

State of Oklahoma Care Delivery Model Assessment

Prepared for
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Center for Health Innovation and Effectiveness

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Table of Contents

- I. Introduction and Background 1
- II. Approach and Methodology 3
- III. Delivery Model Framework 5
- IV. National Care Delivery Models 7
- V. Oklahoma Care Delivery Models..... 20
- VI. Considerations for Accelerating Adoption of Delivery Models..... 32

I. Introduction and Background

The Oklahoma Health Improvement Plan (OHIP) Coalition, chaired by Commissioner of Health Terry Cline, who also serves as Oklahoma's Secretary of Health and Human Services (HHS), is a public-private partnership of stakeholders that oversees the state's progress toward improving Oklahoma's strategic health outcomes. Stakeholders include representation from healthcare providers, businesses, hospitals, long-term care, behavioral health, public health, private and public payers, and consumers. The purpose of the OHIP Coalition was to develop a comprehensive health improvement plan every five years. This document is referred to as the OHIP.

The OHIP was first published in 2010 for the purpose of improving the physical, social, and mental well-being of Oklahomans. In 2015, the Oklahoma State Department of Health (OSDH) published an update to the OHIP to describe statewide health improvement goals for the next five years. This update was referred to as "Healthy Oklahoma 2020" and its purpose was to provide a strategic health improvement plan that addressed the crucial health needs in Oklahoma. As part of this process, the OHIP coalition established goals in four core areas of work: 1) Health Efficiency and Effectiveness, 2) Health Information Technology (IT), 3) Health Workforce, and 4) Health Finance. A workgroup comprised of Oklahoma stakeholders has been established for each of the core areas.

The OHIP Coalition also submitted a proposal for a State Innovation Model (SIM) grant on behalf of the state of Oklahoma to provide a state-based solution to Oklahoma's healthcare challenges. Oklahoma was successful and received the grant in December 2014. The grant is administered by the OSDH, which in turn created the Oklahoma State Innovation Model (OSIM) leadership team (part of the OSDH's Center for Health Innovation and Effectiveness) to manage and direct the work detailed in the SIM grant. The OSIM's goals align with those of the Institute for Healthcare Improvement (IHI) Triple Aim Initiative: to improve health, provide better care, and reduce health expenditures for Oklahomans.

To support the Health Finance workgroup, OSDH engaged Milliman, Inc. (Milliman) to identify the care delivery models in Oklahoma, to describe the care delivery model experience of payers and providers within the state, to analyze the implementation and uptake of care delivery models adopted in other states, and to identify potential factors affecting successful implementation of health care payment reform. The Oklahoma care delivery models described in this report aim to drive statewide health system transformation by taking a variety of approaches to align payment incentives with appropriate healthcare delivery and improve care coordination, outcomes, and efficiency.

This report provides information on specific care delivery models in Oklahoma and nationally and raises key considerations for future adoption of models that drive sustainable system transformation. We examine each model's approach to population-based planning, payer and provider participation, financing and payment methodology, use of quality metrics, and evaluation criteria. We also summarize evaluations of the models, such as assessment of their effects on enrollee utilization, to the extent such information is available. Because some models are new, evidence on their effects may be limited.

Caveats and Limitations

This report was prepared by Milliman, Inc. (Milliman) on behalf of the Oklahoma State Department of Health (OSDH) in accordance with the terms and conditions of the contract between OSDH and Milliman dated April 1, 2015.

This report has been prepared solely for the internal use of, and is only to be relied upon by, the OSDH. Although Milliman understands that this report may be distributed to third parties, Milliman does not intend to benefit, or create a legal duty to, any third-party recipient of its work. If this report is distributed to third parties it should be distributed only in its entirety.

Milliman developed this report with information received from OSDH, as well as based upon discussions conducted with OSDH representatives and stakeholders who participated in interviews. Milliman did not audit the source of any data or information Milliman received, nor did Milliman perform independent verification. If the underlying data or information is inaccurate or incomplete, the results of our work may likewise be inaccurate or incomplete.

II. Approach and Methodology

The OSIM team identified the following eight specific delivery models and initiatives for research and study:

- 1) Bundled Payments for Care Improvement (BPCI) Initiative;
- 2) Comprehensive Primary Care Initiative (CPCI);
- 3) Federally Qualified Health Centers (FQHC) Advanced Primary Care Practice (APCP) Demonstrations;
- 4) Health Homes;
- 5) Health Access Networks (HAN);
- 6) Patient-Centered Medical Homes (PCMH);
- 7) Accountable Care Organizations (ACO); and
- 8) Indian Health Services (IHS).

To gather information about similar models nationally, Milliman conducted interviews, reviewed publicly available literature, and referred to prior Milliman work.

A. Interviews with Subject Experts

Milliman worked with representatives of the OSIM team to identify specific individuals at key organizations for interviews about their experiences implementing and adopting care delivery models. Milliman conducted telephone interviews with individuals representing Oklahoma’s existing care delivery models, healthcare providers, payers, state agencies, and other key stakeholders. Individuals participating in the telephonic interviews included those shown in “*Exhibit 1: Interview Participants.*”

Exhibit 1: Interview Participants

Organization	Name	Role
Blue Cross and Blue Shield of Oklahoma	Joseph Cunningham, M.D.	Chief Medical Officer
Morton Comprehensive Health Care	John Silva	Chief Executive Officer
MyHealth Access Network	David Kendrick, M.D.	Chief Executive Officer
Oklahoma Health Care Authority	Melody Anthony	Director of Provider and Medical Home Services
	Marlene Asmussen	Director of Population Care Management Department
	Becky Pasternik-Ikard	Deputy State Medicaid Director
	Melissa Pratt	Insure Oklahoma, Outreach Administrator
	Connie Steffee	Reporting and Statistics Director

Organization	Name	Role
Oklahoma Primary Care Association	Judy Grant	Deputy Director
	Dee Porter	Chief Executive Officer
	Brent Wilborn	Director of Public Policy
Oklahoma State Department of Health	Isaac Lutz	Health Innovation Planning Manager
	C. Alex Miley	OSIM Project Director
	Valorie Owens	Manager of Statewide Access to Care Planning
QuikTrip	Brice Habeck	Benefits Manager
University of Oklahoma Health Sciences Center	Cynthia Scheideman-Miller	Special Programs Director, Telemedicine
Variety Care	Lou Carmichael	Chief Executive Officer

The goal of these interviews was to develop an understanding of payer and provider experience with care delivery models and payment reform initiatives in Oklahoma. Milliman used the information gathered from the interviews to expand our understanding of implementation challenges and lessons learned as well as assess adoption of specific models throughout Oklahoma.

B. Literature Review

Milliman performed research on publicly available information and evaluations regarding the care delivery models reflected in this report. This research included peer reviewed literature, governmental websites, and other authoritative grey literature, such as websites maintained by public or private sector organizations and sources known for payment and delivery system reform studies. Such sources include the Agency for Healthcare Research & Quality (AHRQ), Commonwealth Fund, Integrated Healthcare Association (IHA), Robert Wood Johnson Foundation (RWJF), and the Centers for Medicare and Medicaid Services (CMS).

C. Industry Knowledge

Milliman also relied on prior Milliman work and experience, including information from Milliman’s previous analysis of Oklahoma’s insurance market. In addition to the research performed for this project, this report was developed with consideration of the approaches Milliman consultants have observed elsewhere. Milliman has incorporated these best practice learnings into this report.

III. Delivery Model Framework

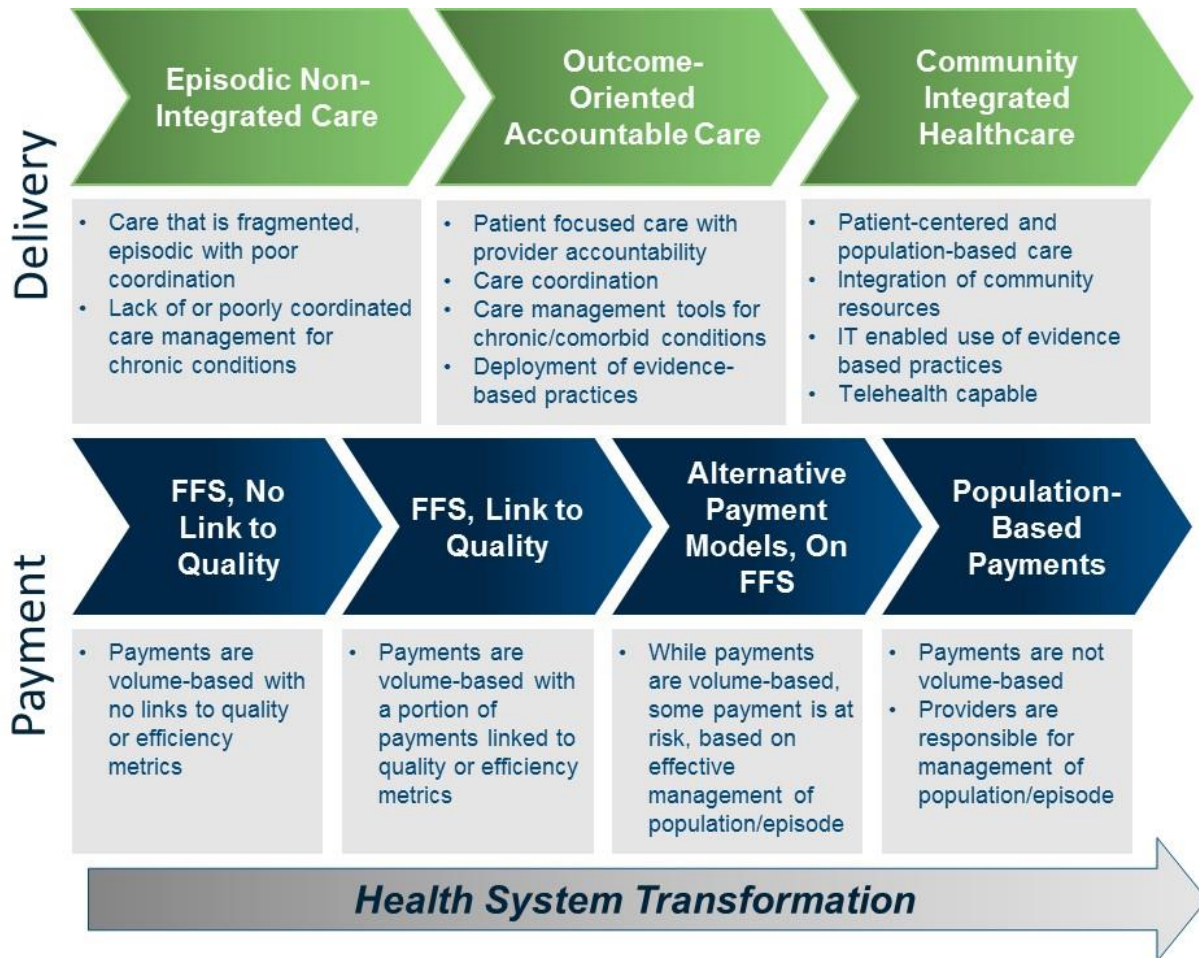
There is broad recognition in the United States that the nation's predominant healthcare payment system is the volume-driven, fee for service (FFS) model. This model creates inherent incentives for the provision of unnecessary services and does not promote coordination of care across the healthcare system. Across the country, many public (local, state, and federal) and private initiatives are being implemented with the goals of changing the underlying incentives in the current system to those that promote value, with an emphasis on care coordination, care management and improved outcomes.

The Patient Protection and Affordable Care Act (ACA) of 2010 is intended to generate market pressures for testing and adopting new payment models which drive improved health outcomes, foster population health management, and support more efficient delivery of care. Specifically, the law provides a platform for payment innovation within the two largest public programs under the purview of CMS, Medicare and Medicaid. Through the ACA, the Center for Medicare and Medicaid Innovation (CMMI) has created multiple opportunities for states and providers to design and participate in innovative care delivery and payment models. For example, the ACA established ACOs under two programs: the Pioneer ACO and the Medicare Shared Savings Program (MSSP). In addition, it has developed alternative payment models under the CMS Hospital-Acquired Condition Reduction Program and Hospital Value-Based Purchasing Program. The ACA also created multiple funding opportunities for states to design new models of care within their Medicaid program such as introducing PCMH Health Home models to better serve their Medicaid population with behavioral health or chronic conditions. In addition, the ACA sets forth penalties designed to reduce avoidable inpatient readmissions.

The delivery models discussed in this report make use of various “levers” to change aspects of healthcare delivery and payment systems. Some models are designed to only directly affect payments, for example, by tying FFS payments to quality of care metrics and/or efficiency thresholds. Others models are designed to only directly affect delivery changes, by making providers responsible for coordinating the care of patients assigned to their panel. Yet other models are designed to directly affect both payment and delivery system changes by allowing providers to take on the financial risk and the accountability for managing a defined population.

“Exhibit 2: Framework for Health System Transformation with Payment and Delivery Model Classification” provides a framework for considering various models for health system transformation.

Exhibit 2: Framework for Health System Transformation with Payment and Delivery Model Classification



Source: Milliman adapted from Rajkumar R, Conway PH, Tavenner M. CMS--engaging multiple payers in payment reform. *JAMA*. 2014 May 21;311(19):1967-8. and Halfon N, et al. Applying a 3.0 Transformation Framework To Guide Large-Scale Health System Reform. *Health Affairs*. November 2014.

The top row, “Delivery,” illustrates the continuum of delivery models moving from episodic and fragmented to community-based and integrated care. The bottom row, “Payment,” illustrates the continuum of payment models moving from volume and FFS-based to value-based and then ultimately to population-based with incentives that promote healthy communities. Each model uses certain levers to directly or indirectly influence payment and/or delivery system changes, as described in Section IV of this report.

For true system transformation to be achieved, both delivery and payment systems must evolve. Oklahoma recognizes this important precept. The majority of current Oklahoma initiatives incorporate these concepts and the state and key stakeholders have already begun to invest in several transformation efforts which are described in detail in Section V of this report.

IV. National Care Delivery Models

To encourage the implementation of value-driven, population-based payment systems and integrated, patient centered, and community-based care delivery models, the ACA mandated changes to the Medicare and Medicaid payment programs and established the Centers for Medicare and Medicaid Innovation (CMMI).

The ACA includes specific provisions that seek to create incentives for payers and providers to adopt coordinated care delivery models and to reward value of care over volume of care. For example, the law enabled the development of a national, voluntary pilot program on bundled payments, which encourages hospitals, doctors, and post-acute care providers to improve patient care and achieve savings for the Medicare program. Recently, the HHS set a goal of tying 50% of Medicare FFS payments to quality or value through alternative payment models, like ACOs or bundled payment arrangements, by the end of 2018.¹ Other healthcare organizations have announced similar transitions from FFS payments to value-based payments. For example, shortly after HHS set their transition goals, UnitedHealth Group announced they would be increasing value-based payments to doctors and hospitals by 20% to an estimated \$43 billion in 2015 and an estimated \$65 billion by the end of 2018.²

To drive fundamental delivery system changes, the ACA includes provisions that support the development of medical homes and increasing access to comprehensive, community based, coordinated care. The law also authorizes grants to states, public health departments, clinics, hospitals, FQHCs, and other nonprofits with the goal of promoting positive health behaviors and outcomes in medically underserved areas through the use of community health workers.³

The CMMI was charged with testing alternative payment and delivery models and accelerating health system transformation. The CMMI and its state and local partners, including Oklahoma, recognize that health system transformation requires a multifaceted approach that engages local stakeholders. Stakeholders, such as provider groups, hospitals, delivery systems, and health plans, need to assess which models are feasible from financial, operational, and strategic perspectives.

In this section we describe models deployed nationally, assess where these models fall on the continuum of system transformation, and summarize evaluations where possible. This section focuses on four national care delivery models that are similar to models that are being tested or have been implemented in Oklahoma: BPCI initiative, CPCI, medical homes models, and ACOs. For each of these models, we illustrate where these models fall on the continuum of system transformation and whether the model has direct or indirect effects on payment or delivery systems. When information is

¹ U.S. Department of Health and Human Services. January 26, 2015. *Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value.*

<http://www.hhs.gov/news/press/2015pres/01/20150126a.html>

² UnitedHealth Group. February 17, 2015. *More Than 11 Million People Can Now Receive Health Care Services from Care Providers Paid by UnitedHealthcare Based on Quality and Patient Outcomes.*

<http://www.unitedhealthgroup.com/newsroom/articles/feed/unitedhealthcare/2015/0217valuebasedcaregrowth.aspx?>

³ Kaiser Family Foundation. July 17, 2012. *Summary of Coverage Provisions in the Patient Protection and Affordable Care Act.*

<http://kff.org/health-costs/issue-brief/summary-of-coverage-provisions-in-the-patient/>

available, we summarize payer and provider participation, payment methodology details, and the use of quality and efficiency metrics. Because many of these models are relatively new, information on participation and outcomes is often limited.

A. Bundled Payments for Care Improvement Initiative

Experimentation with bundled payments has been occurring for several years. The bundled payment model is payment for services on the basis of an episode of care rather than on the FFS basis of an individual test, procedure, or visit.

While the use of bundled payments is growing in the public and private sectors, just 1.6% of payments nationally were made through bundled payment models in 2013.⁴ Several states, like Arkansas, are working to implement multiple stakeholder episode-based payment initiatives and, depending on provider performance, granting providers an opportunity for shared savings and shared risk.

Small scale studies have been conducted to demonstrate potential quality improvements or cost savings due to bundled payments. For example, Blue Cross Blue Shield of North Carolina implemented a bundled payment agreement for knee replacement and reported an 8 to 10% reduction in the average cost per episode.⁵

Despite the positive results noted above, several bundled payment pilots have revealed major implementation challenges.⁶ For example, a pilot funded by AHRQ, called the Bundled Episode Payment and Gainsharing Demonstration, was considered unsuccessful in meeting its goals of developing 20 payer-provider bundled payment contracts throughout California and developing over 500 bundled cases. However, the program did reveal key information on the challenges that arise due to the need to develop and implement episodes, insufficient volume, contracting barriers, and claims and administrative system limitations.⁷ These lessons learned have proven valuable to the design of CMMI's BPCI initiative. For example, volume and participation issues may be less of a constraint when implemented at the scale of a national initiative under Medicare rather than on a local or regional basis. In addition, since 2010, several solutions have been developed to overcome technical barriers, such as improved underlying claim processing systems and tools that can automate administrative handling of specific bundles.⁸

⁴ Delbanco, Suzanne. Health Affairs Blog. July 2, 2014. *The Payment Reform Landscape: Bundled Payment*. <http://healthaffairs.org/blog/2014/07/02/the-payment-reform-landscape-bundled-payment/>

⁵ Overland, Dina. March 22, 2013. *BCBSNC bundles payments for better coordination, quality, and costs*. <http://www.fiercehealthpayer.com/story/bcbsnc-bundles-payments-better-coordination-quality-costs/2013-03-22>

⁶ William, Tom and Yegian, Jill. Bundled Payment: Learning From Our Failures. August 2014. <http://healthaffairs.org/blog/2014/08/05/bundled-payment-learning-from-our-failures/>

⁷ Kary, Wesley. Bundled Episode Payment and Gainsharing Demonstration: September 2013. Technical White Paper. http://www.iha.org/pdfs_documents/bundled_payment/Bundled-Episode-Payment-Gainsharing-Demo-Whitepaper.pdf.

⁸ Dolan, Emma. Implementing Bundled Payment: No Pain, No Gain?. December 2011. <http://healthaffairs.org/blog/2011/12/02/implementing-bundled-payment-no-pain-no-gain/>

The BPCI initiative is primarily a payment reform model designed to motivate efficiency and care coordination for specific bundles of related services from the point of admission to either discharge or 30, 60, or 90 days following discharge, depending on the BPCI model. There are four BPCI models:

- **Model 1: Retrospective Acute Care Hospital Stay Only.** The bundle includes the acute inpatient stay. Participating hospitals agree to receive retrospective payments discounted from the Part A Inpatient Prospective Payment System. Medicare continues to make professional payments based on the Medicare Physician Fee Schedule and physician payments are not included in the bundle. Currently, there are 12 providers participating in Model 1.⁹
- **Model 2: Retrospective Acute Care Hospital Stay plus Post-Acute Care.** The bundle includes the acute inpatient stay and all related services during the episode of care. This includes all Part A and Part B services during the initial inpatient stay, the post-acute period and any readmissions. The episode ends either 30, 60, or 90 days after hospital discharge. Participants can select from 48 eligible bundles. Currently there are 2,180 providers participating in Model 2.¹⁰
- **Model 3: Retrospective Post-Acute Care Only.** The bundle includes all Part A and Part B services furnished during the post-acute period and furnished by a participating skilled nursing facility, inpatient rehabilitation facility, long-term care hospital, or home health agency. The post-acute care services must begin within 30 days of discharge and end 30, 60, or 90 days after a hospital discharge. Participants can select from 48 eligible bundles. Currently, there are 4,727 providers participating in Model 3.¹¹
- **Model 4: Acute Care Hospital Stay Only.** Model 4 is similar to Model 1 except that payment is made prospectively and includes the professional services component. Related readmission(s), within 30-days following discharge is/are also included in the bundle. Participants can select from up to 48 different bundles. Currently, there are 17 providers participating in Model 4.

As illustrated by the figure on the right, the BPCI initiative is based on a FFS model, however, it directly affects payment system and indirectly affects delivery of care included in the bundle of services. Ultimately, it is intended to hold hospitals (and post-acute care partners, if applicable) accountable for services within the established bundle, from the inception to the end of the episode. The BPCI models also indirectly create incentives for delivery system improvements such as care coordination with the hospital, post-discharge planning, and follow-up care management.



⁹ CMS. BPCI Model 1: Retrospective Acute Care Hospital Stay Only. <http://innovation.cms.gov/initiatives/BPCI-Model-1/>

¹⁰ CMS. BPCI Model 2: Retrospective Acute & Post Acute Care Episode. <http://innovation.cms.gov/initiatives/BPCI-Model-2/index.html>

¹¹ CMS. BPCI Model 3: Retrospective Post Acute Care Only. <http://innovation.cms.gov/initiatives/BPCI-Model-3/index.html>

CMS is using the BPCI Initiative to test whether bundled payments can efficiently reduce Medicare’s costs while maintaining or enhancing quality of care.¹² A February, 2015 evaluation of the BPCI initiative summarized the results of Models 2 and 3 during the first year of the initiative for a subset of participants. However, the small sample size of participants included in the evaluation and limited timeframe of the evaluation did not allow for any significant conclusions of the initiative’s impact.

B. Comprehensive Primary Care Initiative

In 2012, CMS started a four-year CPCI to help primary care practices deliver higher quality, better coordinated, and more patient-centered care. As illustrated by the figure on the right, CPCI uses both delivery system and payment incentive levers to drive change in primary care and across the continuum of care. The initiative provides administrative redesign resources to primary care physicians to help them implement comprehensive primary care functions (e.g., continuity of care, care management based on patient risks). It also includes financial incentives through care management fees and opportunities for shared savings.



CPCI resources are intended to help primary care practices work with patients to optimize continuity of care, effectively treat patients with chronic conditions, implement care management for high risk patients, and better coordinate care with other health care providers. The CPCI allows practices to operate in an environment where payer goals and financial incentives are aligned across both public and private payment sources.¹³ Due to the multi-payer collaborative nature of the initiative, the CPCI provides primary care practices support in coordinating care among participating payers; a feature not always found in care delivery innovation programs.

Under the CPCI, Medicare, commercial and State health insurance plans work together to provide incentive payments to primary care doctors who demonstrate better coordination of care for their patients. Incentives are provided through two potential payments:

- Risk-adjusted monthly care management fees: During the first two years of the initiative (2013-14), CMS paid an average rate of \$20 per member per month (PMPM). The average PMPM rate for the next two years will be \$15. Participating payers may also provide an additional monthly fee to help support practices’ efforts to build up primary care capabilities.

¹² Lewin Group. February 2015. *CMS Bundled Payments for Care Improvement (BPCI) Initiative Models 2-4: Year 1 Evaluation and Monitoring Annual Report*. <http://innovation.cms.gov/Files/reports/BPCI-EvalRpt1.pdf>

¹³ Centers for Medicare and Medicaid Services. *Comprehensive Primary Care Initiative*. <http://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative/>

- Shared savings. The shared savings model allows practices to share in a portion of the net Medicare savings. Savings calculations are based on performance relative to targets (including quality metrics) and regional factors.¹⁴

As of May, 2015, there are 475 practice sites in seven regions, representing 2,805 providers and approximately 2.7 million patients, of which about 404,000 are Medicare or Medicaid beneficiaries. The CPCI also includes 38 public or private payers including Medicare, Medicaid, commercial plans, and TRICARE (a health benefits program for military personnel, military retirees, and their dependents).¹⁵

CMS selected public and private payers based on a competitive application process. Interested payers submitted applications demonstrating their alignment with the CPCI approach and commitment to supporting participating primary care practices in achieving quality improvement and cost reduction goals. For example, CMS's scoring criteria included payers' commitment to enter into compensation contracts with participating practices and willingness to provide cost and utilization reports to practices.¹⁶

Practices that met certain eligibility criteria were invited to apply, including: provided primary care predominantly (versus specialty care); served at least 120 Medicare FFS beneficiaries during the two years prior to the initiative; received at least 40 to 50 percent of revenue from participating payers; and had a minimum of \$200,000 in annual revenue per practitioner.¹⁷

CMS released an evaluation of the CPCI conducted by Mathematica Policy Research (MPR) in January 2015.¹⁸ MPR found a reduction in total monthly Medicare expenditures without care management fees of \$14 per beneficiary (2%) during the first year of the program. The CPCI's monthly care management fees were offset by the impact of the initiative, which indicates the initiative was close to "cost neutral" during the first year. MPR measured quality improvement and efficiency gains based on comparing changes in outcomes between the period before and after the CPCI began. Changes were measured for attributed Medicare FFS patients in CPCI practices compared to changes over the same time period for beneficiaries attributed to similar non-CPCI practices in the same region. The outcomes being compared between the two groups include Medicare Part A and Part B monthly expenditures, rates of annual Medicare service use per 1,000 beneficiaries, 10 claims-based quality of care process measures, and 2 claims-based quality of care outcome measures.¹⁹ Quality improvements and efficiency gains included: reduction of annual hospitalizations (2%), annual emergency department (ED) visits (3%), annual specialist visits (2%), and primary care visits in all settings (2%).²⁰

¹⁴ Ibid.

¹⁵ Ibid.

¹⁶ Taylor, Erin F. et al. Mathematica Policy Research. January 2015. *Evaluation of the Comprehensive Primary Care Initiative: First Annual Report*. <http://innovation.cms.gov/Files/reports/CPCI-EvalRpt1.pdf>

¹⁷ Ibid.

¹⁸ Ibid.

¹⁹ Ibid.

²⁰ Ibid.

C. Medical Homes: Including Patient-Centered Medical Homes and Federally Qualified Health Center Advanced Primary Care Practice Demonstrations

As illustrated by the figure on the right, the medical homes model drives delivery system changes directly by assigning patients to a specific primary care office, a clinic, a FQHC/Rural Health Clinic (RHC), or other physician's office where the patient most often receives care for his or her primary condition. The medical home works as a multi-disciplinary team to coordinate care, provide care management, and ensure care is patient-centered and integrated. Medical homes can also be instrumental in integrating care that is typically carved out or separated, such as behavioral health or prescription drug management. While not required to be a medical home, ultimate sustainability necessitates payments such as care management fees, per-visit fees, and/or performance based payments. In this section, we described some of the most common medical home models.



1. Patient-Centered Medical Home

Over the last several years, national organizations, such as the National Committee for Quality Assurance (NCQA), have created recognition programs to recognize sites that have successfully implemented a formal PCMH delivery model. Specifically, PCMHs enable primary care physicians to work with nurses, pharmacists, nutritionists, social workers, and other supporting professionals as a care team that is focused on the patient's needs. This model of care delivery aims to increase access to quality care by reducing wait times and enhancing alternative communication methods like phone and email.²¹

In an effort to reward quality care, this model allows for payment for services that are not typically compensated (e.g. disease management or telehealth enabled services). The Patient-Centered Primary Care Collaborative suggests augmenting traditional FFS payments with appropriate incentives such as: monthly care coordination/care management fees, visit-based payments, and/or performance-based payments through shared savings.²²

NCQA's PCMH recognition program is designed to recognize practices that successfully use systemic processes and information technology to enhance the quality of patient care. PCMH recognized practices offer value to payers and purchasers due to the systems and processes in place that meet nationally recognized standards for delivering high-quality care.²³ Other organizations that have

²¹ AcademyHealth. *New Models to Pay for Health Care*.

http://www.academyhealth.org/files/FileDownloads/AH_RI%202013%20New%20Models.pdf

²² American College of Physicians. *Costs, Benefits and Incentives*.

http://www.acponline.org/running_practice/delivery_and_payment_models/pcmh/cost_benefit/

²³ National Committee of Quality Assurance. *NCQA Patient-Centered Medical Home: A New Model of Care Delivery: Patient-Centered Medical Homes Enhance Primary Care Practices*. <http://www.ncqa.org/Portals/0/PCMH%20brochure-web.pdf>

developed patient medical home recognition, certification, and accreditation programs include URAC, the Joint Commission, and the Accreditation Association for Ambulatory Health Care (AAAHC).²⁴

NCQA updated the requirements and criteria to achieve Levels 1, 2, or 3 PCMH recognition in 2014, the requirements are summarized in “*Exhibit 3: PCMH Standards, Required Elements, and Scoring Criteria.*”

Exhibit 3: NCQA PCMH Standards, Required Elements, and Scoring Criteria

Recognition Level	Required Points (out of 100 Points, 27 Elements, 6 Must Pass Elements)
Level 1	35–59
Level 2	60–84
Level 3	85–100
Standard	“Must-Pass” Element Included in the Standard
Patient-Centered Access	Patient-Centered Appointment Access
Team-Based Care	The Practice Team
Population Health Management	Use Data for Population Management
Care Management and Support	Care Planning and Self-Care Support
Care Coordination and Care Transitions	Referral Tracking and Follow-Up
Performance Measurement and Quality Improvement	Implement Continuous Quality Improvement

Source: NCQA, PCMH 2014 Content and Scoring.

Over the last few years, several provider organizations have evaluated the impacts of their PCMH delivery model. CareFirst, Maryland’s BlueCross BlueShield Plan evaluated their PCMH program in 2014. To establish the program in 2011, CareFirst formed a panel of primary care physicians to provide, organize, coordinate and arrange the care for their patients. The panel was accountable for the quality and cost outcomes of their pooled population and was responsible for meeting quality improvement and cost reduction targets. CareFirst reported a “dramatic slowing in rise of overall costs.” This trend was, in part, attributed to the implementation of the PCMH program which was associated with an unprecedented drop (20%) in hospital inpatient use.²⁵

The Washington State Health Alliance (formerly the Puget Sound Health Alliance) launched a PCMH program in 2011 with seven Medicaid and commercial payers with the intention of reducing avoidable ED visits and hospitalizations while maintaining or improving clinical outcomes. Providers received FFS payment for healthcare services plus PMPM payments for care coordination. Quality and cost reduction targets were set at the beginning of the program and if sites did not meet their targets, they were at risk for repaying up to 50% of their PMPM payments. Sites that reached their targets received a portion of the payers’ corresponding savings. An evaluation of the pilot program is currently taking

²⁴ American College of Physicians. *What is a Patient Centered Medical Home?*
http://www.acponline.org/running_practice/delivery_and_payment_models/pcmh/understanding/what.htm

²⁵ CareFirst BCBS in Maryland. July 30, 2015. *2014 PCMH Program Performance Report.*
<https://member.carefirst.com/carefirst-resources/pdf/pcmh-program-performance-report-2014.pdf>

place and is expected to highlight increased practice capabilities, mixed changes in clinical outcomes, and improvements in provider satisfaction.²⁶

2. Federally Qualified Health Center Advanced Primary Care Practice Demonstrations

The FQHC APCP demonstration was a three-year CMS demonstration that ran from 2011 to 2014. FQHCs are organizations that receive grants under Section 330 of the Public Health Service Act. These health centers serve underserved areas or populations, offer a sliding fee scale, provide comprehensive services, and have ongoing quality assurance programs.²⁷ The FQHC APCP demonstration aimed to show how the PCMH model supports continuous, comprehensive, patient-centered medical care.

In 2011, CMS selected 500 FQHCs to participate in the demonstration project. The purpose of the project was to have the participating FQHCs be recognized by NCQA as Level 3 PCMHs. To reach this goal, CMS provided the participating FQHCs \$42 million over three years to improve the coordination and quality of care they deliver to Medicare beneficiaries and other patients. In addition, the FQHCs received a monthly care management fee of \$6 for each eligible Medicare beneficiary receiving services at their health center.²⁸ NCQA also offered technical assistance to participating FQHCs. Through a formal learning system, FQHCs received training and support from Health Resources and Services Administration (HRSA), a CMS subcontractor, American Institutes for Research (AIR), and primary care associations. Finally, participating FQHCs periodically received feedback at the FQHC level and at the beneficiary level. These reports allowed FQHCs to assess their readiness and compare their performance with other participating FQHCs. A final roster of 439 FQHCs participated in the FQHC APCP demonstration program due to some FQHCs dropping out of the program prior to or during the demonstration.

To assess the success of the demonstration, CMS commissioned RAND to conduct a formal program evaluation, including the PCMH status of participating FQHCs. At the beginning of the demonstration, CMS set a goal of NCQA Level 3 recognition for 90% of participating FQHCs. RAND found that, although the demonstration sites started off slowly in achieving Level 3 recognition, the pace accelerated toward the end. By October 2014, 55% of the demonstration sites had a successfully achieved Level 3 recognition.²⁹

²⁶ Washington State Department of Health. 2012. *2009-2011 Washington Patient-Centered Medical Home Collaborative*. <http://www.doh.wa.gov/Portals/1/Documents/Pubs/345-310-PCMHFinalReport.pdf>

²⁷ Health Resources Services Administration. *What are Federally qualified health centers (FQHCs)?*. <http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Introduction/qualified.html>

²⁸ Merrill, Molly. Healthcare IT News. October 24, 2011. *500 FQHCs receive \$42M as part of PCMH demo project*. <http://www.healthcareitnews.com/news/500-fqhcs-receive-42m-part-pcmh-demo-project>

²⁹ Kahn, Katherine L. et al. RAND. July 2015. *Evaluation of CMS FQHC APCP Demonstration: Second Annual Report*. <http://innovation.cms.gov/Files/reports/fqhc-scndevalrpt.pdf>

D. Accountable Care Organizations

An ACO is a reorganization of the delivery of care and by itself, is not a payment model. An ACO is typically organized as a group of professional and/or hospital providers (and sometimes payers) that assume responsibility for the cost and quality of care they provide to its patients. As illustrated by the figure on the right, an ACO must implement payment and delivery model changes to promote better population management.



There are a wide variety of ACO models, which vary in features including by: ownership structure, degree of healthcare delivery integration, health data exchange activity, payment arrangements, and risk sharing structures. According to a June 2014 study, there are over 600 ACOs around the country, including an estimated 20.5 million covered lives, within the Medicare, Medicaid, and commercial markets. In this section we focus on Medicare and Medicaid ACO models, however, it is important to note that the commercial payers are estimated to cover about 12.4 million lives and thus represent a sizeable portion of the total population attributed to ACOs.³⁰

The payment model most commonly attributed to ACOs is the shared savings model. The shared savings model requires ACOs to meet or exceed certain quality and cost performance measures to be eligible to share any cost-savings attained by the ACO.

1. Medicare ACO Initiatives

CMS has experimented with ACOs since the mid-2000s. The Physician Group Practice demonstration project (PGP) predates the ACA, running from 2005 to 2010. Under the PGP, participating physician groups received shared savings payments from Medicare if they met certain quality targets and exceeded a savings threshold of 2%. Only a minority of providers were able to achieve any cost reductions, but most consistently demonstrated improvements against quality measures.³¹

CMS established the Pioneer ACO Program under the ACA, inviting participation from large medical groups experienced in coordinating care for patients across care settings. The goal of the program was to test the provider groups' ability to move from a shared savings payment model to a population-based model.³² A report evaluating the cost impact and quality of care provided by ACOs in the Pioneer ACO Program was released in March 2015. The results showed that the 32 ACOs in the

³⁰ Petersen, Matthew, et al., *Growth and Dispersion of Accountable Care Organizations: June 2014 Update*.

<http://leavittpartners.com/wp-content/uploads/2014/06/2014-06-Growth-and-Dispersion-of-Accountable-Care-Organizations-June-2014-Update.pdf>.

³¹ Wilensky, Gail. 2011. Lessons from the Physician Group Practice demonstration — A sobering reflection. *NEJM*; 365:1659-1661.

³² Frist, Bill et al. March 2013. *Report of the National Commission on Physician Payment Reform*.

http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf404629

Pioneer ACO Program experienced a total of \$384 million in savings over the first two years of performance.³³ During the evaluation period, the program served over 600,000 Medicare beneficiaries who “reported more timely care and better communication with their providers; used inpatient hospital services less and had fewer tests and procedures; and had more follow-up visits with their providers after hospital discharge.”³⁴ However, in recent years, participation in the Pioneer ACO program has decreased to 19 participants. According to reports, providers participating in the Pioneer ACO program state that participation in Medicare Advantage or the MSSP is likely to be more advantageous, less burdensome, and requires tracking fewer quality metrics.³⁵

In the MSSP program, there are currently 404 ACO entities covering 7.3 million assigned beneficiaries in 49 states including the District of Columbia and Puerto Rico. Of these, 99% (401) are on the Track 1 (one-sided) model in which ACOs can receive bonus payments if their costs are substantially below their per-beneficiary spending target and quality improves on most measures, with no penalties if spending exceeds the target. The remaining 3 MSSP ACOs are on the Track 2 (two-sided) model which requires the ACO to pay a portion of the costs that exceed spending targets but provides greater bonuses for reduced per beneficiary spending trends.^{36 37} Under the MSSP, CMS only pays providers that meet ACO standards using a shared savings payment model.³⁸ Bonus payments are available to ACOs that meet annual performance measures such as patient safety, appropriate use of preventive services, and improved care for at-risk populations.

2. Medicaid ACO Initiatives

State Medicaid delivery systems are implementing Medicaid ACOs as a way to improve patient outcomes and control costs by making providers accountable for risk and quality. Medicaid ACOs are typically developed and driven by the state agency administering the Medicaid program. Nine states have implemented Medicaid ACO programs and eight more states are pursuing them.

³³ L&M Policy Research, LLC. March 10, 2015. *Evaluation of CMMI Accountable Care Organization Initiatives: Pioneer ACO Evaluation Findings from Performance Years One and Two*.

<http://innovation.cms.gov/Files/reports/PioneerACOEvalRpt2.pdf>

³⁴ U.S. Department of Health and Human Services. May 4, 2015. *Affordable Care Act payment model saves more than \$384 million in two years, meets criteria for first-ever expansion: Pioneer ACO Model advances quality and value in health care*.

<http://www.hhs.gov/news/press/2015pres/05/20150504a.html>

³⁵ Advisory Board. September 19, 2014. *From 32 to 19: Three more ACOs drop out of Pioneer program: At least two plan to apply for MSSP*. <https://www.advisory.com/daily-briefing/2014/09/26/from-32-to-19-three-more-acos-drop-out-of-pioneer-program>

³⁶ Centers for Medicare and Medicaid Services. April 2015. *Fast Facts: All Medicare Shared Savings Program ACOs*.

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/All-Starts-MSSP-ACO.pdf>

³⁷ Kocot, S. Lawrence JD. et al. 2013. *Early Experiences with Accountable Care in Medicaid: Special Challenges, Big Opportunities*.

<http://www.brookings.edu/~media/research/files/papers/2013/10/early-experience-accountable-care-medicaid/early-experience-accountable-care-medicaid.pdf>

³⁸ Center for Healthcare Quality and Payment Reform. *The Payment Reform Glossary: Definitions and Explanations of the Terminology Used to Describe Methods and Paying for Healthcare Services*.

<http://www.chqpr.org/downloads/PaymentReformGlossary.pdf>

While payment models vary, typically, Medicaid ACOs employ one of two options: shared savings arrangement or global budget model. The shared savings arrangement allows providers participating in the ACO an opportunity to share in savings if their population uses a less costly set of health care resources than a predetermined baseline. This model can also include a “downside” risk component, where participating providers are held at-risk for a percentage of costs if they exceed a specified threshold. In the global budget model, ACOs provide services and accept full financial risk for the health of their population in exchange for a capitated payment.³⁹

For example, Illinois’s Accountable Care Entities (ACEs) program was launched in response to a state law that required the state Medicaid agency to move 50% of Medicaid beneficiaries to a risk-based care coordination program by January 1, 2015. Illinois Department of Healthcare and Family Services decided to use the opportunity to implement alternative models of care that were provider-driven. The lead ACE entity was required to be a provider organization and not an existing managed care organization. The ACE was to include participation of the primary and specialty care, hospitals, and behavioral health providers.⁴⁰ For the first 18 months, ACEs were paid a PMPM care coordination fee (\$9), and FFS reimbursement with potential for shared savings payments. ACEs are required to begin moving to a capitated payments that limits losses for high-cost individuals after 18 months.⁴¹

Three of the nine state Medicaid ACOs have shown promising results in the early stages of their programs.^{42 43}

- Colorado’s Regional Care Collaborative Organizations (RCCOs) are regionally-based entities which coordinates its participating providers and agree to be accountable for specific Medicaid beneficiaries. RCCOs are required to contract with Medicaid primary care providers, FQHC/RHCs, practices designated as medical homes or are focused on primary care. All Medicaid enrollees can be enrolled, including the dually eligible population. All primary care services are considered in-scope, including preventive care and prenatal and pediatric services. Payments are PMPM capitated payments with opportunity for incentive payments based on performance measures and whether targets are met or exceeded. Preliminary evaluations of

³⁹ Center for Health Care Strategies, Inc. August 2015. *Medicaid Accountable Care Organizations: State Update*. <http://www.chcs.org/media/ACO-Fact-Sheet-8615.pdf>

⁴⁰ Center for Health Care Strategies, Inc. July 2015. *Comparing State Medicaid Accountable Care Organization Governance Models*. http://www.chcs.org/media/ACO-Governance-Matrix_Final_072415.pdf

⁴¹ Illinois Department of Healthcare and Family Services. June 4, 2014. *The Path to Transformation: Illinois 1115 Waiver Proposal* <https://www2.illinois.gov/HFS/PUBLICINVOLVEMENT/1115/Pages/1115.aspx>

⁴² Center for Health Care Strategies, Inc. Technical Assistance Tool. February 2014. *Medicaid Accountable Care Organizations: Program Characteristics in Leading-Edge States*. http://www.chcs.org/media/ACO_Design-Matrix-053014.pdf

⁴³ Center for Health Care Strategies, Inc. Technical Assistance Tool. July 2015. *Comparing State Medicaid Accountable Care Organization Governance Models*. http://www.chcs.org/media/ACO-Governance-Matrix_Final_072415.pdf

the RCCO program reported reduction of ED visits, high-cost imaging, and avoidable hospital readmissions, and \$30 million in savings for Colorado Medicaid.⁴⁴

- Minnesota’s Integrate Health Partnerships (IHPs) use a provider-led ACO model which coordinate with specialty providers and hospitals. Minnesota conducts total cost of care calculations, which makes all primary care services in-scope.⁴⁵ Medicaid eligible adults and children enrolled under both FFS and managed care programs can be included, but dually eligible beneficiaries are excluded. The organizational structure of Minnesota’s IHP program consists of two ACO models: virtual and integrated.
 - The virtual model includes primary care providers and multi-specialty provider groups which are not formally integrated. The number of Medicaid beneficiaries permitted under the virtual model is 1,000 to 1,999. Shared savings payments are the annually calculated difference between the expected and actual total cost of care, if the actual costs are lower. Savings must exceed a minimum performance threshold of 2% and then is split evenly (50/50) with the state.
 - The integrated model is for formally integrated provider groups with a greater number of attributed Medicaid beneficiaries (over 2,000). An integrated IHP is directly responsible for providing a wide scope of outpatient and inpatient care. The payment model moves from a one-sided shared savings model, in year one, to a two-sided shared risk model that distributes savings or losses with the state by year three. During its first two years, Minnesota’s IHP program reported \$76.3 million in savings.⁴⁶
- Oregon’s Coordinated Care Organizations (CCOs) are locally-governed regional organizations which are community-based or statewide organizations that agree to be accountable for a specific Medicaid population. All Medicaid enrollees are eligible, including the dually eligible. CCOs are required to coordinate care all services provided to a beneficiary including primary and specialty care, mental and substance use services, oral health, and covered long term care services. Individual care plans, including the beneficiary’s decisions, are part of the care coordination requirements. Participating providers must demonstrate sufficient access and

⁴⁴ Colorado Department of Health Care Policy & Financing. Creating a Culture of Change: Accountable Care Collaborative 2014 Annual Report. 2014. <https://www.colorado.gov/pacific/sites/default/files/Accountable%20Care%20Collaborative%202014%20Annual%20Report.pdf>.

⁴⁵ Scope of services included are all primary care services and laboratory, radiology, pharmacy, chiropractic, vision, podiatry, rehabilitation therapies, audiology, outpatient mental health and chemical dependency services (intensive or residential services are excluded), outpatient hospital, ambulatory surgery center services, inpatient hospital, anesthesia, hospice, home health (except personal care assistant services) and private duty nursing services.

⁴⁶ Minnesota Department of Human Services. Minnesota’s Medicaid reform initiative saves \$61.5 million in 2nd year. Press release, June 19, 2015. <http://mn.gov/dhs/media/news/news-detail.jsp?id=252-166076>.

availability of covered services through provider, facility and supplier contracts. The CCOs operate within a fixed budget and are tasked with developing alternative payment models which drive system transformation. They are required manage financial risk while maintaining restricted reserves requirements. Eligibility for incentive payments are dependent on 17 measures which include quality and access process and outcome measures. Oregon's CCOs reported a 21% decrease in ED visits and a 48% decrease in admissions related to asthma and chronic obstructive pulmonary disease.⁴⁷

⁴⁷ Oregon Health Authority. Oregon's Health System Transformation: 2014 Mid-Year Report. January 14, 2015. <http://www.oregon.gov/oha/Metrics/Documents/2014%20Mid-Year%20Report%20-%20Jan%202015.pdf>.

V. Oklahoma Care Delivery Models

Oklahoma is seeking to address challenges in health outcomes and costs by implementing new care delivery models and adopting innovative strategies to decrease health costs while maintaining high standards of quality of care. These new care delivery models aim to create a culture of health in Oklahoma and provide incentives for better care coordination, accessibility and affordability of health care, and improved quality of care.

A key driver of the need for implementing new care delivery models in Oklahoma is the current health status of Oklahomans. According to the 2013 United Health Foundation America's Health Rankings, Oklahoma ranks 44th in the nation in overall health. Oklahoma has the 12th highest rate of deaths due to cancer, 4th highest due to stroke, fourth highest due to diabetes, 3rd highest due to heart disease, and the highest rate of deaths due to chronic lower respiratory disease. Oklahoma's rate of death from all causes is 23% higher than the national rate.

The OSDH aimed to address these challenges through the OHIP. This plan includes a health transformation strategy which promotes value based health models across systems that will accelerate health improvement and yield a return on investment. This strategy pursues the use of new healthcare payment models, evidence based public health investments, and partnerships with private payers that yield long term social and health outcome improvements.⁴⁸

In this section, we examine Oklahoma's experience with:

- Accountable Care Organizations,
- Bundled Payments for Care Improvement,
- Comprehensive Primary Care Management Initiatives,
- Federally Qualified Health Center Demonstrations,
- Patient Centered Medical Homes,
- Health Homes,
- Health Access Networks, and
- Indian Health Services care delivery models.

We also offer information on emerging innovations being undertaken by employers and Oklahoma's Medicaid agency. Where possible, we provide Oklahoma-specific information regarding implementation strategies, evaluation methods, payer and provider engagement, and payment models.

A. Accountable Care Organizations

In Oklahoma, three ACOs have formed for the purpose of participating in the CMS MSSP program: Mercy Health ACO (Mercy Health), Oklahoma Health Initiatives (St. John), and SSMOK ACO (St. Anthony). The intent of these ACOs is to provide coordinated care to Medicare beneficiaries not

⁴⁸ Oklahoma State Department of Health. 2014. *Health Oklahoma 2020: Oklahoma Health Improvement Plan Update*.

enrolled through other MSSPs or Medicare Advantage plans. All three ACOs commenced participation in the MSSP program within the last two years.

The ACO care delivery model is person-centered healthcare, and emphasizes prevention and wellness, chronic disease management, and better coordination across the full continuum of care. Provider participation in an ACO is voluntary. The MSSP ACO payment model creates incentives for health care providers to work together to treat individual patients across care settings and rewards ACOs that lower growth in health care costs for their patient population while meeting quality performance standards. ACO providers continue to be paid on a FFS basis for Medicare beneficiaries and receive shared savings payments if the ACO meets the quality performance standards.

Mercy Health was selected by CMS to participate as an ACO beginning January 1, 2015 and continuing through December 31, 2017. The Mercy ACO includes hospital and outpatient services across Missouri, Oklahoma, Arkansas, and Kansas. The goal of the ACO is to provide better care for individuals, better health for populations, and lower growth in health care costs. If the ACO's performance results in the receipt of shared savings, the savings will be used to cover Mercy expenses to expand patient care and access. In addition, savings will be distributed to ACO participants based on performance on quality, service, and patient satisfaction measures.⁴⁹

The St. John ACO was established on January 1, 2014 and will run through December 31, 2016 as part of the Oklahoma Health Initiatives (OKHI) ACO. St. John's participation in CMS' ACO MSSP program follows its participation in CMS' CPCI. As part of the ACO MSSP program, OKHI ACO works with selected doctors, hospitals, and related health care providers to provide coordinated, high-quality care to Medicare patients. The goal of providing coordinated care is to avoid unnecessary services and prevent medical errors to ensure patients get appropriate care based on their individual needs.⁵⁰ If the ACO experiences shared savings, St. John will distribute these savings to ACO physicians (50%), ACO hospitals (15%), infrastructure reinvestment (20%), and ACO affiliates (15%) as performance improvement incentives.⁵¹

St. Anthony began its participation in the Medicare ACO program beginning January 1, 2015 continuing through December 31, 2017 as part of the SSMOK ACO. The SSMOK ACO operates only in Oklahoma and has the highest provider participation in Oklahoma. If the SSMOK ACO experiences shared savings, the savings will be distributed to reinvest in infrastructure and to primary care professionals, specialists, and hospitals participating in the ACO.⁵²

⁴⁹ Mercy Health. *Accountable Care Organization*. <https://www.mercy.net/accountable-care-organization>

⁵⁰ St. John Health System. *Accountable Care Organization*. <http://www.stjohnhealthsystem.com/about/accountable-care-organization>.

⁵¹ St. John Health System. *Composition of ACO*.

https://www.stjohnhealthsystem.com/media/file/1545/ACO_Website_Published_Information_2015-3-23.pdf

⁵² St. Anthony Physicians Group. SSMOK ACO. *Public Reporting for SSMOK ACO, LLC*.

<http://www.saintsok.com/Pages/PublicReporting.aspx>

Oklahoma ACOs participating in the Medicare ACO initiative will be able to assess their quality improvements relative to 4 key domains and 33 quality measures established by CMS. The domains include patient and caregiver experience, care coordination and patient safety, at-risk population, and preventive care.⁵³

B. Bundled Payments for Care Improvement Initiative

A total of 39 sites in Oklahoma are participating in the BPCI initiative. Of these, 18 are participating in Model 2 (retrospective calculation, episode of care includes both acute and post-acute care) of the BPCI initiative and 21 sites are participating in Model 3 (retrospective calculation, episode of care includes post-acute care only).⁵⁴ The purpose of the BPCI initiative is to establish a bundled payment system that allows Medicare to reduce the cost of care through episodic care in the acute and post-acute setting.

This model aims to improve the individual experience of care, improve the health of populations, and reduce the per capita costs of care for populations. This payment delivery model allows providers to enter into payment arrangements that include performance accountability for episodes of care, and to share with each other gains accrued as a result of the delivery of coordinated care across care settings for FFS Medicare beneficiaries.⁵⁵

A preliminary assessment of the BPCI participants based on data from the first quarter of the program has been conducted; however, meaningful evaluations of the cost and health implications of the initiative are not expected to be released until 2016.⁵⁶ When evaluating the BPCI initiative participants, CMS proposes three monitoring questions to help them consider results:

- What are the characteristics of the program and participants at baseline and how have they changed during the course of the initiative?
- What is the impact of BPCI initiative on the costs of episodes, the Medicare program, and the quality of care for Medicare beneficiaries?
- What program, provider, beneficiary, and environmental factors contributed to the various results of the BPCI initiative?

These questions help measure quality and provide a view of the participants' experience with the initiative.

⁵³ RTI International. August 15, 2014. *Accountable Care Organization 2014 Program Analysis Quality Performance Standards Narrative Measure Specifications*. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO-NarrativeMeasures-Specs.pdf>

⁵⁴ Centers for Medicare and Medicaid Services. *Where Innovation is Happening*.

⁵⁵ Integrated Healthcare Association. September 2013. *CMMI's Bundled Payments for Care Improvement Initiative: Overview*. http://www.ihc.org/pdfs_documents/bundled_payment/BPCI_Overview_August_2013.pdf

⁵⁶ Dummit, Laura, et al. The Lewin Group. February 2015. *CMS Bundled Payments for Care Improvement (BPCI) Initiative Models 2-4: Year 1 Evaluation and Monitoring Annual Report*. <http://innovation.cms.gov/Files/reports/BPCI-EvalRpt1.pdf>

C. Comprehensive Primary Care Initiative

In October 2012, CMS launched its CPCI program in seven regions across the US, including the Greater Tulsa Region in Oklahoma, with the purpose of achieving the triple aim of better health care, better health outcomes, and lower costs. The CPCI initiative is a multi-payer initiative fostering collaboration between public and private health care payers to strengthen primary care. The payment model allows Medicare to work with commercial and state health insurance plans to offer bonus payments to PCPs who coordinate care for patients. There are currently 62 primary care practices in the Greater Tulsa Region participating in the CMS CPCI initiative.

Following the selection of Oklahoma's Greater Tulsa Region as one of the seven CPCI regions, CMS invited payers to participate in the initiative. Three Oklahoma payers were chosen to participate: Blue Cross and Blue Shield of Oklahoma, Community Care Oklahoma, and the Oklahoma Health Care Authority (OHCA)⁵⁷. Primary care practices were then selected to participate based on:

- Use of health information technology;
- Ability to demonstrate advanced primary care delivery recognition by accreditation bodies;
- Service to patients covered by participating payers;
- Participation in practice transformation and improvement activities; and
- Diversity of geography, practice size and ownership structure.

CMS ultimately selected 62 primary care practices, 254 providers, serving approximately 45,000 Medicare and Medicaid beneficiaries and approximately 311,000 total patients in the Greater Tulsa Region.⁵⁸

Fourteen practices from the St. John Health System and its St. John Clinic physician group were selected to participate in CMS' CPCI program in 2012, which focuses on strengthening primary care capacity and systems.⁵⁹ Through this multi-payer initiative, St. John Health System and St. John Clinic physician group can receive prospective payments from commercial and state health insurance plans.

In Oklahoma, MyHealth Access Network (MyHealth) is serving as the convener of the CPCI by supporting implementation and data management for the primary care practices selected to participate.

The evaluation process for CPCI practices occurs annually, assessing each practice's capability to deliver on five key functions:

- Access and continuity of care
- Planned chronic and preventive care
- Risk-stratified care management

⁵⁷ Centers for Medicare and Medicaid Services. July 28, 2015. *Comprehensive Primary Care Initiative: Oklahoma: Greater Tulsa Region*. <http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/Oklahoma.html>

⁵⁸ Ibid.

⁵⁹ St. John Clinic. *Fourteen St. John Clinic Primary Care Offices Participate in the Comprehensive Primary Care Initiative (CPCI)*. <http://www.stjohnhealthsystem.com/clinic/patients/comprehensive-primary-care-initiative>

- Patient caregiver engagement
- Coordination of care across the medical neighborhood

In January 2015, Mathematica produced the *Evaluation of the Comprehensive Primary Care Initiative: First Annual Report* which illustrated the early effects of the CPCI on utilization and costs for attributed Medicare FFS beneficiaries through September 2013. Results from the first 12 months of the initiative suggested that the CPCI generated reductions in hospitalizations, outpatient ED visits, primary care physicians visits, and specialist visits. Oklahoma showed the largest reductions in Medicare costs and service use among all regions participating but had significant declines in quality of care process measures.⁶⁰

At the start of the CPCI, a qualitative assessment found that practices in Oklahoma exhibited the greatest opportunity for improvement in primary care. In general, the primary care practices had little experience with the PCMH model and did not have structured processes to ensure continuity of care for their patients. Their patients also had a high admission rate for ambulatory care sensitive conditions (ACSC) – conditions where good outpatient care or early intervention can prevent hospitalizations. The first annual evaluation of the CPCI identified mixed results in Oklahoma. Oklahoma’s participating practices showed the largest reductions in expenditures, hospitalizations, and ED visits as compared to the rest of the participating regions. For example, preliminary results of the initiative showed that Oklahoma’s annual hospitalizations declined by 7%, annual outpatient ED visits declined by 7%, and total annual ED visits fell by 5%. In addition, Tulsa was the only region nationally that experienced statistically significant net savings (net savings of \$41 (5%) PMPM). However, Oklahoma data showed statistically significant reductions in quality-of-care process measures. These reductions were most significant in the number of patients receiving eye exams for diabetes (declined by 6%) and the number patients receiving all four tests for diabetes (declined by 21%).

D. Medical Homes: Including Health Homes, Patient-Centered Medical Homes, Federally Qualified Health Center Advanced Primary Care Practice Demonstrations, and Health Access Networks

There are several types of Medical Home innovation occurring in Oklahoma. In this section we describe each program, the sponsoring organization or agency, and the intended results.

1. Health Homes

Health Homes is an Oklahoma Behavioral Health Homes Initiative implemented in January 2015. This initiative is intended to build a patient-centered system of care that improves outcomes, services, and value for members in the Oklahoma SoonerCare program. SoonerCare is the state Medicaid program administered by the Oklahoma Health Care Authority (OHCA.) Health Homes are an optional Medicaid State Plan benefit that allows states to receive additional funding to develop an

⁶⁰ Taylor, Erin F. et al. Mathematica Policy Research. January 2015. *Evaluation of the Comprehensive Primary Care Initiative: First Annual Report*.

integrated delivery model for a designated population. The SoonerCare Health Home initiative is sponsored by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS.) The targeted populations in Oklahoma are children with serious emotional disturbance (SED) and adults with serious mental illness (SMI).

SoonerCare's Health Homes were implemented to provide integrated care through comprehensive care management, care coordination, health promotion, coordination of transitional care from inpatient to other settings, and use of health IT to link services. Health Homes are designed to be the places where SoonerCare members receive coordinated medical, behavioral, and social supports in a manner tailored to each member's needs. The results of this implementation were expected to improve quality of care, improve the individual's experience with received care, and reduce the use of hospitals, EDs, and other expensive facility-based care.

Health Home services are provided by behavioral health organizations. The Health Home's multi-disciplinary teams are comprised of medical, mental health and chemical dependency professionals to provide integrated service delivery in the behavioral health setting. Providers in the Health Homes program receive PMPM payments based on minimum service delivery and their ability to meet all requirements.⁶¹ As of August 2015, 22 providers at over 150 locations across Oklahoma are participating in the Health Homes. Approximately 8,200 adult and pediatric SoonerCare members, or over 55% of potentially eligible members state-wide, are participating in Health Homes. At the time of this report, no information regarding the effectiveness of Health Homes in Oklahoma is publicly available.

2. Federally Qualified Health Center Advanced Primary Care Practice Demonstrations

Oklahoma is home to 20 primary FQHCs with a total of 75 sites. On November 1, 2011, 3 of these FQHCs were selected by CMS to participate in the FQHC ACPD Demonstration: Great Salt Plains Health Center, Variety Care, and Pushmataha Family Medical Center. The demonstration was intended to transform these FQHCs into advanced primary care practices in support of Medicare beneficiaries.

"Exhibit 4: Distribution of Revenue by Source for Federally Qualified Health Centers (2013)" shows Oklahoma's distribution of revenue by payer source for FQHCs as of 2013. This table shows how Oklahoma's revenue sources compare to the average across the United States. Oklahoma FQHCs receive an above average amount of revenue from Federal Grants but a below average percentage from Medicaid.

⁶¹ Oklahoma Health Care Authority. January 5, 2015. *Health Homes*. <https://www.okhca.org/providers.aspx?id=16525>

Exhibit 4: Distribution of Revenue by Source for Federally Qualified Health Centers (2013)⁶²

Revenue Source	Oklahoma	United States
Medicaid	32%	40%
Medicare	6%	6%
Other Public Insurance	0%	2%
Private Insurance	8%	8%
Self-Pay	9%	6%
Federal Grants	34%	21%
State and Local Grants	7%	10%
Foundation/Private Grants	3%	4%
Other Revenue	1%	4%

FQHCs nationally receive over half of their revenue from Medicaid and Federal Grant funds. In addition, payers in Oklahoma, such as Blue Cross and Blue Shield of Oklahoma, Aetna, UnitedHealthcare, and CommunityCare, have various partnerships with FQHCs around the state. While not all payers offer financial incentives for quality improvement, many do provide grants and special awards to high performing FQHCs. The FQHC demonstration project provided many sites with the necessary resources to provide high quality care and qualify for grants and special awards. These additional funds have been used to improve health information technology and increase data warehousing infrastructure.

The demonstration project tested the effectiveness of doctors and other health professionals working in teams to coordinate and improve care for their Medicare patients. The project aimed to show the PCMH model could improve quality of care, promote better health, and lower costs. CMS is currently analyzing the demonstration data and will publish final results upon completion.

To evaluate the success of the program, the participating FQHCs were expected to reach Level 3 recognition as a PCMH by the end of the demonstration. FQHCs wishing to achieve Level 3 recognition must score 85-100 points out of 100 points and must pass six elements (see *Exhibit 3* in Section IV of this report for details on the must pass elements.)⁶³:

Provider and patient satisfaction is measured by surveys conducted by the FQHCs on an ongoing basis. Three of the PCMH elements include provisions for behavioral health care. PCMH Element 2 requires the FQHCs to demonstrate the “scope of services available within the practice including how behavioral health needs are addressed.” PCMH Element 4 requires the FQHC to establish a systematic process and criteria for identifying patients who may benefit from care management with

⁶² Kaiser Family Foundation. 2013. *Distribution of Revenue by Source for Federally-Funded Federally Qualified Health Centers*. <http://kff.org/other/state-indicator/fqhc-revenue-by-source/>

⁶³ National Committee on Quality Assurance. 2014. *PCMH 2011 – PCMH 2014 Crosswalk*. <http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH/PCMH2011PCMH2014Crosswalk.aspx>

consideration for patients with behavioral health conditions. PCMH Element 5 evaluates the FQHCs ability to maintain agreements with behavioral healthcare providers, to integrate behavioral healthcare providers within the health center, and to provide materials on how behavioral health is integrated with physical health.⁶⁴

Oklahoma FQHCs have advanced their ability to offer behavioral health care through an integrated care model. Treatment of patients' physical and behavioral health conditions are often separate, which can lead to unnecessary services and inadequate care for patients. Many FQHCs in Oklahoma are integrating behavioral health services into their delivery models. Innovative methods of achieving behavioral/medical integration include the Screening Brief Intervention and Referral Treatment (SBIRT), which is an approach that allows for faster assessment of the severity of substance use, shorter intervention periods, and efficient referrals to treatment for patients needing access to specialty care treatment.

3. Patient-Centered Medical Home

Oklahoma PCMHs were introduced by the OHCA in 2009 to align members with a primary care provider who is responsible for meeting access and quality of care standards. Using the NCQA PCMH program as a guideline, Oklahoma's PCMH program, called SoonerCare Choice, relies on a state-developed tier-based program described in Section IV.C.1. As of July 2015, OHCA reported 903 PCMH recognized providers in Oklahoma that serve Medicaid patients. The OHCA PCMH model serves Medicaid members and was developed under Oklahoma's 1115 waiver.

The SoonerCare Choice PCMH model is designed to provide comprehensive, coordinated primary care services to SoonerCare Choice members. This model includes care managers and a health management program to provide in-house care coordination for SoonerCare Choice members with chronic conditions or who are at-risk. The primary care payment structure of this model includes a care coordination component determined by the capabilities of the practice and the populations served. This care coordination payment is a PMPM prospective payment to physicians, funding up-front costs associated with health information technologies (HIT) and other non-face-to-face services. In addition to FFS payments, OHCA pays monthly care management fees in addition to the FFS payments which increase depending on the PCMH level of recognition.⁶⁵ ⁶⁶ The total number of member months and dollars paid for care coordination in State Fiscal Year (SFY) 2014 is shown in "Exhibit 5: SoonerCare Choice SFY 2014 Care Coordination Payments."

⁶⁴ Ibid.

⁶⁵ Oklahoma Health Care Authority. 2014. *SoonerCare In Motion: Annual Report 2014*. http://www.okhca.org/publications/pdflib/AR2014_for%20Web.pdf

⁶⁶ Oklahoma Health Care Authority. *Changes in Payment Structure*. http://www.okhca.org/providers.aspx?id=8488&menu=74&parts=8482_10165

Exhibit 5: SoonerCare Choice SFY 2014 Care Coordination Payments

SoonerCare Choice Medical Home	Member Months	Member Equivalents	Care Coordination Payments
Medical Home Open to All Ages	3,228,957	269,080	\$16,976,477
Medical Home Children Only	1,560,372	130,031	\$7,051,611
Medical Home Adults Only	35,794	2,983	\$195,783

Note: Member equivalents were calculated from the member month data (member months/ 12)

In SFY 2014, PCMH providers also received over \$3.2 million in quality incentive payments for meeting one or more quality benchmarks through a SoonerCare Choice incentive program called SoonerExcel. PCMH performance in Oklahoma has demonstrated consistent improvement in outcomes including a decrease in ED utilization, hospitalization rates for ambulatory care sensitive conditions, hospital readmission rates, and average PMPM costs.⁶⁷

4. Health Access Network

In 2010, the SoonerCare HAN model was launched as part of the SoonerCare Choice program. Like the SoonerCare Choice PCMH, the HAN serves Medicaid members under Oklahoma’s 1115 waiver. The Oklahoma HANs are non-profit administrative entities that work with providers to coordinate and improve quality of care for SoonerCare Choice members. The program was developed with the intention of expanding the SoonerCare Choice PCMH model to serve a subset of PCMH members. The HAN model created community-based, integrated networks designed to increase access to health care services, enhance quality and coordination of care and reduce costs. HANs offer patients access to all levels of care, including primary, specialty outpatient and acute inpatient care, and certain ancillary services.⁶⁸

The Oklahoma HANs receive a \$5 PMPM for agreeing to provide practice enhancement and care management coordination for the HAN-affiliated SoonerCare Choice providers and members. The care management activities are targeted for high-risk SoonerCare Choice members. The enrollment in each HAN is limited to the number of persons the individual HAN can serve.

There are three HAN contractors in Oklahoma: Partnership for Healthy Central Communities, Oklahoma State University Center for Health Sciences (OSU), and Oklahoma University (OU) Sooner HAN. These three contractors encompass 647 HAN-affiliated PCMH providers practicing at 68 sites throughout the state.

The Pacific Health Policy Group evaluated the SoonerCare Choice Program in 2014, including the three Oklahoma HANs. This study provides an overview of the HANs’ performance since the inception of the model. Membership in Oklahoma HANs increased from approximately 25,000 to

⁶⁷ Pacific Health Policy Group. July 2015. *SoonerCare Choice Program Independent Evaluation State Fiscal Year 2014*.

⁶⁸ SoonerCare. Oklahoma. Chapter 25. SoonerCare Choice; Subchapter 9. Health Access Networks. 317:25-9-1-317:25-9-3

approximately 115,000 members over the first five years of the initiative. Membership is distributed among the three HANs as follows: 96,863 (84%) in OU Sooner HAN, 14,899 (13%) in the OSU HAN, and 3,449 (3%) in the Partnership for Health Central Communities. According to the evaluation, utilization and costs trends across all of the Oklahoma HANs have been comparable to the non-HAN SoonerCare population.⁶⁹

E. Indian Health Services

Indian Health Services (IHS) is a federal agency within the HHS, responsible for providing health services to Native Americans. The agency provides health services through direct care provided by IHS or tribal facilities or through care funded by IHS through community-based providers. In addition, IHS's Urban Indian Health Program provides special funding to health programs located in urban areas.

Direct care is provided through an IHS facility or through tribal nations. IHS provides infrastructure and support to Oklahoma's tribal nations, and each nation operates their own health programs ranging from small preventive care programs and behavioral health programs to large scale hospitals. In Oklahoma there are 62 IHS or tribally operated health care facilities, including hospitals and clinics. Ten of these are IHS run facilities and 52 are tribally-run facilities operated by 38 Native American nations.⁷⁰ The data we analyzed did not allow us to quantify the extent to which the IHS provides health care services through purchased care from private providers in Oklahoma.

IHS's Urban Indian Health Program supports urban clinics through Title V of the Indian Health Care Improvement Act. The clinics and programs are for those Native Americans who are unable to access IHS facilities, tribal nation programs or purchased care services because they either do not meet IHS eligibility criteria or reside outside of IHS and tribal service areas.

In Oklahoma there are two urban clinics supported under Title V programs: The Oklahoma City Indian Clinic and the Indian Health Care Resource Center (IHCRC) in Tulsa. The Oklahoma City Indian Clinic serves over 180 tribes and reports over 74,000 outpatient visits a year. The clinics provide medical, wellness, pharmacy, diabetes care and education, dental, women's health care, pediatric clinic, and behavioral health services and utilize electronic health records to coordinate care across their system.⁷¹ The IHCRC Tulsa provides medical, behavioral health, health and wellness, youth programs, dental, optometry, pharmacy, and other programs to over 12,000 patients a year from over 180 tribes. The IHCRC received its fifth accreditation and certification as a Medical Home by the AAAHC through its successful efforts in providing patient centered, quality care.⁷²

⁶⁹ Pacific Health Policy Group. July 2015. *SoonerCare Choice Program Independent Evaluation State Fiscal Year 2014*.

⁷⁰ Indian Health Services. Oklahoma City Area Federal / Tribal / Urban Indian Health System: 2014 Directory <http://www.ok.gov/health2/documents/IHS%20Facilities2014.pdf>.

⁷¹ Oklahoma City Indian Clinic. 2014. *Oklahoma City Indian Clinic Annual Report 2014*. <http://www.okcic.com/annual-report-2014/>

⁷² Indian Health Care Resource Center of Tulsa. 2014. *Indian Health Care Resource Center of Tulsa: Annual Report 2014*. http://issuu.com/ihcrc/docs/annual_report_2014

In addition to the programs discussed above, it is important to note that there are an estimated 133,000 Native Americans enrolled in SoonerCare.⁷³ For this population, SoonerCare reimburses the IHS, tribal, or Urban clinics for covered services furnished by those providers. The OHCA actively works with IHS and its network of providers to ensure that Native American SoonerCare members have improved access to healthcare services.⁷⁴

F. Employer Care Delivery Model Innovation

Employers are key stakeholders in the health care delivery system. They have the opportunity to significantly influence the cost of their employees' health insurance as well as the benefits they receive. The delay of the employer mandate in the ACA until 2016 means that employers with 50 or more full-time equivalent employees will not face penalties for not providing health insurance to employees during 2015. While there is evidence of a national trend of employers (particularly small employers) choosing to reduce or even eliminate coverage, some employers are choosing to invest in programs designed to increase health care quality and improve outcomes as a strategy to manage cost. In addition, ACA enables healthcare innovation programs and initiatives that allow employers to become more directly involved in benefit design and delivery optimization for employees and dependents.⁷⁵

Numerous Oklahoma employers are actively engaged in healthcare delivery innovation. WellOK, Inc., the Northeastern Oklahoma Business Coalition on Health, was created to improve the value of the healthcare received by employees and dependents. The coalition, comprised of 15 Oklahoma employers, focuses on care quality and cost-effectiveness and has identified three strategic initiatives: fostering participation in the Leapfrog Group's Hospital survey; partnering with Consumer Reports® Health in support of the Choosing Wisely Initiative; and collaborating with the OSDH Chronic Disease Division and other stakeholders to provide diabetes prevention programs.

One of the WellOK employer participants, QuikTrip Corporation, a gasoline and convenience store chain, reports favorable outcomes from its approach to providing healthcare. The company provides 79% company-paid health coverage for their employees and 54% for dependents.⁷⁶ QuikTrip operated its own self-funded health plan, including paying claims internally. According to management, QuikTrip has a long history of using data to drive decisions, including provider contracting strategies and initiatives to identify and develop programs to meet employee health needs (e.g., diabetic prevention programs.)

Workplace clinics are another approach to improving health care quality which have been gaining favor among some large employers. QuikTrip partners with CareATC, Inc., an organization offering

⁷³ OHCA. American Indian Fast Facts. June 2015.

<http://www.okhca.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=17533&libID=16515>

⁷⁴ Oklahoma Health Care Authority. *Tribal Relations*.

http://www.okhca.org/providers.aspx?id=128&menu=74&parts=7471_7703

⁷⁵ Schilling, Brian. The Commonwealth Fund. March 2011. *Advancing Quality Through Employer-Led Initiatives*.

<http://www.commonwealthfund.org/publications/newsletters/quality-matters/2011/february-march-2011/in-focus>

⁷⁶ QuikTrip. Great Place to Work. *QuikTrip Corporation: What You Should Know*.

<http://reviews.greatplacetowork.com/quiktrip>

on-site and near-site clinic to provide primary care for QuikTrip employees and dependents. Primary care services and medications provided via CareATC are free to employees and dependents, with modest copayments for specialty, inpatient, and emergent care provided by network providers. QuikTrip network providers share patient data via the MyHealth Health Information Exchange to ensure coordination and continuity of care across primary and specialty care settings.

Other large Oklahoma self-insured employers are also providing incentives for improved health. For example, some offer wellness programs, and/or premium cost sharing reductions for active participation in condition management programs. The 2014 State of Oklahoma Business Health and Wellness Survey provides additional information about some of these initiatives.⁷⁷

G. Emerging Medicaid Care Delivery Innovation

On June 22, 2015, the OHCA issued a Request for Information (RFI) to collect information regarding care coordination models for the SoonerCare programs' aged, blind, and disabled (ABD) members.⁷⁸ The OHCA plans to design a comprehensive care coordination model that provides these members access to quality care at reduced costs. The objective is to identify the best market-based approach that incorporates value-based payment systems and improves health outcomes through evidence-based, patient-centered health care services.

The RFI states that the a care coordination model will ultimately reflect information on existing Oklahoma patient-centered service models, including their populations served, covered services and benefits, provider networks, and provider payment structures. The analysis of the alternative models will consider the potential impact of the proposed model, its market feasibility, and how it integrates with Medicare. Responses to the RFI will be used to determine the market feasibility of a variety of approaches, generate discussion and input among stakeholders, and result in a recommendation for potential models.

⁷⁷ State of Oklahoma Business Health and Wellness Survey. Milliman, Inc., October 23, 2014.

http://www.ok.gov/health/Organization/Office_of_Communications/News_Releases/2014_News_Releases/Oklahoma_Employers_Health_and_Wellness_Survey.html

⁷⁸ Oklahoma Health Care Authority. June 22, 2015. *Oklahoma Health Care Authority: Request for Information Care Coordination for the Aged, Blind, and Disabled*.

VI. Considerations for Accelerating Adoption of Delivery Models

Oklahoma’s stakeholders recognize that health system transformation requires a multifaceted approach, using various levers to drive payment and delivery system changes. The OSIM has been a catalyst for Oklahoma payers, providers, and other stakeholders to work together to test and implement alternative payment models and various delivery system changes focused on improving care coordination, building primary care capacity, and improving chronic care management. Oklahoma can benefit from considering lessons learned and the perspective of other states and national initiatives to accelerate the adoption of these models.

Consider Promoting ACO-like Models

Currently, there are three entities in Oklahoma participating in the MSSP initiative. Those entities that participate in the MSSP, may consider reorganizing to “graduate” up to a new CMS’s ACO initiative called the Next Generation ACO Model. Entities that are not in an ACO may also consider foregoing the MSSP ACO for the Next Generation ACO model, which is intended to test whether “strong incentives for ACOs can improve health outcomes and reduce expenditures for Medicare fee-for-service (FFS) beneficiaries.”⁷⁹ The Next Generation ACO has both additional requirements and flexibility that may be appealing to organizations experienced in managing risk. Specifically it has the following key components:

- Rewards for quality performance;
- Rewards for cost containment;
- A hybrid approach to benchmarking performances by using historical and regional costs that are updated annually;
- A selection of alternative payment mechanisms to allow a transition from FFS payments to capitation; and
- Tools to help ACOs improve engagement with beneficiaries, such as:
 - Additional access to home visits, telehealth services, and skilled nursing facilities
 - Reward payment for receiving care from the ACO;
 - Increased beneficiary input into the selection of his/her ACO; and
 - Collaboration between CMS and ACOs to clearly communicate to beneficiaries the characteristics and potential benefits of ACOs in relation to their care.

The minimum requirement for the number of aligned beneficiaries is 10,000 (7,500 for rural ACOs). Due to these large minimum requirements, it may be advantageous for providers, hospitals and health systems to organize to pool their patient populations.

Critical access hospitals and small rural hospitals in Oklahoma, may consider applying to participate with the National Rural ACO. The National Rural ACO was started in 2013 to address the minimum number of beneficiaries required for Medicare ACO participation. In addition, many small community

⁷⁹ CMS/CMMI. March/April 2015. Next Generation ACO Model: Request for Applications. <http://innovation.cms.gov/Files/x/nextgenacorfa.pdf>.

health providers do not have the system requirements (e.g., IT, care management systems, etc.) to effectively manage a population. The National Rural ACO allows each community to act as its own ACO, with its own benchmark and its own goals, but provides governance and resources (e.g., peer learning network, care management tools for populations with chronic conditions) through a regional consortium.⁸⁰

Oklahoma may consider developing Medicaid ACOs. As discussed in Section IV.D.2, Medicaid ACOs are relatively new, with only 9 states having launched this payment and delivery system model and an additional 10 states in the process.⁸¹ Each model is different and requires each state to consider its own unique State Plan Amendment and market. Colorado and Utah, for example, needed a Section 1915 Waiver to allow managed care organizations to deliver care through the ACO model. Oregon, applied for a Section 1115 Waiver to grant the state the authority to contract directly with providers as they developed their ACO model.⁸²

For any ACO efforts, Oklahoma may consider whether regulatory clarification or guidance are needed, especially as it relates to: governance models, anti-trust prohibition, anti-kickback laws, and minimum protections for risk-bearing entities (e.g. reserve requirements). *The Accountable Care Organization Learning Network Toolkit* produced by The Brookings Institution contains a summary of these considerations from a federal perspective.⁸³ Finally, any efforts to develop ACOs are best considered in the context of the delivery and payment system changes already underway. For example, for the Medicaid market, any ACO development efforts can be built on top of the PCMH and Health Home initiatives that have already been implemented.

Expand Efforts for Behavioral Health Integration

Oklahoma has made strides in integrating behavioral and physical health for populations served by FQHCs and Medicaid beneficiaries, especially for children with SED and adults with SMI. The integration of behavioral and physical health has seen favorable outcomes in reducing inappropriate care, improving screening, and increased coordination among providers, nurses, and practitioners. To the extent feasible, Oklahoma may consider scaling its successes with the Health Homes program to other populations with substance use disorders and other mental health disorders where there are clear standards of care.

Avoid “Measurement Fatigue” by Streamlining Quality and Efficiency Metrics

A common barrier to uptake of delivery and payment reform models is the perception that reporting of performance measures will be duplicative, burdensome and will not provide actionable information

⁸⁰ <http://www.nationalruralaco.com/members.shtml>.

⁸¹ Medicaid Accountable Care Organizations: State Update. August 2015. <http://www.chcs.org/resource/medicaid-accountable-care-organizations-state-update/>.

⁸² Tricia McGinnis and Amanda Van Vleet, Center for Health Care Strategies. November 2012. Core Considerations for Implementing Medicaid Accountable Care Organizations.

⁸³ <https://xteam.brookings.edu/bdacoln/Documents/ACO%20Toolkit%20January%202011.pdf>.

to health care providers. Some of these perceptions are not unfounded; as of 2014, 33 federal programs requested information on 1,675 quality measures.⁸⁴ While there may not be flexibility for programs' reporting requirements, there may be opportunities to streamline data capture and calculate metrics, especially when the measures are based on the same specifications. It may be worthwhile to review all measures required under each model and identify opportunities to streamline the data collection, metric calculation, and measurement reporting processes.

Consider Removing Barriers to Adoption of Enabling Technologies

Removing barriers to adoption of enabling technologies such as telehealth can provide valuable tools to improve health care coordination and outcomes. Telehealth technologies can enable efficient, patient-centered delivery of health care services, especially where there are barriers to accessing in-person care. In addition, telehealth technologies have the potential to support care management functions and address short-term acute care conditions that may prevent an urgent care or ED visit. SoonerCare covers live video visits if the provider determines the service is appropriate for telehealth delivery. "Store and forward" services, such as transmission of images or tests for remote provider review and assessment, are not covered. SoonerCare currently restricts coverage to rural or geographic areas where there is "lack of local medical/psychiatric/mental health expertise."⁸⁵ In 2014, the Oklahoma Board of Medical Licensure & Supervision adopted Telemedicine Rules to clarify that medical services provided to an Oklahoma patient must be provided by a physician fully licensed in Oklahoma. Services may not be furnished across state lines. If Oklahoma is interested in increasing the adoption of telehealth technologies, geographic restrictions, licensing and certification processes, and coverage policies should be examined closely. Of note, Medicare's Next Generation ACO program applicants are required to demonstrate innovative ways for, "Coordination of care and care transitions (e.g., sharing of electronic summary records across providers, telehealth, remote patient monitoring, other enabling technologies)." In addition, these ACOs also have flexibility in terms of Medicare rules related to rural restrictions and originating sites restrictions.

⁸⁴ Beck, Melinda. Debate Heightens Over Measuring Health-Care Quality. January 30, 2015. <http://www.wsj.com/articles/debate-heightens-over-measuring-health-care-quality-1422661664>

⁸⁵ OK Admin. Code Sec. 317:30-3-27(c) (2).