# Oklahoma Health Improvement Plan (OHIP) / Oklahoma State Innovation Model (OSIM) Health Finance Work Group Meeting
## January 27, 2016

Meeting at Oklahoma Health Care Authority (OHCA)
4345 N. Lincoln Blvd, Oklahoma City OK 73105

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

| Agenda Item |
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**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; Dr. Silvia Lopez; OHCA; Keianna Dixon, Deloitte; Bill Hancock, Community Care; John Zubialde, OUHSC; Ken King, Oklahoma State Medical Association; Jim Jones, Deloitte; Pam Cross-Cupit, Health Alliance for the Uninsured; Rick Snyder, OHCA; Becki Moore, OMES

**II. Key Outcomes**

- Received perspectives on the level of responsibility required for providers under the new model
- Received suggestion on an addition to the State Governing Body Quality Measures Committee
- Received suggestion on having potential flexibility on episodes of care each region focuses on

**III. State Health System Innovation Plan (SHSIP) Update**

- Have submitted 9 sections to CMS and Deloitte for review
- Have created a consolidated, draft document and addressed areas of overlap between the sections
- Will place the consolidated, working draft on the OSIM Website on February 1, 2016
- Will hold a public comment period between February 2016 and March 2016
- Will submit plan to CMS at the end of March 2016

**IV. Model Review**

- Reviewed SIM Model Goal:
  - To move the purchasing of health care services from a fee-for-services (FFS) system to a population-based payment structure that incents quality and value while emphasizing primary prevention strategies; by moving to a value-based care coordination model and focusing on the SIM flagship issues, we will improve population health, increase the quality of care, and decrease cost (the Triple Aim)
  - Target issues: tobacco use, behavioral health, diabetes, obesity, hypertension
- Reviewed the conceptual design tenets
  - Incorporate the drivers of health outcomes
  - Integrate the delivery of care

- Drive alignment to reduce provider burden
- Move toward value-based purchasing with realistic goals

- Reviewed the Communities of Care Organizations (CCO)
  - Local, risk-bearing care delivery entities that are accountable for the total cost of care for patients within a particular region of the state
  - Many different organizations already operating within the health care system could become a CCO or come together to form a CCO

*Discussion*

- *Comment:* A stakeholder from the Oklahoma Hospital Association (OHA) believes that they will find very little support from the hospitals for the CCO model. Their members are having difficulty with transferring financial responsibility; this can also reflect an urban vs. rural issue. The stakeholder believes that Oregon's model worked because they had a history of managed care and they only had to modify that structure to create their new model.

- *Comment:* Another stakeholder commented that this is a high-level view of the model but stakeholders will need to understand the details of the plan and understand how they will be better off under the model before they can give their buy-in.
- *Response:* OSDH agrees that there are different levels of readiness among stakeholders to assume a new model for the health system. However, this is why this new model will provide regions flexibility in creating the details of their CCO. The CCOs can choose the alternative payment arrangements for their region that will work for the providers and other stakeholders. OSDH invites comment on any better ways to engage stakeholders to receive their insights.

- *Comment:* A stakeholder commented that providers may have concerns about being responsible for addressing the social determinants of health and would want clarification on the exact responsibilities that the CCO itself will have and that the providers themselves will have.
- *Response:* This current model is a vision of how to move the state forward with value-based purchasing. The governance of the new model will determine more of the details of the model. The CCOs will determine how best to engage with the membership in their region and utilize resources in their region. This will not be a "one size fits all" model.

## V. Governing Body Membership

- Governance structure will reflect the communities in which CCOs serve
- State governing body will serve as the payer for state-purchased health care and be responsible for providing oversight of the CCOs through certification and a continuous minoring process
  - *Membership*: Oklahoma Health Care Authority, Employees Group Insurance Division, Oklahoma State Department of Health, Department of Mental Health and Substance Abuse Services, Oklahoma Insurance Division, Representative from Member Advisory Committee, Representative from Provider Advisory Committee

- *Advisory Committees*: Member Advisory Committee, Provider Advisory Committee, CCO Certification Committee, Episodes of Care (EOC) Alignment Committee, Health Information Technology Committee, Quality Measures Committee
- Want to see the EOC Alignment Committee and Quality Measures Committee roll out this year (2016), prior to the launch of the CCOs
- *Quality Measures Committee*: Will set CCO quality measures benchmarks and reporting requirements. Proposed committee will be composed of 12 members.
- *EOC Committee*: Will propose EOCs and episode framework, including the needed, identified alternations to existing EOCs.
  - There are currently five EOCs slated for the model.
  - They have received pre-vetted definitions for EOCs from Arkansas.
  - They originally proposed a behavioral health EOC but were advised by other states not to begin with this episode due to the difficulty.
  - They will use EOCs to drive multi-payer engagement and alignment at the beginning of this new model for the state. They intend to have the EOCs become obsolete once all of the CCOs fully transition to value-based purchasing (as EOCs still work on the FFS model). If there is a better mechanism to achieve this end, they welcome ideas from stakeholders.

*Discussion*

- *Comment:* A stakeholder recommended adding a hospital administrator to the list of committee members for the Quality Measures Committee. Think of who will be the most influential players regarding quality committee to ensure that they are represented. They may also want to have an odd number of committee members so there would not be a stalemate in decision-making.

- *Question:* Is there flexibility with the EOCs if a certain region has a problem with one particular health condition but not another?
- *Response:* The EOC Alignment Committee will both modify and propose EOCs for the new model, so the committee can determine if EOCs are appropriate for the state and for particular region. Proposing EOCs by region could be an option for how the state will determine episodes; the state will do that for the quality measures.

- *Comment:* A stakeholder recommended that the first step in determining what model components are appropriate will be to gather current data on the areas of greatest need.
- *Response:* This is also why the state would like to have membership from the payers represented in the governance of the model, to have them fully engaged in this effort.

**VI. CCO Certification Requirement**

*Presentation*

- Reviewed the first 10 criteria for the CCOs
- Reviewed the governance for the CCOs

*Discussion*

- *Comment*: A stakeholder commented that Number 2 on the list of certification requirements will be a significant barrier of entry for organizations that want to become CCOs. (Requirement: "Meet minimum financial requirements set by the State Governing Body (e.g., maintaining a level of restricted reserves and net worth")
- *Response*: They do not have the level of detail on what the financial requirements will be at this moment, but they agree that this will be a very important aspect of the CCO certification process.

- *Comment*: A stakeholder commented that they understand that some of these certification criteria will be part of the future state of the new model (e.g., #10 – participating in statewide interoperability and demonstrating the ability to report timeline on standardized outcome and quality measures), but providers should be aware of what these future state requirements will be.

- *Question:* Who will be the capital partners for this new model?
- *Response:* CMS did not announce an additional round of funding for the SIM grant. They believe, however, that CMS has an interest in pooling their Medicaid dollars to fund state-level innovation. They will look at this and other federal sources for funding.
- *Comment:* This stakeholder wanted to make the point that they cannot incentivize people to take on a lot of risk when the infrastructure is not there to support this.
- *Response:* This is part of their argument for the new model. The FFS system does not give providers flexibility to do innovation, so they need to change the infrastructure of the system. They are currently researching funding options for the new model.

**VII. Practice Transformation Center**

- Plan to create a Practice Transformation Center; through stakeholder engagement, a key theme was provider education, transformation, and support systems for the new model
- Goal: Link existing initiatives to ensure coordinated practice transformation, education, and awareness. Connect providers to support services that they will need to succeed in a new payment model from all payers
- Reviewed list of several practice transformation initiatives currently in Oklahoma:
    - Oklahoma Clinical & Translation Science Institute
    - Health Heart for Oklahoma Grant
    - Practice Transformation Networks Grant (Telligen)

- Oklahoma State University (OSU) Center for Healthcare Innovation
- Oklahoma Foundation for Medical Quality
- Comprehensive Primary Care (CPC) Initiative Field Team – This was cited as a game changer to produce the CPCI's results

*Discussion*

- *Comment*: A stakeholder commented that a practice transformation center is a great idea.

**VIII. OSIM Operational Timeline**

- Reviewed OSIM Operational Roadmap
  a. Quality Metrics
     i. Payer Metrics
     ii. Alignment Meeting
     iii. Form Metrics Committee
     iv. Initial Multi-Payer Metrics Report
     v. Initial CCO Metrics Report
  b. Episodes of Care (EOC)
     i. Form EOC Task Force
     ii. Episodes Reporting & Evaluation
  c. Communities of Care Organizations
     i. CMS Waiver Submission
     ii. CCO Enabling Legislation
     iii. CMS Waiver Approval
     iv. CCO Go-Live (2018)

*Discussion*

(There were no stakeholder questions or comments.)

**IX. HIT Plan**

*Discussion*

- Plan is currently under review and will be incorporated into the larger document
- Reviewed the three primary sections for discussion in the model:
  - Goal: The Oklahoma HIT plan creates a vision for interoperable technology infrastructure across the state.
  - Section I: Drivers for HIT
  - Section II: HIT Support for Drivers
  - Section III: Critical Success Factors
- Reviewed how the HIT drivers support the overall OSIM objectives
  - HIT Drivers: The Triple Aim, Patient-Centered Care, Care Transitions, Population Health

- OSIM Target Issues: Diabetes, Hypertension, Behavioral Health, Obesity, Tobacco Use

- Reviewed the HIT critical success factors:
  - Governance
    - Level 1: State Chief Information Officer/HIT Coordinator
    - Level 2: Oklahoma HIT Advisory Board
      - Will provide guidance to the State HIT Coordinator
      - Want to ensure that they have representation from stakeholders across the board. Have received stakeholder feedback on what organizations would be comprised in this advisory board.
    - Level 3: Health Information Network (HIN) Operations, Value-Based Analytics Data (VBA) & Operations, Privacy & Security
      - HIN is the critical components of the HIT Model as it is where the exchange of information will occur for the CCO.
      - VBA will be a state-level analytics component
  - Infrastructure
    - Funding
      - Will pursue opportunity with CMS for public health HIT funding
    - Technology
    - Technical Assistance
    - Staff Resources
  - Policy
    - Alignment with existing HIT efforts
    - Transparency and balance across providers and payers
    - Patient engagement and shared decision-making
    - Multi-payer strategies
- Reviewed Oklahoma HIT Conceptual Governance and Operations Model
  - Want to determine ways in which they can achieve interoperability for the state's two non-profit Health Information Exchanges (HIEs). The Federal Health Information Exchange (which is not an actual HIE organization but rather a vehicle for information exchange) is one opportunity they can join to move toward interoperability.
  - HIN – Will enable information exchange regardless if they have HIE interoperability
  - Payers – Will bring in claims data

*Discussion*

- *Comment:* A stakeholder recommended writing out the information that explains the different components of the Oklahoma HIT Conceptual Governance and Operations Model.
- *Response:* They will create a bulleted list to accompany this model.

**X. Wrap Up & Next Steps**

a. OSIM

- Payer Meeting
- Financial Analysis
- Finish SHSIP Sections- Release for feedback

b. Health Finance Workgroup

- Meeting next month- February 2016
  -Quality Measures Discussion
  -Episodes of Care Discussion
  -Financial Forecast Discussion
- SHSIP Section Review
- Meeting- March 2016