State of Oklahoma Care Delivery Model: Key Findings

Prepared for:
Oklahoma State Department of Health
Center for Health Innovation and Effectiveness

Presented by:
Maureen Tressel Lewis, MBA
Susan Philip, MPP

August 28, 2015
Caveats

This presentation was prepared by Milliman, Inc. (Milliman) for 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.

The subsequent slides are for discussion purposes only. These slides should not be relied upon without benefit of the discussion that accompanied them.

No portion of this slide deck may be provided to any other third party without Milliman’s prior written consent.

In performing this assessment, we relied on data and other information provided by OSDH, from stakeholders interviewed, and from publicly available sources. We have not audited or verified this data and other information. If the underlying data or other information is inaccurate or incomplete, the results of our assessment may likewise be inaccurate or incomplete.
Agenda

- Project Overview
- Framework for Health System Transformation
- Care Delivery Models Nationally and In Oklahoma
- Considerations for Accelerating Adoption of Delivery Models
Background

- State Innovation Model (SIM) Grant was awarded to Oklahoma in December 2014 to provide a state-based solution to Oklahoma’s healthcare challenges
  - The grant is administered by the Oklahoma State Department of Health (OSDH) with oversight by the Oklahoma State Innovation Model (OSIM) group
  - OSIM’s goal is to improve health, provide better care, and reduce health expenditures for more than 1.2 million Oklahomans

- 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
Scope

OSDH engaged Milliman to conduct research on care delivery models and payment reform initiatives deployed nationally and in Oklahoma

The OSIM team identified the following models and initiatives for 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)
8. Indian Health Services (IHS)
# Research Approach

The following steps were used to gather information on care delivery models in Oklahoma and other states.

<table>
<thead>
<tr>
<th>Method</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interviews</td>
<td>Understand payer and provider experience with care delivery models and payment reform initiatives in Oklahoma.</td>
</tr>
<tr>
<td>Research on Publically Available Information</td>
<td>Gain essential background and conclusions on the eight identified care delivery models from public sources.</td>
</tr>
<tr>
<td>Industry Knowledge</td>
<td>Pull relevant information from prior Milliman work with Oklahoma’s insurance market and knowledge of care delivery models in other states.</td>
</tr>
</tbody>
</table>
## Stakeholder Interviews

<table>
<thead>
<tr>
<th>Organization</th>
<th>Name</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Cross and Blue Shield of Oklahoma</td>
<td>Joseph Cunningham, M.D.</td>
<td>Chief Medical Officer</td>
</tr>
<tr>
<td>Morton Comprehensive Health Care</td>
<td>John Silva</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>MyHealth Access Network</td>
<td>David Kendrick, M.D.</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>Oklahoma Health Care Authority</td>
<td>Melody Anthony</td>
<td>Director of Provider/Medical Home Services</td>
</tr>
<tr>
<td></td>
<td>Marlene Asmussen</td>
<td>Director of Population Care Management Department</td>
</tr>
<tr>
<td></td>
<td>Becky Pasternik-Ikard</td>
<td>Deputy State Medicaid Director</td>
</tr>
<tr>
<td></td>
<td>Melissa Pratt</td>
<td>Insure Oklahoma, Outreach Administrator</td>
</tr>
<tr>
<td></td>
<td>Connie Steffee</td>
<td>Reporting and Statistics Director</td>
</tr>
<tr>
<td>Oklahoma Primary Care Association</td>
<td>Judy Grant</td>
<td>Deputy Director</td>
</tr>
<tr>
<td></td>
<td>Dee Porter</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td></td>
<td>Brent Wilborn</td>
<td>Director of Public Policy</td>
</tr>
<tr>
<td>Oklahoma State Department of Health</td>
<td>Isaac Lutz</td>
<td>Health Innovation Planning Manager</td>
</tr>
<tr>
<td></td>
<td>C. Alex Miley</td>
<td>OSIM Project Director</td>
</tr>
<tr>
<td></td>
<td>Valorie Owens</td>
<td>Manager of Statewide Access to Care Planning</td>
</tr>
<tr>
<td>QuikTrip</td>
<td>Brice Habeck</td>
<td>Benefits Manager</td>
</tr>
<tr>
<td>University of Oklahoma Health Sciences Center</td>
<td>Cynthia Scheideman-Miller</td>
<td>Special Programs Director, Telemedicine</td>
</tr>
<tr>
<td>Variety Care</td>
<td>Lou Carmichael</td>
<td>Chief Executive Officer</td>
</tr>
</tbody>
</table>
Agenda

- Project Overview
- Framework for Health System Transformation
- Care Delivery Models Nationally and In Oklahoma
- Considerations for Accelerating Adoption of Delivery Models
Framework for Health System Transformation

Delivery

Episodic Non-Integrated Care
- Care that is fragmented, episodic with poor coordination
- Lack of or poorly coordinated care management for chronic conditions

Outcome-Oriented Accountable Care
- Patient focused care with provider accountability
- Care coordination
- Care management tools for chronic/comorbid conditions
- Deployment of evidence-based practices

Community Integrated Healthcare
- Patient-centered and population-based care
- Integration of community resources
- IT enabled use of evidence based practices
- Telehealth capable

Payment

FFS, No Link to Quality
- Payments are volume-based with no links to quality or efficiency metrics

FFS, Link to Quality
- Payments are volume-based with a portion of payments linked to quality or efficiency metrics

Alternative Payment Models, On FFS
- While payments are volume-based, some payment is at risk, based on effective management of population/episode

Population-Based Payments
- Payments are not volume-based
- Providers are responsible for management of population/episode

Health System Transformation
Agenda

- Project Overview
- Delivery Model Framework
- Care Delivery Models Nationally and in Oklahoma
  - Bundled Payments for Care Improvement Initiative
  - Comprehensive Primary Care Initiative
  - Medical Home Initiatives
  - Accountable Care Organizations Initiatives
  - Indian Health Services
- Considerations for Accelerating Adoption of Delivery Models
National Care Delivery Model Overview

- The ACA mandated changes to the Medicare and Medicaid payment programs and established the CMMI
- The purpose of these mandates was to encourage the implementation of:
  - **Payment Systems** that are value-driven, population-based and
  - **Delivery Models** that are integrated, patient centered, and community-based
- 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.

“HHS has set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018... This is the first time in the history of the Medicare program that HHS has set explicit goals for alternative payment models and value-based payments.”

-- HHS Press Release, January 26, 2015
Oklahoma Care Delivery Model Overview

- 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.

- The OSDH proposed the OHIP which includes a health transformation strategy to promote value based health models across systems that will accelerate health improvement and yield a return on investment.
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.

Overview

- **Model 1:** Retrospective Acute Care Hospital Stay Only
  - National: 11 Sites
  - Oklahoma: 0

- **Model 2:** Retrospective Acute Care Hospital Stay plus Post-Acute Care
  - National: 741 Sites
  - Oklahoma: 18 Sites

- **Model 3:** Retrospective Post-Acute Care Only
  - National: 1,353 Sites
  - Oklahoma: 21 Sites

- **Model 4:** Acute Care Hospital Stay Only
  - National: 21 Sites
  - Oklahoma: 0
Comprehensive Primary Care Initiative

Overview

- The CPCI is a four-year initiative that 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).

Payment Model

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.

Financial Incentives

- Risk-adjusted monthly care management fees
- Shared Savings
Comprehensive Primary Care Initiative

### Primary Care Practice Participation Criteria

<table>
<thead>
<tr>
<th>Use of health information technology</th>
<th>Ability to demonstrate advanced primary care delivery recognition by accreditation bodies</th>
<th>Service to patients covered by participating payers</th>
<th>Participation in practice transformation and improvement activities</th>
<th>Diversity of geography, practice size and ownership structure</th>
</tr>
</thead>
</table>

### Key Practice Functions

- Access and continuity of care
- Planned chronic and preventive care
- Risk-stratified care management
- Patient caregiver engagement
- Coordination of care across the medical neighborhood

### National Payer and Provider Participation

- **475 practice sites**
- **2,805 providers**
- **2.7 million patients: 404,000 Medicare/Medicaid beneficiaries**
- **38 public or private payers**
- **Total monthly reduction in Medicare expenditures of $14/beneficiary (2%), during 1st year**
- **Reduced annual hospitalization (2%); ED (3%); specialist visits (2%); primary care visits (2%)**

### Oklahoma Payer and Provider Participation

- **62 practice sites**
- **254 providers**
- **311,000 patients: 45,000 Medicare/Medicaid beneficiaries**
- **3 public or private payers**
- **Convener: MyHealth**
- **Total monthly reduction in Medicare expenditures during 1st year; Tulsa demonstrated $41PMPM savings (5%)**
- **Reduced annual hospitalization (7%); ED (7%)**
Medical Homes

Overview

- There are a variety of medical home models, but at the core, they seek to drive delivery system changes by assigning a patient to a primary care office, clinic, FQHC/RHC or other physician’s office where the patient most often receives care for his or her primary condition.

National

Medical home models vary in program design and payments methods:

- Alternative payment models/incentives
  - Monthly care coordination/care management fees
  - Visit-based payments
  - Performance-based payments through shared savings
- Many follow the NCQA’s PCMH delivery model and have sought formal recognition

Oklahoma

Deployment of medical home models vary by target populations:

- SoonerCare:
  - SoonerCare Choice (2009)
  - Health Access Network (2010)
  - Oklahoma Behavioral Health Homes (2015)
- FQHC APCP Demonstration
Medical Homes: Patient-Centered Medical Homes

Overview

- 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. Oklahoma’s PCMH model, SoonerCare Choice was launched in 2009

SoonerCare Choice PCMH Model Care Coordination Payments

<table>
<thead>
<tr>
<th>SoonerCare Choice Medical Home</th>
<th>Member Months</th>
<th>Member Equivalents</th>
<th>Care Coordination Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Home Open to All Ages</td>
<td>3,228,957</td>
<td>269,080</td>
<td>$16,976,477</td>
</tr>
<tr>
<td>Medical Home Children Only</td>
<td>1,560,372</td>
<td>130,031</td>
<td>$7,051,611</td>
</tr>
<tr>
<td>Medical Home Adults Only</td>
<td>35,794</td>
<td>2,983</td>
<td>$195,783</td>
</tr>
</tbody>
</table>
Medical Homes: Health Access Networks

Overview
- Launched in 2010 as part of the SoonerCare Choice program, the Oklahoma HANs are non-profit community-based, administrative entities that work with providers to coordinate and improve quality of care for SoonerCare Choice members who are considered high-risk.

Objectives
- Create integrated networks to increase access to care services
- Enhance quality and coordination of care
- Reduce costs

Payment Model
- $5 PMPM for providing practice enhancement and care management coordination

Results
- Evaluation, utilization and costs trends across all of the Oklahoma HANs have been comparable to the non-HAN SoonerCare population

- 647 HAN-affiliated PCMH providers at 68 sites
  - Partnership for Healthy Central Communities: 3,449 (3%)
  - Oklahoma State University Center for Health Sciences (OSU): 14,899 (13%)
  - Oklahoma University (OU) Sooner HAN: 96,863 members (84%)
Medical Homes: Health Homes

Overview

- Oklahoma Behavioral Health Home initiative targets children with SED and adults with SMI. Established in 2015, the program promotes patient-centered system of care that improves outcomes, services, and value for members in the Oklahoma SoonerCare program.

Objectives

- Provide comprehensive care management
- Coordinate care
- Promote health
- Coordinate the transition of care from inpatient to other settings
- Use health IT to link services

Payment Model

- PMPM payments based on minimum service delivery and their ability to meet requirements

Intended Results

- Reduce avoidable hospitalizations, ED visits, and facility costs
- Improve patient experience
- Improve care coordination for medical and mental health services with use of multi-disciplinary teams
Medical Homes: FQHC Advanced Primary Care Practice Demonstrations

Overview

• The purpose of the FQHC APCP was to have participating FQHCs transform selected FQHCs into advanced primary care practices and have them be recognized by NCQA as Level 3 PCMHs by the end of the three year demonstration

FQHCs Organizations

- Serve underserved areas or populations,
- Offer a sliding fee scale, provide comprehensive services,
- Have ongoing quality assurance programs, and
- Receive grants under section 330 of the Public Health Service Act.

National Participation

- 439 Participating FQHCs Nationally

Oklahoma Participation

- 3 Participating FQHCs in Oklahoma
  - Great Salt Plains Health Center
  - Variety Care
  - Pushmataha Family Medical Center

Payment Model

- $42 million was distributed by CMS to all 439 participating FQHCs for coordination and quality of care improvement
- Monthly care management fee of $6 per eligible Medicare beneficiary

Evaluations

- TPA administered evaluation which determined that 55% of demonstration sites achieved Level 3 PMCH recognition.
Accountable Care Organizations

Overview

- There are a variety of ACOs but generally, an ACO is a group of professional and/or hospital providers (and sometimes payers) that are formally organized to assume responsibility for the cost and quality of care they provide to its patient population.

ACO Features

- Ownership structure
- Degree of healthcare delivery integration
- Health data exchange activity
- Payment arrangements
- Risk sharing structures

Payment 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.
Accountable Care Organizations

Physician Group Practice Demonstration Project
- Participating physician groups received shared savings payments if they met certain quality targets and exceeded a savings threshold of 2%
- Ran in the mid-2000s
- Only a minority of providers able to achieve savings but program demonstrated quality improvements

Pioneer ACO Program
- Launched in 2012 with 32 ACOs covering 600,000 Medicare beneficiaries
- Includes large medical groups experienced in managing populations
- First 3 years, total of $384 million in savings, and improved care coordination and some efficiency gains.
- 19 ACOs currently participating. Those dropping reported administrative burden, (e.g. quality metrics)

Medicare Shared Savings Program (MSSP)
- The MSSP program consists of 404 ACO entities and covering 7.3 million beneficiaries in 49 states and is comprised of two models:
  - Track 1 (one-sided) model: 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.
  - Track 2 (two-sided) model: ACOs pay a portion of the costs that exceed spending targets but provides greater bonuses for reduced per beneficiary spending trends.
# Accountable Care Organizations

## National: Medicaid

### Overview

- 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.

### State Participation

- Nine states have implemented Medicaid ACOs
- Eight states are pursuing them

### Payment Options

- **Shared savings arrangement**: This option 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
- **Global budget model**: In this option, ACOs provide services and accept full financial risk for the health of their population in exchange for a capitated payment.
In Oklahoma, three ACOs have formed to provide coordinated care to Medicare beneficiaries not enrolled through other MSSPs or Medicare Advantage plans. All three ACOs commenced participation in the MSSP program within the last two years.

**Overview**

- 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.

- 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. 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.

- 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.
Indian Health Services

Overview

• Indian Health Services provides health services through direct care provided by IHS or tribal facilities or through care funded by IHS through community-based providers. IHS’s Urban Indian Health Program provides special funding to health programs located in urban areas.

Direct Care

- IHS provides direct services or provides support to Oklahoma’s tribal nations
- Each nation operates their own health programs ranging from small behavioral health programs to large scale hospitals.
- There 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.

Urban Indian Health Program

- IHS supports urban clinics for those Native Americans who are unable to access IHS facilities, tribal nation programs or purchased care services
- Two urban clinics, each serving 180 tribes:
  - Oklahoma City Indian Clinic: 74,000 outpatient annual visits
  - Indian Health Care Resource Center: 12,000 outpatient annual visits
Employer Care Delivery Model Innovation

Overview

• 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.

Employer Care Delivery Model Strategic Initiatives

Foster participation in the Leapfrog Group’s Hospital survey
Partner with Consumer Reports® Health in support of the Choosing Wisely Initiative
Collaborate with the OSDH Chronic Disease Division and other stakeholders to provide diabetes prevention programs.

QuikTrip Characteristics

Operates its own self-funded health plan, including paying claims internally
Provides 79% company-paid health coverage for their employees and 54% for dependents
Partners with CareATC, Inc., an organization offering on-site and near-site clinic to provide primary care for QuikTrip employees and dependents
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.
Emerging Medicaid Care Delivery Innovation

Overview

• 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.

RFI Details

• 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.
Table of Contents

- Project Overview
- Framework for Health System Transformation
- Care Delivery Models Nationally and In Oklahoma
- Considerations for Accelerating Adoption of Delivery Models
Considerations for Accelerating Adoption of Delivery Models Overview

- Consider Promoting ACO-like Models

<table>
<thead>
<tr>
<th>Medicaid ACO</th>
<th>National Rural ACO</th>
<th>The Next Gen ACO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requires each state to consider its own unique State Plan Amendment and market</td>
<td>Allows each community to act as its own ACO, with its own benchmark and its own goals, but provides governance and resources through a regional consortium</td>
<td>Intended to test whether “strong incentives for ACOs can improve health outcomes and reduce expenditures for Medicare fee-for-service (FFS) beneficiaries”</td>
</tr>
</tbody>
</table>

- Expand Efforts for Behavioral Health Integration

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.
Considerations for Accelerating Adoption of Delivery Models Overview

- **Avoid “Measurement Fatigue” by Streamlining Quality and Efficiency Metrics**
  - 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.
Discussion