SOONERCARE CHOICE PROGRAM INDEPENDENT EVALUATION

THE PACIFIC HEALTH POLICY GROUP
JULY 2015

INTRODUCTION

- The Pacific Health Policy Group specializes in design, implementation and evaluation of health reform initiatives for publicly-funded populations
- The firm has assisted over 30 state Medicaid programs since 1994
- In recent years the firm has worked on Medicaid managed care engagements for public or managed care organization clients in:

Arizona	***California***	***Florida***	***Georgia***
Hawaii	***Illinois***	***Indiana***	***Iowa***
Kansas	***Kentucky***	***Michigan***	***Missouri***
New Jersey	***New Mexico***	***New York***	***Ohio***
Tennessee	***Texas***	***Vermont***	***Washington***

- The firm was retained to evaluate SoonerCare Choice program performance over time and in relation to national trends

INTRODUCTION *cont'd*

Evaluation questions

- How has SoonerCare Choice evolved and performed over the evaluation period (2009 – 2014)?
  - Access to care
  - Quality of care
  - Cost effectiveness
- How does SoonerCare Choice compare to benchmark managed care programs in Arizona & Florida?

SOONERCARE CHOICE EVALUATION

SoonerCare Choice Overview

SoonerCare Choice Performance

Impact of Recent OHCA Initiatives

Comparison to Benchmark States

SoonerCare Choice Overview

Managing care through the SoonerCare Choice delivery system

- Enrollment
- Patient Centered Medical Homes

SOONERCARE CHOICE OVERVIEW

SoonerCare Choice Managed Care

- The term "Managed Care" refers to any coordinated system for the delivery of health services
- To control costs over the long term, a managed care system should include programs and incentives to increase delivery of primary/preventive services, while averting avoidable trips to the emergency room and inpatient hospital stays
- There are multiple managed care "models", including:
  - Capitated (pre-paid) Managed Care Organizations (MCOs)/Health Maintenance Organizations (HMOs)
  - Preferred Provider Organizations (PPOs)
  - Primary Care Case Management (PCCM)/Patient Centered Medical Home (PCMH) models
- SoonerCare Choice uses the PCCM/PCMH model

SOONERCARE CHOICE OVERVIEW

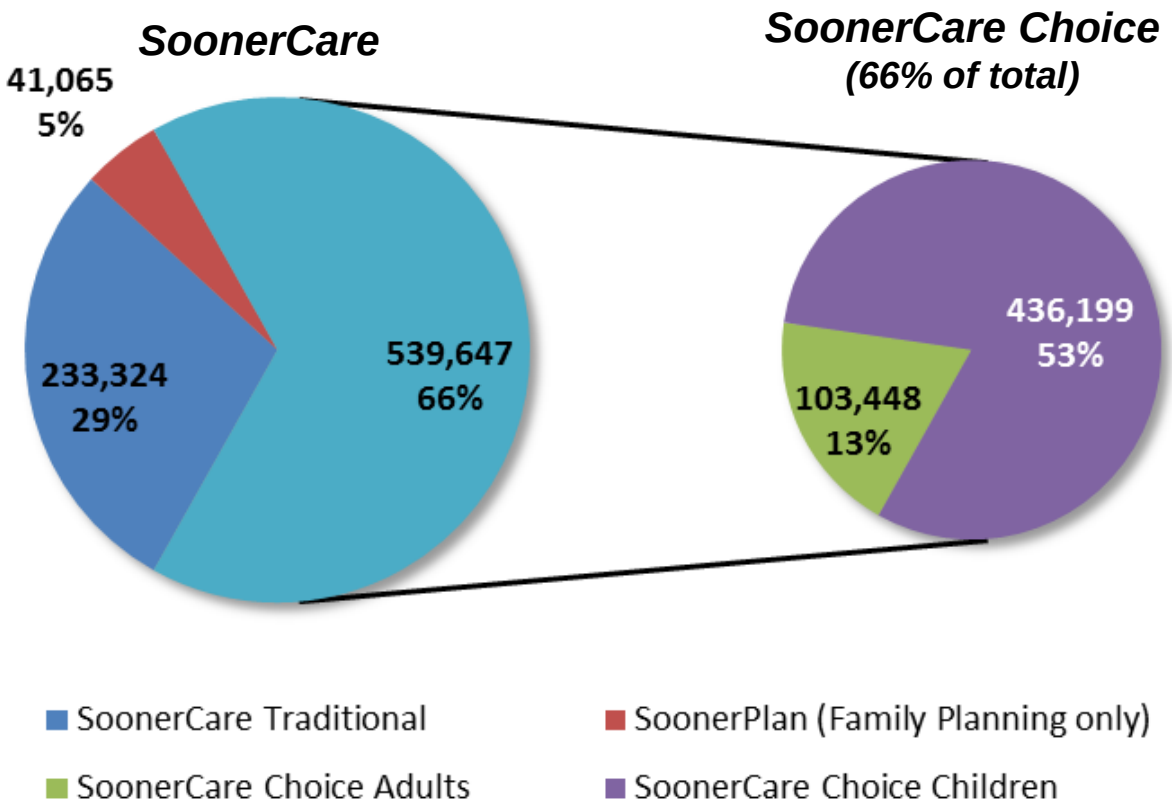
SoonerCare Choice Enrollment

- The SoonerCare Program serves over 800,000 Oklahomans
- SoonerCare Choice is the managed care portion of the larger SoonerCare program
- About 66 percent of SoonerCare members are enrolled in SoonerCare Choice
- Over 80 percent of SoonerCare Choice members are children
- Over 90 percent of SoonerCare Choice members fall into Temporary Aid to Needy Families (TANF) and related aid categories; the remainder are in the non-Medicare Aged, Blind and Disabled (ABD) categories
- Unlike their TANF counterparts, most ABD members are adults

SOONERCARE CHOICE OVERVIEW *cont'd*

SoonerCare – December 2014

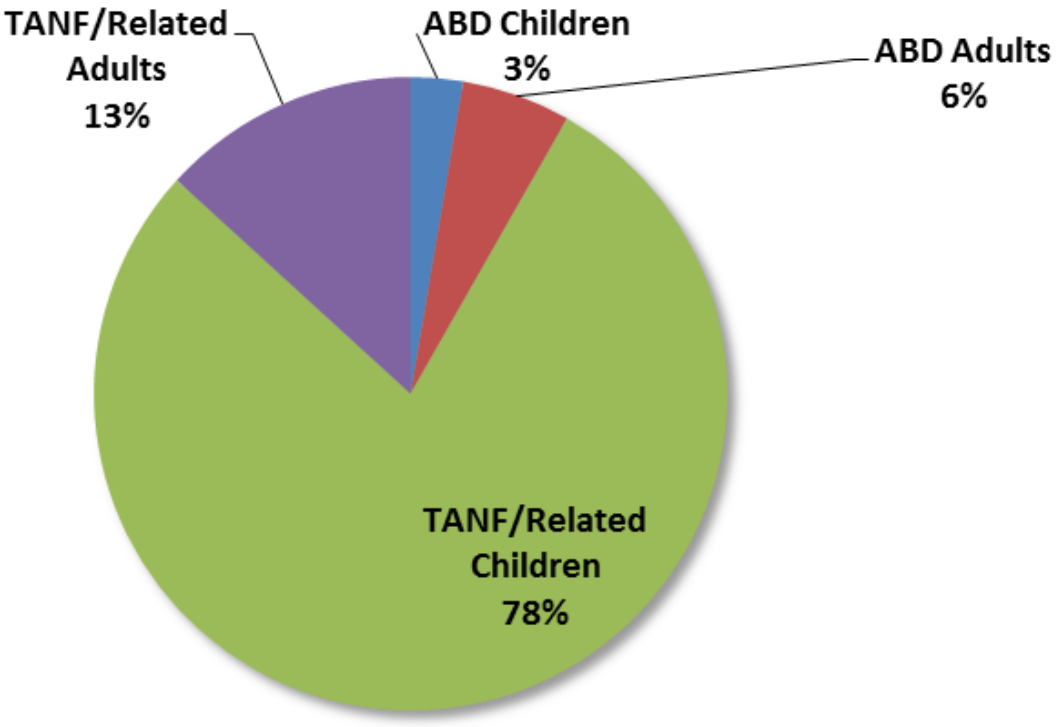
Total Enrollment – 814,036



Source: OHCA Fast Facts

SOONERCARE CHOICE OVERVIEW *cont'd*

SoonerCare Choice Membership by Age/Aid Category (SFY 2014)



Source: OHCA Eligibility Data – SFY 2014 member months

SOONERCARE CHOICE OVERVIEW *cont'd*

Overview of Patient Centered Medical Homes (PCMH)

- PCMH seeks to transform the delivery of primary care through:
  - Interdisciplinary team approach to care coordination
  - Standardization of care in accordance with evidence-based guidelines
  - Tracking of tests and consultations and follow-up after ER visits/hospitalizations
  - Active measurement of quality and adoption of Quality Improvement strategies
- As part of their enrollment in managed care, SoonerCare Choice members are aligned with a PCMH
- The PCMH model was created at the recommendation of a 2007 OHCA Medical Advisory Task Force and is part of a broader national movement to improve primary care for Medicaid members
- Many PCMH providers also are affiliated with SoonerCare Choice Health Access Networks (HANs), which are discussed in detail later in the presentation

SOONERCARE CHOICE OVERVIEW *cont'd*

Overview of Patient Centered Medical Homes

- There is growing evidence from state-level and national studies that patient centered medical homes can improve access and quality, while helping to control costs
- Of 10 peer-reviewed studies published in 2013-2014, six found an association between PCMH and a reduction in costs
- Of 13 peer-reviewed studies published in 2013-2014, 12 found an association between PCMH and a reduction in unnecessary service utilization

Source: The Patient Centered Medical Home's Impact on Cost and Quality, Annual Review of Evidence 2013-2014 (January 2015)

SOONERCARE CHOICE OVERVIEW *cont'd*

SoonerCare Choice PCMH Tiers – SFY 2014

- PCMH includes three tiers with escalating responsibilities and associated per member per month care coordination fees

Tier 1

Entry Level

- **13 requirements**
- Includes 24/7 telephone coverage by medical professional
- $3.46 - $4.85 per month
- Practice with a caseload of 250 receives up to $14,550 per year in care coordination fees

Tier 2

Advanced

- **20 requirements**, including all Tier 1 requirements
- Includes offering at least 30 hours of office time to see patients
- $4.50 - $6.32 per month
- Practice with caseload of 250 receives up to $18,960 per year in care coordination fees

Tier 3

Optimal

- **23 requirements**, including all Tier 1 and Tier 2 requirements
- Includes using health assessment tools to characterize patient needs/risks
- $5.99 - $8.41 per month
- Practice with caseload of 250 receives up to $25,230 per year in care coordination fees

PCMH Payments - SoonerExcel

- Providers also can earn "SoonerExcel" quality incentives for meeting performance targets
- The OHCA periodically updates the targets to reflect priorities for improving care
- PCMH providers earned **over $3.2 million** in SoonerExcel incentive payments in SFY 2014 for meeting quality targets (see next slide)

SOONERCARE CHOICE OVERVIEW *cont'd*

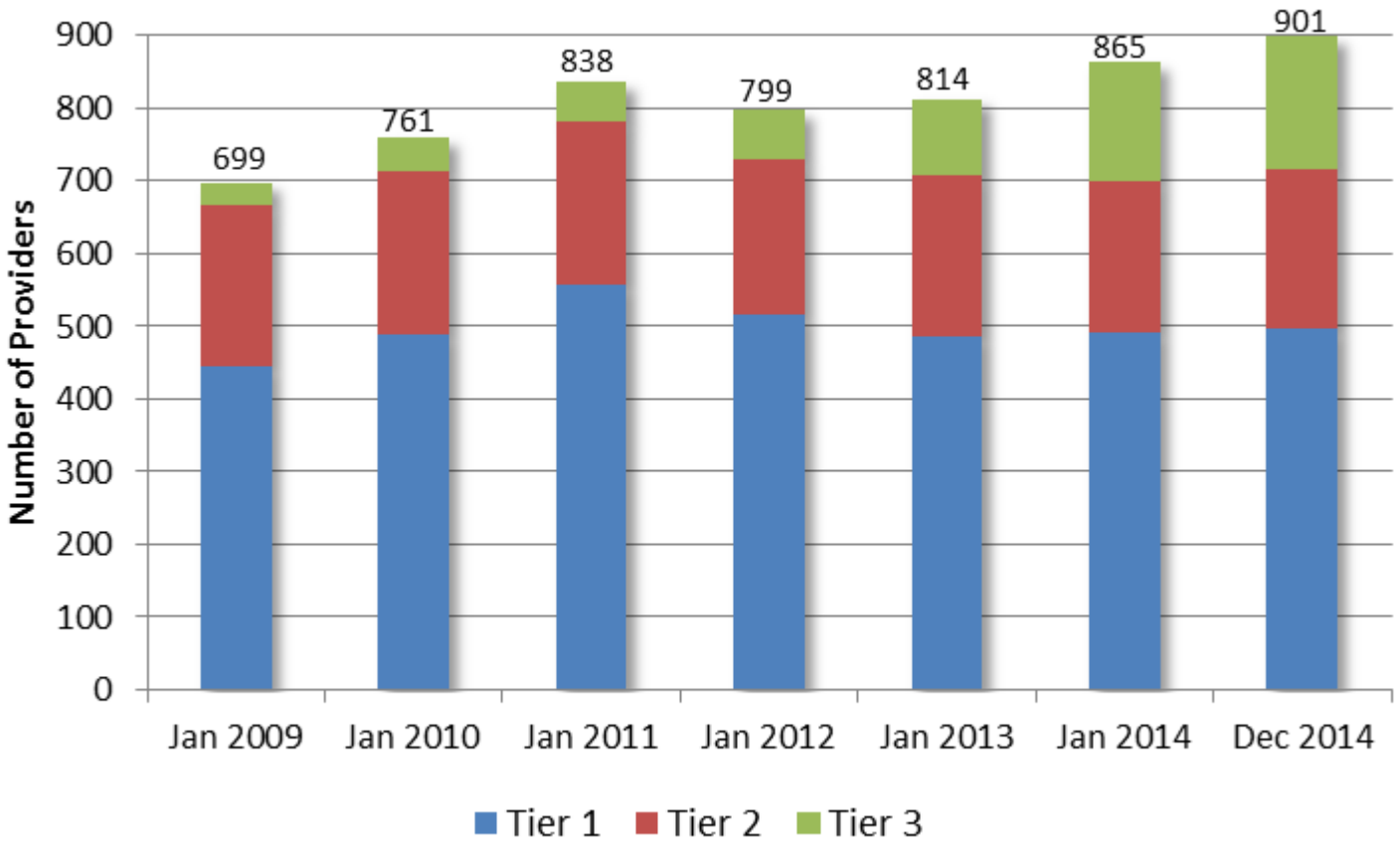
SoonerExcel Quality Measure	Benchmark	Incentive (subject to available funds)	SFY 2014 Payments
4th Diphtheria-Tetanus-Pertussis Vaccine Dose	Immunization prior to age 2	$3.00 per child	In EPSDT Total
Early & Periodic Screening, Diagnosis & Treatment Services (EPSDT)	Meet or exceed appropriate compliance rate	Up to 25 percent bonus on standard Fee-for-Service (FFS) rate for procedure	$1,014,000
Breast/ Cervical Cancer Screens	Payment made for each screen	Amount based on comparison to peers and available funds	$347,000
Emergency Room Utilization	Expected ER/office visit rate (risk adjusted)	Additional PMPM payment for outperforming benchmark	$495,000
Generic Prescribing	Payment made for each Rx, after application of adjustment formula	Provider-specific portion out of quarterly pool of $250,000 *(discontinued as of January 2014)*	$491,000
Physician Hospital Visits	Making inpatient visits	25 percent bonus per procedure + additional $20 per visit if above average of participating providers	$850,000
Behavioral Health	Performing annual BH screen on members age 5+	$2.00 per assessment *(starting in January 2014)*	$20,000
Source: OHCA		***Total***	**$3,217,000**

PCMH Practice Participation

- The total number of participating practices increased significantly from 2009 to 2014
- Since 2009, Tier 3 practices, as a percent of total, have **increased four-fold**, from under five percent to 20 percent
- Nearly 60 percent of SoonerCare Choice members are now enrolled with a Tier 2 or Tier 3 practice

SOONERCARE CHOICE OVERVIEW *cont'd*

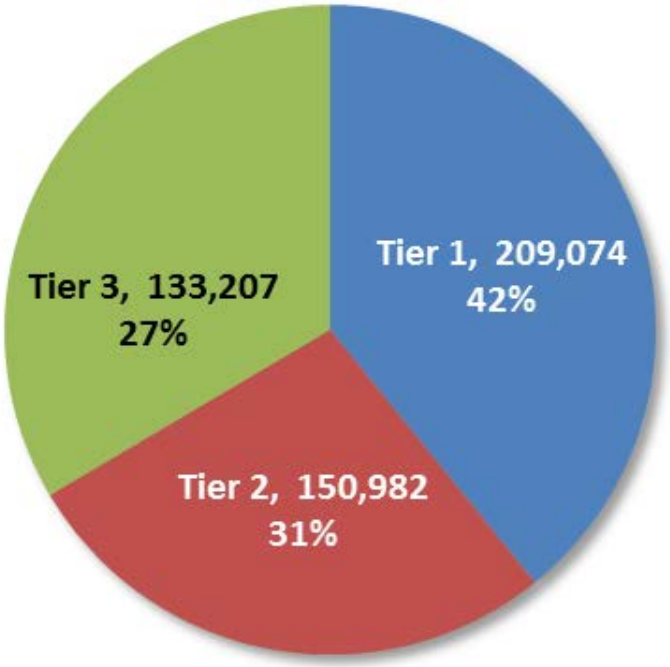
*Participating Practices by Tier Level**



*Note – Practices can include multiple providers
Source: OHCA Provider Fast Facts

SOONERCARE CHOICE OVERVIEW *cont'd*

Member Enrollment by Tier Level – December 2014



Source: OHCA December 2014 PCMH Provider Tiers and Panel Capacity Report

SOONERCARE CHOICE EVALUATION

SoonerCare Choice Overview

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SOONERCARE CHOICE EVALUATION

SoonerCare Choice Performance

- Access Trends
- Quality Trends
- Cost Effectiveness Trends

PERFORMANCE - ACCESS TO CARE

Evaluation Questions

- Is it easy or difficult for SoonerCare Choice members to enroll or renew coverage?
- Once enrolled:
  - Is there an adequate selection of primary care providers?
  - Are services (primary care and specialty) accessible?
- Are members with complex or chronic conditions helped to navigate the system?

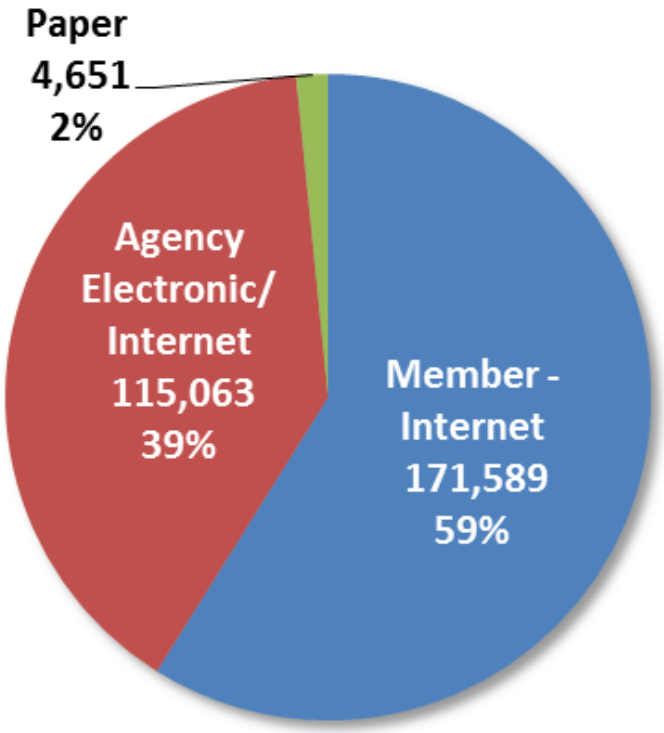
ACCESS TO CARE *cont'd*

Online Enrollment

- Over 24,000 applications for SoonerCare were processed monthly in SFY 2014
- Online enrollment objectives:
  - Provide 24/7 access to enrollment and "real time" determination of eligibility
  - Reduce error rate for eligibility determinations to zero by accessing relevant databases (OK Employment Security Commission; Social Security Administration; etc.)
  - Facilitate selection of a Patient Centered Medical Home
  - Reduce staff hours required for processing applications
- Online enrollment was launched in September 2010 and has had a significant impact on timeliness and accuracy
  - Paper applications have nearly ended
  - A recent eligibility audit determined the error rate to be 0.28 percent, the lowest among 17 states evaluated by the federal government

ACCESS TO CARE *cont'd*

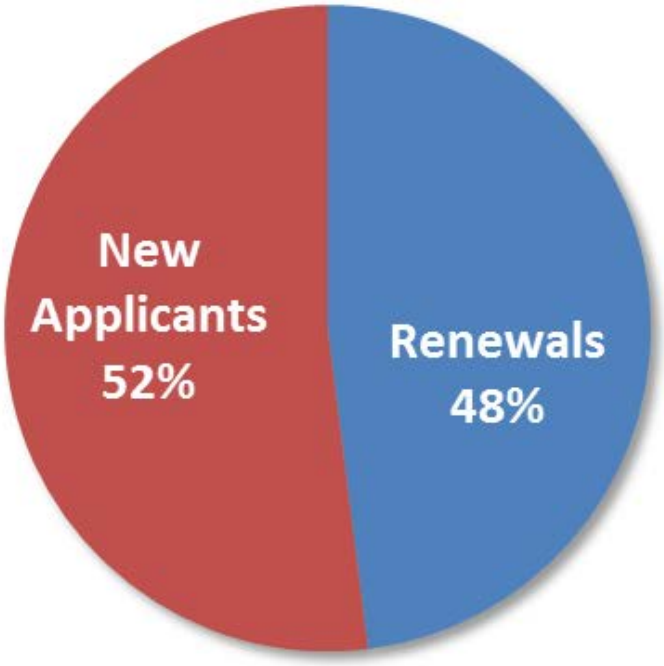
Enrollment Method – SFY 2014



Source: OHCA Enrollment Automation and Data Integrity, Business Enterprises

ACCESS TO CARE *cont'd*

Online Enrollment by Member Status – SFY 2014



Source: OHCA Enrollment Automation and Data Integrity, Business Enterprises

ACCESS TO CARE *cont'd*

Online Enrollment Savings

- The "return on investment" for online enrollment was evaluated by comparing state share of operational costs over the first five years to potential for reallocating caseworker resources
- A separate study was conducted by Mathematica Policy Research of "Express Lane Eligibility" in multiple states, with Oklahoma included as a comparison state
- Both firms estimated annual savings in the initial post go-live period of about **$1.5 million**
- The "savings" represent case worker resources freed-up for other activities, such as assisting individuals applying to DHS for cash assistance or Supplemental Security Income benefits

ACCESS TO CARE *cont'd*

Online Enrollment Savings

- For SFY 2014, online enrollment saved an estimated **$2.6 million** in state funds, versus what would have been spent in a paper application environment

Online Enrollment – Estimated SFY 2014 Savings (State Dollars)*	
Online applications – SFY 2014	286,652
Estimated net savings per application, versus paper*	$9.27
Total savings (state dollars)	$2,657,264

*Note: Savings based on estimated average caseworker time per paper application x estimated wage/benefit for entry level application worker x 50% (to represent state portion of costs, which are shared 50/50 with the federal government)

Sources: Online enrollment statistics provided by the OHCA: caseworker productivity estimate taken from Pacific Health Policy Group 2011 evaluation of online enrollment implementation; caseworker salary data taken from OKDHS website

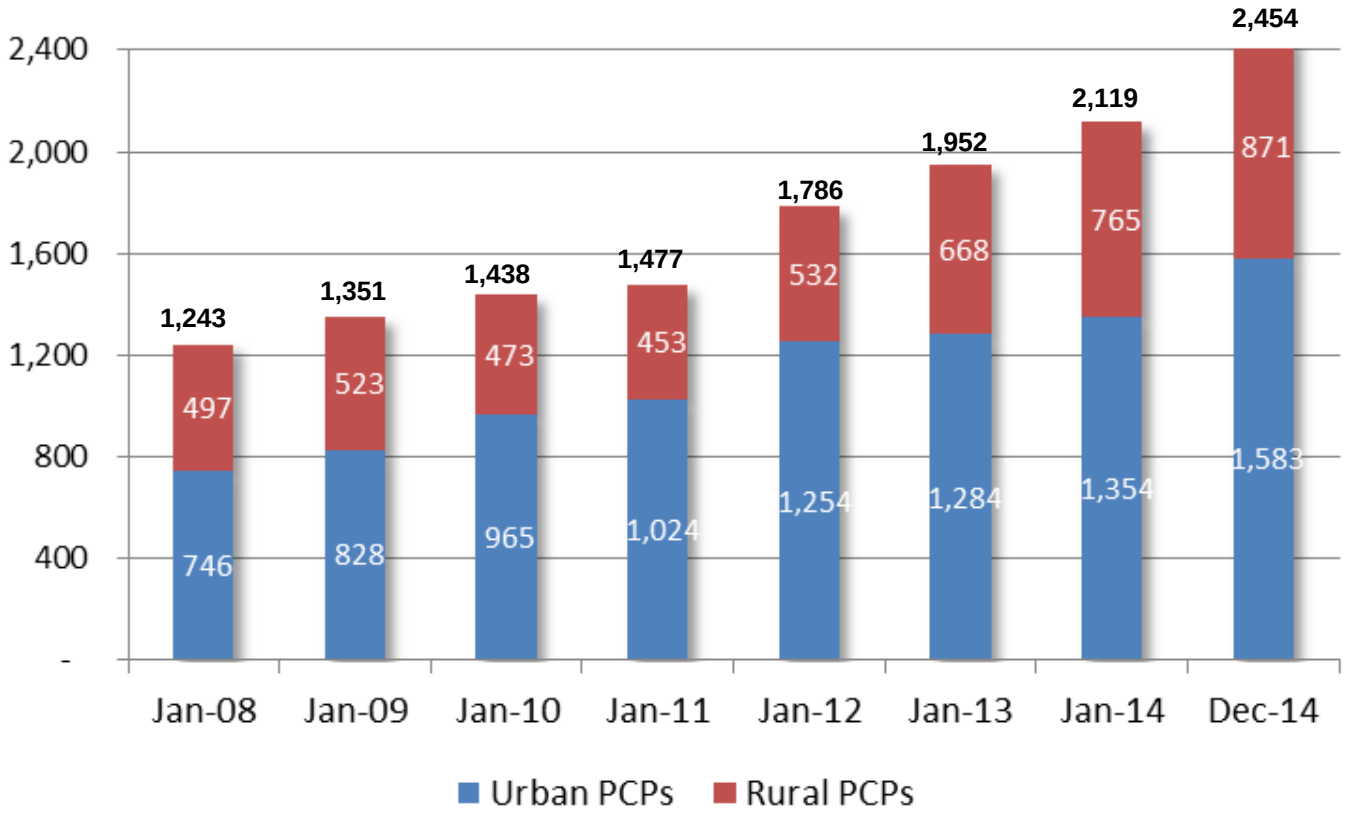
ACCESS TO CARE *cont'd*

Provider Recruitment Strategies

- Primary Care Providers (PCP) are essential to the SoonerCare Choice program and its objective of person-centered care
- In 2009, the OHCA transitioned to the PCMH model, which introduced new PCP accessibility and accountability standards and performance incentives
- PCP participation trends were examined, along with their impact on member caseloads per provider
- The number of participating practices has **increased faster than enrollment**, resulting in **smaller average caseloads** in both urban and rural counties
- The largest segment of PCMH providers have SoonerCare Choice panels ranging in size from 50 to 500 members

ACCESS TO CARE *cont'd*

*Unduplicated PCP (PCMH) Count by Year**

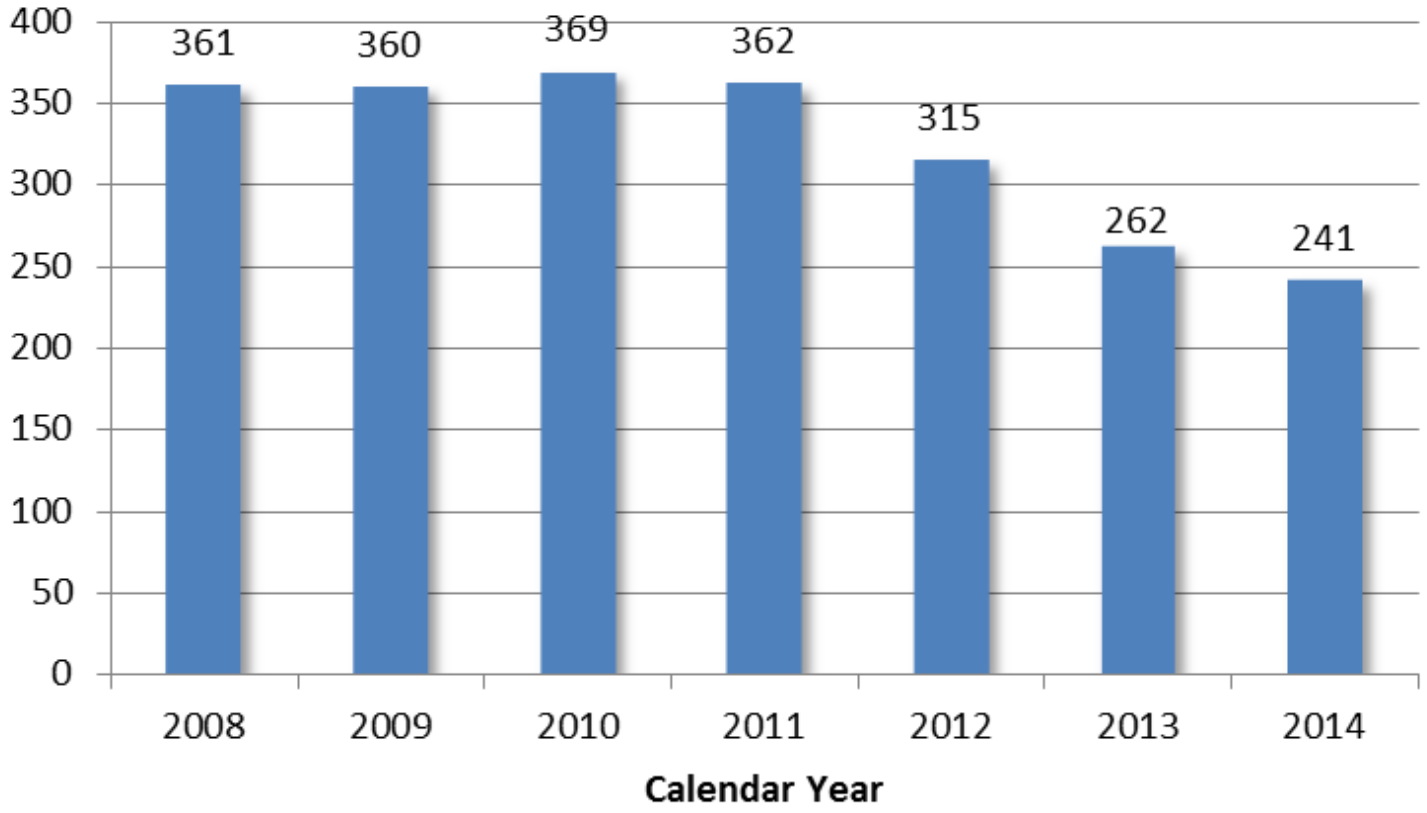


*Note: Urban includes former SoonerCare Plus counties. A portion of the increase may be attributable to more precise taxonomy starting in 2012 - 2013; Ellis County had no PCPs in December 2014 (members were served by PCPs in adjacent counties)

Sources: OHCA Provider Fast Facts Report

ACCESS TO CARE *cont'd*

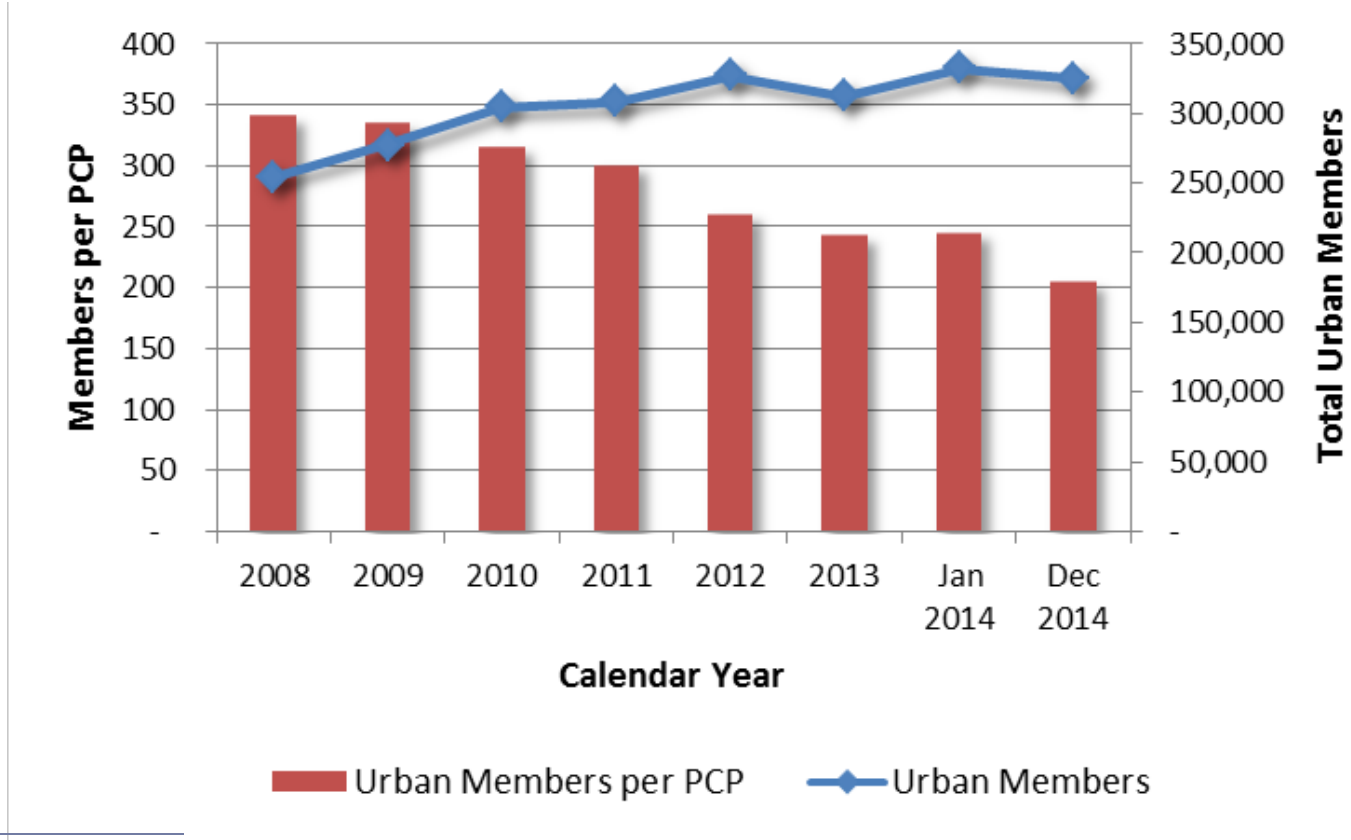
Average SoonerCare Choice Members per PCP (PCMH)



Sources: OHCA Provider and Member Fast Facts Report; Waiver Enrollment Reports

ACCESS TO CARE *cont'd*

Average SoonerCare Choice Members per PCP (PCMH) Urban Counties

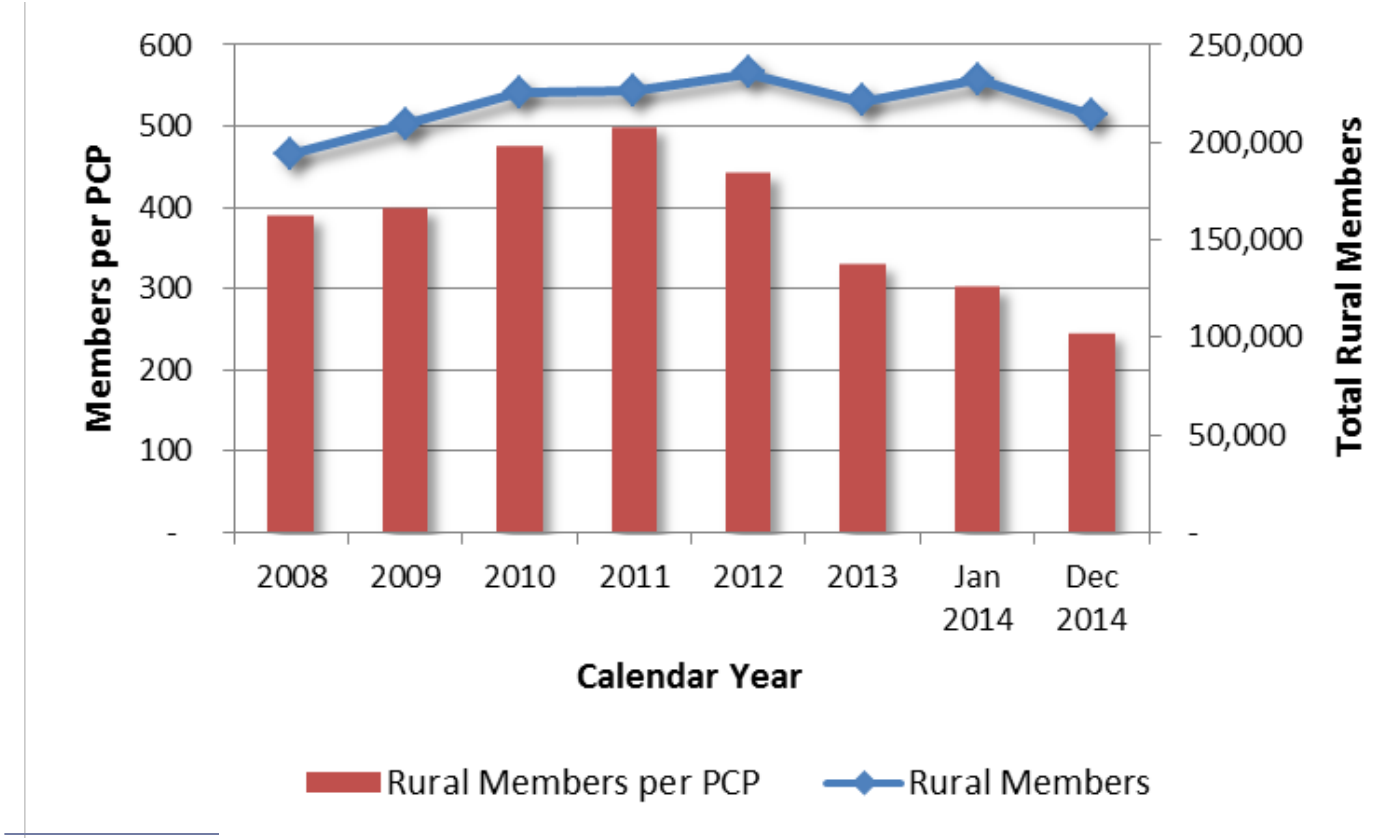


Note: 2008 – 2013 enrollment represents monthly average

Sources: OHCA Provider and Member Fast Facts Report; Waiver Enrollment Reports

ACCESS TO CARE *cont'd*

Average SoonerCare Choice Members per PCP (PCMH) Rural Counties

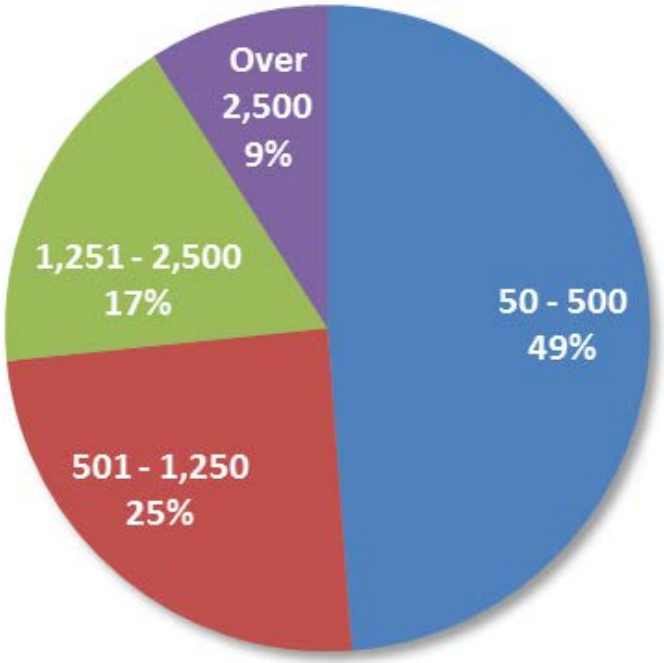


Note: 2008 – 2013 enrollment represents monthly average

Sources: OHCA Provider and Member Fast Facts Report; Waiver Enrollment Reports

ACCESS TO CARE *cont'd*

Percentage of PCMH Providers by Stated Panel Size



Note: PCMH providers specify the panel size (number of SoonerCare Choice members) they are willing to accept as part of the PCMH contracting process

Sources: OHCA PCMH Provider Panel Capacity Chart

ACCESS TO CARE *cont'd*

Appointment Availability

- PCP (and specialist) capacity must translate into appointment availability or members will bypass in favor of the emergency room
- SoonerCare Choice members are routinely surveyed on their ability to see their personal doctor and specialists
- Appointment availability was evaluated through:
  - Review and trending of published survey data
  - Analysis and trending of total SoonerCare Choice emergency room utilization

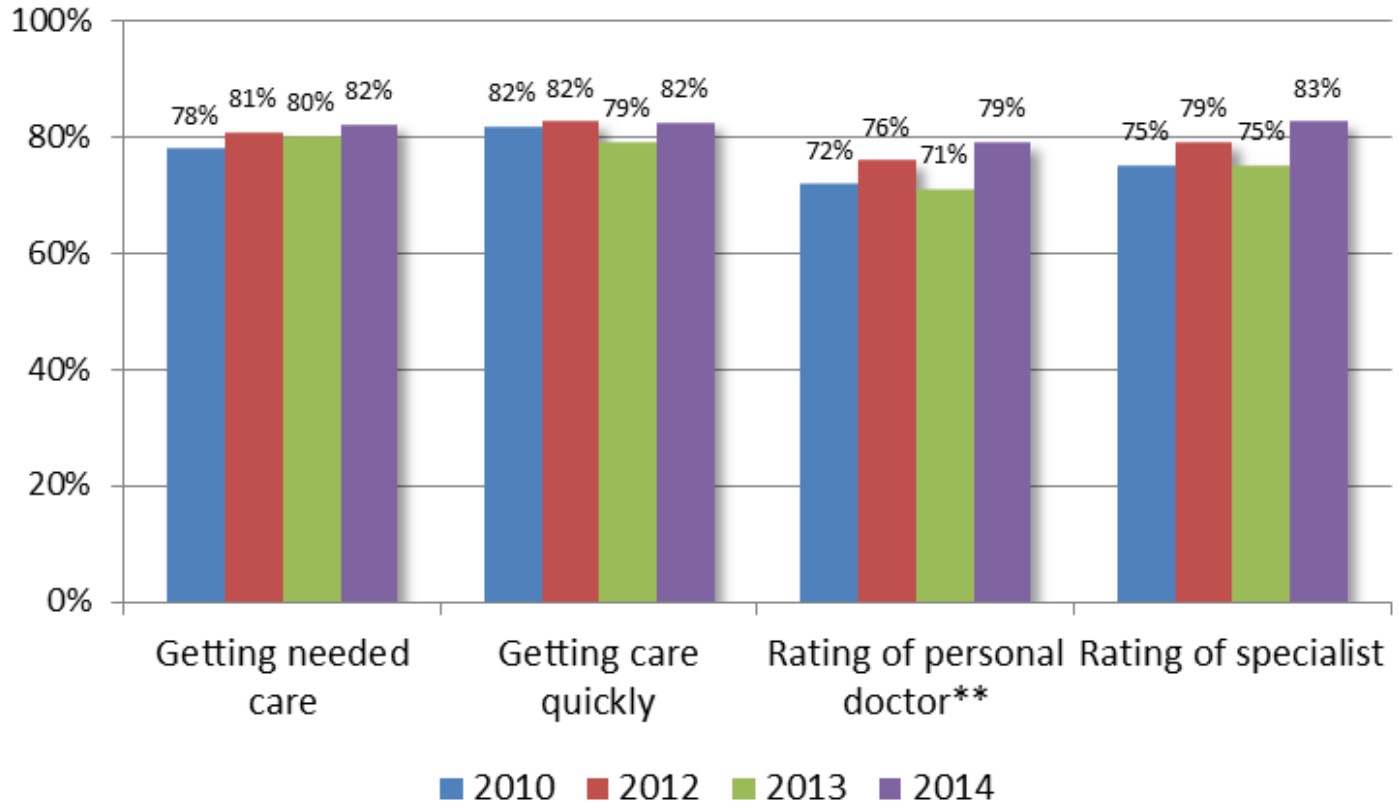
ACCESS TO CARE *cont'd*

Member Satisfaction

- Consumer Assessment of Healthcare Providers and Systems survey (CAHPS) is used to measure member satisfaction
- Satisfaction with adult services has increased since 2010, with all measures rising from 2013 to 2014
- Satisfaction with services for children has shown an almost uninterrupted rise since 2011 across all measures

ACCESS TO CARE *cont'd*

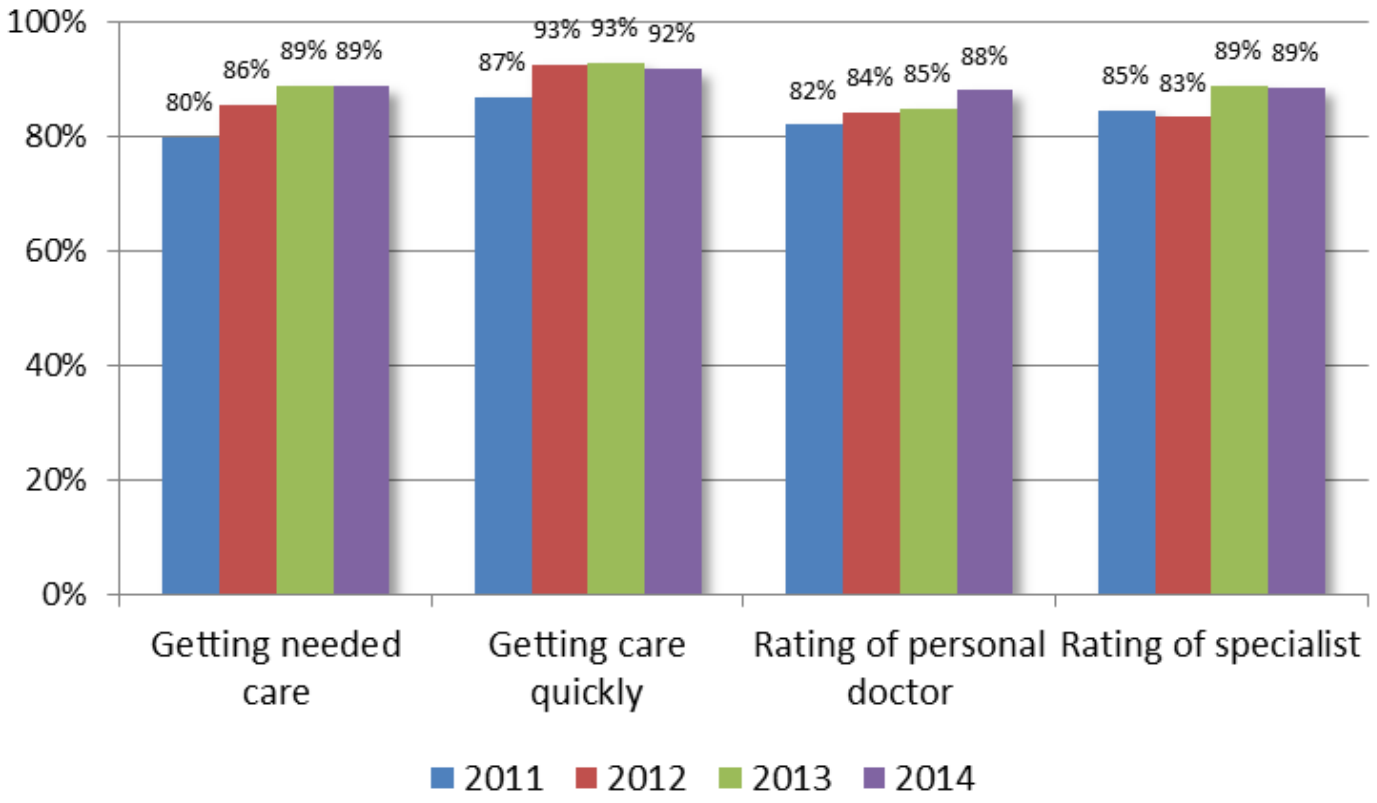
*Satisfaction with Care for Adults**



*Note: Percent rating 8, 9 or 10 on a 10-point satisfaction scale; "Getting care quickly" is a composite measure based on questions regarding satisfaction with obtaining needed care, both urgent and non-urgent
**Increase in Rating of Personal Doctor from 2013 to 2014 was statistically significant
Sources: CAHPS Health Plan Survey Adult Version – Telligen through 2012; Morpace for 2013 - 2014 (surveys are conducted from July to December of year preceding reporting year)

ACCESS TO CARE *cont'd*

*Satisfaction with Care for Children**



*Note: Percent rating 8, 9 or 10 on a 10-point satisfaction scale

Sources: CAHPS Health Plan Survey Child Version – Telligen through 2012; Morpace for 2013 - 2014 (surveys are conducted from July to December of year preceding reporting year)

Emergency Room Utilization

- A Lewin/GDIT study of 2008 Medicaid ER utilization rates in 39 states ranked Oklahoma second highest
- OHCA and provider partners have launched multiple initiatives since 2008 to reduce ER visits:
  - Enrollment of members into Patient Centered Medical Homes
  - Requirement for all PCMH providers to offer 24-hour/7-day telephone coverage by a medical professional
  - Requirement for "Tier 3" PCMH providers to offer extended office hours
  - Targeted intervention with members who visit the ER two or more times in a three-month period by the OHCA and Health Access Networks
  - Physical and behavioral health case management of members with complex/chronic conditions associated with ER use (through OHCA Chronic Care Unit and SoonerCare Health Management Program)

Emergency Room Utilization

- The OHCA is in the process of implementing additional initiatives to further reduce avoidable visits
- These include:
  - Developing a phone app showing providers throughout the state with extended office hours
  - Offering PCMH practices the opportunity to be included on the app and to see patients not on the provider's panel; participants will be able to bill a $7.00 add-on for after-hours care and a $19.00 add-on for weekends and holidays (72 PCMH practices are currently enrolled in the initiative)
  - Proposing new contracts with Urgent Care Centers that includes an enhancement to their rate for treatment of true urgent conditions (e.g., suturing and splints) – subject to federal approval

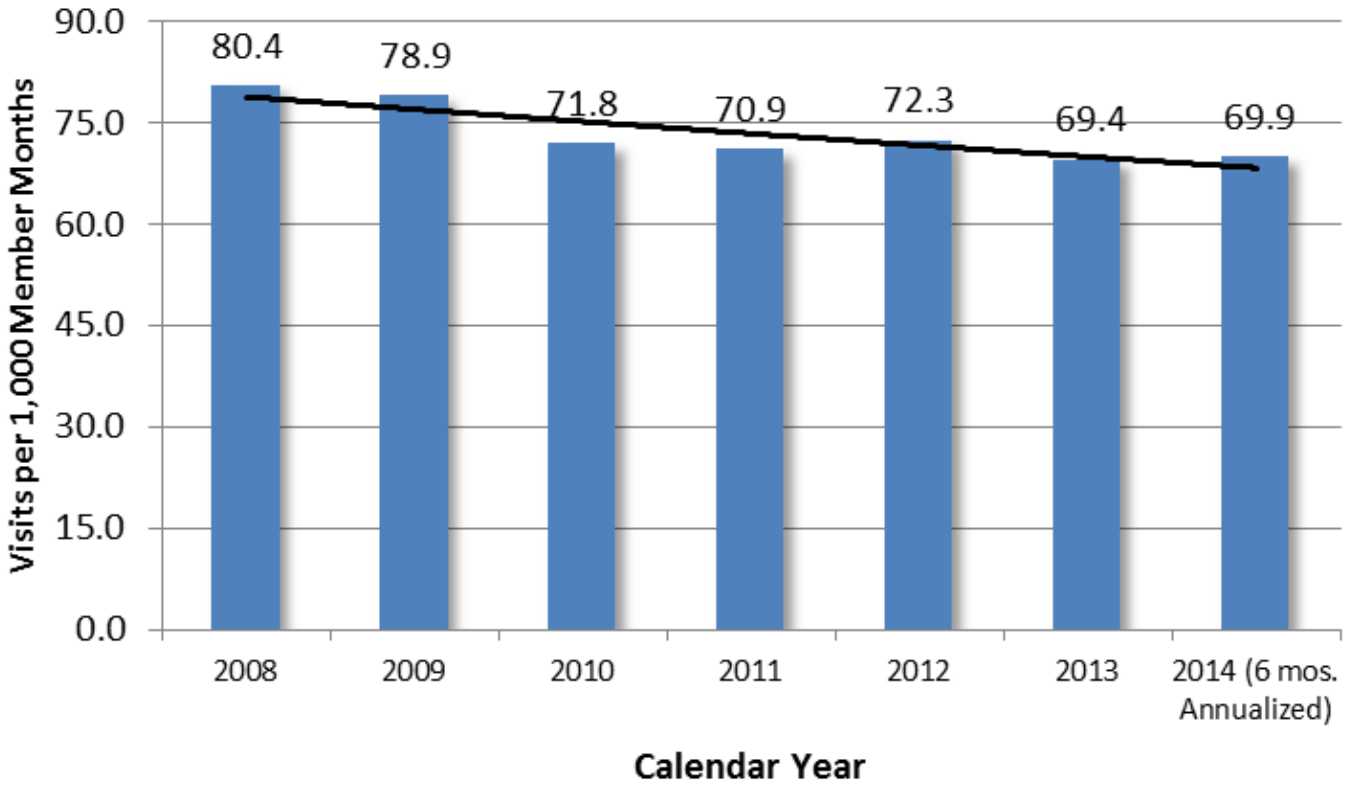
ACCESS TO CARE *cont'd*

Emergency Room Utilization

- The combined initiatives have had a positive impact on ER use
- ER visits, on a per member basis, **declined by 13 percent** from 2008 to 2014, although most of the decline occurred from 2008 – 2010, following introduction of the PCMH model
- The decline from 2008 to 2014 equated to approximately **61,000 avoided ER visits in 2014** (i.e., visits that did not occur, but would have if the 2008 utilization rate had remained unchanged)

ACCESS TO CARE *cont'd*

Emergency Room Utilization per 1,000 Member Months



Source: OHCA paid claims data. ER results include claims with paid amounts for ER services as well as claims with zero pay amounts for ER services, as long as at least one other service on the claim was paid

ACCESS TO CARE *cont'd*

Illustration of ER Utilization per 1,000 Member Months

- In a typical month in 2008, for every 1,000 SoonerCare Choice members:

There were 80 emergency room visits

ACCESS TO CARE *cont'd*

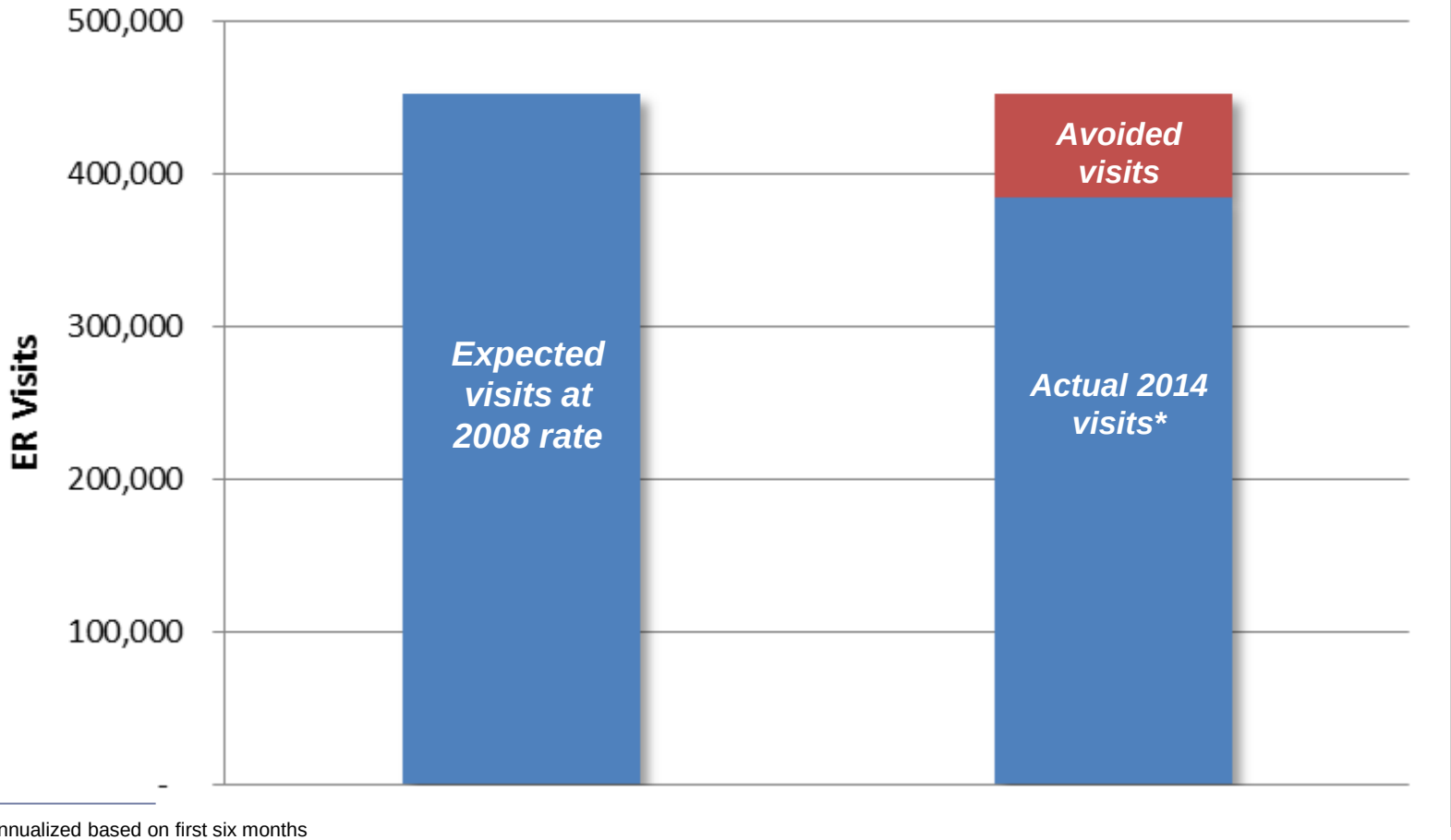
Illustration of ER Utilization per 1,000 Member Months

- In a typical month in 2014, for every 1,000 SoonerCare Choice members:

There were 70 emergency room visits

ACCESS TO CARE *cont'd*

Emergency Room Utilization – Avoided Visits



*Note: Annualized based on first six months

ACCESS TO CARE *cont'd*

- The average claim cost for a SoonerCare Choice member seen in the ER in SFY 2014, but not admitted to the hospital, included:

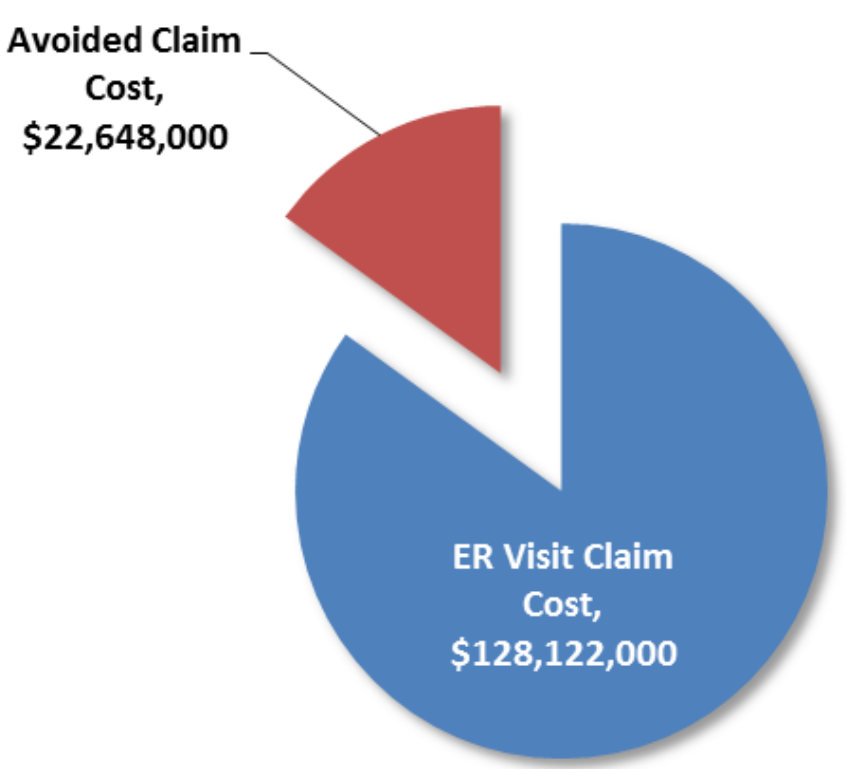
Component	Average Claim Cost*
Facility and Professional	$264.98
Ancillary	$ 68.10
TOTAL	**$333.08**

- The avoided ER visits x average bill = financial impact of ER diversion strategy on ER claim costs

*Note: Ancillary is average for all SoonerCare and includes ambulance, pharmacy, DME, lab/radiology, other professional. Average cost figure derived from OHCA SFY 2014 ED Fast Facts. Amount may overstate actual cost of avoided ER visits to the extent these visits were lower than average in acuity.

ACCESS TO CARE *cont'd*

- The ER diversion strategy helped the State to **avoid an estimated $22.6 million** in SoonerCare Choice ER payments in 2014



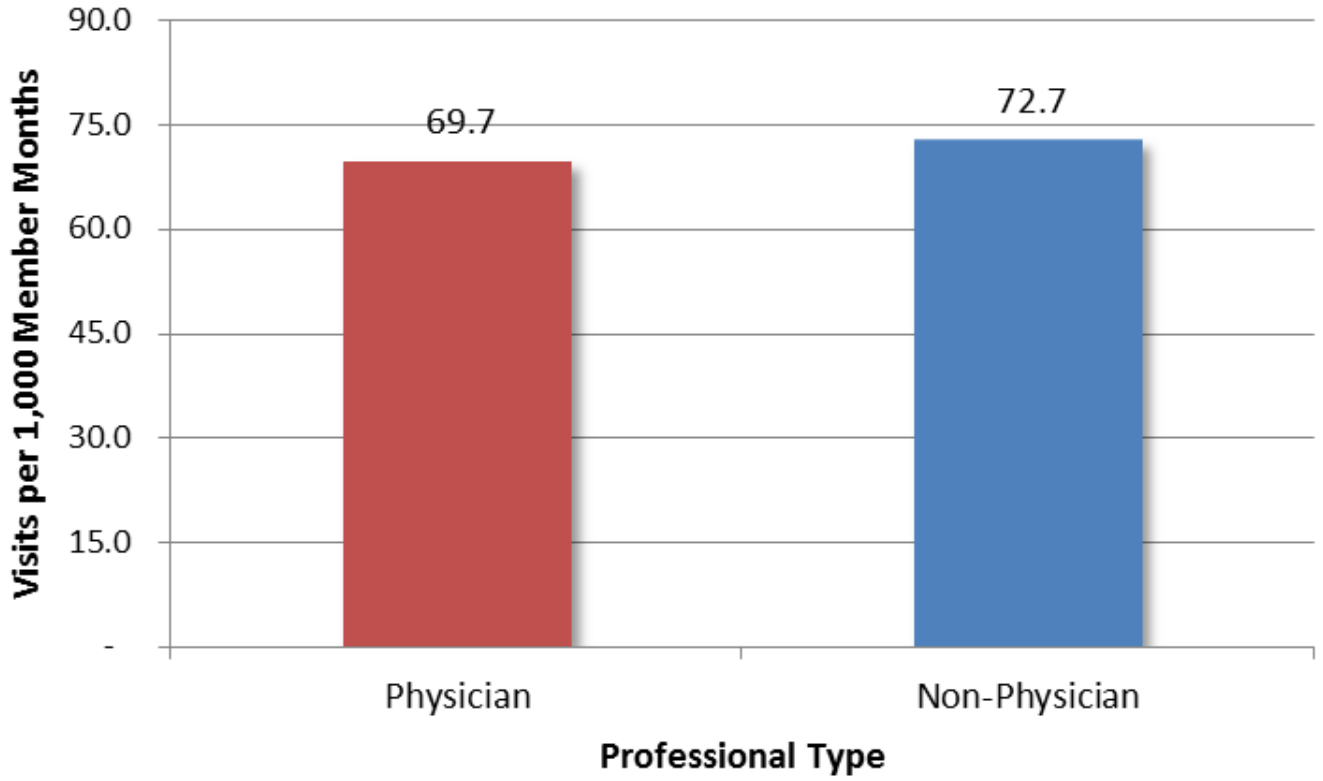
ACCESS TO CARE *cont'd*

- ER use is not uniform across SoonerCare Choice members
- Members with physician PCMH providers use the ER at a slightly lower rate than members with non-physician providers
- Utilization rates for children, adolescents and young adults have fallen since 2008 while rates for older adults have remained relatively flat or increased
- Utilization among SoonerCare Choice members with disabilities (primarily adults) also has risen since 2008, while utilization for other members has fallen
- The primary reasons members visit the ER are for treatment of injuries and behavioral health conditions, although the top five diagnoses vary by age

ACCESS TO CARE *cont'd*

Emergency Room Utilization – PCMH Type

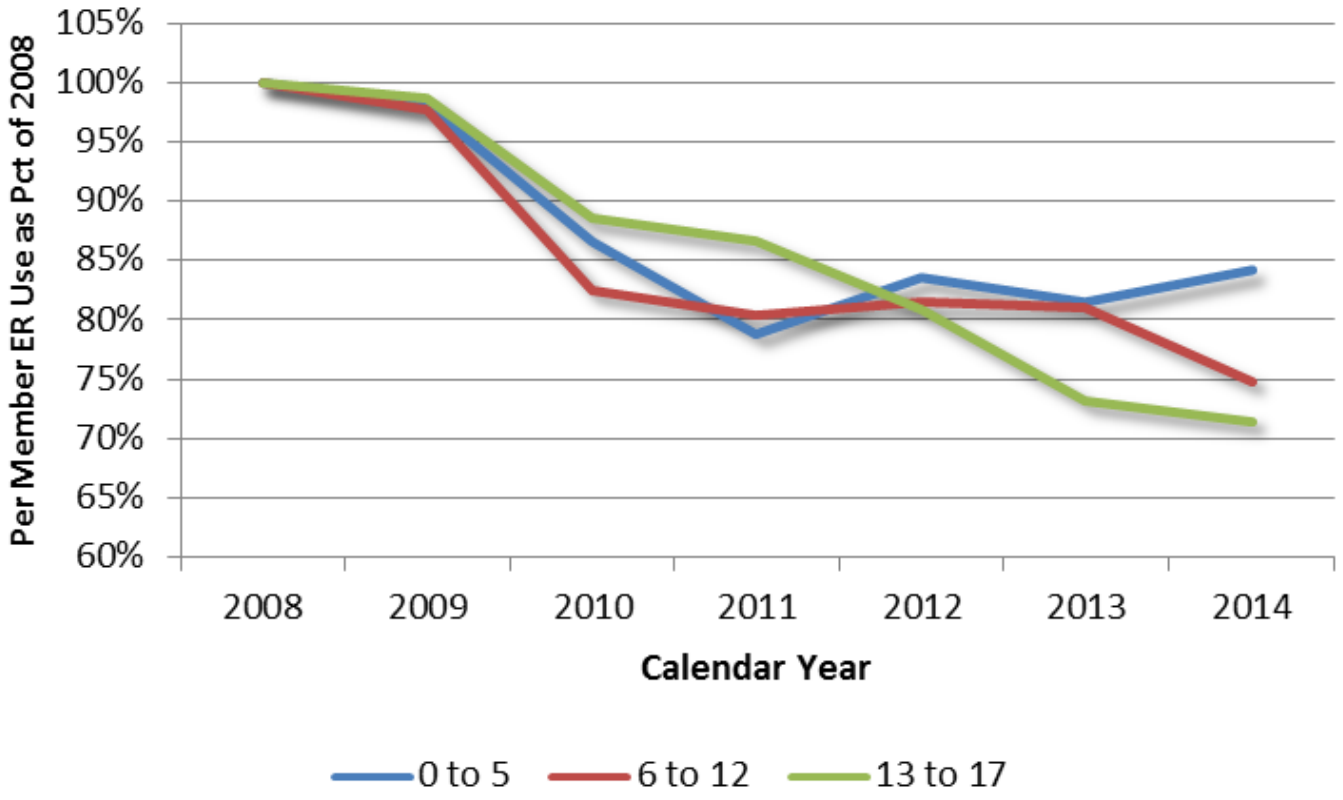
- Members enrolled with a physician PCMH experienced a slightly lower ER use rate in 2014 than members enrolled with a non-physician (physician assistant or nurse practitioner)



Source: OHCA paid claims data

ACCESS TO CARE *cont'd*

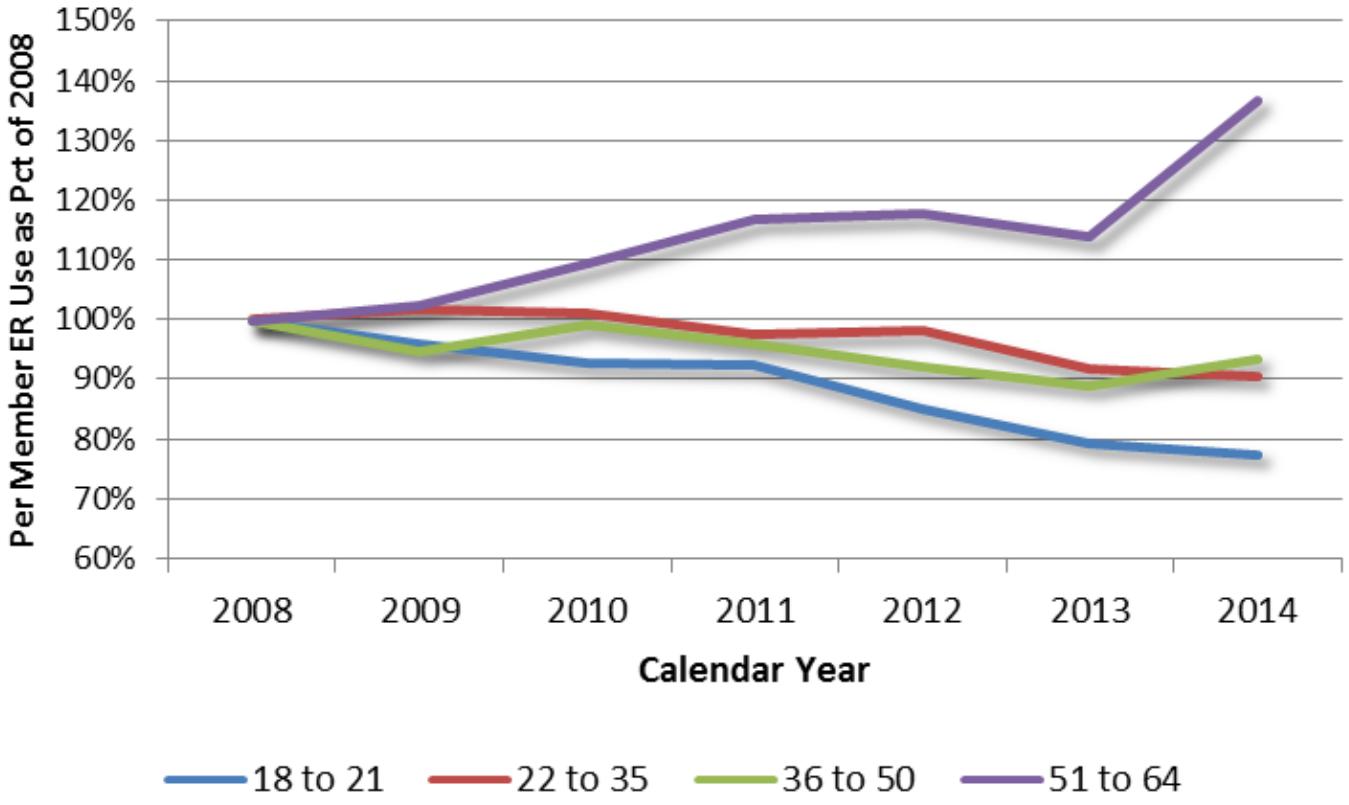
Per Member Emergency Room Utilization Trend
Ages 0 to 17 (2008 = 100%)



Source: OHCA paid claims data

ACCESS TO CARE *cont'd*

Per Member Emergency Room Utilization Trend Ages 18 to 64 (2008 = 100%)

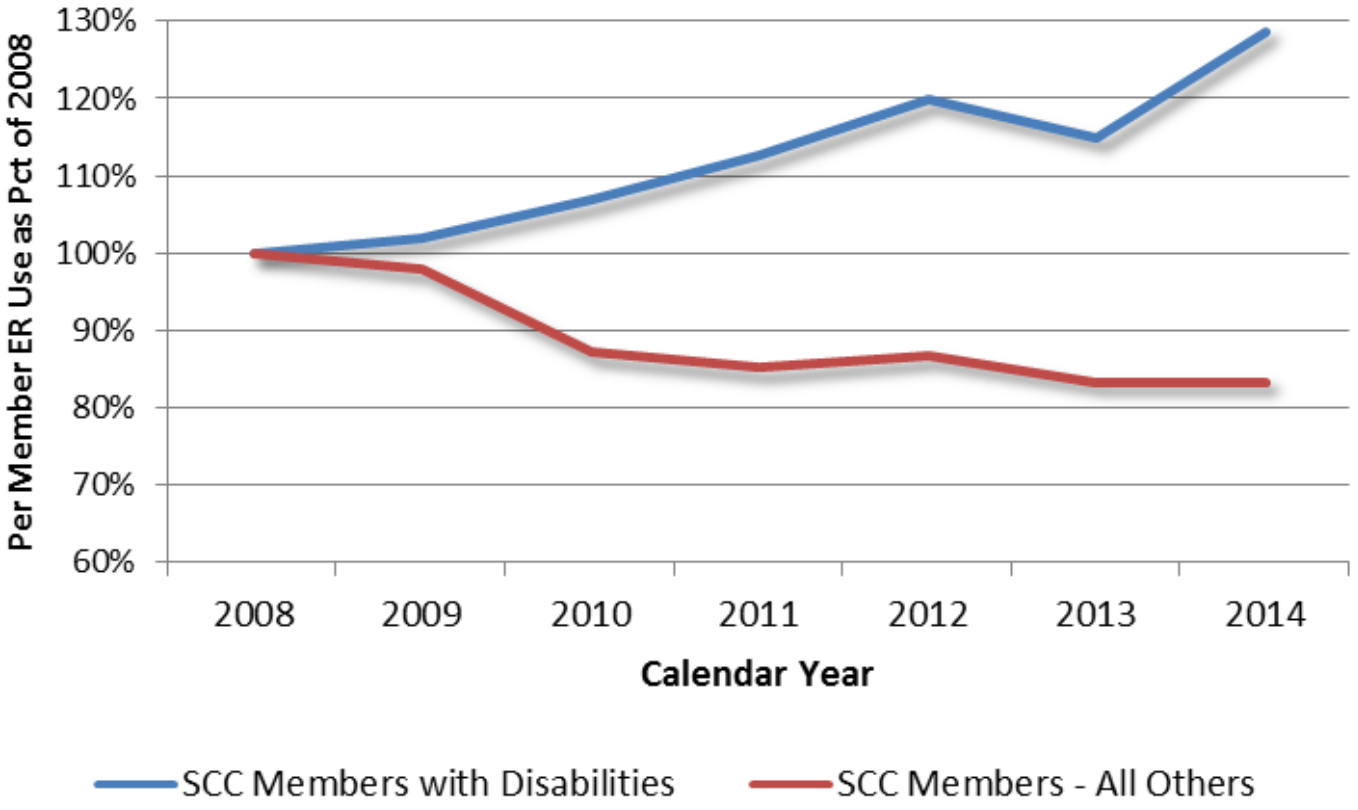


*Note: Volatility of 51 to 64 age cohort trend may be due in part to small population size

Source: OHCA paid claims data

ACCESS TO CARE *cont'd*

Per Member Emergency Room Utilization Trend Disability Status (2008 = 100%)



*Note: Volatility of Members with Disabilities cohort trend may be due in part to small population size

Source: OHCA paid claims data

ACCESS TO CARE *cont'd*

Top 5 Primary ER Diagnoses – 2014
Children & Adolescents

	Ages 0 – 5	Ages 6 – 12	Ages 13 - 17
1	Respiratory disease (18%)	Injury (20%)	Injury (20%)
2	Injury (11%)	Respiratory disease (9%)	Respiratory Disease (6%)
3	Disease of the ear (10%)	COPD, including Asthma (6%)	Neurotic, personality, and other non-psychotic mental disorders (5%)
4	Other viral disease (5%)	Disease of skin (5%)	Disease of musculoskeletal system (5%)
5	Disease of skin (5%)	Disease of the ear (4%)	COPD, including Asthma (4%)
Top 5	49% of visits	44% of visits	40% of visits

Source: OHCA paid claims data

ACCESS TO CARE *cont'd*

Top 5 Primary ER Diagnoses – 2014 Adults

	Ages 18 – 21	Ages 22 – 35	Ages 36 – 50	Ages 51 - 64
1	Complications of pregnancy (10%)	Neurotic, personality, and other non-psychotic mental disorders (11%)	Neurotic, personality, and other non-psychotic mental disorders (11%)	Neurotic, personality, and other non-psychotic mental disorders (10%)
2	Injury (9%)	Injury (8%)	Hypertension (7%)	Hypertension (10%)
3	Neurotic, personality, and other non-psychotic mental disorders (9%)	Complications of pregnancy (6%)	Disease of musculoskeletal system (7%)	Disease of musculoskeletal system (6%)
4	Disease of urinary system (5%)	Disease of musculoskeletal system (6%)	Injury (7%)	COPD, including Asthma (5%)
5	Disease of musculoskeletal system (5%)	Nervous system disease (4%)	Nervous system disease (5%)	Injury (5%)
Top 5	38% of visits	35% of visits	37% of visits	36% of visits

Source: OHCA paid claims data

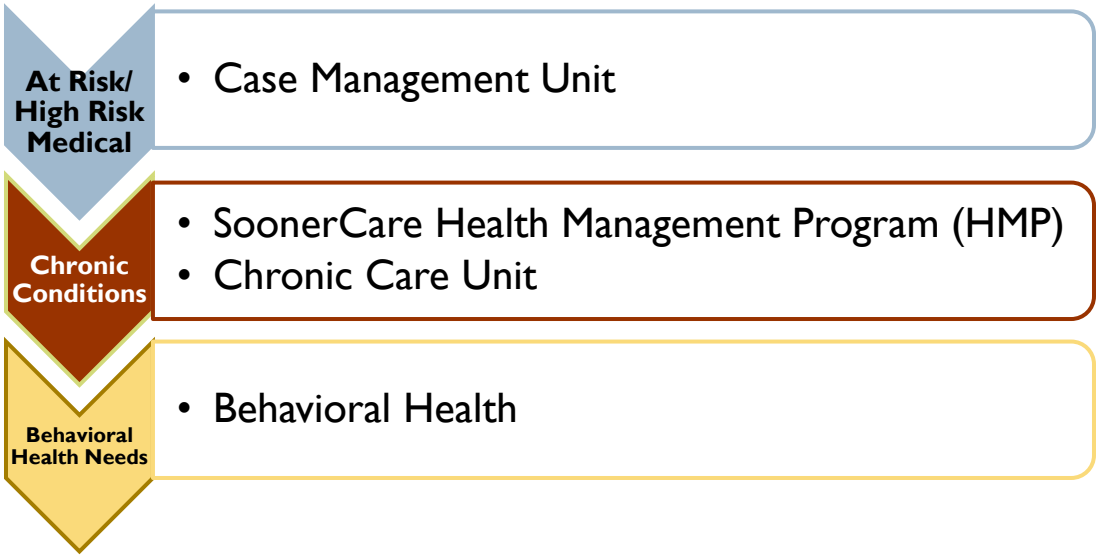
ACCESS TO CARE *cont'd*

- The OHCA's strategy has reduced ER utilization overall since 2008, although Oklahoma's rate remains relatively high and appears to have at least temporarily plateaued
- Adults and persons with disabilities (often the same people) represent the best opportunity for further reduction on a per member basis
- The OHCA's most recent initiatives targeting persons with chronic/complex medical and behavioral health conditions should continue to have a positive effect on ER use among adults
- Because of the prevalence of children in the program, parents also should continue to be a focus for education on proper use of the ER

ACCESS TO CARE *cont'd*

Assistance to Members with Complex/Chronic Needs

- The OHCA Population Care Management and Behavioral Health Departments oversee an integrated, and needs-based (multi-tier) care management structure
- The OHCA also contracts with Oklahoma University Health Sciences Center to operate a care management program for children and adolescents with diabetes
- Pacific Health Policy Group is conducting a targeted evaluation of OHCA's Population Care Management Department and recently initiated a new five-year evaluation of the SoonerCare Health Management Program (HMP) (summary findings from the most recent evaluation report are presented in the next section)



PERFORMANCE – QUALITY OF CARE

Evaluation Questions

- Does the program have mechanisms to measure and reward quality?
- Are members receiving appropriate preventive and diagnostic services?
- Are health outcomes improving?

Preventive and Diagnostic Services

- The OHCA tracks preventive and diagnostic service delivery for SoonerCare Choice through "Healthcare Effectiveness Data and Information Set" (HEDIS®) measures
- HEDIS results were evaluated over time and in comparison to national HEDIS Medicaid MCO rates, where available (see listing on next slide).
- The impact of the OHCA's campaign to reduce tobacco use among SoonerCare Choice members also was analyzed

QUALITY OF CARE *cont'd*

HEDIS Measures

Children/Adolescents	Adults
Access to PCP	Access to preventive/ambulatory health services
Annual dental visit	Breast cancer screening (ages 40 – 69)
Lead screening rate by two years of age	Cervical cancer screening (ages 21 – 64)
Appropriate treatment for urinary tract infection (ages 3 months to 1 year)	Cholesterol management for patients w/cardiovascular conditions (ages 18 – 75)
Appropriate testing for children with pharyngitis (ages 2 – 18)	Comprehensive diabetes care
Appropriate medications for treatment of asthma (children)	Appropriate medications for treatment of asthma (adults)

QUALITY OF CARE *cont'd*

HEDIS Trends – Children/Adolescent Access to PCP

- SoonerCare Choice has achieved improvement in child/adolescent access to PCPs since 2008
- The SoonerCare Choice access rate is higher than the national rate for all groups

HEDIS Measure	2008	2009	2010	2011	2012	2013	2014	Change 2008-14	National Rate
Child access to PCP, 12 - 24 months	94.1%	96.2.%	97.8%	97.2%	96.6%	96.3%	96.2%	↑2.1%	96.1%
Child access to PCP, 25 months - 6 years	83.1%	86.9%	89.1%	88.4%	90.1%	90.2%	89.0%	↑5.9%	88.3%
Child access to PCP, 7 - 11 years	82.7%	87.6%	89.9%	90.9%	91.7%	92.2%	90.9%	↑8.2%	90.0%
Adolescent access to PCP, 12 - 19 years	81.4%	85.8%	88.8%	89.9%	91.6%	92.8%	92.7%	↑11.3%	88.5%

Sources: Oklahoma Health Care Authority (OHCA) for Oklahoma HEDIS® results and National Committee for Quality Assurance (NQCA) "The State of Health Quality 2014" for national Medicaid HMO rates. Reporting years represent results for activity in the prior year

QUALITY OF CARE *cont'd*

HEDIS Trends – Children/Adolescents/Young Adults – Annual Dental Visit

- Dental visit screening rates exceed the national rate across all child/adolescent age cohorts
- However, rates also were down slightly in 2014 from 2013 for all cohorts, suggesting additional room for improvement remains

HEDIS Measure	2013	2014	Change 2013-14	National Rate
Annual dental visit – children 2 to 3	40.4%	39.5%	↓0.9%	34.7%
Annual dental visit – children 4 to 6	65.7%	63.4%	↓2.3%	56.5%
Annual dental visit – children 7 to 10	70.9%	68.8%	↓2.1%	58.6%
Annual dental visit – adolescents 11 to 14	68.7%	66.9%	↓1.9%	53.3%
Annual dental visit – adolescents 15 to 18	62.0%	59.9%	↓2.1%	46.3%
Annual dental visit – young adults 19 to 21	40.6%	38.2%	↓2.4%	32.9%

Sources: Oklahoma Health Care Authority (OHCA) for Oklahoma HEDIS® results and National Committee for Quality Assurance (NQCA) "The State of Health Quality 2014" for national Medicaid HMO rates. Reporting years represent results for activity in the prior year

QUALITY OF CARE *cont'd*

HEDIS Trends – Children/Adolescents (Multiple)

- Lead screening, urinary tract infection treatment and pharyngitis testing rates all have improved
- However, all three rates also are still below the national average

HEDIS Measure	2010	2011	2012	2013	2014	Change 2010-14	National Rate
Lead screening rate	43.5%	44.5%	44.7%	45.9%%	47.6%	↑**4.1%**	67.5%
Appropriate treatment for urinary tract infection	67.7%	69.5%	66.8%	70.8%	72.5%	↑**4.8%**	85.1%
Appropriate testing for children with pharyngitis	38.8%	44.8%	49.1%	50.5%	51.6%	↑**12.8%**	66.5%

Sources: Oklahoma Health Care Authority (OHCA) for Oklahoma HEDIS® results and National Committee for Quality Assurance (NQCA) "The State of Health Quality 2014" for national Medicaid HMO rates. Reporting years represent results for activity in the prior year

QUALITY OF CARE *cont'd*

HEDIS Trends – Adult Access to Preventive Services

- Adult access to preventive/ambulatory services has improved and is nearly 82 percent for members 20 – 44 and over 87 percent for members 45 – 64
- Both rates exceed the national benchmarks

HEDIS Measure	2008	2009	2010	2011	2012	2013	2014	Change 2008-14	National Rate*
Adult access to preventive/ ambulatory services, 20 – 44 years	78.4%	83.3%	83.6%	84.2%	83.1%	82.8%	81.9%	↑**3.5%**	80.0%
Adult access to preventive/ ambulatory services, 45 – 64 years	86.8%	89.7%	90.9%	91.1%	91.0%	87.9%	87.7%	↑**0.9%**	86.1%

*Note: National rate is for 2013 reporting year

Sources: Oklahoma Health Care Authority (OHCA) for Oklahoma HEDIS® results and National Committee for Quality Assurance (NQCA) "The State of Health Quality 2014" for national Medicaid HMO rates. Reporting years represent results for activity in the prior year

QUALITY OF CARE *cont'd*

HEDIS Trends – Adults (Multiple)

- Breast cancer screening rate and cholesterol management rate for patients with cardiovascular conditions have declined slightly since 2008
- The three adult screening rates also are below the national rate
- These represent opportunities for targeted education and incentives to improve provider adherence to care guidelines

HEDIS Measure	2008	2009	2010	2011	2012	2013	2014	Change 2008-14*	National Rate*
Breast cancer screening rate	38.3%	43.0%	41.1%	41.3%	36.9%	37.6%	36.5%	↓1.8%	57.9%
Cervical cancer screening rate	44.4%	46.6%	44.2%	47.2%	42.5%	46.0%	47.5%	↑3.1%	64.5%
Cholesterol management for patients with cardiovascular conditions	*Prior years omitted due to change in calculation methodology in 2013*					49.9%	45.2%	↓4.7%	81.1%

*Note: Cervical cancer national screening rate is for 2013 reporting year

Sources: Oklahoma Health Care Authority (OHCA) for Oklahoma HEDIS® results and National Committee for Quality Assurance (NQCA) "The State of Health Quality 2014" for national Medicaid HMO rates. Reporting years represent results for activity in the prior year

QUALITY OF CARE *cont'd*

HEDIS Trends – Adult Comprehensive Diabetes Care

- Rate for comprehensive diabetes care measures are mixed but SoonerCare Choice rates are below the national rate for all four measures
- This represents another opportunity for targeted improvement

HEDIS Measure	2010	2011	2012	2013	2014	Change 2010-13	National Rate
Hemoglobin A1C testing	71.0%	71.1%	70.5%	71.5%	71.9%	↑0.9%	83.0%
Eye exam (retinal)	32.8%	31.8%	31.8%	32.0%	26.3%	↓5.7%	53.2%
LDL-C screening	63.6%	62.9%	62.0%	63.1%	63.4%	↑0.3%	75.5%
Medical attention for nephropathy	54.4%	55.9%	56.8%	58.7%	53.4%	↓5.3%	78.4%

Sources: Oklahoma Health Care Authority (OHCA) for Oklahoma HEDIS® results and National Committee for Quality Assurance (NQCA) "The State of Health Quality 2014" for national Medicaid HMO rates. Reporting years represent results for activity in the prior year

QUALITY OF CARE *cont'd*

HEDIS Trends – Asthma (Children/Adolescents & Adults)

- SoonerCare Choice rate for appropriate medications for the treatment of asthma is close to the national rate for children and adolescents
- The rate is below the national rate for adolescents and adults and represents another opportunity for targeted improvement

HEDIS Measure	2013	2014	Change 2013-14	National Rate
Appropriate medications for treatment of asthma, ages 5- 11	91.5%	89.7%	↓1.8%	90.2%
Appropriate medications for treatment of asthma, ages 12 - 18	86.4%	82.6%	↓3.8%	86.9%
Appropriate medications for treatment of asthma, ages 19 - 50	63.2%	61.7%	↓1.5%	74.4%
Appropriate medications for treatment of asthma, ages 51- 64	67.3%	62.5%	↓4.8%	70.3%

Sources: Oklahoma Health Care Authority (OHCA) for Oklahoma HEDIS® results and National Committee for Quality Assurance (NQCA) "The State of Health Quality 2014" for national Medicaid HMO rates. Reporting years represent results for activity in the prior year

QUALITY OF CARE *cont'd*

SoonerQuit Tobacco Cessation Activities

- Tobacco use is the single most preventable cause of death in the U.S.
- Oklahoma historically has had one of the nation's highest tobacco use rates and tobacco use among SoonerCare members has exceeded the State average
  - In 2008, 48 percent of SoonerCare Choice adults in the CAHPS survey reported using tobacco products versus 26 percent of the total adult population in 2012 who reported smoking and seven percent who reported using smokeless tobacco products (source: Centers for Disease Control)
  - Twenty-five percent of pregnant SoonerCare Choice members report using tobacco products
- The OHCA's SoonerQuit initiative was launched with the goal of reducing tobacco use among SoonerCare Choice members through:
  - Tobacco cessation counseling and products (e.g., educational materials and prescription/OTC aids)
  - Assistance to prenatal care providers in performing the "5 A's" of tobacco cessation (ask, advise, assess, assist arrange) through practice facilitation
- The OHCA continues to work in coordination with other initiatives, including the Oklahoma Tobacco Helpline

QUALITY OF CARE *cont'd*

HEDIS Trends – Medical Assistance w/Smoking and Tobacco Use

- SoonerCare Choice providers have a high rate of advising tobacco users
- The cessation intervention rate among providers is significantly lower, although the SoonerQuit initiative is having an impact

HEDIS Measure	2013	2014	Change 2013-14	National Rate
Advising smokers and tobacco users to quit	76.3%	75.0%	↓1.3%	75.8%
Discussing cessation medications	45.2%	47.9%	↑2.7%	46.6%
Discussing cessation strategies	41.7%	44.1%	↑2.4%	41.9%

Sources: Oklahoma Health Care Authority (OHCA) for Oklahoma HEDIS® results and National Committee for Quality Assurance (NQCA) "The State of Health Quality 2014" for national Medicaid HMO rates. Reporting years represent results for activity in the prior year

QUALITY OF CARE *cont'd*

SoonerQuit Tobacco Cessation Activities

- Members and providers have responded to SoonerQuit and related initiatives, leading to a decline in tobacco use rates
- Tobacco Helpline call volume increased 82 percent from 2009 to 2012
- Among SoonerCare Choice prenatal care providers who participated in practice facilitation, the portion offering onsite tobacco cessation counseling increased from 29 percent to 68 percent
- The potential health benefits of this decline are substantial. For every dollar spent on tobacco cessation activities, there is an estimated $3.12 saved in the form of reduced cardiovascular-related hospital admissions
- The OHCA should consider adding tobacco cessation interventions to the SoonerExcel initiative, as a means of further encouraging provider engagement

Sources: Oklahoma use rate data provided by the OHCA; provider activity data taken from independent evaluation of SoonerQuit initiative conducted by the Pacific Health Policy Group; hospitalization data provided by OU Health Sciences Center

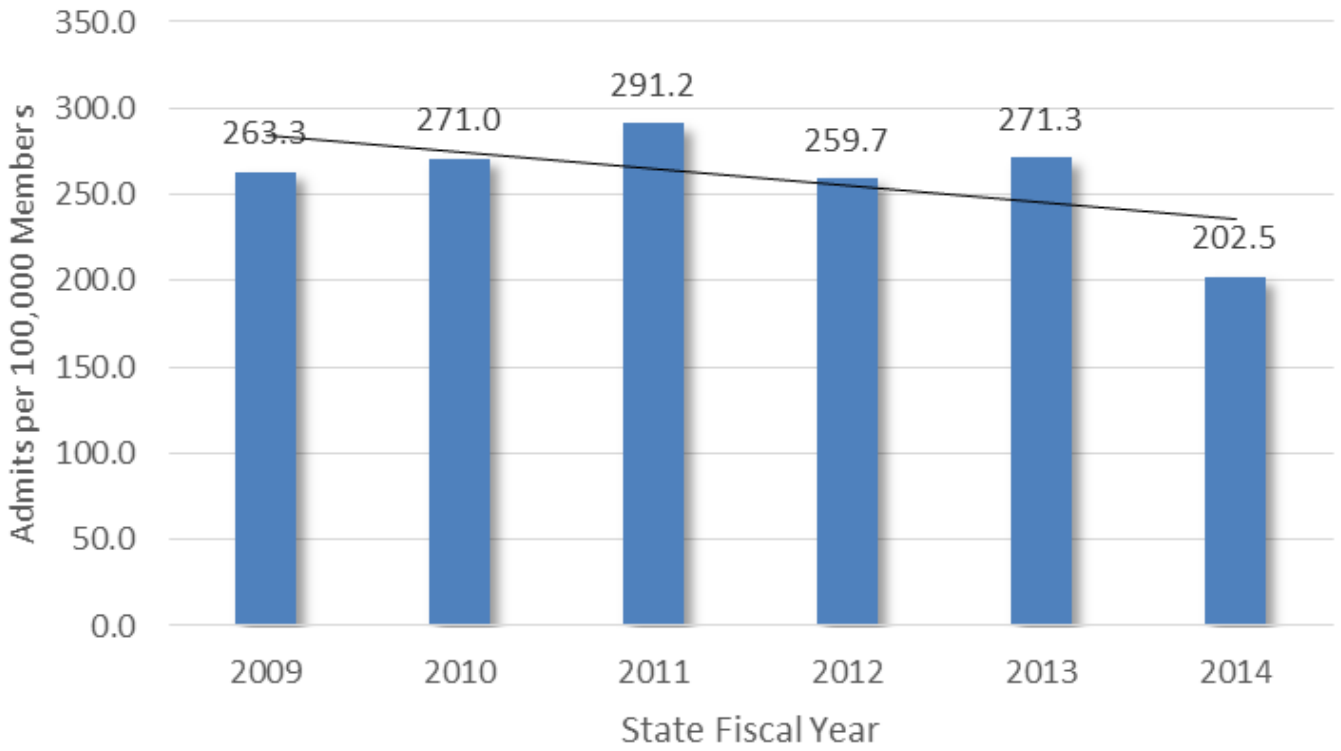
QUALITY OF CARE *cont'd*

Avoidable (Ambulatory Care Sensitive) Hospitalizations

- Avoidable (ambulatory care sensitive) conditions are those for which appropriate ambulatory care prevents or reduces the need for admission to the hospital. The hospitalization rate for these conditions is an effective indicator of the quality of ambulatory health care
- PCMH and SoonerCare Choice care management activities are both directed in part to ensuring access to the right care in the right setting
- Paid claims data was used to evaluate the ambulatory sensitive condition hospitalization rate among SoonerCare Choice members with asthma, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD) and pneumonia (based on admitting diagnosis)
- The **rate fell for all four conditions** from 2009 to 2014

QUALITY OF CARE *cont'd*

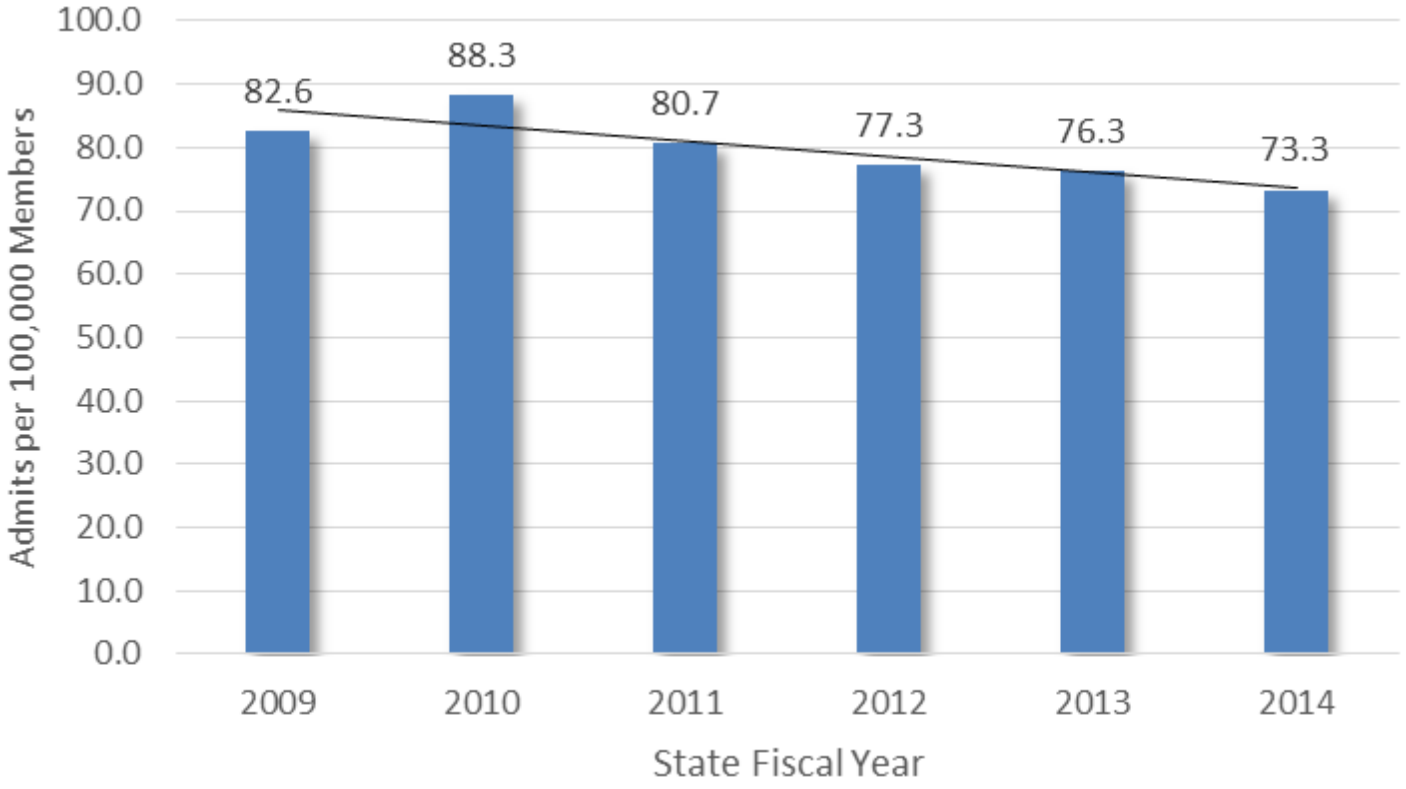
Ambulatory Care Sensitive Hospitalization Rate – Asthma



Source: OHCA paid claims

QUALITY OF CARE *cont'd*

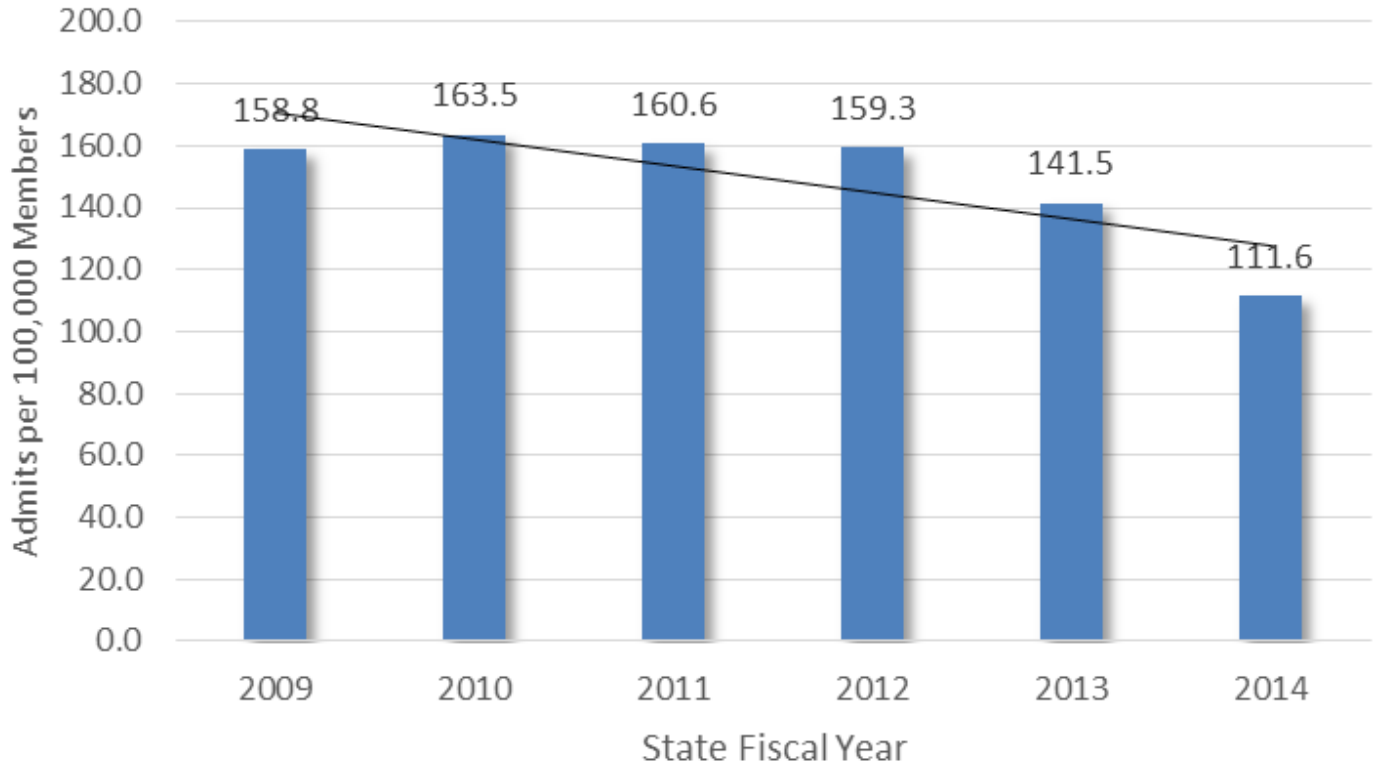
Ambulatory Care Sensitive Hospitalization Rate – CHF



Source: OHCA paid claims

QUALITY OF CARE *cont'd*

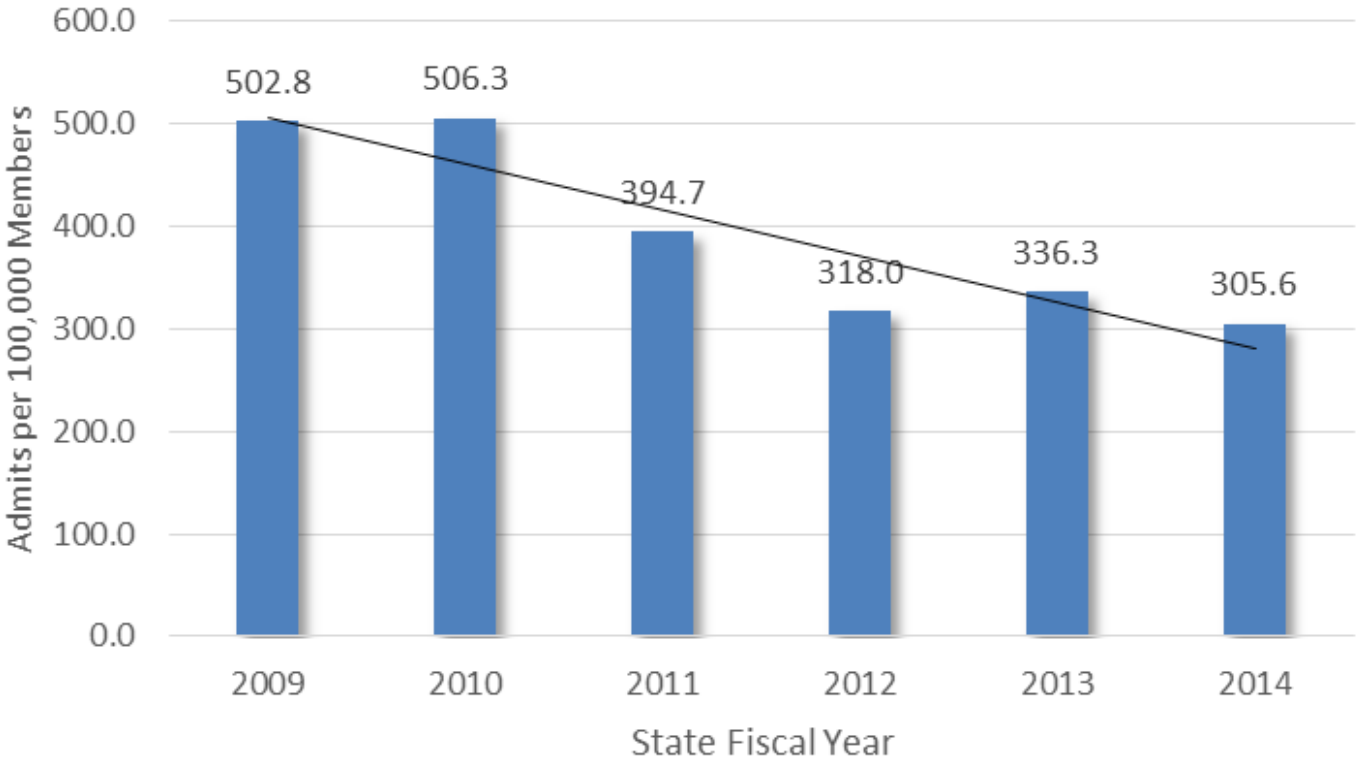
Ambulatory Care Sensitive Hospitalization Rate – COPD



Source: OHCA paid claims

QUALITY OF CARE *cont'd*

Ambulatory Care Sensitive Hospitalization Rate – Pneumonia



Source: OHCA paid claims

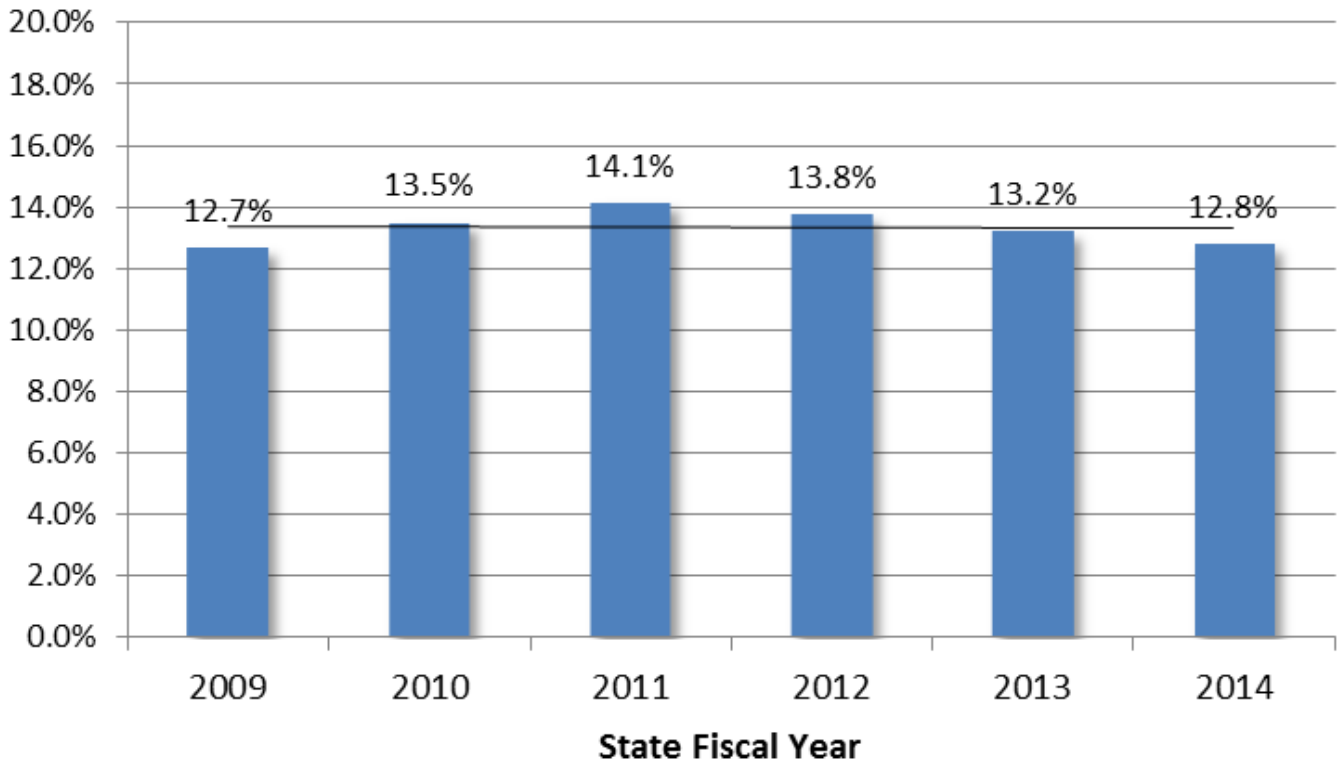
QUALITY OF CARE *cont'd*

Hospital Readmissions

- The hospital 30-day readmission rate is an effective indicator of discharge planning activities, PCP post-discharge care and SoonerCare Choice case management
- Paid claims data was used to evaluate the 30-day readmission rate for 2009 – 2014
- The rate **remained relatively low over the evaluation period** and has declined from its (modest) peak in 2011
- Members who are readmitted return to the hospital an average of 2 – 3 times after their initial admission

QUALITY OF CARE *cont'd*

*Hospital 30-Day Readmission Rate**



*Note: SoonerCare Choice members enrolled in a Patient Centered Medical Home
Source: OHCA paid claims

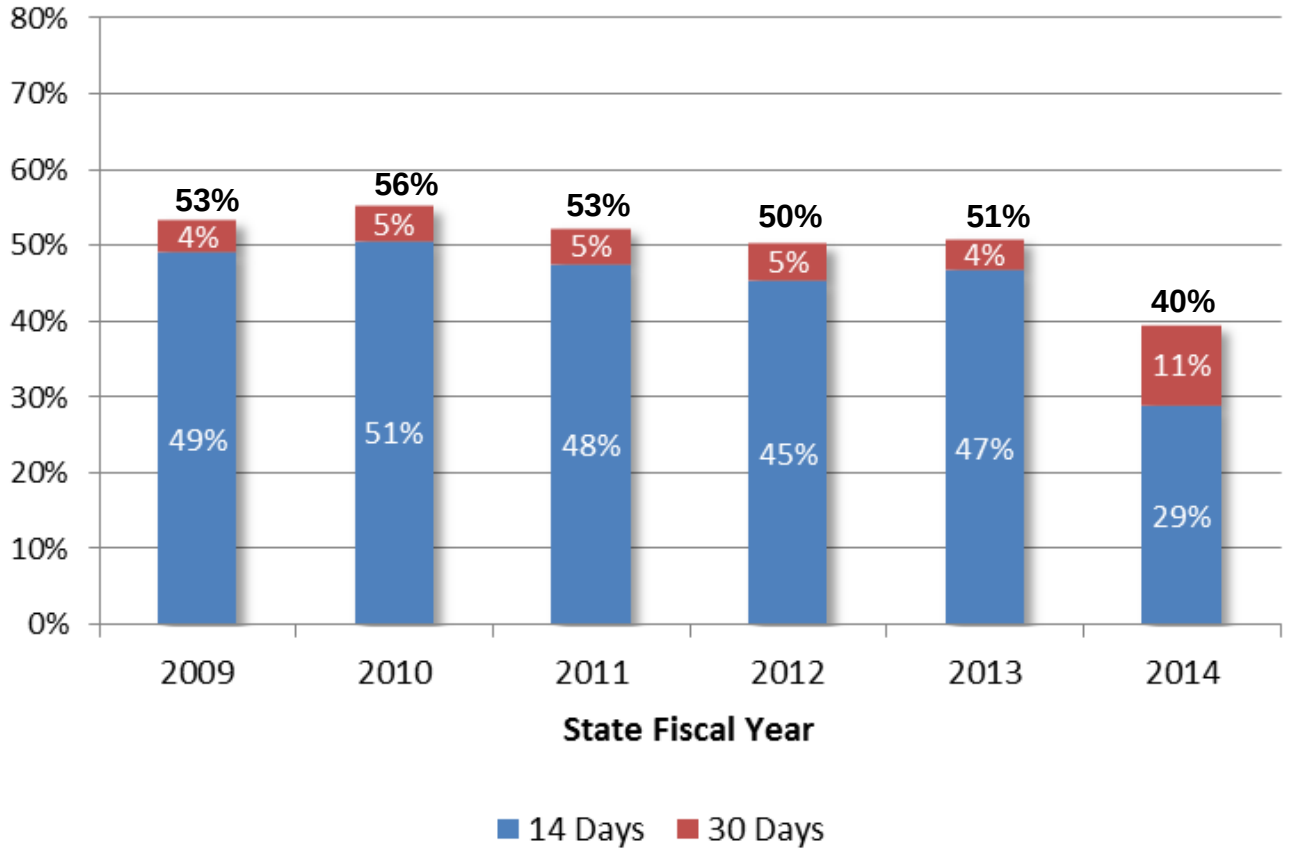
QUALITY OF CARE *cont'd*

Post-Discharge Visit to PCMH

- The post-discharge visit rate to the PCMH is an indicator of PCMH care management activity
- Paid claims data was used to evaluate the 14- and 30-day visit rates for all inpatient stays and for the four ambulatory sensitive conditions
- The post discharge PCMH visit rate has been declining for several years
- However, the rate for ambulatory sensitive conditions has **remained close to 70 percent**
- The ambulatory sensitive follow-up rate should be considered more meaningful, as it excludes admissions for events such as surgeries and deliveries, where appropriate follow-up may be the responsibility of a physician other than the PCMH

TRENDS – QUALITY OF CARE *cont'd*

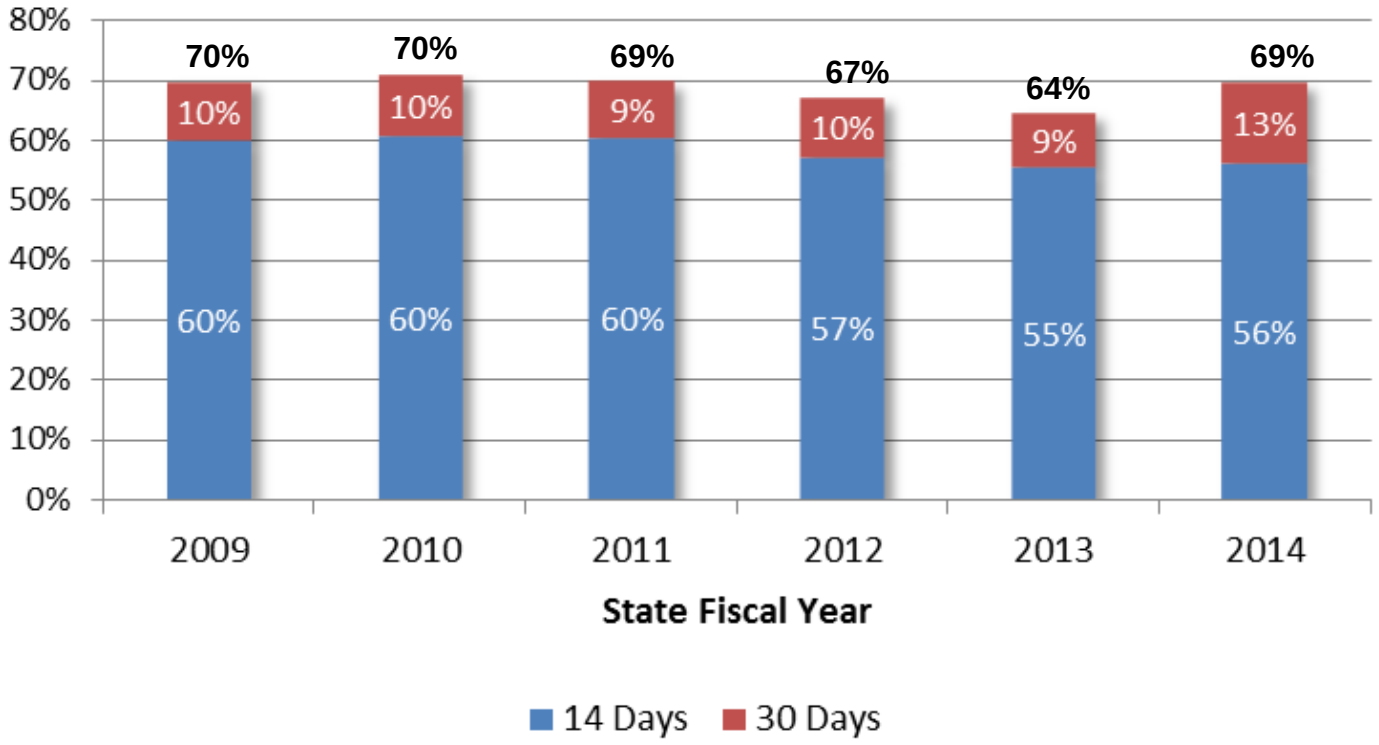
*Visit to PCMH Post-Discharge – All Admits**



*Note: SoonerCare Choice members enrolled in a Patient Centered Medical Home
Source: OHCA paid claims

QUALITY OF CARE *cont'd*

*Visit to PCMH Post-Discharge Ambulatory Sensitive Conditions**



*Note: SoonerCare Choice members enrolled in a Patient Centered Medical Home; conditions are Asthma, CHF, COPD and Pneumonia
Source: OHCA paid claims

PERFORMANCE – COST EFFECTIVENESS

Evaluation Questions

- Is the SoonerCare program cost effective in terms of health care expenditures?
- Is the SoonerCare program cost effective in terms of administrative expenses?

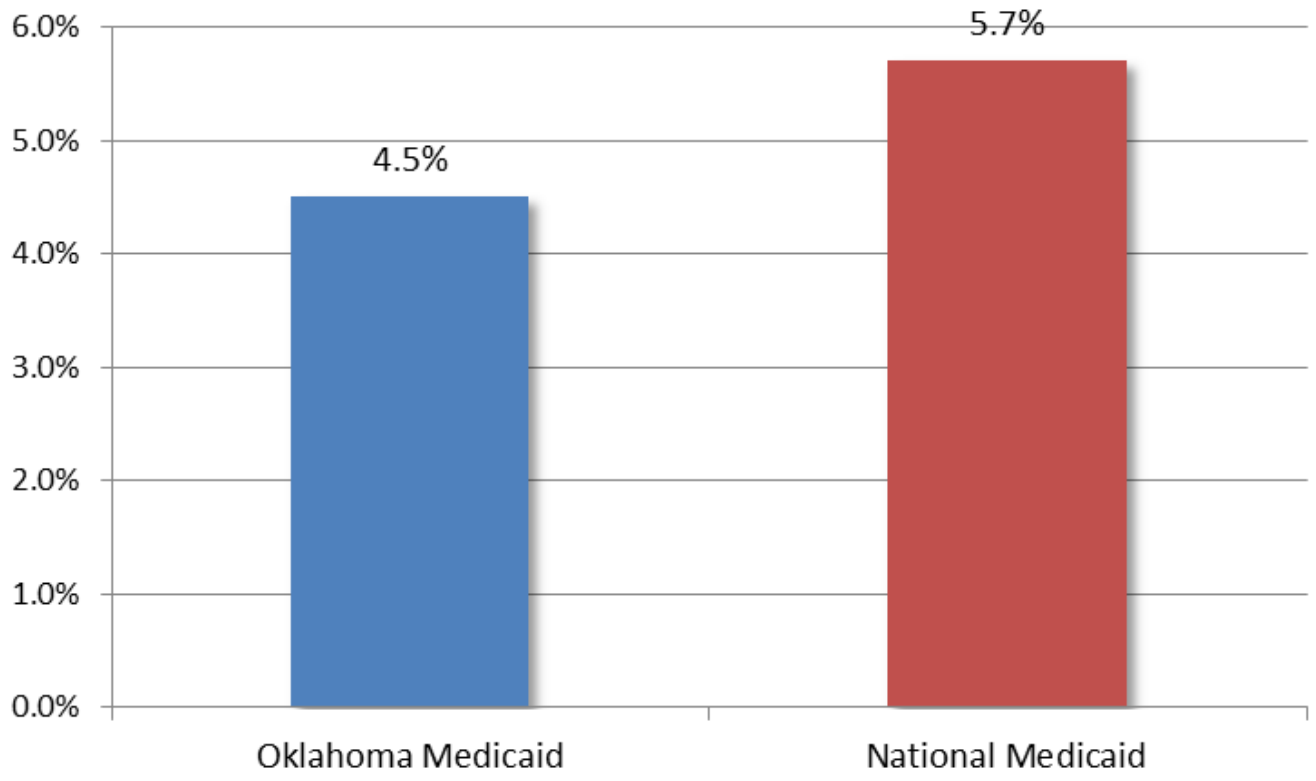
COST EFFECTIVENESS *cont'd*

Health Expenditures

- Improved program performance must be cost effective to be sustainable
- During the period 2010 – 2013, total Medicaid spending on medical services in Oklahoma grew at an average annual rate of **4.5 percent**
- Nationally, Medicaid spending over the same period grew at an average annual rate of **5.7 percent**
- These percentages reflect the impact of both medical inflation and enrollment growth, the latter of which is largely determined by federal law and economic conditions

COST EFFECTIVENESS *cont'd*

Average Annual Medicaid Medical Spending Growth – 2010 – 2013*



*Total program (all populations and services), excluding administrative expenses. National data is available only through 2013.
Sources: Oklahoma - OHCA 2010 and 2013 Annual Reports; National – "Trends in Medicaid Spending Leading up to ACA Implementation", Kaiser Commission on Medicaid and the Uninsured (February 2015)

COST EFFECTIVENESS *cont'd*

Health Expenditures

- Paid claims data was used to calculate per member per month (PMPM) expenditures for SoonerCare Choice members for SFY 2009 through SFY 2014
- The PMPM trend for the period SFY 2010 through SFY 2013 also was calculated to allow for comparison to national Medicaid trends, which were only available for that time period
- SoonerCare Choice PMPM expenditure growth was **nearly flat** from 2009 to 2014 and was **below the national average** for 2010 to 2013

COST EFFECTIVENESS *cont'd*

Health Expenditures

- PMPM medical expenditures for SoonerCare Choice members* were nearly flat over the period 2009 – 2014, with costs rising modestly in 2012 and 2013, before declining in 2014
- During the period 2010 - 2013, PMPM medical expenditures rose by only 0.1 percent

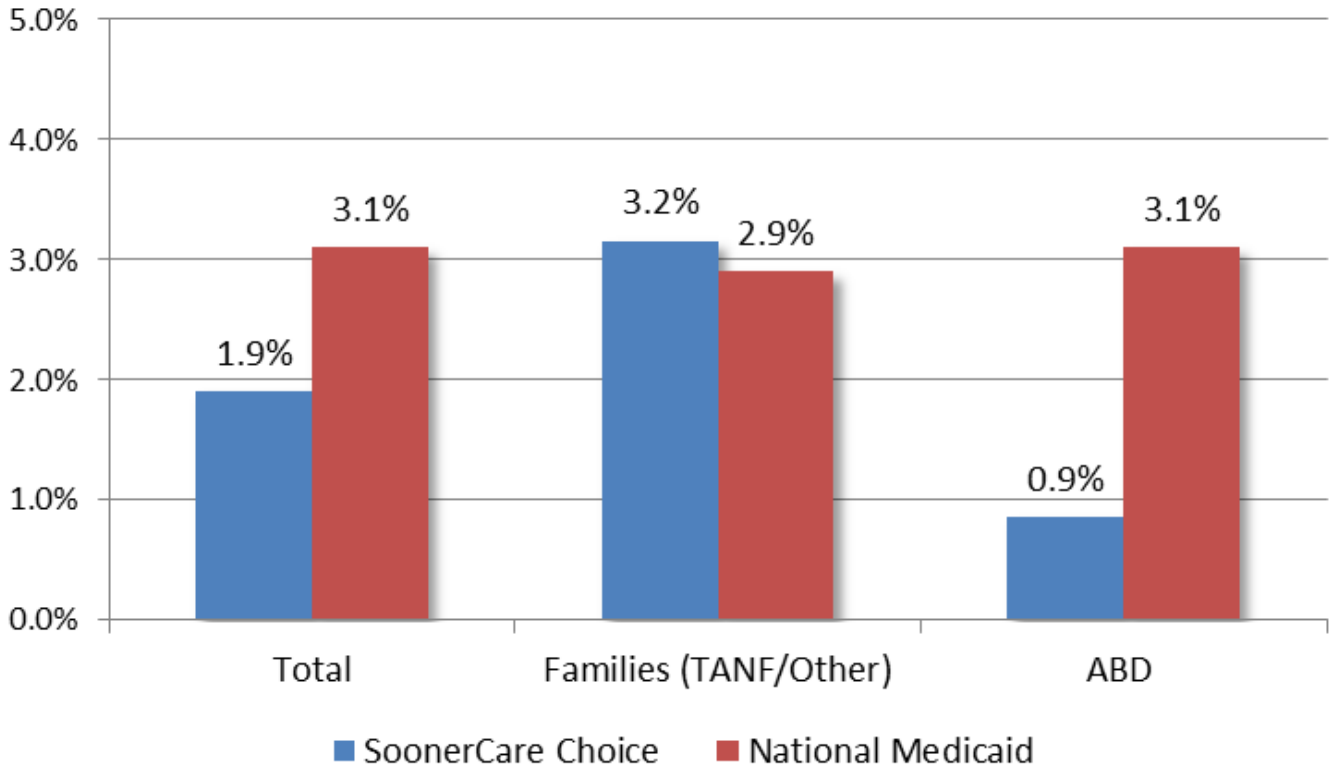
SoonerCare Choice Member PMPM Medical Expenditures (SFY)

Aid Category	2009	2010	2011	2012	2013	2014	Avg. Annual Change 2010-13	Avg. Annual Change 2009-14
ABD (non-duals)	$779	$815	$806	$806	$836	$895	↑0.9%	↑2.8%
TANF/Other	$216	$215	$217	$228	$236	$221	↑3.2%	↑0.5%
TOTAL	$274	$275	$276	$280	$291	$276	↑1.9%	↑0.2%

*Note 1 – Data is for members assigned to a PCMH. Total SCC trend for SFY 2009 – 2014 is lower than ABD and TANF/Other rates due to changes in member mix
Source: OHCA paid claims data

COST EFFECTIVENESS *cont'd*

PMPM Medical Spending Growth – 2010 – 2013



Sources: Oklahoma - OHCA 2010 and 2013 Annual Reports; National – "Trends in Medicaid Spending Leading up to ACA Implementation", Kaiser Commission on Medicaid and the Uninsured (February 2015)

COST EFFECTIVENESS *cont'd*

Administrative Expenditures

- The OHCA contracts for some care management activities (e.g., SoonerCare HMP) but otherwise operates as a state managed care plan
- This structure enables the agency to devote a larger share of expenditures to the delivery of care
- States with MCO contracts can have slightly lower agency costs
- However, each MCO must replicate administrative functions otherwise performed by the state
- MCOs also must comply with state-mandated funding and use requirements for for risk reserves and profits

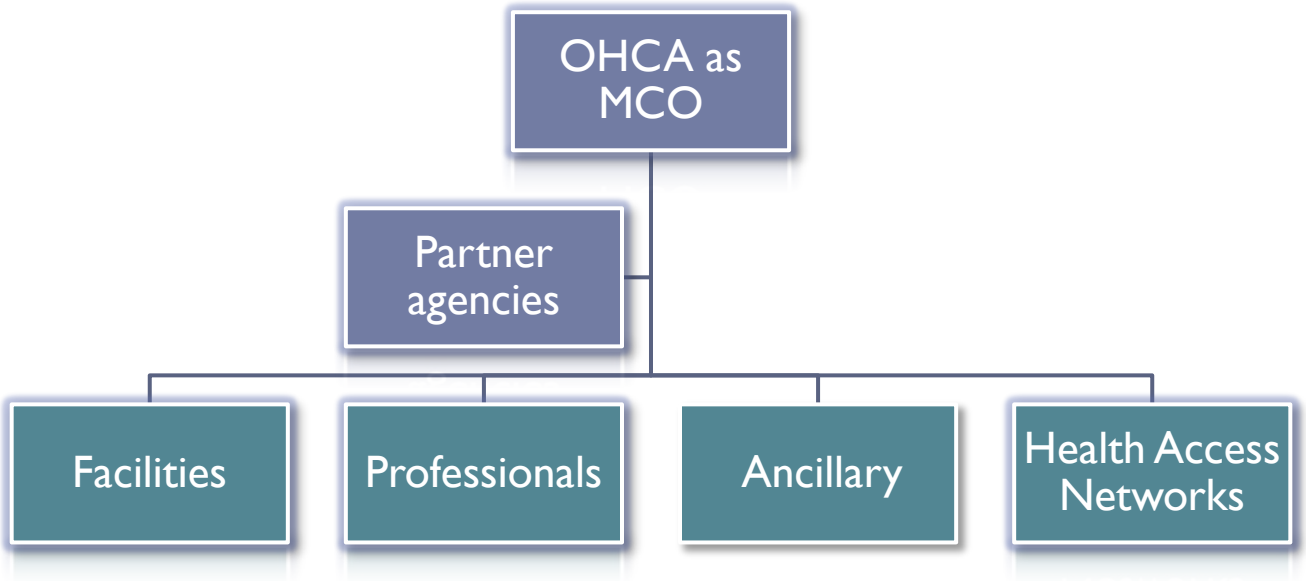
COST EFFECTIVENESS *cont'd*

Both Models Provide the Same Services

Component	SoonerCare OHCA MCO	Private MCO Model
Member Eligibility Standards	*Same for both models*	
Covered Benefits	*Same for both models*	
Contracted Network/Medical Homes	*Yes*	*Yes*
Member Education	*Yes*	*Yes*
Medical/Case Management	*Yes*	*Yes*
Chronic Care/Health Management	*Yes*	*Yes*
Quality Improvement Initiatives	*Yes*	*Yes*
Program Oversight/Administration	*State*	*State + MCO (shared)*

Public (OHCA) Managed Care Model

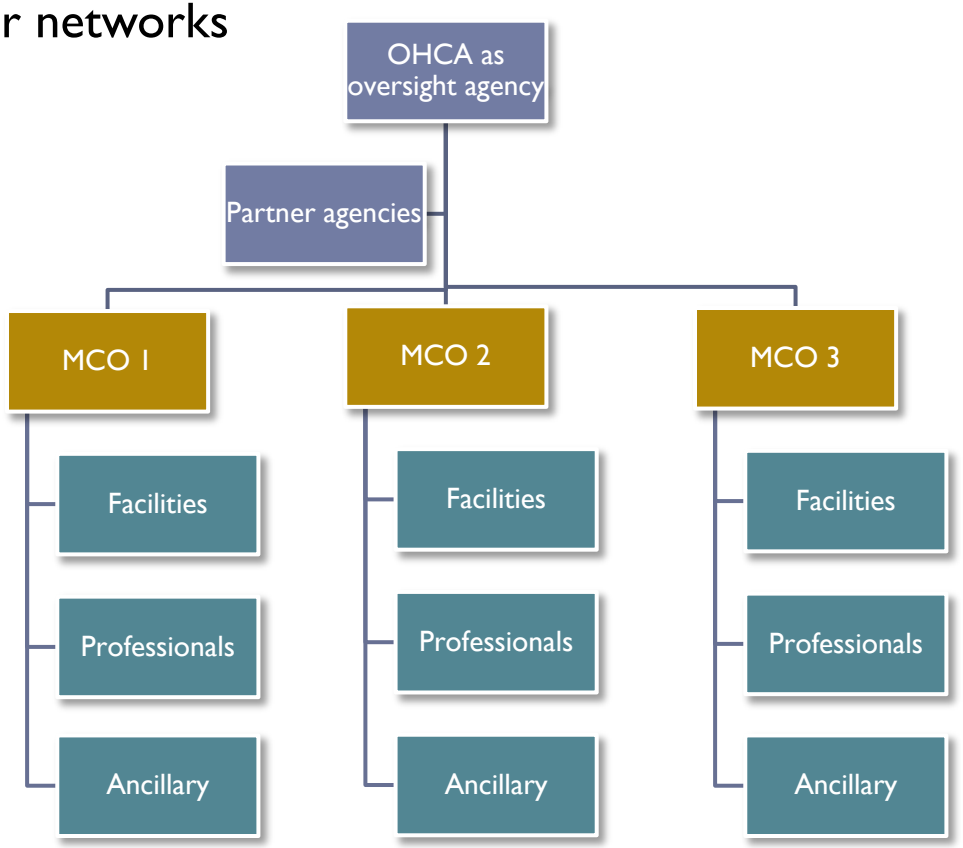
- Under the public model, the OHCA contracts directly with providers and Health Access Networks



COST EFFECTIVENESS *cont'd*

Private Managed Care Model

- Under the private model, the OHCA contracts with MCOs, which in turn construct provider networks

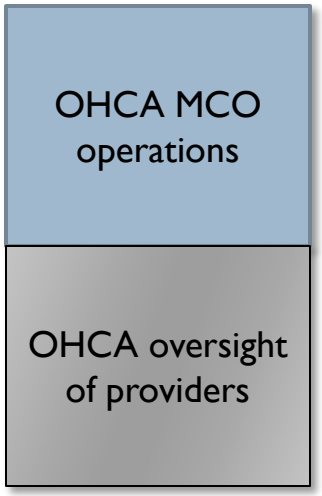


Networks typically contain overlap across MCOs

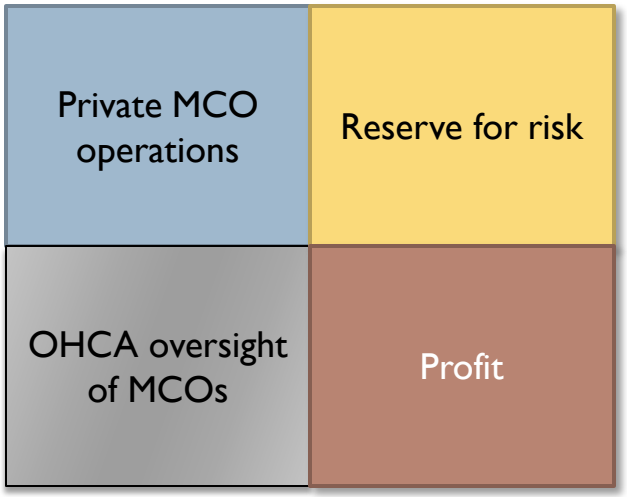
MCO Administrative Resource Needs

- Under both models, OHCA resources must be devoted to oversight functions
- Under the private model, funds also must be allocated for MCO risk and profit

Public MCO Model



Private MCO Model



COST EFFECTIVENESS *cont'd*

Private MCO Administrative Cost

- Administrative costs, as a percentage of total costs, were analyzed for:

Arizona	**Colorado**
Florida	**Kansas**
Louisiana	**New Mexico**
Texas	

- Private MCO administrative costs vary by eligibility type, but average approximately10.9 percent

COST EFFECTIVENESS *cont'd*

Private MCO Administrative Costs

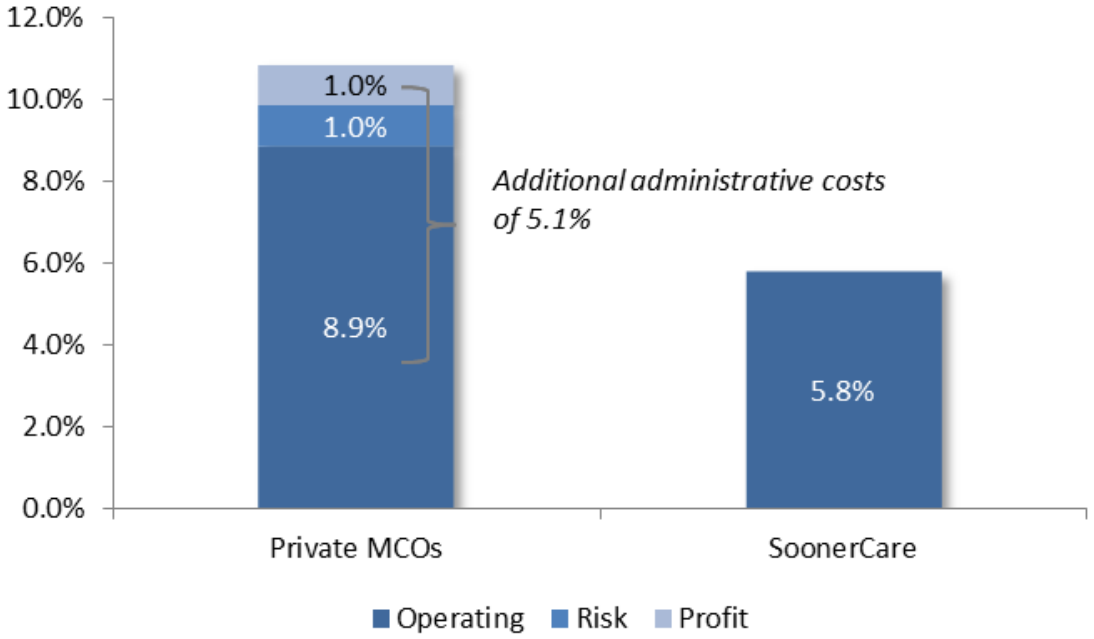
- Private MCO administrative costs average approximately 10.9 percent of total spending in the Medicaid programs examined
- This includes dollars for operations, risk reserves and profits

STATE	YEAR	ALL	TANF	ABD	LTC-HCBS	LTC-FACILITY
Arizona	2014	8.00%	n/a	n/a	n/a	n/a
Colorado	2011	9.00%	n/a	n/a	n/a	n/a
Florida	2012	12.00%	n/a	n/a	n/a	n/a
Kansas	2013	n/a	10.00%	7.50%	9.00%	6.00%
Louisiana	2012	11.50%	n/a	n/a	n/a	n/a
New Mexico	2012	12.00%	n/a	n/a	n/a	n/a
Texas	2012	n/a	13.75%	9.70%	9.00%	n/a
Average (unweighted)		10.50%	11.88%	8.60%	9.00%	6.00%
Average (weighted)		**10.87%**				

COST EFFECTIVENESS *cont'd*

MCO Administrative Cost Comparison

- OHCA MCO administrative cost in SFY 2014 was approximately 5.1 percent of total program expenditures (includes relevant partner agency activities)
- Private MCO administrative cost is approximately 10.9 percent
- Private MCO model also would require resources for OHCA oversight (not reflected in chart)



SOONERCARE CHOICE EVALUATION

SoonerCare Choice Overview

SoonerCare Choice Performance

Impact of Recent OHCA Initiatives

Comparison to Benchmark States

SOONERCARE CHOICE EVALUATION

Impact of Recent OHCA Initiatives

- Health Management Program
- PCMH Tiers
- Health Access Networks

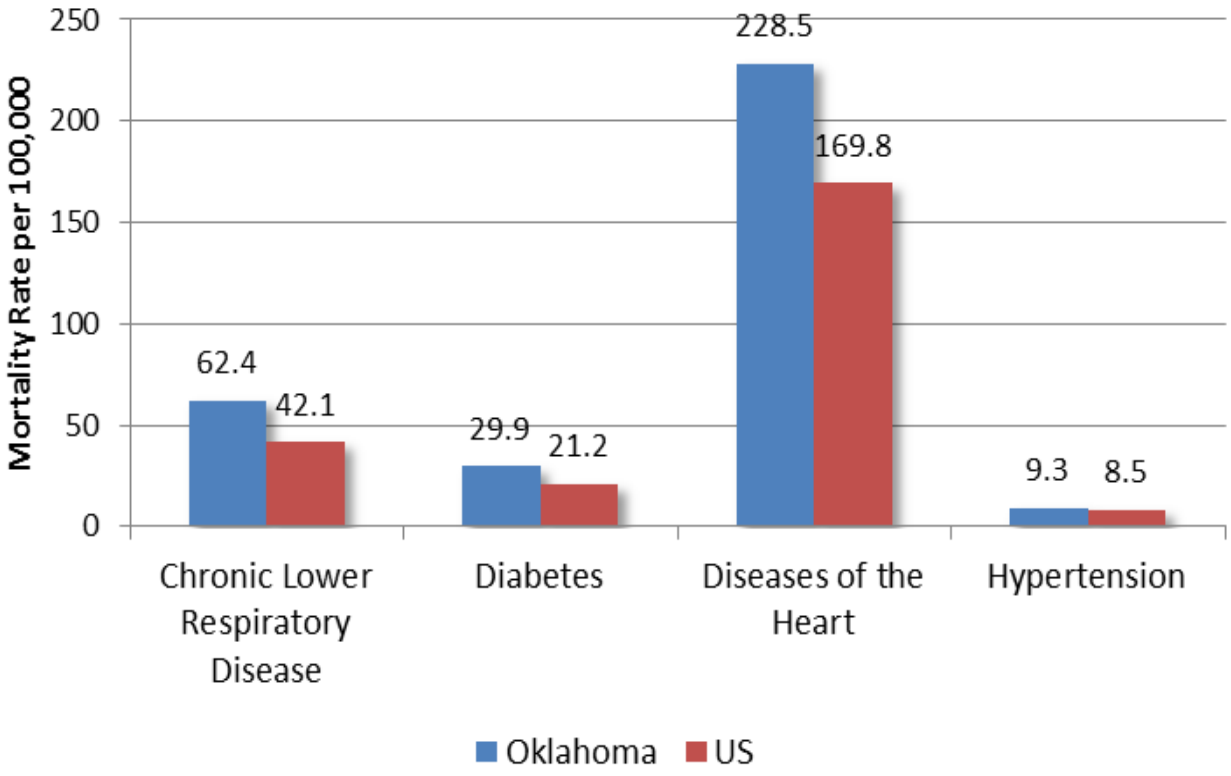
IMPACT - HEALTH MANAGEMENT PROGRAM

Overview

- Chronic diseases are the leading cause of death and disability in the United States
- About one-half of the US adult population has one or more chronic health conditions, such as diabetes, heart disease or hypertension
- Treatment of persons with chronic diseases accounts for nearly 85 percent of health spending
- The mortality rate in Oklahoma for many chronic diseases is higher than for the nation as a whole and accounts for billions of dollars in health expenditures, including $1 billion in SoonerCare costs

HEALTH MANAGEMENT PROGRAM *cont'd*

Chronic Disease Mortality Rates – 2013 Oklahoma and US (Selected Conditions)



HEALTH MANAGEMENT PROGRAM *cont'd*

Oklahoma Chronic Disease Expenditures 2015 Estimate and 2020 Projection (Millions)

Chronic Condition	OK All Payers		SoonerCare	
	2015	2020	2015	2020
Asthma	$433	$538	$146	$182
Cardiovascular Diseases (heart diseases, stroke and hypertension)	$5,516	$7,076	$592	$760
Diabetes	$2,247	$2,869	$250	$319
Total for Selected Conditions	$8,196	$10,483	$988	$1,260

HEALTH MANAGEMENT PROGRAM *cont'd*

- In 2006, the Oklahoma Legislature directed the Oklahoma Health Care Authority (OHCA) to develop a care management program for SoonerCare members with chronic conditions
- The SoonerCare Health Management Program (HMP) was established as a holistic model of care that seeks to proactively address the individual needs of members through planned, ongoing assessment, follow-up and education
- The program is forward looking – targeting members at greatest risk of incurring significant costs, along with the patient centered medical homes (PCMH) where they receive care

HEALTH MANAGEMENT PROGRAM *cont'd*

- Program objectives include:
  - Addressing the complex physical and behavioral health needs of chronically ill members
  - Improving member disease self-management skills and encouraging healthier lifestyles through ongoing care management and health coaching
  - Improving provider management of patients with chronic conditions through practice facilitation
  - Reducing avoidable acute care services (ER visits and hospitalizations) and costs

HEALTH MANAGEMENT PROGRAM *cont'd*

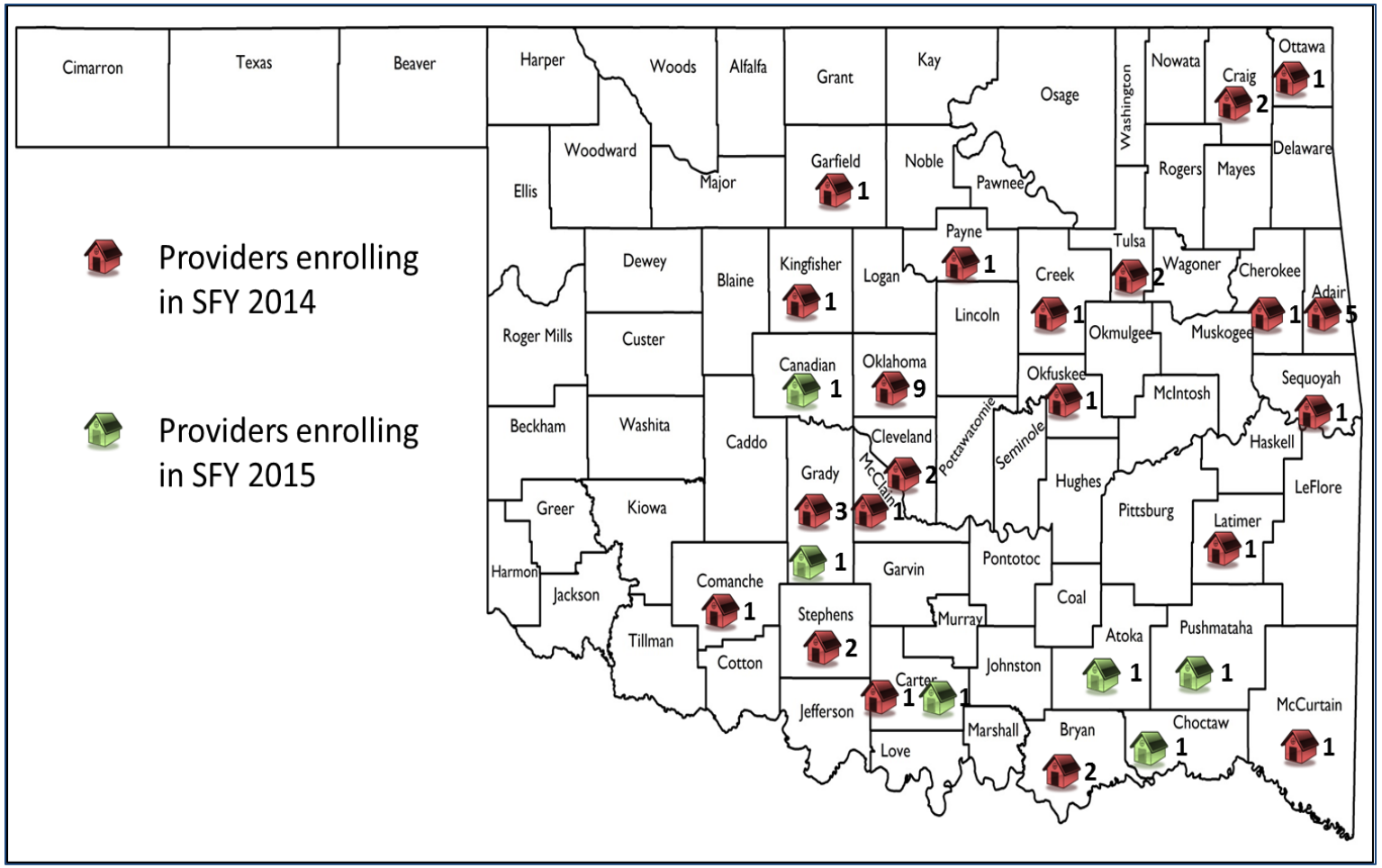
- The program has evolved since its implementation and underwent a major transition in SFY 2014
- Field-based and telephonic nurse care managers were replaced with health coaches who primarily are embedded in provider offices and see members before or after an office visit
- Health coaches use motivational interviewing to engage members in establishing goals and action plans
- Participating providers and their office staffs receive practice facilitation in conjunction with the health coach
- A vendor, Telligen, administers the program and is overseen by a dedicated OHCA unit

HEALTH MANAGEMENT PROGRAM *cont'd*

- MEDai predictive modeling software is used to identify candidates for the program, based on risk of incurring significant costs in the next 12 months
- Members who qualify and whose PCMH is participating in the program are invited to enroll
- Members who qualify but whose PMCH does not participate can receive telephonic care management through the SoonerCare Chronic Care Unit (CCU)
- At the time of transition, existing members were moved to a health coach or the CCU, depending on their provider
- In SFY 2014, the SoonerCare HMP included 41 providers across 32 sites and 6,800 members enrolled for at least one month

HEALTH MANAGEMENT PROGRAM *cont'd*

SoonerCare HMP Participating Providers



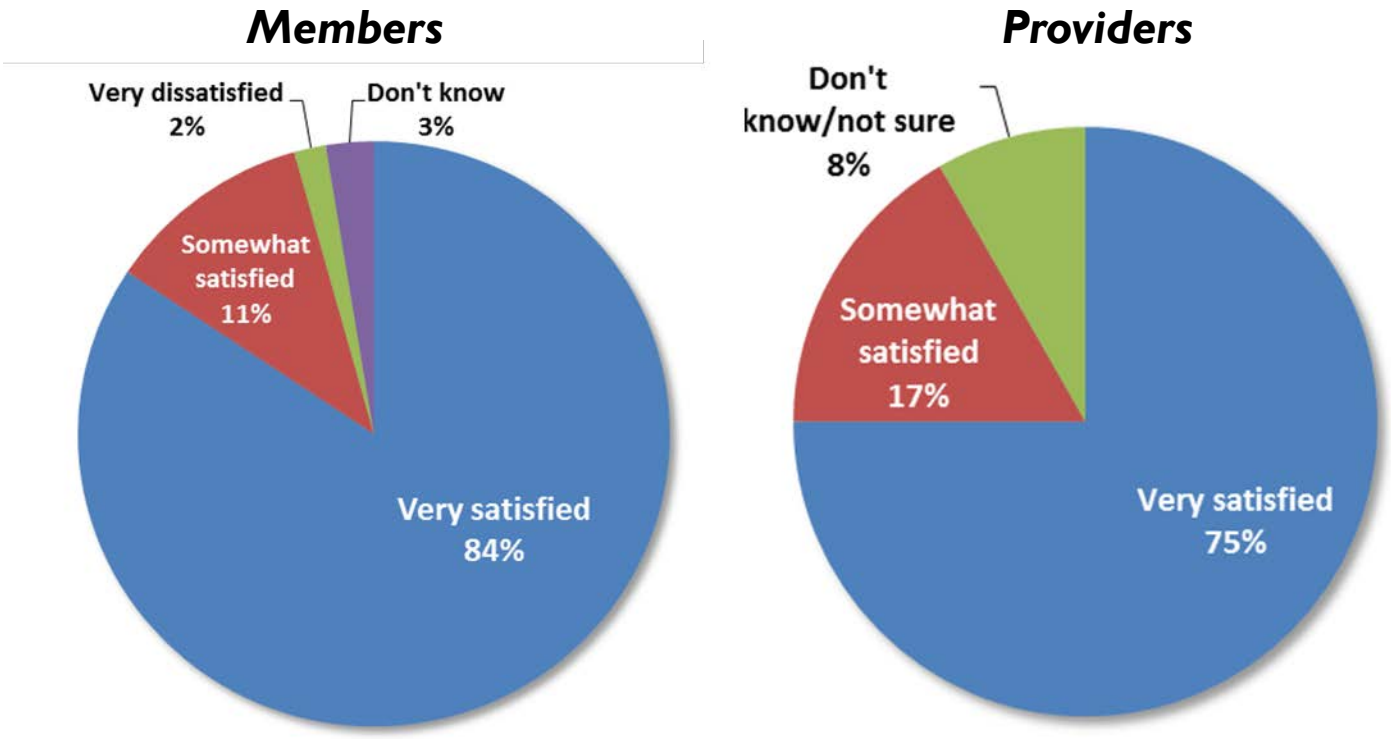
HEALTH MANAGEMENT PROGRAM *cont'd*

- The Pacific Health Policy Group has conducted annual evaluations of the program since its implementation
- Program performance is measured in terms of
  - Participant (member and provider) satisfaction
  - Impact on member lifestyle and self-management of conditions
  - Impact on ER and inpatient utilization
  - Overall cost effectiveness (after accounting for administrative costs)

HEALTH MANAGEMENT PROGRAM *cont'd*

Satisfaction

- Both members and providers express high levels of satisfaction with the program

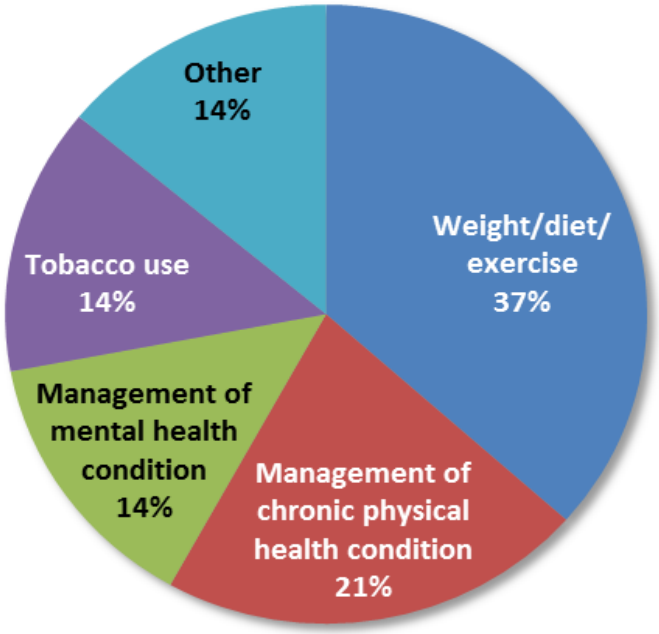


Source: SoonerCare HMP SFY 2014 Annual Evaluation Report

HEALTH MANAGEMENT PROGRAM *cont'd*

- Two-thirds of participants reported selecting an area of their life to change, with the aid of their health coach

Area Selected for Change/Action Plan Development



Source: SoonerCare HMP SFY 2014 Annual Evaluation Report

HEALTH MANAGEMENT PROGRAM *cont'd*

- Half of the participants with an Action Plan reported achieving one or more goals, a notable result given that average tenure in SFY 2014 was only six months

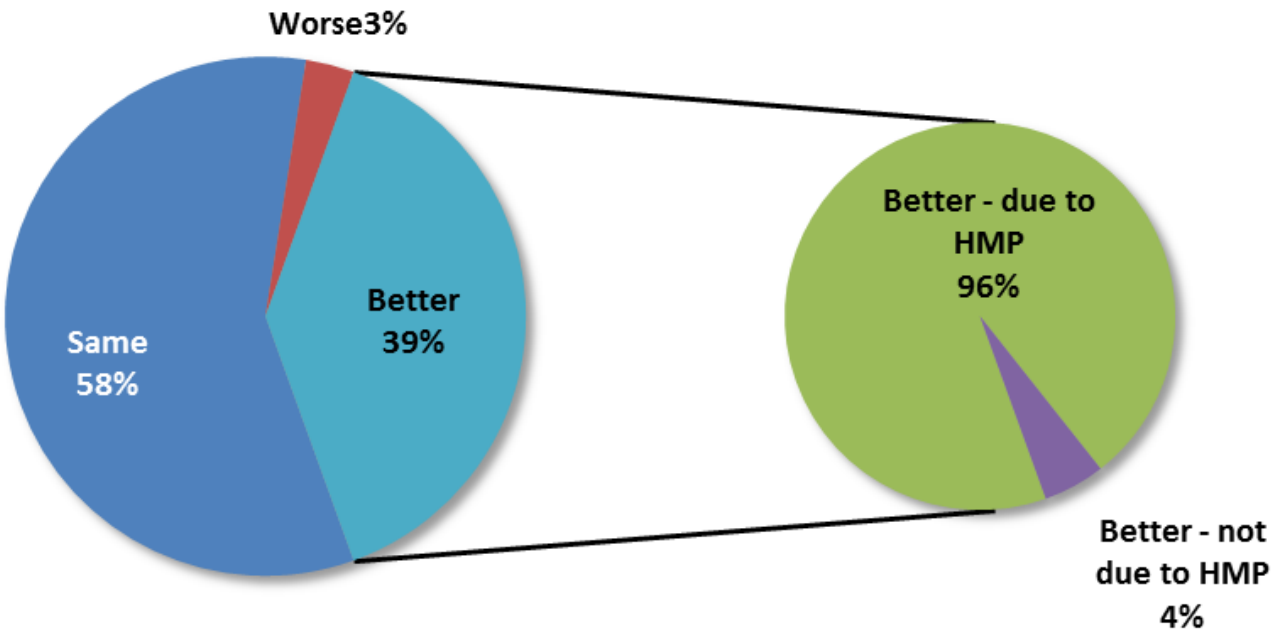
Action Plan Area	Goals Achieved (Examples)
Weight/Diet/Exercise	• Eating better and exercising more • Enrolling in an exercise class
Management of chronic physical health condition	• Better control of asthma with medications • Eating better to control blood sugar
Management of mental health condition	• Starting counseling • Adhering to medication to address condition
Tobacco use	• Cutting back on number of packs smoked per day • Converting to electronic cigarettes

Source: SoonerCare HMP SFY 2014 Annual Evaluation Report

HEALTH MANAGEMENT PROGRAM *cont'd*

- Nearly 40 percent reported improved health since enrolling, with the credit going to health coaching

Health Status since Enrollment



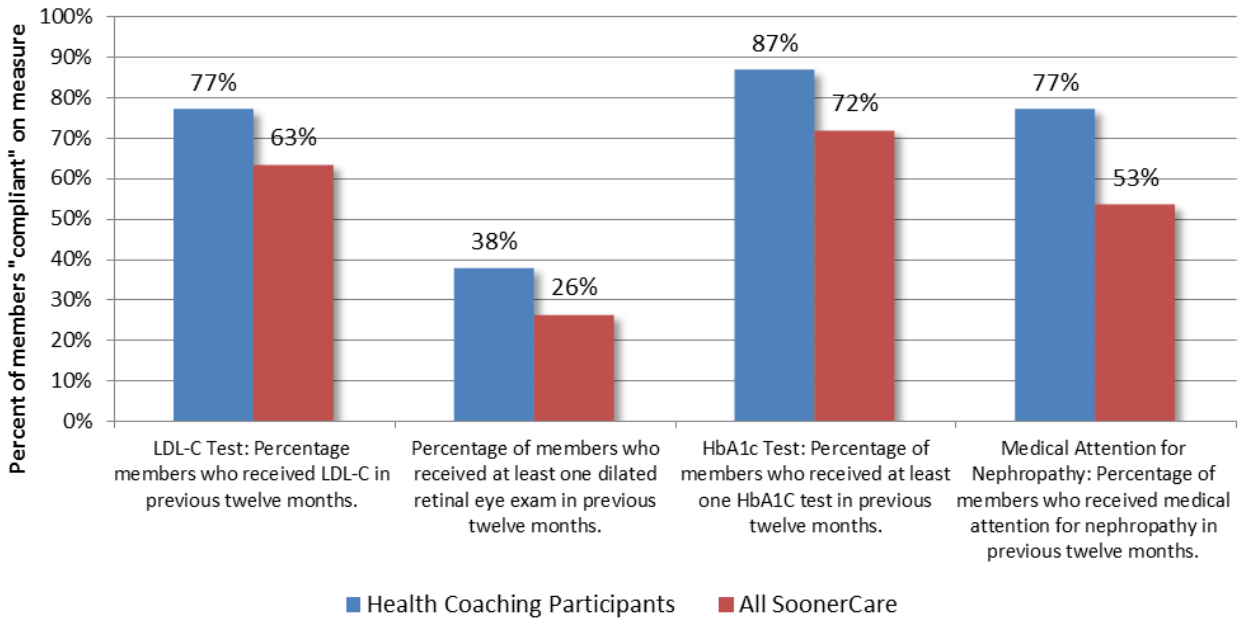
Source: SoonerCare HMP SFY 2014 Annual Evaluation Report

HEALTH MANAGEMENT PROGRAM *cont'd*

Quality of Care

- Quality of care, as measured by member and provider adherence to HEDIS® standards, was tracked by disease state and showed improvement for all conditions over time
- SoonerCare HMP participants also demonstrated greater adherence to recommended care guidelines than a "comparison group" consisting of all SoonerCare members

Quality of Care Evaluation Example – Diabetes



Source: SoonerCare HMP SFY 2014 Annual Evaluation Report

HEALTH MANAGEMENT PROGRAM *cont'd*

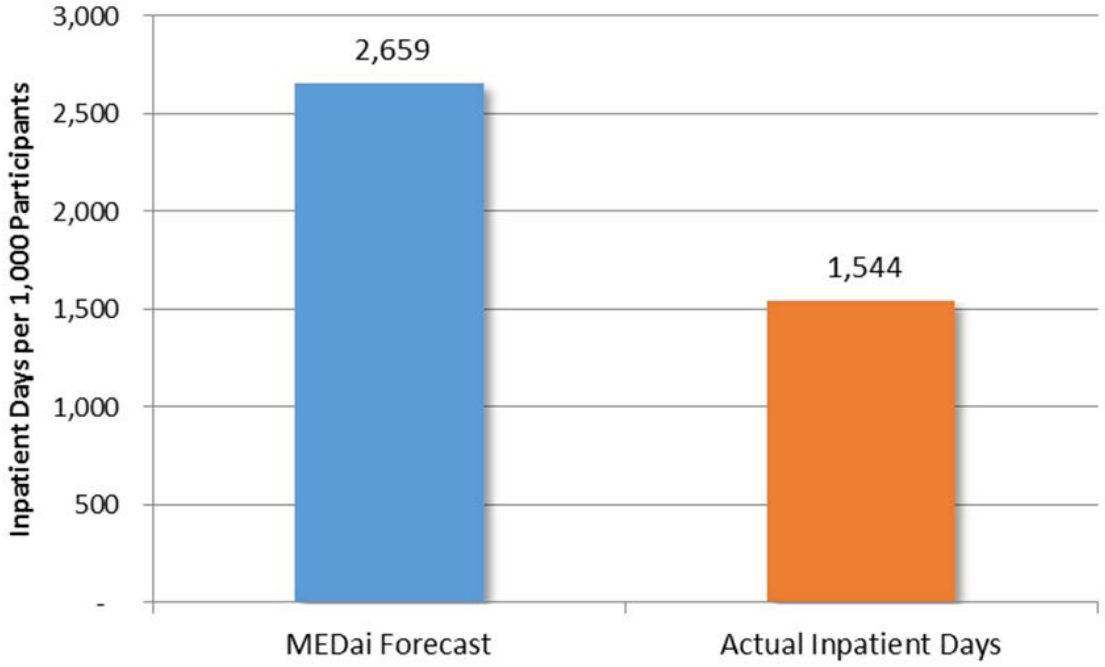
Utilization and Expenditures

- Service utilization and PMPM medical expenditures were evaluated against what would have occurred absent participation in the program:
  - For members – against projected expenditures as calculated by MEDai predictive modeler
  - For providers in Practice Facilitation – expenditures for their patients against MEDai projections, excluding health coaching participants (to avoid double counting)
- The impact on utilization (e.g., inpatient days and ER visits) and expenditures was significant for both HMP groups (results for members shown on next slides)

Utilization

- Inpatient days were significantly below MEDai projections

Inpatient Days – Health Coaching Participants

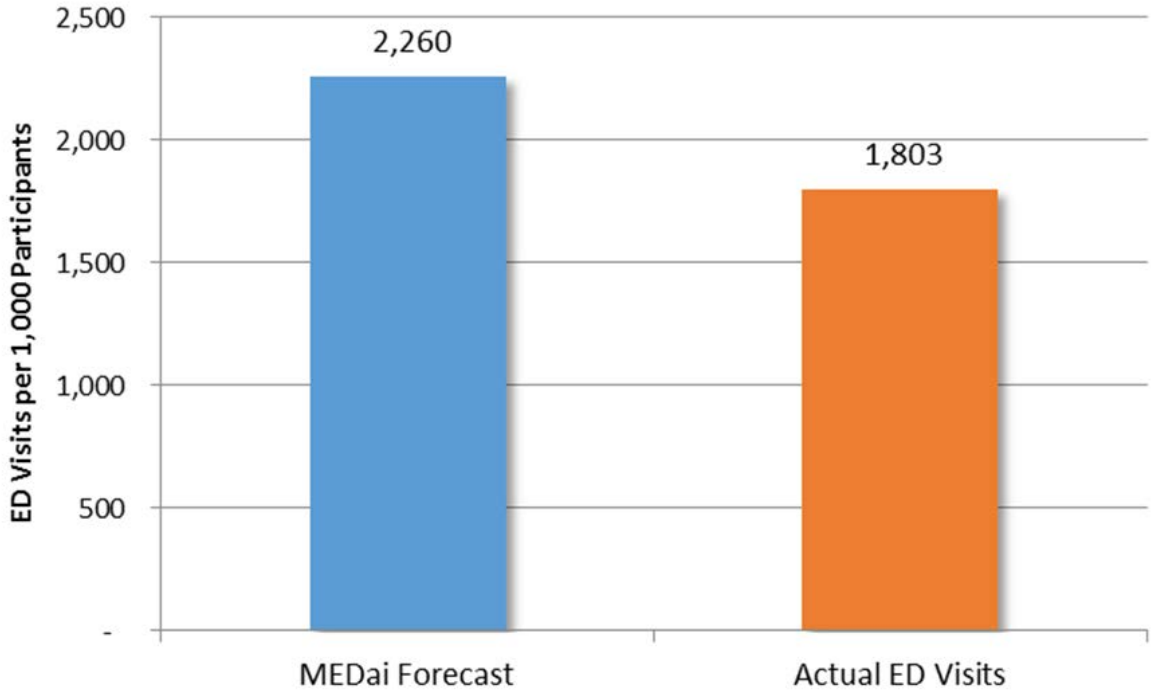


Source: SoonerCare HMP SFY 2014 Annual Evaluation Report

Utilization

- ER visits also were below MEDai projections

ER Visits – Health Coaching Participants

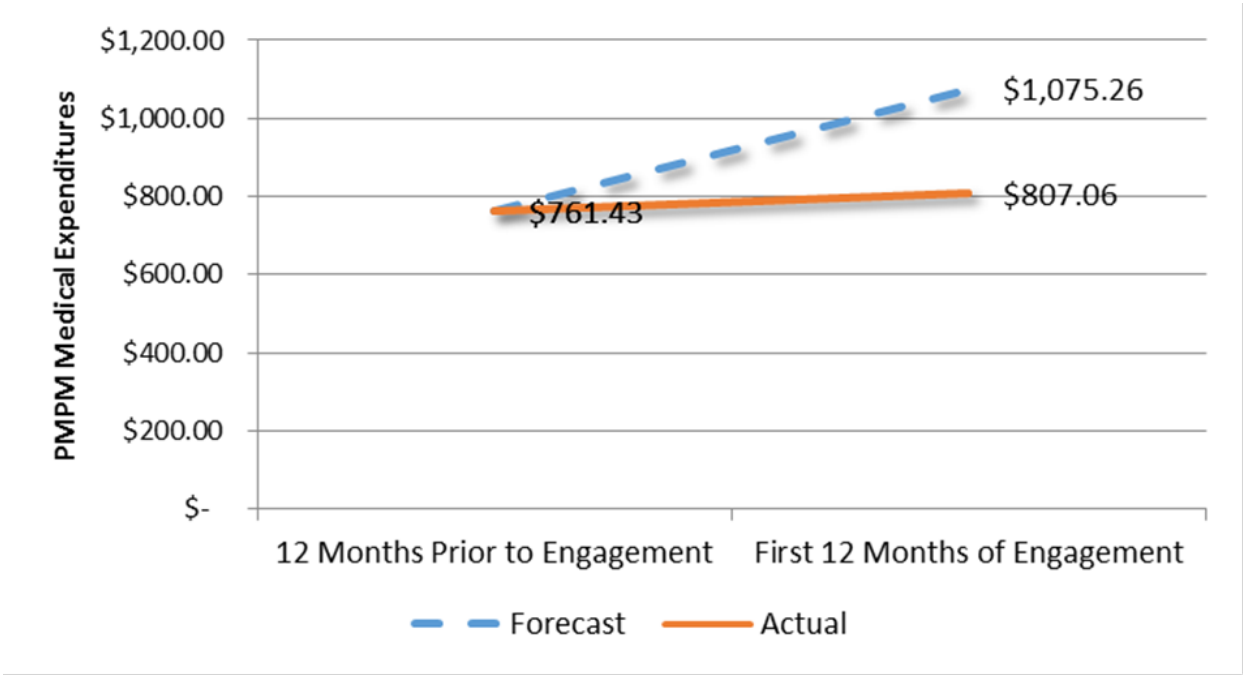


Source: SoonerCare HMP SFY 2014 Annual Evaluation Report

Expenditures

- Per Member Per Month (PMPM) expenditures were 25% below forecast

PMPM Expenditures – Health Coaching Participants



Source: SoonerCare HMP SFY 2014 Annual Evaluation Report

HEALTH MANAGEMENT PROGRAM *cont'd*

Net Cost Effectiveness

- Overall cost effectiveness was measured taking into consideration program administrative costs (OHCA and Telligen)
- In SFY 2014, the program saved nearly $16 million
- From a return-on-investment perspective, the program generated over **two dollars in medical savings for every dollar in administrative expenditures**

IMPACT – PCMH TIERS

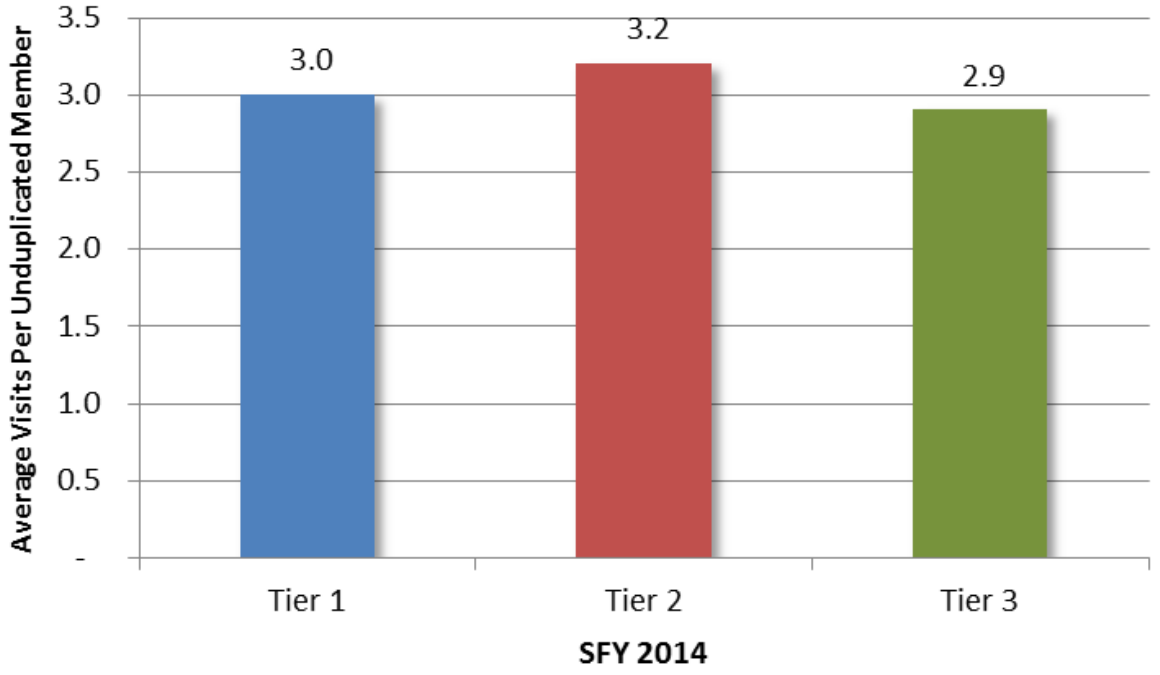
PCMH Targeted Evaluation

- As presented earlier, the PCMH initiative has contributed to positive trends with regard to service utilization and expenditures
- The favorable results are in the aggregate, across all tier levels
- In previous years, when tiers were compared, Tier 1 and Tier 2 providers generally performed as well as their Tier 3 counterparts
- In 2014, however, Tier 3 providers began to show superior results across many categories, including ER utilization, hospital admission rates for ambulatory care sensitive conditions and hospital readmission rates

PCMH TIERS *cont'd*

PCMH Visit Rates (Per Member Per Year)

- Members aligned with a Tier 2 PCMH see their provider slightly more often over the course of a year than members aligned with a Tier 1 or Tier 3 PCMH



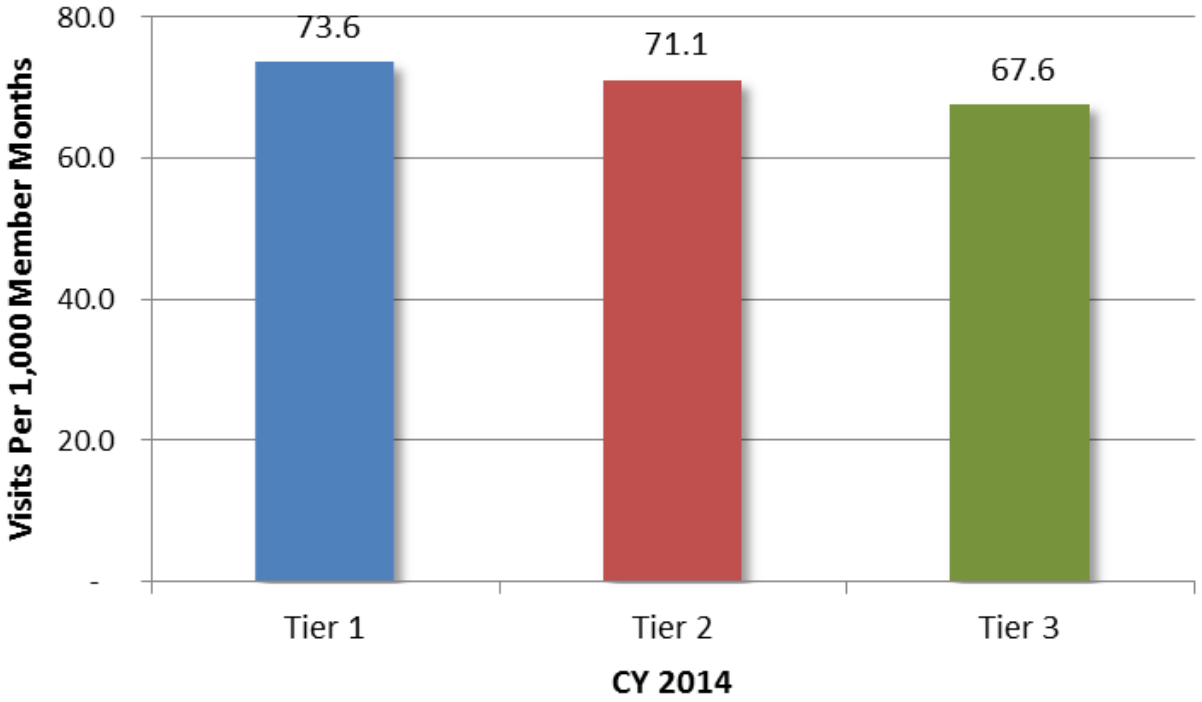
Note: PCMH Tier data is for providers not affiliated with a HAN; results for HAN providers are presented in the next section

Source: SoonerCare HMP Fifth Annual Evaluation Report

PCMH TIERS *cont'd*

Emergency Room Utilization (Per 1,000 Member Months)

- Members aligned with a Tier 3 provider have a moderately lower ER utilization rate than members aligned with Tier 1 and Tier 2 providers



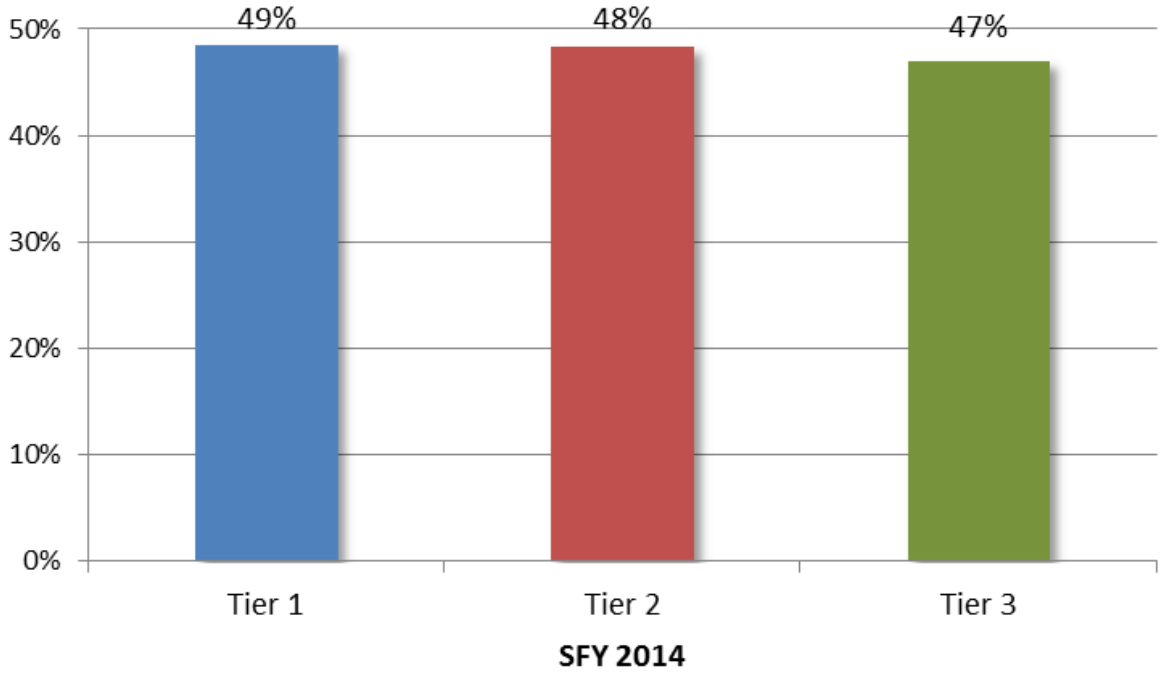
Note: PCMH Tier data is for providers not affiliated with a HAN; results for HAN providers are presented in the next section

Source: SoonerCare HMP Fifth Annual Evaluation Report

PCMH TIERS *cont'd*

Follow-up visit with PCMH within 30 days of ER encounter

- The follow-up rate within 30 days of an ER visit is nearly identical across the three tiers



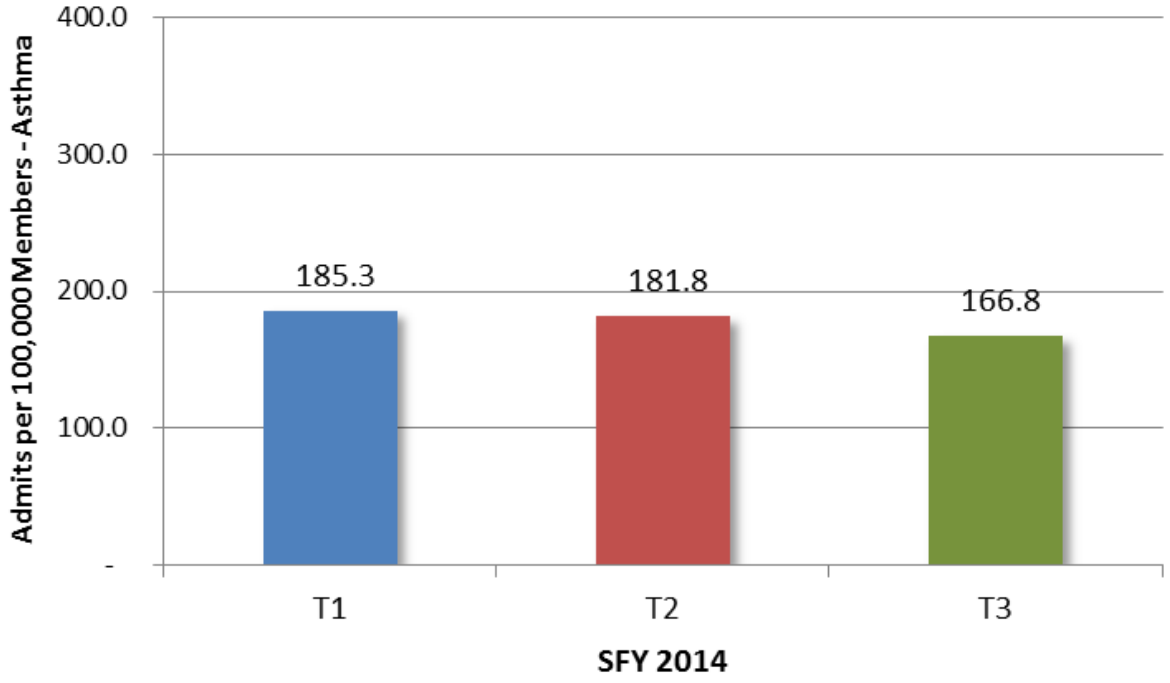
Note: PCMH Tier data is for providers not affiliated with a HAN; results for HAN providers are presented in the next section

Source: SoonerCare HMP Fifth Annual Evaluation Report

PCMH TIERS *cont'd*

Ambulatory Care Sensitive Hospitalization Rate - *Asthma*

- Tier 1 PCMH providers have the highest admit rate for asthma, while Tier 3 providers have the lowest rate



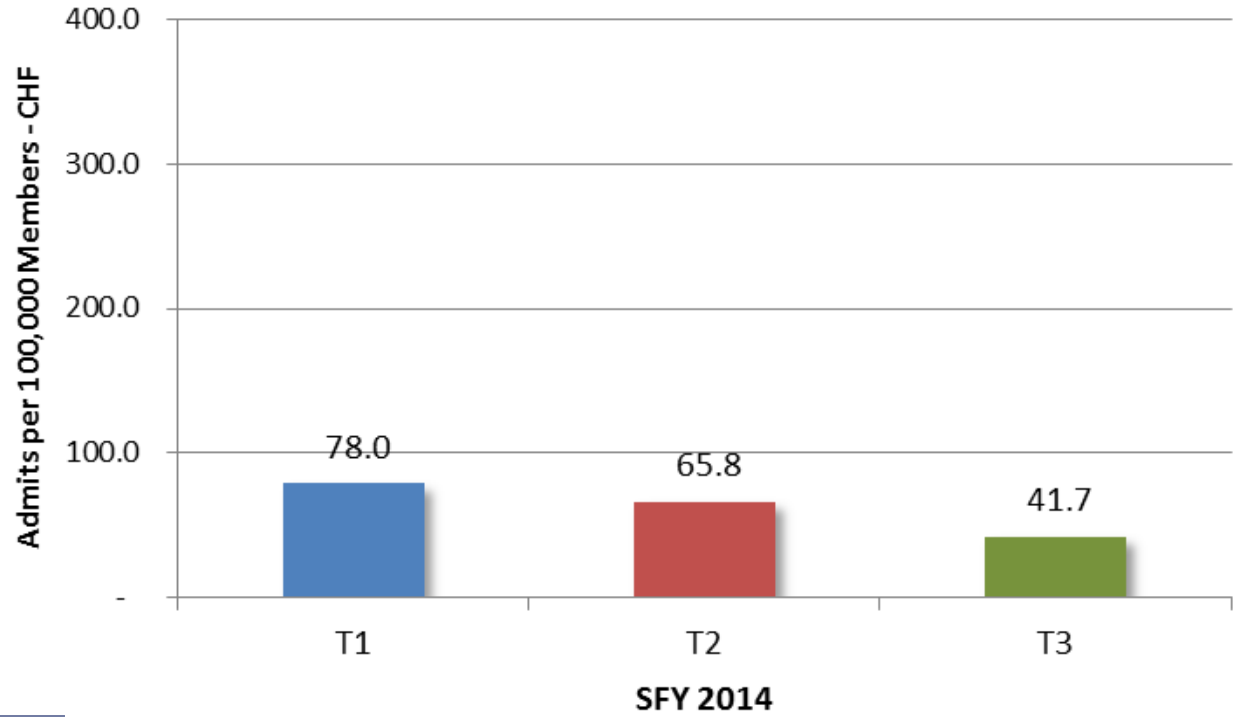
Note: PCMH Tier data is for providers not affiliated with a HAN; results for HAN providers are presented in the next section

Source: SoonerCare HMP Fifth Annual Evaluation Report

PCMH TIERS *cont'd*

Ambulatory Care Sensitive Hospitalization Rate - *CHF*

- Tier 1 PCMH providers also have the highest admit rate for CHF, while Tier 3 providers again have the lowest rate



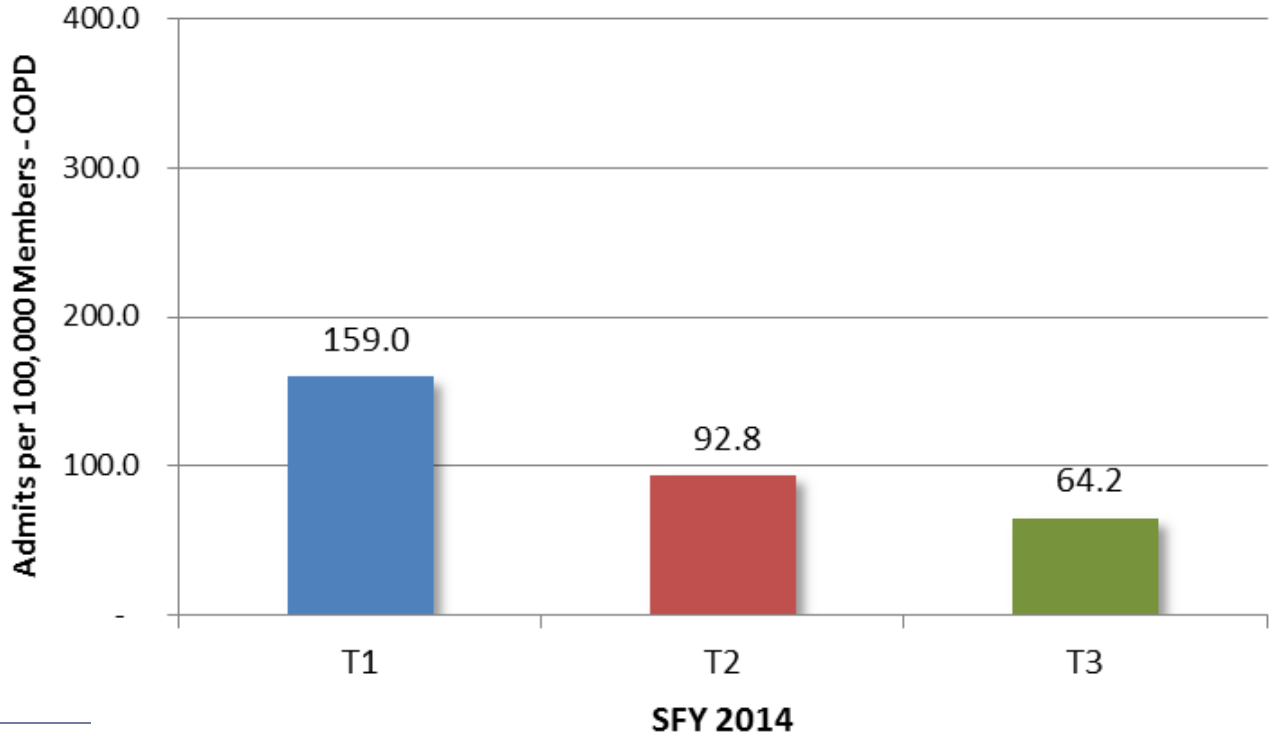
Note: PCMH Tier data is for providers not affiliated with a HAN; results for HAN providers are presented in the next section

Source: SoonerCare HMP Fifth Annual Evaluation Report

PCMH TIERS *cont'd*

Ambulatory Care Sensitive Hospitalization Rate - *COPD*

- Tier 1 PCMH providers also have the highest admit rate for COPD, while Tier 3 providers again have the lowest rate



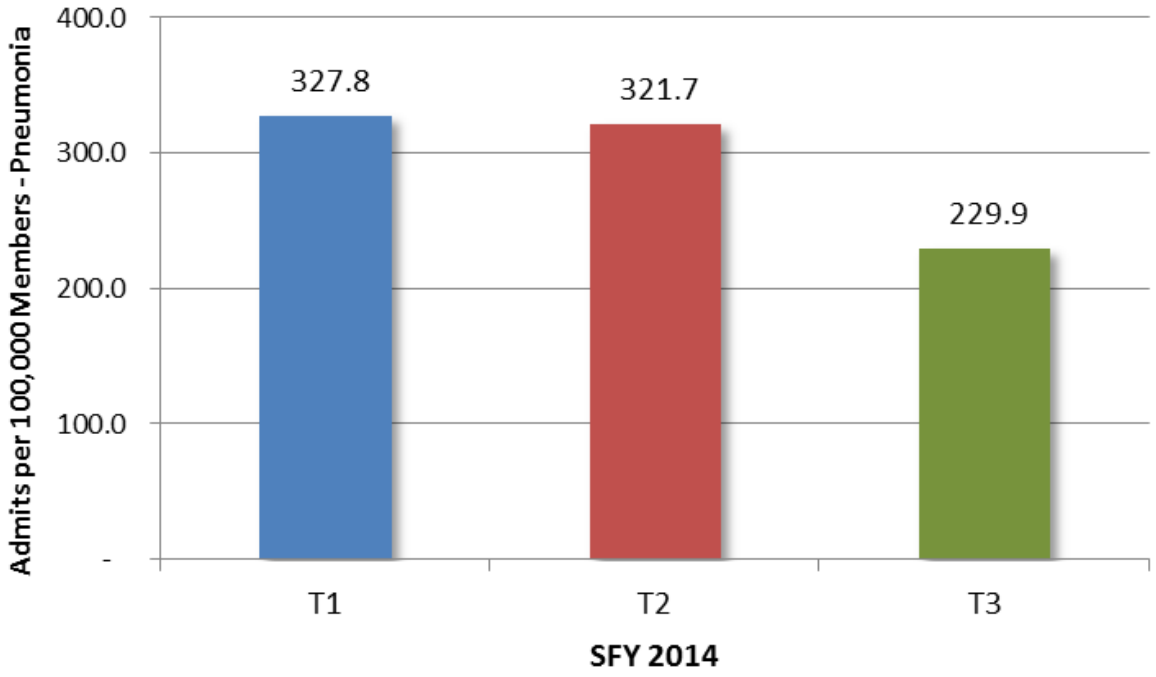
Note: PCMH Tier data is for providers not affiliated with a HAN; results for HAN providers are presented in the next section

Source: SoonerCare HMP Fifth Annual Evaluation Report

PCMH TIERS *cont'd*

Ambulatory Care Sensitive Hospitalization Rate - *Pneumonia*

- Tier 1 PCMH providers also have the highest admit rate for pneumonia, while Tier 3 providers again have the lowest rate



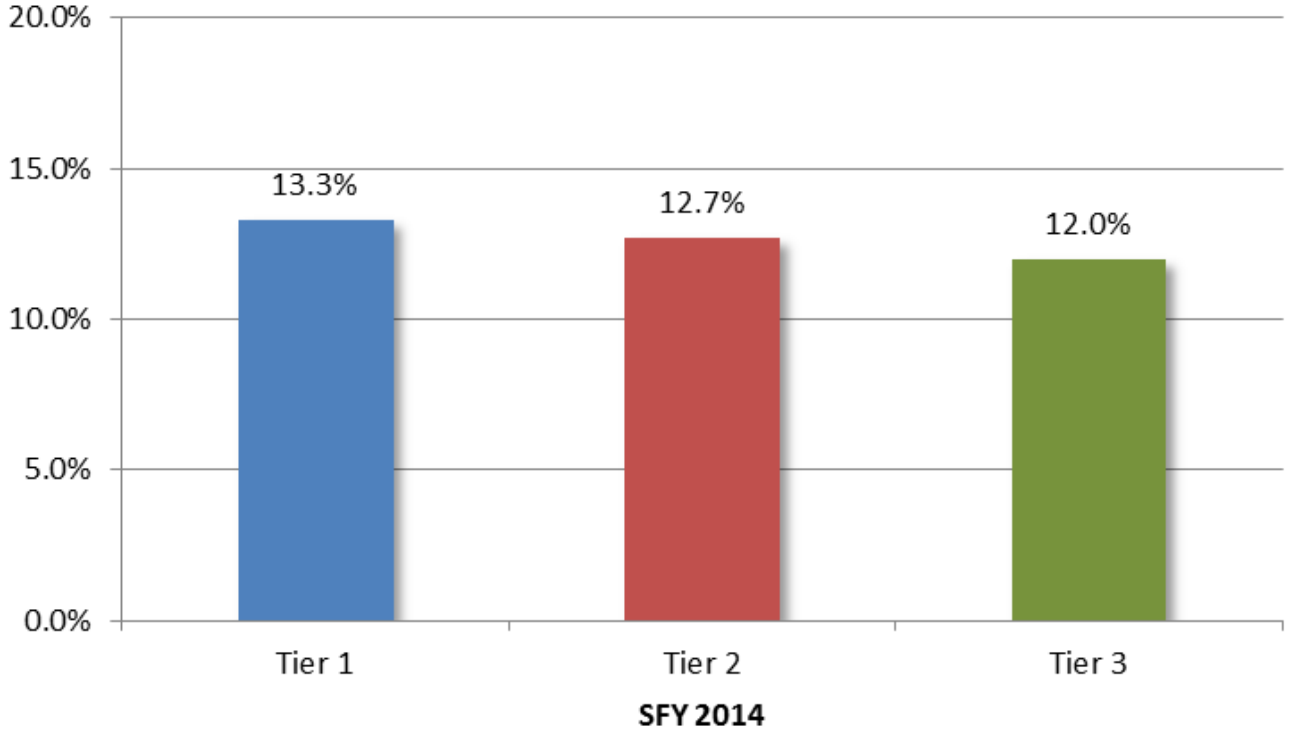
Note: PCMH Tier data is for providers not affiliated with a HAN; results for HAN providers are presented in the next section

Source: SoonerCare HMP Fifth Annual Evaluation Report

PCMH TIERS *cont'd*

Hospital Readmission Rate within 30 Days of Discharge

- Readmission rates are lowest among members aligned with Tier 3 providers



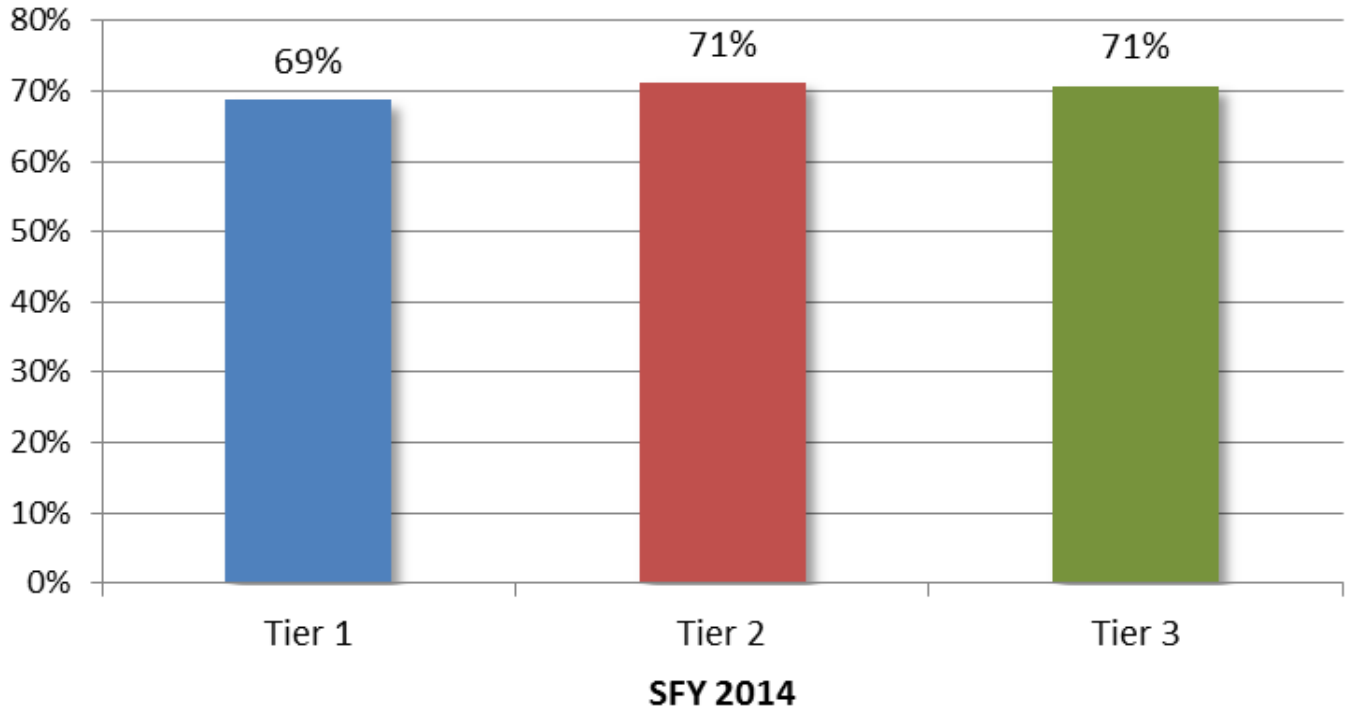
Note: PCMH Tier data is for providers not affiliated with a HAN; results for HAN providers are presented in the next section

Source: SoonerCare HMP Fifth Annual Evaluation Report

PCMH TIERS *cont'd*

Visit to PCMH Post Discharge (30 Days)

- Post Discharge PCMH visit rates are almost identical



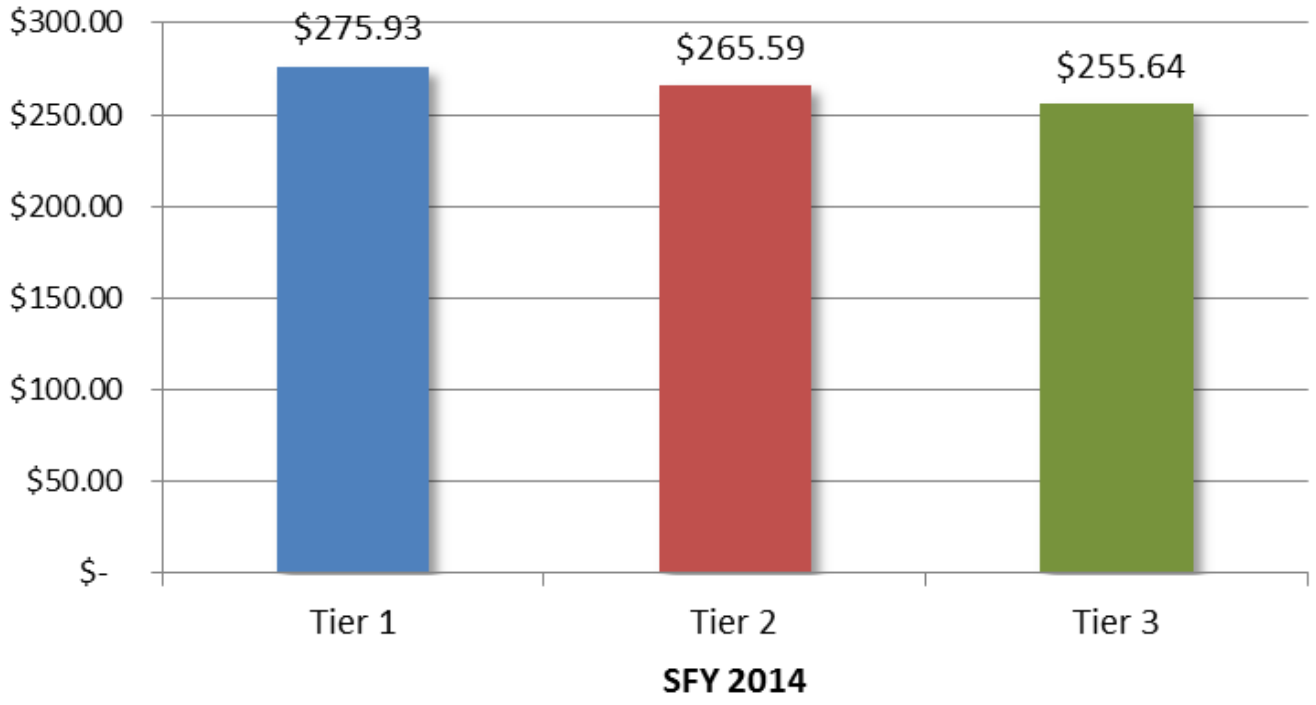
Notes: Discharges for ambulatory care sensitive conditions. PCMH Tier data is for providers not affiliated with a HAN; results for HAN providers are presented in the next section

Source: SoonerCare HMP Fifth Annual Evaluation Report

PCMH TIERS *cont'd*

Average Per Member Per Month Cost (All Services)

- Consistent with their favorable utilization results, members aligned with Tier 3 PCMH providers have the lowest average monthly claim costs (does not include PCMH fees)



Note: PCMH Tier data is for providers not affiliated with a HAN; results for HAN providers are presented in the next section

Source: SoonerCare HMP Fifth Annual Evaluation Report

PCMH TIERS *cont'd*

PCMH Impact: Quantifying Return-on-Investment

- The PCMH model appears to be contributing to positive trend lines for the SoonerCare Choice program as a whole
- PCMH intentionally overlaps with, and amplifies that impact of other OHCA initiatives
- For example, ER utilization is addressed through:
  - Broad-based PCMH patient care requirements
  - Targeted interventions with high ER utilizers by OHCA PCM Department
  - Holistic care management of high risk members through SoonerCare HMP and
  - Health Access Networks (discussed in next section)

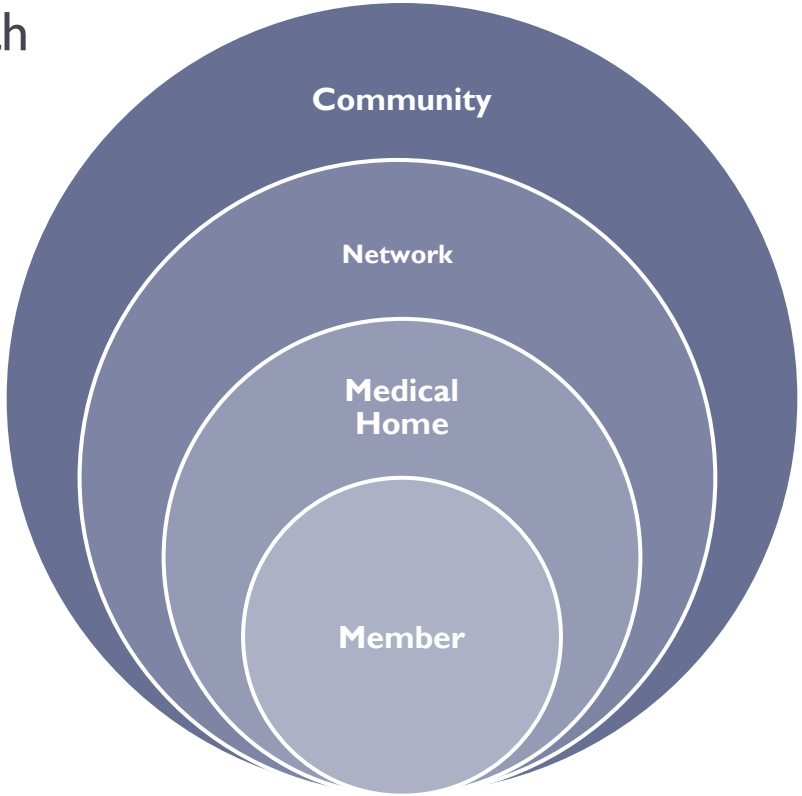
PCMH Impact: Provider Tiers

- There is emerging evidence that Tier 3 providers may be outperforming providers in lower tiers, although it will require another year of similar results to confirm that a trend is underway
- It should be noted that most program requirements apply across all three tiers and OHCA audit findings indicate that providers in all tiers are striving to meet or exceed PCMH requirements
- *"I provide excellent care regardless of tier." – respondent to OU PCMH provider survey*

IMPACT – HEALTH ACCESS NETWORKS

Overview

- The Health Access Network (HAN) model expands on the PCMH by creating community-based, integrated networks intended to:
  - ***Increase*** access to health care services
  - ***Enhance*** quality and coordination of care
  - ***Reduce*** costs



HEALTH ACCESS NETWORKS *cont'd*

Overview

- The HAN model was launched in 2010 and includes:
  - Partnership for Healthy Central Communities (based in Canadian County)
  - OSU Center for Health Sciences
  - OU Sooner Health Access Network
- The HANs receive an additional $5.00 PMPM in part for their care management duties, which focus on high-risk SoonerCare Choice members enrolled with HAN-affiliated PMCH providers

HEALTH ACCESS NETWORKS *cont'd*

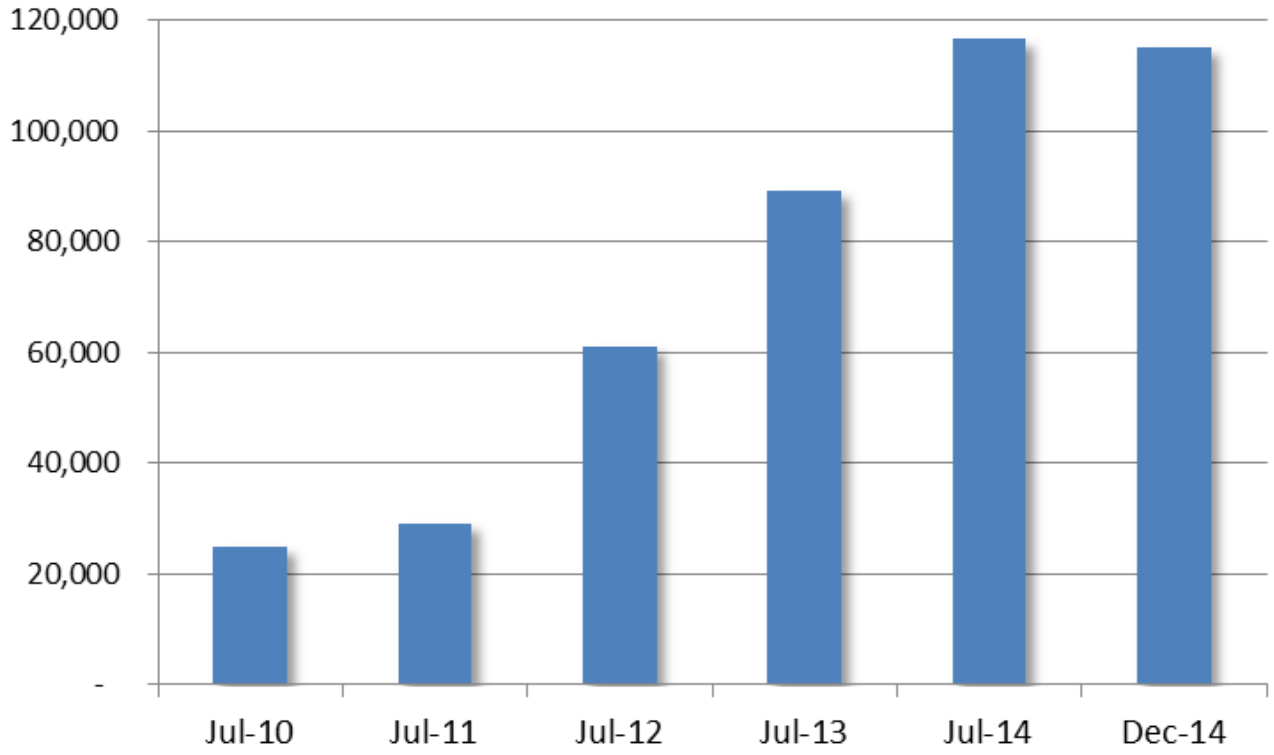
Overview

- Care management target groups include:
  - Breast and cervical cancer patients
  - High Risk pregnancies
  - Persons with hemophilia
  - Frequent emergency room utilizers
- The HANs also support network PCMH providers through facilitation of specialist referrals, expansion of telemedicine and assistance in achieving Tier 3 status
- HAN enrollment has increased rapidly as the HANs have added PCMH providers to their networks

HEALTH ACCESS NETWORKS *cont'd*

Overview - HAN Enrollment (all sites)

- HAN enrollment grew from 25,000 in July 2010 to nearly 117,000 in July 2014 before declining slightly to 115,000 in December 2014

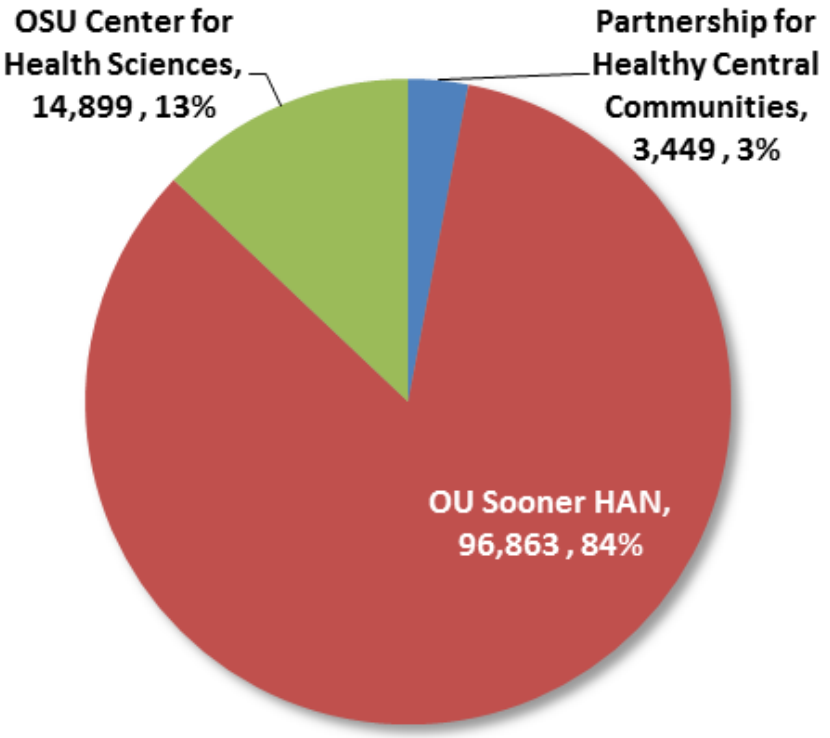


Source: OHCA HAN Total Summary Reports

HEALTH ACCESS NETWORKS *cont'd*

Overview - HAN Enrollment (by site)

- In December 2014, OU Sooner HAN accounted for approximately 84 percent of enrollment; OSU for 13 percent and Central Communities for the remaining three percent

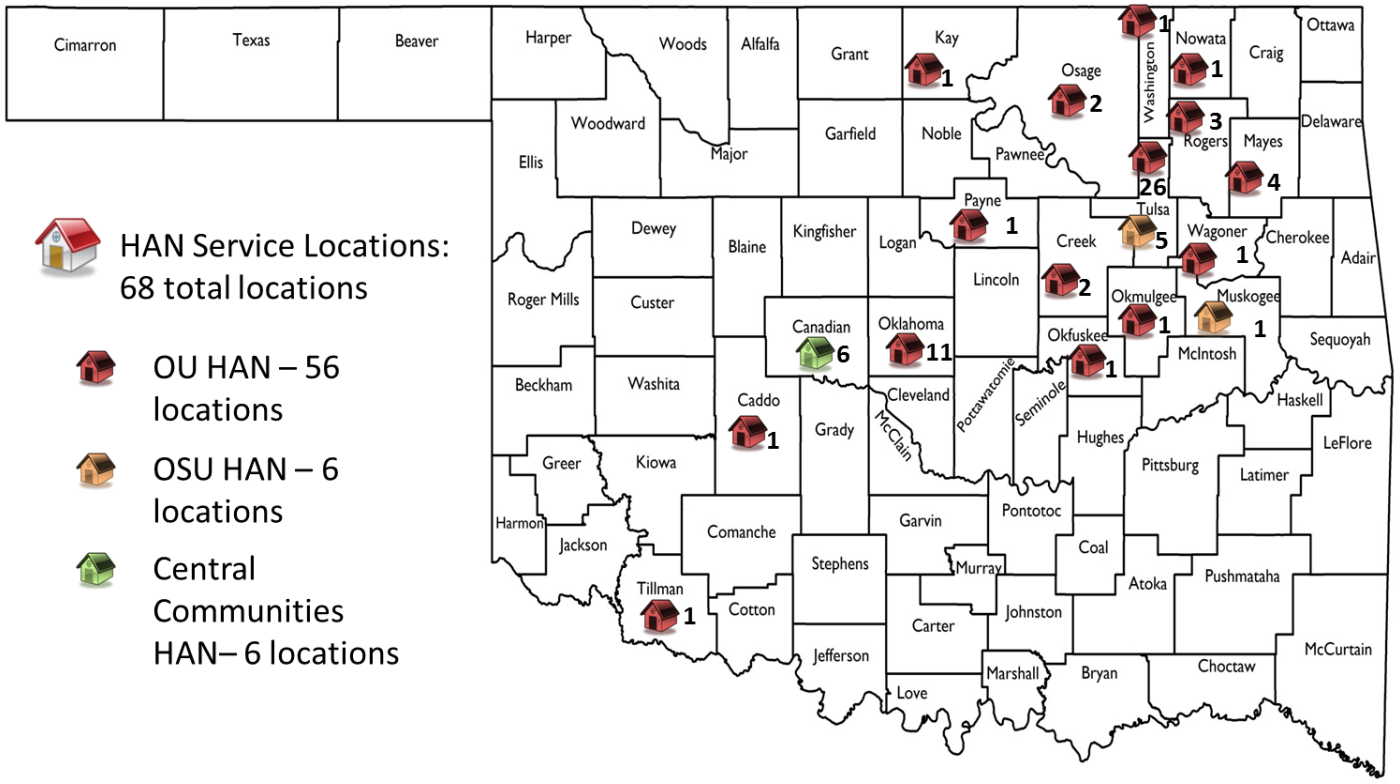


Source: OHCA HAN Total Summary Report – Dec 2014

HEALTH ACCESS NETWORKS *cont'd*

Overview - HAN Provider Sites

- In December 2014, there were 647 HAN-affiliated PCMH providers at 68 locations throughout the State



Source: OHCA

HEALTH ACCESS NETWORKS

Overview – Care Management

- The care management strategies of the three HANs have been tailored to their relative sizes and locations
- The contrast between Central Communities and OU demonstrates how the HAN principles can be advanced along different paths
- Central Communities HAN
  - 2014 staffing included RN Director, two part-time RN case managers and IT support (source: FY 2014 budget)
  - Local focus consistent with founding organization's (El Reno Clinic) service to the community
  - Referral assistance to solo/small group practices through a central database
  - Ensuring/verifying practice compliance with higher PCMH tiers
  - Person-centered care management through a small staff (made feasible due to the organization's small enrollment)
  - Possible role model for other rural communities interested in establishing a HAN

HEALTH ACCESS NETWORKS

Overview – Care Management

- OU Sooner HAN
  - Broad network encompassing OU clinics and affiliated providers
  - 2014 staffing included 40 FTEs, 20 of whom were devoted to care management/coordination and another 17 to associated clinical/quality-related activities (source: FY 2014 budget)
  - Formal care management structure process, including member assessment, education and care coordination carried out by a mix of RNs, Licensed Clinical Social Workers and support staff
  - Focused initiatives to improve primary care effectiveness, reduce ER use and raise provider productivity (e.g., Open Access Initiative)
  - Emphasis on technology to support care initiatives (e.g., Doc2Doc referral system and MyHealth electronic records/assessment platform)
  - Measurement of outcomes and incorporation of findings into quality improvement activities

Overview – Care Management

- OSU Center for Health Sciences
  - Has charted a middle course between the other two HAN's, in terms of staffing and use of technology (staffing is much closer to Central Communities than OU Sooner HAN, despite enrollment differences)
  - 2014 staffing included HAN administrator/case manager, second case manager and medical informatics analyst (source: FY 2014 budget)
  - Blend of direct and telephonic contact between care management and individual members
  - Recently increased care manager staff from one to two, which should enhance capacity to provide one-on-one assistance to members

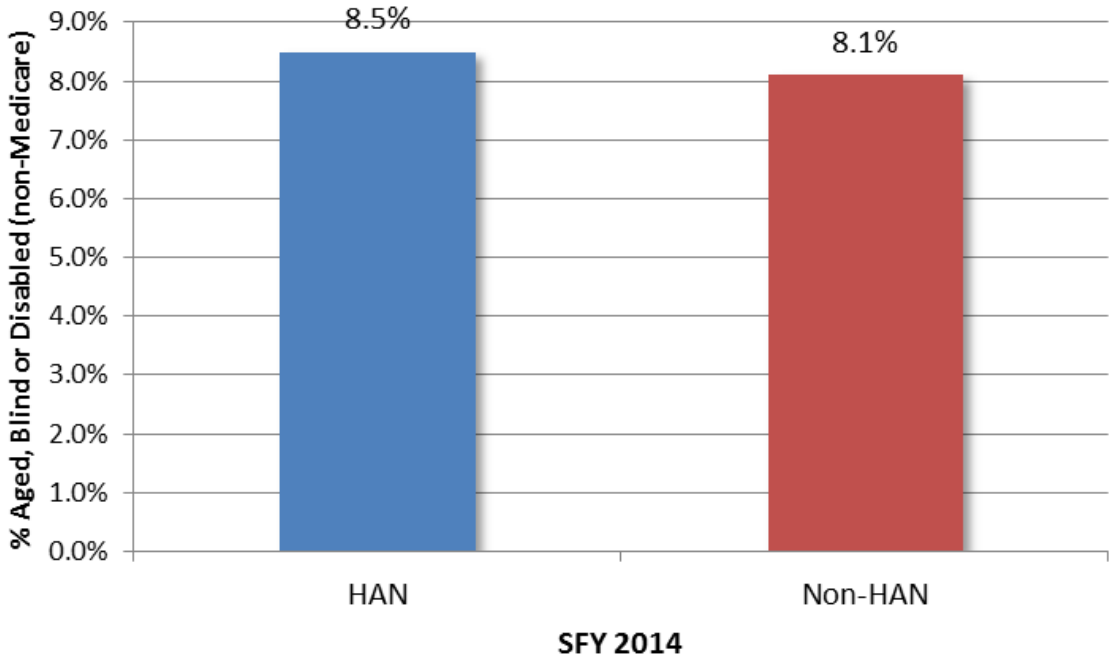
HAN Evaluation

- HAN activities and performance were originally evaluated in SFY 2013 through interviews with HAN managers, claims analysis and review of operational reports
- The evaluation also included a targeted analysis of the two largest target care management populations: frequent ER utilizers and high-risk OB (other groups were too small in number to evaluate separately)
- The claims analysis was updated for SFY 2014 and expanded to include a comparison of individual HAN performance

HEALTH ACCESS NETWORKS

HAN and non-HAN Member Mix

- The HAN network includes a slightly higher percentage of costly Aged, Blind and Disabled (ABD) members than the non-HAN PCMH community, although the gap has decreased as Medicaid and HAN enrollment have grown*



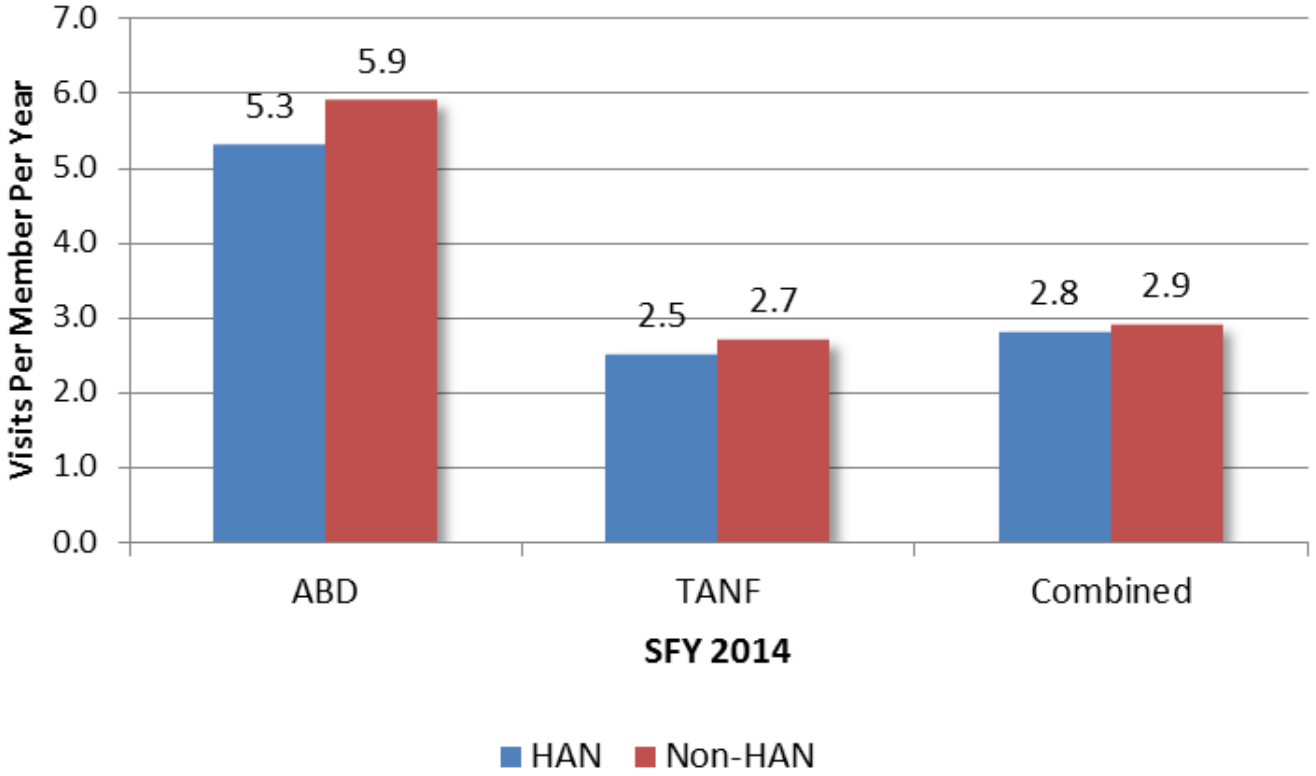
*SFY 2013 ABD percentages were 9.8 percent for HAN and 9.1 percent for non-HAN providers

Source: OHCA paid claims data

HEALTH ACCESS NETWORKS

HAN and non-HAN PCMH Visits

- Members affiliated with a HAN PCMH saw their provider at a slightly lower rate than other members

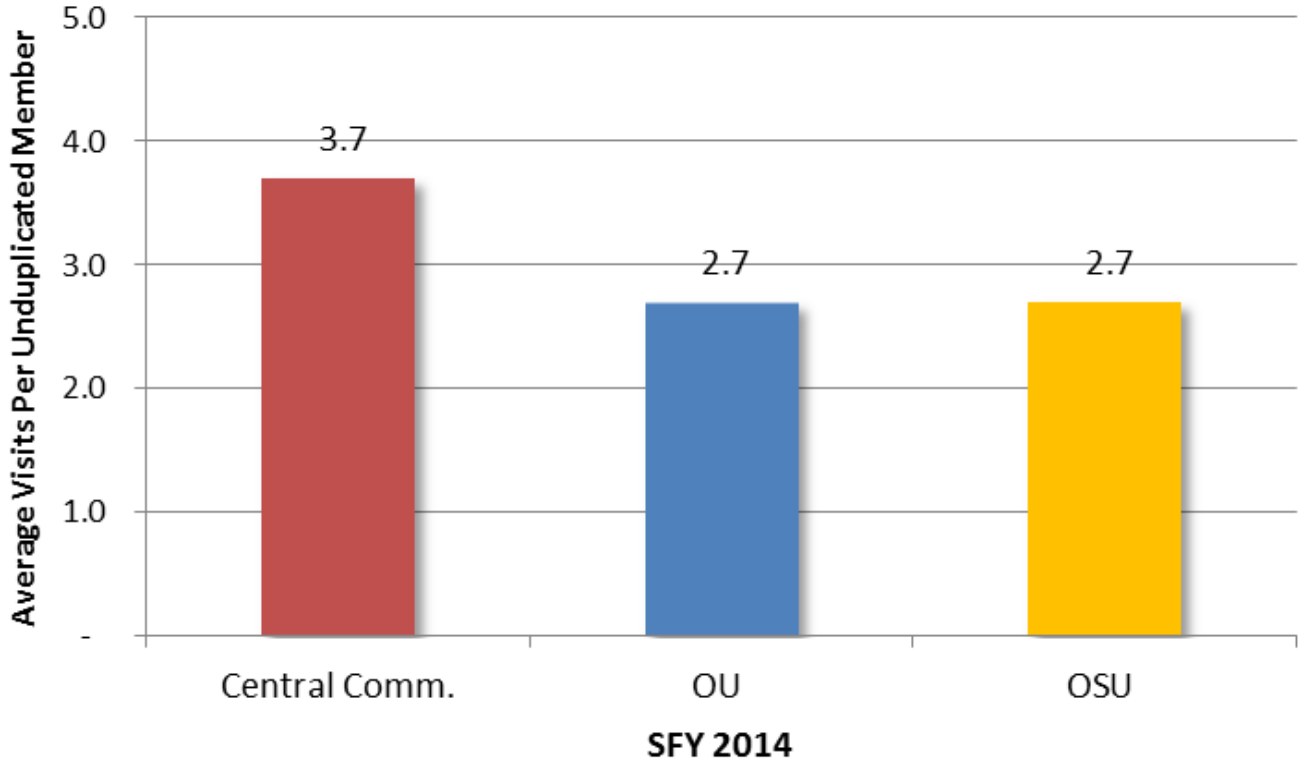


Source: OHCA paid claims data

HEALTH ACCESS NETWORKS

PCMH Visits by Organization

- Central Communities HAN recorded a significantly higher PCMH visit rate than the other two HANs

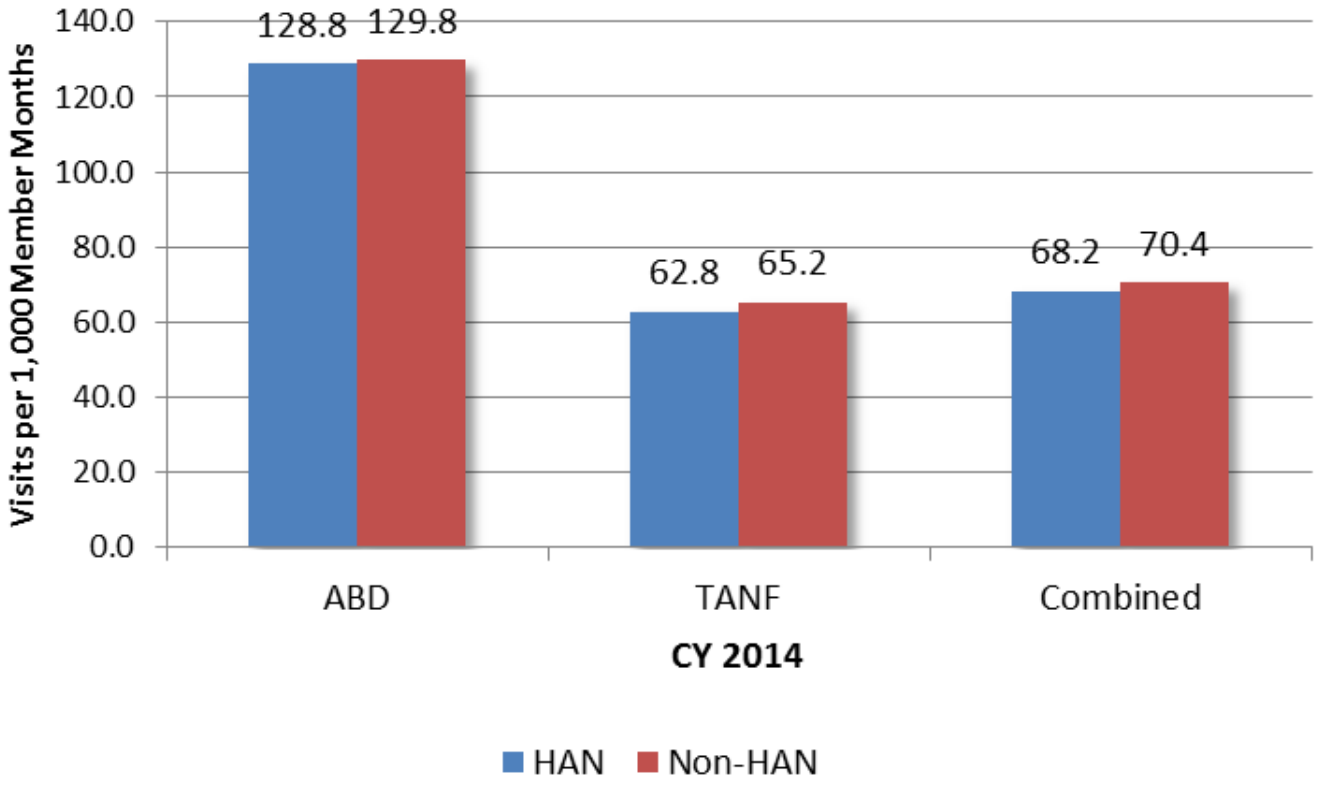


Source: OHCA paid claims data

HEALTH ACCESS NETWORKS

HAN and non-HAN ER Visits

- HAN members – both ABD and TANF – used the emergency room at a slightly lower rate than other members

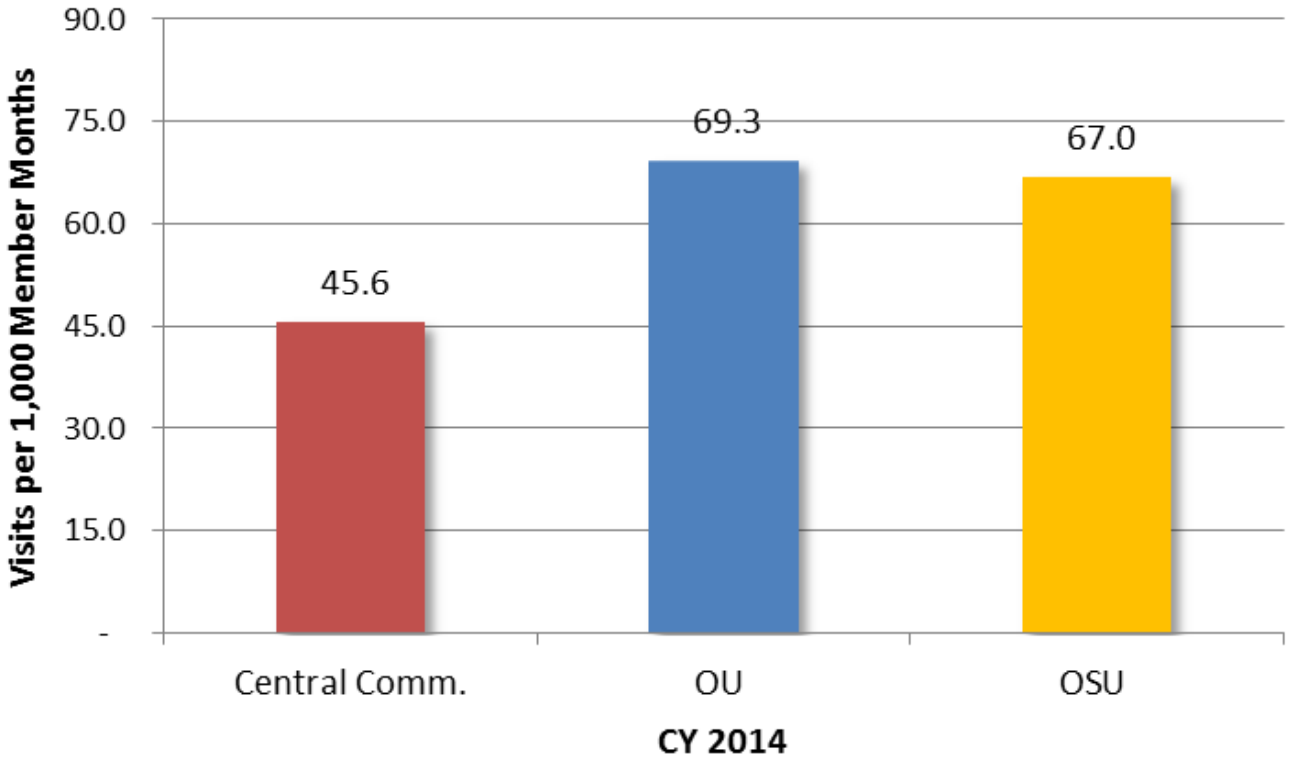


Source: OHCA paid claims data

HEALTH ACCESS NETWORKS

HAN ER Visits by Organization

- Central Communities HAN recorded a significantly lower ER use rate than the other HANs

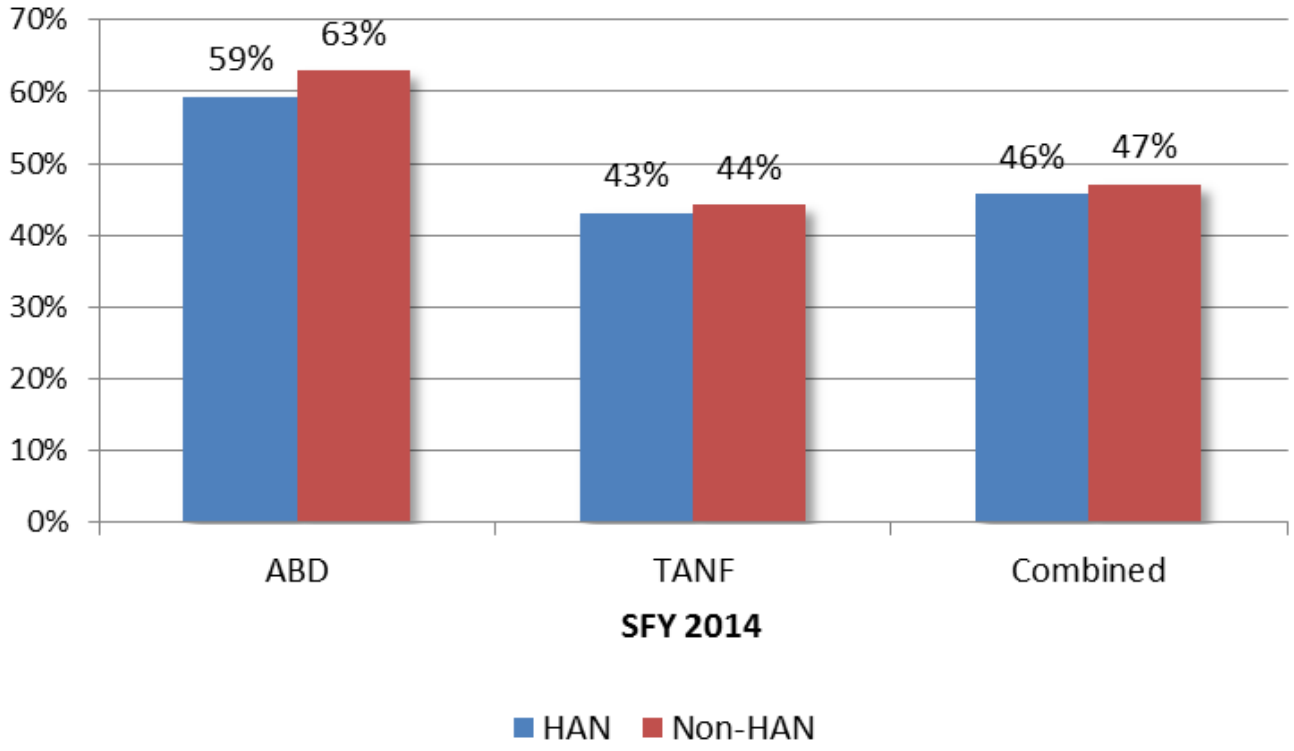


Source: OHCA paid claims data

HEALTH ACCESS NETWORKS *cont'd*

HAN and non-HAN – Post-ER Visit to PCMH

- HAN and non-HAN members were nearly equally likely to see their PCMH provider within 30 days of an ER visit

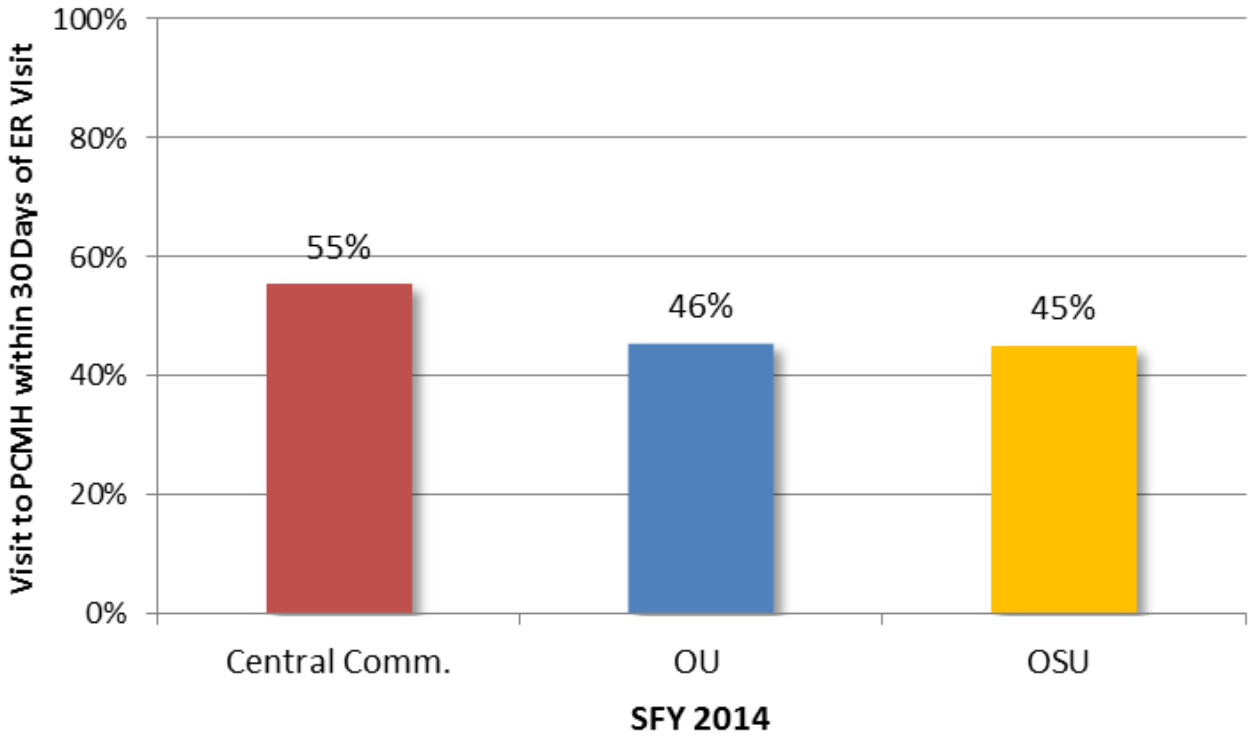


Source: OHCA paid claims data

HEALTH ACCESS NETWORKS

Post ER Visit to PCMH by Organization

- Central Communities HAN recorded a significantly higher post-ER PCMH visit rate than the other two HANs

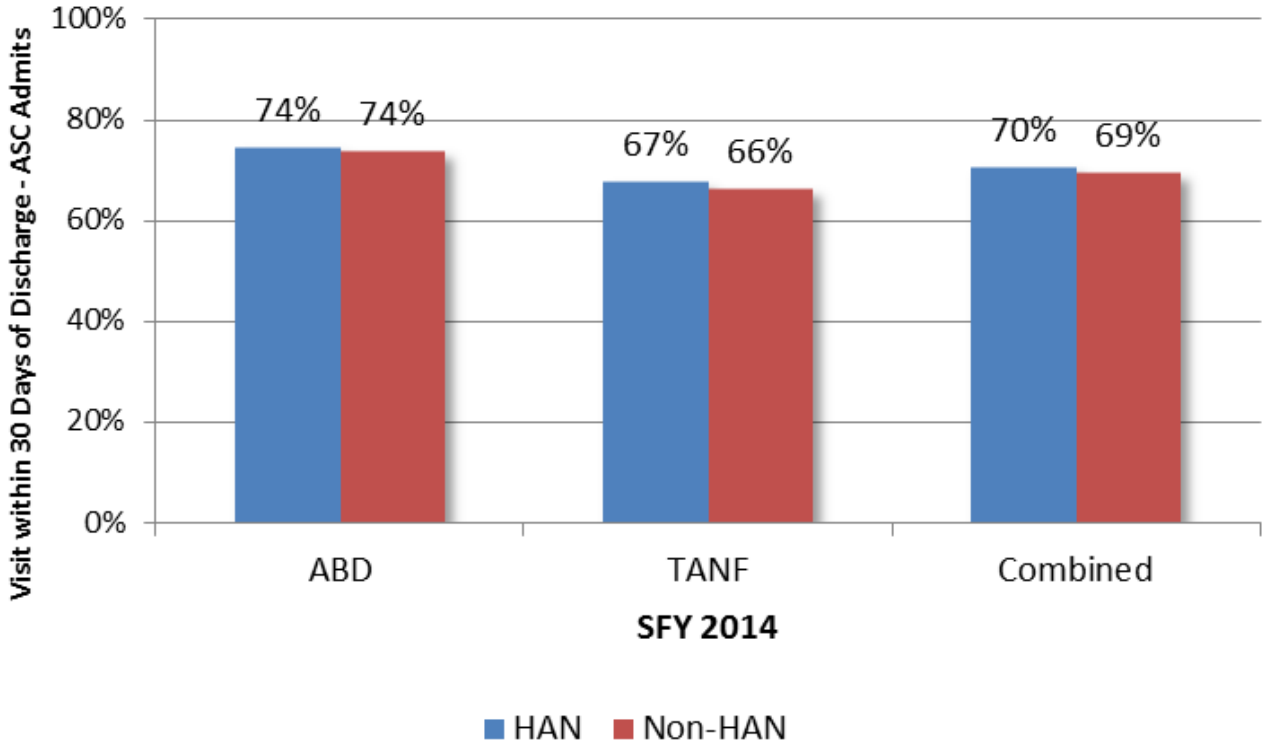


Source: OHCA paid claims data

HEALTH ACCESS NETWORKS *cont'd*

HAN and non-HAN – Post-Discharge Visit to PCMH

- HAN and non-HAN members were nearly equally likely to see their PCMH provider within 30 days of discharge (Ambulatory Sensitive Conditions)

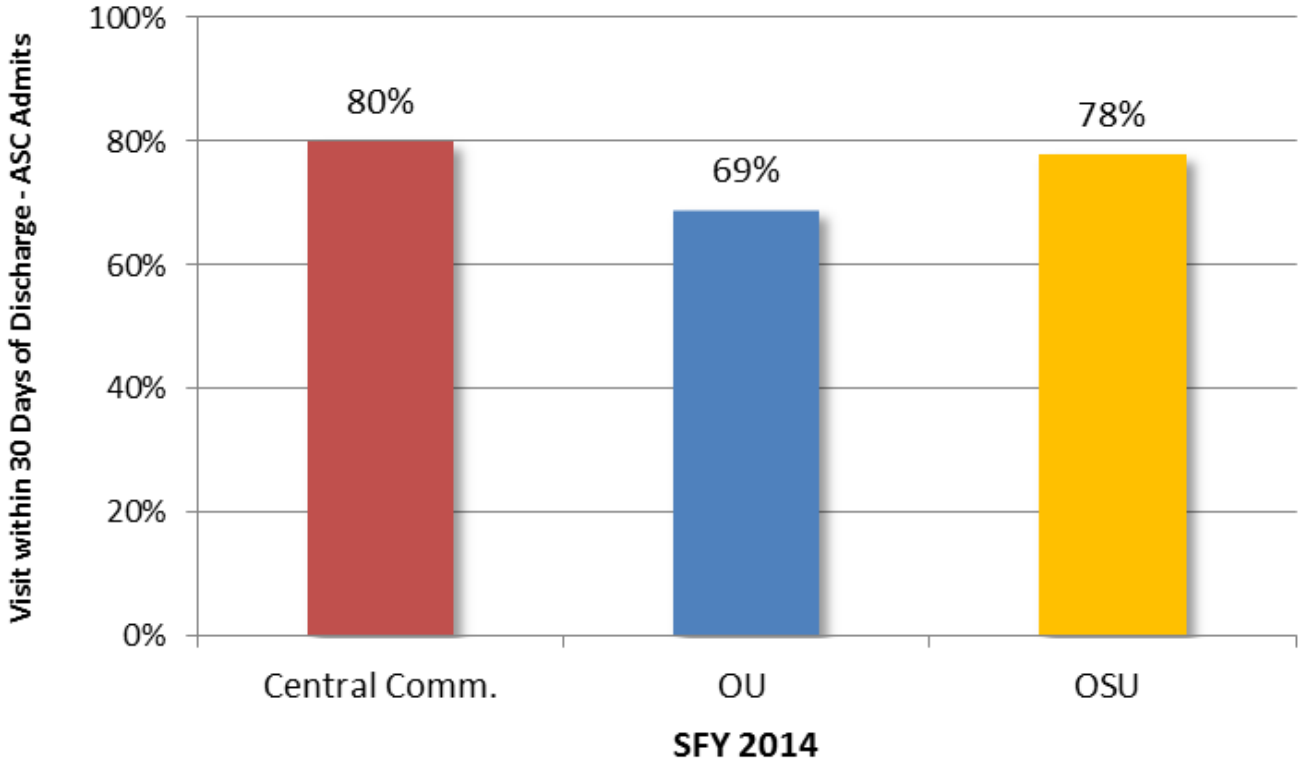


Source: OHCA paid claims data

HEALTH ACCESS NETWORKS

Post Discharge Visit to PCMH by Organization

- Central Communities HAN recorded a significantly higher post-discharge PCMH visit rate than OU Sooner HAN and a slightly higher rate than OSU

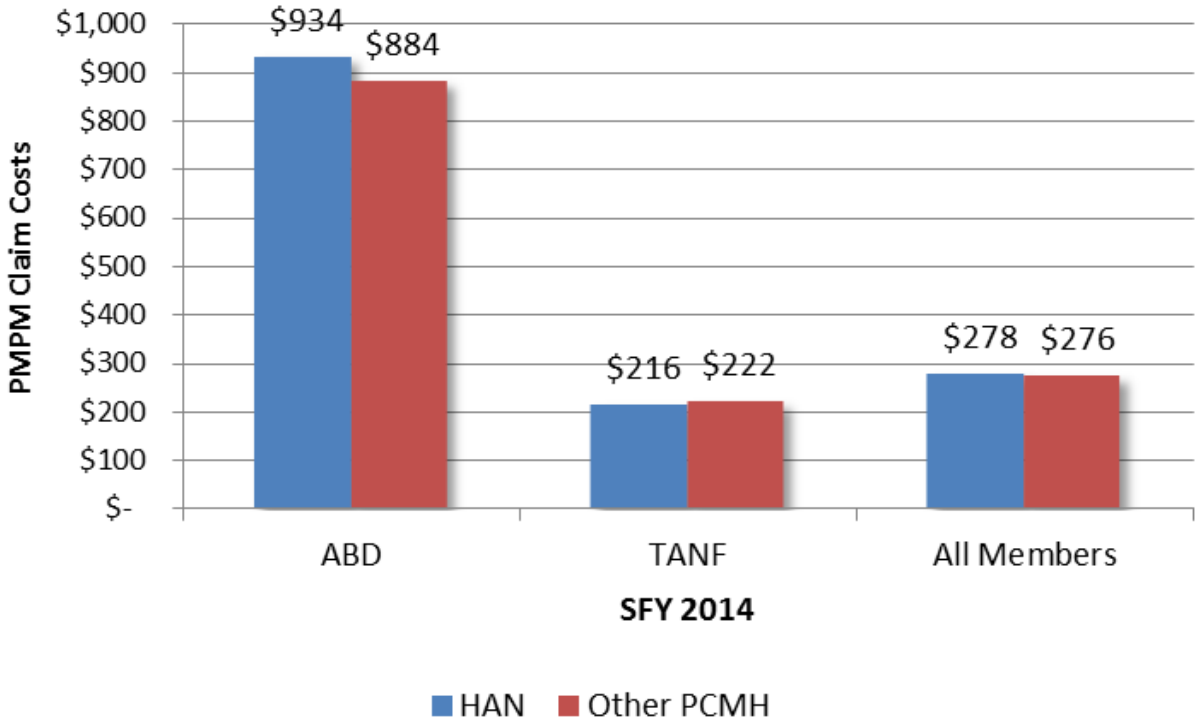


Source: OHCA paid claims data

HEALTH ACCESS NETWORKS *cont'd*

HAN and non-HAN PMPM Claim Costs

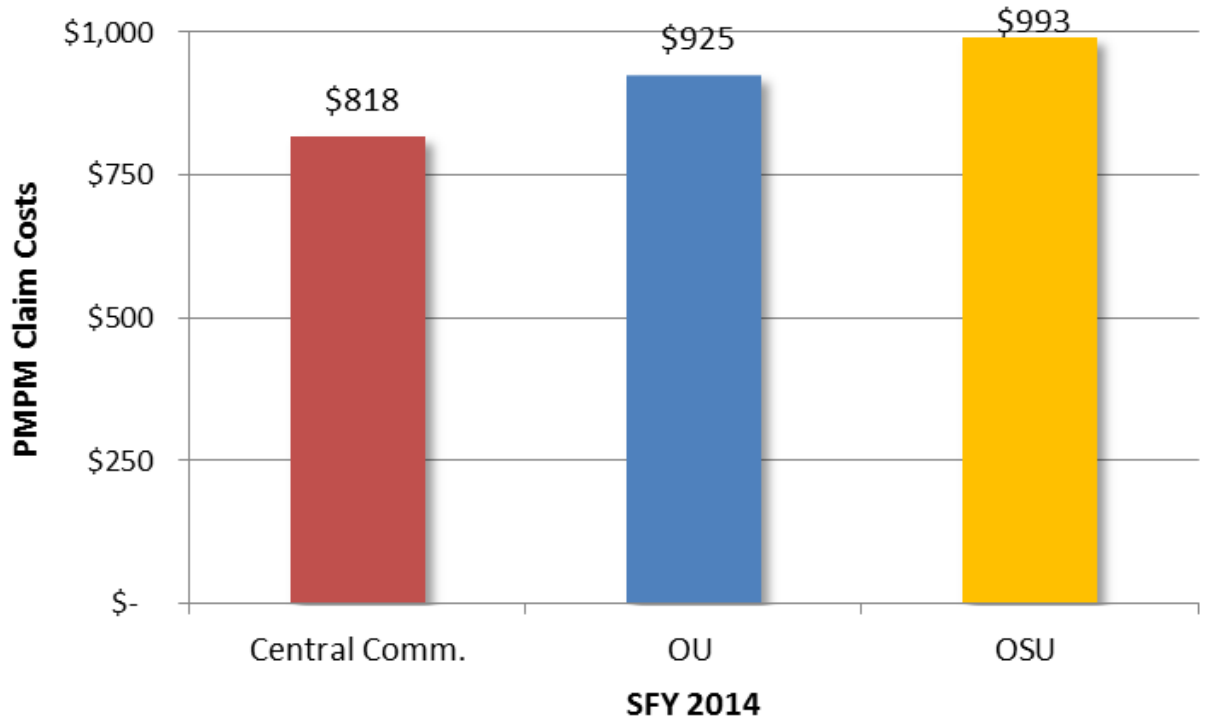
- HAN ABD members had moderately higher claim costs than their non-HAN counterparts in SFY 2014; overall PMPM costs (ABD and TANF) were almost identical



Source: OHCA paid claims data

HAN PMPM Claim Costs by Organization

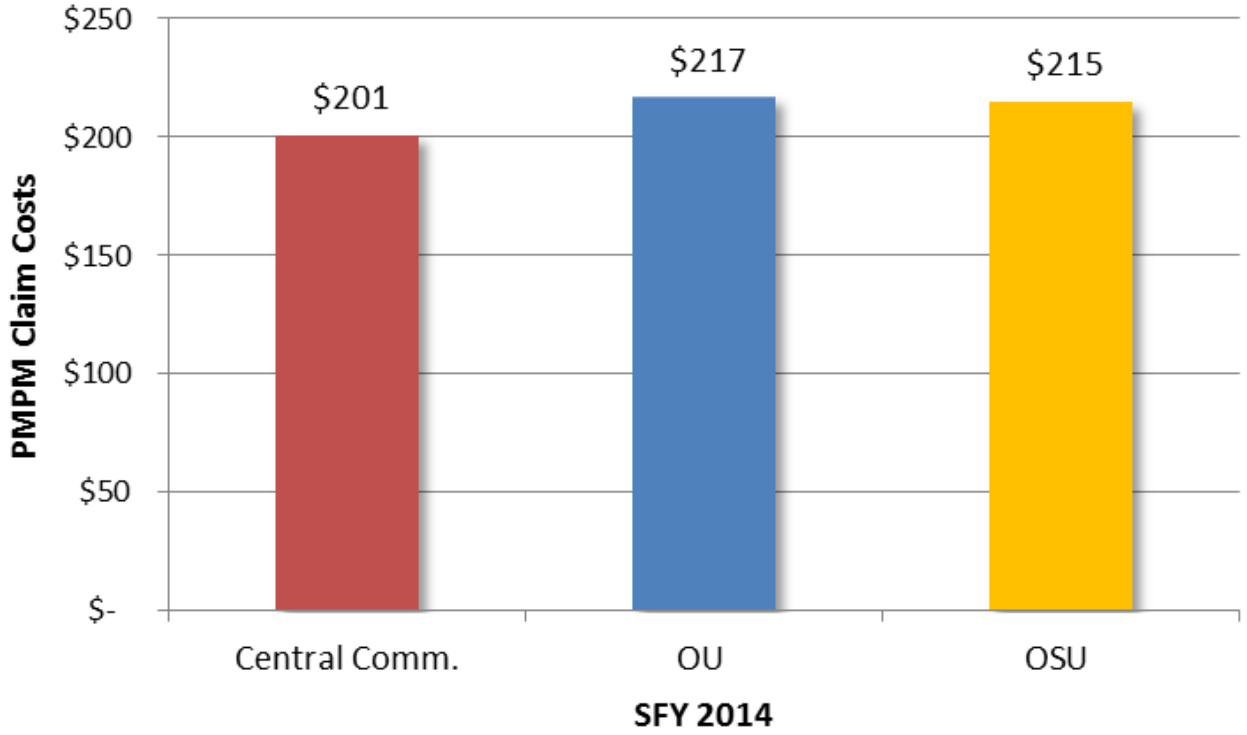
- Central Communities registered significantly lower PMPM claim costs for ABD members than the other two HANs



Source: OHCA paid claims data

HAN PMPM Claim Costs by Organization

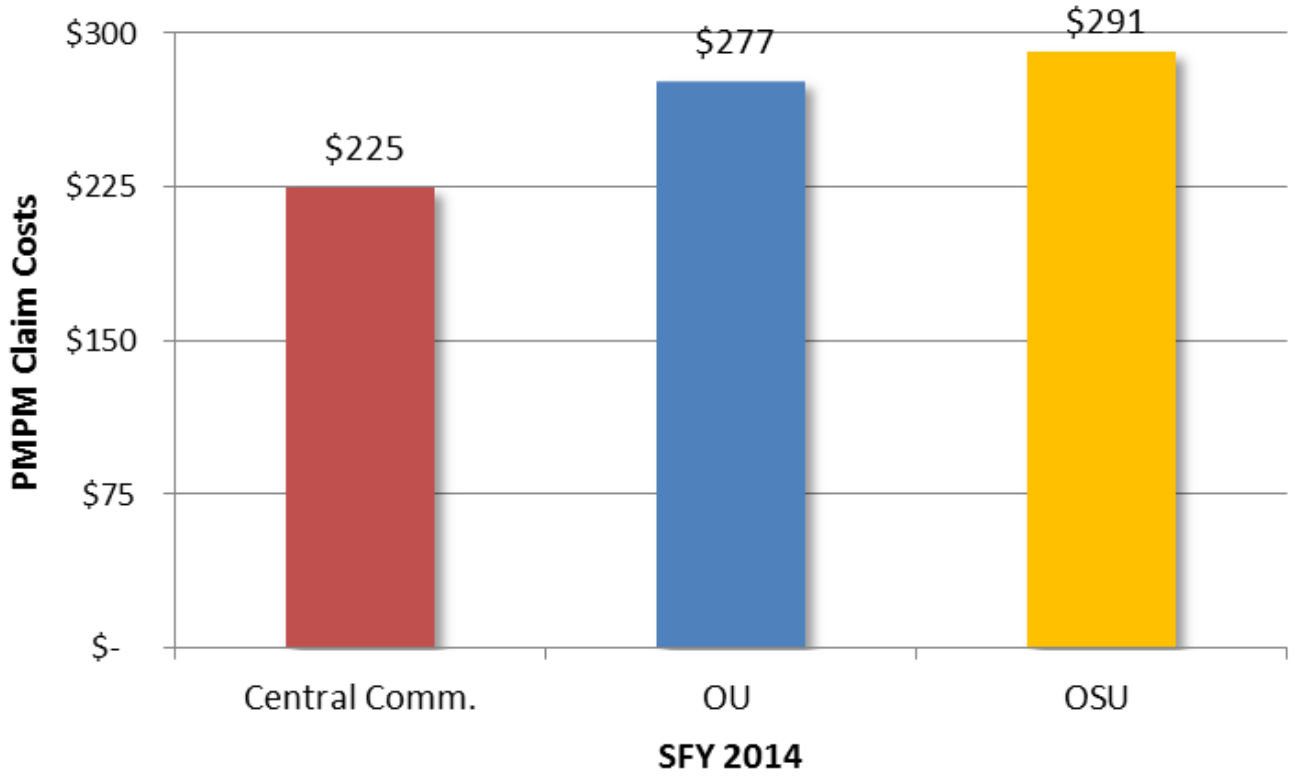
- Central Communities also registered significantly lower PMPM claim costs for TANF members



Source: OHCA paid claims data

HAN PMPM Claim Costs by Organization

- PMPM claim costs for all members (ABD and TANF)



Source: OHCA paid claims data

HAN Care Management – ER Utilizers

- The evaluation examined ER usage among 218 frequent utilizers enrolled by the HANs into care management
- HAN activities include:
  - Member follow-up, after inappropriate ER use
  - Ongoing member outreach and education
  - Requiring the member to use a designated PCMH provider ("PCMH Lock-in"), as a means of fostering a relationship and encouraging the member to seek non-emergent care outside of the ER

HEALTH ACCESS NETWORKS *cont'd*

Central Communities HAN Educational Materials for Frequent ER Cases

HEALTH ACCESS NETWORKS *cont'd*

HAN Care Management – Frequent ER Utilizers (SFY 2013)

- Evaluation compared the 12-month period prior to PCMH lock-in/care management to the subsequent 12 months
- ER utilization, while still high, declined in the second 12-month period
- Although members were not more likely to see their PCMH provider after a trip to the ER, the rate in both time periods significantly exceeded the 42 percent rate for the general HAN population

Measure	12 Months prior to PCMH Lock-in/Care Management	12 Months after PCMH Lock-in/Care Management
Average number of ER visits per member	10.8	8.8
Members with 6 or more visits	51.4%	22.0%
Members with zero ER visits (post-lock in)	--	40.8%
Members seeing PCMH within 30 days of ER visit	59.1%	56.5%

HEALTH ACCESS NETWORKS *cont'd*

HAN Care Management – High Risk OB (SFY 2013)

- Evaluation examined birth outcomes among 351 high risk OB members enrolled with a HAN-affiliated PCMH provider over the period SFY 2011 – SFY 2013
  - SFY 2011 – 5 cases
  - SFY 2012 – 85 cases
  - SFY 2013 – 261 cases
- Because of the relatively small number of cases prior to SFY 2013, the three years were evaluated together; the resulting baseline data can be tracked over time
- HAN activities for the high risk OB population include assisting expectant mothers to obtain appropriate prenatal services and prepare for the birth of the child, as well as linking newborns to a pediatrician
- The HANs often face a significant challenge in reaching high risk OB members because many have a relationship with a prenatal care provider rather than their PCMH

HEALTH ACCESS NETWORKS *cont'd*

HAN Care Management – High Risk OB Outcomes

- The evaluation examined outcomes by state fiscal year and overall for SFY 2011 – SFY 2013
- Although data is presented by year, the three-year average should serve as a combined baseline

Measure (Premature Births)	SFY 2011	SFY 2012	SFY 2013	Average (Baseline)
Total cases	5	85	261	**351**
# premature births	3	46	127	**176**
% premature births	60.0%	54.1%	48.7%	**50.1%**
% of premature births w/NICU stay	66.7%	30.4%	43.3%	**40.3%**
% readmission w/in 30 days of IP stay - premature	66.7%	28.3%	20.5%	**23.3%**
Average # of ER visits – premature birth	5.3	2.2	2.2	**2.3**
Average cost per case – premature birth	$25,447	$20,509	$22,850	**$22,282**

HEALTH ACCESS NETWORKS *cont'd*

HAN Care Management – High Risk OB Outcomes

- The evaluation examined outcomes by state fiscal year and overall for SFY 2011 – SFY 2013
- Although data is presented by year, the three-year average should serve as a combined baseline

Measure (Full-Term Births)	SFY 2011	SFY 2012	SFY 2013	Average (Baseline)
Total cases	5	85	261	**351**
# full-term births	2	39	134	**175**
% full-term births	40.0%	45.9%	52.3%	**49.9%**
% of full-term births w/NICU stay	--	--	1.5%	**1.1%**
% readmission w/in 30 days of IP stay – full-term	--	15.4%	14.2%	**14.3%**
Average # of ER visits – full-term birth	2.0	1.7	1.6	**1.6**
Average cost per case – full-term birth	$13,396	$12,758	$11,977	**$12,167**

HEALTH ACCESS NETWORKS *cont'd*

HAN Impact

- The Health Access Networks serve a slightly higher risk population than the general PCMH provider community
- The HANs are obligated to perform more care management activities, while also offering support to their PCMH networks
- To date, the HANs have performed these additional activities at approximately the same claim cost, and for a modest administrative fee
- Central Communities HAN has demonstrated the strongest performance, suggesting that the grassroots model may be a promising template for other rural parts of the State
- The OHCA is in the process of clarifying and enhancing the contractual standards for the HANs; any enhancements should be made in the context of advancing value based purchasing, as discussed later in the presentation

SOONERCARE CHOICE EVALUATION

SoonerCare Choice Overview

SoonerCare Choice Performance

Impact of Recent OHCA Initiatives

Comparison to Benchmark States

SOONERCARE CHOICE EVALUATION

Comparison to Benchmark States

- Arizona
- Florida

COMPARISON TO BENCHMARK STATES

Managed Care Organization (MCO) Model

- The majority of states introducing or expanding managed care have done so through MCO contracts
- Two "benchmark" states with MCO models were selected for comparison to the SoonerCare Choice program
- Arizona operates the nation's oldest fully-capitated MCO program for Medicaid beneficiaries
- Florida recently expanded a five-county "pilot" MCO program started in 2005 to cover the entire state
- The Pacific Health Policy Group has served as a consultant both to Arizona Medicaid and the Florida Legislature

COMPARISON TO BENCHMARK STATES *cont'd*

Arizona Health Care Cost Containment System (AHCCCS)

- AHCCCS program was implemented in 1982
- Nearly all Medicaid members are enrolled in managed care organizations (including Medicare/Medicaid dual eligibles and long term care recipients residing in nursing facilities or receiving in-home care)
- Total program enrollment in September 2014 was 1.6 million
- Total program expenditures in SFY 2014 were budgeted at $6.7 billion

COMPARISON TO BENCHMARK STATES *cont'd*

Florida Managed Care Demonstration

- Florida introduced a "demonstration" MCO program in five counties in 2005, including Broward (Ft Lauderdale) and Duval (Jacksonville)
- The "demonstration" program was expanded statewide in 2013 – 2014 and now covers the great majority of Medicaid beneficiaries, including dual eligibles and long term care recipients
- Total MCO enrollment in December 2014 was 2.8 million (3.7 million for entire program)
- Total program expenditures in SFY 2014 exceeded $22 billion

COMPARISON TO BENCHMARK STATES *cont'd*

SoonerCare Program

- SoonerCare was implemented in 1995
- SoonerCare Choice members are enrolled in patient centered medical homes, a portion of which are affiliated with Health Access Networks
- Total SCC enrollment in December 2014 was 540,000
- Total OHCA expenditures (SCC and other) in SFY 2014 were approximately $5.2 billion

COMPARISON TO BENCHMARK STATES *cont'd*

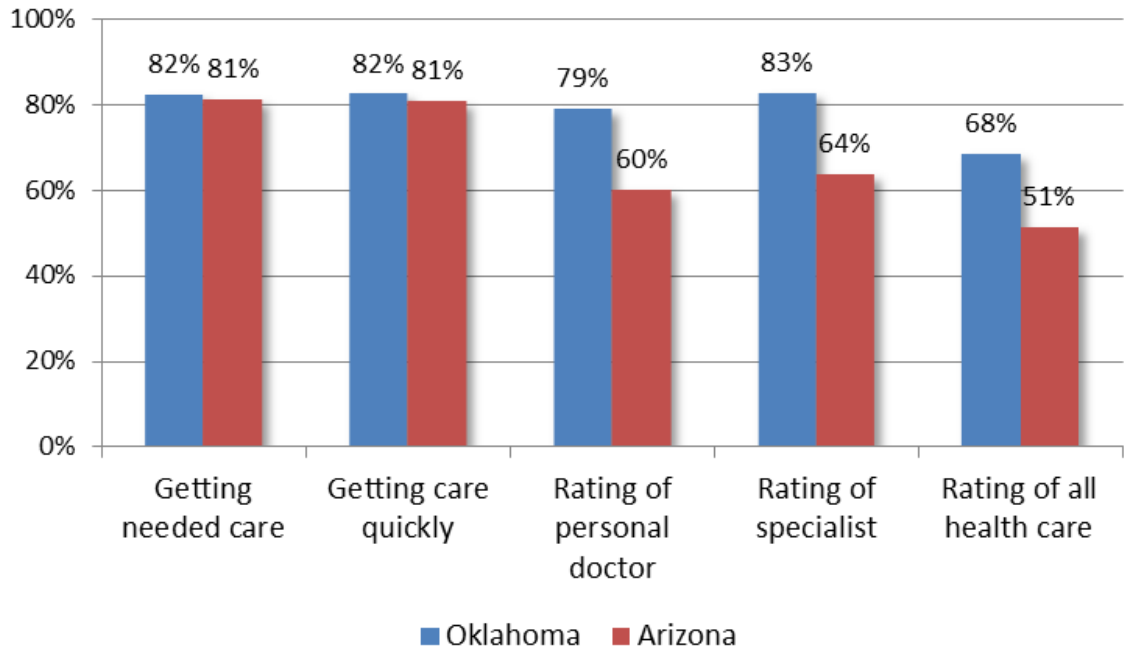
Analysis Approach

- Program performance was compared with respect to:
  - Access
  - Quality and Outcomes
  - Cost
- The scope of the analysis of the limited to the most current available and comparable data across the states
- Florida data is for the portion of the state enrolled in the demonstration program starting in 2005 (approximately 400,000 enrollees)
- In some instances, reporting time periods do not precisely align across states
- Make-up of managed care enrolled populations also differs across states, as noted on previous slides

COMPARISON TO BENCHMARK - ARIZONA

ACCESS TO CARE - Satisfaction among Adults*

- SoonerCare Choice and AHCCCS members report comparable (and high) levels of satisfaction with getting needed care and getting care quickly
- SoonerCare Choice members are significantly more satisfied with their personal doctor, specialist (if applicable) and overall health care

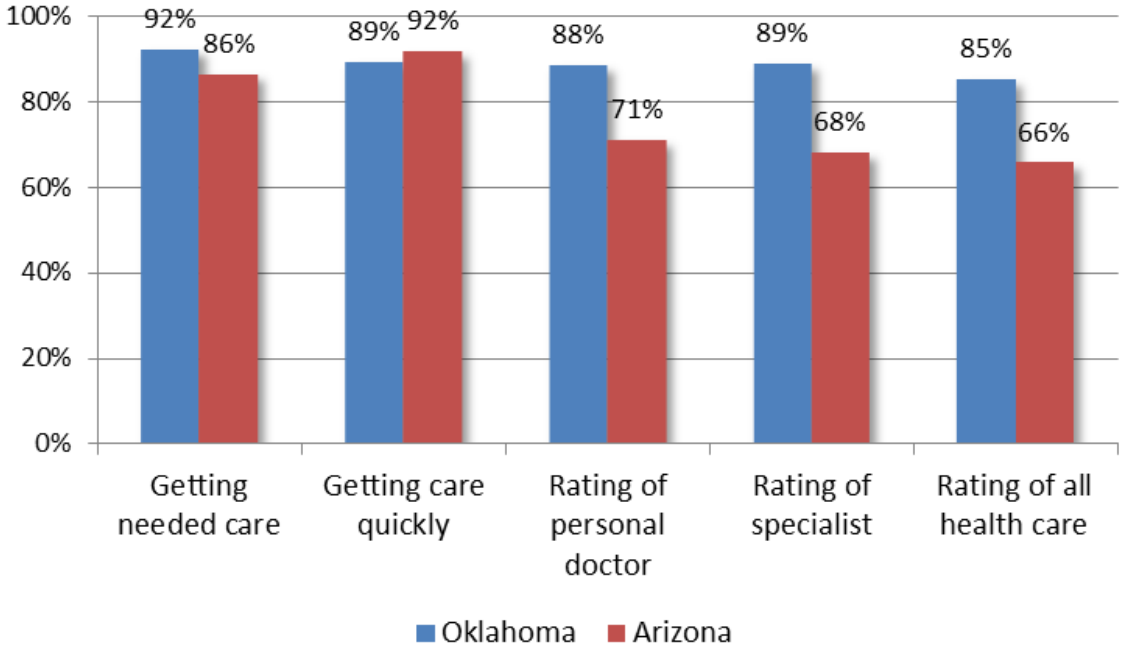


*Note: Percent rating "always" or "usually" for Getting Needed Care and Getting Care Quickly; percent rating 8, 9 or 10 on a 10-point satisfaction scale for other measures
Sources: Oklahoma CAHPS 2014 Health Plan Survey Adult Version; Arizona CAHPS 2013 Health Plan Survey Adult Version

COMPARISON TO BENCHMARK – ARIZONA *cont'd*

ACCESS TO CARE - Satisfaction with Care for Children*

- Parents/guardians of SoonerCare Choice and AHCCCS child members again report comparable levels of satisfaction with getting needed care and getting care quickly
- SoonerCare Choice parents/guardians again are significantly more satisfied with their child's personal doctor, specialist (if applicable) and overall health care

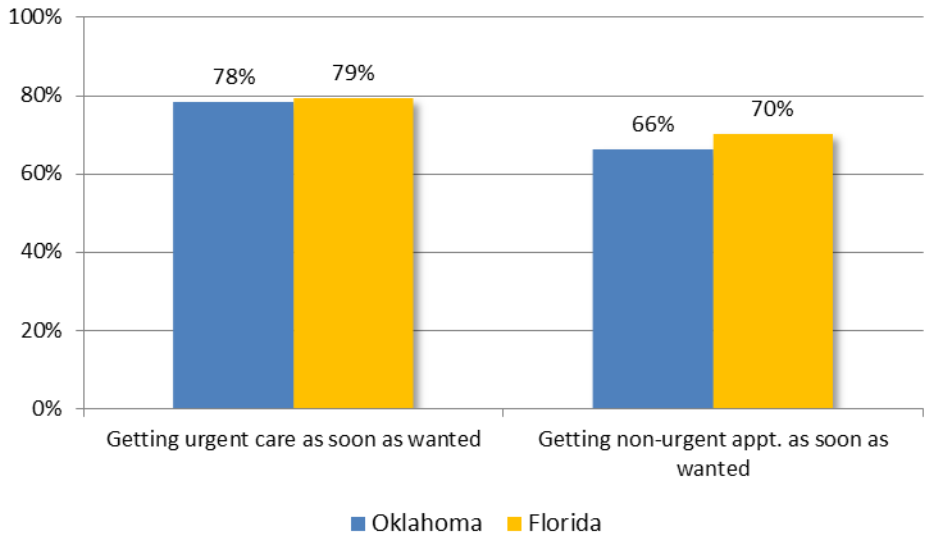


*Note: Percent rating "always" or "usually" for Getting Needed Care and Getting Care Quickly; percent rating 8, 9 or 10 on a 10-point satisfaction scale for other measures
Sources: Oklahoma CAHPS 2014 Health Plan Survey Child Version – CHIP Population; Arizona CAHPS 2013 Health Plan Survey Child Version – KidsCare (CHIP) Population

COMPARISON TO BENCHMARK - FLORIDA

ACCESS TO CARE - Satisfaction*

- SoonerCare Choice and Florida demonstration MCO members report comparable (and high) levels of satisfaction with getting urgent care as soon as wanted
- Satisfaction with access to routine care also is comparable and relatively high (percentage reflects those saying they "always" get appointment as soon as wanted)

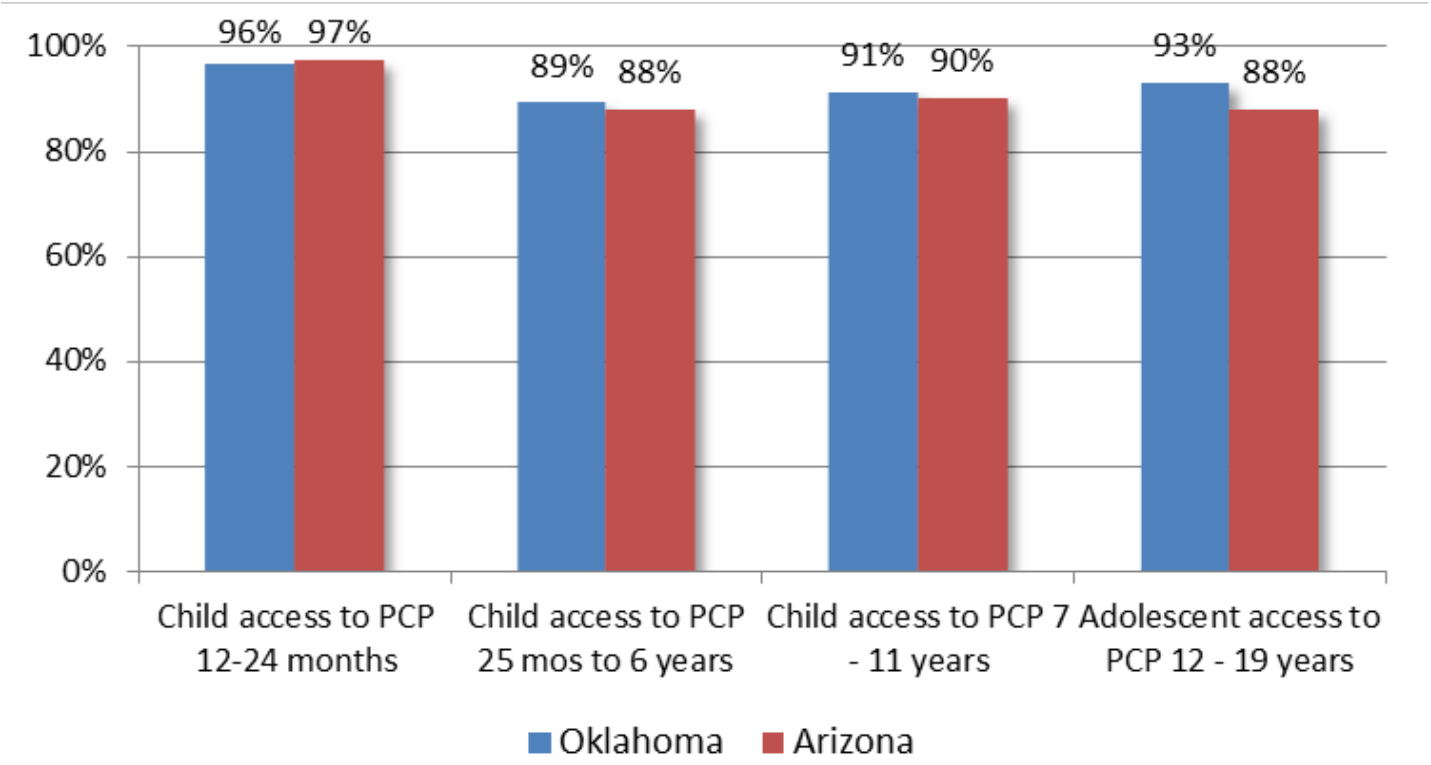


*Note: Percent saying "always"
Sources: Oklahoma CAHPS 2014 Health Plan Survey Child Version; Florida CAHPS data taken from SFY 2014 Demonstration Annual Report – represents children and adults

COMPARISON TO BENCHMARK – ARIZONA *cont'd*

ACCESS TO CARE – HEDIS Measures for Children/Adolescents

- SoonerCare Choice and AHCCCS HEDIS measures both show high levels of access to PCPs among children and adolescents

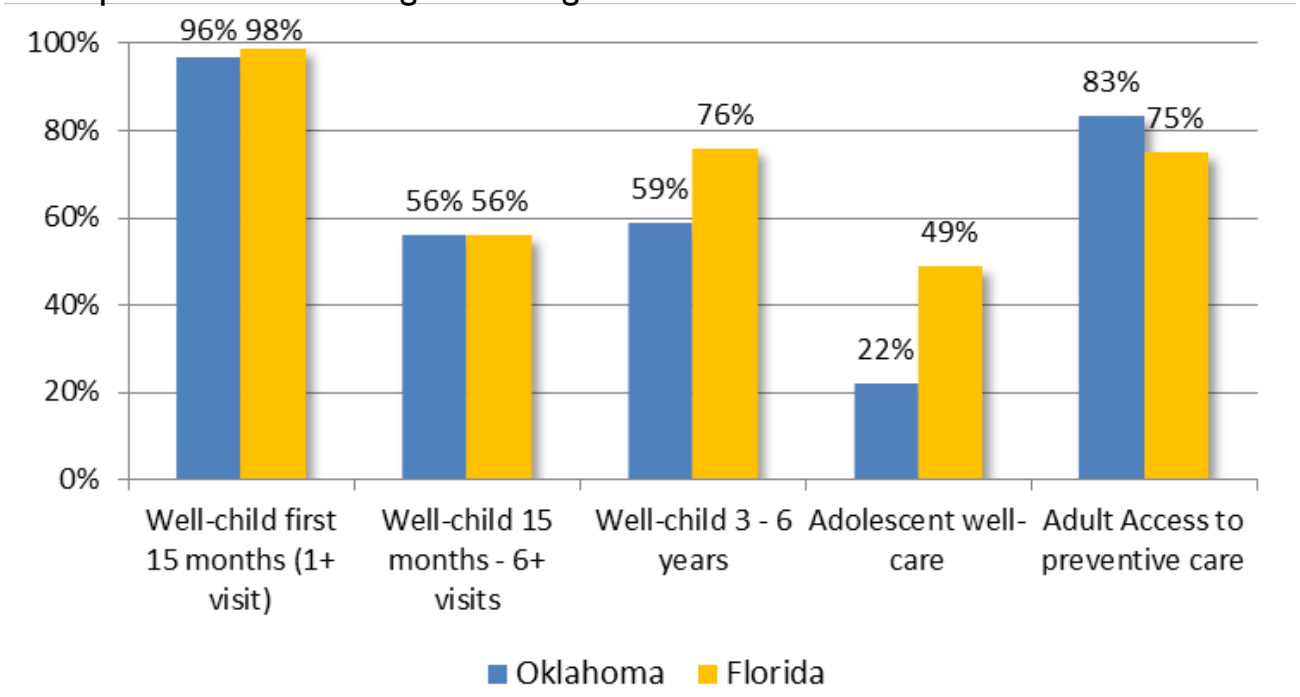


Sources: Oklahoma Health Care Authority and AHCCCS 2012-13 EQRO Annual Report for Acute Care and DES/CMDP Contractors (April 2014)

COMPARISON TO BENCHMARK – FLORIDA *cont'd*

ACCESS TO CARE – HEDIS Measures for Children/Adolescents & Adults

- Florida publishes child and adolescent well-care visit measures, rather than PCP access measures
- SoonerCare Choice and Florida Demonstration enrollees show comparable well-care rates among children at 15 months; Florida's rate is higher among older children and adolescents (Florida has made a concerted effort to increase school-based service capacity as part of its adolescent well-care strategy)
- Adult access to preventive care is higher among SoonerCare Choice members

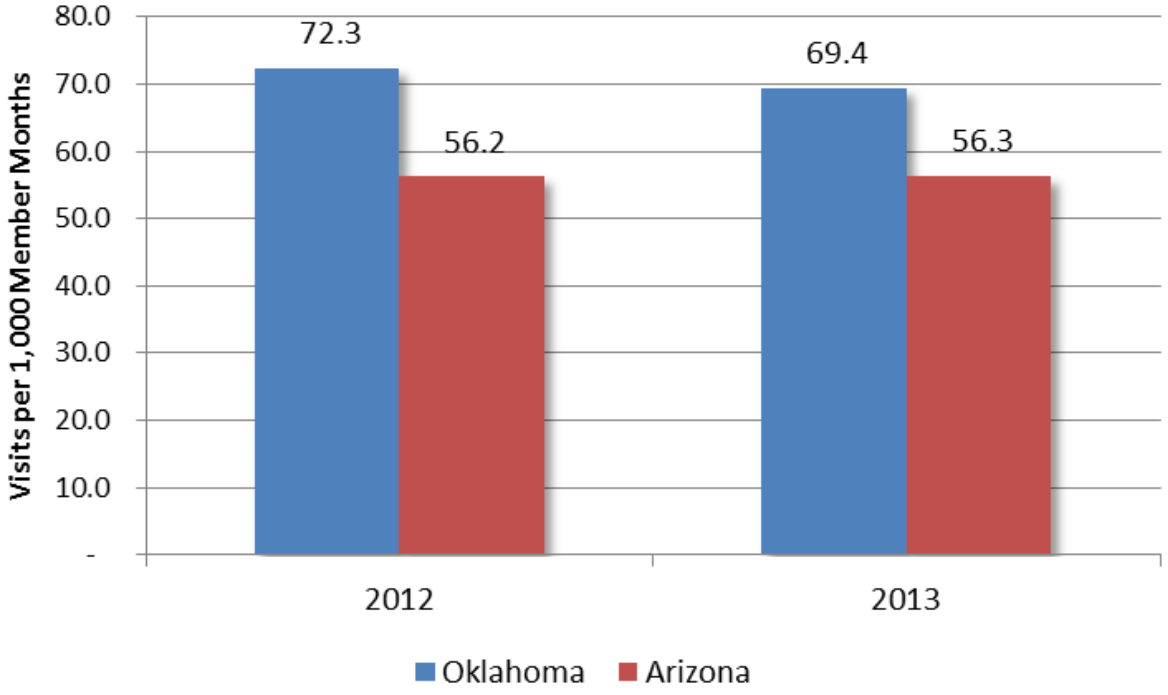


Sources: Oklahoma Health Care Authority and Florida Demonstration SFY 2014 Annual Report

COMPARISON TO BENCHMARK – ARIZONA *cont'd*

ACCESS TO CARE – ER Utilization*

- AHCCCS has achieved a lower ER utilization rate than SoonerCare Choice, although the rate did not decline in the two years for which data has been published (Florida has not published ER utilization data for the Demonstration program)
- AHCCCS requires its MCOs to enroll high utilizers into case management and to coordinate ER use reduction strategies with the separate entities responsible for delivery of behavioral health services



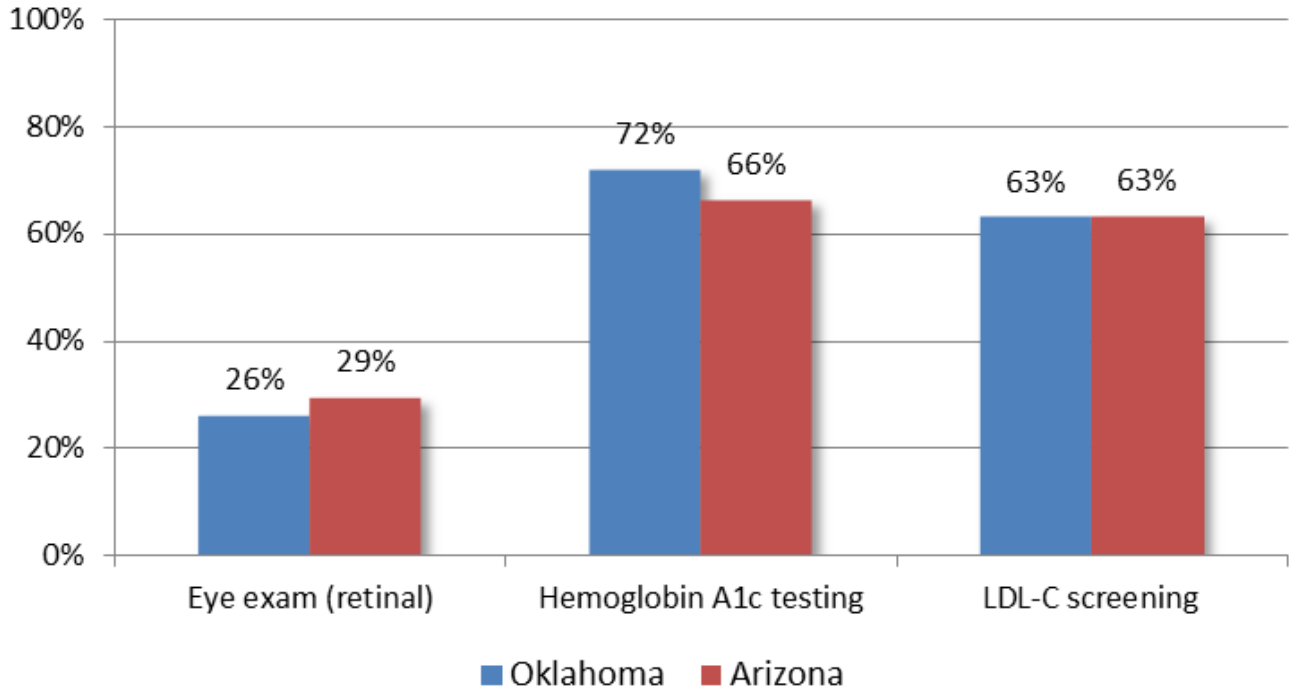
Note: Oklahoma data is calendar year; Arizona data is state fiscal year

Sources: Oklahoma Paid Claims; AHCCCS Report to the Directors of the Governor's Office of Strategic Planning and Budgeting and the Joint Legislative Budget Committee Regarding ED Utilization (December 2014)

COMPARISON TO BENCHMARK – ARIZONA *cont'd*

QUALITY OF CARE – Adult Comprehensive Diabetes Care

- SoonerCare Choice members have lower adult comprehensive diabetes care rates than their AHCCCS counterparts

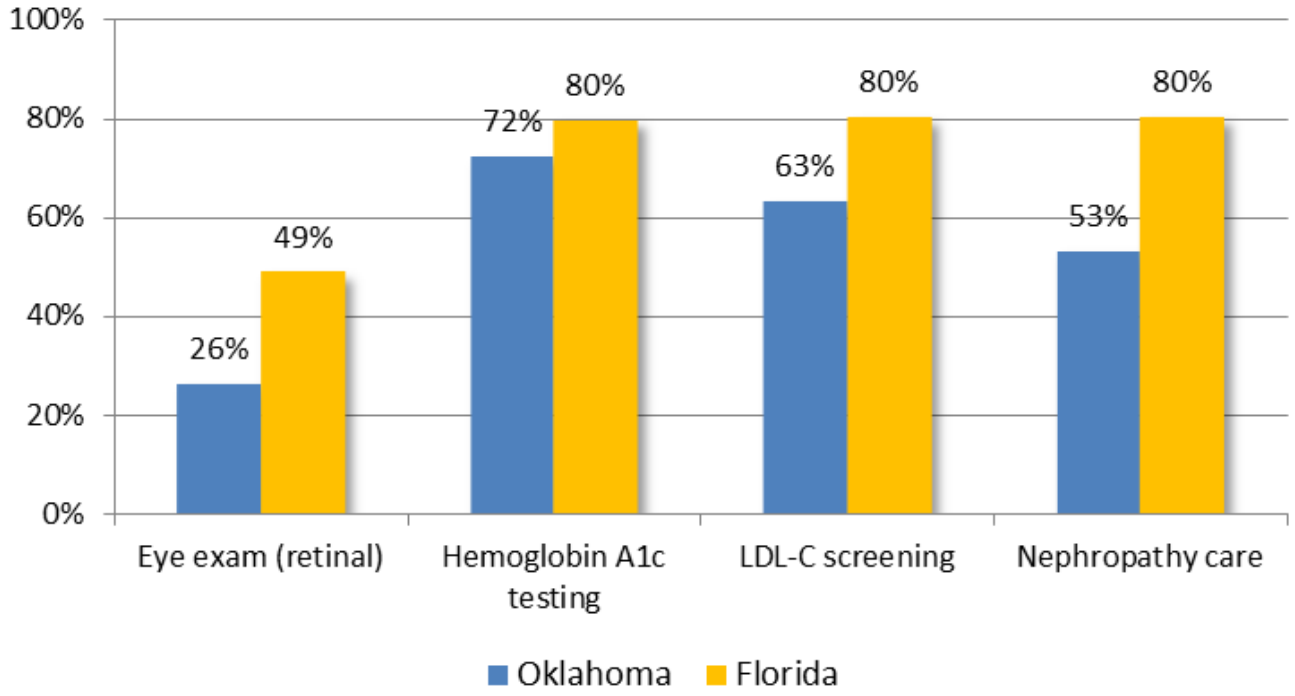


Sources: Oklahoma Health Care Authority and Arizona 2010 – 2011 External Quality Review Annual Report (June 2012)

COMPARISON TO BENCHMARK – FLORIDA *cont'd*

QUALITY OF CARE – Adult Comprehensive Diabetes Care

- SoonerCare Choice members have lower adult comprehensive diabetes care rates than their Florida counterparts for three of four measures

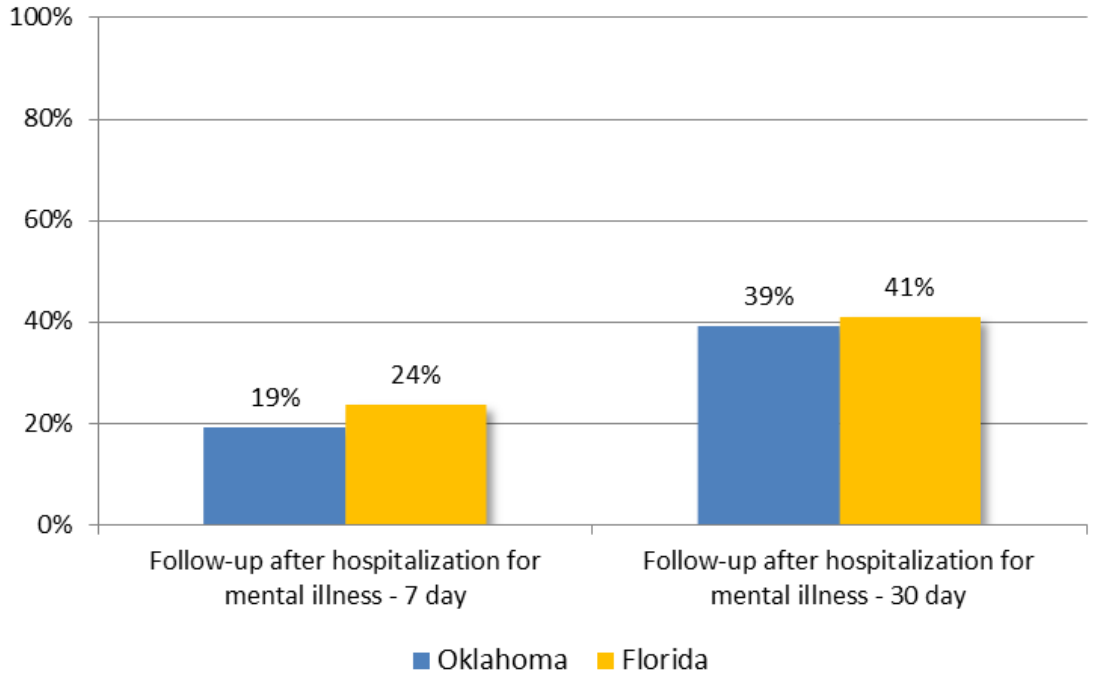


Sources: Oklahoma Health Care Authority and Florida Demonstration SFY 2014 Annual Report

COMPARISON TO BENCHMARK – FLORIDA *cont'd*

QUALITY OF CARE – Follow-up after Hospitalization for Mental Illness

- SoonerCare Choice members hospitalized for a mental illness are slightly more likely than Florida Demonstration members to receive follow-up care following discharge
- The SoonerCare Choice rate is higher at both the 7-day and 30-day milestones, although the 30-day rate for both programs is still below 50 percent

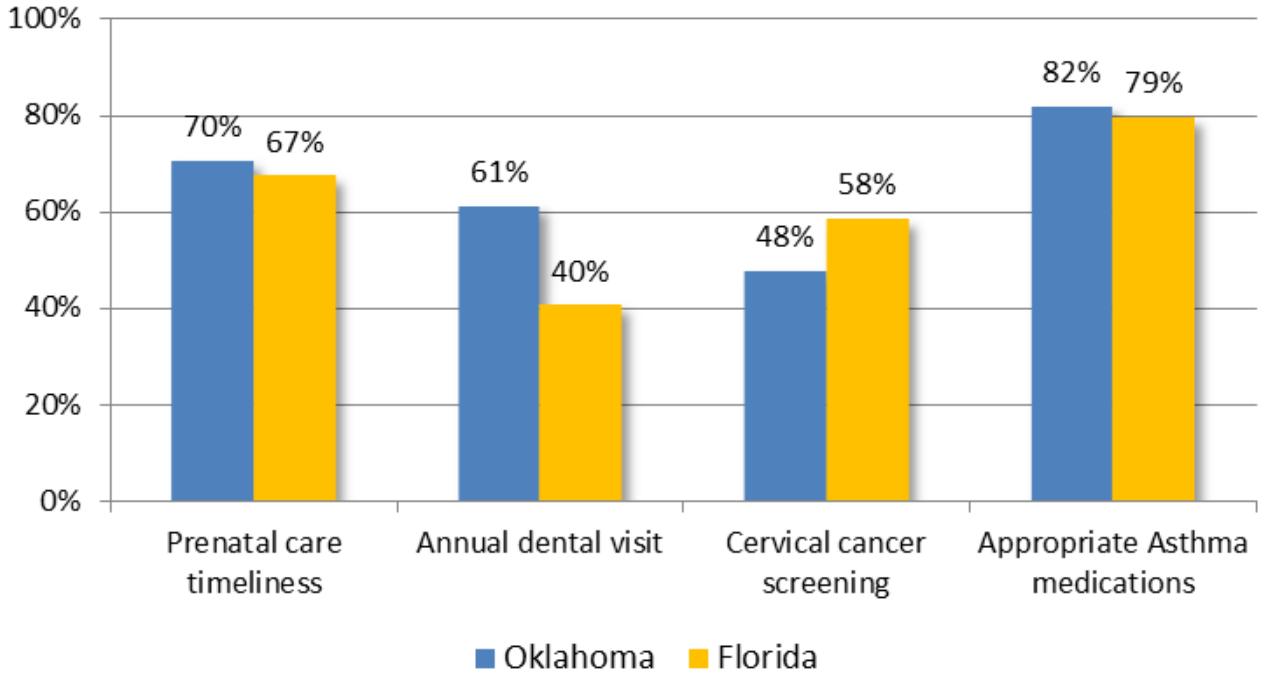


Sources: Oklahoma Health Care Authority and Florida Demonstration SFY 2014 Annual Report

COMPARISON TO BENCHMARK – FLORIDA *cont'd*

QUALITY OF CARE – Additional Measures

- SoonerCare Choice and Florida Demonstration members have comparable rates for two of four other measures published by both programs – prenatal care and appropriate asthma medications
- The Florida rate for cervical cancer screenings exceeds the SoonerCare Choice rate, while the SoonerCare Choice rate for annual dental visits is substantially higher than the Florida rate

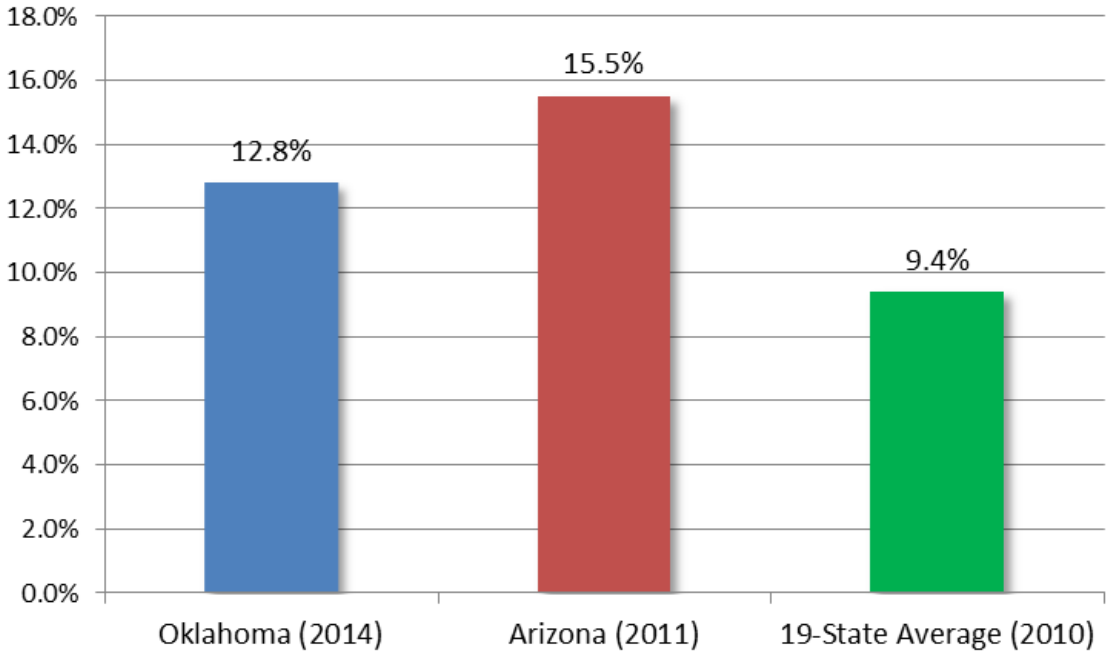


Sources: Oklahoma Health Care Authority and Florida Demonstration SFY 2014 Annual Report

COMPARISON TO BENCHMARK – ARIZONA *cont'd*

QUALITY OF CARE – Inpatient Hospital 30-Day Readmission Rate

- The SoonerCare Choice 30-day readmission rate in SFY 2014 was below the most recently-reported AHCCCS readmission rate (FFY 2011)
- Both programs had a higher readmission rate than the average rate for non-elderly Medicaid beneficiaries in 19 states, including Florida, based on a review of 2.6 million admissions in 2010*

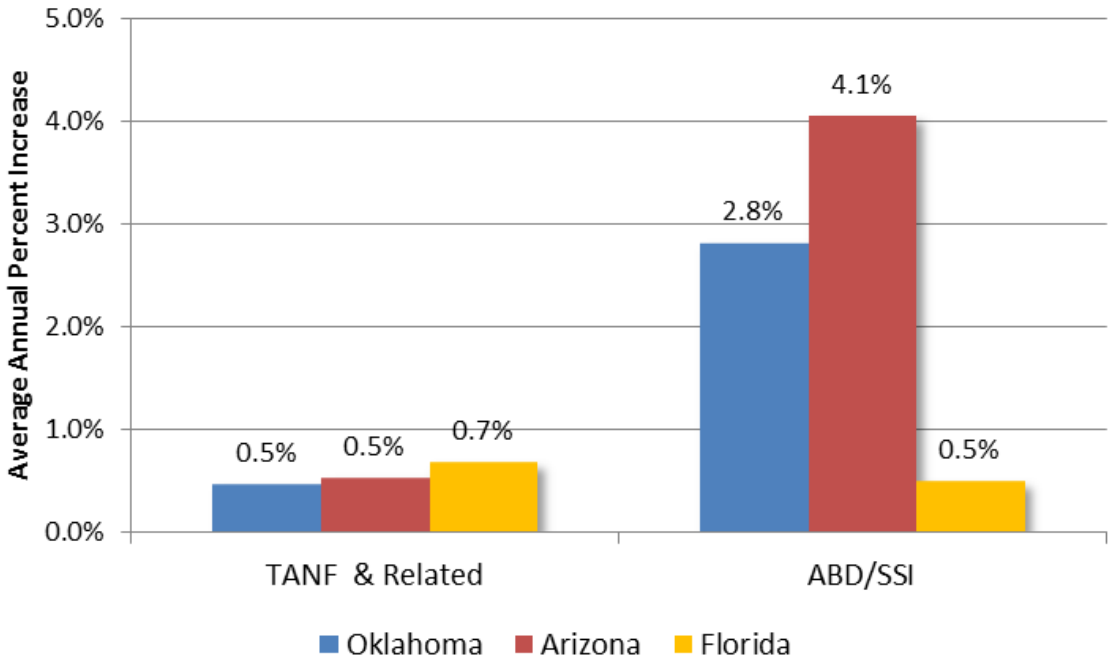


*Note: 19 states were AL, AK, AR, CO, CT, GA, IA, ME, MA, MN, NH, NY, OK, PA, SC, TN, TX, WA and WY . AK, AR, MN and NH data was for 2009
Sources: Oklahoma – OHCA paid claims; Arizona – 2012-2013 External Quality Review Annual Report (April 2014); 19-state average – "Medicaid Admissions and Readmissions: Understanding the Prevalence, Payment, and Most Common Diagnoses", Health Affairs (August 2014)

COMPARISON TO BENCHMARK STATES *cont'd*

COST EFFECTIVENESS – Average Annual PMPM Medical Inflation

- All three programs have registered close to zero inflation in recent years* for their TANF and Related populations
- Florida Demonstration SSI members have incurred the lowest PMPM medical inflation, with SoonerCare Choice falling midway between the other two states



*Note: Oklahoma trend is for SFY 2009 – SFY 2014; Arizona trend is for CYE 2012 – 2014 (actual) and 2015 (projected); Florida trend is for SFY 2007 – SFY 2014
Sources: Oklahoma – OHCA paid claims; Arizona – Actuarial certification reports; Florida – Demonstration SFY 2014 Annual Report

COMPARISON TO BENCHMARK STATES *cont'd*

Conclusions

- ACCESS TO CARE
  - SoonerCare Choice members have a high level of satisfaction with access to care, as do AHCCCS and Florida Demonstration members
  - Arizona has achieved a lower emergency room utilization rate than Oklahoma
- QUALITY OF CARE
  - Arizona and Florida both report somewhat higher compliance rates than SoonerCare Choice with respect to preventive and chronic care measures
  - However, SoonerCare Choice has maintained a lower hospital readmission rate than Arizona, although the rate exceeds a broader multi-state rate
- COST EFFECTIVENESS
  - All three programs have achieved near zero medical inflation for TANF and Related members
  - Florida also has reduced medical inflation to near zero for ABD/SSI members, while the SoonerCare Choice rate falls between the Florida and Arizona rates

FINAL OBSERVATIONS - SUMMARY

- The SoonerCare Choice program continued to demonstrate improved performance with respect to quality and access from 2009 – 2014
- Health care inflation for SoonerCare Choice members has averaged less than one percent per year since 2009 (partly attributable to recent provider rate reductions)
- Care management initiatives, such as the SoonerCare HMP, are having a positive impact on members at greatest risk for significant health costs
- PCMH providers at higher tiers appear to be achieving improved outcomes in response to their higher payments and in accordance with contract requirements
- Health Access Networks show early promise, particularly as a grass roots model for lesser populated communities