Oklahoma State Innovation Model (OSIM) Design Plan
Tribal Consultation

January 28, 2016 10:00 am – 12:00 pm
College of the Muscogee Nation
2170 Raven Circle, Okmulgee OK 74447

Purpose of Tribal Consultation: This comprehensive model design plan focuses on the improvement of statewide health outcomes through multi-payer and healthcare delivery system innovation and redesign, while integrating evidence-based population and clinical interventions. The goal of the Oklahoma State Innovation Model (OSIM) is to provide state based solutions to Oklahoma's healthcare challenges. Oklahoma's plan aims to improve health, provide better care and reduce health expenditures for more all Oklahomans.

The purpose of this tribal consultation is to present the proposed OSIM value based model and receive tribal nation input and feedback. This information will be used to better refine and develop the OSIM model for the final proposal to be submitted to Centers for Medicare and Medicaid Services in March 2016.

Invited Participants: Oklahoma Elected Tribal Officials and Tribal Health Directors and Staff

Discussion Highlights:

- **Welcome**
  Dr. Vark, Interim Secretary of Health, Muscogee Creek Nation
  James Floyd, Principal Chief, Muscogee Creek Nation

- **Introductions and Purpose of Meeting**
  Julie Cox-Kain, Deputy Secretary of Health and Human Services, Senior Deputy Commissioner of Health, Oklahoma State Department of Health

- **Oklahoma State Innovation Model Plan Review**
  Catherine (Alex) Miley, Project Director, State Innovation Model Project, Oklahoma State Department of Health

- **Tribal Nation Input and Comments**
  Julie Cox-Kain

- **Adjournment**
  Dr. Vark

Tribal Consultation Summary

At 10:00 a.m., Dr. Larry Vark, Interim Secretary of Health for the Muscogee Creek Nation, opened the session by welcoming the group and introducing the outcome-based model of healthcare payment reform. He then turned the session over to Ms. Julie Cox-Kain, Senior Deputy Commissioner for the Oklahoma State Department of Health.

Ms. Cox-Kain thanked the participants for their time and welcomed everyone on behalf of Dr. Terry Cline, Commissioner of Health and Secretary of Health and Human Services for the State of Oklahoma. She provided a brief background and overview of the OSIM design plan to pay for outcome and quality across multiple systems and providers. The Oklahoma State Department of Health (OSDH) is about 13 months into the planning process and with about two months left before finalizing the plan. The purpose of today's consultation is to get tribal input before the plan is finalized. OSDH embraces an open stakeholder process and wants everyone to have opportunity for input. Ms. Cox-Kain encouraged everyone to speak openly during the session or speak individually with the state afterwards if they wish.

Ms. Cox-Kain thanked Dr. Vark and Principal Chief James Floyd of the Muscogee Creek Nation for hosting the session. She iterated that tribal consultations are critical to improving population health in Oklahoma. Ms. Cox-Kain then recognized and introduced Mr. Brian Hendrix, Deputy Assistant of Native American Affairs for the State of Oklahoma. She then introduced Ms. Catherine (Alex) Miley, OSIM Project Director for OSDH.

Ms. Miley introduced the OSIM grant and provided background information and an overview of the current progress of the plan (see attached presentation). Ms. Miley reinforced how important stakeholder engagement is and defined the stakeholders involved. She also introduced the concept of the Communities of Care Organizations (CCO) around which the plan would focus.

QUESTION: Will the tribes themselves would be able to form a CCO?

ANSWER: Ms. Cox-Kain replied CCOs are intended to be constructed around flexibility for different areas of the state. Anyone who can assume risk or form a partnership with someone who could (e.g. a commercial insurer), then yes the tribe could indeed become a CCO itself. The question that the state is considering at this time is the overlapping geographic CCOs. CCOs could be implemented as single-region, multi-region or overlapping. Given the investment tribes make to healthcare and public health it is important to get tribal input on this matter.

QUESTION: Clarification on certification for CCOs was requested.

Ms. Cox-Kain replied that CCOs have to be certified because the state has to make sure these organizations can bear risk. It is also necessary to meet federal regulations for Medicaid.

QUESTION: How will the OSIM plan work with patient eligibility being restricted to tribal populations for certain providers?

Ms. Cox-Kain reiterated the need to address both closed and open systems.

A comment was made that tribes are in a very good place to stand up as a CCO because many resources are already in place. Tribes should be included.

Ms. Cox-Kain responded that again, the state needs to structure this considering the fact that tribes may want to be CCOs themselves. Appreciation for these comments was expressed and she reiterated just how important tribal consultation is in order to get this feedback.

QUESTION: Will participation be mandatory for any groups or tribes? Will participation be mandated for Medicare providers?

Ms. Cox-Kain replied that both Medicare and Blue Cross and Blue Shield have indicated moving towards value-based insurance design and have already set some benchmarks. Some healthcare systems would fit in both camps. By moving Employees Group Insurance Division (EGID) and Medicaid to value based system the potential is 55.1 percent to move to block together and create transitional payment structures to mitigate the extremity of the switch. The goal is to move Medicaid and EGID to be 80% value based insurance design, but it has not been discussed yet as to whether tribes would be included in this 80%.

QUESTION: How will attribution models affect tribal services provided to Medicaid patients participating in the model through private practices elsewhere in their community? How does this affect payments in model versus out of model?

Ms. Miley responded that the attribution model would be affected if there was more than one CCO in the region. This goes back to how CCOs should be structured regionally. There is no attribution model just yet. This would have to be further developed down the road.

A comment was made that tribal sovereignty needs to be protected if tribes are to participate in the CCO structures.

QUESTION: Will certain aspects of the COO conflict with the ways tribes manage their healthcare system? Regarding the portion describing inappropriate denials for example, tribes have to deny a number of things because perhaps there is no contract in place for a referral. Right now the tribes decide the outcomes of the appeal process. Who would decide this under a CCO?

Ms. Cox-Kain noted that CCOs need to include tribes in order to navigate tribal sovereignty and governance issues.

A comment was made that health services may be denied based on financial reasons and not necessarily medical reasons. Another layer of complexity is introduced when considering what tribes people belong to and usually when something is referred out to purchased and referred services/contract care the

tribes do not always have control over the reason for the denial. Another consideration is where the patient lives; which impacts tribal jurisdiction.

A comment was made that attribution models get very complicated with tribes due to the many types of healthcare systems interwoven throughout tribal health programs like compacting tribes, direct service tribes and self-governance tribes. Many tribal members go to various tribal clinics and some tribal members even drive out of state to see specialists.

Commendation was expressed by the tribes to the state for trying to work through these complex issues.

Ms. Cox-Kain expressed that the state needs governance feedback. Tribal governance at the highest levels is needed to talk through these governance and sovereignty issues.

Will this plan work with Indian Health Service (IHS) which adds another layer and more oversight? The trust responsibility for IHS to provide care also may conflict with tribal interpretations of trust the responsibility of the federal government. For example, 100% Federal Medicaid Assistance Percentage (FMAP) is a reflection of this trust responsibility.

Ms. Cox-Kain mentioned that the Insure Oklahoma Sponsor Choice Waiver amendment may mitigate some of these examples but the state will need to figure out how to use any ground gained in those negotiations to bring in trust responsibility to the OSIM.

Ms. Cox-Kain then solicited comments regarding local governance and CCOs.

QUESTION/COMMENT: A participant mentioned that there are complexities getting IHS sites involved and getting the federal government to assume some risk. Perhaps federal sites will be excluded but as you get more local then the discussion goes back to what, exactly, that local governance does and the type of risk that has to be shared locally in these communities. Some of the same issues discussed earlier arise when considering local governance too.

Ms. Miley responded that it again depends on whether the system is open or closed (serving tribal versus non-tribal).

QUESTION/COMMENT: A comment was made that some tribal nations may only see tribal patients while others may see all patients. This adds complexity because health care funding must be carefully monitored in these open clinics because IHS funds may only pay for Native Americans and certain Tribal funds are only allocated to Tribal citizens. There is also a great diversity between population groups creating vast difference in goals of services in rural and urban communities. How will IHS and closed tribal health facilities be integrated this into CCOs?

Ms. Cox-Kain replied that the state needs to look further into this and get a better picture of how to integrate IHS and tribal delivery systems into the OSIM design.

Ms. Miley then solicited Health Information Technology (HIT) questions or comments? The goal is for OSIM to be interoperable across the state.

QUESTION: What platform will be used for implementing interoperable HIT across the state?

Ms. Cox-Kain responded that a HIT plan is also being developed in conjunction with the OSIM model development. It is difficult because numerous Health Information Exchanges (HIE) and the model is being designed around the fact that more than one option exist. This system will have a single state portal for providers. If HIEs can each connect to the state system then everyone would be connected and providers could work with any HIE.

QUESTION: What will be the cost of the HIE?

Ms. Cox-Kain replied that this could be built in to Global Payments.

Ms. Miley stated that other agencies are implementing requirements to be connected to an HIE. The goal is for everyone to be connected to an interoperable HIE and these systems would be sustained through Global Payment and Capitation payments towards maintaining the networks and HIEs.

Ms. Cox-Kain stated that members participating in CCOs would be required to provide data for the state to assess whether metrics are being met. She then asked for comments regarding this aspect of the plan.

QUESTION/COMMENT: A participant commented that it is unlikely that IHS would go to either HIE in the state but that is not certain. This would leave a large population out and the state needs to bring in other federal programs like IHS and Veterans Affairs (VA). Additionally, tribes have numerous reporting requirements and if OSIM were to align quality metrics with other reporting standards it would help significantly.

Ms. Cox-Kain responded that the goal is to align quality metrics across payers in Oklahoma.

Ms. Miley stated that the state has mapped the metrics across multiple systems. The OSIM is also connecting the HIE plan with the VA, the Department of Defense and other federal partners but I.H.S. needs to be looked into to see if they would be able to participate.

QUESTION/COMMENT: A comment was made that data collection and community-based quality measures are left out of IHS Resource and Patient Management System (RPMS). This model may not support robust data exchange and needs to be looked into further in regard to Health Information Technology (HIT).

Ms. Cox-Kain is looking into the best way to implement interoperability. The goal is to also allow HIEs from other states to connect with Oklahoma.

Ms. Cox-Kain went on to summarize some of the common themes and main takeaways discussed thus far in the session:

- Tribal health systems are overlapping and complex requiring the use of contract care both in and out of state, federal resources and assets as well as tribal resources and assets, and policies exist that are either dictated by sovereignty or by a lack of resources required to provide full comprehensive care. The OSIM does not address these complexities and issues so the team needs to revisit these concerns with more tribal involvement.
- Additionally, tribal sovereignty is complicated and serious enough that representation is needed at all levels of tribal government to work through these issues. The trust responsibility of the federal government also needs to be considered and how this would flow through the CCOs needs to be worked out.
- Another major issue that needs to be addressed is the attribution models for tribal health care in and among CCOs.

COMMENT: In regards to attribution, with a risk-based model issues arise with tribal citizens that can go anywhere for their healthcare. Tribal citizens don't want to be restricted to a network. Risk based funding going between CCO networks needs to be considered. Who gets Global Payment? Anything that can reduce the current OMB rate will need to be carefully navigated. This could be a hard sell for many tribes.

Ms. Cox-Kain mentioned that benefits could be built in for achieving quality outcomes. Again, the plan needs to maintain the federal government's responsibility to provide care for tribal members.

Ms. Miley went on to explain the quality metrics being considered.

QUESTION/COMMENT: Regarding the clinical metrics and if this would include HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems Patient) or CAHPS type of scoring.

The requirements for CG-CAPS (The Clinician and Group Consumer Assessment of Healthcare Providers and Systems) should be coming soon and many tribes may already be doing this or a version of this. Everyone will likely need to do a CG-CAHPS type of survey soon.

Copies of today's consultation were requested and Ms. Sally Carter, Tribal Liaison with the Oklahoma State Department of Health, will send out the presentation as well as the meeting minutes to participants. All tribal consultation minutes are also posted on the OSDH website per OSDH Tribal Consultation Policy 1-39.

QUESTION/COMMENT: A comment was made that the IHS threshold for NQF 0059 (Comprehensive Diabetes Management/Diabetes Poor Control) is lower than the national goal. This may need to be considered.

Ms. Miley mentioned that benchmarks will be tailored regionally.

QUESTION/COMMENT: A participant mentioned that benchmarks need to be carefully considered because of the vast regional disparities. Many of these metrics require vast resources that some communities simply don't have. Urban versus rural communities needs to be considered when developing these metrics.

Ms. Cox-Kain reiterated that there needs to be local input and that OSIM is considering the fact that models implemented in metropolitan areas are not necessarily scalable to rural communities.

QUESTION/COMMENT: Regarding social determinants being used for patient noncompliance. The onus is being placed on providers with patient responsibility not being considered. Sometimes patients are simply noncompliant. We need to be careful not to punish providers. For example, some patients are hesitant to take western over traditional medicine and the provider may not be able to impact this decision. There are a variety of reasons patients are noncompliant and providers often have no control over this.

Ms. Cox-Kain noted that ceremonial versus commercial tobacco needs to be considered. More broadly, culture and tradition needs to be considered. The problem of environmental and social determinants of health is what OSIM hopes to resolve. She acknowledged that barriers exist at the individual level that lay beyond the patient-provider interaction. As a community (CCO) people need to come together and address some of these underlying social issues. She reiterated that this plan and these metrics hope to mitigate some of these social determinants.

Ms. Miley also mentioned that OSIM may consider patient responsibility by perhaps looking at two different levels, for example. Do patients have factors that lead to noncompliance? This could be considered and factored into the metrics.

QUESTION/COMMENT: A comment was made that Electronic Health Records do not recognize text, like social determinants and factors for noncompliance. Barriers to care are difficult to categorize.

QUESTION/COMMENT: A question was asked regarding whether the state would supply tools for evidence based models and the resources to bring these to the clinics.

Ms. Miley iterated that the CCOs will need to provide these tools and resources to providers. Practice transformation centers would be implemented to assist providers with the transformation. The goal is to have a center to leverage and support initiatives.

Ms. Miley then outlined the 'Episodes of Care' payment method of the plan. This helps to contain cost and improve quality.

Ms. Cox-Kain reminded participants to complete the evaluation forms and submit any questions in writing to the OSDH Tribal Liaison.

Hearing no comments regarding the 'Episodes of Care' overview, Dr. Vark closed the session by graciously thanking the Muscogee Creek Nation staff, the Oklahoma State Department of Health and everyone else in attendance for their time and input. The meeting was adjourned at 12:00 p.m.

At the end of tribal consultation the following written questions were submitted:

- Will tribes be included in the goal of 80% CCO participation?
- Will the model reflect the trust responsibility of the Federal Government?
- Will the model allow for tribal governance of a CCO either alone or in partnership?
- How will the tribes be affected by the attribution model?
- Will the model adjust payments for rural areas?
- How will the resources that are available to patients to utilize in one region be taken into account when judging the results of patient outcomes? The resources available to patients in Okemah are not as great as those for our patients in Koweta; this will affect the outcomes of health for some of those patients – who can this be judged fairly for the providers?
- By developing CCO's will more services be available to tribal members?
- Will this eliminate the need for contract health/purchase and referred services?
- How will this affect the tribal urban clinics?
- With a global system, will the reimbursement rates for tribal agencies change?
- How will you coordinate with Indian Health Service on this model?
- If we move to this model, how will the OHCA be integrated?
- How will this be funded?
- How will the payment structure (AIR) change for those of us who are IHS/Tribes/Urban clinics/facilities?
- Will this new program fall in line with the CMS VBP program we are already subjected to?
- Have we done any projections on standing the model up and the impact it will have on Oklahomans? If so may we receive a copy?
- Attribution models with tribes need to be well understood by the Health Department and considered. Please remember that many of our patients are from out of state.
- In regards to quality measures, please align with CMS measures as best you can.
- Caution – tribal OMB rates and payment structure does not cost our state except for administration costs.