



SoonerCare Choice Program Independent Evaluation State Fiscal Year 2014

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READER NOTE

This report is third in a series of annual evaluations of the SoonerCare Choice program. The updated report includes utilization and expenditure data through SFY 2014, as well as member and provider demographic data through December 2014.

The Pacific Health Policy Group wishes to acknowledge the cooperation of the Oklahoma Health Care Authority in providing the information necessary for the evaluation. PHPG also thanks representatives of the SoonerCare health access networks (HANs) and their affiliated providers for their assistance in the HAN portion of the evaluation.

All findings are solely the responsibility of the Pacific Health Policy Group.

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EXECUTIVE SUMMARY

Background

SoonerCare is Oklahoma’s program for Medicaid beneficiaries; SoonerCare Choice is the managed care portion of SoonerCare. The program is administered by the Oklahoma Health Care Authority (OHCA) and operates under the aegis of a federal “Section 1115 waiver” that permits enrollment of certain groups into managed (coordinated) systems of care.

Nearly seventy percent of all SoonerCare beneficiaries are enrolled in SoonerCare Choice, with children comprising the great majority (80 percent) of SoonerCare Choice members. Although most SoonerCare Choice members are eligible for Medicaid under the Temporary Assistance to Needy Families (TANF) and related aid categories, nearly 10 percent qualify under the non-Medicare Aged, Blind and Disabled (ABD) aid categories.

The SoonerCare Choice program has undergone significant evolution since its early years, but the program’s overarching goals have remained constant: To provide accessible, high quality and cost effective care to the Oklahoma Medicaid population. Recently-launched initiatives have sought to advance these goals.

In 2008, the OHCA implemented the SoonerCare “Health Management Program” (HMP), a holistic person-centered care management program for members with chronic conditions who have been identified as being at high risk for both adverse outcomes and increased health care expenditures. The SoonerCare HMP emphasizes development of member self-management skills and provider adherence to evidence-based guidelines and best practices.

In 2009, the OHCA introduced the “patient centered medical home” model (PCMH), under which members are aligned with a primary care provider responsible for meeting strict access and quality of care standards. PCMH providers are arrayed into three levels, or tiers, depending on the number of standards they agree to meet. The OHCA pays monthly care management fees (in addition to regular fee-for-service payments) that increase at the higher tiers. Providers also can earn “SoonerExcel” quality incentives for meeting performance targets, such as for preventive care, member use of the ER and prescribing of generic drugs.

In 2010, the OHCA expanded upon the PCMH model by contracting with three “health access network” (HAN) provider systems. The HANs are community-based, integrated networks intended to advance program access, quality and cost-effectiveness goals by offering greater care coordination support to affiliated PCMH providers.

Evaluation Scope

In 2007, the OHCA commissioned an evaluation of the SoonerCare Choice program that examined its performance against program access, quality and cost effectiveness goals. The evaluation covered the program from its formation through SFY 2008.

In 2013, the OHCA retained the Pacific Health Policy Group (PHPG) to conduct an interim evaluation of the program for the period covering January 2009 through June 2013 (end of the state fiscal year).

In 2014, PHPG was retained to update the interim findings. The updated evaluation includes utilization and expenditure data through SFY 2014, as well as member and provider demographic data through December 2014.

PHPG employed the data to evaluate SoonerCare Choice performance with respect to access, quality and cost effectiveness. PHPG also conducted an in-depth evaluation of the three person-centered care initiatives launched in recent years: patient centered medical homes, health access networks and the SoonerCare Health Management Program.

In addition, PHPG placed SoonerCare Choice in a national context, by comparing the program's performance to that of two "benchmark" states, Arizona and Florida, that contract with private managed care organizations (MCOs) to serve their Medicaid populations.

SoonerCare Choice Performance: Access, Quality and Cost

Access to Care

Member access to care can be measured beginning with enrollment into the program and continuing through selection of a PCMH provider, scheduling of appointments and navigating the system to receive treatment of acute and chronic health care conditions. PHPG framed the access portion of the evaluation around the following questions:

1. Is it easy or difficult to enroll in SoonerCare Choice?
2. Once enrolled, do members have an adequate selection of primary care (PCMH) providers?
3. Are primary and specialty care services readily available?
4. Are members with complex/chronic conditions able to navigate the system and obtain care?

SoonerCare Choice Enrollment

The OHCA processes over 20,000 applications for SoonerCare Choice every month. Historically, persons applying for coverage in Oklahoma had to travel to a local Department of Human Services (OKDHS) office, meet with a caseworker and complete a paper application. The paper application process presented numerous obstacles to qualified applicants, including enrollment delays measured in weeks, the potential for inconsistent application of eligibility rules and, for some, a stigma associated with applying for coverage in person at a “welfare” office.

In 2007, the OHCA, in partnership with OKDHS and the Oklahoma State Department of Health (OSDH) began implementation of an online enrollment system for new applicants and members renewing their SoonerCare Choice eligibility. The online enrollment system went “live” in September 2010 and had an immediate impact on how SoonerCare applications are filed and processed.

In SFY 2014, all but two percent of applications were filed online directly by applicants or with the assistance of one of the OHCA’s partner agencies. The online enrollment system has significantly reduced application processing times. Under the paper system, new applications required an average of 20 days to process; renewals required 15 days. The online system can process a complete application in minutes.

The consistent application of eligibility rules also has enabled Oklahoma to achieve one of the lowest processing error rates in the nation. Under the federal Payment Error Rate Measurement (PERM) initiative, states must audit the accuracy of their eligibility processes every three years. In 2009, prior to online enrollment, Oklahoma’s error rate was 1.24 percent. In 2012, the most recent audit, Oklahoma’s error rate was 0.28 percent, versus the national average of 5.7 percent .

The system saved an estimated \$1.5 million in State dollars through its first full year of operations. The savings have continued to grow, along with online enrollment volume, and reached an estimated \$2.6 million in State dollars in SFY 2014. (The “savings” represent case worker resources freed-up for other activities, such as assisting individuals applying to DHS for cash assistance or Supplemental Security Income benefits.)

Availability of Primary Care (PCMH) Providers

The OHCA relies on its network of primary care providers (patient centered medical homes) to deliver preventive and primary care services to SoonerCare Choice members and coordinate referrals for specialty and ancillary services. The number of PCMH providers was relatively flat from 2004 through 2009, although provider capacity remained about double the actual SoonerCare Choice enrollment.

In 2009, the OHCA undertook significant outreach efforts to providers throughout the State, to educate them about the new PCMH model and explore their interest in joining the program, if

they did not already participate. The number of “unduplicated”¹ PCMH providers increased from 699 in January 2009 to 901 in December 2014. The increase in the number of participating PCMH providers led to a decrease in the average PCMH SoonerCare Choice member caseload, from 360 patients in 2009 to 241 patients in 2014. The decrease occurred in both urban and rural areas of the State.

Availability of Primary Care and Specialty Services

SoonerCare Choice members are surveyed annually by an independent organization and asked to rate their satisfaction with services, on a scale of 1 to 10. Specific areas of inquiry include satisfaction with: getting needed care; getting care quickly; rating of personal doctor; and rating of specialist (if applicable). A rating of 8, 9 or 10 is considered to be evidence that a respondent is satisfied on a particular measure.

The absolute level of satisfaction with adult care is high, with 79 to 83 percent of respondents rating their care as an 8, 9 or 10, depending on the specific measure. The percent satisfied has generally increased during the last four survey cycles (2010, 2012, 2013 and 2014).

The satisfaction level for care delivered to children (as reported by their parent/guardian) is even higher, with 89 to 92 percent or more of respondents rating the care as an 8, 9 or 10, depending on the specific measure. The percent satisfied also has generally moved in an upward direction over the last four survey cycles.

Another method for evaluating access to primary care is to examine emergency room utilization trends. If access is restricted it may result in more trips to the emergency room for non-emergent problems.

Oklahoma’s Medicaid population has historically used the emergency room at high rates, including for non-emergent and non-urgent care. The OHCA and its partners in the provider community have undertaken a number of initiatives in the past five years to reduce inappropriate emergency room use. These include:

- Enrolling SoonerCare Choice members into patient centered medical homes;
- Requiring all medical home providers to offer 24-hour/7-day telephone coverage by a medical professional;
- Requiring Tier 3 (“optimal”) medical home providers to offer extended office hours;
- Conducting targeted outreach and education with members who visit the ER two or more times in a three-month period; and

¹ Counting each provider once, regardless of his or her number of offices/practice locations.

- Undertaking physical and behavioral health case management of members with complex/chronic conditions associated with ER use, through the OHCA Chronic Care Unit and SoonerCare Health Management Program.

SoonerCare Choice member use of the emergency room declined significantly in 2009 - 2010, a drop that coincided with introduction of the PCMH model and expansion of the primary care provider network. Despite plateauing from 2013 to 2014, the rate in 2014 was approximately 13 percent below the level recorded in 2008.

The combined effect of the various initiatives targeting ER use can be illustrated by comparing actual visits in 2014 to what would have occurred if the visit rate had remained at the level recorded in 2008. There were an estimated 61,000 visits that did not happen because of the reduction in utilization. The avoided visits saved over \$22 million in claim costs versus what would have been spent had utilization remained at the 2008 level.

Even with the improvement recorded since 2008, Oklahoma's ER use rate is still higher than average for a Medicaid program. ER utilization trends also are not constant across demographic groups. Utilization among children and adolescents has fallen steadily while remaining at or above 2008 levels among adults. Similarly, members with disabilities (the majority of whom are adults) have continued to use the ER at historically high levels.

The top ER diagnoses also vary by age group, with injuries comprising a significant (and appropriate) portion of the total for children and adolescents, while among adults, behavioral health conditions (mental health and substance abuse-related) are the number one reason for visits to the ER. Chronic conditions such as hypertension and heart disease also are important contributors in the older adult population.

The OHCA and its provider partners have the proper tools in place to target members with complex/chronic conditions, including adults with disabilities, as well as members presenting with conditions such as asthma that can be managed through appropriate preventive/primary care services. By focusing on education and outreach to members with these presenting symptoms, it should be possible to continue to lower the overall utilization rate.

The OHCA also may wish to explore opportunities for collaboration with the Department of Mental Health and Substance Abuse Services in its outreach to members presenting with behavioral health needs.

Assistance to Members with Complex/Chronic Conditions

The majority of SoonerCare Choice members are healthy children and pregnant women. However, the program also includes thousands of members with complex/chronic physical health conditions, often coupled with a behavioral health disorder.

Members with complex/chronic conditions often are unable to navigate the health care system without support. The OHCA, as the managed care organization for SoonerCare Choice, has put in place a needs-based multi-tiered care management structure for members with complex/chronic conditions.

The Case Management Unit within the Population Care Management Department assists members with high risk medical conditions, including members being discharged from the hospital and members with high risk pregnancies. The Population Care Management Department also provides or arranges for ongoing assistance to members with chronic conditions, such as asthma, diabetes and heart failure.

The SoonerCare Health Management Program provides holistic, in-person health coaching to up to 7,500 members at a time, working in collaboration with members' PCMH providers. The Chronic Care Unit provides telephonic care management to members with chronic conditions who are not enrolled in the SoonerCare HMP.

The Behavioral Health Department and its Behavioral Health Specialist staff provide assistance to members with behavioral health needs, including seriously mentally ill adults and seriously emotionally disturbed children. The Department often works in collaboration with the other care management units to facilitate treatment of members with physical/behavioral health comorbidities.

Quality of Care

The first step in improving quality of care is to have an organized process for measuring quality and incentives for meeting or exceeding program benchmarks. If benchmarks are met the result should be improved health outcomes.

PHPG framed the quality portion of the evaluation around the following questions:

1. Does the program have mechanisms to measure and reward quality?
2. Are members receiving appropriate preventive and diagnostic services?
3. Are health outcomes improving?

Mechanisms to Measure and Reward Quality

The OHCA tracks preventive and diagnostic service delivery for SoonerCare Choice through "Healthcare Effectiveness Data and Information Set" (HEDIS[®]) measures. These measures are used nationally and are validated by the National Committee for Quality Assurance (NCQA). The OHCA contracts with an independent quality review organization to perform the HEDIS analysis.

HEDIS data is used in conjunction with other measures to evaluate the performance of PCMH providers and to reward providers who meet or exceed pre-established targets. In SFY 2014,

the OHCA made over \$3.2 million in “SoonerExcel” quality incentive payments to PCMH providers who met one or more quality benchmarks.

Provision of Appropriate Preventive and Diagnostic Services

PHPG examined HEDIS results for SoonerCare Choice members both longitudinally and in comparison to national data, where available. PHPG documented HEDIS trends in six areas for children/adolescents and six areas for adults during the reporting years 2008 - 2014²:

- Child/adolescent access to PCPs
 - Access to a PCP
 - Annual dental visit
 - Lead screening rate by 2 years of age
 - Appropriate treatment for urinary tract infection (ages 3 months to 1 year)
 - Appropriate testing for children with pharyngitis (ages 2 – 18)
 - Appropriate medications for treatment of asthma (children)

- Adults
 - Access to preventive/ambulatory health services
 - Breast cancer screening (ages 40 – 69)
 - Cervical cancer screening (ages 21 – 64)
 - Cholesterol management for patients with cardiovascular conditions (ages 18 – 75)
 - Comprehensive diabetes care
 - Appropriate medications for treatment of asthma (adults)

The percentage of children and adolescents with access to a PCP increased steadily over the evaluation period and was at 89 percent or higher for all age cohorts in reporting year 2014. The access percentage also was consistently above the national rate.

Preventive service, screening and treatment rates also improved for three other child/adolescent measures: lead screening, treatment of urinary tract infection and testing for pharyngitis. In all three cases, however, the rates were below the national benchmark. The rate for a fourth measure – dental visits – was significantly above the national rate, although down slightly in 2014.

Access to preventive services improved for both younger and older adults, reaching nearly 82 percent in the 2014 reporting year for the former and 88 percent for the latter. Both results exceeded the national rate.

² Data for some measures was only reported starting in 2010 or 2013, due to methodology changes. Reporting years address activity in the prior year.

The screening rates for breast and cervical cancer, and the rate for management of cholesterol among patients with cardiovascular conditions, did not show the same favorable results. In all three instances the 2014 rate was below the national benchmark.

The trends for HEDIS measures related to diabetes care were mixed, with some improving and others declining. However, all of the rates were below the national benchmark in 2014. Diabetes is one of the most common chronic illnesses experienced by SoonerCare Choice members and this represents an opportunity for improvement.

The OHCA recently began a quality improvement initiative under the auspices of an Adult Medicaid Quality Grant to increase cervical screening rates through a combination of provider training and member outreach activities. The OHCA also is using the Adult Medicaid Quality Grant as a vehicle for improving diabetes care management. Grant staff is working with a small sample of PCMH providers and their SoonerCare Choice Members to test best practices for training staff; conducting patient outreach and education; and using electronic health records to collect and report clinical quality measure data.

Results for the final measurement area, asthma, also are mixed. Asthma is a very common chronic condition within the SoonerCare Choice population, both among children/adolescents and adults. In many cases it can be well controlled through prescribing of appropriate medication.

The HEDIS rates for treatment of asthma with appropriate medications are above 80 percent for children and adolescents and close to the corresponding national benchmarks. The rates for younger and older adults are not as favorable, either in absolute terms or in comparison to the national benchmark rates. This represents an opportunity for improvement.

Health Outcomes

The delivery of high quality preventive and primary care should contribute to improved health outcomes. One useful measure of quality is the avoidable, or ambulatory care sensitive condition, hospitalization rate. PHPG examined hospitalization rates for four ambulatory care sensitive conditions from 2009 through 2014: asthma, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD) and pneumonia. The rate dropped significantly across all four conditions, with the sharpest decline occurring among members with pneumonia.

Another measure of health outcomes is the 30-day readmission rate for members who are hospitalized. The rate remained below 15 percent for the entire evaluation period. The 2014 rate of 12.8 percent compares favorably to the national Medicare readmission rate of 17.5 percent, even allowing for the relatively frailer health of the average Medicare beneficiary and the presence of deliveries/newborns (which rarely result in a readmission) in the OHCA data.

Cost Effectiveness

The provision of accessible and high quality care is central to the mission of the SoonerCare Choice program. However, for the program to achieve sustainable results, care must be delivered in a cost effective manner.

At the highest level, there are two types of program expenditures: health services (payments to providers) and administration (OHCA and other agency operating costs). Accordingly, PHPG framed the quality portion of the evaluation around two questions:

1. Is the SoonerCare program cost effective in terms of health care expenditures?
2. Is the SoonerCare program cost effective in terms of administrative expenses?

Health Care Expenditures

PHPG examined SoonerCare Choice health expenditure trends from 2009 through 2014. PHPG analyzed average per member per month (PMPM) expenditures to eliminate any impact associated with change in enrollment.

Annual PMPM expenditure growth for the SoonerCare Choice population was nearly flat over this period, at 0.2 percent, in part attributable to a drop from 2013 to 2014. During 2010 through 2013 (a period for which national data was available), annual PMPM growth was a higher, but still modest 1.9 percent, versus a national Medicaid rate of 3.1 percent.

Administrative Expenditures

SoonerCare operates as a managed care program but its structure differs from a traditional model in which the Medicaid agency contracts with managed care organizations to enroll and serve members. Instead, the OHCA functions as a de facto statewide MCO.

States with MCO contracts are typically able to reduce their agency administrative costs slightly by transferring member service, provider contracting and medical management activities to the plans. However, these savings can be more than offset by the need to cover the administrative costs and profit expectations of multiple contractors.

The OHCA, as a statewide plan, is able to spread administrative costs over a larger population than an MCO that is dividing membership with other plans. This enables a greater share of the healthcare dollar to be paid to providers for care delivery.

To quantify the relative cost effectiveness of the OHCA's model versus the MCO model, PHPG calculated administrative costs for private Medicaid MCOs in states with geographic and demographic characteristics similar to Oklahoma and compared the results to the OHCA's administrative expenditures.

PHPG estimated private MCO administrative costs in the comparison states to be just under 11 percent. This includes monies for direct administration, as well as reserves for risk/contingencies and profit. In contrast, the OHCA's administrative expenditures in SFY 2014, including partner agency costs, stood at 5.8 percent.

In-Depth Evaluation of Person-Centered Care Initiatives

Patient Centered Medical Home Model

PHPG evaluated PCMH performance against an array of service utilization measures, such as average annual member visits rates, emergency room use rates and average per member per month expenditures. PHPG looked at performance by provider tier level and in aggregate.

The PCMH model appears to be contributing to positive trend lines for the SoonerCare Choice program as a whole. At the aggregate level (across tiers), the program demonstrated consistent improvement in outcomes from SFY 2009 through SFY 2014. It also appears that in SFY 2014 members aligned with tier 3 providers began to exhibit better outcomes on some measures than members aligned with tier 1 and tier 2 providers. These include ER utilization, hospitalization rates for ambulatory care sensitive conditions, hospital readmission rates and average PMPM costs.

Health Access Networks

The SoonerCare Choice health access networks were launched in 2010. The HAN model expands on the PCMH by creating community-based, integrated networks intended to increase access to health care services, enhance quality and coordination of care and reduce costs.

There are three HAN contractors:

- Partnership for Healthy Central Communities (based in Canadian County)
- Oklahoma State University (OSU) Center for Health Sciences
- Oklahoma University (OU) Sooner Health Access Network

HAN membership grew dramatically during the initiative's first years, from only 25,000 in July 2010 to 117,000 in July 2014 before levelling off slightly at 115,000 in December 2014. The growth in membership has occurred as the HANs have expanded their affiliated PCMH networks. In December 2014, there were 647 HAN-affiliated PCMH providers located at 68 practice sites throughout the State.

Membership is not evenly distributed across the three HANs. In May 2014, OU Sooner HAN accounted for approximately 84 percent of enrollment, OSU for 13 percent and Central Communities for the remaining three percent. The HANs as a group account for approximately 20 percent of total SoonerCare Choice enrollment.

The rapid membership growth across the three HANs since 2010 is a positive trend, as it reflects expanding participation by PCMH providers in the networks. However, it made evaluation of HAN performance prior to SFY 2014 challenging because of the continual influx of new members.

For SFY 2014, with enrollment largely stabilized, PHPG evaluated HAN member demographics and compared HAN performance on key utilization and expenditure measures to members not aligned with a HAN. PHPG also evaluated performance at the individual HAN level.

SoonerCare Choice includes non-Medicare aged, blind and disabled (ABD) members, as well as Temporary Aid to Needy Families (TANF) and related groups consisting of pregnant women, parents and non-disabled children. ABD members on average have much greater health care needs than their TANF counterparts and are significantly more expensive.

The HAN membership includes a slightly higher number of ABD members, as a percentage of total enrollment (panels), than the non-HAN membership, but the gap has narrowed along with HAN enrollment growth. This may reflect a change in the composition of affiliated providers, as the two larger HANs expanded beyond their academic medical center clinics to include smaller private practices.

SoonerCare Choice HAN and non-HAN members generally utilized services and incurred medical expenses at similar rates in SFY 2014. However, Central Communities HAN members in many areas stood apart from members in the other HANs.

Central Communities' members saw their PCMH providers more frequently, visited the ER less often, were more likely to see their PCMH provider after an ER visit or hospitalization and, on average, cost significantly less per month than their counterparts in the other HANs. Central Communities' performance makes it a potential model for other rural communities considering development of a health access network.

The HANs as a group also demonstrated promising performance with respect to one of the "target" populations they are contracted to manage: frequent ER utilizers. The HANs are required to undertake targeted care management of frequent ER utilizers identified by the OHCA and also to "lock-in" these members to a single PCMH provider for their primary care; these efforts appear to be having an impact.

PHPG examined ER usage among high ER utilizers enrolled by the HANs into care management. The analysis included 218 individuals who were HAN members for at least twelve months prior to selection for care management/lock-in and at least twelve months after lock-in.

The results of the before/after comparison were encouraging. Although average ER utilization remained high, it dropped by approximately 20 percent. The portion of members with six or more ER visits fell by more than half, while over 40 percent of the members in the lock-in period had no trips to the ER.

Overall, the utilization and cost profile of the general HAN membership is comparable in most categories to the non-HAN population, but performance at the individual HAN level has not been uniform. Central Communities HAN has begun to demonstrate impressive outcomes, both in comparison to the other HANs and to the non-HAN PCMH community.

The experience of the SoonerCare Health Management Program (HMP), as discussed in the next section, suggests that it can take several years for the full impact of care management initiatives to emerge, in terms of reducing utilization and expenditures. The OU and OSU networks may begin to match Central Communities' performance in future years. However, it also may prove to be the case that the HAN model is most effective when implemented as a smaller scale, grass roots initiative.

SoonerCare Health Management Program

Chronic diseases are the leading causes of death and disability in the United States. According to the Centers for Disease Control and Prevention (CDC), in 2012 about half of all adults—117 million people—had one or more chronic health conditions such as diabetes or heart disease. One in four adults had two or more chronic health conditions. Almost half of all adults struggle with a chronic health condition that affects performance of their daily activities.

The per capita impact of chronic disease is even greater in Oklahoma than for the nation as a whole. In 2013, 1,269 Oklahomans died due to complications from diabetes. This equated to a diabetes-related mortality rate of 29.9 persons per 100,000 residents, versus the national rate of 21.2. The mortality rate for other chronic conditions, such as chronic lower respiratory disease (heart disease and hypertension), is similarly higher in Oklahoma than in the nation overall.

Chronic diseases are also among the most costly of all health problems. The 50 percent of the US population with one or more chronic conditions accounts for nearly 85 percent of health spending nationally. Providing care to individuals with chronic diseases, many of whom meet the federal disability standard, has placed a significant burden on state Medicaid budgets.

In Oklahoma, the CDC estimates that total expenditures related to treating selected major chronic conditions will surpass \$8.0 billion in 2015 and will reach nearly \$10.5 billion in 2020. The estimated portion attributable to SoonerCare members will be just under \$1.0 billion (state and federal) in 2015 and more than \$1.2 billion in 2020.

Traditional disease management programs focus on individual conditions, such as asthma or diabetes, rather than the total patient. In 2008, the OHCA moved beyond this concept by creating the SoonerCare Health Management Program (HMP), a holistic model that emphasizes development of member self-management skills and provider adherence to evidence-based guidelines and best practices. The program targets SoonerCare Choice members with the most complex needs, most of whom have multiple physical conditions and many of whom have physical and behavioral health co-morbidities.

The program had two major components through June 2013: nurse care management (both field-based and telephonic) and practice facilitation. The nurse care management portion of the program was transformed in July 2013 into a model under which health coaches are embedded in the offices of PCMH providers who have undergone practice facilitation. The coaches work alongside providers and their staff members. Both components are administered by a vendor (Telligen) with oversight from a dedicated SoonerCare HMP Unit within the OHCA.

PHPG has served as an independent evaluator of the SoonerCare HMP since its implementation. The most recent evaluation covered program performance in SFY 2014 and examined member and provider satisfaction; impact on member lifestyle and health; impact on quality of care; impact on service utilization/expenditures; and overall cost return on investment.

Member and Provider Satisfaction

PHPG conducted surveys with members and providers to explore their perceptions of the SoonerCare HMP. Participants gave the program high marks. When asked in a survey to rate their experience, 84 percent of members and 75 percent of providers declared themselves very satisfied.

Member Lifestyle and Health Status

Health coaching employs motivational interviewing to identify lifestyle changes that members would like to make. Once identified, it is the health coach's responsibility to collaborate with the member in developing an Action Plan with goals to be pursued by the member with his/her coach's assistance.

Seventy-seven percent of survey respondents confirmed that their health coach asked them what change in their life would make the biggest difference in their health. Eighty-six percent of this subset (or 67 percent of total) stated that they actually selected an area to make a change.

The most common choice involved some combination of weight loss (or gain), improved diet and exercise. This was followed by management of a chronic physical health condition, such as asthma, diabetes or hypertension, management of a mental health condition and tobacco use/cessation.

Nearly all of the respondents (96 percent) who selected an area stated that they went on to develop an Action Plan with goals. Exactly 50 percent of this group reported achieving one or more goals in their Action Plan.

When asked if their health status had changed since enrolling in the SoonerCare HMP, a majority (58 percent) said it was "about the same". However, a significant minority (39 percent) said their health was "better" and only three percent said it was "worse". Since a majority of

the members had been enrolled less than six months at the time of their survey, these results are encouraging. Among those members who reported a positive change, nearly all credited the SoonerCare HMP with contributing to their improved health.

SoonerCare HMP Impact on Quality of Care

PHPG evaluated the impact of SoonerCare HMP health coaching on quality of care through calculation of HEDIS measures applicable to the SoonerCare HMP population. The evaluation included 19 diagnosis-specific measures and three population-wide preventive measures. For example, the quality of care for participants with asthma was analyzed with respect to their use of appropriate medications and their overall medication management.

PHPG determined the total number of participants in each measurement category, the number meeting the clinical standard and the resultant “percent compliant”. The results were compared to compliance rates for a comparison group consisting of all SoonerCare members (SFY 2014 reporting year), where available, and to national Medicaid MCO benchmarks where SoonerCare data was not available but a national rate was.

The health coaching participant compliance rate exceeded the comparison group rate on 11 of 18 measures for which there was a comparison group percentage. The difference was statistically significant for nine of the 11, suggesting that the program is having a positive effect on quality of care, although there is room for continued improvement.

The most impressive results, relative to the comparison group, were observed for participants with diabetes and mental illness, and with respect to access to preventive care.

SoonerCare HMP Impact on Service Utilization and Expenditures

Most potential SoonerCare HMP participants are identified using a predictive modeling platform developed by Medical Artificial Intelligence (MEDai). As part of its output, the model calculates for each member a 12-month forecast of emergency room visits, hospitalizations and total expenditures.

PHPG conducted the utilization and expenditure evaluation by comparing health coaching participants’ actual claims experience to MEDai forecasts for the 12-month period following the start date of engagement. The same analysis was performed for non-health coaching members aligned with practice facilitation providers, to evaluate the discrete impact of practice facilitation on patient utilization and costs.

The impact on utilization and expenditures was found to be significant. MEDai forecasted that health coaching participants as a group would incur 2,659 inpatient days per 1,000 participants in the first 12 months of engagement. The actual rate was 1,544, or 58 percent of forecast.

MEDai forecasted that health coaching participants as a group would incur 2,260 emergency room visits per 1,000 participants in the first 12 months of engagement. The actual rate was 1,803, or 80 percent of forecast.

PHPG documented total per member per month (PMPM) medical expenditures for all health coaching participants as a group and compared actual medical expenditures to forecast for the first 12 months of engagement. MEDai forecasted that the participant population would incur an average of \$1,075 in PMPM expenditures in the first 12 months of engagement. The actual amount was \$807, or 75 percent of forecast. Similar results were documented for non-health coaching members aligned with practice facilitation providers.

SoonerCare HMP Overall Return-on-Investment

When program administrative costs were accounted for, the SoonerCare HMP was found to have achieved net savings of nearly \$16 million in SFY 2014 and a return on investment of 206 percent. Put another way, the program generated over two dollars in net medical savings for every dollar in administrative expenditures.

SoonerCare Choice: National Perspective

Comparison to Benchmark States

SoonerCare Choice combines community-based systems of care (PCMH and HAN) with support at the State level in the form of chronic care/health management and quality initiatives. The OHCA functions essentially as a statewide MCO, performing some administrative functions directly.

The SoonerCare Choice structure is less common than the private MCO model found in many other states. To measure its relative performance, PHPG selected two states with private MCO models, Arizona and Florida, for comparison to SoonerCare Choice. Arizona operates the nation's oldest Section 1115 waiver program and fully-capitated MCO model for Medicaid beneficiaries, dating back to the early 1980's. Florida implemented a private MCO model through a Section 1115 waiver in major portions of the state in 2005, including the counties encompassing Fort Lauderdale and Jacksonville; the program was expanded statewide in 2014.

PHPG found that the SoonerCare Choice program compares well to the other two, despite operating under a non-traditional managed care model. Oklahoma, Arizona and Florida all have demonstrated favorable outcomes in terms of access, quality and cost effectiveness. None of the three has consistently outperformed the others.

SoonerCare Choice members have a high level of satisfaction with access to care, as do AHCCCS and Florida Demonstration members. Arizona has achieved a lower emergency room utilization rate than Oklahoma.

Arizona and Florida both report somewhat higher rates than SoonerCare Choice for preventive and chronic care. However, SoonerCare Choice has maintained a lower hospital readmission rate than Arizona.

All three programs have achieved lower medical inflation rates than the national Medicaid average, including near zero medical inflation for TANF and Related members. Florida also has reduced medical inflation to near zero for ABD/SSI members, while the SoonerCare Choice rate falls between the Florida and Arizona rates.

Conclusion

SoonerCare Choice has fostered innovation while exhibiting stability for members and providers and has continued to advance its goals of delivering accessible, high quality and cost effective care to Oklahoma's Medicaid population.

CHAPTER 1 – INTRODUCTION

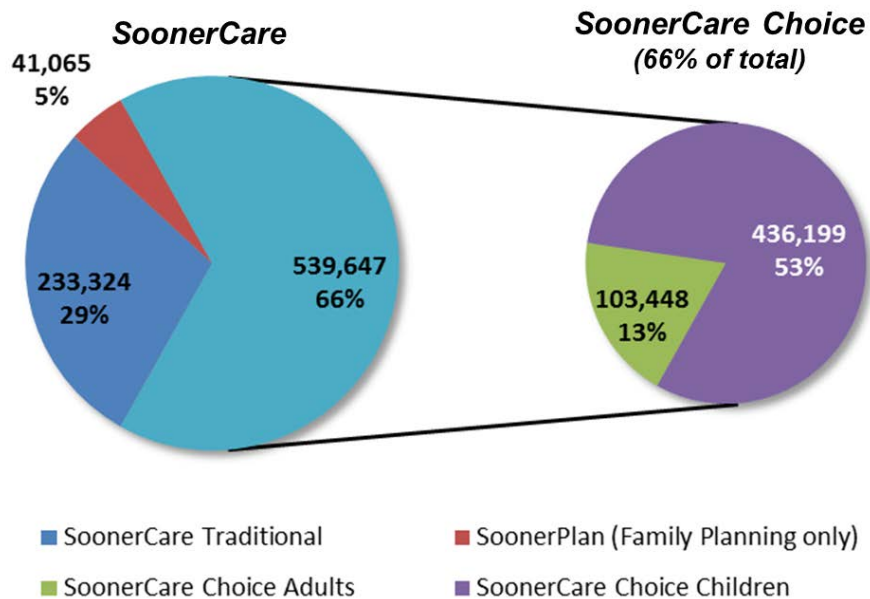
SoonerCare Choice Program

SoonerCare is Oklahoma’s program for Medicaid beneficiaries; SoonerCare Choice is the managed care portion of SoonerCare. The program is administered by the Oklahoma Health Care Authority (OHCA) and operates under the aegis of a federal “Section 1115 waiver” that permits enrollment of certain groups into managed (coordinated) systems of care.

In December 2014, SoonerCare membership stood at 814,000, of which SoonerCare Choice members accounted for 66 percent of the total (Exhibit 1-1).

The other components of SoonerCare are SoonerCare Traditional, which includes Medicare/Medicaid “dual eligibles” and beneficiaries receiving long term care services (most of whom also are dual eligibles) and SoonerPlan, which includes women receiving family planning services-only following birth of a child.

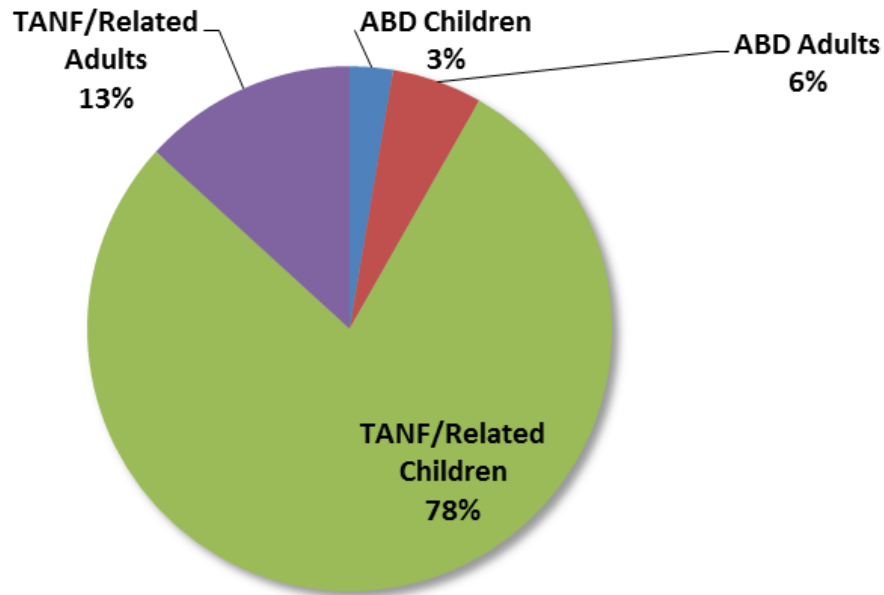
Exhibit 1 – 1 – SoonerCare Population (December 2014)³



³ Source: OHCA Fast Facts.

SoonerCare Choice primarily consists of children enrolled through Temporary Assistance to Needy Families (TANF) and related aid categories. However, enrollment also includes TANF/Related adults and children and adults in the Aged, Blind and Disabled (ABD) aid categories (Exhibit 1-2).

Exhibit 1 – 2 – SoonerCare Choice Population by Age and Aid Category (SFY 201)4⁴



Although the SoonerCare Choice program has undergone significant evolution since its early years, the program’s overarching goals have remained constant: To provide accessible, high quality and cost effective care to the Oklahoma Medicaid population. Recently-launched initiatives have sought to advance these goals.

In 2008, the OHCA implemented the “Health Management Program” (HMP), a holistic person-centered care management program for members with chronic conditions who have been identified as being at high risk for both adverse outcomes and increased health care expenditures. The SoonerCare HMP emphasizes development of member self-management skills and provider adherence to evidence-based guidelines and best practices.

In 2009, the OHCA introduced the “patient centered medical home” model (PCMH), under which members are aligned with a primary care provider responsible for meeting strict access and quality of care standards. The PCMH model is organized around:

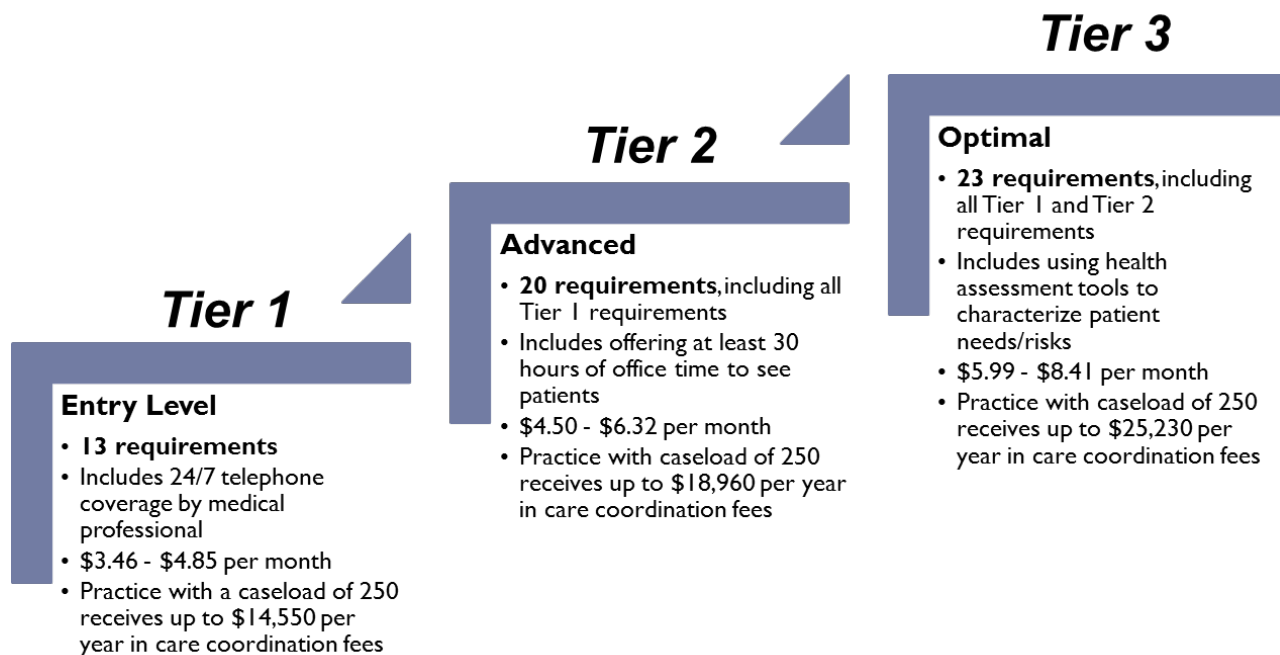
- An interdisciplinary team approach to coordinating patient care;
- Standardization of care in accordance with evidence-based guidelines;

⁴ Source: OHCA eligibility data.

- Tracking of tests and consultations and active follow-up with patients after ER visits and hospitalizations;
- Active measurement of quality and adoption of improvements based on quality outcomes;
- Preparing members to self-manage their conditions (and transition out of program); and
- Enhancing the ability of primary care providers to manage the needs of patients with complex/chronic conditions.

PCMH providers are arrayed into three levels, or tiers, depending on the number of standards they agree to meet (Exhibit 1-3). The OHCA pays monthly care management fees (in addition to regular fee-for-service payments) that increase at the higher tiers. Providers also can earn “SoonerExcel” quality incentives for meeting performance targets, such as for preventive care, member use of the ER and prescribing of generic drugs.

Exhibit 1 – 3 – Patient Centered Medical Home Model



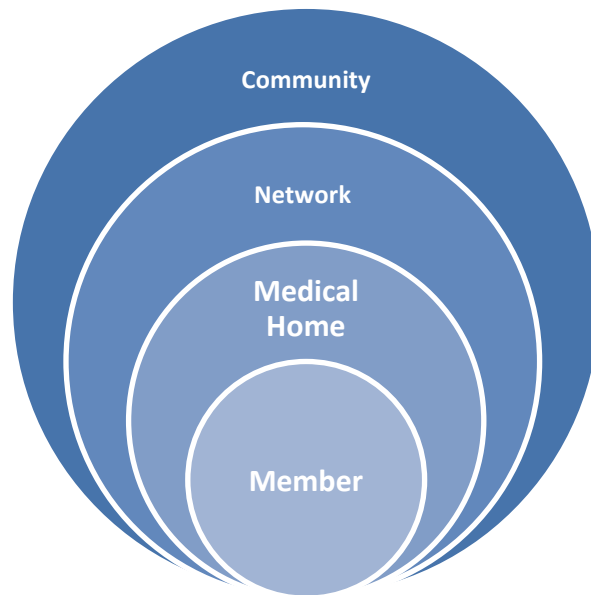
The OHCA’s adoption of patient centered medical homes is part of a broader national movement to define and reward high quality primary care. At the national level, early evidence supports the proposition that PCMH providers can improve access and quality, while helping to control costs⁵:

⁵ Source: The Patient Centered Medical Home’s Impact on Cost and Quality, Annual Review of Evidence 2013-2014 (January 2015)

- Of 10 peer-reviewed studies published in 2013-2014, six found an association between PCMH and a reduction in costs.
- Of 13 peer-reviewed studies published in 2013-2014, 12 found an association between PCMH and a reduction in unnecessary service utilization.

In 2010, the OHCA expanded upon the PCMH model by contracting with three “health access network” (HAN) provider systems. The HANs are community-based, integrated networks intended to advance program access, quality and cost-effectiveness goals by offering greater care coordination support to affiliated PCMH providers (Exhibit 1-4).

Exhibit 1 – 4 – Health Access Network Model



The three initiatives – SoonerCare HMP, patient centered medical homes and health access networks – and their impact on SoonerCare Choice are described in greater detail in chapter three.

SoonerCare Choice Independent Evaluation

In 2007, the OHCA commissioned an evaluation of the SoonerCare Choice program that examined its performance against program access, quality and cost effectiveness goals. The evaluation covered the program from its formation through SFY 2008⁶.

In 2012, the OHCA retained the Pacific Health Policy Group (PHPG) to conduct an interim evaluation of the program for the period covering January 2009 through June 2012 (end of the state fiscal year). In 2013, PHPG was retained to update the interim findings.

In 2014, PHPG was retained to again update evaluation findings. The updated evaluation includes and expenditure data through SFY 2014, as well as member and provider demographic data through December 2014.

The SFY 2014 evaluation also was expanded at the OHCA's direction to address two new lines of inquiry. First, PHPG was asked to compare SoonerCare Choice program performance against "benchmark" states that contract with private managed care organizations (MCOs) to serve Medicaid beneficiaries. PHPG selected the states of Arizona and Florida for this comparison. (The basis for their selection is discussed in chapter four.)

PHPG also was asked to examine national trends with respect to value-based purchasing. Chapter four includes a discussion of initiatives in other states that could inform development of future strategies for SoonerCare Choice.

Methodology

PHPG obtained paid claims data for the SoonerCare Choice program covering July 2008 through June 2014 (SFY 2009 through SFY 2014). The claims data was analyzed to document trends in utilization, expenditures and quality of care over the six year period⁷.

PHPG combined the claims analysis with program data made available by the OHCA covering enrollment, member satisfaction, quality of care and provider contracting trends over the period addressed in the evaluation. The member satisfaction data and a portion of the quality findings were produced by independent research organizations, as discussed in the body of the report.

⁶ See: SoonerCare 1115 Waiver Evaluation: Final Report, Mathematica Policy Research, January 2009.

⁷ PHPG also obtained emergency department claims for January through June 2008 and included these claims in the analysis of emergency department trends. The additional period was analyzed at the OHCA's request to better measure the longitudinal impact of initiatives aimed at lowering ED utilization, some of which were implemented in the second half of calendar year 2008.

Report Chapters

Chapter two of the report examines SoonerCare Choice performance with respect to meeting program access, quality and cost effectiveness goals.

Chapter three presents an in-depth look at three initiatives launched since the previous evaluation. It includes:

- Detailed findings on the impact of the PCMH model on program utilization and expenditures.
- Preliminary information on the HAN model.
- Summary information on the Sooner HMP, taken from a separate, standalone evaluation that PHPG has been conducting since the SoonerCare HMP was implemented in 2008.

Chapter four offers a national perspective by comparing the SoonerCare Choice program with two benchmark states that contract with MCOs: Arizona and Florida. The relative performance of the three programs is examined with respect to access, quality and cost effectiveness.

Chapter five briefly recaps evaluation conclusions.

CHAPTER 2 – SOONERCARE CHOICE PERFORMANCE

The SoonerCare Choice program seeks to provide accessible, high quality and cost effective health care to its members. PHPG evaluated program performance along all three dimensions.

Access to Care

Evaluation Questions

Member access to care can be measured beginning with enrollment into the program and continuing through selection of a PCMH provider, scheduling of appointments and navigating the system to receive treatment of acute and chronic health care conditions. PHPG framed the access portion of the evaluation around the following questions:

1. Is it easy or difficult to enroll in SoonerCare Choice?
2. Once enrolled, do members have an adequate selection of primary care (PCMH) providers?
3. Are primary and specialty care services readily available?
4. Are members with complex/chronic conditions able to navigate the system and obtain care?

Is it Easy or Difficult to Enroll in SoonerCare Choice?

The OHCA processes over 20,000 applications for SoonerCare Choice every month. Historically, persons applying for coverage in Oklahoma had to travel to a local Department of Human Services (OKDHS) office, meet with a caseworker and complete a paper application.

The paper application process presented numerous obstacles to qualified applicants, including⁸:

- Enrollment delays. The typical applicant waited nearly three weeks for his or her application to be reviewed and processed. Factors contributing to this lag time included limited caseworker resources; lack of automated systems to expedite processing and perform tasks after business hours; and incomplete paper applications requiring follow-up from caseworkers to obtain missing information.
- Inconsistent application of eligibility rules. Caseworkers across the 77 counties varied in how they applied eligibility rules, such as for income verification. The variation resulted from differences in caseworker training and use of personal judgment when applying rules to individual cases.

⁸ The discussion of enrollment obstacles is derived from a Policy Innovation Profile of Oklahoma's online enrollment system that can be found at <http://innovations.ahrq.gov/content.aspx?id=3981#a5>.

- Stigma of applying in person. Some applicants for Medicaid were reluctant to apply in person because of the stigma associated with going to a local “welfare” office to obtain insurance.

These obstacles contributed to the size of Oklahoma’s uninsured population, by discouraging qualified applicants from enrolling in the SoonerCare program. For example, an estimated 22,000 children were eligible but not enrolled in SoonerCare Choice in 2010⁹.

In 2007, the OHCA, in partnership with OKDHS and the Oklahoma State Department of Health (OSDH) began implementation of an online enrollment system for new applicants and members renewing their SoonerCare Choice eligibility. Oklahoma was part of a small group of states making the transition from paper to electronic applications during this period.

The new system, which was funded with federal dollars, had three primary objectives:

- Provide 24/7 access to enrollment and accurate, “real time” determination of eligibility
- Facilitate selection of a medical home
- Reduce staff hours required for processing applications

The online enrollment system went “live” in September 2010 and had a dramatic impact on how SoonerCare applications are filed and processed. In SFY 2014, all but two percent of applications were filed online directly by applicants or with the assistance of one of the OHCA’s partner agencies (Exhibit 2-1 on the following page).

Applicants are able to file and have their applications adjudicated on any day of the week and at any time of day. Upon completing their application, new members also are able to review the PCMH providers near their home or place of work and make a selection for each member of the family who is enrolling.

Use of the new system has been split almost evenly between new applications and renewals. In SFY 2014, new applications accounted for 52 percent of transactions and renewals for 48 percent¹⁰.

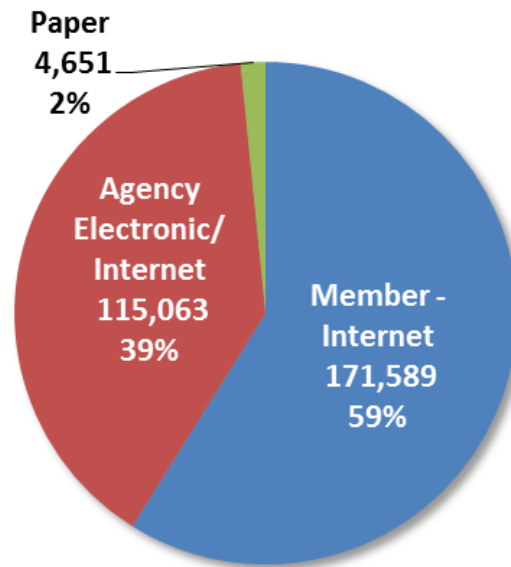
The online enrollment system has significantly reduced application processing times. Under the paper system, new applications required an average of 20 days to process; renewals required 15 days. The online system can process a complete application in minutes. Not surprisingly, SoonerCare Choice members have expressed satisfaction with the online process in focus groups conducted by the OHCA¹¹.

⁹ Figure is an estimate derived from Current Population Survey data on the uninsured by income level.

¹⁰ Source: OHCA Online Enrollment Automation and Data Integrity, Business Enterprises

¹¹ See Policy Innovation Profile for more detail.

Exhibit 2 – 1 – SoonerCare Choice Enrollment Method (SFY 2014)¹²



The consistent application of eligibility rules also has enabled Oklahoma to achieve one of the lowest processing error rates in the nation. Under the federal Payment Error Rate Measurement (PERM) initiative, states must audit the accuracy of their eligibility processes every three years. In 2009, prior to online enrollment, Oklahoma’s error rate was 1.24 percent. In 2012, the most recent audit, Oklahoma’s error rate was 0.28 percent, versus the national average of 5.7 percent¹³.

PHPG evaluated the annual “return on investment” for online enrollment by comparing the State’s expected share of operational costs¹⁴ to the dollar equivalent of caseworker resources which have been freed-up through elimination of paper applications. PHPG’s detailed methodology and findings were originally documented in a study published in 2011¹⁵.

A separate study of Oklahoma’s online enrollment system was conducted by Mathematica Policy Research, as part of a federally-funded review of “Express Lane Eligibility”¹⁶ processes in

¹² Source: OHCA Online Enrollment Automation and Data Integrity, Business Enterprises

¹³ Source: OHCA SoonerCare Choice Demonstration 1115(a) Annual Report, Demonstration Year 18 (April 2014). (Note: despite similarity in title, this is not the PHPG report but a federally-required report submitted to CMS on an annual basis)

¹⁴ With a few exceptions, the federal government pays 50 percent of operating costs for administration of the SoonerCare Choice program, including enrollment activities.

¹⁵ See: “No Wrong Door Online Enrollment – Independent Evaluation Final Report”, The Pacific Health Policy Group, March 2011.

¹⁶ Express Lane Eligibility is an option introduced for states in the federal Child Health Insurance Program Reauthorization Act (CHIPRA) of 2009. It permits state Medicaid and CHIP programs to rely on another agency’s

multiple states¹⁷. Although Oklahoma is not an Express Lane Eligibility state, its system was included in the study for comparison purposes.

Both PHPG and Mathematica concluded that Oklahoma’s online enrollment system saved an estimated \$1.5 million in State dollars through its first full year of operation. PHPG also projected the savings would continue to grow in subsequent years, as online enrollment volume increased. (Mathematica’s analysis did not extend beyond year one.)

For this evaluation, PHPG examined savings associated with online enrollment in SFY 2014. PHPG calculated the savings per online enrollment based on estimated average caseworker time per paper application x estimated wages/benefits for an entry level application worker x 50% (to represent state portion of costs, which are shared 50/50 with the federal government).

The “savings per application” was multiplied by the number of online applications in SFY 2014 to arrive at an aggregate savings figure of more than \$2.6 million (Exhibit 2-2). The “savings” represent case worker resources freed-up for other activities. For example, case worker time could be applied toward assisting individuals seeking cash assistance or Supplemental Security Income benefits through a local OKDHS office.

Exhibit 2 – 2 – SoonerCare Choice Estimated Online Enrollment Savings – SFY 2014

Online Enrollment – Estimated SFY 2013 Savings (State Dollars)	
Online Applications – SFY 2013	286,652
Estimated Net Savings per Application (versus paper)	\$9.27
TOTAL SAVINGS (State dollars)	\$2,657,264

Overall, the online enrollment system has made it easier for individuals and families to enroll in SoonerCare Choice and select a medical home. It has accomplished this while at the same time reducing agency costs.

eligibility findings to qualify children for public health coverage, even when these programs use different methods to assess income or other eligibility criteria.

¹⁷ See: “CHIPRA Express Lane Eligibility Evaluation – Case Study of Oklahoma’s SoonerCare Online Enrollment System”, Mathematica Policy Research, May 2013.

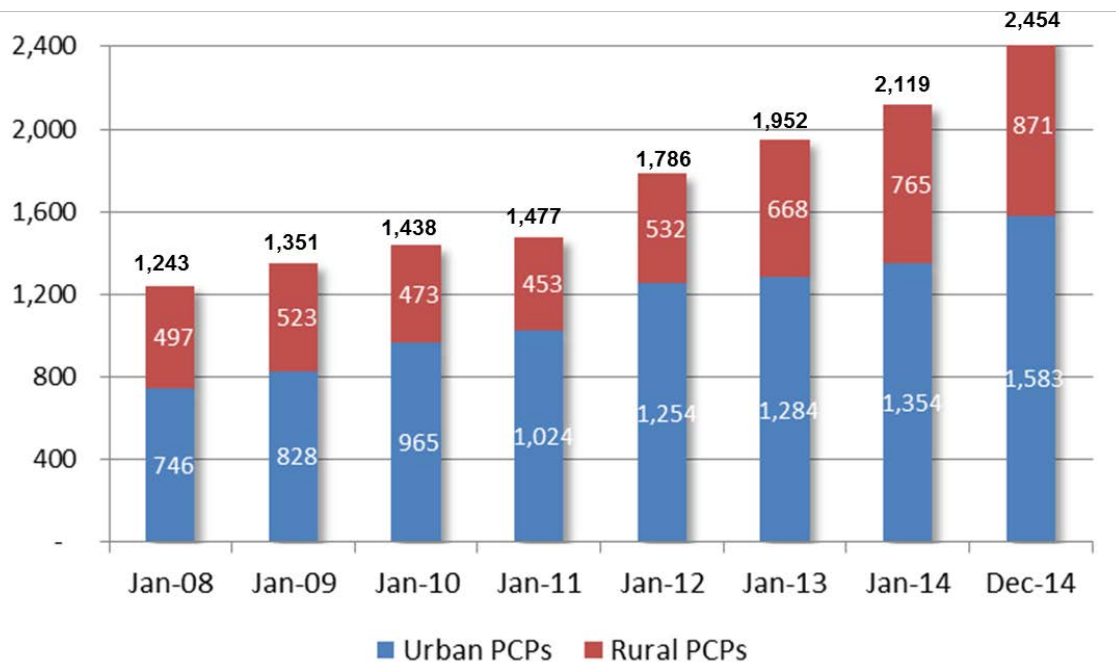
Do SoonerCare Choice Members Have an Adequate Selection of Primary Care Providers?

The OHCA relies on its network of primary care providers (patient centered medical homes) to deliver preventive and primary care services to SoonerCare Choice members and coordinate referrals for specialty and ancillary services. For the program to work as intended, there must be an adequate number of PCMH providers and patient caseloads must be manageable. If access to the PCMH is restricted, a member may forego needed care or resort to using the emergency room for non-emergent care.

The number of PCMH providers was relatively flat from 2004¹⁸ through 2009, although provider capacity remained about twice actual program enrollment. (Providers specify their maximum SoonerCare Choice member caseload when they sign-up to participate in the program.)

In 2009, the OHCA undertook significant outreach efforts to providers throughout the State, to educate them about the new PCMH model and explore their interest in joining the program, if they did not already participate. The number of “unduplicated”¹⁹ PCMH providers approximately doubled from January 2008 through December 2014 (Exhibit 2-3). The growth occurred in both urban and rural counties.

Exhibit 2 – 3 – SoonerCare Choice Unduplicated PCMH Count by Year²⁰



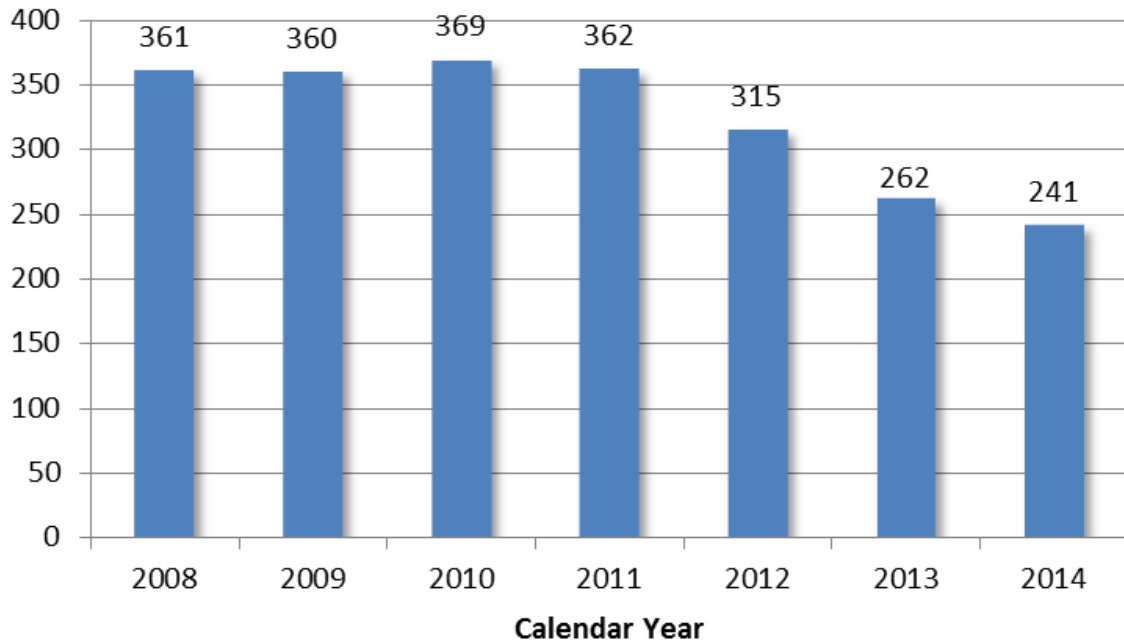
¹⁸ The year that the SoonerCare Plus MCO program in Oklahoma City, Tulsa, Lawton and surrounding areas was discontinued and members were enrolled in SoonerCare Choice alongside members in the rest of the State.

¹⁹ Counting each provider once, regardless of his or her number of offices/practice locations.

²⁰ Source: OHCA Fast Facts. Urban/rural division corresponds to division of counties under SoonerCare Plus and Choice models prior to discontinuation of SoonerCare Plus program. Increase from 2011 to 2012 may be partially due to introduction of more precise taxonomy.

The increase in the number of participating PCMH providers led to a decrease in the average PCMH SoonerCare Choice member caseload, from 361 patients in 2008 to 241 patients in December 2014 (Exhibit 2-4).

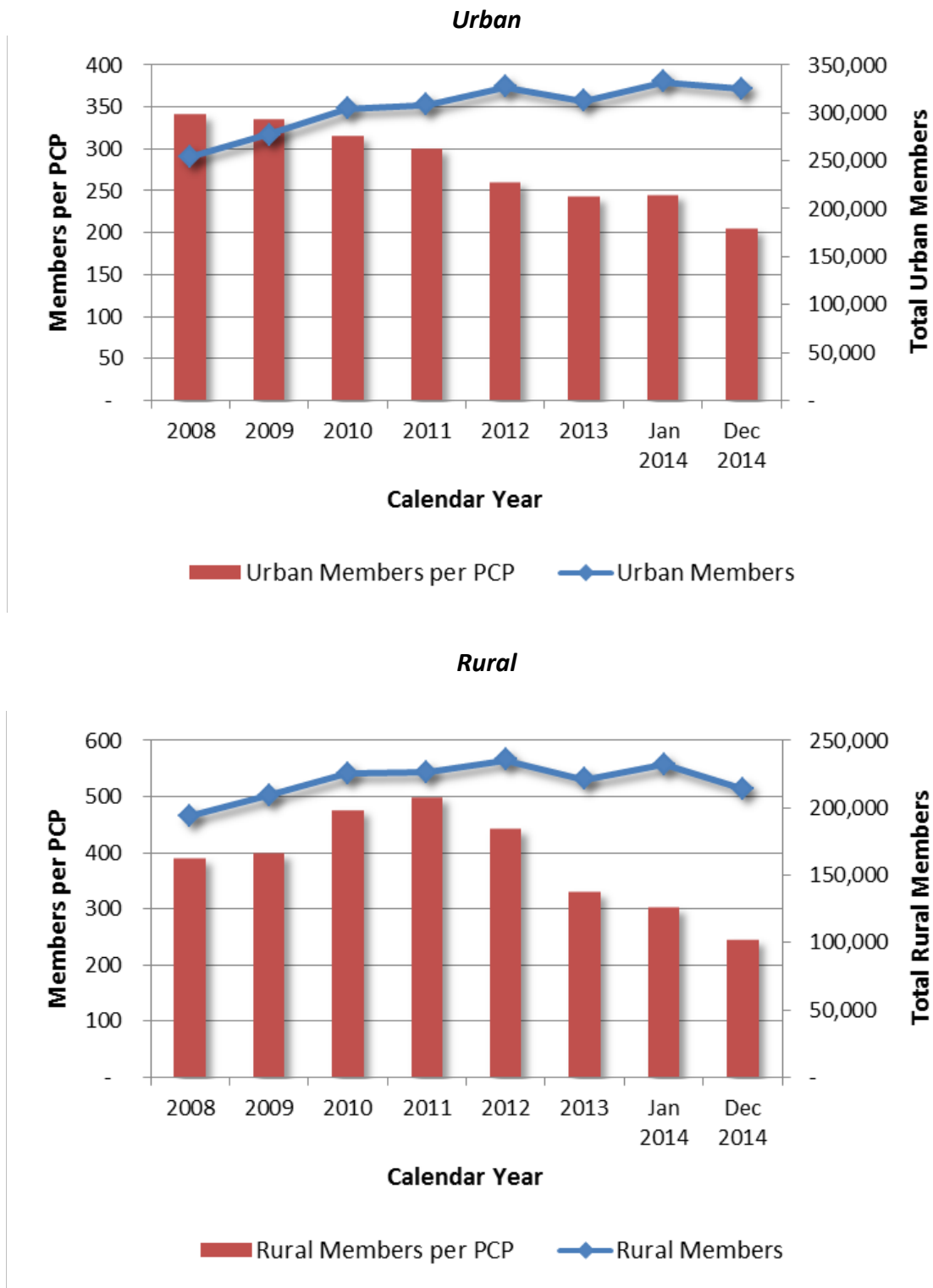
Exhibit 2 – 4 – Average PCMH SoonerCare Choice Member Caseload – Statewide ²¹



The drop in average caseload has occurred in both urban and rural portions of the State, even as enrollment has increased. Although the decline in rural counties started more recently, caseloads in the two regions are well below their peak levels (Exhibit 2-5 on the following page).

²¹ Sources: OHCA Provider Fast Facts Report; Waiver Enrollment Reports; Enrollment Fast Facts (May 2014 data). Annualized member count divided by PCMH count.

Exhibit 2 – 5 – Average PCMH SoonerCare Choice Member Caseload – Urban/Rural²²



²² Urban/rural division corresponds to division of counties under SoonerCare Plus and Choice models prior to discontinuation of SoonerCare Plus program.

Are Primary Care and Specialty Services Readily Available?

Member Perceptions

The favorable trends in PCMH provider participation and capacity are important but should be evaluated in conjunction with what members themselves report concerning access to care. To answer this question, the OHCA contracts with an independent firm, Morpace Market Research and Consulting, to conduct surveys with members on a continuous basis²³.

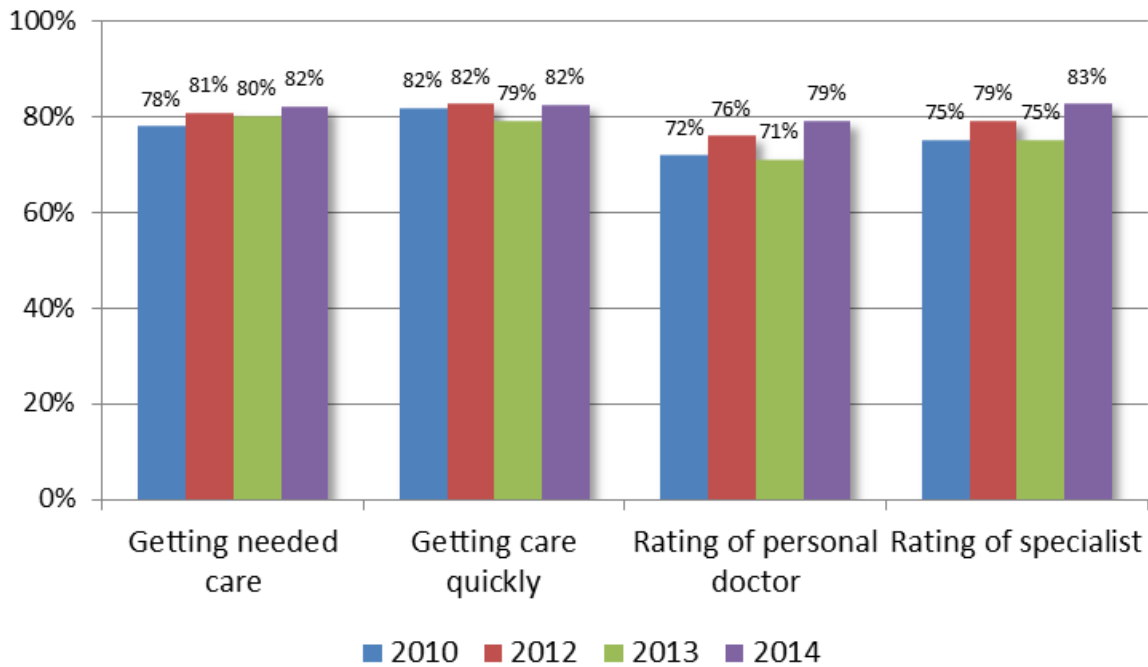
Morpace surveys members using the Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS). The CAHPS is nationally-validated research tool designed for use with the Medicaid managed care population. There are separate surveys for care provided to adults and children. (The latter survey is completed by adults answering with regard to care received by their children.)

The surveys ask members to rate their satisfaction with services, on a scale of 1 to 10. Specific areas of inquiry include satisfaction with: getting needed care; getting care quickly; rating of personal doctor; and rating of specialist (if applicable). A rating of 8, 9 or 10 is considered to be evidence that a respondent is satisfied on a particular measure.

The absolute level of satisfaction with adult care is high, with between 75 and 83 percent of respondents rating their care an 8, 9 or 10, depending on the measure. The percent satisfied also increased for every measure between 2013 and 2014, though the increase was statistically significant for only one measure: Rating of Personal Doctor (Exhibit 2-6 on the following page).

²³ Prior to 2013, Telligen conducted the CAHPS surveys.

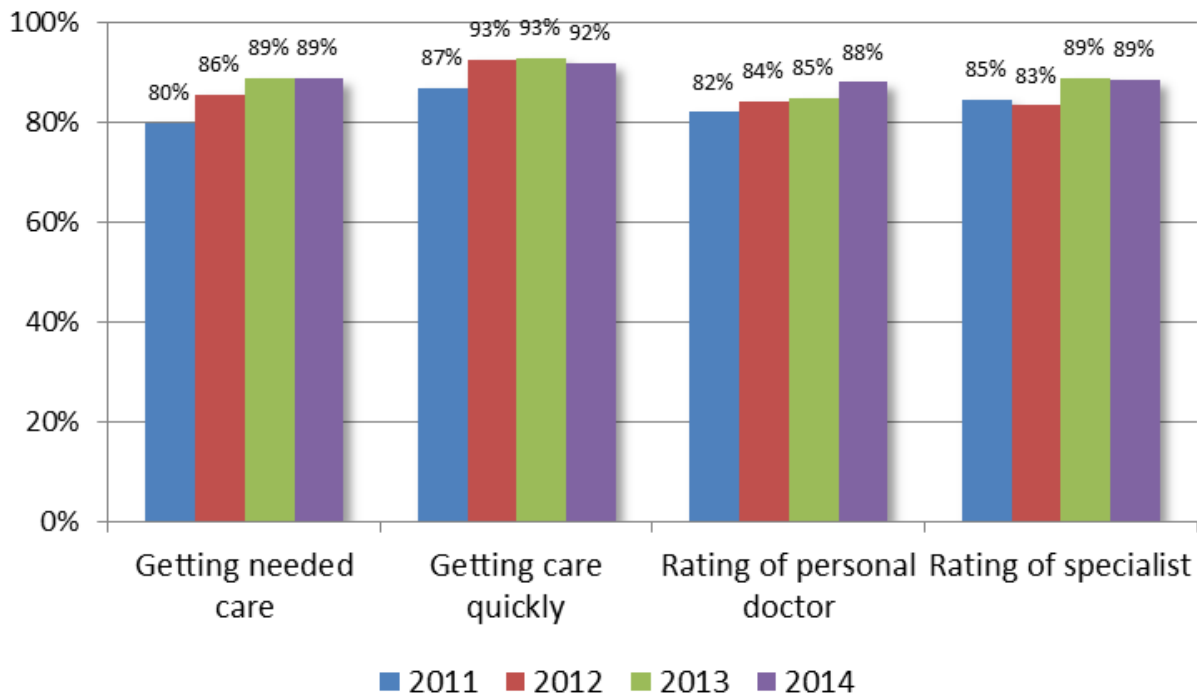
Exhibit 2 – 6 – SoonerCare Choice – Satisfaction with Care for Adults²⁴



The satisfaction level for care delivered to children is even higher, with 89 to 92 percent of respondents rating the care as an 8, 9 or 10, depending on the measure. The percent satisfied also generally moved in an upward direction over the four survey cycles (Exhibit 2-7 on the following page).

²⁴ Sources: CAHPS Health Plan Survey Adult Version – Telligen through 2012; Morpace for 2013 and 2014 (surveys are conducted from July to December of year preceding reporting year). Percent rating 8, 9 or 10 on a 10-point satisfaction scale; “Getting care quickly” is a composite measure based on questions regarding satisfaction with obtaining needed care, both urgent and non-urgent.

Exhibit 2 – 7 – SoonerCare Choice – Satisfaction with Care for Children²⁵



Emergency Room Use

Another method for evaluating access to primary care is to examine emergency room utilization trends. As noted earlier, if access is restricted it may result in more trips to the emergency room for non-emergent problems.

Oklahoma’s Medicaid population has historically used the emergency room at high rates, including for non-emergent and non-urgent care. The OHCA and its partners in the provider community have undertaken a number of initiatives in the past five years to reduce inappropriate emergency room use. These include:

- Enrolling SoonerCare Choice members into patient centered medical homes;
- Requiring all medical home providers to offer 24-hour/7-day telephone coverage by a medical professional;
- Requiring Tier 3 (“optimal”) medical home providers to offer extended office hours;
- Conducting targeted outreach and education with members who visit the ER two or more times in a three-month period; and

²⁵ Sources: CAHPS Health Plan Survey Child Version – Telligen through 2012; Morpace for 2013 and 2014 (surveys are conducted from July to December of year preceding reporting year). Percent rating 8, 9 or 10 on a 10-point satisfaction scale.

- Undertaking physical and behavioral health case management of members with complex/chronic conditions associated with ER use, through the OHCA Chronic Care Unit and SoonerCare Health Management Program.

The OHCA is in the process of developing and implementing a number of additional initiatives to further reduce avoidable visits. Specifically:

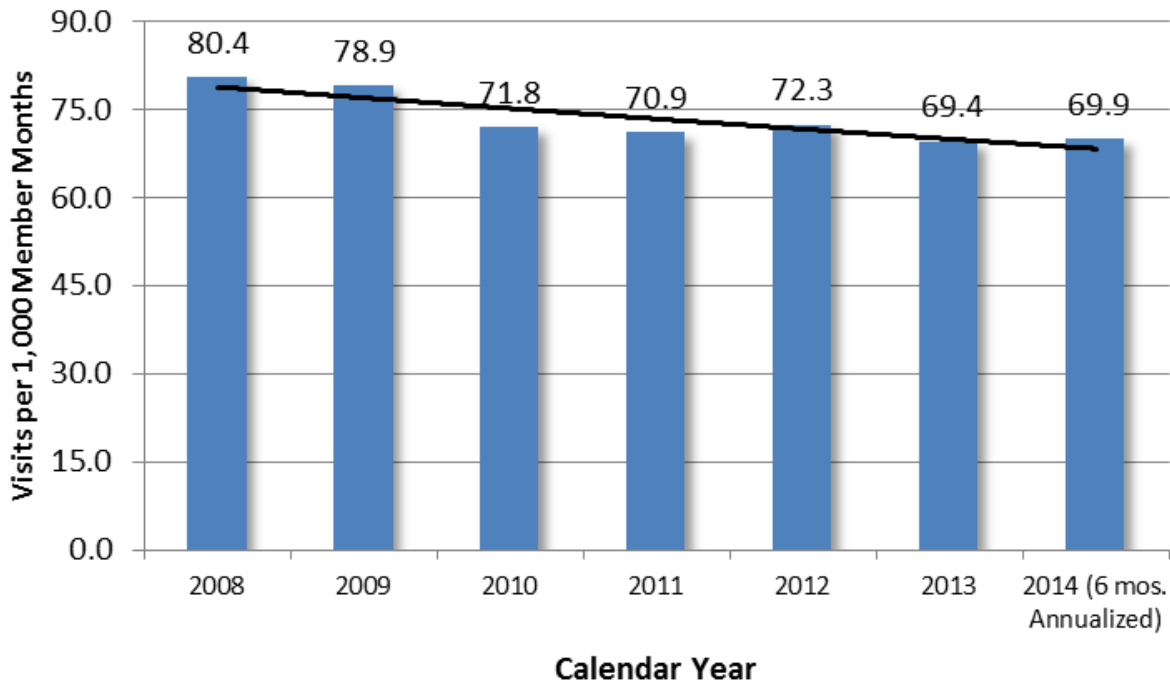
- Developing a phone app showing providers throughout the state with extended office hours;
- Offering PCMH practices the opportunity to be included on the app and to see patients not on the provider’s panel; participants will be able to bill a \$7.00 add-on for after-hours care and a \$19.00 add-on for weekends and holidays (72 PCMH practices are currently enrolled in the initiative); and
- Proposing new contracts with Urgent Care Centers that includes an enhancement to their rate for treatment of true urgent conditions (e.g., suturing and splints) – subject to federal approval

PHPG measured the combined impact of the already-implemented initiatives by examining SoonerCare Choice member use of the emergency room from 2008 to 2014; the year 2008 was selected as the “baseline” because it preceded the OHCA’s efforts of the past six years to reduce inappropriate utilization.

PHPG evaluated utilization on a “per 1,000 member month” basis. This industry standard represents the average number of emergency room visits occurring in a single month among 1,000 SoonerCare Choice members. For example, a utilization rate of “100” would equate to 100 visits per month for every 1,000 SoonerCare Choice members.

The actual utilization rate in 2008 was 80.4. The rate declined from 2008 to 2010, a drop that coincided with introduction of the PCMH model and expansion of the primary care provider network. Despite plateauing from 2013 to 2014, the rate in 2014 of 69.9 was approximately 13 percent below the level recorded in 2008 (Exhibit 2-8 on the following page).

Exhibit 2 – 8 – SoonerCare Choice Emergency Room Utilization – 2008 to 2014^{26,27}

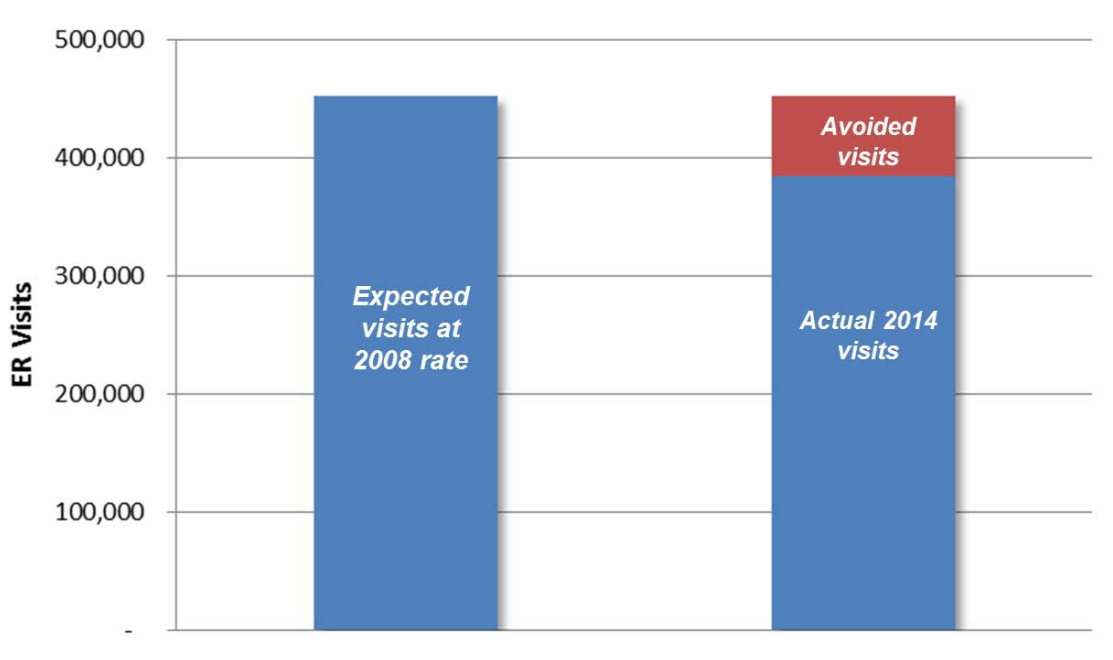


The combined effect of the various initiatives targeting ER use can be illustrated by comparing actual visits in 2014 to what would have occurred if the visit rate had remained at the 2008 level. There were an estimated 61,000 visits that did not happen because of the reduction in utilization (Exhibit 2-9 on the following page).

²⁶ Source: All utilization and expenditure exhibits presented in chapters two through four of the report were produced using paid claims data, unless otherwise specified. ER utilization trends are presented in calendar years to align with an earlier standalone analysis prepared for the OHCA. Results for SFY 2008 – SFY 2013 show the same downward trajectory.

²⁷ ER results include claims with paid amounts for ER services as well as claims with zero pay amounts for ER services as long as at least one other service on the claim was paid.

Exhibit 2 – 9 – SoonerCare Choice Emergency Room Utilization- Avoided Visits in CY 2014²⁸



The dollar value of the avoided visits can be estimated using the average paid amount for a SoonerCare Choice ER visit in 2014 (for members not admitted to the hospital). The amount, inclusive of facility, professional and ancillary (e.g., ambulance, pharmacy, DME, radiology) fees was \$349.61²⁹ (Exhibit 2-10).

Exhibit 2 – 10 – SoonerCare Choice Emergency Room Utilization- Average Cost per Visit

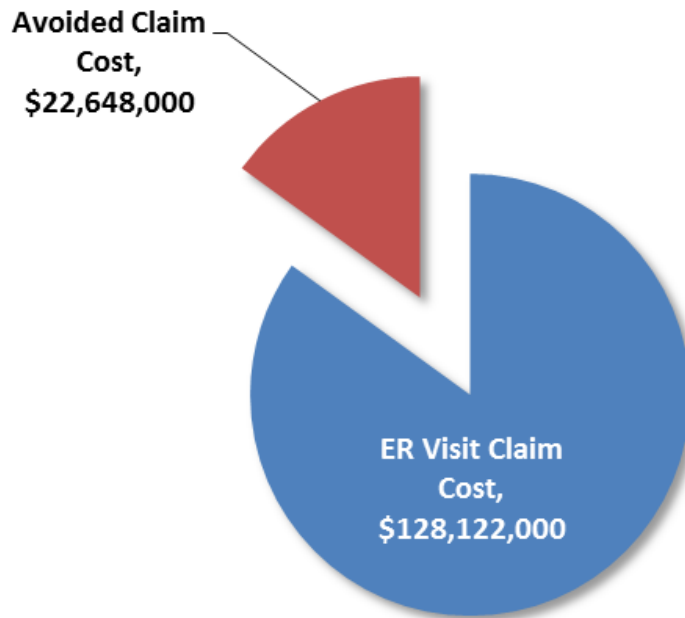
Component	2013 Average
Facility and Professional	\$264.98
Ancillary	\$68.10
TOTAL	\$333.08

The avoided visits saved over \$22 million in claim costs versus what would have been spent had utilization remained at the 2008 level (Exhibit 2-11 on the following page).

²⁸ Annualized, based on six months of data (January – June, 2014).

²⁹ Note: Ancillary is average for all SoonerCare and includes ambulance, pharmacy, DME, lab/radiology, other professional. Average cost figure derived from OHCA SFY 2014 ED Fast Facts. Amount may overstate actual cost of avoided ER visits to the extent these visits were lower than average in acuity. However, it is a reasonable proxy for estimating avoided costs.

Exhibit 2 – 11 – SoonerCare Choice Emergency Room Utilization- Avoided Costs in CY 2014



It is difficult to compare Oklahoma’s ER use rate to the rate across all 50 states because of differences in reporting methods and data quality. However, Oklahoma’s utilization rate still appears to be higher than average.

A 2012 study by The Lewin Group and General Dynamics Information Technology compared Medicaid ER utilization in 39 states, using 2008 paid claims data from the CMS Chronic Condition Data Warehouse. Oklahoma ranked second highest, behind only Kentucky. Even accounting for the progress made since 2008, Oklahoma would still rank among the ten highest states, assuming the rates in other states remained constant. This suggests there is still room for improvement³⁰.

In evaluating opportunities for further reductions, it is important to note that utilization trends have not been uniform across age cohorts or aid categories. Utilization has fallen among children, adolescents and younger adults since 2008 but has remained at or above 2008 levels among older adults (Exhibits 2-12 and 2-13 on the following page).

³⁰ Source: Evaluating Emergency Department Utilization-For Researchers using the CMS Chronic Conditions Data Warehouse, The Lewin Group and General Dynamics Information Technology, May 9, 2012
https://www.ccwdata.org/cs/groups/public/documents/training/ccw_max_research_example_eduse.pdf

Exhibit 2 – 12 – SoonerCare Choice ER Utilization Trend – Children/Adolescents (2008 = 100%)

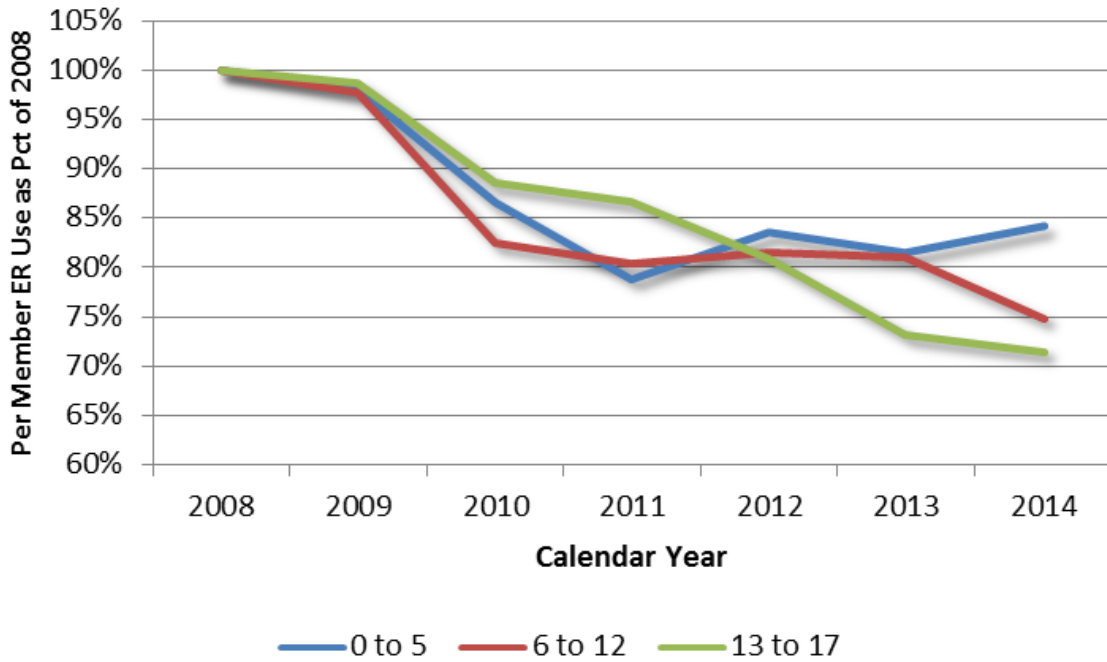
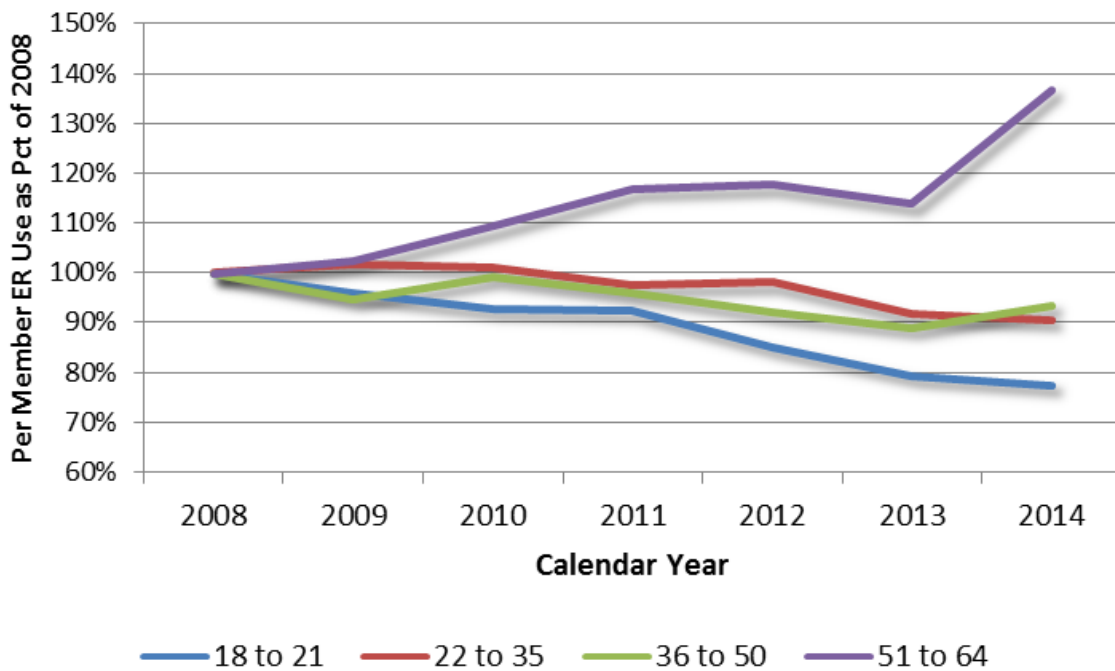


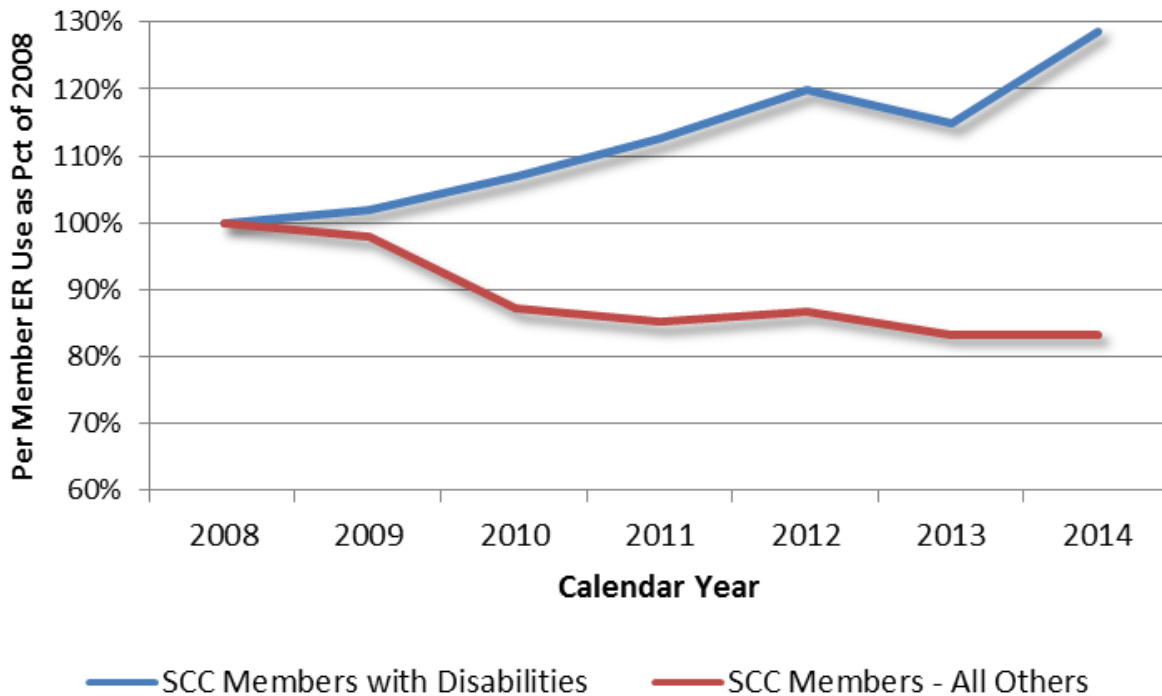
Exhibit 2 – 13 – SoonerCare Choice ER Utilization Trend – Adults (2008 = 100%)³¹



³¹ Note: Spike in 51-64 rate may be due in part to small number of members in that age cohort.

ER utilization also has remained high for SoonerCare Choice members with disabilities, versus other members (Exhibit 2-14). Most of the members with disabilities are adults³².

Exhibit 2 – 14 – SoonerCare Choice ER Utilization Trend – Disability Status (2008 = 100%)



The top ER diagnoses vary by age group, with injuries comprising a significant (and appropriate) portion of the total for children and adolescents (Exhibit 2-15).

Exhibit 2 – 15 – SoonerCare Choice Top Five ER Diagnoses – Children/Adolescents³³

	0 – 5	6 – 12	13 - 18
1	Respiratory disease (18%)	Injury (20%)	Injury (20%)
2	Injury (11%)	Respiratory disease (9%)	Respiratory disease (6%)
3	Disease of the ear (10%)	COPD, including Asthma (6%)	Neurotic, personality, and other non-psychotic mental disorders (5%)
4	Other viral disease (5%)	Disease of skin (5%)	Disease of musculoskeletal system (5%)

³² Note: Spike in disabled rate may be due in part to small number of members in that category.

³³ Data in exhibits 2-16 and 2-17 is for the 18-month period of January 2012 through June 2013. Data represents first diagnosis in claim (grouped by first three digits of diagnosis).

	0 – 5	6 – 12	13 - 18
5	Disease of skin (5%)	Disease of the ear (4%)	COPD, including Asthma (4%)
Top 5	49% of visits	44% of visits	40% of visits

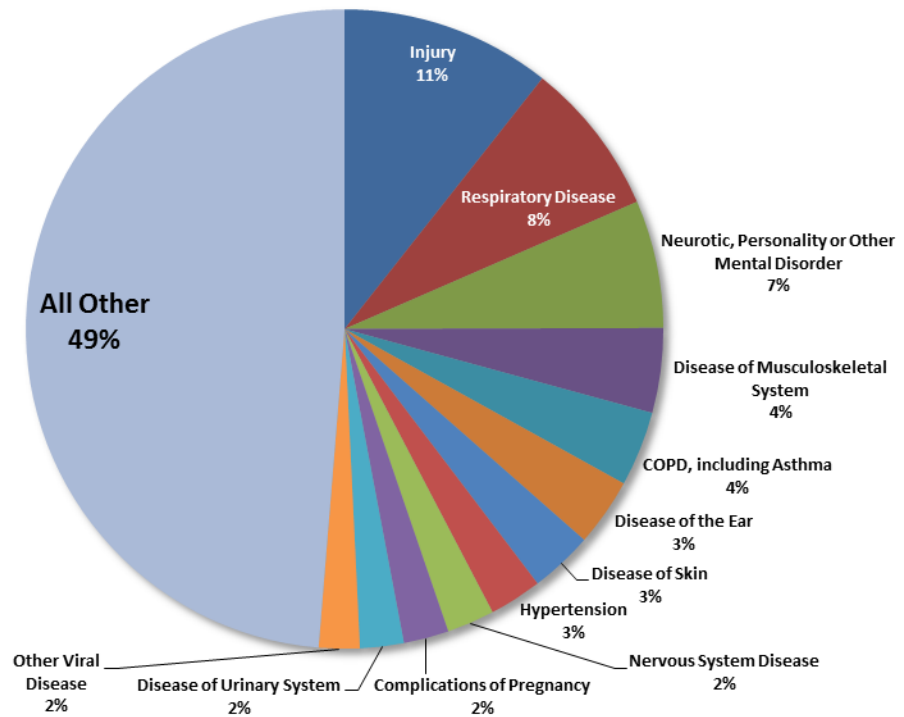
Behavioral health conditions (mental health and substance abuse-related) are the number one reason for visits to the ER among all but the youngest adults, where complications of pregnancy rank first. Chronic conditions such as hypertension and COPD also are important contributors in the older adult population (Exhibit 2-16).

Exhibit 2 – 16 – SoonerCare Choice Top Five ER Diagnoses - Adults

	18 – 21	22 – 35	36 – 50	51 - 64
1	Complications of pregnancy (10%)	Neurotic, personality, and other non-psychotic mental disorders (11%)	Neurotic, personality, and other non-psychotic mental disorders (11%)	Neurotic, personality, and other non-psychotic mental disorders (10%)
2	Injury (9%)	Injury (8%)	Hypertension (7%)	Hypertension (10%)
3	Neurotic, personality, and other non-psychotic mental disorders (9%)	Complications of pregnancy (6%)	Disease of musculoskeletal system (7%)	Disease of musculoskeletal system (6%)
4	Disease of urinary system (5%)	Disease of musculoskeletal system (6%)	Injury (7%)	COPD, including Asthma (5%)
5	Disease of musculoskeletal system (5%)	Nervous system disease (4%)	Nervous system disease (5%)	Injury (5%)
Top 5	38% of visits	35% of visits	37% of visits	36% of visits

Overall, the top diagnoses in 2014 (two percent of more of cases) account for just over one-half of all ER visits (Exhibit 2-17).

Exhibit 2 – 17 – SoonerCare Choice Top Five ER Diagnoses – All Members



The OHCA and its provider partners have the proper tools in place to target members with complex/chronic conditions, including adults with disabilities, as well as members presenting with conditions such as asthma that can be managed through appropriate preventive/primary care services. By focusing on education and outreach to members with these presenting symptoms, it should be possible to continue to lower the overall utilization rate.

The OHCA also may wish to explore opportunities for collaboration with the Department of Mental Health and Substance Abuse Services in its outreach to members presenting with behavioral health needs.

Are Members with Complex/Chronic Conditions Able to Navigate the System and Obtain Care?

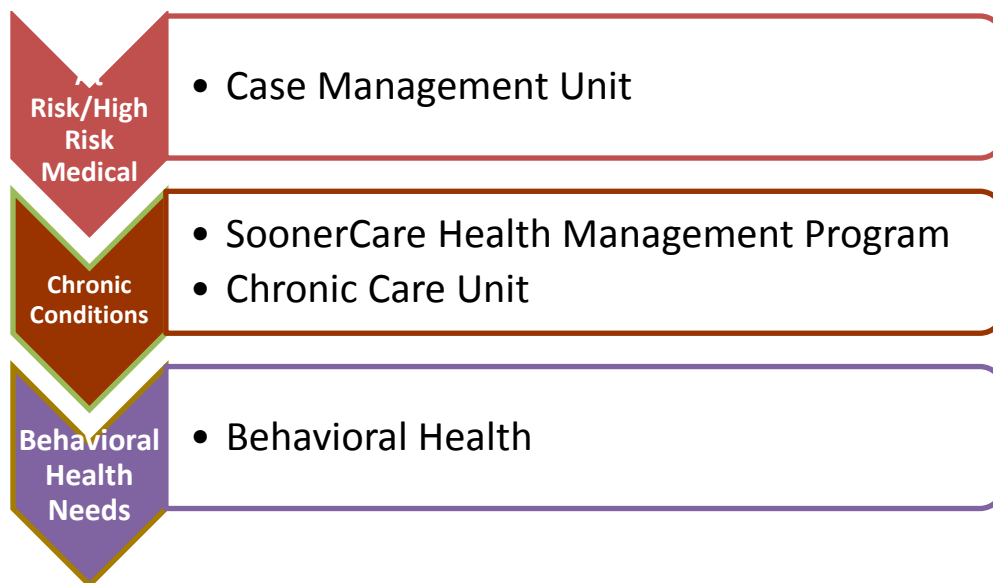
The majority of SoonerCare Choice members are healthy children and pregnant women. However, the program also includes thousands of members with complex/chronic physical health conditions, often coupled with a behavioral health need.

In addition, thousands of SoonerCare Choice members are hospitalized each year or treated on an outpatient basis for acute medical and/or behavioral health needs. And approximately 2,000 pregnancies per year covered under SoonerCare Choice are classified as “high risk”, where the mother and baby face a greater than usual chance of complications and adverse outcomes (e.g., due to age of the mother or history of low birth weight deliveries).

Members with complex/chronic conditions often are unable to navigate the health care system without support. Although their PCMH or prenatal care provider is responsible for directing their care, additional support can make the difference in ensuring that a member sees his or her PCMH and specialist providers as recommended (including after release from the hospital) and takes other steps to manage his or her condition.

The OHCA, as the managed care organization for SoonerCare Choice, has put in place a needs-based multi-tiered care management structure for members with complex/chronic conditions (Exhibit 2-18). The Population Care Management Department directly administers or oversees a wide range of case and care management activities and includes over 50 staff members (managers, clinical personnel and support staff). The Department has access to OHCA medical director staff and physician consultants in the agency’s Medical/Professional Services Department.

Exhibit 2 – 18 – SoonerCare Choice Population Care Management Structure



The Case Management Unit within the Population Care Management Department assists members with high risk medical conditions, including members being discharged from the hospital and members with high risk pregnancies. Exceptional Needs Coordinators (Registered Nurses) in the unit provide telephonic case management to assist members with appointment scheduling, obtaining of medically necessary durable medical equipment and other tasks appropriate to meeting their medical needs.

The Population Care Management Department also provides or arranges for ongoing assistance to members with chronic conditions, such as asthma, diabetes and heart failure. The SoonerCare Health Management Program provides holistic, in-person health coaching to up to 7,000 members at a time, working in collaboration with members' PCMH providers. The Chronic Care Unit provides telephonic care management to members with chronic conditions who are not enrolled in the SoonerCare HMP. The Oklahoma University Health Sciences Center administers a targeted care management program for children and adolescents with diabetes.

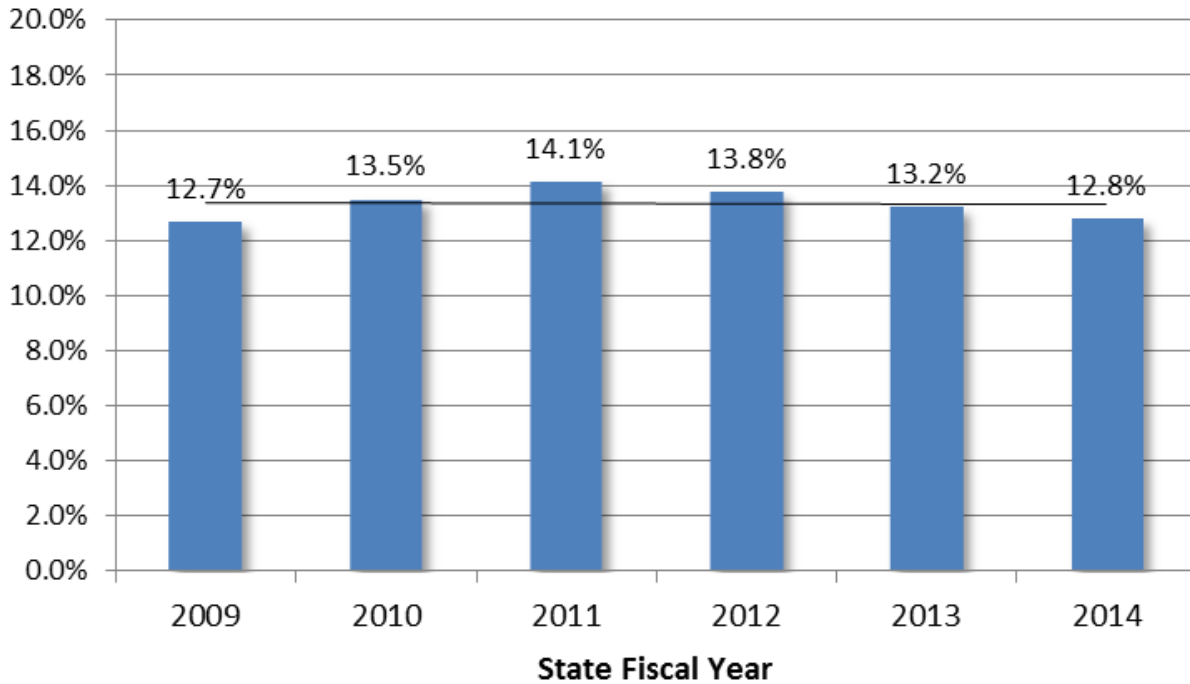
The Behavioral Health Department and its Behavioral Health Specialist staff provide assistance to members with behavioral health needs, including seriously mentally ill adults and seriously emotionally disturbed children. The Department often works in collaboration with the other care management units to facilitate treatment of members with physical/behavioral health comorbidities. The resolution of a behavioral health crisis is often a necessary precondition to getting the member to participate in treating his or her physical health problems.

One important indicator of the effectiveness of Case Management Unit post-discharge activities is the SoonerCare Choice 30-day hospital readmission rate. If members at risk of readmission are identified and provided effective post-acute care case management, this should be reflected in the program's overall readmission rate.

The SoonerCare Choice readmission rate was below 15 percent for the entire evaluation period (Exhibit 2-19 on the following page). The SoonerCare Choice 2014 rate of 12.8 percent compares favorably to the 2013 national Medicare readmission rate of 17.5 percent³⁴, even allowing for the relatively frailer health of the average Medicare beneficiary and the presence of deliveries/newborns (which rarely result in a readmission) in the OHCA data.

³⁴ Source: <http://innovation.cms.gov/Files/reports/patient-safety-results.pdf> 2013 is the most recently-published data for Medicare.

Exhibit 2 – 19 – SoonerCare Choice Care 30-Day Hospital Readmission Rate



The impact on members with chronic physical and/or behavioral health conditions can be assessed through a variety of measures, including adherence to chronic condition preventive care guidelines (e.g., retinal eye exams for diabetics), emergency room and inpatient hospital utilization, average per member per month expenditures and member satisfaction. PHPG has conducted a multi-year evaluation of the SoonerCare Health Management Program (HMP) along each of these dimensions and has reported positive outcomes with respect to member service utilization, health outcomes and satisfaction³⁵. More information on SoonerCare HMP performance is presented in chapter three.

³⁵ For findings covering PHPG's five-year evaluation, see SoonerCare HMP Comprehensive Program Evaluation and Cost Savings Report, May 2014

Quality of Care

Evaluation Questions

The first step in improving quality of care is to have an organized process for measuring quality and incentives for meeting or exceeding program benchmarks. If benchmarks are met the result should be improved health outcomes.

PHPG framed the quality portion of the evaluation around the following questions:

1. Does the program have mechanisms to measure and reward quality?
2. Are members receiving appropriate preventive and diagnostic services?
3. Are health outcomes improving?

Does the Program Have Mechanisms to Measure and Reward Quality?

The OHCA tracks preventive and diagnostic service delivery for SoonerCare Choice through “Healthcare Effectiveness Data and Information Set” (HEDIS[®]) measures. These measures are used nationally and are validated by the National Committee for Quality Assurance (NCQA). The OHCA contracts with an independent quality review organization to perform the HEDIS analysis.

HEDIS data is used in conjunction with other measures to evaluate the performance of PCMH providers and to reward providers who meet or exceed pre-established targets. In SFY 2014, the OHCA made over \$3.2 million in “SoonerExcel” quality incentive payments to PCMH providers who met one or more quality benchmarks, down slightly from 2013 (Exhibit 2-20).

Exhibit 2 – 20 – SoonerExcel Payments – SFY 2013 and SFY 2014

Quality Measure	Benchmark	Incentive (subject to available funds)	SFY 2013 Payments	SFY 2014 Payments
4 th DTaP	Immunization prior to age 2	\$3.00 per child	In EPSDT Total	In EPSDT Total
EPSDT Screen	Meet or exceed appropriate compliance rate	Up to 25 percent bonus on standard FFS rate for procedure	\$984,000	\$1,014,000
Breast/Cervical Cancer Screens	Payment made for each screen	Amount based on comparison to peers and available funds	\$358,000	\$347,000
ED Utilization	Expected ED/office visit rate (risk adjusted)	Additional PMPM payment for outperforming benchmark	\$483,000	\$495,000

Quality Measure	Benchmark	Incentive (subject to available funds)	SFY 2013 Payments	SFY 2014 Payments
Generic Prescribing	Payment made for each Rx, after application of adjustment formula	Provider-specific portion out of quarterly pool of \$250,000 (discontinued as of January 2014)	\$967,000	\$491,000
Physician Hospital Visits	Making inpatient visits	25 percent bonus per procedure + additional \$20 per visit if above average of participating providers	\$760,000	\$850,000
Behavioral Health	Performing annual BH screen on members age 5+	\$2.00 per assessment (starting in January 2014)	---	\$20,000
TOTAL PAYMENTS			\$3,552,000	\$3,217,000

Are members receiving appropriate preventive and diagnostic services?

PHPG examined HEDIS results for SoonerCare Choice members both longitudinally and in comparison to national data, where available. For the comparative analysis, PHPG chose national HEDIS Medicaid Managed Care Organization (MCO) rates, which reflect activity among Medicaid managed care enrollees. Although SoonerCare Choice members are not enrolled in MCOs, they are enrolled in managed care, with the OHCA serving essentially as a statewide MCO.

PHPG documented HEDIS trends in six areas for children/adolescents and six areas for adults (Exhibit 2-21). For some measures, data was available extending back to 2008; for others which have undergone methodology changes data was available starting either in 2010 or 2013.

PHPG also documented through HEDIS and other data the OHCA’s activities aimed at reducing tobacco use among SoonerCare Choice members. Findings are included following the presentation of HEDIS data for the first 12 measures.

Exhibit 2 – 21 – HEDIS Measures by Age Group

Children/Adolescents	Adults
Access to PCP	Access to preventive/ambulatory health services
Annual dental visit	Breast cancer screening (ages 40 – 69)
Lead screening rate by 2 years of age	Cervical cancer screening (ages 21 – 64)

Children/Adolescents	Adults
Appropriate treatment for urinary tract infection (ages 3 months to 1 year)	Cholesterol management for patients w/cardiovascular conditions (ages 18 – 75)
Appropriate treatment for children with pharyngitis (ages 2 – 18)	Comprehensive diabetes care
Appropriate medications for treatment of asthma (children)	Appropriate medications for treatment of asthma (adults)

Child/Adolescent HEDIS Trends

The percentage of children and adolescents with access to a PCP increased steadily over the evaluation period and was above 90 percent for all age cohorts in 2014. The access percentage also was consistently above the national rate (Exhibit 2-22).

Exhibit 2 – 22 – SoonerCare Choice HEDIS Trends – Child/Adolescent Access to PCP³⁶

HEDIS Measure	2008	2009	2010	2011	2012	2013	2014	% Point Change 2008 -14	National Rate
Child access to PCP, 12-24 months	94.1%	96.2%	97.8%	97.2%	96.6%	96.3%	96.2%	↑2.1%	96.1%
Child access to PCP, 3-6 years	83.1%	86.9%	89.1%	88.4%	90.1%	90.2%	89.0%	↑5.9%	88.3%
Child access to PCP, 7-11 years	82.7%	87.6%	89.9%	90.9%	91.7%	92.2%	90.9%	↑8.2%	90.0%
Adolescent access to PCP, 12-18 years	81.4%	85.8%	88.8%	89.9%	91.6%	92.8%	92.7%	↑11.3%	88.5%

HEDIS rates improved for lead screening, treatment for urinary tract infection and testing for pharyngitis but in all three cases was below the national rate. By contrast, the rate for dental visits fell slightly from 2013 to 2014 but remained significantly above the national rate (Exhibits 2-23 and 2-24 on the following page).

³⁶ Sources for all HEDIS data: Oklahoma Health Care Authority (OHCA) for Oklahoma HEDIS® results and National Committee for Quality Assurance (NQCA) “The State of Health Quality 2014” for national Medicaid HMO rates. Reporting years represent results for activity in the prior year. PHPG calculated SoonerCare Choice 2014 rates under a separate engagement for the OHCA. Previous years were calculated by the OHCA.

Exhibit 2 – 23 – SoonerCare Choice HEDIS Trends – Child/Adolescent (Multiple)

HEDIS Measure	2010	2011	2012	2013	2014	% Point Change 2010 -14	National Rate
Lead screening rate	43.5%	44.5%	44.7%	45.9%	47.6%	↑4.1%	67.5%
Appropriate treatment for urinary tract infection	67.7%	69.5%	66.8%	70.8%	72.5%	↑4.8%	85.1%
Appropriate testing for children with pharyngitis	38.8%	44.8%	49.1%	50.5%	51.6%	↑12.8%	66.5%

Exhibit 2 – 24 – SoonerCare Choice HEDIS Trends – Annual Dental Visit

HEDIS Measure	2013	2014	% Point Change 2013 -14	National Rate
Annual dental visit – children 2 to 3	40.4%	39.5%	↓0.9%	34.7%
Annual dental visit – children 4 to 6	65.7%	63.4%	↓2.3%	56.5%
Annual dental visit – children 7 to 10	70.9%	68.8%	↓2.1%	58.6%
Annual dental visit – adolescents 11 to 14	68.7%	66.9%	↓1.9%	53.3%
Annual dental visit – adolescents 15 to 18	62.0%	59.9%	↓2.1%	46.3%
Annual dental visit – young adults 19 to 21	40.6%	38.2%	↓2.4%	32.9%

Adult HEDIS Trends – Preventive Services

Access to preventive services also improved for both younger and older adults from 2008 to 2014, reaching nearly 82 percent in SFY 2014 for the former and 88 percent for the latter (Exhibit 2-25). Both results were down slightly from their peaks in 2011 but exceeded the corresponding national rates.

Exhibit 2 – 25 – SoonerCare Choice HEDIS Trends – Adult Access to Preventive Services

HEDIS Measure	2008	2009	2010	2011	2012	2013	2014	% Point Change 2008 -14	National Rate
Adult access to preventive/ ambulatory services, 20 – 44 years	78.4%	83.3%	83.6%	84.2%	83.1%	82.8%	81.9%	↑3.5%	80.0%
Adult access to preventive/ ambulatory services, 45 – 64 years	86.8%	89.7%	90.9%	91.1%	91.0%	87.9%	87.7%	↑0.9%	86.1%

The screening rates for breast and cervical cancer, and the rate for management of cholesterol among patients with cardiovascular conditions, showed mixed results, with one increasing and two decreasing versus the 2008 base year. The 2014 rate for all three measures was below the corresponding national benchmark (Exhibit 2-26).

Exhibit 2 – 26 – SoonerCare Choice HEDIS Trends – Adult (Multiple)

HEDIS Measure	2008	2009	2010	2011	2012	2013	2014	% Point Change 2008(13) -14	National Rate ³⁷
Breast cancer screening rate	38.3%	43.0%	41.1%	41.3%	36.9%	37.6%	36.5%	↓1.8%	57.9%
Cervical cancer screening rate	44.4%	46.6%	44.2%	47.2%	42.5%	46.0%	47.5%	↑3.1%	64.5%
Cholesterol management for patients with cardio-vascular conditions	N/A	N/A	N/A	N/A	N/A	49.9%	45.2%	↓4.7%	81.1%

³⁷ Cervical cancer national rate is for 2013.

One contributing factor to this fluctuation may have been an ongoing national debate concerning the recommended screening age for mammograms, which was recently raised, and recommended cervical screening intervals, which were recently lengthened. In fact, the 2013 HEDIS technical specifications for cervical cancer screens did not align with the revised cervical cancer screening guidelines from the American College of Obstetricians and Gynecologists.

Prior to 2014, HEDIS required a two-year look back while ACOG is now recommending screens every three-to-five years; thus a member could be current on her screens but still show as having a care gap in HEDIS calculations. The 2014 HEDIS specifications were revised to address this discrepancy but a revised national rate has not yet been calculated. Once an updated national rate is published, Oklahoma should find itself closer to the benchmark; nevertheless, there is still clearly room for improvement, which the OHCA recognizes.

The OHCA recently began a quality improvement initiative under the auspices of an Adult Medicaid Quality Grant to increase cervical screening rates through a combination of provider training and member outreach activities. The agency also is evaluating steps for improving breast cancer screening rates.

Adult HEDIS Trends – Diabetes

Diabetes is one of the most common chronic conditions within the SoonerCare Choice adult population. The trends for HEDIS measures related to diabetes care are mixed, with one improving and three declining. All of the rates are below their corresponding national benchmarks (Exhibit 2-27).

Exhibit 2 – 27 – SoonerCare Choice HEDIS Trends – Diabetes

HEDIS Measure	2010	2011	2012	2013	2014	% Point Change 2010 -14	National Rate
Hemoglobin A1C testing	71.0%	71.1%	70.5%	71.5%	71.9%	↑0.9%	83.0%
Eye exam (retinal)	32.8%	31.8%	31.8%	32.0%	26.3%	↓6.5%	53.2%
LDL-C screening	63.6%	62.9%	62.0%	63.1%	63.4%	↓0.2%	75.5%
Medical attention for nephropathy	54.4%	55.9%	56.8%	58.7%	53.4%	↓1.0%	78.4%

The OHCA also is using the Adult Medicaid Quality Grant as a vehicle for improving diabetes care management. Grant staff is working with a small sample of PCMH providers and their SoonerCare Choice Members to test best practices for training staff; conducting patient outreach and education; and using electronic health records to collect and report clinical quality measure data.

The grant activities are similar to those undertaken within the SoonerCare HMP for members with chronic illnesses, including diabetes. The SoonerCare HMP interventions have resulted in improved preventive service rates and reductions in emergency room and hospital utilization (see chapter three³⁸).

All Ages HEDIS Trends – Asthma

Asthma is another very common chronic condition within the SoonerCare Choice population, affecting all age groups. In many cases it can be well controlled through prescribing of appropriate medication.

The HEDIS rates for treatment of asthma with appropriate medications are above 80 percent for children and adolescents and close to the corresponding national benchmarks. The rates for younger and older adults are not as favorable, either in absolute terms or in comparison to the national benchmark rates. This represents another opportunity for improvement (Exhibit 2-28).

Exhibit 2 – 28 – SoonerCare Choice HEDIS Trends – Asthma

HEDIS Measure	2013	2014	% Point Change 2010 -14	National Rate
Appropriate medications for treatment of asthma, ages 5 - 11	91.5%	89.7%	↓1.8%	90.2%
Appropriate medications for treatment of asthma, ages 12 - 18	86.4%	82.6%	↓3.8%	86.9%
Appropriate medications for treatment of asthma, ages 19 - 50	63.2%	61.7%	↓1.5%	74.4%
Appropriate medications for treatment of asthma, ages 51- 64	67.3%	62.5%	↓4.8%	70.3%

³⁸ See also SoonerCare HMP – Comprehensive Program Evaluation and Cost Savings Report, May 2014.

Tobacco Cessation Activities

Tobacco use is the single most preventable cause of death and poor health outcomes in the United States, responsible for an estimated \$96 billion in health-related expenditures each year³⁹.

Oklahoma historically has had one of the nation’s highest tobacco use rates and tobacco use among SoonerCare members has exceeded the State average. In 2008, 48 percent of SoonerCare Choice adults in the CAHPS survey reported using tobacco products, versus 26 percent of the total adult population in 2012 who reported smoking and seven percent who reported using smokeless tobacco products⁴⁰.

In response, the OHCA launched the SoonerQuit initiative in 2010 with the goal of reducing tobacco use among SoonerCare Choice members through:

- Tobacco cessation counseling and products (e.g., educational materials and prescription/OTC aids);
- Assistance to prenatal care and primary care providers in performing the “5 A’s” of tobacco cessation (ask, advise, assess, assist arrange) through practice facilitation; and
- Coordination with other initiatives in the State, including the Oklahoma Tobacco Helpline.

The OHCA’s efforts appear to have positively influenced provider activities, as reflected in HEDIS data measuring the incidence of tobacco cessation counseling. The Oklahoma rates are comparable to the corresponding national benchmark rates (Exhibit 2-29).

Exhibit 2 – 29 – SoonerCare Choice HEDIS Trends – Medical Assistance w/Smoking & Tobacco Use

HEDIS Measure	2013	2014	% Point Change 2010 -14	National Rate
Advising smokers and tobacco users to quit	76.3%	75.0%	↓1.3%	75.8%
Discussing cessation medications	45.2%	47.9%	↑2.7%	46.6%
Discussing cessation strategies	41.7%	44.1%	↑2.4%	41.9%

³⁹ All information in this section was provided by the OHCA, except where noted.

⁴⁰ Source for total adult population: Centers for Disease Control.

Members and providers have responded to SoonerQuit and related initiatives and tobacco use rates are on the decline:

- Tobacco Helpline call volume increased 82 percent from 2009 to 2012
- Among SoonerCare Choice prenatal care providers who participated in practice facilitation, the portion offering onsite tobacco cessation counseling increased from 29 percent to 68 percent⁴¹
- The tobacco use rate among SoonerCare Choice adults, as reported in CAHPS survey data, declined from 48 percent in 2008 to 43 percent in 2013

The potential health benefits of this decline are substantial. For every dollar spent on tobacco cessation activities, there is an estimated \$3.12 saved in the form of reduced cardiovascular-related hospital admissions.

⁴¹ Source: PHPG independent evaluation of SoonerQuit practice facilitation initiative.

Are Health Outcomes Improving?

Avoidable (Ambulatory Care Sensitive) Hospitalizations

The delivery of high quality preventive and primary care should contribute to improved health outcomes. One useful measure of quality is the hospitalization rate for avoidable, or ambulatory care sensitive, conditions.

If members with chronic, but treatable conditions such as asthma, congestive heart failure (CHF) or chronic obstructive pulmonary disease (COPD) receive effective preventive, primary and specialty care, their risk of an acute episode requiring hospitalization can be reduced. Similarly, members with treatable acute conditions such as pneumonia can often avoid hospitalization if the condition is diagnosed and treated at an early stage.

PHPG examined hospitalization rates for the four ambulatory care sensitive conditions from SFY 2009 through 2014. The rate declined significantly across all four conditions, with the sharpest decline for pneumonia-related admissions (Exhibits 2-30 through 2-33).

Exhibit 2 – 30 – SCC Ambulatory Care Sensitive Hospitalization Rate – Asthma

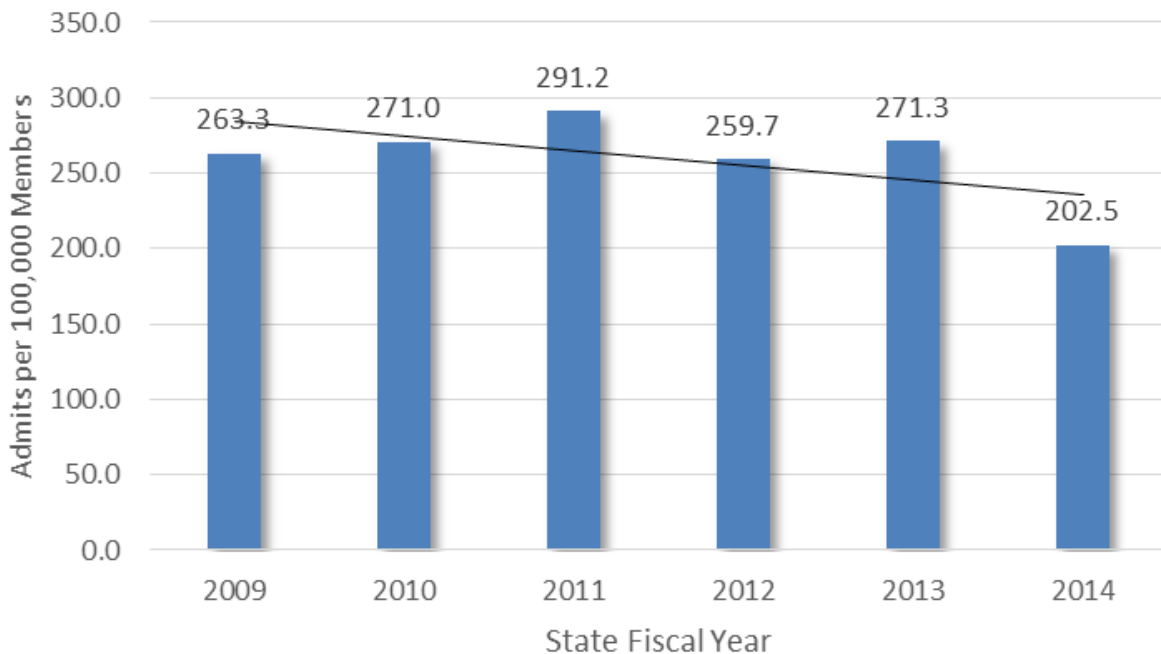


Exhibit 2 – 31 – SCC Ambulatory Care Sensitive Hospitalization Rate – CHF

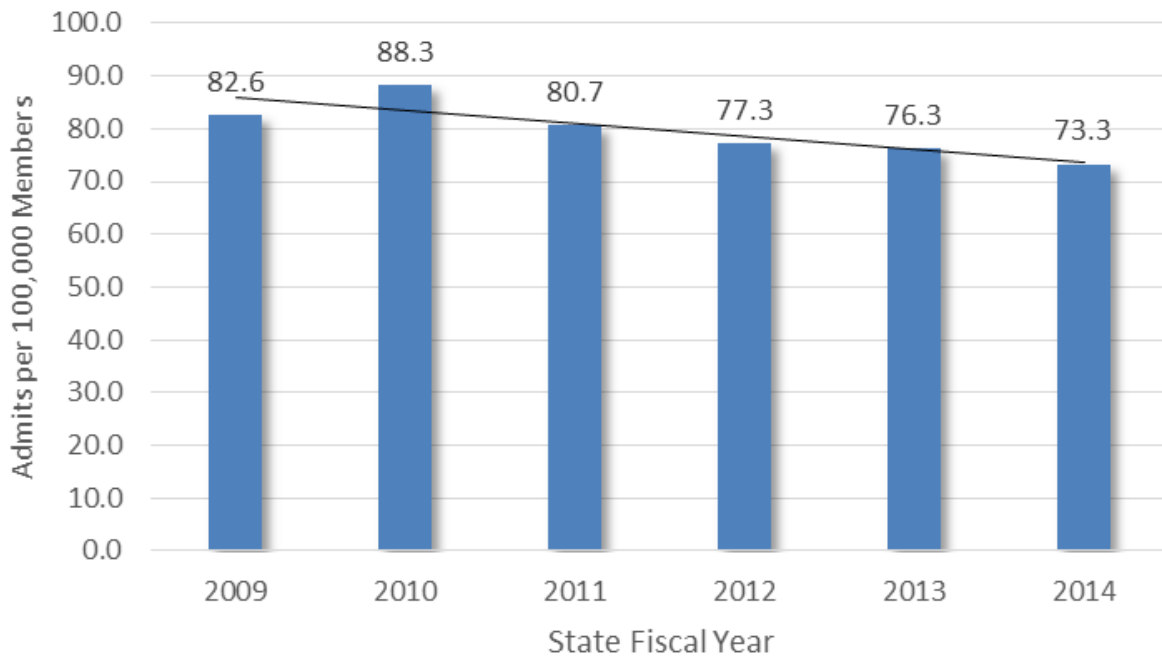


Exhibit 2-32 – SCC Ambulatory Care Sensitive Hospitalization Rate – COPD

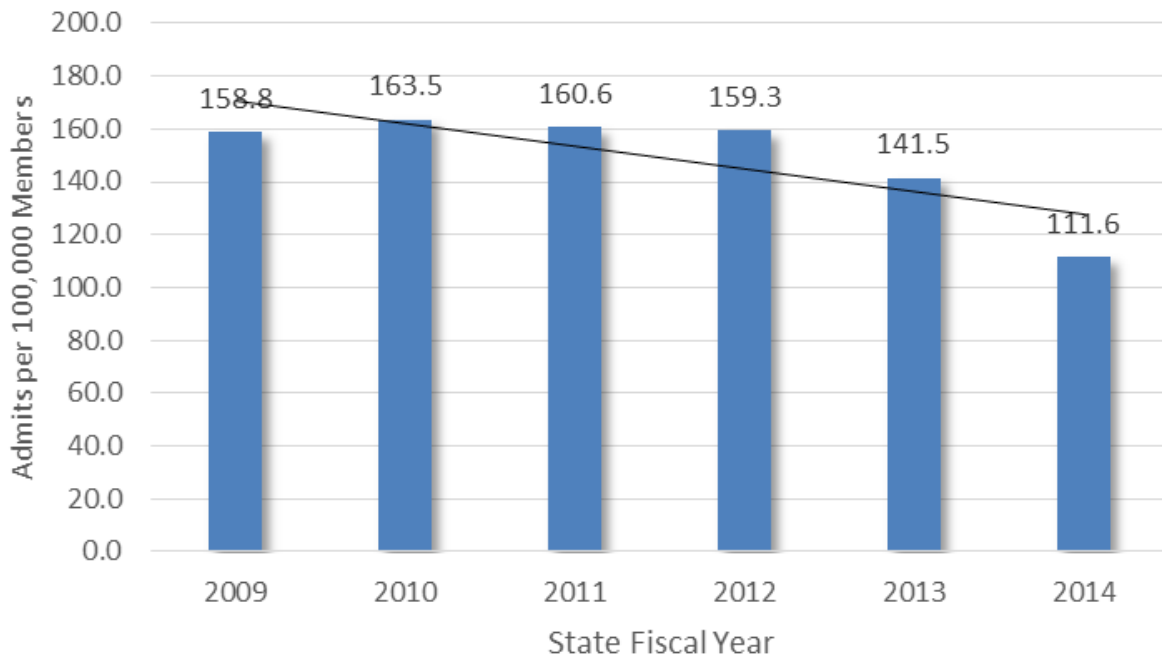
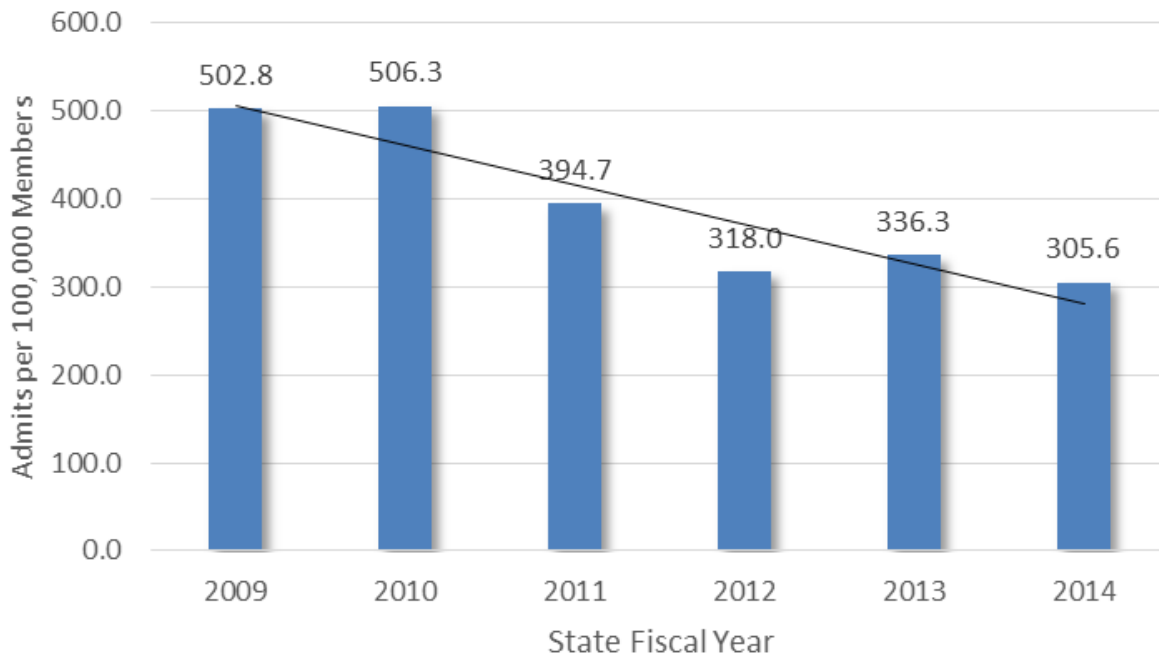


Exhibit 2 – 33 – SCC Ambulatory Care Sensitive Hospitalization Rate – Pneumonia



Post Discharge Care

Another measure of health outcomes is the 30-day readmission rate for members who are hospitalized. The previously reported low rate for 2009 through 2014 (Exhibit 2-19) is an indicator of effective post-discharge care.

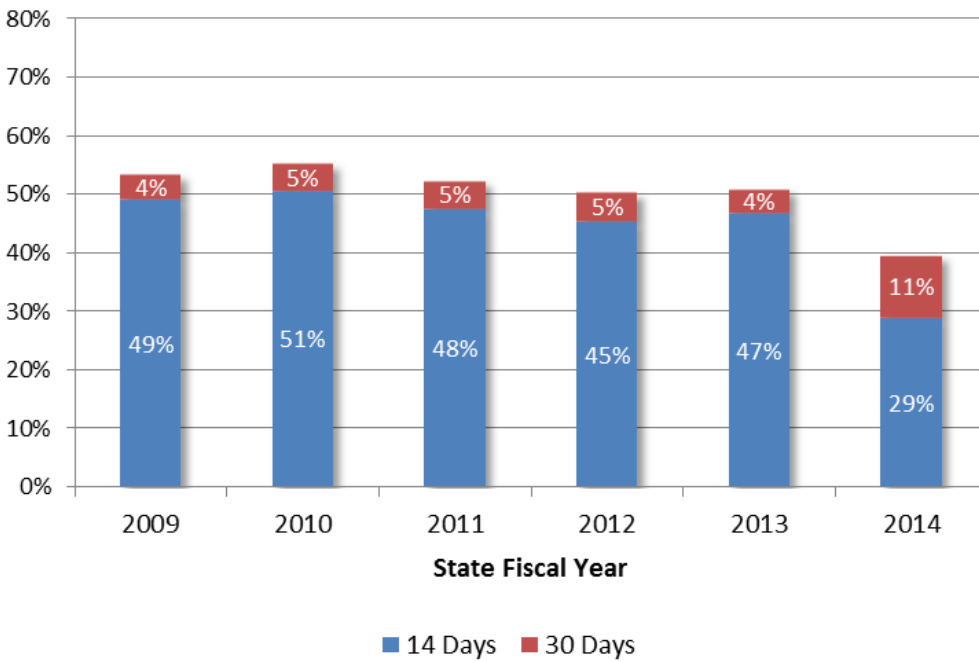
As noted earlier, the OHCA’s care managers are likely responsible for a portion of the improvement. Another contributing factor may be the PCMH provider community.

Effective discharge planning should include a follow-up visit within 30 days (at most) to an outpatient provider. In some cases, this may be to a specialist or surgeon. For ambulatory care sensitive hospitalizations, the PCMH will often be the appropriate person to deliver follow-up care.

PHPG analyzed follow-up visit rates for SoonerCare Choice members recently discharged from the hospital. Visit rates were calculated at 14 and 30 days post-discharge. PHPG examined total discharges and discharges following admission for one of the four ambulatory care sensitive conditions.

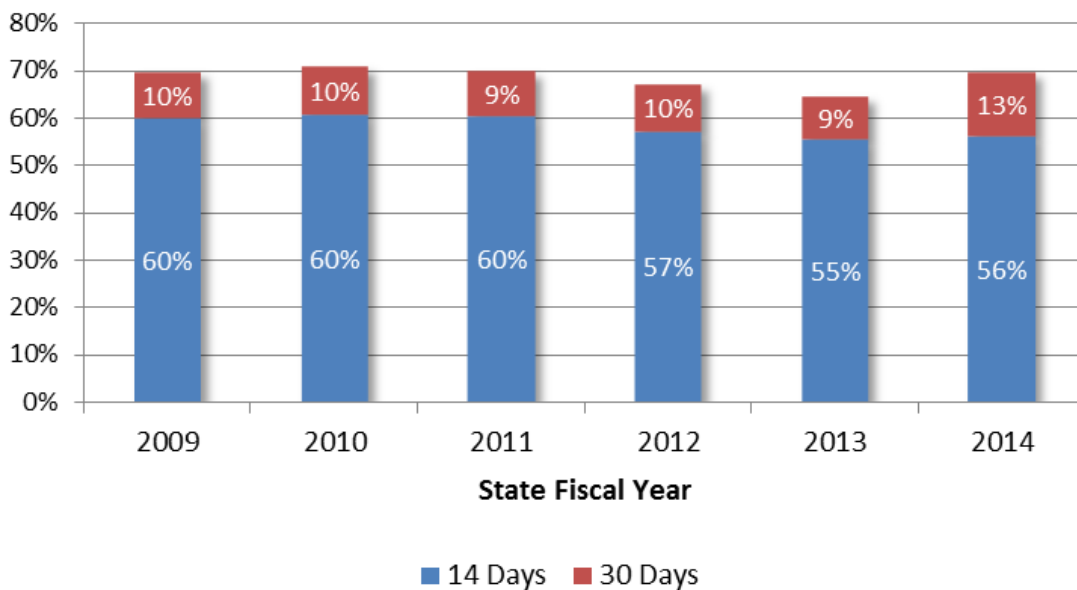
The follow-up rate for all members declined from 2013 to 2014, after remaining relatively steady and above 50 percent from 2009 to 2013 (Exhibit 2-34 on the following page).

Exhibit 2 – 34 – SCC Post-Discharge PCMH Follow-up Visit Rate – All Hospitalizations



The follow-up rate for members hospitalized with one of the four ambulatory sensitive conditions has consistently been above 60 percent and reached a four-year high of 69 percent in 2014 (Exhibit 2-35). The ambulatory care sensitive follow-up rate should be considered more meaningful than the rate for all members, as it excludes admissions for events such as surgeries and deliveries, where appropriate follow-up may be the responsibility of a physician other than the PCMH.

Exhibit 2 – 35 – SCC Post-Discharge PCMH Follow-up Visit Rate – Ambulatory Sensitive



Cost Effectiveness

Evaluation Questions

The provision of accessible and high quality care is central to the mission of the SoonerCare Choice program. However, for the program to achieve sustainable results, care must be delivered in a cost effective manner.

If the growth in program expenditures outstrips the ability of the state to pay for care, both access and quality will suffer as providers exit the program and benefits are reduced. This was the circumstance that confronted the State in the early 1990's when the decision was made to transform the program through implementation of the SoonerCare waiver.

At the highest level, there are two types of program expenditures: health services (payments to providers) and administration (OHCA and other agency operating costs). Accordingly, PHPG framed the quality portion of the evaluation around two questions:

1. Is the SoonerCare program cost effective in terms of health care expenditures?
2. Is the SoonerCare program cost effective in terms of administrative expenses?

Is the SoonerCare Choice Program Cost Effective in Terms of Health Care Expenditures?

PHPG examined SoonerCare Choice health expenditure trends from SFY 2009 through SFY 2014. PHPG analyzed average per member per month (PMPM) expenditures to eliminate any impact associated with change in enrollment, which is not controllable by the OHCA.

PHPG also analyzed members in the TANF and related categories, primarily pregnant women and healthy children, separately from aged, blind and disabled (ABD) members⁴². Although smaller in number, the ABD population has much higher service needs and average costs; a high trend rate for this population could place significant fiscal pressures on the program.

In fact, ABD expenditures increased at an average annual rate of only 2.8 percent, despite a spike from 2013 to 2014. TANF and related population expenditures grew even more moderately, registering an average annual rate of only 0.5 percent.

Annual PMPM expenditure growth for the total SoonerCare Choice population from 2009 - 2014 was nearly flat, at 0.2 percent, in part attributable to a drop from 2013 to 2014⁴³ (Exhibit

⁴² SoonerCare Choice includes ABD members who are not dually eligible for Medicare and Medicaid. Dually eligible members are enrolled in SoonerCare Traditional.

⁴³ The growth rate for all of SoonerCare Choice was lower than the individual rates for ABD and TANF members because of changes in the relative size of the two groups from 2009 to 2014. TANF enrollment grew by 18 percent while ABD enrollment grew by only eight percent. The more rapid enrollment growth for TANF members,

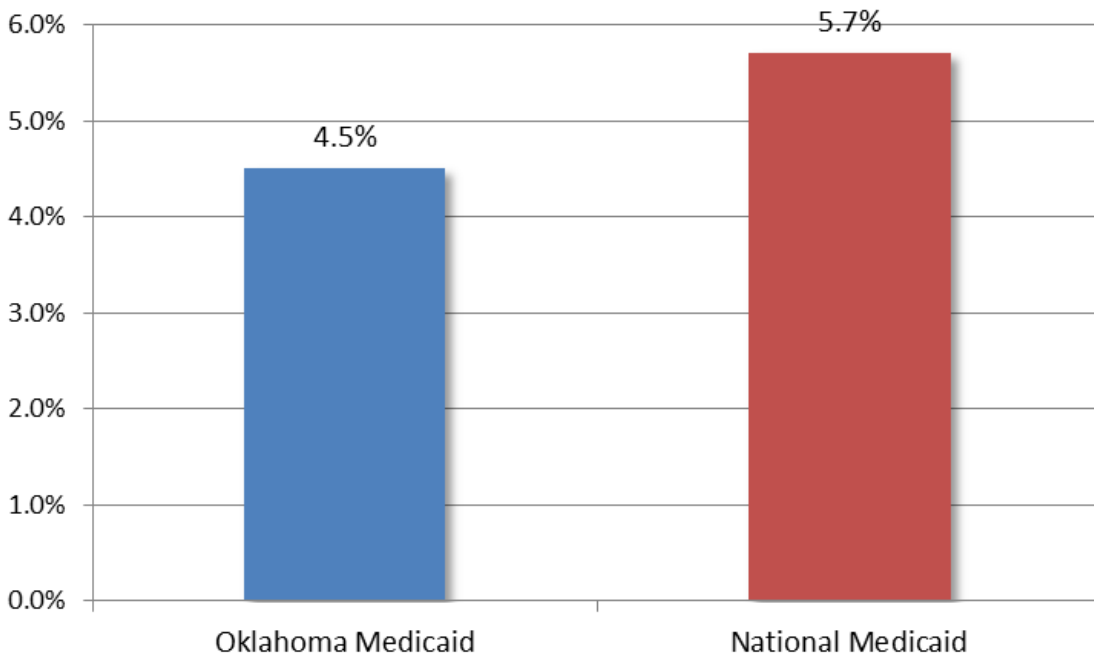
2-36). The rate from 2010 – 2103 was somewhat higher but still a modest 1.9 percent. PHPG calculated the rate for 2010 - 2013 in order to compare to national Medicaid data, which was only available for this period of time.

Exhibit 2 – 36 – SoonerCare Choice PMPM Health Expenditures by State Fiscal Year

Aid Category	2009	2010	2011	2012	2013	2014	Average Annual % Change 2010 - 13	Average Annual % Change 2009-14
ABD (non-duals)	\$779	\$815	\$806	\$806	\$836	\$895	↑0.9%	↑2.8%
TANF/Other	\$216	\$215	\$217	\$228	\$236	\$221	↑3.2%	↑0.5%
TOTAL	\$274	\$275	\$276	\$280	\$291	\$276	↑1.9	↑0.2%

Total medical spending for SoonerCare (all aid categories), inclusive of spending attributable to eligibility growth, increased at an average annual rate of 4.5 percent from 2010 – 2013. This was below the national average of 5.7 percent⁴⁴ (Exhibit 2-37).

Exhibit 2 – 37 – Average Annual Medicaid Medical Spending Growth – 2010 – 2013

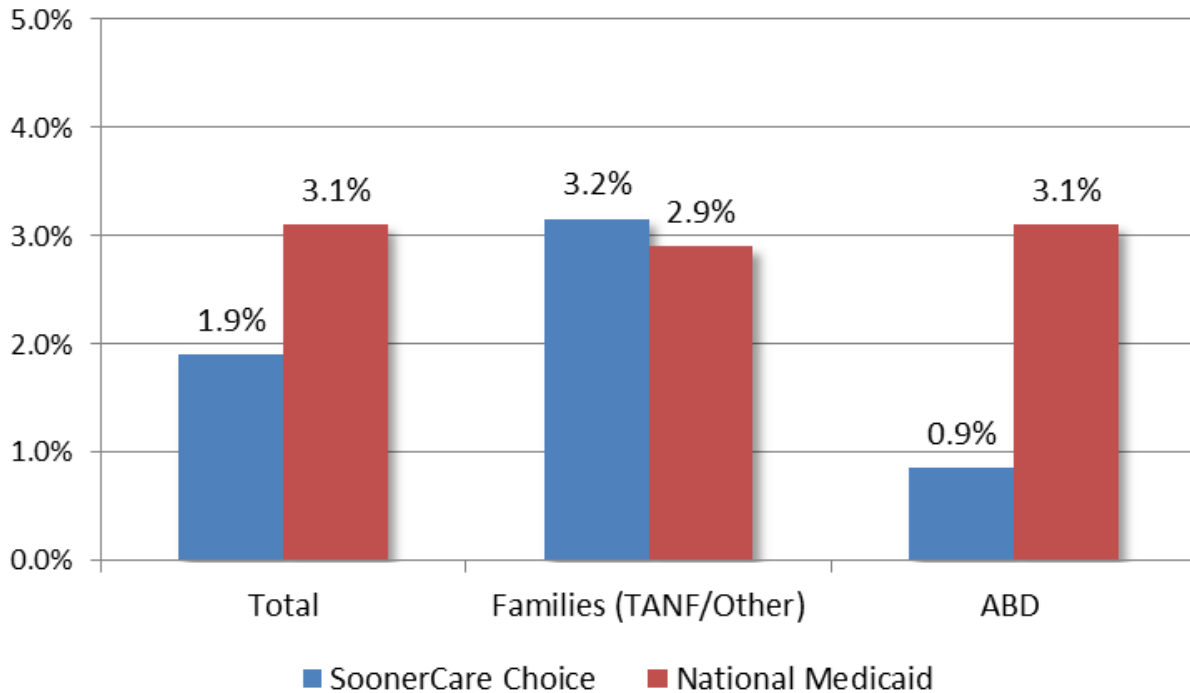


combined with their lower PMPM costs, resulted in the low average annual PMPM percentage change for all SoonerCare Choice members.

⁴⁴ Source: “Trends in Medicaid Spending Leading up to ACA Implementation”, Kaiser Commission on Medicaid and the Uninsured (February 2015)

Controlling for eligibility growth, SoonerCare Choice PMPM medical expenditure growth was significantly below the national rate. The lower overall growth rate for SoonerCare Choice was attributable the ABD aid category; TANF growth was slightly above the national average⁴⁵ (Exhibit 2-38).

Exhibit 2 – 38 – Average Annual PMPM Spending Growth – 2010 – 2013



Is the SoonerCare Program Cost Effective in Terms of Administrative Expenses?

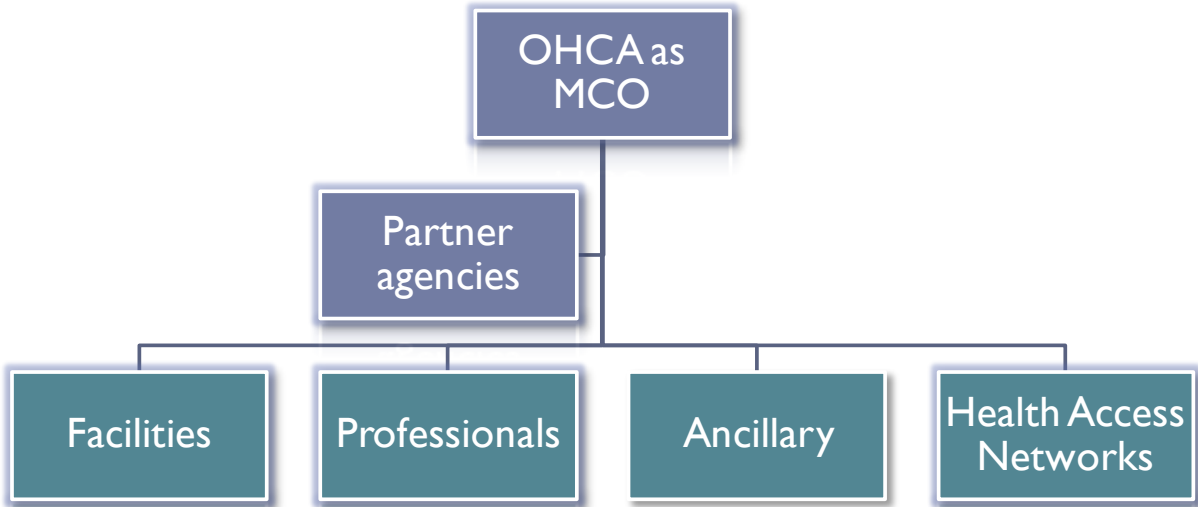
Note: PHPG conducted a detailed evaluation of SoonerCare program administrative expenses under the current model and an alternative model in which the OHCA would contract with private managed care organizations. The evaluation encompassed both SoonerCare Choice and SoonerCare Traditional. PHPG’s findings were presented in May 2014 (see: “Administering the SoonerCare Program: A Comparison of Public and Private Managed Care Costs”). The information presented below is based on the larger report.

SoonerCare operates as a managed care program but its structure differs from a traditional private MCO model. Under SoonerCare, the OHCA operates as a de facto statewide public MCO. In this role, the OHCA has fostered the development of patient centered medical homes and community-based care organizations, such as the health access networks. The OHCA also has created incentives to encourage achievement of quality performance targets and directly monitors program accessibility, quality and cost effectiveness.

⁴⁵ Ibid.

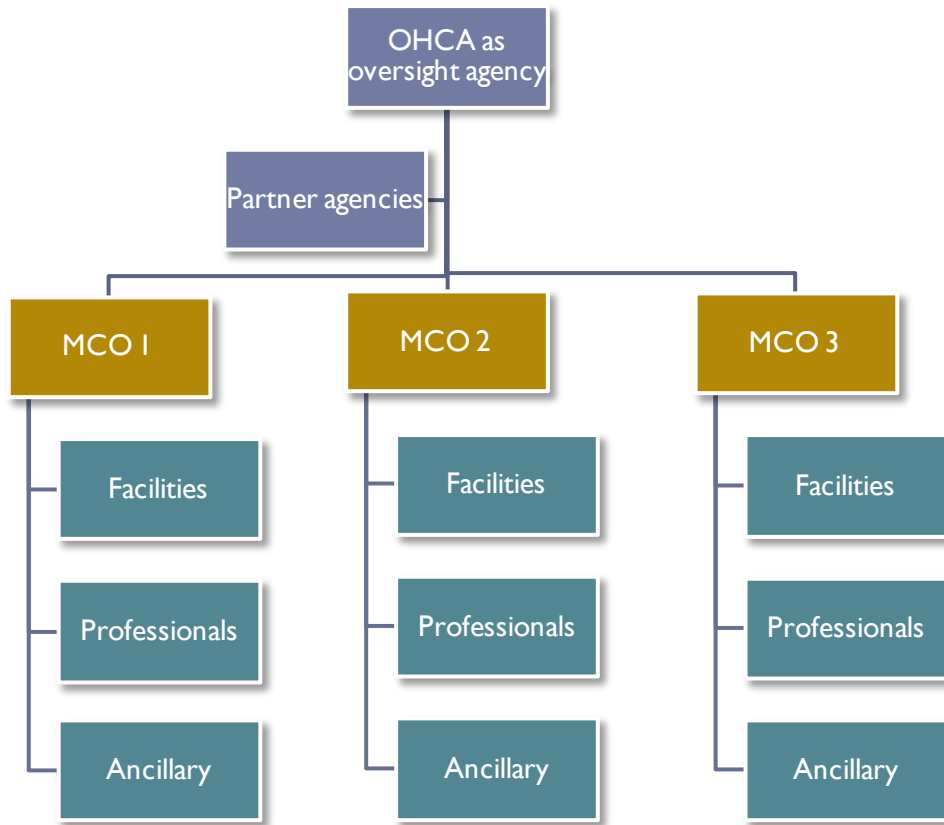
The OHCA collaborates with partner agencies and utilizes vendors for some activities (e.g., Telligen provides health coaching to SoonerCare HMP enrollees). However, the OHCA maintains direct responsibility for ensuring the success of the program (Exhibit 2-39).

Exhibit 2 – 39 – OHCA Administrative Model (Current)



Under the private MCO model, the state typically contracts with three or more health plans, usually with overlapping provider networks, to serve Medicaid members. This is the model that the OHCA operated in the Oklahoma City, Tulsa and Lawton areas under the name “SoonerCare Plus” until 2004 (Exhibit 2-40 on the following page).

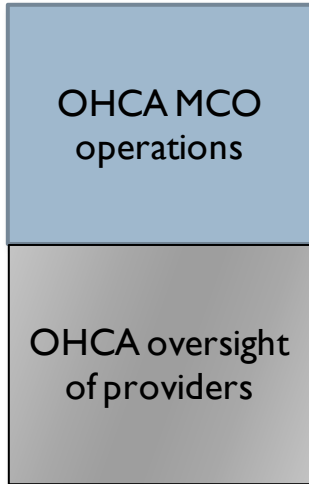
Exhibit 2 – 40 – Private MCO Administrative Model



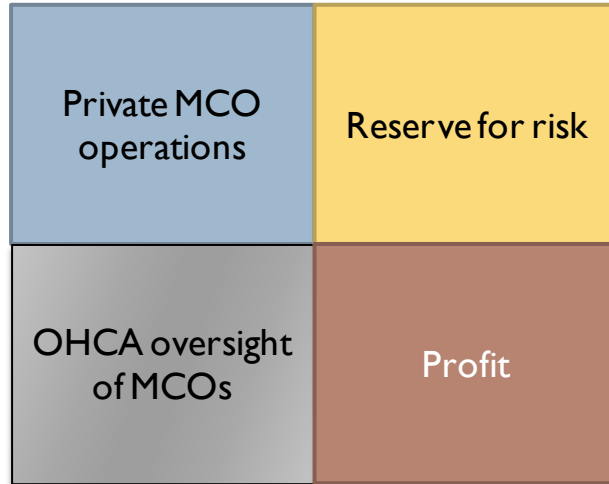
States with MCO contracts are typically able to reduce their agency administrative costs slightly by transferring member service, provider contracting and medical management activities to the plans. However, these savings can be more than offset by the need to cover the administrative costs, risk reserves and profit expectations of multiple contractors. In addition, the state Medicaid agency (the OHCA in Oklahoma) retains responsibility for program oversight (Exhibit 2-41 on the following page).

Exhibit 2 – 41 – Public and Private MCO Models – Administrative Components

Public MCO Model



Private MCO Model



PHPG researched current rate setting methodologies in other states to determine a reasonable expected administrative cost allowance for private MCOs were the OHCA once again to contract with them to serve the SoonerCare population⁴⁶. PHPG focused on states with geographic and demographic characteristics similar to Oklahoma. PHPG’s research necessarily was limited to states utilizing private MCOs, and those with readily and publicly available rate setting information.

The comparison states included four of Oklahoma’s neighbors: Colorado, Kansas, New Mexico and Texas. PHPG also examined rates in Arizona, Florida and Louisiana, as well as data contained in a national study prepared for CMS in 2013 by the actuarial firm of Milliman⁴⁷.

On average, private MCO administrative costs in the comparison states equaled just under 11 percent of total per member per month costs. This includes monies for direct administration, as well as reserves for risk/contingencies and profit (Exhibit 2-42 on the following page).

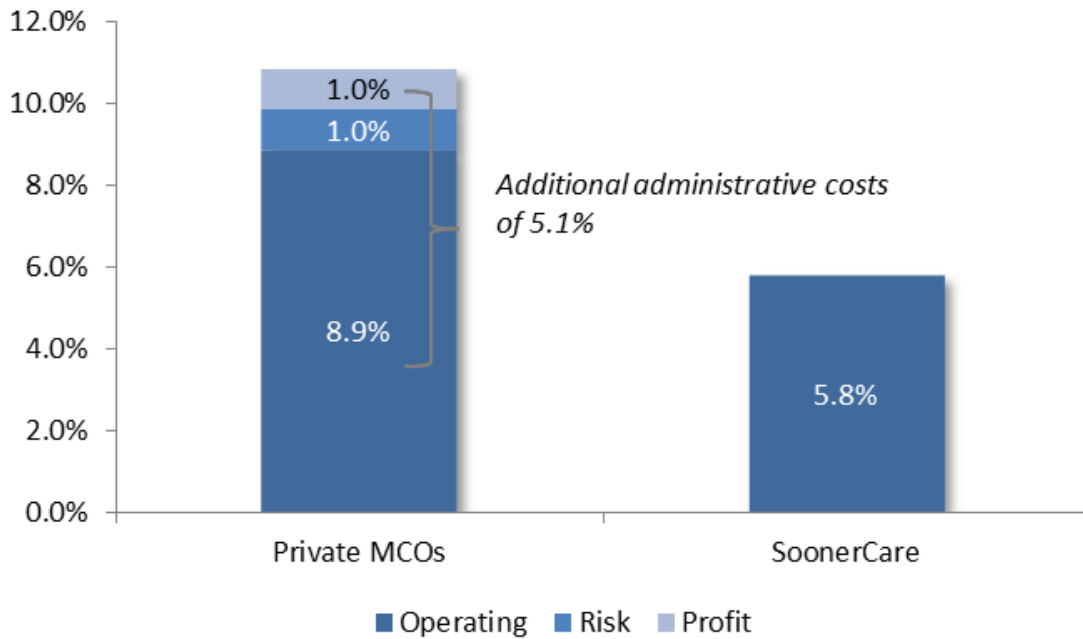
By comparison, the OHCA’s administrative cost in SFY 2014, as documented in the agency’s annual report was 5.8 percent⁴⁸.

⁴⁶ PHPG did not analyze administrative costs in the SoonerCare Plus program because of the number of years that have elapsed since the program’s demise.

⁴⁷ “Medicaid risk-based managed care: Analysis of financial results for 2012,” Milliman, June 2013,

⁴⁸ In the analysis PHPG performed for the May 2014 report, OHCA and partner agency administrative expenses were adjusted to capture only activities comparable to those performed by an MCO; for example, eligibility-related costs were excluded. The adjusted expense percentage, based on SFY 2013 expenses, was 4.2 percent. For simplicity purposes, OHCA’s published SFY 2014 rate has been used in this report. It likely overstates the agency’s MCO-related costs by a small amount.

Exhibit 2 – 42 – Public and Private MCO Models – Admin Costs as Percent of Total Costs



The advantage of the OHCA public MCO model is not difficult to explain. In addition to having no need for risk/contingency reserves or profits, the OHCA, as a statewide plan, is able to spread administrative costs over a larger population than an MCO that is dividing membership with other plans. This enables a greater share of the healthcare dollar to be paid to providers for care delivery. It has, for example, enabled the OHCA to pay physicians 89.2 percent of the Medicare rate in SFY 2015, as compared to the national Medicaid average of 66 percent⁴⁹.

⁴⁹ <http://kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/>. National rate is for 2012.

SoonerCare Choice Performance – Summary

The SoonerCare Choice program generally demonstrated strong performance in absolute terms across all three dimensions of care: Access, Quality and Cost Effectiveness. The program also showed improvement in most trend lines, concurrent with the introduction of a series of care management initiatives beginning in 2008.

The next chapter presents detailed information on the three initiatives: patient centered medical homes, health access networks and the SoonerCare Health Management Program.

CHAPTER 3 – IN-DEPTH EVALUATION: SC CHOICE INITIATIVES

SoonerCare Choice became the OHCA’s sole managed care system upon the discontinuation of SoonerCare Plus MCO contracts at the end of calendar year 2004. Since that time, the OHCA has worked to advance the concept of person-centered care in collaboration with providers and community-based care organizations throughout the State.

Three significant initiatives have been undertaken in recent years:

1. Implementation of Patient Centered Medical Homes
2. Establishment of Health Access Networks
3. Development of SoonerCare Health Management Program

PHPG conducted an in-depth evaluation of each initiative, focusing on their contribution to the OHCA’s goals of accessible, high quality and cost effective care. The results are presented in this chapter.

Patient Centered Medical Homes

Overview

As discussed in chapter one, there are three PCMH levels, or tiers, available to primary care providers. Contracting requirements escalate when moving from tier 1 (“Entry Level”) to tier 2 (“Advanced”) to tier 3 (“Optimal”). However, even tier 1 includes a dozen core requirements, such as 24-hour, seven day a week telephone coverage by a medical professional and coordinated primary care and patient education activities (Exhibit 3-1 on the following page).

PCMH providers are paid for services rendered, such as office visits and also receive per member per month fees intended to support care management activities. The fees vary by member age and gender and by tier. A tier 1 PCMH provider with an average SoonerCare Choice caseload of 250 members could expect to receive nearly \$15,000 in care management payments over the course of a year; his or her tier 3 counterpart could expect to receive over \$25,000.

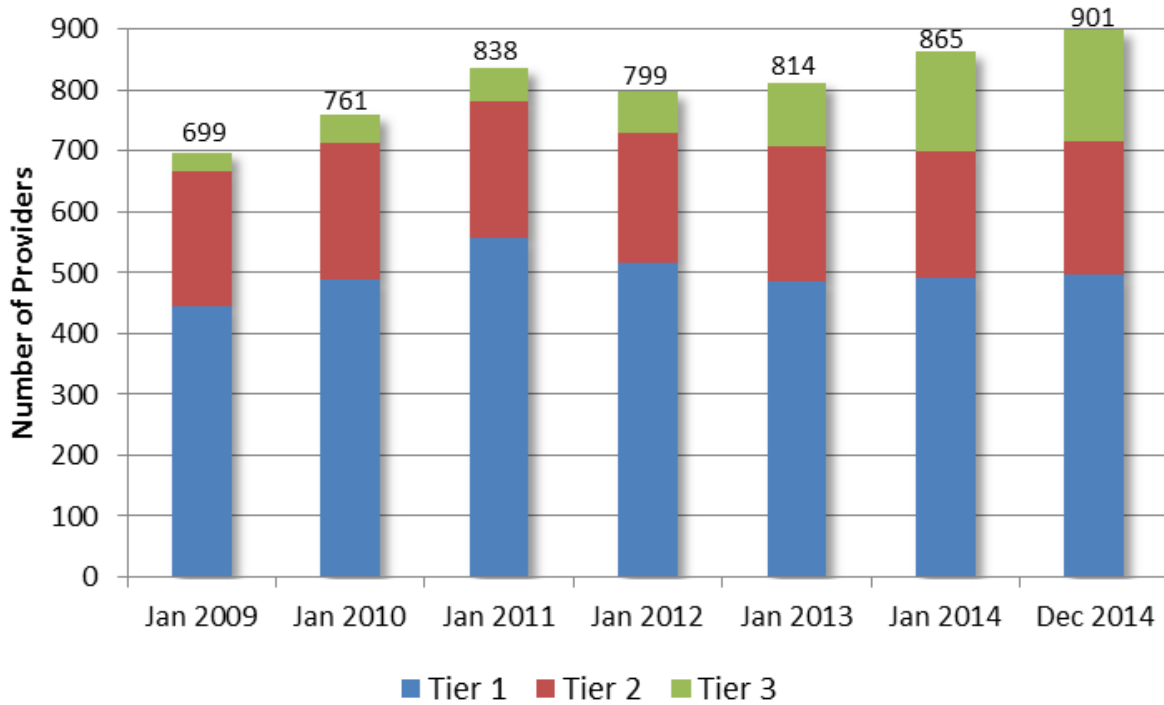
Exhibit 3 – 1 – Patient Centered Medical Home Tiers⁵⁰

PCMH Tier	Requirements (partial list):	PMPM Rate Range*	Practice with caseload of 250patients:
Tier 1 “Entry Level”	<p>13 requirements, including:</p> <ul style="list-style-type: none"> • Coordinated primary care and patient education • 24/7 telephone coverage by medical professional • Maintaining a system to track tests and referrals • Acceptance of electronic communication from OHCA 	\$3.46 to \$4.85	\$14,550 per year
Tier 2 “Advanced”	<p>20 requirements, including all Tier 1 plus:</p> <ul style="list-style-type: none"> • Full-time practice w/enhanced access/after-hours • Inpatient tracking & hospital follow-up • Any 3 of 6 optional enhanced services - practice healthcare team, after visit follow-up, adoption of evidence-based practice guidelines, medication reconciliation, MH screening 	\$4.50 to \$6.32	\$18,960 per year
Tier 3 “Optimal”	<p>23 requirements, including all T1/T2 plus:</p> <ul style="list-style-type: none"> • Using health assessments tools to characterize patient needs and risks <p>Also recommended:</p> <ul style="list-style-type: none"> • Communicating with patients/families through secure, interactive website • Utilizing integrated care plans for patients co-managed with specialists • Regularly measuring performance for quality improvement 	\$5.99 to \$8.41	\$25,230 per year

⁵⁰ The OHCA pays separate rates for providers based on whether they treat adults only, children only or both children and adults . Rates are for SFY 2013. Average practice fee calculation performed using top of rate range for each tier.

The majority of practices have contracted to be tier 1 providers. However, since 2009, tier 3 providers have increased from under five percent to 20 percent of the total (Exhibit 3-2). Over the period January 2009 through December 2014, the absolute number of participating practices also has increased by 29 percent, from 699 to 901.

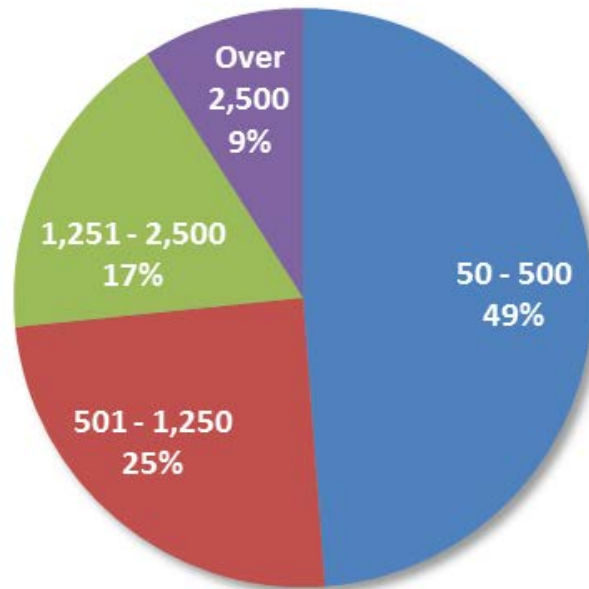
Exhibit 3 – 2 – Patient Centered Medical Home – Participating Practices by Tier⁵¹



PCMH provider panel sizes vary widely. However, the largest portion has SoonerCare Choice panel sizes of 500 or fewer members (Exhibit 3-3 on the following page).

⁵¹ Sources: OHCA PCMH roster data; Patient-Centered Medical Home – Survey of SoonerCare-Contracted PCPs. Practices can include multiple providers.

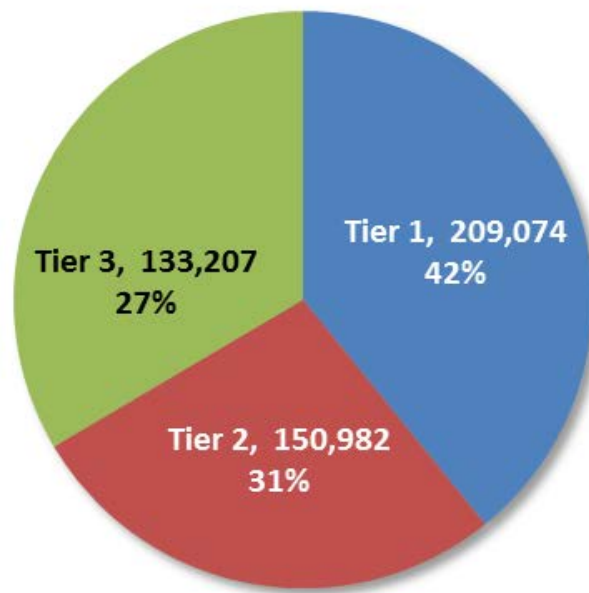
Exhibit 3-3 – SoonerCare Choice PCMH Panel Sizes – December 2014⁵²



Although tiers 2 and 3 make-up less than one-half of PCMH practices, they have larger average caseloads than the tier 1 practices. As a result, 58 percent of SoonerCare Choice members were enrolled in a tier 2 or 3 practice in December 2014 (Exhibit 3-4 on the following page).

⁵² Source: OHCA December 2014 Provider Tiers and Panel Capacity Report

Exhibit 3-4 – SoonerCare Choice Member Enrollment by Tier – May 2014⁵³



PCMH Performance - Aggregate

The PCMH model has contributed to a number of the favorable trends documented in chapter one. These trends, which are influenced by the behavior of primary care providers, include:

- Member satisfaction with quality of care – up significantly for all measures since 2009
- HEDIS measures of access to preventive/ambulatory care services – up for all age groups since 2008 and above the national benchmarks
- Emergency room visit rates – down 13 percent from 2008 to 2014
- Ambulatory care sensitive hospitalization rates – down from 2009 levels for all four conditions evaluated
- Hospital readmission rates – stable at a relatively low level since 2009
- Average PMPM expenditures – 1.9 percent annual growth from 2010 – 2013 versus 3.1 percent for Medicaid nationally

⁵³ Source: Ibid.

PCMH Performance - Tiers

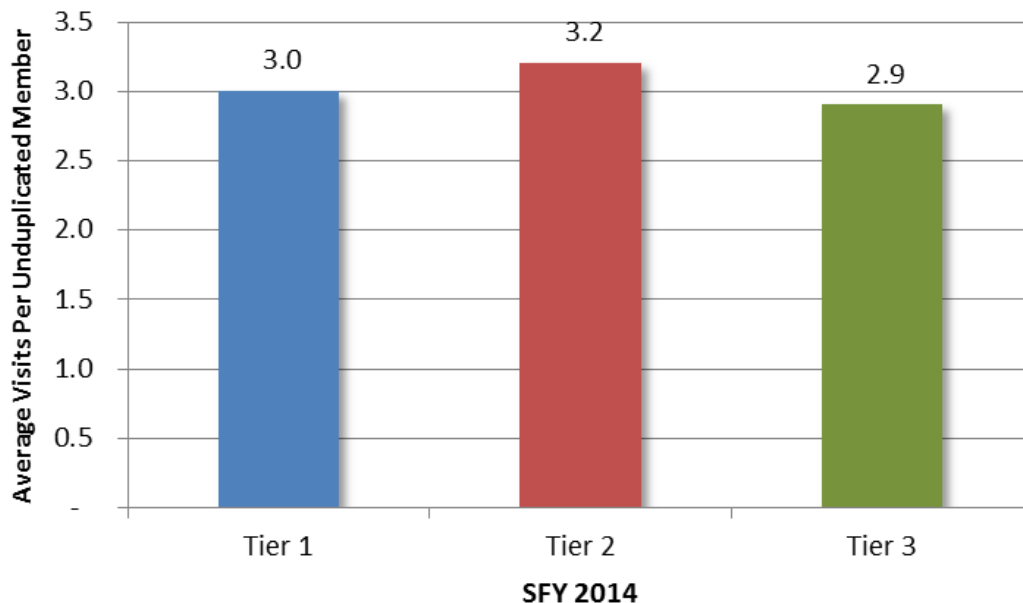
The aggregate success of the PCMH model is critical but leaves unanswered the question of whether the higher payments and standards for Tier 2 and Tier 3 providers has yielded benefits when compared Tier 1 providers. To evaluate PCMH performance by tier, PHPG used SFY 2014 paid claims data to compare the three tiers with respect to six outcome measures that the PCMH can at least partially influence⁵⁴:

- PCMH visit rate
- Emergency room utilization rate
- Follow-up visit rate to the PCMH after an ER encounter
- Ambulatory care sensitive hospitalization rate
- Hospital readmission rate
- Visit rate to PCMH post-discharge

PCMH Visit Rate

SoonerCare Choice members in 2014 averaged about three visits per year to their PCMH provider, which is in line with program expectations. The visit rate was highest among members aligned with tier 2 providers (Exhibit 3-5).

Exhibit 3 – 5 – PCMH Visit Rates – SFY 2014 (per member per year)

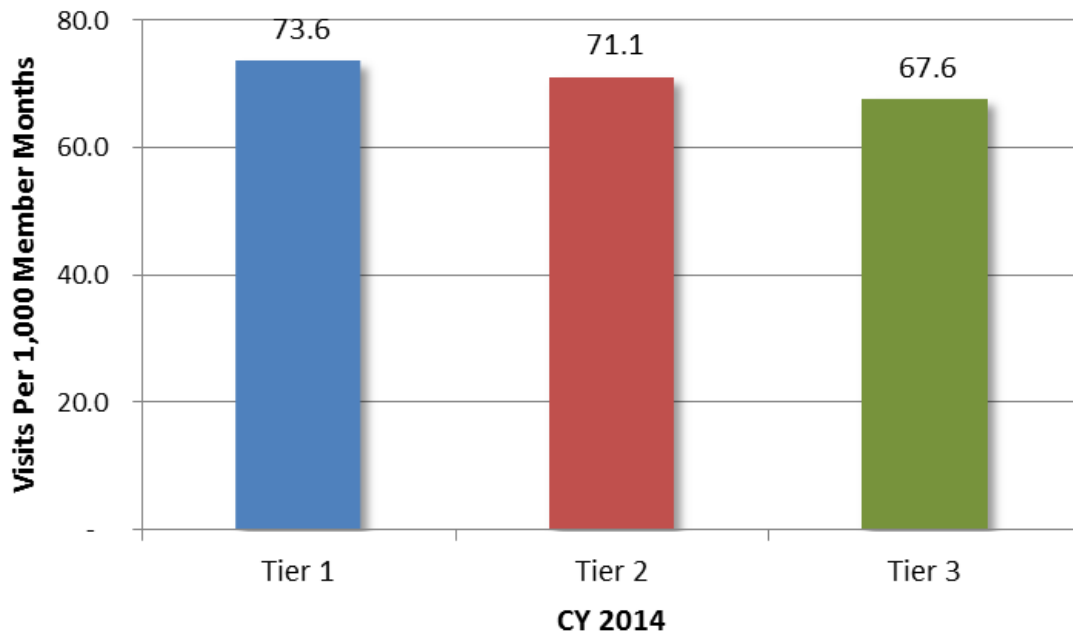


⁵⁴ Data is for PCMH providers not affiliated with a Health Access Network. Findings for HAN-affiliated providers are presented in the next section. Non-HAN providers are responsible for approximately 80 percent of SoonerCare Choice membership.

Emergency Room Utilization Rate

As discussed in chapter two, emergency room utilization declined significantly after introduction of the PCMH model in 2009 and has since remained relatively steady. Members aligned with tier 3 providers used the ER at the lowest rate in SFY 2014 (Exhibit 3-6).

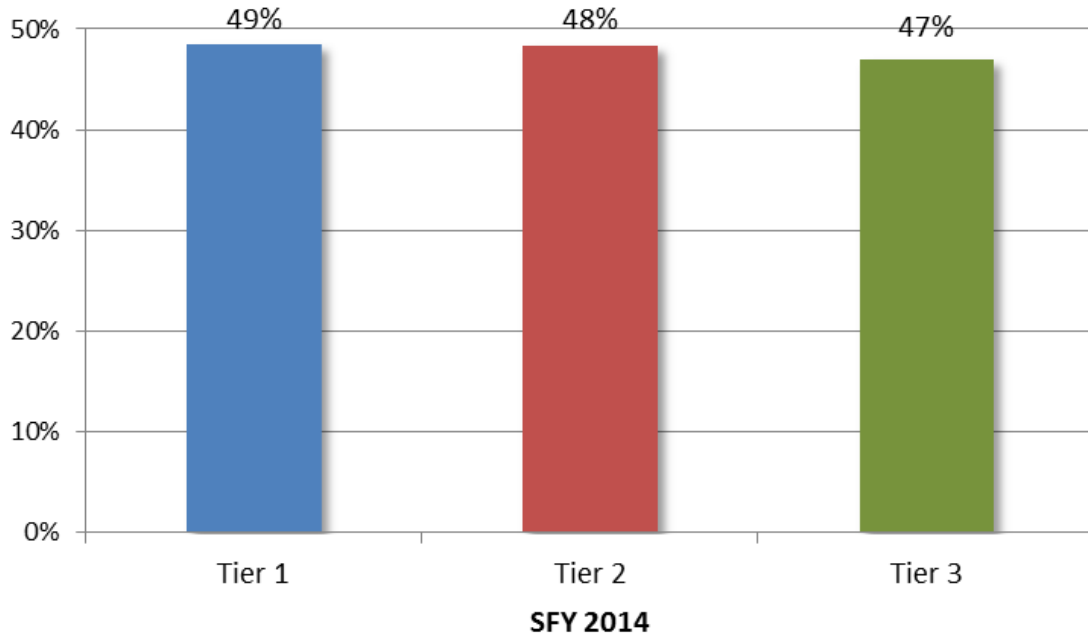
Exhibit 3 – 6 – Emergency Room Utilization Rates – SFY 2014 (per 1,000 member months)



Follow-up Visit Rate to PCMH within 30 Days of ER Encounter

It is the OHCA’s expectation that PCMH providers contact members who have been to the emergency room and schedule follow-up appointments for these members when appropriate. Nearly 50 percent of SoonerCare Choice members with an emergency room encounter did see their PCMH provider within 30 days of the episode; the rate was nearly identical across tiers (Exhibit 3-7).

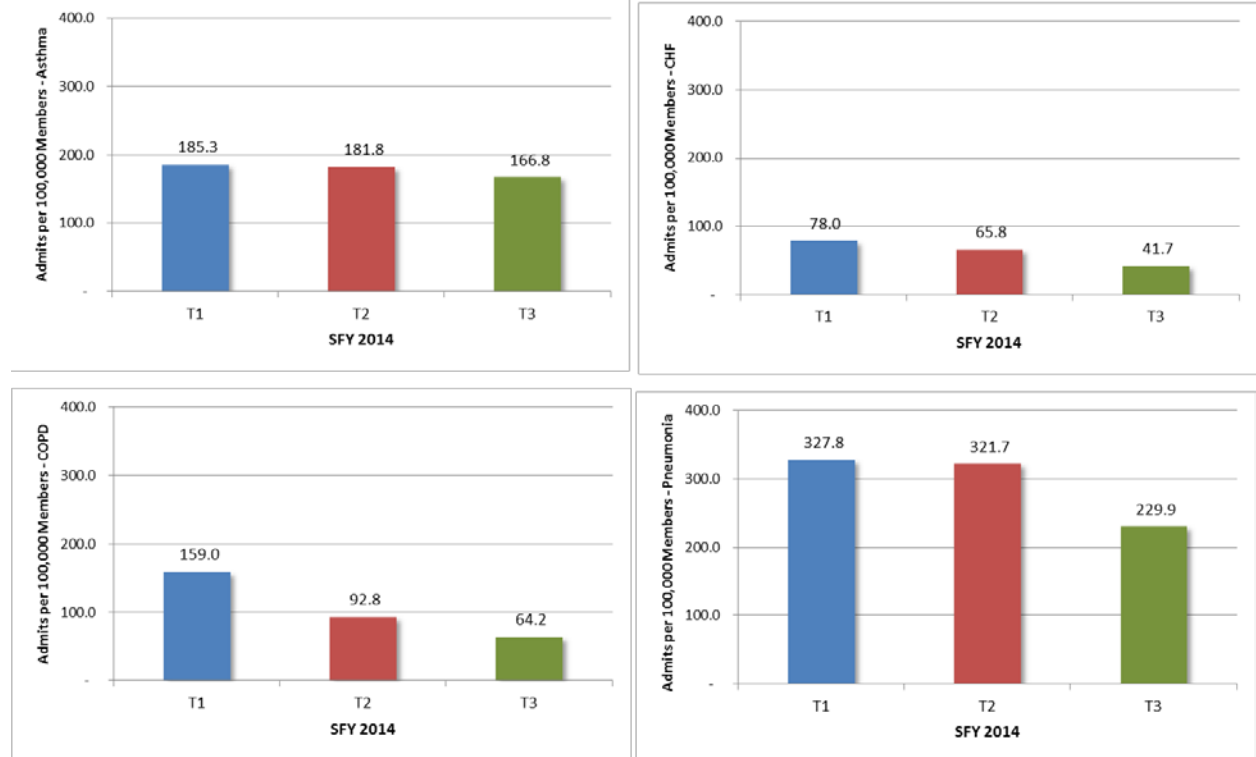
Exhibit 3 – 7 – Follow-up Visit Rate to PCMH within 30 Days of ER Encounter- SFY 2014



Avoidable (Ambulatory Care Sensitive) Hospitalization Rate

As discussed in chapter two, the hospitalization rate for four key diagnoses (asthma, CHF, COPD and pneumonia) fell significantly from 2009 to 2014. The relative rates in SFY 2014 varied by diagnosis, but members aligned with tier 3 providers consistently registered the lowest admission rate, a shift from SFY 2013, when there was no discernable pattern across the tiers (Exhibit 3-8).

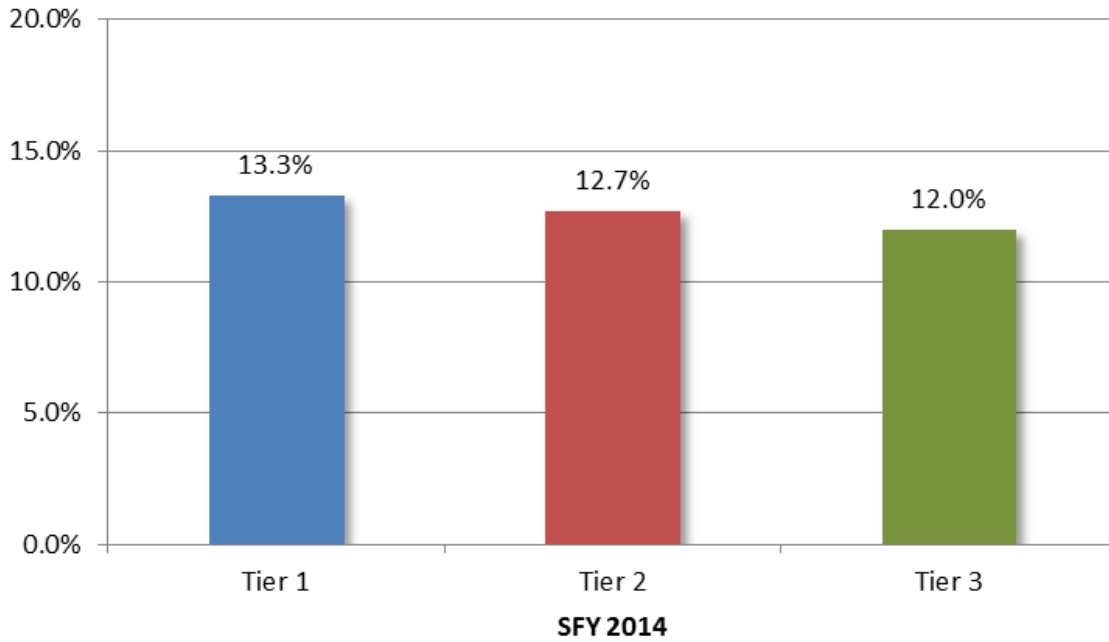
Exhibit 3 – 8 – Ambulatory Care Sensitive Hospitalization Rates – SFY 2014 (per 100,000 members)



Hospital Readmission Rate within 30 Days of Discharge

As discussed in chapter two, the 30 day readmission rate has been stable at a low level since 2009. The rate in SFY 2014 was lowest for members aligned with a tier 3 provider; in SFY 2013 the three tiers were more closely grouped (Exhibit 3-9).

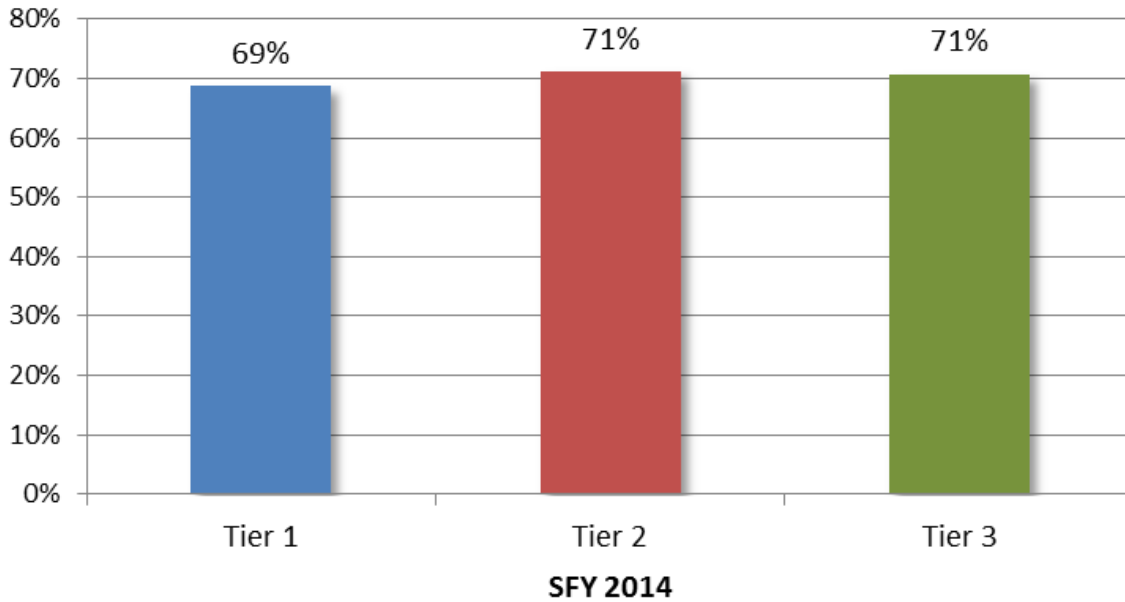
Exhibit 3 – 9 – Hospital 30-Day Readmission Rate – SFY 2014



Post-Discharge 30-Day Visit Rate to a PCMH

The SFY 2014 post-discharge visit rate was nearly identical across tiers in SFY 2014, consistent with results for SFY 2013 (Exhibit 3-10).

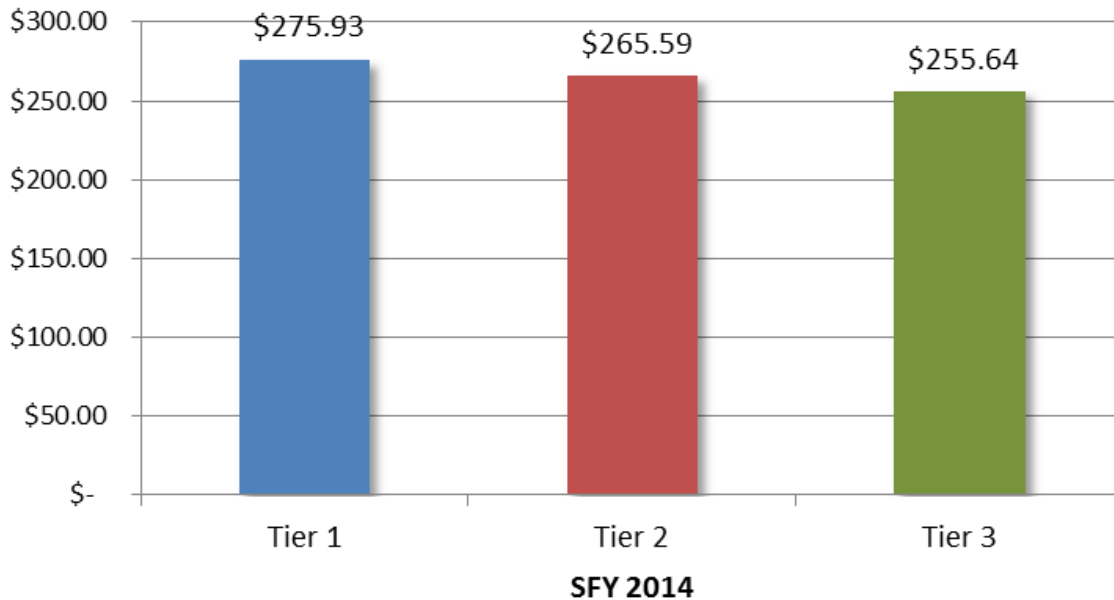
Exhibit 3 – 10 – Post-Discharge 30-Day PCMH Visit Rate – SFY 2014



PMPM Expenditures

As discussed in chapter two, per member per month expenditures grew modestly from 2009 to 2014. Average PMPM expenditures in SFY 2014 were lowest among members aligned with tier 3 providers, a change from SFY 2013 when PMPM costs were very similar across the three tiers (Exhibit 3-11). (PMPM expenditures do not include case management fees.)

Exhibit 3 – 11 – PMPM Expenditures by Provider Tier – SFY 2014



PCMH Impact (Return-on-Investment)

The PCMH model appears to be contributing to positive trend lines for the SoonerCare Choice program as a whole. At the aggregate level (across tiers), the program demonstrated consistent improvement in outcomes from 2009 to 2014. It also appears that in SFY 2014 members aligned with tier 3 providers began to exhibit better outcomes on some measures than members aligned with tier 1 and tier 2 providers.

The lack of differentiation across tiers prior to SFY 2014 could partially be a timing issue. Many tier 2 and 3 practices achieved their status in the last three years, leaving little time prior to SFY 2014 to register a significant impact. Regardless, it is an encouraging development and will take on greater significance if the trend continues in SFY 2015 and beyond.

Health Access Networks

Overview

The SoonerCare Choice health access networks were launched in 2010. As discussed in chapter one, the HAN model expands on the PCMH by creating community-based, integrated networks intended to increase access to health care services, enhance quality and coordination of care and reduce costs.

There are three HAN contractors:

- Partnership for Healthy Central Communities (based in Canadian County)
- Oklahoma State University (OSU) Center for Health Sciences
- Oklahoma University (OU) Sooner Health Access Network

The HANs receive up to an additional \$5.00 PMPM in return for their care management duties, which focus on high risk SoonerCare Choice members enrolled with HAN-affiliated PCMH providers. The OHCA's Population Care Management Department provides monthly rosters to the HANs that identify high risk members aligned with HAN PCMH providers. The rosters include:

- Breast and cervical cancer patients
- High risk pregnancies (based on qualifying diagnosis, as determined by member's OB)
- Persons with hemophilia
- High utilizers of the emergency room 2 + visits in a quarter

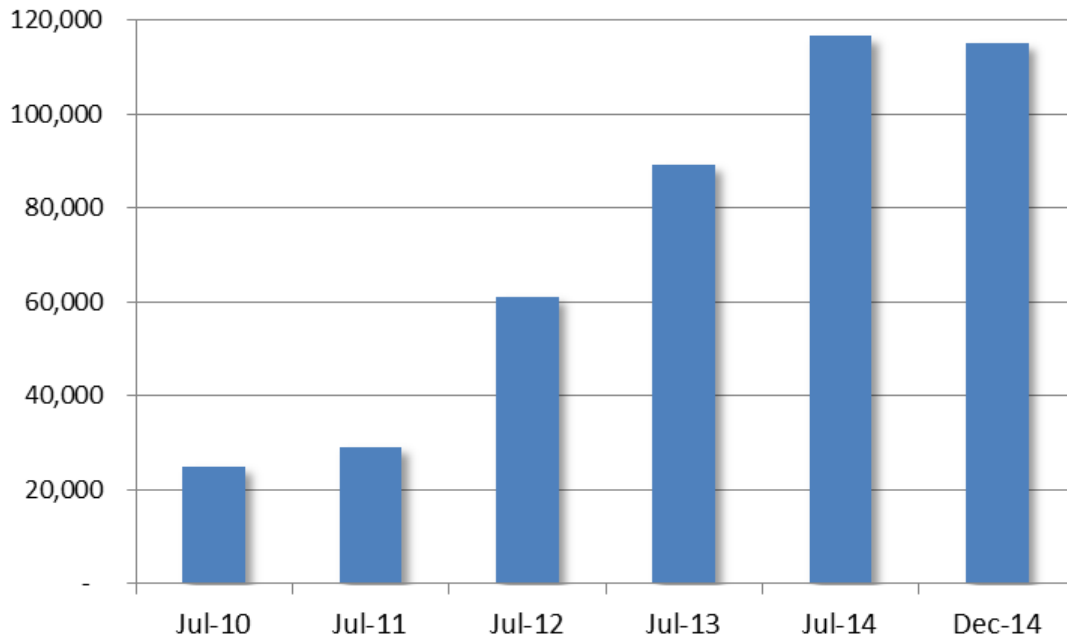
The HANs are required to reach out to high risk members and provide appropriate education and care management. The HANs also are encouraged to offer practice enhancement to their affiliated PCMH providers, including assistance in demonstrating compliance with tier 3 requirements among providers meeting the standards.

The HANs file annual reports and budgets with the OHCA. The reports document the number of members enrolled in care management and the HAN's use of care management dollars.

HAN Membership and Structure

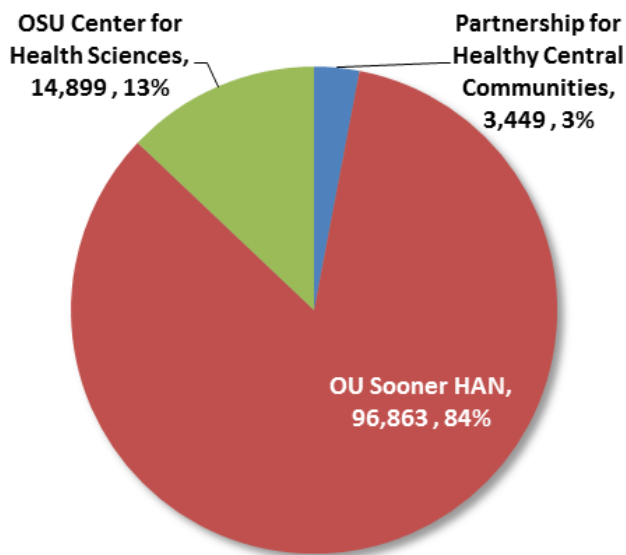
HAN membership grew dramatically during the initiative's first years, from only 25,000 in July 2010 to nearly 117,000 in July 2014 before leveling off for the remainder of the calendar year (Exhibit 3-12 on the following page).

Exhibit 3 – 12 – HAN Membership Growth⁵⁵



Membership is not evenly distributed across the three HANs. In December 2014, OU Sooner HAN accounted for approximately 84 percent of enrollment, OSU for 13 percent and Central Communities for the remaining three percent (Exhibit 3-13).

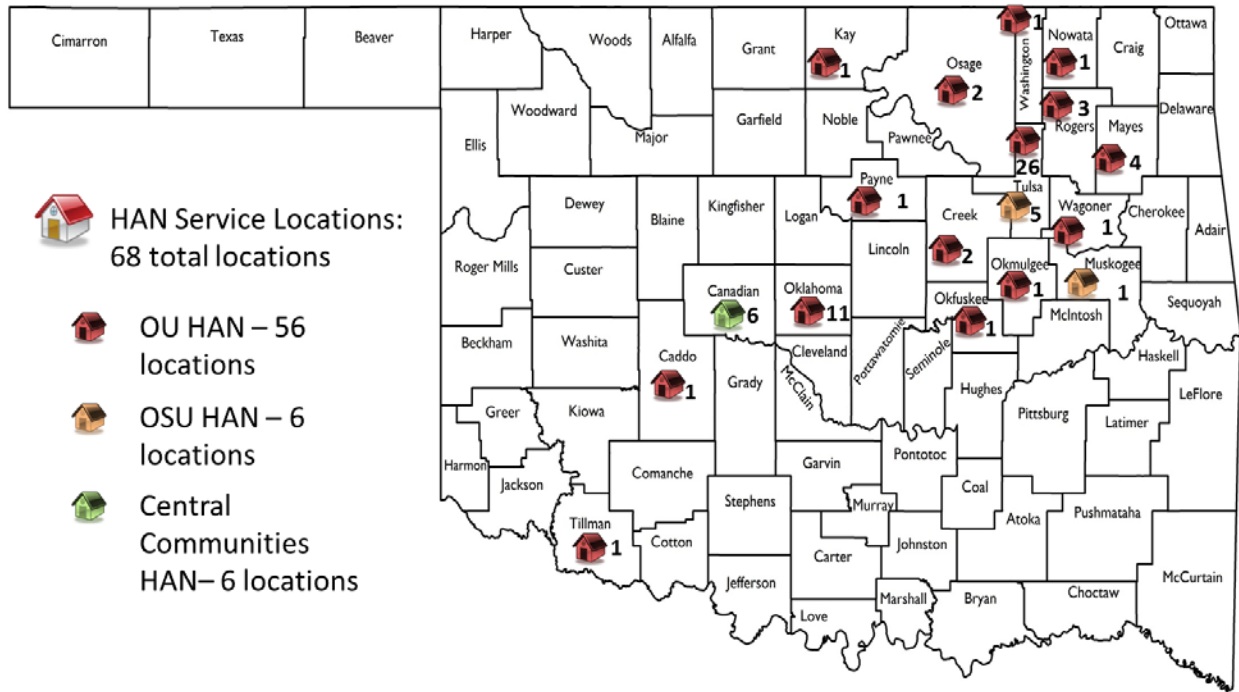
Exhibit 3 – 13 – Membership by HAN – December 2014



⁵⁵ Sources: OHCA HAN Total Summary Report

The growth in membership has occurred as the HANs have expanded their affiliated PCMH networks. There are approximately 600 HAN-affiliated PCMH providers located at 74 practice sites throughout the State (Exhibit 3-14).

Exhibit 3 – 14 – HAN Practice Locations – December 2014⁵⁶



The three HANs have adopted differing approaches to advancing the principles espoused by the OHCA for the initiative. Their care management structures reflect their relative sizes.

Central Communities’ staffing in 2014 included a full-time RN director, two part-time RN case managers and IT support⁵⁷. As the smallest HAN, it has maintained a local focus consistent with founding organization’s (El Reno Clinic) service to the community.

The HAN offers referral assistance to participating solo/small group practices in Canadian County through a central database. It also provides hands-on assistance to practices in documenting compliance with higher PCMH tiers and person-centered care management through a small staff (made feasible due to the organization’s small enrollment). The HAN potentially could serve as a role model for other rural communities interested in establishing a network within a single county or small group of counties.

⁵⁶ Source: OHCA

⁵⁷ Source for staffing at the three HANs is SFY 2014 budget for each organization

At the other end of the spectrum, OU Sooner HAN's staffing in 2014 included 40 FTEs, 20 of which were devoted to care management/coordination and another 17 to associated clinical/quality-related activities. OU Sooner HAN has created a broad network encompassing OU clinics and affiliated providers. The HAN has also established a formal care management structure with member assessment, education and care coordination processes.

OU Sooner HAN has combined care management with focused initiatives to improve primary care effectiveness, reduce ER use and raise provider productivity. For example, in 2013 it launched an "Open Access" initiative to facilitate same day appointments at primary care clinics as a means of reducing member use of the ER for non-emergent problems.

OU Sooner HAN also has placed a significant emphasis on technology to support care initiatives, including through the Doc2Doc referral system and MyHealth electronic records/assessment platform. The information captured through these systems is used to support the organization's measurement of outcomes and incorporation of findings into quality improvement activities.

OSU Health Sciences Center has charted a middle course between the other two HAN's with respect to enrollment. In terms of staffing it closely resembles in Central Communities; in 2014, its staff included a HAN administrator/case manager, second case manager and medical informatics analyst.

HAN Performance – General

The rapid membership growth across the three HANs since 2010 is a positive trend, as it reflects expanding participation by PCMH providers in the networks. However, it made evaluation of HAN performance prior to SFY 2014 challenging because of the continual influx of new members.

For SFY 2014, with enrollment largely stabilized, PHPG evaluated HAN member demographics and compared HAN performance on key utilization and expenditure measures to members not aligned with a HAN. PHPG also evaluated performance at the individual HAN level.

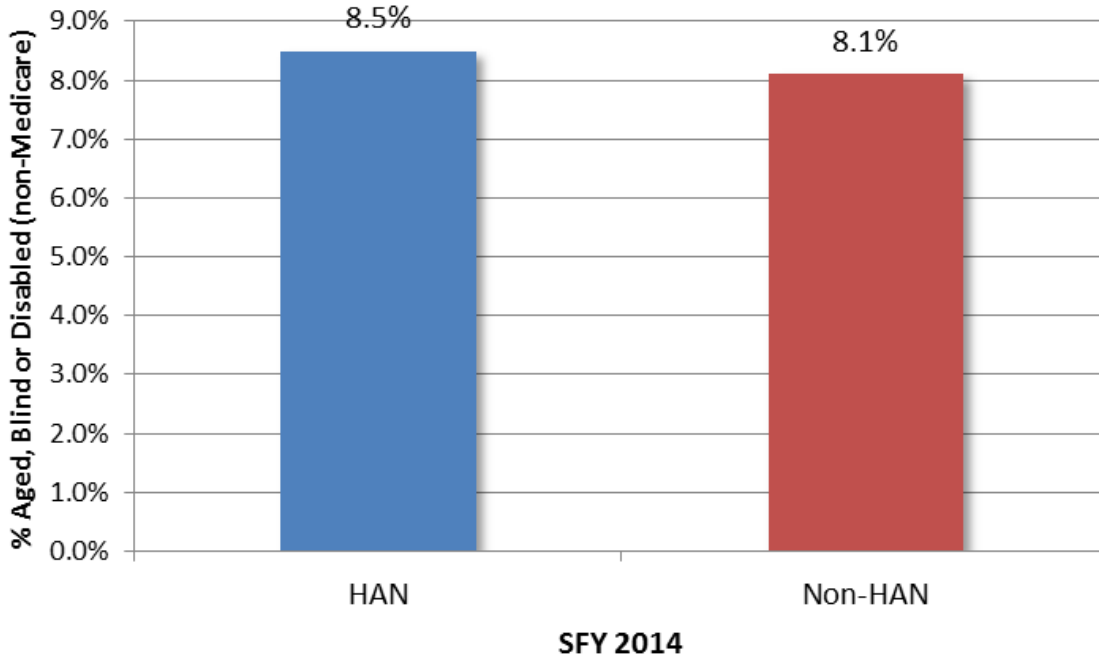
In addition to analyzing total HAN membership, PHPG in SFY 2013 evaluated HAN performance with respect to the two priority care managed populations with largest enrollment: frequent utilizers of the ER and high risk pregnancies. The results of this analysis, which also was included in last year's report, are presented last.

Enrollment by Eligibility Group

SoonerCare Choice includes non-Medicare aged, blind and disabled (ABD) members, as well as Temporary Aid to Needy Families (TANF) and related groups consisting of pregnant women, parents and non-disabled children. ABD members on average have much greater health care needs than their TANF counterparts and are significantly more expensive.

The HAN membership includes a slightly higher number of ABD members, as a percentage of total enrollment (panels), than the non-HAN membership (Exhibit 3-15). The gap was twice as great in SFY 2013 but has narrowed along with HAN enrollment growth. This may reflect a change in the composition of affiliated providers, as the two larger HANs expanded beyond their academic medical center clinics to include smaller private practices.

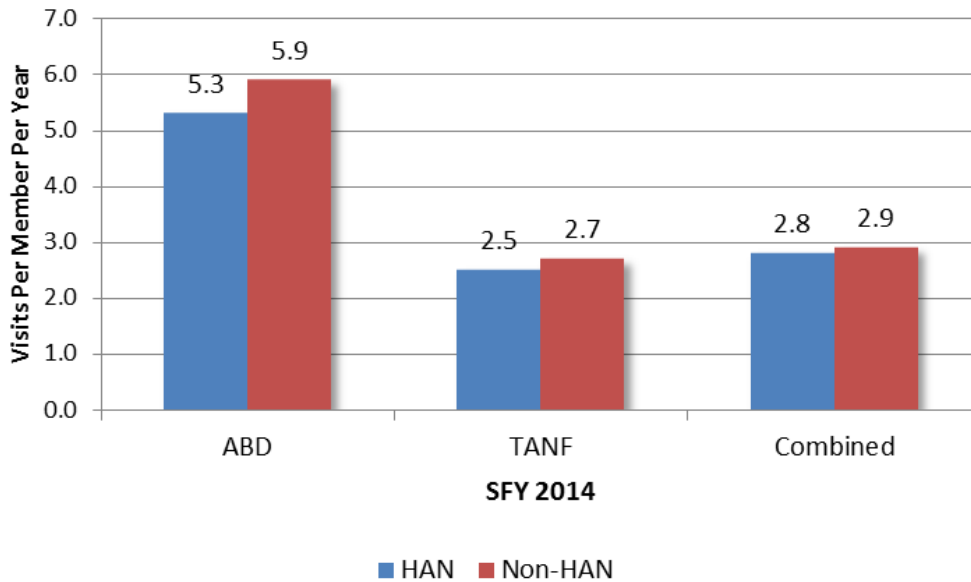
Exhibit 3 – 15 – HAN and non-HAN ABD Enrollment – SFY 2014



Primary Care Visits

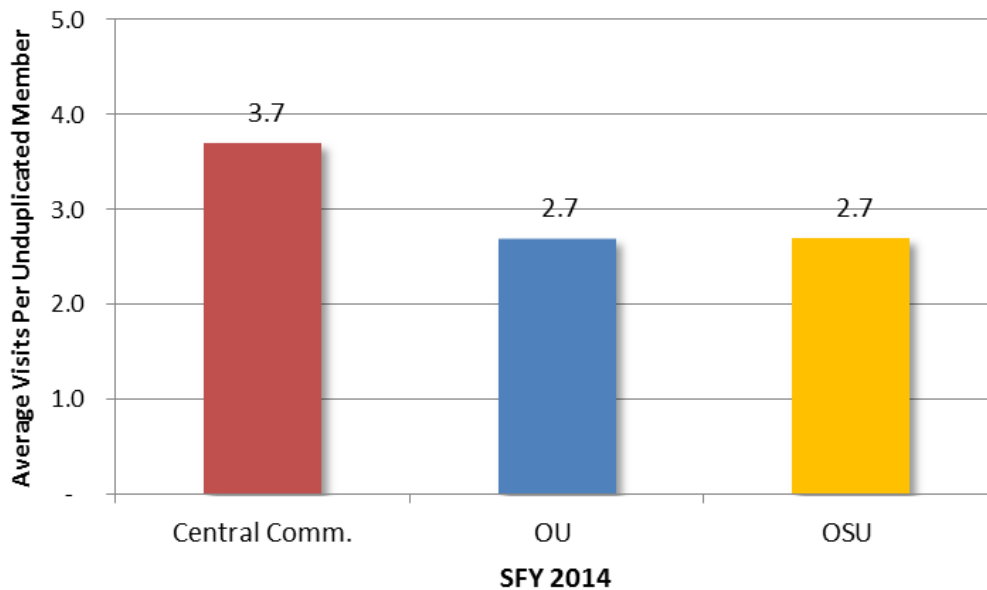
SoonerCare Choice HAN and non-HAN members visited their PCMH providers at similar rates. ABD members saw their PCMH at about double the rate of non-ABD members (Exhibit 3-16).

Exhibit 3 – 16 – HAN and non-HAN PCMH Visits – SFY 2014



Central Communities HAN members registered a higher visit rate than their counterparts at the other HANs (Exhibit 3-17).

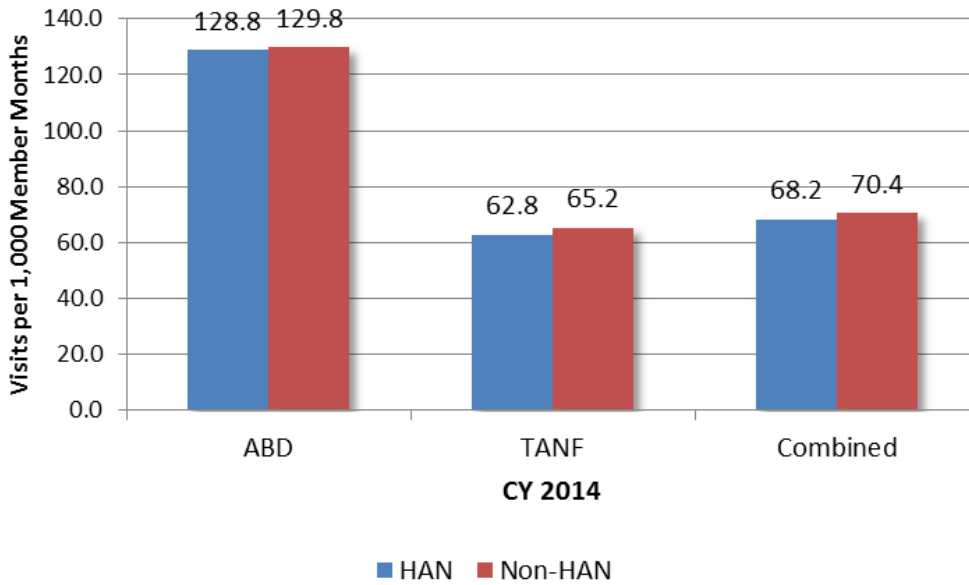
Exhibit 3 – 17 – PCMH Visits by HAN – SFY 2014



Emergency Room Visits

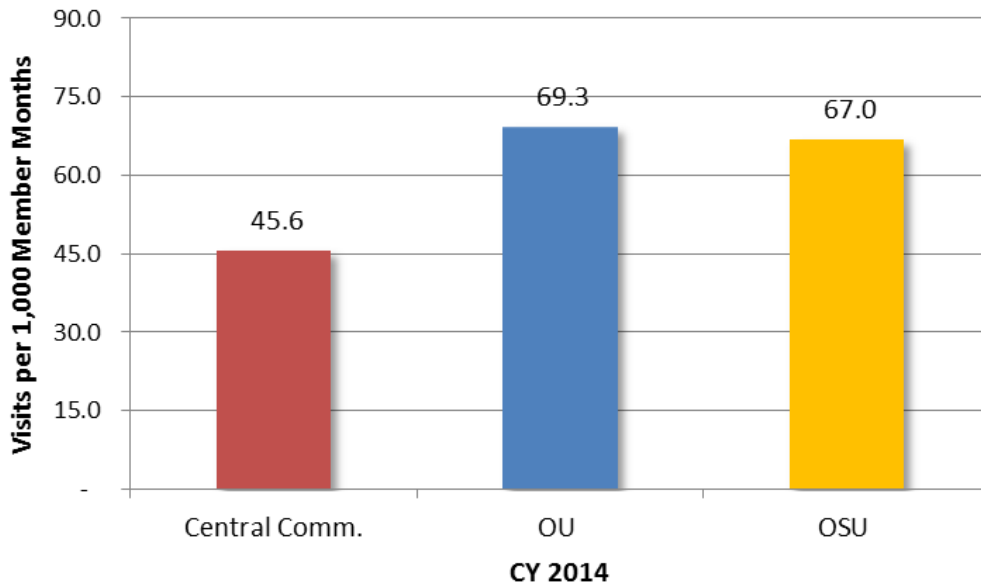
SoonerCare Choice HAN members visited the emergency room at a slightly lower rate than non-HAN (Exhibit 3-18).

Exhibit 3 – 18 – HAN and non-HAN ER Visits – CY 2014



Central Communities HAN members used the ER at a significantly lower rate than their counterparts at the other HANs (Exhibit 3-19).

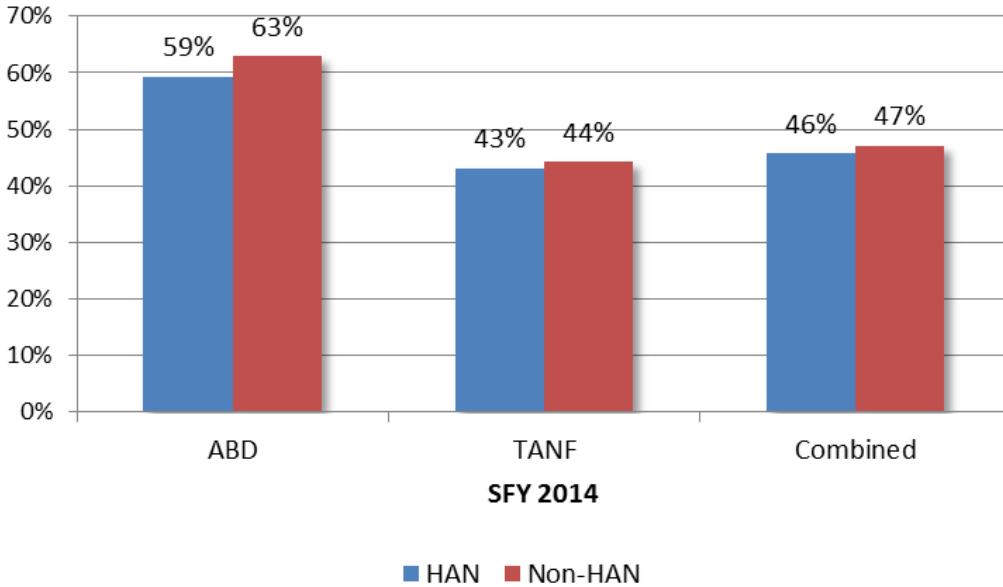
Exhibit 3 – 19 – ER Visits by HAN – SFY 2014



Post-ER Visit to PCMH

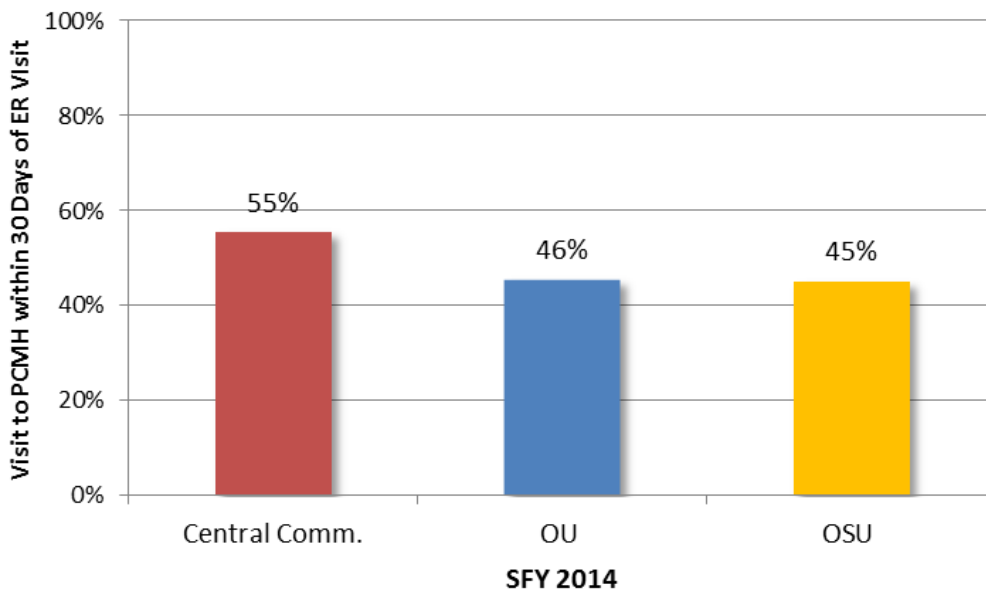
HAN and non-HAN members were about equally likely to see their PCMH provider after a visit to the ER (Exhibit 3-20).

Exhibit 3 – 20 – HAN and non-HAN Post ER Visit to PCMH (Within 30 Days) – SFY 2014



Central Communities HAN members were more likely to visit their PCMH provider than their counterparts at the other HANs (Exhibit 3-21).

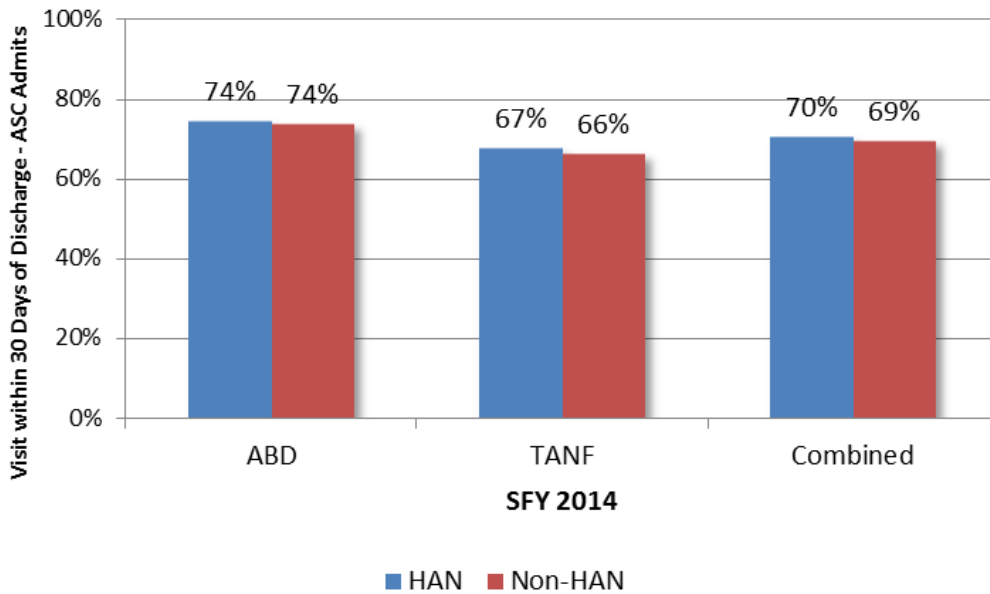
Exhibit 3 – 21 – Post ER Visit to PCMH by HAN (Within 30 Days) – SFY 2014



Post-Discharge Visit to PCMH (Ambulatory Care Sensitive Admissions)

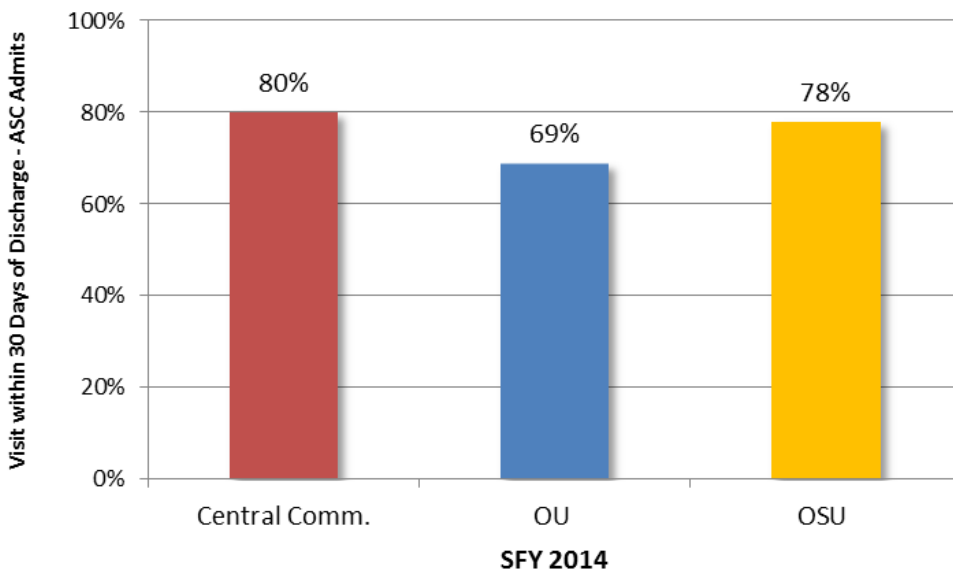
HAN and non-HAN members also were about equally likely to see their PCMH provider after being discharged from the hospital for an ambulatory care sensitive admission (Exhibit 3-22).

Exhibit 3 – 22 – HAN and non-HAN Post Discharge Visit to PCMH (Within 30 Days) – SFY 2014



Central Communities and OSU HAN members were more likely to visit their PCMH provider post-discharge than OU HAN members (Exhibit 3-23).

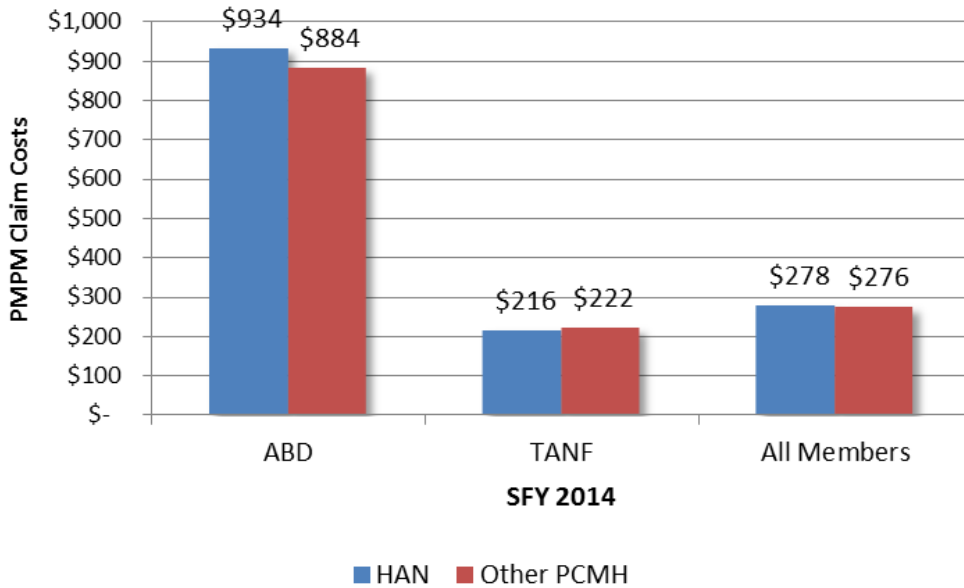
Exhibit 3 – 23 – Post Discharge Visit to PCMH by HAN (Within 30 Days) – SFY 2014



PMPM Expenditures (Claim Costs)

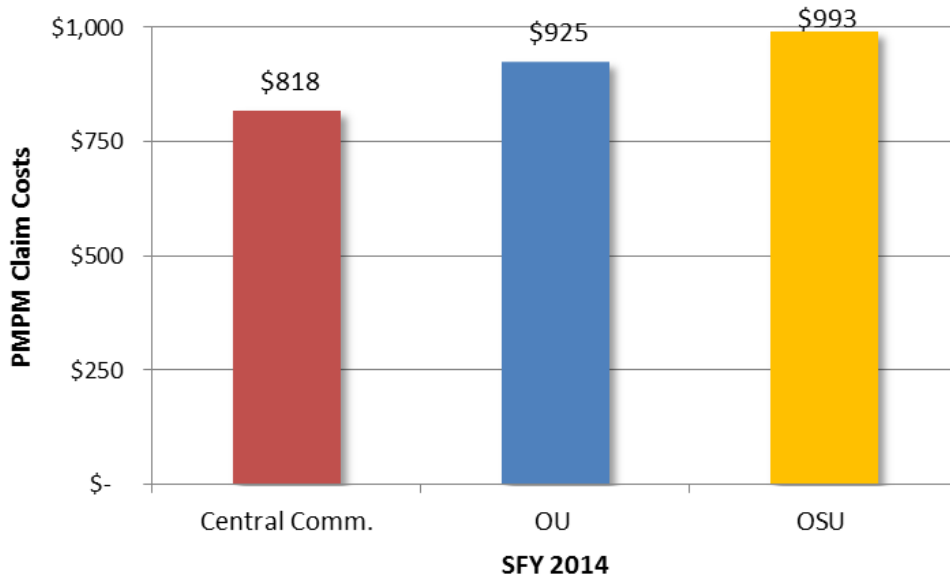
HAN ABD members had moderately higher PMPM claim costs than did non-HAN members, while HAN TANF member costs were slightly lower. Across all members, PMPM claim costs were nearly the same (Exhibit 3-24).

Exhibit 3 – 24 – HAN and non-HAN PMPM Claim Costs – SFY 2014



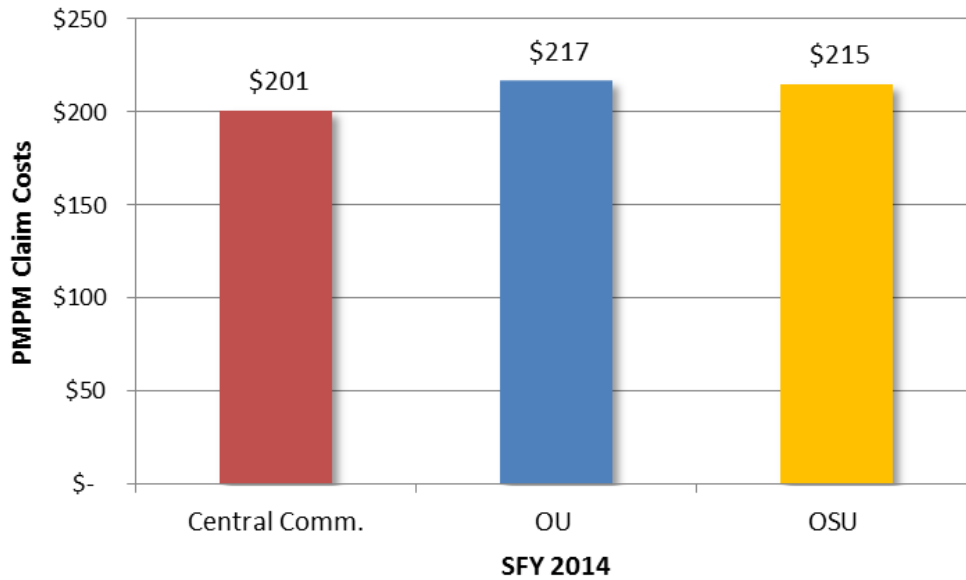
Central Communities ABD members registered significantly lower claim costs than their counterparts at the other HANs, particularly as compared to OSU members (Exhibit 3-25).

Exhibit 3 – 25 – ABD PMPM Claim Costs by HAN – SFY 2014



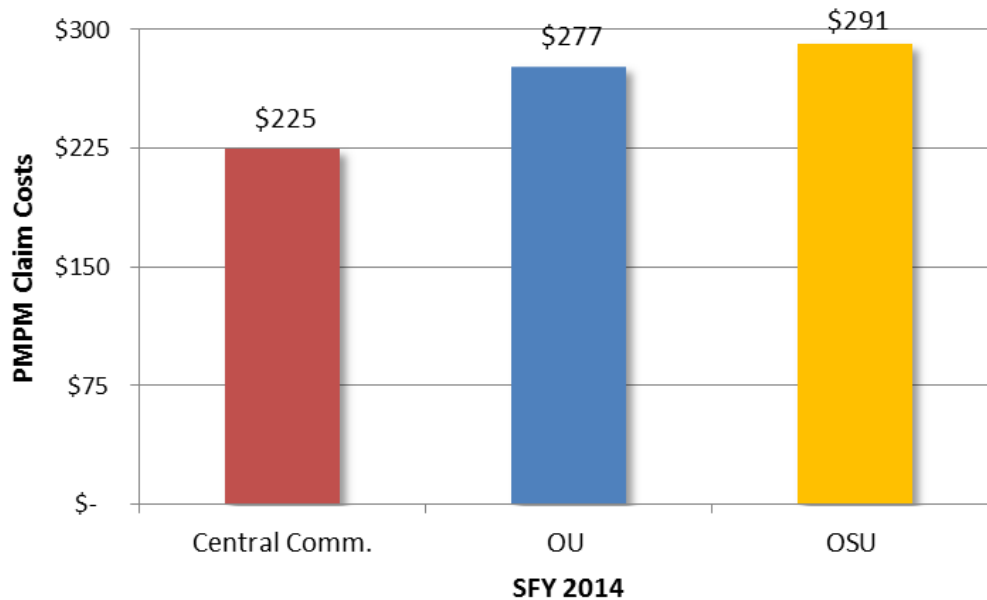
Central Communities TANF members also registered significantly lower claim costs than their counterparts at the other HANs (Exhibit 3-26).

Exhibit 3 – 26 – TANF PMPM Claim Costs by HAN – SFY 2014



Central Communities members in aggregate incurred the lowest costs of the three HANs and also were lower in cost than members aligned with non-HAN PCMH providers (Exhibit 3-27).

Exhibit 3 – 27 – Overall PMPM Claim Costs by HAN – SFY 2014



Performance – High Risk Populations

The HANs provide care management to four high risk populations, two of which – breast/cervical cancer patients and persons with hemophilia – are very small in number (Exhibit 3-28). PHPG examined service utilization and outcomes for the two larger populations – frequent users of the emergency room and high risk pregnancies – to establish baselines for future evaluation of performance.

Exhibit 3 – 28 – HAN High Risk Population Enrollment – Snapshot for November 2013⁵⁸

High Risk Group	Central Comm.	OU Sooner	OSU	TOTAL
Breast/cervical cancer	1	59	5	65
Hemophilia	0	7	2	9
ER – 2 or more visits in second quarter of 2013	81	2,877	533	3,491
High risk pregnancy	0	143	18	161
TOTAL	82	3,086	558	3,726

Frequent Users of the Emergency Room

The HANs are responsible for intervening with members identified as frequent users of the emergency room. This includes members with two or more ER visits in the previous quarter. The intervention takes the form of:

- Follow-up by letter or phone (depending on number of visits);
- Ongoing outreach and education regarding appropriate care settings in non-emergencies (Exhibit 3-29 on the following page); and
- Requiring the member to use a designated PCMH provider, as a means of fostering a relationship and encouraging the member to seek non-emergent care outside of the ER.

⁵⁸ Active (open) cases only. ER group includes a subset of 452 very high utilizing members with 4 or more visits in the quarter.

Exhibit 3 – 29 – Central Communities ER Educational Materials⁵⁹



To evaluate the impact of the HANs' activities, PHPG examined ER usage among high ER utilizers enrolled by the HANs into care management. The analysis included 218 individuals who were HAN members for at least twelve months prior to selection for care management/lock-in and at least twelve months after lock-in.

The results of the before/after comparison were encouraging. Although average ER utilization remained high, it dropped by approximately 20 percent (Exhibit 3-30 on the following page). The portion of members with six or more ER visits fell by more than half, while over 40 percent of the members in the lock-in period had no trips to the ER.

The only metric that did not show improvement was the percentage of members seeing their PCMH within 30 days of an ER visit. However, both the rate – both before and after lock-in – was well above the rate for the general population.

⁵⁹ Provided by Central Communities HAN. The HAN produces updated literature each year based on the most common non-emergent conditions treated at the emergency room in the prior year.

Exhibit 3 – 30 – HAN ER Care Management Impact

Metric	12 months prior to lock-in/ care management	12 months after start of lock-in/ care management
Average number of ER visits per member	10.8	8.8
Members with 6 or more visits	51.4%	22.0%
Members with zero ER visits (post-lock in)	--	40.8%
Members seeing PCMH within 30 days of ER visit	59.1%	56.5%

High Risk Pregnancies

The HANs are responsible for offering care management to pregnant members identified by their prenatal care providers as being at high risk for complications⁶⁰, including premature and low birth weight deliveries. HAN activities include:

- Assisting expectant mothers to obtain appropriate prenatal services and prepare for the birth of the child; and
- Linking newborns to a pediatrician to ensure appropriate infant care.

The HANs often face a significant challenge in reaching high risk pregnant members because many have a relationship with a prenatal care provider rather than their PCMH. In some instances, the HANs are unaware of the existence of the member until notified by the OHCA through the monthly care management rosters.

The number of high risk pregnant members enrolled with the HANs has grown quickly, along with the HANs’ total enrollment. PHPG examined paid claims data and identified five such members in SFY 2011, 85 in SFY 2012 and 261 in SFY 2013⁶¹.

Approximately 50 percent of the high risk pregnancies ended in a premature delivery. PHPG evaluated utilization and outcomes data separately for the premature and full-term deliveries (Exhibits 3-31 and 3-32 on the following page). Information is provided by year but given the small number of cases in SFY 2011 and SFY 2012, the aggregate data should be considered more reliable.

⁶⁰ The member must have a qualifying diagnosis associated with pregnancy risk, such as pre-eclampsia, sickle cell anemia, multiple birth (twins, triplets etc.) or history of preterm labor.

⁶¹ Limited to members who completed their pregnancies and for whom birth outcome data was available.

Exhibit 3 – 31 – HAN High Risk Pregnancy Outcomes – Premature Deliveries

Measure (Premature)	SFY 2011	SFY 2012	SFY 2013	Three-Year Total
Total cases	5	85	261	351
# premature births	3	46	127	176
% premature births	60.0%	54.1%	48.7%	50.1%
% of premature births w/NICU stay	66.7%	30.4%	43.3%	40.3%
% readmission w/in 30 days of IP stay - premature	66.7%	28.3%	20.5%	23.3%
Average # of ER visits – premature birth	5.3	2.2	2.2	2.3
Average cost per case – premature birth	\$25,447	\$20,509	\$22,850	\$22,282

Exhibit 3 – 32 – HAN High Risk Pregnancy Outcomes – Full-Term Deliveries

Measure (Full-Term)	SFY 2011	SFY 2012	SFY 2013	Three-Year Total
Total cases	5	85	261	351
# full-term births	2	39	134	175
% full-term births	40.0%	45.9%	52.3%	49.9%
% of full-term births w/NICU stay	--	--	1.5%	1.1%
% readmission w/in 30 days of IP stay – full-term	--	15.4%	14.2%	14.3%
Average # of ER visits – full-term birth	2.0	1.7	1.6	1.6
Average cost per case – full-term birth	\$13,396	\$12,758	\$11,977	\$12,167

Unsurprisingly, there is a significant utilization and cost difference between pregnancies that end prematurely and pregnancies carried to full term. PHPG recommends treating the SFY 2011 – SFY 2013 data as a baseline for tracking HAN performance with respect to reducing the incidence of premature births⁶².

⁶² In addition to the measures shown in the exhibit, PHPG attempted to calculate an average number of prenatal care visits per member. However, because the OHCA makes a global payment for prenatal care (as opposed to paying per visit), PHPG was unable to quantify prenatal visit activity through the claims data.

If the trend line is not positive, the OHCA should consider removing this population from the HANs and managing the members directly, as occurs now for non-HAN high risk pregnancies. Alternatively, the OHCA could maintain a separate roster of prenatal care providers affiliated with HAN clinics and use that as the basis for assignment to a HAN, rather than the PCMH designation.

HAN Impact – (Return-on-Investment)

The health access networks include PCMH providers with longstanding ties to the SoonerCare population, as well as linkages to key specialists in their service areas. This likely is the reason that the HANs serve a higher risk population (i.e., a higher concentration of ABD members) than the general PCMH provider community.

The HANs are obligated to perform more care management functions than the general PCMH population, while also offering support to their networks in meeting the requirements for the higher PCMH tiers. In return, they receive a nominal per member per month fee, which must be spent on activities directly related to the HAN mission.

Each HAN has provided care management and practice enhancement in the manner best suited for its size and service area. Central Communities HAN, the smallest of the three, has leveraged its deep ties to the community through hands-on assistance; OU Sooner HAN, the largest, has combined a formal care management structure with state-of-the-art technology to support its members. OSU has adopted a middle path, although it remains relatively light in terms of care management staff, with just one full time care manager.

The utilization and cost profile of the general HAN membership is comparable in most categories to the non-HAN population, but performance at the individual HAN level has not been uniform. Central Communities HAN has begun to demonstrate impressive outcomes, both in comparison to the other HANs and to the non-HAN PCMH community.

The experience of the SoonerCare Health Management Program (HMP), as discussed in the next section, suggests that it can take several years for the full impact of care management initiatives to emerge, in terms of reducing utilization and expenditures. The OU and OSU networks may begin to match Central Communities' performance in future years. However, it also may prove to be the case that the HAN model is most effective when implemented as a smaller scale, grass roots initiative.

SoonerCare Health Management Program

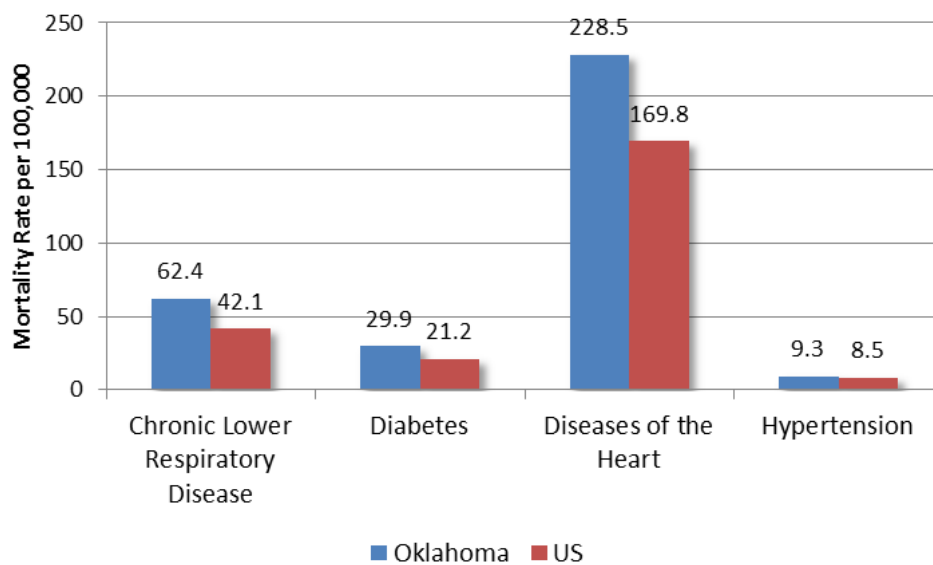
Overview

Chronic diseases are the leading causes of death and disability in the United States. According to the Centers for Disease Control and Prevention (CDC), in 2012 about half of all adults—117 million people—had one or more chronic health conditions such as diabetes or heart disease. One in four adults had two or more chronic health conditions.⁶³ Almost half of all adults struggle with a chronic health condition that affects performance of their daily activities.⁶⁴

The per capita impact of chronic disease is even greater in Oklahoma than for the nation as a whole. In 2013, 1,269 Oklahomans died due to complications from diabetes. This equated to a diabetes-related mortality rate of 29.9 persons per 100,000 residents, versus the national rate of 21.2⁶⁵.

The mortality rate for other chronic conditions, such as chronic lower respiratory disease (heart disease and hypertension), is similarly higher in Oklahoma than in the nation overall (Exhibit 3-33).

Exhibit 3-33 – Chronic Disease Mortality Rates, 2013 – OK and US (Selected Conditions)⁶⁶



⁶³ <http://www.cdc.gov/chronicdisease/overview/>

⁶⁴ Chronic Disease Overview from the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

⁶⁵ http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_02.pdf. Age adjusted rates.

⁶⁶ Ibid. Rate for chronic lower respiratory disease, also known as chronic obstructive pulmonary disease, includes asthma, chronic bronchitis and emphysema. Hypertension rate includes essential hypertension and hypertensive renal disease.

Chronic diseases are also among the most costly of all health problems. The 50 percent of the US population with one or more chronic conditions accounts for nearly 85 percent of health spending nationally⁶⁷. Providing care to individuals with chronic diseases, many of whom meet the federal disability standard, has placed a significant burden on state Medicaid budgets.

In Oklahoma, the CDC estimates that total expenditures related to treating selected major chronic conditions will surpass \$8.0 billion in 2015 and will reach nearly \$10.5 billion in 2020. The estimated portion attributable to SoonerCare members will be just under \$1.0 billion (state and federal) in 2015 and more than \$1.2 billion in 2020⁶⁸ (Exhibit 3-34).

Exhibit 3-34 – Estimated/Projected Chronic Disease Expenditures (Millions)

Chronic Condition	OK All Payers		SoonerCare	
	2015	2020	2015	2020
Asthma	\$433	\$538	\$146	\$182
Cardiovascular Diseases (heart diseases, stroke and hypertension)	\$5,516	\$7,076	\$592	\$760
Diabetes	\$2,247	\$2,869	\$250	\$319
TOTAL FOR SELECTED CONDITIONS	\$8,196	\$10,483	\$988	\$1,260

The costs associated with chronic conditions are typically calculated by individual disease, as shown in the above exhibit. Traditional disease management programs likewise focus on individual conditions rather than the total patient.

In 2008, the OHCA moved beyond this concept by creating the SoonerCare Health Management Program (HMP), a holistic model that emphasizes development of member self-management skills and provider adherence to evidence-based guidelines and best practices. The program targets SoonerCare Choice members with the most complex needs, most of whom have multiple physical conditions and many of whom have physical and behavioral health co-morbidities.

⁶⁷ <http://www.cdc.gov/chronicdisease/overview/>

⁶⁸ Expenditure estimates developed using CDC Chronic Disease Cost Calculator

The SoonerCare HMP was launched in February 2008. Its specific objectives include:

- Better management of the needs of SoonerCare Choice members with complex/chronic conditions;
- Preparation of enrolled members to self-manage their conditions and ultimately “graduate” from care management; and
- Enhancement of the ability of PCMH providers to manage the needs of patients with complex/chronic conditions.

The program had two major components through June 2013: nurse care management (both field-based and telephonic) and practice facilitation. The nurse care management portion of the program was transformed in July 2013 into a model under which health coaches are embedded in the offices of PCMH providers who have undergone practice facilitation. The coaches work alongside providers and their staff members. Both components are administered by a vendor (Telligen) with oversight from a dedicated SoonerCare HMP Unit within the OHCA.

Nurse Care Management and Health Coaching

Nurse care management targeted SoonerCare members with chronic conditions identified as being at high risk for both adverse outcomes and significant forecasted medical costs. Potential participants were identified using claims data and predictive modeling software developed by the firm of MEDai.

The members were stratified into two levels of care, with the highest-risk segment placed in “Tier 1” and the remainder in “Tier 2.”⁶⁹ Prospective participants were contacted and enrolled in their appropriate tier. After enrollment, participants were engaged through initiation of care management activities.

Tier 1 participants received face-to-face nurse care management while Tier 2 participants received telephonic nurse care management. The OHCA’s objective was to provide services at any given time to about 1,000 members in Tier 1 and about 4,000 members in Tier 2.

In July 2013 the OHCA replaced field-based nurse care managers with health coaches stationed in the offices of participating PCMH providers who had undergone practice facilitation (see below). The health coaches work in concert with providers to assist members in developing self-management skills.

The transition to health coaching was not due to a lack of efficacy in the former model but rather to increase the amount of time nurses could spend with members. Under nurse care management, significant resources were often required just to locate members; missed appointments were common and reduced nurse care manager productivity. Under the health coaching model, where the coach is embedded in the provider’s office, the opportunity for

⁶⁹ The nurse care management tiers are unrelated to PCMH tiers. Only the terminology is the same.

face-to-face interaction is increased. The OHCA’s ultimate enrollment target under the health coaching model is 7,000.

Practice Facilitation

The practice facilitation initiative was implemented concurrent with nurse care management and continues to be offered. A team of practice facilitators provides one-on-one, in-office assistance to OHCA-designated primary care providers. The program is voluntary and offered at no charge to the provider. Practice facilitators collaborate with primary care providers and their office staffs to improve their efficiency and quality of care through implementation of enhanced disease management and improved patient tracking and reporting systems.

SoonerCare HMP Performance

PHPG has served as an independent evaluator of the SoonerCare HMP since its implementation. The most recent evaluation covered program performance in SFY 2014 and examined:

- Member and provider satisfaction;
- Impact on member lifestyle and health;
- Impact on quality of care;
- Impact on service utilization and expenditures; and
- Overall return-on-investment.

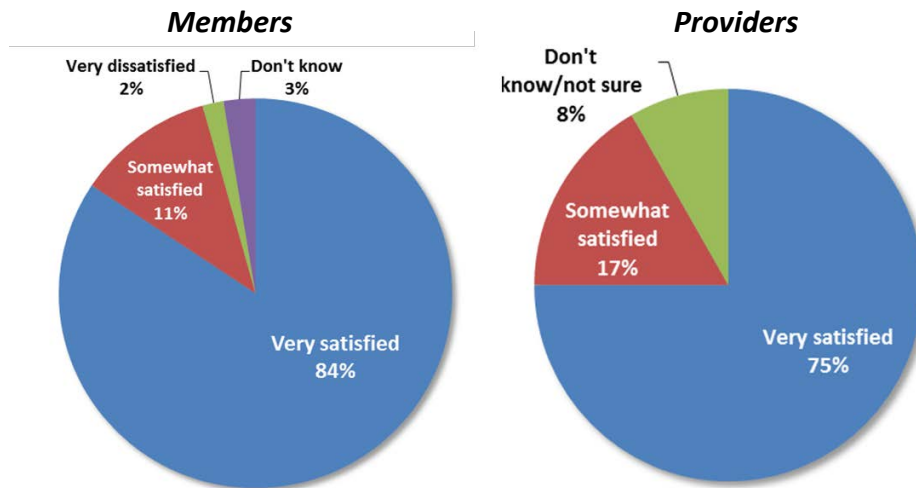
Summary findings from the evaluation are presented starting on the following page. The full report is available from the OHCA⁷⁰.

⁷⁰ See: “SoonerCare HMP – SFY 2014 Annual Evaluation”.

Member and Provider Satisfaction

PHPG conducted surveys with members and providers to explore their perceptions of the SoonerCare HMP. Participants gave the program high marks. When asked in a survey to rate their experience, 84 percent of members and 75 percent of providers declared themselves very satisfied (Exhibit 3-35).

Exhibit 3 – 35 – SoonerCare HMP – Member and Provider Satisfaction

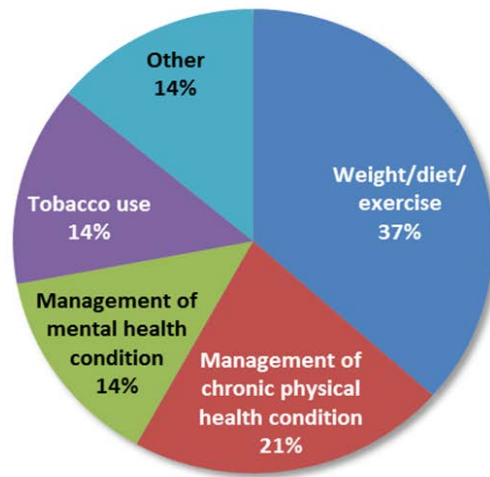


Health coaching employs motivational interviewing to identify lifestyle changes that members would like to make. Once identified, it is the health coach's responsibility to collaborate with the member in developing an Action Plan with goals to be pursued by the member with his/her coach's assistance.

Seventy-seven percent of survey respondents confirmed that their health coach asked them what change in their life would make the biggest difference in their health. Eighty-six percent of this subset (or 67 percent of total) stated that they actually selected an area to make a change.

The most common choice involved some combination of weight loss (or gain), improved diet and exercise. This was followed by management of a chronic physical health condition, such as asthma, diabetes or hypertension, management of a mental health condition and tobacco use/cessation (Exhibit 3-36).

Exhibit 3 – 36 – SoonerCare HMP – Areas Selected for Change/Action Plan Development



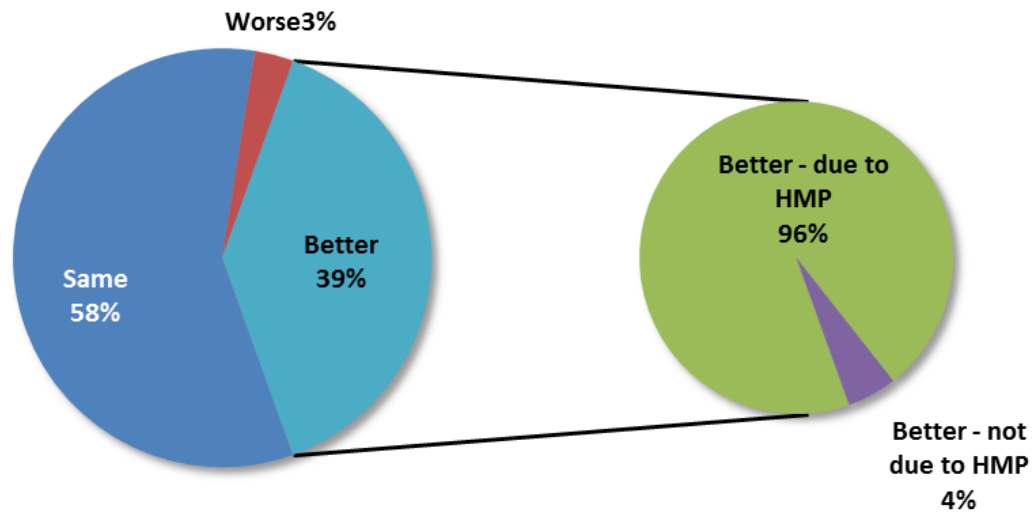
Nearly all of the respondents (96 percent) who selected an area stated that they went on to develop an Action Plan with goals. Exactly 50 percent of this group reported achieving one or more goals in their Action Plan. Among the members who reporting having a goal but not yet achieving it, 71 percent stated they were “very confident” they would ultimately accomplish it, while another 19 percent stated they were “somewhat confident”. Exhibit 3-37 provides examples of the goals members reported achieving.

Exhibit 3-37 – Examples of Achieved Goals

Action Plan Area	Goals Achieved
Weight/Diet/Exercise	<ul style="list-style-type: none"> Eating better and exercising more Enrolling in an exercise class
Management of chronic physical health condition	<ul style="list-style-type: none"> Better control of asthma with medications Eating better to control blood sugar
Management of mental health condition	<ul style="list-style-type: none"> Starting counseling Adhering to medication to address condition
Tobacco use	<ul style="list-style-type: none"> Cutting back on number of packs smoked per day Converting to electronic cigarettes

When asked if their health status had changed since enrolling in the SoonerCare HMP, a majority (58 percent) said it was “about the same”. However, a significant minority (39 percent) said their health was “better” and only three percent said it was “worse”. Since a majority of the members had been enrolled less than six months at the time of their survey, these results are encouraging. Among those members who reported a positive change, nearly all credited the SoonerCare HMP with contributing to their improved health (Exhibit 3-38).

Exhibit 3-38 – Health Status as Compared to Pre-HMP Enrollment



Impact on Quality of Care

SoonerCare HMP health coaches devote much of their time to improving the quality of care for program participants. This includes educating participants about adherence to clinical guidelines for preventive care and for treatment of chronic conditions.

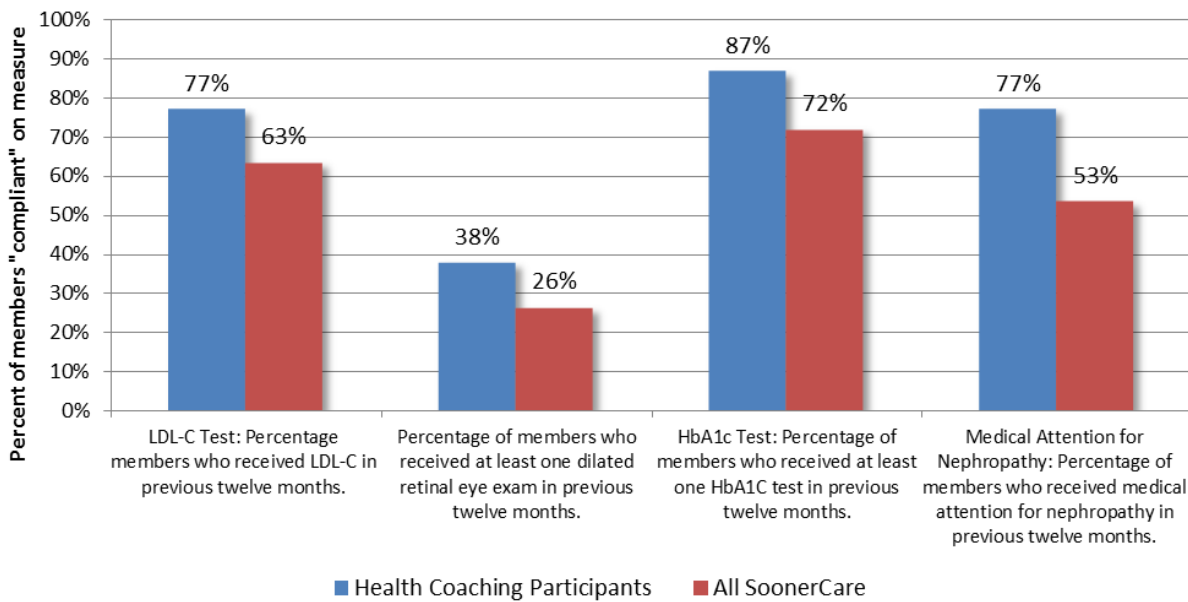
PHPG evaluated the impact of SoonerCare HMP health coaching on quality of care through calculation of HEDIS measures applicable to the SoonerCare HMP population. The evaluation included 19 diagnosis-specific measures and three population-wide preventive measures. For example, the quality of care for participants with asthma was analyzed with respect to their use of appropriate medications and their overall medication management.

PHPG determined the total number of participants in each measurement category, the number meeting the clinical standard and the resultant “percent compliant”. The results were compared to compliance rates for a comparison group consisting of all SoonerCare members (SFY 2014 reporting year), where available, and to national Medicaid MCO benchmarks where SoonerCare data was not available but a national rate was.

The health coaching participant compliance rate exceeded the comparison group rate on 11 of 18 measures for which there was a comparison group percentage. The difference was statistically significant for nine of the 11, suggesting that the program is having a positive effect on quality of care, although there is room for continued improvement.

The most impressive results, relative to the comparison group, were observed for participants with diabetes and mental illness, and with respect to access to preventive care. Diabetes results are presented for illustration purposes in Exhibit 3-39.

Exhibit 3 – 39 – SoonerCare HMP – Diabetes Measures



Service Utilization and Expenditures

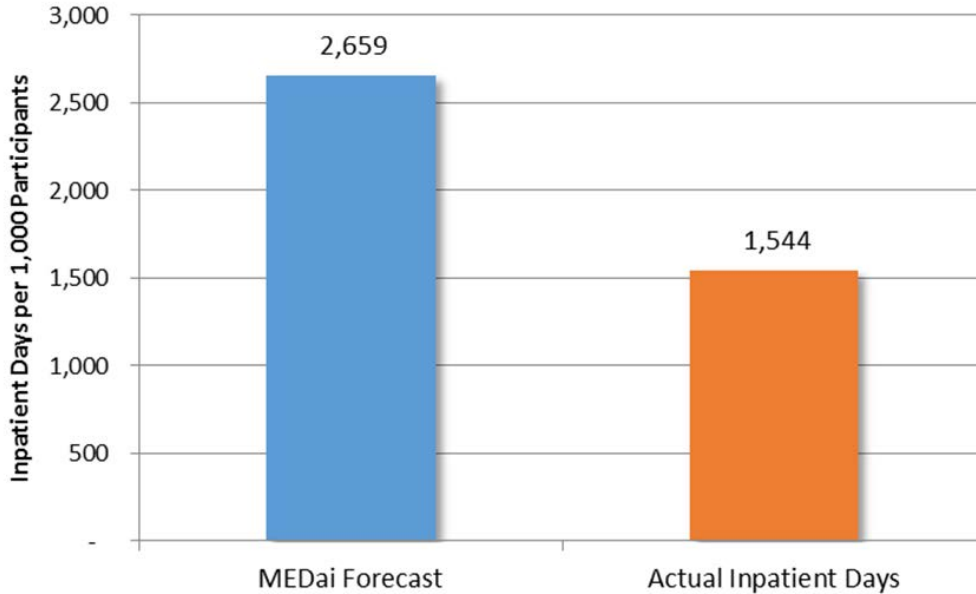
Most potential SoonerCare HMP participants are identified using a predictive modeling platform developed by Medical Artificial Intelligence (MEDai). As part of its output, the model calculates for each member a 12-month forecast of emergency room visits, hospitalizations and total expenditures.

PHPG conducted the utilization and expenditure evaluation by comparing health coaching participants’ actual claims experience to MEDai forecasts for the 12-month period following the start date of engagement. The same analysis was performed for non-health coaching members aligned with practice facilitation providers, to evaluate the discrete impact of practice facilitation on patient utilization and costs.

The impact on utilization and expenditures was found to be significant. MEDai forecasted that health coaching participants as a group would incur 2,659 inpatient days per 1,000 participants

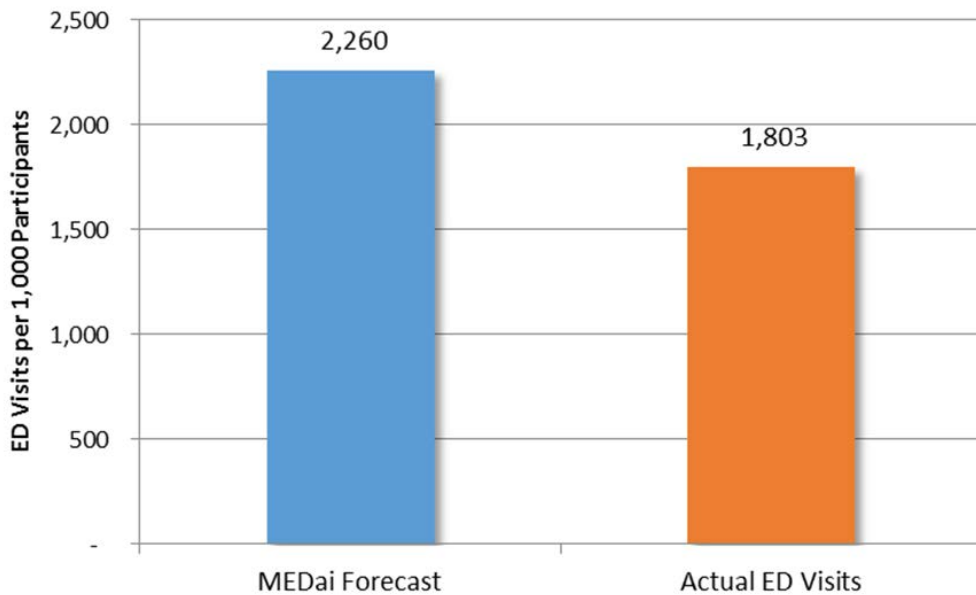
in the first 12 months of engagement. The actual rate was 1,544, or 58 percent of forecast (Exhibit 3-40).

Exhibit 3 – 40 – SoonerCare HMP – Inpatient Days (Health Coaching Participants)



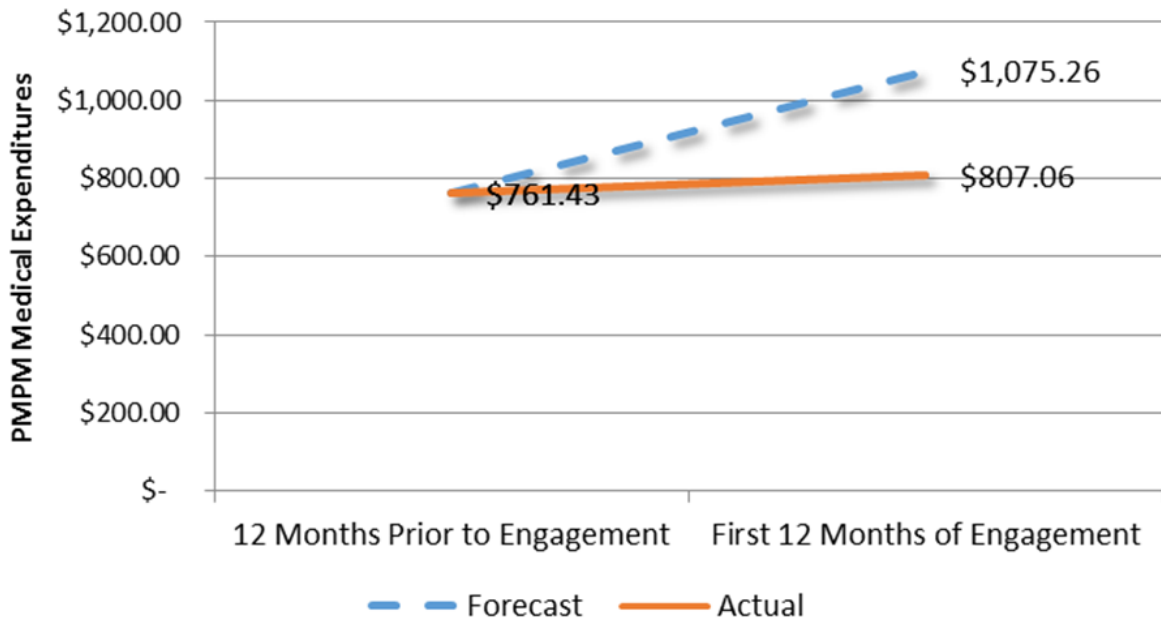
MEDai forecasted that health coaching participants as a group would incur 2,260 emergency room visits per 1,000 participants in the first 12 months of engagement. The actual rate was 1,803, or 80 percent of forecast (Exhibit 3-41).

Exhibit 3 – 41 – SoonerCare HMP – ER Visits (Health Coaching Participants)



PHPG documented total per member per month (PMPM) medical expenditures for all health coaching participants as a group and compared actual medical expenditures to forecast for the first 12 months of engagement. MEDai forecasted that the participant population would incur an average of \$1,075 in PMPM expenditures in the first 12 months of engagement. The actual amount was \$807, or 75 percent of forecast (Exhibit 3-42).

Exhibit 3 – 42 – SoonerCare HMP – PMPM Expenditures (Health Coaching Participants)



Similar results were documented for non-health coaching members aligned with practice facilitation providers. The group’s utilization rates and PMPM expenditures were well below forecast.

When program administrative costs were accounted for, the SoonerCare HMP was found to have achieved net savings of nearly \$16 million in SFY 2014 and a return on investment of 206 percent. Put another way, the program generated over two dollars in net medical savings for every dollar in administrative expenditures.

CHAPTER 4 – SC CHOICE: BENCHMARK STATE COMPARISON

SoonerCare Choice combines community-based systems of care (PCMH and HAN) with support at the State level in the form of chronic care/health management and quality initiatives. The OHCA functions essentially as a statewide MCO, performing some administrative functions directly (e.g., member enrollment, member services, provider contracting, claims payments) and contracting with vendors offering specialized expertise for others (e.g., health coaching and transportation).

The SoonerCare Choice structure is less common than the private MCO model. All but two states enroll at least a portion of their Medicaid population into managed care⁷¹, the majority through contracts with private MCOs. Among Oklahoma’s neighbors, Kansas, Missouri, New Mexico and Texas enroll TANF/CHIP beneficiaries into MCOs; New Mexico and Texas also enroll ABD beneficiaries, including persons who are dually-eligible for Medicaid/Medicare and persons eligible for long term care .

PHPG selected two states with private MCO models, Arizona and Florida, for comparison to SoonerCare Choice⁷². Arizona operates the nation’s oldest Section 1115 waiver program and fully-capitated MCO model for Medicaid beneficiaries, dating back to the early 1980’s. Florida implemented a private MCO model through a Section 1115 waiver in major portions of the state in 2005, including the counties encompassing Fort Lauderdale and Jacksonville; the program was expanded statewide in 2014 (Exhibit 4-1).

Exhibit 4 – 1 – Managed Care Program Comparison

Program Component	Oklahoma	Arizona	Florida
Program Name	SoonerCare Choice	AHCCCS	Managed Medical Assistance Program
Year Implemented	1996	1982	2005 (expanded statewide in 2014)
Populations enrolled in Managed Care	TANF/non-dual ABD	All	TANF/ABD/LTC
Enrollment - 2014	539,000 SC Choice 814,000 SoonerCare	1.6 million (all MCO)	2.8 million MCO 3.7 million total Medicaid
Program Expenditures	\$5.2 billion	\$6.7 billion (SFY 2014 budget)	\$22 billion

⁷¹ The exceptions are Alaska and Wyoming.

⁷² PHPG currently serves as a consultant to the Arizona Medicaid agency and has served as a consultant to the Florida House of Representatives on Medicaid managed care policy.

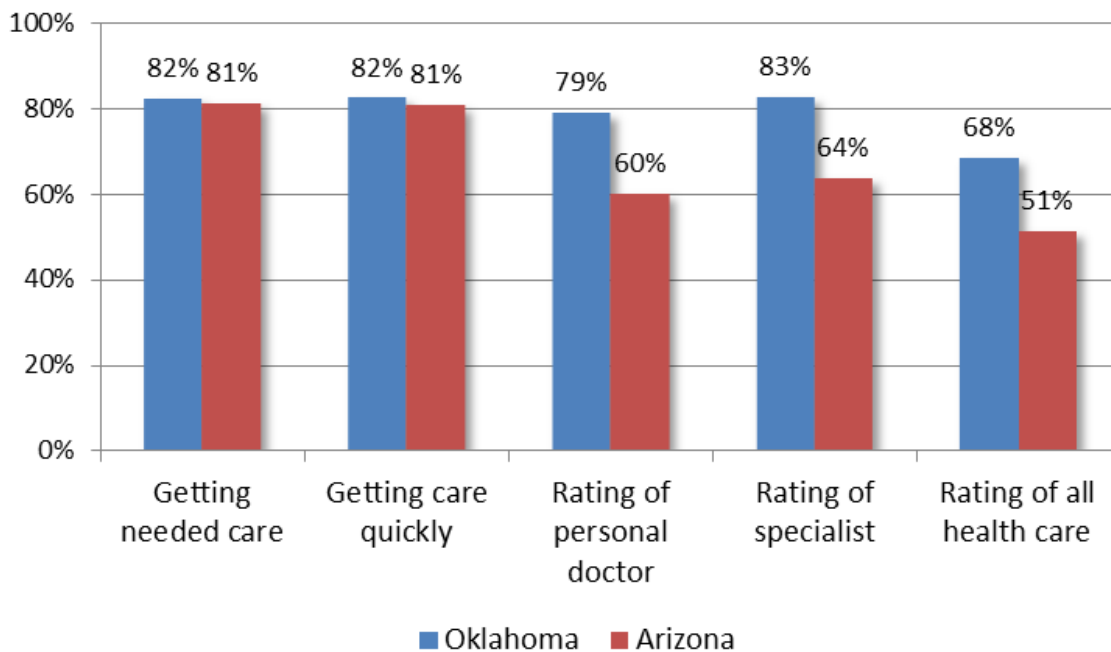
Both Arizona and Florida release data documenting program performance with respect to access, quality and cost effectiveness. PHPG reviewed the data for both programs and evaluated it against comparable data for SoonerCare Choice.

Arizona and Florida do not publish precisely the same data, making it necessary first to compare Oklahoma to Arizona on data points common to the two states and then to repeat the analysis for data points common to Oklahoma and Florida. In the case of Florida, PHPG’s review also was limited to the portions of the state covered by its Section 1115 Demonstration waiver since 2005. (Data is not yet available for the remainder of the state.)

Access to Care – Oklahoma and Arizona

Arizona publishes CAHPS survey data on member satisfaction with access-related components of care. SoonerCare Choice and AHCCCS adult members report comparable (and high) levels of satisfaction with getting needed care and getting care quickly. SoonerCare Choice members are significantly more satisfied with their personal doctor, specialist (if applicable) and overall health care (Exhibit 4-2).

Exhibit 4 – 2 – Access to Care – Satisfaction among Adults^{73,74}

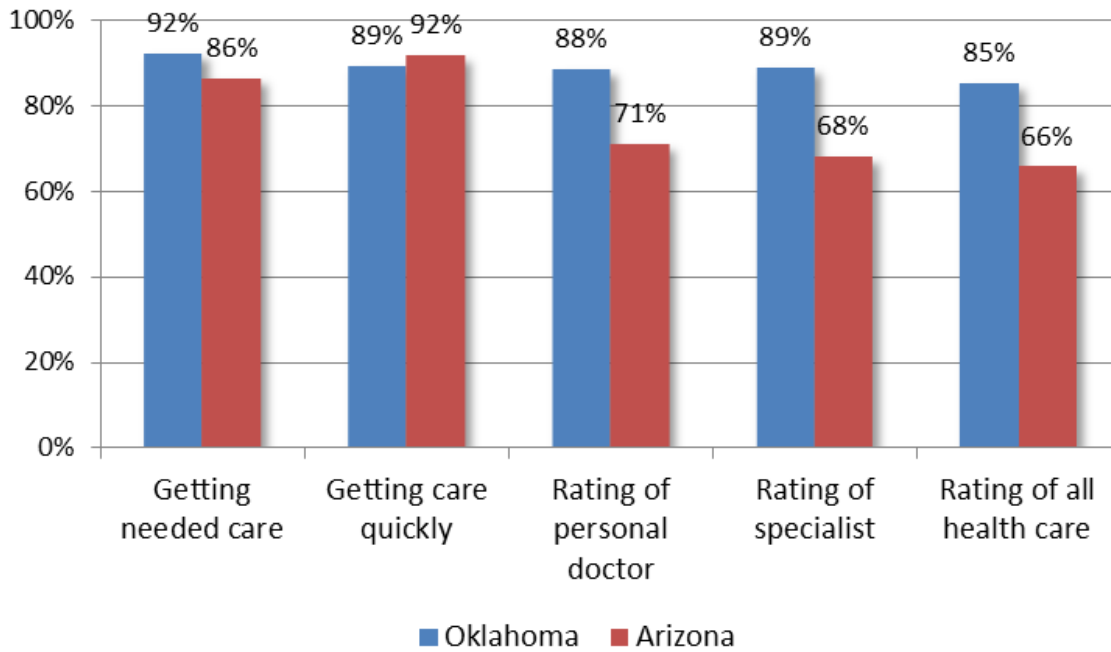


⁷³ Percent rating “always” or “usually” for Getting Needed Care and Getting Care Quickly; percent rating 8, 9 or 10 on a 10-point satisfaction scale for other measures.

⁷⁴ Sources: Oklahoma CAHPS 2014 Health Plan Survey Adult Version; Arizona CAHPS 2013 Health Plan Survey Adult Version.

Parents/guardians of SoonerCare Choice and AHCCCS child members also report comparable levels of satisfaction with getting needed care and getting care quickly. SoonerCare Choice parents/guardians again are significantly more satisfied with their child’s personal doctor, specialist (if applicable) and overall health care (Exhibit 4-3).

Exhibit 4 – 3 – OK & AZ Access to Care – Satisfaction w/Care for Children^{75,76}

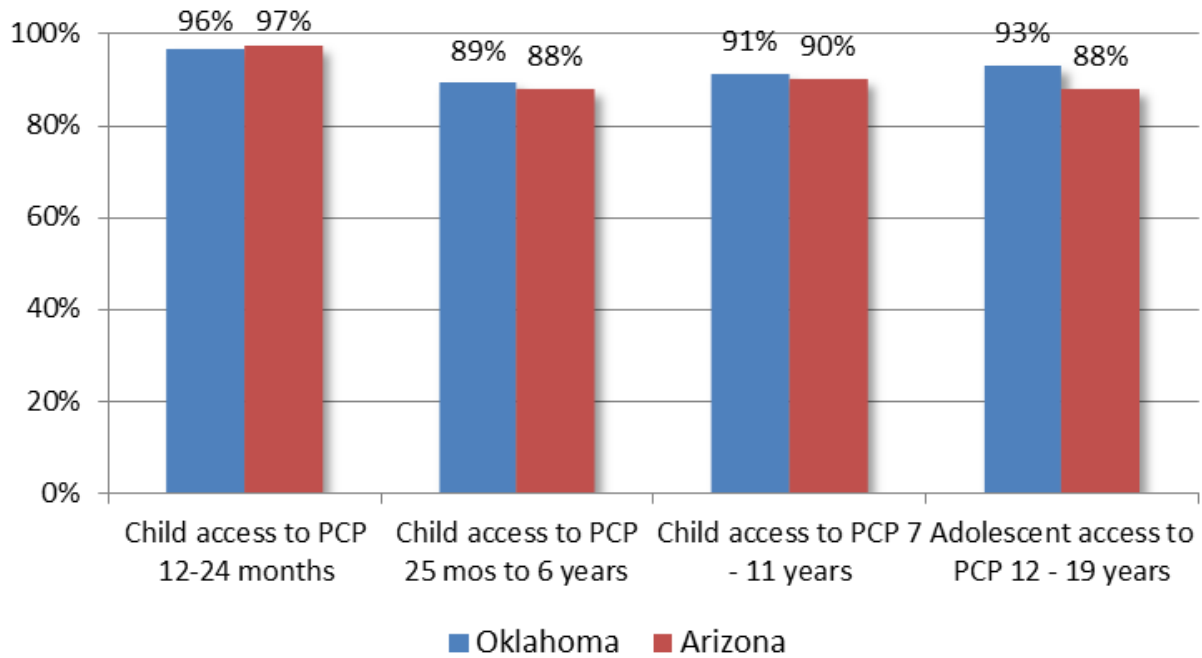


⁷⁵ *Note: Percent rating “always” or “usually” for Getting Needed Care and Getting Care Quickly; percent rating 8, 9 or 10 on a 10-point satisfaction scale for other measures.

⁷⁶ Sources: Sources: Oklahoma CAHPS 2014 Health Plan Survey Child Version – CHIP Population; Arizona CAHPS 2013 Health Plan Survey Child Version – KidsCare (CHIP) Population.

Arizona publishes HEDIS data measuring access to PCPs among children and adolescents. SoonerCare Choice and AHCCCS HEDIS measures both show high levels of access across all age cohorts (Exhibit 4-4).

Exhibit 4 – 4 – OK & AZ Access to Care – HEDIS Measures for Children/Adolescents⁷⁷

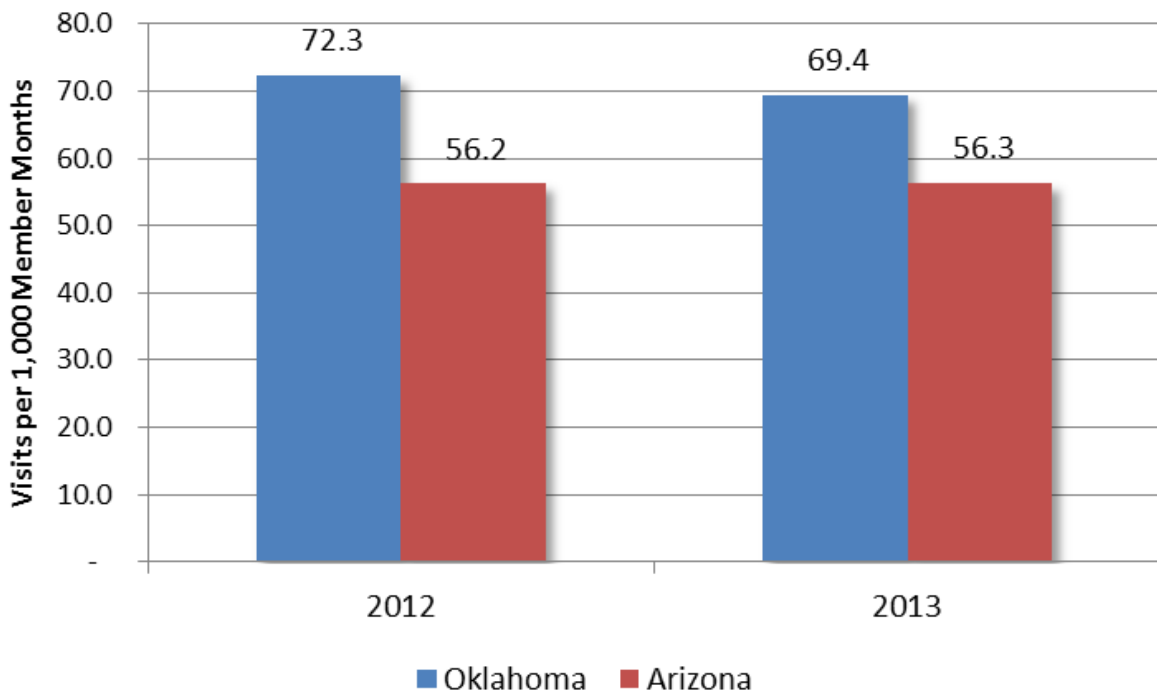


⁷⁷ Sources: Oklahoma Health Care Authority and AHCCCS 2012-13 EQRO Annual Report for Acute Care and DES/CMDP Contractors (April 2014).

Arizona also publishes data on ER utilization among AHCCCS members. AHCCCS has achieved a lower ER utilization rate than SoonerCare Choice, although the rate did not decline in the two years for which data has been published (Exhibit 4-5).

Like Oklahoma, Arizona has been working for a number of years to better control ER utilization. AHCCCS requires its MCOs to enroll high utilizers into case management and to coordinate ER use reduction strategies with the separate entities responsible for delivery of behavioral health services.

Exhibit 4 – 5– OK & AZ Access to Care – ER Utilization⁷⁸

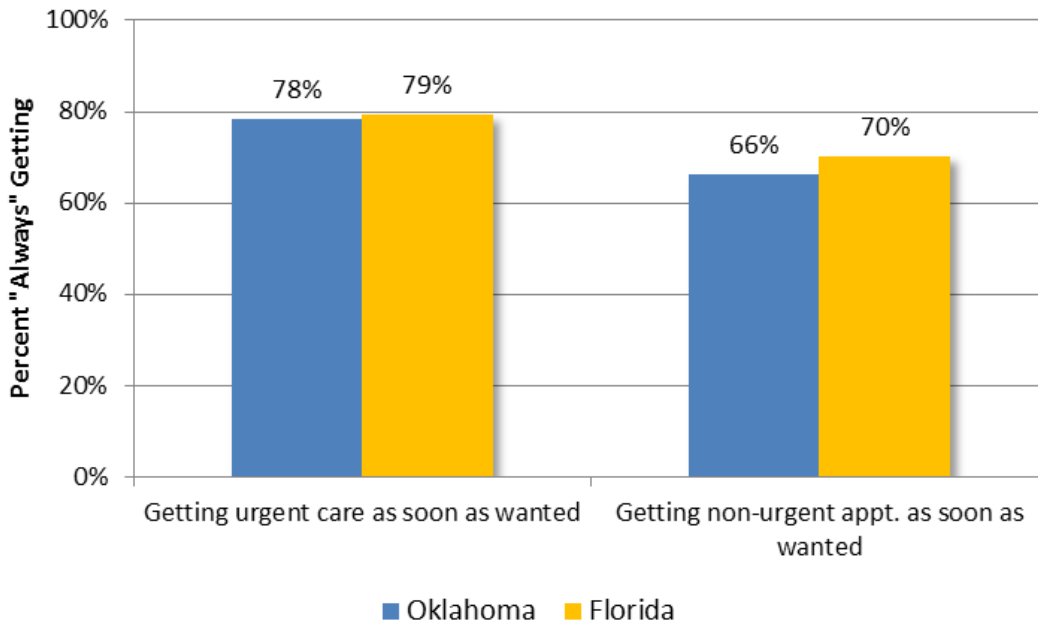


⁷⁸ Sources: Oklahoma Paid Claims; AHCCCS Report to the Directors of the Governor’s Office of Strategic Planning and Budgeting and the Joint Legislative Budget Committee Regarding ED Utilization (December 2014). Oklahoma data is calendar year; Arizona data is state fiscal year.

Access to Care – Oklahoma and Florida

Florida reports results for two CAHPS measures related to access: the percentage of members saying they always get urgent care and the percentage saying they always get routine care as soon as wanted. SoonerCare Choice and Florida demonstration MCO members report comparable (and high) levels of satisfaction with both measures (Exhibit 4-6).

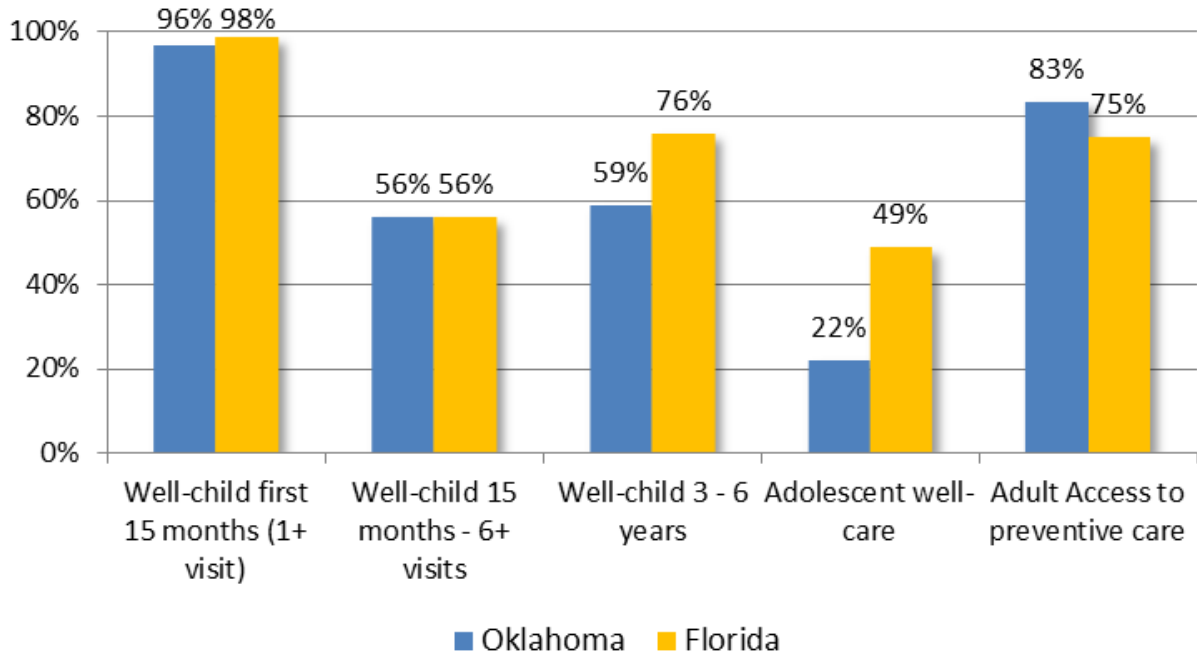
Exhibit 4 – 6 – OK & FL Access to Care – Satisfaction with Urgent and Routine Appointments⁷⁹



⁷⁹ Sources: Oklahoma CAHPS 2014 Health Plan Survey Child Version; Florida CAHPS data taken from SFY 2014 Demonstration Annual Report – represents children and adults.

Florida publishes HEDIS data on child and adolescent well-care visit measures, rather than PCP access measures. SoonerCare Choice and Florida Demonstration enrollees show comparable well-care rates among children at 15 months; Florida’s rate is higher among older children and adolescents (Florida has made a concerted effort to increase school-based service capacity as part of its adolescent well-care strategy, which may have contributed to this result). Adult access to preventive care is higher among SoonerCare Choice members (Exhibit 4-7).

Exhibit 4 – 7 – OK & FL Access to Care – HEDIS Measures⁸⁰

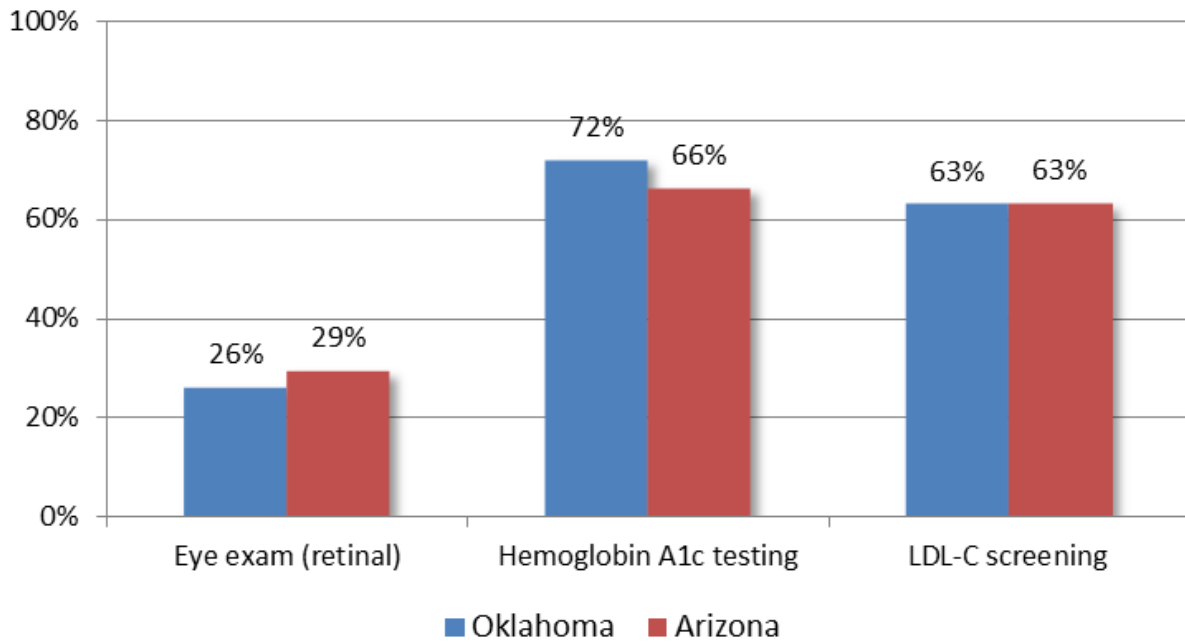


⁸⁰ Sources: Oklahoma Health Care Authority and Florida Demonstration SFY 2014 Annual Report.

Quality of Care – Oklahoma and Arizona

Neither Arizona nor Florida publishes quality-of-care results to the extent Oklahoma does. The sole HEDIS quality measure recently reported by Arizona is for diabetes care, specifically retinal eye exams, Hemoglobin A1c testing and LDL-C screening. Oklahoma trails Arizona on the first measure, surpasses it on the second and equals it on the third (Exhibit 4-8).

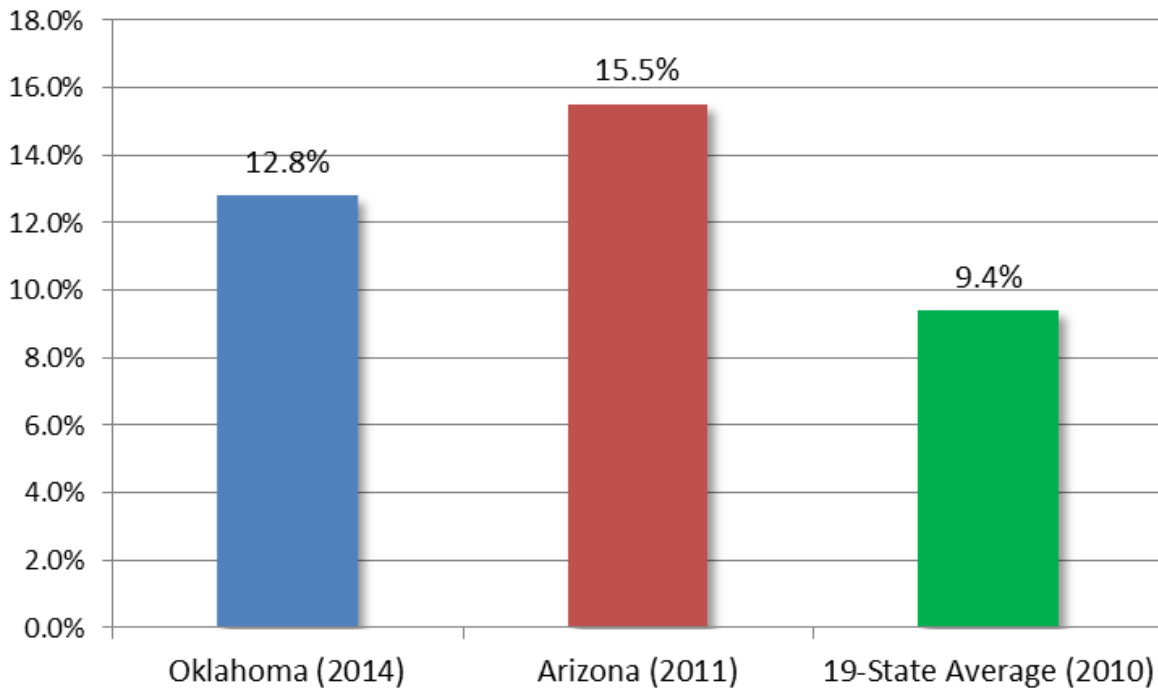
Exhibit 4 – 8 – OK & AZ Quality of Care – HEDIS Measures – Diabetes Care⁸¹



⁸¹ Sources: OHCA and Arizona 2010 – 2011 External Quality Review Annual Report (June 2012).

Arizona published its hospital 30-day readmission rate for federal fiscal year 2011. The SoonerCare Choice 30-day readmission rate in SFY 2014 was below the Arizona rate. Both programs had a higher readmission rate than the average rate for non-elderly Medicaid beneficiaries in 19 states, including Florida, based on a review of 2.6 million admissions in 2010 (Exhibit 4-9). (Florida has not published a state-specific rate.)

Exhibit 4 – 9– OK & AZ Quality of Care – Hospital 30-Day Readmission Rate⁸²

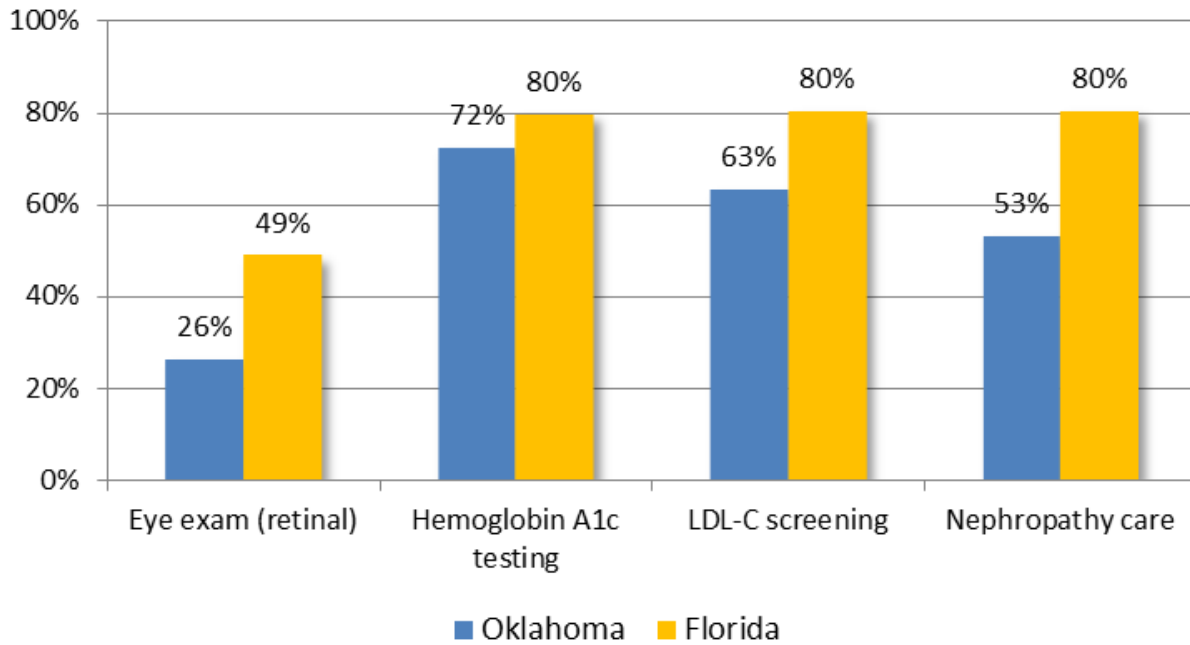


⁸² Sources: Oklahoma – OHCA paid claims; Arizona – 2012-2013 External Quality Review Annual Report (April 2014); 19-state average – “Medicaid Admissions and Readmissions: Understanding the Prevalence, Payment, and Most Common Diagnoses”, Health Affairs (August 2014). Note: 19 states were AL, AK, AR, CO, CT, GA, IA, ME, MA, MN, NH, NY, OK, PA, SC, TN, TX, WA and WY . AK, AR, MN and NH data was for 2009.

Quality of Care – Oklahoma and Florida

Florida publishes a wider variety of HEDIS quality of care-related measures than does Arizona. Florida’s results for diabetes surpass Oklahoma’s (and Arizona’s) (Exhibit 4-10).

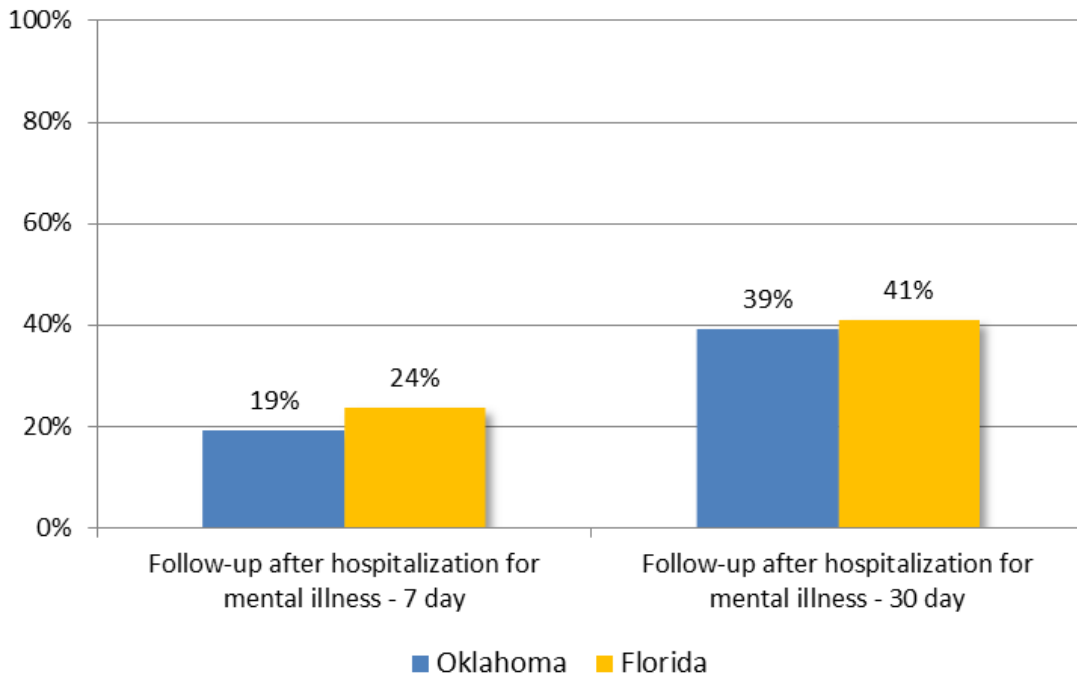
Exhibit 4 – 10– OK & FL Quality of Care – HEDIS – Diabetes Care⁸³



⁸³ Sources: Oklahoma Health Care Authority and Florida Demonstration SFY 2014 Annual Report.

Florida publishes HEDIS results documenting follow-up care for members hospitalized for a mental illness. Florida's rate is slightly higher than Oklahoma's at the seven-day follow-up milestone. The two programs are nearly identical at the 30-day milestone (Exhibit 4-11).

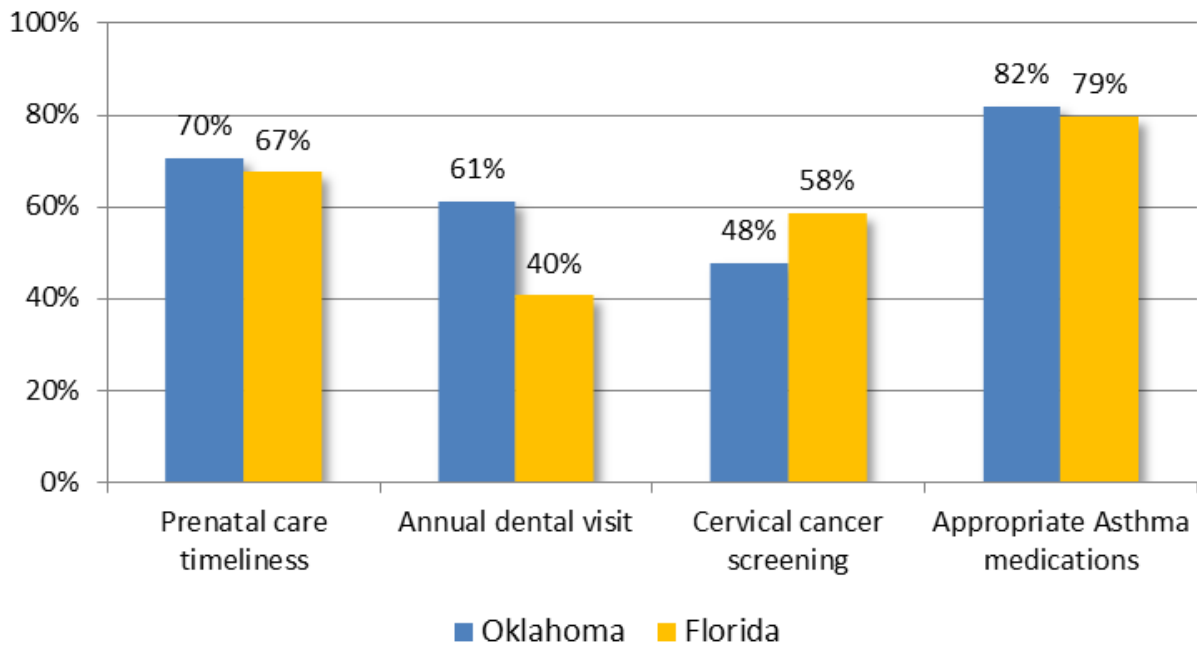
Exhibit 4 – 11 – OK & FL Quality of Care – HEDIS – Follow-up after Admission for Mental Illness⁸⁴



⁸⁴ Sources: Oklahoma Health Care Authority and Florida Demonstration SFY 2014 Annual Report. Oklahoma results are for members ages 21 – 64.

Florida publishes four other quality-related measures for which there is corresponding data for SoonerCare: timeliness of prenatal care, annual dental visits, cervical cancer screenings and appropriate asthma medications. The Florida rate for cervical cancer screenings exceeds the SoonerCare rate, while the SoonerCare rate for annual dental visits is substantially higher than the Florida rate. The other two measures have similar rates across the two states (Exhibit 4-12).

Exhibit 4 – 12 – OK & FL Quality of Care – HEDIS – Other⁸⁵



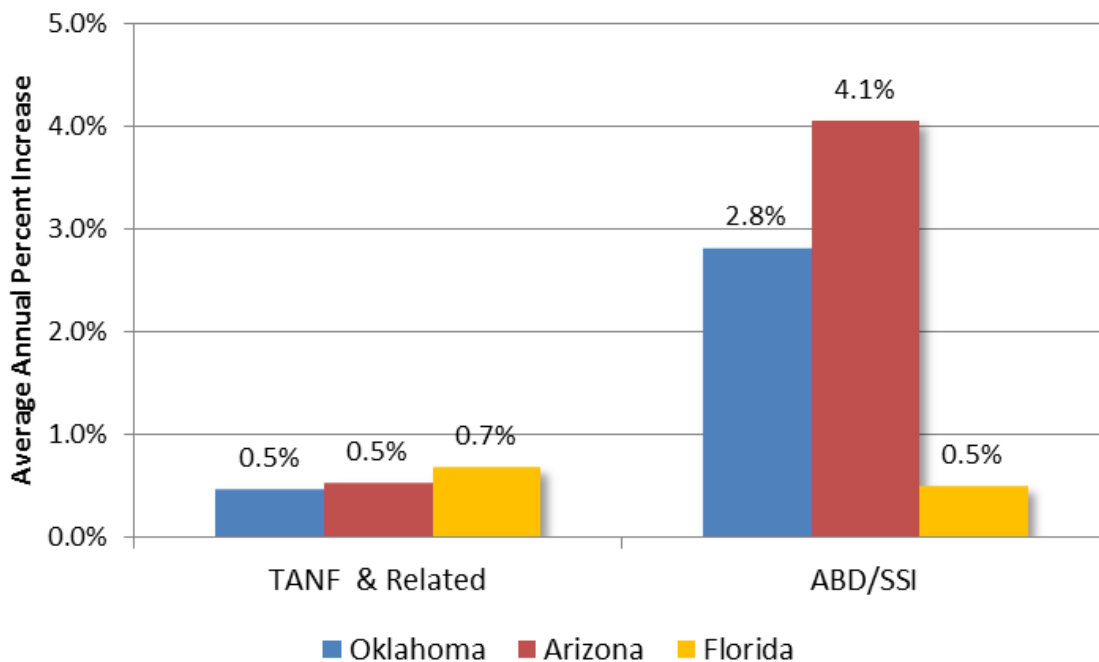
⁸⁵ Sources: Oklahoma Health Care Authority and Florida Demonstration SFY 2014 Annual Report. Oklahoma results are for members ages 21 – 64.

Cost Effectiveness – Oklahoma, Arizona and Florida

All three programs have registered close to zero inflation in recent years for their TANF and Related populations. Florida Demonstration ABD/SSI members have incurred the lowest PMPM medical inflation, with SoonerCare Choice falling midway between the other two states.

All three programs demonstrated cost effectiveness as compared to the national Medicaid inflation rate⁸⁶ of 2.9 percent for TANF and related populations. Oklahoma and Florida also achieved lower medical inflation rates than the 3.1 percent national rate⁸⁷ for the ABD/SSI population; Arizona’s ABD/SSI rate exceeded the national rate (Exhibit 4-13).

Exhibit 4 – 13 – OK, AZ & FL Cost Effectiveness⁸⁸



⁸⁶ Source: “Trends in Medicaid Spending Leading up to ACA Implementation”, Kaiser Commission on Medicaid and the Uninsured (February 2015). Trend is for 2010 – 2013.

⁸⁷ Ibid.

⁸⁸ Sources: Oklahoma – OHCA paid claims; Arizona – Actuarial certification reports; Florida – Demonstration SFY 2014 Annual Report. Note: Oklahoma trend is for SFY 2009 – SFY 2014; Arizona trend is for CYE 2012 – 2014 (actual) and 2015 (projected); Florida trend is for SFY 2007 – SFY 2014.

Summary of Benchmark State Comparison

Oklahoma, Arizona and Florida all have demonstrated favorable outcomes in terms of access, quality and cost effectiveness. None of the three has consistently outperformed the others.

SoonerCare Choice members have a high level of satisfaction with access to care, as do AHCCCS and Florida Demonstration members. Arizona has achieved a lower emergency room utilization rate than Oklahoma.

Arizona and Florida both report somewhat higher rates than SoonerCare Choice for preventive and chronic care. However, SoonerCare Choice has maintained a lower hospital readmission rate than Arizona.

All three programs have achieved lower medical inflation rates the national Medicaid average, including near zero medical inflation for TANF and Related members. Florida also has reduced medical inflation to near zero for ABD/SSI members, while the SoonerCare Choice rate falls between the Florida and Arizona rates.

CHAPTER 5 – CONCLUSIONS

Performance against Program Goals

The SoonerCare Choice program’s overarching goals are to provide accessible, high quality and cost effective care to the Oklahoma Medicaid population. The program demonstrated improved performance with respect to access and quality during the evaluation period, while maintaining cost effectiveness.

In terms of ACCESS:

- The OHCA successfully converted from paper to electronic applications for most SoonerCare Choice members, improving both the speed and accuracy of the enrollment process.
- The OHCA introduced patient centered medical homes and significantly expanded the number of PCMH providers available to serve SoonerCare Choice members.
- Although it remains high by national standards, emergency room utilization declined concurrent with introduction of patient centered medical homes and adoption of initiatives targeting frequent visitors to the emergency room.
- The OHCA has implemented case and care management strategies to assist members in navigating the health care system and improving their self-management skills.
- SoonerCare Choice members report high levels of satisfaction with access to care for both children and adults.

In terms of QUALITY:

- The OHCA has established methods to routinely measure quality of care and reward PCMH providers who meet or exceed quality benchmarks.
- Primary and preventive care quality measures improved for both children and adults and generally exceeded national benchmarks. However, opportunities for improvement remain, particularly with regard to breast/cervical cancer screening, cholesterol; diabetes management; and asthma management for adults.
- Member health outcomes showed improvement with respect to hospitalizations for ambulatory care sensitive conditions and thirty-day readmission rates.

In terms of COST EFFECTIVENESS:

- Medical inflation for SoonerCare Choice members was well below the national Medicaid average.
- OHCA (and partner agencies) administrative costs also were significantly below that of typical private Medicaid MCOs.

Major Initiatives

The OHCA has undertaken three significant person-centered care initiatives since 2008: patient centered medical homes; health access networks; and the SoonerCare Health Management Program.

The most recent of the three, health access networks, have shown robust membership growth and appear to be having a favorable impact on emergency room utilization. The HANs are providing services at about the same claim cost as the non-HAN provider community and have the potential to achieve favorable quality and cost outcomes in coming years as the impact of care management and practice enhancement takes hold.

The patient centered medical homes appear to be contributing directly to the improvements in access and quality occurring for the program as a whole. PCMH providers are building relationships with their members and having a positive impact on service utilization and program costs. There also is emerging evidence that providers in higher tiers outperform their counterparts in tier one, although another year of data will be necessary to verify this trend.

The SoonerCare HMP has similarly had a significant positive impact through its provision of person-centered, holistic care management for members with complex and chronic conditions. The program has improved member adherence to care guidelines and has reduced emergency room and inpatient utilization, resulting in a corresponding reduction in health care expenditures versus what would have occurred absent the program.

Conclusion

SoonerCare Choice has fostered innovation while exhibiting stability for members and providers and has continued to advance its goals of delivering accessible, high quality and cost effective care to Oklahoma's Medicaid population.