

# Program Strengths and Areas for Continuing Improvement

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## *An Evaluation of Oklahoma's SoonerCare Acute Care Program*

Prepared for the Oklahoma Health Care Authority

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## Introduction

In February 2013, the Oklahoma Health Care Authority (OHCA) contracted with Leavitt Partners to evaluate its current Medicaid program and to make recommendations on how to optimize access and quality of health care in the State. The outcomes produced from this work will support the OHCA's overall mission statement, which is to "purchase state and federally funded health care in the most efficient and comprehensive manner possible and to study and recommend strategies for optimizing the accessibility and quality of health care."<sup>1</sup>

The contract includes two separate, but related, projects. The first project is an evaluation of the existing acute care component of SoonerCare, the State's Medicaid program. As part of this evaluation, Leavitt Partners addressed whether SoonerCare is operating efficiently and effectively, what value the program provides to the State, the strengths and weaknesses of the program, and the program's existing opportunities and threats.

For the second project, Leavitt Partners proposed a Medicaid demonstration proposal that outlines recommendations for an "Oklahoma Plan," which includes state-based solutions to improve health outcomes, contain costs, and make efficient use of state resources in providing quality health care and reducing the number of uninsured families. The plan addresses and integrates all points of health care delivery in the State, including Medicaid, the public health system, and the commercial insurance system. It focuses on market-based solutions and population health management.

This report addresses the first component of the contract, evaluating SoonerCare's acute care program. Leavitt Partners' recommended demonstration proposal is provided in a companion report, "Covering the Low-Income, Uninsured in Oklahoma: Recommendations for a Medicaid Demonstration Proposal."

## Environmental Scan

Leavitt Partners used a two-fold approach in its evaluation of the SoonerCare program. It first reviewed the State's current Medicaid program, gathering multiple perspectives of the program and its processes in order to gain an understanding of the social, political, and financial environment in which the program operates. As part of this review, Leavitt Partners performed an extensive environmental scan of SoonerCare by both reviewing publicly available documents and interviewing stakeholders to discuss the program and gain external perspectives on specific issues.

During the interview process, Leavitt Partners met with:

- The Planning Committee of the OHCA Board
- One of the Governor's appointees to the OHCA Board
- The Chairs of five of OHCA's Advisory Committees, including:
  - Child Health Advisory Task Force (CHATF)
  - Member Advisory Task Force (MATF)
  - Medical Advisory Committee (MAC)
  - Medical Advisory Task Force (MAT)
  - Perinatal Advisory Task Force (PATF)

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<sup>1</sup> "About Us," Oklahoma Health Care Authority. Accessed June 17, 2013. <http://www.okhca.org/about.aspx?id=32>.

- Executives of allied State Departments (Health, Human Services, Insurance, Mental Health and Substance Abuse Services)
- Tribal Leaders
- Hospital administrators and representatives from the Oklahoma Hospital Association
- Primary Care Association representatives
- FQHC representatives
- Leadership of the George Kaiser Foundation
- Physician representatives
- The State Chamber of Commerce
- The Oklahoma City/County Health Department
- University representatives
- A commercial insurance executive
- Primary care providers
- Program staff

The second part of Leavitt Partners' approach consisted of reviewing pertinent administrative data, including State Plans, waivers, cost data, legislation, and information gathered through requests made to OHCA and other state agencies. In order to better understand and provide perspective on particular findings from this review, Leavitt Partners gathered information from comparison states and performed additional background research on specific issues related to the Oklahoma program.

## Conclusions and Recommendations

After compiling, organizing, and analyzing the information gathered through the environmental scan, Leavitt Partners developed its conclusions and recommendations. These conclusions and recommendations are presented in this report.

## Oklahoma's Medicaid Program

Oklahoma's Medicaid program covers all federally mandated components as well as provides services to optional populations through targeted benefits. While the traditional mandated and optional populations covered in Oklahoma's base program are more limited in terms of income eligibility relative to other states, these programs are supplemented with additional programs implemented through State Plan Amendments and 1115 waivers.<sup>2</sup>

## Program Funding

SoonerCare is the largest source of federal grants in Oklahoma, accounting for almost 40% of all federal funds coming into the State. The program's budget has steadily increased for at least the last seven years, reaching almost \$2.99 billion in FY2012. Almost 95% of SoonerCare expenditures go to medical payments, with the remaining 5% covering administrative costs. Expenditures equaled an average of \$4,350 per member in FY2012, up only 1% from the previous year. Although disabled members make up a small portion of enrollees, they account for over 47% of total medical expenditures.

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<sup>2</sup> Information included in this section comes from documents OHCA provided to Leavitt Partners for its evaluation of the SoonerCare program as well as public information available from its website: <http://www.okhca.org/>.

## Enrollment

Close to one million individuals were enrolled in the SoonerCare program during the 2012 federal fiscal year.<sup>3</sup> This equates to about 25% of the State's total population. More than half of the enrollees are children and the program's monthly average enrollment is approximately 782,000 individuals.<sup>4</sup> The January 2013 enrollment numbers for each SoonerCare program are listed in Figure 1. Total SFY2012 program expenditures were just under \$4.8 billion.

**Figure 1**

SoonerCare Enrollment Breakout, January 2013			
Category	Adult/Children	Number Enrolled	Percent of Total
Aged/Blind/Disabled	Children	19,577	2.5%
Aged/Blind/Disabled	Adults	132,548	17.0%
Children/Parents	Children	480,026	61.6%
Children/Parents	Adults	75,616	9.7%
Other	Children	54	0.01%
Other	Adults	21,161	2.7%
Oklahoma Cares		826	0.1%
SoonerPlan		49,313	6.3%
TEFRA		444	0.06%
TOTAL		779,565	
Insure Oklahoma			
Employees with ESI		16,705	55.0%
Individual Plan Members		13,791	45.0%
TOTAL INSURE OK		30,496	
TOTAL ENROLLMENT		810,061	

Source: "SoonerCare Fast Facts," OHCA (January 2013).

<sup>3</sup> "Here When It Counts, Oklahoma Health Care Authority 2012 Annual Report," OHCA (June 2012).

<sup>4</sup> Ibid.

## Current Eligibility Groups and Programs

While enrollment in SoonerCare is robust, its eligibility criteria are relatively modest compared to other states. The groups that generally qualify for SoonerCare services are listed in Figure 2.

**Figure 2**

SoonerCare Eligibility Groups, 2013	
Group	Income Limit
Adults with children under age 19	~30% FPL
Children under age 19	185% FPL*
Pregnant Women	185% FPL**
Individuals age 65 and older	~80% FPL
Individuals who are blind or disabled	~80% FPL
Women under age 65 in need of breast or cervical cancer treatment	185% FPL
Men and women age 19 and older with family planning needs	185% FPL

\*Includes the Children's Health Insurance Program.

\*\* In 2009 Medicaid paid for approximately 64% of the State's total births.

Source: "Here When It Counts, Oklahoma Health Care Authority 2012 Annual Report," OHCA (June 2012). Leavitt Partners interviews conducted with OHCA Administrators (March–June 2013).

In addition to the more traditional base programs, the State has added several optional groups based on the needs and priorities of the State. These optional groups include:

### ***Oklahoma Cares (Breast and Cervical Cancer Treatment Program)***

This program provides treatment for breast and cervical cancer and pre-cancerous conditions to eligible women. Oklahoma Cares is a partnership of the Oklahoma State Department of Health (OSDH), OHCA, the Cherokee Nation, the Kaw Nation of Oklahoma, and the Oklahoma Department of Human Services (OKDHS). Women with income up to 185% FPL are eligible for the program.

### ***SoonerPlan***

SoonerPlan is Oklahoma's family planning program for women and men who are not enrolled in regular SoonerCare services and have income below 185% FPL. Services are limited to family planning services offered by contracted SoonerCare providers.

## ***Insure Oklahoma***

The Insure Oklahoma (IO) program is a premium assistance based program designed by the State to provide health care coverage for low-income working adults. It was authorized by the Oklahoma State Legislature in 2004. The Statute specifically directs OHCA to apply for waivers needed to accomplish several goals of the State, including:<sup>5</sup>

- Increase access to health care for Oklahomans;
- Reform the Medicaid Program to promote personal responsibility for health care services and appropriate utilization of health care benefits through the use of public-private cost sharing;
- Enable small employers, and/or employed, uninsured adults with or without children to purchase employer-sponsored, state-approved private, or state-sponsored health care coverage through a state premium assistance payment plan; and
- Develop flexible health care benefit packages based upon patient need and cost.

The Statute also authorizes OHCA to “develop and implement a pilot premium assistance plan to assist small businesses and/or their eligible employees to purchase employer-sponsored insurance or ‘buy-in’ to a state-sponsored benefit plan.”<sup>6</sup> OHCA utilized this directive to create the IO program and enhance it over time.

The program now has a strong Oklahoma brand with wide acceptance and support throughout the community. The program is credited with providing coverage to thousands of individuals who would otherwise have remained uninsured and helping small businesses provide coverage that would have otherwise been cost prohibitive. IO’s success is attributed to several key factors, including its local design and its inclusion of premium sharing across enrollees, businesses, and government—resulting in an affordable option for all parties.

Covered populations include non-disabled working adults and their spouses, disabled working adults, employees of not-for-profit businesses with fewer than 500 employees, foster parents, and full-time college students. The program also offers coverage for dependent children of IO members. The qualifying income limit is 200% FPL.

The IO program consists of two separate premium assistance plans: the Employer-Sponsored Insurance premium assistance plan and Individual Plan premium assistance plan. Under the Employer-Sponsored Insurance (ESI) plan, premium costs are shared by the State (60%), the employer (25%), and the employee (15%). ESI is available to employers with up to 99 employees. The Individual Plan (IP) allows people who can’t access benefits through an employer (including those who are self-employed or may be temporarily unemployed) to buy health insurance directly through the State.

Close to 17,000 individuals are currently enrolled in the ESI plan with almost 14,000 individuals enrolled in the IP plan. The program has an enrollment cap, which is determined by the State’s annual budget. The current enrollment cap is around 35,000.

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<sup>5</sup> Oklahoma Statute, 56-1010.1.D.1.

<sup>6</sup> Oklahoma Statute, 56-1010.1.D.2.

CMS has indicated that it will not allow Oklahoma to extend Insure Oklahoma past 2013, unless the State is willing to make certain changes to comply with federal benefit, cost-sharing, eligibility, and enrollment rules. For example, IO's current benefit package does not include Essential Health Benefits<sup>7</sup> and its cost-sharing amounts would need to be adjusted to meet the standards CMS set forth in its proposed rule.<sup>8</sup> Eligibility for the program would need to be based on Modified Adjusted Gross Income (MAGI). In addition, the U.S. Department of Health and Human Services (HHS) has stated it will no longer approve enrollment caps for the newly eligible or similar populations.<sup>9</sup>

## Benefits

As with most Medicaid programs, the scope of coverage within SoonerCare programs varies by type of enrollee and program. For example, the EPSDT benefit package<sup>10</sup> is richer for children than for adults and some programs, like SoonerPlan, have very targeted benefits to reflect the intent of the program. However, the State's Medicaid benefit packages are generally broad, covering benefits that are comparable to or exceed what is typically covered in commercial plans. As with commercial plans, there are service limits. For example, inpatient hospital days are limited to 24 per year, home and office physician visits are limited to four per month, and pharmacy is limited to six prescriptions per month (two of which can be brand name drugs). There are also nominal copayments. A complete list of benefits and cost-sharing requirements can be found on OHCA's website.<sup>11</sup>

Aside from physician and in/outpatient hospital services, the services most utilized by SoonerCare members include non-emergency transportation, capitated services, prescription drugs, and dental services. Nursing facilities and behavioral health services have some of the highest program expenditures.

## SoonerCare Acute Care Delivery System

The SoonerCare acute care delivery system has undergone several transitions over the past two decades. Throughout this transition process the State has maintained a consistent focus on managed care approaches, although the way it administers managed care has evolved over time. Under the previous banner of "SoonerCare Plus," the program administered risk-based contracts with commercial Medicaid managed care organizations (MCO). These contracts were terminated at the end of 2003 due

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<sup>7</sup> Essential Health Benefits (EHB) are a baseline comprehensive package of items and services that all small group and individual health plans, offered both inside and outside the exchange, must provide starting in 2014.

<sup>8</sup> CMS, Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing, Proposed Rule 42 CFR Parts 430, 431, 433, 435, 440, 447, and 457 (January 22, 2013).

<sup>9</sup> "Affordable Care Act: State Resources FAQ," CMS (April 25, 2013).

<sup>10</sup> The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT helps ensure that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services. Available from "Early and Periodic Screening, Diagnostic, and Treatment," Medicaid.gov. Accessed June 17, 2013. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-Periodic-Screening-Diagnosis-and-Treatment.html>.

<sup>11</sup> "What is Covered?" Oklahoma Health Care Authority. Accessed June 17, 2013. <http://www.okhca.org/individuals.aspx?id=95&parts=11601>.



to several issues and negative experiences the State experienced during SoonerCare Plus' tenure. Some of these issues include:<sup>12</sup>

- Incorporating the aged, blind, and disabled (ABD) populations into the managed care contracts created unanticipated costs, resulting in health plan requests for increased rates.
- Some companies left the program, leaving an open question about the State's ability to maintain a sufficient number of plans required under federal Medicaid regulations<sup>13</sup> and to provide the plans with a strong position at the bargaining table.
- The plans continued to ask for higher rates during the 2002–2003 economic downturn, placing economic pressure on the State.
- In 2003, one plan turned down a 13.6% rate increase, holding out for an 18% increase.

During this same period, OHCA's self-administered, partially capitated Primary Care Case Management (PCCM) SoonerCare Choice plan was performing well and producing results comparable to or better than the MCOs. A determination was also made that OHCA could operate the Choice program at about one quarter of the administrative cost of the Plus program. The Board voted to terminate the Plus program and by April 2004, all Plus enrollees were transitioned to SoonerCare Choice.

Today, Oklahoma offers a variety of programs in its acute care delivery system. Much of the program basics were put in place in 2004, but the program continues to evolve as OHCA sees opportunities for improvement. Today, the program has multiple components that address care access, care coordination, and provider incentives.

The follow section includes descriptions of some of Oklahoma's acute care Medicaid programs. These programs provide different services to different populations in order to address the targeted population's needs.

### ***SoonerCare Traditional***

The traditional fee-for-service (FFS) SoonerCare program comprises a statewide network of providers that includes hospitals, family practice doctors, pharmacies, and durable medical equipment companies. SoonerCare members in this program may choose from any of these contracted providers for needed services.

Members enrolled in this program include:

- Residents of long-term care facilities
- Dually eligible SoonerCare/Medicare members
- Members with private health maintenance organization (HMO) coverage
- Members eligible for Home and Community-Based Services waivers
- Children in state or tribal custody

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<sup>12</sup> Leavitt Partners interviews conducted with SoonerCare stakeholders (March–June 2013); "SoonerCare 1115 Waiver Evaluation: Final Report," Mathematica (January 2009).

<sup>13</sup> Federal Medicaid regulation requires that enrollees have a choice of managed care plans, with the exception of enrollees in certain in rural areas.

### ***SoonerCare Choice***

SoonerCare Choice is a PCCM program in which each member is assigned to a medical home. The medical home primary care provider (PCP) is responsible for coordinating each member’s health care and services as well as providing 24-hour, 7-day telephone coverage. Unless exempt, all SoonerCare members are required to enroll in the PCCM program (enrollment is available on-line).

To qualify, an individual must:

- Qualify for SoonerCare
- Not qualify for Medicare
- Not reside in an institution such as a nursing facility or receive services through a Home and Community-Based Services waiver program
- Not be in state or tribal custody
- Not be enrolled in a HMO

SoonerCare Choice PCPs receive a monthly care coordination payment for each enrolled member. This payment is based on the services provided by the PCP. The PCP is responsible for providing, or otherwise assuring, the provision of primary care and case management services. The PCP is also responsible for making referrals for specialty care.

The SoonerCare Choice program uses three tiers of medical homes in its delivery system: 1) Entry Level Medical Home (Tier 1); 2) Advanced Medical Home (Tier 2); and 3) Optimal Medical Home (Tier 3). The PCP must meet certain requirements to qualify for payments in each tier. Payments are also determined according to patient characteristics as described in Figure 3.

**Figure 3**

<b>SoonerCare Choice Care Coordination Payment Tiers, 2012</b>			
<b>Payments (PMPM)</b>	<b>Tier 1</b>	<b>Tier 2</b>	<b>Tier 3</b>
Children	\$4.32	\$6.32	\$8.41
Children and Adults	\$3.66	\$5.46	\$7.26
Adults	\$2.93	\$4.50	\$5.99

Source: “Here When It Counts, Oklahoma Health Care Authority 2012 Annual Report,” OHCA (June 2012).

### ***Payments for Excellence***

Providers may receive additional incentive payments through the State’s Payments for Excellence program, which recognizes outstanding performance. Incentive payments may not exceed 5% of total FFS payments for authorized services provided during the established period. These payments are made to providers in Indian Health Service (IHS), Tribal, and Urban Indian clinics, as well as to providers in the Insure Oklahoma Network.

### ***Health Management Program***

The Health Management Program (HMP) provides additional services to SoonerCare Choice members who have chronic diseases. Individuals are identified through predictive modeling or other referral and enrollment sources and can enroll through an on-line application. Services provided in the Health Management Program include:

- **Nurse Care Management:** Nurses provide members with education, support, care coordination, and self-management tools (either in person or by phone) that are aimed at improving members' health.
- **Behavioral Health Screening:** All HMP members are asked to complete a behavioral health screening to identify issues they need help managing.
- **Pharmacy Review:** To lessen the chance of medication errors, nurse care managers assist members create a list of their medications that will be reviewed by a contracted pharmacy specialist if problems are identified.
- **Community Resources:** The program helps members locate appropriate health and social service resources.
- **Primary Care Provider Involvement:** Nurse care managers send monthly updates to members' PCPs. These updates include self-management goals, member progress, and information on the health status of the member.

### ***Health Access Networks (HANs)***

HANs are non-profit, administrative entities that work with providers to coordinate and improve care for SoonerCare members. Networks receive a \$5 per member per month (PMPM) payment. HANs are not eligible for tiered PCP care coordination payments. To receive the payment, the HAN must:

- Be organized for the purpose of restructuring and improving the access, quality, and continuity of care to SoonerCare members;
- Ensure patients have access to all levels of care within a community or across a broad spectrum of providers in a service region or the State;
- Submit a development plan to OHCA detailing how the network will reduce costs associated with the provision of health care services, improve access to health care services, and enhance the quality and coordination of health care services to SoonerCare members;
- Offer electronic medical records, improved access to specialty care, telemedicine, and expanded quality improvement strategies; and
- Offer care management/coordination to persons with complex health care needs, including:
  - The co-management of individuals enrolled in the Health Management Program;
  - Individuals with frequent emergency department utilization;
  - Women with breast or cervical cancer enrolled in the Oklahoma Care Program;
  - Pregnant women enrolled in the High Risk OB Program; and
  - Individuals enrolled in the Pharmacy Lock-In Program.<sup>14</sup>

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<sup>14</sup> The Pharmacy Lock-In Program is designed to assist health care providers monitor potential abuse or inappropriate utilization of controlled prescription medications by SoonerCare members. When warranted, a

### ***Services for American Indians***

Eligible SoonerCare members, with the exception of Insure Oklahoma members, may voluntarily enroll with an IHS, Tribal, or Urban Indian clinic for their PCP/care management services. Providers in these clinics receive the tiered PCP care coordination payment as well as an encounter payment rate that is 100% federally funded for certain outpatient services.

### **Per Member per Month (PMPM) Cost for Adult Populations**

SoonerCare programs' per member costs have fluctuated over the past five years. The low income adult populations per member cost increased relatively rapidly for a short period, but then declined, resulting in an average five year increase of 1.7%. A similar pattern occurred with the non-dually eligible disabled adults, although there was a slight decrease in costs between 2008 and 2012. While the cost of Insure Oklahoma Individual Plan adults increased at a much more rapid rate during this period, only the last few years should be considered given that the program was implemented in 2007 and underwent several changes through 2010 (the increase in costs between 2010 and 2012 averaged about 7.5%). Figure 4 shows the annual PMPM cost for select groups of the adult population by year.

**Figure 4**

<b>Annual PMPM Costs for Medicaid Enrolled Adults, SFY2008-2012</b>			
<b>State Fiscal Year</b>	<b>TANF-related Adults</b>	<b>IP Adults</b>	<b>Non-Dual Disabled Adults</b>
SFY2008	\$293	\$221	\$1,549
SYF2009	\$323	\$304	\$1,594
SYF2010	\$328	\$347	\$1,615
SYF2011	\$308	\$343	\$1,562
SYF2012	\$298	\$373	\$1,506

Source: Special report generated by OHCA (2013).

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member may be "locked-in," and therefore required to fill all prescriptions at a single designated pharmacy in order to better manage his or her medication utilization. Available from "Pharmacy Lock-In Program," Oklahoma Health Care Authority. Accessed June 17, 2013. <http://www.okhca.org/providers.aspx?id=8738>.

## Program Evaluation

Almost all of the individuals who Leavitt Partners interviewed hold the SoonerCare Program in high regard, including both the Choice and Insure Oklahoma programs. These positive opinions were confirmed by Leavitt Partners' review of administrative data and information. In the review of the program, many exemplary characteristics of SoonerCare were identified, as well as some areas for continuing improvement.

## Program Strengths

### Feedback Mechanisms, Program Evaluation, and Suggestion Response

A common theme heard from multiple parties was an appreciation for the program administrators' willingness to create processes for feedback, as well as act on suggestions. While there are some concerns related to the number of advisory committees the program supports, the number and breadth of these committees is indicative of the program's willingness to obtain advice and feedback from sources outside the agency. This openness and responsiveness helps the program continually improve and better meet the needs of the community. It also builds the program's local reputation. Although this feedback process requires a great deal of time and resources, the agency understands the importance of maintaining its commitment to receiving feedback as a public agency and acting on suggestions when possible.

This openness in obtaining policy and operational feedback carries over into other areas of the program. Program administrators frequently include other State Departments in discussions on program policy and issues that arise from feedback it receives.

Another feedback mechanism to which OHCA has devoted resources is Tribal consultation. One staff position is dedicated to coordinating the tribal consultation process and managing the relationship between OHCA and Tribes—and the resulting relationship is viewed positively by both groups. While disagreements can and do arise in the government-to-government relationship, OHCA is willing to work through any challenges and come to a mutually acceptable agreement where possible. As an example, OHCA recently partnered with the State Department of Health to conduct a series of listening sessions with the Tribes. These sessions allowed the parties to address common issues and discuss how to make improvements to the population's health status. This approach helps integrate the program with public health goals, and is a positive way to address some of the underlying health issues of Oklahoma's American Indian population.

OHCA also appears to be strengthening ties with the Public Health system. In discussions held over the course of the project, the Health Department was an active participant. Further, because OHCA and the Health Department address common interests, like smoking cessation, OHCA is interested in incorporating public health in its approach to program reforms.

OHCA administrators are clearly interested in understanding program performance in multiple areas. Beyond regular reviews and audits of the Medicaid program, multiple additional evaluations have been performed relating to the quality of care and overall program performance. For example, OHCA employs several tools that are typically used in assessing the quality of commercial MCOs in evaluating its PCCM

program, including Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS). It also utilizes Experience of Care and Health Outcomes (ECHO) to evaluate satisfaction with behavioral health services. The results of these evaluations have generally been positive, and the continuing effort to obtain this type of feedback on program performance is commendable.

## On-line Application and Enrollment Processes

OHCA has aggressively worked to implement and disseminate a state-of-the-art, direct-entry, on-line application process. The process is well-accepted, appreciated, and utilized by recipients and partner agencies. It has significantly increased program efficiency, reducing the need for a large eligibility determination staff for a core part of the program. During the interviews, there were some complaints about individual applicants having a difficult time completing the on-line application process without help from an outside agency. However, program statistics do not seem to support this observation. According to OHCA staff, close to half of all applications are filled out using the “home view” pathway (or without assistance from the agency or one of its partners) and it is estimated that first-time applications take an average of 45 minutes to complete. Reenrollments are estimated to take approximately five minutes. Another 45% of the applications are completed by agency partners, working face-to-face with applicants, and are submitted as an electronic transfer. The remaining 8% of applications are paper submittals.

A recent evaluation of SoonerCare’s online system, conducted by Mathematica, found that

“Operationally, the SoonerCare system permits real-time enrollment with a post-enrollment eligibility review of income and, if needed, a review of documentation of other eligibility criteria (such as pregnancy verification). The system reviews most eligibility data in real time, reducing an application and enrollment process that used to take 20 days or more to complete to just minutes (however long it takes the applicant to complete the online application).”<sup>15</sup>

The on-line system and its real-time capabilities position OHCA well to address the business process and systems reform that will occur in both the Medicaid and commercial insurance market over the next several years. For example, the system will be able to address both new enrollment processes and other changes that will occur as a result of the PPACA, such as the need to transfer information between the State and the federally-facilitated exchange. Having the on-line system already in place will also mitigate potential costs resulting from any future enrollment growth. As such, the investment in the on-line systems will continue to benefit the State for years to come—based both on the positive results already realized and the expected direction of the market.

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<sup>15</sup> “CHIPRA Express Lane Eligibility Evaluation, Case Study of Oklahoma’s SoonerCare Online Enrollment System,” Mathematica (May 31, 2013).

## Professionalism/Expertise of Staff

Maintaining a competent and experienced administrative staff is important given the scope and complexity of Oklahoma's Medicaid program. The program is responsible for over 20% of the State's budget and covers a quarter of the State's population, with many of the programs enrollees being the State's most medically frail and disabled citizens.

As noted in previous evaluations, the OHCA staff has a significant depth of experience in administering all major aspects of the program. In staff interviews and other interactions, Leavitt Partners found OHCA staff to be knowledgeable, competent, and extremely dedicated to both their work and Agency's mission. This experience and dedication was a strong asset in the recent transition to a new CEO following the long tenure of the prior program administrator.

## Medical Home Model

With the termination of SoonerCare Plus, the State decided to enhance SoonerCare Choice, its PCCM model. Since then OHCA has continued to evolve its model of care. It hired over 30 nurse care managers and several social services coordinators to provide care management. It later created the Health Management Program to help improve the health of SoonerCare Choice members with chronic diseases, providing a higher level of care coordination for those who require the additional coverage. SoonerCare Choice moved toward a patient-centered medical home model, providing incentive payments to providers to improve performance in targeted areas. As such, the program is setting an expectation for primary care providers to move toward "advanced tiers" of service.<sup>16</sup> It wants care coordinators to provide assistance and resource education at practice sites and is exploring ways to address population-based care management. The program recently added Health Access Networks (HANs) to encourage better coordination of care. One of the conclusions reached by Mathematica Policy Research, Inc. in its 2009 report to the Board was, "OHCA provides a solid model for other states of how to design, implement, manage, and improve Medicaid managed care programs over time."<sup>17</sup> While there is some room for improvement, as outlined in the "Medical Home Model of Care and Incentives" section below, Oklahoma continues to be a strong model for care coordination and management.

## Provider Reimbursements

During the interviews with both state administrators and community participants, the level of provider reimbursement was highlighted as a strength of the SoonerCare program. For example, OHCA has partnered with the State's medical schools to provide enhanced rates in select areas, like rural communities, to help ensure access. Even for services where the reimbursement levels are below commercial rates, they are considered adequate and described as some of the better Medicaid rates in the country.

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<sup>16</sup> "Here When It Counts, Oklahoma Health Care Authority 2012 Annual Report," OHCA (June 2012).

<sup>17</sup> "SoonerCare Managed Care History and Performance, 1115 Waiver Evaluation," Mathematica Presentation to Oklahoma Health Care Authority Board (January 8, 2009).

As illustrated in Figure 5, a 2012 survey of Medicaid programs shows that Oklahoma’s physician reimbursement rates are eighth highest in the country when compared to the national average (the index is a measurement of each state’s physician fees relative to national average Medicaid fees).<sup>18</sup> Oklahoma’s primary care physician fee index is sixth highest in the country. In terms of the State’s Medicaid rates compared to Medicare rates, Oklahoma ranks fourth highest in the country with a fee index of 0.97.<sup>19</sup> Its primary care physician fee index also ranks fourth highest in the country.

**Figure 5**

Oklahoma’s Physician Reimbursement Rates Compared to Other States, 2012					
Services	National Medicaid Fee Index (U.S. = 1.00)		Medicaid-to-Medicare Fee Index		
	OK	Rank	U.S.	OK	Rank
All Services	1.38	8 <sup>th</sup>	0.66	0.97	4 <sup>th</sup>
Primary Care	1.54	6 <sup>th</sup>	0.59	0.97	4 <sup>th</sup>
Obstetric Care	1.16	15 <sup>th</sup>	0.78	0.97	14 <sup>th</sup>
Other Services	1.27	10 <sup>th</sup>	0.70	0.96	6 <sup>th</sup>

Source: Kaiser State Health Facts. Based on "How Much Will Medicaid Physician Fees for Primary Care Rise in 2013? Evidence from a 2012 Survey of Medicaid Physician Fees," Urban Institute and Kaiser Commission on Medicaid and the Uninsured (December 2012).

<sup>18</sup> The Medicaid fee index measures each state's physician fees relative to national average Medicaid fees. The data are based on surveys sent by the Urban Institute to the forty-nine states and the District of Columbia that have a FFS component in their Medicaid programs. These fees represent only those payments made under FFS Medicaid. The Medicaid fee index is a weighted sum of the ratios of each state's fee for a given service to the corresponding national average fees, where the weight for each service was its share of total Medicaid physician spending among all the surveyed services. Available from Kaiser Family Foundation’s State Health Facts. Accessed June 17, 2013. <http://kff.org/statedata/>.

<sup>19</sup> The Medicaid-to-Medicare fee index measures each state's physician fees relative to Medicare fees in each state. The Medicaid data are based on surveys sent by the Urban Institute. These fees represent only those payments made under FFS Medicaid. Medicare fees were calculated by the Urban Institute using the relative value units (RVUs), geographic adjusters, and conversion factor from the 30 July 2012 Federal Register and the 2012 Clinical Diagnostic Fee Schedule. For each state, the Urban Institute computed the ratio of the Medicaid fee for each service to the Medicare fee, and then, using the same spending weights used in the Medicaid fee index, combined the ratios into one Medicaid-to-Medicare fee index for each state. They also computed a national Medicaid-to Medicare fee index by applying the same enrollment weights used in the Medicaid fee index to the state Medicaid-to Medicare fee indices. Available from Kaiser Family Foundation’s State Health Facts. Accessed June 17, 2013. <http://kff.org/statedata/>.



The level of provider reimbursement has bolstered the program’s reputation in the community and helped retain a robust network of Medicaid providers. While access appears to be a problem in some areas of the State (as discussed in the Areas for Continuing Improvement section below), SoonerCare’s current provider rates appear to be mitigating the situation.

## Cost Control

Cost comparisons on any level should be reviewed with reservation, as it is difficult to produce a valid comparison without a deeper dive into the relevant variables affecting the cost. For example, variables affecting Medicaid program costs include program policy and delivery system choices, the state revenue available to pay for services, the demographics and risk factors of program enrollees, program changes, the isolation of those changes to the program costs being reviewed, the impact of provider rates on access to care, etc. In addition, the administrative authority of a Medicaid agency is limited in its ability to control the costs of the program, often being constrained by state statutes, federal directives, and other external influences that impact public program budgets.

Given the nature and time constraints of this project, an in-depth analysis of program costs was not possible; rather, broad indicators were used to compare program cost trends with other state Medicaid programs. Several states with different delivery systems were included in the comparison (see figures 6–8). Program administrative costs were also reviewed.

### ***Program Expenditures Compared to Other States***

Comparing overall program cost growth to national levels and those of select states reveals that over the past 20 years, Oklahoma’s program has been growing at a rate comparable to other state Medicaid programs.

**Figure 6**

Average Annual Medicaid Expenditure Growth Rates, 1990-2010								
	U.S.	OK	MN	IA	KS	AZ	IN	WV
1990–2001	10.9%	10.2%	9.3%	9.2%	11.9%	15.4%	9.6%	12.9%
2001–2004	9.4%	7.2%	13.1%	10.4%	1.8%	22.8%	6.6%	7.7%
2004–2007	3.6%	9.2%	3.2%	3.7%	6.0%	10.3%	1.3%	3.6%
2007–2010	6.8%	6.9%	7.0%	7.1%	4.5%	12.2%	5.0%	5.5%
Rank for '07–10	n/a	30	29	28	47	1	41	37

Source: Kaiser State Health Facts. Urban Institute estimates based on data from CMS, 2011.

**Figure 7**

Annual Percentage Change in Total State Expenditures, 2010-2012								
	U.S.	OK	MN	IA	KS	AZ	IN	WV
% change 2010–2011	9.6%	5.1%	5.1%	6.4%	1.0%	24.5%	7.0%	6.6%
% change 2011–2012	1.2%	3.6%	10%	7.5%	7.8%	-10.1%	8.7%	7.5%

Source: State Expenditure Report: Examining Fiscal 2010-2012 State Spending, NASBO (December 2012).

**Figure 8**

Medicaid Payments Per Enrollee, 2009								
	U.S.	OK	MN	IA	KS	AZ	IN	WV
Per adult enrollee	\$2,900	\$2,913	\$3,624	\$2,109	\$3,724	\$4,350	\$3,206	\$3,397
Per child enrollee	\$2,305	\$2,414	\$3,254	\$1,993	\$2,218	\$2,441	\$1,896	\$2,371
Per disabled enrollee	\$15,840	\$13,952	\$26,402	\$18,236	\$15,999	\$16,415	\$15,689	\$10,635
Per aged enrollee	\$13,149	\$10,464	\$17,119	\$14,207	\$14,761	\$9,438	\$14,552	\$12,820

Source: Kaiser State Health Facts. Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from CMS data, FY2009.

Another indicator of total program costs is the percentage of the state budget consumed by the Medicaid program. The percentage of Oklahoma’s budget spent on Medicaid is slightly below the national levels, but has been trending at a similar rate as the remainder of the country over the past two years. Nationally, state Medicaid spending as a percent of total state budgets has increased from 22.2% in SFY2010 to 23.7% in SFY2011 and 23.9% in SFY2012. During this same timeframe, Oklahoma has trended from 20.6% to 21.2% to 22.2%.<sup>20</sup>

It should be noted that the 22.2% of the state budget includes all funds, including federal matching dollars. When isolating state general funds, the percent of the state budget spent on Medicaid is more modest, both relative to overall Oklahoma state general fund expenditures and compared to other states. Nationally, in FY12, Medicaid comprised 19.6% of state general fund expenditures; in Oklahoma, the percent was 18.1%.<sup>21</sup>

<sup>20</sup> “State Expenditure Report: Examining Fiscal 2010-2012 State Spending,” NASBO (December 2012).

<sup>21</sup> Ibid.

Based on the cost comparison conducted, the overall cost of Oklahoma's Medicaid program shows to be reasonable. However, when looking at expenditure trends for children and non-disabled adults, program costs are slightly higher than the national average for similar populations. While this may cause some concern, it is important to note that Oklahoma's health status is very poor compared to most other states and that the income levels for these populations are relatively low in Oklahoma's core Medicaid program compared to other states. Both factors would likely drive costs higher. Additionally, when looking specifically at the per member costs described in SoonerCare Choice's SFY2012 Annual Report, the increase has only been 4% over the five-year period of SYF2008 through SFY2012.

### ***Administrative Costs***

Oklahoma has also controlled SoonerCare's administrative costs. The 2012 OHCA Annual Report shows that administrative costs comprise 5.5% of the total Medicaid budget.<sup>22</sup> This figure includes both OHCA direct and contract costs, including funds contracted with other state agencies. This is on par with other states' administrative percentages, which in 2006 were about 5.1% of total program costs, and in 2012 were about 5.0%.<sup>23</sup>

A recent analysis of the North Carolina Medicaid program, published in the "North Carolina News," pointed out that when the administrative costs incurred by state-contracted MCOs were included in the total, overall administrative costs were higher. The article identified the administrative percentages from nine state Medicaid programs that include MCO administrative costs. The average percentage from these nine states was 5.9%, ranging from 3.6% in Missouri to 13.7% in Arizona.<sup>24</sup> The increase in administrative costs is influenced by the mean administrative cost ratios of MCOs, which ranged from 8.9% to 12.7% in 2009.<sup>25</sup> Given the managed care related administrative tasks embedded within the Oklahoma program, OHCA's administrative costs appear to be well within national averages and indicate an efficient use of resources.

SoonerCare's administrative costs are also in line with those of commercial plans. A 2006 Milliman study comparing Medicare to Commercial Plans attempted a valid comparison of administrative costs by deducting commission, premium taxes, and profit from the commercial plans. This comparison showed an average administrative percentage of 8.9% across all markets (individual, small group, and large group). A 2009 paper by the American Academy of Actuaries showed that the administrative percentage for BlueCross BlueShield was also close to this amount. The Academy's figures included provider and medical management, accounting and member administration, and corporate services in the calculation. The median administrative percentage was 10.4%.<sup>26</sup> While a true "apples-to-apples" comparison between commercial and Medicaid administrative costs is very difficult to assess, these figures help support the conclusion that the OHCA is performing efficiently.

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<sup>22</sup> "Here When It Counts, Oklahoma Health Care Authority 2012 Annual Report," OHCA (June 2012).

<sup>23</sup> "State Medicaid Program Administration: A Brief Overview," Congressional Research Service (May 14, 2008).  
"2012 Actuarial Report on the Financial Outlook for Medicaid," CMS Office of the Actuary (2013).

<sup>24</sup> The nine states include Tennessee, Missouri, Georgia, Arizona, North Carolina, New Jersey, Michigan, Illinois, and Massachusetts.

<sup>25</sup> "Financial Performance of Health Plans in Medicaid Managed Care," Medicare & Medicaid Research Review, 2 No. 2 (2012).

<sup>26</sup> "Critical Issues in Health Reform: Administrative Expenses," American Academy of Actuaries (September 2009).

## Program Accuracy

A review of the federal Payment Error Rate Measurement (PERM) indicates that OHCA is achieving positive results in terms of program accuracy—even with modest administrative program costs.

CMS developed the PERM program in order to comply with improper payment estimation and reporting requirements for the Medicaid program. PERM measures improper payments—or payments made that did not meet statutory, regulatory, or administrative Medicaid and CHIP requirements—and calculates error rates for each program. Under PERM, states are reviewed on a three-year rotational cycle with one-third of states reviewed each year. CMS calculates an annual national Medicaid program improper payment estimate using the current year's new data combined with data from the prior two years. The FY2011 national estimated Medicaid improper payment error rate was 8.1%. In comparison, Oklahoma's PERM error rate was 1.2%, the lowest of the 17 states in its cohort and, when reviewing all states, the third lowest PERM error rate in the last three cycles.<sup>27</sup> The error rate across all states ranges from 0.6% to 69.9%.

## Insure Oklahoma

The Insure Oklahoma program is a premium assistance based program designed by the State to provide health care coverage for low-income working adults. As mentioned in the Background Information Section, the Insure Oklahoma program consists of two separate premium assistance plans; the Employer-Sponsored Insurance premium assistance plan and Individual Plan premium assistance plan. Covered populations include non-disabled working adults and their spouses; disabled working adults; employees of not-for profit businesses with fewer than 500 employees; foster parents; and full-time college students. The qualifying income limit for both the ESI and IP programs is 200% FPL.

The Insure Oklahoma (IO) premium support program was universally viewed as a positive addition by all individuals Leavitt Partners interviewed. Premium support programs often struggle to obtain high levels of interest and enrollment.<sup>28</sup> IO has not had this problem, as enrollment is consistently close to the designated enrollment caps and OHCA has had to cut back on outreach in order to stay within its budget. IO is credited with providing coverage to thousands of individuals who would otherwise have remained uninsured and helping small businesses provide coverage that would have otherwise been cost prohibitive. IO's success is attributed to several key factors including its local design and its inclusion of premium sharing across enrollees, businesses, and government—resulting in an affordable option for all parties.

Insure Oklahoma also measures favorably when compared to other state premium support programs. For example, in 2012, enrollment in IO exceeded 4.6% of Oklahoma's total Medicaid program enrollment.<sup>29</sup> Enrollment in other states' premium support programs generally represents less than 1%

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<sup>27</sup> The combined error rates are based on reviews of FFS payments, managed care, and eligibility components of Medicaid and CHIP. Available from "Payment Error Rate Measurement (PERM)," CMS.gov. Accessed June 17, 2013. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/PERM/index.html?redirect=/PERM/>.

<sup>28</sup> "Premium Assistance in Medicaid and CHIP: An Overview of Current Options and Implications of the Affordable Care Act," Kaiser Commission on Medicaid and the Uninsured (March 2013).

<sup>29</sup> "Here When It Counts, Oklahoma Health Care Authority 2012 Annual Report," OHCA (June 2012).

of total Medicaid enrollment. Further, a 2010 GAO report shows the Oklahoma program as having the largest number of employer participants of the states reporting this measure.<sup>30</sup>

In terms of quality outcomes, IO's results indicate the program is performing well on HEDIS outcomes measured by OHCA.<sup>31</sup> The program's results are generally in line with, or exceed, the broader SoonerCare program outcomes. For example, the percent of the IO population receiving Comprehensive Diabetes Care exceeds that of the general SoonerCare population.

The waiver that authorizes Insure Oklahoma is set to expire on December 31, 2013; CMS has informed Oklahoma that the current program must sunset at that time. Leavitt Partners encourages OHCA to continue to work with CMS and HHS to maintain this program until an appropriate alternative is developed. Additional detail is provided in a companion report, "Covering the Low-Income, Uninsured in Oklahoma: Recommendations for a Medicaid Demonstration Proposal."

## Areas for Continuing Improvement

### OHCA Board and Advisory Committees

Several individuals Leavitt Partners interviewed expressed appreciation for the OHCA Board's annual meeting where advisory committee members have the opportunity to interact directly with Board members. However, suggestions to increase communication between the committees and the Board were also made. The large number of advisory committees was also referenced along with a suggestion that consolidation of some committees be considered. A reduction in the number of committees would reduce the time commitment required for both OHCA as well as members who are on more than one committee. With fewer committees, it may also be easier to maintain more frequent and direct communication between the Board and the committees.

While Leavitt Partners is not putting forth a specific recommendation for OHCA to reduce the number of its advisory committees, it is recommending that OHCA examine the feasibility and advisability of committee consolidation. Leavitt Partners also recommends that OHCA work with its Board to ensure that there are sufficient and open channels of communication with the advisory committees to maintain the strong foundation of soliciting and acting on feedback that has been established by the agency.

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<sup>30</sup> Letter to Senator Max Baucus and Representative Henry Waxman Regarding Medicaid and CHIP: Enrollment, Benefits, Expenditures, and Other Characteristics of State Premium Assistance Programs, GAO (January 19, 2010).

<sup>31</sup> It is important to note that OHCA is only able to capture HEDIS outcomes for a small portion of its Insure Oklahoma population (less than 10% of program participants). As such, it is difficult to make concrete inferences from the data. However, given that most results are in line with broader SoonerCare program outcomes, it is likely the small sample provides a reasonable reflection of the program's outcomes.

## HEDIS, CAHPS, ECHO

In its review of the SoonerCare program, Leavitt Partners evaluated three different data sets, HEDIS, CAHPS, and ECHO, which measure the quality of performance and consumer experience.

The Healthcare Effectiveness Data and Information Set (HEDIS) is a standardized set of performance measures managed by the National Committee for Quality Assurance (NCQA). This tool consisting of 75 measures is used to improve health plan performance and is used by employers, health plans, states, and the federal government to compare health plan performance on an equal basis (a complete list HEDIS 2013 Measures is provided in Appendix 2).<sup>32</sup> OHCA first reported HEDIS measures in 2001 and was one of the first states to use the measures within a PCCM program.

The Consumer Assessment of Health Plans Survey (CAHPS) is administered by the U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality (AHRQ) to support and promote the assessment of consumers' experiences with health care.<sup>33</sup> It asks consumers and patients to report on and evaluate their experiences with health care, such as the communication skills of their providers and ease of access to health care services.

The Experience of Care and Health Outcomes (ECHO) survey is designed to collect consumers' ratings of their behavioral health treatment. The OHCA annually administers the ECHO survey to measure members' satisfaction with behavioral health services, alternating between the adult and child populations each year. The methodology for this survey is based on CAHPS and covers aspects of behavioral health services, including access to care, receiving care without long waits, communication with clinicians, family involvement in care, etc. The questionnaire also asks respondents to give overall ratings of the counseling or treatment they received and SoonerCare Choice.<sup>34</sup>

While the quality data on the SoonerCare program show many positive results, some outcomes indicate areas needing improvement as well. Highlights from Leavitt Partners' review are provided below while a more detailed summary is provided in Appendix 1.

### ***Positive Results***

1. Compared to other state Medicaid programs and plans, SoonerCare seems to perform slightly better on most of the HEDIS Quality Measures currently reported by OHCA. For example, in terms of Children's and Adolescents' Access to primary care physicians (PCPs) (aged 12-24 months), SoonerCare reports higher outcomes than the selected comparison states of Iowa, Arizona, and one of Kansas' managed care plans (operating in 2009).<sup>35</sup> It also reports higher

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<sup>32</sup> "HEDIS & Performance Measurement," NCQA. Accessed June 17, 2013.

<http://www.ncqa.org/HEDISQualityMeasurement.aspx>.

<sup>33</sup> "About CAHPS," Agency for Healthcare Research and Quality. Accessed June 17, 2013

<http://cahps.ahrq.gov/about.htm>.

<sup>34</sup> "ECHO Adult Behavioral Health Survey For SoonerCare Choice," APS Healthcare Report Submitted to OHCA (June 2009).

<sup>35</sup> Kansas contracted with three new managed care plans in 2012. To better understand how SoonerCare compares to individual states, Leavitt Partners selected five comparison states based on differences in Medicaid delivery systems (MCO vs. PCCM) and differences in states' overall health status. It is important to note that a direct comparison cannot be made given that some of the plans are not accredited by the NCQA. Also, while the

outcomes on Adults' Access to Preventive/Ambulatory Health Services (aged 45–64 years) than West Virginia, Iowa, Arizona, and Medicaid managed care plans in both Kansas and Minnesota.

In terms of Appropriate Medications for the Treatment of Asthma, SoonerCare reports higher outcomes than Iowa and West Virginia, but lower outcomes than Arizona and Minnesota.<sup>36</sup> It also reports higher outcomes than Iowa on Annual Dental Visits (Iowa is the only other state to report on this measure).

2. In general, SoonerCare Choice adult members report a fairly high level of satisfaction, and satisfaction has increased over the last four years. “How Well Doctors Communicate” consistently has the highest satisfaction rate (85% in 2012). “Shared Decision Making” has the lowest satisfaction rating (58% in 2012).
3. Since 2008, significant increases have occurred in three of the main satisfaction ratings. “Rating of Specialist” increased from 69% in 2008 to 79% in 2012, “Rating of Personal Doctor” increased from 65% to 76%, and “Rating of Health Plan” increased from 62% to 68%. However, overall “Rating of Health Care” is low and could show improvement. In addition, only 52% of surveyed members reported their overall health as excellent, very good, or good. Forty-eight percent reported their overall health as fair or poor.
4. SoonerCare Choice pediatric member parents and guardians also show a high level of satisfaction with the program. “How Well Doctors Communicate” is consistently the highest summary rate, at 93% in 2012. The lowest satisfaction rate is “Shared Decision Making” (75%). In contrast to the adult survey, overall reported health is very positive. Ninety-six percent of all respondents reported their health as being excellent, very good, or good. Seventy-two percent reported excellent or very good health.
5. Since 2009, all SoonerCare Choice Child Member Medical Satisfaction Survey summary measure outcomes increased, and almost all of the increases were statistically significant, showing positive movement in member experiences.
6. On the ECHO SoonerCare Choice Child Member Behavioral Health Satisfaction Survey, “How Well Clinicians Communicate” consistently shows the highest rate, at 91% in 2012. “Getting Treatment Quickly” shows the lowest satisfaction rate at 63%. The dissatisfaction in getting treatment quickly was due to members not being able to get needed counseling by phone.
7. Most ECHO measure outcomes have increased since 2008, with the exception of “Perceived Improvement of Member” and “Getting Treatment Quickly.” Two measures, “Rating of Health Plan” and “Access to Treatment and Information from Health Plan” had significant increases, increasing from 72% and 60% in 2008 to 78% and 71% in 2012.

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timeframes are similar, each state uses a slightly different reporting year. As such, it cannot be determined whether the differences are statistically significant. The selected comparison states include Arizona, Iowa, Kansas, Minnesota, and West Virginia.

<sup>36</sup> Kansas did not report outcomes for this measure.

## ***Areas of Concern***

1. OHCA's HEDIS outcomes are not audited, making it difficult to compare the results to commercial plans in the State, other Medicaid programs, and national results.
2. Differences in the program's outcomes on various quality measures highlight broader areas for improvement. For example, SoonerCare reports consistently high outcomes on Children and Adolescents' Access to PCPs as well as Adults' Access to Preventive/Ambulatory Health Services. Interestingly though, it reports much lower outcomes on Well Child Visits and other adult treatments, such as Comprehensive Diabetes Care and cancer screenings. This may indicate that while SoonerCare is successful in providing necessary access points for receiving care, there is room for improvement in care provided after the point of access.
3. SoonerCare's outcomes on measures such as Comprehensive Diabetes Care, Lead Screening in Children, Appropriate Testing for Children with Pharyngitis, Breast Cancer Screening, Cervical Cancer Screening, and Cholesterol Management for Patients with Cardiovascular Conditions are much lower than both national commercial and Medicaid averages.<sup>37</sup>
4. Comparing SoonerCare to the lowest ranking NCQA-accredited commercial plan operating in Oklahoma illustrates mixed results as well.<sup>38</sup> While SoonerCare reports higher outcomes on Children and Adolescents' Access to PCPs for all age groups, it reports lower outcomes on all other available measures, with substantially lower outcomes on measures such as Comprehensive Diabetes Care, Appropriate Testing for Children with Pharyngitis, Breast Cancer Screening, Cervical Cancer Screening, and Cholesterol Management for Patients with Cardiovascular Conditions.
5. SoonerCare only reports outcomes on a portion of available HEDIS measures (roughly about one quarter the 75 available measures). For example, it does not currently include outcomes on Prenatal and Postpartum Care, Annual Monitoring for Patients on Persistent Medications, Alcohol and Other Drug Dependence Treatment, and Medical Assistance with Smoking and Tobacco Use Cessation, among others. SoonerCare is making improvements in tracking these areas. The State currently tracks Annual Dental Visits for those under age 21 and, in 2012, the state began tracking Childhood Immunization Status, Adolescent Immunization Status, BMI Assessment for Children/Adolescents, ER visits, and Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication. The state is also planning to start collecting outcomes on prenatal care measures, which is important given the portion of the population that uses SoonerCare specifically for pregnancy-related services.

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<sup>37</sup> Because OHCA's HEDIS outcomes are not audited, they are not directly comparable to national commercial and Medicaid averages.

<sup>38</sup> HEDIS measures were publicly available for Aetna Health Inc., which is the lowest ranked NCQA accredited plan in the State. On NCQA's 2012-2013 Health Insurance Plan Rankings, Aetna ranked 420<sup>th</sup>. UnitedHealthcare of Oklahoma ranked 354<sup>th</sup> and UnitedHealthcare Insurance and UnitedHealthcare Services ranked 366<sup>th</sup>. BlueCross BlueShield Oklahoma, CommunityCare Managed Healthcare Plans of Oklahoma, and other plans operating in the State did not report data to NCQA. "NCQA's Health Insurance Plan Rankings 2012-2013—Private Plan Details," NCQA (2012).



6. Measures on which SoonerCare reports lower outcomes than other selected comparison states include Lead Screening in Children, Comprehensive Diabetes Care, Breast Cancer Screening, and Cervical Cancer Screening.<sup>39</sup>
7. Some measures that have not shown improvement in the last year are in areas that OHCA has been targeting in its Payments for Excellence program. This includes Breast and Cervical Cancer Screenings and Well Child Visits.

### ***Recommendations for Improvement***

Based on these findings, Leavitt Partners recommends OHCA:

1. **Broaden the number of HEDIS measures that are tracked.** While other quality measures may be used in program evaluation, HEDIS provides a consistent approach and allows for comparisons with commercial plans in the State, other Medicaid programs, and national results. Suggested additional measures that should be tracked are identified in point #5 above.
2. **Use audited data.** HEDIS is used to compare plan performance. In such a comparison it is important to validate the data collected and reported by the different plans. Despite the publication of specifications, data collection and calculation methods can vary and errors can affect the results. NCQA has confirmed that this concern is justified and, as such, believes that independent audit of data collection and reporting processes is necessary to verify that all specifications are met. Using audited data will ensure that OHCA's data meet NCQA standards and is comparable to commercial plans in the State, other Medicaid programs, and national results, allowing it to better target areas for improvement.
3. **Prioritize and focus on improving the areas where program outcome measures are significantly lagging.** OHCA should focus on improvement efforts on areas that lag behind other states or the commercial insurance market.

Improving Oklahoma's outcomes on quality measures has been a focus of Governor Fallin. In her FY2014 Budget Recommendations, funding was designated for prescription drug abuse prevention, suicide prevention, and efforts to expand the implementation of evidence-based prevention programs to improve infant health outcomes.<sup>40</sup> Governor Fallin also stated in her 2013 State of the State Address that "moving forward, my administration will continue to develop an 'Oklahoma Plan' that focuses on improving the health of our citizens, lowering the frequency of preventable illnesses like diabetes and heart disease, and improving access to quality and affordable health care."<sup>41</sup> Leavitt Partners supports this focus and recommends that improving the State's outcomes on quality measures continue to be an area of attention for the State.

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<sup>39</sup> These outcomes are primarily lower than the results from Minnesota, which reports the individual outcomes of its MCOs. The two Minnesota MCOs included in this analysis are Blue Plus (HMO Minnesota) and Medica.

<sup>40</sup> These recommendations were included in the FY2014 General Appropriations Budget approved by the Legislature on May 14, 2013. Available from "Governor Fallin's FY-2014 Executive Budget," OK.gov. Accessed June 17, 2013. <http://www.ok.gov/governor/documents/2013%20SOTS%20Executive%20Summary.pdf>.

<sup>41</sup> Gov. Fallin, "Governor Mary Fallin's 2013 State of the State Address," Office of Governor Mary Fallin, Press Release (February 4, 2013).

## Payment Performance Incentives

The State of Oklahoma has implemented several initiatives that focus on improving the health status of its citizens. The need for improvement has been reiterated by both the State Legislature and the Governor and, as part of its research and analysis, Leavitt Partners was asked to consider how a Medicaid demonstration can be designed in a way to help improve population health. One approach that can be used to achieve this goal is to establish financial incentives tied to health outcomes.

### ***Provider Incentives***

As outlined above, OHCA has an impressive Medicaid delivery system. OHCA has taken positive steps to develop provider incentives in order to improve specific, fundamental processes. For example, providers can receive payments based on EPSDT screens, use of generic drugs, inpatient admissions and visits, breast and cervical cancer screenings, and emergency department utilization.

Specific examples highlighting the purposes of these incentive payments are detailed below:<sup>42</sup>

- The purpose of the inpatient incentive is to provide supplemental payment to PCPs that provide inpatient admitting and care, as well as to incentivize PCPs to admit and visit their patients while in an inpatient setting.
- The purpose of the Generic Drug payment is to incentivize PCPs to prescribe generic drugs when available and clinically appropriate in place of name brand drugs.
- The purpose of the breast and cervical cancer screening is to provide supplemental payment to PCPs that meet or exceed the target compliance rate for screenings as well as incentivize PCPs to perform and recommend screening services.
- The purpose of the Emergency Department (ED) utilization incentive is to provide supplemental payment to PCPs that meet or exceed the ED utilization compliance rate and incentivize PCPs to educate patients about proper ED usage.

The advantage of these incentive payments is they focus PCPs on areas identified by OHCA as priorities for performance improvements and are areas that are relatively easy to measure. However, while these payments provide incentive to improve specific outcomes (higher screening rates, higher use of generic medications, etc.), they may not necessarily translate to improved overall health outcomes. For example, while initial EPSDT screenings are something OHCA encourages, the fact that the screenings occur does not necessarily result in the accurate identification of conditions that require treatment, that appropriate treatment is provided, or that the expected treatment outcomes are realized.

Leavitt Partners recommends that OHCA consider broadening the incentive program to provide financial incentives for identified improvements in health outcomes, such as tobacco cessation, reductions in obesity, and improved health indicators from diabetes care. OHCA should engage a broad group of stakeholders in the review process as well as a broad group of providers in the incentive program, including primary care physicians, specialists, hospitals, the Health Department, the Department of Mental Health and Substance Abuse Services, etc.

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<sup>42</sup> "SoonerExcel," Oklahoma Health Care Authority. Accessed June 17, 2013.  
[http://www.okhca.org/providers.aspx?id=9426&menu=74&parts=8482\\_10165](http://www.okhca.org/providers.aspx?id=9426&menu=74&parts=8482_10165).

If OHCA chooses to adopt an outcome based incentive program, it has an opportunity to design and provide incentives at varying levels. One approach would reward performance at the individual provider level by providing incentives for improved health outcomes for the patient population. Based on the assumption that coordinated care delivery results in improved health outcomes for Medicaid enrollees, particularly those with chronic conditions and behavioral health needs, an alternative model would target financial incentives towards coordinated teams of providers.

### ***Shared Savings***

Given the prevalence of chronic conditions in the low-income population, and the current direction of the health care industry to more coordinated care, OHCA should consider developing a shared savings approach to incentivizing better health outcomes for the Medicaid population. Not only does this help emphasize the team approach to providing care, it also incentivizes providers to achieve an overall improvement in the health of the State's population.

In the accountable care movement focus is placed on population outcome improvements and one method being deployed to move the market in this direction is shared savings. Shared savings incentivizes movement toward population health improvement by providing "up-side" only financial incentives that address both quality improvement and system cost savings.

Recent research has identified several key elements and strategies common in shared savings arrangements.<sup>43</sup> These elements include:

1. **Agreement on achievement of savings.** Parties need to agree on criteria, baselines, how random events are treated, and how risk is addressed.
2. **Development and agreement on performance measurement.** The payer may want to include a level of minimum improvement in quality before any savings are shared. This may be a single threshold or a tiered approach. Consideration can be given to adherence to evidence based procedures, enrollee satisfaction, targeted health outcomes, etc.
3. **How the payers can support providers in the program.** This may include technical assistance in coordinating care, assistance with start-up costs, provision of needed data, etc.

The OHCA's medical home initiative implements, or is moving toward implementing similar strategies. OHCA has worked with its providers on risk adjustment and incentive payments. Providers have experience in measuring quality, utilizing HEDIS, CAHPS, ECHO, and conducting special studies targeting cost savings and quality improvement. OHCA has taken steps to improve its IT infrastructure to meet health information exchange (HIE) needs, which is an essential tool in a coordinated care, shared savings model. Additionally, OHCA has experience with helping providers become an established medical home.

While there is likely to be significant changes and increased complexity in moving toward a shared savings model, the conceptual framework would not differ substantially from OHCA's current direction. However, there are areas that will require additional attention. For example, there would be a need to continue to shore up the State's infrastructure, including continuing to mature the State's HIE systems. This would include work at the provider level related to utilizing existing systems, as well as maturing

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<sup>43</sup> "The Design And Application of Shared Savings Programs: Lessons from Early Adopters," Health Affairs, 31 No. 9 (September 2012).

the ability to move information across provider boundaries, allowing for greater sharing of appropriate information within the defined network. Additionally, behavioral health capacity and care coordination entities will need to be expanded.

### ***Alternative Approach to Shared Savings***

Another approach that could be used to incentivize outcome based improvements is a reimbursement withhold. In these systems, a percentage of the payment is retained by the payer and disbursed if specified quality improvement targets are met. This is used in the rate setting process with plans in Medicare/Medicaid dual eligible projects where the withhold is applied to the contracting health plans. In a system that does not use health plans, the withhold could be applied directly to the provider's reimbursement. The advantage of this approach is that the incentive to improve quality is not dependent on obtaining savings. A potential disadvantage, however, is it does not necessarily address maximizing efficiency while improving quality.

### ***Fourth Option***

A possible fourth option would meld two approaches by using both a withhold and providing an enhanced payment if savings are also attained. This provides some financial reward for improvement in quality outcomes and a separate incentive to reduce costs. For example, if the defined system meets predefined quality thresholds, and at the same time reduces costs, the 1% withhold would be distributed and the dollars from the predefined savings percentage would also be rewarded. The distribution of the shared savings could be made contingent on the system first meeting the quality improvement thresholds, could be scaled based on level of improvement, or considered as a completely separate incentive program.

## **Shift of Behavioral Health Responsibilities**

Behavioral health is a critical component of state Medicaid programs for a variety of reasons. First, the populations served by Medicaid have a high prevalence and risk for behavioral health disorders. Second, treatment of behavioral health disorders is costly and can influence a person's overall health as well as their ability to seek appropriate care.<sup>44</sup> Third, untreated behavioral health disorders can negatively impact other state and public programs, including the criminal justice system, homeless support agencies, and public assistance due to an increased risk of unemployment.<sup>45</sup>

There are also known relationships between physical and behavioral health that increase the need for closer coordination between Medicaid and behavioral health. Some of the crossover issues include:

- Use of emergency departments and hospital visits occur at a higher rate for people with mental illness, particularly those with serious mental illness.<sup>46</sup>

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<sup>44</sup> "NSDUH Report: Physical Health Conditions among Adults with Mental Illness," Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Administration (April 5, 2012).

<sup>45</sup> "Mental Health Problems of Prison and Jail Inmates," U.S. Department of Justice (September 2006). "Identifying Homeless and Unstably Housed DSHS Clients in Multiple Service Systems," Washington Department of Social and Health Services, Report 11.169 (August 2012). "Adults on TANF in Washington State, Risks and Outcomes for Leavers, Cyclers and Stayers," Washington Department of Social and Health Services Presentation to WorkFirst Subcabinet One Table Group Meeting (August 18, 2010, Revised August 30, 2010).

<sup>46</sup> "NSDUH Report: Physical Health Conditions among Adults with Mental Illness," Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Administration (April 5, 2012).

- Coordination with primary care providers is essential given that rates of hypertension, asthma, cardiovascular disease, diabetes, stroke, and pulmonary disease are substantially higher among individuals with psychiatric disabilities.<sup>47</sup>
- Many psychiatric medications, particularly anti-psychotics, can cause weight gain, obesity, and Type 2 Diabetes.<sup>48</sup>

The recent organizational shift in policy and budget authority for the behavioral health component of Oklahoma’s Medicaid program is an area for possible improvement. While OHCA, as the single state agency for Medicaid, cannot delegate full policy-making authority to another state agency, the State can design an approach where another agency is integral in the policy-making process and provides substantial influence on what policies are ultimately adopted by OHCA. Given the expertise that resides in the Oklahoma Department of Mental Health and Substance Abuse Services (DMHSAS), OHCA could benefit from strengthening its working relationship with this organization.

The need for a strong working relationship between the two agencies is vital. The advantages of integrating physical and behavioral health is becoming increasingly clear and state Medicaid programs have been moving aggressively to enhance such integration under various delivery system models. While the integration approach may differ between states, depending on whether they utilize a PCCM or contract with an independent behavioral health organization, there are common elements that should be included and which require coordination at the state program level. Key elements include:<sup>49</sup>

- Aligning financial incentives
- Sharing information across-systems
- Establishing adequate provider networks
- Supporting multidisciplinary care teams
- Establishing mechanisms for assessing and rewarding quality care

Implementing and maintaining these system elements will require a strong relationship between OHCA and ODMHSAS and a continuing focus on common program goals.

During its interviews, Leavitt Partners sensed some tension between the DMHSAS and OHCA staff. However, it is also clear that both OHCA and DMHSAS recognize the many points of connection between the programs and the populations that are served by them. Their mutual commitment to ensuring the provision of quality services to shared clients can guide agreements between these two agencies as they implement newly defined roles and relationships.

Some possible strategies that can be used include:

- Cross-training and information-sharing between agencies.

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<sup>47</sup> Based on 2009-2010 National Survey on Drug Use and Health (NSDUH) data. “Too Significant To Fail: The Importance of State Behavioral Health Agencies in the Daily Lives of Americans with Mental Illness, for Their Families, and for Their Communities,” National Association of State Mental Health Program Directors (2012).

<sup>48</sup> Ibid.

<sup>49</sup> “State Options for Integrating Physical and Behavioral Health Care,” Integrated Care Resource Center (October 2011).

- Establishing processes that ensure the agencies jointly make policy, planning, and budget decisions, including decisions regarding engagement and communication with tribes, providers, stakeholders, clients, and partner agencies.
- Developing cooperation and collaboration in all relevant areas—working together as partners in a spirit of good faith and mutual negotiation toward effective and efficient operation of the Medicaid program.
- Establishing processes that allow OHCA to maintain its administrative oversight role and allow DMHSAS to contract directly with individuals, entities, tribes, or other governmental units to furnish administrative or programmatic services for which it has responsibility and for which Medicaid funding is expended. These processes would include joint responsibility for rate setting.

While a new alignment of program responsibilities provides an opportunity to create value, it will take dedicated work by all parties to maximize the potential. State behavioral health agencies and Medicaid agencies often have different organizational cultures, priorities, and service delivery philosophies. Given the different perspectives, the policy directions and priorities of the administrative agencies may naturally diverge. A rearrangement of policy and budgetary responsibility may add to this tension for a period of time, requiring the attention of program leaders. However, there is tremendous potential for improvement in services and patient outcomes if the two organizations can combine their agencies' unique skill sets and expertise to address the needs of their shared populations.

## Provider Capacity (Access)

OHCA believes there is generally adequate access to Medicaid primary care providers (both currently and for future enrollment growth); yet, others in the community have indicated that there are serious access issues. One interviewee reported access problems in the Western area of the State, while another indicated there were problems in the Southeastern portion. Several interviewees identified a general access problem in rural areas. The OSU Center for Rural Health's *Oklahoma Healthcare Workforce Data Book* seems to support some of these antidotal reports of provider shortages, particularly in the State's southern areas.

Other indicators highlight access difficulties as well. For example, there are areas in the State that are designated as Health Care Professional Shortage Areas. These are geographic areas that have a documented shortage of providers. Twenty-two percent of Oklahoma's population lived in a Primary Care Shortage Area in 2012 while the national average is 19%.<sup>50</sup> The number of physicians per 10,000 population is another indicator of provider shortage as Oklahoma's rate is 18.9 compared to the national average of 25.7.<sup>51</sup> Oklahoma's ratio is one of the lowest in the nation.

OHCA points to the self-declared capacity of its medical home providers as evidence that there is current and future provider capacity in the State. This view is further supported by the CAHPS results showing that 82% of SoonerCare adults and 93% of the children are able to access care quickly.

<sup>50</sup> "Why Does Medicaid Spending Vary Across States: A Chart Book of Factors Driving State Spending," Kaiser Commission on Medicaid and the Uninsured (November 2012).

<sup>51</sup> Nationally, this ratio ranges from 17.3 in Mississippi to 65.9 in the District of Columbia (although it should be noted that DC is an outlier and the ratios of next highest states are in the mid and upper 30s). Available from Kaiser Family Foundation's State Health Facts. Accessed June 17, 2013. <http://kff.org/statedata/>.

Given these different perspectives regarding provider network capacity, it is recommended that OHCA continue to meet with the Department of Health, Oklahoma State University, and others to determine how best to reconcile the differences. If there is not adequate capacity in select areas of the State, plans should be developed to address this issue (particularly as part of any plan to reduce the number of uninsured).

## Evolving and Competing Delivery System Models

One concern with the current delivery system is the lack of competing models. Several interviewees mentioned that it may be worthwhile to explore reintroducing commercial MCOs as an option for program enrollees. Leavitt Partners agrees that further study and community discussion about the feasibility of such a change would be beneficial to OHCA.

OHCA is already conducting a feasibility study to assess the potential impact of moving the dual eligible to fully capitated managed care. Leavitt Partners believes that the demonstration for the dual eligible population provides a first step for the State in determining if the MCO model is a good fit within the current Oklahoma environment, and recommends waiting for the outcome of the feasibility study before considering this option for other populations. Depending on the results of this study, OHCA should conduct a broader study analyzing the impact of reintroducing MCOs to other population, including the impact of privatizing all or portions of its delivery system, such as capitating dental, behavioral health, or other health care services (a brief summary of capitated managed care and capitated carve out models is provided in Appendix 3).

In studying the impact of moving other Medicaid program enrollees to commercial-based managed care, OHCA is encouraged to analyze numerous factors before making its decision. One factor that should be heavily considered is the potential for cost savings and how the saving will be generated. Also, OHCA should examine the capacity for MCOs to improve care quality, increase care coordination, provide greater integration of physical and behavioral health, and generally improve health outcomes by incorporating public health components that important to the State.

Specific factors that could be considered in a study include:

- **Program history and disruption to the current system:** An argument can be made that Oklahoma engaged in a competitive MCO model in the past with suboptimal outcomes. It was also pointed out by one provider Leavitt Partners interviewed that making major changes to the State's delivery system can be very disruptive to providers who have to negotiate new contracts, establish different points of contact, negotiate new rates (often with multiple plans), become familiar with new approval systems and referral patterns, etc. The value gained by contracting with MCOs may be worth the disruption, but given the relatively recent history of moving away from MCO use, the State should be confident of the added value an MCO system would bring to its program.

- **Source of savings:** While many states are moving to Medicaid managed care models because of its ability to provide controlled and predicted costs, it is also important to note that there is mixed evidence associated with managed care’s ability to provide cost savings. For example, an examination of state Medicaid managed care programs found that nearly all managed care programs realized savings; however, the savings achieved were widely disparate, ranging from 0.5% to 20%.<sup>52</sup> Further, findings from a study evaluating the potential savings of shifting Medicaid recipients from FFS into Medicaid managed care in all 50 states also suggests that cost reductions are not significant for a typical state.<sup>53</sup> This study found that any cost reductions achieved were a function of reducing baseline provider reimbursement rates, rather than a reduction in health care services. This finding is consistent with other studies as well.<sup>54</sup>

As such, states with relatively high historic FFS reimbursement rates have tended to save money when moving to Medicaid managed care, largely due to a general reduction in prices. However, states with low historic FFS reimbursement tend to face cost increases as health plans raise reimbursement rates in order to attract providers.<sup>55</sup> Research suggests other reasons why Medicaid managed care is unlikely to significantly lower costs include: 1) Medicaid FFS is already low compared to commercial insurance or Medicare; 2) states already use tools managed care companies employ to reduce costs, such as prior authorization, utilization review, and other similar tools; 3) it is more costly in the short run for states to develop the necessary administrative infrastructure to contract with and regulate health plans than to pay providers directly; and 4) the federal government requires that health plan capitation rates be “actuarially sound,” providing health plans with a platform to seek higher rates.<sup>56</sup>

Before reintroducing MCOs, Leavitt Partners recommends OHCA research how private plans would realize any cost savings, detailing how care would be improved and the likely impacts on the State’s providers.

- **Current position:** The State already uses an established medical home model to coordinate the care of high need recipients. Because the State would not be converting from an unmanaged FFS system to risk-based MCOs, some of the savings that MCOs might generate from better care management have already been realized by the program. Given this dynamic, OHCA will want to determine how much added value MCOs will provide, and if the value and potential program savings justify the disruption to program enrollees, care providers, and the agency.

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<sup>52</sup> “Medicaid Managed Care Cost Savings – A Synthesis of 24 Studies,” The Lewin Group (March 2009).

<sup>53</sup> “Has the Shift to Managed Care Reduced Medicaid Expenditures? Evidence from State and Local Level Mandates,” National Bureau of Economic Research, Working Paper 17236 (July 2011).

<sup>54</sup> “How Does Managed Care Do It?” RAND Journal of Economics, 31 No. 3 (2000). “Transaction Prices and Managed Care Discounting For Selected Medical Technologies: A Bargaining Approach,” National Bureau of Economic Research, Working Paper 10377 (2004). “Is Managed Care Still an Effective Cost Containment Device?” Forum for Health Economics & Policy, Frontiers in Health Policy Research, 9 No. 1 (2006).

<sup>55</sup> “Medicaid Managed Care: Costs, Access, and Quality of Care,” Robert Wood Johnson Foundation Research Synthesis Report, 23 (September 2012).

<sup>56</sup> Ibid.



- **Changing marketplace:** Due to the implementation of federal regulations, the marketplace is rapidly changing—including revisions in the way Medicaid plans deliver care. For example, more plans are incorporating accountable care approaches within their systems. If Oklahoma’s market is also moving in this direction, this could strongly influence when and how the State would structure a MCO initiative. The State should examine how Accountable Care Organizations (ACO) are being structured throughout the country and whether the model may be a complementary extension of OHCA’s current medical home model (a brief write up on ACOs is provided In Appendix 4).

If the State does decide to reinstitute MCOs into its program delivery system, Leavitt Partners suggests a phased-in approach. For example, the State may consider allowing MCOs to focus first on a specific population (for example, the Medicaid/Medicare dually eligible) in order to obtain more concrete experience in how a broader implementation would likely work.

## Conclusion

There were two high level questions that Levitt Partners was asked to address in its evaluation of the SoonerCare program. The first question was whether OHCA has made correct decisions over the last five years and the second question was what value the program brings to the State? In short, the answers to these questions are yes—in Leavitt Partners’ opinion OHCA has made good choices over the past several years and the State realizes high value from the SoonerCare program.

Leavitt Partners’ evaluation shows that OHCA has attempted to solidify its core program over the past several years, both in terms of both controlling costs and improving quality. For example, it continues to evolve its PCCM program by increasing basic and enhanced care coordination and working with its providers to increase their medical home standards. While some HEDIS quality measure results could be improved, OHCA continues to use the measures to track its program’s effectiveness and is expanding the number of measures utilized. The fact that OHCA frequently evaluates the quality of its programs and seeks community feedback helps to ensure that the program is continually addressing areas of concern.

Leavitt Partners concurs with previous evaluations that the transition from commercial MCOs was the right move for the State. There is some interest in revisiting this decision and Leavitt Partners encourages OHCA to thoroughly examine its options and the feasibility of making such a move. Given the efficiency of its current program, savings realized from moving to commercial MCOs may not be significant. However, Leavitt Partners believes that the expertise OHCA has gained from self-administering processes, such as care coordination, program incentives, and quality oversight, puts it in a better position to contract with MCOs. Past experience has provided OHCA with flexibility to choose from different options moving forward, and to implement these options from a stronger base.

The SoonerCare program provides good health care coverage to approximately one quarter of Oklahoma’s population—over a million low-income residents, many of whom have serious chronic conditions, severe disabilities, and no other feasible source of coverage. The program pays a reasonable rate to Oklahoma providers, supporting the State’s economic base. SoonerCare’s costs also appear to be well in line with other state Medicaid programs. These aspects combined put OHCA in a strong position to respond to the future direction of the health care system.

# Appendix 1: Review of SoonerCare’s HEDIS, CAHPS, and ECHO Outcomes

## HEDIS

The Healthcare Effectiveness Data and Information Set (HEDIS) is a standardized set of performance measures managed by the National Committee for Quality Assurance (NCQA). This tool consisting of 75 measures is used to improve health plan performance and is used by employers, health plans, states, and the federal government to compare health plan performance on an equal basis (a complete list HEDIS 2013 Measures is provided in Appendix 2).<sup>57</sup>

OHCA first reported HEDIS measures in 2001 and was one of the first states to use the measures within a PCCM program. A previous evaluation of SoonerCare found that between 2001 and 2007, SoonerCare showed improvement on all HEDIS measures tracked over that time.<sup>58</sup>

More recent data from OHCA show that between 2011 and 2012, SoonerCare either maintained or improved performance on 21 of 29 HEDIS Quality Measures for which across year comparisons are available.<sup>59</sup> However, there were some statistically significant decreases on several measures during this time period as well—the largest being a 4.4 percentage point drop in Breast Cancer Screenings (for those aged 40-69 years) and a 4.7 percentage point drop in Cervical Cancer Screenings (for those aged 21-64 years).

Differences in outcomes between the various quality measures indicate areas for improvement. For example, SoonerCare reports consistently high outcomes on Children and Adolescents’ Access to PCPs as well as Adults’ Access to Preventive/Ambulatory Health Services. It reports much lower outcomes on Well Child Visits and other adult treatments though, such as Comprehensive Diabetes Care and cancer screenings (see Figure 9). This may indicate that while SoonerCare is successful in providing necessary access points for receiving care, there is room for improvement in care provided after the point of access.

While it is more accurate to analyze HEDIS outcomes within the program and over time (due to different methodologies, aggregations, and program types), comparing SoonerCare’s reported outcomes to commercial and other Medicaid programs can also be useful.<sup>60</sup> When compared to 2011 national commercial plan and national Medicaid managed care (HMO) averages, SoonerCare’s 2011 HEDIS outcomes are generally lower—particularly when compared to commercial plan outcomes.<sup>61</sup> On available measures, SoonerCare reports higher outcomes on only one measure, Children and

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<sup>57</sup> HEDIS & Performance Measurement,” NCQA. Accessed June 17, 2013.

<http://www.ncqa.org/HEDISQualityMeasurement.aspx>.

<sup>58</sup> “SoonerCare 1115 Waiver Evaluation: Final Report,” Mathematica (January 2009).

<sup>59</sup> SoonerCare data does not include outcomes from Insure Oklahoma.

<sup>60</sup> SoonerCare’s HEDIS outcomes are not audited and therefore are not directly comparable to other commercial and Medicaid plans. Further, HEDIS results are somewhat impacted by the populations being served by the plans, which will vary by Medicaid plan and by state.

<sup>61</sup> Comparable data not provided on all available measures. Compared to the 2011 average of accredited and non-accredited commercial and Medicaid HMO plans. “The State of Health Care Quality, 2012, Focus on Obesity and on Medicare Plan Improvement,” NCQA (October 2012).

Adolescents' Access to PCPs for children aged 12-19 years. When compared to national Medicaid managed care plan outcome averages, SoonerCare reports higher outcomes on six of 19 available comparative measures, including Children and Adolescents' Access to PCPs for all age groups and Appropriate Medications for the Treatment of Asthma.

However, SoonerCare's outcomes on measures such as Comprehensive Diabetes Care, Lead Screening in Children, Appropriate Testing for Children with Pharyngitis, Breast Cancer Screening, Cervical Cancer Screening, and Cholesterol Management for Patients with Cardiovascular Conditions are much lower than both national commercial and national Medicaid averages.

Comparing SoonerCare to the lowest ranking NCQA-accredited commercial plan operating in Oklahoma illustrates mixed results as well.<sup>62</sup> While SoonerCare reports higher outcomes on Children and Adolescents' Access to PCPs for all age groups, it reports lower outcomes on all other available measures, with significantly lower outcomes on measures such as Comprehensive Diabetes Care, Appropriate Testing for Children with Pharyngitis, Breast Cancer Screening, Cervical Cancer Screening, and Cholesterol Management for Patients with Cardiovascular Conditions.

It is important to note that SoonerCare only reports on about one quarter of the 75 available HEDIS measures. For example, it does not currently include outcomes on Prenatal and Postpartum Care, Annual Monitoring for Patients on Persistent Medications, Alcohol and Other Drug Dependence Treatment, and Medical Assistance with Smoking and Tobacco Use Cessation, among others. SoonerCare is making improvements in tracking these areas. The State currently tracks Annual Dental Visits for those under age 21 and, in 2012, the state began tracking Childhood Immunization Status, Adolescent Immunization Status, BMI Assessment for Children/Adolescents, ER visits, and Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication. The state is also planning to start collecting outcomes on prenatal care measures.

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<sup>62</sup> HEDIS measures were publicly available for Aetna Health Inc., which is the lowest ranked NCQA accredited plan in the State. On NCQA's 2012-2013 Health Insurance Plan Rankings, Aetna ranked 420<sup>th</sup>. UnitedHealthcare of Oklahoma ranked 354<sup>th</sup> and UnitedHealthcare Insurance and UnitedHealthcare Services ranked 366<sup>th</sup>. BlueCross BlueShield Oklahoma, CommunityCare Managed Healthcare Plans of Oklahoma, and other plans operating in the State did not report data to NCQA. "NCQA's Health Insurance Plan Rankings 2012-2013—Private Plan Details," NCQA (2012).

**Figure 9**

SoonerCare HEDIS Results Compared to State Commercial Plans and National Commercial and Medicaid Plans, 2010-2012						
HEDIS Quality Measures	SoonerCare			OK 2011	National 2011	
	2010	2011	2012	Commercial	Commercial	Medicaid
<b>Children &amp; Adolescents' Access to PCP</b>						
Aged 12-24 months	97.8%	97.2% <sup>1</sup>	96.6% <sup>1</sup>	95.0%	97.9%	96.1%
Aged 25 months-6 years	89.1%	88.4% <sup>1</sup>	90.1% <sup>1</sup>	88.0%	91.9%	88.2%
Aged 7-11 years	89.9%	90.9% <sup>1</sup>	91.7% <sup>1</sup>	87.0%	91.9%	89.5%
Aged 12-19 years	88.8%	89.9% <sup>1</sup>	91.6% <sup>1</sup>	85.0%	89.3%	87.9%
<b>Adults' Access to Preventive/ Ambulatory Health Services</b>						
Aged 20-44 years	83.6%	84.2% <sup>1</sup>	83.1% <sup>1</sup>	94.0%	NA	NA
Aged 45-64 years	90.9%	91.1%	91.0%	95.0%	NA	NA
Aged 65+ years	92.6%	92.1% <sup>1</sup>	92.2%	97.0%	NA	NA
<b>Well Child Visits</b>						
Aged <15 months 6+ visits	48.8%	59.0% <sup>1</sup>	58.6%	NA	78.0%	61.8%
Aged 3-6 years 1+ visits	61.9%	59.8% <sup>1</sup>	57.4% <sup>1</sup>	NA	72.5%	72.0%
Aged 12-21 years 1+ visits	37.1%	33.5% <sup>1</sup>	34.5% <sup>1</sup>	NA	43.2%	49.7%
<b>Appropriate Medications for the Treatment of Asthma</b>						
Aged 5-11 years	90.9%	90.6%	90.3%*	NA	96.0%	90.5%
Total	87.7%	86.9%	85.0%*	87.0%	91.9%	85.0%
<b>Comprehensive Diabetes Care (Aged 18-75 years)</b>						
Hemoglobin A1C Testing	71.0%	71.1%	70.5%	86.0%	90.0%	82.5%
Eye Exam (Retinal)	32.8%	31.8% <sup>1</sup>	31.8%	48.0%	56.9%	53.3%
LDL-C Screening	63.6%	62.9%	62.0%	78.0%	85.3%	75.0%
Medical Attention for Nephropathy	54.4%	55.9% <sup>1</sup>	56.8%	79.0%	83.8%	77.8%

**SoonerCare HEDIS Results Compared to State Commercial Plans  
and National Commercial and Medicaid Plans, 2010-2012**

HEDIS Quality Measures	SoonerCare			OK 2011	National 2011	
<b>Other</b>						
Lead Screening in Children (By 2 years of age)	43.5%	44.5% <sup>1</sup>	44.7%	NA	NA	67.8%
Appropriate Treatment for Children with URI (Aged 3 months-18 years)	67.7%	69.5% <sup>1</sup>	66.8% <sup>1</sup>	65.0%	83.9%	85.3%
Appropriate Testing for Children with Pharyngitis (Aged 2-18 years)	38.8%	44.8% <sup>1</sup>	49.1% <sup>1</sup>	67.0%	80.2%	66.7%
Breast Cancer Screening (Aged 40-69 years)	41.1%	41.3%	36.9% <sup>1</sup>	60.0%	70.5%	50.4%
Cervical Cancer Screening (Aged 21-64 years)	44.2%	47.2% <sup>1</sup>	42.5% <sup>1</sup>	73.0%	76.5%	66.7%
Cholesterol Management for Patients with Cardiovascular Conditions (Aged 18-75 years)	69.5%	69.9%	68.6%	87.0%	88.1%	82.0%

<sup>1</sup> Statistically significant change from previous year.

\*Due to different methodologies, not comparable to 2011.

Note: This table is not inclusive of all measures currently tracked by OHCA.

Source: SoonerCare HEDIS Quality Measures, 2010-2012. Aetna Health Inc. HEDIS 2012 Quality Report Card (Reporting Year 2011). NCQA Commercial and Medicaid HMO Averages, 2011.

The information presented above shows how SoonerCare compares to national Medicaid managed care averages. To better understand how SoonerCare compares to individual states, Leavitt Partners selected five comparison states to provide perspective based on differences in the Medicaid delivery system utilized (MCO vs. PCCM) as well as differences in states' overall health status.<sup>63</sup> Compared to the selected state Medicaid programs and plans, SoonerCare seems to perform slightly better on most of the available comparative HEDIS Quality Measures.<sup>64</sup> For example:

- Children's & Adolescents' Access to PCPs (aged 12-24 months): SoonerCare reports higher outcomes than Iowa, Arizona, and one of Kansas' managed care plans (operating in 2009).<sup>65</sup>

<sup>63</sup> The selected comparison states include Arizona, Iowa, Kansas, Minnesota, and West Virginia. In terms of overall health status, Oklahoma ranks 43<sup>rd</sup>. Arizona ranks 25<sup>th</sup>, Iowa ranks 20<sup>th</sup>, Minnesota ranks 37<sup>th</sup>, Kansas ranks 24<sup>th</sup>, and West Virginia ranks 47<sup>th</sup>. "America's Health Rankings," United Health Foundation (2012).

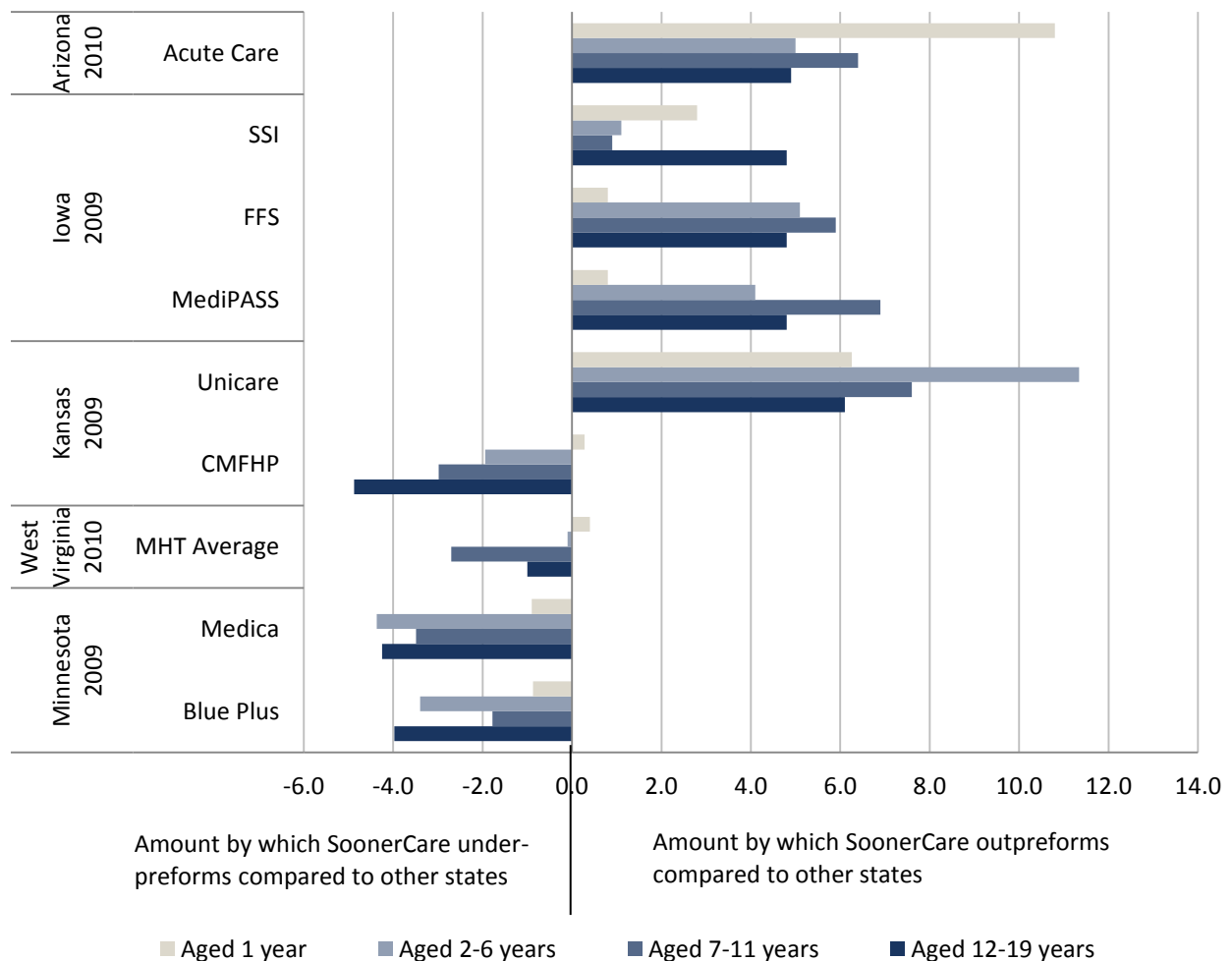
<sup>64</sup> A direct comparison cannot be made given that some of the plans are not accredited by the NCQA. Also, while the timeframes are similar, each state uses a slightly different reporting year. As such, it cannot be determined whether the differences are statistically significant.

<sup>65</sup> Kansas contracted with three new managed care plans in 2012.

- Adults' Access to Preventive/ Ambulatory Health Services (aged 45–64 years): SoonerCare reports higher outcomes than West Virginia, Iowa, Arizona, and plans in both Kansas and Minnesota.
- Appropriate Medications for the Treatment of Asthma: SoonerCare reports higher outcomes than Iowa and West Virginia, but lower outcomes than Arizona and Minnesota.<sup>66</sup>
- It also reports higher outcomes than Iowa on Annual Dental Visits (Iowa is the only other state to report on this measure).

**Figure 10**

**Percentage Point Difference between SoonerCare and other State Outcomes for Children and Adolescent's Access to PCPs (HEDIS Quality Measure), 2009-2010**



Source: SoonerCare HEDIS Quality Measures, 2010. Other select state HEDIS results, 2009-2010.

<sup>66</sup> Kansas did not report outcomes for this measure.

Measures on which SoonerCare reports significantly lower outcomes than other selected comparison states include Lead Screening in Children, Comprehensive Diabetes Care, Breast Cancer Screening, and Cervical Cancer Screening. However, these outcomes are significantly lower than Minnesota, which reports the individual outcomes of its Medicaid MCOs.<sup>67</sup>

## CAHPS Member Satisfaction Measures

The Consumer Assessment of Healthcare Providers and Systems program is a multi-year initiative of the U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality (AHRQ) to support and promote the assessment of consumers' experiences with health care.<sup>68</sup> The Consumer Assessment of Health Plans Survey (CAHPS) asks consumers and patients to report on and evaluate their experiences with health care. 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.

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<sup>67</sup> The two Minnesota MCOs included in this analysis are Blue Plus (HMO Minnesota) and Medica.

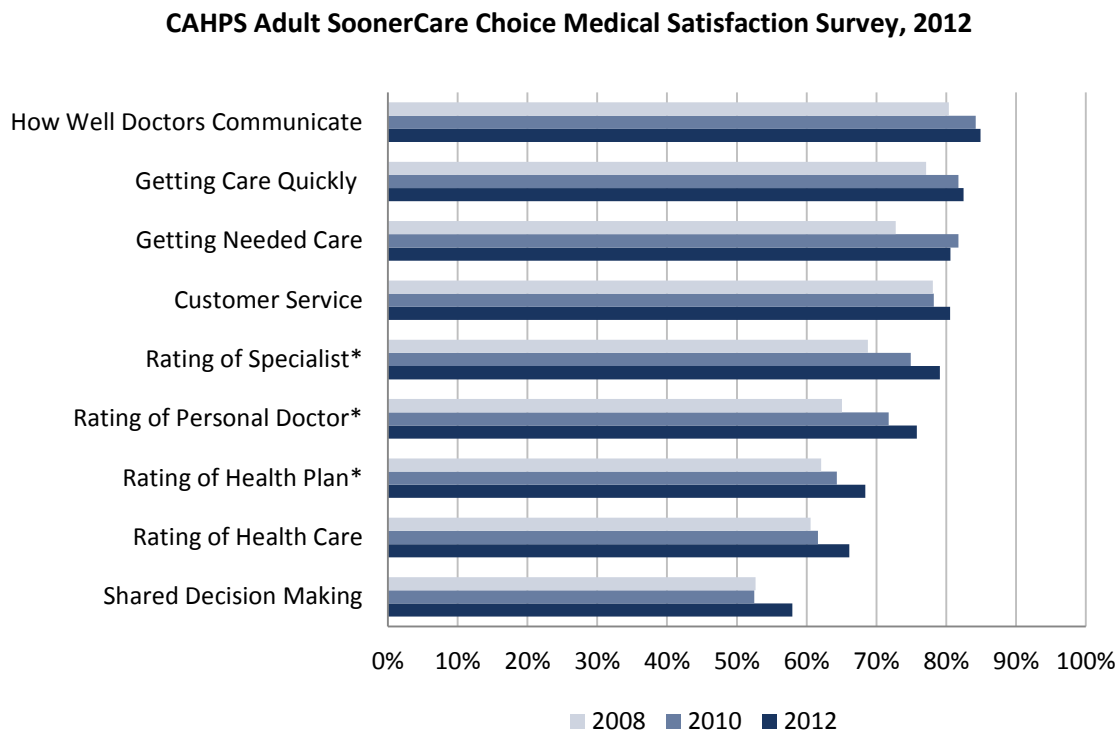
<sup>68</sup> "About CAHPS," Agency for Healthcare Research and Quality. Accessed June 17, 2013  
<http://cahps.ahrq.gov/about.htm>.

### CAHPS SoonerCare Choice Adult Member Medical Satisfaction Survey 2012

In general, SoonerCare Choice members report a fairly high level of satisfaction and satisfaction has increased over the last four years. “How Well Doctors Communicate” consistently has the highest satisfaction rate (85% in 2012); “Shared Decision Making” has the lowest satisfaction rating (58% in 2012).

Since 2008, significant increases have occurred in three of the main satisfaction ratings. “Rating of Specialist” increased from 69% in 2008 to 79% in 2012, “Rating of Personal Doctor” increased from 65% to 76%, and “Rating of Health Plan” increased from 62% to 68%. However, overall “Rating of Health Care” is low and could show improvement. In addition, while not shown in the Figure 11, only 52% of surveyed members reported their overall health as excellent, very good, or good. Forty-eight percent reported their overall health as fair or poor.

Figure 11



\* Significant increases from 2008 to 2012.



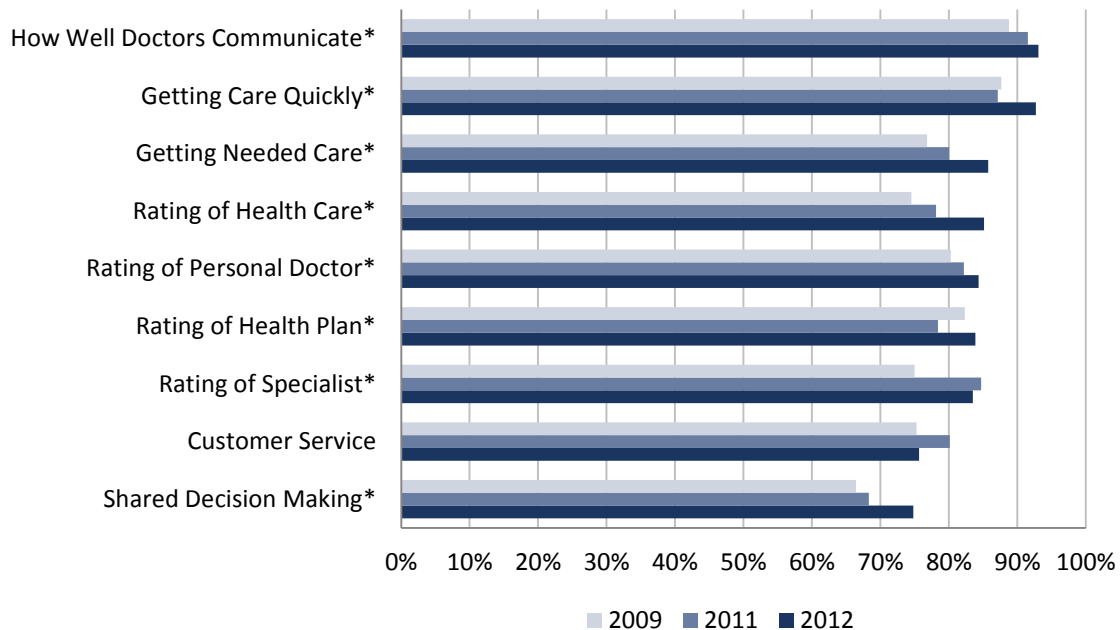
### CAHPS SoonerCare Choice Child Member Medical Satisfaction Survey 2012

SoonerCare Choice pediatric member parents and guardians also show a high level of satisfaction with the program. “How Well Doctors Communicate” is consistently the highest summary rate, at 93% in 2012. The lowest satisfaction rate is “Shared Decision Making” (75%). Also, while not a significant difference, children without chronic conditions consistently scored higher than those with chronic conditions, with the exception of the Shared Decision Making measure. In contrast to the adult survey, overall reported health is very positive. Ninety-six percent of all respondents reported their health as being excellent, very good, or good. Seventy-two percent reported excellent or very good.

Since 2009, all summary measure outcomes increased, and almost all of the increases were statistically significant, showing positive movement in member experiences.

Figure 12

#### CAHPS Child SoonerCare Choice Member Medical Satisfaction Survey, 2012



\* Significant increases from 2009 to 2012.

Because SoonerCare presents separate CAHPS results for adults and children, it is not directly comparable to the national commercial plan and Medicaid HMO averages.<sup>69</sup> However, in general, SoonerCare outcomes are slightly below what is reported nationally by commercial plans and comparable to what is reported nationally by Medicaid plans. In terms of the adult survey, SoonerCare has lower outcomes than commercial plans on all measures, except for “Rating of Health Plan.” It has slightly higher outcomes than Medicaid plans on all measures, except for “How Well Doctors Communicate” and “Rating of Health Plan.” In terms of the children’s survey, SoonerCare has higher or equivalent outcomes to commercial and Medicaid plans on all measures except for “Customer Service.”

## **ECHO SoonerCare Choice Member Behavioral Health Satisfaction Survey**

The Experience of Care and Health Outcomes (ECHO) survey is designed to collect consumers’ ratings of their behavioral health treatment. The OHCA annually administers the ECHO survey to measure members’ satisfaction with behavior health services, alternating between the adult and child populations each year. The methodology for this survey is based on CAHPS and covers the following aspects of behavioral health services:

- Access to care
- Receiving care without long waits
- Communication with clinicians
- Family involvement in care
- Perceived improvement in functioning
- Patient’s rights
- Experiences with the health plan

The questionnaire also asks respondents to give overall ratings of the counseling or treatment they received and SoonerCare Choice.<sup>70</sup>

### ***ECHO SoonerCare Choice Child Member Behavioral Health Satisfaction Survey FY2012***

On the ECHO SoonerCare Choice Child Member Behavioral Health Satisfaction Survey, “How Well Clinicians Communicate” consistently shows the highest satisfaction rating among patients, at 91% in 2012 (respondents are SoonerCare Choice pediatric member parents and guardians). “Getting Treatment Quickly” shows the lowest satisfaction rate at 63%. The dissatisfaction in getting treatment quickly was largely due to members not being able to get needed counseling by phone. Most measures have increased since 2008, with the exception of “Perceived Improvement of Member” and “Getting Treatment Quickly.” Two measures, “Rating of Health Plan” and “Access to Treatment and Information from Health Plan” had significant increases, from 72% and 60% in 2008 to 78% and 71% in 2012.

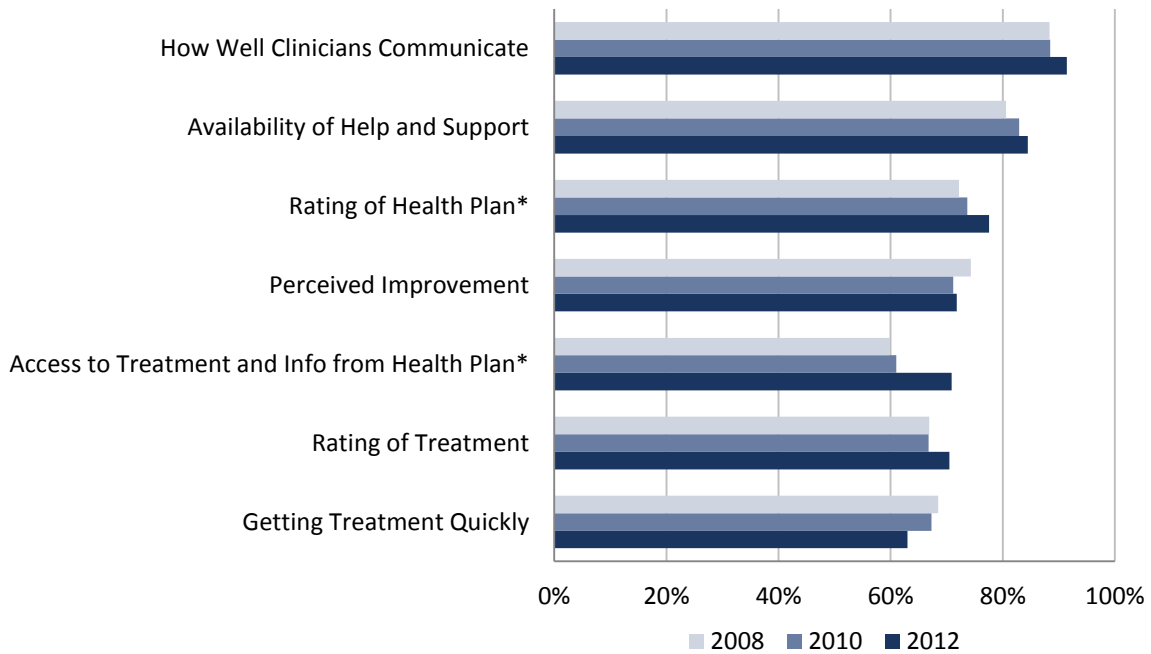
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<sup>69</sup> Results are not directly comparable for other reasons, including “First, Medicaid benchmark scores are reported in the aggregate; significance testing between the individual-level data and the aggregated benchmark scores is not appropriate. Second, several of the CAHPS benchmark measures are aimed at assessing enrollees’ satisfaction with the performance of the health plan as a whole, which is more relevant to MCOs than to PCCM programs like SoonerCare Choice. Last, reporting of data is voluntary and may not be representative of all or most managed Medicaid programs.” Available from “SoonerCare 1115 Waiver Evaluation: Final Report,” Mathematica (January 2009).

<sup>70</sup> “ECHO Adult Behavioral Health Survey For SoonerCare Choice,” APS Healthcare Report Submitted to OHCA (June 2009).

Figure 13

**ECHO Child SoonerCare Choice Member Behavioral Health Satisfaction Survey, 2012**



\* Significant increases from 2008 to 2012.

***ECHO SoonerCare Choice Adult Member Behavioral Health Satisfaction Survey FY2009***

When comparing the 2007 Adult survey to the 2009 survey (the most recent year available to Leavitt Partners), results indicate fairly high levels of satisfaction holding steady across an array of 11 quality measures. As with the Child Member Survey, “Getting Treatment Quickly” shows the lowest satisfaction rate (62% usually or always get treatment quickly). Despite having high satisfaction levels on almost all of the measures, when asked to rate the treatment and counseling received, adult members only provided a mean rating of 2.11 out of 10. This is statistically comparable to the mean rating in 2007, which was 2.10.

The one measure which showed a statistically significant difference over the two years was “Information about Treatment Options.” This measure had a significant increase of members who indicated that they were informed of alternative treatment options between 2007 and 2009 (50.6% vs. 61.0%).

## Appendix 2: 2013 HEDIS Measures

### HEDIS 2013 Measures

#### *Effectiveness of Care*

- Adult BMI Assessment
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents
- Childhood Immunization Status
- Immunizations for Adolescents
- Human Papillomavirus Vaccine for Female Adolescents
- Lead Screening in Children
- Breast Cancer Screening
- Cervical Cancer Screening
- Colorectal Cancer Screening
- Chlamydia Screening in Women
- Glaucoma Screening in Older Adults
- Care for Older Adults
- Appropriate Testing for Children With Pharyngitis
- Appropriate Treatment for Children With Upper Respiratory Infection
- Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Pharmacotherapy of COPD Exacerbation
- Use of Appropriate Medications for People With Asthma
- Medication Management for People With Asthma
- Asthma Medication Ratio
- Cholesterol Management for Patients With Cardiovascular Conditions
- Controlling High Blood Pressure
- Persistence of Beta-Blocker Treatment After a Heart Attack
- Comprehensive Diabetes Care
- Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
- Osteoporosis Management in Women Who Had a Fracture
- Use of Imaging Studies for Low Back Pain
- Antidepressant Medication Management
- Follow-Up Care for Children Prescribed ADHD Medication
- Follow-Up After Hospitalization for Mental Illness
- Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
- Diabetes Monitoring for People With Diabetes and Schizophrenia
- Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia
- Adherence to Antipsychotic Medications for Individuals With Schizophrenia
- Annual Monitoring for Patients on Persistent Medications
- Medication Reconciliation Post-Discharge
- Potentially Harmful Drug-Disease Interactions in the Elderly
- Use of High-Risk Medications in the Elderly

- Fall Risk Management
- Management of Urinary Incontinence in Older Adults
- Osteoporosis Testing in Older Women
- Physical Activity in Older Adults
- Aspirin Use and Discussion
- Flu Shots for Adults Ages 50–64
- Flu Shots for Older Adults
- Medical Assistance With Smoking and Tobacco Use Cessation
- Pneumococcal Vaccination Status for Older Adults

### ***Access/Availability of Care***

- Adults' Access to Preventive/ Ambulatory Health Services
- Children's and Adolescents' Access to Primary Care Practitioners
- Annual Dental Visit
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Prenatal and Postpartum Care
- Call Answer Timeliness

### ***Experience of Care***

- CAHPS Health Plan Survey 5.0H, Adult Version
- CAHPS Health Plan Survey 5.0H, Child Version
- Children With Chronic Conditions

### ***Utilization and Relative Resource Use***

- Frequency of Ongoing Prenatal Care
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
- Adolescent Well-Care Visits
- Frequency of Selected Procedures
- Ambulatory Care
- Inpatient Utilization—General Hospital/ Acute Care
- Identification of Alcohol and Other Drug Services
- Mental Health Utilization
- Antibiotic Utilization
- Plan All-Cause Readmissions

## HEDIS 2013 Physician Measures

### *Effectiveness of Preventive Care*

- Adult BMI Assessment
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
- Childhood Immunization Status
- Immunizations for Adolescents
- Human Papillomavirus Vaccine for Female Adolescents
- Lead Screening in Children
- Colorectal Cancer Screening
- Breast Cancer Screening

### *Effectiveness of Acute Care*

- Cervical Cancer Screening
- Chlamydia Screening in Women
- Glaucoma Screening in Older Adults
- Use of High-Risk Medications in the Elderly
- Care for Older Adults
- Appropriate Treatment for Children With Upper Respiratory Infection
- Appropriate Testing for Children With Pharyngitis
- Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis
- Use of Imaging Studies for Low Back Pain

### *Effectiveness of Chronic Care*

- Persistence of Beta-Blocker Treatment After a Heart Attack
- Controlling High Blood Pressure
- Cholesterol Management for Patients With Cardiovascular Conditions
- Comprehensive Ischemic Vascular Disease
- Comprehensive Adult Diabetes Care
- Use of Appropriate Medications for People With Asthma
- Medication Management for People With Asthma
- Asthma Medication Ratio
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Pharmacotherapy Management of COPD Exacerbation
- Follow-Up After Hospitalization for Mental Illness
- Antidepressant Medication Management
- Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
- Diabetes Monitoring for People With Diabetes and Schizophrenia
- Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia
- Adherence to Antipsychotic Medications for Individuals With Schizophrenia
- Follow-Up Care for Children Prescribed ADHD Medication
- Osteoporosis Management in Women Who Had a Fracture

- Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
- Annual Monitoring for Patients on Persistent Medications
- Potentially Harmful Drug-Disease Interactions in the Elderly
- Medication Reconciliation Post-Discharge

### ***Access/Availability of Care***

- Adults' Access to Preventive/ Ambulatory Health Services
- Children's and Adolescents' Access to Primary Care Practitioners
- Prenatal and Postpartum Care
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

### ***Utilization***

- Frequency of Ongoing Prenatal Care
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
- Adolescent Well-Care Visits

## Appendix 3: Capitated Managed Care and Carve Out Models

### Capitated Managed Care

Managed care has become the most common form of Medicaid delivery system used across the country. Since the early 1990s Medicaid managed care has increasingly been used as a way to provide more coordinated care to Medicaid enrollees as well as to control costs through capitated arrangements. In FY2012 all states except Alaska, New Hampshire, and Wyoming operated comprehensive managed care programs.<sup>71</sup>

In general, Medicaid officials have indicated that managed care provides significant benefits, including: 1) assurance of access to care; 2) a structure to measure and improve quality; 3) a way to reduce program costs and get greater value; and 4) a vehicle to promote important health objectives such as improved prenatal outcomes, obesity reduction, or reduction in non-emergency use of emergency departments.<sup>72</sup>

In FY2012 and FY2013, managed care initiatives occurred or will occur in over two-thirds of the states, increasing the prevalence of managed care in Medicaid. These initiatives include expansions of managed care into new geographic regions, enrollment of new eligibility groups into managed care, a shift from a voluntary to a mandatory enrollment model for specific populations, and new or expanded use of managed long-term care.<sup>73</sup>

Detailed examples of state managed care initiatives are provided in Appendix 2 of a companion report “Covering the Low-Income, Uninsured in Oklahoma: Recommendations for a Medicaid Demonstration Proposal.”

### Capitated Carve Out Models

In both FFS settings and managed care systems, many states contract with plans to provide specific, carved out services. Data from a 2012 report show that almost all states carve out at least one acute-care benefit from their core Medicaid delivery systems, the most common being dental care, behavioral health care, and substance abuse treatment.<sup>74</sup> A similar study shows 25 states that use MCOs or a PCCM program also contract with non-comprehensive pre-paid health plans (PHP) to provide these services.<sup>75</sup> PHPs are risk-based plans, which manage the provision of specific services and benefits to Medicaid enrollees. The most commonly provided benefits by PHPs include inpatient and outpatient behavioral health services and substance abuse treatment, dental care, non-emergency transportation, and

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<sup>71</sup> “Medicaid Managed Care: Key Data, Trends, and Issues,” Kaiser Commission on Medicaid and the Uninsured (February 2012).

<sup>72</sup> “A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey,” Kaiser Commission on Medicaid and the Uninsured (September 2011).

<sup>73</sup> “Medicaid Today; Preparing for Tomorrow, A Look at State Medicaid Program Spending, Enrollment and Policy Trends: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2012 and 2013,” Kaiser Commission on Medicaid and the Uninsured (October 2012).

<sup>74</sup> “Medicaid Managed Care: Key Data, Trends, and Issues,” Kaiser Commission on Medicaid and the Uninsured (February 2012).

<sup>75</sup> At the time this study was completed, only three states (Alaska, New Hampshire, and Wyoming) reported that they did not have any Medicaid managed care (comprehensive MCOs or a PCCM program).



prescription drugs.<sup>76</sup> “Like MCOs, non-comprehensive PHPs may be state-licensed or may operate under a contract with the Medicaid agency regardless of licensure.”<sup>77</sup> Research shows that PHPs providing behavioral health services tend to specialize in Medicaid and are not-for-profit local plans. Conversely, dental PHP plans tend to have more mixed Medicaid and commercial enrollment and are for-profit.

New Mexico uses a private company to manage and provide behavioral health care services to its Medicaid enrollees. In 2004, the New Mexico Legislature passed legislation creating the New Mexico Behavioral Health Collaborative. The Collaborative is a cabinet-level group which brings together 15 different state agencies involved in behavioral health prevention, treatment, and recovery to work together as one entity in order to improve mental health and substance abuse services.<sup>78</sup>

The Collaborative contracts with OptumHealth to manage behavioral health services for the state. OptumHealth manages and administers the combined public funds of the different state agencies. It has built a statewide organization called OptumHealth NewMexico and has regional offices around the state, including a regional team which serves American Indian communities. OptumHealth is charged with locating and providing providers, information technology specialists, care coordinators, claims specialists, and peer and family support specialists to serve in the regional offices.<sup>79</sup>

TennCare is the State of Tennessee’s Medicaid program that provides health care for 1.2 million Tennesseans and operates with an annual budget of approximately \$8 billion dollars. TennCare is one of the oldest Medicaid managed care programs in the country, starting January 1, 1994.

TennCare services are offered through managed care entities. Most medical, behavioral, and long-term care services are covered by risk-bearing MCOs located in each region of the State. Unlike New Mexico, behavioral health is “carved into” managed care in Tennessee, meaning the commercial MCOs manage the provision of mental health and substance abuse services. However, the State contracts with a Pharmacy Benefits Manager for coverage of prescription drugs and a Dental Benefits Manager for provision of dental services to children under age 21. Coordination of care is the responsibility of the enrollee’s primary care provider in his or her MCO.

The State’s PBM, Magellan Health Services, administers the pharmacy claims system which is an on-line system that processes all pharmacy transactions, administers TennCare’s Preferred Drug List and negotiates rebates and discounts with drug manufacturers. Tennessee’s dental benefits are handled by a contracted dental benefit manager, TennDent (Delta Dental of Tennessee).

Capitating carved out Medicaid benefits can help states better manage the provision of health care services that tend to be more costly or are offered on a more limited basis. PHPs reduce the direct risk to states associated with providing these benefits and therefore increase states’ ability to control costs over time. The downside to using PHPs is that it disconnects the carved out services from the care continuum, minimizing the potential long-term effectiveness of coordinated care.

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<sup>76</sup> “A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey,” Kaiser Commission on Medicaid and the Uninsured (September 2011).

<sup>77</sup> Ibid.

<sup>78</sup> “About the Collaborative,” New Mexico Behavioral Health Collaborative. Accessed June 17, 2013. <http://www.bhc.state.nm.us/index.htm>.

<sup>79</sup> “OptumHealth Now Managing New Mexico’s Mental Health and Substance Abuse Programs,” OptumHealth, Press Release (July 1, 2009).

## Appendix 4: Accountable Care Organizations

### Accountable Care vs. HMOs

The shared characteristics of these new models are: 1) risk-based payment, 2) care coordination and 3) outcomes measurement—the combination of which has been heralded as a potentially transformative strategy to improve quality and lower costs. Much of the HMO movement on the other hand was focused on cost-controls where the payer had the incentive to employ gatekeeping and utilization review to lower costs rather than employ provider-based strategies such as best practices and clinically-integrated decision making to eliminate waste and prevent costly readmissions. One of the more meaningful advancements since the 90's has been the development of health information technology that allows groups of providers to build system-like care models that allow the monitoring of patient populations. Another major differentiator is the new-found focus on distributing risk to the level of the practitioner to affect behavior—rather than simply paying capitation at the level of the institution.

### ACO Structure

The archetype for the ACO model, envisioned by academics, was the collaboration between a previously unaffiliated hospital and physician group whereby the outpatient and inpatient services could finally be coordinated and financially aligned through some sort of a joint payment (capitation, shared savings, etc.). In reality, combinations of providers have been much more diverse, ranging from merging health systems seeking to enlarge market share in a response to shrinking reimbursement, to merging physician groups who have in mind to commoditize the hospital through exclusion. Despite the variety of combinations, four main partnerships have begun to emerge:

- **Insurer ACO:** A regional or national insurer who takes the lead in organizing providers in such a way that the health plan bears the burden of ensuring accountable care (e.g. employs care coordinators in addition to providing data analytic technologies, etc.)
- **Insurer-Provider ACO:** The insurer and the provider are equal partners in providing accountable care—both entities furnish services that are above and beyond industry expectations.
- **Single Provider ACO:** Usually an integrated delivery system that receives payment for a population and takes on the responsibility of providing accountable care. The payer's involvement is generally limited to the provision of a risk-based payment such as capitation or shared savings.
- **Multiple-Provider ACO:** Two or more providers (usually a hospital and a physician-organization) have partnered (i.e. do not own each other) to provide accountable care for a population. The insurer involvement, like the single provider ACO, is limited to the provision of a risk-based payment.

### ***Accountable Care and the Patient-Centered Medical Home***

While the Patient-Centered Medical Home (PCMH) has gained much more widespread traction than the ACO model, most view the PCMH model—with its focus on primary care and preventive medicine—as merely a starting point for a more robust system of care (think *medical home* as part of the larger *medical neighborhood*). Policy writers hope that the diffusion of the PCMH model and its focus on primary care will establish the foundation for larger systems that have the ability (and the incentives) to cover more of the care spectrum. Some larger systems are now looking to PCMH-certified physician groups as prime partners for collaboration.

### ***Government and Commercial Initiatives***

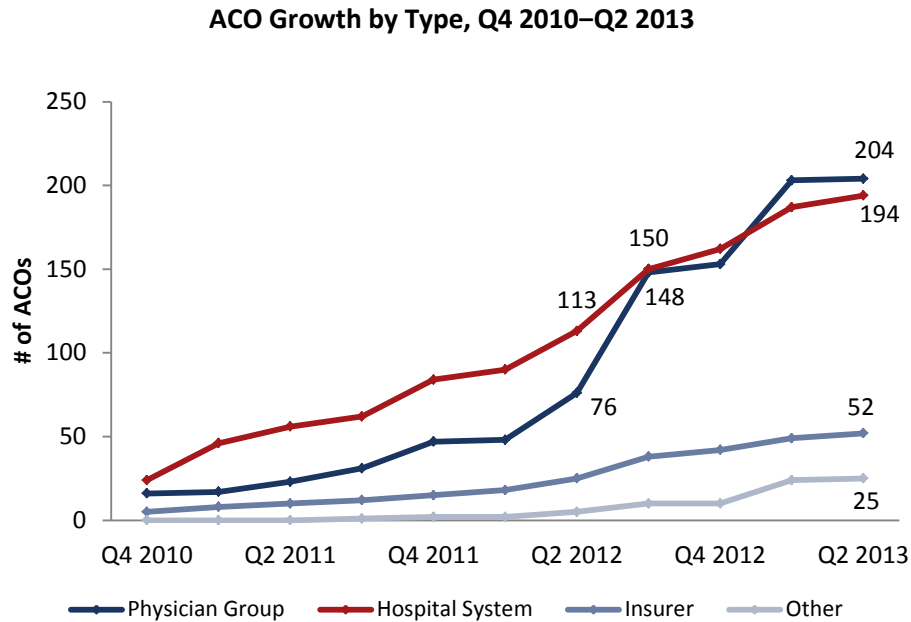
The PPACA included the Medicare and Medicaid Shared Savings Programs, high-profile initiatives that are in large part based on the Physician Group Practice Demonstration which began in 2005. Although the concept has its origin in academia and has been adopted by both the federal and state governments, the private sector has, in large measure, preempted government programs with significant activity coming from multiple corners of the delivery system. Well-capitalized health systems with control over much of the care spectrum were the early adopters of the ACO model. However, the growth of physician-sponsored initiatives, however, have recently eclipsed the hospitals in their sponsorship with insurers continuing to play a major role in helping providers assume more risk.

Despite similar aims between federal and state programs and private sector initiatives, the approaches vary considerably. Commercial partnerships are reassessing on a yearly basis while government contracts are generally evaluated every three years. The result may be faster evolution and greater flexibility outside of the government programs. There is also wide variability among commercial insurers in their use of quality metrics, whereas the federal programs have done much more to standardize such aspects. Providers are eager to have uniformity across payers but are torn by the continued need for flexibility in payment structures.

## Growth of ACOs

The growth in the number of number of ACOs across the country has been remarkable and is accelerating. Figure 14 demonstrates this growth, breaking the increase down by classification.

Figure 14



Source: Leavitt Partners.

With the continued growth and dispersion of ACOs all over the country, 2014 will likely bring with it an emphasis on results. If the Shared Savings Program were to yield financial savings, the likelihood of the program being rolled out more broadly would naturally increase. If savings are minimal to non-existent but there is a measureable increase in quality, the program could see similar acceptance levels.