

F. Value-Based Payment and/or Service Delivery Model

INTRODUCTION

As part of a broader effort to reform Oklahoma’s healthcare system, the Governor of Oklahoma has established a benchmark to have 80 percent of all state-based healthcare insurance payments made under a value-based model by 2020. To achieve this target the Oklahoma State Innovation Model (SIM) project team is proposing the implementation of a model that includes fully capitated Regional Care Organizations (RCO) for state-purchased healthcare, the statewide adoption of multi-payer quality metrics and multi-payer “episodes of care” payments. This model relies on coordination among community healthcare providers and partners and would encourage the delivery of patient-centered care, enable investments in personnel and systems that improve health, and assist local health systems meet high standards for cost and quality outcomes. Below is a diagram of the components of the proposed model.

Figure 32: The Oklahoma Model



This section of the State Health System Innovation Plan (SHSIP) presents a proposed value-based purchasing model and details the relevant attributes and functions of the Oklahoma Model and multi-payer efforts. This model was developed utilizing a robust stakeholder engagement and consultation process and represents the State’s vision for how changes in healthcare payment and delivery will positively impact the health of Oklahomans, improve the quality of care they receive, and reduce the overall growth rate in healthcare spending. By engaging commercial payers in these three model components, Oklahoma will look to reach the goal of 80 percent of payments being in a fee-for-service alternative in Oklahoma; a characteristic closely associated with a transformed healthcare system.

MODEL TENETS

Stakeholder engagement and deliberation has been a crucial component of the model design throughout the Oklahoma SIM planning process. Various care delivery and payment models, including models of other states, were presented to stakeholders to obtain their perspective and feedback regarding the models’ ability to transform Oklahoma’s healthcare system. The Oklahoma SIM project team incorporated stakeholder feedback and commentary to develop the following tenets of an ideal care delivery model for Oklahoma:

Tenet 1: Incorporate the drivers of health outcomes

- Recognize that social and environmental factors play a major role in a person's health.
 - Integrate primary prevention strategies that address social determinants of health into clinical settings.
 - Develop formal relationships between healthcare providers and community resources to address the social determinants that negatively impact health outcomes.

Tenet 2: Integrate the delivery of care

- Ensure that primary, acute, and behavioral healthcare are integrated and managed collectively.
 - Leverage effective care coordination practices currently in place.
 - Enhance and expand the use of health information technology (HIT) through practice transformation and creation of a statewide IT infrastructure.
 - Fully integrate primary care and behavioral health through physical or virtual co-location.

Tenet 3: Drive alignment of the system to reduce provider burden

- Engage with external stakeholders to align quality metrics.
 - Foster buy-in from private payers through engagement in which agreements are reached regarding quality metrics to drive alignment and consensus.
 - Work with CMS to synchronize Medicare quality measures with those proposed in the SHSIP.
- Acknowledge and work to sustain activities, practices, and/or processes that are showing that they meet the Triple Aim.
 - Preserve and successfully integrated health care delivery models that already exist and meet the triple aim in the state when they embark on this health system transformation.

Tenet 4: Move toward value-based purchasing with realistic goals

- Recognize that different levels of readiness for value-based purchasing exist across the state.
- Incorporate a period of transition to value-based purchasing.
- Foster commitment and collaboration across payers, providers and patients to allow for transformation to occur at the practice level.

REGIONAL CARE ORGANIZATIONS

Using the key tenets as guidelines, Oklahoma proposes to implement a Regional Care Organization (RCO) model for all state-purchased healthcare. State-purchased healthcare coverage includes Medicaid

recipients and eligible public employees and their covered dependents. These covered lives represent nearly a quarter of the state's total population.

The RCO will be a provider and community-based care delivery organization that operates under a comprehensive risk contract with the State. RCOs will receive a fully capitated payment for attributed members and will be accountable for the provision of integrated and coordinated healthcare that meets standardized quality and cost measures. Selected quality measures, RCO policy, and governance will ensure the integration of physical and behavioral health and incorporation of community resources that address social determinants of health. Metrics will be reported through a statewide HIT platform that will evaluate the performance of RCOs. The platform will be partially supported by a fixed plan fee assessed to each RCO. A further description of this platform is described in Section H, the HIT Plan, and the financing of the platform is discussed in Section L, the Operational and Sustainability Plan.

In order to create a shared responsibility for the health of the community, the RCO will be governed by a partnership of payers, healthcare providers, community members, and other stakeholders in the health system. The RCO governance will include a separate Board of Accountable Providers and a Community Advisory Board that will strive to identify mutually satisfactory practices and to promote shared responsibilities. The RCOs will be paid through a State Governing Body that administers all RCO contracts. The State Governing Body will also provide oversight of the RCOs to ensure regulatory and quality compliance.

VALUE-BASED PAYMENT

The Oklahoma Model will transition the State's healthcare to a value-based payment system that rewards quality of care and positive health outcomes. To this end, the State will employ a global budget to pay RCOs for the complete cost of healthcare. The state will develop two separate methodologies for each distinct population included in the Oklahoma Model in order to ensure a fair and equitable rate for covering attributed beneficiaries.

State Payment to the RCO

The global budget for the RCO will consist of a capitated risk adjusted per member per month (PMPM) payment for covered services and incentive payments. The PMPM growth rate will be capped by the state to ensure that cost targets are met. There will be two withholds from the capitated payment; a withhold of 0.5 to 3.0 percent will be retained until the RCO meets the required RCO quality target. The RCO will receive this withhold after the reporting period if the report shows that they have met the required quality metrics. Similar to the method that other states have used, Oklahoma is proposing to review annually the withheld amount to determine if an increase in withholding will make a more positive impact. This increase over time could allow organizations to mature and align more of their capitated-rate to quality outcomes. The second withhold will be passed through to the health information network to maintain statewide HIT interoperability. More of the HIT requirements for RCOs are discussed later in this section. RCOs will receive additional payments from the bonus quality incentive pool to reward those that meet incentive pool targets.

Oklahoma estimates that, over time, its per capita healthcare expenditures will decline due to better health outcomes, a coordinated system that incents more efficient utilization of healthcare services, and a cap on the growth rate state spending. It is anticipated that the growth rate of healthcare expenditures will be slower than the rate under the current model. Along with cost savings, this model positions Oklahoma to achieve improvements in population health and quality of care. Understanding that the healthcare system

is dynamic, continued payment innovation based on provider engagement and feedback will be utilized to incent RCOs to continue to deliver improved, cost-effective care to their beneficiaries.

RCO Payments to Networked Providers

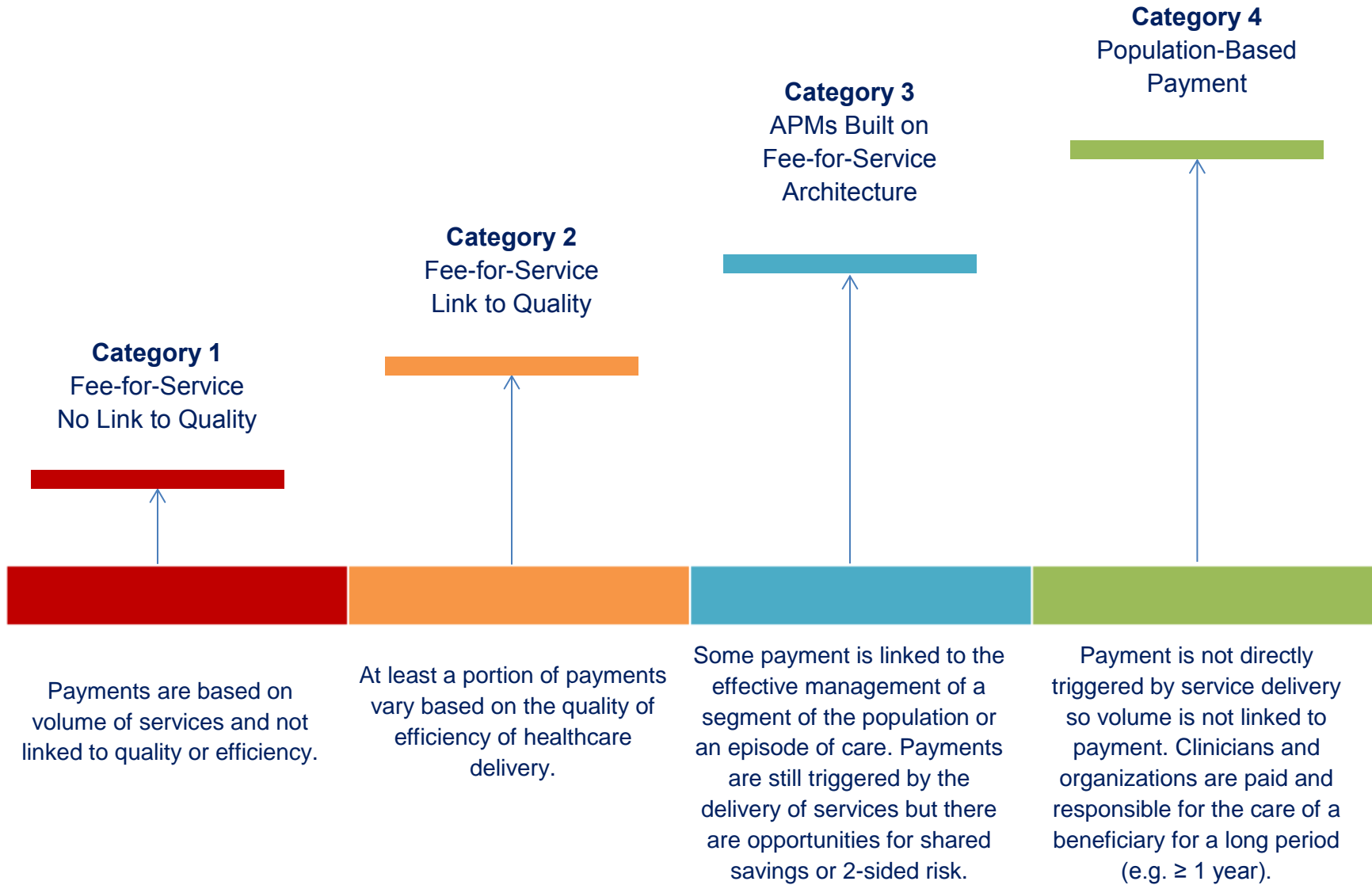
The RCOs will be responsible for implementing value-based alternative payment arrangements (APA) with their provider networks. Each RCO will identify and maintain a provider network that meets capacity and geographic adequacy standards designed to meet the needs of all of Oklahoma's communities. The State Governing Body will oversee efforts and will ensure compliance with quality targets contained in contractual requirements. The State will establish criteria that RCOs must meet as they implement value-based healthcare delivery, including the following:

- Eighty percent of payments made to providers must be value-based by 2020;
- RCOs must participate with the Multi-Payer Episodes of Care;
- One additional APA, as described below, must be utilized; and
- APAs must include mechanisms to encourage both cost savings and high quality care

Outside of these requirements, the decision on how providers within each RCO network are incented and held accountable will be left largely to the RCOs to determine, so that regionally-appropriate methods to move from volume-based to value-based healthcare delivery system innovations can be aligned with regional readiness and successfully implemented.

The Health Care Payment and Learning Action Network continuum of payment, as shown below, will serve as a guide as the State develops direct links to population health outcomes within RCO adopted APAs. Consistent with other efforts across the state and nation, Oklahoma will move state-purchased healthcare further along this continuum in the years to come, moving from process measures to outcome measures as they become more feasible and available. However, flexibility is necessary, as shown by allowing the RCO to pick APAs, to account for the different readiness levels and resources across the state. This is an ambitious payment model but is consistent with industry efforts and should serve to assist Oklahoma's healthcare providers prepare for changes in private sector payment models.

Figure 33: Health Care Payment Learning & Action Network Alternate Payment Methodology Framework



The RCOs will be responsible for developing a network of providers and implementing APAs with aligned quality measures. If there are regions with multiple RCOs, it will be necessary for RCOs to coordinate payment methodologies to ensure clear and consistent goals for providers. Episodes of Care (EOCs) will be a required element of the RCOs' payment methodology for providers. EOCs are payment model in which services related to a condition or procedure are grouped into "episodes" that provide benchmarks for both costs and quality of care. In addition to EOCs, which will be later described in this section, the following APAs will be options for RCOs to utilize:

Bundled Payments

Bundled payments are a modification to the fee-for-service (FFS) structure in which payers reimburse providers for a set of services related to a procedure or health condition rather than reimbursing providers for each service separately. Bundled payments typically focus more on services provided in a hospital or post-acute care setting. A bundled payment often is used to reimburse multiple providers, including hospitals, physicians, and other practitioners. Bundled payments may be retrospective or prospective. The former involves reconciling target and actual costs after care is provided on a FFS basis, while the latter refers to payers providing a predetermined payment amount for services as one sum. If costs are less than the target or predetermined payment amount, providers experience savings. Conversely, providers lose money in instances when their costs exceed the payment amount.

Provider risk: Cost of services delivered may exceed the amount of the bundled payment.

Pay-for-Performance

In pay-for-performance models, providers are rewarded for meeting certain goals, which are generally defined by quality of care or patient outcome measures. Pay-for-performance systems are often focused on creating long-term savings through the improvement of primary healthcare, use of preventive health services, care coordination across providers, and/or physician practice improvements. Pay-for-performance measures are designed to reward providers for focusing on quality of care rather than quantity. This payment model typically involves bonus payments, but may also assess penalties on providers who do not meet benchmarks.

Provider risk: May be upside only or two-sided, depending on whether penalties are included.

Payment Penalties

Under a payment model that includes payment penalties, provider payment may be withheld for failure to meet quality or outcomes goals, provider deviation from evidence-based practice standards, or when provider care is connected to sub-standard outcomes (e.g., certain healthcare acquired conditions, or never events). Payment penalties are designed to create motivation to improve quality of care and to enhance provider accountability for patient outcomes.

Provider risk: Providers are assessed penalties for failing to meet goals or other requirements.

Shared Savings

In a shared savings model, the payer sets a cost target, and if providers meet or exceed those targets while caring for patients, they share in the savings of avoided costs. Shared savings plans usually include quality of care and/or health outcome measures. A provider's eligibility to share in savings usually depends on achieving acceptable scores on identified measures. Shared savings plans are intended to create an incentive for providers to deliver high-value care rather than a high volume of services.

Provider risk: Providers receive a portion of savings they achieve, but have no risk if savings are not realized.

Shared Risk

The shared risk model enhances the shared savings model by also putting the provider at risk if costs exceed the defined target threshold. Under shared savings, providers earn more if they reduce costs below the threshold, but have no downside risk. In shared risk models if costs exceed the threshold providers may pay a penalty or share in the costs exceeding the target.

Provider risk: Providers share in both cost savings and costs that exceed targets (penalties).

Global Capitation

Under capitation, a payer gives a provider, provider group, or health system a single per-patient payment with the intention that the provider or health system will provide all necessary services to that patient during the contract period (usually a year). Capitation models create strong financial incentives for providers to manage patient care efficiently and avoid costly complications or expensive services such as emergency department or inpatient admissions. Capitation contracts almost always include quality of care and patient health outcome measures to ensure that providers are not under serving patients to contain costs. By capitating provider payments, however, services provided under an EOC model will need to be carved out to ensure providers are incented to reduce costs. There is also an option for partial capitation arrangements. These could be beneficial for services that are standardized across the RCO such as primary care and behavioral health. RCOs will have to describe how capitation could be implemented with other models.

Provider risk: Providers are not reimbursed for any costs that exceed the capitated payment. Provider can be at full or partial risk.

Integrating the Social Determinants of Health

Integration of primary prevention strategies to address the social determinants of health is a fundamental component for the Oklahoma Model. A wealth of evidence demonstrates social determinants can affect health outcomes as much, if not more than, direct care. Varying levels of available social service supports across the state and the uncoordinated administration of social services programs limits Oklahoma's providers' ability to address these social determinants. The Oklahoma SIM model aims to connect physical health and social service providers within the RCOs so that providers may effectively refer patients to existing resources and begin to identify gaps in critical resources that must be solved in order to positively affect community health outcomes.

One mechanism for this connection is through the governance structure of the RCO. Each RCO is required to form a Community Advisory Board that comprises community partners who understand the region's social services assets and advocate their use to address the population's social needs. The members of the committee are described later within this section.

To assist in the integration of social services into the healthcare delivery system, Oklahoma will pursue flexible spending arrangements with CMS to allow for the use of federal dollars to pay for non-medical expenditures that are in directed line with the patients care plan. These services and arrangements are described later in the "Covered Services" section and include activities such as mold remediation to alleviate asthma exacerbations and refrigeration of medication among many others.

RCOs will also be required to implement and use a Human Needs Survey that will identify members' social and health needs at the point of program enrollment. The survey will help in the risk stratification of patients on both a medical and social determinant basis and identify those patients with potentially higher needs not yet realized in a proactive manner. If possible, further predictive risk identification and stratification will also be conducted using existing EHR and claims data for the individual.

Lastly, the RCOs will create and maintain a regional asset data system of community resources. This will enable the care team to have an easy referral source for services that can be provided in the community to enable patient health and success. Resources such as food pantries, mobile meal programs, health literacy programs, diabetes prevention programs, and ride sharing services are a few of the many community resources that will be entered into this data store, which will be accessed via a web portal by care coordinators, community health workers and other providers include. Some of the potential resources have been described in Section B, the Description of the State Healthcare Environment. Some organizations around the state have started similar projects to inventory the available resources of their communities. The RCOs will look to partner with and further leverage these projects.

RCO Care Delivery Model

The RCO will be held accountable for high care delivery standards. Delivery standards such as network adequacy, patient wait time, accessible clinic hours, and appointment availability will be set by the State Governing Body and its committees. The benchmark for these standards will vary based upon regional needs. Similarly, the quality metrics that the RCO will be required to report and the targets set to earn back withheld dollars or as incentives will cover clinical, quality, and population attainment and will be determined through the deliberations of the State Governing Body and Quality Metrics Committee.

To account for regional variation, each RCO will be asked to describe how it will meet standards given the resources that are available or may need to be created. While a single delivery system model will not be prescribed, each RCO will need to describe and demonstrate how they will accomplish the following:

- Deliver comprehensive acute and primary care.
- Encourage the use of preventive services.
- Integrate behavioral health and primary care.
- Integrate Federally Qualified Health Centers, County Health Departments, tribal health clinics and other existing entities to create a medical neighborhood
- Use non-traditional healthcare workers to address individual and community social determinants of health and unmet needs.
- Use a centralized multi-specialty care coordinator (among providers) to manage transitions between healthcare settings, connect patients to resources, and perform aftercare follow-ups.
- Integrate telemedicine to increase access to behavioral health and specialty providers, especially in those RCOs serving rural, underserved areas.

Transition to RCO from Primary Care Case Management (PCCM) and other Current Programs

There are numerous existing programs within state purchased healthcare. These will be leveraged and enhanced to transition RCOs in an effective manner. The best practices and guidelines will help shape those of the RCO.

OHCA Programs

Oklahoma already operates a Primary Care Case Management (PCCM) 1115 Waiver called SoonerCare Choice for most of the Oklahoma Medicaid population. With the exception of certain populations, most Medicaid beneficiaries are eligible to be enrolled in the PCCM and choose a primary care provider (PCP) who then serves as the patient's medical home. The PCP is paid a monthly care coordination fee on a PMPM basis to help coordinate the patient's care; the fees are based on three tiers and vary depending upon the type of panel the provider wishes to serve, as described in the Section B. The RCO will look to adopt the best practices of this model into the standards of care carried into the new model proposed here. However, with the delivery of care methodology left to the RCO to articulate, the patient-centered medical model may not be continued in every region based on what the RCO proposes as the best fit.

Other current efforts in the State include the Health Access Networks (HAN) and the SoonerExcel program. The HAN programs take on care management services for Medicaid members and are paid a flat PMPM care-coordination fee. These networks work directly with providers to receive patients and help manage care beyond the provider's walls. These are described in more detail in Section B. As with the PCMH program, the RCO will look to incorporate the best practices of the HANs as benchmarks to be met. These programs may also be continued by the RCO in the HAN regions.

Employees Group Insurance Division Programs

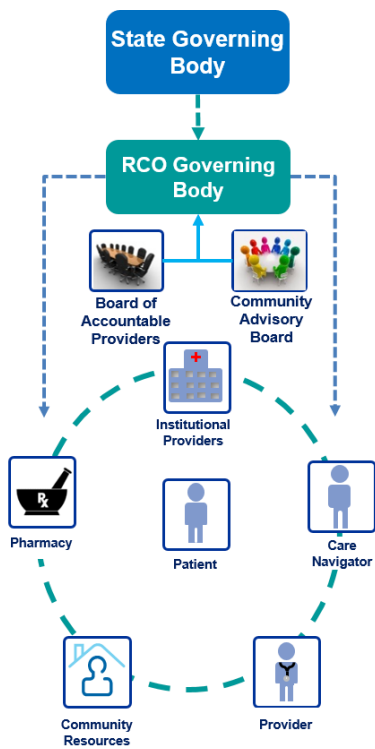
Public employees can choose from a variety of insurance plan options, ranging from a self-insured Preferred Provider Organization (PPO) plan to private Health Maintenance Organization (HMO) plans. The PPO plan, called HealthChoice, is administered by the Employee Group Insurance Division (EGID). EGID has implemented various programs to address cost and quality. EGID has championed programs focused on member education. This includes wellness screenings, education campaigns, and cost sharing programs that help direct members to more cost effective insurance plan options.

Health Information Technology

The RCOs must be able to address their ability to incorporate and direct the use of HIT within their operations and provider networks. The RCOs will be expected to develop a HIT plan for their providers to use HIT meaningfully as they deliver care. This HIT plan should address how the RCOs will ensure their provider networks adopt Electronic Health Record (EHR) technology, connect to interoperable Health Information Exchanges (HIEs), and accurately report actionable data to their provider network. While the State will still encourage providers to meet meaningful use requirements for Medicaid, it expects that the RCOs will also coordinate with its networks to ensure HIT use. The RCO will also be asked to incorporate a consumer-friendly patient portal to engage members in the direction of their healthcare. The State Governing Body will use current information within the Health Information Network (HIN) to actively monitor RCO performance and population health outcomes with a value-based analytics tool described in more detail within the HIT Plan.

Governance

Figure 34: State Governing Body



Currently, two state agencies are responsible for managing state-purchased healthcare. The Oklahoma Healthcare Authority (OHCA) administers and manages healthcare for the Medicaid population through the SoonerCare program, and EGID administers and manages healthcare for most public employees through the PPO HealthChoice plans. In addition to the HealthChoice plans operated by EGID, state employees may also purchase healthcare through an array of private HMO plans. Those carriers that offer HMO plans contract with the Employees Benefits Department (EBD), and EBD collects and pays the premium to the HMOs on behalf of state employees that elect such coverage. The HMOs are then responsible for providing healthcare coverage for those state employees. Both EGID and EBD are divisions within the Office of Management Enterprise Services (OMES), the government agency which manages and supports the basic functioning of state government.

Under the proposed RCO model, a State Governing Body will be responsible for overseeing the care provided by the RCOs for eligible attributed beneficiaries. The State Governing Body will have representation from Oklahoma Health and Human Service agencies, paying institutions, including both private, public and self-insured payers, providers, and consumer advocates. The leadership for this governing body will consist of representatives from the following state agencies: the Oklahoma Health Care Authority, the Employee Group Insurance Division, the Department of Mental Health and Substance Abuse Services, and the Oklahoma Insurance Department. To ensure that the State Governing Body has broad stakeholder representation and consensus from across the health care system, numerous private representatives will also be included based on stakeholder feedback and comment. This includes a representative from the Tribal Nations, a representative from a private healthcare payer association, a representative from a self-insured plan association, and two members each from the Provider Advisory and Member Advisory Committees. The State Governing Body will have a formal charter and governance that will delineate the scope and authority of the body, term limits, and rotation of seats to ensure the body is operational and has adequate representation to act as an authoritative body. Oklahoma will work with the Oklahoma State Legislature, CMS, and relevant agencies to pursue the necessary authority required to enable this model and the State Governing Body, including proposing a new 1115 Demonstration Project Waiver.

The State Governing Body will draft, certify, procure, and administer contracts with eligible entities that wish to serve as RCOs to provide healthcare coverage for the state. The State Governing Body will be responsible for setting the specific RCO requirements in a detailed RFP as a part of the planning and implementation phase. The State Governing Body will be guided by several advisory committees in making these certification and RFP requirements to be a RCO. A few of the advisory committees to guide this body that have proposed to date are the: RCO Certification Committee, Quality Metrics Committee, Episodes of Care Committee, HIT Committee, Health Workforce Committee, and Behavioral Health Promotion Committee. Other requirements will be specified at a later time based on CMS negotiations and further detailed rollout of the model. Below are the proposed functions of the State Governing Body advisory committees:

Figure 35: State Governing Body Advisory Board Committees

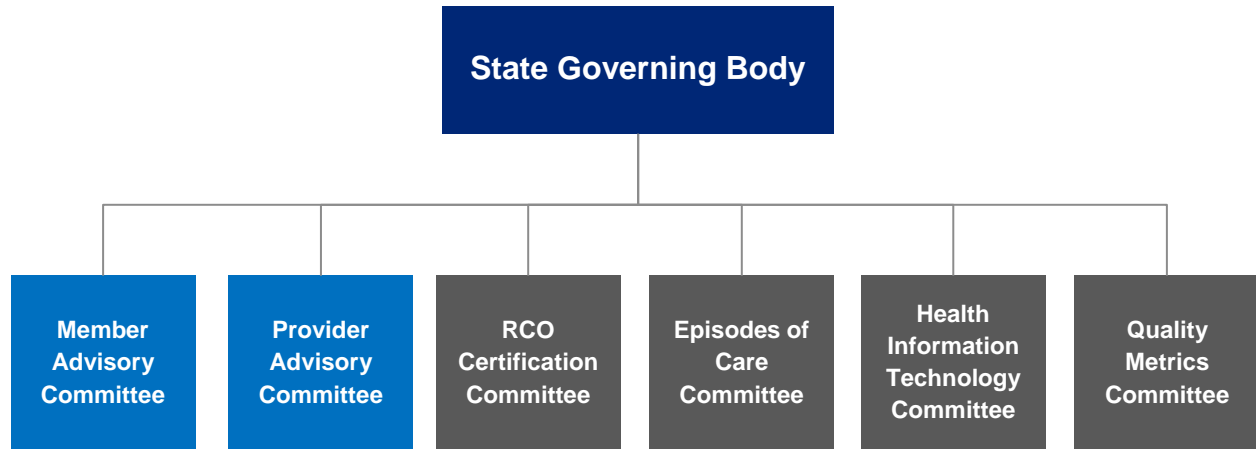


Table 30: State Governing Body Advisory Board Committee Functions

Advisory Committee	Function
RCO Certification	The RCO Certification Committee will create the criteria to certify a RCO, indicating that they have the capacity and plans to meet the goals and requirements to provide services that are in alignment with the goals of this model. The proposed certification criteria for RCOs can be found in Appendix E.
Quality Metrics	The Quality Measures Committee will set RCO quality measure benchmarks and reporting requirements, as well as overseeing RCO monitoring and evaluation.
Episodes of Care	The Episodes of Care Committee will propose episodes of care and episode framework, including needed, identified alterations to existing episodes of care.
Member Advisory Committee	The Member Advisory Committee will consist of the beneficiaries being served by the RCOs in operation around the state and will send one member to be a part of the State Governing Body. This committee will be responsible for ensuring the voice of the member is heard at the highest level of governance
Provider Advisory	The Provider Advisory Committee (PAC) will be an overarching statewide

Committee	committee that will consist of those providing care within the RCO model. The PAC will send one member to be a part of the State Governing Body. This committee will be responsible for ensuring the voice of the provider is heard at the highest level of governance.
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From a RCO performance perspective, the State Governing Body will be responsible for ensuring each RCO reports its quality measures. Through the development and use of the value-based analytics (VBA) platform and other HIT, the State Governing Body can closely monitor RCO activities and performance. The State Governing Body will work with the RCOs to ensure the availability of adequate resources for implementation and monitoring, including education, marketing, outreach, and enrollment.

The Board and its advisory committees will also assure its members of equitable access to services by establishing network adequacy and access requirements. They will also establish standards that the RCO will need to meet to ensure timely access to care and services and member protections are in place.

CCO Governance and Scope

While the State will provide a high degree of oversight of the RCOs, a key characteristic of the Oklahoma Model is to allow flexibility and discretion in the way the RCO organizes to deliver patient-centered care that meet and exceed outcome targets. Other states that have implemented similar types of models have fostered this by allowing RCOs to develop governance and payment models that match local health needs and account for provider maturity to move towards risk-based care. Given Oklahoma’s disparate healthcare system and rural and urban divide, the State is pursuing a similar path to ensure that RCOs can thrive regardless of regional differences.

Each RCO must establish a governance structure that reflects the coordination of care delivery and community resources into one integrated model. To accomplish this, RCOs must include specific stakeholders within the RCO governance and establish two distinct advisory boards. First, the RCO Governing Body must comprise individuals that share in the financial risk of the organization. The RCO Governing Body must also consist of the relevant stakeholders impacted by the RCO’s operations. The suggestions for the makeup of each of these boards are described below:

- The RCO Governing body will be responsible for meeting all cost and quality targets of the RCO. It will direct the RCO on payment and delivery of care to attributed members. This board will consist of:
 - Persons that share in the financial risk of the organization, and who must constitute a majority of the governing body
 - The major components of the healthcare delivery system
 - At least three healthcare providers in active practice, including an Oklahoma licensed physician, a nurse, and a mental health or substance abuse treatment provider
 - At least two members from the community at large, to ensure the organization’s decision-making is consistent with the values of the members and the community
 - At least one member of the Community Advisory Board
- The Board of Accountable Providers (BAP) will be a local provider board established to assure that best clinical practices and innovative approaches to delivering care are being used and are culturally appropriate. They will suggest interventions to address issues with cost and quality

attainment. This board will include representation from provider types (or their representative organizations) active in the RCO's healthcare delivery system.

- The Community Advisory Board (CAB) will have broad regional representation from community partners, such as 501(c)(3) entities, county health departments, social service agencies and organizations, local municipalities and businesses, patient advocates, and community action agencies. This board will help guide the RCO to conduct a community health needs assessment and complete a community health improvement plan (CHIP). These will be used to help guide the RCO to provide regionally-specific care and guide interventions that help address the social determinants of health. The Community Board will be integral in linking the RCO to community resources that support whole-person care and will be required to maintain databases of community resources. The board should include representation from:
 - Consumers, patient, and advocates, forming a majority of the membership
 - Non-profit community organizations
 - County health departments from the counties served by the RCO
 - Tribal nations in the RCO service area
 - FQHCs operating within the service area

One person from the BAP will sit on the CAB and one person from the CAB will sit on the PAB to ensure that there is collaboration between the two boards. The boards will give joint recommendations on how to invest in new models and initiatives that support value-based purchasing. These boards will jointly help to guide the RCO to conduct a community health needs assessment and a community health improvement plan (CHIP).

These boards will be integral to linking the RCO to community resources that support whole-person care. They will also promote effective interventions to improve healthcare delivery, recommend strategies to better integrate community supports and services into healthcare, suggest methods to elicit consumer feedback, and provide culturally aware information that supports the RCO to improve health outcomes in its respective region. Each RCO will be responsible to the State Governing Body to demonstrate how decisions related to its operations have taken input from the board into account. Governance approaches and membership will ultimately be approved by the RCO state governing body.

Populations Covered

Oklahoma is proposing to attribute its Medicaid beneficiaries and state employees to the RCO model, with the exception of those exempt from managed care and those receiving limited benefit packages. The total **number of eligible members to be included in this model is approximately 1,031,618 lives, or a quarter of Oklahoma's population.** Oklahoma can leverage the State's purchasing power and influence over the way healthcare is delivered to all Oklahomans by requiring mandatory enrollment of individuals with state-purchased healthcare into the RCO. By targeting as many individuals who receive healthcare insurance through some type of state-purchased healthcare into the RCO model, Oklahoma can move closer to its value-based benchmark for state-purchased insurance of 80 percent by 2020. A further description of the populations covered within both Medicaid and state employee insurance are described below.

Medicaid Covered Lives

Medicaid covers more than 800,000 individuals through various programs and waivers. Under this proposal, the RCOs will cover the majority of those Medicaid beneficiaries, including children, pregnant women, and individuals who qualify under the Aged, Blind, and Disabled (ABD) category, including persons dually eligible for both Medicaid and Medicare. There will be, though, be some populations excluded from the RCO, such as those receiving family planning services only, the Specified Low-Income Medicare Beneficiaries (SLMBs), Qualifying Individuals and Quality Working and Disabled Individuals and those who receive the Qualified Medicare Beneficiaries (QMBS) benefit only.

Under the proposed RCO model, Medicaid beneficiaries, except those that are exempt from mandatory managed care enrollment, must enroll with a RCO and choose to receive benefits through the RCO. By including nearly all Medicaid beneficiaries, the State can achieve a higher degree of budget predictability and accountability while driving the volume necessary to make RCOs financially viable.

To provide a rough estimate to CMS of the number of Medicaid beneficiaries Oklahoma proposes to cover, the Oklahoma SIM project has identified the various populations currently served under the Medicaid State Plan and various waivers it will attribute to the RCO model.

Table 31: RCO Covered Populations

RCO Covered Populations: Medicaid	Population
1115 Waiver (SoonerCare Choice and Insure Oklahoma)	544,628
SoonerCare Choice	540,708
Insure Oklahoma-Individual Plan	3,920
SoonerCare Traditional	238,083
Total	782,711
1915(c) Home and Community Based Waivers	23,046
Total Medicaid	805,757

Excluded populations:

Oklahoma is proposing to exclude the following Medicaid coverage groups from the RCO:

- Foster care children
- Children in Department of Human Services custody
- Qualified Medicare beneficiaries without full Medicaid
- Specified Low-Income Medicare beneficiaries without full Medicaid
- Qualifying Individuals between 120 percent and 138 percent FPL
- Qualified Disabled Working Individuals
- Insure Oklahoma Employee Sponsored Insurance program enrollees

Public Employee Covered Lives

EGID, the agency responsible for administering and operating HealthChoice, and the HMO plans covering state employees currently have an enrollment of over 225,000 individuals. This number includes active employees, as well as Medicare and pre-Medicare populations, and their dependents. Under this proposal, RCOs will be responsible to provide healthcare services to all individuals enrolled with EGID and HMO plans. The coverage of these individuals will be phased in over time after enrollment of Medicaid populations. HealthChoice, the plan operated by EGID, will be replaced by plans offered by the RCOs. Initially, state employees will be given the option to enroll with a HMO plan currently offered or enroll with a RCO. Once the State Governing Body has developed an adequate number of RCOs to cover state employees, all HMO plans that wish to cover state employees will be required to become a RCO to continue to provide their healthcare coverage to state employees. These plans will be required to meet the same quality measure and community integration requirements of the RCOs that cover Medicaid populations. By including the majority of Medicaid beneficiaries and public employees, over a quarter of the state’s population will be covered under a RCO. The table below illustrates the anticipated number of covered lives of public employees who will eventually be covered by a RCO.

Table 32: Public Employees Covered

RCO Covered Populations: State Employees	Members	Dependents	Total
HealthChoice (Self-Insured)			
Active Employees	87,041	53,006	140,047
Pre-Medicare	7,299	1,702	9,001
Medicare	31,048	4,367	35,415
Total	125,388	59,075	184,463
HMOs			
Active Employees	20,388	16,468	36,856
Pre-Medicare	1,266	221	1,487
Medicare	2,646	409	3,055
Total	24,300	17,098	41,398
All Plans	149,688	76,173	225,861

Integrating the Private Market

As the RCO matures it is envisioned that other private markets could be incorporated as desired by commercial insurers. To date many of the commercial payers and self-insured businesses in Oklahoma have been involved in the discussions about this model. If the RCOs can demonstrate cost and quality improvements as expected, self-funded employers and commercial payers have indicated they will be interested in purchasing healthcare in a similar manner. However, it has been made clear that there are different needs with the populations within the commercial market and this will require different model considerations. For example some services, such as transportation, that are required through Medicaid are not as necessary for the commercial population. These kinds of considerations will have to be taken into account, but with the voice of the commercial payer on the state governing body will help to guide the conversation of how to leverage markets and needs across populations.

Native Americans, Tribal Systems, and SIM

Oklahoma is home to 38 federally recognized tribes and more Native Americans than any other state. These tribes are sovereign nations that have a unique relationship with the United States and the State of Oklahoma. This government-to-government relationship recognizes the right of tribes to self-government and self-determination. The United States also a federal trust obligation to supply Native Americans with access to quality care. As such, the Oklahoma State Innovation Model Design proposal must always take into account the federal trust responsibility and the sovereign status of our tribal partners.

How Will Tribal Health Systems Operate Within an RCO?

Regional Care Organizations will be required to engage Native Americans and their tribes' health systems in several ways, including ensuring tribal representation within their governance structure and contracting for services with tribal facilities in the RCO service area. Tribal representation within the RCO's local governance structure will be a key factor to the RCO's success, as tribal representatives possess irreplaceable knowledge of appropriate care delivery methods for the populations they serve.

As part of their provider contracting process, RCOs will be required to contract [utilizing the Indian Addendum (see Appendix)] with tribal health systems operating within their service area that wish to participate in the RCO delivery system. Tribal health facilities will not be required to contract with a RCO to receive payment, however. 25 U.S.C. §1621(e) provides that these systems retain the right to be paid, whether or not a contract exists with the RCO. This will ensure tribal Medicaid members are allowed to continue seeking services through their preferred tribal health facility.

If the tribal health systems choose to contract with the RCO, the tribal facilities will have the option to participate in an interoperable health information exchange, which will provide valuable resources to tribal health facilities and RCOs in managing Native American members' health across the many settings they interact with over time. This enhanced data interoperability will also allow better quality metric measurement of all RCOs and their members to demonstrate both cost and quality performance. The current metrics proposed to measure RCO performance are in line with what tribes already have to report through the Government Performance and Results Act (GPRA). By aligning data sets and technology with existing platforms, the RCO can reduce burden and create a seamless system that is beneficial for members and tribal systems.

Under the current reimbursement system, tribes are reimbursed the OMB rate for services rendered to tribal Medicaid members. This reimbursement level is important to tribal health systems, and it will continue in an RCO. RCOs will be contractually required to reimburse tribal health systems the OMB rate for services rendered to a tribal Medicaid member, which will still be matched at 100% Federal Medical Assistance Percentage (FMAP).

How Will This Affect Tribal Members?

Tribal members who are also Medicaid members will not automatically be enrolled in the RCO, but will have the option to receive their services through the RCO operating in the region in which the member resides or through the traditional Medicaid program. If they choose to receive their services through an RCO, they will be able to receive services from any provider contracted with the RCO, including their tribal health systems. They will also receive other enhanced benefits, such as care coordination services, integrated behavioral health services, and specialty services that may not be available at a tribal health facility. Tribal members in an RCO will still receive the cost sharing protections they are entitled to under federal law.

Can Tribal Health Systems Become RCOs?

Many of the concepts proposed within the Oklahoma State Innovation Model Design are things tribal health systems have been doing for their members for years, such as the integration of the healthcare delivery system with community resources like housing services and nutrition supplementation. Nevertheless, tribal health systems operate within numerous financial and regulatory boundaries, including those delineated in the Indian Health Care Improvement Act. These boundaries, which vary from tribal system to tribal system, often limit the populations tribal health system may serve and the financial risk they are able to assume. Because RCOs will be required to provide services to all Medicaid members and assume actuarial and performance risk, we came to a mutual determination that the boundaries in which tribal health systems operate would inhibit them from effectively operating an RCO.

Our tribal partners did determine, however, that the creation and the operation of an RCO through a tribe's business operations arm, which would not be subject to the same barriers as tribal health systems, would be of interest to some tribes, as they expand their health offerings to the general population.

Covered Services

The array of services covered by the RCO will include traditional physical, mental health, and chemical dependency services, as seen in the table below, for both Medicaid and public-employee beneficiaries as mandated by applicable regulation. This includes essential health benefits, such as services currently required under Oklahoma statute and, for Medicaid, services indicated under Oklahoma’s Medicaid State Plan and any waivers remaining in effect. There may be differing benefit plans for Medicaid and public employees. In addition to meeting federal regulations set out for Medicaid and federal guidelines for group insurance regarding covered services, the RCOs will also have to meet minimum essential coverage mandates and the applicable state-specific guidelines set out by the Oklahoma Insurance Department for healthcare coverage offered by HMOs. The applicable guidelines will vary depending on the beneficiaries they serve. All covered services offered by the RCO will be established through the procurement process. Oklahoma plans to include as many services within the capitated rate as possible achieve the largest return on investment and population health improvement.

Below are the high-level services Oklahoma intends on eventually including within the RCO. Limitations currently in place for EGID and Medicaid members, including cost sharing, caps on total services, etc., will remain.

Table 33: Covered Services

Services	Medicaid	Public Employees
Inpatient hospital	X	X
Primary Care and Outpatient services	X	X
Pharmacy	X	X
Institutional Long Term Care (both nursing facility and ICF/IID)	X	N/A
Personal Care	X	N/A
HCBS Home and Community Based Services	X	N/A
Inpatient Behavioral Health Services	X	X
Outpatient Behavioral Health Services	X	X
Dental	X	Separate
Non-Emergency Medical Transportation	X	N/A
Durable Medical Equipment (DME)	X	X

Flexible Services

In addition to traditional healthcare covered services, Oklahoma is also looking to provide RCOs with innovative ways to provide care that address social determinants of health. The RCOs will also be required to include alternative non-State Plan services (i.e., flexible services) for Medicaid beneficiaries. The State will also consider how flexible services could be provided for state employees at a 100 percent cost to the State. Since RCOs are to include community resources and stakeholders within their governance, it is anticipated that RCOs may enter into financial agreements or memorandums of

understanding with community organizations for use of flexible services that improve the beneficiaries' health. Services must be both medically necessary and consistent with the member's treatment plan among other requirements. However, the State is exploring investing in resources that impact health outcomes by reallocating dollars normally used for direct healthcare services to flexible services because they may have a more effective impact in improving health and reducing costs. Particular to improving population health, Oklahoma anticipates that its Health and Human Services agencies, local and state-wide non-profits, and other community-led initiatives can optimize value-based care and provide the greatest degree of return on investment by coordinating with the RCOs or entering into contractual relationships to provide flexible services.

Contracting

The State Governing Body will form a detailed request for procurement to solicit vendors for the regions, pursuant with Oklahoma law. The RFP requirements to become certified as a RCO will include requirements discussed here, as well as those that are established through further model development with stakeholders and negotiations with CMS. Once the vendors have been selected, this State Governing Body will be tasked with enforcing and managing those contracts to ensure all cost and quality targets are being met.

Encouraging Participation in the RCOs

To ensure that there is adequate participation from RCOs and to meet federal and state legal and regulatory requirements, the State will employ necessary actuarial tools and analysis to determine actuarially sound capitation amounts for attributed beneficiaries. Additionally, the State will establish accountability mechanisms, learning collaborations, and stakeholder feedback to help RCOs remain sustainable and viable. This design will support the RCOs' maturation progression so that they can achieve success in supporting health outcomes while also experiencing financial incentives to keep their interest in serving these populations. Initial responses from the HB 1566 Request for Information process for a "care coordination model for the ABD population", in which 22 submissions were received, are encouraging. The State will leverage the current interest in coordinated care for this population as it moves toward enrolling the majority of Medicaid beneficiaries and state employees in the RCOs.

QUALITY MEASURES

One of the focuses of Oklahoma SIM project is to implement quality and population-based health measures that reward value over volume and to align them across payment models and payers. The Oklahoma SIM project has incorporated OHIP's flagship goals of obesity, tobacco use, diabetes, hypertension, and behavioral health within the SHSIP and model design to ensure consistent goals are used across health transformation efforts. The Oklahoma SIM flagship issues will be used as the basis for many quality measures used to align payers and assess the RCOs. Another key goal of the Oklahoma SIM project is to develop extensive monitoring tools and quality metrics to assess the effectiveness of Oklahoma's healthcare delivery system.

Oklahoma understands the need to drive improvement through an active commitment to data collection and analyses. Through the HIT Plan, many of the data collection and analysis of RCOs will be further described. The project team considered multiple quality measures and data sources that could be used to evaluate the effectiveness of any model proposed through the Oklahoma SIM project. The proposed measure sets were developed using many data points such as OHIP 2020, extensive research related to

quality measures used in value-based models, stakeholder feedback, alignment with other state and national initiatives, the measures link to clinical outcomes, and national quality accreditation.

RCO Required Evaluation Metrics

The Oklahoma SIM project team has determined that two sets of quality measures are needed to support the State's healthcare transformation efforts. The first set of quality measures will be used to evaluate the performance of the RCOs. To achieve this, RCOs will be required to report on a number of different quality measures as mandated in their contract and to meet quality targets to be paid all or a portion of their withheld capitation payment.

RCO Required Evaluation Metrics

- Metrics used by the state to evaluate the regional RCO entities
- Population-level and process metrics to measure overall population health and quality of care delivered
- Metrics to ensure patient access and patient satisfaction of care

RCO Optional Bonus Evaluation Metrics

- Metrics used by the state to evaluate if the RCO is eligible to receive incentive money from the community quality pool
- Mix of population-level and patient-level metrics

The following sections detail each metrics set.

As shown in the following table, RCOs will also be accountable for reporting on a set of metrics that are meant to gauge health outcomes against specific targets and benchmarks. Specific timeframes and reporting requirements have not been proposed for the SHSIP. However, prior the implementation of the RCO model, the State Governing Board will include metrics and targets in the RCO contract, including how the RCO will be required to fulfill these obligations, as well as the reporting, evaluation and payment timeframes.

These measures are related to the Oklahoma SIM flagship issues or were developed to ensure quality access to care and monitor population health. They are aligned to the OHIP 2020 goals. With the goal of addressing disparities and poor outcomes within populations, these measures will be used to assess how well the RCOs coordinate and manage the care of the individuals attributed to it. Although the Oklahoma SIM project team hopes to include all the quality measures in the table below for both state employees and Medicaid, adjustments to the measures or benchmarks across beneficiary type and region may be made during the planning phase to account for normal variations found within all of state-purchased healthcare. Targets may also vary across the two populations.

Multi-Payer Quality Measure Alignment

Multi-payer involvement is an integral component of the Oklahoma SIM. Alignment across a subset of quality metrics is a foundational first step toward healthcare transformation, as it streamlines provider efforts and allows for better aggregate data collection and analysis. Fostering multi-payer alignment on quality metrics will be an ongoing process of committee discussions. The Oklahoma SIM project has taken the first step of composing an inventory of metrics and reached an agreement, in principle, to align these measures across the carriers participating in the Oklahoma Model. These metrics are a distinct

subset of all the metrics that will be incorporated into the RCO organizations. They will include measures across a wider range of chronic and high costs conditions, as well as system and population level evaluations. The first 11 proposed measures for multi-payer alignment are in the table below and are identified with an asterisk (*).

Table 34: Proposed RCO Required Evaluation Metrics

Measure Name	NQF Measure Number	Oklahoma SIM Flagship Issue/Key Health Indicator
Preventive Care and Screening: Tobacco Use: Screening & Cessation Intervention*	0028	Tobacco
Comprehensive Diabetes Management/Diabetes Poor Control*	0059	Diabetes
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications*	1932	Diabetes
Abnormal Blood Glucose and Type 2 Diabetes: Screening - Adults Aged 40 to 70 Years who are Overweight or Obese*	USPTF	Diabetes
Controlling High Blood Pressure*	0018	Hypertension
Preventive Care and Screening: Body Mass Index (BMI) Screening & Follow-Up*	0421	Obesity
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*	0024	Obesity
Anti-Depressant Medication Management a) Optimal Practitioner Contacts For Medication Management b) Effective Acute Phase Treatment c) Effective Continuation Phase Treatment*	0105	Behavioral Health/Medication Adherence
Depression Screening*	0418	Behavioral Health
Initiation And Engagement of Alcohol And Other Drug Dependence Treatment a) Initiation b) Engagement*	0004	Behavioral Health
Follow Up After Hospitalization (within 30 days) (BH-related primary diagnosis)*	0576	Behavioral Health/Readmissions
Ambulatory Care: Emergency Department Utilization	HEDIS	Emergency Room Utilization
PQI 05: Chronic Obstructive Pulmonary Disease Admission	0275	Tobacco Use
PQI 08: Congestive Heart Failure Admission Rate	0277	Heart Failure
PQI 01: Diabetes, Short Term Complication Admission Rate	0272	Diabetes
PQI 15: Adult Asthma Admission Rate	0283	Tobacco Use
CAHPS Composite: Satisfaction With Care	CAHPS	Patient Satisfaction
Developmental Screening In The First 36 Months Of Life	1448	Children's Health

Prenatal And Postpartum Care: Timeliness Of Prenatal Care	1517	Children's Health
% Of primary care practices co-located with a behavioral health provider	X	Behavioral Health
% Of primary care practices in network with expanded hours (after 5 weekends)	X	Access to Care
% Of primary care practices in network with 24 hour availability	X	Access to Care
% Of population who have an assigned risk score/stratification	X	X
% Of population assigned to a care coordinator with an elevated risk score	X	Care Coordination
% Of network with HIE access	X	HIT Interoperability
Electronic resource guide available to care coordinator/staff	X	Care Coordination
% Of population who screened yes to being a current tobacco user under 18 years of age	X	Tobacco
% Of population who screened yes to being a current tobacco user 18 years of age and older	X	Tobacco
% Of population with a current BMI over 25 who are under 18 years of age	X	Obesity
% Of population with current BMI over 25 who are 18 years of age and older	X	Obesity
% Of population diagnosed with diabetes (type I and II) under 18 years of age	X	Diabetes
% Of population diagnosed with diabetes (type I and II) 18 years of age and older	X	Obesity
% Of population diagnosed with hypertension under 18 years of age	X	Hypertension
% Of population diagnosed with hypertension 18 years of age and older	X	Hypertension
% Of population with a positive screening for depression under 18 years of age	X	Behavioral Health
% Of population with a positive screening for depression 18 years of age and older	X	Behavioral Health
Infant Mortality Rate	X	Children's Health
Deaths Due to Heart Disease	X	Hypertension
Suicide Deaths	X	Behavioral Health

Diabetes Deaths	X	Diabetes
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RCO-Optional Bonus Payment Metrics

The Community Quality Incentive pool will be used as an incentive payment based on the RCO meeting additional quality metrics. The RCO must choose at least seven additional quality metrics to report on and meet minimum thresholds to be eligible for the Community Quality Incentive pool payment. The proposed measures that may be chosen as bonus reporting measures are in the table below.

Table 35: RCO Optional Bonus Payment Metrics

Measure Name	NQF Measure Number	Oklahoma SIM Flagship Issue/Key Health Indicator
Cervical Cancer Screening	0032	Cancer
Colorectal Cancer Screening	0034	Cancer
Influenza Immunization (6months and older)	0041	Immunization
Influenza Immunization (50 and older)	0039	Immunization
Breast Cancer	0031	Cancer
Childhood Immunization Status	0038	Children’s Health
Well-Child Visits: Well-Child Visits in Third, Fourth, Fifth, and Sixth Years of Life	1516	Children’s Health
Plan All-Cause Readmission	1768	Readmission
Dental Sealants On Permanent Molars For Children	X	Children’s Health
Effective Contraceptive Use Among Women At Risk Of Unintended Pregnancy	X	Pregnancy
Chronic Stable Coronary Artery Disease: Lipid Control	0074	Heart Failure
Adherence to Statins	0569	Heart Failure
Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category (Renin Angiotensin System Antagonists, Diabetes Medication, Statins)	0541	Heart Failure, Diabetes
Screening, Brief Intervention, and Referral to Treatment (SBIRT)	SBIRT	Behavioral Health
Cholesterol abnormalities screening: men – 35+, women 45+	USPTF	Heart Failure

Oklahoma Quality Metrics Committee

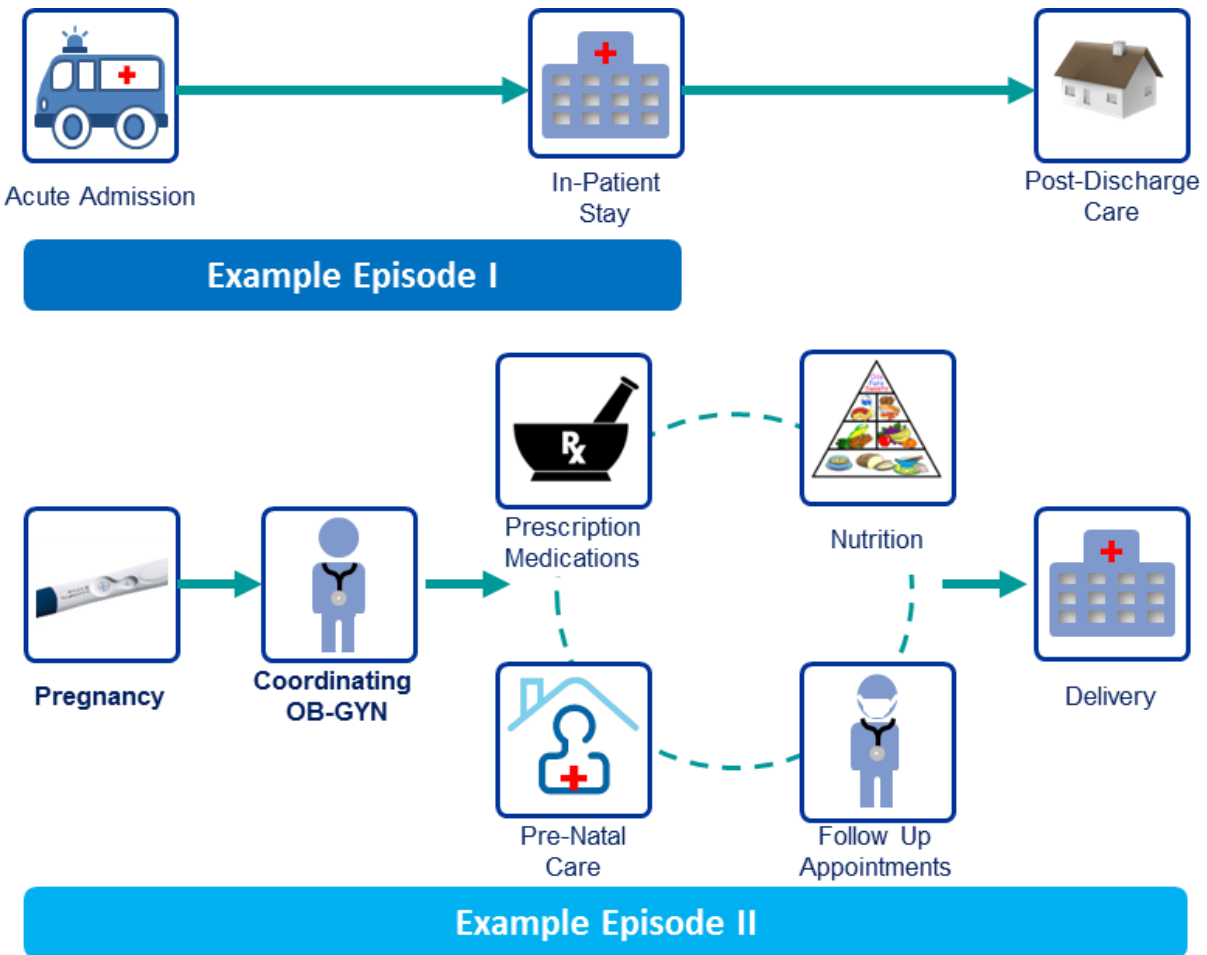
The sets of quality measures discussed here will be the early work and guidance to a new committee that is being proposed, the Oklahoma Quality Measure Committee. This committee will be part of the State Governing Body and responsible for proposing quality metrics that the RCOs and participating payers will require to be reported and how to benchmark and set targets for individual RCOs taking into account regional considerations. This committee will also ensure that data sources and data measurement are standardized across payers and providers by recommending to the State Governing Body valid sources and methods for aligning those measures. Members of this committee would be:

- Six providers from different practice settings and populations:
 - E.g., Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), Pharmacist (PharmD), Nurse, Physician Assistant (PA), Behavioral Health Specialist
- Two quality measure specialists, consultants, or experts
- One HIT/data reporting specialist
- One public health specialist
- One patient advocate
- One practice transformation consultant

EPISODES OF CARE

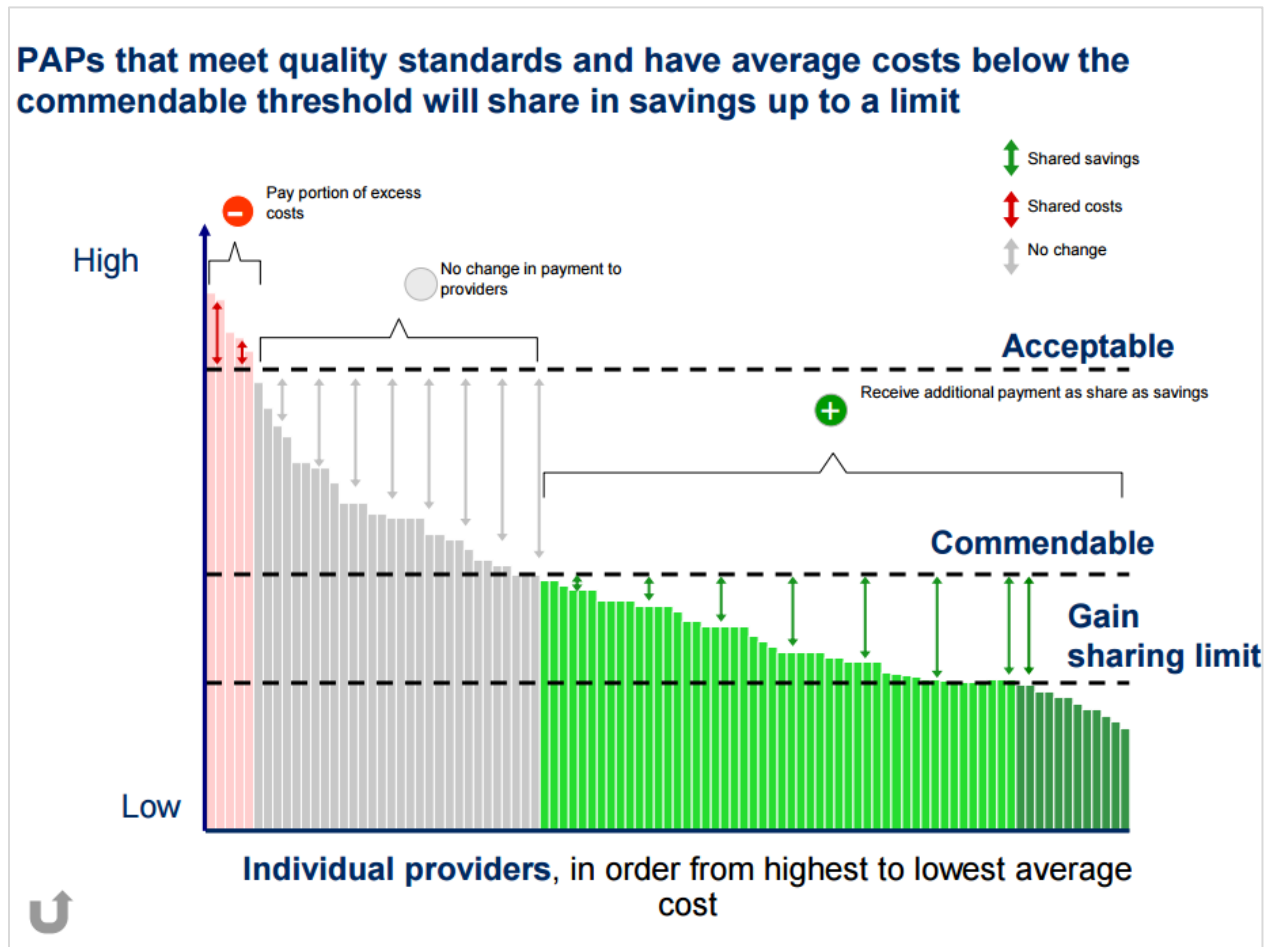
Episodes of Care (EOC) is a payment model in which related services that are provided to treat a specific condition over a specific period of time and are grouped into “episodes”. The episodes can include acute, chronic, and behavioral health conditions and vary in length depending on the condition. The purpose of EOC as an alternative payment arrangement is to encourage provider collaboration, patient coordination, and service efficiency across various care delivery settings. By establishing clear accountability for both outcomes and the total cost of care for an episode, this model rewards high performing providers and reduces variance in cost and quality.

Figure 36: Episode of Care Example



The model requires that a Principle Accountable Provider (PAP) be designated as the provider responsible for quality outcomes and the total cost of care for a given episode over a given time. Factors for determining an episode of care include agreeing to an episode’s time frame and triggering event, the services included within the episode, and situations or conditions that exclude some patients from being included in the episode. Patients who match the episode’s criteria will be attributed to the episode, and PAPs will be evaluated on their performance for *all* patients attributed that episode. “Acceptable” and “commendable” cost benchmarks will be established for the episode, and quality measures are also used to ensure against the rationing of care. The PAP and all associated providers will be paid on a fee-for services basis and then evaluated retrospectively against those acceptable and commendable benchmarks. PAPs with costs below the commendable level for an episode can share in savings. Conversely, PAPs with costs above the acceptable level receive penalties. To be eligible for any savings, the PAP must also meet the quality measures set out for the episode.

Figure 37: Episode of Care Payment Design



The Oklahoma SIM project team proposes to introduce multi-payer EOC within both Medicaid and state-employee healthcare coverage offered through HealthChoice. Because EOC have modular features that could work in other private insurance, the Oklahoma SIM project team will work with its Oklahoma SIM participating carriers to have them incorporate EOC within their payment methodologies. EOCs are being proposed as a way to allow providers to become more familiar APAs and as a starting place for them to begin their journey along the continuum of value based payments. The more payers that participate with EOC will help to realize larger returns from the synergy created by aligning payment methodologies around distinct processes and situations.

Episode Development and Methodology

Implementing Episodes of Care in Oklahoma will require strategic planning to align currently disparate systems. Internal system changes and administrative functions will need to be addressed by both OHCA and EGID to operationalize EOC within state purchased healthcare. The State, though, recognizes the need to develop reporting tools, such as provider and RCO dashboards with timely episodic performance indicators, and a thorough evaluation process to assure providers they can self-monitor and redirect efforts midstream if they are failing to meet quality measures or cost benchmarks. By developing these types of tools, the State can engender trust and transparency with stakeholders who will be a part of this model. Private payers who wish to participate in EOC will also require internal operational reviews to

ensure EOCs can be implemented effectively and provider performance reporting can be done a timely and accurate manner.

EOC will also have to include numerous provisions to help expedite its implementation and effectiveness. Importantly, EOC requires a number of potential payment mechanisms to ensure participating providers are evaluated fairly and accurately. Numerous payment adjustments, including patient, provider, and regional adjustments and stop-loss provisions, will have to be included for the model to be equitable and sustainable. As well, by using the existing fee-for-service payment system instead of grouping services together into one bundled payment, PAPs will not have to enter into new fiduciary relationships with other providers to disseminate the payment components of the bundled payment. The retrospective methodology for evaluation will also limit the number of system enhancements the state will have to develop to reimburse providers, thereby potentially limiting cash flow disruption for providers.

Episodes of Care Task Force

Since the goal of EOC is to address fragmented care and cost and quality variance, provider feedback and expertise will be needed to develop the episodes in a feasible way. Mirroring the work of other states that have implemented EOC, Oklahoma will create an EOC Task Force (Task Force) for each of the episodes proposed in the SHSIP to ensure ongoing stakeholder participation for the episode's design. The Task Force will work collaboratively to institute best practices and guidelines for developing and implementing the EOC. Furthermore, based on previous feedback and research from other states that have used EOC, the State understands that episodes are not static and need ongoing evaluation. Technology and best practices can change over time, affecting the model's ability to reduce costs or improve care. Episodes must be recalibrated and reviewed annually to ensure they still effectively reduce costs and improve quality of care. The Task Force will be a vital resource for the state to use to make EOC sustainable in Oklahoma. Proposed members of the overarching taskforce are:

- A representative from each participating payer
- Provider representatives relevant to each episode of care (PAP)
- A data reporting specialist
- A patient advocate
- The Oklahoma Insurance Department

For each individual episode, the Task Force will, like the Oklahoma SIM workgroups, assign chairpersons and project managers that will be responsible for building consensus and developing the parameters for the episode. Once the episode's criteria are set, the Task Force will continue to meet to address implementation issues, recalibrate cost benchmarks or quality measures, and provide consultation to practitioners participating in the model. Working with both OHCA and EGID, the Task Force can also help evaluate the efficacy of each episode. From the outset, the Task Force will address such episodic issues as:

Designating the PAP

Each episode requires an engaged and informed provider who can best influence the quality and cost of the overall outcome of the episode. The type of PAP will likely vary based on the episode or based on guidance provided by the Task Force. While the PAP may not have to direct financial or managerial control over other providers that participate in the episode, the PAP will, however, be responsible for communicating and coordinating with other providers to improve the overall outcome of the episode.

Episode designated PAPs should be similar across payers but may vary some between state-purchased and private insurance based on the payer's network and accreditation process.

Setting the Episode's Time Frame and Triggering Event

Each episode has a triggering event that attributes the patient to the model and begins the episode. Following a triggering event, a time period is set in which the PAP is accountable for the related costs and quality of the care provided to that patient. While the triggering event and time period vary based on the episode type, the Task Force can use EOC models developed by other states to help guide the optimal triggering event and time period for the episode.

Grouping Services by Episode

Since each episode is a series of related services grouped together to treat one condition, the services included or excluded from the episode must be set out in advance to help providers coordinate optimal and efficient patient care. Using data provided by the OHCA and EGID, the Task Force must determine the services that should ideally be included within an episode following a triggering event. Other states have already developed this type of intricate detail necessary for Oklahoma SIM's proposed episodes. However, further analysis and collaboration is necessary to ensure the services included in the episode meet the need of Oklahoma's Medicaid and state employee population. The Task Force will be responsible for fine-tuning the various episodic algorithms to assure they are representative of Oklahoma.

Episodic Risk and Gain Sharing

The cost thresholds for each episode must be established to incent providers to delivery efficient care to patients and avoid unnecessary costs due to a lack of care coordination. While OHCA and EGID will set out benchmarks for commendable and acceptable cost levels for provider risk and gain sharing, both agencies must ensure those benchmarks are developed transparently to help the provider understand their role in reducing unnecessary costs. By providing an avenue for providers to give input into the development of risk and gain sharing levels through the Task Force, the State can potentially avoid burdening providers with unfeasible benchmarks while still reducing overall cost.

Gain and risk sharing will likely be different for private carriers than for state-purchased healthcare because of differences in reimbursement rates, networks, cost sharing, or other proprietary information related to cost. Each payer will need to establish benchmarks for acceptable and commendable levels based on its historic cost data for the episode. The percentage of gain sharing may also be different between each and payer and the PAP. The Task Force may act in advisory role for carrier-specific payment issues.

Quality Measures

Although reducing costs is a goal of EOC, the State must assure patients that they will still have equitable and timely access to the necessary services related to their condition. Through the introduction of quality metrics that measure patient access, screenings, and follow-up care for the episode, the Task Force can create quality measures that help reduce state healthcare expenditures while still providing high quality care for state employees and Medicaid beneficiaries.

Provider Information

Ideally, EOC requires providers to be highly engaged in the care of their patients as they move across care settings and providers. This level of coordination requires a large commitment from the State to disseminate timely information to the PAPs and other participating providers to help them better evaluate their performance and monitor patient activity. This commitment will include using the Task Force to

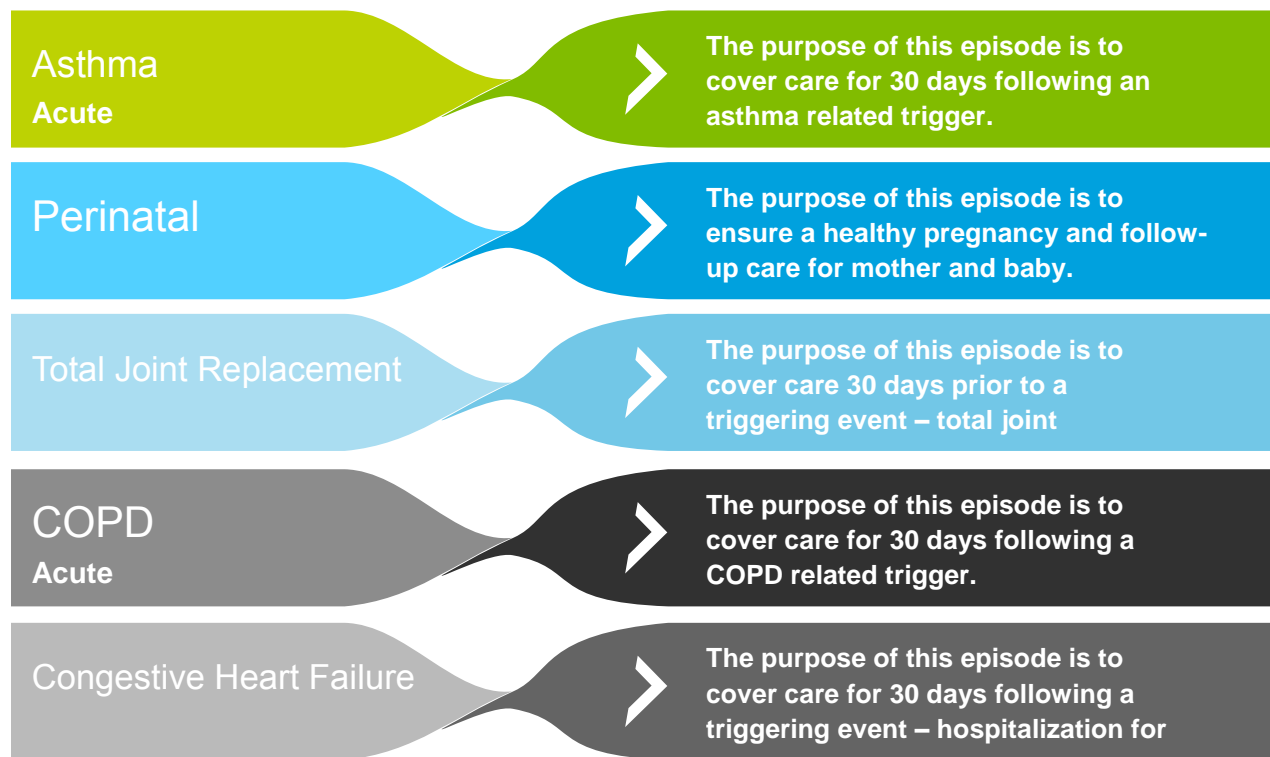
develop provider performance reports, alerts or notifications about recent patient activities, and best or evidence-based practices for treating the episode. Since the Task Force will include frontline providers and administrators who are intimately involved with the design and evaluation of the episode, this group can provide ongoing technical assistance and support to providers that may initially struggle to adapt to this payment model. Where possible, the State will work with private carriers participating in the model to determine the most efficient way to utilize interoperable HIT so providers can access performance reports for all payers in one centralized location.

By using the Task Force, the Oklahoma SIM project team will use technical assistance from CMS and other states to help with the design of each episode.

Proposed Episodes

Using previous research by other states that have implemented EOC, Oklahoma has proposed the following EOC that best align, where possible, with the Oklahoma SIM flagship issues. The Oklahoma SIM project team also considered other factors, such as high cost or high variance services from the Oklahoma SIM High Cost Services Report, in the choosing of the proposed episodes. The State will look to garner support from private payers to adopt the EOC to engender further payment alignment across Oklahoma’s insurance market. A further justification and detail of the proposed episodes are provided below, and examples of the episode’s criteria are included in Appendix F.

Figure 38: Proposed Episodes of Care



Asthma, acute exacerbation

Asthma exacerbation is more commonly known as an asthma attack and occurs when a person's airways become swollen and inflamed, the muscles in the airway contract, and breathing becomes difficult.¹ Although asthma is considered a chronic disease, an asthma episode occurs when a patient is treated in a healthcare setting for the acute exacerbation of their chronic condition. For providers, an asthma episode allows for opportunities to improve the quality and cost of care by preventing emergency department visits and hospital admissions, assuring medication adherence by the patient and family members/care givers, and providing appropriate discharge instructions for proper follow-up care.

Asthma is a costly condition for the state of Oklahoma as it is one of the most prevalent conditions among members of both the Medicaid and EGID populations. The 2014 State of the State's Health Report indicates that 292,000 adults and 123,100 children in the state had asthma.² In 2012, Medicaid paid more than \$23 million³ on asthma related hospital stays, and in 2013 EGID spent almost \$19 million for asthma related claims.⁴ Asthma is often associated with smoking and exposure to secondhand smoke, so the inclusion of the EOC correlates with the Oklahoma SIM flagship issue of tobacco use reduction.

- **Principal Accountable Provider:** The PAP for an asthma acute exacerbation episode is typically the initial facility or hospital emergency department where the triggering event is diagnosed.
- **Triggering Event and Episode Period:** The episode is triggered by an asthma acute exacerbation diagnosis in a healthcare setting, typically an emergency department or inpatient facility, and covers 30 days following the trigger.
- **Example of Services Included in an Episode:** Services that may be included in the episode are: provider visits, medication, labs and diagnostics, care coordination, hospital readmissions, and post-acute care.
- **Episode Quality Measures:** Quality measures for the episode can include hospital readmissions, tobacco cessation counseling, and medication management.

Perinatal

Perinatal refers to the period immediately before and after a woman gives birth to a child. To be included as an episode of care, the pregnancy is typically low to medium-risk. The aim of a perinatal episode is to ensure a healthy pregnancy and follow-up care for mother and baby.

In Oklahoma, Medicaid paid for approximately 60 percent of all births in the state, and covered 31,000 births in state fiscal year 2015. The average costs for the 21,875 deliveries without complications was \$2,106 and \$3,203 for 6,459 deliveries with complications.⁵

- **Principal Accountable Provider:** The PAP for a perinatal episode is typically the physician or nurse midwife who performed the delivery.
- **Triggering Event and Episode Period:** The perinatal episode is triggered by a live birth and covers 40 weeks prior to delivery and 60 days after delivery.
- **Example of Services Included in an Episode:** Services typically included in this EOC are prenatal care, labs, ultrasounds, medication, labor and delivery, and postpartum care.
- **Episode Quality Measures:** Quality measures include rates of prenatal screenings for HIV, chlamydia, and Group B strep, rates of C-section deliveries, and gestational diabetes.

Chronic Obstructive Pulmonary Disease (COPD), acute exacerbation

COPD can describe a serious of lung diseases including emphysema, chronic bronchitis, refractory asthma, and some forms of bronchiectasis. An acute exacerbation of COPD is described as a flare-up of the disease where breathing worsens and is often linked to an infection.⁶

In Oklahoma, lower respiratory disease was the third leading cause of death in 2013, and Oklahoma has one of the highest death rates for these conditions in the nation.² Complications of COPD can cause high rates of preventable hospital admissions, and in 2012 there were 1,567 COPD-related hospital readmissions, accounting for 3.5 percent of all 30-day hospital readmissions.³ For the EGID, COPD was among the top ten conditions for most claims paid in 2013.⁴

- **Principal Accountable Provider:** The PAP for a COPD acute exacerbation episode is typically the facility where and emergency department visit or inpatient admission took place.
- **Triggering Event and Episode Period:** The triggering event for a COPD episode is the diagnosis of an acute exacerbation for COPD in an emergency department or inpatient facility. The episode period is typically 30 days following the triggering event.
- **Example of Services Included in an Episode:** Services that may be included in this EOC are physician visits, medications, care coordination, hospital readmissions, and post-acute care.
- **Episode Quality Measures:** Quality measures for COPD episodes may include hospital readmissions, tobacco cessation counseling, and providing appropriate follow-up care.

Total Joint Replacement

A total joint replacement (TJR) covers the elective replacement of the hip or knee joint. A joint replacement is a surgical procedure where parts of a damaged joint are removed and replaced with an artificial joint, or prosthesis.⁷ The aim of a TJR episode is to reduce duplication of services and costs through better care coordination.

- **Principal Accountable Provider:** For a joint replacement EOC, the PAP is most often the surgeon who performs the joint replacement procedure.
- **Triggering Event and Episode Period:** The triggering event for a joint replacement EOC is the actual joint replacement surgery and the episode typically includes 30 days prior to surgery and 90 days post-operatively.
- **Example of Services Included in an Episode:** For a joint replacement EOC, services typically included are all orthopedic-related costs during the episode time period.
- **Episode Quality Measures:** Quality metrics for this episode can include 30-day readmissions, fracture rates, infection rates, dislocations, and blood transfusions.

Congestive Heart Failure

Congestive Heart Failure (CHF) occurs when the heart muscle does not pump blood properly due to narrowed arteries or high blood pressure, which can gradually leave the heart too weak or stiff to work efficiently.⁸ In Oklahoma, heart disease accounted for one in four deaths in 2012 and was the leading cause of death in the state.² For just the EGID population, heart failure accounted for 19 percent of total claims paid in 2013.⁴ Heart failure and heart disease are also correlated with several of the flagship health issues identified in the SHSIP including tobacco use, obesity, and hypertension. The goal of a CHF episode of care is to improve care coordination for patients in order to reduce costs, especially through preventable hospital readmissions.

- Principal Accountable Provider: The PAP for a heart failure episode of care is typically the hospital with the initial inpatient admission.
- Triggering Event and Episode Period: An episode of care for heart failure is triggered by a hospital admission for congestive heart failure and lasts for 30 days after admission.
- Example Services Included in an Episode: Facility services, inpatient services, emergency department visits, observation, post-acute care, and outpatient services like labs, diagnostics, and medication are covered under this episode.
- Episode Quality Measures: Providers responsible for CHF episodes report on measures related to medication management, ACE-inhibitor or Angiotension Receptor Blockers (ARB) therapy, and hospital re-admissions.

CONCLUSION

This section depicts a broad vision of how to move Oklahoma's healthcare system from fee for service to value based purchasing, the goal of the SIM project. This vision was developed through stakeholder engagement. Through this process, our stakeholders created the model goals and tenets. The model was designed to reach those goals and tenets with an Oklahoma specific approach. Through the Regional Care Organization, Quality Measures, and Episodes of Care, Oklahoma hopes to engage 80% of healthcare payments in a value-based arrangement by 2020. The ultimate goal for Oklahoma is to reach the triple aim through this innovative payment and delivery plan.