Oklahoma State Innovation Model (OSIM) Workgroup Meeting

MEETING NAME
Health Finance Workgroup Meeting

DATE & TIME	Tuesday, February 23, 2016; 10:00AM-12:00PM CST
LOCATION	Oklahoma Health Care Authority 4545 N. Lincoln Boulevard Oklahoma City, Oklahoma
OSDH CENTER FOR HEALTH INNOVATION AND EFFECTIVENESS (CHIE) ATTENDEES	• **Julie Cox-Kain**, Deputy Secretary for Health and Human Services, State of Oklahoma • **Joe Fairbanks**, CHIE Director • **Alex Miley**, SIM Project Director • **Rebecca Moore**, OSDH Director of Health Care Information • **Isaac Lutz**, Health Planning Manager, Health Information Technology Workgroup Project Manager • **Jennifer Kellbach,** Health Planning Coordinator • **Jana Castleberry**, Health Planning Coordinator, Health Workforce Workgroup Project Manager
DELOITTE ATTENDEES	• **Jim Jones**, Specialist Leader • **Keianna Dixon**, Consultant • **Megan Cormier, Specialist Leader**
WORKGROUP ATTENDEES	• **Bill Hancock,** Chief Medical Officer, CommunityCare Oklahoma • **Sylvia Lopez,** Chief Medical Officer, Oklahoma Health Care Authority (OHCA) • **Rick Snyder**, Vice President/Finance & Information Services, Oklahoma Hospital Association (OHA) • **Frank Lawler,** Chief Medical Officer, Employees Group Insurance Division (EGID) • **Mark Doescher,** Interim Associate Director for Cancer Prevention and Control, Cancer Health Disparities Program, University of Oklahoma (OU) Health Sciences Center • **Troy Cupps,** ACO Operations Director, St. John Health System • **Karen Hendren**, President LifeCare LLC • **Pam Cross-Cupit,** Executive Director, Health Alliance for the Uninsured • **Cassidy Heit, Oklahoma Primary Care Association**
STAKEHOLDER SESSION TYPE	Presentation and Discussion
STAKEHOLDER TYPE	Workgroup

KEY OUTCOMES

- The OSIM project team has changed the term for the proposed model from "Communities of Care Organizations" to "Regional Care Organizations" based on stakeholder feedback.
- Stakeholders are still in the process of accessing and reviewing the State Health System Innovation Plan (SHSIP) (available on the OSIM website at osim.health.ok.gov).
- Stakeholders agree on the goals of the proposed model but have different issues currently facing them for health system transformation, including appropriations and resources.
- Stakeholders are interested in how the health system transformation will impact administrative costs and the feasibility of regional care organizations assuming risk for attributed members. Some voiced concern that those that can assume actuarial risk might not be interested given they have to have partners in the governance of the RCO that are outside of their current scope.
- Stakeholders are interested in more detail on how the transition to value-based purchasing will impact providers and how the model will address the administrative burden on providers.
- Stakeholders cited transportation, community resources, and behavioral health services and supports as foundation elements needed for this health system transformation.
- Stakeholders did not have much comment on the timeline for implementation, though additional education on some of the enabling legislation (e.g., Section 1115 Delivery System Reform Incentive Payment Program) may be beneficial for them to achieve a deeper understanding.

ACTION ITEMS

- Collect stakeholder feedback rubrics and incorporate feedback in the model
- Share bill numbers for the enabling legislation of the Section 1115 DSRIP and 1332 waivers submitted to the State Legislature
- Hold an All Workgroup Meeting, tentatively scheduled for March 3, 2016 to discuss the financial analysis

AGENDA

1. Welcome & Meeting Objectives
2. State Health System Innovation Plan Overview
3. Review of Model Goals & Discussion
4. Model Design: Actuarial vs. Performance Risk
5. Governing Body Membership and Responsibilities to Meet Model Goals
6. Timeline: DSRIP – Oklahoma Plan
7. Wrap-Up & Next Steps

DISCUSSION NOTES

SECTION: WELCOME & MEETING OBJECTIVES

Presentation (Julie Cox-Kain)

- They received feedback that stakeholders wanted to provide more comment on the model design.

- They will break down the model design section by section and spend more time reviewing it.

Discussion

- (No discussion)

SECTION: STATE HEALTH SYSTEM INNOVATION PLAN OVERVIEW

Presentation (Alex Miley)

- Reviewed an executive summary of the 8 sections of the SHSIP that have been completed to date:
    - Description of State Healthcare Environment
    - Stakeholder Engagement Report
    - Health System Design and Performance Objectives
    - Value-Based Payment and/or Service Delivery Model
    - Plan for Healthcare Delivery System Transformation
    - Plan for Improving Population Health
    - Health Information Technology Plan
    - Workforce Development Strategy
    - Financial Analysis
    - Monitoring and Evaluation Plan
    - Operational and Sustainability Plan
- Stated that they have changed the name of the proposed model from "Communities of Care Organizations" (CCO) to "Regional Care Organizations" (RCO) based on stakeholder feedback
- Reviewed the new stakeholder comment rubric. Stakeholders can complete the document and email the document back to the OSIM project team to share individual feedback on the project.

Discussion Question: Has anyone accessed the SHSIP document online or does anyone have a question about how to access the document or to find a section?

- Rick Snyder: He has accessed the document but has not yet been able to finish reviewing it.
- (No other stakeholders commented that they have accessed the document.)

SECTION: REVIEW OF MODEL GOALS & DISCUSSION

Presentation (Julie Cox-Kain)

- 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:
    - Achieve the Triple Aim

    - Creative opportunities for multi-payer initiatives that pay for outcome improvement across the primary drivers of poor health and healthcare cost increases
    - Integrate healthcare and population/community health
    - Create a scalable, flexible model that can be implemented in rural Oklahoma settings
    - Address social determinants that prevent individuals from achieving optimal health
    - Focus on the total health system
- Reviewed conceptual design tenets of the proposed model:
    - Incorporate the drivers of health outcomes
    - Integrate the delivery of care
    - Drive alignment to reduce provider burden
    - Move toward value-based payment with realistic goals
- Stated that they received stakeholder feedback that there needed to be foundational elements added to the health system in order to support this transformation

Discussion Questions

1. *Do these goals and tenants reflect the conversation of stakeholders to date?*
2. *Should there be any changes, deletions, or additions?*
3. *Do you believe that there is multi-payer alignment on purpose around these goals and tenets?*
4. *Is there multi-stakeholder agreement around these goals and tenets?*
5. *What are the barriers to achieving these in Oklahoma?*

- Frank Lawler: Do you worry about being too far ahead of the current health care situation with this model?
- Julie Cox-Kain: (In response to the question) They are worried about the strain of health care providers moving towards two models, a Medicaid model and private payer model. There has been analysis on what this does to hospitals and providers. They have sought the assistance of Deloitte to look into this topic.
- Jim Jones: New York has been seeing this issue.
- Julie Cox-Kain: What is the dialogue around this topic for critical access hospitals?
- Rick Snyder: Some of the critical access hospitals will probably have to morph into different forms. Some of them have been shielded from having to move toward value-based purchasing.
- Julie Cox-Kain: What does OHA see as stressors around this process (in the long-term) on transitioning to value-based purchasing?
- Rick Snyder: Stressors include payment changes from the Affordable Care Act and appropriation reductions from federal authorities. Some of these changes jeopardize them in ways that DSRIP cannot compensate for. He thinks that instead of throwing all of the risk on regional organizations, the role of the RCOs should be to incent value-based purchasing to providers. We should also look to ways to achieve value based goals without 100% disruption of fee for service payments and the system
- Mark Doescher: They will need a deeper dive into the details for how value-based purchasing will impact providers, particularly rural hospitals. Changes to the health system must be medically necessary. E.g., scribes are taking away funds from more medically necessarily things.

- Sylvia Lopez: She thinks that they all agree on the goals but the problem is appropriations (referencing cuts to OHCA funding). Providers are taking the hit. Providers are saying that they are tired of being paid the value of a 15-minute patient visit for a 45-minute visit. She thinks that Oklahoma needs to move faster around value-based purchasing and providing appropriate bonus payments to providers (she believes that providers adjust very fast to new payment models). The biggest burden now for providers is administrative – paper work.
- Stakeholder: In rural areas, community support systems are not there (e.g., transportation).
- Stakeholder: They have to think about expectations versus actual outcomes for the model.
- Stakeholder: Some of the resources needed for transformation are available but some are not.

SECTION: MODEL DESIGN (ACTUARIAL VS. PERFORMANCE RISK)

Presentation (Julie Cox-Kain)

- They have received a lot of questions from stakeholders about what the RCOs will look like as well as its components
- Reviewed the definition of RCOs: They will be 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.

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

- Stakeholder: There could be a possible payer monopoly.
- Stakeholder: Will there be one or multiple RCOs in a region?
- Alex Miley: (In response to the question) There are two views on this: Having one RCO per region allows you to have a global view of the entire region through the RCO. Having two RCOs per region allows competition.
- Stakeholder: As this process is advanced, how will this impact administrative costs for payers?
- Jim Jones: (In response to the question) Based on Deloitte research so far, some of the states with high performing health systems have low administrative costs but some also have high administrative costs and are doing very well in terms of population health.
- Bill Hancock: How many of these organizations survived for at least three years in areas of the country where this kind of health system reform has been done? Can this model be developed in a manner in which they can actually delegate risk to these organizations?

- Alex Miley: In Oregon, which most closely relates to this, the success rate over three years has been very high. There have been a few that have dropped out. (I believe) they started with 13 CCOs and now have 16 but those are not all the original CCOs.
- Jim Jones: (In response to the question) Deloitte is examining four states that have made this transition to managed care system and regional care coordination organizations that are in different stages of this process.
- Bill Hancock: Mentioned access to care and timeliness of care issues that they have discussed.
- Bill Hancock: How will the RCO model be better than providers contracting with payers to take on the risk themselves, instead of regional organizations doing this?
- Julie Cox-Kain: (In response to the question) She provided an example of Oregon's model. Oregon reported that the community-level involvement with their care coordination organizations was integral to the health system transformation, demonstrating that such a model where regional organizations integrate community involvement as well as assume risk can be beneficial.

Discussion Question: Does anyone have questions or comments around the actuarial risk of RCOs, as RCOs will have both actuarial and performance risk for their attributed members?

- Bill Hancock: He referenced his previous comment about the RCOs incenting providers to do value-based payment and take on risk as opposed to insurers taking on the risk themselves. Also, concern about what organization that can take on this level or risk will want to report to a community board? Commercial payers may not be interested, instead they can just compete within their own community.

Discussion Question: What foundation elements must be in place to successfully achieve the RCO model?

- Julie Cox-Kain: They have received feedback that the state is not quite ready for this type of health system transformation. What are the technology, skills, training needed and how is community readiness addressed
- Jim Jones: For example, some things that other states have been investing in are technology for housing, nutrition, transportation, and transitions of care.
- Stakeholder: Transportation is a big need especially in rural areas. They placed an attorney from Legal Aid in their hospital to help patients with issues regarding social needs.
- Stakeholder: They have a template for how this would look and be sustained using community resources.
- Stakeholder: Another big missing piece is behavioral health.
- Karen Hendren: They placed space in their hospital for a crisis unit with the intention of helping to address the occupancy levels of the emergency department; this actually exacerbated the problem.
- Sylvia Lopez: Transportation is a need. They have heard from providers that they tend to have a 30% no show rate among patients, very likely due to lack of transportation.
- Isaac Lutz: We will also need to consider what type of transitions of care infrastructure is needed and look at what other states have done.
- Stakeholder: Might want to consider include payers within the existing CHIOs in the state and creating a consistent structure for sustainability within those relationships.

SECTION: GOVERNING BODY MEMBERSHIP AND RESPONSIBILITIES TO MEET MODEL GOALS

Presentation (Julie Cox-Kain)

- Reviewed the proposed advisory board and committees for the State Governing Body
    - Member Advisory Committee
    - Provider Advisory Committee
    - RCO Certification Committee
    - Episodes of Care Alignment
    - HIT Committee
    - Quality Measure Committee
- Reviewed the structure and function of the State Governing Body
    - Function: 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
- The model governance has changed a lot over the past few weeks due to stakeholder feedback. They have also added a tribal representative.

Discussion Questions:

1. *Does this governance model represent the groups necessary to ensure proper governance of the model?*
2. *Are representatives present in numbers to appropriately reflect the stakeholders they represent?*
3. *As a multi-payer initiative, how should state RCO governance evolve the insure proper representation of other payers? Should there be a timeline for this?*
4. *What are challenges or barriers that must be overcome to ensure proper governance?*

- Stakeholder: Are there groups that represent consumer need?
- Sylvia Lopez: For instance, the OHCA has the Members Advisory Task Force.
- (Response to Question: The State Governing Body includes a Member Advisory Committee.)
- Julie Cox-Kain: (As a recap) The consensus is that we will look at the governance model to ensure there is appropriate representation from stakeholder groups to create balance among the members.
- Mark Doescher: The committees will need to ensure that they are represented by various voices. For example, the Provider Advisory Board cannot include just one PCP and adequately represent the voices/concerns of ALL types of providers. The same will be true for the other boards.
- Frank Lawler: He is a little worried that this approach may be too prescriptive and that many organizations are already spread too thin to move forward with this.
- Sylvia Lopez: OHCA was accused of doing the same thing, of being too prescriptive, when they told providers (OB/GYNs) to follow ACOG (American Congress of Obstetricians and

Gynecologists) guidelines from 2001 (so these guidelines were not new) on limiting unnecessary C-sections. In the first year of the project, they saw a dramatic drop in C-sections, from (approximately) 20% to 16%. They have since seen a rise in the rate again so will have to target specific providers that are having issues.

- Joe Fairbanks: (In response to the question) The model leaves it up to the RCOs to tell the State how providers in their region will do value-based purchasing with the goal of 80% of payments being value-based
- Stakeholder: What common threads exist for all of the payers along cost drivers? Examples: behavioral health, tobacco screening, etc. To limit prescriptiveness, the model can recommend topic area screenings aligned with quality measures, but not necessarily determine which screening tool has to be used.
- Alex Miley: This is an interesting comment (above) given that some people when reviewing the quality measures have asked for screening tools to be recommended to give a more standardized approach. Do you all have any recommendation for how prescriptive we should be around that?
- Sylvia Lopez: As long as all recommendations are peer reviewed and evidenced based medicine, you should be fine recommending guidelines and screening tools.

SECTION: TIMELINE (DSRIP – OKLAHOMA PLAN)

Presentation (Julie Cox-Kain, Alex Miley)

- Reviewed the OSIM Operational Roadmap – Healthcare System Initiatives Timeline
    - 2016: Form Quality Metrics Committee. Develop CMS waiver. Form Episodes of Care (EOC) Committee.
    - 2017: Deliberate on core RCO metrics. Initiate EOC tracking and assessment. Pass RCO enabling legislation.
    - 2018-2019: Implement DSRIP and payments. Implement EOC payment. Perform RCO RFI and RFP Evaluation Process. Perform RCO development and transition process.
- Reviewed purpose of the DSRIP Waiver (as part of Section 1115 Waiver): Will help the State to determine what they need to do to prepare for SIM in terms of infrastructure and process
- Reviewed purpose of the Section 1332 Waiver: This is unrelated to SIM and deals with how the State would like to address health insurance access by implementing alternatives to the Affordable Care Act health insurance exchanges that achieve the same results.
- Will send bill numbers for this two enabling bills that are currently in the State legislature

Discussion Question: Is this the correct phasing to ensure an orderly transition to payment and delivery reform?

- Stakeholder: The timeline appears to be fine.
- Rick Snyder: It is hard to comment on the timeline with a vague idea of what DSRIP is.

SECTION: WRAP UP & NEXT STEPS

Presentation (Julie Cox-Kain, Alex Miley)

- They will have an All Workgroup Meeting tentatively scheduled for March 3, 2016 (this meeting schedule has changed; we will be meeting at a later time)
- Please give comments on this presentation and other areas through the comment rubric

Discussion

- (No discussion)