Oklahoma Health Care Authority
Quality Advisory Committee
March 11th, 2025
1:00 – 3:00 PM
Cherokee Landing Conference Room

AGENDA

Please access via zoom:
https://www.zoomgov.com/webinar/register/WN_REWD7osURbe0u5TFtscppw
Telephone: 1-669-254-5252 Webinar ID: 160 055 1933

I. **Welcome and rollcall** – Teresa Huggins, Chairperson (5 mins)

II. **Approval of January 14th, 2024, Minutes**- Teresa Huggins, Chairperson (5 mins)

III. **Health Information Exchange Discussion** – Stephen Miller, Chief Technology Officer (40 mins)

IV. **QAC Subcommittee on Data & Operational Metrics Update/Discussion –** Sarah VanAlstine, OTR/L, LLC. (20 mins)

V. **QAC Subcommittee on Performance Improvement Projects Update/Discussion** – Monica Basu, Sub Committee Chair, PIPs (20 mins)

VI. **QAC Subcommittee on Primary Care Spend Update/Discussion** - Mark Woodring, Sub Committee Chair, Primary Care Spend (20 mins)

- Voting on Primary Care Spend Recommendations

VII. **New Business** – Teresa Huggins, Chairperson (5 mins)

VIII. **Upcoming Meetings**: Teresa Huggins, Chairperson (2 mins)

May 13, 2025
July 8, 2025
September 8, 2025
November 18, 2025

IX. **Adjourn**- Teresa Huggins, Chairperson (3 mins)

Oklahoma Health Care Authority
Quality Advisory Committee
MINUTES of the January 14, 2025, Meeting
4345 N. Lincoln Blvd., Oklahoma City, OK 73105

I. Welcome, and roll call: Ms. Teresa Huggins called the meeting to order at 1:06 PM.

Delegates present were: Dr. Saquib Sheikh, Ms. Monica Basu, Ms. Sandra Gilliland, Mr. Josh Cantwell, Ms. Teresa Huggins, Ms. Sarah Van Alstine, Ms. Robyn Sunday-Allen, Ms. Melissa Abbott, Mr. Todd Clapp, Mr. Jason Lepak, and Ms. Sharon Smallwood providing a quorum.

Alternates present were: Dr. Mary Gowin

Delegates absent without an alternate were**:** Ms. Barbara O'Brien**,** Mr. Tony Willis, Mr. Lance Walker, Ms. Corie Kaiser, Ms. Janet Hixon, and Mr. Rich Rasmussen

II. Approval of the September 10, 2024, Minutes
Medical Advisory Committee
The motion to approve the minutes was by Mr. Tony Willis and seconded by Mr. Josh Cantwell and passed unanimously.

III. Managed Care Update:
Sandra Puebla, Deputy State Medicaid Director

Ms. Puebla presented some information on the SoonerSelect Metrics observing a decrease in total enrollment within the first data set for the SoonerSelect programs beginning in June. Enrollment figures begin to stabilize to observed enrollment figures in September. This trend was also observed for Medicaid overall enrollment. A decrease in rendered services and expenditure is observed within the first set of data for November 2024. This appears to be due to a 10% decrease in member utilization of service in the medical select program, a 12% decrease in member utilization of services on the children's specialty program and a 2% decrease in member utilization of services in the dental select program. This is approximately 9% decrease on average in member utilization of services for all Select programs.

There is a large increase in Psychiatric Residential Treatment Facility (PRTF) reimbursement in the first set of data showing paid month data during the month of July. Reports from the second set of data, which is data reported by the CEs, show that the plans are meeting call center metrics, PA processing timeframes, and claim processing timeframes. The OHCA has a rigorous 90% access metric for meeting network adequacy. While the CEs are reporting they are not meeting the 90% metric for all applicable providers, most CEs' metric for providers not meeting the 90% metric are meeting the metric at the 70-80 percentile. It is important to note that network adequacy standards take time to meet at the 90 percentiles within the first year. It is common for new managed care programs to continue to develop their provider network well past the implementation of the managed care program(s).

IV. QAC Strategic Planning Meeting Update:

Teresa Huggins, Chairperson

Ms. Huggins stated yesterday's discussion was great. The OHCA is currently searching for a dental QAC representative, and the committee also needs by-laws. We are working on the MAC by-laws as a template and will adjust accordingly. OHCA is also working on scorecards for dental and medical, with dental due in February. A new platform OHC is using is GrayMatter Analytics. They will help analyze the internal data.

V. QAC Subcommittee on Data & Operational Metrics Update/Discussion:

Sarah Van Alstine, Sub Committee Chair

Ms. Van Alstine stated the subcommittee held the previous day was beneficial to the members of the board regarding what has been happening and what will happen moving forward. In December the subcommittee held a discussion about the details we would like to bring to the QAC. Such as every 60-90 days metrics, comparing 23 and 24, compare pre-managed care to managed care systems, as well as utilization. A few other metrics include emergency room use compared to other provider types, or preventive care, along with expenditures; is this cost effective? Ms. Van Alstine asked the members for their feedback on what they would like to see in the future. Ideas such as adding diabetes to the PIPs, primary care spend, and access, denials, and utilization data.

VI. QAC Subcommittee on Performance Improvement Projects Updates/Discussion

Monica Basu, Sub Committee Chair

Ms. Basu presented on behalf of Ms. O'Brien stating they did some research on other states and came up with a dashboard on the PIPs. One concern in the PIPs being different for each CE. They are creating a baseline to be fair with each CE. The next set of PIPs are Behavioral Health

VII. QAC Subcommittee on Primary Care Spend Update/Discussion:

Sandra Gilliland, Sub Committee Chair

Ms. Gilliand discussed that a few updates were made to their committee draft. The subcommittee identified the definition of primary care, as well as primary care and view those claims based on current OHCA taxonomy, primary care providers and locations. The subcommittee has identified that there are recognized positions within an interprofessional team that currently do not generate claim revenue, which include care managers, case managers, community health workers, care coordinators, and clinical pharmacists. We have specified that spending for delegated care management can be considered part of the interprofessional team. So long as there's bi-directional

communication occurring between the care management, the care manager and the provider team. We have addressed the importance of value-based care plans, we have specified OHCA to recognize the financial incentives to primary care practices to participate in value-based contracting. We need date transparency, specifically to primary care utilization.

VIII. New Business:

Chairperson, Teresa Huggins

A report didn't make it in time on the agenda and Ms. Huggins asked for a consensus around the table if the document is being built appropriately. One believes they are moving in the right direction with the things we want to focus on.

IX. Upcoming Meeting Dates for Calendar 2025:

Chairperson, Teresa Huggins

March 11, 2025
May 3, 2025
July 8, 2025
September 8, 2025
November 4, 2025

X. Adjourn:

Chairperson, Teresa Huggins

Subcommittee on Primary Care Spend

Recommendations for OHCA in definition of Primary Care Spend

December 2, 2024

The committee recommends OHCA adopt as its definition of primary care:

"The provision of whole-person, integrated, accessible, and equitable healthcare by interprofessional teams who are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities."

National Academies of Sciences, Engineering, and Medicine

The committee recommends OHCA adopt as its definition of primary care spending to include:

1) **Claims as based on the current OHCA taxonomy of primary care providers and locations.**
2) **Non claims based spending to enhance primary care Interprofessional Teams**

- Spending that enhances the interprofessional team accountable for addressing most of the individuals' health and wellness needs shall be considered as primary care spend.
    - Interprofessional team members must work directly with primary care providers as defined within the taxonomy of primary care providers and locations.
    - Payment models that include grants and incentive payments to primary care providers, ongoing capitation payments for primary care providers to employ healthcare professionals who do not directly generate primary care claims, and shared savings programs with primary care providers.
    - Interprofessional team members may include:
        - Care Managers
        - Case Managers
        - Care Coordinators
        - Community Health Workers
        - Clinical pharmacists
- Spending for delegated care management teams (e.g teams employed by a clinically integrated network). These may be considered part of the interprofessional team so long as bidirectional communication occurs regularly between the delegated care management team and the provider team. Examples of bidirectional communication include team huddles, weekly case conferences, and collaborative care plans in which the primary care provider, care manager and patient/family develop goals.
- Spending through value added benefits that directly impacts the ability of primary care providers to meet state quality of care goals should be considered on a case by case basis.
- Therapists, Doulas and Lactation Consultants generally will not fall into this category because their professional services directly generate revenue via claims.

- Cost of care management teams employed directly by insurers **may not** be counted as primary care spend.

Allowable Non-Claims Based Spend Methods

1) Value-Based Care Plans that invest in and share savings with providers.

Shared savings paid to primary care providers either directly or via clinically integrated networks of primary care providers may be considered as primary care spend. Clinically integrated networks have the capacity to meet the regional needs of their communities through innovative solutions for improving wellness and lowering utilization of high-cost healthcare services.

- SoonerSelect plans may financially incentivize primary care practices to participate in value-based contracts via clinically integrated networks. This investment could count as primary care spend.
- Grants, incentives, or bridge payments to primary care providers to hire staff necessary to begin delivery of care either directly in the clinic or through a delegated care management team provided through a clinically integrated network may also be considered primary care spend. While this may include hiring members of the interprofessional team (see above), this may also include hiring staff with experience in clinical data analytics and population health management.
- Grants and Incentive payments for implementation of technology that enhances care coordination in primary care practices may also be considered as primary care spend. This may include software integrated with electronic health records or health information exchanges, or training on use of such technology.
- Adequate preventative dental care may reduce more costly medical care. Grants and Incentive payments to clinically integrated networks for implementation of oral health services in a primary care setting may also be considered for counting toward primary care spend.

When insurers contract with entities delivering both primary care and non-primary care services, only a representative portion of the payments attributable to primary care services should be considered primary care.

2) Value-Added Benefits

The committee recognizes that some of the value-added benefits to SoonerSelect members are designed to specifically enhance the effectiveness of primary care services. To be considered as primary care spend, the benefit should, at a minimum, meet the following criteria:

- Align with the state health plan and OHCA Strategic Quality initiatives.
- Impact quality indicators that primary care providers are expected to meet in value-based contracts.
- Include data transparency and specificity to primary care utilization.

- The service does not supplant a comparable service currently covered by claims-based services of primary care providers.
- May not include cost of medications, medical supplies, or DME.
- Waived-copays for primary care services are considered as an allowable value-added benefit. However, when they are currently included with claims and are thus already included as primary care spend when associated with a primary care provider or location based on taxonomy, then this would not be allowable. These payments must not be double counted.

Examples:

  - Spending on transportation **does meet** the criteria so long as the spending is specific for primary care services.
  - Patient payments for wellness visits and preventative services **does meet** the criteria, as long as it is not counted in claims.
  - Tobacco cessation counseling offered directly by managed care organization staff telephonically **does not** meet the criteria because physicians, PAs and nurse practitioners can offer a comparable service in their primary care practice.
  - Spending on non-prescription medications or nebulizers **does not** meet the criteria.
- *[The subcommittee is considering adding a recommendation to limit the portion of spending on Value-Added Benefits to a certain percentage of the total spending considered as primary care spending]*

Definitions

Primary care providers – those healthcare professionals and locations whose claims meet the definition of primary care under the claims-based criteria (taxonomy).

Case Managers – According to Case Management Society of America, "Case managers are healthcare professionals who serve as patient advocates, supporting, guiding, and coordinating care for patients, families and caregivers as they navigate their health and wellness journeys. They serve as the center of communication, connecting individuals/caregivers with members of the healthcare team and community to impact acute and chronic disease management and improve population health."

Care Managers – According to the National Academy of Certified Care Managers, "A Care Manager is a health and human services specialist who is engaged in a collaborative process of assessment, planning, coordinating, monitoring, and advocacy. Care management is a person-centered, culturally responsive approach that considers the biopsychosocial-spiritual aspects of the client and client system. The goals of care management are to promote the health and well-being of the client and client system and assist the client to effectively access the services and supports they need to achieve their goals."

Care Coordinators – According to the Agency for Healthcare Research and Quality, "Care coordination in the primary care practice involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care.

The main goal of care coordination is to meet patients' needs and preferences in the delivery of high-quality, high-value health care. This means that the patient's needs and preferences are known and communicated at the right time to the right people, and that this information is used to guide the delivery of safe, appropriate, and effective care.

Examples of specific care coordination activities include:

- Establishing accountability and agreeing on responsibility.
- Communicating/sharing knowledge.
- Helping with transitions of care.
- Assessing patient needs and goals.
- Creating a proactive care plan.
- Monitoring and follow up, including responding to changes in patients' needs.
- Supporting patients' self-management goals.
- Linking to community resources.
- Working to align resources with patient and population needs."

Community Health Workers and Promotoras de Salud – According to the American Public Health Association: "A community health worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

A community health worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy."

Promotores or Promotoras de Salud is a Spanish term used to describe community health workers.

Online References

https://cmsa.org/who-we-are/what-is-a-case-manager/

https://www.naccm.net/

https://www.ahrq.gov/ncepcr/care/coordination.html

https://www.apha.org/apha-communities/member-sections/community-health-workers

Subcommittee on Primary Care Members

- Mark Woodring, subcommittee co-chair
- Sandra Gilliland, subcommittee co-chair
- James Willis
- Saqib Sheikh
- Jason Lepak
- Sharon Smallwood