

All Workgroup Meeting Agenda



March 16th, 12:00-1:00pm
Webinar

| Section | | | Presenter |
|----------------------------------|--------|-------|---------------------------------|
| Welcome & Objectives | 5 min | 12:00 | A. Miley |
| Review OSIM Model | 5 min | 12:05 | A. Miley |
| Financial Analysis of OSIM Model | 35 min | 12:10 | M. Lewis & C. Pettit - Milliman |
| Analysis Discussion | 15 min | 12:45 | Milliman |
| Wrap-Up & Next Steps | | 1:00 | A. Miley |



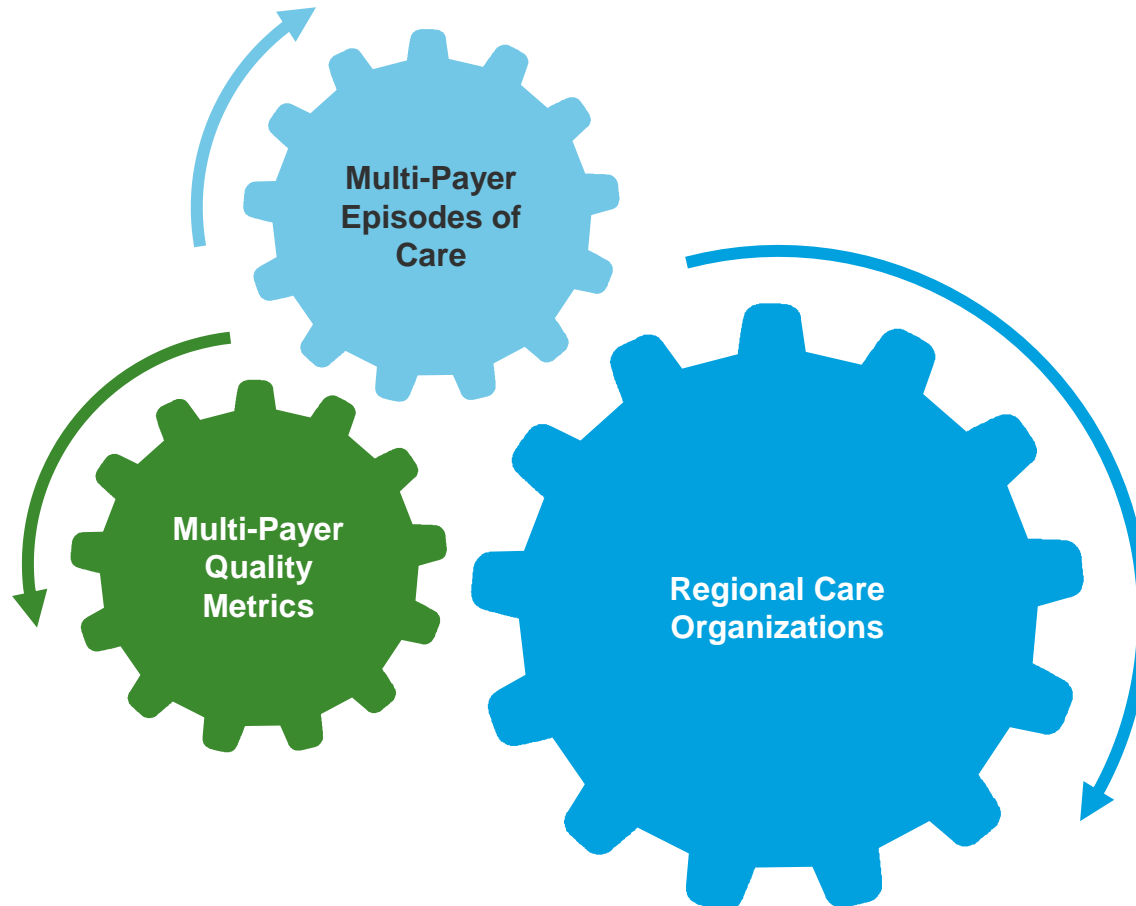
Meeting Objective

1. Review and Discuss the OSIM Model Financial Analysis

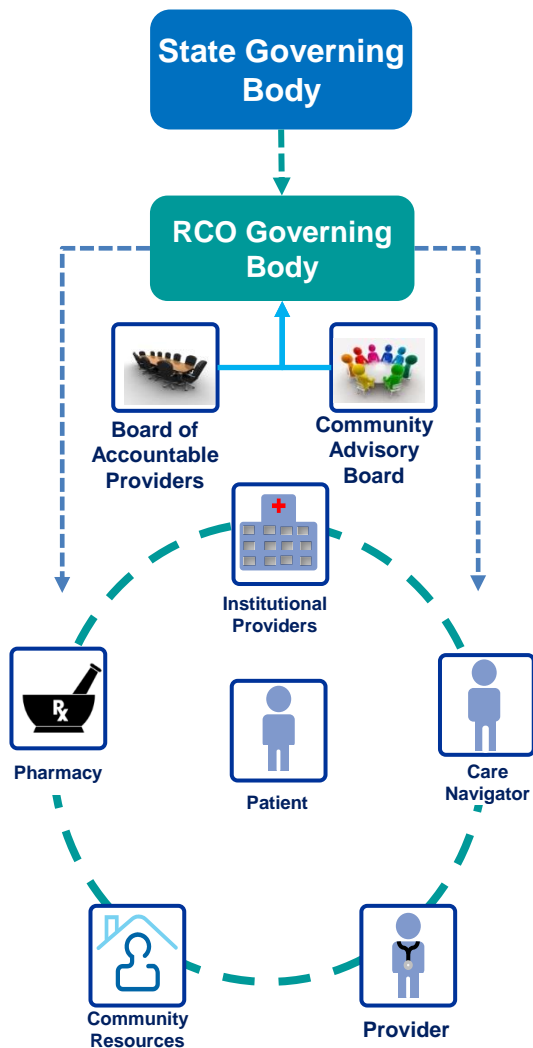


Proposed Model: Three Components

The three components of the proposed model are: Regional Care Organizations (RCOs), Multi-Payer Quality Metrics, and Multi-Payer Episodes of Care.



Regional Care Organization



- Risk adjusted PMPM, globally capitated rate to RCO
- 80% of payments made by RCO to providers will be in a selected APA by 2020
- Community Quality Incentive Pool pays bonuses for meeting quality benchmarks set by SGB – funded through a % withhold from the capitated rate
- Integrate the social determinants of health through CAB, flexible spending, human needs survey, quality measures, and resource guide
- RCO will articulate best delivery system for region to meet a high bar of quality care based on standards set by SGB
- RCOs will organize a governance structure that incorporates the providers and community they serve
- RCOs will connect to an interoperable HIE to ensure the data to best manage patient care and analyze performance is available to all participating

Review Financial Analysis

Oklahoma State Innovation Model Draft Medicaid Financial Forecast

Prepared for:

Oklahoma State Department of Health
Center for Health Innovation and Effectiveness

Presented by:

Chris Pettit, FSA, MAAA
Maureen Tressel Lewis, MBA

March 16, 2016



Caveats

This presentation was prepared by Milliman, Inc. (Milliman) for the Oklahoma State Department of Health (OSDH) in accordance with the terms and conditions of the contract between OSDH and Milliman.

The subsequent slides are for discussion purposes only. These slides should not be relied upon without benefit of the discussion that accompanied them. No portion of this slide deck may be provided to any other third party without Milliman's prior written consent.

This project is not complete. Any preliminary conclusions presented here may change significantly based on this discussion and subsequent analysis.

In performing this assessment, we relied on data and other information provided by OSDH, its vendors, from stakeholders interviewed, and from publicly available sources. We have not audited or verified this data and other information. If the underlying data or other information is inaccurate or incomplete, the results of our assessment may likewise be inaccurate or incomplete.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Chris Pettit is a member of the American Academy of Actuaries and meets the qualification standards for performing the analyses contained herein.

Goals for Today's Session

- Summarize SIM care delivery approach
- Discuss financial forecast on Medicaid populations
 - Impacted populations
 - Baseline projections
 - Provider reimbursement reductions
 - Bill 1566
 - Medicaid projections under SIM implementation
 - High-cost populations
- Update on EGID analysis
- Questions and discussion

Summary of Care Delivery Approach

- Regional Care Organizations
 - Impacts Medicaid (OHCA) and Employees Group Insurance Division (EGID)
 - Managed care basis with RCOs receiving capitation payment
 - Program rollout begins calendar year 2019
 - Requirements on payments, reporting, and shared savings
 - Focus on care coordination and total cost of care
- Multi-payer initiatives
 - Quality of care metrics
 - Episodes of care

Medicaid Financial Forecast-Overview

- Milliman received historical claims and enrollment data from Oklahoma Health Care Authority (OHCA)
 - Encompassed CY 2012 through Q3 2015
- Goal is to develop projections for future time period
 - CY 2018 (Year 0) to CY 2024 (Year 6)
 - Estimate savings between baseline projections and those under the SIM plan
- Forecast is based upon currently proposed delivery approach
 - Accounts for RCO delivery model considering payment and reporting requirements
 - Estimated savings are aligned with shifting Medicaid population from PCCM program to managed care structure

Medicaid Financial Forecast-Populations

| Impacted Populations | |
|----------------------|----------------|
| Insure Oklahoma | TANF |
| Aged | Pregnant Women |
| Blind/Disabled | All Other |

- Population groupings based on aid category from OHCA
 - Agreed upon grouping logic between Milliman, OSDH, and OHCA
 - Institutionalized split between Aged and Blind/Disabled
 - All other includes B&CC, FP, TEFRA, etc.
 - Excludes patients exclusively in MHSAS aid category
- No specific rollout by population under SIM
- Statewide basis

Cost Model Approach

- Categorize claims according to reported codes (DRG, Revenue, CPT-4, etc.)
 - Utilizes Milliman grouping software consistent with *Milliman Health Cost Guidelines*
- Rolled up based on CMS requested information

| Categories of Service | |
|--------------------------|---------------------------|
| Inpatient Hospital | Professional Primary Care |
| Outpatient Hospital | Professional Other |
| Diagnostic Imaging/X-Ray | Home Health |
| Laboratory Services | Prescription Drugs |
| DME | Other |

- Report utilization, unit cost and per member per month (PMPM)

Baseline projections

- Utilized SFY 2014 experience and trend/adjust to projection period
 - SFY 2014 base data compared against OHCA annual report and discussed with OHCA for reasonableness

| | Baseline Estimates (in \$ millions) | | | | | | |
|----------------------|-------------------------------------|---------------|---------------|---------------|---------------|---------------|---------------|
| | Year 0 | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 | Year 6 |
| Insure Oklahoma | \$53.2 | \$55.2 | \$57.4 | \$59.7 | \$62.1 | \$64.5 | \$67.1 |
| Aged | \$486.7 | \$493.2 | \$499.7 | \$506.4 | \$513.2 | \$520.1 | \$526.6 |
| Blind/Disabled | \$1,491.4 | \$1,529.8 | \$1,569.7 | \$1,611.1 | \$1,654.0 | \$1,698.5 | \$1,743.6 |
| TANF | \$1,490.2 | \$1,543.9 | \$1,599.7 | \$1,657.7 | \$1,718.0 | \$1,780.7 | \$1,846.0 |
| Pregnant Women | \$150.1 | \$154.0 | \$158.1 | \$162.4 | \$166.7 | \$171.2 | \$175.9 |
| All Other | <u>\$33.3</u> | <u>\$34.5</u> | <u>\$35.8</u> | <u>\$37.1</u> | <u>\$38.5</u> | <u>\$39.9</u> | <u>\$41.4</u> |
| Total Savings | \$ 3,704.8 | \$ 3,810.7 | \$ 3,920.5 | \$ 4,034.4 | \$ 4,152.5 | \$ 4,275.0 | \$ 4,400.5 |

- PMPM trends range from 0.5% (Inpatient) to 6.5% (Rx)
 - Vary by COS and population
- Enrollment trends of 0% to 1% by population

Additional Considerations

Provider reimbursement reductions

- Base experience period was prior to known rate reductions
 - *July 2014 and January 2016*
- Future reimbursement reductions
 - *Assumes additional change in SFY 2016, but nothing beyond*

Oklahoma House Bill 1566

- Signed in April 2015 to issue request for proposal for care coordination on Aged, Blind, and Disabled population
- Care coordination model selected with potential shift occurring as early as October 2017
 - *Approximately full year prior to SIM implementation on RCOs*
- Potential savings must be separated from SIM and taken into account for purposes of baseline
- Anticipated savings in line with approach for other populations under SIM

Projections under SIM plan

- Applies savings assumptions to the baseline projections

| | Estimates under SIM Model (in \$ millions) | | | | | | |
|----------------------|--|------------|------------|------------|------------|------------|------------|
| | Year 0 | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 | Year 6 |
| Insure Oklahoma | \$53.2 | \$54.7 | \$56.7 | \$58.1 | \$60.2 | \$62.3 | \$64.5 |
| Aged | \$486.7 | \$492.0 | \$498.3 | \$505.1 | \$511.2 | \$517.8 | \$524.1 |
| Blind/Disabled | \$1,491.4 | \$1,526.7 | \$1,565.8 | \$1,609.3 | \$1,648.5 | \$1,692.2 | \$1,736.4 |
| TANF | \$1,490.2 | \$1,517.5 | \$1,566.9 | \$1,618.2 | \$1,671.4 | \$1,726.5 | \$1,783.6 |
| Pregnant Women | \$150.1 | \$152.3 | \$156.0 | \$159.8 | \$163.8 | \$167.8 | \$171.9 |
| All Other | \$33.3 | \$34.0 | \$35.2 | \$36.4 | \$37.6 | \$38.9 | \$40.2 |
| Total Savings | \$ 3,704.8 | \$ 3,777.2 | \$ 3,878.9 | \$ 3,986.9 | \$ 4,092.6 | \$ 4,205.5 | \$ 4,320.7 |

- Savings assumptions driven by care coordination and management
 - Serve to reduce trends on both utilization and cost per service
 - More efficient place of service

Estimated savings

- Projected \$332 million of state and Federal savings over the 6-year projection period
 - \$133 million of state funding based on current 60% FMAP
 - Not included is additional savings attributable to ABD population to managed care (projected \$350-400 million on state and Federal basis)
- Savings assumptions ramp-up over time
 - Expectation is that ultimate savings are not achieved in year 1
- Concept is increasing the degree of healthcare management
- Developed savings are on a net basis when considering claims and administration cost for RCOs
 - Expectation that additional state administrative costs will absorb some of these savings to facilitate development, monitoring and evaluation of program

Assumptions behind savings

- Utilization changes driven by:
 - Reductions in hospital admissions and ER visits
 - Replacing facility claims with office/urgent care visits
 - Increase in preventive care
 - Adherence to prescription drug treatment
- Cost per service changes driven by:
 - Lower negotiated reimbursement
 - Value-based payment methodologies
- Consistent with managed care results observed in other Oklahoma programs and other state Medicaid programs

Link back to High-Cost populations

- Reviewed experience in Medicaid population for patients diagnosed with diabetes, hypertension, or behavioral health condition
 - Mapping based on same methodology utilized in high-cost services report
- Compared experience for diabetes and hypertension to OHCA produced reports
 - Lower number of individuals identified, but cost relativities are similar
- Comparison to relativities illustrated in prior Milliman report
 - Indicates higher relative cost when considering all patients and expenditures (based on SFY 2014 data)

| Population | PMPM | Cost Relativity |
|-------------------|---------|-----------------|
| Diabetes | \$1,611 | 409% |
| Hypertension | \$1,510 | 383% |
| Behavioral health | \$882 | 224% |
| General | \$394 | 100% |

Projection of RCO impact on EGID

- Received updated claims information in early March
- Reviewing and discussing data with OSDH and OMES
- Anticipate similar analysis to Medicaid program
 - Specific to EGID covered populations (HealthChoice and HMO)
- Baseline expenditures and enrollment smaller on EGID population

Discussion and Next Steps



Next Steps

- Incorporate today's comments into financial analysis
- Distribute financial analysis

