State of Oklahoma Care Delivery Model: Key Findings

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

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Milliman

Caveats

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Agenda

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

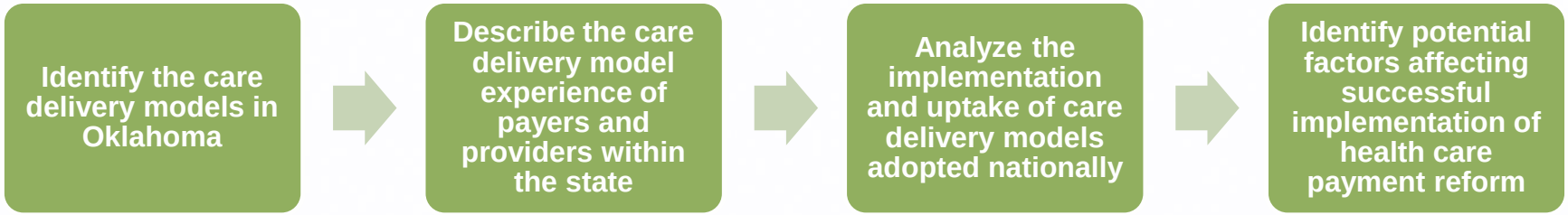
Background

- 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.

Interviews	Understand payer and provider experience with care delivery models and payment reform initiatives in Oklahoma.
Research on Publically Available Information	Gain essential background and conclusions on the eight identified care delivery models from public sources.
Industry Knowledge	Pull relevant information from prior Milliman work with Oklahoma's insurance market and knowledge of care delivery models in other states.

Stakeholder Interviews

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

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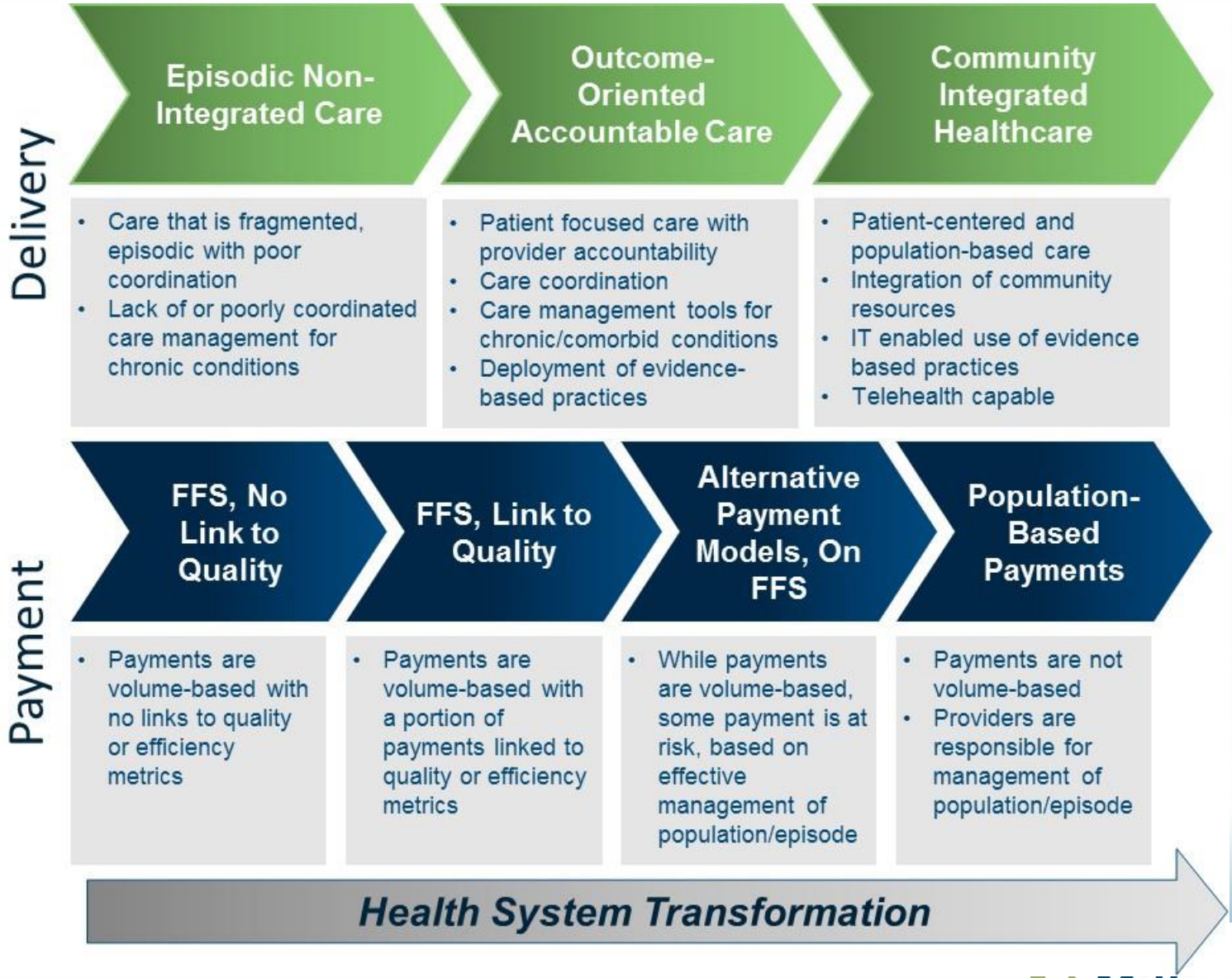
Framework for Health System Transformation



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.

Bundled Payments for Care Improvement

Overview

- 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.

	National	Oklahoma
Model 1: Retrospective Acute Care Hospital Stay Only	11 Sites	0
Model 2: Retrospective Acute Care Hospital Stay plus Post-Acute Care	741 Sites	18 Sites
Model 3: Retrospective Post-Acute Care Only	1,353 Sites	21 Sites
Model 4: Acute Care Hospital Stay Only	21 Sites	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

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

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	475 practice sites	
Payer and Provider Participation	2,805 providers	
	2.7 million patients: 404,000 Medicare/Medicaid beneficiaries	
	38 public or private payers	
Oklahoma	62 practice sites	
Payer and Provider Participation	254 providers	
	311,000 patients: 45,000 Medicare/Medicaid beneficiaries	
	3 public or private payers	
	Convener: MyHealth	

- **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%)**

- **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

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

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

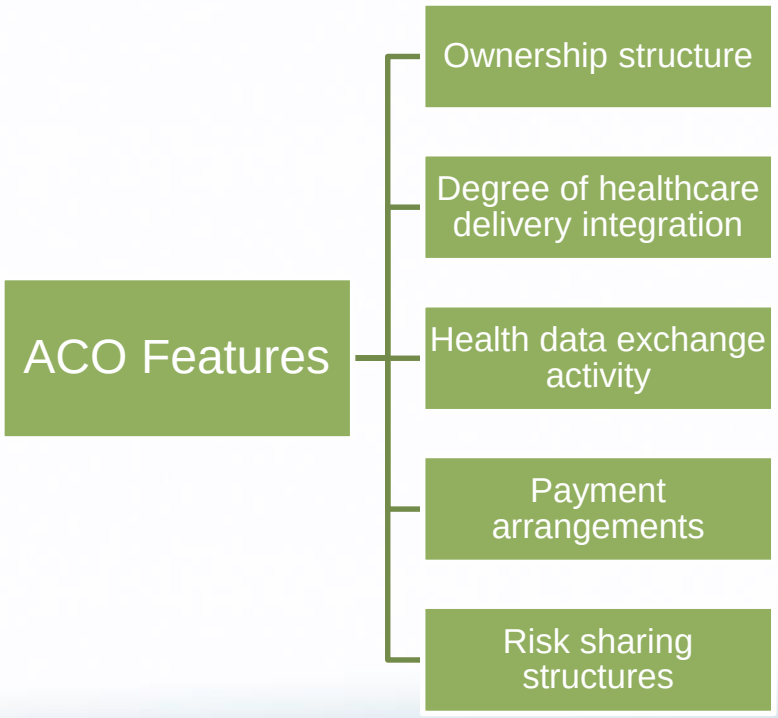
- Serve underserved areas or populations,
- Offer a sliding fee scale, provide comprehensive services,
- Have ongoing quality assurance programs, and
- Receive grants under section 330 of the Public Health Service Act.

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



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

National: Medicare

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.

Accountable Care Organizations

Oklahoma

Overview

- 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.

Mercy Health ACO (Mercy Health)	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.
Oklahoma Health Initiatives (St. John)	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.
SSMOK ACO (St. Anthony)	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.

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Considerations for Accelerating Adoption of Delivery Models Overview

- **Consider Promoting ACO-like Models**

Medicaid ACO	National Rural ACO	The Next Gen ACO
Requires each state to consider its own unique State Plan Amendment and market	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	Intended to test whether "strong incentives for ACOs can improve health outcomes and reduce expenditures for Medicare fee-for-service (FFS) beneficiaries"

- **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