

SB 773 – COORDINATED CARE MODELS FOR CHILDREN IN DHS CUSTODY

Report submitted December 28, 2017

Oklahoma Health Care Authority – Department of Human Services –
Department of Mental Health and Substance Abuse Services

*Summary of the
Request for
Information
Responses*

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Introduction

Oklahoma's Child Welfare Services (CWS) unit of the Department of Human Services (DHS) is committed to improving the safety, permanency and well-being of children and families involved with the system due to abuse or neglect. It works to keep families together whenever safely possible. If a child must be removed from the home to ensure safety, relatives or foster parents support the child and family while efforts are made toward reunification. When reunification cannot occur, CWS works to secure an adoptive family or guardian to ensure permanent, supportive connections that will last through adulthood.

Even taking these efforts into account, nationwide studies document the need to address the specialized needs of the whole child in foster care – medical, behavioral, dental and other areas. Educational attainment, transitions to adulthood, housing needs, career readiness and future achievement of these individuals hangs in the balance.

Adverse childhood experiences are known to significantly impact the lives of adults. Through CWS, professional and community-based partners are working collaboratively to help children in foster care develop healthy relationships and well-being for children and families.

According to the Center for Health Care Strategies, children covered by foster care and SSI/disability account for over 25 percent of behavioral health care service use, half of total behavioral health care costs and only a small portion of children in Medicaid. In Oklahoma, the number of children in care today is down to 9,080, after peaking at 11,303 in October 2014.

The Pinnacle Plan, implemented since July 2012, is the roadmap to improving the safety, permanency and well-being of children served by the CWS. Twice a year DHS makes available public reports to ensure transparency and accountability. The reports contain an analysis of the strategies used to improve

performance in areas targeted by the Compromise and Settlement agreement, along with data showing the progress toward improving CWS performance.

SB 773 Requirements

In the regular session of the 2017 legislature, Senate Bill number 773 was passed. This measure directed the Oklahoma Health Care Authority (OHCA,) which is the single state Medicaid agency, to initiate a Request for Information for care coordination models for newborns through children 18 years of age in DHS custody. Further, the OHCA was instructed to prepare the RFI with assistance from DHS and the Department of Mental Health and Substance Abuse Services (DMHSAS.)

The Request for Information was mandated to require consideration of and incorporate efforts to continue the implementation of relevant initiatives as provided by the Master Settlement Agreement (“Pinnacle Plan”) and administered by DHS.

Finally, the law, which became effective November 1, 2017, requires the three agencies to collaborate on a summary of the request for information responses to be presented to the President Pro Tempore of the Oklahoma State Senate, the Speaker of the Oklahoma House of Representatives and the Governor on or before January 1, 2018. This report is provided to fulfill that requirement in law.

A copy of Senate Bill 773 is included as Attachment One of this report.

Workgroup Process

OHCA identified staff resources to address the requirements of the law. A Certified Procurement Officer guided the workgroup on all matters related to the RFI process. In addition to selected OHCA staff, the leadership of DHS and DMHSAS were invited to name members to participate in the workgroup to develop the RFI and summary report. This group began meeting in July 2017, with an eye toward developing a workable plan to accomplish the distribution of the RFI, allow for questions from the subject matter experts, offer an opportunity for review of the responses and presentations if the vendors were available, and culminate the work with a summary report of the responses to be submitted timely.

Members of the workgroup contributed background information for the RFI, as well as reference documents to post in the RFI Bidders Library, and assisted with the development and editing of the final document.

The RFI timetable included:

Post the RFI on the OHCA web site	Tuesday, September 19, 2017
Respondent questions due	Thursday, September 28, 2017
Answers posted on the OHCA web site	Thursday, October 5, 2017
RFI Responses due	Thursday, October 19, 2017
Presentations	November 6-December 4, 2017

A copy of the RFI and questions and answers is contained in Attachment Two and Three of this report.

Responses from the Experts

Eight vendors submitted responses. Of the eight, five respondents recommended deployment of a Managed Care Organization (MCO) model. Three of the respondents presented a model incorporating the purchase of professional services to address care coordination and data/analytical needs of the population.

A summary of the proposed model recommendations and key provisions is presented below:

	Model	Experience	Financing	Preventing Duplication
Aetna Better Health of Oklahoma	Full risk-based MCO for specialized population, on a foundation of statewide MCO service delivery	Dedicated, national implementation team. 12,000 providers in OK; 5,600 providers participating in Medicare Advantage; ACO and PCMH+ experience. ARIZONA foster care service delivery system	Actuarially certified rates	Differentiate services from state child welfare workers; single view of all services
Amerigroup Oklahoma	Single full risk-based MCO for specialized population, on a foundation of statewide MCO service delivery	Parent company: Anthem. Affiliate health plans serve nearly 58,000 youth in child welfare systems across 10 states.	Actuarially certified rates	Delineate, differentiate services to prevent duplication. Use smart assignments and do not assign health home members to complex care coordination management program simultaneously. Outline clear roles and responsibilities for comprehensive case management,

				care coordination, health promotion, and other areas of potential duplication
Molina Medicaid Solutions	Professional services contract for coordinated care, with possible QIO match for utilization management	Parent Company: Molina Healthcare	Administrative fee basis	Continue Fee-for-Service as in place today
Oklahoma Complete Health/Centene	Sole source statewide MCO program; highly integrated wraparound model of service management/coordination. Foster Care Service Delivery model organized in four tiers. Cover the Former Foster Care Children group up to age 26.	Parent Company: Centene Corporation. 9 years, 10 states, 135,000+ current members in care coordination models for children in state custody. Health plan serves as sole source child welfare health plan in FL, IL, TX, and WA. Active as affiliate or plan option managing foster care children in 7 other states	Happy to discuss with State	Care coordination reduces duplication and redundancy of services
Patient Care Network of Oklahoma	Professional services contract for enhanced patient-centered medical home model; operated within statewide FQHC network	Network was formed in 2015 and contains 19 members which are all Community Health Centers and designated FQHCs. PCNOK operates over 90 clinic sites statewide with 80% of Oklahomans living within a 30 minute drive of	Either Fee-for-Service at Regionalized Prospective Payment System rates plus an additional per member per month care coordination payment +shared savings payment; OR capitation for all FQHC services	Care coordination/PCMHs eliminate duplication

		these health centers. ACO with over 10,000 lives	with other services carved out.	
Telligen	Professional services contract for Health Management Program for Children with a single vendor. Includes personal care coordination and health coaching.	Partnered with OHCA since 2008 on HMP. Saved state more than \$250 million with combined health coaching and practice facilitation.	Either a fixed monthly payment for a defined scope of work; OR a performance based payment model in which the vendor receives a fixed payment amount for care coordination that would increase as more children and families are engaged. Willing to do a pilot for cost.	Those eligible for Health Homes could still be served by CMHCs. Coordinate services to prevent duplication.
United Healthcare Community & State	Fully capitated, risk-based statewide single vendor MCO; OR partial-risk care coordination approach that, over time, increases the level of risk to the coordination entity to a full-risk model	MCO which serves 6.4 million members across 26 states	Actuarially certified rates	Leveraging an MCO model will drive transparency and eliminate overlap
WellCare of Oklahoma	Defer to larger statewide MCO procurement, then add the DHS custody population. Recommend serving this population up to age 26. CommUnity Advocacy program to identify social	WellCare Health Plans Inc. has 30 years' experience serving 2.8 million Medicaid members and 1.5 million Medicare members including children in foster care. Operates Medicaid managed care programs in 11	Actuarially certified rates	Use care coordination, collaboration with community partners, and data sources within IEP to prevent duplication

	safety net barriers and gaps and work at both the individual and community levels to bridge those gaps.	states
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A side-by-side comparison of the proposals is available for review in Attachment Five. In addition, copies of the complete responses from the subject matter experts are contained in Attachment Six.

Respondent Recommendations

The respondents' recommendations consistently echoed certain themes to be taken into consideration:

- The entity providing care coordination must be staffed with personnel who are well-educated and trained to provide trauma-informed care to the children and their families
- The health care provider network should be provided specialized training to ensure that they use trauma-informed methods to serve these children and families
- The child must be at the center of the care coordination model and health care delivery system
- An assessment and risk stratification method to determine the intensity of care coordination services should guide resource deployment
- Focused data analytics combined with care coordination can result in improved outcomes for these children
- The entity that provides care coordination will be a resource to assist child welfare workers
- If possible, the child and family should have one care coordinator point of contact
- For an actual procurement, it will be important for the state to specify which populations in care would be served – adoption subsidy, foster care, juvenile justice involved youth.

Sole Source

Respondents also emphasized that in order to achieve maximum success with an MCO program for foster care children, a sole source approach would be preferred. Respondents indicated this would provide maximum accountability and consistency of the program to ensure a well-integrated service delivery system.

Respondents who Recommended Professional Services Contracting

Companies that designed a model with reimbursement based on an administrative fee were open to different approaches to determining the payment structure.

Incorporating Efforts to Continue Implementation of the Pinnacle Plan

Respondents recognized the accomplishments to date of the Pinnacle Plan and were positive that if they were selected as contractors in a future procurement they could strengthen the work being done by DHS to best serve children in care. Each individual company had its own approach to promoting Pinnacle Plan goals.

Health Homes

Health Homes were viewed as a service that can be capitalized on to serve children in custody. Some respondents identified prior experience in developing and working with Health Homes, with all being positive about this service delivery model. Some also identified the new Certified Community Behavioral Health Clinics as an additional resource.

Staff/Provider Network

The subject matter experts by and large recommended that any businesses chosen to provide care coordination models to support children in DHS custody should have as extensive a local presence as possible, as well as a statewide network that could provide access for children regardless of living situation. While certain key organizational or technology-based functions might be understood to best be handled at the corporate level, these respondents suggested that a local presence will be extremely helpful. More than one vendor discussed the possibility of placing a liaison within the physical working space of DHS or OHCA for easy access and responsiveness if a care coordination model is selected.

Educating the provider network to be trauma informed was a priority for the respondents. Another aspect of ensuring access was reinforcement of the value of telemedicine in serving this youth and families population.

Payment Structure

Respondents offered different approaches for introducing value-based purchasing into the reimbursement system for those providers that might be included in the models recommended. These included advice to implement in phases with extensive education of providers about how the changes would affect them. Incentive payments and shared savings were also featured.

Preventing duplication with DHS

Clear care coordination roles, data mining and analysis techniques and clarification that the role of a care coordination program would not overlap with any role of DHS CWS workers were suggested as means of ensuring that federal oversight would not prevent payments for such a program on the basis of duplicative services.

Reimbursement

Responses on paying for a care coordination model varied from recommending capitation payments to making administrative payments for services – with incentive and shared savings options all considered in the mix. Some vendors suggested models that would include varying degrees of risk.

Impact – Estimated implementation costs & anticipated savings

Estimated implementation costs & anticipated savings The experts in many cases could demonstrate that their care coordination models have both improved health outcomes and the cost of service. If the proposed model has not already been put in place in some other program or state, less data was available to address estimated implementation costs. The majority of respondents that are managed care organizations noted that the economies of scale and wider dispersion of risk is better attained with large pools of enrollees.

Quality and Outcomes

Strong evidence for improved quality and outcomes was presented in the responses from these eight firms. Standardized measures with national validity were preferred, with the experts demonstrating what they have been able to accomplish (primarily in other states) in advancing physical, behavioral and dental health care for children in custody.

For example, compliance rates with measures for dental and primary care access for children in care could be evaluated and trended over time. Dental and primary care access measures for children in care could also be compared to the rates for other enrolled children.

Data Management

The subject matter experts indicate that they have rich data analytical capabilities that can be used at the individual foster care child level to improve lives. Data management may incorporate assessments of children's and families' needs, reporting on status, performing risk stratification and assignment to a supportive level of care coordination that fluctuates based on need, furnishing needed data to the providers serving children in DHS custody and ensuring efficiency of services. If vendors pay claims, this is viewed as an additional resource in the care coordination realm by MCOs. Some experts propose that paying a set amount for specified services to be furnished by the vendor and carving other services out in the Fee-for-Service program is best. Vendors indicate the capacity to customize reports that a state may request in order to better manage the population.

Care Coordination Implementation Timelines

The responses on implementation timelines generally cited at minimum six months to introduce a new program. These experts discussed advance work that should be done with stakeholders, providers, the impacted population of children in care and their families, along with necessary establishment of new systems and monitoring.

Conclusion

The SB 773 Workgroup received eight thoughtfully developed responses in response to the RFI seeking recommendations for care coordination models for children in DHS custody. Responses were split between risk-based MCO approaches and professional services administrative contracting. In addition, respondents suggested nurturing and educating the staff and providers rendering care so that trauma-informed methodology flows through all interactions for the children and their families. These subject matter experts emphasized that these care coordination models can be wrapped around the current CWS

system and the Pinnacle Plan to ensure that the objectives are reached for ensuring well-being for Oklahoma's children in DHS custody.

Attachments

- 1) Senate Bill 773
- 2) Senate Bill 773 Care Coordination for Children in DHS Custody RFI (Revised)
- 3) Senate Bill 773 Care Coordination Q & A
- 4) Comparison Chart of Plans
- 5) Vendor Responses:

Aetna

Amerigroup

Molina

Oklahoma Complete Health/Centene

Patient Care Network of Oklahoma

Telligen

United Healthcare Community Plan

WellCare

An Act

ENROLLED SENATE
BILL NO. 773

By: David of the Senate

and

Mulready of the House

An Act relating to the Oklahoma Medicaid Program; directing Oklahoma Health Care Authority to initiate certain procedures; providing assistance from other agencies; specifying certain consideration; directing submission of certain information; directing promulgation of rules; providing for codification; and providing an effective date.

SUBJECT: Oklahoma Medicaid Program

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 5028.1 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. The Oklahoma Health Care Authority, with assistance from the Department of Human Services and the Department of Mental Health and Substance Abuse Services, shall initiate a request for information for care coordination models for newborns through children eighteen (18) years of age in the custody of the Department of Human Services.

B. Any request for information shall require consideration of and incorporate efforts to continue the implementation of relevant initiatives as provided by the Master Settlement Agreement ("Pinnacle Plan") and administered by the Department of Human Services.

C. The Oklahoma Health Care Authority, with assistance from the Department of Human Services and the Department of Mental Health and Substance Abuse Services, shall provide a summary of the request for information responses to the President Pro Tempore of the Oklahoma State Senate, the Speaker of the Oklahoma House of Representatives and the Governor on or before January 1, 2018.

D. The Oklahoma Health Care Authority Board shall promulgate rules to implement the provisions of this section.

SECTION 2. This act shall become effective November 1, 2017.

Passed the Senate the 15th day of March, 2017.

Presiding Officer of the Senate

Passed the House of Representatives the 26th day of April, 2017.

Presiding Officer of the House
of Representatives

OFFICE OF THE GOVERNOR

Received by the Office of the Governor this _____

day of _____, 20_____, at _____ o'clock _____ M.

By: _____

Approved by the Governor of the State of Oklahoma this _____

day of _____, 20_____, at _____ o'clock _____ M.

Governor of the State of Oklahoma

OFFICE OF THE SECRETARY OF STATE

Received by the Office of the Secretary of State this _____

day of _____, 20_____, at _____ o'clock _____ M.

By: _____

Oklahoma Health Care Authority
REQUEST FOR INFORMATION
CARE COORDINATION FOR CHILDREN IN DHS CUSTODY

SECTION I: GENERAL INFORMATION

1.1 ANNOUNCEMENT

The Oklahoma Health Care Authority (hereinafter OHCA) is issuing this Request for Information to obtain information from subject matter experts regarding Care Coordination Models to serve children who are newborns through age 18 who are in the custody of the Oklahoma Department of Human Services (DHS,) as directed by Senate Bill 773 of the 2017 legislature. Pursuant to this legislation, OHCA has consulted with DHS and the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) in the development of this RFI. OHCA is directed to, with the assistance of DHS and ODMHSAS, prepare a summary of the responses to the RFI to be presented to the President Pro Tempore of the Oklahoma State Senate, the Speaker of the Oklahoma House of Representatives and the Governor on or before January 1, 2018.

1.2 OBJECTIVES

OHCA's major objectives for exploring Care Coordination models are as follows:

1. Determine the best market-based approach(es) to serving Oklahoma's children in DHS custody;
2. Determine the benefits of implementing Care Coordination models in providing clinically appropriate evidence-based health care services to children in DHS custody.
3. Determine how Care Coordination models can serve to reduce the costs of healthcare for children in DHS custody, while maintaining a high quality of care.
4. Determine how to best provide efficient and effective health services and care coordination to children in DHS custody; and,
5. Evaluate how the use of Care Coordination models could incorporate the efforts to implement relevant initiatives as provided by the Compromise and Settlement Agreement ("Pinnacle Plan") as administered by DHS.

1.3 POINT OF CONTACT

This RFI is issued by OHCA and OHCA is the sole point of contact from the date of release of this RFI through the closing date as follows:

Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105
Attention: Gerald Elrod
Phone (405) 522-5850
E-mail: Gerald.Elrod@okhca.org

1.4 RFI TIMETABLE *(All dates are estimates and subject to change)*

RFI available on OHCA website Tuesday, September 19, 2017

All Respondent questions due	Thursday, September 28, 2017
Answers posted on OHCA website	Friday, September 29, 2017
RFI Responses due	Thursday, October 16, 2017
Demonstrations	Est. November 6-10, 2017

1.5 RFI CLOSING DATE

- A. Responses submitted in accordance with this RFI must be received by OHCA no later than **3:00PM Central Time (CT) on October 16, 2017**. Responses should be emailed to the Point of Contact in Section 1.3. Responses received after the closing time and date will not be accepted.
- B. After reviewing submissions, OHCA may invite some or all Respondents to demonstrate their Care Coordination models at OHCA’s offices in Oklahoma City.

SECTION II: BACKGROUND

2.1 SERVING CHILDREN IN DHS CUSTODY

Three state agencies play a leading role in serving children in DHS custody. These roles are discussed in 2.2, 2.3, and 2.4 below:

2.2 OKLAHOMA DEPARTMENT OF HUMAN SERVICES

The Oklahoma Department of Human Services (DHS) is the state agency designated to administer support- programs and services currently provided statewide in 77 county offices, including Child Welfare Services (CWS), Temporary Assistance for Needy Families (TANF), Medicaid, Supplemental Nutrition Assistance Program (SNAP), Aging Services, Developmental Disabilities Services (DDS), Child Care Services, and Child Support Services (CSS).

The DHS mission is to improve the quality of life of vulnerable Oklahomans by increasing people's ability to lead safer, healthier, more independent, and productive lives. CWS is the DHS division responsible for administering the state's child welfare services. The purpose of CWS is to improve the safety, permanence, and well-being of children and families involved in the child welfare system through collaboration with families and their communities.

Section 1-7-103 of Title 10A of the Oklahoma Statutes requires DHS to provide medical care necessary to preserve the child's health. Currently, there are approximately 9,000 children who are in out-of-home-care due to abuse, neglect, or both. The vast majority of these children rely on SoonerCare (Medicaid) fee-for-service coverage to ensure appropriate medical care and treatment. Early Periodic, Screening, Diagnosis, and Treatment (EPSDT) is used to prevent and identify conditions that may interfere with the child's natural growth and development. There are often barriers to ensuring coordinated care for these children, many of whom have experienced trauma that can ultimately impact their overall well-being. Although the goal is to keep children in their local community, it is not always possible. Movement of children in the foster care system provides a unique challenge to coordinate care with caregivers and parents. On January 4, 2012, DHS and Plaintiffs reached agreement in a long-standing federal class action lawsuit against the state of Oklahoma on behalf of children in the custody of DHS due to abuse and neglect by a parent or resource caregiver. That matter, *D.G. vs. Yarborough*, Case No. 08-CV-074, resulted in the Compromise and Settlement Agreement (CSA), which was approved by the United States District Court for the Northern District of Oklahoma on February 29, 2012. The CSA requires (Section 2.10 (a)) that DHS develop a plan setting forth “specific strategies to

improve the child welfare system.” Under the CSA, the parties identified and the court approved Eileen Crummy, Kathleen Noonan, and Kevin Ryan as “Co-Neutrals,” and charged them to evaluate and render judgment about the ongoing performance of DHS to strengthen its child welfare system to better meet the needs of vulnerable children, youth, and families. This plan, hereinafter referred to as the “Pinnacle Plan” provides a framework that must be followed when providing care to children in DHS custody.

Additional Information on DHS Health-related Procedures:

1) How health needs are identified.

Oklahoma utilizes the current Medicaid Early Periodic, Screening, Diagnosis and Treatment (EPSDT) schedule. CWS policy, Oklahoma Administrative Code (OAC) 340:75-6-88, requires EPSDT screening according to the schedule of frequency or at a minimum an annual physical exam. In addition, CWS provides as soon as practicable after the filing of the petition, an initial health screening for each child placed in DHS emergency custody, to identify any health problems that require immediate treatment, diagnose infections and communicable diseases, and evaluate injuries or other signs of abuse or neglect. Section 1-7-103 of Title 10A of the Oklahoma Statutes requires that DHS provide medical care necessary to preserve the child's health and protect the health of others in contact with the child. Each child in DHS custody is to receive:

- yearly mental health or developmental screening;
- yearly dental exam when the child is older than 3 years of age. Children younger than 3 years of age receive dental services as needed;
- immunizations initiated and kept current;
- visual and hearing evaluation exams and corrective lenses or hearing aids, when indicated;
- outpatient or inpatient behavioral mental health treatment, when appropriate;
- physician's services, when the child is sick. This service is not considered a physical exam; and
- follow-up and referral services as recommended by a qualified professional.

2) How health needs identified through screenings will be monitored and treated, including emotional trauma associated with a child's maltreatment and removal from home.

Per OAC 340:75-6-88, the CW specialist schedules initial health and developmental screenings for the child based on the needs and age of each child placed in out-of-home care. The CW specialist ensures, in coordination with the placement provider and parent, when applicable, that the child in out-of-home care receives timely needed routine and specialized medical care, including medical, dental, visual, and counseling services. Subsequently, the CW specialist coordinates with care providers routinely during the required contact with child and placement provider. Child Contact Guides, specific to age ranges, are used by the CW specialist to address the physical environment, health and safety concerns, developmental milestones, and independent living skills, when applicable, for each child in out-of-home care. When there are any resulting concerns, a plan is

developed to document any actions taken regarding risk items or concerns for child abuse or neglect.

CWS recognizes the need to become trauma-informed. In the past few years, CWS offered CW specialists training on trauma and how trauma relates to the child's behavioral, physical, and emotional health. While this training was beneficial, there remain systemic gaps in care coordination and treatment. CWS is in the fifth year of a grant, titled the Oklahoma Trauma Assessment and Service Center Collaborative (OK-TASCC). OK-TASCC is a demonstration grant through the Administration on Children, Youth and Families on the Initiative to Improve Access to Needs-Driven, Evidence-Based/Evidence-informed Mental and Behavioral Health Services in Child Welfare. The goal of this project is to improve the social and emotional well-being and restore the developmentally appropriate functioning of children and youth in the CW system that have mental and behavioral health needs through helping Oklahoma develop and implement a comprehensive, integrated, and reliable continuum of screening, assessment, and aligned service delivery.

CWS, through the OK-TASCC grant, implemented a child behavioral health screener for every child, birth through 17 years of age, who is placed in out-of-home care statewide. The screener assists in identifying behavioral health concerns, possible trauma symptoms, and the level of impairment of social function. The ultimate goal is to ensure access to effective evidence-based/evidence-informed treatments and services that are aligned with the assessed behavioral and mental health needs of infants, children and youth.

CWS, through a trauma-informed/focused approach, enhanced system-wide capacity and the sustainability of the implementation of a child behavioral health screening and assessment practice to address the multiple domains associated with well-being. The OK-TASCC project further enhanced a system-level effort in helping CW staff and leadership move forward from a trauma-informed to a trauma-responsive focus. Furthermore, the project highlights the parallel process of how the organizational culture and staff personal and professional safety and self-care has a direct link to practicing through a trauma-informed lens and ultimately well-being outcomes for children and families involved in the CW system. The very solid, existing partnerships with Oklahoma state child-serving agencies has provided a mechanism for cross-system collaboration for sustainability of the continuum of screening, assessment and aligned service delivery. As the screening and referral processes are sustained, CWS will continue to support our partners to increase access to evidence-based practices and practitioners in Oklahoma beyond the OK-TASCC project.

3) How medical information will be updated and appropriately shared, which may include developing and implementing an electronic health record.

Per OAC 340:75-6-40.2, when a child is in DHS custody and in out-of-home placement, the CW specialist provides the placement provider all known information concerning the child at the time of placement and at a minimum of every six months. In addition, placement providers are given access to the Child's

Passport, a web-based application that provides the placement provider with medical and educational records, among other case plan information, for the child/children in the provider's care. Since the development of the Child's Passport in 2010, DHS has continued to refine and enhance the application with real-time data exchanges from the Oklahoma Health Care Authority (OHCA) as the state Medicaid agency and Oklahoma State Department of Education (OSDE). Prior to 2010, medical and educational information was subject to entry by the CW specialist into KIDS; however, medical and educational information now transfer electronically with the electronic passport. The Medicaid compensable information has been available since the creation of the Child's Passport in 2010. The OSDE data was more challenging to retrieve based on specific identifiers, such as the child's free lunch identifier, that are used versus a client identification number, such as the child's Social Security number. Additionally, a memorandum of understanding was needed to execute the exchange of information between DHS and OSDE. Currently, all agreed upon information is available from OHCA and OSDE. Enhancements to the Child's Passport are realized through a partnership with the Office of Management and Enterprise Services (OMES).

Lessons learned from deploying the Child's Passport will be incorporated into Phase II enhancements planned for the next year. The re-design will make the application more user-friendly when logging on, seeking specific information, and understanding the type of information stored in the Child's Passport. As noted above, OMES is the entity tasked with any enhancements or the re-design of the Passport application. Ongoing testing resulted in approval of the agreed upon enhancements. The testing concluded with a projected release of enhancements by 12/31/2016. Weekly updates are submitted to DHS by OMES.

DHS continues to work with OHCA on enhancing the scope and detail of medical information exchanged, such as providing the pharmacy address instead of a pharmacy identification number and allowing for historical data beyond a three-year period so that when children are adopted this information can be used for disclosure. Since only the placement provider has access to the Child's Passport, the provider is encouraged to print the Passport information prior to taking the child to the health professional for review of the child's medical history and any concerns, inconsistencies, or the need for special services. On 12/18/2016, the following enhancements were realized on the Child's Passport: supplemental instructions and explanatory selections on the Passport that offer a more user-friendly website for resource providers, ultimately increasing Passport usage and reliance; and a streamlined user log-in process by matching primarily on the last name and other identifiers, which reduces name-based login errors. One main enhancement includes the presentation of the Early Periodic, Screening, Diagnosis, and Treatment (EPSDT) schedule after log-in, which is intended to remind the resource provider of scheduled screenings for the child in focus.

OHCA recently surveyed foster parents via email, netting 393 responses from over 4,000 emails sent, noting that approximately 1,500 emails were undeliverable. The responses indicate that foster families understand children in foster care are covered by SoonerCare, and that 93 percent have used their SoonerCare benefits for a well child visit-EPSDT. Of those families that used the Passport, 43 percent of those

used it to understand more about the child's health conditions, 20 percent used it to provide information to the health care provider about the child's health history, and 6 percent used it to inform the scheduling of well child visits or specialty appointments. The goal for SFY 18 is to work on a more strategic means of communications regarding the Passport, including revisions to the OHCA and DHS websites for improved linkage to Passport-related information.

4) Steps to ensure continuity of health care services, which may include establishing a medical home for every child in care.

The Fostering Hope clinic is a medical home clinic that serves children in foster care, as well as those who have achieved permanency through reunification, guardianship, or adoption. In addition, the clinics provide care for families and children who are encountering complex social challenges or are involved in prevention efforts through CWS. Fostering Hope clinics are located in Oklahoma City and Tulsa. In the summer of 2016, a foster clinic was launched in the Oklahoma City Indian Health Services clinic, with support provided by the Oklahoma City Fostering Hope clinic.

Training continues via the OHCA, ODMHSAS, and DHS staff to inform partners of the need to collaborate as a statewide system to provide continuity of coverage for children in out-of-home care. One area of focus for the next five years is to review the medical services policy and procedure. Currently, efforts are under way to clarify and shorten the accompanying medical information necessary for transporting medications from one placement to another. The Child's Passport and Placement Provider Information report are just two means for CW specialists and placement providers to ensure the continuity of services for children in custody.

The CWS nursing program began October 2014 and expanded in 2015 to include one supervisor and six nursing staff located across the state. The nurses embed within CWS offices and provide a variety of supports including case consultation, home visits, medical record review, care coordination between CW and community health and mental health services, coordination with DDS, and training of staff on a variety of medical issues. The nurses are currently engaged in a qualitative review of cases where there has been a referral of medical neglect to ensure that appropriate medical consultation is utilized in CPS decision making.

5) The oversight of prescription medicines, including protocols for the appropriate use and monitoring of psychotropic medications.

Currently, CWS is involved in assessing and monitoring the use of psychotropic medications for children in residential group homes, through a regular review meeting conducted between CWS and OHCA.

The CW nursing staff and the medical director, a pediatrician, assist caseworkers in answering medication questions. Those questions range from answering basic questions about a psychiatric diagnosis or treatment, to asking for formal reviews of medication by a psychiatrist at OHCA. Pediatric Psychiatry phone consultation is

available through OHCA when questions involve children who are in inpatient psychiatric facilities.

The DHS/OHCA/ODMHSAS/OU Department of Pharmacology workgroup developed a health improvement project proposal to improve psychotropic medication tracking and access to case review by child psychiatrists. Data matching between DHS and OHCA established some baseline population information on psychotropic medication prescribing among children and youth in foster care, as well as ensuring that children who were prescribed medication were also obtaining mental health/counseling services. Work is presently being done to create reports that can provide case/individual information about psychotropic medication. Qualitative information about psychotropic medication experiences is also being gathered through focus groups with CW staff, foster parents, inpatient and outpatient psychiatrists, and court partners. An advisory panel was developed to review the quantitative and qualitative data this effort produces and will help guide CWS on next steps. Representation from OHCA, ODMHSAS, DHS, child and adolescent psychiatry, pediatrics, and pharmacology serve on the advisory panel.

6) How the state actively consults with and involves physicians or other appropriate medical or non-medical professionals in assessing the health and well-being of children in foster care and in determining appropriate medical treatment for the children.

CWS continues to contract with a physician to provide system improvement consultation. The physician's knowledge gained from practice in this arena is invaluable to assessing the needs of this population. OHCA provided behavioral health consultations in tandem with CWS staff. These consults include routine conference calls to discuss the best means of serving children with behavioral and mental health needs that require intensive treatment. Additionally, the University of Oklahoma Child Study Center offers case consults for children with behavioral challenges. These consults are requested on an as-needed basis to determine appropriate services as well.

7) Steps to ensure that the components of the transition plan development process required under section 475(5)(H) of the Act that relate to the health care needs of youth aging out of foster care, including the requirements to include options for health insurance, information about a health care power of attorney, health care proxy, or other similar document recognized under state law, and to provide the child with the option to execute such a document, are met.

Several steps are embedded in the CW Practice Model policy that guide CW specialists in assisting youth aging out of foster care with transitioning health-related care. A family team meeting (FTM) is held 120-calendar days prior to a youth aging out of foster care. During the FTM, the youth and supporting adults initiate the youth's My Transition Plan that includes discussion around the 7 Key Elements of Success, with health as one of the elements. The youth is provided a brochure, Congrats! You're 18!, that covers three topics. The first topic is Medicaid options for health insurance that includes the website where the youth, who is 18

years of age, can go to complete an application for Medicaid coverage. The second and third topics focus on the options of executing an advanced directive. The youth can decide whether to receive life-sustaining treatment; select a person to serve as the youth's "health care proxy," and decide to donate the youth's organs. The youth is also referred to a website that provides more detailed information on the advanced directive. A video is available for viewing and copies of the documents are available online. As the youth completes the My Transition Plan, the youth verifies the receipt of the Congrats! You're 18! brochure and whether the youth has executed an advanced directive. DHS and OHCA continue to coordinate extended coverage options for youth who age out of foster care. One of the lessons learned is the need to provide a variety of options to message transition planning and how to impart health care information that requires action on the youth's part. The Oklahoma Successful Adulthood (OKSA) website offers such an option. CWS is continuously working with the Successful Adulthood contractor to develop and improve message delivery to youth who can benefit from health care services.

Role of Targeted Case Management – DHS/CW

Oklahoma's Medicaid State Plan was amended August 1, 1997 to include Targeted Case Management (TCM). Under the plan, the Oklahoma Department of Human Services (OKDHS) is designated as a TCM provider for children under the age of 18 who are in the voluntary, emergency, temporary, or permanent custody of OKDHS and who are in out-of-home care or trial adoption. Specific TCM services are those that assist these children to access needed medical, educational, social, and other services. The Child Welfare (CW) worker:

- (1) selects TCM services when completing the child's placement plan; [[OAC 340:75 6-40.1](#)]
- (2) provides TCM services during contacts with the child or with other persons on behalf of the child; and [[OAC 340:75-6-48](#)]
- (3) documents TCM services on the KIDS Contacts screen. [[OAC 340:75-6-40.6](#)]

2.3 OKLAHOMA HEALTH CARE AUTHORITY

OHCA is the single state Medicaid agency and administers SoonerCare. Medicaid provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. Medicaid is administered by states, according to federal requirements. The program is funded jointly by states and the federal government. Medicaid is administered at the federal level by the Centers for Medicare and Medicaid Services (CMS) within the Department of Health and Human Services (HHS). CMS establishes and monitors certain requirements concerning funding, eligibility standards and quality and scope of medical services. States have the flexibility to determine some aspects of their own programs, such as setting provider reimbursement rates and the broadening of the eligibility requirements and benefits offered within certain federal parameters.

In Oklahoma, children who are in the custody of DHS are eligible for full-scope SoonerCare coverage in the Fee-for-Service delivery system. These children receive all services for children that are covered in the Oklahoma Medicaid State Plan.

2.4 OKLAHOMA DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES (ODMHSAS)

This department is the Single State Agency for Substance Abuse and the State Mental Health Authority. ODMHSAS provides inpatient and community-based mental health and substance use disorder treatment services statewide through a network of state owned/operated and contracted providers including psychiatric hospital services, community mental health centers, crisis intervention centers and alcohol and drug treatment programs. In addition to credentialing certain behavioral health providers, the department is instrumental in shaping behavioral health policy for SoonerCare. In 2015, ODMHSAS implemented SoonerCare Behavioral Health Homes for adults with Serious Mental Illness and children with Serious Emotional Disturbance. However, due to concerns raised by the Centers for Medicare and Medicaid Services about preventing duplicative reimbursement, children in the custody of DHS have not been enrolled in Health Homes for Children. In 2017, ODMHSAS implemented a Certified Community Behavioral Health Clinics pilot using three community mental health center sites throughout the state. These CCBHC sites are responsible for directly providing nine required types of behavioral health treatment services, with an emphasis on the provision of 24-hour crisis care, utilization of evidence based practices, care coordination, and integration with physical health. ODMHSAS certifies and monitors the Health Homes and Certified Community Behavioral Health Clinics. They are required to utilize best practices in describing psychotropic medications. This includes working to decrease the number of psychotropic medications that may have been prescribed for a child in the past, once they are admitted to services, if they have been receiving three or more. This also includes integrating with primary care to ensure contra-indicated prescribing across disciplines does not occur.

In the spring of 2014, DHS and ODMHSAS Oklahoma Systems of Care (OKSOC) began working together to promote a trauma-informed child- and family-serving system as a way to reduce the number of children going into state custody; to reduce the number of children with disrupted placements; and to provide safe, stable, and less restrictive placements. DHS and ODMHSAS collaborated with family advocacy organizations and community stakeholders to expand crisis and response capacity to improve outcomes and provide supports for children and youth. Enhanced community connections were deemed especially important to these efforts. This project, known as Communities of Care (CoC), began in DHS Region 4 which encompasses most of the southeastern quadrant of the state and is the region with the highest percentage of youth in DHS custody.

Additionally, since January of 2015, ODMHSAS has partnered with DHS to employ five Mental Health Consultants (MHCs) and one supervisor who office out of ODMHSAS' central office in Oklahoma City. All of the consultants are licensed professionals in mental health and substance abuse within the state of Oklahoma. They provide case consultation regarding infants, children, youth, adults and families involved with Oklahoma Department of Human Services and the Child Welfare System. The roles of the mental health consultants are to make recommendations to Child Welfare Staff for the purpose of positively impacting the social, mental and emotional well-being of children in state's custody. MHCs help to foster a positive attitude toward mental health and substance abuse, empower the child welfare workers, and enhance services and supports.

2.5 MORE INFORMATION

For additional information, please refer to the posting on the OHCA website where a library of additional relevant documents has been compiled for optional reading.

SECTION III: RFI INFORMATION AND QUESTIONS

3.1 GENERAL RFI INFORMATION

OHCA has been directed by SB773 to conduct an RFI and develop a report to be delivered to the President Pro Tempore of the Oklahoma State Senate, the Speaker of the Oklahoma House of Representatives and the Governor. RFI responses will be used to develop this report and provide an accurate representation of potential Care Coordination models for children in DHS custody. OHCA understands there may be a variety of Care Coordination models, and we encourage respondents to provide us with any information that can help us to develop a comprehensive summary as required by SB773. Respondents may present one or several models in responding to this RFI.

3.2 SCOPE OF WORK

Respondents are asked to propose Care Coordination models for Oklahoma children in DHS custody and address the outline below:

- A. High-Level description of the recommended Patient-Centered service delivery Care Coordination models
 1. Name and describe Respondents chosen models including reason for selecting the models
 2. Describe how the models address the needs of the target population
 3. Explain how Respondents have approached implementation of the models

- B. Access to Health Services
 1. Describe how your care coordination models would ensure that children in care and their families can access needed health services?
 - a. Behavior Health Services?
 - b. Medical Care?
 - c. Dental?
 2. How would you use a care coordination model to include children in care as enrollees of Health Homes?

- C. Staff/Provider Network
 1. Describe, if applicable, how staff and/or provider network recruitment and retention, including types of providers (*for example primary care, specialty care, dental, HCBS, case/care management, LTC, other, etc.*) are addressed.

- D. Payment Structure
 1. Explain payment methodology, assumptions, and constraints related to the care coordination models
 - a. Specific to covered benefits and services
 - b. Specific to other benefits and services
 - c. Show estimated amounts of provider payments for evidence-based performance outcomes (*for example amounts of withholds, performance payments based on quality metrics, etc.*)

2. How does your Care Coordination model address potential CMS concerns regarding duplication of care/payment? Explain how proposed payments comply with existing and proposed Federal and State requirements.
- E. Impact of Model
1. Explain estimated implementation costs and anticipated savings, for the first five years of an implementation of your model.
 - a. Methodology
 - b. Assumptions
 - c. Constraints
 2. Describe the quality and anticipated effect of the care coordination models on the target population with respect to the following.
 - a. CMS recommended benchmarks
 - b. State identified areas including preventive screenings, tobacco cessation, obesity, immunizations, diabetes, hypertension, prescription drug use, hospitalizations, readmissions, emergency room use
 - c. Core measures identified within the Oklahoma Health Plan (OHIP) 2020
 - d. Respondent suggestions for other benchmarks
 - e. Considerations for Value-Based performance designs, specifically those that support and align with objectives identified within the Oklahoma State Innovation Model design
- F. Data Management
1. How does your care coordination model provide for efficient management of data to ensure that the child experiences quality and safety?
- G. Care Coordination Implementation Timelines *(including key activities and milestones)*
1. Based on prior experience, provide insight into what a realistic timeline for implementation of your Care Coordination model might be. Specifically, provide details into the following aspects of implementation of a Care Coordination model similar to what has been described:
 - a. Development
 - b. Transition/Readiness Activities
 - c. Implementation of member enrollment
 - d. Implementation of member service delivery

SECTION IV: RESPONSES

4.1 RESPONSE FORMAT

- A. Respondents are encouraged to provide all requested information to ensure that their response is most useful to OHCA.
- B. Respondents must complete the Cover Page .available on the OHCA website with this RFI
- C. The entire Scope of Work response (As listed in Section 3.3) will not exceed a 50 page limit. Any items over the 50 pages will not be reviewed.

4.2 COST OF PREPARING RESPONSES

- A. All costs incurred by the Respondent for response preparation and participation in this informative process will be the sole responsibility of the Respondent. The State will not reimburse any Respondent for any such costs.
- B. The State reserves the right to withdraw the RFI at any time during this process. Issuance of this RFI in no way obligates the State to award or issue a contract or to pay any costs incurred by any Respondent as a result of such a withdrawal.

4.3 RETENTION OF RESPONSES

- A. Unless otherwise specified in the Oklahoma Open Records Act, Central Purchasing Act, or other applicable law, documents and information a respondent submits are public records and subject to disclosure.
- B. No requests for information to be marked proprietary or confidential will be accepted.

SECTION V: VENDOR PRESENTATIONS

- A. Based on RFI responses, OHCA reserves the right to invite some Respondents to make oral presentations about their programs, capabilities, and approaches to OHCA staff. OHCA may also request telephone interviews with key personnel at the Respondent's organization in addition to or in lieu of a presentation.
- B. Only Respondents who submit complete responses by Thursday, October 12, 2017 will be considered for presentations. OHCA appreciates all responses and may review incomplete responses or those received after the deadline at its discretion.

RFI Questions – Part I

(Gerald & Melinda will address questions in red)

1. How is Care Coordination defined by each agency?
Each agency is interested in learning about the care coordination models proposed by subject matter experts in the responses. We are open to input from respondents.
2. Could you please define the desired outcome of successful Care Coordination or what success looks like?
For purposes of this RFI, we are interested in the definitions of success that the care coordination model experts will propose.
3. How would you prioritize outcomes, such as:
 - a. services or comprehensive services;
 - b. access;
 - c. reduced cost; and
 - d. improved quality?**We don't have specific outcome priorities in mind and are interested in the priorities that the care coordination models experts will present.**
4. Could you please provide the total number of DSHS clients?
9080 children in care
5. Could you please provide a map of the distribution of potential DSHS clients?
The attached map indicates 5 regions for CWS. Each region has a range of 1600 to 2000 plus children in out-of-home care. Region 5 has the highest number in out-of-home care with over 2000.
6. Could you please provide the number of DSHS clients in traditional foster care?
3125 in traditional foster care plus 3386 in kinship foster care.
7. Could you please provide the number of DSHS clients in special foster homes or DDS group homes?
Specialized foster care and agency companion homes serve 28 children, while DDS group homes serve a maximum of 32 children.
8. Could you please provide the number of DSHS clients in in therapeutic foster homes?
272 in TFC
9. Could you please provide the age distribution of DHS clients in each of the above categories?
This information is not available.
10. Is the preferred model global (all services and Care Coordination provided to this population) or care coordination-only focused?
The State does not have a preferred model, and is interested in the possible models that care coordination experts will suggest.
11. Does this RFI seek to replicate another State's successful model, and if so, could you please provide the State and model?
The State is not seeking to replicate another State's successful model, but is seeking solutions and recommendations that may be beneficial for Oklahoma children served in DHS custody.
12. Could you please clarify the dual payment concern referenced within Section 3.2.D.2, page 10?
In some instances, CMS will not approve programs or payments that are considered duplicative of other targeted case management efforts.
13. Could you please provide the proportion of this population currently receiving services from an FQHC, and by FQHC?
This information is not available.

14. Could you please provide the proportion of this population currently receiving services from care coordination programs, such as HAN, Telligen or another?

This population is not currently receiving care coordination program services other than Targeted Case Management furnished by DHS.

15. Could you please provide the costs of all care, including care coordination and medical, in terms of:

- a. total annual cost; and
- b. average cost per beneficiary?

See the OHCA 2016 Annual Report, pages 74 and 75, as found in the RFI Bidders Library.

16. Could you please provide the number of:

- a. minors whose costs fall 2 standard deviations above the mean currently; and
- b. minors whose costs fall 2 standard deviations above the mean in 2015 and 2016?

This information is not available.

17. Could you please provide this population's current levels of quality indicators for:

- a. immunizations;
- b. diabetes;
- c. hypertension;
- d. prescription drug use;
- e. hospitalizations;
- f. readmissions;
- g. emergency room use; and
- h. any others?

This information is not available.

18. RFI Section 3.2.E.1 says, "Explain estimated implementation costs and anticipated savings, for the first five years of an implementation of your model." To be able to better estimate savings, can the State provide the current PMPM, program, and administrative costs for the services described in the RFI?

This information is not available, as additional care coordination services are not being provided.

19. What are the anticipated savings for this program?

This information is not available.

20. Has the State established regions to which children are linked? If so, please provide details.

The five regions are designated in the map in Attachment X.

21. Please provide counts of children in custody that are placed in different levels of foster care, residential care, distribution across the state, and whether they are in-state versus out-of-state.

3125 in traditional foster care; 3386 in kinship foster care; 200 in other foster family care, including tribal and DDS homes; 272 in therapeutic foster care; 936 in trial reunification (returned to own home), 1,161 in other placements, including shelters, group homes, and treatment facilities.

22. Is out-of-state care permitted?

Out-of-state care is through the Interstate Compact on Placement of Children unless the purpose is for treatment services in another state. The OK Health Care Authority manages contracts for out-of-state psychological treatment services.

23. Please provide access to de-identified claims data for this population.

This information is not available.

24. Is it the intent of the State to contract for an at risk solution with a vendor to manage these children/population?

The State has not been directed to prepare to contract with any vendor to manage these children/this population.

25. How many full time equivalents (FTEs) are supporting the current model, listed by their role?

This information is not available.

26. Would the selected vendor be responsible for payment to providers? Or will that be handled by a third party?

We are interested in learning from the subject matter experts what payment models are recommended.

27. Please provide clarity on what the State is expecting to be demonstrated in the November 6-10 meetings. How long does the State anticipate each vendor's meeting will last?

The State would anticipate that invited experts would give brief presentations of the proposed models, and be responsive to questions. Such meetings can be arranged to occur in person or via teleconferencing, based on the preferences of the invited vendors.

28. RFI Section IV, 4.1.C says, "The entire Scope of Work response (As listed in Section 3.3) will not exceed a 50 page limit." The RFI does not have a Section 3.3. It does, however, have a Section 3.2, Scope of Work; is Section 3.2 the correct reference?

This has been reviewed and corrected in the revised RFI posted on our website.

***NOTE: The DHS CWS data are point in time data. The numbers shared are only intended to give guidance on the approximation of services needed as of Oct. 1, 2017.**

	Aetna Better Health of Oklahoma	Amerigroup Oklahoma	Molina Medicaid Solutions	Oklahoma Complete Health/Centene	Patient Care Network of Oklahoma	Telligen	United Healthcare Community & State	WellCare of Oklahoma
Model	Full Risk-Based MCO for specialized population, on a foundation of statewide MCO service delivery	Single full-risk based MCO for specialized population, on a foundation of statewide MCO service delivery	Professional services contract for coordinated care, with possible QIO match for utilization management	Sole source statewide MCO program; highly integrated wraparound model of service management/coordination. Foster Care Service Delivery model organized in four tiers.	Professional services contract for enhanced patient-centered medical home model; operated within statewide FQHC network	Professional services contract for Health Management Program for children with a single vendor. Includes personal care coordination and health coaching.	Fully capitated, risk-based statewide single vendor MCO OR partial-risk care coordination approach that, over time, increases the level of risk to the coordination entity to a full-risk model	Defer to larger statewide MCO procurement, then add the DHS custody population. Community Advocacy program to identify social safety net barriers and gaps and work at both the individual and community levels to bridge those gaps.
Experience	Dedicated, national implementation team. 12,000 providers in OK. Arizona foster care service delivery system	Parent company: Anthem Affiliate health plans serve nearly 58,000 youth in child welfare systems across 10 states and has 17 years' experience.	Parent company: Molina Healthcare	9 years, 135,000+ current members in care coordination models for children in state custody. Health plan serves as sole source child welfare health plan in FL, IL, TX, and WA. Active as affiliate or plan option in 7 other states.	Network formed in 2015 and contains 19 members (Community Health Centers & designated FQHCs). Operates over 90 sites statewide with 80% of Oklahomans living within a 30 min. drive from one.	Partnered with OHCA since 2008 on HMP. Saved state more than \$250 million with combined health coaching and practice facilitation	MCO which serves 6.4 million members across 26 states	WellCare Health Plans, Inc. has 30 years' experience serving 2.8 million Medicaid members and 1.5 million Medicare members including children in foster care. Operates Medicaid managed care programs in 11 states

Financing	Actuarially certified rates	Actuarially certified rates	Administrative fee basis	Open to discussions with state to customize based on approach.	Either fee-for-service at regionalized prospective payment system rates plus an additional per member/per month care coordination payment + shared savings payment OR capitation for all FQHC services	Either a fixed monthly payment for a defined scope of work OR a performance based payment model in which the vendor receives a fixed payment amount for care coordination that would increase as more children and families are engaged. Willing to a pilot.	Actuarially certified rates	Actuarially certified rates
Preventing Duplication	Differentiate services from state child welfare workers; single view of all services	Utilize smart assignments (don't assign to multiple programs). Outline clear responsibilities in areas of potential duplication.	Continue fee-for-service as in place today	Care coordination reduces duplication and redundancy of services. Will collaborate with state.	Care coordination PCMHs eliminate duplication	Those eligible for Health Homes could still be served by CMHCs. Coordinate services to prevent duplication.	Leveraging an MCO model will drive transparency and eliminate overlap	Use care coordination, collaboration with community partners and data sources within IEP to prevent duplication

3.2 Scope of Work

- A. High-Level description of the recommended Patient-Centered service delivery Care Coordination models
 - 1. Name and describe Respondents chosen models including reason for selecting the models
 - 2. Describe how the models address the needs of the target population
 - 3. Explain how Respondents have approached implementation of the models

Aetna recognizes the extraordinary challenges unique to foster care children and the reality that they require our unwavering commitment, collaboration, and compassion. Children in state custody are among the most vulnerable individuals in our society, often facing significant risks that are a combination of physical, behavioral, social, and/or cultural conditions.

Our comprehensive, holistic care approach simplifies communication with children and their families, while aligning our care teams with each child’s health goals. Along with enrollees and their families, our integrated care teams create holistic care plans focused on evidence-based best practices, trauma-informed care, and social determinants of health that result in a positive impact on each child’s life. In partnership with the Oklahoma Department of Health Services (ODHS) to achieve safety and permanency for children, we address the effects of trauma and focus services on the family, both of which are essential to the effectiveness of our patient-centered, integrated care management.

The multiple complexities of children in the custody of child welfare and foster care must be considered in the care planning process. Foster children* may have multiple caregivers, guardians, decision-makers, formal and informal supports, and treatment professionals, depending upon their individual needs, placement stability, or legal circumstances. Within Aetna’s integrated care management model, all caregivers, foster parents, biological family members (whose rights have not been severed), guardians, and formal and informal supports are considered an integral part of the child’s well-being. As a result, they are encouraged to participate in the care planning process. Oklahoma uses the term Family Team to describe the planning process for foster care children which includes the child, guardians, custodians, caregivers, biological parents, foster parents, medical and behavioral health professionals, advocates, informal supports, formal supports, child welfare specialists, and any other person involved in the child’s life. Aetna’s integrated care approach includes all critical members of the child’s Family Team. **Throughout this document, Aetna uses the term foster child/children to represent both children in foster care and children in the custody of Oklahoma Child Welfare Services.*

A.1. Name and describe Respondent’s chosen model including reason for selecting the model

Meeting each enrollee’s needs within a managed care organization is dependent upon a fully integrated system of care that addresses the health disparities, medical, developmental, and biopsychosocial needs of the populations it serves. Use of an integrated care model for a foster

care population affords the highest quality of services in settings of the Family Team’s choice, while managing costs, enhancing care for complex conditions, and reducing unnecessary and expensive admissions. A managed care approach results in measurable improvements in health outcomes and program savings by:

- Offering budget predictability
- Controlling rising costs by reducing duplicate and unnecessary services
- Supporting person-centered, coordinated care through a fully integrated approach that integrates care for all enrollee-facing services—including physical health, behavioral health, pharmacy, and transportation—and results in improved health outcomes and lower costs
- Requiring contracted managed care organizations to contract with and manage a comprehensive network of medical, pharmacy, behavioral health, and dental providers, including inpatient care and home and community-based services providers, along with other nontraditional providers
- Increasing use of wellness and preventive services
- Attending to care transitions to maintain continuity of care and services
- Implementing health equity programs to provide culturally competent care that recognizes the unique backgrounds and cultures of our enrollees

We use an integrated care model because Aetna recognizes that wellness is more than just physical health. The ability to achieve wellness is directly associated with the interaction between the mind and body and the impact of environmental factors and cultural beliefs. Aetna’s holistic, person-centered model is a collaborative approach composed of biopsychosocial assessments, care planning, facilitation, care coordination, evaluation, and advocacy designed to meet our enrollees’ complex care needs. We use evidence-based practices and national chronic care guidelines, and address social determinants of health as part of our approach. Care managers actively partner with enrollees and their families in health awareness, self-advocacy, health literacy, and health promotion activities to empower them to participate in their own health care through improved access. Aetna’s integrated care management approach is proven effective at improving the timeliness, quality, and effectiveness of health care service delivery for children in other states. Furthermore, it directly aligns with the ODHS’s mission to improve the quality of life for vulnerable Oklahomans.

Different service providers, agencies, and organizations work in tandem effectively whenever there is a mutual understanding of and commitment to one another’s roles and responsibilities. As a result, our fully integrated care management model assures the right resources are available, organized, and coordinated to enable enrollees to achieve goals that matter the most to them and their families. We want enrollees to live in the least restrictive and most integrated and supportive environment compatible with their preferences, treatment efficacy, and safety. This minimizes preventable use of high-intensity, high-cost health services such as inpatient hospitalization or residential facilities, and increases stability in family-based placements.

The following elements comprise Aetna’s integrated care management approach:

- Availability and access to a broad, flexible array of effective, community-based services and supports for children and their families that address their emotional, social, educational, and physical needs, including covered and other services, as well as sustaining natural and informal supports
- Individualized services informed by the unique potential and needs of each child and his or her family, guided by a strengths-based, wraparound service planning process and a service plan developed in true partnership with the enrollee and his or her family
- Engagement with enrollees, while recognizing their strengths and capacities when addressing their physical, behavioral, environmental, and psycho-social needs in a culturally competent manner
- Collaboration with enrollees and their families in all aspects of the planning and delivery of services, and in the policies and procedures that govern the care they receive in their communities
- Face-to-face care coordination through a local, community-based plan in concert with the most effective technology-enabled, evidence-based systems and appropriate services and supports to create optimal health outcomes and enhanced quality of life
- Addresses social determinants of health, while providing care management, services, and supports
- Individualized care management and service delivery based on a comprehensive assessment of each enrollee’s needs and goals delivered by an extensive network of high-performing, qualified, traditional and non-traditional providers
- Integration of services at the system level recognizing the linkages across administrative and funding mechanisms
- Integration of services at the community level with linkages across school, faith-based, and advocacy organizations
- Care management at the physician practice level to help ensure multiple services are delivered in a coordinated and therapeutic manner, and that enrollees and their families can move through the system of services in accordance with their changing needs
- Incorporation of accountability and quality improvement mechanisms to track, monitor, and manage the achievement of care goals at the system, practice, and family levels
- Where appropriate or requested, make care managers available to support the State case managers and the enrollee and their biological or foster family with reunification or adoption

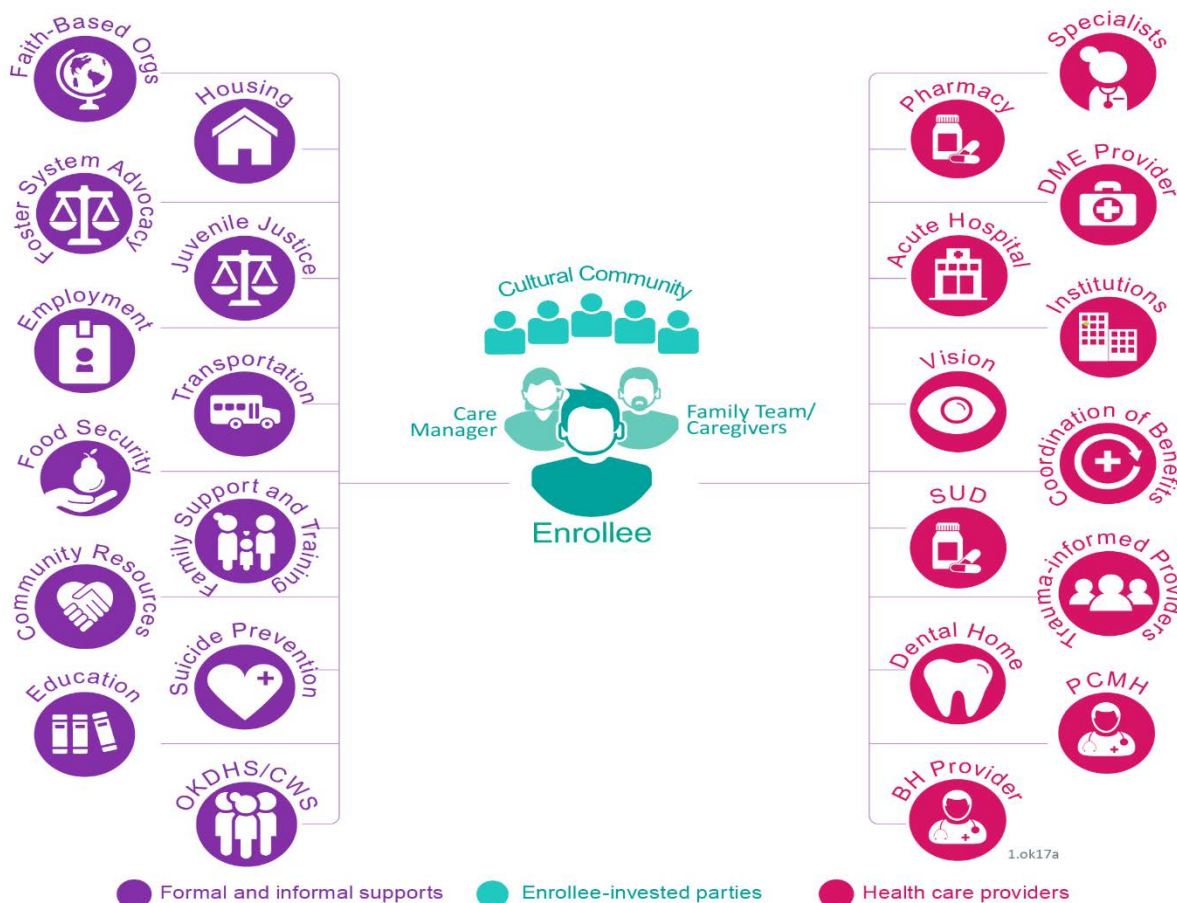


Figure 3.2-1; Aetna’s Integrated Care Management Model

Our person-centered approach to integrated care planning considers all supports to assist enrollees in reaching their individual goals.

Over the past several years, Oklahoma has made tremendous progress in transforming the landscape of children’s welfare. According to Oklahoma’s Pinnacle Plan 2017 fiscal year report, opportunities for further strides in achieving children’s permanency and stability remain. Aetna’s integrated care management approach addresses the barriers that impact a child’s well-being and supports Oklahoma’s Pinnacle Plan to increase stability and permanency for children, provide support to family and caregivers, and increase children’s access to treatment services.

Aetna’s integrated care management model is best utilized as part of a fully capitated managed care delivery system for all Medicaid populations. A fully capitated managed care model offers all Medicaid enrollees the highest quality of services in settings of their choice, manages costs, reduces unnecessary and expensive facility admissions, and emphasizes preventive care and wellness. For enrollees with complex needs and conditions, such as foster care children, a managed care approach provides much-needed coordination of services and programs by assigning that responsibility to the Managed care organization. The managed care plan has the information about an enrollee’s services that can be used to inform care coordination and identify unmet medical, behavioral or social needs. If all Medicaid consumers were served by a managed

care model, children and their families would have access to a broad, statewide provider network and a central care management system that will follow them as they age out or move from one program to another. The flexibility and coordination between providers and community-based services resulting from a managed care approach are ideally suited to serve Oklahoma's vulnerable Medicaid enrollees, including foster care children.

Screening and Assessment

A standardized, comprehensive risk assessment for all enrollees is necessary to garner information that can be used to develop a person-centered care plan that reflects the individual goals and strengths of each enrollee and his or her family. Furthermore, periodic re-assessments guide and adjust resource allocation, an enrollee's care or support level, and the ratio of care managers to enrollees.

Aetna employs an interdisciplinary care team comprised of experienced registered nurses and behavioral health professionals who are fully trained to assess the biopsychosocial profile of each enrollee we serve. Aetna's care managers have specialized training to ensure full understanding of the needs of foster care children. Our team members complete advanced coursework on trauma-informed care, mental health first aid, youth-in-care services, social determinants of health, and permanency planning.

Our care managers collaborate with case workers assigned by the State's Child Welfare Services and all members of the child's family to help to ensure children receive the services and supports necessary to achieve their care plan goals. This includes collaboration with our medical providers, behavioral health providers, specialty care providers, foster care and specialized foster care providers, legal representatives, community-based care managers, community services, and advocacy organizations.

All children receive a comprehensive assessment to determine their health care needs. Aetna's care managers contact each child and his or her family to complete the comprehensive assessment with the child and family either telephonically or face-to-face. Aetna meets the enrollee where they are by working with the guardian or foster parent in the same capacity as we would a biological parent. Aetna care managers work closely with State agencies to coordinate enrollee care, regardless of the living situation, to ensure all parties responsible for the child's care are involved. Whenever necessary, we complete multiple sessions to complete the assessment and help to ensure it is person-centered and driven by the child and family's individual needs. The assessment gathers information about the child's physical and behavioral health, family relationships, social and community supports, education, cultural preferences, strengths, interests, social determinants of health, and other environmental factors influencing their current functioning. We use active listening and motivational interviewing techniques to engage enrollees and their families in determining their care plan goals.

One of Oklahoma Health Care Authority's objectives includes ensuring children within the child welfare system have access to clinically appropriate health care services. Aetna's care managers use multiple clinical and assessment tools to ensure a deep understanding of what each enrollee's needs are from a medical, behavioral, social, functional, and cognitive standpoint, including

dental and vision assessments. This includes a health risk assessment and behavioral health screening tools including the Patient Health Questionnaire-Adolescents (PHQ-A) for depression, the Pediatric Symptom Checklist-17 (PSC-17), and the CRAFFT for substance use. Other specialty assessment tools are used to understand the child's level of trauma such as the Adverse Childhood Experiences (ACE) and the Trauma Symptom Checklist (TSC). Care managers collaborate with service providers to collect existing information to ensure assessment information is comprehensive and reflects social determinants of health.

Additionally, enrollees are stratified into levels of acuity for care management based on the information gathered through assessment activities to focus on biopsychosocial complexity and intensity of needs that impact stability, permanency, and well-being. For children in the Child Welfare system, stratification will be based on assessment of social and environmental factors, information gathered from collaboration among care team members as well as the enrollee's self-reported conditions and health care utilization, such as emergency department encounters or hospital utilization.

Individualized, Comprehensive Care Planning

Every enrollee's right to self-determination is paramount in a person-centered planning and care management approach. In our view, the enrollees and their families are the experts and the principal voices in determining preferences and goals. Our role is to serve as advocates, to help the enrollee discover what is truly important to him or her. By supporting each enrollee this way, we are helping to shape a life plan, as opposed to simply a care plan; therefore, each enrollee's plan must be tailored to specifically meet his or her goals, needs, and preferences.

Person-centered planning improves quality of life and helps enrollees reach their physical, cognitive, psychosocial, and behavioral health goals. Our enrollees, their families, and their preferred support systems all assemble as part of the interdisciplinary care team to articulate their values, beliefs, preferences, and priorities. The team collaborates to develop a comprehensive, holistic individualized care plan that expresses how the enrollee's assessed and articulated goals, needs, and preferences are met.

Each enrollee's integrated care plan is developed, evaluated, and updated through ongoing engagement with the child, his or her birth and foster family, his or her care manager, and the interdisciplinary care team. The care manager continually works with the team to identify the root causes affecting the enrollee's health and eliminate the barriers to care. Our integrated, person- and family-centered approach to developing individual care plans and care coordination align with Oklahoma's system of care model and reflects our belief that fully integrated care management must address each enrollee's biopsychosocial needs in a holistic manner that reflects an individual continuum of acute and chronic needs.

The resulting care plan articulates assessment findings, short- and long-term goals, service needs, and youth and family preferences. We incorporate all relevant information that affects the child's health including services the child is currently receiving, services the child is not receiving but which may be beneficial, the plan for integrating and providing those services, the goals of services and treatments, the child and family's priorities, and the roles and responsibilities of

each member of the team. The care plan also considers school-based information and child welfare plans resulting in a comprehensive roadmap that addresses all aspects of the child's needs. Enrollees facing complex issues are less likely to respond to standard care and are best served by programs and clinical settings that meet their needs in a truly comprehensive manner. Our fully integrated care management approach accomplishes this objective by integrating physical and behavioral health, addressing social determinants of health, and minimizing the complexity and fragmentation of services.

The following are common, key elements of individual care plans for vulnerable children:

- Collaboration with schools to ensure we are fully supporting a child's Individualized Education Plan (IEP) and addressing any gaps in care that support both the school and the child
- Referrals to Head Start for children under the age of five for enhancement of the child's cognitive, social, and emotional development
- Monitoring and tracking all enrollee care and service providers to ensure service continuity and prevent placement disruptions and addressing barriers that may impact permanency
- Collaboration with the primary care physician, foster parents, and others to ensure timely completion of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, including well child visits, dental visits, and immunizations
- Family and care giver support to ensure the foster parents have access to the needed services and information necessary to ensure each child receives the care they need and so they can make informed decisions on behalf of the children they care for

We respect the enrollee's personal story and take the time to listen intently so that we can identify his or her individual needs, preferences, and objectives, as well as connect his or her values to healthy behavior change. The care manager provides information and education as the enrollee needs it and does so in a culturally sensitive manner that considers the enrollee's health literacy. Our goal is to promote improved health literacy and encourage self-management of health conditions whenever possible. Individual care plans also include the prioritization of goals that consider the child and family's needs, along with goals, preferences, culture, abilities, and the desired level of involvement in the care plan.

Connected and Integrated Solutions through CareUnify

CareUnify™, our proprietary population health management information platform, is designed to deliver actionable data to our provider and community service providers to support their care management and care coordination efforts. CareUnify aggregates data from multiple sources including electronic health records (EHR), health information exchanges such as My Health Access Network and Child Passport, and sources such as public health departments to create an individually tailored enrollee profile. The system is designed to seamlessly interface and exchange data from various systems creating specific enrollee and panel dashboard views for each member of the integrated care team. CareUnify provides a longitudinal care record combining key data points such as claims, clinical, behavioral and social data to give a true 360-degree view of each enrollee in real or near-real time. System features include the ability to show all visit history, cost and utilization information, gaps in care, a shared care plan, admission,

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3.2 Scope of Work

discharge and transfer information, medications lists, as well as assessments. CareUnify creates a single unified view of each enrollee where the integrated care team can coordinate care and services on the platform.

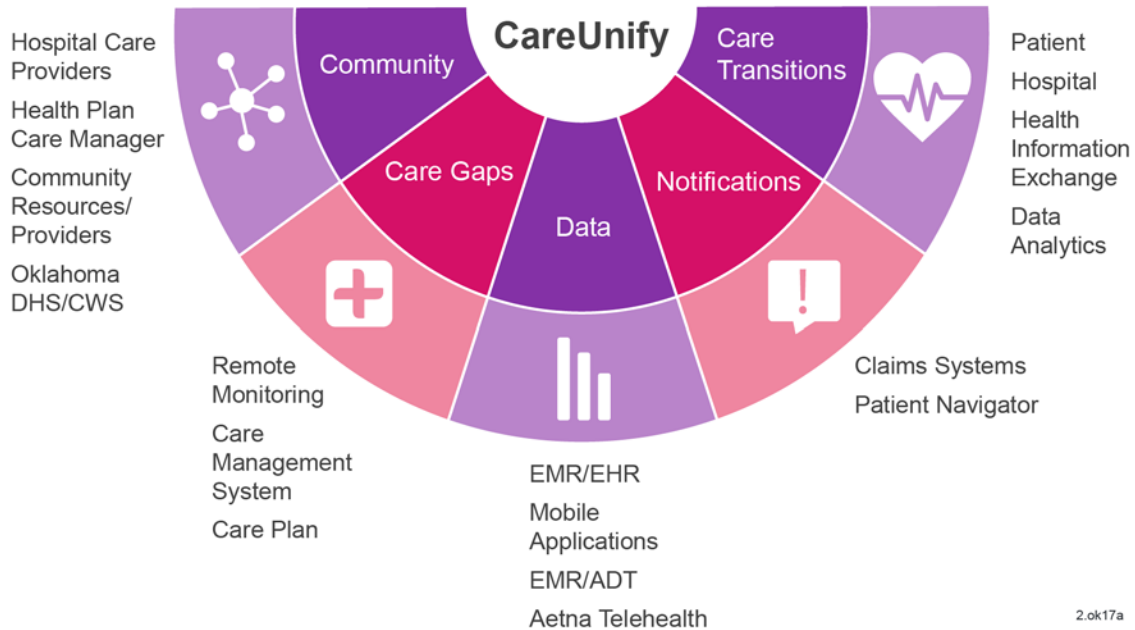


Figure 3.2-2; Aetna’s External Electronic Care Management Component, CareUnify
CareUnify is a versatile outward-facing tool that connects the entire community of health care and resource providers that surround an individual enrollee or group of enrollees.

The system can also support care coordination for members of the integrated care team that may be using different EHR or other documentation systems through the use of care paths. CareUnify’s care paths can be tailored to each provider’s workflow while allowing all participants of the care team, regardless of their system, to be aligned on workflow tied to each enrollee’s episode of care, providing clearer hand-offs and ensuring all aspects of an enrollee’s care are met. CareUnify captures data around social determinants of health and creating real-time enrollee alerts for our care managers. For example, we can address high-risk ZIP codes where families experience housing instability and food insecurity, and where foster care children often face educational barriers.

The following examples illustrate the ways in which Aetna uses CareUnify to promote collaboration between providers:

- Care paths for transitions of care from behavioral health inpatient settings that include a PHQ-A administration
- Care paths to engage with enrollees who have opioid use and medically complex medical issues
- Care path for enrollees to coordinate care after discharged from an inpatient admission



By having all the key enrollee information available in one place, we are able to facilitate timelier and effectively care coordination with and on behalf of the child, their family and their extended support system.

Engaging and Supporting Families

Our care managers recognize that most complex medical, behavioral health, and social issues do not occur in silos and are best addressed by involving the entire family, care providers, and the extended circle of formal and informal support. Aetna's care managers join the child and his or her family members in developing a Family Team wherein the care manager serves as the single point of contact and communication hub. In collaboration with the family, we work to build a trusting relationship that provides optimal support to the child, including covered and community services that align with a wraparound model and address social determinants of health. This often includes the use of family support partners who provide support to foster and biological parents through their unique, lived experience perspectives.

Aetna empowers families to coordinate services and make sure their children receive the care they need through the following:

- Collaboration with discharge planners at inpatient facilities
- Collaboration with State and child welfare departments
- Facilitation of the delivery of family support services for stability and prevention of possible disruption of the child's home
- Initiation of family support services for the biological family with the goal of repatriating the child and adolescent if indicated in the child welfare plan
- Assurance delivery of services is within the least restrictive, most normative environment that is clinically appropriate
- Assurance all members of the child's family are full partners in the planning and delivery of services
- Assurance the policies and procedures that govern the care that families receive includes their voice at all levels of our system, community, State, territory, tribe, and nation
- Facilitation of a smooth transition to adulthood and to the adult service system, if needed
- Establishment of an enrollee advisory committee focused on the foster care population which supports and provides bi-directional communication between Aetna and our enrollees and their families
- Access to 24-hour crisis support services so children and their families can adequately mitigate crisis situations
- Referrals for respite services essential to addressing family and caregiver burnout
- Support reunification and regular visits with the biological parents where safe, appropriate and agreed upon as a goal for the child

A.2. Describe how the models address the needs of the target population

Aetna is committed to ensuring well-being and improved quality of health for vulnerable Oklahomans through our integrated care management model, which addresses the following needs of foster children in Oklahoma:

- Ensuring receipt of EPSDT services
- Coordinating and providing for biopsychosocial needs; performing timely initial assessments and ongoing reassessments of biopsychosocial needs
- Developing individualized care plans through an interdisciplinary team
- Delivering a comprehensive behavioral health network with access to 24/7 services
- Providing complex care coordination services for children identified as having high needs
- Actively participating on Family Teams
- Authorizing necessary services in a timely way
- Actively collaborating with other systems such as the juvenile justice system
- Coordinating with enrollee's formal and informal support system, including those who provide covered and non-covered services

Consistency toward Permanency Outcomes

While the number of children exiting Oklahoma child welfare custody to permanency has increased from 4085 to 5599 from 2012 to 2016 respectively, we recognize the need for continued progress toward permanency. Aetna's care managers will establish and maintain ongoing communication with Oklahoma's child welfare staff to assure alignment between individual care plans and permanency goals, including reunification and adoption, for each child. Aetna can support each child's physical, behavioral, and social determinants needs, and promote child welfare services, by offering home based support services, family support, respite, and school based support as part of our care planning process. As a consistent care coordinator, Aetna will also ensure that services continue as a child transitions from foster care to their permanent adoptive family or as the child transitions to adulthood and independence.

Ensuring Receipt of All Services Required Under EPSDT Regulations

Aetna is dedicated to making sure all children receive EPSDT screenings and their families and providers use preventive services. Our EPSDT program promotes alliance with families, providers, State agencies, community organizations, and other stakeholders to achieve this goal for our enrollees.

To ensure federal and State requirements are met for EPSDT services and access, outreach and education is conducted to inform families of the service benefit. This is particularly important for children that change living situations or move among foster families. Our care managers assist enrollees and families with scheduling appointments and transportation to attend appointments. The State case worker is part of the care team and is included in all communication. We use alerts in our claim system to notify care managers whenever an enrollee needs EPSDT services, such as well child visits, immunizations, and annual dental visits. Gaps-in-care mailers are sent

to providers and birthday cards are sent to each enrollee's placement as a reminder of preventive care needs. In addition, we use the Text4Health messaging system for focused outreach and offer gift cards as incentives for enrollees who complete screenings for well-child and adolescent exams, and behavioral health follow-up to an inpatient mental health admission. In 2016, Aetna performed above the National Committee for Quality Assurance (NCQA) 50th Percentile for completion of Well Child Visits 3-6 Years (73.38 percent) and Adolescent Well Care (55.32 percent).

Experienced Team of Medical and Behavioral Health Experts

As discussed previously, Aetna's integrated care team includes experienced registered nurses and behavioral health professionals. Our team focuses on quality by working with providers to assist in closing gaps in care associated with our health outcome measures. For example, registered nurses review reports to identify gaps in care, such as child or adolescent well visits, immunizations for adolescents, lead screening in children, and body mass index weight assessment, as well as counseling for nutrition and physical activity. Additionally, our community development team provides enrollee education such as distributing enrollee and provider handbooks that contain EPSDT information at health fairs and other community events. Whenever possible, Aetna will collaborate with child welfare staff to provide enrollee education at Oklahoma community events.

Aetna's integrated care management approach is more than a comprehensive inventory of different service providers, agencies, and organizations. They need to work well together—based on a mutual understanding of and commitment to one another's roles and responsibilities—to ensure appropriate resources are available, organized, and coordinated to support each foster child's goals. Our multidisciplinary coordination and collaboration makes it possible for each child to achieve his or her goals of optimal health and well-being. In addition, this model improves quality and reduces total cost of care by managing key clinical events such as placement disruptions, medication reconciliation, care gaps, and transitions of care.

A.3. Explain how Respondents have approached implementation of the models

Aetna employs a dedicated, national implementation team that uses a proven, standardized project management approach that positions us for readiness to implement a large, system-wide health care transformation in Oklahoma. We provide additional details about our implementation approach in Section G, Care Coordination Implementation Timelines.

Our implementation team focuses on key activities and milestones critical to the successful development of a quality driven, cost effective health care delivery system:

- Leveraging Aetna leadership that understands Oklahoma's needs
- Building a comprehensive, integrated provider network based on utilization trends, community, provider, and State feedback, and enrollees' voices

- Supporting the use of existing patient-centered, integrated models such as Certified Community Behavioral Health Clinics (CCBHC) like the Fostering Hope clinic operated through Oklahoma State University (OSU)
- Addressing health care barriers in rural areas by implementing use of telemedicine capabilities
- Communicating and coordinating with State agencies, particularly ODHS and Oklahoma Child Welfare Services, to help ensure a seamless transition for children receiving care
- Training of Aetna’s team to ensure they are fully competent on the specific needs and circumstances of Oklahoma children, including local community resources

Because there is simply no substitute for meeting face-to-face with Oklahomans, hearing their voices, and garnering their invaluable feedback to help shape the program development for foster children, Aetna will meet with foster care-specific groups across the State and will establish an advisory committee. This includes ODMHSAS and ODHS, both of which are critical to identifying the priority of services and needs, particularly in underserved areas.

B. Access to Health Services

1. Describe how your care coordination models would ensure that children in care and their families can access needed health services?
 - a. Behavioral Health Services?
 - b. Medical Care?
 - c. Dental?
2. How would you use a care coordination model to include children in care as enrollees of Health Homes?

Aetna’s holistic, person-centered approach considers the biopsychosocial needs of every enrollee. Our interdisciplinary care team partners with children, families, and providers to help coordinate and promote access to care. We employ care managers who serve as a single point of contact to facilitate timely access to providers and to help ensure children are appropriately screened, assessed, and referred to the right care no matter where they enter the health care system. Our care managers continuously work with the changing needs of the child, engage the Family Team, and monitor care paths to help to ensure each child’s health care needs are met. Aetna regularly reviews its network to ensure adequate capacity in terms of timely access including to specialty providers.

Single Point of Contact

Aetna’s care managers serve as the single point of contact for care planning and integrate all relevant, identified needs that may come from any member of the Family Team or provider network. We recognize that some foster children may move between multiple placements before permanency is established. Furthermore, children may be coping with foster-to-adoption issues or aging out of foster care. Our dedicated care manager becomes the child’s partner throughout his or her treatment to navigate the challenges or obstacles the child may be facing. During transitions, continuity of care is paramount to the child and his or her Family Team. To maintain

this continuity, we approach multiple admissions, placements, and discharges by stabilizing as many of the controllable factors as possible for the child, family, and caretakers. Our care managers use our proprietary CareUnify platform that creates a single unified view of each enrollee so that the integrated care team can coordinate care and services on the platform. We strive to keep children with the same outpatient treatment providers, such as PCPs, behavioral health providers, and other specialists, whenever children move between placements. Furthermore, whenever youth age out of foster care, we work with them and their Family Team to ensure continuity of care as they move into adulthood.

Comprehensive Care Planning

As described in Section A, our care managers complete a comprehensive assessment for each enrollee. The assessment incorporates information from all aspects of the child's life including physical and behavioral health, family, education, social determinants of health, and community supports. Our assessment enables enrollees, their families, and their preferred support systems to assemble as the enrollee's interdisciplinary care team to articulate each enrollee and his or her family's voice, values, beliefs, preferences, and priorities. The Family Team collaborates to develop a comprehensive, holistic, individualized care plan that describes how the enrollee's assessed and articulated goals, needs, and preferences are met.

Individualized, Person-Centered, Adequate Services

Our goal, particularly with children and adolescents, is to provide services that are appropriate, safe, and effective, and that occur in the least restrictive setting possible. This goal forms the underlying foundation of our approach to developing a range of services to meet the varying needs of the vulnerable youth population. By evaluating which services exist and services that may need to be rendered to address the needs of children who require a more intense level of care, we collaboratively and creatively work with the child and his or her family to develop an individual care plan that effectively addresses the services closest to the child's home.

Aetna will prioritize the development of a provider network that meets the needs of the enrollees. This includes timely access to all types of care including specialty providers. Our care managers use their knowledge of local providers to facilitate access to appropriate care. Whenever families request a specialist or a behavioral health provider, we verify that the new provider is both qualified and suitable to treat the enrollee. We also offer providers who are located within close geographic proximity to help mitigate transportation issues. In rural areas where specialty providers may be lacking, telemedicine options are ready to be implemented.

B.1.a Behavioral Health Care Services

According to the American Academy of Pediatrics, behavioral health is the largest unmet need for children in foster care. National child welfare statistics indicate that almost all children involved with the child welfare system report histories of trauma such as abuse or neglect, the impact of removal from their family or siblings, or multiple foster care placements. Social determinants such as lack of safe and stable housing, lack of financial resources, as well as mental health struggles can impact timely and effective access to behavioral health care.

Screening and standardized assessment tools based on best practices are critical components to addressing a child’s behavioral health needs. As needs are identified, treatment services become part of the individual care plan. Care managers facilitate access to providers skilled in applying relevant, evidence-based best practices and community supports necessary to strengthen the child and family. Often, behavioral health needs are identified by non-behavioral health entities such as the primary care physician, foster parents, child welfare specialists, or other members of the Family Team. Aetna’s care managers serve as the single point of contact for care planning and incorporate all relevant, identified behavioral health needs that may come from any member of the Family Team.

Aetna understands that serving children in foster care requires a network capable of meeting children’s behavioral health needs at all points of access. In rural areas where access to behavioral health providers may be limited, Aetna will develop telemedicine capabilities for psychiatric and other needed therapy services. We also offer primary care providers consultation and training in trauma-informed care to improve recognition of children's behavioral health needs and to facilitate appropriate, evidence-based treatment practices.

Aetna is prepared to serve these enrollees through our integrated health homes, an important component of our network strategy. Our integrated health homes integrate physical and behavioral health providers as part of an interdisciplinary team, and have the specialized expertise such as trauma-informed practices to serve children with complex needs. We will include the full continuum of services required by this population, ranging from home-based community care and respite to residential treatment and specialty counseling modalities, such as multi-systemic therapy (MST) and functional family therapy (FFT). We will also collaborate with the State to develop clinically appropriate and safe alternatives to residential treatment to reduce use of residential treatment and promote stability and permanency in the child’s home.

B.1.b. Medical Care

The Congressional Research Service’s 2012 report, *Child Welfare: Health Care Needs of Children in Foster Care and Related Federal Issues*, states that most children enter foster care because they have experienced neglect or abuse by their parents. Between 35 percent and 60 percent of children entering foster care have at least one chronic or acute physical health condition that requires treatment. Additional research on youth who aged out of foster care shows these young adults are more likely than their peers to report having a health condition that limits their daily activities and participating in psychological and substance use counseling.

Aetna promotes preventive care by emphasizing the facilitation of EPSDT services for our child and adolescent enrollees. We combine health promotion and education activities and materials to improve the understanding of the EPSDT program by enrollees and their families and caregivers. Our outreach activities and materials help enrollees and their families and caregivers understand the value of this critical program, provide information on how to access EPSDT services, and assist enrollees in using these services. Our EPSDT outreach and education strategies include:

- **Face-to-face Meetings:** Our care managers meet face-to-face with enrollees and Foster Families to identify needs and provide education on the importance of timely EPSDT services.

- **General Education and Information:** The materials we develop and employ to support EPSDT compliance including the enrollee handbook, enrollee newsletters, surveys, on-hold messaging, health-related brochures, and website content. Our enrollee handbook includes information on the EPSDT program, child health guidelines, and tips to keep children healthy. Our enrollee newsletters include articles about the value of the EPSDT program.
- **Automated Voice Messaging:** We use an automated voice messaging system to remind enrollees of upcoming well-child checkups and to follow up on missed appointments. We also use our Enrollee Services toll-free line to educate callers during their brief on-hold waiting periods about various aspects of the EPSDT program, and include EPSDT reminders on our website. All content presented in these various formats are included on our website for easy reference.
- **Text Message Reminders:** We use Connect4Health text message reminders for well child visits.
- **Population-specific Information:** Our care managers send a variety of age-specific health materials to inform our enrollees and their families and caregivers about our EPSDT program. We mail an age-specific postcard to the homes of enrollees who are due for a well-child visit.
- **Provider Gaps-in-Care Reports:** We provide HEDIS reports with EPSDT measures to providers indicating enrollees in need of services (immunizations, well visits, flu shots, dental visits, etc.). In addition to making the reports available, our health plans also distribute the reports by hand, secure email, mail, and fax.
- **Inbound Call Reminders:** Whenever an enrollee contacts our Enrollee Services Department, flags in our system alert Aetna staff of EPSDT and other services needed.
- **Community Collaboration:** We collaborate with community-based organizations and public agencies to share EPSDT information and information about our provider network at health fairs, group gatherings, and other community events.
- **Educational Mailers:** Our education mailers promote vision screenings and include guidelines recommending retinal screenings for children with diabetes.

A critical aspect of medical care is monitoring prescription medication. It is not unusual for children who are placed in a variety of settings and being assessed by many professionals to be prescribed multiple medications. Aetna tracks medications in our electronic medical record and CareUnify, thus enabling care managers to know the status of each medication and the condition each is intended to treat. Aetna's quality initiatives include analysis of pharmacy claims and coordination with primary care physicians to reduce the use of multiple medications, particularly psychotropics. We also track opioids and medication refills to determine if alternative medications can be prescribed and to track potential for abuse.

Our goal is to assure each enrollee is assigned a provider who is experienced in the health care issues and challenges of vulnerable youth, and who promote quality-driven, cost-effective health care outcomes. In 2015, Oklahoma implemented health homes for children struggling with serious emotional disturbance, which offered the opportunity for a patient-centered system of care. More recently, Oklahoma ODMHSAS licensed Certified Community Behavioral Health Clinics (CCBHC) to offer integrated care to children and youth. Aetna's network in Oklahoma already includes many existing CCBHCs and PCMHs for children. We will encourage families, particularly those with children with co-morbid physical and behavioral health conditions, to

choose primary care physicians in the health home program. Families that have not identified a primary care physician will be auto-assigned to a PCMH. Wherever possible, Aetna will promote access to CCBHCs to ensure focus is on comprehensive, coordinated care that addresses all the child and family's needs.

Aetna supports providers, in all specialties, to be trauma-informed in their work with children and their families to facilitate engagement and effectiveness of treatment. Whenever the family of an enrollee asks to change a PCP, we work with them to facilitate that change, locating a provider with the expertise required for appropriate care. Additionally, we ask for the reasons for the change request to help us determine which provider will be more suitable for the enrollee. We will also follow up with the former provider to address any issues that need to be changed or improved.

B.1.c. Dental Care

Aetna's strategy for improving oral health focuses on three components: education, prevention, and integration. Early and consistent oral health education and prevention services can significantly reduce children's exposure to deleterious oral disease, decrease the need for extensive restorative services in later years, prevent tooth loss, and improve overall health throughout life. Education begins with the family during pregnancy, and training on the value of maintaining good oral health care during pregnancy and its impact on the baby.

Dental screenings are standard components in our integrated care management approach. Care managers will assess all children for these components and according to EPSDT guidelines. Our care managers work with our community partners, dental schools, providers, as well as community health workers and peer support specialists to increase our enrollees' health literacy related to oral health. This includes education about the impact of oral health on physical health. We encourage older children and teens to obtain needed preventative dental visits, including placement of age appropriate sealants on permanent molars. Within our dental quality metrics, we track sealant placement on children ages 6 to 9 and 10 to 12 years of age. We offer provider education and ask our providers to include oral health and dental information during every well visit.

We understand that children are seen earlier and more frequently by primary care providers than by dentists. Aetna educates primary care providers on performing basic oral risk assessments at well child visits and on the significant value of applying fluoride varnishes to children and teens. We ask our primary care providers to include oral health and dental information during every well visit and encourage parents to participate in their child's assigned Primary Care Dental Home.

Aetna will implement a primary care dental home (PCDH) program in Oklahoma. This aligns with our approach to providing consistent, comprehensive care, identifying disparities and gaps in oral health care, and removing barriers to that care. Aetna has been successful in multiple markets in building dental homes, through flexibility in choice and assignment of dental homes. We track trends in PCDH changes through our Quality Management Committee using a variety of enrollee satisfaction surveys and reports. For high-risk, medically compromised enrollees, or

those with oral-facial disabilities, care managers coordinate care with medical and oral health providers.

To build the PCDH program, we will outreach to providers with contracting, recruiting, training, and support efforts, especially to those trained to meet the needs of special populations such as children with developmental disorders or significant behavior disorders. We understand the impact of behavioral health conditions and medications on oral health. To build a competitive dental network, we can negotiate a higher rate for providers through valued-based arrangements. Support of contracted providers is through formation of a dental advisory committee that can consist of oral health stakeholders, including the Oklahoma Dental Association. Periodic meetings can discuss demographics and disparities, use of mobile services in underserved areas, improving utilization of specific services like fluoride varnishes and silver diamine fluoride, identifying high-risk enrollees, and strategies for taking care of those enrollees. We believe when oral health stakeholders are involved at all levels, quality of care improves, and costs are contained.

Aetna educates enrollees about their PCDH selection options through a variety of methods: the enrollee handbook, our enrollee Web portal, and our enrollee mobile application; calls to enrollee services, welcome contacts, and follow-up calls; outreach mailers; responses to gaps-in-care analysis; outreach from pediatric providers to screen children and urge PCD selection; and through outreach from dental providers to remind enrollees of visits and available benefits. Our national dental director provides plan oversight through quarterly Joint Operating Committee (JOC) meetings with plan team members to review dental performance and utilization metrics, quality of care concerns, and any provider/enrollee issues.

2. How would you use a care coordination model to include children in care as enrollees of Health Homes?

In 2015, Oklahoma implemented health homes for children struggling with serious emotional disturbance, which offered the opportunity for a patient-centered system of care. More recently, Oklahoma ODMHSAS licensed Certified Community Behavioral Health Clinics (CCBHC) to offer integrated care to children and youth. Aetna's network in Oklahoma already includes many existing CCBHCs and PCMHs for children. We will encourage families, particularly those with children with co-morbid physical and behavioral health conditions, to choose primary care physicians in the health home program. Families that have not identified a primary care physician will be auto-assigned to a PCMH. Wherever possible, Aetna will promote access to CCBHCs to ensure focus is on comprehensive, coordinated care that addresses all of the child and family's needs.

C. Staff/Provider Network

1. Describe, if applicable, how staff and/or provider network recruitment and retention, including types of providers (*for example primary care, specialty care, dental, HCBS, case/care model, LTC, other, etc.*) are addressed.

With more than a century of experience, Aetna has served Oklahomans since 1900 and currently serves more than 184,000 enrollees through Medicare Advantage, Insure Oklahoma, and commercial plans. Our individual Medicare Advantage plans in Oklahoma are highly rated by CMS with 4 and 4.5 stars. In partnership with providers, community resources, and other key stakeholders, we offer an extensive suite of programs and services that work in concert to meet the individual needs of every Oklahoman we are privileged to serve. We will apply our historical Medicaid experience in Oklahoma administering the Heartland Health Plan including our in-depth understanding of diverse Oklahoma populations and their unique needs.

Ensuring Adequate Network Capacity

Aetna's comprehensive statewide provider network in Oklahoma spans nearly 12,000 providers, including 5,600 participating in our Medicare Advantage service areas. Leveraging these long-term partnerships with Oklahoma providers and health systems, Aetna had already successfully contracted with 4,972 providers representing 10,836 locations—with 100 percent adequacy for PCMH/specialists in all but one panhandle county, and a statewide pharmacy network composed of 936 pharmacies with 100 percent adequacy at 15 miles. Aetna has contracts with 79 hospitals across the State and is actively negotiating with another 29.

Aetna has established strong Oklahoma partnerships for our commercial products, including ACO arrangements with INTEGRIS Health System and St. John Health System. In April of 2016, the Aetna Whole Health St. John Oklahoma Health Initiative was announced, under which Aetna enrollees receive coordinated care through Tulsa-area St. John hospitals and more than 130+ primary care physicians, 580 specialists, and 4 urgent care centers that are part of the St. John accountable care organization, Oklahoma Health Initiatives. We will continue to build on this experience by entering into subcontracts specific to foster care children with these same entities and their large provider systems such as Alliance Health, Mercy Health System, OSU Physicians, and OU Physicians allowing us to implement performance-based initiatives and improved quality outcomes. We have also entered into an enhanced Patient Centered Medical Home (PCMH+) contract with Patient Care Network of Oklahoma (PCNOK) which brings a partnership with 17 FQHCs in a value-based contract. Aetna participates in CPC+ in Ohio and Pennsylvania and will petition the Center for Medicare and Medicaid Services (CMS) to participate in Oklahoma in 2018.

Experience with Behavioral Health

Aetna understands that serving children in child welfare and foster care requires a network that is capable of meeting children's behavioral health needs at all points of access. Aetna is prepared to serve these enrollees through our integrated health homes, an important component of our network and our value based purchasing strategy. We will engage current behavioral health

homes and behavioral health providers committed to the CCBHC demonstration, along with other providers who share this vision to become part of our network. We will include the full continuum of services required by this population, ranging from home based community care and respite to residential treatment and specialty counseling modalities such as multi-systemic therapy (MST) and functional family therapy (FFT). We will also collaborate with the State to develop clinically appropriate and safe alternatives to residential treatment to reduce utilization of residential treatment to promote stability and permanency in the child's home.

We promote the integration of physical and behavioral health across our entire provider network, using the Substance Abuse and Mental Health Services Administration's collaborative integration framework. This model offers a continuum of integration ranging from coordinated to co-located to integrated care. Our integrated health homes not only integrate physical and behavioral health providers as part of an interdisciplinary team, but also have the specialized expertise to serve children with complex needs such as those involved in foster care. This aligns with the Certified Community Behavioral Health Clinic (CCBHC) demonstration program awarded to Oklahoma by the Department of Health and Human Services.

Experience with Children

Aetna is experienced in working with state governments, local provider networks, and provider associations to expand network resources to meet the unique needs of child, adolescent, and young adult populations—including the diverse needs they bring to treatment and diverse geographic locations in which services are needed. Our experience serving children, including foster children, in other states, strengthened by the information we have obtained in discussions with local community advocates and providers, has helped us to understand what the vulnerable youth population, their families, and caregivers need from their providers. As examples:

- Children currently in foster care generally require comprehensive evaluations and assessments to determine what gaps may have occurred in their care and what services they need to address any presenting issues. These services may include preventive care, such as immunizations; mental health screenings to evaluate for trauma; and dental exams, treatment, and possible restorative care.
- Former foster children, particularly transitional age youth who have aged out of the system, require health care appropriate to their developmental stage. We have found that young adults in this category (18 to 26 years old) often need primary preventive care, screening, and education regarding healthy sexuality, sexually transmitted infections, and substance use.
- Children in adoptive families with subsidized care require comprehensive continuity of care plans to address ongoing behavioral and physical health needs, possible developmental, intellectual and physical disabilities, and supportive services for families. These children may be receiving home- and community-based services, which need to be authorized and monitored on a regular basis. Care from specialists is also critical for this group.

Aetna is committed to evaluating the following solutions to known barriers impacting access to quality care for children and families involved with child welfare services:

- Creating specialty networks of providers trained and willing to serve the population in a collaborative and coordinated manner
- Comprehensive provider training specific to the needs of children involved in child welfare
- Offering enhanced rates to providers trained and willing to serve the population
- Considering payment incentives to therapeutic foster-care providers for decreased use of emergency room services
- Implementing home-based telemedicine programs for the population in rural communities
- Face-to-face and web-enabled education programs for parents and caregivers
- Consultative services for PCPs needing support in managing foster children’s developmental and psychiatric needs
- Education and training to local schools by partnering with advocacy organizations
- Contracting with organizations to provide peer and family support services to foster children and their families allowing for optimal engagement of families
- Developing electronic health records capable of sharing data and offering technical assistance to provider agencies on information collection and exchange for coordinating integrated services

Addressing Network Deficiencies

We believe network adequacy is in the eye of the beholder: the enrollee. If an enrollee cannot access a provider, specialist, or pharmacy, then the network is insufficient, regardless of whether the network technically meets a definition of adequate. Aetna will work closely with the State and Oklahoma stakeholders to map and study the existing provider network, find deficiencies, and identify new provider services to achieve adequacy now and in the future. For example, a challenge for network adequacy in providing foster care services is the recruitment of therapeutic foster care providers. Aetna has developed specialized recruitment strategies to increase the number of qualified therapeutic foster care providers in their network and has developed protocols to assure these providers successfully complete necessary credentialing.

Aetna uses state-specific reports to monitor how the provider network compares to the relevant requirements. We recommend analyzing tertiary services within travel distance and after-hours accessibility requirements using a variety of tools, including analysis of appointment availability, appointment wait times, and after-hours surveys as well as analysis of enrollee inquiries, enrollee satisfaction results, and out-of-network utilization. Aetna's comprehensive review evaluates all provider types, including PCPs, specialists, behavioral health providers, hospitals, ancillary providers, pharmacies, telehealth and community-based service providers. We also present a summary of our findings to a Quality Model Oversight Committee (QMOC) for review and feedback. The QMOC is an interdisciplinary committee that includes participating providers and handles our quality program.

Aetna employs multiple strategies to recruit new providers when there are deficiencies. When we identify a need for additional service providers, we add new providers who have met credentialing and joined a provider group. We contact providers who have not joined our

network but are registered with the State; providers who had previously closed their panels; and providers who had previously declined to join the network. We recruit providers who are new to the area by maintaining an extensive and accessible network of professional organizations, soliciting referrals from existing providers or community-based stakeholders, identifying providers who offer specialized services, and seeking recommendations from other providers.

Ensuring Access to 24/7 Services

Aetna recognizes how critical it is to ensure vulnerable youth and their families have access to 24/7 services. We will contractually require relevant provider practices to be available and accessible 24/7. We will also establish a provider after-hours program to incentivize providers where participating providers who see enrollees after regular office hours will receive additional reimbursement for after-hours care. This offers enrollees quick access to a provider instead of unnecessarily heading to an emergency department. We will also require behavioral health providers to offer after-hours availability including use of crisis hotlines and facility-based crisis centers.

Network Compliance

Aetna uses a variety of reports to evaluate and monitor the provider network including:

- Annual appointment and availability access survey
- Review of provider-to-enrollee ratio and capacity review
- Provider panel study
- Secret shopper surveys
- Grievance and appeals trend and analysis reviews

When we receive inbound calls that reveal a challenge to getting a timely appointment, we flag the call for follow-up and outreach the provider to help the enrollee secure the appointment or find another provider if necessary. When we identify that a provider fails to meet appointment availability or after-hours coverage requirements, our quality model and provider services departments determine the appropriate actions, which may include:

- Mailing re-education letters to remind the provider about our contractual requirements for appointment availability and what constitutes appropriate wait times for enrollees
- Conducting tailored, face-to-face re-education to meet the needs of that provider
- Requiring providers to submit Corrective Action Plans (CAP) which detail improvement milestones within appropriate timeframes
- Reporting provider CAP status updates to the appropriate Aetna quality and compliance committees and the State
- Conducting follow-up audits to verify continued compliance with standards
- Restricting new enrollee assignments to the provider's panel
- Terminating the provider contract

Providing Crisis Response

Timely and effective response to behavioral health emergencies is a top priority for children in foster care. Foster care children frequently have histories that include trauma and abuse that require behavioral health treatment in varying intensities. Adolescents and transitional age youth in this population may be struggling with mental health or substance use issues, prescription drug abuse, homelessness, unplanned pregnancies, sexually transmitted diseases, and other challenges. Any of these can initiate a behavioral health emergency that requires compassionate, competent, and timely response.

In our health plans, we offer access to a 24/7 crisis hotline. Our hotline staff understands the recovery and resiliency principles and approaches of our integrated service model. Our behavioral health professionals are credentialed, experienced, and trained to serve our vulnerable youth enrollees. Hotline staff have expertise working within the full scope of behavioral health practice, including crisis situations, children and adolescents with multiple diagnoses, co-occurring mental health and substance use issues, individuals with physical disabilities and Intellectual and Developmental Disabilities (I/DD), and other behavioral health situations that may present during crisis calls. As part of ensuring network adequacy for the foster care population, Aetna will collaborate with the State of Oklahoma to identify the best method for coordination between child welfare hotline, Oklahoma's crisis hotline, and our behavioral health crisis line.

For children and adolescents who require emergency facility-based assessment and intervention, Aetna will leverage its existing partnerships to implement contracts for provision of 24/7 behavioral health services. We will continue working with the CCBHC providers to establish a wide range of crisis intervention services with consideration for emergency respite, mobile crisis response, and facility based emergency psychiatric assessment and intervention. As warranted by circumstances, population needs, and available resources in the community, this may yield additional services for enrollees such as residential crisis respite, which can provide stabilization for children in a behavioral health crisis and help most children avoid hospitalization. Other services can include transition services involving behavioral health clinician support to help transition the enrollee from inpatient care and back to their outpatient settings or peer support for families, helping to reduce stressors for parents and caregivers by offering parallel group services.

Training Providers

Aetna's training program begins with the provider orientation process. Within 30 days of the provider's effective date, Aetna will contact providers—including private practices, hospitals, pharmacies, and specialists—to schedule orientations. In our new provider orientation, our local team meets face-to-face with providers and their staff to introduce the requirements and processes for authorization requests and claims submissions. During our visit, we demonstrate online tools such as how to submit, look up, and view the status of an authorization. Our new provider orientation also includes topics such as reviewing the Provider Manual and the tools and processes for billing.

Aetna covers the secure exchange of enrollee information, including Protected Health Information, according to HIPAA requirements and information related to substance use disorders according to 42CFR Part 2 requirements. We also provide training regarding privacy and confidentiality for our provider portal and mobile app, describing the security features embedded in these programs that only allow authorized individuals to access the information contained.

Aetna offers educational forums with in-depth training on rotating topics for our provider network. Common topics in the provider forums include covered services and enrollment, provider claims disputes, and training to address the unique needs of the covered population, such as trauma-informed care. Providers and their staff can choose from multiple locations and different times of the day to attend educational forums. To support our face-to-face training, we publish reference documents, such as the Provider Manual, bulletins, and quarterly newsletters and make them available to all providers.

Promoting Provider Awareness of Requirements

Providers and their staff must successfully complete specific training on this population. Training can take place in-office, in community-based meetings, and through online resources, and focuses on increasing the capacity of health care providers to provide quality health care for Oklahoma's vulnerable youth population, including children in foster care and children in subsidized adoptions. All training materials will include any material designed by Oklahoma child welfare experts as we will collaborate on training curriculum and design with ODHS and key stakeholders.

Aetna will work with the State and key stakeholders to design a proactive and interactive provider education approach. We will train providers about the needs of vulnerable youth, including existing community-based services, health homes, service coordination, and telemedicine/telehealth, as well as access to care requirements during new provider orientation and routine office visits. This includes:

- Understanding of health, wellness, and care issues concerning foster care children
- Foster care specific barriers to accessing health care services
- Common developmental disabilities and associated secondary conditions including the results of trauma and adverse childhood experiences
- Identification of goals and barriers outlined in the Surgeon General's Call to Action to Improve the Health and Wellness of People with Disabilities and by the Americans with Disabilities Act
- Accurate assessment and delivery of quality care specific to foster care children

Aetna will ensure Oklahoma network providers complete mandatory training which is critical to serving foster care children during provider orientation. This includes:

- PCP reimbursement available for assessing children's behavioral health needs
- Education to PCPs addressing non-traditional therapies available
- Information regarding trauma-informed care and what opportunities exist to attend training and certification in the evidence-based treatments available

- Utilization and collaboration with 24/7 crisis responses services
- Role of the care manager in assessment and care planning
- Overview of available provider network services
- Promotion of early intervention and health screening for identification of behavior health problems
- Utilization of behavioral health screening and assessment tools
- Oklahoma specific initiatives and legislative changes specific to foster care

Compiling the Provider Manual

Aetna’s provider manual encourages strong collaboration with our network of credentialed and contracted providers to administer and manage efficient, effective, and quality health care to enrollees. It provides all the details providers need to successfully provide services to our enrollees. The provider manual offers an in-depth, step-by-step overview of topics, including specific covered health services for which the provider is responsible, prior authorization and referral procedures, multilingual and TDD availability, and others. To offer the most effective response and care possible, we include links to a variety of articles and training opportunities, including those through the Substance Abuse and Mental Health Services Administration (SAMHSA), the U.S. Health Resources & Services Administration, and the Agency for Healthcare Research and Quality.

Care Manager as Single Point of Contact Across Transitions

Continuity of care is paramount as we develop care plans for Oklahoma’s most vulnerable youth. To maintain this continuity, Aetna care managers are the single point of contact in the overarching system allowing for continuity and coordination across a network of providers. Aetna care managers follow the child throughout their treatment using our CareUnify platform regardless of what level of care they may be receiving. We also work to maintain the same outpatient treatment providers, such as PCPs and behavioral health providers. This provides continuity for the enrollee and the providers. Families know that no matter where an enrollee may be placed, their trusted doctors, counselors, and other treatment providers who understand their needs remain active participants in their care.

Aetna works collaboratively with the State, families, and providers to understand why a child is placed out of state and whether there is a way to bring the child back. We want to see children placed as close to their homes and communities as possible. We understand this may not be possible in every case, so we work with child placement agencies and child welfare to complete assessments, evaluations, and care plan reviews while a child is placed out of state. These assessments and reviews will help to determine when a child might be able to return to the community and receive treatment by their local providers.

Collaborative Communication with the State and Local Agencies

A critical element to ensuring recruitment and retention of an adequate provider network is the development and maintenance of very strong relationships with the State, State entities such as Oklahoma Child Welfare Services, and enrollee/provider advocacy stakeholders. Aetna’s goal is

to support and promote effective partnerships through engagement in settings such as community health fairs; community education conferences; professional conferences; faith-based events; community mental health center health fairs and conferences; collaboration with children’s advocacy groups and support organizations.

Telemedicine

Aetna Medicaid has been actively supporting and using telemedicine/telehealth which can be very helpful to facilitate the delivery of services to foster care children in rural areas or areas with limited provider services. During our outreach and discussions with providers across Oklahoma, we met with several organizations engaged in pioneering telehealth in Oklahoma. Because of building these partnerships, we developed a shared vision on how telemedicine can be used to deliver virtual care and services. In addition, to offering our own telemedicine solution, we will collaborate with telehealth leaders that feature program partnerships with Oklahoma State University (OSU), INTEGRIS Health, and the University of Oklahoma.

The OSU Center for Health Sciences, Office of Rural Health telehealth program has long been noted as a leader in establishing foundational competencies in telemedicine and beyond, conducting over 23,000 annual patient encounters with over 120 established sites. In our effort with OSU, we will support their existing rural telehealth medicine network and support their newly launched and promising effort Project Echo initiative that will serve Tulsa and the surrounding rural area. Currently, OSU’s Project Echo supports specialties related to obesity, HIV/AIDS, and psychiatry.

We will work with the OSU Center for Health Systems Innovation (CHSI) to develop new delivery models that will include telehealth with numerous Tulsa-based primary care clinics to enhance integration of behavioral health and specialty care. Similarly, we worked with CHSI to pilot a rural, virtual kiosk/office. The kiosk model establishes secure, safe locations within Oklahoma Cooperative Extension offices or community centers where enrollees can access many services, including a virtual exam with devices such as an otoscope, stethoscope, and weight scale or access a distant provider such as a diabetes educator, pharmacist, PCP, care coordinator, or our health-plan care manager.

Aetna will continue our approach to collaborating with other cutting-edge providers, including the University of Oklahoma and the NOISE network where enrollees can access services remotely for behavioral health needs. Through these innovative local partnerships, we can quickly establish a broader, connected network to create virtual providers that will make it easier to integrate physical and behavioral health, while also placing the enrollee and his or her families at the forefront of the care delivery and decision-making process.

Implementing Value-Based Purchasing Agreements

Aetna’s bases our approach to ensuring retention of a high performing, quality-driven provider network by using a comprehensive value-based purchasing strategy of highly collaborative relationships with the provider community. For full detail on Aetna’s value-based purchasing agreements, please refer to our response detailed in Section D, Payment Structure.

Depending on where providers fall on the health care transformation payment reform continuum, we maximize their participation in our three core programs:

- **Pay-for-Quality (P4Q):** Rewards providers for achieving better performance on a broad spectrum of HEDIS measures and utilization metrics for their enrollee panel
- **Patient-Centered Medical Home (PCMH) and PCMH+ Programs:** Compensates providers with a monthly care coordination fee for increasing the level of care coordination for our enrollees
- **Shared Savings:** Includes a care coordination fee as well as shared savings for achievement of quality and cost measures and outcomes

Aetna has initiated discussions for creative value-based arrangements with the following health systems and large provider groups:

Creating Value-Based Arrangements with Health Systems and Providers

Partnership	Description of Services	Performance Based Agreement
Alliance Health	<ul style="list-style-type: none"> • 9-hospital system serving the rural perimeter OK counties • 70 clinics for primary and specialty care 	Responsible for both service delivery and care management; per enrollee per month (PMPM) arrangement for PCMH+ for care management and shared savings with quality metrics for both facility and physician performance
INTEGRIS (CommercialACO)	<ul style="list-style-type: none"> • 9-hospital system that provides key tertiary care services for the West Region • 160 clinics for primary and specialty care 	Uses the strength of the ACO arrangement with Aetna commercial for Sooner Health+; key partner for the West Region; responsible for both service delivery and care management; PMPM arrangement for PCMH for care management and shared savings with quality metrics for both facility and physician performance
Mercy Health System	<ul style="list-style-type: none"> • 10-hospital system • 65 clinics for primary and specialty care 	Responsible for both service delivery and care management; PMPM arrangement for PCMH+ for care management and shared savings with quality metrics for both facility and physician performance
Oklahoma State University	<ul style="list-style-type: none"> • Key primary and specialty care clinics • Center for Rural Health • Telemedicine Innovation 	Key partner for arrangements that support rural health and telemedicine initiatives; responsible for both service delivery and care management; PMPM arrangement for PCMH+ for care management and shared savings with quality metrics for physician performance

Partnership	Description of Services	Performance Based Agreement
Oklahoma University	<ul style="list-style-type: none"> • 660 primary and specialty care physicians • Tertiary care providers for pediatric subspecialties • Factor VIII Clinic 	Responsible for both service delivery and care management; PMPM arrangement for PCMH+ for care management and shared savings with quality metrics for physician performance
St. John's (CommercialACO)	<ul style="list-style-type: none"> • 5-hospital system that provides key tertiary care services for the East Region • 800 primary and specialty care physicians 	Uses the strength of the ACO arrangement with Aetna commercial for Sooner Health+; key partner for the East Region; responsible for both service deliver and care management; PMPM arrangement for PCMH for care management and shared savings with quality metrics for both facility and physician performance

D. Payment Structure

1. Explain payment methodology, assumptions, and constraints related to the care coordination models
 - a. Specific to covered benefits and services
 - b. Specific to other benefits and services
 - c. Show estimated amounts of provider payment for evidence-based performance outcomes (*for example amounts of withholds, performance payments based on quality metrics, etc.*)
2. How does your Care Coordination model address potential CMS concerns regarding duplication of care/payment? Explain how proposed payments comply with existing and proposed Federal and State requirements.

As described in section C, Aetna’s comprehensive statewide provider network in Oklahoma spans nearly 12,000 providers. Leveraging these long-term partnerships with Oklahoma providers and health systems, Aetna had already successfully contracted with 4,972 providers representing 10,836 locations—with 100 percent adequacy for PCMH/specialists in all but one panhandle county, and a statewide pharmacy network composed of 936 pharmacies with 100 percent adequacy at 15 miles. Aetna also has contracts with 79 hospitals across the State and we are actively negotiating with another 29.

Our payment approach begins with the State of Oklahoma’s existing fee for service rates for covered Medicaid services. Aetna will pay 100 percent of the fee for service rates for existing covered services available to children in the foster care system. Building on the fee-for-service system, Aetna will move toward a comprehensive value-based purchasing strategy of highly collaborative relationships with the provider community to maximize their participation in our three core programs:

- Pay-for-Quality (P4Q): Rewards providers for achieving better performance on a broad spectrum of HEDIS measures and utilization metrics for their enrollee panel
- Patient-Centered Medical Home (PCMH) and PCMH+ Programs: Compensates with a monthly care coordination fee for increasing the level of care coordination for our enrollees
- Shared Savings: Includes a care coordination fee as well as shared savings for achievement of quality and cost measures and outcomes

Oklahoma’s State Innovation Model (SIM) provides a robust framework for achieving improved outcomes and quality while reducing expenditures by driving the adoption of value-based payment and delivery system models. Aetna’s integrated care management incorporates pay-for-quality, PCMH, and shared savings approaches for the foster care population which supports Oklahoma’s SIM health care system reform initiatives. Aetna engages each enrollee in a holistic manner, considering his or her unique and complex system of needs, capabilities, supports, and preferences. Relative to aligning enrollees with PCMHs, CCBHCs, and/or integrated health homes, our primary goal is to maximize choice while managing the appropriateness of care, addressing gaps, and preventing duplication. We believe that positive health outcomes are more likely to occur in vulnerable populations if there is a solid working relationship between the enrollee, providers, and Aetna.

D.1.a. Payment Structure Specific to Covered Services and Benefits

To strengthen our existing integrated care management and promote alignment between physical and behavioral-health managed care organizations in Oklahoma, Aetna will partner with behavioral health managed care organizations in a combined value-based purchasing model that includes primary care and behavioral health care providers. This is designed to reimburse both the primary care physician and the behavioral health provider. We include tailored quality and utilization measures from both the physical and behavioral health sides—a collaborative approach with the providers choosing appropriate metrics for their practice. This approach includes a shared savings payment based on the total cost of care which enables providers to drive effective utilization in both primary and behavioral health care. Providers also benefit from savings that are the result of care in the right place at the right time.

Primary care physicians participating in our basic PCMH model in Oklahoma will receive pay-for-performance incentives in addition to a fee-for-service methodology. However, we encourage eligible primary care physician groups to participate in our PCMH+ model. Our minimum standards for PCMH+ eligibility include group practices with 100 or more Aetna enrollees, an open panel, and after-hours availability. We support the development of PCMH+s by paying a care coordination fee that recognizes the extra clinical and administrative functions practices perform on behalf of enrollees. For practices that have greater capabilities, we can employ either a PCMH+ model alone or a PCMH+ model with a shared-savings component. PCMH+ arrangements may also include a pay-for-quality component during the same performance measurement period which, when combined with a prospective monthly care coordination fee, affords eligible practices the financial leeway to build on providers’ capabilities to better manage a population. Aetna works with provider groups throughout the initial performance period and monitors their progress, supporting the group as appropriate to help them be successful in their transformation into a value-based payment model.

Our initial approach is to contract with a group and over the first year, we monitor five specific performance metrics designed to help them begin to understand the population being managed. Typically, those metrics may include EPSDT appointment requirements and utilization metrics such as emergency room visits per 1,000 enrollees, psychiatric hospitalizations, and readmission rates. Under PCMH+ models, we support extended after-hours care. The use of PCMH+ structure provides an excellent entry into and supports the movement of groups along the Health Care Payment and Learning Action Network alternative payment models (APM) framework. PCMH+ provides a graduated means for an organization to move from APM category two, fee-for-service reimbursement, along to APM category three, including bundled payments, etc., and to the more sophisticated and demanding population health based payment approaches. Aetna works alongside organizations to support their transition and maturation to more progressive arrangements.

The success of any value-based purchasing initiative is dependent upon strong and transparent relationships with both the OHCA and Aetna to help ensure all goals align and continue to do so. Provider education, ongoing support, and helping providers to understand the benefit of APMs to both the enrollee health and provider bottom line are critical to widespread adoption. This three-way partnership stabilizes service delivery and growth.

As provider groups advance from an entry-level agreement to a more sophisticated level, and to nurture their work with data sharing, we offer a shared savings model. Assuming progress remains steady, we may progress the agreements where the group begins to take on more risk, especially as they become more capable and successful with a population-health reimbursement approach. Aetna employs a continuous process for identifying providers as potential partners. We first identify the size of their enrollee panels and then approach those practices with a larger number of assigned enrollees. Once identified, we contact the providers, invite them to collaborate with us, and meet to review provider readiness using a standardized assessment. For those providers with whom we already have a value-based purchasing partnership, we meet with them throughout the year to assess continually their capabilities and interest in moving across the continuum of value-based solutions. However, providers with a smaller number of assigned enrollees can still participate as PCMHs as noted above. In addition, our PCMH+ health homes are supported through a per-enrollee-per-month payment model and deliver integrated physical, behavioral health care (both mental health care and substance use disorder care), and (in some instances) long term services and supports for high-need, high-cost populations with certain chronic conditions. Our agreements are collaborative and outline the expectations of both Aetna and the PCMH so that all share accountability for outcomes. Most importantly, we are flexible with providers to understand their capabilities and modify programming as needed to accommodate them.

Monitoring Use of Evidence-Based Practices that Support Value

For all PCMHs and integrated health homes, as part of their value-based incentive, we regularly share their performance data at least quarterly on program quality metrics. This enables them to monitor their performance to gauge their progress toward receiving incentive payments. As part of our agreements, we also meet with providers at least quarterly to review performance data, discuss challenges and barriers to improvement, and provide technical advice as applicable to

improving population health capabilities. We examine evidence-based practices and share reports to illustrate comparisons of performance. Performance reports from our Assurance integrated health home in Arizona show a reduction in the number of psychiatric hospital admissions by 28 percent and a reduction in the number of medical hospital admissions by 58 percent. In another fully integrated model in Arizona, the number of psychiatric hospital admissions decreased by 16 percent, utilization of the emergency department declined by 37 percent, and the number of enrollees who are homeless dropped by 53 percent.

Data Sharing

Aetna empowers all providers in our PCMH+ programs by providing easy access to CareUnify. CareUnify is the Aetna Medicaid organization's proprietary population health management platform designed to deliver actionable data to our provider and community services providers. It aggregates actionable data from multiple sources, including electronic health records, health information exchanges such as My Health Access Network and Child Passport, and sources such as public health departments to create an individually tailored enrollee profile, as well as a larger clinic or panel view for each provider. As described previously, the system is designed to push and pull data to and from various systems and can align providers from different organizations using care paths to drive care coordination.

Demonstrated Success in the Arizona Medicaid Market

Aetna implemented a value-based purchasing approach with demonstrated outcomes in our Arizona foster care service delivery system. In Arizona, we enroll children receiving Medicaid services with a PCMH. Children assigned to a PCMH showed decreased inpatient hospital utilization by approximately 50 percent since 2006. More specifically, based on a one-year study of dates between October 1, 2015, and September 9, 2015, audited by Arizona Medicaid in January 2017, we achieved improved results in diabetic metrics for enrollees assigned to a PCMH+. Aetna exceeded the minimum standard performance rate for medical care and appointment adherence. The results we achieved in Arizona testify to the fact that a collaborative approach between a care management model and the PCMHs works and will benefit Oklahoma's foster care population.

D.1.b. Payment Structure Specific to Other Benefits and Services

Regardless of whether enrollees are actively engaged in care management, they may require care coordination to access community-based services that address the social determinants that affect their health. Aetna's care management staff members use our extensive database of local community services to access and coordinate non-covered services, such as housing and school-based resources to supplement covered benefits. The following are some of the important ways Aetna partners with community and social supports to assist enrollees:

- Collaboration between our care managers and community resources when benefits are exhausted and/or external community services engagement is necessary to meet an enrollee's needs (e.g., school-based lunch programs, 12-step programs for transitional-aged youth, free legal services for youth who were incarcerated, etc.)

- Referrals to, coordination with, and follow up with afterschool programs, teen suicide hotlines, and community food banks/pantries
- Utilization of advocacy groups such as the Adoption Exchange

Additionally, our clinical tribal liaison will consult and collaborate with Native American tribes and communities, identify opportunities to enhance delivery of health services, and develop strong collaborative partnerships with tribal nations, Native American organizations and associations, and Indian Health Services to ensure we are offering the appropriate support services to these enrollees.

D.1.c. Show estimated amounts of provider payment for evidence based performance outcomes

Aetna’s model will reflect provider proficiency and achievement based on cost, utilization rates of key metrics, and quality measures for evidence-based performance outcomes. Aetna will implement the payment structures described in section 1a and value-based incentives allowing physicians to earn an additional percentage beyond their current fee for service. Aetna will explore additional performance guarantees as we and the providers gain experience in our value-based partnership.

D.2. How does your care coordination model address potential CMS concerns regarding duplication of care/payment? Explain how proposed payments comply with existing and proposed federal and state requirements.

Comprehensive managed care for foster children will place all Medicaid funding and service authorization in the hands of a managed care organization at risk of meeting the child’s needs while staying within the available resources. Aetna’s integrated care management approach enables a single view into all services a child receives to identify potential conflicts of interest or duplicative services. The care management approach, starting from a needs assessment and collaborative care planning, reduces the potential for duplicate or repetitive services that do not advance a child’s health goals.

Additionally, Aetna’s capitated managed care model lowers the risk of enrollees receiving unnecessary or duplicative services and provides the flexibility needed to treat the unique needs of each enrollee in the least restrictive level of care that is safely possible – allowing budget predictability and integrative control. We will include all covered services in this proposed model to allow for coordination of care and integration of services, including covered medical, behavioral health, pharmacy, home and community based services, non-emergency transportation, and dental services.

Aetna recognizes the importance of ensuring payment for the foster care population complies with existing and proposed federal and state requirements. Our integrated care management

model aligns with federal CMS and Oklahoma requirements for health care system design reform.

E. Impact of Model

1. Explain estimated implementation costs and anticipated savings, for the first five years of an implementation of your model.
 - a. Methodology
 - b. Assumptions
 - c. Constraints
2. Describe the quality and anticipated effect of the care coordination models on the target population with respect to the following.
 - a. CMS recommended benchmarks
 - b. State identified areas including preventive screenings, tobacco cessation, obesity, immunizations, diabetes, hypertension, prescription drug use, hospitalizations, readmissions, emergency room use
 - c. Core measures identified within the Oklahoma Health Plan (OHIP) 2020
 - d. Respondent suggestions for other benchmarks
 - e. Considerations for Value-Based performance designs, specifically those that support and align with objectives identified within the Oklahoma State Innovation Model design

E.1.a., b., c. Explain estimated implementation costs and anticipated savings for the first five years of an implementation of your model.

Reducing and Stabilizing Medicaid Costs

For more than 30 years, Medicaid managed care has enabled states to control costs in Medicaid program spending. States proposing comprehensive, risk-based, and capitated managed care for most Medicaid populations and services have done so with the intention of making costs more predictable and stabilizing cost growth. Overall Medicaid program cost increases are lower in states that rely upon managed care, compared to states with a fee-for-service model. Studies suggest that implementing managed care for all Medicaid populations, particularly those remaining in fee-for-service arrangements, would reduce Medicaid spending by \$6.4 billion in 2016.

The financial predictability and anticipated savings achieved through managed care are reflected in the state contracting and rate setting processes. CMS requires managed care rates to be actuarially sound by reflecting the historical costs of Medicaid covered populations and services. The rates also incorporate anticipated savings by applying care management and care coordination techniques through managed care. New federal rules will be implemented in 2016 that reinforce the rigor of the budget process. This allows states to build budgets using predictable annual costs.

State	Savings
Texas	<ul style="list-style-type: none"> • Saved \$3.8 billion between FY 2010 and 2011 through STAR and STAR+PLUS. • Saved 28.4%, or \$7.2 billion, compared to fee-for-service between FY 2001 and 2018.
Missouri	<ul style="list-style-type: none"> • Saved \$108 million from 2010 to 2013. • Annual savings from 2012 to 2013 alone increased from \$2 million to \$48 million.
Louisiana	Managed care rates were 6.7 to 11.2 percent lower than fee for service costs during 2015.
Illinois	<ul style="list-style-type: none"> • Illinois Integrated Care program saved \$35.2 million since inception of the program.
Kentucky	<ul style="list-style-type: none"> • Average annual state spending for children fell \$482 for children and \$1,490 for nonelderly adults after the transition to managed care between 2010 and 2013.

Adding Administrative Capacity for States

States know that improving program administrative practices will reduce healthcare costs, but often do not have state dollars to invest in staff, technology, and program management.

Specifically, relying on health plans for Medicaid administration through managed care helps states respond to the need to identify new practices and innovate as the need for new services or new technologies. Private companies working in multiple states have greater resources and incentives to improve processes to efficiently deliver services within the established rates from the states. State contracts with managed care organizations use the Medicaid assistance matching rate for administration as part of the actuarial calculation of per member rates. Medicaid managed care organizations must find ways to deliver services within the predetermined rates and ensure financial incentives to use technology to pay claims, study utilization patterns, manage enrollee health needs and report results in cost effective ways to delivering high quality care.

E.2.a. Describe the quality and anticipated effect of the care coordination models on the target population with CMS recommended benchmarks

Aetna’s quality performance improvement program provides the structure and processes necessary to identify and improve clinical quality, maximize safe clinical practices, and enhance enrollee and provider satisfaction across the various settings of care within the care delivery system. The basis for this program is continuous quality improvement, compliance with all regulatory requirements and regulations, and addressing areas we recognize as needing improvement with rapid-cycle improvement strategies, as well as short- and long-term interventions and goals.

OKLAHOMA RFI
3.2 Scope of Work

We anticipate the following effect from implementation of our integrated care coordination model for Oklahoma’s foster care population:

- Enhanced engagement with the child and his or her family
- Improved collaboration across all parts of the system - child welfare, schools, providers, and the State – resulting in aligned goal achievement and optimal outcomes
- Increase in health literacy
- Improved enrollee, family, provider, and stakeholder satisfaction
- Decrease in hospitalizations, readmissions, and unnecessary emergency room use
- Increase in preventative care utilization
- A resultant equitable, integrated fully functioning system of care

CMS Core Children’s Measures for 2017 include measures relevant to accessing service delivery for the child welfare population. Aetna’s integrated care approach works with families and providers to ensure children and adolescents receive timely preventive care and treatment intervention. We are committed to making sure all children under the age of 21 receive EPSDT services, and their parents, guardians, and providers use resources effectively. EPSDT is key to ensuring children and adolescents receive appropriate preventive, dental, mental health, and developmental and specialty services.

Areas of focus include the following CMS Core Children’s Health Effectiveness Data and Information Set (HEDIS) measures for 2017:

- Immunizations
- Developmental Screening in the First Three Years of Life
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
- Medication Model for People with Asthma (MMA)
- Appropriate Testing for Children with Pharyngitis (CWP)
- Appropriate Treatment for Children with Upper Respiratory Infection (URI)

The impact of Aetna’s care management program can be seen in the following results from our foster care program in Kentucky. For example, the percent of foster children with at least one dental visit in the past year is 70.26 percent which was 12.75 percentage points higher than the HEDIS rate of 57.51 percent. Similarly, foster children received a higher percentage of well visits with their PCP. More specifically, the 71.22 percent of children aged 3-6 received well visits with their PCP, 13 percentage points higher than the HEDIS rate of 55.66 percent; and, 50.68 percent of adolescents ages 12-21 received well visits with their PCP, 11 percentage points higher than the HEDIS rate of 38.92 percent.

In addition, other HEDIS measures may be relevant to improving the health of children in foster care. These may include:

- Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey
- Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)

- Follow-Up After Hospitalization for Mental Illness: Ages 6–20 (FUH-CH)

E.2.b. Describe the quality and anticipated effect of the care coordination models on the target population with respect to State-identified areas, including preventative screenings, tobacco cessation, obesity, immunizations, diabetes, hypertension, prescription drug use, hospitalizations, readmissions, emergency room use

Aetna offers condition-specific programs that address many of the areas identified by Oklahoma as priority areas. Care managers outreach enrollees and collaborate with guardians and families to connect enrollees to these programs. These programs (described in Section A) address each of the State-identified areas. Additionally, Aetna has programs in collaboration with pharmacy benefit administrators and State agencies to monitor prescription practices for psychotropic medications as indicated by practice guidelines for the American Psychiatric Association (APA). We have found that a lack of integrated services, primarily access to behavioral health professionals, often results in an over-reliance on psychotropic medications. We have also found that promoting trauma-based training, ensuring data sharing, and monitoring informed consent for prescription medications results in improved health care outcomes and well-being for children with less reliance on unnecessary psychotropic medications. Aetna will collaborate with the State and relevant stakeholders on the best method for monitoring prescription medications.

Aetna’s program initiatives have produced positive results in other states where Aetna serves children. For example, our experience has shown us that reminding enrollees at every point of interaction about the importance of wellness checks leads to an increase in the number of enrollees receiving EPSDT services. Aetna’s quality management approach is that continuous quality improvement efforts are performed until the NCQA 75th percentile or higher is met or exceeded for applicable measures such as well visits, immunizations, vision and hearing screenings, lead testing/screenings, etc.

Preventative screenings also impact childhood obesity and the HEDIS weight assessment, physical activity and counseling on nutrition measure. We have proven experience with children’s EPSDT outcomes:

- Seven of our plans are at or above the NCQA 75th percentile for Weight Counseling on nutrition. We had a 4.48 to 49.54 percentage point increase with the WCC measure year over year.
- 92 percent of our plans are at or above the NCQA 50th percentile for adolescent immunizations
- For Annual Dental visits, 57 percent of our plans are at or above the 75th percentile for annual dental visits
- 83 percent of our plans are at above the NCQA 50th percentile for Well Child 15-month visits
- In our integrated care management model, Aetna has demonstrated quality improvements such as:
- 10 out of 15 health plans had significant increases in HEDIS rates for hypertension with an increase in percentage points between 4 and 24

- 53 percent of our Medicaid plans were at or above the NCQA 50th percentile for diabetic A1c testing

One example of outcomes includes reduction of children’s hospital utilization in our Arizona Medicaid market. We have reduced the number of children’s psychiatric admissions by 28 percent and reduced the number of children’s medical admissions by 58 percent using our Assurance integrated health home model. In another Arizona model, we have reduced the number of children’s psychiatric admissions by 16 percent and reduced children’s emergency room utilization by 37 percent.

E.2.c. Describe the quality and anticipated effect of the care coordination models on the target population with respect to core measures identified within the Oklahoma Health Improvement Plan (OHIP) 2020

Aetna’s integrated care management approach actively supports the OHIP 2020 goals with its following programs:

- **Tobacco cessation programs:** The goals of our tobacco cessation treatment are to help our enrollees understand the health risks of tobacco use and elicit changes in behaviors to positively impact their current and future health. Aetna will assist in reducing the prevalence of smoking from 23.7 percent to 18 percent by 2020. We use motivational interviewing to collaborate and engage recipients in identifying their strengths and using those strengths to enhance resiliency and outcomes. This work results in enrollees’ improved condition management and feelings of self-worth.
- **Weight Management/Obesity:** The quality and anticipated effect of Aetna’s integrated care management in reducing adolescent and adult obesity is decreased co-morbidities such as diabetes and high blood pressure, increased well visits for both populations, and for childhood obesity, increase in the HEDIS rates for Weight, Nutrition and Physical Activity Counseling (WCC). Outcomes and overall effectiveness are monitored by obesity-related conditions such as diabetic A1c control, and the Weight, Nutrition and Physical Activity Counseling (WCC) for children age 3 to 17.
- **Child health related to mortality related to injury and infant mortality:** Aetna’s emphasis on the needs of the whole family in care planning encourages family and enrollee access to care thus reducing stress and injury risks.
- **Suicides, addiction, and untreated mental health issues:** Through Aetna’s integrated care management, a comprehensive assessment is completed that includes standardized screening tools for behavioral health concerns such as depression. Working closely with enrollees and their families, other supports, and providers, our care managers ensure that the integrated care plan is implemented and continuously evaluated for ongoing effectiveness and needed changes. Understanding that the child welfare screeners complete a trauma assessment, our care managers will help to ensure that identified trauma and related needs are addressed in the individualized care plan.

In other states, Aetna has implemented the following interventions to address the unique needs of children in the child welfare system:

- Foster care-related trainings developed and presented in collaboration with providers
- Evidence-based practice trainings for trauma-informed cognitive behavioral therapy (CBT) and infant mental health developed and presented in collaboration with providers
- A dedicated foster care 24-hour phone line that includes a warm transfer to behavioral health providers
- Minimum elements for birth-to-five assessments developed in collaboration with local providers
- Foster/Adoptive/Kinship Care workgroup created to aid in identifying and addressing needs in the local network

Aetna will collaborate with the State and providers to determine what types of interventions will be appropriate for Oklahoma’s foster care children and their families.

E.2.d. Describe the quality and anticipated effect of the care coordination models on the target population - suggestions for other benchmarks

Aetna is open to and welcomes suggestions for other benchmarks. We recognize the challenges inherent in applying traditional HEDIS measures to Oklahoma’s foster care population. Although HEDIS does help us verify that these enrollees are receiving the necessary preventive services, we need additional measures to assess a broader range of health care needs and provider types specific to Oklahoma’s foster care children such as:

- Capturing the complexity of each individual child’s needs, because not all needs are measured and recorded by using HEDIS and other standard clinical indicators alone
- Addressing varied expected outcomes among children with the same primary condition
- Addressing more behavioral health-focused measures than provided by traditional HEDIS indicators
- Measuring family involvement and satisfaction in shared decision-making; traditional satisfaction surveys lack sufficient questions
- Capturing access to care issues unique to or more prevalent for foster care children such as transportation barriers and sexually transmitted diseases

Through our ongoing quality monitoring process and input from the enrollee and provider advisory committees, we propose continued assessment and identification of appropriate measures to monitor clinical quality for the unique needs of Oklahoma foster children, such as:

- CHILD CAHPS® item set for Children with Special Health Care Needs
- Penetration rates for foster children receiving behavioral health services
- Transition to adulthood processes
- Quarterly analysis of claims data to identify trends in service-delivery, potential gaps in care, and relevant network development specific to foster care children needs

ODHS intensive care coordination for SED kids uses relevant functional measures which we will incorporate for evaluating this population. Aetna will collaborate with the State and other key stakeholders to determine the best approach for identifying and reporting these functional measures. These measures include:

- School measures such as days absent and days suspended
- Days spent in out-of-home placement
- Presence of self-harming behaviors
- Number of contacts with law enforcement
- Psychometric (problems & functioning) scale measures (Ohio Scales)

We are evaluating ongoing efforts within various nationally recognized organizations and standards bodies, such as the National Quality Forum, to identify and apply additional measures that will be relevant, useful, and statistically valid for services for children with special health care needs. This combined set of measures will give us a more detailed picture of an enrollee's needs and provide better and more comprehensive enrollee-tailored services.

E.2.e. Considerations for Value-Based performance (VBP) designs, specifically those that support and align with objectives identified within the Oklahoma State Innovation Model design

Aetna's quality system incorporates tools and measurement systems such as HEDIS measures, claims, and call center performance metrics. To measure results, we use both manual and automated data collection methods - we capture the data in our information systems, run both periodic and ad hoc reports, monitor trends and patterns, and analyze results to identify opportunities for improvement. Quality process will allow for the implementation and evaluation of value-based payment performance designs that will be most beneficial for foster care children and that will support the Oklahoma State Innovation Model.

Aetna's strategic approach for Oklahoma as described in Sections C and D will continue to target providers in a manner that maximizes the number of enrollees included in VBP payments. We will work collaboratively with the State to develop plans that progress toward Oklahoma's goal of 80 percent of medical spend by 2020.

In Aetna's integrated care program for Oklahoma, we already began collaboration with providers that are most ready and able to participate in value based purchasing strategies. We will also leverage Aetna's commercial and Medicare presence in the State to identify Oklahoma providers that are receptive to VBP arrangements.

We are well positioned to be a partner with Oklahoma Department of Health Services as the performance incentive awards program evolves, including incorporation of chronic disease related metrics. Aetna's holistic, person-centered approach to every enrollee focuses on all aspects of quality of care, from need identification to access to service delivery to outcomes. This approach directly aligns to the Oklahoma triple aim goal of assisting enrollees in becoming self-sufficient and actively engaged in their health care, improved quality and outcomes at lower expenditures.

F. Data Model

1. How does your care coordination model provide for efficient management of data to ensure that the child experiences quality and safety?

Aetna’s care management teams work in concert with Aetna’s medical and quality management programs to monitor utilization data and promote provider use of evidence-based medical guidelines and practices. Using an integrated approach, our case management teams work closely to educate providers on covered services and to help ensure enrollees receive the evidence-based care and services they need—safely and effectively. We use a biopsychosocial clinical model to evaluate the individual needs of enrollees relative to their physical and behavioral health. This model incorporates utilization management decision-making criteria to ensure appropriate evidenced-based clinical settings and services are used to treat both behavioral and physical health conditions.

Aetna case managers further incorporate utilization data analysis and data management; concurrent review, prior authorization, and retrospective review; adoption and dissemination of practice guidelines; and both new medical technologies and new uses of existing technologies, along with care management, care coordination, disease/chronic care management, and drug utilization review to meet program objectives in adherence to contractual requirements that support enrollee safety and quality.

Data Sharing and Integration

CareUnify, our proprietary population health management platform, is designed to deliver actionable data to our provider and community services providers. It aggregates actionable data from multiple sources including electronic health records, health information exchanges such as My Health Access Network and Child Passport, and sources such as public health departments to create an individually tailored enrollee profile as well as a larger clinic or panel view for each provider. The system is designed to push and pull data to and from various systems and can align providers from different organizations using care paths to drive care coordination. For example, CareUnify has several care transition paths that can be tailored to each provider’s workflow while allowing all participants of the care team, regardless of their system, to be aligned on workflow tied to each enrollee’s episode of care, providing clearer hand-offs and ensuring all aspects of an enrollee’s care are met. CareUnify is capable of capturing data around social determinants of health and create real time enrollee alerts for our care managers. We can address high-risk ZIP codes where families are prone to lack of adequate housing needs or health food options, or where foster care children are prone to educational barriers.

The following examples illustrate how Aetna uses CareUnify to collaborate with providers:

- Care paths for transitions of care from behavioral health inpatient settings that include a PHQ-A administration
- Care paths to engage enrollees who have opioid use and medically complex medical issues
- Care paths for enrollees discharged from inpatient admissions

Aetna’s priority is to develop and maintain processes that promote quality and safety through the collection and sharing of enrollee data. An important part of our data-sharing strategy includes direct links to State health information exchanges such as My Health Access Network and Child Passport, from which our CareUnify platform incorporates real-time admission, discharge, and transfer data and other information useful to facilitating care management and early interventions into the patient care record. For example, real-time inpatient alerts enable Aetna’s care managers to contact inpatient facilities’ discharge planners on the day of admission and begin coordinating the enrollee’s discharge with the support of the Family Team.

CareUnify shares actionable data across systems and organizations to promote effective care management—especially for complex, high-risk individuals. CareUnify gives network providers the ability to see aggregated data to support actionable decision making at the point of care. Providers and the child and Family Team are provided with updated individual care plans, which can be easily accessed through the enrollee portal and the provider portal.

Health Information Technology (HIT)

Aetna’s CareUnify™ platform connects the entire community of preferred support, including enrollees. It persistently filters through eligibility, provider, and claims data to create logical relationships among providers and care team members, facilitating communication, collaboration, and information-sharing among all stakeholders. We will partner with My Health Access Network and Child Passport to share data that is pushed directly into our CareUnify population health platform and is viewable by our entire provider network. By connecting to My Health Access Network, we will support our providers to combine the best-of-breed data from that system, our provider electronic health record systems, and our claims and care management data, to create a 360-degree view and robust data set to promote more efficient care coordination.

Aetna will remain compliant with all evolving requirements specified by CMS and ODHS, including data interface and data exchange capabilities to connect to Medicaid Information Technology Architecture 3.0 systems. Information is fed into our electronic care management system and CareUnify, our population health platform, primarily through our system for claims, enrollee, and provider data. This system also houses current provider contracts, claims, enrollee eligibility, authorization, and concurrent review data.

System Alert Flags for Gaps in Care

Aetna reminds enrollees and their families of the importance of wellness checks at every point of contact to help ensure that enrollees experience quality and safety. Flags in our system alert care managers when the enrollee needs services or has a gap in care for HEDIS measures such as flu shots, well visits, and immunizations. This initiative started first in 2015 with our Aetna Better Health of Pennsylvania plan. For Well Child reminders for children 0 to 15 months and children 3 to 6 years old, of the enrollees reminded, we saw an increased number of enrollees receive well visits following completion of the wellness check call. Aetna implemented this initiative in all our health plans following demonstrated success in Pennsylvania.

Ensuring Compliant Exchange of Personal Health Information

Aetna will operate in compliance with HIPAA requirements to make sure the exchange of personal health information is conducted in a compliant manner. Data sharing is critical to our work; we make sure we send and receive data through all required interfaces. Aetna establishes and maintains connectivity with the DoIT data center as required and provides staff with the hardware, software, communication equipment, and training to succeed in their work promptly, accurately, and efficiently, and in accordance with contract requirements. Aetna staff members are trained and tested annually on HIPAA compliance and on privacy laws.

Additionally, Aetna obtains release-of-information approval from the enrollees and families, identifying who and what type of information we can share with others, including documented release specific to behavioral health and substance use outside of transition activities or in times of crisis. The completed form's detail is documented in our database for ease of access by care managers. When an inbound call is received, Aetna staff completes verbal verification of the caller and reviews our database to ensure a documented release information has been entered before providing enrollee personal health information.

When we receive a request for information such as individual care plans, enrollee goals, and nurse notes from another health plan or the Department for transition-of-care purposes, we electronically send them in PDF format via secure email or work to establish a secure data exchange.

Supporting Transitions

Effective data management is crucial in providing safe care transitions, which are critical to maintaining and improving enrollees' quality of care, quality of outcomes, and, most importantly, quality of life. Because enrollees are more vulnerable when transitioning between delivery systems, effective data management is vital to preventing adverse enrollee events. Emphasizing continuity and coordination of care, we work to maintain the stability of enrollees' care. Our processes ensure all enrollee populations receive continuity of care and the highest level of service and oversight to address their unique clinical and care management needs.

Aetna's data management system automatically reviews the daily State 834 file to identify prospective high-needs children or youth in care and trigger immediate triage and outreach prior to their effective date. This enables us to provide support through the transition to aid in continuity of care and assistance in navigating the health care system. Our enrollee transition policy and data management system provide an automatic process that supports a smooth transfer of information and continuation of care, whether an enrollee is transitioning into or out of our health plan.

To facilitate transitions of care, Aetna uses a data feed provided by the previous health plan to capture and set up existing service authorizations within our system. Our utilization model program helps make sure that new enrollees receive continuing care through their current providers.

Prior authorization for covered services—including physical health, behavioral health, home and community-based services, medications, and specialty referrals in place on the day prior to enrollment—will remain in place for 90 days for all enrollees. Whenever we have new enrollees with prior authorizations approved by the previous health plan, we make sure service authorizations remain in place and are honored during the transition period by:

- Turning off edits in our claims system requiring authorizations for a period of 90 days
- Building service authorizations into the system for any case that requires prior authorization or for a non-network provider.

The pharmacy benefit offers a 90-day transition of care supply for all medications within the first 90 days of enrollment. Enrollees receive three consecutive 30-day supplies of medication regardless of formulary status, except for specialty medications or Medicaid-excluded drugs. Aetna sends a letter to enrollees after each transition prescription fill informing them of the formulary status of the drug and on how to obtain a prior authorization from their prescriber.

For enrollees with an existing care or treatment plan in place on the day prior to date of enrollment, Aetna will accept the existing individual care plan for 90 days, or until the enrollee completes a comprehensive assessment and an updated individual care plan has been developed, approved, and implemented. Care managers work closely with the child and Family Team and with the Pharmacy department during the transition period to make sure there are no gaps in the enrollee's access to care and services.

We use a continuity of care form to exchange information about enrollees transferring between managed care organizations. This form is used to share important information about the enrollee's prior inpatient utilization, ER utilization, medications, durable medical equipment, home care services, primary care provider, and specialists. We process all continuity of care forms within three business days of receipt and enter the data into our care management system. Enrollees identified in, or in need of, care management are outreached within five business days by the Care Management staff. These enrollees are offered a face-to-face visit within the first 30 days of enrollment in care management. Our Care Management staff completes health risk screenings and comprehensive assessments to evaluate needed services according to the timeframes outlined by the Department.

Customized Reporting

Aetna will collaborate with the State and Oklahoma Child Welfare Services on identifying reports that specifically show safety and quality concerns for foster care children. This may include reports such as prevalence of psychiatric hospitalizations, readmissions, or emergency department utilization. Reports can be customized to meet the needs of children in foster care. For example, the Oklahoma FY17 Pinnacle Plan report outlined that improvement opportunities remain for children in Oklahoma foster care and permanency outcomes. Our care managers will use information from these reports to modify goals in care planning such as addressing access to care issues and social determinants of health that impact permanency.

G. Care Coordination Implementation Timelines (*including key activities and milestones*)

1. Based on prior experience, provide insight into what a realistic timeline for implementation of your Care Coordination model might be. Specifically, provide details into the following aspects of implementation of a Care Coordination model similar to what has been described:
 - a. Development
 - b. Transition/Readiness Activities
 - c. Implementation of enrollee enrollment
 - d. Implementation of enrollee service delivery

Building and fostering relationships—the kind necessary to make a lasting difference—takes time. We invest that time, through face-to-face meetings, telephone calls, and public forums. We support enrollees’ efforts to change their behaviors, follow their physicians’ treatment recommendations, and adopt healthier lifestyles by caring, empathizing, listening, planning, thinking, and educating enrollees to reach a common understanding and shared goals.

Aetna has an experienced national implementation team that uses a standardized project model approach to implementation. We identify and track completion of key activities, milestones, business owners, start and end dates, duration, task completion, barriers, and resources. Aetna is proposing an 8-month implementation timeline for our integrated care management approach, with a maximum of 12 months depending on the complexity of services needed.

Aetna’s implementation strategy includes oversight by our national implementation team who is solely dedicated to ensuring successful transition of service delivery to our managed care organization. This team is responsible for project oversight, timeliness, communication with State regulators, and task achievement. Aetna uses project management leads and software to track and monitor implementation activities. Our implementation team is also responsible for oversight of “go-live” activities and facilitating post go-live transition and communication.

Aetna will collaborate with OHCA to determine key activities and milestones for this implementation. Typically, our key activities include:

- Initiating implementation
- Executing departments, hiring for departments, and supporting department specific go live tasks
- Initiating, testing, and managing enrollee open enrollment
- Completing a mock readiness review with the State
- Facilitating go live
- Transitioning from implementation to service delivery using our command center approach

G.1.a. Implementation Development

Aetna has learned that the following factors contribute to a seamless transition when implementing health care systems:

- Transparent communication and collaboration with State DHS and Child Welfare Services

- Clear expectations from the State on timelines, milestones and service delivery
- Timely fee schedules

Aetna will outreach Oklahoma Child Welfare Services to build a strategic partnership and collaborate toward achieving outcomes. Aetna will immediately begin coordinating with the State on the 834 enrollment files and encounter data, ensuring file formatting and formatting of reports.

G.1.b. Implementation Transition/Readiness Activities

Aetna will leverage our experience across the Oklahoma and national Aetna enterprise to enable a successful transition for foster care children new to our program. Aetna’s demonstrated success implementing our integrated care management model using our standardized implementation strategy positions us for readiness for this large, system-wide transition in Oklahoma.

Aetna has overcome anticipated challenges in implementing programs for similar populations. The table below illustrates our lessons learned and aids us in achieving more timely and effective future implementations.

Implementation Lessons Learned

Anticipated Challenges and Opportunities	Aetna Solution
Enrollee Population New to Managed Care	Educating families about Aetna’s coordination of care capabilities can help reduce anxiety and make for a better experience for families new to a managed care organization. Recognizing many of the families are transitioning from a fee-for-service model, we have experience with conducting public forums in which families have an opportunity to ask us questions about their programs and services. We can provide an overview of their programs and give families an understanding of our coordination of care capabilities.
Provider Education	As the State’s focus shifts to value and outcomes, Aetna’s provider engagement team will continue work to strengthen partnerships and meet with practice groups composed of family medicine and pediatric specialties, and hospitals that provide obstetric, neonatal, and/or pediatric services. We will provide information on how our integrated care approach can assist to access services including medical, behavioral, in-home, and community supports for children with high needs and their families. Our provider orientation training materials and provider handbook will be updated to include information on early intervention. We also will educate and assist providers who have not been part of a managed care organization before and do not know business fundamentals such as how to bill, how we operate, the check run schedule, and contractual claims payment requirements.

Anticipated Challenges and Opportunities	Aetna Solution
Contact Information	Aetna will continue to work with the State to capture the most accurate contact information for enrollees and with vendors to engage difficult-to-reach enrollees. We will partner with State agencies and community providers, leveraging their contacts and access to locate enrollees.
Coordination and Communication with State Agencies	To prepare for the significant mobility of the children in the care population, Aetna will leverage lessons from our Arizona plan, which focuses on coordination and communication by deploying a dedicated child welfare team that serves as the single point-of-contact for Oklahoma Child Welfare Services.
Trauma-Informed Focus	We will adapt practices from Aetna’s Arizona plan, which has conducted training series on trauma-informed care to support systems to view children’s behavior with a trauma-informed focus. The plan has trained child welfare contracted group homes and offices.
Staff Preparation	Aetna educates our staff on trauma-informed care, our core population health strategy, and uses vehicles such as day-in-the-life training simulation exercises. We will include training on child assessment, wraparound services, and youth in care. Aetna’s staff also will be Youth Mental Health First Aid-certified.
Transitioning from Child To Adult System of Care	Aetna hires child and system of care specialists to work with the enrollee, family, community, and case managers to support enrollees moving from the child to adult system of care.

G.1.c. Implementation of Enrollee Enrollment

Aetna recognizes how critical it is to ensure marketing and messaging to the enrollees and families served in its plans. Typically, we notify families of the availability of program benefits through the Enrollee Handbook (available online); new enrollee welcome calls, messages, and welcome packets; mailings; and direct communications, such as the enrollee newsletter. The Enrollee Handbook explains program specifics for vulnerable youth and lists contact information for requesting integrated care management services at any time.

Once the enrollee is enrolled, Aetna’s care managers describe the integrated care management program in detail during assessment and care planning activities. During this initial contact with the enrollee, our care managers inform the enrollee about the nature of the services, circumstances under which information will be disclosed to third parties (such as complying with

HIPAA), the rationale for implementing care management services, how the services may benefit the enrollee, and the availability of a grievance and appeal process.

We create and enhance enrollee educational materials with the enrollees' needs in mind, as well as our goal to improve health literacy. The programs and materials we provide do not discriminate against enrollees based on their health history, health status, or need for health care services. Our health plans have adopted the enhanced national standards for Culturally and Linguistically Appropriate Services (CLAS) in health and health care developed and promoted by the United States Department of Health and Human Services Office of Minority Health. We strive to meet all 15 standards and through our Cultural Competency Plan (CCP) that addresses each of the standards that support the "Principal Standard." We also have our own standards for developing materials—standards that are consistent with and support the CLAS standards. Because our enrollees' needs and cultural backgrounds are diverse, we tailor our words, the tone of our messages, and any graphic representations to meet their needs, preferences, and expectations. Additionally, for young enrollees, we focus on delivering the message in ways to which they will relate, such as using text messaging, social media, and video messaging through resources such as YouTube.

Aetna creates all enrollee presentations and materials using what we call "plain speak." This means we use active voice in our written communications, avoiding jargon and technical language when possible; we use clear word choices and express complete thoughts; we use legible type in at least 10-point font size, simple layouts, and appropriate space; we write in clear, easy-to-understand language, helping us simplify the complexities of the health care system, including our enrollees' benefits and services; we organize written materials using short sentences and paragraphs; we write materials at or below a sixth-grade reading level, according to the Flesch-Kincaid Reading Ease scale; we translate our written English materials into Spanish and all other identified, commonly used non-English languages, free of charge, according to contract requirements; we ensure all letters receive certification with letters of attestation to verify their accuracy; and we provide materials on our website that are compliant with the Americans with Disabilities Act and Section 508 of the Rehabilitation Act of 1973, as amended 29 USC §794(d).

G.1.d. Implementation of Enrollee Service Delivery

Aetna uses a daily command center methodology to manage transition and ensure readiness. This includes mock readiness reviews regarding every policy, procedure and requirement outlined in the contract scope of work. Aetna facilitates the command center daily for a period of 30-120 days depending on the complexities of the health care system being implemented. We anticipate a two to three-month transition post go live that includes Aetna and providers' C-suite and operational managers regarding communication, reports, claims, and barriers to care. Aetna tests 834 enrollment files prior to go live. We use the enrollment files to drop enrollee ID cards and enrollee mailers, send value add to pharmacy vendors and other vendors. Aetna reviews all welcome packets for quality and ensures timely mailings. We initiate welcome calls are done on go live date forward and typically initiate implementation of our departments the day before or on midnight of the go live date.

Aetna publishes a Provider Manual that is developed in accordance to federal, State, and local requirements. Our Provider Manual encourages strong collaboration with our network of credentialed and contracted providers to administer and manage efficient, effective, and quality health care to enrollees. It also provides all the details providers need to successfully provide services to our enrollees. The Provider Manual offers an in-depth, step-by-step overview of topics, including specific covered health services for which the provider is responsible, prior authorization and referral procedures, multilingual and TDD availability, and others. To offer the most effective response and care possible, we include links to a variety of articles and training opportunities, including those through the Substance Abuse and Mental Health Services Administration (SAMHSA), the U.S. Health Resources & Services Administration, and the Agency for Healthcare Research and Quality. These resources can inform all care provided to this population from primary care to specialty psychiatric interventions.

Aetna offers educational forums with in-depth training on rotating topics for all providers. Aetna collaborates with the State on required training topics. Examples include:

- Navigating Aetna’s behavioral health system
- Reduction of emergency room utilization
- Reduction of racial and ethnic health care disparities to improve health status
- EPSDT
- Children with special health care needs and disease specific care

At Aetna, we believe in meeting face-to-face with our providers regularly to build relationships and rapport around common implementation issues. We discuss claim denials related to prior authorization requirements. For prior authorization issues, our staff conducts a conference call with the provider staff and an enrollee of our Prior Authorization team to review specific examples in the system. To support our face-to-face training, we publish reference documents, such as the Provider Manual, bulletins, and our quarterly newsletters.

In addition to making health care related topics available for training, Aetna will also make available training opportunities regarding child welfare and permanency—a complex topic. We either offer training or provide links through various sources, including in-person workshops and webinars. These training sessions include information on how the system works, which authorizations need to be in place for foster parents to make medical decisions for children, when the child’s child welfare services must be involved, and the requirements for providers to appear at court hearings and clinical staffing.

Please see Section C for additional detail on Aetna’s current provider network and processes for network development that demonstrate our readiness to implement a comprehensive integrated provider network and service continuum.

Partnering with Oklahoma for the Long-term

Embracing the transition to managed care is most successful when it occurs in partnership with an experienced health plan leader with the proven ability to effectively manage utilization of health services and improve health care quality and outcomes. Furthermore, this transition requires a health plan that places enrollees—and the services and supports they need to maintain

and enhance their health and overall quality of life— at the forefront. Aetna stands committed— with confidence and enthusiasm—in our ability to partner with Oklahoma in this transition and to meet the OHCA’s goals and objectives. With its significant strides in recent years to meet the needs of vulnerable and underserved Oklahomans, the OHCA serves as a leading example to other states. In partnership with the OHCA, Aetna welcomes the opportunity to leverage our long-standing, in-depth experience in Oklahoma, vast provider network, expertise in value-based purchasing, innovative technology, rebalancing efforts, and, most importantly, person-centered, fully integrated care, in our mutual quest to help Oklahomans live healthier, happier lives for the long-term.



October 19, 2017

Mr. Gerald Elrod
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

Via email: Gerald.Elrod@okhca.org

RE: Oklahoma Health Care Authority RFI Care Coordination for Children in DHS Custody

Dear Mr. Elrod:

Amerigroup Oklahoma, Inc. (Amerigroup) is pleased to submit our response to the Request for Information (RFI) for the Care Coordination for Children in the Oklahoma Department of Human Services Custody (DHS) issued by the Oklahoma Health Care Authority (OHCA) on September 19th, 2017.

Currently our parent company, Anthem, Inc. (Anthem), and our affiliate health plans serve nearly 58,000 youth in child welfare systems across 10 states. As a Medicaid Managed Care Organization with a strong background of serving youth in foster care, we are excited to offer input and share our experiences with the OHCA.

We are excited about this opportunity and look forward to further conversations and partnership with OHCA. Should you have any questions, please contact me by telephone at (512) 382-4981, or email me at Tisch.Scott@amerigroup.com.

Sincerely,

Tisch Scott
President and CEO
Amerigroup Insurance Company

EXECUTIVE SUMMARY

Amerigroup Oklahoma, Inc. (Amerigroup) appreciates the opportunity to respond to the Oklahoma Health Care Authority (OHCA)'s Request for Information (RFI) expressing the State's desire to obtain information from subject matter experts regarding Care Coordination Models to serve children who are newborns through age 18, who are in the custody of the Oklahoma Department of Human Services (DHS). Amerigroup is part of the Anthem, Inc. family of health plans, which collectively serves more than 6.5 million enrollees in 20 markets. Our organization has more than 26 years of experience providing care management and coordination for state-sponsored health programs, including 17 years of experience serving children in state custody. This strong history of service and expertise as a Medicaid Managed Care Organization (MCO) serving children, youth, and young adults in state custody informs our approach to support our nearly 58,000 members across 10 states who meet these criteria. We understand the vital role MCOs play in promoting safety, permanency, and well-being for our members, as well as providing the right supports and resources needed to become successful adults. As a testament to our commitment to our individuals in state custody, our health plan affiliate in Georgia was recently re-awarded the sole statewide contract overseeing the whole-person care of nearly 28,000 children in state custody that includes foster care, adoption assistance, and juvenile justice.

Amerigroup understands the importance of developing strong relationships with families, communities, providers, state agencies, and other stakeholders in Oklahoma, because these relationships have enormous influence on the well-being, health, success, and overall outcomes for children, youth, and young adults in DHS custody. We understand the strengths and needs of the populations we serve and work hard every day to address the challenges individuals may experience in achieving their personal health and wellness goals.

We recognize the value in the State's work thus far to implement the robust Pinnacle Plan as well as the ongoing Child Welfare Strategic Plan and related initiatives. For the Care Coordination for Children in DHS Custody program, Amerigroup envisions a single-MCO solution. Amerigroup has the experience to be a true partner to the State, bringing additional expertise to what OHCA and DHS have already successfully achieved and helping to unify stakeholders to continue forward with the State's vision and philosophy. *Our person-centered, trauma-informed care model promotes choice among youth and their caregivers, use of natural supports, collaboration, home- and community-based care, and culturally relevant services that are individualized, strengths-based, and outcomes-based.*

At Amerigroup, we believe that health is about choices, and our philosophy is to provide comprehensive health benefit plans that are tailored to our customers' specific needs, and develop new products and services that address the health insurance issues of a modern and progressive society. We go beyond expectations in our commitment to support children, youth, and young adults in their communities, help them become independent, productive members of society, and support them in their transition to adulthood.

SCOPE OF WORK

A. Patient-centered Service Delivery Care Coordination Models

Over our 26 years of experience providing care management and service coordination for state-sponsored health programs, including 17 years of experience serving children in state custody, we have discovered and developed approaches to best serve the needs of children, youth, and young adults in DHS custody. These are performed in collaboration with other stakeholders, including their families, their caregivers, the State, and others involved in the child’s life.

Because children, youth, and young adults in DHS custody face increased risk of exposure to poverty, abuse, neglect, and community violence, they require a coordinated, trauma-informed, whole-person care that addresses mental health, substance use disorder, and physical health challenges unique to this population. Amerigroup believes the best approach to a continuum of care that meets the unique needs of youth in child welfare is *for a single statewide MCO to manage the full range of benefits and services for children, youth, and young adults in DHS custody, as well as their families,* and additionally that this single MCO should be one of the managed care plans for Oklahoman children overall.

1. Description and Rationale for Amerigroup’s Chosen Model

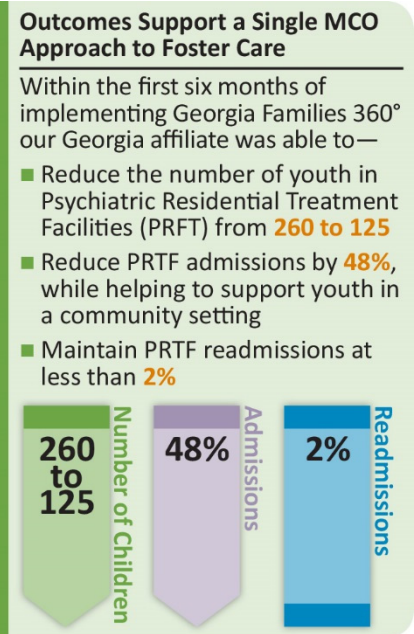
Single, Statewide Managed Care Organization to Serve Children, Youth, and Young Adults in DHS Custody

Amerigroup recommends that DHS select a single statewide MCO that is also a statewide Medicaid MCO, to manage the full range of benefits and services for children, youth, and young adults in DHS custody, to reduce fragmentation and provide better access to the wide array of services and resources members and their families need, when they need them, through a single point of entry.

Amerigroup is committed to helping children, youth, and young adults in DHS custody achieve permanency, and return to their communities as quickly as possible. Through no fault of their own, children frequently move in and out of state custody. The single-MCO approach promotes greater stability and continuity of care for children, youth, and young adults in DHS custody if they move between placements and foster families, and ultimately supports efforts towards permanency. A single, statewide MCO will provide the State a more streamlined, less administratively complex program.

Requiring a single MCO to be responsible for all services and supports enhances accountability for access to care and services and improved health outcomes, minimizes administrative burden for agencies and providers, and takes advantage of economies of scale.

An MCO has the best opportunity to positively impact these members’ health status by building a relationship with each member before they enter DHS custody, during and/or when they transition out. Through these relationships, the MCO can continually assist in addressing social determinants of health, improving members’ outcomes. *Remaining with the same MCO is important for stability and*



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continuity of care for children, youth, and young adults in DHS custody, particularly as they move between placements and foster families, and strengthens permanency planning. In our single-MCO approach, there is one less thing that has to change for members, and those who care for them, when so much else is changing around them. By remaining with the same MCO, children, youth, and young adults in DHS custody have the best chance of keeping their same providers and consistent care and service plans. Our experience indicates the single-MCO approach within a larger program is the best model to help members live in their communities, achieve permanent living situations, and develop the life skills they need to be independent, well-functioning adults.

A single MCO will make coordination with child welfare and other agencies more complete, comprehensive, productive, and effective, which will contribute to a more unified system of care for these children. As recognized in several areas within the Pinnacle Plan Measures, Semi-Annual Summary Report of February 2017 (the “Pinnacle Plan Report”), *continuity of support by a primary case worker and placement stability are important for the success of children, youth, and young adults in DHS custody.* Navigating multiple systems can be frustrating for all stakeholders, and it contributes to both caseworker and provider turnover. The single-MCO approach eliminates the need for foster parents to interact with multiple MCOs, especially for those that are caring for more than one child. Similarly, this model benefits stakeholders throughout the entire system of care, including families, caseworkers, providers, schools, child serving agencies, etc. by promoting collaborative relationships through a dedicated point of contact.

Additionally, a single MCO approach enables investments in the system of care that would otherwise be challenging if membership were fragmented. A single MCO has an advantage in coordinating information and data sharing, thereby decreasing fragmentation and addressing the Pinnacle Plan’s outcomes. A single MCO approach would promote a strong partnership that brings our national expertise to augment what has already been successfully achieved. For example, in our sole statewide Georgia program, we have been able to implement specialized programs to support the State’s many goals.

Person-centered, Trauma-informed Care Coordination Model

Amerigroup’s care coordination model is comprised of people, processes, and systems that are meaningful, proactive and far-reaching, to minimize fragmentation and duplication. Our long-standing philosophy is that *care should be delivered through an integrated approach that is tailored to the individualized needs of children, youth, and young adults in DHS custody.* Our person-centered, trauma-informed, fully integrated care coordination model seamlessly links children, youth, and young adults in DHS custody to the care and services that meet their needs, addressing social determinants and improving their health outcomes. Our model includes regionally-focused teams that meet members and providers where they are, a strong statewide and local, culturally competent, community involvement and engagement strategy that addresses

Specialized Programs Implemented by Our Sole-MCO Georgia Affiliate

- **Partnering with Juvenile Justice** —The Amerigroup Georgia Juvenile Court Health Integration Program partners directly with courts so that when kids come into care, they are connected directly to an EPSDT and Trauma Assessment provider to break down barriers to care. This has led to significant increases in EPSDT compliance rates for youth newly entering care, with some counties achieving **100% compliance**.
- **Coaching and Comprehensive Health Supports (COACHES) Program**—this program employs personal coaches who work one-on-one with young adults, ages 17-20, to improve healthy behaviors and build their skills toward a successful transition to independence.

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needs across both rural and urban areas of the State, and fiscally responsible operations that reduce waste and promote accountability. Amerigroup’s recommended model links members with providers, community resources, technology, OHCA, DHS, and other stakeholders to support the member’s safety, permanency and wellbeing. The critical linkage we create doesn’t stop with the member; instead, our model also connects these resources with *each other*, encouraging collaboration, efficiency, exchange of meaningful information, and shared responsibility for improved outcomes.

Our model supports the following:

- Completion of a trauma responsive health needs assessment of our members’ trauma, medical, behavioral health, dental, and social needs in the required time frame
- Assignment of an experienced care coordinator with the expertise most closely aligned with the member’s needs and conditions
- Development of a whole-person, person-centered, trauma-informed health care service plan (HCSP) and safety crisis contingency plan (SCCP) as needed, based on the member’s current and historical information and assessment results and tailored to the individual strengths and needs of the member and family
- Engagement of the interventions, services, supports, and resources identified on the HCSP and SCCP delivered by community-based providers and organizations to improve the health of our member, drive quality outcomes, and promote consistency across the delivery system to support the member’s safety, well-being, and permanency
- Facilitation of continuous monitoring of service delivery and outcomes data to evaluate the quality, effectiveness, and accessibility of our delivery system
- Initial and continual development of our model includes input from key system partners including state agencies, community-based providers and organizations, and other community stakeholders, such as child welfare advocates and Court-Appointed Special Advocates (CASAs).

2. How Our Model Addresses the Needs of Children, Youth, and Young Adults in DHS Custody

Amerigroup listens and has experience with these populations — children, youth, and young adults in DHS custody — and knows that they have unique personal experiences, and that addressing their needs means more than simply modifying an existing Medicaid program or bringing in a program from another state. It requires understanding the specific challenges they face before and after removal from their homes and families, as well as deep knowledge of the Oklahoma landscape and the system of care to develop a program that can adjust to and meet their particular and diverse needs.

Our care coordination model meets the needs of children, youth, and young adults in DHS custody through an integrated, person-centered, trauma-responsive approach that assures every child, youth, and young adult receives individualized services and social supports at the level needed for their condition and personal growth. This model supports the safety, well-being, and permanency for children, youth, and young adults in DHS custody with a range of needs, including the most complex needs, using care coordination staff who are experienced in trauma-informed care and trained in the concepts of this model.

Additionally, our model includes care coordinators with specialty experience to best meet the needs of our members. This specialty experience can include assessment, psychiatric, and pediatric experience, as well as the ability to coordinate the care for those with complex or specialized health care needs, such as medically fragile members, discharge from higher levels of care, and young adults preparing for transition to adulthood. We make it a priority to hire care coordinators with experience working within their local children's system of care, and that have experience working with individuals with disabilities, individuals from different cultural backgrounds, and individuals that are lesbian, gay, bisexual, transgender, and/or questioning. We also hire care coordinators with maternal and child expertise to coordinate care and services for pregnant and parenting members to address their needs across the spectrum of care, including prenatal, delivery, and postpartum care.

Our member-centered network approach emphasizes community-based, coordinated, culturally competent, accessible care and services. Our model includes a strong infrastructure and tools to build and support *a robust provider network with experience with children, youth, and young adults in DHS custody, Adoption Assistance, and the juvenile justice system*. Our model of support includes tools to reduce administrative burdens and facilitate coordination of care as well as an extensive training and technical assistance program to keep them abreast of the mental health (MH), substance use disorder (SUD), and physical issues that impact our members. As noted in the Pinnacle Plan Report, training and supports for providers have been integral in obtaining better outcomes for Oklahoma's youth in DHS custody. This model would enhance the State's efforts in areas such as shelter services, trauma informed care, cultural competency, psychotropic medications, and placement stability.

Our model also includes statewide community outreach to stakeholders that seeks input and opportunities for system and process improvement. Through outreach, education, participation in local and national boards and community involvement, we advocate for our members on the national, state, and local level to promote understanding of the challenges these young individuals face and to increase support for the vast array of diverse needed services.

3. Amerigroup's Approach to Implementation of this Model

This care coordination model assumes a single statewide MCO that also serves as a managed care plan to manage the full range of benefits and services for Oklahoman children outside of state custody. With a limited population of fewer than 10,000 children, it would be difficult to sustain the development and maintenance of the infrastructure needed to care for children, youth, and young adults in DHS custody. *Having a statewide foundational infrastructure, as well as experience with similar complex child welfare programs, is key to a successful implementation.*

Amerigroup's affiliates have a long history of successfully implementing programs across the country. We have well-established teams and processes prepared to deliver the systems, infrastructure, and network capacity requirements for a successful implementation. In addition to our comprehensive project management resources and expertise deployed for all new Medicaid programs, Amerigroup also has Specialty Product and Advocacy Teams with expertise in child welfare, mental health and substance use disorders, and members with specialized health care and developmental needs, to support this implementation as well as provide ongoing support to promote individual outcomes and program success. We have built our reputation on honoring our

commitments and doing what it takes to meet deliverables on time and to make transitions as seamless as possible for our members.

Our experience with similar programs has taught us that the key steps to a successful implementation include consumer, advocate, provider network development, staffing development, building core operational capabilities, and stakeholder and community engagement — for example, early engagement with parents and organizations that serve children, youth, and young adults in DHS custody and that may be different from those involved with traditional TANF/CHIP members.

B. Access to Health Services

Amerigroup’s approach to ensuring our members have access to the services they need requires person-centered, whole-person care coordination within a statewide network of quality providers, both of which must be monitored through a comprehensive Quality Management system and provider network monitoring processes. Our model serving children, youth, and young adults in DHS custody would be best implemented as part of a larger managed care program to make sure that a sufficient foundational infrastructure exists to meet the complex needs of these members. Additionally, our model provides for a dedicated access process for inquiries and emergencies so that children, youth, and young adults in DHS custody can quickly receive necessary care. To promote timely access to necessary services, our model also uses a robust Member Services department supported by adaptive technology. These resources help connect members to the providers and services they need, including alternatives such as telemedicine, our 24/7 Nurse Helpline, our 24/7 Behavioral Health Crisis Line, and other supportive services.

1. Ensuring Children’s and Families’ Access to Services

Care Coordination to Ensure Access to Care

We promote access to care by linking our members to person-centered, whole-person care through meaningful care coordination. Because we know the impact trauma and adverse childhood experiences have on our members’ emotional and physical development, health, and quality of life, we recommend a care coordination system that meets their immediate needs upon enrollment and continually adjusts to their strengths, needs, and conditions as they move towards resiliency, recovery, permanency, and ultimate independence.

The focus of our model is the safety, permanency, and well-being of each member. We immediately initiate the assessment process for each new member upon enrollment through a single point of entry—our Intake Compliance Team, staffed by experienced Outreach Care Specialists. Additionally, our Member Services Call Center is available twenty-four hours a day, seven days a week (24/7) to assist members and caregivers.

We understand our members enter state custody for varying reasons and no two have the same experiences. For this reason, we recognize the importance and value of a knowledgeable, experienced, and diverse team of care coordinators who are trained on trauma and the principles of our model of care, and who possess the expertise and skills to adapt to and meet the broad range of unique and diverse needs of our members and families. We recruit, hire, train, and retain a variety of licensed and non-licensed clinicians who share and support our vision and mission of one unified system of care.

Our Amerigroup care coordinators employ a comprehensive discovery process to create an Individual Care Plan (ICP) that documents all services and supports across the spectrum of available benefits and aligns with the member's needs, preferences, and goals. Collaboratively, through *real-time access to our Care Management System* and tools, our team will continually monitor and confirm the implementation of the member's ICP, as well as continually assess new changes that warrant a change in the ICP. By verifying that the member receives services and supports they need, and anticipating future service needs that include primary and preventive care and ongoing care for chronic conditions including MH and SUD, we will boost health and social service outcomes and reduce the cost of care.

Analytical and predictive modeling tools, including those developed specifically for foster care children, support care coordination for Amerigroup's members by identifying members at risk for inpatient admissions, psychiatric residential treatment, chronic disease care gaps, and other changes in health care needs. When applicable, we offer members complex case management and other resources to address identified needs.

We also engage providers, our State partners, and graduates of the child welfare system, people with lived experience, and other stakeholders and provide opportunities to hear from them about their experience with access and barriers to care. Through our national experience, we have identified the most common barriers to accessing services, which include: placement changes, separation from home communities, trauma, lack of transportation, geographical barriers, educational disparities, cultural and linguistic barriers, physical or developmental disabilities, and psychological factors. Addressing barriers is not "one size fits all," and we approach each member's experiences individually to incorporate solutions as part of their care coordination. While our approach to addressing barriers is as individual as our members, we have developed programs and technology that provides the framework for addressing common barriers.

Our care coordination approach makes sure the member and family receive the right services and supports at the right time and in the right place. We use key information and resources to determine and respond to our members' initial and continuing needs and risks, engage immediate intervention for urgent and crisis issues, and determine the level of care coordination and types of services needed based on the intensity of those needs.

Trauma-responsive Provider Network

As detailed further in Section C – Staff/Provider Network, our provider network recruitment and retention strategy is designed to promote successful development of a trauma-responsive, comprehensive provider network aligned with State-specific program goals and objectives.

Amerigroup works with our provider network and other systems of care stakeholders to develop new and enhance existing community-based services, supports, and programs. We design these innovations and enhancements to help members address trauma, recover from difficult past experiences and find permanency by promoting a positive sense-of-self, developing problem-solving capabilities, and learning to manage stressful situations. We work parallel paths to achieve long-term provider and system development goals while still employing strategies to meet our members' immediate needs.

We are committed to training and educating our network providers and other systems of care stakeholders on trauma responsive care; understanding, approaching, and engaging members with adverse childhood experiences; types and symptomatology of neglect and abuse; initial and

continuing screening and identification of potential or actual safety needs; the role of the assigned care coordinator; health care services and safety and contingency crisis planning; available crisis services and referral processes; and medical necessity, clinical practice guidelines, and prior authorization processes.

Our regionally based Provider Relations Representatives are in the field every day working with providers to identify opportunities for increasing access to community health services and resources. They provide education and consultation, share best practices, and review Quality Measurement Reports during onsite visits to identify trends and help providers better understand how to use the reports as a self-management tool to facilitate practice transformation.

Quality Management and Network Monitoring Systems

Amerigroup's network management model includes diligently monitoring the access to care and availability of our provider networks according to State requirements and federal regulations. We include access requirements in our provider agreements and provider manual, and we reinforce this through provider education and ongoing monitoring. We monitor utilization so that all members have equal service access and availability, a full network of providers within the applicable mileage standards, and reasonable wait times and appointment access. We also routinely monitor ICPs and service reviews to identify opportunities to improve access to care that will meet the needs of our members and give them choices that will meet their goals and preferences. In all cases, we focus on facilitating access to the full array of services available to them.

Our Provider Network teams routinely monitor access to care across our network and compare against established standards. We analyze our performance with respect to access to care by evaluating numeric and geographic standards against access to various provider types. We gather a variety of data and information sources to assess access to care, including GeoAccess reports, Annual Access to Care surveys, member and provider satisfaction surveys, and trend reports on complaints and grievances. *We believe listening is important, so we consider feedback we receive from staff, our Member Advisory Group, and from our Clinical and Administrative Advisory Committee. We also leverage the input from members and their caregivers to gather feedback,* as well as review data on out-of-network agreements and claims to help us identify gaps or barriers to access.

Our Quality Management model includes objectively and systematically monitoring and evaluating quality performance; identifying and implementing strategies to improve the quality, appropriateness, and accessibility of member services and supports; and facilitating organization-wide integration of quality management principles. Amerigroup maintains robust technology to collect and integrate information, including data from external sources, to support quality activities that include a review of performance measures relevant to assuring access to care for our members and their families.

2. Our Care Coordination Model and Children in Care as Enrollees of Health Homes

Children, youth, and young adults in state custody are typically among the more complex and costly Medicaid beneficiaries (on a per-capita basis), due in part to the prevalence of mental health and substance use disorders in this population. When their health care and social support

needs are not appropriately and effectively addressed, the children may experience further trauma which can exacerbate acute problems and extend into adulthood. For youth with such physical, SUD, and MH conditions, establishing a stable health home, through which a member can obtain and get connected to necessary medical and mental health services, fosters stability and improved overall outcomes. We view the trusting relationships between members and their behavioral health providers as an opportunity to incorporate an array of preventive and primary care services. Amerigroup has implemented health home programs in other states that reflect a variety of care models, ranging from co-location of MH/SUD and medical health care employees to interdisciplinary single-site care teams with fully integrated clinical and administrative functions.

Amerigroup's health homes strategy leverages both our extensive experience with provider collaboration to create innovative medical homes and our proficiency with comprehensive, field-based care management and service coordination for children with complex conditions. It also capitalizes on our ability to capture and analyze large volumes of member data and share it with health home providers through the Health Information Exchange (HIE).

Implementing health homes for children with complex conditions will drive improved health outcomes and reduce fragmentation, thereby reducing costs, for those with the most costly and manageable conditions by promoting delivery of timely and holistic care and services in accordance with evidence-based practices. An effective health homes model is vital to achieving the quality and cost outcomes desired, and Amerigroup's model is built on extensive experience with related programs with similar populations in other states. With this experience, we can tailor a health home model to OHCA's specifications that is grounded in extensive experience developing similar programs. Amerigroup's health homes model reflects a consistent structure for all conditions, but we have molded the health home for each condition to the specific clinical and nonclinical needs of the individuals. This philosophy promotes uniformity in our approach while allowing for refinement where appropriate.

It also reflects an appreciation of the diversity of Oklahomans and the local provider community. We recognize that health care is locally driven in Oklahoma and that provider capacity to act as designated health homes varies by region and by clinical area. We recognize that some systems of care have already begun migrating toward this model (including Community Mental Health Centers (CMHCs) and Federally Qualified Health Centers (FQHCs) working toward integrated care, and primary care practices seeking patient-centered medical home accreditation), and we will capitalize on those existing efforts. Where those capabilities do not yet exist, we will collaborate with providers to develop them.

C. Staff/Provider Network

1. Recruitment and Retention of Staff and Providers

The continuity and quality of our care managers and providers are key to the success of children and youth in state custody. *Our model's strategies for staff and provider recruitment and retention are grounded in a strong local presence supported by our national expertise.*

As we hire new employees, we will look for qualified candidates experienced with children, youth, and young adults in DHS custody and who are well-established with local health care resources in the communities they will serve. Their community ties add to our own, and together we develop and enhance these ties to better serve our members and their families, caregivers, and

guardians. Our provider network will consist of all types of Medicaid providers, including the full range of medical specialties necessary to deliver covered benefits: Primary Care Providers (PCPs), specialists, mental health providers, federally qualified health centers (FQHCs), rural health clinics (RHCs), community mental health centers (CMHCs), hospitals, Indian health care providers, and psychiatric residential treatment facilities (PRTFs). We strive to recruit providers with specific experience in treating trauma and using evidence-based practices. We make a particular effort to add all qualified significant traditional providers as appropriate for the population in order to minimize disruption to the member. Additionally, we educate our providers on cultural competency so that they will be better able to meaningfully serve our members.

We value provider, member, and staff input and incorporate it into our operations through a variety of mechanisms, including analysis of member satisfaction surveys, member and provider complaints and grievances member and provider Advisory Committee feedback, and input from staff who actively work with our members and providers in the community to identify up-to-date information concerning how we can best partner to provide top quality services to our members and their caregivers.

Provider Network Recruitment and Retention

Our provider network recruitment and retention strategy is designed to promote successful development of a comprehensive provider network aligned with State-specific program goals and objectives. Our recruitment strategy defines our provider contracting approach, provider reimbursement methodologies, our processes for assessing network adequacy and identifying access and availability gaps, development and execution of our recruitment work plan, timely application and credentialing processes, and high-touch recruitment approach that allows our network to be built quickly. We leverage all available data sources, including claims and utilization information provided by the State Medicaid agency and State waiver programs to identify eligible providers who have historically provided services to our target population. We collaborate with provider associations and other stakeholders to gather information to create a comprehensive recruitment database of providers able to provide services to our target population.

Our network recruitment work plan structure has been refined through years of experience successfully building networks in new markets. The recruitment plan is designed to define all key tasks, timelines, resources and accountabilities across all phases of the development initiative, from early engagement through post-go-live implementation and assessment. Our strategy for retaining specialists is anchored by our local, hands-on approach. Our local Provider Relations Representatives visit high volume specialists often to provide support and continuing education for providers and their office staff.

We work with providers one-on-one, face-to-face to form an active partnership that benefits them, Amerigroup, and the members we serve together. Our enhanced outreach and support to providers through our provider Collaboration Strategy provides incentives for providers to improve quality and service. Provider practices participating in our provider Collaboration Strategy outperform other practices along various key utilization measures. For providers participating in this program with our Georgia affiliate, well-child visit rates were 5.7 percent higher and adolescent well-care visit rates were 11.4 percent higher than those of providers not participating. Additionally, hospital readmission rates were 12 percent lower and hospital

discharge follow-up was 32 percent higher for members assigned to provider Collaboration Strategy practices.

Staffing and Operations: an Experienced Local Team

Amerigroup's overall model for staffing is built on our strong foundation of local, regionally-focused staff. We maintain high quality standards by recruiting, hiring, and retaining well-qualified and trained staff that share our goals and understand the needs of our members and families. Our staffing plan blends a strong local presence across Oklahoma with the administrative proficiency of centralized back-office functions delivered through our National Medicaid Division. Our local employees in Oklahoma will collaborate with our national support functions to provide a seamless care and service delivery system. Our established sources of recruitment and a commitment to workforce diversity are two major components of our approach that works well for us. Our staffing plan includes:

- A multi-pronged, proven approach to recruiting, hiring, and retaining qualified, top-level staff
- A solid cultural competency plan and diversity in the workforce that matches our membership
- Comprehensive staff training
- Well-developed contingency plans and alternate actions
- Assurances to the State that sufficiently experienced and trained staff will always be available

A key element of our staffing strategy is to have the right people in the right amounts to support an integrated system of care. This strategy enables us to respond rapidly and effectively to each member's individual current needs and anticipate and proactively meet future needs as they arise.

Our staffing plan reaches beyond the simplistic formula, "X members means we need Y employees." Instead, we base our staffing on the *needs* of our members, not simply their numbers, which is especially important to meet the needs of children, youth, and young adults in DHS custody.

D. Payment Structure

Amerigroup believes that a sound foundational development process is critical to the success of a program, including program design and rate development. We would be happy to discuss any additional topics not disclosed in this response at a later time with OHCA.

1. Payment Methodology, Assumptions, and Constraints

Provider Payments for Performance Outcomes

MCOs are well positioned with the ability and experience to improve outcomes through the use of provider incentive programs. Our approach is multi-disciplinary, integrated care continuum-based, designed for populations with specialized health care needs, include those in State custody. These innovative programs reward providers for connecting our members to the health care services they need, the right care in the right place at the right time to improve health outcomes, while simultaneously reinforcing provider accountability and efficiency.

We believe Value Based Payment (VBP) programs drive improvements in quality and slow the growth of health care spending across all clinical measures, including the areas of greatest need throughout the State. **We recommend OHCA allow bidding entities flexibility in their**

proposed VBP models. MCOs should be free to innovate and collaborate to create incentives and VBP arrangements that support each beneficiary’s needs while increasing independence, attainment of goals, overall health, and well-being. If OHCA grants flexibility to bidding entities, then VBP models can expand to a range of provider types from primary care to attendant care, and from small providers to large provider groups. This includes incentive programs that reward providers for connecting beneficiaries to the behavioral, physical, and long-term services and supports they need. *MCOs are positioned to work collaboratively with providers based on their size and capabilities, provide them with actionable information, meet them at their level of technology sophistication, and provide the technical support they need to succeed.*

Amerigroup and our affiliate health plans are leaders in fostering provider collaboration and VBP models. Our experience has shown the greatest innovations can stem from MCOs and providers working together to improve quality and outcomes. As with any major initiative, it is critical for OHCA to continue an open and collaborative discussion with stakeholders throughout the operation of the program.

2. Addressing Duplication of Care/Payment and Compliance with Federal and State Requirements

Amerigroup coordinates benefits from multiple sources and funding, and we have processes and systems in place to build a full picture of the care our members are receiving to maintain continuity of care, and prevent service duplication. We will track and monitor services received from providers and community organizations to maintain the integrity of the program. We use smart assignments to reduce duplication, and we do not assign members in a health home to our complex care management programs at the same time. Our model clearly defines the roles and responsibilities for our staff, provider staff, and community organizations, and collaborates with these stakeholders on data sharing strategies to minimize duplication. We function as part of the multidisciplinary team and coordinate our care management services with all the stakeholders. Additionally, we provide training and support in areas such as recovery coaching, disease management, motivational interviewing, and more. We also incorporate edits into our claim processing system to verify that services are not duplicated. We routinely audit a file sample for this purpose, and we implement improvement activities when needed.

In all of our health home models, *we work with our state partners, providers, and other stakeholders to carefully delineate responsibilities to avoid conflicts and duplications.* We work with the state to define the health home program; delegation of care coordination and types of coordination; train staff on the differing roles and responsibilities of the health home, state agency, community agency, and MCO; and determine eligible members for enrollment into and exclusions from health homes. Additionally, we will partner with the State to build configuration requirements to pay health homes, as compared to other providers, for different care coordination or care management as well as evaluate claims for outcomes to verify there has been no duplication of services. We provide all providers access to data, reporting, and audits for delegation oversight to meet NCQA requirements.

We monitor health home care coordination and case management processes to verify consistent provision of the six health home service activities and to monitor compliance with health home program requirements. Health home service components and protocols will be consistently and objectively applied and outcomes will be continuously measured to determine effectiveness and

appropriateness of processes. Amerigroup’s monitoring and evaluation processes define clear expectations regarding health home performance. These standards of practice are foundational to conflict-free case management and service delivery. Amerigroup will track and trend findings to identify systemic issues of poor performance or non-compliance and promptly analyze and remediate these, implementing strategies to improve Health Home care coordination services and resolve areas of non-compliance. We do this by outlining clear roles and responsibilities for comprehensive case management, care coordination, health promotion, and other areas of potential duplication.

We will expand the reach of the care coordination footprint by making member data/health record available to providers — including Integrated and Chronic Health Homes — for our members under their care through our provider portal. Providers who have members under their care can see the member record via the Amerigroup provider portal, giving them simple, easy-to-access data and information to assist them in engaging members in their health and well-being.

The integrated data will be displayed to make it easy for providers to act on it, filling in gaps in care and making sure their patients are getting the services they need. This view will enable any provider who is treating our members to see the full picture, including care plans and assessment information, enhancing the provider’s ability to reduce redundant efforts and improve the quality of care.

We will work directly with Health Homes to track services and monitor outcomes; promote best practices; enhance quality of care and services; and achieve cost efficiencies. To support comprehensive quality management, providers will be able to view individual member’s utilization and quality information, such as prescription drug fills, gaps in care, encounters, authorizations, emergency department (ED) use, and inpatient admissions using our provider facing data tool. We will work with providers to make sure members receive both Medicaid and non-Medicaid services needed, while avoiding service duplication.

E. Impact of Model

1. Estimated Implementation Costs and Anticipated Savings

Through our extensive experience implementing state-sponsored programs, we have found that implementation costs are variable and dependent on the size and scope of the project, as well as current membership and utilization trends. Including a specialized care coordination model as part of a larger managed care program can mitigate costs by spreading infrastructure development and maintenance costs over a broader population.

Amerigroup works across functional areas to identify and evaluate opportunities for improvement, implementing interventions with members, providers, our care and service partners in the community, and other stakeholders that result in statistically significant improvement on targeted clinical measures, thereby containing costs and improving member outcomes. Establishing a baseline during a program implementation phase is also important, as our experience has shown that care coordination activities may identify unmet physical and behavioral health needs that are addressed through enhanced access to care in the early years of a new program.

Using state plan level data for youth in the state custody and Adoption Assistance aid categories, Amerigroup staff regularly analyzes spending and utilization patterns and trends at the service

level. This allows us to best understand what is happening at the local level and target our program efforts to areas that enhance our services for children, youth, and young adults in DHS custody.

Cost management at Amerigroup represents a comprehensive, integrated array of programs and activities that include cost management processes, innovative utilization management practices, and pilot programs. Cost management also includes a strong Fraud, Waste, and Abuse program that is part of our national Program Integrity initiatives. We have designed our Cost Containment Program process to maximize employee understanding, participation, and accountability in containing costs for services we provide to our members. The program consists of regularly scheduled meetings; formalized Cost Containment Initiatives and projects; and standardized performance data collection, analysis, and reporting. Our program includes the identification and sharing of best practices with our affiliate health plans via formal and informal peer group meetings at local, regional, and national organization levels. This is a hallmark of our culture of collaboration and innovation.

While containing overall costs is a legitimate goal of managed care, ultimately the true value is in enhancing permanence, safety, well-being and quality of life for children, youth, and young adults in DHS custody, and better preparing them for adulthood.

2. Quality and Anticipated Effect of Our Care Coordination Model

Our care coordination model supports integrated and trauma-informed care, and has been successful in improving the health, safety, permanency and well-being of youth in State custody in our other State programs.

In the first year of our Georgia Families 360° Program, our affiliate health plan worked with our State partner to successfully transition over 23,000 youth with a priority on continuity of care; identification of new, undiagnosed, or unmet needs; and development of an Integrated Care Plan through the screening and assessment process. The program's initial results were impressive, including:

- Health Risk Screenings – 97 percent of children have had a health risk screening
- Care Plans – 100 percent of children with Complex Care Coordination needs have care plans
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) – 58 percent EPSDT visit compliance compared to 41 percent prior to program launch

While each State's results will differ based on program design and system priorities, our model addresses CMS recommended benchmarks and is flexible to also meet the priorities of our State partners.

Performance Measures for Care Coordination Models

By analyzing patterns and trends across 6.5 million members in Medicaid and other state-sponsored programs across 20 states, we have identified guiding principles to consider when designing a balanced and effective set of performance measures for Care Coordination Models to serve children who are in State custody. Our suggestions are focused on engaging members, family caregivers and other stakeholders, and are aligned with the thought leadership provided by entities including the National Quality Forum (NQF), the National Committee for Quality Assurance (NCQA), the Agency for Healthcare Research and Quality (AHRQ), and the Centers for Medicare & Medicaid Services (CMS). For example, AHRQ's CAHPS Item Set for Children with Chronic Conditions is a five-item screener that classifies children with chronic conditions

that includes a set of supplemental questions regarding the health care experiences of children with chronic conditions. This example, as well as the aforementioned leading standards, tie in to public health plan indicators such as Oklahoma's 2020 goals.

The design of a measurement program is complex, and Amerigroup would support OHCA and DHS with the technical expertise necessary to establish an effective measurement framework that will improve the health outcomes of children in DHS custody. We propose that, based on the membership size, the program does not select too many quality indicators as there will be abundant specialized management for the members. Focusing on select indicators already established by the CMS Core Set of Children's Health Care Quality Measures for Medicaid and CHIP, applicable HEDIS® measures, and EPSDT will promote program success. Indicators such as blood screenings, dental visits, and overuse of antipsychotic medication should be considered.

Programs for people with specialized service needs must go beyond the traditional measures of clinical care in order to be meaningful for members and reflective of quality of life outcomes and the greater array of services and supports used by people with specialized support needs. Non-clinical measures are not standardized, which presents a challenge for programs serving these members. The Care Coordination for Children program has the opportunity to draw from emerging recommendations for children in custodial care and the expertise of partners like Amerigroup to create accountability and continuous quality improvement.

Including both traditional and non-traditional measures, Amerigroup's care coordination model relies on an approach that concentrates on listening to our members and doing the right thing for our members, provides them with the tools to improve their overall health status, and surrounds them with the appropriate level of care across the health continuum, and benefits members' health in both the short-term and long-term.

Value-Based Purchasing

Our quality improvement strategy is driven by setting goals to improve the health outcomes of our members. Amerigroup will identify and implement initiatives and interventions that align with our strategic plan, vision, and mission to achieve targets for the identified VBP performance measures. We identify and implement initiatives that are most relevant to our members. To identify relevant opportunities for improvement, we continuously mine our data sources to inform our targeted approach to improving quality.

We systematically and objectively measure access to care, demand for services, and quality of care to improve member health outcomes. We do this by analyzing enrollment information, claims, encounters, authorizations, appeals, provider complaints and member grievances, Member Advisory Committee feedback, Provider Advisory Committee feedback, Disease/Case Management documentation, access and availability survey findings, member medical records within provider offices and facilities, surveys by external bodies such as accreditation entities or CMS, quality improvement studies, and CAHPS and HEDIS® results. We will then design initiatives and interventions based on this data analysis and on priorities established by OHCA or DHS.

F. Data Management

Amerigroup collaborates across multiple functional areas to identify, monitor, and prioritize clinical areas for improvement, implementing intervention activities with members, providers, and our employees to drive improvement on targeted performance measures.

1. Providing Efficient Management of Data to Promote Quality and Safety

Data plays an integral role in verifying that members receive appropriate levels of care coordination, and it informs care coordination activities that impact member outcomes. Our data warehouse stores a complete set of Amerigroup's claims data. We also maintain data from care coordination activities, such as health risk assessments, care planning tools, service monitoring, etc. and we participate in Health Information Exchanges with our providers and State partners. Our data is accessible for reporting and analysis through multiple tools, including our Member 360 case management tool, which includes claims data (medical, behavioral health, pharmacy, and labs), authorizations, utilization (including ED and inpatient admissions), and care coordination history. With this data, case managers can view a comprehensive picture of each member's history prior to contact.

Our primary predictive modeling tool evaluates the most recent 12 months of available claims data and assigns risk scores that predict future outcomes. In addition to demographic scoring (age and gender), it gathers diagnostic markers (either single conditions or condition clusters), pharmacy markers (medications that suggest condition severity), and cost percentile markers (cost relative to total population). It then assigns a coefficient score that reflects the relative weight of each marker and an overall risk score based on the relative weights. We then re-index scores to reflect each individual's risk level relative to the average risk score for all Amerigroup members.

Members' claim-driven risk scores then trigger assignment to the appropriate level of case management to review and respond to anticipated member needs. We have an array of specialized predictive modeling tools to address a broad range of risk (including chronic conditions, inpatient admissions, behavioral health "first-time admitter," and readmission risk) and are continuously evaluating and enhancing our predictive modeling system to address member needs. *Recognizing that predictive risk models designed for the overall Medicaid population are not always appropriate for youth in state custody, Amerigroup developed a unique predictive model which helps identify these youths' risk level for better stratification and more appropriate care coordination and care management.*

Complementing our predictive modeling tools, on a daily basis our clinical team regularly reviews other utilization-related reports to identify members who may benefit from more intensive care coordination interventions who may not yet appear on the monthly predictive model report. These include concurrent review reports, the daily inpatient census, and over- and under-utilization reports which identify specific members who may benefit from more intensive care coordination. For example, the daily inpatient census report may list a member in Level 2 Moderate Case Management whose inpatient admission escalates their risk level immediately. In those cases, a case manager initiates contact right away to evaluate the member's needs and specific interventions to promote optimal health outcomes. Additionally, we have a specific "spend and trend" report for children, youth, and young adults in state custody that identifies revenue and expenditures including expenses in specific categories of care. This can be used to

identify and focus on areas that have seen changes to see if we need to develop specific programs to address, including cost of care initiatives. We are also able to share critical data with and throughout the system as necessary.

G. Care Coordination Implementation Timelines

1. Timelines Including Key Activities and Milestones

To provide the most comprehensive, highest quality, and cost effective system of care that meets the needs of those in state custody, significant infrastructure must be developed, which is best supported by the economies of scale that a large MCO offers. We envision a system that will evolve to a more comprehensive model over time. We believe a phased-in approach, implemented concurrently with or subsequently to a foundational statewide managed care system, and accounting for adjusted timelines resulting from possible changes to waiver programs or new federal rules, will best support our proposed model's success and address the challenges specific to Oklahoma.

We recommend that upon award, the selected MCO and the State collaborate to initiate a two-phased implementation. At start-up, the MCO and the State should begin Phase I, which would focus on infrastructure, outreach, and support for the children, youth, and young adults in DHS custody to be enrolled in the program. After the MCO and the State develop the necessary infrastructure and supports, Phase II of the proposed program would introduce enhanced elements over time. The implementation plan should schedule plan elements for Phase I or Phase II based on the State's priorities, the time required to introduce a given element to the plan, and the impact of any regulatory changes. Incorporating these key elements will help deliver exemplary care through collaboration, communication, information sharing, and support.

A successful implementation means initially and seamlessly transitioning all children, youth, and young adults to the new program. In the first year, it will be important to identify improvements and innovations – both large and small. We expect such enhancements and innovations to continue to be part of the growth and evolution of the new system of care, and we believe continued collaboration between OHCA, the selected MCO, and system partners will be crucial. Upon implementation, the State should enroll all children, youth, and young adults in DHS custody in an MCO that provides: care coordination, psychotropic medication management, community outreach and partnerships, a quality management program and structure, predictive modeling, support for biological, foster, and adoptive families, a comprehensive training approach, and transition-age youth programs. As infrastructure development continues, more enhanced services can be incorporated.

Amerigroup Is the Ideal Partner to Help the State Achieve Its Goals

Amerigroup has the expertise and proven solutions to help the State achieve its goals of serving the children in DHS custody. Our care model coordinates a range of services and supports through a phased approach that offers an increasing level of services and programs as the infrastructure develops. With expertise in the areas that are crucial to treating members in DHS custody, Amerigroup's partnership with OHCA, DHS and other stakeholders would further support goals to integrate care. We are experts in:

- The capability to work with all requisite state agencies and community support services on behalf of the children, their caregivers, and their providers

- Coordinating care for children with significant MH/SUD conditions and uncertain family and social supports
- Delivering whole-person care coordination for children with a complex array of conditions spanning physical and behavioral health and bridging into child welfare, juvenile justice, education, and social domains
- Providing resources to produce and follow through on individualized care plans for children with complex diagnoses and medication regimens
- Tracking access to preventive and treatment-related services, and working with all involved parties to address gaps in care
- Assuming an ombudsman role to help protect the rights of the member
- Care coordination to navigate various systems on behalf of the member
- Medication adherence and psychotropic drug management programs

At Amerigroup, we view treatment of children in state custody as a continuum of care with programs that are child-centered and family-focused. Our employees are deeply invested in improving the lives of the children and families we serve. We bring a wealth of experience and knowledge to support and serve these children. Through our experience, we are well positioned to work with the State to develop a comprehensive and integrated program, and we are prepared to partner with the State to develop collaborative solutions for complex system issues and crises as the need arises. We have vast experience designing and implementing unique and innovative solutions.

We welcome the opportunity to discuss with the State our specific programs and strategies to structure a successful model in more detail. We believe coordination and collaboration with our State partners and stakeholders is critical to implementing any successful program. We support the State's efforts and are excited to work together to help design and implement a meaningful, impactful Care Coordination Program for Children in Oklahoma.



The State of Oklahoma Oklahoma Health Care Authority

Molina Response to SB773 – Request for Information Care Coordination for Children in DHS Custody

Molina Medicaid Solutions

Submitted
October 19, 2017

By
Andrew Tramel
Molina Medicaid Solutions
Andrew.Tramel@MolinaHealthcare.com
972.489.8565



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A. High-Level Description of the Recommended Patient-Centered Service Delivery Care Coordination Models

A.1.

Name and describe Respondents chosen models including reason for selecting the models

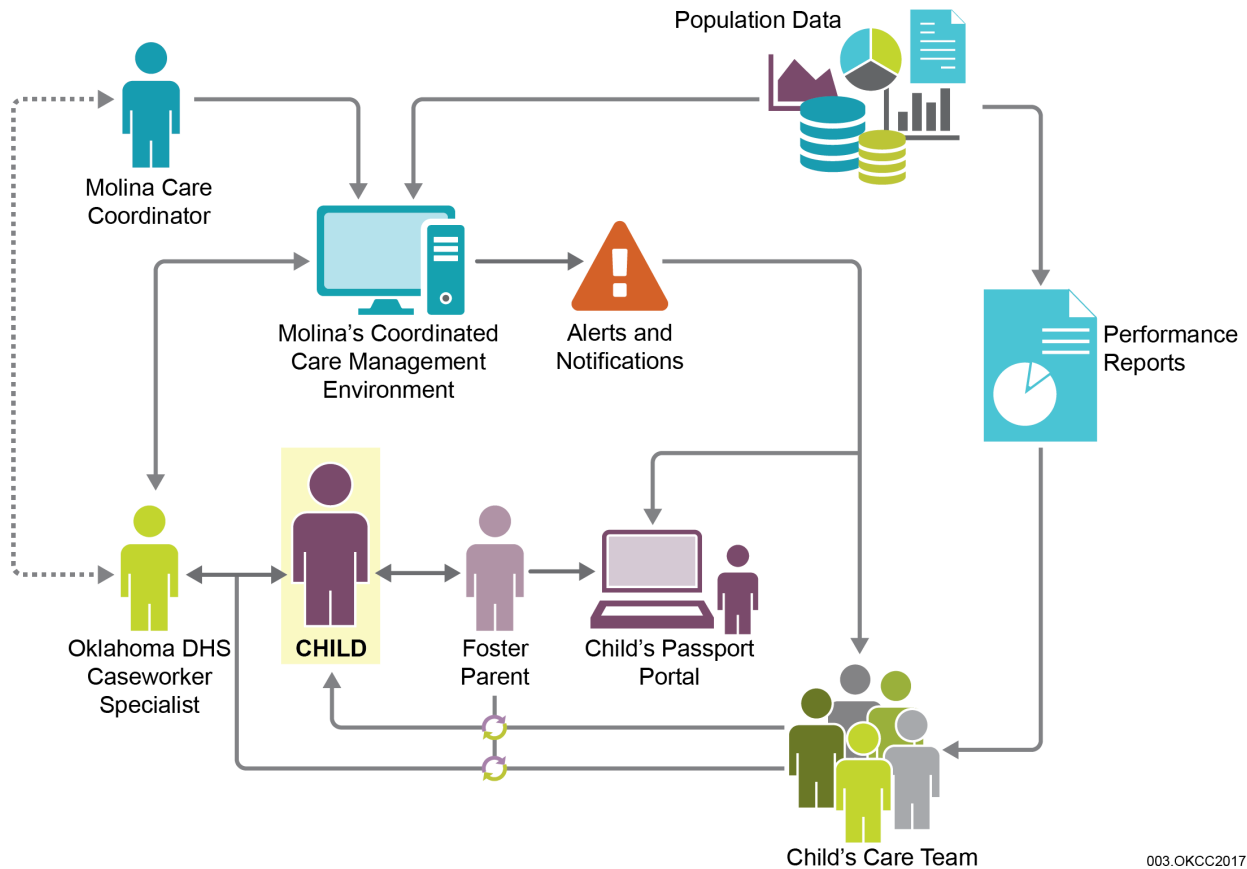
Molina recognizes that care fragmentation across care organizations and environments can put individuals at risk for avoidable health complications and lead to higher service costs. As the Oklahoma Department of Human Services (DHS) knows, for children in State custody, this is especially true. With multiple State agencies, the legal system, educators, medical and behavioral health personnel, primary care givers, and advocates all playing a part in the child’s life, negotiating the competing demands of each requires skill and organization.

For the State of Oklahoma, Molina Medicaid Solutions (Molina) recommends a Coordinated Care model, with a central data store to gather, track, and analyze data and Molina care coordinators to support and augment the State’s caseworker (CW) specialists. Our model begins by gaining a full understanding of the State’s current institutions and resources, clinical personnel, and community social workers that are part of the care provided to children in State custody, and then develops a comprehensive care plan within which to coordinate those services and maximize effectiveness and outcomes for each child.

Our Coordinated Care model seeks to improve how care is administered, educate providers about performance standards and outcomes, and initiate value-based payment approaches.

Once our model is implemented, we establish and measure care outcomes across a wide range of providers and child care agencies. These measurements are then used to introduce alternative payment models, such as value-based payments, to incentivize innovation and continuous quality improvement across the child welfare system.

Figure 1 shows the Molina Coordinated Care model at a high level.



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Figure 1: Molina's Coordinated Care Model

Our Coordinated Care model ensures that the child's care team has all the data and support needed to provide care that is coordinated, on time, and most beneficial to the child's well-being.

At a high level, components of our Coordinated Care model include:

- Central office in Oklahoma City to support contract management, supervisory, and other support staff members
- Clinical staffing based on clinical management standards outlined by Molina case management policies and procedures
- Molina coordinated care staff members in remote home offices throughout Oklahoma's five regions
- Implementation of the case management environment to integrate legacy data and support program initiation and go-live (further discussed in our response to Request for Information (RFI) Question G.1)
- Development of all provider and member-facing training and orientation materials and announcements
- Testing and readiness review of all systems and desk-level procedures



CARE TEAM ENTITIES

Our current understanding of the various entities involved in supporting children in the State’s custody include, but are not limited to, the following, in no particular order:

- Oklahoma Health Care Authority (OHCA)
- DHS
- CW specialists
- Primary care physicians
- Nurses
- School counselors
- Community behavioral health professionals
- Court-appointed special advocates (CASA) workers
- Probation officers
- Social workers
- Hospitals
- Psychiatric residential treatment facilities (PRTFs)
- Group homes
- Therapeutic foster homes
- Foster parents
- Biological family members

MOLINA’S APPROACH TO STAFFING

The Molina Coordinated Care model is staffed by healthcare professionals and support personnel both within the State of Oklahoma and within centralized Molina call center and data processing operations. To keep costs low, we leverage existing Molina administrative and IT personnel for routine tasks. Personnel with specific subject matter expertise and clinical licensure are hired within Oklahoma. This focus allows us to devote resources to hiring Oklahoma-based staff members quickly and efficiently. In addition, by using a case management environment that is easily configured across different populations and not custom built, we can deliver a Web-based and electronic care planning solution within a reasonable period of time.

By leveraging local and State case management resources, administration costs are lower overall. Our regional operational model places resources closer to providers, foster parents, schools, and other child welfare institutions to facilitate direct contact and relationship building among all entities.

Molina Care Coordinators versus DHS CW Specialists

Molina care coordinators include licensed behavioral health staff, registered nurses, certified allied health workers. These care coordinators are supported by administrative support staff and physician consultants as needed on individual cases.



In our Coordinated Care model, the State’s CW specialists continue to manage directly the care plan for the child, while Molina’s care coordinators provide the support to ensure that care plans are enacted efficiently. Their separate roles are envisioned as follows:

- Molina’s care coordinators
 - Oversee care plans
 - Prompt case managers for time-sensitive updates
 - Prompt case managers and providers for planning meetings and service reminders
- OKDHS CW specialists (per Scope of Work defined under OAC 317:30-5-1010.1)
 - Create care plan goals and objectives
 - Conduct assessments
 - Compile information regarding health, social, and educational histories
 - Determine social support and health needs
 - Create and manage service referrals for:
 - Medical clinics
 - Community behavioral health providers
 - Dental, vision, and other health services
 - Coordinates with
 - Schools
 - Juvenile justice workers
 - Foster care agencies and parents
 - Oklahoma Indian Health Services (IHS)

MOLINA’S APPROACH TO IMPLEMENTING VALUE-BASED PERFORMANCE PROGRAMS

We propose that the Coordinated Care model and value-based performance (VBP) programs be introduced, as follows:

Year 1: Enhance the Care Management Process for Children in State Custody

The Molina Coordinated Care model monitors the State’s CW specialists’ care plans for completeness, timeliness, and suitability. A centralized, electronic care plan is maintained and updated by the CW specialist to include care plans and goals, assessments, and contact notes. The Molina care coordinator ensures that care plans are up to date and meeting their primary objectives for each child. Plans that are not complete or out of date are reviewed by the care coordinator with the CW specialist by phone. Automated alerts are generated for scheduled events or deficiencies, as well.

Year 2: Establish Quality-of-Care Benchmarks and Provider Report Carding

Quality improvement, not judgment, is the overarching theme of our performance measurement approach.

Molina starts by benchmarking system-wide quality measures and then comparing current results on a quarterly basis and reporting these to the child’s healthcare providers, foster care agencies and foster parents, CW specialists, OHCA, and other constituents. Specific quality measures are defined in the RFI



and will be incorporated in our model. Placement stability, emergency shelter care utilization, acute hospital care follow-up, and examples of measures will be part of the process.

Year 3: Introduce Value-based Funding Methods

Only after the performance measures are established with the provider community and it is understood how payments will be linked to quality and outcomes, VBPs and other alternative payment models are introduced to the provider community. Molina’s approach to value-based purchasing is to have first assessed the readiness of individual providers and agencies to accept incentivized payment arrangements during the second year. Paying for quality, shared savings, bundled payments, and other methods are presented. It will depend on the type of VBP program(s) that are designed by the State as to whether there will be a need to review for duplication of payments. All of our configurable VBP options meet the proposed federal requirements.

During Year 3, Molina will work with the State to determine whether VBP programs will be implemented, what VBP program(s) will be implemented, and for which vendors program(s) will be implemented.

A.2. Describe how the models address the needs of the target population

Molina’s Coordinated Care model is designed to increase management and supervision across the current child welfare agencies and healthcare resources to maximize efficiencies and improve outcomes among children in the care and custody of the State of Oklahoma. Our data modeling method provides transparent and easy access to reports to help authorized entities evaluate the effectiveness of both our coordinated care interventions and provider performance across a wide range of metrics.

This model is distinct from facility-based or traditional disease state management in that it seeks to manage the system of care rather than performing tasks that duplicate, supplant, or replace community-based case management services for individuals. Under this model, coordinated care activities are essential to identifying needs, removing barriers to care, and ensuring that children receive medical, behavioral health, and educational services in a timely basis. We focus on how the constellation of resources functions with one another so that traditional barriers to care, placement, and scheduling problems can be resolved promptly. By leveraging the resources already in place across Oklahoma—including State employees, providers, and community supporters—Molina’s care coordinators ensure that institutions and community service workers successfully transition each child between care settings and fulfill their ongoing developmental and treatment needs.

A Molina care coordinator is an allied health professional with social work and/or nursing experience with children. These include licensed behavioral health practitioners, medical and psychiatric nurses, and nurse practitioners. Most of our care coordinators will work remotely from home offices throughout each of the Department of Services’ (DHS’) five multi-county regions to assist primary healthcare physicians and workers, school personnel, behavioral health clinicians, State CW specialists, CASA workers, foster families, and other resources with communication, service notification, scheduling, and fulfillment of services for children.

Molina care coordinators work in consultation with child welfare and OHCA delegated entities to help maintain the master care plans for each child. These plans integrate a child’s medical, behavioral health,



legal, educational, and family placement needs into a single electronic document with the following information included:

- DHS CW specialist
- CASA worker
- Behavioral health support members (community behavioral health agencies, individual counselors, and therapists)
- Treating physicians
- Primary care physicians
- Rehabilitation therapy providers
- Durable medical equipment items
- Current placement
- Educational status

Essential team caregivers, such as foster care parents, group home personnel, relatives, and immediate family members also participate in the care planning process, as appropriate, unless contraindicated by one or more factors. Problems, goals, and objectives are documented by the Molina care coordinator in consultation with each child’s CW specialist, primary care provider, and other associated constituents.

In addition to representing a comprehensive view of a child’s care, the care plan includes calendar-based automatic alerts for:

- Upcoming treatment milestones
- Routine dental appointments
- Prescription refill frequency
- Laboratory work
- Scheduled medical treatment
- Physical therapy (PT)/occupational therapy (OT)/speech therapy (ST) appointments
- Individualized education plan meetings
- Ongoing behavioral health treatment and assessment dates
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) schedules
- Medical registries, as applicable

These alerts are automatically generated within the case management workflow for CW specialists and as push notifications to other members of the care team—including the Child’s Passport portal, as appropriate—to prompt foster parents of upcoming appointments, assessments, and other events.

This information is used to facilitate timely communication between all actors within the child’s care team. If necessary, the Molina care coordinator may convene meetings with care providers, IHS workers, Tribal members, school personnel, juvenile justice, family members, and/or other caregivers to identify and evaluate barriers to care. This staff member manages the overall plan to ensure that updates and critical events are not missed due to CW staff turnover, placement changes, or other factors. Each Molina care coordinator’s responsibility includes a care plan created and informed by members of the child’s care team, as described above.



The overarching goal of our approach is to improve care and placement outcomes by ensuring continuity of care for the children in State custody, coordinating across multiple constituents and, over time, developing alternative payment and incentive models for providers, encompassing medical, behavioral health, transportation, and social work. This multi-pronged approach—holding both clinical and non-clinical members of the child’s support system accountable for outcomes—is expected to reduce the use of emergency services, stabilize placements, and provide a more stable and predictable environment for the children in the State’s custody.

A.3. Explain how Respondents have approached implementation of the models

Given the specific needs of OHCA and DHS, Molina has designed a unique model tailored to meet the needs of the Oklahoma children in the State’s custody. Our approach to implementation, as further explained below, draws on our experience and the experience of our parent corporation Molina Healthcare, implementing various programs to ensure that the underserved are properly cared for.

APPROACH TO IMPLEMENTATION

Our implementation planning begins with an analysis of the children’s system of care across the State of Oklahoma. This includes data mining of claims and eligibility records, a review of State law and policies governing children in State custody, interviews with State and county OHCA officials, roundtable discussions with healthcare providers and child advocates at statewide and regional events, and individual meetings with important stakeholders in each region. The information generated by this analysis helps us target specific types of personnel to different areas and communities and provides customized configuration of our case management environment to better support operations.

As shown in **Table 1**, our approach to implementing the Coordinated Care model allows for operations to begin in the first year, and sufficient time to establish care benchmarks and report carding before the State considers introducing value-based payment programs to those vendors selected as ready to participate.

Table 1: Approach to Implementation

Year	Milestones	Activity
Year 1 Months 1 – 6	<ul style="list-style-type: none"> Initial implementation started/completed Initial operations 	<ul style="list-style-type: none"> Enhance the care management process for children in State custody Initial implementation
Year 1 Months 7 – 12	<ul style="list-style-type: none"> Implementation completed (month 12) Model is fully operational (month 12) 	<ul style="list-style-type: none"> Implementation of reporting capabilities and the remainder of electronic data interchange (EDI) interfaces
Year 2	<ul style="list-style-type: none"> Full operations 	<ul style="list-style-type: none"> Establish quality-of-care benchmarks and provider report carding
Year 3	<ul style="list-style-type: none"> VBP programs introduced VBP programs implemented 	<ul style="list-style-type: none"> Introduce value-based funding methods over 3- to 9-month period



AUTHORITY

As an agent of OHCA, Molina’s care coordinators derive authority from existing State policies and requirements outlined within the Yarborough Settlement. In this role, our care coordinator provides expert clinical oversight of interdisciplinary treatment plans that include complete documentation of the child, assessments and notes from the State’s CW specialists, data from the Child’s Passport application, educational and judicial records, and medical and pharmacy claims.

TRAINING AND ORIENTATION

The Coordinated Care model’s scope of work is communicated to stakeholders in all 77 counties in both written documentation and regional trainings. As part of the implementation, Molina establishes a communication plan in consultation with OHCA during the first 30 days of the project kickoff date. Weekly meetings to approve language, materials, notifications, and regional training events are also established and managed to ensure timely approval and distribution to various State and community stakeholders.

Inclusion is vital, particularly at the regional level, with IHS, CASA workers, Child Welfare Services (CWS), individual providers, and advocates. To achieve this, our care coordinators establish and manage local/regional meetings on both a scheduled and ad hoc basis to ensure that individual issues are addressed and resolved. In regional face-to-face and telephonic meetings with State CW specialists, CASA workers, and other constituencies, the program and its role within the existing system of care are introduced and reviewed.

ONGOING COMMUNICATION

Additional meetings with IHS representatives may be needed to identify care and support issues that impact their children. Advisory councils consisting of Tribal authorities, primary care providers and representatives, behavioral health providers, juvenile justice, and foster care and other constituencies convene to identify and escalate healthcare or social issues that complicate care planning. Quality improvement opportunities, in either clinical practice or State medical policy, are identified for additional development. We suggest regular quarterly meetings for all Molina coordinated care staff members and State representatives to report on regional issues, State policy initiatives, and program performance.

TOPIC-DRIVEN COMMITTEES AND WORK GROUPS

OHCA has an impressive array of work groups and committees to address specific topics associated with both the Yarborough Settlement and child welfare. As part of the system of care, these groups support assessments, portals, and other case management tools. We see these entities as vital partners of the coordinated care process. Much of the data produced by these entities are integrated into the plan of care for goal setting, problem management, and measuring outcomes. The data include:

- OK-TASSCC child behavioral health screenings and assessments
- Child’s Passport portal data
- EPSDT Periodicity schedules
- OHCA Foster Parent surveys
- CWS Nursing Program quality improvement review data



- Psychotropic Medication Advisory Panel
- System Improvement: Physician review and University of Oklahoma's Child Study Center

We recommend that these data be provided to our Coordinated Care program for inclusion in the child's electronic care plan. Our case management environment supports both electronic interfaces and scanned paper documentation. Additional discussion of our technical capabilities is included in our response to RFI Question F. To be effective, the CW and Molina care coordinator will need access to comprehensive information vital to care planning and case management. In addition, we recommend that OHCA establish a financial strategy work group to integrate fee-setting policies with provider quality and utilization performance metrics. Inclusion of key provider and child welfare stakeholders is key to designing quality improvement initiatives with broad support and participation.

OUTCOME ANALYSIS AND INTERPRETATION

Performance measurement is a core function of Molina's Coordinated Care model. The scope and content of our outcome analysis process is briefly outlined below.

Because the overarching goal of medical and social services is to help children in State custody to thrive, outcome measures should include both medical and social outcomes, such as placement stability, school achievement, and transitional readiness, goals that are already supported by OHCA and expressed via the Oklahoma Successful Adulthood website.

At Molina, we analyze patient populations for high utilization, risk, chronic co-morbidity, and special needs. Population studies are an ongoing process and risk adjustment and predictive modeling tools are used to help us prioritize patients for specific coordinated care interventions and support activities. Integration of upcoming EPSDT services is also part of the prioritization process.

We will conduct population studies of children in custody across the State with regard to status, location, primary health needs and diagnoses, primary care providers, and behavioral health needs. In addition, we will conduct provider network studies to identify underserved areas, as well as geo-access issues that impact access and timeliness of care.

From these studies, the children in the custody population are stratified into clinical risk categories that reflect documented conditions, service utilization patterns, and current status. This process generates caseload rosters ranked by risk and acuity to help focus resources on those children with the greatest immediate need.

Development of performance standards will be based on both National Committee for Quality Assurance (NCQA) and Centers for Medicare & Medicaid Services (CMS) norms as well as Oklahoma's custom measures. Provider performance against statewide benchmarks will be used to develop value-based purchasing strategies and specific incentives. Since this is a nascent process in Oklahoma, provider report carding will initially be used for education and training purposes. Integration of performance measures with reimbursement models will represent a next step toward an outcome-driven model of care as an alternative to traditional volume-based fee-for-service (FFS) billing.



POLICY DEVELOPMENT AND REFORM

Once implemented, our Coordinated Care model will measure outcomes, cost savings/avoidance, and actionable data. The evolution toward performance-based incentives and service innovation will be data-driven and involve the participation of providers, advocates, and other stakeholders for children in State custody.



B. Access to Health Services

B.1.

Describe how your care coordination models would ensure that children in care and their families can access needed health services?

- a. Behavior Health Services?
- b. Medical Care?
- c. Dental?

Our model monitors all aspects of the child’s care and placement through the integrated care plan and in concert with the CW specialists and other constituents. This includes notification of important treatment events via our alerting process and tracking of contact notes from the CW specialists or other case managers. Planning for urgent or emergent care episodes initiated by the child’s physician, behavioral health providers or prudent laypersons may include call-trees or other notification methods to ensure that essential treatment information is shared between foster and group homes, primary care providers, CW specialists, and behavioral health providers in a timely manner. Discharge and transitional care plans are maintained through CW specialist input as well as contact notes generated by the Molina care coordinator with regard to after-care planning and follow-up care.

a. Behavioral Health Services

Because outpatient behavioral health services are often difficult to schedule in the short term, the Molina care coordinator consults with the CW specialist and community behavioral health providers to establish referral protocols and availability across specialties on a regular basis. Behavioral health provider rosters by county, availability, and scope of practice are maintained by our Coordinated Care program to assist CWs and discharge planners. In addition, alternative support plans are created to address treatment delays due to circumstantial events such as waiting lists, adverse weather events, or a dearth of appropriate resources in remote areas of the State.

Timeliness of service is often the best form of prevention, particularly for children with complex treatment and placement needs, so our emphasis on planning and ongoing communication supports this process.

b. Medical

Ongoing alerts to integrate the EPSDT periodically schedule into the CW specialist’s calendar are provided to ensure that both the placement provider (who receives prompts from the Child’s Passport) and the CW specialist are mutually aware of upcoming appointments, vaccinations, and screenings. Lack of routine care puts the child at risk for a variety of preventable conditions that interrupt the child’s participation in school, the community, and family activities. Our Coordinated Care model integrates the EPSDT periodicity schedule into the child’s care plan, in addition to other scheduled services, to ensure adequate coordination and fulfillment.



c. Dental Care

As with medical services, EPSDT appointments are monitored and incorporated in the care plan for routine dental care, remediation, and orthodontia.

B.2.

How would you use a care coordination model to include children in care as enrollees of Health Homes?

In the event Oklahoma decides to expand enrollment of children in State custody into a Health Home program, Molina will coordinate care planning by monitoring the monthly enrollment status of children in State custody to validate proper provider and child attribution to Fostering Care or any other Health Home entity identified by the State.

Care planning will include coordination with the Health Home to ensure that children receive care from designated Health Home providers, or simply to monitor the process in consultation with the Health Home and the child's State CW specialist for compliance.

A transfer process between Molina's Coordinated Care model and Health Home CW specialists and care coordinators will be developed to ensure that the child's legacy care plan is provided to the Health Home for continued development. Our coordinated care system will also allow new Health Home CW specialists to simply assume responsibility for the child's care plan within its current environment so that there is no lapse in management. When children are transferred out of Health Homes, the care plan is updated and notifications are sent to the appropriate members of the child's care team.



C. Staff/Provider Network

C.1.

Describe, if applicable, how staff and/or provider network recruitment and retention, including types of providers (for example primary care, specialty care, dental, HCBS, case/care management, LTC, other, etc.) are addressed.

Because we are proposing a staffing and system solution to improve case management outcomes for children in the care and custody of the State, we do not anticipate engaging in provider network development or credentialing for this project.

MOLINA’S PROJECT ORGANIZATION

The Molina Coordinated Care model consists of both operational and technical support components. Our operational model includes an operations manager, clinical team leaders, and care coordinators who are supported by clerical support staff and physician consultants. We are further supported by IT and human resources (HR) resources at the corporate level.

Figure 2 provides an overview of our staffing structure and how it will interface with the OHCA and the Oklahoma DHS.

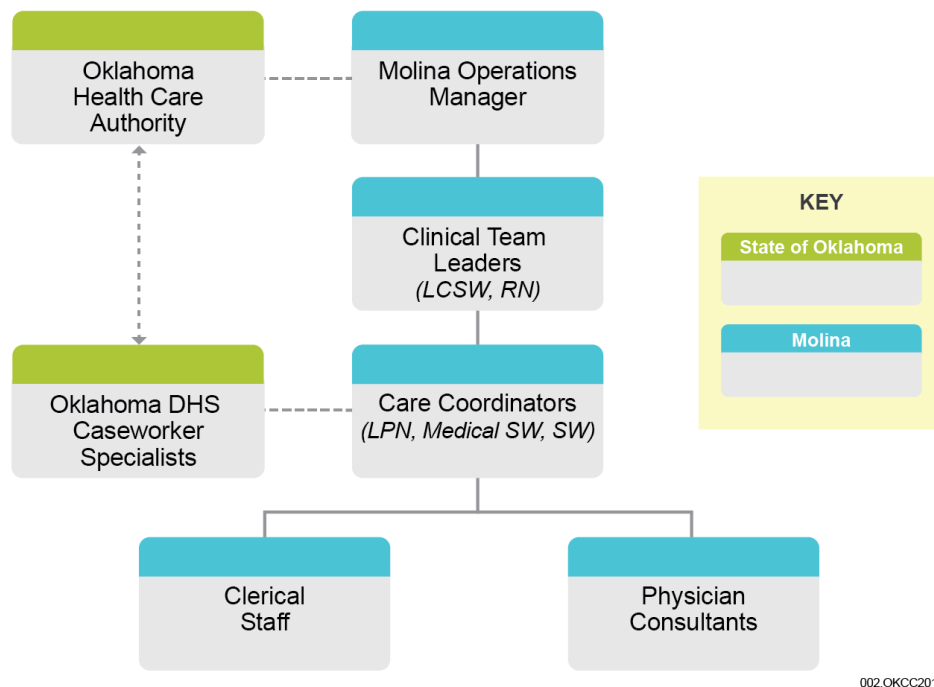


Figure 2: Molina’s Staffing Organization

Molina’s specialized team provides strategic support to the CW specialists, DHS, and OHCA.

Our staffing model consists of establishing an in-State central office, with most care coordinators working remotely from home offices throughout each of DHS’ five multi-county regions. Distribution of resources will be determined by the number of children in each region and any existing Health Homes or legacy programs, such as the Communities of Care program in Region 4.



Because our program is statewide but locally based, each care coordinator has first-hand knowledge of the region and the unique challenges of the foster care system and children in custody.

RECRUITING

Our total dedication to the healthcare market attracts top-notch employees with healthcare and medical backgrounds who can advance within the company while remaining in the healthcare field. Molina recruiters first identify qualified candidates—whether key staff or other project staff—from within the internal Molina resource pool that meet the State’s and Molina’s staffing requirements.

If internal candidates are not immediately available for the required position, recruiters turn to external sources. We actively solicit prospective candidates from universities, job fairs, summer intern programs, corporation layoff lists, advertising media, United States Employment Service offices, community organizations, professional associations, search firms, employment websites, and employment agencies.

Molina’s Internet website (www.molinahealthcare.com) provides descriptions of open positions and allows potential candidates to apply directly through the website. Recruiters also have the flexibility of posting on Internet job boards, which includes top national and international recruiting databases and sites and a more diverse pool of applicants.

During the interview process, recruiters and hiring managers look beyond training and experience requirements to determine the individual candidate’s drive and his or her willingness to learn and grow with the company. We also use a companywide employee referral program to attract and retain the best candidates in the industry. The program provides us with an efficient and economical way to recruit qualified staff while rewarding our employees for their important role in the recruiting process.

In addition to planning, sourcing, interviewing and selecting, and making competitive offers, effective staffing also requires speed and discipline to ensure that positions are rapidly filled. With a focus on operational effectiveness, Molina has invested in a technology-enabled recruitment process, shown in **Figure 3**, which is significantly improving recruitment time. Our technology-enabled recruitment process allows us to locate qualified industry candidates to fill open positions efficiently.

Recognized for Business Excellence

Molina Healthcare received the Alfred P. Sloan Award for Business Excellence in Workplace Flexibility, awarded to selected model employers for their innovative and effective workplace practices.

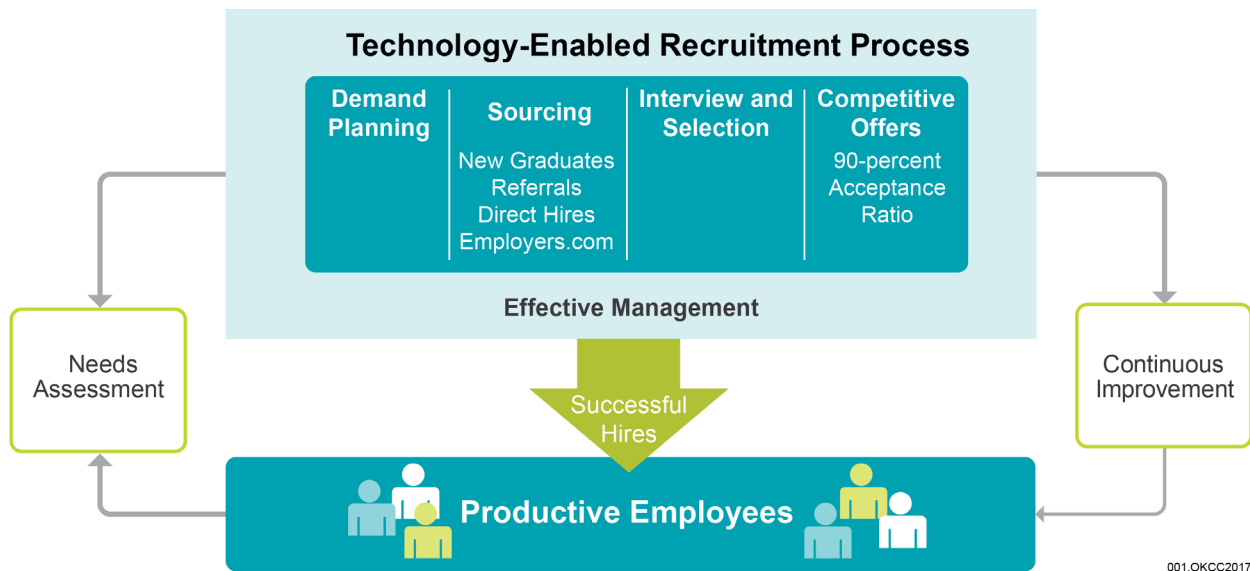


Figure 3: Molina’s Recruitment Process

Molina’s recruitment process allows us to locate qualified candidates and fill open positions rapidly.

Once a candidate is selected and accepts a position, Molina provides new-hire training, shadowing, and coaching to help new staff learn their job duties and become acclimated to their positions. Molina’s formal Staffing Plan describes our approach to hiring specialized, trained, and experienced staff in further detail.

Throughout the life of the contract, Molina’s HR department ensures that adequate staff remains in place. An HR manager works with Molina’s Recruiting Center of Expertise to ensure that staffing requirements are consistently met. The HR manager works with site leadership and managers to address any potential personnel concerns. Due to our proven recruiting practices, we can hire staff quickly, as needed, to meet project deadlines, replace personnel lost due to unforeseen circumstances, or adjust to changing manpower needs.

STAFF RETENTION

Recruiting a qualified employee base is essential to success, and retaining that workforce is just as crucial. Our investment in our employees results in better retention, which, in turn, directly benefits the program by facilitating long-term collaborative relationships, built on shared knowledge and trust. It also preserves customer resources by avoiding repeated learning curves with new personnel.

We believe that our employees are the key to our success, and we strive to offer programs that increase flexibility, improve employee satisfaction and productivity, and reduce stress levels. Key elements of the Molina staff retention strategy include:

- Training programs that successfully acclimate new employees to the company’s culture and processes
- Competitive compensation and incentive programs
- A culture that supports long-term relationships and focuses on providing quality care and service
- Staff development coaching and training to further enhance the performance and value of employees



Our retention program begins with our training of new hires. Every new employee starts with our “New Employee Welcome” training during which long-term employees and company executives introduce each employee to the company’s culture and administrative processes. Each employee then receives new-hire training at his or her work site that includes:

- Review of key company policies
- Review of applicable general administrative procedures
- Work site tour and introductions to onsite staff
- An individual meeting with the employee’s direct supervisor
- Review of hardware and software used in daily work
- Enrollment into company benefit plans

Molina’s environment motivates employees and generates high performance through use of compensation and incentive plans to continually reward and motivate key contributors, including the following:

- Competitive compensation packages
- Employee incentive award bonuses
- 401(k) plan
- Employee stock purchase program (EPSS)

Employees also enjoy development opportunities to increase their value to Molina and our clients while providing additional opportunities for career development for the employee.



D. Payment Structure

D.1.

Explain payment methodology, assumptions, and constraints related to the care coordination models

- a. Specific to covered benefits and services
- b. Specific to other benefits and services
- c. Show estimated amounts of provider payments for evidence-based performance outcomes (*for example amounts of withholds, performance payments based on quality metrics, etc.*)

Molina is certified by CMS as a Quality Improvement Organization (QIO)-like entity to perform utilization management, population stratification, and data analysis of improved health outcomes for our members and customers while controlling costs. This certification provides an enhanced federal financial participation (FFP) matching (75 percent) from CMS for administrative costs associated with utilization control initiatives.

The Molina Coordinated Care model is funded on an administrative fee basis, based on the size of the operation and the cost of administration. The services provided will be maintenance of electronic individual care plans, oversight of CW specialists and coordination of care between multiple institutions, providers, and foster care entities. If desired, Molina may also perform utilization management on specific services or benefits to maximize the federal participation to the State.

Our focus is delivering proven management services for traditional Medicaid FFS payment models. In our corporate parent Molina Healthcare's health plans, an emphasis on health coaching and prevention provides better outcomes for members newly diagnosed with a chronic condition. More intensive case management and coordinated care services are provided to members with complex co-morbidity, special needs, and those with the highest level of clinical risk. By leveraging this experience, we are able to provide the best of managed care techniques to Medicaid customers with FFS members.

Coordinated care is transformative, and we propose to introduce these techniques over time and in conjunction with communicating with the care team entities, as outlined in our response to RFI Question G. This model is customized for State custody children living in a variety of foster, group home, and therapeutic placements. Evaluation of this population includes actuarial modeling and risk scoring according to condition and acuity. We also stratify the population according to Molina's case management protocols to prioritize children for specific case management interventions.

Once the risk level is determined, the CW specialist and other members of the care team can create a member-specific care plan based on the needs, constraints, and limitations of the area or member.

The differentiation in our approach is the transparency of the information available to the care team for creation of the care plan. No longer are there silos of information by team member, organization, or multiple systems. The information is aggregated in a centralized location for sharing based on need-to-know security parameters, with appropriate guardian and child permissions, and then monitored and tracked. The care team and other stakeholder entities have secure access on a need-to-know basis to current and accurate data regarding the child's physical and mental well-being.



To achieve this level of coordination, our approach includes an integrated workflow tool to support coordinated care, care planning, and reporting. It also includes a state-of-the-art data analytics and cost modeling solution to risk stratify the population and forecast future costs for this population. The ability to segment this population based on risk is critical in convincing providers they are protected from adverse selection as the State moves toward value-based or performance-based reimbursement to slow/reduce costs and improve the quality of care delivered.

Our solution integrates with nationally recognized predictive modeling algorithms within our value-based payment management tool to facilitate planning, designing, and executing various VBP models.

MOLINA'S APPROACH TO IMPLEMENTING VALUE-BASED PAYMENTS

During the first year, we are focused on standing up the new operational model and familiarizing all the participants with how it operates. We begin collecting claims and clinical data to support care planning and utilization trending among those children in custody to arrive at a risk score. We understand that introducing a new payment methodology before the participants are familiar with the new operational model can produce fear, mistrust, and resistance. We leverage this time to inform the care team entities about the Coordinated Care model, and the development and refinement of how the measures will be interpreted and applied against quality improvement initiatives and secure their feedback and understanding, as further described in our response to RFI Question G.

Beginning in the second year, Molina begins performing a readiness assessment with individual providers to participate in various alternative payment and incentive models. Our software tool for VBP calculations allows for flexibility and transparency in developing the State-specific VBP program. It is highly configurable, so the State can develop its own specific VBP programs and also have the option to include nationally recognized predictive health modeling in the calculations and nationally recognized quality metrics. Our VBP tool can be used to:

- Manage Regional Care Organization (RCO)/Accountable Care Organization (ACO)/Managed Care Organization (MCO), episodic, and specific disease management VBPs
- Structure “intermediate stage” programs such as point/tier structures for measuring and adjusting payments/add-on rates via attainment of incremental quality and reporting goals
- Run “what-if” scenarios for modifications to VBP programs

COMPREHENSIVE PRIMARY CARE PLUS (CPC+) MODEL

One payment model that OHCA may want to consider could be patterned after the Comprehensive Primary Care Plus (CPC+) model being tested by the CMS. Oklahoma providers are participating in the program and could be a good target group for participation. The issues the program is attempting to address are the same ones OHCA is attempting to address for children in foster care, namely:

- Access and continuity of care
- Planned care and chronic conditions and preventive care
- Risk-stratified care management
- Patient and caregiver engagement
- Coordination of care across the community of care



To address these challenges, CMS began paying medical providers a non-visit care management fee based on a patient’s profile risk score. In exchange, the providers are eligible to participate in alternative payment models such as shared savings and performance-based incentive payments that are based on the level of risk that affords them a level of upside potential. Assuming the providers meet their measurement goals and objectives, their reimbursements are higher than under the normal FFS model. In exchange, Medicare realizes the reduction in healthcare costs as a result of inappropriate utilization and reduced 30 day readmits and emergency room visits.

To adopt a model similar to CPC+, OHCA would have to make this population eligible for a Health Home to enable a provider to assume that role. If adopted, a similar type model could be applied to the children in foster care with modifications made to accommodate different living arrangements and illness severity. By leveraging the risk profile, providers’ concerns of being adversely selected can be minimized with adjustments to the care management fee or to enhanced payment options to compensate them for the additional level of risk.

Assuming that OHCA would make this population eligible for Health Homes, there is still a role for Molina to play moving forward. It is assumed that not all the population will be eligible for Health Homes because of living status or other obstacles or restrictions. The role of the care coordinator would continue to serve in that capacity for that population and as an independent verification source for provider reporting and payment calculations for those who do.

D.2.

How does your Care Coordination model address potential CMS concerns regarding duplication of care/payment? Explain how proposed payments comply with existing and proposed Federal and State requirements.

The Coordinated Care program will continue with the current FFS payment structure that is in place today with providers. We will leverage the priority of payment tracked in Oklahoma’s Medicaid Management Information System (MMIS) and third-party liability to ensure that Medicaid is the payer of last resort and does not duplicate any payments other payers may have responsibility. By leveraging Oklahoma Medicaid policy embedded in the MMIS, we will be in compliance with federal and State requirements. Our payment solution will be an extension to the State’s existing MMIS so that payments and bonus calculations can be tracked, measured, and reported in the analytic system responsible for provider performance and administrator reporting requirements. In addition, our operational process reviews the service mix for each child and coordinates care between providers to prevent service duplication at the care plan level.

Also, in our experience with this process, we recommend integration of utilization management operations (i.e., prior authorization and concurrent review) with the coordinated care process. While this represents a separate operational model beyond the scope of this RFI, the combination of care coordination and utilization management as an integrated process is quite effective with service duplication issues, particularly with regard to outpatient behavioral health and durable medical equipment (DME) product authorizations.

Beginning in the third year, once the Molina Coordinated Care model is implemented and quality-of-care benchmarks are established, Molina will work with the State to start implementing VBP programs, as



appropriate. It will depend on the type of VBP program(s) selected by the State as to whether there will be a need to review for duplication of payments. All of our configurable VBP options meet the proposed federal requirements.



E. Impact of Model

E.1.

Explain estimated implementation costs and anticipated savings, for the first five years of an implementation of your model.

- a. Methodology
- b. Assumptions
- c. Constraints

a. Methodology

Small changes can produce significant results. Seemingly small things—missed phone calls, unscheduled follow-up appointments, and lost paperwork—can lead to larger issues for these wards of the State. Our focus on closing these gaps can produce significant cost avoidance and savings:

- By improving real-time communication between schedulers and healthcare providers, planned medical and dental appointments are more likely to be fulfilled.
- By maintaining consistent ongoing contact between a PRTF discharge planner and case workers, children may be transitioned sooner to community-based placements and treatment.
- By initiating a coordinated care process, we expect to see:
 - Stabilization and reduction of emergency shelter care utilization
 - Reductions in the average length of stay at PRTFs
 - Lower acute care readmission rates
 - Reduced medical errors due to miscommunication between providers
 - Shorter wait-times for placement changes

With these goals in mind, Molina’s model includes working with the State to execute the following steps:

- Analyze high-cost treatment settings, such as acute inpatient psychiatric treatment, residential psychiatric treatment, community behavioral health, pharmacy, and avoidable emergency department care to establish baseline cost, bed day, and service unit values
- Develop reporting formats for quality and performance measures outlined by OHCA, DHS, and other agencies for foster care, group homes, primary care, and child welfare workers
 - Examples include monitoring waiting lists timeframes, average lengths of stay across one or more facility-based care setting, children in custody who are in out-of-state treatment settings, EPSDT compliance, and other factors
- Develop quarterly trending reports based on claims and eligibility data from the State’s fiscal agent, DHS, foster care, group care, and other entities, as appropriate
- Assess the different cost areas to identify duplication of services, choke points, and potential barriers to care
- Identify areas of concern within 90 days of go-live, with quarterly updates thereafter for review and analysis with OHCA and DHS representatives
 - Examples include unusual utilization patterns across providers and levels of care, long out-of-State stays, extended wait-times for services, CW specialist caseloads, and other components



- Establish baseline data points within the first 60 days of go-live across several areas for outcome analysis to be able to assess the Coordinated Care model's performance from quarter to quarter and year to year
 - Annual review of baseline data includes an evaluation of baseline standards with evolving values for average monthly enrollment, changes in rates, and payment methods
 - Examples of baseline data points include average monthly days in shelter care, average cost per child per year and month, total cost of care per child, hospital admission rates, and other metrics
- Review cost-effectiveness return on investment (ROI) findings with regard to the Coordinated Care model's impact from baseline average costs during the first 90 days of go-live

b. Assumptions

- Molina's costs for implementing our Coordinated Care model is limited to labor, software, hosting, and information system support. Additional discussion of the approach to implementation, operations, and staffing appears in our response to RFI Question E.2.
- Molina's status as a QIO-like entity will reduce the State's overall administration cost by 75 percent due to FFP matching funds available from CMS.
- If care management platform is treated as an enhancement to the MMIS, its costs and implementation could qualify for 90/10 FFP.
- Cost avoidance and savings will exceed the cost of administration of this model because the current utilization profile among this population of children is defined by the cost of emergency and long-term institutional placements.
- Implementation of value-based purchasing methods among providers will result in lower overall costs over time due to resource conservation and budgeting.

We expect to see changes in utilization for specific levels of care and placement settings that are most directly impacted by this model. Emergency shelter care, PRTF utilization, acute care readmissions within 30 days and similar settings are often potential areas for cost avoidance and savings. Although the impact on overall spend is difficult to predict, experience teaches us that there are two sides to an ROI: pro-rata cost savings and value.

- In the first, the cost per member and service utilization falls below baseline averages. Per member per month costs are lower, and cost savings may be extrapolated for the population in real dollars.
- In the latter, the average cost and total cost of care flattens, i.e. does not increase, and the total number of services provided to the population increases. One example of this is the elimination of waiting lists and reductions in average length of stay for PRTF care: the number of approved beds remains the same, but the number of children served at this level of care during the year is higher (e.g., doubles). The cost to the Medicaid program is the same, but the value per child is much higher.

Another area of savings that most agree on is when medical inflation is applied to the savings. Children in foster care are a high-cost and risky population. They will always cost more to care for than children who have not faced the obstacles and challenges these children face. Any approach that reduces the over utilization of medical services will have an impact on program costs. An approach that can flat-line these costs or reduce the growth rate in effect has produced savings.



c. Constraints

From our experience, each state requires different functionality and processes, different time lines, and various state-specific rules for their delivery model. In some cases, a client may have state-specific laws that require manual processes that take more time and resources, and consequently, more time and money to complete. With this in mind, Molina provides the following constraints for consideration:

- Cost savings and avoidance may be reduced or eliminated by retroactive rate reductions.
- Children enrolled in Health Homes and not otherwise managed by the Molina Coordinated Care model may artificially impact total cost of care statements and other outcomes.
- A lack of community-based providers in some areas of the State may result in utilization and cost that is beyond the control of the Coordinated Care model.

E.2.	<p>Describe the quality and anticipated effect of the care coordination models on the target population with respect to the following.</p> <ul style="list-style-type: none"> a. CMS recommended benchmarks b. State identified areas including preventive screenings, tobacco cessation, obesity, immunizations, diabetes, hypertension, prescription drug use, hospitalizations, readmissions, emergency room use c. Core measures identified within the Oklahoma Health Plan (OHIP) 2020 d. Respondent suggestions for other benchmarks e. Considerations for Value-Based performance designs, specifically those that support and align with objectives identified within the Oklahoma State Innovation Model design
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Our Coordinated Care model facilitates consistent and reliable communication between all members of a child’s care team— primary care, behavioral health, education, foster care, CASA workers, guardians, and State welfare care workers. Proper and timely screenings, therapies, and wellness check-ups represent the minimal level of support. Beyond this, the child’s ability to thrive depends on a consistent and reliable consort of professionals. CMS, Agency for Healthcare Research and Quality (AHRQ), NCQA, and a host of other accreditation and child welfare entities define specific quality measures to evaluate how the system of care is performing on the child’s behalf.

Here are some considerations for quality improvement initiatives:

1. CMS quality measures are designed for Medicare ACOs. These organizations manage members with different circumstantial and clinical needs. Some of the measures may simply not apply to this population of children in the State’s custody.
2. Survey-based data gathering may require additional resources beyond what is supported in Oklahoma today. The size and utility of the measurement vis-à-vis available resources may become significant with larger numbers of members. This ratio of effort-to-outcome may limit what can be measured. There are Web-based survey strategies for both members and caregivers that we can pursue to help improve the data collection process and lower the overall cost (in both hours and dollars) of the processes from year to year.
3. The Coordinated Care model will require both historic and current claims- and survey-based data for baseline measurement and performance comparisons on an ongoing basis.



- The provider population may not be prepared to respond to performance measures, particularly among groups for which the process is somewhat new or novel. We recommend a report-carding process across a range of measures that best reflect the segments of the provider community that serve this population. Normalizing the data and training providers on the interpretation of the results will go far in ensuring ongoing participation and maturity of the program.

Measuring the impact of coordinated care, case management, and other aspects of care management will include the integration of various federal, State, and industry-standard performance metrics. We recommend establishing utilization, cost, and quality benchmarks prior to implementation that are based on no less than three years of prior data, if available.

a. CMS Recommended Benchmarks

CMS defines 34 quality measures across 4 domains derived from claims and electronic health record (EHR) data for Medicare ACOs to participate in shared-savings incentives. In **Table 2**, the measures include the title, the sponsoring organization, and how the data are obtained. Complete information about these measures is available at the following URL address:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/2017-Reporting-Year-Narrative-Specifications.pdf>

We recommend developing a roadmap for the implementation and evaluation of different quality measures to determine the best mix for this population of children.

Table 2: Measures for Use in Establishing Quality Performance Standards that ACOs Must Meet for Shared Savings

ACO Measure	Measure Title	Measure Steward	Method of Data Submission
Patient/Caregiver Experience	CAHPS: Getting Timely Care, Appointments, and Information	AHRQ	Survey
Patient/Caregiver Experience	CAHPS: How Well Your Providers Communicate	AHRQ	Survey
Patient/Caregiver Experience	CAHPS: Patients' Rating of Provider	AHRQ	Survey
Patient/Caregiver Experience	CAHPS: Access to Specialists	CMS/AHRQ	Survey
Patient/Caregiver Experience	CAHPS: Health Promotion and Education	CMS/AHRQ	Survey
Patient/Caregiver Experience	CAHPS: Shared Decision Making	CMS/AHRQ	Survey
Patient/Caregiver Experience	CAHPS: Health Status/Functional Status	CMS/AHRQ	Survey
Patient/Caregiver Experience	CAHPS: Stewardship of Patient Resources	CMS/AHRQ	Survey



ACO Measure	Measure Title	Measure Steward	Method of Data Submission
Care Coordination/ Patient Safety	Risk-Standardized, All Condition Readmission	CMS	Claims
Care Coordination/ Patient Safety	Skilled Nursing Facility 30-Day All-Cause Readmission Measures (SNFRM)	CMS	Claims
Care Coordination/ Patient Safety	All-Cause Unplanned Admissions for Patients with Diabetes	CMS	Claims
Care Coordination/ Patient Safety	All-Cause Unplanned Admissions for Patients with Heart Failure	CMS	Claims
Care Coordination/ Patient Safety	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	CMS	Claims
Care Coordination/ Patient Safety	Acute Composite (AHRQ Prevention Quality Indicator [PQI] #91)	AHRQ	Claims
Care Coordination/ Patient Safety	Use of Certified EHR Technology	CMS	Quality Payment Program Data
Care Coordination/ Patient Safety	Medication Reconciliation Post Discharge	NCQA	Web Interface
Care Coordination/ Patient Safety	Falls: Screening for Future Fall Risk	American Medical Association (AMA)/PCPI/NCQA	Web Interface
Care Coordination/ Patient Safety	Use of Imaging Studies for Low Back Pain	NCQA	Claims
Preventive Health	Preventive Care and Screening: Influenza Immunization	AMA/PCPI	Web Interface
Preventive Health	Pneumonia Vaccination Status for Older Adults	CQA	Web Interface
Preventive Health	Preventive Care and Screening: Body Mass Index Screening and Follow-up	CMS	Web Interface
Preventive Health	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	AMA/PCPI	Web Interface
Preventive Health	Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan	CMS	Web Interface



ACO Measure	Measure Title	Measure Steward	Method of Data Submission
Preventive Health	Colorectal Cancer Screening	NCQA	Web Interface
Preventive Health	Breast Cancer Screening	NCQA	Web Interface
Preventive Health	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	CMS	Web Interface
At-Risk Population: Depression	Depression Remission at 12 Months	MNCM	Web Interface
Diabetes	Diabetes: Hemoglobin A1c Poor Control	NCQA	Web Interface
Diabetes	Diabetes: Eye Exam	NCQA	Web Interface
Hypertension	Controlling High Blood Pressure	NCQA	Web Interface
Ischemic Vascular Disease	Ischemic Vascular Disease: Use of Aspirin or Another Antithrombotic	NCQA	Web Interface

b. State Identified Areas including Preventive Screenings, Tobacco Cessation, Obesity, Immunizations, Diabetes, Hypertension, Prescription Drug Use, Hospitalizations, Readmissions, Emergency Room Use

Our case management environment enables tracking across a wide range of data points identified and included in our initial configuration for the State of Oklahoma. By aligning the Molina Coordinated Care model with CWS and DHS’ reporting needs, we are also able to report performance metrics associated with the Yarborough Settlement, as listed in **Table 3**.

Table 3: Settlement Performance Measures

Performance Metric	Description	Data Source	Technical Solution
Critical Events	Reports of child abuse and neglect in foster care	CW reports (data entry)	Event reporting procedures (form)
Foster Homes	Counts of foster homes by type: 1. Therapeutic Foster Care 2. (Non-Therapeutic) Foster Care	State reports of enrolled foster homes	State roster of enrolled foster homes
CW Child Visits	Counts of visits by CWs to children on his or her caseload	CW contact notes (data entry)	CW specialist care plan notes
CW Continuity	The number of CWs each child has during a specified timeframe	CW assignments (data entry)	CW specialist care plan assignments



Performance Metric	Description	Data Source	Technical Solution
Average Placement Rate (2+ yrs.)	Annual average number of discrete placements for each child in State custody, aged two years or older, excluding the top and bottom 10% of children	Placement updates reported by case workers (data entry)	Care plan reporting
Top 10% Count of Placement Changes (2+ yrs.)	Count of placements for children, aged two years or older, in the top 10% of those with the highest number of placements	Claims, plus placement updates	Care plan reporting
Average Placement Rate (<2 yrs.)	Annual average number of discrete placements for each child in State custody, under 2 years of age, excluding the top and bottom 10% of children	Claims, plus placement updates	Care plan reporting
Top 10% Count of Placement Changes (<2 yrs.)	Count of placements for children under 2 years of age in the top 10% of those with the highest number of placements	Claims, plus placement updates	Care plan reporting
Bi-annual Report of Children in Shelter Care	Counts of children in Shelters, delineated by even ages <ul style="list-style-type: none"> • Under 2 yrs. • 2 – 4 yrs. • 4 – 6 yrs. • Etc. to age 18 Timeframe: Apr. – Sep and Oct – Mar.	Reports of shelter admits	Native reporting
Average Length of Stay: Shelter Care	Timeframe: Apr. – Sep and Oct – Mar. Average length of stay (days) in Shelter Care, excluding children in the bottom 10% and highest 10%	Claims, plus placement updates	Native reporting
Shelter Care: Top 10% Lengths of Stay	The actual length of stay (count of days) for each child in the top 10% in a shelter care setting	Claims, plus placement updates	Native reporting
Case Load Report	The count of children in each CWs' active case load	Care plan data	Native reporting
Permanency Report	The count of children leaving State custody during the timeframe	CW discharge to home custody report	Child welfare report
Adoption Report	The count of children adopted during the timeframe, plus the failure rate (%) of those returning to State custody after an adoption event	CW discharge to adoptive family notification; CW re-opens case	Child welfare report



c. Core Measures Identified within the Oklahoma Health Plan (OHIP) 2020

As discussed in our response to RFI Question G, our Coordinated Care model is expected to unfold over three years. During the second year, we communicate with providers and care givers to help them understand the quality improvement process and the goals articulated by the State of Oklahoma’s Health Improvement Plan 2020 – Core Measures, as listed in **Table 4**.

Additionally in the second year, we begin report carding for State case workers as well as providers and foster care agencies. And in preparation for value-based and alternative payment models, we will work with the State to explore the provider community’s readiness to participate in shared savings, incentive payments, and/or risk-bearing arrangements.

The success of the program is defined through the monitoring of 14 separate data elements previously listed in **Table 3** and measures to ensure compliance and improvement. Our care coordinators will monitor each child’s status with these metrics and compile performance reports based on the child’s status compared to statewide baselines and the current population. This information will be shared with State case managers and providers, as applicable, and may be used to establish baselines for designing incentive payments or other alternative payment methods for segments of the provider community.

The State of Oklahoma specifies both CMS and custom quality measures used to evaluate the effectiveness of the settlement agreement and care outcomes, as listed in **Table 4**. As part of our solution, we intend to share the performance of providers and CW specialists with critical stakeholders in order to improve performance and transparency of the overall program.

These measures, for example, will be part of a larger evaluation of how the system of care works in total—clinical, social, and educational services combined.

Table 4: State of Oklahoma’s Health Improvement Plan 2020 – Core Measures

Core Measure	Goal
Tobacco Use	<ul style="list-style-type: none"> • Reduce adolescent smoking prevalence from 15.1% in 2013 to 10% in 2020 for high school-aged youth and from 4.8% in 2013 to 2% in 2020 for middle school-aged youth (2018 data) • Reduce adult smoking prevalence from 23.7% in 2013 to 18% in 2020 (2019 data)
Obesity	<ul style="list-style-type: none"> • Reduce adolescent obesity prevalence from 11.8% in 2013 to 10.6% in 2020 (2019 data) • Reduce adult obesity prevalence from 32.5% in 2013 to 29.5% in 2020 (2019 data)
Children’s Health	<ul style="list-style-type: none"> • Reduce infant mortality from 6.8 per 1,000 live births in 2013 to 6.4 per 1,000 live births by 2020 (2018 data) • Reduce Maternal Mortality from 29.1 per 100,000 live births to 26.2 per 100,000 live births by 2020 (2018 data) • Reduce Infant, Child and Adolescent Injury Mortality from 15.2 per 100,000 in 2013 to 13.9 per 100,000 by 2020 (2018 data)



Core Measure	Goal
Behavioral Health	<ul style="list-style-type: none"> • Reduce the prevalence of untreated mental illness from an 86% treatment gap to 76% in 2020 (2018 data) • Reduce the prevalence of addiction disorders from 8.8% to 7.8% by 2020 (2018 data) • Reduce suicide deaths from 22.8 per 100,000 in 2013 to 19.4 per 100,000 by 2020 (2017 data)

d. Respondent Suggestions for Other Benchmarks

We look forward to working with the State to develop a success algorithm for these children. Beyond the performance of the system, the child’s ability to thrive, engage in social development tasks, and develop independent living skills are vital to the long-term success of OHCA’s mission and vision.

This may consist of one or more of the quality measures already discussed in this section, as well as any of the following:

- Engagement of integrated medical and behavioral healthcare settings with the child, his or her family, and foster care givers as a part of routine care maintenance and wellness
 - Improved physical health, including the child’s level of activity and diet
 - Improved psychiatric stability, as measured by decreased incidents of self-harm and risky behaviors, including substance abuse, cutting, and impulsive behavior
 - Fewer incidents of crisis or emergent care for *any* condition
- Quality of social functioning
 - Success in school, including peer interactions as well as academic performance
 - Age- and developmentally-appropriate friendships
 - Increasing confidence with own progress and stability of adult supports
 - Fewer incidents of interpersonal conflict in the community and home
 - Fewer school suspensions and detentions
 - Reduced community police involvement with the child and/or his or her peer group (selected friends)
 - Reduced peer conflict and fighting
- Successful life transitions
 - Between care settings
 - Across cultural milestones and tasks
 - From childhood to adulthood
 - From school to work



e. Considerations for Value-Based Performance Designs, Specifically Those that Support and Align with Objectives Identified within the Oklahoma State Innovation Model Design

Molina has reviewed the Oklahoma State Innovation Model Design Grant, submitted to CMS on March 31, 2016. With the OHCA’s overall goal of meeting the Triple Aim, we understand the State’s objective to transition to VBP design, based on the following precepts:

- Recognition of the different levels of provider readiness for VBP models across the State
- The need to incorporate a period of transition
- The need to foster collaboration across payers, providers, and payments

This document describes how OHCA will transition to a Regional Care Organization model over time. However, certain populations such as children in State custody and children in foster care are excluded from this plan (page 125, *Oklahoma State Innovation Plan*). With this in mind, Molina presents the considerations for a VBP design.

We recommend that the overall VBP design strategy encompass the following key value propositions:

- Design programs that allow providers to participate in VBPs based on level of readiness and advancing to risk-based models as the program matures and providers demonstrate readiness
- Enable community-based providers with little back-office infrastructure to adopt a VBP program and achieve success by supporting providers throughout the process
- Collaborate with providers throughout the development, adoption, and implementation process to ensure buy-in and readiness
- Provide integrated, meaningful data to providers throughout the process to support VBP program success
- Collaborate with providers on strategies for success through ongoing joint “ownership” committee meetings
- Ensure transparency and flexibility in the payment structure design and payment calculations so that providers can adjust delivery models via quality changes and have that directly impact their payment receipts

We recommend that specific VBP objectives and payment model designs be identified and developed based on:

- Data analysis of utilization trends specific to certain providers or types of services
- Gaps in care for optimal quality results for certain providers or geographies
- Unique populations that require the integration of social, behavioral, and physical services

OHCA might consider a tiered approach to introducing VBPs and other alternate payment models (APM) to providers caring for children in State custody. While the Medical Home model already exists via the Fostering Hope clinics in Oklahoma City and Tulsa, there are numerous other providers throughout the State caring for this population. A key premise for adopting any VBP model is to focus on preventive care, in order to avoid more costly care associated with acute incidents of physical and mental illness. This is particularly true for this population based on the issues they are facing. Specific quality metrics should be



utilized based on NCQA Healthcare Effectiveness Data and Information Set (HEDIS) and State preventive measures.

A shared-savings model may want to be considered for the Fostering Hope clinics, based on a set of metrics. For those providers not currently associated with these clinics, a non-risk bonus payment model may be considered. For example, a payment in the range of \$25 to \$50 could be made to providers assigned to meeting each one of the following goals developed by CWS:

- Yearly mental health or developmental screening
- Periodic dental exams based on the age of the child
- Immunizations initiated and kept current
- Visual and hearing evaluation exams and corrective lenses or hearing aids, when indicated
- Outpatient or inpatient behavioral mental health treatment, when appropriate
- Follow-up and referral services as recommended by a qualified professional

Regardless of the approach adopted, adequate provider outreach is a key component of Molina's implementation of VBPs. Providers will need to understand and buy in to the VBPs they are being asked to consider. Finally, timely execution of provider payments is critical for maintaining the ongoing support of providers.



F. Data Management

F.1

How does your care coordination model provide for efficient management of data to ensure that the child experiences quality and safety?

Our Coordinated Care model tracks care plans, care assessments, services, and data across physical, behavioral health, and social support services, providing the child’s care team, CW specialists, and care coordinators with a comprehensive view of the child. To achieve this, our care plans incorporate assessments, service history, and care data from multiple data sources and make them available to providers, members, and CWs through secure online access. Our user interface combines data from multiple sources and allows communication threads with all members of the child’s interdisciplinary care team.

Molina’s Coordinated Care solution includes:

- Care and case management software package
- Secure online Coordinated Care portal that provides secure access to authorized users
- Comprehensive analytics platform to store, track, and report on member care management needs, provider performance, and CW specialist operational tracking
- Detailed member care tracking at the case level
- Case workload dashboard
- Calendar and alerts to continually remind the CW specialist of their upcoming case review tasks and onsite interventions

Case initiation starts with the manual creation of a case for an existing or new member; it can also be promoted by the upload of a member population candidate list from an external source. Once initiated, configured business rules direct and guide the CW specialists to complete the appropriate assessments, authorization requests, care plans, and interventions appropriate to their member’s needs. Assessments, member history, and completion of tasks can all prompt the system to auto-generate follow-up items, care plan creation, and case follow-up with a member or provider. The system constantly reminds the CW specialists of their daily workload and outstanding tasks. Care services that require authorization generate authorization requests. Our analytics platform analyzes case data and then shares select data with authorized providers, care teams, and other entities, as appropriate, within our Coordinated Care portal.

Flexible, Integrated Care Management

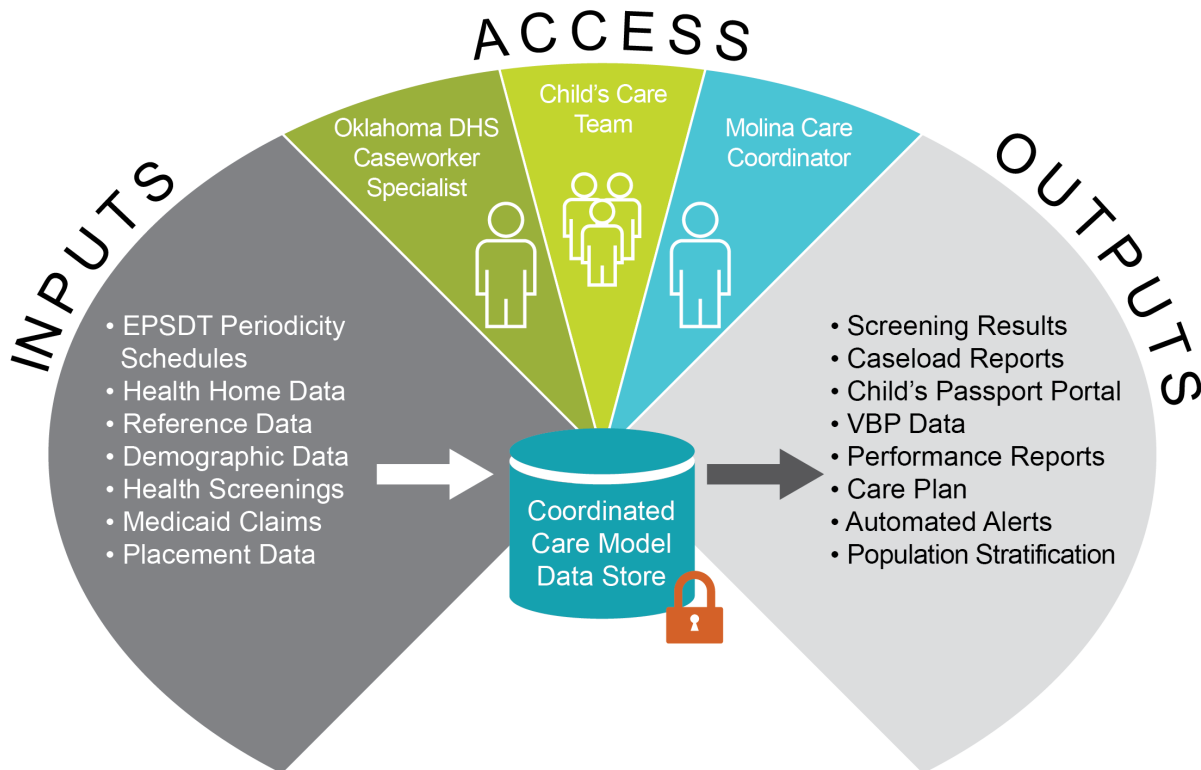
- **Flexible data store that receives and stores data from multiple sources**
- **Secure online portal to share portions of the member care record out to providers, members, and CW specialists in the field**
- **Configurable care management business rules**
- **Comprehensive support for clinical care case management and care coordination**
- **Rules-driven logic allows for the automated creation of plan of care services, goals, and milestones based on assessment responses and care types**
- **Flexible, configurable assessments for rapid adoption of new assessment forms**



CARE COORDINATION DATA MODEL

Molina’s coordinated care platform stores claims and clinical data and tracks care management and coordinated care documentation data, allowing authorized CW specialists, State users, and providers to see a comprehensive picture of member health.

Data pulled from external State data sources, such as Passport, Fostering Hope clinic, child welfare, and MMIS solutions, passes through a central access point—Molina’ EDI/ETL Gateway—that receives, translates, and stores inbound data into a central Coordinated Care data store. **Figure 4** shows a high-level view of our data model. These case data, member data, assessments, and other information are then relayed directly into our coordinated care solution for usage by care coordinators, authorized providers, members, and State staff. CW specialists use this compiled data to create and support a comprehensive case record, complete with member assessments and care plan data.



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Figure 4: The Coordinated Care Data Model

Molina’s ETL/EDI Gateway pulls data from multiple data sources in various formats and stores the data in a centralized data store.

Case data and assessment data are also pulled into our central data store from our Coordinated Care system on a daily basis and combined with known claims, clinical, and other data to allow for comprehensive analyses on member missed services, member care needs, and other clinical alerts.



These alerts are published back into the Molina Coordinated Care solution as member candidate lists, member alerts, and care coordinator tasks. Reports by provider by organization and by member can then be pushed to our Coordinated Care portal for access by authorized State users and providers.

AUTHORIZED ACCESS OF A CHILD'S ELECTRONIC PROFILE

Molina's comprehensive Coordinated Care solution includes a Web portal that has both a public-facing site for general information and a secure portal that can be accessed by authorized entities. Molina can work with DHS to determine who needs to access a child's data—such as providers, foster parents, CW specialists, Department of Education, and care coordinators, and the child upon reaching legal age—and what data each entity is allowed to access—such as vital records, immunization records, and other key clinical data into the member's online record. Authorized users can access only those secure features and data for which they are authorized. Logon requirements comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements for security and privacy.

CW specialist, providers, and other authorized members of the child's care team can access the specific data of a child's known clinical and claims-based data they each need to perform their respective jobs. Through the use of our central coordinated care data store, Molina's solution presents select components of the member's record to the provider, member, and CW specialist community, fostering communication and coordination across the spectrum of care.

Through our secure portal, authorized providers and State users can search for and access a member's known clinical and claims data, along with a high-level overview of the member's case data. Our portal can also display clinical alerts on the member's care, such as the presence of chronic conditions, missed services, and other upcoming or missed key health milestones. CW specialists can access this information securely while they are in the field working on a case, to readily remind them of a member's key health needs.

Children and foster parents can access our Coordinated Care portal to see a member-friendly display of their data, alongside member alerts and member-specific presented care documentation, based on member age and care needs. Member children and foster parents can link out to their Passport online record to access educational records from the public school system. This portal also supports a 'text to you' feature to send regular text communication to members and their foster family to remind them of upcoming care needs and CW specialist visits and follow-up appointments.

A Centralized Coordinated Care Solution

- **Import care plans, assessments, clinical data, and care data from multiple sources**
- **View centralized clinical care plan and profile**
- **Utilize configurable clinical assessments**
- **Create Auto Care Plan based on assessment responses**
- **Access secure portal for providers, CW specialists, and care coordinators**
- **Share care data across organizations**



CARE COORDINATION SUPPORT

Case management programs target members with the most risk and least adherence to medical standards for care. We rely upon the strengths of each of our integrated applications to ensure that the right members receive the right care at the right time from the right provider while making a progressive impact on health metrics and program costs. Our patient-centered approach to support the State's care management program includes the following:

- End user alerts, work queue, and dashboard
- Service plan
- Plan of care
- Increased automation
- Support for medically necessary services
- Remote user support
- Configurable, integrated information and access
- Automated support for assessments
- Productivity tools
- Patient identification and outcomes analysis
- Tracked outcomes related to member case management

Molina's Coordinated Care model provides the tools to access the data required to manage and ensure the care of the children in State custody. The data are accessible and available at all times to ensure that the services can be verified to be part of the child's care plan and to understand the whole plan needed for the child to be cared for.



G. Care Coordination Implementation Timelines

G.1

Based on prior experience, provide insight into what a realistic timeline for implementation of your Care Coordination model might be. Specifically, provide details into the following aspects of implementation of a Care Coordination model similar to what has been described:

- a. Development
- b. Transition/Readiness Activities
- c. Implementation of member enrollment
- d. Implementation of member service delivery

APPROACH TO IMPLEMENTATION

As discussed in our response to RFI Question A.3, we have planned to implement the Coordinated Care model over the first year, with operations beginning in Year 1 and leading up to implementing VBP programs by the third year. To provide children in the State's custody with the full spectrum of support they need, we will need to interface with the many different agencies, services, and other members of their care teams.

In order to support a rapid implementation model, tasks are planned to support a go-live date within 180 days of project start. Additional configuration will occur over a second 180-day period to integrate additional data feeds to support the coordinated care process. Following is an overview of our proposed implementation.

From our experience interfacing with multiple entities, and our understanding of the time and effort required to establish effective interfaces, we propose to implement the Coordinated Care model as follows.

Year 1 Technical Implementation: Start Date – 180 Days

- Build out and prepare central office
- Execute recruitment and hiring plan for office staff, clinicians, and supervisory staff
- Train and orient new Molina staff members
- Configure and set up telecom
- Configure case management system
- Develop and establish interfaces with the State fiscal agent for claims and eligibility data
- Configure and test operational reports
- Configure and test data analytic environment for population stratification and risk analysis
- Prepare for and review operational readiness
- Begin operational go-live

Year 1 Technical Implementation: 180 – 360 Days

- Develop additional ETL interfaces for additional demographic data of foster parents and children from other State agencies and the Child's Passport



- Integrate additional data feeds into case management environment
- Analyze patterns of care for service duplication (ongoing)
- Begin enhancement schedule for State assessment forms, scoring, business rules, and care planning to drive automation of clerical tasks and streamline the case management and coordinated care process:

Year 3 Technical Implementation of VBPs: Up to 270 days

The timeframe for implementing VBP programs will depend on provider readiness and confirmation of OHCA’s desired scope of any alternative payment models. Once established and confirmed, VBP program will take six to nine months to perform:

- System configuration and testing of value-based payments

a. Development

As indicated above, our total recommended development timeframe for implementing our Coordinated Care model is approximately 12 months, depending on the number and complexity of interfaces, unique business rules, and other factors.

With our comprehensive case management solution we support care coordination and care planning activities, assessments conducted by CW specialists, and alerting to providers, foster parents, guardians, and children in transition to adulthood. This requires interfaces to and from multiple sources to allow real- or near-real time data refreshing as well as push notifications to users according to their roles. This includes interfaces with the Passport application to notify appropriate staff of upcoming events related to the child’s care plan, including the EPSDT schedule and other services and milestones.

CARE PLANNING WORKFLOW

Molina uses a powerful workflow tool to create the care planning process, develop custom business rules, alert routines, and provide reporting. It is highly configurable and designed to support caseload management, goal setting, case notes, and scheduled events. Our reporting module supports caseload reports by case manager, case assignments, assessment compliance with established timeframes, and other data.

SECURE PORTAL FOR PROVIDERS, FOSTER CARE PARENTS, AND CHILDREN IN TRANSITION

Managed by login role, our Coordinated Care model’s secure portal allows authorized users to view pertinent data and reports related to their relationship to the child and his or her treatment. As an adjunct to the Child’s Passport, this portal allows additional access to elements of the child’s care plan to improve communication across participants.

If the State decides to initiate a VBP methodology, providers may also review their performance reports, based on both quality and cost metrics as defined by the State.



INTERFACES

Molina’s solution includes a gateway capable of sending and receiving files from multiple data sources and translating received files and storing them in our flexible data store. Inbound data can be pulled from a variety of data sources and formats, including X12, HL7, XML, flat file, and delimited file. Molina IT staff will work directly with the source systems’ IT staff to provide file layout formats and content required to access the necessary data. Technical staff will walk through file requirements, exchange sample files, and perform testing. Secure file exchange methods, such as Secure File Transfer Protocol (SFTP), will be supported.

Examples of data sources that we understand will be valuable to effective care planning for children in the State are listed below:

- Foster care
- Medicaid claims
- External assessment
- Medicaid member demographic and eligibility
- Medicaid provider
- Passport data
- Fostering Hope clinic data
- Child welfare screening

DATA DASHBOARDS AND PERFORMANCE MEASUREMENT

Our reporting solution includes industry-standard data visualization tools to support data modeling and interpretation. Designed to be configurable in real time, our performance measurement process supports a wide range of utilization and cost metrics. We also support HEDIS measures and use a value-based purchasing workflow that allows us to assign shared savings, bundled payments, or other purchasing methods to individual providers as well as groups, such as an ACO or hospital-led regional network of providers.

b. Transition/Readiness Activities

During implementation in the first year, testing of claims and eligibility interfaces from the fiscal agent, the Coordinated Care portal, and the care management application is completed. These data are integrated into Molina’s data store to enable our clinical supervisors to establish caseload assignments to individual care coordinators.

Ongoing orientation and training events are held with OHCA and other stakeholders during implementation.

c. Implementation of Member Enrollment

Initial rosters of children in State custody will be obtained from OHCA and any delegated entities as part of the data integration process during implementation. We anticipate that custody status may be identified on the member’s eligibility record. Exceptions will be managed in consultation with OHCA. Because this process is new to the State, we expect the initial load of existing care plans within the portal to consist of



mostly scanned documentation and assessments entered by CW specialists. With adequate preparation from DHS, we expect to create care plan shells for each child at start-up to ease the transition for CW specialists. The Molina care coordinator will assist CW specialists with using the portal and care management screens.

d. Implementation of Member Service Delivery

Care coordination operations will begin with scheduled and ongoing meetings with individual CW specialists, foster care entities, and other providers as needed. This may consist of face-to-face onsite meetings, conference calls, and/or regional training events, if applicable. Each Molina care coordinator is responsible for initiating services within his or her region, either individually or in concert with Molina peers assigned to the same region. Because the exact challenges within each region will differ, we do not expect a one-size-fits-all approach to assignments. We allow our clinicians the flexibility to make autonomous decisions about care planning within the scope of their clinical expertise.

Training events occur throughout implementation and will include online resources, regional question and answer (Q&A) sessions, webinars, and support for individual issues.



oklahoma complete health™

**OKLAHOMA DEPARTMENT OF HUMAN SERVICES (DHS)
REQUEST FOR INFORMATION (RFI)**

CARE COORDINATION FOR CHILDREN IN DHS CUSTODY

Submitted by:

Oklahoma Complete Health
7700 Forsyth Blvd
St. Louis, MO 63105

Due Date:

October 19, 2017, 3:00 p.m.

RFI CARE COORDINATION FOR CHILDREN IN DHS CUSTODY

3.2 SCOPE OF WORK

Respondents are asked to propose Care Coordination models for Oklahoma children in DHS custody and address the outline below:

A. High-level description of the recommended Patient-Centered service delivery Care Coordination models

- 1. Name and describe Respondents chosen models including reason for selecting the models**
- 2. Describe how the models address the needs of the target population**
- 3. Explain how Respondents have approached implementation of the models**

Oklahoma Complete Health, through our parent company Centene Corporation (Centene) brings unmatched expertise in Care Coordination models for children in state custody both in length and breadth (9 years, 10 states, 135,000 plus current members). Our health plan affiliates serve as the sole source child welfare health plan in four states (Florida, Illinois, Texas and Washington). Our affiliate in Mississippi is also the preferred health plan for child welfare, and we manage a portion of the foster care populations in Kansas, Missouri, Louisiana, New Hampshire, California, and Indiana.

The value of our approach is:

- integrated health services for children and youth in foster care and adoption support programs and young adult alumni of the foster care system
- A proven holistic, Member-centric approach that creates a secure and constant system of care around each individual
- An actively engaged partnership approach that advances permanency, well-being and outcomes.
- Industry leading information technology support designed for data integration, analysis and secure exchange across systems
- A customized network of providers with specialized training and expertise in identifying and treating the needs of the children and youth in DHS custody

HIGH-LEVEL DESCRIPTION OF PATIENT-CENTERED CARE COORDINATION MODEL

Our recommended approach to patient-centered care coordination is a **highly integrated, wraparound model of Service Management/Coordination through a sole-source managed care model**. Through this model the managed care entity collaborates across all systems including foster care families, state agencies, judicial system, child placing agencies, community organizations and of course health care providers to reduce placement disruptions, improve overall health outcomes, and improve overall life outcomes for children and youth in custody of the State.

Our Foster Care Service Delivery model and approaches have been refined over time based on lessons learned about Member needs. For example, we designed our original model to reflect relatively low need for intensive medical services compared to with high need for behavioral

health (BH) services. Our affiliates quickly learned, however, that while BH needs are high, many children and youth in foster care also have complex physical health issues that require intensive service needs and coordination. As a result, new programs and specialized teams (described below) have been developed to serve these Members. Programs and teams have also been developed to meet the needs of other identified subgroups. For example in Texas at any given time, 16-18% of foster care Members are receiving Service Management/Coordination services, compared to about 4% of a traditional Medicaid child population.

Our Foster Care Service Delivery Model is organized in 4 tiers to best address and stratify the needs of this complex population. Members are stratified based on an initial assessment, either developed by the state or by the plan. Members, based on our experience, typically do not stay in one tier, but transition across tiers as conditions improve or as needs increase. Respectively, the experience and qualifications of plan staff, and contact requirements decrease or increase based on the specific needs of each member.

Through our care coordination model we aim to be a consistent and stabilizing force through the approaches identified below:

- Support and provide education to caseworkers and caregivers to ensure children in foster care have consistent and ongoing support for accessing medical and behavior health services across the state.
- Provide the support and care coordination children need regardless of type of placement.
- Be the constant in the system and coordinate directly with caseworkers, caregivers and providers.
- Be a consistent point of contact. Have the same person follow the child.
- Maintain the 24 hour nurse and BH crisis line.
- Provide more information and data on the children in an easy to use and updated electronic format.
- Foster parents need supports, most are not high income and constantly a new group of foster parents entering the system. Better support can help stabilize placements.
- Relative caregivers need a different engagement approach. They can be more afraid to ask for help over fear of a child being taken from them. They can also require more help navigating the system compared to professional foster parents.

Through our recommended model, the managed care entity would serve as a constant, creating and supporting a system of care around each child. Our model is designed to provide high quality treatment for each child, customized for his/her specific clinical, cultural and support needs, available resources and special circumstances. Our model is holistic and integrated including PH and BH services, and social and community-based services. We understand that many stakeholders and systems are deeply involved in the care of children and youth in custody, and we must integrate them into our care planning, decision making and training, regardless of who pays for the service. We achieve this through care coordination,

comprehensive and coordinated training, and sharing of information in a safe and secure manner.

Our care coordination model is built on the premise that a clinical network alone is not sufficient to help a child who has grown up or been thrust into the child welfare system. We focus on the whole child, across all systems, not just when the child encounters the health care system. Our Model is founded in elements of clinical care management and care coordination, trauma-informed care, engagement with the child, caregiver, providers and social services system, including SSS/Social Workers, child placing agencies, attorney ad litem and judges.

B. Access to Health Services

1. Describe how your Care Coordination models would ensure that children in care and their families can access needed health services?

a. Behavioral Health?

b. Medical?

c. Dental?

CARE COORDINATION MODEL AND ACCESS TO HEALTH SERVICES

Our approach to care coordination works to train *all* Network Providers serving the Foster Care population on the special needs and characteristics of children in foster care, all of whom have suffered trauma, loss, and instability. Nationally, we have invested deeply in developing a trauma-informed network, cross-training behavioral health (BH) and physical health (PH) Providers, and continually adapting training to incorporate evidence-based and best practice developments specific to children in foster care. We ensure access by:

- Ensuring key providers are in our network.
- Making sure we have the right providers and high quality, outcome focused providers.
- Leveraging telemedicine and other supports to assist PCPs in facilitating or providing specialty services such as getting support with behavioral health (BH) issues and medication management.
- Help caregivers find providers and make appointments.
- Provide medical expertise to help identify and “de-medicalize” children receiving unnecessary treatments/medications/diagnoses.
- Keep children with providers they were seeing before entering the system if possible.
- Provide culturally specific care and programs. Connect children to providers of same race/culture/gender/community whenever possible.
- Difficulty in maintaining services as children move placements or the reverse, not knowing why a child is receiving a service or medication when they arrive at new placement.
- Assistance with accessing vision and dental/orthodontia services.

Physical Health. We educate Providers about the needs of Caregivers in the foster care system and tailor training by Provider type. For example, we inform EPSDT Providers that Kinship Caregivers need extra support in following EPSDT schedules. In many instances, Kinship caregivers do not take the Member to the provider for EPSDT check-ups because they cannot miss work, do not have transportation and/or do not think they need to take the child to the doctor if the child is not sick, especially when they know and are familiar with the Member's medical history. We provide this knowledge to the Providers and offer additional support to achieve the necessary health outcomes.

Behavioral Health Providers with Specialized Expertise. Through our care coordination approach, we ensure our BH network providers are able to be "foster care experts," and account for the Member's language and culture when providing services and understand the impact on children and youth in foster care who have experienced child abuse, neglect, trauma, transience, and the lack of an intact family. Our individual and facility BH Providers also offer critical expertise in the treatment of disorders related to BH, including substance abuse, mental health, and dual diagnosis, as well as for the more unique characteristics of the foster care population.

2. How would you use a care coordination model to include children in care as enrollees of Health Homes?

HEALTH HOMES

Our model works strongly in collaboration with Health Homes. In accordance with Health Home requirements, the managed care entity's staff contact all Members/caregivers identified as eligible for Health Home services on the 834 eligibility file. For Members who meet Health Home criteria, our managed care entity model works directly with Health Home staff to provide technical support as indicated and ensure appropriate care and service coordination applying the principles of our care coordination model. For Members who opt out of Health Home services we will provide Service Management/Coordination services.

Our Health Home Program uses evidence-based models and minimum standards of care to provide comprehensive care management, coordination, Member/Caregiver support, linkage to community and social supports, Provider training and incentives, and Member/Caregiver health education and motivation. In addition, our regionally based multidisciplinary care teams supplement the services of network Health Home Designated Providers. The managed care entity's staff monitor all Members receiving health home services and their outcomes to ensure that those Members receive comprehensive and coordinated care addressing all identified needs and consistent with clinical guidelines. Overall responsibility for health home services and maintain communication with Members to ensure quality and satisfaction with services is retained by the managed care entity.

C. Staff/Provider Network

1. Describe, if applicable, how staff and/or provider network recruitment and retention, including types of providers (for example primary care, specialty care, dental, HCBS, case/care management, LTC, other, etc.) are addressed.

PROMOTING A NETWORK DESIGNED TO CARE FOR THE CHILDREN AND YOUTH IN CUSTODY

Through our experience with integrated Service Management/Coordination we have gained a unique understanding of the special considerations and innovations necessary to build an accessible Provider network for children and youth in DHS custody. As a managed care entity, we build our access on the foundation of a traditional Medicaid provider network and take into account the state demographics, landscape, distribution of members, distribution of providers, and other unique state characteristics. Additionally, we use our unique understanding of the child welfare/foster care system to develop new Provider innovations and adapt existing network services to meet the complex needs of children and youth in foster care within each state.

Our affiliates across the country proactively identify Providers who offer unique and innovative physical, behavioral health and dental services and identifies specific areas of expertise through the provider credentialing and (re)credentialing process, Provider surveys, trainings, and direct communication with Providers. To further ensure the right access and network support, we work specifically with stakeholders to gain input to identify “VIP” Foster Care providers (seen as essential to the care of the Foster Care population although they may not service a large number of Members).

Within the context of our care coordination model, we also work to expand access to Providers that are fully informed on Trauma Informed Care and other evidence-based practices that support children and youth in custody of the state. We proactively support Providers by offering evidence-based trainings to continuously develop a highly skilled network of Providers with specialized expertise. We enhance services by supporting Providers through activities such as assisting Providers accustomed to going to court, creating linkages between Providers and the Service Management/Coordination function, and providing technology/tools to improve administrative efficiencies and enhance communication.

PH Provider Types (including Dental) necessary for Centene’s Foster Care Network model:

- Primary Care Providers
- OBGYNs
- Pharmacy Providers
- Vision

- ENT
- Hospitals
- Children’s Hospitals
- Dedicated Pediatric Units
- Transplant Centers
- Home Health/Private Duty Nursing Services
- Hemophilia Centers
- Urgent Care Clinics
- Laboratory Services and Diagnostic Imaging
- Dental Providers

BH Provider Types necessary for Centene’s Foster Care Network model:

- Psychiatric Hospitals
- Outpatient BH:
 - Psychiatrists
 - Psychologists
 - Mid-level licensed clinicians (LCSW, LPC, etc)
- In-Home Therapy Providers
- BH Providers Experienced in:
 - Court Ordered Psychiatric Evaluations
 - Substance Abuse
 - Dual Diagnosis Services
 - Eating Disorders
 - Physical and Sexual Abuse
 - LGBT
 - IDD/DD
 - Fetal Alcohol Syndrome or Related Disorders
 - Sex Offender Treatment
 - Significant Trauma

Through this successful approach to network contracting and recruitment our affiliates across the country have worked with physical and BH Providers to identify competencies, skills and supports that can retain providers and maintain a robust network for serving this vulnerable population. Oklahoma Complete Health encourages and supports the use of evidence-based practices and embraces the systemic shift to a trauma informed system.

Staffing. Building on what we have learned and experienced in our affiliate plans, and taking in to account the needs and requirements of DHS and Child Welfare Services, Oklahoma Complete Health recommends specific staffing, systems, and processes dedicated to and tailored for the foster care/child welfare population. In addition to our own staff, we recommend embedded approaches to staffing that place Service Management/ Coordination staff in the communities

they serve, and either with or accessible to child placing agencies and state agency staff to leverage clinical consultation on processes and recommendations to ensure that they are appropriate and within current recognized clinical practice guidelines and that information is safely and appropriately shared to ensure wraparound services and holistic support for Member care.

D. Payment Structure

1. Explain payment methodology, assumptions, and constraints related to the care coordination models

a. Specific to covered benefits and services

b. Specific to other benefits and services

c. Show estimated amounts of provider payments for evidence-based performance outcomes (for example amounts of withholds, performance payments based on quality metrics, etc.)

We would be pleased to offer detailed approaches to payment methodology, including assumptions and constraints through future discussions with DHS.

2. How does your Care Coordination model address potential CMS concerns regarding duplication of care/payment? Explain how proposed payments comply with existing and proposed Federal and State requirements.

Our care coordination approach is committed to system collaboration and coordination with all treating providers working with our Members. Additionally, we utilize safe data sharing methodologies that allow for increased coordination with providers. In this way we seek to reduce duplication and redundancy of services. Our staff are educated on the full scope of services including covered benefits by the managed care entity and those non-covered benefits available through CMS. Our Service Management/Coordination staff are responsible for coordinating all services, including those which we are not financially responsible to cover.

E. Impact of Model

1. Explain estimated implementation costs and anticipated savings, for the first five years of an implementation of your model?

a. Methodology?

b. Assumptions?

c. Constraints?

We would be pleased to offer detailed approaches regarding anticipated costs and savings including methodology, assumptions and constraints through future discussions with DHS. However, below we have provided examples of the types of cost savings we have achieved through this approach in other states across the country.

Oklahoma Complete Health's affiliates have implemented care coordination models that deliver cost savings through system efficiencies, informed Members and caregivers, reductions in inappropriate utilization and increases in preventive and primary care services. We recommend

inclusion of these initiatives, appropriately staffing and resourcing programs that bring value, improve outcomes and generate health care savings.

As illustrated by Superior Health Plan, our affiliate with the longest history administering a state-wide, sole source managed care foster care program, program savings can most easily be demonstrated by looking at specific program results.

In 2011, Superior's Care Managers identified that multiple children in the same placement were receiving 1:1 Private Duty Nursing services (PDN). Superior reached out to HHSC (Medicaid entity) for support in developing a clinical PDN staffing ratio policy to more effectively serve multiple children receiving PDN services in a single home. While reviewing the 217 cases of children receiving PDN services, Superior found 130 Members who met the criteria for shared PDN services. These changes have resulted in a higher degree of fiscal responsibility, **decreasing overall PDN services by 10%; without reducing the quality of services or health outcomes**. In CY 2013, Superior achieved **an estimated savings of \$170,600 for their foster care Asthma Program**. In CY 2010, the foster care Asthma Program achieved a record high of more than **\$610,000 in savings**. In CY 2012, Superior's **savings for its Pediatric Asthma DM Programs across all Medicaid/CHIP products was more than \$5,915,000**. The methodology used estimates the difference in medical expenses for participants between a baseline period prior to engagement and the period of their participation; compares it to the difference in medical expenses for matched non-participants for the same time periods; and assigns estimated financial value to the program effect. Superior's **diabetes program resulted in a savings of about \$138,500** when applying the 2009 average claim cost to the reduction. Between CY 2012 CY 2013, **Superior reduced 30-day readmission rates after diabetes-related inpatient stays from 55.7% to 14.1%**. This rate includes Members ages five and over, and measures the proportion of diabetes related inpatient admissions that are followed within 30 days by another inpatient admission, **saving about \$150,000 from the readmission reductions**, when applying average claim cost to claim decrease.

2. Describe the quality and anticipated effect of the care coordination models on the target population with respect to the following.

a. CMS recommended benchmarks

b. State identified areas including preventive screenings, tobacco cessation, obesity, immunizations, diabetes, hypertension, prescription drug use, hospitalizations, readmissions, emergency room use

c. Core measures identified within the Oklahoma Health Plan (OHIP) 2020

d. Respondent suggestion for other benchmarks

e. Considerations for Value-based performance designs, specifically those that support and align with objectives identified within the Oklahoma State Innovation Model design

We recommend an approach to care coordination in which a sole source managed care entity works collaboratively with state agencies and other stakeholders and partners upon contract award to identify appropriate benchmarks, interventions, core measures, initiatives, and value-based approaches that will align incentives and lead to overall quality improvements for children and youth in custody of DHS. The focus should be on those measures and initiatives

that will have the greatest value and impact on health outcomes of Members. For example, our Washington affiliate, Coordinated Care, has demonstrated quality outcomes on HEDIS results, with a significant improvement in childhood immunization status. For Combo 2 (combined childhood immunizations), HEDIS rates jumped from 64.35% in 2013 to 79.52% in 2014, reaching the NCQA 75th percentile. Coordinated Care's HPV (human papilloma vaccine) for female adolescents is above the NCQA 90th Percentile (2014 rate of 31.43%). For Members with poorly controlled asthma, Coordinated Care partnered with a local County Public Health department to make use of their Clean Air for Kids program, which involves a home visit by a trained Asthma Outreach Worker, at no cost to the Member, to assess asthma symptoms, identify triggers such as allergens in the home, and discuss how to manage them, review treatment plan and proper use of medications, and connect the Member to additional resources as needed.

Our Texas affiliate, Superior, has achieved strong improvements in reducing unnecessary or inappropriate prescribing patterns for psychotropic medication as a result of the Psychotropic Medication Utilization Review (PMUR) program, the Texas foster care PMUR data shows a 23% decrease in overall psychotropic drug use; 44% decrease in class polypharmacy; and a 43% decrease in 5 or more medications, since 2007.

Finally, Disease Management programs have demonstrated great success with the foster care population. In 2012, children in foster care enrolled in Superior's Asthma DM Program were ***less likely to have a respiratory-related admission than non-program participants (by 16% and 23%, respectively); more likely to visit their physician (by 68% and 22%, respectively); and more likely to obtain controller medications (by 30% and 52%, respectively).*** Foster care Members were ***46% more likely to receive flu vaccinations.*** The Integrated Diabetes Program ***reduced the Diabetes Short-Term Complications Admission rates by 45% from FY2009 to CY2012*** (as measured by the EQRO). Between CY2012-CY2013, Superior ***reduced 30-day readmission rates after diabetes related inpatient stays from 55.7% to 14.1%.*** This rate includes Members ages five and over, and measures the proportion of diabetes related inpatient admissions that are followed within 30 days by another inpatient admission.

The Integrated Diabetes Program ***reduced BH inpatient admissions for foster care Members by 78% from Q1 to Q4 FY2013 and by the end of Q4, more than 64% of Members in the program showed functional improvement,*** as measured by the assessment tool that tracks ***caregiver reports of problem behaviors. Program participants also reported a 50.3% improvement*** on the Ohio Youth Problem, Functioning, and Satisfaction Scales during 2013.

These are all programs designed to achieve quality improvements and health outcomes with demonstrated success. We recommend these types of measures and approaches be implemented for a care coordination model in Oklahoma.

F. Data Management

1. How does your care coordination model provide for efficient management of data to ensure that the child experiences quality and safety?

EFFICIENT AND SAFE DATA MANAGEMENT APPROACHES.

Oklahoma Complete Health understands the importance of actionable data sharing that protects Members' confidentiality, but allows all providers and caregivers to exchange information to support a coordinated approach to care in compliance with all applicable State and federal laws. In 2007, in partnership with the state of Texas, Centene successfully pioneered, designed, developed, deployed, and now operate a secure, fully integrated, web-based community health record that supports collaborative care coordination for foster care Members. This includes Provider, Caregiver and Member Portals to keep all care team members up-to-date on Member's health information and establish a clinical data home that is accessible to appropriate and authorized users. The community health record enables secure role-based access, to view key Member contacts, as well as allergies, medications, medical and BH service history (as allowed by statute), including lab results, care plans, PMUR, and other clinical information. Our enterprise data warehouse enables Oklahoma Complete Health to produce a variety of analytic reports on both the individual Member and population levels, drawing from medical, BH, pharmacy and other claims, health assessments and lab results. These can be leveraged to predict health risks, identify care gaps, track Member conditions, identify co-morbidities, and customize outreach and other interventions such as notifying a provider of a needed test or check-up while at the same time alerting our Service Management/Coordination staff to direct the Member to a care provider. This information can then be shared, within HIPAA and other regulatory requirements, with Members' treatment team, to further member-centered care plan goals and support development of best practices and evidence-based care across the State.

G. Care Coordination Implementation Timelines (including key activities and milestones)

1. Based on your prior experience, provide insight into what a realistic timeline for implementation of your Care Coordination model might be. Specifically, provide details into the following aspects of implementation of a Care Coordination model similar to what has been described:

a. Development

b. Transition/Readiness Activities

c. Implementation of member enrollment

d. Implementation of member service delivery

We would be pleased to offer detailed implementation timelines including key activities and milestones through future discussions with DHS. Oklahoma Complete Health's parent company, Centene, has more than thirty years of experience in implementing fully integrated programs for members with complex needs such as children and youth in foster care; children with SSI; as well as TANF and CHIP programs.

Through this experience we understand the key activities for ensuring successful initial and ongoing operations to be: recruiting, onboarding and training staff, planning, building and educating a provider network appropriate to the program membership and benefits, stakeholder engagement and education, development and execution of care transition for members with ongoing services, and a full operational readiness compliance testing process. We understand each implementation is unique, due to programmatic and regulatory requirements, and have significant experience in rapid program standup and implementation. It

will be essential for us to partner with DHS, CWS and all impacted stakeholders throughout key implementation activities to meet the timelines and ensure successful and smooth transition of services.

PATIENT CARE NETWORK OF OKLAHOMA (PCNOK)

RESPONSE

to

OKLAHOMA HEALTH CARE AUTHORITY

REQUEST FOR INFORMATION SB773

CARE COORDINATION FOR CHILDREN IN DHS CUSTODY

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Primary Care Network of Oklahoma Response to SB773 Request for Information Care Coordination for Children in DHS Custody

A. High-Level description of the recommended Patient-Centered service delivery Care Coordination models

1. Name and describe Respondents chosen models including reason for selecting the models.

In this response to SB773 Care Coordination for Children in DHS Custody, the Patient Care Network of Oklahoma (PCNOK) will demonstrate that our care coordination model combined with our network of services will achieve better care, healthier children and reduced costs to provide health care services to children and youth in the custody of the State of Oklahoma. All 19 members of PCNOK are Community Health Centers (CHC) and designated by the Health Resources and Services Administration (HRSA) as Federally Qualified Health Centers (FQHC). A clinically integrated network, PCNOK operates over 90 clinic sites state-wide with 3,090,000 Oklahomans (about 80%) living within a 30-minute drive to these strategically located health centers (please see map in Appendix A). The Network was formed in 2015 with the purpose of harnessing our combined value to apply that combined strength to solve challenging state health problems and improving outcomes in various special populations across Oklahoma.

Serving people in most Oklahoma counties (with the exception of Harper and Ellis), PCNOK is well positioned to help coordinate care for children in custody. PCNOK will use an enhanced approach of the Patient Centered Medical Home Model (PCMH) and will outline how the PCMH platform lays a foundation for a new approach to care management of this fragile population (please see map in Appendices B for patients by zip code and ZCTA).

The National Ambulatory Medical Care Survey (NAMCS) 2006-2008¹, reports FQHCs performed better than private practice physicians on six measures and no differently on 11 measures. These impressive results are despite the greater complexity of patients served at FQHCs and the patients' high poverty rates, low levels of education, chronic health conditions, non-compliance, low literacy, and other challenges. Studies like this and others that show great promise and will be used by legislators, policy makers, governmental and private payors to drive the incentives that will be used to develop new payment and delivery models.

A wide array of pay-for-performance models have been developed to incent or reward providers for producing better outcomes at reduced costs. Between the spectrum of fee-for-service and full capitation lie value-based payment (VBP) demonstration projects including performance-based fees for services, shared savings, and medical home payment and delivery models. In 2016, CMS designated PCNOK a statewide ACO with over 10,000 attributable lives. Care Coordination is at the core of the ACO model using population health strategies aimed at serving special high risk and high cost patients. A data component to share data among PCNOK membership is well underway by the Health Center Controlled Network, "Soonerverse" and

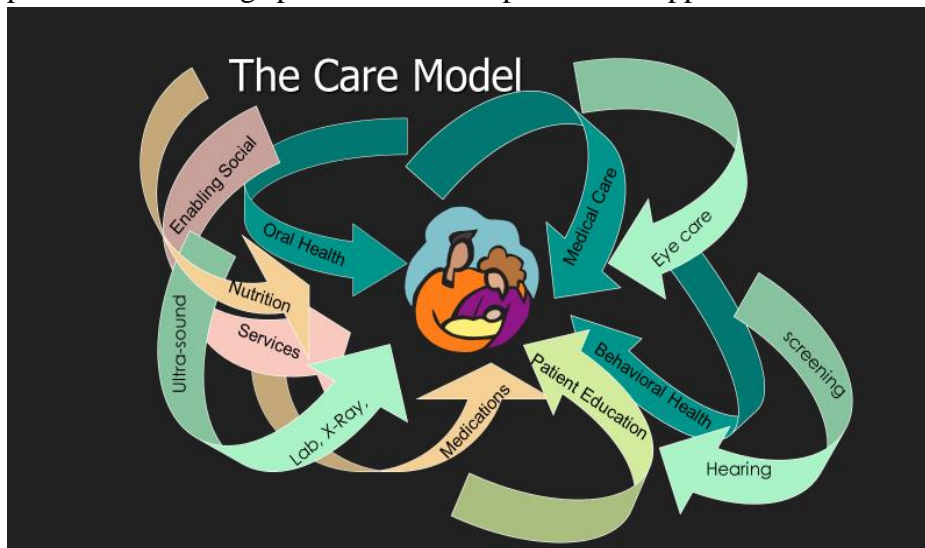
¹ National Ambulatory Medical Care Survey, <https://www.cdc.gov/nchs/ahcd/index.htm>

MyHealth Access Network, the state Health Information Exchange (HIE). All PCNOK health centers have implemented a functioning Electronic Medical Record (EMR) and are engaged in PCMH strategies. Data exchange between practices and PCNOK and its members FQHCs will be discussed later in this response.

The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for archiving a child’s medical record. In its 2002 policy statement, the AAP expanded the medical home concept to include these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care. The American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) have since developed their own models for improving patient care called the “medical home” (AAFP, 2004) or “advanced medical home” (ACP, 2006). Further, designations by state Medicaid agencies, Joint Commission and the National Committee for Quality Assurance (NCQA) have all adopted the concepts and basic framework to transform practice.

In the case of FQHC’s, the medical home model has been a core tenant of service delivery for decades and thus FQHC’s are on the path to or have achieved designation as a medical home. For PCNOK, our 19 grantees across the state all are on the path for designation. As an FQHC all are required to offer basic integrated primary medical, dental and behavioral health services. In 2016, Community Health Centers treated 204,000 of Oklahoma’s most vulnerable families including the working uninsured poor, pregnant women, children, adolescents and young adults, and fragile elderly. Community health centers have built local relationships with other care providers including specialists and hospitals. Our approach to chronic disease management and

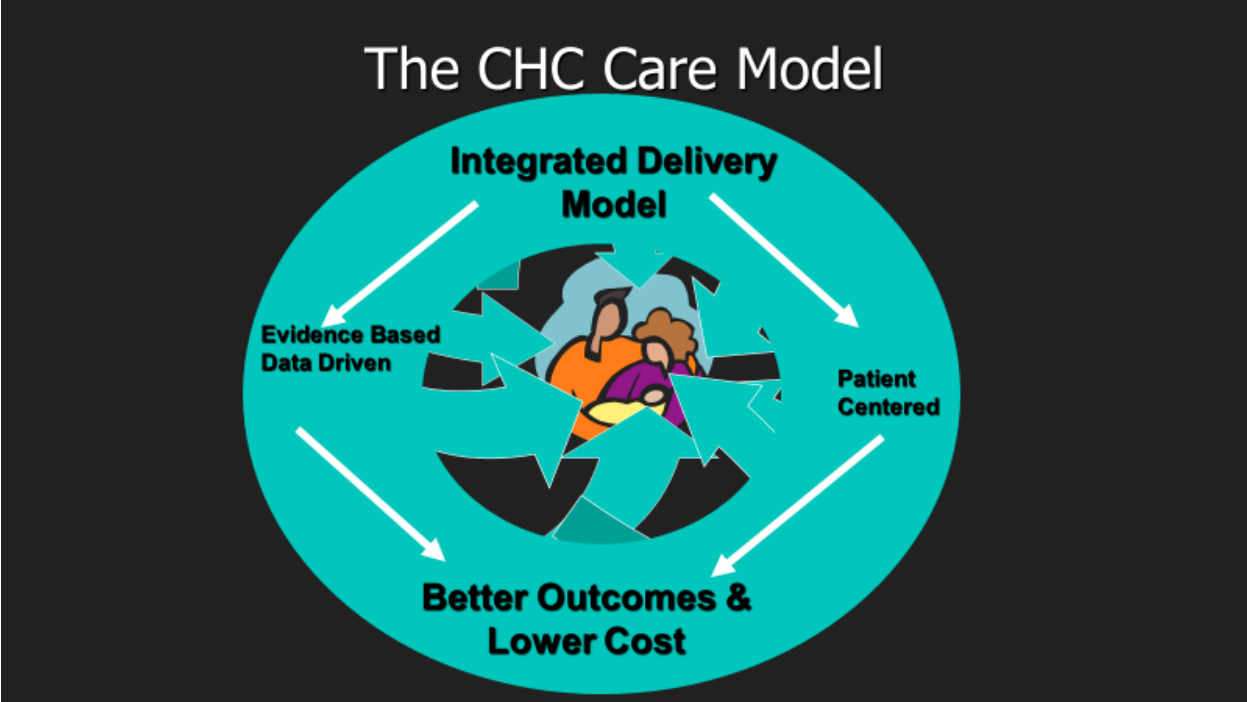
coordination of community resources to affect overall health have been successful.



Using the Care management definition offered by Health Care Strategies, Inc.,² PCNOK will apply systems, science, incentives, and information to improve medical practice and assist children in

custody and their support systems to become engaged in a collaborative process designed to manage medical/social/mental health conditions more effectively. The goal of care management in the Patient Care Medical Home model is to achieve an optimal level of wellness and improve coordination of care while providing cost-effective, non-duplicative services.

² Health Care Strategies, Inc., <http://www.hcare.net/hcs/home.html>.



PCNOK will utilize a tiered approach to care management through its Medical Home Model. For this special population (children in state custody), a thorough assessment will triage the child into one of three categories for care management in a low, mid and high range of intensity. Care teams and care managers will be assigned based on the same stratification and level of acuity and intensity with lower panel assignments going to higher need patients.

PCNOK’s Medical Home Model will improve DSHS’ core performance areas for improvement under its Oklahoma Pinnacle Plan. PCNOK can assist DHS improvement in at least 2 core performance areas - Maltreatment in Care (MIC) cases and children in need of Therapeutic Foster Care (TFC).

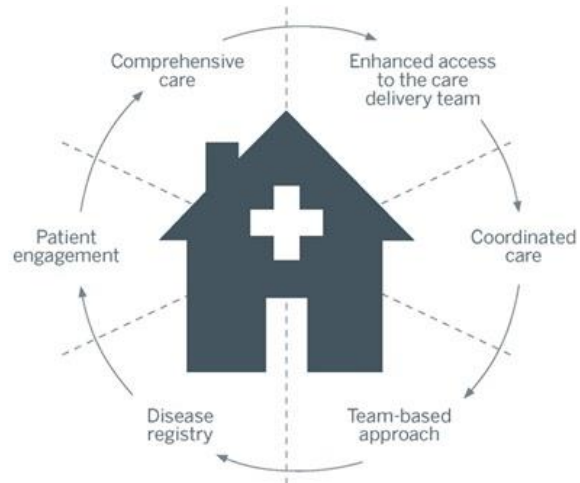
PCNOK’s specialized PCMH will enable DHS to achieve substantial and sustained reductions in the MIC rate of children in DHS custody by more closely integrating the custodial parent into the care experience, providing the care team more family contact. PCNOK’s PCMH will perform risk assessment during each clinic visit using DHS’ designed form. The PCMH care coordination team will assess risk during home visits and phone consults. If risk assessments indicate need, the DHS caseworker will receive notification via an alert system (by phone call, email or MyHealth portal notification) for immediate investigation and intervention.

There are not enough TFC homes for children in DHS custody who have specialized behavioral health or other emotional needs. Although open TFC homes have a persistently high vacancy rate, a large number of children are still waitlisted in need of placement. The Pinnacle Plan requires behavioral health services availability to children on the waiting list. PCNOK’s PCMH will provide these services. PCNOK will customize medical records so DHS caseworkers can document these services for Pinnacle Plan compliance certification. PCNOK’s PCMH will also assist DHS in determination of whether a child in DHS custody should be placed in TFC by

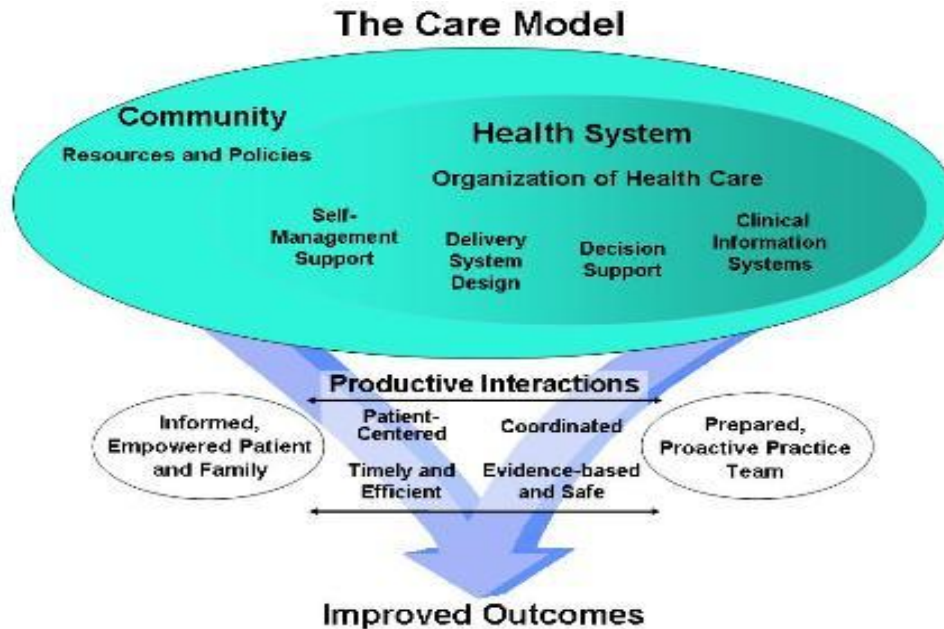
conducting these medical needs assessments.

The following philosophy is the Community Health Center approach to the Patient Centered Medical Home:

- Personal provider - each patient has an ongoing relationship with a personal medical provider trained to provide first contact, continuous and comprehensive care.
- Provider-directed medical practice – the personal provider leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- Whole person orientation – the personal provider is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals. A multi-disciplinary, integrated approach where the care team consists of medical, oral health, mental health, vision and includes nutrition, clinical pharmacy, and psychiatry reduces the amount of care management needed outside the FQHC/Medical Home, due to the broad spectrum of services integrated into PCNOK’s network.
- Care is coordinated and/or integrated across all elements of the complex health care system (e.g. subspecialty care, hospitals, higher therapeutic mental health beyond FQHC offerings) and the patient’s community (e.g., Foster or Kinship family, social worker, CASA volunteer, community-based service providers and others as needed/recognized).
- Care is facilitated by registries, Electronic Health Record (EHR), Health Information Exchange (HIE) and other means to assure patients receive needed care at the appropriate time and level, in a culturally and linguistically appropriate manner. A high emphasis is placed on prevention and early detection of health issues. There is a focus on Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), immunizations, and age-appropriate screening tools and patient education toward a goal of building a healthier life. PCNOK will work with the Child’s Passport application to ensure up to date progress, treatment interventions, tests, and notes.
- All members of the care team are trained in mental health first aid and / or trauma-informed care. This step has become increasingly necessary with evidence that screening means recognition. This has increased the requirement that health centers incorporate behavioral health and mental health acumen into primary care versus referral outside the



health center. This drives compliance and improves outcomes.



PCNOK's health centers emphasize a collaborative team approach with other care providers outside of the PCMH who know and work with the child. We intend to protect and support those relationships. Our collaborative care position embraces team driven, population focused, measurement guided and evidence-based practice. Our value-based approach will align with cost savings. We have engaged with the Oklahoma Health Care Authority, Oklahoma State Department of Health, and the Oklahoma Primary Care Association through the National Academy of State Health Policy (NASHP) to move to Value Based Reimbursement by April 2018. This arrangement provides Per Member Per Month (PMPM) capitation for all Medicaid patients of record for medical, dental, behavioral and wrap around services with the goal of lowering overall all cost through increased access and better care management.

A new study, recently released and published in the November 2016 issue of the American Journal of Public Health,³ confirms significant Medicaid cost-savings among patients at Community Health Centers. The authors analyzed Medicaid claims data for both health center and non-health center patients in 13 states and found that health centers save, on average, \$2,371 (or 24%) in total spending per Medicaid patient when compared to other providers. The study focused on Alabama, Colorado, California, Florida, Iowa, Illinois, North Carolina, Texas, Vermont, Mississippi, West Virginia, Connecticut, and Montana, making it one of the largest multi-state studies of its kind. Researchers found that health center Medicaid patients had lower utilization and spending than non-health center patients across all services studied, including:

³ Nocon, Robert, et al, Health Care Use and Spending for Medicaid Enrollees in Federally Qualified Health Centers Versus Other Primary Care Settings, American Journal of Public Health, November 2016, <http://ajph.aphapublications.org/doi/10.2105/AJPH.2016.303341>.

- 22% fewer specialty care visits
- 33% lower spending on specialty care
- 25% fewer inpatient admissions
- 27% lower spending on inpatient care
- 24 % lower total spending.

Main Findings: Health Center vs non-Health Center

Summary: Health Center patients had lower use and expense across all services

	Non-Health Center	Health Center	% Difference
Primary Care			
Visits	8.2	7.6	-7%
Spending	\$1,845	\$1,430	-23%
Other Outpatient Care			
Visits	15.7	12.2	-22%
Spending	\$2,948	\$1,964	-33%
Rx Drug Spending	\$2,704	\$2,324	-14%
Emergency Room			
Visits	1.3	1.2	-11%
Spending	\$244	\$216	-11%
Inpatient			
Admissions	0.25	0.19	-25%
Length of stay	1.1	0.8	-26%
Spending	\$2,047	\$1,496	-27%
Total Spending	\$9,889	\$7,518	-24%

Consequently, the model follows the goals of the Oklahoma State Innovation Model and Oklahoma Health Improvement Plan⁴ to improve overall health, provide better care, patient engagement and lower costs and is specifically named as a model to improve the overall health of Oklahomans. Specifically, the proposed model supports the following objectives:

Bend the Healthcare Cost Curve

- Promote payment for value over volume
- Increase monitoring and evaluation to ensure the state is meeting cost benchmarks

Improve Quality of Care

- Increase care coordination efforts to drive at-risk patients to preventive care and community-based services and resources
- Improve the monitoring of at-risk patients to ensure that patients have access to preventive care and community-based services and resources
- Increase patient education efforts
- Encourage patient disease self-management

Improve Population Health Goals

⁴ Oklahoma State Health System Improvement Plan, Oklahoma State Department of Health, Submitted to CMS on March 31, 2016.

Tobacco Use

- Increase tobacco prevention education
- Increase utilization of evidence-based tobacco cessation treatments
- Increase quit attempts among current tobacco users
- Increase the implementation of evidence-based interventions and strategies that address vulnerable and underserved populations

Behavioral Health

- Increase public education regarding mental health
- Develop a mental health workforce in both capacity and relevant competencies
- Improve diagnosis and treatment of mental illness

Diabetes

- Increase provider awareness of pre-diabetes and metabolic syndrome diagnoses
- Enhance access to and sustainability of diabetes prevention programs in high prevalence areas
- Increase patient nutrition education
- Increase patient accountability associated with diabetes prevention

Obesity

- Increase access to affordable, healthy foods, especially fruits and vegetables
- Increase access to places for physical fitness activities
- Increase the awareness of benefits and opportunities for healthy living
- Increase provider involvement in screening, diagnosis, and counseling of obesity

Hypertension

- Increase patient accountability
- Foster team-based care coordination
- Increase community involvement

Community Health Centers are required to set objectives for common clinical and financial outcomes, and to report on these measures annually through HRSA's Uniform Data System Reporting. Included in the clinical outcome measures are reducing tobacco use, improving diabetic control, counseling for obese patients, and control of high blood pressure. Many health centers work with local food banks to make healthy food available and negotiate reduced fees at exercise facilities.

The National Alliance on Mental Illness (NAMI) reports, "For most youth, the pediatric primary care setting is the most practical location for integrated care because most families and youth access care in primary care offices. The primary care office is a place where families have often established a trusting relationship with a primary care provider. It is also a place that youth are familiar with and are comfortable visiting."⁵ They go on to say that if the child is receiving intense services at a mental health facility, they too need integration of primary and mental health. We could not agree more. Behavioral health integration with medical care is a focus of HRSA and screening for depression is a required clinical measure. HRSA has funded several special initiatives in recent years to increase access to mental health services among health centers.

⁵ Integrating Mental Health and Pediatric Primary Care, National Alliance on Mental Illness, 2011, https://www.integration.samhsa.gov/integrated-care-models/FG-Integrating_12.22.pdf.

2. Describe how the model addresses the needs of the target population.

Screening and integration of mental health into the primary care setting, coordination, patient advocacy, easy referral and access to all other primary care needs will result in an overall approach to wellness and health. We believe the model's current value has shown its effectiveness in the outcomes that have been measured. Further, the ease of reduced navigation of multi-specialties (medical, dental, vision, mental health, and other health services) will help the entire foster/kinship family and provide a medical home that exists for them beyond custody. The relationship with the care team, including the care coordinator and health workers, will add stability and support to the family unit.

Oklahoma's health centers are aware of the importance of trauma-informed care; many health center behavioral health specialists and outside referral organizations have undergone specialized training in working with children who have experienced adverse childhood experiences (ACE) and trauma. PCNOK membership understands that traumatic experiences can affect a child's wellbeing and ability to cope with their changing environment. Some health centers are working to provide training in trauma-informed care and incorporate an understanding of the effects of ACEs at all levels of their organizations. The trauma experienced by children who have been removed from their home and those who have experienced abuse and maltreatment affects their physical and mental health, which provides additional challenges to helping the child reach a state of wellness. All PCNOK members work with populations challenged by poverty, culture, isolation, mental illness stigma, and the lack of fundamental necessities that allow them to function in a city without adequate public transportation, or in a rural area without any public transportation at all; some health centers work with populations who cannot speak English and are at additional risk for exploitation. We understand the challenges involved in providing services to marginalized and vulnerable people. Many PCNOK members currently work with Child Welfare Specialists to coordinate care for children in DHS custody; our proposed model involves working with DHS at a higher level to ensure children in custody receive all the advantages and stability of a medical home and wrap around services that need not change if they are reunited with their parents, placed with a family member, or placed with a different foster family. We are committed to providing a level of service on which the child and DHS can depend to continue at the same high level of quality throughout a child's life and into adulthood. To ensure the proposed model of care is trauma informed, PCNOK will ask the Oklahoma Primary Care Association to facilitate training for member health centers in collaboration with the University of Oklahoma's Center on Child Abuse and Neglect.

3. Explain how Respondents have approached implementation of the models.

All health centers have embraced the concepts of the triple aim of healthcare transformation and innovation in integration of and coordination of care. Each health center works with their community in a process of Continuous Quality Improvement (CQI) to find ways to improve overall health and wellness of the community. Similarly, PCNOK has a CQI physician-led quality committee. Through the Primary Care Association, which provides technical assistance and introduces new and innovative concepts, CHCs have each received recognition by the Health Resources and Services Administration. Quality initiatives include patient task forces to identify

access and quality issues and achieve goals. Our intent is to form a multi-specialty CQI subcommittee at the state level to work on specific needs and challenges of our populations at various ages (newborn, toddler, children, youth, adolescents and those aging out of custody). In this medical home model, the teen who ages out of custody does not need to find another provider; continuity of care will continue into adulthood. The following table represents a typical clinical flow for the proposed project:

Pre-visit huddle with medical team			BETWEEN VISITS
PATIENT VISIT			
Prior to Provider Entry	Provider Visit	Visit Complete	Nurse / Medical Assistant / Case Manager:
Nurse / Medical Assistant: <ul style="list-style-type: none"> • Discusses patient agenda • Patient history • Medication reconciliation • Orders routine tests and services • Reviews Child's Passport 	Focus is on patient: <ul style="list-style-type: none"> • Revises medical history • Enters progress note into Child's Passport Nurse / Medical Assistant: <ul style="list-style-type: none"> • Documents visit and follow up needed 	Nurse / Medical Assistant: <ul style="list-style-type: none"> • Closes the loop on the visit • Discusses patient concerns • Assists patient to set goals • Assists patient in navigating health system • Updates / Revises Child's Passport 	<ul style="list-style-type: none"> • Follow up with patient and / or family weekly • Addresses barriers • Follows up on concerns • Serves as a link between the patient and / or family, and provider • Updates Child's Passport as needed

B. Access to Health Services

1. Describe how your care coordination models would ensure that children in care and their families can access needed health services.
 - a. Behavioral Health Services
 - b. Medical Care
 - c. Dental

Community Health Centers designated as FQHCs are required to integrate and coordinate Primary **medical, dental and behavioral health** into the care model with other additional services as needed on-site or by referral. This includes access to all life cycles and would include all members of the Foster/Kinship family. In addition, the availability of services by PCNOK's integrated network envisions nurse advice line and Physician on call 24/7 for all patients of record. This population would have the added advantage of a care team and care coordinator to further assist with urgent needs as they arise after hours or on the weekend. After hours' call is available as well as same day appointments, walk in and urgent care after hours.

All Health Centers have extended hours at least once per week at a minimum and many have extended hours Monday through Friday, with some Health Centers providing Saturday access. Assistance with transportation and coordination of appointments will be part of coordination.

PCNOK's current approach incorporating ease of access defines our proposed model. PCNOK envisions a "Pass Card" corresponding to the Child's Passport application, displaying call-in numbers for scheduling and after-hours numbers for triage. All children in custody will be issued a "Pass Card" for identification to PCNOK health centers as clients enrolled in this program. These program clients will be given priority access for urgently needed walk-in visits. EMR identification will alert schedulers and send a message to the care coordinator that an appointment has been scheduled, missed or rescheduled. The care coordinator will also review age and upcoming wellness needs in addition to treatment plans in which the child may already be engaged. Our goal is to ensure timely oral health, immunizations, and other checkups. Our integrated model with all primary medical, dental and most mental health services provided on site will be ideal for the child, easier for the custodial parent, and remove complexity for the Child Welfare Specialist at DHS. Additionally, should the child relocate within the state, PCNOK will ensure reassignment and record transfers to the appropriate PCNOK health center, including connection with a new care coordinator, for the smoothest possible transition.

2. How would you use a care coordination model to include children in care as enrollees of Health Homes?

Our care coordination model utilizes PCNOK's clinically integrated network services while also supporting existing primary and specialty care referral relationships. PCNOK proposes assignment of new clients to PCNOK health centers so that most placements will eventually be assigned to PCNOK's network. Using Health Home guidance, PCNOK proposes the tiered approach enumerated in section A where behavioral health services would be provided at the most appropriate level and setting, including referral to a community provider outside PCNOK when client needs dictate. Our goal is care coordination to eliminate duplicate unnecessary services. PCNOK's Clinically Integrated Network (CIN) provides full-spectrum PCP access as well as strategies to improve health and wellbeing; cost-effectiveness; and patient, family, and DHS satisfaction; as outlined in Section A of this response. Care coordination would include referral to Community Mental Health Centers (CMHC), home-based services, hospitals and other specialty needs, if the most appropriate level of care to achieve the clients needed outcomes, with all other services provided within PCNOK's network of care.

C. Staff / Provider Network

1. Describe, if applicable, how staff and/or provider network recruitment and retention, including types of providers (for example, primary care, specialty care, dental, HCBS, case/care management, LTC, other, etc.) are addressed.

CHCs use a multi-faceted approach to recruit high level, quality providers of care in all disciplines. In accordance with HRSA and Federal Tort Claims Act (FTCA) guidelines, all providers and all certified allied health workers undergo a rigorous primary and secondary source credentialing process. Licensed providers also complete a board-approved privileging

process that clearly defines their scope of work, which involves recommendations from the Chief Medical Officer. Both Credentialing and Privileges are reauthorized at a minimum of every 24 months.

Health centers employ various provider types and support staff (MD’s, DO’s, ARNP’s, PA’s, RN’s, LPN’s, LCSW’s, LPC’s, LADC’s, etc.), with each working to their highest degree of licensure to address the varying needs of different populations. Support staff hiring is focused upon integrated behavioral health, dental services, and patient care coordinators for targeted case management of at risk populations. This staffing model will ensure successful care continuity and improved outcomes for patients.

Psychiatry would be managed by the network physician or through e-Psychiatry, which is currently operational. Clinical Pharmacists would assist both primary and mental health providers with patient medication management. Many Health Centers offer pharmacy services and contract pharmacies are arranged if there is no pharmacy on site. In addition, family members will have access to the same health center services. PCNOK’s clinically integrated network employs 1,451.88 Full Time Equivalent (FTE) staff, including the following:

Staff Category	FTE
Medical	547.74
Primary Care Physicians	79.24
Family/General Physicians	53.96
Internists	5.08
Obstetrician/Gynecologists	8.35
Pediatricians	11.85
Other Specialty Physicians	1.8
Physician Assistants	29.15
Nurse Practitioners	82.77
Nurses	144.88
Other Medical Staff	178.03
Lab and X-ray	30.87
Dental	105.31
Dentists	27.36
Dental Hygienists	15.84
Dental Therapists	0
Other Dental Personnel	62.11
Mental Health	55.21
Psychiatrists	5.18
Licensed Clinical Psychologists	1.55
Licensed Clinical Social Workers	12.14
Other Licensed Mental Health Providers	27.44
Other Mental Health Staff	8.9
Substance Abuse	1.97
Pharmacy	40.88

Other Professional	3.96
Vision	15.71
Enabling Services	114.11
Other Programs/Services Staff	25.47
Quality Improvement Staff	11.55
Patient Support Staff including referral and care management staff	260.85
Management and Other Support Staff	141.17
Facility Staff	36.83
IT Staff	21.2
Fiscal and Billing Staff	69.92
TOTAL	1,451.88

D. Payment Structure

1. **Explain payment methodology, assumptions, and constraints related to the care coordination models.**
 - a. **Specific to covered benefits and services**
 - b. **Specific to other benefits and services**
 - c. **Show estimated amounts of provider payments for evidence-based performance outcomes (for example amounts of withholds, performance payments based on quality metrics, etc.).**

There are two payment methodologies that would be effective in achieving the State’s goals with regard to the provision of health care for children in DHS custody, a regionalized Prospective Payment System (PPS) rate or PMPM capitation rate.

PCNOK membership includes health centers throughout Oklahoma, all of which offer medical, dental, and mental health either directly or through referral agreements with local providers. All required services will be provided, including mental health and development screening, dental exams, immunizations, visual and hearing exams, corrective lenses or hearing aids, outpatient or inpatient behavioral mental health treatment, medical treatment, follow-up and referral services, and participation in care coordination.

Each Community Health Center receives payment for health care services provided at the time of service through the federally mandated Prospective Payment system, which is a risk adjusted cost based reimburse methodology otherwise known as a PPS rate. All covered benefits will be delivered under this model. If service gaps are identified, PCNOK will address with new sites, telehealth, or other resources. The PCNOK quality committee will develop processes for this population according to agreed goals. Attribution methodology, costs and covered benefits need to be discussed and clearly delineated.

Under this scenario, PCNOK would be compensated fee for service at PPS rates, with an additional PMPM care coordination fee (to be established), and payment of shared savings (50% of savings achieved). PCNOK will use its CMS Medicare Shared Savings Plan (MSSP) ACO

care coordination methodologies to ensure the right care is provided at the right time and level to avoid unnecessary care expenses, to achieve savings.

A capitated payment structure incentivizes more radical care delivery transformation by placing PCNOK at risk. Capitation is likely the State's preferred methodology because of its inherent incentives to ensure the best care outcomes are achieved for these clients. PCNOK will work with the Oklahoma Health Care Authority, Oklahoma Department of Human Services, and Oklahoma Department of Mental Health and Substance Abuse Services to develop age sex adjusted rates for this client population, preferably risk adjusted. An actuarially sound PMPM needs to be developed, including identification of capitated services and carve-outs. Our preference is that all FQHC provided services, including lab, radiology, and pharmacy (340B prescription pricing) will be capitated. PCNOK will lower hospital emergency department visits and hospital admissions by increasing primary care visits and care coordination. Other states have demonstrated this model; Alabama, Arkansas, Colorado, Massachusetts, North Carolina, Ohio, Oregon, and Vermont⁶ have developed systems that work. Together, we can develop a model that will work for Oklahoma and the children entrusted to its care.

PCNOK recommends the State designate three or four quality measures that serve as an objective measure of appropriate access and utilization. All health centers are required by their federal FQHC designation to measure and report specific outcomes, several of which are applicable to children.

2. How does your Care Coordination model address potential CMS concerns regarding duplication of care/payment? Explain how proposed payments comply with existing and proposed Federal and State requirements.

Duplication of care will be avoided through the Patient Centered Medical Home model (assignment of each client to a PCNOK health center). The client's assigned PCNOK PCMH ensures timely access to the most appropriate level of care and therefore eliminates duplication of services through care coordination of each client. Health Center and referral provider shall be compensated through PCNOK's capitation under this contract. This system is consistent with successful models of other states that are compliant with state and Federal requirements.

E. Impact of Model

1. Explain estimated implementation costs and anticipated savings, for the first five years of an implementation of your model.

a. Methodology

As a Clinically Integrated Network (CIN) of Federally Qualified Health Centers (FQHC's) that are Primary Care Medical Home (PCMH) certified or seeking certification, PCNOK is already providing care coordination. PCNOK is also a contracted CMS Medicare Shared Savings

⁶ Medicaid ACO Pediatric Quality Measures and Innovative Payment Models, American Academy of Pediatrics, Summer 2015, <https://www.aap.org/en-us/advocacy-and-policy/state-advocacy/Documents/AAPMedicaidPedACOs.pdf>.

Program (MSSP) ACO. An integral part of its ACO operations is care coordination. PCNOK would use its existing ACO methodology to achieve care coordination savings. FQHC's were created to serve these clients, among other underserved populations. As an FQHC network offering a medical home with a Primary Care Provider (PCP), Mental Health (MH) and Dental services, PCNOK is in the best position to offer immediate access at the most appropriate and cost-effective level. PCNOK can open available patient slots, avoiding Emergency Room or other costly medical visits at an inappropriate level of care, and coordinate care for all assigned clients to ensure needed care both inside and outside our respective FQHC systems. Through primary care services and care coordination, PCNOK is a logical choice to ensure clients receive the care they need at the right time and right level, resulting in improved health outcomes and significant health care cost savings.

b. Assumptions

PCNOK's CIN has the infrastructure or can quickly ramp up capability to fulfill a care coordination contract for the target population. However, PCNOK cannot anticipate savings without contractual terms and rates needed to conduct the appropriate calculations.

c. Constraints

One potential constraint for PCNOK's network is that additional care coordinators may be needed if a significantly large number of new patients are assigned or if a large percentage of the attributed patients are determined to be high risk after the risk stratification process is complete. Care coordination is an integral part of PCNOK's ACO operations, however, it is currently unknown to what degree increased assignments will necessitate additional care coordinator staffing. Additionally, training, understanding and agreement as to how Passport can be accessed would be a critical discussion. A strategy to integrate this with the HIE should be discussed in order to gain full benefit from the EHR and Passport.

2. Describe the quality and anticipated effects of the care coordination models on the target population with respect to the following.

a. CMS recommended benchmarks

As an MSSP, PCNOK has implemented the following ACO benchmarks:

2017 Reporting Year ACO Quality Measure Benchmarks

- Patient/Caregiver Experience ACO-1 CAHPS: Getting Timely Care, Appointments, and Information
- Patient/Caregiver Experience ACO-2 CAHPS: How Well Your Providers Communicate
- Patient/Caregiver Experience ACO-3 CAHPS: Patients' Rating of Provider
- Patient/Caregiver Experience ACO-4 CAHPS: Access to Specialists
- Patient/Caregiver Experience ACO-5 CAHPS: Health Promotion and Education
- Patient/Caregiver Experience ACO-6 CAHPS: Shared Decision Making
- Patient/Caregiver Experience ACO-7 CAHPS: Health Status/Functional Status
- Patient/Caregiver Experience ACO-34 CAHPS: Stewardship of Patient Resources

- Care Coordination/Patient Safety ACO-35 Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)
- Care Coordination/Patient Safety ACO-36 All-Cause Unplanned Admissions for Patients with Diabetes
- Care Coordination/Patient Safety ACO-37 All-Cause Unplanned Admissions for Patients with Heart Failure
- Care Coordination/Patient Safety ACO-38 All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions
- Care Coordination/Patient Safety ACO-43 Ambulatory Sensitive Condition Acute Composite (AHRQ Prevention Quality Indicator (PQI) #91)
- Care Coordination/Patient Safety ACO-11 Percent of PCPs who Successfully Meet Meaningful Use Requirements
- Care Coordination/Patient Safety ACO-12 Medication Reconciliation Post-Discharge
- Care Coordination/Patient Safety ACO-13 Falls: Screening for Future Fall Risk
- Care Coordination/Patient Safety ACO-44 Use of Imaging Studies for Low Back Pain
- Preventive Health ACO-14 Preventive Care and Screening: Influenza Immunization
- Preventive Health ACO-15 Pneumonia Vaccination Status for Older Adults
- Preventive Health ACO-16 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow Up
- Preventive Health ACO-17 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- Preventive Health ACO-18 Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan
- Preventive Health ACO-19 Colorectal Cancer Screening
- Preventive Health ACO-20 Breast Cancer Screening
- Preventive Health ACO-42 Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
- At-Risk Population Depression ACO-40 Depression Remission at Twelve Months
- Diabetes Composite ACO-27 and – 41 ACO-27: Diabetes Mellitus: Hemoglobin A1c Poor Control ACO-41: Diabetes: Eye Exam
- At-Risk Population Hypertension ACO-28 Hypertension (HTN): Controlling High Blood Pressure
- At-Risk Population IVD ACO-30 Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
- At-Risk Population CAD ACO-33 Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy – for patients with CAD and Diabetes or Left Ventricular Systolic Dysfunction (LVEF<40%)

PCNOK's FQHC's are oriented toward CMS's Child Core Set listed below and will fully implement them under a care coordination arrangement for clients:

2017 CORE SET OF CHILDREN'S HEALTH CARE QUALITY MEASURES FOR MEDICAID AND CHIP (CHILD CORE SET)

Primary Care Access and Preventative Care

- 0024 NCQA Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Assessment for Children/Adolescents (WCC-CH)
- 0033 NCQA Chlamydia Screening in Women Ages 16–20 (CHL-CH)
- 0038 NCQA Childhood Immunization Status (CIS-CH)
- 1392 NCQA Well-Child Visits in the First 15 Months of Life (W15-CH)
- 1407 NCQA Immunizations for Adolescents (IMA-CH)^a
- 1448 OHSU Developmental Screening in the First Three Years of Life (DEV-CH)
- 1516 NCQA Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34-CH)
- NA NCQA Children and Adolescents’ Access to Primary Care Practitioners (CAP-CH)
- NA NCQA Adolescent Well-Care Visit (AWC-CH)

Maternal and Perinatal Health

- 0139 CDC Pediatric Central Line-Associated Bloodstream Infections (CLABSI-CH)
- 0471 TJC PC-02: Cesarean Section (PC02-CH)
- 1360 CDC Audiological Evaluation No Later Than 3 Months of Age (AUD-CH)
- 1382 CDC Live Births Weighing Less Than 2,500 Grams (LBW-CH)
- 2902 OPA Contraceptive Care – Postpartum Women Ages 15–20 (CCP-CH)*
- NA No current measure steward Behavioral Health Risk Assessment (for Pregnant Women) (BHRA-CH)
- NA NCQA Frequency of Ongoing Prenatal Care (FPC-CH)
- NA NCQA Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)

Care of Acute and Chronic Conditions

- NA NCQA Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)
- NA NCQA Medication Management for People with Asthma (MMA-CH)

Behavioral Health Care

- 0108 NCQA Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)
- 0576 NCQA Follow-Up After Hospitalization for Mental Illness: Ages 6–20 (FUH-CH)
- 1365 PCPI Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (SRA-CH)
- 2801 NCQA Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)*
- NA NCQA Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)

Dental and Oral Health Services

- 2508 DQA (ADA) Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk (SEAL-CH)

- NA CMS Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)

Experience of Care

- NA NCQA Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH)
 - b. State identified areas including preventive screenings, tobacco cessation, obesity, immunizations, diabetes, hypertension, prescription drug use, hospitalizations, readmissions, emergency room use.**

The Oklahoma State Innovation Model (OSIM) measures are either directly correlated to PCNOK’s current ACO measures or are directly related to ACO cost saving methodologies. All clients assigned to PCNOK would receive care coordination according to these measures and would be managed using the best care at the most appropriate level, in the same fashion as PCNOK’s current attributed ACO patients.

c. Core measures identified with the Oklahoma Health Plan (OHIP) 2020

The following measures are consistent with the above measure sets and would be fully implemented under a care coordination arrangement:

Tobacco Use

- Reduce adolescent smoking prevalence from 15.1% in 2013 to 10% in 2020 for high school-aged youth and from 4.8% in 2013 to 2% in 2020 for middle school-aged youth (2018 data).
- Reduce adult smoking prevalence from 23.7% in 2013 to 18% in 2020 (2019 data).

Obesity

- Reduce adolescent obesity prevalence from 11.8% in 2013 to 10.6% in 2020 (2019 data).
- Reduce adult obesity prevalence from 32.5% in 2013 to 29.5% in 2020 (2019 data).

Children’s Health

- Reduce infant mortality from 6.8 per 1,000 live births in 2013 to 6.4 per 1,000 live births by 2020 (2018 data).
- Reduce Maternal Mortality from 29.1 per 100,000 live births to 26.2 per 100,000 live births by 2020 (2018 data).
- Reduce Infant, Child and Adolescent Injury Mortality from 15.2 per 100,000 in 2013 to 13.9 per 100,000 by 2020 (2018 data).
- Behavioral Health
 - Reduce the prevalence of untreated mental illness from an 86% treatment gap to 76% in 2020 (2018 data).
 - Reduce the prevalence of addiction disorders from 8.8% to 7.8% by 2020 (2018 data).

- Reduce suicide deaths from 22.8 per 100,000 in 2013 to 19.4 per 100,000 by 2020 (2017 data).

d. Respondent suggestions for other benchmarks.

Considering PCNOK’s use of the additional ACO benchmarks, we believe this aggregate will ensure a care coordination arrangement that will meet the *Triple Aim of Healthcare*: Improving the patient experience of care (including quality and satisfaction); Improving the health of populations; and, Reducing the per capita cost of healthcare.⁷

e. Considerations for Value-Based performance designs, specifically those that support and align with objectives identified within the Oklahoma State Innovation Model design.

The ACO, CMS Child Set and OHIP measures above are all consistent with OSIM measures. Since CIN’s such as PCNOK are responsible for meeting a wide spectrum of quality measures, PCNOK welcomes either an aggregate set based on the above or measures more closely aligned with OSIM.

F. Data Management

1. How does your care coordination model provide for efficient management of data to ensure that the child experiences quality and safety?

To support the proposed care coordination model, PCNOK recognizes an investment in infrastructure will be necessary to provide the scale and consistency the State seeks to achieve. All health center members of PCNOK have implemented electronic health records and work directly with networks supporting health center activities statewide, including Oklahoma Primary Care Association, which provides training and technical assistance, and the affiliated Health Center Controlled Network SoonerVerse (SVI), which in conjunction with PCNOK, provides members with health information technology technical assistance. In addition, each center is connected to MyHealth, the statewide health information exchange, and has access to data from other member healthcare providers.

This connectivity provides for near real-time access to health information necessary for quality, timely care and efficient management of patient issues, and ensures PCNOK members are in a position to participate and coordinate with child welfare case workers in the use of the Child’s Passport application. Working with the Office of Management and Enterprise Services (OMES), the capability of working with centers in this manner could greatly improve future enhancement efforts to this system and ensure the following aspects would be successful:

- Develop the attribution methodology and process
- Develop the shared savings cost benchmark methodology
- Data aggregation and analytics capacity for claims integration and software components

⁷ Institute for Healthcare Improvement, the IHI Triple Aim, <http://www.ihl.org/Engage/Initiatives/TripleAim/Pages/default.aspx>.

- Data aggregation and analytics capacity for Electronic Health Records and the Child’s Passport system
- Expanded implementation of emergency department, admit, discharge, and transfer data feeds through the MyHealth platform

G. Care Coordination Implementation Timelines (*including key activities and milestones*)

- 1. Based on prior experience, provide insight into what a realistic timeline for implementation of your Care Coordination model might be. Specifically, provide details into the following aspects of implementation of a Care Coordination model similar to what has been described:**

a. Development

Development of care coordination activities by PCNOK members is in progress and well underway. Efforts for Federally Qualified Health Centers to become PCMH accredited began about five years with Health Resources and Services Administration’s directives to improve patient outcomes through the Triple Aim of Healthcare. Due to these efforts, PCNOK members are poised to respond to care coordination with this population in a relatively short timeframe as they are currently in the process providing this service for other at-risk populations.

b. Transition/Readiness Activities

In early 2016, a statewide assessment of member health centers’ clinical and care coordination capacity was completed. The purpose of this assessment was to provide individual health centers with personalized clinical action plans as well as establish common gaps and areas for growth across the state. To conduct the individual assessments, Starling Advisory (an independent consultant firm retained for this assessment) divided Oklahoma Primary Care membership into three regional cohorts representing Northern, Central, and Southeastern Oklahoma. Each health center followed the same assessment process:

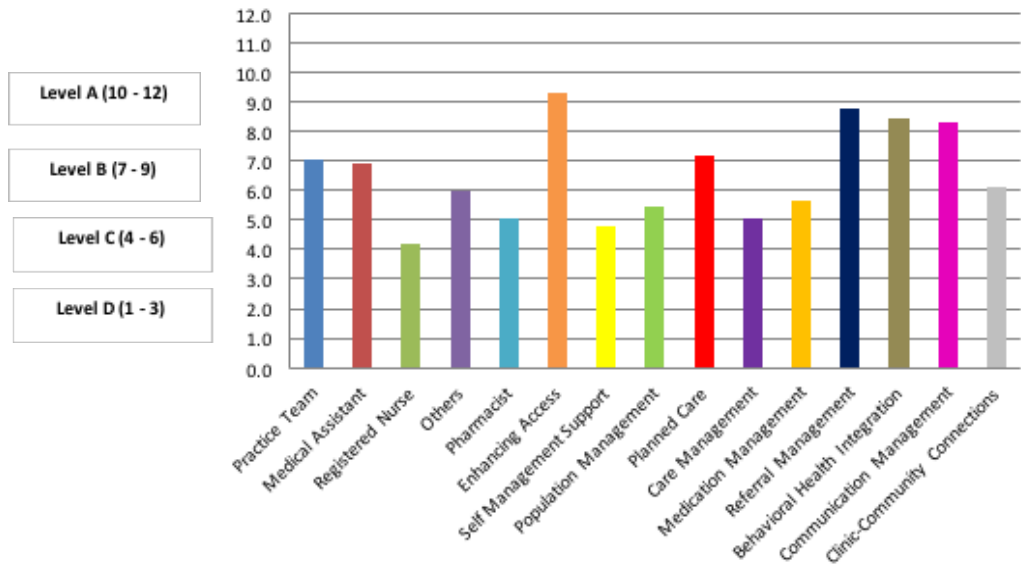
1. Orientation and kick-off call
2. Complete a standardized self-assessment
3. Conduct data clarification interview
4. Reviewing a draft action plan based on assessment results
5. Establish a set of follow-up action items to finalize an action plan

The standardized assessment was developed by the MacColl Center for Health Care Innovation at Group Health Research Institute. It is based on the PCMH-A measures created by MacColl in collaboration with Qualis Health for the Safety Net Medical Home Initiative and supplemented by measures developed by the University of California at San Francisco Center for Excellence in Primary Care. The survey asks respondents to self-assess their current primary care team dynamics, the capacity of various members of their care teams, and organizational capacity for care coordination, behavioral health integration, population health management and other care aspects.

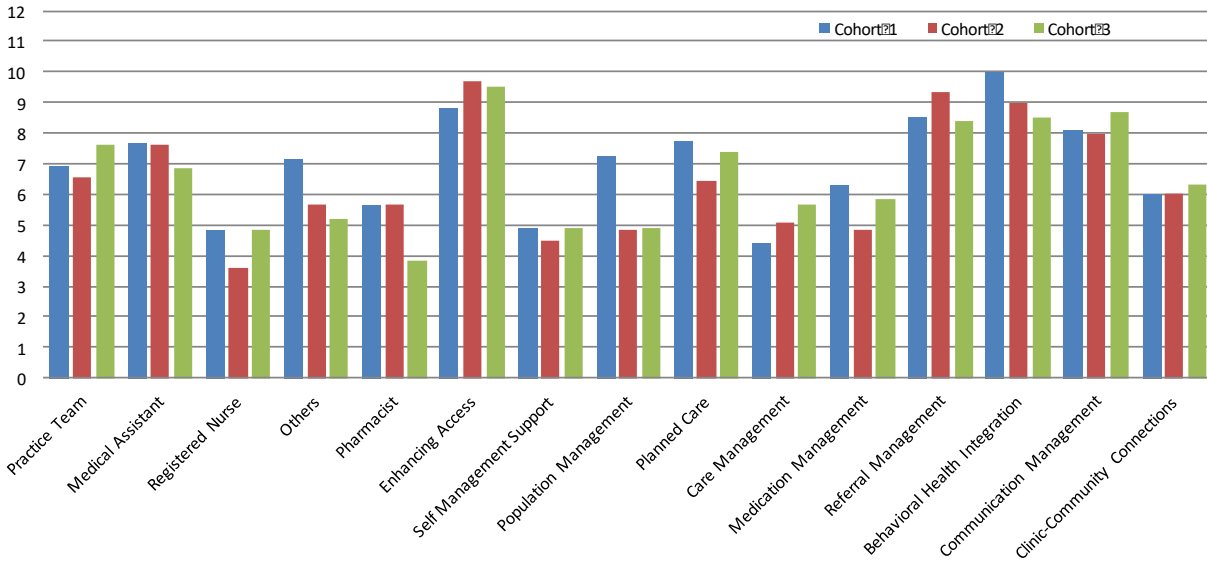
The clinical survey has 15 sections. The first and most comprehensive section asks respondents to self-assess the capacity of their practice team. The next four sections assess the capacity of individual care team members: the medical assistant or LPN, registered nurse, pharmacist and “other” which represents non-licensed members of the clinical care team. The remaining sections address various care capacities. For each section, the practice rates their performance along the following four levels:

- **Level D (Score 1 - 3):** Reflects absent or minimal implementation of the key change addressed.
- **Level C (Score 4 - 6):** Implementing early stages of change, but important fundamental changes are still to be addressed.
- **Level B (Score 7 - 9):** Basic change has been implemented, the practice still has significant opportunities to make progress with regard to one or more important aspects of the key change.
- **Level A (Score 10 - 12):** Most or all of the critical aspects of the key change addressed by the item are well established in practice

As the graph to the right indicates, Oklahoma health centers are well on the way to effective care coordination teams, although at varying levels of completion for each component as well as each center. All PCNOK members are at Level C or higher.



Average Score by Cohort:



Response Rate by Cohort:

- Full Cohort Data – Represents 90% response rate (18 out of 20 health centers)
- Cohort 1 - Represents 85% response rate (6 out of 7 health centers)
- Cohort 2 – Represents 85% response rate (6 out of 7 health centers)
- Cohort 3 - Represents 100% response rate (6 out 6 health centers)

Data Qualifications:

The capacity of health centers is more comprehensive than survey results indicate in the areas of pharmacy and behavioral health services. Other than the larger health centers, most did not have a pharmacist in-house as part of their care team, and thus did not complete this section; however, health centers collaborate with contracted pharmacies to provide services when a pharmacy is located on-site. Similarly, not all health centers have developed behavioral health capacity and thus did not complete this section; when a health center does not provide mental health in-house, there is a plan in place to utilize a referral method to ensure patients have access to these services. Many health centers are partners with local area Community Mental Health Centers and collaborate with these organizations to provide comprehensive services.

Particular areas of high performance, which would benefit children in custody include:

- Enhanced Access, the highest scoring care capacity at a Level B score of 9.2, which indicates that most practices are able to direct patients to their empaneled provider most of the time. It’s possible this high score is related to health centers’ success in pursuing Patient-Centered Medical Home recognition over the last 5 years, as access is a foundational criterion in the recognition process. This also reflects the importance of centralized technical assistance and support by the Oklahoma Primary Care Association, which invested in PCMH coaches that supported many sites with successful PCMH applications

- Referral Management reflects strong relationships with other local providers, something that was echoed in several health center interviews and is impressive given the rural and isolated communities many health centers serve.
- Communication Management reflects quick access to the practice via telephone as well as timely communication of test results and care plans. This high scoring area indicated Oklahoma health centers have strong communication systems and processes, which may also be a result of the widespread implementation of the PCMH model.

c. Implementation of member enrollment

PCNOK will work with OHCA to develop a strategy to enroll patients into the care coordination plan. Many children in custody already receive their care at community health centers and benefit from receiving patient centered medical services. This Request for Information presents an unprecedented opportunity to enhance services as well as build from the current infrastructure to ensure more children in custody will receive the same high-quality comprehensive care management.

Availability of data is one of the most essential components to ensuring the success of the initiative. There are four essential data-related aspects to our program design.

1. Efficient attribution of patients to the PCNOK
Near real-time attribution data from Medicare and Medicaid will support efficiency in outreach initiatives, securing health risk assessment information for patients and allocation of care management resources. This data should be provided month-over-month with clear indications of patients who have been added, dropped, or transferred.
2. Availability of claims data
To effectively manage this population, PCNOK will process and analyze utilization and cost information based on raw claims data, which must be provided within a reasonable turnaround time so care managers may effectively plan their work. Further, access to this data supports transparency and the ongoing evaluation of the program's impact on total cost of care.
3. Emergency department, admissions, discharge, and transfer data from facilities
Timely care coordination and interventions require early identification of patients who are transitioning in and out of custody and the healthcare system. Linking the FQHC to hospitals and other facilities via MyHealth, to which Oklahoma FQHCs already belong, will allow care managers to track and intervene on behalf of their empaneled patients.
4. EHR analytics and care coordination data capability
Data management tools will be necessary to extract and analyze EHR data. These tools will create a consistent care coordination analytics capability, allowing care coordination staff to oversee progress toward care plan goals and identify areas of significant gaps in care. This analytics capability will also be the source of reporting on the progress of care management.

The proposed model is divided into four distinct program development phases:

- **Development Phase (months 0-6)**
 This phase focuses largely on working with the State to establish the initial creation of regulatory and programmatic infrastructure and payment model development. The State will drive most of these activities, but PCNOK anticipates playing an active role in the design and testing of many of the program components.
- **Readiness Phase (months 7-12)**
 This phase focuses on the range of activities that PCNOK will need to undertake to establish the network and Integrated Care Organization level infrastructure necessary to implement the care management interventions. These activities support the ramping up of technology, staff, and other aspects of program implementation.
- **Member Enrollment Phase (Months 13-18)**
 This phase focuses on enrollment activities and further development of close working relationships with partner organizations involved in care for children in custody.
- **Care Coordination Implementation (Months 19-24)**
 This represents the final phase of implementation and the initiation of care management activities. This phase overlaps with the Member Enrollment Phase, as care management activities will begin once beneficiaries are empaneled with Care Managers. Below are specific examples of key activities in each phase.

Timeline Activities	
Development Phase (Months 0-6)	<ul style="list-style-type: none"> ● Claims integration model developed ● Cost baselines identified (State/CMS) ● Actuarial analysis completed on population (State) ● Minimum savings rate determined (State) ● Clinical, operational, and financial performance measures set ● PM/PM model finalized ● State attribution model determined ● Health screening tool developed ● Patient education and outreach materials developed ● Data analytics vendor selected and contracted ● MyHealth service expansion plan developed
Readiness Phase (Months 7-12)	<ul style="list-style-type: none"> ● PCNOK data/claims infrastructure in place (PCNOK) ● Data sharing agreements in place among all parties ● Preliminary attribution and assignment; review by PCNOK ● Preliminary risk stratification/population health management analysis ● Staffing models developed ● Hiring of additional staff ● Care coordination templates and training conducted

	<ul style="list-style-type: none"> • Enrollment training • MyHealth expansion at sites • MOUs with hospitals, long term care and others, in place • Coordination councils established • Implementation of care coordination enabling technology (i.e. care coordination software, telehealth, remote monitoring, etc.)
Member Enrollment Phase (Months 13-18)	<ul style="list-style-type: none"> • Member enrollment activities • Empanelment and health screening and risk stratification
Care Coordination Implementation (Months 19-24)	<ul style="list-style-type: none"> • Care delivery and management activities occur • Quarterly/ongoing performance management by PCNOK

d. Implementation of member service delivery

PCNOK members currently practice a Patient Centered Medical Home methodology; upon enrollment to the care coordination plan, the members would receive services immediately, in line with community health centers’ standard practice of care.

As a member of an at-risk population, upon empanelment and individual risk assessment, each child in custody will receive a customized care plan, housed within the Electronic Health Record of the FQHC serving as the Medical Home as well as the Child’s Passport application for access by the Child Welfare Specialist. The care plan will be formulated according to results from the individual health risk assessment, assessment of social determinants of health, and assessment of health status and comorbidities. This care plan will identify the services that will be the most beneficial to the patient.

Interventions depend on successful tracking and communication of patient referrals and transitions of care. On-line consultations, as well as automated health reminders through MyHealth HIE will be utilized to identify care needs and alert the provider to send notices to the patient. This program would allow the scaling of intervention intensity in direct relation to the acuity of the patient’s situation and condition in addition to an analysis of their individual risk using clinical data from the MyHealth Health Information Exchange (HIE).

Evidenced-based guidelines will be implemented for targeted chronic conditions specific to this population. All participating primary care providers and care coordinators will follow the same standard protocols, ensuring children in custody receive long-term continuity of care and personalized plans targeted to their specific needs.

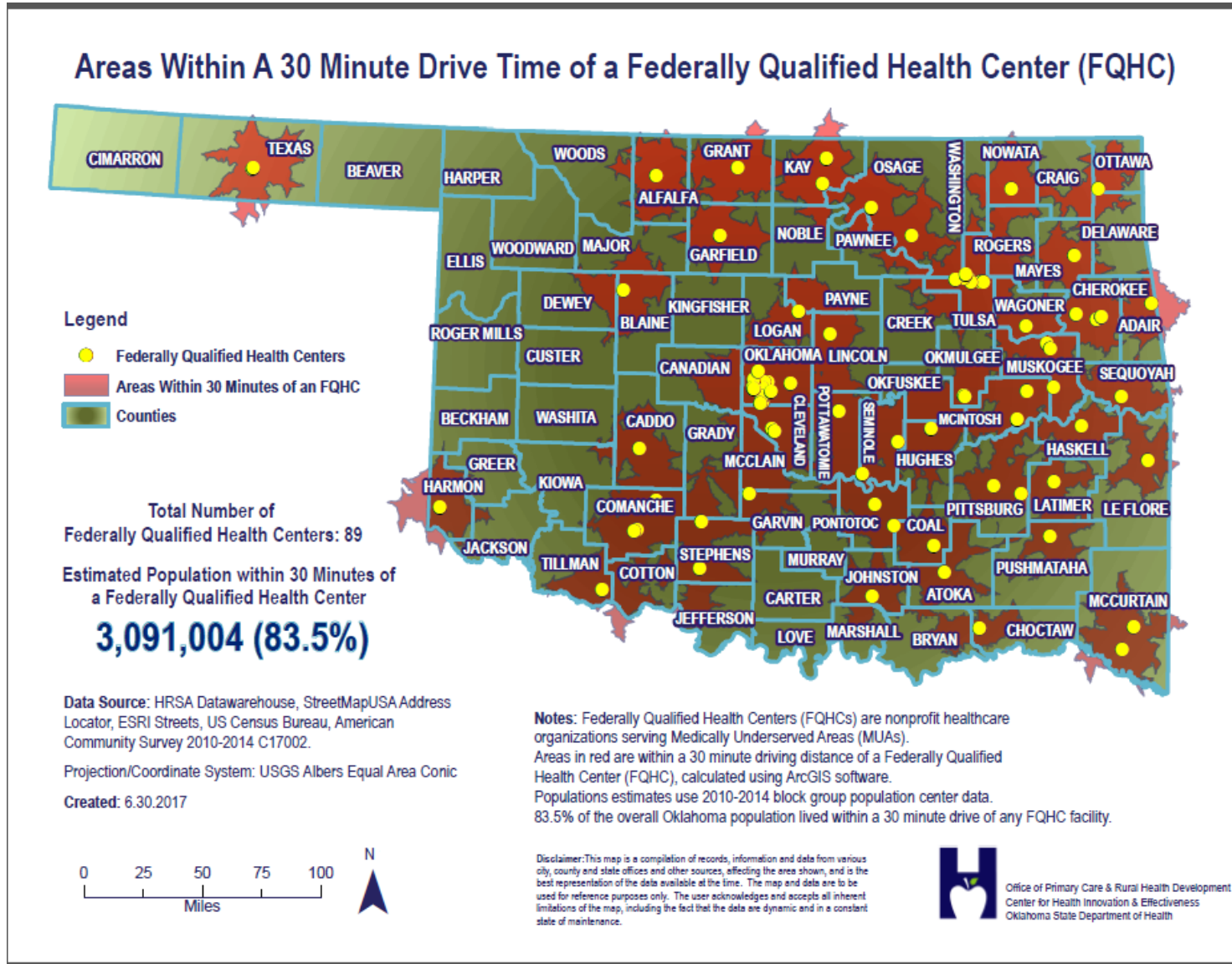
The specific opportunities that our model currently possess include:

- Resources in place to achieve implementation in a relatively short time frame
- Considerable experience helping patients navigate the healthcare system
- Ability to develop techniques for assisting patients to be compliant with their care plans

- Given access to appropriate data, care managers are able to participate in all transitions of care to ensure minimal duplication of cost and service

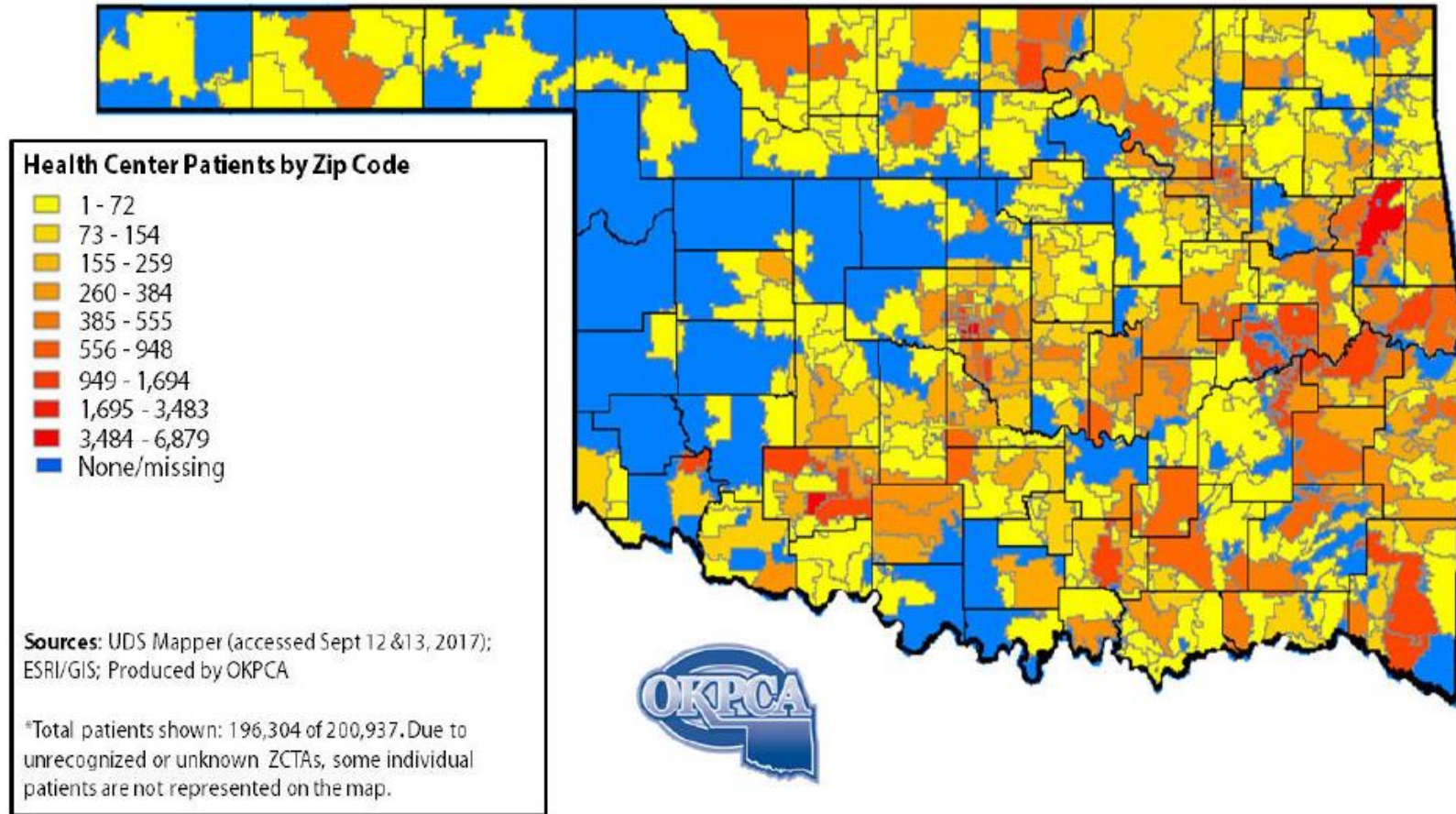
PCNOK welcomes the opportunity to discuss our proposed model of care coordination. We feel strongly that any plan to provide better, more coordinated care for the children in the custody of our state must include creating strong ties between patients, their guardians, and their Patient Centered Medical Home. Our FQHCs are excited to undertake this challenge and equipped to serve these unique and complex patients with compassion and effective treatment planning based on each child's specific situation and needs.

APPENDIX A



APPENDIX B

Oklahoma Health Center Patients by ZCTAs



Oklahoma Health Care Authority (OHCA)
Care Coordination for Children in DHS Custody

Request for Information (RFI) Response

Due: October 16, 2017



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A. HIGH-LEVEL DESCRIPTION OF THE RECOMMENDED PATIENT-CENTERED SERVICE DELIVERY CARE COORDINATION MODELS

1. CARE COORDINATION MODEL

1. Name and describe Respondents chosen models including reason for selecting the models.

Telligen proposes the Health Management Program for Children (HMP-C) as our model for this care coordination contract, the model best addresses the Oklahoma Health Care Authority's (OHCA) major objectives. We understand how important this initiative is for OHCA, as well as its partners – the Department of Human Services (DHS) and the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) – in exploring care coordination models for serving children in DHS custody.

Since February 2008, Telligen has partnered with the OHCA to develop, implement and operate the SoonerCare Health Management Program (HMP). The program is part of a statewide initiative designed to improve the clinical outcomes and lower the cost of care for Medicaid members who have, or are at high risk of developing, chronic disease (Figure 1).

Our proposed model, leverages the proven concepts of the Oklahoma Health Management Program – adapted for children in DHS custody. The benefits of this model have been widely publicized throughout the state for the last nine years, and have included:

- Proven model tailored to our detailed understanding of Oklahoma
- Consistent, positive results confirmed by third-party annual evaluations.
- Significant cost savings to the state.
- Decreased Medical utilization.
- Positive return on investment.
- Improved health outcomes through informed and educated providers, members and their families.

The expectations will be no different when applying the foundation and core aspects of the model to meeting the needs of the children in DHS custody.

Since February 2008, Telligen has partnered with OHCA to develop, implement and operate the SoonerCare HMP. The program is a state-wide initiative designed to improve the clinical outcomes and lower the cost of care for Medicaid members who have or are at risk of developing chronic disease. State fiscal year 2014-2016 showed a combined savings for practice facilitation and health coaching to be \$72 million. Our combined health coaching and practice facilitation program has resulted in *more than \$250 million in net savings* since 2008. The following graphic provides a summary of the success of our SoonerCare Health Management Program (HMP)



Telligen®
Healthcare Intelligence

Success Story

Oklahoma Health Care Authority: State Saves Millions in Costs, Improves Quality

Background

Oklahoma's Medicaid program was facing increasing costs while ranking 49 out of 50 states for clinical performance measures. The poor performance and high-costs led the state's Medicaid agency to contract with Telligen to create the SoonerCare Health Management Program (HMP) in 2008.

Strategy

Telligen identifies members that are high-risk or at-risk for developing chronic conditions; then works with primary care physicians to provide higher-quality, more patient-centered, and cost-effective care.

Telligen has been instrumental in building this strong and comprehensive program . . . Proving itself as a sound and reliable business partner.

*-Della Greg, Program Manager,
SoonerCare HMP*

Successful Components

- **Health Coaching:** Nurse health coaches embedded within primary care practices providing members with one-on-one health coaching, telephone support, and home visits.
 - The health coaching component has demonstrated a net savings of **\$150.9 million**
- **Practice Facilitation:** On-site practice facilitators work directly with providers to redesign clinical processes and eliminate gaps in care.
 - Increased compliance with evidence-based guidelines has saved the state an additional **\$103.6 million**

Results

- **Cost Savings:** The program, now in its ninth year, has saved Oklahoma taxpayers a total of **\$254.5 million**
- **High Satisfaction:** Results from the latest independent evaluation show **89 percent** of members reporting a "very satisfied" experience.

The Client:
Oklahoma Health Care Authority
Total Enrollment: 822,930

The Challenge:
Reduce costs to the State of Oklahoma through decreased utilization and improved health outcomes.

The Solution:
Increased education and support to high-cost, high-risk members and their primary care providers.

**Cost Savings:
SoonerCare HMP**



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Figure 1. Telligen SoonerCare HMP Success Story.

The HMP-C model includes practice facilitation and state-wide care coordination by dedicated HMP-C care coordinators. Our approach includes not only the coordination of care but coaches the child on ways to maintain and improve health. A key component is the emphasizes on specific and comprehensive provider education. This includes promoting standards of care for best practices and implementation of the 2017 Core Set of Children’s Health Care Quality Measures for Medicaid and Children’s Health Insurance Program [(CHIP; Child Core Set) Figure 2].

The HMP-C approach combines the personal care coordination and health coaching of foster children with a macro view of child healthcare. We leverage the 2017 Core Set of Children’s Health Care Quality Measures to monitor and improve the quality of care delivered to children. These measures will help drive quality improvement across providers while our care coordinators seek to improve the healthcare of the individual child. The combination of the individual and State-wide approach improves not only the individual care but also the environment for which the care is given.

The model also ensures that the Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) periodicity schedule is well understood and adhered to. The goal of EPSDT is to assure that individual children get the health care they need, when they need it. It is the *right care to the right child at the right time in the right setting*. This component comprises a significant portion of our education to caretakers and providers that support foster children.

Figure 2 describes the specific measures that comprise the 2017 Core Set of Children’s Health Care Quality Measures (Child Core Set). The measures are delineated by

- Primary Care Access and Preventive Care.
- Maternal and Perinatal Health.
- Care of Acute and Chronic Conditions.
- Behavioral Health Care.
- Dental and Oral Health Service.
- Experience of Care.

The monitoring of these measures will improve the environment that child health care is provided and improve the quality of that care.

2017 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)

NQF #	Measure Steward	Measure Name
Primary Care Access and Preventive Care		
0024	NCQA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Assessment for Children/Adolescents (WCC-CH)
0033	NCQA	Chlamydia Screening in Women Ages 16–20 (CHL-CH)
0038	NCQA	Childhood Immunization Status (CIS-CH)
1392	NCQA	Well-Child Visits in the First 15 Months of Life (W15-CH)
1407	NCQA	Immunizations for Adolescents (IMA-CH) ^a
1448	OHSU	Developmental Screening in the First Three Years of Life (DEV-CH)
1516	NCQA	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34-CH)
NA	NCQA	Children and Adolescents' Access to Primary Care Practitioners (CAP-CH)
NA	NCQA	Adolescent Well-Care Visit (AWC-CH)
Maternal and Perinatal Health		
0139	CDC	Pediatric Central Line-Associated Bloodstream Infections (CLABSI-CH)
0471	TJC	PC-02: Cesarean Section (PC02-CH)
1360	CDC	Audiological Evaluation No Later Than 3 Months of Age (AUD-CH)
1382	CDC	Live Births Weighing Less Than 2,500 Grams (LBW-CH)
2902	OPA	Contraceptive Care – Postpartum Women Ages 15–20 (CCP-CH)*
NA	No current measure steward	Behavioral Health Risk Assessment (for Pregnant Women) (BHRA-CH)
NA	NCQA	Frequency of Ongoing Prenatal Care (FPC-CH)
NA	NCQA	Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)
Care of Acute and Chronic Conditions		
NA	NCQA	Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)
NA	NCQA	Medication Management for People with Asthma (MMA-CH)
Behavioral Health Care		
0108	NCQA	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)
0576	NCQA	Follow-Up After Hospitalization for Mental Illness: Ages 6–20 (FUH-CH)
1365	PCPI	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (SRA-CH)
2801	NCQA	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)*
NA	NCQA	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)
Dental and Oral Health Services		
2508	DQA (ADA)	Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk (SEAL-CH)
NA	CMS	Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)
Experience of Care^b		
NA	NCQA	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH)

^a This measure was added to the 2017 Child Core Set. More information on 2017 Updates to the Child and Adult Core Health Care Quality Measurement Sets is available at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib120516.pdf>.

^b The stand-alone HPV Vaccine for Female Adolescents measure (NQF #1959) has been retired by the measure steward, and added to the IMA-CH measure. Therefore, CMS will retire the standalone HPV-CH measure from the Child Core Set and update the IMA-CH measure accordingly.

^c CMS and AHRQ will test the child version of the Hospital Consumer Assessment of Healthcare Providers and Systems (Child HCAHPS) survey (NQF #2548) to assess the extent to which this hospital-level measure can be reported at the state-level. As such, the measure will not be added to the Child Core Set at this time but CMS will continue to assess its feasibility for possible addition in future Core Sets.

CDC = Centers for Disease Control and Prevention; CHIP = Children's Health Insurance Program; CMS = Centers for Medicare & Medicaid Services; DQA (ADA) = Dental Quality Alliance (American Dental Association); NA = Measure is not NQF endorsed; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; OHSU = Oregon Health and Science University; OPA = U.S. Office of Population Affairs; PCPI = Physician Consortium for Performance Improvement; TJC = The Joint Commission.

Figure 2. 2017 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP.

To be successful, the care coordination model must address the variability of the child's family setting. As described by your website, "Foster Care is planned, goal directed service that provides *24-hour-a-day substitute temporary care* and supportive services in a home environment for children...in Oklahoma DHS custody". Whether a foster child is a temporary placement or one that spans multiple years, the model must address each situation. nature of the family setting. For some, temporary can span multiple years in the same setting. While others may have multiple placements of short duration.

The HMP-C model compensates for these variances by leveraging an industry leading care coordination technology that tracks each interaction with the child, provider, family or agency. While our approach is family-centered and focuses on the individualized needs of the child, we allow for the circumstances of the family to change. This is enabled by the shared information from our coordination activities and the ease of recall and education for any new family members. Qualitrac™, our proprietary care coordination system, provides detailed information accrued from each interaction with relevant stakeholders for the foster child.

Our approach is unique in its flexibility to meet the needs of the families and children as they navigate the complexities of the health care system. For example, based on need and the best solution for success, we will offer phone coaching on a regular basis to help support the family or caretakers. We can also make home visits, act as a liaison for providers and community resources, and meet at physician offices. We are flexible and mobile and in the communities where affected children and families reside.

Another key advantage of our model is compliance. All of our care coordinators have smart phones, which facilitates easy two-way communication at times most convenient for caretakers and families. This provides our coordinators with flexibility and mobility, and enables us to gather the most current contact information for caretakers.

Even though we do not take the place of DHS case workers, and we are not an emergency resource, our ease of communication and coordinator availability will help guide and support foster families in their efforts to access required health care services and community resources, eliminate barriers and provide on-going education. We believe our experience over the past nine years administering the Oklahoma statewide HMP affords us the knowledge, as subject matter experts, to know how to best provide efficient and effective care coordination for children in DHS custody.

We have reviewed the core goals and initiatives addressed in DHS' "Pinnacle Plan" summary, and we applaud the tremendous progress the state has made. *Our approach supports DHS' efforts* to:

- Implement and modify the program to ensure safety of children with quality placements.
- Clearly define roles and responsibilities to reach improved outcomes and sustained accountability.

Our model will address the Oklahoma Pinnacle Plan Point 7, “Community Partnerships and External Stakeholders” by working closely with DHS to engage community partners, other state agencies, as well as the private sector and tribes, in supporting foster children and families.

2. MODEL’S ABILITY TO MEET THE NEEDS OF THE TARGET POPULATION

2. Describe how the models address the needs of the target population.

Our health coaches/care coordinators play a significant role in assessing needs, identifying resources and finding solutions to many barriers. Children are assigned a care coordinator, which helps facilitate a path toward compliance and meeting their health needs. It is important to have someone who is easily accessible, experienced, knowledgeable and has the means to navigate the Oklahoma health care delivery system to achieve targeted outcomes.

The care coordinators will drive health coordination and improvement via our flexible supportive approach. The HMP-C model embraces the whole circle of care and support required to address children’s health needs. We understand that children in foster care often face significant, serious health needs, and must interact with different people and agencies. All of whom are trying to work together to ensure the best outcomes for the child within a fragmented system.

Significant unmet health needs that could include medical, dental, psychological, as well as educational, present challenges for any caretaker to address effectively on their own. We believe the HMP-C model allows opportunities for building the necessary bridges to truly help address children’s physical and behavioral health needs. Our years of experience in Oklahoma as well as interactions with children in a healthcare setting have shown us that a letter, phone call or sporadic contact with a family is not enough to make change. *The primary task for the care coordinator is developing relationships* built on trust, responsiveness and accessibility to support and ensure follow through. We will work closely with the foster and kinship families to meet a variety of needs. We can also provide education on the Child Passport and help them learn about the benefits available within SoonerCare.

Foster care is intended to be temporary, but too often, crosses over multiple years. Temporary, and often multiple, placements over time can make sustained medical care, consistency with medical providers, or access to a current medical record seem like more of a constant goal than reality. Timely transfer of medical information, as well as required screenings and dental care, can be a formidable task.

Fostering is voluntary and comes with expectations and requirements. Typically, we have found that accountability and consequences for foster and kinship families are lacking when it comes to ensuring that children receive necessary medical and behavioral needs screening. It is the family’s key responsibility to ensure that the child/children are receiving required health care interventions. Our approach eliminates excuses by providing solutions that promote action and self-management of their responsibility.

Navigation Assistance

The lack of medical history information, including immunization status, is a problem across states, and one that a survey of your foster families supported as well. We can help improve this gap by educating families and helping them navigate the health care system, as well as

coordinating with local agencies and providers. Your foster care survey indicated families that used the Health Passport benefited from it. That education and awareness must be extended to all families for consistency, and to help aid in continuity of care. Often, one-time exposure to information is not enough for all adult learners. To address this gap, our model embraces specific education to facilitate change and compliance.

In addition to having assigned care coordinators to work with the families, we conduct quarterly surveys regarding our services to the targeted population. This frequent assessment helps us learn about what we are doing right, and what needs improving. *We consistently score 4.5 on a five-point scale.* We see this type of ongoing assessment as beneficial to the foster care population.

Technology and Data to Improve Coordination and Health Tracking

Our Qualitrac™, care coordination and management system, offers sophisticated care tracking, while maintaining accurate demographic and contact information. Knowing how to reach the child and their support infrastructure improves the responsiveness to our efforts. Part of our survey process includes immediately reconnecting with families to address concerns. We also maintain a resource database with more than 500 resources, many of them specific to the Oklahoma health care environment.

As a nine-year partner with OHCA, we have detailed knowledge of their systems, data and resources. This includes access to claims data and the risk predictor tool MEDai which provides predictive analytics to identify and stratify individuals based on risk acuity. We have familiarity with Atlantes, the OHCA care management system, which provides the ability to manage a member's plan of care. The team uses the HP tool, interchange (iCE) which processes claims and contains a variety of data sets. These resources provide a comprehensive data set with robust tools that determine accurate eligibility, health information and provider data. In addition to these tools, Telligen receives daily and monthly data files. While we use this currently for qualifying adults for HMP, it also contains the necessary information for children.

The team will work with DHS and OHCA on the appropriate steps for information management, and appropriate and beneficial access to information and data, adhering to Health Insurance Portability and Accountability Act (HIPAA) and confidentiality.

With detailed knowledge of the State and access to multiple data sets, Telligen has performed geo-mapping across a variety of topics. This has enabled us to map the entire state for eligibility "hot spotting," which identifies the portion of Medicaid members in each area of the state. Southeastern Oklahoma is a highly saturated area. Our knowledge and expertise will ensure we make appropriate staffing and resource decisions.

Oklahomans Serving Oklahoma

Our model provides community-based staff, living and working in the very communities that children in foster care reside. We currently serve all 77 Oklahoma counties in our existing service to the OHCA. A detailed knowledge of Oklahoma and each individual locale allows us to provide effective coordination whether a child resides in the community or county from which they are removed, or another location. Understanding the area resources allows us to be flexible about the child's specific location. Our superior approach accommodates the coordination for a child regardless of the number of times moved or number of families placed.

Having implemented this model for adults, we have found that teamwork and communication drive results for effective care coordination. This is where our health coaches can be of most help on the HMP-C. We are often extensions of existing care teams to support but not duplicate existing efforts. The team can help with health care related training for providers, foster parents, Child Welfare (CWS) Specialists and case workers. This training will be beneficial, as a great deal of their time is split between placement activities, home visits, case consultation and medical record review. Our existing health coaches work directly with the providers and families. We will offer this same level of support for foster children.

We know each of your five regions have between 1,600 and 2,000 children in foster care, with a large portion of children in care located in the northeast region five area and the southeastern quadrant of the state. Because of our presence in these areas, we are familiar with the provider and health care challenges in these areas. We agree with the results of your Communities of Care (CoC) project findings, which stated that enhanced community connections are extremely important. Like CoC, our HMP-C model relies on strong community resource awareness. For us and our HMP-C approach, this means a presence in the community. This promotes effective relationships among family, advocacy and community stakeholders invested in child welfare services (CWS).

An example of the benefits of our community model can be found in Pushmataha, McCurtain and Choctaw counties. There, we have staff volunteering with a local church that recently started a mission project to provide basic needs for kids, e.g., hygiene products, a blanket, a toy, a set of clothing, diapers, wipes for babies, when they are removed from the home and placed into custody. Historically, there have been as many as 300 kids being actively served in the three-county area, with another 100-plus expected annually.

Embedded Team

As we described earlier, our current HMP focuses on high-cost, high-risk individuals with chronic disease, as well as individuals who are categorically identified in the Aged, Blind and Disabled (ABD) population. To best meet the needs of these populations, we have coaches embedded in clinic practice settings, community settings, and office-based coaches, all of whom provide an ongoing coordination in the circle of support to families and providers.

We are proposing a similar approach for the HMP-C model. We will assess needs, find resources, focus on priorities of importance, identify and eliminate barriers and evaluate our effectiveness on an on-going basis. Our efforts connect families and resources; coordinate, communicate and educate. We are proposing this approach with an initial priority focus on 6,500 children in traditional and kinship foster care.

We propose **working from local DHS offices** one or two days a week or month, if OHCA and DHS deem this helpful. This will enable us to connect with hundreds of foster families simultaneously across the state to begin assessing and continuously evaluating needs and address barriers. We will serve as the extended eyes and ears of the state workers, and help provide information for early intervention to avoid potential problems.

We combine our expertise in data with direct relationship in the communities and working with the families. As part of our approach, we seek to identify social determinants of health. This analysis leads to innovative ways to address community health issues, as well as individual barriers for the families. Our expertise serving Oklahoma adults and assisting with children as part of our Medicaid services provides the expertise necessary to provide State leadership information about issues, concerns, trends and needs within Oklahoma as well as nationally.

Children in Custody

Children in custody (CIC) need long-term stability interventions with consistent care and support. However, this often is not what occurs. When children move, relocate and re-unify, their care is interrupted, and they find themselves with caretakers starting over, trying to get their unmet needs established, screenings up-to-date and health issues addressed. We understand the challenges. However, our HMP-C model facilitates caregivers working together and agencies and state CW specialists coordinating and collaborating – delivering education to providers and helping solidify the provider-foster family connection, awareness and resources.

Certified Community Behavioral Health Clinics

We are very interested in the Certified Community Behavioral Health Clinics (CCBHCs), which the state implemented in 2017, and we hope to have a collaborative relationship with the group. We currently have a relationship with the Health Homes, as for the HMP, members can qualify for both HMP and the Health Homes, providing they have significant mental health issues. We will collaborate and assess the best care coordination approach based on need.

We are confident that implementing the HMP-C model will be an effective approach to help move forward the state's initiatives to improve the quality of care for children in DHS custody. Working collaboratively together with DHS, OHCA and ODMHSAS, we can positively impact this initiative.

3. IMPLEMENTATION OF THE MODEL

3. Explain how Respondents have approached implementation of the models.

Telligen has implemented state-wide services for care coordination, care management, disease management, utilization management as well as core standardized assessments. We have a defined implementation approach refined from years of large scale, complex, state-wide service implementation. We leverage project management approaches deployed by certified project managers using sophisticated project management software to ensure an on-time and under budget implementation. Some of the key steps include:

- Meet with stakeholders.
- Refine proposed Strategic Implementation Plan.
- Assess outreach and education components.
- Evaluate available data.
- Deploy Proprietary Care Coordination Application Qualitrac.

Our thorough data analysis will drive the initial implementation strategy. Leveraging our existing data infrastructure, we can quickly initiate data transfer into our Qualitrac system. This will enable our care coordinators to have ready access to as much information as possible to facilitate productive and meaningful support. We possess the ability to sort data in a variety of ways which include by care coordinator, county or zip code to more effectively understand the population to be coordinated. This is extremely useful and enables a stratification of the population based on specific criteria. As part of the implementation, Telligen will provide recommendations to establish a state approved methodology for population stratification. For instance, we may target certain counties based on highest number of out of home placements, or based on available data that identifies most deficits in EPDST screens or immunizations,

In the nearly 10 years since we worked with OHCA to implement the HMP, we have learned valuable lessons, which we can apply to the HMP-C model. For example, we will hire staff in anticipation of engagement levels. With multiple programs in several states, Telligen has developed a robust reporting tool. The inventory of reports has developed overtime and new programs will benefit from our detailed experience and knowledge gained across a variety of clients. Our Qualitrac application provides Telligen with a sophisticated industry leading comprehensive care management system that includes a robust analytics module. We will establish and confirm data element capture that ensures appropriate reporting across a variety of parameters. We've identified key factors to consider in the approach to implementation:

- Conduct stakeholder meetings that result in productive decisions and agreement in initial steps of implementation.
- Conduct thorough and comprehensive data analysis.
- Analyze existing educational and foster care materials and training.
- Prepare thorough and comprehensive training.
- Establish staggered staffing schedule.
- Require both Telligen and DHS staff to participate in training.
- Conduct focus groups of foster parents to assess perceptions and gain insight that may help in our initial implementation priorities.

B. ACCESS TO HEALTH SERVICES

1. ACCESS TO NEEDED HEALTH SERVICES

1. Describe how your care coordination models would ensure that children in care and their families can access needed health services?

Telligen's HMP-C will incorporate motivational interviewing and member/foster family-guided goal setting and action planning which leads to improved member/foster family self-management skills.

Telligen employs health coaches/care coordinators, all of whom are registered nurses. These employees will provide targeted care coordination to children and their families. We provide support to members via three options:

1. Embedded health coaches
2. Face-to-face in member homes, or
3. Telephonic support.

As part of each of these support methods, we use motivational interviewing to better understand our clients and their needs. Our team is adept at asking the right questions and more importantly the appropriate follow-ups to complete all information gaps. This helps set realistic and achievable goals within a patient-centered model.

Telligen's care coordination will provide services to the children in custody (CIC)/foster families across all practice settings, as well as facilitating access to community resources that are relevant to their needs. We have successfully deployed this approach in both rural and urban locations. Our staff location is based on the needs and geographic requirements of the targeted members.

Community Resources

Telligen resource specialists have compiled a list of allied health professionals across Oklahoma delineated by geographic areas. Allied health professionals include pediatric dentists, diabetes educators, pharmacists, social workers, dieticians and other specialties.

Care Management Overview

In Telligen's current contract with OHCA, the SoonerCare HMP, the care coordination component involves providing ongoing support for a select group of high-cost/high-risk individuals. In the initial program, Telligen provided care coordination to the highest risk members through face-to-face visits in members' homes and telephonically to lower risk members. This model has now evolved to include care management via health coaches embedded at the primary care practice site in addition to the face-to-face and telephonic models. Health coaching activities incorporate the following principles:

- Self-managed support.
- Medication adherence.
- Health literacy.
- Coordinated care across the care continuum.
- Liaison with family and other healthcare providers.
- Access to community resources.
- Use of a disease registry or other performance measurement tool.
- Quality improvement activities.

Care coordinators will identify the resource needs of the child and foster family. Following needs identification, the care coordinator will engage the resource specialist to assist locating appropriate resources. If services are available in the area, the care coordinator will facilitate an interaction between the care giver and the allied health professional consultant in one of four ways:

1. If the foster family is receptive to the referral/resource, we will provide the information and evoke change talk regarding intent to follow up.
2. Notify the allied health professional about the member's need and request a follow-up contact.
3. Advise foster family to expect a call from the referred health professional.
4. Arrange for the allied health professional to collaborate with the foster family and health coach to complete the referral.

a. Behavior Health Services?

Each SoonerCare Choice Pediatric member (age five to 18) engaged in the HMP-C will have a completed Behavioral Health (BH) screening. If the CIC needs a referral based on their screening or their/foster family's requests:

- If they are connected to a behavioral health location, we will coordinate or contact the behavioral health location for additional behavioral health services. If the member is unhappy with the location, we will make a referral and specify that they are requesting another behavioral health location.
- The care coordinator will coordinate with the CW specialist and/or the child behavioral health screener to ensure that needs are met.
- The care coordinator will be aware that some psychiatric disorders in children and adolescents, such as anxiety or depression, can present with physical complaints or vague somatic symptoms. Examples of this include: sleep and appetite changes, fatigue, decreased energy, pain, headaches, dizziness, palpitations, and shortness of breath.
- As part of the care coordinator role to integrate and coordinate the physical and mental health care of children in foster care, we will provide the guidance to caregivers that emotional and physical problems are often intertwined.

b. Medical Care?

Children in foster care have often been exposed to social risk factors that drive pediatric health disparities, including poverty, single parent homes, family stress, maternal mental health concerns, minority race/ethnicity, and community and household violence. It is not a surprise, then, that nearly half of the children in foster care have chronic medical problems and unmet health care needs. Environmental determinants of health and disease are pervasive and integral to the assessment, diagnosis, intervention, planning and evaluation components of our care coordination program.

The coordination, monitoring and oversight of health services are important steps in determining what changes, if any, will take place:

- Communication with foster parents will play a major role regarding scheduling appointments, accompanying the child to appointments, and advocating for specialty services.
- The care coordinator coach will arrange and remind caregivers of appointments, help with transportation, obtain copies of records and other activities.
- The care coordinator will track attendance at appointments and review records to determine what additional services are needed.

One primary task of the care coordinator will be documenting health information for each child. This information is critical in the planning and facilitation of health services. Several activities include:

1. Establishing and maintaining a health file for the child. Each child in foster care must have an individual health file in the case record.
2. Obtaining medical consent as needed.
3. Gathering health information.
 - This includes current and past records from medical providers, as well as health information from the child, family, caregivers, schools and other agencies.
4. Recording current and ongoing health status and activities. This involves adding a note or report into the health file when a service is received.
5. Sharing health information as appropriate among the child's health care providers, treatment team and family members.

c. Dental?

Comprehensive dental care for CIC includes routine restorative care and ongoing dental examinations, preventive services and treatment as recommended by the dentist. Follow-up care for all conditions identified in the initial dental assessment is required.

The HMP-C program will identify potential determinants of oral health and dental use among CIC including:

- Linguistic and cultural barriers.
- Lack of systematic health record-keeping.
- Foster parents' resource needs.
- Child behavior problems.
- Lack of dental 'buy in' from adolescents.

HMP-C will help ensure that each child receives timely, coordinated EPSDT dental services, and foster families receive the education needed:

- Addressing linguistic and cultural barriers.
- Researching and providing appropriate resources for dental care.
- Education for children and foster families.

a) Health Homes

2. How would you use a care coordination model to include children in care as enrollees of Health Homes?

CIC in Oklahoma are not members of Health Homes because of possible duplication of care coordination services and Telligen's care coordination model does not suggest the enrollment of CIC in Health Homes. But, ODMHSAS does have a pilot project involving three community mental health center sites, which is responsible for integrating behavioral and primary care of the involved child in custody. Telligen health coaches currently research member eligibility using OHCA's the iCE (MMIS) system. Whenever possible, we seek to avoid episodes of coordination overlap. Often, these situations require examination of each agency's roles and responsibilities to avoid duplication of services. Examples of care coordination are:

- Acting as a liaison between the child, their families and the CCBHC.
- Responding and working to resolve member and family concerns, as well as providing a link to needed community resources.
- Assisting with behavioral health resource referrals, coordination and follow-up.

C. STAFF/PROVIDER NETWORK

1. Describe, if applicable, how staff and/or provider network recruitment and retention, including types of providers are addressed.

Team work and communication are key elements of effective health care coordination. CIC may have special health needs that require a multi-faceted approach to care. A primary health care provider, as well as specialists, including dentists, mental health professionals, optometrists, orthopedists, and other health care providers accessible within the surrounding community may be appropriate for the needs of the child. In addition to identifying a range of health care providers, Telligen will identify and establish relationships with certain specialists such as pediatricians, pediatric dieticians/nutritionists, endocrinologists, pediatric counselor and others as identified by needs of the CIC.

Many primary care and pediatric providers in Oklahoma care for Medicaid members, including children. Many dentists, including pediatric specialty dentists, also care for Medicaid members. Because of the rural nature of Oklahoma and lack of medical services in these areas, partnerships must be developed to improve health and access to health care through guidance, questions and support. Telligen will build a network of providers and staff will to be used for care coordination for CIC through partnerships. The goal of these partnerships is to work together to address the many factors that influence health and well-being. Telligen's approach to serving CIC involves a collaborative approach to support the development of partnerships (see Figure 3), which could include:

- **Local providers and dentists, mental health professionals, optometrists, orthopedists, and other health providers** accessible within the surrounding community served. Ideally, CIC will be served by a patient-centered medical home. The medical home services provided include primary care, as well as referrals to specialist(s).
- **Comprehensive dental care** for CIC includes routine restorative care and ongoing dental examinations, preventative services, and treatment and follow-up care for all conditions identified in the initial dental assessments.
- **Mental health providers** may also be needed by CIC, should mental health needs be identified. Psychiatric, psychological, and other essential services must be made available appropriate to the needs of CIC.
- **Federally Qualified Health Centers (FQHC)** have opened across the state to increase access to care. Collaborating with FQHC clinics to be the Patient-Centered Medical Home (PCMH) for CIC may increase access, compliance with routine care, care readily available for acute needs and access to many specialists. FQHC clinics provide medical, dental, vision, pharmacy, and behavioral health services. FQHC clinics also provide case management for patients requiring referrals, completing paperwork for various programs such as:
 - **Churches** – blessing bags for children taken into custody to provide them with necessities, e.g., pajamas, blankets, underwear, clothing and hygiene basics.

- **School programs** – backpack programs (providing food for days when school food programs are not available); after school programs to decrease latchkey individuals and to help with tutoring needs such as Boys and Girls Clubs, scout programs, 4H programs, and food banks to name a few. Additionally, in many of the smaller schools, counselors and social workers are available to assist students/foster parents with learning as well as psychosocial needs.
- **State and county health departments** – can be instrumental in determining immunization status of individuals through their immunization database. Other services of the County Health Department (CHD) could include growth and development programs such as Children’s First, Early Intervention programs, as well as the women, infant and children (WIC) program for nutritional support services, birth control education and prevention for sexually active individuals, and tobacco cessation counseling.
- **Indian Health Service (IHS)** can provide a variety of services to CIC. IHS provides for individuals with Certificate of Degree of Indian Blood (CDIB) verification. American Indians and Native Americans are the second largest minority population in Oklahoma, consisting of 8.9 percent according to the 2011 American Press census report. All Native Americans and American Indians with a CDIB using the IHS are encouraged to apply for Medicaid services if it is determined that they meet the Medicaid eligibility criteria. Case workers at the IHS help individuals complete the process to qualify for Medicaid services. IHS provides primary care for adults and pediatrics, specialty care, including internal medicine, dental, general counseling and behavior health, acute care, physical therapy, pharmacy, optometry and acute care services at the Indian Health Hospitals.
- **Court Appointed Special Advocates (CASA)** is another resource for CIC individuals. CASA is a national association of volunteers who are appointed by judges to advocate for the best interests of abused and neglected children in court and other settings. The primary responsibility of these volunteers is to gather information, review documents and records, interview children, family members and professionals in their lives.
- **Fostering Hope Project** – this program is dedicated to working with groups that advocate for children who have been abused or neglected. The goal of this organization is to inspire individuals, communities and churches to come forward and help end the generations of child abuse and neglect. The founder, a physician provides direct health care to children in shelters and through the Fostering Hope clinics, which are part of the University of Oklahoma Pediatric Clinics at the Oklahoma City and Tulsa campuses. Other services provided include resources for DHS, CASA workers, courts, families and others involved in the foster system.

Establishing a relationship and credibility with providers is a process that occurs over time. We must invest the time in understanding each other’s perspectives, needs and operational considerations. Mutually positive and beneficial working relationships may require face-to-face communication, both initially and periodically.

To attract health care providers, it will be necessary to address their concerns about treating children in foster care. Health care providers may not wish to care for CIC for many reasons, which may pertain to personal or perceived past experiences, and may include:

- Frequent missed appointments.
- Incomplete health history.
- No consent for care or for release of medical records.
- Inadequate reimbursement for the work or time required to provide care.
- Misperceptions about children in the child welfare system.

Retaining these health care service providers is as important as recruitment. Establishing and maintaining ongoing relationships with providers will facilitate the ongoing development of the relationship and credibility.

The foster parent should have readily available the following:

- Signed consent form.
- Signed release of health records form.
- As much previous health history as possible, e.g., prior health records, immunization records, birth records for an infant, records from inpatient hospital stays.
- Names and telephone numbers of previous health care providers.

The availability of these documents will provide the health care service providers with the information they need to provide comprehensive care therefore leading to care delivery satisfaction and retention.



Figure 3. Telligen HMP for Children in State Custody.

D. PAYMENT STRUCTURE

1. PAYMENT METHODOLOGY, ASSUMPTIONS, AND CONSTRAINTS

1. Explain payment methodology, assumptions, and constraints related to the care coordination models.

Our proposed care coordination program is based on a model in which OCHA contracts with a single vendor for statewide operation of the program.

- a. **Methodology** – Payments to the care coordination vendor could be made in one of two ways: a fixed monthly payment for a defined scope of work; or a performance-based payment model in which the vendor received a fixed payment amount for care coordination that would increase based on the vendor engaging more children and foster families in the program.
- b. **Assumptions** – Our program model is based on the assumption that foster children would automatically be enrolled in the care coordination program. Program participation would not require an affirmative ‘opt-in’ by the foster parents/caregivers.
- c. **Constraints** – The only constraint on the state payment structure for a care coordination vendor would be the availability of state funds to support the state-wide program. It might be necessary to restrict the number of foster children receiving care coordination support if state funds were not sufficient to support all foster children who would qualify for the program.

b) Covered Benefits and Services

a. Specific to covered benefits and services

Telligen’s care coordination model does not include the adjustment of payment methodology specific to covered benefits and services.

c) Other Benefits and Services

b. Specific to other benefits and services

Telligen’s care coordination model does not include the adjustment of payment methodology specific to other benefits and services.

d) Estimated Amounts of Provider Payments for Evidence-based Performance Outcomes

c. Show estimated amounts of provider payments for evidence-based performance outcomes

Our care coordination model does not include adjustment of provider payments for evidence-based performance outcomes.

2. AVOIDING DUPLICATION OF CARE/PAYMENT

a) Avoiding Duplication of Care/Payment

a. How does your Care Coordination model address potential CMS concerns regarding duplication of care/payment?

Telligen's care coordinators will remain present and in the CIC's lives, coordinating their care throughout their foster care experience. As health care advocates with consistent presence, even when children are moved to different foster homes, adopted, or reunified with their birth families, our care coordinators will have knowledge of the care they have received and need to receive.

CIC are not members of Health Homes because of possible duplication of care coordination services. But they can receive care from ODMHSAS' community mental health center sites. Our health coaches currently research eligibility using OHCA's iCE system and avoid coordination overlap situations when possible. Often, these situations require examination of each agency's role and responsibilities to avoid duplication of services.

b) Complying with Existing and Proposed Federal and State Requirements

Explain how proposed payments comply with existing and proposed Federal and State requirements.

Our proposed care coordination program is based on a model in which OCHA contracts with a single vendor for statewide operation of the program and does not include provisions for incentivizing providers in any way.

E. IMPACT OF MODEL

1. ESTIMATED IMPLEMENTATION COSTS AND ANTICIPATED SAVINGS

Explain estimated implementation costs and anticipated savings, for the first five years of an implementation of your model.

Implementation costs to deploy our proposed care coordination program would be minimal since it is based on our existing SoonerCare HMP. Existing processes and data support could be easily modified to address the needs of the CIC population.

Based on savings produced by the HMP program documented in the annual program evaluation completed by OHCA, we anticipate similar savings would be produced by using the same operational model for the CIC population.

a) Methodology

a. Methodology

We suggest using the same methodology to measure program impact and cost savings for the CIC care coordination program as used currently to evaluate the HMP program.

b) Assumptions

b. Assumptions

Although the total dollars saved from the CIC care coordination program would be smaller than HMP savings due to the smaller CIC population, we assume the state would see similar proportional savings across both programs.

c) Constraints

c. Constraints

There are no constraints to our estimated implementation costs and anticipated savings.

2. QUALITY AND ANTICIPATED EFFECT OF CARE COORDINATION MODEL ON TARGET POPULATION

2. Describe the quality and anticipated effect of the care coordination models on the target population with respect to the following:

The Adverse Childhood Experience (ACE) pyramid from the Adverse Childhood Experience Study (Figure 4), depicts how adverse childhood events/experiences influence health and wellbeing. These adverse events were measured by the prevalence of exposure to abuse and household dysfunction, and the more adverse events experienced, the higher the probability for future social, emotional, and physical disorders. CIC are already at substantial risk to measure high on this pyramid due to their own household dysfunction.

Using the ACE pyramid and the adverse events it has highlighted, the HMP-C will use a trauma-informed approach to care coordination and **will work to decrease this exposure through prevention of additional adverse events and other potential stressors.**

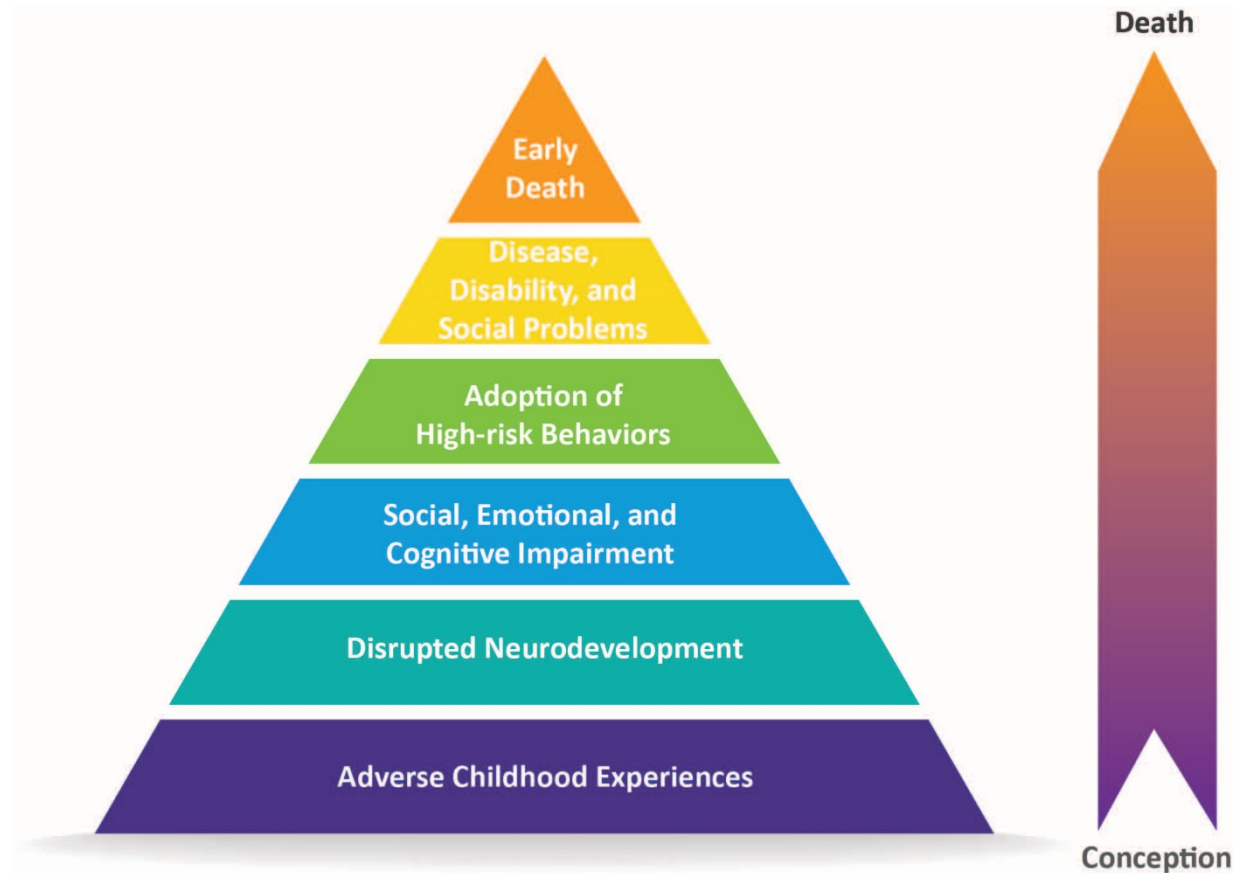


Figure 4. Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan.

a) CMS Recommended Benchmarks

a. CMS recommended benchmarks

The Centers for Medicare & Medicaid Services (CMS) has developed core measures for children's health (see Figure 2), 2017 Children's Health Care Quality Measures for Medicaid and CHIP.

Telligen will use its proven practice facilitation model to work with physicians and other providers to close gaps in care based on these standardized clinical measures. The Telligen HMP currently has practice facilitators located throughout the state working with primary care practices. Some of these practices have pediatricians who have approached our practice facilitators asking for assistance with the pediatric population. Depending on this care coordination contract award timeframe, we recommend using our current HMP practice facilitators to work with pediatric providers across the state with an accelerated facilitation period to close gaps in care for the children's health care quality measures. The practice facilitators would work with the practice/pediatric provider for a year at a time, depending on the needs of the practice. This work would include:

- Engaging with clinic staff members to understand their perception of the clinic's performance in meeting evidence-based measures.
- Using the clinic's data to demonstrate true performance, and work with them to operate more efficiently to close gaps in care. This ultimately improves the quality of care the clinic can provide, improves patient health outcomes, and encourages the providers and other clinical staff to incorporate best practice standards.
- Academic detailing and staff education on the quality measures and other pediatric initiatives focused on CIC.

Although the childhood core measures do not address chronic conditions such as hypertension and diabetes, there are a subset of measures, which follow childhood body mass index (BMI), along with blood pressure and other co-morbid conditions.

b) State Identified Areas of Concern

b. State identified areas including preventive screenings, tobacco cessation, obesity, immunizations, diabetes, hypertension, prescription drug use, hospitalizations, readmissions, emergency room use

Our suggested approach of integrating care coordination for CIC into a comparable model to the very successful Oklahoma specific HMP initiative. This proven approach would result in a significant positive impact on the state-defined areas of preventive screenings, tobacco cessation, obesity, immunizations, diabetes, hypertension, prescription drug use, hospitalizations, readmissions, and emergency room use.

Having administered a portion of the Tobacco Settlement Endowment Trust (TSET), Telligen is very familiar with the protocols to assist with smoking cessation. Our health coaches can incorporate strategies to quit smoking when this attribute is encountered in our targeted population. Oklahoma has experienced a decline in tobacco usage over the past five (5) years. While still above the national average, Oklahoma is making significant progress in limiting the use of tobacco.

The care coordination and management component of the HMP program has already demonstrated a positive impact in several of these areas for the SoonerCare population:

- Increased preventative care screenings.
- Increased immunization status.
- Reduction in tobacco use.
- Reduced hospitalizations.
- Reduced emergency room use.

The key state-identified areas of concern can be impacted by the two-pronged HMP approach using both practice facilitation and health coaching modalities.

c) Core Measures Identified within the Oklahoma Health Plan (OHIP) 2020

c. Core measures identified within the Oklahoma Health Plan (OHIP) 2020

The core measures included in Healthy Oklahoma-2020, the Oklahoma Health Improvement Plan, represent a diverse set of clinical and public health goals, some of which would be impacted by care coordination, while others would not. Listed here are the core measures and the likely impact of the HMP-C:

- **Tobacco use** includes one adolescent measure:
 - **Reduce adolescent smoking prevalence** – The care coordination and practice facilitation model will positively impact adolescent smoking prevalence through increased provider awareness and health coaching support. The HMP has been working with OHCA and the Tobacco Settlement Endowment Trust (TSET) on a tobacco cessation initiative called the SoonerQuit Provider Engagement (SQPE) program for the past three years. This initiative provided education on 5A’s counseling, tobacco cessation aids/medications, documentation and billing practices to providers and their practices. Our health coaches are well-educated in SoonerCare tobacco cessation benefits and have been very successful helping members quit tobacco. This work puts us in a unique position to provide such education to pediatric and adolescent providers, and to foster children/families.
- **Obesity reduction** includes one adolescent measure:
 - **Reduce adolescent obesity prevalence** – The care coordination and practice facilitation model may have a limited positive impact on the rate of obesity in adolescents through increased provider awareness and health coaching support.
- **Children’s Health** includes three core measures:
 - **Reduce infant, child and adolescent injury mortality** – Care coordination may positively impact injury mortality through care support included in the HMP.
- **Behavioral health** includes three core measures:
 - **Reduce the prevalence of untreated mental illness** – Care coordination will positively impact this measure through emphasizing behavioral health integration with physical health in the care management process. All children in state custody have access to behavioral health screeners, and children in state custody should have consults and follow-up care during their supervision period.
 - **Reduce the prevalence of addiction disorders** – While not a huge issue in the adolescent population, 9.4 percent have reported use of an illicit drug within the last month, according to the Substance Abuse and Mental Health Services Administration (SAMHSA).¹ The care coordination and practice facilitation model can positively impact this measure with awareness education to the child/adolescent, the foster families and providers; more frequent and consistent provider office visits; and care coordination support.

¹ <https://www.drugabuse.gov/publications/drugfacts/nationwide-trends>.

The HMP has worked with OHCA on a Chronic Pain Management initiative for provider education on appropriate prescribing and best evidence practice for components of a Pain Management program. Telligen has also been working with the Oklahoma State Health Department (OSDH) on the same type of program but combines education for best evidence guidelines prescribing for acute pain as well as chronic pain. The program with OSDH targets all provider prescribers across the state, including family practice, dentists, surgeons and pediatricians. Our health coaches have been educated on these initiatives and are able to work with members on education on pain medications and self-management of pain conditions. The pain initiatives put us in a unique position to provide appropriate education to pediatricians on proper prescribing guidelines to help reduce exposure to opioids and reduce opioid addiction.

- **Reduce suicide deaths** – Care coordination will have a positive impact on this measure through better integration of BH and the coordination of follow-up care for individuals at risk of suicide.
- **Health transformations** includes three core measures:
 - **Improve population health – reduce heart diseases deaths** – Using the trauma-informed approach to care coordination will affect future social and physical health of this population. impact on this measure. We strive to not only improve current and short-term outcomes, but also the future of this population and the state of Oklahoma in the form of: (1) improved quality of care achieved through the HMP-C combined with (2) improved care coordination among the three primary organizations (DHS, OHCA and ODMHSAS); and (2) along with the focus of primary care will result in better clinical and social outcomes for CIC.
 - **Improve quality of care (reduce preventable hospitalizations)** – Foster parents have verbalized challenges associated with obtaining medical information and records for the children in their care. They are not aware of pre-existing medical conditions or needed medications. Care coordination will be able to positively impact this measure, as the Telligen health coaches have access to state systems and health information exchanges (HIEs), which house pertinent information.

Using this information, the health coaches will be able to complete a more thorough education to foster families and CIC on current health conditions and their medications. Improving the identification of current medical conditions and needed medications will prevent use of the emergency department and possible hospitalizations. Reducing preventable hospitalizations and re-admissions is one of the most often cited benefits of a care coordination model. The HMP has already demonstrated how care management contributes to lower rates of hospitalization. Adding care coordination to the operational model will lead to even larger reductions in the rate of inpatient care.

- **Bend the cost curve (limit annual healthcare cost growth)** – Care coordination will help reduce Medicaid spending through better coordination of services, eliminating duplicate services, reductions in inpatient care, appropriate use of community-based resources, medication reconciliation, and reductions in emergency room use. *The HMP has produced \$72 million in savings within the SoonerCare Choice population during the past three years of the program using the care coordination and practice facilitation model.*

d) Respondent Suggested Benchmarks

d. Respondent suggestions for other benchmarks

The American Academy of Pediatrics (AAP) has developed health care standards for children and teens in foster care. These measures work to help prevent the adverse events depicted in the ACE pyramid. Telligen will implement these measures through practice facilitation and education of the pediatric providers and through health coach education and support to the foster families.

- **Children and teens in foster care should be seen yearly:**
 - To assess for signs and symptoms of child abuse and neglect.
 - To assess for presence of acute and chronic illness.
 - To assess for signs of acute or severe mental health problems.
 - To monitor adjustments to foster care.
 - To ensure the child or teen has all necessary medical equipment and medications.
 - To support and educate parents (foster and birth) and kin.
- **Children and teens in foster care should be seen often upon entry into foster care.**
 - Health screening visit within 72 hours of placement.
 - Comprehensive health admission visits within 30 days of placement.
 - Follow-up health visit within 60 to 90 days of placement.
- **Children and teens in foster care should have an advanced health care schedule.**

Because of a high prevalence of health care problems and often multiple transitions that can adversely impact their health and well-being, children and teens in foster care should have an enhanced health care schedule.

 - To monitor signs and symptoms of abuse or neglect.
 - To monitor a child's or teen's adjustment to foster care and visitation.
 - To ensure a child or teen has all necessary referrals, medical equipment, and medications.
 - To support and educate parents (foster and birth) and kin.

- **Children and teens in foster care should be seen often while they are in foster care.**
 - Monthly for infants from birth to six months.
 - Every three months for children age six months to 24 months.
 - Twice a year for children and teens between 24 months and 21 years of age.
- **Children and teens in foster care should have comprehensive evaluations.** Within 30 days of placement, children and teens in foster care should have the following detailed, comprehensive evaluations:
 - A mental health evaluation.
 - A developmental health evaluation.
 - An educational evaluation if over the age of 5.
 - A dental evaluation.

e) Value-based Performance Designs

e. Considerations for Value-Based performance designs, specifically those that support and align with objectives identified within Oklahoma State Innovation Model design

The Oklahoma State Innovation Model (SIM) represents a plan to improve health, improve care and reduce health expenditures. The model's tenets are:

- Incorporate the drivers of health outcomes.
- Integrate the delivery of care.
- Reduce provider burden through integration.
- Move toward value-based care.

This SIM moves Oklahoma toward a value and outcome-based healthcare delivery model by addressing infrastructure, workforce, culture, and education. Most value-outcome based healthcare models are adult-focused, not childhood-focused. Since February 2008, Telligen has partnered with OHCA to develop, implement and operate the SoonerCare HMP, an innovative model that strives to improve clinical outcomes and lower the cost of care for Medicaid members who have or are at risk of developing chronic disease.

The contracts goals/business objectives are to:

- **Improve care quality while reducing costs** – Telligen achieves this objective using a two-pronged approach:
 - **Practice facilitation** – Telligen's registered nurses (practice facilitators) work directly with primary care providers in the clinical setting to build performance measurement and quality improvement skills. This includes:
 - Reviewing services provided compared to relevant evidence-based clinical guidelines for development of process changes and other interventions to increase guideline compliance.

- Measuring the impact of deployed interventions to assess the impact on reducing gaps in care.
- Provider and staff education of quality measures and necessary tools needed to meet best evidence based care.
- **Care management** – Telligen nurses provided targeted care management support to high-cost and high-risk members in the Medicaid population. We provide support to members via three options: (1) embedded health coaches at rural provider offices/clinics, (2) face-to-face in member homes, or (3) telephonic support. As part of each of these support methods, we use motivational interviewing and help members set realistic and achievable goals within a patient-centered model.

Our health coaches also help with care coordination of services provided to the member across all practice settings, as well as facilitating member access to community resources that are relevant to their needs. These efforts help the member build self-management skills and engage with community resources, which leads to reduced hospital utilization (both inpatient and emergency room) and lower costs.

The cost savings demonstrated with the current HMP model shows how well our two-pronged approach works with the SoonerCare population. The HMP model addresses the same changes as the SIM; infrastructure, workforce, culture, and education; through education and support for the provider and member.

Although the HMP model and most value-outcome based health care models have been historically adult-focused, not childhood-focused, Telligen believes the children in state custody and their foster care families need, and can benefit from, the same level of care coordination. Additionally, we believe that pediatric providers across the state need (and want) the same level of practice facilitation as shown with the SoonerCare HMP.

F. DATA MANAGEMENT

1. EFFICIENT MANAGEMENT OF DATA

1. How does your care coordination model provide for efficient management of data to ensure that the child experiences quality and safety?

Our proposed HMP-C helps ensure efficient data management in these ways:

- Existing data collection tool and process to capture provider performance data for defined clinical measures.
- An existing data application to support the care coordination process.
- An existing data link with OHCA that enables timely and secure data transfer between organizations.
- An existing program data base containing the results of all care coordination activities and provider performance data that can easily be expanded to include additional information for the CIC population.

Because data management infrastructure is already in place, we will be able to launch the HMP-C model more quickly, and more cost effectively.

G. CARE COORDINATION IMPLEMENTATION TIMELINES

1. TIMELINE FOR IMPLANTATION OF CARE COORDINATION MODEL

1. Based on prior experience, provide insight into what a realistic timeline for implantation of your Care Coordination model might be. Specifically, provide details into the following aspects of implementation of a Care Coordination model like what has been described:

a) Development

a. Development

We anticipate approximately 90 days would be needed for a development period to finalize operational details with OHCA, conduct provider educational activities, and establish connections with key data sources. Since our proposed model is based on the existing HMP, we believe successful launch of the care coordination program could be completed in a relatively short period of time with a seasoned and well experienced vendor with detailed knowledge of Oklahoma and existing relationships with providers and community partners throughout the state.

b) Transition/Readiness Activities

b. Transition/Readiness Activities

All transition and readiness activities will be completed during the development period including:

- Installation and testing of all data connections with OHCA the HIEs, and possible access to the Child's Passport and Placement Provider Information.
- Complete hiring and training the team of care coordination staff, and work with HMP personnel to coordinate and integrate program operations.

c) Member Enrollment

c. Implementation of member enrollment

Enrollment into the care coordination program could begin after the completion of the development and transition/readiness activities. This would be approximately 90 days following the program launch date.

Member Service Delivery

d. Implementation of member service delivery

Care coordination activities would begin immediately following enrollment into program, which is approximately 90 days following the program launch date.

October 16, 2017

Attention: Gerald Elrod
Oklahoma Health Care Authority
4345 N. Lincoln Boulevard
Oklahoma City, OK 73105
Phone: (405) 522-5850
gerald.elrod@okhca.org

RE: Oklahoma Health Care Authority Request for Information – Care Coordination for Children in DHS Custody, UnitedHealthcare Community & State Response

UnitedHealthcare Community & State appreciates the opportunity offered by the Oklahoma Health Care Authority (OHCA) to provide feedback on the potential care coordination models for children who are in the custody of the Department of Human Services (DHS) via this request for information (RFI).

We support the state's efforts to determine the best market-based model to deliver high quality, comprehensive care to the approximately 9,000 children currently in out-of-home care due to abuse, neglect, or both. We believe that a fully capitated, managed care approach to coordination for Oklahoma's children in DHS custody will drive higher quality outcomes and improve system performance.

If Oklahoma does not feel the state is prepared to adopt a managed care model for the program at this time, we recommend leveraging a partial-risk care coordination approach that over time, increases the level of risk to the coordination entity to a full-risk model. We would be happy to discuss this model separately if OHCA is interested in exploring this option further. Our enclosed responses speak to the value of a managed care approach towards advancing Oklahoma's goals through continued implementation of the Pinnacle Plan.

As a managed care organization (MCO) serving approximately 6.4 million members across 26 states, including 13 managed long term services and supports programs, two Financial Alignment Demonstrations, and Duals Special Needs Plans (DSNP) in 27 markets, we play an integral role in the care delivered to children and families. We have a vested interest in the thoughtful advancement of new policy reforms that result in an acceleration of new payment and delivery models that improve quality and health outcomes. Based on our experience, we offer the following responses to the questions posed.

If any additional information would be helpful, we would welcome the opportunity to discuss further.

Sincerely,



J. Megan Haddock, Esq.
CEO, UnitedHealthcare Community Plan of OK
(Mobile) 918.520.1440 (Email) megan_haddock@uhc.com

Responses to Section 3.2 – Scope of Work

A. High-level description of the recommended patient-centered service delivery Care Coordination models

- 1. Name and describe the chosen model including reason for selection***
- 2. Describe how the model addresses the needs of the population***
- 3. Explain how respondents have approached implementation of the model***

The optimum health of all children is best achieved with access to appropriate, timely and comprehensive health care benefits that encompass medical care, preventive care (including dental and vision services), acute care, behavioral health services and pharmacy. Children in child welfare programs typically face family disruption and often frequent changes in placement that can affect their access to health services. They require access to healthcare that is high quality, continuous, well-coordinated and culturally informed. Integrated behavioral and medical care is critical to ensuring their well-being. This requires a coordinated systems approach to ensure successful health care delivery that meets the unique needs of this population.

To that end, we recommend that OHCA pursue a **statewide, managed care approach to providing care coordination for children in custody. Oklahoma should seek a single, statewide, at-risk vendor that can be held solely accountable for the success of the program.**

Leveraging a single contractor will streamline inefficiencies in the system, providing those who give support to children in custody – social workers, case managers, and schools, among others – a single point of contact and responsible entity for addressing health care needs. Additionally, a singular statewide contracting approach will limit disruption in care for children who move around the state, which can happen frequently for children in custody.

Leveraging an experienced MCO in a managed care model provides the benefits enhanced structure, oversight, and coordination of physical health, behavioral health, and social services. MCOs have expertise in engaging and coordinating across the spectrum of programs and services. Additionally, MCOs can offer extensive support navigating and ensuring full and appropriate access to needed care. MCOs develop care teams that specialize in the unique needs of children in out-of-home placements, including addressing family support needs, behavioral health and medication support, as well as person-centered transitional services for children who transition to adulthood and out of the child protective services.

Through the use of specifically-designed, trauma informed health risk assessments (HRAs), the MCO will appropriately target care coordination services based on the specific needs and situation of the child. Not all children and not all foster families will benefit from the same type or level of service. The HRA findings and subsequent communications will establish the frequency, duration and methods for care coordination. Managed care coordinators will focus on Medicaid services and supports and will collaborate with DHS case management as appropriate. The responsibilities of case management within DHS will continue to focus on supporting children and families as they seek wellbeing and permanency. Should Oklahoma explore merging the responsibilities of Medicaid managed care coordination and DHS

child protective services case management, we encourage the state to ensure the data systems, funding streams and agency leadership are appropriately prepared for the required coordination.

When engaging an MCO to take on the responsibility or coordinating care for children in custody, the state should look for an MCO that:

- Will leverage proven clinical models to ensure appropriate care, coordination and treatment is targeted to each child's needs;
- Supports culturally-appropriate and relevant care and communication, particularly for children in custody who are members of Native American tribes;
- Has experience and expertise in trauma-informed care;
- Has a demonstrated track record of working collaboratively with state partners, children, families and numerous stakeholders;
- Has expertise serving children who are medically fragile, have special health care needs, extensive behavioral health needs and/or intellectual and developmental disabilities; and
- Is committed to building collaborative partnerships with OHCA, DHS, and other community partners to support the complex needs of children and families.

Additionally, it is important to note, that in a managed care model, the state can hold the MCO accountable to the goals and requirements of the program outlined in the Pinnacle Plan through the contracting process. Oklahoma can work with the MCO to design contract requirements that incentivize the MCO to ensure the requirements of the Pinnacle Plan are met and carry out the Plan's vision effectively.

B. Access to Health Services

1. Describe how your care coordination model would ensure that children in care and their families can access needed health services? Behavioral health services? Medical Care? Dental?

2. How would you use a care coordination model to include children in care as enrollees in Health Homes?

C. Staff/Provider Network

1. Describe, if applicable, how staff and/or provider network recruitment and retention, including types of providers are addressed.

The complexity of the medical, behavioral, and social needs of children in DHS custody cannot be understated and the model put in place to coordinate care must be trauma-informed, empowering, strengths based, and aware of the unique and specific needs of children in care, their caregivers, and the systems with which they interact, to ensure children have appropriate access to the care and services they need.

Under federal law, MCOs are required to offer not only a sufficient number, but also an appropriate geographic distribution, of providers and specialists in their networks. MCOs are also contractually obligated to ensure that enrollees have timely access to care from within the provider network.

In addition, if the provider network is unable to provide contracted necessary services to a particular beneficiary using its existing network, the MCO must cover these services out of network for as long as the provider network is unable to provide them in-network, guaranteeing access to benefits and services.

MCOs are experienced in developing high performing provider networks to meet the needs of the population. For children in DHS custody this would include cultivating a subset of providers who are in-tune with, and sensitive to, the unique needs of children in an out-of-home placement, particularly providers who practice trauma-informed care. These sensitivities would include understanding the needs of children with complex medical or behavioral health conditions. The provider network will also need to be prepared to serve the unique needs of children who have been exposed to exploitation and human trafficking. Additionally, the network will need to include the appropriate providers and specialists to serve children who are medically fragile and/or have intellectual and/or developmental disabilities.

In Texas, for example, our UnitedHealthcare Community Plan of Texas has developed a training program for providers in our network that provides certification on trauma-informed care. This certification increases the number of providers capable of treating the needs of the children in the state's foster care system and also helps our Plan identify the optimal providers to refer the most vulnerable children enrolled with us. In Oklahoma, the MCO should take a similar tactic to develop "centers of excellence," comprised of providers certified to provide appropriately sensitive care to children in custody. The MCO can refer children in custody and their families to these "centers of excellence" to reduce challenges in locating providers that offer care best-tailored to the unique needs of this group.

Provider networks for managed care programs also include safety-net providers such as rural health clinics (RHCs) and Federally Qualified Health Centers (FQHCs). These types of safety-net providers are trusted in their communities, are frequently on the leading edge of implementing evidence-based practices and, in general, also offer behavioral health and oral health care services. To ensure access to appropriate dental services, MCOs can coordinate with FQHCs to provide access to dental therapists who are sensitive to the needs of children in out-of-home placements. MCOs are experienced in contracting with safety-net providers to achieve access and performance goals.

By carefully and strategically building high-performing networks tailored to the population, an experienced MCO can assure access to care for children in custody. A high-performing provider network not only offers basic access to care but is carefully built to address the full spectrum of needs – from primary care and pharmacy services to specialty care and community-based services, as well as ancillary services such as home health and medical equipment. An effective MCO will build highly efficient networks that align alternative payment models to experienced, willing and high quality practices to assist with transforming the delivery system towards population health and outcomes based payments.

MCOs are experienced in addressing physician shortages using other professional clinicians such as physician assistants and nurse practitioners to create adequate access to care, as well as lay personnel such as community health workers and behavioral health peer support specialists to help families and children manage chronic health conditions such as diabetes, asthma and mental illness. The network can also include peer supports specialists, often former foster parents or former children in custody, to help children and families struggling with their placement. These types of peer support specialists can provide a trauma-informed, empathetic and positive influence to help improve tense situations and improve overall quality of life for the family.

In addition, telehealth can be used to supplement access to care, particularly specialists. MCOs further support these efforts by making strategic investments at the practice level through performance-based programs and analytics support to drive practice efficiencies and improvements.

The MCO can also work with schools to supplement access to care. With appropriate permissions, the MCO can talk with a school directly to ensure a child receives necessary services and supports in the school setting, as well as help families understand the most effective ways to talk with the schools and understand their rights through an education advocate. For example, if a child requires occupational therapy in a school setting but is not receiving it, the MCO can work to ensure that child receives their appropriate therapies either in school or in an accessible alternative setting.

As children age and transition out of DHS custody, they maintain some level of benefits and supports, but those supports become narrower in scope and availability. Therefore, it is critical that the health system provide appropriate access to SoonerCare benefits and ensure older children/young adults, particularly with special health care needs, behavioral health conditions, chronic conditions, and/or those recovering from trauma, receive necessary medical and behavioral health services to maintain a healthy lifestyle and successfully transition to independence.

With that goal in mind, the MCO can work with medical and behavioral health providers to establish a health home model for adult children transitioning out of custody to provide coordinate medical and behavioral services, sensitive to the unique needs of the population. A coordinated medical/behavioral model will allow providers to treat the “whole person” and not provide siloed care; this model can also help ensure appropriate medication management as the individual may receive prescriptions from both their medical and behavioral providers as-needed. To successfully develop this model, SoonerCare benefits for the young adult/transition age group must remain in managed care.

D. Payment Structure

1. Explain payment methodology, assumptions, and constraints related to the care coordination model.

In the fully at-risk model, the MCO would receive an actuarially sound, monthly capitation payment for the coordination and provision of the full spectrum of health care services for the population of children in custody. This fixed rate shifts the state’s financial exposure for health care outcomes to the MCO,

which incentivizes them to adopt and implement innovative tools to improve health outcomes and efficiencies.

Managed care can support the implementation of consistent and customized value-based contracting models to reward high-performing providers. Reliance on an MCO to advance performance-based payments in the delivery system allows the state to maximize the number of providers participating and leverages managed care capabilities to advance payment reform based on the unique characteristics of the program and the provider's practice.

For example, a managed care contractor can be utilized to implement a dynamic value based payment model that provides a continuum of alternative payment models from bundled/episodic payments, quality incentives, shared savings and upside/downside risk. This allows for a menu of payment arrangements to align with the practice's interests, goals and capabilities. It also allows for meeting practices and delivery systems where they are at in the evolution of transformation and customize supports to assist practices with achieving their goals.

Any care coordination program should provide sufficient flexibility to the MCO to develop the value-based payment strategies with providers - - holding the full system of care accountable for excellence. This approach allows the MCO to tailor strategies best suited to the provider's readiness and the unique needs of children in custody as well as drive innovation in the market. However, the MCO should also work closely with the state to ensure that all value-based contracting arrangements are aligned with the state's goals related to quality, outcomes, and broad system transformation.

Through our experiences implementing value-based incentive models in other states, we have found the following tenants to be fruitful in the design of such programs:

- Value-based programs typically focus on aligning incentives with performance, moving away from volume- and service-based motivations;
- The outcomes commonly evaluated as part of value-based programs focus on quality and efficiency. Quality metrics tend to be market driven, including HEDIS (see response to Question E for more detail). Efficiency metrics focus on reductions in emergency department and inpatient utilization, as well as total cost of care or benefit cost ratio (BCR) for larger provider groups;
- All managed care plans typically use population risk registries to identify gaps in care and specific utilization profiles;
- Clinical transformation and care coordination are key ingredients to value-based programs, and plans typically work directly with providers to address patient risk.

2. How does your care coordination model address potential CMS concerns regarding duplication of care/payment? Explain how proposed payments comply with existing federal and state requirements.

Leveraging a single, statewide MCO to coordinate care and payments across the full spectrum of stakeholders and services, including state agencies, health care providers, and community organizations,

will ensure appropriate stewardship of tax dollars and eliminate overlap and inefficiencies within the foster care system. Holding a singular entity accountable will help drive transparency into the program and how dollars are spent and care is delivered.

MCOs are held to federal standards under the Medicaid managed care rule issued in 2016 to ensure Medicaid dollars (to which children in custody are entitled) are appropriately spent and accounted for through claims processing, encounter reporting, and quality oversight programs. We encourage OHCA and DHS to leverage Title IV-E, federal adoption assistance funds, to complement Medicaid funding in the care coordination for children in custody. The MCO should be held accountable for appropriate utilization of these funds to support access to medical and behavioral services as well as medication management for this population.

E. Impact of model

1. Explain estimated implementation costs and anticipated savings for the first five years of an implementation of your model.

Implementation cost and anticipated savings of the program are dependent upon the current system's readiness to implement managed care. Because of the fixed rate payment structure for managed care, the state's financial exposure for health care outcomes is transferred to MCOs, which incentivizes them to adopt innovative tools to improve health outcomes and efficiencies.

Managed care provides budget stability and would allow the state to predict future costs for the program. Additionally, a comprehensive program that provides managed care to all SoonerCare beneficiaries in the state would allow Oklahoma to hold the MCOs fully accountable for controlling service use and providing quality care and support.

We are happy to work with OHCA and DHS to assess the preparedness of the system and subsequently work with families, providers, community organizations, and other stakeholders in a coordinated effort to move to a managed care approach.

2. Describe the quality and anticipated effect of the care coordination model on the target population with respect to:

- ***CMS recommended benchmarks***
- ***State identified areas, including: preventive screens, tobacco cessation, obesity, immunizations, diabetes, hypertension, prescription drug use, hospitalizations, readmissions, emergency room use***
- ***Core Measures identified in the Oklahoma Health Plan 2020***
- ***Suggestions for benchmarks***

To evaluate Oklahoma's success in improving care coordination for children in custody and against the directives of the Pinnacle Plan, the state should implement metrics that are meaningful for the outcomes the program is intended to achieve, but also measurable using the data available to OHCA

and DHS. Meaningful metrics are inclusive of the clinical benchmarks that the state is working to achieve in Healthy Oklahoma 2020: reduced obesity and smoking prevalence, improved population health, and reduced gaps in untreated mental illness; but must also be inclusive of how care coordination closes resource gaps across the system, not just health care, and therefore improves quality of life for children in custody and their families.

The evaluation of the care coordination program needs to keep focus on the concept that children in custody are people, and their quality of life cannot be captured through HEDIS metrics alone.

For example, in our Missouri health plan, we developed relationships with a large number of local community-based organizations supporting children in foster care across the state. One organization we partner with is able to provide free eyeglasses to children. The care managers in our Missouri plan refer families to this organization when their children in their care break their eyeglasses (which happen often with active, young children). This simple connection reduces expense for the family (as replacement glasses are not covered by Medicaid benefits), eliminates burden and frustration for the family in trying to locate free/reduced price glasses, and improves quality of life for the children as they are able to gain a new pair of glasses quickly and easily.

This type of activity cannot be easily quantified using claims or clinical data but is crucial to reaching the goals of care coordination for children in custody. We recommend that Oklahoma work with stakeholders and its chosen MCO/care coordination entity to determine most meaningful and impactful areas in terms of services sought, services used, and overall quality of life including experience and perceptions ranging from relationships, supports, and access to non-medical services and benefits.

Regarding clinical and population health metrics, we encourage Oklahoma to consider nationally-validated measures, such as HEDIS and those endorsed by the National Quality Forum (NQF), that are inclusive of outcomes and process:

- Outcome measures assess results of care (e.g., percentage of children that had controlled cholesterol).
- Process measures assess whether an action occurred (e.g., percentage of children that received annual wellness screening).

In 2016, UnitedHealthcare Community and State worked with leading experts in the disability community to develop a recommended framework for measuring quality and well-being for individuals with intellectual and developmental disabilities. While this framework would not be completely transferable or inclusive of all of the measures for children and youth in custody, it could help stimulate conversations about what types of measures could be considered. We would welcome the opportunity to explore this in greater detail should Oklahoma decide to pursue.

F. Data management

1. How does your care coordination model provide for efficient management of data to ensure that the child experiences quality and safety?

MCOs offer modern, data-driven analytical tools that will help Oklahoma manage the program with greater precision and insight. By adopting tools that harness the full spectrum of data from across the state, including claims, clinical and demographic data, Oklahoma will be better able to identify health and cost trends within their populations and deploy limited State resources to address the most critical health and safety needs. In leveraging a singular statewide MCO, the state will be able to access data in real time. By transitioning to a managed care model, OHCA will receive data-driven insights into the quality and clinical activities taking place within the program automatically through the required reporting of encounter data to the state. Additionally, with appropriate quality measure in-place, the MCO will provide reporting on those measures on a regular basis; information on the system OHCA does not have access to in the fee-for-service SoonerCare program. The data and reporting from the MCO will drive immediate transparency into the system which OHCA and DHS do not have today.

Furthermore, by migrating to a managed care platform, Oklahoma can outsource administrative oversight—claims processing and call centers—to the private sector, thereby alleviating that burden on Oklahoma’s limited budget dollars.

Insight into behavioral health care needs is an example of the data capabilities MCOs can drive. Children in custody have a high prevalence of co-occurring medical and behavioral health care needs. MCOs are adept at collecting data to identify opportunities for collaboration between medical and behavioral care including use of psychotropic drugs/special needs of members with severe and persistent mental illness (e.g., HEDIS performance related to antidepressant medication management, ADHD follow-up). The MCOs should routinely monitor access and availability of practitioners providing behavioral health services and through collaboration with local partners, the MCO will collectively analyze the results, identify opportunities for improvement and take actions, as needed, to drive improvement.

G. Care Coordination implementation timelines

1. Based on prior experience, provide insight into what a realistic timeframe for implementation of your Care coordination model might be. Specifically provide details

Based on our prior experience serving as a managed care organization in 26 states, we recommend an implementation timeframe of at least 6 months from notice of contract award. The exact timeframe can be determined following an assessment of Oklahoma’s overall system readiness to adopt managed care.

Stakeholder engagement is critical to preparing the system for managed care and ensuring a mature transition to the new program design. In addition to the MCO, children and families, advocates, providers, community-based organizations, schools, and other entities that play a role in caring for children in custody should be provided a voice in the stakeholder engagement process to ensure the program design represents the most effective model for Oklahoma children. Stakeholder engagement should begin prior to the implementation of the program and continue over time as the program matures.

A. High-Level description of the recommended Patient-Centered service delivery Care Coordination models

1. Name and describe Respondent's chosen models including reason for selecting the models
2. Describe how the models address the needs of the target population
3. Explain how Respondent has approached implementation of this model

WellCare Health Plans, Inc. (WellCare) is pleased to support the Oklahoma Health Care Authority (OHCA) in its efforts to build market-driven solutions to improve access to care for less cost for SoonerCare's children in DHS custody. While WellCare looks forward to becoming a valued partner to the SoonerCare program, given the cancellation of the recent aged, blind, and disabled procurement **we strongly recommend deferring this current population into a larger Medicaid managed care procurement** for the following reasons.

- Provider network development would present a substantial challenge, as hospitals, clinics, behavioral health specialists, others would likely be resistant to contracting with an MCO for such a small number of possible patients
- Care management staff required to successfully manage these children would be difficult to maintain given limited revenue
- With a population of 6,900 children, Oklahoma's children in DHS custody does not present a viable risk pool for an MCO to be successful

Through our singular focus on individuals served through government health care programs for 30 years, WellCare has tailored our approach to meet the unique and often complex needs of individuals in these programs. We currently serve approximately 2.8 million Medicaid and 1.5 million Medicare members including children in foster care, and operate Medicaid managed care programs in eleven states.

Based on this experience, ***we would recommend OHCA adopt an integrated Fully Capitated Managed Care Organization model as its market-based solution to serving the needs of the children in DHS custody population once sufficient Medicaid populations are included to ensure a risk pool large enough for the program to be successful.*** An integrated Fully Capitated Managed Care Organization model provides several advantages for members by using cost effective solutions to help people with complex health care needs reach their optimal levels of independence, wellness and quality of life. The benefits of this model include the following:

- Members traditionally experience improved health outcomes overall and improved quality of life when they have access to integrated care coordination of high quality services across the entire continuum of their medical, behavioral and social safety net needs.
- Member-centered care planning and coordination are the cornerstones of effective managed care. At WellCare, for example, members and caregivers are empowered to drive care plans that meet their unique needs.
- A fully-integrated managed care approach provides members a single point of entry to access the broad array of services and care coordination they need without having to navigate multiple agencies, providers and community partners.
- MCOs with a broad infrastructure like WellCare have the ability to scale up easily to add new populations, services or benefits including behavioral health providers, telepsychiatry, and other facilities or service providers likely to interact with foster children when appropriate.

- Members benefit when MCOs are given the opportunity to innovate and partner with providers, communities and other formal and informal supports and services to meet the unique needs of individual members and/or whole populations in real time. This could be the ability to offer a whole new array of services previously not offered based on an identified need, which is especially important for children in the foster care system.
- Members benefit from continuity as one care manager can help them navigate through care transitions and minimize readmissions into institutional levels of care.
- Member experience is enhanced because MCOs provide an infrastructure to monitor all elements of an individual's care through data platforms and analytics at the individual, community and population levels. This allows us to tailor programs to meet individual member needs in real time.
- Fully-capitated MCOs are incented to help sustain people in the least restrictive setting, but still governed by federal rules allowing members freedom of choice and self-direction so they are protected at every step in the process.
- Mature MCOs, who have worked in the Medicaid space for significant amounts of time such as WellCare, have developed sophisticated approaches to cultural competency which ensures that individuals of all cultural, ethnic and racial backgrounds as well as of diverse disability status are served in a way that meets their unique needs.
- MCOs provide a quality infrastructure backed by national standards to be held accountable and to hold the system accountable to continuous performance improvement.
- Members' access to care is enhanced under the MCO model because MCOs are governed by strict federal and state rules to ensure access and network standards are in place and can be held responsible for ensuring members receive care even when network providers are not available.
- Fully-capitated MCOs provide states much-needed budget predictability.

ADDRESSING THE NEEDS OF THE FOSTER CARE POPULATION: THE RIGHT CARE AT THE RIGHT TIME

Members in the Foster Care population who often have some of the most complex conditions, co-morbid diagnoses, multiple providers, and behavioral health, pharmaceutical and social needs gain specific benefits from the MCO model because of the focus on interdisciplinary care coordination.

Other specific advantages for Foster Care children include:

Enhanced benefits and services: Given an appropriate population size, when implemented with the right levels of flexibility, managed care has the ability to expand the benefits and services available to the Foster Care population. Whether it is adding a special respite service for a child with Serious Emotional Disturbance or other services even if it is not part of the core benefit package, Medicaid managed care plans across the country have significantly enhanced access to benefits for Medicaid members (including Foster Care members) in ways other models are unable able to achieve.

Diversion from institutional care: In an unmanaged or narrowly managed system, members who are in the Foster Care category too often find themselves forced into institutional settings especially during a crisis. With a dedicated care coordinator at their side looking beyond what one provider can see, these members' gaps, barriers and needs can be identified and mitigated quickly regardless of how they manifest themselves.

A bridge to social supports: When done correctly, managed care can provide a bridge to the much needed social safety net. For Foster Care members, this is critically important as the social safety net offers services, beyond those provided by their health care providers, which assist these children not only with the maintenance of their health but also with access to the tools and services they need as they age. At

WellCare, this is a responsibility we take very seriously, having developed our proprietary award-winning CommUnity Advocacy program to identify social safety net barriers and gaps and work at both the individual and community levels to bridge those gaps. This is important because Foster Care children have unique needs that cross over the traditional medical model of care.

Transparency and accountability: Foster care children often have multiple co-morbid conditions and complex needs and benefit from a strong advocacy community. Advocacy works best when advocates are an integral part of program design, implementation and on-going review and oversight. This requires an “open-book” approach. Under an appropriately designed MCO model, transparency and accountability are built into the basic oversight infrastructure giving members and advocates information they need to be directly involved in continued performance improvement.

Realized cost savings: The transition from fee-for-service to managed care has shown to provide significant savings in other states. There is potential for savings for Oklahoma in providing enhanced care coordination for children in the Foster Care system. However, the population is small and the state would benefit from expanding managed care to the larger TANF, CHIP, and ABD population in addition to the Foster Care children. WellCare has found that when members are empowered to control their own health care, costs go down because few people choose the most restrictive, most expensive levels of care unless it is necessary. An example of this is in the state of Georgia, where in 2006 our affiliate health plan, WellCare of Georgia, helped implement a state-wide managed care model across several populations. Since the inception of managed care through 2013, the state of Georgia saved \$940 million. While the reduction in costs may not be dramatic in the beginning as MCOs work to provide unmet and uncoordinated needs with a complex population, as managed care matures and additional populations are phased in, the state should expect to see significant savings.

WellCare strongly believes in the need to coordinate not only medical, behavioral and pharmacy services for Foster Care children but given their circumstances, it is vitally important to coordinate with social services and to provide trauma-informed care management and providers. WellCare’s Foster Care program assumes that the child will be eligible until they are aged 26 and ensures that the system is placement neutral. Our program:

- Helps to prevent the development of chronic conditions as children age
- Provides intensive care coordination based on initial enrollment into WellCare and will vary based on the child’s needs
- Addresses system of care challenges
- Challenges the current high utilization and cost care management model and focuses on holistic integrated member-centered care based on strengths and needs
- Invests in collaborative partnerships and coordination of care across all systems
- Ensures a specialized and highly skilled foster care team with a focus on the child and family
- Includes a “Foster Forward” approach to ensuring literacy and life skills

WellCare’s Foster Care Strategy has a comprehensive model of care focused on the following:

- WellCare’s program is placement neutral. The specially-skilled interdisciplinary care team composed of a care coordinator and physical and behavioral health providers follows the child regardless of setting.
- Continuity of care is a crucial program component. The model of care supports biopsychosocial assessments, diagnosis and the treatment plan. This plan will be continuously evaluated and adjustments will be made as warranted.

- Information is appropriately, but widely shared (e.g., appropriate diagnosis and treatment plan). Ensures evidence-based comprehensive and collaborative care inclusive of polypharmacy management. The care plan process facilitates informal and formal supports and ensures they have the same understanding.
- CommUnity Advocacy program (both corporate and field staff) will help drive efficiencies in coordination of services and systems of care as well as help children and youth in foster care to develop literacy and life skills through community-based programs. (Foster Care Strategy LS 04 11 17, from Felicia Thomas in Product)

In order to be successful this program must create a multi-disciplinary and integrated team dedicated to serving foster children and their informal and formal supports. WellCare's program includes:

- A lead care coordinator who is the primary contact for the child, their caregiver and the providers
- Competencies such as trauma informed care, wraparound philosophy, cultural awareness and competency, creative problem solving, relationship building and advocacy
- Care coordinators experienced in child welfare and highly trained in care planning and team facilitation
- A Child and Family Team (CFT) that meets routinely and is focused on maintaining placement with holistic and integrated care

B. Access to Health Services

1. Describe how your care coordination models would ensure that children in care and their families can access needed health services
 - a. Behavioral Health Services
 - b. Medical Care
 - c. Dental Care
2. How would you use a care coordination model to include children in care as enrollees of Health Homes?

Behavioral Health Services: WellCare has extensive experience in the development and management of diverse and comprehensive Medicaid provider networks. With more than 20 years of Medicaid Managed Care experience, our current networks deliver services to approximately 2.4 million Medicaid members. This broad experience, built through our network development approach and policies, will ensure that covered services are available to the members from a comprehensive network of providers, which includes primary and specialty care physicians, hospitals, and ancillary providers. These networks are developed to ensure not only compliance with federal and state adequacy and access requirements but also address the special needs of our complex populations, including children in the foster care system.

Delivering integrated behavioral health services to Medicaid recipients of all ages and eligibility categories represents a long-running challenge for several state Medicaid programs, especially for children in the Foster Care system. WellCare has built on the lessons learned serving Medicaid beneficiaries to develop a model that addresses this challenge by providing integrated medical and behavioral health services for our Medicare, Medicaid, ABD, Foster Care children and other special needs members. As a result of coordinating care for these members, we have a clear understanding of the range of behavioral health needs and have developed a care management system specially designed to positively impact the health and quality of life of our members by addressing behavioral health needs in an integrated and caring manner. We will use specific strategies to increase access to behavioral health services in underserved areas. These include:

- **Behavioral Health Toolkit:** Our behavioral health toolkit supports the integration of behavioral health and primary care. The toolkit, which is posted on our website and featured in provider newsletters, helps PCPs manage their members with co-occurring behavioral health conditions. In addition, we have PCP training modules on recovery and resiliency programs.
- **Peer Support Resources:** Peer Support has become an effective tool in health care delivery. WellCare will support and collaborate with providers who have established innovative Peer Support programs.
- **Behavioral Health Telehealth:** Partnerships in the delivery of behavioral telehealth services. For example, in Georgia we partnered with Hope House to sponsor a behavioral health telehealth service expansion for a residential substance abuse treatment facility. A process is now established for Hope House to refer members in the program to WellCare for physical and behavioral health care management services.
- **Behavioral Health Crisis Line:** Provides members with access to a 24-hour behavioral health crisis line. Should a member contact the 24/7 Behavioral Health Crisis Line, the call will be answered by a specially trained, non-clinician, within established time frames for call handling.

Medical Care: To successfully address Oklahoma's Foster Care children's full range of medical, functional and behavioral health needs in a coordinated and member-centric manner, WellCare must develop a network that meets the unique needs of this population. WellCare's network development process results in networks that offer members a broad array of high-quality providers who deliver the necessary scope of preventive, primary and specialty services, including behavioral health and substance use disorder services. Our fundamental network development strategy is to:

- Determine expected enrollment
- Accurately determine precise network requirements to meet time, distance and appointment availability standards
- Target providers critical to meeting the program's comprehensive scope of benefits and services
- Expand our core network to encompass as many qualified participants as possible allowing both member choice and increased access to care

Dental Care: Children with special healthcare needs, including those in the foster care system, often have a difficult time accessing dental care. Through our dental provider, we offer a comprehensive approach to assessment, treatment planning and care coordination. This ensures members with special healthcare needs are identified early and receive an evaluation and treatment plan developed in collaboration with the treating provider, our care coordination team and, most importantly, the member. For example, in our Illinois market we have providers like IWS Children's Clinic in Oak Park which provide specialized care for children with special needs as well as space to deliver other services that children may need. These are the type of partnerships WellCare seeks as we build a provider network. It is important to eliminate barriers to care for these members. To streamline access, we secure the necessary specialty care providers for the member and allow for standing referrals in alignment with the service plan. A dedicated dental special needs coordinator works with the dental director to evaluate the member and their condition and develop a course of action for preventive care and treatment.

Given this population is all children it is vital that EPSDT services be integrated into care plans to ensure children receive primary and periodic preventive care and treatment: EPDST is a broad clinical standard that includes important screenings, requirements for timely and effective treatment, and care planning. As needs are identified through assessments or routine surveillance reports, the care manager notes what services are needed and communicates with the member and caregiver. If the member or caregiver needs assistance

scheduling or keeping appointments or arranging for transportation, our care managers assist. During scheduled care plan reviews, our care managers follow up to ensure appointments have been kept, services delivered, and referrals provided, if necessary. By integrating EPSDT screenings and treatment into care plans, we ensure children with special healthcare needs receive timely and appropriate treatment and their routine primary and preventive care is not delayed or deferred as a result of their acute clinical needs.

Integrated Health Homes: We strive to develop relationship with our state health home partners because that relationship is paramount to the success of integration. We continue to explore our contracting models and are considering incentives around common interests such as improving access to services and the co-location of physical health and behavioral health providers with an emphasis on local neighborhood based care that truly addresses member needs in a one stop environment.

WellCare believes strongly in the strength of colocation and integrated health home models to better improve collaboration between physical and behavioral health providers. Some of our strategies, which include emerging strategies as well as enhancements of existing activities, include, but are not limited to the following:

- Cross-train PCPs and behavioral health providers and provide ongoing in-person support where appropriate
- Enhance use and availability of standard screening tools to promote universal patient screening for behavioral health conditions
- Profile PCP practices to understand distribution of behavioral health membership and support accordingly
- Establish member-level reports and specific communication strategies between providers
- Scale the presence of substance use providers within behavioral health and PCP offices
- Incent providers more effectively to co-locate or otherwise expand access to behavioral health services
- Enhance use of behavioral health metrics in value based purchasing arrangements



Our care management programs were founded on the principle of person-centered care. We believe that when members participate fully in the care planning process, they are more likely to be successful in meeting their health goals. Our care managers are trained to elicit from members and their caregivers what is important to them through relationship building and listening, bringing family members into the process and giving members a **voice** in what goals they want to achieve. This collaboration among members, caregivers, family members, providers and specialists means that members get effective, proven care based on best practices. With the guidance and support of care managers, members connect the dots from the quality of life they desire to the steps to control chronic conditions and optimize health outcomes. This **Care Partner** philosophy empowers members and their caregivers to navigate the complexity with confidence and knowledge in health literacy as WellCare provides the scaffolding to support and motivate. Reflective of WellCare's care model, which has been designed to accommodate all varieties of members, the care plan can be used for members with the most complex conditions as well as members who are in good health.



Figure 1: WellCare's Care Model

C. Staff/Provider Network

1. Describe, if applicable, how staff and/or provider network recruitment and retention, including types of providers (*for example, primary care, specialty care, dental, HCBS, case/care management, LTC, other, etc.*)

RECRUITING AND DEVELOPING A COMPREHENSIVE AND COMPLIANT PROVIDER NETWORK

WellCare's network development process results in networks that offer members a broad array of high-quality providers who deliver the necessary scope of preventive, primary and specialty services, along with home and community-based care and long term services and supports.

Communicating and listening to the provider community, understanding providers contracting needs and concerns are key to developing an Oklahoma network. An example of such engagement includes meeting with Indian Health Services' providers, to get a full understanding of their contracting needs and the health issues affecting Native Americans. We believe that the key to successful network development is understanding the specific needs of Oklahoma's provider and member communities through intelligent analytics of claims, enrollment and demographic data related to Oklahoma's natural pockets of care, population clusters and current referral patterns.

As a potential partner, WellCare offers extensive experience in the development and management of diverse and comprehensive provider networks. We deliver services to over 4.1 million members through 348,000 contracted health care providers and 71,000 contracted pharmacies and successfully established statewide Medicaid networks in Georgia, Florida and Kentucky.

ANALYZING OKLAHOMA'S MEMBERS' NEEDS

During the analysis stage, we determine the network size based on eligible members, access and availability standards, patterns of care, member needs and required provider types. WellCare uses a variety of data sources and tools to understand the characteristics and health care needs of our members to guide our recruitment plan targets and strategies.

For example, some key facts and characteristics to be considered for Oklahoma include:

- The United Health Foundation ranked Oklahoma 47th in the health of older adults
- Oklahoma has a very diverse population with 10 percent American Indians, 17 percent Hispanic and Latino, 12 percent African American, 64 percent Caucasian and 8 percent multiple race
 - Providing culturally competent care to all members to reduce racial and ethnic disparities in access to care must be a prime focus of a prospective partner

TARGETING AND IDENTIFYING PROVIDERS

Providing members access to a selection of high quality, credentialed providers is the goal of WellCare's network development plan in each of our markets. To ensure all benefits and services are offered to children in DHS custody, WellCare recommends targeting or proactively identifying providers who are currently participating in OHCA's provider network and additional providers.

WellCare strongly emphasizes meeting the needs of members with all capacity and geographic access standards. The traditional provider networks we build include acute care, primary care, behavioral health, and ancillary providers (including home health.) We also contract with specialty providers such as Durable Medical Equipment companies, Personal Emergency Response System vendors, and Community Care Management Agencies to ensure complete coverage. WellCare develops business relationships with community organizations that serve members with specialized needs such as the Housing Authority, homeless shelters, food banks, transitional housing and employment assistance agencies.

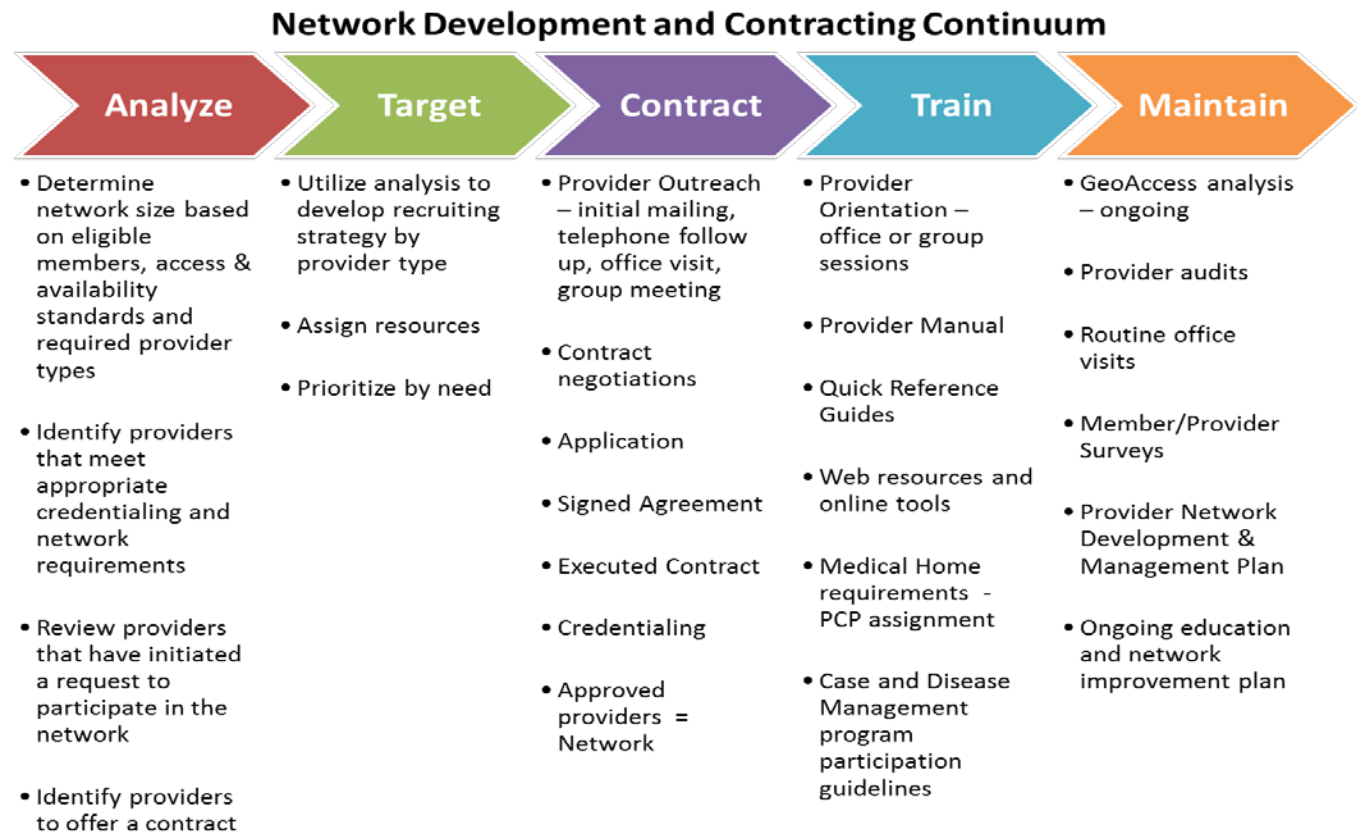


Figure 2: Network Development and Contracting Continuum

TARGETING RURAL POPULATIONS

WellCare understands the complexities and geographical variations that go hand in hand with serving statewide populations. We understand that Oklahoma has a shortage of behavioral health providers. Our network development teams offer deep experience in developing and maintaining networks that meet the unique challenges of the various regions of each state we serve to provide access to members located in rural communities throughout the state.

We identify deficiencies in access by analyzing GeoAccess[®] reports, member grievances and provider complaints on a quarterly basis. For each identified deficiency, we create an action plan using our Network Adequacy Tool (NAT). The NAT identifies the nearest appropriate provider and the surpassed distance a member needs to travel to receive necessary care. To eliminate the deficiency, our Network Management team is responsible for conducting further analysis for potential providers that may be available by looking at competitor provider directories and www.medicare.gov, and using their familiarity with the provider communities they support. As we identify provider leads, we use the NAT to track progress of our contracting efforts. In situations where no provider exists, we arrange transportation for members to the nearest identified provider.

WellCare employs a strong provider engagement model. The partnership between an MCO and its providers are key to improved quality and lower costs. For children in the foster care system it is even more important to ensure continuity of providers in addition to comprehensive care coordination.

Once a primary care provider is contracted, we utilize our provider engagement model which is designed to help both the providers and WellCare achieve our shared goal of improved health outcomes for our members by including the following key components:

- An account management structure to resolve providers' claims issues consistently and efficiently in real-time
- Personnel and tools to help improve quality scores, effective utilization and operational efficiency
- Trained associates who focus on managing relationships, timely performance and issue resolution

To maintain account ownership and accountability, our provider services representatives are the primary point of contact. Field-based associates supporting our provider partnerships include:

- **Provider Services Representatives:** These representatives specialize by provider type and are our primary provider-facing staff. They are focused on overall the provider relationship and performance for driving outcomes in quality, cost and appropriate utilization. They drive adoption of relevant tools, including electronic health records and our provider portal.
- **Quality Practice Advisors:** These highly trained staff members work directly with provider offices with a sole focus on improving health outcomes. They review quality scores against their provider peers and help providers solve issues that hinder their ability to improve health outcomes.
- **Operations Account Representatives:** Industry leading Operations Accounts Representatives are specialists assigned to high volume practices to provide education on billing practices and reimbursement policies; and resolve issues related to claims, reimbursement, authorizations and referrals. These account representatives are able to adjust claims in real time and on-site at the provider's office.
- **CommUnity Advocates:** CommUnity Advocates work closely with social safety net providers to ensure the sustainability of critical social services, establish community planning efforts to collaboratively scale best practices into new areas, and create social services where gaps exist.

Given Oklahoma's rural nature and the use of technology among children and youth we believe the use of telehealth is instrumental in expanding access to providers, especially in the behavioral health arena. WellCare will partner with providers, groups of providers, and others to extend health care resources to those in need using video technology. We work with a telehealth vendor to provide members access to live video visits with licensed physicians and behavioral health providers 24/7 by computer or a mobile application for smart phones and tablets and established telehealth kiosks at strategic locations. Below is a member story from our Georgia affiliate where tailored telehealth solutions were deployed to meet unique needs of a member.

Member Story: Telehealth: Increasing Access to Behavioral Health Care

An adolescent member living in a rural county experienced frequent inpatient behavioral health admissions. The family did not have the resources for transportation and did not want to utilize Medicaid transportation, and his behavioral health condition went largely untreated. In addition, the family experienced multiple socioeconomic stressors that greatly exacerbated the member's condition. The member was enrolled in special education services. The care manager leveraged the existing services and relationship with the school to arrange for Care Partners of Georgia to provide tele-psychiatry in the school for a weekly evaluation, assessment and medication management. As a result of the coordination between WellCare, the school and the provider, telehealth services were provided to create access to needed behavioral health services. The member's condition stabilized and he continues to attend school.

To successfully address Oklahoma's children in foster care's full range of medical, functional and behavioral health needs in a coordinated and member-centric manner, selected managed care organization (MCOs) must have a fully contracted network of providers by the effective date of the Care Coordination program. It is important for OHCA to note that a successful provider network extends beyond signing a contract with providers, it is essential that health plans forge long-term mutually beneficial provider partnerships. These partnerships must be built on trust that comes from communicating in an open and timely manner, listening to member and provider feedback and continually seeking opportunities to improve the providers' experience with both OHCA and its health plan partners.

The development of a provider network for a new managed care program typically takes approximately 12 months. For MCOs to deliver a network that offers comprehensive access to an appropriate range of quality providers, they must be allowed adequate time to recruit, contract and credential the selected providers. We believe it is important that OHCA takes this development effort into consideration as you develop your timeline for the timing of readiness review.

WellCare has vast experience in developing and maintaining Medicaid networks. For example, our affiliate, WellCare of Kentucky recently implemented a statewide provider network that currently serves approximately 442,000 Medicaid members. When our affiliate, 'Ohana Health Plan entered our Hawaii market, we developed a provider network that now supports 47,000 Medicaid members. Our affiliate in Florida, Staywell, recently expanded our network to meet members' growing needs, resulting from a recent increase in our Medicaid membership in Florida.

Transportation Services: Transportation is directly linked to how children in foster care access health care. As such, OHCA may want to consider including a Non-Emergency Medical Transportation (NEMT) benefit in their program. For children and caregivers living in smaller rural areas who lack dependable transportation, NEMT is a vital component to empowering members to effectively manage their health care. For many families, the lack of transportation presents a major barrier that often negatively impacts their ability to manage their health care. Through our experience in other states, WellCare has learned the importance of addressing transportation barriers as a critical component to holistic care management of our members. In other markets, we contract with NEMT vendors who have comprehensive NEMT networks to meet each individual markets' needs.

It is important to offer multiple innovative solutions to address transportation barriers. We often partner with local community agencies or our contracted provider/hospital systems to develop innovative ways to ensure members have access to appropriate providers that can meet all members' unique health care needs. For example in Hawaii, our 'Ohana Health Plan was challenged by the lack of specialty providers on the Island

of Kauai. To address this shortage, 'Ohana established a formal partnership with an Oahu-based hospital and clinic system to provide access to care using traveling specialists.

Telehealth: Telehealth is an excellent avenue to improve access to necessary care to members who reside in rural areas of Oklahoma. WellCare recommends OHCA consider allowing the use of Telehealth providers as an appropriate access remedy to unmet access needs in its' rural communities. In several of WellCare's markets, we successfully leveraged telehealth solutions to eliminate access barriers for members who live in rural areas or who experience functional limitations that make it difficult to access care outside of their local community. Telemonitoring can be a useful tool to address the rural nature of Oklahoma. Our affiliate, WellCare of Kentucky worked with Medicaid behavioral health providers to develop telepsychiatric services to improve access to outpatient follow-up care for patients being discharged from inpatient or residential behavioral health settings. In Georgia, there are over 300 telehealth locations in the state where residents can go to access their primary care physician or a specialist. For Medicaid recipients who live in a small rural town, instead of being transported long distances, our members can leverage many of these sites to access needed care.

Graduate Medical Education: Knowing that Oklahoma has a shortage of physicians in rural areas we recommend OHCA leverage and support graduate medical education programs, such as Oklahoma's Physician Manpower Training Commission (PMTTC). PMTTC's goal is to enhance medical care in rural and underserved areas of Oklahoma by administering residency, internship and scholarship incentive programs that encourage medical personnel to establish practice in rural and underserved Oklahoma communities. Supporting GME programs is an excellent avenue to expand the availability of providers to meet the unique needs of Oklahoma children in DHS custody.

CONTRACTING PROVIDERS

WellCare is staffed to rapidly develop a complete provider network to meet OHCA's foster children's needs. Our contracting policies and procedures are designed to ensure that all of the necessary providers are contracted and that our networks meet the desired standards for participation. Once the benefits and required providers are determined, we begin reaching out to the required providers.

Provider Contract Templates

With input from the various business departments, our in-house Legal team drafts and maintains all provider agreement templates to ensure compliance with all applicable federal and state laws, rules and regulations and our governmental contracts. The provider templates include professional (physician, physician group, IPA), facility (hospital, skilled nursing) and ancillary (DME, home health, laboratory), as well as agreements for "non-traditional" providers for waivers such as Home and Community Based Services (HCBS). The Legal department provides the templates to the Regulatory Affairs department to file with state agencies for notice and approval, as applicable. After receipt of the appropriate approvals, Legal loads these templates into our contract management system.

When new providers are added to our network, we undergo a comprehensive process to audit the contract and accompanying credentialing application for completeness and accuracy.

Common Credentialing Process

WellCare operates credentialing programs for our Medicaid plans in nine states in strict accordance with federal, state and National Committee for Quality Assurance's (NCQA) requirements. Credentialing is performed for every independent practitioner, including physicians and allied health professionals (e.g., nurse practitioners, physician assistants, licensed mental health professional), organizational providers (e.g., hospitals, community mental health centers, nursing facilities, home health agencies, Federally Qualified Health Centers (FQHCs), diagnostic imaging centers), and community-based services providers (e.g., adult daycares, assisted living facilities, private duty nursing, and other direct service providers, as applicable) in



our network. Hospital ancillary providers are not required to be independently credentialed if those providers serve our members only through the hospital. Initial credentialing is conducted prior to the effective date of the provider’s contract. All applicants undergo a comprehensive review and verification of their education, experience, licensing and other requirements in accordance with NCQA guidelines. The credentialing process begins with the provider’s completion and submission of either an electronic or paper application form. The application and all corresponding documentation are collected by our Provider Relations and Network Management department and submitted into our workflow/tracking system to Credentialing. Once the application is determined to be complete, a Credentialing associate reviews it for completeness.

WellCare recommends that OHCA work with its health plan partners to establish unified credentialing standards that leverage the common electronic credentialing resources with the Council for Affordable Quality Healthcare (CAQH). By adopting standardized credentialing standards and processes that are consistent across each health plan, provider abrasion is minimized due to credentialing inconsistencies.

Credentialing Committee

Our Medical Director reviews the application and supporting documentation for clean files. All non-clean files are presented to the Credentialing Committee for review and participation determination. Once a provider’s application is approved, a letter is sent to the provider advising the provider of the approval.

Tools

We use the Computer Assisted Credentialing Tracking Update System (CACTUS), which is an industry-leading credentialing tool, to manage inventory and information accurately and efficiently. CACTUS allows us to customize credentialing practices and generate ad-hoc reports that may be required or requested from internal or external customers. The Provider Relations team is able to use this platform to continually be aware of a provider’s status throughout the loading and credentialing process, which allows them to effectively communicate with the provider community about their credentialing status.

Contract Closure

Once the audit and the credentialing process is completed, our Provider Operations team enters a contract effective date, prints provider welcome letters and returns the letter and one original contract to the Provider Relations manager at the appropriate field office. The other original contract is retained by us. Upon receipt in the field office, the local manager forwards the contract and letter to the designated Provider Relations Representative and provider orientation occurs within 30 days.

MAINTAINING OUR PROVIDERS

Access and Availability Standards

WellCare develops and maintains provider networks that bring the greatest value to our members. We provide available, accessible and adequate high-quality providers for the provision of covered services, including all emergency services, on a 24/7 basis that meet states’ provider access and availability standards. Examples of network access and availability standards in other WellCare markets that we recommend for Oklahoma are as follows:

Provider Type	Drive Time	Availability of Providers
PCPs	Urban: 30 minutes Rural: 60 minutes	Immediate care (24/7) and without prior authorization for emergency situations
Specialists	Urban: 30 minutes Rural: 60 minutes	
Hospitals	Urban: 30 minutes Rural: 60 minutes	Appointments within 24 hours for urgent care and for PCP pediatric sick visits

Provider Type	Drive Time	Availability of Providers
Emergency Services Facilities	Urban: 30 minutes Rural: 60 minutes	Appointments within 72 hours for PCP adult sick visits
Mental Health Providers	Urban: 30 minutes Rural: 60 minutes	
Pharmacies	Urban: 15 minutes Rural: 60 minutes	Appointments within 21 days for PCP visits (routine visits for adults and children)
24-Hour Pharmacy	Urban: 60 minutes Rural: N/A	Appointments within 4 weeks for visits with a specialist or for non-emergency hospital stays

Monitoring Networks

We continually monitor our networks to identify areas for growth using the following methods:

GeoAccess®: WellCare uses the Optum GeoAccess® GeoNetworks® software to analyze and monitor potential provider network gaps. GeoAccess software allows us to comprehensively monitor our network to maintain and exceed the time and distance standards. We use reports from these systems to analyze member access to providers by mapping provider locations against member locations to determine the time and distance to the closest provider and to calculate the number of members per provider to determine capacity. In addition to general geographical access review, we examine the number of primary care providers (PCPs) with open member panels by geographic location.

In addition to GeoAccess reports, we conduct ongoing monitoring activities to ensure network adequacy. Network monitoring tools include HEDIS® results, provider efficiency reports, operational dashboard reports, member grievance and appeal data, provider complaint and appeal data, appointment availability, out-of-network usage reports, and member and provider satisfaction surveys.

Members Complaints Grievances and Appeals: We have a strict and formal process, supported by robust tools and technology that ensures that every complaint, grievance and appeal is appropriately captured, logged, documented, tracked, resolved and reported on from beginning to end. In addition to resolving individual member issues, we trend and analyze grievance and appeals data to identify potential systemic issues so that we can address network needs.

Retention Strategies to Promote Provider Satisfaction and Improve Quality of Care: To enhance the quality of care delivered to members and retain high-quality providers in the network, WellCare invests extensively in a professional Provider Relations staff and information technology. We invest in staff to support preventive health care imperatives and employ professionals who work in local communities to deliver education and consultation to providers and provider practice sites on a number of preventive and chronic health management measures. Staff working in the communities assists provider offices with barrier analysis and developing strategies to better serve members and improve compliance within the practice.

CLOSURE OF NETWORK GAPS

Local provider relations representatives, case managers and member service representatives serve as key resources for identifying gaps in the network. As network gaps are identified an action plans is developed promptly. To eliminate the deficiency, the local Network Management team conducts further analysis for potential providers that may be available by analyzing competitor provider directories, professional society membership data and www.medicare.gov, as well as applying their familiarity with the provider communities they support. As we identify provider leads, we track the progress of our contracting efforts. In situations where no provider exists, we arrange transportation for members to the nearest identified provider and capture the exception data for reporting. Each network gap is thoroughly reviewed and addressed at

each committee meeting, where we address background information and potential solutions. This process occurs even when a gap is longstanding or reoccurring to allow the committee an opportunity to share insight regarding new alternatives for members to receive care.

PROVIDER TRAINING

WellCare recommends offering a robust training program designed for training providers on Medicaid programs. Suggested activities include, but would not be limited to:

- Extensive training curriculum for providers
 - Initial provider orientation
 - Cultural Competency: Provider program
 - Secure provider portal overview
 - Interactive HEDIS Online Portal Training
- Ongoing training, such as:
 - Refresher training
 - Training on new policies, procedures and processes
 - Training on newly offered benefits, etc.
- A variety of modalities and locations, accessible real time at the time and frequency needed by the provider
- Specialized training sessions by provider type such as professional, ancillary, facility, LTSS and behavioral health
- All training material available on a provider website for convenient 24/7 access

RE-CREDENTIALING

Providers are typically re-credentialed every three years. The re-credentialing process includes: mailing a re-credentialing application; reviewing the application; performing primary source verification; and making approvals and decisions through the Medical Director and Credentialing Committee. Following re-credentialing approval, an approval letter is sent to the provider. In the event re-credentialing is denied, the provider is notified of the Credentialing Committee's determination and advised of his or her right to appeal.

D. Payment Structure

1. Explain payment methodology, assumptions, and constraints related to the care coordination models
 - a. Specific to covered benefits and services
 - b. Specific to other benefits and services
 - c. Show estimated amounts of provider payments for evidence-based performance outcomes
2. How does your Care Coordination model address potential CMS concerns regarding duplication of care/payment? Explain how proposed payments comply with existing and proposed Federal and State requirements.

PROVIDER PAYMENT METHODOLOGY

WellCare supports a variety of provider payment structures including fee-for-service, traditional capitation, shared risk and full risk models, with the goal of meeting providers where they happen to sit on this payment and risk continuum. We are providing information on standard provider payment structures with goals that focus on:

- Improving member health outcomes
- Developing and implementing care management protocols to ensure members receive the most clinically appropriate evidence-based health care and services in the most appropriate setting, in a person-centered manner, while delivering care in a cost-efficient manner
- Increasing member satisfaction
- Reducing administrative costs through better coordination of Medicaid payments

Capitation and risk models are most effective when larger Medicaid populations are included in a procurement.

ASSUMPTION

With these goals in mind, we recommend an evolving compensation continuum that over time, usually by the year three of the program, can be transitioned to a value-based purchasing (VBP) model. VBP models are designed to improve members' health outcomes and increase members' quality of care based on providers achieving specified performance levels in Oklahoma.

Descriptions for the various types of compensation for each type of provider follow:

Primary Care Providers (PCPs)

At WellCare, our PCPs are compensated based upon one of the following methods of payment:

- **Fee-for –Service:** PCPs are often paid on a fee-for-service basis as a percentage of the Medicaid fee schedule. In areas of the state where contracting may be more challenging (usually rural areas), PCPs may be paid on a fee-for-service rate that is a higher percentage of the Medicaid fee schedule, at a percentage of the Medicare allowable or a percentage of billed charges.
- **Capitation:** Some PCPs are paid on a capitated basis, which is a flat per member per month (PMPM) rate.
- **Shared Savings:** Shared-savings and shared-risk opportunities can be offered to the applicable PCPs such as Patient Centered Medical Home (PCMH).

Specialty Services

Specialty providers are compensated under the following methods of payment:

- **Fee-for –Service:** Specialists are predominately paid on a fee-for-service basis as a percentage of the Medicaid fee schedule. In some areas where contracting is more challenging (usually rural areas or for less common specialties), specialists are paid on a fee-for-service rate at a higher percentage of the fee schedule, at a percentage of the Medicare allowable or a percentage of billed charges.
- **Per Diem:** Mental health residential services are compensated based on contractually-determined daily rates.
- **Capitation:** Occasionally there may be a need to pay some specialist providers on a capitated basis, which is a flat PMPM rate. Capitation for specialty services is usually paid to a network, which is paid slightly more than the fee-for-service equivalent to provide some administrative services, such as utilization management, customer service, network development, provider relations or claims payment.

Hospitals and Tertiary Facilities

Hospitals, including tertiary care facilities, are most commonly paid at a percentage of the Medicaid rate for inpatient services and a percentage of the Medicaid outpatient line item rate for outpatient services.

Ancillary Providers

Ancillary providers are compensated based upon one of the following methods of payment:

- **Fee-for-Service:** Some ancillary providers are paid on a fee-for-service basis at a percentage of the Medicaid fee schedule.

- **Capitation:** Some ancillary providers are paid on a capitated basis, which is a flat PMPM rate. Capitation for ancillary services is usually paid to a network, which is paid slightly more than the fee-for-service equivalent to provide some administrative services, such as utilization management, customer service, network development, provider relations or claims payment.

Public Health Facilities

Federally-Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are reimbursed through cost-based or fee-for-service methodologies that equal or exceed the Medicaid prospective payment system.

Pharmacies

Pharmacies are paid on a formula of Average Wholesale Price (AWP) minus a percentage plus the dispensing fee or the Maximum Allowable Cost (MAC) plus the dispensing fee; whichever is less.

RECOMMENDATION

We recommend for OHCA to follow a transparent process and publish an Oklahoma standardized Medicaid fee schedule. Complete transparency of the payment structure process facilitates the development of adequate actuarially sound rates and ultimately, the best possible care for Oklahoma's children in DHC custody.

CONSTRAINT/RISK

Deviating from a standardized Medicaid fee schedule—in the event providers desire additional payments—could pose constraints or risks to health plans' development of an adequate network of providers to partner with to offer these children person-centered care coordination.

PROVIDER PERFORMANCE INCENTIVES

WellCare recommends that OHCA encourage the use of alternative payment models that align payment with quality and efficiency to achieve the goals of better care, better health, sustainable costs and equity. We recognize and understand the importance of providers in improving members' health outcomes and quality of life. As noted previously, we view providers as partners in providing care to our members, cost efficiency and improving members' overall quality of life. WellCare believes that our work with our network providers is a partnership where each brings its expertise to bear and the result is improved health for the community and for our members. We provide tools, resources and incentives to enable our providers to achieve that high quality standard.

Value-based purchasing (VBP) program

WellCare recognizes that a MCO's ability to meet members' needs is possible only through robust network of providers who are committed to quality outcomes. WellCare's VBP program links provider reimbursement to improved performance on measures of quality, efficiency and integration. It consists of the following four components:

- Provider Pay for Quality incentive (P4Q) program
- PCMH incentive program
- Shared Savings program

Pay for Quality Incentive (P4Q) program: We design our P4Q programs to align incentives with our provider partners around quality performance. The incentives reinforce our high standards for care rendered to our members and complements key provider quality management activities to ensure compliance with evidence-based practice protocols and clinical practice guidelines, such as regular quality improvement audits, office visits, and outreach and training. Providers who demonstrate high levels of performance or continued significant performance improvements are recognized through our P4Q program. We have considerable experience operating P4Q programs in both Medicaid and Medicare and offer it on an enterprise-wide basis. It is a core component of how we do business. Our Medicare program, for example,

aligns provider bonuses with HEDIS measures and sets the targets for payout at levels consistent with CMS STARS measures. In Medicaid markets, provider offices are encouraged to contact their non-compliant members (using their "Overdue for Visit" reports) and offered financial incentives for strong or improved HEDIS results based on the NCQA's national percentile rankings for HEDIS measures for Medicaid health plans.

Our P4Q programs promote the timely completion of health care and preventive services and improve the quality of care for our members. WellCare pays qualified providers a bonus for ensuring eligible members have received the applicable HEDIS measures' services and that we have received claims/encounters or medical records documenting these services. Our Partnership for Quality (P4Q) program paid providers nearly \$1.2 million in 2016. WellCare does not make specific payments, directly or indirectly under a physician incentive plan, to a provider as an inducement to reduce or limit medically necessary services to members. Our P4Q programs do not contain provisions that provide incentives, monetary or otherwise, for withholding medically necessary care.

Medicaid versions of our P4Q programs are geared towards key HEDIS measures that align with the priorities of our State partners and our most critical areas for performance improvement in population health outcomes. We typically include approximately 10 measures in our Program each year to drive focused improvement. Experience has taught us that having too many measures dilutes physician focus and understanding of the opportunity. In 2015, we made changes to our enterprise P4Q Program to reward either performance or improvement. In the past, we had set targets based on absolute NCQA thresholds (e.g., 50th/75th percentile). However, experience has also taught us that, while we aspire to these highest levels of performance, there are large numbers of providers – particularly in rural and inner city areas – that are not yet operating at these levels. Therefore, recommend offering a more broad incentive opportunity to reward providers at lower levels of absolute performance who have demonstrated year-over-year improvement in their measures.

For new programs, we recommend phasing in the incentives. The following outlines a suggest approach to phasing in P4Q incentives:

- Guiding Principles to WellCare's P4Q Programs - Year One considerations:
 - Ease the provider community's transition into integrated managed care by ensuring physicians are incentivized to see their newly assigned members as quickly as possible and assess their health care needs
 - Align the proposed incentives with the States designated withhold measures, which will result in enhanced provider focus on Oklahoma's managed care Medicaid objectives
 - We will establish baseline performance across our participating provider network
- Operational Aspects WellCare's P4Q Programs (Year One):
 - Open the P4Q program to all participating WellCare providers
 - P4Q incentive payments driven by key CPT codes that are aligned wherever possible to the withhold measures
 - Incentive payments take the form of enhanced fees for specific codes and are paid out during standard claims processing, as opposed to retrospective calculation
 - Establish a set threshold percentage of members that must be seen in a given time frame in order to qualify for ongoing participation; otherwise providers may be subject to removal from the enhanced fee schedule
 - Provide provides extensive education and communication around their respective P4Q payment so that they have a precise understanding of what is being rewarded and why
- Operational Aspects WellCare's P4Q Programs (Year Two)

- Use established baseline performance data and move beyond a transactional model of incentives, to incentives geared toward provider-specific performance on Oklahoma’s withhold measures
- Calculate incentive payments based on increased performance above the baseline, not just billing codes and reward performance or improvement

In new programs, over time our P4Q programs evolve into true VBPs. As our P4Q programs evolve in to value-based contracting tied to both quality improvement and cost efficiency, we more heavily leverage our shared risk and corresponding surplus to reward providers.

PCMH Incentives: WellCare strives to provide a holistic, person-centered approach to members’ care. We do so in a number of ways, including significant investments in PCMH. PCMH recognition is a financially intensive process. As such, we invest in our providers and practices to help them become recognized PCMHs, through the NCQA Partnership in Quality Discount. This investment assists us in building a solid foundation of primary care, where the focus is on the whole person and not just their behaviors or symptoms.

An example of our PCMH incentives is our affiliate WellCare of Georgia’s partnership with NCQA that offers small practices (up to three providers) a 20 percent discount on the per-clinician NCQA application submission fee. Through this discount, we help alleviate some of our providers’ financial burden. WellCare of Georgia also offers three types of technical assistance—documentation templates; documentation review and gap analysis; and training modules on NCQA recognition requirements and standards—to practices with five or fewer provider that want to earn NCQA PCMH recognition.

Participating PCPs, Practice Groups, Independent Practice Associations (IPAs), Physician Hospital Organizations, Federally Qualified Healthcare Centers, and Rural Healthcare Centers that have employed or contracted PCPs are eligible to participate.

Shared Savings Performance Incentives: WellCare provides shared-savings (upside only) and shared- risk (upside and downside) opportunities to large primary care groups. WellCare uses these risk based reimbursement programs as a means to support our efforts to align physician reimbursement and improved quality, and we use shared savings under this program to reinvest in technology, data sharing and care management programs. WellCare’s physician incentive plans provide a framework to encourage physicians to manage the care of their member panels so that the total medical costs divided by the total premium do not exceed a targeted Medical Loss Ratio (MLR). This reimbursement model motivates providers to effectively manage the continuum of care provided to members including key performance measures such as hospital readmissions rates and member emergency room visits.

In 2014 our shared savings and shared risk templates were updated to include the addition of quality metrics and a target quality score. The provider’s performance on the quality metrics has a direct impact on the incentives paid through this type of agreement, including a “quality floor,” below which shared savings achieved through a low MLR will not be paid out.

Addressing potential CMS concerns regarding duplication of services: WellCare’s philosophy of creating a patient-centered care plan and our collaborative nature with community providers and other partners enables us to maximize the very limited resources in a state. It also enables us to ensure that we are not duplicating Federal funds. We currently utilize our data systems to ensure the appropriate payment sources within an Individualized Education Program (IEP) for our Medicaid eligible children. This system could easily be expanded to ensure compliance with all rules and regulations of the Medicaid and the Title IV-E programs.

E. Impact of Model

1. Explain estimated implementation costs and anticipated savings for the first five years of an

implementation of your model

- a. Methodology
- b. Assumptions
- c. Constraints

2. Describe the quality and anticipated effect of the care coordination models on the target population with respect to the following:

- a. CMS recommended benchmarks
- b. State identified areas including preventative screenings, tobacco cessation, obesity, immunizations, diabetes, hypertension, prescription drug use, hospitalizations, readmissions, emergency room use
- c. Core measures identified within the Oklahoma Health Plan (OHIP) 2020
- d. Respondent suggestions for other benchmarks
- e. Considerations for Value-Based performance designs, specifically those that support and align with objectives identified within the Oklahoma State Innovation Model design

It is difficult to predict the specific potential for savings for the SoonerCare Children in DHS population under a Fully Capitated MCO model as the amount of savings is largely dependent on how the program is designed and implemented, specifically whether additional Medicaid populations would be included in any potential procurement. Additionally, significantly more data needs to be made available regarding utilization patterns and member acuity levels to identify specific savings opportunities. However, based on WellCare's experience managing such models in other states, we can provide guidance on conditions that optimize savings potential versus those things that can reduce the program's ability to achieve savings.

Savings are optimized when MCOs are afforded the flexibility to work with providers, members and partner agencies to structure key components of the program to meet member needs without unnecessary prescription that limits innovation. For instance, greater savings can be achieved if the MCOs and their partners are able to control and manage the following:

- Prescription drug costs through the use of their own PDLs
- Contracts, fee schedules and financial alignment tools that are developed and implemented in partnership with network providers
- Specific care management processes that allow for efficiencies while maintaining a member-centered and interdisciplinary approach
- Service and benefit selections that meet individual member needs without prescription for cottage or protected industries that may not provide proven value
- The limited use of non-participating providers through appropriate time limits and rate structures for providers outside the MCO's network (once the MCO has made a substantiated and fair effort to contract with that provider)
- Consideration of alternative emergency room payment structures

WELLCARE'S QUALITY MANAGEMENT PROGRAM

At WellCare, quality management principles are integrated into all aspects of health care policy and operations and reflect a focus on local population health imperatives. Implementing quality management (QM) programs are a core competency for WellCare operating in 11 Medicaid states. With close to 400 dedicated Quality staff members across our shared services and local health plans, we are committed to providing high-quality care that improves our members' well-being and enhances population health outcomes for the communities we serve.

Our QM program structure and processes are strategically planned, systematic and objectively defined and measured. Our quality activities demonstrate the linkage of our quality improvement projects to the Oklahoma State quality strategy, findings from annual internal and external audits, opportunities for improvement identified from the annual HEDIS indicators and member and provider surveys, internal surveillance and monitoring, and findings identified through accreditation activities. WellCare's QM program would incorporate the unique needs of the Oklahoma Medicaid population including members from diverse geographical, racial, ethnic and gender groups.

WELLCARE'S QUALITY MANAGEMENT PROGRAM INFRASTRUCTURE

Quality is fully integrated into each area that impacts the member including behavioral health, utilization management, community advocacy, care and disease management, grievances and appeals, network development and management, operations and pharmacy.

We coordinate with the following shared services quality teams to perform various quality functions:

- Quality Programs & Analytics perform clinical quality program design and implementation, clinical HEDIS project management oversight and campaign/imitative development along with evaluation and oversight.
- Quality Reporting & Analytics performs analysis related to all aspects of quality, retrospective analysis and trend analysis from a quality improvement perspective.
- Quality Accreditation & Audit performs EQRO activities and audits, NCQA[®] accreditation and internal compliance file audits and appeals.
- Quality Strategic Initiatives performs operational implementation and oversight of strategic initiatives. The strategic initiatives link to operational teams, member and provider communications, and overall project management for national campaigns and local action plans. WellCare's establishes local market liaison teams that modify national campaigns to meet the needs of local markets and ensures detailed quality plans are effective.

QUALITY MANAGEMENT PROGRAM LINES OF ACCOUNTABILITY

WellCare's QM program committee structure has been designed for maximum engagement and effectiveness, ensuring participation of multiple voices into the quality process and providing structured and robust oversight of activities and the quality of our program as a whole. Our committee structure and approach includes regular meetings, well-defined operating parameters, documentation of committee activities, clear accountability and would include Oklahoma-based membership.

Ensuring Leadership Accountability Through Committee Engagement

Findings from our Quality interventions are reported to clinical and executive leadership including the market's medical director, Quality Improvement Committee (QIC) and other (QM)-related committees. The QIC directs and reviews WellCare's quality improvement and utilization management activities, and has the authority to create and provide direction to work groups, committees, and departments within the health plan to assess, investigate, and take action related to the health care services received by members.

WellCare also conducts Quarterly Business Reviews (QBRs) with all of the senior management team and several other leaders from across the organization. In these QBRs the team reviews progress on key shared services initiatives, including topics like compliance, care management, quality and operations for effectiveness and efficiency. This also includes reviewing for overall profitability, areas of concern, and progress on agreements made with the government partners. In case any area of opportunity is identified, the QBR ensures an executive owner is assigned to that function.

Member and Provider Advisory Committees

WellCare improves the health of our members and promotes a patient-centered delivery system by building

effective partnerships with the people we serve as well as our provider network and state and local advocates. We’ve been establishing Member Advisory Committees (MACs) and Provider Advisory Committees (PACs) nationally for nearly ten years and we currently have committees in 11 Medicaid states and we will establish these committees in partnership with key providers and members across Oklahoma.

Our MACs and PACs, which are often distributed regionally, meet at least quarterly and are led collaboratively by our Quality Improvement, Community Advocacy and Provider Relations teams. Member Care Support staff also help facilitate committee activities, which include discussions around complaint and appeal trends, member satisfaction data, in-home support service gaps, member appointment wait times, community outreach, provider outreach and quality improvement planning. Issues brought to our committees have improved provider partnerships and member health outcomes.

Improving Operations Through Member Advisory Committee Feedback

Our local health plan in New Jersey helped our shared services web team collect feedback from MACs and PACs that impacted the changes we made to the WellCare public website (<https://www.wellcare.com>). The New Jersey MAC and PAC members, along with other states and channels, completed a survey on the usability of our websites. The feedback revealed areas of opportunity to improve website navigation such as the design of the “Find a Provider” online searchable provider directory along with state identifiers. We redesigned the web site based on feedback including the ability to search the “Find a Provider” tool by keywords such as “heart” in order to find all related results and improve navigation.

SELECTING AREAS OF FOCUS

WellCare builds its areas of focus on the Oklahoma Health Care Authority’s requirements, NCQA standards, HEDIS requirements and clinical practice guidelines. When developing the initiatives in the QM work plan, we start with the OKHCA Quality Strategy, considering the state’s unique demographics and geographic regions. For example, the Oklahoma strategy may frame a population health focus with goals for improving the management of Diabetes, hypertension and obesity, all key indicators for the OHIP 2020 plan and SIM grants. We evaluate HEDIS, CAHPS, Quest data and areas of interest from community meetings to identify areas of opportunity that would have the most benefit for our members. We also incorporate recommendations on opportunities for improvement from providers, WellCare staff and committees, the results of Performance Improvement Projects (PIPs), and improvement goals. We also leverage best practices from across our shared services capabilities, programs, campaigns and tools, modifying them to fit the needs of local Oklahoma populations. The design process uses the Plan-Do-Study-Act (PDSA) method to develop and improve initiatives. Under the PDSA approach, multiple indicators of quality of care and service are reviewed and analyzed against benchmarks of quality in clinical care and service delivery, analyzing intervention results and modifying as needed.



Figure 3: PDSA model

Assessing the Quality of Care

WellCare has extensive analytic and reporting capabilities that are leveraged in a population health approach to assess the quality of care provided to potential Oklahoma members and to monitor the impact of improvement initiatives. For example, we regularly survey our members through CAHPS to assess ongoing

satisfaction with care and we employ rigorous benchmarking using HEDIS measures to identify where under-performance might indicate problem areas that could be improved.

Engaging Associates with WellCare's Quality Line

In January, we launched the WellCare Quality Line to help solve issues close to the frontline where we directly engage our members and their caregivers. The Quality Line allows associates to share quality issues or ideas via telephone or web. The feedback is vital and used to deliver high quality care and service to our members and to improve Quality throughout the organization.

USING EVIDENCE BASED PRACTICES TO IMPROVE QUALITY

Our commitment to continuous quality improvement is demonstrated in our use of evidence-based best practices. Examples of evidence-based best practices aimed at quality improvement are our Quality Practice Advisor (QPA) program, our Patient Care Advocate (PCA) program and our member and Provider Advisory Committees, each of which are described below.

Quality Practice Advisors

Through our efforts to continuously improve our partnership with providers and to improve quality of care for members, a program was created to fit the need of our providers with face-to-face quality education and guidance. The Quality Practice Advisor (QPA) program's goal is to provide continuous quality improvement through WellCare associates with background and training in Quality engaging in direct interaction with our providers. The QPA partners with providers to offer education and guidance on quality trends specific to their practice patterns and membership. They support providers identifying and closing quality of care gaps by providing resources for the provider and member. We currently employ more than 110 QPAs, who consult with providers and their office staff, in person as well as telephonically, to help them

- Understand HEDIS measures and improve data capture including our medical record flat file transfer process and interactive HEDIS online portal
- Access and use available tools (i.e., HEDIS Provider Toolkit, care gap reports)
- Improve medical record documentation
- Identify strategies to overcome barriers and issues of non-compliance (i.e., member outreach, capitalizing on sick visits, unable to contact strategies)
- Understand barriers members may face in adhering to screenings and services
- Maximize available financial incentives

By targeting providers with the greatest share of members in their member panel and aligning them with a QPA, we have improved the delivery of services and related documentation. Using QPA visits data from 2015 as well as claims data for services provided throughout 2015, we analyzed provider-level performance of those PCPs who had a least one QPA visit compared to those PCPs who did not. Every market had improved results with **some achieving as much as statistically significant improvements in over 50 percent of their HEDIS measures.**



Innovation

Patient Care Advocates

Our patient care advocate (PCA) program is both a service enhancement for providers and a best practice. Through our HEDIS and care gap discussions with providers, we found many were engaged and eager to address gaps in care but lacked resources needed to conduct member outreach and follow up. We developed our PCA program in 2013 in response to this need. PCAs are WellCare employees who are colocated in select network provider offices and are focused on scheduling appointments for targeted members with

WELLCARE'S
PATIENT CARE
ADVOCATES
IMPROVE MEMBER
COMPLIANCE

Florida evaluated
their PCA program
and the results
revealed
improvement in

85%

of the measures
studied over the
prior year.

identified gaps in care including immunizations, ADHD follow-up, asthma medication adherence and well child visits.

Using our proprietary PCA database, our PCAs access key member and provider information including members' individual gaps in care and then contact members on behalf of the provider to schedule appointments. During the outreach, the PCA identifies member-specific barriers to care and works with the member to overcome these barriers. PCAs also meet with members prior to their PCP appointments to discuss the identified care gaps and educate them on the importance of preventive care and the need to establish a medical home with a PCP. Our PCAs also collaborate with the PCP by communicating member care gaps that need to be addressed during the visit.

Based on the results of our PCA program, we are confident our investment in PCA resources has helped ensure members' physical and behavioral health needs are being met by improving member and provider adherence to recommended services through the powerful combination of QPAs, PCAs, and P4Q.

SUPPORTING THE OHIP 2020 QUALITY STRATEGY

WellCare's QM program is fully aligned with the OHIP 2020 quality plan and population health focus. We put the infrastructure and processes in place to forward the quality goals as outlined in the State strategy. In alignment with the OHIP 2020 quality strategy, we have made strides in implementing initiatives for populations with Diabetes, obesity and immunizations that have resulted in improvements in multiple HEDIS measures. Our efforts to improve the population health has the following results:

- 39 increases and 42 significant increases in measures for Diabetes
- Increases in asthma medication management
- Increases in measures for controlling high blood pressure across 10 or more populations.

Our QM program also aligns with the quality strategy in its focus on core preventive health measures such as our work on improving Annual Dental Visits and BMI Weight Assessment and Nutritional Counseling.

As part of our commitment to ensuring productive and comprehensive annual preventive visits, we have created a two-page form for Preventive Health Counseling and Education for Children and Adolescents that is associated with seven significant increases across our populations. This form focuses on BMI percentile and all recommended counseling for children. It includes a checklist for ease of use by providers and covers documentation and recommended coding according to NCQA HEDIS guidelines. The form is distributed and available to all providers with pediatric members and our Provider Relations Representatives and Quality Practice Advisors offer additional copies and education.

We design our PIPs around the specific needs of the population we serve, as outlined in the State's Quality Strategy.

USING DATA TO DESIGN, IMPLEMENT AND EVALUATE THE EFFECTIVENESS OF THE PROGRAM

Led by our chief medical director of quality, WellCare's shared services Quality Department supports national program design, data collection, data analysis, and reporting functions for all our locally-based local plans. This multidisciplinary team comprises analysts, developers, data administrators, and informatics experts who know our systems, understand the data within the systems, and have the experience to report the data in a manner that supports the analytics required to effectively manage care for our members.

WELLCARE'S "SHOW ME SMILES" PROGRAM BRINGS DENTAL EDUCATION TO 10,000 CHILDREN

Our affiliate in Missouri partnered with 340 organizations, including Head Start, day care programs, elementary schools and child sports leagues, to educate pre-K to 3rd grade children about the importance of dental health through songs and role playing. Since its debut, more than

64,000

children have received dental supplies, educational coloring books and dental education for their parents. Our Missouri affiliate most recently had 4 significant increases in Annual Dental Visit HEDIS measure across populations.

We have effectiveness measures of our campaigns to inform continuous improvement.

Our local WellCare Quality team executes the quality management program locally, driving clinical and service performance, prioritizing problem areas for resolution, designing strategies for change, collaborating with State and local partners, implementing improvement activities, supporting providers toward improvements, and evaluating success of interventions. This team works closely with our Information Technology Department to provide innovative reporting and trend analysis utilizing the Tableau® server. As part of the local Quality team, QPAs will use this data as well as data from HEDIS reports and the P4Q dashboard to address care gaps with providers and work toward improvement in quality of care. Also part of the local Quality team, PCAs will use similar data to design provider education programs. As stated earlier, we have measured the results of our QPA, our Pay for Quality Programs and member outreach initiatives.

F. Data Management

1. How does your care coordination model provide for efficient management of data to ensure that the child experiences quality and safety?

WellCare has invested extensively in our single, integrated platform that provides a single data repository with comprehensive member information including physical, behavioral health and social services accessed. Information is available, as appropriate, to all members of the care team on multiple platforms (web, tablet, smart phone). Care team wide care gap notifications, even the Community Assistance Line (our social services link) can see gaps in care and alert the member and care giver. This provides a high level of efficiency, quality and safety.

WellCare's data management system incorporates and integrates a comprehensive set of modules designed to proactively support preventative health, wellness, and care management activities. This suite of applications directly incorporates all aspects of quality and clinical outcomes to support the physical (including dental, pharmacy, vision, and others), behavioral, and social needs of our members. The solutions also embrace and incorporate support for leveraging the Integrated Delivery Team, ensuring we involve and provide critical access to all participants in the health system that support member care and outcomes.

In engineering disciplines, form follows function. The result is that the architecture and design of our solutions directly reflect our corporate focus and commitment to delivering holistic, patient-centered, high quality care to our members. Meeting and serving the needs of the Quality and Clinical Outcomes capabilities is a primary focal point of all aspects of our applications.

Key functional attributes of this application include:

Data Collection is critical to the implementation of our holistic, patient-centered, high quality of care model. Properly managed, more data facilitates better outcomes.

Data is collected from various internal and external sources and includes: Information from OHCA's 834 and claims history data, provider and laboratory submissions, transition information from other health plans and Health Information Exchange data. This data is collected and utilized in the following ways:

- Data from internal Operations applications (such as Claims and Encounters) is directly captured and utilized in Quality and Clinical Outcome processing
- Member Health Assessments and Risk Surveys are completed and incorporated as a valuable source of care management opportunities
- Data from all these sources is assembled and compiled to form a complete logical Clinical Repository for use in driving Quality and Clinical outcomes

Identification activities leverage all data sources to identify service and care management opportunities

- Preventative schedules are applied to identify service gaps from programs such as EPSDT, Vaccination, and other preventative schedules based on member information, including follow up activities from EPSDT screenings
- Referrals from providers, caregivers, care managers and other knowledge sources with direct member interaction are captured and utilized
- The Clinical Repository is examined to identify conditions which require or suggest opportunities to provide assistance and care management to members. Examples include identification of chronic conditions, disease states, lab or exam results, and pregnancy indications
- The Clinical Repository and operating data are examined to identify events such as hospital or emergency room admission, provider referrals, and health plan transition
- The Clinical Repository and operating data are reviewed for patterns such as frequent Emergency Room utilization to identify opportunities for education and intervention
- In addition to review during stratification, a member's identification data results in the creation of a Care Gap repository used throughout the WellCare applications to communicate the need for preventative services

Stratification functions result in actionable indicators of the best course of action for each individual member. Numerous factors are considered in determining the nature and intensity of intervention, including:

- The nature and severity of the condition(s) or event(s) leading to the care management opportunity
- The acuteness and complexity of a member's health status (including co-morbid conditions)
- The availability of support from family, social and community resources
- The individual member's preferences, ability to be reached through various communication channels, and historical indications of response
- The reason for facility admission, member's health status, and the facility of discharge
- Transition events provide historical interventions and prevent disruption of existing care management activities
- Conditions such as pregnancy, obesity, chronic illness, and diabetic diagnosis are evaluated for clinical best practices and intervention opportunities

The appropriate **Health Management** resources, plans and activities are initiated based on the results of the Identification and Stratification processes.

- Assignment to specific intervention programs, care management approaches (education, telephonic care management, field based care management) as well as assignment to an appropriate care manager is made
- Care management plans, transition plans, and discharge plans are all initiated based on historical best practices and the stratification results
- Care Management staff are able to evolve and maintain the care plans as appropriate to include all of a member's physical, behavioral, ancillary service and social needs
- The Health Management application ensures participation opportunities for all members of the Interdisciplinary Care Team (ICT) by providing access to critical information and accommodating their preferences for communications
- Ongoing re-evaluation based on member progress, additional information, service utilization, or admission events is monitored and communicated to care managers and ICT participants. Where viable and appropriate, this includes automated notifications (preferably using HIE capabilities)
- All modes of support and activity are supported, including educational notifications, telephonic care management and field-based care management to maintain continuity as individual members require



more or less intense care management activities

Utilization Management includes solutions to facilitate the timely and accurate evaluation of a request for managed services. Primary functional components are:

- Receipt of the service request (pharmacy, medical, admission, social, etc.)
- Evaluation of the request against evidence-based criteria, the member’s health history and status, and any Care Plans by qualified medical staff
- Recording and communication of the decision to members and providers
- Tracking, monitoring, and ensuring compliance with response timelines

Vital to Quality and Clinical Outcomes is the ability to **Monitor & Measure** the adherence to and effectiveness of the programs and actions in place and the ability to implement future enhancements. Key functional capabilities include:

- Generation and ongoing publication of HEDIS results as a primary means of effectiveness
- Generation and communication of Provider Profiles to identify opportunities to collaborate with and educate providers on opportunities to improve member health outcomes
- Tracking individual member health status, participation and adherence to Care Plans and Medication schedules
- Tracking Care Gaps, publishing to members, providers, care givers and care managers to assist in completing these vital preventative health activities

Significant integration and support for these activities is provided by all aspects of the technical solution’s architecture. The table below illustrates how each technical component provides support to the Quality and Clinical Outcomes activities:

Customer Service and Self-Service Solution Components	
WellCare.com – Secured Member Portal	<ul style="list-style-type: none"> • Provides access to educational materials • Provides access to historical communications, including Health Management documents • Provides member access to Care Plans • Used to automatically notify members of Care Gaps
WellCare.com – Secured provider portal	<ul style="list-style-type: none"> • Provides access to educational materials • Provides Integrated Delivery Team member access to Care Plans • Used to automatically notify providers of Critical Care Gaps for members during eligibility verification and in a roster format • Able to be used to provide admission notification in the absence of Health Information Exchange capabilities • Allows direct access to submit Authorization requests, including access to a tool that will indicate if an authorization is even required
MyWellCare – Member Mobile application	<ul style="list-style-type: none"> • Also utilized to notify members of Care Gaps • Includes tools to determine Urgent vs. Emergency needs and provide driving directions to nearby Urgent Care locations
CareConnects	<ul style="list-style-type: none"> • Automatically alerts call center agents to Care Gaps to facilitate closure, including providing assistance in scheduling appointments • Notifies call center agents of the appropriate care manager to



Customer Service and Self-Service Solution Components	
	facilitate transfer as appropriate
Communications and Correspondence Module	<ul style="list-style-type: none"> Generates correspondence on Quality and Clinical Outcomes, accessible via secured member portal as well Assists in determining member preference and reachability to improve the effectiveness of Care Management campaigns
Claims and Encounters Processing	<ul style="list-style-type: none"> Integrates with Utilization Management to ensure payments for authorized services Provides critical service data for inclusion in Care Gap identification and closure, Care Management Identification and Stratification, and Monitoring and Measuring reports
EDI Services	<ul style="list-style-type: none"> Supports the collection and incorporation of Service, Social, Demographic, Clinical, and Transition information using industry-standard and supplier-proprietary formats. Enables the collection of needed data through any means available
Enterprise Information Management	<ul style="list-style-type: none"> Assembles the critical component of a Clinical Repository Calculates HEDIS and other Quality scores and integrates results into the Care Gap Repository and the Provider Profile Provides actionable events such as hospital admissions for the initiation of Care Management activities Provides the repositories to support analytics and identification of Health Outcome programs Provides the repository for ongoing evaluation of clinical program effectiveness and individual health outcomes

G. Care Coordination Implementation Timeline (*including key activities and milestones*)

1. Based on prior experience, provide insight into what a realistic timeline for implementation of your care coordination model might be. Specifically, provide details into the following aspects of implementation of a care coordination model similar to what has been described:

- a. Development
- b. Transition/Readiness Activities
- c. Implementation of member enrollment
- d. Implementation of member service delivery

WellCare has extensive expertise in managing the transition of Medicaid populations from fee-for-service to managed care. Our approach to the implementation of a new state Medicaid health plan ensures that WellCare meets the specifications of OHCA’s Children in DHS Custody program’s design and contract requirements. This approach entails proven and rigorous enterprise project management support, leading up to and through the anticipated start date of the program. Having successfully completed numerous implementations and transitioned more than 2.8 million Medicaid members into managed care, we know that time is of the essence.

WellCare appoints a governance team responsible for the implementation of all deliverables. The governance team oversees the timely completion of all implantation activities, ensures cross-team communication, identifies issues and provides weekly project status reports to our executive leadership team. Following implementation this team provides ongoing management and oversight with unmatched rigor. This includes a comprehensive assessment of the compliance with the program design and contract requirements, including a detailed analysis of processes and outcome metrics. As a potential partner,

WellCare’s corporate compliance and audit team conducts independent and objective assessments of compliance and monitors and reports on any associated corrective action.

In new market implementations like Oklahoma, we believe supplementing traditional operations oversight and the necessary reporting and analytics with ongoing, candid external stakeholder discussions and a rigorous periodic evaluation that goes beyond traditional, obligatory utilization and quality management program evaluations to be highly beneficial.

WellCare recommends that OHCA work with health plan partners to approve implementation plans developed and maintained by them. The plan should detail tasks, staff responsibilities, timelines, milestones and other processes to ensure that contracted services begin at the agreed upon date.

WellCare proactively uses 10 cross-functional project streams and underlying project teams that manage end-to-end implementation activities:

- Network Development
- Member Enrollment
- Member Services
- Care Coordination/Clinical Services
- Quality and Analytics
- Finance
- Staffing and Training
- Regulatory Compliance
- Information Technology
- Readiness Review

The following table outlines the key implementation milestones tasks and the associated timing for each milestone. We recommend that OHCA take the following timeline in to consideration when establishing their timeline for contract award and the program’s “go live” date.

Milestone	Key Tasks	Estimated Timing/ Timeframe
Network Development	<ul style="list-style-type: none"> • Provider Recruitment • Provider Contracting • Provider Credentialing • Provider Contract Load/Configuration • Ancillary (e.g. Dental, Vision, Radiology) • Configure Fee Schedules • EDI Configurations • Provider Directory • Benefits Configuration • Claims Processing Preparation • Portals (member & Provider) • Provider Communications/Materials • P&Ps 	12 months – should be completed by 1 month prior to “go live”
Member Enrollment	<ul style="list-style-type: none"> • 834 File Processing • Data Exchange with OHCA • Member Fulfillment • P&Ps 	8 months – should be completed 3 months prior to “go live”
Member Services	<ul style="list-style-type: none"> • Toll Free Number 	9 months – should be completed by 1



Milestone	Key Tasks	Estimated Timing/ Timeframe
	<ul style="list-style-type: none"> • Hardware and Software Set up • CAREConnects Build • Portals (member & provider) • Tools • Member Communications/Materials • P&Ps 	month prior to “go live”
Care Coordination/ Clinical Services	<ul style="list-style-type: none"> • Integrated Care Model • Care Management • Disease Management • Pharmacy • HRAs • Risk Stratification • Prior Auth/UM • Toll Free Line • P&Ps 	9 months – should be completed 2 months prior to “go live”
Quality and Analytics	<ul style="list-style-type: none"> • Program Description • Internal Reports • EQRO • Performance Improvement Projects • P&Ps 	6 months – should be completed 4 months prior to “go live”
Finance	<ul style="list-style-type: none"> • 820 Files • Cash Tie-out • Rate Table • Rates • Premium Reconciliation • Revenue Reconciliation • Accruals • P&Ps 	3 months – should be completed 2 months prior to “go live”
Staffing and Training	<ul style="list-style-type: none"> • Staffing Plan • Recruitment • Hiring • Training • Office Space • P&Ps 	8 months – should be completed 1 month prior to “go live”
Regulatory Compliance	<ul style="list-style-type: none"> • Reporting • Compliance Oversight of Contract • Program Integrity • Fraud and Abuse • P&Ps 	5 months -- should be completed by “go-live”
Information Technology	<ul style="list-style-type: none"> • Systems Design • Data Exchange • Back-up Systems • P&Ps 	9 months – should be completed 1 month prior to “go live”
Readiness	<ul style="list-style-type: none"> • Readiness Review (conducted by OHCA) • Plan Preparation 	<ul style="list-style-type: none"> • Up to 1 month -- conducted during the month prior to “go live” • 4 month – should be completed 1



Milestone	Key Tasks	Estimated Timing/ Timeframe
		month prior to "go live"