rural	0.225	0.588	-0.869	0.225	0.225	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.078	0.078	-0.001	0.077	0.077	0.000

HEALTH ACCESS NETWORKS - CM - STATEWIDE	2019 All Data (pre-balancing)			2019 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	HAN CM Mean	Comparison Mean	Standardized Difference	HAN CM Mean	Comparison Mean	Standardized Difference
HEDIS Measures						
Asthma - Medication Ratio - 5 to 18 years						
Age	10.401	11.073	-0.171	10.401	10.401	0.000
Gender (0 = male; 1 = female)	0.481	0.493	-0.024	0.481	0.481	0.000
Urban/Rural (0 = urban; 1 = rural)	0.202	0.581	-0.945	0.202	0.202	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.227	0.038	0.452	0.227	0.227	0.000
Asthma - Medication Ratio - 19 to 64 years						
Age	45.766	38.670	0.550	45.766	45.692	0.006
Sex (0 = male; 1 = female)	0.676	0.689	-0.027	0.676	0.676	0.000
Urban/Rural (0 = urban; 1 = rural)	0.192	0.600	-1.038	0.192	0.192	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.787	0.428	0.879	0.787	0.787	0.000
CAD - Persistent Beta-Blocker Treatment after a Heart Attack						
Age	54.294	54.758	-0.054	54.294	54.078	0.025
Sex (0 = male; 1 = female)	0.549	0.526	0.047	0.549	0.549	0.000
Urban/Rural (0 = urban; 1 = rural)	0.177	0.620	-1.163	0.177	0.177	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.902	0.831	0.240	0.902	0.902	0.000
CAD - Cholesterol Management - LDL-C Test	*Same population as CAD Beta Blocker*			*Same population as CAD Beta Blocker*		
Age	54.294	54.758	-0.054	54.294	54.078	0.025
Sex (0 = male; 1 = female)	0.549	0.526	0.047	0.549	0.549	0.000
Urban/Rural (0 = urban; 1 = rural)	0.177	0.620	-1.163	0.177	0.177	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.902	0.831	0.240	0.902	0.902	0.000

HEALTH ACCESS NETWORKS - CM - STATEWIDE	2019 All Data (pre-balancing)			2019 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	**HAN CM Mean**	**Comparison Mean**	**Standardized Difference**	**HAN CM Mean**	**Comparison Mean**	**Standardized Difference**
HEDIS Measures						
COPD - Use of Spirometry Testing						
Age	50.208	46.804	0.204	50.208	50.279	-0.004
Sex (0 = male; 1 = female)	0.625	0.626	-0.002	0.625	0.625	0.000
Urban/Rural (0 = urban; 1 = rural)	0.333	0.648	-0.667	0.333	0.333	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.917	0.656	0.944	0.917	0.917	0.000
COPD - Pharmacotherapy Management of Exacerbation - 14 days						
Age	55.966	52.715	0.508	55.966	55.775	0.030
Sex (0 = male; 1 = female)	0.621	0.684	-0.130	0.621	0.621	0.000
Urban/Rural (0 = urban; 1 = rural)	0.345	0.630	-0.599	0.345	0.345	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.966	0.837	0.706	0.966	0.966	0.000
COPD - Pharmacotherapy Management of Exacerbation - 30 days	*Same population as 14 days*			*Same population as 14 days*		
Age	55.966	52.715	0.508	55.966	55.775	0.030
Sex (0 = male; 1 = female)	0.621	0.684	-0.130	0.621	0.621	0.000
Urban/Rural (0 = urban; 1 = rural)	0.345	0.630	-0.599	0.345	0.345	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.966	0.837	0.706	0.966	0.966	0.000
Diabetes - Members who had LDL-C Test						
Age	50.420	47.676	0.268	50.420	50.507	1.006
Sex (0 = male; 1 = female)	0.618	0.652	-0.069	0.618	0.618	0.000
Urban/Rural (0 = urban; 1 = rural)	0.153	0.617	-1.292	0.153	0.153	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.878	0.688	0.579	0.878	0.878	0.000
Diabetes - Retinal Eye Exam	*Same population as LDL-C*			*Same population as LDL-C*		
Age	50.420	47.676	0.268	50.420	50.507	1.006
Sex (0 = male; 1 = female)	0.618	0.652	-0.069	0.618	0.618	0.000
Urban/Rural (0 = urban; 1 = rural)	0.153	0.617	-1.292	0.153	0.153	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.878	0.688	0.579	0.878	0.878	0.000

HEALTH ACCESS NETWORKS - CM - STATEWIDE	2019 All Data (pre-balancing)			2019 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	HAN CM Mean	Comparison Mean	Standardized Difference	HAN CM Mean	Comparison Mean	Standardized Difference
HEDIS Measures						
Child and Adolescents' Access to PCP - 12 months to 19 years						
Age	7.453	9.025	-0.306	7.453	0.000	0.000
Sex (0 = male; 1 = female)	0.481	0.492	-0.022	0.481	0.000	4.158
Urban/Rural (0 = urban; 1 = rural)	0.209	0.576	-0.904	0.209	0.000	9.592
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.193	0.033	0.407	0.193	0.000	10.357
Adults' Access to Preventive/Ambulatory Health Services						
Age	46.481	39.761	0.542	46.481	46.474	0.001
Sex (0 = male; 1 = female)	0.678	0.694	-0.034	0.678	0.678	0.000
Urban/Rural (0 = urban; 1 = rural)	0.191	0.598	-1.037	0.191	0.191	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.796	0.441	0.881	0.796	0.796	0.000

HEALTH ACCESS NETWORKS - CM - STATEWIDE	2019 All Data (pre-balancing)			2019 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	HAN CM Mean	Comparison Mean	Standardized Difference	HAN CM Mean	Comparison Mean	Standardized Difference
Utilization/Expenditure Measures						
Emergency Room Visits (per 1,000 member months) - All						
Age	18.842	13.419	0.286	18.872	18.872	-0.002
Sex	0.528	0.518	0.021	0.528	0.528	0.000
Urban/Rural	0.195	0.564	-0.931	0.195	0.195	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.396	0.098	0.610	0.396	0.396	0.000
Prior Year PMPM top 5%	0.254	0.047	0.462	0.245	0.245	0.000
Hospital Admissions (per 100,000 member months) - All	*Same population as ER visits*			*Same population as ER visits*		
Age	18.842	13.419	0.286	18.872	18.872	-0.002
Sex	0.528	0.518	0.021	0.528	0.528	0.000
Urban/Rural	0.195	0.564	-0.931	0.195	0.195	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.396	0.098	0.610	0.396	0.396	0.000
Prior Year PMPM top 5%	0.254	0.047	0.462	0.245	0.245	0.000
Per Member Per Month Expenditures - All	*Same population as ER visits*			*Same population as ER visits*		
Age	18.842	13.419	0.286	18.872	18.872	-0.002
Sex	0.528	0.518	0.021	0.528	0.528	0.000
Urban/Rural	0.195	0.564	-0.931	0.195	0.195	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.396	0.098	0.610	0.396	0.396	0.000
Prior Year PMPM top 5%	0.254	0.047	0.462	0.245	0.245	0.000

HEALTH ACCESS NETWORKS - CM - STATEWIDE	2020 All Data (pre-balancing)			2020 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	HAN CM Mean	Comparison Mean	Standardized Difference	HAN CM Mean	Comparison Mean	Standardized Difference
HEDIS Measures						
Asthma - Medication Ratio - 5 to 18 years						
Age	10.409	11.389	-0.194	10.409	10.409	0.000
Gender (0 = male; 1 = female)	0.469	0.492	-0.045	0.469	0.469	0.000
Urban/Rural (0 = urban; 1 = rural)	0.192	0.576	0.976	0.192	0.192	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.196	0.034	0.409	0.196	0.196	0.000
Asthma - Medication Ratio - 19 to 64 years						
Age	42.914	35.222	0.556	42.914	42.883	0.002
Sex (0 = male; 1 = female)	0.723	0.699	0.052	0.723	0.723	0.000
Urban/Rural (0 = urban; 1 = rural)	0.147	0.580	-1.222	0.147	0.147	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.679	0.285	0.844	0.679	0.679	0.000
CAD - Persistent Beta-Blocker Treatment after a Heart Attack						
Age	54.361	55.551	-0.137	54.361	54.361	0.000
Sex (0 = male; 1 = female)	0.528	0.509	0.038	0.528	0.528	0.000
Urban/Rural (0 = urban; 1 = rural)	0.167	0.623	-1.223	0.167	0.167	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.889	0.824	0.207	0.889	0.889	0.000
CAD - Cholesterol Management - LDL-C Test	*Same population as CAD Beta Blocker*			*Same population as CAD Beta Blocker*		
Age	54.361	55.551	-0.137	54.361	54.361	0.000
Sex (0 = male; 1 = female)	0.528	0.509	0.038	0.528	0.528	0.000
Urban/Rural (0 = urban; 1 = rural)	0.167	0.623	-1.223	0.167	0.167	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.889	0.824	0.207	0.889	0.889	0.000

HEALTH ACCESS NETWORKS - CM - STATEWIDE	2020 All Data (pre-balancing)			2020 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	**HAN CM Mean**	**Comparison Mean**	**Standardized Difference**	**HAN CM Mean**	**Comparison Mean**	**Standardized Difference**
HEDIS Measures						
COPD - Use of Spirometry Testing						
Age	29.756	37.031	-0.301	30.200	30.262	-0.003
Sex (0 = male; 1 = female)	0.512	0.553	-0.082	0.500	0.500	0.000
Urban/Rural (0 = urban; 1 = rural)	0.220	0.611	-0.946	0.225	0.225	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.634	0.527	0.223	0.625	0.625	0.000
COPD - Pharmacotherapy Management of Exacerbation - 14 days						
Age	51.529	53.066	-0.170	52.813	53.035	-0.025
Sex (0 = male; 1 = female)	0.706	0.645	0.134	0.750	0.750	0.000
Urban/Rural (0 = urban; 1 = rural)	0.235	0.585	-0.824	0.188	0.188	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.941	0.821	0.512	0.938	0.938	0.000
COPD - Pharmacotherapy Management of Exacerbation - 30 days	*Same population as 14 days*			*Same population as 14 days*		
Age	51.529	53.066	-0.170	52.813	53.035	-0.025
Sex (0 = male; 1 = female)	0.706	0.645	0.134	0.750	0.750	0.000
Urban/Rural (0 = urban; 1 = rural)	0.235	0.585	-0.824	0.188	0.188	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.941	0.821	0.512	0.938	0.938	0.000
Diabetes - Members who had LDL-C Test						
Age	50.238	46.351	0.399	50.238	50.123	0.012
Sex (0 = male; 1 = female)	0.733	0.667	0.151	0.733	0.733	0.000
Urban/Rural (0 = urban; 1 = rural)	0.124	0.597	-1.438	0.124	0.124	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.857	0.586	0.775	0.857	0.857	0.000
Diabetes - Retinal Eye Exam	*Same population as LDL-C*			*Same population as LDL-C*		
Age	50.238	46.351	0.399	50.238	50.123	0.012
Sex (0 = male; 1 = female)	0.733	0.667	0.151	0.733	0.733	0.000
Urban/Rural (0 = urban; 1 = rural)	0.124	0.597	-1.438	0.124	0.124	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.857	0.586	0.775	0.857	0.857	0.000

HEALTH ACCESS NETWORKS - CM - STATEWIDE	2020 All Data (pre-balancing)			2020 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	HAN CM Mean	Comparison Mean	Standardized Difference	HAN CM Mean	Comparison Mean	Standardized Difference
HEDIS Measures						
Diabetes - HbA1c Testing	*Same population as LDL-C*			*Same population as LDL-C*		
Age	50.238	46.351	0.399	50.238	50.123	0.012
Sex (0 = male; 1 = female)	0.733	0.667	0.151	0.733	0.733	0.000
Urban/Rural (0 = urban; 1 = rural)	0.124	0.597	-1.438	0.124	0.124	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.857	0.586	0.775	0.857	0.857	0.000
Diabetes - Medical Attention for Nephropathy	*Same population as LDL-C*			*Same population as LDL-C*		
Age	50.238	46.351	0.399	50.238	50.123	0.012
Sex (0 = male; 1 = female)	0.733	0.667	0.151	0.733	0.733	0.000
Urban/Rural (0 = urban; 1 = rural)	0.124	0.597	-1.438	0.124	0.124	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.857	0.586	0.775	0.857	0.857	0.000
Hypertension - LDL-C Test						
Age	50.966	47.621	0.335	50.966	51.012	-0.005
Sex (0 = male; 1 = female)	0.705	0.624	0.179	0.705	0.705	0.000
Urban/Rural (0 = urban; 1 = rural)	0.082	0.588	-1.841	0.082	0.082	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.836	0.584	0.680	0.836	0.836	0.000
Hypertension - ACE/ARB Therapy	*Same population as LDL-C*			*Same population as LDL-C*		
Age	50.966	47.621	0.335	50.966	51.012	-0.005
Sex (0 = male; 1 = female)	0.705	0.624	0.179	0.705	0.705	0.000
Urban/Rural (0 = urban; 1 = rural)	0.082	0.588	-1.841	0.082	0.082	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.836	0.584	0.680	0.836	0.836	0.000
Child and Adolescents' Access to PCP - 12 months to 19 years						
Age	7.335	9.254	-0.367	7.335	48.164	0.000
Sex (0 = male; 1 = female)	0.469	0.493	-0.048	0.469	0.469	0.000
Urban/Rural (0 = urban; 1 = rural)	0.204	0.574	-0.919	0.204	0.204	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.154	0.029	0.347	0.154	0.154	0.000
Adults' Access to Preventive/Ambulatory Health Services						
Age	44.546	37.771	0.525	44.546	44.505	0.003
Sex (0 = male; 1 = female)	0.729	0.725	0.010	0.729	0.729	0.000
Urban/Rural (0 = urban; 1 = rural)	0.139	0.578	-1.266	0.139	0.139	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.709	0.320	0.857	0.709	0.709	0.000

HEALTH ACCESS NETWORKS - CM - STATEWIDE	2020 All Data (pre-balancing)			2020 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	**HAN CM Mean**	**Comparison Mean**	**Standardized Difference**	**HAN CM Mean**	**Comparison Mean**	**Standardized Difference**
Utilization/Expenditure Measures						
Emergency Room Visits (per 1,000 member months) - All						
Age	16.590	13.515	0.176	16.530	16.695	-0.009
Sex	0.523	0.519	0.008	0.523	0.523	0.000
Urban/Rural	0.185	0.574	-1.004	0.185	0.185	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.317	0.087	0.494	0.316	0.316	0.000
Prior Year PMPM top 5%	0.195	0.046	0.378	0.194	0.194	0.000
Hospital Admissions (per 100,000 member months) - All						
Age	16.590	13.515	0.176	16.530	16.695	-0.009
Sex	0.523	0.519	0.008	0.523	0.523	0.000
Urban/Rural	0.185	0.574	-1.004	0.185	0.185	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.317	0.087	0.494	0.316	0.316	0.000
Prior Year PMPM top 5%	0.195	0.046	0.378	0.194	0.194	0.000
Per Member Per Month Expenditures - All						
Age	16.590	13.515	0.176	16.530	16.695	-0.009
Sex	0.523	0.519	0.008	0.523	0.523	0.000
Urban/Rural	0.185	0.574	-1.004	0.185	0.185	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.317	0.087	0.494	0.316	0.316	0.000
Prior Year PMPM top 5%	0.195	0.046	0.378	0.194	0.194	0.000

HEALTH ACCESS NETWORKS - CM - STATEWIDE	2021 All Data (pre-balancing)			2021 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	HAN CM Mean	Comparison Mean	Standardized Difference	HAN CM Mean	Comparison Mean	Standardized Difference
HEDIS Measures						
Asthma - Medication Ratio - 5 to 18 years						
Age	10.550	11.257	-0.178	10.550	10.550	0.000
Gender (0 = male; 1 = female)	0.462	0.491	-0.057	0.462	0.462	0.000
Urban/Rural (0 = urban; 1 = rural)	0.224	0.589	-0.876	0.224	0.224	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.201	0.029	0.428	0.201	0.201	0.000
Asthma - Medication Ratio - 19 to 64 years						
Age	40.711	33.357	0.493	40.702	40.678	0.002
Sex (0 = male; 1 = female)	0.708	0.688	0.045	0.708	0.708	0.000
Urban/Rural (0 = urban; 1 = rural)	0.166	0.594	-1.152	0.166	0.166	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.592	0.233	0.730	0.592	0.592	0.000
CAD - Persistent Beta-Blocker Treatment after a Heart Attack						
Age	56.020	55.940	0.010	55.816	55.569	0.031
Sex (0 = male; 1 = female)	0.460	0.501	-0.083	0.469	0.469	0.000
Urban/Rural (0 = urban; 1 = rural)	0.120	0.622	-1.545	0.122	0.122	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.889	0.824	0.207	0.889	0.889	0.000
CAD - Cholesterol Management - LDL-C Test	*Same population as CAD Beta Blocker*			*Same population as CAD Beta Blocker*		
Age	56.020	55.940	0.010	55.816	55.569	0.031
Sex (0 = male; 1 = female)	0.460	0.501	-0.083	0.469	0.469	0.000
Urban/Rural (0 = urban; 1 = rural)	0.120	0.622	-1.545	0.122	0.122	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.889	0.824	0.207	0.889	0.889	0.000

HEALTH ACCESS NETWORKS - CM - STATEWIDE	2021 All Data (pre-balancing)			2021 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	HAN CM Mean	Comparison Mean	Standardized Difference	HAN CM Mean	Comparison Mean	Standardized Difference
HEDIS Measures						
COPD - Use of Spirometry Testing						
Age	55.861	53.918	0.285	55.861	55.870	-0.001
Sex (0 = male; 1 = female)	0.558	0.629	-0.142	0.558	0.558	0.000
Urban/Rural (0 = urban; 1 = rural)	0.140	0.671	-1.534	0.140	0.140	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.634	0.527	0.223	0.625	0.625	0.000
COPD - Pharmacotherapy Management of Exacerbation - 14 days						
Age	54.682	56.097	-0.196	55.412	55.069	0.048
Sex (0 = male; 1 = female)	0.455	0.659	-0.411	0.588	0.588	0.000
Urban/Rural (0 = urban; 1 = rural)	0.136	0.633	-0.145	0.118	0.118	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.941	0.821	0.512	0.938	0.938	0.000
COPD - Pharmacotherapy Management of Exacerbation - 30 days	*Same population as 14 days*			*Same population as 14 days*		
Age	54.682	56.097	-0.196	55.412	55.069	0.048
Sex (0 = male; 1 = female)	0.455	0.659	-0.411	0.588	0.588	0.000
Urban/Rural (0 = urban; 1 = rural)	0.136	0.633	-0.145	0.118	0.118	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.941	0.821	0.512	0.938	0.938	0.000
Diabetes - Members who had LDL-C Test						
Age	49.659	46.105	0.297	49.659	49.553	0.009
Sex (0 = male; 1 = female)	0.659	0.677	-0.038	0.659	0.659	0.000
Urban/Rural (0 = urban; 1 = rural)	0.135	0.618	-1.410	0.135	0.135	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.857	0.586	0.775	0.857	0.857	0.000
Diabetes - Retinal Eye Exam	*Same population as LDL-C*			*Same population as LDL-C*		
Age	49.659	46.105	0.297	49.659	49.553	0.009
Sex (0 = male; 1 = female)	0.659	0.677	-0.038	0.659	0.659	0.000
Urban/Rural (0 = urban; 1 = rural)	0.135	0.618	-1.410	0.135	0.135	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.857	0.586	0.775	0.857	0.857	0.000

HEALTH ACCESS NETWORKS - CM - STATEWIDE	2021 All Data (pre-balancing)			2021 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	HAN CM Mean	Comparison Mean	Standardized Difference	HAN CM Mean	Comparison Mean	Standardized Difference
HEDIS Measures						
Diabetes - HbA1c Testing	*Same population as LDL-C*			*Same population as LDL-C*		
Age	49.659	46.105	0.297	49.659	49.553	0.009
Sex (0 = male; 1 = female)	0.659	0.677	-0.038	0.659	0.659	0.000
Urban/Rural (0 = urban; 1 = rural)	0.135	0.618	-1.410	0.135	0.135	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.857	0.586	0.775	0.857	0.857	0.000
Diabetes - Medical Attention for Nephropathy	*Same population as LDL-C*			*Same population as LDL-C*		
Age	49.659	46.105	0.297	49.659	49.553	0.009
Sex (0 = male; 1 = female)	0.659	0.677	-0.038	0.659	0.659	0.000
Urban/Rural (0 = urban; 1 = rural)	0.135	0.618	-1.410	0.135	0.135	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.857	0.586	0.775	0.857	0.857	0.000
Hypertension - LDL-C Test						
Age	51.842	48.613	0.290	51.842	51.786	0.005
Sex (0 = male; 1 = female)	0.638	0.617	0.044	0.638	0.638	0.000
Urban/Rural (0 = urban; 1 = rural)	0.133	0.610	-1.408	0.133	0.133	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.836	0.584	0.680	0.836	0.836	0.000
Hypertension - ACE/ARB Therapy	*Same population as LDL-C*			*Same population as LDL-C*		
Age	51.842	48.613	0.290	51.842	51.786	0.005
Sex (0 = male; 1 = female)	0.638	0.617	0.044	0.638	0.638	0.000
Urban/Rural (0 = urban; 1 = rural)	0.133	0.610	-1.408	0.133	0.133	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.836	0.584	0.680	0.836	0.836	0.000
Child and Adolescents' Access to PCP - 12 months to 19 years						
Age	7.910	9.832	-0.356	7.910	7.904	0.001
Sex (0 = male; 1 = female)	0.470	0.492	-0.044	0.470	0.000	4.256
Urban/Rural (0 = urban; 1 = rural)	0.226	0.587	-0.863	0.226	0.000	8.838
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.154	0.029	0.347	0.154	0.154	0.000
Adults' Access to Preventive/Ambulatory Health Services						
Age	44.043	37.063	0.496	44.043	43.994	0.004
Sex (0 = male; 1 = female)	0.702	0.729	-0.057	0.702	0.702	0.000
Urban/Rural (0 = urban; 1 = rural)	0.156	0.594	-1.206	0.156	0.156	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.709	0.320	0.857	0.709	0.709	0.000

HEALTH ACCESS NETWORKS - CM - STATEWIDE	2021 All Data (pre-balancing)			2021 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	HAN CM Mean	Comparison Mean	Standardized Difference	HAN CM Mean	Comparison Mean	Standardized Difference
Utilization/Expenditure Measures						
Emergency Room Visits (per 1,000 member months) - All						
Age	16.213	13.992	0.133	16.213	16.288	-0.005
Sex	0.516	0.524	-0.017	0.516	0.516	0.000
Urban/Rural	0.200	0.588	-0.970	0.200	0.200	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.304	0.078	0.491	0.304	0.304	0.000
Prior Year PMPM top 5%	0.171	0.045	0.335	0.171	0.171	0.000
Hospital Admissions (per 100,000 member months) - All						
Age	16.213	13.992	0.133	16.213	16.288	-0.005
Sex	0.516	0.524	-0.017	0.516	0.516	0.000
Urban/Rural	0.200	0.588	-0.970	0.200	0.200	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.304	0.078	0.491	0.304	0.304	0.000
Prior Year PMPM top 5%	0.171	0.045	0.335	0.171	0.171	0.000
Per Member Per Month Expenditures - All						
Age	16.213	13.992	0.133	16.213	16.288	-0.005
Sex	0.516	0.524	-0.017	0.516	0.516	0.000
Urban/Rural	0.200	0.588	-0.970	0.200	0.200	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.304	0.078	0.491	0.304	0.304	0.000
Prior Year PMPM top 5%	0.171	0.045	0.335	0.171	0.171	0.000

3. HAN Statistical Significance Test Results - 2019 – 2021 and 3-Year Pooled

HEALTH ACCESS NETWORKS - TOTAL - STATEWIDE	Percent Compliant				P-Value/Statistical Significance (p < .05)			
HEDIS and Utilization/Expenditure Measures	2019	2020	2021	Pooled	2019	2020	2021	Pooled
HEDIS Measures								
Asthma - Medication Ratio - 5 to 18 years								
HAN	77.9%	81.3%	90.8%	83.3%	0.0046	0.0000	0.0002	0.0000
Comparison Group	80.0%	85.3%	92.4%	85.9%	**Yes**	**Yes**	**Yes**	**Yes**
Asthma - Medication Ratio - 19 to 64 years								
HAN	66.9%	72.2%	84.9%	74.7%	0.0002	0.3125	0.0043	0.0001
Comparison Group	74.1%	71.4%	87.2%	77.6%	**Yes**	No	**Yes**	**Yes**
CAD - Persistent Beta-Blocker Treatment after a Heart Attack								
HAN	41.7%	38.8%	39.9%	40.1%	0.5647	0.0000	0.0000	0.0000
Comparison Group	43.5%	50.5%	47.2%	47.1%	No	**Yes**	**Yes**	**Yes**
CAD - Cholesterol Management - LDL-C Test								
HAN	62.8%	51.5%	53.7%	56.0%	0.0951	0.0507	0.0000	0.1010
Comparison Group	57.9%	57.7%	59.0%	58.2%	No	No	**Yes**	No
COPD - Use of Spirometry Testing								
HAN	23.3%	37.5%	13.5%	24.8%	0.6561	0.0137	0.2011	0.1828
Comparison Group	22.2%	33.3%	15.5%	23.7%	No	**Yes**	No	No
COPD - Pharmacotherapy Management of Exacerbation - 14 days								
HAN	65.8%	59.6%	62.9%	62.8%	0.8995	0.1846	0.0138	0.0237
Comparison Group	66.3%	66.1%	71.4%	67.9%	No	No	**Yes**	**Yes**
COPD - Pharmacotherapy Management of Exacerbation - 30 days								
HAN	73.4%	69.9%	69.5%	70.9%	0.6047	0.5542	0.4805	0.3002
Comparison Group	75.4%	67.1%	66.2%	69.6%	No	No	No	No

HEALTH ACCESS NETWORKS - TOTAL - STATEWIDE	Percent Compliant				P-Value/Statistical Significance (p < .05)			
HEDIS and Utilization/Expenditure Measures	**2019**	**2020**	**2021**	**Pooled**	**2019**	**2020**	**2021**	**Pooled**
HEDIS Measures								
Diabetes - HbA1c Testing								
HAN	76.7%	72.2%	65.2%	71.4%	0.0000	0.0000	0.3736	0.0000
Comparison Group	71.9%	65.8%	66.0%	67.9%	**Yes**	**Yes**	No	**Yes**
Diabetes - LDL-C Test								
HAN	60.0%	54.5%	49.1%	54.5%	0.0000	0.0099	0.0000	0.0017
Comparison Group	55.1%	50.5%	52.0%	52.5%	**Yes**	**Yes**	**Yes**	**Yes**
Diabetes - Retinal Eye Exam								
HAN	35.3%	29.8%	22.2%	29.1%	0.0000	0.0000	0.0000	0.0000
Comparison Group	24.7%	19.8%	19.9%	21.5%	**Yes**	**Yes**	**Yes**	**Yes**
Diabetes - Medical Attention for Nephropathy								
HAN	85.2%	80.8%	76.7%	80.9%	0.0391	0.0178	0.6270	0.0170
Comparison Group	83.1%	78.6%	76.2%	79.3%	**Yes**	**Yes**	No	**Yes**
Hypertension - LDL-C Test								
HAN	57.3%	48.9%	52.3%	52.8%	0.0343	0.2288	0.0000	0.3645
Comparison Group	55.1%	50.1%	53.8%	53.0%	**Yes**	No	**Yes**	No
Hypertension - ACE/ARB Therapy								
HAN	60.7%	59.5%	57.7%	59.3%	0.6181	0.2629	0.0000	0.0013
Comparison Group	61.3%	60.6%	61.1%	61.0%	No	No	**Yes**	**Yes**
Mental Health - Follow-up after Hospitalization - 7 days - 6 to 20								
HAN	58.9%	64.5%	52.3%	58.6%	0.2330	0.0057	0.1610	0.3663
Comparison Group	62.0%	56.9%	55.5%	58.1%	No	**Yes**	No	No
Mental Health - Follow-up after Hospitalization - 7 days - 21 and older								
HAN	56.8%	42.9%	45.3%	48.3%	0.2451	0.9467	0.3407	0.3784
Comparison Group	50.7%	43.4%	48.3%	47.5%	No	No	No	No

HEALTH ACCESS NETWORKS - TOTAL - STATEWIDE	Percent Compliant				P-Value/Statistical Significance (p < .05)			
HEDIS and Utilization/Expenditure Measures	**2019**	**2020**	**2021**	**Pooled**	**2019**	**2020**	**2021**	**Pooled**
HEDIS Measures								
Mental Health - Follow-up after Hospitalization - 30 days - 6 to 20								
HAN	84.2%	86.6%	79.8%	83.5%	0.0000	0.7896	0.9170	0.1788
Comparison Group	87.5%	86.1%	79.9%	84.5%	**Yes**	No	No	No
Mental Health - Follow-up after Hospitalization - 30 days - 21 and older								
HAN	80.6%	72.9%	72.1%	75.2%	0.3203	0.6956	0.4191	0.0870
Comparison Group	76.4%	70.1%	69.8%	72.1%	No	No	No	No
Adults' Access to Preventive/Ambulatory Health Services								
HAN	84.6%	79.5%	69.3%	77.8%	0.7139	0.2155	0.0000	0.0000
Comparison Group	84.5%	79.1%	73.5%	79.0%	No	No	**Yes**	**Yes**
Child and Adolescents' Access to PCP - 12 months to 19 years								
HAN	92.5%	88.7%	81.5%	87.6%	0.0000	0.0000	0.0000	0.0000
Comparison Group	92.4%	88.5%	84.3%	88.4%	**Yes**	**Yes**	**Yes**	**Yes**

HEALTH ACCESS NETWORKS - TOTAL - STATEWIDE	Percent Compliant				P-Value/Statistical Significance (p < .05)			
HEDIS and Utilization/Expenditure Measures	**2019**	**2020**	**2021**	**Pooled**	**2019**	**2020**	**2021**	**Pooled**
Utilization/Expenditure Measures								
Emergency Room Visits (per 1,000 member months) - All								
HAN	54.5	36.4	40.8	43.9	0.0000	0.0000	0.0000	0.3617
Comparison Group	54.8	36.2	40.5	43.8	**Yes**	**Yes**	**Yes**	No
Hospital Admissions (per 100,000 member months) - All								
HAN	764.4	606.6	608.8	659.9	0.0000	0.0000	0.0000	0.0000
Comparison Group	632.0	489.8	468.1	530.0	**Yes**	**Yes**	**Yes**	**Yes**
Per Member Per Month Expenditures - All								
HAN	$ 213.32	$ 187.94	$ 202.83	$ 201.36	0.0000	0.0000	0.0000	0.0000
Comparison Group	$ 201.62	$ 182.75	$ 200.60	$ 194.99	**Yes**	**Yes**	**Yes**	**Yes**

HEALTH ACCESS NETWORKS - CM - STATEWIDE	Percent Compliant				P-Value/Statistical Significance (p < .05)			
HEDIS and Utilization/Expenditure Measures	2019	2020	2021	Pooled	2019	2020	2021	Pooled
HEDIS Measures								
Asthma - Medication Ratio - 5 to 18 years								
HAN	82.0%	89.1%	91.5%	87.5%	0.4403	0.1584	0.3849	0.2745
Comparison Group	81.2%	84.0%	92.2%	85.8%	No	No	No	No
Asthma - Medication Ratio - 19 to 64 years								
HAN	75.0%	63.6%	82.1%	73.6%	0.4603	0.1230	0.1696	0.1419
Comparison Group	74.0%	73.9%	87.1%	78.3%	No	No	No	No
CAD - Persistent Beta-Blocker Treatment after a Heart Attack								
HAN	45.1%	30.6%	42.9%	39.5%	0.7596	0.0295	0.4346	0.0510
Comparison Group	42.8%	48.8%	48.8%	46.8%	No	**Yes**	No	No
CAD - Cholesterol Management - LDL-C Test								
HAN	64.7%	55.6%	46.9%	55.7%	0.3418	0.8602	0.1111	0.2935
Comparison Group	57.9%	57.1%	59.2%	58.1%	No	No	No	No
COPD - Use of Spirometry Testing								
HAN	33.3%	27.5%	11.6%	24.1%	0.1649	0.8378	0.2325	0.2265
Comparison Group	19.0%	26.0%	18.1%	21.0%	No	No	No	No
COPD - Pharmacotherapy Management of Exacerbation - 14 days								
HAN	51.7%	62.5%	52.6%	55.6%	0.2075	0.7597	0.0101	0.0800
Comparison Group	64.4%	58.4%	71.4%	64.7%	No	No	**Yes**	No
COPD - Pharmacotherapy Management of Exacerbation - 30 days								
HAN	79.3%	75.0%	73.7%	76.0%	0.3242	0.1803	0.4040	0.0804
Comparison Group	71.2%	58.6%	71.8%	67.2%	No	No	No	No
Diabetes - HbA1c Testing								
HAN	78.6%	76.6%	71.8%	75.7%	0.0408	0.0110	0.3467	0.0010
Comparison Group	71.0%	65.8%	68.4%	68.4%	**Yes**	**Yes**	No	**Yes**

HEALTH ACCESS NETWORKS - CM - STATEWIDE	Percent Compliant				P-Value/Statistical Significance (p < .05)			
HEDIS and Utilization/Expenditure Measures	**2019**	**2020**	**2021**	**Pooled**	**2019**	**2020**	**2021**	**Pooled**
HEDIS Measures								
Diabetes - LDL-C Test								
HAN	65.6%	60.4%	56.5%	60.8%	0.0200	0.0234	0.9170	0.0051
Comparison Group	55.6%	50.5%	56.9%	54.3%	**Yes**	**Yes**	No	**Yes**
Diabetes - Retinal Eye Exam								
HAN	39.7%	34.4%	37.1%	37.1%	0.0000	0.0001	0.0000	0.0000
Comparison Group	24.5%	19.8%	20.7%	21.7%	**Yes**	**Yes**	**Yes**	**Yes**
Diabetes - Medical Attention for Nephropathy								
HAN	91.6%	88.6%	92.9%	91.0%	0.0039	0.0069	0.0000	0.0000
Comparison Group	84.2%	78.6%	80.7%	81.2%	**Yes**	**Yes**	**Yes**	**Yes**
Hypertension - LDL-C Test								
HAN	67.5%	48.3%	52.7%	56.2%	0.0012	0.4277	0.3436	0.1759
Comparison Group	56.6%	51.1%	55.6%	54.4%	**Yes**	No	No	No
Hypertension - ACE/ARB Therapy								
HAN	64.6%	57.5%	59.9%	60.7%	0.4818	0.3841	0.4494	0.3168
Comparison Group	62.2%	60.6%	62.1%	61.6%	No	No	No	No
Adults' Access to Preventive/Ambulatory Health Services								
HAN	97.9%	95.4%	92.5%	95.3%	0.0000	0.0000	0.0000	0.0000
Comparison Group	87.5%	83.4%	79.4%	83.4%	**Yes**	**Yes**	**Yes**	**Yes**
Child and Adolescents' Access to PCP - 12 months to 19 years								
HAN	99.0%	95.8%	93.5%	96.1%	0.0000	0.0000	0.0000	0.0000
Comparison Group	93.2%	89.4%	86.4%	89.7%	**Yes**	**Yes**	**Yes**	**Yes**

HEALTH ACCESS NETWORKS - CM - STATEWIDE	Percent Compliant				P-Value/Statistical Significance (p < .05)			
HEDIS and Utilization/Expenditure Measures	**2019**	**2020**	**2021**	**Pooled**	**2019**	**2020**	**2021**	**Pooled**
Utilization/Expenditure Measures								
Emergency Room Visits (per 1,000 member months) - All								
HAN	161.8	114.3	124.4	133.5	0.0000	0.0000	0.0000	0.0000
Comparison Group	124.0	84.8	91.1	100.0	**Yes**	**Yes**	**Yes**	**Yes**
Hospital Admissions (per 100,000 member months) - All								
HAN	3431.4	2260.1	2312.8	2668.1	0.8365	0.8129	0.5090	0.4014
Comparison Group	3515.0	2182.8	2488.2	2728.7	No	No	No	No
Per Member Per Month Expenditures - All								
HAN	$ 680.44	$ 620.76	$ 579.62	$ 626.94	0.6591	0.4133	0.0000	0.0001
Comparison Group	$ 697.17	$ 653.91	$ 726.29	$ 692.46	No	No	**Yes**	**Yes**

4. HAN CEM Covariate Balance Tables for CAHPS Measures

HAN AND HMP PROGRAMS - STATEWIDE		All Data (pre-balancing)			Matched Data (post-balancing)		
CAHPS Measures		Treatment Group Mean	Comparison Mean	Standardized Difference	Treatment Group Mean	Comparison Mean	Standardized Difference
All Measures							
HAN Adults							
	Age Range*	3.242	4.372	-0.753	0.727	0.727	0.000
	Gender (0 = male; 1 = female)	0.727	0.674	0.119	3.242	3.242	0.000
	Urban/Rural (0 = urban; 1 = rural)	N/A	N/A	N/A	N/A	N/A	N/A
	ABD/non-ABD (0 = non-ABD; 1 - ABD)	N/A	N/A	N/A	N/A	N/A	N/A
HAN Children							
	Age	11.696	14.127	-0.192	11.693	11.960	-0.021
	Sex (0 = male; 1 = female)	0.438	0.439	-0.091	0.438	0.438	0.000
	Urban/Rural (0 = urban; 1 = rural)	N/A	N/A	N/A	N/A	N/A	N/A
	ABD/non-ABD (0 = non-ABD; 1 - ABD)	N/A	N/A	N/A	N/A	N/A	N/A
*	Adult age ranges: 1 - 18-24; 2 - 25-34; 3 - 35-44; 4 - 45-54; 5 - 55-64; 6 - 65-74; 7 - 75 or older						

5. HAN Statistical Significance Test Results for CAHPS Measures

	Adults			Children		
CAHPS Measure	**HAN** ***N = 33***	**Comparison Group** ***N = 213***	**P-Value**	**HAN** ***N = 283***	**Comparison Group** ***N = 668***	**P-Value**
Getting Needed Care (Composite)						
Always or Usually	90.0%	85.1%	*0.2272*	90.2%	87.8%	*0.1444*
Rating of Health Care (8, 9 or 10)						
8 - 10	72.0%	72.8%	*0.4611*	86.7%	85.1%	*0.2605*
Rating of Health Plan (8, 9 or 10)						
8 - 10	80.6%	71.3%	*0.1332*	87.0%	81.6%	*0.0210*
Rating of Personal Doctor (8, 9 or 10)						
8 - 10	88.0%	83.3%	*0.8397*	89.6%	87.3%	*0.1594*

6. HAN Member SDOH Targeted Survey Instrument

Hello, my name is _____ and I am calling on behalf of the SoonerCare program. May I please speak to {RESPONDENT NAME}?

INTRO1. **We are conducting a short survey to find out about where SoonerCare members get their health care and their experiences with doctors and nurses. The purpose of the survey is to learn about how we can make the program better. The survey is voluntary and if you decide not to participate it will not affect your benefits. Anything you tell us will be kept confidential. The information will not be shared with your doctor or nurse and will not affect any treatment you may be receiving. The survey takes about 10 minutes.**
[ANSWER ANY QUESTIONS AND PROCEED TO QUESTION 1]

INTRO2. **[If need to leave a message] We are conducting a short survey to find out about where SoonerCare members get their health care and about their experiences with their doctors and nurses. We can be reached toll-free at 1-888-941-9358.**

[IDENTIFY HAN NAME & CASE MANAGER NAME ON MEMBER SURVEY ROSTER BEFORE BEGINNING INTERVIEW. IF MEMBER IS A MINOR (DOB AFTER CURRENT MONTH IN 2004), ASK PARENT/GUARDIAN SCREENING QUESTION BEFORE BEGINNING SURVEY]

Parent/Guardian Screening Question: Are you the parent or guardian of [NAME]? [IF YES, PROCEED TO QUESTION 1. IF NO, ASK TO SPEAK TO PARENT/GUARDIAN. IF UNABLE TO REACH, END CALL]

1. The SoonerCare program is a health insurance program offered by the state. Are you currently enrolled in SoonerCare?[91] [IF MINOR → Is [NAME] currently enrolled in SoonerCare?]
    a. Yes
    b. No → [ASK IF ENROLLED IN MEDICAID. IF NO, END CALL]
    c. Don't Know/Not Sure → [ASK IF ENROLLED IN MEDICAID. IF NO, END CALL]
2. Our records show that you chose or were assigned a doctor to be your/your child's regular SoonerCare provider for check-ups, when you need advice about a health problem or get sick or hurt. Is that right? [If respondent says provider is a Nurse Practitioner, record as "Yes"]
    a. Yes → [GO TO QUESTION 4]
    b. No → [GO TO QUESTION 3]
    c. Don't Know/Not Sure → [GO TO QUESTION 3]
3. Where do you usually go to get health care (health care for your child)?
    a. Emergency Room
    b. Urgent Care Clinic
    c. No usual place

[91] All questions include a "don't know/not sure" or similar option which is unprompted by the surveyor; this response is listed on the instrument to allow surveyors to document such a response. Questions are reworded for parents/guardians completing the survey on behalf of program participants.

d. Have never tried to get care
e. Don't Know/Not Sure

4. Some SoonerCare members see providers who belong to what is known as a Health Access Network. One of these is [READ HAN NAME]. Have you heard this name?
    a. Yes
    b. No→ [GO TO QUESTION 6]
    c. Don't Know/Not Sure → [GO TO QUESTION 6]

5. Have you seen a provider who is part of [READ HAN NAME]?
    a. Yes
    b. No
    c. Don't Know/Not Sure

6. [READ HAN NAME] has nurses who are available to help patients who are referred by their provider. Have any nurses from [READ HAN NAME] helped you?
    a. Yes
    b. No → [GO TO QUESTION 8]
    c. Don't Know/Not Sure → [GO TO QUESTION 8]

7. Do you remember the name of the nurse who helped you?
    a. Yes [RECORD NAME. IF MORE THAN ONE NAME PROVIDED, RECORD FIRST] → [GO TO QUESTION 9]
    b. No
    c. Don't Know/Not Sure

8. One of the nurses at [READ HAN NAME] is [CASE MANAGER NAME]. Have you talked to [CASE MANAGER NAME]?
    a. Yes
    b. No → [READ TERMINATION SCRIPT]
    c. Don't Know/Not Sure → [READ TERMINATION SCRIPT]

[TERMINATION SCRIPT – THE REST OF OUR QUESTIONS TODAY ARE ABOUT HELP PEOPLE RECEIVED FROM NURSES. THANK YOU FOR YOUR TIME.]

9. What kind of help did you receive from [CASE MANAGER]? [RECORD ALL HELP]
    a. Child Care
    b. Child Car Seat
    c. Clothing
    d. Dental
    e. Diapers

f. Durable Medical Equipment
g. Education [SPECIFY TOPIC(S)]
h. Family Planning/Contraception
i. Food Pantry/other Food Assistance
j. Health Education – Asthma/COPD
k. Health Education – Diabetes
l. Health Education – Heart Disease
m. Health Education – Hypertension
n. Health Education – Obesity
o. Health Education – Other [SPECIFY]
p. Housing/Rent
q. Legal Aid
r. Long Term Care Waiver (ADvantage or Independent Living)
s. Long Term Care Waiver (DDSD)
t. Medical/Behavioral Health Appointment(s) [SPECIFY]
u. Medication Assistance (not covered by SoonerCare)
v. Nutrition/WIC
w. Recreation/Camp
x. School Supplies
y. SoonerSuccess [SPECIFY HELP]
z. Tobacco Cessation
aa. Transportation to Medical Appointment
bb. Transportation to Other [RECORD]
cc. Utility – HVAC
dd. Utility – Gas
ee. Utility – Electric
ff. Utility - Water
gg. Other – Referral [SPECIFY]
hh. Other [RECORD]
ii. Don't Know/Not Sure

10. How important was the help you received from [CASE MANAGER]?
    a. Very Important
    b. Somewhat Important
    c. Not Very Important → [GO TO QUESTION 14]
    d. Not at all Important → [GO TO QUESTION 14]
    e. Don't Know/Not Sure → [GO TO QUESTION 14]

11. In what ways was it important? [RECORD ANSWER]

12. How satisfied are you with the help you received from [CASE MANAGER]?
    a. Very Satisfied
    b. Somewhat Satisfied
    c. Somewhat Dissatisfied
    d. Very Dissatisfied
    e. Don't Know/Not Sure → [GO TO QUESTION 16]

13. Why did you choose that answer? [RECORD REASON]

14. The [READ HAN NAME] nurses try to make it easier for patients to take care of their health, even if it means helping with other kinds of problems. Would you say the help you received from [CASE MANAGER] made it easier for you to take care of your health (your child's health)?
    a. Yes
    b. No → [GO TO QUESTION 16]
    c. Don't Know/Not Sure → [GO TO QUESTION 16]

15. How did it make it easier? [RECORD ANSWER]

16. Could [CASE MANAGER] have been more helpful to you? If yes, how? [RECORD ANSWER]

17. In general, how would you rate your (your child's) overall health? Would you say it is "excellent", "good", "fair" or "poor"?
    a. Excellent
    b. Good
    c. Fair
    d. Poor
    e. Don't Know/Not Sure

That is all the questions I have today. Thank you for your help.

7. HAN-Aligned PCMH Targeted Survey Instrument

The Oklahoma Health Care Authority (OHCA) would like to hear about your experience as a SoonerCare (Medicaid) Patient Centered Medical Home (PCMH) affiliated with a SoonerCare Health Access Network (HAN) (NAME HERE). The Pacific Health Policy Group (PHPG), an outside company, has been contracted by the OHCA to survey SoonerCare PCMH providers. The purpose of the survey is to gather information on the type of assistance you may have received from the Health Access Network and its importance to your practice.

Awareness of SoonerCare and the (NAME HERE) Health Access Network

18. Were you aware that your practice is designated as a "Patient Centered Medical Home" within the Oklahoma SoonerCare (Medicaid) program?
    a. Yes
    b. No
19. Were you aware that PCMH practices in SoonerCare receive a monthly case management fee for each SoonerCare member on their panel, and that the fee amount is based in part on the practice's "tier level"?
    a. Yes
    b. No
20. Were you aware that, as part of SoonerCare, your practice is affiliated with **(NAME HERE)**?
    a. Yes
    b. No

If you answered "no" to question 3, please complete the final page and return. Do not answer the remaining questions.

Health Access Network Activities

21. SoonerCare Health Access Networks provide support to medical practices with which they are affiliated. Which of these kinds of support, if any, has **(NAME HERE)** provided to your practice? (Select all that apply, or select "K. None" if no support provided)

    a. Assistance in qualifying for a higher PCMH tier level under SoonerCare (i.e., moving from Tier 1 to Tier 2 or 3, or moving from Tier 2 to Tier 3)

    b. Assistance in preparing for, and/or undergoing audits performed by the Oklahoma Health Care Authority's Quality Assurance department

    c. Adoption of evidence-based guidelines for the care of patients with chronic health conditions

    d. Care management of SoonerCare patients with complex healthcare needs and/or chronic health conditions

    e. Care management of SoonerCare patients who are frequent users of the emergency room

    f. Facilitating use of telehealth or telemedicine

    g. Facilitating referrals/patient access to specialty care

    h. Facilitating referrals/patient access to ancillary services (e.g., transportation)

    i. Facilitating referrals/patient access to social services (e.g., heating assistance, rental assistance, food)

    j. Other. Please specify: _____

    k. None **(Please go to Question 6)**

22. For each of the areas you identified in question four, please record your level of satisfaction with assistance your practice received. Include any additional comments explaining your ratings in the space provided.

Support Area	Very Satisfied	Somewhat Satisfied	Somewhat Dissatisfied	Very Dissatisfied
A. Higher tier level support				
B. Audit support				
C. Evidence-based guidelines				
D. Complex/chronic care mgmt.				
E. High ER utilizer care mgmt.				

Support Area	Very Satisfied	Somewhat Satisfied	Somewhat Dissatisfied	Very Dissatisfied
F. Telehealth/telemedicine				
G. Specialty care referrals				
H. Ancillary service referrals				
I. Social service referrals				
J. Other				

Additional Comments: _____

_____

_____

23. Overall, how satisfied are you with the support your practice has received from (NAME HERE)
    a. Very satisfied
    b. Somewhat satisfied
    c. Somewhat dissatisfied
    d. Very dissatisfied
    e. No opinion
24. Other than raising payment amounts, are there ways in which the SoonerCare program overall, or (NAME HERE) could better support your practice? If yes, please describe how in the space provided.
    a. Yes
    b. No

Additional Support:

_____

_____

8. HMP CEM Covariate Balance Tables for CAHPS Measures

HAN AND HMP PROGRAMS - STATEWIDE		All Data (pre-balancing)			Matched Data (post-balancing)		
CAHPS Measures		Treatment Group Mean	Comparison Mean	Standardized Difference	Treatment Group Mean	Comparison Mean	Standardized Difference
All Measures							
HMP Adults							
	Age Range*	0.000	0.000	0.000	0.000	0.000	0.000
	Sex (0 = male; 1 = female)	0.000	0.000	0.000	0.000	0.000	0.000
	Urban/Rural (0 = urban; 1 = rural)	N/A	N/A	N/A	N/A	N/A	N/A
	ABD/non-ABD (0 = non-ABD; 1 - ABD)	N/A	N/A	N/A	N/A	N/A	N/A
HMP Children					*Same population as CAD Beta Blocker*		
	Age	0.000	0.000	0.000	0.000	0.000	0.000
	Sex (0 = male; 1 = female)	0.000	0.000	0.000	0.000	0.000	0.000
	Urban/Rural (0 = urban; 1 = rural)	N/A	N/A	N/A	N/A	N/A	N/A
	ABD/non-ABD (0 = non-ABD; 1 - ABD)	N/A	N/A	N/A	N/A	N/A	N/A
*	Adult age ranges: 1 - 18-24; 2 - 25-34; 3 - 35-44; 4 - 45-54; 5 - 55-64; 6 - 65-74; 7 - 75 or older						

9. HMP Statistical Significance Test Results for CAHPS Measures

	Adults			Children		
CAHPS Measure	**HMP *N = 591***	**Comparison Group *N = 213***	**P-Value**	**HMP *N = 77***	**Comparison Group *N = 668***	**P-Value**
Getting Needed Care (Composite)						
Always or Usually	76.5%	85.1%	*0.0043*	85.9%	87.8%	*0.3160*
Rating of Health Care (8, 9 or 10)						
8 - 10	71.8%	72.8%	*0.3902*	85.9%	85.1%	*0.4258*
Rating of Health Plan (8, 9 or 10)						
8 - 10	82.3%	71.3%	*0.0004*	82.8%	81.6%	*0.3982*

10. HMP CEM Covariate Balance Tables (Pre- and Post-Matching) 2019 - 2021

HEALTH MANAGEMENT PROGRAM - STATEWIDE	2019 All Data (pre-balancing)			2019 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	HMP Mean	Comparison Mean	Standardized Difference	HMP Mean	Comparison Mean	Standardized Difference
HEDIS Measures						
Asthma - Medication Ratio - 5 to 18 years						
Age	12.218	11.073	0.306	12.218	12.218	0.000
Gender (0 = male; 1 = female)	0.508	0.493	0.031	0.508	0.508	0.000
Urban/Rural (0 = urban; 1 = rural)	0.361	0.581	-0.459	0.361	0.361	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.341	0.038	0.640	0.341	0.341	0.000
Asthma - Medication Ratio - 19 to 64 years						
Age	50.698	38.670	1.141	50.698	50.672	0.002
Sex (0 = male; 1 = female)	0.645	0.689	-0.092	0.645	0.645	0.000
Urban/Rural (0 = urban; 1 = rural)	0.581	0.600	-0.040	0.581	0.581	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.766	0.428	0.797	0.766	0.766	0.000
CAD - Persistent Beta-Blocker Treatment after a Heart Attack						
Age	56.602	54.758	0.268	56.662	56.531	0.019
Sex (0 = male; 1 = female)	0.505	0.526	-0.042	0.510	0.510	0.000
Urban/Rural (0 = urban; 1 = rural)	0.607	0.620	-0.028	0.610	0.610	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.876	0.831	0.137	0.882	0.882	0.000
CAD - Cholesterol Management - LDL-C Test	*Same population as CAD Beta Blocker*			*Same population as CAD Beta Blocker*		
Age	56.602	54.758	0.268	56.662	56.531	0.019
Sex (0 = male; 1 = female)	0.505	0.526	-0.042	0.510	0.510	0.000
Urban/Rural (0 = urban; 1 = rural)	0.607	0.620	-0.028	0.610	0.610	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.876	0.831	0.137	0.882	0.882	0.000

HEALTH MANAGEMENT PROGRAM - STATEWIDE	2019 All Data (pre-balancing)			2019 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	HMP Mean	Comparison Mean	Standardized Difference	HMP Mean	Comparison Mean	Standardized Difference
HEDIS Measures						
COPD - Use of Spirometry Testing						
Age	54.640	46.804	0.960	54.804	54.578	0.028
Sex (0 = male; 1 = female)	0.645	0.626	0.040	0.650	0.650	0.000
Urban/Rural (0 = urban; 1 = rural)	0.637	0.648	-0.023	0.639	0.639	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.861	0.656	0.591	0.865	0.865	0.000
COPD - Pharmacotherapy Management of Exacerbation - 14 days						
Age	56.578	52.715	0.620	56.531	56.354	0.029
Sex (0 = male; 1 = female)	0.640	0.684	-0.092	0.641	0.641	0.000
Urban/Rural (0 = urban; 1 = rural)	0.592	0.630	-0.076	0.589	0.589	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.886	0.837	0.156	0.895	0.895	0.000
COPD - Pharmacotherapy Management of Exacerbation - 30 days	*Same population as 14 days*			*Same population as 14 days*		
Age	56.578	52.715	0.620	56.531	56.354	0.029
Sex (0 = male; 1 = female)	0.640	0.684	-0.092	0.641	0.641	0.000
Urban/Rural (0 = urban; 1 = rural)	0.592	0.630	-0.076	0.589	0.589	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.886	0.837	0.156	0.895	0.895	0.000
Diabetes - Members who had LDL-C Test						
Age	52.323	47.676	0.485	52.292	52.231	0.006
Sex (0 = male; 1 = female)	0.653	0.652	0.003	0.653	0.653	0.000
Urban/Rural (0 = urban; 1 = rural)	0.587	0.617	-0.062	0.586	0.586	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.796	0.688	0.266	0.795	0.795	0.000
Diabetes - Retinal Eye Exam	*Same population as LDL-C*			*Same population as LDL-C*		
Age	52.323	47.676	0.485	52.292	52.231	0.006
Sex (0 = male; 1 = female)	0.653	0.652	0.003	0.653	0.653	0.000
Urban/Rural (0 = urban; 1 = rural)	0.587	0.617	-0.062	0.586	0.586	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.796	0.688	0.266	0.795	0.795	0.000

HEALTH MANAGEMENT PROGRAM - STATEWIDE	2019 All Data (pre-balancing)			2019 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	HMP Mean	Comparison Mean	Standardized Difference	HMP Mean	Comparison Mean	Standardized Difference
HEDIS Measures						
Diabetes - HbA1c Testing	*Same population as LDL-C*			*Same population as LDL-C*		
Age	52.323	47.676	0.485	52.292	52.231	0.006
Sex (0 = male; 1 = female)	0.653	0.652	0.003	0.653	0.653	0.000
Urban/Rural (0 = urban; 1 = rural)	0.587	0.617	-0.062	0.586	0.586	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.796	0.688	0.266	0.795	0.795	0.000
Diabetes - Medical Attention for Nephropathy	*Same population as LDL-C*			*Same population as LDL-C*		
Age	52.323	47.676	0.485	52.292	52.231	0.006
Sex (0 = male; 1 = female)	0.653	0.652	0.003	0.653	0.653	0.000
Urban/Rural (0 = urban; 1 = rural)	0.587	0.617	-0.062	0.586	0.586	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.796	0.688	0.266	0.795	0.795	0.000
Hypertension - LDL-C Test						
Age	53.422	49.071	0.474	53.388	53.311	0.008
Sex (0 = male; 1 = female)	0.610	0.612	-0.003	0.611	0.611	0.000
Urban/Rural (0 = urban; 1 = rural)	0.577	0.607	-0.061	0.576	0.576	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.803	0.684	0.301	0.803	0.803	0.000
Hypertension - ACE/ARB Therapy	*Same population as LDL-C*			*Same population as LDL-C*		
Age	53.422	49.071	0.474	53.388	53.311	0.008
Sex (0 = male; 1 = female)	0.610	0.612	-0.003	0.611	0.611	0.000
Urban/Rural (0 = urban; 1 = rural)	0.577	0.607	-0.061	0.576	0.576	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.803	0.684	0.301	0.803	0.803	0.000
Opioid - Use of Opioids at High Dosage						
Age	53.402	47.712	0.645	53.423	53.388	0.004
Sex (0 = male; 1 = female)	0.643	0.698	-0.114	0.643	0.643	0.000
Urban/Rural (0 = urban; 1 = rural)	0.645	0.639	0.012	0.645	0.645	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.833	0.620	0.571	0.834	0.834	0.000

HEALTH MANAGEMENT PROGRAM - STATEWIDE	2019 All Data (pre-balancing)			2019 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	HMP Mean	Comparison Mean	Standardized Difference	HMP Mean	Comparison Mean	Standardized Difference
HEDIS Measures						
Opioid - Concurrent Use of Opioids and Benzodiazepines						
Age	52.710	45.810	0.740	52.655	52.554	0.011
Sex (0 = male; 1 = female)	0.659	0.709	-0.105	0.660	0.660	0.000
Urban/Rural (0 = urban; 1 = rural)	0.635	0.632	0.006	0.636	0.636	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.809	0.566	0.618	0.809	0.809	0.000
Child and Adolescents' Access to PCP - 12 months to 19 years						
Age	11.843	9.025	0.619	11.843	11.843	0.000
Sex (0 = male; 1 = female)	0.507	0.492	0.030	0.507	0.507	0.000
Urban/Rural (0 = urban; 1 = rural)	0.374	0.576	-0.417	0.374	0.374	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.357	0.033	0.676	0.357	0.357	0.000
Adults' Access to Preventive/Ambulatory Health Services						
Age	51.247	39.761	10.087	51.247	51.139	0.010
Sex (0 = male; 1 = female)	0.641	0.694	-0.111	0.641	0.641	0.000
Urban/Rural (0 = urban; 1 = rural)	0.582	0.598	-0.033	0.582	0.582	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.773	0.441	0.793	0.773	0.773	0.000

HEALTH MANAGEMENT PROGRAM - STATEWIDE	2019 All Data (pre-balancing)			2019 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	**HMP Mean**	**Comparison Mean**	**Standardized Difference**	**HMP Mean**	**Comparison Mean**	**Standardized Difference**
Utilization/Expenditure Measures						
Emergency Room Visits (per 1,000 member months) - All						
Age	48.869	13.419	2.559	48.840	48.813	0.002
Sex	0.649	0.518	0.275	0.649	0.649	0.000
Urban/Rural	0.599	0.564	0.071	0.599	0.599	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.791	0.098	1.703	0.792	0.792	0.000
Prior Year PMPM - Top 2%	0.272	0.047	0.506	0.272	0.272	0.000
Hospital Admissions (per 100,000 member months) - All	*Same population as Emergency Room*			*Same population as Emergency Room*		
Age	48.869	13.419	2.559	48.840	48.813	0.002
Sex	0.649	0.518	0.275	0.649	0.649	0.000
Urban/Rural	0.599	0.564	0.071	0.599	0.599	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.791	0.098	1.703	0.792	0.792	0.000
Prior Year PMPM - Top 2%	0.272	0.047	0.506	0.272	0.272	0.000
Hospital Readmission Rate - All	*Same population as Emergency Room*			*Same population as Emergency Room*		
Age	48.869	13.419	2.559	48.840	48.813	0.002
Sex	0.649	0.518	0.275	0.649	0.649	0.000
Urban/Rural	0.599	0.564	0.071	0.599	0.599	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.791	0.098	1.703	0.792	0.792	0.000
Prior Year PMPM - Top 2%	0.272	0.047	0.506	0.272	0.272	0.000
Per Member Per Month Expenditures - All	*Same population as Emergency Room*			*Same population as Emergency Room*		
Age	48.869	13.419	2.559	48.840	48.813	0.002
Sex	0.649	0.518	0.275	0.649	0.649	0.000
Urban/Rural	0.599	0.564	0.071	0.599	0.599	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.791	0.098	1.703	0.792	0.792	0.000
Prior Year PMPM - Top 5%	0.272	0.047	0.506	0.272	0.272	0.000

HEALTH MANAGEMENT PROGRAM - STATEWIDE	2020 All Data (pre-balancing)			2020 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	HMP Mean	Comparison Mean	Standardized Difference	HMP Mean	Comparison Mean	Standardized Difference
HEDIS Measures						
Asthma - Medication Ratio - 5 to 18 years						
Age	12.873	11.139	0.447	12.873	12.873	0.000
Gender (0 = male; 1 = female)	0.522	0.492	0.061	0.522	0.522	0.000
Urban/Rural (0 = urban; 1 = rural)	0.409	0.576	-0.340	0.409	0.409	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.252	0.034	0.502	0.252	0.252	0.000
Asthma - Medication Ratio - 19 to 64 years						
Age	47.820	35.222	1.055	47.820	47.788	0.003
Sex (0 = male; 1 = female)	0.701	0.699	0.004	0.701	0.701	0.000
Urban/Rural (0 = urban; 1 = rural)	0.529	0.580	-0.104	0.529	0.529	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.638	0.285	0.736	0.638	0.638	0.000
CAD - Persistent Beta-Blocker Treatment after a Heart Attack						
Age	56.889	55.551	0.198	56.952	56.952	0.000
Sex (0 = male; 1 = female)	0.511	0.509	0.005	0.506	0.506	0.000
Urban/Rural (0 = urban; 1 = rural)	0.576	0.623	-0.094	0.580	0.580	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.856	0.824	0.092	0.865	0.865	0.000
CAD - Cholesterol Management - LDL-C Test	*Same population as CAD Beta Blocker*			*Same population as CAD Beta Blocker*		
Age	56.889	55.551	0.198	56.952	56.952	0.000
Sex (0 = male; 1 = female)	0.511	0.509	0.005	0.506	0.506	0.000
Urban/Rural (0 = urban; 1 = rural)	0.576	0.623	-0.094	0.580	0.580	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.856	0.824	0.092	0.865	0.865	0.000

HEALTH MANAGEMENT PROGRAM - STATEWIDE	2020 All Data (pre-balancing)			2020 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	HMP Mean	Comparison Mean	Standardized Difference	HMP Mean	Comparison Mean	Standardized Difference
HEDIS Measures						
COPD - Use of Spirometry Testing						
Age	52.325	37.031	1.318	52.414	52.267	0.013
Sex (0 = male; 1 = female)	0.629	0.553	0.157	0.634	0.634	0.000
Urban/Rural (0 = urban; 1 = rural)	0.591	0.611	-0.041	0.596	0.596	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.861	0.656	0.591	0.865	0.865	0.000
COPD - Pharmacotherapy Management of Exacerbation - 14 days						
Age	55.660	53.066	0.369	55.780	55.737	0.006
Sex (0 = male; 1 = female)	0.618	0.645	-0.055	0.627	0.627	0.000
Urban/Rural (0 = urban; 1 = rural)	0.557	0.585	-0.057	0.550	0.550	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.901	0.821	0.268	0.909	0.909	0.000
COPD - Pharmacotherapy Management of Exacerbation - 30 days	*Same population as 14 days*			*Same population as 14 days*		
Age	55.660	53.066	0.369	55.780	55.737	0.006
Sex (0 = male; 1 = female)	0.618	0.645	-0.055	0.627	0.627	0.000
Urban/Rural (0 = urban; 1 = rural)	0.557	0.585	-0.057	0.550	0.550	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.901	0.821	0.268	0.909	0.909	0.000
Diabetes - Members who had LDL-C Test						
Age	51.814	46.351	0.538	51.806	51.738	0.007
Sex (0 = male; 1 = female)	0.651	0.667	-0.034	0.651	0.651	0.000
Urban/Rural (0 = urban; 1 = rural)	0.547	0.597	-0.101	0.548	0.548	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.748	0.586	0.374	0.748	0.748	0.000
Diabetes - Retinal Eye Exam	*Same population as LDL-C*			*Same population as LDL-C*		
Age	51.814	46.351	0.538	51.806	51.738	0.007
Sex (0 = male; 1 = female)	0.651	0.667	-0.034	0.651	0.651	0.000
Urban/Rural (0 = urban; 1 = rural)	0.547	0.597	-0.101	0.548	0.548	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.748	0.586	0.374	0.748	0.748	0.000

HEALTH MANAGEMENT PROGRAM - STATEWIDE	2020 All Data (pre-balancing)			2020 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	HMP Mean	Comparison Mean	Standardized Difference	HMP Mean	Comparison Mean	Standardized Difference
HEDIS Measures						
Diabetes - HbA1c Testing	*Same population as LDL-C*			*Same population as LDL-C*		
Age	51.814	46.351	0.538	51.806	51.738	0.007
Sex (0 = male; 1 = female)	0.651	0.667	-0.034	0.651	0.651	0.000
Urban/Rural (0 = urban; 1 = rural)	0.547	0.597	-0.101	0.548	0.548	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.748	0.586	0.374	0.748	0.748	0.000
Diabetes - Medical Attention for Nephropathy	*Same population as LDL-C*			*Same population as LDL-C*		
Age	51.814	46.351	0.538	51.806	51.738	0.007
Sex (0 = male; 1 = female)	0.651	0.667	-0.034	0.651	0.651	0.000
Urban/Rural (0 = urban; 1 = rural)	0.547	0.597	-0.101	0.548	0.548	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.748	0.586	0.374	0.748	0.748	0.000
Hypertension - LDL-C Test						
Age	52.680	47.621	0.522	52.680	52.630	0.005
Sex (0 = male; 1 = female)	0.632	0.624	0.017	0.632	0.632	0.000
Urban/Rural (0 = urban; 1 = rural)	0.552	0.588	-0.071	0.552	0.552	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.762	0.584	0.419	0.762	0.762	0.000
Hypertension - ACE/ARB Therapy	*Same population as LDL-C*			*Same population as LDL-C*		
Age	52.680	47.621	0.522	52.680	52.630	0.005
Sex (0 = male; 1 = female)	0.632	0.624	0.017	0.632	0.632	0.000
Urban/Rural (0 = urban; 1 = rural)	0.552	0.588	-0.071	0.552	0.552	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.762	0.584	0.419	0.762	0.762	0.000
Opioid - Use of Opioids at High Dosage						
Age	52.168	47.419	0.494	52.193	52.149	0.005
Sex (0 = male; 1 = female)	0.655	0.702	-0.098	0.656	0.656	0.000
Urban/Rural (0 = urban; 1 = rural)	0.605	0.602	0.006	0.606	0.606	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.754	0.575	0.417	0.754	0.754	0.000

HEALTH MANAGEMENT PROGRAM - STATEWIDE	2020 All Data (pre-balancing)			2020 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	HMP Mean	Comparison Mean	Standardized Difference	HMP Mean	Comparison Mean	Standardized Difference
HEDIS Measures						
Opioid - Concurrent Use of Opioids and Benzodiazepines						
Age	51.291	45.297	0.585	51.284	51.226	0.006
Sex (0 = male; 1 = female)	0.673	0.716	-0.092	0.673	0.673	0.000
Urban/Rural (0 = urban; 1 = rural)	0.580	0.600	-0.040	0.580	0.580	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.717	0.514	0.452	0.718	0.718	0.000
Child and Adolescents' Access to PCP - 12 months to 19 years						
Age	13.464	9.254	0.954	13.464	13.464	0.000
Sex (0 = male; 1 = female)	0.546	0.493	0.107	0.546	0.546	0.000
Urban/Rural (0 = urban; 1 = rural)	0.421	0.574	-0.310	0.421	0.421	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.249	0.029	0.509	0.249	0.249	0.000
Adults' Access to Preventive/Ambulatory Health Services						
Age	48.603	37.771	0.917	48.603	48.536	0.006
Sex (0 = male; 1 = female)	0.695	0.725	-0.066	0.695	0.695	0.000
Urban/Rural (0 = urban; 1 = rural)	0.530	0.578	-0.097	0.530	0.530	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.653	0.320	0.699	0.653	0.653	0.000

HEALTH MANAGEMENT PROGRAM - STATEWIDE	2020 All Data (pre-balancing)			2020 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	HMP Mean	Comparison Mean	Standardized Difference	HMP Mean	Comparison Mean	Standardized Difference
Utilization/Expenditure Measures						
Emergency Room Visits (per 1,000 member months) - All						
Age	46.526	13.515	2.247	46.417	46.308	0.007
Sex	0.687	0.519	0.364	0.688	0.688	0.000
Urban/Rural	0.535	0.574	-0.080	0.535	0.535	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.662	0.087	1.216	0.666	0.666	0.000
Prior Year PMPM - Top 5%	0.263	0.046	0.494	0.264	0.264	0.000
Hospital Admissions (per 100,000 member months) - All	*Same population as Emergency Room*			*Same population as Emergency Room*		
Age	46.526	13.515	2.247	46.417	46.308	0.007
Sex	0.687	0.519	0.364	0.688	0.688	0.000
Urban/Rural	0.535	0.574	-0.080	0.535	0.535	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.662	0.087	1.216	0.666	0.666	0.000
Prior Year PMPM - Top 5%	0.263	0.046	0.494	0.264	0.264	0.000
Hospital Readmission Rate - All	*Same population as Emergency Room*			*Same population as Emergency Room*		
Age	46.526	13.515	2.247	46.417	46.308	0.007
Sex	0.687	0.519	0.364	0.688	0.688	0.000
Urban/Rural	0.535	0.574	-0.080	0.535	0.535	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.662	0.087	1.216	0.666	0.666	0.000
Prior Year PMPM - Top 5%	0.263	0.046	0.494	0.264	0.264	0.000
Per Member Per Month Expenditures - All	*Same population as Emergency Room*			*Same population as Emergency Room*		
Age	46.526	13.515	2.247	46.417	46.308	0.007
Sex	0.687	0.519	0.364	0.688	0.688	0.000
Urban/Rural	0.535	0.574	-0.080	0.535	0.535	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.662	0.087	1.216	0.666	0.666	0.000
Prior Year PMPM - Top 5%	0.263	0.046	0.494	0.264	0.264	0.000

HEALTH MANAGEMENT PROGRAM - STATEWIDE	2021 All Data (pre-balancing)			2021 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	HMP Mean	Comparison Mean	Standardized Difference	HMP Mean	Comparison Mean	Standardized Difference
HEDIS Measures						
Asthma - Medication Ratio - 5 to 18 years						
Age	12.347	11.257	0.278	12.347	12.347	0.000
Gender (0 = male; 1 = female)	0.433	0.491	-0.115	0.434	0.434	0.000
Urban/Rural (0 = urban; 1 = rural)	0.403	0.589	-0.380	0.403	0.403	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.511	0.029	0.963	0.511	0.511	0.000
Asthma - Medication Ratio - 19 to 64 years						
Age	48.795	33.357	1.295	48.795	48.771	0.002
Sex (0 = male; 1 = female)	0.671	0.688	-0.036	0.671	0.671	0.000
Urban/Rural (0 = urban; 1 = rural)	0.513	0.594	-0.163	0.513	0.513	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.701	0.233	1.022	0.701	0.701	0.000
CAD - Persistent Beta-Blocker Treatment after a Heart Attack						
Age	57.565	55.940	0.000	57.452	57.295	0.023
Sex (0 = male; 1 = female)	0.506	0.501	0.000	0.501	0.501	0.000
Urban/Rural (0 = urban; 1 = rural)	0.566	0.622	0.000	0.569	0.569	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.701	0.233	1.022	0.701	0.701	0.000
CAD - Cholesterol Management - LDL-C Test	*Same population as CAD Beta Blocker*			*Same population as CAD Beta Blocker*		
Age	57.565	55.940	0.000	57.452	57.295	0.023
Sex (0 = male; 1 = female)	0.506	0.501	0.000	0.501	0.501	0.000
Urban/Rural (0 = urban; 1 = rural)	0.566	0.622	0.000	0.569	0.569	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.701	0.233	1.022	0.701	0.701	0.000

HEALTH MANAGEMENT PROGRAM - STATEWIDE	2021 All Data (pre-balancing)			2021 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	HMP Mean	Comparison Mean	Standardized Difference	HMP Mean	Comparison Mean	Standardized Difference
HEDIS Measures						
COPD - Use of Spirometry Testing						
Age	56.017	53.918	0.314	56.125	56.068	0.009
Sex (0 = male; 1 = female)	0.612	0.629	-0.035	0.617	0.617	0.000
Urban/Rural (0 = urban; 1 = rural)	0.593	0.671	-0.159	0.598	0.598	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.861	0.656	0.591	0.865	0.865	0.000
COPD - Pharmacotherapy Management of Exacerbation - 14 days						
Age	57.507	56.097	0.224	57.863	57.952	-0.014
Sex (0 = male; 1 = female)	0.637	0.659	-0.046	0.669	0.669	0.000
Urban/Rural (0 = urban; 1 = rural)	0.541	0.633	-0.184	0.547	0.547	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.861	0.656	0.591	0.865	0.865	0.000
COPD - Pharmacotherapy Management of Exacerbation - 30 days	*Same population as 14 days*			*Same population as 14 days*		
Age	57.507	56.097	0.224	57.863	57.952	-0.014
Sex (0 = male; 1 = female)	0.637	0.659	-0.046	0.669	0.669	0.000
Urban/Rural (0 = urban; 1 = rural)	0.541	0.633	-0.184	0.547	0.547	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.861	0.656	0.591	0.865	0.865	0.000
Diabetes - Members who had LDL-C Test						
Age	52.790	46.105	0.663	52.701	52.668	0.003
Sex (0 = male; 1 = female)	0.633	0.677	-0.090	0.631	0.631	0.000
Urban/Rural (0 = urban; 1 = rural)	0.534	0.618	-0.167	0.531	0.531	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.748	0.586	0.374	0.748	0.748	0.000
Diabetes - Retinal Eye Exam	*Same population as LDL-C*			*Same population as LDL-C*		
Age	52.790	46.105	0.663	52.701	52.668	0.003
Sex (0 = male; 1 = female)	0.633	0.677	-0.090	0.631	0.631	0.000
Urban/Rural (0 = urban; 1 = rural)	0.534	0.618	-0.167	0.531	0.531	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.748	0.586	0.374	0.748	0.748	0.000

HEALTH MANAGEMENT PROGRAM - STATEWIDE	2021 All Data (pre-balancing)			2021 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	HMP Mean	Comparison Mean	Standardized Difference	HMP Mean	Comparison Mean	Standardized Difference
HEDIS Measures						
Diabetes - HbA1c Testing	*Same population as LDL-C*			*Same population as LDL-C*		
Age	52.790	46.105	0.663	52.701	52.668	0.003
Sex (0 = male; 1 = female)	0.633	0.677	-0.090	0.631	0.631	0.000
Urban/Rural (0 = urban; 1 = rural)	0.534	0.618	-0.167	0.531	0.531	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.748	0.586	0.374	0.748	0.748	0.000
Diabetes - Medical Attention for Nephropathy	*Same population as LDL-C*			*Same population as LDL-C*		
Age	52.790	46.105	0.663	52.701	52.668	0.003
Sex (0 = male; 1 = female)	0.633	0.677	-0.090	0.631	0.631	0.000
Urban/Rural (0 = urban; 1 = rural)	0.534	0.618	-0.167	0.531	0.531	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.748	0.586	0.374	0.748	0.748	0.000
Hypertension - LDL-C Test						
Age	53.999	48.613	0.567	53.992	53.956	0.004
Sex (0 = male; 1 = female)	0.605	0.617	-0.025	0.605	0.605	0.000
Urban/Rural (0 = urban; 1 = rural)	0.535	0.610	-0.152	0.535	0.535	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.762	0.584	0.419	0.762	0.762	0.000
Hypertension - ACE/ARB Therapy	*Same population as LDL-C*			*Same population as LDL-C*		
Age	53.999	48.613	0.567	53.992	53.956	0.004
Sex (0 = male; 1 = female)	0.605	0.617	-0.025	0.605	0.605	0.000
Urban/Rural (0 = urban; 1 = rural)	0.535	0.610	-0.152	0.535	0.535	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.762	0.584	0.419	0.762	0.762	0.000
Opioid - Use of Opioids at High Dosage						
Age	53.954	48.313	0.563	53.575	53.475	0.011
Sex (0 = male; 1 = female)	0.654	0.698	-0.092	0.655	0.655	0.000
Urban/Rural (0 = urban; 1 = rural)	0.597	0.629	-0.065	0.596	0.596	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.754	0.575	0.417	0.754	0.754	0.000

HEALTH MANAGEMENT PROGRAM - STATEWIDE	2021 All Data (pre-balancing)			2021 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	HMP Mean	Comparison Mean	Standardized Difference	HMP Mean	Comparison Mean	Standardized Difference
HEDIS Measures						
Opioid - Concurrent Use of Opioids and Benzodiazepines						
Age	52.772	45.450	0.734	52.772	52.696	0.000
Sex (0 = male; 1 = female)	0.671	0.720	0.000	0.671	0.008	2.946
Urban/Rural (0 = urban; 1 = rural)	0.576	0.626	0.000	0.576	0.576	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.717	0.514	0.452	0.718	0.718	0.000
Child and Adolescents' Access to PCP - 12 months to 19 years						
Age	13.157	9.832	0.746	13.157	13.130	0.006
Sex (0 = male; 1 = female)	0.440	0.492	-0.105	0.440	0.440	0.000
Urban/Rural (0 = urban; 1 = rural)	0.400	0.587	-0.383	0.400	0.400	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.249	0.029	0.509	0.249	0.249	0.000
Adults' Access to Preventive/Ambulatory Health Services						
Age	49.930	37.063	1.090	49.926	49.845	0.007
Sex (0 = male; 1 = female)	0.666	0.729	-0.133	0.666	0.666	0.000
Urban/Rural (0 = urban; 1 = rural)	0.516	0.594	-0.156	0.516	0.516	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.653	0.320	0.699	0.653	0.653	0.000

HEALTH MANAGEMENT PROGRAM - STATEWIDE	2021 All Data (pre-balancing)			2021 Matched Data (post-balancing)		
HEDIS and Utilization/Expenditure Measures	HMP Mean	Comparison Mean	Standardized Difference	HMP Mean	Comparison Mean	Standardized Difference
Utilization/Expenditure Measures						
Emergency Room Visits (per 1,000 member months) - All						
Age	46.822	13.992	2.113	46.772	46.719	0.003
Sex	0.645	0.524	0.251	0.646	0.646	0.000
Urban/Rural	0.517	0.588	-0.143	0.516	0.516	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.740	0.078	1.508	0.742	0.742	0.000
Prior Year PMPM - Top 5%	0.268	0.045	0.504	0.269	0.269	0.000
Hospital Admissions (per 100,000 member months) - All	*Same population as Emergency Room*			*Same population as Emergency Room*		
Age	46.822	13.992	2.113	46.772	46.719	0.003
Sex	0.645	0.524	0.251	0.646	0.646	0.000
Urban/Rural	0.517	0.588	-0.143	0.516	0.516	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.740	0.078	1.508	0.742	0.742	0.000
Prior Year PMPM - Top 5%	0.268	0.045	0.504	0.269	0.269	0.000
Hospital Readmission Rate - All	*Same population as Emergency Room*			*Same population as Emergency Room*		
Age	46.822	13.992	2.113	46.772	46.719	0.003
Sex	0.645	0.524	0.251	0.646	0.646	0.000
Urban/Rural	0.517	0.588	-0.143	0.516	0.516	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.740	0.078	1.508	0.742	0.742	0.000
Prior Year PMPM - Top 5%	0.268	0.045	0.504	0.269	0.269	0.000
Per Member Per Month Expenditures - All	*Same population as Emergency Room*			*Same population as Emergency Room*		
Age	46.822	13.992	2.113	46.772	46.719	0.003
Sex	0.645	0.524	0.251	0.646	0.646	0.000
Urban/Rural	0.517	0.588	-0.143	0.516	0.516	0.000
ABD/non-ABD (0 = non-ABD; 1 - ABD)	0.740	0.078	1.508	0.742	0.742	0.000
Prior Year PMPM - Top 5%	0.268	0.045	0.504	0.269	0.269	0.000

11. HMP Statistical Significance Test Results - 2019 – 2021 and 3-Year Pooled

HEALTH MANAGEMENT PROGRAM - HEALTH COACHING	Percent Compliant				P-Value/Statistical Significance (p < .05)			
HEDIS and Utilization/Expenditure Measures	2019	2020	2021	Pooled	2019	2020	2021	Pooled
HEDIS Measures								
Asthma - Medication Ratio - 5 to 18 years								
HMP	72.7%	75.3%	88.4%	78.8%	0.1570	0.0496	0.2969	0.0000
Comparison Group	81.5%	84.3%	92.4%	86.1%	No	**Yes**	No	**Yes**
Asthma - Medication Ratio - 19 to 64 years								
HMP	80.6%	78.0%	90.8%	83.1%	0.0448	0.7251	0.2542	0.0001
Comparison Group	74.1%	77.0%	87.2%	79.4%	**Yes**	No	No	**Yes**
CAD - Persistent Beta-Blocker Treatment after a Heart Attack								
HMP	44.1%	46.0%	49.6%	46.6%	0.5611	0.6924	0.4286	0.2814
Comparison Group	42.6%	47.1%	47.4%	45.7%	No	No	No	No
CAD - Cholesterol Management - LDL-C Test								
HMP	65.8%	63.6%	67.3%	65.6%	0.0985	0.0232	0.0000	0.0001
Comparison Group	61.7%	57.7%	60.3%	59.9%	No	**Yes**	**Yes**	**Yes**
COPD - Use of Spirometry Testing								
HMP	24.9%	24.2%	18.1%	22.4%	0.5372	0.0171	0.0697	0.0028
Comparison Group	23.3%	18.2%	14.3%	18.6%	No	**Yes**	No	**Yes**
COPD - Pharmacotherapy Management of Exacerbation - 14 days								
HMP	68.9%	62.7%	66.2%	65.9%	0.2360	0.2583	0.1081	0.1390
Comparison Group	64.0%	67.6%	74.5%	68.7%	No	No	No	No
COPD - Pharmacotherapy Management of Exacerbation - 30 days								
HMP	76.8%	69.9%	80.6%	75.8%	0.2900	0.5519	0.1823	0.1315
Comparison Group	72.7%	72.3%	74.4%	73.1%	No	No	No	No
Diabetes - HbA1c Testing								
HMP	80.2%	77.9%	80.0%	79.4%	0.0000	0.0000	0.0000	0.0000
Comparison Group	72.5%	65.8%	68.2%	68.8%	**Yes**	**Yes**	**Yes**	**Yes**

HEALTH MANAGEMENT PROGRAM - HEALTH COACHING	Percent Compliant				P-Value/Statistical Significance (p < .05)			
HEDIS and Utilization/Expenditure Measures	2019	2020	2021	Pooled	2019	2020	2021	Pooled
HEDIS Measures								
Diabetes - LDL-C Test								
HMP	65.5%	64.8%	67.2%	65.8%	0.0000	0.0000	0.0000	0.0000
Comparison Group	58.1%	50.5%	56.7%	55.1%	**Yes**	**Yes**	**Yes**	**Yes**
Diabetes - Retinal Eye Exam								
HMP	32.2%	32.8%	36.0%	33.7%	0.0000	0.0000	0.0000	0.0000
Comparison Group	25.3%	19.8%	21.5%	22.2%	**Yes**	**Yes**	**Yes**	**Yes**
Diabetes - Medical Attention for Nephropathy								
HMP	89.3%	85.8%	86.9%	87.3%	0.0000	0.0000	0.0000	0.0000
Comparison Group	84.7%	78.6%	80.7%	81.3%	**Yes**	**Yes**	**Yes**	**Yes**
Hypertension - LDL-C Test								
HMP	62.0%	61.5%	64.4%	62.6%	0.0000	0.0000	0.0000	0.0000
Comparison Group	58.1%	53.4%	57.2%	56.2%	**Yes**	**Yes**	**Yes**	**Yes**
Hypertension - ACE/ARB Therapy								
HMP	67.1%	65.5%	67.5%	66.7%	0.0000	0.0000	0.0000	0.0000
Comparison Group	63.8%	62.8%	64.1%	63.6%	**Yes**	**Yes**	**Yes**	**Yes**
Opioid - Use of Opioids at High Dosage								
HMP	4.3%	3.0%	3.4%	3.6%	0.4017	0.0000	0.2208	0.0133
Comparison Group	4.9%	4.4%	4.2%	4.5%	No	**Yes**	No	**Yes**
Opioid - Concurrent Use of Opioids and Benzodiazepines								
HMP	12.9%	9.2%	10.2%	10.8%	0.0000	0.0000	0.6626	0.0001
Comparison Group	15.5%	12.6%	10.6%	12.9%	**Yes**	**Yes**	No	**Yes**
Child and Adolescents' Access to PCP - 12 months to 19 years								
HMP	98.3%	99.2%	98.0%	98.5%	0.0000	0.0000	0.0000	0.0000
Comparison Group	93.5%	90.5%	83.4%	89.1%	**Yes**	**Yes**	**Yes**	**Yes**
Adults' Access to Preventive/Ambulatory Health Services								
HMP	87.4%	97.2%	97.5%	94.0%	0.0000	0.0000	0.0000	0.0000
Comparison Group	88.7%	84.5%	82.1%	85.1%	**Yes**	**Yes**	**Yes**	**Yes**

HEALTH MANAGEMENT PROGRAM - HEALTH COACHING	Percent Compliant				P-Value/Statistical Significance (p < .05)			
HEDIS and Utilization/Expenditure Measures	**2019**	**2020**	**2021**	**Pooled**	**2019**	**2020**	**2021**	**Pooled**
Utilization/Expenditure Measures								
Emergency Room Visits (per 1,000 member months) - All								
HMP	162.7	142.4	137.5	147.5	0.0000	0.0000	0.0000	0.0000
Comparison Group	186.8	158.9	158.0	167.9	**Yes**	**Yes**	**Yes**	**Yes**
Hospital Admissions (per 100,000 member months) - All								
HMP	3324.3	2736.2	2654.5	2905.0	0.3855	0.0000	0.0000	0.0158
Comparison Group	3518.2	3112.8	3161.5	3264.2	No	**Yes**	**Yes**	**Yes**
Hospital Readmission Rate - All								
HMP	6.0%	5.3%	5.7%	5.7%	0.1680	0.3613	0.4568	0.0098
Comparison Group	6.9%	5.8%	6.1%	6.3%	No	No	No	**Yes**
Per Member Per Month Expenditures - All								
HMP	$ 550.09	$ 616.09	$ 690.77	$ 618.98	0.0000	0.0000	0.0000	0.0000
Comparison Group	$ 728.57	$ 743.48	$ 829.46	$ 767.17	**Yes**	**Yes**	**Yes**	**Yes**

12. HMP Member Targeted Survey Instrument (SDOH Component)

1. The SoonerCare Health Management Program can help members deal with non-medical problems. For example, the program can help with eligibility issues or getting equipment like a wheelchair or getting help with food, electricity, heating and other needs. Did you know the Health Management Program can provide this kind of help?
    a. Yes
    b. No
    c. Don't Know/Not Sure

2. Some of this help is provided by Community Resource Specialists. Have you heard of the Community Resource Specialists?
    a. Yes
    b. No
    c. Don't Know/Not Sure

3. Have you or your Health Coach used a Community Resource Specialist to help you with a problem like the ones I mentioned? [IF NO] Has your Health Coach himself/herself helped you with a problem like the ones I mentioned?
    a. Yes – CRS helped
    b. Yes – Health Coach helped
    c. No to both → [GO TO Q40]
    d. Don't Know/Note Sure → [GO TO Q40]

4. Thinking about the last time you received help, what problem did get help in resolving?
    a. Housing/rent
    b. Food
    c. Child care
    d. Transportation. SPECIFY DESTINATION:
    _____
    e. Don't Know/Not Sure
    f. Other. SPECIFY:
    _____

5. How helpful was the Community Resource Specialist or Health Coach in solving the problem? Would you say s/he was very helpful, somewhat helpful, not very helpful or not at all helpful?

a. Very helpful
b. Somewhat helpful
c. Not very helpful
d. Not at all helpful
e. Don't Know/Not Sure

6. What did the Community Resource Specialist or Health Coach do?
    a. RECORD:
    _____
    b. Don't Know/Not Sure

13. Retroactive Eligibility Analysis Survey Instrument

Hello, my name is _____ and I am calling on behalf of the Oklahoma SoonerCare program. May I please speak to {RESPONDENT NAME}?

INTRO1. We are conducting a short survey to find out about where SoonerCare members get their health care. The survey takes about 10 minutes.

[ANSWER ANY QUESTIONS AND PROCEED TO QUESTION 1]

INTRO2. [If need to leave a message] We are conducting a short survey to find out about where SoonerCare members get their health care. We can be reached toll-free at 1-888-941-9358.

2. SoonerCare and Insure Oklahoma are health insurance programs offered by the state. Are you currently enrolled either in SoonerCare or Insure Oklahoma?[92]
    a. Yes, SoonerCare → [GO TO QUESTION 6]
    b. Yes, Insure Oklahoma → [GO TO QUESTION 6]
    c. No
    d. Don't Know/Not Sure → [ASK IF ENROLLED IN MEDICAID. IF NO, END CALL]

3. The SoonerCare program also is known as Medicaid. Are you currently enrolled in the Oklahoma Medicaid program?
    a. Yes → [GO TO QUESTION 6]
    b. No
    c. Don't Know/Not Sure

4. Have you been enrolled in SoonerCare or Oklahoma Medicaid in the past?
    a. Yes
    b. No → [EXPLAIN THAT THE SURVEY IS FOR SOONERCARE MEMBERS. END CALL]
    c. Don't Know/Not Sure → [EXPLAIN THAT THE SURVEY IS FOR SOONERCARE MEMBERS. END CALL]

5. About how long ago did you disenroll?
    a. Within the past month
    b. One to three months ago
    c. Four to six months ago
    d. Seven months to one year ago
    e. More than one year ago

[92] All questions include a "don't know/not sure" or similar option which is unprompted by the surveyor; this response is listed on the instrument to allow surveyors to document such a response.

f. Don't Know/Not Sure

6. Did you reapply for the program after you were disenrolled? If yes, what happened?
    a. Reapplied – waiting for determination
    b. Reapplied – approved [CONFIRM MEMBER IS NOT CURRENTLY ENROLLED]
    c. Reapplied – denied
    d. Did not reapply – had other health coverage
    e. Did not reapply – did not have other health coverage
    f. Don't Know/Not Sure

[USUAL CARE QUESTIONS] *Red italics – baseline survey only*

These first questions ask about your own health care. Do not include care you got when you stayed overnight in a hospital. Do not include the times you went for dental care visits.

7. In the last six months *prior to your enrollment in SoonerCare (Insure Oklahoma)*, how often was it easy to get the care, tests or treatment you needed? [CAHPS 5.0H – HEALTH PLAN ADULT SURVEY]
    a. Never
    b. Sometimes
    c. Usually
    d. Always
    e. Don't Know/Not Sure

8. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors and other doctors who specialize in one area of health care. In the last six months *prior to your enrollment in SoonerCare (Insure Oklahoma)*, did you make any appointments to see a specialist? [CAHPS 5.0H – HEALTH PLAN ADULT SURVEY]
    a. Yes
    b. No → [GO TO Q9]
    c. Don't Know/Not Sure → [GO TO Q9]

9. In the last six months *prior to your enrollment in SoonerCare (Insure Oklahoma)*, how often did you get an appointment to see a specialist as soon as you needed? [CAHPS 5.0H – HEALTH PLAN ADULT SURVEY]
    a. Never
    b. Sometimes
    c. Usually
    d. Always
    e. Don't Know/Not Sure

10. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last six months *prior to your enrollment in SoonerCare (Insure Oklahoma)*? [CAHPS 5.0H – HEALTH PLAN ADULT SURVEY]

    RECORD NUMBER _____

11. This next question asks about your experience with your SoonerCare (Insure Oklahoma) health plan. Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan? [CAHPS 5.0H – HEALTH PLAN ADULT SURVEY]

    RECORD NUMBER _____

[HEALTH STATUS]

These next questions ask about your health.

12. Would you say that in general your health is? [BRFSS 2018]
    a. Excellent
    b. Very Good
    c. Good
    d. Fair
    e. Poor
    f. Don't Know/Not Sure

13. Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good? [BRFSS 2018]
    a. None
    b. Record Number between 1 and 30 _____
    c. Don't Know/Not Sure

14. Now thinking about your mental health, which includes stress, depression and problems with emotions, for how many days during the past 30 days was your mental health not good? [EMPHASIZE “MENTAL HEALTH” TO ENSURE DISTINCTION IS MADE] [BRFSS 2018]
    a. None
    b. Record Number between 1 and 30 _____
    c. Don’t Know/Not Sure

15. In the last 12 months, how many times did you go to an emergency room to get care for yourself? [CAHPS 5.0H – HEALTH PLAN ADULT SURVEY]
    a. None
    b. 1 time
    c. 2 times
    d. 3 times
    e. 4 times
    f. 5 to 9 times
    g. 10 or more times
    h. Don’t Know/Not Sure

16. Have you been hospitalized overnight in the past 12 months? Do not include an overnight stay in the emergency room [FHOSPYR, NHIS DRAFT 2018 - FAMILY]
    a. Yes
    b. No
    c. Don’t Know/Not Sure

Those are all the questions I have today. We may contact you again in the future to follow-up and learn if anything about your health care has changed. Thank you for your help.

14. Retroactive Eligibility CEM Covariate Balance Tables for Survey Measures

RETROACTIVE ELIGIBILITY ANALYSIS	All Data (pre-balancing)			Matched Data (post-balancing)		
Retroactive Eligibility Survey Measures	**Population Subject to Waiver Mean**	**Comparison Mean**	**Standardized Difference**	**Population Subject to Waiver Mean**	**Comparison Mean**	**Standardized Difference**
All Measures						
Matching Variables						
Age	36.960	34.963	0.195	37.120	37.120	0.000
Gender (0 = male; 1 = female)	0.586	0.810	-0.454	0.642	0.642	0.000
Urban/Rural (0 = urban; 1 = rural)	0.456	0.469	-0.025	0.448	0.448	0.000

15. Retroactive Eligibility Statistical Significance Test Results for Survey Measures

Survey Measure	Population Subject to Waiver	Comparison Group	P-Value	Statistically Significant
Self-Reported Health Status				
Excellent	11.9%	4.5%	*0.1191*	*No*
Very Good	29.9%	13.0%	*0.0585*	*No*
Good	36.6%	17.0%	*0.00215*	*Yes*
Fair	16.2%	51.6%	*0.0030*	*Yes*
Poor	5.4%	13.9%	*0.0539*	*No*
Number of ED Visits in Past 12 Months				
None	68.4%	53.7%	*0.2675*	*No*
1 Visit	18.6%	17.1%	*0.8147*	*No*
2 Visits	5.4%	15.3%	*0.1763*	*No*
3 Visits	3.8%	5.9%	*0.4500*	*No*
4 Visits	1.3%	1.7%	*0.7057*	*No*
5 - 9 Visits	2.0%	4.7%	*0.1981*	*No*
10 or More Visits	0.4%	1.5%	*0.2660*	*No*
Hospitalized in Past 12 Months				
Yes	12.6%	13.3%	*0.8382*	*No*
No	87.4%	86.7%		
Not Healthy Days out of Past 30 Days				
Physical Health - Mean	4.6	10.0	*0.0069*	*Yes*
Mental Health - Mean	6.2	12.3	*0.0220*	*Yes*

Appendix D

External Quality Review Organization (EQRO) & Quality Assurance Monitoring Summaries

Consumer Assessment of Healthcare Providers & Systems® (CAHPS®) Surveys

SoonerCare CAHPS® surveys are contracted through an External Quality Review Organization (EQRO) who works with a Healthcare Effectiveness Data and Information Set® (HEDIS®) certified vendor to conduct the surveys. As of 2022, the current EQRO for SoonerCare is KFMC Health Improvement Partners and the HEDIS® certified vendor is SPH Analytics. The most recent quality assurance monitoring for the SoonerCare Choice program include the surveys listed in Exhibit 1.

Exhibit 1. 2021 Quality Assurance Monitoring

Year	Survey	EQRO
2022	My 2021 CAHPS® Medicaid Adult 5.1 Survey	KFMC Health Improvement Partners / SPH Analytics
2018	2018 CAHPS® Adult Medicaid Survey Summary Report	Telligen / Morpace (Now known as SPH Analytics)
2022	MY 2021 CAHPS® SoonerCare Child with CCC 5.1 Survey	KFMC Health Improvement Partners / SPH Analytics
2021	MY 2020 CAHPS® Medicaid Child 5.1 Final Report	KFMC Health Improvement Partners / SPH Analytics

The objective of the CAHPS® survey are to capture accurate and complete information about consumer-reported experiences with SoonerCare Choice by:

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

OHCA conducts the CAHPS® survey designed for children annually. The sample is from members enrolled via the Children's Health Insurance Program (CHIP) except for 2022 which is the general Title XIX population.

Exhibit 2. CAHPS® Medicaid Adult and Child Member Satisfaction Survey Results

CAHPS® Child Survey Key Measure	2019 Summary Rate	2020 Summary Rate	2021 Summary Rate (CHIP)	2022 Summary Rate (TXIX)
Getting Needed Care	87.2%	87.4%	90.2%	86.0%
Getting Care Quickly	91.8%	90.3%	91.0%	89.0%
How Well Doctors Communicate	96.5%	96.9%	95.3%	95.2%
Customer Service	91.7%	88.1%	91.0%	89.4%
Rating of Health Care	70.0%	73.1%	74.6%	67.6%
Rating of Personal Doctor	76.3%	74.5%	77.9%	73.7%
Rating of Specialist	75.3%	71.4%	69.9%	75.4%
Rating of Health Plan	87.0%	86.2%	73.0%	68.9%

CAHPS® Adult Survey Key Measure	2018 Summary Rate	2020 Summary Rate	2022 Summary Rate
Getting Needed Care	86%	85.3%	86.5%
Getting Care Quickly	86%	85.4%	84.5%
How Well Doctors Communicate	92%	90.7%	93.9%
Customer Service	85%	90.2%	88.8%
Rating of Health Care	73%	55.7%	56.8%
Rating of Personal Doctor	82%	69.0%	71.5%
Rating of Specialist	83%	65.0%	70.9%
Rating of Health Plan	70%	56.6%	51.1%

The 2018 report did not provide data with decimal. For comprehensive CAHPS® survey results, please visit Studies and Evaluations under the Member Satisfaction Surveys of the OHCA Data and Reports website.

HEDIS® Quality Measures

The OHCA's Quality Assurance department began compiling HEDIS® data in 2010. The services were contracted out to Pacific Health Policy Group (PHPG) in 2013. PHPG recalculated the 2019 rates and updated the methodology to the latest HEDIS, which means that some of the rates may not be comparable to previous years' rates. Exhibit 3 indicates HEDIS® year measures using the new methodology.

Exhibit 3. HEDIS® Quality Measures

HEDIS® Measures 2018-2021	HEDIS® 2018	HEDIS® 2019	HEDIS® 2020	HEDIS® 2021
Sealant Receipt on Permanent First Molar				
Rate 1: At Least 1 Sealant	Not Available	Not Available	Not Available	40.9%
Rate 2: All 4 Molars Sealed by 10th Birthday	Not Available	Not Available	Not Available	27.5%

HEDIS® Measures 2018-2021	HEDIS® 2018	HEDIS® 2019	HEDIS® 2020	HEDIS® 2021
Child & Adolescent Well-Care Visits				
Aged 3 - 11 Years	Not Available	Not Available	45.1%	40.7%
Aged 12 - 17 years	Not Available	Not Available	37.5%	34.2%
Aged 18 - 21 years	Not Available	Not Available	15.4%	14.5%
Adults' Access to Preventive/Ambulatory Health				
Aged 20-44 years	79.6%	81.4%	80.9%	75.3%
Aged 45-64 years	89.9%	90.2%	90.4%	86.8%
Aged 65+ years	77.8%	89.0%	91.4%	86.9%
Well-Child Visits in the First 30 Months of Life				
First 15 Months 6+ Visits	Not Available	Not Available	Not Available	59.4%
15-30 Months 2+ Visits	Not Available	Not Available	Not Available	63.0%
Asthma Medication Ratio				
Aged 5-11 years	66.3%	83.8%	82.5%	88.7%
Aged 12-18 years	60.8%	77.4%	76.9%	83.5%
Aged 19-50 years	52.1%	70.1%	68.0%	79.7%
Aged 51-64 years	54.6%	78.6%	77.3%	86.2%
Screening Rates				
Lead Screening in Children (by 2 years of age)	57.1%	56.3%	52.1%	50.0%

HEDIS® Measures 2018-2021	HEDIS® 2018	HEDIS® 2019	HEDIS® 2020	HEDIS® 2021
Breast Cancer Screening (aged 50-74 years)	40.5%	33.2%	39.4%	34.3%
Chlamydia Screening in Women (aged 16-24 years)	56.4%	40.2%	43.7%	41.5%
Cervical Cancer Screening (aged 21-64 years)	44.3%	41.6%	38.2%	38.6%

Access Survey

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

Exhibit 4. 2021 Access Survey

2021 Access survey	Jan- March	April-June	July-Sept	Oct-Dec
Number of Providers Called	948	961	948	531
Percent of Providers with 24-hour access on Initial Survey	88.1%	88.7%	87.7%	85%
Percent of Providers Educated for Compliance	11.9%	11.3%	12.3%	15%

Medical Home Audits

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

**Due to the Public Health Emergency, on-location evaluations were not conducted in 2021.*

Appendix E

Documentation of Compliance with Public Notice Process

Pursuant to the public notice process set forth in 42 CFR 431.408 and 431.420 the Oklahoma Health Care Authority (OHCA) provided public notice of its intent to submit the 1115(a) demonstration renewal request to the Centers for Medicare & Medicaid Services (CMS).

The OHCA regularly hosts tribal policy consultations to present and receive comment on proposed changes to the Medicaid program and other relevant topics that could impact Oklahoma tribes which do business with the State Medicaid Agency, OHCA. The Agency sent ITU Notice 2022-07 to tribal partners on August 26, 2022, to initiate the 60-day tribal consultation comment period for the 1115(a) SoonerCare demonstration renewal. A tribal consultation meeting was held on September 6, 2022, (via teleconference) to further discuss the proposal; 65 attendees were present. No comments were received from tribal partners during the consultation period nor at the tribal consultation meeting.

The Agency began its public notice process November 1, 2022 and concluded on November 30, 2022. The full public notice was posted on the OHCA's website and the abbreviated notice within six Oklahoma-based newspapers. A copy of the full public notice and instructions about the public comment process is available at oklahoma.gov/ohca/policies-and-rules/public-notices. The draft renewal was also posted for public review allowing for public comment; no written comments were received. The archived blog posting may be reviewed at https://oklahoma.gov/ohca/policies-and-rules/archived-proposed-policy-changes.html.

During the public hearing held via webinar on November 15, 2022, one commenter asked if the savings shown in the slide presentation were derived were projected or actual savings. The State responded the savings were projected. Another commenter asked if this renewal was a contingency plan if the managed care waiver amendment is not approved. The state responded that this renewal is unrelated to the managed care amendment.

The attachments that follow contain the proof of public notice including the:

- ITU Notice 2022-07;
- September 6, 2022 Tribal Meeting Attendees;
- Newspaper abbreviated public notice affidavits;
- Full public notice posted to the OHCA public website; and
- OHCA's website blog posting allowing for public comment.

Kevin Corbett | Chief Executive Officer

J. Kevin Stitt | Governor

I/T/U Public Notice 2022-07
August 26th, 2022

RE: Oklahoma Health Care Authority Proposed Rule, State Plan and Waiver Amendments

Dear Tribal Representative:

The purpose of this letter is to notify you of proposed changes that will be reviewed at the tribal consultation meeting on **September 6th, 2022, at 11 a.m**. OHCA invites you to attend this meeting via webinar, and we welcome any comments regarding the proposed changes. The agency is committed to active communication with tribal governments during the decision-making and priority-setting process to keep you apprised of all proposed changes.

Enclosed are summaries of the current proposed rules, state plan and waiver amendments for your review. The summaries describe the purpose of each change.

Please note that these are only proposed changes and have not yet taken effect. Before implementation, proposed changes must obtain budget authorization and approval by the OHCA board, and when applicable, federal and governor approval must be obtained.

Additionally, OHCA posts all proposed changes on the agency's Policy Change Blog and the Native American Consultation Page. These public website pages are designed to give all constituents and stakeholders an opportunity to review and make comments regarding upcoming policy changes. To ensure that you stay informed of proposed policy changes, you may sign up for web alerts to be automatically notified when any new proposed policy changes are posted for comment.

OHCA values consultation with tribal governments and will provide your representatives a reasonable amount of time to respond to this notification. If you have any questions or comments about the proposed policy changes, please use the online comment system found on the Policy Change Blog and/or the Native American Consultation Page.

Sincerely,
Dana Miller
Director, Tribal Government Relations

Proposed Rule, State Plan, and Waiver Amendments

Statewide Health Information Exchange (HIE) — Oklahoma senate bill 1369 revised the Statewide HIE program. Policy revisions are need to comply with those changes, including creating the Office of the State Coordinator for HIE; designating that the Office of the State Coordinator for HIE will oversee the state-designated entity for HIE; revising the definition of "health information exchange organization" to indicate that it is an organization governed by its stakeholders; and, providing that beginning July 1, 2023, all qualified health care providers, as defined by OHCA rules who are licensed by and located in Oklahoma, shall be actively engaged with onboarding process of connecting to the HIE in order to meet the legislative requirement to report data to and utilize the state-designated HIE entity.

Anticipated Tribal Impact: direct; contracted ITUs are qualified health care providers (tribal notice posted on July 26, 2022)
Proposed Rule Timeline:
Rules public comment period: August 16, 2022-September 15, 2022
Medical Advisory Committee: September 8, 2022
OHCA Board meeting: September 21, 2022
Effective date: November 5, 2022, is the Governor's 45th day to approve

Transition to Managed Care: State Rules – The Agency will promulgate managed care rules for contracted entities, inclusive of managed care entities (MCEs), provider-led entities (PLEs), and dental benefit managers (DBM), through at least two emergency rulemaking sessions.

The first set of rule additions/revisions will include State-sanctions and complementary non-compliance remedies required of the contracted entities (CEs). Furthermore, Agency rule additions/revisions will define terms, processes, and regulations that were outlined in the approved delivery system reform State legislation and the published Request for Proposal (RFP)/Model Contract. Other rule additions will include, but are not limited to, managed care mandatory and voluntary populations (American Indian/Alaskan Native

(AI/AN) members), processes for network adequacy, provider requirements, termination of contracts, transition of care policies, medical necessity, required notices, and grievances and appeals. Of note, American Indian/Alaskan Native (AI/AN) members will voluntarily choose to enroll with a contracted entity for medical and/or dental care through an opt-in process

Additionally, the current Chapter 50 OHCA managed care rules, which were promulgated during the previous managed care effort will be updated to reflect changes made to the new RFP and legislative requirements.

Future emergency rules will address any clean-up or additional content needed from the initial set of emergency rules including but not limited to, covered services and limitations (when applicable), prior authorization requirements, allowed/dissallowed marketing practices by the contracted agency, and any other outstanding federal and/or state requirements for operationalizing SoonerSelect, SoonerSelect Children's Specialty Program, and SoonerSelect Dental not otherwise previously addressed in rules.

Anticipated Tribal Impact: direct; language mentions specifically AI/AN population opt-in enrollment

Proposed Rule Timeline

60-day Tribal Consultation Period: August 30, 2022 - October 29, 2022

1st EME Rulemaking Session:

Public Comment Period: October 7, 2022-November 7, 2022
Medical Advisory Committee: November 10, 2022
OHCA Board: November 16, 2022
Governor's 45th Day: January 3, 2023, or upon governor's signature if earlier

2nd EME Rulemaking Session:

Public Comment Period: April 3, 2023-May 3, 2023
Medical Advisory Committee: May 11, 2023*

OHCA Board: June 28, 2023*
Requested Effective Date-October 1, 2023
**Board and MAC dates are tentative and could be subject to change*

1115(a) SoonerCare Choice Demonstration Waiver Renewal – The Oklahoma Health Care Authority (OHCA) will request federal approval from the Centers of Medicare and Medicaid (CMS) to extend the SoonerCare 1115(a) waiver demonstration (Project Number 11-W-00048/6). If approved, the request will renew the current demonstration, ending on December 31, 2023, from January 1, 2024, through December 31, 2028. The waiver demonstration authorizes the State to offer a Primary Care Case Management (PCCM) health care delivery service model called the SoonerCare Choice Patient-Centered Medical Home (PCMH). The PCMH health care delivery model allows the State to contract directly with health care providers, on a statewide basis, for the provision of Medicaid services to SoonerCare Choice PCMH members; allows for care coordination payments; and provides authority to operate the Health Management Program (HMP), Health Access Networks (HANs), and the Insure Oklahoma (IO) Employer Sponsored Insurance (ESI) program.

The current demonstration ends December 31, 2023. The agency must submit a renewal request to CMS by 12/31/2022.

Anticipated Tribal Impact: indirect; ITUs are not contracted as PCMH providers but receive a PM/PM case coordination fee

Proposed Waiver Renewal Timeline

60-day Tribal Consultation Period: August 30, 2022 - October 29, 2022
Public Comment Period*: November 1, 2022 - November 30, 2022
Requested Effective Date: January 1, 2024
**Tentative*

Dental Services Reimbursement Methodology - The Oklahoma Health Care Authority proposes a state plan amendment (SPA) to update the rate methodology used to pay for dental services as the Agency was appropriated dollars within the state fiscal year 2023

budget to increase dental rates. The proposed rate methodology to pay dental services will continue to use a calculation of Relative Value Units (RVUs) times a Conversion Factor; however, the State will update the RVUs annually with the Optum Coding Relative Values for Dentists Data File and a new conversion factor which is different for children and adults. The current Conversion Factor is the same for all populations and has not been updated in several years. Dental providers will see a rate increase in the aggregate of over 5% for children and over 14% for adults through the new rate methodology.

This update will improve the Agency's ratio of Medicaid reimbursement to private dental insurance reimbursement to 73.02% which is over a 10% improvement; compared to other states, the new dental service rates will be over what New Mexico Medicaid pays for dental services and on par with what Colorado Medicaid pays.

Anticipated Tribal Impact: indirect; ITU reimbursement for dental services is set at the established OMB rate

Proposed SPA Timeline

Expedited 30-Day Tribal Consultation Period: August 26, 2022 - September 25, 2022
30-Day Public Comment Period: September 6, 2022 - October 6, 2022
Proposed Effective Date: October 1, 2022

Tribal Consultation Meeting Agenda
11 am, September 6, 2022
Online Microsoft Teams Meeting

ONLINE: Tribal Partners	ONLINE: OHCA Staff
1. Adriana Worth - BIA-OJS District II &VI	1. Carley Fryrear
2. Alyssa Goodfox – Pawnee Indian Health Center	2. Chad Sickler
3. Amy Rubin - OCAO - IHS	3. Dana Miller
4. Andrea Scott - Kickapoo Tribe	4. David Ward
5. Angela Daugherty - Iowa Nation	5. Harvey Reynolds
6. Annette D. Pratchard - Citizen Potawatomi	6. Heather Cox
7. Brenda Teel - Chickasaw Nation	7. Jimmy Witcosky
8. Brian Hail - Cherokee Nation	8. Johnney Johnson
9. Carmelita Skeeter - Indian Health Care Resource Center	9. Karen Luce
10. Charlotte Juarez - Lawton Indian Hospital - IHS	10. Kasie McCarty
11. Cindy Labounty - Muscogee Nation	11. Kathrine Mccoy
12. Deanna Holman - Indian Health Care Resource Center	12. Latrita Bradford
13. Deborah Margerum - Ponca Tribe	13. Mary Triplet
14. Emily Christie - Cherokee Nation	14. Megan Brister
15. Heidi M. Couch - Choctaw Nation	15. Melissa Goree
16. Jason Loepp - Cherokee Nation	16. Melissa Richey
17. Jessica Buchanan – Sac & Fox Tribe	17. Patrick Schlecht
18. Judy Parker - Chickasaw Nation	18. Rachel Peterson
19. Kim Goodbear - Cheyenne and Arapaho Tribe	19. Sandra Puebla
20. Krystal Ross - Lawton Indian Hospital - IHS	20. Sean Webster
21. Lewanda Teehee - Cherokee Nation	21. Sherry Deangelis
22. Lindsay Messer - Wichita and Affiliated Tribes	22. Terry Cothran
23. Martha Ketcher - Cherokee Nation	23. Vickie Sams
24. Marty Wafford - Chickasaw Nation	24. Yolanda Downing
25. Melanie Fourkiller - Choctaw Nation	
26. Michelle Dennison - OKCIC	
27. Pam Benedict - Chickasaw Nation	
28. Rhonda Beaver - Muscogee Nation	
29. Robyn Sunday-Allen - OKCIC	
30. Sandra Sealey - OCAO - IHS	
31. Sheri Brown - Sac & Fox Tribe	
32. Stephanie Lovell - Anadarko Health Center	
33. Tenesha Washington- OKCIC	
34. Terrie Nolan – Kickapoo Tribe	

35. Terry Withrow - Citizen Potawatomi 36. Todd Hallmark - Choctaw Nation 37. Travis Scott - OCAO - IHS 38. Travis Watts - OCAO - IHS 39. Valentina Manwell - Kickapoo Tribe 40. Yvonne Myers – Citizen Potawatomi	
ONLINE: Other Attendees	
41. Nicolas Barton - Southern Plains Tribal Health Board	

Total Attendees: 65

NORMAN TRANSCRIPT 10/30/22

PROOF OF PUBLICATION

~~In the District Court of Cleveland County, State of Oklahoma~~

OHCA Public Notice

Affidavit of Publication

State of Oklahoma, County of Cleveland, ss:
I, the undersigned publisher, editor or Authorized Agent of the Norman Transcript, do solemnly swear that the attached advertisement was published in said paper as follows:

1st Publication October 30, 2022

2nd Publication _____

3rd Publication _____

4th Publication _____

That said newspaper is Daily, in the city of Norman, Cleveland County, Oklahoma, a Daily newspaper qualified to publish legal notices, advertisements and publications as provided in Section 106 of Title 25, Oklahoma Statutes 1971, as amended, and complies with all other requirements of the laws of Oklahoma with reference to legal publications.

That said Notice, a true copy of which is attached hereto, was published in the regular edition of said newspaper during the period and time of publications and not in a supplement, on the above noted date [redacted]

[redacted] Signature

Signature

Subscribed and sworn before me on the 31 day of Oct. 2022.

[redacted]

My commission expires 07/10/22

Notary Public Commission # 20008340

PAY TO:
The Norman Transcript
P.O. Drawer 1058
Norman, OK 73070

TINA ANDERSON NOTARY # 20008340 EXP. 07/10/24 PUBLIC STATE OF OKLAHOMA

Please include the case number on your check.

(Published in The Norman Transcript October 30, 2022, 1t)

ABBREVIATED NOTICE OF PUBLIC COMMENT PERIOD FOR RENEWAL OF SOONERCARE SECTION 1115 DEMONSTRATION

Pursuant to the Code of Federal Regulations at Title 42 Sections 431.408 and 447.205, the Oklahoma Health Care Authority (OHCA) is required to provide public notice of its intent to submit an application to the Centers for Medicare & Medicaid Services (CMS) for renewal of its 1115(a) SoonerCare Choice Demonstration waiver, as required by the demonstration's special terms and conditions. The OHCA currently has an approved 1115 waiver that expires on December 31, 2023.

This notice provides details about the waiver renewal submission and serves to open the 30-day public comment period, which closes on November 30, 2022. In addition to the 30-day public comment period, during which the public will be able to provide written comments to the OHCA, the agency will host two public hearings, during which the public may provide oral comments.

Virtual Public Hearing
November 15, 2022, at 02:00 PM Central Time
Register for Public Hearing:
https://www.zoomgov.com/meeting/register/vJIs-cumhqDwuHvsmZlnzdGmrLQ7DXNy5Mco
Dial-in: 833-568-8864
Meeting ID: 161 509 6744

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Dial-in: 833-568-8864
Meeting ID: 160 175 5005

The waiver renewal application requests an extension of the current SoonerCare model. The OHCA will submit a separate 1115 waiver amendment request in 2023 to enroll a portion of the SoonerCare population into the SoonerSelect managed care programs. The SoonerSelect amendment request will be addressed through a separate public notice.

Prior to finalizing the proposed waiver renewal application, the OHCA will consider all written and verbal public comments received. The comments will be summarized and addressed in the final version submitted to CMS.

Waiver Renewal Summary and Objectives

SoonerCare Choice is a statewide Primary Care Case Management (PCCM) model in which the OHCA contracts directly with providers throughout the State to provide SoonerCare Choice members a Patient-Centered Medical Home (PCMH) which offers Health Management Program and Health Access Networks services. SoonerCare Choice also authorizes the Insure Oklahoma program. Medical Homes are paid monthly care coordination payments for each beneficiary on their panel coupled with fee-for-service payment of medical claims. The 1115(a) SoonerCare Choice Demonstration serves Title XIX and CHIP populations, excluding

- Individuals dually eligible for Medicare and Medicaid;
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- Individuals in the Former Foster Care group;
- Pregnant women with incomes between 134 percent and 185 percent FPL; and
- Individuals with other creditable coverage.

The requested extension does not change the current approved budget neutrality methodology and does not contemplate any changes to program eligibility, benefits, or program financing that would require modifications to the existing model. The proposed renewal will request a five-year extension period, from January 1, 2024 to December 31, 2028. OHCA proposes to continue to advance the same five critical objectives under the renewal period as in the current Demonstration period. Specifically:

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

Additional Information and Comments

Interested persons may visit oklahoma.gov/ohca/policies-and-rules/public-notices to view a copy of the public notice(s) and location and times of public hearings and visit oklahoma.gov/ohca/policies-and-rules/proposed-changes to view a copy of the proposed demonstration waiver renewal request, supplemental information, updates, and a link to provide public comments on the proposal. Persons wishing to present their views in writing or obtain copies of the proposed waiver may do so via mail by writing to: Oklahoma Health Care Authority, Federal Authorities Unit, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma 73105, or by email at federal.authorities@okhca.org. Written comments or requests for copies of the proposed waiver will be accepted by contacting OHCA as indicated. Comments submitted through the OHCA policy blog will be available for review online at oklahoma.gov/ohca/policies-and-rules/proposed-changes. Other written comments are available upon request at federal.authorities@okhca.org. Comments will be accepted from November 1, 2022 until November 30, 2022.

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Dial-in: 833-568-8864
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The waiver renewal application requests an extension of the current SoonerCare model. The OHCA will submit a separate 1115 waiver amendment request in 2023 to enroll a portion of the SoonerCare population into the SoonerSelect managed care programs. The SoonerSelect amendment request will be addressed through a separate public notice.

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Waiver Renewal Summary and Objectives

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The requested extension does not change the current approved budget neutrality methodology and does not contemplate any changes to program eligibility, benefits, or program financing that would require modifications to the existing model. The proposed renewal will request a five-year extension period, from

in writing or obtain copies of the proposed waiver may do so via mail by writing to: Oklahoma Health Care Authority, Federal Authorities Unit, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma 73105, or by email at federal.authorities@okhca.org. Written comments or requests for copies of the proposed waiver will be accepted by contacting OHCA as indicated. Comments submitted through the OHCA policy blog will be available for review online at oklahoma.gov/ohca/policies-and-rules/proposed-changes. Other written comments are available upon request at federal.authorities@okhca.org. Comments will be accepted from November 1, 2022 until November 30, 2022.

Lawton Constitution
11/1/22

The Lawton Constitution
P.O. Box 2069-L
Lawton, OK 73502
580-585-5000

Proof of Publication

IN THE DISTRICT COURT OF COMANCHE COUNTY OKLAHOMA

State of Oklahoma, County of Comanche

1115 Demonstration

I, DAVID R. STRINGER, of lawful age, being duly sworn upon oath, deposes and says: That I am the Publisher of The Lawton Constitution, a daily newspaper printed and published in the city of Lawton, County of Comanche, and state of Oklahoma, and that the advertisement above referred to, a true and the publication dates listed below.

Publication The Lawton Constitution: 11/01/22.

That said newspaper has been published continuously and uninterruptedly in said county during a period of one hundred and four consecutive weeks prior to the publication of the attached notice or advertisement: that it has been admitted to the United States mail as second-class mail matter, that it has a general paid circulation, and publishes news of general interest, and otherwise conforms with all of the statues of the State of Oklahoma governing legal publications.

Signed: [redacted]

Signature

SUBSCRIBED and sworn to be me this day of **7th day of November, 2022**

NOTARY PUBLIC State of OK
TONI WILSON
Comm. # 05011169
Expires 12-12-2025

[redacted]

Notary Public

Acct #51016 **Ad #1056144**

Published in
The Lawton Constitution
November 1, 2022
ABBREVIATED NOTICE
OF PUBLIC COMMENT
PERIOD FOR RENEWAL OF
SOONERCARE SECTION
1115 DEMONSTRATION

ABBREVIATED NOTICE OF PUBLIC COMMENT PERIOD FOR RENEWAL OF SOONERCARE SECTION 1115 DEMONSTRATION

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Meeting ID: 160 175 5005

The waiver renewal application requests an extension of the current SoonerCare model. The OHCA will submit a separate 1115 waiver amendment request in 2023 to enroll a portion of the SoonerCare population into the SoonerSelect managed care programs. The SoonerSelect amendment request will be addressed through a separate public notice.

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Waiver Renewal Summary and Objectives

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- Waiver Objective 4: To expand access to affordable health insurance for low income working adults and their spouses; and
- Waiver Objective 5: To optimize quality of care through effective care management.

Additional Information and Comments

Interested persons may visit oklahoma.gov/ohca/policies-and-rules/public-notices to view a copy of the public notice(s) and location and times of public hearings and visit oklahoma.gov/ohca/policies-and-rules/proposed-changes to view a copy of the proposed demonstration waiver renewal request, supplemental information, updates, and a link to provide public comments on the proposal. Persons wishing to present their views

The Black Chronicle
CLASSIFIED

Black Chronicle 11/3/22

The Black Chronicle
P.O. Box 17498 1528 N.E. 23rd Street
OKLAHOMA CITY, OKLAHOMA 73136
DISPLAY (405) 424-4695
CLASSIFIED (405) 424-4525
FAX (405) 424-6708

1-13 Words	$10.75
14-20 Words	$12.75
21-27 Words	$14.65
28-34 Words	$16.00
35-41 Words	$18.00

Advertising Deadline, Tuesdays at 1 p.m.!
An additional 40 cents per word is charged for ads over 41 words.

ADVERTISING – 1

Put your message where it matters most – IN OKLAHOMA NEWSPAPERS. We can place your ad in 146 newspapers. For more information or to place an ad, contact Landon Cobb at (405) 499-0022 or toll-free in OK at 1-888-815-2672.

FOR SALE –28

500 PAIRS. FR royal blue coveralls. Sizes 36-46, 60-70 Reg. $125 now $25. Take all @ $10.00 pair. Call or Fax for more information PH: 800-252-7412 Fax: 580-255-5511

GUN SHOW –29

WORLDS LARGEST GUN SHOW. November 12 & 13. Tulsa, OK Fairgrounds. Saturday 8-6, Sunday 8-4. WANENMACHER'S TULSA ARMS SHOW. Free appraisals. Bring your guns! www.TulsaArmsShow.com

Classified Deadline Is Tuesday at 1p.m.!

WANT TO BUY—32

OLD GUITARS WANTED! LARRY BRINGS CASH for vintage USA guitars, tube amps, banjos, mandolins, etc. Fender, Gibson, Martin, Gretsch, others. Call or text 918-288-2222. www.stringswest.com

OWN RURAL LAND? Earn $5,000+ Every Year from Hunting Leases. Upfront payments from our hunters. Reduce risk with FREE liability insurance. Call for a free quote. (888) 871-1982.

OKLAHOMA ALCOHOLIC BEVERAGE LAWS ENFORCEMENT COMMISSION NOTICE OF INTENTION TO APPLY FOR AN ALCOHOLIC BEVERAGE LICENSE

In accordance with Title 37, Section 522 and Title 37A, Section 2-141 Mehak Trade, LLC DBA Friendly Food Mart 6120 E reno Ave, Midwest City, Oklahoma 73110 a/an Limited Liability Company hereby publishes notice of its intention to apply within Sixty days from this date to the Oklahoma Alcoholic Beverage Laws Enforcement Commission for a beer and wine license License under authority of and in compliance with the said Act: That it intend(s) if granted such license to operate as a beer and wine establishment with business premises located at 6120 E reno Ave in Midwest city, Oklahoma under the business name of Friendly Food Mart.

Dated this 18th day of October 2022

Signature of applicant (s): If partnership, all partners must sign. If corporation an officer of the corporation must sign. If limited liability company a manager must sign.
Mohammad Younas
County of Oklahoma, State of Oklahoma
Before me, the undersigned notary public, personally appeared: Mohammad Younas
To me known to be the person (s) described in and who executed the foregoing application and acknowledged that he executed the same as his free act and deed.

Jacqueline Turner	05/18/2025
(Notary Public)	(My commission expires)

OKLAHOMA ALCOHOLIC BEVERAGE LAWS ENFORCEMENT COMMISSION NOTICE OF INTENTION TO APPLY FOR AN ALCOHOLIC BEVERAGE LICENSE

In accordance with Title 37, Section 522 and Title 37A, Section 2-141 Portland E cig's LLC DBA RN Quick Stop 3152 N. Portland Ave Oklahoma City, Oklahoma 73112 a/an Limited Liability Company hereby publishes notice of its intention to apply within Sixty days from this date to the Oklahoma Alcoholic Beverage Laws Enforcement Commission for a retail beer License under authority of and in compliance with the said Act: That it intend(s) if granted such license to operate as a retail beer establishment with business premises located at 3152 N. Portland Ave in Oklahoma City, Oklahoma under the business name of RN Quick Stop

Dated this 19th day of October 2022

Signature of applicant (s): If partnership, all partners must sign. If corporation an officer of the corporation must sign. If limited liability company a manager must sign.
Mohammad Anwar
County of Oklahoma, State of Oklahoma
Before me, the undersigned notary public, personally appeared: Mohammad Anwar
To me known to be the person (s) described in and who executed the foregoing application and acknowledged that he executed the same as his free act and deed.

Jacqueline Turner	05/18/2025
(Notary Public)	(My commission expires)

ABBREVIATED NOTICE OF PUBLIC COMMENT PERIOD FOR RENEWAL OF SOONERCARE SECTION 1115 DEMONSTRATION

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Memorial Park Cemetery

13313 N. Kelley Ave. Oklahoma, Okla. 73131
Burial plots½ off retail.
A total of 2 burial plots in Memorial Cemetery in Edmond, Okla.
There are 2 lots.
Specific.
Location on request.
$1800 EACH plot or best offer.
Transfer fees paid by buyer.
Contact Owner 405 740 4566

Wanted!
Circulation Representatives

The Black Chronicle
The paper that tells the truth

The Black Chronicle is accepting applications for circulation representatives. Successful applicants will, with their own reliable transportation, distribute (and make sales collections for) the weekly newspaper at client stores, service stations and other businesses located throughout the Oklahoma City metropolitan area.

Representatives work Thursday afternoons and nights, and Friday mornings, and receive generous compensation. Excellent work for parttime job-seekers and retired persons.

Apply at Black Chronicle, 1528 NE 23rd St., Oklahoma City, Okla., 9 a.m. until 5 p.m., Mondays through Fridays.

The Black Chronicle
The paper that tells the truth

PLUMBERS AND PIPEFITTERS APPRENTICESHIP

Applications are available at the Plumbers and Pipefitters Training Center (5315 S. Shartel Ave., Oklahoma City) between 9:00 a.m. and 4:00 p.m. Monday through Thursday and between 9:00 a.m. and 12:00 noon on Friday. Applications may be obtained in person, fax, or requested from the web site (www.plumbersandpipefitters.com) and will be mailed in 5 to 7 business days.
The application must be returned, with all required documents, before the deadline for the next interview session.
QUALIFICATIONS ARE AS FOLLOWS:
Minimum 18 years of age prior to being accepted into the Program; must be a high school graduate or have a GED and provide transcript.
We anticipate accepting 10 to 15 apprentices this year. Applicants will be selected based on highest qualifications without regard to race, color, religion, national origin, sex (including pregnancy and gender identity), sexual orientation, genetic information, or
because they are an individual with a disability or a person 40-year-old or older. The P.H.C.C. Contractors, party to the Plumbers and Pipefitters J.A.T.C. Agreement, are Equal Opportunity Employers.

Wage Rates
1st Year - $17.75 4th Year - $23.07
2nd Year - $19.52 5th Year - $26.62
3rd Year - $21.30 Journeyman - $35.50

LOCALiQ

The Oklahoman

PO Box 631643 Cincinnati, OH 45263-1643

PROOF OF PUBLICATION

Aei Advertising
Aei Advertising
772 E MOUNTAIN SAGE DRIVE

PHOENIX AZ 85048

STATE OF OKLAHOMA, COUNTY OF OKLAHOMA

The Oklahoman, a daily newspaper of general circulation in the State of Oklahoma, and which is a daily newspaper published in Oklahoma County and having paid general circulation therein; published and personal knowledge of the facts herein state and that the notice hereto annexed was Published in said newspapers in the issues dated on:

10/30/2022

and that the fees charged are legal.
Sworn to and subscribed before on 10/30/2022

Legal Cl[redacted]

Notary, State of WI, County of Brown

9.19.25

My commision expires

# of Copies:
1

PO #:

THIS IS NOT AN INVOICE!

Please do not use this form for payment remittance.

VICKY FELTY
Notary Public
State of Wisconsin

OKLAHOMAN
10/30/22

ABBREVIATED NOTICE OF PUBLIC COMMENT PERIOD FOR RENEWAL OF SOONERCARE SECTION 1115 DEMONSTRATION

Pursuant to the Code of Federal Regulations at Title 42 Sections 431.408 and 447.205, the Oklahoma Health Care Authority (OHCA) is required to provide public notice of its intent to submit an application to the Centers for Medicare & Medicaid Services (CMS) for renewal of its 1115(a) SoonerCare Choice Demonstration waiver, as required by the demonstration's special terms and conditions. The OHCA currently has an approved 1115 waiver that expires on December 31, 2023.

This notice provides details about the waiver renewal submission and serves to open the 30-day public comment period, which closes on November 30, 2022. In addition to the 30-day public comment period, during which the public will be able to provide written comments to the OHCA, the agency will host two public hearings, during which the public may provide oral comments.

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November 15, 2022, at 02:00 PM Central Time
Register for Public Hearing:
https://www.zoomgov.com/meeting/register/vJIscumhqDwuHvsmZInzd6mrLQ7DXNy5Mco
Dial-in: 833-568-8864
Meeting ID: 161 509 6744

Virtual Public Hearing
November 17, 2022, at 05:00 PM Central Time
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https://www.zoomgov.com/meeting/register/vJItdu6tqzsqH39zub1eJbI9cQaiQpUaGE8
Dial-in: 833-568-8864
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The waiver renewal application requests an extension of the current SoonerCare model. The OHCA will submit a separate 1115 waiver amendment request in 2023 to enroll a portion of the SoonerCare population into the SoonerSelect managed care programs. The SoonerSelect amendment request will be addressed through a separate public notice.

Prior to finalizing the proposed waiver renewal application, the OHCA will consider all written and verbal public comments received. The comments will be summarized and addressed in the final version submitted to CMS

Waiver Renewal Summary and Objectives
SoonerCare Choice is a statewide Primary Care Case Management (PCCM) model in which the OHCA contracts directly with providers throughout the State to provide SoonerCare Choice members a Patient-Centered Medical Home (PCMH) which offers Health Management Program and Health Access Networks services. SoonerCare Choice also authorizes the Insure Oklahoma program. Medical Homes are paid monthly care coordination payments for each beneficiary on their panel coupled with fee-for-service payment of medical claims. The 1115(a) SoonerCare Choice Demonstration serves Title XIX and CHIP populations, excluding

- Individuals dually eligible for Medicare and Medicaid;
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- Individuals infected with tuberculosis covered under Title XIX
- Individuals covered by a Managed Care Organization other than the SoonerCare demonstration PCCM;
- Individuals in the Former Foster Care group;
- Pregnant women with incomes between 134 percent and 185 percent FPL; and
- Individuals with other creditable coverage.

The requested extension does not change the current approved budget neutrality methodology and does not contemplate any changes to program eligibility, benefits, or program financing that would require modifications to the existing model. The proposed renewal will request a five-year extension period, from January 1, 2024 to December 31, 2028. OHCA proposes to continue to advance the same five critical objectives under the renewal period as in the current Demonstration period. Specifically:

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

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La Semana 11/3/22

Bella Zaidle nombrada estudiante del año de La Semana

Bella Zaidle named La Semana Student of the Year

VIENE DE LA PÁGINA A-1

Bella es residente de Tulsa, y como muchos otros chicos se graduó hace cuatro años de la secundaria Booker T Washington. Pero el resto de su historia no ha sido nada ordinaria, muy por el contrario, la joven ha marcado un camino de excelencia y reconocimientos que parecen no tener fin.

Bella estudia en OU, donde recibirá un diploma en honores en Estudios constitucionales y relaciones públicas con campo menor en español. Y no solo se dedica plenamente al estudio, sino que también, como muchos hispanos con vocación de servicio, Bella dedica su vida al refuerzo de la comunidad estudian- til.

Actualmente es presidente panhelénica de la universidad, y miembro del comité asesor del vicepresidente de la facultad, desde allí, Bella intenta mejorar las experiencias de todos los estudiantes de OU.

Como podría esperarse, Bella es presidente de su fraternidad Tri Delta, donde ha servido como dirigente de actividades sociales y académicas. Además, ha sido becada en la Sociedad de estudios constitucionales y recibió los premios de honor presidencial, por su increíble promedio de 4.0 en los años 2019, 2020, 2021 y 2022.

Muy pronto Bella se graduará con honores de la Universidad de Oklahoma y espera ingresar en la escuela de derecho poco después. La Semana la felicita por sus logros y le desea una gran carrera al servicio de la comunidad.

ENGLISH

Bella is a resident of Tulsa and graduated from Booker T Washington high school. But the rest of her story is not so common, a path of awards and recognition that celebrate the effort of a very successful person.

Bella is studying at OU to earn a double major in Honors Letters specializing in Constitutional Studies and Honors Public Relations with a Spanish minor. And not only does she focus on her studies, but like many other Hispanics makes time to serve her community. Currently she is the University of Oklahoma's Panhellenic President and a member of the University Vice President Advisory Committee, where she tries to improve the experiences of all students at OU.

Bella was also chair of her fraternity, the Tri Delta Sorority where she has served as Academic Chair and Social Chair. She has also been named as A Society of Constitutional Studies Fellow and awarded the President's Honor Roll recognizing for her outstanding 4.0 GPA in 2019, 2020, 2021 and 2022.

Bella is on track to graduate from the University of Oklahoma Summa Cum Laude this Spring and attend Law School. La Semana congratulates her efforts and wishes her a successful career. (La Semana)

PSO celebra el centenario de la central eléctrica de Tulsa

PSO Celebrates Centennial of Tulsa Power Station

La presidenta y directora de operaciones de PSO, Leigh Anne Strahler, el alcalde G.T. Bynum y la comisionada del condado Karen Keith se unieron a los empleados de TPS para celebrar un siglo de servicio.

Nadie sabe con exactitud cuándo empezó a producir electricidad la central eléctrica de Tulsa. Oklahoma Power Company comenzó a construir TPS en la orilla oeste del río Arkansas en 1920. PSO compró Oklahoma Power Company en 1927 y ese mismo año añadió el icónico cartel de 336 pies en la parte superior del edificio de TPS.

Aunque inicialmente era una central de carbón, TPS se convirtió en una central de gas natural a finales de la segunda guerra mundial. Sigue siendo una parte vital de la flota de generación de PSO.

"La central eléctrica de Tulsa ilumina la noche, un audaz emblema del servicio de PSO a la comunidad", dijo Strahler. "Más de 100 años después de su apertura, TPS sigue utilizando recursos y trabajadores de Oklahoma para suministrar energía a todas nuestras comunidades de Oklahoma. Los empleados de TPS han trabajado duro durante más de 100 años para que PSO siga siendo sinónimo de fiabilidad, y trabajaremos juntos para continuar con ese récord".

ENGLISH

PSO President and Chief Operating Officer Leigh Anne Strahler, Mayor G.T. Bynum and County Commissioner Karen Keith joined TPS employees to celebrate a century of service.

No one is certain exactly when Tulsa Power Station began producing electricity. Oklahoma Power Company began construction on TPS on the west bank of the Arkansas River in 1920. PSO purchased Oklahoma Power Company in 1927 and added the iconic 336-foot sign to the top of the TPS building that same year.

Initially, a coal-powered plant, TPS was converted to natural gas fuel near the end of World War

II. It remains a vital part of PSO's generating fleet.

"Tulsa Power Station lights up the night, a bold emblem of PSO's service to the community," Strahler said. "More than 100 years after opening, TPS continues to use Oklahoma resources and Oklahoma workers to deliver power to all our Oklahoma communities. TPS employees have worked hard for more than 100 years to keep PSO synonymous with dependability, and we will work together to continue that record."

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Account Number
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AEI ADVERTISING
SARAH WOODS
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PHOENIX, AZ 85048

Date
November 01, 2022

Date	Category	Description	Ad Size
11/01/2022	Legal Notices	ABBREVIATED NOTICE OF PUBLIC	3 x 93.00 CL

Affidavit of Publication

I, Brenda Brumbaugh, of lawful age, am a legal representative of the Tulsa World of Tulsa, Oklahoma, a daily newspaper of general circulation in Tulsa County, Oklahoma, a legal newspaper qualified to publish legal notices, as defined in 25 O.S. § 106 as amended, and thereafter, and complies with all other requirements of the laws of Oklahoma with reference to legal publication. That said notice, a true copy of which is attached hereto, was published in the regular edition of said newspaper during the period and time of publication and not in a supplement, on the DATE(S) LISTED BELOW

11/01/2022

[redacted]
Legal Representative

Newspaper reference: 0000781755

Sworn to and subscribed before me this date: 11-1-22

[redacted]
Notary Public

My Commission expires 10-14-24

M MARSHALL
NOTARY PUBLIC - STATE OF OKLAHOMA
MY COMMISSION EXPIRES OCT. 14, 2024
COMMISSION #20012760

Fmsol

TULSA WORLD
11/1/22

781755
Published in the Tulsa World, Tulsa County, Oklahoma, November 1, 2022

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- Individuals with other creditable coverage.

The OHCA seeks to renew the SoonerCare 1115 Demonstration with no modifications to the program's delivery system, eligibility requirements, benefit coverage, nor cost sharing or to the Special Terms and Conditions under which it is authorized to operate. The renewal would cover the same Medicaid Eligibility Groups currently served under the Demonstration. The proposed renewal would be a five-year period, from January 1, 2024 to December 31, 2028.

The OHCA proposes to continue to advance the same five critical objectives under the renewal period as in the current Demonstration period. Specifically:

- Waiver Objective 1: To improve access to preventive and primary care services;
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FISCAL PROJECTIONS

The requested renewal does not change the budget neutrality model for current Demonstration populations. The tables on the following page present the estimated enrollment and expenditures for the renewal period with and without the Demonstration.

The table below presents projected enrollment and expenditures without the Demonstration.

Demonstration Year		29	30	31	32	33	Total
Calender Year		2024	2025	2026	2027	2028	
Medicaid Per Capita							
TANF-Urban	Total	$ 2,393,503,043	$ 2,586,863,435	$ 2,795,844,546	$ 3,021,708,305	$ 3,265,818,586	$ 14,063,737,916
	PMPM	$ 500.50	$ 524.53	$ 549.71	$ 576.09	$ 603.74	
	Member Months	4,782,187	4,931,793	5,086,078	5,245,191	5,409,281	
TANF-Rural	Total	$ 1,497,510,465	$ 1,614,919,681	$ 1,741,534,124	$ 1,878,075,511	$ 2,025,322,143	$ 8,757,361,923
	PMPM	$ 507.65	$ 532.02	$ 557.56	$ 584.32	$ 612.37	
	Member Months	$ 2,949,881	$ 3,035,458	$ 3,123,518	$ 3,214,133	$ 3,307,376	
ABD-Urban	Total	$ 629,089,430	$ 669,840,151	$ 713,230,595	$ 759,431,755	$ 808,625,702	$ 3,580,217,634
	PMPM	$ 1,713.35	$ 1,795.60	$ 1,881.78	$ 1,972.11	$ 2,066.77	
	Member Months	$ 367,168	$ 373,046	$ 379,018	$ 385,086	$ 391,251	
ABD-Rural	Total	$ 369,040,856	$ 382,821,617	$ 397,116,980	$ 411,946,162	$ 427,329,097	$ 1,988,254,712
	PMPM	$ 1,368.01	$ 1,433.67	$ 1,502.49	$ 1,574.61	$ 1,650.19	
	Member Months	$ 269,765	$ 267,022	$ 264,306	$ 261,618	$ 258,958	
TOTAL		**$ 4,889,143,794**	**$ 5,254,444,884**	**$ 5,647,726,245**	**$ 6,071,161,733**	**$ 6,527,095,529**	**$ 28,389,572,185**

The table below provides a summary of "with waiver" expenditures. Projected expenditures for the Demonstration renewal period are lower than the "without waiver" expenditure projections and therefore meet Section 1115 budget neutrality requirements.

Demonstration Year	29	30	31	32	33	Total
Calender Year	2024	2025	2026	2027	2028	
Medicaid Per Capita						
TANF-Urban	$ 1,292,854,506	$ 1,397,298,431	$ 1,510,179,914	$ 1,632,180,585	$ 1,764,037,145	$ 7,596,550,582
TANF-Rural	$ 822,355,956	$ 846,553,087	$ 987,533,902	$ 1,170,635,016	$ 1,028,717,828	$ 4,855,795,788
ABD-Urban	$ 556,862,616	$ 592,934,679	$ 631,343,393	$ 672,240,120	$ 715,786,027	$ 3,169,166,835
ABD-Rural	$ 423,015,978	$ 438,812,283	$ 455,198,456	$ 472,196,522	$ 489,829,332	$ 2,279,052,571
Medicaid Aggregate - WW only						
Non-Disabled Working Adults ESI	$ 46,129,945	$ 48,425,186	$ 50,834,629	$ 53,363,957	$ 56,019,133	$ 254,772,851
TEFRA Children	$ 16,292,302	$ 18,700,789	$ 21,465,321	$ 24,638,534	$ 28,280,842	$ 109,377,789
Full-Time College Students ESI	$ 539,068	$ 567,186	$ 596,770	$ 627,898	$ 660,649	$ 2,991,570
Non-Disabled Working Adults IP	$ 589,041	$ 618,349	$ 649,116	$ 681,413	$ 715,318	$ 3,253,237
Full-Time College Students IP	$ 5,863	$ 6,154	$ 6,460	$ 6,782	$ 7,119	$ 32,379
HAN Expenditures	$ 12,533,288	$ 13,042,771	$ 13,572,964	$ 14,124,711	$ 14,698,885	$ 67,972,619
HMP Expenditures	$ 15,101,479	$ 16,006,074	$ 16,964,856	$ 17,981,070	$ 19,058,156	$ 85,111,634
Medical Education Programs	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	**$ 3,186,280,042**	**$ 3,372,964,990**	**$ 3,688,345,781**	**$ 4,058,676,607**	**$ 4,117,810,435**	**$ 18,424,077,855**

DEMONSTRATION EVALUATION

The approved evaluation design includes hypotheses related to evaluation of access, quality and cost effectiveness under the Demonstration. The evaluation design will be retained for the new Demonstration period to facilitate trending of performance across Demonstration periods.

The approved evaluation design identifies evaluation activities specific to the Demonstration's current care coordination models, SoonerCare Health Access Networks (HANs) and the SoonerCare Health Management Program (HMP). Hypotheses specific to the current care coordination models relate to improved access to care, health quality/outcomes, satisfaction, emergency room utilization and cost-effectiveness. The evaluation design will be modified to also test these hypotheses for individuals enrolled in SoonerSelect.

The approved evaluation design also includes hypotheses related to waiving of retroactive eligibility for a portion of the existing SoonerCare population. The design adheres to CMS guidance for evaluation of retroactive eligibility waivers in all states for which such waivers are a component of the Demonstration.

Following approval of the amendment request, the OHCA will prepare and submit a formal Evaluation Design for CMS review and approval, in accordance with requirements and timelines specified by CMS.

WAIVER AND EXPENDITURE AUTHORITY

The OHCA seeks to extend currently approved waivers, including:

Freedom of Choice Section 1902(a)(23)(A): To enable the State to restrict beneficiaries' choice of care management providers, and to use selective contracting that limits freedom of choice of certain provider groups to the extent that the selective contracting is consistent with beneficiary access to quality services.

Retroactive Eligibility Section 1902(a)(34): To enable the State to waive retroactive eligibility for Demonstration participants, with the exception of pregnant women (and during the 60-day period beginning on the last day of pregnancy), children described in section 1902(l)(4) of the Act, the Tax Equity and Fiscal Responsibility Act (TEFRA) and Aged, Blind, and Disabled populations.

The OHCA seeks to extend the currently approved expenditure authorities, including all those listed below for specific Demonstration populations. Note that the OHCA has received approval to phase-out Demonstration Populations 12 – 16, whose members are now covered under the Medicaid expansion. The phase-out will occur following termination of the Public Health Emergency.

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

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

Demonstration Population 8: Expenditures for health benefits coverage for no more than 3,000 individuals at any one time who are full-time college students age 19 through age 22 and have income not to exceed 200 percent of the FPL, who have no creditable health insurance coverage, and work for a qualifying employer.

Demonstration population 10: Expenditures for health benefits coverage for foster parents who work for an eligible employer and their spouses with household incomes no greater than 200 percent of the FPL.

Demonstration Population 11: Expenditures for health benefits coverage for individuals who are employees and spouses of not-for-profit businesses with 500 or fewer employees, work for a qualifying employer, and with household incomes no greater than 200 percent of the FPL.

Demonstration Population 12: Expenditures for health benefits coverage for individuals who are "Non-Disabled Low Income Workers" age 19–64 years whose employer elects

not to participate in the Premium Assistance Employer Coverage Plan, who are self-employed, or unemployed, and have income up to 100 percent of the FPL, and their spouses.

Demonstration Population 13. Expenditures for health benefits coverage for individuals who are "Working Disabled Adults" 19-64 years of age whose employer elects not to participate in the Premium Assistance Employer Coverage Plan, as well as those who are self-employed, or unemployed (and seeking work) and who have income up to 100 percent of the FPL.

Demonstration Population 14. Expenditures for health benefits coverage for no more than 3,000 individuals at any one time who are full-time college students age 19 through age 22 and have income not to exceed 100 percent of the FPL, who have no creditable health insurance coverage, and do not have access to the Premium Assistance Employer Coverage Plan.

Demonstration Population 15. Expenditures for health benefits coverage for individuals who are working foster parents, whose employer elects not to participate in Premium Assistance Employer Coverage Plan and their spouses with household incomes no greater than 100 percent of the FPL.

Demonstration Population 16. Expenditures for health benefits coverage for individuals who are employees and spouses of not-for-profit businesses with 500 or fewer employees with household incomes no greater than 100 percent of the FPL, and do not have access to the Premium Assistance Employer Coverage Plan.

Health Access Networks Expenditures. Expenditures for Per Member Per Month payments made to the Health Access Networks for case management activities.

Premium Assistance Beneficiary Reimbursement. Expenditures for reimbursement of costs incurred by individuals enrolled in the Premium Assistance Employer Coverage Plan and in the Premium Assistance Individual Plan that are in excess of five percent of annual gross family income.

Health Management Program. Expenditures for otherwise non-covered costs to provide services authorized through the Health Management Program as described in these STCs.

Medical Education Programs. Expenditures, not to exceed $115,517,737 total computable, to phase down federal expenditures for the state's medical education programs operated at the University of Oklahoma and Oklahoma State University.

The OHCA requests any additional waivers or expenditure authorities deemed necessary by CMS for continued operation of the Demonstration in its current form.

ADDITIONAL INFORMATION AND COMMENTS

Interested persons may visit www.okhca.org/PolicyBlog to view a copy of the proposed waiver amendment, public notice(s), location and times of public hearings, a link to provide public comments on the proposal, supplemental information, and updates.

Interested persons may visit oklahoma.gov/ohca/policies-and-rules/public-notices to view a copy of the public notice(s) and location and times of public hearings and visit oklahoma.gov/ohca/policies-and-rules/proposed-changes to view a copy of the proposed demonstration waiver renewal request, supplemental information, updates, and a link to provide public comments on the proposal. Persons wishing to present their views in writing or obtain copies of the proposed waiver may do so via mail by writing to: Oklahoma Health Care Authority, Federal Authorities Unit, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma 73105, or by email at federal.authorities@okhca.org. Written comments or requests for copies of the proposed waiver will be accepted by contacting OHCA as indicated. Comments submitted through the OHCA policy blog will be available for review online at www.okhca.org/PolicyBlog. Other written comments are available upon request at federal.authorities@okhca.org. Comments will be accepted from November 1, 2022 until November 30, 2022.

1115(a) SoonerCare Choice Demonstration Waiver Renewal

The Oklahoma Health Care Authority (OHCA) will request federal approval from the Centers of Medicare and Medicaid (CMS) to extend the SoonerCare 1115(a) waiver demonstration (Project Number 11-W-00048/6). If approved, the request will renew the current demonstration, ending on December 31, 2023, from January 1, 2024 through December 31, 2028. The waiver demonstration authorizes the State to offer a Primary Care Case Management (PCCM) health care delivery service model called the SoonerCare Choice Patient-Centered Medical Home (PCMH). The PCMH health care delivery model allows the State to contract directly with health care providers, on a statewide basis, for the provision of Medicaid services to SoonerCare Choice PCMH members; allows for care coordination payments; and provides authority to operate the Health Management Program (HMP), Health Access Networks (HANs), and the Insure Oklahoma (IO) Employer Sponsored Insurance (ESI) program.

The requested extension does not change the current approved budget neutrality methodology and does not contemplate any changes to program eligibility, benefits, cost sharing, or program financing that would require modifications to the existing model.

The OHCA will submit a separate 1115 waiver amendment request in 2023 to enroll a portion of the SoonerCare population into the SoonerSelect managed care programs. The SoonerSelect amendment request will be addressed through a separate public notice.

Please view the draft renewal application here: **1115(a) SoonerCare Choice Demonstration Waiver Renewal Application** and submit feedback via the comment box below. Additionally, the OCHA will be conducting two virtual public hearings during which the public may provide oral comments.

Tuesday, November 15, 2022, at 02:00 PM Central Time: **Register Here**

Thursday, November 17, 2022, at 05:00 PM Central Time: **Register Here**

View the full public notice here: **1115(a) SoonerCare Choice Demonstration Waiver Renewal Full Public Notice**. View the Oklahoma 1115(a) SoonerCare Choice Demonstration page on the CMS web site here: **Oklahoma SoonerCare 1115 Waiver CMS Web Site**.

Prior to finalizing the proposed waiver renewal application, the OHCA will consider all written and verbal public comments received. The comments will be summarized and addressed in the final version submitted to CMS.

Tribal Consultation Period: 8/30/2022 – 10/29/2022

Tribal Consultation Meeting: 9/6/2022

Circulation Date: 11/1/2022

Comment Due Date: 11/30/2022

Submit a Comment

Name

Email

Comment

I'm not a robot

reCAPTCHA
Privacy - Terms

Submit

After you submit your comment, you should be re-directed to a confirmation page. If you are not, please submit your comment through e-mail to **federal.authorities@okhca.org**.

Please note that all comments must be reviewed and approved prior to posting. Approved comments will be posted Monday through Friday between the hours of 7:30 a.m. – 4 p.m. Any comments received after 4 p.m. will be posted on the following business day.

Comments

No comments.

MATERNAL HEALTH TASK FORCE
OPQIC QUARTERLY MEETING

OCTOBER 18, 2022

OKLAHOMA
State Department
of Health

OPQIC

Agenda

- Updates
- OHCA Updates
  - OHCA 1115 SoonerCare Choice Demonstration

    Waiver Post Award Forum
  - OHCA Doula Services and Postpartum Extension
- OPQIC Updates
- Other Business

PARTNER UPDATES

SOONERCARE CHOICE POST-AWARD FORUM

Kasie McCarty, Policy Director

October 18, 2022

PURPOSE

2021 SOONERCARE CHOICE PROGRESS

Amendments

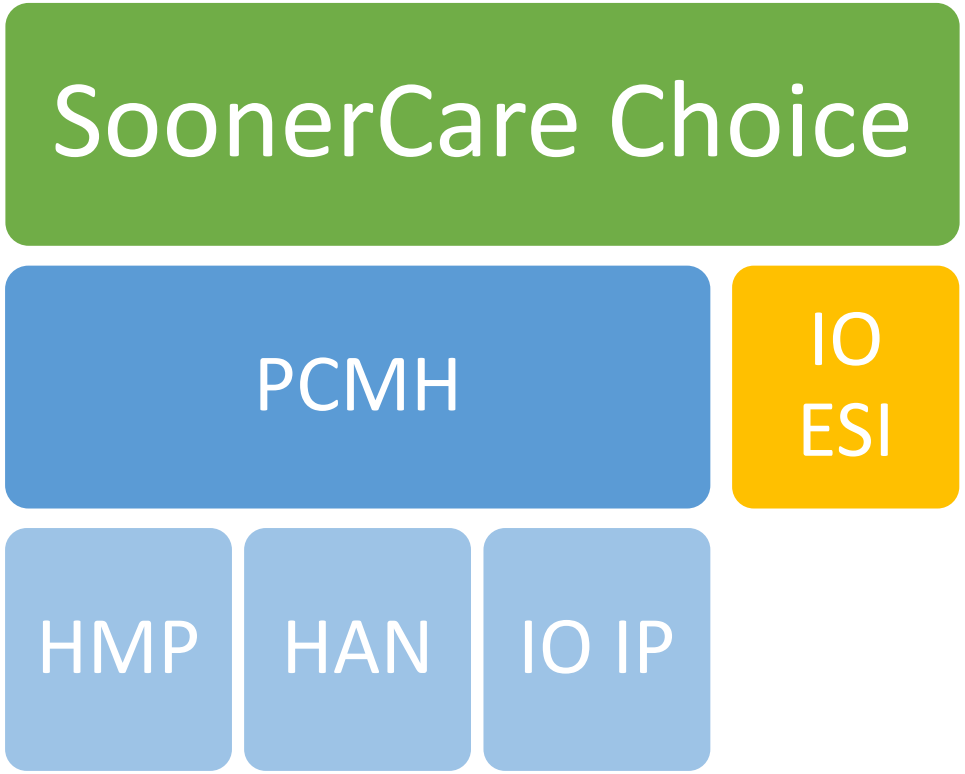
Challenges & achievements

Access, Quality and Outcomes

Program Monitoring

Looking ahead

Public input



WAIVER AMENDMENTS

2021 WAIVER AMENDMENTS

Waiver Request	Submission Date	Status
ITU care coordination rate increase amendment	5/1/2020	Pending CMS approval during the reporting period, officially withdrawn July 2021
Insure Oklahoma Employee Sponsored insurance (ESI) amendment	11/16/2020	Pending CMS approval
Insure Oklahoma phase-out plan	11/16/2020	Pending CMS approval
Enrollment of the Expansion Adult Group and Former Foster Care Group under the SoonerCare Demonstration, Waiver or Retroactive Eligibility for the Expansion Adult Group	2/19/2021	On Hold
Implementation of SoonerSelect (MCO)	2/19/2021	On Hold

CHALLENGES & ACHIEVEMENTS

KEY CHALLENGES

Delivery System Transformation

Public Health Emergency

Medicaid Expansion

- Insure Oklahoma (IO) Insure Plan Phase-out
- Transition of IO Individual members

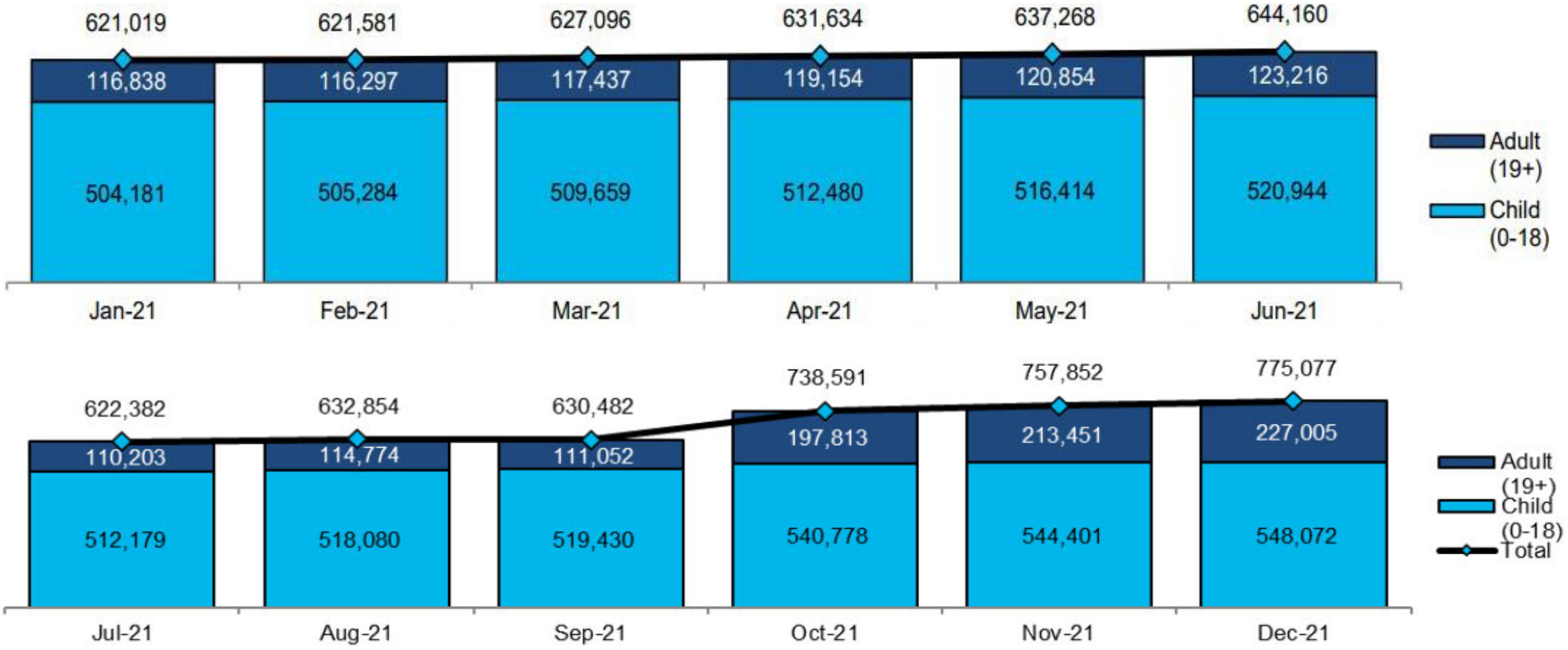
KEY ACHIEVEMENTS

Medicaid Expansion

- Over 230,000 adult expansion members enrolled as of December 2021

Governor’s Award

SOONERCARE CHOICE 2021 ENROLLMENT



ACCESS, QUALITY AND OUTCOMES

HEALTH MANAGEMENT PROGRAM

Health Coaching Participants

Aggregate Savings Net of Administrative Expenses
CY 2019 - 2020

Medical Savings	Administrative Costs	Net Savings
$25,887,05	($15,481,053)	$10,405,999

WORK

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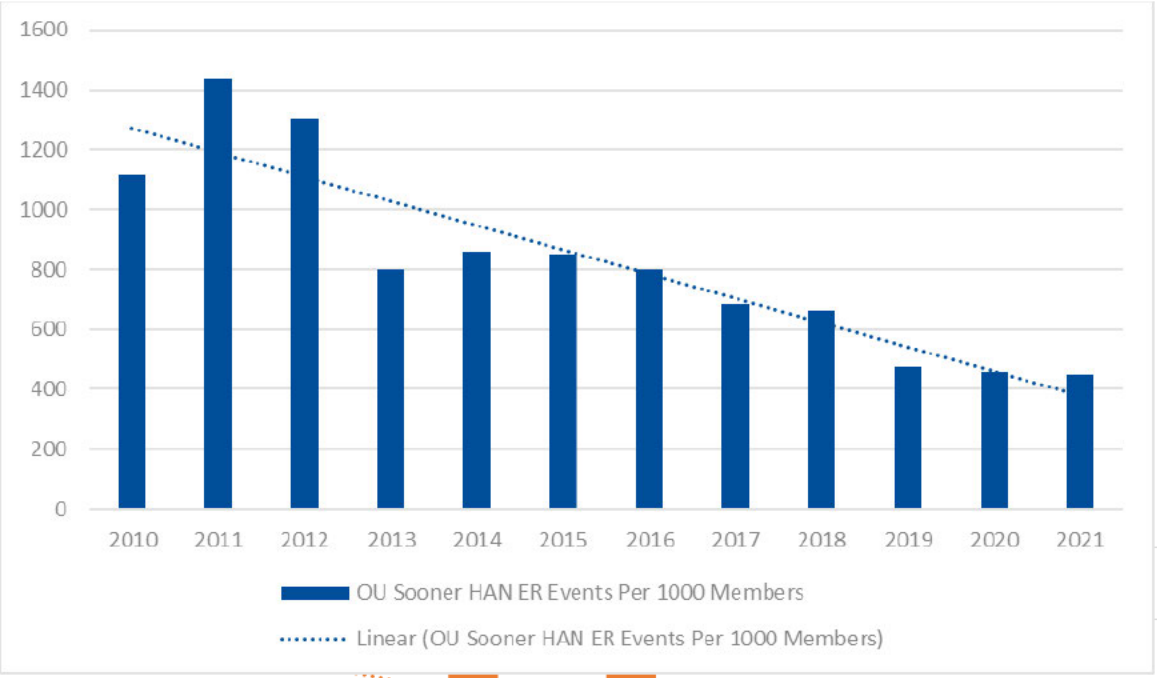
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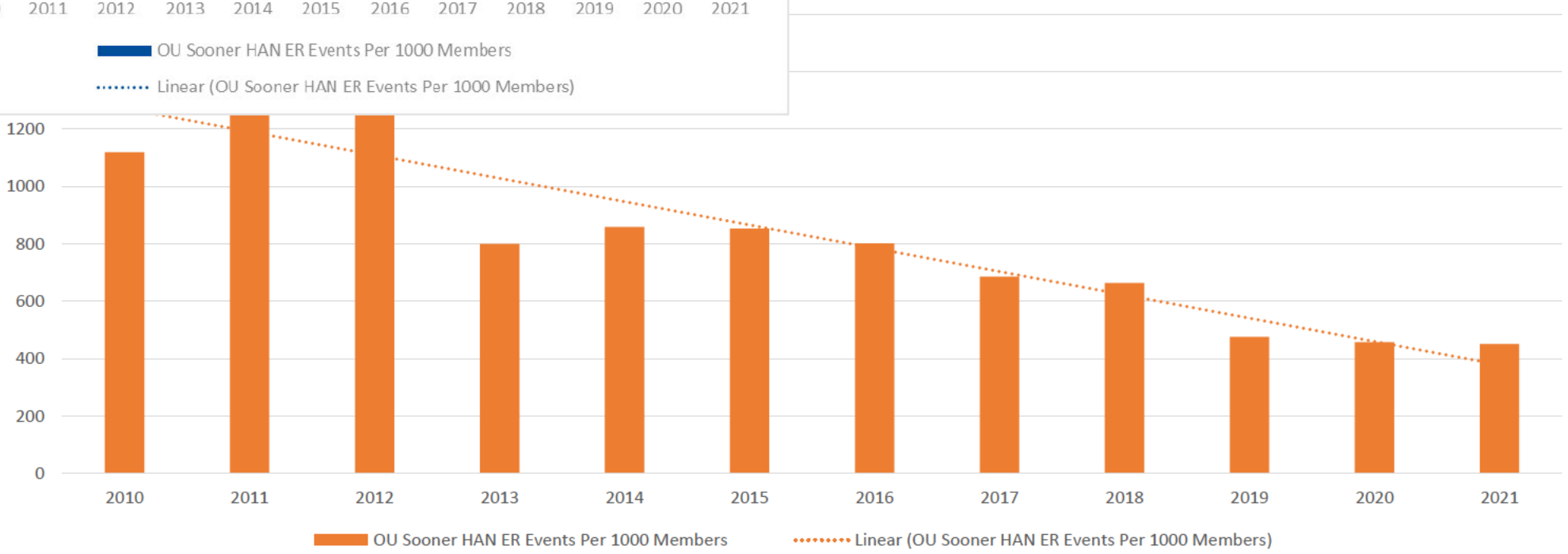
OU Sooner HAN ER Events Per 1000 Members
Linear (OU Sooner HAN ER Events Per 1000 Members)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OU Sooner HAN ER Events Per 1000 Members
Linear (OU Sooner HAN ER Events Per 1000 Members)

PROGRAM MONITORING

BUDGET NEUTRALITY & EVALUATION DESIGN

During 2021, expenditures:

- Remained consistent with previous years
- Were lower than expenditures absent the waiver
- Increased due to the PHE continuous eligibility requirement

EVALUATION DESIGN

Waiver Component	IO	Retroactive Eligibility	HAN	HMP
Access to Care	✓	✓	✓	✓
Quality of Care		✓	✓	
Cost Analysis			✓	✓
Enrollment				✓
Satisfaction				✓
Utilization of ER				✓

LOOKING FORWARD

LOOKING FORWARD

2021 Evaluation Design

2023 – 2028 Renewal

SoonerSelect 2.0

FEEDBACK

FEEDBACK

Submit Questions/comments via

E-mail

Federal.Authorities@okhca.org

OHCA policy blog

oklahoma.gov/ohca/policies-and-rules/proposed-changes

OKLAHOMA
Health Care Authority

GET IN TOUCH

4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

oklahoma.gov/ohca
mysoonercare.org

Agency: 405-522-7300
Helpline: 800-987-7767

SoonerCare Doula Services, Pregnant Woman FPL Increase, & Postpartum Extension

Sandra Puebla, MSW
Deputy State Medicaid Director

DOULA SERVICES – STAKEHOLDER ENGAGEMENT

- Stakeholder Engagement:
  - External stakeholder meetings began in March 2022.
  - Workgroup members consisted of practicing doulas and community members interested in maternal & infant health outcomes.
  - Involved stakeholders weighed in on the program design and reimbursement.

PROPOSED OKLAHOMA DOULA SERVICES MODEL - COVERAGE

- Proposed Implementation Date: May 2023 or after

- Prenatal & Postpartum Visits
  - Up to eight (8) visits

- Labor & Delivery
  - One (1) visit

- Visit Requirements
  - 60 minutes minimum visit length
  - Must be face-to-face
    - Prenatal and postpartum visits may be conducted via telehealth
    - Labor and delivery services may not be conducted via telehealth

PROPOSED OKLAHOMA DOULA SERVICES MODEL – COVERAGE (CONT.)

- The service must be recommended by a physician or other licensed practitioner of the healing arts within their scope of practice under State law.

- The following providers may make a recommendation for doula services:
  - Obstetricians
  - Certified Nurse Midwives and
  - Primary Care Providers
    - Physician
    - Physician Assistant
    - Certified Nurse Practitioners

PROPOSED OKLAHOMA DOULA SERVICES MODEL – COVERAGE (CONT.)

- OHCA will create a form/template that may be used to meet documentation requirement for the referral.

- No Prior Authorization (PA) will be required to access the standard benefit of eight (8) prenatal / postpartum visits and one (1) labor and delivery visit.

- A PA may be submitted to request additional visits beyond the eight (8) prenatal / postpartum visits for members with extenuating medical circumstances.

PROPOSED OKLAHOMA DOULA SERVICES MODEL – VISIT LOCATION

- Doulas coordinate directly with the member and their family to determine the most appropriate service location for prenatal and postpartum visits. Service locations may include:
  - Member's place of residence;
  - Doula's office;
  - Physician's office;
  - Hospital; or
  - In the community.
    - There is no coverage for home births

PROPOSED OKLAHOMA DOULA SERVICES MODEL – EXCLUSIONS

The following are excluded from reimbursement:

- Travel time & mileage;
- Transportation provided to the member, infant, and/or family (SoonerRide available);
- Room & board;
- Phone calls, text messages, and emails;
- Payment for certification and/or recertification expenses;
- Administrative overhead
- No-calls / no-shows;
- Group services;
- Services that are not medically necessary;
- Multiple births (twins, triplets, etc.) are not eligible for additional reimbursement
- There is no separate reimbursement for false labor
  - Payment for false labor is included in the labor and delivery fee

PROPOSED DOULA MODEL – PROVIDER REQUIREMENTS

- Must be 18 years of age;
- Required to obtain an NPI;
- Required to use taxonomy 374J00000X;
- ACA screening fee will not be required for individual doulas;
- Provider type: 57 – Other Service Provider;
- A provider specialty will be assigned in the system.

PROPOSED OKLAHOMA DOULA SERVICES MODEL – CERTIFICATIONS

- Types of Accepted Certifications:
  - Birth Doula
  - Postpartum Doula
  - Full-Spectrum Doula
  - Community-Based Doula

PROPOSED DOULA MODEL – CERTIFYING ORGANIZATIONS

- Birth Arts International (BAI)
- Birth Boot Camp
- BirthWorks International
- Black Doula Training (BDT)
- Childbirth International (CBI)
- Childbirth and Postpartum Professional Association (CAPPA)
- Commonsense Childbirth
- Community Birth Sista/Doula Program
- DONA International
- Doula Trainings International (DTI)
- International Childbirth Education Association (ICEA)
- International Doula Institute
- MaternityWise
- National Black Doulas Association (NBDA)
- SMC Full Circle Doula Training
- ToLabor
- Tulsa Birth Equity Initiative (TBEI)
- Uzazi Village

PROPOSED DOULA MODEL – REIMBURSEMENT

- Reimbursement will be based on a percentage of the current physician schedule
- Prenatal / Postpartum Visits
  - Flat rate per visit
- Labor & Delivery Visits
  - Rate for vaginal delivery
  - Rate for caesarean delivery
  - Rate for a vaginal delivery after previous caesarean
  - Rate for a caesarean delivery following a vaginal delivery attempt after previous caesarean delivery

PREGNANT WOMAN FPL % INCREASE

- Proposed Effective Date: January 1, 2023.
- Purpose: To increase access to services and improve pregnancy / birth outcomes.
- Proposed Change: Increase the federal poverty level (FPL) percentage for pregnant women in SoonerCare.
  - 138 % FPL to 205% FPL, plus applicable 5% MAGI disregards

POSTPARTUM COVERAGE EXTENSION

- Proposed Effective Date: January 1, 2023.
- Purpose: To increase access to services and improve postpartum outcomes.
- Proposed Change: Extend the current 60-day postpartum coverage to a 12-months continuous eligibility postpartum coverage period.

CONTACT INFORMATION

SANDRA PUEBLA, MSW

Deputy State Medicaid Director

Oklahoma Health Care Authority

4345 N. Lincoln Blvd. | Oklahoma City, OK 73105

Cell: (405) 227-3465 | E: sandra.puebla@okhca.org

Questions & Answers

UPDATES FROM THE OKLAHOMA PERINATAL QUALITY IMPROVEMENT COLLABORATIVE

-TeamBirth
-Staffing Changes

Barbara O'Brien, MS, RN
Director, OPQIC

OPQIC
OKLAHOMA PERINATAL QUALITY
IMPROVEMENT COLLABORATIVE

ARIADNE LABS
DELIVERY DECISIONS INITIATIVE

OPQIC
OKLAHOMA PERINATAL QUALITY IMPROVEMENT COLLABORATIVE

OKLAHOMA State Department of Health

TeamBirth: Process Innovation for Clinical Safety, Effective Communication, and Dignity in Childbirth

Oklahoma is First Statewide Initiative

This project is Supported by the State Maternal Health Innovation Program Grant, Maternal and Child Health Bureau, Health Resources and Services Administration, Department of Health and Human Services.

Pilot Hospital - 2019

- Saint Francis Hospital, Tulsa

GKFF Supported Hospitals - 2021

- Hillcrest Medical Center, Tulsa
- OSU Medical Center, Tulsa

OPQIC Statewide Initiative, Supported by OSDH/HRSA Funding

Cohort 1 Hospitals

Launched in March/April 2022

- Ascension St. John, Tulsa
- Bailey Medical Center, Owasso
- Hillcrest Hospital Claremore
- Hillcrest Hospital South, Tulsa
- Mercy Hospital, OKC
- Saint Francis Hospital, Tulsa
- Saint Francis Hospital Muskogee
- Saint Francis Hospital South, Tulsa
- St. Mary's Regional Medical Center, Enid

Cohort 2 Hospitals

Launched in October 2022

- Ascension St. John Jane Phillips, Bartlesville
- Ascension St. John Owasso
- INTEGRIS Baptist Medical Center, OKC
- INTEGRIS Bass Baptist Health Center
- INTEGRIS Canadian Valley Hospital
- INTEGRIS Health Edmond
- INTEGRIS Miami Hospital
- McAlester Regional Health Center
- Cherokee Nation WW Hastings Hospital, Tahlequah
    - *Launch in January 2023*


NICU
EXIT


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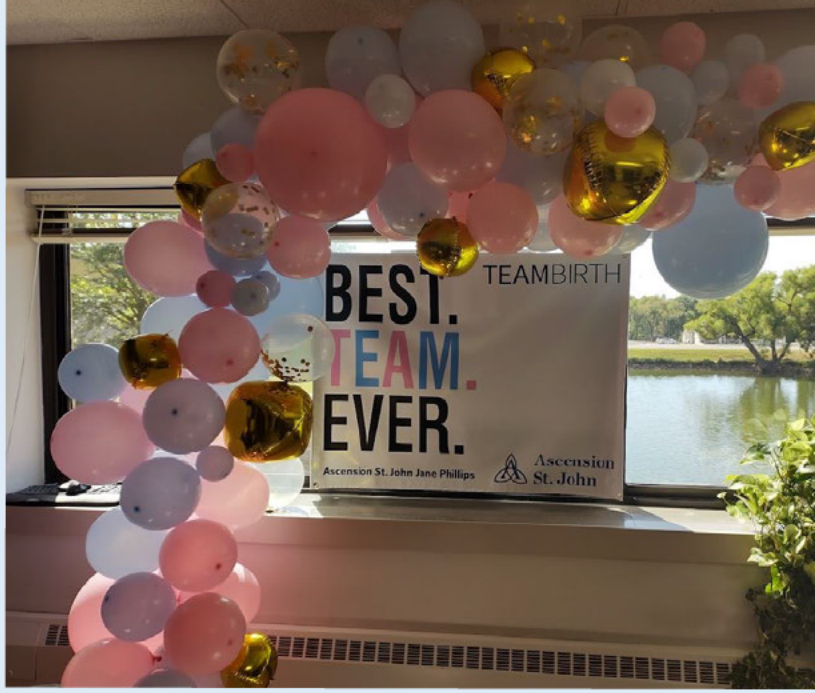
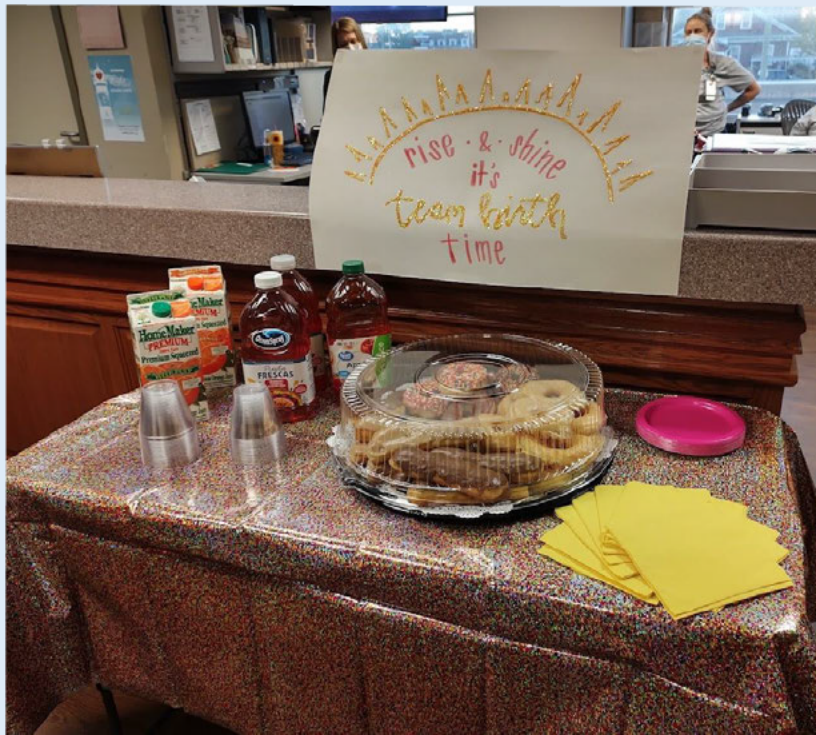
BABY
PROGRESS
NEXT HUDDLE
Early Labor
Active Labor
Pushing


BEST.
TEAM.
EVER.
TEAMBIRTH
Ascension St. John Jane Phillips
Ascension St. John


TEAM
BIRTH


#TeamBirth


rise & shine
it's
team birth
time


Pink or Blue
We're Here For You!

Cohort 3 Hospitals

Learning Sessions Began October 2022
Estimated Launch March/April 2023

- AllianceHealth Ponca City
- Chickasaw Nation Medical Center
- Mercy Hospital Ardmore
- Norman Regional Health System - HealthPlex Campus
- SSM Health St. Anthony Hospital - Oklahoma City
- SSM Health St. Anthony Hospital - Shawnee
- Stillwater Medical Center

Still recruiting more!

OPQIC Staffing Changes

- **Barbara Koop, Program Manager has retired. Barbara will continue to work on a contractual basis.**
- **Elizabeth Ouk, Administrative Assistant has moved out of state.**
- **Kimberly Melton, Administrative/Financial Coordinator has joined our team**

JOIN US IN PERSON FOR OUR

8TH ANNUAL

OPQIC SUMMIT

DATE: NOV 18, 2022

TIME: 9 AM - 4 PM

REGISTRATION STARTS AT 8:30 AM

COST: FREE

LOCATION: MOORE NORMAN TECHNOLOGY CENTER, S PENN CAMPUS

https://opqic.org/summit2022

focus forward oklahoma

LONG-ACTING REVERSIBLE CONTRACEPTIVE TRAINING

who

Providers who have a reasonable expectation of providing contraception as part of their practice. (e.g., Family Medicine, Pediatrics, OB/GYN, Internal Medicine, etc.). Additionally, any Clinical Staff (RN, LPN, MA) and/or Administrative Staff (Practice Managers, Billing/Coding) who are assisting with contraceptive care.

what

The no cost training conference will provide the most up-to-date information on the provision of contraception.

when/Where

DATE	CITY
Saturday, November 12, 2022	ARDMORE
Saturday, December 10, 2022	TULSA
Saturday, March 4, 2023	LAWTON
Saturday, April 15, 2023	OKLAHOMA CITY

How

Register Online Using the QR Code or visit our website: www.focusforwardok.org

For more information, please email our Trainee Liaison: Sarah Coleman at Sarah-Coleman@ouhsc.edu

Maternal Mental Health Hotline

- Phone or text access to professional counselors
- Real-time support and information
- Response within a few minutes, 24 hours a day, 7 days a week
- Resources
- Referrals to local and telehealth providers and support groups
- Culturally sensitive support
- Counselors who speak English and Spanish
- Interpreter services in 60 languages

The hotline is accessible by phone or text at 1-833-9-HELP4MOMS (1-833-943-5746) in English and Spanish. TTY Users can use a preferred relay service or dial 711 and then 1-833-943-5746.

The Maternal Mental Health Hotline is not intended as an emergency response line and individuals in behavioral health crisis should continue to contact the National Suicide Prevention Lifeline at 1-800-273-TALK (8255).

For more information: https://mchb.hrsa.gov/national-maternal-mental-health-hotline/faq

QUESTIONS/OTHER BUSINESS?

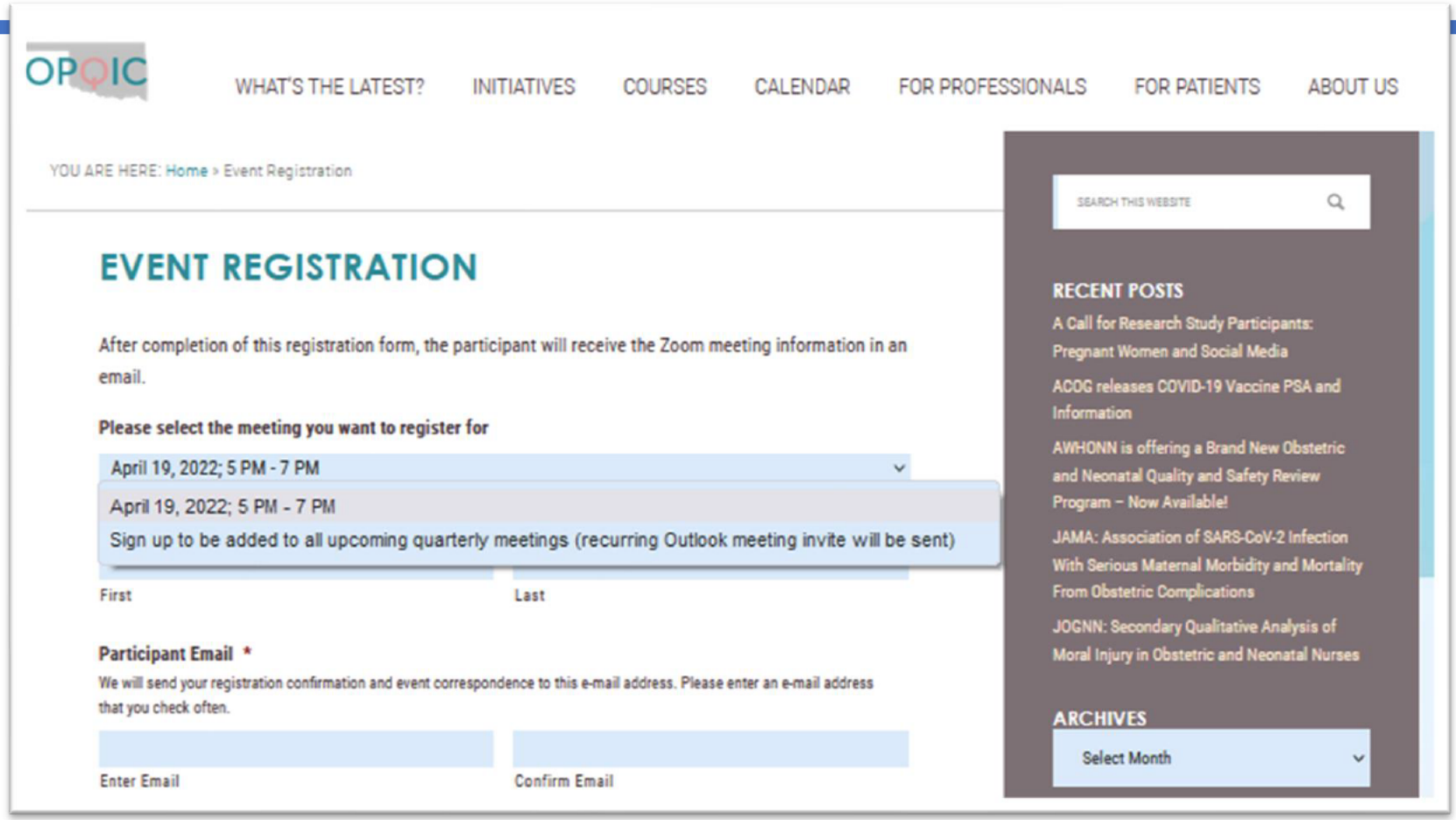
- You may unmute to ask any questions or address any other business items
- If joining on a phone, press *6 to unmute

Quarterly Meetings

Register now to be added to all upcoming OPQIC Quarterly Meetings.

You will be added to a recurring Outlook invite.

Go to https://opqic.org/register



Future Meeting Dates:

- January 17, 2022
- April 18, 2023
- July 18, 2023

5:00pm – 7:00pm

OPQIC

Upcoming Events

To Register, visit https://opqic.org/opqic-upcoming-events/

- November 18, 2022: **OPQIC 8th Annual Summit**
  - https://opqic.org/summit2022

- Project ECHO Maternal Health Webinar Series
  - 1st and 3rd Thursdays of every month, @12:00 PM to 1:00 PM

THANK YOU FOR JOINING US!