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## SoonerCare Choice Program Independent Evaluation

*Prepared for:*

*State of Oklahoma  
Oklahoma Health Care Authority*

*September 2014*

***PHPG***

Oklahoma  
**HealthCare**  
Authority

## READER NOTE

This report is an update to an interim evaluation of the SoonerCare Choice program released in 2013. The updated report includes utilization and expenditure data through SFY 2013, as well as member and provider demographic data through May 2014.

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

All findings are solely the responsibility of PHPG.

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## EXECUTIVE SUMMARY

### Background

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

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

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

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

### Evaluation Scope

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

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

In 2013, PHPG was retained to update the interim findings. The updated evaluation includes utilization and expenditure data through SFY 2013, as well as member and provider demographic data through May 2014.

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

## **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 SFY 2013, all but three 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 saved an estimated \$1.5 million in State dollars through its first full year of operations. The savings have continued to grow, along with online enrollment volume, and reached an estimated \$6 million in State dollars in SFY 2013. (The “savings” represent case worker resources freed-up for other activities, such as assisting individuals applying to DHS for cash assistance or Supplemental Security Income benefits.)

#### *Availability of Primary Care (PCMH) Providers*

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

In 2009, the OHCA undertook significant outreach efforts to providers throughout the State, to educate them about the new PCMH model and explore their interest in joining the program, if they did not already participate. The number of PCMH providers increased from 1,243 in January 2009 to 2,192 in May 2014. The increase in the number of participating PCMH providers led to a decrease in the average PCMH SoonerCare Choice member caseload, from 360 patients in 2009 to 254 patients in May 2014. 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.

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.

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

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

SoonerCare Choice member use of the emergency room declined significantly in 2009 - 2010, a drop that coincided with introduction of the PCMH model and expansion of the primary care provider network. Despite an uptick in 2012 the rate has remained well below the 2008 level and reached a new low in 2013.

The combined effect of the various initiatives targeting ER use can be illustrated by comparing actual visits in 2013 to what would have occurred if the visit rate had remained at the level recorded in 2008. There were an estimated 61,000 visits that did not happen because of the reduction in utilization. The avoided visits saved over \$21 million in claim costs versus what would have been spent had utilization remained at the 2008 level.

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

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

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

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

#### *Assistance to Members with Complex/Chronic Conditions*

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

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

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

The SoonerCare Health Management Program provides holistic, in-person health coaching to up to 7,000 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<sup>®</sup>) 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 2013, the OHCA made over \$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 six areas for children/adolescents and six areas for adults during the reporting years 2008 - 2013<sup>1</sup>:

- Child/adolescent
  - Access to a PCP
  - Annual dental visit
  - Lead screening rate by 2 years of age
  - Appropriate treatment for urinary tract infection (ages 3 months to 1 year)
  - Appropriate testing for children with pharyngitis (ages 2 – 18)
  - Appropriate medications for treatment of asthma (children)
- Adults
  - Access to preventive/ambulatory health services
  - Breast cancer screening (ages 40 – 69)

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<sup>1</sup> Data for some measures was only reported starting in 2010.

- Cervical cancer screening (ages 21 – 64)
- Cholesterol management for patients with cardiovascular conditions (ages 18 – 75)
- Comprehensive diabetes care
- Appropriate medications for treatment of asthma (adults)

The percentage of children and adolescents with access to a PCP increased steadily over the evaluation period and was above 90 percent for all age cohorts in 2013. The access percentage also was consistently above the national rate.

Preventive service, screening and treatment rates also improved for the four other child/adolescent measures. One measure – dental visits – was significantly above the national rate while two others – lead screening and urinary tract infection treatment – were below the national rate.

Access to preventive services also improved for both younger and older adults, reaching nearly 83 percent in SFY 2013 for the former and 90 percent for the latter. Both results exceeded the national rate.

The screening rates for breast and cervical cancer, and the rate for management of cholesterol among patients with cardiovascular conditions, did not show the same favorable trends. In all three instances the 2013 rate was below the baseline year and below the national benchmark.

The trends for HEDIS measures related to diabetes care were mixed, with some improving and others declining. However, all of the rates were below the national benchmark in 2013. Diabetes is one of the most common chronic illnesses experienced by SoonerCare Choice members.

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.

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

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

The HEDIS trends for treatment of asthma with appropriate medications are generally very positive. The rate among children and adolescents has risen and is close to 100 percent. The rate among adults is lower but also improving and nearly on par with the national benchmarks.

### *Health Outcomes*

The delivery of high quality preventive and primary care should contribute to improved health outcomes. One useful measure of quality is the avoidable, or ambulatory care sensitive condition, hospitalization rate. PHPG examined hospitalization rates for four ambulatory care sensitive conditions from 2009 through 2013: asthma, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD) and pneumonia.

The rate dropped significantly across three of the four conditions – CHF, COPD and pneumonia – with the sharpest decline occurring among members with pneumonia. The rate for asthma declined through 2012, before rising slightly above the 2009 baseline in 2013. The improvement in prescribing of appropriate medications observed in HEDIS data could contribute to stabilization or decline in the asthma hospitalization rate in subsequent reporting periods.

Another measure of health outcomes is the 30-day readmission rate for members who are hospitalized. The rate remained below 15 percent for the entire evaluation period. The 2013 rate of 13.2 percent compares favorably to the national Medicare readmission rate of 18.4 percent, even allowing for the relatively frailer health of the average Medicare beneficiary and the presence of deliveries/newborns (which are less likely to result in a readmission) in the OHCA data.

### Cost Effectiveness

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

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

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

### *Health Care Expenditures*

PHPG examined SoonerCare Choice health expenditure trends from 2009 through 2013. 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 1.5 percent, exactly half the average annual per capita national health expenditure increase of 3.0 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 quantify the relative cost effectiveness of the OHCA's model versus the MCO model, PHPG constructed an administrative cost profile for the SoonerCare program and compared it to administrative costs for private Medicaid MCOs in states with geographic and demographic characteristics similar to Oklahoma.

PHPG estimated the OHCA's MCO-related administrative expenditures in SFY 2013 to be 4.22 percent of total expenditures (administration plus medical services). PHPG estimated private MCO administrative costs in the comparison states to be just under 11 percent. This includes monies for direct administration, as well as reserves for risk/contingencies and profit.

## In-Depth Evaluation of Person-Centered Care Initiatives

### Patient Centered Medical Home Model

PHPG evaluated PCMH performance against an array of service utilization measures, such as average annual member visits rates, emergency room use rates and average per member per month expenditures. PHPG looked at performance by provider tier level and in aggregate. The PCMH model appears to be contributing to positive trend lines for the SoonerCare Choice program as a whole. At the aggregate level (across tiers), the program demonstrated consistent improvement in outcomes from SFY 2009 through SFY 2013.

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. Given this lack of differentiation, the OHCA may wish to explore options for restructuring the program. These could include:

- *Collapsing Tiers* – The three tier model could be consolidated into two tiers, with tier 3 standards applied to the upper tier. However, if this resulted in the elimination of Tier 1 it would increase program costs.
- *Pre-certification audits for Tier 3* – All tier 3 providers are subject to audits following entry into the program, to verify conformance with tier 3 standards. The OHCA could introduce universal pre-certification audits for new applicants, to ensure conformance with program standards prior to receiving the tier 3 designation.
- *Adoption of NCQA standards in place of tiers 2 and 3* – The National Committee for Quality Assurance (NCQA) released enhanced standards for patient center medical home “recognition” in 2014. The enhancements focus on areas of importance to the OHCA, including care management of high needs populations; integration of physical and behavioral health; and demonstration by participating practices of a sustained commitment to the medical home concept. The OHCA could designate one or more of the higher NCQA PCMH levels as eligible for case management fees under SoonerCare, while retaining the existing tier 1 designation, which emphasizes access to care.
- *Reserving a Portion of Tier 3 Funds for Incentive Payments* - A portion of Tier 3 case management fees could be tied to performance targets and paid only upon achievement of the targets (separate from SoonerExcel payments, which would remain open to all PCMH providers).



## Health Access Networks

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

There are three HAN contractors:

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

HAN membership grew dramatically during the initiative's first years, from only 25,000 in July 2010 to 117,000 in May 2014. The growth in membership has occurred as the HANs have expanded their affiliated PCMH networks. There currently are approximately 600 HAN-affiliated PCMH providers located at 74 practice sites throughout the State.

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

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

PHPG conducted what should be considered a preliminary evaluation of the HANs, focusing on demographic and utilization data for SFY 2013. The HAN population was compared to SoonerCare Choice members enrolled with non-HAN providers, to identify differences between the two groups.

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

The HANs include PCMH providers with longstanding ties to the SoonerCare population, as well as linkages to key specialists in their service areas. This likely has affected HAN membership mix, which contains a higher number of ABD members, as a percentage of total enrollment (panels), than the non-HAN membership. Although the difference is less than one percentage point (9.8 percent versus 9.1 percent), it is enough to affect the overall cost profiles of the HAN and non-HAN populations.

SoonerCare Choice HAN and non-HAN members visited their PCMH providers at nearly equal rates in SFY 2013, when adjusting for differences in member mix. With one exception, other

utilization measures and PMPM costs also were nearly identical at the eligibility group level (HAN ABD versus non-HAN ABD and HAN TANF versus non-HAN TANF).

The exception was emergency room utilization, which was approximately 10 percent lower for HAN members than non-HAN members. The HANs are required to undertake targeted care management of frequent ER utilizers identified by the OHCA and also to “lock-in” these members to a single PCMH provider for their primary care; these efforts appear to be having an impact.

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

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

Overall, the HANs are serving a higher risk membership than the general SoonerCare Choice population for the same claim cost, while undertaking care management for a nominal per member monthly fee. The experience of the SoonerCare Health Management Program (HMP), as discussed in the next section, suggests that it can take several years for the full impact of care management initiatives to emerge, in terms of reducing utilization and expenditures.

### 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 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 16 of 21 diagnosis-specific measures. The difference was statistically significant for 13 of the 16, 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 2013 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 2013 achieved aggregate savings in excess of \$124 million, or 15 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 2013 was \$43.70. This figure, when multiplied by practice facilitation site member months yielded aggregate savings of approximately \$58 million (state and federal dollars), or 6.4 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 2013 was 562 percent. Put another way, the SoonerCare HMP generated over six 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.

SoonerCare Choice 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. States considering adoption of an MCO model should address the following as part of implementation planning:

- Incorporation of state's priorities for access, quality and cost effectiveness into MCO contract requirements, to ensure MCO's focus on the areas of greatest need.
- Development of an objective and defensible procurement process that can withstand challenges from losing offerors.
- Inclusion of contract language that penalizes MCO's from exiting the program before expiration of their contract term.

## Conclusion

SoonerCare Choice demonstrated broad and sustained improvement during the evaluation period. Recent initiatives, including HMP, PCMH and HAN, are contributing to the overall success of the program.

Along with these generally favorable findings, there are aspects of the program that stand out as areas of future focus for the OHCA, including:

- ER utilization, while down, remains high by national standards, particularly for adults and persons with disabilities.
- While quality measures generally show improvement and exceed national benchmarks, there are important exceptions. Lower rates were observed for breast/cervical cancer screening, lead screening, cholesterol screening and components of diabetes care.
- The PCMH model has demonstrated effectiveness in the aggregate but there is no evidence that higher payments to Tier 2 and Tier 3 providers have resulted in better outcomes, as compared to Tier 1.

The OHCA is developing strategies to improve performance in each of the above areas as part of its continuous quality improvement activities.

Overall, 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

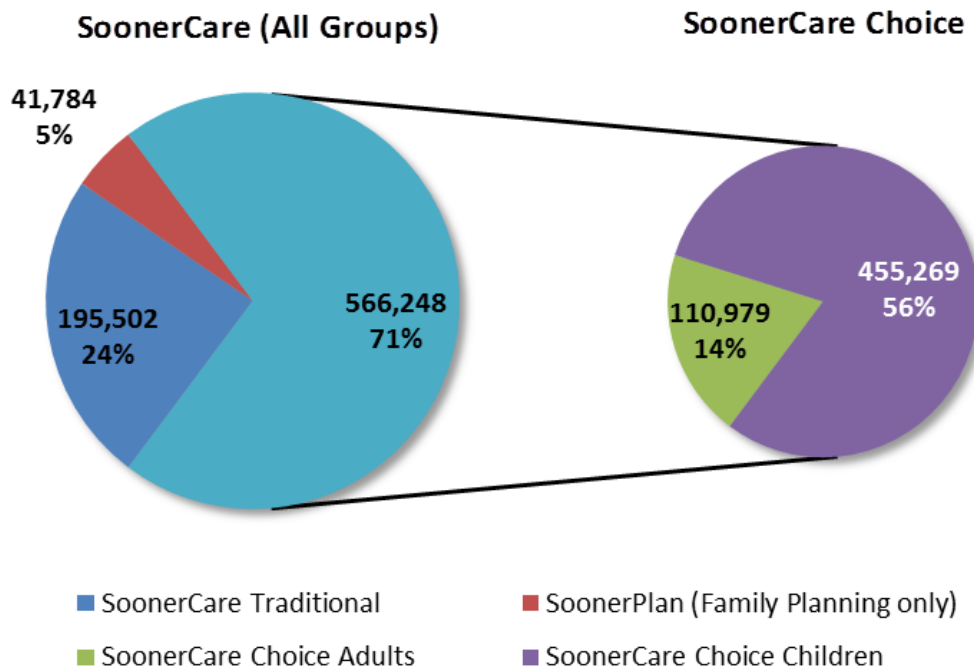
### SoonerCare Choice Program

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.

Seventy 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 (May 2014)<sup>2</sup>**



<sup>2</sup> 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.

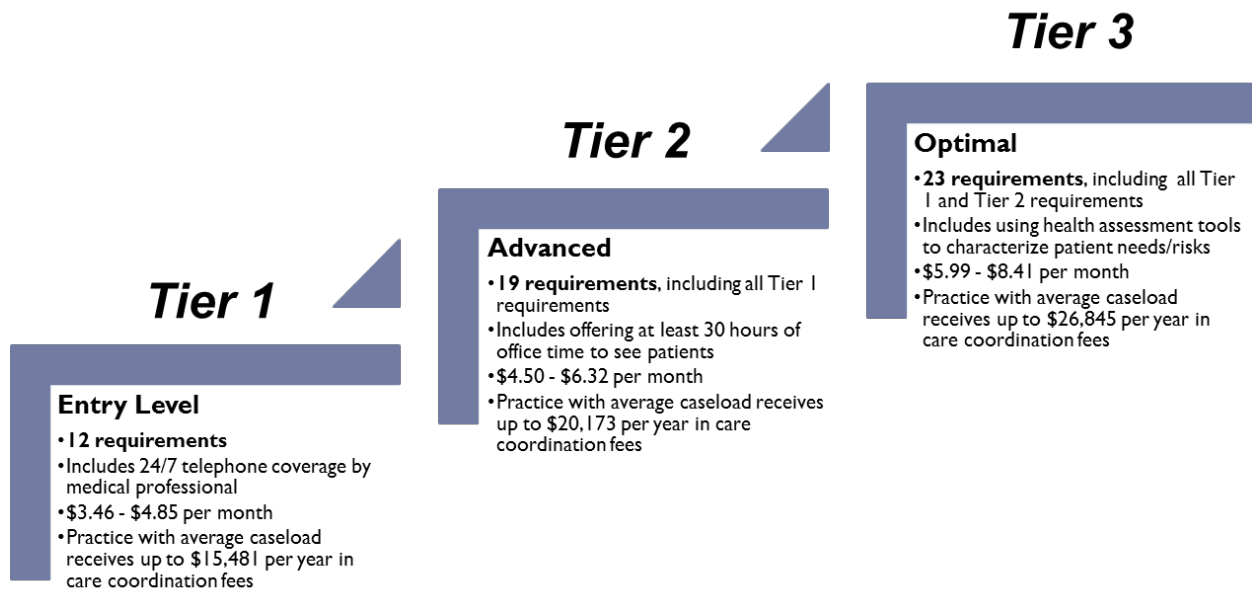
In 2008, the OHCA implemented the “Health Management Program” (HMP), a holistic person-centered care management program for members with chronic conditions who have been identified as being at high risk for both adverse outcomes and increased health care expenditures. The SoonerCare HMP emphasizes development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

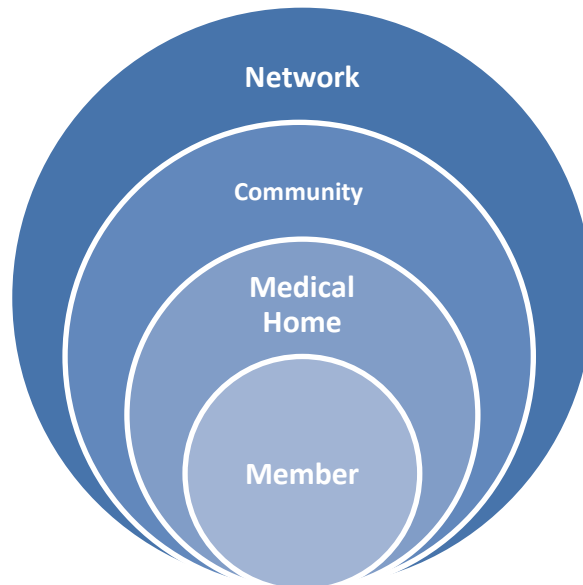
PCMH providers are arrayed into three levels, or tiers, depending on the number of standards they agree to meet (Exhibit 1-2 on the following page). The OHCA pays monthly care management fees (in addition to regular fee-for-service payments) that increase at the higher tiers. Providers also can earn “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 – SoonerCare HMP, patient centered medical homes and health access networks – 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 2008<sup>3</sup>.

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

In 2013, PHPG was retained to update the interim findings. The updated evaluation includes utilization and expenditure data through SFY 2013, as well as member and provider demographic data through May 2014.

### Methodology

PHPG obtained paid claims data for the SoonerCare Choice program covering July 2008 through June 2013 (SFY 2009 through SFY 2013). The claims data was analyzed to document trends in utilization and expenditures over the five year period<sup>4</sup>.

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.

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

<sup>4</sup> PHPG also obtained emergency department claims for January through June 2008 and included these claims in the analysis of emergency department trends. The additional period was analyzed at the OHCA's request to better measure the longitudinal impact of initiatives aimed at lowering ED utilization, some of which were implemented in the second half of calendar year 2008.

- Summary information on the Sooner HMP, taken from a separate, standalone evaluation that PHPG has been conducting since the SoonerCare HMP was implemented in 2008.

Chapter four offers a national perspective by comparing the SoonerCare Choice program, and its emphasis on community-based coordinated care with managed care programs 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 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, including<sup>5</sup>:

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

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<sup>5</sup> The discussion of enrollment obstacles is derived from a Policy Innovation Profile of Oklahoma's online enrollment system that can be found at <http://innovations.ahrq.gov/content.aspx?id=3981#a5>.

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

These obstacles contributed to the size of Oklahoma’s uninsured population, by discouraging qualified applicants from enrolling in the SoonerCare program. For example, an estimated 22,000 children were eligible but not enrolled in SoonerCare Choice in 2010<sup>6</sup>.

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

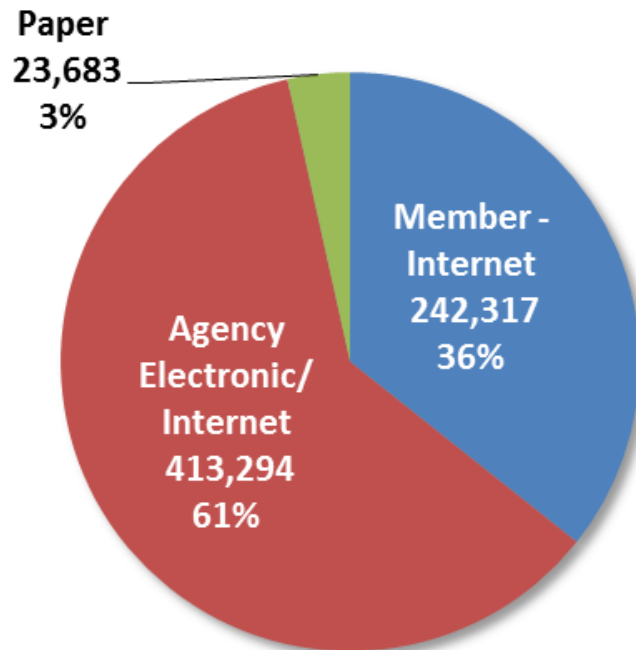
The online enrollment system went “live” in September 2010 and had an immediate impact on how SoonerCare applications are filed and processed. In SFY 2013, all but four percent of applications were filed online directly by applicants or with the assistance of one of the OHCA’s partner agencies (Exhibit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

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

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<sup>6</sup> Figure is an estimate derived from Current Population Survey data on the uninsured by income level.

**Exhibit 2 – 1 – SoonerCare Choice Enrollment Method (SFY 2013)<sup>7</sup>**



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 OHCA<sup>8</sup>.

Use of the new system has been split almost evenly between new applications and renewals. In SFY 2013, new applications accounted for 54 percent of transactions and renewals for 46 percent<sup>9</sup>.

PHPG evaluated the “return on investment” for online enrollment by comparing the State’s expected share of operational costs<sup>10</sup> 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 study published in 2011<sup>11</sup>.

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<sup>7</sup> Source: OHCA Online Enrollment Automation and Data Integrity, Business Enterprises

<sup>8</sup> See Policy Innovation Profile for more detail.

<sup>9</sup> Source: OHCA Online Enrollment Automation and Data Integrity, Business Enterprises

<sup>10</sup> With a few exceptions, the federal government pays 50 percent of operating costs for administration of the SoonerCare Choice program, including enrollment activities.

<sup>11</sup> See: “No Wrong Door Online Enrollment – Independent Evaluation Final Report”, The Pacific Health Policy Group, March 2011.

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”<sup>12</sup> processes in multiple states<sup>13</sup>. Although Oklahoma is not an Express Lane Eligibility state, its system was included in the study for comparison purposes.

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

For this evaluation, PHPG examined savings associated with online enrollment in SFY 2013. PHPG calculated the savings per online enrollment based on estimated average caseworker time per paper application x estimated wages/benefits for an entry level application worker x 50% (to represent state portion of costs, which are shared 50/50 with the federal government).

The “savings per application” was multiplied by the number of online applications in SFY 2013 to arrive at an aggregate savings figure of more than \$6 million (Exhibit 2-2). The “savings” represent case worker resources freed-up for other activities. For example, case worker time could be applied toward assisting individuals seeking cash assistance or Supplemental Security Income benefits through a local OKDHS office.

**Exhibit 2 – 2 – SoonerCare Choice Estimated Online Enrollment Savings – SFY 2013**

Online Enrollment – Estimated SFY 2013 Savings (State Dollars)	
Online Applications – SFY 2013	655,611
Estimated Net Savings per Application (versus paper)	\$9.27
<b>TOTAL SAVINGS (State dollars)</b>	<b>\$6,074,272</b>

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.

<sup>12</sup> 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.

<sup>13</sup> See: “CHIPRA Express Lane Eligibility Evaluation – Case Study of Oklahoma’s SoonerCare Online Enrollment System”, Mathematica Policy Research, May 2013.

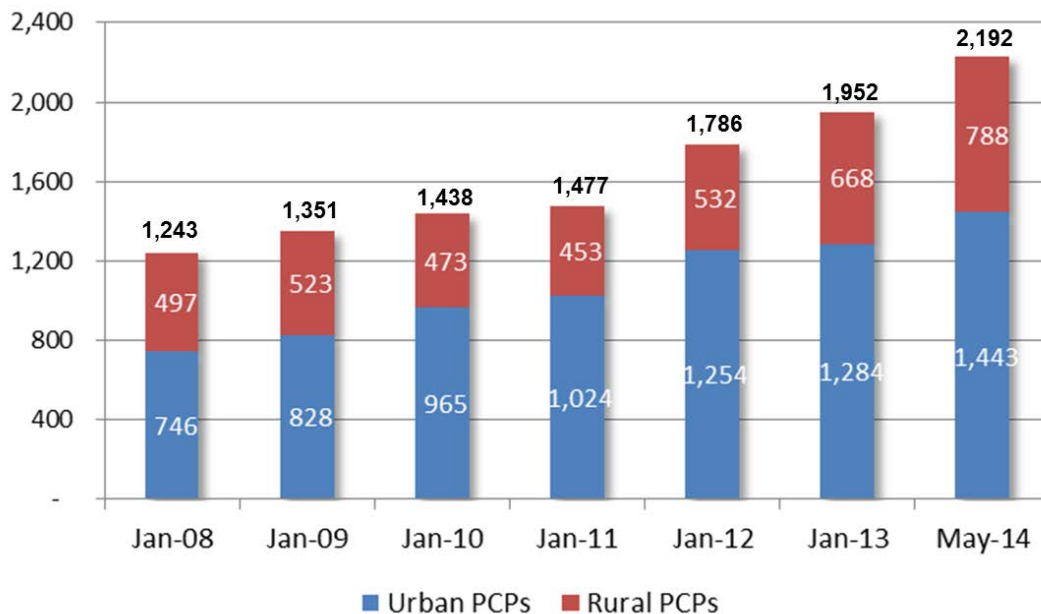
Do SoonerCare Choice Members Have an Adequate Selection of Primary Care Providers?

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

The number of PCMH providers was relatively flat from 2004<sup>14</sup> 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”<sup>15</sup> PCMH providers increased by 76 percent from January 2008 through May 2014 (Exhibit 2-3). The growth occurred in both urban and rural counties.

**Exhibit 2 – 3 – SoonerCare Choice Unduplicated PCMH Count by Year<sup>16</sup>**



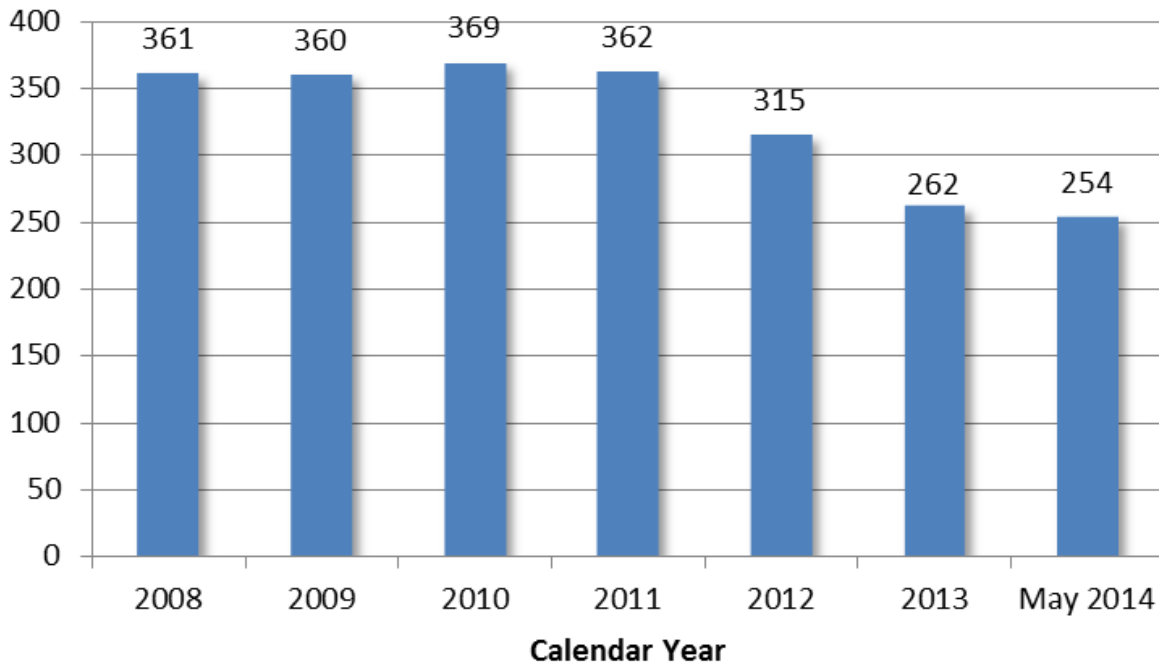
<sup>14</sup> The year that the SoonerCare Plus MCO program in Oklahoma City, Tulsa, Lawton and surrounding areas was discontinued and members were enrolled in SoonerCare Choice alongside members in the rest of the State.

<sup>15</sup> Counting each provider once, regardless of his or her number of offices/practice locations.

<sup>16</sup> Source: OHCA Fast Facts. Urban/rural division corresponds to division of counties under SoonerCare Plus and Choice models prior to discontinuation of SoonerCare Plus program. Increase from 2011 to 2012 may be partially due to introduction of more precise taxonomy.

The increase in the number of participating PCMH providers led to a decrease in the average PCMH SoonerCare Choice member caseload, from 361 patients in 2008 to 254 patients in May 2014 (Exhibit 2-4).

**Exhibit 2 – 4 – Average PCMH SoonerCare Choice Member Caseload – Statewide <sup>17</sup>**



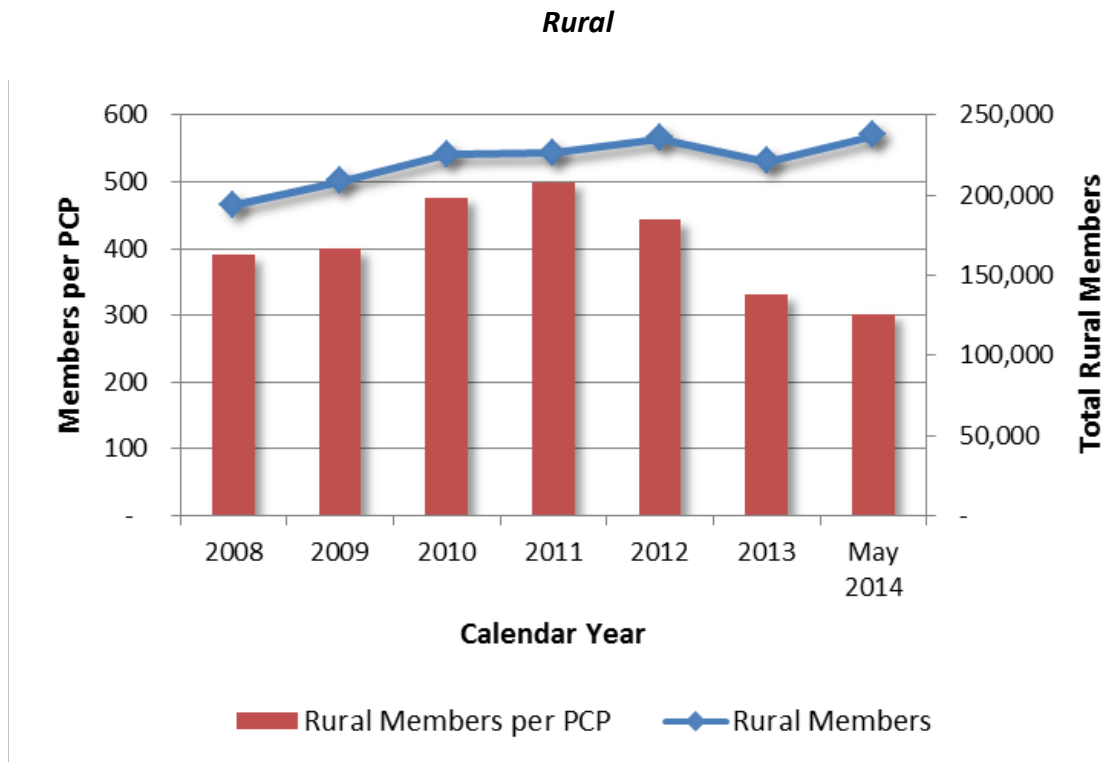
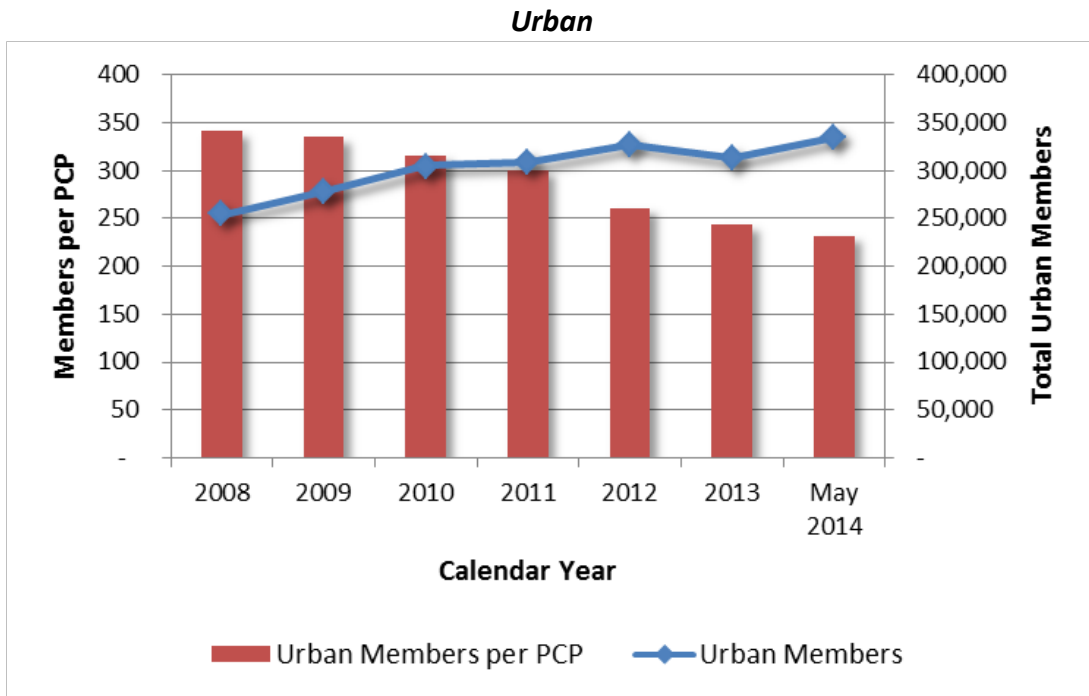
The drop in average caseload has occurred in both urban and rural portions of the State, even as enrollment has increased. Although the decline in rural counties started more recently, caseloads in the two regions are well below their peak levels (Exhibit 2-5 on the following page).

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<sup>17</sup> Sources: OHCA Provider Fast Facts Report; Waiver Enrollment Reports; Enrollment Fast Facts (May 2014 data). Annualized member count divided by PCMH count.



**Exhibit 2 – 5 – Average PCMH SoonerCare Choice Member Caseload – Urban/Rural<sup>18</sup>**



<sup>18</sup> Urban/rural division corresponds to division of counties under SoonerCare Plus and Choice models prior to discontinuation of SoonerCare Plus program.

## Are Primary Care and Specialty Services Readily Available?

### *Member Perceptions*

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

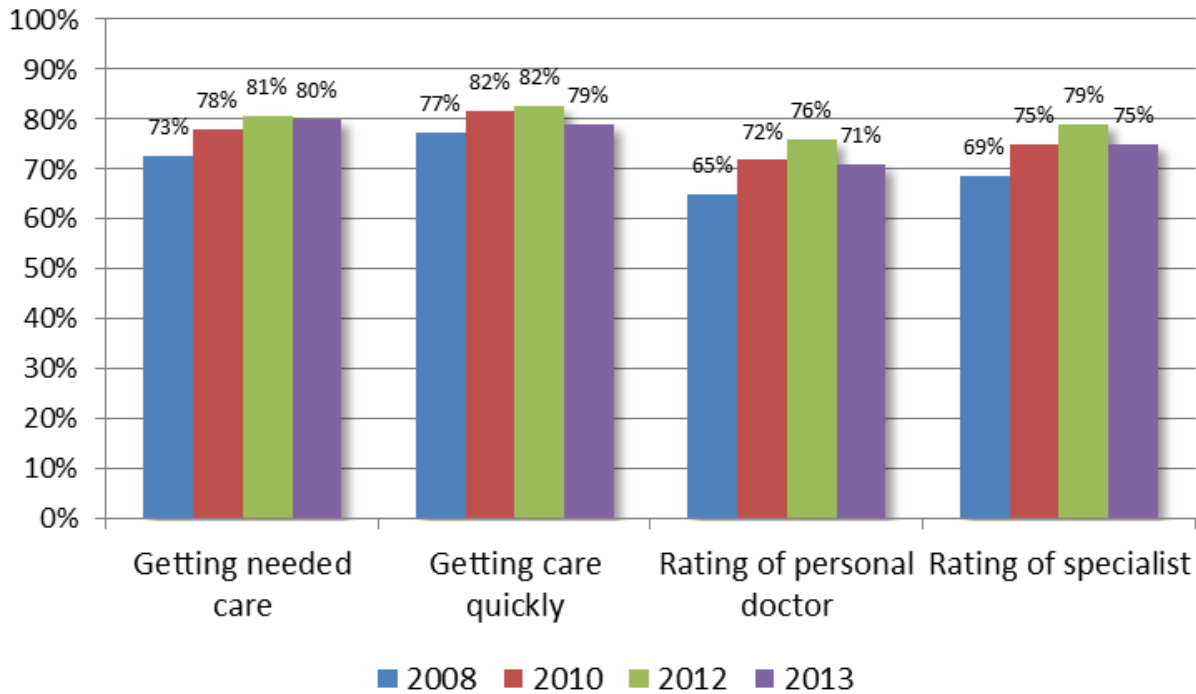
The surveys ask members to rate their satisfaction with services, on a scale of 1 to 10. Specific areas of inquiry include satisfaction with: getting needed care; getting care quickly; rating of personal doctor; and rating of specialist (if applicable). A rating of 8, 9 or 10 is considered to be evidence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

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<sup>19</sup> (Exhibit 2-6 on the following page).

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<sup>19</sup> The CAHPS data presented in the earlier interim report is still the most recent to be released and is presented here again.

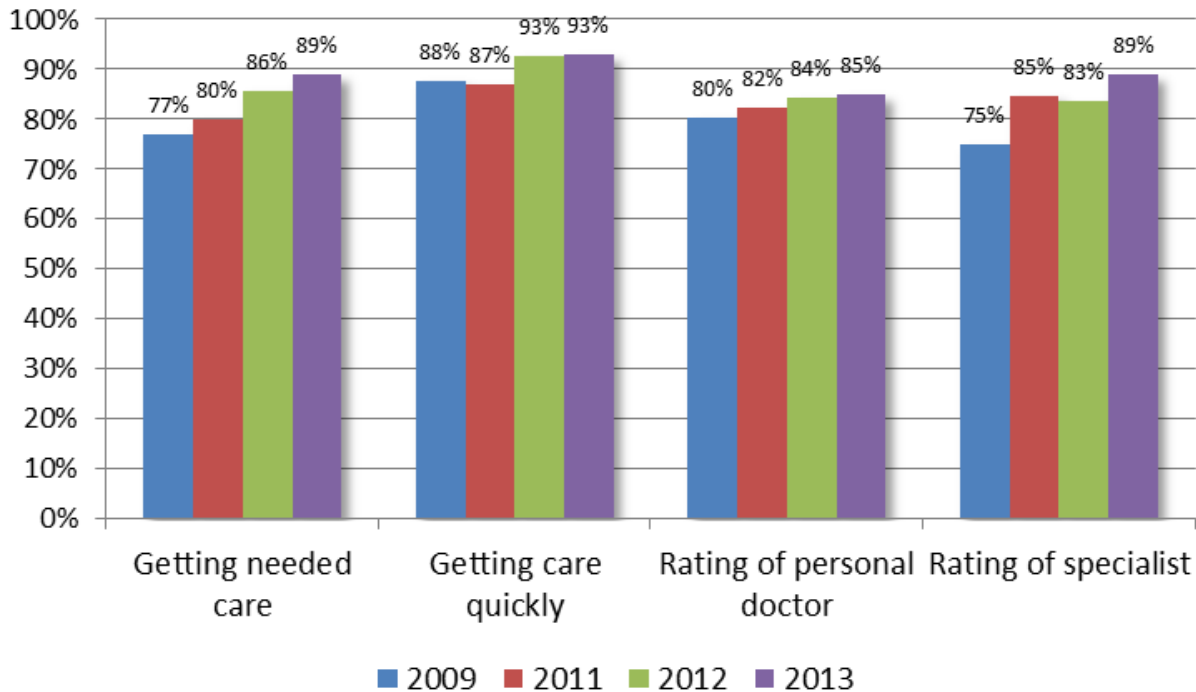
**Exhibit 2 – 6 – SoonerCare Choice – Satisfaction with Care for Adults<sup>20</sup>**



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 2-7 on the following page).

<sup>20</sup> 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 – 7 – SoonerCare Choice – Satisfaction with Care for Children<sup>21</sup>**



*Emergency Room Use*

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

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

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

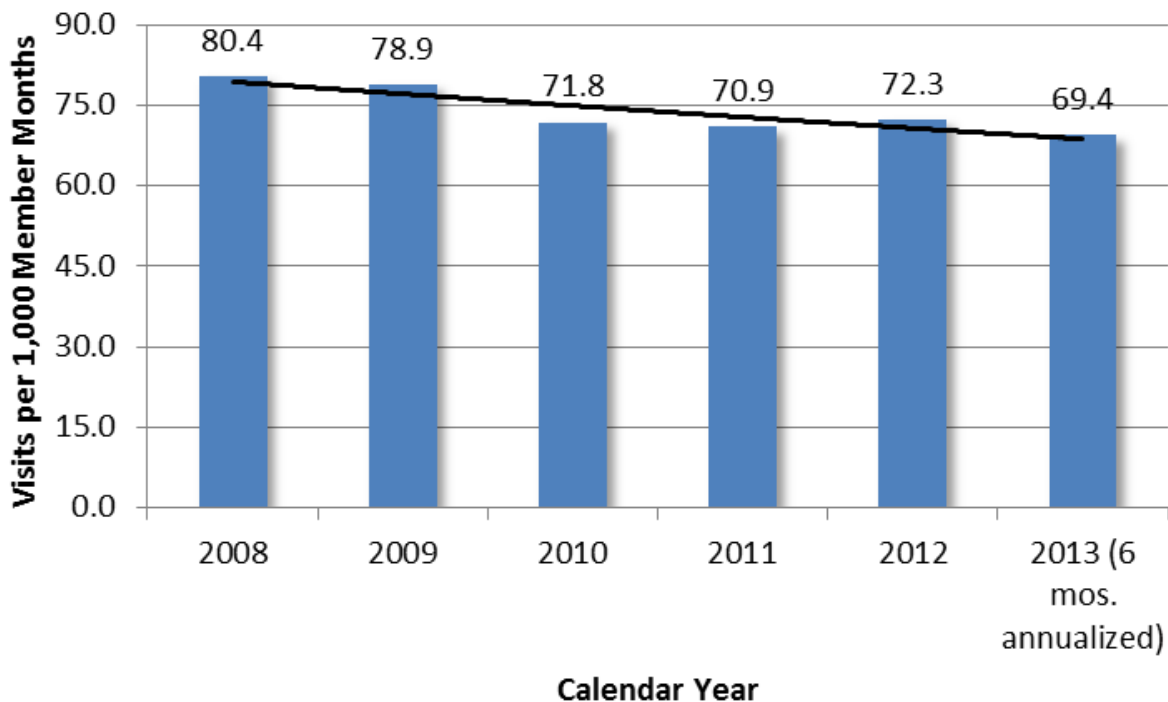
<sup>21</sup> Sources: CAHPS Health Plan Survey Child Version – Telligen through 2012; Morpace for 2013 (surveys are conducted from July to December of year preceding reporting year). Percent rating 8, 9 or 10 on a 10-point satisfaction scale.

PHPG measured the combined impact of these initiatives by examining SoonerCare Choice member use of the emergency room from 2008 to 2013; the year 2008 was selected as the “baseline” because it preceded the OHCA’s efforts of the past five years to reduce inappropriate utilization.

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

The actual utilization rate in 2008 was 80.4. The rate declined from 2008 to 2010, a drop that coincided with introduction of the PCMH model and expansion of the primary care provider network. Despite an uptick in 2012 the rate has remained under the 2008 level and reached a new low of 69.4 in 2013, approximately 13 percent below the 2008 rate (Exhibit 2-8).

**Exhibit 2 – 8 – SoonerCare Choice Emergency Room Utilization – 2008 to 2013<sup>2223</sup>**

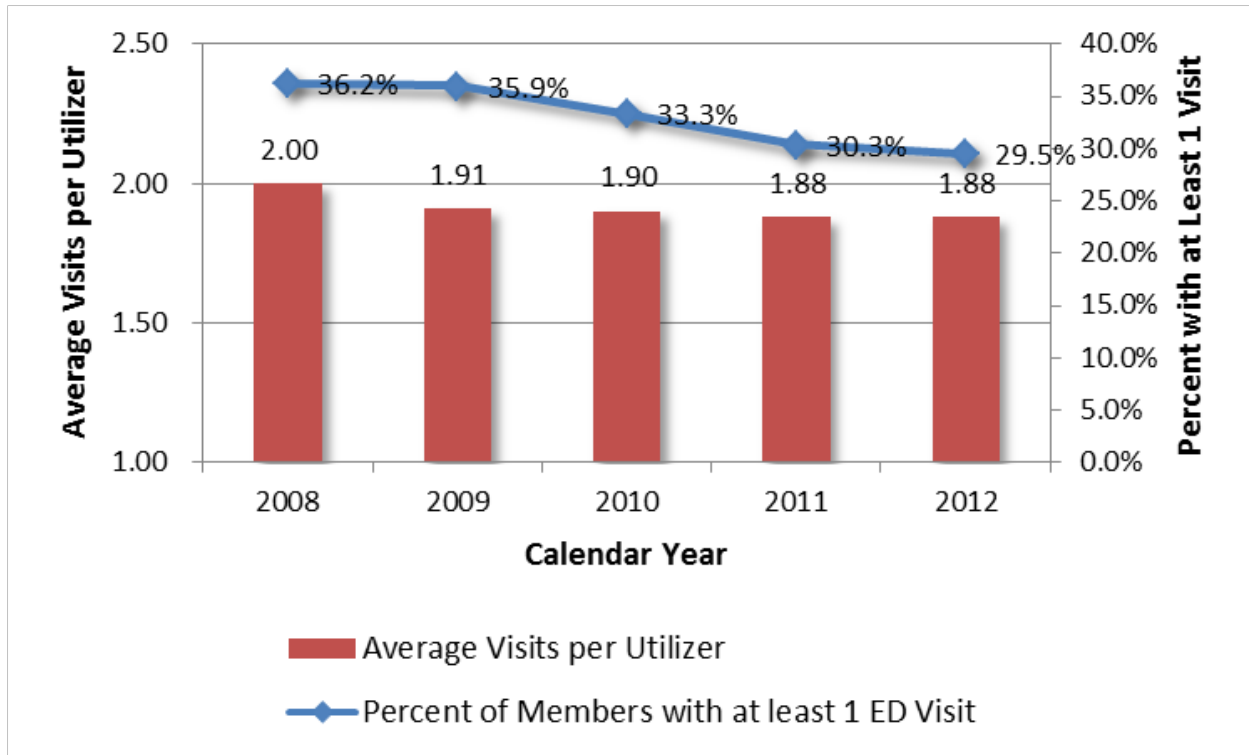


<sup>22</sup> Source: All utilization and expenditure exhibits presented in chapters two and three of the report were produced using paid claims data, unless otherwise specified. ER utilization trends are presented in calendar years to align with a standalone analysis prepared for the OHCA earlier this year. Results for SFY 2008 – SFY 2013 show the same downward trajectory.

<sup>23</sup> ER results include claims with paid amounts for ER services as well as claims with zero pay amounts for ER services as long as at least one other service on the claim was paid.

The portion of SoonerCare Choice members with at least one ER visit declined along with the overall utilization rate, falling from 36 percent in 2008 to under 30 percent in 2012<sup>24</sup>. The average number of visits per year by ER utilizers also fell modestly over the same period, from 2.00 to 1.88 (Exhibit 2-9).

**Exhibit 2 – 9 – SCC Emergency Room Utilization – Portion w/1+ Visits & Average Visit Count**

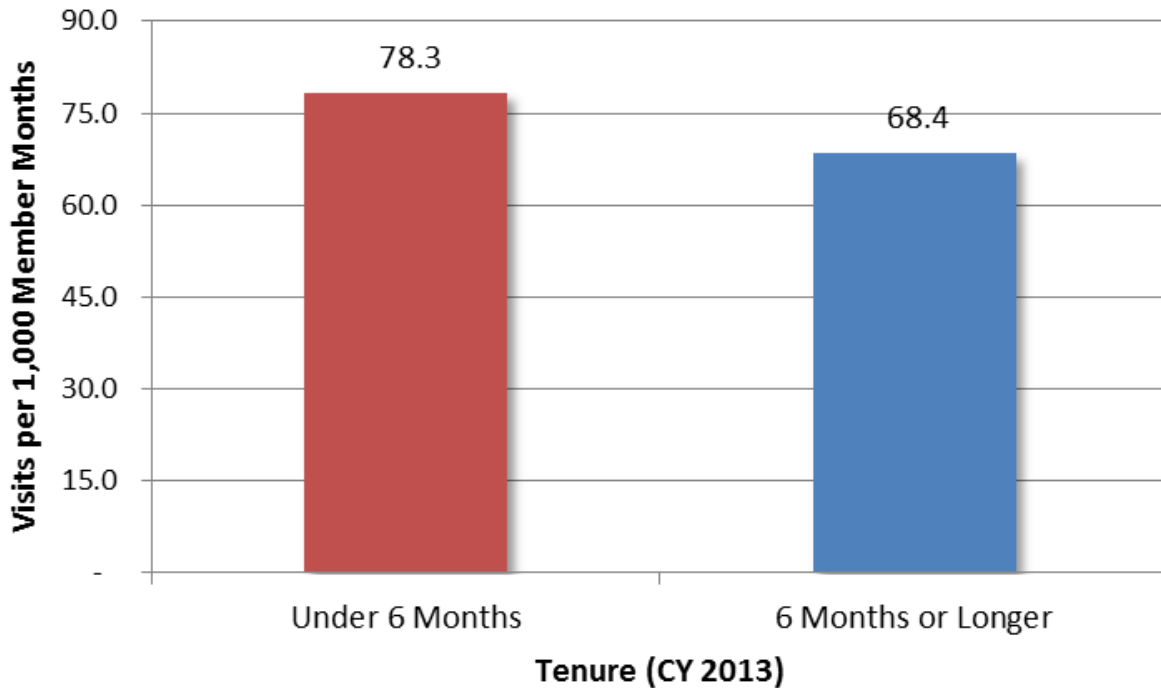


The contribution of the patient centered medical home to the drop in ER visits is supported by the difference in use rates between new and established SoonerCare Choice members. If members come to view their PCMH providers as an accessible alternative to the emergency room, this should be demonstrated through lower visit rates among those with longer relationships.

Using six months of enrollment as the dividing point, PHPG compared visit rates for new and established members in 2013 and found a significant difference. The emergency room use rate for established members was 12.6 percent below that of new SoonerCare Choice members (Exhibit 2-10 on the following page).

<sup>24</sup> CY 2013 excluded from trend as only six months of data were available; analysis requires a full year.

**Exhibit 2 – 10 – SoonerCare Choice Emergency Room Utilization- Comparison by Tenure**



Another factor contributing to the drop in ER visits appears to be the OHCA’s 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 PCMH providers to educate these members about proper use of the emergency room and the available alternatives. The health access networks also work with their high utilizing members to reduce inappropriate emergency room use.

PHPG examined the impact of the HANs on high utilizing ER members and found strong evidence that their interventions have reduced ER visits within this difficult-to-manage population. Results of the analysis are presented in the HAN evaluation section of chapter three.

The combined effect of the various initiatives targeting ER use can be illustrated by comparing actual visits in 2013 to what would have occurred if the visit rate had remained at the 2008 level. There were an estimated 61,000 visits that did not happen because of the reduction in utilization (Exhibit 2-11).

**Exhibit 2 – 11 – SoonerCare Choice Emergency Room Utilization- Avoided Visits in CY 2013**



The dollar value of the avoided visits can be estimated using the average paid amount for a SoonerCare Choice ER visit in 2013 (for members not admitted to the hospital). The amount, inclusive of facility, professional and ancillary (e.g., ambulance, pharmacy, DME, radiology) fees was \$349.61<sup>25</sup> (Exhibit 2-12 on the following page).

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<sup>25</sup> The average amount may overstate the cost of avoided visits, to the extent that these visits included a greater proportion of low acuity patients. However, it is a reasonable proxy for estimating avoided costs.

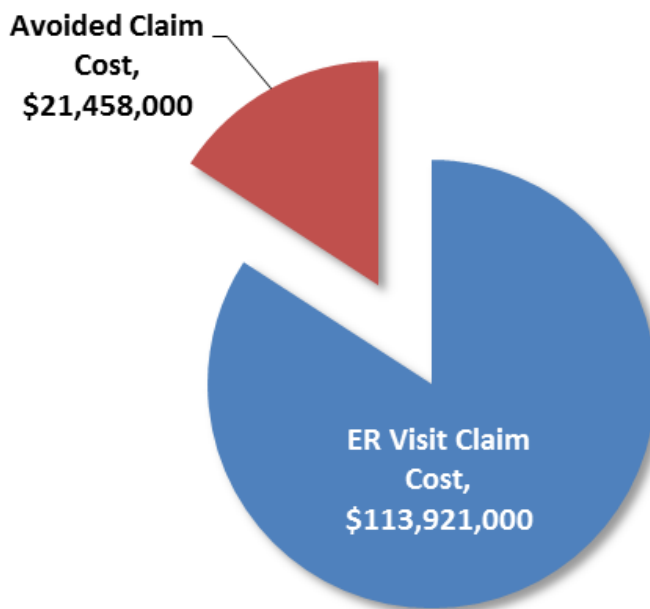


**Exhibit 2 – 12 – SoonerCare Choice Emergency Room Utilization- Average Cost per Visit**

Component	2013 Average
<b>Facility</b>	\$180.19
<b>Professional</b>	\$116.06
<b>Ancillary</b>	\$53.36
<b>TOTAL</b>	<b>\$349.61</b>

The avoided visits saved over \$21 million in claim costs versus what would have been spent had utilization remained at the 2008 level (Exhibit 2-13).

**Exhibit 2 – 13 – SoonerCare Choice Emergency Room Utilization- Avoided Costs in CY 2013**



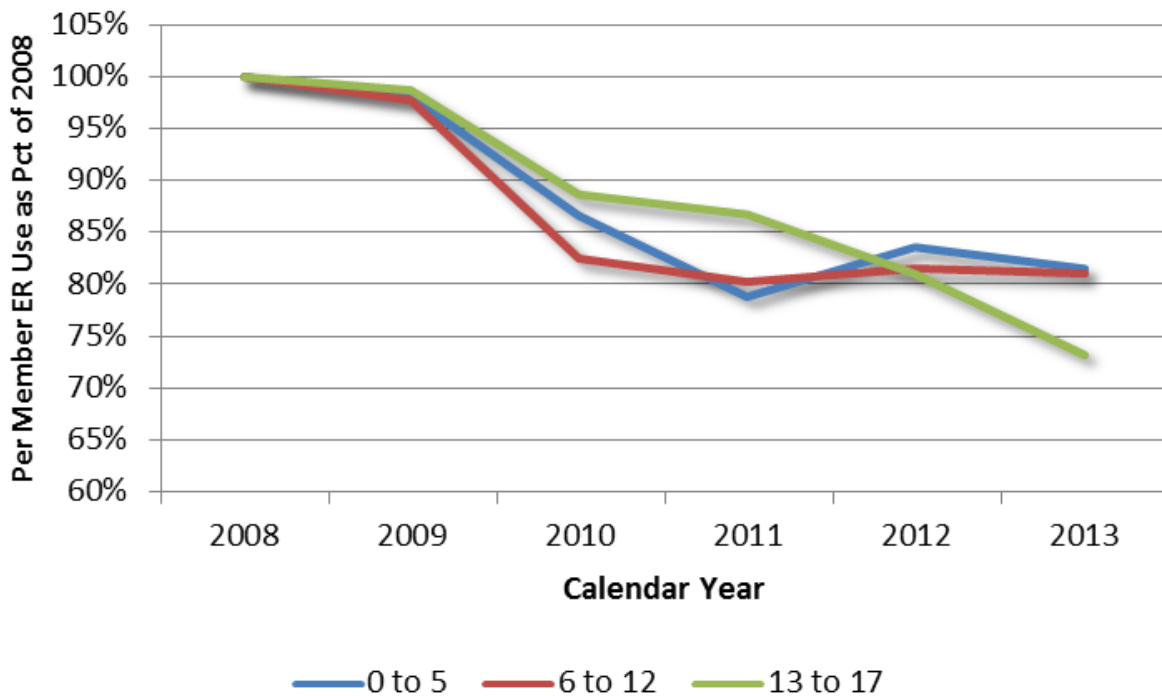
It is difficult to compare Oklahoma’s ER use rate to the rate across all 50 states because of differences in reporting methods and data quality. However, Oklahoma’s utilization rate still appears to be higher than average.

A recent study by The Lewin Group and General Dynamics Information Technology compared Medicaid ER utilization in 39 states, using 2008 paid claims data from the CMS Chronic Condition Data Warehouse. Oklahoma ranked second highest, behind only Kentucky.

Even accounting for the progress made since 2008, Oklahoma would still rank among the ten highest states, assuming the rates in other states remained constant. This suggests there is still room for improvement<sup>26</sup>.

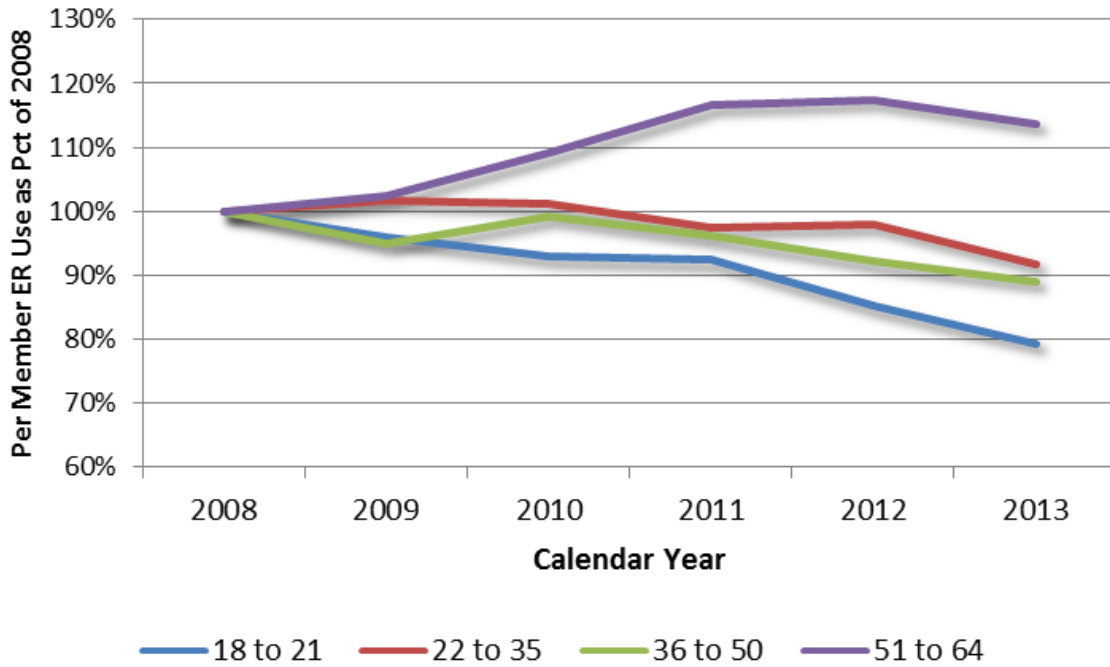
In evaluating opportunities for further reductions, it is important to note that utilization trends have not been uniform across age cohorts or aid categories. Utilization has fallen among children, adolescents and younger adults since 2008 but has remained at or above 2008 levels among older adults (Exhibits 2-14 and 2-15).

**Exhibit 2 – 14 – SoonerCare Choice ER Utilization Trend – Children/Adolescents (2008 = 100%)**



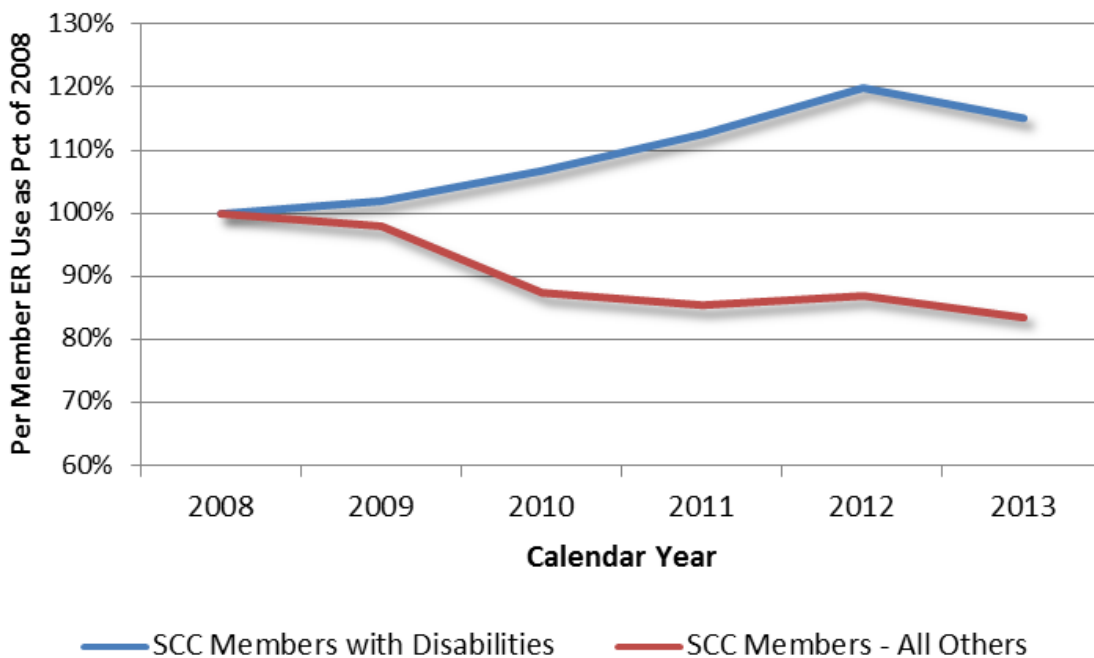
<sup>26</sup> Source: Evaluating Emergency Department Utilization-For Researchers using the CMS Chronic Conditions Data Warehouse, The Lewin Group and General Dynamics Information Technology, May 9, 2012  
[https://www.ccwdata.org/cs/groups/public/documents/training/ccw\\_max\\_research\\_example\\_eduse.pdf](https://www.ccwdata.org/cs/groups/public/documents/training/ccw_max_research_example_eduse.pdf)

**Exhibit 2 – 15 – SoonerCare Choice ER Utilization Trend – Adults (2008 = 100%)**



ER utilization also has remained high for SoonerCare Choice members with disabilities, versus other members (Exhibit 2-16). Most of the members with disabilities are adults.

**Exhibit 2 – 16 – SoonerCare Choice ER Utilization Trend – Disability Status (2008 = 100%)**



The top ER diagnoses vary by age group, with injuries comprising a significant (and appropriate) portion of the total for children and adolescents (Exhibit 2-17).

**Exhibit 2 – 17 – SoonerCare Choice Top Five ER Diagnoses – Children/Adolescents<sup>27</sup>**

	0 – 5	6 – 12	13 - 18
1	Respiratory disease (15%)	Injury (22%)	Injury (21%)
2	Injury (13%)	Respiratory disease (9%)	Neurotic, personality, and other non-psychotic mental disorders (7%)
3	Disease of the ear (9%)	Disease of musculoskeletal system (5%)	Disease of musculoskeletal system (6%)
4	Disease of skin (4%)	Disease of the ear (4%)	COPD, including Asthma (6%)
5	Other viral disease (4%)	COPD, including Asthma (4%)	Disease of skin (3%)
Top 5	45% of visits	44% of visits	43% of visits

Among adults, behavioral health conditions (mental health and substance abuse-related) are the number one reason for visits to the ER. Chronic conditions such as hypertension and heart disease also are important contributors in the older adult population (Exhibit 2-18).

**Exhibit 2 – 18 – SoonerCare Choice Top Five ER Diagnoses - Adults**

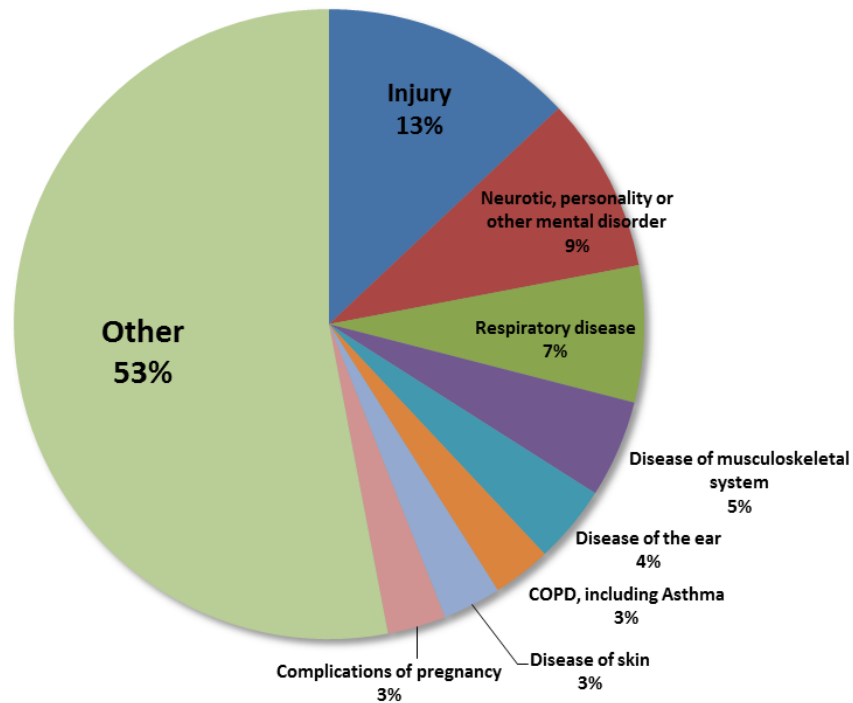
	18 – 21	22 – 35	36 – 50	51 - 64
1	Neurotic, personality, and other non-psychotic mental disorders (11%)	Neurotic, personality, and other non-psychotic mental disorders (15%)	Neurotic, personality, and other non-psychotic mental disorders (15%)	Neurotic, personality, and other non-psychotic mental disorders (13%)
2	Injury (10%)	Injury (8%)	Injury (14%)	Disease of musculoskeletal system (13%)
3	Complications of pregnancy (8%)	Disease of musculoskeletal system (6%)	Disease of musculoskeletal system (7%)	Hypertension (7%)

<sup>27</sup> Data in exhibits 2-16 and 2-17 is for the 18-month period of January 2012 through June 2013. Data represents first diagnosis in claim (grouped by first three digits of diagnosis).

	18 – 21	22 – 35	36 – 50	51 - 64
4	Respiratory disease (5%)	Complications of pregnancy (5%)	Hypertension (7%)	Injury (7%)
5	Disease of genital organs (4%)	Respiratory disease (3%)	Nervous system disease (5%)	Heart disease (6%)
Top 5	38% of visits	37% of visits	48% of visits	46% of visits

Overall, the top diagnoses (three percent of more of cases) account for just under one-half of all ER visits (Exhibit 2-19).

**Exhibit 2 – 19 – SoonerCare Choice Top Five ER Diagnoses – All Members**



The OHCA and its provider partners have the proper tools in place to target members with complex/chronic conditions, including adults with disabilities, as well as members presenting with conditions such as asthma that can be managed through appropriate preventive/primary care services. By focusing on education and outreach to members with these presenting symptoms, it should be possible to continue to lower the overall utilization rate. The OHCA also may wish to explore opportunities for collaboration with the Department of Mental Health and Substance Abuse Services in its outreach to members presenting with behavioral health needs.

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

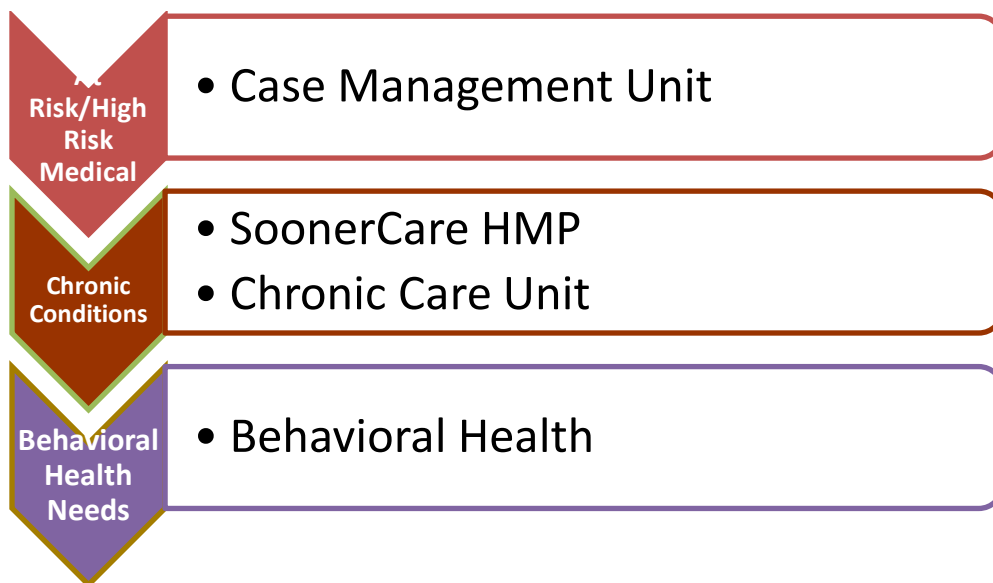
The majority of SoonerCare Choice members are healthy children and pregnant women. However, the program also includes thousands of members with complex/chronic physical health conditions, often coupled with a behavioral health need.

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

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

The OHCA, as the managed care organization for SoonerCare Choice, has put in place a needs-based multi-tiered care management structure for members with complex/chronic conditions (Exhibit 2-20). 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 – 20 – SoonerCare Choice Population Care Management Structure**



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

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

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

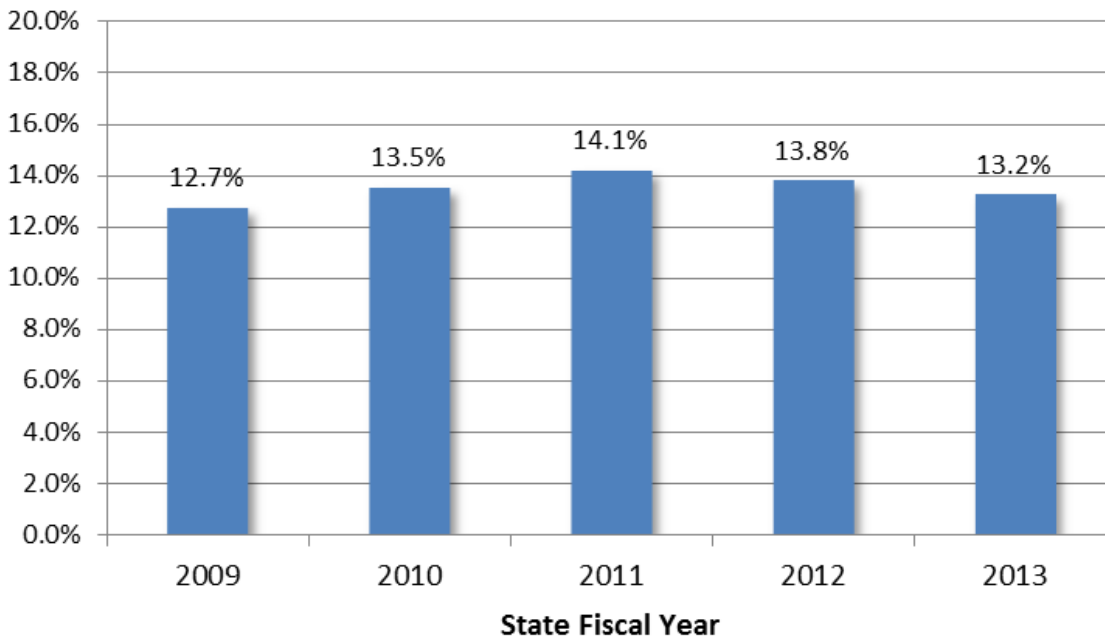
One important indicator of the effectiveness of Case Management Unit post-discharge activities is the SoonerCare Choice 30-day hospital readmission rate. If members at risk of readmission are identified and provided effective post-acute care case management, this should be reflected in the program's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

The SoonerCare Choice readmission rate was below 15 percent for the entire evaluation period (Exhibit 2-21 on the following page). The 2013 rate of 13.2 percent compares favorably to the national Medicare readmission rate of 18.4 percent<sup>28</sup>, even allowing for the relatively frailer health of the average Medicare beneficiary and the presence of deliveries/newborns (which are less likely to result in a readmission) in the OHCA data.

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<sup>28</sup> Source: <http://www.cms.gov/mmrr/Briefs/B2013/mmrr-2013-003-02-b01.html>.

**Exhibit2 – 21 – SoonerCare Choice Care 30-Day Hospital Readmission Rate**



The impact of care management 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 satisfaction<sup>29</sup>. More information on SoonerCare HMP performance is presented in chapter three.

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<sup>29</sup> 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:

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

### Does the Program Have Mechanisms to Measure and Reward Quality?

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

HEDIS data is used in conjunction with other measures to evaluate the performance of PCMH providers and to reward providers who meet or exceed pre-established targets. In SFY 2012, the OHCA made over \$3.4 million in “SoonerExcel” quality incentive payments to PCMH providers who met one or more quality benchmarks. In SFY 2013, the payments exceeded \$3.5 million (Exhibit 2-22).

### ***Exhibit 2 – 22 – SoonerExcel Payments – SFY 2012 and SFY 2013***

Quality Measure	Benchmark	Incentive (subject to available funds)	SFY 2012 Payments	SFY 2013 Payments
4 <sup>th</sup> DTaP	Immunization prior to age 2	\$3.00 per child	In EPSDT Total	In EPSDT Total
EPSDT Screen	Meet or exceed appropriate compliance rate	Up to 25 percent bonus on standard FFS rate for procedure	\$985,000	\$984,000
Breast/Cervical Cancer Screens	Payment made for each screen	Amount based on comparison to peers and available funds	\$358,000	\$358,000
ED Utilization	Expected ED/office visit rate (risk adjusted)	Additional PMPM payment for outperforming benchmark	\$496,000	\$483,000

Quality Measure	Benchmark	Incentive (subject to available funds)	SFY 2012 Payments	SFY 2013 Payments
Generic Prescribing	Payment made for each Rx, after application of adjustment formula	Provider-specific portion out of quarterly pool of \$250,000	\$967,000	\$967,000
Physician Hospital Visits	Making inpatient visits	25 percent bonus per procedure + additional \$20 per visit if above average of participating providers	\$614,000	\$760,000
<b>TOTAL PAYMENTS</b>			<b>\$3,420,000</b>	<b>\$3,552,000</b>

Are members receiving appropriate preventive and diagnostic services?

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

PHPG documented HEDIS trends in six areas for children/adolescents and six areas for adults (Exhibit 2-23). For some measures, data was available extending back to 2008; for others data was available starting in 2010.

PHPG also documented the OHCA’s activities aimed at reducing tobacco use among SoonerCare Choice members. Findings are discussed following the presentation of HEDIS data.

**Exhibit 2 – 23 – HEDIS Measures by Age Group**

Children/Adolescents	Adults
Access to PCP	Access to preventive/ambulatory health services
Annual dental visit	Breast cancer screening (ages 40 – 69)
Lead screening rate by 2 years of age	Cervical cancer screening (ages 21 – 64)
Appropriate treatment for urinary tract infection (ages 3 months to 1 year)	Cholesterol management for patients w/cardiovascular conditions (ages 18 – 75)
Appropriate treatment for children with pharyngitis (ages 2 – 18)	Comprehensive diabetes care
Appropriate medications for treatment of asthma (children)	Appropriate medications for treatment of asthma (adults)

*Child/Adolescent HEDIS Trends*

The percentage of children and adolescents with access to a PCP increased steadily over the evaluation period and was above 90 percent for all age cohorts in 2013. The access percentage also was consistently above the national rate (Exhibit 2-24).

**Exhibit 2 – 24 – SoonerCare Choice HEDIS Trends – Child/Adolescent Access to PCP<sup>30</sup>**

HEDIS Measure	2008	2009	2010	2011	2012	2013	% Point Change 2008 -13	National Rate
Child access to PCP, 12-24 months	94.1%	96.2%	97.8%	97.2%	96.6%	97.0%	<b>↑2.9%</b>	96.1%
Child access to PCP, 3-6 years	83.1%	86.9%	89.1%	88.4%	90.1%	90.6%	<b>↑7.5%</b>	88.2%
Child access to PCP, 7-11 years	82.7%	87.6%	89.9%	90.9%	91.7%	92.4%	<b>↑9.7%</b>	89.5%
Adolescent access to PCP, 12-18 years	81.4%	85.8%	88.8%	89.9%	91.6%	92.8%	<b>↑11.4%</b>	87.9%

Preventive service, screening and treatment rates also improved for the four other child/adolescent measures. One measure – dental visits – was significantly above the national rate while two others – lead screening and urinary tract infection treatment – were below the national rate (Exhibit 2-25).

**Exhibit 2 – 25 – SoonerCare Choice HEDIS Trends – Child/Adolescent (Multiple)**

HEDIS Measure	2008	2009	2010	2011	2012	2013	% Point Change 2008(10) -13	National Rate
Annual dental visit under 21 years	59.7%	62.1%	60.2%	62.0%	64.0%	64.1%	<b>↑4.4%</b>	49.2%
Lead screening rate	N/A	N/A	43.5%	44.5%	44.7%	48.2%	<b>↑4.7%</b>	67.5%
Appropriate treatment for urinary tract inf.	N/A	N/A	67.7%	69.5%	66.8%	73.1%	<b>↑5.4%</b>	85.1%
Appropriate testing for children with pharyngitis	N/A	N/A	38.8%	44.8%	49.1%	53.2%	<b>↑14.4%</b>	--

<sup>30</sup> Sources for all HEDIS data: 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.

*Adult HEDIS Trends – Preventive Services*

Access to preventive services also improved for both younger and older adults, reaching nearly 83 percent in SFY 2013 for the former and over 90 percent for the latter (Exhibit 2-26). Both results exceeded the national rate.

**Exhibit 2 – 26 – SoonerCare Choice HEDIS Trends – Adult Access to Preventive Services**

HEDIS Measure	2008	2009	2010	2011	2012	2013	% Point Change 2008 -13	National Rate
Adult access to preventive/ ambulatory services, 20 – 44 years	78.4%	83.3%	83.6%	84.2%	83.1%	82.8%	↑4.4%	80.0%
Adult access to preventive/ ambulatory services, 45 – 64 years	86.8%	89.7%	90.9%	91.1%	91.0%	90.8%	↑4.0%	86.1%

The screening rates for breast and cervical cancer, and the rate for management of cholesterol among patients with cardiovascular conditions, did not show the same favorable trends. In all three instances the 2013 rate was below the baseline year and below the national benchmark (Exhibit 2-27). The rate for cholesterol management was still relatively high while the breast and cervical cancer screening rates rose from the 2008 to 2009 reporting years before declining.

**Exhibit 2 – 27 – SoonerCare Choice HEDIS Trends – Adult (Multiple)**

HEDIS Measure	2008	2009	2010	2011	2012	2013	% Point Change 2008(10) -13	National Rate
Breast cancer screening rate	38.3%	43.0%	41.1%	41.3%	36.9%	36.5%	↓1.8%	51.9%
Cervical cancer screening rate	44.4%	46.6%	44.2%	47.2%	42.5%	41.0%	↓3.4%	64.5%
Cholesterol management for patients with cardiovascular conditions	N/A	N/A	69.5%	69.9%	68.6%	68.2%	↓1.3%	81.5%

One contributing factor to this fluctuation may have been an ongoing national debate concerning the recommended screening age for mammograms, which was recently raised, and

recommended cervical screening intervals, which were recently lengthened. In fact, the 2013 HEDIS technical specifications for cervical cancer screens did not align with the revised cervical cancer screening guidelines from the American College of Obstetricians and Gynecologists.

HEDIS requires a two-year look back while ACOG is now recommending screens every three-to-five years; thus a member may be current on her screens but still show as having a care gap in HEDIS calculations. Nevertheless, there is still clearly room for improvement, which the OHCA recognizes.

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

*Adult HEDIS Trends – Diabetes*

Diabetes is one of the most common chronic conditions within the SoonerCare Choice adult population. The trends for HEDIS measures related to diabetes care are mixed, with some improving and others declining. However, all of the rates are below the national benchmark (Exhibit 2-28).

**Exhibit 2 – 28 – SoonerCare Choice HEDIS Trends – Diabetes**

HEDIS Measure	2010	2011	2012	2013	% Point Change 2010 -13	National Rate
Hemoglobin A1C testing	71.0%	71.1%	70.5%	71.5%	↑0.5%	83.0%
Eye exam (retinal)	32.8%	31.8%	31.8%	32.0%	↓0.8%	53.2%
LDL-C screening	63.6%	62.9%	62.0%	63.1%	↓0.5%	75.5%
Medical attention for nephropathy	54.4%	55.9%	56.8%	58.7%	↑4.3%	78.4%

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

The grant activities are similar to those being undertaken within the SoonerCare HMP for members with chronic illnesses, including diabetes. The SoonerCare HMP interventions have

resulted in improved preventive service rates and reductions in emergency room and hospital utilization (see chapter three<sup>31</sup>).

*All Ages HEDIS Trends – Asthma*

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

The HEDIS trends for treatment of asthma with appropriate medications are generally very positive. The rate among children and adolescents has risen and is close to 100 percent. The rate among adults is lower but also improving and nearly on par with the national benchmarks (Exhibit 2-29<sup>32</sup>).

**Exhibit 2 – 29 – SoonerCare Choice HEDIS Trends – Asthma**

HEDIS Measure	2010	2011	2012	2013	% Point Change 2010 -13	National Rate
Appropriate medications for treatment of asthma, ages 5 - 11	90.9%	90.6%	90.3%	94.0%	↑3.1%	89.6%
Appropriate medications for treatment of asthma, ages 12 - 18	N/A	N/A	85.2%	95.2%	↑10.0%	85.6%
Appropriate medications for treatment of asthma, ages 19 - 50	N/A	N/A	60.4%	68.9%	↑8.5%	73.9%
Appropriate medications for treatment of asthma, ages 51- 64	N/A	N/A	56.9%	74.1%	↑17.2%	71.4%

*Tobacco Cessation Activities*

Tobacco use is the single most preventable cause of death and poor health outcomes in the United States, responsible for an estimated \$96 billion in health-related expenditures each year<sup>33</sup>.

<sup>31</sup> See also SoonerCare HMP – Comprehensive Program Evaluation and Cost Saving Report, June 2014.

<sup>32</sup> The age bands for asthma measures were revised starting with the 2012 reporting year. The revisions affected data for persons ages 12 and older.

<sup>33</sup> All information in this section was provided by the OHCA, except where noted.

Oklahoma historically has had one of the nation's highest tobacco use rates and tobacco use among SoonerCare members has exceeded the State average. In 2008, 48 percent of SoonerCare Choice adults reported using tobacco products, as did 25 percent of pregnant SoonerCare Choice members.

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

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

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

- Tobacco Helpline call volume increased 82 percent from 2009 to 2012.
- Among SoonerCare Choice prenatal care providers who participated in practice facilitation, the portion offering onsite tobacco cessation counseling increased from 29 percent to 68 percent<sup>34</sup>.
- The tobacco use rate among SoonerCare Choice adults, as reported in CAHPS survey data, declined from 48 percent in 2008 to 43 percent in 2013.

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

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<sup>34</sup> Source: PHPG independent evaluation of SoonerQuit practice facilitation initiative.

Are Health Outcomes Improving?

*Avoidable (Ambulatory Care Sensitive) Hospitalizations*

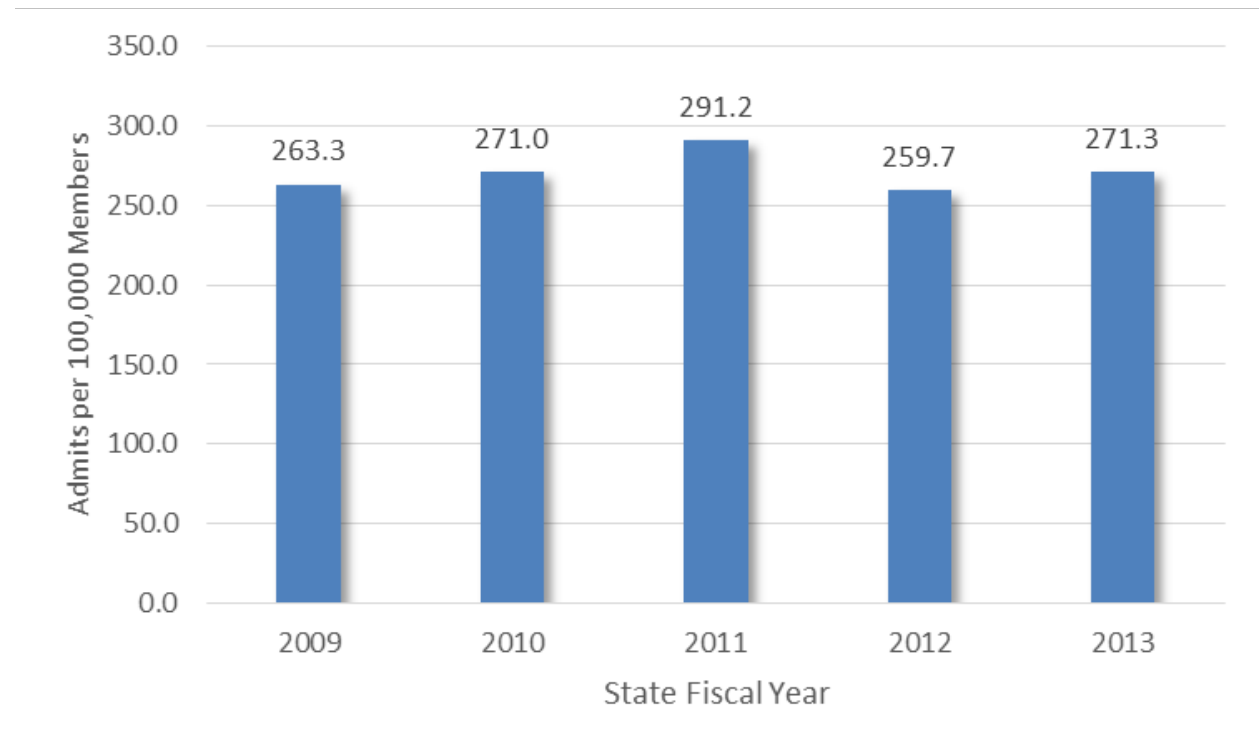
The delivery of high quality preventive and primary care should contribute to improved health outcomes. One useful measure of quality is the hospitalization rate for avoidable, or ambulatory care sensitive, conditions.

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

PHPG examined hospitalization rates for the four ambulatory care sensitive conditions from SFY 2009 through 2013. The rate dropped significantly across three of the four conditions, with the sharpest decline occurring among members with pneumonia (Exhibits 2-30 through 2-33).

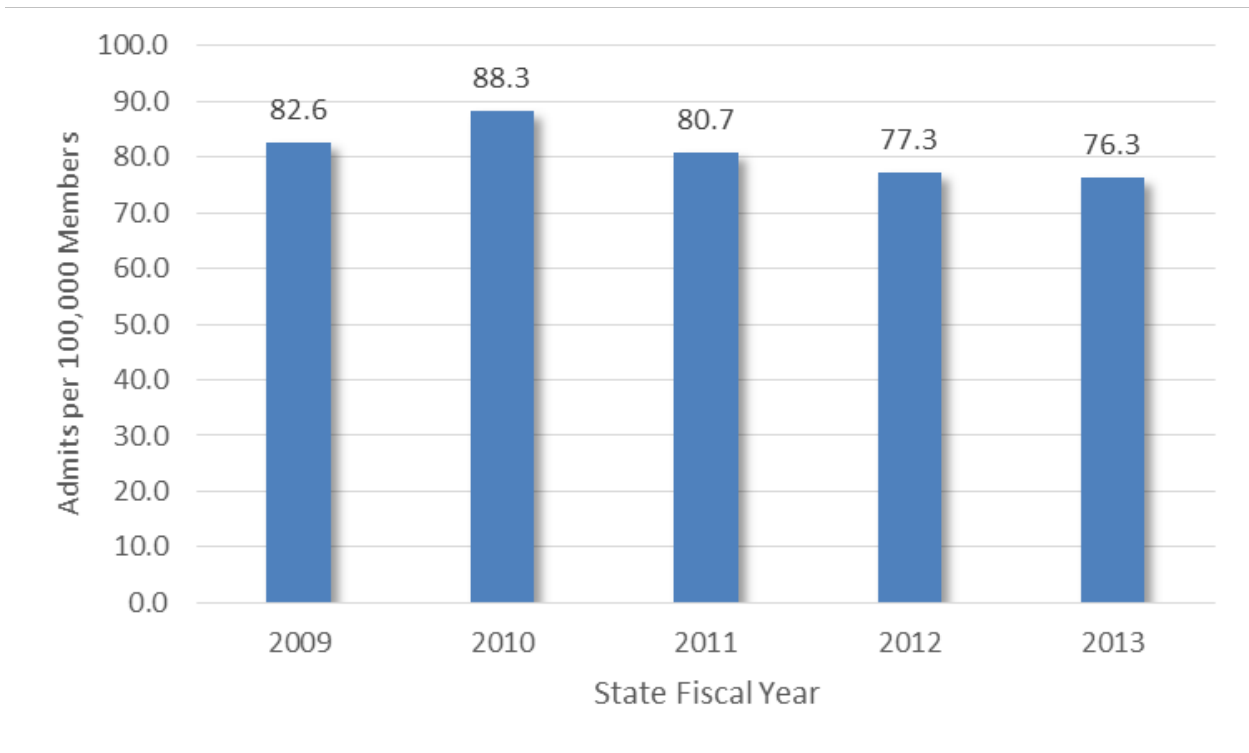
The rate for asthma declined in 2012 from its peak in 2011, before rising slightly above the 2009 baseline in 2013. The improvement in prescribing of appropriate medications could be expected to result in stabilization or decline in the asthma hospitalization rate in subsequent reporting periods.

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

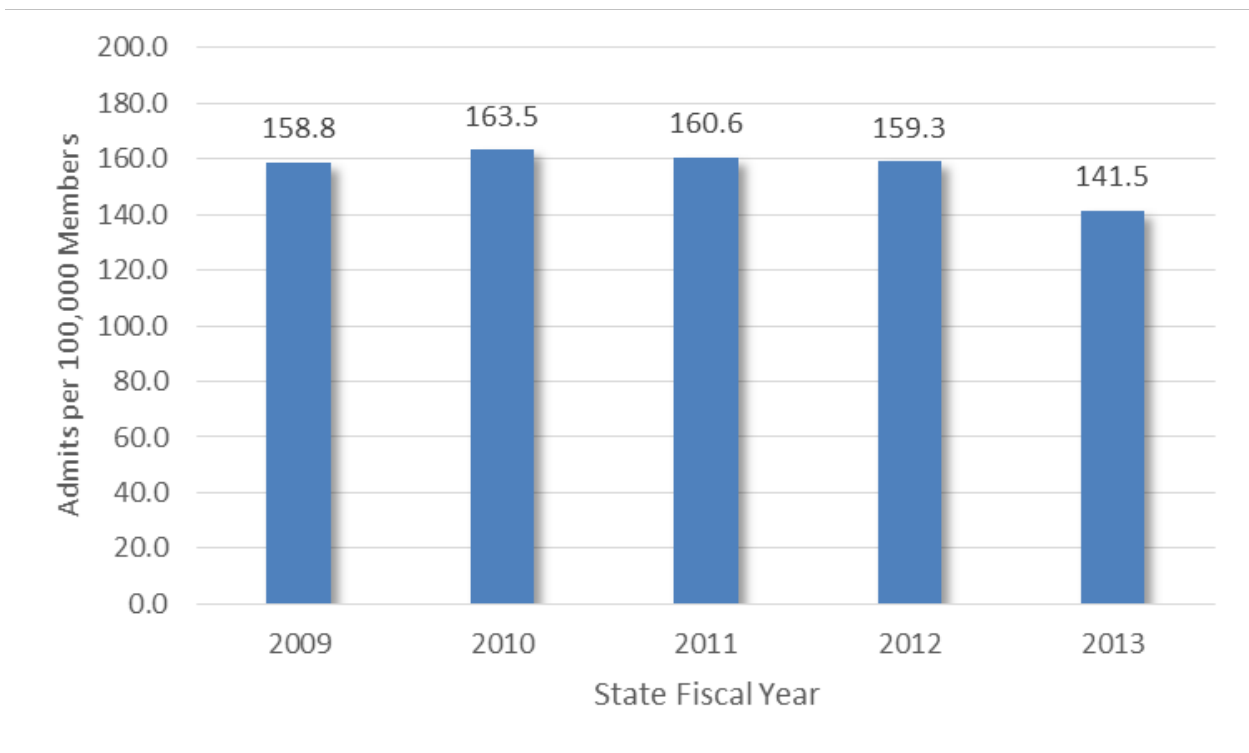




**Exhibit 2 – 31 – SCC Ambulatory Care Sensitive Hospitalization Rate – CHF**



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



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



*Post Discharge Care*

Another measure of health outcomes is the 30-day readmission rate for members who are hospitalized. The previously reported low rate for 2009 through 2013 (Exhibit 2-1) is an indicator of effective post-discharge care.

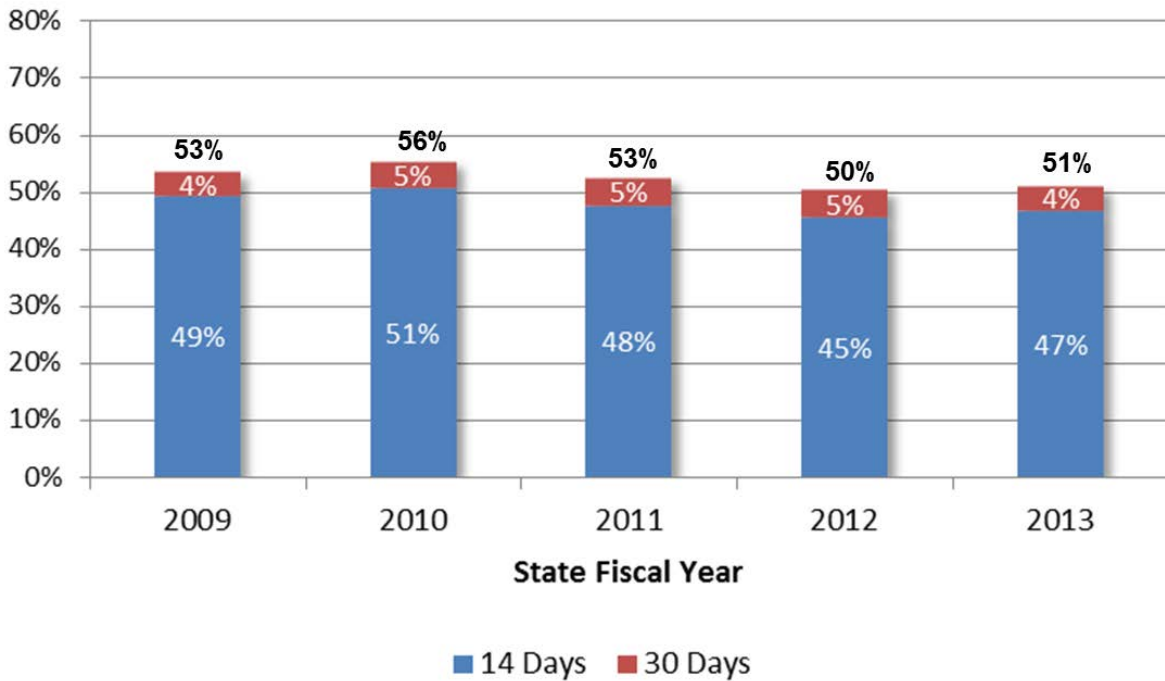
As noted earlier, OHCA’s care managers are likely responsible for a portion of the improvement. Another contributing factor may be the PCMH provider community.

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 ambulatory care sensitive hospitalizations, the PCMH will often be the appropriate person to deliver follow-up care.

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

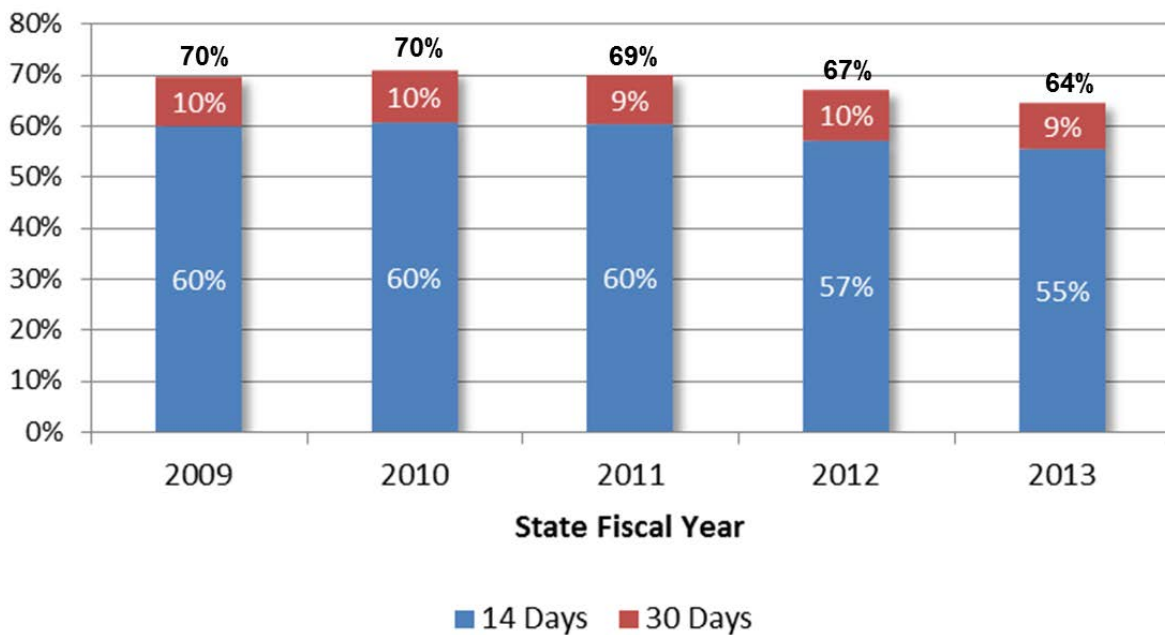
The follow-up rate for all members has been relatively steady and above 50 percent since 2009. Most visits occur within the first 14 days following discharge (Exhibit 2-34 on the following page).

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



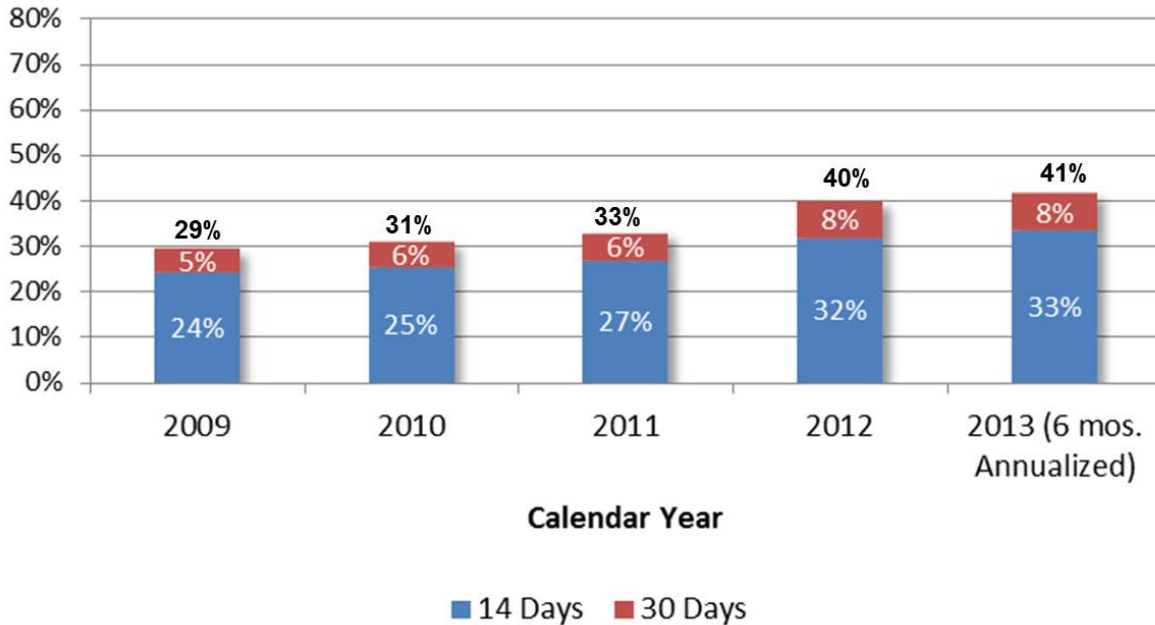
The follow-up rate for members hospitalized with one of the four ambulatory sensitive conditions has consistently been above 60 percent, although it has declined slightly from its high point in 2009-2010 (Exhibit 2-35).

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



The follow-up rate for members hospitalized with a behavioral health condition has historically been lower but has increased significantly in recent years and is now over 40 percent (Exhibit 2 -36).

**Exhibit 2 – 36 – SCC Post-Discharge BH Provider Follow-up Visit Rate – BH Admits**



## Cost Effectiveness

### Evaluation Questions

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

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

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

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

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

PHPG examined SoonerCare Choice health expenditure trends from SFY 2009 through SFY 2013. PHPG analyzed average per member per month (PMPM) expenditures to eliminate any impact associated with change in enrollment, which is not controllable by the OHCA.

PHPG also analyzed members in the TANF and related categories, primarily pregnant women and healthy children, separately from aged, blind and disabled (ABD) members<sup>35</sup>. 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 nearly flat over the evaluation period, increasing at an average annual rate of only 1.8 percent. TANF and related population expenditures also grew moderately, at an average rate of 2.3 percent.

Annual PMPM expenditure growth for the total SoonerCare Choice population was 1.5 percent<sup>36</sup>, or exactly half the average annual per capita national health expenditure increase of 3.0 percent over the same period (Exhibit 2-37 on the following page).

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<sup>35</sup> SoonerCare Choice includes ABD members who are not dually eligible for Medicare and Medicaid. Dually eligible members are enrolled in SoonerCare Traditional.

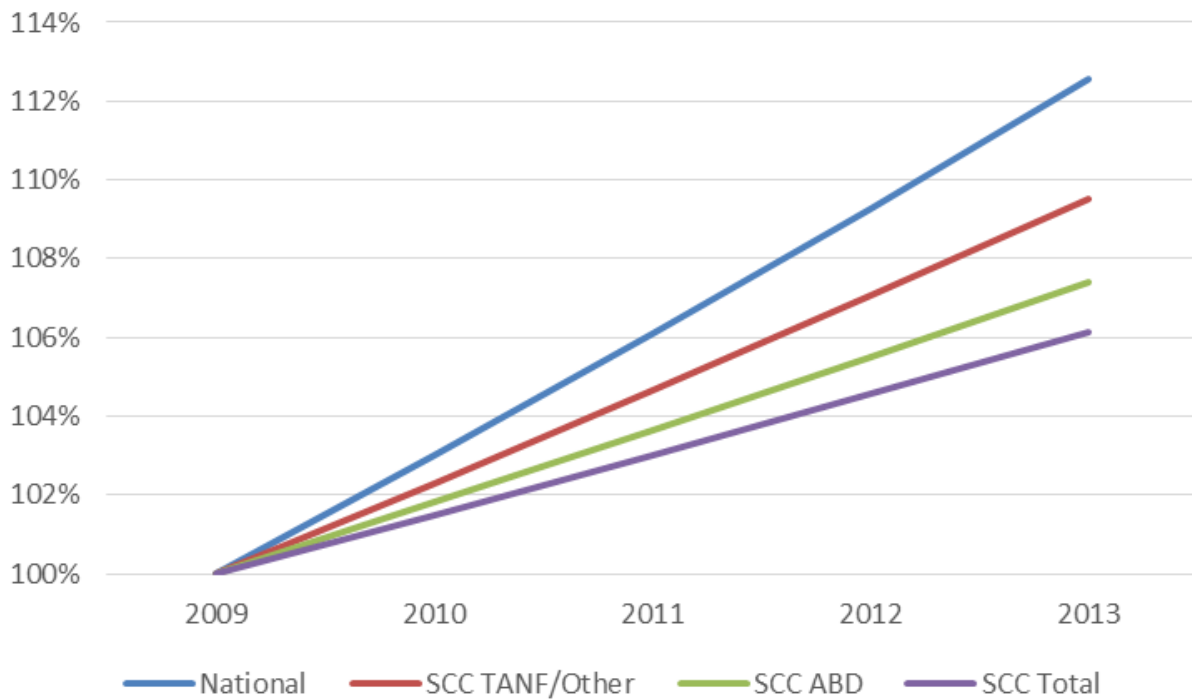
<sup>36</sup> The growth rate for all of SoonerCare Choice was lower than the individual rates for ABD and TANF members because of changes in the relative size of the two groups from 2009 to 2013. TANF enrollment grew by 24 percent while ABD enrollment grew by only six percent. The more rapid enrollment growth for TANF members, combined

**Exhibit 2 – 37 – SoonerCare Choice PMPM Health Expenditures by State Fiscal Year**

Aid Category	2009	2010	2011	2012	2013	Average Annual % Change	National per capita
ABD (non-duals)	\$779	\$815	\$806	\$806	\$836	↑1.8%	N/A
TANF/Other	\$216	\$215	\$217	\$228	\$236	↑2.3%	N/A
TOTAL	\$274	\$275	\$276	\$280	\$291	↑1.5%	↑3.0%

The OHCA’s lower average annual inflation rate, when considered over the full five years, has resulted in significantly lower expenditures than would have occurred had Oklahoma’s rate matched the national percentage (Exhibit 2-38).

**Exhibit 2 – 38 – Comparison of SoonerCare Choice and National Rates (2009 = 100%)**



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

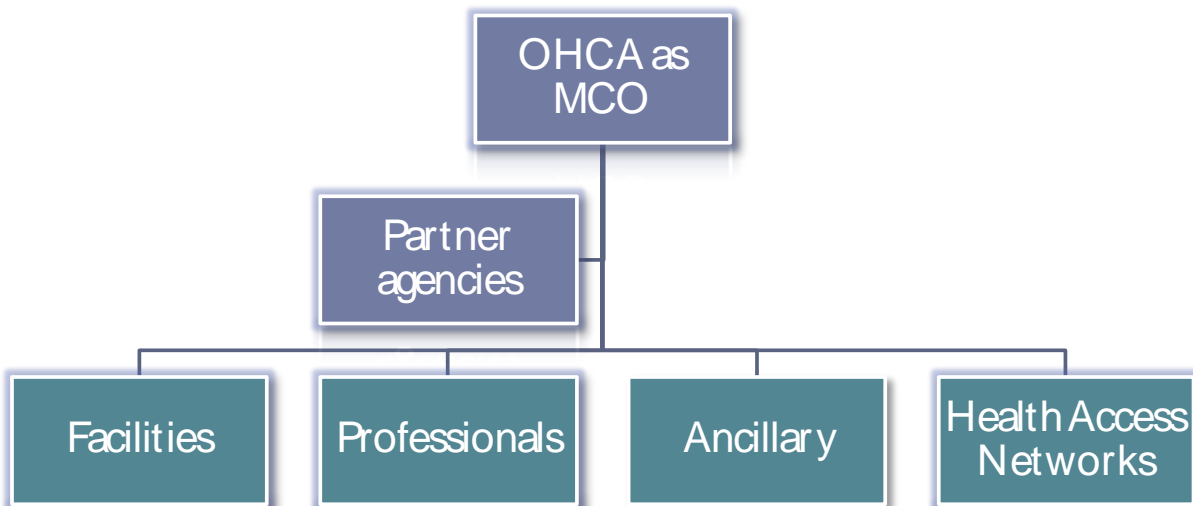
Is the SoonerCare Program Cost Effective in Terms of Administrative Expenses?

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

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

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

**Exhibit 2 – 39 – OHCA Administrative Model (Current)**



PHPG constructed an administrative cost profile for the SoonerCare program using state fiscal year (SFY) 2013 data provided by the OHCA. This included OHCA and contractor expenses as documented in the SFY 2013 annual report and CMS-64 reports filed with the federal government.

The profile also included detailed administrative expenditure data provided by partner agencies, including the Oklahoma Department of Human Services (OKDHS), Oklahoma Department of Mental Health and Substance Abuse Services (DMHSAS) and Oklahoma State Department of Health (SDOH). The partner agency reports documented activities performed on behalf of SoonerCare applicants and members for which federal Medicaid matching dollars were claimed<sup>37</sup>.

The preliminary expenditure total was adjusted downward to account for activities performed by the OHCA that are not typically the responsibility of private MCOs (e.g., eligibility determination). It also was adjusted upward to account for new dollars for MCO activities that the OHCA does not currently perform, or for which additional resources would be required to match performance expectations typically established for private MCOs.

The OHCA's adjusted, MCO-related administrative expenditures in SFY 2013 were estimated to be \$170.7 million. This represented 4.22 percent of total expenditures (administration plus medical services).

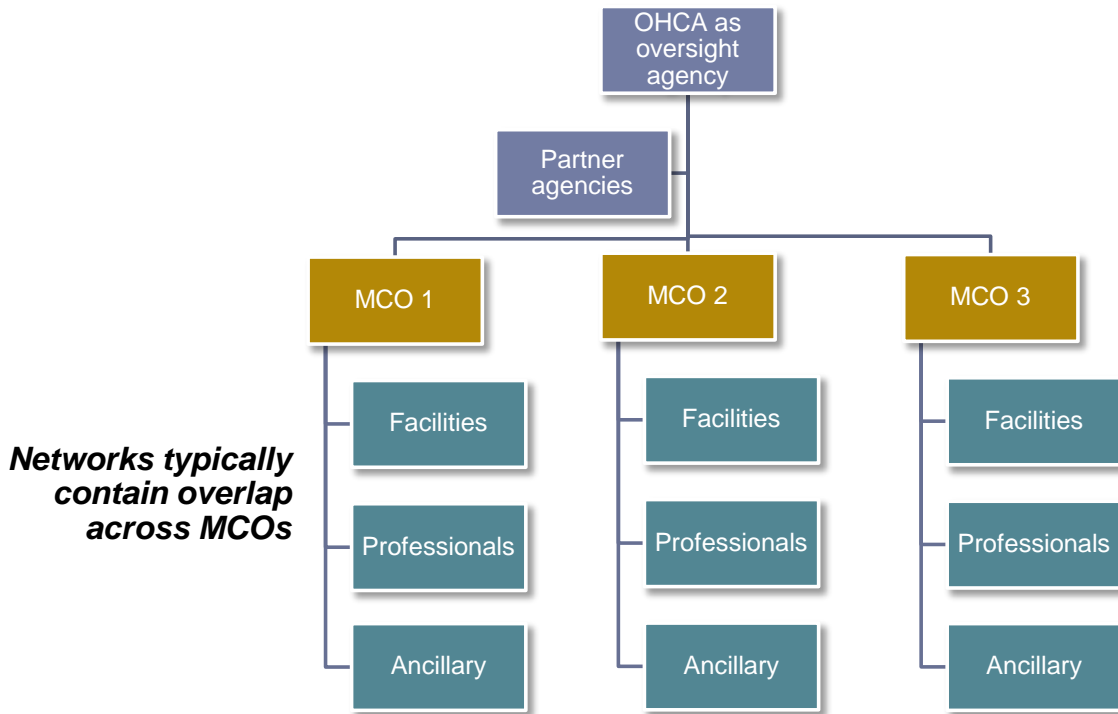
Under the private MCO model, the state typically contracts with three or more health plans, usually with overlapping provider networks, to serve Medicaid members. (Exhibit 2-40 on the following page).

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<sup>37</sup> The adjustments are described in detail in the full report.



**Exhibit 2 – 40 – Private MCO Administrative Model**

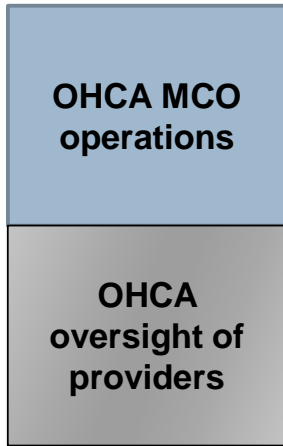


States with MCO contracts are typically able to reduce their agency administrative costs slightly by transferring member service, provider contracting and medical management activities to the plans. However, these savings can be more than offset by the need to cover the administrative costs, risk reserves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

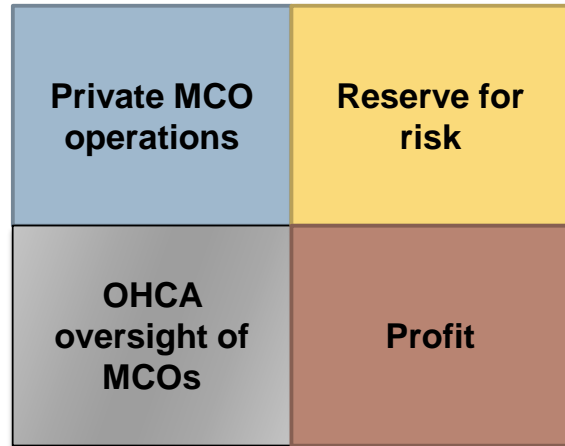
In addition, the state Medicaid agency (the OHCA in Oklahoma) retains responsibility for program oversight (Exhibit 2-41 on the following page).

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

**Public MCO Model**



**Private MCO Model**



PHPG researched current rate setting methodologies in other states to determine a reasonable expected administrative cost allowance for private MCOs were the OHCA once again to contract with them to serve the SoonerCare population<sup>38</sup>. PHPG focused on states with geographic and demographic characteristics similar to Oklahoma. PHPG’s research necessarily was limited to states utilizing private MCOs, and those with readily and publicly available rate setting information.

The comparison states included four of Oklahoma’s neighbors: Colorado, Kansas, New Mexico and Texas. PHPG also examined rates in Arizona, Florida and Louisiana, as well as data contained in a national study prepared for CMS in 2013 by the actuarial firm of Milliman<sup>39</sup>.

For purpose of the baseline analysis, PHPG assumed average SoonerCare PMPM medical costs would be the same under a public or private MCO model. PHPG estimated this amount, across all SoonerCare members (SoonerCare Choice + SoonerCare Traditional), would be approximately \$455 in SFY 2015.

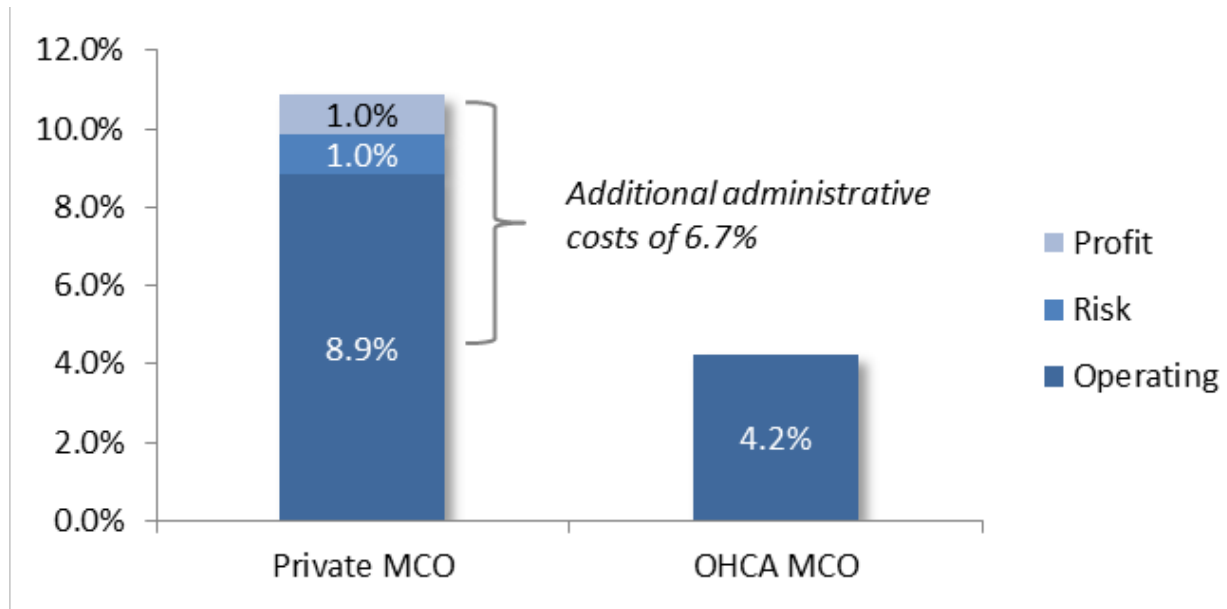
On average, private MCO administrative costs in the comparison states equaled just under 11 percent of total per member per month costs. This includes monies for direct administration, as well as reserves for risk/contingencies and profit (Exhibit 2-42 on the following page).

<sup>38</sup> PHPG did not analyze administrative costs in the SoonerCare Plus program because of the number of years that have elapsed since the program’s demise.

<sup>39</sup> “Medicaid risk-based managed care: Analysis of financial results for 2012,” Milliman, June 2013,

By comparison, as noted before, the OHCA’s administrative cost in SFY 2013 for MCO-related activities was 4.2 percent. This percentage was solely for administrative activities as the OHCA does not have to set allocate funds for risk/contingency or profit.

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



The difference in costs is not difficult to explain. In addition to having no need for risk/contingency reserves or profits, the OHCA, as a statewide plan, is able to spread administrative costs over a larger population than an MCO that is dividing membership with other plans. This enables a greater share of the healthcare dollar to be paid to providers for care delivery. It has, for example, enabled the OHCA to pay physicians 89.2 percent of the Medicare rate in SFY 2015, as compared to the national Medicaid average of 66 percent<sup>40</sup>.

<sup>40</sup> <http://kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/>. National rate is for 2012.

## SoonerCare Choice Performance – Summary

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

The evaluation did identify areas of future focus for the OHCA, including:

- ER utilization, while down, remains high by national standards, particularly for adults and persons with disabilities.
- While quality measures generally show improvement and exceed national benchmarks, there are important exceptions. Lower rates were observed for breast/cervical cancer screening, lead screening, cholesterol screening and components of diabetes care.

The OHCA is developing strategies to improve performance in both areas as part of its continuous quality improvement activities.

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

## CHAPTER 3 – IN-DEPTH EVALUATION: SC CHOICE INITIATIVES

SoonerCare Choice became the OHCA’s statewide managed care system in January 2005. Since that time, the OHCA has worked to advance the concept of person-centered care in collaboration with providers and community-based care organizations throughout the State.

Three significant initiatives have been undertaken in recent years:

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

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

### Patient Centered Medical Homes

#### Overview

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

PCMH providers are paid for services rendered, such as office visits and also receive per member per month fees intended to support care management activities. The fees vary by member age and gender and by tier. A tier 1 PCMH provider with an average SoonerCare Choice caseload of 266 members<sup>41</sup> could expect to receive nearly \$15,000 in care management payments over the course of a year; his or her tier 3 counterpart could expect to receive over \$25,000.

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<sup>41</sup> Average in May 2014.

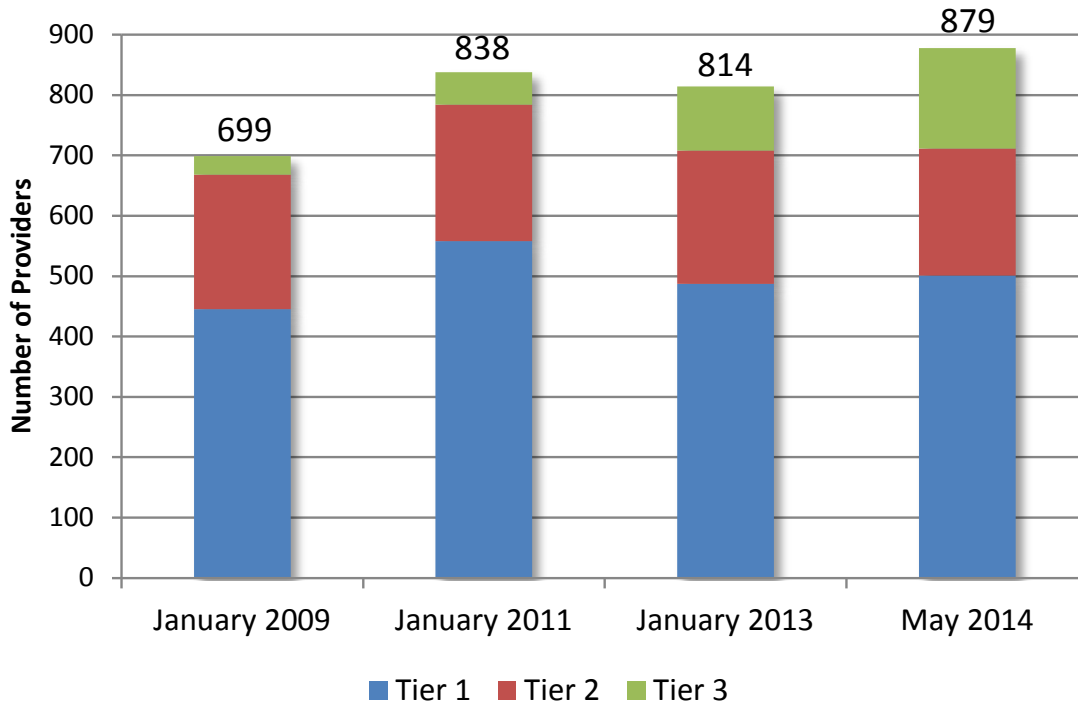
**Exhibit 3 – 1 – Patient Centered Medical Home Tiers<sup>42</sup>**

PCMH Tier	Requirements (partial list):	PMPM Rate Range*	Practice with average caseload of 254 patients:
Tier 1 "Entry Level"	<p><i>12 requirements, including:</i></p> <ul style="list-style-type: none"> <li>• Coordinated primary care and patient education</li> <li>• 24/7 telephone coverage by medical professional</li> <li>• Maintaining a system to track tests and referrals</li> <li>• Acceptance of electronic communication from OHCA</li> </ul>	\$3.46 to \$4.85	\$14,783 per year
Tier 2 "Advanced"	<p><i>19 requirements, including all Tier1 plus:</i></p> <ul style="list-style-type: none"> <li>• Full-time practice w/enhanced access/after-hours</li> <li>• Inpatient tracking &amp; hospital follow-up</li> <li>• Any 3 of 6 optional enhanced services - practice healthcare team, after visit follow-up, adoption of evidence-based practice guidelines, medication reconciliation, MH screening</li> </ul>	\$4.50 to \$6.32	\$19,263 per year
Tier 3 "Optimal"	<p><i>23 requirements, including all T1/T2 plus:</i></p> <ul style="list-style-type: none"> <li>• Using health assessments tools to characterize patient needs and risks</li> </ul> <p>Also recommended:</p> <ul style="list-style-type: none"> <li>• Communicating with patients/families through secure, interactive website</li> <li>• Utilizing integrated care plans for patients co-managed with specialists</li> <li>• Regularly measuring performance for quality improvement</li> </ul>	\$5.99 to \$8.41	\$25,634 per year

<sup>42</sup> The OHCA pays separate rates for providers based on whether they treat adults only, children only or both children and adults . Rates are for SFY 2013. Average practice fee calculation performed using top of rate range for each tier.

The majority of practices have contracted to be tier 1 providers. However, since 2009, tier 3 providers have increased from five percent to 19 percent of the total (Exhibit 3-2). Over the period January 2009 through May 2014, the absolute number of participating practices also has increased by 25 percent, from 699 to 879.

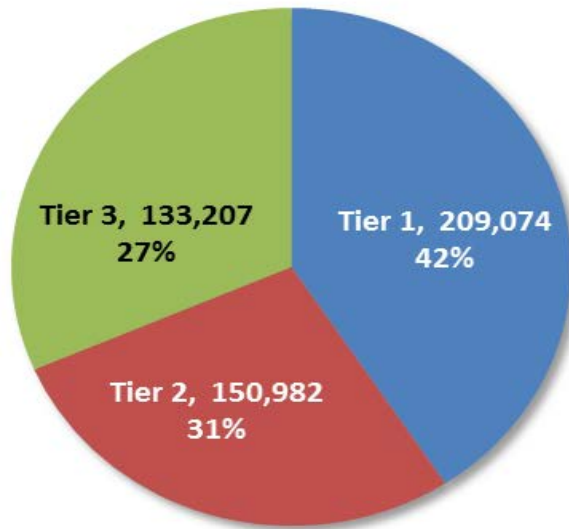
**Exhibit 3 – 2 – Patient Centered Medical Home – Participating Practices by Tier<sup>43</sup>**



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

<sup>43</sup> Sources: OHCA PCMH roster data; Patient-Centered Medical Home – Survey of SoonerCare-Contracted PCPs. Practices can include multiple providers.

**Exhibit 3-3 – SoonerCare Choice Member Enrollment by Tier – May 2014<sup>44</sup>**



PCMH Performance - Aggregate

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

- Member satisfaction with quality of care – up significantly for all measures since 2009;
- HEDIS measures of access to preventive/ambulatory care services – up for all age groups since 2008 and above the national benchmarks;
- Emergency room visit rates – down nearly 12 percent from 2009 to 2013;
- Ambulatory care sensitive hospitalization rates – down from 2009 levels for three of four conditions evaluated;
- Hospital readmission rates – stable at a relatively low level since 2009; and
- Average PMPM expenditures – half the rate of growth of the national benchmark.

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<sup>44</sup> Source: OHCA May 2014 Provider Tiers and Panel Capacity Report



### PCMH Performance - Tiers

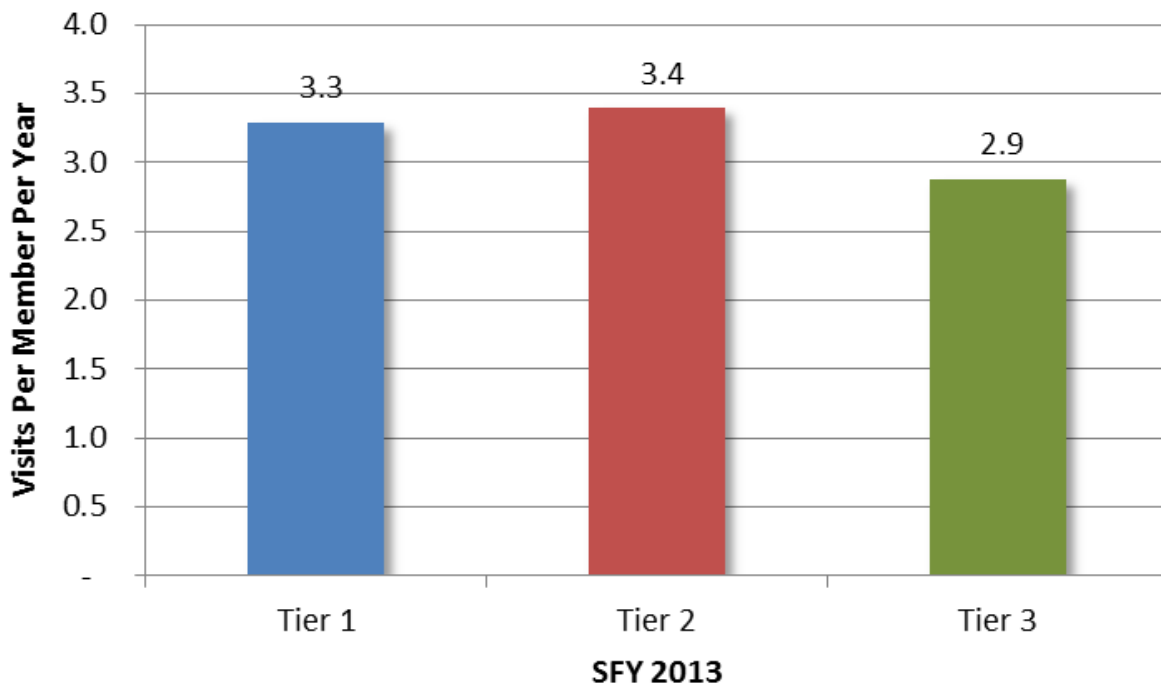
The aggregate success of the PCMH model is critical but leaves unanswered the question of whether the higher payments and standards for Tier 2 and Tier 3 providers has yielded benefits when compared Tier 1 providers. To evaluate PCMH performance by tier, PHPG used SFY 2013 paid claims data to compare the three tiers with respect to six outcome measures that the PCMH can at least partially influence:

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

#### *PCMH Visit Rate*

SoonerCare Choice members in 2013 averaged about three visits per year to their PCMH provider, which is in line with program expectations. However, the rate for members aligned with tier 3 providers was slightly lower than the rate for other members (Exhibit 3-4).

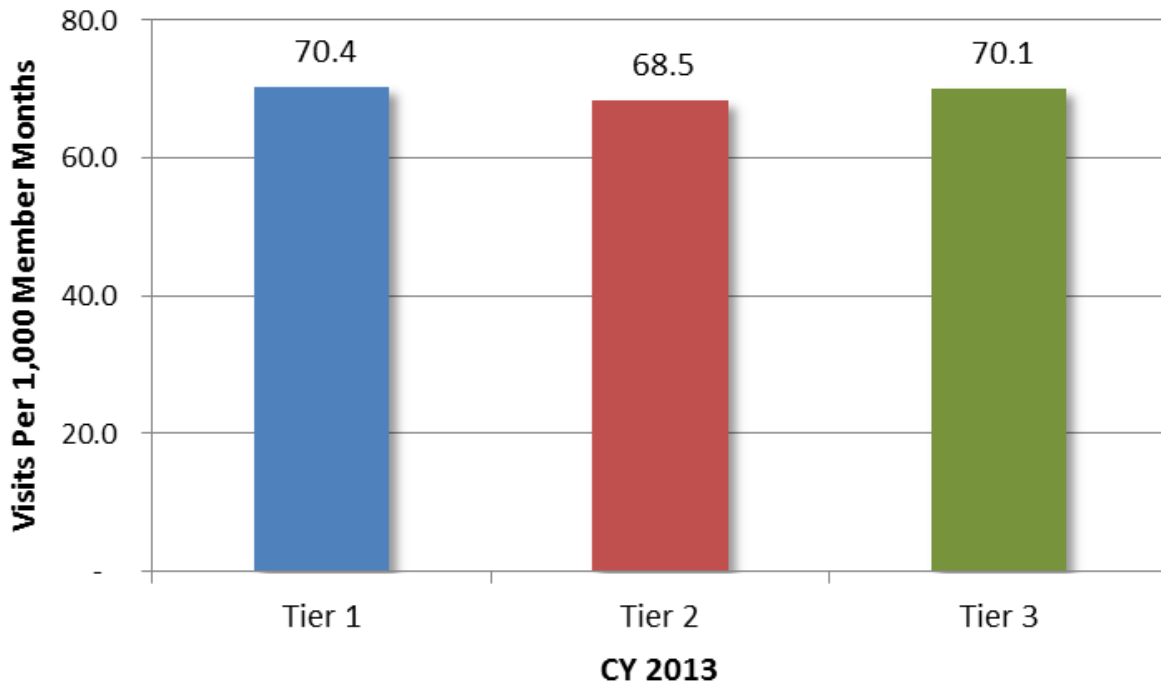
**Exhibit 3 – 4 – PCMH Visit Rates – SFY 2013 (per member per year)**



### *Emergency Room Utilization Rate*

As discussed in chapter two, emergency room utilization declined significantly after introduction of the PCMH model in 2009 and has since remained relatively steady. There was little difference in member use rates across the three tiers (Exhibit 3-5).

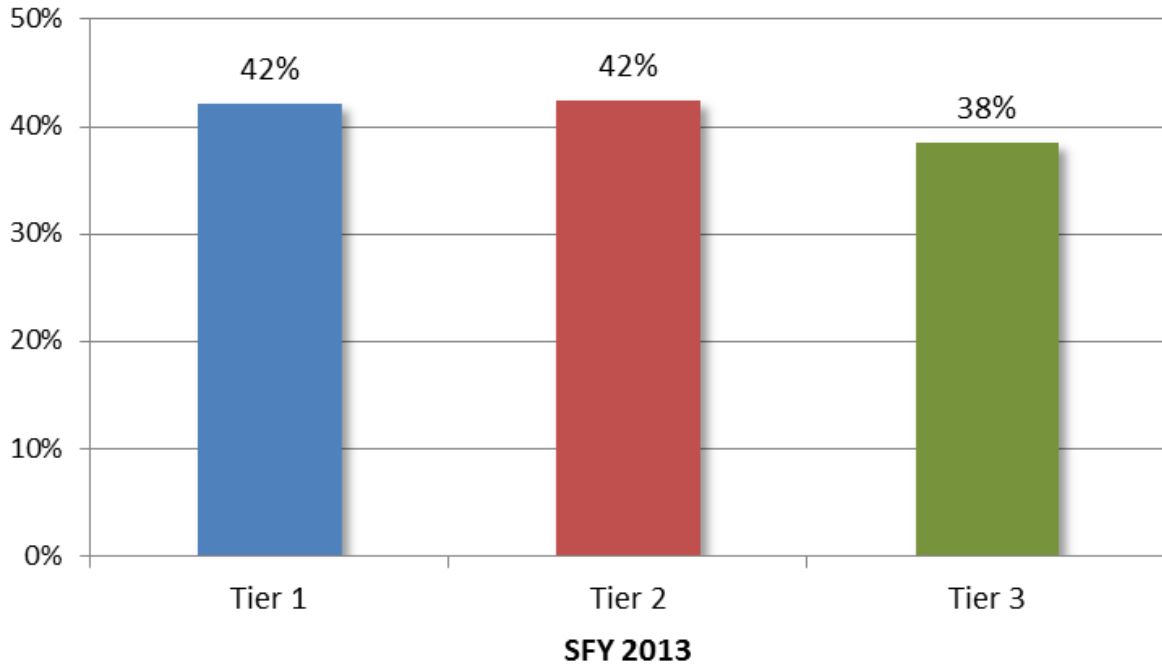
**Exhibit 3 – 5 – Emergency Room Utilization Rates – SFY 2013 (per 1,000 member months)**



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

It is the OHCA’s expectation that PCMH providers contact members who have been to the emergency room and schedule follow-up appointments for these members when appropriate. Over 40 percent of SoonerCare Choice members with an emergency room encounter did see their PCMH provider within 30 days of the episode, although the percentage was slightly lower for members aligned with Tier 3 providers (Exhibit 3-6).

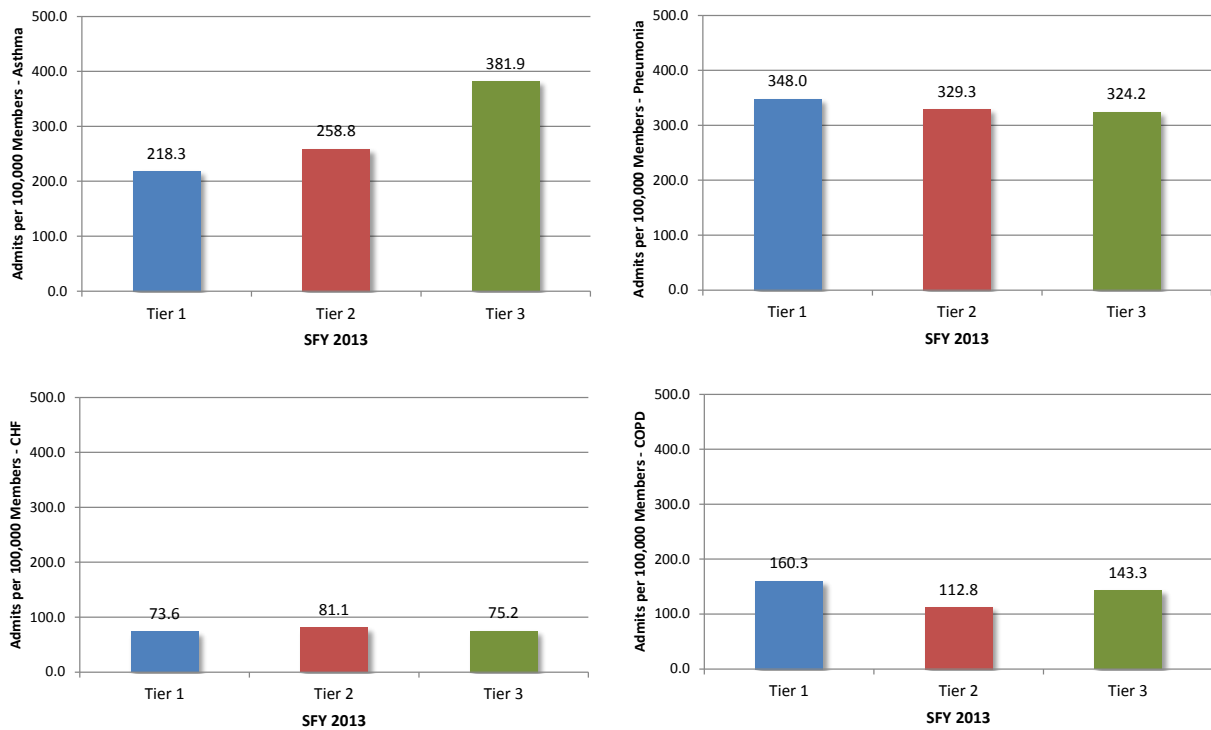
**Exhibit 3 – 6 – Follow-up Visit Rate to PCMH within 30 Days of ER Encounter- SFY 2013**



*Avoidable (Ambulatory Care Sensitive) Hospitalization Rate*

As discussed in chapter two, the hospitalization rate for three key diagnoses (CHF, COPD and pneumonia) fell significantly from 2009 to 2013. The relative rates in SFY 2013 varied by diagnosis, with no consistent differentiation across tiers. Members aligned with tier 1 PCMH providers had the lowest rates for asthma and CHF, while members aligned with tier 2 PCMH providers had the lowest rate for COPD and members aligned with tier 3 PCMH providers had the lowest rate for pneumonia (Exhibit 3-7).

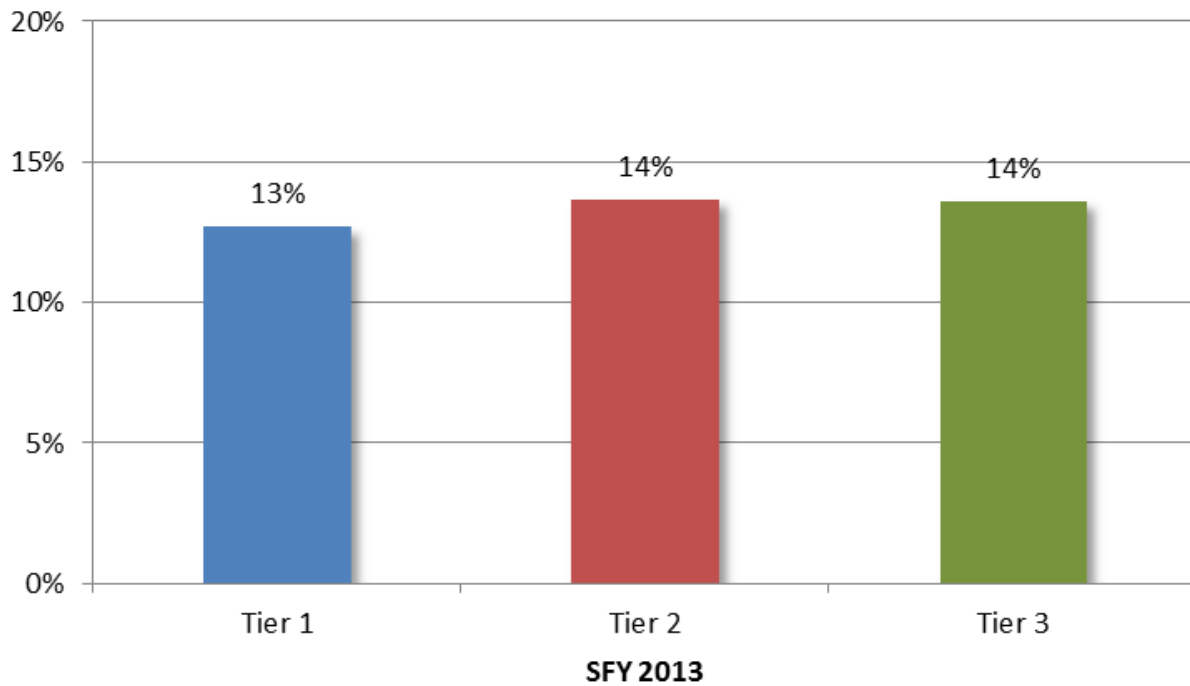
**Exhibit 3 – 7 – Ambulatory Care Sensitive Hospitalization Rates – SFY 2013 (per 100,000 members)**



*Hospital Readmission Rate within 30 Days of Discharge*

As discussed in chapter two, the 30 day readmission rate has been stable at a low level since 2009. The rate in SFY 2013 was nearly identical across tiers (Exhibit 3-8).

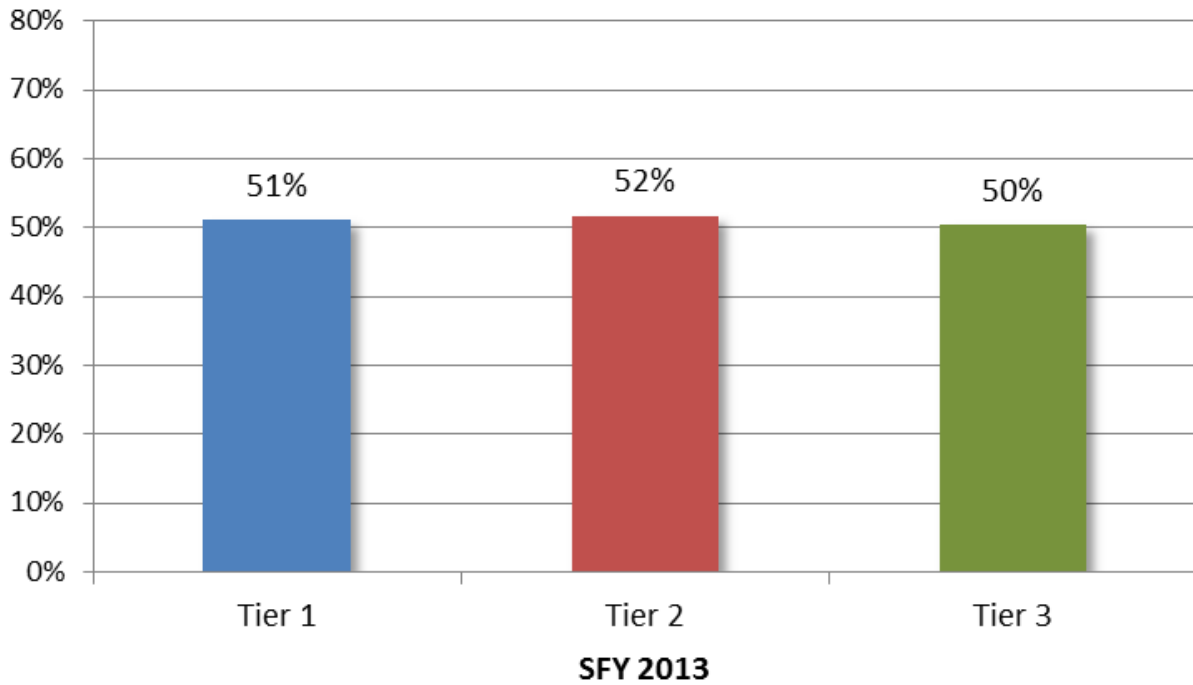
**Exhibit 3 – 8 – Hospital 30-Day Readmission Rate – SFY 2013**



*Post-Discharge 30-Day Visit Rate to a PCMH*

The SFY 2013 post-discharge visit rate also was nearly identical across tiers (Exhibit 3-9).

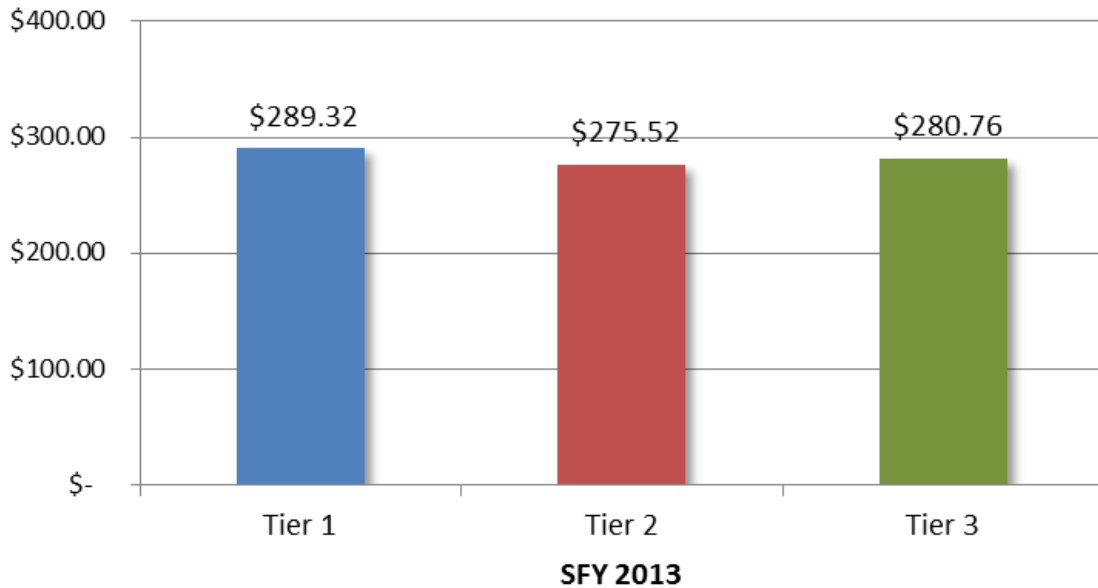
**Exhibit 3 – 9 – Post-Discharge 30-Day PCMH Visit Rate – SFY 2013**



*PMPM Expenditures*

As discussed in chapter two, per member per month expenditures grew modestly from 2009 to 2013. Average PMPM expenditures in SFY 2013 were very similar across the three tiers (Exhibit 3-10). Although tier 1 had the highest average claim cost, as depicted below, tier 2 and tier 3 providers received higher monthly case management fees.

**Exhibit 3 – 10 – PMPM Expenditures by Provider Tier – SFY 2013**



PCMH Impact (Return-on-Investment)

The PCMH model appears to be contributing to positive trend lines for the SoonerCare Choice program as a whole. At the aggregate level (across tiers), the program demonstrated consistent improvement in outcomes from 2009 to 2013

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.

It also is difficult at this stage to identify any positive correlation between provider tiers and outcomes. In most instances there is 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 in the last two years, 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.

If the tiers continue to show little difference in outcomes, the OHCA may wish to explore options for restructuring the program. These could include:

- *Collapsing Tiers* – The three tier model could be consolidated into two tiers, with tier 3 standards applied to the upper tier. However, if this resulted in the elimination of Tier 1 it would increase program costs.
- *Pre-certification audits for Tier 3* – All tier 3 providers are subject to audits following entry into the program, to verify conformance with tier 3 standards. However, the initial awarding of tier 3 status occurs through an attestation process, under which the applicant affirms his/her practice meets certification standards. The OHCA could introduce universal pre-certification audits for new applicants, to ensure conformance with program standards prior to receiving the tier 3 designation.
- *Adoption of NCQA standards in place of tiers 2 and 3* – The National Committee for Quality Assurance (NCQA) released enhanced standards for patient center medical home “recognition” in 2014. The enhancements focus on areas of importance to the OHCA, including care management of high needs populations; integration of physical and behavioral health; and demonstration by participating practices of a sustained commitment to the medical home concept. The OHCA could designate one or more of the higher NCQA PCMH levels as eligible for case management fees under SoonerCare, while retaining the existing tier 1 designation, which places a heavy emphasis on access to care.
- *Reserving a Portion of Tier 3 Funds for Incentive Payments* - A portion of Tier 3 case management fees could be tied to performance targets and paid only upon achievement of the targets (separate from SoonerExcel payments).



## Health Access Networks

### Overview

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

There are three HAN contractors:

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

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

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

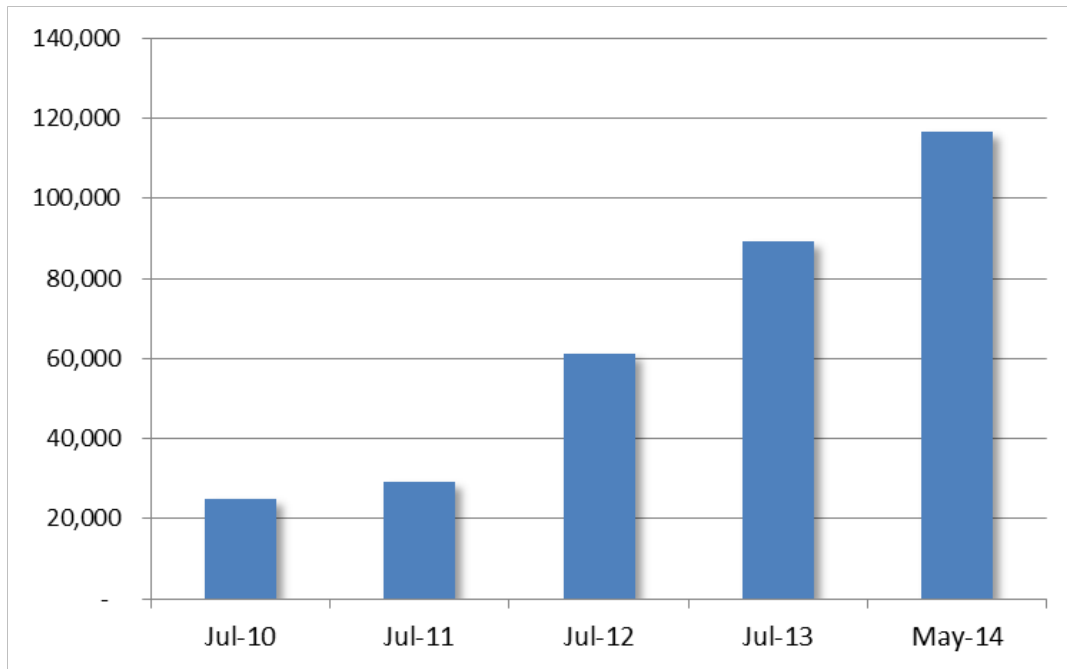
The HANs are required to reach out to high risk members and provide appropriate education and care management. The HANs also are encouraged to offer practice enhancement to their affiliated PCMH providers, including assistance in demonstrating compliance with tier 3 requirements among providers meeting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

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

### HAN Membership and Structure

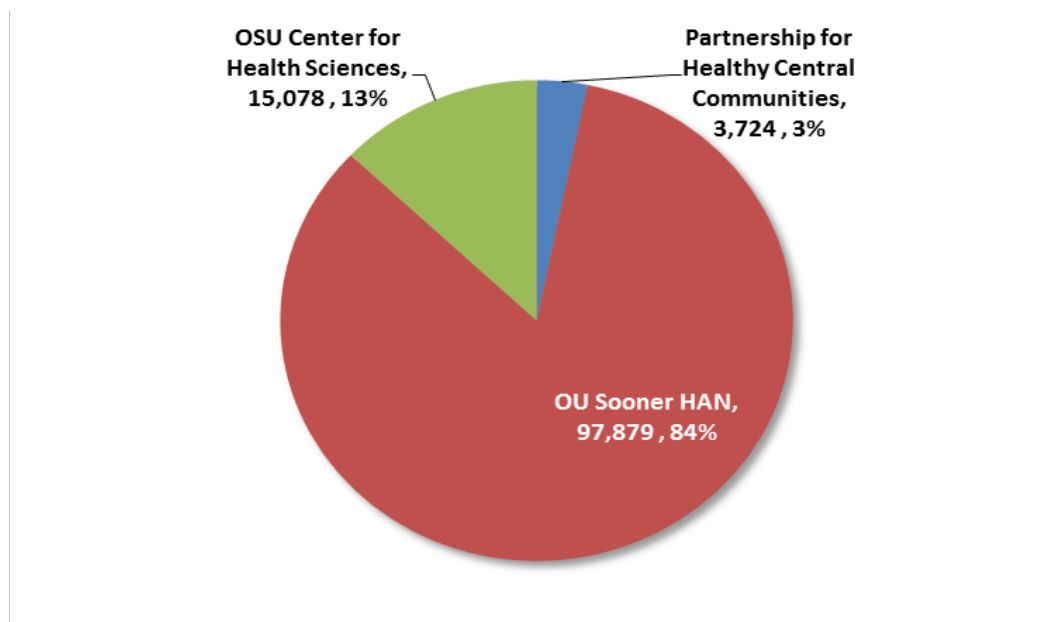
HAN membership grew dramatically during the initiative's first years, from only 25,000 in July 2010 to nearly 117,000 in May 2014 (Exhibit 3-11 on the following page).

**Exhibit 3 – 11 – HAN Membership Growth<sup>45</sup>**



Membership is not evenly distributed across the three HANs. In May 2014, OU Sooner HAN accounted for approximately 84 percent of enrollment, OSU for 13 percent and Central Communities for the remaining three percent (Exhibit 3-12).

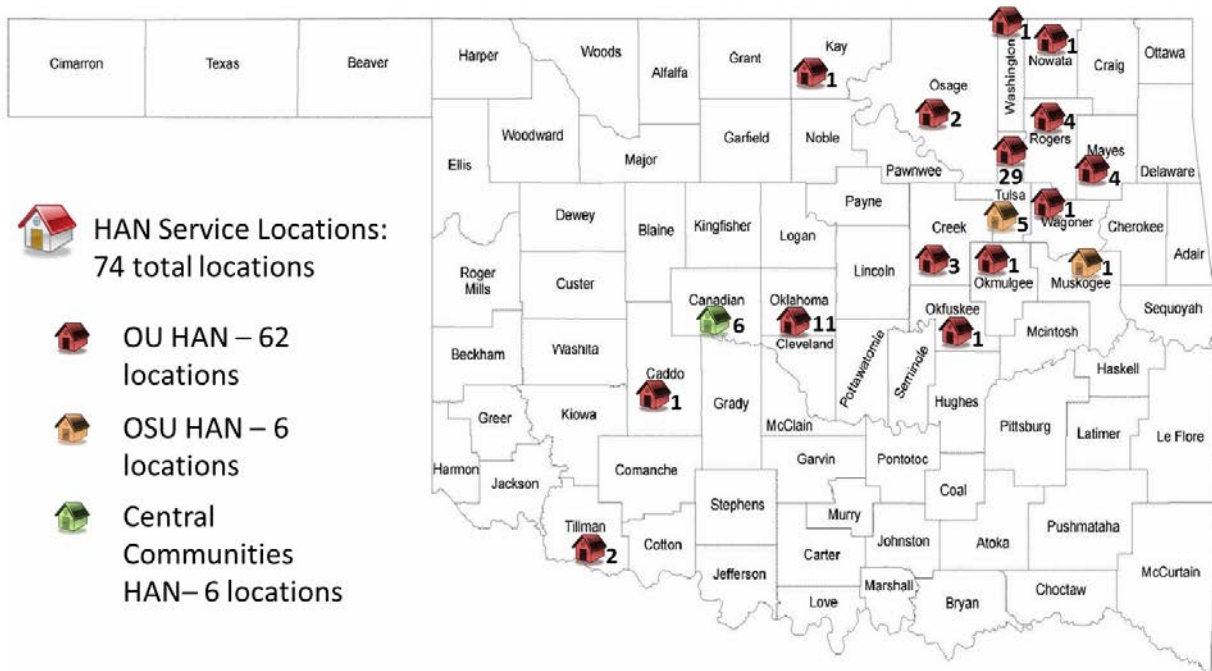
**Exhibit 3 – 12 – Membership by HAN – May 2014**



<sup>45</sup> Sources: OHCA HAN Total Summary Report

The growth in membership has occurred as the HANs have expanded their affiliated PCMH networks. There are approximately 600 HAN-affiliated PCMH providers located at 74 practice sites throughout the State (Exhibit 3-13).

**Exhibit 3 – 13 – HAN Practice Locations – May 2014<sup>46</sup>**



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

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

At the other end of the spectrum, OU Sooner HAN has created a broad network encompassing OU clinics and affiliated providers. The HAN has also established a formal care management structure with member assessment, education and care coordination processes. It currently utilizes a team of 12 care managers, comprised of seven Registered Nurses and five Licensed Clinical Social Workers.

<sup>46</sup> Source: OHCA

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

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

OSU Health Sciences Center falls in between the other organizations, although its care management structure (and enrollment) is much closer to Central Communities than OU Sooner HAN. Like Central Communities HAN, at the time of the evaluation it had one full time staff member assigned to care management activities. (A second care manager was recently added.)

#### HAN Performance – General

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

PHPG conducted what should be considered a preliminary evaluation of the HANs, focusing on demographic and utilization data for 2013. The HAN population was compared to SoonerCare Choice members enrolled with non-HAN providers, to identify differences between the two groups. Since it is only for the most recent year, the utilization data can be treated as a baseline for use in tracking performance over the next several years.

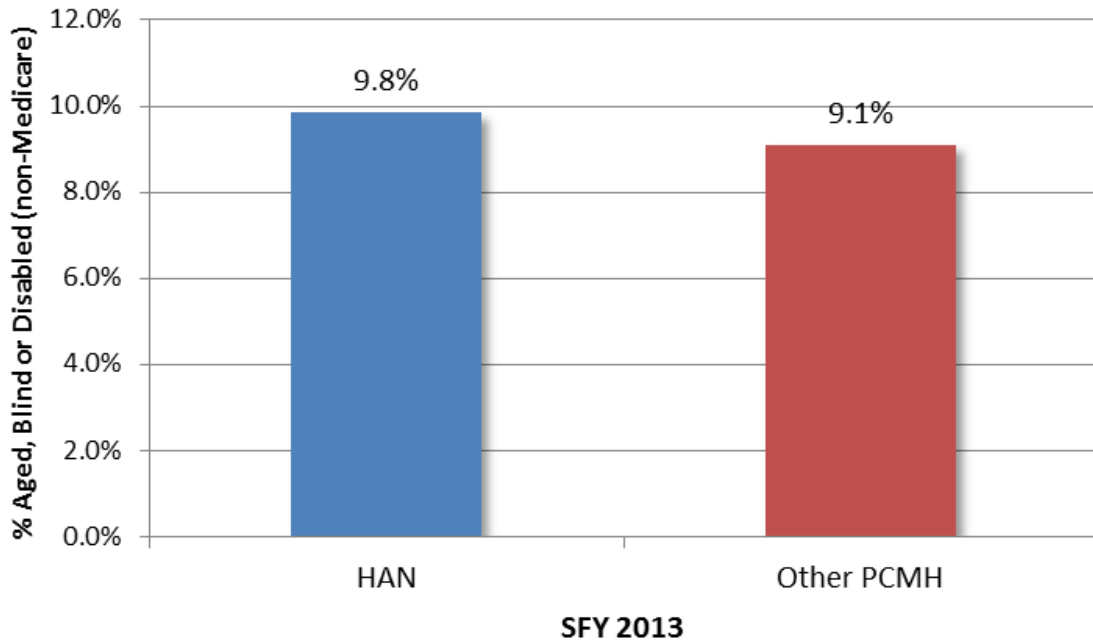
The analysis of the total HAN population is followed by a targeted review of the two priority care managed populations with largest enrollment: frequent utilizers of the ER and high risk pregnancies.

#### *Enrollment by Eligibility Group*

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

The HAN membership includes a higher number of ABD members, as a percentage of total enrollment (panels), than the non-HAN membership (Exhibit 3-14 on the following page). Although the difference is less than one percentage point, it is enough to affect the overall cost profiles of the HAN and non-HAN populations, as discussed later in this section.

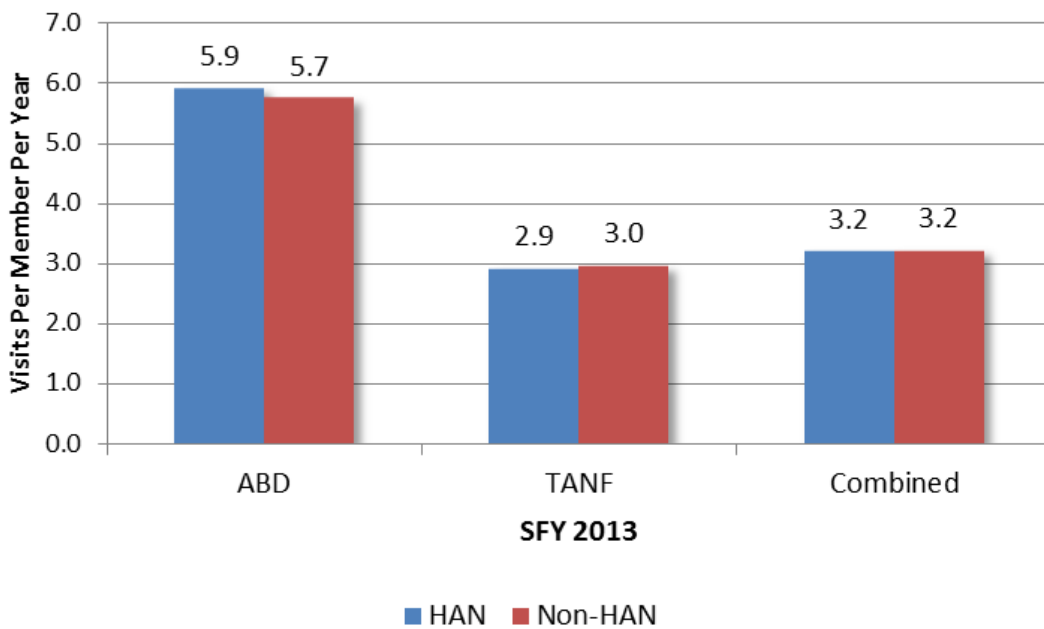
**Exhibit 3 – 14 – HAN and non-HAN ABD Enrollment – SFY 2013**



*Primary Care Visits*

SoonerCare Choice HAN and non-HAN members visited their PCMH providers at nearly equal rates in SFY 2013. ABD members saw their PCMH at about double the rate of non-ABD members (Exhibit 3-15).

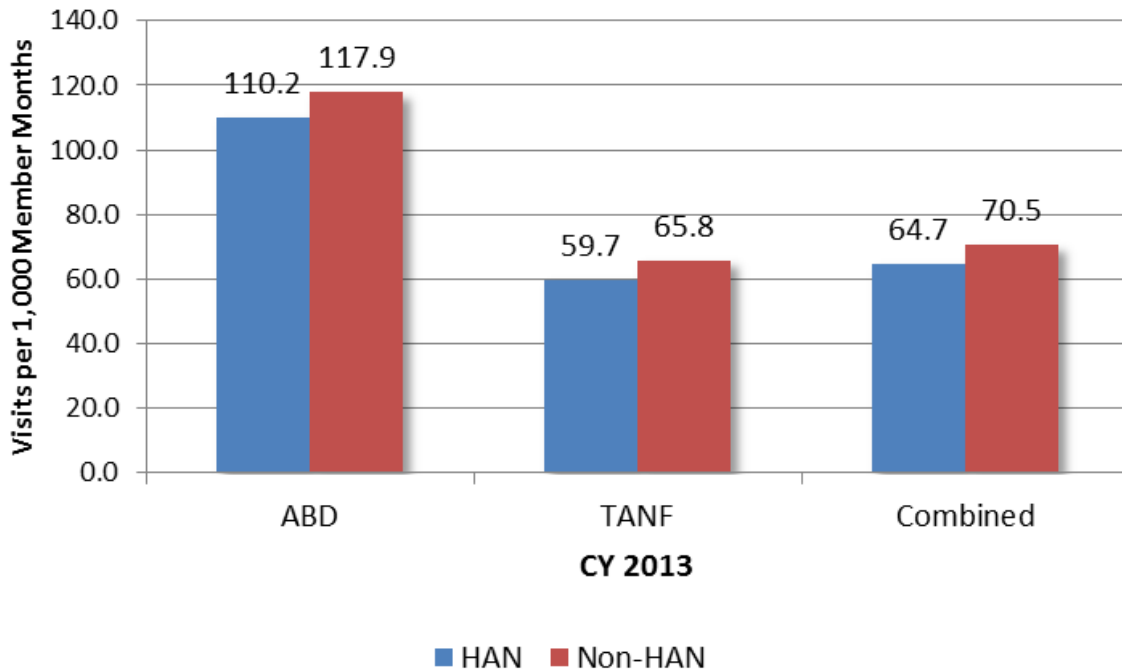
**Exhibit 3 – 15 – HAN and non-HAN PCMH Visits – SFY 2013**



### Emergency Room Visits

SoonerCare Choice HAN members – both ABD and TANF – visited the emergency room at a lower rate than non-HAN members in SFY 2013 (Exhibit 3-16). The HANs also significantly reduced ER use among members targeted for intervention based on frequent visits to the ER, as discussed in the next section.

**Exhibit 3 – 16 – HAN and non-HAN ER Visits – CY 2013<sup>47</sup>**



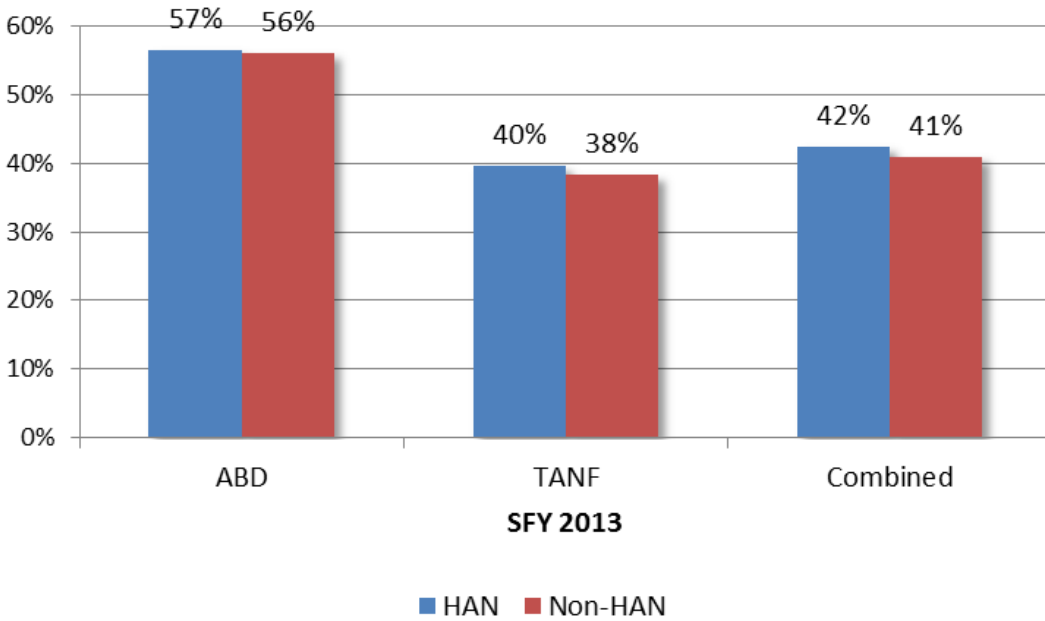
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<sup>47</sup> ER utilization is presented on a calendar year basis to align with the time period used for a standalone analysis of ER utilization prepared for the OHCA earlier in 2014. SFY 2013 results are comparable.

*Post-ER Visit to PCMH*

HAN and non-HAN members in both eligibility groups are about equally likely to see their PCMH provider after a visit to the ER (Exhibit 3-17).

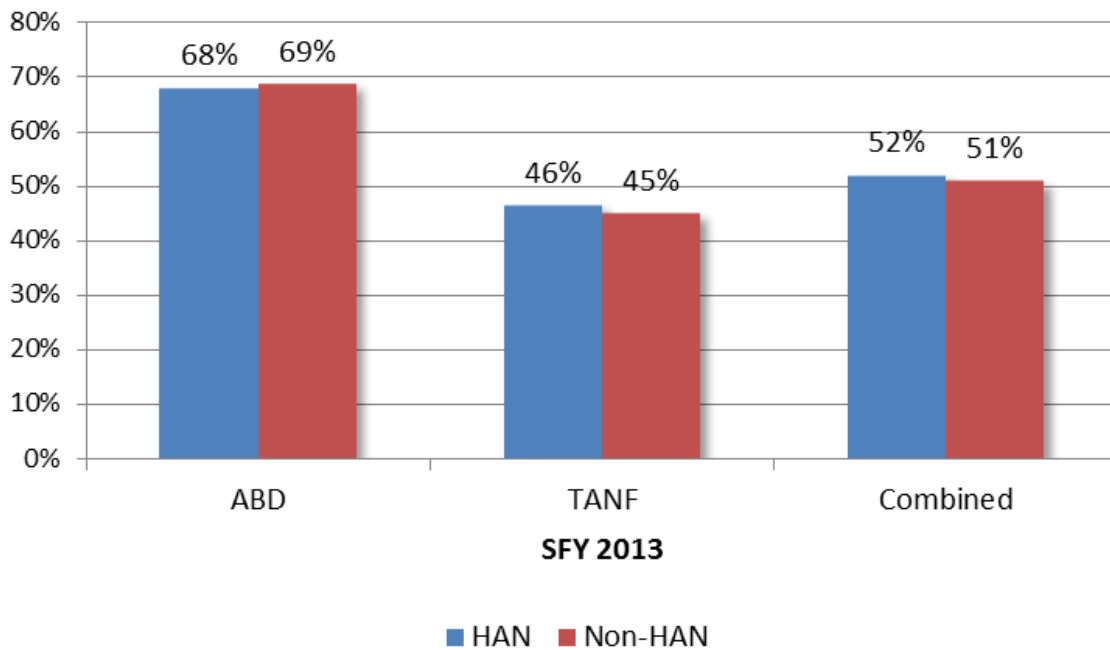
**Exhibit 3 – 17 – HAN and non-HAN Post ER Visit to PCMH (Within 30 Days) – SFY 2013**



*Post-Discharge Visit to PCMH*

HAN and non-HAN members in both eligibility groups also are about equally likely to see their PCMH provider after being discharged from the hospital (Exhibit 3-18).

**Exhibit 3 – 18 – HAN and non-HAN Post Discharge Visit to PCMH (Within 30 Days) – SFY 2013**

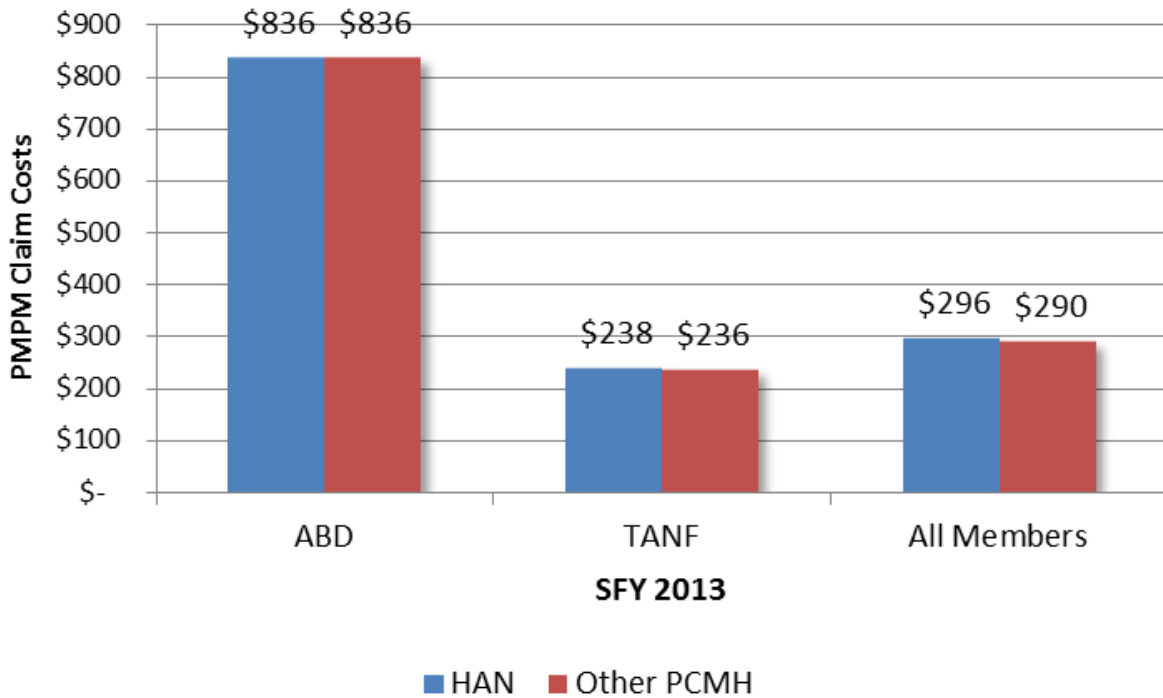




*PMPM Expenditures*

HAN and non-HAN members have nearly identical PMPM claim costs within the two eligibility groups. HAN members in aggregate are slightly more expensive because of the larger percentage of ABD beneficiaries within the HAN member mix (Exhibit 3-19).

**Exhibit 3 – 19 – HAN and non-HAN PMPM Claim Costs – SFY 2013**



### Performance – High Risk Populations

The HANs provide care management to four high risk populations, two of which – breast/cervical cancer patients and persons with hemophilia – are very small in number (Exhibit 3-20). PHPG examined service utilization and outcomes for the two larger populations – frequent users of the emergency room and high risk pregnancies – to establish baselines for future evaluation of performance.

**Exhibit 3 – 20 – HAN High Risk Population Enrollment – Snapshot for November 2013<sup>48</sup>**

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

### *Frequent Users of the Emergency Room*

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

- Follow-up by letter or phone (depending on number of visits);
- Ongoing outreach and education regarding appropriate care settings in non-emergencies (Exhibit 3-21 on the following page); and
- Requiring the member to use a designated PCMH provider, as a means of fostering a relationship and encouraging the member to seek non-emergent care outside of the ER.

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<sup>48</sup> Active (open) cases only. ER group includes a subset of 452 very high utilizing members with 4 or more visits in the quarter.

**Exhibit 3 – 21 – Central Communities ER Educational Materials** <sup>49</sup>



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

The results of the before/after comparison were encouraging. Although average ER utilization remained high, it dropped by approximately 20 percent (Exhibit 3-21). The portion of members with six or more ER visits fell by more than half, while over 40 percent of the members in the lock-in period had no trips to the ER.

The only metric that did not show improvement was the percentage of members seeing their PCMH within 30 days of an ER visit. However, the rate – both before and after lock-in – was well above the rate for the general population (see Exhibit 3-22 on the following page).

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<sup>49</sup> Provided by Central Communities HAN. The HAN produces updated literature each year based on the most common non-emergent conditions treated at the emergency room in the prior year.

**Exhibit 3 – 22 – HAN ER Care Management Impact**

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

*High Risk Pregnancies*

The HANs are responsible for offering care management to pregnant members identified by their prenatal care providers as being at high risk for complications<sup>50</sup>, including premature and low birth weight deliveries. HAN activities include:

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

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

The number of high risk pregnant members enrolled with the HANs has grown quickly, along with the HANs’ total enrollment. PHPG examined paid claims data and identified five such members in SFY 2011, 85 in SFY 2012 and 261 in SFY 2013<sup>51</sup>.

Approximately 50 percent of the high risk pregnancies ended in a premature delivery. PHPG evaluated utilization and outcomes data separately for the premature and full-term deliveries (Exhibits 3-23 and 3-24 on the following page). Information is provided by year but given the small number of cases in SFY 2011 and SFY 2012, the aggregate data should be considered more reliable.

<sup>50</sup> The member must have a qualifying diagnosis associated with pregnancy risk, such as pre-eclampsia, sickle cell anemia, multiple birth (twins, triplets etc.) or history of preterm labor.

<sup>51</sup> Limited to members who completed their pregnancies and for whom birth outcome data was available.

**Exhibit 3 – 23 – HAN High Risk Pregnancy Outcomes – Premature Deliveries**

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

**Exhibit 3 – 24 – HAN High Risk Pregnancy Outcomes – Full-Term Deliveries**

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

Unsurprisingly, there is a significant utilization and cost difference between pregnancies that end prematurely and pregnancies carried to full term. PHPG recommends treating the SFY 2011 – SFY 2013 data as a baseline for tracking HAN performance with respect to reducing the incidence of premature births<sup>52</sup>.

<sup>52</sup> In addition to the measures shown in the exhibit, PHPG attempted to calculate an average number of prenatal care visits per member. However, because the OHCA makes a global payment for prenatal care (as opposed to paying per visit), PHPG was unable to quantify prenatal visit activity through the claims data.

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

#### HAN Impact – (Return-on-Investment)

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

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

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

The utilization and cost profile of the general HAN membership is comparable in most categories to the non-HAN population, with the HANs demonstrating some success in reducing ER visit rates among their membership. The experience of the SoonerCare Health Management Program (HMP), as discussed in the next section, suggests that it can take several years for the full impact of care management initiatives to emerge, in terms of reducing utilization and expenditures.

At the time of the evaluation, the OHCA was in the process of updating HAN contracts to clarify performance expectations. This provides an opportunity to ensure that the HANs are adequately staffed to meet care management responsibilities and also, possibly, to modify HAN responsibilities with regard to members with high risk pregnancies.

## 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. Potential participants were identified using claims data and predictive modeling software developed by the firm of MEDai.

The members were stratified into two levels of care, with the highest-risk segment placed in “Tier 1” and the remainder in “Tier 2.”<sup>53</sup> 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 as an independent evaluator of the SoonerCare HMP since its implementation. The most recent evaluation covered program performance through June 2013 and examined:

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

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<sup>53</sup> The nurse care management tiers are unrelated to PCMH tiers. Only the terminology is the same.

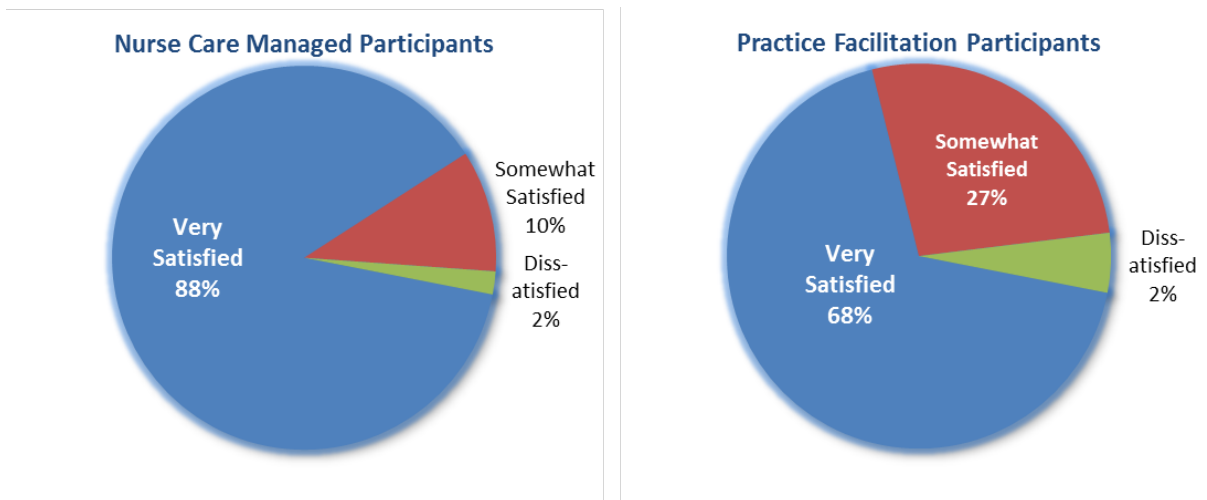


Summary findings from the evaluation are presented below. The full report is available from the OHCA<sup>54</sup>.

*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 3-25).

**Exhibit 3 – 25 – SoonerCare HMP – Member and Provider Satisfaction**



Survey findings were supported by member comments in focus groups. Representative comments 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.”*

<sup>54</sup> See: “SoonerCare HMP – Fifth Annual Evaluation”, February 2013. Also see “Sooner Care HMP – Comprehensive Program Evaluation and Cost Savings Report”, May 2014. The latter report contains evaluation findings for the first five years of the program.

- *“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.

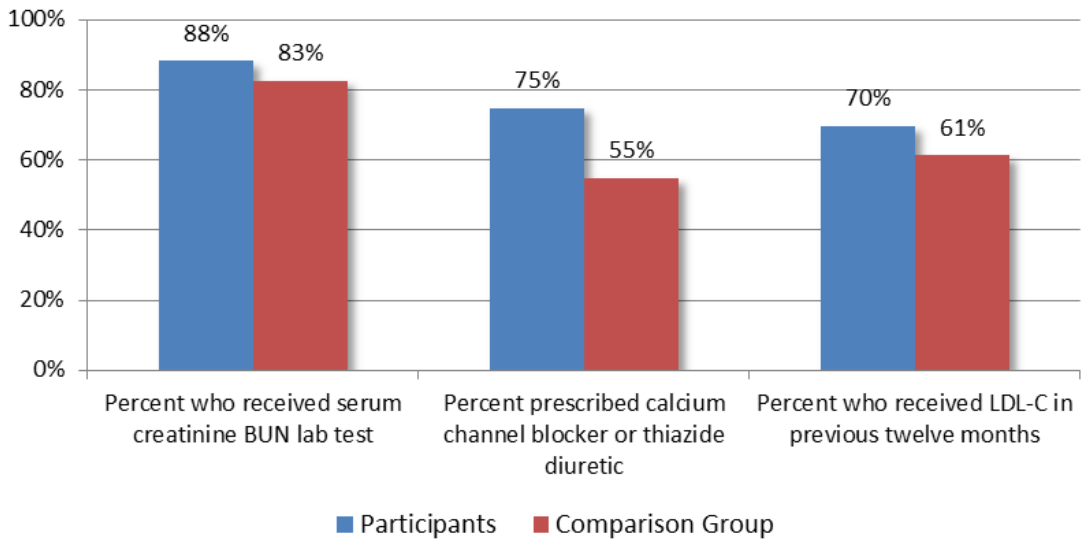
### *Impact on Quality of Care*

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 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. PHPG also calculated the SFY 2013 compliance rates for a “comparison group” consisting of SoonerCare members found eligible for, but not enrolled in the SoonerCare HMP.

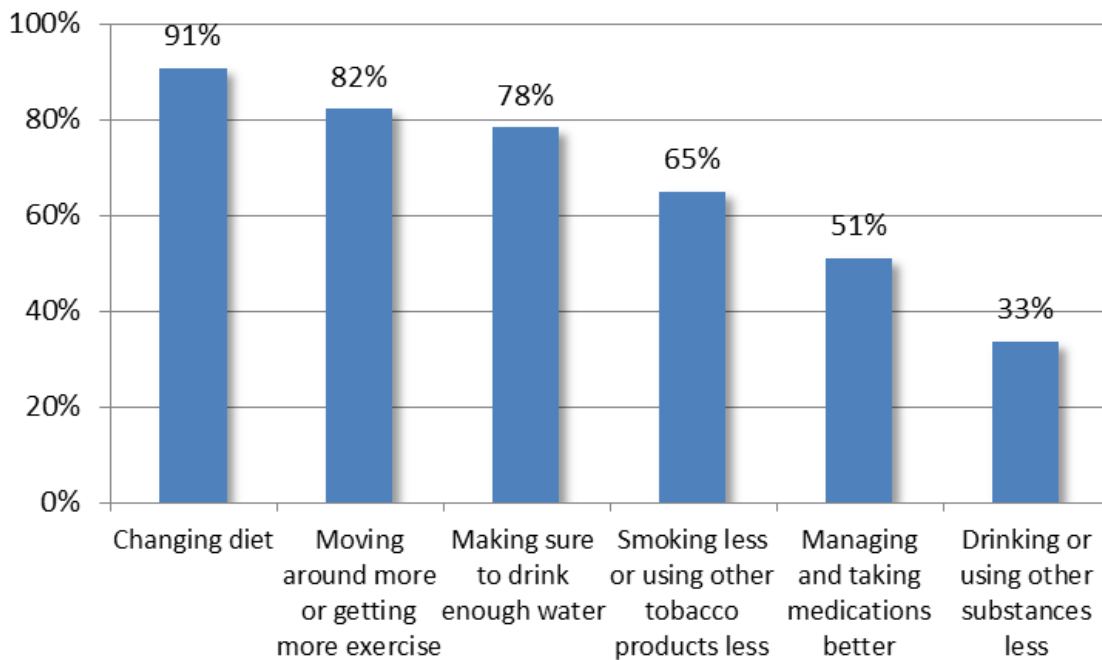
Findings from the analysis were promising. The participant compliance rate exceeded the comparison group rate for 16 of 21 diagnosis-specific measures. The difference was statistically significant for 11 of the 16, suggesting that the program is having a positive effect on quality of care. The most impressive results, relative to the comparison group, were observed for participants with CHF, COPD, diabetes and hypertension. Results are shown below for three hypertension measures with a statistically significant difference in compliance rates between participants and the comparison group (Exhibit 3-26 on the following page).

**Exhibit 3 – 26 – SoonerCare HMP – Hypertension Measures**



The improvement in HEDIS measures was not the only evidence of the program’s impact on quality of care and member health. Among those members enrolled in nurse care management for at least six months, a large percentage reported making important lifestyle changes with the encouragement and assistance of their nurse care manager (Exhibit 3-27).

**Exhibit 3 – 27 – SoonerCare HMP – Lifestyle Changes**

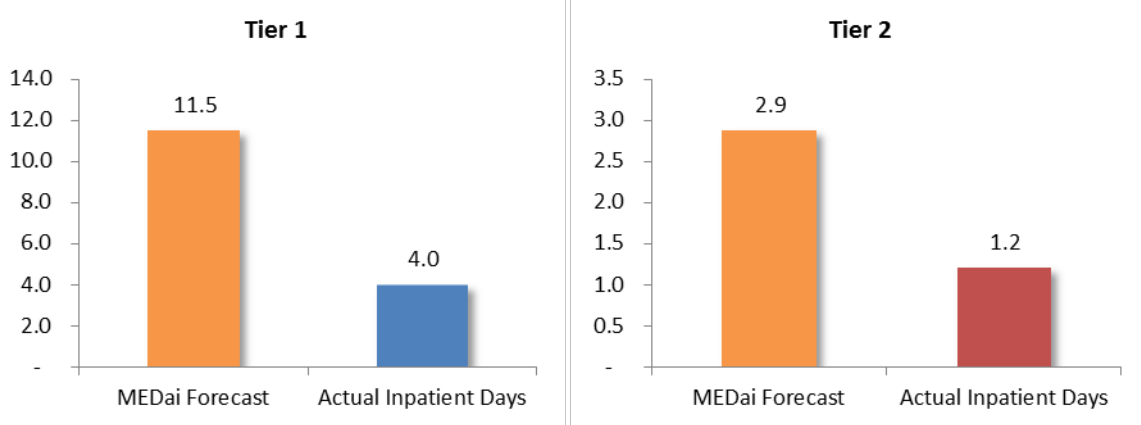


Service Utilization and Expenditures

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.

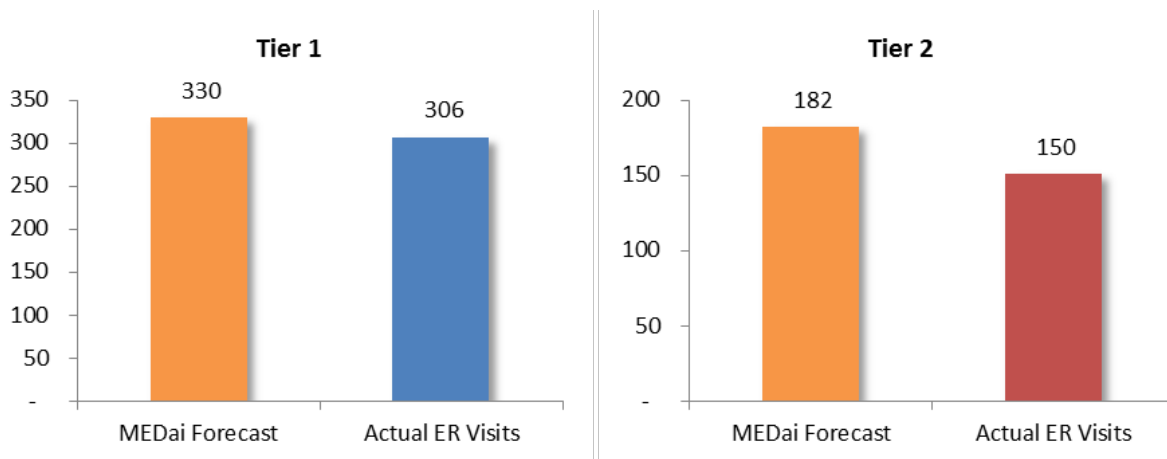
The impact on member utilization through June 2013 was found to be significant, particularly with respect to inpatient hospital admissions/days and emergency room visits. Actual inpatient days were substantially below forecast for both Tier 1 and Tier 2 members (Exhibit 3-28). (Reminder: Tier 1 and Tier 2 refer to in-person and telephonic nurse care management; the term as used here is not related to PCMH tiers.)

**Exhibit 3 – 28 – SoonerCare HMP – Impact on Nurse Care Managed Member Inpatient Days**



The impact on emergency room utilization has been somewhat less dramatic but still significant (Exhibit 3-29).

**Exhibit 3 – 29 – SoonerCare HMP – Impact on Nurse Care Managed Member ER Visits**



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.”<sup>55</sup>

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 and accelerated in SFY 2012 and SFY 2013. Overall, the nurse care management portion of the SoonerCare HMP through SFY 2013 achieved aggregate five-year savings of approximately \$124 million (state and federal dollars), or 15 percent of total medical claim costs.

PHPG also examined expenditures for chronically ill patients being treated by practice facilitation providers, to test that 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 \$634 through SFY 2013, after factoring-in program administrative expenses. This compared favorably to a \$678 PMPM expenditure forecast for the same patients absent practice facilitation.

The net difference in PMPM expenditures (forecast minus actual) through SFY 2013 was approximately \$44. This figure, when multiplied by practice facilitation site member months yielded aggregate savings of approximately \$58 million (state and federal dollars), or 6.4 percent as measured against total medical claims costs.

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<sup>55</sup> See: SoonerCare HMP Second Annual Evaluation, July 2011, page 7.

*Return on Investment*

Total SoonerCare HMP savings through June 2013, net of vendor payments, OHCA staffing and overhead, stood at \$181 million (Exhibit 3-30).

**Exhibit 3 – 30 – SoonerCare HMP – Net Savings (Millions of Dollars)<sup>56</sup>**

Program Component	Administrative Costs	Medical Savings	Net Savings	ROI
NCM – Tier 1	(\$10,068,727)	\$36,007,971	\$25,939,244	258%
NCM – Tier 2	(\$10,050,900)	\$107,999,018	\$97,948,117	975%
<b>Total NCM</b>	(\$20,119,627)	\$144,006,988	\$123,887,361	616%
Practice Facilitation	(\$12,251,082)	\$70,245,367	\$57,994,284	473%
<b>Total Program</b>	<b>(\$32,370,709)</b>	<b>\$214,252,355</b>	<b>\$181,881,645</b>	<b>562%</b>

The ROI for the program in total through SFY 2012 was 562 percent. Put another way, the SoonerCare HMP generated over five dollars in medical savings for every dollar in administrative expenditures.

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<sup>56</sup> The program began in late SFY 2008. Data for these first months is included within the SFY 2009 totals.

## 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.

SoonerCare Choice 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 on the following page). 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 <sup>57</sup> .	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 <sup>58</sup>

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.

<sup>57</sup> The North Carolina program has been under review during the past two years by both the governor’s office and legislature. After considering a conversion to MCOs, the state most recently has been exploring contracts with provider-sponsored Accountable Care Organizations, which resemble the HANs in structure, particularly OU Sooner HAN and OSU, with their affiliated specialty physician and inpatient services.

<sup>58</sup> 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.



### Traditional MCO Programs

All but two states enroll at least a portion of their Medicaid population into managed care<sup>59</sup>, 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 people dually-eligible for Medicaid/Medicare and persons eligible for long term care<sup>60</sup>.

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 lives<sup>61</sup>.

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. States considering adoption of an MCO model should address the following as part of implementation planning:

- Incorporation of state’s priorities for access, quality and cost effectiveness into MCO contract requirements, to ensure MCO’s focus on the areas of greatest need.
- Development of an objective and defensible procurement process that can withstand challenges from losing offerors.
- Inclusion of contract language that penalizes MCO’s from exiting the program before expiration of their contract term.

### Comparison of Approaches

The community-based and MCO approaches both include the key components of managed care (Exhibit 4-2 on the following page). The MCO model presents a particularly 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).

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<sup>59</sup> The exceptions are Alaska and Wyoming.

<sup>60</sup> Texas enrolls home- and community-based long term care members but not institutionalized persons.

<sup>61</sup> The seven plans are Aetna, Anthem Blue Cross, Centene, Health Net, Molina, UnitedHealth Group and WellCare Health Plans.

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.

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

Program	SoonerCare Choice	MCO Model
Member Eligibility Standards	<i>Same for both models<sup>62</sup></i>	
Covered Benefits	<i>Same for both models<sup>63</sup></i>	
Contracted Network	<i>Yes</i>	<i>Yes</i>
Patient Centered Medical Homes	<i>Yes</i>	<i>Yes</i>
Provider Pay-for-Performance	<i>Yes</i>	<i>Yes</i>
Member Education	<i>Yes</i>	<i>Yes</i>
Medical/Case Management	<i>Yes</i>	<i>Yes</i>
Chronic Care/Health Management	<i>Yes</i>	<i>Yes</i>
Quality Improvement Initiatives	<i>Yes</i>	<i>Yes</i>
Program Oversight/Administration	<i>State</i>	<i>Shared</i>
Stability	<i>High</i>	<i>Variable</i>
MCO-Related Administrative Expense	<i>4.2% (SFY 2013)</i>	<i>10%+</i>

<sup>62</sup> Refers to Medicaid/CHIP eligibility criteria. Managed care enrollment may be limited to a subset of all Medicaid-eligible persons.

<sup>63</sup> Refers to total benefit package. Some benefits may be provided outside of managed care.

## CHAPTER 5 – CONCLUSIONS

### Performance against Program Goals

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

In terms of ACCESS:

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

In terms of QUALITY:

- The OHCA has established methods to routinely measure quality of care and reward PCMH providers who meet or exceed quality benchmarks.
- Primary and preventive care quality measures improved for both children and adults and generally exceeded national benchmarks. Exceptions to these trends were breast and cervical cancer screening rates; cholesterol management for patients with cardiovascular conditions; and diabetes management. All of these areas represent opportunities for improvement through PCMH education and targeted care management initiatives.
- Member health outcomes showed improvement with respect to hospitalizations for ambulatory care sensitive conditions; thirty-day readmission rates; and post-discharge

follow-up by behavioral health providers following a behavioral health-related hospitalization.

In terms of COST EFFECTIVENESS:

- Medical inflation for SoonerCare Choice members averaged half the national per capita health care expenditure growth rate.
- OHCA (and partner agency) administrative costs less than half that of typical private Medicaid MCOs.

### Major Initiatives

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

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

The patient centered medical homes appear to be contributing directly to the improvements in access and quality occurring for the program as a whole. PCMH providers are building relationships with their members and having a positive impact on service utilization and program costs. There is no clear evidence that providers in higher tiers outperform their counterparts in tier one and it may be beneficial for the OHCA to explore consolidating tiers and/or revising the standards for the higher tier(s).

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.