SoonerSelect

Oklahoma SoonerSelect Quality Strategy

Final Version Available September 6, 2023

ADDRESS
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

WEBSITES
oklahoma.gov/ohca
mysoonercare.org

PHONE
Admin: 405-522-7300
Helpline: 800-987-7767

Report Summary

Appendices

List of Tables and Figures

Report

Tables

Figure(s)

Appendices

Tables

Oklahoma SoonerSelect Quality Strategy
September 6, 2023

Introduction and Overview

This Quality Strategy, a requirement of 42 Code of Federal Regulations (CFR) § 438.340 and 42 CFR § 457.1240(e), identifies the goals of the SoonerSelect program, which will begin in April 2024. The SoonerSelect program will provide comprehensive, integrated health services to specific populations within Medicaid.

The Oklahoma Health Care Authority (OHCA), founded in 1993, administers Oklahoma's Medicaid program, commonly known as SoonerCare. Medicaid gives access to health care for those who are uninsured or underinsured. SoonerCare works to ensure that health care benefits and services are available to qualifying Oklahomans, primarily based on income eligibility requirements. The categories of eligibility include the aged, blind, and disabled (ABD); families qualifying under federal Temporary Assistance to Needy Families (TANF) guidelines; qualified Medicare beneficiaries; children qualified under the Tax Equity and Fiscal Responsibility Act (TEFRA); women with breast and cervical cancer; and certain children and pregnant women. State Medicaid programs are funded with both federal and state dollars in accordance with a federally approved State Plan, and beginning July 1, 2021, a new adult expansion group was added to Oklahoma's Medicaid program.

SoonerCare has been administered under a fee-for-service delivery system by a large array of providers to a diverse member population. There are currently approximately 1,351,000 members with diverse backgrounds and health care needs. This represents approximately 34% of Oklahoma's population; after the COVID-19 Public Health Emergency winds down, SoonerCare is expected to cover approximately 25% of Oklahoma, or nearly 1 million residents. Approximately 40% of members identify as a non-white race/ethnicity. As of January 2023, there were 69,529 contracted providers, 9,073 of which are primary care providers.

OHCA is committed as an organization to improving the health and quality of life of SoonerCare members in a cost-effective manner, as noted in its Vision and Mission:

Vision:	Our vision is for Oklahomans to be healthy and to have access to quality health care services regardless of their ability to pay.
Mission:	Our mission is to responsibly purchase state and federally funded health care in the most efficient and comprehensive manner possible; to analyze and recommend strategies for optimizing the accessibility and quality of health care; and to cultivate relationships to improve the health outcomes of Oklahomans.

OHCA seeks to effect cultural and behavioral changes resulting in healthier Oklahomans, a stable and coordinated provider network, and improved outcomes

achieved through a focus on preventive care and care coordination. OHCA has made great strides in improving the quality of health care among SoonerCare enrollees through the care coordination programs listed below.

- Patient Centered Medical Home (PCMH): A statewide enhanced Primary Care Case Management (PCCM) model in which OHCA contracts directly with Primary Care Providers (PCPs) to serve as PCMHs.
- Health Access Network (HAN): Non-profit, administrative entities that work with affiliated providers to coordinate and improve the quality of care provided to SoonerCare enrollees.
- Health Management Program (HMP): An initiative developed to offer Care Management to SoonerCare enrollees most at risk for chronic disease and other adverse health events.

OHCA continues to build upon previous successes, promoting robust preventive and care coordination services through its fee-for-service program and the new health care model, SoonerSelect.

In May 2022, the Ensuring Access to Medicaid Act, 56 O.S. § 4002.3a directed OHCA to enter public-private partnerships with contracted entities (CEs), through risk-based capitated contracts, to provide Medicaid integrated medical services to specified populations. OHCA issued requests for proposals from CEs in Quarter 4 of 2022, with the intent to implement managed care (SoonerSelect) in April 2024. The Oklahoma Privatization of State Functions Act (Privatization Act, 74 O.S. §§ 586, et seq.) establishes guidelines for the privatization of State services to ensure that such privatization is cost effective and in the best interest of the State. OHCA, in partnership with CEs or organizations similar to health plans, will soon implement SoonerSelect.

Populations Included in SoonerSelect

SoonerSelect includes three distinct programs that will provide comprehensive, integrated health services including, but not limited to, medical, behavioral health, dental and pharmacy services to the Medicaid population. Each program serves a specific population of SoonerSelect eligibles, described in Table 1. Populations excluded from SoonerSelect will remain in the current fee-for-service model.

Table 1. SoonerSelect Populations

Mandatory Enrollment Populations		
SoonerSelect Health Plan	SoonerSelect Children's Specialty Program (CSP)	SoonerSelect Dental Plan
• Children • Pregnant Women • Deemed Newborns • Parents and Caretaker Relatives • Expansion Population	• Children in Foster Care • Certain children in the custody of the Office of Juvenile Affairs • Former Foster Care Children (may opt to select a health plan CE) • Children Receiving Adoption Assistance (may opt to select a health plan CE)	• Children • Pregnant Women • Deemed Newborns • Parents and Caretaker Relatives • Expansion Population • Children in Foster Care • Former Foster Care Children • Juvenile Justice-Involved Children • Children Receiving Adoption Assistance

Table 1. SoonerSelect Populations (Continued)		
Voluntary Enrollment Populations		
SoonerSelect Health Plan	SoonerSelect CSP	SoonerSelect Dental Plan
• American Indian/Alaskan Native may opt in	• Children in Tribal Custody • Juvenile Justice-Involved Children	• American Indian/Alaskan Native eligible may opt in
Excluded Populations (all programs)		
• Individuals enrolled in a home and community-based service (HCBS) waiver • Individuals receiving long-term services and supports (LTSS) • Dual eligible individuals • Individuals determined eligible for Medicaid on the basis of age, blindness, or disability • Individuals enrolled in the Medicare Savings Program • Individuals infected with tuberculosis eligible for tuberculosis-related services • Individuals determined eligible for SoonerCare on the basis of needing treatment for breast or cervical cancer • Undocumented persons eligible for Emergency Services only • Insure Oklahoma Employee Sponsored Insurance dependent children • Coverage under Title XXI for the benefit of unborn Children ('Soon-to-be-Sooners') • Populations other than those described above that remain enrolled due to the continuous enrollment and maintenance of effort requirement of Section 6008(b)(3) of the Families First Coronavirus Response Act		

Quality Strategy Development

It is OHCA's intent to build upon our solid foundation of health care quality to address the needs and opportunities in the current health care environment. This Managed Care Quality Strategy, also referred to as the Quality Strategy, incorporates extensive stakeholder feedback, as well as input from the OHCA Executive Staff, the Medical Advisory Committee (MAC), and the OHCA Board.

OHCA has contracted with KFMC Health Improvement Partners (KFMC) as the External Quality Review Organization (EQRO) to conduct independent review of quality, timeliness, and access to the health services that CEs furnish to SoonerSelect enrollees. Additionally, KFMC has assisted OHCA with stakeholder engagement and development of the State's Quality Strategy. KFMC facilitated virtual stakeholder feedback sessions in late 2021 and early 2022 to gather input on the Comprehensive Quality Strategy (CQS) priority areas. While the CQS focused on the entire Oklahoma Medicaid population, feedback from the CQS stakeholder sessions has been incorporated into the 2023 Managed Care Quality Strategy.

The stakeholders involved in the feedback sessions included the Member Advisory Task Force (MATF), Tribal Consultation (representing nine tribes and Indian Health Services), providers across multiple specialties and geographic regions who were invited to participate by MAC members, and other State Agencies, such as the State Department of Health, Oklahoma Department of Mental Health and Substance Abuse, Department of Corrections, and the Department of Human Services, among others. All CQS stakeholder sessions included gathering information and suggestions about Social Determinants of Health (e.g., areas of stress or unmet needs) and three focus areas (smoking and other tobacco use, obesity, and teen pregnancy). The Tribal Consultation, provider, and other State Agency groups were also asked about their related existing programs and were asked for feedback about measures selected to

evaluate overall program goals and the three focus areas. OHCA sought further information through SoonerCare enrollee and Provider Town Hall meetings. Also, an electronic member survey was conducted, targeting members with the least number of claims to better understand reasons enrollees may not be accessing health care services.

In 2023, feedback on the SoonerSelect Quality Strategy was solicited from the Tribal Consultation, MAC, MATF, State Department of Health and the Oklahoma Department of Mental Health and Substance Abuse. In addition, the Quality Strategy was posted on the OHCA website for public comment for a period of 30 days. Details regarding the incorporation of stakeholder feedback and public comment into interventions and measures can be found in Appendix B.

OHCA will make the final Quality Strategy available on its website.

Plan for Updating the Quality Strategy

Updates to the Quality Strategy will be a part of OHCA's continuous quality improvement process and will consider the recommendations provided by the EQRO, as required by 42 CFR 438.340(c)(2)(iii). These updates will be made to ensure continual alignment with environmental factors and agency priorities, as well as to regularly renew the ongoing effort to improve member health outcomes.

The Quality Strategy will be reviewed and updated as needed, but no less than once every three years as required by the Centers for Medicare & Medicaid Services (CMS) Medicaid Managed Care Final Rule or when there is a significant change, as defined below. The process for reviewing the Quality Strategy includes an evaluation of its effectiveness in the previous three years, with results publicly posted on the OHCA website.

Significant change:

- The scheduled update that occurs every three years and includes input from the Medical Advisory Committee, beneficiaries, Tribal Consultation, and other stakeholders.
- Any major changes to the delivery system model (e.g., payment model changes expected to affect more than 20% of enrollees or more than 20% of spending, or new waivers with similar impact).

Quality Strategy Goals

OHCA's overarching goal is to improve the health outcomes of our members and to advance Governor Stitt's plan to transform Oklahoma into a Top Ten state in health outcomes. To optimize success, OHCA will use the balanced framework of the Quadruple Aim. The Institute for Healthcare Improvement (IHI) described the Triple Aim[1] as the goal of population health activities in general; the Triple Aim refers to the three goals of improving health outcomes for the population, improving patient experience, and decreasing the cost of care per capita. OHCA is embracing the

[1] Institute for Healthcare Improvement Triple Aim http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx. Accessed April 17, 2023

addition of the fourth aim—improving provider experience—considering the key role providers play in the agency reaching its goals[2]. Together, this creates the Quadruple Aim, four core domains within which OHCA Medicaid goals are structured. OHCA also incorporated the goals established by the Oklahoma Legislature and Governor Stitt into the Quality Strategy.

The aims of the SoonerSelect Program are:

- Improve the health of Oklahoma Medicaid members and the health of Oklahoma communities and the State as a whole;
- Improve care delivery through a provider-led model with emphasis on access to high-quality, person-centered, and coordinated care;
- Improve member experience;
- Improve provider experience; and
- Improve financial sustainability of the Oklahoma Medicaid Program.

The Quality Strategy outlines the mechanisms by which OHCA will meet these aims through the assessment of the quality and appropriateness of care via performance improvement and measurement, state standard compliance monitoring, and external quality review. In addition, OHCA will undertake delivery system reform initiatives, develop new interventions, and maintain existing programs to improve quality of care to SoonerSelect members. Table 2 demonstrates the aims, goals, and objectives of the Quality Strategy, with key interventions and measures that align to the objectives. Detailed information on quality measure reporting requirements, performance withhold measures, and targets can be found in Appendix A.

This area intentionally left blank

[2] Bodenheimer T, Sinsky C, From triple to quadruple aim: care of the patient requires care of the provider. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4226781/. Accessed April 17, 2023

Table 2. Quality Strategy Aims, Goals, Objectives, and Aligned Programs, Interventions and Measures			
Aims	**Goals**	**Objectives**	**Programs & Interventions Aligned Measures**
Aim 1: Improve the health of Oklahoma Medicaid members and the health of Oklahoma communities and the State as a whole	Goal 1: Promote wellness and prevention	Objective 1.1: Promote child health, development, and wellness	**Programs & Interventions** • The health plan and CSP CEs will implement population health management, including review of gaps in care, health risk screening, education/outreach to providers and enrollees, and targeted performance improvement projects.
			Aligned Measures/Metrics • Child and Adolescent Well-Care Visits (WCV-CH) • Developmental Screening in the first 3 years of Life (DEV-CH) • Lead Screening in Children (LSC-CH) • Contraceptive Care - All women 15-20 Years (CCW-CH) • Chlamydia Screening in Women Ages 16-20 (CHL-CH) • Screening for Depression and Follow-up Plan: Ages 12-17 (CDF-CH) • 1st Well-Care Visit within 30 Days of Initial Entry into Foster Care • Appropriate Number of Well-Care Visits for Their Age During Foster Care • Care Coordination Letters at Foster Home Changes
		Objective 1.2: Promote women's health	**Programs/Interventions** • To Be Determined (TBD)
			Aligned Measures/Metrics • Breast Cancer Screening (BCS-AD) • Cervical Cancer Screening (CCS-AD) • Chlamydia Screening in Women Ages 21-24 (CHL-AD) • Contraceptive Care – All Women Ages 21-44 (CCW-AD)
		Objective 1.3: Promote preventive health in adults	**Programs/Interventions** • TBD
			Aligned Measures/Metrics • Colorectal Cancer Screening (COL-AD) • Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD) • Screening for Depression and Follow-up Plan: Age 18 and Older (CDF-AD)

Table 2. Quality Strategy Aims, Goals, Objectives, and Aligned Programs, Interventions and Measures (Continued)			
Aims	**Goals**	**Objectives**	**Programs & Interventions Aligned Measures**
		Objective 1.4: Improve access to oral health care for SoonerSelect dental plan enrollees	**Programs/Interventions** • Dental plan CEs will implement dental-focused performance improvement project (PIP) required in contract
			Aligned Measures/Metrics • Oral Evaluation, Dental Services (OEV-CH) • Topical Fluoride for Children (TFL-CH) • Sealant Receipt on Permanent First Molars (SFM-CH) • Periodontal Evaluation in Adults with Periodontitis
	Goal 2: Improve behavioral & chronic condition management	Objective 2.1: Improve behavioral health care	**Programs/Interventions** • Health plan and CSP CEs will implement behavioral health-focused PIP required in contract
			Aligned Measures/Metrics • Follow-Up After Emergency Department Visit for Substance Use: Age 18 and Older (FUA-AD) • Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Ages 13-17 (FUA-CH) • Follow-Up After Emergency Department Visit for Mental Illness Ages: 6-17 (FUM-CH); Age 18 and Older (FUM-AD) • Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD) • Initiation and Engagement of Substance Use Disorder Treatment (IET-AD)
		Objective 2.2: Improve diabetes management	**Programs/Interventions** • TBD
			Aligned Measures/Metrics • Hemoglobin A1c Control for Patients with Diabetes (HBD-AD) • Diabetes Short-term Complications Admissions Rate (PDI 15)
		Objective 2.3: Improve asthma management	**Programs/Interventions** • TBD
			Aligned Measures/Metrics • Asthma Medication Ratio: Ages 5 to 18 (AMR-CH) • Asthma Medication Ratio: Ages 19 to 64 (AMR-AD) • Asthma Admission Rate (PDI 14)

Table 2. Quality Strategy Aims, Goals, Objectives, and Aligned Programs, Interventions and Measures (Continued)

Aims	Goals	Objectives	Programs & Interventions Aligned Measures
			• Preventable Hospital Admissions – Asthma in Younger Adults Admission Rate (PQI 15-AD) • Chronic Obstructive Pulmonary disease (COPD) or Asthma in Older Adults Admission Rate (PQI 05-AD)
		Objective 2.4: Improve hypertension management	Programs/Interventions • TBD
			Aligned Measures/Metrics • Controlling High Blood Pressure (CBP-AD)
	Goal 3: Collaborate with community partners and other State agencies to improve population health	Objective 3.1: Address unmet health-related resource needs	Programs/Interventions • Health plan CEs will develop and implement strategies to address social determinants of health impacting enrollees, which will include health risk screenings, needs-based referrals to social services, and partnering with community-based social service providers and non-traditional health workers.
			Aligned Measures/Metrics • TBD
		Objective 3.2: Address the opioid crisis	Programs/Interventions • TBD
			Aligned Measures/Metrics • Concurrent Use of Opioids and Benzodiazepines (COB-AD) • Use of Opioids at High Dosage in Persons without Cancer (OHD-AD) • Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)
		Objective 3.3: Address tobacco use	Programs/Interventions • TBD
			Aligned Measures/Metrics • Current Cigarette Smoking or Tobacco Use • Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD) measures
		Objective 3.4: Promote health equity	Programs/Interventions • National Committee for Quality Assurance (NCQA) Heath Equity Accreditation requirement for CEs
			Aligned Measures/Metrics • Pending CMS Measures for Health Equity

Table 2. Quality Strategy Aims, Goals, Objectives, and Aligned Programs, Interventions and Measures (Continued)			
Aims	**Goals**	**Objectives**	**Programs & Interventions Aligned Measures**
		Objective 3.5: Address obesity	**Programs/Interventions** • TBD
			Aligned Measures/Metrics • Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)
		Objective 3.6: Improve maternal and infant health outcomes	**Programs/Interventions** • Health plan CEs will address poor maternal and infant health outcomes by implementing new strategies such as the doula benefit and maternal health-related performance improvement projects.
			Aligned Measures/Metrics • Live Births Weighing Less Than 2500 Grams (LBW) • Contraceptive Care – Postpartum Women Ages 15 – 20 (CCP-CH) • Contraceptive Care – Postpartum Women Ages 21 to 44 (CCP-AD) • Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH) • Prenatal & Postpartum Care: Postpartum Care (PPC-AD)
Aim 2: Improve care delivery through a provider-led model with emphasis on access to high-quality, person-centered, and coordinated care	Goal 4: Ensure appropriate access to care	Objective 4.1: Ensure services are available geographically	**Programs/Interventions** • Network adequacy standards for geographic availability,
			Aligned Measures/Metrics • Monthly Network Adequacy Report (specific indicators TBD)
		Objective 4.2: Ensure timely access to care	**Programs/Interventions** • Network adequacy standards for appointment access and after-hours primary care
			Aligned Measures/Metrics • Monthly Network Adequacy Report (specific indicators TBD) • Getting Care Quickly Composite Measures (Consumer Assessment of Healthcare Providers and Systems [CAHPS®] Health Plan Survey)
	Goal 5: Drive patient-centered, whole-person care	Objective 5.1: Address behavioral and physical health conditions	**Programs/Interventions** • Incentivizing behavioral health (BH) screenings in primary care setting and primary care provider (PCP) referrals for BH treatment, if applicable (Screening, Brief Intervention, and Referral to Treatment [SBIRT]).

Table 2. Quality Strategy Aims, Goals, Objectives, and Aligned Programs, Interventions and Measures (Continued)			
Aims	Goals	Objectives	Programs & Interventions Aligned Measures
			• Integration of primary care services in Certified Community Behavioral Health Clinics (CCBHCs) for members with severe and persistent mental illness.
			Aligned Measures/Metrics • Screening for Depression and Follow-up Plan: Ages 12-17 (CDF-CH) • Screening for Depression and Follow-up Plan: Age 18 and Older (CDF-AD) • Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD) • Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)
		Objective 5.2: Facilitate member access to appropriate care management and care coordination services	Programs/Interventions • Process for all members to be contacted to complete Initial Health Risk Screening within 90 days of SoonerSelect initial enrollment date with CE and subsequent development of individualized care plan.
			Aligned Measures/Metrics • Getting Needed Care Composite Measures (CAHPS Health Plan Survey)
		Objective 5.3: Increase collaboration between medical and dental professionals.	Programs/Interventions • TBD
			Aligned Measures/Metrics • TBD
		Objective 5.4: Reduce non-emergent ED utilization	Programs/Interventions • Incentivizing PCPs through additional reimbursement tied to Current Procedural Terminology (CPT®) codes for after-hours visits. • Follow-up with members post-ED visits via Admission, Discharge and Transfer (ADT) alerts to care management staff from the State Designated Entity for Health Information Exchange (SDE-HIE)
			Aligned Measures/Metrics • Emergency Department Utilization (EDU) • Ambulatory Care: ED Visits (AMB-CH)

Table 2. Quality Strategy Aims, Goals, Objectives, and Aligned Programs, Interventions and Measures (Continued)			
Aims	**Goals**	**Objectives**	**Programs & Interventions Aligned Measures**
Aim 3: Improve member experience	Goal 6: Increase member satisfaction with dental plan, health plan and CSP	Objective 6.1: Increase member ratings of satisfaction with dental plan, health plan and CSP providers	**Programs/Interventions** • Member service-related PIP requirement for CEs
			Aligned Measures/Metrics • Applicable CAHPS, Experience of Care and Health Outcomes (ECHO) member satisfaction survey results
		Objective 6.2: Increase engagement with SoonerSelect dental plan enrollees	**Programs/Interventions** • Dental plan CEs will provide high-quality outreach and education materials and regularly scheduled activities to engage with SoonerSelect dental plan enrollees

			Aligned Measures/Metrics
			• Children's Dental CAHPS: Applicable dental plan services measures such as:
			  o Found needed information from toll-free number, website, and written information (Q27A-C).
			  o Plan's customer service gave you information or help needed
			• Adult Dental CAHPS: Applicable dental plan services measures such as:
			  o 800 number, written materials and website provided needed information
			  o Plan's customer service gave you information or help needed

Aim 4: Improve provider experience	Goal 7: Increase provider satisfaction with dental plan, health plan and CSP	Objective 7.1: Improve provider ratings of satisfaction with health plan and CSP	**Programs/Interventions** • Provider-led Effort (PLE) structure for health plan and CSP CEs
			Aligned Measures/Metrics • Applicable provider satisfaction survey measures
		Objective 7.2: Improve provider ratings of satisfaction with dental plan	**Programs/Interventions** • PLE structure for dental plan CEs
			Aligned Measures/Metrics • Applicable provider satisfaction survey measures
Aim 5: Improve financial sustainability of the Oklahoma Medicaid Program	Goal 8: Transition from volume-based to value-based payment structure	Objective 8.1: Implement performance withhold program	**Programs/Interventions** • All health plan CEs will implement new Value-Based Payments (VBPs)
			Aligned Measures/Metrics • All Performance Withhold Measures

Quality Assessment and Performance Improvement

Based on the 2022 America's Health Rankings[3], Oklahoma is ranked 45th in the country in overall health. With OHCA reimbursing health care services for approximately one in every four Oklahomans, there is significant potential for improving the health of Oklahomans through improving the health of SoonerSelect members. To this end, OHCA expects the CEs to increase access to quality care and improve health outcomes through care coordination, prioritization of preventive care, and encouraging enrollees to seek care from the appropriate health care provider type.

In accordance with 42 C.F.R. § 438.330(a)(1), OHCA requires all CEs to establish and implement an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) program for the services it furnishes. The QAPI program will comply with all requirements of state and federal law and regulations. The program should use standards and guidelines from the CEs' Accrediting Entity including standards for Quality Management, Quality Improvement, Quality Assessment, and Performance Improvement Programs.

The QAPI program shall include all the following, at minimum:

- Performance Improvement Projects (PIPs) that evaluate clinical and nonclinical areas, including all SoonerSelect Program population groups, care settings, and types of services;
- Collection and submission of performance measurement data, including the performance measures determined by OHCA;
- Mechanisms to detect both underutilization and overutilization of services; and
- Assessment of the quality and appropriateness of care furnished to enrollees with Special Health Care Needs, in accordance with 42 C.F.R. § 438.330(b)(4).

CEs will submit an annual QAPI program description and associated work plan to OHCA that addresses its strategies for performance improvement and for conducting their quality management activities. In addition, the CEs shall submit an annual evaluation of the previous year's QAPI program to OHCA. The annual QAPI program description, associated work plan, and program evaluation will be submitted as specified in the Reporting Manual and exclusive to Oklahoma Medicaid, not containing documentation from any other state Medicaid program(s). The QAPI program description should include goals, objectives, structure, and policies and procedures.

OHCA or its designee will perform oversight and monitoring functions, evaluate the impact and effectiveness of each CE's QAPI program, review performance and all reporting, and monitor the SoonerSelect Program contractual obligations. The CEs will be responsible for the day-to-day performance and operational requirements. The CEs will report to the OHCA Quality Advisory Committee in accordance with 56 O.S. § 4002.13. Any changes to the QAPI program structure will require prior written approval from OHCA 90 days prior to implementation.

[3] 2022 America's Health Rankings https://www.americashealthrankings.org/learn/reports/2022-annual-report/state-summaries-oklahoma Accessed March 10, 2023.

Performance Measures

OHCA is committed to the delivery of high-quality health care through the development of a data-driven, outcomes-based, continuous quality improvement process. OHCA requires CEs to report annually on patient outcome performance measures, including the Healthcare Effectiveness Data and Information Set (HEDIS®[4]) quality metrics, CMS Adult and Child Core Set, Consumer Assessment of Healthcare Providers and Systems (CAHPS®[5]) measures, and State-specified quality measures. Measures will include target performance rates that will be reviewed annually. OHCA may adjust measure thresholds as needed. Required quality performance measures include measures for physical, behavioral and dental health. Performance measures have been selected to provide evidence of the overall quality of care and specific services provided to each SoonerSelect Program population group (see Appendix A). As the continuous quality improvement process evolves, OHCA will refine the measures required from CEs based on CE performance, the evolution of national clinical standards, and state-specific opportunities for improvement.

To incentivize a core set of quality and health outcomes, OHCA will withhold a portion of the CEs' Capitation Payments. Performance withhold measures are noted in Table A.8 and are subject to change. The CEs may earn back the performance withhold for the measurement year based on incentive-based measures relative to targets established by OHCA. Performance withholds are not applicable in the first measurement period, as it serves as the baseline.

Annually, the CMS Adult and Child Core Set and performance withhold measures will be publicly reported on the OHCA website.

Value-Based Payments

To incentivize quality, health outcomes, and value over volume to achieve the goals of better care, smarter spending, and healthier people, OHCA requires each health plan CE to implement VBP strategies to align payments between payers and providers. While not required of the CSP and dental plan CEs, OHCA encourages them to employ VBP strategies as well. The health plan CEs must enter into value-based contracts with a growing portion of its contracted providers over the five-year contract period, through payment arrangements that meet the criteria of the Health Care Payment (HCP) Learning and Action Network (LAN) Advanced Payment Model (APM)[6]. The VBP strategy places emphasis on the establishment of provider payment arrangements designated as Category 2 and 3[7] and the evolution of providers along the APM model continuum from less sophisticated (i.e., pay for reporting) to more advanced categories (i.e., shared savings) with consideration of provider readiness to take on financial risk. See Figure 1 for VBP target requirements. It is anticipated that this movement toward VBP will facilitate progress toward the Quality Strategy goals

[4] HEDIS® is a registered trademark of the National Committee for Quality Assurance.
[5] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[6] https://hcp-lan.org/apm-framework/
[7] https://hcp-lan.org/workproducts/apm-figure-1-final.pdf

of enhanced quality of care, improved outcomes, and reduced costly and avoidable care.

Each health plan CE is required to submit an annual VBP Plan to OHCA. The VBP Plan will detail the CE's strategy for meeting the targets set forth by OHCA, including specifying the CE's intermediate targets in year two and year three of the contract with OHCA. The VBP Plan should also describe the CE's methodology or methodologies by type of Participating Provider. The CEs will submit VBP reports on a quarterly basis to OHCA detailing the specific payments for that quarter.

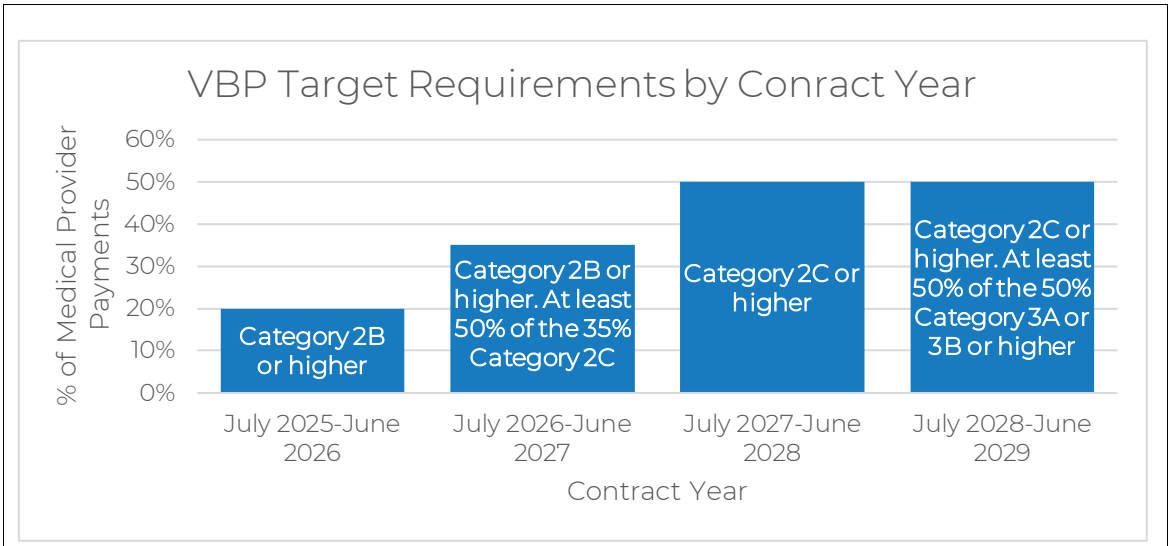

Figure 1. VBP Targets for SoonerSelect Health Plan CEs[8]

Performance Improvement Projects

SoonerSelect health plan and Children's Specialty Program CEs are required to conduct at least three PIPs annually. Upon implementation and as applicable when adjustments are appropriate, the CEs shall propose one non-clinical and two clinical PIPs, including at least one that addresses physical health and one that addresses behavioral health. The dental plan CEs are required to conduct two PIPs annually, one clinical and one non-clinical. While OHCA has not defined specific focus areas, PIP topics will be reviewed and approved by OHCA, with input from the EQRO. PIP proposals will be reviewed to ensure they are relevant and impactful to enrollees and align with OHCA's Quality Strategy goals and objectives. PIP topics may be identified by CMS, the CE, or OHCA and are subject to annual independent validation by the EQRO to ensure compliance with CMS protocols and OHCA's policy, including timeline requirements. Specific PIP topics will be included in future Quality Strategy updates, and approved PIPs will be described in the External Quality Review Annual Technical Report, which will be available on the OHCA website in 2025.

[8] https://hcp-lan.org/apm-framework/

Each PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction, in accordance with 42 C.F.R. § 438.330(d)(2), and must include the following elements:

- Measurement of performance using objective quality indicators;
- Implementation of interventions to achieve improvement in the access to and quality of care;
- Evaluation of the effectiveness of the intervention based on the performance measures collected as part of the PIP; and
- Planning and initiation of activities for increasing or sustaining improvement.

The CEs will report the status and results of each PIP as requested by OHCA, which shall be no less than annually, or as needed. Improvement must be measured through comparison of a baseline measurement and an initial re-measurement following application of an intervention. Annual changes will be evaluated for statistical significance using a 95% confidence interval. Status reports on PIPs may be requested more frequently by OHCA.

Annual External Independent Reviews

In accordance with 42 C.F.R. § 438.350, CEs in every program will undergo an annual, independent External Quality Review (EQR) of timeliness, quality outcomes, and accessibility of services. As previously noted, OHCA has retained the services of KFMC Health Improvement Partners, a qualified External Quality Review Organization (EQRO), in accordance with the qualifications for competence and independence at 42 C.F.R. § 438.354. The current EQRO contract extends to June 30, 2027. KFMC will conduct EQR activities, including all necessary audits and review of information, as well as any additional optional audits and review of information that further OHCA's management and oversight of the SoonerSelect Program. All EQRO-related quality activities will comply with all State and federal regulations, including 42 C.F.R. § 438.358. The CEs shall cooperate fully with the EQRO and demonstrate compliance with managed care and quality standards as set forth in federal regulation and by OHCA.

KFMC will conduct the following mandatory activities in accordance with 42 C.F.R. § 438.358(b):

- Validation of the CEs' Performance Improvement Projects (PIPs) that were underway during the preceding 12 months;
- Validation of the CEs' performance measures required or CE performance measures calculated by the State during the preceding 12 months;
- A review, conducted within the previous three-year period, to determine the CEs' compliance with the standards set forth in 42 C.F.R. Subpart D and the QAPI requirements described at 42 C.F.R. § 438.330; and
- Validation of the CE's Network adequacy during the preceding 12 months.

Additionally, an assessment of the CEs' information system capabilities is conducted as part of the previous mandatory EQR Protocol activities.

At least annually, OHCA will evaluate the need for additional EQR activities and may elect to have KFMC perform one or more of the following optional review activities:

- Validation of encounter data reported by the CEs;
- Administration or validation of Quality of Care surveys;

- Calculation of additional performance measures;
- Implementation of additional PIPs;
- Conducting focus studies of health care quality;
- Assisting with Quality Rating of CEs.

OHCA anticipates obtaining KFMC's assistance with Quality Rating of CEs and encounter data validation during the initial years of SoonerSelect.

The EQRO will produce an annual EQR Technical Report on quality outcomes, including timeliness of services and access to services covered by the SoonerSelect Program. The Technical Report will detail, analyze, and aggregate the data from all activities conducted in accordance with 42 C.F.R. § 438.358. The Technical Report must include:

- The results of the EQR-related activities;
- The EQRO's assessment of each CE's strengths and weaknesses related to quality, timeliness, and access;
- Recommendations for improving the quality of health care services furnished by each CE and recommendations for how the State can target goals and objectives in the State Quality Strategy;
- Methodologically appropriate, comparative information about all CEs; and
- An assessment of the degree to which each CE has addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR.

The information obtained by the SoonerSelect Program EQRO will be obtained consistent with protocols established in 42 C.F.R. § 438.352 and the results made available as specified in 42 C.F.R. § 438.364.

The CEs will participate with the SoonerSelect Program EQRO in various other tasks and projects identified by OHCA to gauge CE performance in a variety of areas, including, but not limited to, care management and treatment of special populations. The CEs will ensure the SoonerSelect Program EQRO has sufficient information to carry out this review. OHCA may also request that the SoonerSelect Program EQRO provide technical assistance to a CE in conducting activities relating to the mandatory and optional activities described in this section.

OHCA has determined that data and results from any Medicare or private accreditation reviews of a CE are not a substitute for the quality improvement and measurement work that OHCA and its EQRO perform with CEs in Oklahoma. Therefore, OHCA will not use the non-duplication of efforts option and does not use information from any Medicare or private accreditation review of a CE to provide information for the annual EQR.

OHCA reserves the right to exempt the CE from the EQR if all conditions of 42 C.F.R. § 438.362(a) and all other relevant State and federal regulations are met and OHCA determines it is the appropriate course of action.

Disparities Plan

The Robert Wood Johnson Foundation's definition of health equity is "that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care." Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health based on characteristics historically linked to discrimination or exclusion (e.g., primary language; race and ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability[9]; sexual orientation; or geographic location). These inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment.

While challenging to address, OHCA is committed to every member reaching their best health possible, as reflected in OHCA's strategic framework that advances health equity through its aims, goals, objectives, programs, interventions, and measures (see Table 2). In addition to efforts regarding population health management, patient-centered and whole-person care, health risk screening, addressing unmet health-related resource needs, and care coordination, Objective 3.4 specifically focuses on promoting health equity. This includes national health equity accreditation requirements for CEs and reporting CMS Health Equity measures.

OHCA requires all CEs, regardless of program, to participate in and support OHCA's efforts to reduce health disparities and to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency, diverse cultural and ethnic backgrounds, and disabilities, regardless of gender, sexual orientation, or gender identity. CEs will develop and implement strategies to address social determinants of health impacting enrollees, which include partnering with community-based social service providers and non-traditional health workers. When selecting CEs, OHCA considered each CE's plan to improve health equity across the state, and CEs were required to identify specific health disparities that present the most potential for improvement. Certain value-added benefits provided by the CEs address barriers to healthcare, such as enhanced transportation benefits.

The CEs will collect and use enrollee-identified race, ethnicity, language, and Social Determinants of Health data to identify, evaluate, and reduce disparities in health care access, services, and outcomes. This includes, when possible, stratifying HEDIS,

[9] OHCA defines disability as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted (or can be expected to last) for a continuous period of not less than twelve (12) months. Disability is determined using available medical records, the Social Security Administration's (SSA) Blue Book, the SSA Compassionate Allowance list, and consultation with OHCA medical experts. https://oklahoma.gov/okdhs/library/policy/current/oac-317/chapter-35/subchapter-5/parts-1/determining-categorical-relationship-to-the-disabled.html

CAHPS, and Health Risk Assessment results by race, ethnicity, language, or other relevant demographics and implementing a strategy to reduce identified disparities.

Consistent with SoonerSelect goals, the CEs shall maintain health equity representatives who are actively involved in improvement initiatives intended to reduce disparities and adverse health outcomes among enrollees. Health equity initiatives will involve obtaining input from enrollees and direct service providers, determining root causes of inequities, developing targeted interventions and measures, and collecting and analyzing data to track progress in disparity reduction efforts.

Furthermore, health plan and CSP CEs must earn the National Committee for Quality Assurance's (NCQA's) Health Equity Accreditation in the State of Oklahoma within two years from the Operation's start date and maintain Health Equity Accreditation throughout the term of their contract. In the future, OHCA will require CE reporting of CMS health equity measures that will be included in Quality Strategy updates.

State Standards for Program Compliance

Provider Network Adequacy Standards and Availability of Services

Oklahoma's CE contracts include robust requirements to ensure that CEs meet federal and State requirements and standards for adequate SoonerSelect enrollee access to covered services. All standards for network adequacy and availability of services are in accordance with the access and network adequacy standards set forth in the applicable federal regulations and should consider the anticipated Medicaid enrollment, expected utilization of services, health needs of the Medicaid population and the number of network providers who are not accepting new Medicaid patients.

All CEs are expected to maintain and monitor a network of appropriate Participating Providers, supported by a signed Provider Agreement that is sufficient to provide adequate access and availability to all covered services for all enrollees, including those with limited English proficiency (LEP) or physical or mental disabilities. The CEs shall provide reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment for Emergency Medical Conditions and shall make arrangements with, or referrals to, a sufficient number of physicians and other practitioners to ensure that the services can be furnished promptly and without compromising the quality of care. In accordance with 42 C.F.R. § 438.14(b)(1), each CE shall demonstrate there are sufficient Indian health care providers (IHCPs) participating in their network to ensure timely access to services available from such providers for American Indian/Alaska Native SoonerSelect enrollees who are eligible to receive services.

The CEs shall provide for a second opinion from a Participating Provider or arrange for the enrollee to obtain a second opinion outside the Network at no cost to the enrollee. If a CE's Provider Network is unable to provide necessary covered services to a particular enrollee, the CE must adequately and timely cover the services out of Network for as long as the CE's provider network is unable to provide them. The CE shall coordinate payment with non-participating providers and ensure the cost to the

enrollee is no greater than it would be if the services were furnished within the Network.

OHCA encourages the appropriate utilization of telehealth services as a mechanism to deliver medically necessary services to enrollees. The CEs shall develop and submit to OHCA policies and procedures that implement telehealth services in accordance with Oklahoma Administrative Code (OAC) 317:30-3-27. The CEs shall, at a minimum, provide education to providers and enrollees about telehealth through the Provider Manual and Enrollee Handbook, respectively.

SoonerSelect health P=plan and CSP CEs are expected to have an adequate network of PCPs, Obstetrics and Gynecology (OB/GYN), specialists, behavioral health, hospital, and pharmacy providers. Additionally, they must demonstrate that their Participating Provider Network includes sufficient family planning providers to ensure timely access to covered services.

Primary Care Providers

PCPs include the following provider types:

a. Physicians licensed in the state where they practice and who are engaged in a general practice or in family medicine, general internal medicine, or general pediatrics;
b. IHCPs;
c. Advanced practice nurses licensed in the state where they practice and have prescriptive authority;
d. Physician assistants licensed in the state where they practice; and
e. Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) provider groups, physicians, advanced practice nurses, and physician assistants who meet the descriptions above and are authorized within their scope of practice under state law to provide these services.

The SoonerSelect health plan and CSP CEs may allow enrollees to select a specialist or subspecialist as a PCP, where medically appropriate and provided that the selected specialist provider is willing to perform all responsibilities of a PCP. If a female enrollee's designated PCP is not a women's health specialist, the CE shall provide the enrollee with direct access to a women's health specialist within the Provider Network for covered routine and preventive women's health care services.

Specialists

The SoonerSelect health plan and CSP CEs will provide enrollees with access to network care for at least the following specialty Provider types:

a. Physician (Medical Doctor [MD]/Doctor of Osteopathy [DO]) specialists and subspecialists to provide specialty care services as required in the benefit package;
b. Anesthesiologist assistants;
c. Audiologists;
d. Nutritionists;
e. Opticians;

f. Optometrists;
g. Podiatrists; and
h. Therapists to provide specialty care services as required in the SoonerSelect health plan or SoonerSelect CSP benefits package.

Behavioral Health Providers

The SoonerSelect health plan and CSP CEs' networks shall include all the following behavioral health Provider types:

a. Acute and residential treatment facilities;
b. Case management and psychosocial rehabilitation services providers;
c. Medication Assisted Treatment providers;
d. Community Mental Health Centers (CMHCs);
e. Certified Community Behavioral Health Clinics (CCBHCs);
f. Inpatient psychiatric hospitals;
g. Licensed behavioral health practitioners;
h. Licensure candidates;
i. Opioid treatment programs;
j. Crisis intervention and crisis stabilization facilities;
k. Behavioral health urgent care clinics;
l. Outpatient behavioral health agencies, clinics and facilities;
m. Programs for Assertive Community Treatment (PACTs);
n. Psychiatrists and psychologists;
o. Outpatient, residential, and medically supervised withdrawal management Substance Use Disorders (SUD) treatment providers; and
p. Therapeutic behavioral services, family support and training and peer recovery support providers.

Hospitals and Essential Community Providers

The SoonerSelect health plan and CSP CE networks shall include a sufficient number and type of hospitals and essential community providers to ensure that enrollees may access a range of covered physical and mental health services in the setting most appropriate for the enrollee's treatment needs.

Hospitals include the following provider types:

a. Disproportionate Share Hospital (DSH) and DSH-eligible hospitals;
b. Children's hospitals;
c. Sole community hospitals;
d. Critical Access Hospitals (CAHs); and
e. Level 1 Trauma Centers.

The CEs shall contract with essential community providers in the CE's service area to the extent possible and practical. If the CE is unable to contract with essential community providers as required below, the CE shall demonstrate to OHCA that both adequate capacity and an appropriate range of services for vulnerable populations

exist to serve the expected enrollment in the CE's service area without contracting with essential community providers.

Essential community providers include the following provider types:

a. FQHCs and RHCs;
b. Family planning providers (Title X family planning clinics and Title X "look-alike[10]" family planning clinics);
c. IHCPs;
d. County health departments or city-county health departments;
e. Government-funded/operated CMHCs/CCBHCs;
f. Government-operated state mental health hospitals;
g. State agencies, including but not limited to Office of Juvenile Affairs (OJA), Oklahoma State Department of Health (OSDH), and Oklahoma Human Services (OHS);
h. Local, regional, and state educational services agencies;
i. Local health departments;
j. Long-Term Care Hospitals Serving Children (LTCHs-C);
k. A teaching hospital owned, jointly owned, or affiliated with and designated by the University Hospitals Authority, University Hospitals Trust, Oklahoma State University Medical Authority, or Oklahoma State University Medical Trust;
l. A provider employed by or contracted with, or otherwise a member of the faculty practice plan of a public, accredited medical school in this State or a hospital/health care entity directly or indirectly owned or operated by the University Hospitals Trust or the Oklahoma State University Medical Trust;
m. A Provider employed by or contracted with a primary care residency program accredited by the Accreditation Council for Graduate Medical Education;
n. A comprehensive community addiction recovery center;
o. A hospital licensed by the State of Oklahoma including all hospitals participating in the Supplemental Hospital Offset Payment Program;
p. CCBHCs; and
q. Other entities certified by CMS as an essential community as specified under 45 C.F.R. §156.235.

Pharmacy Providers

The SoonerSelect health plan and CSP CE Provider Networks shall include a sufficient number of pharmacies to ensure that enrollees have access to all prescription drugs and pharmacy-based medical supplies in the Program benefit package and to meet program access standards. The CEs shall not require as a condition for participation in its pharmacy network any limitations that would exclude independent retail pharmacies. The CE or its pharmacy benefits manager (PBM) shall not steer or require any providers or enrollees to use a specific pharmacy for regular prescriptions, refills, or specialty drugs.

The CEs may utilize mail-order pharmacies in their Participating Provider Network but shall not require or incentivize enrollees to use a mail-order pharmacy, including

[10] https://bphc.hrsa.gov/funding/funding-opportunities/health-center-program-look-alikes#what

through different enrollee cost sharing. Enrollees who elect to use this service must not be charged fees, including postage and handling fees.

Dental Providers

The SoonerSelect Dental CEs are expected to provide and maintain an adequate network of Primary Care Dental Providers (PCD) to ensure that SoonerSelect dental plan enrollees have access to all comprehensive dental services in the benefit package. The CEs shall ensure that each SoonerSelect dental plan enrollee has a PCD provider.

PCD providers include the following Provider types:

a. FQHC and RHC provider groups, dentists and dental specialists who meet the descriptions above and are authorized within their scope of practice under State law to provide these services; and
b. IHCPs.

The dental plan CEs may allow SoonerSelect dental plan enrollees to select a specialist or subspecialist as their PCD provider, where medically appropriate, and provided that the selected specialist provider is willing to perform all responsibilities of a PCD provider.

The Dental CE Participating Provider Network shall include a sufficient number and type of adult and pediatric specialty dental providers to ensure that SoonerSelect dental plan enrollees have access to all specialty dental care services in the SoonerSelect Dental program benefit package and to meet program access standards for adequate capacity.

Any CE may submit a formal written request for a waiver of the distance standards (see Table 3) where there are no Participating Providers within the required driving distance, or the CE is unable to enter into a Provider Agreement with a particular provider type. OHCA will monitor enrollee access to that provider type on an ongoing basis and include the findings to CMS in the managed care program assessment report required under § 438.66.

Table 3. Time and Distance Standards

Provider Type	Urban Distance	Rural Distance	Appointment Time
Adult PCP Pediatric PCP	Within 10 miles of an enrollee's residence	Within 30 miles of an enrollee's residence	a. Not to exceed 30 days from date of the enrollee's request for routine appointment. b. Within 72 hours for non-urgent sick visits. c. Within 24 Hours for urgent care. d. Each PCP shall allow for at least some same-day appointments to meet acute care needs.

Table 3. Time and Distance Standards (Continued)			
Provider Type	**Urban Distance**	**Rural Distance**	**Appointment Time**
OB/GYN	Within 10 miles of an enrollee's residence	Within 45 miles of an enrollee's residence	OB/GYN: a. Not to exceed 30 days from date of the enrollee's request for routine appointment. b. Within 72 hours for non-urgent sick visits. c. Within 24 hours for urgent care. Maternity Care: a. First Trimester – Not to exceed 14 calendar days. b. Second Trimester – Not to exceed seven calendar days. c. c. Third Trimester – Not to exceed three business days
Adult Specialty Pediatric Specialty	Within 15 miles of an enrollee's residence	Within 60 miles of an enrollee's residence	a. Not to exceed 60 days from date of the enrollee's request for routine appointment. b. Within 24 hours for urgent care.
Adult and Pediatric Behavioral Health Adult and Pediatric Substance Use	a. Within 10 miles of an enrollee's residence for outpatient visits b. Within 60 miles of an enrollee's residence for all other treatment settings	a. Within 30 miles of an enrollee's residence for outpatient visits b. Within 90 miles of an enrollee's residence for all other treatment settings	a. Not to exceed 30 days from date of the enrollee's request for routine appointment. b. Within seven days for residential care and hospitalization. c. Within 24 hours for urgent care.
Hospitals	Within 10 miles of an enrollee's residence	Within 45 miles of an enrollee's residence	Not applicable
Essential Community Providers	Within 10 miles of an enrollee's residence	Within 45 miles of an enrollee's residence	Not specified
Adult PCD Pediatric PCD	Within 20 miles of an enrollee's residence	Within 60 miles of an enrollee's residence	a. Not to exceed 30 days from date of the enrollee's request for routine appointment. b. Within 24 hours for urgent care. c. Each PCD shall allow for at least some same-day appointments to meet acute care needs.
Dental Specialist	Within 25 miles of an enrollee's residence	Within 60 miles of an enrollee's residence	a. Not to exceed 60 days from date of the enrollee's request for routine appointment. b. Within 24 hours for urgent care.
Pharmacy Distance			
Urban Service area, meaning a five-digit zip code in which the population density is greater than 3,000 individuals per square mile	**Suburban Service Area,** meaning a five-digit zip code in which the population density is between 1,000 and 3,000 individuals per square mile	**Rural service area,** meaning a five-digit zip code in which the population density is less than 1,000 individuals per square mile	
At least 90% of enrollees reside within two miles of a retail pharmacy participating in the PBM's retail pharmacy network	At least 90% of enrollees reside within five miles of a retail pharmacy in the PBM's retail pharmacy network	At least 70% of enrollees reside within 15 miles of a retail pharmacy in the PBM's retail pharmacy network	

Clinical Practice Guidelines

Development and dissemination of Clinical Practice Guidelines by the CEs, as detailed below, ensures the promotion of evidence-based care and that CE decisions and enrollee education are consistent with up-to-date standards, requirements for evidence-based practices, and community practice standards in the state.

Pursuant to 42 C.F.R. § 438.236, the SoonerSelect health plan and CSP CEs shall adopt physical and behavioral health Clinical Practice Guidelines that meet the following requirements:

- Are based on current, valid and reliable clinical evidence or a consensus of health care professionals in the field, such as federal guidelines (e.g., the United States Preventive Services Taskforce or Centers for Disease Control and Prevention recommendations, and the Advisory Committee on Immunization Practices) or specialty society guidelines;
- Consider the needs of enrollees in each of the eligibility groups enrolled with the CE;
- Are adopted in consultation with Participating Providers; and
- Are reviewed and updated as needed or at least every two years.

The SoonerSelect Dental CEs shall adopt oral health guidelines meeting the same four requirements. Guidelines from the American Academy of Pediatric Dentistry is an example of a national consensus of health care professionals.

The CEs shall ensure decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply must be consistent with the guidelines. The CEs shall coordinate the development of Clinical Practice Guidelines with each other to avoid the possibility that Providers receive conflicting Clinical Practice Guidelines from different CEs. The CEs shall disseminate Clinical Practice Guidelines to all affected Participating Providers and, upon request, to enrollees or eligibles. The CEs shall include the Clinical Practice Guidelines within Provider Agreements and measure provider compliance with Clinical Practice Guidelines.

Provider Selection, Credentialing and Recredentialing

The CEs are required to develop and utilize a standardized approach to contracting with Providers for participation in the CE's Participating Provider Network.

In accordance with 42 C.F.R. §§ 438.12(a)(2) and 438.214(c), the CEs' written policies and procedures on Participating Provider selection, retention and termination shall not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment.

The CEs shall conduct background checks and similar activities as required under State and federal law, including querying the National Practitioner Data Bank, on all providers before entering into a Provider Agreement with the provider. The CE may not knowingly have an individual or affiliate, as defined in the Federal Acquisition Regulation (FAR) at 48 C.F.R. § 2.101, who has been debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from

participating in non-procurement activities under regulations issued under Executive Order No. 12549, appearing at 51 FR 6370, or under guidelines implementing Executive Order No. 12549.

All SoonerSelect health plan and Children's Specialty Program CEs will align and utilize the same single Credential Verification Organization (CVO) that is certified by an approved accrediting organization and approved by OHCA as part of its provider credentialing and recredentialing process. All SoonerSelect Dental CEs will also align and utilize a single CVO meeting the same requirements. The CVO will facilitate the provider enrollment process, including the collection and verification of provider education, training, experience, and competency. The CVO will be responsible for receiving completed applications, attestations, and primary source verification documents. The CEs' credentialing and re-credentialing processes will be consistent with recognized managed care industry standards and comply with relevant State and federal regulations relating to provider credentialing and notice.

Confidentiality

All enrollee information is regarded as confidential information, and OHCA requires CEs to ensure that personal health information is protected and disclosed only as permitted or required. The CEs are not to release the information governed by laws and regulations to any other person or entity without the approval of OHCA or as required by law or court order. OHCA requires the CEs to implement, maintain, and document appropriate technical, physical, and administrative safeguards and comply with 45 C.F.R. Part 164 with respect to electronic protected health information (PHI) to prevent use or disclosure of PHI other than as provided for by contract with OHCA. CEs are expected to protect the confidentiality, integrity, and availability of PHI that they create, receive, maintain or transmit for or on behalf of OHCA in accordance with the Health Information Portability and Accountability Act (HIPAA) Rules. Members are notified of their privacy rights under HIPAA through the Enrollee Handbook, which will be available on each CE's website. CEs shall provide training to all employees, agents, and subcontractors in HIPAA to protect OHCA's PHI and prevent, detect, contain, and correct security violations in accordance with the HIPAA Rules. A CE must report any breach of confidentiality to OHCA immediately and take immediate corrective action. Additionally, beneficiaries must be notified of any inappropriate disclosures as required by law and defined by OHCA.

Health Information Technology

All CEs, regardless of program, will maintain a Management Information System (MIS) in full compliance with all requirements of the HIPAA, requirements set forth in the Health Information Technology for Economic and Clinical Health (HITECH) Act, § 6504(a) of the Affordable Care Act and all other applicable State and federal laws and regulations.

The CEs' information systems shall collect, analyze, integrate, and report data as set forth by OHCA. The CEs will make all information and data collected by their information system available (in a usable format specified) to OHCA and, upon request, to CMS. The CEs shall ensure that its MIS is compliant with any future State or

Federal regulations and shall collect and submit all data required for Transformed Medicaid Statistical Information System (T-MSIS) reporting and other CMS-required reporting.

CEs shall also be required to demonstrate sufficient data analysis and ability to interface with OHCA systems. The CEs shall ensure medical information will be kept confidential at all times, through security protocol, and with heightened sensitivity as data relates to personal identifiers and sensitive services.

As required by OHCA, the CEs will participate in the State Designated Entity for Health Information Exchange (SDE-HIE) for submission of encounter data and exchange of clinical information. This will improve the quality and efficiency of health care delivery in numerous ways, including reducing medical errors, decreasing duplicative or unnecessary services, improving data quality for public health research, promoting population health management, reducing manual, labor-intensive monitoring and oversight, and reducing Fraud and Abuse.

The CEs will develop, implement, and participate in Health Information and Technology (HIT) and data-sharing initiatives to improve the quality, efficiency, and safety of health care delivery in the State. The CEs may assign staff to participate in the governance of the SDE-HIE. The purpose of this participation is to enhance the data submission requirements and improve the accuracy, quality, and completeness of the encounter data submission to the SDE-HIE.

Enrollment and Disenrollment

OHCA has sole authority for determining eligibility for SoonerCare and determining whether an eligible can be enrolled in a SoonerSelect program. OHCA, or its designee, will be responsible for educating eligibles about the SoonerSelect programs and providing unbiased Choice Counseling concerning enrollment options. Choice Counseling will be available at the time of initial enrollment, during the annual open enrollment period and under the provisions of the disenrollment request process. OHCA will provide notice to prospective enrollees regarding the CE selection process and the importance of selecting in accordance with informational and timing requirements as specified in 42 C.F.R. § 438.54. OHCA, at its discretion, may allow up to 60 days for SoonerSelect eligibles to select a CE prior to the enrollee's start of coverage. Subsequent to program implementation, SoonerCare applicants eligible for any SoonerSelect program will have an opportunity to select a CE on their application. Eligibles who do not make an election within the allowed timeframe will be assigned to a CE. Applicants who are eligible to choose a CE and fail to make an election on the SoonerCare application will be assigned to the CE that is due next to receive an auto assignment, considering quality weighted assignment factors. Once assigned to an initial CE, the enrollee shall have 90 calendar days to request a transfer to another CE. OHCA reserves the right to modify the auto-assignment algorithm at any time. It is OHCA's intent to modify the assignment algorithm in future years to take into consideration the CEs' performance in improving health outcomes.

A CE may not refuse an assignment or otherwise discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation,

gender identity, or disability and may not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability. A CE also may not discriminate against an enrollee based on expectations that the enrollee will require frequent or high-cost care, or on the basis of health status or need for health care services, or due to an adverse change in the enrollee's health. The CEs shall accept individuals eligible for enrollment in the order in which they are enrolled (unless otherwise authorized by CMS) up to the limits set by OHCA.

A CE may not request disenrollment because of a change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from their special needs, except when their continued enrollment with the CE seriously impairs the CE's ability to furnish services to either the enrollee or another enrollee. A CE may request disenrollment of members if there is sufficient documentation or evidence of fraud, forgery, or unauthorized use/abuse of services by the member.

Enrollees will be permitted to change CEs, without showing cause, during their first 90 days of enrollment with a CE, or during the 90 days following the date OHCA sends the enrollee notice of that enrollment, whichever is later. Enrollees will also be permitted to change CEs, without cause, during the annual Open Enrollment period. After the enrollee's period for disenrollment from the CE has lapsed, enrollees will remain enrolled with the CE until the next Open Enrollment period unless:

a. The enrollee is disenrolled due to loss of SoonerCare eligibility;
b. The enrollee becomes a foster child under custody of the State;
c. The enrollee becomes Juvenile Justice-Involved under the custody of the State;
d. The enrollee is a Child in Foster Care or Child Receiving Adoption Assistance and opts to enroll in the SoonerSelect Children's Specialty Program;
e. The enrollee demonstrates cause;
f. A temporary loss of eligibility or enrollment has caused the enrollee to miss the annual disenrollment period, then the enrollee may disenroll without cause upon reenrollment; or
g. OHCA imposes Intermediate sanctions on the CE and allows enrollees to disenroll without cause.

An enrollee may initiate a request for disenrollment from a CE if the CE does not cover needed services because of moral or religious objections, because the member requires related services to be delivered at the same time as determined by the member's PCP or other provider that are not available with the CE, and due to lack of access to covered benefits and services, quality care or appropriately experienced providers.

Enrollees shall seek redress through the CE's grievance process before OHCA will make a determination on an enrollee's request for disenrollment. The CEs shall accept enrollee requests for disenrollment orally or in writing and complete a review of the request within 10 days of the enrollee filing the grievance. If the enrollee remains dissatisfied with the result of the grievance process, the CE shall refer the

disenrollment request to OHCA and send records gathered during the grievance process to OHCA to facilitate OHCA's decision-making process.

Transitions of Care

OHCA strives to ensure a continuum of care approach to enrollees and will monitor the development and maintenance of effective continuity of care activities by the CEs.

The CEs are required to take all necessary steps to ensure continuity of care when enrollees transition from one CE to another CE or SoonerCare program, including the initial program implementation. The CEs shall ensure that established enrollee and Provider relationships, current services and existing prior authorizations (PAs) and care plans will remain in place during the 90-day Continuity of Care period. Transition to a new CE shall be as seamless as possible for enrollees and their providers.

The CEs shall take special care to provide continuity of care for new enrollees who have physical health conditions, behavioral health conditions and/or functional needs and are under the care of existing treatment providers and whose health could be placed in jeopardy, or who could be placed at risk of hospitalization or institutionalization, if covered services are disrupted or interrupted.

The CEs shall make transition of care (TOC) policies available to enrollees and potential enrollees and provide instructions on how to access continued services during the Continuity of Care period. This information shall be available, at minimum, in the Enrollee Handbook, new enrollee materials and via enrollee call center representatives. Language used in all forms of communication shall conform with requirements specified in 42 C.F.R. § 438.10.

The CEs shall ensure that all enrollees are held harmless by providers for payment for any existing covered services, other than required cost sharing, during the Continuity of Care period.

The CEs shall implement a TOC policy that, at a minimum, is consistent with the requirements in 42 C.F.R. § 438.62(b)(1) and at least meets OHCA's defined TOC policy. The CEs shall have additional TOC policies and procedures that include at least the following:

a. A schedule that ensures that the transition does not create a lapse in service;
b. A process for timely information exchange (including transfer of an enrollee record, including the enrollee's care plan as applicable based on the CE assignment in accordance with its Risk Stratification Level Framework);
c. A process for assuring confidentiality;
d. A process for allowing enrollees to request and be granted a change of provider;
e. An appropriate schedule for transitioning enrollees from one provider to another when it is medically necessary for ongoing care, including a process for ensuring the enrollee's new provider(s) are able to obtain copies of the enrollee's medical records, as appropriate and consistent with federal and State law;

f. A process for transitioning enrollees from one care setting to another; and
g. A process for transitioning enrollees from or to another CE.

When an enrollee transitions between CEs, the new CE is responsible for making a request to the surrendering CE for any data that will facilitate a seamless transition. When a CE receives requests from another CE for transition information on a former enrollee, the CE shall transmit the information within five days for data that is available electronically, and within 30 days for data that is not stored electronically.

CEs shall ensure all PAs for covered benefits are in place on the day prior to the enrollee's enrollment with the CE and remain in place for 90 days following an enrollee's enrollment. This requirement applies during both initial program implementation and Steady State Operations. During the 90-day Continuity of Care period, PAs may not be denied on the basis that the authorizing provider is not a Participating Provider. Payment to non-participating providers shall be made at the current Medicaid fee schedule rate and in accordance with OHCA's payment timeliness standards during the Continuity of Care period.

Notwithstanding the foregoing requirement to honor existing PAs for 90 days, the CEs shall have additional procedures in place that address the continuity of care needs of at least the following populations:

a. Pregnant Women for continuation of medically necessary prenatal care services, delivery, and postnatal care, through follow-up checkups within 12 weeks of delivery;
b. Enrollees receiving chemotherapy or radiation treatment, dialysis, major organ or tissue transplant services, bariatric surgery, Synagis® treatment, medications for Hepatitis C treatment or who are terminally ill;
c. Children receiving private duty nursing services.

CEs shall allow enrollees with an existing relationship with a non-participating provider to retain that provider during and after transition to the CE. The CE shall continue to pay an enrollee's existing providers until such time as the CE can reasonably transfer the enrollee to a Participating Provider without impeding service delivery necessary to the enrollee's health or to prevent hospitalization or institutionalization. In the event there is no Participating Provider available who meets the enrollee's needs, the CE shall allow the enrollee to retain their current provider until either the current provider becomes a Participating Provider or a Participating Provider who meets the enrollee's needs becomes available.

Grievance System Standards

In accordance with 42 C.F.R. §§ 438.402, 438.228(a), and 438.228(b), each CE, regardless of program, shall operate an enrollee Grievance and Appeal System to handle appeal of an Adverse Benefit Determination and Grievance, as well as the processes to collect and track information about them. At all times, the enrollee Grievance and Appeal System shall comply with the requirements in all applicable State and federal laws, regulations, and sub-regulatory guidance or policies required by OHCA. An enrollee, Provider, or Authorized Representative acting on behalf of the enrollee as permitted by State law, may file a grievance or appeal with a CE orally or in

writing. The CE must ensure an oral request seeking to appeal an Adverse Benefit Determination is treated as an appeal and shall allow the enrollee to file an appeal to the CE within 60 calendar days from the date on the Adverse Benefit Determination notice. The CE shall acknowledge receipt of each grievance and appeal of an Adverse Benefit Determination in accordance with 42 C.F.R. § 438.406(b)(1).

The CE shall resolve each grievance or standard appeal and provide notice, as expeditiously as the enrollee's health condition requires, which shall be within 30 calendar days from the date the CE receives the grievance or appeal. The CE must have an expedited appeal process for cases in which the CE determines, or when the Provider, as the enrollee's Authorized Representative, indicates that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. The CE shall resolve each expedited appeal and provide notice, as expeditiously as the enrollee's health condition requires, which shall be within 72 hours from the date the CE receives the expedited appeal. The grievance or appeal resolution timeframe may be extended by the CE by up to an additional 14 calendar days if the enrollee or Provider acting as Authorized Representative requests an extension, or the CE shows to the satisfaction of OHCA, upon request, that there is a need for additional information and how the delay is in the enrollee's interest.

If the CE extends the timeframe for resolution of a grievance or appeal and such extension was not at the request of the enrollee, the CE must make reasonable efforts to give the enrollee prompt oral notice of the delay and give the enrollee written notice of the reason for the decision to extend the timeframe within two calendar days and inform the enrollee of the right to file a Grievance if the enrollee disagrees with that decision. An appeal must be resolved as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

The CE shall provide written notice of resolution of a grievance or appeal to the impacted enrollee within three calendar days of the resolution. OHCA will establish the content that must be included in the notice. For appeals not resolved wholly in favor of the enrollee, the notice shall include at least the following:

a. The right to request a State Fair Hearing;
b. How to request a State Fair Hearing;
c. The right to request and receive continuation of benefits while the State Fair Hearing is pending;
d. How to request the continuation of benefits while the State Fair Hearing is pending; and
e. Notice that the enrollee may, consistent with OHCA policy, be held liable for the cost of those benefits if the State Fair Hearing decision upholds the CE's Adverse Benefit Determination.

The CE shall provide information about the Grievance and Appeal System and State Fair Hearing procedures and timeframes to enrollees or the enrollee's Authorized Representative, providers, and subcontractors consistent with all applicable State and federal laws, regulations, OHCA policy, and guidance.

The CEs shall ensure that all notices related to Grievance and Appeal are available in a format and language that, at a minimum, meet the requirements of 42 C.F.R. § 438.10,

including taglines in each State-established prevalent non-English language as well as large print explaining the availability of written translations or oral interpretation to understand the information provided and the toll-free and Teletypewriters/Telecommunications for the Deaf (TTY/TDD) telephone number of the entity providing customer service. Auxiliary aids and services will be made available upon request at no cost.

The CEs' Grievance and Appeal Systems shall include provision of reasonable assistance to enrollees in completing Grievance or Appeal forms and taking other procedural steps related to the Grievance or Appeal. The CE's reasonable assistance to the enrollee shall include, at minimum, availability of enrollee care support staff and auxiliary aids and services upon request.

Grievance, Appeal, and State Fair Hearing procedures and timeframes, consistent with 42 C.F.R. Subpart F, shall be included in the Enrollee Handbook, as well as communicated to all providers and subcontractors.

At minimum, this information shall include:

a. Enrollee Grievance, Appeal, and State Fair hearing procedures and timeframes as defined by OHCA;
b. The enrollee's right to file Grievance and Appeal and the requirements and timeframes for filing;
c. The availability of assistance to the enrollee with filing Grievance and Appeal;
d. The enrollee's right to request a State Fair Hearing after the CE has made a determination on an enrollee's Appeal which is adverse to the enrollee; and
e. The enrollee's right to request continuation of benefits the CE seeks to reduce or terminate during an Appeal or State Fair Hearing filing, if filed within allowable timeframes. The enrollee may be liable for the cost of any continued benefits while the Appeal or State Fair Hearing is pending if the final decision upholds the CE's determination that is adverse to the enrollee.

At a minimum, the CE shall include information on the Grievance and Appeal System in applicable enrollee written notifications, Enrollee Handbook, Provider Manual, provider and subcontractor contracts with the CE, provider and subcontractor training materials and any other materials as required by State or federal laws, regulations and OHCA.

In accordance with the requirements of 42 C.F.R. § 438.402, the CE's Grievance and Appeal System shall:

a. Have only one level of Appeal for enrollees;
b. Allow an enrollee to file a Grievance and request an Appeal with the CE, with the ability for the enrollee to request a State Fair Hearing before OHCA after receiving notice that the Adverse Benefit Determination is upheld;
c. Allow an enrollee to file a Grievance with the CE, either orally or in writing, at any time; and
d. Provide that an enrollee, upon receiving notice of an Adverse Benefit Determination, shall have 60 days from the date on an Adverse Benefit

Determination notice in which to file a request for an Appeal to the CE, which may be filed either orally or in writing.

The CEs shall ensure that individuals making grievance and appeals determinations have the appropriate expertise to make such determinations, and were not involved in, nor a subordinate of any individual involved in any previous level of review or decision-making. The decision-makers shall consider all comments, documents, records, and other information submitted by the enrollee or the enrollee's Authorized Representative without regard to whether such information was submitted or considered by the CE in the initial Adverse Benefit Determination, and without regard as to its admissibility in a court of competent jurisdiction. The CE shall also provide the enrollee a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The CE must inform the enrollee of the limited time available for this sufficiently in advance of the resolution timeframes for Appeal and Expedited Appeal. The CE shall provide the enrollee their case file, including all medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the CE, or at the CE's direction, in connection with the appeal of the Adverse Benefit Determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframes for appeal and expedited appeal.

The CEs shall maintain records of all Grievances and Appeals and shall review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to OHCA's Quality Strategy. The CEs shall accurately maintain the records in a manner accessible to OHCA and available upon request to CMS. Except as is established by OHCA, the CEs shall produce records to OHCA staff no later than three business days after the date of request, in the format (electronic or hard copy) requested. The record of each Grievance or Appeal shall contain, at minimum, the following:

a. A general description of the reason for the Grievance or Appeal;
b. Date the Grievance or Appeal request was received by the CE;
c. Date of each review or, if applicable, review meeting;
d. Resolution at each level of the Grievance or Appeal, if applicable;
e. Date of resolution at each level, if applicable; and
f. Name of the enrollee for whom the Grievance or Appeal was filed.

An enrollee may request a State Fair Hearing only after receiving notice from the CE upholding an Adverse Benefit Determination. The enrollee shall have 120 calendar days from the date of the Adverse Benefit to request a State Fair Hearing. Enrollees will have the right to request a continuation of benefits while the appeal is pending.

Subcontracting Standards

A CE in any program may enter into written subcontracts for performance of certain responsibilities. All subcontracts must be in writing and fulfill the requirements of 42 C.F.R. §§ 438.230 and 438.3(k) that are appropriate to the service or activity being delegated. The CE shall actively monitor subcontractors to ensure their compliance with State and federal standards and verify the quality of their services.

The CE shall provide OHCA written notice at least 30 days in advance of any contractual changes in subcontracted services. Notice of these changes shall describe how the CE will notify enrollees and Providers, as applicable, of the change and how the CE will maintain continuity of care for those affected enrollees. At its discretion, OHCA may elect to conduct a Readiness Review of the CE and/or subcontractor(s) pursuant to a change in subcontracted services. The CE shall provide immediate notice to OHCA of any action or suit filed, including a bankruptcy filing, and of any claim made against the CE or its subcontractor(s) that, in the opinion of the CE, may result in litigation.

In accordance with 42 C.F.R. § 438.602(i), a CE may not enter into any subcontract for the performance of any duty under their contract with OHCA in which such services are to be transmitted or performed outside of the United States.

Care Management Standards

SoonerSelect health plan and CSP CEs operate a care management and population health model with an approach that is person-centered and holistically identifies and addresses the physical health, behavioral health and community and social support needs of the enrollees. The approach includes interventions that address OHCA clinical and quality improvement focus areas, including, but not limited to:

a. Opioid and other substance use disorders (SUDs);
b. Tobacco cessation;
c. Childhood obesity;
d. Behavioral health;
e. Diabetes;
f. Cardiovascular disease;
g. Prenatal care and postpartum outcomes;
h. Children receiving private duty nursing services;
i. Children in out-of-home placements;
j. Access to preventive health services;
k. Enrollee health literacy; and
l. Other emerging health trends among the SoonerCare population at the direction of OHCA or identification by the CE.

CEs shall develop a Health Risk Screening tool and Risk Stratification Level Framework, both subject to approval by OHCA. Each enrollee will receive a Health Risk Screening within 90 days of program enrollment during SoonerSelect implementation and within 30 days during Steady State Operations. Reassessments should occur with any change in enrollee health status. The Risk Stratification Level Framework determines the intensity and frequency of care management and population health interventions received by enrollees. The CE's Risk Stratification Level Framework shall determine the appropriate level of care management and population health intervention for each enrollee based on assessed needs, as determined through Health Risk Screenings, comprehensive assessments, predictive modeling, claims review, physician referrals and enrollee and caregiver requests.

The CEs will assign every enrollee to a risk level and deliver interventions in an amount, duration and scope based on its Risk Stratification Level Framework. The CE Risk Stratification Level Framework shall consider factors such as:

a. Acuity of any diagnosed health conditions;
b. Behavioral health diagnoses;
c. SUD diagnoses;
d. Pregnancy status and maternal risk factors;
e. Inpatient or emergency department utilization; and
f. Social Determinants of Health.

The CEs evaluate enrollees for needed changes in intensity and frequency of care management and population health interventions when there is a significant change in the enrollee's needs or circumstances, or progress in meeting care plan goals.

Dental plan, health plan, and CSP CEs will leverage, coordinate, or engage with local Oklahoma provider organizations, local provider groups, and community agencies delivering Care Coordination or case management to enrollees to minimize duplication and ensure collaboration with other entities delivering these services.

Special Health Care Needs and Long-Term Support Services

As previously noted, SoonerCare members receiving LTSS and HCBS are excluded from the SoonerSelect program and will receive services under FFS. If a CE identifies an enrollee needs LTSS, they are required to notify OHCA immediately for OHCA to support their LTSS needs.

OHCA defines members with Special Health Care Needs (SHCN) as individuals who have or are at risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health or related services of a type and amount beyond that generally required. Members with SHCN can be identified through the health plan or CSP CEs' Health Risk Screening tool or by OHCA through responses to health status screening questions on the SoonerCare eligibility application. The CEs are expected to conduct a comprehensive assessment on these enrollees and incorporate the findings into their Risk Stratification Level Framework to inform the level of care management for those individuals.

All enrollees with SHCN will have a care plan in place that is accessible to the enrollee's providers in real time. The care plan should be developed to support strength-based goals and health and functional outcome improvements. The care plan should be reviewed and revised at least annually, upon enrollee request, or when the enrollee's circumstances or needs change significantly. All CEs, including dental plans, will implement a mechanism to ensure enrollees with SHCN can directly access a specialist as appropriate for their conditions and identified needs. All CEs, regardless of program, are expected to assess the quality and appropriateness of care provided to enrollees with SHCN in their QAPI.

Sanctions

OHCA may impose any or all sanctions, including requiring a CE to take remedial action, imposing intermediate sanctions, and/or assessing liquidated damages due to non-compliance with contract requirements or applicable federal or state laws.

In accordance with 42 C.F.R. §§ 438.700(b), 438.726, 438.730(e), and Section 1903(m)(5)(B)(ii) of The Act, OHCA may establish Intermediate Sanctions if it determines that a CE in any program:

a. Fails substantially to provide medically necessary services that the CE is required to provide, under law or under its contract with OHCA, to an enrollee covered under the Contract;
b. Imposes on enrollee premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program;
c. Acts to discriminate among enrollees on the basis of their health status or need for health care services;
d. Misrepresents or falsifies information that it furnishes to CMS or to OHCA; or
e. Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or provider.

In accordance with 42 C.F.R. § 438.702, OHCA may impose the following Intermediate Sanctions:

a. Civil money penalties in the amounts specified in 42 C.F.R. § 438.704;
b. Grant enrollee(s) the right to terminate enrollment without cause and notifying the affected enrollees of their right to disenroll;
c. Suspend all new enrollment of enrollee(s), including default enrollment, after the date OHCA notifies the CE of a determination of a violation of any requirement under § 1903(m) or § 1932 of The Act;
d. Suspend or recoup Capitation Payments to the CE for enrollees enrolled after the effective date of the sanction and until OHCA is satisfied that the reason for imposition of the sanction no longer exist and is not likely to recur;
e. Impose additional sanctions provided for under State statutes or regulations to address noncompliance; and
f. Appoint temporary management if OHCA has determined:
    i. There is continued egregious behavior by the CE;
    ii. There is substantial risk to enrollee health; or
    iii. The sanction is necessary to ensure the health of the CE's enrollees while improvements are made to remedy violations that require sanction, or until there is an orderly termination or reorganization of the CE.

OHCA must apply temporary management if it finds the CE has repeatedly failed to meet substantive requirements in 42 U.S.C. §§ 1396b(m) or 1396u-2(e)(2). OHCA may not delay the imposition of temporary management to provide a hearing. OHCA will not terminate temporary management until it determines, at its sole discretion that the CE can ensure the non-compliant behavior will not recur.

When temporary management is imposed, OHCA will notify and grant enrollees the right to terminate enrollment with the CE without cause. If temporary management

is imposed, the CE shall cooperate fully in the transition process to ensure any disruption to enrollees and providers is minimized.

OHCA or its designees shall have full and exclusive power of management and control of the CE as necessary to ensure the uninterrupted care to enrollees pending the CE's termination from the SoonerSelect Program or remedying of the underlying deficiency. OHCA has the authority to hire staff, execute any instrument in the name of the CE and to commence, defend and conduct in its name any action or proceeding in which the CE may be a party during the temporary management period.

The CE shall be responsible for all reasonable expenses related to the direct operation of the SoonerSelect Program, including but not limited to attorney fees, cost of preliminary or other audits of the CE and expenses related to the management of any office or other assets of the CE.

This area intentionally left blank

Appendix A

SoonerSelect Quality Strategy

Performance Measures

Aim 1: Improve the health of Oklahoma Medicaid members and the health of Oklahoma communities and State as a whole

Goal 1. Promote wellness and prevention

Table A.1 describes the quality measures for the assessment of Goal 1.

Table A.1. Wellness and Prevention Measures							
Indicator	Measure Steward	Contracted Entity Type	Indicator Description		Performance Target	Baseline Data	Comparison with Benchmark or Selected Measure
			Denominator	Numerator			
Objective 1.1: Promote child health, development, and wellness							
Child and Adolescent Well Care Visits Total (WCV) Child CMS Core Set (CH)	NCQA (National Quality Forum [NQF] 1516)	Health plan and CSP	Members, ages 3 to 21 years	Members, 3 to 21 years, who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year	Will establish specific targets after first year's baselines.	2021 Rate: 37.1%	NCQA Quality Compass
Developmental Screening in the First Three Years of Life (DEV-CH).	Oregon Health and Science University (OHSU) (NQF 1448)	Health plan and CSP	Children who turn 1, 2, or 3 years of age between January 1 and December 31 of the measurement year (Children who are enrolled continuously for 12 months prior to the child's 1st, 2nd, or 3rd birthday).	Children who were screened for risk of developmental, behavioral, and social delays using a standardized tool, in the 12 months preceding first, second, or third birthday.		2021 Rate: Age 1 year: 23.9% Age 2 years: 30.6% Age 3 years: 28.9% Total: 27.8%	CMS
Lead Screening in Children (LSC-CH)	NCQA	Health plan and CSP	Members, age 2 years	Members 2 years of age who had one or more lead blood tests performed for lead poisoning by their second birthday.		2021 Rate: Total: 43.7%	NCQA Quality Compass

Table A.1. Wellness and Prevention Measures (Continued)							
Indicator	Measure Steward	Contracted Entity Type	Indicator Description		Performance Target	Baseline Data	Comparison with Benchmark or Selected Measure
			Denominator	Numerator			
Objective 1.1: Promote child health, development, and wellness (Continued)							
Contraceptive Care - All women 15 to 20 years (CCW-CH)	Office of Population Affairs (OPA) (NQF 2903/2904)	Health plan and CSP	Women ages 15 to 20 at risk of unintended pregnancy (defined as those that have ever had sex, are not pregnant or seeking pregnancy, and are fecund)	Women ages 15 to 20 at risk of unintended pregnancy who were provided a most effective or moderately effective Food and Drug Administration (FDA) approved method of contraception.		2021 Rate: 28.4%	CMS
			Women ages 15 to 20 at risk of unintended pregnancy (defined as those that have ever had sex, are not pregnant or seeking pregnancy, and are fecund)	Women ages 15 to 20 at risk of unintended pregnancy who were provided a long-acting reversible method of contraception (LARC)		2021 Rate: 3.3%	CMS
Chlamydia Screening in Women Ages 16 to 20 (CHL-CH)	NCQA (NQF 0033)	Health plan and CSP	Women, ages 16 to 20	Women ages 16 to 20 who were identified as sexually active and who had at least one test for chlamydia during the measurement year.		2021 Rate: 31.2%	NCQA Quality Compass
Screening for Depression and Follow-Up Plan: Ages 12 to 17 years (CDF-CH)	CMS (NQF 0418/0418e)	Health plan and CSP	Members, age 12 to 17 with at least one eligible encounter	Members ages 12 to 17 who were screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the eligible encounter.		2021 Rate: 1.0%	CMS

Table A.1. Wellness and Prevention Measures (Continued)							
Indicator	Measure Steward	Contracted Entity Type	Indicator Description		Performance Target	Baseline Data	Comparison with Benchmark or Selected Measure
			Denominator	Numerator			
Objective 1.1: Promote child health, development, and wellness (Continued)							
1st well-care visit within 30 days of initial entry into Foster Care	State-Defined Measure	CSP		CE to have care coordinators review visits happen within 30 days and following up with those not having visits		New OHCA measure	Annual State Comparison
Appropriate number of well care visits for their age during Foster Care	State-Defined Measure	CSP		CE to have care coordinators review visits		New OHCA measure	Annual State Comparison
Care coordination letters at foster home changes	State-Defined Measure	CSP		CE to send care coordination letters at foster home changes		New OHCA measure	Annual State Comparison
Objective 1.2: Promote women's health							
Breast Cancer Screening (BCS) Adult CMS Core Set (AD)	NCQA (NQF 2372)	Health plan	Women, 50–74 years of age	Women 50–74 years of age who had at least one mammogram to screen for breast cancer in the past two years		2021 Rate: 50 to 64 years: 31.3% 65 and older: 28.6%	NCQA Quality Compass
Cervical Cancer Screening (CCS-AD)	NCQA (NQF 0032)	Health plan and CSP	Women, 21–64 years of age	Women 21–64 years of age who were screened for cervical cancer using any of the following criteria: • Women 21–64 years of age who had cervical cytology performed within the last 3 years. • Women 30–64 years of age who had		2021 Rate: 37.5%	NCQA Quality Compass

Table A.1. Wellness and Prevention Measures (Continued)							
Indicator	Measure Steward	Contracted Entity Type	Indicator Description		Performance Target	Baseline Data	Comparison with Benchmark or Selected Measure
			Denominator	Numerator			
Objective 1.2: Promote women's health (Continued)							
				cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years. • Women 30–64 years of age who had cervical cytology/hrHPV cotesting within the last 5 years.			
Chlamydia Screening in Women Ages 21 to 24 (CHL-AD)	NCQA (NQF 0033)	Health plan and CSP	Women, ages 21 to 24	Women ages 21 to 24 who were identified as sexually active and who had at least one test for chlamydia during the measurement year.		2021 Rate: 43.4%	NCQA Quality Compass
Contraceptive Care — All Women Ages 21 to 44 (CCW-AD)	OPA (NQF 2903/2904)	Health plan and CSP	Women ages 21 to 44 at risk of unintended pregnancy (defined as those that have ever had sex, are not pregnant or seeking pregnancy, and are fecund)	Women ages 21 to 44 at risk of unintended pregnancy who were provided a most effective or moderately effective FDA approved method of contraception.		2021 Rate: 22.6%	CMS
			Women ages 21 to 44 at risk of unintended pregnancy (defined as those that have ever had sex, are not pregnant or seeking pregnancy, and are fecund)	Women ages 21 to 44 at risk of unintended pregnancy who were provided a long-acting reversible method of contraception (LARC)		2021 Rate: 4.0%	CMS

Table A.1. Wellness and Prevention Measures (Continued)							
Indicator	Measure Steward	Contracted Entity Type	Indicator Description		Performance Target	Baseline Data	Comparison with Benchmark or Selected Measure
			Denominator	Numerator			
Objective 1.3: Promote preventive health in adults							
Colorectal Cancer Screening (COL-AD)	NCQA (NQF 0034)	Health plan	Members 50-75 years of age with a visit during the measurement period	Members with one or more screenings for colorectal cancer		2022 Rate: 50 to 64 years: 39.6% 65 to 75 years: 39.2%	NCQA Quality Compass
Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD)	NCQA (NQF 0039) CAHPS Health Plan Survey	Health plan	Members, 18–64 years of age	Adults 18–64 years of age who report receiving an influenza vaccination between July 1 of the measurement year and the date when the CAHPS survey was completed.		2021 Rate: 45.1%	NCQA Quality Compass
Screening for Depression and Follow-up Plan: Age 18 and Older (CDF-AD)	CMS (NQF 0418/0418e)	Health plan and CSP	Members, age 18 and older with at least one eligible encounter	Members, age 18 and older who were screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the eligible encounter.		2021 Rates: 18 to 64 years: 2.2% 65 and older: 1.3%	CMS
Objective 1.4: Improve access to oral health care for SoonerSelect dental plan enrollees							
Oral Evaluation, Dental Services (OEV-CH)	CMS Core Set Dental Quality Alliance (DQA)	Dental plan	Unduplicated number of children, under age 21 years	Children, under age 21 years, who received a comprehensive or periodic oral evaluation as a dental service	Will establish specific targets after first year's baselines.	2021 Rates: <1: 0.6% 1—2: 17.0% 3—5: 43.7% 6—7: 51.6% 8—9: 53.5% 10—11: 53.3%	CMS

Table A.1. Wellness and Prevention Measures (Continued)							
Indicator	Measure Steward	Contracted Entity Type	Indicator Description		Performance Target	Baseline Data	Comparison with Benchmark or Selected Measure
			Denominator	Numerator			
Objective 1.4: Improve access to oral health care for SoonerSelect dental plan enrollees (Continued)							
	American Dental Association (ADA) 2517					12—14: 51.1% 15—18: 43.8% 19—20: 23.0% Total: 42.3%	
Topical Fluoride for Children (TFL-CH)	CMS Core Set CMS 416 DQA (ADA) 2528/3700/ 3701	Dental plan	Children aged 1 through 20 years	Children aged 1 through 20 years enrolled in SoonerCare who received at least two topical fluoride applications as: a. dental OR oral health services, b. dental services, and c. oral health services within the reporting year	Will establish specific targets after first year's baselines.	New measure	CMS
Sealant Receipt on Permanent First Molars (SFM-CH)	CMS Core Set DQA (ADA)	Dental plan	All Four Molars Sealed: SoonerCare members who turn age 10 in the measurement year. Note: Excludes children who received treatment on all four molars in the 48 months prior	All Four Molars Sealed: Enrolled children who have received a sealant on all four permanent first molar teeth in the 48 months prior to the 10th birthdate.	Will establish specific targets after first year's baselines.	2021 Rate: 28.5%	Improvement over previous year or meeting OHCA-identified benchmark
Periodontal Evaluation in Adults with Periodontitis	DQA (ADA)	Dental plan		Percentage of enrolled adults aged 30 years and older with history of periodontitis who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the reporting year	Will establish specific targets after first year's baselines.	New measure	Improvement over previous year or meeting OHCA-identified benchmark

Goal 2. Improve behavioral & chronic condition management

Table A.2 describes measures for the assessment of Goal 2.

Table A.2. Behavioral & Chronic Condition Management Measures							
Indicator	Measure Steward	Contracted Entity Type	Indicator Description		Performance Target	Baseline Data	Comparison with Benchmark or Selected Measure
			Denominator	Numerator			
Objective 2.1: Improve Behavioral Health Care							
Follow-Up After Emergency Department Visit for Substance Use: Age 18 and Older (FUA-AD)	NCQA (NQF 3488)	Health plan and CSP	Emergency Department (ED) visits among members, age 18 and older, with a principal diagnosis of alcohol or other drug abuse or dependence	ED visits for which the member received a follow-up visit or a pharmacotherapy dispensing event within seven days after the ED visit; and ED visits for which the member received follow-up within 30 days.		2021 Rates: 7-Day Follow-up: 18 to 64 years: 7.0% 65 and over: 4.7% Overall: 6.87% 30-day Follow-up: 18 to 64 years: 10.9% 65 and over: 6.2% Total: 10.62%	NCQA Quality Compass

Table A.2. Behavioral & Chronic Condition Management Measures (Continued)							
Indicator	Measure Steward	Contracted Entity Type	Indicator Description		Performance Target	Baseline Data	Comparison with Benchmark or Selected Measure
			Denominator	Numerator			
Objective 2.1: Improve Behavioral Health Care (Continued)							
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Ages 13 to 17 (FUA-CH)	NCQA (NQF 3488)	Health plan (CSP measure in Goal 2)	ED visits among members, age 13 to 17, with a principal diagnosis of alcohol or other drug abuse or dependence	ED visits for which the member received a follow-up visit or a pharmacotherapy dispensing event within seven days after the ED visit; and ED visits for which the member received follow-up within 30 days.	Will establish specific targets after first year's baselines.	2021 Rates: 7-day Follow-up: 6.6% 30-day Follow-up: 10.2%	NCQA Quality Compass
Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17 (FUM-CH)	NCQA (NQF)3489	CSP (Health plan measure in Goal 1)	ED visits for members 6 to 17 years of age with a principal diagnosis of mental illness or intentional self-harm.	ED visits for members 6 to 17 years of age with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. 1. Within 30 days of the ED visit. 2. Within seven days of the ED visit.	Will establish specific targets after first year's baselines.	2021 Rates: 7-Day Follow-up: 46.9% 30-Day Follow-up: 65.4%	NCQA Quality Compass
Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)	NCQA (NQF 3489)	Health plan (CSP measure in Goal 1)	Inpatient discharges for a diagnosis of mental illness or intentional self-harm among patients ages 18 years and older	Inpatient discharges for a diagnosis of mental illness or intentional self-harm among patients ages 18 years and older that resulted in follow-up care with a mental health Provider within seven and 30 days.	Will establish specific targets after first year's baselines.	2021 Rates: 18—64 years: 7-day follow-up: 39.8% 30-day follow-up: 51.9%	NCQA Quality Compass

Table A.2. Behavioral & Chronic Condition Management Measures (Continued)							
Indicator	Measure Steward	Contracted Entity Type	Indicator Description		Performance Target	Baseline Data	Comparison with Benchmark or Selected Measure
			Denominator	Numerator			
Objective 2.1: Improve Behavioral Health Care (Continued)							
Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)	NCQA (NQF 0576)	Health plan and CSP	Patients 18 years of age and older who were discharged from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness or intentional self-harm	A follow-up visit with a mental health practitioner within 7 and within 30 days after acute inpatient discharge		2021 Rates: 7-Day Follow-up: 18 to 64 years: 24.9% 65 and over: 7.9% Total: 19.2% 30-day Follow-up: 18 to 64 years: 42.3% 65 and over: 18.9% Total: 34.4%	NCQA Quality Compass
Initiation and Engagement of Substance Use Disorder Treatment (IET-AD)	NCQA (NQF 0004)	Health plan and CSP	**Initiation:** SoonerCare members 13 years and older who were diagnosed with a new episode of alcohol or drug dependency during the first 10½ months of the measurement year.	**Initiation:** SoonerCare members who began initiation of treatment through an inpatient admission, residential, outpatient visits, intensive outpatient encounter, or partial hospitalization within 14 days of the index episode start date		2021 Rate: 28.9%	NCQA Quality Compass

Table A.2. Behavioral & Chronic Condition Management Measures (Continued)							
Indicator	Measure Steward	Contracted Entity Type	Indicator Description		Performance Target	Baseline Data	Comparison with Benchmark or Selected Measure
Objective 2.1: Improve Behavioral Health Care (Continued)							
			Engagement: SoonerCare members 13 years and older who were diagnosed with a new episode of alcohol or drug dependency during the first 10½ months of the measurement year.	**Engagement:** Initiation of treatment and two or more engagement events (inpatient admissions, residential, outpatient visits, intensive outpatient encounters or partial hospitalizations) with any alcohol or drug diagnosis within 34 days after the initiation visit.		2021 Rate: 6.3%	NCQA Quality Compass
Objective 2.2: Improve diabetes management							
Hemoglobin A1c Control for Patients with Diabetes (HBD-AD)	NCQA (RFP 0059/ 0575)	Health plan (CSP measure in Goal 1)	Members 18–75 years of age with diabetes.	Members 18 – 75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.	Will establish specific targets after first year's baselines.	New OHCA measure	NCQA Quality Compass
Diabetes Short-term Complications Admission Rate (PDI 15)	Agency for Healthcare Research & Quality (AHRQ)	CSP	Hospitalizations with a principal diagnosis of diabetes, for members 6—17 years of age.	Hospitalizations with a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 population, ages 6 through 17 years. Exclude transfers from other institutions, and obstetric discharges.		New OHCA measure	Annual State Comparison

Table A.2. Behavioral & Chronic Condition Management Measures (Continued)							
Indicator	Measure Steward	Contracted Entity Type	Indicator Description		Performance Target	Baseline Data	Comparison with Benchmark or Selected Measure
Objective 2.3: Improve asthma management							
Asthma Medication Ratio: Ages 5 to 18 (AMR-CH)	NCQA (NQF 1800)	Health plan and CSP	Children and adolescents ages 5 to 18 who were identified as having persistent asthma.	Children and adolescents ages 5 to 18 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.		2021 Rates: 5 to 11 years: 92.4% 12 to 18 years: 88.2%	NCQA Quality Compass
Asthma Medication Ratio: Ages 19 to 64 (AMR-AD)	NCQA (NQF 1800)	Health plan and CSP	Adults ages 19 to 64 identified as having persistent asthma	Adults ages 19 to 64 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.		2021 Rate: 86.8%	NCQA Quality Compass
Asthma Admission Rate (PDI 14)	AHRQ	Health plan and CSP		Hospitalizations with a principal diagnosis of asthma per 100,000 population, ages 2 through 17 years. Excludes discharges with a diagnosis code for cystic fibrosis and anomalies of the respiratory system; transfers from other institutions and obstetric discharges.		New measure	Annual State Comparison

Table A.2. Behavioral & Chronic Condition Management Measures (Continued)							
Indicator	Measure Steward	Contracted Entity Type	Indicator Description		Performance Target	Baseline Data	Comparison with Benchmark or Selected Measure
Objective 2.3: Improve asthma management (Continued)							
Preventable Hospital Admissions – Asthma in Younger Adults Admission Rate (PQI 15-AD)	AHRQ	Health plan	Members, ages 18 years and older	Members 18 years an older admitted with a primary diagnosis of asthma, excluding admissions with diagnoses of cystic fibrosis or other respiratory anomalies (excluding transfers and obstetric discharges)		2021 Admissions per 100,000 member months: 18 to 39 years: 4.74 40 to 64 years: 3.98 65 and older: 0.77 Total 3.86	Annual State Comparison
Chronic Obstructive Pulmonary disease (COPD) or Asthma in Older Adults Admission Rate (PQI 05-AD)	AHRQ	Health plan	Members, ages 40 years and older	Discharges for patients ages 40 years and older, with either a principal diagnosis of COPD, or asthma.		2021 Admissions per 100,000 member months: 40 to 64: 44.50 65 and older: 15.75 Total: 18.47	Annual State Comparison
Controlling High Blood Pressure (CBP-AD)	NCQA (NQF 0018)	Health plan and CSP	Adults 18–85 years of age with a diagnosis of hypertension	Adults 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg).		New measure	CMS

Goal 3. Collaborate with community partners and other State agencies to improve population health.

Table A.3 describes the measures for the assessment of Goal 3.

Table A.3. Collaborate to Improve Population Health Measures							
Indicator	Measure Steward	Contracted Entity Type	Indicator Description		Performance Target	Baseline Data	Comparison with Benchmark or Selected Measure
			Denominator	Numerator			
Objective 3.1: Address unmet health-related resource needs							
TBD							
Objective 3.2: Address the opioid crisis							
Concurrent Use of Opioids and Benzodiazepines (COB-AD)	Pharmacy Quality Alliance (PQA) (NQF 3389)	Health plan and CSP	SoonerCare members ages 18 years and older without cancer. Note: Excludes patients in hospice care and those with cancer.	SoonerCare members ages 18 years and older with concurrent use of prescription opioids and benzodiazepines for at least 30 days		2021 Rate: 9.1%	CMS
Use of Opioids at High Dosage in Persons without Cancer (OHD-AD)	PQA (NQF 2940)	Health plan and CSP	Members 18 years of age and older who received prescriptions for opioids, excluding those with cancer or sickle cell disease.	Received prescriptions for opioids with an average daily dosage of ≥90 morphine milligram equivalents (MME) over a period of ≥90 days.		2021 Rate: 18 to 64 years: 3.4% 65 and over: 3.3% Total: 3.4%	CMS
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)	CMS (NQF 3400)	Health plan and CSP	Members ages 18 to 64 years, who had at least one encounter with a diagnosis of opioid abuse, dependence, or remission (primary or other) at any time during the measurement year.	Had at least one prescription filled, or who were administered or dispensed an FDA-approved medication for opioid use disorder (OUD) during the measurement year		2021 Rate: 33.9%	CMS

Table A.3. Collaborate to Improve Population Health Measures (Continued)							
Indicator	Measure Steward	Contracted Entity Type	Indicator Description		Performance Target	Baseline Data	Comparison with Benchmark or Selected Measure
			Denominator	Numerator			
Objective 3.3: Address tobacco use							
Current Cigarette Smoking or Tobacco Use	NCQA CAHPS Health Plan Survey	Health plan	Members 18 years and older	Members, 18 years and older who reported smoking cigarettes or using tobacco every day or some days.		Oklahoma CAHPS Measure-ment Year (MY) 2022 Rate: 34.9%	NCQA Quality Compass
Medical Assistance with Smoking and Tobacco Use Cessation among 18 years and older – Advice to quit smoking or using tobacco by a doctor or other health provider (MSC-AD)	NCQA (NQF 0027) CAHPS Health Plan Survey	Health plan	SoonerCare Members CAHPS Survey Respondents who currently smoke cigarettes or use tobacco every day or some days.	Current smokers or tobacco users who always/ usually/sometimes receive the advice to quit smoking or using tobacco by a doctor or health provider in members' plan.		2022 Adult CAHPS Summary Rate: 73%	NCQA Quality Compass
Medical Assistance with Smoking and Tobacco Use Cessation among 18 years and older – Cessation Medications recommended or discussed by a doctor or other health provider (MSC-AD)	NCQA (NQF 0027) CAHPS Health Plan Survey	Health plan	SoonerCare Members CAHPS Survey Respondents who currently smoke cigarettes or use tobacco every day or some days.	Current smokers or tobacco users with whom a doctor or other health provider always/usually/ sometimes recommended or discussed cessation medication to assist with quitting smoking or using tobacco		2022 Adult CAHPS Summary Rate: 45.7%	NCQA Quality Compass

Table A.3. Collaborate to Improve Population Health Measures (Continued)							
Indicator	Measure Steward	Contracted Entity Type	Indicator Description		Performance Target	Baseline Data	Comparison with Benchmark or Selected Measure
			Denominator	Numerator			
Objective 3.3: Address tobacco use (Continued)							
Medical Assistance with Smoking and Tobacco Use Cessation among 18 years and older – Cessation Strategies Other than Medications provided or discussed by a doctor or other health provider (MSC-AD)	NCQA (NQF) 0027 CAHPS Survey	Health plan	SoonerCare Members CAHPS Survey Respondents who currently smoke cigarettes or use tobacco every day or some days.	Current smokers or tobacco users with whom a doctor or other health provider always/usually/ sometimes provided or discussed cessation strategies other than medication to assist with quitting smoking or using tobacco		2022 Adult CAHPS Summary Rate: 42.8%	NCQA Quality Compass
Objective 3.4: Promote health equity							
TBD, pending CMS measures							
Objective 3.5: Address obesity							
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)	NCQA (NQF # 0024)	Health plan and CSP	Children, 3 through 17 years of age	Children ages 3 to 17 who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year: a. Body mass index (BMI) percentile documentation; b. Counseling for nutrition; and c. Counseling for physical activity.	TBD	2021 – BMI Percentile Assessment Rate: 10.2% 2021 – Counseling for Nutrition: 3.4% 2021 – Counseling for Physical Activity: 3.2%	NCQA Quality Compass

Table A.3. Collaborate to Improve Population Health Measures (Continued)							
Indicator	Measure Steward	Contracted Entity Type	Indicator Description		Performance Target	Baseline Data	Comparison with Benchmark or Selected Measure
			Denominator	Numerator			
Objective 3.6: Improve maternal and infant health outcomes							
Live Births Weighing Less Than 2500 grams (LBW-CH)	Centers for Disease Control and Prevention (CDC)/National Center for Health Statistics (NCHS) (NQF 1382)	Health plan and CSP	Live births	Live births that weighed less than 2,500 grams at birth during the measurement year.		2021 Rate: 9.8%	CMS
Contraceptive Care – Postpartum Women Ages 15 to 20 (CCP-CH)	OPA 2902	Health plan and CSP	Women ages 15 to 20 who had a live birth	Women ages 15 to 20 who had a live birth who were provided within 3 and 60 days of delivery a most effective or moderately effective FDA approved method of contraception.		2021 Rates: 3 days: 6.1% 60 days: 42.2%	CMS
			Women ages 15 to 20 who had a live birth	Women ages 15 to 20 who had a live birth who were provided within 3 and 60 days of delivery a long-acting reversible method of contraception (LARC).		2021 Rate: 3 days: 2% 60 days: 12.6%	CMS

Table A.3. Collaborate to Improve Population Health Measures (Continued)							
Indicator	Measure Steward	Contracted Entity Type	Indicator Description		Performance Target	Baseline Data	Comparison with Benchmark or Selected Measure
			Denominator	Numerator			
Objective 3.6: Improve maternal and infant health outcomes (Continued)							
Contraceptive Care – Postpartum Women Ages 21 to 44 (CCP-AD)	OPA 2902	Health plan and CSP	Women ages 21 to 44 who had a live birth	Women ages 21 to 44 who had a live birth who were provided within 3 and 60 days of delivery a most effective or moderately effective FDA approved method of contraception.		2021 Rate: 3 days: 11.7% 60 days: 39.9%	CMS
			Women ages 21 to 44 who had a live birth	Women ages 21 to 44 who had a live birth who were provided within 3 and 60 days of delivery a long-acting reversible method of contraception (LARC).		2021 Rate: 3 days: 1.3%% 60 days: 9.1%	CMS
Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)	NCQA (NQF 1517)	Health plan and CSP	Deliveries with live births	Deliveries in which women had a prenatal care visit in the first trimester, on or before the Enrollment start date or within 42 Days of Enrollment in the organization.	Will establish specific targets after first year's baselines.	2021 Rates: 30.2% (bundled payments) 25.6% (unbundled)	NCQA Quality Compass
Prenatal and Postpartum Care: Postpartum Care (PPC-AD)	NCQA (NQF 1517)	Health plan (CSP measure in Goal 1)	Deliveries with live births	Deliveries in which women had a postpartum visit on or between seven and 84 days after delivery.	Will establish specific targets after first year's baselines.	2021 Rates: 51.8% (bundled payments) 30.6% (unbundled)	NCQA Quality Compass

Aim 2: Improve care delivery through a provider-led model with emphasis on access to high quality, person-centered, and coordinated care

Goal 4: Ensure appropriate access to care

Table A.4 describes the measures for the assessment of Goal 4.

Table A.4. Appropriate Access to Care Measures						
Indicator	Measure Steward	Contracted Entity Type	Indicator Description Examples of question topics regarding the health plan	Performance Target	Baseline Data	Comparison with Benchmark or Selected Measure
Objective 4.1: Ensure services are available geographically						
Monthly Network Adequacy Report (specific indicators TBD)						
Objective 4.2: Ensure timely access to care						
Getting Care Quickly (Composite Score)	CAHPS Health Plan Survey	Health plan and CSP	Getting Care Quickly Composite Score: Calculated by taking the average of the rates of two questions (% Always or Usually): • Q4. In the last 6 months, when you needed care right away, how often did you get care as soon as you needed? • Q6. In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?		2022 Scores: Adult: 84.5% General Child: 89.0% Children's Health Insurance Plan (CHIP): 87.5%	NCQA Quality Compass
Monthly Network Adequacy Report (specific indicators TBD)						

Goal 5: Drive patient-centered, whole-person care

Table A.5 describes the measures for the assessment of Goal 5.

Table A.5. Patient-Centered, Whole-Person Care Measures							
Indicator	Measure Steward	Contracted Entity Type	Indicator Description		Performance Target	Baseline Data	Comparison with Benchmark or Selected Measure
			Denominator	Numerator			
Objective 5.1: Address behavioral and physical health conditions							
Screening for Depression and Follow-Up Plan: Ages 12 to 17 years (CDF-CH)	CMS (NQF 0418/0418e)	Health plan and CSP	Members, age 12 to 17 with at least one eligible encounter	Members ages 12 to 17 who were screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the eligible encounter.		2021 Rate: 1.0%	CMS
Screening for Depression and Follow-up Plan: Age 18 and Older (CDF-AD)	CMS (NQF 0418/0418e)	Health plan and CSP	Members, age 18 and older with at least one eligible encounter	Members, age 18 and older who were screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the eligible encounter.		2021 Rates: 18 to 64 years: 2.2% 65 and older: 1.3%	CMS

Table A.5. Patient-Centered, Whole-Person Care Measures (Continued)							
Indicator	Measure Steward	Contracted Entity Type	Indicator Description		Performance Target	Baseline Data	Comparison with Benchmark or Selected Measure
			Denominator	Numerator			
Objective 5.1: Address behavioral and physical health conditions (Continued)							
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)	NCQA (NQF 1932)	Health plan and CSP	Members 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication.	A diabetes screening test performed during the measurement year.		2021 Rate: 71.6%	NCQA Quality Compass
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	NCQA (NQF 2607)	Health plan and CSP	Members, ages 18 to 75 with a serious mental illness and diabetes (type 1 or type 2)	Members, ages 18 to 75 with a serious mental illness and diabetes (type 1 or type 2) who had Hemoglobin A1c (HbA1c) in poor control (>9.0%)		New measure	NCQA Quality Compass
Objective 5.2: Facilitate member access to appropriate care management and care coordination services							
Getting Needed Care (Composite Score)	CAHPS Health Plan Survey	Health plan and CSP	**Getting Needed Care Composite Score:** Calculated by taking the average of the rates of two questions (% Always or Usually): • In the last 6 months, how often was it easy to get the care, tests, or treatment you/your child needed? • In the last 6 months, how often did you get an appointment to see a specialist as soon as you/your needed?			2022 Scores: Adult: 86.5% General Child: 86.0% CHIP: 84.7%	NCQA Quality Compass
Objective 5.3: Increase collaboration between medical and dental professionals							
TBD							

Table A.5. Patient-Centered, Whole-Person Care Measures (Continued)							
Indicator	Measure Steward	Contracted Entity Type	Indicator Description		Performance Target	Baseline Data	Comparison with Benchmark or Selected Measure
			Denominator	Numerator			
Objective 5.4: Reduce non-emergent ED utilization							
Emergency Department Utilization (EDU)	NCQA	CSP (Health plan measure in Goal 2)	Members 18 years and older	ED utilization among members 18 and older	Will establish specific targets after first year's baselines.	New measure	NCQA Quality Compass
Ambulatory Care: Emergency Department Visits, Adult (AMB)	NCQA	Health plan	Members >19 years enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period	Number of ED visits among members >19 years old during the measurement period.		New measure	Annual State Comparison

This area intentionally left blank

Aim 3: Improve member experience

Goal 6: Increase member satisfaction with dental plan, health plan and CSP

Table A.6 describes the measures for the assessment of Goal 6.

Table A.6. Member Experience Measures						
Indicator	Measure Steward	Contracted Entity Type	Indicator Description Examples of question topics regarding the health plan	Performance Target	Baseline Data	Comparison with Benchmark or Selected Measure
Objective 6.1: Increase member ratings of satisfaction with dental plan, health plan and CSP providers						
Applicable CAHPS member satisfaction survey results	AHRQ CAHPS Health Plan Survey	Health plan and CSP	Measures such as: • Rating of Health Plan (8, 9, or 10 on a scale of 0 to 10) • Rating of Person Doctor (8, 9, or 10 on a scale of 0 to 10)			NCQA Quality Compass
Applicable ECHO member satisfaction survey results	CAHPS ECHO® Survey	Health plan and CSP	Measures such as: • Global Rating of Counseling and Treatment • Information about Treatment Options			Annual State Comparison
Objective 6.2: Increase engagement with SoonerSelect dental plan enrollees						
Children's Dental CAHPS: Applicable dental plan services measures	CAHPS Dental Plan Survey	Dental plan	Measures such as: • Found needed information from toll-free number, website, and written information (Q27A-C). • Plan's customer service gave you information or help needed			Annual State Comparison
Adult Dental CAHPS: Applicable dental plan services measures	CAHPS Dental Plan Survey	Health plan and CSP	Measures such as: • 800 number, written materials and website provided needed information • Plan's customer service gave you information or help needed			Annual State Comparison

Aim 4: Improve provider experience

Goal 7: Increase provider satisfaction with dental plan, health plan and CSP

Table A.7 describes the measures for the assessment of Goal 7.

Table A.7. Provider Satisfaction Measures						
Indicator	Measure Steward	Contracted Entity Type	Indicator Description	Performance Target	Baseline Data	Comparison with Benchmark or Selected Measure
Objective 7.1: Improve provider ratings of satisfaction with health plan and CSP						
Applicable provider satisfaction survey results		Health plan and CSP	Potential question topics: • Provider customer service • Provider network • Authorizations • Case management • Claims and payment management • Pharmacy and drug benefits • Overall satisfaction		New survey	Annual State comparison
Objective 7.2: Improve provider ratings of satisfaction with dental plan						
Applicable provider satisfaction survey results		Dental plan	Potential question topics: • Provider customer service • Provider network • Authorizations • Claims and payment management • Overall satisfaction		New survey	Annual State comparison

Aim 5: Improve financial sustainability of the Oklahoma Medicaid Program

Goal 8: Transition from volume-based to value-based payment structure

Table A.8 describes the performance withhold measures for the assessment of Goal 8.

Table A.8. Performance Withhold Measures							
Indicator	Measure Steward	Contracted Entity Type	Indicator Description		Performance Target	Baseline Data	Comparison with Benchmark or Selected Measure
			Denominator	Numerator			
Objective 8.1: Implement quality withhold program							
Childhood Immunization Status Combination 3 (DTAP, IPV, MMR, HIB, Hepatitis B, VZV and PCV (CIS-CH)	NCQA (NQF 0038)	Health plan and CSP	Children 2 years of age	The percentage of Children 2 years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella; (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.	Will establish specific targets after first year's baselines.	2021 Rate: Combo 3: 22%	NCQA Quality Compass

Table A.8. Performance Withhold Measures (Continued)							
Indicator	Measure Steward	Contracted Entity Type	Indicator Description		Performance Target	Baseline Data	Comparison with Benchmark or Selected Measure
			Denominator	Numerator			
Objective 8.1: Implement quality withhold program (Continued)							
Well-Child Visits in the First 30 Months of Life (W30-CH)	NCQA (NQF 1392)	Health plan and CSP	Children who turned 15 months old during the measurement year. Children who turned 30 months during the measurement year.	Children who turned 15 months old during the measurement year and had at least six well-child visits with a primary care physician during their first 15 months of life. Children who turned 30 months old during the measurement year and had at least two well-child visits with a primary care physician in the last 15 months.	Will establish specific targets after first year's baselines.	2021 Rates: 15 months: 61.0% 15—30 months: 56.6%	NCQA Quality Compass
Immunizations for Adolescents Combination One (IMA-CH)	NCQA (NQF 1407)	Health plan and CSP	Adolescents 13 years of age	Adolescents 13 years of age who had one dose of meningococcal vaccine, one Tdap vaccine and the complete human papillomavirus vaccine series by their thirteenth birthday.	Will establish specific targets after first year's baselines.	2021 Rate: Combo 1: 62.0%	NCQA Quality Compass
Child and Adolescent Well Care Visits Total (WCV-CH)	NCQA (NQF 1516)	Health plan and CSP	Members, ages 3 to 21 years	Members, 3 to 21 years, who had at least one comprehensive well-care visit with a PCP or an OB/ GYN practitioner during the measurement year	Will establish specific targets after first year's baselines.	2021 Rate: 37.1%	NCQA Quality Compass

Table A.8. Performance Withhold Measures (Continued)							
Indicator	Measure Steward	Contracted Entity Type	Indicator Description		Performance Target	Baseline Data	Comparison with Benchmark or Selected Measure
			Denominator	Numerator			
Objective 8.1: Implement quality withhold program (Continued)							
Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)	NCQA (NQF 1517)	Health plan and CSP	Deliveries with live births	Deliveries in which women had a prenatal care visit in the first trimester, on or before the Enrollment start date or within 42 Days of Enrollment in the organization.	Will establish specific targets after first year's baselines.	2021 Rates: 30.2% (bundled payments) 25.6% (unbundled)	NCQA Quality Compass
Prenatal and Postpartum Care: Postpartum Care (PPC-AD)	NCQA (NQF 1517)	Health plan (CSP measure in Goal 1)	Deliveries with live births	Deliveries in which women had a postpartum visit on or between seven and 84 days after delivery.	Will establish specific targets after first year's baselines.	2021 Rates: 51.8% (bundled payments) 30.6% (unbundled)	NCQA Quality Compass
Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)	NCQA	Health plan and CSP	Members 0 to 19 years enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period	Number of ED visits among members 0 to 19 years per 1000 member months	Will establish specific targets after first year's baselines.	2021 ED visits per 1,000 member months. Ages: <1: 88.65 1—9: 66.66 10—19: 55.08 Total: 62.31	NCQA Quality Compass
Emergency Department Utilization (EDU)	NCQA	Health plan (CSP measure in Goal 1)	Members 18 and older	ED utilization among members 18 and older	Will establish specific targets after first year's baselines.	New measure	NCQA Quality Compass

Table A.8. Performance Withhold Measures (Continued)							
Indicator	Measure Steward	Contracted Entity Type	Indicator Description		Performance Target	Baseline Data	Comparison with Benchmark or Selected Measure
			Denominator	Numerator			
Objective 8.1: Implement quality withhold program (Continued)							
Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)	NCQA (NQF 0576)	Health plan and CSP	Inpatient discharges for a diagnosis of mental illness or intentional self-harm among members ages 6—17	Inpatient discharges for a diagnosis of mental illness or intentional self-harm among members ages 6 years to 17 that resulted in follow-up care with a mental health provider within seven and 30 days.	Will establish specific targets after first year's baselines.	2021 Rates: 7-day follow-up: 40.4% 30-day follow-up: 64.2%	NCQA Quality Compass
Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)	NCQA (NQF 3489)	Health plan (CSP measure in Goal 1)	Inpatient discharges for a diagnosis of mental illness or intentional self- harm among patients ages 18 years and older	Inpatient discharges for a diagnosis of mental illness or intentional self- harm among patients ages 18 years and older that resulted in follow-up care with a mental health Provider within seven and 30 days.	Will establish specific targets after first year's baselines.	2021 Rates: 18—64 years 7-day follow-up: 39.8% 30-day follow-up: 51.9%	NCQA Quality Compass
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPD-AD)	NCQA (RFP 0059/ 0575)	Health plan (CSP measure in Goal 1)	Members 18–75 years of age with diabetes.	Members 18 – 75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.	Will establish specific targets after first year's baselines.	New OHCA measure	NCQA Quality Compass

Table A.8. Performance Withhold Measures (Continued)							
Indicator	Measure Steward	Contracted Entity Type	Indicator Description		Performance Target	Baseline Data	Comparison with Benchmark or Selected Measure
			Denominator	Numerator			
Objective 8.1: Implement quality withhold program (Continued)							
Plan All-Cause Readmissions (PCR-AD)	NCQA (NQF 1768)	Health plan (CSP measure in Goal 1)	Adult acute inpatient and observation stays	Adult acute inpatient and observation stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge.	Will establish specific targets after first year's baselines.	2021 Rates: Observed: 12.2% Expected: 12.0% Observed/Expected Ratio: 1.02	NCQA Quality Compass
Follow-Up Care for Children Prescribed Attention-Deficit/ Hyperactivity Disorder (ADHD) Medication (ADD-CH)	NCQA (NQF 0108)	CSP (Health plan measure in Goal 1)	Children 6–17 years of age with newly prescribed ADHD	Number of children ages 6 through 12 years of age with newly prescribed ADHD medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days from the time the first ADHD medication was dispensed.	Will establish specific targets after first year's baselines.	2021 Rates: Initiation phase: 50.9% Continuation phase: 60.8%	NCQA Quality Compass
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	NCQA (NQF 2801)	CSP (Health plan measure in Goal 1)	Children and adolescents 1–17 years old who had a new prescription for an antipsychotic medication	Children and adolescents 1–17 years old who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.	Will establish specific targets after first year's baselines.	2021 Rate: 58.6%	NCQA Quality Compass

Table A.8. Performance Withhold Measures (Continued)							
Indicator	Measure Steward	Contracted Entity Type	Indicator Description		Performance Target	Baseline Data	Comparison with Benchmark or Selected Measure
			Denominator	Numerator			
Objective 8.1: Implement quality withhold program (Continued)							
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Ages 13 to 17 (FUA-CH)	NCQA (NQF 3488)	CSP (Health plan measure in Goal 2)	ED visits among members, age 13 to 17, with a principal diagnosis of alcohol or other drug abuse or dependence	ED visits for which the member received a follow-up visit or a pharmacotherapy dispensing event within seven days after the ED visit; and ED visits for which the member received follow-up within 30 days.	Will establish specific targets after first year's baselines.	2021 Rates: 7-day Follow-up: 6.6% 30-day Follow-up: 10.2%	NCQA Quality Compass
Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17 (FUM-CH)	NCQA (NQF)3489	CSP (Health plan measure in Goal 1)	ED visits for members 6 to 17 years of age with a principal diagnosis of mental illness or intentional self-harm.	ED visits for members 6 to 17 years of age with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. a. Within seven days of the ED visit. b. Within 30 days of the ED visit.	Will establish specific targets after first year's baselines.	2021 Rates: 7-Day Follow-up: 46.9% 30-Day Follow-up: 65.4%	NCQA Quality Compass
Oral Evaluation, Dental Services (OEV-CH)	CMS Core Set DQA (ADA) 2517	Dental plan	Unduplicated number of children, under age 21 years	Children, under age 21 years, who received a comprehensive or periodic oral evaluation as a dental service	Will establish specific targets after first year's baselines.	2021 Rates: <1: 0.6% 1—2: 17.0% 3—5: 43.7% 6—7: 51.6% 8—9: 53.5% 10—11: 53.3% 12—14: 51.1% 15—18: 43.8% 19—20:23.0% Total: 42.3%	CMS

Table A.8. Performance Withhold Measures (Continued)							
Indicator	Measure Steward	Contracted Entity Type	Indicator Description		Performance Target	Baseline Data	Comparison with Benchmark or Selected Measure
			Denominator	Numerator			
Objective 8.1: Implement quality withhold program (Continued)							
Topical Fluoride for Children (TFL-CH)	CMS Core Set CMS 416 DQA (ADA) 2528/3700/3701	Dental plan	Children aged 1 through 20 years	Children aged 1 through 20 years enrolled in SoonerCare who received at least two topical fluoride applications as: a. dental OR oral health services, b. dental services, and c. oral health services within the reporting year	Will establish specific targets after first year's baselines.	New measure	CMS
Sealant Receipt on Permanent First Molars (SFM-CH)	CMS Core Set DQA (ADA)	Dental plan	**All Four Molars Sealed:** SoonerCare members who turn age 10 in the measurement year. Note: Excludes children who received treatment on all four molars in the 48 months prior	**All Four Molars Sealed:** Enrolled children who have received a sealant on all four permanent first molar tooth in the 48 months prior to the 10th birthdate.	Will establish specific targets after first year's baselines.	2021 Rate: 28.5%	Improvement over previous year or meeting OHCA-identified benchmark
Annual Dental Visit	CMS Core Set NCQA HEDIS	Dental plan		Assesses SoonerSelect dental plan enrollees 2 – 20 years of age with dental benefits, who had at least one dental visit during the year.	Will establish specific targets after first year's baselines.	New measure	Improvement over previous year or meeting OHCA-identified benchmark

Table A.8. Performance Withhold Measures (Continued)							
Indicator	Measure Steward	Contracted Entity Type	Indicator Description		Performance Target	Baseline Data	Comparison with Benchmark or Selected Measure
			Denominator	Numerator			
Objective 8.1: Implement quality withhold program (Continued)							
Periodontal Evaluation in Adults with Periodontitis	DQA (ADA)	Dental plan		Percentage of enrolled adults aged 30 years and older with history of periodontitis who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the reporting year	Will establish specific targets after first year's baselines.	New measure	Improvement over previous year or meeting OHCA-identified benchmark

This area intentionally left blank

Appendix B

SoonerSelect Quality Strategy

Examples of Measures and Interventions Related to Stakeholder Feedback

In addition to feedback specific to the SoonerSelect Quality Strategy, Table B.1 details how stakeholder feedback regarding the Comprehensive Quality Strategy has been incorporated into the SoonerSelect Quality Strategy.

Table B.1. Examples of Measures and Interventions Related to Stakeholder Feedback

Objective	Member Feedback	Provider Feedback	Tribal and Other Stakeholder Feedback
Objective 1.1: Promote child health, development, and wellness	Housing that has high levels of lead. • Lead Screening in Children (LSC-CH) Teenagers should have access to contraceptive medications. • Contraceptive Care - All women 15-20 Years (CCW-CH) • Contraceptive Care – Postpartum Women Ages 15 – 20 (CCP-CH)	Preventive visits are the most important population health measure to include in Quality Strategy. • Child and Adolescent Well Care Visits Total (WCV) CMS Child Core Set (CH) • Developmental Screening in the First Three Years of Life (DEV-CH)	Teens need easy access to contraceptives/sterilization if desired (Tribal). • Contraceptive Care - All women 15-20 Years (CCW-CH) • Contraceptive Care – Postpartum Women Ages 15 – 20 (CCP-CH)
Objective 1.2: Promote women's health	No specific feedback was solicited.	No specific feedback was solicited.	No specific feedback was solicited.
Objective 1.3: Promote preventive health in adults	Behavioral health was identified as the most important stressor for members. • Screening for Depression and Follow-up Plan: Age 18 and Older (CDF-AD)	Preventive visits are the most important population health measure to include in Quality Strategy. • Colorectal Cancer Screening (COL-AD) • Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD)	Preventive visits are the most important population health measure to include in Quality Strategy (Tribal). • Colorectal Cancer Screening (COL-AD) • Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD)
Objective 1.4: Improve access to oral health care for SoonerSelect dental plan enrollees	Access to dental providers is limited. • Dental-focused Performance Improvement Project (PIP) requirement for dental plan CEs	Preventive dental visits identified as an important population health measure to include in the Quality Strategy. • Oral Evaluation, Dental Services (OEV-CH) • Topical Fluoride for Children (TFL-CH) • Sealant Receipt on Permanent First Molars (SFM-CH)	Preventive dental visits are the third most important population health measure to include in Quality Strategy (Tribal). • Oral Evaluation, Dental Services (OEV-CH) • Topical Fluoride for Children (TFL-CH) • Sealant Receipt on Permanent First Molars (SFM-CH)

Table B.1. Examples of Measures and Interventions Related to Stakeholder Feedback (Continued)			
Objective	Member Feedback	Provider Feedback	Tribal and Other Stakeholder Feedback
Objective 2.1: Improve behavioral health care	Care management is very limited for members with behavioral health needs. • All ED follow-up measures listed for this objective in Table 1. • Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH) Mental health services are not available, and/or quality of services needs to improve. • BH-focused PIP requirement for CEs Transition support from inpatient to home does not happen for adults or children. • Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)	There are no adequate options in Oklahoma for children with autism spectrum disorder/intellectual disability (ASD/ID) needing inpatient or high-intensity support. • BH-focused PIP requirement for CEs • Follow-Up After Emergency Department Visit for Mental Illness Ages: 6-17 (FUM-CH) Substance abuse treatment identified as third most important population health measure to include in Quality Strategy • Initiation and Engagement of Substance Use Disorder Treatment (IET)	Substance abuse treatment identified as second most important population health measure to include in Quality Strategy by Tribal members and most important by Other Stakeholders • Initiation and Engagement of Substance Use Disorder Treatment (IET) The State Department of Health recommended aligning measures with the National Academy for State Health Policy performance measures on behavioral health that are used as the data source for the Maternal Mental Health report card. • The following measures are under consideration for future inclusion: o Prenatal Depression Screening and Follow-up (PND) o Postpartum Depression Screening and Follow-up (PDS)
Objective 2.2: Improve diabetes management	No specific feedback was solicited.	Diabetes Short-Term Complications Readmissions is the second most important measure for reducing per capita cost. • Diabetes Short-term Complications Admissions Rate (PDI 15)	Diabetes Short-Term Complications Readmissions is the most important measure for reducing per capita cost by Tribal members and second most important by Other Stakeholders • Diabetes Short-term Complications Admissions Rate (PDI 15)
Objective 2.3: Improve asthma management	No specific feedback was solicited.	Substandard housing can contribute to respiratory illnesses. • Asthma Medication Ratio: Ages 5 to 18 (AMR-CH) • Asthma Medication Ratio: Ages 19 to 64 (AMR-AD)	No specific feedback was solicited.
Objective 2.4: Improve hypertension management	No specific feedback was solicited.	No specific feedback was solicited.	No specific feedback was solicited.

Table B.1. Examples of Measures and Interventions Related to Stakeholder Feedback (Continued)			
Objective	Member Feedback	Provider Feedback	Tribal and Other Stakeholder Feedback
Objective 3.1: Address unmet health-related resource needs	Help is needed to understand social programs/supports available. • Health plan CEs will develop and implement strategies to address social determinants of health impacting enrollees which will include health risk screenings, needs based referrals to social services, and partnering with community based social service providers and non-traditional health workers.	Community based mental health supports, such as "mental health doulas" and social work services should be reimbursed. • Health plan CEs will develop and implement strategies to address social determinants of health impacting enrollees which will include health risk screenings, needs based referrals to social services, and partnering with community based social service providers and non-traditional health workers.	Many Tribal members live in very rural areas. Everything from transportation to stable broadband for telehealth is unavailable. (Tribal) • Health plan CEs will develop and implement strategies to address social determinants of health impacting enrollees which will include health risk screenings, needs based referrals to social services, and partnering with community based social service providers and non-traditional health workers.
Objective 3.2: Address the opioid crisis	No specific feedback was solicited.	Substance abuse treatment was identified as third most important population health measure to include in Quality Strategy. • Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)	Substance abuse treatment was identified as the most important population health measure to include in Quality Strategy by Other Stakeholders and second most important by Tribal members. • Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)
Objective 3.3: Address tobacco use	Providers are hesitant to prescribe smoking cessation medications. • Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD) measures	Tobacco use was identified as the second most important population health measure to include in Quality Strategy. • Current Cigarette Smoking or Tobacco Use • Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD) measures	Incentivize/educate providers about cessation, billing, and motivational interviewing (Other Stakeholders). • Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD) measures
Objective 3.4: Promote health equity	No specific feedback was solicited.	No specific feedback was solicited.	Tribal members were supportive of the health equity accreditation required of the CEs. • National Committee for Quality Assurance (NCQA) Heath Equity Accreditation requirement for CEs

Table B.1. Examples of Measures and Interventions Related to Stakeholder Feedback (Continued)			
Objective	Member Feedback	Provider Feedback	Tribal and Other Stakeholder Feedback
Objective 3.5: Address childhood obesity	Weight loss programs are provided only one time in a year. • Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescent (WCC)	Most providers at the Provider Townhall do not bill and code for nutrition or physical activity counseling. • Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescent (WCC)	Obesity is often not considered a disease and treatment is inadequately funded/covered (Tribal). • Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescent (WCC)
Objective 3.6: Improve maternal and infant health outcomes	Teenagers should have access to (and information on how to access) contraceptive medications • Contraceptive Care – Postpartum Women Ages 15 to 20 (CCP-CH)	SDOH play a key role in a teen's level of understanding of reproductive health and the impact of pregnancy. The following challenges contribute to poor maternal and infant health outcomes: logistics of acquiring contraceptive prescriptions, attending follow-up appointments, or getting refills, cultural barriers, transportation, social media influence, lack of overall support, late entry into care, and language barriers. • Implement doula benefit • Contraceptive Care – Postpartum Women Ages 15 – 20 (CCP-CH) • Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH) • Prenatal & Postpartum Care: Postpartum Care (PPC-AD)	Teens need easy access to contraceptives and sterilization if desired. • Contraceptive Care – Postpartum Women Ages 15 to 20 (CCP-CH) The State Department of Health recommended additional measures. • The suggested additional measures will be considered for future inclusion.
Objective 4:1: Ensure services are available geographically	Members must travel out of state to see some specialists and access to dental and vision providers is limited. Very few providers serve children and persons with developmental disabilities in Oklahoma. • Network adequacy standards for geographic availability	Providers reported difficulties in patients/clients seeing specialists, in part due to specialists not accepting SoonerCare members in their practice. • Network adequacy standards for geographic availability	Transportation identified as top social determinant of health and many Tribal members live in very rural areas. • Network adequacy standards for geographic availability
Objective 4.2: Ensure timely access to care	There is a delay in getting appointments with providers and it is difficult for members to access primary care due to work schedules.	Members cannot see their primary provider, and so must access urgent care for services.	No specific feedback was solicited.

Table B.1. Examples of Measures and Interventions Related to Stakeholder Feedback (Continued)			
Objective	Member Feedback	Provider Feedback	Tribal and Other Stakeholder Feedback
	• Network adequacy standards for appointment access and after-hours primary care	• Network adequacy standards for appointment access and after-hours primary care	
Objective 5.1: Address behavioral and physical health conditions	Mental health care needs should be identified and addressed at an early age. • Screening for Depression and Follow-up Plan: Ages 12-17 (CDF-CH) Need member education, understanding, and acceptance of mental health help • Incentivizing behavioral health (BH) screenings in primary care setting and primary care provider (PCP) referrals for BH treatment, if applicable (Screening, Brief Intervention, and Referral to Treatment [SBIRT]). • Integration of primary care services in CCBHCs for members with severe and persistent mental illness.	Behavioral and mental health needs impact patient self-efficacy and compliance with treatment plans. • Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD) • Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	When considering measures to reduce per capita costs, consider the impact of persons in a mental health crisis presenting to the ED and the need to reduce behavioral health readmissions. • Screening for Depression and Follow-Up Plan: Ages 12 to 17 years (CDF-CH) • Screening for Depression and Follow-up Plan: Age 18 and Older (CDF-AD)
Objective 5.2: Facilitate member access to appropriate care management and care coordination services	Members need assistance to understand social programs and supports available to them. Transition support from inpatient to home is needed. True care management is not available, except for specific programs and those don't address the needs of the whole family. Help should be available to members in finding a PCP, or specialist as needed. • Process for all members to be contacted to complete Initial Health Risk Screening within 90 days of SoonerSelect initial enrollment date with CE and subsequent development of individualized care plan.	Members and families need support in collaborating with providers. Health literacy affects the ability of a member to manage their conditions. • Process for all members to be contacted to complete Initial Health Risk Screening within 90 days of SoonerSelect initial enrollment date with CE and subsequent development of individualized care plan.	It would be helpful to identify members with "rising-risk" and with obesity, who have other social determinants of health. • Process for all members to be contacted to complete Initial Health Risk Screening within 90 days of SoonerSelect initial enrollment date with CE and subsequent development of individualized care plan.

Table B.1. Examples of Measures and Interventions Related to Stakeholder Feedback (Continued)			
Objective	Member Feedback	Provider Feedback	Tribal and Other Stakeholder Feedback
Objective 5.3: Increase collaboration between medical and dental professionals	No specific feedback was solicited.	No specific feedback was solicited.	Increase coordination between primary providers and dentists regarding tobacco use. • TBD
Objective 5.4: Reduce non-emergent ED utilization	There is a dependence on emergency care due to a lack of evening/weekend PCP and specialist hours. • Incentivizing PCPs through additional reimbursement tied to Current Procedural Terminology (CPT®) codes for after-hours visits.	ED visits were identified as the most important measure for reducing per capita cost. • Emergency Department Utilization (EDU) • Ambulatory Care: ED Visits (AMB-CH)	ED visits were identified as the most important measure for reducing per capita cost by Other Stakeholders and second most important by Tribal members. • Emergency Department Utilization (EDU) • Ambulatory Care: ED Visits (AMB-CH)
Objective 6.1: Improve member ratings of satisfaction with medical and children specialty plans and providers	It is important to have health care providers who are from the community to whom members belong. • Member service-related PIP requirement for CEs • Applicable CAHPS, ECHO member satisfaction survey results	No specific feedback was solicited.	No specific feedback was solicited.
Objective 6.2: Increase engagement with SoonerSelect dental plan enrollees	The SoonerCare website does not provide the level of detail needed to identify certain specialists, such as dentists. • Children's Dental CAHPS: Applicable dental plan services measures such as: o Found needed information from toll free number, website, and written information (Q27A-C). o Plan's customer service gave you information or help needed • Adult Dental CAHPS: Applicable dental plan services measures such as" o 800 number, written materials and website provided needed information	No specific feedback was solicited.	No specific feedback was solicited.

Table B.1. Examples of Measures and Interventions Related to Stakeholder Feedback (Continued)			
Objective	Member Feedback	Provider Feedback	Tribal and Other Stakeholder Feedback
	○ Plan's customer service gave you information or help needed Lack of access to dental providers identified as a social determinant of health. • Dental plan CEs will provide high-quality outreach and education materials and regularly scheduled activities to engage with SoonerSelect dental plan enrollees		
Objective 7.1 Improve provider ratings of satisfaction with medical and children specialty plans	No specific feedback was solicited.	Provider Relations and Claims Processing were identified as the most important items to include in the provider survey. • Provider-led Effort (PLE) structure for CEs • Applicable provider satisfaction survey results	Provider Services and Provider Relations were identified as the most important items to include in the provider survey by Tribal members and the second most important by Other Stakeholders. • Provider-led Effort (PLE) structure for CEs • Applicable provider satisfaction survey results
Objective 7.2: Improve provider ratings of satisfaction with dental plans	No specific feedback was solicited.	Provider Relations and Claims Processing were identified as the most important items to include in the provider survey. • Provider-led Effort (PLE) structure for CEs • Applicable provider satisfaction survey results	Website/Portal Access and Provider Relations were identified as the most important items to include in the provider survey by Other Stakeholders. • Provider-led Effort (PLE) structure for CEs • Applicable provider satisfaction survey results
Objective 8.1 Implement performance withhold program	No specific feedback was solicited.	Wellness initiatives are a primary way to reduce costs. • Health plan CEs will implement new VBPs While feedback was not solicited specific to measures for performance withholds, noted measure topics of importance included well-child visits, ED visits, hospital readmissions, behavioral health, chronic disease	While feedback was not solicited specific to measures for performance withholds, noted measure topics of importance included well-child visits, ED visits, substance use disorder treatment, chronic disease management, maternal and infant mortality, preventive dental visits, and vaccination rates. • Well-Child Visits in the First 30 Months of Life (W30-CH)

Table B.1. Examples of Measures and Interventions Related to Stakeholder Feedback (Continued)			
Objective	Member Feedback	Provider Feedback	Tribal and Other Stakeholder Feedback
		management, and preventive dental visits. • Well-Child Visits in the First 30 Months of Life (W30-CH) • Child and Adolescent Well Care Visits Total (WCV-CH) • Ambulatory Care: ED Visits (AMB-CH) • ED Utilization (EDU) • Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH) • Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD) • Plan All-Cause Readmissions (PCR-AD) • Follow-Up Care for Children Prescribed Attention-Deficit/ Hyperactivity Disorder (ADHD) Medication (ADD-CH) • Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH) • Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Ages 13 to 17 (FUA-CH) • Follow-Up After Emergency Department Visit for Mental Illness (Ages 6 to 17) (FUM-CH) • Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPD-AD) • Oral Evaluation Dental Services (OEV-CH) • Annual Dental Visit	• Child and Adolescent Well Care Visits Total (WCV-CH) • Ambulatory Care: ED Visits (AMB-CH) • ED Utilization (EDU) • Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Ages 13 to 17 (FUA-CH) • Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPD-AD) • Oral Evaluation Dental Services (OEV-CH) • Annual Dental Visit • Prenatal and Postpartum Care: Timeliness of Prenatal) • Prenatal and Postpartum Care: Postpartum Care (PPC-AD) • Childhood Immunization Status Combination 3 (DTAP, IPV, MMR, HIB, Hepatitis B, VZV and PCV (CIS-CH) • Immunizations for Adolescents Combination One (IMA-CH)

Appendix C

SoonerSelect Quality Strategy

List of Abbreviations and Acronyms

List of Abbreviations and Acronyms	
Abbreviation/ Acronym	Description
ABD	Aged, Blind, and Disabled
AD	Adult CMS Core Set Measure
ADHD	Attention Deficit/Hyperactivity Disorder
AHRQ	Agency for Healthcare Research & Quality
APM	Advanced Payment Model
BH	Behavioral Health
BMI	Body Mass Index
CAH	Critical Access Hospital
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CCBHC	Certified Community Behavioral health Clinic
CDC	Centers for Disease Control and Prevention
CE	Contracted Entity
CFR	Code of Federal Regulations
CH	Child CMS Core Set Measure
CHIP	Children's Health Insurance Program
CMHC	Community Mental Health Center
CMS	Centers for Medicare & Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
CQS	Comprehensive Quality Strategy
CSP	Children's Specialty Program
CVO	Credential Verification Organization
DO	Doctor of Osteopathy
DQA (ADA)	Dental Quality Alliance (American Dental Association)
DSH	Disproportionate Share Hospital
ECHO	Experience of Care and Health Outcomes
ED	Emergency Department
EQR	External Quality Review
EQRO	External Quality Review Organization
FAR	Federal Acquisition Regulation
FDA	Food and Drug Administration
FQHC	Federally Qualified Health Center
HAN	Health Access Network
HCBS	Home and Community Based Service
HCP	Health Care Payment
HEDIS	Healthcare Effectiveness Data and Information Set
HIPAA	Health Information Portability and Accountability Act (of 1996)
HIT	Health Information Technology
HITECH	Health Information Technology for Economic and Clinical Health
HMP	Health Management Program
HRSA	Health Resources and Services Administration
IHCP	Indian Health Care Provider
IHI	Institute for Healthcare Improvement

List of Abbreviations and Acronyms	
Abbreviation/ Acronym	Description
KFMC	KFMC Health Improvement Partners
LAN	Learning and Action Network
LARC	Long-acting reversible method of contraception
LEP	Limited English Proficiency
LTCHs-C	Long-Term Care Hospitals Serving Children
LTSS	Long-Term Services and Supports
MAC	Medical Advisory Council
MATF	Member Advisory Task Force
MD	Medical Doctor
MIS	Management Information System
MSC	Medical Assistance with Smoking and Tobacco Use Cessation
MY	Measurement Year
NCHS	National Center for Health Statistics
NCQA	National Committee for Quality Assurance
NQF	National Quality Forum
OAC	Oklahoma Administrative Code
OB/GYN	Obstetrician/Gynecologist
OHCA	Oklahoma Health Care Authority
OHS	Oklahoma Human Services
OHSU	Oregon Health and Science University
OJA	Office of Juvenile Affairs
OPA	U.S. Office of Population Affairs
OSDH	Oklahoma State Department of Health
PA	Prior Authorization
PACT	Program for Assertive Community Treatment
PBM	Pharmacy Benefit Administrator
PCCM	Primary Care Case Management
PCD	Primary Care Dentist
PCMH	Patient Centered Medical Home
PCP	Primary Care Provider
PHI	Protected Health Information
PIP	Performance Improvement Project
PLE	Provider-led Effort
PQA	Pharmacy Quality Alliance
QAPI	Quality Assurance and Performance Improvement
RHC	Rural Health Clinic
SHCN	Special Health Care Needs
SSA	Social Security Administration
SSI	Supplemental Security Income
SDE-HIE	State's Designated Entity for Health Information Exchange
SUD	Substance Use Disorders

List of Abbreviations and Acronyms	
Abbreviation/ Acronym	Description
TANF	Temporary Assistance to Needy Families
TBD	To Be Determined
TEFRA	Tax Equity and Fiscal Responsibility Act
T-MSIS	Transformed Medicaid Statistical Information System
TOC	Transitions of Care
TTY/TDD	Teletypewriter/Telecommunications Device for the Deaf
VBP	Value-Based Payment