Financial Models to Support State Efforts to Coordinate Care for Medicare-Medicaid Enrollees

Demonstration Proposal

Oklahoma

Summary: In July 2011, CMS released a State Medicaid Directors' letter regarding two new models CMS will test for States to better align the financing of the Medicare and Medicaid programs, and integrate primary, acute, behavioral health and long term supports and services for Medicare-Medicaid enrollees. These two models include:

- Capitated Model: A State, CMS, and a health plan enter into a three-way contract, and the plan receives a prospective blended payment to provide comprehensive, coordinated care.
- Managed Fee-for-Service Model: A State and CMS enter into an agreement by which the State would be eligible to benefit from savings resulting from initiatives designed to improve quality and reduce costs for both Medicare and Medicaid.

To participate, States must demonstrate their ability to meet or exceed certain CMS established standards and conditions in either/both of these models. These standards and conditions include factors such as beneficiary protections, stakeholder engagement, and network adequacy among others. In order for CMS to determine whether the standards and conditions have been met, States are asked to submit a demonstration proposal that outlines their proposed approach for the selected financial model(s). The Oklahoma Health Care Authority has submitted this proposal for CMS review.

As part of the review process, CMS will seek public comment through a 30-day notice period. During this time, interested individuals or groups may submit comments to help inform CMS' review of the proposal.

CMS will make all decisions related to the implementation of proposed demonstrations following a thorough review of the proposal and supporting documentation. Further discussion and/or development of certain aspects of the demonstration (e.g., quality measures, rate methodology, etc.) may be required before any formal agreement is finalized.

Publication of this proposal does not imply CMS approval of the demonstration.

Invitation for public comment: We welcome public input on this proposal. To be assured consideration, please submit comments by 5 p.m. EDT, July 1, 2012. You may submit comments on this proposal to OK-MedicareMedicaidCoordination@cms.hhs.gov.

State Demonstrations to Integrate Care for Dual Eligible Individuals

This document is Oklahoma's proposal for "State Demonstrations to Integrate Care for Dual Eligible Individuals". The document describes in detail how the Oklahoma Health Care Authority (OHCA), Oklahoma's single state Medicaid agency, will implement and operate an integrated delivery system and payment model aimed at improving the quality, coordination, and cost-effectiveness of care for dual eligible individuals. Through the submission of this proposal to the Center for Medicare and Medicaid Innovation (CMMI), Oklahoma is pursuing a three-pronged approach for integrating care for the state's dual eligible population.

1) Oklahoma's care coordination program design fully integrates the health services delivery mechanisms for Medicare and Medicaid (known as SoonerCare in Oklahoma) for Oklahoma's dually eligible members. By looking at claims and working with an interdisciplinary care team, this approach creates the ability to better manage a dually eligible member's care. This level of integration will create a better understanding of benefits and services available to those served by SoonerCare and Medicare. Through the newly developed care coordination program, OHCA seeks to improve member access to appropriate services, integrate a comprehensive range of services for individuals, and create significant cost savings.

2) In partnership with the University of Oklahoma School of Community Medicine at Tulsa (SOCM), the second approach to care integration that Oklahoma is pursuing is a multi-tiered approach to care coordination by focusing on a) the redesign of the practice to incorporate behavioral health and care coordination services, b) the inclusion of population level clinical analytics to facilitate the management of the population, c) the use of community level integrated care plans, d) the development of community level evidence based protocols in the management of chronic disease, and e) the integration of these methodologies into graduate medical education.

3) Oklahoma's final approach to the integration of care for duals involves the creation of an Integrated Care Sites (ICS) demonstration design that would utilize the proven infrastructure of the Program of All Inclusive Care for the Elderly (PACE) model, while making some modifications to the existing PACE criteria. The ICS will allow for a greater number of individuals to benefit from the proven high quality of care received through the integrated care system of the PACE model. The ICS demonstration is an effort to display ways that will enhance the scalability and effectiveness of the PACE model.

Concept #1- SoonerCare Silver

Executive Summary

In order to more efficiently provide quality health care to our dual eligible population, the OHCA has designed a model of care coordination services. This model will impact the health outcomes for the target population by improving care management and access, while reducing costs by improving efficiency and reducing duplication of services. Care for the dual eligible population has historically been fragmented with services often duplicated, gaps in care and overall poor health outcomes.

The OHCA care coordination program known as "SoonerCare Silver" aims to improve the integration of care by adding care coordination to the infrastructure of services a dually eligible member currently receives. The care coordinator will serve as a bridge between Medicare, Medicaid, providers and the member to improve communication, reduce redundancies and help to ensure the member is receiving all the quality care he or she needs. This care will center on an Interdisciplinary Care Team (ICT) that will

work collectively to develop and implement the member's action plan to achieve a positive health outcome.

Table 1: Care Coordination Overview Chart

Target Population (All full benefit Medicare-Medicaid enrollees/ subset/etc.)	All full benefit Medicare-Medicaid enrollees
Total Number of Full Benefit Medicare-Medicaid Enrollees Statewide	79,891
Total Number of Beneficiaries Eligible for Demonstration	79,891
Geographic Service Area (Statewide or listing of pilot service areas)	Statewide
Summary of Covered Benefits	Along with existing Medicare and Medicaid health benefits, care coordination services will be offered to the eligible full benefit Medicare-Medicaid enrollees.
Financing Model	Fee-for-Service
Summary of Stakeholder Engagement/Input (Provide high level listing of events/dates—Section D asks for more detailed information)	Full Stakeholder Meetings: September 2011 thru March 2012 Workgroup meetings: October 2011 thru February 2012 Member/Caregiver Focus Groups: February 2012 Stakeholder Proposal Review Session: March-May 2012 Proposal Posted for Public Comment: April 20, 2012
Proposed Implementation Date(s)	July 2013

Background

Oklahomans who are considered to be full benefit dual eligible members receive services from both Medicare and SoonerCare. Individuals considered Specified Low-income Medicare Beneficiaries (SLMB) only and Qualifying Individuals (Q1) are not considered "full benefit" duals. The bulk of Medicare spending is for physician visits, inpatient, outpatient, hospital services, prescription drug coverage, and skilled nursing; the bulk of Medicaid spending for dually eligible individuals is for long-term care services. Fragmented care and lack of coordination between Medicare and Medicaid services often lead to poor health outcomes, and extremely high costs. Recently, national attention is being directed to the utilization patterns and rate of expenditures for this population.

In response to the opportunity provided by CMMI, the OHCA seeks to better coordinate care for dually eligible SoonerCare members by utilizing proven strategies to overcome barriers to effective health care delivery services resulting in 1) integrated access to primary care and behavioral health services, 2) improved care coordination and health outcomes and 3) reduced costs for care to the target population.

The Oklahoma care coordination program seeks to respect the differences between Medicare and SoonerCare while providing care coordination at the point of member access to services through the two healthcare systems. Through the implementation of this program, these dually eligible SoonerCare members will have a care coordination process that connects duals to their health providers in an efficient and culturally competent fashion; connects new dual eligible members to the service delivery system as quickly as possible; and offers ongoing assistance to navigate both Medicare and Medicaid.

Historically, barriers to effective care coordination between Medicare and Medicaid have been differences in benefits, different billing systems, different processes for eligibility, enrollment and appeals, and different payment methodologies. Care coordination of services will reduce member barriers to gaining information, and allows members to have an initial awareness of the comprehensive

benefits that are afforded them through combined benefit offerings. Care coordination program staff can direct members to physicians and providers who have agreed to serve people who are dually eligible, and who are more thoroughly educated about the complex health needs of duals and frequently reoccurring comorbidities.

Figures from March 2011 SoonerCare fact sheet and the Medicare Resource Center indicates that of the 727,369 SoonerCare members, and 607,465 Medicare members, there were 7.8% or 104,538 people who were eligible in both categories at the same time, and are called dually eligible[1]. In June 2011, there were 79,891 full benefit Medicare-Medicaid enrollees statewide[2]. Total enrollment for dual eligible SoonerCare members are comprised of Caucasian 77.9%, Hawaiian or other Pacific Islander 1%, African American 12.5%, Asian 1.3%, American Indian 7.5%, and those with multiple races are 0.7%[3]. By age and gender, the demographics of this population are: females 65 and older-36%; females less than 65 years-27%; males 65 and older-15%; and males less than age 65 -22%[4].
The dual eligible population has higher rates of poor health than those members on just Medicare or SoonerCare. They are characterized as weak, frail, and having multiple chronic conditions. They also may be lower functioning, have mental and behavioral health impairments and have a higher rate of being low-income[5]. Analysis of SoonerCare claims for dual eligible members supports national trending in categories of services delivered and rate of expenditures. Dual eligible members present a challenge as they constitute a small percentage of the SoonerCare population, but represent a much higher percentage of spending. Looking at those without existing case management services, 62 percent were characterized by high per member per month spending with high rates of inpatient, outpatient, Skilled Nursing Facility (SNF) and/or physician utilization. The top 10 costliest conditions for all dual eligibles are presented in appendix A in more detail.

The chart below describes an internal analysis of Long-term Care Support (LTSS) services for all Oklahoma duals as of June 2011:

Chart 1- Long Term Care Support Services Analysis

	Overall	Individuals receiving LTSS in institutional settings	Individuals receiving LTSS in HCBS settings	other
Overall total	105,532	13,486	21,821	
Individuals age 65+	54,313	10,709	12,028	
Individuals under age 65	51,219	2,777	9,793	
Individuals with a serious mental illness	8,421	383	1,085	6,953

Care Model Overview

Oklahoma's 77 counties are categorized as urban, rural and mixed (urban and rural). The four urban counties, Cleveland, Comanche, Oklahoma and Tulsa account for 45.4% of the state's population. Another 8.9% of the population lives in one of the five mixed counties, Canadian, Logan, Creek, McClain and Wagoner, with the remaining 45.7% of the state's citizens living in one of the remaining 68 rural counties[6]. The Oklahoma SoonerCare Silver care coordination program will cover dual eligible members residing in all of Oklahoma's counties with limited exceptions.

[1] Retrieved from the Medicare Resource Center http://www.medicareresources.org/oklahoma
[2] June 2011 Internal document with detailed analysis pulled from SoonerCare enrollment records.
[3] June 2011 Internal document with detailed analysis pulled from SoonerCare enrollment records.
[4] June 2011 Internal document with detailed analysis pulled from SoonerCare enrollment records. **Data extracted for Race and Age details were at a different point in time than overall numbers.
[5] Kaiser Family Foundation, 2007
[6] Retrieved from State of the State's rural Health http://www.healthsciences.okstate.edu/ruralhealth/mapshow/images/07-CntyClass_lg.jpg

Individuals receiving care coordination through other programs such as Tulsa's Health Innovation Zone (THIZ), PACE and the ICS will be excluded from the SoonerCare Silver care coordination program. All other dual eligible individuals who are not receiving care coordination services through their current benefit program will be eligible to receive care coordination through the SoonerCare Silver program.

General eligibility information is summarized in the following table. Complete Medicare and Medicaid Eligibility guidelines are described in Appendix B.

Table 2-Eligibility Criteria

Medicare	**Medicaid**
Generally, you are eligible for Medicare if you or your spouse worked for at least 10 years in Medicare-covered employment and you are 65 years or older and a citizen or permanent resident of the United States. If you are not yet 65, you might also qualify for coverage if you have a disability or with End-Stage Renal disease (permanent kidney failure requiring dialysis or transplant). There are conditions and guidelines for obtaining Part A benefits at age 65 without having to pay premiums. There are conditions and guidelines for obtaining Part A benefits under age 65 without having to pay premiums.	In general, the following groups of individuals may qualify for SoonerCare services: Adults with children under 19 Children under 19 and pregnant women Individuals 65 and older Individuals who are blind or who have disabilities Women under 65 in need of breast or cervical cancer treatment Sooner Plan - Men and women 19 and older with family planning needs In addition to the citizenship and the state residency requirements, a SoonerCare applicant must meet categorical and financial requirements. SoonerCare Income Guidelines are available on OHCA's website http://www.okhca.org/

As a part of the proposed care coordination program, individuals eligible for full benefits of Medicaid and Medicare will automatically be enrolled in the SoonerCare Silver program. Members will be required to make a decision and take action to opt out of the program, should they choose to no longer participate and be contacted by a care coordinator. Outreach and education of potential members prior to auto-enrollment in SoonerCare Silver will be detailed in the three way contract between an outside vendor, OHCA, and CMS.

Oklahoma's care coordination model for duals will benefit from a well-established network of support for implementation, with a variety of proven programs that provide long-term care services and support for dual eligible members. These members will now be offered the additional service of care coordination, as an overlay for long-term care and waiver participants. The added benefit of care coordination will become the hub of what links all of the member's services together. The care coordinator will work directly with individuals and those who provide services for a dual eligible, such as the nurse case manager, social worker and other providers who are currently providing services to the member. For all members, no changes will be made to coverage for existing Part D services. Care coordinators will help members navigate Part D services as needed. The care coordinator will also serve as a liaison to the ICT to ensure the best plan of care for the individual member residing in the community or a facility.

The SoonerCare Health Management Program (HMP) is an example of a successfully operated OHCA care management program. This program utilizes a two-armed approach. Currently, selected SoonerCare Choice Primary Care Providers (PCPs) are offered one-on-one staff assistance, called "practice facilitation". Providers are generally selected for the program through predictive modeling software that identifies them to have a panel of patients with high chronic disease burden. In general,

practice facilitators collaborate with PCPs and their office staff to improve their efficiency and quality of care through implementation of enhanced disease management protocols and improved patient tracking and reporting systems[7]. The second arm of the HMP is Nurse Care management. This program is offered to 5,000 SoonerCare Choice members with chronic disease determined by predictive modeling software to be at highest risk. These members receive a comprehensive assessment which results in education, an individualized action plan and self-management supports.

Lessons learned from OHCA's HMP will be incorporated into the care coordination program, providing appropriate and proficient services that address the needs of the Medicare and Medicaid population. People who are dually eligible, even those with the most complex health needs, are excluded from HMP. But, the HMP has developed effective protocols for addressing the health needs that can be modeled for the dually eligible. Such medical and supportive services can be used with the dual eligible population to identify opportunities for intervention within the care coordination program.

Another successful care management program administered by OHCA is SoonerCare Care Management (SCCM). SCCM is for members who have complex medical and behavioral health needs who are directed to specific programs that address their exceptional health care needs and accompanying costs. SCCM targets specific health issues for members including, but not limited to: the coordination of out of state care; breast and cervical cancer; high risk obstetrics and pregnancies; hemophilia; at-risk infants and early childhood mortality prevention; coordination of bilingual services, and a range of referrals for supportive services, such as private duty nursing; assessment of waivers, and some in home assessments.

OHCA is currently partnering with the State Mental Health Authority (SMHA) and the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) to implement the health homes model. Health homes are designed to serve people with chronic mental illnesses. Children diagnosed as Serious Emotional Disturbance (SED) - the term used to describe children who qualify, and Seriously Mentally Ill (SMI) - the term for qualifying adults are served by a nurse care manager, who coordinates a team of professionals that determine the best services for the member.

Health homes will be hosted by ODMHSAS through the statewide network of community mental health centers (CMHCs) and their satellite locations, which have historically provided community-based mental health services. The CMHCs provide screening, assessment and referral services, emergency services, therapy, psychiatric rehabilitation, case management, and other community support services designed to assist adult mental health consumers with living as independently as possible and to provide therapeutic services for children who are demonstrating symptoms of emotional disturbance. All CMHCs provide services to both adults and children.

With the integration of health homes, the CMHC's will have the additional offering of providing wrap around comprehensive behavioral health services to eligible members with an established PCP relationship. There are fifteen CMHCs, five of which are state-operated facilities and the other ten are contracted non-profit providers, together they provide services in all 77 counties in Oklahoma. Most centers have satellite offices or other specialized programs within their service areas. Projections about numbers of health homes participants indicate approximately 1400 adults are estimated to be dual eligible. CMHCs and their service areas can be viewed as Appendix C, or at ODMHSAS' website http://ok.gov/odmhsas/.

Another community support program for children with behavioral health conditions is Systems of Care. The purpose is to reduce inpatient hospitalization with a team comprised of the member, a Care

[7] SoonerCare HMP Evaluation

Coordinator (CC), a Family Support Provider (FSP), OKDHS Child Welfare Worker, counselor, teacher, and others. A care plan is developed and each person on the team is responsible for a task to be completed. Weekly visits by the CC and FSP to the member are maintained and the team meets once a month.

As identified earlier, these programs are not specifically targeted towards members who are dually eligible, (HMP excludes dual eligibles altogether, and SCCM serve some duals but not exclusively) these programs still provide a rich array of information that can be used to significantly improve the delivery of all Medicare and Medicaid services. As well as provide an improved response to the need for a complex care continuum, based on their respective program's steady responses to a population who resides in the same state, and whose health needs are strikingly similar. Health Homes and Systems of Care are additional programs that will help provide a framework of information for providing care coordination to the duals.

Roughly, 35,000 duals are enrolled in either a waiver or long-term care program. Through these programs, members are offered case management services. While case management provides some help with support services and other programs along with monitoring a member's health and welfare, case management does not offer clinical disease management services.

A care coordinator monitoring a dual enrolled in a waiver or long term-care program, may offer services complementary to existing services with the added benefit of disease management. For example, individuals with End-Stage Renal Disease (ESRD) and mental disabilities are assigned a care coordinator who knows how to handle these complex issues. The care coordinator will be responsible for working with the ICT to come up with an action plan specific to these individual's needs. No services will be added to those with End Stage Renal Disease and mental disabilities other than layering care coordination on their existing services.

These individuals would benefit from the care coordination program, because services they would receive would be oriented toward quality oversight and addressing gaps in their existing care. Care coordination will not duplicate existing services given to a member. Those members not in a waiver or HCBS, will receive the full services of care coordination encompassing both Medicare and Medicaid savings.[8] Table 3 outlines the Waiver and Long-term services that may already be provided to a dual eligible member; notice none are receiving disease management services.

Table 3-Summary of Waiver and Long-Term Care Programs in Oklahoma (Publicly Funded)

Name	Operator	Targeted Population	Services	Funding	Case Management Services Provided
Advantage Waiver	OKDHS-Aging	Elderly, physically disabled 21+	HCBS	OKDHS	Case managers from private industry provider agencies develop a waiver services plan that takes into account the member's informal supports and other programs. These providers are responsible for monitoring the adequacy of the plan and the member's health and welfare. Disease management is not in case management scope.
Community Waiver	OKDHS-DDSD	MR/DD ages 3 and older	HCBS	OKDHS	For each of these waiver programs, State agency case managers develop service plans, which include residential services. These case managers are responsible for monitoring the adequacy of the plan and the member's health and welfare. Disease
Homeward Bound Waiver	OKDHS-DDSD	Class members	HCBS	OKDHS	

[8] PHPG

Name	Operator	Targeted Population	Services	Funding	Case Management Services Provided
In-home Supports for Adults Waiver	OKDHS-DDSD	MR/DD 18 and older	HCBS	OKDHS	management is not in case management scope.
In-home Supports for Children Waiver	OKDHS-DDSD	MR/DD ages 3-17	HCBS	OKDHS	
PACE	OHCA-OLL	55 and older	Capitated model	Medicare & Medicaid	The PACE provider furnishes case management and is responsible for development of a service plan.
Living Choice demonstration	OHCA-OLL	19 and older	HCBS	OHCA	For these waiver programs, case managers from private industry provider agencies develop a transition/community plan that takes into account the member's informal supports and other programs. These providers are responsible for monitoring the adequacy of the plan and the member's health and welfare. Disease management is not in case management scope.
My Life; My Choice Waiver	OHCA-OLL	Living Choice (MFP) graduates with physical disabilities and younger than 65	HCBS	OHCA	
Sooner Seniors Waiver	OHCA-OLL	Living Choice (MFP) graduates who are 65 and older	HCBS	OHCA	
Medically Fragile Waiver	OHCA-OLL	19 and older	HCBS	OHCA	
Nursing Facilities or ICFs-MR	OHCA			OHCA	Member is admitted to facility under physician's orders and is monitored 24/7 by staff. A Minimum Data Set is completed and the care plan is developed accordingly. The MDS is reviewed at least quarterly or when a significant change in the member's condition occurs.
State Plan Personal Care	OKDHS-Aging	All ages	Personal care	OKDHS	Nurses from private industry provider agencies develop a personal care services plan that takes into account the member's informal supports and other programs. These providers are responsible for monitoring the adequacy of the plan and the member's health and welfare. Disease management is not in the scope of personal care services. In addition, the State agency nurse who assesses the member performs ongoing monitoring and makes a determination regarding level of care.
Key terms: OKDHS- Oklahoma Department of Human Services; HCBS- Home & Community Based Services; OKDHS/DDSD- Developmental Disabilities Services Division; MR/DD- Mentally Retardation/Developmentally Disabled; OLL- Opportunities for Living Life; MFP- Money Follows the Person; ICF-MR- Intermediate Care Facilities for Mental Retardation					

Once the dual eligible member is enrolled in SoonerCare Silver and agrees to care coordination, the care coordinator will review the member's current level of participation to determine if the member is already enrolled in any existing program. The care coordinator will specifically check other OHCA programs, to determine if the member is engaged with a) current Medicaid waivers and/or State plan services available to this population; (b) existing managed long-term care programs; (c) existing specialty behavioral health plans; (d) integrated programs via Medicare Advantage Special Need Plans (SNPs) or PACE programs, and (e) other state payment/delivery initiatives or demonstrations. The care coordination staff can monitor the member's participation through the case manager or through case management electronic data access. Table 4 below is an overall comparison of expenditures and utilization rates for the dually eligible.

In an analysis by the Pacific Health Policy Group (PHPG), members can be separated by four distinct populations.

1) Frail elderly and persons with physical disabilities enrolled in the AD*vantage* Home and Community Based Services (HCBS) waiver;
2) Nursing facility residents;
3) Persons with developmental disabilities, including those enrolled in the Developmental Disabilities Service Division (DDSD) waiver;
4) "Target" group consisting of persons not falling into one of the first three categories.

Table 4- Summary Comparison of Enrollment, Expenditures and Utilization Rates (CY 2009)

Population	Chronically Ill Dual Eligibles	Medicare Member Months	Total Medicare/ Medicaid Spending	PMPM Spending	Total IP Admissions per 1,000	Total OP Visits per	Total SNF Days per 1,000	Total Physician Visits per 1,000
Target	48,423	550,730	$742,405,173	$1,348	428	4,073	685	6,073
AD*vantage*	17,807	202,190	$749,839,047	$3,709	927	6,130	3,537	8,183
Nursing	10,685	112,872	$596,809,419	$5,287	1,102	7,441	16,151	1,892
DD	1,200	13,937	$92,656,620	$6,648	311	7,928	302	3,568
TOTAL (Unduplicated	**78,115**	**879,729**	**$2,181,710,259**	**$2,480**	**627**	**5,039**	**3,319**	**5,982**

Until this point, this document has referenced existing supports for dual eligible members. This section will briefly describe potential sources of support that have been available, but have historically served a slightly different purpose in the dual eligible service system, and will require a new approach to solve an old problem.

ER Utilization Program

People who are dually eligible often have high rates of emergency room participation and hospital admissions. As a part of implementing this proposal, traditional relationships with hospitals and their professional associations will need to be strengthened. The hospitals serve as a significant provider of medical services to the dual population and SoonerCare. An opportunity is now presented to discuss hospitalization and related issues with hospital administrators, focusing on methods that challenge inappropriate hospital use and reduce potentially avoidable hospitalizations (PAH). According to a recent CMS Policy Insight Brief, in 2005 about 25% of hospitalizations were potentially avoidable, that is, by definition, "hospitalizations that could have been avoided, either because the condition could have been prevented or treated outside a hospital setting of care". Collaborating around the issue of Potentially Avoidable Hospitalizations (PAHs) creates an opportunity to improve both the quality of care for duals and reduce expenditures for all concerned. OHCA has a chance to exploit the timing of

the recent initiative "Partnership for Patients" which lists reducing hospital admissions by 20% as one of its goals.

Through the development of relationships with dual eligible members, care coordinators can connect members to their PCP, and schedule appointments for their care around the member's personal schedule. This anticipated relationship is intended to help the member plan for health care services and visit the emergency room less frequently, because their needs are being addressed by their PCP.

Facilitating a members schedule for more primary care office visits rather than ER visits and subsequent hospitalizations will result in tremendous cost savings, as members become more familiar with their PCP and the culture of scheduling health services. Health care providers prepare daily to address the specific needs of the people who are scheduled, and become familiar with their health history and chronic conditions in preparation for the members visit. In addition, practice facilitators, referenced earlier, educate providers about how the office can more effectively address the needs of each member/patient.

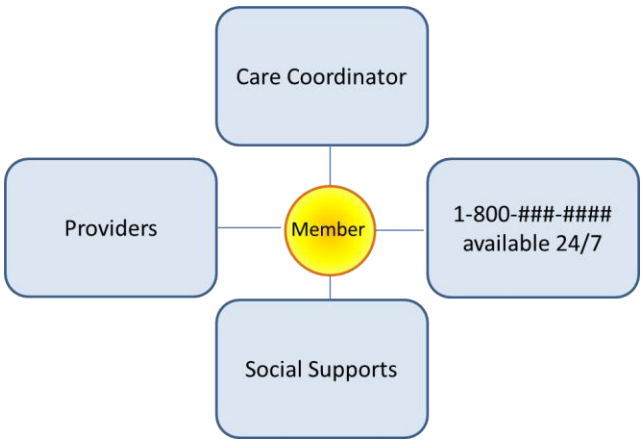
Hospital Integrations

Excerpts from a Kaiser Health Network article indicated that "Hospitals can expect renewed efforts from CMS to cut readmissions. In an effort to save money and improve care, Medicare, is about to release a final rule aimed at getting hospitals to pay more attention to patients after discharge. A key component of the new approach is to cut back payments to hospitals where high numbers of patients are readmitted, prompting hospitals to make sure patients see their doctors and fill their prescriptions."

The article continues, "With readmission rates affecting the bottom line, hospitals will feel the financial consequences to take action. Many hospitals are already experimenting with transitional care programs that help manage the patient's care from the hospital to their home. The Medicare reimbursement change could have lasting effects on *care coordination* with hospitals thinking about patients on an outpatient basis, rather than solely inpatient." Dual eligible program administration is in a position to foster a new type of partnership with an old partner, both of whom share the common goals of quality care and reduced costs. The care coordinator will work with the member's hospital to allow a better coordination between a member and hospital services.

As the new care coordination program is implemented, an ICT will be consulted in order to come up with a patient's action plan. This will include nurse care managers, along with social workers, pharmacists, and others, who can review the member's initial completed assessment data and make a recommendation about the most appropriate and most immediate medical intervention. The review team can provide their recommendation by reviewing the data within the patient's records.

Figure 1- Interdisciplinary Care Team



SoonerCare Silver Job Descriptions

Care Coordinator

This position will require a nursing degree from an accredited college or university with a current valid license as a Registered Nurse in Oklahoma. A minimum of two years full time professional clinical experience is required and preference will be given to those that have Medicaid or Medicare experience and who have worked with people with disabilities. Responsibilities will include: Notifying the member of their new service, coordinating and facilitating access to medical and behavioral health care, helping manage their Part D coverage, completing action plans, incident reports as well as documenting progress of a member. Routinely the Care Coordinator will review, research, and identify barriers to the improvement of a member's health care. It will also be essential to maintain interaction with the member's primary care physician and relay or act as intermediary between the member and the provider/interdisciplinary team to communicate needed medical information. The care coordinator will also address any language barriers between a member and their needed health services. This may require a care coordinator to be bilingual.

Social Services Coordinator

The minimum requirement for this position is a bachelor degree in social work, behavioral or medical science or related field. Also requires a minimum of two years of full-time social medical experience in an acute medical or psychiatric setting working with people with disabilities. The Social Service Coordinator will facilitate activities related to the interdisciplinary team decisions which involve the member and their medical/ behavioral health care document progress. The Social Services Coordinator will also address the social and daily living skills of the member. Referrals will be made to community resources/social agencies in a member's residency area if needed. Individuals may assist in educating a member how to care for their individual medical or behavioral health care needs.

Nurse Care Management Supervisor

This position will require a nursing degree from an accredited college or university with a current valid license as a Registered Nurse in Oklahoma. In addition the position will require four years minimum of experience in a medical or behavioral health setting and one year as a Nurse Care Coordinator working with people with disabilities. The ability to write reports, study and interpret governmental regulations as well as ensuring adherence of outline plans will also be necessary. The Nurse Care Management Supervisor will have the ability to effectively present information to different groups of interest or to the public in general. Additional duties will include: interviewing, training staff, assigning, monitoring, and tracking performance.

Behavioral Health Specialist

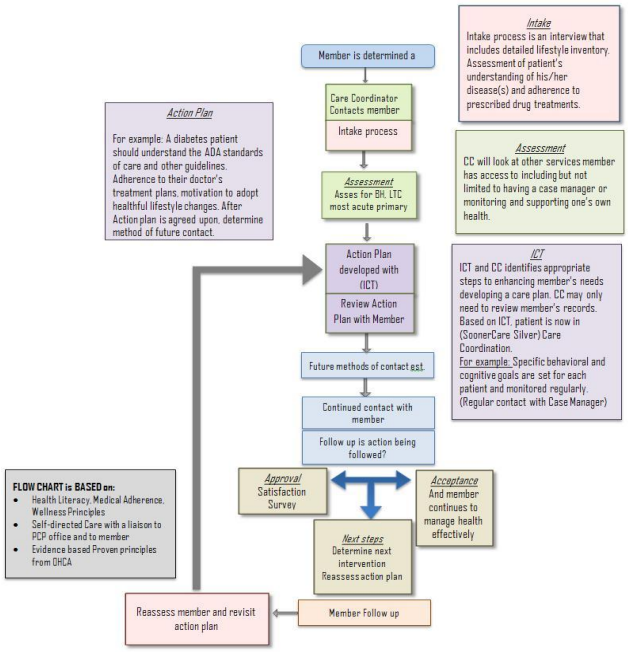
The staff for this position will possess a master's degree or higher in social work or psychology, or in a program which qualifies for licensure in any of these areas: licensed professional counselor, or licensed marital and family therapist, or psychologist. This position also calls for at least four years of full time professional experience with at least one year of experience in administrative or management position. This position will refer members to behavioral health community resources and have the ability to communicate with the interdisciplinary care team to ensure services needed are linked with the member.

Administrative/Management

The remaining administrative/management duties will be contracted by an outside vendor that will be responsible for:

- Hiring staff
- Ensuring staff educate members and caregivers respective of individual illnesses
- Enrollment/disenrollment of members
- Adhering to guidelines in relation to rules and regulations set in contract
- Assuring no gaps in services for the members in continuity of care process
- Providing quality of care and satisfaction surveys
- Referral and authorization processes
- Assist with claims submission
- Ensuring all personnel be trained in an appropriate manner for the population being served.
- Determining how care coordination between hospitals, care transitions and operations and the care coordinator will be handled

Figure 2-Member Process into the SoonerCare Silver Program



The flow chart above describes the member's movement through the care coordination system, and the services that are available as the member completes enrollment and engages with the care coordination process. Note that a member has the freedom to exit the system at any time during the process. The member's caregiver who is typically a family member or a friend will be considered a vital part of the support team and included in the discussions and decision making regarding the member's care plan.

This caregiver will assist with communication with the care coordinator and the ICT to ensure that the member receives needed services and the best quality of care.

The recommend process for serving dual eligible members is based on a summary of OHCA's experience with existing care coordination efforts and findings of evidenced based practices that appear to have relevance for Oklahoma's dual eligible population. OHCA will implement a care coordination program replicating the major evidence based features that are associated with program success and that appear to match the health care needs of the dual eligible population. Those evidenced based features are:

- Staffing ratio and qualifications of the ICT.
- Frequency and method of contact (# of times monthly, in-person or by phone.)
- Examining patterns of hospitalization and immediate risk of hospitalization (in the near term).
- Work with hospitals to gain timely information on patient's hospitalization and enhance the care coordinator's potential to manage transitions and reduce short-term readmissions.
- Provide member education about medication and general health literacy.
- Ensure that the care coordinator has frequent opportunities to interact formally with physicians. Some practices have made onsite space available for the care coordinator to meet with the patients privately before or after their visits.
- Allowing members to opt-out or change their level of participation at any time during the program.
- Estimates of Return on Investment (ROI).
- Improved outcomes and member satisfaction.

After a member is contacted by a care coordinator, the care coordinator will be required to perform ongoing assessments. Should a member need help with arranging hospitalization services; the care coordinator will help arrange those services. A member may also be given a referral from a behavioral health specialist on the ICT, who contacts the member directly, and provides information on behavioral health resources convenient to their geographic location.

Nearly half of the dually eligible have some combination of physical and behavioral health co-morbidities. Behavioral health is an important component of the integration of care for the dual eligible population, due to its continuing presence in the co-morbidities (including substance abuse issues) and must be given special attention, or risk being omitted from traditional primary care services. Currently, both SoonerCare and Medicare have limited behavioral health services and rely heavily on acute psychiatric hospitalization, outpatient treatment and pharmaceutical services. The implementation of a care coordination model with such a focus ensures that initial assessments address behavioral health concerns and that case managers and care coordinators have access to and are knowledgeable about the importance of behavioral health services, and that they be made available through the service system. It is also imperative to ensure 24/7 staff availability to authorize certain behavioral health services through the vender using family members/caregivers and non-medical staff to support members in connecting with community-based resources that will help stabilize needed links to alternatives to hospitalization, emergency room dependency and episodic crisis. Exactly how the care coordinator will work with the community mental health services will be specified in the contract agreement with the vendor(s). Prospectively, the care coordinator will refer the member to the appropriate mental health service available in the community. Through community programs such as Programs of Assertive Community Treatment (PACT) or Systems of Care and other community resources, the member can be referred to help discontinue the cycle of inpatient hospitalization.

OHCA will oversee all of the processes (of selected vendors by way of a risk based contract) that are necessary for a comprehensive range of integrated services for people who are dually eligible. Project staff will oversee the procurement process and subsequent contract award and development; the implementation of the care coordination process; the development of the information services platform to support the care coordination process; the selection and implementation of the software and member service tracking system and monitoring all project activities and their impact upon and progress toward project outcomes.
A major focus of the design work will be to continue to leverage Medicaid and merged data sets; to obtain stakeholder input from beneficiaries, advocates, providers, insurers, and academics; and to conduct actuarial analysis to solidify estimates of shared savings to include in the financing structure.

Vendors/Contractor(s) who are delivering the care coordination services will be supported by predictive modeling software, which will be used to stratify populations, assist in designing interventions and determine the appropriate intensity of interventions, based on the risk assessment for each participant. One of the software systems available and utilized for some of the programs in SoonerCare is the MedAI system. This system is used for population management, physician profiling and measurement, clinical surveillance, outcomes analysis, and predictive analytics. Under the Care Coordination services program, MedAI may be used to identify members with the most complex and comorbid illnesses among other functions. Although the contractor is not required to use the MedAI software system, and may use a system of its own, MedAI is being used within current OHCA care management systems, and is an established software program with the ability to support sound clinical and financial decisions. MedAI's website describes its strength as a provider of analytics for healthcare[9].

The Atlantes Case Management System is established as the proven system for tracking, documenting members' participation, progress, and providing data that helps determine if modifications need be made to their plan of care. Atlantes is designed for multiple professional users to access health records, and a care coordinator can obtain a combination of responses electronically, if a face-to-face meeting is not warranted for the decision about the members' care. This system supplies case managers and care coordinators with the necessary tools to prepare and intervene for all at-risk members. For example, care coordinators will receive claims data after a patient has visited their doctor, or ER allowing a care coordinator to review orders of a test to be run, claims information, member history information, PCP information, etc. This information will help a care coordinator along with the ICT to develop an action plan for the member. Atlantes has the capability to help complete assessments, determine areas of concerns, develop a treatment plan, monitor outcomes, and report savings. It supports the overall coordination of care among various disciplines to promote high quality care with cost-effective outcomes. The different types of Case Coordination and Management (Atlantes Levels of Care) are: Care Management; Behavioral Health; Disease Management; and Non-Medical Management. Additional levels of care can be added as needed.

Atlantes can assist with data collection and tracking, and the development of a comprehensive set of quality metrics that will be used to record activity and assess performance at all levels. Using Atlantes, vital information can be shared as medically warranted, and the care coordinator can support the member in a number of different ways without being employed by the same organizational entity that provides medical care, as long as there is a close linkage between the medical and other components that comprise effective care coordination. Atlantes has the ability for a care coordinator to note all active engagement by the member, family and others involved with the healthcare of the member.

[9] http://www.medai.com/.

As in most cases, the awarded vendor may use other software processes, but will be obligated to meet (at a minimum) the standards already established in the state's existing care management programs. In regards to the care coordination services, Atlantes will be available for the care coordinator to access the history or background information of the member. Once this information has been reviewed, the care coordinator will have the ability to meet with the other team members including the member and the individual's family to ensure services are not duplicated and to refer or link appropriate services to the member through the developed care plan. Information from Atlantes will also be used to track progress and update ongoing services. MMIS is used in Atlantes for tracking adjustments, claims, finance information, displaying information to determine level of care, pharmacy usage, provider visits, and contracts on a member's account.

The care coordination services are the only new services being added and these services will be contracted out to vendors. At this time modifications are not anticipated to be needed within the current infrastructure. OHCA staff will oversee the care coordination services provided by the vendor through contract management and current audit procedures, quality evaluation measures and monitoring cost savings.

In determining what is the most vital service to benefit the dual population- research was performed and concluded that care coordination proved to be viable with effective clinical foundations and shared factors that build on existing services. Studies conducted regarding care coordination and evidence based practices models in Appendix D show seven common key elements:

1. Build rapport and trust with members and their families/caregivers via an average of one contact in person per month for the care coordinator to be considered an important part of their care team.
2. Members who prove not to benefit from care coordination are those who pose too low or high of risk for hospitalizations to have an impact on a two to four year follow-up on frequencies of readmissions.
3. Members need to be educated on how to take their medications.
4. To reduce short term readmissions, the care coordinator worked in conjunction with local hospital staff to provide programs with timely information on patients to manage transitions.
5. Care coordinators and physicians communicated often regarding member's cases. Physicians that participated in the studies ensured space was available for the care coordinator and member to meet prior to or after health care appointments.
6. Members were given the choice to opt-out or change level of participation at any time.
7. In initiating contact, at least five attempts to contact members were made by the care coordinator.

The results of these studies vary in reference to dollars saved. The SoonerCare Silver model of care coordination will apply all of these elements to provide the best quality of services to members addressing chronic diseases such as congestive heart failure, diabetes, chronic obstructive pulmonary disease, coronary artery disease, stroke, depression, dementia/Alzheimer's, Arthritis, and Affective and other serious disorders. The Care Coordinator can assist with planning and arranging any tests, therapy, and other aspects of disease management that might currently be arranged by the member.

This chart shows how all components of a member's care will have to work together, with the Care Coordinator being the missing link between the member and any of these services.

Figure 3- Care Coordination Flowchart

Stakeholder Engagement and Beneficiary Protections

The dual eligible demonstration project began with stakeholder meetings where project staff unveiled the timelines and intent of the demonstration project. The stakeholder group then divided into workgroups that had smaller, focused sessions, regarding the project design. Since September of 2011, dual project staff members have been seeking partners across the state of Oklahoma, including, but not limited to, people who are dually eligible; family members and advocates; organizations whose membership includes dual eligible members; advocacy groups, service providers and organizations, government staff, elected officials and anyone who has an interest in the design of a service delivery model for people who are dually eligible for Medicare and Medicaid[10].

The stakeholders work groups are designed to ensure that a spectrum of viewpoints be represented. Project staff members also see that the work of different workgroups be coordinated, that members of workgroups are aware of the related tasks and recommendations of other workgroups, and those principles that support the overall project be met. Below shows Stakeholder Meeting dates and location(s):

1st Stakeholder Meeting	September 29th, 2011	Boldt Construction Center
2nd Stakeholder Meeting	November 30th, 2011	Metro Technology Center
3rd Stakeholder Meeting	January 19th, 2012	OHCA
4th Stakeholder Meeting	March 22nd, 2012	OUHSC College of Allied Health
5th Stakeholder Meeting	April 20th, 2012	OU Tulsa Campus (Tulsa, OK)
6th Stakeholder Meeting	May 3rd, 2012	Cameron University (Lawton, OK)
7th Stakeholder Meeting	May 14th, 2012	National Weather Center (Norman, OK)

Workgroups were assembled into four groups. They are: All things Communications; Care Coordination; Behavioral Health; and Financing Strategies and Quality Outcomes. These subsequent meetings were held on the alternate months of our Stakeholder Meetings. The majority of our workgroup meetings took place at OHCA.

[10] A complete list of invitees and participates can be found at http://www.okhca.org/providers.aspx?id=13291

Two Member Focus group meetings were held in the month of February.

Member Focus Group Meeting	February 15th, 2012	Golden Corral Restaurant
Member Focus Group Meeting	February 28th, 2012	Oklahoma Dept. of Mental Health

Different sites were chosen in order to make the locations convenient for all attendees. The stakeholders and workgroup invitations were sent by e-mails, corresponding newsletters, various events and tribal consultation board meetings. In addition, we were invited to speak at quarterly Inter-Tribal Health Boards, Tribal Consultations and appeared as guests to numerous Tribal nations to give an overview of the demonstration design proposal. The member focus group meetings were initiated through our community partners from various behavioral health centers, housing assistance agencies, and community mental health centers. This proved to be very effective and gathered excellent feedback for our member's group meeting. These interactions allow OHCA to maintain and create relationships with stakeholders, gaining their valuable input as to the design and implementation of projects and programs serving the citizens of our state.

People with grievances and/or appeals are to use the same process that is available for all SoonerCare members. Complaints are to be addressed to the SoonerCare helpline. Appeals are to be submitted directly to the OHCA using the process outlined on page 3 of the Member Handbook, written in English and in Spanish. Appeals are used to address a member's denial of services or treatment, as requested by their provider. A phone number is provided and addresses are provided for written submission appeals[11].

OHCA hosts its annual board retreat along with health partners, advocacy groups, legislators and other stakeholders to focus on planning and development strategies, policy procedures, discussion of agency upcoming enhancements, agency goals, and agency challenges. These meetings help guide and set the strategic plan for that specific year. Leading up to the annual event, OHCA staff conducted numerous formal and informal discussions with stakeholders across the state.

The planning and development unit of the agency, on a daily basis, conducts large and small workgroups, ad hoc meetings, task oriented small groups, open meetings, etc. all for the purpose of seeing the planning process through to implementation. The planning and development unit is comprised of project managers tasked with gathering experts both inside and outside the agency to design and oversee implementation of high priority projects. This effort requires substantial buy-in and involvement of many stakeholders.

Steering committees will replace the monthly stakeholder meetings and continue to engage the involvement and support around the agency and outside partners. It is anticipated that this project will seek out involvement of partners by invitation to an initial meeting to discuss the opportunity, and then follow the processes already set forth by OHCA which convenes a large working group, smaller sub-groups tasked with specific solution gathering, and ad hoc discussions/meetings.

After proposal submission, OHCA and the awarded vendor will continue updates of the project through email, web updates, and attending Tribal meetings. Stakeholders will have continuing opportunity to provide feedback, starting with their comments about the program design, and thereafter. Upon implementation, stakeholder meetings will resume as members will be asked to continue as advisors to dual eligible implementation, and staff members will continue to seek input from members on a

[11] http://www.okhca.org/publications/pdflib/SC_handbook.pdf

scheduled basis, along with other OHCA advisories that have beneficiaries as members. According to OHCA's public information office, "a number of voices help to shape SoonerCare programs and policies."

The Medical Advisory Committee was established to advise the OHCA about health and medical care services and make recommendations on: Policy development and program administration; financial concerns related to the administration of the agency; Information related to the management, and operation of OHCA. It has a wide range of professional representation as well as consumers and other state agency representation. See Appendix E for Advisory Sub -Committees

Staff will also continue to use the website to provide updates, exchange information and receive feedback about the project. http://www.okhca.org/providers.aspx?id=13291.

Financing and Payment

OHCA is pursuing the managed Fee-For-Service model, and the state is fully committed to identifying the resources needed to enter into an agreement by which the State will be eligible to benefit from savings thereto. OHCA is researching methods to overcome the challenges of the upfront investment in care coordination until the state is eligible for a retrospective performance payment from resulting savings to Medicare. The care coordination model will be designed to create savings while meeting or exceeding established quality thresholds for the Medicare-Medicaid enrollees in the program.

Oklahoma's dual eligible population enrollment continues to increase, as is indicated by increasing Medicare and Medicaid enrollment figures. At a growth rate of approximately 3.5% per year, increasing enrollment figures are matched by increasing costs, and it seems a logical conclusion to examine increasing enrollment and associated costs for potential opportunities to reduce the cost of services. OHCA has recently commissioned detailed data and claims analysis for services to people who are dually eligible.

PHPG is a national consulting firm specializing in the design and implementation of innovative health care initiatives for government-sponsored/funded programs. PHPG has been hired by OHCA to review Medicare and Medicaid claims, and has analyzed claims for SFY 2010 through 2011. Based on their most recent computations of crossover claims, Medicare spending for people who are dually eligible in Oklahoma for SFY 2011 year was $1,336,053,852. Medicaid spending for people who are dually eligible in that time period was $686,058,529. Because these amounts are Medicaid payments of Medicare premiums and inpatient stay cost paid by Medicaid not covered by Medicare, without the full range of Medicare costs, these figures are only a portion of the actual Medicare costs for the period of time described. Preliminary analysis (crossover claims only) suggests that an integrated care model creates potential for significant savings in many of the areas that have historically been cost drivers for the target population. Targeted for reduction are the areas of inpatient hospitalization visits, outpatient visits, and emergency room services. The identification of such areas is supported by patterns of expenditures in most states; by a review of evidenced based and effective practices (as indicated in the current care coordination model literature).

Chart 2-Oklahoma Expenditures Summary

	Medicare	Medicaid	Total
Inpatient	$395,776,818.40	$33,079,505	$428,856,323.40
Outpatient	$131,925,606.10	$10,486,050	$142,411,656.10
LTC	$87,950,404.08	$429,903,442	$517,853,846.08
Prescriptions	$322,484,815.00	$2,213,584	$324,698,399.00

Physicians	$117,267,205.40	$40,168,064	$157,435,269.40

High-level analysis of the target population's use of these services indicates that better coordination and management of these members could yield significant savings. Initial savings projections are derived from overall Medicare expenditures in the initial years, but more specific and ongoing data analysis will have to take place to effectively identify available cost savings and projections for subsequent years. Ongoing claims analysis, after the service has been rendered and paid, along with predictive modeling that can be used in advance of service delivery can identify specific areas (diagnoses, activities, risk factors, et al) where cost savings may be achieved.

Chronically Ill Dually Eligible SoonerCare Members: All Dual Members
Per Member Expenditures and Utilization (CY 2009)

Diagnostic Category	PMPM Spending	Total IP Admissions	Total OP Visits	Total SNF Days	Total Physician Visits
1. Acute Myocardial Infarction	$6,373	3,262	9,467	13,688	8,769
2. Chronic Kidney Disease	$5,895	1,882	9,895	11,393	8,301
3. Other Psychotic Disorders	$5,746	1,525	8,301	12,564	5,053
4. Developmental Disorders	$5,531	440	5,071	2,091	4,691
5. Heart Failure	$5,102	2,870	8,515	38,409	5,928
6. Substance Related Disorders	$5,036	1,763	8,246	3,312	9,917
7. Lung Cancer	$4,990	2,164	10,373	5,877	12,287
8. Colorectal Cancer	$4,962	1,614	9,616	6,560	10,598
9. ADHD	$4,960	1,323	7,528	7,271	5,420
10. Other Depressive Disorders	$4,853	631	4,929	1,846	6,339

These high cost today are costs OHCA would expect to see a certain threshold of savings in the first year due to Care Coordination.

A number of additional variables need to be more fully analyzed in the demonstration design phase to refine savings estimates, to reflect program design decisions, to determine adequate enrollment levels, and to better target medical interventions. A holistic care coordination program will ultimately encompass more than a person enrolling in the program. The high prevalence of behavioral health conditions will also influence the nature of the care coordination program where a similarly high rate of co-morbidity exists, care managers often must address the member's behavioral health needs before seeking to improve their physical health and chronic care self-management skills[12]. The first year of the project addresses the introduction of care coordination in an integrated services model. In future years, the contracted vendor will be responsible for using clinical practices that more effectively prevent or reduce unnecessary hospitalizations and readmissions and avoidable emergency department visits[13].

[12] PHPG.
[13] Massachusetts Health and Human Services offices of Medicaid 2011

With the current fiscal climate resulting in limited state funding, the OHCA has decided to seek a risk based contract with an outside vendor or vendors who will provide care coordination services and receive payment based on Medicare savings. This will be accomplished by releasing a request for proposal (RFP) to pursue the award of a contract for care coordination services with a qualified vendor(s). The OHCA intends to pursue a three-way contract between OHCA, CMS and the vendor(s). The vendor(s) will receive payment from CMS upon meeting required milestones, savings and quality measures determined by CMS and OHCA.
The RFP will discuss in detail how the care coordination program will actually operate. After the RFP has been released, the OHCA will better be able to determine if the contract will be with one single vendor, or smaller regional vendors. The SoonerCare Silver program is intended to be statewide covering all full benefit dual eligibles.

Expected Outcomes
The statistics and reporting unit at OHCA will work with refining collection and reporting of data to CMS. Program data is organized and distributed monthly via "Fast Facts." Member satisfaction will be tracked as a requirement of the vendor. Our Quality Assurance Department monitors claim accuracy and utilization of all OHCA programs. Using our proven effective methods to track data on key metrics related to the care coordination program ensures beneficiaries receive high quality care for the purposes of evaluation by CMS.

After extensive review of literature, SoonerCare Silver expects to improve outcomes of the following services: Emergency Room visits, hospital readmission rates, inpatient expenses, outpatient expenses, prescription expenses and physician visits. All services will be reported monthly, along with methods of reporting measures. Components from the review of literature will be incorporated into the care coordination program to reasonably presume some suggested savings. In a randomized trial of care management offered over the phone, we expect to see a 10% reduction annually in avoidable hospital admissions with the dual eligible population. Evidence from a comprehensive geriatric assessment, discharge planning, discharge support and education proved effective in reducing costs to overall patient services. Hospital readmission rates are expected to be reduced by about 20%. Heart failure education from a care coordinator should show savings of 50% annually, considering a study by the University of Michigan Hospital who reported improvements in clinical outcomes in patients with chronic heart failure due to discharge. This study showed improvements in clinical outcomes in patients with chronic heart failure due to discharge education. Implementing care coordination could reduce emergency room visits annually by 5%. Studies also support evidence that show blood pressure measures likely to decrease 1.31% across the total population. All of these contribute to better health outcomes and overall lower expenditures

Based on results from current SoonerCare programs, initially, a care coordinator actively promoting adherence to pharmacologic regimens and use of appropriate drugs may increase pharmacy costs. However, after three years, with care coordination overall reduction in prescription coverage is likely to occur. Through care coordination, follow-up care on new medications and usage of durable medical equipment will be established within 2 days of a doctor's prescribed order. Care coordination hopes to show the following outcomes and results as outlined in Table 6.

Table 6- Predicted Outcomes and Results in order to generate savings

Outcome	Results
• Increase member participation in health literacy and medical adherence	• Increased member scheduled appointments with PCP • Increased kept appointments with PCP

Outcome	Results
• Increased member participation in disease –specific education and self-directed care	• Increased number of action plans being followed
• Increase in primary care provider use and expenditures. increased expenditures in year 1 , year 2, and leveling off in year 3	• Increased PCP services, fewer repeat tests and lab work. • No change in annual expenditures
• Increase in physician specialty use with decreased expenses	• Decrease in total expenditures related to physician specialty services
• Decrease in avoidable emergency room use- decreased expenses in year 1 and subsequent decreased visits by people who are dually eligible	• Decrease in total avoidable ER expenses
• Decrease in hospital admissions and readmissions (within 30 days, 60 days, 90 days)	• Decrease in re-admissions after 30days • Decrease in re-admissions after 60 days • Decrease in re-admissions after 90 days
• Increase in institutional long-term care (Medicare skilled nursing days	• Better management of overall health for duals • Fewer duals managing care though avoidable ER
• Increase in home- and community-based service use and expenditures.	• Increase in HCBS expenditures

Analysis of the target population's use of these services indicates that better coordination and management of these members could yield significant savings. Initial savings projections are derived from overall Medicaid expenditures in the initial years, but more specific and ongoing data analysis will have to take place to effectively identify available cost savings and projections for subsequent years. Ongoing claims analysis, after the service has been rendered and paid, along with predictive modeling that can be used in advance of service delivery can identify specific areas (diagnoses, activities, risk factors, et al) where cost savings may be achieved. Based on current spending and applying anticipated cost savings Table 7 shows the total dollars that could be saved by applying care coordination.

Table 7- Anticipated Savings Based Off Of Current Spending

Services	Total Spending	% quality outcomes	Yr. 3 for RX	year 1	year 2	year 3
Inpatient	$428,856,323.40	0.05		$21,442,816.17	$21,442,816.17	$21,442,816.17
Outpatient	$142,411,656.10	0.03		$4,272,349.68	$4,272,349.68	$4,272,349.68
LTC	$517,853,846.08	0.03		$15,535,615.38	$15,535,615.38	$15,535,615.38
Prescriptions	$324,698,399.00	0.05	0.1%	$16,234,919.95	$16,234,919.95	$32,469,839.90
Physicians	$157,435,269.40	0.05		$7,871,763.47	$7,871,763.47	$7,871,763.47

Infrastructure and Implementation

The state's infrastructure involves the Oklahoma Health Care Authority as the primary single agency for the Oklahoma Medicaid (SoonerCare) program. OHCA is the primary division in the state of Oklahoma heading and controlling costs of state-purchased health care. OHCA has the capacity to oversee multiple million dollar contracts. OHCA plans to outsource services to an external vendor(s) so additional OHCA staffing will not be required.

The contracts division of OHCA will go through the Department of Central Services (DCS) to arrange for the release an RFP that supports the provision of services for the care coordination program. Contract vendors interested in the RFP will have guidelines to follow regarding adherence to documentation. This will include member notification, assessments, and deadline requirements. The selected contracted vendor(s) in communities throughout the state of Oklahoma will be responsible for

day to day operations of the proposal demonstration services. Vendor(s) will also be tasked to manage enrollments, budget/finances, and data analysis for Medicare and Medicaid to measure effectiveness to lower costs and ensure quality of care of services. Vendor(s) will be responsible for hiring prospective staff to include:

- Program Management
- Nurse Care Coordinators
- Social services workers
- IT staff
- Administrative staff

Due to no new services proposed in the SoonerCare Silver plan, no Medicaid and/or Medicare rules have been identified as needing to be waived to implement this program. OHCA will work with CMS to determine if any amendments are needed to current waivers or rules. Otherwise, existing waiver service programs will remain the same through the 19159(c) waiver and HCBS waivers.

There are no plans at this time to expand to populations other than the dual eligible members and the SoonerCare Silver program will not focus on a subset of individuals. OHCA will be including all full benefit duals in the 77 counties in the state of Oklahoma except for those areas covered by the THIZ, PACE and the ICS. In this demonstration, it is intended to communicate the expectation that the program is created to enhance the options available especially to individuals who have no type of care coordination services as part of this initiative to provide pertinent and invaluable information to all ages.

The work plan/timeline is detailed in appendix D.

Feasibility and Sustainability

The State of Oklahoma is experiencing the economic downturn that has been experienced recently by most states. The Oklahoma State budget is currently experiencing a $600 million dollar shortfall. From all indications, funding for new programs is unavailable, and requests for legislative funding would be considered untimely. Long term implementation of the dual eligible project will rely solely on the costs savings projected through the reductions available through implementation[14].

Project staff members have designed a detailed process for the implementation of a care coordination program for people who are dual eligible. OHCA will have a financial challenge to effectively implement the project that will require funding for three primary components very early on. Those components are: 1) development and testing of the MMIS platform for data tracking and monitoring for dual eligibles services; which would include adding Medicare data 2) funding for the award of care coordination RFP; and 3) funding for outreach to hospitals and other primary care providers about people who are dual eligible and their patterns of hospitalization. If cost projections are accurate, and the first payment to OHCA (based on costs savings) is 18 months after implementation, it will be difficult for the agency to sustain the project budget for that period of time without additional funding.

There will be no statutory or regulatory changes needed with the state to move forward with implementation. Care coordination services may have an impact on services already in the state plan and within waiver administration.

Startup dollars are needed to ensure the appropriate changes in the Information Technology platform that will manage dual eligible enrollment, tracking systems and data collection systems. New dollars will be needed to develop a system that responds to dual eligibles and enrolls them into the new system,

[14] Office of the Governor Mary Fallin 2012

and maintains a secure database to access information about their dual eligible activity in the service delivery system. Although health services to those who are dually eligible will be funded by the projected costs savings from streamlining the current system, dollars are needed to build and maintain a platform for services to the duals, and administer the program for the eighteen months until the first reimbursement payment.

The dual eligible model can be used elsewhere as it provides services to people who are Medicare and Medicaid eligible. In Oklahoma, serving the target population involves the state Medicaid authority, OHCA, for administration of the payment system; the state's mental health authority, ODMHSAS, for the behavioral health services delivery system; the department of human services, OKDHS for member enrollment and eligibility determination, and for the waiver services delivery system; and the state health department (OSDH) for oversight of Medicare ADvantage services. The project will have significant impact and state level agencies in any state should be able to use the care coordination program to deliver a complex range of services.

Principles of care coordination are universal, in that all people who are managing their care can use assistance at some time. As a result of the care coordination program, people who are dual eligible in Oklahoma will benefit from universal principles of being more fully engaged in, more fully informed about, and having new opportunities to access the system that manages their health care services.

Interaction with Other HHS/CMS Initiatives

Partnership for Patients: Better Care, Lower Costs

The Oklahoma Hospital Association (OHA) is participating in the Partnership for Patients: Better Care, Lower Costs striving to improve the quality and safety, and affordability of health care for all Americans. There are two goals OHA is working to achieve:

- **Keep patients from getting injured or sicker.** By the end of 2013, preventable hospital-acquired conditions would decrease by 40% compared to 2010. Achieving this goal would mean approximately 1.8 million fewer injuries to patients with more than 60,000 lives saved over three years.
- **Help patients heal without complication.** By the end of 2013, preventable complications during a transition from one care setting to another would be decreased so that all hospital readmissions would be reduced by 20% compared to 2010. Achieving this goal would mean more than 1.6 million patients would recover from illness without suffering a preventable complication requiring re-hospitalization within 30 days of discharge.

OHCA will work with the OHA and Hospital Engagement Networks to identify solutions to reduce health care acquired conditions, and work to spread these solutions to other hospitals and health care providers. Along with identifying solutions OHCA will help develop collaborative learning for hospitals to improve patient safety.

HHS Action Plan to Reduce Racial and Ethnic Health Disparities

OHCA's outreach to Native Americans has been nationally recognized by the Center for Health Care Strategies (CHCS) for reducing racial and ethnic disparities in Medicaid managed care. OHCA continues to build on key actions steps that include:

1. Enhancing the integration of the missions of offices across the Department to avoid the creation of silos.
2. Aligning core principles and functions with the goals, strategies, and actions presented in the HHS Disparities Action Plan.

OHCA has representatives who are active participants in the national workgroup that is addressing "Improving Health Care Quality for Racially and Ethnically Diverse Populations," to ensure programs provide quality health care to racial and ethnic populations while improving health disparities.

Concept #2- The Tulsa Health Innovation Zone

Executive Summary

The dually eligible population represents a group of members who present with complex care needs spanning clinical, mental health, and social services. To address key barriers to care, the University of Oklahoma School of Community Medicine (SOCM) proposes a multi-tier approach focusing on 1) the redesign of the practice to incorporate behavior health and care coordination services, 2) the inclusion of population level clinical analytics to facilitate the management of the population, 3) the use of community level integrated care plans 4) the development of community level evidence based protocols to manage chronic disease, and 5) the integration of these methodologies into graduate medical education.

Combined, the instruments and methods described herein represent a paradigm shift in how health care is delivered to complex beneficiaries. This proposal describes not only how to impact clinical outcomes, but also how to address overlooked behavioral and social confounders which often silently and negatively affect health status. The inclusion of novel community level tools such as a Health Information Exchange and associated analytics, a community wide Integrated Care Plan, the adoption of population level protocols for the management of chronic disease, and the corresponding integration of these methods into the graduate medical education system establishes a firm foundation upon which to begin the transformation of the future of healthcare delivery.

Table 1: THIZ Overview Chart

Target Population (All full benefit Medicare-Medicaid enrollees/ subset/etc.)	Those Medicare-Medicaid members who receive primary care services through participating practices.
Total Number of Full Benefit Medicare-Medicaid Enrollees Statewide	79,891
Total Number of Beneficiaries Eligible for Demonstration	Approximately 3,200
Geographic Service Area (Statewide or listing of pilot service areas)	Tulsa, Oklahoma and surrounding region
Summary of Covered Benefits	multi-tier approach
Financing Model	PMPM Payment
Summary of Stakeholder Engagement/Input (Provide high level listing of events/dates—Section D asks for more detailed information)	THIZ Stakeholder Meetings: July 2011 to February 2012 Provider Focus Group: August 2011 Focus Group/Interview: September to December 2011 Ben Focus Group Life Senior Services: September 2011 Dual Finance & Governance Meeting: November 2011 Proposal Posted for Public Comment: April 20, 2012
Proposed Implementation Date(s)	July 2013

Background

The dually eligible population represents a group of members who present with complex care needs spanning clinical, mental health, and social services. Members present in primary care, often with three or more comorbidities. These members require extended coordination of care and in many instances benefit from more frequent and intensive primary care visits. Often, the complexities of a mental health diagnosis complicate clinical care in the primary care setting and in many instances result in unnecessary hospital admissions from the emergency department, extended hospital stays. Poor

coordination between primary care and behavioral health remains a major barrier to care. Further, members often lack sufficient access to social, long term, and home and community based support services which directly affect quality of life and ability to comply with their prescribed care plans. The integration of primary care, behavioral health, and care coordination and case management services are necessary to address gaps and barriers to care present in the current health system.

While lack of effective coordination across the spectrum of care presents as a primary barrier, the clinician's lack of access to data about the entirety of the members' clinical history or current clinical utilization limits presents as a confounder in the clinician's ability to provide timely and appropriate care. The introduction of a community wide health information exchange will assist in addressing this issue. Clinicians will have timely (real time or next day) knowledge of their patients who present at the emergency department, admit or discharge from the hospital, or present across the community with other complex or acute health needs. Clinicians would then have the ability to schedule timely follow up visits to ensure continuity of care. Further, primary care physicians will have an enhanced capability through the use of electronic tools to assist in the management of complex diseases and identification of those in need of preventive services. Such a system lends itself to the development of a mechanism to coordinate member care plans of providers across the community.

Historically, providers develop care plans for their patients, based on perceived clinical needs. Each provider often acts alone, unable to coordinate plans of care with specialist physicians and non-provider clinicians, who may be actively co-managing the patient. In addition, communication amongst providers across the community participating in the care of an individual is limited. Medications and orders often change from specialist to primary care and vice-versa. In many instances these changes to the care plan are not communicated back to the original prescribing provider. Additionally, ancillary services such as physical therapy, hospice, durable medical equipment organizations, vision, dental, adult day health, speech therapy, respiratory therapy, occupational therapy, as well as environmental modification, personal care, and other social service agencies have limited if any ability to communicate back to the prescribing physician. The lack of a unified care plan for provider coordination presents as a substantive barrier to care. The development of a community level integrated care plan is warranted to address this issue. Through such a mechanism the member's care plan would be centrally held within the community health information exchange and, ideally, managed by the member's primary care physician. Evidenced based protocols for the management of chronic disease shall be incorporated into the integrated care plan tool to ease in the facilitation of its use across the community.

Those individuals presenting with chronic conditions such as congestive heart failure, COPD, and diabetes directly benefit from the integration of evidence based protocols into their respective care plans. The ability to develop and manage such protocols requires a well-developed practice and the capacity to coordinate care across multiple lines of service. The introduction of chronic disease management protocols, (along with tools necessary to assess the efficacy of such protocols) has heretofore been unattainable in most settings. Such evidence based protocols should be developed and integrated into the clinical practice to maximize quality and lower cost.

While the barriers to care addressed above represent changes to a pre-existing healthcare delivery system, it is critical to focus on those key elements that will drive its future, the students and residents within the Graduate Medical Education system. These new providers represent the physician leaders of tomorrow. They will serve as primary change agents in their future organizations, demanding an environment, comparable to the one in which they were educated. The methods discussed above shall be tightly integrated into future curricula, fostering demand for a new paradigm in clinical education – in which advanced tools can be leveraged to provide better care for individuals and populations.

To address these key barriers to care, SOCM proposes a multi-tier approach focusing on 1) the redesign of the practice to incorporate behavioral health and care coordination services, 2) the inclusion of population level clinical analytics to facilitate the management of the population, 3) the use of community level integrated care plans 4) the development of community level evidence based protocols in the management of chronic disease, and 5) the integration of these methodologies into graduate medical education.

Success has been achieved through other similar programs within the state of Oklahoma. The University of Oklahoma, SOCM operates a population level intervention program for Medicaid members called the "Health Access Network". This program builds upon the existing statewide Patient Centered Medical Home Model, providing additional capabilities beyond those of most practices. The HAN contributes skills in health system design, chronic disease and population management, clinical analytics, epidemiology and biostatistics, care management, care coordination, and overall operational facilitation and training methodologies. Through this program, Medicaid primary care providers may enroll to receive services at which point all those members assigned to the providers' Patient Centered Medical Home program are eligible to receive services under the HAN. This program has been highly successful in expanding the capability of participating practices in caring for the populations under their purview. Currently, the HAN provides service for the Medicaid SoonerCare Choice population. The HAN model could easily be extended to support the dually eligible population within the state.

We propose a direct expansion of the Health Access Network. Under this model, the HAN's administrative function will allow for the enrollment and evaluation of primary care practices, specialty care practices and other facilities (long stay nursing facilities for example). Upon joining, those practices and facilities, along with those members attributed to them would become eligible for service and/or payment under this program. No exclusions to eligibility are planned or necessary.

Care Model Overview

Through the proposed program dually eligible members residing predominately within the Tulsa, OK region and who are identified as receiving care by practices and organizations participating in the Health Access Network shall be enrolled. To support members across the continuum of care, the Tulsa region provides three substantial health systems: two schools of medicine, an Office of the National Coordinator for Health IT funded Health Information exchange (MyHealth), two Federally Qualified Health Centers spanning six locations, a mature web of social services, a highly effective network of Home and Community Based Providers, numerous hospices, and other clinical, behavior, and social support service agencies. This network of medical and supportive services providers are brought together by this program to deliver comprehensive coverage for the dually eligible population.

Based on information obtained from a series of focus groups, one-on-one provider and patient interviews, CMS utilization patterns, as well as current evidence based best practices; the SOCM proposes a new care plan. The plan defines a multi-tier approach focusing on:

1) The redesign of the care team to incorporate behavioral health and care coordination services,
2) The inclusion of population level clinical analytics to facilitate the management of the population
3) The use of a community level integrated care plan
4) The development of community level evidence based protocols in the management of chronic disease,
5) The integration of these methodologies into graduate medical education.

Redesign of the Care Team:
SOCM proposes a program that patient-centered multi-disciplinary teams, focused on at risk, high cost dually eligible members. Teams are physician led, based on the specific needs of the member (Adult Primary Care, Pediatric, Psychiatric, or Palliative Care). Teams are comprised not only of individuals in traditional clinical roles (physician, nurse, physician assistant) but also behavioral health specialists, Pharmacists, and a patient centered Care Coordinator. The Care Coordinator serves as a central facilitator of the member's care, assisting in transitions of care between clinical, behavioral, and social settings. This key role serves to ensure all necessary transitions of care are completed successfully and outcomes communicated back to the team participants. Most members will need brief, infrequent Care Coordination visits, but a small number of patients with complex needs will require regular, 'high-touch' interventions. A 'tiered' system will be developed to determine the degree of services members require. A proposed care coordination tier model follows:

Tier 1: members who have few complications and require minimal to no care management.

- Intervention consists of tracking patient referrals and transitions of care, on-line consultations and automated health reminders for annual or recurring tests or procedures due for all Members. The MyHealth HIE will be utilized to identify care needs and alert the provider to send notices to the Member.

Tier 2: members with multiple chronic care needs.

- Tier 2 is a hybrid criterion set developed from evidenced-based programs such as Eric Colman's Care Transitions Intervention (CTI) and Mary Naylor's Care Transitions Model (CTM). The eligibility criteria factors in a root cause analysis of Tulsa hospitals Medicare Beneficiary readmissions. A major focus of the model is to reduce the number of hospital readmissions by managing disease more effectively, while addressing clinical and behavioral concerns, and improving access to social, community and home based support services. Such interventions will improve quality of life for individuals and better health for populations. This program would allow the scaling of intervention intensity in direct relation to the acuity of the members condition in addition to an analysis of the members risk using clinical data from the MyHealth Health Information Exchange (HIE).

Population Level Clinical Analytics:
Utilizing the MyHealth HIE, providers will determine which members require preventive services such as immunizations and wellness exams. Timely reminders will be sent, encouraging visit scheduling. Cloud applications will provide evidence-based decision support for managing targeted chronic diseases. Auto-reminders will be sent to PCPs and Care Coordinators to assure that best practices are being followed. The Pentaho business intelligence tool will be used to determine if the interventions are achieving desired quality and adherence standards.

Community Level Integrated Care Plan
At the core of the proposed Care Coordination model is a written Integrated Care Plan (ICP). Composed of discreet sections pertaining to the physical, emotional and social well-being of the member, the ICP captures and summarizes all pertinent information that can be shared across medical disciplines. Like many electronic health records, the ICP lists medical problems, updated medications, allergies, and the primary/specialty physicians providing care for the member. The ICP aggregates and communicates not only traditional clinical data, but goes a step further by focusing on the patient's desired health goals, listing actions plans for each stated goal. For example, a diabetic patient may list "reading better" and "walking daily" as two principal health goals. Therefore, the primary physician will narrow his focus on improving the patient's glycemic control and preventing vascular complications. Meanwhile, the Care

Coordinator will assure the patient is referred to ophthalmology and physical therapy, thus reducing the symptoms of retinopathy and neuropathy respectively. The Care Coordinator will regularly review progress with the primary physician and the patient, constantly readjusting aspects of the ICP to best meet changing health care needs. Stakeholder and member focus groups indicate that when patients, physicians and family members are aligned toward explicit care goals facilitated by a coordinated ICP, health quality will improve, costs will fall, and the experience of care will improve.

Long term support and Community Based Services:

Care Coordination services under this program will bridge the gap between acute care and home and community based and long term care services. Members coping with the effects of chronic illness or disabilities often need long term monitoring and assistance with disease self-management, activities of daily living and social issues. To effectively carry out our plan, we must engage with community social service agencies, mustering their support for this proposal. We have already invited a large number of stakeholders to participate in the planning process, including representatives from mental health services, elder care, FQHC's, housing organizations, transportation programs, and local Native American Tribal leaders. Their feedback has been invaluable, allowing us to better shape our efforts toward providing better health care for our population. With the local community's backing, care Coordinators will be able to deliver the full spectrum of services across the healthcare continuum, which includes those members receiving long term care. Eligible members will be linked to the state's home and community based long term care services system (HCBS) ensuring patients can remain safely in their own homes for as long as possible. Care Coordinators will facilitate transitions of care amongst those residing in nursing facilities to assure safe transitions and adequate follow up care. Integrating acute and long term care services through Care Coordination closes a critical loop in delivering efficient and quality health care.

Evidence Based Protocols

Evidenced-based guidelines will be developed for targeted chronic conditions including heart failure, diabetes, and COPD. All participating primary care physicians and care coordinators will follow the same standard protocols, ensuring that high risk patients receive long-term, personalized care. Tulsa will develop integrated care teams working with patients to 1) coordinate care and establish better information sharing among multiple caregivers; 2) encourage shared-decision making to ensure patients are empowered to manage their care, 3) encourage treatment adherence, and 4) avoid unnecessary hospitalizations, readmissions and emergency room use. An Evidence-Based Tool kit recommending best practices will be made available for the physicians and care coordinators that includes, but is not limited to, recommended tests, treatments, checklists, medication reconciliation tools, care delivery strategies and specific care coordination service delivery expectations. Protocols will be evaluated and monitored by a committee composed of the program staff, and participating practice care teams. This group will meet as needed on a regular basis to establish new protocols as well as review outcomes and recommend revisions to existing protocols.

Graduate Medical Education

As practice environments evolve, newly graduated student and resident physicians must shift from practice models based on volume to ones based on quality and value. It is incumbent upon medical school educators to integrate the tools and methods necessary for graduating physicians toward accomplishing the 'Triple aim' of improving the health of individuals, improving the health of populations, while reducing overall cost. The SOCM proposes the integration of the tools and methods described above into new curricula, preparing the next generation of physician leaders to serve as visionary change agents within their chosen organizations.

Combined, the instruments and methods described herein represent a paradigm shift in how health care is delivered to complex members. This proposal describes not only how to impact clinical outcomes, but also how to address overlooked behavioral and social confounders which often silently and negatively affect overall health status. The inclusion of novel community level tools such as Health Information Exchange and associated analytics, a community wide Integrated Care Plan, and the adoption of population level protocols for the management of chronic disease establishes a firm foundation upon which begin the transformation of the future of healthcare delivery.

Stakeholder Engagement and Beneficiary Protections

Stakeholder Engagement: Stakeholders in Northeastern Oklahoma as well as state leaders participated in the planning of this proposal. Numerous engagements were held; various planning and work groups formed to design the proposed plan. To better gage ways to accomplish our goals, we held focus groups to solicit member feedback. Throughout the operation of the proposed program stakeholders will continue to be engaged to solicit feedback and guidance. Recommendations for change based on the outcomes of the various engagements are incorporated within this proposal. Dates of engagements follow:

Meeting	Data
Tulsa Health Innovation Zone Stakeholder Meeting (IHCRC)	07/14/2011
Tulsa Health Innovation Zone Stakeholder Meeting	07/27/2011
Provider Focus Group	08/12/2011
Tulsa Health Innovation Zone Stakeholder Meeting	08/18/2011
Focus Group/Interview	09/07/2011
Focus Group/Interview	09/14/2011
Focus Group/Interview	09/15/2011
Focus Group/Interview	09/16/2011
Dual Eligible Focus Group Life Senior Services	09/27/2011
Dual Eligible Stakeholder Meeting Oklahoma City	09/29/2011
Dual Finance & Governance Meeting	11/02/2011
Focus Group/Interview	11/07/2011
Focus Group/Interview	12/08/2011
Tulsa Health Innovation Zone Stakeholder Meeting	12/16/2011
Tulsa Health Innovation Zone Stakeholder Meeting	02/06/2012
OHCA Dual Eligible Stakeholder Meeting	03/22/2012

In order to assess the efficacy of the proposed Care Coordination model, planning members engaged Dual Eligible members within the community. Dual-Eligible members were visited in their homes to determine the presence of gaps in care among members and their caregivers. Physician uptake of the Care Coordination program was also examined.

Through focus groups our members told us:

1) They believe there is poor communication between Medicare and Medicaid,
2) They believed they could help lower costs if they were more involved in managing their care,
3) They felt a care coordinator at the local level would be helpful, especially as an advocate.

These results and others shaped the design of the proposal.

Our findings have demonstrated the following conclusions:

1) A disconnect exists between the advice offered by physicians in the office, and the execution of such recommendations at home.

2) Barriers exist to medication reconciliation – including poor home delivery management systems, costs of drugs, uncertainty of why certain drugs are prescribed, and lack of oversight by physicians and pharmacists.
3) Uncontrolled symptoms, including chronic pain, dyspnea, and asthenia often lead to poor quality of life.
4) Debilitating depression and anxiety are poorly treated by the health care system; the lack of non-pharmacologic therapies (e.g. counseling) is particularly underutilized.
5) Physicians may recommend at-home Physical Therapy and Nutritional Counseling for their patients – but actual execution of such programs does not occur at reliable rates. Such failures in coordination are often not communicated back to the prescribing physician.
6) Some members are eligible for government benefits (Medicare, Disability, etc.) and social service support but often lack the knowledge/resources to take advantage of such services.
7) Specialist physicians are treating patients and recommending therapies for their patients without the knowledge/coordination with the primary care physician.
8) Electronic Health Records are capturing many health care interventions (diagnoses, medications, laboratory results) inaccurately. Locating needed results through the EHR is not intuitive, and can be time-consuming for care coordinators and providers. A central, normalized system is necessary to aggregate and standardize health information across the community.
9) When asked, patients/caregivers often have their own stated goals for their health – which remain unknown to their providers.
10) Primary care physicians have little knowledge of what occurs once patients leave the office. Physicians' understanding of their patients' goals, intervention programs, and medication regimens remains poorly understood.

Based on these experiences and observations, we make the following recommendations:

1) Care Coordination is essential to carrying out and relaying recommendations made by all providers to benefit patient care.
2) Care Coordination provides a mechanism for all providers to share recommendations with each other.
3) Targeted patients should have an integrated care plan clearly delineating the patient's goals of care. The Care Coordinator can capture the ICP.
4) A pharmacist will be essential to ensuring medications are reconciled properly.
5) Most patients will need brief, infrequent Care Coordination visits, but a small number of patients will require regular, high-touch interventions. A 'tiered' system will be developed to determine the level/extent of services patients will require.
6) It is estimated that a small number of patients will not benefit from Care Coordination due to excessively high levels of dysfunction (substance abuse, familial discord, poor impulsive behavior.)
7) Care Coordinators should be co-located, and affiliated with physician offices, where they can be integrated with office personnel and operational systems.
8) Information Technology and EHR systems will need to be examined, and retooled when appropriate, to ensure that data is shared among providers and coordinators.
9) Even when patients are located in close proximity, Care Coordinators can most likely conduct no more than four to six homebound (or six to eight facility visits) visits per day.
10) Regular follow-up of all recommendations, interventions, and programs must be reviewed by the Care Coordinator, and shared with providers. Instructions should be evaluated and retooled on a routine basis to help patients (and their caregivers) progress toward their stated goals in the ICP.

Description of Protections: Primary care physicians and care coordination providers shall adopt a patient-centered, population health-based approach to coordinating and delivering care to members. Providers shall actively engage members, families and caregivers in culturally sensitive shared decision making, and require individualized care plans for high-risk members that incorporate strong linkages to community resources. Quality and safety of care are upheld while applying evidence-based clinical recommendations, clinical decision-support tools, performance measures and active participation of members in decision making. Members receive written materials regarding exercising the complaint and grievance process and are encouraged to express their concerns without fear of reprisal.

Services are provided to members without discrimination as to race, color, religion, sex, national origin, language, sexual orientation, disability or age. Information shall be made available to Members in languages other than English to include, but not limited to Spanish. Members have access to care, timely post-hospitalization follow up appointments, same day urgent care appointments within normal hours of operation, after-hours access by telephone and may use new communication systems to facilitate coordination of care. Members are involved to the greatest extent possible in the development and implementation of their care plan. Care plans incorporate family, friends, and community resources to further enhance and strengthen their support, and promote their own self-care, independence, culture and autonomy.

Primary care physicians and care coordination providers are committed to providing the highest quality medical care, which is often delivered in office based practices and, in some cases, at home, avoiding unnecessary hospitalizations and readmissions and emergency room visits whenever possible.

Practice standards as well as policies and procedures are in place and are philosophically grounded by member rights that support individual empowerment independence, and guided self-care.

Financing and Payment

The program proposes a Medicare per member per month payment that will range from $20 to $198 risk adjusted based on a three year retrospective look at three years prior claims data and hierarchical condition category (HCC) scores. In year three of the initiative, PBPM payments are to reduce by 20%. Starting from year three, providers may receive a return of up to 50% of saving achieved to reflect efficiencies gained and shift reliance to accountable forms of payment. Practices will receive core function support from the Health Access Network as described below and have discretion to use this enhanced, non-visit based compensation to support non-billable practitioner time, augment care teams (care managers, community health workers social workers, pharmacists, nutritionist, behaviorist) through direct hiring or community health teams, and/or invest in technology or data analysts.

Expected Outcomes

The Tulsa region will utilize the MyHealth® HIE to monitor, collect and track data on key metrics related to the model's clinical quality, access to care, patient and caregiver engagement, utilization of services, and cost outcomes for the target population. Member experience will be reported by participating practices through CAHPS surveys delivered through the practices' standard business operations. Reports will be communicated to participating providers and stakeholders to motivate continued best practices and adoption of methods that achieve improved results. Performance will be trended over time to provide a longitudinal view of performance.

The following measures will be used to assess efficacy of the model:

Name of Measure	Standard	Target
Comprehensive Diabetes Care: HbA1c Control (<8%)	NQF 0575	
Diabetes Measure Pair: A Lipid Management: Low Density Lipoprotein	NQF 0064	

Name of Measure	Standard	Target
Cholesterol (LDL-C <130, B Lipid Management: LDL-C <100		
Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility	NQF 0097	
Drugs to be Avoided in the Elderly: A) Patients who receive at least one drug to be avoided B) Patients who receive at least two different drugs to be avoided	NQF 0022	
Reduce Unnecessary Specialty Referals	MyHealth 14	5% Reduction
Decrease the time required for patients to receive an initial review from specialty care	MyHealth 15	
Decrease time from visit request initiation to scheduling of specialist visit (not the actual visit, but the time at which the appointment is made)	MyHealth 16	
Visit scheduled within requested timeframe	MyHealth 21	
Decrease Admissions for Asthma	MyHealth 25	5% Reduction
Decrease Admissions for COPD	MyHealth 26	5% Reduction
CHF Admission Rate	NQF 0277	5% Reduction
Decrease ED visits for Asthma	MyHealth 28	5% Reduction
Decrease ED visits for COPD	MyHealth 29	5% Reduction
Decrease ED visits for CHF	MyHealth 30	5% Reduction
All- Cause Readmission Index (Risk Adjusted)	NQF 0329	
30 Day Readmission CHF		
CAHPS Patient Satisfaction Survey		

The program expects to effect a reduction in combined risk adjusted Medicare / Medicaid spending for the population enrolled. The PMPM payment will support the redesign of the clinical practice, care coordination, analytics other services necessary to support the effective implementation of the program and associated care model within participating practices.

Infrastructure and Implementation

Tulsa proposes an extension of the state's Medicaid Health Access Network (the HAN) currently in place. The HAN provides focused care management, care coordination, and care transition services as well as population health services for a subset of the Medicaid population within the state. The HAN further provides detailed analytics on the Medicaid population enrolled and facilitates improvements in care. The HANs existing administrative and operational capabilities will allow for rapid implementation and assessment of the program. Further, aligning incentives between this program and the Medicaid Health Access Network provides an economy of scale for CMS, the state of Oklahoma, and the provider implementing practice change. To accomplish these tasks, the following measures will be undertaken:

- Existing infrastructure shall be expanded to support additional care management capacity and metrics unique to this proposal.
- All participating practices shall follow guidelines promoted by the patient centered medical home model.
- Each practice shall participate as a member of the MyHealth HIE which provides practice and provider level quality metrics.

Each of these preexisting programs bolsters a combined infrastructure and facilitates uniform adoption of standard processes across practices. Timelines are addressed within the master timeline (*see the included appendices)*

Feasibility and Sustainability

While existing statutory and regulatory limitations as well as actions taken by the state now or in the future may impact the ability to implement the program described, the SOCM will defer to those issues

discussed within the overall state proposal, section one of the combined proposal. Further, SOCM defers to the state regarding state funding actions.

Models similar to the model proposed have been successfully implemented within the Medicaid Health Access network program throughout the state. The HAN operated by the University of Oklahoma School of Community Medicine has a current enrollment of 39,000 members. As enrollment increases, additional economies of scale are achieved, allowing for higher efficiency and productivity. This program follows a similar model - which is equally scalable. The proposed model can easily be expanded to support additional populations and service areas as necessary.

A proposed timeline for implementation is included within the appendices.

Interaction with Other HHS/CMS Initiatives

The OU School of Community Medicine has adopted an, "all in" approach to CMS initiatives to improve care for individuals and populations. As such, many HHS/CMS initiatives have been awarded either to the community, or a community partner of the University. Programs which may positively impact the effective implementation of this proposal are described below:

Awarded:
Office of the National Coordinator Beacon Community Program, MyHealth – community partner
Comprehensive Primary Care Initiative – Tulsa Region

Submitted:
CMMI Innovation Challenge, MyHealth – community partner
Implementation of a community wide care coordination tool and a FFS payment to assess the impact of its use.

CMMI Innovation Challenge, Western New York – national partner
3 Beacon proposal to assess impact of a FFS payment for Medication Therapy Management in community

Pending Submission:
3026, MyHealth – community partner
Program to reduce 30 day readmissions across the community
Initiative to Reduce Avoidable Hosp. Among Nursing Fac Res, Tulsa Health Innovation Zone – community partner

Concept #3- ICS Demonstration Model

Table 1: ICS Demonstration Model Overview Chart

Target Population (All full benefit Medicare-Medicaid enrollees/ subset/etc.)	All full benefit Medicare-Medicaid enrollees age 45 and older living in the geographic region of proposed ICS site.
Total Number of Full Benefit Medicare-Medicaid Enrollees Statewide	79,891
Total Number of Members Eligible for Demonstration	22,332
Geographic Service Area (Statewide or listing of pilot service areas)	In the Oklahoma City or Lawton metropolitan areas and a rural area of the state.
Summary of Covered Benefits	All existing Medicare and Medicaid health benefits currently available to members enrolled in a PACE program

Financing Model	Capitated model
Summary of Stakeholder Engagement/Input (Provide high level listing of events/dates—Section D asks for more detailed information)	Full Stakeholder Meetings: July to November 2011 Presentations August 2011 thru April 2012 Stakeholder Proposal Review Session: March-May 2012 Proposal Posted for Public Comment: April 20, 2012
Proposed Implementation Date(s)	July 2013

Background

The vision of the OHCA is to build upon the foundation of an established and successful integrated care program. The PACE model is centered on the belief that it is better for the well-being of seniors with chronic care needs and their families to be served in the community whenever possible. PACE is a federal program designed to keep elders living in their homes, connected with their communities and out of nursing facilities. It combines services of an adult day health center, primary care office, and rehabilitation facility into a single location. PACE provides an all-inclusive and comprehensive continuum of care designed to maintain and ideally to improve the quality of life for the elderly. The current PACE model has been somewhat limited in its ability to have exponential growth. There are 86 operating PACE programs in 29 states[15]. There are approximately 25,000 PACE participants. Although, PACE has a twenty year history of being a proven model of integrated care and financing, it has not seen the spur in growth desired.

There is currently one PACE program in the state of Oklahoma. Cherokee Elder Care is the first and only PACE program sponsored by a Native American tribe. Cherokee Elder Care is available to eligible individuals living within the five surrounding counties of Tahlequah, Oklahoma. Cherokee Elder Care has a current enrollment of 100 participants. Approximately 96% of the participants are eligible for both Medicare and Medicaid. Cherokee Elder Care participants have demonstrated improvement in health as a result of being frequently monitored, having input in their managed care plan, and living with as much independence as possible within the community. Cherokee Elder Care has also shown significant savings to the state. With 100 participants, the state of Oklahoma saves approximately $103,587 a month or $1,243,044 a year.

Oklahoma believes that PACE is the foundation upon which to build. Therefore we are proposing to establish a design that utilizes the solid infrastructure of the PACE model and includes some modifications that would enhance its ability to achieve the aim of better care, better health, and increased cost- effectiveness. The proposed design, entitled Integrated Care Sites (ICS), will protect the integrity of the current PACE model, but will enhance its ability to improve the quality of life for substantially more people than it currently has the ability to reach and serve.

There are approximately *105,538* individuals eligible for Medicare and Medicaid in the State of Oklahoma. Those individuals eligible for both Medicare and Medicaid who are at least 45 years of age or older and reside in the Integrated Care Sites defined geographic service area will be eligible to participate in the proposed plan. The proposed demonstration would specifically exclude individuals who are dually eligible and younger than age 45. The demonstration will also exclude individuals who are dually eligible and do not reside in the specified service area of the ICS. OHCA seeks to pilot the ICS demonstration in the metropolitan areas of Oklahoma City and/or Lawton and in at least one other area of the state. Chart 3 below shows the number of individuals eligible in Oklahoma City, Lawton and three rural areas that have a high concentration of duals. In addition to including those eligible for both

[15] NPA, 2012

Medicare and Medicaid, those individuals who exclusively have Medicare or Medicaid and may also be eligible for the ICS program.

Chart 3- ICS Eligible Duals

Location	Number of Duals Age 45+
Oklahoma City, Oklahoma	11,255
Lawton, Oklahoma	1,568
Cleveland County	3,730
Muskogee County	3,128
Leflore County	2,651

Care Model Overview

The ICS model will include the following modifications/flexibilities to the traditional PACE model:

Eligibility Modifications/Flexibilities

- Eligibility for the ICS would be expanded to those who are aged 45 and older.
- Eligibility for the ICS will not be contingent on an individual meeting nursing facility level of care as defined by the state.
- Eligibility for the ICS would require a person to have at a minimum two or more complex and chronic medical conditions as well as some functional limitations as determined by at the minimum meeting Personal Care level of care.

Operational Modifications/Flexibilities

- The ICS model will allow the Interdisciplinary Team (IDT) to be configured based on the needs of the individual participant with the core members remaining constant. Core members include a Primary Care Physician, Registered Nurse, and Social Worker.
- The ICS model will allow for the use of nurse practitioners to collaborate with physicians as consistent with state law and have the ability to meet the current PACE requirements related to assessments, care planning, and providing primary care to participants.
- The ICS model would also allow for greater flexibilities in regard to settings where services are provided to participants.

The overall goal in proposing the aforementioned flexibilities is to provide expanded scalability potential and growth of the traditional PACE model. In May of 2012 a query was ran which showed there are approximately 66,456 full benefit dually eligible individuals who are age 45 or older in the state of Oklahoma. The proposed modification to lower the age of eligibility to age 45 has the potential of allowing more individuals the ability to be eligible for the program. Modifying the age of eligibility will allow the states to utilize the ICS model as a broader solution for addressing the needs of a larger proportion of the dual eligible population. At the core of the traditional PACE model is the notion of preventive care services. The proposed modification of eligibility no longer being contingent on an individual's ability to meet nursing facility level of care will allow for greater emphasis being placed upon preventive care services. The state hopes that by intervening earlier, it will be possible to improve care and better manage the use of Medicare and Medicaid covered services provided to these individuals, as well as prevent or delay nursing facility eligibility for some portion of individuals who would otherwise eventually require nursing facility care.

The state believes that it will take both eligibility and operational changes to accomplish the goal of expanding the growth and capacity of the traditional PACE model. Therefore the OHCA is proposing that ICS organizations be allowed to configure the IDT based on the needs of the individual participant with the three core members (PCP, RN, and MSW) remaining constant. This proposed modification

would parallel the nature of the ICS model as being a participant centered model. The smaller core team with requirements to add additional team members as determined necessary on the basis of the participant's individual health needs has the potential to enhance program efficiency without compromising quality of care. The OHCA also proposes an expanded role for Nurse Practitioners as consistent with state law. The state of Oklahoma is primarily a rural state which makes employing PCPs a challenging exercise. Traditional PACE growth has been stifled by this challenge as well, as growth is limited by the PACE center's ability to hire PCPs. The expanded use of nurse practitioners as consistent with state law could effectively resolve the challenges of finding PCPs. The state proposed operational modification of greater flexibilities in regard to settings where services are provided is not intended to eliminate the need for a physical ICS location. The intent is to allow the ICS organization to assure the provision of all necessary services through an expanded network of contracted providers, including adult day health care center, senior centers, etc. Start-up costs and the capital needed to construct a building are very costly and is a barrier to many organizations to becoming PACE providers. This modification will give those organizations the flexibility to contract with an adult day health center or senior center and begin serving participants while in the process of constructing a building, or in absence of constructing a building, that comprises both a clinic and adult day health center.

OHCA plans to pilot the ICS model in Oklahoma metropolitan areas as well as more rural areas of the state where a high concentration of individuals who are dually eligible reside. OHCA does not intend to mandate that the pilot ICS programs include all of the proposed modifications, rather that each pilot program, in consultation with the state, would encompass at least two of the modifications requested. The ICS will serve individuals living in the specified geographical areas where the demonstration is being piloted. The process of specifying the geographic area will occur through consultation with the ICS provider. The specified geographic service area may be identified by county, zip code, street boundaries, census tract, block, or tribal jurisdictional area.

Individuals who meet the Age, Blind, and/or Disabled category of Medicaid eligibility are enrolled in the Medicaid program at their county Department of Human Services (DHS) office. This same office also helps those individuals enroll in the Medicare program, if they have not met the automatic qualifications for Medicare enrollment. The DHS workers also serve as enrollment brokers as they inform the members of the options of services and programs available to them. For example those individuals who reside in the service area of the Cherokee Elder Care PACE center are told about the option of PACE along with the other HCBS the individual may qualify for.

Enrollment in the ICS program will be dependent on the ability of persons to meet the eligibility criteria. The eligibility criteria for the ICS program will be as follows:

- An individual must be 45 years of age or older
- An individual must live in the defined service area
- An individual must be eligible for both Medicare and Medicaid and/or eligible for either Medicare or Medicaid exclusively
- An individual must at a minimum have two or more complex and chronic medical conditions as well as some functional limitations, at the minimum meeting State Plan Personal Care Level of Care
- An individual must be able to safely reside in the community at the time of enrollment as determined by the ICS provider

Upon verification of program eligibility, the individual will be scheduled to undergo an evaluation period where they will be assessed by the IDT. The IDT will meet after the completion of the evaluation, discuss their assessment, and develop a plan of care for the individual. After the plan of care

is developed, an enrollment conference will be convened. During the enrollment conference, the ICS staff will review the plan of care and the individual will have the opportunity to discuss any concerns with the plan of care. Following this discussion, the enrollment agreement will be reviewed and signed by the individual, thereby establishing the individual's enrollment in the program.

The ICS Model will utilize a seamless integrated benefit design. The ICS will be accountable for the delivery and management of all covered medical and LTSS for their participants. ICSs will employ or contract with providers that will deliver team-based integrated primary and behavioral health care to program participants. The ICS will also be responsible for coordinating the care of participants across providers. The ICS will arrange for the availability of care and services by specialists, hospitals, and providers of LTSS and other community supports. Integration will extend to all administrative processes, including outreach and education, customer service, and grievance and appeals.

The ICS will be all- inclusive benefits and services models. All services and benefits offered through Medicare will be available to participants as well as all benefits offered through Medicaid. All services and benefits deemed to be necessary for participant care by the IDT will be provided. The services that are excluded will be any service that is not authorized by the IDT, unless it is an emergency service. A more in depth description of items and services included in the benefits package can be found in Appendix G.

The ICS model will utilize the infrastructure and foundation of the proven PACE model. The PACE model is an innovative, fully-integrated provider of care for the frailest and most costly members of society. The PACE model's focus on prevention and wellness has resulted in health improvements and cost savings. PACE participants also express high satisfaction with their care and experience less pain, fewer hospitalizations, less likelihood of depression, and many other health benefits, all at reduced cost to the Medicare and Medicaid programs.

In a study of effective models of care for older patients with chronic illness, PACE is identified as a comprehensive, primary care model with great potential to improve quality of care and quality of life for its patients, in part due to the presence of four critical processes[16]. Those four processes are the development of a comprehensive patient assessment that includes a complete review of all medical, psychosocial, lifestyle and value issues; creation and implementation of an evidence-based plan of care that addresses all of the patients health needs; communication and coordination with all who provide for the care of the patient; and promotion of patients' and their family caregivers' engagement in their own health care. A national evaluation of PACE found higher quality of care and better outcomes among PACE participants compared to HCBS clients[17]. PACE participants reported: better self-rated health status; better preventive care, with respect to hearing and vision screenings, flu shots, and pneumococcal vaccines; fewer unmet needs; less pain interfering with normal daily functioning; less likelihood of depression; and better management of health care.

PACE provides comprehensive care management through its interdisciplinary team with the objective of improving participants' quality of life, health and outcomes while avoiding unnecessary care and costs. A 2005 study found that PACE participants have low risks of long term nursing home placement. The risk of admission to a nursing home for 30 days or longer was 14.9% over a period of 3 years. Fewer than 20% of PACE participants spent more than 30 days in a nursing home over the course of their

[16] Boult, C. (2010). Comprehensive primary care for older patients with multiple chronic conditions: "Nobody rushes you through." Journal of the American Medical Association, Vol. 304, No. 17, pp. 1937-1943.

[17] Leavitt, M. (2009). Interim Report to Congress: The Quality and Cost of the Program of All-Inclusive Care for the Elderly. U.S. Department of Health and Human Services.

enrollment[18]. PACE participants also experience fewer hospitalizations and fewer re-hospitalizations than their counterparts in other Medicaid funded programs. The hospital rate for PACE participants in 2009/2010 was 43% lower than the rate for dual eligible recipients of Medicaid home and community based services and 24% lower than dual eligibles receiving Medicaid nursing home services. The 30 day re-admission rate in PACE was 17% lower than the national readmission rate for 65+ dual eligible members in 2008[19]. These numbers are notable given the significantly higher acuity of PACE participants.

Stakeholder Engagement and Beneficiary Protections

The PACE expansion component of the dual eligible demonstration project was of great interest to a variety of entities across the State of Oklahoma. Through the stakeholder engagement process, we garnered the attention of some who had previously shown interest in PACE and enlightened individuals who were unfamiliar with the PACE concept. Stakeholder contacts were made through e-mail, phone, and referrals from stakeholders. Meetings were held throughout the state of Oklahoma in an effort to gain the insight of individuals throughout the state. We held numerous group meetings, attended and spoke at various board and advisory committees, and conferences. We also had two member attended focus groups. Multiple follow-up visits were made to groups who expressed increased interest and had additional questions. All of our meeting dates and locations are shown below. A detailed overview of stakeholder meetings can be found in Appendix H.

Central Oklahoma Economic Development District, Aging Services	July 21st, 2011	Shawnee, OK
Tulsa Health Community Leaders	August 1st, 2011	Tulsa, OK
Daily Living Centers	August 2nd, 2011	Oklahoma City, OK
Citizen Potawatomi Nation	August 3rd, 2011	Shawnee, OK
Kiamichi Economic Development District of Oklahoma	August 4th, 2011	Wilburton, OK
Share Medical Center	August 9th, 2011	Alva, OK
Eastern Economic Development District	August 11th, 2011	Muskogee, OK
Metropolitan Better Living Center	August 12th, 2011	Oklahoma City, OK
St. John's Metropolitan Baptist Church	August 16th, 2011	Oklahoma City, OK
Ada Senior Care Center	August 17th, 2011	Ada, OK
Morton Comprehensive Health Care	September 1st, 2011	Tulsa, OK
Wyatt F Jeltz Senior Center	September 8th, 2011	Oklahoma City, OK
Chickasaw Health Administration	September 12th, 2011	Ada, OK
Full Circle Senior Adult day Center	September 20th, 2011	Norman, OK
Shawnee Senior Center	September 21st, 2011	Shawnee, OK
Chickasaw Nation Sovereign Medical Solutions	November 1st, 2011	Ada, OK
Alva Senior Nutrition Center (Focus Group Forum)	August 9th, 2011	Alva, OK
Wyatt F Jeltz Senior Center (Focus Group Forum)	September 29th, 2011	Oklahoma City, OK

Below are dates of presentations made to advisory committees, boards, seminars, and supplemental meetings attended.

Via Christi HOPE PACE Center	August 18th, 2011	Wichita, KS
OHCA Board Retreat	August 24th, 2011	Tulsa, OK
OHCA SoonerCare Tribal Consultation Annual Meeting	October 12th, 2011	Shawnee, OK

[18] Friedman, S., Steinbach's, D., Rathoutz, P., Burton, L., & Mukamel, D. (2005). Characteristics Predicting Nursing Home Admission in the Program of All-Inclusive Care for Elderly People. The Gerontologist, Volume 45, No. 2, pp. 157-166.

[19] Oelschlaeger, A. (n.d.). www.academyhealth.org/files/2011/sunday/oelschlaeger.pdf. Centers for Medicare and Medicaid Services

Medical Advisory Committee	November 16th, 2011	Oklahoma City, OK
Oklahoma City Area Inter-tribal Health Board Directors Meeting	January 10th, 2012	Oklahoma City, OK
County Health Department	January 12th, 2012	Oklahoma City, OK
Leading Age Oklahoma Annual Conference	March 13th, 2012	Oklahoma City, OK
Oklahoma City Area Inter-Tribal Health Board Meeting	April 10th, 2012	Talihina, OK

Each and every meeting presented a promising opportunity to gather new ideas and look at the challenges that are presented with the design of a PACE like model. Some of the common themes heard from stakeholders were the inability to afford program start-up and operations costs, not being able to provide services to many of the people currently served due to PACE eligibility restrictions, and the inability to provide the infrastructure of the PACE model (physical building consisting of both a clinic and ADHC and staff). Some of these common themes are directly addressed in the proposed design such as lowering the age of eligibility and removing the requirement to meet nursing facility level of care, so that organizations can continue providing services to more of their current members. Also, in response to the comments from stakeholders, the proposed design gives greater flexibility in where a participant can receive care. This flexibility will allow for greater provider creativity and ability to provide services to participants while a physical center is being established or in place of the establishment of a center that encompasses all of the current PACE requirements. The proposed design offers an opportunity to both members and organizations to receive and provide care that is both accessible and highly efficient.

The ICS will be responsible for establishing and maintaining a participant bill of rights. The bill of rights will be designed to protect and promote the rights of the participant. Examples of these rights are included in Appendix I. The ICS will also be responsible for establishing an internal grievance and appeals process. The ICS must establish a formal written process to evaluate and resolve medical and non-medical grievances by participants, their family members, or representatives. The ICS will have a formal written appeals process to address non-coverage or nonpayment of a service. If a participant is unsatisfied with the outcome of the internal ICS grievance or appeals process, he or she will have the opportunity to file a grievance or appeal directly to the OHCA. The OHCA will provide ongoing monitoring and oversight of the ICS internal grievance and appeals process.

Financing and Payment

The State will utilize the capitated approach to integration for Medicare-Medicaid enrollees for the ICS model. The State plans to enter a three-way agreement with CMS and the ICS provider. The ICS provider will receive a prospective blended payment to provide comprehensive seamless coverage.

Utilizing the capitated financial approach, payments will be made to ICS providers through a full-risk capitation payment type. CMS and the State will pay a blended payment to the ICS provider on a per member per month basis. The state intends to establish rates based on the identified participant sub-populations. Specifically, the state is proposing to set a standard rate for those participants who meet the minimum standard of at least two or more complex and chronic medical conditions as well as some functional limitations as determined by having met State Plan Personal Care Level of Care. The state will set another standard rate for those who do meet nursing facility level of care. The rate for the latter sub-group will include an increased amount to account for the cost of long term care services.

Expected Outcomes

The OHCA utilizes an array of systems that provide the landscape of its analytic capacity. One such program utilized by OHCA is MedAI The MedAI system is a risk navigation system that uses predictive

modeling to identify high-risk members and predicted costs associated with those members. Dual eligible members can be included in predictive modeling, grouping patients by disease state and chronic illnesses to direct more efficient care. The MedAI system also has the ability to track utilization, patient compliance, and provider efficiency. SoonerCare MMIS can support multiple enrollment, benefit and payment methodologies. Fully capitated managed care, partially capitated managed care and patient centered medical home delivery models can all be supported by the MMIS. Oklahoma's MMIS uses HP's Interchange claims processing system, which currently processes approximately 4 million claims per month for Medicaid and other Health and Human Services agencies in the state.

The following table displays the expected outcomes of the ICS demonstration. Expected outcomes are based on the outcomes that have been noted historically in PACE sites.

Table 8-ICS Expected Outcomes

Improvement Targets	Evidence	Measurement
Decrease in avoidable hospitalizations	Decrease in admissions after 60 days Decrease in admissions after 90 days Decrease in admissions after 120 days	10% Decrease 10% Decrease 10% Decrease
Decrease in Emergency Room utilization	Decrease in ER expenditures for target population	10% Decrease
Decrease in number of prescribed drugs	Decrease in number of drugs prescribed to target population Decrease in prescription drug expenditures for target population	5% Decrease
Increase in preventive care services	Increase in PCP visits	10% Increase
Increase in participant satisfaction with care	Increase in satisfaction as self- reported	10% Increase

Infrastructure and Implementation

OHCA is a multi-billion dollar agency with a total budget exceeding $4 billion dollars. In state fiscal year 2011, 968,296 Oklahomans were served by Oklahoma Medicaid programs. OHCA is among the top Medicaid agencies in terms of members served and total operating budget. OHCA expects to utilize a three-way agreement process for the proposed demonstration. OHCA will enter a contract agreement with CMS and the ICS provider organization.

OHCA will have to complete an 1115 Research and Demonstration application in order to implement the proposed demonstration. The 1115 Research and Demonstration process includes the states assurance that the proposal will be budget neutral, public posting and comment, public hearings to seek public input, tribal consultation, and submission of the application to CMS.

The OHCA plans to focus the initial implementation of the proposed program on the metropolitan areas of Oklahoma. OHCA will hope to replicate this program in other areas as the outcomes are measured and cost savings are achieved. Integrated Care sites design and proposal timeline is shown in Appendix I.

Feasibility and Sustainability

State funding is a significant challenge and could impact the ability to successfully implement the proposal. The proposed plan must be found to be budget neutral in order to receive the approval of the State to implement through an 1115 Waiver process. If the proposed plan is not found to be budget neutral, it will not be approved or implemented. As a part of the 1115 Research and Demonstration application process, legislative approval may be necessary to proceed with implementation of the proposed demonstration.

The State will release a Request For Proposal in an effort to discover an organization that has the ability and desire to make application to become an Integrated Care Site provider. While the demonstration is not limited to participation by the current PACE organization as an ICS, PACE organizations will be considered to meet the requirements for being an ICS because the PACE program agreement requirements address all of the ICS criteria for participation. For organizations not already operating as a PACE organization, an ICS application will be issued for new organizations to submit for the state and CMS to review. The RFP and application process will have to be completed before full implementation of the design can begin.

The proposed demonstration will utilize the infrastructure of the PACE program model. The PACE program model progressed from inception as a single site to a multisite demonstration. It then further progressed to a permanent part of the Medicare program and a Medicaid state plan option. The proposed demonstration will have the same potential as the PACE model it is built upon, to go from a single site demonstration to a multisite demonstration. The proposed program is a demonstration of the possibility increased program flexibilities give to the scalability of the current PACE model and has the potential of being replicated at other current PACE sites and new PACE or PACE – like sites in multiple states.

Attachments

Appendix A
Top 10 Costliest Conditions And PMPM Expenditures

The diagnostic categories that the vendor could see likely promises for members are Acute Myocardial Infarction, Chronic Kidney Disease, Colorectal Cancer, Coronary Artery Disease, Heart Failure, HIV/AIDS Lung Cancer Multiple Sclerosis, Other Depressive Disorders, Other Psychotic Disorders, Personality Disorders, Substance Related Disorders, and Tobacco Use[20].

Chronically Ill Dually Eligible SoonerCare Members: All Members
Total Enrollment and Spending (CY 2009)

Diagnostic Category	Members	% of Total Members	Member Months	Total Medicare/ Medicaid Spending
1. Hypertension	23,822	30.5%	272,405	$986,297,142
2. Hip/Pelvic Fracture	21,977	28.1%	247,839	$820,167,314
3. Depression	17,218	22.0%	189,530	$784,798,299
4. Diabetes	20,630	26.4%	234,990	$770,312,021
5. Ischemic Heart Disease	19,148	24.5%	222,493	$666,446,909
6. Chronic Kidney Disease	10,176	13.0%	110,146	$649,270,412
7. Coronary Artery Disease	11,186	14.3%	126,733	$602,992,307
8. COPD	13,813	17.7%	156,829	$531,799,390
9. RA/OA	17,850	22.9%	205,821	$525,563,980
10. Tobacco Use	8,964	11.5%	101,089	$425,495,983

Chronically Ill Dually Eligible SoonerCare Members: All Duals
PMPM Expenditures and Utilization per 1,000 Members (CY 2009)

Diagnostic Category	PMPM Spending	Total IP Admissions	Total OP Visits	Total SNF Days	Total Physician Visits
1. Acute Myocardial Infarction	$6,373	3,262	9,467	13,688	8,769
2. Chronic Kidney Disease	$5,895	1,882	9,895	11,393	8,301
3. Other Psychotic Disorders	$5,746	1,525	8,301	12,564	5,053
4. Developmental Disorders	$5,531	440	5,071	2,091	4,691
5. Heart Failure	$5,102	2,870	8,515	38,409	5,928
6. Substance Related Disorders	$5,036	1,763	8,246	3,312	9,917
7. Lung Cancer	$4,990	2,164	10,373	5,877	12,287
8. Colorectal Cancer	$4,962	1,614	9,616	6,560	10,598
9. ADHD	$4,960	1,323	7,528	7,271	5,420

[20] PHPG

Diagnostic Category	PMPM Spending	Total IP Admissions	Total OP Visits	Total SNF Days	Total Physician Visits
10. Other Depressive Disorders	$4,853	631	4,929	1,846	6,339

Appendix B
Medicare/ Medicaid Eligibility

Medicare	Medicaid
Generally, you are eligible for Medicare if you or your spouse worked for at least 10 years in Medicare-covered employment and you are 65 years or older and a citizen or permanent resident of the United States. If you are not yet 65, you might also qualify for coverage if you have a disability or with End-Stage Renal disease (permanent kidney failure requiring dialysis or transplant). Here are some simple guidelines: You can get Part A at age 65 without having to pay premiums if: • You already get retirement benefits from Social Security or the Railroad Retirement Board. • You are eligible to get Social Security or Railroad benefits but have not filed for them. • You or your spouse had Medicare-covered government employment. If you are under 65, you can get Part A without having to pay premiums if you have: • Received Social Security or Railroad Retirement Board disability benefits for 24 months. • End-Stage Renal Disease and meet certain requirements. While you do not have to pay a premium for Part A if you meet one of those conditions, you must pay for Part B if you want it. The Part B monthly premium in 2012 is $99.90. For additional details, see our FAQ titled: Note: You will be eligible for Medicare when you turn 65 even if you are not eligible for Social Security retirement benefits.	• Adults with children under age 18 • Recipients of the Temporary Assistance to Needy Families (TANF) program are automatically eligible for health benefits. • Adults with children under the age of 18 who do not receive TANF may, in some circumstances, also be eligible for medical services. • Children under age 19 and pregnant women. • Children under the age of 19 and pregnant women whose family incomes meet • Aged, Blind or Disabled • Individuals who are 65 or older are eligible if they meet the financial criteria. To be eligible for medical benefits in Oklahoma, a person will need to apply for and receive a disability determination from the Social Security Administration. To be considered disabled, a person must have a physical or mental impairment, disease or loss that appears reasonably certain to continue at least 12 months without significant improvement and that substantially impairs his/her ability to perform labor or services or to engage in a useful occupation. In addition, people eligible for Medicare Part A may qualify to have medical benefits pay their Medicare premiums, co-payments and deductibles as a Qualified Medicare Beneficiary (QMB), a Qualified Disabled and Working Individual (QDWI) or a Specified Low Income Medicare Beneficiary (SLMB). (Get more information about these programs). The recipient's monthly income and resources must meet guidelines. People who belong to the "aged, blind and disabled" group may also qualify for a State Supplemental Payment.

Appendix C
CMHC Service Areas

City	Program	Telephone
El Reno	**Canadian County Systems of Care** *comprehensive services support for children*	**405-262-3209**
Elk City	**Beckham County Systems of Care** *comprehensive services support for children*	**580-323-6021**
Lawton	**Parkview Supervised Apartments** *supportive residential program*	**580-357-7967**
Norman	**Thunderbird Clubhouse, Inc.** *psychosocial clubhouse*	**405-321-7331**
Norman	**Transition House, Inc.** *supportive residential program* **http://www.thouse.org**	**405-360-7926**
Oklahoma City	**NAMI Oklahoma** *advocacy group*	**405-230-1900**
Oklahoma City	**Oklahoma Mental Health Consumer Council, Inc.** *advocacy group*	**405-604-6975 or toll-free at 1-888-424-1305**
Oklahoma City	**Oklahoma County Systems of Care** *comprehensive services support for children*	**405-858-2880**
Oklahoma City	**Parents as Partners Oklahoma Federation of Families for Children's Mental Health**	**405-232-2796 or toll-free at 1-866-492-KIDS**
Oklahoma City	**University of Oklahoma Health Sciences Center , Department of Pediatrics** *screening for effects of prenatal substance abuse exposure*	**405-271-6824 Ext. 110**
Ponca City	**Kay County Systems of Care** *comprehensive services support for children*	**580-762-8121**
Poteau	**LeFlore County Youth Services** *youth crisis intervention*	**918-647-4196**
Tulsa	**Crossroads, Inc.** *psychosocial clubhouse*	**918-749-2141**
Tulsa	**Mental Health Association in Tulsa-Safe Haven** *services to homeless*	**918-585-3337**
Tulsa	**TAMI/NAMI Tulsa** *advocacy program*	**918-582-8264**
Tulsa	**Tulsa County Systems of Care** *comprehensive services support for children*	**918-495-0770**
Tulsa	**Tulsa Day Center for the Homeless**	**918-583-5588**

Appendix D
SoonerCare Silver Workplan/Timeline

Timeframe	Key Activities/Milestones	Responsible Parties
Feb 1 thru 29, 2012	Draft proposal document Analyze current OHCA programs that serve similar populations Review literature, and summarize effective care coordination models Identify evidenced based practices that best support care coordination models for OK duals	Dual eligible staff
Feb 1 thru Apr 20, 2012	Analyze Medicare and Medicaid data for significant themes and patterns of utilization Identify target population and service parameters for OK duals	Dual eligible staff PHPG consultants
Feb 27 thru Apr 20, 2012	Create draft dual eligible proposal	Dual eligible staff
Mar 15 thru May20, 2012	Draft proposal review Submit draft proposal to community partners, OHCA advisories, tribal partners and leaders Convene public comment session/post draft proposal on state website Respond to and incorporate public comments for draft proposal	Dual eligible staff Stakeholders
Mar 22 to May 20, 2012	Public comment period	Public
May 31, 2012	Submit proposal to CMS	Dual eligible staff
May 31 thru Jun 15, 2012	Determine requirements for implementation and start date Clarify potential rule changes and SPA's Finalize MMIS requirements for systems creating platform for enrollment, identification and data exchange Identify budget needs/budget neutrality	OHCA staff
May 31 thru Aug 15, 2012	CMS proposal review	CMS OHCA staff
June 15 thru Aug 15, 2012	Develop MOU with CMS Develop evaluation plan and major project goals and outcomes	CMS OHCA staff
Jun 1 thru Jul 30, 2012	Develop terms and conditions for RFP	OHCA staff
Aug 15 thru Sep 30, 2012	Finalize MOU with CMS Notify stakeholders and member community of fully executed agreement	CMS OHCA staff
Aug 1, 2012	Release RFP	OHCA staff
Sep 1 thru Oct 1, 2012	Review RFP responses and select proposal	OHCA staff
Dec 1, 2012 thru Feb 1, 2013	Finalize with MMIS about software requirements and standards for installation and implementation,	Dual eligible staff
Oct 31, 2012	Award contract	OHCA staff
Oct 31 thru Dec 31, 2012	Negotiate and finalize three way contract with vendor(s) and CMS	OHCA staff, vendor, CMS
Jan 1 thru Jul 1,	Hold implementation meetings to develop final project design and implementation	OHCA staff,

Timeframe	Key Activities/Milestones	Responsible Parties
2013	strategy.	vendor
Jul 1, 2013	Begin demonstration	OHCA staff, vendor

Appendix E
THIZ Workplan/Timeline

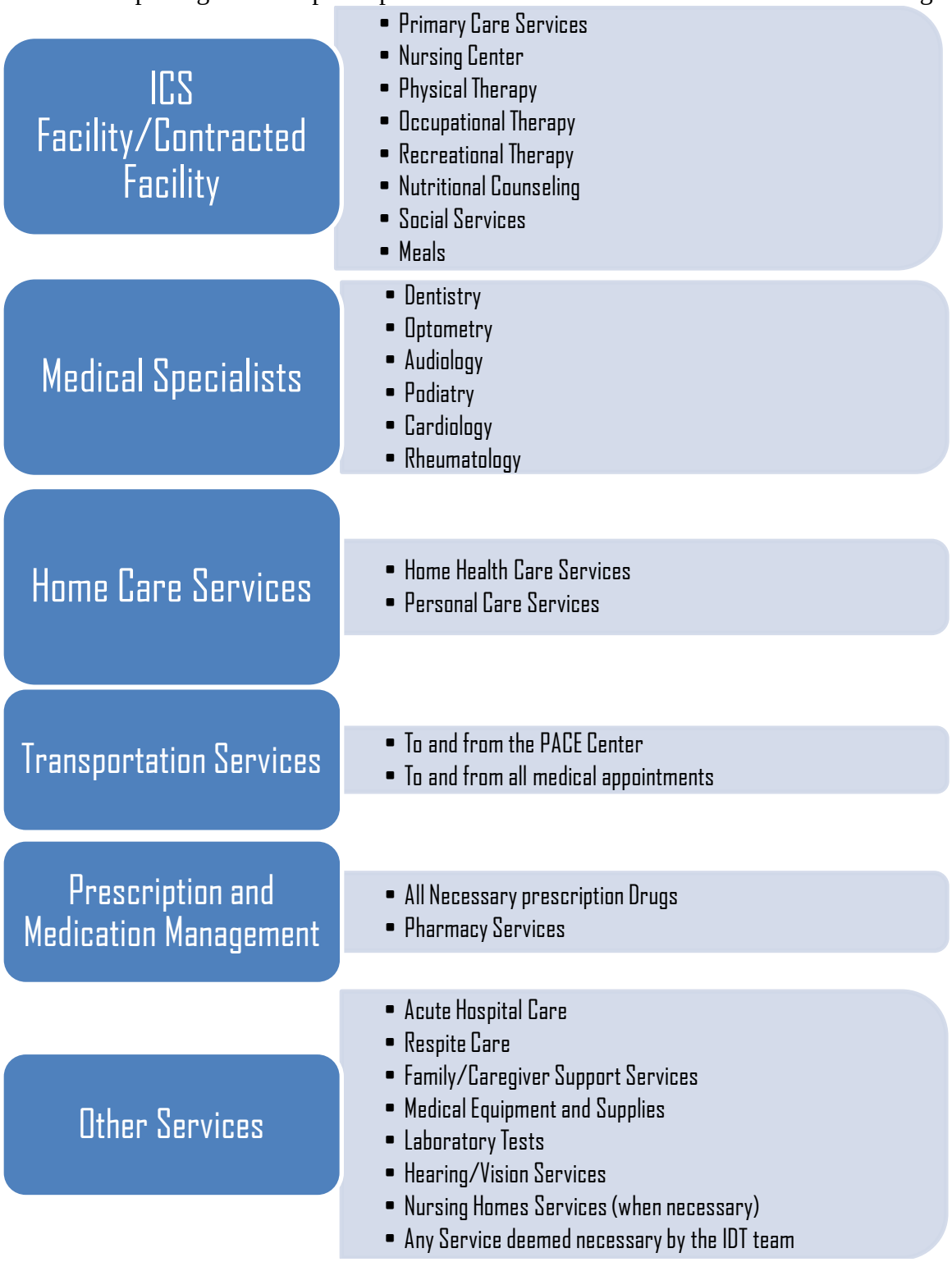
Timeframe	Key Activities/Milestones	Responsible Parties
Mar 12- Apr 20, 2012	Draft proposal review Submit draft proposal for initial dual stakeholder review Integrate stakeholder comments Respond to and incorporate public comments for draft proposal	OHCA/THIZ and Stakeholders
Mar 20- May 20, 2012	Public comment period	Public
May 31, 2012	Submit proposal to OHCA for CMS	THIZ
Apr 27 – Jun 15, 2012	Establish MyHealth HIE connection	THIZ
Jun 15- Jan 22, 2013	Develop Measures	THIZ
Jun 15- Oct 22, 2012	Develop Evidence Based Protocols	THIZ
Aug 23- Sep 23, 2012	Development of agreement	THIZ /OHCA
Sep 23- 30, 2012	Sign an agreement with OHCA	THIZ /OHCA
Oct 1-Nov 1, 2012	Develop project documents Revise timelines, develop job descriptions	THIZ
Jun 1- Dec 1, 2013	Hire project staff	THIZ
Jun 15- Jul 15, 2013	Begin demonstration	THIZ

Appendix F
Budget Requested for THIZ

Category	Position	Summary of Duties	% FTE	$
Staff	Project Manager	Project Management, program development, staff and contract supervision	1.0	$87,619
	Clinical Analyst	Develop new systems as necessary to support the implementation for the proposal.	1.0	$67,464
	Data Analyst	Develop metrics and measurement tools necessary for evaluation of the program.	1.0	$67,464
	Epidemiologist	Continuously evaluate ongoing efficacy of system. Make recommendations for change based on data available.	.5	$40,200
	Trainer	Develop curriculum and train participating organizations in fulfilling the model	1.0	$67,464
	Report Developer	Develop and produce reports to view and report measurement metrics.	1.0	$67,464
Sub-total Personnel				***$397,675***
HIE	Information Exchange	Health Information Exchange Access and analysis platform, data transfer and management		$100,000
Travel	Airfare, Lodging, per diem for required meetings Mileage for meetings	Use funds for state staff travel necessary to support the design activities and discussions with federal partners ,Quarterly Project meetings, community meeting mileage	3 staff @ 4 meetings Mileage	$ 22,000
Meetings	Member/Stakeholder Community	Regional meetings to introduce care coordination model, meals for guests, facilities		$ 40,000
Supplies and Materials		Member mailings, brochures, training materials, and publications		$ 10,000 $105,000
Sub Total Misc.				***$283,000***
Total				**$680,675**

Appendix G
Integrated Care Sites Benefits

The benefits package for ICS participants will include but not be limited to the following:



Appendix H
Detailed Description of ICS Stakeholder Meetings

Stakeholder Group	Central Oklahoma Economic Development District, Aging Services
Area	Shawnee – Pottawatomie and Seminole Counties
# of Attendees	7
Discussion Topics	• Overview of PACE • Overview of Duals Project • Cherokee Elder Care • Adult Day Center vs. PACE • PACE Enrollment • PACE Disenrollment • Availability of Partnerships
Feedback: Concerns/ Barriers/Interests	• Partnerships would avoid duplication services • Transportation is major barrier • Funding is major Barrier • Possible locations for a PACE center is a barrier • Adequate staff is a barrier to meet full IDT requirement

Stakeholder Group	Tulsa Health Community Leaders
Area	Tulsa, Oklahoma (Northeast Oklahoma)
# of Attendees	14
Discussion Topics	• Brief Overview of Current Senior Programs in Tulsa • Brief Overview of Current Federal Community Health Center in Tulsa • Brief Overview of Hospital Network in Tulsa • Overview of PACE • Challenges of PACE • Interest of Tulsa Health Leaders in PACE
Feedback: Concerns/ Barriers/Interests	• PACE marketing may be challenging • Collaborating with other community agencies to integrate services • Age Criteria of PACE – have current clients who would not be able to participate in PACE due to age

Stakeholder Group	Daily Living Centers – Adult Day Health Organizations
Area	Oklahoma City, Oklahoma (Central Oklahoma)
# of Attendees	6
Discussion Topics	• Overview of PACE model • Financial Impact of PACE • Cost of Starting a PACE program • Partnerships with State Medicaid and CMS
Feedback: Concerns/ Barriers/Interests	• Does not trust partnering with the state and CMS • Concerned that rates would drop significantly once program is started • Concerned that there is no financial assistance available for start-up costs • Eligibility Age criteria is a barrier as many younger adults need PACE like care

Stakeholder Group	Kiamichi Economic Development District of Oklahoma
Area	Wilburton, Oklahoma (Southeast Oklahoma)
# of Attendees	8
Discussion Topics	• Overview of PACE model • Possible partnership to develop PACE • PACE impact on Southeast Oklahoma • Current PACE program in Oklahoma Health Care Authority

	• Current organizations providing services in Southeast Oklahoma
Feedback: Concerns/ Barriers/Interests	• Limited finances for implementation and operation is a barrier • Resources for partnerships and contracting is limited • Elderly leaving current primary care provider may be a challenge

Stakeholder Group	Share Medical Group
Area	Alva, Oklahoma (Northwest Oklahoma)
# of Attendees	8
Discussion Topics	• Overview of PACE model • City's involvement in establishing PACE • Possible locations for PACE in Alva • Infrastructure and Transportation • Stability of PACE • Financial Model of PACE
Feedback: Concerns/ Barriers/Interests	• Current Financial Projections are a barrier to PACE implementation • No adult day health program in the town • Concerned that alternative sites cannot be used for PACE program • Area is very rural

Stakeholder Group	Eastern Oklahoma Development District
Area	Muskogee, Oklahoma (Northeast Oklahoma)
# of Attendees	7
Discussion Topics	• Overview of Duals Project • Overview of PACE Expansion • Testimonies on behalf of PACE participants • Locations for possible PACE Center • Barriers and Challenges to Expanding PACE
Feedback: Concerns/ Barriers/Interests	• Start-up costs is a barrier • Location for PACE center/services

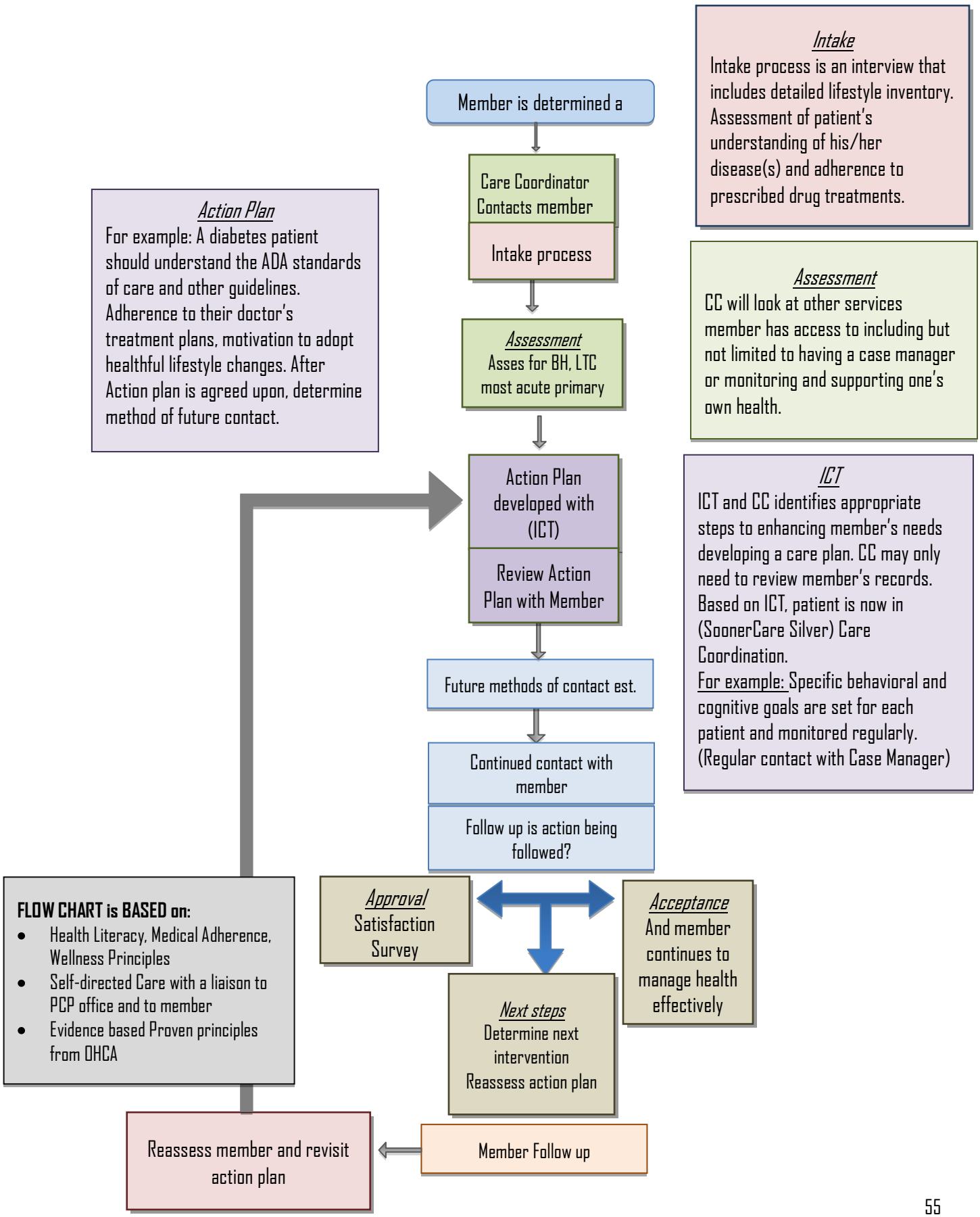
Member Focus Group Forum #1	Senior Citizens Nutrition Center
# of Attendees	32
Questions	Responses
How many people receive Medicare benefits?	• Majority of hands raised
How many people receive Medicaid benefits?	• Some hands raised
What are some things you like about your current health plan?	• Medicare pays the bills • Medicare does the paperwork • Likes supplemental insurance plan • Likes mostly everything about plan
What are some things you dislike about your current health plan?	• Does not cover eye care • Does not cover vision care • Does not cover dental care
Describe what it is like when you go to a doctor's visit.	• Dr. appointments are usually a long waiting process • Dr. rushes to get you out of the office • Dr. does not stick around long enough to help you • No time spent on answering questions about personal health
What health benefits/services are most important to you?	• Eye care • Ear care • Dental care • Foot Care

	• Chiropractor services should be in benefit plan
How satisfied are you with your prescription drug plan?	• Most people fairly satisfied • Some feel like they do not get the quality/quantity of medications for what they pay • Dissatisfied with the increased costs of prescriptions
How would you feel if your health services, social interaction, meals, and therapy were located in one location?	• Too Good to Be True • Sounds like Obamacare – don't like it
Additional Comments/Concerns	• Wants a health care plan that does not charge a premium • Does not want to travel outside home area for routine care • Does not want to travel far for specialty care • Would like PCP to listen more • Would change PCP if necessary to get better care/services

Appendix I

Integrated Care Site Design Proposal Timeline

Timeframe	Key Activities/Milestones	Responsible Parties
July – September 2011	• Contacted organizations to schedule stakeholder and focus group meetings • Facilitated Stakeholder meetings across the State of Oklahoma • Held PACE workgroups to gather specific data relative to PACE expansion	State PACE Staff
October – December 2011	• Analyze Medicare and Medicaid data for significant themes and patterns of utilization • Attend National Seminars and Conference Workshops to gather information regarding trends in PACE implementation • Held additional Stakeholder Meetings, conducted follow-up visits to organizations	State PACE Staff
January – February 2012	• Gathered data to explore a PACE model with expansion criteria(s) • Create draft dual eligible proposal	State PACE Staff
March – May 2012	• Revised Dual Eligible Proposal to include expanded PACE criteria • Post Dual Eligible Proposal for Public Review and Comment • Facilitated two additional Stakeholder Meetings • Submitted Final Proposal • Approval from OHCA Executive Staff to begin 1115 Waiver application	State PACE Staff
June – July 2012	• CMS proposal review • Release RFI	CMS/OHCA
July – December 2012	• 1115 Waiver application process • Review RFI • Release RFP	PACE Staff/OHCA
January – March 2013	• Review RFP responses • Approve organizations to complete & submit ICS applications	State PACE Staff
March – December 2013	• Review ICS Applications • Approve ICS Application	State PACE Staff
January 2014	• Program Implementation	ICS organization


Member is determined a
Care Coordinator Contacts member
Intake process
Assessment
Asses for BH, LTC most acute primary
Action Plan developed with (ICT)
Review Action Plan with Member
Future methods of contact est.
Continued contact with member
Follow up is action being followed?
Approval
Satisfaction Survey
Acceptance
And member continues to manage health effectively
Next steps
Determine next intervention
Reassess action plan
Member Follow up
Reassess member and revisit action plan
Intake
Intake process is an interview that includes detailed lifestyle inventory. Assessment of patient's understanding of his/her disease(s) and adherence to prescribed drug treatments.
Assessment
CC will look at other services member has access to including but not limited to having a case manager or monitoring and supporting one's own health.
Action Plan
For example: A diabetes patient should understand the ADA standards of care and other guidelines. Adherence to their doctor's treatment plans, motivation to adopt healthful lifestyle changes. After Action plan is agreed upon, determine method of future contact.
ICT
ICT and CC identifies appropriate steps to enhancing member's needs developing a care plan. CC may only need to review member's records. Based on ICT, patient is now in (SoonerCare Silver) Care Coordination.
For example: Specific behavioral and cognitive goals are set for each patient and monitored regularly. (Regular contact with Case Manager)
FLOW CHART is BASED on:
Health Literacy, Medical Adherence, Wellness Principles
Self-directed Care with a liaison to PCP office and to member
Evidence based Proven principles from OHCA