



OHIP/OSIM Health Efficiency & Effectiveness Workgroup Meeting Minutes



Health Efficiency & Effectiveness Workgroup Meeting	
DATE	March 1, 2016
TIME	1:30 pm – 3:30 pm
LOCATION	Oklahoma Health Care Authority, Board Room
FACILITATORS	Chair, HEE Workgroup: Becky Pasternik-Ikard OSIM Project Director: Alex Miley
MEMBER ATTENDEES	<ul style="list-style-type: none"> • Members Present: Lou Carmichael, Marla Throckmorton • Members via Conference Call: Claire Dowers, Debbie Spaeth, LaWanna Halstead, Lisa Anderson, Lynn Mitchell, Marisa New, Toni Moore • Project Manager Present: Valorie Owens
GUESTS	<ul style="list-style-type: none"> • Guests Present: Joe Fairbanks, Isaac Lutz, Martina Ordonez, Melissa Pratt, Kristen Kirkenbauer, Marlene Rasmussen, Keianna Dixon, Jim Jones, James Rose
HANDOUTS	HEE Workgroup PowerPoint Presentation, Comment Rubric

AGENDA

1. Welcome / Introductions

Welcome and Meeting Objectives, Becky Pasternik-Ikard, OHCA State Medicaid Director

2. OSIM State Health System Innovation Plan Status (refer to PowerPoint Presentation)

Alex Miley, OSIM Project Director

- State Health System Innovation Plan (SHSIP): Eight sections currently ready for review, with three more sections to be completed by mid-March (Financial Analysis, Monitoring and Evaluation, and Operational and Sustainability Plan).
- Based on stakeholder feedback, the name Community Care Organization (CCO) has been changed to Regional Care Organization (RCO) to mitigate any confusion with existing entities that have the same acronym.
- Over 140 meetings have been held with stakeholders. A list of all organizations that have been consulted will be included in the appendices.
- Emphasized that the SHSIP is a living document and will continue to be once SIM is over.

3. State Health System Innovation Plan Review (refer to PowerPoint Presentation)

Alex Miley, OSIM Project Director

Description of the State Healthcare Environment

- Discussed population health outcomes, health system performance trends, environmental context, and current initiatives for health improvement.

Health System Design and Performance Objectives

- **Health Expenditures Goal:** By 2020, limit annual state-purchased healthcare cost growth through both Medicaid and EGID to 2% less than the average annual percentage growth rate of the projected national health expenditures, as set by CMS.
- **Quality of Care Goal 1:** Reduce the rate of potentially preventable hospitalizations per 100,000

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Oklahomans by 20%, from 1656 (2013) to 1324.8, by 2020.

- **Quality of Care Goal 2:** Reduce the rate of hospital emergency room visits per 1,000 population by 20%, from 500 (2012) to 400 visits, by 2020.
- **Population Health Goal 1:** Tobacco: Reduce the adult smoking prevalence from 23.7% to 18.0% by 2020.
- **Population Health Goal 2:** Behavioral Health: Reduce the prevalence of untreated mental illness from 86% to 76% by 2020.
- **Population Health Goal 3:** Diabetes: Decrease the prevalence of diabetes from 11.2%(2014) to 10.1% by 2019.
- **Population Health Goal 4:** Obesity: Reduce the prevalence of obesity from 32.5% (2013) to 29.5% by 2020.
- **Population Health Goal 5:** Hypertension: Reduce deaths from heart disease by 13% from 9,703 in 2013 to 8,441 in 2020.

Value-Based Payment and/or Service Delivery Model

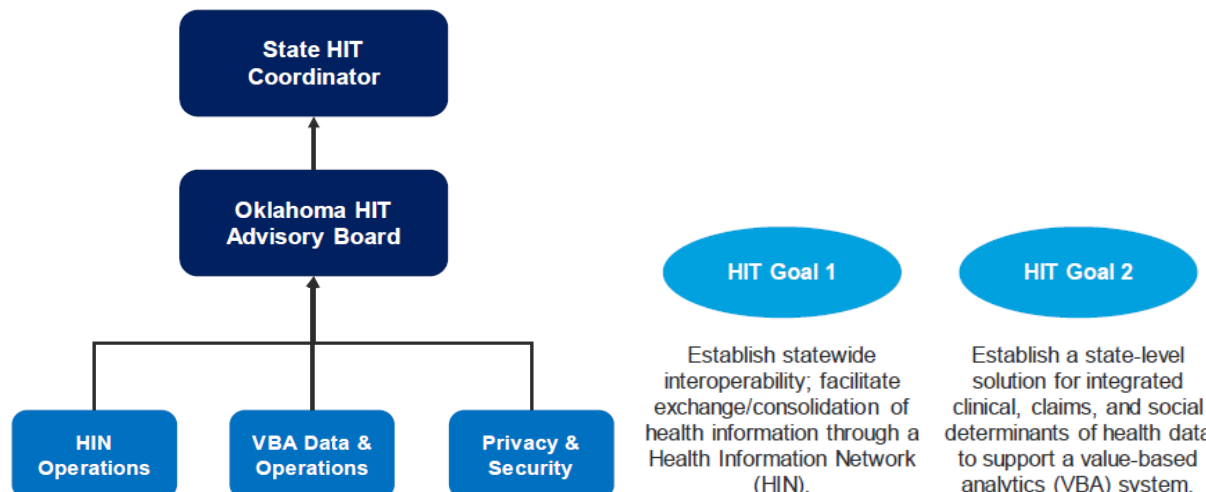


Plan for Improving Population Health: details how overall population health will be improved through current initiatives and the proposed Oklahoma Model.

- Federal, State, and Local Initiatives
- SIM Strategies and Activities
- Roadmap to Health Improvement

Health Information Technology (HIT) Plan

- Objectives and strategies to achieve HIT interoperability in Oklahoma and move toward value-based purchasing.



Workforce Development Strategy

- Data collection and analysis
- Statewide coordination of efforts
- Workforce redesign
- Pipeline recruitment and retention

SHSIP Questions/Comments

Comment: Alex Miley: Tribal consultation continues with another consultation slated for the end of March.

Question: Stakeholder expressed that from the tribal perspective, the RCO is their biggest concern. The tribe receives funding for their health care system based on member utilization. If tribal members use health care outside of the tribal health care system, how will this impact these member utilization funds? How will this impact third party revenue? *Alex Miley: The SIM Project Team has been using their tribal liaison to explore tribal needs. They have also been meeting directly with tribal groups; their next meeting is tomorrow (March 2, 2016). Becky Pasternik-Ikard: CMS released guidelines for Native American health care and the expansion of the scope of services. Will email this letter to the Workgroup.*

Question: What is the timeline for public comment? *Alex Miley: The deadline for public comment is March 15th. The OSIM team will incorporate these comments into the SHSIP and submit this updated version to CMS on March 31st. They will then have another round of comments after this date to enable a 90-day review period, which will end at the end of June 2016.*

Question: Stakeholder noted that some of the most important reports that will drive decisions have not yet been released, and asked when they would be able to review these (referring to the financial analysis, operational and sustainability plan, and the monitoring and evaluation plan.) *Alex Miley: Two of these reports are almost complete, and will be included in the next version of SHSIP. The financial analysis will be available soon, at which time an All Workgroup Meeting will be held to review and discuss this document.*

Goal to Model Tenets

- **Reviewed goal of the OSIM project:** To achieve a multi-payer state plan to move current healthcare payment methodologies from volume-driven fee-for service to a system where payments to providers are based on methodologies that reward value and address persistent issues with cost, quality, and population health.
- **Reviewed additional goals to achieve the Triple Aim:** create opportunities for multi-payer initiatives that pay for outcome improvement across the primary drivers of poor health and healthcare cost increases (tobacco, obesity, hypertension, diabetes, and behavioral health); integrate healthcare and population/community health; create a scalable and flexible model that can be implemented in rural settings; address social determinants that prevent individuals from achieving optimal health, including implementing payment mechanisms or processes that address or mitigate the following barriers to health: poverty, poor education, poor housing, employment, physical environment.
- **Reviewed Conceptual Design Tenets:** incorporate what drives health outcomes, integrate the delivery of care, drive alignment to reduce provider burden, and move toward value-based purchasing with realistic goals.

Model Goals Questions/Comments

Comment: Great models currently exist in our state - how do we 1) ensure that these are not torn apart

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to make way for the new overarching plan; 2) recognize these in some fashion within the report? Some entities are further along than others in the goal towards the Triple Aim. Some are moving along with the changes but others cannot manage and are trying to get out. *Alex Miley: The goal is to maintain what is currently working well so that people will not have to continue starting and stopping on this “rollercoaster” of new health care initiatives, or constantly construct to deconstruct. Isaac Lutz: The RCO Provider Advisory Board will also offer provider supports.*

Comment: Stakeholder emphasized the importance of reducing provider burden. *Alex Miley: They are creating a targeted approach that providers would follow during the transition to this proposed new model. They are looking at that “fourth aim” (to the Triple Aim) of reducing provider burden; they want to bring joy back to the practice of medicine. Comment: This is also relevant to tribal health care, the “fourth aim”.*

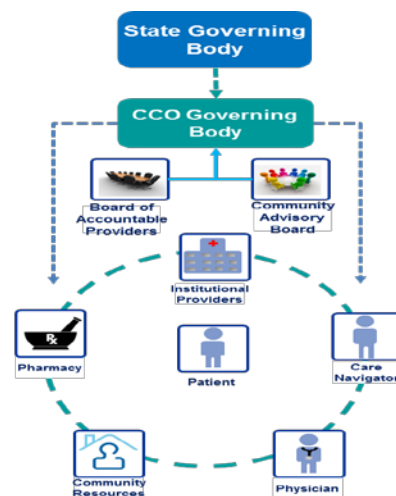
Becky Pasternik-Ikard: Do you see RCOs continuing the good work of FQHCs? *Stakeholder: Yes. We also need to leverage and align existing resources at the regional level.*

Becky Pasternik-Ikard: Is this community focus also conducive to tribal health care delivery? *Stakeholder: Yes. The biggest concern at the community-level is not hearing back from patient referrals (when they refer patients out to another provider or into the private sector for treatment for specialized care). While they want to respect people’s free will to see whatever providers they choose to, they also want to close this referral loop. Stakeholder: We agree that we want to implement quality improvement efforts, but do not want to negate all of the work that has already been done that has been extensive (e.g., provider contracts). Many of these organizations are large and unwieldy, and change does not happen overnight so the word “transition” is important.*

Question: As to population conditions of flagship issues – are there other concentrations that certain regions of the state should focus on? *Child health and a focus on prevention.*

Stakeholder: Will provide information on “Living Longer, Living Stronger”, an evidence-based program that contributes to satisfying the Triple Aim.

Regional Care Organization (RCO) Overview



Reviewed the definition of RCOs: Local risk-bearing care delivery entities that are accountable for the total cost of care for patients within a particular region of the state.

- Reviewed organizations that could become an RCO or join together to become an RCO
 - Integrated system partnerships with health plans
 - Provider and system partnerships
 - Independent physician associations

- Reviewed the payment model for RCOs: RCOs will receive risk-adjusted per member per month (PMPM), globally capitated rates. Eighty percent (80%) of payments made by RCOs to providers will be in a selected alternative payment arrangement (APA) by 2020.
- Reviewed the risk-bearing aspects of RCOs: RCOs would accept actuarial risk and performance risk for the attributed population within the geographic region, which will drive improvement in both areas.

RCO Model Questions/Comments

Discussion Question: How likely is this as a multi-payer model?

Stakeholder: Multi-payer alignment is where the system is heading. There is already a lot of alignment with payers. It is important and good to see that the model is not centralized and that there are alignments based on regional and community approaches.

Discussion Question: If a region had a choice to focus on another population/condition than what is presented in the model, what would it be?

Stakeholder: Prevention. Her organization had two children under age 9 who were diagnosed with Type 2 diabetes.

Discussion Question: What does the full integration of primary care and behavioral health care look like?

Stakeholder: At the office level, they have health care screenings and behavioral health providers to help at the scene. However, they also need to act on the results of these screenings. To her, the integration of behavioral health care and primary care means having a behavioral health provider onsite to help in order to prevent crisis events.

Stakeholder: Statewide, having a behavioral health provider onsite may not be realistic. However, it is good to have these linkages between behavioral health care and primary care. Joe Fairbanks: In Colorado, they co-located behavioral health and primary care providers and saw an increase in savings.

Stakeholder: All providers should be equipped with mental health “first aid” provider supports.

Stakeholder: Recommended having a mental health counseling office onsite at provider locations.

Discussion Question: Is this model and payment mechanism feasible in Oklahoma?

Stakeholder: Until they can review the Financial Analysis, it will be difficult to determine this.

Stakeholder: So many factors are in play here. Also, is comparing Oklahoma to Colorado comparing apples to oranges?

Stakeholder: In this model, there is a great dependence on the safety net, which is really fragile. Things are being cut. This is a feasibility issue for the model.

Stakeholder: How will Native Americans be carved out or addressed in this model? *Becky Pasternik-Ikard: The initial model coverage will be for state-purchased health care. They will determine how the model will work for the Native American population once they perform additional research.*

Stakeholder: What changes will this model entail for a payer, provider, or member? *Alex Miley: Payers will have the opportunity to participate in this new model. Providers will have the opportunity to be involved in value-based care delivery. Members will have greater coordinated care.*

Isaac Lutz: This model will provide cleaner lines towards health outcomes. Those with chronic conditions need treatment help as well as someone to help them become more accountable for their health. Referenced examples of care coordination models with OHCA programs (Health Access Networks, Comprehensive Primary Care Initiative, etc.). We are thinking about how we can accelerate

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the impact of such programs in the long-term.

Stakeholder: Providers have asked how other stakeholders can be held more accountable. *Isaac Lutz: Acknowledged this point. They also want to ensure that as they ask providers to be accountable, they give them the opportunities and resources to do so.*

Stakeholder: Have we engaged non-profits, e.g., United Way, to vet this plan (regarding safety net resources)? *Joe Fairbanks/Alex Miley: Debbie Hampton, President and CEO of United Way of Central Oklahoma, is on the OSIM Executive Steering Committee. The organization has seen the plan and is excited. Additionally, states like Oregon were able to negotiate flexible spending, another aspect of community resources, in their Medicaid waiver, as an example of what Oklahoma could do.*

Stakeholder: It is important to them that they track these kind of resources to measure what they have accomplished as well as the cost of doing so.

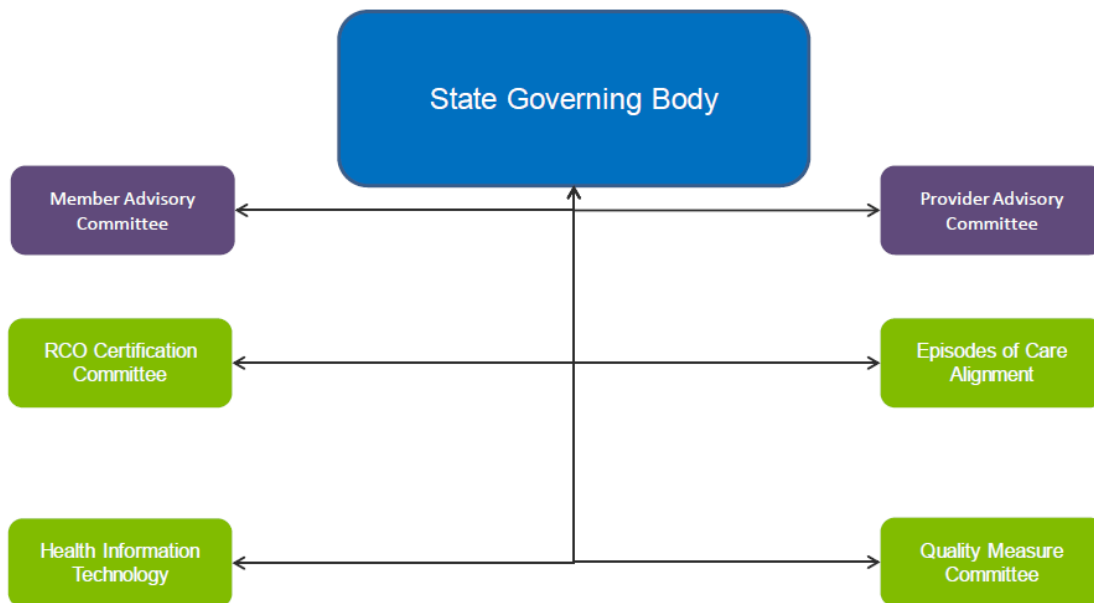
Stakeholder: Evidence-based programs can provide such resources to do these evaluations. *Jim Jones: They introduced an idea to have a quality metric for social determinants of health. They also want to re-invest savings into the community to keep this initiative moving forward. This is beyond what payers have done before.*

Stakeholder: Made a comment about the model's similarity to "the old managed care model." *Alex Miley: This refers to the health maintenance organizations (HMOs) of the 1980s and 1990s. These HMOs contrast with this new model that they are proposing, which focuses on community-level integration and participation from providers and members. Jim Jones: This new model should be seen not as an HMO but rather as a CMO (community maintenance organization).*

Stakeholder: There are many lessons to be learned from tribal organizations that have had capitated payments for a long-time; the expectations for health outcomes are very high. *Alex Miley: The SHSIP includes examples of such innovations from across the state.*

Governing Body Membership and Responsibilities to Meet Model Goals

Reviewed the proposed advisory board and committees for the State Governing Body



The State Governing Body will provide oversight to the RCOs through certification and a continuous quality monitoring process for state purchased health care.

- Members: OHCA, EGID, OSDH, Oklahoma Department of Mental Health and Substance Abuse

Services, Oklahoma Insurance Department, Representative from Member Advisory Committee and Provider Advisory Committee, Tribal Representation

RCO Model Questions/Comments

Discussion Questions: Does this governance model represent the groups necessary to ensure proper governance of the proposed new model for the state?

Stakeholder: Previously, she recommended ensuring that nurses were represented. She also recommends including a nursing licensing board member, as well as to include payer representation.

Alex Miley: They want to walk a fine line to ensure that they have a “magic number” for the State Governing Body board so that it can be productive. Constant battle between “too large to manage” or “too small to be inclusive”.

Becky Pasternik-Ikard: How many people do you think are enough to make the board functional?

Stakeholder: No fewer than 9, no more than 22. Really, anytime the number goes beyond 15 the group becomes unwieldy.

Alex Miley: They have received a lot of suggestions to have either 9 or 13 board members. An odd number to prevent tie votes.

Stakeholder: Stakeholders are concerned about having people who absolutely represent them on the board. Maybe they should have a discussion about what are the appropriate organizations to represent different stakeholder groups (e.g., hospitals, federally qualified health centers, community mental health clinics). This would be helpful to ensure that whomever is on the board properly represents these stakeholders.

Joe Fairbanks: There will be a Provider Advisory Committee to the State Governing Body that will elect one person to serve on the State Governing Body board, to represent providers.

Discussion Question: Are representatives present in numbers to appropriately reflect the stakeholders they represent?

Stakeholder: Have they considered an adequate representation number for urban versus rural perspectives and needs? *Joe Fairbanks:* Yes, and also received a suggestion about putting term limits as well as rotations on the elected members of the State Governing Body board. *Becky Pasternik-Ikard:* Two years is a common term limit. However, there is also the question about how long it will take to “learn” a new position. *Jim Jones:* There are consulting firms that specialize in helping organizations ensure that they have a well-functioning board so that it will not fail. The state can pursue this.

Stakeholder: Do we want to include someone that represents both physical and mental health?

Stakeholder: They could have the president of an association for a particular stakeholder group be a voting member on the State Governing Body board so that whenever the president changes, the person in that role on the board also changes. There could also be positions that are ex-officio.

Discussion Question: Should they include commercial or self-insured payers on the State Governing Body?

Joe Fairbanks: They have received recommendations to have health plans represented by an association in the state so that there is broader representation of payers and so that no one payer is explicitly represented (to prevent conflict of interests).

Alex Miley: We will take additional comments for this topic offline.

Timeline Presentation

Reviewed the OSIM Operational Roadmap – Healthcare System Initiatives Timeline

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- 2016: Form Quality Metrics Committee. Develop waiver. Form EOC Committee.
- 2017: Deliberate on core RCO metrics. Initiate EOC tracking and assessment. Pass RCO enabling legislation.
- 2018-2019: Implement DSRIP program and payments. Implement EOC payment. Perform RCO RFI and RFP Evaluation Process. Perform RCO development and transition process.

Reviewed the Delivery System Reform Incentive Payment (DSRIP) Program:

- Includes federal funding for four domain areas: infrastructure development, innovation and redesign, clinical outcome improvement, and population-focused improvement
- Provided example of the funding structure for New York State, which allowed providers to go above the upper limit for payments in certain areas

Discussed Senate Bill 1386 (Governor’s Request Bill):

- Authorizes the state to explore the development of a Section 1115 Waiver (for the DSRIP Program) and Section 1332 Waiver (related to introducing different options for private health insurance coverage than what is proposed in the Affordable Care Act). There is no preconception that the state will use either waiver even if the bill passes. If the bill passes, there would be a task force set up to do this exploration with the relevant stakeholders.
- Clarified that the rumors that have been circulating about the bill are false – this is regarding the bill authorizing the state to use Medicare dollars to fund Syrian rebels, and DSRIP endangering supplemental and enhanced payments to providers and universities

Wrap Up & Next Steps

- Request to email stakeholder comment rubrics to Osim@health.ok.gov or catherineam@health.ok.gov
- Health IT Workgroup Meeting on March 18th
- Health Finance Workgroup Meeting on March 22th
- Health Efficiency and Effectiveness Workgroup Meeting on March 28th
- Health Workforce Workgroup Meeting on March 30th
- Will hold an All Workgroup Meeting on the Financial Analysis in the coming weeks

ACTION ITEMS

1. Email CMS Letter.
2. Email HPSA updates.
3. Email information on the “Living Longer, Living Stronger” program.