SoonerCare Choice: Oklahoma's PCCM Program

oklahoma health care authority

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SoonerCare Program 1995 - 2003

- **SoonerCare Plus**
  - Managed Care Organization (MCO)
  - Full Risk
  - Expanded benefits
- **SoonerCare Choice**
  - Primary Care Case Management (PCCM)
  - Partial Risk
  - Some adult limits

Objectives

- Improve access to preventive services, primary care and early prenatal care
- Alignment with Primary care provider
- Expand the rural provider network
- Budget predictability

What Happened?

- Based on estimates from actuaries, the Legislature appropriated base rate increase of 13.6% for the MCOs for CY04
- Final actuarial certified rate was 19.1% increase
- Agency bid MCO rate at 13.6% increase as funded for CY04
- 2 of 3 MCOs accepted bid
- State left with only one plan in each of three service areas

Alternatives

- Pay higher rates to MCOs by reducing eligibility; or
- Revise existing 1115 waiver to seek approval for operating MCO program with only one plan in each area; or
- Revise existing 1115 waiver to operate a single statewide PCCM program

Ongoing Debate: Equity between the Two Programs

- Program equity – comparability of benefit packages
- Provider equity – federal requirement of actuarially certified rates resulted in funding MCO rates first, leaving fee-for-service providers last in consideration for increased funding
- Program cost – would statewide PCCM model result in less costly service delivery system than MCOs?

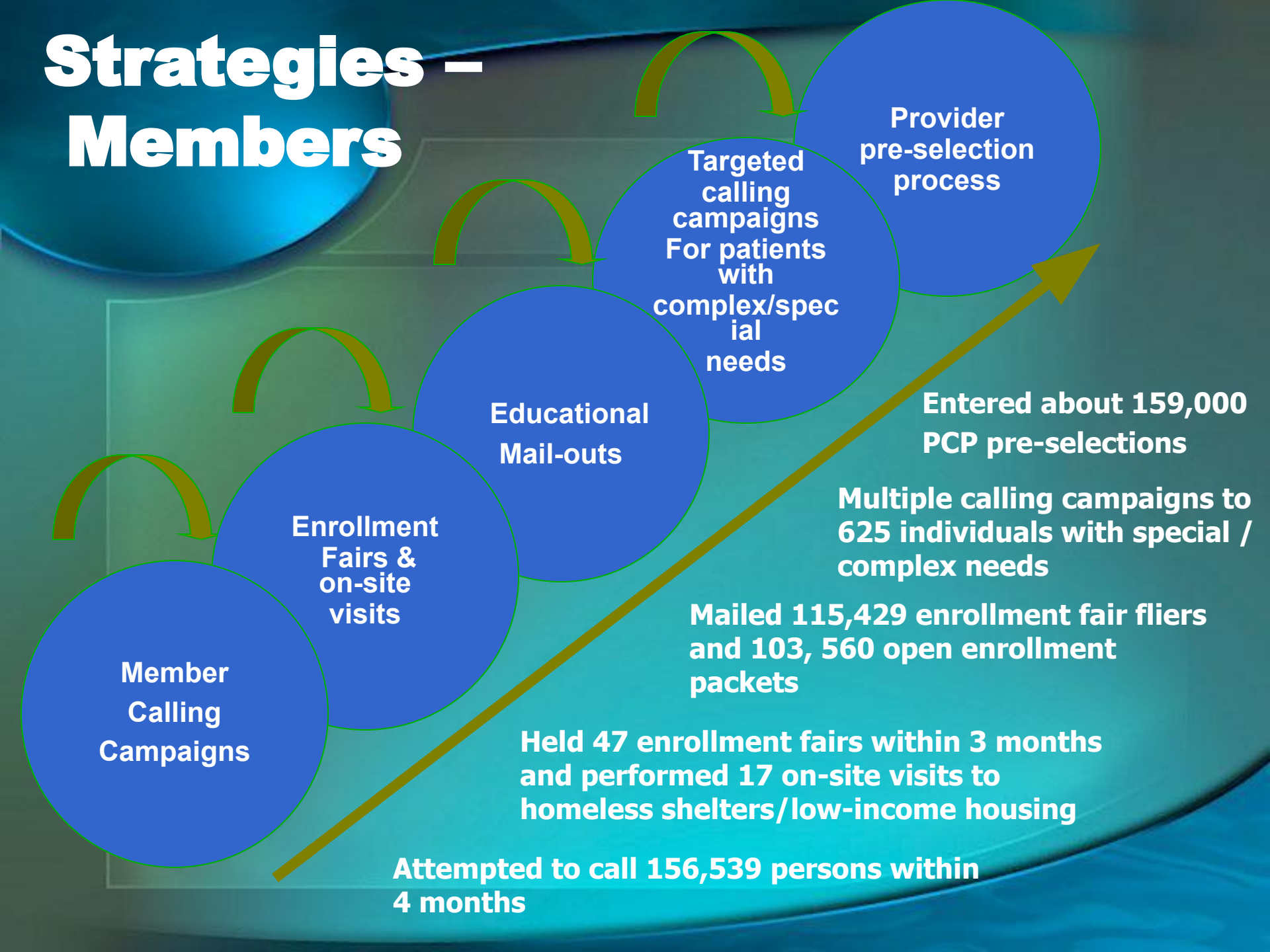
Agency Analysis of Statewide PCCM Program

- Better use of agency resources – both staff and money
- Equality of benefits to all enrollees
- Equality in provider rate structure
- Level playing field for future benefit structure and appropriated rate increases
- Solid alternative service delivery structure
- Comparable quality program indicators

Managed Care Transition

- Board voted
  11-7-03 to eliminate MCO program effective 12-31-03
- Transition of nearly 200,000 enrollees to Fee-for-Service, then to PCCM program in 4 months
- Formed interagency transition team
- Aggressive enrollee outreach campaign
- Provider contracting to extend network statewide
- Expanded care management & program supports

Strategies – Members



Attempted to call 156,539 persons within 4 months

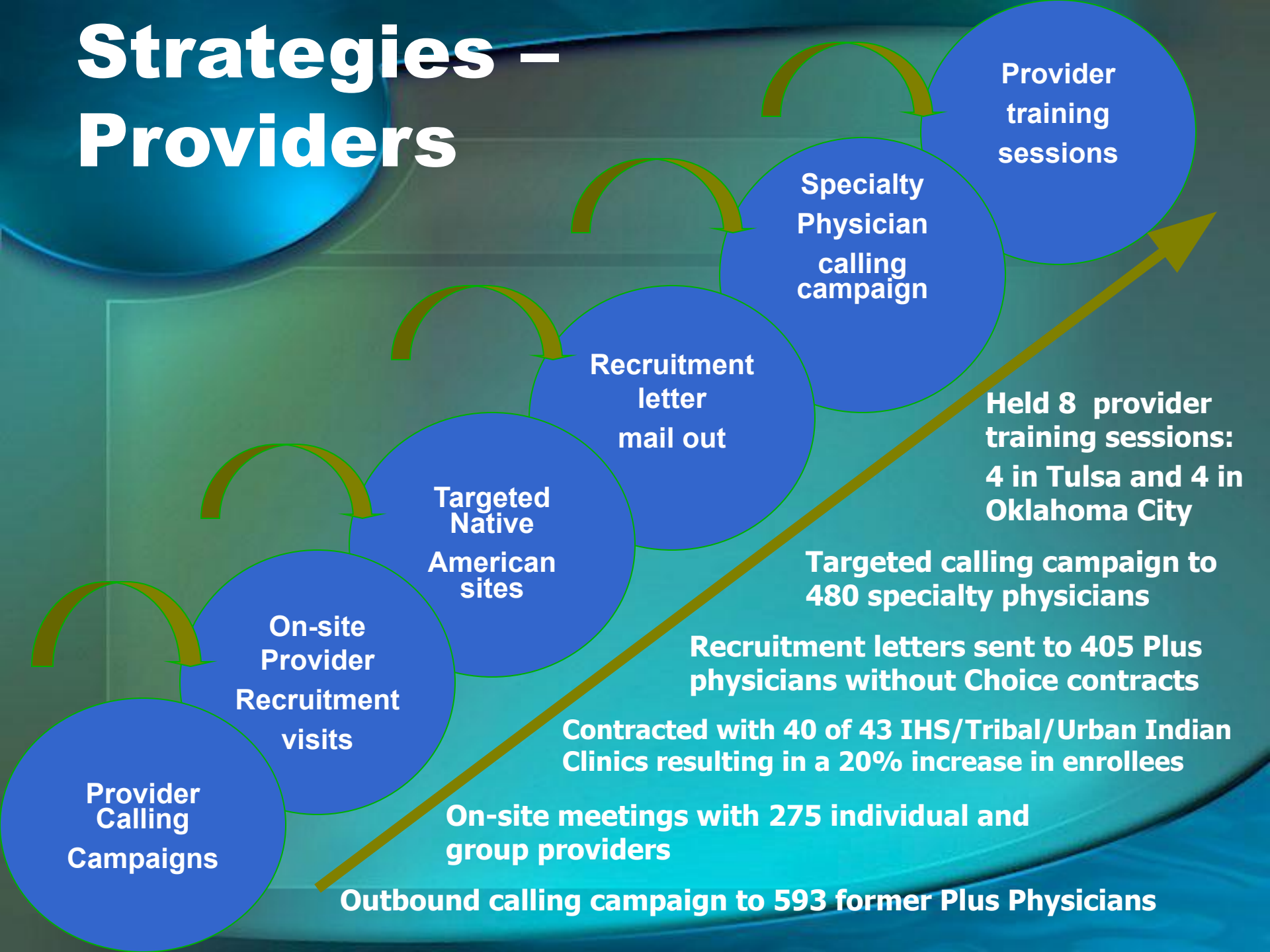
Held 47 enrollment fairs within 3 months and performed 17 on-site visits to homeless shelters/low-income housing

Mailed 115,429 enrollment fair fliers and 103, 560 open enrollment packets

Multiple calling campaigns to 625 individuals with special / complex needs

Entered about 159,000 PCP pre-selections

Strategies – Providers



Held 8 provider training sessions: 4 in Tulsa and 4 in Oklahoma City

Targeted calling campaign to 480 specialty physicians

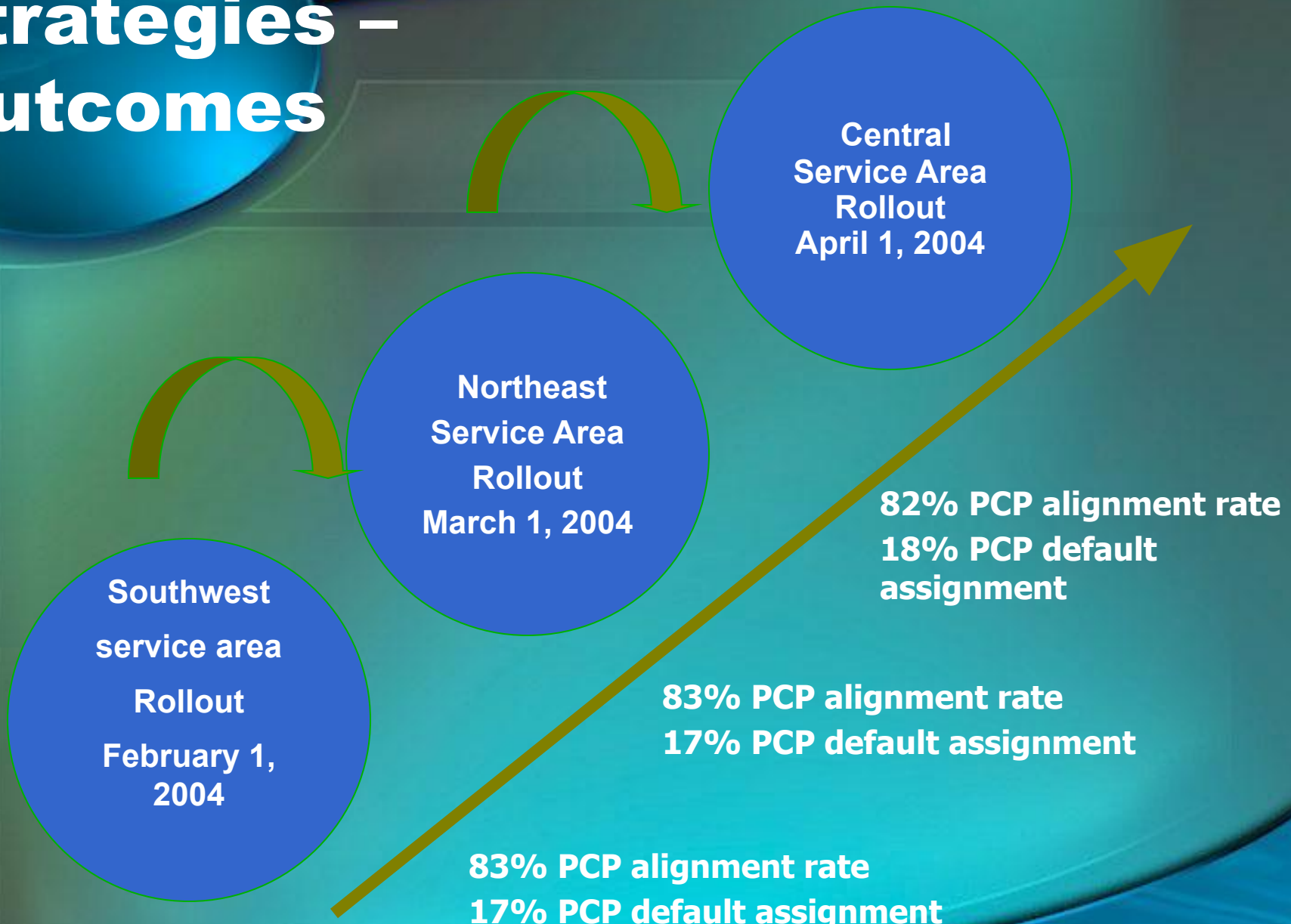
Recruitment letters sent to 405 Plus physicians without Choice contracts

Contracted with 40 of 43 IHS/Tribal/Urban Indian Clinics resulting in a 20% increase in enrollees

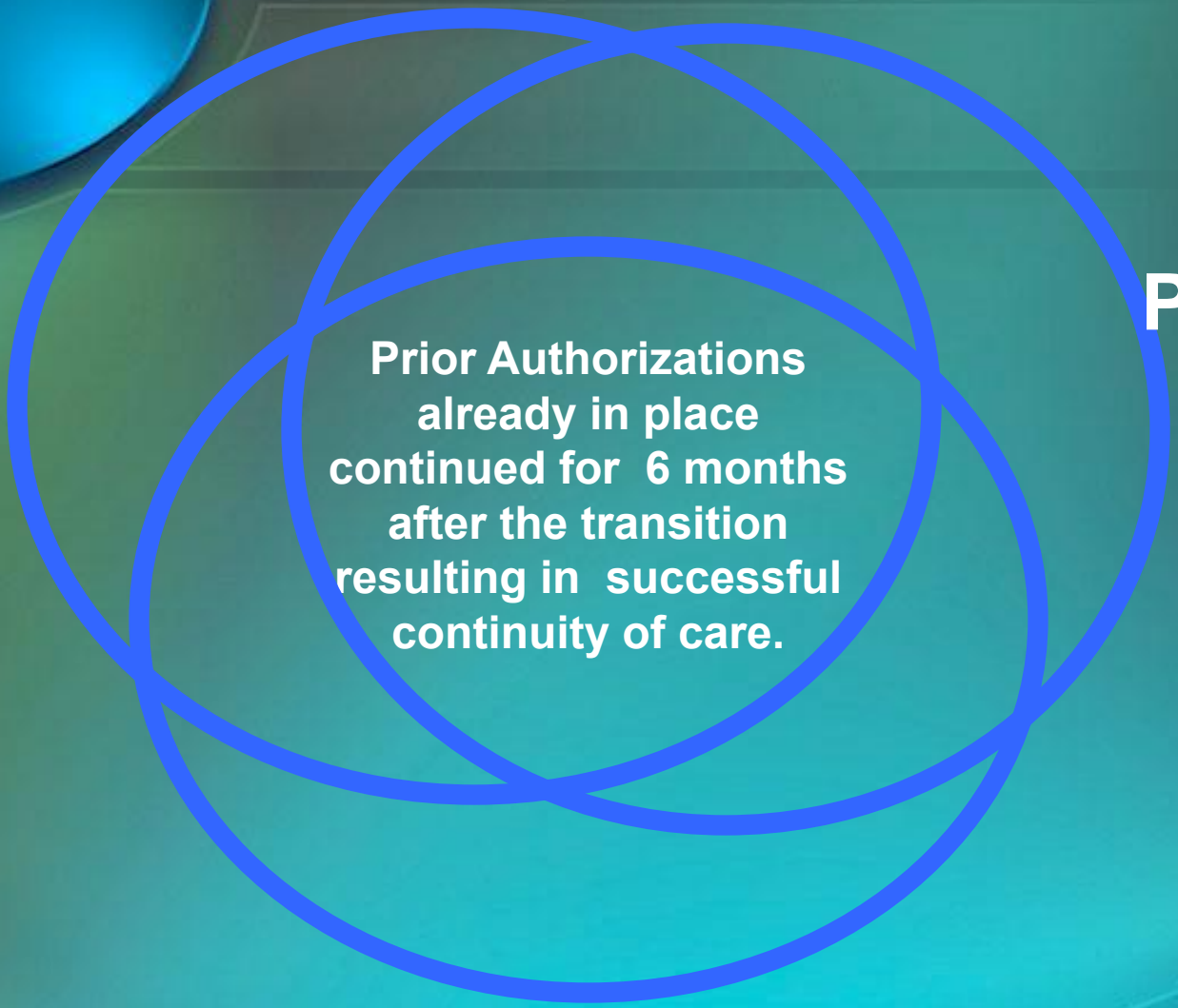
On-site meetings with 275 individual and group providers

Outbound calling campaign to 593 former Plus Physicians

Strategies – Outcomes



Continuity of Care



Strategies – Administrative

- Agency wide determination of additional in-house FTE required: costs estimated to include salaries, benefits and operating expenses
- Agency wide review of all contracted services, including fiscal agent, quality improvement organization, enrollment broker and transportation broker to determine the marginal increase required

Results Jan-June 2004

- Budget reduced by $23.9 million for medical payouts
- Budget reduced by $24.8 million for cash flow gain
- Budget increased by $6.9 million for estimated administrative costs
- Revenues decreased by $37.5 million, including federal funds
- Agency saved the projected $4.3 million in state dollars for SFY04

Results SFY2005

- Expenditure reduction of $85.5 million
- Revenue reduction of $81.6 million
- Achieved overall savings of $3.9 million

SoonerCare Choice Today

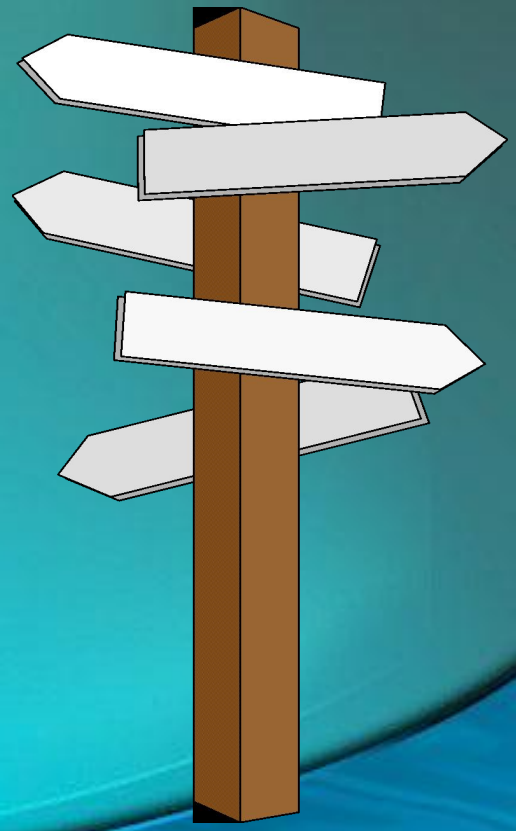
- Statewide serving 77 counties
- 405,709 members enrolled
- Mandatory enrollment
- 185% FPL
- Exclusions
  - Dual eligibles
  - Waiver members
  - Children in State or Tribal Custody, or subsidized adoption
  - HMO members
  - Institutionalized members

SoonerCare Choice
Contracting

- Contract directly with individual and group Providers
- MD, DO, PA & ARNP
- Indian/Tribal/Urban Indian Clinic Case Management only

SoonerCare Choice
Provider Network

- 1,239 Providers at 586 sites in 75 of 77 counties
- 50 I/T/U clinic contracts
- 45-mile, 45-minute access standard
- >1.184 million member capacity



SoonerCare Choice
Payment Methodologies

- Actuarially-certified statewide rates
- Partially-capitated and case management payment structure for 9 age/sex cells
- 2008 rates
  - TANF/BCC/SCHIP blended rate: $18.21 PMPM
  - ABD/TEFRA blended rate: $24.14 PMPM
- CM component of rate is $2 to $3 PMPM
- I/T/U CM cap payment of $2 to $3 PMPM

Capitated Benefit Package

Primary and Preventive Care

- Medically necessary office visits to the PCP with no co-pay
- Well child screenings (EPSDT)
- Injections, immunizations
- Limited CLIA waived lab services
- Basic family planning services
- Case management including referrals

Non-Capitated Benefits

FFS reimbursement policies/program limits

- Hospital coverage
- Prescriptions (adults limited to 6 monthly; up to 3 brand name)
- Specialty Care (adults limited to four visits monthly)
- Medically necessary transportation
- Specified self-referral services

SoonerCare Choice
Program Components

- Annual member handbook and benefits update
- Annual provider directory
- Select primary care provider
- Default assignment if no selection made
- Can change PCP up to 4 times per year

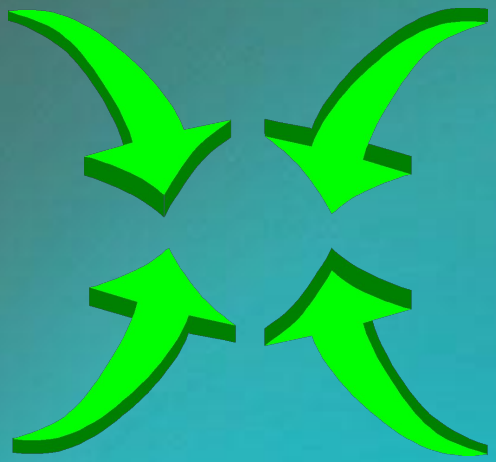
Program Enhancements

Incentive Payments

Standing Referral

Provider Representatives / Toll-free Helpline

Real Time Claims Adjudication



SoonerCare Member Helpline

Specialty Referral Network

Care Management

Patient Advice Line

Non-emergency Transportation

In-house Provider Support

- 32 FTEs with 22 Provider Reps
- Program, policy and claims education
- Coordinate access to care issues
- PCP recruitment and retention
- Monitor PCP and Specialty network

In-house Care Management

- 38 FTEs; manage 5,000 cases monthly
- 33 nurses with average caseload of 187
- 2 social services coordinators
- Handled some 116,000 telephone calls July 2006-June 2007
- Utilize web-based clinical case management system

Care Management

Population & Services

- In-home assessments using standardized evaluation tool for all children with private duty nursing
- Women eligible for Breast & Cervical Cancer Treatment Program
- TEFRA eligible children
- High-risk pregnancy
- Organ transplant candidates/recipients
- Out-of-state care coordination
- Monthly staffing with large provider groups

Quality & Compliance Activities

- PCP on-site audits
- QAPI monitoring
- ER utilization program
- Provider profiling
  - ER Utilization
  - Breast and Cervical Cancer Screening Rates
  - EPSDT Screens

Quality & Compliance Activities

- CAHPS
- HEDIS
- Encounter data validation and quality improvement
- Agency-wide Quality Assurance Committee
- Focused studies/performance improvement projects

P4P in Oklahoma

- In 1997, Oklahoma implemented a provider incentive to increase EPSDT compliance.
- In 2006, Oklahoma's EPSDT visits for the 0-15 months age group were above the National Medicaid mean.
- Added a targeted incentive to increase specific immunizations in children.

EPSDT Incentive

Year	Threshold	Providers Reviewed	Providers Paid	Amount Paid
2002	50%	149	95	$216,704
2003	60%	585	110	$171,849
2004	65%	983	243	$419,723
2005	65%	824	254	$668,817
2006	65%	836	247	$789,346

- Threshold for incentive was increased as more providers reached targets in the program.

Targeted Immunization Incentive

- Review of children's immunizations showed that most children were not receiving the 4th DTaP.
- In 2002, Oklahoma started an incentive for providers that administered a 4th DTaP to children prior to age 2.

DTaP Results

- In 2006, 117 providers received an incentive payment for providing the 4th DTaP.
- In 2006, 3,140 children received the 4th DTAP as compared to 922 before the incentive program (2001).

Summary Achievements

- Between 2002 and 2006, there was an 160% increase in the number of providers that received an EPSDT incentive payment.
- During this same time period, there was a 264% increase in the amount of incentives paid to providers.
- Between 2001 and 2006, 29% more children received the 4th DTAP prior to the age of 2.

Where Do We Go From Here?

Agency Considerations

Budget Impact

Provider concerns

Provider input

Member Access

Improved Outcomes

Legislative Interest

CMS Approval

Where Do We Go From Here?

- Develop Transition Plan
- System Modifications
- Provider Education
- Support of Stakeholders

Medical Home Model

The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, as a way to enhance the care of children with special needs.

Medical Home Model

In March 2007 the AAP, AAFP, ACP, and AOA, representing approximately 333,000 physicians, developed the following joint principles to describe the characteristics of the PC-MH.

Medical Home Principles

- ✔ Personal Physician
- ✔ Enhanced Access
- ✔ Physician Directed Practice
- ✔ Quality and Safety
- ✔ Whole Person Orientation
- ✔ Adequate Payment
- ✔ Coordinated and / or integrated care

Enhanced Access

The medical home model is generating much interest nationally as the "new" model of care and potential payment.

- Medicare
- Private payers
- Large self-insured employers
- Patient-centered primary care collaborative
- State Government

North Carolina Model
Community Care of NC (CCNC)

CCNC provides care to more than 750,000 Medicaid recipients in North Carolina, relying heavily on patient-centered medical homes, population health management, case management services and community-based networks to deliver care. Since its inception in 1999, the program has saved North Carolina nearly a half a billion dollars, becoming a driver of quality initiatives in the state in the process.

Since 1999, CCNC has grown to encompass 15 networks, 3,500 primary care physicians and 1,000 medical homes.

CC
NC

The Essentials of CCNC

- Networks of Primary Care Offices
- Governmental Partnership
- Community Partnerships
- Physician Champions
- Resources to manage patients
- Adequate reimbursement

CC
NC

What Networks Do

- Assume responsibility for Medicaid patients
- Implement improved care management and disease management systems
- Identify costly patients and costly services
- Develop and implement plans to manage utilization and cost
- Create the local systems to improve care and reduce variability

CC
NC

Reimbursements/Costs

- Fee for service: 95% of Medicare
- Practice Incentive:$3.00 pmpm
- Network funding: $3.00 pmpm
- 750,000 patients = $4,500,000
- Total NC Medicaid budget = over $5 billion

Alabama Model

More than 420,000 Alabamians currently participate in Patient 1st, a primary care case management (PCCM) program operated by the Alabama Medicaid Agency.

The present program was approved by the Centers for Medicare and Medicaid Services (CMS) in August 2004 and includes expanded technology and tools to help doctors and other health professionals better manage the increasing cost of health care while promoting better care for Medicaid patients.

PMP Responsibilities

- Primary Care
- Patient Coordination/Management
- 24 / 7 Availability
- Participate in Agency Utilization and Quality Programs
- Coordination of Referrals

Case Management Components

- EPSDT
- Vaccines for Children
- Medical Home Project Training
- 24 / 7 Arrangements
- Hospital Admitting
- Disease Management
- InfoSolutions
- Electronic Notices
- Electronic Educational Materials

Patient 1st

Incentive Payments
Shared Savings

- Medicaid shares 50% of documented savings with Medical Home providers
- Distribution based on combination of efficiency and process outcomes
- $5.7 mill pool distributed first year

Patient 1st

PMP Determines Case Management Fee

- Provides adult preventive services $0.20
- Provides EPSDT/immunization services $0.25
- VFC participant $0.10
- 24/7 voice-to-voice coverage $0.75
- Hospital admitting privileges $0.20
- Provides continuity of care/referral tracking $0.15
- Actively participates in health management program $0.10
-
- Participates in CMS Physician Voluntary Reporting Program $0.10
- Maintains electronic health records $0.50
- Actively utilizes e-prescribing $0.10
- Completes OHCA-approved “medical home” CME course $0.05
- Receives electronic notices/educational materials from the OHCA $0.10

TOTAL $2.60

Reimbursement

- Case Management Fee
  - PMP determines based on self declared components
- Office Care
  - Fee for service
- Incentive payments
  - PMP will share in any savings

Evaluation of NCCC and Alabama Patient First

- Research both programs
- Site visit of NCCC model for additional information.
- Development of agency work group to evaluate the different options available.
- Update to Medical Advisory Taskforce for provider inputs and recommendations.
- Informed Child Health Advisory Taskforce and Peri-Natal Taskforce for additional input

Re-design Option

- FFS and variable Case Management component based on criteria self-designated by provider (similar to Alabama model)

How would you build your Medical Home?

1. What of our current system works now and what would you like to see change?
2. What do you think are the most important components to stress?
3. How do we reimburse for this?

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Thank you!