Oklahoma Health Care Authority

2013-2015 Final Evaluation Design for the SoonerCare §1115(a) Waiver Demonstration 11-W-00048/6

Re-submitted September 9, 2013

I. OVERVIEW

The Oklahoma Health Care Authority (OHCA), Oklahoma's single-state Medicaid agency, administers the 1115(a) SoonerCare Choice Research and Demonstration waiver. The waiver is currently in its eighteenth year of operations and has been renewed by the Centers for Medicare and Medicaid Services (CMS) a total of five times.

OHCA recently received CMS's approval for the 2013-2015 demonstration extension period on December 31, 2013, with the State acknowledging the approval of the renewal application and the Special Terms and Conditions (STC) on January 30, 2013.

The State operates the SoonerCare Choice program as a means to address Oklahoman's health care needs by providing quality care, as well as increasing access to care. OHCA identifies five objectives for the Choice demonstration in which to support program goals. The SoonerCare Choice program objectives include:

- Improving access to preventive and primary care services;
- Increase the number of participating primary care providers, and overall primary care capacity, in both urban and rural areas;
- Providing active, comprehensive care management to members with complex and/or exceptional health care needs;
- Integrating Indian Health Services' members and providers into the SoonerCare delivery system; and
- Expanding access to affordable health insurance for low-income adults in the work force, their spouses, and college students.

In accordance with STC XIV, OHCA proposes this SoonerCare Choice Evaluation Design for the 2013-2015 extension period to outline the hypotheses and reporting methodologies the State will use to evaluate the demonstration as it relates to the program's objectives, as well as CMS's Three-Part Aim approach.

II. OVERVIEW OF SOONERCARE CHOICE PROGRAM

SoonerCare Choice

The SoonerCare Choice demonstration operates under a Primary Care Case Management (PCCM) model in which the OHCA contracts directly with primary care providers throughout the state who serve members as a medical home. Providers are paid monthly care coordination payments for each member on their panels in amounts that vary depending on the level of medical home services provided and the mix of adults and children the provider accepts. Providers are also eligible for performance incentive payments when certain quality improvement goals, defined by the State, are met. Aside from care coordination, all other services provided in the medical home or by specialists, hospitals, or other providers, are reimbursed on a fee-for-service basis.

The SoonerCare Choice demonstration serves state plan populations including 1931 low-income families, IV-E foster care or adoption assistance children with voluntary enrollment, as well as children in mandatory state plan groups, pregnant women, and Aged, Blind, and Disabled (ABD) members. OHCA also serves individuals in need of breast or cervical cancer treatment, in accordance with Senate Bill 741; as well as disabled children in accordance with the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). The SoonerCare Choice program currently serves some 538,000[1] members.

Insure Oklahoma Premium Assistance Program

The OHCA operates the Insure Oklahoma premium assistance program under the 1115(a) SoonerCare Choice Research and Demonstration waiver. The Insure Oklahoma program provides two pathways for individuals to receive premium assistance – Employer Sponsored Insurance (ESI) and the Individual Plan (IP). Individuals in ESI enroll in an Insure Oklahoma private health plan and pay up to 15 percent of the premium, with costs also divided among the employee and the state/federal government. Individuals in the IP program are responsible for health plan premiums up to four percent of their monthly gross household income[2].

The Insure Oklahoma program serves non-disabled, low-income working adults, and their spouses, who work for an employer with 99 or fewer employees; working disabled adults, and their spouses; foster parents, and their spouses; qualified employees of not-for-profit businesses, and their spouses, who work for an employer with 500 or fewer employees; full-time college students; and dependent children of parents in the Insure Oklahoma program. The Insure Oklahoma program currently serves some 16,932 individuals enrolled in the ESI program and some 13,368 individuals enrolled in the IP program for an overall program total of some 30,300[3] individuals.

In accordance with Section VI of Oklahoma's Special Terms and Conditions for the 1115(a) SoonerCare Choice waiver demonstration, it should be noted that CMS will expire the Insure Oklahoma premium assistance program, effective December 31, 2013.

[1] February 2013, SoonerCare Choice Fast Facts.
[2] In accordance with Oklahoma Administrative Code 317:45-11-24, American Indians providing documentation of ethnicity are exempt from premium payments.
[3] February 2013, Federal Poverty Level Fast Facts.

Health Access Networks (HANs)

OHCA has three health access network program pilots under the 1115(a) SoonerCare Choice Research and Demonstration waiver – the OU Sooner HAN, the Partnership for a Healthy Canadian County (PHCC) HAN, and the OSU Network HAN. Each HAN is a non-profit, administrative entity that works with affiliated providers to coordinate and improve the quality of care provided to SoonerCare Choice members. Health Access Networks receive a nominal per member per month payment, initially established at $5, which is made in addition to the care coordination payments paid to providers.

The health access networks offer care management and care coordination to persons in the SoonerCare Choice program with complex health care needs including individuals with frequent emergency room utilization, women enrolled in the Oklahoma Cares program diagnosed with breast or cervical cancer, pregnant women enrolled in the high-risk OB program, individuals with hemophilia, and individuals enrolled in the pharmacy lock-in program. The health access networks also co-manage individuals enrolled in the Health Management Program. The OU Sooner HAN currently serves some 45,606[4] individuals, the PHCC HAN serves some 3,118 individuals, and the OSU HAN serves some 14,998 individuals.

Health Management Program (HMP)

The HMP is a statewide program under the 1115(a) SoonerCare Choice Research and Demonstration waiver developed to manage chronic disease of the most at-risk SoonerCare Choice members. The program is administered by the OHCA and is managed by a vendor obtained through competitive bid.

The SoonerCare HMP serves SoonerCare Choice beneficiaries ages 4 through 63 with chronic illness who are at highest risk for adverse outcomes and increased health care expenditures. Chronic illness includes asthma, chronic obstructive pulmonary disease, congestive heart failure, diabetes, and renal disease. Currently, the HMP serves some 888[5] Tier 1 participants and some 3,242[6] Tier 2 participants.

Initially, the HMP was comprised of two components – nurse case management and practice facilitation. Members at high-risk of chronic illness, designated as Tier 2 members, receive services telephonically by nurse care managers. Members at highest risk of chronic illness, designated as Tier 1 members, receive face-to-face nurse case management services. Additionally, practice facilitation services are offered to selected medical home PCPs to enhance primary care services and support chronic disease prevention.

In anticipation of the first expiration of the HMP administrator's contract term in June 2013, OHCA used the re-bidding process as an opportunity to make modifications to the HMP program. Beginning July 2013, the HMP will transition to Phase II of the program; the program will continue practice facilitation but will change from nurse case management to health coaching. Health coaches will be embedded within the PCP practices that have a high number of SoonerCare Choice members. The health coaches will work with individual SoonerCare Choice members on becoming a more informed and engaged patient.

[4] Data as of December 2012.
[5] Full enrollment is 1,000 participants.
[6] Full enrollment is 4,000 participants.

III. EVALUATION DESIGN PLAN

Since the program's inception, OHCA has provided a set of waiver objectives for the demonstration that establish the purpose and the goals of the SoonerCare Choice program. The following Evaluation Design waiver objectives refer back to the still-relevant goals from the program's inception, as well as taking into consideration the program's populations and goals for the 2013-2015 extension period, and CMS's three-part aim.

2013-2015 SoonerCare Choice Waiver Objectives:

1. Improving access to preventive and primary care services;
2. Increase the number of participating primary care providers, and overall primary care capacity, in both urban and rural areas;
3. Providing active, comprehensive care management to members with complex and/or exceptional health care needs;
4. Integrating Indian Health Services' members and providers into the SoonerCare delivery system; and
5. Expanding access to affordable health insurance for low-income adults in the work force, their spouses, and college students.

CMS's Three Part Aim:

1. Improving access to and experience of care;
2. Improving quality of health care; and
3. Decreasing per capita costs.

All data reported will be based on the entire universe of SoonerCare Choice members being evaluated within each hypothesis, unless a sample of the larger population is specified.

Each of the hypotheses targets a SoonerCare initiative for which there is no parallel initiative whose effect must be isolated as part of the analysis. Therefore, OHCA did not deem it necessary to develop specific steps to isolate the effects of the SoonerCare program from others in the state.

OHCA and the state's External Quality Review Organization will be responsible for evaluation and reporting on the hypotheses. OHCA will report interim evaluation findings and hypothesis data in the quarterly operational reports.

In accordance with the Special Terms and Conditions, the State will submit to CMS a draft evaluation report 120 days after the end of the 2013-2015 extension.

Hypothesis 1
Hypothesis 1: Child Health Checkup Rates *This hypothesis directly relates to SoonerCare Choice waiver objective #1 and #1 of CMS's Three Part Aim.* The rate for age-appropriate well-child and adolescent visits will improve between 2013-2015. A. Child health checkup rates for children 0 to 15 months old will be maintained at or above 95 percent over the life of the extension period. B. Child health checkup rates for children 3 through 6 years old will increase by three percentage points over the life of the extension period. C. Adolescent child health checkup rates will increase by three percentage points over the life of the extension period.
Research Methodology: The visit rates will be calculated separately for each of the age cohorts (0 to 15 months, 3 to 6 years, and 12 to 21 years) in accordance with each year's HEDIS® guidelines, using administrative data (paid claims and encounters).
Population Studied: SoonerCare Choice members ages 0 to 15 months, 3 to 6 years, and 12 to 21 years.
Numerators: A. The number of SoonerCare Choice members who turned 15 months old during the measurement year and who received one or more well-child visits with a primary care provider during their first 15 months of life. B. The number of SoonerCare Choice members who were three, four, five, or six years of age during the calendar year and who received one or more well-child visits with a primary care provider during the calendar year. C. The number of SoonerCare Choice members who were twelve to twenty-one years of age during the calendar year and who received one or more well-child visits with a primary care provider during the calendar year. The following primary care provider types are recognized under SoonerCare Choice: - Physicians - Family Medicine Practitioner - General Practitioner - General Pediatrician - General Internist - Clinics - EPSDT Clinic - Family Planning Clinic - FQHC/RHC - Medical Clinic - Nurse Practitioner Clinic - Pediatric Clinic - Other - Family Nurse Practitioner - Other Nurse Practitioner - Pediatric Nurse Practitioner - Physician Assistant

Hypothesis 1
Denominators: A. Number of children enrolled in SoonerCare Choice continuously from their date-of-birth (DOB) + 31 days to their DOB + 15 months, allowing for a gap of one month, and who are enrolled in SoonerCare on their "anchor date" (DOB + 15 months). B. Number of children enrolled in SoonerCare Choice for 11 or 12 months in the measurement year, including on the anchor date (December 31 of measurement year), with no more than one gap in enrollment of up to 45 days during the continuous enrollment period. C. Number of adolescents enrolled in SoonerCare Choice for 11 or 12 months in the measurement year, including on the anchor date (December 31 of measurement year), with no more than one gap in enrollment of up to 45 days during the continuous enrollment period.
Data Source: Oklahoma Medicaid Management Information System.
Baseline Data: Demonstration year 2012 well-child visit rate. (HEDIS® 2013 data are not yet available.)
Reporting Frequency: OHCA compiles HEDIS® data on a calendar year basis and reports data six to nine months after the close of the calendar year.
Statistical Analysis OHCA will determine whether a change (increase or decrease) from one year to the following year is statistically significant. The HEDIS® data will be analyzed using a statistical procedure called the test of two independent proportions, or a z-test. The z-test determines the value of the number of standard deviations between the two proportions.

Hypothesis 2
Hypothesis 2: PCP Visits *This hypothesis directly relates to SoonerCare Choice waiver objective #1 and #1 of CMS's Three Part Aim.* The rate of adult members who have one or more preventive health visits with a primary care provider in a year will improve by three percentage points as a measure of access to primary care in accordance with HEDIS® guidelines between 2013-2015.
Research Methodology: Health visits will be calculated separately for each of the age cohorts (20-44 years and 45-64 years) in accordance with HEDIS® guidelines, using administrative data (paid claims and encounters).
Population Studied: SoonerCare Choice members ages 20-44 years and 45-64 years.
Numerator: The number of SoonerCare Choice members ages 20 years through 44 years and 45 years through 64 years continuously enrolled during the measurement year that have had one or more preventive health visits during the year. The only exclusions will be for inpatient procedures, hospitalizations, emergency room visits, and visits primarily related to mental health and/or chemical dependency. The following primary care provider types are recognized under SoonerCare Choice: - Physicians - Family Medicine Practitioner - General Practitioner - General Pediatrician - General Internist - Clinics - EPSDT Clinic - Family Planning Clinic - FQHC/RHC - Medical Clinic - Nurse Practitioner Clinic - Pediatric Clinic - Other - Family Nurse Practitioner - Other Nurse Practitioner - Pediatric Nurse Practitioner - Physician Assistant
Denominator: The number of adults ages 20 through 44 and 45 through 64 enrolled in SoonerCare Choice for 11 or 12 months of the calendar year, including on the "anchor date" (December 31 of the calendar year), with no more than one gap in enrollment of up to 45 days during the continuous enrollment period.
Data Source: Oklahoma Medicaid Management Information System.
Baseline Data: Demonstration year 2012 preventive health access rate for adult age cohorts. (HEDIS® 2013 data are not yet available.)
Reporting Frequency: OHCA compiles HEDIS® data on a calendar year basis and reports data six to nine months after the close of the calendar year.
Statistical Analysis: OHCA will determine whether a change (increase or decrease) from one year to the following year is statistically significant. The HEDIS® data will be analyzed using a statistical procedure called the test of two independent proportions, or a z-test. The z-test determines the value of the number of standard deviations between the two proportions.

Hypothesis 3
Hypothesis 3: PCP Enrollments *This hypothesis directly relates to SoonerCare Choice waiver objective #2 and #1 of CMS's Three Part Aim.* The number of SoonerCare primary care practitioners enrolled as medical home PCPs will maintain at or above the baseline data between 2013-2015.
Research Methodology: SoonerCare Choice PCPs are calculated by counting the number of service locations of individual providers who are contracted as Choice PCPs and the number of members of group practices that are contracted as Choice PCPs.
Population Studied: Contracted SoonerCare Choice PCPs.
Data Source: Provider Fast Facts
Baseline Data: Demonstration year 2012. (December 2012 – 1,932)
Reporting Frequency: The OHCA Reporting and Statistics unit compiles the Provider Fast Facts on a monthly basis.

Hypothesis 4
Hypothesis 4: PCP Capacity Available *This hypothesis directly relates to SoonerCare Choice waiver objectives #1 and #2, and #1 of CMS's Three Part Aim.* There will be adequate PCP capacity to meet the health care needs of the SoonerCare members between 2013-2015. Also, as perceived by the member, the time it takes to schedule an appointment should improve between 2013-2015. A. The available capacity will equal or exceed the baseline capacity data over the duration of the waiver extension period. B. As perceived by the member, the time it takes for the member to schedule an appointment should exceed the baseline data between 2013-2015.
Research Methodology: A. Capacity will be calculated in terms of total capacity and the average number of SoonerCare Choice members per PCP. B. The member's perception of timeliness to schedule an appointment will be calculated using OHCA's External Quality Review contractor who will conduct a CAHPS® member survey, and include a question relating to the time it takes to schedule an appointment.
Population Studied: A. SoonerCare Choice members. B. A sample group from the SoonerCare Choice population, who meet certain eligibility criteria.
Numerators: A. The total number of SoonerCare Choice members in each measurement month. B. The total number of eligible members who give a positive response to the CAHPS® survey question relating to the time it takes to schedule an appointment.
Denominators: A. The total contracted capacity across SoonerCare Choice PCPs, as recorded in the provider subsystem of the Medicaid Management Information System. B. The total number of eligible members who complete the CAHPS® survey question relating to the time it takes to schedule an appointment.
Data Resources: A. The total contracted capacity, as recorded in the Medicaid Management Information System, as derived from PCP contract data; and the average number of members per PCP, calculated by dividing the total number of members in the measurement month by the total number of contracted PCPs in that same month. B. Survey responses collected through mail and telephone will be systematically entered into a central database. Once the survey collection period ends, the statistical analysis software SAS® will be used with the CAHPS® Analysis Program to complete the necessary cleaning and preparation of the data as well as the analysis. The survey responses will be recorded in order to perform the necessary calculations using assigned numeric values from the CAHPS® Survey and Reporting Kit.

Hypothesis 4
Data Sources: A. Oklahoma Medicaid Management Information System. B. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0 Medicaid Adult or Child Member Satisfaction Surveys
Baseline Data: A. December 2012 total contracted capacity (1,092,850) and average members per PCP (279.11). B. CAHPS® survey, September 2012
Reporting Frequency: A. The OHCA receives the data quarterly, no later than 90 days after close of the measurement period. B. The CAHPS® survey is reported annually on a state fiscal year basis.
Statistical Analysis: OHCA's vendor for the CAHPS® member survey will determine whether a change (increase or decrease) from one year to the following year is statistically significant. The data will be analyzed using a statistical procedure called the test of two independent proportions, or a z-test. The z-test determines the value of the number of standard deviations between the two proportions.

Hypothesis 5
Hypothesis 5: Integration of Indian Health Services, Tribal Clinics, and Urban Indian Clinic Providers *This hypothesis directly relates to SoonerCare Choice waiver objective #4, and #1 of CMS's Three Part Aim.* The percentage of American Indian members who are enrolled with an Indian Health Services, Tribal, or Urban Indian Clinic (I/T/U) with a SoonerCare Choice American Indian primary care case management contract will increase nine percentage points during the 2013-2015 extension period (this is three percentage points each year).
Research Methodology: The American Indian SoonerCare Choice enrollment percentage will be calculated based on PCP assignment data.
Population Studied: American Indian SoonerCare Choice members who are enrolled with an Indian Health Services, Tribal or Urban Indian Clinic (I/T/U) with a SoonerCare American Indian primary care case management contract.
Numerator: The total number of SoonerCare Indian Health Services enrollees in December of each measurement year who have an I/T/U PCP.
Denominator: The total number of SoonerCare Indian Health Service's enrollees in December of each measurement year.
Data Resource: The total I/T/U contracted capacity, as recorded in the MMIS from PCP contract data. The member PCP alignment data, as recorded in the eligibility subsystem of the MMIS.
Data Source: Oklahoma Medicaid Management Information System.
Baseline Data: Total contracted I/T/U capacity in December 2012 (124,400), and percentage of SoonerCare IHS enrollees with an I/T/U PCP in December 2012 (21.04 percent).
Reporting Frequency: The OHCA will analyze the data every year, no later than 90 days after the close of the measurement year.

Hypothesis 6
Hypothesis 6: Eligible Member Enrollments in Medical Homes *This hypothesis directly relates to SoonerCare Choice waiver objective #1 and #1 of CMS's Three Part Aim.* The proportion of members eligible for SoonerCare Choice who do not have an established PCP will decrease within 90 days of the primary care claims analysis report.
Research Methodology: OHCA will decrease the proportion of members not enrolled with a PCP using Member Services and Provider Services Productivity Reports against claims data.
Population Studied: SoonerCare Choice members with one or more claims who are not enrolled with a PCP.
Numerator: The number of SoonerCare Choice members who did not have an established PCP when filing a claim, but was enrolled by Member Services or Provider Services.
Denominator: The number of SoonerCare Choice members with a claim who are not enrolled with a PCP.
Data Source: Oklahoma Medicaid Management Information System; Member Services and Provider Services Productivity Reports.
Baseline Data: OHCA will use the first year's data (2013) as the baseline data.
Reporting Frequency: OHCA runs the primary care claims analysis data monthly; productivity reports are run within 90 days of the primary care claims analysis data.

Hypothesis 7
Hypothesis 7: Impact of Health Access Networks on Quality of Care *This hypothesis directly relates to SoonerCare Choice waiver objective #3 and #2 of CMS's Three Part Aim.* Key quality performance measures, asthma and Emergency Room (ER) utilization, tracked for PCPs participating in the HANs will improve between 2013-2015. A. Decrease asthma-related ER visits for HAN members with an asthma diagnosis identified in their medical record. B. Decrease 90-day readmissions for related asthma conditions for HAN members with an asthma diagnosis identified in their medical record. C. Decrease overall ER use for HAN members.
Research Methodology: A. ER visits will be reviewed to identify ER visits related to an asthma diagnosis and compared to HAN members with asthma identified as a problem in their medical records. ER visits for unrelated illnesses will not be included in the measure. B. Readmissions that occurred within 90 days of first admission will be reviewed to identify readmissions related to an asthma diagnosis and compared to HAN members with asthma identified as a problem in their medical records. Readmissions for unrelated illnesses will not be included in the measure. C. ER visits will be reviewed for all HAN members regardless of reason.
Population Studied: Members in the HAN.
Numerator: A. Total number of ER visits by HAN members with asthma identified in their problem list for an asthma-related diagnosis. B. Total number of HAN members with asthma identified in their problem list who were readmitted to the hospital for an asthma-related illness within 90 days of a previous asthma-related hospitalization. C. Total number of ER visits for HAN members.
Denominator: A. All HAN members with an asthma diagnosis identified in their medical record. B. All HAN members with an asthma diagnosis identified in their medical record and having at least one inpatient stay related to asthma. C. All HAN members.
Data Resource: Claims data as recorded in the claims subsystem of the Medicaid Management Information System. Patient data recorded in electronic medical records, community Health Information Exchange (HIE) or self-report by providers.
Data Source: Oklahoma Medicaid Management Information System. Provider electronic medical record, MyHealth HIE, and self-report by providers in absence of access to EMR or MyHealth data.
Baseline Data: A. The number of ER visits for HAN members continuously enrolled in the HAN for at least 90 days with a related diagnosis of asthma for CY2013 will serve as the numerator for baseline data. The number of ER visits for HAN members continuously enrolled in the HAN for at least

Hypothesis 7
90 days for CY2013 will serve as the denominator for baseline data. B. The number of HAN members continuously enrolled in the HAN for at least 90 days with asthma identified in their problem list who were readmitted to the hospital for an asthma related illness within 90 days of a previous asthma related hospitalization for CY 2013 will serve as the numerator for baseline data. The number of HAN members continuously enrolled in the HAN for at least 90 days with an asthma diagnosis identified in their medical record and having at least one inpatient stay related to asthma for CY 2013 will serve as the denominator for baseline data. C. The number of ER Visits for any cause for HAN members continuously enrolled in the HAN for at least 90 days for CY 2013 will serve as the numerator for baseline data. The number of ER Visits for any cause for HAN members continuously enrolled in the HAN for at least 90 days for CY 2013 will serve as the denominator for baseline data.
Reporting Frequency: The HANs will evaluate results annually and perform quarterly reviews throughout each calendar year.

In addition to the hypothesis, the HANs will include in their annual report an analysis of the HANs effectiveness in:

- Improving access to and the availability of health care services to SoonerCare beneficiaries served by the HAN;
- Improving the quality and coordination of health care services to SoonerCare beneficiaries served by the HAN with specific focus on the populations at greatest risk including those with multiple chronic illnesses; and
- Enhancing the state's patient-centered medical home program through an evaluation of PCP profiles that incorporates a review of utilization, disease guideline compliance, and cost.

Hypothesis 8
Hypothesis 8: Impact of Health Access Networks on Effectiveness of Care *This hypothesis directly relates to SoonerCare Choice waiver objective #3 and #3 of CMS's Three Part Aim.* Reducing costs associated with the provision of health care services to SoonerCare beneficiaries served by the HANs. A. Average per member per month expenditures for members belonging to a HAN affiliated PCP will continue to be less than those members enrolled with non-HAN affiliated PCPs during the period of 2013-2015.
Research Methodology: A PMPM comparison will be calculated between Choice members' whose PCPs are in a HAN and those PCPs who do not participate in a HAN.
Population Studied: SoonerCare Choice members' whose PCPs are in a HAN and SoonerCare Choice PCPs not participating in a HAN.
Numerator: A. The monthly total of paid claims, care coordination payments, HAN network payments, and Sooner Excel payments for members whose PCPs belong to a HAN. B. The monthly total of paid claims, care coordination payments, and Sooner Excel payments for members whose PCPs do not belong to a HAN.
Denominator: A. Member months for all PCPs in a HAN. B. Member months for all PCPs not in a HAN.
Data Source: Oklahoma Medicaid Management Information System.
Baseline Data: PMPM comparison for SFY 2012.
Reporting Frequency: Completed on a yearly basis three to four months after the end of each state fiscal year.

Evaluation of the Health Management Program
OHCA discusses the goals, objectives, and specific hypotheses that are being tested through the Health Management (HMP) program.

OHCA and the HMP contractor will partner together to evaluate the effectiveness of the HMP program as it relates to the HMP program goals and CMS's three-part aim.

2013-2015 HMP program Objectives:

- Improving health outcomes and reducing medical costs of the population served;
- Reducing the incidence and severity of chronic disease in the member population;
- Encouraging and enabling members to better manage their own health;
- Improving the effectiveness of providers in caring for members with chronic disease or at risk for such disease; and
- Having the ability to provide services to providers and members in any area of the state, urban or rural.

CMS's Three Part Aim:

- Improving access to and experience of care;
- Improving quality of health care; and
- Decreasing per capita costs.

Hypothesis 9a
Hypothesis 9a: Health Management Program (HMP); Impact on Enrollment Figures *This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #3, and #1 of CMS's Three Part Aim.* The implementation of phase two of the SoonerCare HMP, including introduction of physician office-based Health Coaches for nurse care managed members and closer alignment of nurse care management and practice facilitation will yield increased enrollment and active participation (engagement) in the program. A. The percentage of SoonerCare members identified as eligible for nurse care management, who enroll and are actively engaged, will increase as compared to baseline. B. The percentage of members actively engaged in nurse care management in relation to the providers' total SoonerCare Choice panel.
Research Methodology: The percentages for research item A will be calculated using data provided by the program contractor (Telligen) on the number of members identified as eligible to enroll in nurse care management and the number who actually enroll, as well as the Health Coach (and associated practice) assignment of engaged members. The percentages for research item B will be calculated using data provided by the program contractor and overall PCP assignment data provided by the OHCA.
Population Studied: A. SoonerCare Choice members identified as eligible for nurse care management. B. SoonerCare Choice nurse care managed members whose PCP has undergone practice facilitation.
Numerator: A. The number of members actively engaged in nurse care management aligned with a PCP. B. The number of members actively engaged in nurse care management aligned with a PCP.
Denominator: A. All members identified as eligible for nurse care management, either through predictive modeling or physician referral. (Members identified through predictive modeling but not aligned with a practice that has a Health Coach will be referred to the OHCA Chronic Care Unit for follow-up and will be excluded from the denominator.) B. All SoonerCare members assigned to the panels of practices with health coaches.
Data Resource: SoonerCare HMP contractor (Telligen).
Data Source: Monthly rosters denoting PCP panel assignment, members eligible for nurse care management, status of each case (not contacted, declined to enroll, or enrolled and engaged), and Health Coach/practice alignment, if applicable.
Baseline Data: Participation data for SFY2013 (final year of phase one of the SoonerCare HMP).
Reporting Frequency: Telligen will submit monthly reports to the OHCA and the OHCA will prepare monthly PCP assignment reports. The monthly reports will be trended and the findings included in the annual progress report prepared by the SoonerCare HMP independent evaluator.

Hypothesis 9b
Hypothesis 9b: Health Management Program (HMP); Impact on Access to Care *This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #4, and #1 of CMS's Three Part Aim.* The incorporation of Health Coaches into primary care practices will result in increased PCP contact with nurse care managed members, versus baseline for two successive years and a comparison group of eligible but not enrolled members.
Research Methodology: The contact rates will be calculated through analysis of visit activity, as derived from paid claims data, for members identified by the program contractor (Telligen) as engaged in nurse care management or eligible but not enrolled.
Population Studied: SoonerCare Choice members who receive nurse care management and Choice members eligible for nurse care management but not receiving nurse care management (comparison group).
Numerator: A. Total PCP visits for members engaged in nurse care management for a 12-month continuous period, starting in SFY2014 (engaged group). B. Total PCP visits for members engaged in nurse care management for the 12-month continuous period comprising SFY2013 when nurse care management occurred through telephonic outreach and in-home visits (baseline group). C. Total PCP visits for members eligible but not enrolled in either nurse care management or the OHCA Chronic Care Unit for a 12-month continuous period, starting in SFY2014 (comparison group).
Denominator: A. Total member months in SFY2014 for engaged group. B. Total member months in SFY2013 for baseline group. C. Total member months in SFY2014 for comparison group.
Data Resource: SoonerCare HMP contractor (Telligen) and MMIS contractor (HP).
Data Source: Monthly rosters denoting members eligible for nurse care management, status of each case (not contacted, declined to enroll, or enrolled and engaged), and Health Coach/practice alignment, if applicable. Monthly paid claims extract.
Baseline Data: Average number of PCP visits per nurse care managed member in SFY2013.
Reporting Frequency: Telligen will submit monthly reports to the OHCA. The Telligen reports and paid claims extracts will be provided to the SoonerCare HMP independent evaluator. Findings will be presented in the annual progress report prepared by the evaluator.

Hypothesis 9c
Hypothesis 9c: Health Management Program (HMP); Impact on Identifying Appropriate Target Population *This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #2, and #2 of CMS's Three Part Aim.* The implementation of phase two of the SoonerCare HMP, including introduction of physician office-based Health Coaches for nurse care managed members and closer alignment of nurse care management and practice facilitation will improve the process for identifying eligible members and result in an increase in average complexity of need within the nurse care managed population.
Research Methodology: The type and number of physical and behavioral health chronic conditions for engaged members will be analyzed using diagnosis codes from paid claims data. The average chronic impact score generated by MEDai using paid claims data also will be analyzed.
Population Studied: SoonerCare Choice members in nurse care management.
Numerator: A. Number of members engaged in nurse care management at any time in a 12-month period with 2, 3, 4, etc. chronic physical health conditions. B. Sum of chronic physical health conditions across all members engaged at any time in a 12-month period. C. Number of members engaged in nurse care management at any time in a 12-month period with at least one chronic physical health condition and one behavioral health condition. D. Sum of chronic impact scores across all members engaged at any time in a 12-month period.
Denominator: A. Total members engaged in nurse care management for the 12-month period. B. Total members engaged in nurse care management for the 12-month period. C. Total members engaged in nurse care management for the 12-month period. D. Total members engaged in nurse care management for the 12-month period.
Data Resource: SoonerCare HMP contractor (Telligen), MEDai and MMIS contractor (HP).
Data Source: Monthly rosters denoting members engaged in nurse care management, monthly MEDai data runs and monthly paid claims extracts.
Baseline Data: Same metrics for nurse care managed population in SFY2013.
Reporting Frequency: Telligen and MEDai will submit monthly reports/data runs to the OHCA. The Telligen reports, MEDai data runs, and paid claims extracts will be provided to the SoonerCare HMP independent evaluator. Findings will be presented in the annual progress report prepared by the evaluator.

Hypothesis 9d
Hypothesis 9d: Health Management Program (HMP); Impact on Health Outcomes *This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #5, and #2 of CMS's Three Part Aim.* The use of a disease registry by Health Coaches will improve the quality of care for nurse care managed members.
Research Methodology: The percentage of engaged members documented through the registry as compliant on diagnosis-specific quality measures and preventive health measures will be analyzed and trended over time. Measures will be derived from the Initial Set of Health Care Quality Measures for Medicaid-Eligible Adults and CHIPRA Core Set of Children's Healthcare Quality Measures.
Population Studied: SoonerCare Choice members who receive nurse care management.
Numerator: Sum of measures across all reporting practices documented in the registry as compliant on each quality measure (separate analysis for each measure).
Denominator: Sum of members across all reporting practices entered into the registry for reporting purposes.
Data Resource: SoonerCare HMP contractor (Telligen).
Data Source: Monthly extract from registry.
Baseline Data: Same metrics for nurse care managed population in SFY2013 for measures reported that year. SFY2014 metrics for new measures.
Reporting Frequency: Telligen will submit monthly registry extracts to the OHCA and the SoonerCare HMP independent evaluator. Findings will be presented in the annual progress report prepared by the evaluator.

Hypothesis 9e
Hypothesis 9e: Health Management Program (HMP); Impact on Cost/Utilization of Care *This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #1, and #2 of CMS's Three Part Aim.* Nurse care managed members will utilize the emergency room at a lower rate than members in a comparison group comprised of eligible but not enrolled members.
Research Methodology: Emergency room utilization rates for both groups will be calculated through analysis of paid claims data as reported on a per 1,000 member basis.
Population Studied: SoonerCare Choice members who receive nurse care management and Choice members eligible for nurse care management but not receiving nurse care management (comparison group).
Numerator: A. Total emergency room visits over a 12-month period for members engaged in nurse care management for at least a 3-month continuous period within the 12 months, starting in SFY2014 (engaged group). B. Total emergency room visits over a 12-month period for members eligible but not enrolled in nurse care management or the OHCA Chronic Care Unit, starting in SFY2014 (comparison group).
Denominator: A. Total nurse care managed member months in the 12-month period for engaged group included in analysis. B. Total member months in the 12-month period for comparison group members.
Data Resource: SoonerCare HMP contractor (Telligen) and MMIS contractor (HP).
Data Source: Monthly rosters denoting members eligible for nurse care management and status of each case (not contacted, declined to enroll, or enrolled and engaged). Monthly paid claims extract.
Baseline Data: Average emergency room visit rate per 1,000 engaged members and comparison group members in SFY2014.
Reporting Frequency: Telligen will submit monthly reports to the OHCA. The Telligen reports and paid claims extracts will be provided to the SoonerCare HMP independent evaluator. Findings will be presented in the annual progress report prepared by the evaluator.

Hypothesis 9f
Hypothesis 9f: Health Management Program (HMP); Impact on Cost/Utilization of Care *This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #1, and #2 of CMS's Three Part Aim.* Nurse care managed members will have fewer hospital admissions and readmissions than members in a comparison group comprised of eligible but not enrolled members.
Research Methodology: Hospital admission and 30-day readmission rates for both groups will be calculated through analysis of paid claims data and reported on a per 1,000 member basis.
Population Studied: SoonerCare Choice members who receive nurse care management and Choice members eligible for nurse care management but not receiving nurse care management (comparison group).
Numerator: A. Total hospital admissions in a 12-month period for members engaged in nurse care management for at least a 3-month continuous period within the 12 months, starting in SFY2014 (engaged group). B. Total hospital readmissions within 30 days of discharge for members engaged in nurse care management for at least a 3-month continuous period within the 12 months, starting in SFY2014 (engaged group). C. Total hospital admissions for members eligible but not enrolled in nurse care management or the OHCA Chronic Care Unit, starting in SFY2014 (comparison group). D. Total hospital readmissions within 30-days of discharge for members eligible but not enrolled in nurse care management or the OHCA Chronic Care Unit, starting in SFY2014 (comparison group).
Denominator: A. Total nurse care managed member months in SFY2014 for engaged group included in analysis. B. Total nurse care managed member months in SFY2014 for engaged group included in analysis. C. Total member months in SFY2014 for comparison group members. D. Total member months in SFY2014 for comparison group members.
Data Resource: SoonerCare HMP contractor (Telligen) and MMIS contractor (HP).
Data Source: Monthly rosters denoting members eligible for nurse care management and status of each case (not contacted, declined to enroll, or enrolled and engaged). Monthly paid claims extract.
Baseline Data: Average hospital admission and readmission rate per 1,000 engaged members and comparison group members in SFY2014.
Reporting Frequency: Telligen will submit monthly reports to the OHCA. The Telligen reports and paid claims extracts will be provided to the SoonerCare HMP independent evaluator. Findings will be presented in the annual progress report prepared by the evaluator.

Hypothesis 9g
Hypothesis 9g: Health Management Program (HMP); Impact on Satisfaction/Experience with Care *This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #3, and #2 of CMS's Three Part Aim.* Nurse care managed members will report higher levels of satisfaction with their care than members in a comparison group comprised of eligible but not engaged members.
Research Methodology: Nurse care managed members and members in the comparison group will be surveyed regarding their satisfaction with their personal provider and overall health care. The survey will include validated questions derived from the CAHPS® instrument, to also permit comparison to the broader SoonerCare population.
Population Studied: SoonerCare Choice members who receive nurse care management and Choice members eligible for nurse care management but not receiving nurse care management (comparison group).
Numerator: A. Nurse care managed members surveyed in a 12-month period and reporting satisfaction level of 8, 9 or 10 on a 10-point scale (engaged group). B. Members eligible but not enrolled in nurse care management or the OHCA Chronic Care Unit surveyed in a 12-month period and reporting satisfaction level of 8, 9 or 10 on a 10-point scale (comparison group).
Denominator: A. Total nurse care managed members surveyed in a 12-month period. B. Total comparison group members surveyed in a 12-month period.
Data Resource: SoonerCare HMP contractor (Telligen) and independent evaluator.
Data Source: Monthly rosters denoting members eligible for nurse care management and status of each case (not contacted, declined to enroll, enrolled and engaged). Survey data collected by independent evaluator.
Baseline Data: Satisfaction rates for engaged members and comparison group members in SFY2014.
Reporting Frequency: Telligen will provide monthly rosters to the independent evaluator for use in contacting survey respondents. Findings will be presented in the annual progress report prepared by the evaluator.

Hypothesis 9h
Hypothesis 9g: Health Management Program (HMP); Impact of HMP on Effectiveness of Care *This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #1, and #3 of CMS's Three Part Aim.* Total and PMPM expenditures for members enrolled in HMP will be lower than would have occurred absent their participation in nurse care management.
Research Methodology: Actual expenditures for nurse care managed members will be calculated and compared to projected expenditures as derived through MEDai predictive modeling software. In order to measure the program's true cost effectiveness, the actual expenditures will include both paid claims and administrative expenses (vendor payments and OHCA salary/overhead expenses) associated with the nurse care management portion of the HMP. The same analysis will be performed on members eligible but not enrolled in either nurse care management or the OHCA Chronic Care Unit, to isolate and, if appropriate, adjust for variance not attributable to nurse care management. (Health-related expenses only; there will be no HMP-related administrative expenses allocated to this group). The trend line for the eligible but not enrolled population also will be used to track the impact of nurse care management on the engaged population after the initial 12-month period of enrollment (MEDai data projections extend out only 12 months).
Population Studied: SoonerCare Choice members enrolled in HMP and receiving nurse care management, and Choice members not enrolled in HMP who do not receive nurse care management.
Numerator: A. Total and PMPM expenditures incurred over a 12-month period by members engaged in nurse care management for at least a 3-month continuous period within the 12 months, starting in SFY2014 (engaged group). B. Total and PMPM expenditures incurred over a 12-month period for members eligible but not enrolled in nurse care management or the OHCA Chronic Care Unit, starting in SFY2014 (comparison group).
Denominator: A. Total and PMPM projected health expenditures in the initial 12-month period for nurse care managed members, as calculated by MEDai predictive modeling software. (Subsequent 12-month periods to be trended based on actual experience of comparison group). B. Total projected health expenditures in the initial 12-month period for comparison group beneficiaries, as calculated by MEDai predicitive modeling software.
Data Source: Monthly rosters denoting members eligible for nurse care management and status of each case (not contacted, declined to enroll, or enrolled and engaged). Monthly MEDai expenditure forecasts for the same population. Monthly paid claims extract. Vendor payment and OHCA administrative expense data.
Baseline Data: Total projected health expenditures in the initial 12-month period for nurse care managed members.

Hypothesis 9h
Reporting Frequency: Telligen will submit monthly reports to the OHCA. The Telligen reports and paid claims extracts will be provided to the SoonerCare HMP independent evaluator. Findings will be presented in the annual progress report prepared by the evaluator.

Hypothesis 10
Hypothesis 10: Retroactive Eligibility *This hypothesis directly relates to SoonerCare Choice waiver objective #5 and #1 of CMS's Three Part Aim.* The state's systems performance will ensure seamless coverage between Medicaid and the Exchange after changes outlined in the Affordable Care Act are effectuated.
Research Methodology: Data will be obtained from the online enrollment system beginning in October 2013. The number of account transfers from the online enrollment system to the Exchange will be obtained monthly.
Numerator: A. The number of complete eligibility determinations made broken down by type, such as application, transfer, and redetermination. B. The number of individuals correctly determined ineligible broken down by procedural vs. eligibility reasons. C. The number of individuals correctly disenrolled broken down by procedural vs. eligibility reasons.
Denominator: A. The total number of eligibility determinations made broken down by type, such as application, transfer, and redetermination. B. The total number of individuals determined ineligible broken down by procedural vs. eligibility reasons. C. The total number of individuals disenrolled broken down by procedural vs. eligibility reasons.
Data Source: The online enrollment and eligibility system.
Baseline Data: The baseline data for this measure will be established based on the first year of operations.
Reporting Frequency: This data should be available on a monthly basis.