

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.

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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 eligible¹. In June 2011, there were 79,891 full benefit Medicare-Medicaid enrollees statewide². 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-income⁵. 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

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

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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 counties⁶. The Oklahoma SoonerCare Silver care coordination program will cover dual eligible members residing in all of Oklahoma’s counties with limited exceptions.

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
<p>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).</p> <p>There are conditions and guidelines for obtaining Part A benefits <u>at age 65</u> without having to pay premiums.</p> <p>There are conditions and guidelines for obtaining Part A benefits <u>under age 65</u> without having to pay premiums.</p>	<p>In general, the following groups of individuals may qualify for SoonerCare services:</p> <ul style="list-style-type: none"> 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 <p>In addition to the citizenship and the state residency requirements, a SoonerCare applicant must meet categorical and financial requirements.</p> <p>SoonerCare Income Guidelines are available on OHCA’s website http://www.okhca.org/</p>

⁶ Retrieved from State of the State’s rural Health http://www.healthsciences.okstate.edu/ruralhealth/mapshow/images/07-CntyClass_1g.jpg

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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 systems⁷. 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

⁷ SoonerCare HMP Evaluation

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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 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

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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 management is not in case management scope.
Homeward Bound Waiver	OKDHS-DDSD	Class members	HCBS	OKDHS	
In-home Supports for Adults Waiver	OKDHS-DDSD	MR/DD 18 and older	HCBS	OKDHS	
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
My Life; My Choice Waiver	OHCA-OLL	Living Choice (MFP) graduates with physical disabilities and	HCBS	OHCA	

⁸ PHPG

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Name	Operator	Targeted Population	Services	Funding	Case Management Services Provided
		younger than 65			not in case management scope.
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 *ADvantage* 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;

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- 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 1,000	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
ADvantage	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 (Unduplicate)	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.

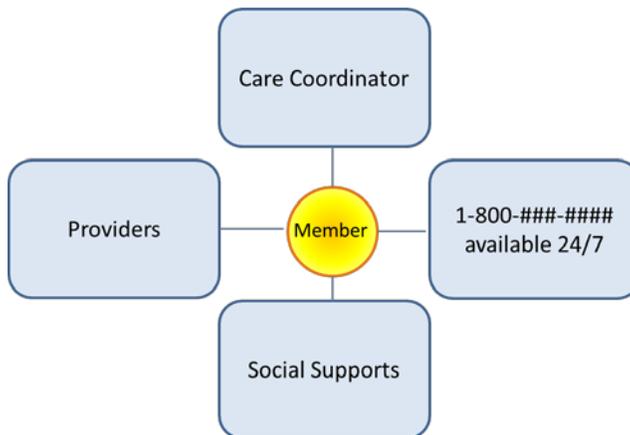
Hospital Integrations

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,

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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

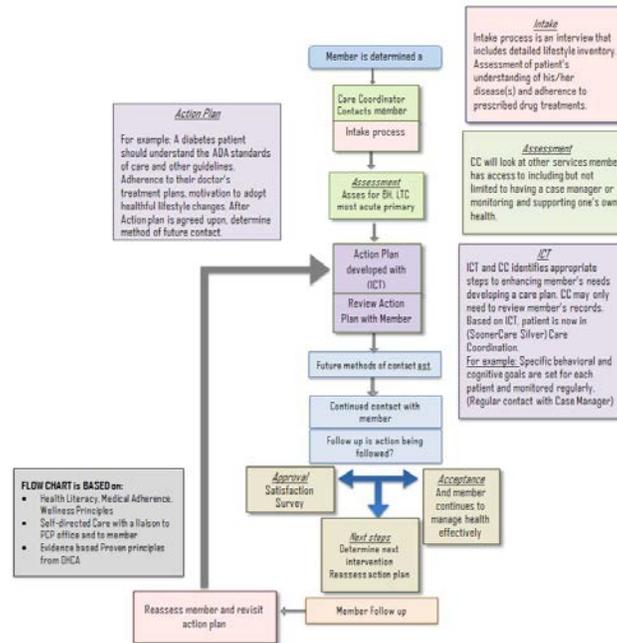
The remaining administrative/management duties will be contracted by an outside vendor that will be responsible for:

- 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

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- 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.

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- 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 comorbidities. 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 vendor 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.

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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 healthcare⁹.

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.

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

⁹ <http://www.medai.com/>.

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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.

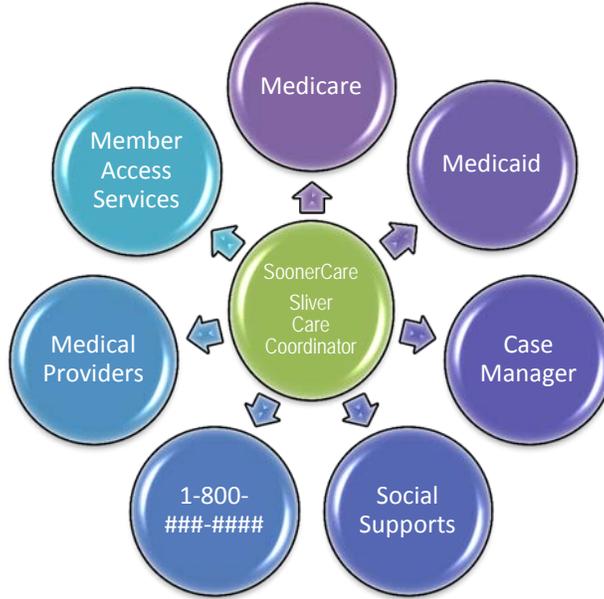
In determining what is the most vital service to benefit the dual population- research was performed and concluded that care coordination proved to be viable with effective clinical foundations and shared factors that build on existing services. Studies conducted regarding care coordination and evidence 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 Medicaid¹⁰.

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):

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

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

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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.

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 appeals¹¹.

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

¹¹ http://www.okhca.org/publications/pdf/lib/SC_handbook.pdf

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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 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

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(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
<i>Inpatient</i>	\$395,776,818.40	\$33,079,505	\$428,856,323.40
<i>Outpatient</i>	\$131,925,606.10	\$10,486,050	\$142,411,656.10
<i>LTC</i>	\$87,950,404.08	\$429,903,442	\$517,853,846.08
<i>Prescriptions</i>	\$322,484,815.00	\$2,213,584	\$324,698,399.00
<i>Physicians</i>	\$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 skills¹². 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 visits¹³.

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

¹² PHPG.

¹³ Massachusetts Health and Human Services offices of Medicaid 2011

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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
<ul style="list-style-type: none"> • Increase member participation in health literacy and medical adherence 	<ul style="list-style-type: none"> • Increased member <u>scheduled</u> appointments with PCP • Increased <u>kept</u> appointments with PCP
<ul style="list-style-type: none"> • Increased member participation in disease –specific education and self-directed care 	<ul style="list-style-type: none"> • Increased number of action plans being followed
<ul style="list-style-type: none"> • Increase in primary care provider use and expenditures. increased expenditures in year 1 , year 2, and leveling off in year 3 	<ul style="list-style-type: none"> • Increased PCP services, fewer repeat tests and lab work. • No change in annual expenditures
<ul style="list-style-type: none"> • Increase in physician specialty use with decreased expenses 	<ul style="list-style-type: none"> • Decrease in total expenditures related to physician specialty services
<ul style="list-style-type: none"> • Decrease in avoidable emergency room use- decreased expenses in year 1 and subsequent decreased visits by people who are dually eligible 	<ul style="list-style-type: none"> • Decrease in total avoidable ER expenses
<ul style="list-style-type: none"> • Decrease in hospital admissions and readmissions (within 30 days, 60 days, 90 days) 	<ul style="list-style-type: none"> • Decrease in re-admissions after 30days • Decrease in re-admissions after 60 days • Decrease in re-admissions after 90 days
<ul style="list-style-type: none"> • Increase in institutional long-term care (Medicare skilled nursing days) 	<ul style="list-style-type: none"> • Better management of overall health for duals • Fewer duals managing care though avoidable ER
<ul style="list-style-type: none"> • Increase in home- and community-based service use and expenditures. 	<ul style="list-style-type: none"> • 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
<i>Inpatient</i>	\$428,856,323.40	0.05	0.1%	\$21,442,816.17	\$21,442,816.17	\$21,442,816.17
<i>Outpatient</i>	\$142,411,656.10	0.03		\$4,272,349.68	\$4,272,349.68	\$4,272,349.68
<i>LTC</i>	\$517,853,846.08	0.03		\$15,535,615.38	\$15,535,615.38	\$15,535,615.38
<i>Prescriptions</i>	\$324,698,399.00	0.05		\$16,234,919.95	\$16,234,919.95	\$32,469,839.90
<i>Physicians</i>	\$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 implementation¹⁴.

¹⁴ Office of the Governor Mary Fallin 2012

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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, 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.