OHIP/OSIM
Health Efficiency & Effectiveness/Health Finance Workgroup Meeting Minutes

	Joint Health Efficiency & Effectiveness Workgroup and Health Finance Workgroup Meeting
DATE	August 28, 2015
TIME	9:00 am – 11:00 am
LOCATION	Oklahoma Health Care Authority
FACILITATORS	Chair, HEE Workgroup: Becky Pasternik-Ikard Project Manager, HEE Workgroup: Valorie Owens Project Manager, Health Finance Workgroup: Isaac Lutz
MEMBER ATTENDEES	Lisa Anderson, Mary Brinkley, Lou Carmichael, Dr. Steven Crawford, Pam Cross-Cupit, Claire Dowers, LaWanna Halstead, Bill Hancock, Jon Lowry, Toni Moore, Marisa New, Rick Snyder, Brent Wilborn. Conference Call Participants: Laura Brookins, Donna Dyer, Melissa Gower, John Silva, Marla Throckmorton
GUESTS	Marlene Asmussen, Jana Castleberry, Malinda Douglas, Alisha Hemani-Harris, Mollie Kimpel, Spencer Kusi, Alex Miley, Martina Ordonez, Jeremy Palmer, Chris Pettit, Melissa Pratt, James Rose, Maureen Tressel Lewis. Conference Call Participants: Tori Hall, Aaron Schneider
HANDOUTS & REQUESTS	Joint Health Finance and Health Efficiency & Effectiveness PowerPoint Presentation, Analysis on Delivery of High-Cost Services, State of Oklahoma Care Delivery Model Assessment

AGENDA

1. Welcome / Introductions

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

2. OSIM Overview and Triple Aim

—Alex Miley, OSIM Project Director

- Discussed the overall OSIM Timeline and activities remaining in Phase 2. Discussed the OSIM State Health System Innovation Plan (SHSIP), which is the primary deliverable of the OSIM initiative. Provided updates on all four Workgroups, and discussed next steps for stakeholders.

3. Deliverable Review and Discussion: Analysis on Delivery of High-Cost Services

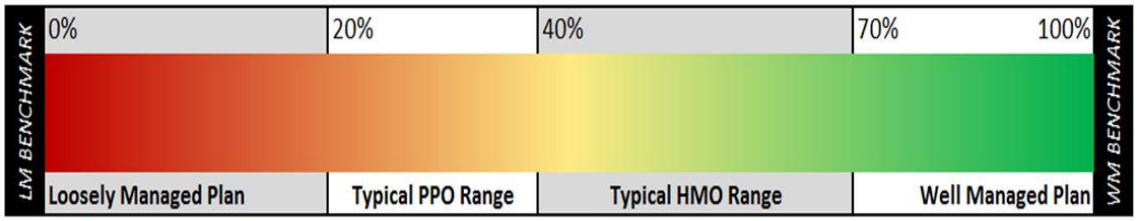
—Jeremy Palmer and Chris Pettit, Milliman

For more information, please refer to the report titled, *Analysis on Delivery of High-Cost Services*.

- High Risk Patients + High Cost Services = High Cost Patients <- who we need to target
  -80/20 rule in health care expenditures: 20% of the population account for 80% of the cost
- Analysis of High Cost vs. Average Cost Patients
  -Most notable differences in cost percentage: high cost patients had a significantly larger proportion of hospital inpatient cost, and a smaller proportion of outpatient/professional services cost.
- Comparison cost for the average patient: Commercial vs. Medicaid vs. Medicare
  -Obese commercial patients cost 380% more on average than non-obese commercial patients, more than 10,000 per year

-Obese and tobacco using Medicaid patients cost twice as much as non-obese, non-smoking Medicaid patients, on average
-Those with diabetes on Medicare cost 2.27 times as much as those on Medicare without diabetes

- Types of Services
  -Patients who use tobacco or are obese, have hypertension and/or diabetes spend more in inpatient care than the average patient spends on all forms of health care alone
- Degree of Healthcare Management



-Potential savings are available as we move along the continuum to a well-managed system

QUESTIONS/COMMENTS
-Question: *How many inpatient stays were triggered by an ER visit?* Milliman: Not sure. INTEGRIS Health representative: In relation to the notion of significant cost of inpatient hospital visits to high-cost patients, most admitted in-patient individuals came through the emergency room department.
-Question: *Are we addressing 30-day readmissions – and if not, can we do this in the report?* Yes.
-Question: *How is the Medicaid obesity rate 36% when the majority of the Medicaid population is children?* Will further review the source and methodology.
-Question: *Can you provide an example of a well-managed plan, and what the composition of the team is in a well-managed plan versus a loosely-managed plan?* Example provided of a well-managed plan was Kaiser Permanente (comprising the Kaiser Foundation Health Plan, Kaiser Foundation Hospitals, and Permanente Medical Groups) which is the largest nonprofit integrated health care delivery system in the United States. The composition of a well-managed team was stated to be one with tight integration, where there are different alignments of incentives, information is flowing, and the care delivery model is patient-centered.
-Question: *Did the cost of implementation go into the estimated savings?* No – it might be a year before you would see any savings.
-Question: *Is Medicaid considering a chronic care platform similar to Medicare?* They do have a health management plan currently for chronic conditions, and they use predictive analytics and embedded coaches. With this, is has shown to have great return on investment. They have also witnessed an impact of providing onsite practice reporting.
-Comment: We need to analyze the uninsured for comparative analysis. If we are talking about cost reduction, it should be included in the report.
-Question: *Did Milliman analyze the cost of the uninsured in the state?* No, from a data standpoint this is difficult. The uninsured are not generating claims the same way as insured patients, and are harder to track. The uninsured are being examined through market analysis.
-Comment: Not considering the uninsured is a Catch-22. Any dollars saved would still be drained by the uninsured population, and we need to identify and quantify the costs of this group or a lot of decisions will be made without this critical information.
-Comment: From the public health perspective, it is very important that we focus on preventive care – not just treating those who are already ill or have chronic conditions.
-Comment: Many Workgroup Members made statements stressing the importance of considering the uninsured population and addressing these related costs in this report and the overall SHSIP.

-Comment: The uninsured population will eventually be on Medicare or Medicaid/Disability and become a significant cost to the state. This group needs to be addressed now.

4. Deliverable Review and Discussion: State of Oklahoma Care Delivery Model Assessment

—Maureen Tressel Lewis, Milliman

For more information, please refer to the report titled, *State of Oklahoma Care Delivery Model Assessment.*

Identified eight models and initiatives for study:

1. Bundled Payments for Care Improvement (BPCI) Initiative: Primarily a payment reform model designed to motivate efficiency and care coordination for specific bundles of related services from the point of admission to discharge or 30, 60, or 90 days following discharge, depending on the BPCI model.
2. Comprehensive Primary Care Initiative (CPCI): Four-year initiative that provides administrative redesign resources to primary care physicians to help them implement comprehensive primary care functions (e.g., continuity of care, care management based on patient risks).
3. Federally Qualified Health Centers (FQHC) Advanced Primary Care Practice (APCP) Demonstrations: Form of medical home. Transforms selected FQHCs into advanced primary care practices and has them be recognized by NCQA as Level 3 PCMHs by the end of the three year demonstration.
4. Health Homes: Oklahoma Behavioral Health Home initiative targets children with SED and adults with SMI. Established in 2015, the program promotes patient-centered system of care that improves outcomes, services, and value for members in the Oklahoma SoonerCare program.
5. Health Access Networks (HAN): Form of medical home. Launched in 2010 as part of the SoonerCare Choice program, the Oklahoma HANs are non-profit community-based, administrative entities that work with providers to coordinate and improve quality of care for SoonerCare Choice members who are considered high-risk.
6. Patient-Centered Medical Homes (PCMH): Enable primary care physicians to work with nurses, pharmacists, nutritionists, social workers, and other supporting professionals as a care team that is focused on the patient's needs. Oklahoma's PCMH model, SoonerCare Choice was launched in 2009.
7. Accountable Care Organizations (ACOs): Group of professional and/or hospital providers (and sometimes payers) that are formally organized to assume responsibility for the cost and quality of care they provide to its patient population. Three ACOs in OK: Mercy Health ACO, St. John (OK Health Initiatives), and St. Anthony (SSMOK ACO)
8. Indian Health Services (IHS): Provides health services through direct care provided by IHS or tribal facilities or through care funded by IHS through community-based providers. IHS's Urban Indian Health Program provides special funding to health programs located in urban areas.

Also discussed:

- Employer Care Delivery Model – e.g., QuikTrip: Numerous Oklahoma employers are actively engaged in healthcare delivery innovation. WellOK, Inc., the Northeastern Oklahoma Business Coalition on Health, was created to improve the value of the healthcare received by employees and dependents.
- Emerging Medicaid Care Delivery Innovation: In June 2015, the OHCA issued a Request for Information (RFI) to collect information regarding care coordination models for the SoonerCare programs' aged, blind, and disabled (ABD) members. The RFI states that the care coordination

model will ultimately reflect information on existing Oklahoma patient-centered service models, including their populations served, covered services and benefits, provider networks, and provider payment structures.

QUESTIONS/COMMENTS
-Comment: Overview of the Healthy Hearts Oklahoma initiatives, more information can be found at the following link: http://www.ahrq.gov/professionals/systems/primary-care/evidencenow.html
-Comment: In regards to behavioral health, the traditional approach for the seriously ill is to receive treatment separately from medical care.
-Comment: In many of the Aged, Blind, Disabled presentations, there has been no separation between behavioral health and primary care.
-Comment: A good report on avoidable hospital conditions to review is the *Medicare-Medicaid Eligible Beneficiaries and Potentially Avoidable Hospitalizations*, located at the following link: https://www.cms.gov/mmrr/Downloads/MMRR2014_004_01_b01.pdf
-Comment: FQHCs are co-locating primary care providers into community mental health centers.
-Question: *Are there any aspects of care delivery model that we have not included, that we must include?* A prevention piece on lifestyle change.
-Comment: In many discussions, a common theme has been the need to address behavioral health, to have a social work component in any care delivery model, and to include a section on how to address the uninsured.
-Question: *When does the intervention begin?* This depends on what model we choose.

5. Additional Discussion Items and Future Meetings

— Isaac Lutz

Next Meetings

- Value-Based Analytics and Model Design Workshops
  - September 9th: 2:30-4:30 PM – Oklahoma City, OUHSC Samis Education Center
  - September 11th: 1:00-3:00 PM – Tulsa, Tulsa Chamber of Commerce
- Meeting and other OSIM Information: osim.health.ok.gov