



State of Oklahoma

State Innovation Model Design Grant

Oklahoma State Health System Innovation Plan

Submitted to CMS on March 31, 2016

Executive Summary

If Oklahoma is to achieve its shared goals of health and prosperity for all citizens, its healthcare system must transform and embrace the shift towards value-based care delivery. The goal of healthcare transformation is the “Triple Aim” - the improvement of health outcomes and quality of care, while simultaneously reducing costs.

Figure A.1: The Triple Aim



The State Innovation Model (SIM) program provides a robust framework for achieving the Triple Aim by driving the adoption of value-based payment and delivery system models. Value-based models are those that expressly link provider reimbursement with improved quality of care and health outcomes. This linkage helps to ensure high-quality, patient-centered care by incentivizing providers to adhere to clinical best practices and to help their patients to navigate the complex healthcare system through enhanced coordination with other providers. As part of the broader effort to reform the healthcare system, the Governor adopted a goal of having 80 percent of all state-based healthcare insurance payments made under a value-based purchasing model by 2020.

To achieve this 80 percent target, the SIM team proposes implementing the Oklahoma Model, a value-based delivery system approach which it developed throughout the course of the SIM initiative. The Oklahoma Model includes three distinct elements:

- The creation of Regional Care Organizations (RCOs) for state-purchased healthcare, which includes the Medicaid program and eligible public employees and their dependents who purchase healthcare from the state;
- Statewide adoption of multi-payer quality measures; and
- Multi-payer “episodes of care” payments.

The Oklahoma Model is a state-based approach to healthcare transformation that accelerates the system-wide shift towards value-based care by moving all state-purchased healthcare into such a model. Through the RCOs, Oklahoma can leverage state purchasing power to drive system-level changes that will influence the way healthcare is delivered to all Oklahomans. The Oklahoma Model also encourages multi-payer adoption of a consistent set of quality measures and reimbursement strategies to advance statewide transformation in a coherent manner across the healthcare system.

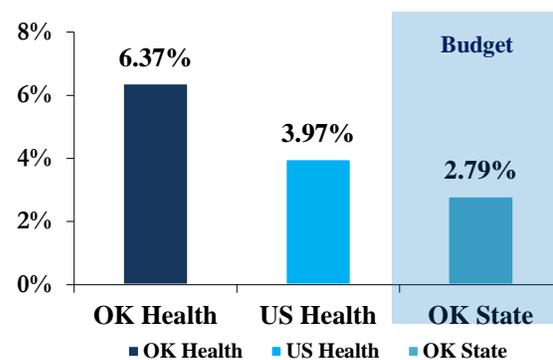
The State Health System Innovation Plan (SHSIP) describes how the Oklahoma Model will achieve the Triple Aim and details the framework necessary to support it. The SIM team developed the SHSIP over the course of a year-long process that incorporated significant stakeholder collaboration, technical assistance, and consultant services. While the SHSIP provides a high-level plan for achieving the goals and objectives of Oklahoma healthcare transformation, it is the beginning, not the end, of the process. Healthcare system stakeholders and policy makers must remain involved and engaged to continue to execute the plan laid out in the SHSIP, with the ultimate goal of improving the lives of all Oklahomans through the achievement of the Triple Aim.

THE CASE FOR CHANGE

Oklahoma has very poor health outcomes, ranking 50th in the nation by the Commonwealth Fund Scorecard on State Health System Performance in 2015. A major component of this ranking is the limited access to primary care and high incidences of hospitalizations for conditions that could have been treated in primary care or outpatient settings, but the drivers for health outcomes in the state go beyond just shortcomings in its healthcare delivery system. These outcomes result from a complex interplay of challenges in the healthcare environment, unaddressed social determinants of health, and poor lifestyle behaviors from many of its residents. Leading healthcare environment challenges include provider shortages, medically underserved regions, and problems accessing care. Housing, food insecurity, and a lack of transportation are foremost among unaddressed social determinants, and impactful behavioral aspects include tobacco use, poor nutrition, and a lack of physical activity, among others.

Poor health outcomes are not the only health-related issue facing the Oklahoma. Low system performance also contributes to excessive and unsustainable costs to taxpayers, businesses, and individuals. State health spending has increased twice as fast as the state budget and one and a half times as fast as the US total health care expenditures (see Figure A.2). Recent state revenue failures put further strain on the ability of the state to pay for healthcare. This situation is unsustainable. If Oklahoma is to bend the cost growth of state-purchased healthcare expenditures, it must address the factors that drive cost, including reducing the rate of potentially preventable hospitalizations and improving the management of chronic conditions.

Figure A.2: Health Spending Average Annual Percentage Increase, 2005-15



Given the complexity of the issues facing healthcare in Oklahomans, improvement efforts will require a comprehensive approach. Many efforts and initiatives are underway across the state to improve Oklahoma's health outcomes and to reduce overall healthcare costs. One of the largest statewide efforts has been the Oklahoma Health Improvement Plan (OHIP). The OHIP Coalition is a public and private partnership of stakeholders that convene on a regular basis to develop a comprehensive state health improvement plan and oversee the state's progress toward improving health outcomes and healthcare system goals. These strategies also include address the social determinants of health to ensure planning efforts take a holistic view of improving health outcomes.

The OHIP Coalition focuses on strategic health topics and priority populations for rapid improvement within flagship issues. The Oklahoma SIM project team adopted many of those OHIP flagship issues and expanded those areas to include other highly prevalent and high-cost conditions: obesity, hypertension, diabetes, tobacco usage, and behavioral health (which includes mental health and substance abuse). Extensive research and stakeholder engagement was conducted around these SIM flagship issues to create a framework for analysis and understanding of the relative costs and impacts these issues have on Oklahoma's health outcomes and healthcare system. This framework was then used, in part, to help the Oklahoma SIM project team create the Oklahoma Model for its SIM proposal.

THE CURRENT STATE OF OKLAHOMA HEALTHCARE

Oklahoma faces serious health challenges for its residents. Oklahoma is burdened by an increasing prevalence of chronic diseases. The high rate of diabetes, hypertension, obesity, and tobacco use correlates to Oklahoma’s high mortality rate, the fourth highest in the nation and 23 percent higher than the national average. Mental illness and substance abuse are also more prominent in Oklahoma than in most other states. Often chronic conditions are comorbid and create complex health needs for patients that strain the healthcare system’s ability to manage care in an effective manner. Listed below are the SIM flagship issues, their prevalence rates, and key considerations as to how they impact health outcomes.

SIM Flagship Issue	Prevalance	Considerations
<i>Diabetes</i>	12%	The state has the eighth highest rate in the nation. Risk of heart disease and stroke increase for individuals with diabetes. Lifestyle factors, such as physical inactivity, poor diet, obesity, and tobacco use, can exacerbate both the symptoms of diabetes and the risk of acquiring another chronic condition. However, many complications from diabetes can be reduced through proper prevention, timely diagnosis, and disease management programs.
<i>Hypertension</i>	37.5%	High blood pressure increases the risk for heart disease and stroke and can typically be controlled through medications, medical care, and lifestyle management. Uncontrolled hypertension can result in serious health consequences and preventable hospitalizations.
<i>Tobacco Use</i>	21.1%	Smoking and tobacco use increases one’s risk for developing diabetes, hypertension, and cancer. Tobacco use alone is responsible for the death of 7,500 Oklahomans each year. ¹ Oklahoma is consistently among the highest states for tobacco usage, but focused efforts to reduce and prevent tobacco use have resulted in a 19 percent decrease in the past four years and an all-time low of adult smokers.
<i>Obesity</i>	33%	Oklahoma has one of the top ten highest rates of adult obesity in the nation. Poor nutrition and physical inactivity can be contributing factors to obesity, which can lead to many chronic conditions like hypertension, heart disease, and diabetes. Many factors are also related to the social determinants of health, such as access to healthy foods, safe places to exercise, transportation, and health literacy and education about proper nutrition and exercise.
<i>Mental Health</i> & <i>Substance Abuse</i>	21.9%* 12%	Oklahoma is ranked 40 th nationally for mental illness prevalence among adults. ² Additionally, data from the 2014 State of the State Health Report ranked Oklahoma 39 th in the average number of poor mental health days each month reported by adults. Mental illness and substance abuse has skyrocketed in the state, with an estimated 985,000 Oklahomans in need of either mental health or substance abuse treatment service

* In 2014, 21.9 percent of adults in the state reported having a mental health issue.

Preventable diseases and unmanaged chronic illnesses stress the healthcare system and waste resources because patients often receive treatment at higher cost and higher acuity settings, such as hospitals or emergency departments, rather than seeking primary or preventive care. This impairs the overall performance of the health system and makes care delivery and treatment reactionary in nature rather than preventive.

Reducing preventable hospitalizations, non-emergent emergency department (ED) utilization, and hospital readmissions are key components to improving state health system performance and overall improve population health. Listed below are some of the key indicators of health system performance in Oklahoma.

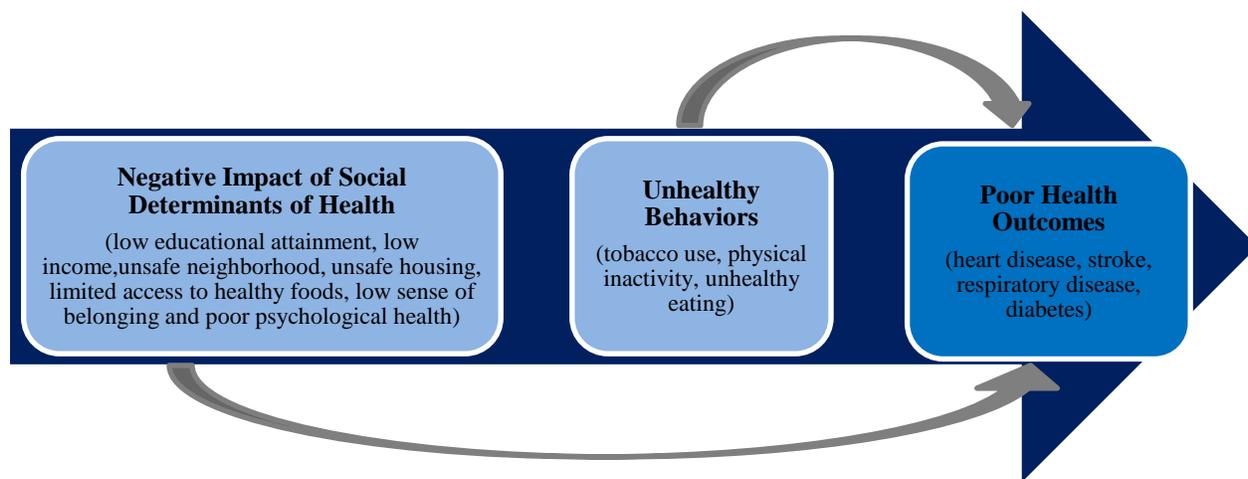
Health System Performance Indicator	Key Characteristic	Considerations
Preventable Hospitalizations	1836.2 preventable hospitalizations per 100,000 hospitalizations ³	Preventable hospitalizations are defined as stays that might have been avoided with timely and effective outpatient care and appropriate self-management. The most common diseases that were associated with preventable hospitalizations included the SIM flagship issues, such as diabetes and hypertension. Research indicates that, with minimal reductions in preventable hospitalizations, significant avoidable costs are mitigated.
Non-Emergent Emergency Department Utilization	In 2014, the total ED cost for the Medicaid population in Oklahoma was over \$151 million, with an average cost of \$264 per visit and each member averaging two ED visits per year. ⁴	Non-emergent care is generally not considered appropriate to be provided in an emergency setting. ED usage is higher for individuals with serious chronic diseases, like diabetes, hypertension, or COPD, and for those that lack access to primary care. These diagnoses demonstrate that EDs are being used for health problems that could be treated in a primary care setting, resulting in unnecessary costs.
Readmissions	Percent of Adult Discharges Resulting in Readmissions in 2012: <ul style="list-style-type: none"> • Medicare: 16.7% • Medicaid: 13.1% • Uninsured: 10.9% • Commercial: 9.3% 	A readmission is defined as a subsequent admission to a hospital within 30 days of discharge. Readmissions potentially indicate poor care, poor care coordination, and/or incomplete treatment. An important driver of readmissions is a co-morbidity of chronic disease and mental illness.

A confluence of factors results in poorer health outcomes, higher rates of disease, and overall higher total deaths for Oklahoma as compared to the rest of the nation. These factors include the social determinants of health, such as education level, income, and family, social, and community resources and supports. The

social determinants of health are one of the greatest indicators for health outcomes and behaviors. Social circumstances alone account for 15 percent of premature deaths and significantly influence behaviors.⁵

Many Oklahomans lack basic needs such as an adequate income, housing, and nutrition, which not only affect overall health but health behaviors as well. Individuals who are negatively impacted by social determinants of health such as a lack of food, housing, and economic constraints are more likely to engage in unhealthy behaviors, such as the use of tobacco, alcohol, and other drugs. To improve health outcomes, states must begin to look more closely at the social determinants of health and develop preventive health strategies that address both clinical and social needs of patients.

Figure A.3: Relationship between Social Determinants, Health Behaviors, and Health Outcomes



The Oklahoma Model targets the SIM flagship issues since they have the biggest impact on overall health and healthcare costs. The statewide prevention strategies contained in the Oklahoma Model address those factors that lead to high rates of morbidity, including system performance and the social determinants of health. Healthcare transformation can create a sustainable health model capable of delivering optimal care through the prevention of disease, care coordination, and ensuring access to quality care for all Oklahomans.

The SIM conducted financial analysis to assess the relative costs of the SIM flagship issues within Oklahoma’s commercial markets and state-purchased healthcare, focusing on the most prevalent and expensive chronic conditions. Figure A.3 illustrates the increased costs that those individuals with chronic conditions incur to the system, parsed by payer.

Condition	Total Cost of Care (PMPM)			
	Commercial	Medicare	EGID	Medicaid
General/Composite	\$416	\$822	\$422	\$395
Diabetes	\$1,452	\$1,291	\$929	\$1,610
Hypertension	\$1,178	\$1,044	\$740	\$1,510
Behavioral Health	\$1,302	\$1,841	\$724	\$880
Adult Tobacco*	\$1,435	\$1,751	\$486	\$454

*Due to inadequate coding information EGID and Medicaid are based on a generalized 115% from published research, which is likely an underestimate

This table indicates that chronic conditions dramatically increase health expenditures when compared to the general population. As chronic conditions often extend beyond the walls of the current fee for service healthcare system, addressing them adequately in a way that reduces costs will require a more comprehensive approach.

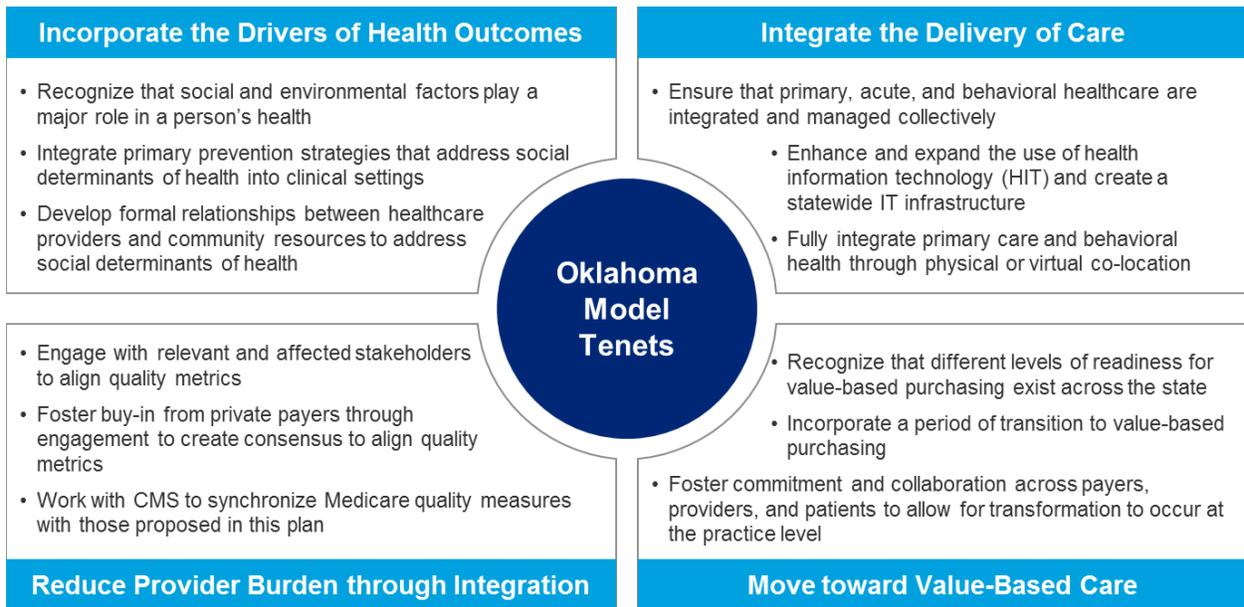
THE FUTURE VISION FOR OKLAHOMA HEALTHCARE – A VALUE-BASED MODEL

To remedy this state of affairs, Oklahoma proposes to transition its current health care system to the RCO model. The flexibility of the RCO approach uniquely positions it to address the complexity of the factors contributing to negative health outcomes in the state. Rather than downplaying patient life circumstances, RCOs emphasize the broader environmental, socio-demographic, and behavioral factors affecting health outcomes. Their flexibility enables them to deliver non-medical services alongside medical benefits, removing the barriers to effective care and ameliorating the root causes of many conditions. This perspective will be critical to developing innovative and personalized solutions to the obstacles that Oklahomans face to leading healthier lives.

Model Tenets

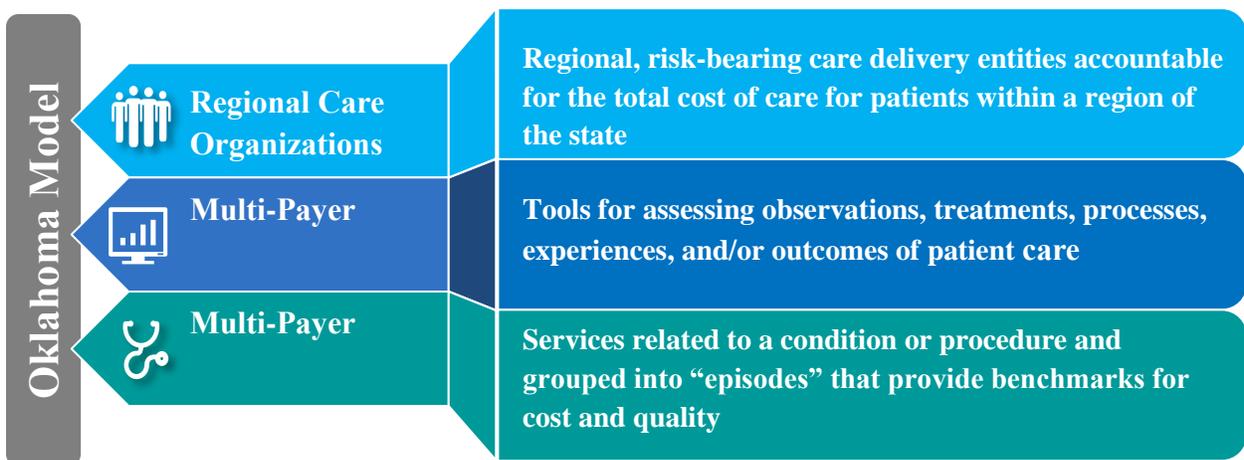
Given the ongoing health challenges of Oklahoma and the regional, environmental, and cultural differences of its population and healthcare system, it was necessary for the Oklahoma SIM project team to highlight a shared set of values and ideas stakeholders believed represented an ideal healthcare system. Feedback and discussions with a variety of diverse stakeholders resulted in a consensus as to the tenets that the model design should incorporate. These tenets are depicted in Figure A.4.

Figure A.4: Oklahoma Healthcare System Transformation Model Design Tenets



Using these tenets as guidelines, the state used a multi-pronged approach to create a model for moving to a value-based, transformed healthcare system that includes the creation of Regional Care Organizations (RCO) for state-purchased healthcare, statewide adoption of multi-payer quality metrics, and multi-payer “episodes of care” payments. These tenets are exemplified throughout the Oklahoma Model and highlight the commitment of the SIM team to incorporating stakeholder feedback into the final design.

Figure A.5: The Oklahoma Model



Regional Care Organizations (RCOs)

The first component of the model is the creation of Regional Care Organizations (RCO) for all state-purchased health care. State-purchased healthcare includes both Medicaid beneficiaries and eligible public employees who purchase healthcare through the state, which includes individuals employed by state agencies, school districts, other governmental units of the State of Oklahoma, and their dependents.

Oklahoma is proposing to attribute a majority its Medicaid beneficiaries and eligible public employees and their covered dependents to the RCO model, comprising a quarter of Oklahoma’s population.

An RCO is a regionally based care delivery organization that operates under a comprehensive risk contract with the state. Like managed care organizations (MCOs), RCOs bear full financial risk for the cost of care of the assigned population and receive a fully capitated payment for attributed members within their geographic region. Improving upon the MCO model, RCOs must develop a governance structure that reflects the coordination of care delivery and community resources into one integrated model.

This model design encourages RCOs to address complex factors contributing to the poor health outcomes and high healthcare costs, including environmental, socio-demographic, and behavioral factors. This is accomplished, in part, through formal partnerships with social services and community groups. RCOs may also spend funds on services that are traditionally not “medically necessary,” such as housing specialists or mold remediation.

The state will utilize a global budget to pay RCOs for the complete cost of healthcare for all members within their geographic region. The global budget for the RCO will consist of a risk adjusted, capitated per member per month (PMPM) payment for covered services. The PMPM growth rate will be capped by the state to ensure cost targets are met and growth is restrained.

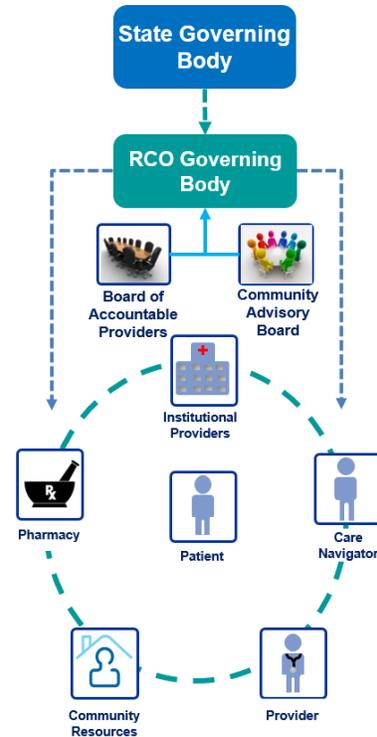
Each RCO must meet standardized quality and cost measures so the state can evaluate their performance. The quality measures will be aligned with the new Medicare payment and delivery reform and Alternative Payment Models (APM) adopted by commercial carriers to reduce provider burden and engender consensus from providers and commercial carriers. Many RCO quality measures will be based on the SIM flagship issues. To incentivize RCO performance on these measures, the state will withhold a percentage of the capitated rate which can be earned back by the RCO upon meeting performance benchmarks and quality measures.

In addition, RCOs must participate in statewide interoperable health information technology (HIT). Interoperable HIT adoption and utilization is critical to helping monitor RCO performance and population health outcomes with a value-based analytics tool.

The RCOs are responsible for creating regional provider networks and implementing value-based alternative payment model (APM) within those networks. The state will establish criteria that RCOs must meet as they implement value-based healthcare delivery, including the following:

- Eighty percent of payments made to providers must be value-based by 2020;
- RCOs must participate with the Multi-Payer Episodes of Care;
- One additional APM (e.g. bundled payments, pay-for-performance, and shared savings and shared risk) must be utilized; and
- APMs must include mechanisms to encourage both cost savings and high quality care.

Figure A.6: RCO Model



Outside of these requirements, the decision on how providers within each RCO network are incentivized and held accountable are left largely to the RCOs to determine so that regionally-appropriate, scalable methods to move from volume-based to value-based healthcare delivery system innovations can be aligned with regional readiness and successfully implemented.

RCO Governance and Scope

While the state will provide a high degree of oversight of the RCOs, a key characteristic of the Oklahoma Model is flexibility and discretion in the way the RCO organizes to deliver patient-centered care that meet and exceeds outcome targets. Other states that have implemented similar types of models have fostered this by allowing RCOs to develop governance and payment models that match local health needs and account for provider maturity to move towards risk-based care.

The RCO Governing Body is a partnership of those individuals that share in the financial risk of the organization, healthcare providers, community members, and other stakeholders in the health system. The RCOs must also establish two distinct advisory boards, a Board of Accountable Providers and a Community Advisory Board, to advise the RCO Governing Body on evidence-based, locally-tailored practices that promote coordinated care. This governance structure ensures that providers, payers, and patients are committed to achieving the triple aim in a collaborative fashion.

State Oversight of the RCOs: The State Governing Body

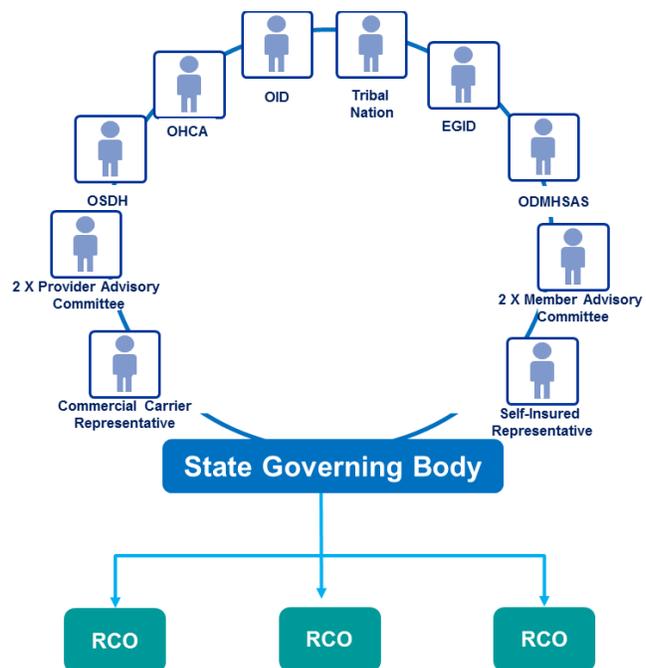
Currently, two state agencies are responsible for managing state-purchased healthcare. The Oklahoma Health Care Authority (OHCA) administers and manages healthcare for the Medicaid population through the SoonerCare program; EGID administers and manages healthcare for most public employees and their dependents through self-insured Preferred Provider Organization (PPO) plans, called HealthChoice. State employees may also purchase healthcare through an array of private HMO plans.

Under the Oklahoma Model, Oklahoma will create the State Governing Body to provide oversight of state-purchased healthcare to ensure regulatory and quality compliance. It will be responsible for overseeing the care provided by the RCOs for eligible attributed beneficiaries. The State Governing Body will have a formal charter and governance that will delineate its scope and authority, term limits, and rotation of seats to ensure it is operational and has adequate representation to act authoritatively.

Each RCO will be certified by the State Governing Body to demonstrate their experience and capacity to deliver care; manage financial risks; coordinate and integrate the delivery of physical and behavioral health and community supports; and participate in statewide interoperable HIT.

The leadership for this governing body will

Figure A.7: State Governing Body Representatives



consist of representatives from the following state agencies: the Oklahoma Health Care Authority, the Employee Group Insurance Division, the Department of Mental Health and Substance Abuse Services, and the Oklahoma Insurance Department.

The State Governing Body will also have broad stakeholder representation from across the healthcare system. This includes a representative from tribal nations, a representative from a private healthcare payer association, a representative from a self-insured plan association, and two provider and consumer representatives.

Multi-Payer Quality Measures

Multi-payer involvement is an integral component of the Oklahoma Model. All payers will be asked to use common quality measures to help them improve health outcomes and evaluate quality of care for their covered lives. The SIM flagship issues will be used as the basis for many multi-payer quality measures to ensure consistent goals are used across payers.

Alignment across a set of quality measures is a foundational first step toward healthcare transformation, as it sends powerful market signals to providers as to how their performance will be measured for the quality of care they provide, regardless of the health insurance coverage of the patient. Multi-payer alignment of quality measures also prevents an unnecessary workload from being placed on providers due to multiple measure sets required by various payers in Oklahoma. The Oklahoma SIM project has taken the first step of composing an inventory of quality measures and reached an agreement, in principle, to align these measures across the carriers participating in the Oklahoma Model.

Oklahoma Quality Metrics Committee

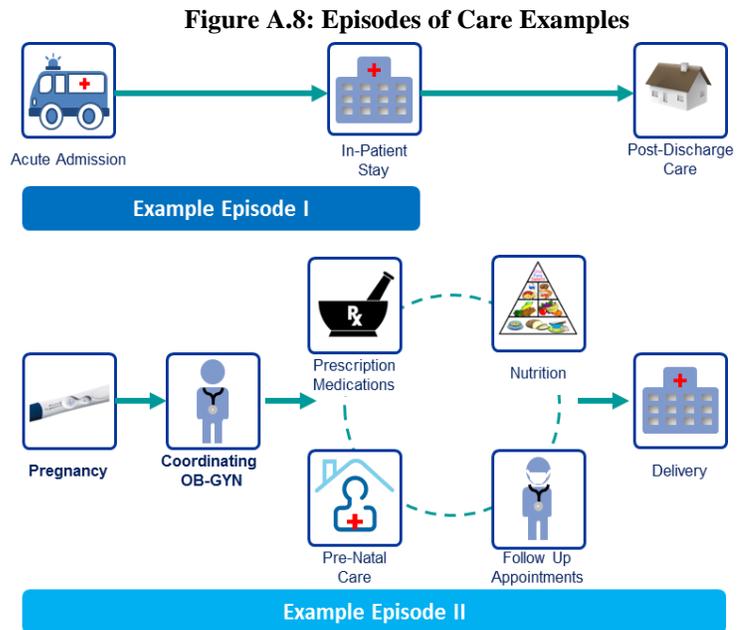
Operationalizing the multi-payer quality measures will take additional collaboration and guidance. To help lead this effort, an Oklahoma Quality Measure Committee will be created. This committee will be part of the State Governing Body to ensure alignment with the RCO performance measures. It will be responsible for proposing quality measures sets that can be applicable to the RCO and engaging multi-payer alignment.

Members of this committee will include multiple provider types from different practice settings and organizations, quality measure experts, HIT reporting specialists, and other relevant stakeholders with the necessary experience and expertise to propose, review, and implement both clinical and population health quality measures.

Multi-Payer Episodes of Care (EOC)

Another important aspect of multi-payer participation in the Oklahoma Model is the implementation of multi-payer Episodes of Care (EOC). Because EOC have modular features that could work in commercial insurance, the Oklahoma SIM project team will work with its Oklahoma SIM participating carriers to have them incorporate EOC within their payment methodologies. The Oklahoma SIM project team also proposes to introduce EOC within state-purchased healthcare to create an onramp to more comprehensive forms of value-based purchasing and move closer to the gubernatorial value-based goal.

EOC is a payment model in which related services that are provided to treat a specific condition over a specific period of time and are grouped into “episodes.” The episodes can include acute, chronic, and behavioral health conditions and vary in length depending on the condition. The purpose of EOC as an alternative payment arrangement is to encourage provider collaboration, patient coordination, and service efficiency across various care delivery settings. By establishing clear accountability for both outcomes and the total cost of care for an episode, this model rewards high performing providers and reduces variance in cost and quality.



The model requires that a Principle Accountable Provider (PAP) be designated as the provider responsible for quality outcomes and the total cost of care for a given episode over a given time. Factors for determining an episode of care include agreeing to an episode’s time frame and triggering event, the services included within the episode, and situations or conditions that exclude some patients from being included in the episode. Patients who match the episode’s criteria will be attributed to the episode, and PAPs will be evaluated on their performance for all patients attributed that episode.

“Acceptable” and “commendable” cost benchmarks will be established for the episode, and quality measures are also used to ensure against the rationing of care. The PAP and all associated providers will be paid on a fee-for-services basis and then evaluated retrospectively against those acceptable and commendable benchmarks. PAPs with costs below the commendable level for an episode can share in savings. Conversely, PAPs with costs above the acceptable level receive penalties. To be eligible for any savings, the PAP must also meet the quality measures set out for the episode.

Proposed Multi-Payer Episodes

Using previous research by other states that have implemented EOC, Oklahoma has proposed the following episodes that best align, where possible, with the Oklahoma SIM flagship issues. The Oklahoma SIM project team also considered other factors, such as high cost or high variance services based on available claims data. The state will look to garner support from private payers to adopt the EOC to engender further payment agreement across Oklahoma’s insurance market.

Episode of Care Condition	Description
Asthma (Acute)	The purpose of this episode is to cover care for 30 days following an asthma related trigger.
Perinatal	The purpose of this episode is to ensure a healthy pregnancy and follow-up care for mother and baby.
Total Joint Replacement	The purpose of this episode is to cover care 30 days prior to a triggering event – total joint replacement – and 90 days postoperatively.
Chronic Obstructive Pulmonary Disease (COPD)	The purpose of this episode is to cover care for 30 days following a COPD related trigger.
Congestive Heart Failure	The purpose of this episode is to cover care for 30 days following a triggering event – hospitalization for congestive heart failure.

Episodes of Care Task Force

Implementing EOC in Oklahoma will require strategic and collaborative planning to align providers and payers across the delivery system. The state recognizes the need to develop reporting tools and a thorough evaluation process to assure providers they can self-monitor and redirect efforts midstream if they are failing to meet quality measures or cost benchmarks for episodes. By developing these types of tools, the state can engender trust and transparency with stakeholders who will be a part of this model.

Mirroring the work of other states that have implemented EOC, Oklahoma will create an EOC Task Force (Task Force) for each of the episodes proposed in the SHSIP to ensure ongoing stakeholder participation for the episode’s design. The Task Force will work collaboratively to institute best practices and

guidelines for developing and implementing the EOC. The Task Force will include stakeholders from participating payers, provider representatives, data reporting specialists, and consumer advocates.

Model Supports

Large system shifts, like the one Oklahoma is proposing, require the state to develop the resources and infrastructure necessary to support providers, payers, and patients throughout the transition to value-based care. The Oklahoma SIM project team is preparing to provide ample guidance and resources to ensure that stakeholders can meet the demands of this transformation. Many of the model supports the project will leverage are pre-existing entities and initiatives within the state. Other infrastructural components, like interoperable HIT and redesigning the healthcare workforce, may require more extensive development from the state.

Stakeholder Engagement

Throughout the SIM project, the Oklahoma SIM project team has encouraged collaboration and discourse to ensure incorporation of stakeholder input, facilitate agreement, and foster the buy-in necessary to shape the design of the state's model. The Oklahoma SIM project will continue its engagement strategy and hold meetings to ensure stakeholders participate in the Oklahoma Model implementation. Stakeholder engagement will ensure that the model is implemented in a feasible and inclusive manner that accounts for the regional, cultural, and environmental differences of the state.

At a high-level, the strategies of this SIM Stakeholder Engagement Plan included:

1. Leveraging the OHIP governance structure and workgroups to ensure representatives with the appropriate subject matter expertise and practical experience facilitate, monitor, and evaluate the various activities and deliverables of the Oklahoma SIM project.
2. Utilizing the Tribal Public Health Advisory Committee to seek feedback and recommendations for the model design from Oklahoma's tribal nations and partners.
3. Deploying Oklahoma SIM staff and a Stakeholder Engagement Facilitator to work together in the field to engage new communities and stakeholders throughout Oklahoma to solicit more interest, support, and subject matter expertise for the Oklahoma SIM project.

The Oklahoma SIM project team also expanded its engagement effort to include additional consumers, businesses, public health coalitions, healthcare associations, the state's top payers, and other healthcare organizations to achieve a broader range of support. The Oklahoma SIM project team disseminated information about project goals and objectives, assembled stakeholders, and hosted regional and community meetings. The Oklahoma SIM project team also met consistently with stakeholders to keep them abreast of the design, impact, and implementation strategy of the model throughout its development.

Health Information Technology

Health Information Technology (HIT) is a vital component to healthcare transformation. Studies have demonstrated the benefits of HIT in improving quality, safety, effectiveness, and efficiency of the delivery of care. Effective use of HIT can also help the state collect, evaluate, and make recommendations for care improvement so providers, payers, and consumers can have access to the right information, at the right time, to make decisions about the way care is delivered.

To accomplish this, the state will need to establish the technology infrastructure to support statewide health information exchange and a state-level value-based analytics (VBA) tool to integrate clinical information and payment information (e.g. encounter data or claims information). By integrating these two types of data, the state can get a better understanding of the cost of clinical services, the clinical outcomes and quality of care provided for those services, and the value of rendered services provided under value-based purchasing models. Thus, the VBA tool is vital to the model as it will inform future payment reform efforts.

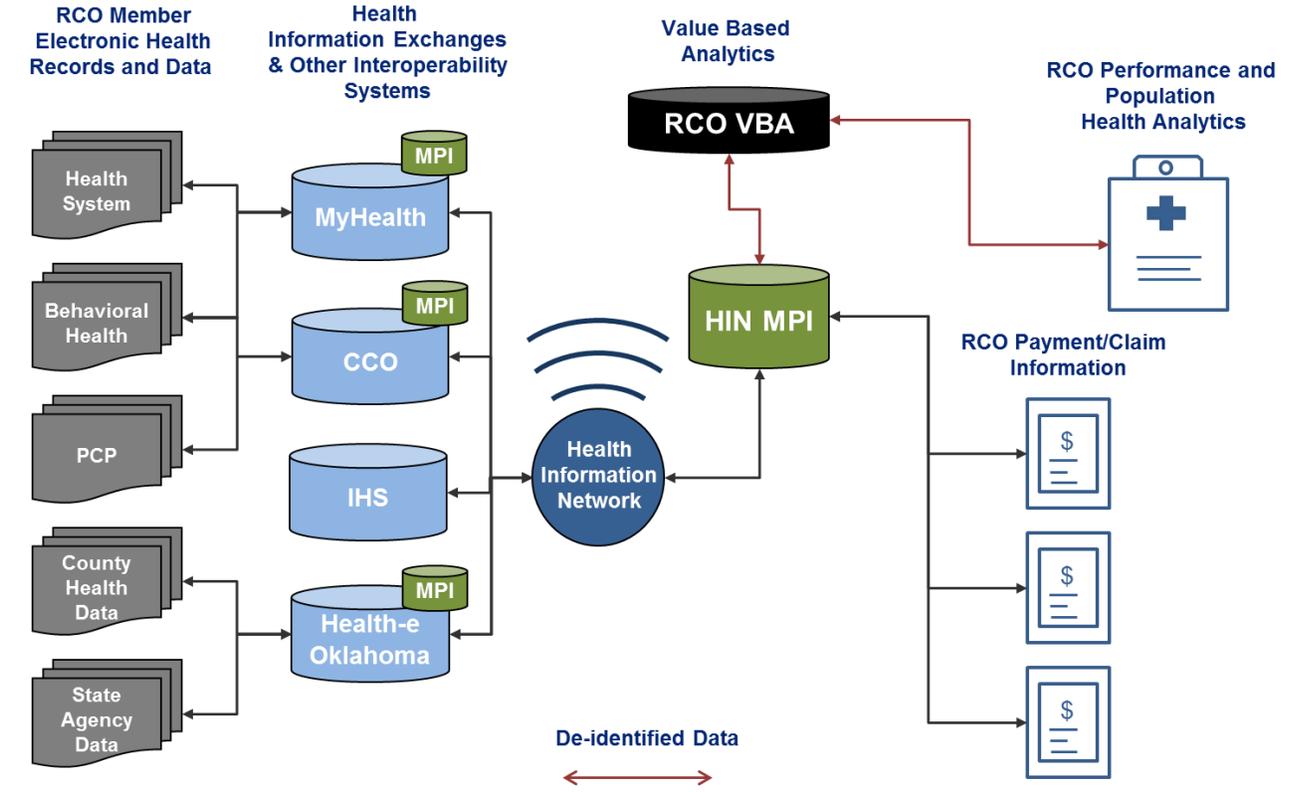
The Oklahoma Health Information Technology (HIT) Plan identifies two major goals with objectives, each related to health information exchange and establishing a VBA tool to support the Oklahoma model.

- **Goal 1: Establish a statewide health information exchange**
 - Establish governance to ensure transparency and collaboration
 - Increase certified EHR adoption and utilization
 - Increase adoption and utilization of Health Information Exchanges (HIEs)
 - Identify technology supports for interoperability and integration of data for retention, aggregation, reporting, and analysis
 - Facilitate statewide information exchange through a Health Information Network (HIN) for HIEs and other interoperability systems, including Health-e Oklahoma and Indian Health Services

- **Goal 2: Develop a state-level solution for integrated clinical, claims, and social determinants of health data to support a value-based analytics (VBA) tool.**
 - Establish governance to ensure transparency and collaboration
 - Identify technology supports
 - Identify and develop staff resources to support the VBA tool

These goals and objectives are critical for the success of the Oklahoma SIM model, particularly for the RCO model. Without the interoperability provided by the HIN and a VBA tool, the state will not have the necessary information to report, collect, and evaluate the efficacy of the Oklahoma model. The VBA tool, in conjunction with the HIEs, will provide data to support model participation and performance metrics. The Oklahoma SIM project team has created a conceptual diagram for how it will use HIT to support the model.

Figure A.9: Proposed Oklahoma HIT Design



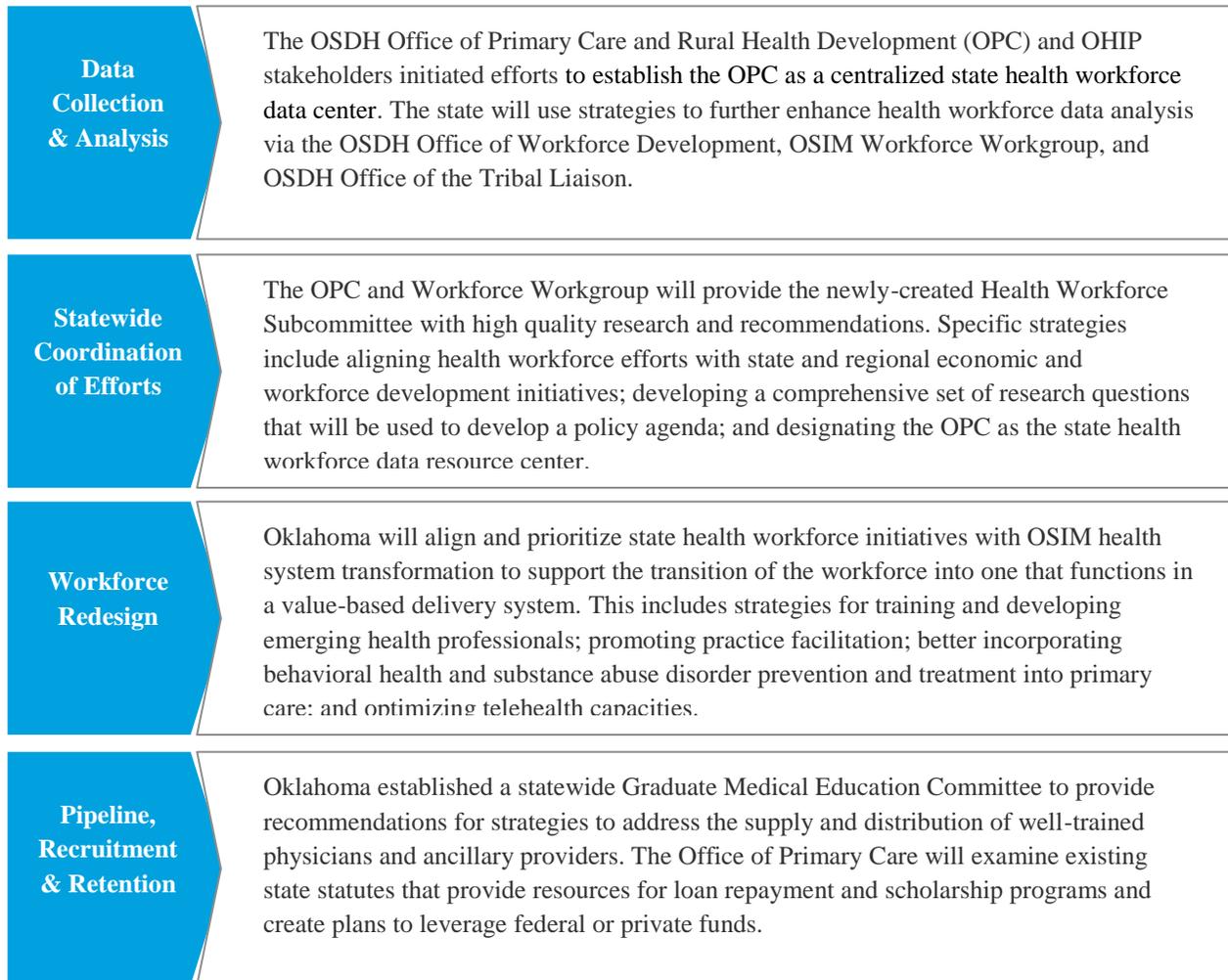
To help operationalize the HIN and VBA, the state will continue to partner with and support the existing private, nonprofit HIEs. The state is also developing the Oklahoma Health and Human Services (HHS) interoperability system, Health-e Oklahoma. The purposes of Health-e Oklahoma are to share data within and across state health agencies, enable the consumption of health information from the two nonprofit HIEs, and providers to submit public health data. This type of health information exchange across both HIEs and state agencies will require multiple levels of governance to ensure transparency, balance, and public/private stakeholder input regarding to the transfer, collection, and use of patient health information. The state will create governing bodies that can help support those efforts and ensure HIT activities, including health information exchange and VBA functionality, align with the Oklahoma model.

Health Workforce

Healthcare transformation requires a well-trained, flexible, and appropriately distributed health workforce. The state created a strategic plan to identify the policies, programs, and resources needed to create a workforce that can support healthcare transformation. Technical assistance and support from numerous stakeholders, including the OHIP Coalition, the National Governors Association (NGA) Policy Academy, and a core team of industry leaders and decision makers, collaborated with the Oklahoma SIM project team to develop the “Health Workforce Action Plan and the SIM Workforce Development Strategy,” both designed to support a transformed system of care.

Central to the plan, the state will launch the initiation and implementation of the four core areas of the health workforce strategy: Health Workforce Data Collection and Analysis; Statewide Coordination of Workforce Development Efforts; Health Workforce Redesign; and Pipeline, Recruitment, and Retention. Those strategies and objectives are detailed in Figure A.10.

Figure A.10: Oklahoma Health Workforce Development Initiative Core Focus Areas



Oklahoma SIM project team will continue to convene stakeholders to implement the core strategies outlined in the Health Workforce Action Plan and the SIM Workforce Development Strategy. The Oklahoma SIM project team will ensure other aspects of model implementation complement and coincide with these workforce strategies to redesign and support its health workforce for healthcare transformation.

Practice Transformation

Healthcare transformation is also likely to affect providers in disparate ways. Independent primary care providers, for example, particularly those in more rural regions of the state, may be less ready for, and more negatively impacted by, rapid system change than those providers who are supported by hospitals or large health systems in urban areas. Since the state is seeking statewide improvement across its entire system, the state recognizes the need for different strategies and supports for providers as the various aspects of the Oklahoma Model are implemented.

To accommodate disparities in provider readiness and to create the environment - both infrastructural and cultural - needed for healthcare transformation, Oklahoma proposes to create a Practice Transformation Center (The Center) to support providers as they move to new value-based payment models. Ideally, practice transformation would be a multi-payer effort that supports all payers as they move to value-based purchasing and implement the multi-payer quality measures and EOC proposed in the Oklahoma Model. The Center will serve as a hub for disseminating evidence-based practices, preventive care strategies, and best practices for incorporating Health Information Technology (HIT) into care delivery to advance all transformation phases. Practice transformation is a critical success component for all value-based purchasing efforts in Oklahoma.

There are already many practice transformation efforts underway in Oklahoma, including the Agency for Healthcare Research and Quality (AHRQ) grant, Healthy Hearts for Oklahoma (H2O), and the Comprehensive Primary Care Initiative (CPCI), that are providing practice transformation resources and personnel. The state will leverage the best practices and information learned through those initiatives to ensure The Center sustains and advances all statewide efforts to achieve the triple aim.

Financial Forecast of the Oklahoma Model

A financial forecast of the Oklahoma Model was provided by an actuarial consultant, Milliman, to estimate the potential savings produced by the proposed innovations in the Oklahoma Model. The forecast analyzed the different programs and populations targeted by SIM, developed projections of future expenditures under the current baseline scenario, and projected future expenditures under the proposed Oklahoma Model to calculate the potential savings between the baseline and the Oklahoma Model scenarios.

Oklahoma is proposing to roll these changes out on a statewide basis beginning calendar year 2018, with RCO implementation in calendar year 2019. The Milliman analysis attempts to capture savings reasonably achievable under all three model elements proposed in the Oklahoma Model, but projected savings from the analysis are heavily dependent upon the impact the RCO model will be able to make on the Medicaid and EGID populations in the state of Oklahoma.

The following table provides a summary of the Projection Year 0 and Projection Year 6 baseline costs for each of the noted population groupings across the Medicaid population.

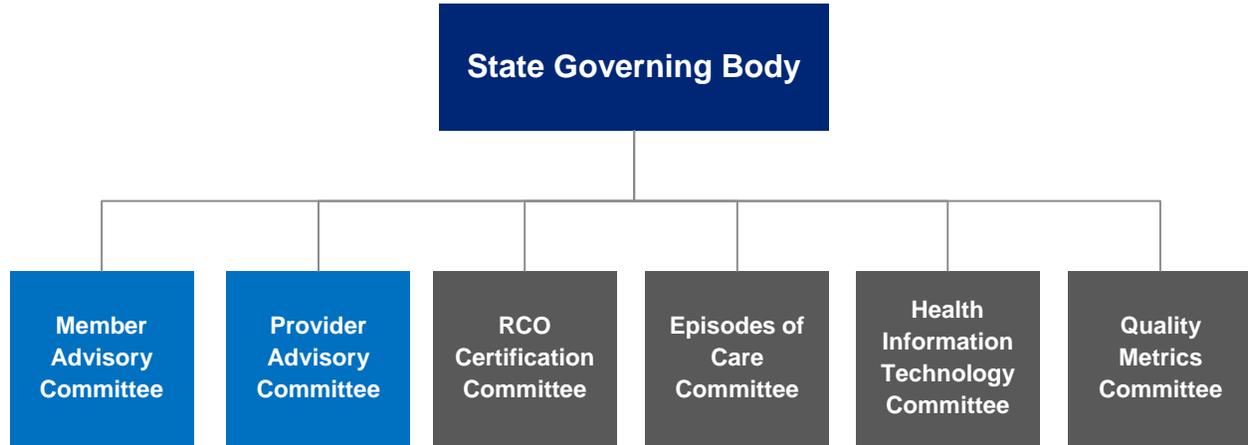
Potential Medicaid Savings (in Millions)			
Calendar Year 2018 to Calendar Year 2024			
Population	Baseline Projected Spend	OSIM Plan Projected Spend	Potential Savings
Insure Oklahoma	\$450	\$440	\$10
Aged	3,560	3,540	20
Blind/Disabled	11,750	11,720	30
TANF	12,050	11,780	270
Pregnant Women	1,150	1,130	20
All Other	270	270	0
Total Spend	\$29,230	\$28,880	\$350

Overall the implementation of The Oklahoma Plan will generate a net savings of \$350 million dollars by 2024, with an estimated 1.8% annual savings thereafter. This return on investment alone makes health transformation attractive for the state, especially so considering the improved health outcomes and superior care that the revised system will provide for all Oklahomans.

SIM OPERATIONAL PLAN

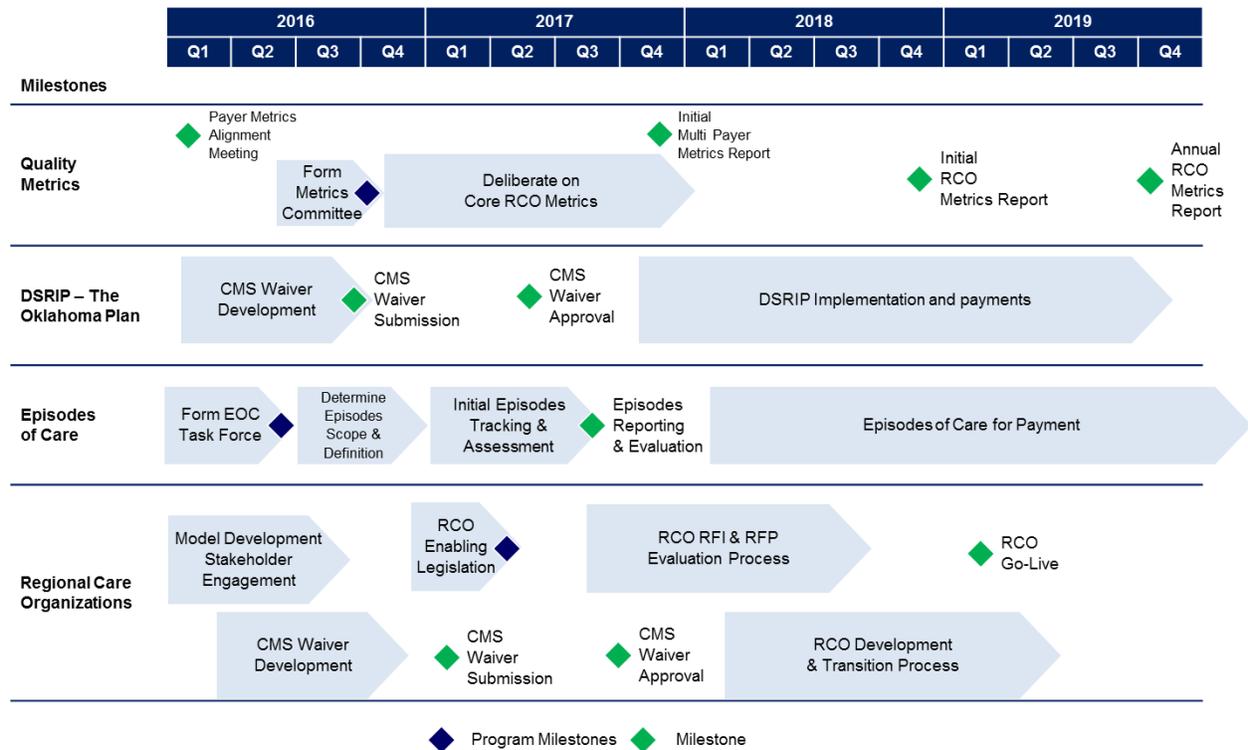
The Oklahoma SIM project team has developed a high-level operational plan and timeline that describes the various implementation activities. Once the governance structure for each proposed initiative (RCOs, multi-payer quality measures, and multi-payer EOCs) is established, the project team will develop a more detailed operational plan that describes specific resources, tasks, and milestones. This will include budgetary items, performance targets, and resource allocation. The governing bodies will include an array of stakeholders from across the health system in order to achieve inclusivity and drive broader consensus in Oklahoma. Figure A.11 shows a diagram of the State Governing Body advisory committees for the Oklahoma Model that will help implement the model.

Figure A.11: State Governing Body Advisory Committees



To support this governance structure, the SIM team has developed a detailed operational plan for operationalizing The Oklahoma Plan. The roadmap in Figure A.12 provides high level overview of the activities that will be required to implement the three SIM initiatives within a six-year period. The Oklahoma SIM team drew on the successful examples of healthcare transformation efforts of other states to develop this roadmap and its supporting, detailed operational plan.

Figure A.12: SIM Operational Roadmap



CONCLUSION

Oklahoma's health system transformation has a high likelihood of success and sustainability. The estimated 1.8% annual savings of the Oklahoma Model warrants investment and participation from providers, payers public and private, and consumers to help the state implement the various components of the model. The state also plans to invest the necessary time and resources to lay the groundwork for a strong foundation to advance the new model for state-purchased healthcare. The state will do so by working with key stakeholders at the state level, including legislators, beneficiaries, health plans, providers, advocacy organizations, and partners at the federal level through CMS.

Foundational changes are needed to transform the healthcare system Oklahoma to a value and outcomes based model. These changes include: infrastructure, workforce, culture, and education. All of these efforts will require significant federal investment that can be used to support hospitals and other entities in changing how they provide care to Medicaid beneficiaries and public employees. The state will need the ability to pursue projects that address these changes and enhance health care programs for Medicaid and public employee health coverage while maintaining current delivery capacity and access. The Oklahoma Model provides the framework to redress the poor health outcomes and excessive health expenditures that affect the current system, and its successful execution should improve the lives of all Oklahomans.