Description	Three part model that includes a variable Case Management payment based on criteria self-designated by the provider with traditional fee for service (FFS) office visits and a performance based component.
Funding	Elimination of the current partially capitated system will likely result in savings (based on CY2008 utilization data). The savings will be used to fund transition payments and an incentive plan. The transition payments will address cash flow issues as providers realize the benefits of moving to a payment structure based upon incentives for excellence. While providers have recommended limiting transition payments to the first six months, OHCA is prepared to make these payments for two years before these funds are used solely for incentive payments.
PMPs	• Physicians in family medicine, pediatrics, internal medicine. • Exclude OB/GYN. • Physician assistants. • ARNPs. • Health departments. • FQHCs/RHCs – these providers will be paid $0 case mgmt fee; will be paid PPS rate at claim pymt. Current I/T/U system remains the same. Current O-EPIC CM remains the same. PMPs provide coordination/continuity of care, providing needed member referrals, but a referral number in Box 17A is not required for claims payment. The current self-referral items remain the same. Member visits for adults and children with their PMPs have no co-pays. Children and adults have unlimited medically necessary visits with their PMPs; adults are limited to four additional physician visits per month.
Transition Plan	Phase One uses 50% of the savings pool for pay for excellence and 50% for transition assistance (i.e. providers are paid x% of their last year's capitation payment to ease cash-flow impact)
	Phase Two uses 75% of the savings pool for pay for excellence and 25% for transition assistance
	Phase Three uses 100% of the savings pool for pay for excellence
	Transition assistance payments will be made quarterly Providers eligible for transition assistance will include those who: Are in good standing with agency-wide QA committee Were contracted a minimum of 10 of 12 months in 2008 Continue to see comparable number of enrolled members in 2009 Have capacity for or enrollment between 1,500-2,000 members with utilization in 2008 of approximately ? % (to be determined in analysis)
New Services	Open up payment for after hours codes, urgent care clinics??
Case Management	See attached.

Components	
Pay for Excellence Components	EPSDT bonus payment and 4th DTaP incentive dollars are not rolled in due to CMS limits on incentives.
	Make first payment in first quarter 2009 based on 2008 profile. Is there a way to incorporate with HMP?
	Creates incentives for use of best practices and may include:
	Improved cervical cancer screening rates
	Improved breast cancer screening rates
	Improved rates of child health screens – weight about 50 percent
	Improved HbA1c screening rates for diabetics
	Improved (lowered) rates of hospital admits for members with asthma? Members with asthma with a home management plan?
	Improved ?? for men's health care
	Improved ER provider profiling scores (i.e. fewer patients going to the ER) – weight about 10 percent of all incentive pymts?
	Could we develop criteria for excellence in serving ABD members, members with Special Health Care Needs?
Member Education	Determine open enrollment schedule and slate member information fairs, mailings, etc.
Provider Education	Set Town Hall/ Regional provider meetings to inform about new program Seek provider association endorsement (Oklahoma chapters AAP, AAFP, OSMA, OOA) Participate in conventions, speak at meetings January-September 2009 is next contract period on current contract Determine impact on PMP audit/review process
Enrollment	Members enroll by calling SoonerCare Helpline or filling out Action Form at provider's office. Member enrollment for 2009 will roll over with existing provider unless member makes a change. Any new or returning members will be in FFS, eligible for medical home enrollment until the PMP is selected. Family alignment and realignment with previous PMP will not systematically occur. Members may change PMPs up to four times per year. A change request will be honored in real time and retrospectively if documentation is furnished. When will case management PMP payment be made? Based on enrollment as of when? When No Wrong Door is implemented, members will select their PMP during the application phase.
CMS Approval	Do we want to request approval for voluntary enrollment of custody children?
Rules	Replace Chapter 25