2023
SOONERCARE DEMONSTRATION
11-W-00048/6
§1115(a) SEMI-ANNUAL REPORT

JAN. 1, 2023-JUNE 30, 2023 | REVISION SUBMITTED SEPT. 14, 2023

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

Waiver Requests	Date of Submission	Status of Request
Enrollment of Pregnant Women with income between 134% and 185% FPL	3/8/2023	Approved 6/29/2023
Disaster Relief Waiver of Cost Sharing	4/4/2023	Pending CMS approval

Public Health Emergency

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

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

The Consolidated Appropriations Act (CAA) funding bill passed in late December 2022 decoupled the continuous enrollment requirement from the PHE and set a hard end date of March 31, 2023, for continuous enrollment of the PHE-protected group. The agency initiated the unwinding period and began reprocessing renewals and making eligibility determinations in May 2023, and it will continue through December 2023. OHCA implemented the unwinding approach including the communication plan to inform members, the media and stakeholders of the notification process and actions to take if members are notified that they are no longer eligible.

Adult Medicaid Expansion

Due to the passing of State Question (SQ) 802, a new state constitution article was added to expand Medicaid in Oklahoma no later than July 1, 2021; therefore, OHCA submitted an 1115 waiver amendment and phase-out plan to sunset the Insure Oklahoma Individual Plan (IP) program and to move members within the Employer-Sponsored Insurance (ESI) plan with incomes at or below 133% FPL (plus any applicable income disregards) to Medicaid coverage provided under Title XIX. All phase-out activities were completed as of June 30, 2021, and CMS provided the state with approved STCs on Jan. 31, 2022; however, the program has remained in the STCs due to the PHE maintenance of effort (MOE) requirements.

Delivery Model Transformation

Oklahoma Senate Bill (SB) 1337 directs the agency to obtain federal authority to add a new health care delivery model transforming the Medicaid program by prioritizing health outcomes for SoonerCare members, seeking to improve SoonerCare member satisfaction, moving the state toward a value-based payment system, containing costs by investing in preventive and primary care, and increasing cost predictability to the state. The legislation directs OHCA to award no less than three capitated contracts for medical, one contract for the Children's Specialty Plan, and no less than two capitated contracts for dental managed care programs. SB 1337 directs OHCA to award at least one urban region contract to a provider-led entity if it otherwise meets all the Request for Proposal (RFP) requirements and agrees to expand to statewide coverage within five years. Populations transitioning into new delivery reform program(s) include: pregnant women, children, deemed newborns, parent-caretaker relatives, and the expansion population for services related to physical health, dental, behavioral health, and prescription drug services. The Children's Specialty Plan will serve children in foster care, juvenile justice-involved children, and children receiving adoption assistance. The American Indian/Alaska Native population is considered voluntary and will have the option of receiving services through a managed care contracted entity or through the current fee-for-service program operated by OHCA.

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

The SoonerSelect Dental RFP was released on Sept. 1, 2022, with a proposal submission deadline of October 31. Bids were reviewed, oral presentations were conducted, and recommendations were made to executive staff. The two successful Dental Benefit Plans (DBP) were announced on January 19, 2023, and are tasked with implementing comprehensive care coordination strategies for members, which will redirect members from using emergency department services, increase preventive care, reduce the need for high-cost restorative procedures, and improve provider and specialist networks.

The SoonerSelect Medical RFP was released on Nov. 10, 2022, with a proposal submission deadline of Feb. 8, 2023. On June 8, 2023, three successful contracted entities were announced to serve as the medical plans, and one will also serve the Children's Specialty Program.

The two DBP and three contracted entities are undergoing readiness review activities at the time of this report.

1115 Research and Demonstration Waiver Renewal

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

The agency submitted its renewal application to CMS on Dec. 29, 2022, requesting a five-year renewal from Jan. 1, 2024, through Dec. 28, 2028. The federal comment period was open from Jan. 5, 2023, through Feb. 4, 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 376,699 adult expansion members as of June 2023.

Traylor Rains Named to NAMD Board of Directors

The National Association of Medicaid Directors (NAMD) Board of Directors elected Oklahoma State Medicaid Director Traylor Rains to serve as a south region representative on its Board of Directors. Rains joins 13 other Medicaid directors, elected by their peers, to lead the association in increasing awareness about the impact of Medicaid and the Children's Health Insurance Program (CHIP), as well as the role and expertise of Medicaid leaders to drive innovation and high performance of Medicaid and CHIP programs. The board is responsible for shaping and guiding the association's mission, vision and objectives, as well as providing strategic and financial oversight of the association.

Issues or Complaints

There were no new issues or complaints during the reporting period.

Lawsuits or Legal Actions

There were two 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 between January and June 2023.

Legislative Updates

In 2023, the first regular session of the 59th Legislature met from Feb. 6, 2023, and adjourned Sine Die on May 26, 2023. The 2023 special session began May 17, 2023, and is ongoing.

There were three bills requested by the agency that were subsequently signed into law during regular session.

- House Bill 1657 requires the OHCA to streamline the process for Medicaid provider enrollment and credentialing for any fee-for-service and managed care delivery systems. Effective Nov. 1, 2023.
- House Bill 1658 requires entities to obtain the appropriate HMO certificate of authority from the Department of Insurance prior to entering into a contract with the OHCA. Effective May 15, 2023.
- House Bill 1791 increases the priority of the OHCA in certain lien proceedings and establishes a standard reimbursement formula for payments due to be recovered. Effective Nov. 1, 2023.

Signed Legislation Affecting the Agency	Special Session/Budget Impact Bills
SB 225 - Adjusts certain reporting requirements by the Oklahoma Health Care Authority to the governor and legislature to require reporting every fifth year rather than odd-numbered years and creates a school nurse pilot program fund. Effective date: 11/01/2023.	SB 23 - Adjusts provisions related to payment methodology and reimbursement for ground emergency transportation services. Effective date: 06/02/2023.
SB 292 - Requires health care providers to follow certain standards for syphilis testing during pregnancies, such required testing to be covered by health benefit plans. Effective date: 11/01/2023.	SB 32 - Sets budget limits for the Oklahoma Health Care Authority: $30M for HIE connections, $47M for long-term care and ICF/IID rates, and $200M for hospitals. Effective date: 07/01/2023.
SB 444 - Requires health benefit plans that provide mental health or substance abuse disorder benefits to provide reimbursement for benefits that are delivered through certain collaborative care models. Effective date: 11/01/2023.	HB 1004 - General appropriations bill. Effective date: 07/01/2023.
SB 513 - Requires insurers, including the state's Medicaid program, to cover biomarker testing in certain instances. Effective date: 01/01/2024.	
SB 563 - Includes that anesthesia is to continue to be reimbursed equal to or greater than the established fee schedule, with value-based payment arrangements possible for services furnished to Medicaid members. Effective date: 05/25/2023.	
SB 613 - Prohibits gender-affirming treatment and care for any persons under the age of 18, physicians to be guilty of unprofessional conduct upon violation. Effective date: 05/01/2023.	

SB 712 - Directs the Dept. of Mental Health to provide hospitals with opioid antagonists to be given to persons presenting to emergency departments with the symptoms of an opioid overdose or related disorder upon discharge from the hospital. Effective date: 11/01/2023.	
SJR 22 - Approves certain proposed permanent rules of various state agencies. Effective date: 05/31/2023.	

Public Forums

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 2023. OHCA staff presented 32 proposed policy changes inclusive of state rules, SPAs and waiver amendments. Topics at the tribal consultation meetings included but were not limited, to:

- Tribal Partner Traction Plan
- 988 Mental Health Lifeline
- SoonerSelect
- Community health events
- Public health emergency unwinding

Member Advisory Task Force

The Member Advisory Task Force (MATF) 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 from January through June 2023, and the following items were discussed:

- Postpartum coverage expanding from 60 days to 12 months
- Public health emergency unwinding
- Mobile app development
- Preventive services
- SoonerSelect
- Health Information Exchange
- SoonerCare comprehensive quality strategy

During this evaluation period, OHCA implemented the following recommendations made by the MATF:

- A purple graphic to share information regarding resuming renewals post-public health emergency
- An increase in private duty nursing rates
- Updated call center service technology
- Clarified SoonerSelect communication including letters, documents and social media posts

Public Comments Received in Post-Award Forum

The state did not conduct the 2023 post-award forum during this reporting period.

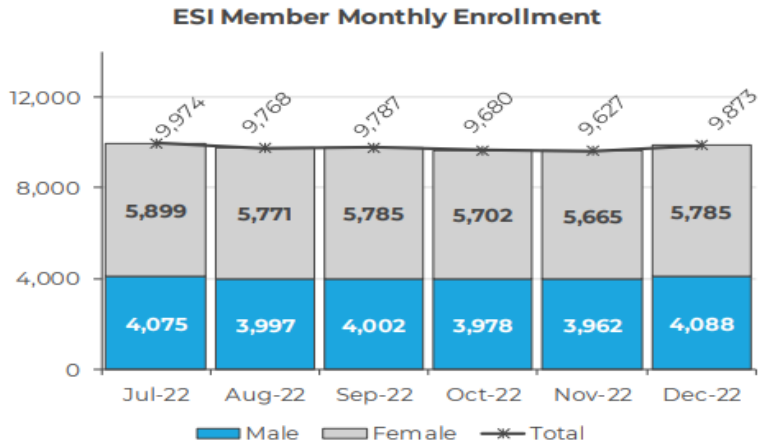
III. PERFORMANCE METRICS

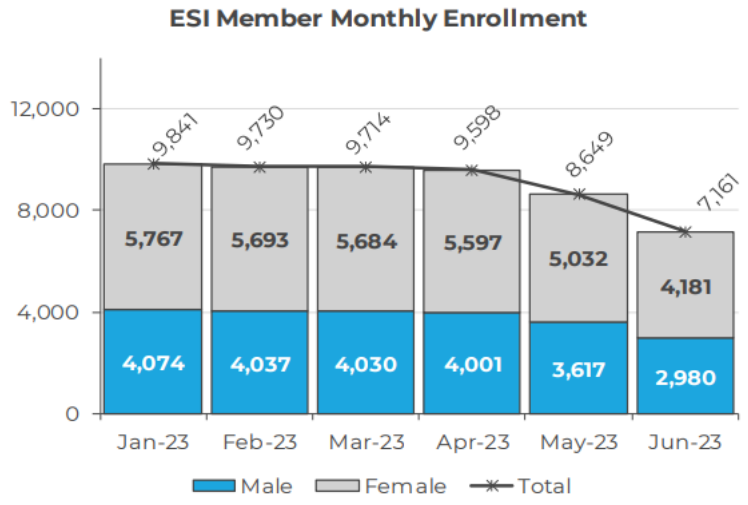
Impact of Coverage

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

The Consolidated Appropriations Act (CAA) funding bill passed in late December 2022 decoupled the continuous enrollment requirement from the PHE and set a hard end date of March 31, 2023, for continuous enrollment of the PHE-protected group. Changes in enrollment can be attributed to the PHE unwinding process which began in May 2023 and will continue through December 2023.

Enrollment for the ESI program is shown in the graph below for the periods of July through December 2022 and January through June 2023.

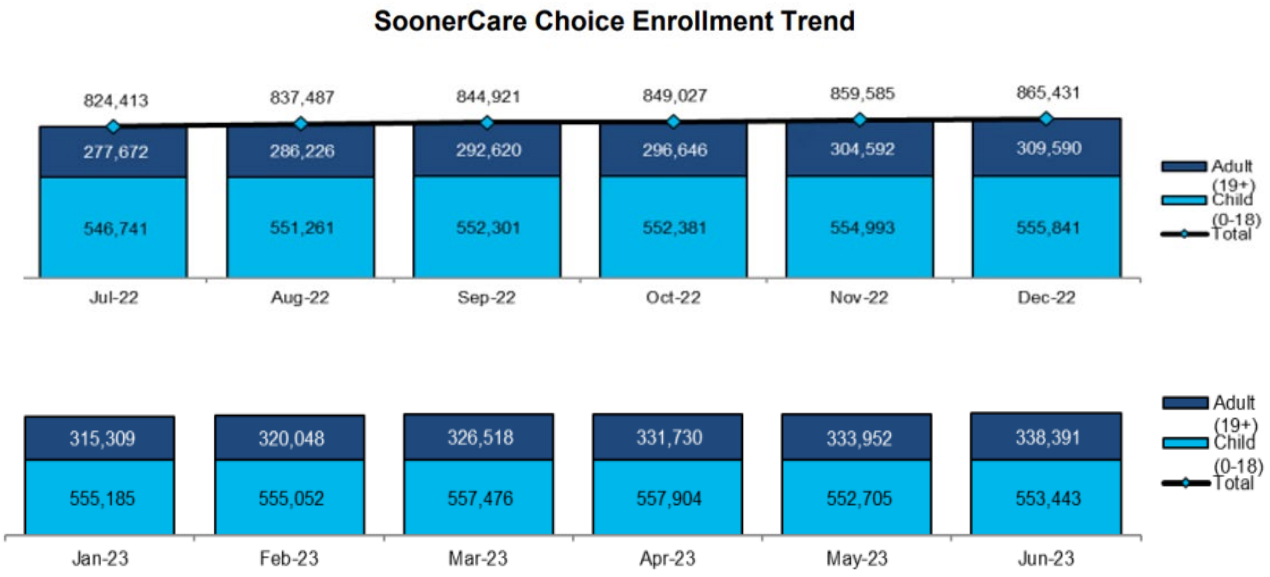




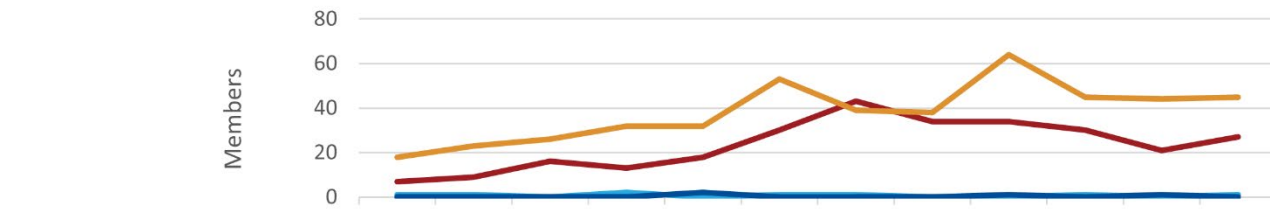
Eligibility and Coverage

SoonerCare Choice and its patient-centered medical home managed care delivery system cover the majority of eligible members. Enrollment in SoonerCare Choice remained relatively stable during this reporting time and ended with 891,834 members in June 2023, which is nearly a 9% increase in enrollment from June 2022 (819,266 members). During the public health emergency, eligibility was continual without closures unless the member dies, moves out of state or requests the termination.

The Consolidated Appropriations Act (CAA) funding bill passed in late December 2022 decoupled the continuous enrollment requirement from the PHE and set a hard end date of March 31, 2023, for continuous enrollment of the PHE-protected group. Changes in enrollment can be attributed to the PHE unwinding process which began in May 2023 and will continue through December 2023.



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



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

Access, Quality and Outcomes

Quantitative Data

On June 1, 2023, the OU Sooner Health Access Network (HAN) was awarded NCQA accreditation. They received the "highest accreditation status of Accredited – three years for service and quality that demonstrates strong performance of NCQA's rigorous requirements for case management."

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 reward high-achieving practices relative to all PCMH providers and those that make significant improvements in performance.

Payments and provider scorecards are distributed on a quarterly basis. These scorecards demonstrate providers' performance on all four incentive measures, as well as how they performed compared to their peers. For the Emergency Department Utilization measure, providers scoring in the top half of scores receive a bonus payment. Providers that showed improvement from the previous quarter's status received an improver payment. For the other three measures, providers received a payment for scoring in the top third of all scores and a reduced payment for being in the middle third of all scores. As with the Emergency Department Utilization measure, providers that showed improvement from the previous quarter's status received an improver payment.

In April 2023, OHCA delivered what was the 4th set of quarterly scorecards and payments, covering the calendar year of 2022. See table below.

			Payment Disbursement by Measure			
Scorecard & Payment Delivery	**Period Covering**	**Scorecards Sent**	**Behavioral Health**	**Diabetic Control**	**ED Utilization**	**Obesity**
July 2022	January 2022 through March 2022	671	$187,500	$187,500	$250,000	$125,000
October 2022	April 2022 through June 2022	702	$187,500	$187,500	$250,000	$125,000
January 2023	July 2022 through September 2022	720	$187,500	$187,500	$250,000	$125,000
April 2023	October 2022 through December 2022	736	$187,500	$187,500	$250,000	$125,000

Case Studies

Below are case studies provided to OHCA by the Health Management Program and Health Access Networks.

- Member engaged in the Health Management Program for improved management of diabetes. Other health conditions included obesity, anxiety, disorder of lipid metabolism, persistent asthma, and chronic pain. Social determinants of health (SDOH) needs

identified included financial, physical and transportation barriers. SDOH were addressed by HMP Resource Managers including information on the Double Down program, local food banks, SoonerCare helpline information for billing issues, dental resources, and utility assistance. A care plan was created in collaboration with the health coach to achieve an A1c of less than 6% over six months through education, nutrition and treatment plan adherence to medications and to schedule follow-up visits. Upon engagement, the member's A1c was 7.5%. Since collaborating with the health coach, the member successfully implemented daily glucose monitoring, has been compliant with medications, and made healthy changes to their diet resulting of an A1c of 6.9% as of April 2023.

- A 55-year-old man had COPD, heart disease, hypertension, and continuous oxygen. He was staying with a friend in a very isolated area of a house that had only partial heat in one room. Member had no source of income. His friend received Social Security benefits. When his friend's vehicle broke down, they had no transportation. We worked to arrange for SoonerRide to transport him to appointments, but they had trouble locating him and he missed appointments. We encouraged him to ask for telehealth visits and provided him with information on some of the local churches, who might help him get to his medical appointments. His prescriptions ran out and he could not get refills until he saw his medical providers. He applied for disability, but still had no income. While working with him to get the resources he needed, he became unreachable by phone and we were concerned about his safety. The sheriff's office was contacted to do a welfare check. They reported back that he was safe, but his phone had been disconnected. It took several weeks before we were able to reach him by phone. His roommate had procured a working vehicle and was able to take him to appointments. He was approved for disability and started receiving checks. He was appreciative that we had requested the welfare check and said, "no one has ever cared enough for me in my life to do something like that." This member used his disability money to rent a room in OKC that is more accessible to health care.
- "I have been very grateful to my health coach. On countless occasions, she has always offered help no matter what was needed. I wish she wasn't retiring [as she] always answers my numerous questions."
- "[Health Coach] is a very understanding person and she knows how to work with people who have special needs. I'm very glad to have her as my health coach."
- "I don't have any bad comments on [Health Coach], she has been great on helping me with my health issues and talking about my medications that I take every month. We talk about the same and new things that I may have needed help with. I would love to keep [Health Coach] as my health provider."

Member Satisfaction Surveys, Grievances and Appeals

Member Satisfaction

Between April 30, 2023, and June 30, 2023, approximately 60,000 members have not been able to have their eligibility renewed following the conclusion of the PHE. OHCA began a partnership with Unite Us to assist members with resource needs such as alternate health care coverage, food insecurity, utility assistance, personal safety, etc. Data related to this effort will be included in future reports.

A randomized group of 500 members participating in the Health Coaching component of the Health Management Program were asked to complete a satisfaction survey during the second quarter of 2023. Of the 72 respondents (14%), 93% reported their coach helped them manage their health problem, 96% worked with them to develop a plan to reach their health goals, and 97.3% rated their overall experience with the health coach as good or very good.

Grievances and Appeals

The table below provides the number of grievances (appeals) filed by category for the SoonerCare program during the reporting period. Cases not counted as granted or denied are pending or have been closed for reasons other than a decision (settled, withdrawn, not filed timely, etc.). All cases are heard and, at minimum, provided an initial decision within 90 days, absent agreement of the parties to continue the case. The year-to-date breakdown as of June 2023 demonstrates that 3% of grievances are granted, 12% denied, 28% are settled/resolved, 19% are dismissed, and 40% are pending. There are no noteworthy or concerning trends.

SoonerCare Grievances (January to June 2023)

	Filed	Granted	Denied
SoonerCare Eligibility	71	1	1
Dental	17	0	4
Prior Authorization	52	1	11
Private Duty Nursing	100	5	16
Misc. (unpaid claims, etc.)	20	2	1
All Other	4	1	0
Total:	264	10	33

The state continued to receive a steady number of appeals related to private duty nursing during this reporting period with an average of 16 per month with a brief spike in February (23) and March (25) 2023. PDN grievance figures include both initial PDN requests and re-reviews for children already on PDN service. The spike in February and March is likely related to the timing of re-review cycles. Additionally, in March 2023, OHCA implemented Interqual criteria for PDN authorizations for both new requests and re-reviews of children on service. The objective criteria in use likely also contributed to additional denials and therefore appeals.

IV. BUDGET NEUTRALITY AND FINANCIAL REPORTING

Budget Neutrality Model

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

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

The state submitted the budget neutrality workbook for 2022 through the PMDA portal on Feb. 21, 2023. The next submission will be made prior to the Aug. 30, 2023, deadline and will cover the period through June 30, 2023. Of note, budget neutrality figures remain similar to previous submissions, however, there has been an increase in overall SoonerCare enrollment numbers due to continuing eligibility during the public health emergency. OHCA will monitor the impact the PHE unwinding process has on budget neutrality.

V. EVALUATION ACTIVITIES AND INTERIM FINDINGS

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

SoonerCare 1115 Evaluation Activities

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

CMS approved the interim evaluation report in July 2023. CMS also provided recommendations for enhancing the summative evaluation report, due to be submitted no later than June 2025. PHPG is incorporating these recommendations into the evaluation methodology.

PHPG currently is documenting calendar year 2022 evaluation findings, for inclusion in the summative evaluation report. The table below summarizes current evaluation activities.

Waiver Component	Progress Summary
Health Access Networks	
Impact on Costs – The implementation and expansion of the HANs will reduce costs associated with the provision of health care services to SoonerCare beneficiaries served by the HANs.	PHPG will be obtaining an eligibility file and paid claims extract for calendar year 2022 in April 2023. The extract will be used to calculate ER visit rates, hospital admission rates and PMPM expenditures for HAN beneficiaries (general and care managed) and a comparison group of beneficiaries not enrolled in a HAN or the SoonerCare Health Management Program. The comparison will be selected using Coarsened Exact Matching (CEM), in accordance with guidance provided by CMS.
Impact on Access – The implementation and expansion of the HANs will improve access to and the availability of health care services to SoonerCare beneficiaries served by the HANs.	The independent evaluator using the claims extract described above to evaluate access through HEDIS® child and adult preventive care measures. The evaluation includes the same comparison group methodology as described above. The OHCA provides PHPG with annual adult and child CAHPS survey data from its CAHPS vendor. The vendor's files contain de-identified member-level data, with HAN-affiliated respondents flagged within the database. PHPG will request the latest CAHPS data in September 2023, to document HAN member responses to access-to-care questions, as well as responses from a comparison group consisting of the non-HAN population.
Impact on Quality of Care – The implementation and expansion of the HANs will improve the quality and coordination of health care services to SoonerCare beneficiaries served by the HANs, including specifically populations at greatest risk (e.g., those with multiple chronic illnesses).	The independent evaluator using the claims extract described above to evaluate access through HEDIS® child and adult preventive care measures. The evaluation includes the same comparison group methodology as described above. PHPG obtained in July an updated roster of HAN-affiliated beneficiaries who have been enrolled in care management. PHPG will begin surveying the beneficiaries in August, to document satisfaction with the assistance received, including with respect to social determinants of health. PHPG also obtained an updated list of HAN-affiliated providers who have received HAN practice support and will survey them in August, to document satisfaction with the assistance received.

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

Impact on Cost/Utilization of Care – Hospital – Beneficiaries using HMP services will have fewer admissions and readmissions to hospitals, compared to beneficiaries not receiving HMP services (as measured through claims data).	The evaluator is in the process of calculating hospital cost/utilization for 2022 by applying the same methodology for HMP participants as described above for HAN-affiliated beneficiaries.
Impact on Satisfaction/Experience with Care – Beneficiaries using HMP services will have higher satisfaction, compared to beneficiaries not receiving HMP services (as measured through survey data employing CAHPS questions).	The beneficiary survey also included the CAHPS question set addressed above for the HAN population. PHPG is evaluating HMP beneficiary responses against the same comparison group universe as used in the HAN analysis.
Impact on Effectiveness of Care – Total and per member per month expenditures for members enrolled in HMP will be lower than would have occurred absent their participation in nurse care management.	The evaluator is calculating PMPM expenditures for 2022 by applying the same methodology for HMP participants as described above for HAN-affiliated beneficiaries.
Insure Oklahoma	
The evaluation will support the hypothesis that Insure Oklahoma is improving access to care for low-income Oklahomans not eligible for Medicaid, as measured by the number of individuals enrolled in Insure Oklahoma.	OHCA produces monthly reports of Insure Oklahoma member enrollment. The evaluator is using the reports to document program enrollment trends. Note that former beneficiaries in this program have been transitioned almost entirely to Medicaid within the Adult Expansion MEG.
The evaluation will support the hypothesis that Insure Oklahoma is improving access to care for low-income Oklahomans not eligible for Medicaid, as measured by the number of employers participating in the ESI portion of Insure Oklahoma.	OHCA produces monthly reports of Insure Oklahoma employer counts. The evaluator is using the reports to document employer participation trends. Note that former beneficiaries in this program have been transitioned almost entirely to Medicaid within the Adult Expansion MEG.
The evaluation will support the hypothesis that Insure Oklahoma is improving access to care for low-income Oklahomans not eligible for Medicaid, as measured by the number of primary care providers participating in the Individual Plan portion of Insure Oklahoma.	OHCA produces monthly reports of Insure Oklahoma primary care provider counts. The evaluator is using the reports to document PCP participation trends. Note that former beneficiaries in this program have been transitioned almost entirely to Medicaid within the Adult Expansion MEG.

Waiver of Retroactive Eligibility	
Impact on Access to Care – Eliminating retroactive eligibility will increase the likelihood of enrollment and enrollment continuity.	The evaluator is using the eligibility extract described above to calculate quarterly enrollment of members subject to the waiver and a comparison group of members not subject to the waiver. The comparison group is being selected using CEM. Note that this analysis will be affected by the extension of eligibility for covered populations during the COVID-19 public health emergency.
Impact on Quality of Care – Health Status at Enrollment – Eliminating retroactive eligibility will increase enrollment of eligible people when they are healthy relative to those eligible people who have the option of retroactive eligibility.	The evaluator drafted a health status survey in accordance with CMS technical assistance/guidance and is conducting the survey by telephone on members subject to the waiver and a comparison group of members not subject to the waiver. The survey is conducted at time of enrollment (baseline) and at 12, 18 and 24-months post-enrollment. The populations subject to the retroactive eligibility waiver were modified in the current Demonstration period and OHCA implemented the modifications in spring 2020. The evaluator began baseline surveys in August 2020. Follow-up surveys commenced in August 2021, starting with members who received baseline surveys in August 2020.
Impact on Quality of Care – Health Outcomes – Through greater continuity of coverage, health outcomes will be better for those subject to retroactive eligibility waivers compared to other Medicaid beneficiaries who have access to retroactive eligibility.	Self-reported health outcomes are being evaluated using the survey process described above.

VI. ATTACHMENTS

None

VII. STATE CONTACT

Oklahoma Health Care Authority
4345 N. Lincoln Boulevard
Oklahoma City, OK 73105

Ellen Buettner
Chief Executive Officer
Phone: 405-522-7417

VIII. DATE SUBMITTED TO CMS

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