OHIP/OSIM
Health Workforce Workgroup
Meeting Minutes

	Health Workforce Workgroup Meeting
DATE	December 16, 2015
TIME	1:30 pm – 3:30 pm
LOCATION	Oklahoma State Department of Health
FACILITATORS	Chair, HW Workgroup, Deidre Meyers Project Manager, HW Workgroup, Jana Castleberry OSIM Project Manager, Alex Miley
MEMBER ATTENDEES	Buffy Heater, Cynthia Scheideman-Miller, Jackye Ward, JT Petherick, Randy Curry, Others not listed
GUESTS	Alisha Hemani-Harris, Spencer Kusi, Isaac Lutz, Joe Fairbanks, Jenny Kellbach, Others not listed Conference Call Participants include Keianna Dixon, Rachel Mix, Others not listed
HANDOUTS & REQUESTS	Health Workforce OSIM Update PowerPoint Presentation

AGENDA

1. Welcome / Introductions

Welcome from Jana Castleberry, HW Workgroup Project Manager.

2. OSIM Status Update

Alex Miley, OSIM Project Director

- SIM model proposal, quality measures, episodes of care, and State Health System Innovation Plan (SHSIP) sections have been developed over the past few months (2nd-4th Quarter of 2015).
- Model development will continue to incorporate feedback. Individual meetings with stakeholders will continue through January 2016. January-March is the public comment period.
- The Centers for Medicare and Medicaid Services (CMS) has approved a 2 month extension; final model submission date is March 31st to CMS (instead of Jan. 31st, 2016).
- OHIP Workgroups will have regular meetings during this period to review the model and provide input.

3. Overview: Proposed OSIM Model for Communities of Care Organizations

Alex Miley, OSIM Project Director

- Health spending in Oklahoma is increasing at a rate greater than the national average.
- Fee for-Service Systems (FFS) often do not incentivize innovation.
- Incorporating the social determinants of health into the health system is critical to improving population health.
- High cost spending report for Oklahoma shows five conditions that are big cost drivers. All these costs are increasing, and are not in isolation. High cost conditions include diabetes, obesity, tobacco usage, behavioral health, and hypertension.
- Social determinants and how they affect health make the case for change in the healthcare

system. Innovation is difficult in an FFS system. Patients are often seen as a diagnosis rather than a whole person. FFS does not help with person-centered care because providers operate in isolation. The current health system does not take social determinants into account.

- After months of feedback and review of models, the executive steering committee reviewed all comments and decided on a Communities of Care Organization model.
- OSIM team has made good connections with stakeholders and technical assistance teams.

OSIM Model Goals: To move payments to providers from a FFS system to a payment structure based on value and integration of primary prevention strategies.

- Incorporate drivers of health outcomes.
- Integrate the delivery of care to break down silos.
- Drive quality measures alignment to reduce provider burden.
- Move toward value-based payments with realistic goals.

4. Communities of Care Organizations (CCO) Model

Alex Miley, OSIM Project Director

CCOs are local risk-bearing entities that are accountable for the total cost of care for patients within a specific geographic region. A CCO can consist of different types of organizations, depending on how they propose to meet requirements. Examples include health plans in Oregon that joined a Federally Qualified Health Center (FQHC) system and individual physicians to create a 21 member board with 11 physicians and 12 stakeholders.

- Payment is capitated, and initially the model would apply to state purchased health care (Medicaid and public Employees Group Insurance Division).
- Payment methodology for the CCO is per member per month with (X%) withheld for a quality incentive pool and additional quality metrics. Savings are reinvested in serving community needs. Data infrastructure will be needed to meet cost and availability.

CCOs are required to coordinate care for covered patients, with a focus on primary care, behavioral health, and social or community services. CCOs must be governed by a representative board of accountable providers and a community advisory board. The exact nature of care teams and delivery models will be determined by the CCO, with a State Governing Body reviewing and monitoring each CCO to maintain standards.

CCO also will focus on value-based payments to providers. Flexibility to meet the goals is important. Providers and health systems enter into value-based payment arrangements with the CCO in their region, and are responsible for accountability of outcomes for attributed patients under the model. Integration of social determinants is a responsibility of the community advisory board, which will formally integrate the resources within the community. Members of the Board will know the existing resources and the communities. Providers can incorporate assistance with services that address social determinants directly affecting health. Examples include electricity to properly store insulin and practices to deal with mold remediation. Local boards will be able to stratify risks more effectively by identifying medical and social determinants of health.

Health Information Technology Integration is built into the model. All CCOs will create and maintain a database of community resources and will work with existing entities already doing work in their areas. The CCO will utilize its assets to deliver patient-centric care and resources. One size does not fit all. There is a need to be flexible when integrating comprehensive primary care into existing care entities.

- Goals, benchmarks, and delivery model designs will be determined by each CCO. Each CCO must show how they achieve patient-centered care.
- Data predicates success. An interoperable Health Information Exchange (HIE) will show where

individuals are seeking care and share the health status to care teams. A CCO also must show how it is reporting back to providers.

- A value-based analytics tool and health information network (HIN) will assist providers. Access to a consumer-friendly portal is required.

Comments, Questions and Discussion on CCO Model

- The plan looks to build on top of what is already going on in the state, such as local Turning Point coalitions. The model seeks to integrate non-traditional partners into the health care system. Entities may coordinate differently to share resources. However, they realize the need to unite efforts across the state to move the needle on health outcomes.
- The estimated timeline is 18-24 months for the implementation of the model as well as provider transformation and education needed for the new model. A model similar to the Comprehensive Primary Care Initiative (CPCI) field team or the practice transformation network may be used to support implementation.
- No decision has been made about how regions should be created. The goal is not to cut off providers from their current patient referral patterns.
- A regional hospital or health system would have to make some modifications and come together to have network adequacy to form a proposal for a CCO. Integrated systems are anticipated to be large players in this new model based on how they already operate.

Stakeholder Comments

- Focus on the business community and Chambers of Commerce.
- With a different structure and a new administration, there is no guarantee that existing agencies or entities will not change or may not be a part of the CCO. (OSDH has considered this and will expect the CCO to work with the unique structures of their community.)
- Suggest helping providers understand the value early, adapt early to get involved, and to adopt best practices.
- In some places in Oklahoma, it may be difficult for providers to see the value of switching from value to volume. This will be a significant area to focus on for these efforts. There may be a fear factor for those providers who are already struggling with their current situation. (OSDH acknowledged this and welcomes ideas to overcome this barrier.)

5. Proposed Quality Metrics

Alex Miley, OSIM Project Director

Multi-payer measures allow assessment of providers and health systems. The goal of measurement of providers is to drive the system toward improvement for the key population health goals of obesity, diabetes, tobacco use, hypertension, and behavioral health.

A quality metrics workgroup or committee will determine if measures are meeting goals. Almost all states with CCOs have workgroups or committees.

Clinical, quality and population measures serve as data sources and multi-payer measures. Payers can review and align quality metrics.

- Multiple value-based arrangements are possible under a CCO structure. Practices may continue other payments arrangements with payers outside of the model such as private insurers.
- All multi-payer measurements in a final proposal will be submitted and reviewed by a committee.
- Primary care, care coordination, and social determinants must be components in a CCO. CCOs could integrate non-traditional workers and services into a globally capitated model that would initially cover Medicaid and state workers.
- The payment methodology for a CCO is a per-member-per-month with X% withheld for a quality

incentive pool and additional quality metrics. Savings are reinvested in serving community needs. Data infrastructure will be needed to meet cost and availability.

CCOs also will focus on value-based payments to providers. Providers and health systems will enter into value-based payment arrangements with the CCO in their region, and are accountable for outcomes for attributed patients under the model.

Comments, Questions, and Discussion on multi-payer quality metrics

- A Quality Metrics Workgroup/Committee will help with setting the benchmarks for the quality measures at the state governing level. The CCO governance would help with setting measures specific for their particular regions to account for their regional differences.

6. **Episodes of Care**

Isaac Lutz, Manager of Health Planning, Center for Health Innovation and Effectiveness (CHIE)

- Multi-payer episodes of care have been shown effective at containing costs and improving outcomes.
- Multi-payer episodes of care focus attention on the patient, not the insurance carrier.
- Five episodes of care are part of the plan to align to Medicaid. Asthma, perinatal, chronic obstructive pulmonary disease (COPD), total joint replacement, and congestive heart failure are the episodes selected for the model.
- Some episodes may exclude high risk patients.
- Other states are aggressively expanding episodes of care.
- Payment model design proposes that services will be paid initially on a fee-for-service basis and then evaluated retroactively against benchmarks.

Comments, Questions, and Discussion on Episodes of Care

- Once moved to a fully capitated model, episodes of care will become obsolete. However, CCOs will have autonomy in determining how long the episodes of care model would continue.
- The episodes selected have had good results in other states. Originally, other states also included Attention-deficit/hyperactivity disorder (ADHD) but removed this episode based on stakeholder input. These are potential proposed episodes, as feedback is needed from Workgroup members.
- It is critical to remain vigilant in order to make a seamless transition from episodes of care to the full CCO rollout.

Stakeholder Comments

- There is some concern that there may be difficulty moving from episodes of care to the full CCO rollout. OSDH will review this closely and invite stakeholder feedback on the best path forward.
- A taskforce will be needed to move from the episodes of care model to a fully capitated model under the CCOs.

Wrap Up and Next Steps

- Plan Presentations will continue through January 2016.
- OSIM team is submitting plan to CMS and technical assistance teams for feedback.
- More information is available at www.osim.health.ok.gov.