



OHIP/OSIM Health Efficiency & Effectiveness Workgroup and Workforce Workgroup Joint Meeting Minutes



Health Efficiency & Effectiveness Workgroup and Workforce Workgroup Joint Meeting	
DATE	January 19, 2016
TIME	1:30 pm – 3:30 pm
LOCATION	Oklahoma Health Care Authority, Eufaula Room
FACILITATORS	Chair, HEE Workgroup: Rebecca Pasternik-Ikard OSIM Project Director: Alex Miley OSDH Director of Health Care Information: Rebecca Moore
MEMBER ATTENDEES	<ul style="list-style-type: none"> • Members Present: Dr. William Pettit, Buffy Heater, Rachel Mix, Andy Fosmire, Lana Ivy, Matt Harney, Debbie Blanke, Kyle Foster, Glenda Armstrong, Jackye Ward, Cynthia Scheideman-Miller, Jane Nelson, Antonia Pratt Reid • Project Managers Present: Valorie Owens, Jana Castleberry • Members via Conference Call: Jon Lowry, Lou Carmichael, Dr. Steven Crawford, Dr. Lynn Mitchell, LaWanna Halstead, Marisa New, Monty Evans, Janie Thompson, Tracie Patten, Randy Curry, Toni Moore, Debbie Spaeth, Teresa Huggins, Mary Holter, Annie Smith, Chad Landgraf
GUESTS	<ul style="list-style-type: none"> • Guests Present: Joe Fairbanks, Isaac Lutz, Martina Ordonez • Conference Call Participants: Annie Smith, Debbie Spaeth, Melissa Pratt, Reji Varghese, Tracie Patten, Janie Thompson, Tony Moore, Joyce, Mary Holter, Teresa Huggins, Amber Sheikh, Keianna Dixon, Spencer Kusi, James Rose, Mollie Kimpel, Jane Garner
HANDOUTS	Joint HEE and Workforce Workgroup PowerPoint Presentation, Draft of CCO Certification Criteria

AGENDA

1. Welcome / Introductions

Welcome and Meeting Objectives from HEE Chair, Becky Pasternik-Ikard, OHCA Deputy State Medicaid Director

- State Health System Innovation Plan Update
- Model Review
- HIT Plan Review – Review and Feedback
- Next Steps

2. OSIM State Health System Innovation Plan Update

Alex Miley, OSIM Project Director

- State Health System Innovation Plan: The goal is to draft a single cohesive document by the first of February. Stakeholder engagement plan spans the whole process.

3. OSIM Model Review

Alex Miley, OSIM Project Director

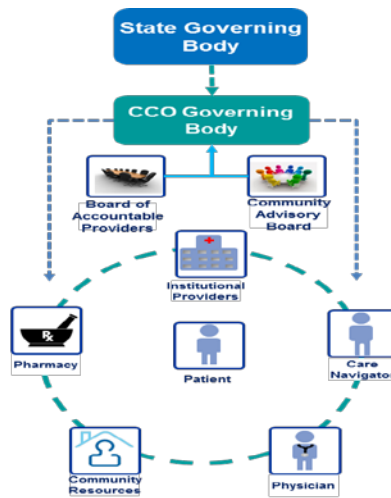
- OSIM Model Proposal Conceptual Design Tenets
- Incorporate what drives health outcomes, integrate the delivery of care, drive alignment to

**OHIP/OSIM HEALTH EFFICIENCY &
EFFECTIVENESS, AND WORKFORCE WORKGROUP
MEETING MINUTES**

reduce provider burden, and move toward value-based purchasing with realistic goals.

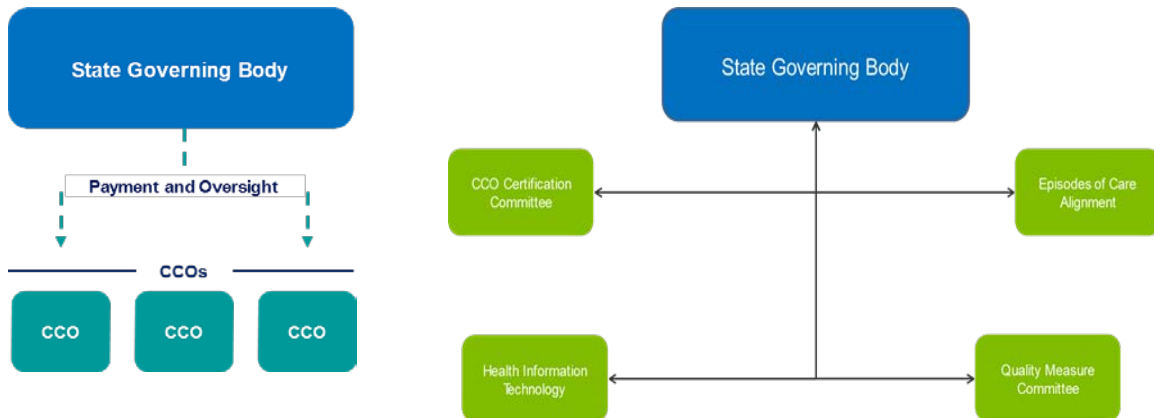
Communities of Care Organizations Overview

- CCOs are local, risk-bearing care delivery entities that are accountable for the total cost of care for patients within a specific geographic region.
- Governed by a partnership of health care providers, community members and other stake holders.
- Focus on primary care and prevention, using care coordination and integration of social services and community resources into the delivery of care.
- Utilize global, capitated payments with strict quality measures accountability to pay for outcomes and health.
- Reimburse non-traditional health care workers and services, such as community health workers, peer wellness specialists, housing, et al.
- Initially, this model is proposed for all state purchased health care, which comprises a quarter of the state’s population.



Oklahoma Communities of Care Organization: Governance

- The State Governing Body will serve as the payer for state purchased health care and be responsible for providing oversight of the CCOs through certification and a continuous quality monitoring process.



- Members of the State Governing Body will include the Oklahoma Health Care Authority, the Employee Group Insurance Division, the Oklahoma State Department of Health, the Department of Mental Health and Substance Abuse Services, and the Oklahoma Insurance Department

QUESTIONS/COMMENTS

Comment: The members of the State Governing Board (SGB) were chosen due to the initiative initially only encompassing public employees and Medicaid population. This may be expanded upon in the future to include private payers and providers.

Comment: It is appropriate to have providers on the governing structure, as well as representatives from boards and associations. Providers want to be heard in a way that is influential, so if decisions are made at the SGB level, then providers need to be included as members. Also, the SGB should include patients/consumers/patient advocates. An insurance representative should be on the board – if we allow one voice, need to allow multiple voices from different perspectives on the SGB.

Comment: Best practices indicate that a 9-member board is optimal, otherwise the board may get unwieldy. The governing structure for the CCOs requires a board of providers to represent each CCO.

Comment: It is important to engage the private sector, and this is broader than insurance companies – the payers of health care, the employers, should be represented on the SGB. Also, to get buy-in from providers, you need to include them on the SGB.

Question: The SGB would *seem to need to be very large to be able to monitor all of the CCO regulations?* State agencies would monitor the CCOs and whether they are meeting the 10 CCO requirements.

Question: *Under the SGB, would there be an agency made up of all agencies? Or would each involved agency monitor a small portion? Who would actually perform the day-to-day monitoring?* OHCA and EGID will function as they do today. The SGB will oversee these operations, and both OHCA and EGID are on the SGB.

Question: *Where does decision-making on benefit design fall?* This is left to the CCOs, as they will be forming the provider network and assuring network adequacy.

Comment: There is much support for adding a provider and a patient advocate voice to the SGB.

Quality Measures Committee

- The Quality Measures Committee will set CCO quality measure benchmarks and reporting requirements. This proposed committee will have 12 members: MD, DO, Pharm.D., Nurse, PA, Behavioral Health Specialist, 2 quality measure specialists, 1 HIT specialist, 1 public health specialist, 1 patient advocate, 1 practice transformation consultant.
- The six suggested providers are examples only.

Questions/Comments

Comment: FQHCs provide a particularly robust model to serve certain populations and can provide valuable insight for ideas of practice transformation across the state.

Episodes of Care Committee

- The Episodes of Care Committee will propose episodes of care and episode framework, including alterations to existing episodes of care. Proposed membership: representative from each participating payer, provider representatives relevant to each episode of care, a data reporting specialist, and a patient advocate.
- There is no prescribed size of the committee.
- Certification requirements drafted thus far: criteria to be a CCO.

**OHIP/OSIM HEALTH EFFICIENCY &
EFFECTIVENESS, AND WORKFORCE WORKGROUP
MEETING MINUTES**

Questions/Comments

Comment: A care management representative should be one of the members of the Episodes of Care Committee.

Comment: Does anyone represent the disabled community on this committee? A member advocate should be included on the committee.

Question: *What episodes are we talking about? Do we currently have episodes targeted towards children?* These proposed episodes are asthma, perinatal, COPD, total joint replacement, and congestive heart failure.

CCO Certification Criteria (refer to CCO Certification Criteria document)

Question: *Are all managed members under this model?* That is something we'll have to continue working on at this point. All will be rolled into CCOs over time. Oregon started with children and adults, but initially left out long term care patients due to the complexity.

Question: The sixth criteria to be a CCO is "coordinating and integrating the delivery of physical health care, mental substance abuse services, and other required services delineated by the SGB." Could we consider services that increase functionality, such as within the Aged, Blind, Disabled community, long-term care, home health and community-based services? These would need to be phased in at a later time.

Question: *Can a CCO select patients within their service area?* No, they cannot choose to provide services to just public employees, or just to Medicaid patients. They must provide services to all public employees and Medicaid patients in their service area.

Question: *Are there incentives for physicians for quality outcomes? Additional incentives for member satisfaction?* These are included in the quality benchmarks that CCOs will have to meet. In a value-based system, providers should receive the award for meeting criteria, not just the CCOs, so providers will share the savings.

Question: *Can insurance companies be CCOs?* Yes.

Question: *Are tribes eligible to be CCOs?* Yes, many tribes are well positioned to meet the 10 criteria to be a CCO.

Question: The sixth criteria to be a CCO is "coordinating and integrating the delivery of physical health care, mental substance abuse services, and other required services delineated by the SGB." Could we consider services that increase functionality, such as within the Aged, Blind, Disabled community, long-term care, home health and community-based services?

Question: *Where are Advantage Waivers at in this plan?* They may be phased in at a later time.

Comment: Members of a consumer advisory board could comprise any number of people who have the consumer interest at heart like the AARP or any community organization including patients. This is currently interpreted broadly, but will be prescribed directly in the coming months once feedback has been received.

Creating a Practice Transformation Center

- Key theme throughout stakeholder engagement was provider education, transformation, and support systems for the new model.
- Several current initiatives to leverage, promote, and sustain these efforts.
- OSIM proposes a multi-payer effort to create a Practice Transformation Center that would: (1) Link existing initiatives to ensure coordinated practice transformation, education, and awareness. (2) Connect providers to support services to succeed in new payment models from all payers.

Questions/Comments

Comment: This kind of center already exists. The Oklahoma Primary Healthcare Extension Program by Jim Mold was put into place several years ago. The program uses three components—the Public Health Institute of Oklahoma, four regional extension centers, and 70 county health improvement organizations. There are a variety of players in this arena.

Question: *Would it be better to leverage this center rather than starting with something completely new?* Yes. Also, it is based on the healthy hearts grant, which is a model used to get funding, but the model can be applied much broader to something that is related to what is trying to be accomplished and could be built upon in the coming years. Will provide link to the program to share with the workgroups.

Comment: Maybe it could be built into more of a virtual center. There could be criteria established to qualify a practice as a practice transformation center.

Timeline

- This is a hypothetical timeline created to show the step-by-step process to operationalize this initiative.
- CCO service delivery would initiate in early 2018.
- An operational plan is being developed to parse out details. This timeline may shift depending on state and federal laws, so flexibility is needed.
- Stakeholder engagement process will continue throughout this grant and beyond.

Health Information Technology (HIT) Plan

- The HIT Plan is currently under review and comments are appreciated. Will provide the plan to workgroup members for comments.
- Critical success factors: governance, infrastructure, and policy.
- The Oklahoma HIT plan proposes the creation of four governing bodies that will each manage distinct components
- HIT Advisory Board: Authority around any state technology managed by the state. Proposed 9 members.
- Three additional governing groups under advisory board: Health Information Network Operations; Value-Based Analytics Data & Operations; and Privacy and Security.
- Advisory board not just quality improvements around CCOs, but also for quality improvement for surrounding HIT metrics.
- Infrastructure domains: funding, technology, technical assistance, staff resources.
- Policy topics: alignment with existing HIT efforts: we do NOT want to silo efforts.
- Transparency and balance across providers and payers.
- Patient engagement and shared decision-making: not only have patients engaged with what we do with health information, but give them access through a patient portal in order to make decisions based upon their own information provided. Multi-payer strategies. Payers participating in HIT initiatives.

Questions/Comments

Question: How do you see the HIT Plan interfacing with the SGB? There would be some overlap as the HIT Coordinator is the Chair of the HIT Workforce Workgroup.

**OHIP/OSIM HEALTH EFFICIENCY &
EFFECTIVENESS, AND WORKFORCE WORKGROUP
MEETING MINUTES**

Next Steps

OSIM

- Payer Meetings
- Financial Analysis
- Finish SHSIP Sections – release for feedback

Health E&E and Workforce Workgroups

- Meeting next month – February 2016
 - Quality Measure Discussion
 - Episodes of Care Discussion
 - Financial Forecast Discussion
- SHSIP Section Review
- Meeting – March 2016
 - SHSIP Submission
 - Operationalizing SIM

ACTION ITEMS

1. Email HIT Plan to Workgroup Members.

2. Email links regarding the Oklahoma Primary Healthcare Extension Program.