

October 2, 2008



Health Access Networks

The Oklahoma Health Care Authority (OHCA) has created an opportunity for a Health Access Network (HAN) pilot program serving Oklahoma SoonerCare members. It is envisioned the HAN pilot program will be initially made available for up to four sites located across Oklahoma. The four HAN pilot sites may be comprised of university-affiliated organizations, county medical provider associations, or private corporations. The locations of the HAN pilot sites may include various regions of the state, comprised of both urban and rural areas. The HAN pilot program is anticipated to operate up to one year at a time, with the option of 6 month staggered starting periods (see section V below for details on HAN pilot periods). The following sections I through IV outline the criteria the OHCA has developed pertaining to the Health Access Networks. Section V contains a description of the documentation an entity must furnish to become approved as a HAN.

I. Eligible Providers

The OHCA is seeking approval from CMS to operate a pilot program (within funding limits) evaluating the role of health access networks under the 1115 waiver demonstration. For purposes of this document a Health Access Network (**HAN**), is:

An entity representing a collection of providers which may include hospitals, community health centers, public health departments, physicians, rural health clinics (RHCs), federally qualified health centers (FQHCs), or other recognized safety net providers, that--

- is organized for the purpose of restructuring and improving the access, quality, and continuity of care to SoonerCare members, the uninsured and the underinsured; and
- offers patients access to all levels of care, including primary, outpatient, specialty, certain ancillary services, and acute inpatient care, within a community or across a broad spectrum of providers across a service region or State.

Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) that receive federally designated prospective payments are not eligible to be an independent HAN but could be part of another network to improve access to care.

Networks must provide documentation that they meet at least two of the following:

- (1) Have a formal affiliation agreement / partnership at the community-level with traditional and non-traditional providers;
- (2) Have a formal program to promote public health principles, community development, and local educational programs to address the challenges of rural and underserved populations; and
- (3) Have 501(c)3 or not-for-profit entity status.

II. Performance and Reporting Requirements

Qualifying networks must submit a development plan to the OHCA or designated entity that details how the network plans to:

- Reduce costs associated with the provision of health care services to SoonerCare, uninsured and underinsured individuals;
- Improve access to, and the availability of, health care services provided to individuals served by the health access network;
- Enhance the quality and coordination of health care services provided to such individuals through mutually defined quality improvement initiatives;
- Improve the health status of communities served by the health access network;
- Reduce health disparities in such communities; and
- Identify all PCPs, specialty providers, and other provider types affiliated with the health access network.

HANs must have an organized and systematic quality improvement process, including the identification of measurable performance targets.

Among the identified performance targets the HAN must also include details as to the methods used to meet the following requirements:

- Use of secure electronic communication between the patient and the health care team.
- Measures performance on clinical quality and patient experiences (including but not limited to at-risk patient groups) at a minimum on a quarterly basis and uses data to set goals and take action to improve performance, providers are expected to analyze their own data, or data provided by OHCA (such as provider profiles), to incorporate practice changes.
- Tracks and meets quality standards set forth in CMS Quality Measures Compendium, vol. 2.0. For the compendium, including a list of all affiliated entities, please access the website <http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/Downloads/pmfinalaugust06.pdf>. These measures will be mutually agreed upon by the HAN and OHCA, with final determination made by the OHCA. The HAN must (1) develop baseline data for the SoonerCare population; (2) develop strategies and initiatives for identified problem areas; and (3) establish benchmarks for quality initiative implementation.
- Uses searchable electronic data to generate lists of patients who are identified as needing services as well as clinicians to render the services, and implements systems to generate reminders (paper based or electronic) to patients and clinicians about preventive services and chronic care needs at the point of care.

- Plans to use secure systems that provide for patient access to personal health information, within a time period acceptable to the OHCA.
- Provides call center support to network-affiliated PCP practices providing 24/7 Voice to Voice telephone coverage with immediate availability of an on-call medical professional.
- Contracts with the OHCA as a telemedicine network.
- Identifies a finite network service area of PCPs and specialty providers within a minimum of three Oklahoma counties.
- Access to specialty care must be provided equally to SoonerCare members as other payers' patients.
- Establishes or utilizes a disease registry system for high risk / high cost conditions afflicting the HAN members. The disease registry system is used to track and provide early interventions from a population level.
- Identifies certain PCPs and assists them in becoming an advanced (tier 2) medical home provider.
- Identifies at least 20 percent of network affiliated PCPs as non-employed PCPs.

Preference may be given to those networks with service areas which include more than three counties. Preference may also be given to those networks in which specialty care utilization demonstrates members, whose PCPs are outside of the network, have access to care.

The HAN may also choose to contract with a pay-for-performance program provider. The purpose of the program is to test a program's value proposition that offers financial incentives to both the health care provider and the patient for incorporating evidence-based medicine guidelines and information therapy prescriptions in the rendering and utilizing of health care. This program may offer the health care provider the flexibility to use the health care provider's clinical judgment to adhere to or deviate from the program's guidelines and still receive a financial incentive as long as the health care provider prescribes information therapy to the patient. The program shall offer a financial reward to the patient for responding to the information therapy prescription:

- (1) by demonstrating the patient's understanding of the patient's health condition,
- (2) by demonstrating adherence to recommended care, and
- (3) by judging the quality of care given to the patient against these guidelines.

The program shall be offered and administered through an Internet application. This program shall collect and analyze data over a period of one year or other reasonable time frame. At the end of the period the HAN shall report the outcomes / findings of the program in order to determine its effectiveness.

OHCA will monitor networks to ensure that all requirements are met.

III. Reimbursement

The PCPs of the network will receive a care coordination payment based on the type of panel that they see and the level of medical home furnished to members. In contrast, the network will receive \$5 per member per month as a supplemental network payment.

Quarterly network payments will be made to the HAN. The network will identify to the OHCA the PCPs associated with their network. The OHCA will determine the number of member months paid to those PCPs and multiply by the network payment. The HAN must document the contractual relationship between the PCP and the network if the PCP is not employed by the network.

The network payment will be subject to recoupment and / or termination of this component for failure to properly meet the reporting requirements.

IV. Funding

HANs may be required to use local funds as state match in Year 1 of the Medical Home. Preference may be given to those networks with the ability to use local funds as state match. For those HANs who may not have sufficient local funds available, their participation as a HAN will be assessed on a case by case basis, as available funding is identified. Health access networks will be required to identify measurable performance targets and demonstrate progress in order to qualify for future year funding. This will be subject to annual limits on payment.

V. Documentation Requirements

HAN applications, including all required documentation, must be submitted to the OHCA according to the following schedule. In order to be considered for participation in the pilot program for calendar year 2009, HAN applications must be received on or before November 1, 2008. In order to be considered for participation in the pilot program for the period beginning July 1, 2009 and ending June 30, 2010, HAN applications must be received on or before May 1st, 2009. HAN applications will be evaluated in the order in which they are received. The HAN application documentation requirements include:

- 1) Submit the name, title, address and phone number, and email address for the primary contact for the HAN application.
- 2) Submit the name, title, address and phone number, and email address and resume for the person responsible for quality improvement for the HAN applicant.
- 3) Describe how the HAN applicant accomplishes quality improvement.
- 4) Describe how the HAN applicant meets the requirements in each Section, I through IV listed above.
- 5) Submit one original, paper application as well as one electronic version to:

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