

Oklahoma
HealthCare
Authority

**Service Efforts &
Accomplishments
SFY2014**

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Introduction

Welcome to the Oklahoma Health Care Authority (OHCA) Service Efforts and Accomplishment Report for state fiscal year (SFY) 2014.

Since January 1995, OHCA has been the primary purchaser of state and federally funded health care for low income Oklahomans. OHCA operates as the state's Medicaid agency by authority created under Title XIX of the Social Security Act of 1965. The agency strives to ensure that the health care provided meets acceptable standards of care and those citizens who rely on state-purchased health care are served in a comprehensive and effective manner.

Because OHCA's programs, including SoonerCare and Insure Oklahoma, are critical in providing care to Oklahomans, the performance and administration of these programs must be continuously examined and evaluated. Stakeholders need understandable, relevant performance data to stay informed about the progress being made towards a healthier Oklahoma.

This report is intended to provide information needed to evaluate the agency's performance. It includes key performance measures tracked by the agency to ensure OHCA's efforts are consistent with its state-mandated mission and the strategic goals and objectives set forth by its Board of Directors. The report shows how the agency has performed in each of seven goal areas. For quick reference, agency goals, objectives and key performance measures are presented in a dashboard format to allow the reader to see performance data "at-a-glance" along with an indication of how it's trending. The technical notes section includes specifics on the data presented in the dashboard. For more in-depth analysis, each agency goal is presented along with the objectives and performance measures related to it. Narrative is included to provide context, and anticipate future events that may impact the goal area.

The key performance measures reported are intended to provide data about the resources OHCA has been allocated (inputs), the work done (outputs), and the success in meeting objectives (outcomes). Expanded resources can be compared to those outcomes and outputs (efficiencies).

While the information contained in this report will help the reader to evaluate the performance of the agency, it doesn't tell the entire story. The dashboards and charts are a quantitative glimpse of how Oklahomans are impacted by SoonerCare through greater access to health care and services.

For more information about SoonerCare please visit: <http://www.okhca.org/>.

We hope you find this report informative and helpful.

OHCA Mission & Goals

Mission Statement

Our mission is to responsibly purchase state and federally funded health care in the most efficient and comprehensive manner possible; and to analyze and recommend strategies for optimizing the accessibility and quality of health care; and to cultivate relationships to improve the health outcomes of Oklahomans.

Goal #1 – Financing and Reimbursement

To responsibly purchase cost effective health care for members by maintaining appropriate rates and to continue to strengthen health care infrastructure

Goal #2 – Program Development

To ensure that medically necessary benefits and services are responsive to the health care needs of our members

Goal #3 – Personal Responsibility

To educate and engage members regarding personal responsibilities for their health services utilization, behaviors, and outcomes

Goal #4 – Satisfaction and Quality

To protect and improve member health and satisfaction, as well as ensure quality, with programs, services and care

Goal #5 – Eligibility and Enrollment

To provide and improve health care coverage to the qualified populations of Oklahoma




Goal #6 – Administration


To foster excellence and innovation in the administration of the OHCA

Goal #7 - Collaboration

To foster collaboration among public and private individuals and entities to build a responsive health care system for Oklahoma

Oklahoma Health Care Authority
Performance Measures Dashboard -- SFY2014

Trend Key	
	GREEN Indicates movement in the desired direction.
	RED Indicates movement is not in the desired direction.
	YELLOW Indicates no significant change over time.
//	Indicates no desired direction. The data presented is informational and provides context to the objective.








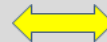

Goal #1 – Financing and Reimbursement						
To responsibly purchase cost effective health care for members by maintaining appropriate rates and to continue to strengthen health care infrastructure						
		<u>2012</u>	<u>2013</u>	<u>2014</u>	<u>Variance</u>	<u>Trend</u>
I.1	Objective: To reimburse providers, when applicable Medicare rates are available, at 100 % of Medicare rates					
I.1.1	Total expenditures for physicians & midlevel practitioners' services	536,168,016	\$ 563,294,097	\$ 590,844,401	4.89%	//
I.1.2	Total expenditures for other medical costs	463,506,349	\$ 478,831,256	\$ 483,641,315	1.00%	//
I.1.3	Reimbursement as a % of medicare rates	96.75%	96.75%	96.75%	0.00%	
I.2	Objective: To reimburse hospital providers at 100% of federal upper payment limit					








1.2.1	Total expenditures for general medical/surgical hospital services	\$787,399,203	\$792,207,386	\$817,878,530	3.24%	//
1.2.2	Total expenditures for psychiatric hospitals and psychiatric residential treatment facilities (PRTF)	\$101,475,080	\$107,798,074	\$103,640,348	-3.86%	//
1.2.3	Reimbursement as a % of federal upper payment limit	85.24%	83.33%	87.96%	5.56%	↑
1.3	Objective: To reimburse long-term care facilities at 100% of federal upper payment limit					
1.3.1	Total expenditures for nursing home care	\$488,657,238	\$536,153,689	\$573,448,789	6.96%	//
1.3.2	Average % reimbursement for nursing home costs per patient day	89.00%	89.00%	99.42%	11.71%	↑
1.3.3	Total expenditures for ICF/IDs	\$113,041,471	\$111,373,096	\$96,493,124	-13.36%	//
1.3.4	Average % reimbursement for ICF/ID facility costs per patient day	100.00%	100.00%	99.81%	-0.19%	↓
1.4	Objective: To reimburse eligible professionals/hospitals for participation in the Electronic Health Records (EHR) Incentive Program					
1.4.1	# of eligible professionals receiving an EHR incentive payment	718	780	1,022	31.03%	//
1.4.2	# of eligible hospitals receiving an EHR incentive payment	44	46	55	19.57%	//
1.4.3	Total EHR incentive payments to eligible professionals/hospitals	\$44,062,545	\$38,968,791	\$32,553,188	-16.46%	//
1.4.4	% of eligible professionals in compliance with meaningful use of EHR	3.76%	45.26%	60.96%	34.70%	↑
1.4.5	% of eligible hospitals in compliance with meaningful use of EHR	4.55%	73.91%	98.18%	32.83%	↑
1.5	Objective: To strive to accurately project the future costs of providing SoonerCare health benefits to Oklahomans					

1.5.1	Total # of unduplicated SoonerCare members enrolled	1,007,356	1,040,332	1,033,114	-0.69%	//
1.5.2	Total SoonerCare program expenditures (by type of service)	\$4,075,519,279	\$4,240,915,548	\$4,397,896,751	3.70%	//
1.5.3	Average SoonerCare program cost (per member enrolled)	\$4,046	\$4,077	\$4,257	4.41%	//
1.6	Objective: To strive to accurately project the future costs of providing Insure Oklahoma health benefits to Oklahomans					
1.6.1	Total # of unduplicated Insure Oklahoma members enrolled	48,616	45,855	40,261	-12.20%	//
1.6.2	Total expenditures for Insure Oklahoma	\$119,399,496	\$113,536,514	\$94,609,661	-16.67%	//
1.6.3	Average cost per Insure Oklahoma member	\$2,677	\$2,670	\$2,350	-11.99%	//
1.7	Objective: To strive to restructure and improve the access, quality, and continuity of care for members by providing appropriate per member per month payment to Health Access Networks by roster size					
1.7.1	Average monthly enrollment in Health Access Networks (HANs)	50,295	64,730	109,194	68.69%	↑
1.7.2	Total payments made to HANs	\$3,017,725	\$3,885,990	\$6,551,610	68.60%	↑
1.7.3	Total # of HAN member months	603,545	776,756	1,310,322	68.69%	↑


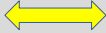
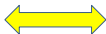
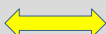






Goal #2 – Program Development					
To ensure that medically necessary benefits and services are responsive to the health care needs of our members					
	<u>2012</u>	<u>2013</u>	<u>2014</u>	<u>Variance</u>	<u>Trend</u>


2.1	Objective: To ensure that SoonerCare Choice members receive coordinated health care services through a medical home					
2.1.1	# of members enrolled in SoonerCare Choice	479,492	539,670	560,887	3.93%	↑
2.1.2	# of members enrolled in SoonerCare Traditional	240,920	194,294	202,934	4.45%	//
2.1.3	% of SoonerCare members enrolled in SoonerCare Choice	66.56%	73.53%	73.43%	-0.1%	↔
2.1.4	% of members aligned with tier 1 entry-level medical homes	46%	42%	41%	-1.00%	↔
2.1.5	% of members aligned with tier 2 advanced medical homes	31%	31%	28%	-3.00%	↓
2.1.6	% of members aligned with tier 3 optimal medical homes	23%	27%	31%	4.00%	↑
2.1.7	# of members aligned with tier 1 entry-level medical homes	220,566	226,661	229,964	1.46%	↔
2.1.8	# of members aligned with tier 2 advanced medical homes	148,643	167,298	157,048	-6.13%	↓
2.1.9	# of members aligned with tier 3 optimal medical homes	110,283	145,711	173,875	19.33%	↑
2.2	Objective: To maintain a provider network that can adequately meet the needs of members					
2.2.1	SoonerCare provider network count	40,825	38,486	39,726	3.22%	↑
2.2.2	SoonerCare Choice providers	1,933	2,170	2,309	6.41%	↑
2.2.3	SoonerCare Choice providers' total capacity	1,202,168	1,139,130	1,177,398	3.36%	↑
2.2.4	SoonerCare Choice providers' % of capacity used	37.85%	44.06%	42.26%	-1.80%	↔




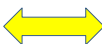




2.2.5	% of tier 1 entry-level medical homes	64.88%	58.60%	56.90%	-1.70%	
2.2.6	% of tier 2 advanced medical homes	26.37%	27.70%	24%	-3.70%	
2.2.7	% of tier 3 optimal medical homes	8.75%	13.70%	19.10%	5.40%	
2.2.8	# of tier 1 entry-level medical homes	534	502	503	0.2%	
2.2.9	# of tier 2 advanced medical homes	217	237	212	-10.55%	
2.2.10	# of Tier 3 Optimal Medical Homes	72	117	169	44.44%	
2.3	Objective: To promote responsive health care delivery through the Case Management unit for SoonerCare members with episodic or event-based case management needs					
2.3.1	# of new high-risk OB members	1832	1998	2474	23.82%	
2.3.2	# of new at-risk OB members	713	637	618	-2.98%	
2.3.3	# of new fetal infant mortality reduction outreach to moms (outreach in 10 counties)	2,274	2,041	1,781	-12.74%	//
2.3.4	# of new fetal infant mortality reduction outreach to babies (outreach in 10 counties)	1,713 (11 mos.)	2,100	2,138	1.81%	//
2.4	Objective: To promote responsive health care delivery through the Health Management Program (HMP) for SoonerCare members who have, or are at risk, for developing chronic diseases through engagement in active self-management					
2.4.1	# of members in HMP (The Health Management Program expanded in SFY14)	4,130	1,394	7,500	438.02%	

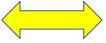


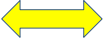


2.4.2	Actual PMPMs for HMP members	\$1,173	\$1,125	\$1,149	2.13%	
2.4.3	% below forecast for HMP members	16.50%	18.20%	17.34%	-0.86%	
2.4.4	# of providers with on-site practice facilitation (new program model effective SFY14)	53	50	33	-34.00%	
2.5	Objective: To promote responsive health care delivery through the Chronic Care unit (CCU) for SoonerCare members diagnosed with or who are at risk for a chronic condition(s)					
2.5.1	# of unduplicated members in the chronic care unit (SFY13 included 6 months of reporting)		206	978	375%	//
2.5.2	% of members with a diagnosis of hemophilia		31.00%	10.1%	-20.90%	//
2.5.3	% of members with a diagnosis of sickle cell anemia		41.30%	12.9%	-28.4%	//
2.5.4	% of members with a combination of chronic conditions (SFY13 is not comparable to SFY14. Only 6 months of data available)		27.70%	77.00%	49.30%	//
2.6	Objective: To enhance the Patient-Centered Medical Home by working with SoonerCare primary care providers to offer coordination and improvement of quality, access, and continuity of care for a segment of the SoonerCare population currently enrolled in health access networks (HANs)					
2.6.1	# of contracted HANs	3	3	3	0%	
2.6.2	Total # of enrollees (at June 30)	61,078	90,688	118,107	30.23%	
2.6.3	# of members identified to be offered care management (in SFY14, there was a change in reporting methodology)	1,961	1,418	740	-47.81%	
2.6.4	# of unduplicated providers in HANs	309	484	584	20.66%	

Goal #3 – Personal Responsibility						
To educate and engage members regarding personal responsibilities for their health services utilization, behaviors, and outcomes						
		<u>2012</u>	<u>2013</u>	<u>2014</u>	<u>Variance</u>	<u>Trend</u>
3.1	Objective: To strive for SoonerCare children to receive necessary preventive care through Child Health / EPSDT services					
3.1.1	First 15 months	98.3%	97.3%	N/A	-1.0%	↔
3.1.2	3 to 6 years	57.4%	57.6%	N/A	0.3%	↔
3.1.3	Adolescents	34.5%	31.6%	N/A	-8.4%	↓
3.1.4	EPSDT participation ratio	56.0%	56.0%	N/A	0.0%	↔
3.2	Objective: To partner with other child serving organizations in the state to strive for Oklahoma’s children to meet the federal immunization goal of 80% compliance					
3.2.1	Immunization rate	61.0%	62.7%	N/A	2.8%	↔
3.3	Objective: To increase ambulatory/preventive care use by adults					
3.3.1	% of adults 20 to 44 years utilizing ambulatory/preventive care	83.1%	82.8%	N/A	-0.4%	↔
3.3.2	% of adults 45 to 64 years utilizing ambulatory/preventive care	91.0%	90.8%	N/A	-0.2%	↔
3.4	Objective: To encourage the responsible use of pharmacy services and prescription drugs through the lock-in program and clinical decision support rules concerning pill counts and duplication of therapy					
3.4.1	# of Medicaid members assigned to the lock-in program	273	313	404	29.07%	↑








3.5	Objective: To increase the number of pregnant women seeking medical care before delivery					
3.5.1	% of Medicaid members seeking prenatal care	97.1%	97.3%	97.7%	0.41%	
3.5.2	# of births to Medicaid members	33,669	32,915	32,254	-2.01%	//
3.5.3	# of members seeking prenatal care	31,958	32,034	31,507	-1.65%	//
3.5.4	Deliveries with prenatal care services beginning in the 1st trimester	19,331	20,306	19,881	-2.09%	
3.5.5	Deliveries with prenatal care services beginning in the 2nd trimester	8,890	8,289	8,088	-2.42%	
3.5.6	Deliveries with prenatal care services beginning in the 3rd trimester	3,737	3,439	3,538	2.88%	
3.5.7	Deliveries without prenatal care	946	881	747	-15.21%	
3.6	Objective: To decrease emergency room utilization by increased use of ambulatory care services					
3.6.1	# of SoonerCare Choice members with greater than 2 ER visits in a quarter	17,203	23,098	19,499	-15.58%	
3.6.2	# of SoonerCare Choice members with greater than 4 ER visits in a quarter	2,046	2,808	2,219	-20.98%	
3.6.3	% of SoonerCare Choice members with greater than 2 ER visits in a quarter	3.67%	4.50%	3.47%	-22.97%	
3.6.4	% of SoonerCare Choice members with greater than 4 ER visits in a quarter	0.44%	0.55%	0.40%	-27.91%	
3.7	Objective: To provide members the resources they need to decrease or prevent tobacco use					
3.7.1	# of Medicaid members calling tobacco helpline	5,778	5,575	4,076	-26.89%	





3.7.2	# Of Medicaid members utilizing tobacco cessation benefits	25,098	22,790	21,610	-5.18%	
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Goal #4 – Satisfaction & Quality						
To protect and improve member health and satisfaction, as well as ensure quality, with programs, services and care						
		<u>2012</u>	<u>2013</u>	<u>2014</u>	<u>Variance</u>	<u>Trend</u>
4.1	Objective: To seek and evaluate member feedback on satisfaction with services received when accessing SoonerCare benefits					
	<u>Customer Survey Results (CAHPS) Adults</u>					
4.1.1	Customer Service		90%	82%	-8%	
4.1.2	How Well Doctors Communicate		87%	90%	3%	
4.1.3	Getting Care Quickly		79%	82%	3%	
4.1.4	Getting Needed Care		80%	82%	2%	
4.1.5	Shared Decision Making		48%	50%	2%	
	<u>Customer Survey Results (CAHPS) Children</u>					
4.1.6	Customer Service		84%	88%	4%	
4.1.7	How Well Doctors Communicate		93%	97%	4%	
4.1.8	Getting Care Quickly		93%	92%	-1%	




4.1.9	Getting Needed Care		89%	89%	0%	
4.1.10	Shared Decision Making		52%	60%	8%	
4.2	Objective: To partner with Oklahoma’s long-term care facilities to strive for quality long-term care services					
4.2.1	% of 5-star facilities in Focus on Excellence	15%	18%	17%	-1%	
4.2.2	% of 4-star facilities in Focus on Excellence	16%	29%	29%	0%	
4.2.3	% of members participating in the Resident Satisfaction Survey rating overall quality as excellent or good		94%	93%	-1%	
4.2.4	% of employees participating in the Employee Satisfaction Survey who rate overall satisfaction as excellent or good		88%	85%	-3%	
4.3	Objective: To ensure members and providers have access to assistance through member and provider services					
4.3.1	# of member calls	88,473	78,746	86,509	10%	//
4.3.2	# of provider calls	32,090	34,027	44,061	29%	//
4.4	Objective: To maintain a quality provider community by following appropriate procedures to identify noncompliant providers and determine the appropriate course of action to resolve issues					
4.4.1	# involuntary provider contract terminations	59	43	95	121%	//
4.5	Objective: To train and educate SoonerCare providers, both on an “as-needed” and a proactive basis, through group and/or individual training and other communication					
4.5.1	Seminars/workshops	43	28	29	10%	//

4.5.2	Onsite trainings attendees	5,200	5,242	7,211	10%	//
4.5.3	Policy letters	104	70	43	10%	//

Goal #5 – Eligibility & Enrollment						
To provide and improve health care coverage to the qualified populations of Oklahoma						
		<u>SFY 2012</u>	<u>SFY 2013</u>	<u>SFY 2014</u>	<u>Variance</u>	<u>Trend</u>
5.1	Objective: To reduce the number of Oklahomans without access to medical coverage					
5.1.1	Unduplicated medicaid enrollment - total	1,007,356	1,040,332	1,033,114	-0.70%	//
5.1.2	% of enrollment change (includes Insure Oklahoma)	4.0%	3.3%	-0.7%	-4.00%	//
5.1.3	Insure Oklahoma—Employee Sponsored enrollment	16,865	16,502	13,729	-16.80%	
5.1.4	Insure Oklahoma—Individual Plan enrollment (eligibility changed in SFY2014)	13,511	13,358	4,737	-64.54%	
5.1.5	% of SoonerCare & Insure Oklahoma population who are children	57%	57%	57%	0%	
5.1.6	% of SoonerCare & Insure Oklahoma population who are adults	43%	43%	43%	0%	
5.1.7	Estimated count of eligible-but-not-enrolled population (EBNE)	64,860	64,965	58,699	-9.65%	
5.1.8	% of online enrollment applications that are new	57%	55%	52%	-3.00%	
5.1.9	% of online enrollment applications that are recertifications	43%	45%	48%	3.00%	

% of OE applications by media type:						
5.1.10	Home internet	47%	55%	59%	4.00%	
5.1.11	Paper	9%	5%	5%	0.00%	
5.1.12	Agency internet	24%	26%	35%	9.00%	
5.1.13	Agency electronic (OKDHS shifted use to agency internet category)	20%	14%	1%	-13.00%	

Goal #6 – Administration						
To foster excellence and innovation in the administration of the OHCA						
		<u>2012</u>	<u>2013</u>	<u>2014</u>	Variance	<u>Trend</u>
6.1	Objective: To consistently perform administrative responsibilities within funding budgeted					
6.1.1	% of administration budgeted dollars used	86.60%	65.79%	73.00%	7.21%	
6.2	Objective: To control administrative costs while providing appropriate support and services to SoonerCare members					
6.2.1	Per capita OHCA administrative cost	\$136.28	\$119.92	\$138.96	15.88%	
6.3	Objective: To pay SoonerCare claims within an accuracy rate of at least 97 %, considering policy and systems issues and member eligibility					
6.3.1	# of claims paid	36,636,568	49,829,140	51,226,118	2.80%	//
6.3.2	Payment accuracy measurement rate	97.60%	95.50%	97.64%	2.14%	

6.4	Objective: To maintain appropriate prior authorization requirements for the health of the member				
6.4.1	# of prior authorizations generated for prescriptions	155,644	115,206	-0.28%	
6.4.2	% of automatic prior authorizations for prescriptions	24.60%	22.10%	-2.50%	//
6.4.3	% of manual prior authorizations for prescriptions	75.40%	77.90%	2.50%	//
6.5	Objective: To maintain and/or increase program and payment integrity efforts which may result in recoveries and/or cost prevention				
6.5.1	Payment integrity recoveries	\$3,008,884.00	\$2,359,957.00	\$2,822,343.00	19.60% 
6.5.2	# of provider audits	133	285	114.29%	
6.5.3	# of providers referred to Medicaid Fraud Control Unit	1	0	-100.00%	//
6.6	Objective: To actively pursue all third party liability payers, rebates and fees and recover or collect funds due to the SoonerCare and federal Medicare program				
6.6.1	Third party liability recoveries	\$40,258,563	\$53,212,491	\$37,965,691	-28.66% //
6.6.2	# of SoonerCare members with third party insurance	163,006	160,271	-1.68%	//
6.6.3	% of SoonerCare members with third party insurance	20.60%	20.30%	-0.30%	//

Goal #7 – Collaboration
To foster collaboration among public and private individuals and entities to build a responsive health care system for Oklahoma

		SFY 2012	SFY 2013	SFY 2014	Variance	Trend
7.1	Objective: To partner with others to enroll qualifying children, parents and other adults into SoonerCare					
7.1.1	% of online applications by source (agency view)	21.41%	23.06%	30.98%	8%	↑
7.1.2	% of online applications by source (home view)	47.55%	54.88%	60.34%	5%	↑
7.1.3	% of online applications by source (combined home and agency view)	68.97%	77.94%	91.32%	13%	↑
7.2	Objective: To partner with other state entities in activities with joint objectives targeting SoonerCare populations					
7.2.1	Accumulated state and federal revenue generated by collaborations to provide services	\$848,660,601	\$1,230,314,375	\$1,292,233,657	5%	↑
7.2.2	Accumulated state and federal revenue generated by collaborations to provide medical education	\$94,138,193	\$126,057,898	\$136,788,040	9%	↑
7.3	Objective: To engage in partnerships promoting education, job growth, and self-sufficiency					
7.3.1	# of individuals who completed certification through the Certified Nurse Aide (CNA) Waiver Training Program	957	711	405	-43%	↓
7.4	Objective: To effectively serve Oklahoma's SoonerCare qualified American Indian population by maintaining partnerships with Oklahoma's 39 federally recognized American Indian tribes					
7.4.1	# of tribal enrollment partnerships	N/A	14	16	14%	↑
7.4.2	# of tribes represented at tribal consultations	N/A	11	17	55%	//
7.4.3	# of tribal consultations per year	N/A	7	9	29%	//

TECHNICAL NOTES

The following notes pertain to goals, objectives and measures in the preceding Performance Measures Dashboard. Variances and trends are based on changes in the data between SFY2013 and SFY2014.

Goal 1

- 1 Any variance less than 5% is considered to indicate no significant change over the previous year.
- 1.1.2 Other Medical Costs should include the other costs related to Physicians like: Clinics, Dentists, Home Health Care, Lab & Radiology, Medical Supplies, Other Practitioners, and Personal Care Services.

Goal 2

- 2 Any variance less than 3% is considered to indicate no significant change over the previous year.
- 2.4.1 In July 2013, the HMP transitioned to a new model that embeds health coaches in the offices of participating practices. The significant decrease in enrollment noted for SFY2013 was in preparation for the transition to the new model including the decline in practice facilitation in SFY2014. The health coaching model replaces field and telephonic-based nurse care management (Tiers). Projections are provided for SFY2014 forward.
- 2.6 This data represents a point-in-time. (June 30)
- 2.6.3 ER referrals were removed from this number; change in previous reporting methodology. In the future, more flexibility will be given to the HANs in identifying members in need of care management services.

Goal 3

- 3 Any variance less than 5% is considered to indicate an insignificant change over the previous year.
- 3.1 HEDIS data is reported by report year, not data year, and data for SFY2014 was not available at the time of publication.
- 3.2 Immunization Rates are reported by calendar year.
- 3.3 HEDIS data is reported by report year, not data year, and data for SFY2014 was not available at the time of publication.
- 3.5 The variance for prenatal care percentages before delivery is calculated by the difference between SFY2014 and SFY2015.

Goal 4

- 4 Any variance less than 3% is considered to indicate no significant change over the previous year. Typical year-to-year variances in CAHPS results hover below the 3% threshold.
- 4.1 CAHPS survey questions were revised in 2013. Results are not directly comparable to previous years.
- 4.2 The Focus on Excellence Satisfaction Survey Report of Oklahoma's Nursing Facilities reports results every January for the prior calendar year.
- 4.4 The significant increase in the number of involuntary provider contract terminations is the result of an increase in the number of DME provider and physician assistant terminations. Durable Medical Equipment provider terminations resulted from the implementation of policy changes that took effect at the renewal period. The new policy requires that out-of-state providers who do not provide a "specialty" product may not contract with OHCA. The increase in the

number of terminations of Physician Assistant contracts is due to the implementation of a new process in which OHCA receives more frequent updates regarding expired, suspended, and terminated licenses.

Goal 5

- 5 Any variance less than 3% is considered to indicate no significant change over the previous year.
- 5.1.4 The significant decrease in the percentage of Insure Oklahoma Individual Plan enrollment is due to a change in eligibility thresholds from 200% FPL to 100% FPL. This change occurred during SFY 2014 in January 2014.
- 5.1.7 The Estimated Count of Eligible-But-Not-Enrolled Population (EBNE) also referred to as the "woodwork" population is the population of Oklahomans that were previously ineligible for Medicaid but have now become eligible.
- 5.1.8 -- The numbers for online enrollment applications for December 2013 to May 2014 were revised to remove passive
- 5.1.13 that were inflating the numbers for online enrollment.
- 5.1.12 -- Due to technological changes the Oklahoma Department of Human Services (OKDHS) is now utilizing the non-direct
- 5.1.13 online enrollment system to enroll members accounting for the significant increase in the Agency Internet media type and significant decrease in the agency electronic media type.
- 5.1.13 As noted in parentheses in Objective 5.1.13 the Oklahoma Department of Human Services shifted use to the agency internet category as result of the decision to not modify their information systems to accept new MAGI standards set by CMS.

Goal 6

- 6 Any variance less than 5% is considered to indicate no significant change over the previous year, with the exception of Objective 6.3.
Projections achieved by taking data input for FY 09 thru FY 14 and using Excel to trend the numbers forward for SFY 15 and those numbers were copied for future years.
- 6.3 The Payment Accuracy Rate is based on the Federal Payment Error Rate which measures variances down to the level of 100th of a percent. Due to the minute level of calculations, the threshold variance for indicating significant change is 2%.

Goal 7

- 7 Any variance less than 5% is considered to indicate no significant change over the previous year.
- 7.1 Online enrollment activity includes new applications and recertifications, as well as the applications that are accepted a denied.
Not all can apply online. Of those who can apply online approximately 90% do.
- 7.2 These measures report the accumulated state and federal revenue generated by collaborations with other state agencies and state universities to provide services and medical education.
- 7.1.1; OKDHS is excluded as a partner agency to illustrate the change in the application source following the implementation
- 7.1.3 of online enrollment in September 2010. Prior to online enrollment, all Medicaid applications were processed by OKDHS. In SFY2014, 1.7% of applications were paper and OKDHS was the source of 6.7% of application (8.4% combined paper and OKDHS applications).
- 7.3.1 Programmatic change occurred in 2014 resulting in significant decrease in the number of individuals completing

certification.

7.4.1 Tribal enrollment partners provide application assistance using agency view and the home view of online enrollment

GOAL 1 — FINANCING & REIMBURSEMENT

TO RESPONSIBLY PURCHASE COST EFFECTIVE HEALTH CARE FOR MEMBERS BY MAINTAINING APPROPRIATE RATES AND TO CONTINUE TO STRENGTHEN HEALTH CARE INFRASTRUCTURE

Objective 1.1:

To reimburse providers, when applicable Medicare rates are available, at 100% of Medicare rates

Measured By:

1.1.1— Total expenditures for physicians & midlevel practitioners' services

1.1.2— Total expenditures for other medical costs

1.1.3— Reimbursement as a % of Medicare rates

Why is this objective important?

To ensure adequate numbers of providers and that they are able to maintain quality services, technical expertise and current best practices, it is critical that they are reimbursed at appropriate rates. Reimbursement rates may affect providers' decisions to serve SoonerCare members.

What trends do the measures indicate?

Total expenditures for physicians' and mid-level practitioners' services (Fig. 1.1.a) rose about 10% from 2012 to 2014. Expenditures for other medical services (e.g. clinics, dentists, home health care, lab & radiology, medical supplies, other practitioners, personal care services) have risen about 4% during that time. Reimbursement as a percentage of Medicare rates remained stable at 96.75% from 2011 to 2014. While total expenditures for medical services are expected to continue rising, the OHCA has recommended a decrease in reimbursement rates to 89.25% of Medicare rates in order to reduce agency spending and balance the state budget. This temporary decrease is not expected to have a long-term negative impact on access to or quality of care provided to SoonerCare members.

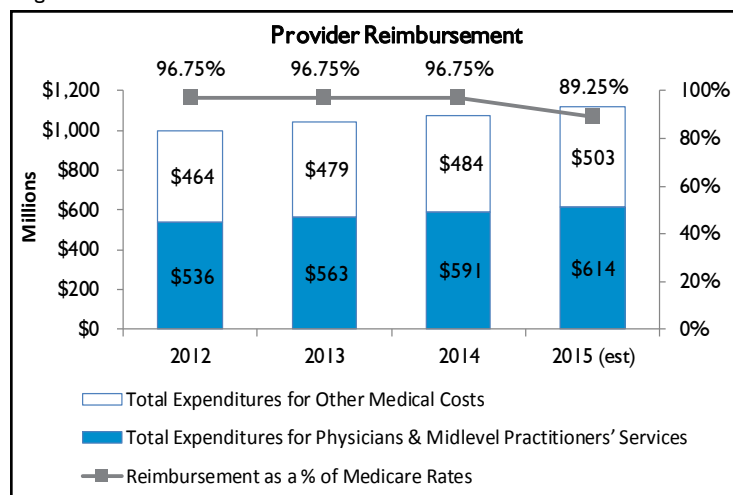
Are the trends headed in the right direction?

Due to budget constraints, the OHCA is currently reimbursing providers at less than 100% of applicable Medicare rates and that percentage is expected to be lower for 2015.

What is the agency doing to influence performance towards the objective?

OHCA is committed to reimbursing providers at appropriate rates. In the past, OHCA worked diligently to increase provider reimbursement to 100% of Medicare rates. However, due to budget constraints in SFY 2010, it was necessary to cut those rates in to 96.75% and another cut planned for SFY 2015 will lower rates to 89.25% of Medicare rates. Annual agency budget requests are made seeking to restore the provider rates back to 100%.

Fig. 1.1.a



Source: OHCA Financial Services Division

Objective 1.2:

To reimburse hospital providers at 100% of Federal Upper Payment Limit (UPL)

Measured By:

1.2.1— Total expenditures for general medical/surgical hospital services

1.2.2— Total expenditures for psychiatric hospitals and psychiatric residential treatment facilities (PRTF)

1.2.3— Reimbursement as a % of federal UPL

Why is this objective important?

Hospitals are an important part of Oklahoma's health care safety net since they are major providers of care for low-income and uninsured populations. It is important to maintain reimbursement amounts at the UPL in order to ensure continued availability of hospital care to Oklahoma's low-income population.

What trends do the measures indicate?

Total expenditures for general medical and surgical hospitals (Fig. 1.2.a) rose 3.9% from 2012 to 2014 while expenditures for psychiatric hospitals and PRTFs rose only 2.1%. Despite a slight dip in 2013, hospital reimbursements as a percentage of Federal UPL show an upward trend overall. Hospitals are being paid a higher percentage of Federal UPL in 2014 than in previous years. The percentage of Federal UPL is expected to stay at the current rate (87.96%) but total expenditures for hospital care are expected to rise for 2015.

Are the trends headed in the right direction?

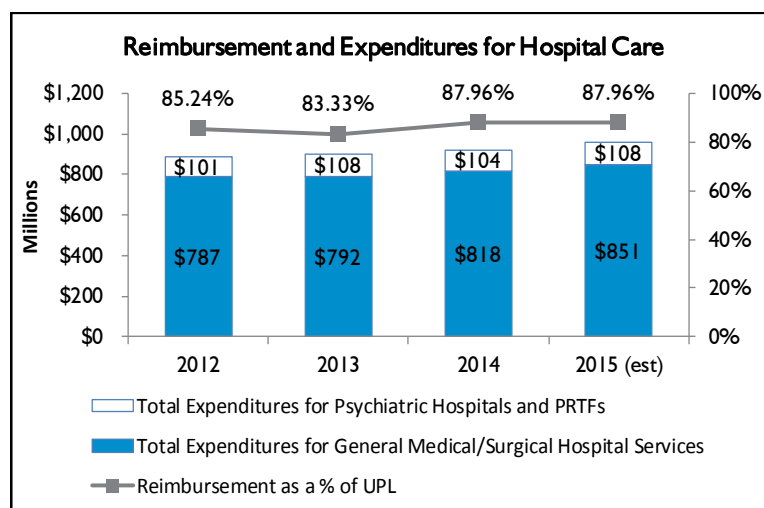
The trend for hospital reimbursements as a percentage of the federal UPL is headed in the right direction. Hospitals are being paid a higher percentage of the federal UPL than in the previous 3 years.

What is the agency doing to influence performance towards the objective?

To assure access to quality care for SoonerCare members, the Oklahoma legislature enacted the Supplemental Hospital Offset Payment Program (SHOPP) Act in 2011. In accordance with federal rules and regulations, hospitals in Oklahoma are assessed a fee to be used as state funds in order to garner federal

matching funds to be invested in maintaining and improving Medicaid hospital rates as supplemental payments for those who pay the fee. This enables OHCA to pay the hospitals at the Federal UPL without passing this fee on to patients. This is intended to supplement the existing state appropriations to maintain the rates paid to hospitals. OHCA’s aim is to reimburse hospitals at a maximum rate not exceeding the statutory ceiling of the Federal UPL.

Fig. 1.2.a



Source: OHCA Financial Services Division

Objective 1.3:

To reimburse long-term care facilities at 100% of the Federal Upper Payment Limit (UPL)

Measured By:

1.3.1— Total Expenditures for Nursing Facility (NF) Care

1.3.2— Average Percentage (of UPL) Reimbursement for NF Costs (per Patient Day)

1.3.3— Total Expenditures for Intermediate Care Facilities for the Intellectually Disabled (ICF/ID) Care

1.3.4— Average Percentage (of UPL) Reimbursement for ICF/ID Costs (per Patient Day)

Why is this objective important?

OHCA understands the important function of long-term care facilities: providing the best quality of life for residents. Medicaid continues to be the main source of long-term care financing in the U.S. It is estimated that Medicaid is responsible for reimbursing some 65% of NF care costs. Maintaining sound reimbursement rates to help preserve the stability that long term care facilities provide is a goal of OHCA.

What trends do the measures indicate?

The average percentage of reimbursement for NF costs (Fig. 1.3.a) has risen from 89% to 99.4% since 2012. The average percentage of reimbursement for ICF/IDs dropped slightly in 2014 from 100% to 99.8%. The

total cost of NF care by 17.4% and the total cost of care for ICF/IDs fell 14.6% from 2012 to 2014. The total cost of all long-term care in 2014 was nearly \$670 million and is expected to rise to about \$696 million in 2015

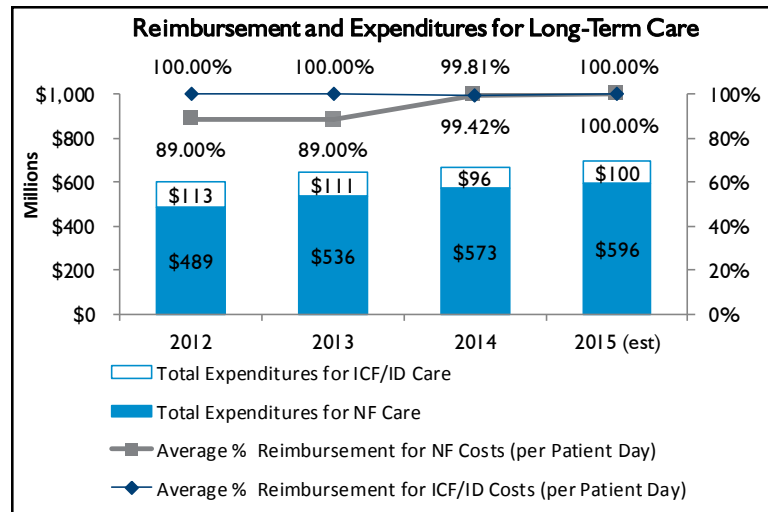
Are the trends headed in the right direction?

Reimbursement rates, as a percentage of UPL, for NF and ICF/ID costs are very close to the target of 100%. However, trends are mixed. While the percentage of reimbursement paid to ICF/IDs is higher than that paid to NFs, that rate fell slightly in from 100% in 2013 to 99.8% in 2014. Conversely, the rate for NFs improved from 89% to 99.4% during that time.

What is the agency doing to influence performance towards the objective?

The Focus on Excellence (FOE) program was designed to encourage nursing facility improvements in quality, life, and care. OHCA initiated this program in 2007 with the aim of having top-rated care in nursing facilities, thereby enhancing the lives of residents as well as their families. Additional Medicaid payments are made to facilities that meet or exceed established FOE threshold requirements for the quality performance measures.

Fig. I.3.a



Source: OHCA Financial Services Division

Objective I.4

To reimburse Eligible Professionals/Hospitals for participation in the Electronic Health Records (EHR) Incentive Program

Measured By:

- I.4.1 -- Number of Eligible Professionals Receiving an EHR Incentive Payment
- I.4.2 -- Number of Eligible Hospitals Receiving an EHR Incentive Payment
- I.4.3 -- Total EHR Incentive Payments to Eligible Professionals/Hospitals
- I.4.4 -- Percentage of Eligible Professionals in compliance with meaningful use of EHR

1.4.5 -- Percentage of Eligible Hospitals in compliance with meaningful use (MU) of EHR

Why is this objective important?

The Centers for Medicare and Medicaid Services (CMS) has implemented the EHR Incentive Program to incentivize eligible professionals and eligible hospitals that adopt, implement, upgrade, or successfully demonstrate meaningful use of certified Electronic Health Record technology. The ultimate goals of the program are to improve population health, quality of care, and to reduce the cost of healthcare by eliminating duplication of services.

What trends do the measures indicate?

The number of eligible professionals and hospitals receiving EHR incentive payments and complying with MU requirements is steadily rising (Fig. 1.4.a). However, the total amount of EHR incentive payments to professionals and hospitals has dropped steadily from 2012 to 2014. This is largely due to the reduction in incentive payments to providers after their first year of participation. First year payments are \$21,250 and payments for years 2 – 6 are \$8,500 each year. The total amount of EHR incentive payments is expected to rise by 29% in 2015 due to an expected increase in new participants.

More information about the Oklahoma EHR Incentive Program can be found at www.okhca.org/ehr-incentive.

Are the trends headed in the right direction?

The trends for participation in the EHR incentive program are headed in the right direction. The program is designed to provide incentives to eligible professionals/hospitals to adopt or develop EHR systems. The incentive payments are no longer needed after the EHR system is fully implemented. As the number of providers who have implemented EHR increases, total incentive payments have decreased as expected. Likewise the percentage of providers achieving MU compliance has increased toward the maximum of 100%.

What is the agency doing to influence performance towards the objective?

OHCA is in the process of implementing the ePrescribing Payor Enablement system to assist providers in meeting Meaningful Use requirements. When the system is implemented in November 2015, providers who use SureScripts directly or have EHR systems that connect to SureScripts, will be able to view member eligibility, medication claims history, and drug formulary information online. Enhanced funds have been requested from CMS to allow additional resources from the Oklahoma State Department of Health to be used to assist providers in submitting immunization, certain lab results, and other disease registry information electronically to the relevant systems maintained at OSDH.

OHCA staff provides communication and outreach to the provider community and hospitals. OHCA representatives participate in numerous meetings with associations and providers, as well as conduct workshops to explain the program and encourage those eligible professionals and eligible hospitals to participate. OHCA conducts formal training sessions, showcasing eligibility requirements, the enrollment process, and answering questions about the program. Provider Education Specialists at OHCA respond to inquiries from providers covering all aspects of the EHR program.

OHCA is also committed to supporting health information exchange efforts and continues to seek out opportunities to collaborate with our Oklahoma-based health information organizations as they support our

providers and members.

Fig. 1.4.a

EHR Incentive payments	2012	2013	2014	2015 (est)
# of Eligible Professionals Receiving an EHR Incentive Payment	718	780	1,022	1,500
% of Eligible Professionals in compliance with meaningful use of EHR	3.8%	45.3%	61.0%	75.0%
# of Eligible Hospitals Receiving an EHR Incentive Payment	44	46	55	60
% of Eligible Hospitals in compliance with meaningful use of EHR	4.5%	73.9%	98.2%	100.0%
Total EHR Incentive Payments to Eligible Professionals/Hospitals	\$ 44,062,545	\$ 38,968,791	\$ 32,553,188	\$ 42,000,000

Source: OHCA Business Enterprise Services Division

Objective 1.5

To strive to accurately project the future costs of providing SoonerCare health benefits to Oklahomans

Measured By:

- 1.5.1— Total Number of Unduplicated SoonerCare Members Enrolled
- 1.5.2— Total SoonerCare Program Expenditure
- 1.5.3— Average SoonerCare Program Expenditure per Member

Why is this objective important?

Accurately predicting the future costs of providing services to SoonerCare members is a task that involves an element of uncertainty. OHCA uses the past and the current expenditures to come up with an estimate for the coming years. Due to the uncertain nature of the economy and political environment, the forecasted costs may not hold good in the changed circumstances.

What trends do the measures indicate?

The number of SoonerCare members (Fig. 1.5.a) decreased slightly in 2014 but the overall trend from 2012 to 2014 shows an increase of 2.6%. SoonerCare expenditures (Fig. 1.5.a) have risen faster than membership with an increase of 7.9% from 2012 to 2014 resulting in a 5.2% increase in the average amount paid per member (Fig. 1.5.b). OHCA projects a net increase of about 23,000 SoonerCare members in 2015 and expenditures are expected to rise by about \$176 million resulting in an increase in average expenditures to about \$4,427 per member.

Are the trends headed in the right direction?

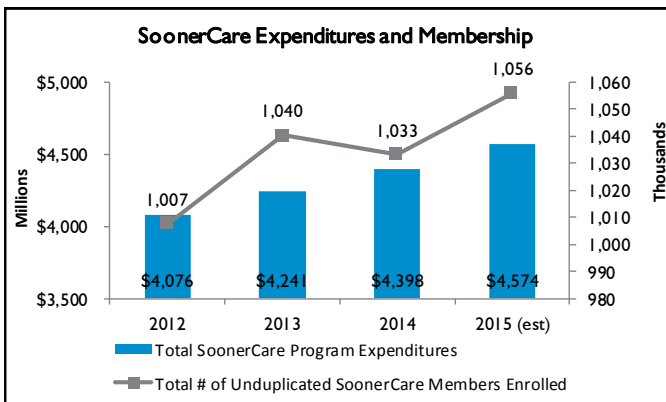
The decrease in the number of SoonerCare members in SFY2014 is an indication of the overall strength of the economy in Oklahoma. When the economy is good fewer people enroll in the program. The increase in expenditures can be attributed to the general increases in health care costs. However, historically SoonerCare costs rise at a rate far below the national health care inflation rate.

What is the agency doing to influence performance towards the objective?

OHCA strives in many ways to keep the Average SoonerCare Program Cost per Member as low as possible. Our Population Care Management division manages multiple member populations who are at risk due to chronic or acute conditions. Our Finance and Medical Authorizations division ensures that a high percentage of claims are paid appropriately at the time of payment. The Centers for Medicare & Medicaid Services (CMS) measures improper Medicaid payments through the Payment Error Rate Measurement (PERM) program. Oklahoma’s error rate for federal fiscal year (FFY) 2012 was 0.28%; the national average error rate was 5.8%. In State Fiscal Year (SFY) 2013, OHCA increased the number of staff performing post-payment reviews, so that more claims could be examined for medical appropriateness.

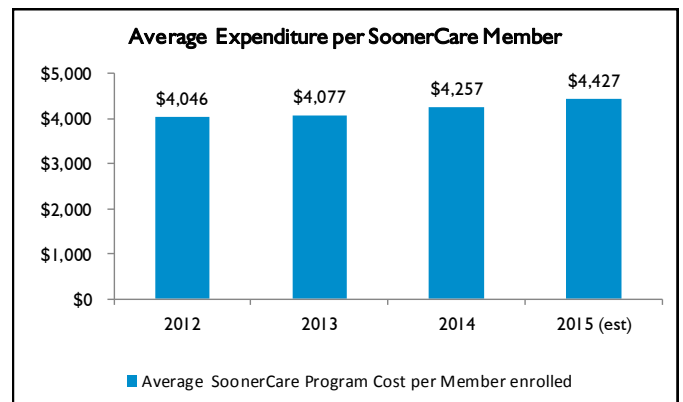
OHCA has implemented multiple system verifications in our Online Enrollment application to ensure the integrity of member enrollment applications. Enhanced verifications of employment, income, and Social Security Number validity are examples of these.

Fig. 1.5.a



Source: OHCA Financial Services Division

Fig. 1.5.b



Source: OHCA Financial Services Division

Objective 1.6:

To strive to accurately project the future costs of providing Insure Oklahoma health benefits to Oklahomans

Measured By:

- 1.6.1— Total number of unduplicated Insure Oklahoma members enrolled
- 1.6.2— Total Expenditure for Insure Oklahoma
- 1.6.3— Average Expenditure per Insure Oklahoma member

Why is this objective important?

Funded through a combination of state tobacco tax revenues and federal funds, the Insure Oklahoma program provides insurance options for low-income, working Oklahomans. Enrollment into the program is capped based on available resources. Therefore it is essential that OHCA carefully budget future expenditures of the program in order to manage new enrollments and ensure the program’s sustainability.

What trends do the measures indicate?

Insure Oklahoma membership and expenditures have steadily decreased from 2012 to 2014. Membership (Fig. 1.6.a) has decreased a total 17.2% to 40,261 in 2014. Total expenditures (Fig. 1.6.a) have decreased even more dramatically (20.8%) from \$119.4 million to \$94.6 million in the past 3 years. Average expenditures per member (Fig. 1.6.b) followed this trend with a 12.2% decrease from 2012 to 2014. However, OHCA is projecting increases in membership and expenditures for Insure Oklahoma in 2015.

More information about Insure Oklahoma can be found here: <http://www.insureoklahoma.org/>.

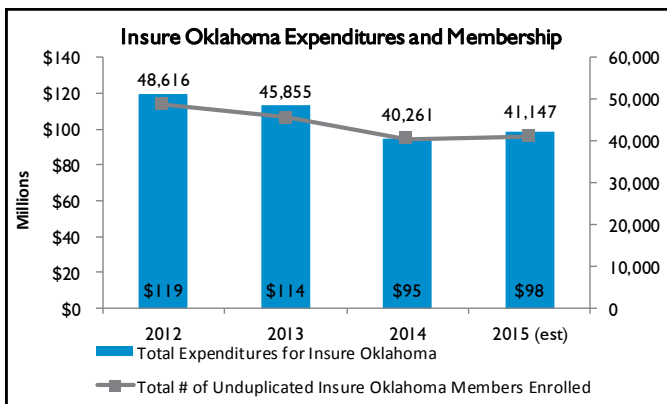
Are the trends headed in the right direction?

Membership and total expenditures for the Insure Oklahoma program have been falling steadily since 2012. This trend is headed in the right direction and is an indication of economic improvement in the state.

What is the agency doing to influence performance towards the objective?

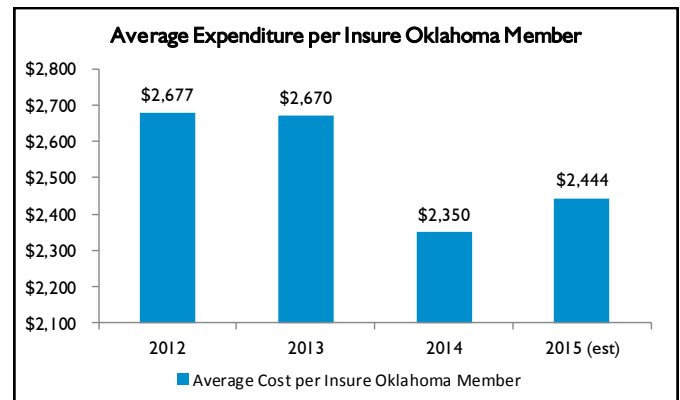
OHCA recently received approval from CMS to extend the Insure Oklahoma program for another year, through calendar year 2015. Oklahoma continues to work with federal partner CMS to extend the program for the long-term through the waiver process. OHCA is reviewing the decrease in tobacco tax revenue and looking at alternative state funding options that will allow Insure Oklahoma to raise the cap on covered applicants to the program.

Fig. 1.6.a



Source: OHCA Financial Services Division

Fig. 1.6.b



Source: OHCA Financial Services Division

Objective 1.7:

To strive to restructure and improve the access, quality, and continuity of care for members by providing appropriate per member per month payment to Health Access Networks (HANs) by roster size

Measured By:

- 1.7.1— Average monthly enrollment in HANs
- 1.7.2— Total payments made to HANs
- 1.7.3 — Total number of HAN member months

Why is this objective important?

HANs are the non-profit administrative entities that work with providers to coordinate and improve the quality of care for SoonerCare members. HANs are organized for the purpose of restructuring and improving the access, quality, and continuity of care to SoonerCare members. ANs are reimbursed on a per member per month (PM/PM) rate based on the number of member months paid to the PCPs affiliated with a particular HAN. Because HANs are located in the community where their patients live, HANs are connected to local resources and providers and can best coordinate our members' access to quality health care. When members with complex health care needs are assigned to a primary care provider who is affiliated with a HAN, those members have access to a local care coordinator who can help them navigate the health care system. It is important that OHCA provide appropriate PM/PMs to HANs in order to maintain their financial viability.

What trends do the measures indicate?

Average monthly enrollments and payments (Fig 1.7.a) have more than doubled since 2012 but projected increases for 2015 are much smaller. OHCA expects HANs will have an average monthly enrollment of nearly 112,000 with total payments to HANs of about \$6.8 million.

Are the trends headed in the right direction?

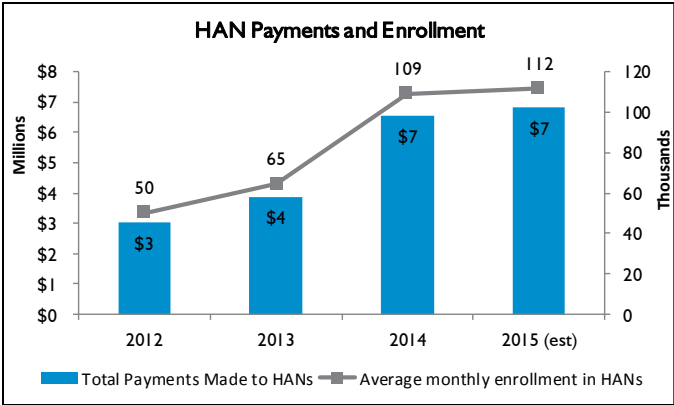
Increased enrollment in HANs is a trend in the right direction. Increased HAN membership means more people have access to quality, coordinated care.

What is the agency doing to influence performance towards the objective?

OHCA has developed rules that govern the participation and service delivery of the HANs. These rules are meant to provide assurance that HANs will work with providers to coordinate and improve the quality of care for SoonerCare members. Any network wishing to participate as a SoonerCare contracted HAN must submit an application to OHCA. The application must provide details about how the network plans to reduce costs of providing services to SoonerCare members, uninsured and underinsured persons; improve access to health care services; enhance the quality and coordination of health care services; and improve the health status of communities served by the HAN. The application to participate as a SoonerCare contracted HAN is approved after completion of a readiness review by OHCA staff and by OHCA's Medical Advisory Taskforce.

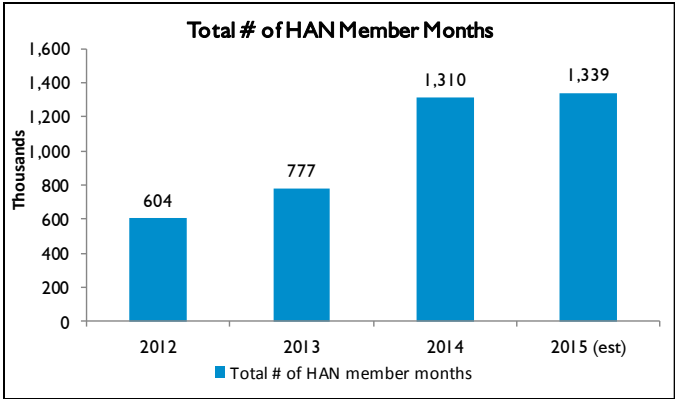
To monitor performance, OHCA requires HANs to submit annual reports detailing the number of providers participating in the network and the number of member services coordinated. The performance of HANs is evaluated by OHCA's contracted third party reviewer, Pacific Health Policy Group. The evaluation results are used to make policy changes and to improve and enhance the performance of HANs.

Fig. 1.7.a



Source: OHCA Financial Services Division

Fig. 1.7.b



Source: OHCA Financial Services Division

GOAL 2 — PROGRAM DEVELOPMENT

TO ENSURE THAT MEDICALLY NECESSARY BENEFITS AND SERVICES ARE RESPONSIVE TO THE HEALTH CARE NEEDS OF OUR MEMBERS

Objective 2.1:

To ensure that SoonerCare Choice members receive coordinated health care services through a medical home

Measured By:

- | | |
|---|--|
| 2.1.1— Number of Members enrolled in SoonerCare Choice | 2.1.6— % of Members Aligned with Tier 3 Optimal Medical Homes |
| 2.1.2— Number of Members enrolled in SoonerCare Traditional | 2.1.7— Number of Members Aligned with Tier 1 Entry-Level Medical Homes |
| 2.1.3— % of SoonerCare Members enrolled in SoonerCare Choice | 2.1.8— Number of Members Aligned with Tier 2 Advanced Medical Homes |
| 2.1.4— % of members Aligned with Tier 1 Entry-Level Medical Homes | 2.1.9— Number of Members Aligned with Tier 3 Optimal Medical Homes |
| 2.1.5— % of Members Aligned with Tier 2 Advanced Medical Homes | |

Why is this objective important?

Committed to a high-quality and cost effective health care delivery system, OHCA operates a Patient-Centered Medical Home (PCMH) model of care. SoonerCare Choice members select a medical home for individualized medical care and receive coordination of specialty care and other services. Individuals or groups of Primary Care Providers (PCPs) contract as PCMHs and provide quality health care by focusing on a member’s health care needs through the relationship formed with the member. A small percentage of SoonerCare members remain in SoonerCare Traditional but, when eligible, members are aligned with a PCMH to ensure coordinated health care services are provided. More information is provided at the [SoonerCare Choice](#) link.

What trends do the measures indicate?

Historically, the trend for SC enrollment has shown steady year-to-year growth. SoonerCare Choice enrollment numbers have continued to show growth through the years. In SFY2014, SoonerCare Traditional showed a slight increase from the previous year. For SFY2014, the percentage of SC members enrolled in SC Choice experienced a small-scale decrease when compared with the prior year (Fig. 2.1.a —SoonerCare Members). Over time the number and percentage of members aligned with Tier 3 medical homes has increased, creating movement among the tier levels (Fig. 2.1.b —SoonerCare Choice Members Aligned by Tiers).

Are the trends headed in the right direction?

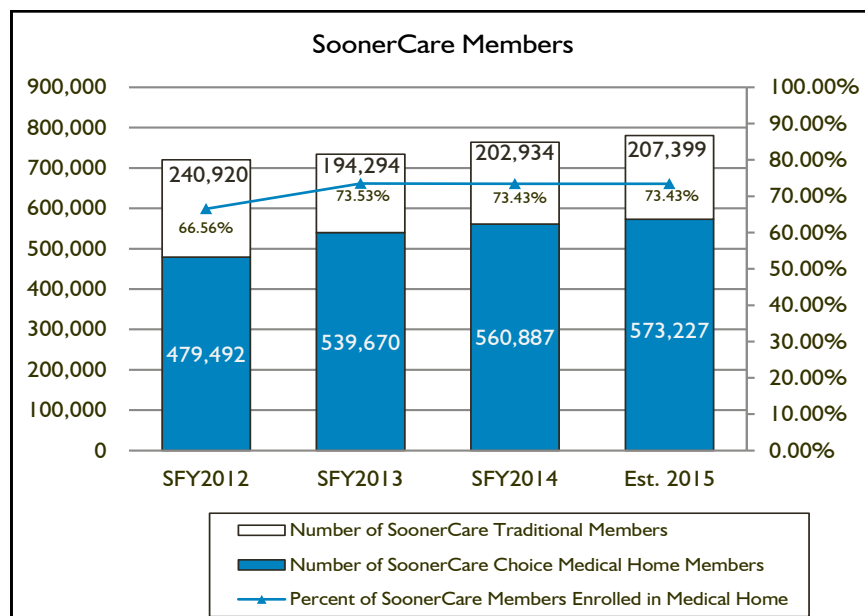
The SC enrollment pattern represents a steady increase. The proportion of SC Choice members to SC Traditional members is around 3 to 1, allowing those eligible to be enrolled with a PCMH. The percentage of SC Choice members being aligned with a PCMH is important as it guarantees the availability of quality health care through a medical home setting. The movement in tier alignment indicates the growth of the PCMH network at all tier levels, providing members with the opportunity to partner with a PCMH that best fits their

needs.

What is the agency doing to influence performance towards the objective?

Online enrollment is allowing Oklahomans with internet access to apply for SoonerCare from anywhere, at any time. The approved applicant selects a PCP as part of the application process; this has been a very successful feature of Online Enrollment. In the event a member does not use Online Enrollment, members who qualify for SoonerCare Choice PCMH are temporarily enrolled in SC Traditional fee-for-service. Every month, these members are identified through an automated process and are sent letters encouraging them to enroll with a PCP. These letters include lists of available PCPs who are taking new patients in the members' areas including contact information.

Fig. 2.1.a



Source: OHCA Fast Facts — Numbers reflect point-in-time data at June 30,2014

Fig. 2.1.b

SoonerCare Choice Members Aligned by Tiers						
	Tier 1	% of Members	Tier 2	% of Members	Tier 3	% of Members
SFY2012	220,566	46%	148,643	31%	110,283	23%
SFY2013	226,661	42%	167,298	31%	145,711	27%
SFY2014	229,964	41%	157,048	28%	173,875	31%
Est. SFY2015	235,023	41%	160,504	28%	177,700	31%

Source: Provider Services — Numbers reflect point-in-time data at June 30,2014

Objective 2.2:

To maintain a provider network that can adequately meet the needs of members

Measured By:

- | | |
|---|---|
| 2.2.1— SoonerCare Provider Network Count | 2.2.6— % of Tier 2 Advanced Medical Homes |
| 2.2.2— SoonerCare Choice Providers | 2.2.7— % of Tier 3 Optimal Medical Homes |
| 2.2.3— SoonerCare Choice Providers’ Total Capacity | 2.2.8— Number of Tier 1 Entry-Level Medical Homes |
| 2.2.4— SoonerCare Choice Providers’ Percentage of Capacity Used | 2.2.9— Number of Tier 2 Advanced Medical Homes |
| 2.2.5— % of Tier 1 Entry-Level Medical Homes | 2.2.10— Number of Tier 3 Optimal Medical Homes |

Why is this objective important?

Maintaining a strong provider network is important in ensuring that members are able to access needed medical care, especially in a largely rural state. The SoonerCare provider network is able to provide access by contracting with Medical Doctors, Doctors of Osteopathy, Physician Assistants (PAs) and Nurse Practitioners (NPs). Access to care and overall capacity is increased as a result of SoonerCare recognizing PAs and NPs as part of the primary care team, functioning as medical home sites. Adequate primary care for SoonerCare members is vital and medical homes are the entry point to needed care; providing important access to preventive health care services. A good mix of primary and specialty care providers in both urban and rural areas is ideal.

What trends do the measures indicate?

The total SoonerCare provider network has remained relatively stable; the methodology for counting providers changed effective SFY2013 to count provider networks for a more accurate representation of the provider network (Fig. 2.2.a —SoonerCare Provider Network Count). The number of SoonerCare Choice providers continues to trend upward (Fig. 2.2.b—SoonerCare Choice Provider Count). Self-reported providers’ capacity to serve members shows a slight decrease in the percentage of utilized capacity, remaining strong as the percentage utilized is still beneath half of the reported capacity (Fig. 2.2.c — SC Choice Provider Capacity and Percentage Utilized). PCMHs, when examined by tier levels, indicate that Tier 3 medical homes are on the rise and this trend has been demonstrated over the years (Fig. 2.2.d — SoonerCare Choice Patient-Centered Medical Home Providers by Tiers).

Are the trends headed in the right direction?

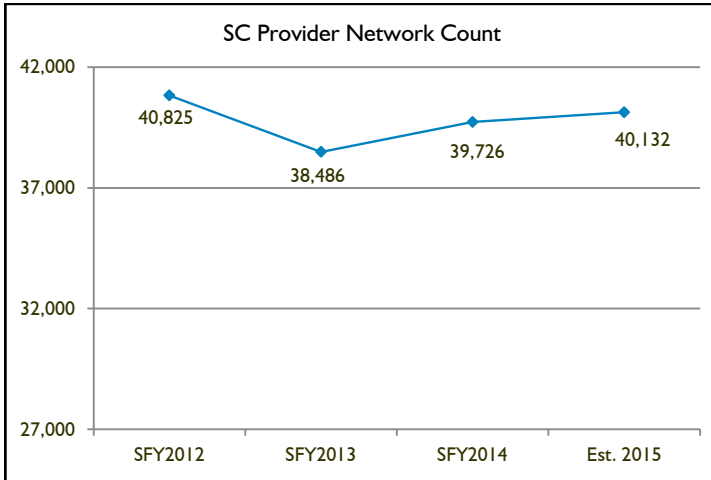
The increasing number of SoonerCare Choice providers is an indication that the provider network is growing which is crucial to ensuring that the needs of members can be adequately met. While the level of provider capacity available is sufficient; monitoring will continue to be important to ensure this trend is maintained. The rise in percentage of Tier 3 medical homes is a positive indicator. In addition to regular fee-for service rates, these medical homes earn higher care coordination payments in relation to the 3-tiered PCMH structure (Tier 1 being considered entry-level).

What is the agency doing to influence performance towards the objective?

OHCA continues ongoing recruitment efforts for new providers as well as retention efforts for currently contracted providers. Continued provider outreach and training is important to keep contracted providers informed of policies, procedures, and changes as well as maintaining a good relationship by seeking input for suggested areas of improvement. Streamlining processes and offering more functionality is important for

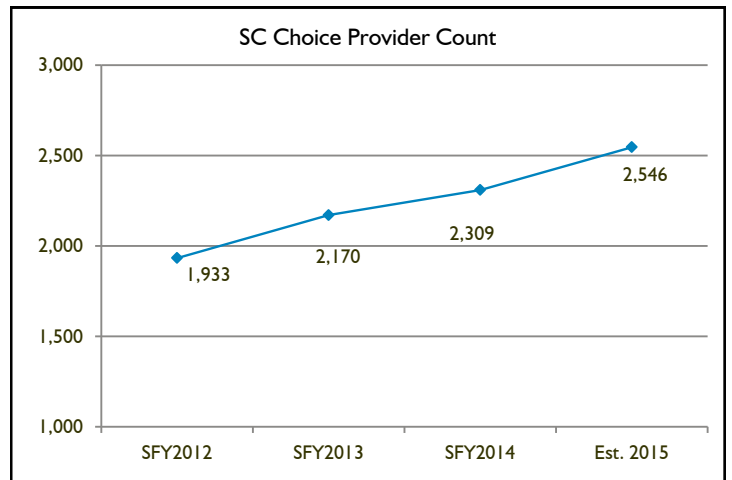
providers; in SFY2014, the Secure Site was upgraded with an efficient and user-friendly SoonerCare Provider Portal. Some of the features it provides users is the ability to securely search for specialty providers in the provider database, generate electronic referrals, and send and receive messages to OHCA representatives. OHCA recognizes that maintaining competitive reimbursement rates are important in retaining a sufficient provider network; therefore, after OHCA reduced reimbursement rates, monitoring the provider network for changes in enrollment will be essential.

Fig. 2.2.a



Source: OHCA Fast Facts — Numbers reflect point-in-time data at June 30,2014

Fig. 2.2.b



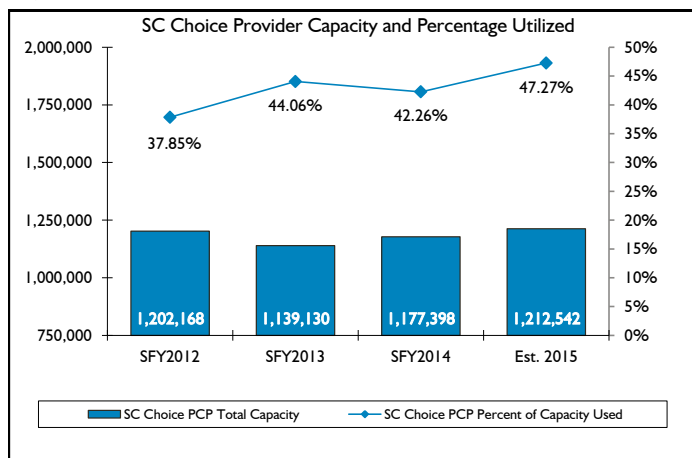
Source: OHCA Fast Facts — Numbers reflect point-in-time data at June 30,2014

Fig. 2.2.d

	SoonerCare Choice Patient-Centered Medical Home Providers by Tiers									
	Tier 1			Tier 2			Tier 3			
	% in Tier	In-state PCMHs	In-state and Out-of-state PCMHs	% in Tier	In-state PCMHs	In-state and Out-of-state PCMHs	% in Tier	In-state PCMHs	In-state and Out-of-state PCMHs	
SFY2012	64.9%	517	534	26.4%	209	217	8.7%	70	72	
SFY2013	58.6%	485	502	27.7%	225	237	13.7%	116	117	
SFY2014	56.9%	489	503	24%	199	212	19.1%	167	169	
Est. SFY2015	56.9%	498	514	24%	204	217	19.1%	171	173	

Source: OHCA Fast Facts — Numbers reflect point-in-time data at June 30,2014

Fig. 2.2.c



Source: OHCA Fast Facts — Numbers reflect point-in-time data at June 30,2014

Objective 2.3:

To promote responsive health care delivery through the Case Management unit for SoonerCare members with episodic or event-based case management needs

Measured By:

- 2.3.1— Number of New High-Risk OB members
- 2.3.2— Number of New At-Risk OB members
- 2.3.3— Number of New Fetal Infant Mortality Reduction Outreach to Moms
- 2.3.4— Number of New Infant Mortality Reduction Outreach to Babies

Why is this objective important?

OHCA is committed to helping SC members achieve optimal health outcomes by identifying and intervening early with episodic or event-based needs. Resources are allocated to these designated populations to promote healthy lifestyles and practices. Targeted groups receive early case management engagement and intervention. Case Management workers seek to ensure that the most appropriate care is received by the member. Maximizing positive outcomes can be brought about by engaging and educating members about making positive life-style changes while encouraging them to be active participants in their health care.

What trends do the measures indicate?

While the observed trend for the number of New High-Risk OB members continues to rise, both the number of New At-Risk OB Members and the New Fetal Infant Mortality reduction outreach to Moms remains flat. (Fig. 2.3.a —Obstetrical Cases managed). However, an upward trend is noted in the number of New Infant Mortality newborns identified for outreach over the years (Fig. 2.3.b —Newborn Cases managed).

Are the trends headed in the right direction?

OHCA is able to assist more SC members through increased enrollment in the High Risk OB program; this is expected to have a positive impact on outcomes as nurse care managers initiate and maintain contact with expectant moms through the postpartum period. More data will be required to develop trends for the At-Risk OB population as this number may be affected by many factors. These women are at-risk of experiencing possible adverse outcomes and are routinely followed through their pregnancies. These proactive services provide an opportunity to improve the outcome for the At-Risk OB member and the unborn child. Currently, OHCA aimed its efforts at lowering infant mortality rates in the ten worst performing counties in Oklahoma. The numbers reported are reflective of the number of women being newly identified within these 10 counties; more years of data will need to be examined before trends can be established. Every pregnant woman that is enrolled in the SoonerCare program is given the opportunity for identification of any medical needs related to the pregnancy; these care management efforts are expected to lead to healthier pregnancies and infants. The increase in the identification of New FIMR Newborn members is positive in that it allows a partnership to be developed between a nurse care manager and an infant’s mom; both working toward helping to ensure important, age-appropriate milestones are being met for each infant.

What is the agency doing to influence performance towards the objective?

OHCA is proactive in impacting positive outcomes for members with episodic or event-based needs. Clinically skilled staff intervene early through outreach activities, utilizing specialized interventions, for targeted populations. This is an optimal opportunity for members to be provided the necessary tools and support to make better health decisions. Member awareness is advanced through education and coordination of services

is provided for the member in the outreach process. Fostering engagement of members in their health care allows for positive change while affecting health outcomes and preventing medical costs. Newly identified members entering the programs highlighted in this section represent a portion of the large number of case-managed SC members

Fig. 2.3.b

Newborn cases managed	SFY2012	SFY2013	SFY2014	Est. SFY2015
New FIMR Newborn Members (1 month & under)	1,713*	2,100	2,138	2,161

Source: Population Care Mgmt. — Numbers reflect aggregate for 12-month period, SFY 2014
*Represents 11-month period

Fig. 2.3.a

Obstetrical Cases managed	SFY2012	SFY2013	SFY2014	Est. SFY2015
New High-Risk OB Members	1,832	1,998	2,474	2,523
New At-Risk OB Members	713	637	618	618
New FIMR OB Members	2,274	2,041	1,781	1,781

Source: Population Care Mgmt. — Numbers reflect aggregate for 12-month period, SFY 2014

Objective 2.4

To promote responsive health care delivery through the Health Management program (HMP) for SoonerCare members who have, or are at risk, for developing chronic diseases through engagement in active self-management.

Measured By:

2.4.1— Number of Members in HMP

2.4.3— % below forecast for HMP Members

2.4.2— Actual PMPMs for HMP Members

2.4.4— Number of Providers with On-Site Practice Facilitation

Why is this objective important?

Managing the medical needs of SC members who have, or are at risk, for developing a chronic condition is critical. It is known that chronic diseases are costly and a significant amount of health care dollars are expended on treatment for these health issues. Developing self-management skills for their medical condition can aid SC members in making better decisions regarding their care. Education and motivation for making lifestyle changes and taking a proactive role in their health is paramount to a member's long-term success for improved health outcomes.

What trends do the measures indicate?

The Forecasted versus the Actual per member per month (PM/PM) costs show the actual PM/PM lower than the forecasted PM/PM over the years (Fig. 2.4.a —Forecasted versus Actual PM/PM medical expenditures for HMP Members). The enrollment in HMP significantly decreased in SFY2013 while rapid growth in enrollment is shown in SFY2014 and future years. The number of providers with on-site practice facilitation showed a decrease in SFY2014 from past years (Fig. 2.4.b —HMP Enrollment and Practice Facilitation).

Are the trends headed in the right direction?

The forecasted per member per month rates for HMP members shows positive results in the reduction of medical costs and more predictable utilization trends; however, this measure will need to be studied over time as the enrollment numbers in the program have changed effective SFY2014. The significant decrease in

enrollment noted for SFY2013 was in preparation for the transition to a new model as was the decline in practice facilitation in SFY2014. Making program adjustments and changes to enhance a program’s effectiveness is of vital importance to securing long-term gains. The HMP core objectives remain the same, but one of the methods for reaching members has changed, allowing the entry of more members into the program.

What is the agency doing to influence performance towards the objective?

OHCA remains committed to making necessary changes to continue its effectiveness in managing the care of patients enrolled in the Health Management Program. These changes will be introduced more fully and evaluated in next year’s report with the SFY2014 evaluation completed by the contracted vendor, PHPG.

The HMP will continue to be involved in activities that offer assistance to individuals with chronic diseases that promote better health outcomes. Since its implementation, according to an independent evaluation by the PHPG for SFY2013, the OHCA HMP has been credited with preventing costs totaling over \$181 million dollars while improving in 16 of the 21 clinical measures. The OHCA encourages programs that advance the development of self-management skills thereby reducing costs and affecting predictable utilization trends.

Fig. 2.4.a

Forecasted versus Actual PMPM medical expenditures for HMP Members			
First 12 mos following participation in the HMP	Forecast PMPM	Actual PMPM	% below forecast
SFY2012	\$1,405	\$1,173	16.50%
SFY2013	\$1,375	\$1,125	18.20%
SFY2014	\$1,390	\$1,149	17.34%
Est. SFY2015	\$1,418	\$1,172	17.34%

Source: PHPG ; projections provided for 2014 — Numbers reflect point-in-time data at June 30,2013

Fig. 2.4.b

HMP Enrollment and Practice Facilitation	SFY2012	SFY2013	SFY2014	Est. SFY2015
Number of members in HMP	4,130	1,394	7,500	8,500
# of providers with on-site practice facilitation	53	50	33	53

Source: PHPG ; projections provided for 2014 — Numbers reflect point-in-time data at June 30,2013

Objective 2.5:

To promote responsive health care delivery through the Chronic Care unit (CCU) for SoonerCare members diagnosed with or who are at risk for a chronic condition(s)

Measured By:

- | | |
|--|--|
| 2.5.1— Number of Unduplicated Members in the Chronic Care unit | 2.5.3— % of members with a Diagnosis of Sickle Cell Anemia |
| 2.5.2— % of Members with a Diagnosis of Hemophilia | 2.5.4— % of Members with a Combination of Chronic Conditions |

Why is this objective important?

Utilizing evidence-based approaches is important when assisting SoonerCare members with chronic condition(s) or those who are at risk for developing a chronic condition(s). Educating SC members on their medical condition(s) while encouraging positive, healthy life-style changes is crucial. Promoting self-management of their health care needs is essential in helping members to achieve the goal of overall better health. The desired aim is to provide SC members with the tools necessary for managing their own condition(s) and being active participants in their own health care. This unit promotes self-management that produces healthier populations while reducing health costs.

What trends do the measures indicate?

More data will be required before trend details can be established and reported. SFY2013 data contains 6 months of information. SFY2014 data shows a substantial uptake in member participation for this new unit. In SFY2014, an increase in the number of members with a combination of chronic conditions is shown (Fig. 2.5.a —Chronic Care unit).

Are the trends headed in the right direction?

While more information will be required before trends can be developed, the rise in participation in the Chronic Care unit allows these SC members the opportunity to examine the challenges of their medical conditions while optimizing their health outcomes. The partnership formed will help the member gain the confidence necessary to take responsibility for their own health while support is given in the enhancement of self-management skills.

What is the agency doing to influence performance towards the objective?

OHCA offers telephonic care management support to members managed in the CCU with the aim of identifying and addressing gaps in members’ care while improving health-related behaviors. Productive interactions between OHCA clinically skilled staff help by forming a partnership with members; it is beneficial for sharing the importance of self-management as well as encouraging members to take an active role in understanding their medical condition(s). A depression screening is completed to ensure that Behavioral Health needs are met; follow-up referrals are addressed as necessary. This unit is recognized by OHCA as being critical to members becoming healthier and moving toward managing their illness, making informed decisions regarding their care, and improving health outcomes while reducing costs.

Fig. 2.5.a

Chronic Care unit (CCU)	SFY2013	SFY2014	Est. SFY2015
Number of unduplicated members in Chronic Care unit	206*	978	998
% of members with diagnosis of Hemophilia	31.0%	10.1%	10.1%
% of members with diagnosis of Sickle Cell Anemia	41.3%	12.9%	12.9%
% of members with a combination of chronic conditions	27.7%	77.0%	77.0%

Source: Chronic Care unit — Numbers reflect point-in-time data at June 30, 2014 * Represents a 6-month period

Objective 2.6:

To enhance the Patient-Centered Medical Home by working with SoonerCare Primary Care Providers to offer coordination and improvement of quality, access, and continuity of care for a segment of the SoonerCare population currently enrolled in Health Access Networks(HANs)

Measured By:

2.6.1— Number of contracted HANs

2.6.2— Total number of enrollees

2.6.3— Number of members identified to be offered Care Management

2.6.4— Number of unduplicated providers in HANs

Why is this objective important?

The HANs were structured to act as an enhancement to PCMHs to provide support to providers by enhancing their capabilities in the areas of access to care, coordination of care, and quality improvement. The HANs play an important role by offering care management (CM)/care coordination to members with specific complex health care needs. Targeted populations were identified to receive care management services, but the HANs are not limited to these populations, if other members are identified as needing care management. Some activities of the HANs can include helping to coordinate appointments for members and aligning members with specialty care. The HANs identify and integrate community resources, bringing together community-based services; this supplies a beneficial enhancement to the PCMHs that are affiliated with a HAN.

What trends do the measures indicate?

The number of contracted HANs has remained constant over time while the number of enrollees has continued to increase. In SFY2014, the number of members identified to be offered care management appears to have decreased although the number of unduplicated providers has shown steady upward growth over the years (Fig. 2.6.a —Health Access Networks).

Are the trends headed in the right direction?

The number of unduplicated providers that are aligning with the 3 HANs continues to increase. In addition to the other services mentioned, the HANs also assist PCMHs with Tier advancement. The number of members enrolled in the HANs continues to expand and is nearing the set enrollment capacity of 125,000. The reported number of members to be offered care management is from specific categories of identified populations; however, several changes took place in SFY2014. During this period, the OHCA changed the threshold for care management referrals based on ER visits in a quarter. The number of ER members showed

rapid upward change and is not reported in Fig.2.6.a. This is a change from the reporting methodology in previous years. Additionally, the HANs are now given greater flexibility in identifying members in need of care management services. This measure will require a revision to capture the understated number of members that receive care management services through the HANs.

What is the agency doing to influence performance towards the objective?

OHCA understood the importance of the SoonerCare Choice initiative of adding community-based Health Access Networks to work with affiliated PCMH providers to coordinate and improve the quality of care for SoonerCare members; PCMH providers serve as the backbone for healthcare access to SC members. OHCA is pleased with the relationships built with the 3 pilot HANs, though enrollment is currently nearing capacity; OHCA will explore the expansion of the HANs statewide although there is no active plan to expand in the near future. In an evaluation completed by PHPG, released in September 2014, emergency room utilization was approximately 10% lower for HAN members than for non-HAN members. Because HANs have been required to offer care management services in targeted populations such as frequent ER utilization; this discovery substantiates the efforts of the HAN. Additionally, HANs pursue quality improvement initiatives focused on the improvement of health outcomes.

Fig. 2.6.a

Health Access Networks (HAN)	SFY2012	SFY2013	SFY2014	Est. SFY2015
Number of Contracted HANs	3	3	3	3
Number of enrollees	61,078*	90,688	118,107	125,000
Number of members offered CM	1,961	1,418	740**	740**
Number of unduplicated providers	309	484	584	619

Source: Provider Services — Numbers reflect point-in-time data at June 30,2014

* 10-month period of enrollment represented for OSU HAN in SFY2012

** ER referrals removed

GOAL 3 — PERSONAL RESPONSIBILITY

TO EDUCATE AND ENGAGE MEMBERS REGARDING PERSONAL RESPONSIBILITY FOR THEIR HEALTH SERVICES UTILIZATION, BEHAVIORS, AND OUTCOMES

Objective 3.1:

To strive for SoonerCare children to receive necessary preventive care through Child Health / EPSDT services

Measured By:

3.1.1— First 15 Months

3.1.2— 3 to 6 years

3.1.3— Adolescents

3.1.4— EPSDT Participation Ratio

Why is this objective important?

Babies, kids, and teenagers need to get regular check-ups to stay healthy. Regular checkups are both necessary to help prevent the usual range of childhood illnesses, and to also allow the primary care doctor to track a child's development, and help pinpoint any problems that may arise. Children and teens enrolled in SoonerCare should take part in these preventive health care services.

What trends do the measures indicate?

While the total SoonerCare children receiving preventive care through Child Health/EPSDT services during their first 15 months or from 3 to 6 years of age has remained stable, the number of adolescents receiving the same care decreased (Fig. 3.1.a,3.1.b,3.1.c —Well Child Visits by Age - First Fifteen Months, 3—6 Years Old, Adolescents.) HEDIS data is reported by report year, not data year, and data for SFY2014 was not available at the time of publication. The EPSDT Participation Ratio indicates the number of children receiving recommended visits remained stable (Fig. 3.1.d EPSDT Participation Ratio.)

More information about children's health programs can be found at www.okhca.org/individuals.aspx?id=15315

Are the trends headed in the right direction?

The percentage of babies receiving necessary preventive services decreased slightly but still is at 97.3%. The trends of 3 to 6 year olds and adolescents has remained stable. OHCA hopes to increase the percentage of 3 to 6 year olds and adolescents receiving necessary preventive care.

What is the agency doing to influence performance towards the objective?

OHCA is doing several things to encourage members to visit their primary care physicians, including these interventions which are geared towards increasing the participation of children in getting the recommended well-child visits.

Interventions include:

- Sending reminder letters to members when well-child visits are due.
- Health Promotion and Community Relations staff providing information about well-child visits to OSDH immunization representatives with the hope that these representatives will promote the importance of well-child visits when meeting/talking with providers and members.
- Community Relations Coordinators in each quadrant of the state work with community partners to promote child health screenings. For example--Healthy Start, educates teen mothers in parenting classes; works with county health departments doing community baby showers and provides child health information.
- Tell Us Your Story campaign promoting child health visits on OHCA's website and social media.
- An OSDH/OHCA joint effort targeting an increase in childhood immunizations in Bryan County.
- OHCA has a partnership with SmartStart OK and OETA airing commercials promote children's health exams, dental health and developmental screening.
- OHCA sent letters to school districts on how to order Child Health Guides online and the importance of these screenings.
- CR Coordinators met with partners in the counties with the lowest EPSDT rates in their area to better understand challenges and encourage them to share our materials around EPSDT screenings.
- OHCA added customized messages into text4baby messages to let parents know that SoonerCare covers well child visits and that it is important to take your child into the doctor for a check-up even when they are not sick.
- Provider incentive for providers that meet compliance rate for EPSDT screenings.
- Provider incentive for members receiving 4th DTaP prior to age 2.

Figure 3.1.a

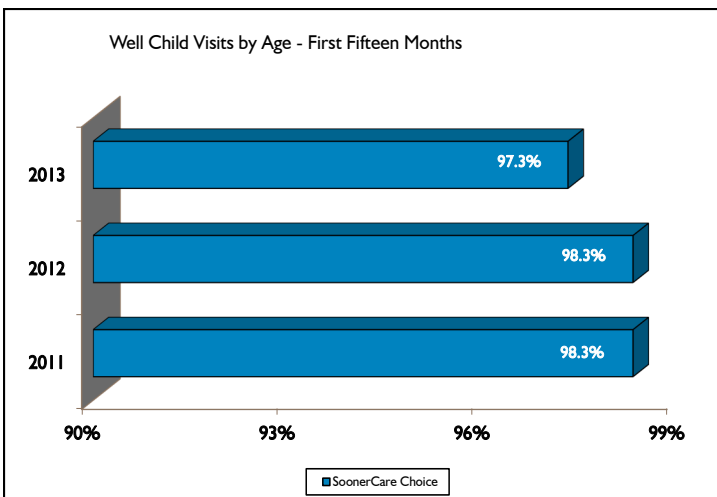
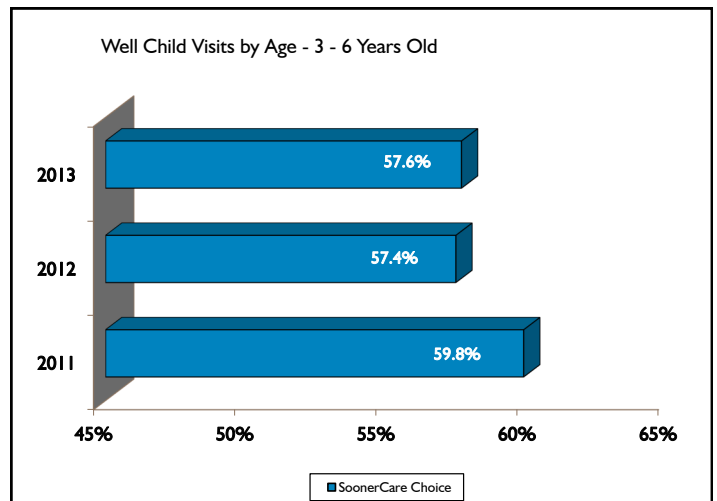


Figure 3.1.b



Source: OHCA's MMIS Claims Processing System using HEDIS criteria.

Fig. 3.1.c

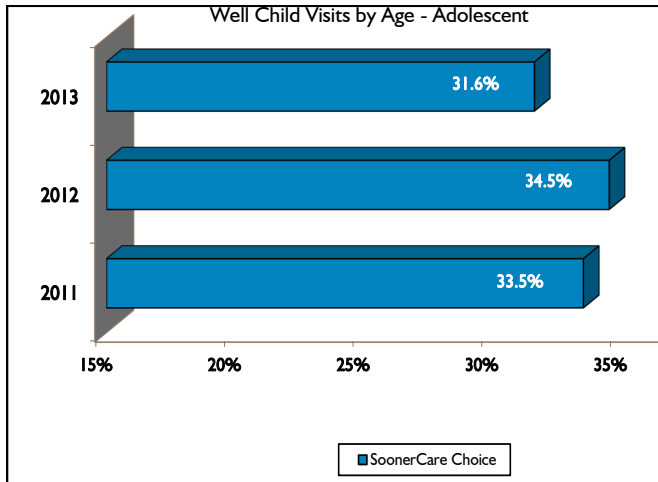


Fig. 3.1.d

EPSDT Participation Ratio	
FY 2009	58%
FY 2010	56%
FY 2011	55%
FY 2012	56%
FY 2013	56%

Source: OHCA's MMIS Claims Processing System using HEDIS criteria.

Objective 3.2:

To partner with other child serving organizations in the state to strive for Oklahoma's children to meet the federal immunization goal of 80% compliance

Measured By:

3.2.1— Immunization Rate

Why is this objective important?

Vaccines save lives and protect people against permanent disabilities or death. Because of vaccines, Oklahoma doctors rarely see diseases that once devastated families and disrupted lives. Unfortunately, vaccine-preventable diseases continue to pose a threat to children. According to Healthy People 2020, approximately 42,000 adults and 300 children in the United States die each year from vaccine-preventable diseases. Vaccination remains a critical health strategy as cures are unavailable for most vaccine-preventable diseases. Young children especially need vaccines early and often to ensure their immune systems are able to respond when needed. Maintaining high childhood immunization levels is vital to assuring the public's health.

What trends do the measures indicate?

Immunization rates have remained relatively stable (Fig. 3.2.a — Immunization Rates for Oklahoma and Surrounding States) More information about childhood immunizations can be found at <http://www.okhca.org/individuals/immunizations>. For more information about Healthy People 2020, visit <http://www.healthypeople.gov>.

Are the trends headed in the right direction?

Immunization rates in Oklahoma and surrounding states have remained stable, fluctuating only a few

percentage points since last year. Immunization rates are often dependent upon the available supply of vaccines and the public perception of the need for vaccinations.

What is the agency doing to influence performance towards the objective?

Children enrolled in SoonerCare receive free medical, vision, hearing, and dental check-ups. Immunizations are a part of SoonerCare covered well-child visits. The goal of the program is to improve the health status of children by making sure they receive preventive services and follow-through care. Seeing a health care provider regularly, even when feeling well, may help prevent serious health problems in the future.

OHCA has also partnered with the Oklahoma State Department of Health to collaborate on finding ways to increase immunization rates among Oklahoma children. The Immunization workgroup’s aim is to increase the immunization rates for all Oklahoma children; however, the first initiative targets children 19-35 months of age in Bryan County. Bryan County was ranked among 10 Oklahoma counties with the lowest completion rates for the immunization series targeted according to data from the Oklahoma State Immunization Information System (OSIIS). The workgroup efforts include providing outreach and education to providers through face-to-face visits and education to members and the community; developing educational materials highlighting the importance of childhood immunizations; issuing news releases; and providing immunization information on the OHCA website, and social media.

Fig. 3.2.a

Immunization Rates for Oklahoma and Surrounding States for Calendar Years 2010-2013

	Oklahoma	Kansas	Missouri	Arkansas	Louisiana	Texas	New Mexico
2010	70.8%	80.5%	71.7%	58.9%	60.0%	61.2%	56.8%
2011	66.0%	71.6%	64.1%	60.4%	69.6%	72.7%	69.8%
2012	61.0%	65.0%	63.9%	66.4%	68.5%	64.8%	71.6%
2013	62.7%	68.7%	67.9%	57.1%	69.1%	72.5%	65.7%

Source: Centers for Disease Control, National Immunization Program at www.cdc.gov/vaccines/stats-surv/imz-coverage.htm#chart

Objective 3.3:

To increase ambulatory/preventive care use by adults

Measured By:

3.3.1— % of adults 20 to 44 years utilizing ambulatory/preventive care

3.3.2— % of adults 45 to 64 years utilizing ambulatory/preventive care

Why is this objective important?

Access to primary care correlates with reduced hospital and emergency room use while also preserving quality medical care for patients. Studies show that costly and inappropriate care can be reduced through shared decision-making between well-informed physicians and patients. Physicians play a key role in nurturing these quality-enhancing strategies that can help to slow the growth of health care expenditures. Continued rising health care costs in the U.S. affect all levels of the health care delivery system. Encouraging and making

access to primary and preventive care services available is one strategy to lower hospital utilization while maintaining the quality of care delivered.

What trends do the measures indicate?

The number of adults utilizing ambulatory/preventive care decreased slightly in SFY2013 but remained relatively stable. (Fig. 3.3.a and 3.3.b —Ambulatory Care for Adults),

More information about the provider network and capacities can be found at <http://www.okhca.org/providers>

Are the trends headed in the right direction?

SoonerCare members in the 20 to 44 year old age group and the 45 to 64 year old age group have continued to use preventive/ambulatory care at slightly decreasing rates over the previous year.

What is the agency doing to influence performance towards the objective?

OHCA is continually reaching out to members in hopes of improving the members use of preventive/ambulatory care. Through the use of social media sites such as Facebook, Twitter, Pinterest, and YouTube, OHCA is sending the message of personal responsibility to both its members and all Oklahomans.

In addition to airing commercials online, OHCA has broadcasted its message cable networks throughout the state. Messages in the videos include urging Oklahomans to eat healthy, exercise, and get routine check-ups.

In early SFY 2015, OHCA will be launching www.SoonerFit.org, a website devoted to the fitness and health of OHCA members as well as all Oklahomans. The objective of the SoonerFit program will be to innovatively communicate physical activity and nutrition recommendations to members via the SoonerFit website, newsletters, public service announcements, and community partners.

Follow the link below to OHCA's Community Relations web page:

<http://www.okhca.org/individuals.aspx?id=12274>.

Fig. 3.3.a

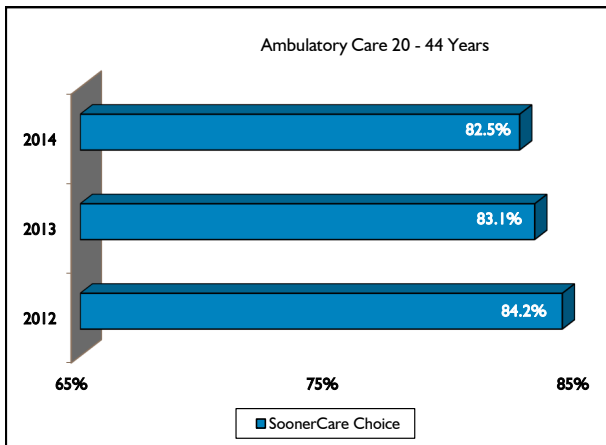
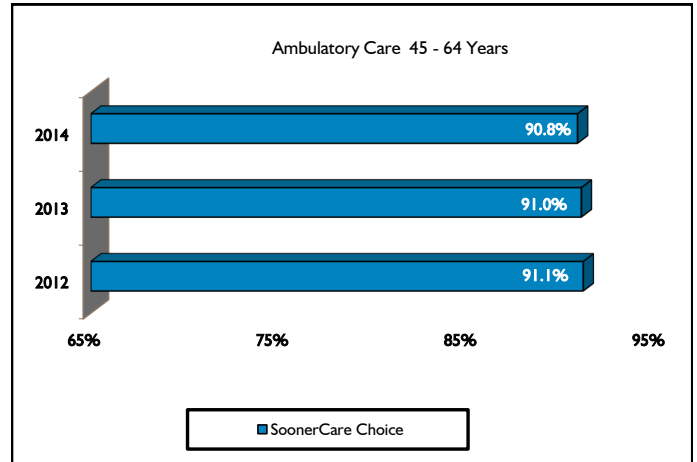


Fig. 3.3.b



Source: OHCA's MMIS Claims Processing System using HEDIS criteria.

Objective 3.4:

To encourage the responsible use of pharmacy services and prescription drugs through the lock-in program and clinical decision support rules concerning pill counts and duplication of therapy

Measured By:

3.4.1 — Number of Medicaid members assigned to the lock-in program

Why is this objective important?

Misuse of prescription drugs is an immense public health concern, with approximately 22 million persons initiating nonmedical pain reliever use since 2002. More than 12 million people reported using prescription painkillers non-medically in 2010, that is, using them without a prescription or for the feeling they cause. The misuse and abuse of prescription painkillers was responsible for more than 475,000 emergency department visits in 2009, a number that nearly doubled in just five years.

Although many types of prescription drugs are abused, there is currently a growing, deadly epidemic of prescription painkiller abuse. Nearly three out of four prescription drug overdoses are caused by prescription painkillers—also called opioid pain relievers. The unprecedented rise in overdose deaths in the US parallels a 300 % increase since 1999 in the sale of these strong painkillers. These drugs were involved in 14,800 overdose deaths in 2008, more than cocaine and heroin combined. In 2010, Oklahoma ranked fifth highest in the nation in prescription drug overdose deaths at 19.4 per 100,000 people. The drug overdose mortality rates in Oklahoma tripled from 1999 to 2010.

What trends do the measures indicate?

The number of SoonerCare members assigned to the Pharmacy Lock-In Program has increased steadily the last few years. (Fig. 3.4.a —Members Assigned to Lock-In).

More information about OHCA's Medicaid Lock-in Program can be found at <http://www.okhca.org/providers.asp38>

Are the trends headed in the right direction?

The increasing number of SoonerCare members in the Pharmacy Lock-In program indicates that OHCA is doing its part to reach members in need of the program.

What is the agency doing to influence performance towards the objective?

In order to be assigned to the lock-in review program, an individual must be currently enrolled in SoonerCare or the Insure Oklahoma Individual Plan.

If the member's utilization is determined to be potentially inappropriate, the lock-in process is started, and the member is required to fill all prescriptions at a single pharmacy. The member is able to choose a designated pharmacy. This pharmacy is contacted for consent prior to the member being locked-in. In order to enhance the effectiveness of the Lock In Program, OHCA implemented changes that will require members to select a single preferred prescriber, in addition to a preferred pharmacy. This change went into effect July 20, 2014.

Opioid Quantity Limit

A new clinical decision support rule will be put in place late in 2014 that will limit the amount of short-acting opioid analgesics and combination products allowed to be dispensed. This quantity limit edit (QLE) will restrict the amount on opioid analgesic drugs based on the amount per day prescribed; these are categorized as acute or chronic therapies.

- Acute therapies are defined as days supply of medication less than or equal to 10 days. Based on the days' supply on the prescription, the quantity allowed per day will be 8 dosage forms or less for oral medications.
- Chronic therapies are defined as greater than 10 days' supply. Based on the days' supply of the prescription, the quantity allowed per day will be 4 dosage forms.

Duplication of Therapy

Duplication of therapy occurs when multiple medications are inadvertently or intentionally used from the same therapeutic class (chemical family) at the same time. This may occur when members use multiple pharmacies, a second medication is given to replace the first and the member doesn't discontinue the first medication, and to a much lesser extent "diversion" or "doctor shopping" (use of multiple providers in order to abuse or resell the medications). Decreasing the occurrence of duplication of therapy also reduces the potential for adverse consequences, suboptimal member outcomes and unnecessary costs. OHCA's duplication of therapy clinical support rule will reduce this risk by ensuring members have not had similar medications within the last 30 days and their current prescription is more than 90 % used. Early 2015 is the target date for implementation.

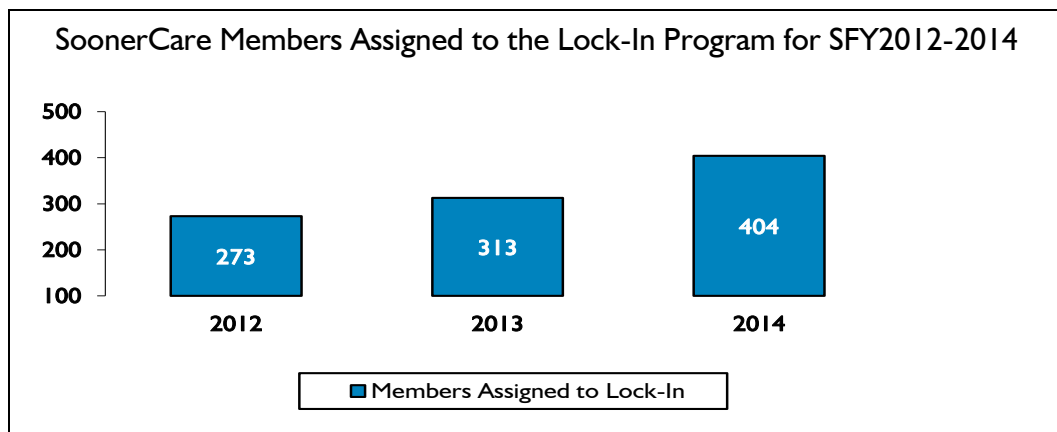
OSDH Collaboration

A joint workgroup with OSDH has explored possible interventions to reduce prescription drug abuse in Oklahoma. The Prescription Drug Abuse workgroup's goals are: a) to develop data-driven interventions; b) to support the appropriate use of prescription drugs; and c) to decrease the number of prescription drug

overdose related deaths in Oklahoma.

The workgroup is focused on the following interventions and activities. The group will identify geographic areas with high prevalence of controlled substance purchases paid by Medicaid, identify Medicaid High Prescribers, and match records in the Unintentional Poisoning Database with Medicaid enrollment data to determine what percentage of decedents were Medicaid members in 2012 & 2013. This data will be used to develop future interventions and develop strategies to reduce abuse. By sending a survey to hospital CEOs and emergency department directors, the group will assess and report the effectiveness, successes and barriers of the ED & UCC Opioid Prescription Guidelines. The group will develop an intervention proposal, with a focus on Naloxone, for a target Medicaid population in hopes of saving lives of individuals who may have taken a fatal prescription drug overdose. In August 2014, the Centers for Disease Control and Prevention, National Center for Injury Prevention and Control announced Oklahoma was an awardee for the Prescription Drug Overdose: Boost for State Prevention grant. This grant will enable Oklahoma to expand Prescription Drug Abuse prevention efforts.

Fig. 3.4.a



Source: OHCA Program Integrity; Oklahoma University College of Pharmacy

Objective 3.5:

To increase the number of pregnant women seeking medical care before delivery

Measured By:

- 3.5.1— % of Medicaid members seeking prenatal care
- 3.5.2— Number of births to Medicaid members
- 3.5.3— Number of members seeking prenatal care

Why is this objective important?

SoonerCare covers approximately 63% of the births in Oklahoma. Prenatal care is beneficial for all mothers-

to-be. Women who see a health care provider regularly during pregnancy have healthier babies, are less likely to deliver prematurely, and are less likely to have other serious problems related to pregnancy.

What trends do the measures indicate?

While the total SoonerCare members giving birth decreased in SFY2014, the percentage of those members seeking prenatal care increased. (Fig. 3.5.a — Total SoonerCare Births and Percentage of Mothers Seeking Prenatal Care for SFY2012-2014). Women seeking prenatal care by trimester has remained stable over the last three years. (Fig. 3.5.b — SoonerCare Members Who Sought Prenatal Care - By Trimester - SFY2012—2014)

More information about prenatal care provided to Oklahoma Medicaid members can be found at <http://www.okhca.org/individuals.prenatalcare>

Are the trends headed in the right direction?

The total SoonerCare births decreased slightly in SFY2014 but the number of mothers seeking prenatal care has remained high and stable at 98%.

What is the agency doing to influence performance towards the objective?

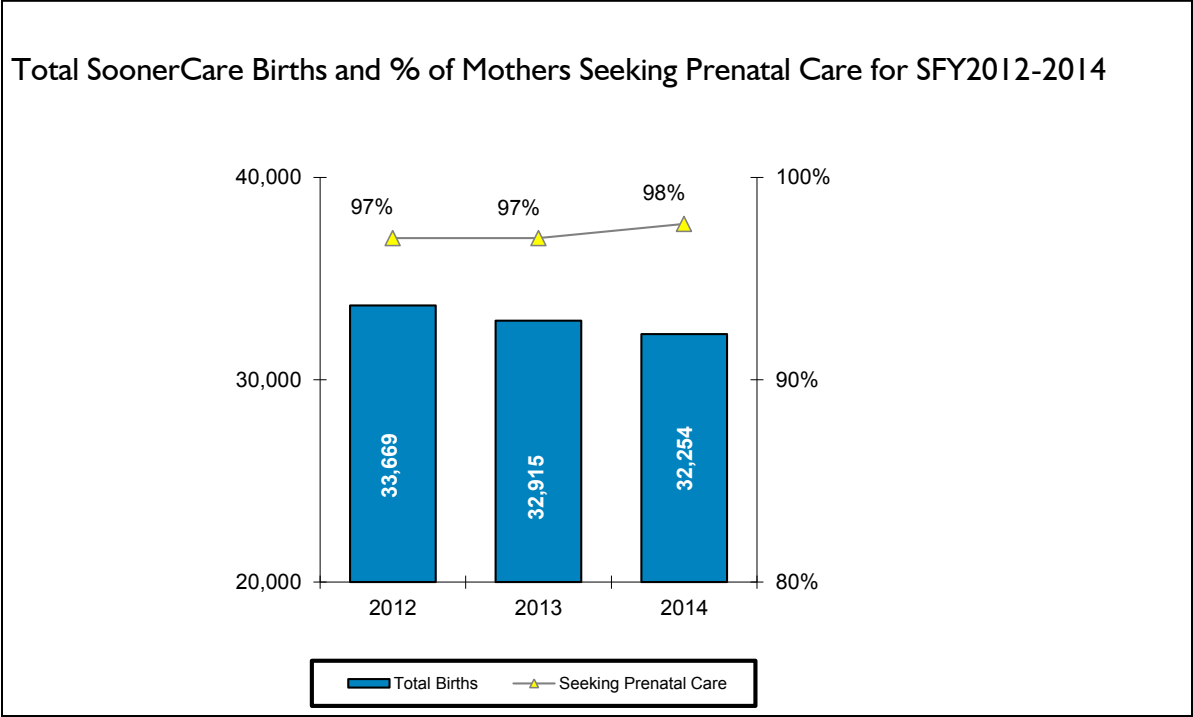
OHCA continuously seeks to increase the benefits and services available to mothers and babies. Since its first meeting in May 2005, the OHCA-OSDH Perinatal Advisory Task Force has made several recommendations regarding expansion of benefits and services to pregnant women. OHCA has been able to implement many of these recommendations. Learn more at [www.okhca.org/about-us/Perinatal Task Force](http://www.okhca.org/about-us/Perinatal-Task-Force).

OHCA has also developed Strong Start, a grant-funded initiative that implements group prenatal health care through several clinical partners. These clinical partners, along with physicians, will introduce women to the Strong Start program. Strong Start for Mothers and Newborns has three main goals: decrease the incidence of preterm birth, improve maternal and neonatal outcomes within the SoonerCare population, and to do so in a cost-effective manner. Since the inception of the grant, twenty-five participants have delivered full term births, one delivery was preterm birth at 36 weeks gestation and one delivery was a stillbirth at 23 weeks gestation.

Text 4 Baby is a CMS grant funded national initiative and the first mobile information service designed to promote maternal and child health through text messaging. Women who text BABY (or BEBE for Spanish) to 511411 receive three free text messages a week, timed to their due date or their baby's birth date, through pregnancy and up until the baby's first birthday. The messages address topics such as labor signs and symptoms, prenatal care, urgent alerts, developmental milestones, immunizations, nutrition, birth defect prevention, safe sleep, safety, and more.

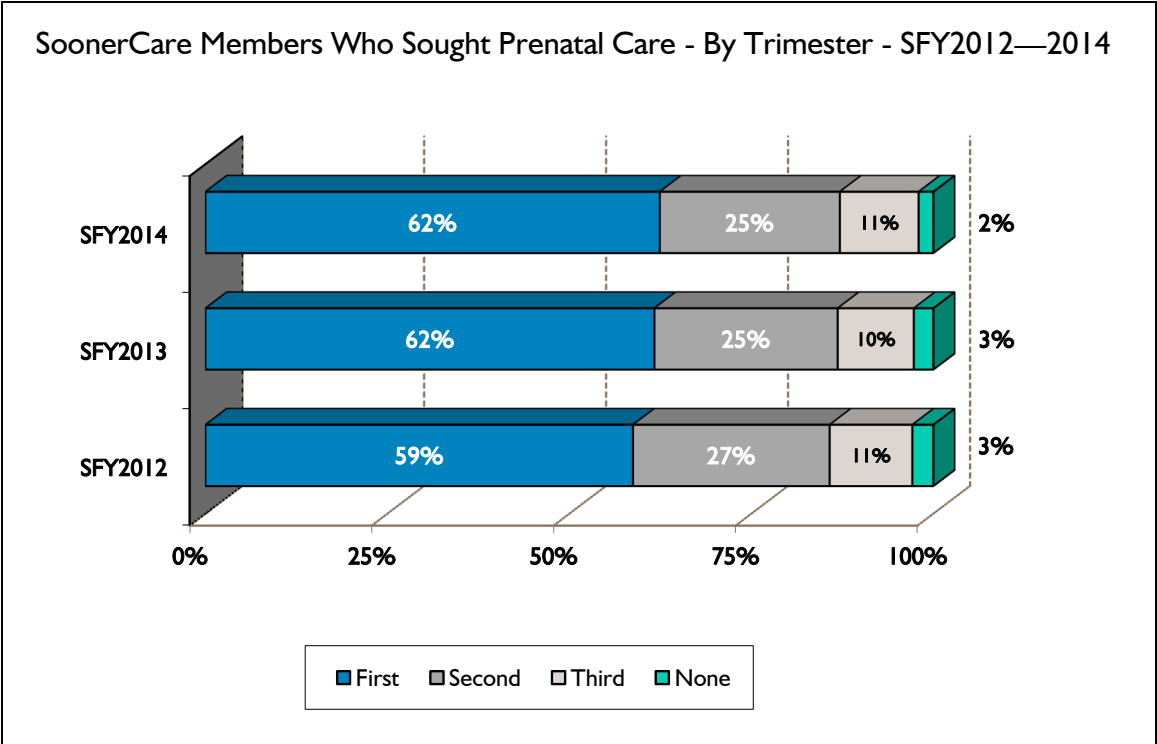
OHCA was awarded a grant in which CMS provided support in customizing the texts to include messages specific to Oklahoma women. The OHCA is currently working through partnerships with pharmacies to promote the Text 4 Baby program to pregnant moms; future focus includes use of fax referrals of information on pregnant moms to point of sale visits at pharmacies, direct marketing of Text 4 Baby, customization of messages to the individual member, continued exploration of possible additional funding, and engagement of community partners and outreach workers in the program activities.

Fig. 3.5.a



Source: OHCA MMIS

Fig. 3.5.b



Source: OHCA MMIS

Objective 3.6:

To decrease emergency room utilization by increased use of ambulatory care services

Measured By:

3.6.1— Number of SoonerCare Choice Members with greater than 2 ER Visits in a quarter

3.6.2— Number of SoonerCare Choice Members with greater than 4 ER Visits in a quarter

3.6.3— % of SoonerCare Choice Members with greater than 2 ER Visits in a quarter

3.6.4— % of SoonerCare Choice Members with greater than 4 ER Visits in a quarter

Why is this objective important?

High emergency room (ER) utilization is a considerable concern for the increasing cost of health care. Frequent and inappropriate use of hospital ERs is extremely costly and care could be provided in a less expensive setting. Patients, when possible, should be treated by their primary care provider for non-emergency conditions in order to promote consistent, quality care.

What trends do the measures indicate?

The total number of SoonerCare Choice member ER usage has decreased significantly from 2013, but is still higher than 2012. (Fig. 3.6.a —SCC ER Usage by Number and Percentage SFY12-14)

More information about limiting emergency room use of SoonerCare members can be found at <http://www.okhca.org/research.aspx?id=87&parts=7447&parts=7447>. For more information about Patient-Centered Medical Homes visit <http://www.okhca.org/individuals.aspx?id=548>.

Are the trends headed in the right direction?

Preventing unnecessary ER visits has long been a goal of OHCA and the number of SoonerCare Choice members utilizing ER benefits is trending in the right direction.

What is the agency doing to influence performance towards the objective?

OHCA and the Primary Care Health Policy Division of the University of Oklahoma Health Sciences Center Department of Family Medicine are working together to determine the various reasons for unnecessary ER visits and to design cost-effective and efficient programs to reduce unnecessary ER visits.

During the 2014 Legislative Session, the Governor signed a bill asking for OHCA to conduct a study of current and potential emergency department diversion models for persons who are enrolled in Medicaid that may be implemented in the state and explore options for cost containment and delivery alternatives that are consistent with the existing Patient-Centered Medical Home program. The study will include an assessment of the present emergency department utilization environment for the Medicaid population in Oklahoma; an identification of opportunities to leverage and partner with current community-based resources in order to reduce emergency department utilization; an analysis of current initiatives, both statewide and nationwide, with the aim of more cost-effective, coordinated care for persons with overutilization of the emergency department; and the development of recommendations accompanied with any associated projected

expenditures or cost savings.

Oklahoma’s Medicaid population has historically used the emergency room at high rates for non-emergent and non-urgent care. The OHCA and its partners in the provider community have already undertaken a number of steps in the past five years to reduce inappropriate emergency room use. These initiatives include:

- Requiring all medical home providers to offer 24-hour/7-day telephone coverage by a medical professional;
- Enrolling SoonerCare Choice members into patient centered medical homes;
- Requiring Tier 3 (“optimal”) medical home providers to offer extended office hours; and
- Conducting targeted education and outreach with members who visit the ER two or more times in a three-month period.

Fig. 3.6.a

SCC ER Usage by Number and % SFY12-14			
	2012	2013	2014
ER - SCC Members with 2 or > visits per quarter to ER	17,023	23,098	19,499
ER - % of SCC members with 2 or > visits per quarter to ER	3.67%	4.50%	3.48%
ER - SCC Members with 4 or > visits per quarter to ER	2,046	2,808	2,219
ER - % of SCC members with 4 or > visits per quarter to ER	0.44%	0.55%	0.40%

Source: OHCA MMIS

Objective 3.7:

To provide members the resources they need to decrease or prevent tobacco use

Measured By:

3.7.1— Number of Medicaid Members Calling Tobacco Helpline

3.7.2— Number Of Medicaid Members Utilizing Tobacco Cessation Benefits

Why is this objective important?

Tobacco is Oklahoma's leading cause of preventable death, killing more Oklahomans each year than alcohol, auto accidents, AIDS, suicides, murders, and illegal drugs combined. Over 6,000 Oklahomans die each year from tobacco related illness and over 120,000 suffer from serious tobacco caused illnesses. Tobacco abuse is expensive as well. It costs Oklahomans over \$2.8 billion annually in medical expenses and lost productivity. It is vitally important that OHCA do its part to reduce tobacco abuse among Oklahomans.

What trends do the measures indicate?

The total number of Oklahomans calling the Tobacco Settlement Endowment Trust (TSET) Tobacco Helpline decreased significantly in SFY2014. (Fig. 3.7.a —Oklahomans calling the TSET Tobacco Helpline). The number of SoonerCare members utilizing smoking cessation benefits is also trending downward in SFY2014. (Fig. 3.7.b—Smoking Cessation Benefits Utilization)

More information about the Oklahoma Tobacco Helpline can be found at www.ok.gov/tset/. For more information about SoonerCare Tobacco Cessation Benefits, visit <http://www.okhca.org/individuals.aspx?id=2733>.

Are the trends headed in the right direction?

The number of Oklahomans utilizing the Tobacco Helpline and smoking cessation benefits decreased significantly in SFY2014. At this time, it is unclear why utilization is decreasing. TSET is collaborating with OSDH to identify reasons why utilization might be decreasing, whether it is from market saturation, the increasing use of e-cigarettes, or discrepancies in the method of data collection.

What is the agency doing to influence performance towards the objective?

OHCA has collaborated with TSET and the Oklahoma State Health Department to offer resources to Oklahomans that wish to quit or reduce tobacco use.

Through the Helpline, callers receive one-on-one quit coaching, specialized materials, and referrals to community resources. Callers interested in receiving follow-up can enroll in the Helpline's multiple call program in which they will receive a series of telephone based coaching sessions with a Quit Coach.

SoonerCare offers a tobacco cessation benefit to help members with their attempt to stop smoking. Members may receive counseling as well as prescription and over-the-counter medications to help you stop using tobacco.

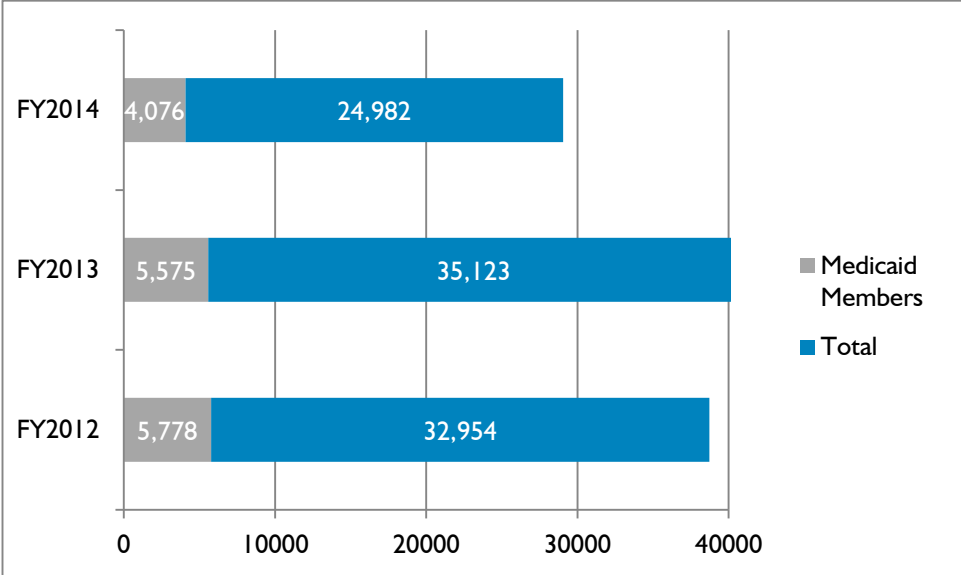
Benefit Includes Counseling sessions with your SoonerCare physician to help you quit using tobacco, over the counter medications – patches, gum & lozenges, and Prescription medications which include Zyban, Chantix,

inhaler & nasal spray.

Collaboration with the Oklahoma State Department of Health has produced a work group tasked with reducing the smoking dependence of Oklahomans. The Tobacco workgroup aims to reduce the tobacco smoking rate among Oklahomans by increasing referrals to the Oklahoma Tobacco Helpline and removing certain barriers to obtaining tobacco cessation products for SoonerCare members. Efforts include training the staffs of targeted country health departments in the Helpline referral process and increasing the number of Helpline referrals for SoonerCare members by OHCA.

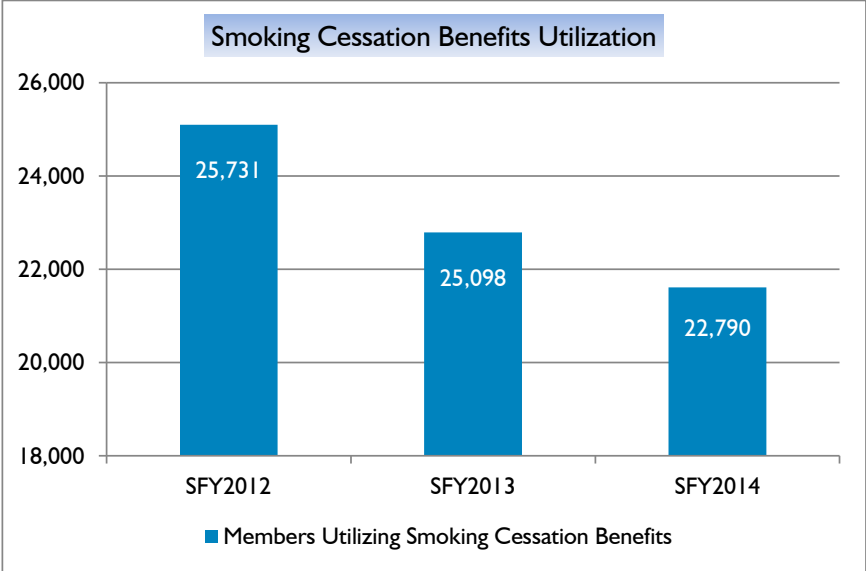
Fig. 3.7.a

Oklahomans calling the TSET Tobacco Helpline



Source: Oklahoma Tobacco Settlement Endowment Trust

Fig. 3.7.b



Source: OHCA Health Promotions and Community Relations

GOAL 4 — SATISFACTION & QUALITY

TO PROTECT AND IMPROVE MEMBER HEALTH AND SATISFACTION, AS WELL AS ENSURE QUALITY, WITH PROGRAMS, SERVICES AND CARE

Objective 4.1:

To seek and evaluate member feedback on satisfaction with services received when accessing SoonerCare benefits

Measured By:

Customer Survey Results (CAHPS) Adults

4.1.1— Customer service

4.1.2— How well doctors communicate

4.1.3— Getting care quickly

4.1.4— Getting needed care

4.1.5— Shared decision making

Customer Survey Results (CAHPS) Children

4.1.6— Customer service

4.1.7— How well doctors communicate

4.1.8— Getting care quickly

4.1.9— Getting needed care

4.1.10— Shared decision making

Why is this objective important?

Member satisfaction is a key measure of the performance of any health plan. Satisfaction surveys give members an opportunity to express their opinions about SoonerCare and the services they received and are instrumental in providing OHCA with member insight. They help OHCA to identify any gaps in the expectations that members may have about services received compared to services rendered. These gap analyses can be used to adjust or enhance programs, services, and care to ensure members are receiving the level of quality they need. Survey results may also be used as talking points during provider training sessions and to guide policy and planning discussions.

What trends do the measures indicate?

Customer survey results indicate relatively stable or increasing levels of satisfaction in most survey areas for both the adult and the child populations. Member satisfaction ratings are over 80% for every measure except “Shared decision making”, which is 50% for adults (Fig. 4.1.a — CAHPS® Medicaid Member Satisfaction Survey—Adults) and 60% for children (Fig. 4.1.b — CAHPS® Medicaid Member Satisfaction Survey—Children). The adult survey rating for “Customer service” has fallen by 8% from 90% to 82%.

To see the 2014 Adult and Child CAHPS® surveys visit: <http://www.okhca.org/research.aspx?id=88&parts=7447>

Are the trends headed in the right direction?

The generally increasing and stable levels of satisfaction indicate that OHCA has sought out member feedback and that members are satisfied with the services and quality they have been receiving.

What is the agency doing to influence performance towards the objective?

The agency will continue to have the CAHPS surveys administered for adults and for children. Normally, due to budgetary constraints, the adult survey is administered for OHCA every 2 years. However, grant funding did allow the agency to have the survey run during an off year (SFY2013) and will also allow the survey to be run on the next off year (SFY2015). To meet reporting requirements, the child survey is administered for

CHIP children every year. Running the surveys every year allows for year-to-year comparisons for decision making. With CAHPS surveys, the agency has the flexibility to add questions to gain insight into particular areas of interest. For example, a few questions regarding smokeless tobacco use were recently added to the adult survey.

Fig. 4.1.a

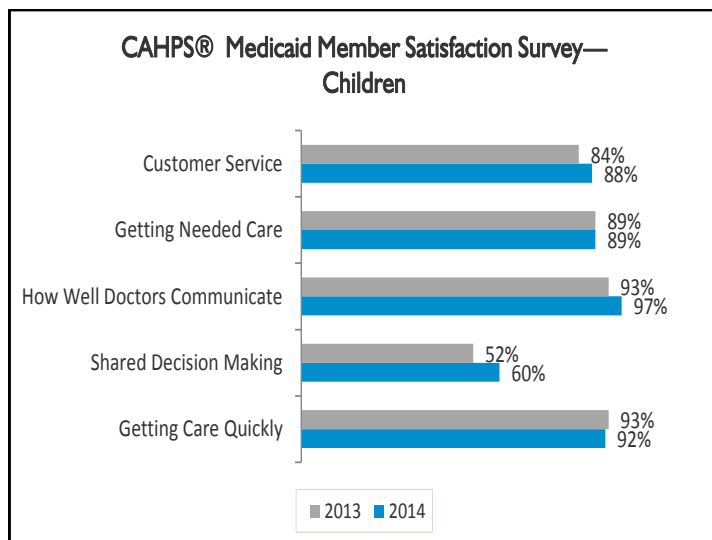
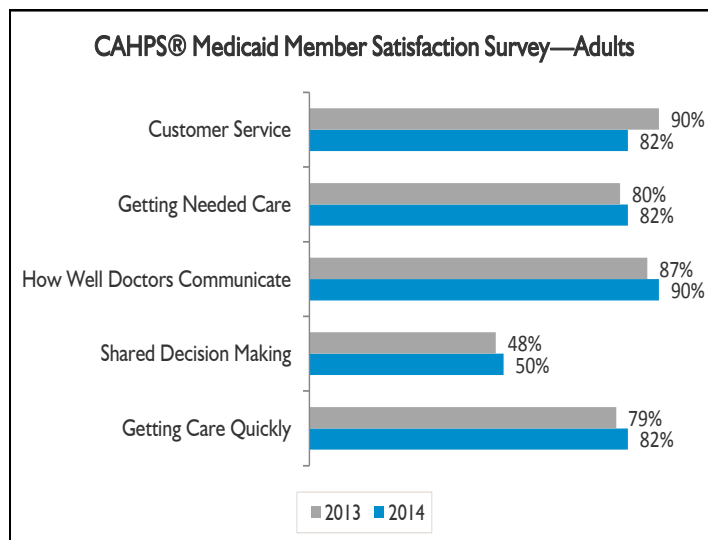


Fig. 4.1.b



Source: OHCA Fast Facts — Numbers reflect point-in-time data at June 30, 2014

Objective 4.2:

To partner with Oklahoma’s long-term care facilities to strive for quality long-term care services

Measured By:

4.2.1 — % 5-star facilities

4.2.3 — % members rating quality as excellent or good

4.2.2 — % 4-star facilities

4.2.4 — % employees rating quality as excellent or good

Why is this objective important?

Approximately 13,000 nursing home residents receive SoonerCare support on any day, with some 21,000 served over the course of a year. This population is smaller than a decade ago, but as a group they are frailer and more dependent and thus the challenge to meet their needs at the highest level of quality and consistency is more important than ever.

What trends do the measures indicate?

The percentages of 5-star rated and 4-star rated long-term care facilities has remained stable (Fig. 4.2.a — Focus on Excellence Star Ratings). Resident and employee satisfaction surveys show mixed results with the percentage of members rating overall quality as excellent or good remaining at 93% and the percentage of employees rating overall quality as excellent or good dropping 3 percentage points from 88% to 85% (Fig. 4.2.b — Focus on Excellence Resident and Employee Satisfaction).

More information about the Focus on Excellence program visit: <http://www.okhca.org/research.aspx?id=10323&parts=7447>.

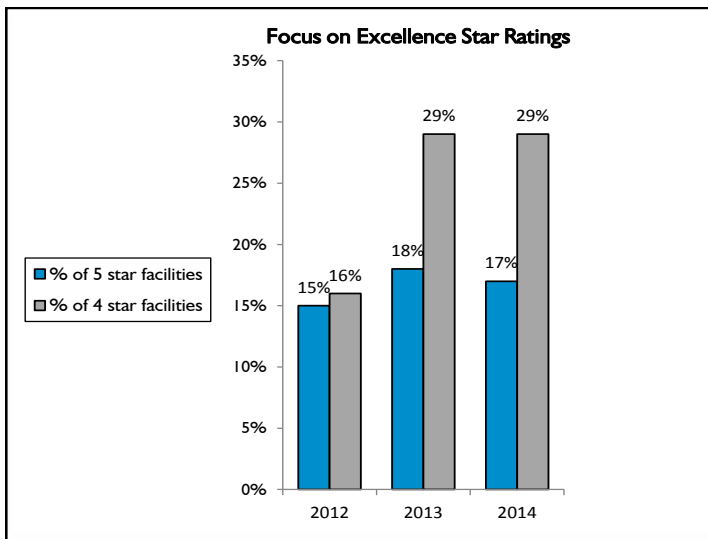
Are the trends headed in the right direction?

The short-term trend shows that Focus on Excellence is a stable program. OHCA will continue to partner with LTC facilities to strive for quality care and services.

What is the agency doing to influence performance towards the objective?

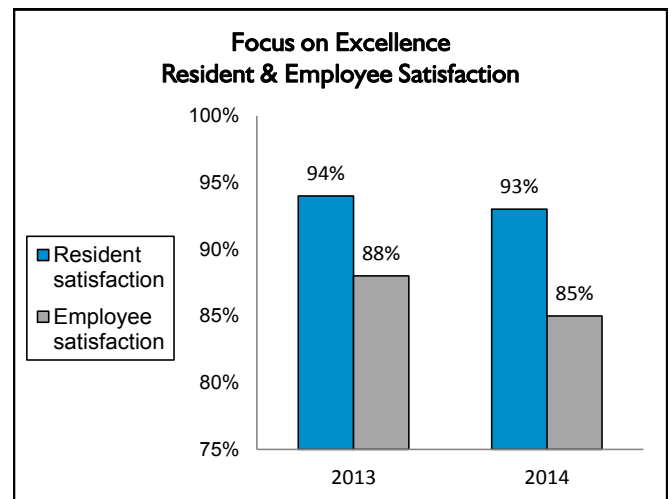
The agency operates the Focus on Excellence (FOE) program which is designed to measure and ensure the integrity, and quality of Long-Term Care (LTC) facilities and the overall wellness of members in the facilities. The program oversees the public website, www.oknursinghomeratings.com. The site allows consumers to search for LTC facilities that are in the FOE program and uses a star rating system to help consumers determine which facilities meet the needs of their loved ones. Additional Medicaid payments may be earned by nursing facilities that meet or exceed targets on any of nine separate performance measures. Recently, the agency began conducting onsite visits to nursing facilities to conduct reviews to ensure the program is being run at its highest potential within the facilities culture. Reviews include procedures designed to ensure that the responses facilities provide accurately reflect what is being done within the facility. The agency also offers training on best practices to help facilities to improve program performance metrics.

Fig. 4.2.a



Source: OHCA FOE Annual Reports

Fig. 4.2.b



Source: OHCA FOE Annual Reports

GOAL 4 — SATISFACTION & QUALITY

TO PROTECT AND IMPROVE MEMBER HEALTH AND SATISFACTION, AS WELL AS ENSURE QUALITY, WITH PROGRAMS, SERVICES AND CARE

Objective 4.3:

To ensure members and providers have access to assistance through member services and provider services

Measured By:

4.3.1— Number of member calls

4.3.2— Number of provider calls

Why is this objective important?

Members and providers often have questions and issues related to SoonerCare. Situations may arise needing timely resolutions. The OHCA strives to be vigilant in its support of SoonerCare members and providers. One way that OHCA ensures its responsiveness to the needs of stakeholders is by providing assistance through call centers.

What trends do the measures indicate?

The volume of calls indicates that both member and providers have access to assistance through the call centers.

Are the trends headed in the right direction?

There is no desired trend direction for the call center data. The data is informational and shown to provide context.

What is the agency doing to influence performance towards the objective?

OHCA operates a system of two-tiered call centers to answer both member calls and provider calls. Tier one calls are first-line, more routine calls and are answered through agency contracted call centers. The more complex calls are routed to the tier two call centers that are operated by OHCA staff. Tier two calls may require research and a higher level of decision making.

Fig. 4.3.a

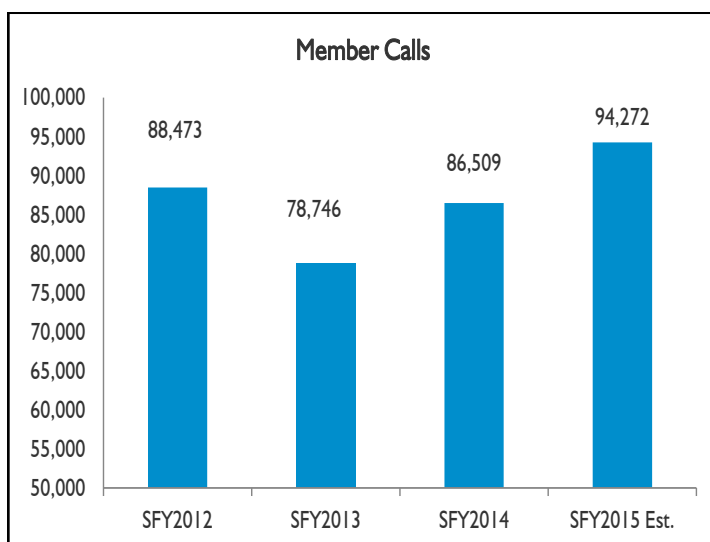
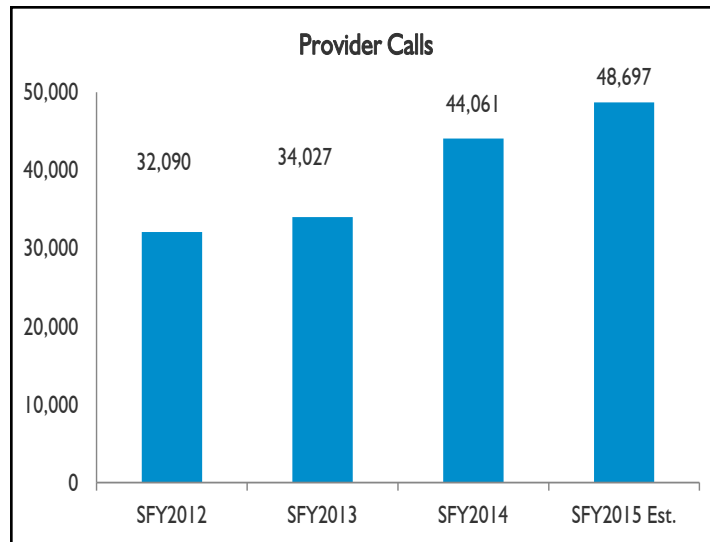


Fig. 4.3.b



Source: OHCA Fast Facts — Numbers reflect point-in-time data at June 30, 2014

Objective 4.4:

To maintain a quality provider community by following appropriate procedures to identify noncompliant providers and determine the appropriate course of action to resolve issues

Measured By:

4.4.1— Number of involuntary provider contract terminations

Why is this objective important?

It is the responsibility of OHCA to ensure that SoonerCare providers are fulfilling the terms of their contracts and providing the quality care of care expected by OHCA's members. States are required to report the names of terminated providers for inclusion in a national database and must terminate the participation of any individual or entity if such individual or entity is terminated under Medicare, or any other state's Medicaid program, or CHIP.

What trends do the measures indicate?

The number of involuntary provider contract terminations is an indication that OHCA is diligent and exercises due care in investigating provider complaint referrals.

Are the trends headed in the right direction?

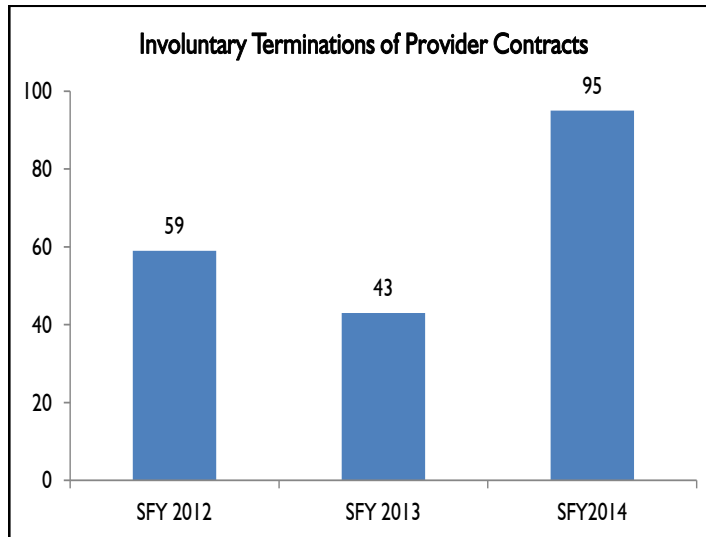
There is no desired trend direction for the number of involuntary contract terminations. The data is informational and shown to provide context.

What is the agency doing to influence performance towards the objective?

OHCA typically receives 20-40 provider complaint referrals weekly. Referrals are received from many sources, including: departments within OHCA; members; providers; legislators; and through audit and review findings. The OHCA Quality Assurance /Quality Improvement (QA/QI) unit reviews medical records when

referrals are centered on quality issues and forwards complaints to other areas of OHCA when they fall outside the scope of the QA/QI unit. Also, the OHCA Quality Assurance Committee meets each month. The meetings focus on individual cases, but diverse and targeted program issues are also covered, as necessary. All information that could impact a provider’s status is given to each committee member to review. A provider may be terminated based upon a recommendation by the committee. SoonerCare provider contracts may be terminated if they are identified through program integrity efforts as not meeting quality standards, medical necessity, or contractual requirements; if their license is suspended or revoked; or if they appear on a federal or state exclusion list such as OIG Medicare Exclusion Database (MED). In some cases, quality issues are identified, but termination is not warranted. A provider may then be referred to the agency’s external quality review organization for peer-to-peer education and assistance in developing a corrective action plan.

Fig. 4.4.a



Source: OHCA Legal Services — Numbers reflect point-in-time data at June 30, 2014

Objective 4.5:

To train and educate SoonerCare providers, both on an “as-needed” and on a proactive basis, through group and/or individual training and other communication

Measured By:

4.5.1— Number of seminars/workshops

4.5.2— Number of onsite training attendees

4.5.3— Number of policy letters

Why is this objective important?

As the health care environment is in a state of constant change, so is the OHCA and SoonerCare. Providers must be kept up-to-date regarding these changes. The OHCA continues its commitment to training and educating providers to ensure they are informed of the latest policies, procedures, and other program related topics.

What trends do the measures indicate?

Provider training data is tracked and the data is presented here to demonstrate that OHCA continues to focus on keeping the provider community trained and educated to ensure quality programs, services, and care are provided to members. This in-turn ensures that members are satisfied with their care. While the number of seminars and workshops has remained steady, the number of attendees has risen (Fig. 4.5.a — Provider Training). The number of policy letters is down compared to the previous year (Fig. 4.5.a — Provider Training).

Are the trends headed in the right direction?

The increasing number of providers attending onsite trainings shows that providers are taking responsibility for being informed about OHCA programs, policies, and procedures. The decrease in the number of policy letters is simply an indication that OHCA policies already in place remained relatively unchanged over the period and there were fewer new policies put in place compared to the previous period.

What is the agency doing to influence performance towards the objective?

Seminars, workshops, bi-annual regional trainings, and on-site trainings are available to providers throughout the year. Written communications are offered via provider letters, fax blasts, and global messages or banners. Training opportunities cover topics such as claims processing procedures, new or changing policies, and other topics relevant to providers’ efforts. An important aspect of these forums is that they are also an opportunity for providers to give feedback and to have questions answered.

Fig. 4.5.a

Provider Training	SFY2012	SFY2013	SFY2014
Seminars/Workshops/Biannual	43	28	29
Seminars/Workshops/Biannual Attendees	5,200	5,242	7,211
Policy Letters	104	70	43

Source: OHCA Provider Training and Policy Trackers — Numbers reflect point-in-time data at June 30,2014

GOAL 5 — ELIGIBILITY & ENROLLMENT

TO PROVIDE AND IMPROVE HEALTH CARE COVERAGE TO THE QUALIFIED POPULATIONS OF OKLAHOMA

Objective 5.1:

To reduce the number of qualified Oklahomans without access to medical coverage

Measured By:

- | | |
|---|--|
| 5.1.1— Unduplicated Medicaid Enrollment | 5.1.8— % of Online Enrollment Applications That Are New |
| 5.1.2— % of Enrollment Change (includes Insure Oklahoma) | 5.1.9— % of Online Enrollment Applications That Are Recertifications |
| 5.1.3— Insure Oklahoma—Employee Sponsored Enrollment | 5.1.10—% of Online Enrollment Applications By Media Type (Home Internet) |
| 5.1.4— Insure Oklahoma—Individual Plan Enrollment | 5.1.11—% of Online Enrollment Applications By Media Type (Paper) |
| 5.1.5— % of SoonerCare & Insure Oklahoma Population Who are Children | 5.1.12—% of Online Enrollment Applications By Media Type (Agency Internet) |
| 5.1.6— % of SoonerCare & Insure Oklahoma Population Who Are Adults | 5.1.13—% of Online Enrollment Applications By Media Type (Agency Electronic) |
| 5.1.7— Estimated Count of Eligible-But-Not-Enrolled Population (EBNE) | |

Why is this objective important?

Reducing the number of qualified Oklahomans without access to medical coverage is paramount to ensuring a healthier, more productive population and workforce while improving the health outcomes of those Oklahomans. Ensuring that qualified Oklahomans have access to medical coverage can help reduce the disproportionate utilization of emergency rooms for non-emergent health issues. Utilizing a primary care provider for these non-emergent issues control the overall cost of state-purchased health care. SoonerCare and Insure Oklahoma have been integral in ensuring that qualified Oklahomans have access to medical coverage and quality health care despite an inability to pay for that coverage.

What trends do the measures indicate?

Although overall unduplicated Medicaid enrollment has remained fairly flat over the past few state fiscal years there was a noted decrease in overall unduplicated Medicaid enrollment in SFY2014 (Figure 5.1.a — Medicaid Enrollment) indicating an improvement in Oklahoma’s economy and the ability of Oklahomans to purchase medical coverage. While there was a modest decrease in SFY2014 for Insure Oklahoma employee sponsored enrollment there was a much more significant decrease in Insure Oklahoma individual plan enrollment (Figure 5.1.b — Insure Oklahoma Enrollment) as a result of program eligibility changes. The percentage of children and adults that are enrolled in either SoonerCare or Insure Oklahoma has remained flat for the past three fiscal years indicating consistent enrollment year over year (Figure 5.1.c — SoonerCare & Insure Oklahoma Population). Although the estimated count of eligible-but-not-enrolled (EBNE) population has remained flat during the previous two state fiscal years there was a significant decrease in SFY2014 (Figure 5.1.d—Estimated Count of Eligible-But-Not-Enrolled Population (EBNE)) indicating approximately 6,000 previously uninsured

qualified Oklahomans have obtained medical coverage. A steady increase in the number of online enrollment applications that are recertifications coupled with a decrease in the number of new applications represents a trend of uninterrupted enrollment among SoonerCare members (Figure 5.1.e — Online Enrollment Applications). While the percentage of paper applications for online enrollment has remained flat, there has been a minor increase in the number of home internet applications. There was a significant increase in the number of agency internet applications and a significant decrease in agency electronic applications (Figure 5.1.f—Percentage of Online Enrollment Applications by Media Type). This trend indicates a shift in the technological landscape of online enrollment by consumers and agencies.

Are the trends headed in the right direction?

The decreasing number of Oklahomans without access to medical coverage is an indication that Oklahoma's economy continues to improve which is essential to ensuring more Oklahomans are able to afford medical coverage. Online enrollment has been growing increasingly more user friendly and has proven to be a much easier option for SoonerCare members and the state.

What is the agency doing to influence performance towards the objective?

As a result of the excellent administration by OHCA and continued success of Insure Oklahoma, the program was renewed through December 31, 2015 by Governor Mary Fallin on June 30, 2014. Renewal of the program ensures continued coverage for approximately 19,000 working Oklahomans and their families thereby reducing the number of qualified Oklahomans without access to medical coverage.

OHCA's online enrollment system continues to be improved to ensure compliance with federal legislation and also to enhance the enrollment process for new and existing SoonerCare enrollees. A streamlined home-view application that meets web design best practices for mobile and tablet device technology was implemented in the first of half of 2014 that included language updates to instructions and help text, reduced application review steps within new and renewal processes, improved placement of text, images, etc. on secure site and fewer questions within each application step. Later this year OHCA is going to be releasing a couple more updates for the online enrollment application that will include a Spanish version of the online application and an upgrade to the security of online enrollment to allow things such as member password reset and account management functions. All of these enhancements are expected to result in the increased enrollment for medical coverage of qualified Oklahomans.

Fig. 5.1.a

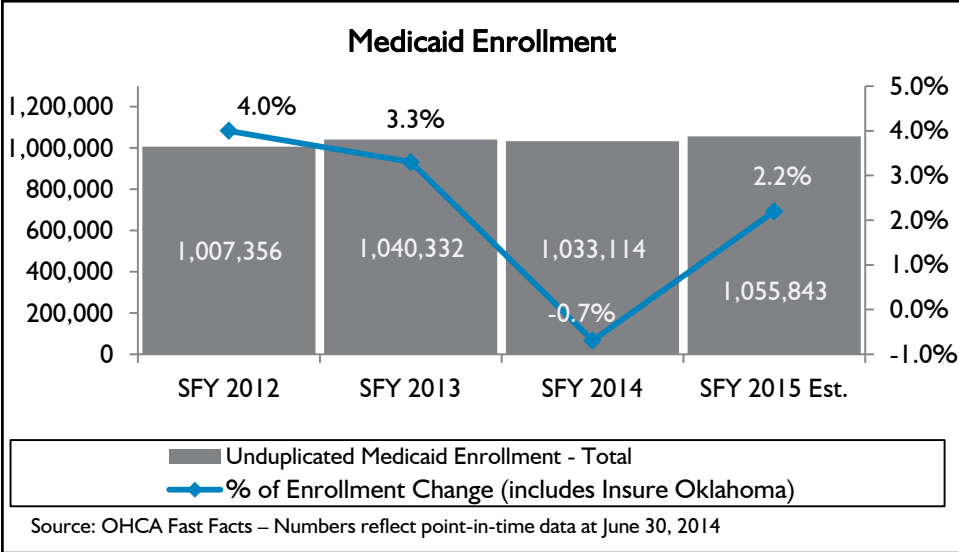


Fig. 5.1.b

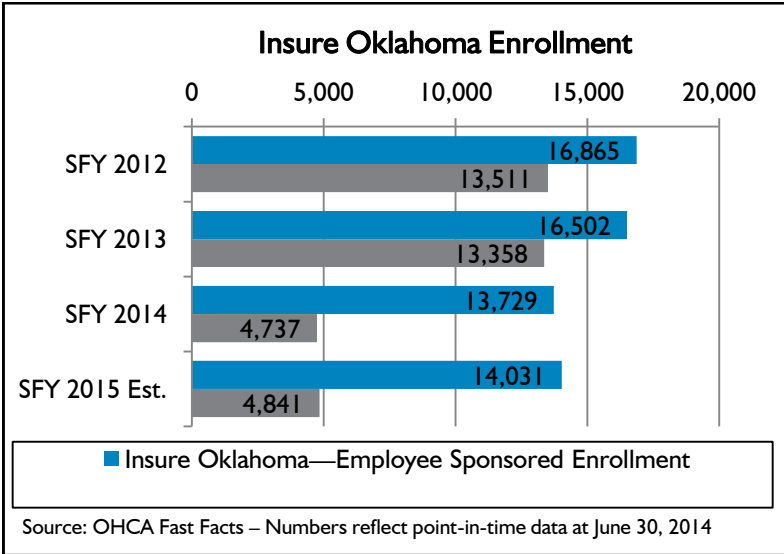


Fig. 5.1.c

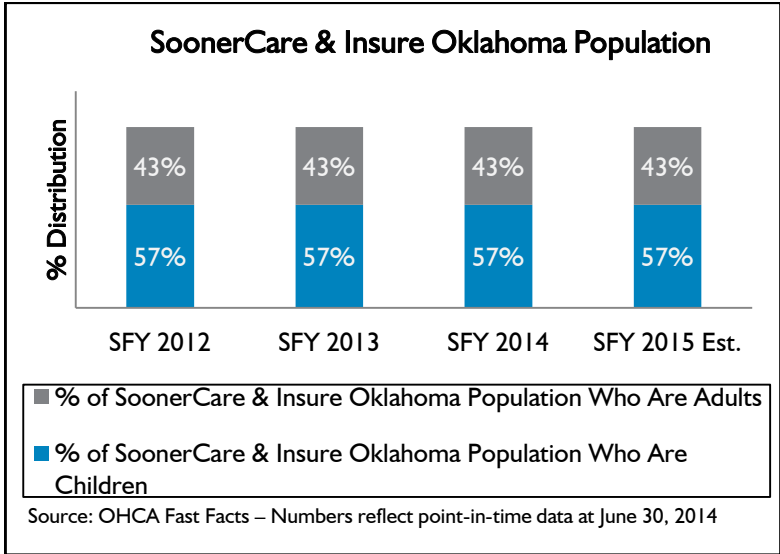


Fig. 5.1d

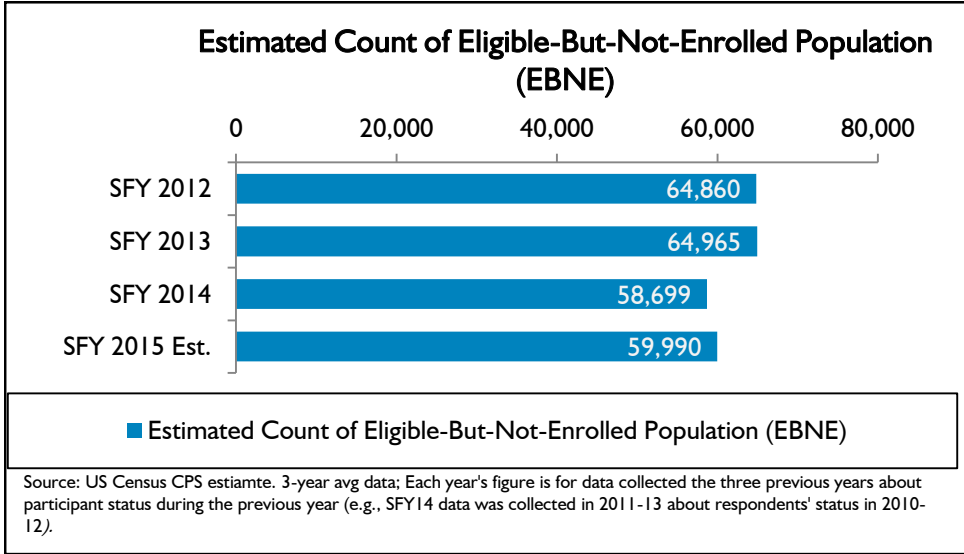


Fig. 5.1.e

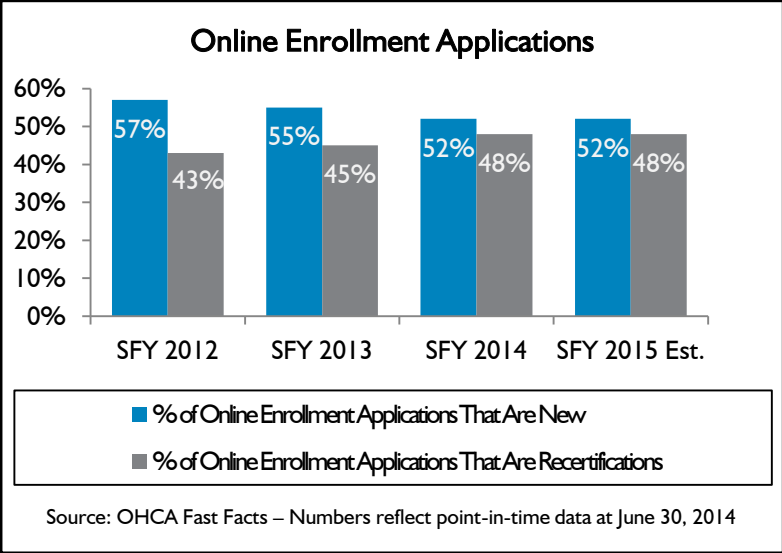
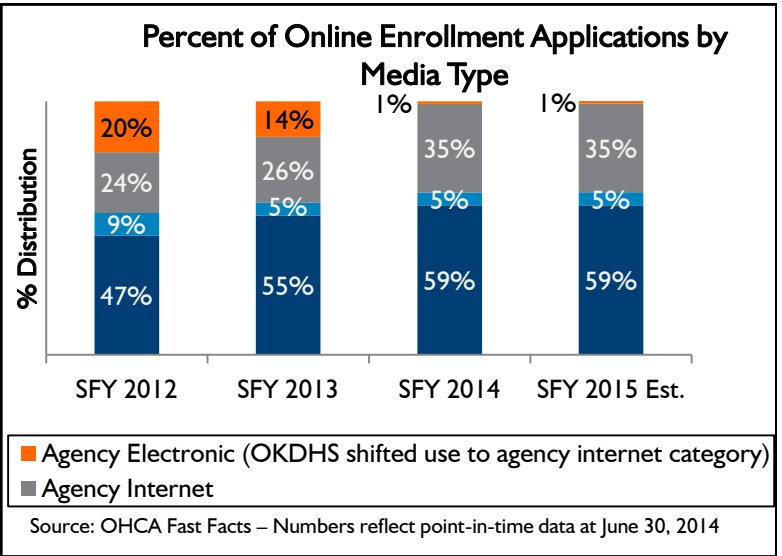


Fig. 5.1.f



GOAL 6– Administration

TO FOSTER EXCELLENCE AND INNOVATION IN THE ADMINISTRATION OF THE OKLAHOMA HEALTH CARE AUTHORITY

Objective 6.1:

To consistently perform administrative responsibilities within funding budgeted

Measured By:

6.1.1— % of administration budgeted dollars used

Why is this objective important?

Due to limited resources and a very tight budget, OHCA is committed to being a good steward of public funds. Efforts to administer the SoonerCare program in an efficient manner are shown by keeping administrative costs down.

What trends do the measures indicate?

OHCA has consistently kept administrative costs within the budgeted funding amount. This measure shows the commitment to efficiency and responsibility.

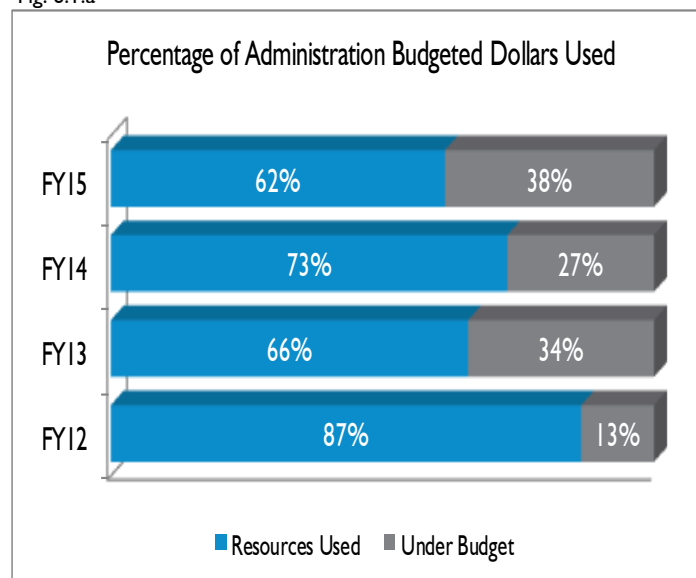
Are the trends headed in the right direction?

The decreasing administrative costs demonstrate OHCA’s continued effort to streamline services and provide the highest quality of care in the most efficient manner.

What is the agency doing to influence performance towards the objective?

OHCA carefully tracks expenses by reviewing policy changes and growth trends. Creating precise projections allows the agency to plan and budget administrative costs in a manner that allows for efficient operation of the SoonerCare program.

Fig. 6.1.a



Source: OHCA Financial Services Division

Objective 6.2:

To control administrative costs while providing support and services to SoonerCare members

Measured By:

6.2.1-Per Capita OHCA administrative cost

Why is this objective important?

The per capita cost for the administration of SoonerCare demonstrates effective and efficient management of SoonerCare. Enrollment number increases may give the perception of increased spending. The per capita costs gives a true picture of how efficiently the SoonerCare program is operated.

What trends do the measures indicate?

Persistent efforts by OHCA to increase the efficiency of SoonerCare have achieved success in managing the per capita administrative costs.

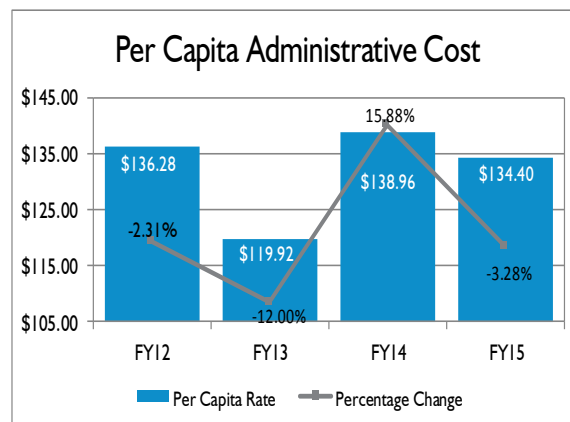
Are the trends headed in the right direction?

Despite some minor fluctuation, the per capita administrative costs for the SoonerCare program continue to be kept at a manageable rate. Oklahoma ranks well below the national average for per enrollee spending¹, providing continued evidence of the efforts by OHCA to control costs while providing quality care to our SoonerCare members.

What is the agency doing to influence performance towards the objective?

OHCA closely monitors expenditures related to the administration of the SoonerCare program and works closely with state agencies and officials to ensure responsible spending. Evaluating cost information and trends allow the agency to accurately forecast and prepare for future needs in order to affect policy change and program effectiveness.

Fig. 6.2.a



Source: <http://kff.org/medicaid/state-indicator/medicaid-payments-per-enrollee/>

Objective 6.3:

To pay SoonerCare claims within an accuracy rate of at least 95 %, considering policy, systems issues and member eligibility

Measured By:

6.3.1- Number of claims paid

6.3.2- Payment Accuracy Measurement Rate

Why is this objective important?

The Payment Accuracy Measurement (PAM) tracks and reports improper payments to providers in the SoonerCare program to create a payment accuracy rate. Identifying payment errors allows OHCA to correct mistakes, recoup improperly paid funds and make needed policy changes in order to ensure claims are paid appropriately.

What trends do the measures indicate?

OHCA has modeled its PAM program after the Federal Payment Error Rate Measurement (PERM) program. The Federal PERM measures errors instead of accuracy. Every 3 years the state undergoes a PERM review. OHCA has achieved an accuracy rate higher than the National rate in spite of having a significant increase in the number of claims processed.

Are the trends headed in the right direction?

The number of claims processed is subject to fluctuation, however the OHCA PAM program has consistently maintained a high rate of accuracy and appropriate payment of claims.

What is the agency doing to influence performance towards the objective?

The OHCA PAM program measures the accuracy of paid claims through a retrospective review. A randomly selected sample of paid claims is selected and review for payment accuracy and medical necessity. OHCA performs the internal PAM review annually. Areas of concern are corrected through provider education, policy changes and referrals to OHCA program integrity unit for further investigation.

OHCA is also generating system improvements to ensure accurate payments. A secure site for providers on the Oklahoma Medicaid Management Information System allows providers to enter information online and submit claims electronically. This system provide providers with prompts for errors in order to allow providers to correct the errors and resubmit the claims.

Fig. 6.3.a

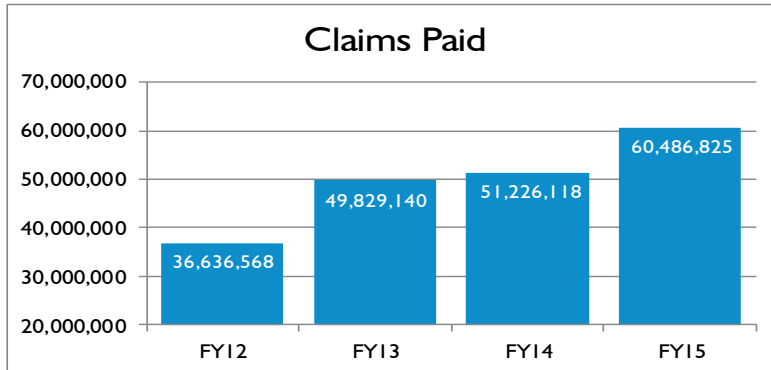
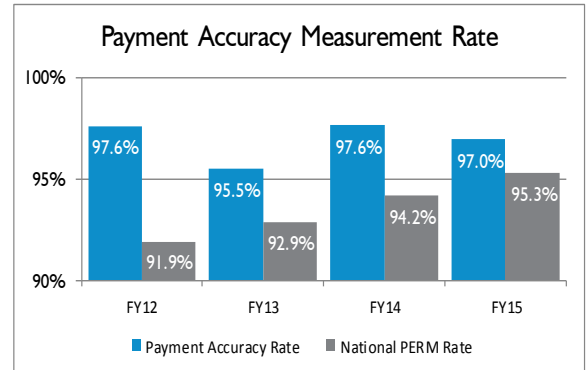


Fig. 6.3.b



Source: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/Downloads/2013MedicaidandCHIPImproperPaymentsReport.pdf>

Objective 6.4:

To maintain appropriate prior authorization requirements for the health of the member

Measured By:

6.4.1— Number of prior authorizations generated for prescriptions

6.4.2— Percentage of automatic vs. manual prior authorizations for prescriptions

Why is this objective important?

To ensure efficient and appropriate use of prescription medications, OHCA requires prior authorization for certain medications. These prior authorizations are done via an automated system if approved criteria are met or processed manually for medical necessity.

What trends do the measures indicate?

These measures report the total number of prescriptions prior authorized and a comparison of the automated PAs vs the manual prior authorizations. To insure medical necessity and proper utilization of prescription medications, a significant number of PAs are completed manually.

Are the trends headed in the right direction?

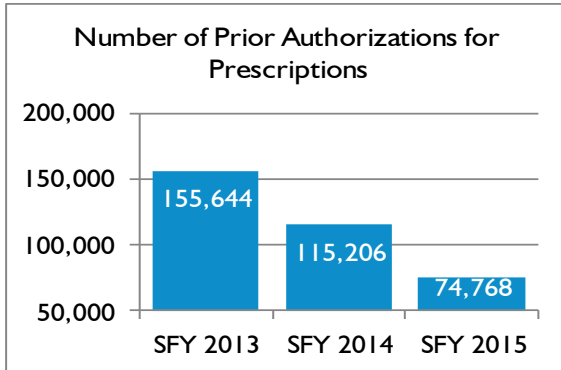
Due to changes in guidelines and utilization protocols, the number of prescription medications requiring prior authorization may fluctuate. Continued monitoring of prescription drug claims and input from the Drug Utilization Review board will ensure appropriate medications are subject to prior authorization.

What is the agency doing to influence performance towards the objective?

Prior authorizations are used for several reasons such as scope control to insure a drug is used for approved indications and is therapeutically appropriate. Utilization controls are used to limit quantities or duration of use.

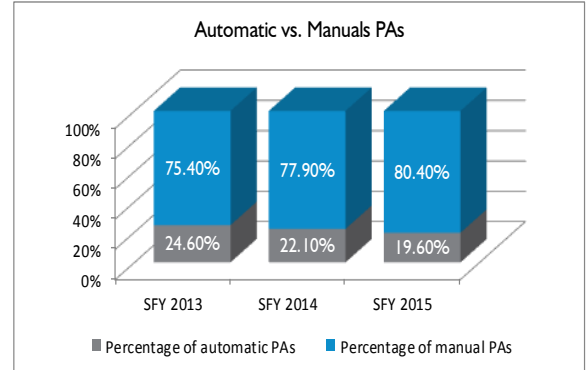
Certain prior authorizations are used to divide categories of drugs into tiers. Tier I is the preferred first step for treatment. With each higher tier, step therapy criteria are required to ensure the member received the best treatment in the most cost effective manner.

Fig. 6.4.a



Source: OHCA MMIS

Fig. 6.4.b



Source: OHCA MMIS

Objective 6.5:

To maintain and/or increase program and payment integrity efforts which may result in recoveries and/or cost prevention.

Measured By:

6.5.1— Payment integrity recoveries

6.5.2— Number of provider audits

6.5.3— Number of providers referred to Medicaid Fraud Control Unit

Why is this objective important?

In order to ensure that the SoonerCare program is being operated efficiently, it is important that OHCA verify that claims for services are being paid correctly. This objective is one of the activities that OHCA performs to ensure that claims are paid accurately and potential fraud is identified. OHCA uses audit and review functions, internal controls monitoring and prepayment edits to prevent and detect erroneous claim payments and identify suspected fraud and abuse.

What trends do the measures indicate?

Consistent audit practices in reviewing claims for appropriate billing and compliance with OHCA policy will ensure maximum recovery and fraud identification. The amount of recoveries may be expected to fluctuate from year to year. This fluctuation is a reflection of provider billing practices and not a lack of vigilance on the part of OHCA staff.

Are the trends headed in the right direction?

Recovery amounts can fluctuate depending on staffing levels and the types of audits being conducted. Additional variations in recovery amounts will occur when system edits or policy changes are made, which can reduce payment errors. OHCA is demonstrating due vigilance by increasing the number of provider audits being conducted, regardless of whether or not these audits result in recoveries.

What is the agency doing to influence performance towards the objective?

OHCA has various units responsible for separate areas of potential recovery. The program integrity unit prevents unnecessary utilization and performs audits and reviews of external providers. These reviews can be initiated by complaints from providers, members, concerned citizens or other state agencies. Risk based assessments are also used to initiate reviews. Reviews resulting in a suspicion of fraud are forward to the Medicaid Fraud Control Unit for further investigation. There were no providers referred to the Medicaid Fraud Control Unit in FY14.

Fig. 6.5.a

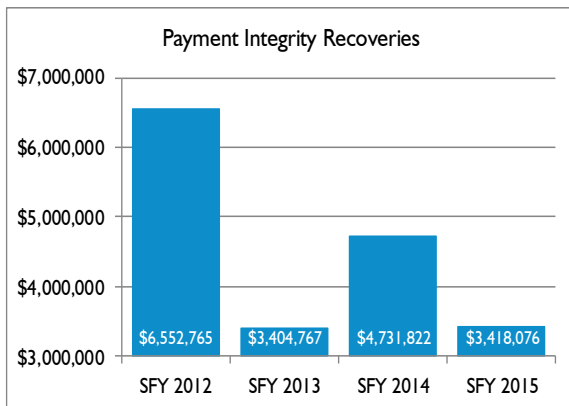


Fig. 6.5.b

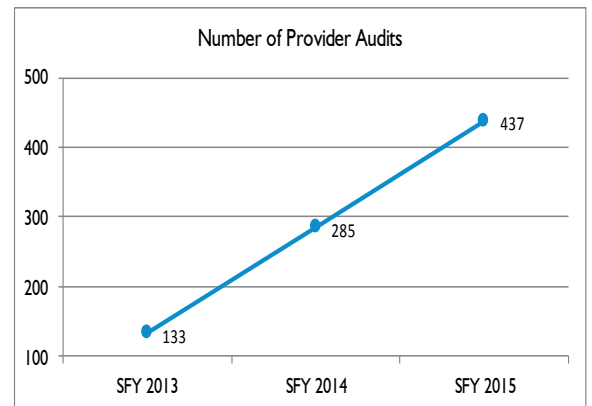


Fig. 6.5.

Providers Referred to the Medicaid Fraud Control Unit

	FY13	FY14	FY15
# Providers	1	0	1

Source: OHCA Program Integrity Unit

Objective 6.6:

To actively pursue all third party liability payers, and recover or collect funds due to the SoonerCare program

Measured By:

6.6.1— Third Party Liability Collections

6.6.2— Number of SoonerCare members with third party insurance

Why is this objective important?

Third Party Liability (TPL) occurs when other payers have a responsibility to pay for the medical costs of SoonerCare members. SoonerCare is designated by law to be the payer of last resort for its members. When members have other coverage such as private health insurers or Medicare, that coverage is considered the primary payer.

What trends do the measures indicate?

TPL collections occur when OHCA has already paid a medical claim for a member before discovering the responsible party. When the TPL party is known prior to a medical claim being paid, the claim is cost avoided allowing the TPL entity to act as the primary payer.

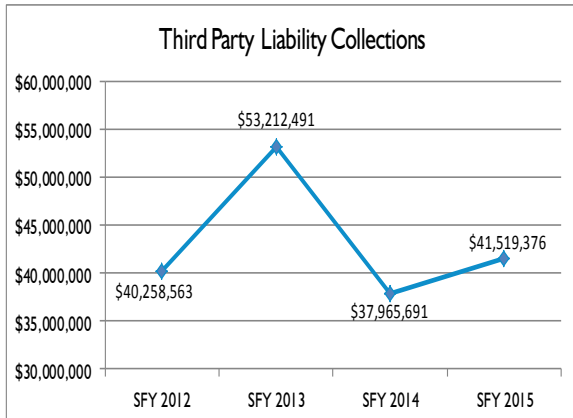
Are the trends headed in the right direction?

The agency ensures that appropriate payments and recoveries are made as required by law. Fluctuations in collections and the numbers of SoonerCare members with third party insurance are expected as members access to other coverage sources is subject to change.

What is the agency doing to influence performance towards the objective?

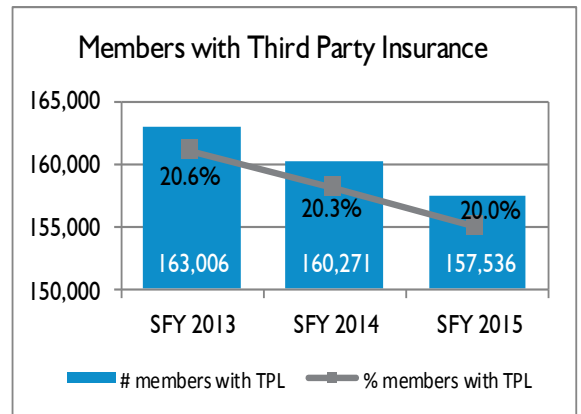
Consisting of a cost avoidance section, a cost recovery section and a tort and estate recovery section, the TPL unit works with a private contracting firm HMS, to search national databases to identify members with private health insurance coverage. HMS also acts as OHCA's electronic billing agent in cases where the claim was not cost avoided.

Fig. 6.6.a



Source: OHCA Financial Services Division

Fig. 6.6.b



Source: OHCA Financial Services Division

GOAL 7 — Collaboration

TO FOSTER COLLABORATION AMONG PUBLIC AND PRIVATE INDIVIDUALS AND ENTITIES TO BUILD A RESPONSIVE HEALTH CARE SYSTEM FOR OKLAHOMA.

Objective 7.1:

To partner with others to enroll qualifying children, parents, and other adults into SoonerCare.

Measured By:

7.1.1— % of online applications by source (agency view)

7.1.2— % of online applications by source (home view)

7.1.3— % of online applications by source (combined home and agency view)

Why is this objective important?

OHCA implemented Online Enrollment in September 2010 and transferred the responsibility of eligibility and enrollment of more than 500,000 Oklahomans from the Oklahoma Department of Human Services (OKDHS) to OHCA. Prior to Online Enrollment, applicants had to visit an OKDHS County office in person, or fill out a paper application and mail it to OKDHS, where the eligibility determination and ensuing enrollment could take up to a month to complete. Online enrollment provided real time eligibility determination and enrollment, and opened new possibilities for community-based enrollment assistance to SoonerCare applicants. Since an online home application can be submitted from any computer with internet access, and the online agency application is used by partners, SoonerCare applicants now have greater access to enrollment assistance when needed.

What trends do the measures indicate?

The trends indicate more SoonerCare members are utilizing the home internet version of Online Enrollment and accessing application assistance through partners, while the use of the paper application continues to decline, falling to a low of 1%. More information about OHCA Online Enrollment is available [here](#) under OHCA Statistics and Data.

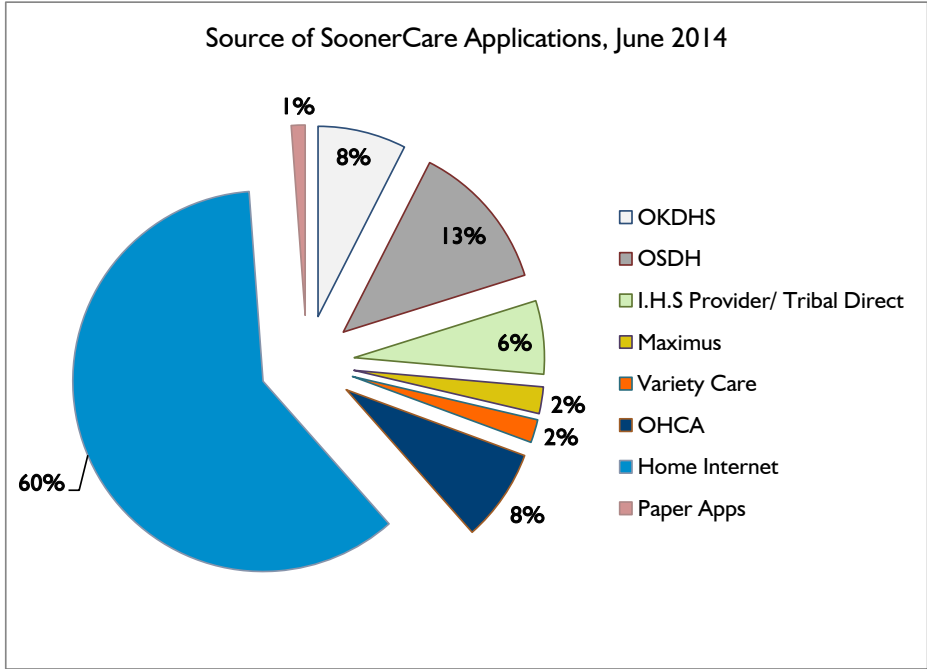
Are the trends headed in the right direction?

These trends continue to move in the right direction. Online enrollment provides a more convenient and faster option for those able to access the internet and complete the application on line. There is also an increase in the number of applications submitted through partner agencies using the agency version of online enrollment, suggesting an increase in the use of community partners by SoonerCare members seeking application assistance.

What is the agency doing to influence performance towards the objective?

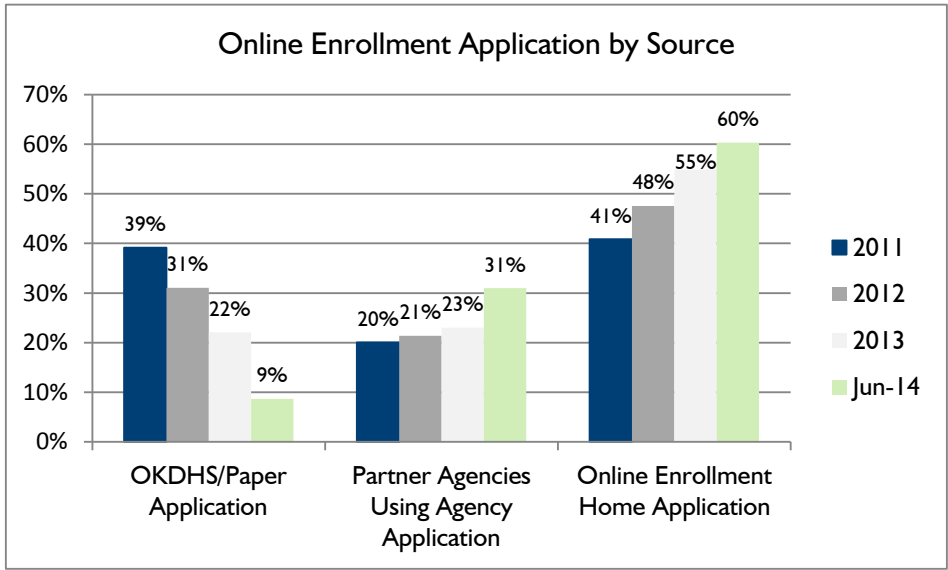
OHCA continually monitors Online Enrollment to identify issues and incorporate user feedback to best serve the needs of current SoonerCare members and those potentially qualified for services. OHCA has plans to upgrade the online application so that it works with all internet browsers as well as make the online application compatible with mobile devices. OHCA has a formalized training system enabling the agency to train partners on-site or through webinars when enhancements or changes are made to online enrollment.

Fig. 7.1.a



Source: OHCA Fast Facts — Numbers reflect point-in-time data at June 30, 2014 for the month of June 2014

Fig. 7.1.b



Source: OHCA Fast Facts — SFY 2011 is a partial year (October 2010 to June 2011); Numbers for SFY 2012 -2013 are for the 12 month period, while the numbers for SFY 2014 reflect point-in-time data for June 2014 .

Objective 7.2:

To partner with other state entities in activities with joint objectives targeting SoonerCare populations

Measured By:

7.2.1— Accumulated state and federal revenue generated by collaborations to provide services

7.2.2— Accumulated state and federal revenue generated by collaborations to provide medical education

Why is this objective important?

Partnering with other state entities in activities with joint objectives targeting SoonerCare populations finances a significant amount of combined state and federal dollars for providing medical services and medical education in Oklahoma. Other agencies are able to leverage the federal matching dollars as a result of the collaborative relationship with the OHCA. Without these relationships, other state agencies would have to find additional state dollars to provide an equivalent level of medical services and medical education. The Oklahoma Department of Human Services, the Oklahoma Department of Mental Health and Substance Abuse Services, the Oklahoma State Health Department, and the Oklahoma Department of Corrections contribute the state share to provide services. The two entities contributing the state share to provide medical education are the University of Oklahoma and Oklahoma State University.

What trends do the measures indicate?

The measures indicate trends related to state and federal financing of health care services and medical education. Changes in these trends indicate a budget impact on OHCA's collaborative entities and affect the financing of services and medical education.

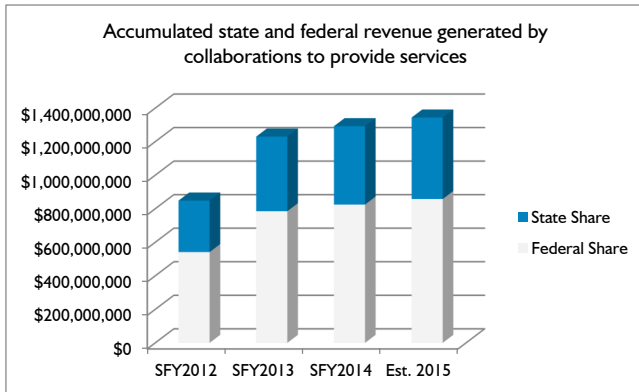
Are the trends headed in the right direction?

The trends show an increase over the past three years in accumulated state and federal revenue generated by collaborations to provide services and medical education. These trends continue to head in the right direction.

What is the agency doing to influence performance towards the objective?

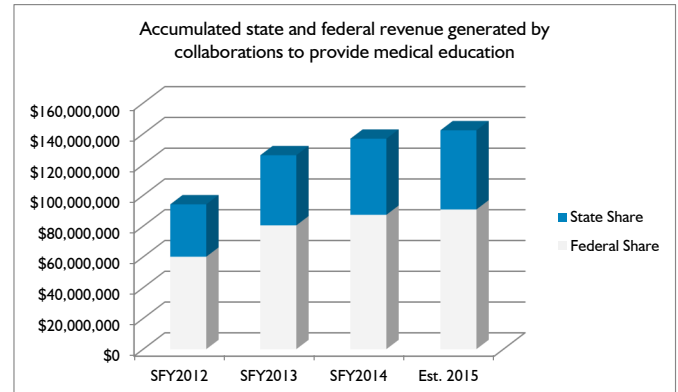
The OHCA continually monitors the accumulated state and federal revenue generated by collaborations to provide services and medical education so these funds provide the maximum results for the citizens of Oklahoma. OHCA has various advisory committees, councils and task forces that work with OHCA to develop programs and identify areas mutually benefitting state entities. Some of the groups performing these duties include: the Child Health Advisory Task Force, the Drug Utilization Review Board, the Living Choice Advisory Committee, the Medical Advisory Committee, the Perinatal Task Force, the OHCA State Plan Amendment Rate Committee, Tribal Consultation meetings, and the Joint Legislative Oversight Committee. Additional information is available on the OHCA website, www.okhca.org, under [Boards and Committees](#).

Fig. 7.2.a



Source: OHCA Financial Services

Fig. 7.2.b



Source: OHCA Financial Services

Objective 7.3:

To engage in partnerships promoting education, job growth, and self-sufficiency

Measured By:

7.3.1— Number of individuals who completed certification through the Certified Nurse Aide Training Program

Why is this objective important?

The OHCA supports collaborative efforts promoting opportunities to gain additional education and develop job skills for positions in high demand. As the state Medicaid agency, the OHCA believes the agency has a role in ensuring our state workforce is healthy and productive. As populations are better trained and able to achieve higher paying and more secure jobs, their self-sufficiency increases and reliance on public programs decreases. Increasing income and reducing poverty are good for the state's economic health and improving the state's overall health outcomes.

What trends do the measures indicate?

The Certified Nurse Aide Training Program aims to decrease the nurse aide shortage in SoonerCare contracted Long Term Care (LTC) facilities by paying for the training of qualified individuals to become Certified Nurse Aides. The program provides students with a choice of educational facilities in several areas of Oklahoma, including rural areas, and an opportunity to increase job skills at no cost. In return, the student assures a 12 month commitment to work in an OHCA SoonerCare contracted LTC facility. While the aim of this measure is to alleviate the shortage of trained nurse aides working in LTC facilities, there continues to be a decline in the number that work in LTC facilities.

Are the trends headed in the right direction?

The number of individuals who completed certification through the Certified Nurse Aide Training Program declined from 711 in SFY2013 to 405 in SFY2014. Beginning July 1, 2014 the program underwent policy changes. The OHCA projects the change will lead to lower participation, but produce an improved outcome of trained nurses aides working in nursing facilities.

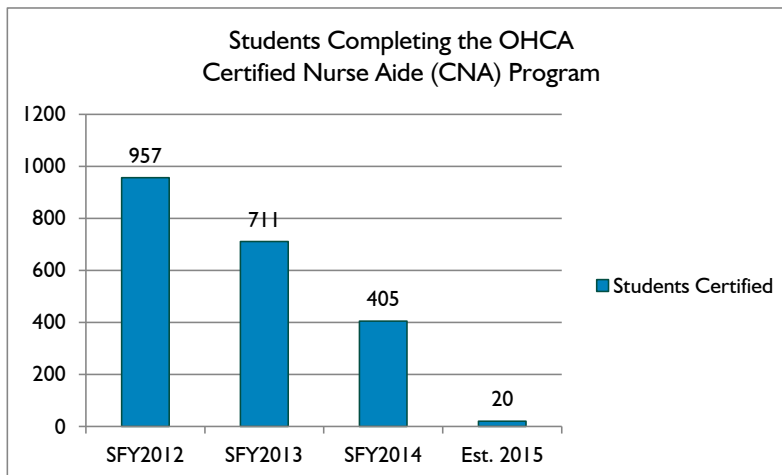
What is the agency doing to influence performance towards the objective?

Over the past six years, OHCA has not shown an increase in the number of certified nursing assistants working in nursing facilities. In 2014, the OHCA implemented rate and method changes to the Certified Nurse Aide Training Program in an effort to improve the performance of the program. Starting July 1, 2014 OHCA no longer pays upfront for the training, but will instead reimburse Certified Nurse Aides following certification. The Certified Nurse Aides will be reimbursed on a quarterly basis during their first 12 months of employment in a LTC facility. With this programmatic change, the OHCA anticipates 20 participants during SFY2015.

More information about the Certified Nurse Aide Training Program can be found [here](#).

The OHCA also plans to work with the Oklahoma Department of Commerce to identify areas where additional partnerships between health care and businesses can be made mutually beneficial.

Fig. 7.3.a



Source: OHCA Provider Services

Objective 7.4:

To effectively serve Oklahoma's SoonerCare qualified American Indian population by maintaining partnerships with Oklahoma's 39 Federally-recognized American Indian Tribes.

Measured By:

- 7.4.1— Number of tribal enrollment partnerships
- 7.4.2— Number of tribes represented at tribal consultations
- 7.4.3— Number of tribal consultations per year

Why is this objective important?

The OHCA Tribal Relations Unit performs tribal stakeholder liaison services between the OHCA, the Centers for Medicare & Medicaid Services, the Indian Health Service, Tribal service providers, and the tribes

of Oklahoma for state and national level issues including American Indian work groups, policy development and compliance, tribal consultation, payment issues and elimination of health disparities. This objective is important because it guides the OHCA Tribal Relations Unit goal to develop and implement a service delivery model within the current Medicaid program (SoonerCare in Oklahoma) to increase access to services for American Indians.

What trends do the measures indicate?

The trends for the tribal consultation measures indicate the continual process by which OHCA engages with Tribal stakeholders to best serve the American Indian population in Oklahoma. An increase in tribal enrollment partnerships indicates improved access to application assistance for American Indian applicants.

Are the trends headed in the right direction?

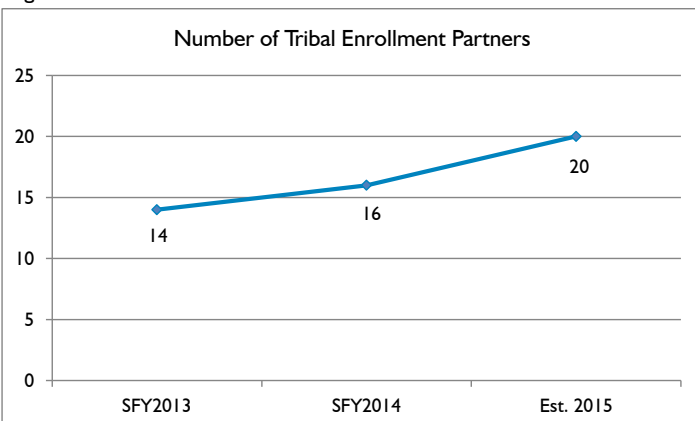
The OHCA assumes the number of tribal consultations per year will remain the same, while OHCA would like to see the average number of tribes represented at tribal consultations increase. The number of tribal enrollment partnerships increased between 2013 and 2014 and OHCA believes this trend is headed in the right direction.

What is the agency doing to influence performance towards the objective?

The OHCA expects tribal participation and enrollment partnership increases due to active outreach efforts by tribal relations staff to maintain, solicit and strengthen partnerships with tribes. Examples of active outreach efforts to tribal partners include frequent written and verbal communication to elected tribal officials and their designees, travel to tribal communities for face to face meetings with tribal leaders, and active participation with stakeholders, such as attendance at the OKC Area Inter-Tribal health board and the Five Tribes Council quarterly meetings (together these two organizations represent 15 Oklahoma tribes).

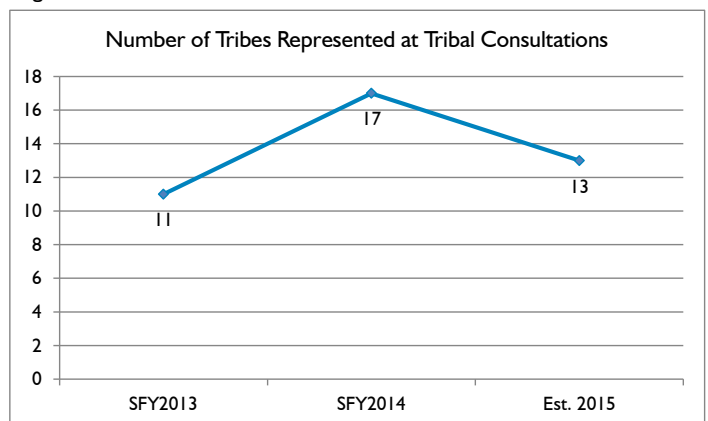
More information about the OHCA Tribal Relations unit can be found [here](#).

Fig. 7.4.a



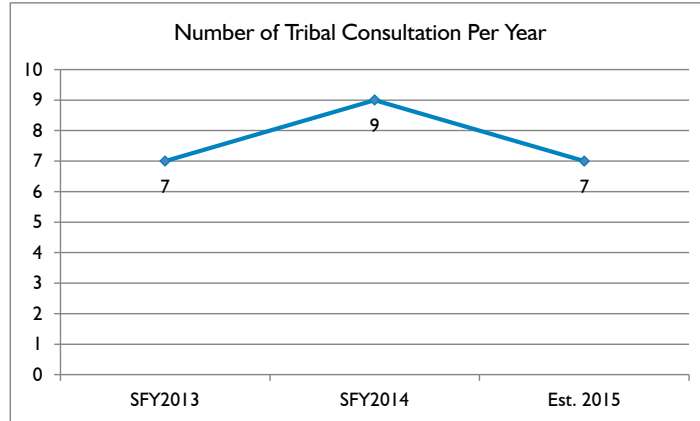
Source: OHCA Tribal Relations

Fig. 7.4.b



Source: OHCA Tribal Relations

Fig. 7.4.c



Source: OHCA Tribal Relations