Oklahoma Health Improvement Plan (OHIP) / Oklahoma State Innovation Model (OSIM) Health Finance Work Group Meeting
December 17, 2015

Oklahoma State Department of Health (OSDH)
1000 NE 10th Street, Oklahoma City OK 73117

Center for Health Innovation & Effectiveness (CHIE)
OSIM Project Director: Alex Miley

Agenda Item

I. Introductions & OSIM Overview

a. In attendance: Julie Cox-Kain, Deputy Secretary of HHS, OSIM Leadership Chair; Alex Miley, OSIM Project Director; Joseph Fairbanks, CHIE Director; Isaac Lutz, Health Finance Workgroup Project Manager; Melissa Fenrick, Health Planning Coordinator; Keianna Dixon, Deloitte; Pamela Smoot, Choctaw Nation; John Zubalde, OUHSC; Anne Barnes, OUHSC; Pam Cross-Cupit, Health Alliance for the Uninsured; Sylvia Lopez, OHCA, Rick Snyder, OHCA; Dr. Frank Lawler, EGID; Melissa Gower; Chickasaw

II. OSIM Project Update

a. Reviewed milestone updates
b. Major accomplishments include the model proposal, quality measures, episodes of care, and writing of the State Health System Innovation Plan (SHSIP) sections
c. CMS granted a two-month extension for SIM and the SHSIP (through March 2016); this will allow for a public comment period following the completion of the SHSIP in January
d. Reviewed SIM initiative timeline
    i. Model Development
    ii. SHSIP Development
    iii. Payer Alignment
    iv. Public Comment Period
    v. Workgroup Meetings
e. Reviewed rising health care spending as a percentage of the state's budget (2005-2015)
f. Reviewed high-cost spending in relation to the OSIM five flagship population health issues
g. Reviewed primary prevention strategies and ROI for addressing social determinants of health
h. Reviewed case for change: value-based payment, patient-centered care, innovation, prevention
i. Reviewed SIM 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
j. Reviewed the continuum of value-based purchasing – where we are and where we want to go
k. Reviewed past stakeholder engagement: workgroups, steering committee, technical assistance, and other stakeholders. Have been developing the OSIM model since September.
l. Reviewed OSIM Model proposal conceptual design tenets (influenced by stakeholder input)
    i. Incorporate the drivers of health outcomes
    ii. Integrate the delivery of care to break down silos
    iii. Drive quality measures alignment to reduce provider burden
    iv. Move toward value-based payment with realistic goals

III. OSIM Model Proposal

a. Reviewed Communities of Care Organization (CCO) Model
b. Overview – CCOs are local, risk-bearing care delivery entities that are accountable for the total cost of care for patients within a particular geographic region
    i. They are initially proposing this model for all state-purchased health care.
c. Eligibility to Become a CCO – Many different organizations already operating within the health care system could become a CCO or join together to become a CCO
d. Payment Methodology – CCOs will receive a fully capitated, risk-adjusted per member per month (PMPM) payment for the total cost of member services
e. Integration of Social Determinants of Health
    i. Community Advisory Board – Will serve as the mechanism for the formal integration of social determinants of health within the proposed CCO model
    ii. Flexible Spending – Will assist in addressing social determinants of health
    iii. Human Needs Survey – Will analyze patient social needs
    iv. Quality Metrics – Will include a social determinant of health aspect
f. Delivery Model – CCOs will be required to articulate back to the governing body the mechanisms by which they will deliver patient-centered care.
g. Health Information Technology (HIT) Integration – All CCOs must establish connection to an interoperable Health Information Exchange (HIE); a portion of their PMPM capitated payment will go toward HIE interoperability.
h. Governance
    i. State Governing Body: CCO Model Alignment, Quality Measure Committee, HIT, Health Workforce Committee, Episodes of Care, Behavioral Health
    ii. CCO Governing Body: CCOs must show that they have network adequacy to provider care for all patients in their region
    iii. Board of Accountable Providers – Will represent all service areas of the CCO in the region and CCO members
    iv. Community Advisory Board – Will have broad representation from the region for stakeholders across the health care spectrum

Discussion – Questions (Q) & Answers (A)

i. Q: How do they see county health departments integrating into the CCO model?
    i. A: They want the county health departments to be more involved than they currently are with service delivery. CCOs will determine how they want to integrate them into the delivery model.
j. Q: Are hospitals and rehabilitation facilities classified as institutional providers? If so, would CCOs be responsible for payment for institutional providers, and would that be capitated as well?
    i. A: Yes. There will be a phasing in of the services that CCOs will cover.
k. Q: How will you address the new Oklahoma Health Care Authority (OHCA) health system RFP?
    i. A: They are working with the OCHA about how best to address this new RFP and ensure that there is a seamless transition to the CCO model. The goal is to create one system and not two.

l. Q: Will there be criteria for creating a CCO? Who will do the due diligence to ensure that successful applicants have the proper resources to carry out the CCO model?
   i. A: The state governing body will determine the criteria and will receive guidance from the state governing body committees. To begin operating as a CCO, entities will first have to become certified as a CCO. They are still deciding on further details regarding this process.

IV. Proposed Multi-payer Quality Metrics

a. Importance of quality metrics and how they will be incorporated into the model
   i. Want to bring payers together to reduce provider burden with measures
   ii. Want to ensure that providers do not sacrifice on quality for sake of cutting cost
b. Required Multi-Payer and CCO Measures
c. Data Sources – Clinical, Quality, Population
d. Quality Metric Workgroup/Committee – Will ensure they are meeting quality goals. Will evaluate and recommend quality metrics that incentivize high-quality, high-value care
e. Required Clinical and Quality Measures – Reflect multi-payer measures, CCO measures (clinical and population), as well as feedback from stakeholder meetings with providers
f. Optional Bonus Measures

Discussion – Questions (Q) & Answers (A)

g. Q: Is there a measure that captures peer-to-peer provider satisfaction? (The stakeholder's organization does an internal provider satisfaction survey but she would want to see this different perspective as well) How will they capture and evaluate provider satisfaction and concerns?
   i. A: They will look into this and invite further comments and feedback from stakeholders (including via the online public comment boxes on the OSIM website).

V. Proposed Episodes of Care

a. Reviewed the importance of episodes of care and how they will be integrated into CCO model
   i. Episodes of care will be another pathway to achieving the goal of having at least 80% of care deliver to the population in some kind of value-based payment arrangement.
   ii. They are proposing five episodes of care as part of their model for Oklahoma. Other states are moving more aggressively with episodes of care.
   iii. As they move toward global provider payments, episodes of care will become obsolete.
   iv. Episodes will reduce provider burden; the more congruity there is between the payers, the less burden will be placed on providers in terms of how they have to deliver care.
b. Reviewed the scope, care model, payment model, and attribution for episodes of care
   i. Overview – Payment model in which services related to a condition or procedure are grouped into "episodes" that provide benchmarks for both costs and quality of care.
c. Payment Model Design – The service will initially be paid on fee-for-service basis then retroactively evaluated against set benchmarks. A fundamental aspect of this model is

rewarding the providers for containing costs.
   i. Principle Accountable Providers (PAPs) that meet quality standards and have average costs below the commendable threshold will share in savings, up to a limit.

d. Five Proposed Episodes of Care – They had initially proposed ADHD as well to address behavioral health but were advised by other states this that this was a difficult episode to roll out in the first phase. All of these episodes relate to a Medicaid, Medicare, OHIP, or other population health issue. They will create a taskforce to ensure that episodes are rolled out smoothly.
   i. Asthma (acute exacerbation)
   ii. Perinatal
   iii. COPD (acute exacerbation)
   iv. Total Joint Replacement
   v. Congestive Heart Failure

Discussion – Questions (Q) & Answers (A)

e. Q: How will providers be aware of where they may be at risk before they start participating in the episodes of care? It may helpful to communicate to providers participating in Year 1 of the model about risk areas so that they will not learn about this mid-way through the year.
   i. A: For providers who want to participate in the model, they will provide them with an indication of areas in which they may want to improve to be eligible for cost savings.

f. Q: How do providers work with hospitals to get within the commendable area of costs? For instance, one provider may be within the commendable area but her/his partner may not.
   i. A: There is an incentive for providers to use care coordinators to help contain costs and develop relationships with colleagues to determine optimal ways to contain costs.

g. Q: A stakeholder voiced concern about the lack of provider buy-in into episodes of care and value-based payment models. Another stakeholder, an internist from Tulsa, responded more optimistically. Based on his experience in his region, he believes that Oklahoma has the beginnings of a structure for health system change and just needs the resources to fill out this structure. He agrees that they need more provider buy-in but is more optimistic.
   i. A: The SIM initiative has had strong provider input since the first stakeholder meetings in March 2015. They have also met with most of the major payers. They are doing a very good job at collecting and incorporating this provider and payer input.

VI. Wrap Up & Next Steps

a. Plan presentations
   i. Tribal Public Health Advisory Committee Meeting (December 4, 2015)
   ii. OSIM Workgroups (December 2016)
   iii. OSIM Steering Committees (Early January 2016)
   iv. Individual Stakeholder Meetings (Ongoing)

b. Plan review
   i. Submitting to CMS for feedback (December 18, 2015)
   ii. Submitting to Technical Assistance for review (December 18, 2015)