

**CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS**

NUMBER: 11-W-00048/6
TITLE: SoonerCare
AWARDEE: Oklahoma Health Care Authority

I. PREFACE

The following are the Special Terms and Conditions (STC) for Oklahoma’s “SoonerCare” section 1115(a) Medicaid demonstration extension (hereinafter “demonstration”). The parties to this agreement are the Oklahoma Health Care Authority (state) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state’s obligations to CMS during the life of the demonstration. The STCs are effective as of August 31, 2018, through December 31, 2023, unless otherwise specified.

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II. PROGRAM DESCRIPTION, HISTORICAL CONTEXT

The SoonerCare Demonstration was initially approved in January 1995. The demonstration operates under a Primary Care Case Management (PCCM) model in which the Oklahoma Health Care Authority (OHCA) contracts directly with primary care providers throughout the state to provide basic health care services. The primary care providers (PCPs) receive a monthly care coordination payment for each enrolled beneficiary, based upon the services provided at the medical home.

The demonstration provides for a modification of the service delivery system for family and child populations and some aged and disabled populations. The benefits for individuals affected by or eligible only under SoonerCare, with the exception of individuals enrolled in the Insure Oklahoma Premium Assistance Employer Coverage and the Premium Assistance Individual Plan, are state plan benefits.

Historical Context of Demonstration Extensions and Amendments:

At the program's inception in 1995, the "SoonerCare" demonstration covered Medicaid state plan populations of AFDC (TANF) and related children and adults, including pregnant women up to the minimum federal poverty level (FPL) standards as defined by state law. The original SoonerCare populations were separated into Urban and Rural Eligibility Groups (EGs). The Urban EG included three catchment areas: Central (Oklahoma City and surrounding areas), Northeast (Tulsa and surrounding areas) and Southwest (Lawton and surrounding areas). The Rural EG included the rest of the state. The original SoonerCare demonstration also granted authority for the state to mandatorily enroll non-Medicare Aged, Blind and Disabled (ABD) beneficiaries into managed care.

In 2005, the state expanded the demonstration's state plan breast and cervical cancer group to qualifying women under age 65 and three additional eligibility groups, including: low income non-disabled workers and spouses employed by small employers; working disabled adults; and children eligible pursuant to the state option under 1902(e)(3) of the Act (TEFRA children).

On January 3, 2009, CMS approved amendments that:

- a. Changed the service delivery model from a Prepaid Ambulatory Health Plan (PAHP) to an exclusive Primary Case Management (PCCM) model;
- b. Added an expansion population to the state's Employer Sponsored Insurance program, Insure Oklahoma, for full-time college students age 19 through age 22 not to exceed 200 percent of the federal poverty level (FPL), up to a cap of 3,000 participants;
- c. Expanded the size of employers who can participate in Insure Oklahoma, from 50 employees to 250 employees;
- d. Expanded the description of qualified PCPs to permit County Health Departments to serve as medical homes for beneficiaries who choose these providers;
- e. Included an option for the voluntary enrollment of children in state or tribal custody in the SoonerCare demonstration;

- f. Implemented a new “Payments for Excellence” program to build upon the current Early Periodic Screening, Diagnosis, and Treatment (EPSDT) and Fourth Diphtheria, Tetanus and Pertussis (DTaP) Bonus program; and
- g. Amended cost-sharing requirements for the Insure Oklahoma Program and added a \$1 co-pay for non-pregnant adults in SoonerCare.

The following programmatic changes were approved under the SoonerCare demonstration extension that was effective January 1, 2010.

- a. Approval of the Health Access Network (HAN) pilot program;
- b. Expanded eligibility under the Insure Oklahoma program to non-disabled working adults and their spouses, disabled working adults, and full-time college students, from 200 percent of the FPL up to and including 250 percent of the FPL; and
- c. Added two new eligibility groups under the Insure Oklahoma program for foster parents up to and including 250 percent of the FPL and for not-for-profit businesses having fewer than 500 employees, up to and including 250 percent of the FPL.

On August 1, 2011, CMS approved an amendment that eliminated the \$10 co-pay for the initial pre-natal visit under the Insure Oklahoma, Individual Plan.

The following programmatic changes were approved under the SoonerCare demonstration extension that was effective January 1, 2013

- a. CMS has removed the waiver authority that allowed the state to exclude parental income in determining eligibility for disabled children eligible in the TEFRA category because the state has this authority under the state plan.
- b. Financial eligibility under the Insure Oklahoma program for all populations was reduced from up to and including 250 percent of FPL to up to and including 200 percent of FPL.
- c. CMS has approved a limitation on the adult outpatient behavioral health benefit in the Insure Oklahoma individual plan to limit the number of visits to 48 per year consistent with the limitation on behavioral health visits for children. This benefit is limited to individual licensed behavioral health professionals (LBHP).
- d. CMS has approved an amendment to the Health Management Program (HMP), as reflected in Section VIII to rename nurse care managers as health coaches and to increase face-to-face care management by embedding health coaches within physician practices with the highest concentration of members with chronic illnesses.

The following programmatic changes were approved under the SoonerCare demonstration amendment that was effective September 6, 2013, and the SoonerCare demonstration was extended through December 31, 2015.

- a. The Title XXI Targeted Low-Income Child eligibility group for children ages 0-18 was added to the mandatory state plan group chart.
- b. Eligibility under the Insure Oklahoma program for populations eligible for the Individual Plan from up to and including 200 percent of the FPL has been reduced to up to and including 100 percent of FPL. Because the eligibility levels are no longer the same as those for individuals with employer-sponsored coverage, the previously authorized demonstration populations were limited to the employer-based coverage

- populations, and new demonstration populations were separately defined for the individual plan coverage populations. These new demonstration populations have been added to the Expenditure Authorities and Demonstration Expansion Groups in the eligibility chart. This includes: non-disabled working adults and their spouses; disabled working adults; employees of not-for profit businesses having fewer than 500 employees; foster parents and full-time college students.
- c. The authority for Insure Oklahoma populations was extended only through December 31, 2014.
 - d. The following groups were added to the SoonerCare Eligibility Exclusions:
 - Individuals in the Former Foster Care group; and
 - Pregnant women with incomes between 134 percent and 185 percent FPL.
 - e. Language was added to reference the fact income will be calculated using Modified Adjusted Gross Income (MAGI) for determination of SoonerCare eligibility.
 - f. The charts listing the Individual Plan benefits and the Insure Oklahoma cost-sharing were deleted and language was added to reference the state changing the benefits and cost-sharing to align with federal regulations.

On August 13, 2014, CMS approved an amendment adding individuals with other creditable healthcare coverage to the SoonerCare demonstration eligibility exclusion list. In addition, the STCs were amended to reflect the extension of the Insure Oklahoma program through December 31, 2015 that was approved on June 27, 2014.

On July 9, 2015, CMS approved a one-year extension of the SoonerCare demonstration, with no changes, through December 31, 2016.

On November 30, 2016, CMS approved a one-year extension of the SoonerCare demonstration, with no changes, through December 31, 2017.

On December 29, 2017, CMS approved a one-year extension of the SoonerCare demonstration, with technical corrections to the STCs to reflect current CMS policy around monitoring and evaluation requirements, through December 31, 2018.

On August 31, 2018, CMS approved a five-year extension of the SoonerCare demonstration, with the following changes: technical corrections to make numbering and grammatical updates; removal of the authority to waive retroactive eligibility for pregnant women and children under 19; and expenditure authority for one year of phase-down expenditures for the state's medical education program.

On November 1, 2019, CMS approved two amendments to the SoonerCare demonstration making changes to its Health Management Program (HMP) and Health Access Networks (HANs). The amendments provide the HMP with more options for data analytics to identify beneficiaries for HMP services beyond the current HMP predictive modeling software to include Medicaid Management Information System (MMIS) claims, health information exchange information, provider referrals, and other sources; modify the "services" language under the HMP to further define health coaching and practice facilitation; newly incorporate emerging interventions such as health navigation, performance improvement projects, and assistance with

transitions of care. The amendment also modifies language in the STCs that describes the HAN's duties. The previous language, originally written in 2010, relates to ensuring patient access to all levels of care, submitting a development plan to the state detailing how the network will reduce costs and improve access and quality, and offering core components of electronic health records (EHR). This language change reflects that the HAN program is no longer a pilot program, and has been evaluated by the state with results showing that the HAN does reduce cost and improve access and quality for beneficiaries. As such, the language requiring the HANs to submit development plans to the state, and to offer core components of EHR, is being removed. Remaining language continues to describe the HAN program as organized for improving access, quality, and continuity of care for SoonerCare members, and offering care management and coordination to persons with complex health care needs.

On January 31, 2022, CMS approved an amendment to modify the STCs to update the Insure Oklahoma Individual Plan benefits to be equivalent to the state's approved Alternative Benefit Package (ABP) for the state plan adult group as of July 1, 2021. This amendment also approved the phase-out plan for the Insure Oklahoma (IO) Individual Plan (IP). Upon the expiration of the COVID-19 public health emergency (PHE), the state will determine eligibility for those individuals in the IO IP who have incomes over 133 percent FPL who Oklahoma has maintained enrollment in the demonstration on the basis of section 6008(b)(3) of the Families First Coronavirus Response Act (FFCRA) (the "continuous coverage" provision), but for the continuous coverage provision, would have been terminated due to excess income. Upon the expiration of the PHE, the state will review the eligibility of those individuals above the 133 percent FPL threshold and make appropriate assessments towards coverage.

III. GENERAL PROGRAM REQUIREMENTS

- 1. Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and Section 1557 of the Affordable Care Act (Section 1557).
- 2. Compliance with Medicaid and Child Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in federal law, regulation, and policy statement not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the demonstration.
- 3. Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 business days in advance of the expected approval date of the amended

STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.

- a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change, as well as a modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for budget neutrality agreements are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 7) as a result of the change in FFP.
- b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of federal law, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

5. State Plan Amendments. The state will not be required to submit title XIX or title XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plan governs.

6. Changes Subject to the Amendment Process. Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or service-based expenditures, will be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below, except as provided in STC 3.

7. Amendment Process. Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to, failure by the state to submit required elements of a viable amendment request as found in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

- a. An explanation of the public process used by the state, consistent with the requirements of STC 12. Such explanation must include a summary of any public

feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

- b. A data analysis worksheet which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
- c. An up-to-date CHIP allotment neutrality worksheet, if necessary;
- d. A detailed description of the amendment, including the impact on beneficiaries, with sufficient supporting documentation, including a conforming title XIX and/or XXI state plan amendment, if necessary; and,
- e. The state must provide updates to existing demonstration reporting, quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

8. Extension of the Demonstration. States that intend to request an extension of the demonstration must submit an application to CMS from the Governor or Chief Executive Officer of the state in accordance with the requirements of 42 Code of Federal Regulations (CFR) 431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs must submit a phase-out plan consistent with the requirements of STC 9.

9. Demonstration Phase-Out. The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements;

- a. Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than six (6) months before the effective date of the demonstration’s suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 12. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state’s response to the comment and how the state incorporated the received comment into a revised transition and phase-out plan.
- b. Transition and Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary’s appeal rights), the process by which the state will conduct redeterminations of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.

- c. Transition and Phase-out Plan Approval: The state must obtain CMS’s approval of the transition and phase-out plan prior to implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS’s approval of the transition and phase-out plan.
- d. Transition and Phase-out Procedures: The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210 and 431.213. In addition, the state must assure all applicable appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR section 431.230. In addition, the state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to termination, 42 CFR 435.916. For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).
- e. Exemption from Public Notice Procedures 42 CFR 431.416(g): CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).
- f. Enrollment Limitation during Demonstration Phase-out: If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state’s obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.
- g. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP must be limited to normal closeout costs associated with termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries’ appeals, and administrative costs of disenrolling participants.

10. Withdrawal of Waiver or Expenditure Authority. CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and/or title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS’ determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authorities, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling participants.

11. Adequacy of Infrastructure. The state will ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

12. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The state must comply with the state notice procedures as required in 42 CFR 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the public notice procedures set forth in 42 CFR section 447.205 for changes in statewide methods and standards for setting payment rates.

The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, and contained in the state's approved state plan, when any program changes to the demonstration, either through amendment as set out in STC 7 or extension, are proposed by the state.

13. Federal Financial Participation. No federal matching funds for expenditures for this demonstration, including administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

14. Administrative Authority. When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, MCOs, and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

15. Common Rule Exception. The state must ensure that the only involvement of human subjects in research activities which may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs; procedures for obtaining Medicaid benefits or services; possible changes in or alternatives to Medicaid or CHIP programs and procedures; or possible changes in methods or levels of payments for Medicaid benefits or services. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(d)(5).

IV. ELIGIBILITY

16. Use of Modified Adjusted Gross Income (MAGI) Based Methodologies For Demonstration Groups. Mandatory and optional state plan groups described below derive their eligibility through the Medicaid State Plan, and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid State Plan, except as expressly waived in this demonstration and as described in these STCs. Any Medicaid State Plan Amendments to the eligibility standards and methodologies for these eligibility groups, including the conversion to a MAGI standard October 1, 2013, will apply to this demonstration. These

state plan eligible beneficiaries are included in the demonstration for use of the managed care network and access to additional benefits not described in the state plan.

17. State Plan Populations Affected. Title XIX and title XXI populations are affected by the demonstration as shown in the table below. Effective January 1, 2019, the waiver of retroactive eligibility does not apply to pregnant women, including in the 60-day post-partum period, or children under 19 years of age.

Mandatory State Plan Groups	FPL and/or Other Qualifying Criteria	Applicable Waivers and CNOMs (See Waiver List Summary)	Demonstration Population (See STC 59)
Pregnant women and infants under age 1 1902(a)(10)(A)(i)(IV)	Up to and including 133 % FPL	Freedom of Choice,	Populations 1,2,3,4
Children 1-5 1902(a)(10)(A)(i)(VI)	Up to and including 133 % FPL	Freedom of Choice	Populations 1,2,3,4
Children 6-18 1902(a)(10)(A)(i)(VII)	Up to and including 133% FPL	Freedom of Choice	Populations 1,2,3,4
IV-E Foster Care or Adoption Assistance Children	Automatic Medicaid eligibility	Freedom of Choice	Populations 1,2,3,4
1931 low-income families	73% of the AFDC standard of need.	Freedom of Choice, Retroactive Eligibility (not applicable to children under 19)	Populations 1,2,3,4
SSI recipients	Up to SSI limit	Freedom of Choice	Populations 3,4, 7
Pickle amendment	Up to SSI limit	Freedom of Choice	Populations 1,2,3,4
Early widows/widowers	Up to SSI limit	Freedom of Choice	Populations 1,2,3,4
Disabled Adult Children (DACs)	Up to SSI limit	Freedom of Choice	Populations 3,4

Mandatory State Plan Groups	FPL and/or Other Qualifying Criteria	Applicable Waivers and CNOMs (See Waiver List Summary)	Demonstration Population (See STC 59)
1916(b)	SSI for unearned income and earned income limit is the 1916(b) threshold amount for Disabled SSI members, as updated annually by the SSA.	Freedom of Choice	Populations 3,4,7
Targeted Low-Income Child	Up to and including 185% FPL	Freedom of Choice	Population 9

Optional State Plan Groups	FPL and/or Other Qualifying Criteria	Applicable Waivers and CNOMs (See Waiver List Summary)	Demonstration Population (See STC 59)
Infants under age 1 through CHIP Medicaid expansion	Above 133% - 185% FPL and for whom the state is claiming title XXI funding.	Freedom of Choice	Population 9
Children 1-5 through CHIP Medicaid expansion	Above 133% - 185% FPL and for whom the state is claiming title XXI funding.	Freedom of Choice	Population 9
Children 6-18 through CHIP Medicaid expansion	Above 133% - 185% FPL and for whom the state is claiming title XXI funding.	Freedom of Choice	Populations 9

Non-IV-E foster care children under age 21 in State or Tribal custody	AFDC limits as of 7/16/1996	Freedom of Choice, Retroactive Eligibility (not applicable to children under 19)	Populations 1,2,3,4
Aged, Blind and Disabled	From SSI up to and including 100% FPL	Freedom of Choice	Populations 3,4,7
Eligible but not receiving cash assistance	Up to SSI limit	Freedom of Choice	Populations 3,4
Individuals receiving only optional State supplements	100% SSI FBR + \$41 (SSP)	Freedom of Choice	Populations 3,4
Breast and Cervical Cancer Prevention and Treatment	Up to and including 185% FPL	Freedom of Choice, Counting Income and Comparability of Eligibility	Populations 1,2,3,4
Optional State Plan Groups	FPL and/or Other Qualifying Criteria	Applicable Waivers and CNOMs (See Waiver List Summary)	Demonstration Population (See STC 59)
TEFRA Children (under 19 years of age) without creditable health care insurance coverage	Must be disabled according to SSA definition, with gross personal income at or below 200% FPL, and for whom the state is claiming title XXI funding.	Freedom of Choice, Counting Income and Comparability of Eligibility	Population 7

18. Demonstration Eligibility. The following includes individuals enrolled in the Employer Sponsored Premium Assistance Plan who receive a premium assistance benefit. Additionally, Premium Assistance Individual Plan populations are made eligible only through this demonstration, and receive premium assistance only under the demonstration through the Insure Oklahoma program.

Demonstration Expansion Groups	FPL and/or Other Qualifying Criteria	Applicable Waivers and CNOMs (See Waiver List Summary)	Demonstration Population (See STC 59)
Insure Oklahoma Employer-Sponsored Plan			
Non-Disabled Low Income Workers and Spouse (ages 19-64) (Employer Sponsored Plan)	Up to and including 200% FPL, who work for an eligible employer with 250 or fewer employees. Spouses who do not work are also eligible to enroll on their working spouse's coverage.	Retroactive Eligibility, Comparability, Cost Sharing Requirements, Freedom of Choice	Population 5
Working Disabled Adults (ages 19-64) (Employer Sponsored Plan)	Up to and including 200% FPL, who are ineligible for Medicaid due to employment earnings, and who otherwise, except for earned income, would be eligible to receive Supplemental Security Income (SSI) benefits. No limit on employer size.	Retroactive Eligibility, Comparability, Cost Sharing Requirements, Freedom of Choice	Population 6
Full-time College Students (ages 19-22) (Employer Sponsored Plan)	Full time college students with FPL not to exceed 200% (limited to 3,000 participants), who have no creditable health insurance coverage, work for a qualifying employer.	Retroactive Eligibility, Comparability, Cost Sharing Requirements, Freedom of Choice	Population 8

Demonstration Expansion Groups	FPL and/or Other Qualifying Criteria	Applicable Waivers and CNOMs (See Waiver List Summary)	Demonstration Population (See STC 59)
Foster Parents (ages 19-64) (Employer Sponsored Plan)	Up to and including 200% FPL, who work full-time or part-time for an eligible employer. Spouses who do not work are also eligible to enroll on their working spouse's coverage. No limit on employer size.	Retroactive Eligibility, Comparability, Cost Sharing Requirements, Freedom of Choice	Population 10
Qualified Employees of Not-for-profit Businesses (ages 19-64) (Employer Sponsored Plan)	Up to and including 200% FPL, who work for an eligible employer with access to an ESI with 500 or fewer employees. Spouses who do not work are also eligible to enroll on their working spouse's coverage.	Retroactive Eligibility, Comparability, Cost Sharing Requirements, Freedom of Choice	Population 11
Insure Oklahoma Individual Plan			
Non-Disabled Low Income Workers and Spouse (ages 19-64) (Individual Plan)	Individuals up to and including 100% FPL, who are self-employed, or unemployed. Spouses who do not work are also eligible to enroll on their spouse's coverage.	Retroactive Eligibility, Assurance of Transportation	Population 12

Demonstration Expansion Groups	FPL and/or Other Qualifying Criteria	Applicable Waivers and CNOMs (See Waiver List Summary)	Demonstration Population (See STC 59)
Working Disabled Adults (ages 19-64) (Individual Plan)	Individuals up to and including 100% FPL, who are ineligible for Medicaid due to employment earnings, and who otherwise, except for earned income, would be eligible to receive Supplemental Security Income (SSI) benefits.	Retroactive Eligibility (not applicable to pregnant women), Assurance of Transportation	Population 13
Full-time College Students (ages 19-22) (Individual Plan)	Full time college students with FPL not to exceed 100% (limited to 3,000 participants) and who do not have access to employer sponsored insurance, do not have creditable insurance coverage.	Retroactive Eligibility (not applicable to pregnant women), Assurance of Transportation	Population 14
Foster Parents (ages 19-64) (Individual Plan)	Individuals up to and including 100% FPL, who work full-time or part-time. Spouses who do not work are also eligible to enroll on their working spouse's coverage.	Retroactive Eligibility (not applicable to pregnant women), Assurance of Transportation	Population 15

Demonstration Expansion Groups	FPL and/or Other Qualifying Criteria	Applicable Waivers and CNOMs (See Waiver List Summary)	Demonstration Population (See STC 59)
Qualified Employees of Not-for-profit Businesses (ages 19-64) (Individual Plan)	Individuals up to and including 100% FPL, who work for a not-for-profit with 500 or fewer employees. Spouses who do not work are also eligible to enroll on their working spouse's coverage.	Retroactive Eligibility (not applicable to pregnant women), Assurance of Transportation	Population 16

19. Eligibility Exclusions. The following persons are excluded from the SoonerCare demonstration:

- a. Individuals dually eligible for Medicare and Medicaid;
- b. Individuals residing in an institution or nursing home;
- c. Individuals receiving home and community-based waiver services;
- d. Individuals infected with tuberculosis covered under 1902(a)(10)(A)(ii)(XII) and 1902(z)(1);
- e. Individuals covered by a Managed Care Organization other than the SoonerCare demonstration PCCM;
- f. Individuals in the Former Foster Care group;
- g. Pregnant women with incomes between 134 percent and 185 percent FPL; and
- h. Individuals with other creditable coverage.

20. TEFRA Children, Population 7. The population known as “TEFRA Children” is defined as children:

- a. Under 19 years of age;
- b. Disabled according to the Social Security Administration definition;
- c. A U.S. citizen or qualified alien;
- d. With established residency in the state of Oklahoma;
- e. Who have a Social Security Number or have applied for one;
- f. Whose gross personal income is less than the current FBR income limit (300 percent of SSI maximum);
- g. Whose countable assets do not exceed \$2,000.00 (the parent's assets are not considered); and
- h. Who would be considered Medicaid eligible if they met an institutionalized level of care.

21. TEFRA Children Retroactive Eligibility. TEFRA Children will have retroactive eligibility

and will not be subject to default enrollment. SoonerCare member services staff will consult with the parents or guardians of the TEFRA-eligible children to select an appropriate Primary Care Provider/Case Manager (PCP/CM) and provide program orientation and education. Eligible TEFRA children will be able to voluntarily enroll and select a PCP/CM from the SoonerCare PCP or IHS/Tribal/Urban Indian clinic network. TEFRA Children are eligible to receive SoonerCare services and retain other health insurance. SoonerCare will be the secondary payer to other insurance plans. However, if the child is insured through a health maintenance organization, the child will be excluded from the SoonerCare demonstration and enrolled in the FFS Medicaid program in the state.

22. Eligibility Conditions for Full-Time College Students, Populations 8 and 14. The population known as “full-time college student” is described below.

- a. Income eligibility Documentation. Applicants must complete the Free Application for Federal Student Aid (FAFSA) as a component of their application. Parental income will not be considered in the state’s eligibility determination if the FAFSA or the university’s financial aid office verifies that the college student is financially independent. Parental income will be considered in the eligibility determination if the college student is deemed by the college or university to be a dependent. An eligible full-time college student can have no other creditable health coverage as defined by section 2701(c) of the Public Health Service Act, whether provided by their parents, their college/university, or their employer.
- b. Enrollment Cap. There is an enrollment cap of 3,000, at any given time, on full-time college students. The state may also impose an enrollment cap on other populations covered under Insure Oklahoma, including the non-disabled low income workers and spouses and working disabled, in order to remain within state funding limits. The state must notify CMS 60 days prior to implementing a waiting list for individuals covered under Insure Oklahoma. This notification must include a plan for how the waiting list will be implemented. When a cap is imposed, the state must institute a separate waiting list for each phase of the Insure Oklahoma program; the Premium Assistance Employer Coverage Plan and the Premium Assistance Individual Plan. To insure resources are available statewide, the state will be divided into six regions with each region eligible to receive a population density, pro-rata share of funding. Any employer or individual already approved for either the Premium Assistance Plan or the Individual Plan may continue to re-enroll not subject to the waiting list. The state will provide written notification to CMS at least 15 days before re-opening enrollment of the demonstration.

V. SOONERCARE BENEFITS AND COST SHARING

23. SoonerCare Benefits. All demonstration participants except those receiving Insure Oklahoma benefits receive SoonerCare Choice benefits. SoonerCare Choice benefits are the benefits covered under the State Plan, except that there are no limits on PCP visits, and there are four specialty visits per month. Under the state plan, physician services are limited to four visits per month, including specialty visits. Insure Oklahoma Individual Plan enrollees (demonstration populations 12 through 16) will receive benefits outlined in the state’s alternative benefit plan for the adult group and any subsequent amendments. These benefits

are described in Attachment E. Benefits for Insure Oklahoma Premium Assistance Employer Coverage enrollees are limited to premium assistance and cost sharing reductions, as described in section VI. Benefits for Insure Oklahoma Premium Assistance Individual Plan enrollees are limited to benefits offered by the Individual Plan Program in accordance with STC 28.

24. SoonerCare Cost Sharing. Under the SoonerCare demonstration, cost-sharing is not allowed for:

- American Indians with an I/T/U provider;
- Pregnant women;
- Children (including TEFRA children) up to and including age 18;
- Emergency room services;
- Individuals enrolled in the Breast and Cervical Cancer Prevention and Treatment program; and
- Family planning services.

Cost-sharing for non-pregnant adult SoonerCare beneficiaries, who would otherwise be eligible under the state plan, is the cost sharing set forth in the state plan. Cost sharing for individuals who would otherwise not be eligible under the state plan is described in Section VI, which describes Insure Oklahoma premium assistance benefits and cost sharing.

VI. INSURE OKLAHOMA PREMIUM ASSISTANCE BENEFITS AND COST SHARING

25. Insure OK: Premium Assistance Employer Coverage. Premium Assistance Employer Coverage provides qualifying low-income non-disabled workers and their spouses, working foster parents, disabled workers, and full-time college students ages 19-22 up to and including 200 percent of the FPL (subject to any enrollment caps), with premium assistance coverage if they are employed by a qualifying employer. In order for an employer to participate in the Premium Assistance Employer Coverage program the employer must:

- a. Have no more than 250 employees (however, working foster parents and working college students participating in the program may enroll in Premium Assistance Employer Coverage regardless of the size of their employer);
- b. Have no more than 500 employees if the business is not-for-profit;
- c. Have a business that is physically located in Oklahoma;
- d. Be currently offering or intending to offer within 90 calendar days an Insure Oklahoma qualifying plan, as outlined in STC 26;
- e. Offer the Insure Oklahoma qualifying plan coverage to employees in accordance with Oklahoma Small Business Statutes, Oklahoma Department of Insurance, and all other regulatory agencies; and,
- f. Contribute a minimum 25 percent of the eligible employee monthly health plan premium for non-disabled workers, disabled workers, and employed college students.

26. Insure OK: Premium Assistance Employer Coverage IO Qualifying Plans. An Insure Oklahoma qualifying plan is a health plan that meets the definition of a Qualified Health Plan as defined in Oklahoma Administrative Code 317:45-5-1 for the purposes of Insure

Oklahoma. Qualifying health plans must also be approved by the Oklahoma Insurance Department for participation in the Oklahoma market. If the health plan requires co-pays or deductibles, amounts cannot exceed the limits outlined in STC 30.

27. Insure OK: Premium Assistance Individual Plan (Insure Oklahoma). The Premium Assistance Individual Plan is a “safety net” option provided to working disabled adults and those non-disabled low income workers and spouses whose employer elects not to participate in the Premium Assistance Program as well as the self-employed, unemployed, and qualifying working disabled who do not have access to employer sponsored insurance (ESI). The Premium Assistance Individual Plan is also available to full-time college students, ages 19-22 up to and including 100 percent of the FPL (subject to the participant cap), who do not have access to Premium Assistance Employer Coverage. Benefits under the plan are described in STC 28.

- a. Application Process. Qualifying non-disabled low income workers and spouses, working disabled workers, and full-time college students employed by qualifying, but non-participating firms, will file an application directly with the OHCA, documenting their income, place of employment, and application for worker or worker and spouse coverage.
- b. Premium Schedule. Once the application is approved, the enrollee will be provided information on coverage. Enrollees will be required to make their premium payment before the first of the month to which coverage applies. The enrollment effective dates must be consistent with the policy term for the existing SoonerCare demonstration.
- c. Delinquent Premium Payments. If the state has billed an enrollee for a premium payment, and the enrollee does not pay the amount due within 60 days of the date on the bill, then the beneficiary’s eligibility for benefits will be terminated. The beneficiary must receive a written notice of termination prior to the date of the termination.
- d. Repayment Process. The beneficiary’s eligibility will not be terminated if the beneficiary, prior to the date of termination, pays all amounts which have been billed or establishes a payment plan acceptable to the state. After such a payment plan has been established, the state will bill the beneficiary for (a) payments in accordance with the payment plan, and (b) monthly premiums due subsequent to the establishment of the payment plan. If the enrollee does not make payments in accordance with the payment plan within 30 days of the date on the bill, the beneficiary’s eligibility will be terminated.
- e. Waiver of Premiums. If the state determines that the requirement to pay a premium results in an extreme financial hardship for an enrollee, the state may, in its sole discretion, waive payment of the premium or reduce the amount of the premiums assessed to a family or individual.
- f. Reenrollment. A disenrolled beneficiary may make a new application for enrollment immediately upon receiving termination notice. In the event the state has implemented a waiting list, any disenrolled beneficiary who reapplies will be placed on the waiting list and notified once the state is open to their enrollment. When the state is able to open enrollment for those on the waiting list, the beneficiaries’ eligibility will be processed in the order they were placed on the waiting list.

28. Premium Assistance Individual Plan (Insure Oklahoma) Benefit. The benefits provided under the Premium Assistance Individual Plan meet the essential health benefit requirements that would be applicable to alternative benefit plans under federal regulations found in 42 CFR section 440.347. All changes to covered and non-covered services and benefits must be submitted to CMS for prior approval.

29. Insure Oklahoma Cost-Sharing. Cost-sharing for individuals covered under a Premium Assistance Employer Coverage Plan cannot exceed the amounts outlined in STCs 30 and 31. Under the Oklahoma Premium Assistance Individual Plan, cost-sharing shall not exceed amounts permitted under the federal regulation 42 CFR section 447 and are set forward in a public schedule dated July 15, 2013 that is incorporated by reference in these STCs. The co-pay for emergency services is exempted from this requirement, and will remain \$30, unless the individual is admitted to the hospital. The state may lower the actual required copayment amounts at any time by notifying CMS in writing at least 30 days prior to the effective date. A family's total annual out-of-pocket cost-shares, including premiums and co-payments, cannot exceed 5 percent of the family's gross income.

30. Premium Assistance Employer Coverage Co-Payments and Deductibles. For individuals participating in Insure Oklahoma Premium Assistance Employer Coverage, co-pays will be those required by the enrollee's specific health plan, as defined in STC 26, subject to the following limitations:

- a. Copayments for physician office visits cannot exceed \$50 per visit;
- b. Annual pharmacy deductibles cannot exceed \$500 per individual;
- c. An annual out-of-pocket maximum cannot exceed \$3,000 per individual, excluding pharmacy deductibles; and
- d. The maximum amount of all cost sharing (co-pays, deductibles and premiums) cannot exceed five percent of a family's total income.

31. Premium Assistance Employer Coverage Plan Premiums. Individuals/families participating in Employer Coverage Programs will be responsible for up to 15 percent of the total health insurance premium not to exceed 3 percent out of the 5 percent annual gross household income cap.

- a. The state will provide reimbursement for out-of-pocket costs incurred by the household in excess of the 5 percent annual gross household income cap for individuals (or their eligible Insure Oklahoma spouse) enrolled in Premium Assistance Employer Coverage. A medical expense must be for an allowed and covered service by the health plan to be eligible for reimbursement. The state calculates the 5 percent threshold for each enrollee on a monthly basis and applies the premiums paid by the enrollee toward the 5 percent cap. The state also records co-payments made by the enrollee based upon documentation submitted by the enrollee. Reimbursement is provided by the state once the 5 percent cap is met.
- b. For each enrollee participating in an Employer Coverage Plan, the percentage of premium paid by the state, employer, and enrollee is outlined in the following table:

Premium Assistance Employer Coverage Premium Responsibilities
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Enrollee	State/Federal Share	Employer	Enrollee	Annual Household Income Cap
Non Disabled Worker *	Minimum of 60 percent	Minimum of 25%	Up to 15% of premium, (not to exceed 3% out of the 5% household income cap)	5%
Non Disabled Worker Spouse	Minimum of 85 percent	Minimum of 0%	Up to 15% of premium, (not to exceed 3% out of the 5% household income cap)	5%
Disabled Worker	Minimum of 60 percent	Minimum of 25%	Up to 15% of premium, (not to exceed 3% out of the 5% household income cap)	5%
Full-time College Students (when employed by covering employer)	Minimum of 60 percent	Minimum of 25%	Up to 15% of premium, (not to exceed 3% out of the 5% household income cap)	5%
Full-time College Students (when dependent on parental policy)	Minimum of 85 percent	Minimum of 0%	Up to 15% of premium, (not to exceed 3% out of the 5% household income cap)	5%

* If children are covered the employer must contribute at least 40 percent of the premium cost. If coverage is for the employee only, the employer must contribute at least 25 percent of the premium cost.

32. Premium Assistance Individual Plan Premiums. Individual Plan premiums will be imposed as follows:

- a. For each state fiscal year, the state will establish age/gender premium bands for the Insure Oklahoma Individual Plan that are based on the estimated cost of the coverage. The monthly premium for an individual/family will be set at 20 percent of the age/gender band.
- b. To calculate a monthly premium for the household, the premiums for all covered members will be added together and multiplied by 20 percent. The household

contribution to the premium will be capped, not to exceed 4 percent of the monthly gross household income.

- c. The state will require all individuals participating in the Premium Assistance Individual Plan to be responsible for any co-payments and premiums subject to a 5 percent annual gross household income cap.
- d. The state will provide reimbursement for incurred costs by the household in excess of the 5 percent annual gross household income cap, for individuals (or their eligible Insure Oklahoma spouse) enrolled in the Premium Assistance Individual Plan. A medical expense must be for an allowed and covered service by the health plan, to be eligible for reimbursement.

VII. SOONERCARE DELIVERY SYSTEMS (OTHER THAN INSURE OKLAHOMA)

33. Description of Managed Care Program. Under the terms of this demonstration, the state authorizes the Primary Care Case Management (PCCM) program to provide case management services to SoonerCare beneficiaries through the Health Management Program (HMP).

34. Compliance with Managed Care Regulations. The state, its PCCM program, and any subcontracted entity delegated to perform activities under the managed care contract must comply with the managed care regulations published at 42 CFR part 438, except as expressly waived or specified as not applicable to an expenditure authority in these STCs.

35. Access and Service Delivery. With the exception of individuals receiving benefits through Insure Oklahoma, all SoonerCare Choice beneficiaries select or are assigned a PCP/CM responsible for furnishing primary and preventive services and making medically necessary referrals. For purposes of determining the member’s choice of PCP, the most recent selection received by the OHCA determines the PCP with which the member is enrolled, as long as capacity is available. If capacity is not available or the member does not choose, the member is assigned to a PCP according to the assignment mechanism as defined by the OHCA. A member, who is eligible for SoonerCare Choice but is not assigned, may request enrollment with a PCP by contacting the SoonerCare Helpline. Members may also request a change to their PCP by contacting the SoonerCare Helpline.

PCP/CMs must belong to one of the provider types listed below.

Provider	Required Qualifications
Primary Care Physician	Engaged in Family Medicine, General Internal Medicine, General Pediatrics or General Practice; may be board certified or board eligible; or meet all Federal employment requirements, be employed by the Federal Government and practice primary care in an Indian Health Services (IHS) facility.
Specialist Physician	At discretion of OHCA CEO, based on consideration of percentage of primary care services delivered in physician’s practice, the availability of primary care physicians in the geographic area, the

	extent to which the physician has historically served Medicaid and his/her medical education and training.
Advanced Practice Nurse	Must be licensed by the state in which s/he practices and have prescriptive authority; or meet all Federal employment requirements, be employed by the Federal Government and practice in an IHS facility.
Physician's Assistant	Must be licensed by the state in which s/he practices; or meet all Federal employment requirements, be employed by the Federal government and practice primary care in an IHS facility.
Medical Resident	The resident has obtained a medical license or a special license for training from the appropriate regulatory state medical board; and has the appropriate contract on file with the OHCA to render services within the scope of their licensure.
Health Department Clinics	Beneficiaries would be served by one of 68 county health departments or the two city-county health departments in Oklahoma City and Tulsa.

36. Care Coordination Payments.

- a. Monthly Care Coordination Payments Defined. PCPs receive a monthly care coordination payment for each enrolled beneficiary, based upon the services provided at the medical home. In return, they are responsible for providing or otherwise assuring the provision of medically necessary primary care and case management services and for making specialty care referrals. There are three tiers of Medical Homes: Entry Level Medical Home, Advanced Medical Home (Tier 2), and Optimal Medical Home (Tier 3). The contracted PCP must meet certain requirements to qualify for payments in each tier. Payments are also stratified according to the PCP panel composition; children only, children and adults, or adults only. PCPs are also responsible for providing 24-hour/7-day telephone coverage for their beneficiaries.
- b. Monthly Schedule of Care Coordination Payments. Monthly care coordination payments are paid to PCPs based on the following schedule, effective October 1, 2019:

Care Coordination Payments

PMPM	Tier 1	Tier 2	Tier 3
Children	\$3.63	\$4.73	\$6.28
Children and Adults	\$4.39	\$5.73	\$7.61
Adults	\$5.08	\$6.63	\$8.82

Effective January 1, 2009, the state may extend the three-tiered Medical Home care coordination reimbursement methodology to the Indian Health Service, Tribal and Urban Health Clinics for American Indians, and the Insure Oklahoma Network.

- c. Monthly Care Management Payments. In addition to the monthly care coordination payments described above, the state also makes monthly care management payments to PCPs and IHS, tribal or Urban Indian Clinic (ITU) PCPs participating in the SoonerCare program. Care management payments range from \$2.00 to \$3.00 per member, per month based on the age and eligibility category of the member.

37. Other Medical Services. All other SoonerCare benefits (with the exception of non-emergency transportation and PACE, which are paid through a capitated contract) are paid through the state's FFS system.

38. Health Access Networks. The state may implement Health Access Networks (HANs) statewide. HANs are non-profit, administrative entities that will work with providers to coordinate and improve the quality of care for SoonerCare beneficiaries. Networks will receive a nominal Per Member per Month (PMPM) payment. This PMPM payment, initially established at \$5, will be made in addition to the care coordination payment paid to PCPs as outlined in STC 36. HANs are not eligible for the care coordination payment outlined in STC 36. The state must not make duplicative payments to the HANs for Medicaid services covered under the Medicaid state plan.

The HAN must:

- a. Be organized for the purpose of restructuring and improving the access, quality, and continuity of care to SoonerCare beneficiaries;
- b. Facilitate patients access to all levels of care, including primary, outpatient, specialty, certain ancillary services, and acute inpatient care, within a community or across a broad spectrum of providers across a service region of the state through improved access to specialty care, telemedicine, and expanded quality improvement strategies; and
- c. Offer care management/care coordination to persons with complex health care needs as specified in the state-HAN provider agreement.

39. Provider Performance. The state may provide additional incentive payments, through the state's Payments for Excellence program, to contracted providers to recognize outstanding performance. Incentive payments will be based on provider practice behavior that may include EPSDT screens, DTaP immunizations, Inpatient Admitting and Visits, Breast and Cervical Cancer Screenings, Behavioral Health Screens, and Emergency Department Utilization. The state certifies that incentive payments will not exceed five percent of the total FFS payments for those services provided or authorized by the PCP for the period covered.

The state furnishes the Provider Performance Payments for Excellence Program to the Indian Health Service, Tribal, and Urban Health Clinics for American Indians, and the Insure Oklahoma Network.

40. Services for American Indians. Eligible SoonerCare beneficiaries, with the exception of Insure Oklahoma beneficiaries, may elect to enroll with an IHS, tribal or urban Indian clinic as their PCP/Care Manager. This voluntary enrollment links American Indian members with these providers for primary care/case management services. The providers receive the care coordination payment paid to PCPs as outlined in STC 36. All of Oklahoma's IHS, tribal, or urban Indian clinics must have a SoonerCare American Indian PCCM contract.

41. Contracts. Procurement and the subsequent final contracts developed to implement

selective contracting by the state with any provider group shall be subject to CMS approval prior to implementation. Existing contracts with Federally Qualified Health Centers shall continue in force.

- 42. TEFRA Children.** TEFRA Children, as defined in STC 20, must receive services through the SoonerCare program and its network of participating providers. The OHCA’s nurse Exceptional Needs Coordinators in the Care Management Department and SoonerCare Member Services Coordinators provide extensive outreach, assessment, and enrollment assistance to TEFRA Children.

VIII. HEALTH MANAGEMENT PROGRAM

- 43. Health Management Program Defined.** The SoonerCare Health Management Program (HMP) is a voluntary program offered statewide and serves SoonerCare Choice beneficiaries’ ages 4 through 63 with chronic illness who are at highest risk for adverse outcomes and increased health care expenditures. SoonerCare Choice beneficiaries for whom HMP services may be appropriate (HMP beneficiaries) are identified based on data analysis that includes but is not limited to claims in the state’s Medicaid Management Information System (MMIS), Health Information Exchange information, provider referral, and other sources as determined by the state. The state must include in the Semi-Annual Operational Report, described in STC 51, a report on HMP activities including a description of populations served and services provided.

- 44. Health Management Program Services.** HMP services are grounded in motivational interviewing and evidence-based guidelines. The HMP services are designed by the HMP vendor and approved by OHCA. The HMP vendor’s activities may include services delivered directly to SoonerCare Choice beneficiaries or activities in connection with health care providers that are designed to benefit SoonerCare Choice beneficiaries.

SoonerCare beneficiaries may remain in the HMP until the maximum benefit has been achieved, as determined by OHCA. The maximum benefit is determined individually for each beneficiary served by the HMP, and considers diagnoses, goals, and progress achieved.

The HMP is reimbursed through a professional services contract and is not a service delivery system. More specifically, the HMP does not maintain a provider network or make PCP assignments, make coverage or medical necessity determinations, maintain a formulary drug list, send OHCA encounter data, or pay provider claims. HMP services and activities may include the following:

- a. Health Coaching. Health coaching is a support service for beneficiaries that includes a comprehensive initial evaluation, beneficiary goals-based plan of care (POC) development, education, referrals, and assistance with self-management. This service may be telephonic, in person, or a combination of both.
- b. Practice Facilitation. Practice facilitation is a service offered to enhance primary care services and support chronic disease prevention. Practice Facilitation includes examining staff roles on the care team and ensuring that each team member is practicing at the top of their license to ensure quality care for members. In addition to

structural guidance, Practice Facilitation focuses on incorporating evidence-based guidelines in treatment decision-making for members with chronic health conditions, and includes emerging health care trends, including but not limited to pain management and treatment of opioid use disorder (OUD).

- c. Health Navigation. Health navigators assist members with community-based services and needs related to social determinants of health (SDOH). Health navigators primarily identify resources and link the beneficiary with such resources.
- d. Performance Improvement Projects (PIP). The HMP vendor may design PIP independently or in collaboration with the state Medicaid agency, as approved by the OHCA Quality Improvement Committee, and outlined in the OHCA Quality Improvement Plan.
- e. Transitions of Care Assistance. Transition of Care Assistance services aim to assist selected beneficiaries in hospital admissions, discharges, and transfers by furnishing the support that beneficiaries need to avoid repeat hospital admissions and reduce inappropriate Emergency Department care.

IX. PROGRAM MONITORING

45. Monitoring Aggregate Costs for Eligibles in the Premium Assistance Program.

- a. The state will monitor the aggregate costs for the Premium Assistance Employer Coverage Plan versus the cost of providing coverage through the Premium Assistance Individual Plan. On a semi-annual basis, the state will compare the average monthly premium assistance contribution per Employer Coverage enrollee to the cost per member per month of the expansion population enrolled in the Individual Plan.
- b. On an annual basis, the state will calculate the total cost per enrollee per month for individuals receiving subsidies under the Premium Assistance Employer Coverage Plan, including any reimbursement made to enrollees whose out-of-pocket costs exceeded their income stop loss threshold (5 percent of income). The cost for this group will then be compared to the “per enrollee per month” cost for those individuals enrolled in the Premium Assistance Individual Plan.

46. Monitoring Employer Sponsored Insurance.

- a. The state will monitor the aggregate level of contributions made by participating employer’s pre and post-implementation of the Premium Assistance Plan.
- b. The state must require that all participating employers report annually on their total contributions for employees covered under the Premium Assistance Plan. The state will prepare an aggregate analysis across all participating employers summarizing the total statewide employer contribution level under the demonstration.
- c. Similarly, the state will monitor changes in covered benefits and cost sharing requirements of employer-sponsored health plans and document any trends in these two areas over the life of the demonstration.

X. GENERAL REPORTING REQUIREMENTS

47. Submission of Post-approval Deliverables. The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

- 48. Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of \$5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singly or collectively referred to as “deliverable(s)”) are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the current demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement. The following process will be used: 1) Thirty (30) days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) Thirty days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:
- a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).
 - b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state’s anticipated date of submission. Should CMS agree to the state’s request, a corresponding extension of the deferral process can be provided. CMS may agree to a corrective action plan submitted by the state as an interim step before applying the deferral, if the state proposes a corrective action plan in the state’s written extension request.
 - c. If CMS agrees to an interim corrective plan in accordance with subsection (b), and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) with all required contents in satisfaction of the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children’s Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.
 - d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement with respect to required deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the requirements specified in these STCs, the deferral(s) will be released.
 - e. As the purpose of a section 1115 demonstration is to test new methods of operation or services, a state’s failure to submit all required reports, evaluations and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

49. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional 1115 demonstration reporting and analytics functions, the state will work with CMS to:

- a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

- b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and
- c. Submit deliverables to the appropriate system as directed by CMS.

50. Cooperation with Federal Evaluators. As required under 42 CFR 431.420(f), the state must cooperate fully and timely with CMS and its contractors' in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state must include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they must make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 48.

XI. MONITORING
51. Monitoring Reports. The state must submit one (1) Semi-Annual Report and one (1) compiled Annual Report each DY. The Semi-Annual Reports are due no later than sixty (60 calendar days) following the end of each demonstration six (6) month period. The compiled Annual Report is due no later than ninety (90 calendar days) following the end of the DY. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.

- a. Operational Updates. Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.
- b. Performance Metrics. Per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, measures associated with eligibility and coverage (including the waiver of retroactive eligibility) as well as outcomes of care, quality of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, and grievances and appeals. The required monitoring and performance metrics must be included in writing in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.
- c. Budget Neutrality and Financial Reporting Requirements. Per 42 CFR 431.428, the 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 these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs should be reported separately on the CMS-64.

- d. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

52. Close-Out Report. Within 120 calendar days prior to the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

- a. The draft Close-Out Report must comply with the most current Guidance from CMS.
- b. The state will present to and participate in a discussion with CMS on the Close-Out report.
- c. The state must take into consideration CMS' comments for incorporation into the final Close-Out Report.
- d. The final Close-Out Report is due to CMS no later than 30 calendar days after receipt of CMS' comments.
- e. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 48.

53. State Data Collection. The state must collect data and information necessary to oversee service utilization and rate setting by provider/plan, comply with the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) and the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), collectively referred to as the CMS Child and Adult Core Measure Sets for Medicaid and CHIP, and comply with other existing federal measure sets.

- a. The state will use this information in ongoing monitoring of individual well-being, provider/plan performance, and continuous quality improvement efforts, in addition to complying with CMS reporting requirements.
- b. The state must maintain data dictionary and file layouts of the data collected.
- c. The raw and edited data must be made available to CMS within 30 calendar days of a written request.

54. Monitoring Calls. CMS will convene periodic conference calls with the state.

- a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, enrollment and access, budget neutrality, and progress on evaluation activities.
- b. CMS will provide updates on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration.
- c. The state and CMS will jointly develop the agenda for the calls.

55. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (30) calendar days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Semi-Annual Report associated with the quarter in which the forum was held, as well as in its compiled Annual Report.

56. General Financial Requirements. The state must comply with all General Financial Requirements under Title XIX set forth in Section XII and all General Financial Reporting Requirements under Title XXI set forth in Section XIII.

57. Reporting Requirements Related to Budget Neutrality. The state must comply with all reporting requirements for Monitoring Budget Neutrality set forth in Section XIV.

XII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

58. Quarterly Expenditure Reports. The state shall provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section XIV.

59. Reporting Expenditures Under the Demonstration. In order to track expenditures under this demonstration, Oklahoma must report demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the state Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX of the Act must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were paid).

a. For each demonstration year, eighteen (18) separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER must be completed, using the waiver name noted below, to report expenditures for the following demonstration populations.

i. **Demonstration Population 1: TANF-Urban** includes low-income families, pregnant women and children, and women who are eligible under the Breast and Cervical Cancer Treatment Program, receiving health care services in the designated Central, Northeast, and Southwest urban areas of the state;

- ii. **Demonstration Population 2: TANF-Rural** includes low-income families, pregnant women and children, and women who are eligible under the Breast and Cervical Cancer Treatment Program receiving health care services in the rural areas of the state;
- iii. **Demonstration Population 3: ABD-Urban** includes the Aged, Blind and Disabled receiving health care services in the designated Central, Northeast, and Southwest urban areas of the state;
- iv. **Demonstration Population 4: ABD-Rural** includes the Aged, Blind and Disabled receiving health care services in the rural areas of the state;
- v. **Demonstration Population 5: Non-Disabled Working Adults** includes non-disabled low income workers and their spouses with household incomes no greater than 200 percent of the FPL;
- vi. **Demonstration Population 6: Working Disabled Adults** includes low income working disabled adults with household incomes no greater than 200 percent of the FPL;
- vii. **Demonstration Population 7: TEFRA Children** includes children defined in STC 20;
- viii. **Demonstration Population 8: Full-Time College Students** includes full-time college students ages 19-22 up to and including 200 percent of the FPL (limited to 3,000 individuals at any given time);
- ix. **Demonstration Population 9: CHIP Medicaid Expansion Children** includes infants under age 1, children ages 1-5, and children ages 6-18, and targeted low-income children. Note: the state must report information in the Form CMS-64.9 Waiver and/or 64.9P Waiver for this population when using title XIX funds
 - x. **Demonstration Population 10: Foster Parents** includes working foster parents with household incomes no greater than 200 percent of the FPL. The spouse of a working employee can be covered;
 - xi. **Demonstration Population 11: Not-for-Profit Employees** includes employees and spouses of not-for-profit businesses with 500 or fewer employees with household incomes no greater than 200 percent of the FPL;
- xii. **Demonstration Population 12: Non-Disabled Working Adults** effective through 12/31/13 includes non-disabled low income workers and their spouses with household incomes no greater than 200 percent of the FPL; effective 1/1/14 eligible individuals will be eligible up to 100 percent of the FPL;
- xiii. **Demonstration Population 13: Working Disabled Adults** effective through 12/31/13 includes low income working disabled adults with household incomes no greater than 200 percent of the FPL; effective 1/1/14 eligible individuals will be eligible up to 100 percent of the FPL;
- xiv. **Demonstration Population 14: Full-Time College Students** effective through 12/31/13 includes full-time college students ages 19-22 up to and including 200 percent of the FPL (limited to 3,000 individuals at any given time); effective 1/1/14 includes full-time college students ages 19-22 up to

- and including 100 percent of the FPL (limited to 3,000 individuals at any given time);
- xv. **Demonstration Population 15: Foster Parents** effective through 12/31/13 includes working foster parents with household incomes no greater than 200 percent of the FPL. The spouse of a working employee can be covered. Effective 1/1/14 eligible individuals will be eligible up to 100 percent of the FPL;
 - xvi. **Demonstration Population 16: Not-for-Profit Employees** effective through 12/31/13 includes employees and spouses of not-for-profit businesses with 500 or fewer employees with household incomes no greater than 200 percent of the FPL; effective 1/1/14 eligible individuals will be eligible up to 100 percent of the FPL;
 - xvii. **Demonstration Expenses 1: HAN Expenditures** includes PMPM expenditures made to the HANs.
 - xviii. **Demonstration Expenses 2: HMP Expenditures** includes expenditures to provide health coaches and practice facilitation services through the Health Management Program.
 - xix. **Medical Education Programs**: Phase down expenditures include expenditures to University of Oklahoma and Oklahoma State University as specified in expenditure authority 14.
- b. For each HAN, the state must collect quarterly data of expenditures made by the HAN. The state must report summary expenditure data, for each HAN, in the Narrative section of Form CMS-64.9 for demonstration Expenses 1.
 - c. For the HMP, the state must collect quarterly data of expenditures made by the HMP. The state must report summary expenditure data in the Narrative section of Form CMS-64.9 for demonstration Expenses 2.
 - d. Specific Reporting Requirements for Medicaid expansion children (including TEFRA children) who revert to title XIX only when the state has exhausted its title XXI allotment.
 - i. The state is eligible to receive title XXI funds for expenditures for these children, up to the amount of its title XXI allotment. Expenditures for these children under title XXI must be reported on separate Forms CMS-64.21U and/or CMS-64.21UP in accordance with the instructions in section 2115 of the State Medicaid Manual.
 - ii. Title XIX funds are available under this demonstration if the state exhausts its title XXI allotment (including any reallocations or redistributions). If the state exhausts its title XXI allotment prior to the end of a Federal fiscal year, title XIX Federal matching funds are available for these children. During the period when title XIX funds are used, expenditures related to this demonstration population must be reported as waiver expenditures on the Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver. The state shall provide CMS with 120 days prior notice before it begins to draw down title XIX matching funds for these demonstration populations.
 - iii. The expenditures attributable to this demonstration population will count toward the budget neutrality expenditure cap calculated under Section XIV, STC 71, using the per member per month (PMPM) amounts for children in the

- TANF Rural and TANF Urban populations described in Section XII, STC 59(a)(i-ii), and will be considered expenditures subject to the budget neutrality cap as defined in STC 71, so that the state is not at risk for claiming title XIX federal matching funds when title XXI funds are exhausted.
- e. The sum of the quarterly expenditures for all demonstration years will represent the expenditures subject to the budget neutrality cap as defined in STC 71.
 - f. Specific Reporting Requirement for the Medical Education Programs' phase down expenditures, described in expenditure authority 14:
 - i. CMS must approve a plan for eligible expenditures. The plan to phase down the federal investment must be approved by CMS and will be attached to these STCs once approved. The state must comply with the plan in order to draw down FFP and must document expenditures in accordance with the plan.
 - ii. In order to claim FFP for phase down expenditures, the state will provide CMS a summary worksheet that identifies phase down expenditures by university each quarter.
 - iii. For all eligible phase down expenditures, the state will maintain and will make available to CMS upon request:
 1. Certification of expenditures
 2. Actual expenditure data from state financial information system or state client sub-system.
 - iv. The certification will describe the procedures used that ensure that FFP is not claimed for non-permissible expenditures.
 - v. The state will claim FFP for phase down expenditures quarterly based on actual expenditures.
 - vi. The state will establish standard documentation of each phase down expenditure, to be specified in the plan.
 - vii. The state will report all expenditures for phasedown payments to eligible medical education programs described in expenditure authority 14 on Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver under the waiver name "Medical Education Phase Down." Federal funds must be claimed within two years following the calendar quarter in which the state incurs the phase down expenditures during the performance period described above in expenditure authority 14. Claims cannot be submitted for state expenditures associated with medical education programs described in expenditure authority 14 above incurred after June 30, 2019. Sources of non-federal funding for the medical education program for the period from August 31, 2018 through June 30, 2019 must be permitted under section 1903(w) of the Act and applicable implementing regulations.
 - g. For purposes of this section, the term "expenditures subject to the budget neutrality cap" must include all Medicaid expenditures on behalf of individuals who are enrolled in this demonstration under STC 59. All expenditures that are subject to the budget neutrality cap are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver.
 - h. Administrative costs will not be included in the budget neutrality agreement, but the state must separately track and report additional administrative costs that are directly

- attributable to the demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or CMS-64.10P Waiver.
- i. All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.
 - j. Premiums and other applicable cost sharing contributions from enrollees that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. Additionally, both the total computable and Federal share amounts that are attributable to the demonstration must be separately reported on the CMS-64 Narrative.
 - k. Mandated Increase in Physician Payment Rates in 2013 and 2014. Section 1202 of the Health Care and Education Reconciliation Act of 2010 (Pub. Law 110-152) requires state Medicaid programs to pay physicians for primary care services at rates that are no less than what Medicare pays, for services furnished in 2013 and 2014. The federal government provides a federal medical assistance percentage of 100 percent for the claimed amount by which the minimum payment exceeds the rates paid for those services as of July 1, 2009. The state may (at its option) exclude from the budget neutrality test for this demonstration the portion of the mandated increase for which the federal government pays 100 percent. Should the state elect this, these amounts must be reported on the base forms CMS-64.9, 64.21, or 64.21U (or their “P” counterparts), and not on any waiver form.

60. Reporting Member Months. The following describes the reporting of member months for demonstration populations:

- a. For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the state must provide to CMS, as part of the quarterly report required under STC 58, the actual number of eligible member months for EGs defined in STC 59(a). The state must submit a statement accompanying the quarterly report which certifies the accuracy of this information. To permit full recognition of “in-process” eligibility, reported counts of member months may be subject to revisions for an additional 180 days after the end of each quarter.
- b. The term “eligible member months” refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.
- c. The “demonstration eligibles” that do contribute to the calculation of the budget neutrality ceiling for the SoonerCare Program include the TANF-Urban, TANF-Rural, ABD Urban and ABD Rural populations as defined in STC 71(a).
- d. The “demonstration eligibles” that do not contribute to the calculation of the budget

neutrality ceiling for the SoonerCare Program include the non-disabled working adults, disabled working adults, parents of foster children, full-time students, individuals enrolled in the Premium Assistance Individual Plan, and the TEFRA Children as defined in STC 59(a).

61. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the demonstration. Oklahoma must estimate matchable demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure agreement and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments and state and local administration costs. CMS shall make Federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

62. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS shall provide FFP at the applicable federal matching rates for the demonstration as a whole as outlined below, subject to the limits described in Section XIII:

- a. Administrative costs, including those associated with the administration of the demonstration;
- b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan;
- c. Net medical assistance expenditures made under section 1115 demonstration authority, with dates of service during the demonstration extension period; and
- d. Net premiums and net medical assistance expenditures for persons enrolled in the Insure Oklahoma Program.

63. Sources of Non-Federal Share. The state certifies that the matching non-federal share of funds for the demonstration is state/local monies. Oklahoma further certifies that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. Premiums paid by enrollees and collected by the state shall not be used as a source of non-federal share for the demonstration. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

- a. CMS may review the sources of the non-federal share of funding for the demonstration at any time. Oklahoma agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
- b. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding.

Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the

state government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care provider-related taxes), fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

64. State Certification of Funding Conditions. The state must certify that the following conditions for non-Federal share of demonstration expenditures are met:

- a. Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.
- b. To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
- c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for Federal match.
- d. The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

XIII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XXI

65. Quarterly Expenditure Reports. In order to track title XXI expenditures under this demonstration, the state must report quarterly demonstration expenditures through the MBES/CBES, following routine CMS-64.21 reporting instructions as outlined in sections 2115 and 2500 of the State Medicaid Manual. Eligible title XXI demonstration expenditures are expenditures for services provided to title XXI children who are eligible with FPL levels

within the approved CHIP state plan. CMS will provide enhanced FFP only for allowable expenditures that do not exceed the state's available title XXI funding.

Title XXI expenditures must be reported on separate Forms CMS-64.21U Waiver and/or CMS-64.21UP Waiver, identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made).

66. Claiming Period. All claims for expenditures related to the demonstration (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the Form CMS-64.21:

- a. The standard CHIP funding process must be used during the demonstration. Oklahoma must estimate matchable CHIP expenditures on the quarterly Form CMS-64.21B. On a separate CMS-64.21B, the state must provide updated estimates of expenditures for the demonstration population. CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64.21U and/or CMS-64.21UP Waiver. CMS will reconcile expenditures reported on the Form CMS-64.21 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state; and,
- b. The state will certify that state/local monies are used as matching funds for the demonstration. The state further certifies that such funds shall not be used as matching funds for any other federal grant or contract, except as permitted by federal law. All sources of non-federal share of funding and distribution of monies involving federal match are subject to CMS approval. Upon review of the sources of the non-federal share of funding and distribution methodologies of funds under the demonstration, all funding sources and distribution methodologies deemed unacceptable by CMS shall be addressed within the timeframes set by CMS. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding.

67. Limitation on Title XXI Funding. Oklahoma will be subject to a limit on the amount of federal title XXI funding that the state may receive for demonstration expenditures during the demonstration period. Federal title XXI funding available for demonstration expenditures is limited to the state's available allotment, including any redistributed funds. Should the state expend its available allotment and redistribution, no further enhanced federal matching funds will be available for costs of the demonstration until the next allotment becomes available. Once all available title XXI funds are exhausted, the state will continue to provide coverage to Medicaid expansion children (demonstration Population 9) covered under the demonstration and is authorized to claim federal funding under title XIX funds until further title XXI federal funds become available.

XIV. MONITORING BUDGET NEUTRALITY

68. Limit on Title XIX Funding. Oklahoma shall be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using a per capita cost method. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the state to CMS to set the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the state's compliance with these annual limits will be done using the Schedule C report from the Form CMS-64.

69. Risk. Oklahoma shall be at risk for the per capita cost for demonstration enrollees under this budget neutrality agreement, but not for the number of demonstration enrollees in each of the groups. By providing FFP for all demonstration enrollees, Oklahoma will not be at risk for changing economic conditions which impact enrollment levels. However, by placing Oklahoma at risk for the per capita costs for demonstration enrollees, CMS assures that the federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration.

70. Demonstration Populations Subject to the Budget Neutrality Agreement. The following demonstration populations are subject to the budget neutrality agreement and are incorporated into the demonstration EGs used to calculate budget neutrality.

- a. **Eligibility Group 1 (Demonstration Population 1):** Temporary Assistance to Needy Families recipients in urban areas of the state;
- b. **Eligibility Group 2 (Demonstration Population 2):** Temporary Assistance to Needy Families recipients in rural areas of the state;
- c. **Eligibility Group 3 (Demonstration Population 3):** Aged, Blind and Disabled Medicaid recipients (regardless of SSI eligibility) in urban areas of the state;
- d. **Eligibility Group 4 (Demonstration Population 4):** Aged, Blind and Disabled Medicaid recipients (regardless of SSI eligibility) in rural areas of the state; and,
- e. **Eligibility Group 5 (Demonstration Population 9):** Medicaid expansion children (including TEFRA children) who revert to title XIX.

71. Budget Neutrality Expenditure Limit. The following describes the method for calculating the budget neutrality expenditure limit for the demonstration:

- a. For each year of the budget neutrality agreement an annual budget neutrality expenditure limit is calculated for each EG described in STC 59 as follows:
 - i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the state under STC 60, for each EG, times the appropriate estimated PMPM costs from the table in subparagraph (iii) below.
 - ii. The PMPM costs in subparagraph (iii) below are net of premiums paid by demonstration eligibles.
 - iii. The PMPM costs for the EGs used to calculate the annual budget neutrality expenditure limit for this demonstration are specified below.

Eligibility Category	2018 PMPM	Trend Rate	2019 PMPM	2020 PMPM	2021 PMPM	2022 PMPM	2023 PMPM
1) TANF-Urban	\$396.34	3.8%	\$411.40	\$427.03	\$443.26	\$460.10	\$477.58
2) TANF-Rural	\$402.00	3.8%	\$417.27	\$433.13	\$449.59	\$466.67	\$484.40
3) ABD-Urban	\$1,369.89	3.6%	\$1,419.21	\$1,470.30	\$1,523.23	\$1,578.07	\$1,634.88
4) ABD-Rural	\$1,093.79	3.6%	\$1,133.16	\$1,173.95	\$1,216.21	\$1,259.99	\$1,305.35

b. The overall budget neutrality expenditure limit for the three-year demonstration period is the sum of the annual budget neutrality expenditure limits calculated in subparagraph (a)(iii) above for each of the 5 years. The federal share of the overall budget neutrality expenditure limit represents the maximum amount of FFP that the state may receive for expenditures on behalf of demonstration populations and expenditures described in STC 59(a) during the demonstration period.

72. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. The budget neutrality test for the demonstration extension may incorporate net savings from the immediately prior demonstration period consisting of the immediately prior demonstration periods of January 1, 2013 through December 31, 2017, but not from any earlier approval period.

73. Exceeding Budget Neutrality. If at the end of this demonstration period the budget neutrality limit has been exceeded, the excess federal funds must be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision shall be based on the time elapsed through the termination date.

74. Budget Neutrality Savings Phase-Down. Beginning with the demonstration period that begins on January 1, 2018, the net variance between the without-waiver cost and actual with-waiver cost will be reduced. The reduced variance will be calculated as a percentage of the total variance, which will then be substituted for the total variance to determine overall budget neutrality for the demonstration. The formula for calculating the reduced variance is: reduced variance equals total variance times applicable percentage. The percentages are determined based on how long Medicaid populations have been subject to the demonstration. In the case of Oklahoma, the program will retain 25 percent of the total variance as future savings for the demonstration. Should the state request an extension of its demonstration

beyond December 31, 2023, budget neutrality will be adjusted again to reflect revised PMPMs based on the data from the current extension.

XV. EVALUATION OF THE DEMONSTRATION

75. Independent Evaluator. At the beginning of the demonstration period, the state must arrange with an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in accord with the CMS-approved, draft Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. The state evaluation must follow the approved methodology, however, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

76. Evaluation Budget. A budget for the evaluation must be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.

77. Draft Evaluation Design. The draft Evaluation Design must be developed in accordance with Attachments A and B of these STCs.

- a. The state must submit, for CMS comment and approval, a draft Evaluation Design with implementation timeline, no later than one hundred eighty (180) calendar days after approval of the demonstration. Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable. The state may choose to use the expertise of the independent party in the development of the draft Evaluation Design.
- b. The state must evaluate the impact of the waiver of retroactive eligibility. Possible areas of focus for hypotheses include the effect of the waiver on 1) enrollment and enrollment continuity (including for different types of enrollees such as prospective applicants, applicants and existing beneficiaries, and for individuals who are healthy and those with complex medical needs; 2) health outcomes; and 3) the financial impact on beneficiaries (including assessment of medical debt) and providers (such as uncompensated care costs). The state will utilize evaluation findings to inform changes to the demonstration and/or its implementation as appropriate. Consistent with subparagraph a, the state must submit a revised evaluation design 120 days after the demonstration is approved.

78. Evaluation Design Approval and Updates. The state's draft Evaluation Design may be subject to multiple revisions until a format and the content is agreed upon by CMS. The state must submit a revised draft Evaluation Design within 60 days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be

included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within 30 calendar days of CMS approval. The state must implement the evaluation design and submit a description of its evaluation implementation progress in each of the Semi-Annual and Annual Monitoring Reports. Once CMS approves the evaluation design, if the state wishes to make changes, the state must submit a revised evaluation design to CMS for approval if the changes are substantial in scope; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in monitoring reports.

For any amendment to the demonstration, in consultation with CMS, the state will either update the approved evaluation design (Attachment D) to accommodate the amendment component, or will provide the details for necessary modifications to the approved evaluation design (Attachment D) via the monitoring reports. The updates to the evaluation design must be submitted to CMS for review no later than one hundred eighty (180) calendar days after CMS's approval of the demonstration amendment. Any such modifications to the evaluation design must also be reflected in the interim and summative evaluation reports, described below.

79. Evaluation Questions and Hypotheses. Consistent with Attachments A and B of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

80. Evaluation of Health Access Networks. The draft evaluation design required under STC 77 must include a discussion of the goals, objectives and specific hypotheses that are being tested through the HAN program. The evaluation design must incorporate the use of baseline data collected by the HANs and include an analyses of the HANs' effectiveness in meeting the following program goals:

- a. Impact on Costs: The implementation and expansion of the HANs will reduce costs associated with the provision of health care services to SoonerCare beneficiaries served by the HANs;
- b. Impact on Access: The implementation and expansion of the HANs will improve access to and availability of health care services to SoonerCare beneficiaries served by the HANs;
- c. Impact on Quality and Coordination: The implementation and expansion of the HANs will improve the quality and coordination of health care services to SoonerCare beneficiaries served by the HANs, with specific focus on the populations at greatest risk including those with multiple chronic illnesses; and,
- d. Impact on PCMH Program: The implementation and expansion of the state's patient-centered medical home program through an evaluation of PCP profiles that

incorporates a review of utilization, disease guideline compliance, and cost.

81. Evaluation of the Health Management Program. The draft evaluation plan required under STC 77 must include a discussion of the goals, objectives and specific hypotheses that are being tested through the Health Management Program. The evaluation plan must incorporate the use of baseline data collected by the HMP and include specific research questions/hypotheses, description of study design employed to address the research questions/hypotheses, any quantitative outcome measures and detailed specifications of those measures (numerator and denominator), any qualitative measures being captured, and an analysis plan that describes how the effects of the HMP program will be isolated from other initiatives. The following hypotheses must be addressed at a minimum:

- a. Impact on Enrollment Figures: The implementation of the HMP program, including health coaches and practice facilitation, will result in increase in enrollment as compared to baseline.
- b. Impact on Access to Care: Incorporating health coaches into primary care practices will result in increased contact with HMP beneficiaries by the PCP (measured through claims encounter data) as compared to baseline when care management occurred via telephonic or face-to-face contact with a health coach.
- c. Impact on Identifying Appropriate Target Population: The implementation of the HMP program, including health coaches and practice facilitation, will result in a change in the characteristics of the beneficiary population enrolled in the HMP (as measured through population characteristics including disease burden and co-morbidity obtained through claims and algorithms) as compared to baseline.
- d. Impact on Health Outcomes: Use of disease registry functions by the health coach will improve the quality of care delivered to beneficiaries as measured by changes in performance on the initial set of Health Care Quality Measures for Medicaid-Eligible adults or CHIPRA Core Set of Children's Healthcare Quality Measures.
- e. Impact on Cost/Utilization of Care: Beneficiaries using HMP services will have fewer ER visits as compared to beneficiaries not receiving HMP services (as measured through claims data).
- f. Impact on Cost/Utilization of Care: Beneficiaries using HMP services will have fewer readmissions to hospitals as compared to beneficiaries not receiving HMP services (as measured through claims data).
- g. Impact on Satisfaction/Experience with Care: Beneficiaries using HMP services will have higher satisfaction compared to beneficiaries not receiving HMP services (as measured through CAHPS survey data)
- h. 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.

82. Evaluation of Eligibility and Enrollment Systems. The interim evaluation report required in STC 83 must contain documentation demonstrating the state's systems performance to ensure seamless coverage between Medicaid, CHIP, and the Exchange. This documentation will answer one of the hypotheses that the demonstration is testing, specifically whether there is a need for retroactive eligibility after changes outlined in the Affordable Care Act are effectuated. CMS may issue further guidance to the state on the specific performance

measures, however, the state, at a minimum, must include the following data in its interim evaluation report. This is not an exhaustive list, and the state is free to include any other data that informs an assessment of whether the state's systems ensure readiness, eligibility, and enrollment.

- a. The number of eligibility determinations made broken down by type, such as application, transfer and redetermination;
- b. The number of individuals determined ineligible broken down by procedural vs. eligibility reasons;
- c. The average application processing times broken down by type, such as application, transfer and redetermination;
- d. The rate of timely eligibility determinations broken down by completed within 5 days, 10 days and 30 days;
- e. The number of individuals disenrolled broken down by procedural vs. eligibility reasons;
- f. The internal churn rate (i.e., the number of disenrolled beneficiaries reenrolling within 6 months); and
- g. The accurate transfer rate, (i.e., the number of individuals transferred to Medicaid, CHIP or the Exchange), as applicable, who are determined eligible by the agency.

83. Interim Evaluation Report. The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the Evaluation Report should be posted to the state's website with the application for public comment.

- a. The interim evaluation report will discuss evaluation progress and present findings to date as per the approved evaluation design.
- b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.
- c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and hypotheses, and how the design was adapted should be included. If the state is not requesting a renewal for a demonstration, an Interim Evaluation report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.
- d. The state must submit a revised Interim Evaluation Report 60 calendar days after receiving CMS comments on the draft Interim Evaluation Report. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's website.
- e. The Interim Evaluation Report must comply with Attachment B (Preparing the Interim and Summative Evaluation Report) of these STCs.

84. Summative Evaluation Report. The draft Summative Evaluation Report must be developed in accordance with Attachment B of these STCs. The state must submit a draft

Summative Evaluation Report for the demonstration’s current approval period, August 31, 2018—December 31, 2023, within 18 months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

- a. Unless otherwise agreed upon in writing by CMS, the state shall submit a revised Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft.
- b. Upon approval from CMS, the final Summative Evaluation Report must be posted to the state’s Medicaid website within 30 calendar days of approval by CMS.

85. State Presentations for CMS. CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the interim evaluation, and/or the summative evaluation.

86. Public Access. The state shall post the final documents (e.g., Monitoring Reports, Close Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state’s Medicaid website within thirty (30) calendar days of approval by CMS.

87. Additional Publications and Presentations. For a period of twelve (12) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given ten (10) business days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

88. Cooperation with CMS Evaluators. Should CMS conduct an independent evaluation of any component of the demonstration; the state will cooperate fully with CMS or the independent evaluator selected by CMS. The state will submit the required data to the contractor or CMS.

XVI. SCHEDULE OF DELIVERABLES

Type	Deliverable	STC Reference
Semi-Annual	By September 1, 2019 – Semi-Annual Operational Report	Section XI, STC 51
Annual	By April 1, 2020 – Draft 2019 Annual Report	Section XI, STC 51
Semi-Annual	By September 1, 2020 – Semi-Annual Operational Report	Section XI, STC 51
Annual	By April 1, 2021 – Draft 2020 Annual Report	Section XI, STC 51
Semi-Annual	By September 1, 2021 – Semi-Annual Operational Report	Section XI, STC 51

Annual	By April 1, 2022 – Draft 2021 Annual Report	Section XI, STC 51
Semi-Annual	By September 1, 2022 – Semi-Annual Operational Report	Section XI, STC 51
Annual	By April 1, 2023 – Draft 2022 Annual Report	Section XI, STC 51
Semi-Annual	By September 1, 2023 – Semi-Annual Operational Report	Section XI, STC 51
Annual	By April 1, 2024 – Draft 2023 Annual Report	Section XI, STC 51
Quarterly	Quarterly Expenditure Reports	Section XIII, STC 65
Quarterly	CMS-64 Reports	Section XII, STC 58
Quarterly	Eligible Member Months	Section XII, STC 60
Draft Evaluation Design	180 days after approval date	Section XV, STC 77
Revised Evaluation Design	60 days after receipt of CMS comments	Section XV, STC 78
Draft Interim Evaluation Report	December 31, 2022, or with renewal application	Section XV, STC 83(c)
Final Interim Evaluation Report	60 days after receipt of CMS comments	Section XV, STC 83(d)
Draft Summative Evaluation Report	Within 18 months after December 31, 2023	Section XV, STC 84
Final Summative Evaluation Report	60 days after receipt of CMS comments	Section XV, STC 84

Attachment A

Developing the Evaluation Design

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions.

CMS expects Evaluation Designs to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: <https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html>. If the state needs technical assistance using this outline or developing the Evaluation Design, the state should contact its demonstration team.

Expectations for Evaluation Designs

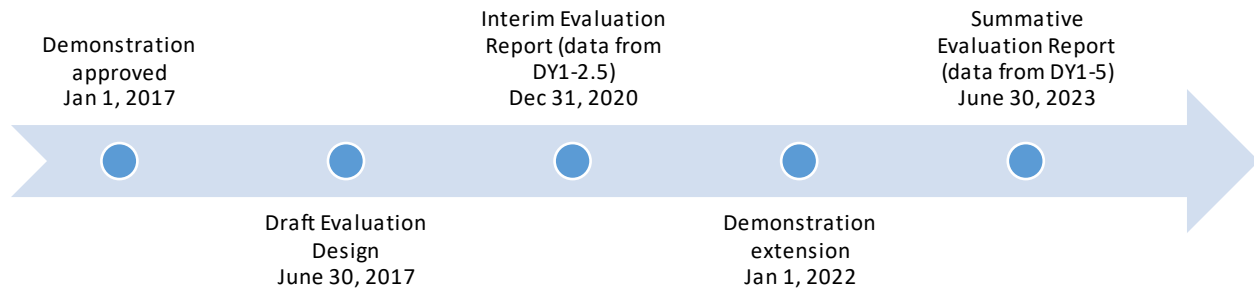
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration, followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

- A.** General Background Information;
- B.** Evaluation Questions and Hypotheses;
- C.** Methodology;
- D.** Methodological Limitations;
- E.** Attachments.

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Design and Reports. (The graphic below depicts an example of this timeline for a 5-year demonstration). In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within thirty (30) calendar days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of All Evaluation Designs

The Evaluation Design sets the stage for the Interim and Summative Evaluation Reports. It is important that the Evaluation Design explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology (and limitations) for the evaluation. A copy of the state’s Driver Diagram (described in more detail in paragraph B2 below) should be included with an explanation of the depicted information.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).
2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation,
3. A brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of the demonstration,
4. For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes,
5. Describe the population groups impacted by the demonstration.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1. Describe how the state’s demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.
2. Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram is a particularly effective modeling tool when working to improve health and health care through specific interventions. The diagram includes information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: <https://innovation.cms.gov/files/x/hciatwoaimsdrrvs.pdf>.
3. Identify the state’s hypotheses about the outcomes of the demonstration:

- a. Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;
 - b. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.
3. **Methodology** – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable, and that where appropriate it builds upon other published research (use references).

This section provides the evidence that the demonstration evaluation will: use the best available data; reports on, controls for, and makes appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what will be measured and how. Specifically, this section establishes:

1. *Evaluation Design* – Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?
2. *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, incorporating the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.
3. *Evaluation Period* – Describe the time periods for which data will be included.
4. *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by “owning”, defining, validating; securing; and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:
 - a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.
 - b. Qualitative analysis methods may be used, and must be described in detail.
 - c. Benchmarking and comparisons to national and state standards should be used, where appropriate.
 - d. Proposed health measures could include CMS’s Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).
 - e. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).

- f. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.
5. *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data. Discuss the quality and limitations of the data sources.
 - a. If primary data (data collected specifically for the evaluation) – The methods by which the data will be collected, the source of the proposed question/responses, the frequency and timing of data collection, and the method of data collection. Copies of any proposed surveys must be reviewed with CMS for approval before implementation.
6. *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative measures to adequately assess the effectiveness of the demonstration. This section should:
 - a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example of how the state might want to articulate the analytic methods for each research question and measure.
 - b. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison groups.
 - c. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).
 - d. The application of sensitivity analyses, as appropriate, should be considered.
7. *Other Additions* – The state may provide any other information pertinent to the Evaluation Design of the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides detailed information on the limitations of the evaluation. This could include the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize the limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

E. Special Methodological Considerations – CMS recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. Examples of considerations include:

1. When the demonstration is:
 - a. Long-standing, non-complex, unchanged, or
 - b. Has previously been rigorously evaluated and found to be successful, or
 - c. Could now be considered standard Medicaid policy (CMS published regulations or guidance)

2. When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
 - a. Operating smoothly without administrative changes; and
 - b. No or minimal appeals and grievances; and
 - c. No state issues with CMS-64 reporting or budget neutrality; and

- d. No Corrective Action Plans (CAP) for the demonstration.

F. Attachments

- 1) **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation, prepare an objective Evaluation Report, and that there would be no conflict of interest. The evaluation design should include a "No Conflict of Interest" statement signed by the independent evaluator.
- 2) **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design, if CMS finds that the draft Evaluation Design is not sufficiently developed, or if the estimates appear to be excessive.
- 3) **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The Final Evaluation Design shall incorporate the Interim and Summative Evaluation Reports. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation Report is due.

Attachment B: Preparing the Interim and Summative Evaluation Reports

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provide important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments need improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Reports

Medicaid section 1115 demonstrations are required to conduct an evaluation that is valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). To this end, the already approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. States should have a well-structured analysis plan for their evaluation. With the following kind of information, states and CMS are best poised to inform and shape Medicaid policy in order to improve the health and welfare of Medicaid beneficiaries for decades to come. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances. When submitting an application for renewal, the interim evaluation report should be posted on the state's website with the application for public comment. Additionally, the interim evaluation report must be included in its entirety with the application submitted to CMS.

Intent of this Attachment

Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

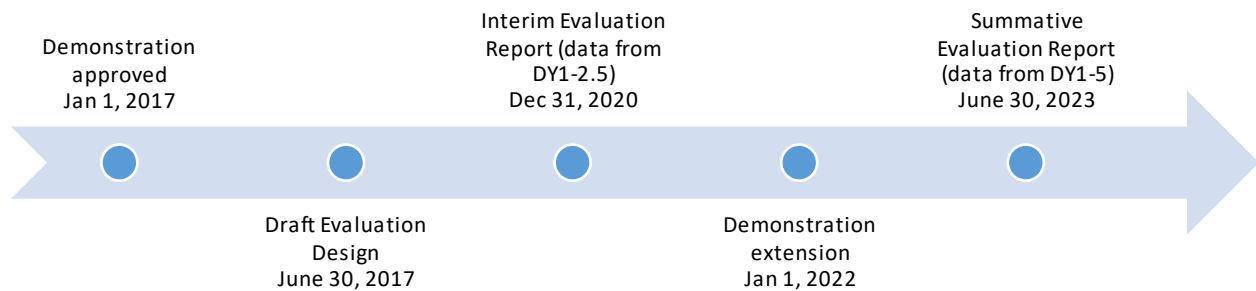
The format for the Interim and Summative Evaluation reports are as follows:

- A. Executive Summary;
- B. General Background Information;
- C. Evaluation Questions and Hypotheses;

- D. Methodology;
- E. Methodological Limitations;
- F. Results;
- G. Conclusions;
- H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
- I. Lessons Learned and Recommendations; and
- J. Attachment(s).

Submission Timelines

There is a specified timeline for the state’s submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the evaluation design and reports to the state’s website within 30 days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of Interim and Summative Evaluation Reports

The section 1115 Evaluation Report presents the research about the section 1115 Demonstration. It is important that the report incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. A copy of the state’s Driver Diagram (described in the Evaluation Design Attachment) must be included with an explanation of the depicted information. The Evaluation Report should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy. Therefore, the state’s submission must include:

- A. Executive Summary** – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.
- B. General Background Information about the Demonstration** – In this section, the state should include basic information about the demonstration, such as:

- 1) The issues that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
- 2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
- 3) A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration;
- 4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes.
- 5) Describe the population groups impacted by the demonstration.

C. Evaluation Questions and Hypotheses – In this section, the state should:

- 1) Describe how the state’s demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.
- 2) Identify the state’s hypotheses about the outcomes of the demonstration;
 - a. Discuss how the goals of the demonstration align with the evaluation questions and hypotheses;
 - b. Explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable); and
 - c. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration consistent with the approved Evaluation Design. The evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research (use references), and meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An interim report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an interim evaluation.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used; reported on, controlled for, and made appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section

should provide enough transparency to explain what was measured and how. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

- 1) *Evaluation Design*—Will the evaluation be an assessment of: pre/post, post-only, with or without comparison groups, etc?
- 2) *Target and Comparison Populations*—Describe the target and comparison populations; include inclusion and exclusion criteria.
- 3) *Evaluation Period*—Describe the time periods for which data will be collected
- 4) *Evaluation Measures*—What measures are used to evaluate the demonstration, and who are the measure stewards?
- 5) *Data Sources*—Explain where the data will be obtained, and efforts to validate and clean the data.
- 6) *Analytic methods*—Identify specific statistical testing which will be undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
- 7) *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

E. Methodological Limitations

This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. Results – In this section, the state presents and uses the quantitative and qualitative data to show to whether and to what degree the evaluation questions and hypotheses of the demonstration were achieved. The findings should visually depict the demonstration results (tables, charts, graphs). This section should include information on the statistical tests conducted.

G. Conclusions – In this section, the state will present the conclusions about the evaluation results.

- 1) In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?
- 2) Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:
 - a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. Interpretations, Policy Implications and Interactions with Other State Initiatives –

In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long range planning. This should include interrelations of the demonstration with other aspects of the state’s Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretation of the data using evaluative reasoning to make

judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

- I. Lessons Learned and Recommendations** – This section of the Evaluation Report involves the transfer of knowledge. Specifically, the “opportunities” for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders is just as significant as identifying current successful strategies. Based on the evaluation results:
- 1) What lessons were learned as a result of the demonstration?
 - 2) What would you recommend to other states which may be interested in implementing a similar approach?

J. Attachment

- 1) Evaluation Design: Provide the CMS-approved Evaluation Design

Attachment C: Phase-Down Expenditures Plan (Reserved)

Attachment D: Approved Evaluation Design

A. GENERAL BACKGROUND INFORMATION

Medicaid is the largest health care provider in the state of Oklahoma. In State Fiscal Year (SFY) 2018, the program provided coverage to over 860,000 Oklahomans, out of a total population of approximately four million (22 percent). In calendar year 2016 (the most recent year available), the program covered 30,490 births out of a statewide total of 52,607 (58 percent).

The Oklahoma Health Care Authority (OHCA), Oklahoma's Single-State Agency for Medicaid, administers SoonerCare, the State's Section 1115(a) Research and Demonstration waiver, which includes SoonerCare Choice managed care and Insure Oklahoma (11-W-00048/6). The Demonstration was originally approved to begin operations in January 1996. The OHCA received approval in August 2018 of its latest renewal application, for the period August 31, 2018 – December 31, 2023.

1. Demonstration Goals

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

In accordance with Section XV of the SoonerCare Special Terms and Conditions (STCs), the OHCA proposes this Evaluation Design for the August 31, 2018 – December 31, 2023 extension period. The design has been developed and is organized in accordance with CMS guidance, as outlined in STC Attachment A.

The OHCA will amend the Evaluation Design as waiver amendments are approved over the life of the demonstration, to ensure it continues to align with program policies and initiatives.

2. Description of the Demonstration

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

The OHCA was established to oversee the program's transition to managed care and implement and administer the SoonerCare Demonstration. The program initially included

children in mandatory state plan groups, pregnant women and 1931 low income families. SoonerCare members were enrolled in managed care organizations (MCOs) in three metropolitan areas (Oklahoma City, Tulsa and Lawton) and a primary care case management (PCCM) model in the remainder of the State. In its original design, the PCCM model included a partial capitation payment to cover primary care services and office-based laboratory and radiology services.

The Demonstration has evolved and expanded significantly over the years. The program's covered populations and major components are described below. They include the core SoonerCare Choice program, Insure Oklahoma, Health Access Networks and Health Management Program.

Covered Populations (Populations Impacted by the Demonstration)

The Demonstration today covers children in mandatory state plan groups, pregnant women and Aged, Blind and Disabled (ABD) members who are not dually-eligible and not receiving long term care, as well as 1931 low-income families and IV-E foster care or adoption assistance children, the latter with voluntary enrollment. In accordance with Oklahoma Senate Bill 741, the OHCA serves individuals in need of breast or cervical cancer treatment and children with disabilities in accordance with the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

In May 2019, SoonerCare Choice program enrollment stood at 527,929. (Total Medicaid enrollment was 789,497, including 233,602 SoonerCare Traditional members, such as dual eligibles and long-term care recipients, and 27,966 SoonerPlan family planning members.)

SoonerCare Choice (Core Program)

The Demonstration operates statewide under an enhanced PCCM model in which the OHCA contracts directly with primary care providers to serve as patient centered medical homes (PCMH) for SoonerCare Choice members. PCMH providers receive monthly care coordination payments for each member on their panels.

Payments vary depending on the PCMH provider's tier level¹ and the mix of children and adults on the provider's panel. Providers also can qualify for "SoonerExcel" performance incentive payments by meeting one or more OHCA-defined quality improvement targets. Aside from care coordination, all services furnished in the medical home and by other providers (specialists, hospitals etc.) are reimbursed fee-for-service.

Insure Oklahoma Premium Assistance Program

The OHCA operates the Insure Oklahoma premium assistance program under the authority of the SoonerCare waiver. Insure Oklahoma offers two ways for individuals to receive premium assistance: Employer Sponsored Insurance (ESI) and Individual Plan (IP) programs.

¹ There are three tiers – 1 "Entry Level", 2 "Advanced" and 3 "Optimal".

Individuals in ESI enroll in an Insure Oklahoma-participating private health plan and pay up to 15 percent of the premium. The remaining premium cost is shared between the individual's employer and the state and federal governments.

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

In May 2019, Insure Oklahoma enrollment totaled 19,113. This included 13,681 ESI members and 5,432 IP members.

Health Access Networks

The OHCA has contracted with three Health Access Networks (HANs) under the Demonstration: University of Oklahoma (OU) Sooner HAN; Partnership for Healthy Central Communities (PHCC) HAN; and Oklahoma State University (OSU) HAN. Each HAN is a non-profit, administrative entity that works with affiliated providers to coordinate and improve the quality of care provided to SoonerCare Choice members. The HANs receive a nominal \$5.00 per member per month (PMPM) payment.

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

In October 2018, total HAN enrollment was 176,323. OU Sooner HAN served approximately 87 percent of the members, followed by OSU HAN with 11 percent and PHCC HAN with two percent.

Under prior Demonstration periods, the HANs operated as a less-than-statewide pilot program, with affiliated providers located in a mix of urban and rural counties. STC 40, which addresses HAN operations, no longer classifies the HANs as a pilot and permits the HANs to expand statewide. (The OHCA will be requesting that CMS update the corresponding STC 84, which addresses evaluation of the HANs and still refers to the program as a pilot.)

Health Management Program

The SoonerCare Health Management Program (HMP) is an initiative under the Demonstration developed to offer care management to SoonerCare Choice members most at-risk for chronic disease and other adverse health events. The program is administered by

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

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

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

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

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

In addition to health coaching, the SoonerCare HMP incorporates Practice Facilitation into each location with an embedded health coach. A practice facilitator nurse assesses the office’s existing processes related to care of patients with chronic conditions. The practice facilitator then undertakes education and academic detailing appropriate to the office’s needs before deployment of the health coach.

In 2014, the OHCA authorized its vendor to resume telephonic case management (health coaching) and, in limited cases, care coordination in members’ homes. Telephonic health coaches would focus their efforts on engaging new members, actively pursuing members needing assistance with care transitions and serving high risk members not assigned to a

primary care provider with an embedded coach. The majority of health coaching would continue to occur through the embedded health coaches at provider offices.

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

The OHCA recently re-procured SoonerCare HMP vendor services for a “third generation” contract to take effect in July 2019. (The incumbent vendor, Telligen, was awarded the contract.) The OHCA will require the vendor to do the following under the new contract:

- Implement an assessment and person-centered care planning process that aligns with processes used by the HANs and internal OHCA care management staff;

- Employ a risk stratification methodology to identify the appropriate mode and frequency of health coaching, based on each member’s needs and goals;

- Integrate pain management into general health coaching and practice facilitation activities, as part of promoting whole person care; and

- Expand practice facilitation by offering it to interested providers who may be unable to host an embedded health coach.

The OHCA is aligning SoonerCare HMP, HAN and internal care management activities to ensure all SoonerCare Choice members have access to this level of support, regardless of their location or PCMH provider. This is part of a broader strategy under the SoonerCare Demonstration to advance managed care principles and a statewide Quality Improvement Program (QIP)² through delivery and financing models other than traditional risk-based managed care organizations.

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

Retroactive Eligibility

The evaluation design also addresses another important feature of the Demonstration: the impact of the OHCA’s waiver of a retroactive eligibility period for a portion of the SoonerCare population. As described in the STCs, the retroactive eligibility waiver tests the efficacy of measures designed to encourage eligible individuals to enroll earlier, to maintain health insurance coverage even while healthy, and to obtain preventive health care. Under the approved STCs, the OHCA is permitted to waive retroactive eligibility for the following groups:

² Formal name is the OHCA Performance & Health Improvement Program, or PHIP.
Oklahoma SoonerCare
Approval Period: August 31, 2018 – December 31, 2023
Amendment Approved: January 31, 2022

1931 low-income families;
Non-IV-E foster care children in state or tribal custody, ages 19-20;
Non-disabled low-income workers and spouses, ages 19-64 (employer-sponsored plan);
Working disabled adults, ages 19-64 (employer-sponsored plan);
Full-time college students, ages 19-22 (employer-sponsored plan);
Foster parents, ages 19-64 (employer-sponsored plan)
Qualified employees of not-for-profit business, ages 19-64 (employer-sponsored plan);
Non-disabled low-income workers and spouses, ages 19-64 (individual plan);
Working disabled adults, ages 19-64 (individual plan);
Full-time college students, ages 19-22 (individual plan);
Foster parents, ages 19-64 (individual plan); and
Qualified employees of not-for-profit business, ages 19-64 (individual plan).

B. EVALUATION QUESTIONS AND HYPOTHESES

1. Quantifiable Targets for Improvement

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

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

A subset of the measures (e.g., HEDIS®) have national benchmarks. The OHCA also will evaluate SoonerCare outcomes against these national benchmarks, where available. The target will be to exceed the applicable national benchmark value (e.g., median rate for Medicaid managed care, in the case of HEDIS measures).

2. Driver Diagrams

The Driver Diagrams presented below (Exhibits 1 and 2) illustrate the relationship between the OHCA's overall goals for SoonerCare Choice and the primary and secondary drivers for achieving these goals.

As depicted in the diagrams, the HAN and HMP initiatives serve as the platforms, or primary drivers, for achieving Demonstration aims with respect to access/quality (Exhibit 1) and cost effectiveness (Exhibit 2). Both initiatives are supported by secondary drivers related to changes in preventive/primary care access, utilization of emergency room and inpatient services, provider payment systems and enrollment continuity (for beneficiaries who are subject to the retroactive eligibility waiver).

Exhibit 1 - SoonerCare Choice Driver Diagram (Access & Quality)

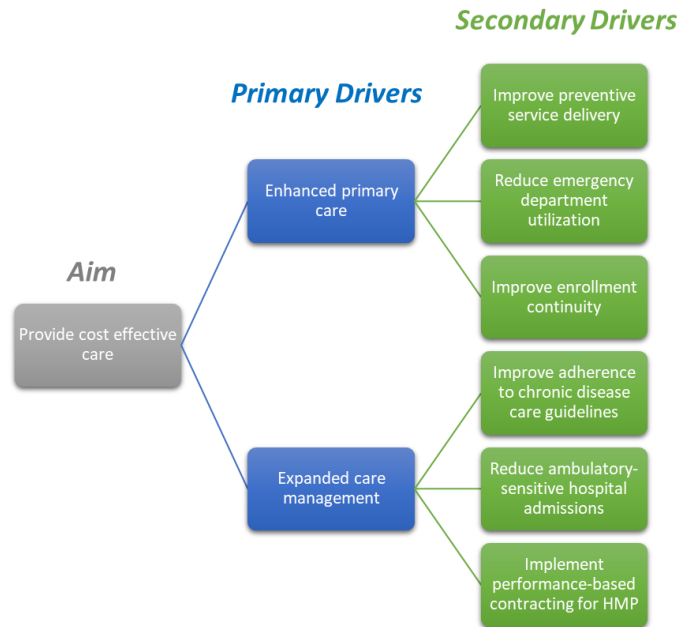
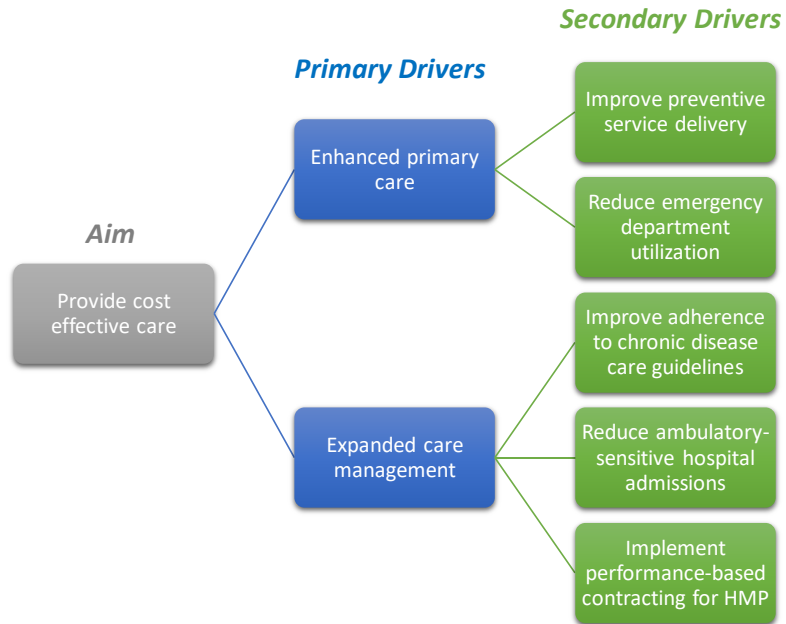


Exhibit 2 - SoonerCare Choice Driver Diagram (Cost Effectiveness)



3. Demonstration Hypotheses

The Demonstration will be evaluated through testing of hypotheses related to the HANs, HMP, Insure Oklahoma program and waiver of retroactive eligibility. Specifically:

1. Evaluation of Health Access Networks

- a. *Impact on Costs:* The implementation and expansion of the HANs will reduce costs associated with the provision of health care services to SoonerCare beneficiaries served by the HANs;
- b. *Impact on Access:* The implementation and expansion of the HANs will improve access to and the availability of health care services to SoonerCare beneficiaries served by the HANs;
- c. *Impact on Quality and Coordination:* The implementation and expansion of the HANs will improve the quality and coordination of health care services to SoonerCare beneficiaries served by the HANs, with specific focus on the populations at greatest risk, including those with multiple chronic illnesses; and
- d. *Impact on PCMH Program:* The implementation and expansion of the HANs will enhance the State's Patient Centered Medical Home program by making HAN care management support and practice enhancement available to more providers, as documented through an evaluation of PCP profiles that incorporates a review of utilization, disease guideline compliance and cost.

2. Evaluation of the Health Management Program

- a. *Impact on Enrollment Figures:* The implementation of the third generation HMP, including health coaches and practice facilitation, will result in an increase in enrollment, as compared to baseline;
- b. *Impact on Access to Care:* Incorporating health coaches into primary care practices will result in increased contact with HMP beneficiaries by the PCP (measured through claims encounter data), as compared to baseline, when care management occurred (exclusively) via telephonic or face-to-face contact with a nurse care manager;
- c. *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;

- d. *Impact on Health Outcomes:* Use of disease registry functions by the health coach will improve the quality of care delivered to beneficiaries, as measured by changes in performance on the initial set of Health Care Quality Measures for Medicaid-Eligible Adults or CHIPRA Core Set of Children’s Healthcare Quality Measures;
 - e. *Impact on Cost/Utilization of Care - ER:* Beneficiaries using HMP services will have fewer ER visits, compared to beneficiaries not receiving HMP services (as measured through claims data);
 - f. *Impact on Cost/Utilization of Care - Hospital:* Beneficiaries using HMP services will have fewer (admissions and) readmissions to hospitals, compared to beneficiaries not receiving HMP services (as measured through claims data);
 - g. *Impact on Satisfaction/Experience with Care:* Beneficiaries using HMP services will have higher satisfaction, compared to beneficiaries not receiving HMP services (as measured through survey data employing CAHPS® questions); and
 - h. *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.
3. *Evaluation of 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:
 - a. The number of individuals enrolled in Insure Oklahoma;
 - b. The number of employers participating in the ESI portion of Insure Oklahoma; and
 - c. The number of primary care providers participating in the Individual Plan portion of Insure Oklahoma.
 4. *Evaluation of Retroactive Eligibility Waiver:* The evaluation will support the hypothesis that the waiver of retroactive eligibility is an appropriate feature of the program, as measured by:

- a. *Impact on Access to Care – Enrollment:* Eliminating retroactive eligibility will increase the likelihood of enrollment and enrollment continuity;
- b. *Impact on Quality of Care – Health Status at Enrollment:* Eliminating retroactive eligibility will increase enrollment of eligible people when they are healthy relative to those eligible people who have the option of retroactive eligibility; and
- c. *Impact on Quality of Care - Health Outcomes:* Through greater continuity of coverage, health outcomes will be better for those subject to retroactive eligibility waivers compared to other Medicaid beneficiaries who have access to retroactive eligibility.

Alignment of Demonstration Goals and Hypotheses

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

Exhibit 3 – Alignment of Goals and Hypotheses

Goal	Demonstration Component	Hypothesis/Research Question(s)
<i>Health Access Networks</i>		
Accessible Care	Health Access Network	Will the implementation and expansion of the HANs improve access to and the availability of health care services to SoonerCare beneficiaries served by the HANs?
High Quality Care	Health Access Networks	Will the implementation and expansion of the HANs improve the quality and coordination of health care services to SoonerCare beneficiaries served by the HANs, including specifically populations at greatest risk (e.g., those with multiple chronic illnesses)? Will the implementation and expansion of the HANs enhance the

Goal	Demonstration Component	Hypothesis/Research Question(s)
		<p>State’s Patient Centered Medical Home program by making HAN care management support and practice enhancement available to more providers (as documented through an evaluation of PCP profiles that incorporates a review of utilization, disease guideline compliance and cost)?</p> <p>Will beneficiaries enrolled with a HAN PCMH provider have higher satisfaction, compared to beneficiaries enrolled with a non-HAN PCMH (as measured through CAHPS survey data)?</p>
Cost Effectiveness	Health Access Networks	Will the implementation and expansion of the HANs reduce cost associated with provision of health care services to SoonerCare beneficiaries served by the HANs?
<i>Health Management Program</i>		
Accessible Care	Health Management Program	<p>Will implementation of the third generation HMP, including health coaches and practice facilitation, result in an increase in enrollment, as compared to baseline?</p> <p>Will incorporating health coaches into primary care practices result in increased contact with HMP beneficiaries by the PCP (measured through claims encounter data), as compared to baseline, when care management occurred (exclusively) via telephonic or face-to-face contact with a nurse care manager?</p>
High Quality Care	Health Management Program	Will implementation of the third generation HMP result in an increase in the average risk profile of newly-enrolled members (based

Goal	Demonstration Component	Hypothesis/Research Question(s)
		<p>on the average number of chronic conditions) as the program becomes available to qualified members who do not currently have access to the HMP?</p> <p>Will the use of disease registry functions by the health coach (along with other coaching activities) improve the quality of care delivered to beneficiaries, as measured by changes in performance on the initial set of Health Care Quality Measures for Medicaid-Eligible Adults or CHIPRA Core Set of Children’s Healthcare Quality Measures?</p> <p>Will beneficiaries using HMP services have higher satisfaction compared to beneficiaries not receiving HMP services (as measured through CAHPS survey data)?</p>
Cost Effectiveness	Health Management Program	<p>Will ER and hospital utilization for members enrolled in the HMP be lower than would have occurred absent their participation?</p> <p>Will total and per member per month expenditures for members enrolled in the HMP be lower than would have occurred absent their participation?</p>
<i>Insure Oklahoma</i>		
Accessible Care	Insure Oklahoma	Will the evaluation support the hypothesis that Insure Oklahoma is improving access to care for low-

Goal	Demonstration Component	Hypothesis/Research Question(s)
		income Oklahomans not eligible for Medicaid?
<i>Waiver of Retroactive Eligibility</i>		
Accessible Care	Waiver of Retroactive Eligibility	<p>Do eligible people subject to retroactive eligibility waivers enroll in Medicaid at the same rates as other eligible people who have access to retroactive eligibility?</p> <p>What is the likelihood of enrollment continuity for those subject to a retroactive eligibility waiver compared to other Medicaid beneficiaries who have access to retroactive eligibility?</p> <p>Do beneficiaries subject to retroactive eligibility waivers who disenroll from Medicaid have shorter enrollment gaps than other beneficiaries who have access to retroactive eligibility?</p>
High Quality Care	Waiver of Retroactive Eligibility	<p>Do newly-enrolled beneficiaries subject to a waiver of retroactive eligibility have higher self-assessed health status than other newly enrolled beneficiaries who have access to retroactive eligibility?</p> <p>Do beneficiaries subject to the retroactive eligibility waiver have better health outcomes than other beneficiaries who have access to retroactive eligibility?</p>

Promotion of Title XIX Objectives

The Affordable Care Act (ACA) included provisions for Medicaid related to quality of care and delivery systems. Specifically, the ACA anticipates that, “improvements will be made in the quality of care and the manner in which that care is delivered, while at the same time reducing costs.”³

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

³ <https://www.medicaid.gov/about-us/program-history/index.html>

C. METHODOLOGY

The SoonerCare Choice evaluation is designed to measure the Demonstration's performance in achieving program goals, while also providing actionable information for improving the program in the future. The proposed methodology is outlined in detail below.

1. Evaluation Design (Overview)

The evaluation will use a combination of analytical techniques, as determined by best available data and the presence or absence of a valid comparison group. The evaluation will employ nationally-validated measures (e.g., HEDIS and CAHPS) where appropriate and State-specific measures where a national measure does not exist (e.g., data on enrollment or PCMH status, as well as member surveys tailored to assess specific HAN and HMP care management activities). Nationally-validated measures that are part of the CMS Scorecard will be given priority for measure selection.

As discussed below, the evaluation will include a comparison group for a portion of the analysis. It also will include an interrupted time series analysis for the HMP program, which is transitioning to an enhanced model of care in July 2019.

The analysis will be stratified into urban and rural subgroups, subject to sample size limitations. The urban subgroup will consist of the counties comprising the greater Oklahoma City, Tulsa and Lawton metropolitan areas; the rural subgroup will consist of the remainder of the State⁴.

2. Target and Comparison Populations

HAN and HMP Component of Evaluation

The SoonerCare Choice target populations are HAN and HMP members. The two populations do not overlap; the OHCA reviews enrollment data monthly to identify and resolve any instances of members being co-enrolled in both programs.

The evaluation is structured to isolate, as much as possible, the discrete impact of the HAN and HMP initiatives with respect to access, quality and cost effectiveness. This will be accomplished by stratifying SoonerCare Choice members into three population segments for applicable measures: members enrolled with a SoonerCare HAN PCMH; members

⁴ Due to space constraints, Exhibit 5, which presents the detailed evaluation measure set, does not specify urban/rural stratification by measure. However, the independent evaluator will apply urban/rural stratification across measures, in accordance with sample size requirements.

enrolled in the SoonerCare HMP; and all other SoonerCare Choice members (comparison group).

The HAN and HMP programs are expanding statewide and have sufficient enrollment to be evaluated in isolation. The OHCA estimates that the HMP population in 2019 will be approximately 10,000 members, while the HAN population will be approximately 200,000 members. The residual comparison group will exceed 300,000 members.

The HAN population closely resembles the comparison group population in terms of demographics. HAN members are primarily non-disabled children, pregnant women, parents and members with disabilities who are not eligible for Medicare. (High risk pregnant women receive care management directly from the OHCA, regardless of HAN status, and therefore are not a focus of the HAN evaluation.)

The HMP population consists primarily of adults and has a higher percentage of ABD members than the comparison group population. The differences will be controlled for in the evaluation, including through stratification of the three populations by aid category (ABD or TANF), age cohort and health condition(s). Propensity score matching also will be used to account for differences between the HMP population and the comparison group.

The evaluation will encompass the entire universe of members, with the exception of member surveys (CAHPS and program-specific surveys). These will be conducted on a randomly-selected representative sample of HAN and HMP members.

Comparison Group Method

All SoonerCare Choice members should have access to preventive services through their PCMH, regardless of their status in terms of HAN or HMP enrollment. An in-state comparison group method therefore will be used for calculation of HEDIS rates across the three populations. This will include both population-wide preventive measures and preventive care measures specific to various chronic health conditions.

The comparison group method also will be used for evaluating CAHPS ratings among HAN, HMP and comparison group members with respect to access to care. The OHCA's CAHPS vendor is able to stratify CAHPS results for the HAN and comparison group populations, although not for the HMP population. The evaluator will include CAHPS-validated questions in a targeted HMP member survey to obtain equivalent data for the HMP population.

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

Interrupted Time Series

The SoonerCare HMP will be transitioning to an enhanced model of care in July 2019. The OHCA will use an interrupted time series analysis to evaluate the impact of the enhanced model on beneficiary utilization and costs. The time series will include three years of data preceding the program changes.

Beneficiary Surveys

The evaluation will assess member satisfaction with access to care and care management, including the member's perception of care management's impact on health status, through a combination of CAHPS and targeted surveys. The targeted survey samples will be randomly drawn from the care managed population in each of the two programs.

Insure Oklahoma Evaluation

The evaluation of Insure Oklahoma is distinct from other portions of the design and is based on tracking beneficiary, employer and provider participation rates over time. It does not require use of comparison groups or qualitative research to attain reliable findings.

Waiver of Retroactive Eligibility

The evaluation of the waiver of retroactive eligibility for a portion of the SoonerCare Choice population also is distinct from the other portions of the design. The OHCA has reviewed and followed CMS guidelines⁵ in designing this component of the evaluation.

The OHCA waiver is atypical in that, prior to the new renewal period, the retroactive eligibility waiver applied to all Demonstration MEGs except Tax Equity and Fiscal Responsibility Act (TEFRA) and Aged, Blind, and Disabled populations. Effective with the start of the new waiver period, retroactive eligibility will be restored for pregnant women and children under 19, while the waiver remains in place for the populations listed in Section A.2 of the design.

The OHCA therefore proposes to evaluate both the ongoing impact of the retroactive eligibility waiver on beneficiaries to whom it continues to apply and the impact of restoring retroactive eligibility for pregnant women and children.

Comparison Group Method

An in-state comparison group method will be used for evaluating enrollment rates and continuity within the population subject to the retroactive eligibility waiver⁶. Non-pregnant adults not subject to the retroactive eligibility waiver will be employed as the comparison group. Propensity score matching will also be used to account for differences between the retroactive eligibility population and the comparison group.

Interrupted Time Series

The OHCA will use an interrupted time series analysis to evaluate the impact of restoring retroactive eligibility for pregnant women and children. The time series will include one year of data preceding the elimination of the waiver.

Beneficiary Surveys

The OHCA will conduct surveys to evaluate the impact of the retroactive eligibility waiver on enrollment rates of beneficiaries subject to the waiver, as well health outcomes over

⁵ Appendix to Eligibility & Coverage Evaluation Guidance – Retroactive Eligibility Waivers (March 2019).

⁶ The OHCA gave serious consideration to use of comparison groups from other states. However, the OHCA believes the impact associated with differences in enrollment processes and outreach/notification practices across states would be difficult to control for as part of any evaluation.

time. The survey will be conducted at time of enrollment and at 12-, 18- and 24-months post-enrollment.

3. Evaluation Period

The HAN program is being expanded and the HMP program is undergoing both expansion and enhancement, as described in Section A. Therefore, although the OHCA’s Independent Evaluator already is tracking a portion of the evaluation measures for the renewal period, the OHCA proposes, with one exception⁷, to treat 2019 as a base year. Program performance in 2020 – 2023 will be assessed against performance in 2019⁸.

The OHCA’s Independent Evaluator will produce findings on a state fiscal year (July to June), rather than calendar year basis for all measures except HEDIS. The OHCA believes this is the most appropriate time period, as it aligns with HMP and HAN contract cycles.

The OHCA recently conducted a procurement to select a vendor to administer the third generation Health Management Program. The new contract will take effect on July 1, 2019 (SFY 2020) and will include provisions for expanding the program statewide and introducing new health coaching modalities. The vendor will be required to offer beneficiaries in-office, telephonic or home-based health coaching, depending on the preferences and needs of the beneficiary.

The OHCA also will be revising contracts with the HANs to address geographic expansion (both within existing counties and into new counties). The new HAN contracts will take effect in SFY 2020.

HEDIS measures will be calculated on a calendar year basis, in accordance with HEDIS specifications, with calendar year 2019 serving as the baseline reporting year (2018 results). (Calculating “HEDIS-like” values on state fiscal year cycle would require generating results twice per year, since the calendar year measures would still be necessary for meeting CMS scorecard reporting requirements.)

⁷ The evaluation design for the HMP includes both a comparison group analysis and an interrupted time series. For the interrupted time series portion, the evaluation will use SFY 2017 – SFY 2019 (final three years of predecessor contract) as the prior program comparison period.

⁸ The waiver renewal period begins August 31, 2018. The independent evaluator will present data for the final four months of 2018, along with the 2019 base data, where appropriate. The 2018 partial year data will be informational, with 2019 serving as the formal base year period.

Exhibit 4 summarizes the overall evaluation and measurement periods.

Exhibit 4 – Demonstration Years & Measurement Periods

Measures	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
Non-HEDIS	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024
HEDIS	CY 2018 ⁹	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023

4. Evaluation Measures

The proposed evaluation measures are listed below, by evaluation component and hypothesis/question. Detailed specifications for each measure are presented in Exhibit 5, immediately following the list.

Evaluation of Health Access Networks – Access to Care

Hypothesis/Question: Will the implementation and expansion of the HANs improve access to and the availability of health care services to SoonerCare beneficiaries served by the HANs?

HAN access and availability will be evaluated through the following measures:

- Child and adolescent access to PCPs – 12 months to 19 years
- Adult access to preventive/ambulatory health services
- Getting needed care – children and adults
- Rating of health care – children and adults
- Rating of health plan – children and adults
- Rating of personal doctor – children and adults

Evaluation of Health Access Networks – Quality of Care

Hypothesis/Question: Will the implementation and expansion of the HANs improve the quality and coordination of health care services to SoonerCare beneficiaries served by the HANs, including specifically populations at greatest risk (e.g., those with multiple chronic illnesses)?

HAN quality and coordination will be evaluated through the following measures:

- Number of members engaged in care management

⁹ 2019 Reporting cycle for 2018 values .

Asthma measures

- Use of appropriate medications for people with asthma
- Medication management for people with asthma – 75 percent

Cardiovascular (CAD and heart failure) measures

- Persistence of beta-blocker treatment after a heart attack
- Cholesterol management for patients with cardiovascular conditions – LDL-C test

COPD measures

- Use of spirometry testing in the assessment and diagnosis of COPD
- Pharmacotherapy management of COPD exacerbation – 14 days
- Pharmacotherapy management of COPD exacerbation – 30 days

Diabetes measures

- Percentage of members who had LDL-C test
- Percentage of members who had retinal eye exam performed
- Percentage of members who had Hemoglobin A1c (HbA1c) testing
- Percentage of members who received medical attention for nephropathy
- Percentage of members prescribed angiotensin converting enzyme inhibitors or angiotensin receptor blockers (ACE/ARB therapy)

Hypertension measures

- Percentage of members who had LDL-C test
- Percentage of members prescribed ACE/ARB therapy
- Percentage of members prescribed diuretics
- Percentage of members prescribed ACE/ARB therapy or diuretics with annual medication monitoring

Mental Health measures

- Follow-up after hospitalization for mental illness – 7 days
- Follow-up after hospitalization for mental illness – 30 days

Social Determinants of Health

- Member satisfaction with SDOH assistance (targeted member survey)
- Impact of assistance on member self-reported health status (targeted member survey)

Hypothesis/Question: Will the implementation and expansion of the HANs enhance the State's Patient Centered Medical Home program by making HAN care management support and practice enhancement available to more providers, as documented through an evaluation of PCP profiles that incorporates a review of utilization, disease guideline compliance and cost?

HAN performance with respect to enhancement of the PCMH program will be evaluated through the following measures:

- Number and percentage of HAN-affiliated PCMH providers who have attained the highest level of OHCA accreditation
- PCMH provider satisfaction with HAN practice support activities
- PCMH provider adoption of chronic care disease guidelines
- Emergency room utilization
- Per member per month costs

PCMH patient compliance with HEDIS chronic disease measures for asthma, CAD, COPD, diabetes and hypertension (measures identified for preceding hypothesis/question) also will be included in the evaluation of this hypothesis/question, as higher compliance rates would be driven by PCMH activities.

Evaluation of Health Access Networks – Cost Effectiveness

Hypothesis/Question: Will the implementation and expansion of the HANs reduce cost associated with provision of health care services to SoonerCare beneficiaries served by the HANs?

HAN cost effectiveness will be evaluated through the following measures:

- Emergency room utilization
- Hospital admissions
- Per member per month costs

Evaluation of Health Management Program – Access to Care

Hypothesis/Question: Will the implementation of the third generation HMP, including health coaches and practice facilitation, result in an increase in enrollment, as compared to baseline?

HMP enrollment will be evaluated through the following measure:

- Number of members engaged in health coaching for a minimum of three months in a 12-month period

Hypothesis/Question: Will incorporating health coaches into primary care practices result in increased contact with HMP beneficiaries by the PCP (measured through claims encounter data), as compared to baseline, when care management occurred (exclusively) via telephonic or face-to-face contact with a nurse care manager?

HMP contacts will be evaluated through the following measure:

PCMH contacts (total and average number per engaged member)

Evaluation of Health Management Program – Quality of Care

Hypothesis/Question: Will the implementation of the third generation HMP, including health coaches and practice facilitation, 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?

HMP beneficiary population risk will be evaluated through the following measures:

Average number of chronic conditions

Percentage of members with physical/behavioral health co-morbidities

Hypothesis/Question: Will the use of disease registry functions by the health coach (along with other coaching activities) improve the quality of care delivered to beneficiaries, as measured by performance on the initial set of Health Care Quality Measures for Medicaid-Eligible Adults or CHIPRA Core Set of Children’s Healthcare Quality Measures?

HMP quality of care will be evaluated through the following measures:

Asthma measures

- Use of appropriate medications for people with asthma
- Medication management for people with asthma – 75 percent
- COPD or asthma in older adults admission rate
- Asthma in younger adults admission rate

Cardiovascular (CAD and heart failure) measures

- Persistence of beta-blocker treatment after a heart attack
- Cholesterol management for patients with cardiovascular conditions – LDL-C test
- Heart failure admission rate

COPD measures

- Use of spirometry testing in the assessment and diagnosis of COPD

- Pharmacotherapy management of COPD exacerbation – 14 days
- Pharmacotherapy management of COPD exacerbation – 30 days

Diabetes measures

- Percentage of members who had LDL-C test
- Percentage of members who had retinal eye exam performed
- Percentage of members who had Hemoglobin A1c (HbA1c) testing
- Percentage of members who received medical attention for nephropathy
- Percentage of members prescribed angiotensin converting enzyme inhibitors or angiotensin receptor blockers (ACE/ARB therapy)
- Diabetes short-term complications admission rate

Hypertension measures

- Percentage of members who had LDL-C test
- Percentage of members prescribed ACE/ARB therapy
- Percentage of members prescribed diuretics
- Percentage of members prescribed ACE/ARB therapy or diuretics with annual medication monitoring

Mental Health measures

- Follow-up after hospitalization for mental illness – 7 days
- Follow-up after hospitalization for mental illness – 30 days

• Opioid measures

- Use of opioids at high dosage in persons without cancer
- Concurrent use of opioids and benzodiazepines

Social Determinants of Health

- Member awareness and use of available SDOH assistance (targeted member survey)
- Member satisfaction with SDOH assistance (targeted member survey)

Hypothesis/Question: Will beneficiaries using HMP services have higher satisfaction compared to beneficiaries not receiving HMP services (as measured through survey data employing CAHPS questions)?

HMP performance with respect to member (beneficiary) satisfaction will be evaluated through the following measures:

Getting needed care – children and adults
Rating of health care – children and adults
Rating of health plan – children and adults
Rating of personal doctor – children and adults

Evaluation of Health Management Program – Cost Effectiveness

Hypothesis/Question: Will beneficiaries using HMP services have fewer ER visits compared to beneficiaries not receiving HMP services and compared to beneficiaries enrolled in the predecessor (second generation) HMP (as measured through claims data)?

HMP effectiveness in reducing ER utilization will be evaluated through the following measure:

Emergency room utilization – HMP members versus comparison group
Emergency room utilization – second versus third generation HMP members

Hypothesis/Question: Will beneficiaries using HMP services have fewer (admissions and readmissions) compared to beneficiaries not receiving HMP services and compared to beneficiaries enrolled in the predecessor (second generation) HMP (as measured through claims data)?

HMP effectiveness in reducing hospital utilization will be evaluated through the following measures:

Hospital admissions and readmissions – HMP members versus comparison group
Hospital admissions and readmissions – second versus third generation HMP members

Hypothesis/Question: Will total and per member per month expenditures for members enrolled in HMP be lower than would have occurred absent their participation?

HMP cost effectiveness will be evaluated through the following measures:

- Per member per month costs – HMP members versus comparison group
Per member per month costs – second versus third generation HMP members

Evaluation of Insure Oklahoma – Access to Care

Hypothesis/Question: Will the evaluation support the hypothesis that Insure Oklahoma is improving access to care for low-income Oklahomans not eligible for Medicaid?

Insure Oklahoma will be evaluated through the following measures:

The number of individuals enrolled in Insure Oklahoma

The number of employers participating in the ESI portion of Insure Oklahoma
The number of primary care providers participating in the Individual Plan portion of Insure Oklahoma

Evaluation of Retroactive Eligibility Waiver – Access to Care

Hypothesis/Question: Will eligible people subject to retroactive eligibility waivers enroll in Medicaid at the same rates as other eligible people who have access to retroactive eligibility?

The impact of the waiver of retroactivity eligibility on enrollment rates will be evaluated through the following measures:

The number of individuals enrolled in Medicaid by eligibility group, by quarter
The number of new enrollees in Medicaid by eligibility group, by quarter

Hypothesis/Question: Will the presence or absence of retroactive eligibility affect enrollment continuity, as measured by Medicaid enrollment rates?

The impact of the waiver of retroactivity eligibility on enrollment continuity will be evaluated through the following measures:

Probability of completing the renewal (recertification) process, by eligibility group
Probability of remaining enrolled in Medicaid for 12-, 18-, 24- consecutive months, by eligibility group
Number of months with Medicaid coverage (average tenure) (1-12)

Hypothesis/Question: Will beneficiaries subject to retroactive eligibility waivers who disenroll from Medicaid have shorter enrollment gaps than other beneficiaries who have access to retroactive eligibility?

The impact of the waiver of retroactivity eligibility on enrollment on enrollment gaps will be evaluated through the following measures:

Probability of re-enrolling in Medicaid after a gap in coverage of six months
Number of months without Medicaid coverage, up to six months

Evaluation of Retroactive Eligibility Waiver – Quality of Care

Hypothesis/Question: Will the presence or absence of retroactive eligibility affect enrollment of eligible people when they are healthy?

The impact of the waiver of retroactivity eligibility on enrollment of healthy people will be evaluated through the following measures:

Beneficiary self-reported health status (through beneficiary survey)

Beneficiary self-reported prior year utilization (through beneficiary survey)

Hypothesis/Question: Will health outcomes, through greater continuity of coverage, be better for those subject to retroactive eligibility waivers compared to other Medicaid beneficiaries who have access to retroactive eligibility?

The impact of the waiver of retroactivity eligibility on health outcomes will be evaluated through the following measures:

Beneficiary self-reported health status; healthy days (beneficiary survey)

Change in physical and mental health status, measured at baseline and at 12, 18, 24 months (beneficiary survey)

Exhibit 5 – Evaluation Measures

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
Evaluation of Health Access Networks – Access to Care							
1	Will the implementation and expansion of the HANs improve access to and the availability of health care services to SoonerCare beneficiaries served by the HANs?	Child and adolescent access to PCPs – 12 months to 19 years	Members within age cohort enrolled with a HAN-affiliated PCMH	In accordance with HEDIS specifications (administrative data only)	SoonerCare Choice members within age cohort not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching
2		Adult access to preventive/ambulatory health services	Members within age cohort enrolled with a HAN-affiliated PCMH	In accordance with HEDIS specifications (administrative data only)	SoonerCare Choice members within age cohort not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching
3		Getting needed care – children and adults	Adult members enrolled with a HAN-affiliated PCMH Child members enrolled with a HAN-affiliated PCMH	In accordance with CAHPS specifications	SoonerCare Choice adult members not enrolled with a HAN-affiliated PCMH SoonerCare Choice child members not enrolled with a HAN-affiliated PCMH	Source - CAHPS survey data file Steward – CAHPS	T-tests Regression with propensity score matching

Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
4		Rating of health plan – children and adults	Adult members enrolled with a HAN-affiliated PCMH Child members enrolled with a HAN-affiliated PCMH	In accordance with CAHPS specifications	SoonerCare Choice adult members not enrolled with a HAN-affiliated PCMH SoonerCare Choice child members not enrolled with a HAN-affiliated PCMH	Source - CAHPS survey data file Steward – CAHPS	T-tests Regression with propensity score matching
5		Rating of personal doctor – children and adults	Adult members enrolled with a HAN-affiliated PCMH Child members enrolled with a HAN-affiliated PCMH	In accordance with CAHPS specifications	SoonerCare Choice adult members not enrolled with a HAN-affiliated PCMH SoonerCare Choice child members not enrolled with a HAN-affiliated PCMH	Source - CAHPS survey data file Steward – CAHPS	T-tests Regression with propensity score matching
Evaluation of Health Access Networks – Quality of Care							
6	Will the implementation and expansion of the HANs improve the quality and coordination of health care services to SoonerCare beneficiaries served by the HANs, including specifically	Number of members engaged in care management	Total unduplicated members engaged in care management at any point during year Unduplicated members with multiple chronic illnesses engaged in care management at	Numerators – members engaged in care management (total and population with multiple chronic conditions) Denominators – all members (total and population with multiple	N/A	Source - HAN care management databases Steward - HANs	Time series

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Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
	populations at greatest risk (e.g., those with multiple chronic illnesses)?		any point during the year	chronic conditions)			
7		Asthma – use of appropriate medications for people with asthma	HAN members with asthma	In accordance with HEDIS specifications	SoonerCare Choice members with asthma not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching
8		Asthma – Medication management for people with asthma – 75 percent	HAN members with asthma	In accordance with HEDIS specifications	SoonerCare Choice members with asthma not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching
9		CAD – Persistent beta-blocker treatment after a heart attack	HAN members with CAD and heart failure	In accordance with HEDIS specifications	SoonerCare Choice members with CAD/heart failure not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching
10		CAD – Cholesterol management for patients with cardiovascular conditions – LDL-C test	HAN members with CAD and heart failure	In accordance with HEDIS specifications	SoonerCare Choice members with CAD/heart failure not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching

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Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
11		COPD – Use of spirometry testing in the assessment and diagnosis of COPD	HAN members with COPD	In accordance with HEDIS specifications	SoonerCare Choice members with CAD/heart failure not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching
12		COPD – pharmacotherapy management of COPD exacerbation – 14 days	HAN members with COPD	In accordance with HEDIS specifications	SoonerCare Choice members with COPD not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching
13		COPD – pharmacotherapy management of COPD exacerbation – 30 days	HAN members with COPD	In accordance with HEDIS specifications	SoonerCare Choice members with COPD not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching
14		Diabetes – Percentage of members who had LDL-C test	HAN members with diabetes	In accordance with HEDIS specifications	SoonerCare Choice members with diabetes not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching

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Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
15		Diabetes – percentage of members who had retinal eye exam performed	HAN members with diabetes	In accordance with HEDIS specifications	SoonerCare Choice members with diabetes not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching
16		Diabetes – percentage of members who had HbA1c testing	HAN members with diabetes	In accordance with HEDIS specifications	SoonerCare Choice members with diabetes not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching
17		Diabetes - Percentage of members who received medical attention for nephropathy	HAN members with diabetes	In accordance with HEDIS specifications	SoonerCare Choice members with diabetes not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching
18		Diabetes - Percentage of members prescribed ACE/ARB therapy	HAN members with diabetes	In accordance with HEDIS specifications	SoonerCare Choice members with diabetes not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching

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Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
19		Hypertension – Percentage of members who had LDL-C test	HAN members with hypertension	In accordance with HEDIS specifications	SoonerCare Choice members with hypertension not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching
20		Hypertension – Percentage of members prescribed ACE/ARB therapy	HAN members with hypertension	In accordance with HEDIS specifications	SoonerCare Choice members with hypertension not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching
21		Hypertension – Percentage of members prescribed diuretics	HAN members with hypertension	In accordance with HEDIS specifications	SoonerCare Choice members with hypertension not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching
22		Hypertension – Percentage of members prescribed ACE/ARB therapy or diuretics with annual medication monitoring	HAN members with hypertension	In accordance with HEDIS specifications	SoonerCare Choice members with hypertension not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching

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Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
23		Mental Health – Follow-up after hospitalization for mental illness – 7 days	HAN members hospitalized for mental illness	In accordance with HEDIS specifications	SoonerCare Choice members hospitalized for mental illness not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching
24		Mental Health – Follow-up after hospitalization for mental illness – 30 days	HAN members hospitalized for mental illness	In accordance with HEDIS specifications	SoonerCare Choice members hospitalized for mental illness not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching
25		SDOH – Member satisfaction	Randomly selected sample of HAN members receiving assistance with SDOH as part of care management	Numerator – Members reporting satisfaction Denominator – All respondents	N/A	Source - HAN care management databases for sample Steward - SoonerCare Independent Evaluator for survey data	Descriptive statistics

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Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
26	Will the implementation and expansion of the HANs enhance the State's PCMH program by making HAN care management and support available to more providers, as documented through an evaluation of PCP profiles that incorporates a review of utilization, disease guideline compliance and cost?	Number and percentage of HAN-affiliated PCMH providers who have attained the highest level of OHCA accreditation	HAN-affiliated PCMH providers	Numerator – PCMH providers with Tier 3 accreditation (or highest level under any future redesign of PCMH tiers) Denominator – All HAN-aligned PCMH providers	PCMH providers not aligned with a HAN	Source – MMIS Steward – OHCA	Time series
27	<i>(Note: HEDIS chronic disease measures from preceding hypothesis/question also will be included in evaluation of this hypothesis/question, as PCMH providers drive member compliance.)</i>	PCMH provider satisfaction with HAN practice support activities	Randomly selected sample of HAN-affiliated PCMH providers	Numerator – Providers reporting satisfaction Denominator – All respondents	N/A	Source – MMIS for provider sample Steward – SoonerCare Independent Evaluator for survey data	Descriptive statistics
28	<i>(Note: HEDIS chronic disease measures from preceding hypothesis/question also will be included in evaluation of this hypothesis/question, as PCMH providers drive member compliance.)</i>	PCMH provider adoption of chronic care disease guidelines (self-reported)	Randomly selected sample of HAN-affiliated PCMH providers	Numerator – Providers reporting compliance by disease state Denominator – All respondents	N/A	Source – MMIS for provider sample Steward – SoonerCare Independent Evaluator for survey data	Descriptive statistics

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Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
Evaluation of Health Access Networks – Cost Effectiveness							
29	Will the implementation and expansion of the HANs reduce cost associated with provision of health care services to SoonerCare beneficiaries served by the HANs?	Emergency room utilization	SoonerCare Choice HAN members	Numerator – ED visits Denominator – total member months	SoonerCare Choice members not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source – MMIS Steward – OHCA	T-tests Regression with propensity score matching
30		Hospital admissions	SoonerCare Choice HAN members	Numerator – IP admissions Denominator – total member months	SoonerCare Choice members not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP PCMH and not enrolled in the HMP	Source – MMIS Steward – OHCA	T-tests Regression with propensity score matching
31		Evaluation of Health Access Networks – PMPM Expenditures	SoonerCare Choice HAN members	Numerator – total expenditures (paid claims and PCMH case management fees) Denominator – total member months	SoonerCare Choice members not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source – MMIS Steward – OHCA	T-tests Regression with propensity score matching

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Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
Evaluation of Health Management Program – Access to Care							
32	Will implementation of the third generation HMP, including health coaches and practice facilitation, result in an increase in enrollment, as compared to baseline?	Number of members engaged in health coaching	SoonerCare HMP members engaged in health coaching (minimum of three months), by coaching method	N/A	HMP beneficiaries enrolled in second generation HMP	Source – HMP contractor database Steward – HMP contractor	Interrupted time series
33	Will incorporating health coaches into primary care practices result in increased contact with HMP beneficiaries by the PCP (measured through claims encounter data), as compared to baseline, when care management occurred (exclusively) via telephonic or face-to-face contact with a nurse care manager?	Number of PCP contacts (total and per member engaged in health coaching)	SoonerCare HMP members engaged in health coaching (minimum of three months), by coaching method	Numerator - Member contacts (visits) with PCMH, by coaching method Denominator – Member months, by coaching method	Members receiving health coaching in PCMH offices will be compared to members receiving field-based and telephonic health coaching	Source – MMIS; HMP contractor database Steward – OHCA for claims; HMP contractor for member assignments	T-tests Regression with propensity score matching

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Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
Evaluation of Health Management Program – Quality of Care							
34	Will implementation of the third generation HMP result in an increase in the average risk profile of newly-enrolled members (based on the average number of chronic conditions) as the program becomes available to qualified members who do not currently have access to the HMP?	Average number of chronic conditions	SoonerCare members enrolled in the HMP, by coaching method	Numerator – Number of chronic conditions Denominator – Number of members	HMP beneficiaries enrolled in second generation HMP	Source – MMIS; HMP contractor database Steward – OHCA for claims; HMP contractor for member assignments	Interrupted time series
35	Will the use of disease registry functions by the health coach (along with other coaching activities) improve the quality of care	Percentage of members with physical/behavioral health co-morbidities	SoonerCare members enrolled in the HMP, by coaching method	Numerator – Number of members with at least one chronic physical and one behavioral health condition Denominator – Number of members	HMP beneficiaries enrolled in second generation HMP	Source – MMIS; HMP contractor database Steward – OHCA for claims; HMP contractor for member assignments	Interrupted time series
36	Will the use of disease registry functions by the health coach (along with other coaching activities) improve the quality of care	Asthma – use of appropriate medications for people with asthma	HMP members with asthma	In accordance with HEDIS specifications	SoonerCare Choice members with asthma not enrolled with a HAN-affiliated PCMH and not	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching

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	delivered to beneficiaries, as measured by changes in performance on the initial set of Health				enrolled in the HMP HMP beneficiaries enrolled in second generation HMP		Interrupted time series
37	Care Quality Measures for Medicaid-Eligible Adults or CHIPRA Core Set of Children’s Healthcare Quality Measures?	Asthma – Medication management for people with asthma – 75 percent	HMP members with asthma	In accordance with HEDIS specifications	SoonerCare Choice members with asthma not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching Interrupted time series
38		Asthma - COPD or asthma in older adults admission rate	HMP members with asthma or COPD	In accordance with AHRQ specifications	SoonerCare Choice members with COPD or asthma not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source - MMIS Steward - AHRQ	T-tests Regression with propensity score matching Interrupted time series
39		Asthma – Asthma in younger adults admission rate	HMP members with asthma	In accordance with AHRQ specifications	SoonerCare Choice members with COPD or asthma not enrolled with a HAN-affiliated PCMH and not	Source - MMIS Steward - AHRQ	T-tests Regression with propensity score matching

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Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
					enrolled in the HMP HMP beneficiaries enrolled in second generation HMP		Interrupted time series
40		CAD – Persistent beta-blocker treatment after a heart attack	HMP members with CAD and heart failure	In accordance with HEDIS specifications	SoonerCare Choice members with COPD or asthma not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching Interrupted time series
41		CAD – Cholesterol management for patients with cardiovascular conditions – LDL-C test	HMP members with CAD and heart failure	In accordance with HEDIS specifications	SoonerCare Choice members with COPD or asthma not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching Interrupted time series
42		CAD – Heart failure admission rate	HMP members with heart failure	In accordance with AHRQ specifications	SoonerCare Choice members with COPD or asthma not enrolled with a HAN-affiliated	Source - MMIS Steward - AHRQ	T-tests Regression with propensity score matching

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Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
					PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP		Interrupted time series
43		COPD – Use of spirometry testing in the assessment and diagnosis of COPD	HMP members with COPD	In accordance with HEDIS specifications	SoonerCare Choice members with COPD or asthma not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching Interrupted time series
44		COPD – pharmacotherapy management of COPD exacerbation – 14 days	HMP members with COPD	In accordance with HEDIS specifications	SoonerCare Choice members with COPD or asthma not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching Interrupted time series
45		COPD – pharmacotherapy management of COPD exacerbation – 30 days	HMP members with COPD	In accordance with HEDIS specifications	SoonerCare Choice members with COPD or asthma not enrolled with a HAN-affiliated	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching

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Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
					PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP		Interrupted time series
46		Diabetes – Percentage of members who had LDL-C test	HMP members with diabetes	In accordance with HEDIS specifications	SoonerCare Choice members with COPD or asthma not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching Interrupted time series
47		Diabetes – percentage of members who had retinal eye exam performed	HMP members with diabetes	In accordance with HEDIS specifications	SoonerCare Choice members with COPD or asthma not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching Interrupted time series
48		Diabetes – percentage of members who had HbA1c testing	HMP members with diabetes	In accordance with HEDIS specifications	SoonerCare Choice members with COPD or asthma not enrolled with a HAN-affiliated	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching

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Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
					PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP		Interrupted time series
49		Diabetes - Percentage of members who received medical attention for nephropathy	HMP members with diabetes	In accordance with HEDIS specifications	SoonerCare Choice members with COPD or asthma not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching Interrupted time series
50		Diabetes - Percentage of members prescribed ACE/ARB therapy	HMP members with diabetes	In accordance with HEDIS specifications	SoonerCare Choice members with COPD or asthma not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching Interrupted time series
51		Diabetes – Diabetes short-term complications admission rate	HMP members with diabetes	In accordance with AHRQ specifications	SoonerCare Choice members with COPD or asthma not enrolled with a HAN-affiliated	Source - MMIS Steward - AHRQ	T-tests Regression with propensity score matching

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Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
					PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP		Interrupted time series
52		Hypertension – Percentage of members who had LDL-C test	HMP members with hypertension	In accordance with HEDIS specifications	SoonerCare Choice members with COPD or asthma not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching Interrupted time series
53		Hypertension – Percentage of members prescribed ACE/ARB therapy	HMP members with hypertension	In accordance with HEDIS specifications	SoonerCare Choice members with COPD or asthma not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching Interrupted time series
54		Hypertension – Percentage of members prescribed diuretics	HMP members with hypertension	In accordance with HEDIS specifications	SoonerCare Choice members with COPD or asthma not enrolled with a HAN-affiliated	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching

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Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
					PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP		Interrupted time series
55		Hypertension – Percentage of members prescribed ACE/ARB therapy or diuretics with annual medication monitoring	HMP members with hypertension	In accordance with HEDIS specifications	SoonerCare Choice members with COPD or asthma not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching Interrupted time series
56		Mental Health – Follow-up after hospitalization for mental illness – 7 days	HMP members hospitalized for mental illness	In accordance with HEDIS specifications	SoonerCare Choice members with COPD or asthma not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching Interrupted time series
57		Mental Health – Follow-up after hospitalization for mental illness – 30 days	HMP members hospitalized for mental illness	In accordance with HEDIS specifications	SoonerCare Choice members with COPD or asthma not enrolled with a HAN-affiliated	Source - MMIS Steward - NCQA	T-tests Regression with propensity score matching

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Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
					PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP		Interrupted time series
58		Opioid – Use of opioids at high dosage in persons without cancer	HMP members prescribed opioids (through Medicaid)	In accordance with PQA specifications	SoonerCare Choice members with COPD or asthma not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source - MMIS Steward - PQA	T-tests Regression with propensity score matching Interrupted time series
59		Opioid – Concurrent use of opioids and benzodiazepines	HMP members prescribed opioids (through Medicaid)	In accordance with PQA specifications	SoonerCare Choice members with COPD or asthma not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source - MMIS Steward - PQA	T-tests Regression with propensity score matching Interrupted time series
60		SDOH – Member awareness of SDOH available assistance	Randomly selected sample of HMP members enrolled in HMP	Numerators – Members reporting awareness and use of SDOH	N/A	Source – SoonerCare Independent Evaluator	Descriptive statistics

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Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
				assistance available through HMP Denominator – All respondents		survey data file Steward - SoonerCare Independent Evaluator for survey data	
61		SDOH – Member satisfaction with SDOH available assistance	Randomly selected sample of HMP members enrolled in HMP	Numerator – Members reporting satisfaction with SDOH assistance Denominator – All respondents reporting use of assistance	N/A	Source – SoonerCare Independent Evaluator survey data file Steward - SoonerCare Independent Evaluator for survey data	Descriptive statistics
62	Will beneficiaries using HMP services have higher satisfaction compared to beneficiaries not receiving HMP services (as measured through CAHPS survey questions)?	Rating of health care – children and adults	Adult HMP members Child HMP members	In accordance with CAHPS specifications	SoonerCare Choice adult members not enrolled with a HAN-affiliated PCMH SoonerCare Choice child members not enrolled with a HAN-affiliated PCMH	Source – SoonerCare Independent Evaluator survey data file Steward – CAHPS	T-tests Regression with propensity score matching
63		Getting needed care – children and adults	Adult HMP members	In accordance with CAHPS specifications	SoonerCare Choice adult members not enrolled with a	Source – SoonerCare Independent	T-tests

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Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
			Child HMP members		HAN-affiliated PCMH SoonerCare Choice child members not enrolled with a HAN-affiliated PCMH	Evaluator survey data file Steward – CAHPS	Regression with propensity score matching
64		Rating of health plan – children and adults	Adult HMP members Child HMP members	In accordance with CAHPS specifications	SoonerCare Choice adult members not enrolled with a HAN-affiliated PCMH SoonerCare Choice child members not enrolled with a HAN-affiliated PCMH	Source - SoonerCare Independent Evaluator Steward – CAHPS	T-tests Regression with propensity score matching
65		Rating of personal doctor – children and adults	Adult HMP members Child HMP members	In accordance with CAHPS specifications	SoonerCare Choice adult members not enrolled with a HAN-affiliated PCMH SoonerCare Choice child members not enrolled with a HAN-affiliated PCMH	Source - SoonerCare Independent Evaluator data file Steward – CAHPS	T-tests Regression with propensity score matching
Evaluation of Health Management Program – Cost Effectiveness							
66	Will beneficiaries using HMP services have fewer ER	ER utilization – HMP members versus comparison group	SoonerCare HMP members (minimum of three months)	Numerator – ED visits	SoonerCare Choice members not enrolled with	Source – MMIS	T-tests

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Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
	visits as compared to beneficiaries not receiving HMP services (as measured through claims data)?			Denominator – total participants	a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Steward – Independent Evaluator	Regression with propensity score matching Interrupted time series
67	Will beneficiaries using HMP services have fewer (admissions and) readmissions as compared to beneficiaries not receiving HMP services (as measured through claims data)?	Hospital admissions – HMP members versus comparison group Hospital readmissions (30 days) – HMP members versus comparison group	SoonerCare HMP members (minimum of three months) SoonerCare HMP members with at least one hospitalization	Numerator – Admissions Denominator – total participants Numerator – Unique members with readmissions within 30 days following an admission Denominator – total members with admissions in 30-day period	SoonerCare Choice members not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP HMP beneficiaries enrolled in second generation HMP	Source – MMIS Steward – SoonerCare Independent Evaluator	T-tests Regression with propensity score matching Interrupted time series
68	Will total and per member per month expenditures for members enrolled in HMP be lower than would have	PMPM costs – HMP members versus comparison group	SoonerCare HMP members (minimum of three months)	Numerator – total expenditures (paid claims) and program administrative costs (vendor payments and	SoonerCare Choice members not enrolled with a HAN-affiliated PCMH and not enrolled in the HMP	Source – MMIS Steward – SoonerCare Independent Evaluator	T-tests Regression with propensity score matching

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Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
	occurred absent their participation?			agency direct/overhead expenses) Denominator – member months	HMP beneficiaries enrolled in second generation HMP		Interrupted time series
Evaluation of Insure Oklahoma – Access to Care							
69	Will the evaluation support the hypothesis that Insure Oklahoma is improving access to care for low-income Oklahomans not eligible for Medicaid?	The number of individuals enrolled in Insure Oklahoma	Insure Oklahoma beneficiaries, both ESI and Individual Plan	N/A	N/A	Source – OHCA eligibility system Steward – OHCA	Descriptive statistics
70		The number of employers participating in the ESI portion of Insure Oklahoma	Employers participating in the ESI portion of the program	N/A	N/A	Source – Insure Oklahoma Steward – OHCA	Descriptive statistics

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Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
71		The number of primary care providers participating in the Individual Plan portion of Insure Oklahoma	Primary care providers (PCMH providers) participating in the Individual Plan network	N/A	N/A	Source – MMIS Steward – OHCA	Descriptive statistics
Evaluation of Retroactive Eligibility – Access to Care							
72	Do eligible people subject to retroactive eligibility waivers enroll in Medicaid at the same rate as other eligible people who have access to retroactive eligibility?	The number of individuals enrolled in Medicaid by eligibility group, by quarter	Beneficiaries subject to retroactive eligibility waiver Beneficiaries newly covered by retroactive eligibility (non-disabled children under age 19 and pregnant women)	N/A	Non-pregnant adults covered by retroactive eligibility waiver Beneficiaries previously subject to retroactive eligibility waiver	Source – OHCA eligibility system Steward - OHCA	Regression with propensity score matching Interrupted time series

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Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
73		The number of new enrollees in Medicaid by eligibility group, by quarter	Beneficiaries subject to retroactive eligibility waiver Beneficiaries newly covered by retroactive eligibility (non-disabled children under age 19 and pregnant women)	N/A	Non-pregnant adults covered by retroactive eligibility waiver Beneficiaries previously subject to retroactive eligibility waiver	Source – OHCA eligibility system Steward - OHCA	Regression with propensity score matching Interrupted time series
74	What is the likelihood of enrollment continuity for those subject to a retroactive eligibility waiver compared to other Medicaid beneficiaries who have access to retroactive eligibility?	Probability of completing the renewal (recertification) process, by eligibility group	Beneficiaries subject to retroactive eligibility waiver Beneficiaries newly covered by retroactive eligibility (non-disabled children under age 19 and pregnant women)	N/A	Non-pregnant adults covered by retroactive eligibility waiver Beneficiaries previously subject to retroactive eligibility waiver	Source – OHCA eligibility system Steward - OHCA	Regression with propensity score matching Interrupted time series

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Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
75		Probability of remaining enrolled in Medicaid for 12-, 18-24- consecutive months, by eligibility group	Beneficiaries subject to retroactive eligibility waiver Beneficiaries newly covered by retroactive eligibility (non-disabled children under age 19 and pregnant women)	N/A	Non-pregnant adults covered by retroactive eligibility waiver Beneficiaries previously subject to retroactive eligibility waiver	Source – OHCA eligibility system Steward - OHCA	Regression with propensity score matching Interrupted time series
76		Number of months with Medicaid coverage (average tenure) (1-12)	Beneficiaries subject to retroactive eligibility waiver Beneficiaries newly covered by retroactive eligibility (non-disabled children under age 19 and pregnant women)	N/A	Non-pregnant adults covered by retroactive eligibility waiver Beneficiaries previously subject to retroactive eligibility waiver	Source – OHCA eligibility system Steward - OHCA	Regression with propensity score matching Interrupted time series

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Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
77	Do beneficiaries subject to retroactive eligibility waivers who disenroll from Medicaid have shorter enrollment gaps than other beneficiaries who have access to retroactive eligibility?	Probability of re-enrolling in Medicaid after a gap in coverage of six months	Beneficiaries subject to retroactive eligibility waiver Beneficiaries newly covered by retroactive eligibility (non-disabled children under age 19 and pregnant women)	N/A	Non-pregnant adults covered by retroactive eligibility waiver Beneficiaries previously subject to retroactive eligibility waiver	Source – OHCA eligibility system Steward - OHCA	Regression with propensity score matching Interrupted time series
78		Number of months without Medicaid coverage, up to six months	Beneficiaries subject to retroactive eligibility waiver Beneficiaries newly covered by retroactive eligibility (non-disabled children under age 19 and pregnant women)	N/A	Non-pregnant adults covered by retroactive eligibility waiver Beneficiaries previously subject to retroactive eligibility waiver	Source – OHCA eligibility system Steward - OHCA	Regression with propensity score matching Interrupted time series

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Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
Evaluation of Retroactive Eligibility – Quality of Care							
79	Do newly-enrolled beneficiaries subject to a waiver of retroactive eligibility have higher self-assessed health status than other newly enrolled beneficiaries who have access to retroactive eligibility?	Beneficiary self-reported health status; reported prior year utilization	Beneficiaries subject to retroactive eligibility waiver	N/A	Non-pregnant adults covered by retroactive eligibility waiver	Source – SoonerCare Independent Evaluator survey data file Steward - SoonerCare Independent Evaluator for survey data	Descriptive regression model (due to lack of baseline data; waiver is ongoing from prior period)
80	Do beneficiaries subject to the retroactive eligibility waiver have better health outcomes than other beneficiaries who have access to retroactive eligibility?	Beneficiary self-reported health status; healthy days	Beneficiaries subject to retroactive eligibility waiver	N/A	Non-pregnant adults covered by retroactive eligibility waiver	Source – SoonerCare Independent Evaluator survey data file Steward - SoonerCare Independent Evaluator for survey data	Regression with propensity score matching
81		Change in physical and mental health status, measured at baseline and at 12, 18 and 24 months	Beneficiaries subject to retroactive eligibility waiver	N/A	Non-pregnant adults covered by retroactive eligibility waiver	Source – SoonerCare Independent Evaluator	Regression model of change in self-reported health status among Medicaid

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Ref	Research Question	Measure	Population	Numerator/ Denominator	Comparison Group	Data Source & Measure Steward	Analytic Methods
						survey data file Steward - SoonerCare Independent Evaluator for survey data	beneficiaries initially enrolled and subject to waiver

Evaluation Measures – Additional Considerations

The OHCA has taken into account the additional considerations for evaluation measures outlined in Attachment A of the Special Terms and Conditions. Specifically:

- *Process and Outcome Measures* – The proposed measure list contains assessments of both process (e.g., HEDIS measures) and outcomes (e.g., utilization and cost measures) to evaluate the effectiveness of the demonstration.
- *Qualitative Analysis* – The evaluation will include qualitative findings in the form of beneficiary and PCMH provider survey data. The beneficiary surveys will include CAHPS-validated questions and will be conducted on a randomly-selected sample of the target population(s). PCMH provider surveys also will be conducted on a randomly-selected sample of the target population. Survey questions will be tested on a small number of providers for clarity and reliability before the survey is finalized and fielded on a larger scale.
- *Benchmarking and Comparisons to National and State Standards* – HEDIS, AHRQ, PQA and CAHPS measures will be compared to national Medicaid managed care benchmarks, where available.
- *Use of CMS Core Set Measures* – Core set measures are included in the evaluation.
- *Use of Nationally-Recognized Metrics* – Nationally-recognized metrics are included in the evaluation.
- *Opportunities for Improving Quality of Care, Health Outcomes and Cost Effectiveness* – The evaluation measure set addresses quality, outcomes and cost effectiveness, consistent with demonstration goals and areas identified for improvement through the OHCA’s Quality Improvement Program and CMS scorecard data.

5. Data Sources

The evaluation will include primary data collection by the Independent Evaluator in the form of targeted beneficiary and provider surveys. CAHPS-validated questions will be used for targeted beneficiary surveys, where applicable. Draft survey instruments will be shared with CMS for approval prior to use.

Beneficiary and provider surveys will be conducted by telephone, although providers will be given the option of completing and returning hard copies of the surveys. The OHCA’s

Independent Evaluator has conducted beneficiary and provider surveys for over a decade using this methodology and has attained high response rates (in excess of 50 percent) with both survey groups. The high response rates have been achieved by conducting surveys both during and after business hours and on weekends. Beneficiaries and providers also are given the option of calling an 800-number to complete a survey at a time of their choosing.

Targeted beneficiary surveys for HAN and HMP members receiving care management will be scheduled using the engagement date as the anchor point, with surveys occurring six months post-engagement.

Beneficiary surveys for evaluation of the retroactive eligibility waiver will be scheduled to occur at time of enrollment and at 12-, 18-, and 24-months post-enrollment, as applicable.

Provider surveys will be conducted on a rolling basis throughout the year.

6. Analytic Methods

Statistical Tests

Exhibit 5 presents the statistical tests to be undertaken for each measure.

Both t-tests and regression models with propensity score matching will be used for evaluating care managed and comparison group populations.

To assess change over time, the regression analysis will use Poisson or negative binomial regression models for the utilization measures, generalized linear models for the cost measures, and logistic regression for the quality measures. Age and gender will be controlled for in the models examining cost and utilization measures. Statistically significant results will be reported based on $p \leq 0.05$. The specific method used will be determined by the evaluator after reviewing the available claims and encounter data.

If t-test and propensity score matching results yield the same findings, the former will be favored for public reporting purposes, to make the results accessible to a broader audience, including state policy makers. (Both sets of data will be shared with CMS.)

In addition, descriptive statistics will be used to describe the basic features of the data along with the measures that do not have a comparison group, measurement across time, or forecasted data (e.g., satisfaction).

Survey Samples

For all non-CAHPS beneficiary surveys, a repeated measures power analysis will be utilized to determine the appropriate sample size. Effect size estimates used in the power

calculation will be based on the effect size of prior surveys of a similar nature conducted in the State by the outside evaluator. The attrition rate of the same prior surveys also will be used to estimate the necessary sample size.

Similar methods will be employed to identify the target sample size for provider surveys. However, actual sample size will likely be determined by feasibility.

Isolating Effects of the Demonstration

The SoonerCare Choice program operates under managed care principles, with PCMH providers, Health Access Networks and the Health Management Program performing key managed care functions. SoonerCare Choice members are not co-enrolled in the HAN and HMP, making these programs unique in their composition.

The evaluation is designed to isolate the effects of the HANs and HMP from other activities through creation of a comparison group comprised of members not enrolled in either program (but still enrolled with a non-HAN affiliated PCMH). As presented in Exhibit 5, results for the comparison group will be generated wherever applicable.

The demographics of the HAN and comparison group populations are very similar, reflecting the large number of beneficiaries (200,000 HAN members and 300,000 or more comparison group members). The HANs also are well-represented in both urban and rural portions of the State.

The demographics of the HMP population skew older than the comparison group and include more ABD beneficiaries as a percentage of the total enrollment. The specifications for HEDIS measures should minimize differences in the evaluation populations but other measures will be stratified by age and aid category, as appropriate, to achieve greater accuracy in findings.

Sensitivity Testing

The data analytics used for predictive modeling is expected to provide a standard error along with the forecast values. The Independent Evaluator will explore using the standard error output to perform sensitivity analyses for predictive model measures.

D. METHODOLOGICAL LIMITATIONS

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

- *Lack of true experimental control groups* – The evaluation design includes a comparison group that serves as a reasonable proxy for the two target populations. However, it is not a true experimental control group.
- *Reliance on administrative data* – HEDIS measures account for a significant portion of the evaluation measure set. The OHCA calculates HEDIS rates using administrative data, which limits the accuracy of measures that require a hybrid method to capture fully beneficiary/provider activity. The OHCA has accounted for this limitation by selecting measures that can be calculated accurately using administrative data.

E. SPECIAL METHODOLOGICAL CONSIDERATIONS

The SoonerCare Demonstration meets many of the “special methodological considerations” criteria outlined by CMS in Attachment A. The demonstration is long-standing (2019 is DY 24) and has demonstrated its success in prior evaluations.

However, the Special Terms and Conditions addressed this limitation by focusing on two program components that are changing. The HAN and HMP both are expanding and adopting enhanced care management processes, with the intent of improving access, quality and cost-effectiveness. The evaluation will examine the performance of the programs across all three domains, while treating the remainder of the program as a statewide comparison group.

ATTACHMENTS

1. Independent Evaluator

The OHCA procures evaluation services through a qualification RFP process, in which potential contractors furnish information on their qualifications, along with references through which the OHCA can verify past performance. The OHCA has signed a task order with one of these contractors, The Pacific Health Policy Group (PHPG), to perform the independent evaluation.

The OHCA selected PHPG because the firm has performed multiple independent evaluations of SoonerCare Choice program components over the past decade, including the first and second generation SoonerCare HMP and the Health Access Networks. PHPG's evaluations included use of comparison groups where applicable, consistent with the methodology outlined for the SoonerCare Choice evaluation.

PHPG also serves as the OHCA's contractor for calculation of core measures for reporting to CMS. The firm therefore is knowledgeable about the OHCA MMIS and the process for generating HEDIS rates using OHCA administrative data.

In addition to its evaluation work in Oklahoma, PHPG serves as the Independent Evaluator of the Vermont Global Commitment to Health Section 1115 demonstration and the New Mexico Centennial Care Section 1115 demonstration (the latter under a subcontract to, and in partnership with, Deloitte Consulting).

The OHCA's Policy and Quality Improvement functions will oversee PHPG activities throughout the evaluation, to ensure it is conducted in accordance with the evaluation design. The OHCA will schedule regular meetings with PHPG's Project Manager/Principal Investigator to receive updates on the evaluation and address any issues that arise with respect to data collection and clarity/accuracy of findings.

PHPG has signed a "No Conflict of Interest" declaration covering the evaluation. A scanned image of the document is included on the next page.



PHPG

The Pacific Health Policy Group

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December 18, 2018

Catina Baker
Senior Research Analyst
Oklahoma Health Care Authority
4345 North Lincoln Boulevard
Oklahoma City, Oklahoma 73105

Dear Ms. Baker:

The purpose of this letter is to affirm that the Pacific Health Policy Group (PHPG) has no conflict of interest with respect to serving as a independent evaluator of the SoonerCare Choice Section 1115a waiver program.

Very truly yours,

The Pacific Health Policy Group



Andrew Cohen, Director

2. Evaluation Budget

The proposed evaluation budget is presented below.

EVALUATION AREA/TASK	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5
HAN Evaluation					
CAHPS survey					
Analysis of HAN beneficiary responses	\$ 7,500	\$ 7,500	\$ 7,500	\$ 7,500	\$ 7,500
SDOH beneficiary targeted survey					
Creation of survey instrument	\$ 3,000	\$ -	\$ -	\$ -	\$ -
Data collection	\$ 22,500	\$ 22,500	\$ 22,500	\$ 22,500	\$ 22,500
Analysis of HAN SDOH beneficiary responses	\$ 7,500	\$ 7,500	\$ 7,500	\$ 7,500	\$ 7,500
HAN PCMH targeted survey					
Creation of survey instrument	\$ 6,000	\$ -	\$ -	\$ -	\$ -
Data collection	\$ 30,000	\$ 30,000	\$ 30,000	\$ 30,000	\$ 30,000
Analysis of HAN PCMH responses	\$ 7,500	\$ 7,500	\$ 7,500	\$ 7,500	\$ 7,500
Claims/utilization analysis					
Creation and testing of paid claims extract	\$ 30,000	\$ 30,000	\$ 30,000	\$ 30,000	\$ 30,000
Creation of eligibility file, stratified by HAN, HMP and other	\$ 15,000	\$ 15,000	\$ 15,000	\$ 15,000	\$ 15,000
Analysis of paid claims for HEDIS/utilization measures	\$ 105,000	\$ 105,000	\$ 105,000	\$ 105,000	\$ 105,000
HMP Evaluation					
HMP beneficiary targeted survey					
Creation of survey instrument	\$ 3,000	\$ -	\$ -	\$ -	\$ -
Data collection	\$ 45,000	\$ 45,000	\$ 45,000	\$ 45,000	\$ 45,000
Analysis of HMP beneficiary responses	\$ 15,000	\$ 15,000	\$ 15,000	\$ 15,000	\$ 15,000
Claims/utilization analysis					
Creation and testing of paid claims extract	\$ 30,000	\$ 30,000	\$ 30,000	\$ 30,000	\$ 30,000
Creation of eligibility file, stratified by HAN, HMP and other	\$ 15,000	\$ 15,000	\$ 15,000	\$ 15,000	\$ 15,000
Analysis of paid claims for HEDIS/utilization measures	\$ 105,000	\$ 105,000	\$ 105,000	\$ 105,000	\$ 105,000
Waiver of Retroactive Eligibility Evaluation					
Creation of monthly eligibility file extracts	\$ 9,000	\$ 9,000	\$ 9,000	\$ 9,000	\$ 9,000
Analysis of eligibility measures	\$ 15,000	\$ 15,000	\$ 15,000	\$ 15,000	\$ 15,000
Evaluation Reports					
Annual/Interim Reports (Interim in Year 4, in lieu of Annual)	\$ -	\$ 37,500	\$ 37,500	\$ 37,500	\$ 52,500
Final Summative Report (included in Year 5)	\$ -	\$ -	\$ -	\$ -	\$ -
TOTAL	\$ 471,000	\$ 496,500	\$ 496,500	\$ 496,500	\$ 511,500

3. Timeline and Major Milestones (Calendar Years)

ACTIVITY/MILESTONE	2019 (DY 24)				2020 (DY 25)				2021 (DY 26)				2022 (DY 27)				2023 (DY 28)				2024				2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Health Access Network Evaluation																												
Development of targeted surveys (for CMS review)																												
Targeted survey data collection																												
CAHPS survey data collection																												
Survey data analysis																												
Paid claims data collection and prep for non-HEDIS measures																												
Paid claims analysis - non-HEDIS measures																												
Paid claims data collection and prep for HEDIS measures																												
Paid claims analysis - HEDIS measures																												
Health Management Program Evaluation																												
Development of targeted surveys (for CMS review)																												
Targeted survey data collection																												
Survey data analysis																												
Paid claims data collection and prep for non-HEDIS measures																												
Paid claims analysis - non-HEDIS measures																												
Paid claims data collection and prep for HEDIS measures																												
Paid claims analysis - HEDIS measures																												
Retroactive Eligibility Waiver Evaluation																												
Collection and prep of eligibility data																												
Eligibility data analysis																												
Reporting																												
Submission of draft semi-annual reports for CMS review																												
Submission of draft annual reports for CMS review																												
Submission of draft interim report for CMS review																												
Submission of draft summative report for CMS review																												

**Attachment E:
Insure Oklahoma Individual Plan Benefits**



Alternative Benefit Plan

State Name:

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: OK - 21 - 0002

Benefits Description	ABP5
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The state/territory proposes a "Benchmark-Equivalent" benefit package.

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."



Alternative Benefit Plan

1. Essential Health Benefit: Ambulatory patient services

Collapse All

Benefit Provided:	Source:	Remove
Primary Care Visits to Treat Injury or Illness	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
Authorization required in excess of limitation	Medicaid State Plan	
Amount Limit:	Duration Limit:	
4 visits/month	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Reference approved State Plan, Attachment 3.1-A, section 5. Amount limits can be exceeded based on medical necessity.		

Benefit Provided:	Source:	Remove
Specialty Visits	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
Authorization required in excess of limitation	Medicaid State Plan	
Amount Limit:	Duration Limit:	
4 visits/month	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Reference approved State Plan, Attachment 3.1-A, section 5. Amount limits can be exceeded based on medical necessity.		

Benefit Provided:	Source:	Remove
Other Practitioner Office Visits	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
Authorization required in excess of limitation	Medicaid State Plan	
Amount Limit:	Duration Limit:	
4 visits/month for PA and APRN visits	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Reference approved State Plan, Attachment 3.1-A, section 6.d.		



Alternative Benefit Plan

Amount limits can be exceeded based on medical necessity.

Benefit Provided:

Outpatient Facility (ambulatory surgery ctr)

Source:

State Plan 1905(a)

Remove

Authorization:

No

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 2.a.

Benefit Provided:

Dialysis

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 2.a.

Benefit Provided:

Allergy Testing

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

60 tests/3 years

Duration Limit:

None

Scope Limit:

None



Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 5
Reference approved State Plan, Attachment 3.1-A, section 6.d.
Amount limits can be exceeded based on medical necessity.

Benefit Provided:

Chemotherapy

Source:

State Plan 1905(a)

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 2.a.

Benefit Provided:

Radiation

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 2.a.

Benefit Provided:

Outpatient Surgery Physician/Surgical Services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None



Alternative Benefit Plan

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 2.a.

Benefit Provided:

Source:

Remove

Authorization:

None

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add



Alternative Benefit Plan

2. Essential Health Benefit: Emergency services

Collapse All

Benefit Provided:	Source:	Remove
Emergency Room Services	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Reference approved State Plan, Attachment 3.1-A, section 2.a.		

Benefit Provided:	Source:	Remove
Emergency Transportation/Ambulance	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Reference approved State Plan, Attachment 3.1-D.		

Benefit Provided:	Source:	Remove
Urgent Care Center	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		



Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 9.

Add



Alternative Benefit Plan

3. Essential Health Benefit: Hospitalization

Collapse All

Benefit Provided:

Inpatient Hospital Services (Inpatient Stay)

Source:

State Plan 1905(a)

Remove

Authorization:

No

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 1.

Benefit Provided:

Inpatient Physician & Surgical Services

Source:

State Plan 1905(a)

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Inpatient physician services: 24 days per individual per State Fiscal Year (SFY); one visit per day per physician.
Inpatient surgical services: no limit.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 5.
Reference approved State Plan, Attachment 3.1-A, section 1.
Amount limits can be exceeded based on medical necessity.

Benefit Provided:

Organ Transplants

Source:

State Plan 1905(a)

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

All transplantation services, except kidney and cornea, must be prior authorized.



Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-E.

Benefit Provided:

Reconstructive Surgery

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Non-cosmetic; breast reconstruction/implantation/removal is covered only when it is a direct result of a mastectomy which is medically necessary.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 1.

Benefit Provided:

Source:

Remove

Authorization:

Other

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add



Alternative Benefit Plan

4. Essential Health Benefit: Maternity and newborn care

Collapse All

Benefit Provided:	Source:	Remove
Prenatal & Postnatal care	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Reference approved State Plan, Attachment 3.1-A, section 3. Reference approved State Plan, Attachment 3.1-A, section 5. Reference approved State Plan, Attachment 3.1-A, section 6.d. Reference approved State Plan, Attachment 3.1-A, section 17. Reference approved State Plan, Attachment 3.1-A, section 20 and section 21.		

Benefit Provided:	Source:	Remove
Delivery & Inpatient Services for Maternity Care	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Reference approved State Plan, Attachment 3.1-A, section 1. Reference approved State Plan, Attachment 3.1-A, section 3. Reference approved State Plan, Attachment 3.1-A, section 5. Reference approved State Plan, Attachment 3.1-A, section 6.d. Reference approved State Plan, Attachment 3.1-A, section 17. Reference approved State Plan, Attachment 3.1-A, section 20.		

Benefit Provided:	Source:	Remove
Authorization:	Provider Qualifications:	
No		
Amount Limit:	Duration Limit:	



Alternative Benefit Plan

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Source:

Remove

Authorization:

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add



Alternative Benefit Plan

5. Essential Health Benefit: Mental health and substance use disorder services including behavioral health treatment

Collapse All

The state/territory assures that it does not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

Benefit Provided:	Source:	Remove
Mental/Behavioral Health Outpatient Services	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Reference approved State Plan, Attachment 3.1-A, section 13.d.1. Amount limits can be exceeded based on medical necessity.		

Benefit Provided:	Source:	Remove
Mental/Behavioral Health Inpatient Services	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Reference approved State Plan, Attachment 3.1-A, section 1. Amount limits can be exceeded based on medical necessity.		

Benefit Provided:	Source:	Remove
Substance Abuse Disorder Outpatient Services	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
No	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		



Alternative Benefit Plan

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 13.d.1.
Amount limits can be exceeded based on medical necessity.

Benefit Provided:

Source:

Remove

Authorization:

None

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add



Alternative Benefit Plan

6. Essential Health Benefit: Prescription drugs

- The state/territory assures that the ABP prescription drug benefit plan is the same as under the approved Medicaid State Plan for prescribed drugs.

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):

- Limit on days supply
- Limit on number of prescriptions
- Limit on brand drugs
- Other coverage limits
- Preferred drug list

Authorization:

No

Provider Qualifications:

State licensed

Coverage that exceeds the minimum requirements or other:

The state's ABP prescription drug benefit is the same as the approved Medicaid state plan for prescribed drugs.



Alternative Benefit Plan

7. Essential Health Benefit: Rehabilitative and habilitative services and devices

Collapse All

- The state/territory assures that it is not imposing limits on habilitative services and devices that are more stringent than limits on rehabilitative services (45 CFR 156.115(a)(5)(ii)). Further, the state/territory understands that separate coverage limits must also be established for rehabilitative and habilitative services and devices. Combined rehabilitative and habilitative limits are allowed, if these limits can be exceeded based on medical necessity.

Benefit Provided:	Source:	Remove
Outpatient Rehabilitation Services	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
15 visits/year for each OT, PT, & ST	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Reference approved State Plan, Attachment 3.1-A, section 2.a. The benefit amount limits exceed the quantity limits within the base benchmark.		

Benefit Provided:	Source:	Remove
Home Health	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
No	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
Provided by Home Health agencies		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Reference approved State Plan, Attachment 3.1-A, section 7.		

Benefit Provided:	Source:	Remove
Durable Medical Equipment	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
Prior Authorization	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	



Alternative Benefit Plan

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Some items may require prior authorization.
Reference approved State Plan, Attachment 3.1-A, section 12.c.
Reference approved State Plan, Attachment 3.1-A, section 7.

Benefit Provided:

Prosthetic Devices

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Some items may require prior authorization.
Reference approved State Plan, Attachment 3.1-A, section 12.c.

Benefit Provided:

Orthotic Devices

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Some items may require prior authorization.
Reference approved State Plan, Attachment 3.1-A, section 12.c.

Benefit Provided:

Habilitation Services

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan



Alternative Benefit Plan

Amount Limit:

15 visits/year for each OT, PT, & ST

Duration Limit:

None

Scope Limit:

Provided only in outpatient hospitals

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 2.a.
The benefit amount limits exceed the quantity limits within the base benchmark.

Benefit Provided:

Skilled Nursing Facility/Inpatient Rehab Hospital

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

90 days per individual per State Fiscal Year (SFY)

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 1.
Amount limits can be exceeded based on medical necessity.

Benefit Provided:

Source:

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add



Alternative Benefit Plan

8. Essential Health Benefit: Laboratory services

Collapse All

Benefit Provided:	Source:	Remove
Imaging (CT/PET scans, MRIs)	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
Prior Authorization	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Reference approved State Plan, Attachment 3.1-A, section 2.a. Reference approved State Plan, Attachment 3.1-A, section 3.		

Benefit Provided:	Source:	Remove
Laboratory Outpatient & Professional Services	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Reference approved State Plan, Attachment 3.1-A, section 2.a. Reference approved State Plan, Attachment 3.1-A, section 3.		

Benefit Provided:	Source:	Remove
X-rays & Diagnostic Imaging	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Reference approved State Plan, Attachment 3.1-A, section 2.a.		



Alternative Benefit Plan

Reference approved State Plan, Attachment 3.1-A, section 3.

Add



Alternative Benefit Plan

9. Essential Health Benefit: Preventive and wellness services and chronic disease management

Collapse All

The state/territory must provide, at a minimum, a broad range of preventive services including: “A” and “B” services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA’s Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided:	Source:	Remove
Diabetes Education	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
Prior Authorization	Medicaid State Plan	
Amount Limit:	Duration Limit:	
10 hours/first year; 2 hours/subsequent year	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Reference approved State Plan, Attachment 3.1-A, section 6.d. Amount limits can be exceeded based on medical necessity.		

Benefit Provided:	Source:	Remove
Preventive Care/Screening/Immunization	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Reference approved State Plan, Attachment 3.1-A, section 5. Reference approved State Plan, Attachment 3.1-A, section 6.d.		

Benefit Provided:	Source:	Remove
Nutritional Services	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
No	Medicaid State Plan	
Amount Limit:	Duration Limit:	
6 hours/year	None	



Alternative Benefit Plan

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 6.d.
Amount limits can be exceeded based on medical necessity.

Benefit Provided:

Source:

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add



Alternative Benefit Plan

10. Essential Health Benefit: Pediatric services including oral and vision care

Collapse All

Benefit Provided:

Medicaid State Plan EPSDT Benefits

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 4.b.

Add



Alternative Benefit Plan

11. Other Covered Benefits from Base Benchmark

Collapse All



Alternative Benefit Plan

12. Base Benchmark Benefits Not Covered due to Substitution or Duplication

Collapse All

Base Benchmark Benefit that was Substituted:

Hospice - Substitution

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Hospice services are a base benchmark benefit substituted with 1945 health home services covered under the State Plan, Attachment 3.1-H and are within 14, other 1937 covered benefits that are not essential health benefits.

Base Benchmark Benefit that was Substituted:

Private Duty Nursing (PDN) - Substitution

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

PDN services are a base benchmark benefit substituted with skilled nursing under the home health services benefit covered under the State Plan, Attachment 3.1-A, section 7 and are within EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted:

Chiropractic Services - Substitution

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Chiropractic services are a base benchmark benefit substituted with rehabilitation occupational therapy, physical therapy, and speech therapy services in the outpatient hospital setting covered under the State Plan, Attachment 3.1-A, section 2.a. and are within EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted:

Substance Abuse Disorder Outpatient Services - Dup

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Substance abuse disorder outpatient services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 13.d.1. and are within EHB 5, mental health and substance use disorder services including behavioral health treatment.

Base Benchmark Benefit that was Substituted:

Substance Abuse Disorder Inpatient Services - Sub

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Substance Abuse Disorder Inpatient Services are a base benchmark benefit substituted with the Mental/Behavioral outpatient services array; particularly Intensive Outpatient BH services covered under the State Plan, Attachment 3.1-A, section 13.d.1. and are within EHB 5, mental health and substance use disorder services including behavioral health treatment.



Alternative Benefit Plan

Base Benchmark Benefit that was Substituted:

Accidental Dental - substitution

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Accidental Dental is a base benchmark benefit substituted with medically necessary extractions covered under the State Plan, Attachment 3.1-A, section 10 and are within 14, other 1937 covered benefits that are not essential health benefits.

Base Benchmark Benefit that was Substituted:

Primary Care Visit to Treat Injury/Illness - Dup

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Primary care visits to treat injury or illness are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 5 and are within EHB 1, ambulatory patient services.

Base Benchmark Benefit that was Substituted:

Specialist Visits - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Specialty visits are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 5 and are within EHB 1, ambulatory patient services.

Base Benchmark Benefit that was Substituted:

Other Practitioner Office Visits - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Other practitioner office visits are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 6.d. and are within EHB 1, ambulatory patient services.

Base Benchmark Benefit that was Substituted:

Outpatient Facility (Ambulatory Surgery Ctr) - Dup

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Outpatient facility fee (e.g., ambulatory surgery center) services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. and are within EHB 1, ambulatory patient services.

Base Benchmark Benefit that was Substituted:

Outpatient Surgery Physician/Surgical - Dup

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Outpatient surgery physician/surgical services are a base benchmark benefit covered under the State Plan,



Alternative Benefit Plan

Attachment 3.1-A, Section 2.a. and are within EHB 1, ambulatory patient services.

Base Benchmark Benefit that was Substituted:

Urgent Care Centers or Facilities - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Urgent care centers or facilities services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 9 and are within EHB 2, emergency services.

Base Benchmark Benefit that was Substituted:

Home Health Care Services - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Home health care services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 7 and are within EHB 7, rehabilitation and habilitative services and devices.

Base Benchmark Benefit that was Substituted:

Emergency Room Services - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Emergency room services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. and are within EHB 2, emergency services.

Base Benchmark Benefit that was Substituted:

Emergency Transportation/Ambulance - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Emergency transportation/ambulance services are a base benchmark benefit covered under the State Plan, Attachment 3.1-D and are within EHB 2, emergency services.

Base Benchmark Benefit that was Substituted:

Inpatient Hospital Services - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Inpatient hospital services (inpatient stay) are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 1 and are within EHB 3, hospitalization.

Base Benchmark Benefit that was Substituted:

Inpatient Physician & Surgical Services - Dup

Source:

Base Benchmark

Remove



Alternative Benefit Plan

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Inpatient physician & surgical services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 1 & section 5 and are within EHB 3, hospitalization.

Base Benchmark Benefit that was Substituted:

Skilled Nursing Facility/Inpatient Rehab - Dup

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Skilled nursing facility services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 1 and are within EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted:

Prenatal and Postnatal Care - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Prenatal and postnatal care is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 3, section 5, section 6.d., section 17, section 20, & section 21 and is within EHB 4, maternity and newborn care.

Base Benchmark Benefit that was Substituted:

Delivery & Inpatient Services for Maternity - Dup

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Delivery & all inpatient services for maternity care is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 1, section 3, section 5, section 6.d., section 17, & section 20 and is within EHB 4, maternity and newborn care.

Base Benchmark Benefit that was Substituted:

Mental/Behavioral Health Outpatient Services - Dup

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Mental/behavioral health outpatient services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 13.d.1. and are within EHB 5, mental health and substance use disorder services including behavioral health treatment.

Base Benchmark Benefit that was Substituted:

Mental/Behavioral Health Inpatient Services - Dup

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Mental/behavioral health inpatient services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 1. and are within EHB 5, mental health and substance use disorder services



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including behavioral health treatment.

Base Benchmark Benefit that was Substituted:

Habilitation Services - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Habilitation services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. and are within EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted:

Durable Medical Equipment - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Durable medical equipment is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 12.c. & section 7 and is within EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted:

Hearing Aids for Children - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Hearing aids for children are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 4.b. and are within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted:

Imaging (CT/PET Scans, MRIs) - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Imaging (CT/PET Scans, MRIs) services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. & section 3 and are within EHB 8, laboratory services.

Base Benchmark Benefit that was Substituted:

Preventive Care/Screening/Immunization - Dup

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Preventive care/screening/immunization services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 5 & section 6.d. and are within EHB 9, preventive and wellness services and chronic disease management.

Base Benchmark Benefit that was Substituted:

Routine Eye Exam for Children - Duplication

Source:

Base Benchmark

Remove



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Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Routine eye exams for children are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 4.b. and are within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted:

Eye Glasses for Children - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Eye glasses for children are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 4.b. and are within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted:

Dental Check-Up for Children - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Dental check-up for children are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 4.b. and are within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted:

Well Baby Visits and Care - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Well baby visits and care are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 4.b. and are within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted:

Lab Outpatient & Professional Services - Dup

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Laboratory outpatient & professional services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. & section 3 and are within EHB 8, laboratory services.

Base Benchmark Benefit that was Substituted:

X-rays and Diagnostic Imaging - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

X-rays and diagnostic imaging services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. & section 3 and are within EHB 8, laboratory services.



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Base Benchmark Benefit that was Substituted:

Basic Dental Care – Child - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 4.b. and are within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted:

Orthodontia – Child - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Basic dental care for children is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 4.b. and is within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted:

Major Dental Care – Child - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Major dental care for children is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 4.b. and is within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted:

Transplant - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Transplant services are a base benchmark benefit covered under the State Plan, Attachment 3.1-E and are within EHB 3, hospitalization.

Base Benchmark Benefit that was Substituted:

Dialysis - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Dialysis is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. and is within EHB 1, ambulatory services.

Base Benchmark Benefit that was Substituted:

Allergy Testing - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:



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Allergy testing is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 5 & section 6.d. and is within EHB 1, ambulatory services.

Base Benchmark Benefit that was Substituted:

Chemotherapy - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Chemotherapy is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. and is within EHB 1, ambulatory services.

Base Benchmark Benefit that was Substituted:

Radiation - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Radiation is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. and is within EHB 1, ambulatory services.

Base Benchmark Benefit that was Substituted:

Diabetes Education - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Diabetes education is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 6.d. and is within EHB 9, preventive and wellness services and chronic disease management.

Base Benchmark Benefit that was Substituted:

Prosthetic Devices - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Prosthetic devices is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 12.c. and is within EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted:

Nutritional Counseling - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Nutritional counseling is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 6.d. and is within EHB 9, preventive and wellness services and chronic disease management.



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Base Benchmark Benefit that was Substituted:

Reconstructive Surgery - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Reconstructive surgery is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 1 and is within EHB 3, hospitalization.

Base Benchmark Benefit that was Substituted:

Rehabilitation Speech Therapy - Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Rehabilitation speech therapy services are a base benchmark benefit duplicated with outpatient rehabilitation services covered under the State Plan, Attachment 3.1-A, section 2.a. and are within EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted:

Rehab Occupational & Physical Therapy - Dup

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Rehabilitation occupational and physical therapy services are a base benchmark benefit duplicated with outpatient rehabilitation services covered under the State Plan, Attachment 3.1-A, section 2.a. and are within EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted:

Outpatient Rehabilitation Services - Dup

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Outpatient rehabilitation services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. and are within EHB 7, rehabilitative and habilitative services and devices.

Add



Alternative Benefit Plan

13. Other Base Benchmark Benefits Not Covered

Collapse All

Base Benchmark Benefit not Included in the Alternative Benefit Plan:

Basic Dental - Adult

Source:

Base Benchmark

Remove

Explain why the state/territory chose not to include this benefit:

It is not a mandatory benefit

Base Benchmark Benefit not Included in the Alternative Benefit Plan:

Orthodontia - Adult

Source:

Base Benchmark

Remove

Explain why the state/territory chose not to include this benefit:

It is not a mandatory benefit

Base Benchmark Benefit not Included in the Alternative Benefit Plan:

Major Dental Care - Adult

Source:

Base Benchmark

Remove

Explain why the state/territory chose not to include this benefit:

It is not a mandatory benefit

Base Benchmark Benefit not Included in the Alternative Benefit Plan:

Infusion Therapy

Source:

Base Benchmark

Remove

Explain why the state/territory chose not to include this benefit:

It is not a mandatory benefit

Base Benchmark Benefit not Included in the Alternative Benefit Plan:

Routine Dental - adult

Source:

Base Benchmark

Remove

Explain why the state/territory chose not to include this benefit:

It is not a mandatory benefit

Add



Alternative Benefit Plan

14. Other 1937 Covered Benefits that are not Essential Health Benefits

Collapse All

Other 1937 Benefit Provided:

LTC/Nursing home

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Reference approved State Plan Section 3.1-A, section 15.

Other 1937 Benefit Provided:

Medically Necessary Extractions - Adult

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

No

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Reference approved State Plan, Attachment 3.1-A, section 10.

Other 1937 Benefit Provided:

Family planning

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

See below

Duration Limit:

None

Scope Limit:

None

Other:

Reference approved State Plan, Attachment 3.1-A, section 4.c.



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<input type="text"/>		
Other 1937 Benefit Provided:	Source:	Remove
<input type="text" value="Bariatric Surgery"/>	<input type="text" value="Section 1937 Coverage Option Benchmark Benefit Package"/>	
Authorization:	Provider Qualifications:	
<input type="text" value="Other"/>	<input type="text" value="Medicaid State Plan"/>	
Amount Limit:	Duration Limit:	
<input type="text" value="None"/>	<input type="text" value="None"/>	
Scope Limit:		
<input type="text" value="Bariatric surgery is not covered for the treatment of obesity alone."/>		
Other:		
<input type="text" value="Reference approved State Plan, Attachment 3.1-A, section 1."/> Reference approved State Plan, Attachment 3.1-A, section 5.		
Other 1937 Benefit Provided:	Source:	Remove
<input type="text" value="Non-emergency transportation"/>	<input type="text" value="Section 1937 Coverage Option Benchmark Benefit Package"/>	
Authorization:	Provider Qualifications:	
<input type="text" value="Prior Authorization"/>	<input type="text" value="Medicaid State Plan"/>	
Amount Limit:	Duration Limit:	
<input type="text" value="None"/>	<input type="text" value="None"/>	
Scope Limit:		
<input type="text" value="Covers expenses for transportation (and meals and lodging) that are determined necessary to secure medical or behavioral health services."/>		
Other:		
<input type="text" value="Reference approved State Plan, Attachment 3.1-A, section 24a."/> Reference approved State Plan, Attachment 3.1-D .		
Other 1937 Benefit Provided:	Source:	Remove
<input type="text" value="1945 Health Homes"/>	<input type="text" value="Section 1937 Coverage Option Benchmark Benefit Package"/>	
Authorization:	Provider Qualifications:	
<input type="text" value="Other"/>	<input type="text" value="Medicaid State Plan"/>	
Amount Limit:	Duration Limit:	
<input type="text" value="None"/>	<input type="text" value="None"/>	
Scope Limit:		
<input type="text" value="None"/>		



Alternative Benefit Plan

Other:

Reference approved State Plan, Attachment 3.1-H.

Other 1937 Benefit Provided:

Podiatric services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

4 office visits/month

Duration Limit:

None

Scope Limit:

None

Other:

Reference approved State Plan, Attachment 3.1-A, section 6.a.

Other 1937 Benefit Provided:

Eye care to treat a medical or surgical condition

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

4 office visits/month

Duration Limit:

None

Scope Limit:

Services are to treat to treat a medical or surgical condition only.

Other:

Reference approved State Plan, Attachment 3.1-A, section 6.b.

Other 1937 Benefit Provided:

Meals and Lodging

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None



Alternative Benefit Plan

Scope Limit:

Payment for lodging and/or meals assistance for an eligible member and an approved medical escort, if needed, is provided only when medically necessary in connection with transportation to and from SoonerCare compensable services.

Other:

Reference approved State Plan, Attachment 4.19-B, transportation, section C, meals and lodging.

Other 1937 Benefit Provided:

Personal Care Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Reference approved State Plan, Attachment 3.1-B, section 24.f.

Other 1937 Benefit Provided:

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

Other:

Add



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15. Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

Collapse All

PRA Disclosure Statement

Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) for the purpose of standardizing data. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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