This document summarizes responses to the Oklahoma Health Care Authority's Request for Information on care coordination for the SoonerCare Aged, Blind and Disabled Medicaid population. It is organized by RFI section (A through J). The OHCA received 22 responses.

The summary was prepared by the Pacific Health Policy Group, which is solely responsible for its content. As a summary document, RFI responses are necessarily condensed to allow for easier comparison across organizations. Persons interested in more detail are encouraged to review the actual RFI responses.

STATE OF OKLAHOMA
SUMMARY OF RESPONSES TO ABD CARE COORDINATION RFI

A - Model Description

			Aetna Medicaid Administrators, LLC.	Amerigroup Corporation	AmeriHealth Caritas Family of Companies	Blue Cross Blue Shield of Oklahoma	Care Management Technologies, Inc.	Centene Corporation	DentaQuest
1		**Name and Description of Model(s) Selected**							
	A	Medicaid Fee for Service							
	B	Risk-based Arrangements							X
	C	Fully Capitated Managed Care Organization (MCO)	X	X	X	X		X	X
	D	Partially Capitated-							
	E	Medicare Shared Savings Program							
	F	The Program of All-Inclusive Care for the Elderly (PACE)							
	G	Shared Savings							
	H	Health Home							
	I	Long-Term Support and Services (LTSS)							
	J	Home & Community Based Services (HCBS)							

STATE OF OKLAHOMA
SUMMARY OF RESPONSES TO ABD CARE COORDINATION RFI

A - Model Description

			GlobalHealth Holdings, LLC.	Magellan Healthcare, Inc.	Maximus, Inc.	McAlester Regional Health Center	MCNA Insurance Company	Meridian Health Plan	Molina Healthcare, Inc.
1		**Name and Description of Model(s) Selected**							
	A	Medicaid Fee for Service			X				
	B	Risk-based Arrangements							
	C	Fully Capitated Managed Care Organization (MCO)	X	X	X		MCNA classifies its model as a hybrid, although it appears to meet the definition of full capitation: Pre-paid Dental Benefit Program Management (DBPM) model where the OHCA pays a capitated rate to MCNA and MCNA uses FFS for provider payment.	X	X
	D	Partially Capitated-			X	X			
	E	Medicare Shared Savings Program							
	F	The Program of All-Inclusive Care for the Elderly (PACE)							
	G	Shared Savings							
	H	Health Home							
	I	Long-Term Support and Services (LTSS)							
	J	Home & Community Based Services (HCBS)							

STATE OF OKLAHOMA
SUMMARY OF RESPONSES TO ABD CARE COORDINATION RFI

A - Model Description

			Oklahoma Superior Select, Inc.	Optum	Patient Care Network of Oklahoma, LLC.	Res-Care Oklahoma, Inc.	Telligen	United Healthcare Community & State	Valir PACE Foundation
1		**Name and Description of Model(s) Selected**							
	A	Medicaid Fee for Service	X				Managed Fee for Service (FFS) model where providers are paid for clinical services on a FFS basis with comprehensive care coordination services delivered by a third party vendor contracted by the state.		
	B	Risk-based Arrangements							
	C	Fully Capitated Managed Care Organization (MCO)						X	
	D	Partially Capitated-							
	E	Medicare Shared Savings Program							
	F	The Program of All-Inclusive Care for the Elderly (PACE)							X
	G	Shared Savings	X			Shared Savings Model that uses a fee-for-service model with shared savings for those home care providers who not only reduce costs but also achieve specified performance measures. The ResCare HomeCare (RCHC) model will provide care management, telehealth and require providers meet performance measures and process measures.			
	H	Health Home							
	I	Long-Term Support and Services (LTSS)	X						
	J	Home & Community Based Services (HCBS)							

STATE OF OKLAHOMA
SUMMARY OF RESPONSES TO ABD CARE COORDINATION RFI

A - Model Description

			WellCare Health Plans, Inc.
1		**Name and Description of Model(s) Selected**	
	A	Medicaid Fee for Service	
	B	Risk-based Arrangements	
	C	Fully Capitated Managed Care Organization (MCO)	X
	D	Partially Capitated-	
	E	Medicare Shared Savings Program	
	F	The Program of All-Inclusive Care for the Elderly (PACE)	
	G	Shared Savings	
	H	Health Home	
	I	Long-Term Support and Services (LTSS)	
	J	Home & Community Based Services (HCBS)	

STATE OF OKLAHOMA
SUMMARY OF RESPONSES TO ABD CARE COORDINATION RFI

A - Model Description

			Aetna Medicaid Administrators, LLC.	Amerigroup Corporation	AmeriHealth Caritas Family of Companies	Blue Cross Blue Shield of Oklahoma	Care Management Technologies, Inc.	Centene Corporation	DentaQuest
	K	Other			Fully capitated model includes BH, LTSS and pharmacy.	BCBSOK recommends a hybrid model, a Health Plan Community Collaborative (HPCC) model, which would be at full risk and paid through a PMPM capitation payment. The HPCC would form provider partnerships and payment structures that would accommodate the different provider types through risk-based, shared savings, health home, and partially capitated arrangements with providers and hospitals willing to participate. Non-participating providers would be paid via Medicaid FFS, with opportunities for incentives and bonuses tied to quality and efficiency. HPCC would include HCBS and LTSS and would co-exist and/or collaborate with PACE.	Care Management Technologies, Inc. (CMT) is a behavioral health analytics company that offers analytics and decision support tools. No reimbursement model was proposed in their response.		DQ would consider a full risk or shared risk model.
2		**How Model Addresses Needs of ABD Population**	Aetna uses an Integrated Care Management (ICM) model that identifies the most complex and vulnerable members. ICM model is person-centered and focuses on wellness and strengths, and aims for member to be in least restrictive setting. Standardized assessment tools are used with face-to-face assessments.	Amerigroup (AG) recommends a single point of accountability for coordination of services across the care continuum to reduce fragmentation and duplication while improving access. AG may use a multi-disciplinary team for members with complex needs. AG uses person-centered planning and technology to support care coordination. AG manages delivery of physical and behavioral health services for SSI/ABD members across 15 states.	Full integration of physical health, behavioral health, pharmacy, and LTSS allows for optimal care coordination. As they have in other states, they will customize their value-added services to meet the needs of the ABD members and will invest in community supports. They will form Community Advisory Committees.	"One size fits all" models do not work for ABD; more flexibility is needed, which the hybrid approach provides. HPCC is based on member-centric interdisciplinary team approach; Care Coordinator leads team of member, member's chosen provider, case managers, disease management clinicians, QA as needed, care coordination, and community social services staff. Members receive a health risk assessment, which is face-to-face for high-risk members, and care plan creation. Care coordinator interacts with utilization management and providers. Care coordinator advocates for appropriate physical health, BH, and LTSS. Various provider contracting models give providers a stake in members' health through value-based payment systems. Community-based partners might share or manage coordination activities.	This section was not addressed in the RFI.	ABD members require individual assessments and a systemized approach to care coordination. Centene's approach offers care coordination tailored to meet the needs of the ABD population and flexible enough to go beyond health care services to include housing, transportation, education, and employment.	Although DentaQuest (DQ) is proposing to cover all SoonerCare members, the model could be crafted with incentives specific to ABD. DQ uses teledentistry and remote dental teams, which could help the ABD population with mobility problems. DQ partners with schools and community centers to offer free screenings and education, which has lowered per-patient costs in KY from $328 to $124/visit. DQ uses outreach in the form of phone calls and mailings, which helps vulnerable populations initiate and maintain preventive care.

STATE OF OKLAHOMA
SUMMARY OF RESPONSES TO ABD CARE COORDINATION RFI

A - Model Description

			GlobalHealth Holdings, LLC.	Magellan Healthcare, Inc.	Maximus, Inc.	McAlester Regional Health Center	MCNA Insurance Company	Meridian Health Plan	Molina Healthcare, Inc.
	K	Other	Hybrid model combines capitated managed care with embedded components of other care coordination models, including fee-for-service payments, risk-based arrangements, shared savings, health homes, LTSS, and HCBS. Fee-for-service payment approximate to the current Oklahoma Medicaid Fee Schedule coupled with a quality shared savings payment method that is based on results achieved at provider group level. Additional consideration will be given to a bundled payment method for certain higher volume, complex acute services, as well as support of critical rural facilities/providers in certain identified areas.	Elements of other models can be incorporated into a fully capitated MCO model. OHCA should require selected health plans to develop health homes to maximize care coordination while incorporating risk-based arrangements and shared savings programs into the provider payment structure. In addition OHCA can collaborate with CMS to authorize MCO coverage for LTSS and HCBS by the selected health plans.	This plan calls for three networks with three separate models in place. Providers could choose to participate in one or more networks, based upon their capabilities and the needs of their individual practice. These networks aren't necessarily partially capitated, fully capitated, and FFS but those are the three models suggested in the RFI. OHCA would contract with a third party to perform provider application processing, screening, credentialing, and site audits for all providers across the state. "In-depth counseling" with the consumers to help them understand their needs and which model might fit them will be provided by the third-party provider.				
2		**How Model Addresses Needs of ABD Population**	Members will be assigned to a PCP Health Home who assures access to specialists and ancillary services. Care coordination responsibilities are detailed in provider contracts and monitored through reviews of claims and health outcomes/quality data tat identify referral patterns, gaps in care, missed appointments, and changes in a member's health acuity status.	MCOs must develop person-centered care coordination approaches, engage members, partner with providers, and integrate community resources and non-traditional services within the local health systems. Value-based programs will align provider financial incentives with common goals such as quality objectives. Quality measures continually address improvement. Implement quality measures to ensure ease in comparing plans. MCOs will provide flexible and enhanced services based on the assessed needs of an individual and reduce service duplication. Coordinate through the continuum of care, including medical, behavioral health, pharmacy, and LTSS.	Options for different models for consumers to fit their preference and level of need. Models would also be able to function within communities to cater to needs within that community. An "in-depth counseling process" with the consumer would help them better understand which model is most appropriate for them.	The Care Transitions Management Clinic (CTMC) will provide patient specific/centered primary care for all patients entering and rostered into the CTMC. The CTMC will use information to drive strategic and operational decisions while engaging stakeholders from across the enterprise in the decision-making process.	MCNA has a dedicated Case Management Unit with experience with ABD population.	The fully capitated managed care model allows Managed Care Organizations (MCOs) to streamline the delivery of care by ensuring that appropriate care is delivered at the appropriate time. MCOs approach care delivery from a holistic approach, integrating all levels and types of care into one streamlined system of care. Oklahoma's ABD beneficiaries require more than physical health benefit coordination. Recognizing that Oklahoma ABD beneficiaries may require services outside the scope of physical health services, the MCO model is designed to integrate all levels and types of services into one harmonious system.	Members identified for care management receive a face-to-face health risk assessment. Their care management model includes 4 programmatic levels that assist case managers with determining urgency of need and appropriate interventions. Levels are as follows: 1) Health management program that provides education, coaching, and self-management skills for chronic conditions; 2) Case management; 3) Complex case management; and 4) Intensive needs case management.

STATE OF OKLAHOMA
SUMMARY OF RESPONSES TO ABD CARE COORDINATION RFI

A - Model Description

			Oklahoma Superior Select, Inc.	Optum	Patient Care Network of Oklahoma, LLC.	Res-Care Oklahoma, Inc.	Telligen	United Healthcare Community & State	Valir PACE Foundation
	K	Other		Some of the tenets of Optum's scalable model include: 1. Supporting OHCA in implementing administrative oversight; 2. New provider reimbursement models, shared savings and performance incentives; 3. OHCA include both care coordination and utilization management; 4. OHCA require contractor to provide 24-hour telephonic clinical advice for members; 5. Consider QIO or QIO-like entity where services; and 6. Phased implementation of program components (e.g., provider profiling, development of medical homes, expansion of LTSS, etc.); and 7. Health Homes.	Accountable Care Organization (ACO) statewide shared savings model whereby Medicare and Medicaid would contract through Patient Care Network of Oklahoma (PCNOK) to pay the FQHCs Integrated Care Organizations (ICOs) at existing rates. Any shared savings to be shared between ACO and two payers with no downside risk initially. Employ a local Care Coordination model with dedicated care managers and robust IT and data infrastructure provided by PCNOK. State would provide Per Beneficiary Per Month (PBPM = PMPM) at tiered levels based on patient acuity to FQHC ICOs for care coordination and PCMH activities.				
2		**How Model Addresses Needs of ABD Population**	This model will address the understanding that a member's ability to become and stay healthy and stable is tied to identifying the necessary services and support for the right member at the right time. This approach addresses the needs of the ABD population within and outside an institution by expanding services toward the home and community. Especially with the rural environment that Oklahoma has in many parts of the state, they believe this approach will fill in gaps of care and service. In addition, partnering with proactive community-based programs and organizations as well as expanding efforts in self-management programs and care coordination partnerships will enable members and the ABD population to access diverse sets of services for their individual needs.	Optum's model addresses the needs of ABD population by: 1. Focus on most serious and complicated medical conditions; 2. Engaging members with locally based clinical and non-clinical resources; 3. Alternative reimbursement strategies; 4. Gradual evolution of Accountable Care Organizations (ACOs) and risk bearing options; 5. Contractor provides both consultation and administrative services; and 6. Provide OHCA with the option to add other administrative services such as UM and claims payment.	By using a PCMH framework that provides patients with primary care-led care management. This builds upon the history that Oklahoma FQHCs have in coordinating behavioral health (BH) and physical health (PH) and services. Continuity of care is provided by preserving the patient/provider relationships.	RCHC's model will reduce hospitalizations. RCHC caregivers will see the individual more often than the physicians so any changes will be detected sooner. RCHC care coordinators will collaborate with other service providers including PCPs, specialists, and therapists. RCHC provides a chart of how they will meet the OCHA's strategic goals. RCHC offers a Chronic Disease Awareness Program and proprietary telehealth program.	Telligen's model would address the needs of the ABD population by: 1. Leveraging data analysis to identify member for targeted resource coordination; 2. Integrating behavioral health and health coaching; 3. Components of the model have improved quality of care and reduced costs for SoonerCare Choice members; 4. Coordination of LTSS and HCBS providers; 5. Work directly with both providers and caregivers; 6. Addresses behavioral barriers to treatment adherence; 7. Provider transitional care coordination services across all settings; 8. Supports integration and coordination of mental health and physical health services; and 9. Improves the identification of care gaps for preventive services and best practices for condition management.	The MCO model is person-centered and holistic, includes data driven care planning and alignment of care management resources to provide care to members across the continuum of clinical and other social supports. United highlights the value of MCO model: 1. Care coordination improves member health; 2. Improves the care experience for Medicaid members; 3. Improves member access to care; 4. Improves program efficient and financial predictability; 5. Allows states to leverage data and technology to modernize operations; and 6. States transfer administrative oversight (claims, call center) to the private sector.	PACE is a quasi-adult day care center staffed with health care providers. They provide transportation to and from the center as well as to and from other health care appointments. PACE provides three meals/day, case management, social services, and activities. PACE also provides home-based services, including assessments. PACE is financially responsible for all facets of health care.

A - Model Description

			WellCare Health Plans, Inc.
	K	Other	
2	**How Model Addresses Needs of ABD Population**		WellCare's model addresses the needs of ABD population by: 1. Offer enhanced benefits and services; 2. Dedicated care manager to divert the member from institutional care; 3. Health Connections model connects members to social supports; 4. Transparency and accountability to members and advocates; and 5. Realized cost savings for the state based on managed care experience.

STATE OF OKLAHOMA
SUMMARY OF RESPONSES TO ABD CARE COORDINATION RFI

A - Model Description

		Aetna Medicaid Administrators, LLC.	Amerigroup Corporation	AmeriHealth Caritas Family of Companies	Blue Cross Blue Shield of Oklahoma	Care Management Technologies, Inc.	Centene Corporation	DentaQuest
3	**Approach for Implementation**	Aetna has transitioned members from FFS to managed care in many states. Aetna has 103 staff in OK and uses a local, community-based approach, meeting providers and organizations in their communities. They have established relationships with key community organizations. Aetna has a dedicated organization and teams to implement new programs. They believe in maintaining members' relationships with current providers. They use culturally appropriate outreach to members. They will meet regularly with stakeholders throughout implementation.	AG will use a deliberative planning process that engages key stakeholders in open and frequent dialogues, establishes extensive provider and community resource networks, assists providers in transitioning to managed care, reaching out to members with acute needs, identifying critical activities and timelines.	AmeriHealth Caritas (AHC) recommends a 2-phase implementation approach: 1) Integration of primary, acute, specialty, BH, and pharmacy for ABD, but not I/DD and LTSS 2) LTSS and I/DD individuals would be enrolled after at least one year. AHC recommends this approach since the Phase 2 members are very fragile and require a unique Model of Care that incorporates significant levels of BH. Enrollment of the ABD members should be mandatory. Members should be allowed 60-90 days to select a plan, and OHCA should consider using community navigators. Auto-enrollment protocols should evolve one to two years after implementation.	Five key elements to implementing HPCC: 1) Building provider network; 2) Forming relationships with community partners; 3) Partnering and engaging with regulators, stakeholders, and advocacy groups; 4) Implementing OHCA contractual requirements; and 5) Recruiting, training, and onboarding staff. BCBSOK forms a governance structure for each new implementation. Each new implementation has a customized onboarding and training plan and job descriptions. Staff receive face-to-face and computer-based training.	This section was not addressed in the RFI.	Centene has implemented ABD managed care programs in other states. Their implementation process has 4 stages, each with multiple steps: 1) Initiation phase; 2) Pre-implementation phase; 3) Implementation phase; and 4) Cut-over/plan operations period. They use a Business Implementation and Integration team who are detail-oriented and have experience. They do extensive post-implementation monitoring and maintain regular cross-functional communication using a variety of means.	DQ has implemented effective managed care programs in many states. As one of 3 plans in TX, DQ helped design new orthodontic clinical criteria that led to an 82% reduction in cost. In TN DQ has reduced claims costs by $22 million and achieved a 90% trending dental screening rate, which exceeded the state's requirement of 80%.
	Other Notes	Fully-capitated model is the best model for managing costs, coordinating services, reducing unnecessary admissions, and emphasizing preventive care. Aetna successfully uses this approach for duals in AZ under contract with AHCCCS and CMS. Their AZ plan was independently evaluated with positive results.						

A - Model Description

		GlobalHealth Holdings, LLC.	Magellan Healthcare, Inc.	Maximus, Inc.	McAlester Regional Health Center	MCNA Insurance Company	Meridian Health Plan	Molina Healthcare, Inc.
3	**Approach for Implementation**	Focus is on how to engage beneficiaries and its predictive modelling, clinical care management activities, and its Quality Improvement Program.	Internal implementation activities should include: 1. Use a dedicated project management structure and experienced Project Managers (PMs) 2. Engage an experienced leadership and implementation team comprised of subject matter experts from each functional area 3. Commit to transparency and open communication with OHCA and all stakeholders 4. Develop a disciplined and detailed project schedule and implementation process 5. Create a well-defined risk mitigation strategy 6. Use a formal change management process 7. Provide initial and ongoing staff training and education 8. Ensure accessible and supportive leadership involvement 9. Provide comprehensive status updates during startup and post-implementation 10. Conduct quality monitoring during startup and post-implementation 11. Collaborate with OHCA on the details of the implementation plan	The OHCA, an Administrative Service Organization (ASO) and provider networks would work together to implement this system. The ASO would conduct outreach and recruit providers, eventually performing health risk assessments for consumers. The ASO would perform the functions necessary to support the individual consumer's selection of the optimal provider and care delivery model. The ASO would provide comprehensive reporting and data analytics capabilities. It would also perform consumer satisfaction monitoring, while OHCA undertakes contracting with providers, determining payment structure, and processing payments.	MRHC will begin, as part of the primary care clinic, a Transitional Care Management Service in November 1, 2015. Identified, high risk, patients will be routed through this clinic post discharge from acute inpatient, observation, and/or outpatient services. Patients will be seen within 48 hours of discharge by a midlevel provider. Patients who are unable to travel will be seen at their place of residence. The visit post discharge will be the time that the midlevel provider will review discharge instructions, education, medication reconciliation, and develop a patient specific plan of care. If a patient has an established Primary Care Physician (PCP) the transitional care team will facilitate a smooth transition back to the PCP while maintaining an open line of communication. However, if a patient meets the criteria for the CTMC and/or is not happy with their current PCP, they will then be transitioned into the MRHC CTMC for care management.	MCNA uses SMART strategy to develop project plan and measure progress and will work with OHCA to define project management and reporting standards. They have successfully implemented programs in multiple states.	State would contract with two to three MCOs in order to ensure member choice is adequate. Execute contracts with MCOs. Readiness reviews for MCOs, then go-live in January 2017.	Molina recommends a geographic, population-based phased implementation approach. They contract with LTSS providers, including adult day care, transportation, companion care, environmental modification, home-delivered meals, NFs, palliative care, personal care and homemaking services, personal emergency response system, and respite care. Molina will use past claims to risk stratify new enrollees.
	Other Notes					Keeping dental separate ensures program accountability and eliminates duplicative administrative costs since most medical plans subcontract with dental plans.		Molina believes that a fully capitated model with an MCO that uses a variety of service delivery models offers predictable financial performance and administrative simplification while achieving program goals. Molina has experience doing this in other states. Molina understands CMS's Triple Aim to improve quality, cost, and patient satisfaction.

STATE OF OKLAHOMA
SUMMARY OF RESPONSES TO ABD CARE COORDINATION RFI

A - Model Description

		Oklahoma Superior Select, Inc.	Optum	Patient Care Network of Oklahoma, LLC.	Res-Care Oklahoma, Inc.	Telligen	United Healthcare Community & State	Valir PACE Foundation
3	**Approach for Implementation**	OSSI recommends a phased-in geographic approach based on the need of service, by counties, in Oklahoma. This will promote targeted care coordination for areas that need this service first and an understanding of the health care environment of Oklahoma through care coordination implementation.	Optum has dedicated implementation teams that leverage Optum and UnitedHealthcare's experience. They propose an incremental program implementation to ensure each program element is functioning effectively before adding new program components.	PCNOK's implementation relies on key steps: 1. State coordinates with CMS to ensure contracting with Medicare/SoonerCare is set up to support shared savings, PMPM and enrollment methodology (passive enrollment); 2. PCNOK to partner with OHCA to develop and implement data and claims infrastructure; 3. Leverage use of MyHealth HIE; 4. Hire and train ICO Care Managers; 5. Health Risk Assessments (HRAs) for current PCNOK ABD patients; 6. Outreach, enrollment and HRAs for Phase 2 (new PCNOK patients); and 7. Review performance metrics.	RCHC recommends the OHCA use CMS' Home Health Measures. The OHCA should consider the past costs associated with the provision of care to the ABD population and project future costs. The best way to account for variations is to set a "corridor" around the benchmark. RCHC recommends the OHCA implement this model in stages, starting with a single performance measure and gradually adding others. Once the model has proven successful, it can be expanded to other counties throughout the state. It takes RCHC approximately three to six months to get a new branch established.	Telligen recommends the integration of care coordination activities into the existing SoonerCare Health Management Program (HMP). They recommend an integrated care management and care coordination program with a single entity providing both.	United recommends the OHCA implement a statewide mandatory model with a two-phase geographic implementation plan. Phase one includes more populous counties in the Central and Eastern Regions of the state and Phase two includes the remaining counties resulting in a statewide program to occur no later than nine months after Phase One. Limiting the number of contracts to two MCOs will ensure a reasonable amount of enrollment for each MCO minimizing the negative risk that comes with small membership thereby ensuring program success. the State should consider the development of an enrollment algorithm that balances types of membership among the two awarded MCOs with enrollment based on quality after year one.	Valir currently operates a PACE in Oklahoma City. They have identified other areas in which it would be feasible to establish a PACE. Valir would submit an application to the OHCA, and the OHCA would recommend them to CMS. Valir would then submit all necessary documentation to CMS. The process of obtaining approval is around 18 months from start to finish.
	Other Notes	Oklahoma Superior Select Inc.'s (OSSI) response to this RFI includes the recommendation that OHCA implement a plan providing full ABD population coverage with an LTSS model utilizing a D-SNP or D-SNP-type plan. They also recommend integration and coordination with Medicare by having the Medicaid programs and waivers continue as fee-for-service (FFS) under an Accountable Care Organization (ACO) structure with Medicare being integrated separately through a D-SNP structure.					United recommends the state require a 12-month enrollment period and give members the option to change after initial assignment.	Valir is Joint Commissioned Accredited and has been providing health care for the indigent, geriatric population in OK since 1997.

A - Model Description

		WellCare Health Plans, Inc.
3	**Approach for Implementation**	Key facets of WellCare's approach to implementation include: 1. Locally based care team model; 2. Member-centered and culturally competent; 3. All services are integrated and delivered by an interdisciplinary team; 4. Partnerships with network providers and community agencies; 5. Single care management platform; 6. Proprietary database of social safety net providers to connect members with services; and 7. Value-based purchasing strategies.
	Other Notes	

B - Populations Served

			Aetna Medicaid Administrators, LLC.	Amerigroup Corporation	AmeriHealth Caritas Family of Companies	Blue Cross Blue Shield of Oklahoma	Care Management Technologies, Inc.	Centene Corporation	DentaQuest
1		**Proposed Eligible Population (Y/N)**							
	A	Non-Duals	X	X	X	X	This section was not addressed in the RFI.	X	X
	B	Dually Eligible	X	X	X	X	This section was not addressed in the RFI.	X	X
	C	Individuals with Chronic Conditions	X	X	X	X	This section was not addressed in the RFI.	X	x
	D	Elderly and Physically Disabled: Community	X	X	X	X	This section was not addressed in the RFI.	X	X
	E	Elderly and Physically Disabled: Institutional	X	X	X (Phase 2)	X (After two years--individuals in the program who move into institutional care before 2 years could stay in the program.)	This section was not addressed in the RFI.	X	X
	F	Intellectual and Developmental Disabilities: Community	X (after Year 2)	X	X (Phase 2)	X (Response says "all eligible ABD populations)	This section was not addressed in the RFI.	X	X
	G	Intellectual and Developmental Disabilities: Institutional	X (after Year 2)	X	X (Phase 2)	X (after two years)	This section was not addressed in the RFI.	X	X
	H	Individuals with Serious Mental Illness	X	X	X	X	This section was not addressed in the RFI.	X	X
	I	Adults	X	X	X	X	This section was not addressed in the RFI.	X	X
	J	Children	X	X	X	X	This section was not addressed in the RFI.	X	X
	K	Other1 (describe)							DQ proposes to serve all SoonerCare members, not just ABD, but would be willing to serve only the ABD population.

B - Populations Served

			GlobalHealth Holdings, LLC.	Magellan Healthcare, Inc.	Maximus, Inc.	McAlester Regional Health Center	MCNA Insurance Company	Meridian Health Plan	Molina Healthcare, Inc.
1		**Proposed Eligible Population (Y/N)**							
	A	Non-Duals	X	X	X	X	X	X	X
	B	Dually Eligible	X	X	X	X	X	X	X
	C	Individuals with Chronic Conditions	X	X	X	X	X	X	X
	D	Elderly and Physically Disabled: Community	X		X	X	X	X	X
	E	Elderly and Physically Disabled: Institutional	X	X	X	X	X	X	X
	F	Intellectual and Developmental Disabilities: Community	X		X		X	X	X
	G	Intellectual and Developmental Disabilities: Institutional	X	X	X		X	X	X
	H	Individuals with Serious Mental Illness	X	X	X	X	X	X	X
	I	Adults	X	X	X	X	X	X	X
	J	Children	X	X	X	X	X	X	X
	K	Other1 (describe)	GlobalHealth would serve all ABD eligible beneficiaries.	Available to the ABD under these definitions: Aged - 65 or over; Blind - central visual acuity of 20/200 or less in better eye with use of corrective lens; and Physically disabled - an individual who is unable to engage in any substantial gainful activity by reason of any medically determinable physical impairment which can be expected to result in death, or which has lasted for a continuous period of 12 months or more.	The ASO services would be available for all populations. Network models with different risk parameters and levels of care coordination would likely vary according to geographic location and provider penetration.	Identification of possible readmission risk by way of PACE readmission risk assessment tool	Specific populations not named but MCNA states that they want to serve all Medicaid beneficiaries eligible for dental coverage, not just ABD.		

STATE OF OKLAHOMA
SUMMARY OF RESPONSES TO ABD CARE COORDINATION RFI

B - Populations Served

			Oklahoma Superior Select, Inc.	Optum	Patient Care Network of Oklahoma, LLC.	Res-Care Oklahoma, Inc.	Telligen	United Healthcare Community & State	Valir PACE Foundation
1		**Proposed Eligible Population (Y/N)**							
	A	Non-Duals	X	X	X	X	X	X	X
	B	Dually Eligible	X	X	X	X	X	X	X
	C	Individuals with Chronic Conditions		X	X- Patients with at least one chronic condition and "poor social determinants of health".	X	X	X	X
	D	Elderly and Physically Disabled: Community		X		X	X	X	X
	E	Elderly and Physically Disabled: Institutional		X		X	X	X	
	F	Intellectual and Developmental Disabilities: Community		X		X	X	X	
	G	Intellectual and Developmental Disabilities: Institutional		X		X	X	X	
	H	Individuals with Serious Mental Illness		X		X	X	X	
	I	Adults	X	X	X	X	X	X	X
	J	Children	X	X	X	X	X	X	
	K	Other1 (describe)	It is OSSI's recommendation to create an ABD program for all individuals that qualify for all ABD waiver programs using full ABD population-based coverage inclusive of all individuals that are eligible for both Medicaid and/or Medicare.	Optum recommends including all eligible populations and doing whatever customization is required to meet member needs.		Recommend including individuals who are a member of one of Oklahoma's 39 Federally-recognized American Indian nations.	Under Telligen's model, there would be no categorical exclusions based on geography, aid category or specific health condition. Although all ABD members would be eligible for care coordination, not all would need it. An analytic process would be used to stratify the ABD population into four categories.	United recommends individuals with developmental disabilities or the most severe mental illness be phased in after managed care is implemented for the ABD population as part of a defined future implementation timeline.	

B - Populations Served

			WellCare Health Plans, Inc.
1		**Proposed Eligible Population (Y/N)**	
	A	Non-Duals	X
	B	Dually Eligible	X
	C	Individuals with Chronic Conditions	X
	D	Elderly and Physically Disabled: Community	X
	E	Elderly and Physically Disabled: Institutional	X
	F	Intellectual and Developmental Disabilities: Community	X
	G	Intellectual and Developmental Disabilities: Institutional	X
	H	Individuals with Serious Mental Illness	X
	I	Adults	X
	J	Children	X
	K	Other1 (describe)	

B - Populations Served

		Aetna Medicaid Administrators, LLC.	Amerigroup Corporation	AmeriHealth Caritas Family of Companies	Blue Cross Blue Shield of Oklahoma	Care Management Technologies, Inc.	Centene Corporation	DentaQuest
	Other2 (describe)							
	Other3 (describe)							
2	**Geographic Area (Statewide or list regions/counties)** *Note if different service areas for different populations*	Statewide model	Statewide model	Statewide model	Statewide model	This section was not addressed in the RFI.	Statewide model	Statewide model
	Other Notes		AG affiliates operate statewide programs for ABD in other states (Kansas and Tennessee).			CMT is not proposing to serve members directly but is offering their services to develop technical solutions for flagging non-standard care, improving the efficiency of care delivery, analyzing health trends of specific populations, using real-time claims and clinical data analysis to speed decision-making, and proactively managing quality and outcomes.		

B - Populations Served

			GlobalHealth Holdings, LLC.	Magellan Healthcare, Inc.	Maximus, Inc.	McAlester Regional Health Center	MCNA Insurance Company	Meridian Health Plan	Molina Healthcare, Inc.
		Other2 (describe)		Excluded populations include: SoonerCare Home and Community-Based (HCBS) Waiver enrollees Money Follows the Person grant enrollees Persons eligible for the PACE program who voluntarily elect PACE coverage					
		Other3 (describe)		Tribal populations should be enrolled voluntarily.					
2	**Geographic Area (Statewide or list regions/counties)** *Note if different service areas for different populations*		Statewide	Statewide	Statewide	Pittsburg County, Oklahoma and individuals from the seven surrounding counties, which are McIntosh, Haskell, Latimer, Pushmataha, Atoka, Coal, and Hughes.	Statewide model	Statewide model	Statewide model
	Other Notes				Providers could come together in different types of organizational configurations (such as Accountable Care Organizations (ACOs), Regional Care Coordination Organizations (RCCOs), shared savings arrangements, and so forth), so that service delivery could be available in different geographic locations based on region, medical service area, practice pattern of providers, and hospital coverage areas. The geographic regions would likely mirror the existing Health Information Exchange (HIE) and be established around major hospital locations. To address physician shortages and access issues in the many rural areas of the state, the ASO could facilitate the use of telemedicine capabilities that multiple providers could share, providing access to specialists in larger tertiary hospitals outside the typical service area.				

B - Populations Served

		Oklahoma Superior Select, Inc.	Optum	Patient Care Network of Oklahoma, LLC.	Res-Care Oklahoma, Inc.	Telligen	United Healthcare Community & State	Valir PACE Foundation
	Other2 (describe)			PCNOK recommends ABD patients currently served by FQHC ICOs be eligible (est. 10K enrollees). PCNOK also proposes to recruit new patients to participate (est. 7,500 enrollees) or approximately 12 percent of Oklahoma's ABD population.	Include people with tobacco related conditions, diabetes, obesity, and heart conditions.	Those with complex healthcare needs and little ability to self-serve would benefit from care coordination. Those having less complex healthcare needs and a greater ability to manage their care would be in a second group for care management. The third group represents even fewer health issues and greater independence. These people would be best served through guidance and education. For the final group, these individuals have fewer health needs and could be presented education material to better self-serve to meet their healthcare needs.		
	Other3 (describe)			PCNOK's model would exclude patients enrolled in Medicare Advantage,Advantage Waiver, DDSD Waiver, and the PACE program.				
2	**Geographic Area (Statewide or list regions/counties)** *Note if different service areas for different populations*	At a minimum, the State should seek out a regionalized approach when creating service geographies, specifically a division between Western and Eastern Oklahoma.	Statewide model	Statewide model	RCHC proposes to pilot the program in the Tulsa and Oklahoma City markets. A list of pilot counties is provided.	Statewide model	Statewide model with a geographically phased rollout schedule to support the development of infrastructure and supports statewide (United includes the schedule in its proposal).	PACE can serve only people who live 20-30 minutes from PACE center. They have identified 27 counties that could support a PACE center. They would have to further evaluation rural areas for suitability for a PACE center.
	Other Notes			19 FQHC ICOs operate 50 clinical sites that serve 57 counties. The Northwest region of the state is currently not served by PCNOK network.				The proposed FFY 16 budget includes expansion of PACE to younger individuals with disabilities.

B - Populations Served

			WellCare Health Plans, Inc.
		Other2 (describe)	
		Other3 (describe)	
2	**Geographic Area (Statewide or list regions/counties)** *Note if different service areas for different populations*		Statewide model
	Other Notes		WellCare encourages the state to consider: 1. Ensuring entities providing coordinated care programs for ABD have the ability to be statewide so Oklahoma's rural communities are effectively reached; 2. Ensuring a balanced assignment of members so plans have a strong mix of rural and urban membership; and 3. Seeking innovative solutions to reaching traditionally under-served areas.

C - Covered Services and Benefits

			Aetna Medicaid Administrators, LLC.	Amerigroup Corporation	AmeriHealth Caritas Family of Companies	Blue Cross Blue Shield of Oklahoma	Care Management Technologies, Inc.	Centene Corporation	DentaQuest
1		**Proposed Covered Services and Benefits**							
	A	Acute Care	X	X	X	X	This section was not addressed in the RFI.	X	
	B	Medicaid Cost Sharing for Medicare-Covered Services (Dual Eligibles)	X	X	X	X	This section was not addressed in the RFI.	X	
	C	Mental Health and Substance Abuse Treatment	X	X	X	X	This section was not addressed in the RFI.	X	
	D	Elderly and Physically Disabled: Community	X	X	X	X	This section was not addressed in the RFI.	X	
	E	Elderly and Physically Disabled: Institutional	X	X	X (Phase 2)	X (after 2 years)	This section was not addressed in the RFI.	X	
	F	Intellectual and Developmental Disabilities: Community	X (after 2 years)	X	X (Phase 2)	X	This section was not addressed in the RFI.	X	
	G	Intellectual and Developmental Disabilities: Institutional	X (after 2 years)	X	X (Phase 2)	X (after 2 years)	This section was not addressed in the RFI.	X	
	H	Dental	X	X	X (either within MCO or outside)	X	This section was not addressed in the RFI.	X	X
	I	Care Coordination/Case Management	X	X	X	X	This section was not addressed in the RFI.	X	
	J	Other1 (describe)	Emergency and non-emergency medical transportation	Money Follows the Person and recommends PACE be included	Durable medical equipment and services	Additional dental care		Vision (including eyeglasses), PT/OT, Prosthetics	

C - Covered Services and Benefits

			Aetna Medicaid Administrators, LLC.	Amerigroup Corporation	AmeriHealth Caritas Family of Companies	Blue Cross Blue Shield of Oklahoma	Care Management Technologies, Inc.	Centene Corporation	DentaQuest
		Other2 (describe)	Vision	AG recommends that all waiver programs be included.	Pharmacy and vision care	Vision		Additional dental care, including dentures; pharmacy	
		Other3 (describe)	Pharmacy (administered by MCO)	AG recommends an "in lieu of" benefits that allows the MCO to substitute a non-covered service for a covered service on an individual basis.	Non-emergency transportation	Member incentives for preventive services, such as $10 gift card for completing HRA or making PCP appointment, free car seat for completing prenatal appointment, or free diapers for completing post-partum appointment.		Transportation, chiropractic services, others	
2	**Clinical Effectiveness and Evidence Base Supporting Proposed Services**		Strategies include reduction in preventable readmissions through ICM model (program in place in Maryland); reduction in ED and inpatient utilization (successful program in IL and Delaware); rebalancing NFs and HCBS; use of predictive modeling and risk stratification tailored for Medicaid.	AG's affiliate's program in Kansas includes the full range of populations and services, and it has realized significant cost savings, an increase in access to primary care, increase in HCBS, and reduction in inpatient care. Tennessee program has reduced ED visits and inpatient episodes, increased primary care and preventive care. Positive results in Texas also.	AHC uses a population-based health management program that provides comprehensive care management, including assessing social conditions. They blend high-technology tools for stratification and analysis. They use community-based services, person-centered approach, involvement of family, and payment models to incent providers.	This section was not addressed in the RFI.	This section was not addressed in the RFI.	Based on Centene's experience, a comprehensive benefit package produces better health outcomes and allows members to be supported in the community, reducing unnecessary acute and institutional care. Integration of physical health and BH is effective. In Kansas Centene achieved an 8.9% reduction in overall BH admissions and a 12% decrease in average length of stay for the LTSS population between 2013 and 2014. They achieved a 27.6% improvement in Florida in timeliness of initiation of HCBS. For members with Intellectual and Developmental Disabilities in Kansas, they reduced unnecessary psychotropic medication use by 39%.	Data-driven preventive practices are central to what DQ does. Their foundation gives millions of dollars in grant funds to initiatives across the country, and then uses lessons learned from these initiatives to improve care. They have a program in 6 states that follows up with patients who visit the ED for dental issues, which has resulted in a 26% decrease in ED use for dental issues. Another program enrolled children for risk assessments, preventive, and restorative care; this program reduced the rate of decay by 69% and the cost by 38%. In MA they educated Primary Care Providers (PCPs) on the benefits of fluoride varnish treatment, and use of such treatment went from 28% to 74%.

C - Covered Services and Benefits

		Aetna Medicaid Administrators, LLC.	Amerigroup Corporation	AmeriHealth Caritas Family of Companies	Blue Cross Blue Shield of Oklahoma	Care Management Technologies, Inc.	Centene Corporation	DentaQuest
3	**Reason(s) for Any Proposed Non-Covered Services**			AHC does not recommend coverage of experimental services or services not proven to be effective. Services that do not fall within the scope would be evaluated on a case by case basis.		This section was not addressed in the RFI.	Centene recommends that OHCA allow the MCO to include value-added and case-by-case services.	
	Other Notes							

C - Covered Services and Ben

			GlobalHealth Holdings, LLC.	Magellan Healthcare, Inc.	Maximus, Inc.	McAlester Regional Health Center	MCNA Insurance Company	Meridian Health Plan	Molina Healthcare, Inc.
1		**Proposed Covered Services and Benefits**							
	A	Acute Care	X	X				X	X
	B	Medicaid Cost Sharing for Medicare-Covered Services (Dual Eligibles)						X	X
	C	Mental Health and Substance Abuse Treatment		X				X	X
	D	Elderly and Physically Disabled: Community	X	X				X	X
	E	Elderly and Physically Disabled: Institutional	X	X				X	X
	F	Intellectual and Developmental Disabilities: Community						X	X
	G	Intellectual and Developmental Disabilities: Institutional	X	X				X	X
	H	Dental		X			X	X	X
	I	Care Coordination/Case Management	X	X	X	X		X	X
	J	Other1 (describe)		Enrollees will receive full SoonerCare benefits, including but not limited to: 1. Ambulatory Care 2. Home and Community Based Services 3. Emergency Services 4. Pediatric Services (including oral and vision) 5. Hospitalization 6. Prescription Drugs 7. Maternity and Newborn Care 8. Laboratory Services 9. Behavioral Health/ Mental Health and Substance Use Disorder Services 10. Rehabilitative and Habilitative Services and Devices 11. Long Term Services and Supports 12. Transportation 13. Preventative Wellness and Chronic Disease Management 14. Dental	The State would identify the covered services and benefits, which would likely mirror the existing services and benefits for the initial year of the new models. Once the State determined the covered services and benefits and incorporated this information into contracts signed with providers, the ASO would track the affiliations of all providers, as well as the covered services and benefits for each network model with which a provider is associated (e.g., FFS, ACO, PACE program, nursing home, and so forth). If the State decides to vary the benefit levels, this may allow for the design of a model intended to encourage more or less case management. The consumer would have the option of choosing the program with benefits and services applicable to their specific health needs.	Services encompassed in provider taxonomy code 207Q00000X (i.e. primary care): Comprehensive, patient specific, primary care plans that include but are not limited to: Problem list, expected outcome and prognosis, measurable treatment goals, symptom management, planned interventions and identification of the individuals responsible for each intervention, medication management, a description of how services of agencies, and specialists outside the primary care clinic will be directed/coordinated. (Note: other agencies and specialists work not included in capitation payment amount – they are to be separately paid according to the appropriate Medicaid fee schedule), schedule for periodic review, and when applicable, revision of care plan.	MCNA recommends that OHCA consider additional adult benefits to reduce emergency care: 2 exams, 2 cleanings, and 1 set of x-rays per year with capped dollar amount for restorative care.	Meridian proposes additional value added benefits such as the following: 1. Extra Pharmacy instead of the four drug per month limit; 2. Extra transportation to and from medical appointments, pharmacy, and medical equipment providers; and 3. Nurse Advice Line.	Molina will propose value-added services designed to meet the specific needs of SoonerCare members. An example is consumer-directed care waivers that allow consumers to participate in directing funds to purchase health care services.

C - Covered Services and Ben

			GlobalHealth Holdings, LLC.	Magellan Healthcare, Inc.	Maximus, Inc.	McAlester Regional Health Center	MCNA Insurance Company	Meridian Health Plan	Molina Healthcare, Inc.
		Other2 (describe)		MCOs should have the flexibility to offer a series of expanded benefits, including but not limited to the following, which lead to improved outcomes and long-term savings from avoided emergency room visits, institutionalization, and decline in health status: 1. Home Modifications; 2. Workforce Development; 3. Housing Support; and 4. Self-Directed Care.					Vision
		Other3 (describe)							
2	**Clinical Effectiveness and Evidence Base Supporting Proposed Services**		GlobalHealth analyzes its covered services and benefits each year considering Medicare national and local coverage determination policies, Milliman Care Guidelines, national and regional payer trends, and industry publications. New technologies are evaluated for coverage consideration through intensive review, including the use of outside experts as needed to evaluate the risks, safety, efficacy, benefits, and alternative treatment availability.	MCC's ability to coordinate and fully integrate members' care is evident by their implementation of the Iowa Integrated Health Homes (IHH) initiative. MCC's IHH initiative is improving overall wellness while reducing emergency room visits and inpatient admissions for a very complex population in a rural state with many of the same inherent resource challenges as Oklahoma. Through their evidenced-based clinical protocols and programs, MCC has established a comprehensive process for collecting, monitoring, analyzing, evaluating, and reporting utilization data. Their data processes enable MCC to achieve the goal of improving outcomes, quality, and cost-effectiveness of care by providing the right service at the right time and at the right level of care.	Maximus already works in eleven states, nine of which have the Financial Alignment Demonstration for Medicaid-Medicare. They say this approach "meets providers where they are", offering a gradual transition to more risk-based models.	McAlester Regional, as an organization, had a total number of patients (unique) registered for medical services in Fiscal Year 2015 of 70,901. Of those, the total number of patients (unique) with dual eligibility registered for medical services in Fiscal Year 2015 was 1,625, which constitutes 23 percent of patients. The OHCA reports in June 2015 Fast Facts that 1,861 dual enrollees reside in Pittsburg County.	MCNA was first dental plan to receive claims processing and dental plan accreditation from URAC; UM program follows standards of care set by various national dental organizations. MIS has edits to prevent inappropriate use of services.	Fully Capitated Managed Care Organization (MCO) relies on collaboration between the State Agency, Managed Care Organizations (MCOs), and the States respective Medical authority. The proposed covered services include all of the services available to current SoonerCare beneficiaries. Meridian would propose that the current Medical Authority continue to review and make determinations of clinical effectiveness under the proposed MCO model. Managed care has proven to be more effective when all benefits are carved-in under the managed care model. When benefits are carved-in to the MCO, integration of care and improved care coordination occur.	Molina uses industry standard, evidence-based clinical guidelines including McKesson, CMS, Milliman, and Apollo. They use evidence-based predictive modeling tools and standard assessments. They provide disease management programs for Medicare, Medicaid, and CHIP in 12 states and can apply best practices in OK; opt-out rates in these states are less than 1 percent. They have a Quality Assessment and Performance Improvement Program and include several examples of successful initiatives in other states. One program is STAR+PLUS in TX, which was specifically designed for the ABD population, which has lowered health care costs and created high levels of satisfaction among members. This program uses a managed care medical home model.

C - Covered Services and Ben

		GlobalHealth Holdings, LLC.	Magellan Healthcare, Inc.	Maximus, Inc.	McAlester Regional Health Center	MCNA Insurance Company	Meridian Health Plan	Molina Healthcare, Inc.
3	**Reason(s) for Any Proposed Non-Covered Services**	Non-covered services include Medicare exclusions and services/items that are not medically reasonable and necessary for the treatment of an illness, injury, or malformed body part and/or not accepted by the medical community as being reasonable and proper treatment.	There are no benefits or services traditionally covered by SoonerCare that MCC recommends excluding.	In their model it is up to the state to determine both covered and non-covered services and benefits.	No specific exclusions as this is primary care only.		Meridian Health Plan (Meridian) believes in a holistic approach to Medicaid managed care. Meridian would suggest including all benefits physical, behavioral, pharmaceutical, Long-Term Services and Supports, dental, and vision under a Fully Capitated Managed Care Organization (MCO) model. However, while Meridian proposes the incorporation of an extensive benefit package, Meridian would recommend the OHCA maintain the required list of excluded benefits, as mandated by Medicaid agencies in other states in which Meridian operates.	
	Other Notes					MCNA has a continuous quality improvement program.		

C - Covered Services and Ben

			Oklahoma Superior Select, Inc.	Optum	Patient Care Network of Oklahoma, LLC.	Res-Care Oklahoma, Inc.	Telligen	United Healthcare Community & State	Valir PACE Foundation
1		**Proposed Covered Services and Benefits**							
	A	Acute Care			X			X	X
	B	Medicaid Cost Sharing for Medicare-Covered Services (Dual Eligibles)						X	X
	C	Mental Health and Substance Abuse Treatment	X		X			X	X
	D	Elderly and Physically Disabled: Community	X		X			X	X (elderly)
	E	Elderly and Physically Disabled: Institutional	X					X	
	F	Intellectual and Developmental Disabilities: Community	X					X	
	G	Intellectual and Developmental Disabilities: Institutional	X					X	
	H	Dental	X		X			X	X (will be added on-site but currently contracts for this service)
	I	Care Coordination/Case Management	X	Optum proposes a Local Care Coordination (LCC) program through a combination of telephonic and on-the-ground support.	X	X	X	X	X
	J	Other1 (describe)	OSSI supports a full ABD-based population with an LTSS-focused model. Along with current medical and behavioral health services OSSI provides to members, they propose that their model include administration of all applicable waivers for the ABD population	Establish a Health Home program where Optum can recruit, credential, train and provide care management services for providers. Optum can also assist the OHCA to administer financial incentives.	PCNOK proposes additional service extender benefits such as transportation and home visits to meet beneficiary needs.	Proposed services include: 1. Personal care; 2. Respite care; 3. Homemaking; 4. Nursing wellness; 5. Life management; 6. Personal Emergency Response System and Remote Tele-Care Giving; 7. Hospital discharge support; 8. Telehealth monitoring; and 9. Emergency preparedness and disaster relief.		United recommends including all acute benefits, as well as long-term services and supports such as nursing homes and personal care attendants. Likewise, all appropriate 1915 (c) waiver benefits should be included to support the efforts of the State to meet community placement goals.	Pharmacy, PT/OT, hospice, DME

C - Covered Services and Ben

			Oklahoma Superior Select, Inc.	Optum	Patient Care Network of Oklahoma, LLC.	Res-Care Oklahoma, Inc.	Telligen	United Healthcare Community & State	Valir PACE Foundation
		Other2 (describe)	OSSI currently offers an I-SNP that enrolls over 90 percent dual eligible beneficiaries.	The contractor could be responsible for primary care case management and medical homes.				Behavioral health and pharmacy benefits should be included.	Vision (will be added on-site but currently contracts for this service)
		Other3 (describe)						United recommends the OHCA limit any waiting list or slot barriers that may exist with current waivers. They suggest that MCOs have the ability to determine eligibility for waivers with appropriate oversight from OHCA or other agencies as appropriate.	Adult day care, transportation, home modifications, household tasks, social assessments
2	**Clinical Effectiveness and Evidence Base Supporting Proposed Services**		To ensure that the most vulnerable and those with the most serious health conditions are targeted, OSSI utilizes various minimum categories to identify these members which include: two or more ER visits within the past 12 months; six or more HCC diagnoses; HRAT scores of above 6; or two or more inpatient readmissions within 30 days. Care Managers will work closely with beneficiaries to monitor each person's health. They will be tasked with completing health risk assessments (HRAs) and bridge communications during transitions in care between institutions and providers, updating the two regarding a member's health and suggestions on improvements on quality of care. OSSI cites several outcomes based on its model.	Optum provided the results of three studies to support UM integration, to focus on members who have the most complex needs and to include a 24-hour nurse advice line: Study #1: Transition Management Program (TMP) at discharge; Study #2: High Risk Care Management; and Study #3: Nurse Line Evaluation Study.	This was not addressed in the RFI response.	RCHC provides readmission reductions by diagnosis based on their model. They also quote studies that highlight the benefits of post-discharge follow-up.	Telligen cited an Agency for Healthcare Research and Quality (AHRQ) publication that documents the clinical effectiveness of care coordination (Technical Review #9-Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies, Volume 7-Care Coordination).	United provided the following recommendations: 1. MCOs should be required to demonstrate an ability to identify both gaps in member care as well as providers who can benefit from education regarding evidence-based interventions; 2. MCOs should be required to demonstrate evidence of their experience and tools used to ensure care managers have a clear understanding of evidence-based best practices; and 3. MCOs should have tools that can identify individual providers or broader geographies that are not employing evidence-based practices.	PACE has an interdisciplinary team that develops and manages care plans. Studies of PACE participants show favorable outcomes, including: 1) Fewer hospitalizations; 2) Fewer NF admissions; 3) More frequent primary care; 4) Longer survival rates; 5) Increase in number of days in community; 6) Better quality of life; 7) Greater satisfaction with health care arrangement; and 8) Increased independence. Valir conducts ongoing participant surveys, with the result that 97% would recommend that others enroll in the program.

C - Covered Services and Ben

		Oklahoma Superior Select, Inc.	Optum	Patient Care Network of Oklahoma, LLC.	Res-Care Oklahoma, Inc.	Telligen	United Healthcare Community & State	Valir PACE Foundation
3	**Reason(s) for Any Proposed Non-Covered Services**	Nutritional Counseling is proposed as a non-covered service because we know that counseling helps members develop the behavioral changes required to positively modify their diets thus leading to increased health outcomes and a lower cost of care. The benefit will allow members to have access to individualized nutritional counseling assessments. The nutritional interventions are guided by the Academy of Nutrition and Dietetics and performed by registered dietitians. The benefit consists of three sessions taking place over the phone.	Optum strongly advocates for peer and family support services for members receiving BH services. They also believe in working collaboratively with advocacy groups.		This proposal focuses solely on Home Care for the ABD population. Therefore, it does not include other services this population may need including outpatient services, laboratory costs, physician services, etc.	Telligen does not recommend any expansion of non-covered services as a result of the care coordination program.		
	Other Notes			Hospice and nursing home care carved out.				

C - Covered Services and Ben

			WellCare Health Plans, Inc.
1		**Proposed Covered Services and Benefits**	
	A	Acute Care	X
	B	Medicaid Cost Sharing for Medicare-Covered Services (Dual Eligibles)	X
	C	Mental Health and Substance Abuse Treatment	X
	D	Elderly and Physically Disabled: Community	X
	E	Elderly and Physically Disabled: Institutional	X
	F	Intellectual and Developmental Disabilities: Community	X
	G	Intellectual and Developmental Disabilities: Institutional	X
	H	Dental	X
	I	Care Coordination/Case Management	X
	J	Other1 (describe)	The OHCA may consider focusing the service array on robust in-home, rehabilitative, preventive, and recovery benefits and services.

C - Covered Services and Ben

			WellCare Health Plans, Inc.
		Other2 (describe)	
		Other3 (describe)	
2	**Clinical Effectiveness and Evidence Base Supporting Proposed Services**		Services aimed at empowering people toward independence have the most effectiveness in achieving both individual goals and improved population health outcomes. The effectiveness of these services can be seen through reduction in costs related to longer term out-of-home placement, but most importantly in the improved quality of life and wellness of members who benefit from these services. The key to developing an effective behavioral health treatment program is having a flexible array of services as SMI adults tend to have periodic episodes of intense treatment needs along the way even when they are working a recovery program.

C - Covered Services and Ben

		WellCare Health Plans, Inc.
3	**Reason(s) for Any Proposed Non-Covered Services**	Improved member quality of life, improved member satisfaction, leading to higher rates of proactive member selection, and mitigation of the need for higher levels of care through the effective provision of preventive services. Examples of proposed non-covered services include: LTSS, Durable Medical Equipment (DME), and Non-Emergency Transportation (NET).
	Other Notes	

D - Provider Network

			Aetna Medicaid Administrators, LLC.	Amerigroup Corporation	AmeriHealth Caritas Family of Companies	Blue Cross Blue Shield of Oklahoma	Care Management Technologies, Inc.	Centene Corporation	DentaQuest
1		Provider Recruitment and Retention							
	A	Primary Care	X	X	X	X	This section was not addressed in the RFI.	X	
	B	Specialty Care	X	X	X	X	This section was not addressed in the RFI.	X	
	C	Dental	Not specifically listed	X	X		This section was not addressed in the RFI.	X	X
	D	HCBS: EPD	X	X	X	X	This section was not addressed in the RFI.	X	
	E	HCBS: IDD	X (in 2 years)	X	X (Phase 2)	X	This section was not addressed in the RFI.	X	
	F	Care Coordination/Case Management: EPD	X	X	X	X	This section was not addressed in the RFI.	X	
	G	Care Coordination/Case Management: IDD	X (in 2 years)	X	X (Phase 2)	X	This section was not addressed in the RFI.	X	
	H	Institutional: EPD	X	X	X (Phase 2)	X	This section was not addressed in the RFI.	X	
	I	Institutional: IDD	X (in 2 years)	X	X (Phase 2)	X	This section was not addressed in the RFI.	X	
	J	Home & Community Based Services (HCBS)	X	X	X	X	This section was not addressed in the RFI.	X	
	K	Mental Health and Substance Abuse Providers	X	X	X	X	This section was not addressed in the RFI.	X	
	L	Other1 (describe)	Transportation	Indian Health Services	Pharmacy, DME, others	Pharmacy, DME, PT/OT			
		Other2 (describe)	Indian Health Services and tribal clinics	Pharmacy and vision		Transportation			
		Other3 (describe)	Community-based organizations, women's health clinics, ancillary providers, lab services, others	Transportation					

D - Provider Network

			GlobalHealth Holdings, LLC.	Magellan Healthcare, Inc.	Maximus, Inc.	McAlester Regional Health Center	MCNA Insurance Company	Meridian Health Plan	Molina Healthcare, Inc.
1		Provider Recruitment and Retention							
	A	Primary Care	X	X	X	X		X	X
	B	Specialty Care	X	X	X			X	X
	C	Dental		X	X		X	X	X
	D	HCBS: EPD		X	X			X	X
	E	HCBS: IDD			X			X	X
	F	Care Coordination/Case Management: EPD		X	X			X	X
	G	Care Coordination/Case Management: IDD		X	X			X	X
	H	Institutional: EPD			X			X	X
	I	Institutional: IDD			X			X	X
	J	Home & Community Based Services (HCBS)		X	X			X	X
	K	Mental Health and Substance Abuse Providers		X	X			X	X
	L	Other1 (describe)			Maximus would provide coverage for "all types of providers."			Ancillary providers (i.e., durable medical equipment, home health, skilled nursing facilities, ambulance, laboratories, etc.), and pharmacies.	Vision
		Other2 (describe)							
		Other3 (describe)							

D - Provider Network

			Oklahoma Superior Select, Inc.	Optum	Patient Care Network of Oklahoma, LLC.	Res-Care Oklahoma, Inc.	Telligen	United Healthcare Community & State	Valir PACE Foundation
1		Provider Recruitment and Retention							
	A	Primary Care	X		X		X		X (employed directly by PACE))
	B	Specialty Care	X				X		X (by contract)
	C	Dental			X		X		X (by contract)
	D	HCBS: EPD	X			X	X		X
	E	HCBS: IDD	X			X	X		
	F	Care Coordination/Case Management: EPD	X		X	X	X		X
	G	Care Coordination/Case Management: IDD	X				X		
	H	Institutional: EPD	X				X		
	I	Institutional: IDD	X				X		
	J	Home & Community Based Services (HCBS)	X				X		X
	K	Mental Health and Substance Abuse Providers	X		X		X		X (by contract)
	L	Other1 (describe)	OSSI we will create an Oklahoma-specific network consisting of all HCBS providers that can serve the ABD population under the various waiver programs.				All SoonerCare providers will be included in the program across all provider types and ultimately long term care institutional providers after two years.	Specific provider types were not addressed though United stressed the need for a sufficient number of providers in their networks, including a mix of specialties and geographic distribution.	DME, vision
		Other2 (describe)						To ensure minimal disruption in care and broad access to LTSS, we believe the State should consider requiring provider participation for nursing homes, ICF-DD and HCBS providers for the initial one to two years of the program.	
		Other3 (describe)							

D - Provider Network

			WellCare Health Plans, Inc.
1		**Provider Recruitment and Retention**	
	A	Primary Care	X
	B	Specialty Care	X
	C	Dental	X
	D	HCBS: EPD	X
	E	HCBS: IDD	X
	F	Care Coordination/Case Management: EPD	X
	G	Care Coordination/Case Management: IDD	X
	H	Institutional: EPD	X
	I	Institutional: IDD	X
	J	Home & Community Based Services (HCBS)	X
	K	Mental Health and Substance Abuse Providers	X
	L	Other1 (describe)	Adult day care, group homes, personal attendant services/personal care, supportive employment services, DME, transportation (including NEMT), home delivered meals, telehealth, and personal emergency response system providers.
		Other2 (describe)	
		Other3 (describe)	

D - Provider Network

	Aetna Medicaid Administrators, LLC.	Amerigroup Corporation	AmeriHealth Caritas Family of Companies	Blue Cross Blue Shield of Oklahoma	Care Management Technologies, Inc.	Centene Corporation	DentaQuest
Other Notes	Aetna recommends that Oklahoma require submission of fully contracted network as part of RFP submission since it causes confusion among providers. Also recommends that rates be set at 90 percent of the Medicaid FFS rate for non-contracting providers. Aetna recommends telemedicine where feasible and mobile outreach clinics if telemedicine not feasible in certain areas.	AG recommends that sufficient time be allowed pre- and post-award to recruit providers and complete credentialing. LTSS and small providers may need special training. AG suggests that OHCA require all providers have a National Provider Identifier, define "clean claim," set payment floors for certain LTSS services, and establish reduced rates for providers who don't participate. Administrative processes should be streamlined. OHCA and AG should collaborate on incentive programs and performance metrics specific to needs of ABD population.	AHC has a centralized Provider Network Management team but also uses local account representatives for recruitment and retention. They use a local, face-to-face approach. They meet NCQA standards in all markets. They recommend the use of an Integrated Care Provider Council to advise on policy and administration. AHC hosts an FQHC National Advisory Board.	BCBSOK already has a provider network in OK but will never consider their network as "complete," since members will continue to have unique service needs, services change, and providers move in/out of state. They have a very low turnover of providers. They have provider representatives located throughout the state.	CMT does not have a provider network.		DQ has the ability to compare providers to their peers for a number of metrics. In IL they increased their network by 250 percent in response to concerns over network size. They have dramatically increased their network size in other states as well.

D - Provider Network

	GlobalHealth Holdings, LLC.	Magellan Healthcare, Inc.	Maximus, Inc.	McAlester Regional Health Center	MCNA Insurance Company	Meridian Health Plan	Molina Healthcare, Inc.
Other Notes	GlobalHealth assumes there could be opportunities to pursue value-based purchasing contracts with vendors providing non-essential services, such as preventative adult dental and preventive adult vision services. Similarly, GlobalHealth may propose such value-based payment opportunities for providers of LTSS and HCBS services.	MCC recommends the OHCA include the following types of providers to serve the ABD population: 1. Primary Medical Providers; 2. County Health Departments; 3. Acute Care Hospitals; 4. Urgent Care Clinics; 5. LTSS Providers/ HCBS Providers; 6. Pharmacies; 7. Nursing Homes; 8. Vision Providers; 9. Inpatient Psychiatric Facilities; 10. Community MH Centers; 11. Specialist and Ancillary Providers; 12. Dentists; 13. Non-Psychiatric Behavioral Health Providers; 14. Indian Healthcare Providers; 15. Physician Extenders; 16. Community-Based Organizations; 17. Community Health Centers and School-Based Health Centers; and 18. FQHCs and RHCs	The ASO would provide network recruitment and maintenance for all types of providers (such as primary care, specialty care, dental, HCBS, case/care management, LTSS, and all others), as a part of the provider application and credentialing function. The ASO would provide outreach and education, working with the state to develop educational materials about the different network model offerings, providing data about consumer choices, and helping the providers to decide what network model affiliations to consider.	Midlevel providers, care management specialist, RN, Case Management, and Health Coaches. While MRHC will not be at risk for services other than primary care, they will attempt to minimize costs by utilizing specialists and other providers that are affiliated with MRHC whenever possible.	MCNA has exceeded contractual requirements for network access in TX, LA, FL, KY, IN and will establish trust with providers through orientations and webinars. MCNA has a Provider Portal for educational and informational materials, continuous recruitment of general and specialty dentists, credentialing process approved by NCQA, professional relationships with dental associations across nation, and streamlined processes to reduce hurdles for providers.	Meridian's comprehensive provider networks include PCPs, specialists, Federally Qualified Health Centers/Rural Health Clinics (FQHC\RHCs), hospitals, ambulatory surgery centers, mental health providers, ancillary providers (i.e., durable medical equipment, home health, skilled nursing facilities, ambulance, laboratories, etc.), and pharmacies.	Molina has been successful in provider retention through the use of provider satisfaction surveys, operational efficiencies, timely payment processing, and web-based claims submission.

D - Provider Network

	Oklahoma Superior Select, Inc.	Optum	Patient Care Network of Oklahoma, LLC.	Res-Care Oklahoma, Inc.	Telligen	United Healthcare Community & State	Valir PACE Foundation
Other Notes		Optum recommends the OHCA require the contractor to work with the existing SoonerCare enrolled providers versus build and contract their own network. Specific provider types were not addressed in the RFI response.	All other provider types (e.g., specialists, hospitals, long term care, etc.) would fall outside of the FQHC setting.	RCHC has a centralized network of care managers and would manage onboarding through their centralized resource center. RCHC manages 600 Care Managers who are RN, LVN, LPN, or Social Workers. As part of the onboarding process, RCHC would manage the criminal background checks, licensure, OIG and SAMS checks, TB testing, drug screens, and resumes.			

D - Provider Network

	WellCare Health Plans, Inc.
Other Notes	

E - Provider Payment Structure

			Aetna Medicaid Administrators, LLC.	Amerigroup Corporation	AmeriHealth Caritas Family of Companies	Blue Cross Blue Shield of Oklahoma	Care Management Technologies, Inc.	Centene Corporation	DentaQuest
1a		**Payment Methodology, Assumptions and Constraints***							
	A	Acute Care	Various payment structures including FFS; FFS plus incentives for provider investment in care management, technology, and training; total cost of care, including shared savings, risk sharing, full risk.	Primary care, specialists: FFS; hospitals and tertiary facilities: DRG and per diem for inpatient and fixed rate per line item for outpatient; ancillary: FFS or case rate.	Uses Medicaid FFS structure initially and then gradually develops value-based structures as described below.	BCBSOK will work within the current Medicaid FFS structure for first year or two for all provider types and services until potential additions of shared savings, quality measures, or other risk/incentive models are adopted. This may not apply to LTSS. After first two years BCBSOK will determine which providers or provider groups have the capability to take on more risk.	This was not addressed in the RFI response.	Centene uses a variety of payment strategies for all providers, including: 1) Activity-based reimbursement; 2) Pay for performance; 3) Gain sharing/incentive-based contracting; 4) Episode of care or bundled payments; 5) Upside and downside risk-sharing model.	
	B	Medicaid Cost Sharing for Medicare-Covered Services (Dual Eligibles)			For dual eligibles AHC recommends having providers submit one claim to the MCO, which would process one payment to the provider.		This was not addressed in the RFI response.		
	C	Mental Health and Substance Abuse Treatment	Same array for all providers (PHPG interpretation)	FFS			This was not addressed in the RFI response.		
	D	Elderly and Physically Disabled: Community	Same array for all providers (PHPG interpretation)	FFS consistent with current state unit methodology.			This was not addressed in the RFI response.		
	E	Elderly and Physically Disabled: Institutional	Same array for all providers (PHPG interpretation)	Per diem	AHC would like to develop a program with NFs where the providers could share in the savings achieved by moving members back to the community.		This was not addressed in the RFI response.		

E - Provider Payment Structur

			GlobalHealth Holdings, LLC.	Magellan Healthcare, Inc.	Maximus, Inc.	McAlester Regional Health Center	MCNA Insurance Company	Meridian Health Plan	Molina Healthcare, Inc.
1a		**Payment Methodology, Assumptions and Constraints***							
	A	Acute Care	X						Molina uses value-based reimbursement (VBR) across an "accountable care continuum," which includes physical, behavioral, and community-based providers. They have implemented more than 40 VBR and P4P models in other states. They offer both financial and non-financial incentive program phases.
	B	Medicaid Cost Sharing for Medicare-Covered Services (Dual Eligibles)							
	C	Mental Health and Substance Abuse Treatment							
	D	Elderly and Physically Disabled: Community							
	E	Elderly and Physically Disabled: Institutional							

E - Provider Payment Structur

			Oklahoma Superior Select, Inc.	Optum	Patient Care Network of Oklahoma, LLC.	Res-Care Oklahoma, Inc.	Telligen	United Healthcare Community & State	Valir PACE Foundation
1a		Payment Methodology, Assumptions and Constraints*							
	A	Acute Care			There is no modification of rates proposed.				FFS
	B	Medicaid Cost Sharing for Medicare-Covered Services (Dual Eligibles)							FFS
	C	Mental Health and Substance Abuse Treatment			There is no modification of rates proposed.				FFS
	D	Elderly and Physically Disabled: Community			There is no modification of rates proposed.	To establish the baseline, the OHCA should use complete data from the year prior to the start of the performance period since prior year data reflects the most recent policies. OHCA should trend baseline data forward and may risk-adjust it. The State may want to segment baselines and trends based on specific population characteristics to account for cost variations associated with each subpopulation (i.e. children, elderly, etc.). OHCA will use the resulting calculations as benchmarks to measure performance. RCHC recommends the State use paid claims data from the Medicaid Management Information System (MMIS) as the data source for the total cost of care.			FFS
	E	Elderly and Physically Disabled: Institutional							

E - Provider Payment Structur

			WellCare Health Plans, Inc.
1a		Payment Methodology, Assumptions and Constraints*	
	A	Acute Care	Fee-for-service, capitation and shared savings.
	B	Medicaid Cost Sharing for Medicare-Covered Services (Dual Eligibles)	
	C	Mental Health and Substance Abuse Treatment	Fee-for-service, per diem and capitation.
	D	Elderly and Physically Disabled: Community	HCBS, LTSS and non-traditional providers are typically compensated consistent with the market's existing Medicaid services payment schedules.
	E	Elderly and Physically Disabled: Institutional	HCBS, LTSS and non-traditional providers are typically compensated consistent with the market's existing Medicaid services payment schedules.

E - Provider Payment Structure

			Aetna Medicaid Administrators, LLC.	Amerigroup Corporation	AmeriHealth Caritas Family of Companies	Blue Cross Blue Shield of Oklahoma	Care Management Technologies, Inc.	Centene Corporation	DentaQuest
	F	Intellectual and Developmental Disabilities: Community	Same array for all providers (PHPG interpretation)	FFS consistent with current state unit methodology			This was not addressed in the RFI response.		
	G	Intellectual and Developmental Disabilities: Institutional	Same array for all providers (PHPG interpretation)	DRG and per diem for inpatient and fixed rate per line item for outpatient			This was not addressed in the RFI response.		
	H	Dental	Same array for all providers (PHPG interpretation)				This was not addressed in the RFI response.		FFS
	I	Care Coordination/Case Management	Same array for all providers (PHPG interpretation)				This was not addressed in the RFI response.		

E - Provider Payment Structur

			GlobalHealth Holdings, LLC.	Magellan Healthcare, Inc.	Maximus, Inc.	McAlester Regional Health Center	MCNA Insurance Company	Meridian Health Plan	Molina Healthcare, Inc.
	F	Intellectual and Developmental Disabilities: Community							
	G	Intellectual and Developmental Disabilities: Institutional							
	H	Dental					MCNA proposes FFS using State's Medicaid fee schedule, with claims submitted using current ADA form. They encourage electronic submittal and pay claims within 30 days, most payments by EFT. They do not use withholds.		
	I	Care Coordination/Case Management				X			

E - Provider Payment Structur

			Oklahoma Superior Select, Inc.	Optum	Patient Care Network of Oklahoma, LLC.	Res-Care Oklahoma, Inc.	Telligen	United Healthcare Community & State	Valir PACE Foundation
	F	Intellectual and Developmental Disabilities: Community							
	G	Intellectual and Developmental Disabilities: Institutional							
	H	Dental			There is no modification of rates proposed.				FFS
	I	Care Coordination/Case Management			The PMPM range is $20 to $90 PMPM depending on severity of clinical, BH and social risk factors. PCNOK estimates that 60 percent of 9,836 ABD duals will enroll (5,926 patients). Twenty percent will be Tier 1 (highest need), 30 percent will fall into Tier, 40 percent will fall into Tier 3, and 10 percent will fall into Tier 4 (lowest need).		Creation of a new HCPCS procedure code for care coordination and a change in Medicaid policy to allow providers to use this procedure code. This model would replace (or reduce) the current PMPM payments to Patient Centered Medical Homes (PCMH's) and offer these advantages: 1. Procedure code would be processed through the MMIS system to be less complex to administer; 2. All SoonerCare providers would receive additional compensation for care coordination (not just PCPs practicing in a certified PCMH); and 3. Offering the financial incentive to all providers increases the likelihood of provider participation.		Care coordinators are on salary by PACE.

E - Provider Payment Structur

			WellCare Health Plans, Inc.
	F	Intellectual and Developmental Disabilities: Community	HCBS, LTSS and non-traditional providers are typically compensated consistent with the market's existing Medicaid services payment schedules.
	G	Intellectual and Developmental Disabilities: Institutional	HCBS, LTSS and non-traditional providers are typically compensated consistent with the market's existing Medicaid services payment schedules.
	H	Dental	
	I	Care Coordination/Case Management	

E - Provider Payment Structure

			Aetna Medicaid Administrators, LLC.	Amerigroup Corporation	AmeriHealth Caritas Family of Companies	Blue Cross Blue Shield of Oklahoma	Care Management Technologies, Inc.	Centene Corporation	DentaQuest
	J	Other1 (describe)		MCOs should be given flexibility to determine which services may be offered as value-added benefits, as well as reimbursement methodologies.					
		Other2 (describe)							
		Other3 (describe)							

E - Provider Payment Structur

			GlobalHealth Holdings, LLC.	Magellan Healthcare, Inc.	Maximus, Inc.	McAlester Regional Health Center	MCNA Insurance Company	Meridian Health Plan	Molina Healthcare, Inc.
	J	Other1 (describe)	Payment reciprocity will be implemented with non-contracted, out-of-state providers serving members who seek services from bordering states.	This RFI addresses the concept of rate-setting more nebulously, stipulating what considerations should be taken when setting rates but never addressing a particular issue beyond saying MCOs should favor community LTSS over institutional because of cost issues.	The OHCA, working with other state agencies, would determine payment methodology for each specific network model based upon its set of covered benefits and services, which would likely change over time as market dynamics and provider attitudes would drive such changes. The state would initially negotiate with the different network models on the rates, bonus, or withhold arrangements, and other aspects of the payment model for all services covered under the benefit package. As consumer demand for different types of arrangements drive providers to experiment more, it is likely that some payment structures would disappear and others will become more prominent.	Capitation per member per month for primary care (minimum of 2500 lives would be $125 PMPM). FFS based on Medicaid fee schedule with a 10 percent withhold distributed as a bonus to providers based on outcome scores.		Meridian provides monetary incentives based on progress at reaching milestones related to PCMH accreditation. Provider practices receive technical assistance and funding to support project implementation. Meridian offers enhanced payments to PCMH-recognized practices through the payment of new billing codes (such as after-hours care), bonus payments based on HEDIS® scores, and a tiered administrative bonus payment based on performance.	In the absence of actuarily sound Medicaid fee schedule payment methodologies for other benefits and services, Molina recommends using Medicare payment rates adjusted for Medicaid funding and payment levels.
		Other2 (describe)						Meridian's filing has pages and pages of detailed incentive program payout schedules for PCMH programs and for meeting HEDIS measures.	
		Other3 (describe)							

E - Provider Payment Structur

			Oklahoma Superior Select, Inc.	Optum	Patient Care Network of Oklahoma, LLC.	Res-Care Oklahoma, Inc.	Telligen	United Healthcare Community & State	Valir PACE Foundation
	J	Other1 (describe)	OSSI proposes that providers would continue to be paid FFS by the state. The current payment structure has shown to be extremely effective in care delivery while maintaining low provider costs – in fact, one of the lowest among the states. Oklahoma's Medicaid costs are below the national average despite reimbursing providers at higher rates than most states which has made it financially feasible for providers to take on significant Medicaid patient numbers.	Optum highlights their experience with value-based contracts, which comprises $25 billion of their national network healthcare spend. They also offer performance based inpatient behavioral health contracts, which represent 10 percent of national spend on behavioral health.	The OHCA and PCNOK will negotiate an "annual cost-benchmark" for the attributed (enrolled) population. The cost-benchmark will be a weighted average of the previous three years' total medical expense for each patient based on paid claims data. An appropriate growth factor, linked to the three-year average increase in medical costs, will be applied.			United recommends the State maintain the fee schedule for all covered benefits and services under the State Plan, including services available through 1915 (c) waivers. They also recommend the OHCA not limit an MCO's ability to create incentive models with providers to increase quality and encourage appropriate access to services.	
		Other2 (describe)	OSSI proposes an ACO-type shared savings model that establishes target costs and utilization similar to the Medicare Shared Savings Program offered by CMS. The plan will have a separate arrangement to distribute any savings to providers. They propose an ACO payment						
		Other3 (describe)							

E - Provider Payment Structur

			WellCare Health Plans, Inc.
	J	Other1 (describe)	
		Other2 (describe)	
		Other3 (describe)	

E - Provider Payment Structure

		Aetna Medicaid Administrators, LLC.	Amerigroup Corporation	AmeriHealth Caritas Family of Companies	Blue Cross Blue Shield of Oklahoma	Care Management Technologies, Inc.	Centene Corporation	DentaQuest
1b	**Other Methodologies**			AHC develops customized programs such as: 1) ACO incentive model (upside only) with incentive compensation based on utilization and quality scores; higher performance yields larger percentage of shared savings; PMPM savings; PCP member attribution based on claims; and 2) Full risk model with minimum and maximum guardrails. Outcome measures used: 1) Preventable hospital admissions and readmissions; 2)Low-acuity ED visits; 3) Risk-adjusted actual and expected utilization measures; 4) Neonatal ICU length of stays; 5) Obstetric and primary care HEDIS measures; and 6) Appropriate care measures.	Two additional types of compensation: 1) Additional payment amount for key quality metrics by compliant members; 2) Incentives funded by shared savings and compensation for quality metrics (outcomes).	This was not addressed in the RFI response.	Centene gave two examples of value-based payment models their affiliates have implemented: 1) In Indiana they implemented a shared savings incentive program for PCPs that includes quality measures and cost-efficiency metrics such as decreased ED use and improved generic medication use; and 2) In Washington they use a network model that includes risk-based and collaborative contracting relationships under Patient-Centered Medical Home models; providers can receive incentives or be subject to decreased payments based on quality outcomes.	In TX they offered financial incentives to dentists to use sealants and fluoride; restoration costs were reduced by 30 percent.
1c	**Estimated Amounts of Provider Payments for Evidence-Based Performance Outcomes**	Aetna commits to 75 percent of contracts having value-based solutions nationwide by 2020.	Ten percent of members receiving primary care from provider participating in evidence-based performance outcomes contract within first year, with increased percentage over time. OHCA should set year-over-year improvement goals.	Currently 40 percent of AHC's managed care members receives care from a provider or delivery system that participated in their PerformPlus shared savings program. They also have a shared savings program specifically designed for FQHCs.	This section was not addressed in the RFI.	This was not addressed in the RFI response.	Centene has value-based payment models in 18 states. Their P4P program for PCPs pays 5percent to 20 percent of base payments for delivering on quality. 70 percent of their PCP spend is included in such arrangements with incentives potential of 1-2 percent of total medical expenses. They also have capitated arrangements with PCPs that account on average for 15 percent of total Medicaid spend. Their Washington affiliate uses a network model that incorporates risk-based and shared savings, value-based purchasing. For 2015 they estimate that 35 percent of total medical expenses will be covered by this model.	RFI did not address this subject.

E - Provider Payment Structur

		GlobalHealth Holdings, LLC.	Magellan Healthcare, Inc.	Maximus, Inc.	McAlester Regional Health Center	MCNA Insurance Company	Meridian Health Plan	Molina Healthcare, Inc.
1b	**Other Methodologies**		This was not addressed in the RFI response.	Network models will have significant flexibility to incorporate different benefits and services as part of given network arrangments. Maximus believes that the most integrated care with the best outcomes that provide the greatest flexibility will be overwhelmingly selected by consumers.		Encourages Oklahoma to authorize pay-for-quality program; has bonus program in TX.		
1c	**Estimated Amounts of Provider Payments for Evidence-Based Performance Outcomes**	GlobalHealth's initial aggregate goal will be an estimated 5 to 8 percent reduction in risk-adjusted PMPM costs over an 18 to 24 month period. The best performing groups will see increased assignment of the population and will receive the greatest amount of shared savings payment based on performance. Quality shared savings payments can result in an additional 25 percent above the traditional FFS payments for those high performing provider groups.	This was not addressed in the RFI response.	The state would need to continually adjust the rates for different types of network models, depending on the dynamics of the market. To assist the state in administration of its payment structures, the ASO could provide monitoring of the different network models, collecting and analyzing information on performance, payment rates, and performance metrics.	A 10 percent withhold would be distributed as a bonus to providers based on outcome scores.	Would welcome the opportunity to design a P4Q program based on Oklahoma's goals.	This was not addressed in the RFI response.	Molina spends around 15 percent of PCP reimbursement in some type of quality or evidence-based performance payment. Their goal is to increase this over the next few years, and to engage more integrated delivery systems and accountable care organizations in value-based arrangments.

E - Provider Payment Structur

		Oklahoma Superior Select, Inc.	Optum	Patient Care Network of Oklahoma, LLC.	Res-Care Oklahoma, Inc.	Telligen	United Healthcare Community & State	Valir PACE Foundation
1b	**Other Methodologies**				RCHC advises the OHCA to include appropriate risk mitigation to account for outliers, minimize incentives for patient selection and diagnosis and other risks to achieve more confident savings measurement. The OHCA should re-base the baseline data to integrate changes associated with reform efforts or other state Medicaid program changes. Assumptions and constraints are provided.			Primary care physicians are salaried, as are nursing staff. Non-medical services such as transportation, home visits and assessments dieticians, activities, and meals are paid through PACE general operations.
1c	**Estimated Amounts of Provider Payments for Evidence-Based Performance Outcomes**		Optum does not provide specific provider payment rates. They note that "without a more comprehensive understanding of the current reimbursement levels in Oklahoma, we cannot offer an informed recommendation about the estimated or recommended amounts of provider payments."	100 percent quality indicator scores met - 60 percent of savings paid to network 75 percent - 50 percent paid to network 50 percent - 25 percent paid to network Below 50 percent - 0 percent paid to network	RCHC proposes the OHCA create a tiered model. Depending on the number of individuals served, percentage cost reduction, and outcome performance, the provider would receive a percentage of the cost savings. In order to receive the highest percentage of payment, the provider must meet a specified percentage of the tier's benchmarks.	Telligen is unable to accurately estimate the amount of provider payments that would result from this new model without substantial data analysis ad modeling. Total provider payments would be based on the number of SoonerCare members likely to need care coordination and the payment amount assigned to the new procedure code.	United recommends the OHCA allow MCOs the necessary flexibilities to meet providers where they are willing to participate in value-based contracting and encourage MCOs to work with providers to bring them along the continuum to achieve greater clinical integration and accountability. to develop MCO rates that encourage the transformation of practices to pay-for-value arrangements; and ensure that any incentives offered are appropriately reflected as medical expense with a reporting methodology that allows for the capture of incentive payments.	Valir does not reimburse contracted providers for outcomes or quality measures. CMS conducts medical record reviews and may impose sanctions if not satisfactory.

E - Provider Payment Structur

		WellCare Health Plans, Inc.
1b	**Other Methodologies**	WellCare recommends an evolving compensation continuum that over time, usually by year three of the program, can be transitioned to the value-based purchasing (VBP) model.
1c	**Estimated Amounts of Provider Payments for Evidence-Based Performance Outcomes**	WellCare's value-based purchasing program consists of three components: 1. Provider Pay for Performance Quality incentive (P4Q) program; 2. Investment in providers and practices to help them become recognized PCMHs; and 3. WellCare provides shared-savings (upside only) and shared risk (upside and downside) opportunities to large primary care groups. No specific payment amounts were provided.

E - Provider Payment Structure

	Aetna Medicaid Administrators, LLC.	Amerigroup Corporation	AmeriHealth Caritas Family of Companies	Blue Cross Blue Shield of Oklahoma	Care Management Technologies, Inc.	Centene Corporation	DentaQuest
Other Notes			AHC has developed a BH value-based program centered on: 1) Timely follow-up after psychiatric discharge; 2) Medication adherence; 3) Engagement/treatment; 4) Enhanced communication; between BH and physical health providers; 5) Well care for Serious Mental Illness population; and 6) Dash boarding/transparency tools.		CMT does not pay providers but is presenting its technology solution as a way to support value-based payments.	Because HEDIS measures do not generally apply to LTSS, they recommend these quality measures: 1) Completion of functional assessments on new members; 2) Rate of inpatient admissions; 3) Receipt of outpatient BH services; 4) Incidence of wounds or falls in the community setting; 5) Disease-specific measures for chronic conditions.	

*Potential Categories: Based on Medicaid, Percent of Medicaid, Performance-Based Payments

E - Provider Payment Structur

		GlobalHealth Holdings, LLC.	Magellan Healthcare, Inc.	Maximus, Inc.	McAlester Regional Health Center	MCNA Insurance Company	Meridian Health Plan	Molina Healthcare, Inc.
	Other Notes	GlobalHealth considers performance incentives that reflect the health acuities of a provider's assigned ABD members as opposed to applying a "one size fits all" strategy that reflects upfront withholds of reimbursement amounts for services rendered.						

*Potential Categories: Based on

E - Provider Payment Structur

		Oklahoma Superior Select, Inc.	Optum	Patient Care Network of Oklahoma, LLC.	Res-Care Oklahoma, Inc.	Telligen	United Healthcare Community & State	Valir PACE Foundation
	Other Notes				Withholds should be limited to 5 or 10 percent of provider payments, which is the largest amount that provider organizations can lose because of poor performance. The OHCA may reduce payments to providers who do not achieve an acceptable level or improvement of performance. The OHCA can deny payment for services that appear to be ineffective, harmful, or inefficient (i.e. preventable errors).			Valir PACE carries reinsurance.

*Potential Categories: Based on

E - Provider Payment Structur

		WellCare Health Plans, Inc.
	Other Notes	

*Potential Categories: Based on

F - State Payment Structure

			Aetna Medicaid Administrators, LLC.	Amerigroup Corporation	AmeriHealth Caritas Family of Companies	Blue Cross Blue Shield of Oklahoma	Care Management Technologies, Inc.	Centene Corporation	DentaQuest
1		**State Payment Methodologies, Assumptions and**							
	A	Medicaid Fee for Service							
	B	Risk-based Arrangements							X
	C	Fully Capitated Managed Care Organization (MCO)	X	X	AHC recommends prospective rate setting method using at least 24 months' historical medical cost by type of service, medical cost and utilization trends, expected program changes, an allowance for administrative costs, and an appropriate margin for risk and surplus contributions.	Capitated payment amounts would be based on benefits provided, health status, and locality, with risk adjustment.		Centene recommends that Oklahoma hire an actuary experienced in capitation rate development specifically for Medicaid programs. Centene offers a monthly payment structure based on number of members, and including volume discounts. They will contract as a percentage of revenue, a PMPM fee, or fixed fee for managed care services.	X
	D	Partially Capitated-							
	E	Medicare Shared Savings Program							
	F	The Program of All-Inclusive Care for the Elderly (PACE)							
	G	Shared Savings							
	H	Health Home							

F - State Payment Structure

			GlobalHealth Holdings, LLC.	Magellan Healthcare, Inc.	Maximus, Inc.	McAlester Regional Health Center	MCNA Insurance Company	Meridian Health Plan	Molina Healthcare, Inc.
1		**State Payment Methodologies, Assumptions and**							
	A	Medicaid Fee for Service			X				
	B	Risk-based Arrangements							
	C	Fully Capitated Managed Care Organization (MCO)	X	X	X		The OCHA would set actuarially sound rate with payments made to DBPM monthly on a PMPM basis. PMPM rates vary based on category and benefit. DBPM bears full risk.	X	The State will pay an actuarially sound rate per enrollee category, with Molina assuming full risk for medical costs. Some states set MCO incentives based on pre-defined metrics. Molina makes these assumptions: 1) There should be enough members for each MCO to make the operational start-up costs viable; 2) Data must be accurate over a sufficient time period in order to calculate rates per enrollee category; 3) Periodic review of the MCO risk profile will be performed.
	D	Partially Capitated-			X	X			
	E	Medicare Shared Savings Program							
	F	The Program of All-Inclusive Care for the Elderly (PACE)							
	G	Shared Savings							
	H	Health Home							

F - State Payment Structure

			Oklahoma Superior Select, Inc.	Optum	Patient Care Network of Oklahoma, LLC.	Res-Care Oklahoma, Inc.	Telligen	United Healthcare Community & State	Valir PACE Foundation
1		**State Payment Methodologies, Assumptions and**							
	A	Medicaid Fee for Service	X- Using OSSI's approach, state payments will continue to be paid for Medicaid and LTSS benefits using the current state FFS reimbursement schedules.						
	B	Risk-based Arrangements							
	C	Fully Capitated Managed Care Organization (MCO)						Rates must be actuarially sound, financially viable and include reasonable savings assumptions. For individuals who are receiving LTSS services, the OHCA should establish rates based upon a blended rate methodology.	
	D	Partially Capitated-							
	E	Medicare Shared Savings Program							
	F	The Program of All-Inclusive Care for the Elderly (PACE)							X
	G	Shared Savings	X - OSSI proposes an ACO-type shared savings model that establishes target costs and utilization similar to the Medicare Shared Savings Program offered by CMS. They propose an ACO payment target for both nursing home and home-based members. A target will be established similar to the Medicare ACO shared savings demonstrations based on historical FFS data for attributed members trended to the current period. Savings compared to 100 percent of FFS would be shared between OSSI and the state. Shared savings would be paid for by reduced inpatient re-admissions and ER visits.	Optum recommends a PMPM payment for each ABD member through a combination of financial incentives and shared savings opportunities. The assumption is that the OHCA is establishing a non-risk bearing contact.		OHCA should create a tier system based on the size of the provider's beneficiary population. For small providers, the lower tier reduces the fluctuations in shared savings that may occur for high-cost clients, which is more pronounced with a smaller group of enrollees. The performance and cost savings measures should be reviewed quarterly. RCHC anticipates that improved health outcomes and therefore reduced savings will be seen in the high-cost population within the first six months. Additional savings among the remaining population will be realized within the first year.			
	H	Health Home							

F - State Payment Structure

			WellCare Health Plans, Inc.
1		State Payment Methodologies, Assumptions and	
	A	Medicaid Fee for Service	
	B	Risk-based Arrangements	
	C	Fully Capitated Managed Care Organization (MCO)	X
	D	Partially Capitated-	
	E	Medicare Shared Savings Program	
	F	The Program of All-Inclusive Care for the Elderly (PACE)	
	G	Shared Savings	
	H	Health Home	

F - State Payment Structure

			Aetna Medicaid Administrators, LLC.	Amerigroup Corporation	AmeriHealth Caritas Family of Companies	Blue Cross Blue Shield of Oklahoma	Care Management Technologies, Inc.	Centene Corporation	DentaQuest
	I	Long-Term Support and Services (LTSS)							
	J	Home & Community Based Services (HCBS)							
	K	Other	Aetna recommends transparency in rate-setting with meaningful quality goals and withholds; Aetna requests that actuarial information be made available to Aetna in advance of submission to CMS. Assumptions in first year should not be aggressive since moving members out of institutions is not in the mix.				Care Management Technologies, Inc. (CMT) described customary reimbursement arrangements in other states, including PMPY for population-based activtities, but did not propose a reimbursement model in the RFI response.		DQ would consider a full-risk or risk-share model. Under the risk-share model, the state and plan share in the savings and losses. The vendor assumes some risk and is incentivized to monitor the effective and efficient delivery and medical necessity of services. DQ manages both full-risk and shared-risk programs in other states.
2		**How Methodology(ies) Comply with proposed Federal and State Requirements**	Aetna's recommendations are consistent with programs in other states already approved by CMS.	Payment methodology would be evaluated for actuarial soundness using new or revised federal and state requirements prior to program implementation.	Rate development should follow guidance in the "Draft 2016 Medicaid Managed Care Rate Development Guide" published by CMS on June 5, 2015.	Actuarially sound rate should be developed based on CMS rule on Medicaid Managed Care (CMS-2390-P). BCBSOK's proposed payment structure is compliant with 42 CFR Section 438.6(c), the current 2015 Managed Care Rate Setting Consultation Guide published by CMS in September 2014, and with the recently proposed CMS rule on Medicaid Managed Care.	This was not addressed in the RFI response.	Actuarially sound capitation payments must comply with 42 CFR 438.6(c) currently being revised by CMS. There may be unique state guidance as well. Actuary must follow generally accepted actuarial principles and practices.	DQ is well versed in federal Medicaid regulations and also have to follow state regulations in the states in which they operate.
		Entity Proposes Risk-Adjusted Payment Rates (e.g., based on conditions/needs)	Aetna proposed risk-adjusted capitation rates based on characteristics that cause costs to differ (diagnosis-based).	Rates should account for differences in clinical acuity, setting, types of service utilization (physical or behavioral health, LTSS), and dual eligible status. LTSS risk adjustment should be adjusted based on outcomes of individuals' periodic assessments, not on clinical status and utilization. State could propose a blended rate for LTSS and HCBS. OHCA should incentivize MCO with quality bonuses for achieving performance metrics.	Rates should be risk-adjusted. There should be separate rates for acute care and LTSS, not blended. OHCA should consider doing a risk assessment after the first 6 months of operations and adjust rates retroactive to the start of the rating period. For LTSS members, risk adjustment should be based on functional status assessment, not diagnosis.	Diagnosis or claims-based risk adjustment mechanism, using a model such as Chronic Illness and Disability Payment System.	This was not addressed in the RFI response.	Actuary may recommend risk mitigation strategies such as: 1) Case rate payments for higher-cost claims; 2) Risk adjustment to align payment rates with the relative health of members; 3) Reinsurance, risk pools, risk corridors; 4) Performance incentives and withholds.	

F - State Payment Structure

			GlobalHealth Holdings, LLC.	Magellan Healthcare, Inc.	Maximus, Inc.	McAlester Regional Health Center	MCNA Insurance Company	Meridian Health Plan	Molina Healthcare, Inc.
	I	Long-Term Support and Services (LTSS)						X	
	J	Home & Community Based Services (HCBS)						X	
	K	Other	Care coordination vendors to be paid using a prospective, risk-based PMPM reimbursement methodology for contracted services. These payments would be made by electronic funds transfer from OHCA to participating MCOs. Year 1 capitation rates would be negotiated with OHCA.	This was not addressed in the RFI response.	The state determines and implements the payment structure for the various types of provider network models operating across the state. As certain networks become favored by consumers, state will gain control over rates for covered services. The ASO provides education and matching mechanism to consumers , allowing market forces to drive behavior and payments.	Monthly payment to the clinic no later than the 5th of each month calculated as number of assigned lives times $125		Meridian recommends the OHCA risk-adjust each MCOs rates, based on the relative morbidity of their enrolled members to the statewide population. Total payments by the State will be risk score neutral, meaning MCOs' rates will be adjusted both up and down, according to the morbidity of their enrolled members relative to all enrolled members. Risk adjustment should be calculated separately for the LTSS population and the non-LTSS population.	
2		**How Methodology(ies) Comply with proposed Federal and State Requirements**	Capitation rates to pay capitated MCOs for rendered managed care services is an accepted industry practice for both Medicare and Medicaid managed care rules and regulations. Will be subject to Federal and State requirements, including revised Medicaid managed care rules, CMS' HCBS services final rule and related requirements issued January 2014, CMS' Draft 2016 Medicaid Managed Care Rate Developed Guide dated June 5, 2015, and OHCA's adjustment of its Medicaid Fee Schedule based on SoonerCare revised requirements for multiple waivers.	This was not addressed in the RFI response.	This plan assumes that the state will take into account both federal and state requirements when setting actuarial rates for the different types of network models.	Bi-monthly primary care visit plus other encounters as required (e.g. facility rounding). Constraint= capacity of 144 office visits per day within the clinic.	MCNA's approach is consistent with CMS requirements and is in use in MCNA programs in LA and TX.	Demonstrated by the significant number of States utilizing the CMS waiver programs, the model and proposed payments outlined throughout this request for information (RFI).	A full capitated MCO model complies with CMS waiver policy 1915(b) Managed Care Waiver and 1915(c) HCBS waiver. Molina will comply with provisions in House Bill 1566.
		Entity Proposes Risk-Adjusted Payment Rates (e.g., based on conditions/needs)	X					X	

F - State Payment Structure

			Oklahoma Superior Select, Inc.	Optum	Patient Care Network of Oklahoma, LLC.	Res-Care Oklahoma, Inc.	Telligen	United Healthcare Community & State	Valir PACE Foundation
	I	Long-Term Support and Services (LTSS)							
	J	Home & Community Based Services (HCBS)							
	K	Other			Maintenance of the payment relationship between SoonerCare and Medicare as payers and FQHC in PCNOK for all base, contracted services within the current benefits and services.		Members would be automatically enrolled. Payments could be made in one of two ways: 1. A fixed monthly payment for a defined scope of work; or 2. A performance based payment model in which the vendor received a fixed payment amount for care coordination that would increase based on the vendor engaging more members in the program.		
2		**How Methodology(ies) Comply with proposed Federal and State Requirements**	Since OSSI's approach contemplates utilizing current FFS programs and ACO-type arrangements, the proposed payments comply with existing regulations.	CMS has recently issued proposed rules for establishing Medicaid managed care capitation payments. While Optum is not recommending an at-risk capitated program, the administrative range of 10-15 percent of the cost of members' treatment services is in line with those proposed guidelines.	PCNOK's payment model aligns with state and federal regulations: 1. It is consistent with federal protections for payment models for primary care, BH and oral health services furnished within an FQHC and 2. It is sufficiently "value-based" in that it contains elements of payment tied to Triple Aim goals.	The participating providers must notify the beneficiary that the beneficiary's claims data may be shared with appropriate parties. The regulations establish quality performance measures and a methodology for linking quality and financial performance. In order to draw down federal matching funds, Oklahoma must contribute a recognized non-federal share of state or local funds.	This was not addressed in the RFI response.	Developing actuarially sound rates and including all health care benefits as well as activities intended to support improved quality and ensure members' ability to live in integrated setting as part of a Medical Loss Ratio (MLR) requirement is consistent with the recently proposed Medicaid managed care regulations.	CMS sets the capitated rate for participants based on demographics, past medical history, and frailty. If participant is Medicaid only, OHCA pays a flat capitated rate of $3444/month.
		Entity Proposes Risk-Adjusted Payment Rates (e.g., based on conditions/needs)							Risk adjustment is included in the CMS payment model.

F - State Payment Structure

			WellCare Health Plans, Inc.
	I	Long-Term Support and Services (LTSS)	
	J	Home & Community Based Services (HCBS)	
	K	Other	
2		**How Methodology(ies) Comply with proposed Federal and State Requirements**	This was not addressed in the RFI response.
		Entity Proposes Risk-Adjusted Payment Rates (e.g., based on conditions/needs)	WellCare recommends the state's actuaries develop rates for bidder's to consider during the bidding process. Bidders will then be scored only on their ability to provide the services needed for the populations and their experience providing these services successfully.

F - State Payment Structure

	Aetna Medicaid Administrators, LLC.	Amerigroup Corporation	AmeriHealth Caritas Family of Companies	Blue Cross Blue Shield of Oklahoma	Care Management Technologies, Inc.	Centene Corporation	DentaQuest
Entity Proposes Risk Sharing Arrangement	Aetna proposes a 2-year risk corridor where OK and Aetna share profit or loss outside a certain range and no minimum MLR. Typical risk corridor is ± 5% of target MLR with 80% share.		OHCA should consider risk corridors to share upside and downside risk for a limited time period. ACA-defined risk corridors could be used.	HPCC would also consider certain profit sharing or withhold measures. Profit sharing, or a risk corridor, would be in place to mitigate risk for state and health plan from inaccurate rate setting, unexpected changes in population, or similar unexpected variances. The risk corridor might not be continued after some period of time.	This was not addressed in the RFI response.		
Entity Proposes MLR	Not during 2-year risk corridor.			MLR should be consistent with that defined for Qualified Health Plans, with differences specific to OK. Care coordination efforts are generally placed within the quality improvement portion of the MLR calculation. A "credibility" adjustment may be applied to MLR calculation to manage large claim fluctuations in small plans. CMS rule proposes a minimum MLR for HPCCs; BCBSOK recommends applying a unique minimum MLR to each "rate cell," or capitated payment amount.	This was not addressed in the RFI response.		
Other Notes					This was not addressed in the RFI response.		

F - State Payment Structure

		GlobalHealth Holdings, LLC.	Magellan Healthcare, Inc.	Maximus, Inc.	McAlester Regional Health Center	MCNA Insurance Company	Meridian Health Plan	Molina Healthcare, Inc.
	Entity Proposes Risk Sharing Arrangement							
	Entity Proposes MLR	X						
	Other Notes							

F - State Payment Structure

		Oklahoma Superior Select, Inc.	Optum	Patient Care Network of Oklahoma, LLC.	Res-Care Oklahoma, Inc.	Telligen	United Healthcare Community & State	Valir PACE Foundation
	Entity Proposes Risk Sharing Arrangement							
	Entity Proposes MLR							
	Other Notes							

F - State Payment Structure

		WellCare Health Plans, Inc.
	Entity Proposes Risk Sharing Arrangement	
	Entity Proposes MLR	
	Other Notes	

G - Impact of Model

			Aetna Medicaid Administrators, LLC.	Amerigroup Corporation	AmeriHealth Caritas Family of Companies	Blue Cross Blue Shield of Oklahoma	Care Management Technologies, Inc.	Centene Corporation	DentaQuest
1		**Estimated Implementation Costs and Savings**							
	A	Costs: Methodology, Assumptions and Constraints	Implementation costs would be built into the capitation rate. The MCO model will address several weaknesses identified in the 2013 Leavitt Partners report to Oklahoma.	Estimate of costs is based on AG's affiliates' experience in carrying out 100 publicly-funded program implementations. Cost estimate assumes OHCA accepts AG's suggested model.	AHC does not currently operate in Oklahoma as a Medicaid MCO and so cannot offer a forecast of costs.	Costs will vary depending on the state's Medicaid requirements. The majority of costs will be driven by health plan system changes (integration with OHCA and OK state agency systems, programming on specific benefit requirements, and establishing billing and reconciliation processes), reporting and data transfers, staffing, and potential vendors and subcontractors needed.	This was not addressed in the RFI response.	Most of the services and programs needed exist within Centene's organization today. Estimating costs and savings is developed by defining goals in patient care, determining how provider payment will be made, and identifying what tools will be available to help reach goals. Centene gives these examples of capital expenses: 1) Centene may subsidize the development of new capabilities, relationships, roles, and services that providers don't now have; and 2) The shift to a value-based model will require capital to implement and configure systems to more effectively manage care and shift to outcome-based processes.	Implementation costs would be primarily limited to staff time with the transition.
		Year 1	The RFI did not provide specific cost amounts for each year.	Total costs in range of $2.5 to $4 million.	The RFI did not provide specific cost amounts for each year.	The RFI did not provide specific cost amounts for each year.		The RFI did not provide specific cost amounts for each year.	The RFI did not provide specific cost amounts for each year.
		Year 2							
		Year 3							
		Year 4							
		Year 5							
		Five-Year Total							

G - Impact of Model

			GlobalHealth Holdings, LLC.	Magellan Healthcare, Inc.	Maximus, Inc.	McAlester Regional Health Center	MCNA Insurance Company	Meridian Health Plan	Molina Healthcare, Inc.
1		**Estimated Implementation Costs and Savings**							
	A	Costs: Methodology, Assumptions and Constraints	GlobalHealth acknowledges that a significant investment will be required for staff that will be dedicated to serving the ABD beneficiaries. Their existing Oklahoma infrastructure is scalable and they are prepared to make additions.	Cost avoidance model to estimate savings. Considerations of the model include: 1. Benchmark FFS eligibility costs; 2. Eligibility criteria for the populations in the managed care program; 3. Provider acceptance of managed care; 4. Time to affect provider practice patterns and member behavior; 5. Benchmark medical costs including: -medical services to be covered under the managed care model -medical services to be carved out from the managed care model, if any -other medical cost transactions 6. Geographic adjustments for rural and urban eligibility; and 7. Administrative costs.	The state would establish a payment structure to control costs. Maximus acknowledges all the ambiguities surrounding the practical implementation of its choice and instead lists all individual costs that would be associated with this model.		MCNA is not able to estimate a dollar amount without full access to enrollment data.	Expected implementation costs for MCOs will vary depending on the size and scope of the project. Expenses related to licensure with State Insurance Commission, staffing, operations, and local infrastructure can be expected by MCOs selected to participate in the program.	Implementation costs (launch operations, hire resources, participate in readiness reviews, establish business processes, and deploy systems) are internal set-up costs not charged directly to state. These costs will be recouped through savings.
		Year 1	The RFI did not provide specific cost amounts for each year.	The RFI did not provide specific cost amounts for each year.	The RFI did not provide specific cost amounts for each year.	The RFI did not provide specific cost amounts for each year.	The RFI did not provide specific cost amounts for each year.	The RFI did not provide specific cost amounts for each year.	
		Year 2							
		Year 3							
		Year 4							
		Year 5							
		Five-Year Total							

STATE OF OKLAHOMA
SUMMARY OF RESPONSES TO ABD CARE COORDINATION RFI

G - Impact of Model

			Oklahoma Superior Select, Inc.	Optum	Patient Care Network of Oklahoma, LLC.	Res-Care Oklahoma, Inc.	Telligen	United Healthcare Community & State	Valir PACE Foundation
1		**Estimated Implementation Costs and Savings**							
	A	Costs: Methodology, Assumptions and Constraints	Implementation costs would consist primarily of contracting a provider network and setting up the care coordination model. A detailed budget can be prepared during the implementation time period after the program has been defined more specifically.	Optum does not have access to comprehensive ABD utilization data for Oklahoma. As part of responding to an RFP, that includes sufficient ABD utilization data, Optum will analyze the information provided, estimate the cost of implementation and project cost savings over the course of a five-year contract.	PCNOK's major categories of start up costs are: 1. Attribution methodology & cost $200,000; 2. Shared savings benchmark methodology $400,000; 3. Claims data integration $250,000 -EHR data analytics capability $1,300,000; 4. MyHealth expansion $400,000; 5. Total start-up costs $2,550,000.	RCHC anticipates minimal implementation costs under the pilot model proposed. Annual cost projections were not provided.	Telligen estimates implementation costs would be minimal, limited to staff recruitment and training costs for the new care coordination personnel and the IT costs associated with establishing data links with the state HIEs. The proposed model would be based on integration of care coordination into the HMP program. Annual cost projections were not provided.	Annual cost projections were not provided. United asserts that implementation of an MCO model for the ABD population will result in reasonable implementation costs. The OHCA will experience implementation costs related to developing a competitive procurement and conducting readiness reviews to ensure awarded MCOs are ready to serve members.	Implementation costs are: 1) Capital and human resources for submitting the PACE application; and 2) PACE location: building a new facility or remodeling an existing facility. Valir estimates $220,000 for application costs but could be reduced; building a new facility could cost $250/square foot, but remodeling or leasing would be less
		Year 1	The RFI did not provide specific cost amounts for each year.	The RFI did not provide specific cost amounts for each year.	PMPM payments $2,981,775	The RFI did not provide specific cost amounts for each year.	The RFI did not provide specific cost amounts for each year.	The RFI did not provide specific cost amounts for each year.	$3,235,693
		Year 2			PMPM payments $3,364,592				$7,235,078
		Year 3			PMPM payments $3,759,345				$9,605,721
		Year 4			PMPM payments $4,166,405				$10,778,064
		Year 5			PMPM payments $4,585,317				$11,379,907
		Five-Year Total			Total PMPM payments $18,857,434				$38,998,770

G - Impact of Model

			WellCare Health Plans, Inc.
1		Estimated Implementation Costs and Savings	
	A	Costs: Methodology, Assumptions and Constraints	Annual cost projections were not provided. WellCare recommends the State consider the implementation costs in initial years.
		Year 1	The RFI did not provide specific cost amounts for each year.
		Year 2	
		Year 3	
		Year 4	
		Year 5	
		Five-Year Total	

G - Impact of Model

			Aetna Medicaid Administrators, LLC.	Amerigroup Corporation	AmeriHealth Caritas Family of Companies	Blue Cross Blue Shield of Oklahoma	Care Management Technologies, Inc.	Centene Corporation	DentaQuest
	B	Savings: Methodology, Assumptions and Constraints	Constraint in mature programs is community's capacity to manage high-acuity members outside of institutions, so additional savings after initial years could decrease. Aetna has reduced costs in other programs; for example: 1)$136 PMPM in mental health costs and $175 PMPM for medical care costs for members with comorbid depression and diabetes; 2) $2000-$5000 PMPM savings for moving members from facilities to home or assisted living.	AG used the OHCA's Annual Report for State Fiscal Year 2014. They assumed unit cost and utilization trends to be 2 percent/year and population growth of 1 percent/year. Administrative cost differences are incorporated in the savings calculations. Services not typically provided in FFS environment were added. They based some estimates on their experience in other states.	AHC did not offer specific savings amounts, but said an integrated model would provide diversion from institutional care, but that savings could take several years to realize.	Savings estimates were based on experience in other states. BCBSOK used baseline national PMPM costs for each eligibility subgroup and category of service for 2011 using CMS data; 2011 annual health care market trend; and assumptions specific to the HPCC model. Other assumptions were (for non-duals) a 20 percent reduction in inpatient and outpatient hospital services and prescription drug costs; 10% reduction in home health, lab, and imaging, and a 5 percent reduction in physician costs. Assumptions for reductions for duals were lower.	A behavioral health home in Missouri used CMT's analytic solution and reduced costs by $23.1 million over 18 months. Using Opioid Prescription Intervention Analytics, Missouri's Medicaid Agency achieved a 36.8 percent reduction in hospital admissions and a 14.8-19.1 percent reduction in average dose of opioids. CMT cites another success story in Manitoba of a study of prescribing behavior of physicians that resulted in decreases in inappropriate prescribing.	Savings will be dependent on a number of factors, including member morbidity, current level of health care management being performed, covered service details, and current claims mix. Centene expects they would be able to deliver cost savings related to inpatient and ED claims, and moderate savings in outpatient, specialist, and other medical categories. There would most likely be moderate increases in PCP visits.	In TX, DentaQuest saved $22 million in the first year alone, and they exceeded all requirements around timeliness of access and network.
		Year 1	The RFI did not provide specific savings amounts for each year.	17,723,000	The RFI did not provide specific savings amounts for each year.	$30,027,786		The RFI did not provide specific savings amounts for each year.	The RFI did not provide specific savings amounts for each year.
		Year 2		$39,215,000		$57,793,779			
		Year 3		$40,948,000		$87,733,015			
		Year 4		$42,758,000		$119,974,902			
		Year 5		$44,648,000		$154,655,777			
		Five-Year Total		$184,841,000		$450,185,259			

G - Impact of Model

			GlobalHealth Holdings, LLC.	Magellan Healthcare, Inc.	Maximus, Inc.	McAlester Regional Health Center	MCNA Insurance Company	Meridian Health Plan	Molina Healthcare, Inc.
	B	Savings: Methodology, Assumptions and Constraints	GlobalHealth estimates anticipated savings for the Capitated MCO Care Coordination model. Methodology focuses on development and use of actionable health data on a member's behalf by stakeholders to make more effective and coordinated decisions. Assumptions are a reduction in risk-adjusted PMPM costs over an 18 to 24 month period of 5-8 percent. Constraints that may reduce the efficacy of the capitated model include inaccurate or untimely availability of claims encounter and diagnostic data, and capitation rates for these ABD beneficiaries that are not risk adjusted or are determined unsound.	Based on MCC's Medicaid Managed Care experience in other markets and on national data, we expect gross savings of 10-11 percent in Years 1-3 of the fully capitated managed care model. In Years 4-5, the improving efficiencies will create gross savings of 15 percent.	Savings will grow over time and be dependent on consumers making "rational" choices and cooperating with providers in supporting this model.	The biggest savings are from reduced ED visits and hospitalizations. There will also be savings associated with better management of referrals to specialists. The savings takes into account fewer ED visits and hospitalizations only. The savings assumes the same 2,500 members the entire 5-year period. If this attributed lives were to grow, so too would the potential savings. As they get experience in managing the population in the first three years, the reduction in ED visits and hospitalizations will grow.	The risk is on DBPM, so it is a fixed cost program.	Provided Michigan Medicaid savings model results from 2001-2004.	High levels of savings are achieved on inpatient medical, inpatient surgical and ED visits. Moderate levels of savings are achieved on categories such as mental health, outpatient hospital, and non-institutional LTC. Molina typically experiences low levels of utilization trends through efficient ABD population management. Whether or not the MCO is permitted to use its own prescription drug program will impact savings.
		Year 1	The RFI did not provide specific savings amounts for each year.	The RFI did not provide specific savings amounts for each year.	The RFI did not provide specific savings amounts for each year.	$247,000	MCNA estimates a 10 percent savings in first year.	9 percent savings	As a general rule states can expect to save 2 percent in first year, with additional savings to the cost curve in years 2-5.
		Year 2	5-8 percent			$279,000	Savings in first 3 years in TX and LA were 28.4 percent and 13.9 percent as measured by independent studies.	5 percent savings	
		Year 3				$293,000		2 percent savings	
		Year 4				$266,000		3 percent savings	
		Year 5				$242,000		1 percent savings	
		Five-Year Total				$1,327,000		20 percent savings (note: the savings percentages shown here are as reported in the response; PHPG's own calculation using Meridian's numbers yields a five-year savings percentage of approximately 3.8% ($660 million in savings on a base of $17.3 billion)).	

G - Impact of Model

			Oklahoma Superior Select, Inc.	Optum	Patient Care Network of Oklahoma, LLC.	Res-Care Oklahoma, Inc.	Telligen	United Healthcare Community & State	Valir PACE Foundation
	B	Savings: Methodology, Assumptions and Constraints	Any savings to be incorporated into the target used to calculate shared savings will be determined during the implementation period.		Net savings are before distribution of potential shared savings to PCNOK.	RCHC provides a chart of anticipated savings per member per county for year one but does not provide membership projections in order to calculate total savings in Year 1. RCHC took 58 percent of the 2014 Medicaid Expenditures from the Fast Facts Total Enrollment by County Report. The Pew Charitable Trust's 2010 State Healthcare Spending on Medicaid stated that 58 percent of Medicaid spending in Oklahoma was for ABD claims. The new figure was divided by the number of people in the ABD population.	Telligen estimates savings during the first five years would exceed the savings produced during the first five years of HMP ($182 Million). Annual savings projections were not provided. A higher level of savings would result from a larger member base eligible for care coordination than members who receive care management under HMP. Annual savings projections were not provided.	Annual savings projections were not provided. United recommends including minimal savings assumptions in Year 1. It is United's experience that the savings in Year 1 should offset MCO implementation costs. Savings in Year 2 and beyond depends on multiple factors including but not limited to the populations and benefits included, the number of members enrolled and limitation requirements (such as continuity of care or network mandates.)	A Kitchener 2002 study of HCBS found that on average it saved $43,947 per participant per year. Another study found that the reduction in hospital admissions saved $520 per month per life. A 2009 PACE study showed PACE enrollees to have 38% lower costs than FFS Medicare, and 5-15% lower costs than FFS Medicaid.
		Year 1	The RFI did not provide specific savings amounts for each year.	The RFI did not provide specific savings amounts for each year.	Net $2,106,114		The RFI did not provide specific savings amounts for each year.	The RFI did not provide specific savings amounts for each year.	The RFI did not provide specific savings amounts for each year.
		Year 2			Net $5,361,882	1-5 percent			
		Year 3			Net $6,322,230	1-5 percent			
		Year 4			Net $3,749,583	1-5 percent			
		Year 5			Net $1,201,876	1-5 percent			
		Five-Year Total			Total Net $18,741,685				

G - Impact of Model

			WellCare Health Plans, Inc.
	B	Savings: Methodology, Assumptions and Constraints	Annual savings projections were not provided as the amount of savings is largely dependent on how the program is designed and implemented. Significantly more data needs to be made available regarding utilization patterns and member acuity levels to identify specific savings opportunities. WellCare has found that savings are optimized when MCOs are afforded the flexibility to work with providers, members and partner agencies to structure key components of the program to meet member needs without unnecessary prescription that limits innovation. Further consideration should be given when the institutionalized population is brought into the program. Savings are obtained when members are able to avoid unnecessary custodial care in skilled nursing facilities.
		Year 1	The RFI did not provide specific savings amounts for each year.
		Year 2	
		Year 3	
		Year 4	
		Year 5	
		Five-Year Total	

G - Impact of Model

			Aetna Medicaid Administrators, LLC.	Amerigroup Corporation	AmeriHealth Caritas Family of Companies	Blue Cross Blue Shield of Oklahoma	Care Management Technologies, Inc.	Centene Corporation	DentaQuest
2	Impact on Health Outcomes								
	A	CMS Benchmarks	Aetna recommends these CMS benchmarks: 1) Controlling high blood pressure; 2) Use of high-risk medications for elderly; 3) Preventive care and screening for tobacco use; 4) Use of imaging studies for low back pain; 5) Preventive care and screening for clinical depression; 6) Documentation of current medications; 7) Preventive care and screening for Body Mass Index; 8) Closing the referral loop receipt of specialist report; and 9) Functional status assessment for complex chronic conditions.	AG recommends that OHCA measure performance through industry standard measures (such as HEDIS, CAHPs, and provider satisfaction surveys). They anticipate these measures: 1) Increased access to preventive care; 2) Increase in participants in the community; 3) Reduced unnecessary inpatient stays and ED use; 4) Increased access to HCBS; 5) Improved quality and lower costs through improved coordination; 6) Reduced or prevented decline in function and need for more intensive interventions; and 7) Increased member involvement and self-directed care.	This section was not addressed in the RFI.	BCBSOK cites two examples of CMS measures: 1) Controlling high blood pressure (also an OK SIM measure): HPCC models have shown rates exceeding 75% in the aged population; 2) Tobacco use (also a SIM measure).		Centene uses a continuous quality improvement cycle, selecting areas for improvement based on industry benchmarks, such as the most current CMS recommended benchmarks, HEDIS, and Medicare STARS, as well as state goals.	Most of the CMS Recommended Core Measures do not directly apply to dental, but good oral health plays a big role in overall health. For example, there is a conclusive link between dental disease and diabetes and heart disease.
	B	State Identified Areas	Aetna's model incorporates each of the OK-identified areas for quality management intervention.	AG recommends developing outcome measures that align with core values of new program.	This section was not addressed in the RFI.	HPCC model can support members in weight loss through offering rewards, gym memberships, healthy eating programs, educational materials, fitness tracking devices, and other means. Care coordinators can reach out to members to encourage screenings and immunizations, as well as assisting with appointment scheduling. HPCCs have experience with programs to promote medication adherence for high blood pressure and other conditions. Maternity programs may arise within the ABD population.		Centene uses state goals such as those outlined in the OK State Plan (OHIP) 2020.	Some of concerns cited in the OK State Innovation Model key in DQ's goals associated with medical-dental integration and overall wellness.

G - Impact of Model

			GlobalHealth Holdings, LLC.	Magellan Healthcare, Inc.	Maximus, Inc.	McAlester Regional Health Center	MCNA Insurance Company	Meridian Health Plan	Molina Healthcare, Inc.
2	**Impact on Health Outcomes**								
	A	CMS Benchmarks	GlobalHealth's Quality Improvement Program (QIP) includes CMS recommended benchmarks. GlobalHealth would incorporate ABD beneficiaries into the current QIP. QIP evaluates based on Member and Provider surveys, HEDIS and QRS quality reporting, and improvement action plans.	In other states, Magellan's programs have already developed and implemented clinical protocols and care management programs to address many of the CMS recommended core measures and OHIP goals.	Put into place a "star rating" system so consumers can choose their plan and effectiveness of the plan will drive choice.	McAlester provides ten measures for inclusion.	CMS 2014 Clinical Quality Measures do not include oral health.	Using a local approach, Meridian will be able to develop strategic goals that align with the State's requirements as well as those benchmarks recommended by the Centers for Medicare and Medicaid Services. These goals will focus on controlling high blood pressure, prescription medications (i.e., high-risk medications), preventative care, tobacco cessation, health risk assessments, behavioral health, complex\chronic conditions, and many other items.	As is standard operating practice for all of its state MCO health plans, Molina utilizes evidence based practices, practical experience, industry standards, and national standards and benchmarks to establish key performance indicators used to ensure meeting CMS requirements and demonstrate accountability.
	B	State Identified Areas	The following are projections over 18-24 months: 1) Preventive health screenings increase by 15-20%; 2) Tobacco cessation enrollment increase by 25%; 3) PMPM cost reduction of 10-15% within obesity/diabetes/ hypertension patient cohorts; 4) prescription drug use improvement by 20% in terms of adherence, contra-indication, and high-risk medication; 5) PMPM cost reduction of 5-10% within CAD/CHF/COPD cohorts; 6) PMPM cost reduction of 5-10% within mental and behavioral health patient cohorts; 7) ER visits and ER direct inpatient admissions reduction of 10-15%; and 8) R+K24eadmission reduction of 10-15%	This section was not addressed in the RFI.	Maximus would work with the state and providers to identify the specific metrics they would use for these conditions. The state would use performance metrics in calculating defined payment structure and contracts with providers.	1. Tobacco cessation and education. 2. Increase access to Primary Care providers. 3. Recognition and screening of behavior health issues. 4. Participation is health care prevention by establishing regular interval visits with health care provider. a. Healthy- Encourage healthy lifestyles. b. At Risk- Intervene risk and keep from becoming chronic. c. Chronic- Prevent disease progression and avoid unnecessary complications. d. Catastrophic- Mange benefits, controls costs, provide dignity through end of life. 5. Nutritional support and education to decrease obesity.	This section was not addressed in the RFI.	There were no specific measures that were provided in the response.	This section was not addressed in the RFI.

G - Impact of Model

			Oklahoma Superior Select, Inc.	Optum	Patient Care Network of Oklahoma, LLC.	Res-Care Oklahoma, Inc.	Telligen	United Healthcare Community & State	Valir PACE Foundation
2	**Impact on Health Outcomes**								
	A	CMS Benchmarks	OSSI recommends national and industry standards for outcomes and measurements proven to be effective, such as the Health Care Effective Data and Information Set (HEDIS) as well as cooperating with organizations and states to review health and health measures. OSSI recommends that the OHCA require plans to have a comprehensive system of data and self-reporting and have the ability to use these reports to improve outcome, coordination, and knowledge regarding Oklahoma's ABD population.	At this time, Optum does not have the data or depth of understanding of Oklahoma's ABD Medicaid beneficiaries to provide a reasonable projection of improvements that might be anticipated in these areas.	This section was not addressed in the RFI.	RCHC includes a table of the CMS' Clinical Quality Measures (CQM) and how their model will meet these outcomes (e.g., assessment, care plans, disease management programs, etc.).	Telligen feels there are significant gaps in the CMS Core Measures as it relates to assessing the impact of care coordination. The Core Measures included in the Respondent's Library were designed to measure meaningful use of Health Information Technology.	United provides a table of quality indicators for the OHCA to consider for the ABD population (i.e., patient safety, access and availability, member and provider satisfaction, care in the least restrictive setting, and program/process measures).	In 2015 CMS contracted with a vendor to add benchmarks for PACE models as follows: 1) Falls; 2) Pressure ulcers, including prevention; 3) Number of hospital admissions and readmissions; and 4) Number of admissions and days spent in NF.
	B	State Identified Areas	OSSI's approach includes all of the state identified areas such as preventive screenings, tobacco cessation, obesity, immunizations, diabetes, hypertension, prescription drug use, hospitalizations, readmissions, emergency room use and other risk areas.		This section was not addressed in the RFI.	RCHC provides feedback on how their model will improve preventive screenings, tobacco cessation and prescription drug use, obesity, immunizations, diabetes and hypertension, and hospitalizations and readmissions.	The care management component of HMP has already demonstrated a positive impact in several of the state identified areas.	United recommends the OHCA ensure that the quality framework encourages MCOs to incentivize physicians, structure community interventions and support health outcomes.	PACE has programs in place for diabetes, obesity smoking, ED reduction, and addiction.

G - Impact of Model

			WellCare Health Plans, Inc.
2	**Impact on Health Outcomes**		
	A	CMS Benchmarks	This section was not addressed in the RFI.
	B	State Identified Areas	Of particular interest for Oklahoma are defined measurable outcomes in such areas as diabetes or heart disease management and obesity.

G - Impact of Model

			Aetna Medicaid Administrators, LLC.	Amerigroup Corporation	AmeriHealth Caritas Family of Companies	Blue Cross Blue Shield of Oklahoma	Care Management Technologies, Inc.	Centene Corporation	DentaQuest
	C	Core Measures: OHIP 2020	This section was not addressed in the RFI.	This section was not addressed in the RFI.	This section was not addressed in the RFI.	Proposed model would allow for an effective initial alignment between OHIP/OHCA, OSIM, and health plan.		Centene uses state goals such as those outlined in the OK State Plan (OHIP) 2020.	Same as above. Also, DQ is taking substantial steps to reduce ED usage for dental problems.
	D	Respondent Suggestions				Some additional benchmarks: 1) Ambulatory care follow-up within 14 days of inpatient discharge; 2) Follow-up after hospitalization for mental illness; 3) Anti-depressant medication management; 4) Utilization of the PHQ-9 to monitor depression symptoms for adolescents and adults; and 5) Movement of members between NFs and community.		Centene has programs in place, such as prenatal care programs, concurrent review to decrease readmissions, and disease management programs for smoking cessation, weight management, depression, and chronic pain management. They also have incentive programs to increase member compliance with preventive health services. Their provider payment strategies have resulted in improved adherence to population health clinical practice guidelines, such as monitoring BMI and educating patients about smoking cessation.	

G - Impact of Model

			GlobalHealth Holdings, LLC.	Magellan Healthcare, Inc.	Maximus, Inc.	McAlester Regional Health Center	MCNA Insurance Company	Meridian Health Plan	Molina Healthcare, Inc.
	C	Core Measures: OHIP 2020	These integrated managed care coordination strategies, activities, and tools will be employed to enhance and support the OHIP 2020 core measure improvement targets and initiatives, including but not limited to, behavioral health services access and utilization, obesity reduction, and tobacco cessation.	In other states, Magellan's programs have already developed and implemented clinical protocols and care management programs to address many of the CMS recommended core measures and OHIP goals.	Similar to state-defined metrics. ASO would be cognizant of these measures and the outcomes of the providers on the metrics in helping consumer select providers.	Tobacco use, obesity reduction, children's health, and behavioral health, are our largest identified areas for improvement with the majority of this population being between the ages of 18-64.	OHIP does not contain oral health measures.	Restated OHIP goals: Reduce adult smoking prevalence from 23.7 percent in 2013 to 18 percent in 2020, Reduce adolescent obesity prevalence from 11.8 percent in 2013 to 10.6 percent in 2020, Reduce infant mortality from 6.8 per 1,000 live births in 2013 to 6.4 per 1,000 live births, Improve population health – Reduce heart disease deaths by 11 percent by 2020, and Reduce the prevalence of untreated mental illness from an 86 percent treatment gap to 76 percent in 2020. Provided examples of relevant initiatives in other states.	Based on Molina's experience with their current 12 health plans, State can expect a 3-8 percent positive impact on preventive screenings, immunizations, diabetes, hypertension, prescription drug use, hospitalizations, readmissions, ER use, children's health, and BH. They are finalizing metrics related to tobacco use and obesity.
	D	Respondent Suggestions	GlobalHealth suggests quality measures that are nationally recognized. Sample benchmarks for LTSS/HCBS services and recipients include: 1)COPD in older adults readmission rate; 2) CHF readmission rate; 3) Uncontrolled diabetes admission rate; 4) Prevention quality overall composite; 5) Prevention quality chronic composite; and 6) Hospitalization due to pressure ulcers	The MCOs must collaborate with members and caregivers to develop care plans focused on independent living for people who have disabilities. This focus must be included in the program goals, so LTSS and HCBS specific measures should be used to monitor its success, including but not limited to: 1. Member satisfaction 2. Provider satisfaction (to ensure continued access to a broad network of LTSS providers) 3. Community transitions 4. Extended community tenure 5. Self-direction 6. Supportive employment and continued employment.	Broaden base for bonus payments (including consumer satisfaction/quality of life metrics), incentivize healthy behaviors, broaden allowable reimbursements, and provide preventive services.	Other benchmarks include: 1. Accessibility to see patients same day and/or within 24 hours of request. 2. Decrease in ER visits. 3. Increase in patient and provider satisfaction. 4. Community involvement in providing a better environment for all residents. 5. Number of visits to Primary Care Provider, ER, Hospital Stays, and/or any other health care service provided. 6. Disease management and care coordination.	MCNA uses HEDIS measure for children completing annual visit; 5 preventive care standards include prophylaxis, fluoride application, sealant for molars, recall visits, and dental home.	Meridian offers evidence-based, Disease Management (DM) programs developed from clinical guidelines to target chronic conditions. Meridian also incorporates a whole-person approach to coordinating services and highlights the importance of coordinating services for all members' physical, behavioral, and social needs, including members with multiple comorbidities. Meridian DM programs offer coordination services for diabetes, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), asthma, coronary artery disease (CAD), chronic kidney disease (CKD), end-stage renal disease (ESRD), and depression.	Additional benchmarks include: 1) HCBS spend as percent of total LTSS spend; 2) Percent of NFs with 4+ STAR Medicare ratings; 3) Percent of patients admitted to acute care hospital for at least 24 hours while receiving home health care; 4) Percent of patients receiving home health care who needed urgent or unplanned care in ER; 5) Long-stay, high-risk residents with pressure ulcers; 6) Long-stay residents who self-report moderate to severe pain; 7) Long-stay residents whose need for help with daily activities increases; 8) Long-stay residents assessed and appropriately given the pneumococcal vaccination; 9) Long-stay residents assessed and appropriately given the seasonal flu vaccination.

G - Impact of Model

			Oklahoma Superior Select, Inc.	Optum	Patient Care Network of Oklahoma, LLC.	Res-Care Oklahoma, Inc.	Telligen	United Healthcare Community & State	Valir PACE Foundation
	C	Core Measures: OHIP 2020	Tobacco cessation, Obesity, Children's health, and behavioral health measures are noted in the response.	This section was not addressed in the RFI.	PCNOK's work is highly aligned with the work of OHIP.	RCHC outlines the OHIP core measures and goals and how RCHC will meet these.	The core measures within OHIP represent a diverse set of clinical and public health goals, some of which will be impacted by care coordination while others are not. Telligen highlights each of these in their proposal.	This section was not addressed in the RFI.	
	D	Respondent Suggestions	Along with national and industry standards, benchmarks should be established that measure the effectiveness of the care coordination services provided and whether adherence to the services provided are having a positive or negative effect on the member due to indirect circumstances. Specific suggestions are noted in the response.		PCNOK proposes to work with the OHCA to set new baselines and performance improvement goals.	RCHC recommends the OHCA use CMS' Home Health benchmarks included in Attachment 1-3 of their response.	Telligen recommends the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP.		

G - Impact of Model

			WellCare Health Plans, Inc.
	C	Core Measures: OHIP 2020	WellCare recommends that OHCA ensure that: 1. Nationally recognized metrics are used where available to meet State measurement goals; 2. Adequate testing and validation of measures have been completed prior to use; 3. Selected performance measures apply to areas that are within health plan control; 4. Methodologies behind proposed metrics are publically available at the time of implementation; 5. Benchmarks are established in collaboration with health plans and other relevant stakeholders; and 6. Adequate display years are used prior to implementation of quality withholds or incentive payments.
	D	Respondent Suggestions	WellCare recommends the OCHA identify initially selected performance measures that rely on administrative data such as claims and encounters, rather than metrics that use medical records or clinical extraction. Administrative data also includes data derived from paper records but created in electronic format as is allowed by HEDIS currently.

G - Impact of Model

		Aetna Medicaid Administrators, LLC.	Amerigroup Corporation	AmeriHealth Caritas Family of Companies	Blue Cross Blue Shield of Oklahoma	Care Management Technologies, Inc.	Centene Corporation	DentaQuest
E	Considerations for Value-Based Performance Designs/Alignment with OK SIM Model	This section was not addressed in the RFI.	AG recommends: Phase 1: Bring together experts from across the state to define performance measures Phase 2: OHCA, MCO, and providers develop a multi-payer, value-based purchasing model that fairly compensates providers, incentivizes healthy behaviors, and reinforces quality Phase 3: OHCA should require MCO to proactively use data analytics to identify opportunities to enhance member outcomes. Providers should be encouraged to adopt EHR.	This section was not addressed in the RFI.	Results should be measured using claims, EHRs, clinical results, and not dependent on medical record review.		This section was not addressed in the RFI.	This section was not addressed in the RFI.
	Other Notes	Aetna recommends through ongoing quality monitoring and input from OHCA to identify other measures such as: 1) CHILD CAHPS item set; 2) Member satisfaction with care management; 3) Quality of LTSS and BH services; 4) Transportation complaints; 5) Home health assessment of needed preventive services; 6) Immunizations, asthma action plans, home safety measures; and 7)Caregiver stress.	AG recommends that OHCA continue to include a range of HEDIS measures . Additional measures to evaluate LTSS performance should be developed, such as home environment, participation of caregivers, use of self-direction, social interactions, level of independence of member, and care setting. Quality of life measures should also be considered, such as the National Core Indicators. All measures should align with value-based purchasing approaches.				Centene recommends measures that can be calculated using encounter data or other electronically available data to ensure consistency. They support increasing the adoption of Electronic Medical Records and the promotion of statewide Health Information Exchanges.	

G - Impact of Model

			GlobalHealth Holdings, LLC.	Magellan Healthcare, Inc.	Maximus, Inc.	McAlester Regional Health Center	MCNA Insurance Company	Meridian Health Plan	Molina Healthcare, Inc.
E		Considerations for Value-Based Performance Designs/Alignment with OK SIM Model	GlobalHealth's Capitated MCO model is complementary to the goals and objectives of the Oklahoma State Innovation Model (OSIM). It supports CMS' and OSIM's Triple Aim objectives.		The ASO would be cognizant of these objectives and work with the State to develop core measures to assess providers to determine value-based incentives that encourage the types of behavior the State wishes to incentivize.	1. Efficiency: a. Decrease the overall spend amount for the patients indicated above. b. Increase appropriate utilization of individual's time. 2. Reduce Readmissions: a. Proactively manage the health of those who have chronic conditions to prevent the acute exacerbation episodes. b. Provide education to increase the overall knowledge of disease specific indications and decrease knowledge deficit. c. Encourage participation in local support groups to provide the ability to network with others with similar chronic conditions.	MCNA has program (called "STARR") in TX to reward providers for performance in the five preventive care measures.	If selected as the model of choice, the OHCA should require MCOs to notify the State of any risk sharing agreements arranged with providers and should require in the provider agreement submission of encounter data within 90 days of the date of service for any providers paid on a capitated basis.	Molina's VBR and P4P programs will allow them to engage in all 3 SIM phases.
		Other Notes				The American Community Survey conducted by the U.S. Census bureau estimated that in 2013, 15.4% of people in the United States over the age of 65 had independent living difficulties, defined as difficulty doing errands alone such as visiting a doctor's office or shopping because of physical, mental, or emotional problem.			

G - Impact of Model

			Oklahoma Superior Select, Inc.	Optum	Patient Care Network of Oklahoma, LLC.	Res-Care Oklahoma, Inc.	Telligen	United Healthcare Community & State	Valir PACE Foundation
E		Considerations for Value-Based Performance Designs/Alignment with OK SIM Model	OSSI recommends: 1. Pay-for-performance; 2.Pay-for-quality; and 3. Accountable care arrangements.	Optum endorses the SIM framework and encourages the OHCA to work with its stakeholders and consider performance-based incentives for members and providers.	This section was not addressed in the RFI.	We suggest OHCA uses the Value-Based Purchasing Goals listed below to measure providers' success: 1. Payment incentives; 2. Joint accountability; 3. Effectiveness; 4. Ensuring access; 5. Safety, transparency; 6. Smooth transitions; and 7. Improved technology.	This section was not addressed in the RFI	United supports the continued advancement and P4P investments in future years. Capitation rates should reflect the value of the portion of withholds for targets that the MCOs can reasonably achieve. The capitation rates should not reflect the value of incentives. The actuary should also consider any limitations to the amount of incentive payments or withholds specified in legislative regulations or guidance.	
		Other Notes							

G - Impact of Model

			WellCare Health Plans, Inc.
	E	Considerations for Value-Based Performance Designs/Alignment with OK SIM Model	The standardization of metrics while also allowing innovation and flexibility among plans will be an important component of a strong Value-Based System. While the state has a history of provider-based managed care, the transition to standard MCO model calls for a phased in approach to value purchasing. WellCare discourages prescriptive, one-size fits all models of value-based purchasing or value-based system design.
		Other Notes	

H - Timelines - Key Activities and Milestones

			Aetna Medicaid Administrators, LLC.	Amerigroup Corporation	AmeriHealth Caritas Family of Companies	Blue Cross Blue Shield of Oklahoma	Care Management Technologies, Inc.	Centene Corporation	DentaQuest
1		**Development** *(list by population, if appropriate)*							
	A		Market development, outreach, and provider network development: Apr-Jun 2016. Expansion of infrastructure and provider network development: May-Oct 2016 (6 months).	Network development: April 2016 through implementation.	Business requirements, final project plan, staffing, training, provider contracting and credentialing: 6-8 months.	Initial contract start-up (establish project management and work groups): 1 month.	This was not addressed in the RFI response.	Project Initiation Phase includes: 1) Program scope creation; 2) Contractual requirements/timeline; 3) Work plan development; and 4) Resource planning/accountability matrix. Centene did not include specific dates or timeframes.	Initiation and requirements definition, systems analysis/general design, technical design, development. DQ estimates a 5-month implementation period is needed after contract award.
	B								
	C								
	D								
	E								
	F								

H - Timelines - Key Activities a

			GlobalHealth Holdings, LLC.	Magellan Healthcare, Inc.	Maximus, Inc.	McAlester Regional Health Center	MCNA Insurance Company	Meridian Health Plan	Molina Healthcare, Inc.
1	**Development** *(list by population, if appropriate)*								
	A		They estimate that a full implementation plan could be successfully completed in approximately 4 to 6 months from contract execution date to member service delivery go-live date.	Magellan expects implementation to take place 8-12 months after contract awards. A detailed timeline was not included in the response.	Maximus proposes creation of an ASO in 3-6 months.	Development began with a research into Population Health in October of 2014. The research derived was put into business proposal form and presented to the Administrative Executive Team and Business Development Committee for the Board of Trustees in February 2015.	Go-live within 30 days of contract award.	Four months	System development and data transfer, network development/adequacy, administration and key personnel, material subcontractor site visits, organizational and financial readiness: 8 months.
	B								
	C				Determine best alternative for housing the ASO centrally				
	D				Establish the organizational and governance structure for field-based staff operations				
	E				Create the organizational chart and job descriptions				
	F				Develop the requisite policies and procedures for both provider and				

H - Timelines - Key Activities a

			Oklahoma Superior Select, Inc.	Optum	Patient Care Network of Oklahoma, LLC.	Res-Care Oklahoma, Inc.	Telligen	United Healthcare Community & State	Valir PACE Foundation
1	**Development** *(list by population, if appropriate)*								
	A		Month 1: At this time, framework discussions, community hearings, and stakeholder identification begins. Concept regarding implementation and development of the model should be discussed with authority figures including appropriate government legislative bodies and appropriation committees.	A typical implementation for this type of program would span six months assuming draft contract, requirements, model of care, and operating model drafts were available upon award to allow adequate preparation for a successful program go-live.	18 months (months 0-18)	RCHC's model can be rolled out within 9 months of decision.	Telligen anticipates approximately 90 days would be needed following program implementation to finalize operational details with the OHCA since the proposed model is based on the existing HMP.	United recommends 9-12 months between contract award and the date that services "go-live" for members.	Since the OHCA allows only one Chapter 10 application per month, it would be a 10-12 month process. This could go faster if the OHCA decided to allow more than one per month. Application to CMS review could be 90 days.
	B		Month 2: Public input should continue. White paper publications should be published and disseminated to the public regarding the implementation process. Advisory meetings should be held with government health care organizations and non-governmental stakeholders.					United recommends the OHCA: 1. Provide adequate time and removing obstacles for network development; 2. Avoid requiring highly specified relationships with vendors or providers that can complicate an MCO's ability to negotiate rates and build adequate networks; 3. Allow for the use of proprietary assessment tools to minimize implementation burdens; 4. Recruiting qualified staff to support members; 5. Define, as early as possible, (ideally during the procurement process) any specific technology requirements to allow MCOs adequate time if new processes need to be built; and 6. Define and disclose to MCOs as early as possible (ideally during the procurement process), any and all benefits, to allow time to build a provider network that will meet all benefit requirements.	
	C		Month 3: Discussions with the OHCA regarding waiver requests, assuming no policy changes with waivers. Network adequacy development and discussions should begin.					United highlights key implementation activities to be: 1. Time to establish office space to carry out the operations of the program; 2. Staffing and not requiring in-state requirements; 3. Design, build and test systems; and 4. Development of specific Oklahoma policies and procedures.	
	D		Month 4: Procurement approach should be developed, either internally or in conjunction with the OHCA.						
	E		Month 5: Discussions and arrangements with enrolment brokers and third party vendors should begin.						
	F								

H - Timelines - Key Activities a

			WellCare Health Plans, Inc.
1		**Development** *(list by population, if appropriate)*	
	A		12 months total with network development taking the most tine. Details for each implementation activity and their timeframes are provided.
	B		
	C		
	D		
	E		
	F		

H - Timelines - Key Activities and Milestones

			Aetna Medicaid Administrators, LLC.	Amerigroup Corporation	AmeriHealth Caritas Family of Companies	Blue Cross Blue Shield of Oklahoma	Care Management Technologies, Inc.	Centene Corporation	DentaQuest
	G								
	H								
	I								
	J								
	K								
2	**Transition/Readiness Activities** *(list by population, if appropriate)*								
	A		Hiring staff, begin communications with stakeholders, providers, members: Sep-Nov 2016.	Outreach to stakeholders, implementation meetings between OHCA and MCO, readiness reviews, finalize provider network, member assessments completed: Jan-Oct 2017.	Ensure staffing and plant resource, MIS development and readiness testing, benefit configuration activities, electronic health record implementation, provider interface, interface with data warehouse for state and federal reporting, contingency plan, transition plan: 1-2 months overlapping with development period.	Staffing, develop provider network identify subcontractors, establish relationships with community partners and services, develop business requirements for all operational areas: 9-12 months.	This was not addressed in the RFI response.	Transition activities include: 1) Resource monitoring and engagement; 2) Risk assessment and mitigation; and 3) Transition of knowledge. Centene did not include specific dates or timeframes.	Communicate with members, assess operational readiness, documentation, develop and report distribution schedules, finalize conversion plan. DQ estimates a 5-month implementation period is needed after contract award.
	B								
	C								
	D								
	E								
	F								
	G								
	H								
	I								
	J								
	K								

H - Timelines - Key Activities a

			GlobalHealth Holdings, LLC.	Magellan Healthcare, Inc.	Maximus, Inc.	McAlester Regional Health Center	MCNA Insurance Company	Meridian Health Plan	Molina Healthcare, Inc.
	G				Identify the infrastructure requirements, plan necessary				
	H				Develop the training program for consumer services, provider				
	I				Working with the state, select or develop an appropriate consumer				
	J				Working with stakeholders and the Maximus Center for Health Literacy,				
	K				Plan marketing and PR				
2	**Transition/Readiness Activities** *(list by population, if appropriate)*								
	A		They estimate that a full implementation plan could be successfully completed in approximately 4 to 6 months from contract execution date to member service delivery go-live date.	Member letters distributed 90 days prior to go-live.	Prepare shared-services facility for new staff	The MRHC nursing leadership and IT have worked tirelessly for months to redesign our discharge routine within our Electronic Health Record. It is now going to be a multidisciplinary care transitions model for all areas of care to document and communicate with one another. This will go live the middle of August.	Transition plan will include all activities that must be completed prior to start date, including OHCA Readiness Reviews. They anticipate weekly internal team meetings, documentation of requirements, continuous risk management, dedicated resources, and continuous communication with OHCA. They have 2 decades experience serving Medicaid and CHIP populations.	1 month	Testing, readiness review, transition plan: 3 months concurrent with the final 3 months of development.
	B				Implement ASO systems				
	C				Develop consumer materials to include notices, enrollment package, health insurance literacy curriculum, choice counseling scripts, outreach strategies, and any necessary translation of materials				
	D				Develop provider materials				
	E				Onboard staff				
	F				Train staff				
	G				Perform provider education and recruitment				
	H				Ensure care delivery infrastructure is ready to proceed				
	I				Perform readiness reviews				
	J				Implement consumer and provider marketing campaigns				
	K				Perform transfer of individuals already enrolled with providers and				

H - Timelines - Key Activities a

			Oklahoma Superior Select, Inc.	Optum	Patient Care Network of Oklahoma, LLC.	Res-Care Oklahoma, Inc.	Telligen	United Healthcare Community & State	Valir PACE Foundation
	G								
	H								
	I								
	J								
	K								
2	**Transition/Readiness Activities** *(list by population, if appropriate)*								
	A		Month 6: Review of contracts with providers and facilities should begin.	A typical implementation for this type of program would span six months assuming draft contract, requirements, model of care, and operating model drafts were available upon award to allow adequate preparation for a successful program go-live.	12 months (months 18-30)	RCHC provides three phases of readiness: 1. Phase 1: 1-2 years to pilot program, early experimentation 2. Phase 2: 3-4 years for additional and more complex clinical, efficiency, and quality measures; and 3. Phase 3: 5+ years for Increased sophistication and complexity.	Following development, Telligen anticipates another 30 days needed to install and test data connections with the OHCA and HIEs, complete hiring and training in the team of care coordination staff and work with HMP personnel to coordinate and integrate program operations.	United recommends the OHCA plan for all readiness activities (desk reviews and systems readiness) 90 days before services "go-live" for members. United recommends the OHCA provide MCOs with complete and finalized information on requirements and provide the readiness timeframe and the OHCA's evaluation criteria.	Activities include: 1) Determine territories for additional PACE centers; 2) Identify physical location and hire staff. Total of 5-9 months.
	B		Month 7: Contracts should be finalized and ready for implementation. Care coordination efforts should begin including dissemination of communication materials, information systems, protocols, and letters of agreement.						
	C		Month 8-9: Formal agreements of notice are sent out to LTSS providers regarding care coordination changes. Full compliance of contract.						
	D								
	E								
	F								
	G								
	H								
	I								
	J								
	K								

H - Timelines - Key Activities a

			WellCare Health Plans, Inc.
	G		
	H		
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	K		
2	**Transition/Readiness Activities** *(list by population, if appropriate)*		
	A		Allow up to one month. Readiness to be conducted during the month prior to "go live".
	B		
	C		
	D		
	E		
	F		
	G		
	H		
	I		
	J		
	K		

H - Timelines - Key Activities and Milestones

			Aetna Medicaid Administrators, LLC.	Amerigroup Corporation	AmeriHealth Caritas Family of Companies	Blue Cross Blue Shield of Oklahoma	Care Management Technologies, Inc.	Centene Corporation	DentaQuest
3	**Implementation of Member Enrollment** *(list by population, if*								
	A		End of Nov 2016	Member enrollment, continuity of care process, member choice: Jul-Sep 2017.	60-90 day period for members to choose plan	Phased enrollment period	This was not addressed in the RFI response.	Implementation includes: 1) Eligibility system and file transfer configuration; 2) Receipt of historical claims history from OHCA; 3) Auto assignment algorithm defined; 4) Open enrollment; and 5) New member packets mailed. Centene did not include specific dates or timeframes.	DQ estimates a 5-month implementation period is needed after contract award.
	B								
	C								
	D								
	E								
	F								
	G								
	H								
	I								
	J								
	K								

H - Timelines - Key Activities a

			GlobalHealth Holdings, LLC.	Magellan Healthcare, Inc.	Maximus, Inc.	McAlester Regional Health Center	MCNA Insurance Company	Meridian Health Plan	Molina Healthcare, Inc.
3	**Implementation of Member Enrollment** *(list by population, if*								
	A		They estimate that a full implementation plan could be successfully completed in approximately 4 to 6 months from contract execution date to member service delivery go-live date.	Enrollment begins 2 months prior to go-live.	Implement enrollment awareness marketing campaign	Patients will have to meet the criteria as identified	MIS can receive and process enrollment files in format and frequency specified by OHCA.	1/1/2017	Process production data including member eligibility, provider, authorizations, claims, encounters: 3 months.
	B				Send materials explaining new process to individuals and invite potential members to call toll free number				
	C				Provide notices at the 30 day, 60 day, and 90 day mark				
	D				Perform outreach campaign to those not making choices				
	E				Initiate health risk assessment and choice counseling for those calling				
	F				Enroll members and send enrollment transactions to different				
	G								
	H								
	I								
	J								
	K								

H - Timelines - Key Activities a

			Oklahoma Superior Select, Inc.	Optum	Patient Care Network of Oklahoma, LLC.	Res-Care Oklahoma, Inc.	Telligen	United Healthcare Community & State	Valir PACE Foundation
3	**Implementation of Member Enrollment** *(list by population, if*								
	A		Month 10-11: Phased enrolment begins. As members are stratified based on risk attribution, specific providers are assigned based on member need and health status.	A typical implementation for this type of program would span six months assuming draft contract, requirements, model of care, and operating model drafts were available upon award to allow adequate preparation for a successful program go-live.	12 months (months 30-42)	RCHC suggests the OHCA initially focus on individuals with the highest utilization costs. After an initial successful pilot program, OHCA can identify individuals appropriate for transition out of nursing facilities and ICF/IDD to their own homes.	This would take approximately 120 days following the program launch date.	United recommends the OHCA provide member contact information to MCOs and allow communication before the "go-live" date. They encourage sharing information such as claims history, past completed assessments, and recent prior authorizations. To ensure that all new members receive assessments, the OHCA should establish an appropriate window of time to complete assessments for all members, regardless of individual complexity such as 120 - 180 days.	Enrollment is simple. Assessment and plan of care follows.
	B							MCOs should be able to transition members from existing services upon completion of assessments and development of comprehensive plans of care without arbitrary timeframes to maintain services that do not align with the plans of care.	
	C								
	D								
	E								
	F								
	G								
	H								
	I								
	J								
	K								

H - Timelines - Key Activities a

			WellCare Health Plans, Inc.
3	**Implementation of Member Enrollment** *(list by population, if*		
	A		Allow up to eight months. This should be completed 3 months prior to "go live".
	B		
	C		
	D		
	E		
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	I		
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H - Timelines - Key Activities and Milestones

			Aetna Medicaid Administrators, LLC.	Amerigroup Corporation	AmeriHealth Caritas Family of Companies	Blue Cross Blue Shield of Oklahoma	Care Management Technologies, Inc.	Centene Corporation	DentaQuest
4	**Implementation of Member Service Delivery** *(list by population, if*								
	A		Go live: Jan 2017	Go live: Oct 2017	Go live: 10-12 months	Go live: 9-12 months after contract award	This was not addressed in the RFI response.	Centene did not include specific dates or timeframes.	DQ estimates a 5-month implementation period is needed after contract award.
	B		Aetna recommends that OK provide complete historical data files (claims, authorizations, service plans) at least 60-90 days prior to go-live.						
	C								
	D								
	E								
	F								
	G								
	H								
	I								
	J								
	K								

H - Timelines - Key Activities a

			GlobalHealth Holdings, LLC.	Magellan Healthcare, Inc.	Maximus, Inc.	McAlester Regional Health Center	MCNA Insurance Company	Meridian Health Plan	Molina Healthcare, Inc.
4	**Implementation of Member Service Delivery** *(list by population, if*								
	A		They estimate that a full implementation plan could be successfully completed in approximately 4 to 6 months from contract execution date to member service delivery go-live date.	One month open enrollment period every year after implementation.	Provide counseling of consumers on network they've chosen	Approval of TCMC	Benefit administration can begin immediately upon enrollment.	1/1/2017	Member service delivery will begin 12 months after contract award.
	B				Transmit Health Risk Assessment Data to providers	Care mapping/resources identified/scope of care defined			
	C				Provide ongoing care coordination for non-MCO providers as desired	Organization chart developed/forms approved			
	D				Perform data analysis, ongoing monitoring of provider	Identification of appropriate staff/approval of job descriptions			
	E					Soft opening of TCMC			
	F					Data review (community health needs assessment)			
	G					Hard opening of TCMC			
	H					Identify applicable metrics			
	I					3 PDCA cycles			
	J					6 month review of processes for TCMC			
	K								

H - Timelines - Key Activities a

			Oklahoma Superior Select, Inc.	Optum	Patient Care Network of Oklahoma, LLC.	Res-Care Oklahoma, Inc.	Telligen	United Healthcare Community & State	Valir PACE Foundation
4	**Implementation of Member Service Delivery** *(list by population, if*								
	A		Month 12+: Plan goes live. New LTSS model program begins with continued actions as previously stated.	A typical implementation for this type of program would span six months assuming draft contract, requirements, model of care, and operating model drafts were available upon award to allow adequate preparation for a successful program go-live.	20 months (months 30-60)	Refer to implementation of member enrollment above.	Care coordination activities would begin immediately following member enrollment into the program, which would be approximately 120 days following the program launch.	United recommends the OHCA consider allowing MCOs to use technology to aid the onboarding of new members.	Begins immediately after enrollment and assessment.
	B								
	C								
	D								
	E								
	F								
	G								
	H								
	I								
	J								
	K								

H - Timelines - Key Activities a

			WellCare Health Plans, Inc.
4	**Implementation of Member Service Delivery** *(list by population, if*		
	A		Care coordination development takes nine months. This should be completed two months prior to "go live".
	B		
	C		
	D		
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STATE OF OKLAHOMA
SUMMARY OF RESPONSES TO ABD CARE COORDINATION RFI

I - Market Feasibility - Considerations, Observations and Potential Opportunities

		Aetna Medicaid Administrators, LLC.	Amerigroup Corporation	AmeriHealth Caritas Family of Companies	Blue Cross Blue Shield of Oklahoma	Care Management Technologies, Inc.	Centene Corporation	DentaQuest
1	**Environmental Conditions**	Aetna will work to cultivate collaborative relationships with rural providers. They support OK's efforts in offering incentives to providers who adopt electronic health records. Transportation must cover a range of geographic and member-specific needs.	AG recommends that OHCA consider these factors: 1) Urban concentration of services and geographically remote areas; 2) OK's large tribal population of Native Americans and Alaska Natives; 3) OK's unique managed care history.	Rural areas present challenges in access to care.	OK ranks 44th out of 50 states in overall health. ABD population accounts for 46.4 percent of SoonerCare spending, and OK has annual budget challenges.	This was not addressed in the RFI response.	As is true in other states, the ABD population accounts for almost half of expenditures. Rural areas lack sufficient number of providers.	Since managed care has not been widely used in OK, there may be some resistance.
2	**Conditions Unique to the Oklahoma Market**	Aetna recommends the use of telemedicine and mobile health care resources for rural areas. Aetna recommends particular emphasis on addressing cultural and linguistic needs of Native Americans and is willing to recruit additional providers.	Oklahoma has 35 percent of population in rural areas, and there are 55 Indian tribes. Oklahoma has a low managed care penetration rate compared to national average. Oklahoma ranks among lowest in nation in health outcomes. According to AARP, Oklahoma ranks low in performance of its LTSS program.	Oklahoma has three major urban areas with the rest rural. Rural areas will require different care management strategies. OK struggles with physician shortages, especially primary care and dental. AHC recommends the use of telemedicine.	Oklahoma is a rural state and has provider shortages in those areas, especially PCPs, dentists, or BH providers. The HPCC would develop new partnerships with community groups and agencies.	This was not addressed in the RFI response.	Oklahoma State University (OSU) and U. of Oklahoma have medical schools that can create member-specific programs. OSU offers telemedicine services. Oklahoma ranks low in overall health and has shown the least improvement in age-adjusted death rate. Many people in rural areas go to hospital Emergency Rooms. The uninsured rate is 5% higher than the national average. There is a severe shortage of PCPs. There is a strong advocacy community for ABD population, a resource that can be useful, as well as the Tribal Public Health Advisory Committee.	This section was not addressed in the RFI.

STATE OF OKLAHOMA
SUMMARY OF RESPONSES TO ABD CARE COORDINATION RFI

I - Market Feasibility - Consid

		GlobalHealth Holdings, LLC.	Magellan Healthcare, Inc.	Maximus, Inc.	McAlester Regional Health Center	MCNA Insurance Company	Meridian Health Plan	Molina Healthcare, Inc.
1	**Environmental Conditions**	Environmental considerations include: 1. Medicaid budgeted amounts at the state level are unsustainable, forecasting budget unpredictability; 2. An aging Baby Boomer generation and other labor market trends, including increased participation in both Medicare and Medicaid, will continue growing; 3. Predictive modeling and informatics data analysis techniques will help identify high risk individuals; 4. Innovation in service delivery; 5. Enactment of legislation permitting direct public access to most laboratory tests as accessible by patients at pharmacy walk-in locations; 6. Increased and ongoing use of web-based apps to monitor health; and 7. Continuing shift in delivery of services by and payments to nurse practitioners.	MCC understand that nearly five of every ten SoonerCare dollars were paid for services rendered to the ABD population. This group comprised 16.4 percent of SoonerCare membership and accounted for 46.4 percent of SoonerCare expenditures. This situation presents both opportunities and threats to the continued viability of SoonerCare and the Oklahoma public healthcare delivery system. A fully insured, capitated model would mitigate OHCA's risk and give it predictability of expense that other models like a PCCM/FFS or ASO Management model would not.	Flexibility means exploring risk profiles without all the constraints of MCOs. Greater opportunity to optimize costs as the state has greater negotiating power and consumers will "vote with their feet".	Pittsburg County has 10 percent of the state's Medicaid population.	Oklahoma is similar to TX and LA in which there are rural areas where adequate utilization is difficult.	Political, geographic and economic factors noted.	Molina provides these considerations: 1) Declining FMAP rates, state budget challenges, and aging population require OK to consider improving its health care system, and has gained traction in doing so on several fronts; 2) OK trails other states in certain key performance indicators; 3) OK has access issues in rural areas; 4) OK has a limited number of providers in Medicare's shared savings programs; and 5) Fragmented care inhibits ability to achieve cost and clinical outcomes.
2	**Conditions Unique to the Oklahoma Market**	Chronic health conditions in Oklahoma include high rates of diabetes, cancer mortality, heart disease mortality, obesity, smoking rates, low dental visits, and poor overall health outcomes. Other factors to be considered are overall household and per capita income measures, lack of general health knowledge, lack of awareness in local communities, access to providers, tribal relationships.	Provider type shortage, mental health provider shortage. Good fit for telehealth, building upon community-based safety-net providers, working with behavioral and rehabilitative health providers in rural and frontier areas.	Historical resistance in Oklahoma to move to fully capitated MCOs. This could complicated implementation of managed care systems in the state. The approach proposed by Maximus should best align costs with needs of consumers.	High percentage of Medicaid population, high population of diabetes and CHF. Rural areas		Oklahoma has a commendable approach to delivering Medicaid benefits through the primary care case management (PCCM) program. Care management appears to be priority for administration and the OHCA. Oklahoma is not currently a managed care model state, implementing MCO for the ABD population could be delayed due to administrative preparedness for the transition.	Molina provides these considerations: 1) According to Kaiser, OK is in top 4 states for the most favorable physician Medicaid payment ratio relative to Medicare; 2) OK's American Indian population is 2nd only to CA; and 3) The OHCA structure is somewhat unique with its appointed governance board, executive management team, and operational flexibility.

STATE OF OKLAHOMA
SUMMARY OF RESPONSES TO ABD CARE COORDINATION RFI

I - Market Feasibility - Consid

		Oklahoma Superior Select, Inc.	Optum	Patient Care Network of Oklahoma, LLC.	Res-Care Oklahoma, Inc.	Telligen	United Healthcare Community & State	Valir PACE Foundation
1	**Environmental Conditions**	Oklahoma ranks as one of the most medically underserved regions in the country. Over 60 of the 77 counties in Oklahoma have been designated as medically underserved, according to the US HHS Health Resources and Services Administration. Shortages of physicians and facilities are found throughout the state. While access is limited, Medicare costs are relatively high as indicated by the Medicare Advantage benchmarks. Additionally, Kaiser reports that Oklahoma Medicaid fee schedules are relatively high compared to other states. However, overall per-capita Medicaid costs in Oklahoma are low as reported in the Medicaid Analytic Extract published by CMS. Some other considerations include: Large population of Tribal Indians:	Environmental conditions include: 1. Rural nature of the State where services may not be easily accessible by all members. Optum has successfully used technology and new service models in rural and frontier areas in other states; 2. Optum sees an opportunity to build provider services in rural areas such as health homes. Optum delivers provider education and services in person and via technology.	Environmental conditions include: 1. State budget shortfall and need to rein in costs; 2. PCNOK shared savings potential would allow them to scale program quickly; and 3. PCNOK can tap into the cost savings and care management strategies of other ACOs operating in Oklahoma.	Environmental conditions that could potentially impact the model Oklahoma chooses include: 1. Budget shortfalls that reduce the amount of Federal Medicaid dollars; 2. Growing healthcare costs; and 3. Aging population and the cost of providing care to them.	Access to care to specialists, psychiatrists and other mental health providers can be problematic. A referral to a specialist who practices in a community several hours away results in no shows. The objective of care coordination would be to look for alternatives that would be more convenient for the member and, when no alternatives exist, provide support to address the barriers encountered when the member must access care in a location outside their home community.	United recommends the OHCA develop a stakeholder advisory group to solicit engagement through the design and implementation of an MCO model. On an ongoing basis, MCOs should be required to develop advisory groups including stakeholders, providers, members and caregivers to inform their ability to effectively improve quality and maintain high levels of customer satisfaction. Educating members, their families and caregivers is vital to minimize concerns about the introduction of an MCO model. Organizations that directly impact and influence members should be engaged in an education campaign before implementation.	OK has rural areas that may not be suitable for a PACE, but there may be some rural areas that could be served. The Cherokee PACE Center in Tahlequah is an example.
2	**Conditions Unique to the Oklahoma Market**	High costs, rural populations and limited access create unique market conditions in Oklahoma. Oklahoma has one of the lowest per diem payment rates to long term care facilities in the nation. It also has one of the lowest managed care penetration rates. Most of the state is extremely rural and access to care is limited.	Native Americans are an important part of SoonerCare. Optum meets directly with tribal leaders to negotiate agreements and tailors provider education to meet the needs of Native American providers.	PCNOK's model will need to be sensitive to the following conditions: OHIP Coalition; Telligen; MyHealth; Sooner HAN; and geographic barriers to specialist care.	The State has experienced budget shortfalls due to lower than expected tax revenue and declining federal medical assistance percentage rates (FMAP). Falling oil prices have caused many business to decrease their workforce. Poor overall health rankings result in increased health care costs. Oklahoma ranks 47th in the nation for an aging population. Rate reductions have forced some providers to leave the State or reduce services.	OHCA has invested considerable time and effort to build a "managed FFS model" in which the state operates like a health plan. Telligen feels this model is less disruptive and more efficient with lower administrative costs than managed care organizations can provide.	The rural and frontier nature of a significant portion of the State may require a geographic rollout of the program. United believes Native Americans should be included in covered populations.	PACE is new in OK, so it will take time for providers, community leaders state officials, and members to understand the model. Valir can learn from other states who implemented PACE centers before OK.

I - Market Feasibility - Consid

		WellCare Health Plans, Inc.
1	**Environmental Conditions**	This section was not addressed in the RFI.
2	**Conditions Unique to the Oklahoma Market**	Challenges in Oklahoma include: 1. Reaching a rural population; 2. Reducing high rates of smoking, obesity, diabetes and heart disease; 3. Improving the use of Health Information Technology; 4. Identifying and Responding to social determinants that influence poor health outcomes; and 5. Enhancing access for behavioral health services.

I - Market Feasibility - Considerations, Observations and Potential Opportunities

		Aetna Medicaid Administrators, LLC.	Amerigroup Corporation	AmeriHealth Caritas Family of Companies	Blue Cross Blue Shield of Oklahoma	Care Management Technologies, Inc.	Centene Corporation	DentaQuest
3	**Conditions Not Unique to the Oklahoma Market**	Greatest threat is the willingness of providers and members to make positive change. The right incentive programs are critical.	OHCA should consider strategies for implementing managed care that provide for stakeholder, provider, and member engagement; detailed project plans and regular communication; updated policy manuals; updated MMIS requirements. Community-based organizations need to be engaged.	OK is experiencing growth in the 60+ population; OK could see 24-45 percent growth by 2030.	Recent health care reform changes have been difficult for most provider types. NFs have expressed resistance to new proposed programs. Delay in NF enrollment is not necessarily negative, if the delay can be used to provide further education and establish positive working relationships. HPCC care coordinators have been welcomed in other states since it relieved provider staff of these duties. Consistency in messaging from HPCC and OHCA is important, as is early member and stakeholder engagement: no surprises. Member communication should consider literacy levels, tech "savviness" of ABD population. In-person education is best.	This was not addressed in the RFI response.	Because of the needs of the ABD population, the MCO needs to offer care coordination that goes beyond health care services. Risks are not having strategic partners in place or an adequate network.	This section was not addressed in the RFI.
4	**Availability and Range of Community Resources**	As they have done in other states, Aetna will actively work to establish relationships with community organizations and will provide training.		AHC would seek to build relationships with stakeholders and community-based providers by convening stakeholder events in community centers, libraries, senior centers, hospitals, and other venues. AHC would establish relationships with AAAs as organizations that have the trust of seniors.	HPCC will need to assess availability and range of community resources throughout the state. The 11 Area Agencies on Aging will be important contacts, as well as partnerships with tribal communities.	This was not addressed in the RFI response.	In addition to working with state universities, Centene would work with Life Senior Services Group, senior living centers, adult day care centers, NFs, and LTC facilities. OK also has county health departments and two city-county health departments that offer a variety of services. Centene would align with advocacy groups, community organizations, DME agencies, visiting nurses or physician associations, and faith-based organizations.	This section was not addressed in the RFI.

I - Market Feasibility - Consid

		GlobalHealth Holdings, LLC.	Magellan Healthcare, Inc.	Maximus, Inc.	McAlester Regional Health Center	MCNA Insurance Company	Meridian Health Plan	Molina Healthcare, Inc.
3	**Conditions Not Unique to the Oklahoma Market**	ACA Medicaid expansion will continue to be uneven until at least 2017. More program enrollees in the future may be dual eligibles as Boomers retire. Beneficiary uses web and mobile-based technology to access personal health information continues to outpace both medical community's adoption of complementary communications methods and the regulatory environment's health information privacy and security requirements. Health statuses of certain populations continue to be outside best practice norms for health outcomes in certain chronic conditions.	Barriers to helping adults with serious mental illness. Recommendation to implement model similar to Iowa's Integrated Health Homes (IHH) program that coordinates physical and behavioral care for individuals.	In a number of states, smaller providers that are not necessarily affiliated with a fully capitated risk plan, including either an ACO or an MCO, cannot afford to provide care management services for their patients through their individual practices.	Mostly rural with two areas of urban residency. Access to health care can be difficult.		There are a significant number of States moving to Medicaid managed care. Many anticipated non-expansion States moving to expansion. There is political opposition from both pro and anti-Medicaid managed care.	Molina suggests the following: 1) Physician shortages in rural areas are not unique to OK; 2) Some OK providers have very limited managed care experience; and 3) Provider fragmentation, lack of transitional care, and less than optimal system navigation are challenges.
4	**Availability and Range of Community Resources**	GlobalHealth will conduct network development activities statewide to develop and assess: 1. Primary care groups in every county as feasible, reflecting appropriate referral patterns both to neighboring counties and out-of-state; 2. Specialty care physicians 3. Integrated health systems 4. Community hospitals and health centers; 5. Long-term care facilities; 6. Advanced practitioners 7. Care coordinators, such as area agencies on aging; 8. Home and community based service providers; and 9. Behavioral health support services.	Disjointed county, state, and local resources.	By offering alternatives to both FFS and MCOs and creating several different options of network models, this approach is likely to engage more providers of community resources, as there would be significant choice available to these entities as to how they engage with the different network models.	After hours availability through urgent care center and participation in projects such as Oklahoma Project Women.	To outreach members that do not follow recommended periodicity they use community agencies, faith-based organizations, health fairs, social media, and text messaging.	Incorporating community resources and other Long Term Supports and Service (LTSS) providers should be priority for those Managed Care Organizations (MCOs) selected to participate in this program.	Molina partners and contracts with community resources, such as child care, adult day care, legal and financial consultation, respite care, personal care, meal delivery, transportation, employment, housing and clothing assistance, and utility assistance. Molina's Community Connectors are navigators who live and know the communities.

I - Market Feasibility - Consid

		Oklahoma Superior Select, Inc.	Optum	Patient Care Network of Oklahoma, LLC.	Res-Care Oklahoma, Inc.	Telligen	United Healthcare Community & State	Valir PACE Foundation
3	**Conditions Not Unique to the Oklahoma Market**	Medicaid and long term care costs are consuming an ever increasing portion of State budgets. States are seeking ways to stabilize the program while providing improved access and quality.	The need to coordinate care for ABD members, difficulty engaging ABD members, and the complex needs of the ABD population. Optum's provider collaboration with case managers and home health staff has led to a more than 40 percent member engagement rate.	ABD patients have low health literacy levels making it challenging for them to navigate the health care system; compliance issues with care plans, poor quality of life, and lack of alignment of incentives between Medicare and Medicaid budgets. PCNOK's model presents these opportunities: 1. Resources are in place to address health literacy issues; 2. Experience helping patients navigate the healthcare system; 3. Techniques for helping patients remain compliant with treatment plans; and 4. Actively participates in all transitions of care to minimize cost and duplication of services.	Refer to J.1 for information on conditions not unique to the Oklahoma market.	This section was not addressed in the RFI.	As more and more states turn to an MCO model as a delivery system for complex populations, while each state has their nuances, there is a dwindling list of unique challenges for a managed care delivery system.	Underlying movement for better delivery of health care.
4	**Availability and Range of Community Resources**	There are large portions of the State that do not have adequate access to medical care. Many counties do not have acute care facilities. Others lack the number of physicians and specialists that are adequate to serve the needs of the resident population. Additionally, community resources, such as home health, meals on wheels and other programs are in short supply. OSSI's Nursing Homes Without Walls (NHWOW) model addresses these shortages by coordinating service delivery through existing facilities and programs.	Optum strongly supports a local based system of care where community-based staff participate in existing community groups. The more community-based clinicians and paraprofessional staff Optum hires, the more they can participate. The RFP requirements and weighting given to pricing impact their staffing levels. Optum develops a Community Resource Database to refer/link members to local resources.	FQHCs provide the following resources: primary care and wraparound services; comprehensive enrollment programs; are already serving Oklahoma's ABD population; have expanded hours, employ a team-based approach; offer free transportation to/from appointments; offer BH services; perform outreach and education; use Care Managers; have access to financial counseling, insurance assistance and integrated BH services; pharmacy access; nutrition services; and link patients with social and medical services.	Inadequate access to quality healthcare contributes to 10 percent of poor health and premature death in Oklahoma. Oklahoma is rural and in some areas resources are not readily available. Therefore, this program will be piloted in the Oklahoma City and Tulsa markets.	The availability and distribution of community resources in Oklahoma is uneven. To be successful, a care coordination program must have detailed knowledge of the resources that are available in every county as well as provider referral patterns.	Managed care rates should include sufficient administrative cost flexibility to support the advancement of access through network development activities and engagement with community-based organizations. The State should remove any regulatory barriers that would prohibit the expansion of access to services.	PACE centers supplement their services with community resources, including volunteers, food banks, donations of supplies, and financial contributions.

I - Market Feasibility - Consid

		WellCare Health Plans, Inc.
3	**Conditions Not Unique to the Oklahoma Market**	WellCare pointed out the rising cost of health care, the need to rebalance so members are able to access the least restrictive settings of their choice and the move from a provider-based managed care and fee-for-service model to a Fully-Capitated MCO model provides challenges that have been experienced in several other states.
4	**Availability and Range of Community Resources**	WellCare uses a proprietary HealthConnections model to support community partners and safety net providers and link members to support services. Their programs include: 1. Community based health and wellness events leveraging existing programs; 2. Community planning councils focused on quantifying the social services available; 3. Facilitating member connections to social services and bridging gaps in available community-based programs and services; and 4. Strategic philanthropic granting program to support community-based innovation and to pilot potential social service payment models.

STATE OF OKLAHOMA
SUMMARY OF RESPONSES TO ABD CARE COORDINATION RFI

I - Market Feasibility - Considerations, Observations and Potential Opportunities

		Aetna Medicaid Administrators, LLC.	Amerigroup Corporation	AmeriHealth Caritas Family of Companies	Blue Cross Blue Shield of Oklahoma	Care Management Technologies, Inc.	Centene Corporation	DentaQuest
5	**Existing and Proposed Federal Regulation(s)**	Aetna has experience in serving ABD and LTSS populations in other states; everything proposed is in compliance with current federal regulations and waivers.	OHCA should select MCOs with a national presence, Medicaid managed care experience, as well as an understanding of HCBS regulations.	AHC is familiar with the proposed managed care regulations recently released by CMS.	The proposed model will require a combination of state plan and waiver authority, depending on the final design. Programs that limit choice and/or vary the amount, duration, and scope amongst various populations may need a waiver.	This was not addressed in the RFI response.	Centene serves SNP members in several states and has experience in dealing with the complex current and future CMS regulations.	This section was not addressed in the RFI.
6	**Data Attainment, Cross-walking to Medicaid, and Use**	Aetna has systems to collect information from claims and encounter data, and has worked with state partners to develop efficient data transfer systems.	OHCA should consider a comprehensive set of care and service plan requirements, and care plans should be accessible across all relevant stakeholders to ensure coordination. All participating payors should be required to share member data. AG recommends that OHCA provide MCO member claims histories for the previous 6-12 months, information on members' special health needs, members on waiting list for HCBS, and members enrolled in Money Follows the Person.	AHC has experience with ABD and dual eligibles in other states and would work closely with OK on MIS development and readiness testing; IT framework to support policy, practice, implementation, budget and payment systems; integrated electronic health records; and interface with provider records.	OHCA must provide the HPCC an eligibility roster via secure communication channels that includes multiple data elements.	This was not addressed in the RFI response.	Centene's technology integrates data from internal and external sources and produces actionable reports to integrated care teams. Their system processes enrollment and eligibility data in a format that is inbound and outbound and can interface with state and federal agencies.	This section was not addressed in the RFI.

I - Market Feasibility - Consid

		GlobalHealth Holdings, LLC.	Magellan Healthcare, Inc.	Maximus, Inc.	McAlester Regional Health Center	MCNA Insurance Company	Meridian Health Plan	Molina Healthcare, Inc.
5	**Existing and Proposed Federal Regulation(s)**	The model may be impacted by a number of existing and proposed federal regulations, including but not limited to: 1. Submission of a section 1115 managed care waiver to CMS for the Capitated MCO Care Coordination model; 2. Reform of Requirements for Long-Term Care Facilities; 3. Revisions to Medicare Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016; and 4. Medicare and Medicaid Programs: CY 2016 Home Health Prospective Payment System Rate Update.	CMS approval of contracts, selected health plans meeting certain requirements, choice in MCOs for beneficiaries, specialized services outside of the provider network, and states delegating authority of LOC determinations to MCOs are all considerations MCC recommends.	OHCA must ensure that whatever network models it approves comply with the LTSS regulations issued last March by CMS. They must also focus on those entities working with individuals to help them select a provider/network option, ensuring that those entities are conflict-free.	This model will inevitable effect the pay-for-performance measures that hospitals are already accustom too. With the passing of the Impact Act the post-acute world will soon follow suit. Bundled payments are knocking on our door so the responsibility to provide patient centered continuum of care is more important than ever for organizations to continue to thrive and market sustainability.	Their existing DBPMs in other states comply with all regulations.	As a Medicaid MCO, Meridian observes and complies at all times with all, then and current, Federal and State laws related to or affecting this request for proposal (RFP) or the contract, including any law that may be enacted during the term of this RFP or the contract. In addition, Meridian will maintain compliance with all applicable Federal and State laws pertinent to member confidentiality and rights and ensure that its staff, network providers, and subcontractors take those rights into account when furnishing services to members.	Molina supports regulations that help coordinate and streamline governmental agencies, MCOs, providers, and enrollees. As additional Medicaid/Medicare demonstrations are implemented, they hope lessons learned can modify regulations going forward. An opportunity would be to allow direct communication from MCOs to enrollees similar to that allowed for Medicare Advantage plans. Regulations that streamline the oversight of performance between the stakeholders to reduce administrative cost is a potential opportunity.
6	**Data Attainment, Cross-walking to Medicaid, and Use**	The majority of GlobalHealth's health plan operations, including authorizations, benefits, eligibility, enrollment, claims adjudication, plan accumulators, and customer call management; are facilitated using Epic Systems' Tapestry product.	OHCA may wish to consider the following points for data attainment: 1.Bolstering the use of Health Information Exchanges (HIEs); 2. Facilitate data attainment and sharing, MCOs should use an integrated platform capable of adjudicating claims, performing cost avoidance tasks, verifying member eligibility, and paying Medicaid claims; 3. MCOs must develop connectivity with the various systems and agencies that will be part of the new program.	The state will need to establish data exchange agreements and protocols with different provider types. This will require extensive data collection that the state will use for determining which providers are meeting their metrics and cost-saving targets.	MRHC has presented a Data Analytic software to our Finance Board and will take it forward to our Board of Trustees on August 5, 2015 for final approval. This will give our hospital and physicians clinic EMRs the ability to talk to one another, along with many other features to stratify our data for study and analysis. Thus allowing for substantial increase in real time accurate data that can be utilized to identify areas of weakness and strength. The software will also allow for MRHC to measure, monitor, and analyze almost any indicator one can think of. It will also allow for us to monitor all ABD, dual eligible, and/or any other identified high risk patients that have entered into our ER, acute care, in-patient rehab, and/or our skilled unit.	They exchange data with multiple states for 3.2 million members served.	The MCOs selected to participate in the proposed MCO model should individually develop systems and processes to accommodate the Oklahoma ABD population. The MCOs should also develop capabilities to integrate with the technological requirements at the agency level.	Molina's claims processing system is configured to coordinate benefits across plans. They can process both Medicaid and Medicare payments from a single claim submission. They work with other payers and providers to gain electronic access to utilization data, or failing that, they reach out by phone and email on a case-by-case basis to align and coordinate care planning. For duals, Molina has access to hospital census and pharmacy data. An opportunity is to facilitate a proactive design to create a data sharing model between the state, CMS, providers, and the health plan.

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		Oklahoma Superior Select, Inc.	Optum	Patient Care Network of Oklahoma, LLC.	Res-Care Oklahoma, Inc.	Telligen	United Healthcare Community & State	Valir PACE Foundation
5	**Existing and Proposed Federal Regulation(s)**	Existing Federal Medicaid regulations limit managed care options to those covered by waivers. Our approach works within these regulations by incorporating the principles of an Accountable Care Organization similar to the Medicare Shared Savings Program.	Contract partners would consult on existing and proposed regulations if included in the bid.	PCNOK's proposal is consistent with federal regulation and HHS priorities: 1. Proposal demonstrates significant components of value-based purchasing; 2. Aligned with FQHC Medicare and Medicaid PPS; and 3. Ability to use Medicare Care Coordination codes.	RCHC highlights the threats and opportunities of the December 2014 Final Rule.	This section was not addressed in the RFI.	Should OHCA implement an MCO model for the ABD population, it will be important to ensure the program design is consistent with Notice of Proposed Rule Making (NPRM) to modernize the federal Medicaid managed care and CHIP regulations.	The PACE delivery model has been growing across the country; CMS has worked to design legislation adapted to growth.
6	**Data Attainment, Cross-walking to Medicaid, and Use**	In order for the OHCA and any Plan to successfully operate in Oklahoma, it must have the capacity to collect and aggregate data. Fortunately, Oklahoma is ahead of the trend by becoming the first state to approve medical professionals for payments using the Oklahoma Electronic Health Records Incentive Program. The program, essentially, incents providers to use or adopt EHR technology thereby increasing the amount and speed of data available. With this program in place, OSSI believes that integrating its system with Oklahoma's No Wrong Door – Online Enrolment is the next step. We believe integrating three sets of data will be crucial to ensuring accurate data attainment.	Immediate and continuous access to Medicaid utilization and enrollment information as well as access to provider files is critical. The contractor needs a full understanding of the benefit package to be made available. If coordination with other funding streams is required (e.g. Medicare), then data from those systems must be available.	Four essential data aspects to PCNOK's program design are: 1. Will require real-time enrollment data; 2. Require timely access to Medicare and Medicaid utilization and claims data; 3. Linking hospitals and facilities to MyHealth to track admissions, discharges and transfers; and 4. EHR analytics and care coordination data capability.	RCHC believes Oklahoma can achieve significant cost savings by better integrating data attainment, cross-walking between the two programs, and implementing their Shared Savings Home Care model. Data sharing between the two programs is difficult, which has resulted in inadequate care coordination.	This section was not addressed in the RFI.	The State should provide historic, member-specific utilization information with sufficient time in advance of implementation to engage with members proactively to ensure seamless transition. The State should provide access to any Medicare data it has available to ensure the MCOs' ability to appropriately engage with members regarding their acute utilization patterns to minimize unnecessary risk for institutionalization.	PACE offers more services and full-time staff than NFs and at a lower cost.

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		WellCare Health Plans, Inc.
5	**Existing and Proposed Federal Regulation(s)**	This section was not addressed in the RFI.
6	**Data Attainment, Cross-walking to Medicaid, and Use**	This section was not addressed in the RFI.

I - Market Feasibility - Considerations, Observations and Potential Opportunities

		Aetna Medicaid Administrators, LLC.	Amerigroup Corporation	AmeriHealth Caritas Family of Companies	Blue Cross Blue Shield of Oklahoma	Care Management Technologies, Inc.	Centene Corporation	DentaQuest
7	**Coordination of Benefits and Services Between Medicare and Medicaid**	Aetna administers Medicare and Medicaid benefits through an integrated process.	The MCO should have experience with coordinating benefits across Medicaid, Medicare, and other insurance.	AHC recommends a fully integrated approach with Medicare, with all payments and services coordinated through a single health plan. AHC has extensive experience serving populations through integrated programs in S. Carolina and Michigan.	BCBSOK sister plans have experience in coordinating benefits in New Mexico and Illinois. Members should be enrolled in Medicare plans that align with their Medicaid plan. Since this is not always the case, it will take time to improve alignment.	This was not addressed in the RFI response.	Centene operates Medicare Special Needs Plans in 8 states and serves dual eligibles through duels demonstrations in 5 states. They can coordinate the full continuum of Medicare and Medicaid benefits through their proposed model.	This section was not addressed in the RFI.
8	**Alignment of Payment Structures and Goals**	There is a threat when populations are carved out of lack of clarity about claim payment responsibility; they will work with state to develop guidelines.	OHCA should provide quality bonuses for achieving performance metrics, such as: 1) Rates of diversion from nursing homes to HCBS; 2) Appropriate use of skilled nursing facility days; 3) Member participation in service planning; 4) Reductions in NF, ED, and hospital admissions/readmissions; 5) Participant satisfaction.	Each AHC value-based contract is customized to meet goals and ensure providers have the tools they need for success.	In a shared savings program, everyone has the same incentives. It has to be outcome-based and not just based on activities and processes. Comparison of providers increases provider performance. Some providers may not have enough members to participate in these programs; at least 500 members are needed for credible statistics.	This was not addressed in the RFI response.	Centene's flexible approach to provider payment structures supports providers at various levels of capability and readiness for quality incentives and payment reform. In all markets they steer providers away from FFS.	This section was not addressed in the RFI.

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		GlobalHealth Holdings, LLC.	Magellan Healthcare, Inc.	Maximus, Inc.	McAlester Regional Health Center	MCNA Insurance Company	Meridian Health Plan	Molina Healthcare, Inc.
7	**Coordination of Benefits and Services Between Medicare and Medicaid**	GlobalHealth will require that any participating capitated MCO be also involved in Medicare Advantage and GlobalHealth recommends alignment of MCOs requirement in the capitated MCO Care Coordination model.	This section was not addressed in the RFI.	Providers will have to closely collaborate to ensure that hand-offs from acute care to LTSS are coordinated carefully, especially around the care transitions that are likely to be prevalent for this audience. For this particular cohort, it is likely that more formalized network models, such as an ACO would be able to create this coordination easier than would be the case for individual providers. Therefore, it would be appropriate for the ASO to encourage dual eligibles to select the network models that are offering the most integrated care arrangements.	Strategic development of patient-specific plan of care will allow for alignment of benefits and services to increase efficiency as it relates to utilization, time management, medication reconciliation, prevention, participation in outreach, etc.	They provide dental services to Medicare Advantage plan members. They will coordinate benefits in accordance with State and federal laws.	Meridian has both technology-based solutions for benefit management, as well as, organizational practices for coordinating member benefits. Meridian provides members with streamlined coordination of benefits for those members eligible for Medicare and Medicaid benefits. Meridian's systems allow staff to monitor and coordinate services for members to ensure they receive services for which they are eligible, regardless of payer. Medicare and Medicaid have differing rules and benefit structures which can lead to confusion for both members and providers. Meridian's Care Coordination staff act as liaisons between members and providers to help coordinate care as efficiently as possible to ensure the well-being and quality of care for members.	Molina has experience with dual eligible members and currently serves 85,000 of these members. They have experience with SNPs and D-SNPs. They have implemented administrative efficiencies for providers and members, such as eliminating crossover claims, and integrating the two programs so that they appear seamless to members.
8	**Alignment of Payment Structures and Goals**	Recommendations to the OHCA include but are not limited to: 1. Providing an integrated pharmacy benefit; 2. Eliminating cost shifting opportunities between the programs; 3. Reducing avoidable hospitalizations and related hospital acquired conditions; 4. Performing post-discharge follow-up activities; 5. Incentivizing MCOs to make upfront investments in LTSS, and especially home environmental modifications; 6. Continuing both Medicare and Medicaid covered services during the service appeals process; and 7. Building capitation risk adjustment models using blended rates to reflect both Medicare acute services and Medicaid LTSS/HCBS	To ensure the alignment of payment structures and OHCA goals, MCC recommends OHCA work closely with the health plans to oversee, monitor, and measure the effectiveness of the MCO performance-based reimbursement programs with providers. The value-based purchasing programs should focus on the long-term goals detailed in OHCA's 2014 Strategic Plan, including elements that address quality, member satisfaction, and financial responsibility	The ASO would play a critical role in operation of the system by providing in-depth enrollment counseling based upon hard data that incentivizes high-utilizing consumers to select care models most appropriate to their needs. By instilling such transparency into the health care system, ASO choice counselors could show consumers quality metrics and cost comparisons to provide the information they need to make rational choices.	MRHC will be able to control costs by aligning patients with primary care providers, emergency after hours care through our urgent care centers and emergency room, when appropriate. By aligning patients with primary care providers, MRHC can assist them with appropriate follow up care and prescription management to prevent them from finding themselves in an emergency situation. Our 24/7 availability offers reasonable cost when patients are able to follow up with their primary care providers or be seen in our urgent care centers, avoiding emergency room visits and hospitalization whenever we can.	Their FFS payment structure for providers aligns with program goals.	MCOs can develop a partnership that targets inefficiencies within the current model, while identifying advantages within the current SoonerCare program and Federal initiatives, to create new approaches, provider partnerships, innovative cost saving programs, and products that can create a high-quality, cost-effective system that results in increased measurable goals and outcomes.	Over the last 5 years, Molina has transitioned FFS contracts into VBR. They support PCMHs and strategic provider partnerships. Their goal is to transition 75% of Medicaid members to PCMHs. Providers without experience in VBR can be resistant to change, and must have a critical mass of business. Certain rural areas of OK may not be suitable for VBR strategies.

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		Oklahoma Superior Select, Inc.	Optum	Patient Care Network of Oklahoma, LLC.	Res-Care Oklahoma, Inc.	Telligen	United Healthcare Community & State	Valir PACE Foundation
7	**Coordination of Benefits and Services Between Medicare and Medicaid**	The coordination of benefits and services between Medicare and Medicaid is similar to the current fee-for-service system with the addition that incentives are aligned through OSSI. For Medicaid benefits, OSSI will form an ACO covering the entire region. For Medicare covered services, OSSI will form either an ACO or expand the service area and population for its current Medicare Advantage Special Needs Plan (if feasible). The challenge for expanding the SNP is qualifying a provider network that meets CMS requirements throughout the region where, as noted above, there are many medically underserved areas.	Through UnitedHealthCare, Optum supports individuals who are dually eligible in multiple states. They have unmatched industry experience coordinating benefits for individuals who are dually eligible. Optum's approach and strategies for coordinating care for dual eligible members includes: 1. Proactive identification of dual eligible members; 2. Coordination of Medicaid and Medicare services; 3. LTSS benefits coordination; 4. Transitions of care; and 5. Access to a trained care manager who has knowledge of Medicare and Medicaid benefits.	PCNOK will coordinate Care/Medicaid benefits by: 1. Each patient will have a customized care plan housed in the EHR ; 2. HIE to analyze member risk and identify care needs; and 3. Evidenced based guidelines and Evidenced Based Toolkit.	The State must better manage and coordinate the data attainment and cross-walking mechanism in order to achieve any meaningful cost savings in the ABD population.	This section was not addressed in the RFI.	Refer to United's response to, "Approach to Integration with "Medicare."	Under PACE the payment system and coordination of care is no longer fragmented.
8	**Alignment of Payment Structures and Goals**	OSSI' approach, using the shared saving model, closely aligns payment with overall goals of improved access, lower costs and high quality. Shared savings are distributed when cost targets are met and quality goals are achieved. Similar to the MSSP approach, baseline data is established, savings goals are established and periodic measurements are conducted. OSSI and the State settle-up annually after all data has been captured. Similarly, quality of care goals are established and OSSI must meet certain thresholds to be eligible to participate in the shared savings.	Optum strongly supports the alignment of payment structures and goals. The more the state is transparent about its financial and programmatic goals, and the greater the stakeholder involvement, the more likely the program will achieve its goals.	PCNOK's proposed payment approach is: 1. A PBPM care coordination fee with four risk-adjusted tiers; 2. Shared savings opportunity; and 3. All other providers, whether in network or not, will continue to receive their pre-arranged payments for Medicare and Medicaid.	RCHC contends that payment and health care delivery system reforms are needed to enable coordinated care and focus on value instead of volume.	This section was not addressed in the RFI.	Payments to MCOs should be fully capitated and cover all benefits included in the program design.	The payment rate and structure for Medicaid is based on a formula mandated by CMS.

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		WellCare Health Plans, Inc.
7	**Coordination of Benefits and Services Between Medicare and Medicaid**	This section was not addressed in the RFI.
8	**Alignment of Payment Structures and Goals**	This section was not addressed in the RFI.

I - Market Feasibility - Considerations, Observations and Potential Opportunities

		Aetna Medicaid Administrators, LLC.	Amerigroup Corporation	AmeriHealth Caritas Family of Companies	Blue Cross Blue Shield of Oklahoma	Care Management Technologies, Inc.	Centene Corporation	DentaQuest
	Other Notes							

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		GlobalHealth Holdings, LLC.	Magellan Healthcare, Inc.	Maximus, Inc.	McAlester Regional Health Center	MCNA Insurance Company	Meridian Health Plan	Molina Healthcare, Inc.
	Other Notes							

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	Oklahoma Superior Select, Inc.	Optum	Patient Care Network of Oklahoma, LLC.	Res-Care Oklahoma, Inc.	Telligen	United Healthcare Community & State	Valir PACE Foundation
Other Notes						Additional considerations for an MCO model serving ABD members with LTSS needs include: 1. Blended rate methodology; 2. OHCA should blend the cost experience of individuals living in nursing homes with the experience of members who meet the nursing home level of care but live in the community into a single rate; 3. Establish two additional rate cells to account for the significant variance in Medicaid costs between the non-dually eligible non-LTSS and dually eligible non-LTSS; 4. Rates should include reasonable savings assumptions and nursing home displacement rates; and 5. Rates should be adjusted annually and benchmarked from the previous year's rebalancing efforts.	OK could consider adopting a model from Wisconsin, which allows a PACE center to provide care for people between 55 and 64 while waiting for CMS approval.

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	WellCare Health Plans, Inc.
Other Notes	

J - Approach to Integration with Medicare - Considerations, Observations and Potential Opportunities and Threats

		Aetna Medicaid Administrators, LLC.	Amerigroup Corporation	AmeriHealth Caritas Family of Companies	Blue Cross Blue Shield of Oklahoma	Care Management Technologies, Inc.	Centene Corporation	DentaQuest
a	**Existing and Proposed Federal regulation(s)**	Everything that Aetna has proposed for Oklahoma is underway in other states and is compliant with regulations.	AG recommends that OHCA choose MCOs with experience in coordinating benefits for members who are dually eligible in the FFS and Medicare Advantage environment.	AMC recommends a fully-capitated, at-risk model that includes all Medicare and Medicaid services. Many performance measures (process and outcome) developed by national and state projects are similar to those found in 1915(c) programs. AHC will work with OHCA to ensure that all federal and state regulations are met.	Medicare Part D for dual eligibles impacts the design and implementation of a coordinated care model since the health plan has to coordinate pharmacy coverage with Part D. OHCA could require the HPCC to become a Medicare Advantage Special Needs Plan (SNP) so that benefits are delivered through one entity.	This was not addressed in the RFI response.	Centene already serves dual eligibles in many states. The pending Medicaid regulations strengthen the integration concept.	DQ serves dual eligibles in other states and is familiar with the payment structures at the intersection of Medicaid and Medicare. Their programs are in compliance with all existing federal regulations.
b	**Data Attainment, Cross-walking to Medicaid, and Use**	Aetna's model allows for efficient data transfer between the MCO and OHCA intermediaries for cross-walk to Medicare data.	AG affiliates participate in duals demonstrations and have received Medicare claims and encounter data, that in combination with Medicaid data, provide a complete picture of a member's health status. This can support rapid identification gaps. OHCA should consider approaching CMS about data sharing options outside the duals demonstrations so MCOs could address all of a member's needs.	AHC's proposed integrated model would facilitate data attainment and cross-walking. AHC can leverage their technology to integrate data.	If not doing so already, OHCA can request Part A, B, and D historical claims data, Master Beneficiary Summary Files, and assessment datasets. This data can be shared with health plans for more efficient coordination.	This was not addressed in the RFI response.	Centene understands the issues resulting from the lack of availability of Medicare data. Medicare Part D information is not shared. States have the ability to obtain Coordination of Benefits Agreements data from CMS, and could share the date with the MCO. Centene would assist the state in developing these requirements.	They have a flexible operating platform that can be configured to meet multiple criteria.
c	**Coordination of Benefits and Services between Medicare and Medicaid**	Aetna's model includes coordination of claims adjudication for ABD members across all payers.	MCO should have primary responsibility for care coordination and service planning to maximize benefit coverage through all programs available to them.	AHC's care coordinators are effective in coordinating physical health, BH, and LTSS.	BCBS has experience coordinating benefit through its programs in New Mexico and Illinois.	This was not addressed in the RFI response.	Centene recommends voluntary enrollment for dual eligible D-SNP plans and a requirement that MCOs provide Medicare coordination when a D-SNP is not in place. A multi-payer approach is often necessary to achieve enough membership to make provider incentives work. MCOs should be required to coordinate benefits whether or not they pursue a D-SNP. A phased-in approach to a formal D-SNP is best; OHCA should consider not requiring the D-SNP as a condition of an RFP submission, but only by some future date. OHCA should eventually pursue a more formal 3-way contract with CMS as an MMP, FIDA, or whatever partnership opportunities exist at that time.	Their platform captures 3rd-party eligibility and will ensure that Medicaid is the payer of last resort.

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		GlobalHealth Holdings, LLC.	Magellan Healthcare, Inc.	Maximus, Inc.	McAlester Regional Health Center	MCNA Insurance Company	Meridian Health Plan	Molina Healthcare, Inc.
a	**Existing and Proposed Federal regulation(s)**	Some of the factors that may impact GlobalHealth's model include: 1. Reform of Requirements for Long-Term Care Facilities; 2. Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B; 3. 2016 Home Health Prospective Payment System Rate Update; 4. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; and 5. Medicare Program: End-Stage Renal Disease Prospective Payment System, and Quality Incentive Program.	This section was not addressed in the RFI.	Recently, CMS has been actively pursuing policies around LTSS with the regulation it passed last March and the section on LTSS in the just issued a Notice of Proposed Rule Making that governs Medicaid and CHIP managed care. By offering a neutral third party in the form of the ASO, Maximus' approach complies with the regulation requiring that there be no conflict of interest between those entities performing the assessment and care plan (the ASO) and those providing services (the network models).	McAlester Regional Health Center is a community owned regional hospital, that serves many surrounding rural towns, and are financially strong.	Their programs in other states fully comply with federal regulations.	The Affordable Care Act (ACA) ushered in a new wave of regulations that seek to better align the coordination of Medicare and Medicaid benefits. Meridian has experience working with both CMS and State agencies through the Medicare Medicaid Alignment Initiatives (MMAI) initiative in Illinois and the MI Health Link program in Michigan, also referred to as a Medicare-Medicaid Plan (MMP). Meridian also has experience operating a dual-eligible special needs plan (D-SNP) in Michigan, Illinois, and Iowa. Meridian's MMP product provides services for members who are entitled to Medicare Part A, enrolled under Medicare Part B, receive full Medicaid benefits, and live within a specified service area.	Molina did not include a J section in their response, but they did address most of these questions in I.
b	**Data Attainment, Cross-walking to Medicaid, and Use**	GlobalHealth will utilize Medicare Part A, B and D data, internal claims and EMR information along with Medicaid data, shared through EDI, to support accurate enrollment, benefit utilizations and claims reimbursement. This information will also include accumulation of plan service limits and deductibles as outlined by the plan. The combined data will be integrated into GlobalHealth's business intelligence analytics to identify and stratify members based upon need and risk.	With the FIDE (fully integrated dual eligible) SNP model, one health plan will be accountable for the holistic management of care across the governmental programs. With one MCO managing the whole person, data gathering and sharing with OHCA and CMS will be simplified, timelier and more accurate.	ASO will perform data collection and analysis then use that data to provide counseling to beneficiaries.	MRHCs EMR and practice management software is fully capable to report and derive data directly from CMS, Medicaid, and all other payers.	They successfully exchange data with multiple states.	Meridian's Medicaid affiliate in Iowa has attained remote electronic medical record (EMR) access or electronic data exchange for more than 40 percent of its membership. Meridian uses a multifaceted approach to growing its EDI program. QPI, Provider Services, Operations and the Information Technology departments work collaboratively to identify opportunities for new EDI partners.	Molina did not include a J section in their response, but they did address most of these questions in I.
c	**Coordination of Benefits and Services between Medicare and Medicaid**	This section was not addressed in the RFI.	MCC recommends that OHCA consider a model similar to the Fully Integrated Dual Eligible (FIDE) Special Needs Plan (SNP) which promotes the full coordination of Medicaid and Medicare benefits for dual eligible beneficiaries by a single managed care organization. This model provides OHCA an option for integration of the governmental programs that does not require federal waiver authority – by contracting with FIDE SNPs to also provide Medicaid services to dual eligibles.	ASO would collect and analyze data from multiple different network models to create an all-payer's database and reduce duplications.	iii. Coordination of Benefits and services between Medicare and Medicaid: Strategic development of patient-specific plan of care will allow for alignment of benefits and services to increase efficiency as it relates to utilization, time management, medication reconciliation, prevention, participation in outreach, etc.	Medicare does not have a dental benefit, but they serve Medicare Advantage members and will coordinate for dual eligibles if State adopts enhanced benefit for adults.	MCOs should maintain systems, or partner with subcontracted entities that specialize in benefit coordination, to ensure proper payments are made by the correct entity. MCOs should also develop internal processes and systems to provide guidance on what benefits and services are available to each member. Meridian conducts two weeks totaling 80 hours of care coordination classroom training with overall dual-eligible member education built into this curriculum.	Molina did not include a J section in their response, but they did address most of these questions in I.

J - Approach to Integration w

		Oklahoma Superior Select, Inc.	Optum	Patient Care Network of Oklahoma, LLC.	Res-Care Oklahoma, Inc.	Telligen	United Healthcare Community & State	Valir PACE Foundation
a	**Existing and Proposed Federal regulation(s)**	OSSI will integrate with Medicare either through a Medicare Advantage D-SNP or ACO. Both of these arrangements exist under current Federal regulations. However, current policies in Medicaid and Medicare's infrastructure allow these programs to operate according to different systems and rules. In order to fully operate an integrated system of care coordination, it is imperative that the federal and state governments and health care organizations align their systems and objectives. The newly released Managed Care regulations have shown that there is an intent to move in this direction.	According to Optum, a fee-for-service approach to providing care coordination poses no threat to items a through d.	This section was not addressed in the RFI.	There are many patients who need behavioral and social support that is critical to avoiding hospitalizations, but they may not meet the requirements in the law to be eligible for the home health benefit. Home care is not currently geared toward providing intensive care over shorter periods of time, particularly immediately post-discharge. Older Americans and individuals with disabilities often lack the infrastructure and support to age in place. Addressing all of these issues would facilitate optimal patient care.	This section was not addressed in the RFI.	This section was not addressed in the RFI.	Integration of Medicare and Medicaid is a key premise of the PACE model. Federal legislation has bolstered its presence in the health care industry.
b	**Data Attainment, Cross-walking to Medicaid, and Use**	OSSI will need the state to provide Medicaid data for both services provided by plan providers as well as by non-contracted providers. For Medicare services, OSSI will either have paid the claim (DSNP) or have data provided by CMS (ACO). Using a crosswalk of member identifications, the plan can combine Medicare and Medicaid data to get a complete picture of the member's health status.	This section was not addressed in the RFI.	This section was not addressed in the RFI.	RCHC will work with the OHCA to ensure the Crosswalk meets the updated requirements. They have staff dedicated to Medicare and Medicaid claims submission.	There are multiple HIEs in various stages of development and operation and a somewhat competitive relationship exists among them. The care coordination program can be the focal point where information from disparate HIE systems come together.	This section was not addressed in the RFI.	
c	**Coordination of Benefits and Services between Medicare and Medicaid**	Individuals who qualify both for Medicare and Medicaid benefits have the potential to coordinate Medicare benefits with state-administered Medicaid benefits. Beneficiaries would be in a single managed care organization that delivers both Medicaid and Medicare services.	This section was not addressed in the RFI.	This section was not addressed in the RFI.	RCHC will identify individuals who are currently enrolled in both programs using the Medicare Monthly Roster (MMR). They recommend expanding a health information exchange such as MyHealth Access Network to share data across providers and identify members in need of care coordination.	This section was not addressed in the RFI.	United encourages the OHCA to evaluate Medicare Advantage and SNP penetration in the State, the market characteristics that drive competition, and the rationale for limited participation by Medicare Advantage Organizations (if applicable) in parts of Oklahoma. It is important for the State to design a program that is capable of attracting experienced MCOs and adjust for circumstances and geographies that may limit the development of a Medicare Advantage or SNP including unmanageable Medicare rates.	Under the PACE model there is no fragmentation of services.

J - Approach to Integration w

		WellCare Health Plans, Inc.
a	**Existing and Proposed Federal regulation(s)**	According to the CMS Medicare-Medicaid Coordination Office, the benefits of fully integrating Medicaid and Medicare under a member's single plan include: 1. Streamlining the process for accessing benefits and services regardless of who is paying the bill; 2. Improving continuity of care, particularly as members move through different levels of care; 3. Reducing "cost-shifting" between plans and payers because an integrated program does not inadvertently place incentives into the system to drive members to higher levels of care; and 4. Aligning quality and performance metrics to make accountability and performance improvement more meaningful.
b	**Data Attainment, Cross-walking to Medicaid, and Use**	Oklahoma's efforts through the OHIP/OSIM project to expand the use of HIT and connections to HIE can be leveraged under an MCO model to help shape data sharing efforts as part of the overall program design and in collaboration with participating MCOs.
c	**Coordination of Benefits and Services between Medicare and Medicaid**	Through the kinds of preventive and rehabilitative benefits Medicaid can offer to members, Medicaid often serves as the catalyst to savings on the Medicare side which makes alignment of benefits so beneficial to members.

J - Approach to Integration with Medicare - Considerations, Observations and Potential Opportunities and Threats

		Aetna Medicaid Administrators, LLC.	Amerigroup Corporation	AmeriHealth Caritas Family of Companies	Blue Cross Blue Shield of Oklahoma	Care Management Technologies, Inc.	Centene Corporation	DentaQuest
d	**Alignment of Payment Structures and Goals**	The MCO administration of benefits supports OHCA's management of multiple funding streams for ABD and SSI beneficiaries.	OHCA should adopt quality bonuses for achieving performance metrics. Payment rates should be actuarially sound and account for differences in clinical acuity, setting, and dual status.	The use of a full risk, capitated model with a single payment to the health plan for all covered services is a critical component, combined with appropriate provider incentives. AHC has created P4P programs in other states that use financial bonuses and shared savings.	Provider payment structures and goals should be consistent across payers; however, if the Medicare member has another insurer for Medicare services there will be limited integration. A potential solution is building out a fully integrated dual entity (FIDE) Special Needs Plan (SNP) or requiring development of a subset D-SNP where the member must first enroll in the Medicaid plan and then can elect to enroll in the D-SNP. In both cases services are covered by one entity, and payment structures and goals can be aligned.	This was not addressed in the RFI response.	The Medicare-Medicaid Alignment Initiative is an example of federal and state governments working together to align program structure and blend funding streams. States can also put health plans at risk for certain elements of coordination. Medicaid MCOs can work toward aligning payment structures by emulating Medicare payment methodologies related to value-based purchasing and bundled payments.	This section was not addressed in the RFI.
	Other Notes							

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		GlobalHealth Holdings, LLC.	Magellan Healthcare, Inc.	Maximus, Inc.	McAlester Regional Health Center	MCNA Insurance Company	Meridian Health Plan	Molina Healthcare, Inc.
d	**Alignment of Payment Structures and Goals**	Recommendations to the OHCA include but are not limited to: 1. Providing an integrated pharmacy benefit; 2. Eliminating cost shifting opportunities between the programs; 3. Reducing avoidable hospitalizations and related hospital acquired conditions; 4. Performing post-discharge follow-up activities; 5. Incentivizing MCOs to make upfront investments in LTSS, and especially home environmental modifications; 6. Continuing both Medicare and Medicaid covered services during the service appeals process; and 7. Building capitation risk adjustment models using blended rates to reflect both Medicare acute services and Medicaid LTSS/HCBS services.	Oklahoma is in a position to utilize FIDE SNPs to foster an innovative reimbursement model with singular MCO accountability and align holistic performance incentives within the health plan to improve individual outcomes across the spectrum of Medicare and Medicaid services.	e. By doing the health risk assessment and providing evidence-based choice counseling, ASO staff would counsel dual eligibles toward providers most willing to take the time to integrate services for the most complex patients. These providers, in turn, would most likely form associations with other providers of similar propensity, leading over time to specialty practices, ACOs, or potentially down the road, to fully capitated national MCOs bringing experience with Dual SNPs to the State.	MRHC will be able to control costs by aligning patients with primary care providers, emergency after hours care through our urgent care centers and emergency room, when appropriate. By aligning patients with primary care providers, MRHC can assist them with appropriate follow up care and prescription management to prevent them from finding themselves in an emergency situation. Our 24/7 availability offers reasonable cost when patients are able to follow up with their primary care providers or be seen in our urgent care centers, avoiding emergency room visits and hospitalization whenever we can.	Their FFS structure aligns with OHCA goals.	MCOs selected to administer benefits through the proposed MCO model should develop internal systems, or partner with subcontracted entities, to ensure proper payment and benefit eligibility are monitored and properly administered. Through partnerships with MCOs, States can contract administrative functions out to MCOs who understand Federal and State payment responsibility. Proper payment by the correct entity aligns with the overall goals of this RFI-reduction of cost and improved care coordination.	Molina did not include a J section in their response, but they did address most of these questions in I.
	Other Notes							

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		Oklahoma Superior Select, Inc.	Optum	Patient Care Network of Oklahoma, LLC.	Res-Care Oklahoma, Inc.	Telligen	United Healthcare Community & State	Valir PACE Foundation
d	**Alignment of Payment Structures and Goals**	In this model, the state would pay the ACO a portion of any savings. Because the state pays Medicaid claims on a fee-for-service basis, no capitated payments are involved. To ensure the ACO is performing as expected, quality measures should be established and reported on an annual cycle. Eventually, OSSI will need to transition into a D-SNP to be a more effective plan.	This section was not addressed in the RFI.	This section was not addressed in the RFI.	Under RCHC's model, Oklahoma would receive payments based on Medicare savings that are achieved from the healthcare provided to dual eligible members. Oklahoma would receive a performance payment if a target level of Medicare savings were achieved net of increased federal Medicaid costs.	In March 2015, CMS changed Medicare billing policy to allow providers to include a HCPCS code on their Medicare claim and receive reimbursement for care management/care coordination activities. Aligning Medicare and Medicaid billing policy in this area would provide an additional incentive for providers to participate in care coordination activities.	Rates for Medicare and Medicaid should be mutually exclusive and evaluated for adequacy based upon each individual program.	
	Other Notes		At times, Optum has encountered obstacles related to obtaining Medicare utilization data. In addition, when unnecessary utilization of inpatient is reduced, the state Medicaid agency bears the cost of prevention (e.g. care coordination). But, because of the improvement in health conditions expected, Optum believes it is more than worthwhile to include dual eligible individuals.				For Oklahoma to achieve some type of Medicare and Medicaid coordination outside of the Financial Alignment Demonstration, the State will need to develop a program built upon a Medicare Advantage or DSNP platform (i.e., DSNP plan or Fully Integrated Dual Eligible Special Needs Plan (FIDE)).	

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		WellCare Health Plans, Inc.
d	**Alignment of Payment Structures and Goals**	The newly released managed care regulations certainly indicate a desire to move in this direction. As such, WellCare is working on both sides to help support these efforts. In Arkansas, their D-SNP plan is working closely with the state Medicaid program, even though the state does not currently have a managed care Medicaid model to align quality metrics to more consistently drive performance improvement and accountability regardless of payer or provider.
	Other Notes	