STATE BOARD OF HEALTH
OKLAHOMA STATE DEPARTMENT OF HEALTH
1000 N.E. 10th
Oklahoma City, Oklahoma 73117-1299

Tuesday, January 13, 2015 11:00 a.m.

Dr. Ronald Woodson, President of the Oklahoma State Board of Health, called the 395th regular meeting of the Oklahoma State Board of Health to order on Tuesday, January 13, 2015 at 11:08 a.m. The final agenda was posted at 11:00 a.m. on the OSDH website on January 12, 2015, and at 11:00 a.m. at the building entrance on January 12, 2015.

ROLL CALL

Members in Attendance: Ronald Woodson, M.D., President; Cris Hart-Wolfe, Secretary-Treasurer; Jenny Alexopulos, D.O.; R. Murali Krishna, M.D.; Charles W. Grim, D.D.S.; Timothy E. Starkey, M.B.A.; Robert S. Stewart, M.D.
Absent: Martha Burger, M.B.A., Vice-President; Terry Gerard, D.O.

Central Staff Present: Terry Cline, Commissioner; Julie Cox-Kain, Chief Operating Officer; Henry F. Hartsell, Deputy Commissioner, Protective Health Services; Steve Ronck, Deputy Commissioner, Community and Family Health Services; Toni Frioux, Deputy Commissioner, Prevention and Preparedness Services; Mark Newman, Director of Office of State and Federal Policy; Don Maisch, Office of General Counsel; Jay Holland, Director of Internal Audit and Office of Accountability Systems; Tony Sellars, Director of Office of Communications; Officer; VaLauna Grissom, Secretary to the State Board of Health; Janice Hiner, Sr. Advisor to the Commissioner of Health; Felesha Scanlan, Commissioner's Office.

Visitors in attendance: (see sign in sheet)

Call to Order and Opening Remarks
Dr. Woodson called the meeting to order. He welcomed special guests in attendance.

REVIEW OF MINUTES

Dr. Woodson directed attention to review of the minutes of the December 9, 2014, Regular Board meeting.

Dr. Alexopulos moved Board approval of the minutes of the December 9, 2014, regular Board meeting, as presented. Second Ms. Wolfe. Motion carried.

AYE: Alexopulos, Grim, Krishna, Stewart, Wolfe, Woodson
ABSTAIN: Starkey
ABSENT: Burger, Gerard

APPOINTMENTS

Trauma and Emergency Response Advisory Council Appointments (Presented by Henry F. Hartsell, Jr.)
Appointment: Susan M. Watkins
Authority: 63 O.S., § 1-103a.1.
Members: The Advisory Council shall consist of seven (7) members. Membership is defined in statute. One critical care nurse shall be appointed by the State Board of Health.

Dr. Grim moved Board approval of the recommended appointment, as presented. Second Dr. Stewart. Motion carried.

AYE: Alexopulos, Grim, Krishna, Starkey, Stewart, Wolfe, Woodson
ABSENT: Burger, Gerard

OKLAHOMA HOSPITAL ASSOCIATION PRESENTATION: Craig W. Jones, FACHE, President, Oklahoma Hospital Association

Transforming Health Care:

A Proposal for Oklahoma's Future

Presentation to the Oklahoma State Board of Health

January 13, 2015

Craig W. Jones, FACHE

OHA Oklahoma Hospital Association

2

This presentation was developed in conjunction with Manatt Health and informed by discussions with multiple public and private stakeholders.

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Elements of the Proposal 3

- The Case for Change
- Payment and Delivery System Reforms
- Broadening Coverage in Oklahoma

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4

The Case for Change

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The *"New Reality"*

- **Transitioning from "Curve 1 to 2"**

FIRST		SECOND
– Volume	vs.	Value
– Fee/Service	vs.	Quality/Efficiency
– Acute care	vs.	Chronic care
– Stand-alone	vs.	Highly integrated

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Forces Driving Reform of Health Care in Oklahoma 6

- To achieve a balanced budget, Oklahoma must control state spending.
  - Oklahoma spends approximately $5 B annually (36% of which is state funds) on the Medicaid program.
- Despite the state's investment in health care, more than 630,000 remain uninsured (17% of the population) in Oklahoma; cost of that care is shifted to the private sector.
- **Oklahoma has poor health outcomes**, as evidenced by high rates of smoking, obesity, and diabetes.
- The high rates of uninsurance and poor health status contribute to the **high cost of health care in Oklahoma.**

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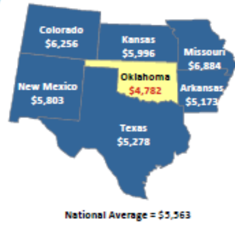
Oklahoma Must Become a Value-Based Purchaser 7

- Medicaid spending per beneficiary in Oklahoma is less than the national average and less than spending in neighboring states.



National Average = $5,563

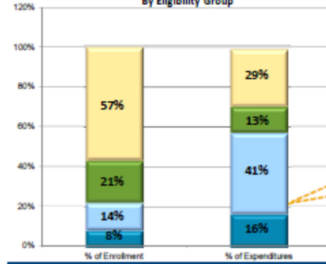
Even so....

- Oklahoma can become a more **prudent purchaser of care,** ensuring access and improving transparency, accountability and value.

Sources: Kaiser State Health Facts; FHPC, "SoonerCare Choice Program Independent Evaluation," Sept. 2014

A Small Percentage of Beneficiaries Drive Costs 8

22% of beneficiaries account for 57% of program costs



Medicaid Payments per Aged and Disabled Enrollees are $10,085 and $13,820, respectively, compared to $2,462 for children and $2,973 for adults.

Source: Kaiser State Health Facts, Oklahoma.

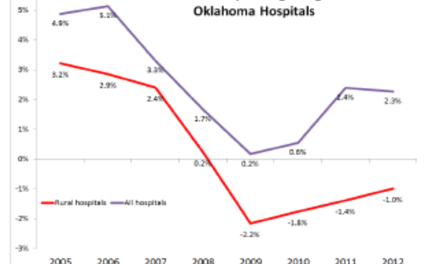
1

Broadening Coverage Reduces Uncompensated Care Costs 9

- In 2012, Oklahoma hospitals absorbed **$547 million in uncompensated care costs**, which represented 6.1% of Oklahoma hospitals' total expenses.
- The cost of treating **the uninsured disproportionately affects rural hospitals.**
  - Uncompensated care accounted for 10-17% of the expenses for 20 rural Oklahoma hospitals (compared to the 6.1% state average).
- **Rural hospitals are less able to shift costs** to insured patients given their payer mix. (7 bankruptcies in recent years)

Sources: American Hospital Association/OHA/OSDH Annual Cooperative Hospital Survey

Investment in Coverage Preserves Access in Rural Communities 10



Sources: CMS Healthcare Cost Report Information System

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Behavioral Health Is a Key Investment Area 11

Top 10 Diagnoses for Readmissions
2011

Medicaid
Mood disorders
Schizophrenia, other psychosis
Diabetes mellitus
Other complications of pregnancy
Alcohol-related disorders
Early or threatened labor
Congestive Heart Failure*
Septicemia (except labor)*
COPD and bronchiectasis*
Substance-related disorders

Four of the top 10 diagnoses related to readmissions are for behavioral health conditions.

Source: 2011, Data, Healthcare Cost and Utilization Project (HCUP), Agency for Healthcare Research and Quality (AHRQ). http://www.ahrq.gov/research/data/hcup/index.html

Coverage Increases Resources for Behavioral Health 12

- Federal dollars are available to pay for mental health and substance abuse services currently funded with state dollars.
  - Increasing coverage would result in the federal government covering $34 M of Department of Mental Health and Substance Abuse expenditures annually.
  - The Department would then be able to use the freed up state dollars on other services that are not reimbursable by the federal government, e.g. social supports.
- The Department of Corrections would save $11 M in spending on prisoner hospitalizations.
  - Individuals discharged from prisons become eligible for Medicaid.
  - Access to physical and behavioral health services during transition could help prevent recidivism.

In addition to these savings, the state would save $2.4 M in Department of Health expenditures for a total of $48.2 M in annual state savings.

Source: OHCA, as described in Leavitt Partners: "Covering the Low-Income, Uninsured in Oklahoma"

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Investing in Coverage Provides a High Rate of Return 13

- **An additional $8.6 B in available federal funds** flows to the state over 10 years.
- **13,211* new jobs** in Oklahoma are created over 10 years.
- **$50 M** in state expenditures for health services are replaced by federal dollars annually, including a significant amount for behavioral health services.
- **Uncompensated** care costs for hospitals, physicians, and other providers **go down**, particularly benefiting rural communities.
- **Cost shifting** between payers and between the uninsured and the insured **is reduced.**

*Based on median coverage take-up rate.

Sources: Urban Institute; Leavitt Partners: "Covering the Low-Income, Uninsured in Oklahoma"

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With such factors as these, driving and/or influencing the status of Oklahoma's health care....

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Goals for the State's Investment in Health Care (15)

1. **Improve quality, outcomes and value** by holding providers accountable through value based purchasing models emphasizing care coordination and transparency.
2. **Improve access** by broadening coverage, identifying gaps in provider capacity and targeting resources more effectively.
3. **Contain costs** by targeting medically complex, high-cost populations (e.g. individuals with co-morbid physical and behavioral health conditions) and reducing unnecessary emergency department visits and potentially preventable admissions and readmissions.
4. **Improve sustainability and budget certainty** of the Medicaid program.

Building Blocks for an Oklahoma Plan (16)

Payment & Delivery System Reform	Coverage Reform
Improve quality & contain costs by moving from volume-based to value-based purchasing.	Build on Insure Oklahoma
Reduce unnecessary utilization, including ER visits and hospitalizations, through enhanced care coordination and access to primary care.	Engage the private sector
Integrate services for high cost, high need beneficiaries with physical and behavioral health comorbidities.	Require personal responsibility
	Incent work and education
	Ensure sustainability

Enables budget predictability for the state

1

(17)

Payment & Delivery System Reforms

Oklahoma's Health Care Investment Goals & Strategies (18)

Goals	Strategies
Improve Quality, Outcomes, and Value	• Support care coordination • Build accountability into payment models through shared savings tied to both quality and cost metrics • Improve transparency
Improve Access	• Broaden coverage using Insure Oklahoma as a framework • Target resources to providers and services where additional capacity required (e.g. primary care and behavioral health) • Provide technical assistance to providers with less familiarity with insurance models (e.g. behavioral health providers)
Contain Costs	• Target medically complex, high cost populations, providing coordinated care and integrating social supports • Support beneficiaries in accessing preventive care and receiving care in the most appropriate setting
Improve Sustainability & Budget Certainty	• Transition to payment models that include both upside and downside risk sharing • Evaluate transition to community-led capitated models

Metrics for Success Developed Collaboratively

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Proposed Building Blocks of Reform in Oklahoma (19)

Medical Homes	Health Homes	Community-Led Accountable Care Models
• Expand patient-centered medical homes (PCMHs) to all Medicaid beneficiaries • Establish linkages between and among PCMHs, hospitals and FQHCs • Build on Health Access Networks to support medical home development • PCMHs, partner hospitals and FQHCs eligible for shared savings	• Expand health homes for individuals with behavioral health conditions • Establish health homes for individuals with chronic conditions • Establish linkages with hospitals and FQHCs • Health homes, partner hospitals and FQHCs eligible for shared savings	• Enroll beneficiaries in community-led accountable care models • PCMHs and health homes provide care coordination and support services; foundation of accountable care • Payment model developed over three years beginning with shared savings and transitioning to full capitation

Transition to Provider Risk-Bearing Models Over Time

(20)

Broaden Coverage in Oklahoma

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Increased Coverage Facilitates Medicaid Reform (21)

- Reduces churn between types of coverage and uninsurance
- Enables the management of care for individuals – directing them to preventive services and the most appropriate setting of care
- Reduces cost shifting across payers and employers
- Improves access to care and retains providers in the Medicaid delivery system
- Facilitates financial sustainability for providers who are particularly vulnerable to high rates of uninsured patients (e.g. rural providers)
- Returns Oklahoma tax dollars via additional federal dollars to support transformation efforts "the Oklahoma way."

Closing the Coverage Gap: Newly Eligible Adults (22)

NEWLY ELIGIBLE ADULTS

- Childless adults with income below 138% FPL ($16,105)
- Parents with incomes between 42% - 138% FPL *(Example: family of two with parent and child, income between $6,606-$21,707)*
- Estimated 233,334 individuals would enroll in coverage over 10 years based on medium take-up rate

Source: Kaiser State Health Facts; Leavitt Partners: "Covering the Low-Income, Uninsured in Oklahoma"

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Insure Oklahoma: Proposed Coverage Solution

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1. **Insure Oklahoma: Employer Sponsored Insurance (ESI)** – Newly eligible adults with access to ESI.
2. **Insure Oklahoma: Individual Plan** – Medically frail newly eligible adults.
2. **Insure Oklahoma: Individual Plan** – Newly eligible adults who do not have access to cost-effective ESI.
3. **Insure Oklahoma: Individual Market** – Newly eligible individuals who do not have access to cost-effective ESI.

FPL 0% 100% 138%

Coverage Proposal: Rationale and Considerations

24

Insure Oklahoma

1. **Insure Oklahoma: ESI** builds on the existing premium assistance program. Employer funding stays in the system.
2. **Insure Oklahoma: Individual Plan** builds on existing program and incorporates personal responsibility features for newly eligible adults, including cost sharing and non-coverage of non-emergent use of the ER, and payment and delivery system reforms holding providers accountable for improved quality and outcomes with a particular focus on high need beneficiaries.
3. **Insure Oklahoma: Individual Market** provides premium assistance to individuals enrolled in commercial health plans coupled with personal responsibility features including premiums and cost-sharing.

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Examples of the Newly Insured Adults

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Rachel
Single Working Mother
Annual Income: $12,584

Rachel is a single mom who works part-time for a large company. While pregnant, she was covered through SoonerCare Choice. However, 60 days post-partum her income exceeded the limit for SoonerCare Choice. Her employer is too large to participate in Insure Oklahoma and she cannot afford her employer's premiums. Her daughter, Anne, is enrolled in SoonerCare. (IO: ESI)

Rob, Janet, & Peter
Family with Working Parent
Annual Income: $17,811

Rob works full time making $9/hour for an employer in Texas that does not offer insurance. Janet stays at home with their 1-year-old son, Peter. Peter is enrolled in SoonerCare Choice. Rob and Janet are uninsured. Their income is too high to qualify for SoonerCare, and because Rob's employer is based out-of-state, he and Jan are not eligible for Insure Oklahoma. (IO:IP)

Jim
Working Adult
Annual Income: $11,086

Jim works for a small construction company. His employer used to offer health insurance for which employees paid 50% of the cost of the premiums. The company can no longer afford to offer insurance. If Jim's employer were enrolled in Insure Oklahoma, both Jim and his employer would receive assistance toward the cost of the premiums, with the state covering at least 60%. (IO: ESI)

Donna
Unemployed Adult
Annual Income: $0

Donna recently lost her job as a result of missed days due to treatments for liver cancer. Because of the illness, she is not currently looking for work. She is not eligible for SoonerCare due to her type of cancer (i.e., not breast or cervical cancer). Meanwhile, she is not eligible for Insure Oklahoma because she is not working or looking for work. (IO: IP)

Features of this New Coverage Approach for Okla.

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Benefits. Alignment of the alternative benefit plan for newly eligible adults with the benefits offered by QHPs to the maximum extent possible.

Premiums and Cost-Sharing. Targeted use of premiums and cost sharing for individuals with incomes above 100% FPL.

Healthy Behavior Incentives. Incentives for meeting health or wellness standards, including elimination or reduction of co-pays or premiums.

Work and Education Referrals. Referrals to job training and placement programs (e.g., www.OKJobMatch.com) for unemployed individuals with incentives for participation.

State Protections. Use of a trust fund and a provider fee backstop to cover the non-federal share of the newly eligible; adoption of a provision to sunset coverage should the federal match rate go down. Sunset provision.

2

Time Frame for Implementation of Proposals

27

Current	Phase 1 (2015-2016)	Phase 2 (2017-2020)
• Multi-stakeholder process to develop specific coverage and reform features and develop metrics for success.	• Expand Insure Oklahoma: ESI • Expand Insure Oklahoma: Individual Plan • Launch Insure Oklahoma: Individual Market • Expand PCMHs and develop shared savings program • Expand health homes and develop shared savings program • Develop community-led accountable care model(s) and launch initially with FFS and shared savings	• Transition community-led model(s) to capitated payments, potentially requiring a health plan or other state license.

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Thank You…

Comments or Questions?

jones@okoha.com
405-427-9537

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Appendix

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States Cover ABP Benefits for New Adults at Enhanced Match

30

ALTERNATIVE BENEFIT PLAN (ABP)

- 10 Essential Health Benefits
  - Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Mental health and substance use disorder services, including behavioral health treatment
  - Prescription drugs
  - Rehabilitative and habilitative services and devices
  - Laboratory services
  - Preventive and wellness services and chronic disease management
  - Pediatric services, including oral and vision care
- Early Periodic Screening, Diagnosis, and Treatment (EPSDT) for 19 and 20 year olds
- Non-emergency medical transportation

YEAR	ENHANCED FEDERAL MATCHING RATE NEWLY ELIGIBLE ADULTS UP TO 138% FPL	
	State Share	Federal Share
2014	0%	100%
2015	0%	100%
2016	0%	100%
2017	5%	95%
2018	6%	94%
2019	7%	93%
2020+	10%	90%

4
5

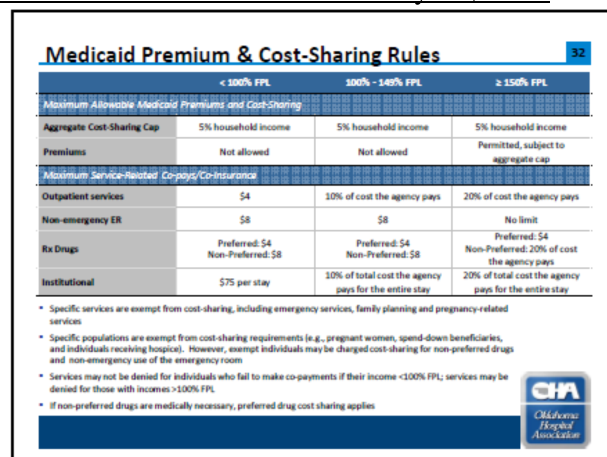
Personal Responsibility: Premiums and Cost Sharing 31

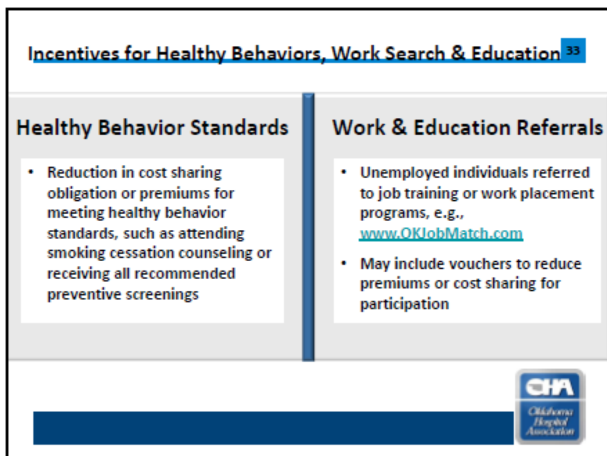
Premiums

- Individuals with incomes 100% to 138% FPL subject to a premium up to 2% of household income
- Failure to pay premium for 90 days results in disenrollment
  - Re-enrollment not tied to repayment of back premiums
  - Unpaid premiums are a collectible debt
  - Consistent with PA's approach
- Individuals with incomes <100% FPL have no premium obligation

Cost Sharing

- Cost sharing consistent with federal rules for newly eligible adults 100-138% FPL (*see appendix*)
- Medicaid cost sharing for individuals >100% FPL generally aligns with QHP cost sharing for individuals <150% FPL





Protections Used in Other States 34

Trust Fund

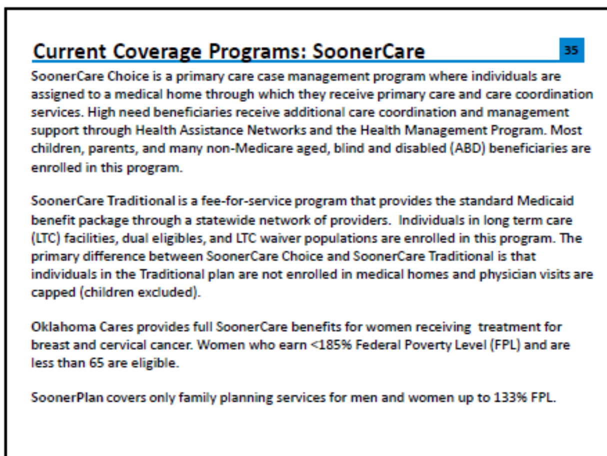
- Savings generated from increased coverage set aside to offset the State's share beginning in 2017.
- Sources of savings: cost of services for new adults currently funded with state dollars (e.g., mental health and substance abuse programs) and enhanced match for coverage of some existing eligibility groups e.g., Insure Oklahoma.

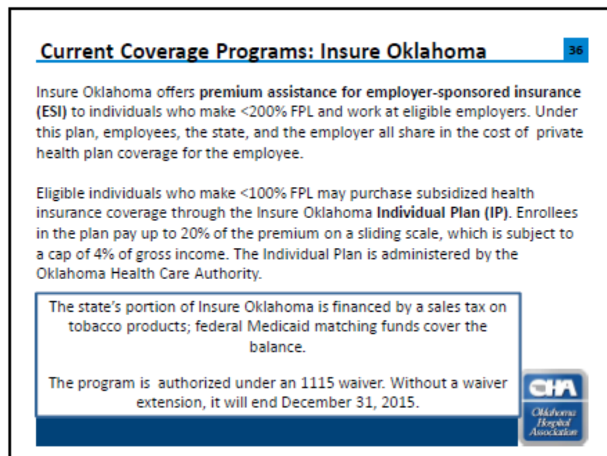
Provider Fee Backstop

- Revenue generated from provider fee may be used to cover a portion of the State's share for increased coverage if cost for new adults exceeds an established target.

Sunset Provision

- Termination of coverage for new adults if Congress reduces the federal share authorized by the Affordable Care Act (federal share is 100% through 2016 and decreases overtime until it reaches 90% in 2020).





The presentation concluded. Dr. Woodson thanked Mr. Jones for taking the time to present to the State Board of Health.

Mr. Starkey directed attention toward elements of the proposal seeking to address insurance coverage for Oklahomans. He asked the Board to consider endorsing the plan as presented. Following Board member discussion requesting additional time to review the presentation, and after consultation with Dr. Cline regarding the necessity for the agenda to reflect actionable items, the Board agreed to table the request for further consideration at a future board meeting.

STRATEGIC MAP UPDATE PRESENTATION: Mark Newman, Ph.D., Director, Office of State and

1 Federal Policy

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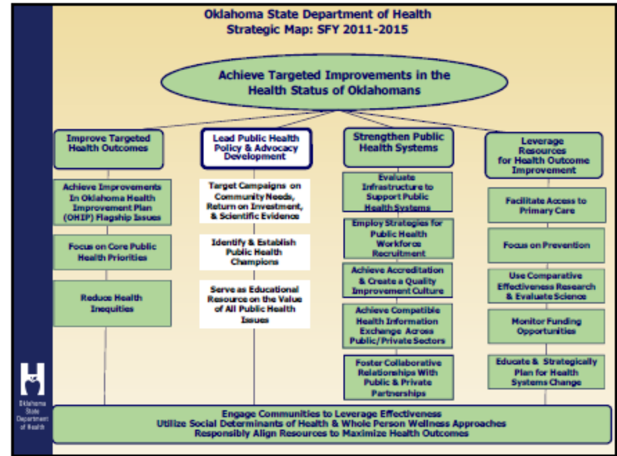

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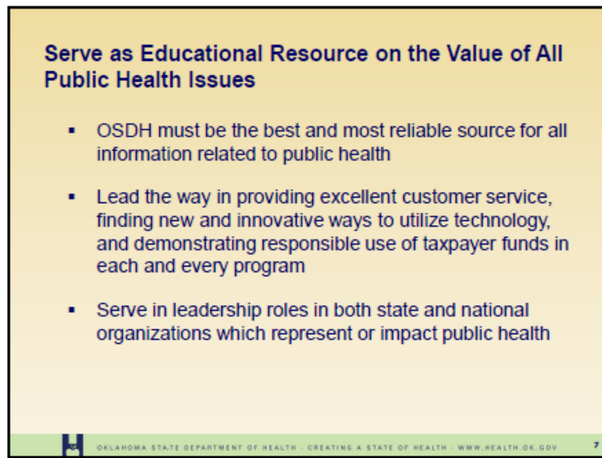

One pager informational handouts also provided to the Board regarding Department programs.

At Dr. Krishna, request, Dr. Mark Newman agreed to provide assistance to Board members as they prepare to meet with legislators as well as facilitate meetings with legislators at their request. Dr. Stewart thanked Dr. Newman for challenging the Board members in their advocacy efforts.

The presentation concluded.

CONSIDERATION OF STANDING COMMITTEES' REPORTS AND ACTION

Executive Committee

Dr. Woodson invited the Board to attend the upcoming Certified Healthy Awards Ceremony on February 4, 2015 in Norman at the Embassy Suites.

Finance Committee

Ms. Wolfe directed attention to the Financial Brief provided to each Board member and presented the following SFY 2015 Finance Report and Board Brief as of December 29, 2014:

- Approximately $427 million budgeted for state fiscal year 2015
- Forecasted expenditure rate of 97.08% through June 30, 2015
- "Green Light" overall for Department, with three divisions in "Yellow Light" status:
  - Public Health Infrastructure is in "Yellow Light" status due to recent vacancies/retirements.
  - Information Technology is in "Yellow Light" status due to final IT contract amount being less than anticipated.
  - Health Improvement Services is in "Yellow Light" status due to program growth and vacancies including recent notification of $2 million State Innovation Model (SIM) grant award.

The ***Financial Brief*** focused on the Comprehensive Annual Financial Report (CAFR) Audit.

Accountability, Ethics, & Audit Committee

The Accountability, Ethics, & Audit Committee met with Jay Holland. Dr. Alexopulos indicated there were no known significant audit issues to report at this time.

Public Health Policy Committee

The Policy Committee met on Tuesday, January 13, 2015. Mr. Starkey stated the Policy Committee discussed legislative agenda items, budget request items and the agency's future budget hearings with the House and Senate Appropriation Subcommittees.

The Committee discussed the advocacy components of the presentation on the strategic map by Mark Newman. Mark Newman will be providing talking points on all legislative and budget issues throughout the session to assist Board Members in speaking to legislators, community leaders, professional organizations, and the media. Members will receive legislative update reports following the January Board Meeting.

1 Board members are encouraged to contact Mark Newman for any questions or concerns regarding the
2 legislative session.
3
4 Mr. Starkey also expressed his concern for the state budget, particularly the February forecast. With recent
5 news of a Tulsa safety net organization unable to accept new patients, shortfalls are even more concerning
6 and present compelling reasons to fully utilize federal dollars.
7
8 The next meeting of the Policy Committee will be prior to the February Board Meeting.
9
10 **PRESIDENT'S REPORT**
11 No report.
12
13 **COMMISSIONER'S REPORT**
14 Dr. Cline thanked Dr. Henry Hartsell and his staff for their planning efforts in kicking of the Governor's
15 Healthy Aging Summit held December 15th at the Reed Center in Midwest City. The initiative seeks to
16 improve the health of older adults over the next four years.
17
18 Dr. Cline also highlighted the first session for the newly established Tribal Public Health Advisory
19 Committee (TPHAC) represented by Oklahoma Indian Tribal Nations and tribal serving entities. The
20 TPHAC's primary purpose is to strengthening collaboration with tribal nations and key stakeholders related
21 to public health responsibilities. Dr. Cline noted that the sessions will be conducted on a regular basis and
22 those dates will be published soon.
23
24 Next, Dr. Cline commented on the ASTHO Million Hearts Collaborative. This is a partnership with the
25 Centers for Disease Control and ASTHO seeking to address heart disease and stroke as the leading causes of
26 death in the U.S. ASTHO Million Hearts has funded a public-private pilot project in southeast Oklahoma.
27 The Oklahoma Heartland Project seeks to address and reduce heart attacks and strokes within a five county
28 area.
29
30 Lastly, Dr. Cline highlighted a recent visit from the Robert Wood Johnson Foundation (RWJF). He thanked
31 Gary Cox of the Oklahoma City County Health Department for organizing a portion of the visit. He also
32 thanked Dr. Krishna for his hosting a dinner meeting during the visit as well. The RWJF awards many
33 millions of dollars annually to improve health and healthcare.
34
35 The report concluded.
36
37 **NEW BUSINESS**
38 No new business.
39
40 **PROPOSED EXECUTIVE SESSION**
41 **Dr. Krishna moved Board approval to go in to Executive Session at 12:30 PM** pursuant to 25 O.S.
42 Section 307(B)(4) for confidential communications to discuss pending department litigation, investigation,
43 claim, or action; pursuant to 25 O.S. Section 307(B)(1) to discuss the employment, hiring, appointment,
44 promotion, demotion, disciplining or resignation of any individual salaried public officer or employee and
45 pursuant to 25 O.S. Section 307 (B)(7) for discussing any matter where disclosure of information would
46 violate confidentiality requirements of state or federal law.
47 • Annual performance evaluation for the Commissioner of Health
48 **Second Dr. Alexopulos. Motion carried.**
49
50 **AYE: Alexopulos, Grim, Krishna, Starkey, Stewart, Wolfe, Woodson**
51 **ABSENT: Burger, Gerard**
52
53 **Dr. Alexopulos moved Board approval to move out of Executive Session. Second Ms. Wolfe. Motion**
54 **carried.**
55

1 **AYE: Alexopulos, Grim, Krishna, Starkey, Stewart, Wolfe, Woodson**
2 **ABSENT: Burger, Gerard**
3
4 **ADJOURNMENT**
5 **Mr. Grim moved Board approval to Adjourn. Second Alexopulos. Motion carried.**
6
7 **AYE: Alexopulos, Grim, Krishna, Starkey, Stewart, Wolfe, Woodson**
8 **ABSENT: Burger, Gerard**
9
10 The meeting adjourned at 1:30 p.m.
11
12
13 Approved
14
15
16
17 Ronald W. Woodson, M.D.
18 President, Oklahoma State Board of Health
19 February 10, 2015