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

JAN 1, 2022 – JUNE 30, 2022 | SUBMITTED SEPT. 1, 2022

OKLAHOMA HEALTH CARE AUTHORITY

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I. INTRODUCTION

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

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

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

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

II. OPERATIONAL UPDATES

Policy or Administrative Difficulties

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

Key Challenges

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

Public Health Emergency

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

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

Adult Medicaid Expansion

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

Payments for Excellence

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

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

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

Webinars were held in January, March, and May 2022 regarding the changes with approximately 35 providers attending each webinar.

Delivery Model Transformation

Oklahoma Senate Bill (SB) 1337, directs the Agency to obtain federal authority to add a new health care delivery model transforming the Medicaid program by prioritizing health outcomes for SoonerCare members, seeking to improve SoonerCare member satisfaction, moving the State toward a value-based payment system, containing costs by investing in preventive and primary care, and increasing cost predictability to the State. The legislation directs OHCA to award no less than three capitated contracts for medical, one contract for the Children's Specialty Plan and no less than two capitated contracts for dental managed care programs. SB 1337 directs OHCA to award at least one urban-region contract to a provider-led entity if it otherwise meets all the Request for Proposal (RFP) requirements and agrees to expand to statewide coverage within five years. Populations transitioning into new delivery reform program(s) include: pregnant women, children,

deemed newborns, parent-caretaker relatives, and the expansion population for services related to physical health, dental, behavioral health, and prescription drug services. The Children's Specialty Plan will serve children in foster care, juvenile-justice involved children, and children receiving adoption assistance. The American Indian/Alaska Native population is considered voluntary and will have the option of receiving services through a managed care contracted entity or through the current fee-for-service program operated by OHCA.

The required implementation date is October 1, 2023, contingent upon CMS review and approval and the State began actively working with consultants to achieve the aggressive timeline.

1115 Research and Demonstration Waiver Renewal

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

Key Achievements

Adult Medicaid Expansion

Since the agency began enrollment for newly eligible adults on June 1, 2021, with an effective date of July 1, 2021, for qualified individuals. There were 230,000 adult expansion members as of December 2021, and as of June 30, 2022, there were 304,103.

Issues or Complaints

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

Lawsuits or Legal Actions

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

Unusual or Unanticipated Trends

Neither SoonerCare nor Insure Oklahoma experienced any unanticipated trends in the first half of 2022.

Legislative Updates

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

Signed Legislation Affecting the Agency	Budget Impact Bills
SB 1337 codifies the system design for a transformed Medicaid program, which prioritizes access and quality health outcomes for SoonerCare members and creates preferential scoring opportunities for Oklahoma provider led entities to partner with OHCA as contracted entities under this new model. Under the law, contracted entities can include accountable care organizations, provider-led entities, commercial plans and/or dental benefit managers	SB 1396 makes several adjustments to the supplemental hospital offset payment program and the Health Care Authority's regulations regarding SHOPP
SB 1467 requires the Health Care Authority to conduct an annual review of all medications and forms of treatment for sickle cell disease to determine if such treatments are adequately covered by Medicaid, with a report to the House and Senate.	SB 1661 establishes standards for nonstate government owned medical facilities within the Medicaid supplement program;
SB 1369 creates the Office of the State Coordinator for Health Information Exchange within the Health Care Authority and requires health care entities to report data to said office	SB 1040 includes the SFY23 budget agreement. The OHCA received a 9.7% increase in appropriations for FY23.
SB 1323 allows self-funded and self-insured health care plans which are recognized by the Insurance Dept. and meet certain standards to qualify under the Medicaid Premium Assistance Program	SB 1074 contained OHCA's budget limits and directives for replacing funding no longer available, maintaining and enhancing programs, implementing an enhanced payment for certain intermediate care facilities for individuals with intellectual disabilities.
HB 2322 provides updates to Medicaid coverage to bring it in-line with the Ensuring Access to Medicaid Act;	

Public Forums

The Provider Engagement department conducted webinars held in January, March, and May 2022 regarding the Payments for Excellence changes with approximately 35 providers attending each webinar.

Tribal Consultation

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

Four virtual and on-site tribal consultation meetings were held between January and June 2022. OHCA staff presented 38 proposed policy changes inclusive of state rules, SPAs, and waiver amendments. Topics at the tribal consultation meetings included, but were not limited, to:

- HIV taskforce updates.
- RHC and FQHC visit limitation revisions.
- Removing PCMH panel limits.
- OHCA comprehensive quality strategy.
- 2022 OMB rate increase.
- SB1337 SoonerSelect.

Member Advisory Task Force

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

MATF met four times between January and June 2022 and the following items were discussed:

- Community partners.
- Quality care form, including how to file a complaint or provide feedback about care received.
- Public health emergency.
- SoonerCare member portal and application changes.

Public Comments Received in Post-Award Forum

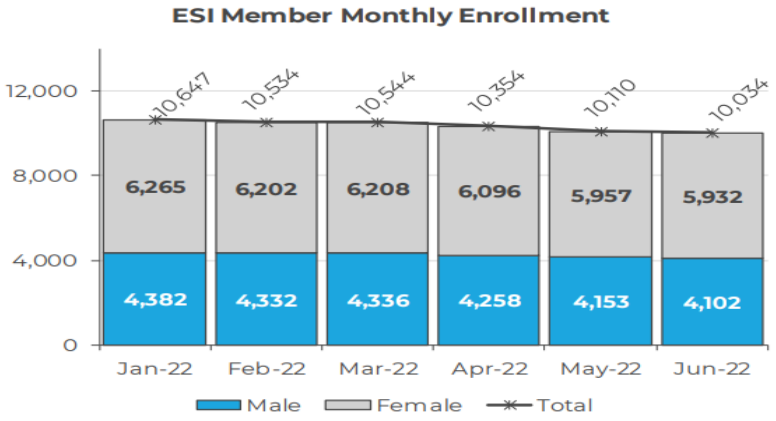
The State did not conduct the 2022 post-award forum during this reporting period.

II. PERFORMANCE METRICS

Impact of Coverage

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

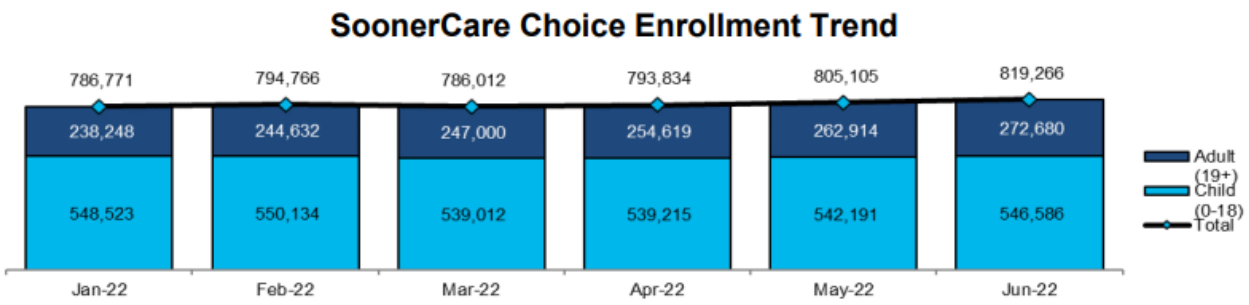
Enrollment for the ESI program is shown in the graph below for the period of January 2022 through June 2022.



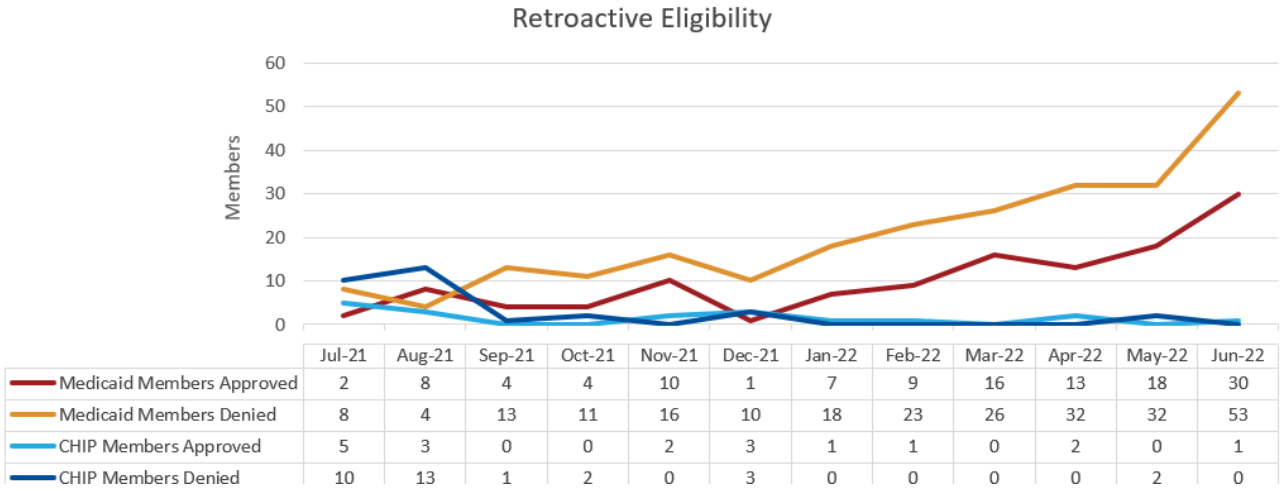
Eligibility and Coverage

SoonerCare Choice and its patient-centered medical home managed care delivery system cover the majority of eligible members. Enrollment in SoonerCare Choice continues to increase each month and is up 27% since June 2021 (644,160 enrollment) following the implementation of adult Medicaid

expansion on July 1, 2021. During the public health emergency, eligibility is continual without closures unless the member dies, moves out of state, or requests the termination.



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



	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Medicaid Members Approved	2	8	4	4	10	1	7	9	16	13	18	30
Medicaid Members Denied	8	4	13	11	16	10	18	23	26	32	32	53
CHIP Members Approved	5	3	0	0	2	3	1	1	0	2	0	1
CHIP Members Denied	10	13	1	2	0	3	0	0	0	0	2	0

Access, Quality and Outcomes

Quantitative Data

Of the over 300,000 adult Medicaid expansion members, 238,193 have received a compensable service through June 2022. The tables below demonstrate access to care for this population.

Table 1. Total number of expansion adults that received a Medicaid service with reimbursement

Members Served	Total Expansion Enrollment	Total Expansion Served | Reimbursement
Total	330,066	238,193 | $1,152,522,670

Table 2. Total number of expansion adults that received a Medicaid service by age group

Client Age As Of Specified Date	Total Expansion Enrollment	Total Expansion Served | Reimbursement
24 & Under	75,716	50,044 | $124,399,307
25 to 34	90,955	63,600 | $221,854,488
35 to 44	75,684	54,051 | $254,672,994
45 to 54	48,629	38,169 | $276,867,744
55 and Older	39,082	32,329 | 274,728,137

Table 3. Total number of expansion adults that received a Medicaid service by urban/rural designation

Urban/Rural	Total Expansion Enrollment	Total Expansion Served | Reimbursement
Urban	201,651	144,212 | $678,383,315
Rural	128,415	93,981 | $474,139,356

Table 4. Top 10 categories of service utilized by expansion adults based on spend

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

Case Studies

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

Member Satisfaction Surveys, Grievances and Appeals

Member Satisfaction

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

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

Grievances and Appeals

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

SoonerCare Grievances (January to June 2022)

	Filed	Granted	Denied
SoonerCare Eligibility	31	2	7
Dental	16	0	4
Prior Authorization	49	1	7
Private Duty Nursing	82	0	12
Misc. (unpaid claims, etc.)	10	6	7
All Other	2	0	0
Total:	190	9	37

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

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

III. BUDGET NEUTRALITY AND FINANCIAL REPORTING

Budget Neutrality Model

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

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

The state submitted the budget neutrality workbook through the PMDA portal on March 16, 2022, and on August 18, 2022. Of note, budget neutrality figures remain similar to previous submissions, however, there has been an increase in overall SoonerCare enrollment numbers due to continuing eligibility during the public health emergency.

IV. EVALUATION ACTIVITIES AND INTERIM FINDINGS

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

SoonerCare 1115 Evaluation Activities

The State's independent evaluator, Pacific Health Policy Group (PHPG), continued evaluation activities in 2021 in accordance with the evaluation design approved by CMS on September 26, 2019. The approved design addresses four major waiver components: Health Access Networks (HANs), SoonerCare Health Management Program (HMP), Insure Oklahoma (premium assistance program) and retroactive eligibility waiver. A summary of the progress of evaluation activities is presented below by waiver component.

The table below summarizes evaluation activities to-date (calendar years 2019 – July 2022) for the SoonerCare Demonstration. OHCA and PHPG have reviewed the most recent CMS technical guidance/technical assistance on the implications of COVID-19 to Demonstration monitoring and evaluation activities and are incorporating the guidance, as applicable, into the evaluation. The OHCA and PHPG likewise have reviewed NCQA guidance with respect to use and interpretation of HEDIS® measures affected by the public health emergency.

OHCA received approval from CMS to enroll the adult Medicaid expansion population into the program's patient centered medical home (PCMH) model. This makes the expansion population a component of the 1115 evaluation design. PHPG will include the expansion population within the larger evaluation and will stratify the analysis between traditional and expansion MEGs in order to isolate the impact of the expansion on the overall program.

PHPG's evaluation findings for 2019-2021 will be presented in the SoonerCare interim evaluation report to be submitted to CMS in December 2022. The report will accompany the Agency's waiver renewal application.

Waiver Component	Progress Summary
Health Access Networks	
Impact on Costs – The implementation and expansion of the HANs will reduce costs associated with the provision of health care services to SoonerCare beneficiaries served by the HANs.	OHCA has provided PHPG with eligibility/paid claims extracts for the first three years of the current Demonstration period – calendar years 2019 (baseline), 2020 and 2021. PHPG is calculating ER visit rates, hospital admission rates and PMPM expenditures for HAN beneficiaries and a comparison group of beneficiaries not enrolled in a HAN or the SoonerCare Health Management Program. The comparison group is being selected using Coarsened Exact Matching (CEM) in accordance with guidance provided by CMS in its comments to the summative evaluation report for the prior Demonstration period (calendar years 2016 – 2018).
Impact on Access – The implementation and expansion of the HANs will improve access to and the availability of health care services to SoonerCare beneficiaries served by the HANs.	The independent evaluator using the claims extract described above to evaluate access through HEDIS® child and adult preventive care measures. The evaluation includes the same comparison group methodology as described above. The Agency provided SoonerCare Choice CAHPS survey data from the CAHPS contractor. The file contained de-identified member-level data, with HAN-affiliated respondents flagged within the database. PHPG is documenting HAN member responses to access-to-care questions, as well as responses from a comparison group consisting of the non-HAN population. The adult CAHPS file includes 33 HAN beneficiaries and 215 other (comparison group) beneficiaries. The child data set includes 283 HAN beneficiaries and 668 other (comparison group) beneficiaries.
Impact on Quality of Care – The implementation and expansion of the HANs will improve the quality and coordination of health care services to SoonerCare beneficiaries served by the HANs, including specifically populations at greatest risk (e.g., those with multiple chronic illnesses.	The evaluator is evaluating quality using HEDIS® chronic care measures for Asthma, CAD, COPD, Diabetes, Hypertension and Mental Health. The evaluator conducted surveys of HAN- affiliated members who have been enrolled in care management, to document satisfaction with the assistance received, including with respect to social determinants of health. The survey universe was stratified by HAN. PHPG completed 150 surveys in total. PHPG is also surveying HAN-affiliated providers who have received HAN practice support, to document satisfaction with the assistance received. PHPG has completed 12 surveys to-date. Due to the small sample size, the provider surveys will be treated as qualitative data in the evaluation. Note: although the HAN surveys were conducted in 2022, many of the activities addressed occurred in 2021. The findings therefore will be included in the interim evaluation report.

Health Management Program	
Impact on Enrollment Figures – The implementation of the third generation HMP, including health coaches and practice facilitation, will result in an increase in enrollment, as compared to baseline.	The HMP contractor routinely provides updated rosters to the independent evaluator. The evaluator uses the rosters to track new enrollments, disenrollments and continuing participants on a monthly basis.
Impact on Access to Care – Incorporating health coaches into primary care practices will result in increased contact with HMP beneficiaries by the PCP (measured through claims encounter data), as compared to baseline, when care management occurred (exclusively) via telephonic or face-to-face contact with a nurse care manager.	The evaluator is using the paid claims extract described above to document the average number of PCMH visits incurred by HMP participants. The analysis is stratified by health coaching mode. However, the COVID-19 PHE disrupted health coaching patterns in 2020 and early 2021 (i.e., telephonic coaching was substituted for office- and home-based coaching), reducing the efficacy of comparing across modes. PHPG will explore stratification of results for the summative report, which will include two additional years of post-PHE data.
Impact on Identifying Appropriate Target Population – The implementation of the third generation HMP, including geographic expansion and introduction of additional health coaching modalities, will result in an increase in the average risk profile of newly-enrolled members (based on the average number of chronic conditions) as the program becomes available to qualified members who do not currently have access to the HMP.	The evaluator is using the paid claims extract described above to document the average number of chronic conditions among HMP participants and percentage of participants with a physical/behavioral health co-morbidity.
Impact on Health Outcomes – Use of disease registry functions by the health coach will improve the quality of care delivered to beneficiaries, as measured by changes in performance on the initial set of Health Care Quality Measures for Medicaid-Eligible Adults or CHIPRA Core Set of Children's Healthcare Quality Measures.	The evaluator is using the claims extract described above to evaluate health outcomes using HEDIS® chronic care measures for Asthma, CAD, COPD, Diabetes, Hypertension, Mental Health, and pain management. The evaluator also is conducting surveys of HMP-participating PCMH providers and members, to document satisfaction with HMP practice support activities (provider surveys) and HMP quality-of-care management, including assistance with social determinants of health (member surveys). Both surveys are being conducted on a continuous basis. In 2019 – 2021, the evaluator completed approximately 1,940 initial and 925 follow-up surveys. The 2021 beneficiary survey also included the CAHPS question set addressed above for the HAN population. PHPG is evaluating HMP beneficiary responses against the same comparison group universe as used in the HAN analysis.

Impact on Cost/Utilization of Care - ER – Beneficiaries using HMP services will have fewer ER visits, compared to beneficiaries not receiving HMP services (as measured through claims data).	The evaluator is calculating ER cost/utilization for 2019 – 2021 by applying the same methodology for HMP participants as described above for HAN-affiliated beneficiaries.
Impact on Cost/Utilization of Care – Hospital – Beneficiaries using HMP services will have fewer admissions and readmissions to hospitals, compared to beneficiaries not receiving HMP services (as measured through claims data).	The evaluator is in the process of calculating hospital cost/utilization for 2019 – 2021 by applying the same methodology for HMP participants as described above for HAN-affiliated beneficiaries.
Impact on Satisfaction/Experience with Care – Beneficiaries using HMP services will have higher satisfaction, compared to beneficiaries not receiving HMP services (as measured through survey data employing CAHPS questions).	The 2021 beneficiary survey also included the CAHPS question set addressed above for the HAN population. PHPG is evaluating HMP beneficiary responses against the same comparison group universe as used in the HAN analysis.
Impact on Effectiveness of Care – Total and per member per month expenditures for members enrolled in HMP will be lower than would have occurred absent their participation in nurse care management.	The evaluator is calculating PMPM expenditures for 2019 – 2021 by applying the same methodology for HMP participants as described above for HAN-affiliated beneficiaries.
Insure Oklahoma	
The evaluation will support the hypothesis that Insure Oklahoma is improving access to care for low-income Oklahomans not eligible for Medicaid, as measured by the number of individuals enrolled in Insure Oklahoma.	The OHCA produces monthly reports of Insure Oklahoma member enrollment. The evaluator is using the reports to document program enrollment trends. Note that Insure Oklahoma enrollment declined significantly in the second half of 2021 as beneficiaries newly-eligible for Medicaid due to adult expansion were transitioned from Insure Oklahoma to TXIX.
The evaluation will support the hypothesis that Insure Oklahoma is improving access to care for low-income Oklahomans not eligible for Medicaid, as measured by the number of employers participating in the ESI portion of Insure Oklahoma.	The OHCA produces monthly reports of Insure Oklahoma employer counts. The evaluator is using the reports to document employer participation trends.

The evaluation will support the hypothesis that Insure Oklahoma is improving access to care for low-income Oklahomans not eligible for Medicaid, as measured by the number of primary care providers participating in the Individual Plan portion of Insure Oklahoma.	The OHCA produces monthly reports of Insure Oklahoma primary care provider counts. The evaluator is using the reports to document PCP participation trends. Note that the OHCA discontinued in 2021 the portion of Insure Oklahoma that included direct contracts with primary care providers. This component of the evaluation will be discontinued going forward.
Waiver of Retroactive Eligibility	
Impact on Access to Care – Eliminating retroactive eligibility will increase the likelihood of enrollment and enrollment continuity.	The evaluator is using the eligibility extract described above to calculate quarterly enrollment of members subject to the waiver and a comparison group of members not subject to the waiver. The comparison group is being selected using CEM. Note that this analysis will be affected by the extension of eligibility for covered populations during the COVID-19 public health emergency.
Impact on Quality of Care – Health Status at Enrollment – Eliminating retroactive eligibility will increase enrollment of eligible people when they are healthy relative to those eligible people who have the option of retroactive eligibility.	The evaluator drafted a health status survey in accordance with CMS technical assistance/guidance and is conducting the survey by telephone on members subject to the waiver and a comparison group of members not subject to the waiver. The survey is conducted at time of enrollment (baseline) and at 12, 18 and 24-months post-enrollment. The populations subject to the retroactive eligibility waiver were modified in the current Demonstration period and the OHCA implemented the modifications in the spring of 2020. The evaluator began baseline surveys in August 2020 (for members enrolled in July 2020) and has completed 5972 through December 2021. Follow-up surveys commenced in August 2021, starting with members who received baseline surveys in August 2020.
Impact on Quality of Care – Health Outcomes – Through greater continuity of coverage, health outcomes will be better for those subject to retroactive eligibility waivers compared to other Medicaid beneficiaries who have access to retroactive eligibility.	Self-reported health outcomes are being evaluated using the survey process described above.

V. ATTACHMENTS

None

VI. STATE CONTACT

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Oklahoma City, OK 73105

Kevin Corbett
Chief Executive Officer
Phone: 405.522.7417

VII. DATE SUBMITTED TO CMS

September 1, 2022