Oklahoma State Department of Health

Oklahoma State Innovation Model

Health Finance Workgroup

March 22, 2016

Health Finance Meeting Agenda

March 22st, 1:00-3:00PM
Oklahoma State Department of Health
Room 307

Section			Presenter
Welcome	**5 min**	**1:00**	**J. Cox-Kain**
Financial Analysis	**60 min**	**1:05**	**C. Pettit - Milliman**
Health Finance OHIP 2020 Goals	**20 min**	**2:05**	**I. Lutz**
State Health System Innovation Plan	**20 min**	**2:25**	**A. Miley**
Next Steps	**20 min**	**2:45**	**J. Cox-Kain**

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:
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Maureen Tressel Lewis, MBA

March 16, 2016

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Milliman

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.

Goal's 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

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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

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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

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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

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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)

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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	$33.3	$34.5	$35.8	$37.1	$38.5	$39.9	$41.4
Total Spend	$ 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

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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

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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 Spend	$ 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

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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

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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

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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%

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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

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Discussion and Next Steps

Health Finance OHIP 2020 Goals

OHIP 2020: Health Finance OHIP 2020 Goal and Objectives

Health Finance- Goal

- Transform healthcare payment models utilizing a multi-payer approach to create a value-based and sustainable healthcare system available for all Oklahomans.
  - Objective 1: Decrease the percentage of uninsured individuals from 17% in 2013 to 9.5% by 2020.
  - Objective 2: By 2020, limit annual state-purchased (Medicaid and Employee Group Insurance Division (EGID)) healthcare cost growth to 2% less than the projected national health expenditures average annual percentage growth rate as set by the Center for Medicare and Medicaid Services (CMS)

OHIP 2020: Health Finance OHIP 2020 Objectives and Strategies

Health Finance- Objectives

- Objective 1: Decrease the percentage of uninsured individuals from 17% in 2013 to 9.5% by 2020.
  - Strategy 1: Pursue the use of premium assistance programs, such as Insure Oklahoma or tribal sponsored premium coverage programs, with an emphasis on increasing the uptake minimal essential insurance coverage.
  - Strategy 2: Explore opportunities to use waivers, demonstration projects (vehicles that states can use to test new or existing ways to deliver and pay for healthcare services in Medicaid and the Children's Health Insurance Program) and other sources of funding to create sustainable, value-driven healthcare models in order to increase access to care, improve quality, and reduce costs.

Health Finance- Objectives

- Objective 2: By 2020, limit annual state-purchased (Medicaid and Employee Group Insurance Division (EGID)) healthcare cost growth to 2% less than the projected national health expenditures average annual percentage growth rate as set by the Center for Medicare and Medicaid Services (CMS).
  - Strategy 1: Increase the percentage of healthcare spending in the state that is contracted under value-based payment models that reward providers for quality of care.
  - Strategy 2: Use payment models that adequately incentivize and support high-quality team-based care focused on the needs and goals of patients and families
  - Strategy 3: Align health system incentives, including payer and provider incentives, to better coordinate care, promote health outcomes, and ensure quality measures are achieved which limit health expenditure growth

OHIP 2020: Existing Initiatives

- Numerous existing initiatives will help the State achieve the OHIP 2020 goals and objectives for healthcare transformation

- Objective 1: Decrease the Uninsured Rate
  - Initiatives
    - The Insure Oklahoma Sponsor's Choice Waiver

- Objective 2: Decrease healthcare cost growth for state-purchased healthcare
  - Initiatives
    - The Oklahoma SIM grant
    - Comprehensive Primary Care (CPC) Initiative

OHIP 2020: Newly Proposed Initiatives

- SB1386 would create state legislation to explore the potential development of new Innovation Waivers for the purpose of creating Oklahoma health insurance products that improve health and healthcare quality while controlling costs.
  - 1332 State Innovation Waivers (1332 Waiver)
    - Create a **1332 Task Force** to explore whether a 1332 Waiver could potentially be used to create a regulatory environment that provides affordable, high quality healthcare options in Oklahoma's commercial insurance market
  - Delivery System Reform Incentive Payment (DSRIP)
    - Work with the OHCA to potentially develop a 1115 Waiver that enables the state to transition to value-based purchasing and accelerate improvement in Oklahoma's system performance and health outcomes

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OHIP 2020: 1332 Waiver

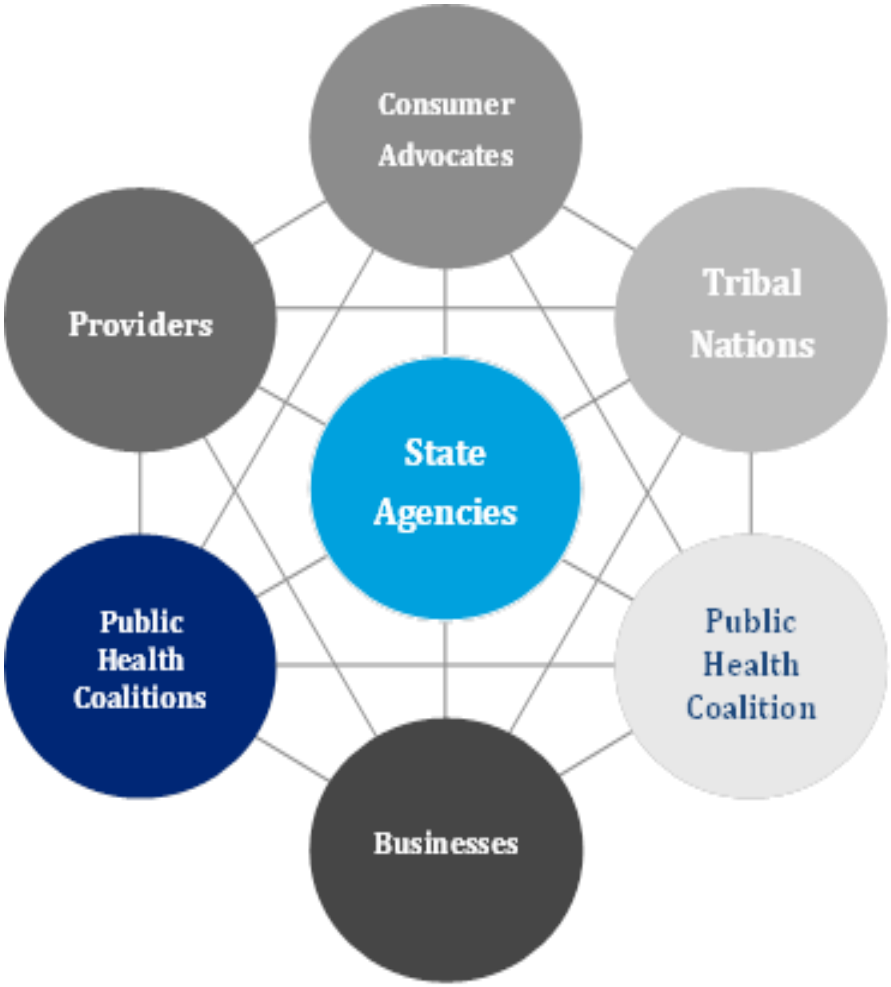
- These renewable five-year waivers may propose minor modifications to the ACA, or they can propose sweeping changes that could alter the way tax credits or subsidies are delivered in a state.
  - **Benefits and Subsidies:** States can modify rules related to covered benefits and subsidies
  - **Exchanges and Qualified Health Plans:** States can modify or eliminate insurance exchanges and qualified health plans as the means for determining subsidy eligibility and insurance enrollment
  - **Individual Mandate**: States can modify or eliminate tax penalties for individuals
  - **Employer Mandate:** States can modify or eliminate penalties for large employers

OHIP 2020: 1332 Waiver Task Force

- The 1332 Task Force will be a coalition of private and public stakeholders that will conduct a series of public meetings to discuss possibilities for Oklahoma's 1332 Waiver proposal

- The meetings will be open to the public, and any interested stakeholder may participate in the Task Force and provide comment and feedback for the 1332 Waiver

- The waiver proposal will be presented to the legislature with the public comments received throughout the process



OHIP 2020: DSRIP Waiver

- DSRIP waivers create a separate supplemental incentive pool(s) for providers to help with the transition into new value based insurance programs

- They can be implemented alongside any payment delivery system but are meant to assist providers during the transition from fee-for-service to new or innovative payment models

- In DSRIP waivers, Medicaid creates a separate funding pool to encourage healthcare providers to invest in the tools and infrastructure necessary to be successful under new value-based payment models and helps buffer the financial impacts of making the transition to population or outcome based healthcare models

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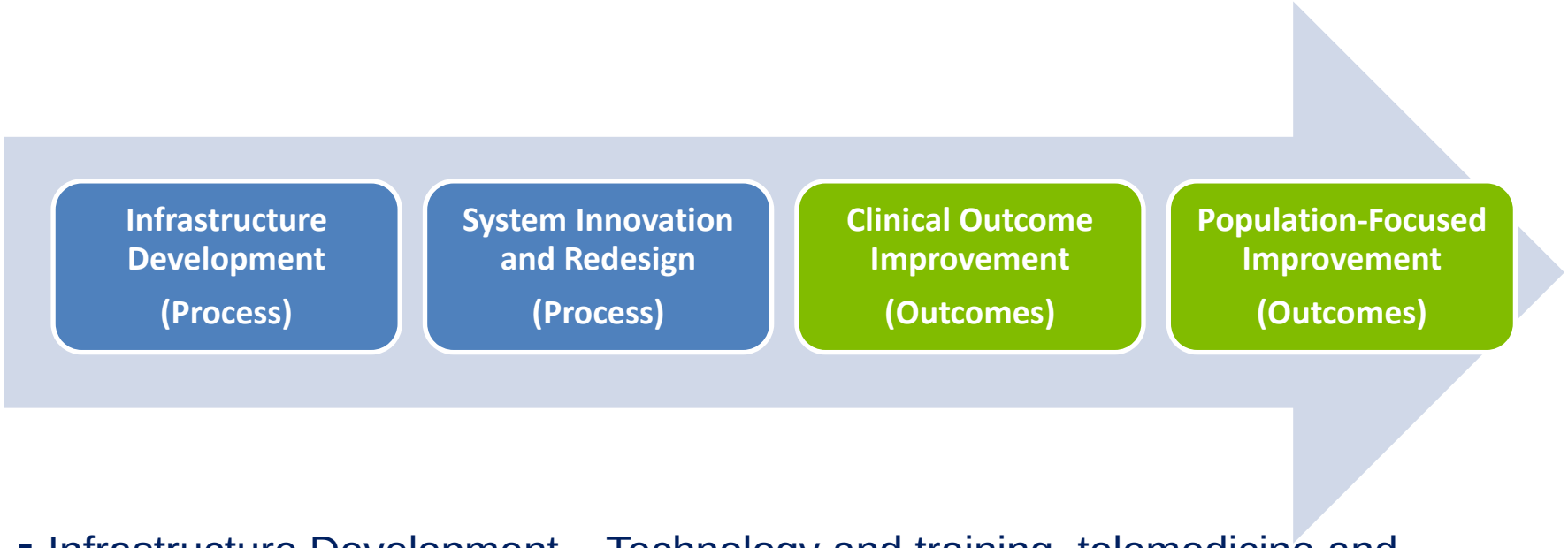
OHIP 2020: DSRIP Waiver



- Infrastructure Development – Technology and training, telemedicine and disease registries
- System Innovation and Redesign – Patient navigation, chronic care and medication management
- Clinical Outcome Improvement – Payment for hypertension or diabetes control among patients
- Population-Focused Improvement – Community wide efforts to reduce chronic disease (e.g., obesity and tobacco prevention and cessation initiatives)

RCO Supporting Technology: Feedback and comment

Considerations

- The proposed waivers Oklahoma is considering could rapidly transform Oklahoma's healthcare system while maintaining its current capacity and access
- Once the Oklahoma SIM grant period ends, the workgroups will need to evolve and refocus its efforts on achieving the goals and objectives of OHIP by pursuing multiple strategic initiatives within their collective domain of interest and expertise

Discussion Questions

- What other initiatives should the Health Finance Workgroup pursue to help accomplish its goals and objectives?
- How should we use the Finance Workgroup to accomplish these goals (e.g. meeting frequency, formal role of the workgroup)?

State Health System Innovation Plan

SHSIP Versions and Dates

Version	Release Date	SHSIP Sections
1	February 4, 2016	Included: • Description of State Healthcare Environment • Stakeholder Engagement Report • Health System Design and Performance Objectives • Value Based Payment and/or Service Delivery Model • Plan for Healthcare Delivery System Transformation • Plan for Improving Population Health • Health Information Technology (HIT) Plan • Workforce Development Strategy
2	February 19, 2016	Updated Released Sections
3	March 17, 2016	Added: • Monitoring and Evaluation Plan • Operational and Sustainability Plan

State Health System Innovation Plan – Status

SHSIP Section	Section Draft Status	Internal Review Status	Deloitte Review Status	CMS Review Status	Public Comment Status
1. Description of State Healthcare Environment	Complete	Complete	Complete	Complete	Out for Review
2. Stakeholder Engagement Report	Complete	Complete	Complete	Complete	Out for Review
3. Health System Design and Performance Objectives	Complete	Complete	Complete	Complete	Out for Review
4. Value Based Payment and/or Service Delivery Model	Complete	Complete	Complete	Complete	Out for Review
5. Plan for Healthcare Delivery System Transformation	Complete	Complete	Complete	Complete	Out for Review
6. Plan for Improving Population Health	Complete	Complete	Complete	Complete	Out for Review
7. Health Information Technology Plan	Complete	Complete	Complete	Complete	Out for Review
8. Workforce Development Strategy	Complete	Complete	Complete	Complete	Out for Review
9. Financial Analysis	In Progress	Not Started	Not Started	Not Started	Not Started
10. Monitoring and Evaluation Plan	Complete	Complete	Complete	Complete	Out for Review
11. Operational and Sustainability Plan	Complete	Complete	Complete	Complete	Out for Review

Workgroup Feedback on the SHSIP

	Comments/Questions	Results
Model Tenets and Goals	• Acknowledge/preserve activities in the state that are meeting the triple aim. Ensure that we do not lose them in this transformation.	• Added: Acknowledge and work to sustain activities, practices, and/or processes that are showing that they meet the Triple Aim. • Preserve and successfully integrate health care delivery models that already exist and meet the Triple Aim in the state when they embark on this health system transformation.
Governance	• Create space for commercial and self insured on State Governing Body (SGB). • Add term limits and rotating seats for the SGB.	• Added private public and self insured members of the SGB. • Added language to call for a SGB charter that would delineate these functions.
Other	• Acknowledge the need to standardize the data set for any quality metric. • Add a list of stakeholders as an appendix. • Add top 25 health professions as an appendix.	• Added within HIT and VBP sections language calling for standardized data sources for QMs • Added: a list of Stakeholders in the appendix • Added: top 25 health professions as appendix

CMS and Technical Assistance Feedback on the SHSIP

Comments/Questions	Results
• Clarify how HCLAN payment continuum will be used.	• The HCLAN (Health Care Learning and Action Network) payment continuum will be a guide.
• Can providers enter into partial capitation with RCOs?	• Yes. This language was clarified.
• Is the Provider Advisory Committee statewide?	• Yes, the PAC (Provider Advisory Committee) is a statewide body. The RCO will have a BAP that is local.
• Can you say more about integrating the private market?	• Updated language in the SHSIP
• Should the community advisory board include actual members?	• Yes. Clarified language in the SHSIP to include members.
• Describe in more detail how this has the potential to meet 80% of payments statewide to be in a VBP model.	• By engaging commercial payers in the three model components
• Please identify the current healthcare provider organizations in the state.	• Added to the SHSIP Environment section and Appendices
• How will the plan be finalized?	• With advice and input from the OHIP and SIM Executive Steering Committee, the Grantee Project Director for SIM will authorize the submission of the Oklahoma SHSIP.
• How will you ensure per capita expenditures will decline over time?	• The per member per month (PMPM) growth rate will be capped.

External Stakeholder Feedback on the SHSIP

	Comments/Questions	Results
Tribal Consultation	• How does this affect tribal sovereignty?	• It does not affect sovereignty.
	• The capitated rate goes against the Federal Trust Requirement	• Tribal members would maintain an option to be a FFS beneficiary or a FFS RCO beneficiary.
	• How does this affect the OMB rate?	• the OMB rate will remain unchanged.
	• Is this required of tribal members to participate?	• No. They may choose to receive services either in a FFS Medicaid population or FFS through the RCO as a pass through.
	• Can a tribe be an RCO?	• Potentially, as explained in new SIM, Tribal Health, and Native Americans section in the SHSIP.
Individual Stakeholder Meetings	• Ensure that it is understood that this model means something different for commercial populations.	• Included language in the new commercial integration section of the SHSIP.
	• Managed care alone will not work, unless you can do something similar to Oregon where providers are involved.	• The model is similar to Oregon. We are looking for provider participation both statewide and locally.
	• Care coordination will work but not managed care, which is very harmful to the frail and elderly.	• Care coordination is the centerpiece of this model. We will definitely want to protect the medically fragile and elderly in this process and look forward to more discussion on how to do so.
	• Take more time with the governance structure. Many people in the state heard of this initiative by word of mouth so give more time to the stakeholder engagement of this plan.	• SIM held over 150 meetings and engaged over 100 organizations in the year. The next steps of SIM include more stakeholder engagement and governance discussions that will reach more stakeholders to contribute

Overall Stakeholder Feedback on Strengths of the SHSIP

OSIM/OHIP Workgroups

- Stakeholders expressed agreement on SIM model goals and tenets.

Center for Medicare and Medicaid Innovation (CMMI) Project Officer

- Oklahoma's has accomplished a lot through the SIM planning grant and it is evident in the SHSIP.

Center for Health Care Strategies (CHCS)

- SHSIP is a thorough report, addressing at a high level how to move to value based care. It is clear there is needed governance to operationalize the plan and begin to drive more discrete decisions to fulfill this vision.

State Health Access Data Center (SHADAC)

- Clearly lays out core tenets that will drive the value based approach

Office of the National Coordinator for HIT (ONC)

- The (HIT) plan leverages solutions already in place and has been very responsible in taking the states needs into consideration.

Centers for Disease Control and Prevention (CDC)

- The (PHIP) plan is a very good plan. The model takes into account the social determinants of health and shows where public health's role is in this solution.

Next Steps for SIM

Submit the State Health System Innovation Plan

Step 1

Comments

- Comments on the plan will be taken through March 25th.

Submission

- The plan will be submitted to CMS on March 31st.
  - After submission the CMS will give their final feedback.
  - The grant period will close 90 days after submission.
- Note: The submission of the SHSIP is NOT:
  - A test grant application
  - A waiver submission
  - The final discussion of plan components

Continue Stakeholder Engagement

Step 2

Workgroups

- All workgroups will continue to meet.
  - Workgroup meetings will begin to address specific work areas and plans for OHIP.
  - Workgroups will be engaged in operationalizing SIM as it relates to their OHIP work.

Operationalize the SHSIP

Step 3

Committees

- Establish committee structures to start meeting around the SIM vision.
  - State Governing Body
  - Quality Metrics Committee
  - Episodes of Care Task Force
  - Administrative Burden Task Force

Funding

- Seek funding for infrastructure improvements to support vision.
  - DSRIP (Delivery System Reform Incentive Payment)
  - HIT
  - CDC

Authorization

- Begin work toward State and Federal Authorization.

OSIM Operational Roadmap: Healthcare System Initiatives

Milestones	2016				2017				2018				2019			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Quality Metrics	Payer Metrics Alignment Meeting; Form Metrics Committee				Deliberate on Core RCO Metrics			Initial Multi Payer Metrics Report			Initial RCO Metrics Report				Annual RCO Metrics Report	
DSRIP – The Oklahoma Plan	CMS Waiver Development			CMS Waiver Submission			CMS Waiver Approval	DSRIP Implementation and payments								
Episodes of Care	Form EOC Task Force		Determine Episodes Scope & Definition		Initial Episodes Tracking & Assessment			Episodes Reporting & Evaluation	Episodes of Care for Payment							
Regional Care Organizations	Model Development Stakeholder Engagement				RCO Enabling Legislation			RCO RFI & RFP Evaluation Process				RCO Go-Live				
	CMS Waiver Development			CMS Waiver Submission			CMS Waiver Approval	RCO Development & Transition Process								

Program Milestones Milestone