OHIP/OSIM
Health Efficiency & Effectiveness Workgroup
Meeting Minutes

	Health Efficiency & Effectiveness Workgroup Meeting
DATE	December 14, 2015
TIME	1:30 pm – 3:30 pm
LOCATION	Oklahoma Health Care Authority, Board Room
FACILITATORS	Chair, HEE Workgroup: Rebecca Pasternik-Ikard Project Manager, HEE Workgroup: Valorie Owens
MEMBER ATTENDEES	Mary Brinkley, Lou Carmichael, Dr. Steven Crawford, Donna Dyer, Jon Lowry, Dr. Lynn Mitchell. Members via Conference Call: Steve Buck, Dr. Anthony Natale, Priscilla Haynes, Lisa Anderson, Toni Moore
GUESTS	Joseph Fairbanks, Melissa Fenrick, Jennifer Kellbach, Alisha Hemani-Harris, Alex Miley, Isaac Lutz, Martina Ordonez, James Rose, Candace Macedo, Erica Stovall. Conference Call Participants: Annie Smith, Christin Kirckenbauer, Denna Wheeler, Keianna Dixon, Meredreth Maynard, Melissa Pratt, Spencer Kusi, Jana Castleberry
HANDOUTS & REQUESTS	Health Efficiency & Effectiveness PowerPoint Presentation, Oregon's Annual Health System Transformation Report

MEETING MINUTES

1. Welcome / Introductions

- Welcome from Chair, Becky Pasternik-Ikard, OHCA Deputy State Medicaid Director

2. OSIM Status Update

Alex Miley, OSIM Project Director

- Substantial progress has been made in the intervening months since the previous meeting
- CMS has granted Oklahoma a two month extension for the OSIM initiative, which will allow for a thorough public engagement and comment period, and result in a more robust State Health System Innovation Plan (SHSIP) to guide health transformation efforts
- The final four months of the OSIM design phase will incorporate substantial stakeholder involvement

3. OSIM Proposed CCO Model and Discussion: ***please refer to the PowerPoint Presentation for complete details***

Alex Miley, OSIM Project Director

Oklahoma Department Spending Share 2005-15

- Oklahoma's health spending has increased its share of the total state budget from 13.6% to 19.2%, since 2005.
- Oklahoma's health spending has increased twice as fast as the state budget and 1.5 times as fast as US total healthcare expenditures.

Case for Change

- Current system is not focused on prevention efforts that can lead to better health and reduce costs.

- Fee for Service (FFS) system incentivizes volume, making it difficult to contain costs.
- FFS has created reason to view patients as diagnoses and inhibits ability to provide person centered care.
- FFS payments do not incentivize investment in innovative delivery methods or systems.
- Changes to the payment system are necessary to transform provider behavior to allow for person-centered care and investments to enable population management.

OSIM Model Goal: To move payments to providers from a fee-for-service system to a payment structure based on value and integration of primary prevention strategies.

- By moving to value-based purchasing and a care coordinated model, will improve population health while addressing the OSIM flagship issues: Obesity; Diabetes; Tobacco Use; Hypertension; and Behavioral Health.

OSIM Model Proposals- Conceptual Design Tenets

- Incorporate what drives health outcomes, integrate the delivery of care, drive alignment to reduce provider burden, and move toward value-based payments (VBP) 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.
- 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, etc.
- Governed by a partnership of health care providers, community members and other stake holders.
- Initially, this model is proposed for **all state purchased health care**, which comprises a quarter of the state's population.

State Governing Body
CCO Governing Body
Board of Accountable Providers
Community Advisory Board
Institutional Providers
Pharmacy
Patient
Care Navigator
Community Resources
Physician

Payment Methodology

- CCOs will receive fully capitated, risk-adjusted per member per month payment.
- Incentives paid through a Community Quality Incentive Pool.
- If savings are accrued, a portion must be reinvested in the community to serve human needs.

- A percentage of the capitated rate will be paid to a health information network (HIN) for interoperability and data infrastructure.
- CCO will implement an Alternate Payment Arrangement (APA) with the providers in their networks.
- CCOs will work to meet the following targets:
  1. 80% of payments made to providers will be value-based by 2020 to align with Medicare;
  2. Participation in Multi-Payer Episodes of Care;
  3. At least one additional APA must be utilized; and
  4. APAs must include mechanisms to encourage both cost savings and high quality care.

Integration of Social Determinants

- A Community Advisory Board will serve as a mechanism for formal integration of the social determinants of health within the proposed model.
- Oklahoma will pursue the use of flexible spending as a reimbursable service within the CCOs.
- At enrollment members will complete a human needs survey which analyzes patients' social needs.
- Quality metrics include a social determinant aspect.
- All CCOs must keep an up-to-date regional asset database for easy referral.

Delivery Model

- Many delivery model components, such as care coordination, the role of the primary care provider, and creation of care teams will be left to the CCO to articulate back to the governing body how they will deliver patient-centered care.

Health Information Technology Integration

- All CCOs must establish connection to an interoperable Health Information Exchange (HIE).
- HIE views will be required to be established for the care team.
- Data analytics for payment will be done with a VBA tool using data that will be available within the Health Information Network.
- Ensure access to a consumer-friendly patient portal.

Oklahoma Communities of Care Organization: Governance

QUESTIONS/COMMENTS

Comment: Primary Care Physicians (PCPs) are struggling with the high demands of HIT rules and documentation. Comment that physicians are not going into the primary care practice in part because of

these changes. The new trend, starting in medical school where physicians would traditionally go into primary care, is to go instead into hospice care, urgent care, emergency care, etc.

- Follow-up Question: *Is there a reason for this trend?* Too much control has been instilled into the process of how physicians practice. Profit margins for PCPs are extremely low and too much of their time is taken up with record keeping. Record keeping is painstakingly time consuming for little benefit, and physicians' time with patients is reduced.

Question: *Do you feel that there is pressure for physicians to bill for volume?* No, but the current system is set up to encourage that mindset. But there is no evidence that this is occurring.

Comment: Electronic Medical Records (EMR) – this required documentation is difficult to complete in a timely fashion and it is a convoluted process. Additionally, this work does not provide a measurable benefit for analytics. There is also no standardization of data collection between health systems and EMR systems on information that is captured. PCPs are essentially becoming expensive data entry clerks.

- Hiring a scribe may work for larger networks/employers, however, small and/or rural practices are taking on an inherent risk and it is difficult to balance the number of scribes needed.

Comment: Metrics should go down to the provider level, so that providers may use their own data to target and focus resources so that they feel like they're moving in the right direction. This also increases provider satisfaction.

Multi-Payer Quality Measures

- Allow healthcare payers and providers to gauge the quality of care.
- Help assure cost-effectiveness is not achieved at the expense of quality care.
- Multi-payer quality measures will reduce provider burden and create synergy around achieving a high level of performance on selected measures.

How are they Incorporated?

- Participating payers will be asked to make the measures a requirement to report from all applicable providers in contract with the CCO.
- Participating payers will be asked to develop alternative payment method (APM) strategies around measures with as much alignment among plans as possible.
- These measures will be among those asked to be reported by CCOs.

Quality Metric Data Sources: ***please refer to slides 37-41 in the PowerPoint Presentation***
Creation of a Quality Metrics Workgroup/Committee will help with setting the benchmarks for the quality measures at the state governing level. The CCO governance will help with setting measures specific for their particular regions to account for their regional differences.

- Clinical Measures: Clinical Data & Claims Data
- Quality Assurance: Independently Reported by CCO
- Population Measures: Clinical Data; BRFSS; Death Data

QUESTIONS/COMMENTS
Question: *Will the CCO model proposed for OSIM require legislative action and an 1115 waiver? Is there a timeline for Medicaid transformation? Is there political will to pass?* This proposal will require an 1115 waiver and state legislation. No timeline yet, but would prefer sooner rather than later, possibly the end of 2016 for pre-implementation. It is estimated to be an 18-24 month process.

Question: *Can there be multiple CCOs per region?* Yes, but this is normally only seen in urban areas.

Question: *What if a provider is out of state (e.g. in a rural area like the panhandle)?* This will be addressed in the network adequacy profile prior to implementation of the CCO.

Question: *Is there a merger in the works between the OHCA and EGID under this new proposal?* Not necessarily. OHCA receives federal match whereas EGID does not.

Question: *Who appoints the state governing body for the boards of the CCOs?* This matter remains under consideration.

Question: *What other states have models that are similar to the one that is being proposed in Oklahoma?* Oregon, Colorado, North Carolina, and Alabama.

Question: *What is the difference between the 1990 and early 2000's era of HMO managed care and the current model?* Current model covers non-traditional services, there is participation of two boards, a minimal threshold of quality metrics have to be met, and it includes the integration of social determinants.

Question: *Do we know what the cost of implementation of something like this will be?* Milliman is currently putting together a financial forecast and will discuss assumptions of the study in January (TBD). Oregon has achieved their first year goal of a 2% reduction in cost growth and they estimate between $57 million - $114 million in cost savings.

Question: *Do we know the percent of the state budget that could be saved?* We do not know yet. However, it may be beneficial to review Oregon's progress, as the state is required to post annual performance reviews for all metrics that have been met or not met.

Question: *What are the differences between MCOs and CCOs?* CCOs have many more requirements. CCOs use low-level captured data for analytics.

Question: *Does this proposal include community organizations and not just healthcare organizations?* Yes, community organizations are vital to the success of this model.

Question: *How does the nursing home population fall into this?* These details are still up for discussion.

Comment: The uninsured population has high costs because they get sicker and end up in nursing homes eventually. This needs to be addressed to mitigate the cycle.

Comment: Requiring specific quality measurements is not optimal unless they are weighted. A lot of issues that would fall under the five flagship issues are on the optional list. Optional list also includes cancers that are pre-cursers to expensive diseases if not caught early. There needs to be a better balance of optional and required. Currently it seems the list caters to treatment and not prevention. All three screenings for cancers should be on the required list.

Question: *Is there a measure for physician or provider satisfaction?* Not yet, but would welcome any

suggestions on this measurement.

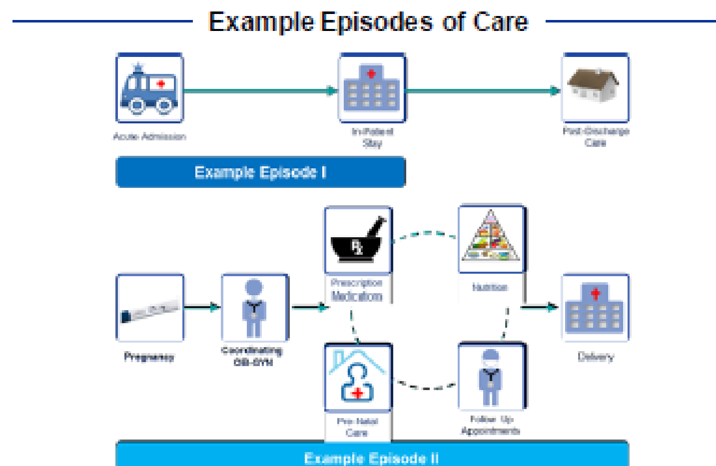
Episodes of Care – Payment Model Design
Isaac Lutz, Manager of Health Planning, CHIE

Multi-Payer Episodes of Care

- Multi-Payer episodes of care have been shown effective at containing costs and improving outcomes.
- Multi-payer episodes focus attention on the patient, not the insurance carrier.
- Five episodes are part of the plan that aligns to Medicaid: asthma, perinatal, COPD, total joint replacement, and congestive heart failure.
- Some episodes may exclude high risk patients.
- Other states are aggressively expanding episodes of care.

Episodes of Care Payment Model Design

- Episodes begin with a triggering event and last until a pre-determined duration elapses.
- Episodes define which related services and patients will be considered within the episode's performance year.
- Principle Accountable Providers (PAPs) are initially paid for on a fee for service basis and then retroactively evaluated against a set benchmark for the average cost of the care delivered per episode.
- Each episode for a particular condition has an overall performance year in which all patient episodes for that condition are aggregated and evaluated against benchmarks for cost and/or quality of care
- PAPs that come in under the cost benchmarks receive a percentage of the savings as a bonus, provided they also meet quality benchmarks
- PAPs that exceed the acceptable level of costs may have to pay a portion of the overrun as a penalty (penalties are capped to ensure provider viability)



Next Steps
Plan Presentations

- OSIM Steering Committee (January 13, 2016)
- Individual meetings (please contact with requests)

- Next Health E&E Meeting (January 19, 2016)

Plan Review

- Submitting to CMS for feedback
- Email questions and comments
- Milliman Financial Analysis Review (January 13, 2016)

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