

# Oklahoma **HealthCare** Authority



Strategic Plan SFY2017-2018



# OKLAHOMA HEALTH CARE AUTHORITY

## STRATEGIC PLAN

### SFY 2017-2018

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# INTRODUCTION

This year, 2015 is a year of significant anniversaries for the Medicaid program. The federal Medicaid program marks 50 years since the Social Security Act was signed into law by President Lyndon B. Johnson, commencing the establishment of Medicaid programs across the nation. In addition, Oklahoma's single Medicaid agency - the Oklahoma Health Care Authority (OHCA) - celebrates its 20<sup>th</sup> anniversary of administering the SoonerCare and Insure Oklahoma programs. Lastly, the Insure Oklahoma program celebrates 10 years of serving small businesses and their qualified employees by making health care coverage affordable and accessible.

SoonerCare (Oklahoma Medicaid) remains a vital source of health care for more than one million of Oklahoma's eligible children, elderly and disabled populations, especially during times of economic recession. OHCA plays a major role as a purchaser of health benefits and an economic force in Oklahoma.

The Insure Oklahoma program endures as an effective way of making health care coverage more affordable for specific groups of low-income, uninsured adults to promote their continued working status.

SoonerCare is an ever-changing program. OHCA strives to be on the cutting edge of new ideas and trends; engaging in discussion and comment surrounding proposed rules and regulations; and seeking lessons that can be drawn from other states' experiences.

Many efforts are underway which may significantly change the health status of those served by SoonerCare. The OHCA Strategic Plan provides a single document through which the reader may better understand how OHCA is working on to bring about positive change.

## Strategic planning responsibilities of OHCA

As SoonerCare evolves, so does its impact on health care in Oklahoma. OHCA regularly and thoroughly participates in information gathering from a wide range of stakeholders (at both state and national levels) to learn best practices and emerging trends. This information helps shape recommendations for future SoonerCare initiatives.

Strategic planning helps OHCA leaders to consider the future. Strategic planning at OHCA also engages staff. Our strategic plan helps us do a better job, as it focuses the energy, resources and time of everyone in the agency in the same direction. However, OHCA cannot operate alone. We recognize that effective strategic planning is coordinated alongside statewide goals and among a variety of stakeholders. This collaborative planning is critical to our success. Everyone benefits from having a carefully crafted plan.

## The strategic planning process

Throughout the strategic planning process, the question is asked, "Where do we, as the Oklahoma state Medicaid agency, want to go in the next one to five years?"

Answering this in light of the OHCA's opportunities and challenges, as well as the agency's strengths and weaknesses, helps us to develop our strategic plan. The planning process must address potential changes (in both the internal and external environments) that would require significant adjustments to the way the OHCA carries out its responsibilities. Developing assumptions and flexibility for an unforeseen future is an important aspect of our planning process.

The first step of our state fiscal year (SFY) 2015 planning process involved information gathering and review of OHCA culture and values, the external environment and the opportunities and threats the future holds for SoonerCare. Next, we assessed our primary strategic goals - a short list of our major emphases over the next several years. These goals represent not only our understanding of the agency's statutory responsibilities but our broader sense of purpose and direction formed by a common set of agency values.

Subsequently, the planning process turned the OHCA goals into a plan of action, with roles and responsibilities distributed throughout the agency and among stakeholders. This action-planning step collected new ideas from multiple stakeholders, which are then and evaluated. We identified the opportunities and challenges presented by particular projects and considered alternatives based on available resources. Buy-in and input from others were sought. In the end, some strategies did not prove practical upon closer examination and may have been refined or even eliminated. Other strategies were implemented immediately, while others may have required legislative changes.

Following the action plan, these priority-setting decisions came together with the proposed strategic budgeting process, or resource allocation decisions. This ensured that program and resource decisions were based on shared goals, priorities and the strategies to achieve them.

Finally, successful strategic planning builds in accountability for results. Key performance measures (KPMs) were designed to identify and monitor the activities set forth in this strategic plan. These KPMs allow OHCA to reach agency goals in a controlled and targeted way. These detailed performance measures are available in the OHCA companion report entitled "Service Efforts and Accomplishments."

# ABOUT OHCA

At OHCA, planning is never a closed book. We organize planning by continuously reviewing the effectiveness of the strategies used to achieve our goals and priorities.

## Mission

Our mission is to responsibly purchase state and federally funded health care in the most efficient and comprehensive manner possible; and to analyze and recommend strategies for optimizing the accessibility and quality of health care; and to cultivate relationships to improve the health outcomes of Oklahomans.

## Vision

Our vision is for Oklahomans to be healthy and to have access to quality health care services regardless of their ability to pay.

## Values and Behaviors

The OHCA staff will operate as members of the same team, with a common mission and each with a unique contribution to make to our success; OHCA will be open to new ways of working together; and OHCA will use qualitative and quantitative data to guide and evaluate our actions and improve our performance in a purposeful way over time.

## Long-term goals

- Goal #1 (Financing & Reimbursement) - To responsibly purchase cost-effective health care for members by maintaining appropriate rates and to continue to strengthen health care infrastructure
- Goal #2 (Program Development) - To ensure that medically-necessary benefits and services are responsive to the health care needs of our members
- Goal #3 (Personal Responsibility) - To educate and engage members regarding personal responsibilities for their health services utilization, behaviors and outcomes
- Goal #4 (Satisfaction and Quality) – To protect and improve member health and satisfaction, as well as ensure quality, with programs, services and care
- Goal #5 (Eligibility and Enrollment) – To provide and improve health care coverage to the qualified populations of Oklahoma
- Goal #6 (Administration) – To foster excellence and innovation in the administration of the OHCA
- Goal #7 (Collaboration) – To foster collaboration among public and private individuals and entities to build a responsive health care system for Oklahoma

## Purpose of an environmental assessment

OHCA's environmental assessment is intended to identify issues critical to the future of the organization. This section looks at the economic, social, and other environmental changes taking place in public health and health care systems. These trends in the external environment will support and guide the development of agency goals, objectives and strategies. The success of SoonerCare and Insure Oklahoma depends on our ability to predict, plan around and impact environmental trends. Issues considered in the external environment include:

- Economic indicators
  - National outlook
  - Oklahoma outlook
  
- Social/Demographic issues
  - Demographics
  - Education
  - Employment
  - Poverty and income
  - Health care access
  - Health concerns
  - Aging
  
- Government and regulatory issues
  - Care coordination for aged, blind and disabled (ABD) populations
  - Backdating application dates from other states for military personnel
  - Plan to reduce incidence of diabetes
  - Home and community-based setting requirements
  - Medicaid/CHIP provider fingerprint-based criminal background check
  - Department of Labor or domestic service employee
  
- Technology
  - Medicaid information technology modernization

- Industry trends
  - Integrated care management
  - Increasing prescription drug costs
  - Health care delivery and payment reform
- Politics
  - Medicaid - state and federal government perspectives
- Competition/Marketplace
  - Provider Network
- Internal environment and workforce plan
  - Workforce recruitment and retention

## Environmental assessment summary

The results of the OHCA environmental assessment help to support and guide the development of agency goals, objectives and strategies. This assessment takes a look at the following:

- Economic indicators
  - Topics that include the U.S. economy, Oklahoma's economy and health care spending
- Social/Demographic issues
  - Topics that include the uninsured, the aged population, and health concerns for all Oklahomans
- Government and regulatory issues
  - Overarching issues such as fraud and abuse; conversion to a Social Security income (SSI) criteria state; and change in promulgation of permanent rulemaking
- Technology
  - Topics covered include Medicaid Information Technology Architecture (MITA) Initiative, health information exchange (HIE) and online enrollment
- Industry trends
  - Issues that include the use of technology in health care delivery; models of care delivery; and genetic testing

- Politics  
A look at federal health reform, the federal insurance marketplace and the Insure Oklahoma program
- Competition/Marketplace  
In this section, we consider health care providers, specialists, and an increasing number of enrollees.
- Internal Environment and workforce plan  
An examination of workforce recruitment, retention and a competitive salary plan

## Economic indicators

### National outlook

While the expected federal budget deficit in 2015 of \$468 billion is less than the budget deficit of 2014, the Congressional Budget Office (CBO) forecasts the long-term economic growth of the United States to stand still, and deficits to massively increase over the next 10 years. The economy is expected to expand slightly over the next few years, but in 2017 and beyond, CBO projects Gross Domestic Product (GDP) will grow “at a rate that is notably less than the average growth during the 1980s and 1990s.”<sup>1</sup>

The deficits in CBO’s projections remain stable as a percentage of GDP through 2018 but they rise after that. The deficit in 2025 is projected to be \$1.1 trillion, or 4 percent of GDP; combined deficits over the 2016–2025 period are projected to total \$7.6 trillion. CBO expects that federal debt will amount to 74 percent of GDP at the end of 2025, which is more than twice what it was at the end of 2007. These deficits will be driven in part by an increase in expenditures due to the retirement of the baby boom generation, the expansion of federal subsidies for health insurance, increasing health care costs per beneficiary, and rising interest rates on federal debt.<sup>2</sup>

### Oklahoma outlook

In February 2015, Oklahoma’s seasonally-adjusted unemployment rate was unchanged at 3.9 percent, ranking the sixth lowest unemployment rate among all states and tied with New Hampshire and Vermont.

Oklahoma’s relatively strong economy, when compared to the nation as a whole, has resulted in the state receiving yet another reduction in its Federal Medical Assistance Percentage. For federal fiscal year (FFY) 2016, Oklahoma’s FMAP will be 61.25 percent. This is a reduction from 62.30 percent in FFY 2015 and 65.90 in FFY 2009.<sup>3</sup> Oklahoma’s strong economy has not resulted in an increase in state funds; therefore, OHCA faces budget constraints at both state and federal levels.

While Oklahoma performed well in key economic indicators, state government faced yet another budget shortfall that forced additional cuts. In February 2015, state officials increased Oklahoma’s projected budget shortfall to \$611 million. This happened when the year’s state budget was already \$680 million smaller than six years ago after inflation.<sup>4</sup> As a result, the Oklahoma Legislature had to reevaluate budgeting priorities, and many state agencies faced additional budget cuts.

OHCA operated under a budget of \$953 million in SFY 2015 and sought a \$120 million increase to cover the costs of program growth. When the final budget state was signed in late May, OHCA received funding from the legislature that remained unchanged from the previous year. This reality forced OHCA to make targeted service cuts and reduce reimbursement rates to mid-level practitioners by five percent.

Due to the state budget shortfall and declining federal medical assistance percentage (FMAP), OHCA faces budget pressure that forces the agency to make tough choices which threaten our ability to pay adequate provider rates. In SFY 2015, OHCA was able to avoid across-the-board rate cuts due through administrative savings and targeted service cuts. However, the agency must continue to be diligent in its efforts to reduce expenses while maintaining current services and provider rates.

## Demographics and social issues

### Demographics

Oklahoma's total population grew from 3,751,616 to 3,878,051 between 2010 and 2014, an increase of 3.4 percent.<sup>5</sup> In 2013, the diversity of Oklahoma's population was 75.4 percent White alone, 7.7 percent Black or African American alone, 9.0 percent American Indian and Alaska Native alone, 2.0 percent Asian alone, and 0.2 percent Native Hawaiian and Other Pacific Islander alone. Additionally, 9.6 percent of Oklahoma's were Hispanic or Latino, 67.5 percent White alone, not Hispanic or Latino, and 5.8 percent reported two or more races.<sup>6</sup> Oklahoma's population by age in 2013 was 24.6 percent persons under 18 years, 61.1 percent 18 to 64 years of age, and 14.3 percent persons 65 years and over.<sup>7</sup>

### Education

In Oklahoma, between 2009 and 2013, 86.4 percent of persons age 25 and older were a high school graduate or higher. During the same time period, 23.5 percent of persons age 25 and older had a bachelor's degree or higher.<sup>8</sup>

### Employment

Oklahoma's unemployment rate declined from 5.2 percent in January 2014 to 3.9 percent in January 2015<sup>9</sup> but shows signs of an upward trend in 2015, due to fluctuations in the energy industry. However, at 4.1 percent in April 2015, the Oklahoma unemployment rate remained lower than the U.S. unemployment rate of 5.4 percent.<sup>10</sup>

### Poverty and income

In 2013, 16.7 percent of Oklahomans were in poverty, including 23.8 percent of children aged 0 to 17.<sup>11</sup> The state poverty rate by county ranged from a low of 7.3 percent (Canadian County) to high of 30.4 percent (Adair County).<sup>12</sup>

In 2014, the personal finance website WalletHub evaluated the 50 states and the District of Columbia according to income, GDP per capita and tax dollars per capita. The site adjusted for population and used data from the U.S. Census Bureau, U.S. Bureau of Economic Analysis and the U.S. Internal Revenue Service to determine a ranking of 2014's richest and poorest states.<sup>13</sup> Based on this analysis, Oklahoma ranked

number 40 and is grouped among the poorest states in the U.S. Oklahoma's high rate of poverty and low median household income contribute to this low ranking.<sup>14</sup>

### Health care access

From 2013 to 2014, Oklahoma's uninsured rate dropped from 17 percent to 14 percent, according to data from the U.S. Census Bureau, Current Population Survey.<sup>15</sup> During the same period, the U.S. uninsured rate dropped from 15 percent to 13 percent. While the reduction in the uninsured rate is a positive trend, more than 520,000 Oklahomans remained uninsured in 2014.

Many of the uninsured are working adults ages 19 to 64. Often their employers do not offer health insurance for various reasons, such as prohibitive costs, extensive paperwork or they are not legally required to do so. Being uninsured is a barrier to accessing the routine health services needed to maintain one's health. Limited access to quality health care not only impacts the uninsured individual, but it also impacts that person's family, employer, local community and the state's overall health.

OHCA provides health care services to eligible populations such as children, pregnant woman and the aged, blind and disabled. The largest group of the uninsured in Oklahoma is low-income, working adults (19 to 64) who are generally not eligible for SoonerCare.

### Health concerns

Health issues such as obesity, infant immunizations, diabetes, infant mortality and cardiovascular deaths contribute to the poor overall health of Oklahoma. In the United Health Foundation 2014 America's Health Rankings, Oklahoma ranked 46<sup>th</sup> in the nation in overall health.<sup>16</sup> In order to improve the state's health status and reduce health care costs, it is urgent for Oklahoma to address the major health challenges facing its residents.

Improving the health of Oklahomans will require contributions from state and local governments, businesses, community and tribal leaders, and individuals across the state. OHCA collaborates with several other state agencies and community partners on the Oklahoma Health Improvement Plan (OHIP), which has identified several flagship priorities in the areas of children's health, obesity, tobacco use and behavioral health.<sup>17</sup>

In 2014, OHCA launched a collaborative effort with the Oklahoma State Department of Health (OSDH) to improve statewide health in five priority areas: tobacco use, prescription drug abuse, diabetes/hypertension, childhood immunizations and obesity. Each workgroup defines a quality improvement goal, develops and implements an intervention, and monitors the results (see action plans for more detail). These workgroups will continue joint strategic planning activities through at least 2016.

Nationally, Oklahoma's population does not perform well in many health outcomes. However, through inter-agency collaboration, OHCA is working to reverse this trend.

### Aging

The first of the baby boomer generation (those born between 1946 and 1964) turned 65 in 2011. Nationally, there are approximately 44.5 million individuals above the age of 65. The number of individuals over the age of 65 is expected to reach 71.5 million by 2030.

By 2030, it is also predicted that approximately 60 percent of baby boomers will experience more than one chronic health condition. As these individuals turn 65, a large part of the financial responsibility for their care will begin to shift from the private sector to publicly-financed programs, including Medicare and Medicaid .

As a result of improved medical care and prevention efforts, life expectancy has dramatically increased in the United States. The average life span of Americans as of the 2010 census was 78.7 years. As Americans get older, they are less able to care for themselves or have access to support from a spouse or family members. The cost of providing health care for an older American is 3-to-5 times greater than the cost for someone younger than 65. As a result, the nation's health care spending is projected to increase by 25 percent by 2030.

According to United Health Foundation's 2015 Senior Health Rankings, Oklahoma senior's rank 46<sup>th</sup> in the nation for health.<sup>18</sup> Several factors considered in this ranking include nursing home quality, hospital readmission rates, chronic health conditions, and community involvement. Oklahoma seniors are challenged with a high prevalence of physical inactivity, and a low percentage of these seniors receive recommended hospital care. This low health ranking indicates Oklahoma will face additional challenges in treating the baby boomer generation in the years to come.

An estimated 3.3 million Americans were projected to live in the nation's nearly 16,000 nursing homes during 2013. That number translates to 1 in 7 people ages 65 and older, with more than 1 in 5 of those age 85 and older.<sup>19</sup> Medicaid continues to be the main source of long-term care financing in the U.S. In Oklahoma an estimated 70 percent of long-term care residents are funded by SoonerCare. In 2013, average annual nursing home costs topped \$80,000 per year per person nationally. Medicaid-financed long-term care includes nursing home services and the use of home and community-based care services (HCBS). Through the Center for Medicare & Medicaid Service's (CMS) Center for Medicare and Medicaid Innovation (CMMI), OHCA is pursuing efforts to assist this aging population through the promotion of HBCS. HBCS supports can be accessed through eight waiver programs, including Advantage; Community; Homeward Bound; In-Home Supports for Children; In-Home Supports for Adults; Medically Fragile; My Life, My Choice; and Sooner Seniors.

The aged population is growing and many of these individuals will need some type of long-term care; an estimated two-thirds will need Medicaid to help finance all or part of that care. Long-term care costs account for one-third of national Medicaid budgets. These costs must be better managed and improvements in care identified, so that system efficiencies can be applied more widely.

### Dual Eligibles

Individuals enrolled in both Medicare and Medicaid programs are called dual eligibles. Medicaid covers services and costs for these individuals that not covered by Medicare. As of July 2014, there were 125,915 Oklahomans classified as dual eligibles – 62 percent were women, 38 percent were men and 51 percent of the duals were age 65 and over. According to a November 2013 report by the Pacific Health Policy Group (PHPG), about 67 percent of duals in Oklahoma have a chronic physical health condition, 47 percent have a mental health condition and over half (54 percent) of dual enrollees with a chronic physical condition also exhibit some type of mental health condition.

Dual enrollees are an expensive population to cover, and costs will continue to grow as the general population ages. To better improve health outcomes and control costs in the future, it is important that OHCA explore opportunities to better manage this population.

## Government and regulatory issues

Strategic planning at OHCA must be responsive to changes from state and federal leadership. Each year, we face changes to rules and regulations that govern the agency's programs. In recent years, there has also been a push toward regulatory authority which directs some of our operations and areas of study. In addition, efforts to implement many of the remaining provisions of the Patient Protection and Affordable Care Act of 2010, known as the Affordable Care Act (ACA), continue through 2015. Therefore, OHCA must remain aware of all regulatory modifications and their associated timelines, while being mindful of the resources necessary to develop, test and implement the changes. We must assess state laws and regulations that impact OHCA programs and operations with vigilance, to ensure they are integrated in future strategic plans.

Three examples of state legislation include:

Care coordination for ABD populations - House Bill 1566 in the 2015 legislative session instructs OHCA to initiate a request for proposals (RFP) for care coordination models for persons who are aged, blind and disabled (ABD).

Backdating application dates from other states for military personnel - Senate Bill 293 in the 2015 legislative session directs that if a member of the armed forces makes application for assistance with either the Department of Human Services (DHS) or OHCA, and has a pending application for the same type of assistance in another state, the agency will consider the pending application as if it had been made in this state.

Plan to reduce incidence of diabetes - Senate Bill 250 directs OHCA and OSDH to collaborate to identify benchmarks and develop goals to reduce the incidence rates of, improve health care services for, and control complications resulting from diabetes.

Additionally, three examples of recent federal regulation are:

Home and community-based setting requirements - 42 CFR 441 ensures that individuals receiving long-term services and supports through HCBS programs under the 1915(c), 1915(i) and 1915(k) Medicaid authorities have full access to the benefits of living in the community and the opportunity to receive services in the most integrated setting appropriate.

Medicaid/CHIP provider fingerprint-based criminal background check - Section 6401 of the ACA, which amended sections 1866(j)(2) and 1902 of the Social Security Act, requires the Secretary of the Department of Health and Human Services to establish procedures for screening providers and suppliers under Medicaid and Medicare, and for state Medicaid agencies to comply with those procedures. CMS enacted the screening requirements with federal regulations at 42 C.F.R. Part 455 subpart E and at 42 C.F.R. § 457.990, which makes Part 455 applicable to the Children's Health Insurance Program (CHIP).

The final rule includes requirements that, based on a provider's level of risk, Medicaid agencies may need to perform fingerprint-based criminal background checks (FCBCs). The final rule also states that Medicaid agencies have 60 days following implementation of further subregulatory guidance by CMS on FCBCs to begin applying the FCBC requirement. This subregulatory guidance was finally issued on June 1, 2015, when CMS delivered a letter to state Medicaid directors. Accordingly, state Medicaid agencies had until July 31, 2015, to begin implementation of the requirements outlined and have until July 31, 2016, to complete the execution.

Furthermore, the guidance, in accordance with 42 C.F.R. § 455.434, requires state Medicaid agencies to establish categorical risk levels for providers and provider categories which pose increased financial risk of fraud, waste or abuse to the Medicaid program. The levels are “limited,” “moderate” and “high.” With some exceptions, the methods for determining which providers fall into each category lies with the state Medicaid agencies. If a provider’s risk level is “high,” the state Medicaid agency must require that provider to consent to criminal background checks, including fingerprinting. This requirement also applies to any person with at least 5 percent direct or indirect ownership interest in the provider’s practice. The state Medicaid agency has the power to determine the type and extent of the background checks performed, as well as the method for submitting fingerprints. It may also require providers to pay the fingerprinting costs.

U.S. Department of Labor, domestic service employee - In 1974, Congress extended the protections of the Fair Labor Standards Act (FLSA) to “domestic service” employees. However, it exempted from the Act’s minimum wage and overtime provisions domestic service employees who provide “companionship services” to elderly people or people with illnesses, injuries or disabilities who require assistance to care for themselves. It also exempted from the overtime provision domestic service employees who reside in the household in which they provide services. This final rule better reflects Congressional intent, given the changes made to the home care industry and workforce through the years. Most significantly, the U.S. Department of Labor (DOL) is revising the definition of “companionship services” to clarify and narrow the duties that fall within the term. In addition, third-party employers, such as home care agencies, will not be able to claim either of these exemptions. The major result of this final rule is that more domestic service workers will be protected by the FLSA’s minimum wage, overtime and recordkeeping provisions. The rule went into effect Jan. 1, 2015.

State and federal leadership play an integral part in guiding the direction of the SoonerCare program through rules and regulations. As a good steward of public funds, OHCA integrates rules and guidance from state legislation and our federal partners in order to achieve the desired aims.

### Technology

Since 2010, OHCA has utilized online enrollment to provide Oklahoman’s the opportunity to apply for health care services through the Internet and receive an immediate eligibility determination. This eligibility and enrollment system continues to receive enhancements, including technological upgrades (e.g., improved member numbering linkages; development of an online enrollment application that is compatible across multiple browsers and enhanced for mobile use; and improved self-service options for members (e.g., security log-on and email notifications). Moreover, in 2014, OHCA integrated Insure Oklahoma into the online enrollment and eligibility application. This decision will allow OHCA to develop payment and provider selection modules, an employer portal, and improve data exchanges.

In 2013, OHCA purchased and installed an enterprise service bus (ESB) with the intent to expand the use of web services and link multiple applications in a service-oriented architecture (SOA). This technology enables OHCA to link with other agencies and health information organizations across the state. Furthermore, this SOA allows the agency to connect to the Health Insurance Exchange (HIX), also known as the Federally-facilitated Marketplace (FFM). The use of an ESB and SOA adhere to MITA standards and make use of HIPAA-compliant transactions. Future plans related to the ESB and SOA include connectivity and functionality with Oklahoma DHS and enterprise-level arrangement with additional Oklahoma Health and Human Services agencies.

As part of MITA 3.0, OHCA completed a state self-assessment in 2014 and received recommendations to help us move forward with system changes to meet additional MITA goals in the future. OHCA plans to update the MITA self-assessment regularly, and the CMS Seven Standards and Conditions will guide our reprocurement.

These standards and conditions are: modularity standard, MITA condition, industry standards condition, leverage condition, business results condition, reporting condition and interoperability condition.<sup>20</sup>

The MITA State Self-Assessment 2014 coincided with the kickoff to reprourement. The technological pieces of the Oklahoma Medicaid Management Information System (MMIS) often have lifecycles of five to seven years and must be continually upgraded to maintain a modern system. Reprourement is a process OHCA conducts to either upgrade or replace all or parts of its MMIS and fiscal agent services with service delivery models that are both flexible and adaptable. Vendors are informed of procurement needs in order to redefine systems and business processes for SoonerCare. In 2014, to comply with CMS's Modularity Standard, OHCA decided to renew its existing contract with Hewlett Packard (HP) for operation of its MMIS, as is, with the exception of the care management and decision support systems (DSS).

In 2014, the Coordinated Care of Oklahoma (CCO) health information organization (HIO) became the second HIO in the state. Oklahoma's first HIO, MyHealth Access Network, was founded in 2009. Initiatives, such as the Comprehensive Primary Care initiative (CPCi), aim to leverage HIE capabilities in the state made possible by organizations such as CCO and MyHealth. OHCA continues to explore options to connect with HIE's in Oklahoma and sees the opportunity for the value gained through improved analytics leading to better health outcomes.

In 2014, OHCA conducted a staff strategic plan survey and a theme emerged around expanding the use of mobile communication and technology to help relay vital information to our members to improve effectiveness and reach. In response to these suggestions, OHCA has developed an online after-hours care locator for members, which takes advantage of existing smartphone technology. Other initiatives are expanding efforts related to texting health-related information to members.

Data security in today's technological environment is important to keep millions and millions of health records safe for members of health insurance organizations. As a health care payer, OHCA performs numerous security protections and processes for data housed at OHCA (as well as with data for our contracted vendors) to ensure the safety of SoonerCare and Insure Oklahoma member and provider data. Those protections and processes include conducting multiple security assessments required by CMS and other regulatory bodies on a regular basis; adherence to National Institute of Standards and Technology (NIST) security standards; compliance with MITA standards; and implementing industry best practices while maintaining other required security rules.

Telehealth is the use of electronic information and telecommunications technologies to support long-distance clinical health care patient and professional health-related education, public health and health administration. Technologies include videoconferencing, the Internet, store-and-forward imaging, streaming media, and land and wireless communications. In August 2014, OHCA made significant changes to its telehealth policy. Those changes included the removal of distance requirements, updated payment structures and elimination of cell phone use restrictions. Instead, the agency chose to rely on the provider's discretion to deliver care with quality equal to a face-to-face visit. OHCA will continue to review telemedicine policy regularly to develop future strategies and outline potential opportunities for continued use of telemedicine and telehealth in support of health information technology/exchange.

Technology continues to change rapidly, while adoption and upgrade of modern technology remains a significant investment of resources. OHCA continually works to assess the benefits of using new technology to solve existing problems or to make the workload easier. The ultimate goal is to use technology to provide the most efficient and effective services to the members we serve.

## Industry trends

### Integrated care management

In an effort to improve patient access to coordinated, high-quality health care, a patient-centered philosophy has gained support in recent years. The medical home is becoming a widely accepted model, offering team-based care that focuses on treating the whole person. Also known as the patient-centered medical home (PCMH), it offers coordinated access to a team of providers, including both medical professionals and social services. Coordinated services are managed in part through the use of electronic health records (EHR), which allow providers instant access wherever they are located. Payment reform is also included within the medical home model, transforming the traditional fee-for-service method of paying providers. Provider payment incentives are aligned with patient health outcomes, supporting the idea that healthier patients require fewer services. This lowers their health care costs over time.

PCMHs have been adopted by payers including Medicare, private payers, state governments, and large, self-insured employers. Following an extensive revision in 2009, Oklahoma's SoonerCare Choice provides medical homes to most enrolled Medicaid members. PCMHs are divided into three tier levels: entry, advanced and optimal. Provider payments are based on three components: traditional fee-for-service reimbursement; quarterly, performance-based incentives payments; and a tiered member per month care management payment.

### Increasing prescription drug costs

The prescription drug landscape greatly changed in 2014, ushering in a remarkable increase in prescription drug costs. Various elements have contributed to these increases. These include a growing supply of specialty drugs, new innovations in common therapy drugs, as well as a decrease in the reduction of generic drug pricing. This is causing concern among patients and providers, as well as pharmacy benefit managers.

Both private and public payers have the difficult job of managing these increased costs in an effort to continue to offer fully-developed prescription drug benefits affordably.

### Health care delivery and payment reform

With the purpose of improving quality of care, improving population health and reducing costs, states are exploring a variety of groundbreaking health care delivery and payment systems. Many of these models incorporate some type of care coordination in an effort to improve access and reduce duplication of services.

Below are some examples of the systems either being considered or implemented across the country.

- Patient-centered medical homes (PCMHs) offer a widely-accepted delivery system that coordinates care among providers and focuses treatment on the whole person through all stages of life.
- Health homes (HHs), while similar to the PCMH model, target patients with multiple chronic diseases. HHs add in behavioral health services and social services with their primary care.
- Although continuing to evolve, accountable care organizations (ACOs) build on delivery systems such as the HH and PCMH and usually include at least one hospital. ACO providers are responsible for

coordinating care for their shared patients in an effort to improve quality and efficiency. If quality performance standards and cost-saving targets are met, the ACO shares in these savings.

- With the goal of reducing avoidable hospital use by 25 percent over five years, the delivery system reform incentive payment (DSRIP) initiative allows states to reinvest expected saved Medicaid dollars. This money will be used toward clinical improvement and a system makeover designed to improve population health. New York recently announced that it will be allowed to reinvest \$8 billion in federal savings expected due to Medicaid redesign team (MRT) reforms. Kansas, Massachusetts, California, New Jersey and Texas put DSRIP program waivers in place in fiscal year 2014.
- CMS has recently proposed a rule that promotes the modernization of Medicaid managed care regulations. This proposal has boosted efforts by states to reassess traditional fee-for-service payment models and consider broad delivery system and payment reforms.
- A growing number of states are implementing initiatives such as managed long-term services and supports (MLTSS), which better coordinate Medicare and Medicaid services. This is generally through capitated managed care. Enrollees include seniors and people with disabilities. The goal is to offer access to HCBS in the place of institutional care. Currently there are 19 capitated Medicaid MLTSS waivers.

Like the majority of states, Oklahoma operates Medicaid managed care in the form of primary care case management (PCCM). In this situation, the primary care provider serves as a member's "medical home" for primary and preventive care and does not assume any financial risk. The state has also uses patient-centered medical homes (PCMHs) as well as health homes (HHs).

## Politics

SoonerCare and Insure Oklahoma continue to be a central focus of the state's leadership and legislature, especially when discussing the state's budget. Central to these discussions are two major issues: how to increase coverage options for various populations (specifically without the Medicaid expansion included in federal law) and the push towards a revamped health care delivery system for SoonerCare's aged, blind and disabled (ABD) members. Traditionally, strong support for coverage initiatives come from provider groups and patient advocates; while interest in exploring payment reform has originated with "free market" groups and private managed care plans. However, things changed in 2015. Two large provider organizations and the state's largest private insurer came together to support a bill directing OHCA to release a request for proposal (RFP) to explore care coordination models.

Political leaders are determined that reform is important, but little agreement has been reached. Some believe the priority is creating healthier citizens through realizing better health outcomes; others argue the most important issue is an "out of control" health care cost; while even others demand that creating access to affordable health care coverage should be front and center.

This search for the perfect balance of quality, access and cost in health care is not new. However, recognition of new and groundbreaking pathways to delivering the best health care goods and services remain central to the mission of OHCA.

OHCA leadership is aware and involved as guidance comes down from our state leaders and federal partners. We continue to work to keep the SoonerCare and Insure Oklahoma programs moving forward in a positive and efficient manner, while being responsive to the changes being considered by state leadership.

## Competition and marketplace

Like every other state in the nation, Oklahoma has many residents without health insurance. As of 2013, 14.1 percent of Oklahomans did not have health insurance.<sup>21</sup> More than 50 percent had employer or other private insurance; 17 percent had Medicaid ; and 15.4 percent were on Medicare.

As of May 2015, 825,722 Oklahomans were on Medicaid<sup>22</sup>. For private insurance, more than 700,000 Oklahomans relied on Blue Cross and Blue Shield of Oklahoma.<sup>23</sup> More than 200,000 Oklahomans received health insurance through the Office of Management and Enterprise Services (OMES) Employees Group Insurance Division (EGID) through HealthChoice or a related HMO.

Low reimbursement rates may lead providers to not participate in the SoonerCare program. OHCA has always strived to maintain high provider reimbursement rates. According to the Kaiser Family Foundation Medicaid-to-Medicare Fee Index, only three states paid higher rates than Oklahoma in 2012.<sup>24</sup>

Reimbursement to providers as a percentage of Medicare rates remained stable at 96.75 percent from 2011 to 2014. While total expenses for medical services continued to increase, it was necessary for OHCA to decrease reimbursement rates to 89.25 percent of Medicare rates in order to reduce agency spending and balance the state budget. This decrease was not expected to have a long-term, negative impact on access to or quality of care provided to SoonerCare members.

In February 2015, the Oklahoma State Board of Equalization certified a \$611 million budget shortfall, meaning the Legislature had about 8.5 percent less to spend than the previous year. A reduction in oil and natural gas prices are partially to blame for this decline in state funds.

The drop in state funds, along with a drop in Oklahoma's Federal Medical Assistance Percentage or FMAP (61.25 percent in FFY 2016, a reduction from 62.30 percent in FFY 2015<sup>25</sup>) put pressure on OHCA's budget.

### Provider network

Maintaining a strong provider network is important. It helps members to access needed medical care, especially in a largely rural state. Even through the two most recent rate cuts, OHCA has been able to maintain and even increase its provider network and overall patient capacity<sup>26</sup>.

OHCA continues ongoing recruitment efforts for new providers and retention efforts for currently contracted providers. Provider outreach and training is important to keep contracted providers informed of policies, procedures and changes, as well as to maintain a good relationship by seeking input for suggested areas of improvement. During the state budgeting process of 2015, OHCA met with all provider interest groups to inform them of the possible upcoming shortfall and asked for input on possible ways to save money and become more efficient.

OHCA recognizes that maintaining competitive reimbursement rates is important in retaining a sufficient provider network. Therefore, monitoring the provider network for changes in enrollment is essential.

The SoonerCare provider network provides health care access by contracting with medical doctors, doctors of osteopathy, physician assistants (PAs) and nurse practitioners (NPs). By recognizing PAs and NPs as part of the primary care team, access to care is increased. Adequate primary care for SoonerCare members is vital, and medical homes provide important access to preventive health care services. A good mix of primary and specialty care providers in both urban and rural areas of the state is ideal.

Oklahoma as a whole suffers from a provider shortage. The Sooner state ranks 49th in the nation in primary care providers (United Health Foundation Health Care Rankings), with 80.2 physicians per 100,000 citizens. According to the American Medical Association (AMA), Oklahoma ranks last in the nation in physician to patient ratio.<sup>27</sup> However, while Oklahoma is struggling, OHCA is doing an excellent job in utilizing available providers to offer coverage to our SoonerCare members. As of June 2015, SoonerCare Choice Primary Care provider capacity was at 42.92 percent capacity used.<sup>28</sup>

In spite of continued budget reductions and revenue losses in SFY 2015, OHCA, was able to maintain a balanced budget through targeted program cuts. With continued budget pressures, OHCA leadership is aware of the effect this has on providers. To combat this, we are committed to maintain and improve provider relations and services.

## Workforce plan

The retirement of employees and its impact on the agency business is significant. One hundred twenty-three (123) employees (representing 22.24 percent of the agency) meet retirement eligibility requirements in the next two calendar years. Fifty-one (51) (9.22 percent) additional staff members are eligible for retirement within the next five calendar years. Combined, that means approximately 31.46 percent of the OHCA workforce is eligible to retire by the year 2021.

OHCA recognizes the need to honor our transitioning employees and manage the transfer of their valuable knowledge. Mentorship through the OHCA Executive Leadership Program (ELP) is one opportunity that assists in the latter.

The agency also forecasts conditions which might encourage potential retirees to stay on the job or support their interest in retirement. A planned Transition Assistance Program will help employees prepare for retirement, as well as provide assistance to those facing a work world outside the OHCA family.

Development of a comprehensive training and cross-training program for employees has also begun. The recent addition of a training coordinator to our staff has kick started this progressive program.

We believe the next five years will bring significant changes to our workforce. OHCA is preparing to meet those changes with solid, innovative programs aimed at the basics of recruitment, retention, retirement, training and modernization.

OHCA is aggressively implementing programs to ensure that a high-quality, skilled workforce is recruited and retained within the agency through succession plans, cross-training and leadership development programs.

## Business plan

A business plan is a set of documents prepared by a company's management detailing its goals for the future and explaining how they will be achieved. The OHCA approach to business planning is much broader. Our business plan is a collection of reports, stakeholder involvement, collaborations, communications and marketing, project management, and performance management. It is a direct, intentional reflection of OHCA values and culture.

### Reporting

Along with required federal reporting, OHCA prepares many reports which inform business processes and provide transparency in the agency's operations. Every year, OHCA prepares a set of general purpose financial reports (GPFR) which include the Comprehensive Annual Financial Report (CAFR), the Annual Report, the Service Efforts and Accomplishments (SEA) report (performance report) and the Strategic Plan. Internal reports include the Core Functions report (which describes the purpose, staffing and responsibilities of each unit within the agency) and the monthly Fast Facts reports, which present information about agency operations and areas of interest. For more on OHCA Research and Statistics, please click [here](#). To access our Fast Facts, please click [here](#).

### Stakeholder involvement

The support of our partners and the public is vital to the success of OHCA as the state Medicaid agency. OHCA boards and committees are groups of health professionals, members, advocates and elected officials who ensure that decisions best serve our members' needs while maintaining the fiscal integrity of the agency. To learn more about our boards and committees, please click [here](#).

### Collaborations

In a time of limited resources and relatively poor health outcomes for Oklahomans, it is important for OHCA to collaborate with other entities to leverage expertise and resources to move in the right direction.

### Communications and marketing

Communicating with both internal and external stakeholders is essential to ensure the agency meets the needs of Oklahomans in an open proactive manner. Internal communications help to foster an inclusive culture and awareness among agency staff. External communications, such as the use of websites, social media and letters, provide many convenient ways for stakeholders to get the information they need.

### Project management

A Project and Portfolio Management Office (PPMO) helps an organization to organize, orchestrate, prioritize and evaluate projects. OHCA is currently implementing a PPMO. This PPMO will help to ensure the efficient use of agency resources, provide transparency concerning projects, assist the decision-making process for executive staff, and ensure that projects are aligned with agency and statewide goals.

## Performance management

Performance management and the development and reporting of key performance measures continues to gain support at the statewide budgeting and planning level. The state of Oklahoma is now using performance-informed budgeting to assist in the appropriations process.

OHCA has utilized elements of performance management in everyday operations and external reporting for many years. Agency key performance measures (KPMs) are reported on every year in our Service Efforts and Accomplishments (SEA) report. These KPMs can be directly related to agency goals and objectives and can show how the agency contributes to the achievement of statewide goals.

OHCA strives to develop and implement agency programs and initiatives (through effective business planning and project management) that ensure open, effective use of resources, adherence to timelines, and compliance with applicable laws and regulations.

## Action plan summary

The thinking and decision-making that occurred during this year’s planning process were expanded in the development of the action plans. Our action plans involved individuals at all levels of the organization and focus on one of the seven agency goals, comprising the following major themes:

- 1) Financing
- 2) Program Development
- 3) Personal Responsibility
- 4) Satisfaction and Quality
- 5) Eligibility
- 6) Administration
- 7) Collaboration

Each action plan offers a short description detailing , OHCA’s role in the plan, and specific, actionable steps (known at the time of this report) expected in the future.

Short description (not in priority order)	Report reference	Agency goal category
Mandates		
ABDs/ HBI 566	1	Program Development
Other		
Insure Oklahoma changes 2016	2	Eligibility
Health information initiatives	3	Administration

Health homes For enrollees with chronic and mental health conditions	4	Program Development
Comprehensive Primary Care initiative (CPCi)	5	Financing
Money Follows the Person (MFP) Tribal Initiative	6	Satisfaction and Quality
Adult Medicaid Quality	7	Satisfaction and Quality
SIM grant collaboration	8	Financing
Member engagement strategies	9	Administration
OB initiatives	10	Program Development
Partner grant opportunities	11	Collaboration
OSDH Joint Strategic Plan Quality Initiative (QI) - Tobacco	12	Collaboration
OSDH Joint Strategic Plan QI- Immunizations	13	Collaboration
OSDH Joint Strategic Plan QI- Obesity	14	Collaboration
OSDH Joint Strategic Plan QI-Prescription drug abuse	15	Collaboration
OSDH Joint Strategic Plan QI- Diabetes and hypertension	16	Collaboration
Central Project Management Office	17	Administration
Targeted quality measures	18	Satisfaction and Quality
Presumptive eligibility	19	Eligibility
After-hours Locator launch, member education	20	Personal Responsibility
Make a Space: Enhancing employee's work life	21	Administration
OHCA prescription drug initiatives	22	Personal Responsibility
Hospital readmissions	23	Satisfaction And Quality
Expand Program of All-Inclusive Care for the Elderly (PACE)	24	Eligibility
Family expectations and outreach	25	Collaboration

## I. HB 1566 ABD Care Coordination

HB 1566, passed by the Oklahoma Legislature in 2015, has charged the OHCA with the creation of a Request for Proposal (RFP) for care coordination model(s) for the Aged, Blind and Disabled (ABD) SoonerCare

populations. To comply with the direction of the bill, OHCA will solicit information and input from a wide variety of stakeholders including, but not limited to, members, advocates, providers, health care systems, and the general public. This will be conducted through a Request for Information (RFI) process for the development and requirements of the RFP.

OHCA is gathering contact information for stakeholders who are interested in being a part of these discussions. Participating stakeholders will receive periodic updates as well as notifications of future stakeholder meetings. There is a public webpage for the ABD Care Coordination RFP to share information with interested parties. The webpage is used as a central point of information regarding the timeline and progress of the ABD Care Coordination project.

OHCA has released an RFI to get input from market providers of care coordination services. Respondents to the RFI were invited to conduct public demonstrations in order to encourage public engagement. Additionally, OHCA has contracted with a development consultant to assist in the review of the RFI responses, conduct stakeholder and focus group meetings, and analyze information gathered.

An evaluation consultant was selected to evaluate the RFP process and stakeholder engagement. This independent evaluation will provide valuable feedback as OHCA goes through the process of developing the RFP.

Action plans include:

- Reviewing and analyzing the RFI responses
- Working with the development consultant to hold monthly stakeholder meetings and regional focus groups
- Working with the evaluation consultant to ensure full stakeholder engagement and best practices are followed
- Selecting the best care coordination model(s) and creating an RFP for release.

## 2. Insure Oklahoma changes for 2016

Insure Oklahoma (IO) continues to bridge the gap in health care coverage by exploring innovative ways to provide premium assistance to Oklahomans. On July 9, 2015, the Centers for Medicaid and Medicaid Services (CMS) approved a one-year extension (January 1, 2016 to December 31, 2016) for the IO Premium Assistance Program without any modifications. This keeps the program available for qualified employees working for small businesses (with fewer than 200 employees) and whose family incomes are at or below 200 percent of the Federal Poverty Level (FPL).

In 2015, OHCA began changes to make IO enrollment electronic. Beginning in 2016, IO members and providers can sign up and make enrollment changes online, in real time. Also in 2015, OHCA (along with state and tribal partners) initiated the development of a proposed waiver amendment intended to create a “third leg” of IO called Sponsor’s Choice. The purpose of Sponsor’s Choice would be to provide premium to American Indians and Alaska Natives (AI/ANs) through the Medicaid program in Oklahoma. This waiver amendment is currently in development.

Action plans include:

- OHCA working with CMS to secure the continuation of the Insure Oklahoma (IO) program
- Implementing online enrollment for IO
- Developing and implementing systems changes including an automated wait list and development of the Sponsor's Choice waiver amendment

### 3. Health information technology plan

OHCA is committed to being a part of a larger collaborative of private and public entities/individuals currently developing a statewide health information technology (HIT) plan. The Oklahoma State Department of Health (OSDH) is leading the initiative. The HIT plan will help guide the development of a statewide health information exchange (HIE), which will help health care providers to better communicate with each other across the state.

#### MyHealth/CCO

OHCA continually strives to protect and improve member health and satisfaction. In September 2015, OHCA, through contracts with health information organizations (HIOs) MyHealth and Coordinated Care of Oklahoma (CCO), gained access to comprehensive health data. Data provided through these contracts will help the OHCA Population Care Management (PCM) division to obtain a full picture of the SoonerCare members they assist. It will also help to improve the unit's current care management practices.

#### DISCUSS

OHCA, the Oklahoma State Department of Health (OSDH), the Department of Mental Health and Substance Abuse Services (ODMHSAS) and the Department of Rehabilitation Services (DRS) have formed a shared-services governance board, under the direction of the Oklahoma Health and Human Services Cabinet Secretary, identified as DISCUSS (Deliver Interoperable Solution Components Utilizing Share Services). DISCUSS focuses on identifying shared technology and gathering resources for the mutual benefit of the partnership. Development of a statewide health information exchange (HIE) is one prominent project DISCUSS is pursuing.

#### Modernization efforts

The Medicaid Management Information System (MMIS) is the primary system used by the OHCA to manage member enrollment and process provider claims. In April 2011, the Centers for Medicare and Medicaid Services (CMS) published a document titled "Enhanced Funding Requirements: Seven Conditions and Standards,"<sup>29</sup> which describes technology-related requirements that must be met by states in order for Medicaid technology investments to be eligible for federal enhanced funding. In August 2014, OHCA received CMS approval to enhance our MMIS and related processes that will meet these requirements. OHCA intends to address some major areas where the opportunity is greatest to bring the existing MMIS system to a much higher level of alignment with both Medicaid Information Technology Architecture (MITA) goals and the CMS Seven Conditions and Standards whilst gaining the best return on investment. Two of these areas are the Decision Support System (DSS) and our Care Management (CM) systems. OHCA issued two Requests for Information (RFI) in August and September 2014: one for a new Care Management (CM) System and the other a new Enterprise Data Warehouse system. RFI vendor demonstrations were held in January and February 2015.

#### New care management system

OHCA's current Care Management system was implemented in 2003, at which time which the OHCA Care Management team was focused on a relatively small population of our members. OHCA's Care Management,

Behavioral Health, and Long-term Care Waiver divisions now oversee and interact with a wide variety of member populations, including high-risk infants, high-risk children and adults with chronic conditions, members in the breast and cervical cancer program, behavioral health and Long-term Care Waiver members, among many others. The system used to track care management efforts no longer fully meets the needs of the divisions or the needs of our members and providers. A new care management system will enable OHCA clinical staff to coordinate member access to appropriate, timely and quality care more effectively and efficiently.

### New Enterprise Data Warehouse System

Enhanced reporting abilities, analytics, trending, predictive modeling, and dashboard capabilities will enable OHCA to measure performance and outcomes in new ways and assist agency leaders in making well-timed, better-informed decisions. New decision support and business intelligence reporting tools, as well as a new enterprise data warehouse designed for high volume analysis and reporting, transformation and standardization of data, could assist in these decisions. This could be achieved through integrating crossover claims, 'what if' decision support analytics, and trends reporting.

Action plans include:

- Continued development of a statewide Health Information Technology (HIT) plan
- Further collaboration with the MyHealth and Coordinated Care of Oklahoma (CCO) to enhance OHCA's care management efforts
- Continued identification and development of projects by DISCUSS

## 4. Health homes

The Affordable Care Act of 2010, Section 2703, created an optional Medicaid State Plan benefit for states to establish health homes. Health Homes are for people with Medicaid who have two (2) or more chronic health conditions, have one chronic condition and are at risk for a second, or have one serious and persistent mental health condition.

Oklahoma has chosen to develop health homes to treat serious and persistent mental health conditions. Contracted providers integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person. A health home must provide all six (6) of the following services (based on members' changing needs) which must be linked and found appropriate by health information technology (HIT):

1. Comprehensive care management,
2. Care coordination,
3. Health promotion,
4. Comprehensive transitional care from inpatient to other settings (including appropriate follow-up and transition from pediatric to adult settings),
5. Individual and family support, and
6. Referral to community and social support services.

The expectation is improved quality of care and more cost efficiencies for behavioral health homes; improved member experiences; and reductions in the use of hospitals, emergency departments and other expensive facility-based care, such as psychiatric residential treatment for children. In this model, patients receive comprehensive, person-centered care.

Oklahoma chose to provide health home services statewide. As of July 1, 2015, adult and children health home enrollment figures totaled 8,241 individuals (Oklahoma Department of Mental Health & Substance Abuse Services). There are contracts with some 22 unique provider agencies, with 127 health home sites statewide.

Action plan: This project began in February of 2015; no new services are planned. The goal is to carry out all parts of the program.

## 5. Comprehensive Primary Care initiative

The Comprehensive Primary Care initiative (CPCi) is a four-year, multi-payer proposal to strengthen primary care. Medicare<sup>1</sup> works with private and state health insurance plans (such as SoonerCare), adding payments for primary care providers who agree to arrange care coordination for their patients. Participating practices receive resources to improve management of primary care for their Medicare patients. In Oklahoma, the insurance payers include: Medicare, BlueCross BlueShield, Community Care and SoonerCare.

The Centers for Medicare & Medicaid Services (CMS) released its request for applications for the CPCi on September 28, 2011. Eligible practices in each market were invited to apply to participate and start delivering enhanced health care services in the fall of 2012. Practices were selected through a competitive application process. Across the nation there are 4 states (OR, CO, AR, NJ) and 3 regional areas in Oklahoma, Ohio and New York participating in the initiative. As of March 2015, there are 475 primary care practices participating in the national CPCi. Sixty-two of those practices are located in the Oklahoma (specifically in the Greater Tulsa region). Participating providers serve an estimated 340,506 Medicare beneficiaries across the nation, 47,435 of whom are located in Oklahoma.

CPCi practices deliver intensive care management for patients with serious or multiple medical conditions and high needs. Because health care needs and emergencies are not restricted to office operating hours, primary care practices must be accessible to patients at all times (24/7) and be able to use patient data tools to give real-time, personal health care information to patients in need. These practices actively engage patients and their families in their care. In addition, primary care doctors and nurses work collectively with a patient's other health care providers and the patient to make decisions as a team.

The MyHealth Access Network (a health information organization) provides support to all CPC practices, allowing clinical and administrative claims data to be pooled and analytics tools used to inform practices of their patients' health outcomes. Practices are also supported by a field service team comprised of employees from the payer community. This team helps the practice meet milestones, manage expectations and connect practices to share lessons learned. There are four face-to-face meetings every year to discuss challenges, opportunities and garner peer-to-peer support among practices.

Through the CPCi, OHCA shares development, implementation and operational advice on our Patient

1 Medicare is the federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD). See <https://www.medicare.gov/sign-up-change-plans/decide-how-to-get-medicare/whats-medicare/what-is-medicare.html> for more information about Medicare.

Centered Medical Home (PCMH) program with collaborators. It is hoped that other payers will embrace the PCMH principles and build very similar financial incentives for their contracted PCPs.

The nine CMS-prescribed milestones for 2015 are in effect. Practices are required to build upon milestones from the previous year. These milestones include:

1. reporting actual expenditures and revenue, as well as completion of an annual budget forecast projecting expenses associated with practice change
2. risk stratifying at least 75 percent of patients, provide care management to at least 80 percent of high-risk patients, maintain at least 95 percent empanelment to provider and care teams, and implement specific care management strategies aimed at behavioral health, self-management and/or medication management
3. attesting that patients continue to have access to 24-hour, 7 days a week access to service providers (using asynchronous forms) and medical records;
4. evaluating and improve patient experience (using surveys and advisory councils) and communicate practice changes, detailing changes that have occurred during each reporting period
5. reporting and reviewing the electronic health records (EHR) clinical quality measures and provide panel reports from them
6. engaging the medical community by tracking patients with emergency department (ER) visits, following up with those patients who are admitted to the hospital
7. implementing shared decision-making tools and measure the impact of those decisions on patients
8. participating in required learning collaborative opportunities and at least one advanced primary care action group
9. that all eligible professionals attesting to meaningful use upgrade EHR technology to 2014 Office of National Coordinator for Health Information Technology (ONC)<sup>30</sup> certification, and identifying elements capable of being shared through health information exchange (HIE).

Action plans include:

- continued collaboration with providers, payers and CMS as the pilot project gains experience;
- monitoring and reporting on overall performance of the initiative, including payments made, savings accumulated and improved health of patient populations;
- the widespread adoption of a single PCMH program where PCPs follow one set of principles surrounding financial incentives, regardless of the payer; and
- allowing and encouraging the PCP to focus on providing the best care possible, instead of the having to deal with various and sometimes conflicting payer guidelines surrounding PCMH or wellness program incentives.

## 6. Money Follows the Person – Tribal Initiative (MFP-TI)

The purpose of the Money Follows the Person (MFP) Tribal Initiative grant is to create a system that allows American Indian/Alaska Native (AI/AN) seniors to transition into culturally-appropriate community living. Tribal

partners benefiting from the grant will design a long-term care arrangement that will fit the cultural values of that tribe and will one day serve as a model for other tribal communities to follow for creating their own programs. It is hoped that this will lead to the development of many other partnerships between the state and the tribal community.

OHCA staff will use grant funding to assist tribal partners with their program design, utilizing the MFP/Living Choice infrastructure that is currently in place. The relationship that OHCA's Tribal Government Relations Unit has built with the state's tribal communities is crucial to the implementation of this initiative. Three staff persons were hired to work with the 39 tribes that reside in the state of Oklahoma to develop the groundwork needed to carry out the program. They also work to develop a data reporting process for the submission of monthly, quarterly and semi-annual reports to CMS. MFP-TI staff has visited 27 of Oklahoma's 39 tribal nations in order to share project information and gather support for participation in the initiative. At the time of writing, six (6) tribes have committed to participate in the MFP-TI. On July 16, 2015, MFP-TI staff led a statewide stakeholders meeting and needs assessment activity for tribes participating in Oklahoma's MFP-TI.

**Action Plan:** Based on information gathered from participating tribes during a July 16, 2015, MFP-TI stakeholder's meeting; MFP-TI staff will develop and submit to CMS:

7. A concept paper that outlines state-tribal partnership commitment agreement to pursue the initiative, and
8. A description of relevant tribal characteristics in the state, including a tribal needs assessment and population details

Phase One of the MFP-TI will end when the state and tribe/tribal organization (T/TO) receives approval from CMS.

Upon approval of the submitted concept paper from CMS, the MFP-TI project will move forward into Phase Two. Phase Two will include the development of an operational protocol for each participating tribe, to include a detailed timeline and description of project activities. MFP-TI staff will continue to assist and provide guidance to participating tribes during this time.

## 7. Adult Medicaid Quality Grant

In December 2012, OHCA received a two-year Adult Medicaid Quality grant through CMS. The total amount awarded was close to \$1 million for year one and an additional \$1 million for year two, which ended June 2015. The grant was used to increase OHCA's capacity for standardized data collection and reporting of data on the quality of health provided to adults receiving SoonerCare benefits. OHCA identified and worked on reports for 15 of the 26 Initial Core set of Adult Health Measures. These measures dealt with a variety of health care services ranging from tobacco use cessation and chlamydia screenings to diabetes care and asthma treatments.

Grant funds were also used to conduct two quality improvement projects (QIP) that were completed in June 2015. The QIPs respectively focused on improving the screening rate for cervical cancer and on improving diabetic care by increasing the performance of Hemoglobin A1c (HbA1c) testing. A number of outreach materials were developed as part of the QIPs, such as postcards, posters and toolkits. Nearly 74,000 postcards were sent to SoonerCare members to remind them of the importance of cervical cancer screenings and HbA1c testing. Also, posters in both English and Spanish were sent to providers to post in their offices to remind patients of the need for cervical cancer screenings and HbA1c testing. Lastly, we developed toolkits to educate providers on the Adult Medicaid Quality Grant (AMGQ) and electronic health records (EHR) systems.

The QIPs were successful in improving both the screening rates for cervical cancer screenings as well as the performance of Hemoglobin A1c (HbA1c) testing. Screening rates for cervical cancer screenings and HbA1c testing surpassed their expected increases of 3.5 percent (cervical cancer screening) and 5 percent (HbA1c test) over the two-year grant period.

Provider training to promote health screenings for patients in providers' offices was the primary focus for improving the 15 identified Initial Core set of Adult Health Measures. OHCA hired an electronic health records (EHR) specialist to educate providers about their EHR systems, their functionalities and capabilities. One hundred fourteen (114) providers participated in this initiative during the two-year grant period with varied increases in compliance rates for both cervical cancer and HbA1c screenings. Certain practices experienced increases of approximately 37 percent from their baseline compliance rate for HbA1c testing and increases of approximately 17 percent from their baseline compliance rate for cervical cancer Screenings.

Action plans include: OHCA continuing to report Adult Core Measures after the conclusion of the AMQ grant in November 2015. During the last three (3) months of the grant, OHCA AMQG staff will host small health fairs at various participating clinics that were identified as having a high number of SoonerCare members. We expect the events will continue to increase compliance rates for cervical cancer screenings and HbA1c testing in these practices.

## 8. State Innovation Model Grant Collaboration

OHCA is a participating partner in the Oklahoma State Innovation Model (OSIM) grant. The goal of the OSIM is to provide state-based solutions for Oklahoma's health care challenges and reduce health expenditures for more than 1.2 million Oklahomans. CMS awarded Oklahoma a Round Two Model Design Grant in December 2014, with an initiative start date of February 2, 2015. The Oklahoma State Department of Health (OSDH) is the grant administrator.

The model design plan Oklahoma proposes is comprehensive and relies upon multi-payer and healthcare delivery system innovation and redesign, while integrating evidence-based population and clinical interventions.

The plan is divided into three phases of work: Phase One seeks to achieve consensus among coalition stakeholders on the alignment of a socio-ecological model that includes clinical and population-based health measures for selected health topics (e.g., obesity, diabetes, hypertension and tobacco). In Phase Two, stakeholders will assess and determine what multi-payer; value-based purchasing model realistically achieves common priorities and goals. At the same time, in Phase Three, stakeholders will identify strategies to increase adoption of electronic health records (EHR) and attainment of meaningful use (MU) among providers; initiate planning for the development of a value-based analytics (VBA) tool for health care data analysis; determine benchmarks aimed at improving clinical and population health outcomes; and identify potential savings across multi-payer structures.

The OSIM grant hired a project manager and project coordinator to oversee grant activities. The state has begun executing development of the State Health System Innovation Plan (SHSIP), the final deliverable of the project. The OSIM initiative management team has set a targeted completion date for first quarter (1Q) 2016.

Action Plan: The OSIM process includes regular meetings with executive leadership, as well as a series of OSIM/OHIP workgroups that are each dedicated to a major task of the initiative. The OSIM team coordinates these meetings, as well as others across the state, to educate stakeholders about the OSIM project and ask for feedback on the plan. Many OHCA staff members sit on the leadership and workgroup teams. The OSIM initiative will continue to rely on their knowledge, expertise and contributions as the SHSIP is completed.

## 9. Member engagement strategies

### SoonerFit.org

Launched in 2014, the SoonerFit website ([www.soonerfit.org](http://www.soonerfit.org)) helps SoonerCare members, health care providers and all Oklahomans lead fit and healthy lifestyle in fun, affordable and easy ways. The website includes links to local farmers' markets that take SNAP (Supplemental Nutrition Assistance Program) benefits, tobacco cessation resources, healthy recipes, exercise routines, and more. In addition to the website, the SoonerFit Team implemented several interactive program components including "SoonerFit Summer" (which highlighted local outdoor events and activities around Oklahoma), the SoonerFit Art Contest for school-age children, and a social media "Commit to SoonerFit" campaign kicked off by State Senator AJ Griffin. There are plans to expand resources available on the website as well as partnerships with traditional and non-traditional entities around the state.

### Text messaging

During 2015, OHCA, the George Kaiser Family Foundation and Voxiva partnered to implement a two-year pilot study expanding the Text4baby program. This expansion includes mobile health messages for SoonerCare members ages 1 and older. This package, called Connect4health, encompasses three separate programs: Text4baby, Text4kids and Text4health. Connect4health mobile messages will be customized by OHCA staff and partners to promote specific preventive health benefits (including well-child visits), medication compliance, appropriate emergency room (ER) use, and SoonerCare application renewal reminders. OHCA plans to begin implementation of Connect4health in November 2015.

Eligible SoonerCare members will be enrolled into Connect4health through auto-notification via text message, which is the current methodology used by Text4baby. However, OHCA is working toward auto-enrollment, through which all eligible members will be automatically enrolled and have the option to opt-out of the program. Consent language will be added to the SoonerCare application authorizing OHCA to send mobile health messages to our members. The automatic enrollment process is scheduled to begin in spring 2016.

### Social Media

OHCA uses social media such as Facebook and Twitter to engage SoonerCare members. Currently, about 75 percent of Americans are on social media of which 52 percent are on multiple platforms. As of 2014, more than 50 percent of Americans over age 65 were on Facebook. OHCA sees potential in using social media to drive behavior change and improve health outcomes of SoonerCare members. As part of OHCA's developing digital communication strategy, the agency is employing tools such as tracking Google search trends to identify topics of interest to members, custom-tailoring promotional information to specific target audiences, and using conversion tracking to identify the success of social media campaigns.

Action plans include: developing an OHCA digital communication strategy, completing a redesign of the OHCA website in 2016, and developing an approach to centrally coordinate text messaging initiatives between different vendors.

## 10. Prenatal, pregnancy and early childhood initiatives

OHCA works in proud partnership with many external entities to promote access and appropriate use of health care for SoonerCare members, especially pregnant women and their unborn babies. These partners include key state agencies with similar interests in promoting health, state and local organizations, private and non-profit agencies and other groups that serve or come in contact with current or potential SoonerCare members. Collaboration is often a critical factor in establishing and maintaining successful initiatives. Partners can often provide support and additional resources necessary to conceive, develop, implement and promote OHCA initiatives and programs to benefit SoonerCare members.

The Office of Health Promotion and other OHCA units partner with organizations with the goal of reducing health risks and improving the health status of targeted groups. Below is a list of several collaborative activities including, Oklahoma State Department of Health (OSDH) projects and workgroups.

### Strong Start

Strong Start for Mothers and Newborns is a grant-funded initiative awarded by the Center for Medicare and Medicaid Services (CMS) Innovation Center to OHCA. Strong Start promotes three different models of prenatal care: Birth Center, Group Prenatal Care and Maternity Home. OHCA initially only participated in Group Prenatal Care but now offers either Group Prenatal or Maternity Home. Currently the program is offered in four clinical sites: Oklahoma City Indian Clinic, Mary Mahoney, Variety Care and Choctaw Nation.

Since the inception of the grant, 128 participants have delivered with 92 percent of them being full-term deliveries

Action plans include: OHCA staff continuing to monitor the initiative and provide objective analysis of outcomes at each site. OHCA will continue to seek additional community partners to increase the number of members participating in the program. The two-year clinical portion of the program ends in 2016. The following year will be devoted to data collection and the production of a final data report.

### Text4baby

Text4baby is the nation's largest and only free mobile messaging service for pregnant women and mothers with infants under age 1 that sends important health and safety information. Oklahoma is one of only four states where the Centers for Medicare and Medicaid Services (CMS) are supporting a project with Text4baby co-founders Voxiva, Inc. and Zero to Three. The pilot project began in August 2013; state-level implementation began January 1, 2014.

The pilot project is implementing innovative outreach and promotional efforts to achieve the following:

- Increased enrollment of pregnant SoonerCare recipients in Text4baby;
- Customized Text4baby content to include state-specific programs and resources; and
- An assessment of Text4baby's impact on improving health quality measures, including postpartum visits and smoking cessation during pregnancy.

In October 2014, OHCA became the first (and currently the only) state Medicaid agency to implement an automated process to notify and enroll pregnant women and new mothers covered by Medicaid into Text4baby. OHCA continues to collaborate with key partners to promote Text4baby to targeted audiences via media outlets such as radio, billboards, bus shelters, PSAs, newsletters, social media and more.

Action plans include:

- formulating customized messages to be used in Connect4health;
- identifying efficient ways to get SoonerCare members enrolled in Connect4health; and
- tracking the progress of the program.

### Infant Mortality Reduction

Through the Infant Mortality Reduction (IMR) program and Interconception Care Project, OHCA strives to improve SoonerCare coverage and health outcomes after delivery of the baby in targeted areas with high infant mortality. The project provides care management to pregnant women residing in 10 targeted counties and their infants through their first birthday. It further extends care management to teen mothers in these counties for 12 months after the birth of their babies.

OHCA continues to explore partnerships with the State Department of Health (OSDH) that offer resources and support to these members. OHCA recently extended IMR to three additional counties with high infant mortality: Marshall, Major and Grant. The program has recently completed a formal, independent evaluation. The results may include recommendations for program revision.

Action plans include:

- continuing to identify options to increase the number of counties served by the IMR program;
- continued program evaluation to further enhance the positive impact on birth outcomes and find ways to influence the health of targeted populations;
- including ongoing staff training in motivational interviewing, which helps to better engage members in changing unhealthy behaviors.

### Long -acting Reversible Contraception (LARC) Program

Long-acting reversible contraceptives (LARCs) are methods of birth control that provide effective, extended contraception without requiring patient compliance. LARCs include injections, intrauterine devices (IUDs) and subdermal implants. In addition to being long-lasting, convenient and well-liked by users, LARCs are very cost-effective. Typically, LARC users can save thousands of dollars over a five-year period compared to the use of condoms and birth control pills.

In September 2014, OHCA began compensating hospitals separately for LARCs when the procedure is performed after delivery and before the mother leaves the hospital.

OHCA recently announced a collaborative partnership that will be privately funded for two years. Under this partnership, OHCA will hire a program manager to coordinate all efforts of LARC in Oklahoma, with both OHCA and private payers.

Action plans include:

- continuing to promote awareness and education of the LARC program as well as monitor utilization and satisfaction;
- hiring a program manager for the new two-year LARC collaboration and
- implementing the new program across the state.

### Obstetrical Medical Home (OBMH)

The Obstetrical Medical Home (OBMH) program is currently in development and will include psychosocial support, care coordination and management, and health promotion (in addition to traditional prenatal care) and will be provided through a partnership between the patient and the provider. We plan for care coordination to be implemented face-to-face at identified clinical sites, by phone, or both. The OBMH initiative will include developing patient/practice partnerships, improving clinical care, utilizing care management, linking to community resources, development and measurement of quality metrics/performance improvements. Lastly, we plan to reform payment/reimbursement through incentive payments to providers who achieve certain metrics such as postpartum visits and contraception counseling performed. Case management intensity will be determined based on the medical and social needs of the expectant mother who is enrolled in the OBMH initiative. Women with higher-risk medical and/or social needs will receive more frequent interventions.

Action plans include continued development of the OBMH initiative and associated quality metrics, with implementation planned for late 2016.

## 11. Partner Grant Opportunities

Due to funding available for agency operations, grant opportunities are a great way to test new programs or services, improve processes or even evaluate current programs without placing additional financial burden on the agency.

When searching for potential grant opportunities, OHCA often finds grants that could benefit SoonerCare members, but the overarching aim of these grants are not a good fit with agency goals and programs. In order to make the most of these grant opportunities, OHCA will partner with another state agency or community organization. For some grants, OHCA may be a full and active partner, participating in the development and operation of the grant activity. For other grants, OHCA may simply supply a letter of support and share information. Whatever the scope of OHCA participation, these partnerships provide an effective way of improving processes, analyzing data and enhancing services for our SoonerCare population.

Embracing the spirit of collaboration, the agencies that OHCA has partnered with for grant opportunities are a diverse group of state agencies, private payors, universities and community organizations. Some of the partnership grants in which OHCA currently participates include: the Comprehensive Primary Care Initiative, the No Wrong Door (NWD) Long Term Services and Supports grant, the State Innovation Model and the Distance Learning and Telehealth grant.

Action plans include OHCA continuing to work closely with partner agencies and organizations, seeking new opportunities to collaborate on grant applications and activities in order to provide quality, efficient health care to our SoonerCare members and improve the health outcomes of all Oklahomans.

## 12. OSHD Joint Strategic Plan QI – Tobacco

Oklahoma ranks 48<sup>th</sup> in the nation in adult smoking rates<sup>39</sup>, with approximately 630,000 adults who are smokers. The Tobacco Workgroup, a joint quality initiative (QI) with the State Department of Health (OSDH), aims to reduce the tobacco smoking rate among Oklahomans by improving access to tobacco cessation products and services. This is to be achieved through data-driven assessment to inform system and policy recommendations related to best practices in tobacco treatment.

Action plans include:

- conducting a tobacco related data assessment, gap identification, and needs assessment;
- identifying gaps in data, policy and systems used to measure tobacco use and/or tobacco cessation services;
- developing requirements and recommendations for changes to OSDH EHR system;
- developing recommendations for policy changes for county health departments; and
- pursuing policy changes at OHCA to remove barriers to access to tobacco cessation products and services.

## 13. OSDH Joint Strategic Plan QI- Immunizations

According to America's health Rankings 2014 report, Oklahoma ranks 47<sup>th</sup> in the nation for the percentage of children up-to-date with their primary vaccines. Many times parents begin the immunization series on time but are unable to complete the shots. Neighboring states such as Texas (17) and Kansas (32) are doing much better at achieving their immunization goals. Oklahoma's low rates of immunization put our children at risk of preventable diseases. In response, OHCA and the State Department of Health (OSDH) have formed a joint workgroup to address interventions aimed at improving Oklahoma's childhood immunization rates.

The first initiative, in 2014, targeted increasing the percentage of completed 4:3:1:3:3:1 immunization series in children ages 19-35 months living in Bryan County. This shot series consists of: four (4) doses of DTaP, three (3) doses of polio, one (1) dose of MMR, three (3) doses of Hib, three (3) doses of HepB, and one (1) dose of varicella (commonly referred to as chickenpox). The successful initiative resulted in a 3.5 percent increase in this immunization rate.

Building off this success, the next phase of interventions is aimed at increasing the percentage of completed 4:3:1:3:3:1:4 immunization series, which adds four (4) doses of PCV. The target audience remains the same.

The Immunization Workgroup's efforts include provider outreach and education about missed opportunities, as well as communicating the importance of vaccines to parents through face-to-face visits. Educational materials developed specifically for the initiative highlight the importance of immunizations to parents and caretakers. Community partners have assisted in spreading the message, and news releases, social media messages and other public information has been distributed by both OHCA and OSDH.

Action plans include:

- continuing efforts in vaccine education/information and provider visits;
- tracking the success of outreach; and
- developing additional targeted interventions to increase the rates of immunizations in the specified region.

#### 14. OSDH Joint Strategic Plan QI-Childhood Obesity

Oklahoma ranks 45th in overall health in the nation, according to America's Health Rankings 2015 report. Oklahoma faces challenges such as a high rate of drug-related deaths, low immunization coverage among children, scarcity of primary care physicians (particularly in rural areas), obesity, smoking, cardiovascular deaths, and diabetes, among others. We must overcome these challenges if we want to improve the health of Oklahomans.

To address these obstacles, state leadership has developed the Oklahoma Health Improvement Plan (OHIP) to improve the physical, social and mental well-being of all Oklahomans through a high-functioning public health system. OHIP targets children's health improvement, tobacco use prevention and obesity reduction.

OHCA and the State Department of Health (OSDH) have developed joint strategies to address the state's challenges of prescription drug abuse, childhood immunizations, tobacco use, childhood obesity, and hypertension and diabetes. Toward this end, five workgroups have been created comprising subject matter experts from other agencies with each workgroup focusing on one specific area.

The Childhood Obesity workgroup has developed two (2) strategies for implementation:

Increase the utilization of nutritional services for SoonerCare members age 3-19 in Comanche County by July 2016. This involves identifying and partnering with current SoonerCare providers for participation in this Childhood Obesity QI Project, specifically to be a champion for referring members to nutritional counseling services paid for by SoonerCare/Medicaid.

Integrate childhood obesity prevention efforts into the early childhood education (ECE) setting within Comanche County by July 2016 in order to improve nutrition and physical activity opportunities for children, parents, and staff, increase knowledge and utilization of local resources, and build readiness to apply for Certified Healthy status. This involves utilizing childcare subsidy and SoonerCare childhood obesity data, in addition to Certified Healthy Oklahoma Early Childhood Program information, identify a subset of ECEs within Comanche County for a quality improvement project. Offer a baseline assessment to ECEs (e.g., Go NAP SACC, Certified Healthy Early Childhood Program application, etc.), followed by individualized technical assistance in order to improve current ECE obesity prevention efforts. This may include changing the nutrition profile, increasing physical activity, reducing screen time, etc. ECEs will once again take the assessment at the end of the project cycle. In addition to ECE intervention, a parent education component, including assessment of outreach materials pre and post-tests, will be integrated into this strategy. This parent outreach component will assess family lifestyle, perceptions, readiness, knowledge related to service availability, as well as provide information around childhood obesity prevention, including resources and linkage to nutritional services and opportunities for physical activity.

Action plans include: Lawton Community Health Center (LCHC) referring SoonerCare members for nutritional counseling services to registered dieticians at Comanche County Health Department (CCHD). Referred SoonerCare members will also be offered services for in-home nutritional counseling with the OSU extension program in Comanche County. Group will pull data on the number of referrals made and services utilized for SFY2015 (before project starts), at six month mark, and in June at the end of SFY 2016 to review and analyze any increase in utilization of nutritional services.

Additionally, staff from the OSDH, Center for the Advancement of Wellness (CAW), will work with the CCHD to make contact with ECEs in Comanche County with a high rate of children receiving DHS childcare subsidies. These centers will be targeted with advanced technical assistance from CAW staff for both the Certified Healthy Program and CDC project, GO NAPP SAC to promote healthy policies related to nutrition, screen time, and physical activity. Parents of children at these centers will be provided with informational packets for community resources related to physical activity, nutrition, and information regarding the availability of nutritional counseling through SoonerCare. The group will track the number of centers who apply for Certified Healthy as well as those that improve their certification level from last year. A survey will also be provided to parents receiving the educational materials to gauge how useful they found the information.

#### 15. OSDH Joint Strategic Plan QI-Prescription Drugs

Prescription drug abuse is a major cause of drug related deaths in Oklahoma, especially in regard to opiate painkillers, or opioids. Building on activities from the previous year, the OSDH Joint Strategic Plan Workgroup is using data to identify prescribers who are associated with prescriptions of SoonerCare members who died due to prescription drugs as noted in the Unintentional Poisoning Database. The workgroup then designed education, outreach, and other appropriate interventions for these providers. The three levels of interventions include: provider letters, onsite visits and referral to OHCA Quality Assurance division or appropriate governing boards. The workgroup is also working to increase opioid overdose education in Oklahoma, including the use of naloxone, through provider and pharmacist training.

Action plans include:

Completing data matching for 2015 and identifying providers who need intervention;

Sending out provider letters, making in-office visits, and referring prescribers to appropriate boards when necessary; and developing and tracking education efforts for naloxone and other overdose education outreach methods.

#### 16. OSDH Joint Strategic Plan QI-Diabetes/Hypertension

As recent as 2014, Oklahoma had the 4<sup>th</sup> highest rate of deaths attributed to diabetes-related complications, with 1 in 3 Oklahomans having Type 2 diabetes or being prediabetic. Likewise, hypertension afflicts nearly 1 in 3 Americans, with Oklahoma ranking 42<sup>nd</sup> in the nation in prevalence.

During 2015, the OSDH/OHCA diabetes/hypertension quality improvement workgroup is developing an intervention promoting referrals to a chronic disease self-management education program in a pilot county with a high prevalence of diabetes and hypertension. Through a collaborative relationship with the TMF Quality Innovation Network, the workgroup aims to assess the effectiveness of utilizing multiple referral points and community resources to connect individuals to a series of six weekly diabetes self-management education classes. The intervention utilizes the TMF Quality Innovation Network's "Everyone with Diabetes Counts" initiative and the Diabetes Empowerment Education Program (DEEP) classes TMF is implementing

in Oklahoma. TMF is the regional Medicare Quality Innovation Network-Quality Improvement Organization, under contract with CMS through 2019 to implement the “Everyone with Diabetes Counts” initiative and DEEP.

The DEEP was developed to provide community residents with the tools to better manage their diabetes in order to reduce complications and lead healthier, longer lives based on principles of empowerment and education. The main goals of DEEP are: to improve and maintain the quality of life of persons with diabetes or persons who have diabetes risk factors, to prevent complications and incapacities, to improve eating habits and maintain adequate nutrition, to increase physical activity, to develop self-care skills, to improve the relationship between patients and health care providers and to utilize the available resources.

Action plans include: By June 30, 2016 the workgroup aims to promote provider and community referrals to at least six separate series of self-management education classes in Bryan County. During this pilot, the workgroup will be identifying ways to monitor diabetes and hypertension quality improvement measures of SoonerCare members completing the DEEP classes.

## 17. Central Portfolio and Project Management Office

OHCA recognizes that effective portfolio and project management processes contribute to the success and control of our implementation of projects. Our goal is to ensure efficiency and eliminate duplication, and to improve communication and awareness of agency projects. We have developed an overarching, coordinated project management approach and tools which OHCA is using to manage our project portfolio and the individual projects within it. The OHCA Division of Strategic Planning and Reform is now operating as the agency’s portfolio and project management office (PMO).

The new project management approach and tools were implemented in July 2015. Near-term benefits that the agency will derive include the development of S.M.A.R.T. (Specific, Measurable, Achievable, Realistic and Time-Bound) objectives, alignment with OHCA goals, Statewide goals, and Oklahoma Health Improvement Plan (OHIP) goals, and use of formalized monitoring tools to track not only project progress but project performance and return on investment.

As OHCA progresses through the year, we anticipate management and staff suggestions that will assist in optimizing the new standards and tools to ensure the highest level of efficiency and effectiveness. We have incorporated the process of asking for, receiving, and implementing these suggestions, into our project lifecycle. This is part of our long-term PMO implementation plan for SFY 2016.

In SFY 2016, OHCA plans to implement the “Single Intake Form,” a tool for staff across the agency to submit their request for a new project, policy, system enhancement, or other type of SoonerCare program-related change. The goals of the form include increased transparency across the agency, improved communication regarding projects, and streamlined processing of requests.

OHCA plans to investigate and implement enhancements to tools used for the Portfolio and Project Management Office. These tools will provide tighter integration between the portfolio and project sites, as well as custom software used by our Policy and Medical/Professional divisions.

We are also looking at ways to increase the level of project management knowledge for key staff across the agency. Some basic project management training was provided as part of our PMO implementation in SFY 2015, but more is needed to improve project performance. To that end, an over-arching project management training program will be developed and implemented during SFY 2016.

Action plans include: Project alignment with agency, statewide, and OHIP goals; Project Planning and Performance Monitoring with respect to SMART Objectives; PMO standards and tools optimization; Single Intake Form; PMO integration; and Project Management Training.

## 18. Quality Measures

Quality measures seek to measure the degree to which evidence-based treatment guidelines are followed, where indicated and assess the results of care. The use of quality measurement helps strengthen accountability and support performance improvement initiatives at numerous levels. These measures can be used to demonstrate a variety of activities and health care outcomes for particular populations.<sup>31</sup> (i.e. Children’s Health Insurance Program [CHIP] enrollees).

The Oklahoma Health Care Authority (OHCA) is required to measure and report results annually on the quality of care provided to individuals enrolled in SoonerCare. This includes measures that are required or suggested by the Centers for Medicare and Medicaid Services (CMS). The OHCA also reports results to various stakeholders for additional measures selected from the Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®).

The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America’s health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 81 measures across 5 domains of care. Because so many plans collect HEDIS data, and because the measures are so specifically defined, HEDIS makes it possible to compare the performance of health plans on an “apples-to-apples” basis<sup>32</sup>.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services<sup>33</sup>.

### Core Set/ Quality Report<sup>34</sup>

The Center for Medicaid and CHIP Services (CMCS) has worked with stakeholders to identify two core sets of health care quality measures that can be used to assess the quality of health care provided to children and adults enrolled in Medicaid and CHIP. The core sets are tools states can use to monitor and improve the quality of health care provided to Medicaid and CHIP enrollees. The goals of this effort are to: encourage national reporting by states on a uniform set of measures, and support states in using these measures to drive quality improvement.

The OHCA strives to be as transparent in its operations as possible. The agency’s “Fast Facts” reports present data every month on a variety of programs and areas around the agency. Fast Facts include statistical data using

graphics and explanatory notes. Areas covered include: Enrollment, Insure Oklahoma, Provider and Services and data related to specific chronic diseases. The agency has recently also begun to present interactive data dashboards as a way for stakeholders to find the data they need.

Action plans include: Developing a crosswalk to relate measures to programs and statewide goals; Looking at optional core set and other chronic measures for future development and tracking; Releasing condition specific, targeted quality measures.

## 19. Hospital Presumptive Eligibility

The Affordable Care Act mandates that qualified hospitals that participate in their state's Medicaid program be given the opportunity to determine presumptive eligibility (PE) for certain Medicaid-eligible populations. Hospitals that participate in the PE program must agree to comply with state and federal regulations, policies, and procedures; and they must meet OHCA's performance measurements.

Although in Oklahoma, hospitals are able to make real-time eligibility determinations through OHCA's innovative online enrollment program. Hospitals may use HPE to manually enroll individuals into Medicaid. A patient will fill out a HPE paper application that includes some basic information about his or her individual or family income and household size. If the patient or family appears likely to be eligible for Medicaid using eligibility guidelines set forth by OHCA, a hospital can determine that individual or family to be "presumptively eligible" for Medicaid. The hospital will get paid for the services provided, even if the patient will not have been determined eligible through OHCA's real-time eligibility online enrollment system.

OHCA has created performance metrics that will be used to judge hospitals' accuracy in granting PE and following PE policy. Hospitals that fail to meet the metrics or state or federal regulations will be put on a corrective action plan, and if they fail to improve their performance or abide by HPE rules, failing hospitals will be dismissed from the HPE program.

OHCA is currently planning on offering Oklahoma hospitals the option to begin the process of becoming a HPE entity in September 2015. OHCA has completed the metrics for the program, and has drafted processes that will identify how hospitals will be trained, how applications will be submitted and how hospitals will be paid.

Action plans include notifying hospitals of the availability of HPE in October, initiating paperwork process to allow Hospital to do HPE, conducting training at OHCA in November, allowing hospital staff that pass training to begin HPE determinations, and collecting data on how HPE is working to gauge metric and program performance.

## 20. After-hours locator and member education

In 2015, OHCA developed a new after-hours provider locator. The mobile-friendly website, [www.afterhoursok.com](http://www.afterhoursok.com), is searchable by zip code, age and a location radius of 2 to 50 miles. The purpose of the mobile-friendly website is to connect SoonerCare members seeking after-hours acute care with available SoonerCare providers. The search results list the provider's office hours and a phone number, allowing members to locate and contact providers that are open outside the conventional office hours of 8 a.m. to 5 p.m.

In addition to creating the mobile-friendly website, OHCA promoted the availability of the tool to locate provider access after regular business hours through social media, print materials, and advertisements in the member newsletter and handbook.

Action plans includes the development of an Urgent Care Center provider type that is able to provide additional services not readily available at individual providers (e.g. sutures, x-ray, lab, etc); development of Urgent Care Center reimbursement rates above those of individual providers yet below the rates of ER's; and development of incentive payments for providers who agree to provide after-hours access outside regular office hours. OHCA also plans to promote the after-hours locator in ER outreach letters to those members that frequent the ER often and OHCA is exploring ways to send text messages to members following an ER visit for acute care.

## 21. OHCA Organizational Culture Development

With the purpose of supporting a strategy framework for organizational culture development, a cultural survey was distributed to all OHCA staff to ascertain identifiable aspects of the current OHCA culture, perceptions of collaboration within the agency and overall job satisfaction. Once organizational values are established, these surveys offer a method of illuminating areas within the culture that can be improved upon.

Further supporting these efforts are 360 evaluations, which are currently being considered. Still in its early development, these allow employees to be evaluated by peers and subordinates, as well as supervisors and enable workers to receive feedback regarding job performance that they may not otherwise have access to.

The final leg of this process is the 'make a space a place' initiative, which focuses on building a community work environment that promotes multiple enrichment opportunities. The goal is to transform the work space into a place employees want to be. An example of this concept at work is the puzzle stations placed in various locations around the agency.

Action Plan: The culture survey will be repeated annually for five years. A workgroup has been established for the 360 evaluation. Research is being conducted in order to consider all options of delivery. Potential 'make a space a place' locations are being considered and ideas are currently in development.

## 22. OHCA Opioid and Prescription Drug Initiatives

Prescription abuse is a problem both nationwide and in Oklahoma. From 2012-2013, there were 1,075 unintentional prescription drug overdose deaths in Oklahoma, and 36 percent of those people were SoonerCare members. According to the Centers for Disease Control and Prevention, Oklahoma is the 6th highest state for drug overdose deaths in the U.S.

OHCA is involved in many programs and activities that will combat the overuse and abuse of prescription drugs among its members. In order to track and monitor these programs, OHCA created a Drug Abuse Workgroup Steering committee that meets quarterly to review OCHA activities regarding prescription drugs. This steering committee consists of unit and division leads as well as executive staff members. A smaller workgroup operates beneath the steering committee. Led by Dr. Mike Herndon, this workgroup tracks the progress of all agency activities and has developed an action plan that includes all activities, project leads, timelines, recommendations, and follow-up items.

The OHCA Prescription Drug Workgroup is currently tracking the following activities:

**Pain Management Program:** The SoonerCare Pain Management Program is a program designed to equip SoonerCare providers with the knowledge and skills to appropriately treat members with chronic pain. To accomplish this, OHCA has developed a proper prescribing toolkit. Two practice facilitators will be delegated to implement the components of the toolkit within selected SoonerCare practices. Additionally, two behavioral health resource specialists will be dedicated to assist providers with linking members with substance use disorder, or other behavioral health needs, to the appropriate treatment.

OHCA is identifying prescribers through several methods, including incorporating OB/GYN high prescribers, using OSDH death match data and the QI workgroup to find prescribers with high number of patient fatalities, and through targeted data analysis

**Lock-In Review:** OHCA's pharmacy lock-in program currently has over 400 members locked in to one pharmacy and one prescriber. OHCA is implementing a Level 2 Lock-In program that will review the activities of those that do not follow lock-in guidelines.

Action plans include continuing to review and develop OHCA programs that deal with prescription drug abuse, implementing the SoonerCare Pain Management Program and tracking its progress, continuing to work with the QI Prescription Drug Abuse workgroup to implement its interventions, and finalizing the Level 2 program for the Pharmacy Lock-in.

## 23. Hospital Readmissions Initiative

There is growing interest in readmissions as a quality of care indicator, as deficiencies in clinical care or coordination of service may contribute to excess readmissions. One challenge of evaluating and comparing facilities using readmissions as a metric is distinguishing readmissions that are preventable from those that are unavoidable. A solution that has been implemented in other states—including Texas, Illinois, and Florida—is 3M's Potentially Preventable Readmissions (PPR) software that uses administrative claims data to determine whether a hospital admission is potentially preventable. OHCA's ultimate goal is to reduce the rate of preventable admissions. One approach to achieving this goal is payment reduction for those facilities that have higher than expected PPR rates after adjusting for the types of diagnoses, severity of illness, age groups and mental health comorbidities seen at individual facilities.

OHCA collects data from all inpatient admissions, but some admissions are excluded from the analysis by the 3M software. Global exclusions include admissions related to HIV or eye care, admissions where the patient left against medical advice, most malignancy and neonatal admissions and non-events such as transfers between acute care facilities or admission to non-acute care facilities. Admissions with behavioral health-related DRGs are included.

OHCA has chosen to focus on 30-day readmissions, which means a maximum of 30 days can elapse between the discharge date of an admission and the admitting date of a readmission. If the 3M PPR algorithm determines that a readmission is clinically related to a prior admission, it is considered a PPR. The prior hospitalization that is clinically related to the PPR is called an Initial Admission (IA). An initial admission is the start of a PPR chain that includes at least one PPR; more than one PPR can be attributed to a single initial admission. In other words, the number of initial admissions equals the number of PPR chains. A hospitalization that is not clinically related to a prior or subsequent admission within a 30-day period is considered an Only Admission (OA). Initial Admissions and Only Admissions combined are Qualifying Admissions (QA), which are used in calculating PPR rates.

The key component of the 3M PPR assignment is the proprietary algorithm that determines whether admissions are clinically related. 3M considers readmissions to be potentially preventable in the following cases:

- Medical readmission for a continuation or recurrence of the reason for the IA, or for a condition closely related to the reason for the IA
- Ambulatory care sensitive conditions as designated by the Agency for Healthcare Research and Quality (AHRQ)
- All other readmissions for a chronic problem that may be related to care either during or after the IA
- Medical readmission for an acute medical condition or complication that may be related to or may have resulted from care during the IA or in the post-discharge period after the IA
- Readmission for a surgical procedure to address a continuation or a recurrence of the problem causing the IA
- Readmission for a surgical procedure to address a complication that may be related to or may have resulted from care during the IA
- Readmission for mental health or substance abuse reasons

Each admission is assigned to one of 314 All Patient Refined Diagnosis Related Groups (APR DRGs) according to the reason for admission. Each admission is also assigned to one of four severity of illness (SOI) levels based on both comorbidities and severity of the underlying illness. A statewide average PPR rate for each APR DRG-SOI combination is defined by the ratio of IA/QA for that APR DRG-SOI. APR DRG-SOI combinations with less than five QA across the state are excluded from the analysis.

The 3M software also identifies admissions with secondary diagnoses of major mental health conditions. It is well-established that individuals with mental health comorbidities are more likely to be readmitted. Therefore, the 3M output can be used to calculate a PPR adjustment factor to account for the presence or absence of mental health comorbidities when determining the number of expected PPRs for a facility. Likewise, an age group adjustment factor is applied to account for the fact that pediatric patients are less likely to be readmitted than adults.

The 3M software classifies each admission within a specific facility as an IA, OA, readmission, or excluded admission. Each admission is also assigned to an APR DRG-SOI. For each APR DRG-SOI observed within each hospital's data set, the expected number of PPR chains is calculated by multiplying the statewide average PPR rate for that APR DRG-SOI by the number of QA for that APR DRG-SOI. That expected value is also multiplied by the adjustment factor for the appropriate age group and mental health status.

Some states set a “target” PPR rate that is different from the statewide average PPR rate. At this time, OHCA has chosen a target rate of 100 percent, so the target rate is equal to the statewide average rate for each APR DRG-SOI. If a higher or lower target were chosen, the expected value described above would also be multiplied by the target percentage.

The expected number of PPR chains for the hospital is the sum of the expected number of PPR chains across all APR DRG-SOI. If a hospital has a higher number of actual PPR chains than would be expected based on the statewide average, then the number exceeding the expectation are considered excess PPR chains and are subject to payment reduction. The payment reduction is equal to the number of excess PPR chains multiplied by the average reimbursement for PPRs clinically related to initial admissions originating at that facility.

To be included in the reporting process, a hospital must have at least 40 qualifying admissions, five actual PPR chains, and five expected PPR chains. At this time, only facilities that are paid on a DRG basis are subject to payment reduction.

Action plans include provide facility-specific reports for calendar year 2013 as soon as possible. Reports for calendar year 2014 will be provided in the fourth quarter of state fiscal year (SFY) 2015. Calendar year 2015 will be the first evaluation year. Analysis of calendar year 2015 data will occur in the fourth quarter of SFY 2016. Any hospital that has an actual PPR rate above their target rate for PPRs occurring in calendar year 2015, will be subject to a payment reduction in the fourth quarter of SFY 2016. Additionally, OHCA will process the payment reduction through a lump sum recoupment process.

## 24. Expand PACE Sites

The Program of All-inclusive Care for the Elderly (PACE) is a managed care model of acute and long-term care in Oklahoma and it is centered on the belief that it is better for the well-being of seniors with chronic care needs and their families to be served in the community whenever possible. It integrates the provision and financing of medical and long-term care services.

The first PACE Center opened in August 2008. It is Cherokee Elder Care in Tahlequah. In January of 2015, two more PACE centers became active. They are Life PACE in Tulsa and Valir PACE in Oklahoma City. The goal is to maximize the participant’s autonomy and ability to reside in their community while receiving quality care at lower cost relative to the Medicare, Medicaid and private-pay traditional payment systems.

Action Plan: OHCA’s website has been updated to reflect program goals, mission and contact information. A generic brochure has been created as a handout for individuals and providers. OHCA is also looking at marketing to other places throughout the state for the possibility of opening more centers.

## 25. Family Expectations & Outreach

Family Expectations is a project that was initiated by Family Expectations in collaboration with OHCA, in an effort to help connect families who are eligible for the Family Expectations program with an evidence-based program that strives to promote a healthy, stable relationship between parents who are expecting or have a newborn. In this initiative, OHCA, Automated Mailing Services (AMS) & Family Expectations entered into a three-way agreement to allow for OHCA to protect our members’ identity while making them aware of a

community resource through a mailer paid for by Family Expectations. OHCA's role is to provide a monthly list to AMS by the 15th of each month of newly enrolled pregnant women in the zip codes identified by Family Expectations as being their service area.

Family Expectation's role is to develop and provide a mailer to AMS to promote their program designed to keep families intact and to help connect them with resources and a support system.

AMS mails the promotional flier to our members and bills Family Expectations for mailing costs.

OHCA will not provide any Personal Health Information (PHI) to Family Expectations. There will not be any monetary exchange between OHCA and either entity. Family Expectations is financially responsible for both the printing of the mailers and the postage.

Action Plan: This project started in May 2015 and Family Expectations received OHCA's most recent batch of addresses on July 15th, the 1st report encompassing the 1st two months of work has also been submitted by Family Expectations. Quarterly reports will follow beginning in October to reflect the July-September 2015 quarter.

## Assumptions

- Goal 1: Effective November 25, 2015 (FFY2016), Oklahoma's federal medical assistance percentage (FMAP) decreased to the lowest percentage on record to date at 59.94 percent.<sup>1</sup> The financial impact on OHCA was significant. Since Oklahoma is statutorily required to maintain a balanced budget, the OHCA examined measures to stay within budgetary constraints. OHCA will determine the best way to deal with these types of financial issues as they arise while continuing to maintain a balanced budget.

**Source:** 1. Federal Medical Assistance Percentages or Federal Financial Participation in State Assistance Expenditures FMAP, FFY2016, <http://aspe.hhs.gov/health/fmap.cfm>

- Goal 1: The State's per capita personal income is trending up; 93.52 percent of the national average for 2014, 93.36 for 2013, and 92.88 for 2012.<sup>2</sup> As a result of this trend, the FMAP has been reduced. If the upward trend continues, FMAP may be reduced in future years resulting in a lower federal match and the need for more state dollars. Rising personal income is a positive for Oklahoma's economy, but the trade-off is a reduction in FMAP.

**Source:** 2. Bureau of Economic Analysis (State BEARFACTS), 2014, 2013, 2012, and SA30. <http://www.bea.gov/regional/bearfacts/action.cfm>

- Goal 5: OHCA completed an analysis of 19 counties where the conditions of high SoonerCare enrollment and high unemployment rates existed.<sup>3</sup> It was determined that there were certain industries with a high percentage of county employment, paying wages well below the state average.<sup>4</sup> The assumption is that SoonerCare enrollment will continue to be high in these identified areas and other locations in the state as low-wage jobs are held by 31.9 percent of Oklahomans while the national rate is 21 percent.<sup>5</sup>

**Sources:** 3. Counties and industries in the OHCA analysis included: Adair County, Manufacturing; McCurtain County, Health Care and Social Assistance; Choctaw County, Health Care and Social Assistance; Harmon County, Retail Trade & Public Administration; Sequoyah County, Health Care and Social Assistance; Pushmataha County, Manufacturing & Retail Trade & Health Care and Social Assistance; Marshall County, Wholesale Trade & Public Administration; Okfuskee County, Health Care and Social Assistance & Public Administration; Tillman County, Health Care and Social Assistance & Public Administration; and Mayes County, Health Care and Social Assistance. 4. OHCA used the following sources to gather county economic, Medicaid, and employment data: Oklahoma Quarterly Census of Employment and Wages (QCEW) 2012, November 2013,

[https://www.ok.gov/oesc\\_web/Services/Find\\_Labor\\_Market\\_Statistics/QCEW/](https://www.ok.gov/oesc_web/Services/Find_Labor_Market_Statistics/QCEW/);

SHADAC Oklahoma County Chart Packs, 2008-2012,

[http://www.shadac.org/files/shadac/publications/aff\\_2701\\_OKcounties\\_5yr\\_2008\\_2012.pdf](http://www.shadac.org/files/shadac/publications/aff_2701_OKcounties_5yr_2008_2012.pdf); Oklahoma Policy Institute,

<http://www.countyhealthrankings.org/app/#!/oklahoma/2013/overview>;

U.S. Census Bureau, 2008-2012 American Community Survey,

[http://factfinder2.census.gov/faces/nav/jsf/pages/community\\_facts.xhtml](http://factfinder2.census.gov/faces/nav/jsf/pages/community_facts.xhtml);

Oklahoma Employment Security Commission,

[https://www.ok.gov/oesc\\_web/Services/Find\\_Labor\\_Market\\_Statistics/](https://www.ok.gov/oesc_web/Services/Find_Labor_Market_Statistics/); and

Oklahoma Health Care Authority, Monthly Fast Facts,

<http://www.okhca.org/research.aspx?id=46&parts=7447>.

5. Bureau of Labor and Statistics, 2014, and Occupational Employment Statistics.

- Goal 5: Fewer people are participating in the workforce; Oklahoma's rate is 62.8 percent, however the unemployment rate has decreased from 4.8 percent in February of 2014 to 4.3 percent as of May 2015.<sup>6</sup> The statewide economic indicators tend to suggest in the short term there may be little to no change in the amount of people relying on SoonerCare. When the state's economy has trouble in these areas, though, it generally equates to people relying on SoonerCare. This may be affected by the youth unemployment rate which is currently at 14.5 percent.<sup>7</sup>

**Source:** 6. Bureau of Labor and Statistics, Current Population Survey, May 2015, <http://www.bls.gov/lau/ststdsadata.txt> 7. Bureau of Labor and Statistics, Current Population Survey, March 2015.

- Goal 5: The income poverty level (under 100 percent FPL) for Oklahoma is 16.9 percent when compared to 15.4 nationally.<sup>8</sup> For the state, a higher amount of individuals affected by low income rates make it difficult for families to get by, struggling to provide needed necessities, including health care. Based on this information, it is anticipated that this condition will result in higher enrollment as Oklahomans depend on SoonerCare for health care needs.

**Source:** 8. American Community Survey, 2013, [http://factfinder.census.gov/faces/nav/jsf/pages/community\\_facts.xhtml](http://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml)

- Goal 1: All health spending in the United States is projected to grow at an annual average rate of 5.8 percent for the period 2012 through 2022.<sup>9</sup> SoonerCare total expenditures increased by 3.7 percent from SFY2013 to SFY2014. It will be important for OHCA to continue to keep the average cost per SoonerCare member from inflating.

**Source:** 9. Health Affairs Blog, "National Health Expenditure Projections, 2012-22: Slow Growth Until Coverage Expands and Economy Improves," <http://content.healthaffairs.org/gca?gca=healthaff%3B32%2F10%2F1820&allch=&submit=Go>.

- Goal 2: The SoonerCare average cost per member per month has remained relatively low from SFY2012-15. The success in containing per member costs is the result of innovation in benefits coverage and reimbursement and state-of-the-art service delivery, while maintaining priority in the purchase of high quality, effective care and treatment.
- Goal 5: Oklahoma's uninsured rate for 2013 is estimated to be around 18 percent; the national rate is 14.9 percent.<sup>11</sup> While, both rates have remained relatively stable from last year, a high uninsured rate might result in a higher number of Oklahoma citizens applying for and being found eligible for SoonerCare benefits.

**Source:** 11. U.S. Census Bureau, American Community Survey, 2013.

<http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF>

- Goal 1: In order for OHCA to continue to draw federal dollars, it is critical that OHCA comply with CMS rules. Providing oversight of Medicaid programs, CMS, continues to require frequent and sometimes unanticipated changes to OHCA programs. The changes come as federal officials themselves continue to learn the complexities of the overall health market. This often results in the high probability of rework and decreased efficiencies. At times, when faced with CMS regulatory changes, state executive leadership is at odds with federal direction. To OHCA, this means a balance must be struck between the use of federal funds while working to achieve a vision for the state as a whole. The agency must manage multiple, competing priorities to ensure compliance with federal regulations and continued federal financial participation.
- Goal 6: Many times the changes CMS prescribes to states involves eligibility levels. The ACA required significant eligibility changes to the Insure Oklahoma and SoonerCare programs. To implement these changes, the OHCA expended considerable resources that otherwise could have been devoted to agency goals. The OHCA must manage multiple competing priorities to ensure compliance with federal regulations and continued federal financial participation.
- Goal 2: OHCA recognized the widespread support for the Insure Oklahoma program. Federal authority for another one-year extension has been received through continued negotiations with CMS; this will allow IO to operate through December 31, 2016. The continuance of this program is considered an effective solution to the health care needs of thousands of low-income Oklahomans.
- Goal 3: The uninsured live with the knowledge that they may not be able to afford to pay for their family's medical care, which can cause anxiety and potentially lead them to delay or forgo care. About 61 percent of the uninsured said the main reason they were uninsured was due to high cost or loss of a job; most are in low-income working families (i.e. 6 in 10) with family incomes below 200 percent of poverty.<sup>12</sup> Due to Oklahoma's high uninsured rate, our overall health status falls well below that of other states. By the time a major illness is found, and the individual enrolls in SoonerCare, the costs could be higher than if preventive services were utilized. Many SoonerCare enrollees have not previously had health insurance coverage. Their access to preventive care has been limited and in some cases health conditions and chronic diseases have gone untreated.

**Source:** 12. Kaiser Family Foundation, October 2014, (Figure 6), "Key Facts about the Uninsured Population," <http://files.kff.org/attachment/key-facts-about-the-uninsured-population-fact-sheet>

- Goal 4: Because SoonerCare covers approximately 62 percent of the births in Oklahoma, it continues to be of utmost importance to promote early outreach to pregnant women. In calendar year 2013, SoonerCare deliveries were 32,841 of the 53,351 overall state births (Oklahoma State Department of Health final figures accessed 9/4/14).<sup>13</sup> It is known that women who deliver at full term tend to have healthier babies and the costs associated with term births are much lower. Outreach to pregnant women is of paramount importance to OHCA; assistance offered by Population Care Management is an advantageous method of helping with access to quality care and education of pregnancy-related issues while promoting and maximizing the health of moms and babies - promoting a lifetime of good health.

**Source:** 13. Oklahoma Health Care Authority, SoonerCare Delivery Fast Facts, SFY 2014

- Goal 3: Teen pregnancy rates continue to be high and according to the National Center for Health Statistics, Oklahoma ranks 3<sup>rd</sup> in the nation for birth rates to teen females between the ages of 15-19.<sup>14</sup> Teen mothers have greater challenges: completion of high school, completion of college, and holding valuable, well-paying employment that keeps them above the Federal Poverty Level and above entitlement program thresholds. Thirty percent of all teen girls who have dropped out of high school cite pregnancy or parenthood as a

key reason.<sup>15</sup> As a result, OHCA identified this population for targeted outreach in 10 Oklahoma counties; actively engaging teen moms during their pregnancy and 1-year post-partum.<sup>16</sup> Issues such as health care coordination, reproductive life planning and life goal setting are all areas of focus. OHCA seeks to decrease the number of subsequent pregnancies for teen moms with the overall result of decreasing the number of Oklahomans relying on entitlement programs.

**Sources:** 14. Centers for Disease Control and Prevention, National Vital Statistics Report, (Volume 64, number 1), [http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64\\_01.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_01.pdf).

15. Shuger, L., “Teen Pregnancy and High School Dropout: What Communities Can Do to Address These Issues. Washington, DC: The National Campaign to Prevent Teen and Unplanned Pregnancy and America’s Promise Alliance,” 2012. 16. Targeted outreach in the following 10 counties: Atoka, Choctaw, Coal, Garfield, Greer, Jackson, Latimer, Lincoln, McIntosh, and Tillman.

- Goal 4: Historically, C-section rates have continued to steadily and consistently increase without a corresponding improvement in maternal or neonatal outcomes. It is known that women, who deliver without surgical intervention, when not medically indicated, tend to have babies with better outcomes and lower costs. OHCA, in partnership with the Oklahoma State Department of Health, sought to support the most appropriate treatment for mom and baby during the delivery, with consideration of associated risks and benefits, for both short and long term by establishing a primary C-section rate of less than 18 percent. The SoonerCare primary C-section rate was lowered in SFY2014 to 17.6 percent from 19.5 percent in 2011. OHCA seeks to decrease non-medically indicated C-section deliveries in an effort to improve the outcome of deliveries for both newborns and mothers.
- Goal 3: The state has experienced rising numbers of students failing to receive high school diplomas. Because they did not complete high school or earn certifications in other skilled trades, they are unable to secure jobs leading to greater earning capacities. These degrees/certifications correspond to the market’s demand for matching skills and abilities. Average wages for occupations requiring skills and/or education are significantly more than 300 percent of the federal poverty rate. According to the Bureau of Labor Statistics, entry-level, skilled trades such as electricians earn a median annual salary of \$49,840.<sup>17</sup> When Oklahomans earn more income, their reliance on entitlement programs decreases.

**Source:** 17. United States Department of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook, 2014, <http://www.bls.gov/ooh/construction-and-extraction/home.htm>.

- Goal 2: “Oklahoma Cares” is Oklahoma’s Breast and Cervical Cancer Treatment Program. In SFY15, 959 unduplicated women qualified for this program, due to their abnormal cancer screening, which otherwise likely would have been uninsured.<sup>18</sup> The program provides payment for services that would have been the primary responsibility of the patient and provides support through a Nurse Case Manager. The Oklahoma Cares program coordinates care and provides appropriate treatment to those who otherwise likely would not have the means or resources to pay for these services.

**Source:** 18. Oklahoma Health Care Authority, Oklahoma Cares Fast Facts, June 2015.

- Goal 2: OHCA recognizes that Fetal and Infant Mortality Review (FIMR) is an important issue in Oklahoma. Women who deliver at full term tend to have healthier babies and the costs associated with term births are much lower. The OHCA intervenes early in the ten counties with the poorest infant outcomes by offering nurse case management.<sup>19</sup> The Nurse Case Managers follow the mothers through their pregnancies.

Additionally, the babies born to these mothers are case managed through their first birthday (longer for infants that need additional care). OHCA emphasizes the importance of FIMR, ensuring these children and their families are placed on a path for good health and a high-quality life.

**Source:** 19. Targeted outreach in the following 10 counties: Atoka, Choctaw, Coal, Garfield, Greer, Jackson, Latimer, Lincoln, McIntosh, and Tillman.

- Goal 2: In 2012, about half of all adults in the United States had one or more chronic health conditions. In 2013, 1,269 Oklahomans died due to complications from diabetes. Additionally, Oklahoma's mortality rate for chronic conditions such as heart disease and hypertension is higher than the nation overall. Oklahoma was rated as one of the 10 worst states in the UHF (United Health Foundation) rankings, and experienced high costs associated with the poor rankings. These rankings indicated high health care costs, poor health statuses and diminished productivity among Oklahomans. These factors triggered the Oklahoma legislature and OHCA to mandate programs aimed at reversing this trend. With resources available, the Health Management Program (HMP) offers services to 5,000 members, providing care coordination to members and practice facilitation to providers. HMP has resulted in preventing costs of \$16 million dollars in SFY 2014, as well as the improvement in 11 of 18 clinical measures.<sup>20</sup> The OHCA continues to encourage programs that advance the development of self-management skills thereby reducing costs and affecting predictable utilization trends.

**Source:** 20. SoonerCare Fifth Annual Health Management Program Evaluation, PHPG, 2014.

- Goal 3: In 1990 around 11.6 percent of Oklahoma's population was considered obese as compared to some 27.5 percent in 2011 according to America's Health Rankings. In 2014, 29.4 percent of Oklahoma adults were considered obese. This concerning progression in obesity rates secured Oklahoma's ranking at 46th in the nation for obese adults.<sup>21</sup> Oklahoma has demonstrated a rising trend in obesity rates. It is known that obesity raises the risk for other health problems such as coronary heart disease, high blood pressure, stroke, type 2 diabetes, and arthritis. Although it is becoming more common, obesity comes with a price; it decreases the quality of life and increases health care costs.<sup>22</sup> Additionally, obesity has also been linked with chronic absence from work.<sup>23</sup> While the medical community provides treatment for such conditions, the OHCA recognizes that personal engagement and responsibility for healthy behaviors has a more profound impact on an individual's health than the medical care alone. The OHCA encourages individual responsibility by providing multiple educational opportunities and modeling a culture of personal concern for one's own health.

**Sources:** 21. America's Health Rankings Annual Addition, 2013,

<http://www.americashealthrankings.org/measures/Measure/OK/Obesity>.

22. Harvard School of Public Health, "Weight Problems Take a Hefty Toll on Body and Mind,"

<http://www.hsph.harvard.edu/obesity-prevention-source/obesity-consequences/health-effects/>.

23. Centers for Disease Control and Prevention, "Adult Obesity Causes & Consequences," <http://www.cdc.gov/obesity/adult/causes.html>

- Goal 2: Medicaid is the nation's primary payer of long-term care (LTC) services and supports. Medicaid will continue to play a significant role, together with Medicare, in providing care to elderly Americans as the 76 million "Baby Boomers" get older and require long-term care services and supports.<sup>24</sup> SoonerCare operates five programs to provide home and community care as a cost-effective alternative to institutionalization. This empowers personal responsibility for a member by assisting with access to the most appropriate choice for LTC services and supports available to them through the SoonerCare system. Because of the growing number of those requiring LTC services and supports and the relatively higher cost of their care,

SoonerCare will require an increased amount of state funding in future years for appropriate services for this population.

**Source:** 24. Kaiser Commission on Medicaid and the Uninsured, “Medicaid’s Role in Meeting the Long-Term Care Needs of America’s Seniors,” 2013, <http://kff.org/medicaid/issue-brief/medicaids-role-in-meeting-the-long-term-care-needs-of-americas-seniors/>

- Goal 2: The U.S. population is aging: longer life spans and aging baby boomers; these two factors will double the population of Americans 65 years of age or older during the next 25 years to about 72 million. Older adults will account for roughly 20 percent of the U.S. population by 2030. Two out of every three older Americans have multiple chronic conditions, 66 percent of the country’s health care budget accounts for treatment for this population.<sup>25</sup> Due to the rising number in the aged population, the OHCA will need to remain at the cutting edge of creative ways to serve the needs and health challenges of this growing population.

**Source:** 25. Centers for Disease Control and Prevention, “The State of Aging & Health in America, 2013,” [http://www.cdc.gov/features/agingandhealth/state\\_of\\_aging\\_and\\_health\\_in\\_america\\_2013.pdf](http://www.cdc.gov/features/agingandhealth/state_of_aging_and_health_in_america_2013.pdf)

- Goal 5: The percent of Oklahomans with a computer or laptop at home is about 85.8 percent and 71.1 percent have access to internet connectivity.<sup>26</sup> Discrepancies exist between urban and rural locations with access to broadband connectivity. Many barriers have been removed with the online enrollment process allowing individuals to apply anytime and anywhere. When online access is not available in the home setting, members may use computers available to them in the community such as a library or a mobile phone.

**Source:** 26. “American Community Survey Reports: Computer and Internet Use in the U.S. 2013,” <http://www.census.gov/history/pdf/2013computeruse.pdf>

- Goal 7: OHCA recognizes the benefits of collaboration with community partners. Through these endeavors, OHCA is able to identify localized challenges and access to care issues that impact the health of SoonerCare members in specific areas, allowing efforts to be directed toward better health outcomes. Through engagement with communities, OHCA is better able to provide resources such as education with the goal of promoting the use of necessary medical services (e.g. well-child exams) or identification of individuals that might be eligible for SoonerCare, but not enrolled. Collaboration with communities provides a constructive relationship that OHCA will continue to foster in the future.
- Goal 7: There are an increasing number of new opportunities for state collaborative efforts including multiple payer initiatives, performance incentives, quality initiatives and reimbursement methodology. In the current health care environment, inter and intra-state collaborations continue to be necessary for coordinated improvements in the health care delivery system.
- Goal 5: SoonerCare Choice enrollment experienced more than a 2.25 percent increase from July 2014.<sup>27</sup> Another increase in enrollment can be anticipated for the upcoming year.

**Source:** 27. Oklahoma Health Care Authority, Quarterly SoonerCare Choice Fast Facts, June 2015.

- Goal 5: SoonerCare children ages 18 and under continue to make up the majority, 81 percent, of the SoonerCare Choice population, while approximately 19 percent of the SoonerCare Choice population are made up of adults ages 19 and over.<sup>28</sup> The trend of children representing the majority of the SoonerCare Choice population is expected to continue.

**Source:** 28. Oklahoma Health Care Authority, Quarterly SoonerCare Choice Fast Facts, June 2015.

- Goal 6: As of June 2015, there were approximately 2,501 SoonerCare Choice contracted providers rendering services to SoonerCare members throughout the state.<sup>29</sup> OHCA continues an ongoing effort to contract with SoonerCare providers including, but not limited to, those who will render specialty services to members. Since Choice providers utilize less than half (42.92 percent) of their self-reported panel capacity, there is available capacity for additional members to be served. However, when examining specific geographical sections of the state, there can be less capacity available. Ongoing efforts are made to monitor, retain and bolster the current provider network within the OHCA.

**Source:** 29. Oklahoma Health Care Authority, Provider Fast Facts, June 2015.

- Goal 4: State of Primary Care – OHCA contracts with 16,155 physicians, 2,983 Advanced Practice Nurses (APNs), and 1,509 Physician Assistants (Pas.)<sup>30</sup> PCPs need additional supports and education on how to handle at-risk and complex needs population. OHCA has been providing this identified need through practice facilitation efforts. OHCA has come to expect that through these PCP supports, the state benefits from healthier populations and more predictable utilization trends that are preventive in nature rather than acute.

**Source:** 30. Oklahoma Health Care Authority, Provider Fast Facts, June 2015.

- Goal 4: The state's physician workforce – The state of Oklahoma is currently ranked 48th in the nation by The United Health Foundation in the number of primary care physicians.<sup>31</sup> According to the Health Planning and Grants/Office of Primary Care for the Oklahoma State Department of Health, 64 of Oklahoma's 77 counties, some represented may be partial counties, are federally designated as primary care health professional shortage areas (HPSAs). Additionally, 69 are mental health HPSAs and nine are dental care HPSAs.<sup>32</sup> OHCA recognizes that Oklahoma has large rural zones and areas lacking adequate physician coverage.

**Source:** 31. America's Health Rankings, Primary Care Physicians, 2013, <http://www.americashealthrankings.org/OK/PCP/2014>.

**Source:** 32. Oklahoma State Department of Health, OK Health Workforce Databook, 2015, [http://www.ok.gov/health/Organization/Center\\_for\\_Health\\_Innovation\\_and\\_Effectiveness/Data\\_&\\_Reports/](http://www.ok.gov/health/Organization/Center_for_Health_Innovation_and_Effectiveness/Data_&_Reports/).

- Goal 6: OHCA relies on the physician extender workforce such as APNs and PAs to provide primary care; these practitioners play an important role in the Patient-Centered Medical Home (PCMH) team approach. The OHCA recognizes APNs and PAs as essential to the PCMH workforce mix, which includes various levels of medical staff, office personnel, care coordinators, and specialists. As a result, OHCA does not reflect the primary care workforce shortage in the same severity that other groups show, since the agency considers APNs and PAs as Primary Care deliverers.
- Goal 2: The Health Access Networks currently have funding to serve SoonerCare members within the three pilot programs in the state. With the successful impact the Health Access Networks have had in providing telemedicine services, care management, access to specialty services and population health monitoring and targeted efforts in their local areas, it is likely these networks will be taken statewide in future years.

- Goal 4: Telemedicine is an up-and-coming trend in the health care industry as it is a more efficient way to provide access to specialty care. Telemedicine is a health care delivery method currently being utilized statewide, in rural and underserved communities, to improve access to specialty medical care for members and providers where there is a lack of medical specialty in areas such as high-risk obstetrics, psychiatric, or behavioral health. The overarching goal is to improve medical outcomes in these areas. OHCA strives to ensure appropriate use of telemedicine in certain settings and to make it more beneficial and effective for the SoonerCare population.
- Goal 6: PHPG calculated OHCA's administrative costs as 5.8 percent of total expenditures for SFY2013 while estimated private MCO administrative costs in comparison states was slightly under 11 percent.<sup>33</sup> OHCA continues to demonstrate low administrative costs and this trend is expected to continue.

**Source:** 33. PHPG SoonerCare Choice Evaluation, 2014.

## Financial Performance

As the single state agency charged with operating Oklahoma’s Medicaid program, known as SoonerCare, OHCA works closely with other state officials to ensure responsible stewardship of program funds. OHCA staff regularly review expenditures to evaluate cost trends and forecast financial needs. This enables staff to analyze the efficiency and effectiveness of policy and programs. These proactive steps guarantee that members receive appropriate access to quality services in the most cost effective manner possible.

The constantly changing local and national economic climates directly impact the SoonerCare program. OHCA staff must constantly review and analyze these changes in order to meet objectives of optimum service delivery and program performance. The continual influence of major changes to the economy in Oklahoma can be seen by SoonerCare’s fluctuating enrollment numbers and operating costs. Compliance with state and federal mandates and changes to the levels of federal funding received through the FMAP are additional factors to be considered.

Unduplicated enrollment numbers have reached over one million for each of the past three years. These growing enrollment numbers consistently increase OHCA’s total expenditures. OHCA anticipates this growth pattern will continue over the five years of the strategic plan and will continue to cause growth in expenditures needed to achieve agency goals. Despite the expected increase in overall expenditures, OHCA maintains low administrative costs which contribute to OHCA’s success in keeping our per capita administrative costs well below the national average. OHCA will continue to seek innovative methods such as utilizing funding from federal grant sources to develop and test new programs and services in order to contain costs while maintaining the highest quality care and treatment for our members.

Much of the funding for the SoonerCare program comes from federal funding through the FMAP for the Medicaid program. The Medicaid program is a jointly funded program with both federal and state governments sharing the costs. In the federal budget, Medicaid is an “open-ended entitlement” program, which means the federal government is required by law to pay its share of Medicaid costs regardless of the total amount. The percentage of federal funding differs for each type of Medicaid expenditure; administration costs for each state are funded at 50 percent with enhanced percentages for some administrative activities, such as fiscal agent operations. Based on Oklahoma’s per capita incomes, the FMAP is adjusted every year with the state being required to use state or local tax dollars (called “state matching dollars”) to pay some of the costs of the SoonerCare program.

OHCA is required to estimate and recalculate projections in order to accurately forecast agency funding and staffing needs. Both immediate and long term budget predictions are critical to ensuring the SoonerCare program is ran efficiently and effectively.

## Endnotes

- 1 Congressional Budget Office, The Budget and Economic Outlook: 2015 to 2025, <http://www.cbo.gov/publication/49892>
- 2 Congressional Budget Office, The Budget and Economic Outlook: 2015 to 2025, <http://www.cbo.gov/publication/49892>
- 3 OHCA Annual Report SFY 2014
- 4 Oklahoma Policy Institute, "Options to Fix Oklahoma's Budget Shortfall, March 17, 2015
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