



Oklahoma State Innovation Model (OSIM) Design Plan Tribal Consultation

**March 23, 2016 10:00 am – 12:00 pm
Carl Albert Service Center
1001 N Country Club Rd
Ada, OK 74820**

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 all Oklahomans.

The purpose of this tribal consultation is to present the proposed OSIM value based model plan and receive tribal nation input and feedback. This information will be used to better refine and develop the OSIM model plan for the final proposal to be submitted to Centers for Medicare and Medicaid Services on March 31, 2016.

Invited Participants: Oklahoma Elected Tribal Officials and Tribal Health Directors and staff, and interested Tribal partners, state agencies and community representatives.

Discussion Highlights:

- **Welcome**
Dr. Judy Goforth Parker
Secretary of Health, Chickasaw 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 Brief Refresher**
Catherine (Alex) Miley, Project Director, State Innovation Model Project, Oklahoma
State Department of Health
- **Alterations to the Model Plan As a Result of Previous Tribal Consultation**
Joseph Fairbanks, Director, Center for Health Innovation and Effectiveness,
Oklahoma State Department of Health
- **Tribal Consultation, Feedback and Comments**
Julie Cox-Kain
- **Adjournment**
Dr. Judy Goforth Parker



Participants

NAME		TITLE	ORGANIZATION
CJ	Aducci	Executive Officer	Chickasaw Nation Department of Family Services
James	Allen	Director, PHI	Oklahoma State Department of Health
Sally	Carter	Tribal Liaison	Oklahoma State Department of Health
Andie	Chan	Strategic Planning Coordinator	Oklahoma State Department of Health
Julie	Cox-Kain	Deputy Secretary of Health and Human Services	Oklahoma State Department of Health
Kymberly	Cravatt	Assistant General Counsel, Legal Division	Chickasaw Nation
Todd	Crawford	Executive Director	Chickasaw Nation
Shannon	Dial	Executive Officer, Integrated Services Division	Chickasaw Nation Department of Family Services
Michael	Echelle	Regional Health Director	Oklahoma State Department of Health
Paul	Emrich	Under Secretary	Chickasaw Nation
Joe	Fairbanks	Director, CHIE	Oklahoma State Department of Health
Melanie	Fourkiller	Policy Analyst	Choctaw Nation
Melissa	Gower	Senior Policy Analyst	Chickasaw Nation
Keri	Harjo	Clinic Manager	Citizen Potawatomi Nation Health Services
Brian	Hendrix	Deputy Assistant of Native American Affairs	Secretary of State & Native American Affairs
Renee	Hogue	Resource Management Manager	Chickasaw Nation Department of Family Services
Johnny	Johnson	Tribal Government Relations	Oklahoma Health Care Authority
Carrie	Law	Executive Officer of Hospital and Clinical Excellence	Chickasaw Nation



NAME		TITLE	ORGANIZATION
Catherine	Miley	Project Director, OSIM	Oklahoma State Department of Health
Dana	Miller	Director, Tribal Relations	Oklahoma Health Care Authority
Yvonne	Myers	Medicaid Consultant	Citizen Potawatomi Nation Health Services
LeAndrea	Nez	Tribal Liaison	Oklahoma Department of Mental Health and Substance Abuse Services
Laura	Nickell	Executive Officer of CNMC Clinics	Chickasaw Nation Department of Health
Judy	Parker	Secretary of Health	Chickasaw Nation
Tracie	Patten	Area Pharmacy Consultant	Indian Health Service
Brenda	Potts	Regional Administrative Director	Oklahoma State Department of Health
Kelli	Radar	Regional Administrative Director	Oklahoma State Department of Health
Mark	Rogers	Executive Director of Health	Absentee Shawnee Health System
Carmelita	Skeeter	Chief Executive Officer	Indian Health Care Resource Center of Tulsa
Heather	Summers	Under Secretary of Hospital Operations	Chickasaw Nation
Robyn	Sunday-Allen	Chief Executive Officer	Oklahoma City Indian Clinic
Melpherd	Switch	Medical Board Director	Absentee Shawnee
Brenda	Teel	Executive Officer of Revenue	Chickasaw Nation
Kari	Thorton	Contract Health Coordinator	Citizen Potawatomi Nation Health Services
Marla	Throckmorton	Clinic Administrator	Absentee Shawnee Health System
Marty	Wafford	Under Secretary	Chickasaw Nation Department of Health



NAME		TITLE	ORGANIZATION
Stephen	Weaver	Program Consultant	Oklahoma State Department of Health
Terry	Withrow	Business Manager	Citizen Potawatomi Nation Health Services
Billie	Womack	Special Assistant	Chickasaw Nation

There were 39 people in attendance.

Consultation Summary

At 10:00 am Dr. Judy Goforth Parker opened the meeting by welcoming the participants and thanking them for their time. She thanked the Oklahoma State Department of Health for the partnership and the opportunity for tribal consultation.

Ms. Sally Carter, Tribal Liaison for the Oklahoma State Department of Health, thanked the participants for their time and feedback and expressed sincere gratitude for the many partnerships and initiatives that the tribal nations around the table have engaged with the Oklahoma State Department of Health. Ms. Carter reminded participants that there is a written comment section on the website for input and feedback regarding the OSIM plan design.

[https://www.ok.gov/health/Organization/Center for Health Innovation and Effectiveness/Oklahoma State Innovation Model \(OSIM\)/](https://www.ok.gov/health/Organization/Center%20for%20Health%20Innovation%20and%20Effectiveness/Oklahoma%20State%20Innovation%20Model%20(OSIM)/)

Ms. Catherine Miley, OSIM Project Director for the Oklahoma State Department of Health, gave an overview of the Oklahoma State Innovation Model plan design and Mr. Joe Fairbanks, Director of the Center for Health Innovation and Effectiveness for the Oklahoma State Department of Health, provided an overview of the changes that were incorporated based upon initial tribal feedback.

QUESTION: Will there be a Request for Proposals for the Regional Care Organizations (RCOs) outlining the requirements and providing more details? More specifically, what will the requirements be for an RCO regarding the financial aspect and cash reserves?

Ms. Miley responded there is no set cash reserve requirement yet. Mr. Fairbanks mentioned there will be RCO certification criteria. The RCO will have to be certified by the state and financial reserves will be included in these guidelines. There is no number set currently.

The most recent version of OSIM is online for review.



QUESTION: How will the quality criteria be determined? Tribes must report quality measures/outcomes to numerous organizations. Standardization across this spectrum would increase efficiency and significantly reduce financial and administrative burdens on the tribes.

Ms. Miley responded the measures are being crosschecked against already established common measures and that the OSIM team will be working on developing quality metrics around the highest impacts on health outcomes.

QUESTION: What are the Quality Improvement Organizations (QIO) on contract?

Ms. Miley responded the Texas Medical Foundation (TMF), which services Texas, Oklahoma and Kansas is the organization on contract with the state and they are working closely with the OSIM team around developing these metrics. A 'metrics committee' is also being established to assist with this process.

QUESTION/COMMENT: Reiterated cross measures being considered would be very helpful. Tribes are I.H.S. providers so if OSIM could include GPRA metrics it would be very beneficial to the tribes.

Ms. Miley mentioned that the Government Performance and Results Act (GPRA) Public Law 103-62 is being considered and the OSIM team would like to go back out to tribal consultation for the metrics and will also seek tribal representation on the 'metrics committee'.

QUESTION/COMMENT: Veterans Affairs (VA) should be considered in quality measures as well. Tribes can bill the VA for services to veterans as long as VA quality metrics are met.

Ms. Miley responded provider burden is a concern and there is a need to reduce and address this burden. Standardization will be critical.

QUESTION: How will RCO structure impact Medicaid? For example, if a tribal member on Medicaid opts in to the RCO but the tribe does not contract with an RCO, does the tribal member have a choice on where to receive services?

Yes.

QUESTION: Will reimbursement be impacted at that point and would the burden be on the tribal facility? If the tribe does not contract with the RCO will they have access to the Health Information Exchange (HIE)?

Mr. Fairbanks replied the reimbursement will not be affected. If a tribal member receives services through an RCO the tribe would still receive the OMB Rate. In regards to the data sharing piece, this is where interoperable systems will be critical.



Ms. Miley replied the tribe would have access through HIEs that they already belong to or they would have the option to join one. The RCO may provide additional analytics or other data sharing opportunities that the tribe would not have access to if not involved with the RCO.

QUESTION: Is there an anticipated number of RCOs to be established?

Mr. Fairbanks responded there is no way to anticipate this at the moment. The first step is determining logical regions to divide the state into (population, natural health referral pathways, etc.). Oregon has implemented this model, and with a similar population to Oklahoma has 16 RCOs. Sometimes there are multiple RCOs within the same region.

Ms. Julie Cox-Kain mentioned if tribal business arms are interested then that would also impact the number of RCOs in Oklahoma.

COMMENT: With overlapping areas, there could be multiple RCOs for tribes to contract with in order to participate. This is adding another layer complexity and burden on tribes.

COMMENT: Patient impact needs to be considered and how this will affect tribal providers. If patients may have they option of closer or more convenient providers under the RCOs they may not go to the tribe for care.

COMMENT: Historic trauma needs to be considered. Native Americans are hesitant to engage in agreements with governing bodies. Skepticism persists today. The Indian health care system is evolving and becoming more and more advanced. Tribes are now able to hire a highly skilled workforce with experience and education to help the Indian systems. Quality of tribal health programs/systems has dramatically increased.

QUESTION/COMMENT: Is the 'Opt-in Model' just for Medicaid or will public employees be included?

Mr. Fairbanks replied 'Opt in Model' is just for the Medicaid population.

QUESTION/COMMENT: Gratitude was expressed to OSDH for incorporating tribal concerns into the plan. It was mentioned the definition of "Tribal Health System" needs to include Indian Health Service (I.H.S.) and the urban clinics. Would I/T/U's still have the ability to receive reimbursement from the Oklahoma Health Care Authority (OHCA) even if the tribal member goes to an RCO?

Additionally, referrals for specialty care need to be considered. Crossing network lines is a concern. We don't want patient care to be disrupted (i.e. have to go to a different RCO to see a specialist.)



There are also special considerations surrounding conditions for participation (sovereignty, law applicability such as federal or state, forums for disputes, etc.) that need to be considered as possible barriers or issues that could arise when contracting with tribes or tribal entities.

Additionally, multiple payers need to be considered. Do these basic premises apply to these multiple payers as well?

QUESTION: Please elaborate on the Health Information Exchanges (HIEs). What is the vision for HIEs?

Ms. Cox-Kain responded that OSIM requires RCOs to participate with an existing HIE. There are currently two major HIEs in Oklahoma; “My Health” and “Coordinated Care Oklahoma (CCO).” The other piece to this is that the state has developed an interoperability system with a master person index allowing us to transmit data between the 5 largest Health and Human Services agencies. OSIM has not anticipated requiring any new HIE but is always an option in a “private-option state” where there is no requirement for a centralized HIE. The design is looking like if Medicaid and Employees Group Insurance Division (EGID) contract with an RCO, then metrics/data would be built in and the state could assess whether RCOs are meeting quality metrics. OSIM is not asking RCOs to develop new technology. It is expected that existing technology can be utilized.

QUESTION/COMMENT: A question was posed to the group regarding if tribes are connected to HIEs currently? Will OSIM and RCOs connect with I.H.S. systems?

Marla Throckmorton responded that Absentee Shawnee is receiving grant funding that will allow them to access an HIE.

Mr. Fairbanks responded that I.H.S. interoperability needs to be considered and will be discussed in a future discussion with I.H.S.

QUESTION/COMMENT: The OSIM draft requires RCOs to be licensed to sell insurance for the organization to bear actuarial risk. How will this work? Why is it necessary to be licensed to sell insurance?

Ms. Miley responded since an RCO is at actuarial risk to provide care to members within their region and within their budget. This technically makes them an insurer. The goal is to have RCOs local and at the community level. This means some may have trouble bearing this risk so local organizations may partner with a larger insurer who is more able to bear risk. The RCO could become certified themselves and take on the risk itself, keeping everything at the local level. Being certified as an insurance company means they have sufficient financial resources to assume actuarial risk.

Ms. Cox-Kain iterated the certification process will assure ability (reserve funds) to bear this risk. This insurance requirement will verify/assure that the RCO has actuarial risk. There may be a group of providers that come together with an insurer to form an RCO. There are multiple options.



QUESTION/COMMENT: Please elaborate on the Community Advisory Boards and what function they will serve.

Ms. Miley replied certifications for RCOs will list the requirements for composition of these boards. The majority of membership would be people served by the RCO. Community partnerships would be a part of the board as well. Members from the community partners will also be on the board. The goal is for these boards to be diverse and community engaged to be able to solve community problems.

Ms. Cox-Kain proceeded to discuss the model a bit further. With Oregon's 1115 waiver, CMS put Oregon at actuarial risk. What made it work was good governance, especially at the local level. Comments received from carriers indicate the social determinants of health are the biggest problems. What Oregon found is that by forcing this governance structure (bringing together housing, public health, and other community members) to sit next to the people bearing actuarial risk it draws connections and encourages people to work together to solve issues. Global payments are a concern as well. For example, housing is impossible to pay for under the current Medicaid structure unless a system like this is implemented. RCO's can help address these social determinants by funding housing, for example. This is why the model is structured the way that it is. It is the community bearing the risk and it gets everyone invested and interfacing with each other. It creates combined efforts instead of just one insurance company bearing risk and making all the decisions.

QUESTION/COMMENT: Has there been any discussion regarding RCOs being nonprofit vs for profit?

This has happened both ways in other states. RCOs will not be mandated either way.

QUESTION/COMMENT: Have any organizations shown interest in establishing an RCO?

Ms. Miley responded that there are 3 types of organizations: 1) Payers – have shown interest but local governance is a concern for them 2) Providers – want to retain power to make the decisions. Smaller and more rural providers are more hesitant. 3) Community Organizations - are excited about it because it allows them more access to the system and decisions.

Mr. Fairbanks added that there are also differences in opinions from payers. Some want to be RCOs while some would like to contract and work with RCOs. It really depends on the particular business model of the payer.

QUESTION/COMMENT: Will this be expanding beyond Medicaid? More team based payments, care etc.?

Ms. Miley replied that yes, the workforce workgroup has been considering this. It has been acknowledged that everyone is needed to be included to provide proper levels of care. Each RCO will have to have primary care strategy. Hurdles exist but can be overcome.



Mr. Fairbanks added the OSIM team is engaged with the health workforce committee on numerous initiatives. Part of this process was identifying future needs. The group identified 30 critical health occupations. Keeping in mind the transition to value-based is critical and will need a diversity of providers engaged. One example would be paramedic groups; do they have the potential and the time to help with chronic disease management?

COMMENT: Pharmacy is uniquely placed within the ITU system. Pharmacists can help with these interventions as well.

Ms. Cox-Kain replied the evidence supports pharmacy interventions. One requirement in the SIM model will be on a primary care focus but beyond those, the value-based models will be locally driven. A large element to delivering health care is local. We are considering scalability and this is why we want to stay local.

Discussion Question

Ms. Cox-Kain then posed a discussion question for the group:

- Did OSIM team accurately capture the main concerns of the tribes with the OSIM model?

COMMENT: Yvonne Myers reiterated that a greater definition of tribal health systems included in the plan. Additionally, I/T/U's should retain the right to receive payment from OHCA. The suggestion would be to change language to read "...right to be paid by OHCA..." Direct billing is an existing working system that works well and tribes want option to stay with that.

COMMENT: Mr. Fairbanks reiterated if tribes want to form their own RCO through their private enterprises then OSIM will need to consider sovereignty.

COMMENT: Private carriers – when making referrals to private providers they need to recognize existing networks and make sure patient services are uninterrupted.

QUESTION/COMMENT: Governing boards of RCOs need more clarification. We don't want to confuse with current I/T/U governing boards or service units.

QUESTION: Will the state plan define that RCOs can dictate accreditation/certification by outside organizations?

Mr. Fairbanks replied that locally there must be tribal representation when making this determination. OSIM is creating an 'administrative burden' task force. This task force will sort out accreditation and refine credentialing of providers. We will be looking into streamlining this across multiple systems for everyone.

COMMENT: All I/T/Us are currently accredited by multiple organizations but recent experience on the pharmacy side has revealed new accreditation measures may be required or dictated when contracting for services. This creates undue burdens.



QUESTION/COMMENT: If a tribe chooses to contract with an RCO will they be required to connect with an HIE?

Ms. Cox-Kain replied that on the conceptual design we need to include I.H.S. in addition to HIEs because, currently, RCOs are required to be attached to an HIE and have performance measures around interoperability and the number of providers exchanging information. There are requirements on the RCO to be connected as well as providers exchanging data in meaningful way. We need to go back and show I.H.S. as a separate HIE entity.

This is a State Plan, not waiver. This will naturally get more detailed as we go and everyone will have opportunity, through March 25th, to give comments through the websites or emails and phone calls to Ms. Miley. This is not a final discussion of the plan components. Healthcare transformation takes a long time and we will continue to discuss as we walk this path together.

We have had great conversations in many advisory groups and entities such as the Tribal Public Health Advisory Committee (TPHAC). OSIM will continue to engage TPHAC as well as other groups.

Ms. Cox-Kain thanked Dr. Parker for hosting the consultation and for her numerous partnerships. Dr. Parker closed out the session at 12:00 pm.