



INTERIM REPORT FOR JANUARY 2009 – JUNE 2012

SoonerCare Choice Program Independent Evaluation

Prepared for:

*State of Oklahoma
Oklahoma Health Care Authority*

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PHPG



READER NOTE

The Pacific Health Policy Group (PHPG) is conducting an independent evaluation of the SoonerCare Choice Program, covering the period January 2009 through June 2013. This interim report contains findings through June 2012. PHPG wishes to acknowledge the cooperation of the Oklahoma Health Care Authority in providing the information necessary for the evaluation. All findings are solely the responsibility of PHPG.

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Background

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

Nearly 70 percent of all SoonerCare beneficiaries are enrolled in SoonerCare Choice, with children comprising the great majority of SoonerCare Choice members.

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

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

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

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

Evaluation Scope

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

In 2012, the OHCA retained the Pacific Health Policy Group (PHPG) to conduct an evaluation of the program for the period covering January 2009 through June 2012 (end of the state fiscal year). The evaluation time period was recently extended to include SFY 2013.

PHPG examined overall SoonerCare Choice performance with respect to access, quality and cost effectiveness. PHPG also conducted an in-depth evaluation of the three person-centered care initiatives launched in recent years: patient centered medical homes, health access networks and the SoonerCare Health Management Program. Finally, PHPG placed SoonerCare Choice in a national context, by comparing the OHCA’s strategy of collaborating with community-based partners, such as patient centered medical homes, to the traditional managed care organization (MCO) structure favored by many states.

This report includes interim evaluation findings through June 2012, which are summarized below. The report will be updated in the near future to include data for July 2012 through June 2013.

SoonerCare Choice Performance: Access, Quality and Cost

Access to Care

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

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

SoonerCare Choice Enrollment

The OHCA processes over 30,000 applications for SoonerCare Choice every month. Historically, persons applying for coverage in Oklahoma had to travel to a local Department of Human Services (OKDHS) office, meet with a caseworker and complete a paper application. The paper application process presented numerous obstacles to qualified applicants, including enrollment delays measured in weeks, the potential for inconsistent application of eligibility rules and, for some, a stigma associated with applying for coverage in person at a “welfare” office.

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

In February 2013, the most recent month for which data is available, all but five percent of applications were filed online directly by applicants or with the assistance of one of the OHCA's partner agencies. The online enrollment system has significantly reduced application processing times. Under the paper system, new applications required an average of 20 days to process; renewals required 15 days. The online system can process a complete application in minutes.

The system also saved an estimated \$1.5 million in State dollars through its first full year of operations. These savings will continue to grow, as online enrollment volume increases, and could reach \$22 million in total over the first five years of operations, for a return on investment of 153 percent on projected operating costs of \$14.5 million.

Availability of Primary Care (PCMH) Providers

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

In 2009, the OHCA undertook significant outreach efforts to providers throughout the State, to educate them about the new PCMH model and explore their interest in joining the program, if they did not already participate. The number of "unduplicated"¹ PCMH providers increased by 70 percent from January 2008 through June 2013. The increase in the number of participating PCMH providers led to a decrease in the average PCMH SoonerCare Choice member caseload, from 361 patients in 2008 to 259 patients in June 2013. The decrease occurred in both urban and rural counties throughout the State.

Availability of Primary Care and Specialty Services

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

The absolute level of satisfaction with adult care is high, with over 70 percent of respondents rating their care on each measure as an 8, 9 or 10. The percent satisfied also increased for three consecutive survey cycles before declining slightly in the most recent cycle, completed in 2013.

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

The satisfaction level for care delivered to children (as reported by their parent/guardian) is even higher, with 85 percent or more of respondents rating the care on each measure as an 8, 9 or 10. The percent satisfied also moved in an upward direction over the four survey cycles.

Another method for evaluating access to primary care is to examine emergency room utilization trends. If access is restricted it may result in more trips to the emergency room for non-emergent problems. SoonerCare Choice member use of the emergency room declined significantly from 2009 to 2010, a drop that coincided with introduction of the PCMH model and expansion of the primary care provider network. It has since remained near the level recorded in 2010.

Assistance to Members with Complex/Chronic Conditions

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

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

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

The SoonerCare Health Management Program provides holistic, in-person health coaching to up to 7,000 members at a time, working in collaboration with members' PCMH providers. The Chronic Care Unit provides telephonic care management to members with chronic conditions who are not enrolled in the SoonerCare HMP.

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

Quality of Care

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

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

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

Mechanisms to Measure and Reward Quality

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

HEDIS data is used in conjunction with other measures to evaluate the performance of PCMH providers and to reward providers who meet or exceed pre-established targets. In SFY 2012, the OHCA made nearly \$3.5 million in “SoonerExcel” quality incentive payments to PCMH providers who met one or more quality benchmarks.

Provision of Appropriate Preventive and Diagnostic Services

PHPG examined HEDIS results for SoonerCare Choice members both longitudinally and in comparison to national data, where available. PHPG documented HEDIS trends in four areas for the reporting years 2008 - 2012:

- Child/adolescent access to PCPs
- Adult access to preventive services
- Annual dental visit rates for members under 21
- Breast and cervical cancer screening rates

The percentage of children and adolescents with access to a PCP increased steadily over the evaluation period and was above 90 percent for all age cohorts in 2012. The access percentage also was consistently above the national rate.

Access to preventive services also improved for both younger and older adults, exceeding 83 percent in SFY 2012 for the former and reaching 91 percent for the latter. The percentage of members under age 21 who made an annual visit to the dentist improved modestly over the evaluation period, reaching 64 percent in SFY 2012.

The final two measures, breast and cervical cancer screening rates, were exceptions to the broader positive trends presented above. Both rates rose and fell throughout the evaluation period, finishing in SFY 2012 slightly below the SFY 2008 rates.

One contributing factor to this fluctuation may have been an ongoing national debate concerning the recommended screening age for mammograms, which was recently raised, and recommended cervical screening intervals, which were recently lengthened. However, the SoonerCare Choice rate is lower than the national rate, indicating there is room for improvement.

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

Health Outcomes

The delivery of high quality preventive and primary care should contribute to improved health outcomes. One useful measure of quality is the avoidable, or ambulatory care sensitive condition, hospitalization rate. PHPG examined hospitalization rates for four ambulatory care sensitive conditions from January 2009 through June 2012: asthma, congestive heart failure, chronic obstructive pulmonary disease and pneumonia. The rate dropped significantly across all four conditions, with the sharpest decline occurring among members with pneumonia, which fell by nearly 17 percent.

Another measure of health outcomes is the 30-day readmission rate for members who are hospitalized. During the evaluation period, the readmission rate fell by 26 percent.

Cost Effectiveness

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

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

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

Health Care Expenditures

PHPG examined SoonerCare Choice health expenditure trends from January 2009 through June 2012. PHPG analyzed average per member per month (PMPM) expenditures to eliminate any impact associated with change in enrollment.

Annual PMPM expenditure growth for the SoonerCare Choice population was 1.4 percent, less than half the average annual per capita national health expenditure increase of 3.2 percent over the same period.

Administrative Expenditures

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

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

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

To gauge the relative cost effectiveness of the OHCA's model versus the MCO model, PHPG compared SoonerCare administrative expenses, as a percentage of total spending, to the administrative expenses in the Arizona AHCCCS Medicaid managed care program. Arizona was chosen because it operates the nation's oldest statewide Medicaid managed care system, dating back to 1982. Arizona contracts with MCOs to provide virtually all care to its Medicaid population.

The SoonerCare program's administrative expenses are less than half of Arizona's, when agency and MCO administrative/profit expenditures are taken into account. SoonerCare administrative expenses in SFY 2012 were slightly under 5.5 percent of total spending; the equivalent percentage for Arizona in 2013 is projected to be 11.4 percent.

In-Depth Evaluation of Person-Centered Care Initiatives

Patient Centered Medical Home Model

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

The PCMH model appears to be contributing to positive trend lines for the SoonerCare Choice program as a whole. At the aggregate level (across tiers), the program demonstrated consistent improvement in outcomes from January 2009 through June 2012.

However, it is difficult at this stage to identify any positive correlation between provider tiers and outcomes. In most instances there was less differentiation between tiers than might be anticipated, given the greater demands placed on the higher tiers.

The lack of differentiation could partially be a timing issue. Many tier 2 and 3 practices achieved their status only in the final 12 to 24 months of the evaluation period, leaving little time to register a significant impact. It also could suggest that the separation of practices into three tiers is unnecessary, since the majority of requirements are imposed on tier 1 providers, and in interviews and focus groups, providers consistently express the intent to meet as many requirements as possible, regardless of their formal tier assignment.

PHPG will be updating the PCMH evaluation to include data through June 2013, which should help to clarify the issue and better define if and how the OHCA should respond.

Health Access Networks

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

HAN membership grew dramatically during the initiative's first years, from only 25,000 in July 2010 to nearly 90,000 in July 2013. The OHCA expects membership ultimately to reach 120,000 across the three networks.

The rapid membership growth is a positive trend, as it reflects expanding participation by PCMH providers in the networks. However, it makes evaluation of HAN performance problematic because of the continual influx of new members. PHPG will attempt to evaluate HAN performance along the same dimensions as the PCMH evaluation in the updated report to be issued in 2014.

SoonerCare Health Management Program

Chronic diseases are among the most costly of all health problems. Treatment of chronic disease accounts for more than 75 percent of total U.S. health care spending. Traditional disease management programs focus on individual conditions rather than the total patient.

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

The program had two major components through June 2013: nurse care management and practice facilitation. The nurse care management portion of the program was transformed in

July 2013 into practice-based health coaching. Both components are administered by a vendor (Telligen) with oversight from a dedicated SoonerCare HMP Unit within the OHCA.

PHPG has served as an independent evaluator of the SoonerCare HMP since its implementation. For the most recent evaluation period, PHPG conducted surveys and focus groups/in-depth interviews with members and providers to explore their perceptions of the SoonerCare HMP. Participants in nurse care management gave the program high marks. When asked in a survey to rate their experience, nearly 90 percent of respondents declared themselves very satisfied. A smaller but still significant portion (27 percent) believed their health had improved due to participation in the program.

Practice facilitation providers also were satisfied and considered the program to be of significant value. Survey respondents credited the program with improving their adherence to clinical guidelines. Nearly all (91 percent) would recommend the program to a colleague.

To measure the program's impact on quality of care, PHPG evaluated the preventive and diagnostic services provided to SoonerCare HMP participants with six targeted chronic conditions: asthma, CHF, COPD, coronary artery disease, diabetes and hypertension. PHPG also examined compliance rates for a "comparison group" consisting of SoonerCare members found eligible for, but not enrolled in the SoonerCare HMP.

Findings from the analysis were promising. The participant compliance rate exceeded the comparison group rate for 14 of 21 diagnosis-specific measures. The difference was statistically significant for nine of the 14, suggesting that the program is having a positive effect on quality of care.

SoonerCare HMP Impact on Service Utilization and Expenditures

PHPG evaluated service utilization and expenditures among the nurse care managed population and among patients of providers who underwent practice facilitation and compared the utilization to what would have occurred absent the program. The comparison was made against projected expenditures generated by predictive modeling software developed by MEDai.

The impact on member utilization through June 2012 was found to be significant, particularly with respect to inpatient hospital admissions/days and emergency room visits. Actual inpatient days were substantially below forecast. Overall, the nurse care management portion of the SoonerCare HMP through SFY 2012 achieved aggregate savings in excess of \$93 million, or 21 percent of total medical claim costs.

PHPG also examined expenditures for chronically ill patients being treated by practice facilitation providers to test the initiative's cost effectiveness. The net difference in PMPM expenditures (forecast minus actual) through SFY 2012 was \$74.91. This figure, when multiplied by practice facilitation site member months yielded aggregate savings of approximately \$46

million (state and federal dollars), or 11.5 percent as measured against total medical claims costs.

Overall Return-on-Investment

PHPG calculated the SoonerCare HMP's return on investment (ROI) by comparing administrative expenditures to net medical savings across both program components (nurse care management and practice facilitation).

The ROI for the program in total through SFY 2012 was 524 percent. Put another way, the SoonerCare HMP generated over five dollars in medical savings for every dollar in administrative expenditures.

SoonerCare Choice: A National Perspective

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

Since expanding SoonerCare Choice statewide in 2005, the OHCA has achieved a level of stability in operations that previously did not exist. Under the SoonerCare Plus program, participating MCOs entered and exited the three service areas annually, forcing members to transfer between plans and, in many cases, to terminate existing relationships with providers because of differences in networks.

SoonerCare Choice also has served as an effective platform for innovation. The OHCA was able to introduce the PCMH model, Health Access Networks and the SoonerCare HMP across the State without relying on third party intermediaries, i.e., MCOs. This enabled the OHCA to roll-out the initiatives on a schedule of its choosing and to make adjustments swiftly to enhance program effectiveness (e.g., conversion of SoonerCare nurse care management to health coaching).

The SoonerCare Choice structure is less common than the MCO model found in many other states. The decision to contract with MCOs is often predicated by the desire to implement managed care rapidly in states with no managed care infrastructure at the agency level. In such an environment, MCO contracts can be an attractive alternative to building a community-based system such as Oklahoma's.

MCOs can bring expertise from other markets into a state implementing or expanding its managed care program. However, they also bring their own set of challenges, including:

- Willingness to delay implementation of programs through protests of state contracting decisions, if procurement results are not entirely favorable to them.
- Willingness to depart states if profit expectations are not met in a particular year. This can result either in program instability or a “give back” by the state of initial savings.
- Unwillingness in some cases to modify national practices to accommodate state preferences and expectations, unless compensated to make the changes.
- Relatively high administrative costs.

The community-based model requires more time and up-front agency effort to put in place. Once established, however, it can operate at a lower administrative cost and often with greater stability than the MCO model, even as it provides a vehicle for faster implementation of innovative managed care practices.

Conclusion

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

CHAPTER 1 – INTRODUCTION

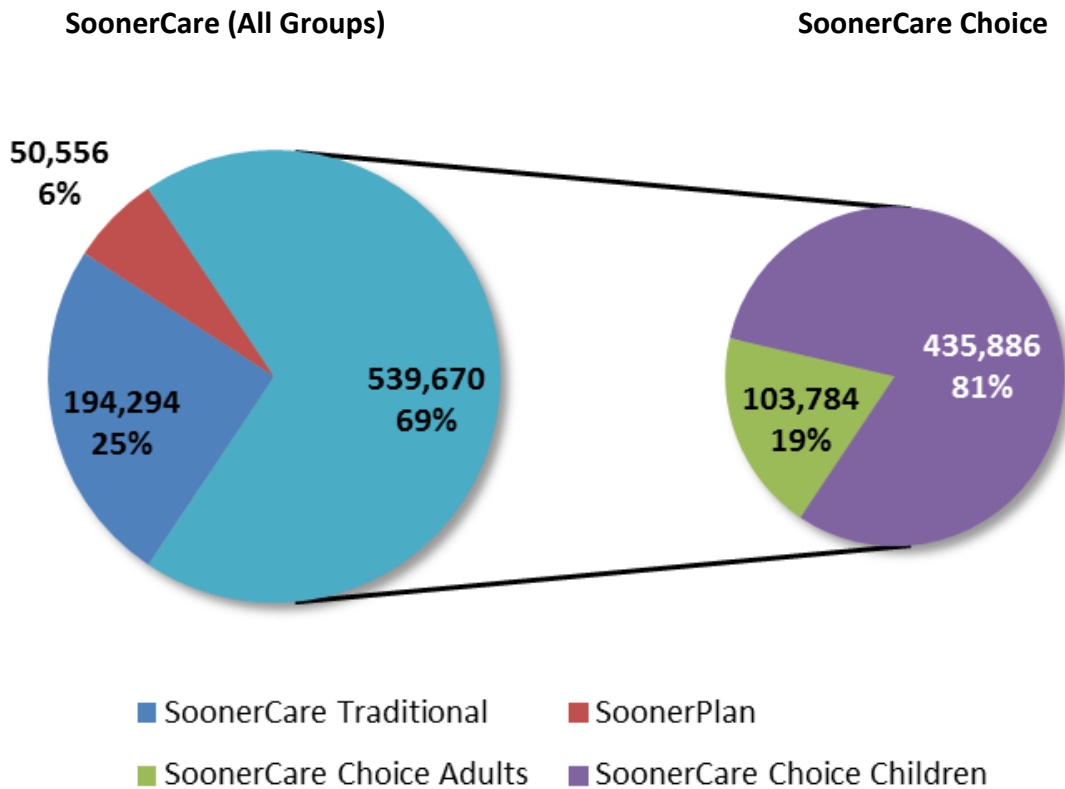
SoonerCare Choice Program

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

Nearly 70 percent of all SoonerCare beneficiaries are enrolled in SoonerCare Choice, with children comprising the great majority of SoonerCare Choice members (Exhibit 1-1).

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

Exhibit 1-1 – SoonerCare Population (June 2013)²



² Source: OHCA Fast Facts.

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

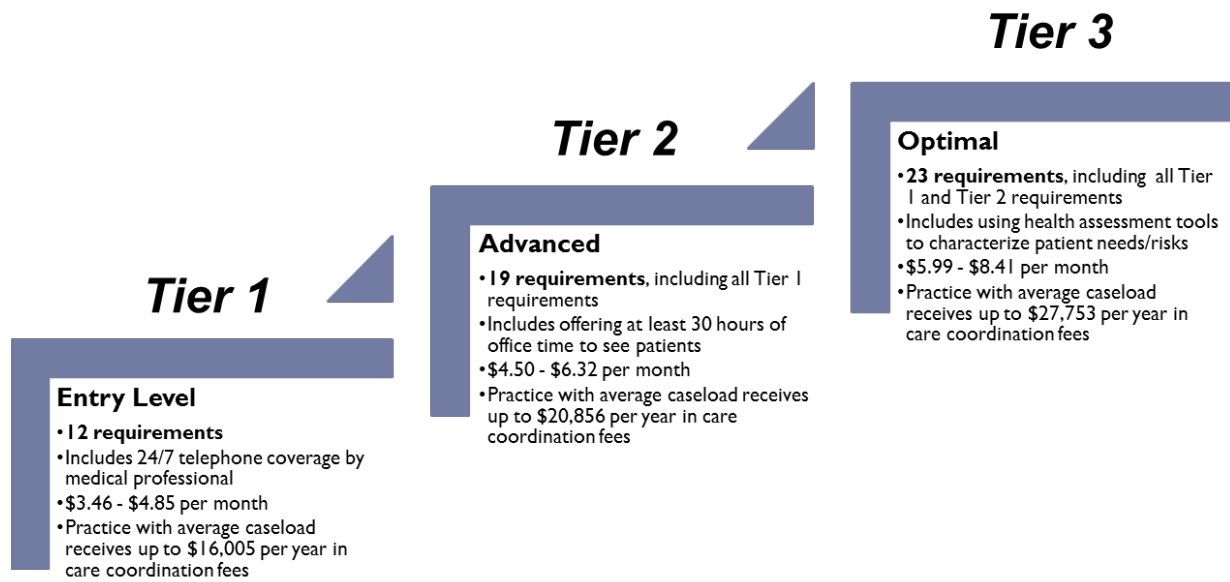
In 2008, the OHCA implemented the “Health Management Program” (HMP), a holistic person-centered care management program for members with chronic conditions who have been identified as being at high risk for both adverse outcomes and increased health care expenditures. The SoonerCare HMP emphasizes development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

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

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

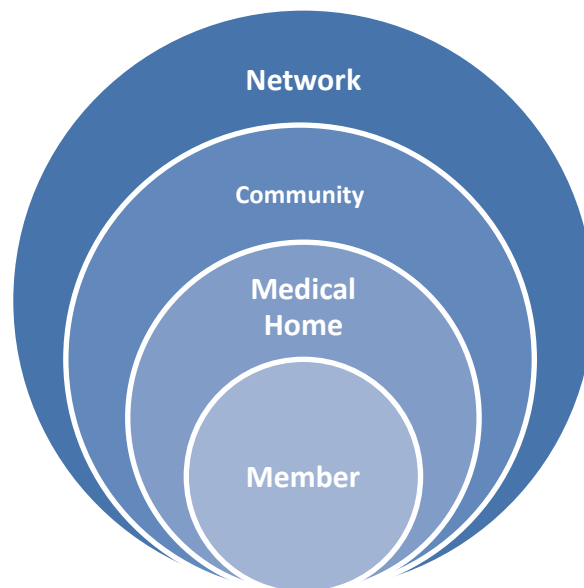
PCMH providers are arrayed into three levels, or tiers, depending on the number of standards they agree to meet (Exhibit 1-2). The OHCA pays monthly care management fees (in addition to regular fee-for-service payments) that increase at the higher tiers. Providers also can earn “SoonerExcel” quality incentives for meeting performance targets, such as for preventive care, member use of the ER and prescribing of generic drugs.

Exhibit 1-2 – Patient Centered Medical Home Model



In 2010, the OHCA expanded upon the PCMH model by contracting with three “Health Access Network” (HAN) provider systems. The HANs are community-based, integrated networks intended to advance program access, quality and cost-effectiveness goals by offering greater care coordination support to affiliated PCMH providers (Exhibit 1-3).

Exhibit 1-3 – Health Access Network Model



The three initiatives are described in greater detail in chapter three.

SoonerCare Choice Independent Evaluation

In 2007, the OHCA commissioned an evaluation of the SoonerCare Choice program that examined its performance against program access, quality and cost effectiveness goals. The evaluation covered the program from its formation through SFY 2008³.

In 2012, the OHCA retained the Pacific Health Policy Group (PHPG) to conduct an evaluation of the program for the period covering January 2009 through June 2012 (end of the state fiscal year). The evaluation time period was recently extended to include SFY 2013.

This report includes interim evaluation findings through June 2012. It will be updated in the near future to include data for July 2012 through June 2013.

Methodology

PHPG obtained paid claims data for the SoonerCare Choice program covering January 2009 through June 2012. The claims data was analyzed to document trends in utilization and expenditures over the three and one-half year period.

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

Report Chapters

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

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

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

³ See: SoonerCare 1115 Waiver Evaluation: Final Report, Mathematica Policy Research, January 2009.

Chapter four offers a national perspective by comparing the SoonerCare Choice program, and its emphasis on community-based coordinated care with the more traditional “managed care organization” model used in other states.

Chapter five briefly recaps evaluation conclusions.

CHAPTER 2 – SOONERCARE CHOICE PERFORMANCE

The SoonerCare Choice program seeks to provide accessible, high quality and cost effective health care to its members. PHPG evaluated program performance during January 2009 through June 2012 along all three dimensions.

Access to Care

Evaluation Questions

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

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

Is it Easy or Difficult to Enroll in SoonerCare Choice?

The OHCA processes over 30,000 applications for SoonerCare Choice every month. Historically, persons applying for coverage in Oklahoma had to travel to a local Department of Human Services (OKDHS) office, meet with a caseworker and complete a paper application.

The paper application process presented numerous obstacles to qualified applicants, including⁴:

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

⁴ The discussion of enrollment obstacles is derived from a Policy Innovation Profile of Oklahoma's online enrollment system that can be found at <http://innovations.ahrq.gov/content.aspx?id=3981#a5>.

from differences in caseworker training and use of personal judgment when applying rules to individual cases.

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

These obstacles contributed to the size of Oklahoma’s uninsured population, by discouraging qualified applicants from enrolling in the SoonerCare program. For example, an estimated 22,000 children were eligible but not enrolled in SoonerCare Choice in 2010⁵.

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

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

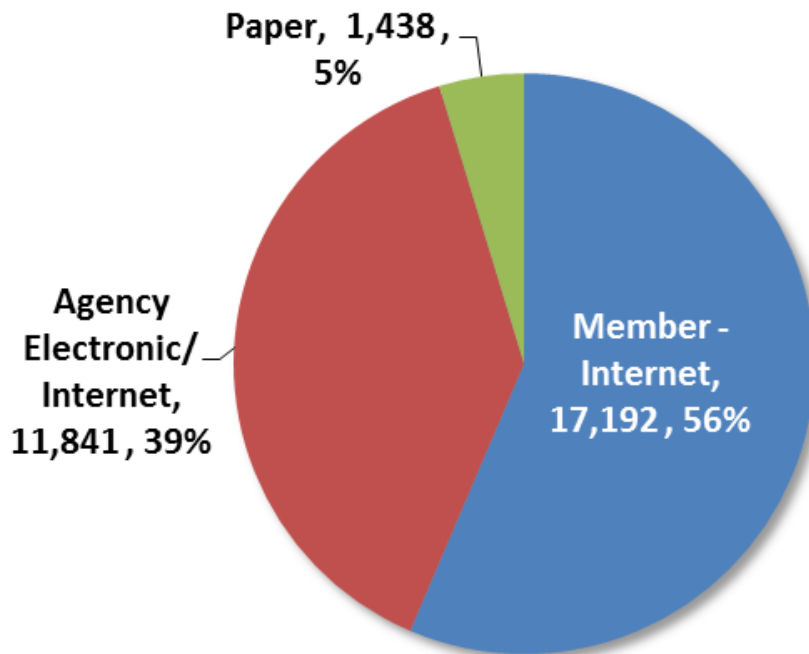
- Provide 24/7 access to enrollment and accurate, “real time” determination of eligibility
- Facilitate selection of a medical home
- Reduce staff hours required for processing applications

The online enrollment system went “live” in September 2010 and had an immediate impact on how SoonerCare applications are filed and processed. In September 2013, all but five percent of applications were filed online directly by applicants or with the assistance of one of the OHCA’s partner agencies (Exhibit 2-1).

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

⁵ Figure is an estimate derived from Current Population Survey data on the uninsured by income level.

Exhibit 2-1 – SoonerCare Choice Enrollment Method (September 2013)



The online enrollment system has significantly reduced application processing times. Under the paper system, new applications required an average of 20 days to process; renewals required 15 days. The online system can process a complete application in minutes. SoonerCare Choice members have expressed satisfaction with the online process in focus groups conducted by the OHCA⁶.

PHPG evaluated the “return on investment” for online enrollment by comparing the State’s expected share of operational costs⁷ over the first five years to the dollar equivalent of caseworker resources which have been freed-up through elimination of paper applications. PHPG’s detailed methodology and findings were originally documented in a separate study published in 2011⁸.

A separate study of Oklahoma’s online enrollment system was conducted by Mathematica Policy Research, as part of a federally-funded review of “Express Lane Eligibility”⁹ processes in

⁶ See Policy Innovation Profile for more detail.

⁷ With a few exceptions, the federal government pays 50 percent of operating costs for administration of the SoonerCare Choice program, including enrollment activities.

⁸ See: “No Wrong Door Online Enrollment – Independent Evaluation Final Report”, The Pacific Health Policy Group, March 2011.

⁹ Express Lane Eligibility is an option introduced for states in the federal Child Health Insurance Program Reauthorization Act (CHIPRA) of 2009. It permits state Medicaid and CHIP programs to rely on another agency’s eligibility findings to qualify children for public health coverage, even when these programs use different methods to assess income or other eligibility criteria.

multiple states¹⁰. Although Oklahoma is not an Express Lane Eligibility state, its system was included in the study for comparison purposes.

Both PHPG and Mathematica concluded that Oklahoma’s online enrollment system saved an estimated \$1.5 million in State dollars through its first full year of operation. PHPG projected the savings would continue to grow in subsequent years, as online enrollment volume increased, and could reach \$22 million in total over the first five years of operations, for a return on investment of 153 percent on projected operating costs of \$14.5 million. (Mathematica’s analysis did not extend beyond year one.)

The “savings” calculated by PHPG represent case worker resources freed-up for other activities. For example, case worker time could be applied toward assisting individuals seeking cash assistance or Supplemental Security Income benefits through a local OKDHS office.

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

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

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

The number of PCMH providers was relatively flat from 2004¹¹ through 2009, although provider capacity remained about double the actual SoonerCare Choice enrollment. (Providers specify their maximum SoonerCare Choice member caseload when they sign-up to participate in the program.)

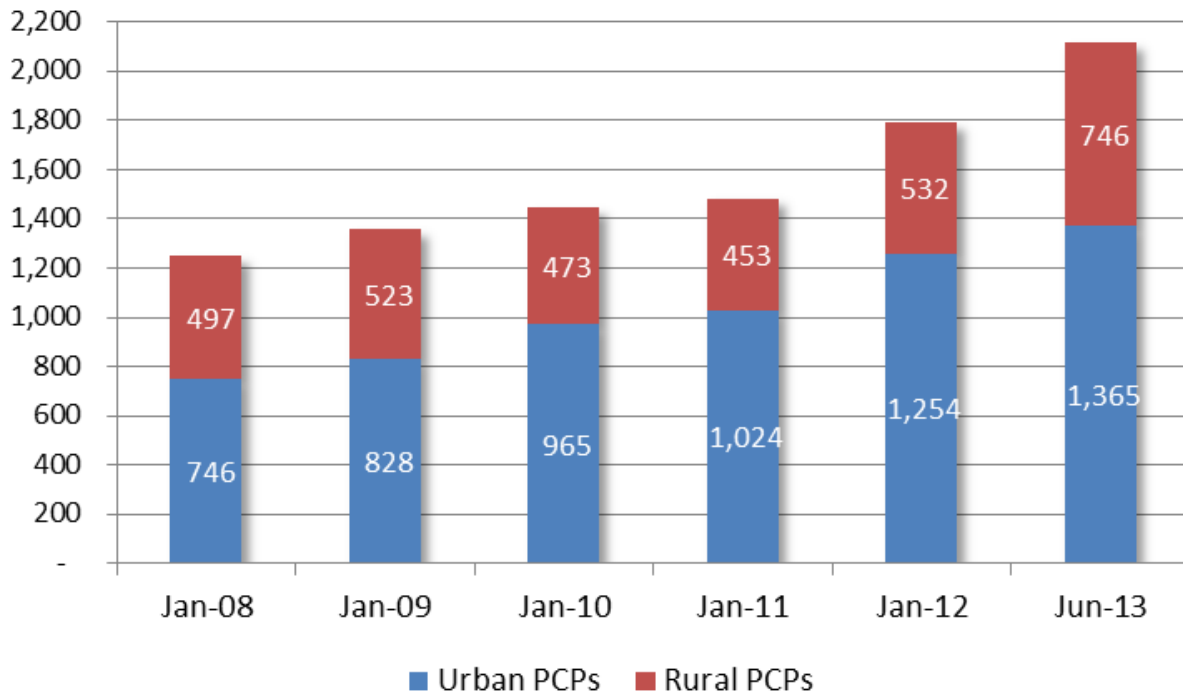
In 2009, the OHCA undertook significant outreach efforts to providers throughout the State, to educate them about the new PCMH model and explore their interest in joining the program, if they did not already participate. The number of “unduplicated”¹² PCMH providers increased by 70 percent from January 2008 through June 2013 (Exhibit 2-2). The growth occurred in both urban and rural counties.

¹⁰ See: “CHIPRA Express Lane Eligibility Evaluation – Case Study of Oklahoma’s SoonerCare Online Enrollment System”, Mathematica Policy Research, May 2013.

¹¹ The year that the SoonerCare Plus MCO program in Oklahoma City, Tulsa, Lawton and surrounding areas was discontinued and members were enrolled in SoonerCare Choice alongside members in the rest of the State.

¹² Counting each provider once, regardless of his or her number of offices/practice locations.

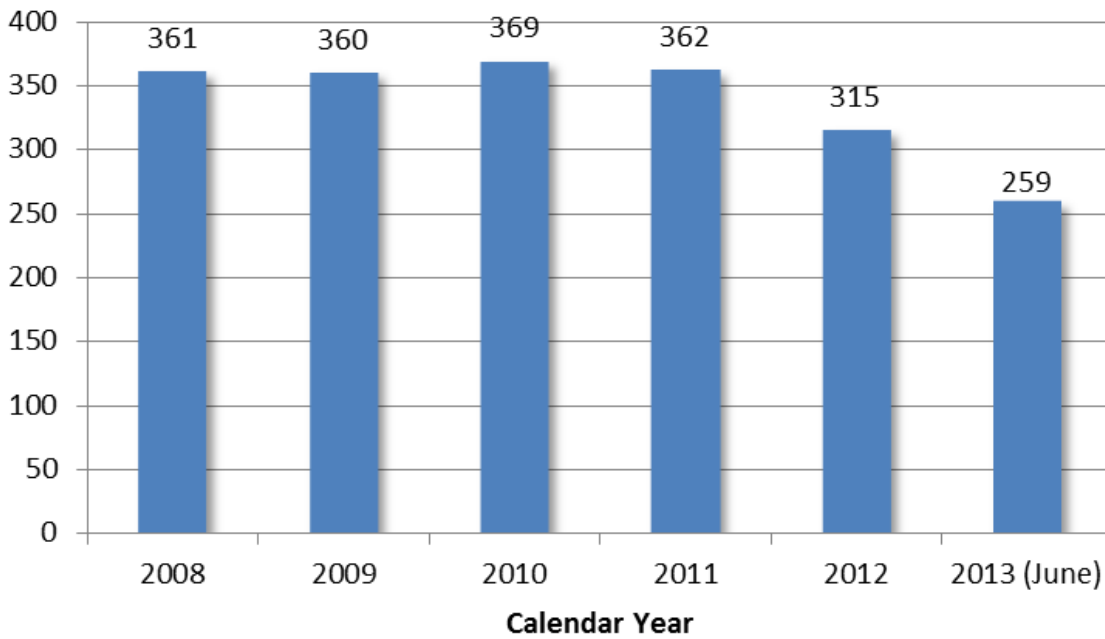
Exhibit 2-2 – SoonerCare Choice Unduplicated PCMH Count by Year¹³



The increase in the number of participating PCMH providers led to a decrease in the average PCMH SoonerCare Choice member caseload, from 361 patients in 2008 to 259 patients in June 2013 (Exhibit 2-3).

¹³ Source: OHCA Fast Facts. Urban/rural division corresponds to division of counties under SoonerCare Plus and Choice models prior to discontinuation of SoonerCare Plus program. Increase from 2011 to 2012 may be partially due to introduction of more precise taxonomy.

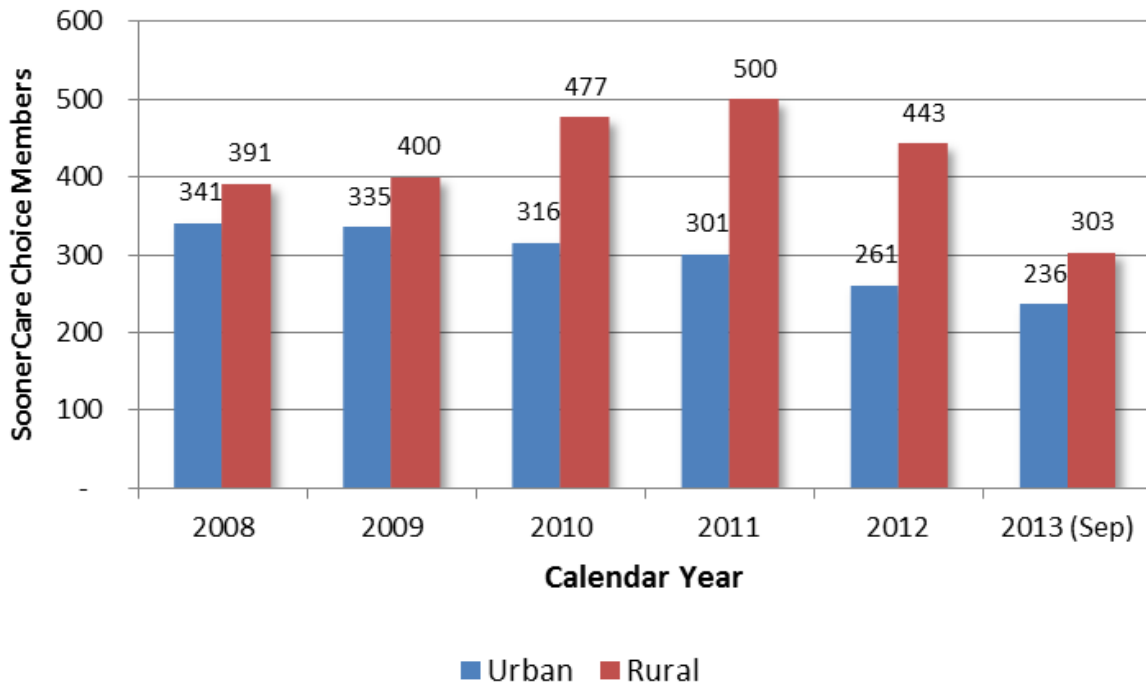
Exhibit 2-3 – Average PCMH SoonerCare Choice Member Caseload – Statewide ¹⁴



The decline occurred in both urban and rural portions of the State, although the decline in rural counties started more recently and average caseloads remain higher in rural Oklahoma (Exhibit 2-4).

¹⁴ Sources: OHCA Provider Fast Facts Report; Waiver Enrollment Reports; Enrollment Fast Facts (May 2013 data). Annualized member count divided by PCMH count.

Exhibit 2-4 – Average PCMH SoonerCare Choice Member Caseload – Urban/Rural¹⁵



Are Primary Care and Specialty Services Readily Available?

Member Perceptions

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

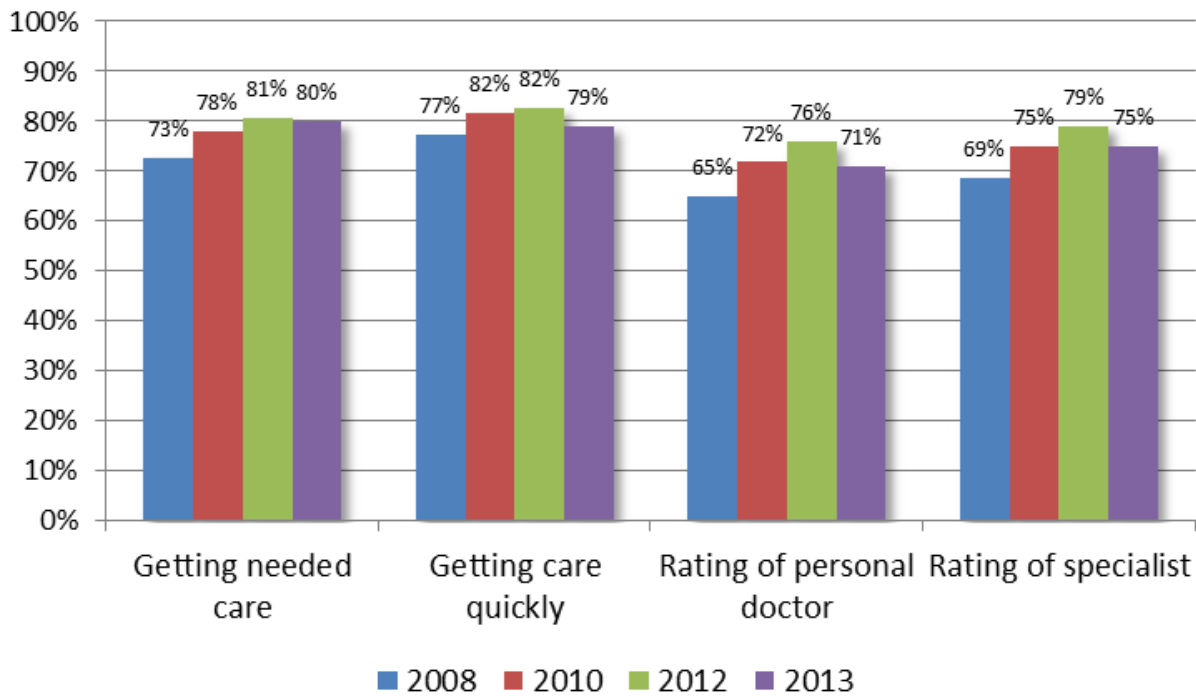
Telligen surveys members using the Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS). The CAHPS is nationally-validated research tool designed for use with the Medicaid managed care population. There are separate surveys for care provided to adults and children. (The latter survey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

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

¹⁵ Urban/rural division corresponds to division of counties under SoonerCare Plus and Choice models prior to discontinuation of SoonerCare Plus program.

The absolute level of satisfaction with adult care is high, with over 70 percent of respondents rating their care on each measure as an 8, 9 or 10. The percent satisfied also increased for three consecutive survey cycles before declining slightly in the most recent cycle, completed in 2013 (Exhibit 2-5).

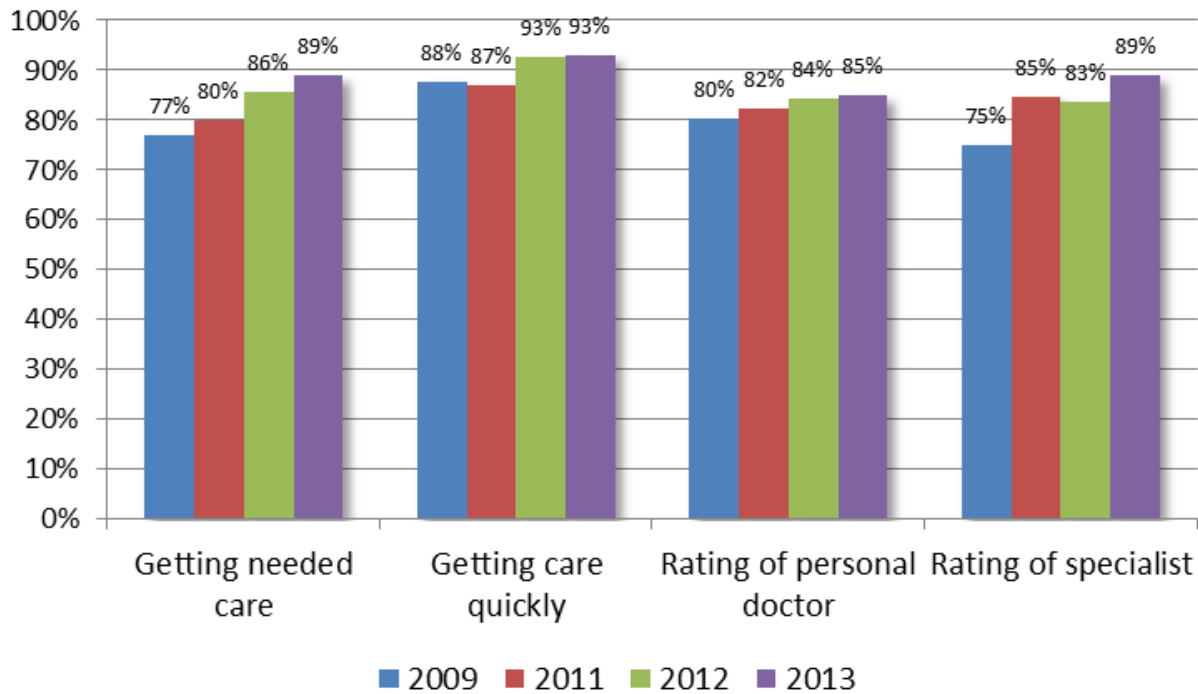
Exhibit 2-5 – SoonerCare Choice – Satisfaction with Care for Adults¹⁶



The satisfaction level for care delivered to children is even higher, with 85 percent or more of respondents rating the care on each measure as an 8, 9 or 10. The percent satisfied also moved in an upward direction over the four survey cycles (Exhibit 2-6).

¹⁶ Sources: CAHPS Health Plan Survey Adult Version – Telligen through 2012; Morpace for 2013 (surveys are conducted from July to December of year preceding reporting year). Percent rating 8, 9 or 10 on a 10-point satisfaction scale; “Getting care quickly” is a composite measure based on questions regarding satisfaction with obtaining needed care, both urgent and non-urgent.

Exhibit 2-6 – SoonerCare Choice – Satisfaction with Care for Children¹⁷

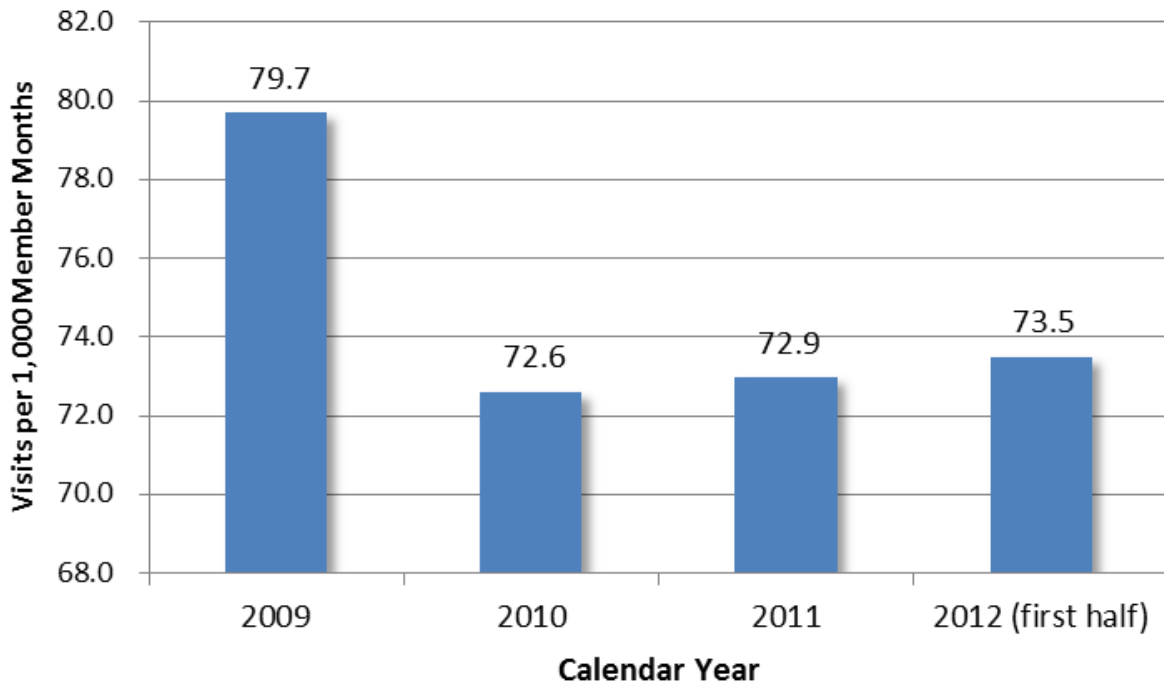


Another method for evaluating access to primary care is to examine emergency room utilization trends. As noted earlier, if access is restricted it may result in more trips to the emergency room for non-emergent problems.

PHPG examined SoonerCare Choice member use of the emergency room, on a per 1,000 member month basis, from January 2009 through June 2012. The use rate declined significantly from 2009 to 2010, a drop that coincided with introduction of the PCMH model and expansion of the primary care provider network (Exhibit 2-7).

¹⁷ Sources: CAHPS Health Plan Survey Child Version – Telligen through 2012; Morpace for 2013 (surveys are conducted from July to December of year preceding reporting year). Percent rating 8, 9 or 10 on a 10-point satisfaction scale.

Exhibit 2-7 – SoonerCare Choice Emergency Room Utilization¹⁸



The rate stabilized after the initial decline and has remained relatively steady near the lower level achieved in 2010. It is difficult to compare Oklahoma’s rate to the rate in other states because of differences in reporting methods, but the Oklahoma rate appears still to be higher than average. This suggests there is still room for improvement.

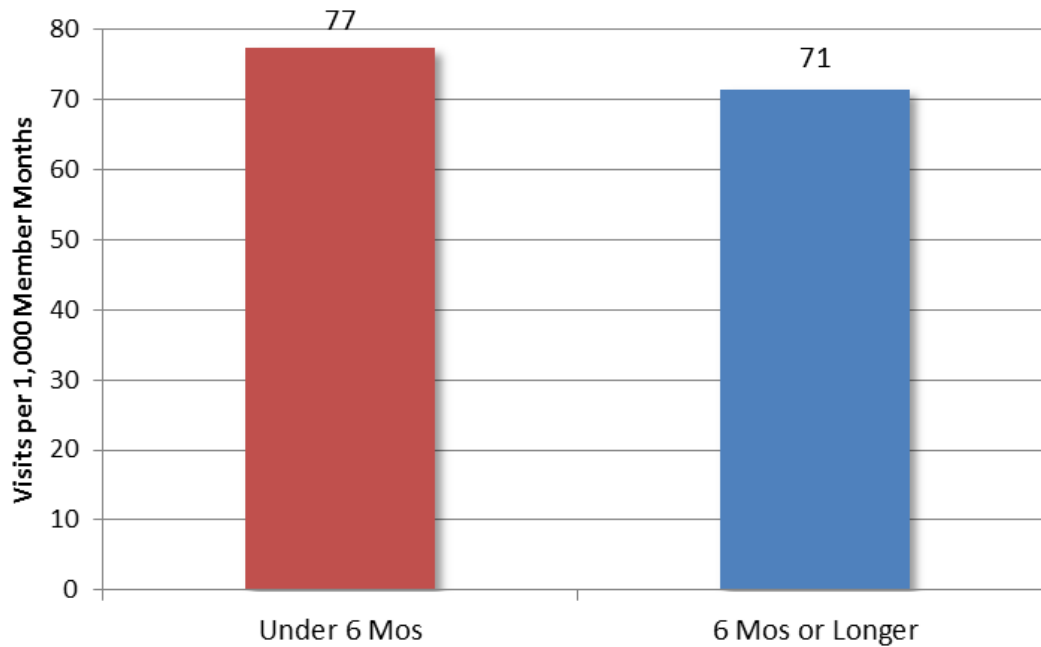
However, it is also relevant to note that in rural parts of the State, the emergency room is often the after-hours “on call” location, including for urgent but not emergent care. This is more efficient for local providers than opening their offices after hours to see patients.

The possible impact of the PCMH model on emergency room use was further explored by comparing use rates between new and established SoonerCare Choice members, using six months in the program as the dividing line. If members come to view their PCMH providers as an accessible alternative to the emergency room, this should be demonstrated through lower visit rates among established members.

PHPG compared visit rates for new and established over the entire evaluation period (January 2009 through June 2012) and found a significant difference. The emergency room use rate for established members is nearly ten percent lower than for new SoonerCare Choice members (Exhibit 2-8).

¹⁸ SoonerCare Choice members enrolled in a Patient Centered Medical Home; 2012 rate includes seasonality adjustment to compensate for missing six months; data excludes dual eligibles whose ER claims are paid by Medicare.

Exhibit 2-8 – SoonerCare Choice Emergency Room Utilization- Comparison by Tenure¹⁹



In addition to the role played by PCMH providers, the OHCA has an initiative targeting the most persistent emergency room utilizers, defined as those with 30 or more visits in the prior three quarters (excluding visits resulting in a hospitalization). The OHCA collaborates with the members’ PCMH providers to educate them about proper use of the emergency room and the available alternatives. The Health Access Networks also are expected to work with their high utilizing members to reduce inappropriate emergency room use.

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

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

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

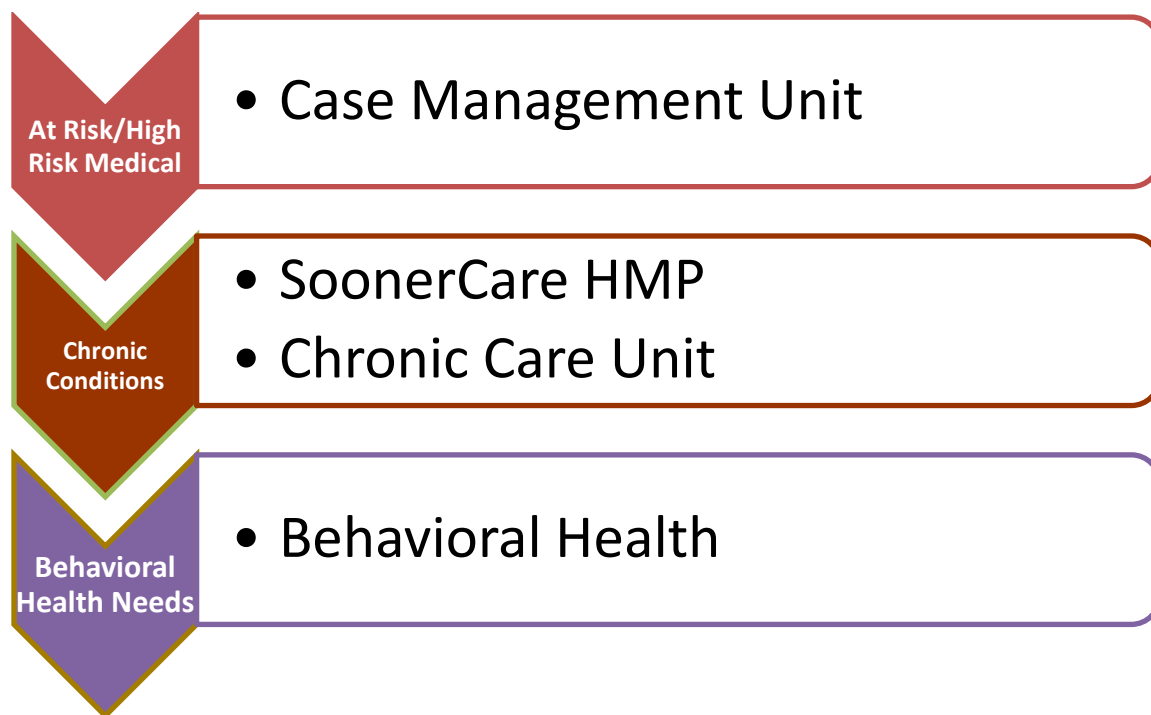
Members with complex/chronic conditions often are unable to navigate the health care system without support. Although their PCMH or prenatal care provider is responsible for directing their care, additional support can make the difference in ensuring that a member sees his or

¹⁹ Source: OHCA paid claims data. Average for January 2009 – June 2012.

her PCMH and specialist providers as recommended (including after release from the hospital) and takes other steps to manage his or her condition.

The OHCA, as the managed care organization for SoonerCare Choice, has put in place a needs-based multi-tiered care management structure for members with complex/chronic conditions (Exhibit 2-9). The Population Care Management Department directly administers or oversees a wide range of case and care management activities and includes over 50 staff members (managers, clinical personnel and support staff). The Department has access to OHCA medical director staff and physician consultants in the agency’s Medical/Professional Services Department.

Exhibit 2-9 – SoonerCare Choice Population Care Management Structure



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

The Population Care Management Department also provides or arranges for ongoing assistance to members with chronic conditions, such as asthma, diabetes and heart failure. The SoonerCare Health Management Program provides holistic, in-person health coaching to up to 7,000 members at a time, working in collaboration with members’ PCMH providers. The

Chronic Care Unit provides telephonic care management to members with chronic conditions who are not enrolled in the SoonerCare HMP.

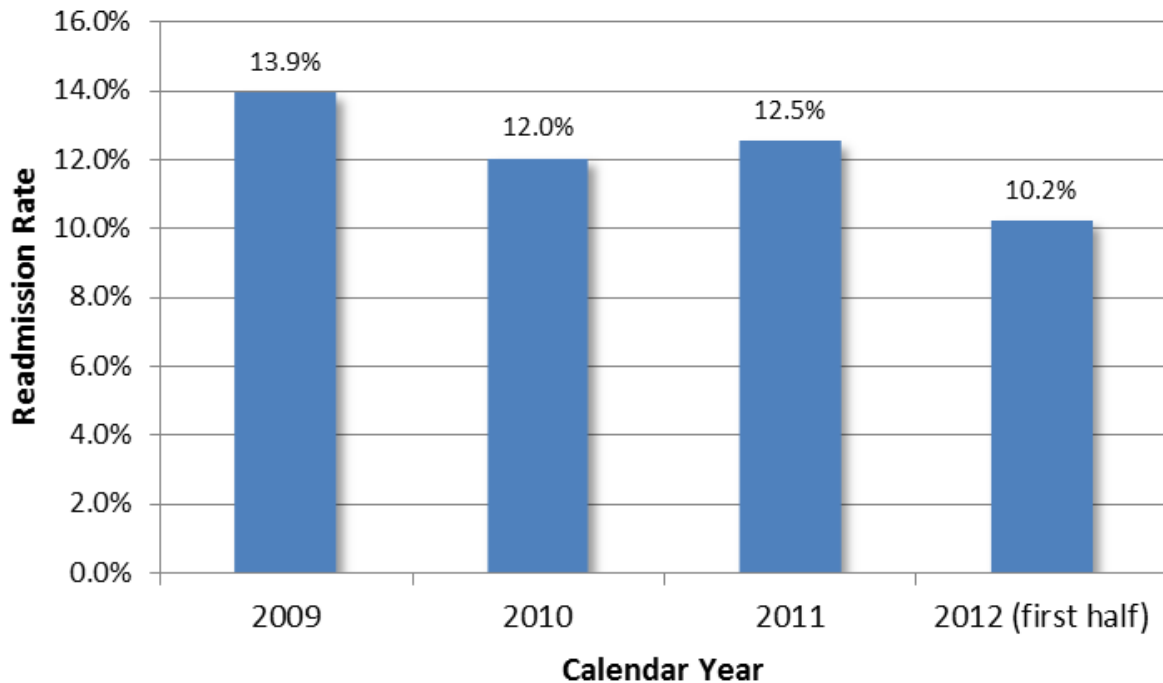
The Behavioral Health Department and its Behavioral Health Specialist staff provide assistance to members with behavioral health needs, including seriously mentally ill adults and seriously emotionally disturbed children. The Department often works in collaboration with the other care management units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

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

During the evaluation period (January 2009 through June 2012), the readmission rate fell by 26 percent (Exhibit 2-10). The 2012 rate of 10.2 percent compares favorably to the national Medicare readmission rate of 18.4 percent²⁰, even allowing for the relatively frailer health of the average Medicare beneficiary and the presence of deliveries/newborns (which rarely result in a readmission) in the OHCA data.

²⁰ Source: <http://www.cms.gov/mmrr/Briefs/B2013/mmrr-2013-003-02-b01.html>.

Exhibit 2-10 – SoonerCare Choice Care 30-Day Hospital Readmission Rate²¹



The impact on members with chronic physical and/or behavioral health conditions can be assessed through a variety of measures, including adherence to chronic condition preventive care guidelines (e.g., retinal eye exams for diabetics), emergency room and inpatient hospital utilization, average per member per month expenditures and member satisfaction. PHPG has conducted a multi-year evaluation of the SoonerCare HMP along each of these dimensions and has reported positive with respect to member service utilization, health outcomes and satisfaction²². More information on SoonerCare HMP performance is presented in chapter three.

²¹ Source: OHCA paid claims. SoonerCare Choice members enrolled in patient centered medical home.

²² For the most recent findings, see SoonerCare HMP Fourth Annual Evaluation, March 2013.

Quality of Care

Evaluation Questions

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

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

4. Does the program have mechanisms to measure and reward quality?
5. Are members receiving appropriate preventive and diagnostic services?
6. Are health outcomes improving?

Does the Program Have Mechanisms to Measure and Reward Quality?

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

HEDIS data is used in conjunction with other measures to evaluate the performance of PCMH providers and to reward providers who meet or exceed pre-established targets. In SFY 2012, the OHCA made nearly \$3.5 million in “SoonerExcel” quality incentive payments to PCMH providers who met one or more quality benchmarks (Exhibit 2-11).

Exhibit 2-11 – SoonerExcel Payments – SFY 2012

Quality Measure	Benchmark	Incentive (subject to available funds)	SFY 2012 Payments
4 th DTaP	Immunization prior to age 2	\$3.00 per child	In EPSDT Total
EPSDT Screen	Meet or exceed appropriate compliance rate	Up to 25 percent bonus on standard FFS rate for procedure	\$1,000,000
BCC Screens	Payment made for each screen	Amount based on comparison to peers and available funds	\$358,000
ED Utilization	Expected ED/office visit rate (risk adjusted)	Additional PMPM payment for outperforming benchmark	\$500,000
Generic Prescribing	Payment made for each Rx, after application of adjustment formula	Provider-specific portion out of quarterly pool of \$250,000	\$1,000,000

Quality Measure	Benchmark	Incentive (subject to available funds)	SFY 2012 Payments
Physician Hospital Visits	Making inpatient visits	25 percent bonus per procedure + additional \$20 per visit if above average of participating providers	\$614,000

Are members receiving appropriate preventive and diagnostic services?

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

PHPG documented HEDIS trends in four areas for the reporting years 2008 - 2012:

- Child/adolescent access to PCPs
- Adult access to preventive services
- Annual dental visit rates for members under 21
- Breast and cervical cancer screening rates

The percentage of children and adolescents with access to a PCP increased steadily over the evaluation period and was above 90 percent for all age cohorts in 2012. The access percentage also was consistently above the national rate (Exhibit 2-12).

Exhibit 2-12 – SoonerCare Choice HEDIS Trends – Child/Adolescent Access to PCP²³

HEDIS Measure	2008	2009	2010	2011	2012	% Point Change 2008 -12	National Rate
Child access to PCP, 12-24 months	94.1%	96.2%	97.8%	97.2%	96.6%	↑2.5%	96.1%
Child access to PCP, 3-6 years	83.1%	86.9%	89.1%	88.4%	90.1%	↑7.0%	88.2%
Child access to PCP, 7-11 years	82.7%	87.6%	89.9%	90.9%	91.7%	↑9.0%	89.5%
Adolescent access to PCP, 12-18 years	81.4%	85.8%	88.8%	89.9%	91.6%	↑10.2%	87.9%

²³ Source: Oklahoma Health Care Authority (OHCA) for Oklahoma HEDIS® results and National Committee for Quality Assurance (NQCA) for national Medicaid HMO rates. Reporting years represent results for activity in the prior year.

Access to preventive services also improved for both younger and older adults, exceeding 83 percent in SFY 2012 for the former and reaching 91 percent for the latter (Exhibit 2-13). (There is no national rate for this measure.)

Exhibit 2-13 – SoonerCare Choice HEDIS Trends – Adult Access to Preventive Services²⁴

HEDIS Measure	2008	2009	2010	2011	2012	% Point Change 2008 -12	National Rate
Adult access to preventive/ ambulatory services, 20 – 44 years	78.4%	83.3%	83.6%	84.2%	83.1%	↑4.7%	--
Adult access to preventive/ ambulatory services, 45 – 64 years	86.8%	89.7%	90.9%	91.1%	91.0%	↑4.2%	--

The percentage of members under age 21 who made an annual visit to the dentist improved modestly over the evaluation period, reaching 64 percent in SFY 2012 (Exhibit 2-14). (There is no national rate for this measure.)

Exhibit 2-14 – SoonerCare Choice HEDIS Trends – Annual Dental Visit Members under 21²⁵

HEDIS Measure	2008	2009	2010	2011	2012	% Point Change 2008 -12	National Rate
Annual dental visit under 21 years	59.7%	62.1%	60.2%	62.0%	64.0%	↑4.3%	--

The final two measures, breast and cervical cancer screening rates, were exceptions to the broader positive trends presented above. Both rates rose and fell throughout the evaluation period, finishing in SFY 2102 slightly below the SFY 2008 rates (Exhibit 2-15).

²⁴ Source: Oklahoma Health Care Authority (OHCA) for Oklahoma HEDIS[®] results and National Committee for Quality Assurance (NQCA) for national Medicaid HMO rates. Reporting years represent results for activity in the prior year.

²⁵ Source: Oklahoma Health Care Authority (OHCA) for Oklahoma HEDIS[®] results and National Committee for Quality Assurance (NQCA) for national Medicaid HMO rates. Reporting years represent results for activity in the prior year.

Exhibit 2-15 – SoonerCare Choice HEDIS Trends – Breast/Cervical Cancer Screening²⁶

HEDIS Measure	2008	2009	2010	2011	2012	% Point Change 2008 -12	National Rate
Breast cancer screening rate	38.3%	43.0%	41.1%	41.3%	36.9%	↓1.4%	50.4%
Cervical cancer screening rate	44.4%	46.6%	44.2%	47.2%	42.5%	↓1.9%	66.7%

One contributing factor to this fluctuation may have been an ongoing national debate concerning the recommended screening age for mammograms, which was recently raised, and recommended cervical screening intervals, which were recently lengthened. However, the SoonerCare Choice rate is lower than the national rate, indicating there is room for improvement.

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

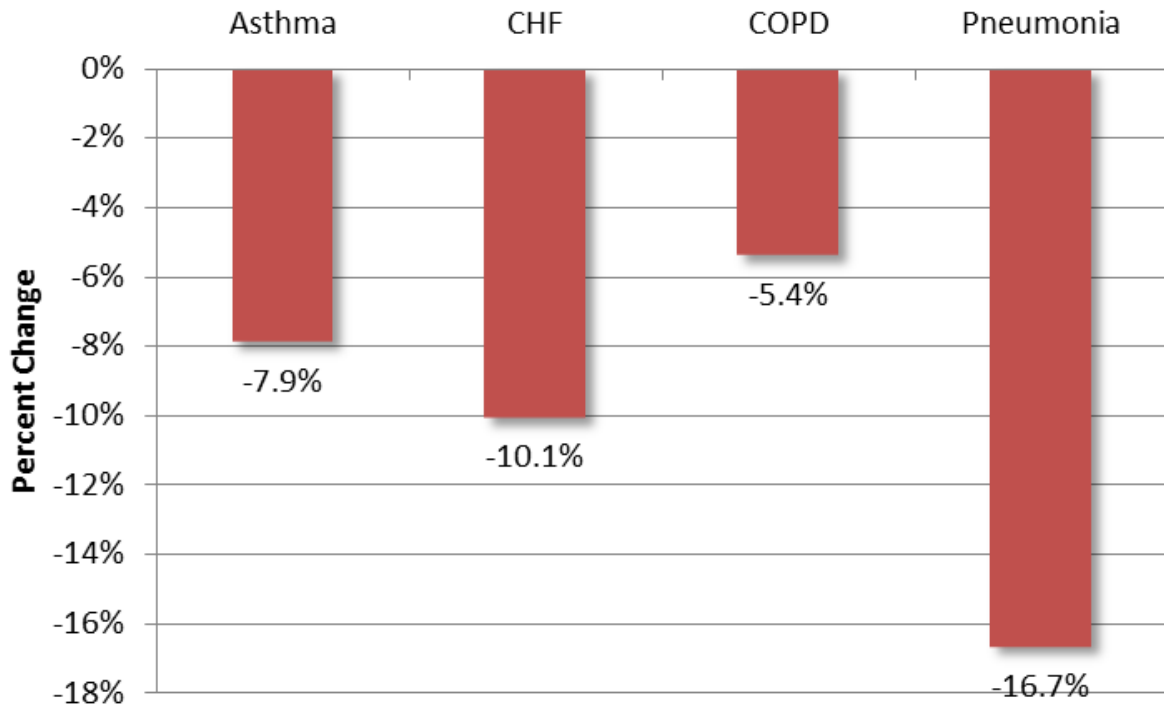
Are Health Outcomes Improving?

The delivery of high quality preventive and primary care should contribute to improved health outcomes. One useful measure of quality is the avoidable, or ambulatory care sensitive condition, hospitalization rate. If members with chronic, but treatable conditions such as Asthma, Congestive Heart Failure (CHF) or Chronic Obstructive Pulmonary Disease (COPD) receive effective preventive, primary and specialty care, their risk of an acute episode requiring hospitalization can be reduced. Similarly, members with treatable acute conditions such as pneumonia can often avoid hospitalization if the condition is diagnosed and treated at an early stage.

PHPG examined hospitalization rates for the four ambulatory care sensitive conditions from January 2009 through June 2012. The rate dropped significantly across all four conditions, with the sharpest decline occurring among members with pneumonia (Exhibit 2-16).

²⁶ Source: Oklahoma Health Care Authority (OHCA) for Oklahoma HEDIS® results and National Committee for Quality Assurance (NQCA) for national Medicaid HMO rates. Reporting years represent results for activity in the prior year.

Exhibit 2-16 – SoonerCare Choice Avoidable Hospitalization Rate²⁷



Another measure of health outcomes is the 30-day readmission rate for members who are hospitalized. The previously reported decline from January 2009 through June 2012 (Exhibit 2-10) is an indicator of effective post-discharge care.

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

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

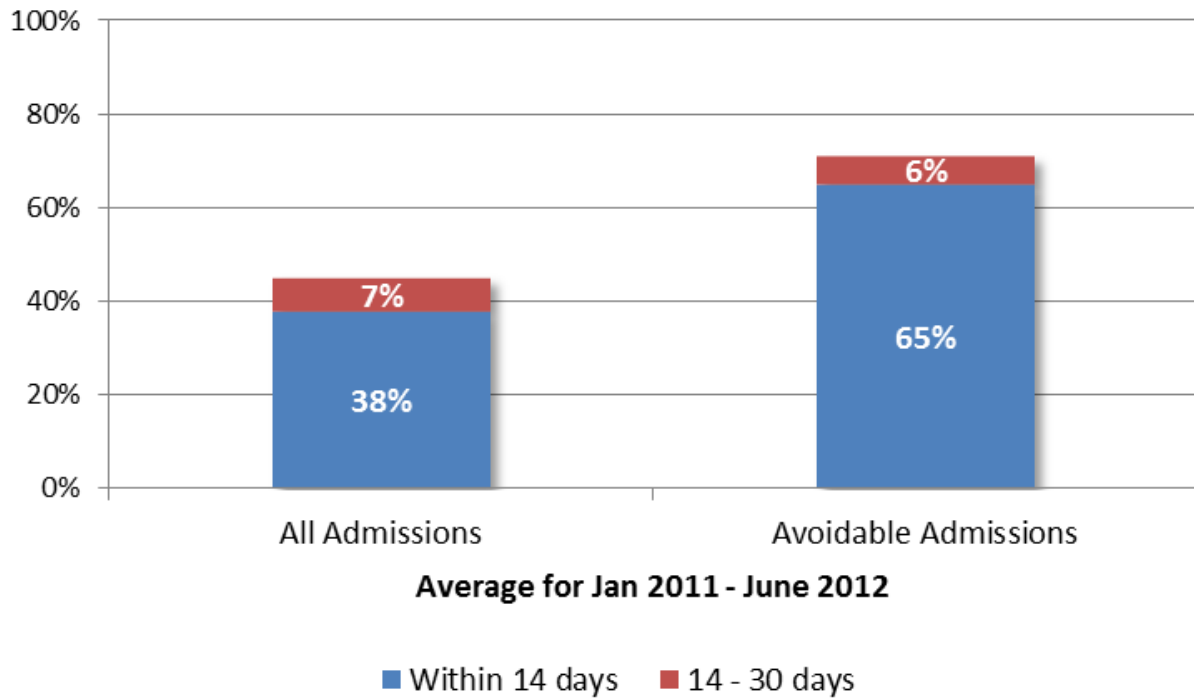
PHPG analyzed follow-up visit rates for SoonerCare Choice members recently discharged from the hospital. Visit rates were calculated at 14 and 30 days post-discharge. PHPG examined total discharges and discharges following admission for one of the four ambulatory care sensitive conditions.

The follow-up rate for members with an ambulatory care sensitive condition was over 70 percent during the period 2011 through the first six months of 2012 and nearly all of the visits

²⁷ Source: OHCA paid claims. SoonerCare Choice members enrolled in a patient centered medical home.

occurred within the 14-day window (Exhibit 2-17). The rate for all discharges was a lower 45 percent, but this was expected for the reasons discussed above.

Exhibit 2-17– SoonerCare Choice Post-Discharge PCMH Follow-up Visit Rate²⁸



²⁸ Source: OHCA paid claims. SoonerCare Choice members enrolled in a patient centered medical home.

Cost Effectiveness

Evaluation Questions

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

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

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

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

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

PHPG examined SoonerCare Choice health expenditure trends from January 2009 through June 2012. PHPG analyzed average per member per month (PMPM) expenditures to eliminate any impact associated with change in enrollment.

PHPG also analyzed members in the TANF and related categories, primarily pregnant women and healthy children, separately from aged, blind and disabled (ABD) members²⁹. Although smaller in number, the ABD population has much higher service needs and average costs; a high trend rate for this population could place significant fiscal pressures on the program.

In fact, ABD expenditures were flat over the evaluation period, while TANF and related population expenditures grew at a moderate annual rate of 3.2 percent. Annual PMPM expenditure growth for the total SoonerCare Choice population was 1.4 percent, less than half the average annual per capita national health expenditure increase of 3.2 percent over the same period (Exhibit 2-18).

²⁹ SoonerCare Choice includes ABD members who are not dually eligible for Medicare and Medicaid. Dually eligible members are enrolled in SoonerCare Traditional.

Exhibit 2-18– SoonerCare Choice PMPM Health Expenditures³⁰

Aid Category	2009	2010	2011	2012	Average Annual % Change	National per capita
ABD (non-duals)	\$863	\$851	\$848	\$862	↓0.0%	--
TANF/Other	\$205	\$199	\$206	\$225	↑3.2%	--
TOTAL	\$274	\$264	\$277	\$286	↑1.4%	↑3.2%

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

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

The OHCA contracts with vendors to administer some elements of the managed care system under its direction. For example, Telligen provides health coaching to SoonerCare HMP enrollees, although its activities are overseen by OHCA staff in the SoonerCare HMP Unit.

The OHCA also has fostered the development of patient centered medical homes and community-based care organizations, such as the Health Access Networks. The OHCA has created incentives to encourage their development and achievement of quality performance targets and directly monitors their accessibility, quality and cost effectiveness.

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

The OHCA, as a statewide plan, is able to spread administrative costs over a larger population than an MCO that is dividing membership with other plans. This enables a greater share of the healthcare dollar to be paid to providers for care delivery. It has, for example, enabled the OHCA to pay physicians 96.76 percent of the Medicare rate in 2012, as compared to the national Medicaid average of 66 percent³¹.

To gauge the relative cost effectiveness of the OHCA’s model versus the MCO model, PHPG compared SoonerCare administrative expenses, as a percentage of total spending, to the administrative expenses in the Arizona AHCCCS Medicaid managed care program. Arizona was

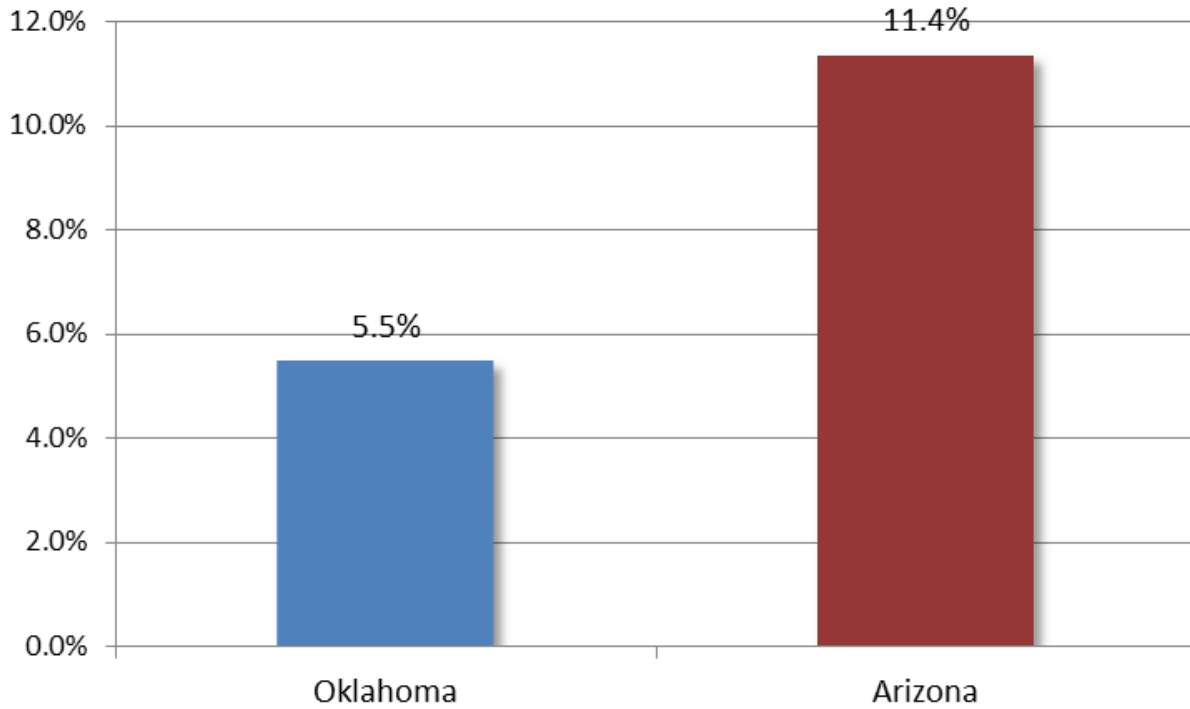
³⁰ Source: OHCA paid claims. SoonerCare Choice members enrolled in a patient centered medical home.

³¹ <http://kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/>.

chosen because it operates the nation’s oldest statewide Medicaid managed care system, dating back to 1982. Arizona contracts with MCOs to provide virtually all care to its Medicaid population.

The SoonerCare program’s administrative expenses are less than half of Arizona’s, when agency and MCO administrative/profit expenditures are taken into account (Exhibit 2-19).

Exhibit 2-19 – Administrative Costs – Oklahoma and Arizona³²



³² Sources: OHCA 2012 Annual Report; Arizona AHCCCS FY 2013 budget. Oklahoma expenses include OHCA and other agencies with administrative responsibilities (e.g., OKDHS and OSDH).

SoonerCare Choice Performance – Summary

PHPG evaluated the SoonerCare Choice program for the period January 2009 through June 2012. The program generally demonstrated strong performance in absolute terms across all three dimensions of care: Access, Quality and Cost Effectiveness. The program also showed improvement in most trend lines, concurrent with the introduction of a series of care management initiatives beginning in 2008.

The next chapter presents detailed information on the three initiatives: Patient Centered Medical Homes, Health Access Networks and the SoonerCare Health Management Program.

CHAPTER 3 – IN-DEPTH EVALUATION: SOONERCARE CHOICE INITIATIVES

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

Three significant initiatives have been undertaken in recent years:

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

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

Patient Centered Medical Homes

Overview

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

PCMH providers are paid for services rendered, such as office visits and also receive per member per month fees intended to support care management activities. The fees vary by member age and gender and by tier. A tier 1 PCMH provider with an average SoonerCare Choice caseload of 275 members could expect to receive up to \$16,000 in care management payments over the course of a year; his or her tier 3 counterpart could expect to receive around \$27,000.

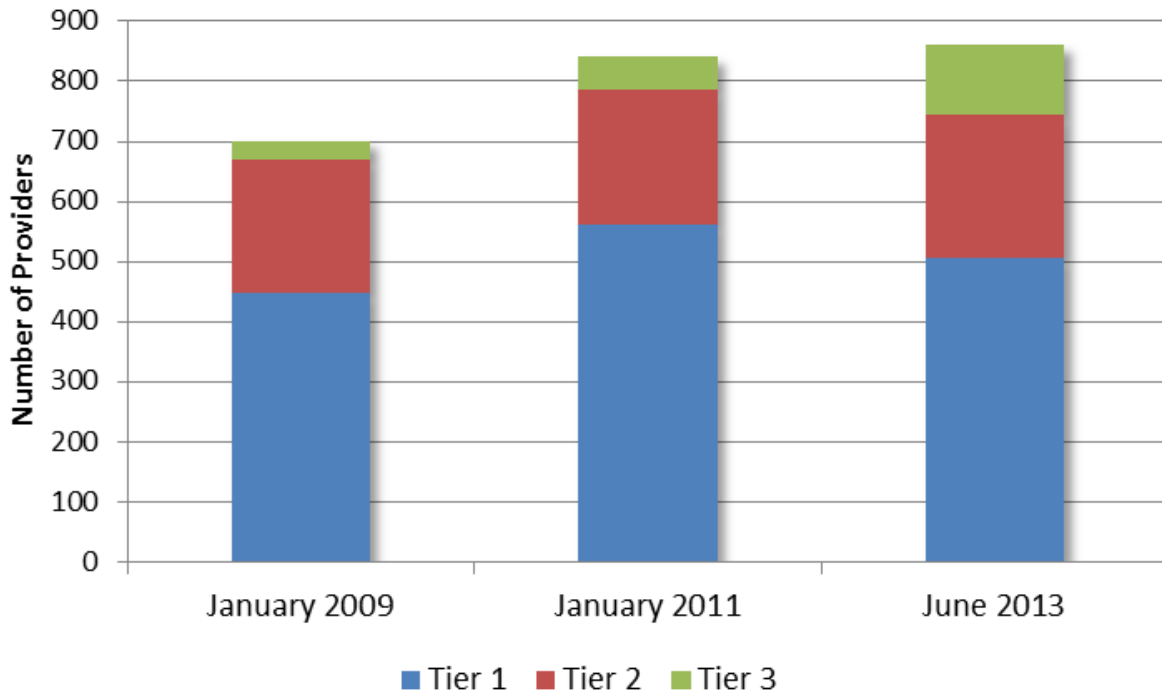
Exhibit 3-1 – Patient Centered Medical Home Tiers³³

PCMH Tier	Requirements (partial list):	PMPM Rate Range*	Practice with average caseload of 275 patients:
Tier 1 “Entry Level”	<p>12 requirements, including:</p> <ul style="list-style-type: none"> • Coordinated primary care and patient education • 24/7 telephone coverage by medical professional • Maintaining a system to track tests and referrals • Acceptance of electronic communication from OHCA 	\$3.46 to \$4.85	\$16,005 per year
Tier 2 “Advanced”	<p>19 requirements, including all Tier 1 plus:</p> <ul style="list-style-type: none"> • Full-time practice w/enhanced access/after-hours • Inpatient tracking & hospital follow-up • Any 3 of 6 optional enhanced services - practice healthcare team, after visit follow-up, adoption of evidence-based practice guidelines, medication reconciliation, MH screening 	\$4.50 to \$6.32	\$20,856 per year
Tier 3 “Optimal”	<p>23 requirements, including all T1/T2 plus:</p> <ul style="list-style-type: none"> • Using health assessments tools to characterize patient needs and risks <p>Also recommended:</p> <ul style="list-style-type: none"> • Communicating with patients/families through secure, interactive website • Utilizing integrated care plans for patients co-managed with specialists • Regularly measuring performance for quality improvement 	\$5.99 to \$8.41	\$27,753 per year

The majority of practices have contracted to be tier 1 providers. However, since 2009, tier 3 providers have increased from six percent to nearly 14 percent of the total (Exhibit 3-2). Over the period January 2009 through June 2012, the absolute number of participating providers also has increased significantly, from 699 to 858.

³³ The OHCA pays separate rates for providers based on whether they treat adults only, children only or both children and adults . Rates are for SFY 2012. Average practice fee calculation performed using top of rate range for each tier.

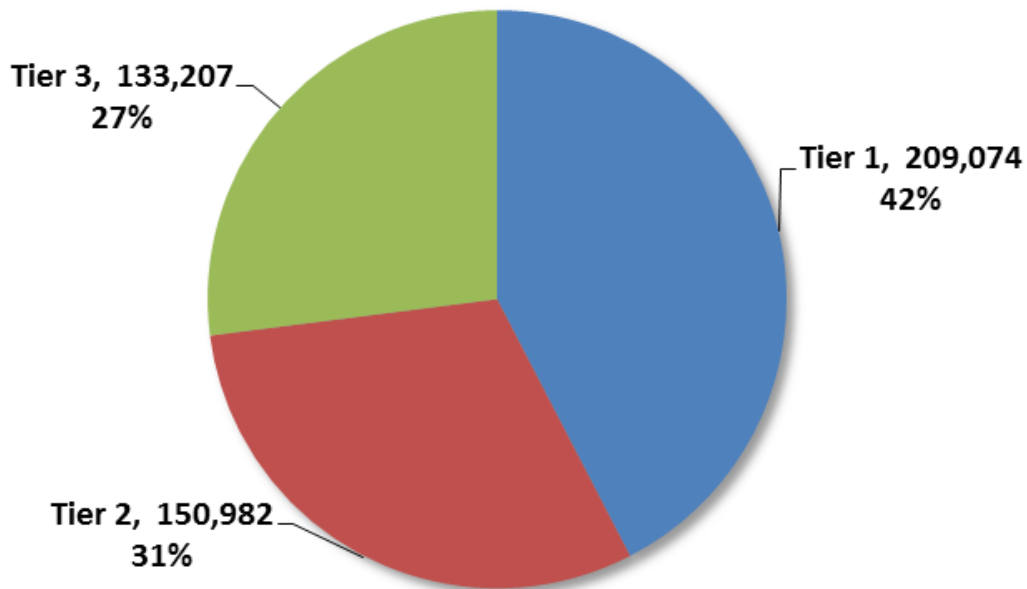
Exhibit 3-2 – Patient Centered Medical Home – Participating Practices by Tier³⁴



Although tiers 2 and 3 make-up less than one-half of PCMH practices, they have larger average caseloads than the tier 1 practices. As a result, 73 percent of SoonerCare Choice members were enrolled in a tier 2 or 3 practice in June 2013 (Exhibit 3-3).

³⁴ Sources: OHCA PCMH roster data; Patient-Centered Medical Home – Survey of SoonerCare-Contracted PCPs. Approximately 20 percent of practices surveyed in 2012 reported that their tier level had changed at some point; practices can include multiple providers.

Exhibit 3-3 – SoonerCare Choice Member Enrollment by Tier³⁵



PCMH Performance

The PCMH model was implemented in 2008. PHPG used paid claims data to evaluate utilization and expenditure trends during the period January 2009 through June 2012. Although the model is still relatively new, the 42 months studied were sufficient to identify trends at the aggregate level (across all tiers). Many of these trends were favorable.

PHPG evaluated PCMH performance with respect to the following:

- PCMH visit rates
- Emergency room utilization rates
- Follow-up visit rate with PCMH within 30 days of ER encounter
- Avoidable hospitalization rate
- Hospital readmission rate within 30 days of discharge
- Use of a PCP other than the member's assigned PCMH
- Use of a specialist without prior visit to PCMH within prior 30 days
- Average PMPM expenditures

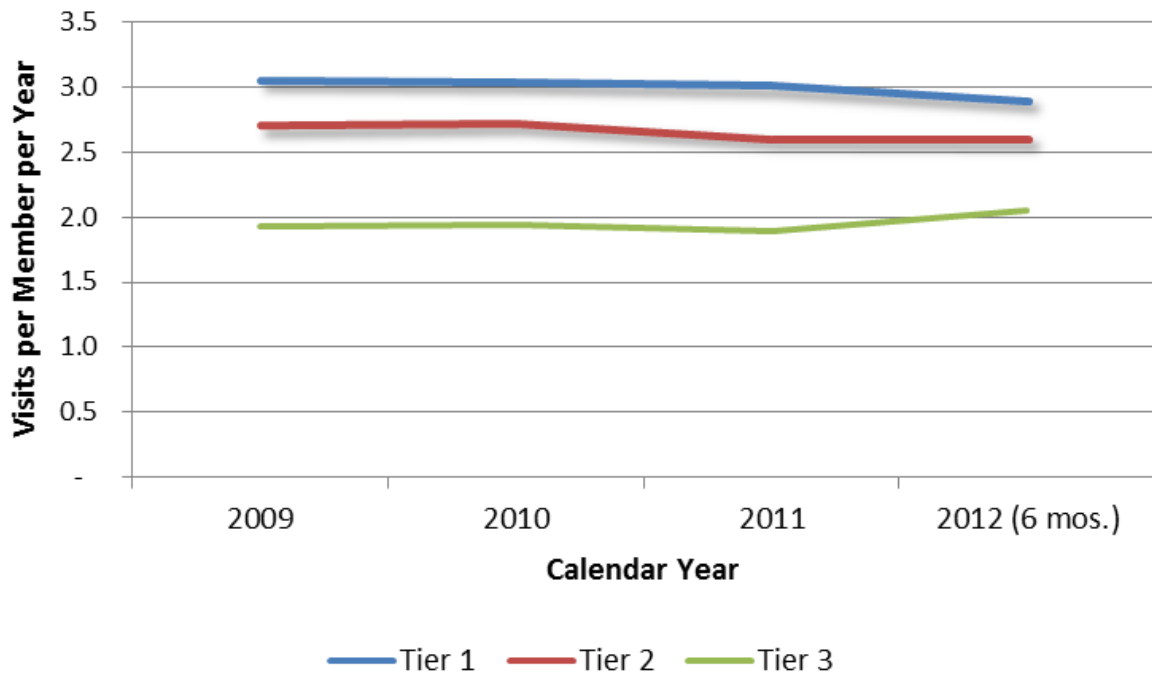
³⁵ Source: OHCA June 2013 Fast Facts.

Some of these performance measures were presented in chapter two but are presented again here broken out by provider tier.

PCMH Visit Rates

SoonerCare Choice members across all age groups have averaged about 2.5 visits per year to their PCMH provider. This visit rate is in line with program expectations and has held steady since 2009. The rate for members aligned with a tier 3 provider has actually been slightly lower than for other members (Exhibit 3-4).

Exhibit 3-4 – PCMH Visit Rates (per member per year)³⁶

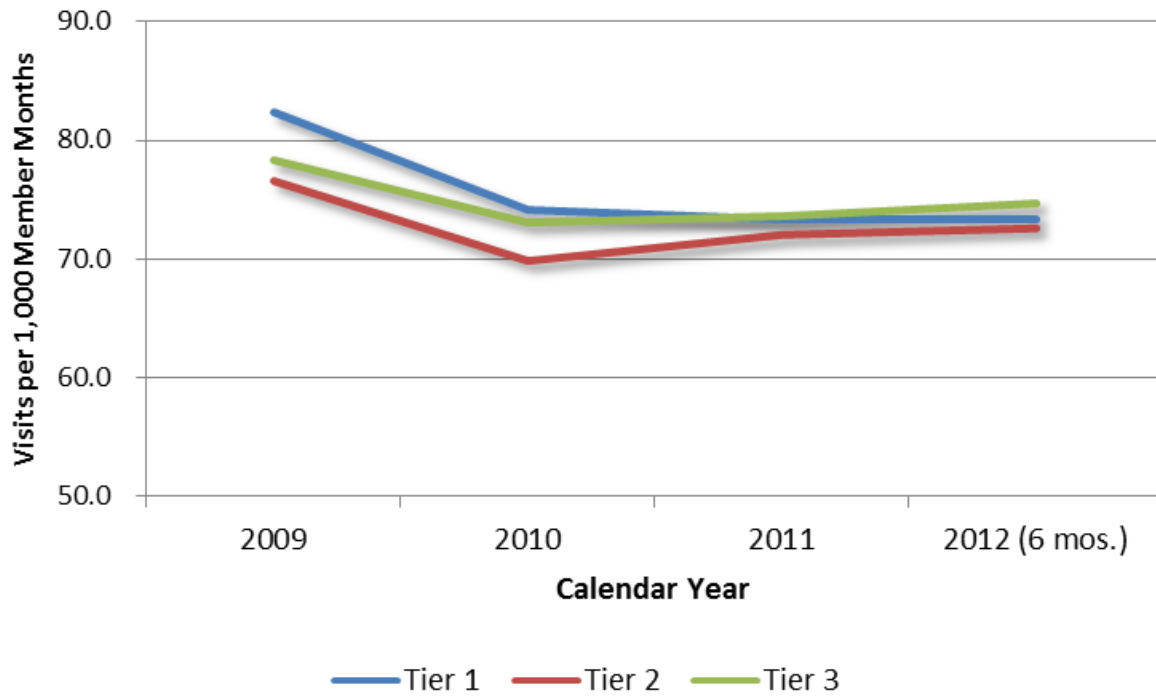


³⁶ Source: OHCA paid claims data.

Emergency Room Utilization Rates

As discussed in chapter two, emergency room utilization declined significantly after introduction of the PCMH model in 2009 and has since remained relatively steady. There was almost no difference in member use rates across the three tiers (Exhibit 3-5).

Exhibit 3-5 – Emergency Room Utilization Rates (per 1,000 member months)³⁷

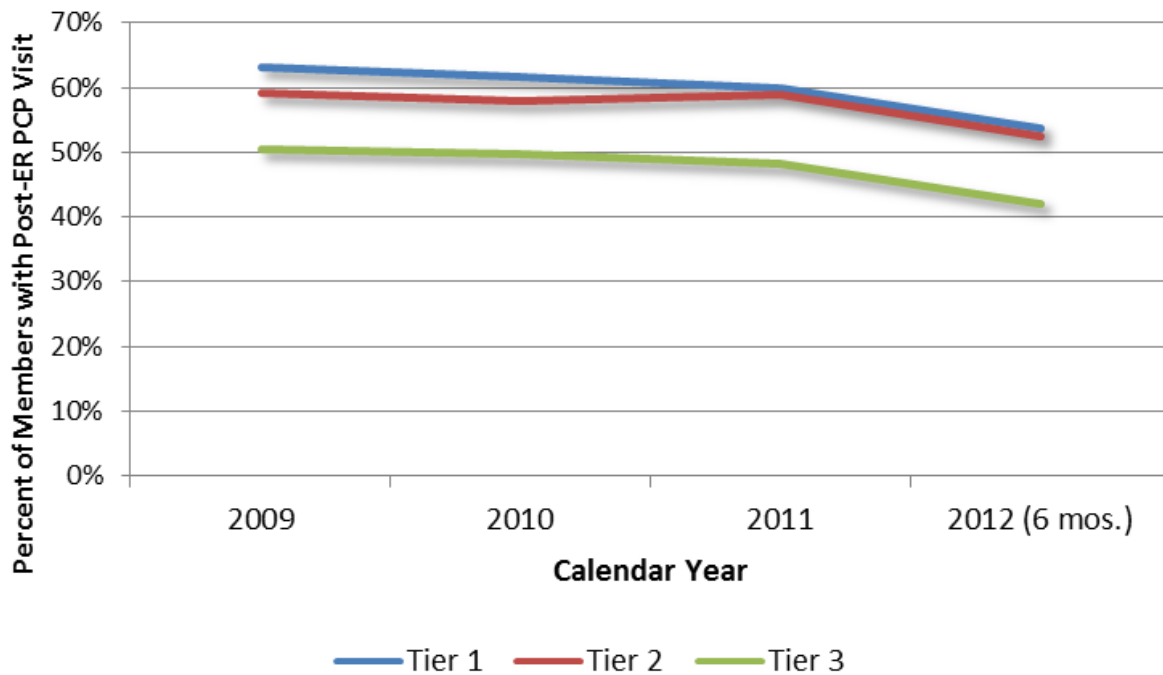


³⁷ Source: OHCA paid claims data.

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

It is the OHCA’s expectation that PCMH providers contact members who have been to the emergency room and schedule follow-up appointments for these members when appropriate. Over 50 percent of SoonerCare Choice members with an emergency room encounter did see their PCMH provider within 30 days of the episode, although the percentage dropped slightly in 2012. Tier 3 providers were somewhat less likely to see members after an emergency room encounter (Exhibit 3-6).

Exhibit 3-6 – Follow-up Visit Rate to PCMH within 30 Days of ER Encounter³⁸

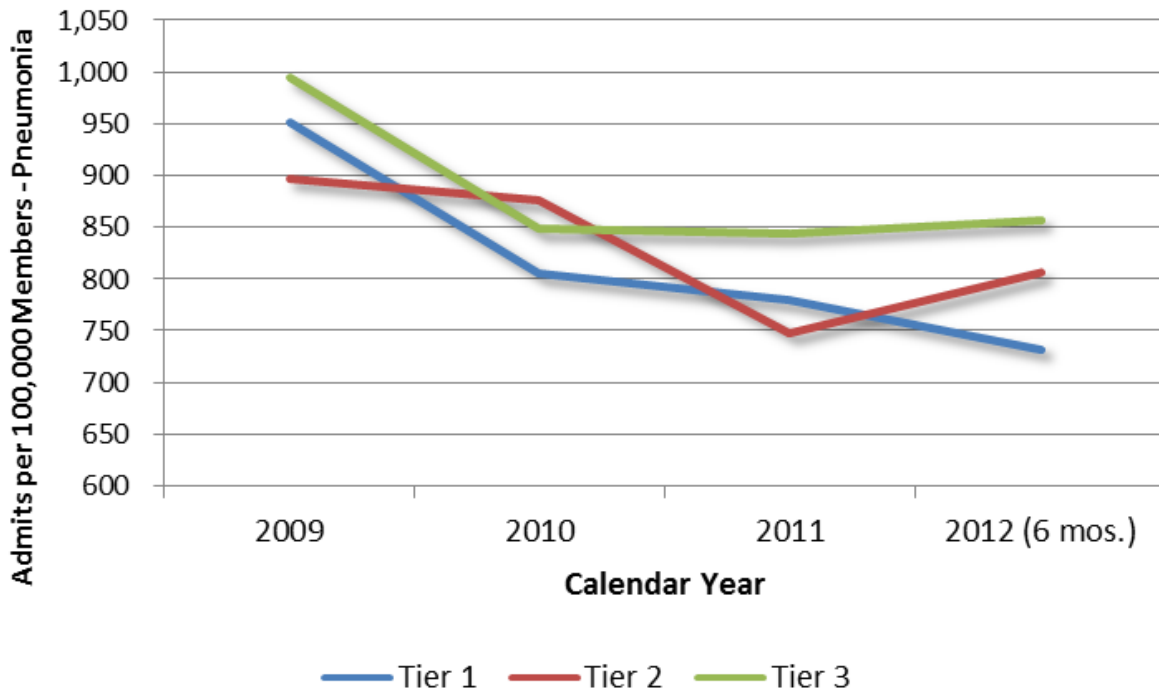


³⁸ Source: OHCA paid claims data.

Avoidable Hospitalization Rate

As discussed in chapter two, the hospitalization rate for four key diagnoses (asthma, CHF, COPD and pneumonia) fell significantly from 2009 to 2012. The rate of decline varied by tier, but was not consistent from one year to the next. The trend line for pneumonia is depicted below but similar results were found for all four diagnoses (Exhibit 3-7).

Exhibit 3-7 – Avoidable Hospitalization Rate - Pneumonia (per 100,000 members)³⁹

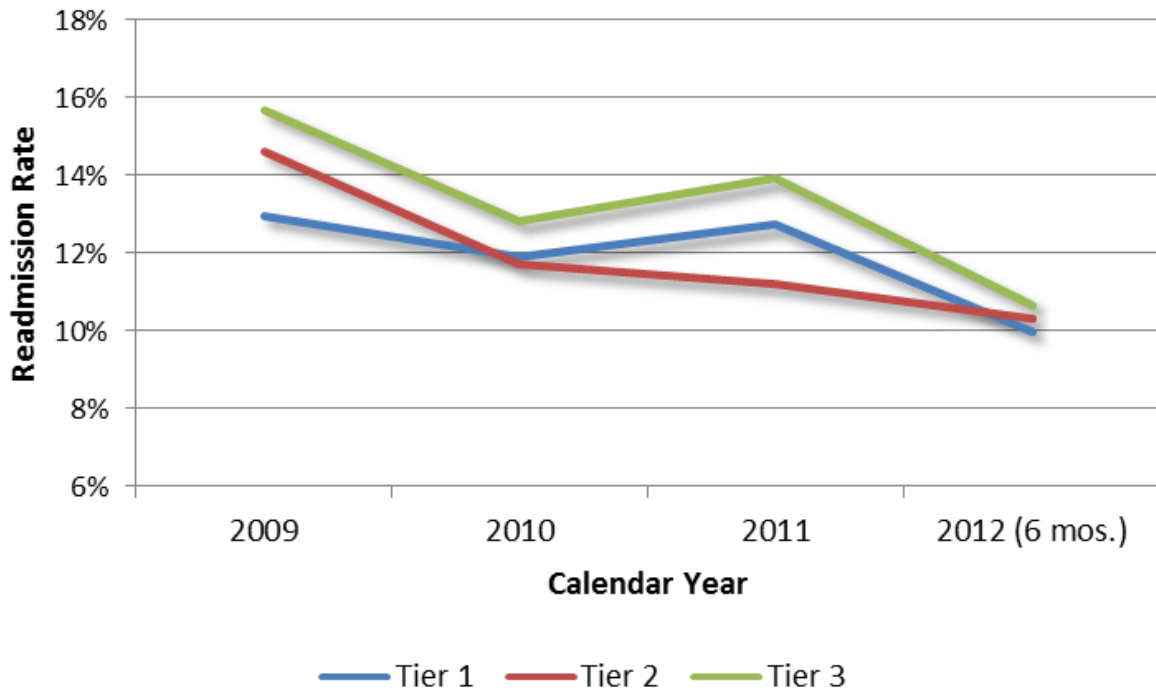


³⁹ Source: OHCA paid claims data.

Hospital Readmission Rate within 30 Days of Discharge

As discussed in chapter two, the 30 day readmission rate fell from 2009 to 2012, despite a slight uptick in 2011. After showing some differences from 2009 to 2011, the readmission rate converged across all three tiers in 2012 (Exhibit 3-8).

Exhibit 3-8 – Hospital 30-Day Readmission Rate⁴⁰



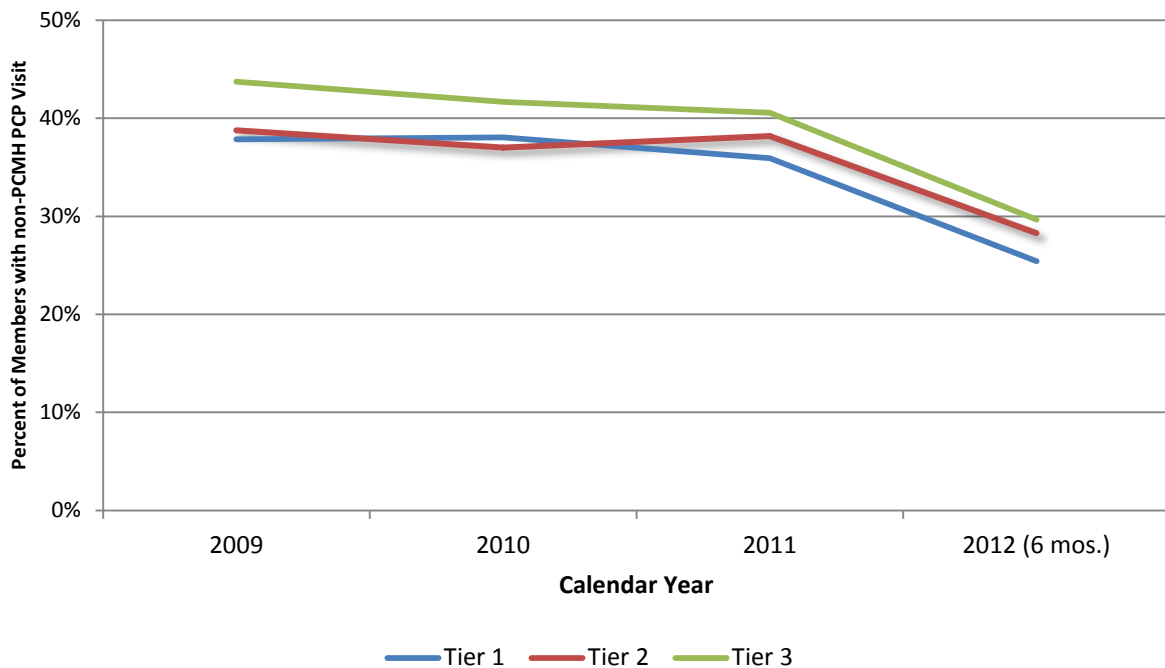
⁴⁰ Source: OHCA paid claims data.

Use of a PCP other than the Member’s Assigned PCMH

Historically, Medicaid beneficiaries have shown a tendency to jump from doctor to doctor, which reduces the prospects for effective care management. The patient centered medical home model is designed to reduce this tendency by fostering strong relationships between members and their primary care providers.

The incidence of SoonerCare Choice members seeing a primary care provider other than their own at least once declined during the evaluation period from around 40 percent to less than 30 percent. The decline occurred across all tiers (Exhibit 3-9).

Exhibit 3-9 – Visit to a PCP other than Member’s PCMH⁴¹



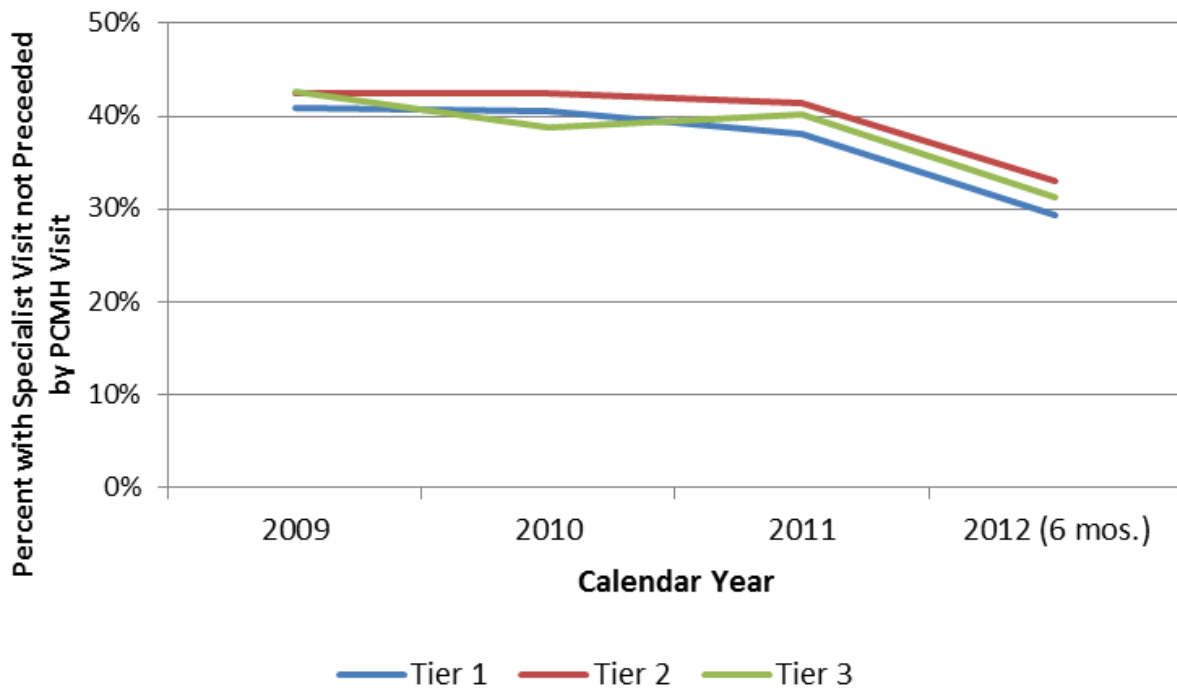
⁴¹ Source: OHCA paid claims data. Visits to a PCP in a county other than the member’s county of residence were excluded on the assumption that the visit may have been for an urgent problem requiring attention while the member was away from his or her home.

Use of a specialist without prior visit to PCMH within prior 30 days

Under the PCMH model, the member’s primary care provider should be managing all aspects of the member’s care, including referrals to specialists. As an indirect measure of PCMH activity in this area, PHPG examined the incidence of members seeing a specialist without having first visited their PCMH provider in the prior 30 days. Some activity would be expected, as the result of standing referrals for persons with chronic conditions, but the desired trend would be downward.

The portion of members making at least one specialist visit without a prior PCMH visit held steady at about 40 percent through 2011 before dropping in 2012 into the low to mid 30 percent range, depending on the provider tier (Exhibit 3-10). An additional year of data should indicate whether the drop was the beginning of a trend or an aberration.

Exhibit 3-10 – Visit to a Specialist without Prior Visit to PCMH within 30 Days⁴²

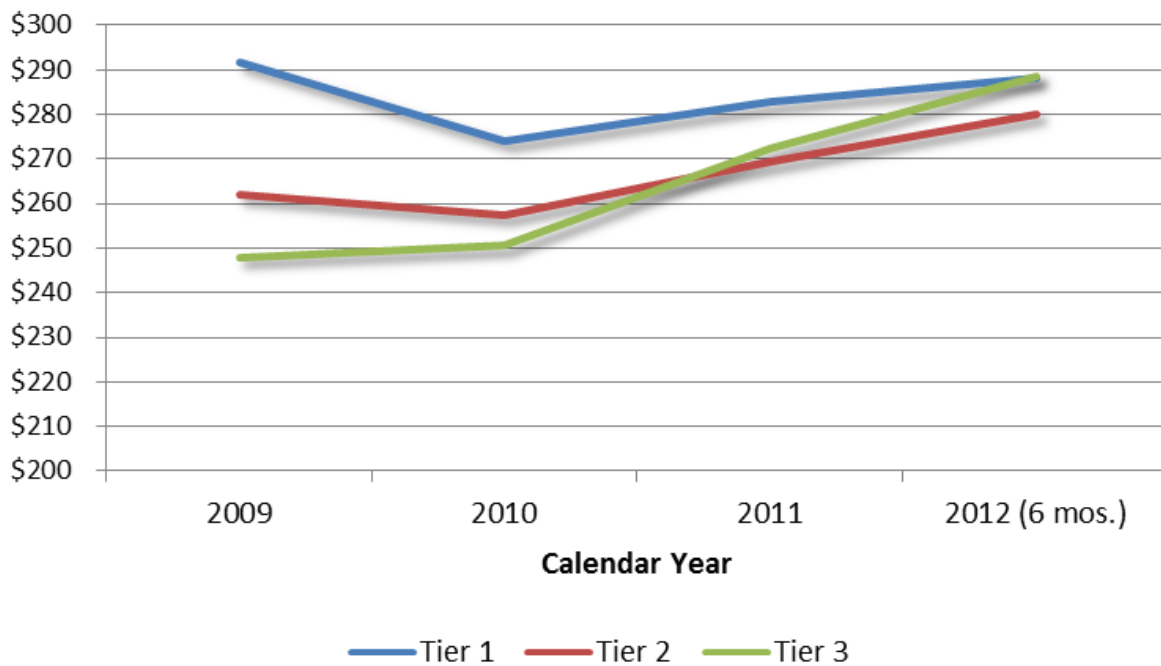


⁴² Source: OHCA paid claims data.

PMPM Expenditures

As discussed in chapter two, per member per month expenditures grew modestly from January 2009 through June 2012. The average PMPM expenditure in 2009 was significantly higher among members aligned with a tier 1 provider than those with a tier 2 or tier 3 provider, but the gap was largely eliminated by the first half of 2012, particularly between tiers 1 and 3 (Exhibit 3-11).

Exhibit 3-11 – PMPM Expenditures by Provider Tier⁴³



PCMH Impact (Return-on-Investment)

The PCMH model appears to be contributing to positive trend lines for the SoonerCare Choice program as a whole. At the aggregate level (across tiers), the program demonstrated consistent improvement in outcomes from January 2009 through June 2012.

It is difficult to isolate the precise effect of the PCMH model in many areas since, by the OHCA’s design, PCMH requirements often overlap with, and amplify the impact of other program initiatives. For example, PCMH providers are rewarded through SoonerExcel payments for reducing inappropriate use of the emergency room by their patients. Emergency room utilization also is addressed through OHCA care management and targeted interventions with members who are high utilizers.

⁴³ Source: OHCA paid claims data. Includes all categories of service. Decline from 2009 to 2010 coincided with reduction in physician fee schedule from 100 percent of Medicare to 97 percent of Medicare.

It also is difficult at this stage to identify any positive correlation between provider tiers and outcomes. In most instances there was less differentiation between tiers than might be anticipated, given the greater demands placed on the higher tiers.

The lack of differentiation could partially be a timing issue. Many tier 2 and 3 practices achieved their status only in the final 12 to 24 of the evaluation period, leaving little time register a significant impact. It also could suggest that the separation of practices into three tiers is unnecessary, since the majority of requirements are imposed on tier 1 providers, and in interviews and focus groups, providers consistently express the intent to meet as many requirements as possible, regardless of their formal tier assignment.

PHPG will be updating the PCMH evaluation to include data through June 2013, which should help to clarify the issue and better define if and how the OHCA should respond.

Health Access Networks

Overview

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

There are three HAN contractors:

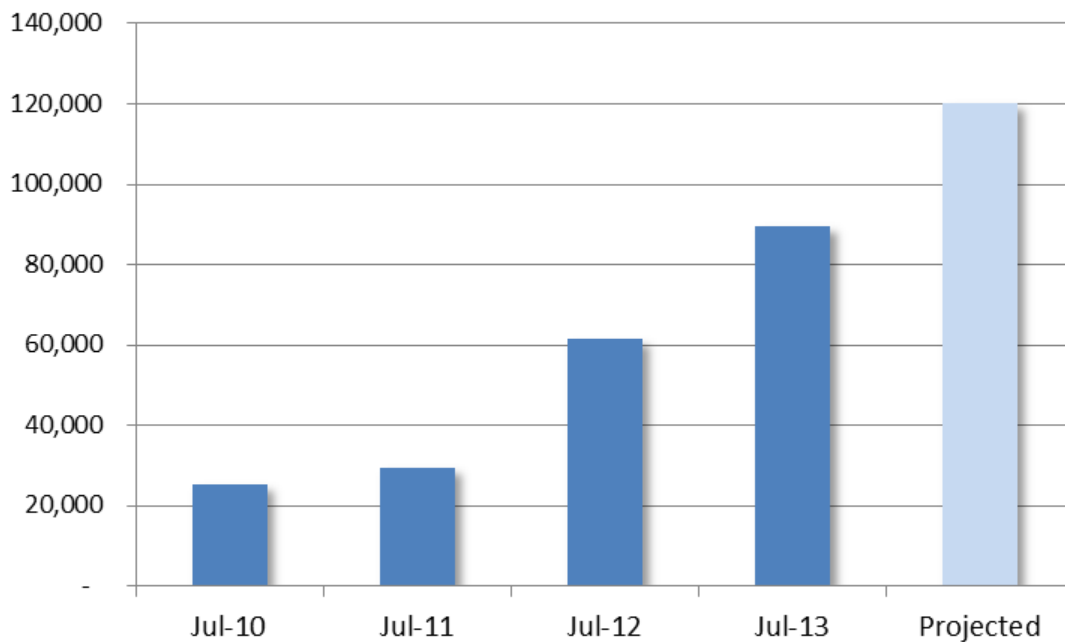
- Canadian County (Partnership for a Healthy Canadian County)
- Oklahoma State University (OSU) Center for Health Sciences
- Oklahoma University (OU) Sooner Health Access Network

The HANs receive an additional \$5.00 PMPM in return for their care management duties, which include offering telemedicine and other specialty care assistance to PCMH providers.

HAN Membership Trend and Performance

HAN membership grew dramatically during the initiative’s first years, from only 25,000 in July 2010 to nearly 90,000 in July 2013. The OHCA expects membership ultimately to reach 120,000 across the three networks (Exhibit 3-12).

Exhibit 3-12 – HAN Membership Growth⁴⁴



⁴⁴ Sources: OHCA enrollment and payment data for historical; OHCA for projection.

The rapid membership growth is a positive trend, as it reflects expanding participation by PCMH providers in the networks. However, it makes evaluation of HAN performance problematic because of the continual influx of new members. PHPG will attempt to evaluate HAN performance along the same dimensions as the PCMH evaluation in the updated report to be issued in 2014.

SoonerCare Health Management Program

Overview

Chronic diseases are among the most costly of all health problems. Treatment of chronic disease accounts for more than 75 percent of total U.S. health care spending. Providing care to individuals with chronic diseases, many of whom meet the federal disability standard, has placed a significant burden on state Medicaid budgets. Under the Oklahoma Medicaid Reform Act of 2006 (HB2842), the Legislature directed the OHCA to develop and implement a management program for chronic diseases, such as asthma, COPD and diabetes.

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

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

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

The program had two major components through June 2013: nurse care management and practice facilitation. The nurse care management portion of the program was transformed in July 2013 into practice-based health coaching. Both components are administered by a vendor (Telligen) with oversight from a dedicated SoonerCare HMP Unit within the OHCA.

Nurse Care Management and Health Coaching

Nurse care management targeted SoonerCare members with chronic conditions identified as being at high risk for both adverse outcomes and significant forecasted medical costs. The members were stratified into two levels of care, with the highest-risk segment placed in “Tier 1” and the remainder in “Tier 2.” Prospective participants were contacted and enrolled in their appropriate tier. After enrollment, participants were engaged through initiation of care management activities.

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

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

The transition to health coaching was not due to a lack of efficacy in the former model but rather to increase the amount of time nurses could spend with members. Under nurse care management, significant resources were often required just to locate members; missed appointments were common and reduced nurse care manager productivity. Under the more efficient health coaching model, where the member comes to the nurse, the OHCA has been able to increase the enrollment target from 5,000 to 7,000 at any given time.

Practice Facilitation

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

SoonerCare HMP Performance

PHPG has served an independent evaluator of the SoonerCare HMP since its implementation. The most recent evaluation covered program performance through June 2012 and examined:

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

Summary findings from the evaluation are presented below. The full report is available from the OHCA⁴⁵.

⁴⁵ See: SoonerCare HMP – Fourth Annual Evaluation, March 2013.

Member and Provider Satisfaction

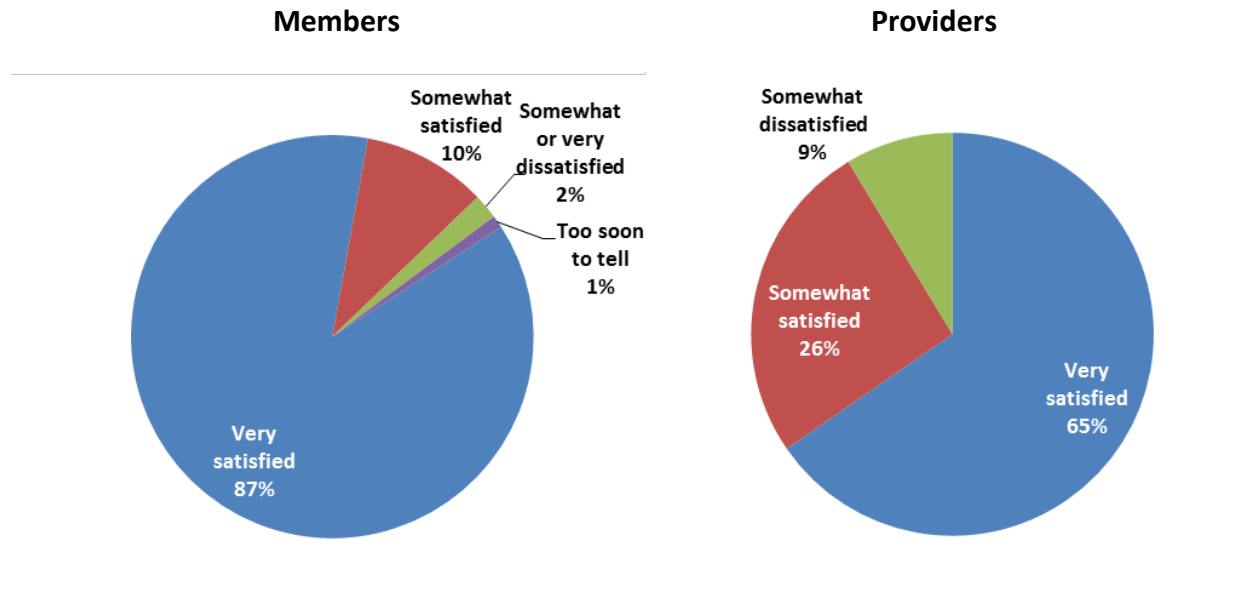
PHPG conducted surveys and focus groups/in-depth interviews with members and providers to explore their perceptions of the SoonerCare HMP. Participants in nurse care management gave the program high marks. When asked in a survey to rate their experience, nearly 90 percent of respondents declared themselves very satisfied. A smaller but still significant portion (27 percent) believed their health had improved due to participation in the program (Exhibit 3-13).

Survey findings were supported by member comments in focus groups. Representative examples include:

- *“Well, I mean, health-wise, I feel like I’m better. I lost, like, 92 pounds. I started that prior to my hip surgery because I’d recover faster. But after my hip surgery, I had to go on the ADvantage program. I’m exercising three times a week...and when it’s warm I try to walk as much as I can outside. When it’s cold I walk inside my apartment building in the hall. There’s other things going on too, but my nurse also helped me to come up with a plan to lose weight.”*
- *“She keeps my health and my mind together. Exercising and eating right and taking my medication, my blood sugar and my blood pressure.”*
- *“Not sure if it’s a correlation with the nurse program. But, I am seeing my doctor more often than I was. I was seeing different doctors every three months so now I’m on a one month schedule with one doctor.”*
- *“I love it that someone’s checking up on me and making sure that I’m OK every month. I can’t say that anybody I’ve given birth to would do that!”*

Practice facilitation providers also were satisfied and considered the program to be of significant value. Survey respondents credited the program with improving their adherence to clinical guidelines. Nearly all (91 percent) would recommend the program to a colleague.

Exhibit 3-13 – SoonerCare HMP – Member and Provider Satisfaction⁴⁶



Impact on Quality of Care

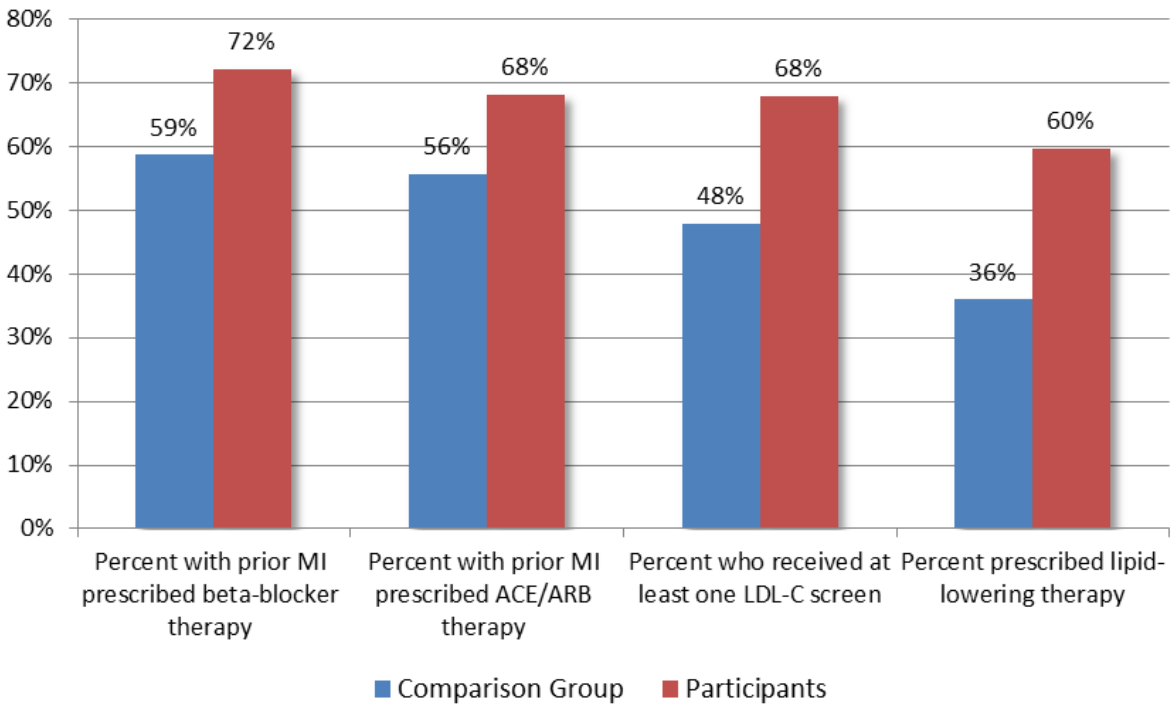
Nurse care managers/health coaches devote their time to improving members’ quality of care and quality of life. This includes helping to schedule appointments; educating members about the importance of managing their illness; and educating members about the importance of seeing their provider for preventive and diagnostic services. Ultimately, if participants adhere to chronic care guidelines, there should be a reduction in their risk profile and need for expensive acute care services.

To measure the program’s impact on quality of care, PHPG’s subcontractor APS Healthcare evaluated the preventive and diagnostic services provided to SoonerCare HMP participants with six targeted chronic conditions: asthma, CHF, COPD, coronary artery disease, diabetes and hypertension. The evaluation was performed using administrative (paid claims) data. APS also calculated the SFY 2012 compliance rates for a “comparison group” consisting of SoonerCare members found eligible for, but not enrolled in the SoonerCare HMP.

Findings from the analysis were promising. The participant compliance rate exceeded the comparison group rate for 14 of 21 diagnosis-specific measures. The difference was statistically significant for nine of the 14, suggesting that the program is having a positive effect on quality of care. The most impressive results, relative to the comparison group, were observed for participants with congestive heart failure, coronary artery disease and hypertension. Results are shown below for coronary artery disease measures with a statistically significant difference in compliance rates between participants and the comparison group (Exhibit 3-14).

⁴⁶ Source: SoonerCare HMP Fourth Annual Evaluation, March 2013.

Exhibit 3-14 – SoonerCare HMP – Coronary Artery Disease Quality Measures⁴⁷



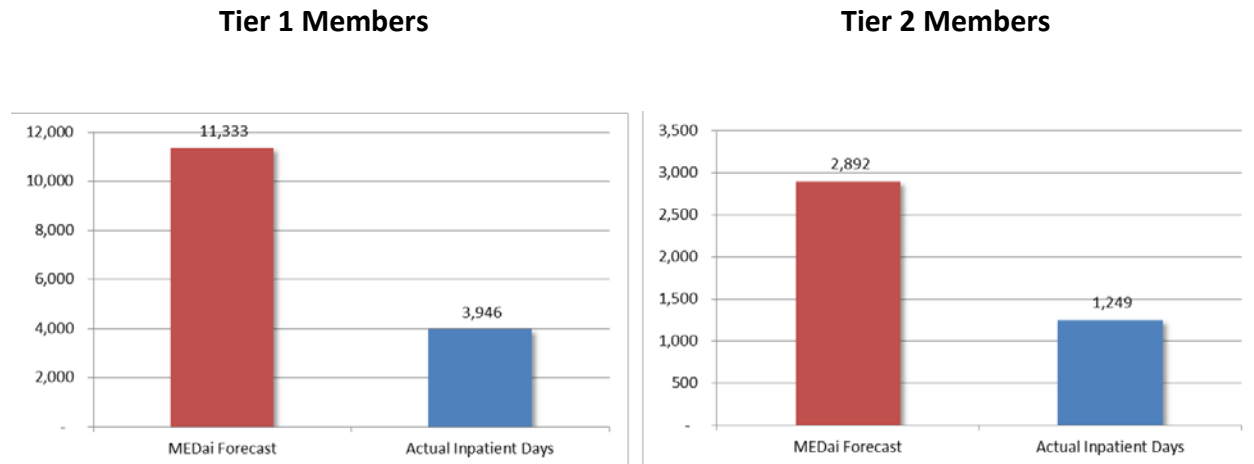
Service Utilization and Expenditures

PHPG evaluated service utilization and expenditures among the nurse care managed population and among patients of providers who underwent practice facilitation and compared the utilization to what would have occurred absent the program. The comparison was made against projected expenditures generated by predictive modeling software developed by MEDai.

The impact on member utilization through June 2012 was found to be significant, particularly with respect to inpatient hospital admissions/days and emergency room visits (Exhibit 3-14). Actual inpatient days were substantially below forecast for both Tier 1 and Tier 2 members. (Reminder: Tier 1 and Tier 2 refer to in-person and telephonic nurse care management; the term is not related here to PCMH tiers.)

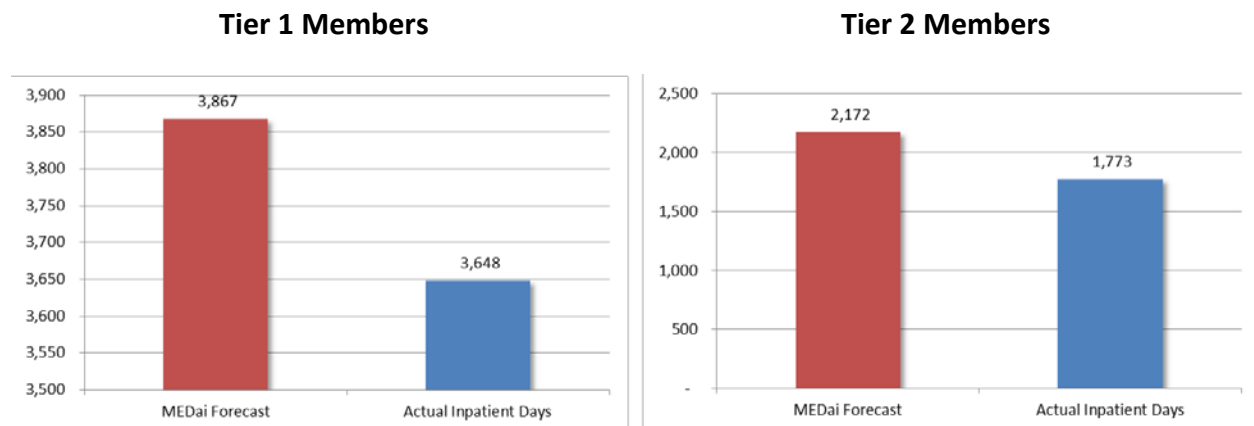
⁴⁷ Source: SoonerCare HMP Fourth Annual Evaluation, March 2013.

Exhibit 3-15 – SoonerCare HMP – Impact on Nurse Care Managed Member Inpatient Days⁴⁸



The impact on emergency room utilization has been somewhat less dramatic but still significant (Exhibit 3-16).

Exhibit 3-16 – SoonerCare HMP – Impact on Nurse Care Managed Member ER Visits⁴⁹



In SFY 2010, the SoonerCare HMP was found to be running a small deficit during the first 12 months of participant engagement, when front-end costs associated with providing preventive services and addressing deferred health needs were incurred, and administrative expenses were highest. However, the deficit converted to savings after month 12, when the impact of improved chronic care self-management began to be felt. PHPG hypothesized at the time that, “These savings can be expected to outweigh front-end costs and begin producing aggregate program savings as the program continues to operate and mature.”⁵⁰

⁴⁸ Source: SoonerCare HMP Fourth Annual Evaluation, March 2013.

⁴⁹ Source: SoonerCare HMP Fourth Annual Evaluation, March 2013.

⁵⁰ See: SoonerCare HMP Second Annual Evaluation, July 2011, page 7.

In SFY 2011, the addition of another year of experience did in fact result in greater program aggregate savings for both tier groups, a trend that continued in SFY 2012. Overall, the nurse care management portion of the SoonerCare HMP through SFY 2012 achieved aggregate savings in excess of \$93 million, or 21 percent of total medical claim costs.

PHPG also examined expenditures for chronically ill patients being treated by practice facilitation providers to test the initiative’s cost effectiveness. Similar to the method used for the nurse care management evaluation, PHPG analyzed PMPM medical expenditures for patients treated during the evaluation period compared to MEDai forecasts. PMPM expenditures for practice facilitation patients (post-provider initiation) averaged \$579 through SFY 2012, after factoring-in program administrative expenses. This compared favorably to a \$653 PMPM expenditure forecast for the same patients absent practice facilitation.

The net difference in PMPM expenditures (forecast minus actual) through SFY 2012 was \$74.91. This figure, when multiplied by practice facilitation site member months yielded aggregate savings of approximately \$46 million (state and federal dollars), or 11.5 percent as measured against total medical claims costs.

Savings calculations are net of administrative expenditures. These include payments to Telligen plus OHCA staffing and overhead costs. Total net savings through June 2012 stood at \$139 million dollars (Exhibit 3-17).

Exhibit 3-17 – SoonerCare HMP – Net Savings (Millions of Dollars)⁵¹

Program Component	2009	2010	2011	2012	Total
NCM – Tier 1	(\$0.5)	(\$2.0)	\$14.6	\$14.3	\$26.4
NCM – Tier 2	(\$2.0)	\$3.2	\$31.2	\$34.4	\$66.8
Total NCM	(\$2.5)	\$1.2	\$45.8	\$48.7	\$93.1
Practice Facilitation	(\$0.6)	\$7.1	\$27.1	\$12.5	\$46.1
Total Program	(\$3.1)	\$8.3	\$72.9	\$61.2	\$139.2

Return on Investment

PHPG calculated the SoonerCare HMP’s return on investment (ROI) by comparing administrative expenditures to net medical savings across both program components (nurse care management and practice facilitation).

⁵¹ Source: SoonerCare HMP Fourth Annual Evaluation, March 2013.

The ROI for the program in total through SFY 2012 was 524 percent. Put another way, the SoonerCare HMP generated over five dollars in medical savings for every dollar in administrative expenditures.

CHAPTER 4 – SOONERCARE CHOICE: A NATIONAL PERSPECTIVE

Community-Based Managed Care

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

The program also includes the types of market-based incentives commonly used by MCOs to encourage and reward high quality care. The OHCA's SoonerExcel payments to PCMH providers are consistent with "pay-for-quality" initiatives employed by private plans.

Since expanding SoonerCare Choice statewide in 2005, the OHCA has achieved a level of stability in operations that previously did not exist. Under the SoonerCare Plus program, participating MCOs entered and exited the three service areas annually, forcing members to transfer between plans and, in many cases, to terminate existing relationships with providers because of differences in networks.

SoonerCare Choice also has served as an effective platform for innovation. The OHCA was able to introduce the PCMH model, Health Access Networks and the SoonerCare HMP across the State without relying on third party intermediaries, i.e., MCOs. This enabled the OHCA to roll-out the initiatives on a schedule of its choosing and to make adjustments swiftly to enhance program effectiveness (e.g., conversion of SoonerCare nurse care management to health coaching).

The SoonerCare Choice structure is less common than the MCO model discussed below but it is not unique to Oklahoma. Other community-based managed care systems can be found around the country (Exhibit 4-1). One of the hallmarks of these programs is their stability; the oldest date back to the early 1980's.

Exhibit 4-1 – Community-Based Managed Care

Program	Description	Year Established
California – County Organized Health Systems	Eight counties operate managed care waiver programs under the COHS model. The largest is in Orange County (population three million). County Medicaid agency contracts directly with providers and other community-based organizations to serve Medicaid beneficiaries.	1983
North Carolina – Community Care of NC/ACCESS	North Carolina contracts with providers under a structure similar to the Oklahoma PCMH model and offers additional care management support through monitoring and disease management initiatives ⁵² .	1991
Vermont – Global Commitment to Health	Vermont’s Medicaid agency functions as a statewide health plan in the same manner as the OHCA. The Vermont program enrolls all beneficiaries, including dual eligibles and long term care recipients into managed care.	1995 ⁵³

Oklahoma also is not the only state to adopt a community-based model after previously relying on MCO contracts. In 2012, Oregon converted its Section 1115 Medicaid managed care program through establishment of patient centered primary care homes and coordinated care organizations, consisting of networks of health care providers who agreed to work together in their local communities to serve Medicaid beneficiaries. CCOs are focused on prevention and helping members to manage chronic conditions.

Traditional MCO Programs

All but two states enroll at least a portion of their Medicaid population into managed care⁵⁴, the majority through contracts with MCOs. Among Oklahoma’s neighbors, Kansas, Missouri, New Mexico and Texas enroll TANF/CHIP beneficiaries into MCOs; New Mexico and Texas also enroll ABD beneficiaries, including persons dually-eligible for Medicaid/Medicare and persons eligible for long term care⁵⁵.

⁵² In July 2013, the North Carolina legislature directed the governor to study the feasibility of transitioning to MCO managed care. Study findings are to be released in March 2014.

⁵³ Original waiver program was known as Vermont Health Access Plan and included MCOs. Community-based system was adopted in 2001. Current waiver enacted in 2006; name change reflects conversion to global budget cap as part of waiver special terms and conditions.

⁵⁴ The exceptions are Alaska and Wyoming.

⁵⁵ Texas enrolls home- and community-based long term care members but not institutionalized persons.

The decision to contract with MCOs is often predicated by the desire to implement managed care rapidly and to achieve savings in year one through aggressive capitation rate setting. In states with no managed care infrastructure at the agency level, MCO contracts can be an attractive alternative to building a community-based system such as Oklahoma's.

The growth in Medicaid MCO managed care has led to industry consolidation and the emergence of a group of large national plans. Seven of the largest together have a combined enrollment in excess of six million lives⁵⁶.

These plans can bring expertise from other markets into a state implementing or expanding its managed care program. However, they also bring their own set of challenges, including:

- Willingness to delay implementation of programs through protests of state contracting decisions, if procurement results are not entirely favorable to them.
- Willingness to depart states if profit expectations are not met in a particular year. This can result either in program instability or a “give back” by the state of initial savings.
- Unwillingness in some cases to modify national practices to accommodate state preferences and expectations, unless compensated to make the changes.

As discussed in chapter two, contracting with multiple MCOs also raises program administrative costs, thereby reducing funds available to reimburse providers and reward higher quality.

Comparison of Approaches

The community-based and MCO approaches both include the key components of managed care (Exhibit 4-2). The MCO model presents an attractive option for states with little managed care infrastructure or experience working with providers, particularly if the goal is to achieve immediate savings (whether long lasting or not).

The community-based model requires more time and up-front agency effort to put in place. Once established, however, it can operate at a lower administrative cost and often with greater stability than the MCO model, even as it provides a vehicle for faster implementation of innovative managed care practices.

⁵⁶ The seven plans are Aetna, Anthem Blue Cross (WellPoint), Centene, Health Net, Molina, UnitedHealth Group, and WellCare Health Plans.

Exhibit 4-2 – Community-Based and MCO Managed Care

Program	SoonerCare Choice	MCO Model
Contracted Network	Yes	Yes
Patient Centered Medical Homes	Yes	Yes
Provider Pay-for-Performance	Yes	Yes
Member Education	Yes	Yes
Medical/Case Management	Yes	Yes
Chronic Care/Health Management	Yes	Yes
Quality Improvement Initiatives	Yes	Yes
Program Oversight/Administration	<i>State</i>	<i>Shared</i>
Stability	<i>High</i>	<i>Variable</i>
Administrative Expense	<i>5.46% (SFY 2012)</i>	<i>10%+</i>

CHAPTER 5 – CONCLUSIONS

Performance against Program Goals

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

In terms of ACCESS:

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

In terms of QUALITY:

- The OHCA has established methods to routinely measure quality of care and reward PCMH providers who meet or exceed quality benchmarks.
- Primary and preventive care quality measures improved for both children and adults and generally exceeded national benchmarks. Two exceptions to these trends were breast and cervical cancer screening rates; the OHCA is developing strategies to increase adherence by members and providers to screening guidelines.
- Member health outcomes showed improvement with respect to hospitalizations for ambulatory care sensitive conditions and thirty-day readmission rates.

In terms of COST EFFECTIVENESS:

- Medical inflation for SoonerCare Choice members averaged less than half the national per capita health care expenditure growth rate.
- OHCA (and partner agency) administrative costs were less than half that of a typical state with Managed Care Organization contracts.

Major Initiatives

The OHCA has undertaken three significant person-centered care initiatives since 2008: Patient Centered Medical Homes; Health Access Networks; and the SoonerCare Health Management Program.

The most recent of the three, health access networks, have shown robust membership growth but are too new to evaluate with respect to their performance. PHPG will seek to provide more information in the updated evaluation covering SFY 2013 activities.

The patient centered medical homes appear to be contributing directly to the improvements in access and quality occurring for the program as a whole. PCMH providers are building relationships with their members and having a positive impact on service utilization and program costs. There is no clear evidence yet that providers in higher tiers outperform their counterparts in tier one, but PHPG will revisit the tier-level analysis as part of the SFY 2013 update.

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

Conclusion

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