Oklahoma State Department of Health

Health Efficiency & Effectiveness Workgroup Meeting

December 14, 2015

Health Efficiency and Effectiveness Workgroup Meeting Agenda

December 14, 2015, 1:30-3:30pm
Oklahoma Health Care Authority
4345 N. Lincoln Blvd, OKC, OK 73105
Health Efficiency and Effectiveness Workgroup Chair: Becky Pasternik-Ikard

Section			Presenter
Meeting Overview & Objectives	**10 min**	**1:30**	
OSIM Status Update ▪ **Progress** ▪ **Timeline**	**10 min**	**1:40**	**A. Miley**
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Wrap-Up & Next Steps	**5 min**	**3:25**	

Meeting Objectives

1

Update on overall OSIM initiative status

- Progress to date
- Model Discussion
- Next Steps

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OSIM Progress Update

The OSIM initiative has made substantial progress in the intervening months since the previous workgroup meeting

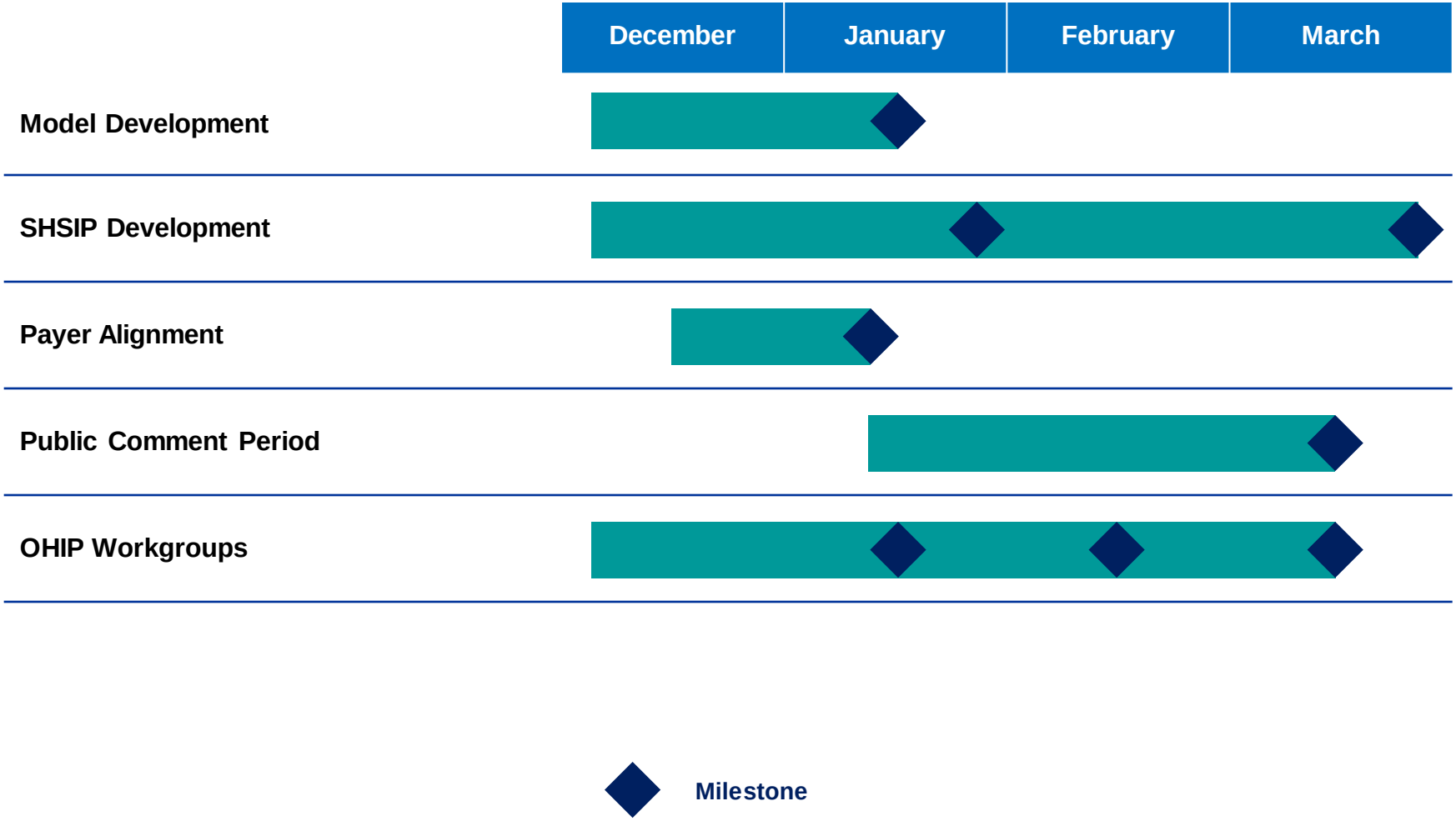
Milestone Updates

- Major OSIM accomplishments
  - Model proposal
  - Quality measures
  - Episodes of care
  - Writing of SHSIP sections
    - HIT Plan
    - Workforce Redesign
    - Environmental Scan

- CMS has granted Oklahoma a two month extension for the OSIM initiative
  - Allows for a thorough public engagement and comment period
  - Will result in a more robust State Health System Innovation Plan (SHSIP) to guide health transformation efforts in Oklahoma

SIM Initiative Timeline

The final four months of the OSIM design phase will incorporate substantial stakeholder involvement



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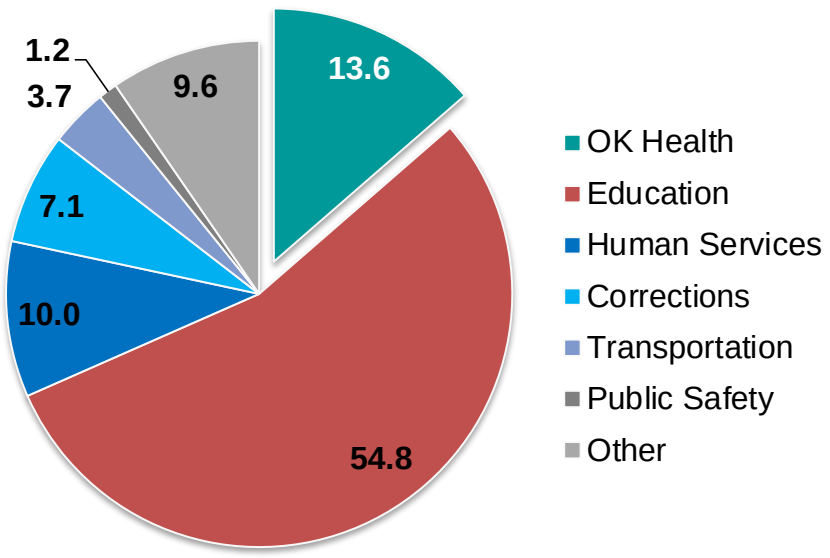
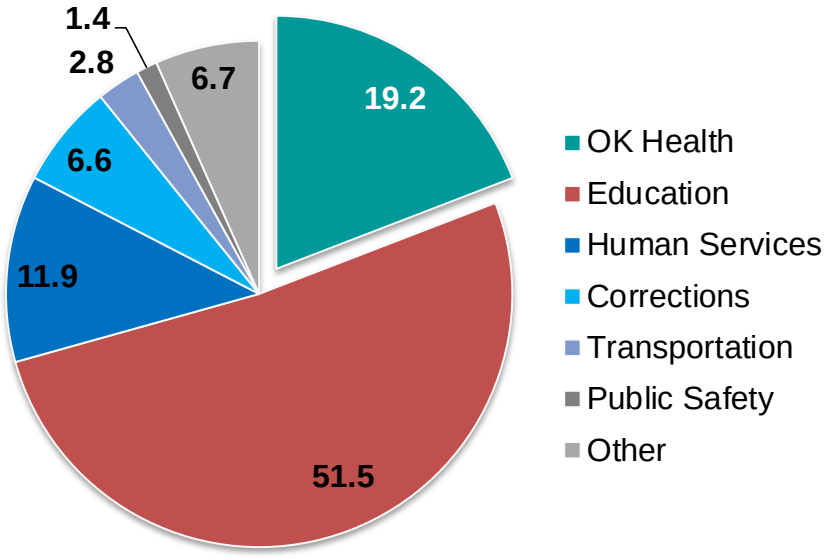
Oklahoma Department Spending Share 2005-15

Oklahoma's health spending has increased its share of the total state budget by 5.6 percentage points, from 13.6% to 19.2%, since 2005

Percentage Department Spending (%), 2005



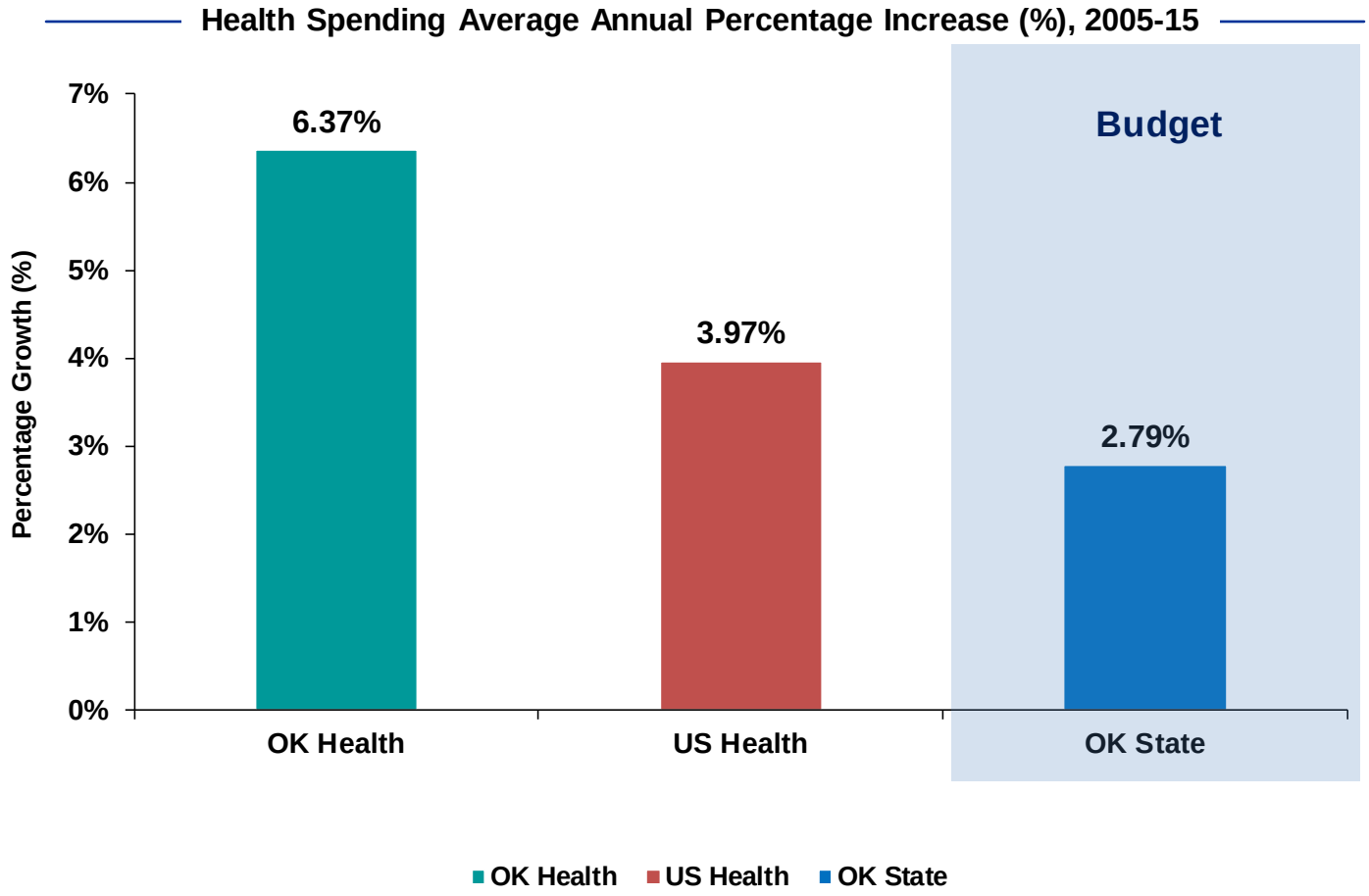
Percentage Department Spending (%), 2015



Source: Oklahoma Comprehensive Annual Financial Reports, CHIE Analysis

Oklahoma Health Spending Average Annual Increase 2005-15

Oklahoma's health spending has increased twice as fast as the state budget and one and a half times as fast as US total healthcare expenditures



Source: Oklahoma Comprehensive Annual Financial Reports, CMS National Health Expenditure Data, CHIE Analysis

Oklahoma Healthcare Costs

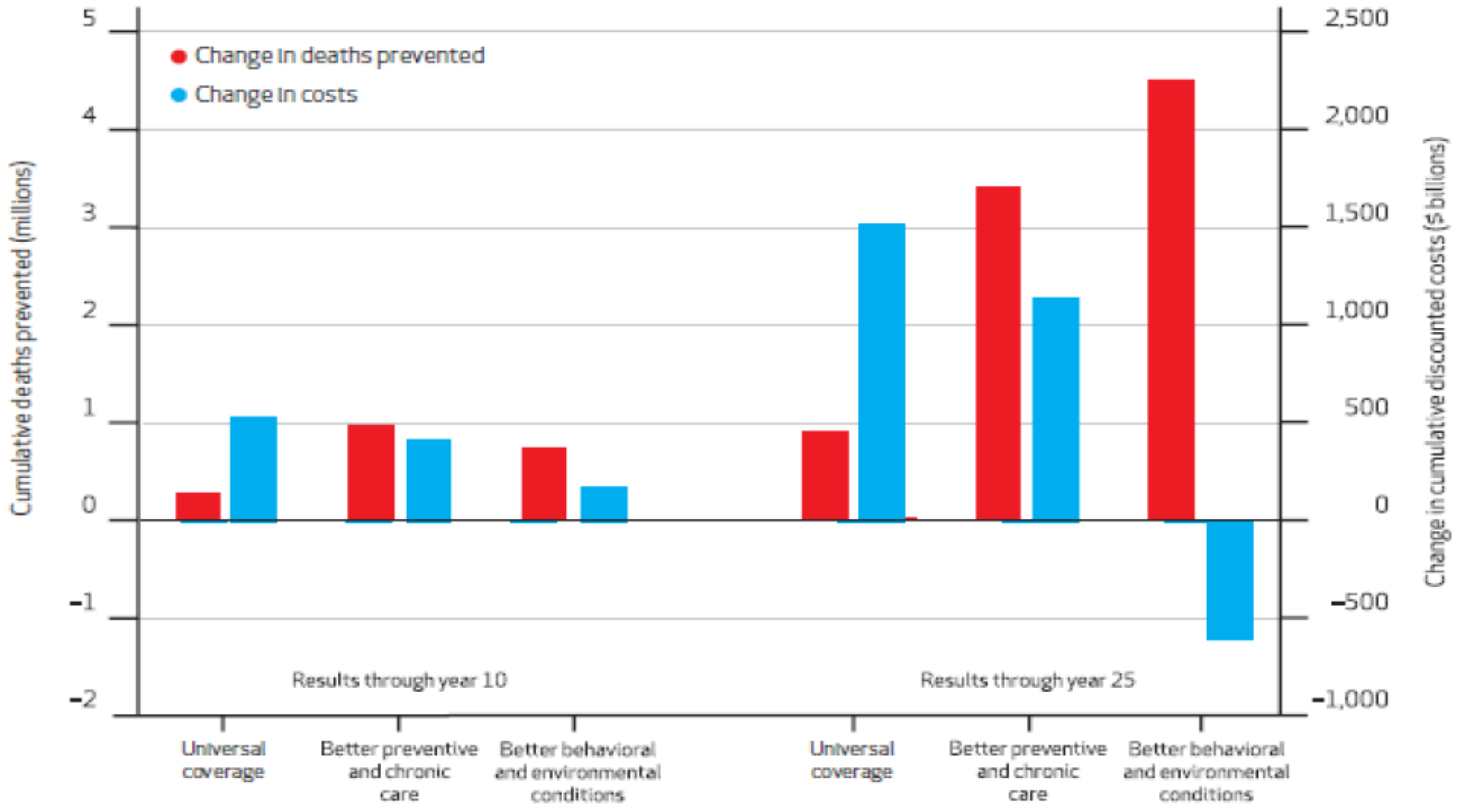
State of Oklahoma High-Cost Condition Relative Cost		
	% Increase	Average Annual Cost
Entire Population	1.00	$4,993
Diabetes	349%	$17,426
Obesity	343%	$17,126
Tobacco Usage	345%	$17,226
Behavioral Health	313%	$15,628
Hypertension	283%	$14,130

The Case for Change

- Current system is not focused on prevention efforts that can lead to better health and reduce costs
- The current Fee for Service system incentivizes volume, making it difficult to contain costs
- Fee for Service has created reason to view patients as diagnoses and services instead of individuals with needs for highly coordinated care, inhibiting providers' ability to provide person-centered care
- Fee for Service 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 in the systems necessary to enable population management

Primary Prevention Strategies Needed

Figure 3. A comparison of changes in deaths prevented and costs associated with expanding health coverage, improving care and investing in community primary prevention.



Milstein et al. (2011) Why Behavioral and Environmental Interventions are needed to Improve Health at Lower Costs. *Health Affairs*. 30, No. 5 (2011): 823-832.

SIM Model Goal

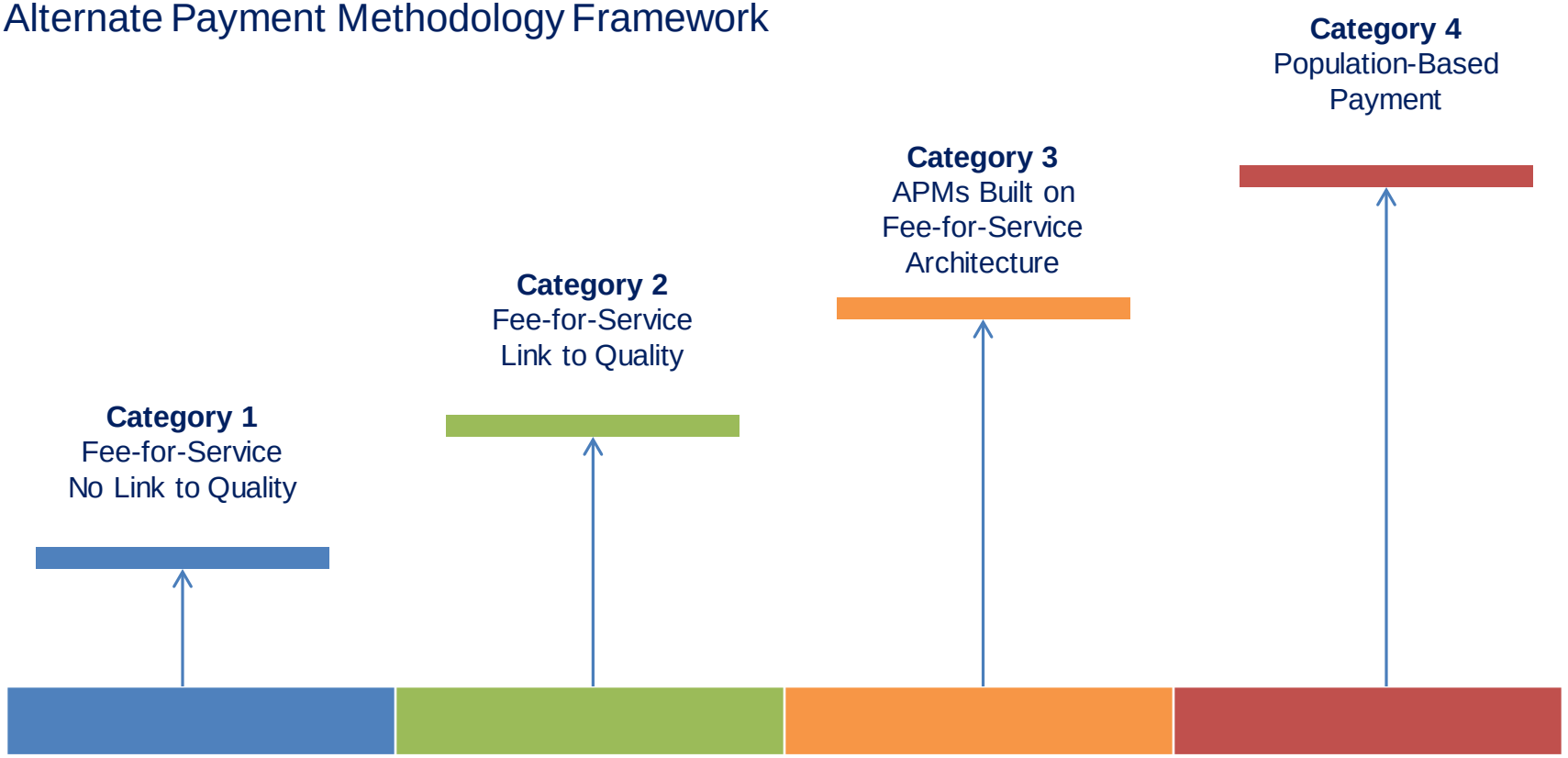
To move payments to providers from a fee-for-service system to a payment structure based on value and integration of primary prevention strategies.

By moving to value-based purchasing and a care coordinated model, we will improve population health while addressing the SIM flagship issues:

- Obesity
- Diabetes
- Tobacco Use
- Hypertension
- Behavioral Health

Where Are We Going?

Health Care Payment Learning & Action Network
Alternate Payment Methodology Framework



How Did We Get Here?

The Oklahoma SIM project used the expertise of our OHIP/OSIM workgroups, the SIM All Payer and Executive Committees, technical assistance contractors, and dozens of stakeholders from our communities and health systems.

- OHIP/OSIM Workgroups
- Executive Steering Committee
  - After reviewing stakeholder feedback, directed the SIM team to proceed with the development of a model concept similar to a Care Coordination Organization.
- Technical Assistance
  - Deloitte Consulting
  - SIM and Non-SIM States
  - Centers for Medicare and Medicaid Innovation
    - SHADAC
    - ONC
- Other Oklahoma Stakeholders
  - Turning Point, Rural Health Association, OKPCA, OHA, et al

OSIM Model Proposals – Conceptual Design Tenets

Through this process the OSIM team identified several key tenets to build the OSIM model

Incorporate What Drives Health Outcomes

- Expand from an integrated clinical view of patients to include social determinants of health and associated health enabling elements
  - Address behavioral health needs
  - Develop stronger relationships with social services and community resources

Integrate The Delivery Of Care

- Ensure that various aspects of patient care are integrated and managed collectively, rather than in an isolated fashion
  - Leverage Care Coordination practices already in place
  - Enhance and expand use of health information technology
  - Fully integrate primary care and behavioral health

Drive Alignment To Reduce Provider Burden

- Engage with external stakeholders to align quality metrics from OSIM
  - Foster buy-in from private payers
  - Work with Medicare to synchronize evaluative metrics

Move Toward VBP With Realistic Goals

- Understand that value-based purchasing will need a transition period
- This is a large commitment that needs to be collaborative to allow for transformation to occur at the practice level

SIM Goal:

To move payments to providers from a fee-for-service system to a value-based payment structure

Communities of Care Organizations	Multi-Payer Quality Measures	Multi-Payer Episodes of Care

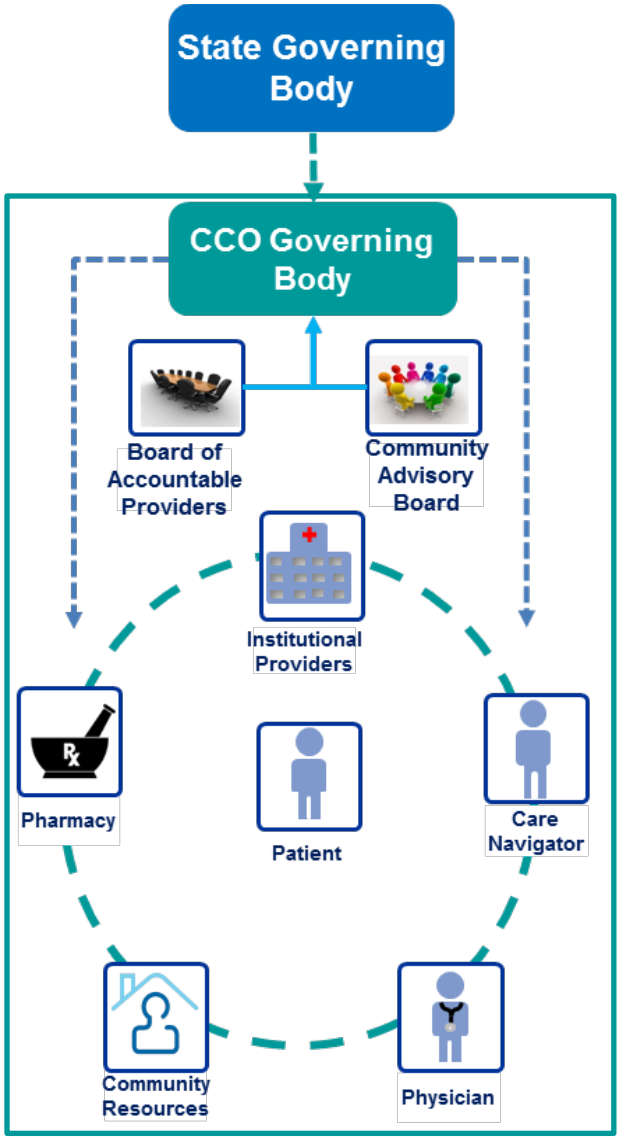
Table of Contents

I. Communities of Care Organizations: Overview

What is a Communities of Care Organization?

- CCOs are local, risk-bearing care delivery entities that are accountable for the total cost of care for patients within a particular geographic region
- CCOs focus on primary care and prevention, using care coordination and the integration of social services and community resources into the delivery of care
- Utilize global, capitated payments with strict quality measure 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
- Governed by a partnership of health care providers, community members, and other stakeholders in the health systems to create shared responsibility for health
- Initially, this model is proposed for all state purchased health care, which comprises a quarter of the state's population
  - Medicaid (SoonerCare): 805,757 members
  - Public Employees: 225,861 members

I. Communities of Care Organization



- Geographically distinct, provider and community-led care delivery entities that are each accountable for the total cost of care for patients within their geography
- Receive a capitated payment from the State Governing Body to cover total cost of member services
- CCOs create a network of providers and community resources that will deliver care to the attributed members
- CCOs will organize a governance structure that incorporates the community they serve

II. Payment Methodology – CCO

- CCOs will receive a fully capitated, risk-adjusted per member per month payment
- Incentives paid through a Community Quality Incentive Pool
  - X% of capitated rate will be withheld for a community quality incentive pool that pay bonus payments for meeting performance and quality benchmarks
  - The percent of withhold will increase over time to accelerate move toward outcome-based payments
- If savings are accrued, a portion must be reinvested in the community to serve human needs affecting health (e.g., transportation, housing, mold remediation, food access).
- A percentage of the capitated rate will be paid to a Health Information Network for interoperability and data infrastructure (see Health Information Technology Plan)

II. Payment Methodology – CCO to Network Providers

- The CCO will implement an Alternate Payment Arrangement (APA) with the providers in their networks
  - Allowing CCOs to choose the payment arrangements gives the model flexibility to meet providers and regions where they are in their practice transformation
  - Strict interpretation of what constitutes an APA is needed

- The CCOs will work to meet the following targets:
  - 80% of payments made to providers will be value-based by 2020 to align with Medicare;
  - Participation with the Multi-Payer Episodes of Care;
  - At least one additional Alternative Payment Arrangement must be utilized; and
  - APAs must include mechanisms to encourage both cost savings and high quality care

- Alternate payment arrangements include, but are not limited to:
  - Pay for Performance
  - Payment Penalties
  - Shared Savings
  - Shared Savings and Shared Risk
  - Full Capitation

III. Integration of Social Determinants

- A Community Advisory Board will serve as the mechanism for formal integration of the social determinants of health within the proposed model.
  - Their guidance will address population needs outside of the normal scope of healthcare to help the CCO create better care and cost savings

- Oklahoma will pursue the use of flexible spending as a reimbursable service within the CCOs. This is a new concept for CMS and state partners to consider when looking at addressing social determinants.
  - Purpose is to give providers and patients access to non-medical services that can have a direct, positive impact on their health
  - Must be negotiated with CMS

- At enrollment members will complete a human needs survey which analyzes patient social needs
  - Used in risk stratification of member
  - Proactively identify needs before seeking care

- Quality metrics include a social determinant aspect

- All CCOs must keep an up-to-date regional asset database for easy referral

IV. Delivery Model

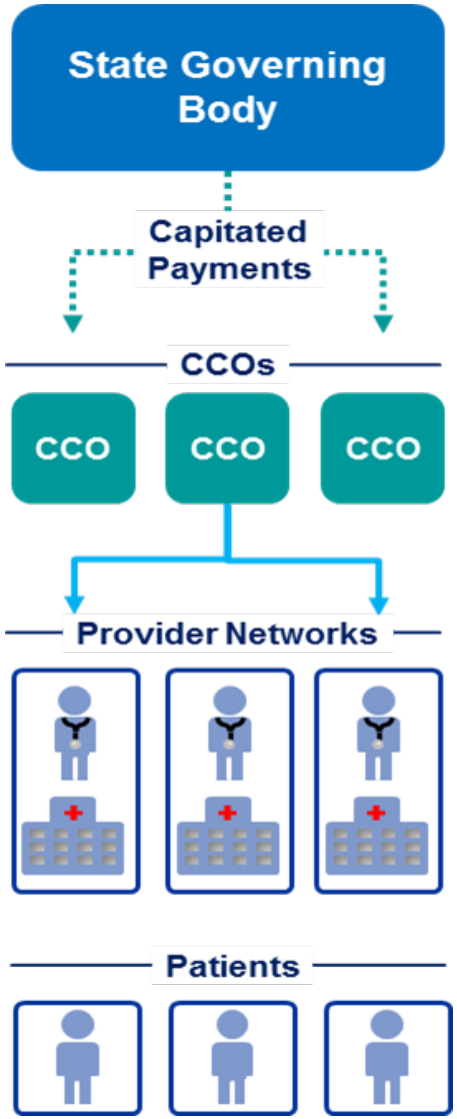
- Many delivery model components such as care coordination, primary care provider role, and creation of care teams will be left to the CCO to articulate back to the governing body how they will deliver patient centered care

- Delivery model designs should show how the CCO will:
  - Focus on comprehensive primary care and prevention
  - Integration of Federally Qualified Health Centers
  - Integrate County Health Departments in care delivery and coordination
  - Use non-traditional healthcare workers
  - Integration of behavioral health and primary care
  - Role of a centralized (among providers) multi-specialty care coordinator
  - Integration of telemedicine
- The best practices of the current Medicaid PCMH and HAN model will be part of the CCO quality metrics, but will not be required within the CCO
  - 24 hour availability, expanded clinic hours
  - Co-Management and integrated health plans among healthcare disciplines
  - Use of EHR and e-Prescribing, supporting patient with educational materials and patient reminders for tests/screenings
- Other best practices and quality metrics will be set out so that each CCO must show how they achieve a high degree of patient-centered team-based care.

V. Health Information Technology Integration

- All CCOs must establish connection to an interoperable Health Information Exchange
  - An interoperable Health Information Exchange (HIE) is an HIE that is interoperable with any other HIE exchanging the health data of Oklahoma residents
  - Due to the necessity of interoperability for model success a percentage of the capitated rate will be paid to the HIN for maintenance and upkeep of interoperability
  - This will support providers in actively managing the patients care to meet cost and quality targets
- 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 HIN
- Ensure access to a consumer-friendly patient portal

VI. Oklahoma Communities of Care Organization: Governance



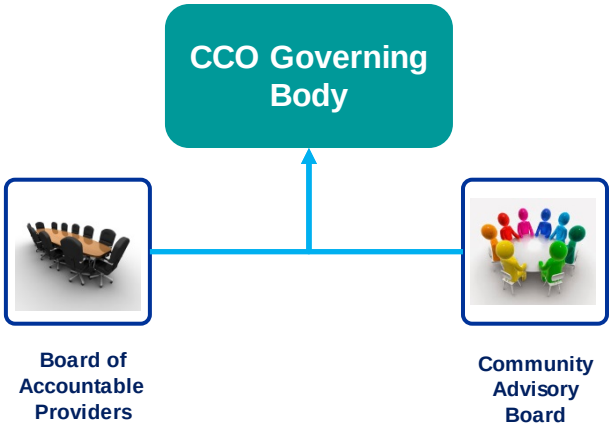
State CCO Governing Body

- Governing body consisting of members of health and human service agencies, paying institutions, and providers
- Sets and monitors contracting requirements
- Uses data-driven methods to evaluate CCOs performance
- Sustains key activities for plan maintenance

Communities of Care Organization

- Must show they have network adequacy and population size to support model
- Must meet Oklahoma Insurance Department requirements to be a risk bearing entity and sell insurance products in Oklahoma

VI. CCO Governing Body



- A Board of Accountable Providers and a Community Advisory Board will be established by the CCO. If the CCO operates in multiple regions, they will set up a separate board in each region
- Each CCO must establish a governance structure that reflects the coordination of care delivery and community services and resources in a single integrated model
- To ensure the organizations decision-making is consistent with community members' values, the CCO governing board must include relevant stakeholders who will be impacted by the CCO, including community members and providers

VI. Board of Accountable Providers (BAP) and Community Advisory Board (CAB)

Members

- BAP: Will represent all service areas of the CCO in the region and CCO members. Set numbers and types of providers should be dictated to the CCO
- CAB: Broad representation from the region including but not limited to: 501c3 entities, County Health Departments, tribal nations, consumer advocates, local churches, businesses, patient advocates and community action agencies. Specific numbers and types of community partners will need to be established through contracting, as determined by the state

Duties

- Assure culturally aware use of clinical best practices and innovative approaches to delivering care
- Suggest interventions to address issues with cost and quality attainment
- Help guide the CCO to provide regionally-specific care and guide interventions that help address the social determinants of health
- Maintain a database of community resources to facilitate linking the CCO to resources that support whole-person care
- Assist the CCO with 3 functions:
  - Community Health Needs Assessment
  - Community Health Improvement Plan
  - Recommendations for reinvesting savings

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Model Discussion

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Communities of Care Organizations	Multi- Payer Quality Measures	Multi-Payer Episodes of Care

Multi-Payer Quality Measures

Why Are These Important?

- Quality measures allow healthcare payers and providers to gauge the quality of care being delivered
- These can 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 they contract with
- Participating payers will be asked to form APM strategies around measures with as much alignment among plans as possible
- These measures will be among those asked to be reported by the CCOs

Proposed Quality Metrics: Multi-Payer and CCO Required

The following quality metrics were determined based on the following criteria:

- Utilized and endorsed by a national authority on healthcare quality metrics
- Relation to the core OHIP 2020 goals
  - OHIP 2020 and OSIM specifically targets obesity, diabetes, hypertension, tobacco use, and behavioral health as areas for improvement
- Links to clinical outcomes
- Alignment with State and National initiatives
  - Initiatives such as : CPCI, SoonerVerse, PQRS, Healthy Hearts for Oklahoma, Meaningful Use, eCQMs, FFM QRS, ACO measures, FQHCs, GPRA

Quality Metric Data Sources

- Clinical Measures:
  - Clinical Data
  - Claims Data
- Quality Assurance:
  - Independently Reported Via CCO
- Population Measures:
  - Clinical Data
  - BRFSS
  - Death Data

Quality Metric Workgroup/Committee

The measure set today is a proposed measure set. To ensure we are meeting our goals, it is anticipated that a diverse workgroup to evaluate and recommend quality metrics will be assembled to ensure we are evaluating CCOs effectively and driving payer alignment through coordination of plan initiatives.

Examples of these groups:

- **Alabama:** Regional Care Organization Quality Assurance Committee – established by Act 2013-261 to identify objective outcome and quality measures for ambulatory care, inpatient care, chemical dependency and mental health treatment, oral health care, and all other health services provided.

  Membership: 60% physicians who provide care to Medicaid Beneficiaries served by Regional Care Organization; 40% other

- **Oregon:** Metrics and Scoring Committee - The Metrics and Scoring Committee was established in 2012 by Senate Bill 1580 for the purpose of recommending outcomes and quality measures for Coordinated Care Organizations (CCOs). The nine members are appointed by the Director of the Oregon Health Authority and serve two-year terms.

  Membership: Three members at large; three individuals with expertise in health outcomes measures; and three representatives of coordinated care organizations.

Communities of Care Organization – Required Clinical Measures

CCO – Clinical Measures	
NQF 0028: Tobacco Use Screening & Cessation Intervention	NQF 0059: Comprehensive Diabetes Management/Diabetes Poor Control
USPTF: Abnormal Blood Glucose and Type 2 Diabetes: Screening - Adults Aged 40 to 70 Years who are Overweight or Obese	NQF 1932: Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications
NQF 0018: Controlling High Blood Pressure	NQF 0421: Body Mass Index Screening & Follow-Up
NQF 0024: Weight Assessment and Counseling for nutrition and physical activity	NQF 105: Anti – Depressant Medication Management
NQF 0418: Depression Screening	NQF 0004: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
NQF 0576: Follow-Up after Hospitalization (within 30 days) (BH primary diagnosis)	HEDIS: Ambulatory Care: Emergency Department Utilization

Communities of Care Organization – Required Clinical Measures

CCO – Clinical Measures Continued	
NQF: 0275 PQI 05: Chronic Obstructive Pulmonary Disease Admission Rate	NQF: 0277 PQI 08: Congestive Heart Failure Admission Rate
NQF: 0272 PQI 01: Diabetes, Short Term Complication Admission Rate	NQF: 0283 PQI 15: Adult Asthma Admission Rate
CAHPS Composite: Satisfaction With Care	NQF: 1448 Developmental Screening In The First 36 Months Of Life
NQF: 1517 Prenatal And Postpartum Care: Timeliness Of Prenatal Care	

Communities of Care Organization – Required Quality Metrics

CCO – Quality Assurance	
% Of population with co-located behavioral health provider	% Of primary care practices in network with expanded hours (after 5pm/weekends)
% Of primary care practices in network with 24-hour availability	% Of population with an assigned risk score/stratification
% Of population assigned to a care coordinator with an elevated risk score	% Of network with HIE access
Electronic resource guide available to care coordinator/staff	

Communities of Care Organization – Required Quality Metrics

CCO – Population Measures	
% Of population who screened yes to being a current tobacco user under 18 years of age	% Of population who screened yes to being a current tobacco user 18 years of age and older
% Of population with a current BMI over 25 who are under 18 years of age	% Of population with current BMI over 25 who are 18 years of age and older
% Of population diagnosed with diabetes (type I and II) under 18 years of age	% Of population diagnosed with diabetes (type I and II) 18 years of age and older
% Of population diagnosed with hypertension under 18 years of age	% Of population diagnosed with hypertension 18 years of age and older
% Of population with a positive screening for depression under 18 years of age	% Of population with a positive screening for depression 18 years of age and older
Infant Mortality Rate	Deaths Due to Heart Disease
Suicide Deaths	Diabetes Deaths

Communities of Care Organization – Optional Bonus Measures

CCO – Optional Bonus Measures		
NQF 0032- Cervical Cancer Screening	NQF 0034- Colorectal Cancer Screening	NQF 0041- Influenza Immunization (6 months and older)
NQF 0039- Influenza Immunization (50 years and older)	NQF 0031- Breast Cancer Screening	NQF 0038- Childhood Immunization Status
NQF 1516- Well Child Visits	NQF 1768: Plan All-Cause Readmission	Dental Sealants for Children
Effective Contraceptive Use	NQF 0074: Chronic Stable Coronary Artery Disease – Lipid Control	NQF 0569: Adherence to Statins
NQF 0541: Portion of Days Covered	Screening, Brief Intervention, and Referral to Treatment	USPTF: Cholesterol Abnormalities Screening

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Quality Metrics Discussion

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Communities of Care Organizations	Multi-Payer Quality Measures	Multi-Payer Episodes of Care

Multi-Payer Episodes of Care

Why is this important?

- Episodes have been shown to be effective tools to contain cost and improve quality and outcomes
- These episodes can help providers become accustomed to bearing risk within the delivery of healthcare
- Multi-payer episodes reduce provider burden by focusing the attention of the provider on the patient instead of who the patient's carrier might be

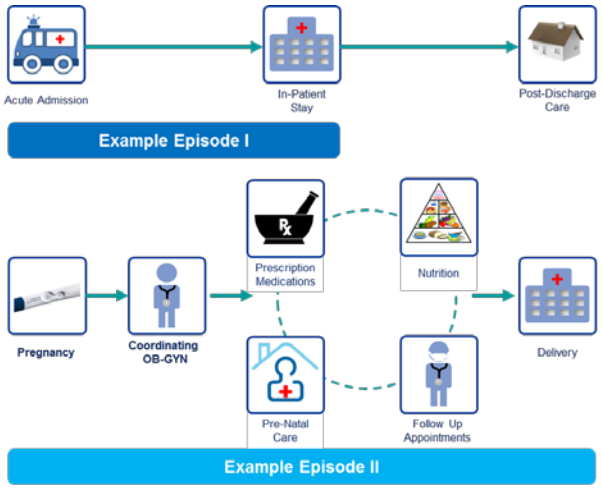
How is this part of the Model?

- Participating payers will be asked to make the episodes a requirement to report from all applicable providers they contract with

Episodes of Care

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
Scope	▪ Principle Accountable Provider (PAP) is assigned and is responsible for the episode's outcome ▪ Episodes may include acute, chronic, or behavioral health conditions
Care Model	▪ Encourage provider efficiency and care coordination to avoid the need for further intervention or complications
Payment Model	▪ PAPs are assigned by the carrier and initially paid on a fee-for-service basis. They are retroactively evaluated against a set of benchmarks for the average cost of care delivered over the episode’s performance period ▪ PAPs are rewarded with a percentage of savings or charged a portion of costs in excess of the benchmarks
Attribution	▪ Patient has a triggering event or certain number of claims related to an episode with a participating provider

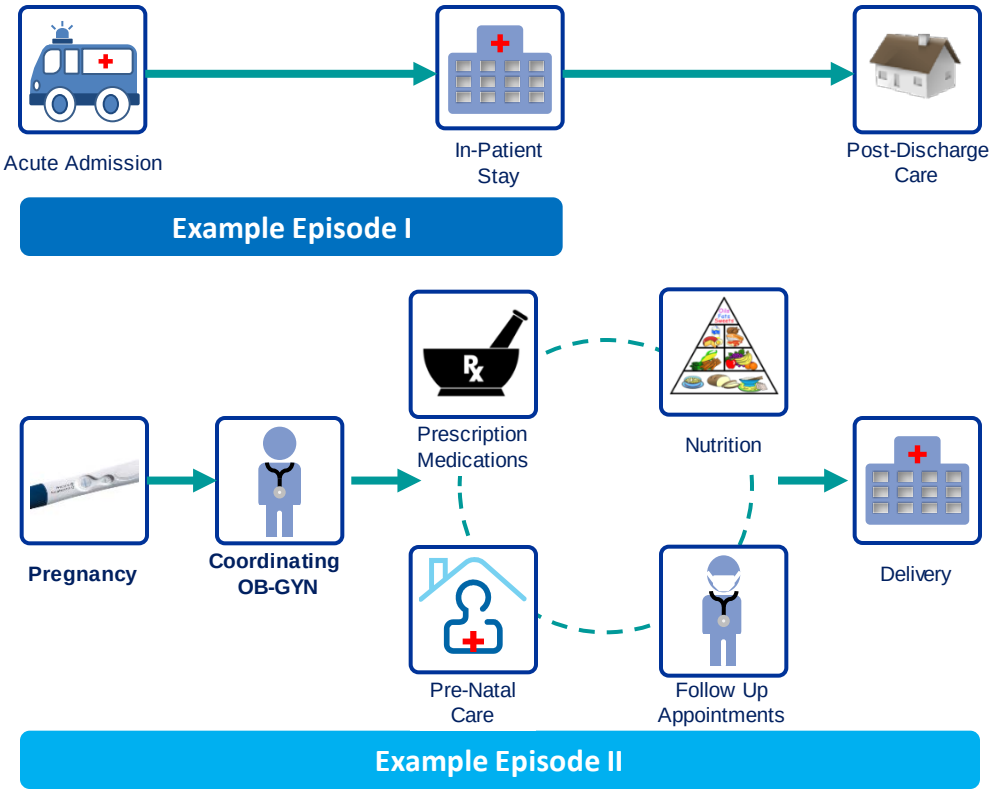
Example Episodes of Care



Results & Considerations

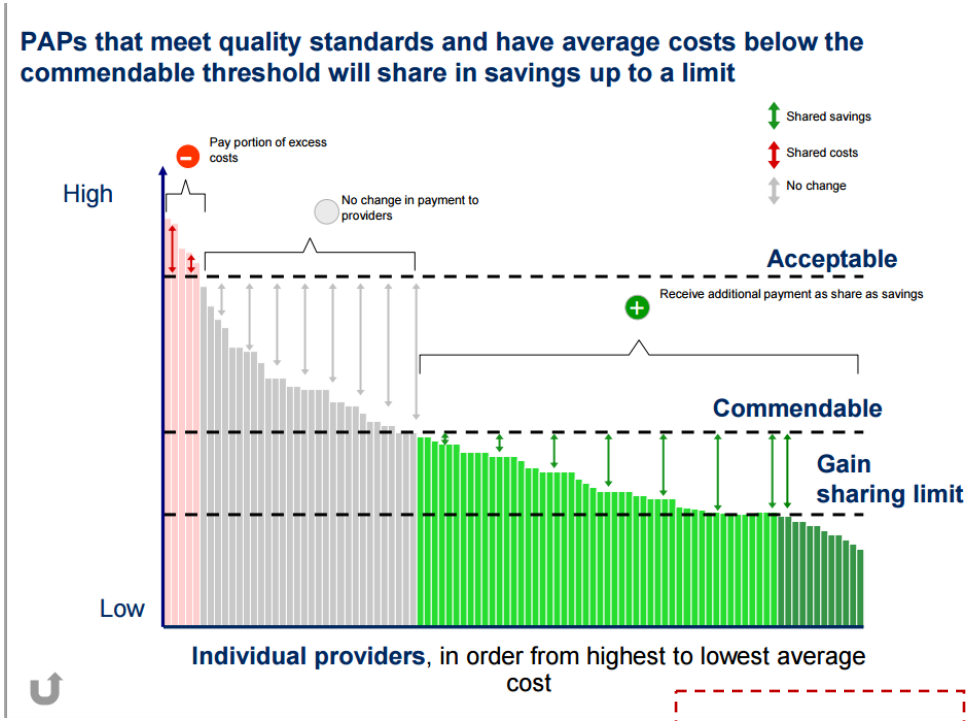
- Episodes can be difficult to define, and changes in best practices or technology can render even well designed episodes obsolete
- Pricing episodes correctly can require significant data
- Costs can vary based on inherent risk within patient population
  - Patient volume considerations to ensure appropriate distribution of risk

Episodes of Care – Payment Model Design



- Episodes begin with a triggering event
  - E.g. Acute admission to a hospital
  - E.g. Confirmation of pregnancy
- Episode lasts until a pre-determined duration elapses
  - E.g. 60-day postpartum upon completion or termination of pregnancy
- Episodes define which related services and patients will be considered within the episode's performance year
  - E.g. Certain patients with complex conditions may be excluded and non-related services would also be excluded for episode
- PAPs are initially paid on a fee for service basis and then retroactively evaluated against a set benchmark for the average cost of the care delivered per episode

Episodes of Care – Payment Model Design (continued)



Source: http://www.paymentinitiative.org/

Illustrative

- 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

Proposed Episodes of Care

1. Asthma (acute exacerbation)

   Overview: Covers care for 30 days following an asthma related trigger (typically an asthma diagnosis on an emergency department or inpatient facility claim). This episode typically covers physician visits, medication, care coordination, and can include hospital readmissions and post-acute care.

2. Perinatal

   Overview: The aim of the perinatal episode is ensuring a healthy pregnancy and follow-up care for mother and baby. Perinatal episodes include all pregnancy-related care including: prenatal care, labs, medications, ultrasounds, labor and delivery, and postpartum care. The triggering event for this episode is a live birth and delivery diagnosis code and the episode covers 40 weeks of care prior to the delivery and up to 60 days after delivery.

Proposed Episodes of Care

3. COPD (acute exacerbation)

Overview: Covers care for 30 days following a COPD related trigger (typically a COPD diagnosis on an emergency department or inpatient facility claim). This episode typically covers physician visits, medication, care coordination, and can Include hospital readmissions and post-acute care.

4. Total Joint Replacement

Overview: The purpose of a joint replacement (TJR) episode of care is to reduce duplication of services and increased costs through better care coordination. This episode covers 30 days prior to triggering event – total joint replacement – and 90 days postoperatively. This episode typically covers all orthopedic related costs during the episode.

5. Congestive Heart Failure

Overview: Episodic care for congestive heart failure (CHF) is aimed at reducing preventable hospitalizations and improving care coordination. The triggering event for this episode is a hospitalization for congestive heart failure; the episode typically covers the admission day and 30 days after. Episodes include facility services, inpatient services, emergency department visits, observation, and post-acute care; can also cover outpatient services: labs, diagnostics, and medications.

Health Efficiency and Effectiveness Workgroup Meeting Agenda

December 14, 2015, 1:30-3:30pm
Oklahoma Health Care Authority
4345 N. Lincoln Blvd, OKC, OK 73105
Health Efficiency and Effectiveness Workgroup Chair: Becky Pasternik-Ikard

Section			Presenter
Meeting Overview & Objectives	**10 min**	**1:30**	
OSIM Status Update ▪ **Progress** ▪ **Timeline**	**10 min**	**1:40**	**A. Miley**
OSIM Proposed CCO Model	**25 min**	**1:50**	**A. Miley**
Comments, Questions, and Discussion on CCO Model	**20 min**	**2:15**	
OSIM Proposed Quality Metrics	**15 min**	**2:35**	**A. Miley**
Comments, Questions, and Discussion on Quality Metrics	**15 min**	**2:50**	
OSIM Proposed Episodes of Care	**25 min**	**3:05**	**I. Lutz**
Wrap-Up & Next Steps	**5 min**	**3:25**	

Next Steps

1. Plan Presentations

- Tribal Public Health Advisory Committee meeting
  - December 4, 2015
- Health E&E Workgroup Meeting
  - Today
  - HIT- 12/11
  - Health Workforce – 12/16
  - Health Finance – 12/17
- OSIM Steering Committee Meeting
  - TBD, January 2016
- Individual meetings

- Next Health E&E Meeting
  - TBD, January

2. Plan Review

- Submitting to CMS for Feedback
  - 12/18/15

- Email questions and comments

- Deloitte and Milliman Review
  - 12/18/15
  - Milliman will be hosting an "Assumptions Review" meeting in early January for the financial analysis

SIM Initiative Timeline

The final four months of the OSIM design phase will incorporate substantial stakeholder involvement