2024
SOONERCARE DEMONSTRATION
11-W-00048/6
§1115(a) ANNUAL REPORT

JAN 1, 2024 – DEC 31, 2024 | SUBMITTED MAR 26, 2025

OKLAHOMA HEALTH CARE AUTHORITY

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INTRODUCTION

The Oklahoma Health Care Authority is the single state agency that administers the SoonerCare Choice and Insure Oklahoma programs under a Section 1115(a) demonstration project. 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.

The demonstration was originally approved in January 1996. Most recently, the State submitted a demonstration renewal application dated December 28, 2022. CMS approved a temporary 1-year extension of the demonstration to allow the State and CMS to continue negotiations with a current expiration date of December 31, 2025.

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. Pursuant to section XI, Monitoring, STC 56, annual reports are due no later than 90 calendar days following the end of each demonstration period. The sections within this report includes all required elements as per 42 CFR 431.428 and follows the framework provided by CMS.

OPERATIONAL UPDATES

ADMINISTRATIVE DIFFICULTIES & POLICY REVISIONS

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

Waiver Requests	Date of Submission	Status of Request
Sponsor's Choice Option	3/4/2016	OHCA withdrew application on 6/26/2024
SoonerCare Choice Community Engagement waiver amendment	12/7/2018	On hold
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	OHCA withdrew application on 5/20/24

1115(a) SoonerCare Choice Demonstration Renewal Application	12/28/2022	Temporary 12-month extension granted on 11/1/2023 which expired on December 31, 2024. Temporary extension granted on 11/7/2024 for an additional 12-month to expire on December 31, 2025.
Add AI/AN Members with IHS Creditable Coverage	3/8/2023	OHCA withdrew application on 5/20/24
Exclude Individuals Served within Risk-Based Managed Care	3/8/2023	Pending CMS Approval

KEY CHALLENGES

Oklahoma Senate Bill 1752 grants the Oklahoma Insurance Department additional authority over the self-funded/self-insured plans for the purpose of participating in the premium assistance program. This bill also includes provisions for modifying participation requirements in specific premium assistance initiatives and sets new rules related to Medicaid oversight.

This bill has introduced challenges for the State's premium assistance program, Insure Oklahoma Employer Sponsored Insurance (IO-ESI), affecting compliance, requiring operational adjustments, and potential financial implications. Additionally, this bill will also require the state to change how services are delivered, provide additional oversight at the agency level, and modify our existing program.

The IO-ESI program staff is currently assessing the bill's impact to ensure compliance with any new requirements.

1115 Research and Demonstration Waiver Renewal

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. CMS approved two temporary extensions for the SoonerCare Demonstration to allow the state and CMS to continue negotiations. The Demonstration currently expires on December 31, 2025. The current STCs will remain in place until December 31, 2025, or until the demonstration is extended, whichever is sooner.

Premium Assistance Program & Non-Emergency Medical Transportation (NEMT)

The State is actively working alongside its contracted consulting firm, GuideHouse, to comply with the CMS mandate, SMD# 23-006, which requires the State to ensure NEMT services are provided by the commercial insurance plans that participate in the State's premium assistance program, Insure Oklahoma Employer Sponsored Insurance (IO-ESI). The State updated the prior SoonerRide Request for Proposal (RFP) to align with CMS guidance and the OHCA priorities to develop policies, contractual requirements, procedures, and workflow. The RFP was completed and is currently under review. The State is on track to ensure this directive is implemented within the IO-ESI program by July 2025.

KEY ACHIEVEMENTS

During the demonstration period, no major changes were made to the patient-centered medical home (PCMH) model. However, the OHCA Provider Engagement department formed a team to review PCMH requirements and processes. They identified opportunities to improve provider monitoring to ensure members receive necessary care coordination while also assisting providers.

ISSUES OR COMPLAINTS

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

LAWSUITS OR LEGAL ACTIONS

There were no new lawsuits related to the 1115(a) Demonstration filed during the reporting period.

UNUSUAL OR UNANTICIPATED TRENDS

The State experienced no unusual or unanticipated trends as it relates to this Demonstration during the reporting period.

LEGISLATIVE UPDATES

In 2024, the first session of the 59th Legislature met from Feb. 5, 2024, and adjourned Sine Die on May 30, 2024.

Senate Bill 1703 was requested by the agency to prohibit insurers from denying the Health Care Authority claims solely based on prior authorization and mandates certain response time from insurers to the Authority. The bill was subsequently signed into law during regular session, effective June 14, 2024.

The following bills are recently signed legislation that will impact this demonstration:

- SB 1739 - Allows certain care to be provided by birthing centers that are not licensed as a hospital but are accredited as a birthing center, halts the licensure of certain facilities by OSDH, charges OHCA to seek federal approval for Medicaid reimbursement. Effective date: November 1, 2024

- SB 1752 - Self-funded or self-insured health care plans shall be recognized by the Insurance Dept for the exclusive purpose of participation in the premium assistance program if they meet certain requirements. Effective date: July 1, 2024

Additionally, there were interim studies conducted by the Oklahoma House of Representatives from July 1, 2024, to December 31, 2024. Interim study 24-046 primarily examined regional Presenters emphasized the needs for rural community collaboration.

PUBLIC FORUMS

Tribal Consultation

Tribal consultation serves as a venue for discussion between OHCA and tribal governments on proposed SoonerCare policy changes, Title XIX and Title XXI state plan amendments (SPA), 1115(a), 1915(a), and 1915(b) 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 tribal consultation meetings were held between January and June 2024. OHCA staff presented 14 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
- Private Duty Nursing Coverage Limitations
- Collaborative Care Model Reimbursement
- Hospital-Administered Opioid Antagonist Reimbursement
- ITU Provider Quarterly Training

For the months of July and December 2024 there were three virtual tribal consultation meetings, and one in-person Tribal Consultation Annual meeting. OHCA staff presented 24 proposed policy changes inclusive of state rules, SPAs and waiver amendments. Topics at the tribal consultation meetings included but were not limited to:

- Coverage of Prescribed Drugs during a Drug Shortage
- Medication-Assisted Treatment (MAT) Clarification
- Updating Abortion Policy
- Doula Certifying Organization Criteria
- Electronic Visit Verification (EVV) Rule Revisions
- Update SoonerCare Choice Eligibility Policy

Nine virtual ITU provider workgroup meetings were held between July and December 2024. The OHCA Tribal Government Relations unit presented and collaborated with internal and external partners on topics included but not limited to:

- The Director of the Native American Center for Cancer Health Equity, Stephenson Cancer Center presented on the high rates of cancer in Indian Country and emphasized the importance of early screening.
- The IHS Oklahoma City Area HIV/HCV/STI Coordinator presented public health issues affecting tribal communities.
- Consultation held to discuss the CMS-approved demonstration amendment allowing coverage for traditional healthcare practices that would allow coverage of traditional health care practices.

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 six times from January through December 2024, and the following items were discussed:

- SoonerSelect implementation and questions
- Feedback on SoonerSelect communication
- SoonerRide

OHCA established a SharePoint site and collaborated with Opportunity Finance Network (OFN) to improve streamlined collaboration between entities. This effort enhanced access to document storage and provided policy clarification on upcoming MATF changes and requirements. The MATF group also assisted several members with access to care issues, renewals, and special needs resources. During this evaluation period, no recommendations were made by the MATF as it relates to the Demonstration.

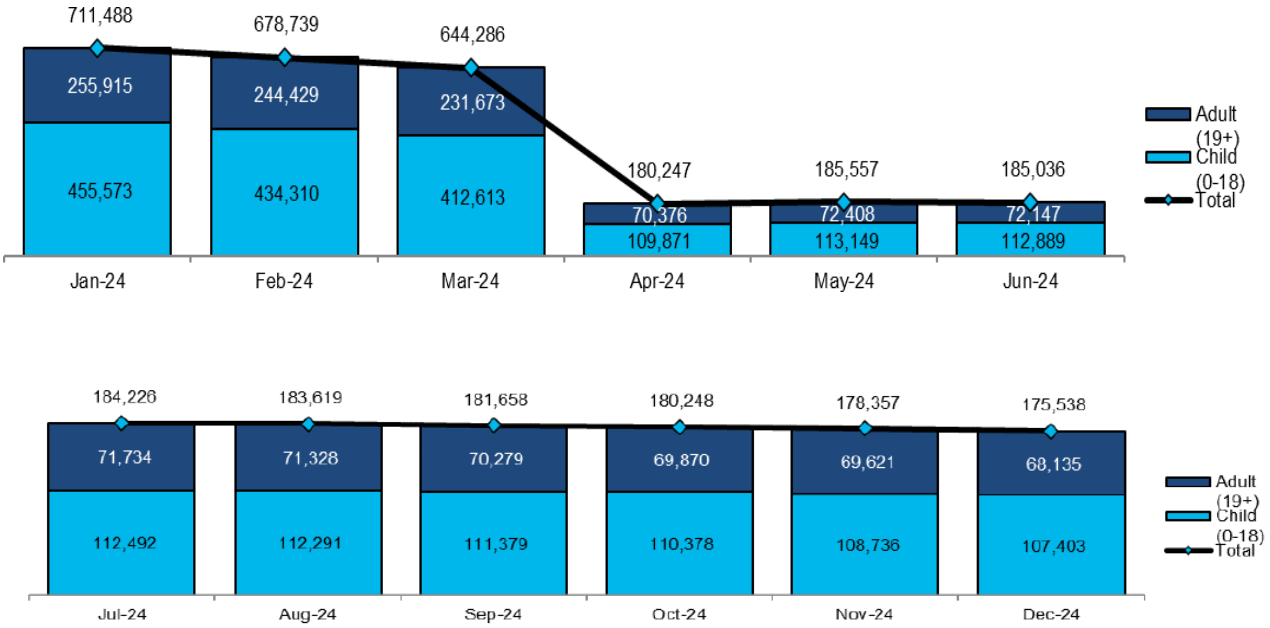
PUBLIC COMMENTS RECEIVED IN POST-AWARD FORUM

The State held the annual post-award forum during the OHCA Medical Advisory Committee meeting on November 7, 2024; no comments were received from the committee members, stakeholders, providers, members or the general public.

PERFORMANCE METRICS

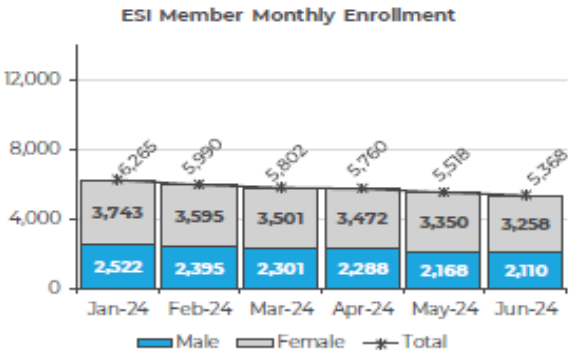
ELIGIBILITY AND COVERAGE

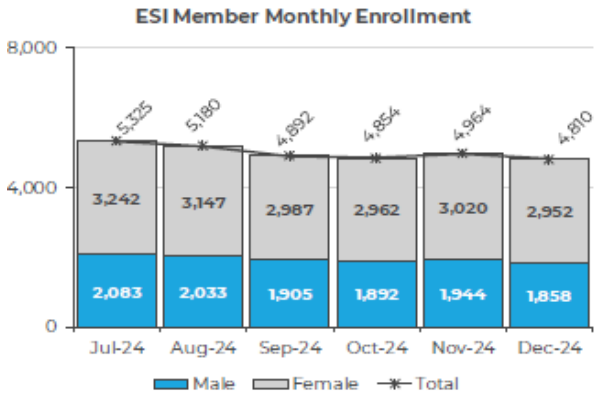
Enrollment in SoonerCare Choice dropped by nearly 75%, from 711,488 members in January to 180,247 in April 2024. While part of this decline may be attributed to the end of the Public Health Emergency (PHE) unwind, the majority—464,039 members—transitioned from SoonerCare Choice to the new SoonerSelect program between March and April. In May 2024, enrollment in SoonerCare Choice began to slightly rebound, reaching 185,557 members, likely as members adjusted to the reinstated eligibility verification process. Since then, enrollment has stabilized, holding steady at approximately 180,000 members.



In the months of January through June 2024, IO-ESI experienced a trend of steadily declining enrollment likely due to factors such as changes in eligibility and enrollment procedures. However, data as of December 2024 shows that enrollment has stabilized, and it remains steady at around 4,800 members. Program staff will continue to monitor this data.

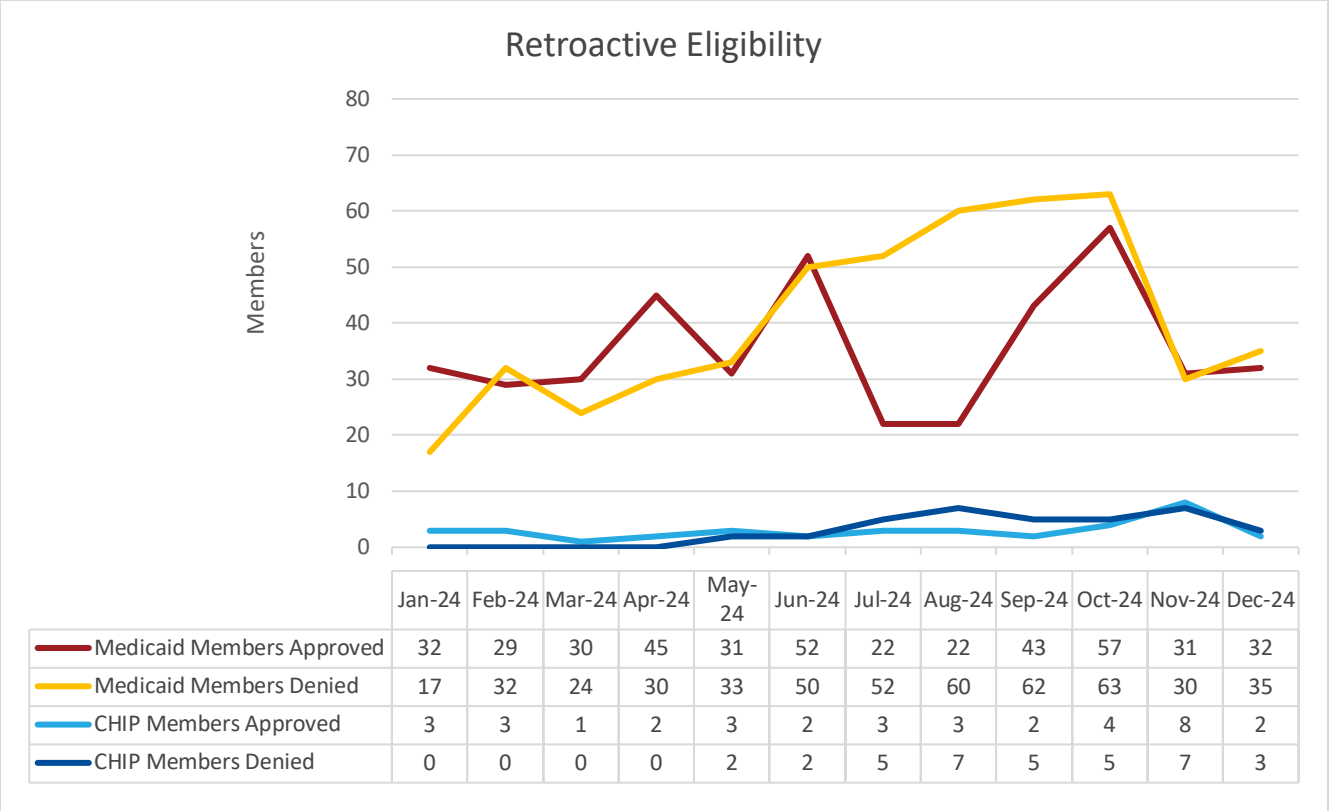
Enrollment for the ESI program is shown in the graph below for the periods of January 2024 through December 2024.





WAIVER OF RETROACTIVE ELIGIBILITY

In May of 2020, OHCA completed its work to implement retroactive eligibility for Medicaid and CHIP pregnant women and children. Below is an updated chart reflecting how many Medicaid and CHIP members who had an approved or denied retroactive eligibility application.



	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Medicaid Members Approved	32	29	30	45	31	52	22	22	43	57	31	32
Medicaid Members Denied	17	32	24	30	33	50	52	60	62	63	30	35
CHIP Members Approved	3	3	1	2	3	2	3	3	2	4	8	2
CHIP Members Denied	0	0	0	0	2	2	5	7	5	5	7	3

ACCESS, QUALITY AND OUTCOMES

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 directions 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. OHCA Quality Department reviews the scorecards and deploys staff to assist providers that may benefit from scorecard discussions.

In January 2025, OHCA delivered what was the 11th set of quarterly scorecards and payments going back to data from 2022. The payments listed below represent the SoonerExcel bonus payments, which is the incentive plan for our SoonerCare Choice providers. This is a performance-based component that recognizes achievement of excellence in improving quality and providing effective care.

			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
July 2023	January 2023 through March 2023	753	$187,500	$187,500	$250,000	$125,000
October 2023	April 2023 through June 2023	763	$187,500	$187,500	$250,000	$125,000
January 2024	July 2023 through September 2023	774	$187,500	$187,500	$250,000	$125,000
April 2024	October 2023 through December 2023	779	$187,500	$187,500	$250,000	$125,000
July 2024	January 2024 though March 2024	808	$187,500	$187,500	$250,000	$125,000
October 2024	April 2024 through June 2024	805	$187,500	$187,500	$250,000	$125,000
January 2025	July 2024 through September 2024	815	$187,500	$187,500	$250,000	$125,000

Member Case Studies/Testimonies

Below are member testimonies submitted to OHCA by PHPG related to the Health Management Program and Health Access Networks.

- "I have two nurses. [They have] helped me so much with my doctors. I was having to wait months to get into a pain management doctor and [my nurse] made a phone

call and got my appointment moved up by a month. She also helped get my pain injections and now I am pain free in my back. [My other nurse] helped me get eyeglasses. They have been so great; I don't want to lose them."

- "[My health coach] saved my life. My doctor dropped the ball and missed the spot on my lung. [She] got involved and got me an appointment with my cancer doctor and I got the surgery I needed. Without her, I would probably still be waiting. She is the best and I don't ever want to lose her."

- "She's helped me so much. [My son's] doctors kept putting me off. I knew something was wrong with my son but they kept just pushing me off. The coach really pushed and pushed to get him tested and he does have autism. I didn't where to go from there. She helped get him into speech therapy, because he wasn't talking. I could not have gotten any of this done without her help."

- "We were told it would take months to get him into the doctor for his sensory issues and she got him in within a few weeks. We were worried he would have to start school without any help, but she saved us."

- "[My health coach] helped a lot with resources. I got Rocky Mountain Spotted Fever from a tick which caused problems with my liver and kidneys and spleen. [She] made calls to find drug companies to provide medications that weren't covered and also got me a glucose monitor. She spent a lot of time and had her co-workers helping too."

- "My two nurses are the two best people I talk to, and I talk to many. They deserve an award. They are patient, kind, resourceful, and are like family. They treat me with such respect and have beautiful hearts. I cannot say enough good things about them. They keep me accountable in a respectful and kind way. They listen to me when I have a bad day. Never get rid of those two. Never take them away from me! They should train the others. Others go through the motions and don't really care, these two truly care and it means the world to me."

- "[My health coach] sent me a lot of papers on my autoimmune disease which helped me explain what it was to my kids. She also showed me what foods to stay away from so I don't have flare ups. Some foods would make me feel depressed and have anxiety. I thought it was my mood, but it was actually the Grave's disease reacting to certain foods I was eating. Her teaching me that helped me a lot."

MEMBER SATISFACTION SURVEYS, GRIEVANCES AND APPEALS

Member Satisfaction

PHPG attempts to conduct a telephone survey with all SoonerCare HMP members within their first six-months post-enrollment and a follow-up again six months later. Both surveys inquire about the member's perceptions of the program, including experience and satisfaction with the member's health coach, program impact on the member's health status and overall satisfaction with the SoonerCare HMP.

PHPG completed 772, initial health coach surveys and 245 follow-up surveys during the period of January 2024 to December 2024. During this timeframe, 93.4% of the initial survey respondents and 95.9% of the follow-up survey respondents reported that they were very satisfied with their coach.

Grievances and Appeals

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

SoonerCare Grievances (January to December 2024)

	Filed	Granted	Denied
SoonerCare Eligibility*	198	2	24
Dental	21	0	3
Prior Authorization	111	0	13
Private Duty Nursing	31	0	37
Misc. (unpaid claims, etc.)	46	1	1
All Other	1	0	0
Total:	408	3	78

*The agency experienced an increase in eligibility appeals during the unwinding process, but has largely managed to keep pace by utilizing expanded eligibility dockets. The OHCA arranged for additional attorneys to represent the agency in these hearings through an agreement with the Attorney General's Office, which has improved scheduling. The agency is actively working through the backlog of appeals and aim to have it cleared by June 2025.

BUDGET NEUTRALITY AND FINANCIAL REPORTING

BUDGET NEUTRALITY MODEL

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. 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.

The updated budget neutrality workbook for this reporting period reflects the following:

- The budget neutrality figures for Children's Health Insurance Program (CHIP) payments decreased due to system changes implemented in January 2024, which unexpectedly caused members to transition from S-CHIP to a different aid category which resulted in lower CHIP enrollment.

    - A prior period adjustment for these quarters will be made once a system fix is in place and will be reflected in the budget neutrality report for that quarter.
- The move to SoonerSelect transitioned most SoonerCare Choice members from Choice, effective in April 2024.
- The SoonerSelect transition also resulted in a decrease in HAN payments.
- It is expected that SoonerCare Choice enrollment will remain lower than previous years.

Budget neutrality figures remain similar to previous submissions.

EVALUATION ACTIVITIES AND INTERIM FINDINGS

On September 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 July 1, 2026. PHPG is incorporating these recommendations into the evaluation methodology.

In approving a second one-year extension of the SoonerCare demonstration, CMS allowed the State to include the extension years in either the current or next evaluation cycle. The State has elected to include them in the next cycle, retaining the original timeframe for the current evaluation. This decision reflects the 2024 transition of non-ABD SoonerCare beneficiaries to the SoonerSelect 1915(b) waiver, which would complicate trend analysis if the evaluation period were extended.

PHPG is currently compiling evaluation findings from calendar years 2019 through 2023 for inclusion in the summative evaluation report. The table below provides an overview of ongoing 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.	The OHCA provided PHPG with a calendar year 2023 claims extract in April 2024 for the purpose of evaluating HAN impact on costs in the final year of the evaluation. PHPG is preparing an analysis file that 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 any OHCA care management program. The comparison group is being 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.	HEDIS Component: PHPG is preparing to use the same claims extract to evaluate access in calendar year 2023 through HEDIS child and adult preventive care measures. The evaluation includes the same comparison group methodology. CAHPS Component: 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 received an extract from the OHCA in April 2024 with the most recent (2023) survey data. PHPG analyzed the data in April and May and documented findings for inclusion in the summative evaluation report.
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).	HEDIS Component: PHPG is preparing to use the same claims extract described above in 1.a to evaluate quality of care in calendar year 2023 through HEDIS chronic care measures for Asthma, CAD, COPD, Diabetes, Hypertension and Mental Health. The evaluation includes the same comparison group methodology as described above in 1.a. Survey Component: In March 2024, PHPG conducted a survey of HAN beneficiaries enrolled in care management in 2023 (as identified through rosters furnished by the

	HANs). PHPG surveyed the beneficiaries to explore satisfaction with the assistance received, including with respect to social determinants of health. PHPG completed in April 2024 its analysis of the survey data and documented findings for inclusion in the summative 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 telephone or face-to-face contact with a nurse care manager.	PHPG uses the paid claims extract described above to calculate HEDIS preventive care measure rates for the HMP population versus a comparison group identified using Coarsened Exact Matching. The HMP analysis is conducted concurrently with the HAN analysis.
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.	PHPG uses the 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 Health Care	HEDIS Component: PHPG uses the claims extract described above to evaluate health outcomes using HEDIS chronic care measures for Asthma, CAD, COPD, Diabetes, Hypertension, Mental Health and Opioid Use Disorder. The HMP analysis is conducted concurrently with the HAN quality of care analysis.

Quality Measures.	**Survey Component**: PHPG conducts surveys of HMP-participating beneficiaries and PCMH providers, 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 conducted on a continuous basis. In 2019 - 2023, PHPG completed 3,103 initial and 1,602 follow-up surveys. PHPG completed in March 2024 its analysis of the survey data and documented findings for inclusion in the summative evaluation report. The beneficiary surveys also include the CAHPS question set for the HAN population. PHPG evaluated HMP beneficiary responses against the same comparison group universe as used in the HAN analysis. Survey data collection is continuing, in anticipation that it will be a component of the subsequent evaluation cycle. In calendar year 2024, PHPG completed 607 initial and 336 follow-up surveys.
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).	PHPG uses the claims extract described above to evaluate HMP hospital cost/utilization of care. The evaluation includes the same comparison group methodology. The HMP analysis is conducted concurrently with the HAN cost/utilization analysis.
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).	PHPG uses the claims extract described above to evaluate HMP hospital cost/utilization of care. The evaluation includes the same comparison group methodology. The HMP analysis is conducted concurrently with the HAN cost/utilization analysis.
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).	Information on the HMP CAHPS analysis described above.

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.	PHPG uses the claims extract described above to evaluate HMP effectiveness of care. The evaluation includes the same comparison group methodology as described above in 1.a. The HMP analysis is conducted concurrently with the HAN cost/utilization analysis.
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.	The OHCA produces monthly reports of Insure Oklahoma employer counts. PHPG is using the reports to document employer participation trends. Note that most beneficiaries in this program have been transitioned 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.	The OHCA produces monthly reports of participating primary care provider counts. PHPG 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.	PHPG is using the eligibility extract described above in 1.a 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 has been affected by the extension of eligibility for covered populations during the COVID-19 Public Health Emergency. However, with the termination of the PHE, disenrollments are again occurring.

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.	PHPG 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 summer of 2020. PHPG began baseline surveys in August 2020. Follow-up surveys commenced in August 2021, starting with members who received baseline surveys in August 2020. PHPG completed survey data collection in December 2023. The final survey data set included 2,007 initial surveys, 246 12-month follow-up surveys and 56 18-month follow-up surveys. The data was analyzed in April 2024 and findings were documented for inclusion in the summative evaluation report. Survey data collection is continuing, in anticipation that it will be a component of the subsequent evaluation cycle. In calendar year 2024, PHPG completed 614 initial surveys, 125 12-month follow-up surveys, 51 18-month follow-up surveys and 25 24-month follow-up surveys.
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 have been evaluated using the survey process described above.

ATTACHMENTS

None

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