

OHIP/OSIM Health Finance Meeting  
July 17, 2015  
Meeting Minutes

1. **Introductions:** Isaac Lutz will now be the project manager for the Health Finance work group. His email is [isaacl@health.ok.gov](mailto:isaacl@health.ok.gov) and phone is (405) 271-9444 ext. 52542 Jennifer Kellbach will still be assisting with meeting set ups, reminders, and communications.

A. In attendance: A. Hemani-Harris (OSDH), J. Rose (OSDH), B. Hancock (Community Care), B. Wilborn (OKPCA), L. Fleet (OAHP), P. Cross-Cupit (Health Alliance for the Uninsured), K. King (OK State Medical Assoc.), A. Miley (OSDH), I. Lutz (OSDH), M. Fenrick (OSDH), J. Kellbach (OSDH), J. Fairbanks (OSDH). Via Webinar: T. Harris (Milliman), J. Rogers (Milliman), F. Lawler (EGID), R. Snyder (OHA), J. Castleberry (OSDH), K. Duncan (Dewberry), M. Doescher (OUHSC), T. Cupps (St. John), A. Paul (St. John), M. Gower (Chickasaw Nation)

2. **OSIM Update**

A. Slide 7 of the presentation discusses the deliverables being vetted by the other OHIP/OSIM workgroups.

- All documents (once finalized) will be available on the OSIM website ([osim.health.ok.gov](http://osim.health.ok.gov)).
- Each workgroup has its own page on the site with comment boxes.
- Comments can be submitted through these boxes or sent directly to Alex ([catherineam@health.ok.gov](mailto:catherineam@health.ok.gov)) or Isaac ([isaacl@health.ok.gov](mailto:isaacl@health.ok.gov))

3. **Deliverable Review and Discussion: Market Effects of Health Care Transformation**

\*Note: these slides outline the key findings from the reports and are NOT the final versions. The workgroup is encouraged to review and provide guidance to Milliman for the final version which will be available for the group in the next week.

A. **Slide 5:** Questions related to data on “other government” insurance coverage – Indian Health Service is not a form of insurance – Milliman will need to investigate further and clarify in the report. [Milliman stated there is a separate section in the report on the AI/AN population.](#) Melissa Gower offered to [review that section and](#) assist with any questions related to the American Indian population in Oklahoma.

B. **Slide 7**

1. Are self-insured plans Federally regulated (i.e. ERISA and ability to get more info about market share and utilization)?
2. Census and MLR data are reported to CMS – this chart did not include getting data from insurance carriers

C. **Slide 8**

1. Questions regarding the number of uninsured Oklahomans – other reports have conflicting numbers.

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2. Isaac will share a source related to the individual mandate's effect in getting newly insured into the FFM and its effect on the uninsured rate to Milliman
- D. Slide 9:** Isaac – provide surveys and analysis on enrollees who had different coverage and switched and were not uninsured getting coverage for the first time.
- E. Slide 10:** 126,000 – selected a plan but not necessarily paid premium; need effectuated and pre-effectuated data
- F. Slide 13**
1. Why is the Medicaid population for 100-199% so much higher? Potentially driven by women and children?
  2. Need to look into where data for 200%+ for Medicaid came from – Medicaid coverage only goes to 185%FPL
- G. Slide 20:** Can COPD be included in the chronic condition analysis?
- H. Notes from workgroup on Market Effects Presentation**
1. Ken: need to review networks in the new market as the narrowing of the markets may be driving some people back to traditional insurance plans. An example from Florida is one FFM plan has one surgeon for the entire state. Perception can impact willingness to participate in FFM plans. Milliman can address this in their report.
  2. Premium increases and high deductible plans are also an issue for individuals enrolling in FFM plans. Although they technically have coverage, it is too costly to use.
  3. Need to clarify the definition of small group insurance – those size employers approach benefits differently than other employers. The same is true for large group.
  4. SIM tie-in: Market analysis – who is utilizing a value-based model? How does the state get more lives covered under value-based models? The goal is for 80% of lives to be covered by value-based options.
    - a. How will value-based implementation change the insurance market in Oklahoma?
    - b. Do any group members have additional data or better data sources that could assist with this analysis?
  5. EGID is looking into bundled service options to save and increase value-based options.
  6. Effect on concierge medicine? While this is not considered insurance, it is increasing in popularity. Can this be tracked?

#### **4. Deliverable Review and Discussion: Healthcare Delivery Models**

- I. Slide 3: no data is available for savings due to ACOs yet in Oklahoma.
- J. Slide 4
  1. Milliman – please add notation to the ACO section of the final report to distinguish ACOs as a Medicare shared-savings program
  2. Ann noted that there are several ACO plans in bordering states that included covered lives from Oklahoma, but are not based in OK – the report should acknowledge this also.
  3. Ken noted that we also need to acknowledge that the ACO model is dynamic and something to watch in OK as we anticipate more to start up in coming years

- K.** Slide 6 – note that St. Anthony is currently only operating in OKC metro area; the other dots on map are for their Clinically Integrated Organizations
- L.** Slide 7
  - 1. 2014 data from St. John will be available in the next 2-3 months – it has to be submitted and released by CMS first.
  - 2. St. John will be the only ACO with OK state data being published in 2015
  - 3. Milliman – please note that St. John goes by Oklahoma Health Initiatives
  - 4. Ann noted that the ACO names need to be used by their formal, legal name rather than by the health system that supports them
- M.** Slide 8 – will need to clarify St. Anthony providers denoted on map since the ACO program is based in the OKC metro and some of the providers on the map may be involved in different programs not affiliated with the ACO.
- N.** Slide 10 – Selection criteria for the states in the analysis was based on region, commonalities with OK related to Medicaid expansion (or not) and use of the FFM over a state-based exchange.
- O.** Slide 12 – Reason why OK may have lower population in MA plans – due to most MA plans being restricted to the metro areas and a large population living in rural areas without access to these plans. Comment was also made that most HMOs are only the in the metro area as well.
- P.** Slide 13 – Isaac noted that the final report may include reason why BPCI models 1 and 4 are not being utilized in Oklahoma.
- Q.** Slide 15
  - 1. Milliman – please define bundled payments and BPCI to differentiate the two for the readers of the report
  - 2. Other Bundled Payment models in the state?
    - a. CMS bundled payment for post-acute care – need to determine if this is the same as already described and if not, if it is occurring in OK
    - b. Comprehensive care for joint replacement project – OKC Metro area included in the proposal
- R.** Slide 16
  - 1. Milliman is still conducting interviews related to these models
  - 2. Need to add concierge medicine as a deliver model here
- S.** Slide 17
  - 1. Oklahoma does not put Medicaid members into and HMO, this may be the reason why we have lower enrollment compared to other states
  - 2. Milliman – please check on number of HMOs in the state, 31 seems too high
- T.** Notes from workgroup on Healthcare Delivery Models Presentation
  - 1. All current ACOs in Oklahoma are at large Catholic systems and are very different. How will we compare because state programs are so different? Something to consider when data becomes available.
  - 2. How are we accounting for dual eligible?
    - a. Some CMS programs are – Milliman is unsure of these are currently in OK

b. Tahlequah ([Cherokee Nation](#)) has a PACE program and there is also one in Tulsa

c. Duals are excluded from SoonerCare Choice \*include in report – 1566 for ABD population care coordination program

3. Should we include FQHCs as a delivery models? Brent can assist in expanding on what they are and do; they are currently working on a data warehouse.
4. Delivery Models – need to take into consideration how disparate systems are working together and organized; current programs are willing systems coming together to create models; need to consider how to separate payments and incentives throughout the system. What is being done in OK? Scaling? Urban v. rural majorly impacts models.
5. Mark – AHRQ grant for healthy hearts for primary care to have practice facilitators at the county level to provide care coordination.
  - a. Need to look into these models specifically for implementation in rural areas (Kingfisher County). Need to provide information on this program to Milliman.
6. Care delivery and payment models are critical to OSIM and working towards a value-based system.
  - a. Need to consider how people are attributed to models – who is accountable for costs and outcomes?
  - b. More detail should be available in the coming months.

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#### 5. Upcoming Meetings

-**July 24** meeting is cancelled – this will be rescheduled for August 4 or 6 – communication will be sent out to see which date works best for the group.

-**August 13** – statewide webinar. All workgroup members should have received call-in information, this information is also available on the OSIM website at [osim.health.ok.gov](http://osim.health.ok.gov)

-**August 28** – Joint meeting with the Health E&E workgroup to go over the High Cost Services deliverable. Note: This meeting will be held at the Oklahoma Health Care Authority – meeting location information can also be found at [osim.health.ok.gov](http://osim.health.ok.gov)