OKLAHOMA HEALTH CARE AUTHORITY

AGED, BLIND AND DISABLED (ABD)

CARE COORDINATION STAKEHOLDER MEETING

4345 NORTH LINCOLN BLVD.

OKLAHOMA CITY, OKLAHOMA 73105

2:00 P.M. TO 4:00 P.M.

REPORTED BY: Lacy Antle, CSR, RPR

MS. HEATER: Well, good afternoon. I guess the room is quiet, so that's my cue to come up to the podium, right?

How is everybody this afternoon? Everybody good? Okay. Very good, surviving the heat and no rain out there this morning.

My name is Buffy Heater, I'm the chief strategy officer here for the Health Care Authority. I'd like to welcome everyone back today. I know we've had several months of hiatus that, as we work through some things at state level, the Health Care Authority took a look at our state budgetary amounts and we know that there was some uncertainty with this project being on hold for several months. I am please to be back before you so that we can get things back in action and also provide you an update of the activities that have been going on since we have been taken off hold, due to the successful budget negotiations by this agency help be able to keep it moving forward.

A couple items I'd like to bring to your attention. Some of you may already know these things, but we have made some updates to the ABD Care Coordination website, so if any of you are curious about the next steps, timelines, if you have

new partners that may be interested in receiving the e-mails or signing up as a stakeholder, to get some of that regular communication, please know that that public website is available to anyone and everyone, that you can go out and access information and sign off and sign up. Please feel free to share that widely with any of your counterparts or colleagues. That is our primary vehicle of getting information out about this effort.

Another thing to pay attention to is that all of these stakeholders meetings are also posted on that public website. For those of you that were engaged before we went on hold, you will remember that we were having stakeholders meetings on a monthly basis, but from this point moving forward, those will be on an every-other-month basis, so we're calling everyone together here in July, we will not have an August meeting, but there is a next regular stakeholder meeting scheduled for, I believe, in September.

The last thing that I'd like to point out today is, you know, from the Health Care Authority standpoint, we recognize that we are doing the best that we can to be able to put out information to all of you in a completely transparent manner, but I do

want you to recognize that any dates that we're putting out on our timeline moving forward are draft. There are many different moving parts in this. There's a series of activities that has to take place as we're developing an RFP and each one is contingent upon the one before it and the one before it, so please recognize that we're making changes, perhaps, to that timeline moving forward. We're going to get those uploaded as soon as possible.

The revised dates that you will see up here as of today. As of today, we are looking to have a first draft of an RFP to CMS hopefully late October/early November with an RFP being released in late November or December, and then we'll be looking at middle of next year for an actual RFP award, so operational processes would take place thereafter and we're still looking at 2018 to have for a service delivery date. So I know those are kind of some major points that you all are first and foremost interested in, but please understand that those are subject to change as we progressively evolve on that RFP.

With that being said, let me remind everyone to make sure that, as you go through these

presentations, take note of any questions that you have and then whenever we get to that portion on the agenda that you have a question, make sure that you're speaking loudly. We are, I believe, recording, if not broadcasting, today's meeting to folks that couldn't be with us in person, so we want to make sure that they can hear everyone's questions and comments. I believe we're using the room microphone system, so I don't believe that you have to have a microphone -- we will have microphones? Okay. So please wait until you have a microphone in your hand to make that comment or ask your question so we can make sure that the folks that can't be here with us will be able to hear that.

Without further ado, I'll pass the mic over to Mr. Andy Cohen -- sorry, he's with Dana, all right, thank you. All right. To do Dana Northrup.

MS. NORTHRUP: Good morning.

Yes, it is afternoon, thank you.

My name is Dana Northrup. I am the project manager for the ABD Care Coordination Project.

So what we are going to start off with today is we need a name for our program. We have, for quite some time, been calling it the "ABD Care

Coordination Program," but we need something that's a little better. So we have been polling staff members here at the Health Care Authority, members of our spirit committee, and we've narrowed it down to four choices and I'm going to ask you today to help us make that final choice. So if you see a name you like, raise your hand. I've got helpers counting the number of hands raised. You may vote on as many of the names as you like. I'm not going to sit here and say only one vote per person. And hopefully, at the end of this little exercise, we will have a name for our care coordination program.

The first name we have is Sooner Health Plus. If you like Sooner Health Plus, please raise your hand. You can vote for all of them, if you want. It's just if you like this name.

Okay. ABD Connect. Does anybody like ABD Connect? Okay. You guys are a tough crowd.

Soonercare Plus. Okay. And last but not least, Sooner Align Plus.

AUDIENCE MEMBER: The first one.

MS. NORTHRUP: So Sooner Health Plus? Okay. It looks like we have a winner, Sooner Health Plus.

Also, before I turn everything over to

Andy Cohen to go over the presentation of the RFP and where we're at right now, I would like to take a minute to introduce our friends from Mercer. We have Michael Nordstom, who is the lead actuary handling the acute care side of it and Kevin Russell, who will be dedicated to look at long-term care. They have signed on our actuary consultants and will be helping us developing our rates for our program. That being said, let me turn it over to Andy Cohen.

I'm sorry, I forgot. We have our evaluation consultants with Westat here with us today. They're going to be handing out a survey. If you wouldn't mind taking a couple minutes to fill out the survey, and there's someone at the front desk -- or the table outside that will be collecting it. If you need to leave early for some reason, please make sure -- does he have some out there -- to grab a survey off the table and fill it out before you leave. Thank you.

MR. COHEN: The name of the program, ABD Connect, aren't you glad you voted?

All right. There we go, Sooner Health Plus. Your wish is our command.

Well, it's a pleasure to be back and I see

lots of familiar faces from our previous meetings. I don't want to take credit where credit is not due, but I will let you know that my landing here last night exactly coincided with the heaven's opening up and the rain coming down and the lightning, so take that for what you will.

What I want to do today, since we have not met for -- it's been a little while since we last met, is I'm going to take just a few minutes up front and I'm going to recap the group we've done as stakeholders and OHCA over the preceding months to get us to the point that we're at today, so that will be just a little bit of a walk back through some our previous activities, or if this is a new meeting for you, it will be a catch up for you on the work that has occurred up until now.

Then we'll pivot and we'll take a look at some new information around the request for proposals in status right now, how we are using information that you have provided to us as stakeholders representing all the various constituencies that are going to be affected by this program, how we use your input to actually form the standards that are going into the RFP.

So I always like to begin with this just

to remind us why we are all here today and why we're not all off doing something else, and that is HB 1566, legislature which instructed OHCA to initiate an RFP care coordination models for the ABD populations with the persons or residents of institutional settings coming into the facility.

You may recall this slide from some of our earlier meetings when we were asking the question of who are the ABD members that are going to be covered by HB 1566, and we took note early on that it's not one elitist group, which I think many of us in the room are already aware of, but in fact, the ABD population is comprised of a number of distinct populations and groups, each with particular needs, concerns, service requirements, aspects of the program that may work better or less well for them in today's environment. We have Medicaid/Medicare due eligibles who are or not receiving long-term care, these are, in some cases, individuals who are in relatively good health today.

We have Soonercare Choice Medicaid only APA members, so these are folks who don't qualify for Medicare, so their costs primarily are exclusively being paid for by the Medicaid program, but many of them have chronic conditions, multiple

needs, health needs.

And then we have our long-term care populations, we have our frail elders and persons with physical disabilities who either are receiving services through a home-community-based waiver, such as Advantage, or who are residents of nursing facilities, and we have their counterparts with intellectual development disabilities who either are receiving services in waiver or who may be in the Soonercare program receiving state plan services, or on the waiting list, or who may be a resident of an ICFID today.

And then across all of these groups we have individuals who have some level of behavioral health needs, in addition to physical health needs, and those are not unique to any one group.

So as I said, I want to take a few minutes to talk about the stakeholder process over the past months, then we will move on to an update of the request for proposals. I want talk about the drafting of the request for proposals, and within that, something that you'll see referred to as a "model contract," and that's -- it's a component of the RFP, it's really the heart of it, where we describe the operational standards and requirements

that managed care organizations who choose to bid participation in the program will be helped. And as we talk about developing the model contract, I also want to say a few things as we get into that part of the presentation about CMS, Centers for Medicare and Medicaid Services, which some of you are familiar and have been now for some time, over the last couple years, who have been working on some national standards for Medicaid-managed care programs, so that they can have higher uniform standards as a starting point at least that would be consistent across all states. And for some time now they have been referred to as "proposed rules" that were out, and I think we talked about those in some of the earlier meetings and we apprized we were doing our work to be cognizant of those rules and those standards in making certain that we always met them, and in some cases exceeded them, if we thought that was appropriate for the needs of our population in Oklahoma.

Well, those rules moved from being proposed to being final a few months ago and so we've been busy going through and making certain that any changes that occur reflected ultimately in the RFP and the model contract.

And then, of course, most importantly. We have worked through the recommendations that came from the stakeholder community to ensure that those have been addressed in the RFP standards and model contract standards. So we'll go through that process, I'll share with you what I can as to where we are today, and then we will wrap up with the discussion about next steps and timelines, keeping the draft aspect of that in mind.

So we had, leading up to today, a series of stakeholders meetings during which time we did a lot of the initial groundwork, talking about the programs that exist today to different populations, but it's not really one program, there's a program, really, associated with each of the ABD populations. A program has characteristics that are unique to each population. And so we spent some time going through that and taking a look at strengths and weaknesses and gaps in the program and so forth and we had a series of meetings, of course, here in this room in Oklahoma City with a mix of attendees, as we have today.

Some of you may recall that last August, coming up on a year now, we also, through a request for information process, had solicited ideas,

thoughts from potential contractors who would be working with OHCA in accordance with HB 1566 to provide care management or care coordination and we asked them for their notions of what might be appropriate models for these populations, so some of you came to the presentation that those organizations gave, in addition to the bid submissions last August.

Well, we didn't just stay put in Oklahoma City, but I have opportunity to go out and see the state and so we, in last September, took our show on the road and we met with stakeholders in meetings like this, not quite this big, except in Tulsa, which may have been bigger, except the room may have been one-fifth this size, so this felt bigger, but we had meetings with stakeholders throughout Oklahoma so that we could learn about difference in terms of how the program works and needs and concerns, recommendations from around the state. And then we had some targeted needs as well as I can with particular groups and their representatives and their families in October.

In the larger stakeholder meetings we had providers of various sorts attending, we had members and their families represented, we had some other

types of stakeholders, like elected officials. And in the meetings the kind of things that we talked about, we began the meetings at the beginning, which is fine, HB 1566 talked about releasing an RFP for care coordination. What does that mean? What do those two words mean?

So we began there, by talking with stakeholder groups about care coordination and what it comprises. And out of that you may recall, for those of you that were part of that process, what we were hearing from stakeholders ultimately came through to us as really being not some static definition, just one description to capture everything, but rather that care coordination could be thought of a cycle with several steps.

There are actually five steps that are in that cycle that a member and their family would go through before the cycle would repeat again. And once we had gotten that cycle defined and described, and we'll look at it again here in a moment, and we knew what each step in the care coordination cycle could be described as, then that raised the question of what would be examples or definition of effective care coordination at each step, what would we want to see achieved by way of care coordination as we

move through the cycle?

Which then, of course, led to the last two questions: How well are those principles in private care coordination being met today in the program, and to the extent that they could be improved upon, how might we go about doing that, how might we go about strengthening care coordination cycle to our members and their families?

The meetings themselves, they were unique to the folks who attended them. No two were identical. The regions, we did identify some differences as we went across the regions of the state in terms of what we were hearing, so a lot of commonality, too. I would say more commonality and more common grounds than there were differences from meeting to meeting throughout the state. And that allowed us, then, to really begin to identify what we saw as principles of effective care coordination, care coordination that would be both member and family centered in its design.

So these were all meetings where people were talking with us face to face, but we also encourage and we received some very thoughtful written submissions from stakeholders describing their areas of greatest concern, their greatest

priorities and offering us recommendation for how the program can be improved upon, or in some cases, if we went in a direction that they weren't recommending, what they would like to see as protections for members or providers, as a way to address concerns that they might have that would lead them not to make their choice, in terms of a care coordination model.

Now, I have a note here at the bottom that I always want to remind folks. You know, we talked with lots of people, it's a great turnout here today, lots of interesting people have participated in this process and have brought tremendous amounts of information to us that will allow us to do our job. We could not have done it otherwise. I won't pretend that every stakeholder in Oklahoma has been heard from, but they are relying on those who have chose to participate. I feel confident that you have done a great job of representing the stakeholders that stand behind you, that I think has the same concerns, preferences, would have the same recommendations as you do, so I think we've gotten a good sense of where the stakeholder communities' sentiments lie, based on this process, but I have that caveat because I didn't meet with every last

person in the state.

So the care coordination cycle, just referring to, so you may remember this slide if you've been to some of the early meetings, it's not particularly fancy because I did this and I predate PowerPoint by quite a few years, but I did my best.

In the middle we've got the member and their family being supported by their care team, whoever that may be, and then we have the cycle going around. But it begins at the top with determination of eligibility and enrollment in the program. You may recall we received quite a bit of feedback from stakeholders about the upfront eligibility process, which sits outside of what we are doing vis-a-vis HB 1566, but the enrollment piece is part of it, so I don't have enrollment squeezed into that box, but we'll talk about enrollment here in a moment.

Once somebody has been found eligible in the program, then their needs are assessed, and out of that assessment of needs and identification of needs that a care plan is developed that needs to be member centered and family centered in its nature. The care plan includes whatever services that are identified is appropriate and necessary for the

member and desired by the member and their family, and from that, then services are authorized and the true care management or care coordination is on ongoing basis, from that then we monitor out.

So within the care plan, in addition to the services being authorized, there should be member goals that those services are intended to advance, so how well is the care plan or the services doing in advancing the goals that the member and the family has established for themselves? And after a period of time, eligibility is recertified, assessments are updated, and the cycle repeats.

I see folks taking notes, and by the way, this wasn't posted. I think sometimes we post this in advance, but I think the intent will be to post it. So you'll still be able to take notes, but if you're scrambling to get it down, know that it will be there for you on the website.

So that sort of takes us up to where we were now. And there was a lot more detail in the earlier meetings around what we heard from stakeholders about at each step along the way, what represent effective principles of care coordination and how the program works well today, because there

was some elements where people think we work well and how it can be done better, and if I went through all those slides, that would be all we were doing. And so those are out there also on the website and if you were not at some of those meetings and to want to see how we got to where we are now.

What I want to do now is pivot to talk about the RFP process itself. So the draft RFP, which includes within it, most of what it consists of is this contract with the standards, the operational and standards for our contractors is nearing completion. And I use "nearing completion" as a good general vague term that tells me, as well as the folks writing it, we're well past the half way point, the point of no return, as they say in the aviation industry, but it's not done yet, so the work continues.

Now, what will happen is, when the draft is completed we'll look at some -- probably touch on some dates and we'll look at dates here at the end of my presentation, but the draft has been completed, then it gets submitted to CMS for CMS's review and approval. CMS has the right of review approval for RFPs like this one for programs like this, so it'll go to CMS for that purpose.

Now, under the procurement rules that we live under in the Oklahoma, it goes to them on a confidential basis, because we can't release something in draft form that's going to go out as a procurement document, but I'm going to try and give you some sense of how we've been approaching the standards by looking at some aspects of what we've done as it relates to some of the key recommendations that we heard from stakeholders. And if we could do more, we would do more, but we have to abide by the law, so we can't go any further than slides.

But CMS will do its evaluation, give us its feedback, and then from that, finalize and release the RFP.

In addition to the portion that CMS will be looking at, in terms of standards, we'll also be finished post submission requirement section. And so that will be the part where we ask potential contractors for the information that we need in order to make decisions, and I'll give you some sense of what that is about in a few minutes. Also, our actuaries that they introduced are -- will be busy on papers that will be with the comments.

So I think I've said this three or four

times, because I couldn't wait for my own slide, but the model contract portion of the RFP has these operational standards within it and it's been formed by a number of components or inputs. First, we did take look, there has been -- as he talked about in some earlier meetings, there's been a great deal of activity in other states around the country in terms of enrolling the ABD populations into managed care and so we've tried to take advantage of that by looking at best practices in other programs around the country to draw upon those best practices, and at the same time lessons learned.

So we talked to folks in other states and got the experience of other states and where there are lessons learned, then we can also use to inform and design the process, we've done that as well.

And then, as we've talked about already, we work to make certain that we meet the final rule requirements, in some cases going beyond them, and of course, we work through the recommendations that are coming to the state. As I said, those recommendations came from both meetings, face to face and then written submissions, they both were used, have been used and are being used in drafting the contract standards.

Many of the recommendations that we received from stakeholders, particularly the written recommendations, mirrored or were posted online with the CMS rule and that's, I think, appropriate. What, in some cases, stakeholders did, I think, was take a look at what was in those proposed rules and those elements that were of greatest importance to them they wanted to highlight for us and sometimes added to that information, and so that, I think, was an effective exercise for part of the state who did that.

But in addition to that, of course, we had lots of very thoughtful information and recommendations that came in based specifically on situations that we face here in Oklahoma in the program that we have today and what works well and where we have gaps that can be addressed.

So I have here that the model contract, which you can't see, is 300 plus pages. It's actually, at the moment, 300 pages exactly, but I'm sure it will only get bigger, so I think the plus sign's safe. And it covers over 20 operational areas, and these are not all 20, but here are some examples of how it's organized. When it is released you'll see it goes through operational areas, and so

I've just kind of listed here some that are truly member related, some that are providor related, some that are quality related. So the member related we'll talk about in just a moment.

We talked about requirements for member services, about transition of care, both at the program's beginning when people are coming in, who may be served today and who will be moving into a managed care organization, but also people who are in the managed care organizations and have a transition, say, of setting, somebody coming from the hospital back home, for example. Medical management requirements, care of disease management, obviously critical, because I think it's safe to say that's the biggest section within the contract, that's what brought us all here. Native American population has some specific requirements and protections associated with it, and then if somebody has a complaint or appeal to file down the road, then we have very specific requirements regarding how that works.

Provider related, we'll have requirements around network composition, service accessibility, which also applies to members, of course, around contracting rules and provider services, so those

who will be doing provider relations activities, our aging health care providers are specifically addressed, just as our members are.

And then, of course, there are lots of operational rules around getting claims paid timely and accurately, so on and so forth. And then lots of quality related requirements around licensure, administration, about staffing requirements, around quality improvement programs, performance standards, and program integrity and compliance activities. And this isn't everything, again, but this is just to give you a sense.

Okay. So now here where we're all tiptoeing, as far as we can go without something from legal or contracting dragging me off the stage and away from the podium, and that is that I'm going to provide some examples of how -- recommendations that we receive, which you may recognize yourself in these recommendations because I tried to take them verbatim, although I have not identified where they came from. But taking these recommendations and showing you how we try to address them in the model contract.

Now, not every -- you know, we're going to go through a number of slides here, and as I said,

the model contract when I got up this morning was 300 pages, it's probably 301 just while I've been talking to you here, it will continue to grow like a tree in California. But you're not going to see everything, so just because you don't see something, even within a responsible recommendation, doesn't mean that we don't have something that speaks to it, it just means that I didn't squeeze it on this particular slide. I wanted to get as much as I could, without squishing it too much.

So the full list is much more -- the full list of recommendations we got you're also not going to see anywhere close to all the recommendations we got, much more extensive as to contract requirements.

Now, what we are working to do, alongside the development contractor, and I hope this will be helpful to folks who submit written recommendations, is we're preparing a companion document, a matrix, that takes all the written recommendations that OHCA received, list them all out, and then has alongside of it a description of how that recommendation was addressed within the model contract, so it may be that it was addressed precisely as requested, it may be that the recommendation was made for X plus Y and

we tell you X is there and Y is not there exactly, but something similar is there, whatever it may be. And so that should help facilitate your review, since 300 plus pages could otherwise be a lot of -- I'm sure many will read it stem to stern away, but hopefully that will facilitate your review when that occurs. Please tell me that it did, because the folks, some of you have been checkmarking who have been spending large parts of their lives working on that, so if you do think otherwise, then don't tell me.

So I'm going to walk you through, and the way I've organized this is around the steps on the site, you can take advantage of that concept. So at the top we have eligibility/enrollment and here are two recommendations we received as examples.

The first recommendation was that we should be using an independent third party to provide options counseling to all eligible members. So before anybody would be enrolled with a managed care organization, and they'll have a choice among several, the recommendation was that there be somebody independent of OHCA, independent of managed care organizations, who would be working on behalf of the member's interest and would be counseling

them, educating them prior to them making a selection, so they are able to make the most informed choice possible.

And OHCA will, in fact, be using an independent options counseling member for that purpose. They haven't been selected yet, so I don't have a name for you, but that is the intent.

Members will be educated about the program, and one of the things that will be honed in on is, if the member has existing provider relationships, helping them to identify which MCOs their providers will participate in today, that could be, really, the beginning of the end for some folks. And then we want to allow lots and lots of time, particularly during this initial transitional period when people are going to be moving from one program to a different program, we don't -- we know that will already be a stressful time for some people, we don't want it to be a hurried process, so they will have up to 90 days, three months, to make a choice of what plan. And once the program's up and running, then it will become 30 days. We don't want it to sit out there at 90 forever because we want people to get in and get a care coordination, but if somebody's coming in new to the program, it's

not quite the same, but we'll still allow 30 days for someone new coming in. If somebody hasn't made a choice at the end, they'll be assigned to a plan. We will, in our assignment, be looking at the same things that they would be considering if they had made a choice, such as, again, they have an existing relationship that you know of.

The second recommendation, members should have the option to continue enrollment existing successful programs. Remember I said a few minutes ago was part of what we heard from stakeholders is, while the program can be made better, there are some aspects some people like, such as PACE, behavioral health homes, and patient centered medical homes. So PACE, this is actually not news, because I think we had said this one earlier, but PACE will continue to be offered as an option to qualifying members. So if somebody's coming into the program, if they qualify for PACE, if there's a slot open in PACE, then that will be an option that will be ascribed to them. If they're already in PACE, they don't have to do anything, they'll stay in PACE, they don't have to go out and back back in or anything like that.

Behavioral health homes, which are a newer

delivery model in the state have been growing and the general experience today has been very positive. Within those people are receiving care coordination already, they're receiving integrated care across physical and behavioral health, so the decision was to sort of co-enroll them into a managed care organization didn't make a lot of sense. So if somebody's in a behavioral home, they will not be co-enrolled in a MCO, they will be in the behavioral health home for however long they're in the behavioral health, that will be their source of care coordination.

In the terms of patients that are at medical homes, that will be a core requirement of the MCO, so everybody coming into the program who is Medicaid only will have patient center medical home that they're aligned with. If somebody is Medicare/Medicaid dual eligible, their physician services are first and foremost in Medicare, so the requirement isn't quite as stringent, it's still something that can be done as an option.

So the next step on the cycle -- how are we doing on time? 2:40. So we're fine, we don't have too awful much.

The next step of the cycle is somebody has

been enrolled and we want to take a look at what their service needs are based on their profile. So the first requirement or recommendation was to require the MCOs to provide person centered assessments to all members, which does not occur today. As we've talked about in some of the previous meetings, there are lots of Soonercare ABD members today who do not receive any sort of formalized screening or assessment of their needs. For example, with a Soonercare Choice member population, those who don't have Medicare and are not in long-term care, there's only a small percentage who will receive formal assessments and care plan activities.

So the first bullet you see on the right-hand side is that yes, in fact, MCOs will be required to perform an initial health risk screening on all their members and they'll be required to report to OHCA their screening results so that OHCA is able to monitor, almost in real-time, their performance on the screening. And based on results of the screens, the members are going to be assigned a risk level, except for those that are the lowest risk, those would be folks that are healthy, have no real service needs or desires, everybody else moves

to yet another stage and we see a -- we had some assessment in person across all the various domains that you see listed here, medical needs, functional needs, activities of daily living, mental activities of daily living, if they need help getting dressed, bathing, if they need help with activities such as shopping or cleaning, so forth, behavioral health needs, social service needs, so beyond just classic medical and behavioral health, but also social service needs and preferences. Member choice and family being first and foremost in determining needs in regard to the care plan.

And the second recommendation was to require MCOs to reassess members at least annually and they will be required, per the recommendation, to do at least annual reassessments and updates to care plans as appropriate, but in addition to that, if a significant change occurs within 72 hours of that event, having an update to their assessment.

So they've enrolled, they've been assessed, lots of cases through that comprehensive assessment stage, and then based on that, we move to the care plan step.

The first recommendation was, and it kind of follows along making certain everybody receives a

screening, is that we require MCO to provide first and foremost care planning to all members. In fact, MCOs will be required to develop person-centered care plans for all members, so one bullet matches the other and there's a lot behind that, but person-centered care planning, the model contract has lots to say what we mean by that and what our expectations are, more than I think that this can take you through here now, but as I said, just because you don't see things described doesn't mean that you won't find that they're ultimately in the contract.

The second recommendation: Allow the member to participate in development of care plan and require member sign off of the care plan upon initial development and any subsequent changes to the plan.

And this certainly isn't approximate, when we say person centered, member centered, there's a larger family involved in that family centered, that certainly gets the crux of what we mean by that.

So you see a reference here of "interdisciplinary team," so that's a term that didn't appear on the earlier slide, but the expectation is going to be that if somebody's moving

toward having a care plan developed, all the comprehensive assessment, that there be an interdisciplinary team, multidisciplinary in nature, created appropriate to each individual, so the team may differ in terms of who's on as you go from member to member. But included on that team will absolutely be the member or their legal guardian as a full participant, and if a member wants to invite someone else to sit on that team as well, then they'll have the power to do that.

The care plan itself will go back to the member or their guardian for signature required for recommendation, but the absolute intent is to have the member -- the cycle, the member and their family is in the middle, and that's not just meant to be for purpose of creating a PowerPoint slide, that's how the operational requirements of the program are being drafted.

So we get to the point in the cycle where we have done the care planning, services have been identified, a service plan developed, a backup plan developed, so if the primary service provider is not available, we know what happens next so that the member doesn't experience a gap in care, similar to what we have in the Advantage Way program today.

That's all been developed. The care plan also identifies the goals that we're trying to achieve and then services can begin and the ongoing care coordination occurs.

The first recommendation here we had -- thinking back to these care plans just a moment, was to require MCOs to continue existing care plans during a time of transition, until new providers are in place and new providers can take over the care plan. So we heard this and this is something that, I think, certainly has served as a best practice in other state programs that we looked at as part of our contract, and so -- and this is really focusing on that initial implementation period. Members that have existing care plans, those care plans have to be accepted intact, the services essentially continue to be authorized, and stay in place for 90 days, which is meant to be the amount of time necessary for the MCOs to get out and do their initial assessment, and out of that, potentially leave the care plan as is, perhaps working with the member and their family, making some modification to the care plan, but we want that period of time to be in place, so people have 90 days to choose a plan and then the next 90 days that they have a care plan

is to work thoughtfully through with the MCO and interdisciplinary team to determine what's appropriate for them based on the assessment occurred, the updated assessment that occurs, to meets their needs and goals.

The next recommendation/requirement is decrease or eliminate existing services for a member to undergo a secondary review prior to implementation. So they've gone through that stage in that first 90 days and the recommended change is one that reduces services, so we have a requirement first within the MCO itself that all care plans must be reviewed by a supervisory level care manager prior to implementation, so we have heard that recommendation built in as a requirement secondary to reduce them.

Then the IDD members in particular, where there has been less experience, not no experience, but less experience with this population in managed care than for other populations, we also included the step here where, during the transitional period, PHS/PBS, which contain both these care plans, will also be taking a look, prior to any updates or changes occurring.

So then we come to the last step in the

cycle, which is outcomes monitoring. A couple of recommendations here related to quality. The first, the state must have in place a comprehensive quality management system that measures the effectiveness of services in assisting individuals to achieve personal goals, turning back to the goals that I've talked about that are part of the care plan. The MCOs will be required to have a continuously updated quality improvement program that will be monitored by OHCA.

The next recommendation: Standard national quality metrics must be incorporated, it's beyond a recommendation, with outcomes reported no less than quarterly. So a couple of things to say about that.

The model contract itself is going to include a comprehensive schedule, a physical health, behavioral health, HCBS, clinical performance measures that we're going to use, that OHCA will use to monitor MCO performance on a continuous basis and some of those measures will be reported quarterly, some less frequently, it just depends on what makes sense for however they capture in a particular measure, but we're not just going to look at so-called clinical measures because that doesn't

describe the entirety of the experience for those that are interacting with MCOs, either members, their families, or providors, so they'll have a pretty comprehensive listing of measures that we'll be looking at that are not clinical in nature.

So member services, as we mentioned, that's one area that's addressed in the model contract. Can members and their families get through if they phone the MCO there in Tulsa, are they able to get through? If they have complaints, how are those complaints resolved? Are they resolved within the satisfaction of members?

For providers, I'm going to guess you're going to be interested in whether or not your claims are being paid timely and accurately and so shall the OHCA, so that's something that will be reported on later in the month.

So that takes us through the cycle. I have one more slide where I wanted to put up a couple of items that relate to the model contract and draft that are specific to member rights. And I wanted to include these because these were in written recommendations, they also came up in some of our face-to-face meetings, I know that they were viewed as priorities by a number of stakeholders,

many stakeholders, so it didn't fit perfectly in one of the steps in the cycle, but they were important, so I wanted to touch on them as well.

The first was recommendation that OHCA require a newly funded ABD Coordinated Care state program be included within the ABD Coordinated Care Program, now known to be Soonerhealth Plus. So this recommendation was, I think, directed toward OHCA state and that's not something we can address through an MCO model contract, but there were some things that we thought we could do within the outlines of the contract.

And so what we have done is to create a position that we're calling member advocate/ombudsman. These will be individuals that will have a direct reporting relationship in the MCO to their executive management, so there weren't any filters between them and the folks that are ombudsman in the plan and they're going to have responsibility for a whole variety of aspects of the plan, operations that are going to be important to members and their experience.

So they're going to be looked to to advocate on behalf of members and their preferences and working with members and their families to make

sure that those are recognized and respected within the care planning process. If there are resources out in the community beyond what the MCO is directly responsible for that a member may benefit from, helping the member to identify those resources and to access them, and then providing them information about other available services inside or outside the plan. And then, again, in the unlikely event that somebody someday somewhere somehow has a complaint or wants to file an appeal, they'll be there to help them do that,so they'll essentially be working on their behalf within the plan to do that.

The second recommendation: That OHCA shall appoint at least three family advisors to a quality of care review committee and these appointees shall represent and educate and diversify Medicaid recipient families. I think this recommendation may have been directed certainly at the OHCA level.

What I can speak to here is what we're doing in terms of the requirement in the model contract, and that is to mandate the establishment of an advisory board that will be member majority in composition within each MCO, they'll include members, member representatives, advocates,

providers, and this will be a board whose admission will have at its core -- this won't be the only thing that they'll be potentially empowered to do, but we want its core mission to be focused on quality, quality within the plan -- yes, sir.

MR. WHITED: Andrew, going back one to the advocates or the ombudsman being --

MR. COHEN: I'm sorry, yeah.

MR. WHITED: Now, from what I'm reading here, the ombudsman advocate will be employed by the managed care organization?

MR. COHEN: Yes, or contract with them, yes.

MR. WHITED: Which my name is Bill Whited and I'm the state long-term care ombudsman. That would be like me -- I'm sorry. I'm Bill Whited, I'm the state long-term care ombudsman. If the ombudsman advocates are employed by the managed care organization, that would be like me working for the nursing homes and trying to advocate for members with the very individuals that pay my salary. That is a tremendous concern and I think a huge flaw in the design of what you're describing.

MR. COHEN: Perfect timing for hearing that. It's been all good news until now, mainly

because that was the first comment that I recognized from the board that made this plan.

I'd say a couple things. First, again, as I mentioned, I think this recommendation may have been actually directed as something that would occur at the state level and isn't precluded by whatever requirement be built into the MCO contract.

What we're able to do within the four corners of the MCO contract is talk about standards that are applied to the MCOs, so I think that could occur outside, that's great, and that's somebody else will do that. What we're able to do within the MCO contract, though, is try to build in this kind of advocacy position on behalf of the members. And I can only speak from what I have seen in other programs.

I mentioned that we looked at best practices, this is something that has been pioneered in a few other states and I would say don't dismiss the potential for individuals who come to this position with the right intentions, which that's the type of people that are typically recruited for these positions, to do a good job on behalf of the members. I have seen people fill these positions and do an effective job. If they don't, if it fails

within MCO, I think we're going to learn that. We're going to see that both directly to the fact that they're not going to be able to keep people in those jobs, as well as indirectly through things like member complaints, which aren't being -- those are increasing in areas where member ombudsman, we would expect, to be able to do some work on behalf of the members. If members are unaware of community resources that are available and that kind of assistance isn't being provided, I think we'll learn through those kind of monitoring activities that this needs some work and development of the plan, but we'll see.

Not everything that we try will necessary prove to be a home run, but I'd say I think I've seen this have value in other programs and so I think it's worth giving a try here. But again, it does not at all preclude what I think as part of what was built into this recommendation, whichever stakeholder submitted this.

So let me just take you a little bit through the last part of the RFP document. So we've been talking here up until now for the last, I guess 40 minutes or so, about the model contract, to the extent that I'm able to talk about it in specifics.

And the other piece that will go with it, as I mentioned briefly before, is the proposal submission section. This is where we gather the information that we need in order to, we hope, be able to select from what will be a large and enthusiastic response from potential contractors who can filter through those proposals and find who does the best job on behalf of our members and working with providers in the state and they'll be both a technical piece to that and a price piece to that.

The technical piece is going to address a whole variety of operational aspects of the plans. First, bidders proposed regions, if they are proposing a regional response, or if they're proposing statewide. I think we've had in some of the earlier meetings discussion around require statewide proposals or maybe allow for something less than statewide as a way to give an opportunity to organizations who might not be in a position to participate throughout the whole state but have something of value to bring. And so we want to give that opportunity, so that's something that, obviously, would be addressed in the proposal submission, of whether somebody is looking to serve all of Oklahoma or a portion of thereof. And then

the information on licensure, financial stability, and so forth underlying structure of the organization to ensure that it's an organization that's in a position to be able to take financial risk to serve members.

Then we'll want to take a look at experience and past performance, first in Oklahoma, if applicable. So if an organization is in the state today serving members who are either at risk or maybe from a provider standpoint, not just, necessarily, the ABD members, but if they are serving Medicare, serving even Insure Oklahoma or commercial, we want to know how that -- that brings some knowledge to the state provider system in Oklahoma to the table. And then, of course, if it's an organization that operates today at risk in other states for populations like those that will be covered under this program, that's relevant experience that we'll explore further.

A lot of what will be in this part of the RFP will be questions about their approach to meeting contract requirements, how will you. We don't want just affirmation or a promise that someone understands the requirement and will meet it. We want to hear how they're going to meet that

requirement, because it's in the "how" that we really learn whether or not the requirement is well understood and somebody has a realistic plan for meeting, or in some cases we're hoping exceeding, whatever that standard or requirement is, those will be the how-will-you kind of questions.

Then I'm a stronger believer that you have to get beyond just the abstract description of how you're going to do something to take a look at the actual people who will be covered under the program and we do that through case studies. We don't take real members and use their information, that would violate their privacy, but we do construct case studies around members who are representative of all populations that will be covered under this program. So we have a whole variety of different members with different situations living in different parts of the states with different concerns, issues, needs and we ask them for a plan for serving those members and we see how those plans stack up against our expectations and against plans and meets our selection process.

We're very interested in Medicare/Medicaid integration strategies, since most of us know most of these people have Medicare in addition to

Medicaid. Innovative approaches, maybe something that was tried in another state that worked well, whatever may be the case, if there's innovation that can be brought to the program, if there are value-added services that are -- that a potential contractor is willing to offer up, we want to know about that as well, because we want everybody to meet these requirements in model contract.

But if we're going to have the choice for members, and we will, then we'll have some differentiation beyond those standards in terms of different innovative approaches that plans will take and that can be a basis for complying with best practices in Oklahoma and then other states will come and look at us for best practices, rather than us looking at somewhere else.

The price portion will address the capitation rates, that's how these organizations will be paid each month on a per member, per month basis to care for the members, pay their services and perform the care advantage activities and so forth.

The last bullet here is -- I put it here I believe there have been some questions that come through providers, perhaps maybe other stakeholders.

As we move toward the proposal submission period, when we get to that, whether or not MCOs and want-to-be contractors will have to come to us with fully formed provider networks with contracts having been signed by all providers that will be in their networks? And the answer to that is no. And the reason we say "no" is not because we don't believe that is a critical component of what the plans are going to be doing, but we don't want to put providers in a position of having to sign contracts with organizations with whom they may never do business because those organizations don't get a contract from OHCA.

Instead, what we want to do, we will ask about contracting strategies and about contracts as they exist at the time the proposals come in, because there will be some level of contracting that will have occurred, some organizations who are here now in the state, they have existing contracts with providers and some of that may be captured within this program as well. And that's all well and good, hopefully what we want to do is leave sufficient time at time of contract work to implementation for those activities to be completed. To be completed on a schedule that we'll lay out with milestones and

benchmarks to ensure that it's happening fast enough to meet our schedule for implementation.

I think that will take some burden off of providers on the front end and the MCOs, too, but particularly for providers not having to entertain lots and lots of contracting opportunities, many which of them may never bear fruit.

So next steps, here are my draft dates. I think it's long enough since I put these up here that you may not remember what dates you gave, although Dana and I were securing to look at the slide and I think they line up. So finalization of submission of draft model contract to CMS, the tentative date is possibly August of 2016. I think we'll do it.

CMS, we're giving them from August to October, they're taking as much damn time as they like, but that's what we're giving them, and if that were the case, then we could have the RFP out, it says here November, I think partly because of the pause that we had in getting them started a little bit later on the rates, that might come a little bit later, but we'll see. We might also have this come out and have rates a little bit later. We'll work through that, but I think we're looking towards the

end of the year for that part of the process. Try not to do a release -- if there are any potential contracts, we'll try not to do a release on December 24th, try not to.

There was a neighboring state here that released their RFP a few years back and then scheduled a mandatory actuaries in person bidders conference on December 27th. I won't say who they were, but the conference was in Topeka.

So then as Buffy said, mid 2017, which here is May, but May, June, what have you, for contract reports, that's assuming these proposals are coming in about 60 days after. Then you see you have lots of time for readiness activities for networking, so forth, we move into start of services in 2018, April maybe a little bit later than April, but sometime in mid 2018 for start of services.

We are not -- this is not a implemented-in-haste kind of schedule, but the time will go fast for all of us. And I have seen states try to do these kinds of programs in haste and the results are pretty predictable, so OHCA is well aware of that and they've had conversations with other states that have formed their own schedule here, so I think whatever the dates need to be in

order for this program to be implemented appropriately, properly, and safely, and to the betterment -- betterment is a better word -- for the betterment of our members and providers, that will be the schedule we look to.

So these last two slides are just acronyms.

So as I said, this will be out on the website for you to turn to shortly. Seeing no questions --

AUDIENCE MEMBER: Do you have a contingency plan for change in administration and review of the ACA?

MR. COHEN: I don't know that there's a whole lot about what we're doing here that's directly related to ACA, so I don't know -- say ACA was appealed on January 21 by NPA or whoever they see fit, I don't know that really changes anything, aside from the fact that we have a state law on the books that we have to adhere so, but beyond that, there isn't really anything here that directly links it. There are some programs in other states where they are directly linked to, and where that will happen, they will be doing some scurrying but here, nothing.

AUDIENCE MEMBER: Has there been a decision on any services carved out of the program, pharmacy or vision or dental?

MR. COHEN: It's part of what -- one section of the model contract will be covered in that capitation benefits, so-called, it's part of what the MCOs are paid to do and those that are not. I'm not in a position to get into specifics, but that is something that is part of the planning process, in fact, I'm a leader of that.

MS. NDIAYE: Here's a question here. Please state your name for our court reporter.

AUDIENCE MEMBER: You actually answered my question with what you just said, so I'll pass.

MR. COHEN: That's my favorite stakeholder.

MS. NORTHRUP: Before the next question, I would kind of like to kind of point out to those who are viewing this via webinar, there is a chart feature and you can ask questions remotely.

MS. HARRISON: Sandra Harrison, Oklahoma Hospital Association. Have you identified any potential funding that is needed to roll up this process, and if so, are those dollars already available?

MR. COHEN: You want me to answer that?

The short answer is, the first part of your question is yes. And so, for example, I talked about the enrollment counseling, there's obviously a cost associated with that on behalf of the members.

MR. GOMEZ: Niko Gomez, the Oklahoma Health Care Authority. I think the question, whatever -- there's no money if -- whatever the cost is, we have not asked for, so it will go into a future budget request at the appropriate time.

AUDIENCE MEMBER: My question is, have you addressed if a participant has an NCO wants to switch to PACE, or if they're in PACE and then they decide they didn't want PACE and switch back, is there a transition between programs or is there certain time when that has to happen?

MR. COHEN: We'll talk in the model contract about how folks will move back and forth, if that's their choice --

AUDIENCE MEMBER: Thank you.

MR. COHEN: -- when they'll have the opportunity to do that, but our intent is to keep the PACE program up and running and thriving, serving members, because like behavioral health as an example, so we don't want to disrupt something

that's working.

MR. SNIDER: Rick Snider from the Oklahoma Hospital Association. I saw an article from the Des Moines Register last week, and as you know, Iowa recently went through a transition to managed care organizations in their Medicaid program, and just a couple sentences to give you the gist of the article: The title was "Medicare Managers are Slow to Pay Bills, Agencies Say. Many agency leaders say they're going into debt because many of their bills continue to be rejected for trivial or unclear reasons more than three months after private firms took control of Iowa's Medicaid program."

The article quotes a board member from one of the advocacy groups saying, "It's getting to a crisis situation where some smaller agencies are probably going to have to close their doors."

It's understandable, to an extent, when you have a big transition like Iowa is going through that you're going to have destructions, yet in other states that have converted their Medicaid programs to managed care, we see those situations continuing for years after the transition, Kansas and Kentucky are some examples I'm familiar with, so my question is: What safeguards can the Health Care Authority

build into that model contract to minimize the opportunity for unreasonable denials by managed care companies and what kind of administrative processes you can have to intervene and correct those situations?

MR. COHEN: I saw that article, too, and it's alarming when you read something like that because you have organizations, provider organizations, that operate on very thin margins and they're not in a position to offer a float to managed care organizations or to the state for some extended period of time. So to the extent that that occurs during the transition, it's a step backwards from what was there before. And I talked before about lessons learned, that would be -- that's a really lesson learned in the sense of assuring that doesn't happen.

And I'd say a couple things about that; first, it's incumbent on a state program, state agency, to have built in the right monitoring mechanisms to know early on if there are any issues arising around paying of claims, either timeliness or accuracy, so from an operational monitoring standpoint, it's something that has to happen beginning day one. It can't be something that's

learned about when the article appears in pages of the Oklahoman, because then we failed doing our due diligence and fulfilling our responsibility.

And then, without getting into details of what might be in the model contract, it has mechanisms in place to enforce those standards and intervene quickly, if necessary, to ensure that the situation is resolved one way or the other and doesn't fester for months, and certainly not for years.

So it's something to know going in that some states have experienced it as a problem and it's addressing it to those kind of mechanisms on the front end. I saw that article and I have seen others over the years. I've seen some states do the transition well and some states not so well and we want to be, certainly, in that first category and build our practices on states that have done that appropriately.

The other piece I would say, and this is something that being thoughtful in the implementation rollout gives you more time for, is to have requirements for and time for an appropriate outreach to and education of providers about appropriate billing practices, how to do claims

submission to the MCO that they're contracting with. Where before they may have been doing claim submission to a state Medicaid agency directly or a physical intermediary, and that's a responsibility of the MCOs working with the state to ensure that that happens.

And where I have seen that kind of up-front education occur, that could resolve, in many cases, a lot of problems, because you're talking about -- I think in that article it wasn't talking so much about hospitals, it was talking about case management and HCS service providers and they don't have the sophistication. I don't worry quite so much about a major hospital being able to find its way in the world, dealing with managed care today, insurance companies today, but it's for those smaller providers that, in particular, we want to make certain that they are educated and knowledgeable about how they are to get paid before the program ever begins.

MS. PUTNAM: Carlie Putnam, Oklahoma Policy Institute. Building somewhat on Rick's question, you've discussed at multiple points looking to other states for guidance, both positive and negative models, can you go into greater deal

about which states and what aspects you've looked to for things that went well and also things that haven't?

MR. COHEN: I think, am I right that the -- is the document you put together that had the information by state, is that something that went up on the website or was that just in front of management?

MS. NORTHRUP: I want to say it's not.

MR. COHEN: Maybe because it's not the most user friendly. It's something, certainly, that went through contract standards in industry by state to try to have some reference point. Rather than leave out of a state or put a state in one category, let me get that answer back to you and to everybody in writing or put something up on the website that can point you towards something, states that I think have worked better, and without offending, some states some that have not worked quite so well. That's a good question.

MS. ARBUCKLE: I'm Holly Arbuckle with Outreach Health Services. Do you know if there will be any changes to the CD-PASS program, more specifically, adding more physical agents?

MR. COHEN: Have to be careful here, the

physical agent component of CD-PASS is requirements associated with how that would work are addressed and I'm going to get in trouble.

AUDIENCE MEMBER: Oh, go ahead.

MR. COHEN: Steady as she goes, is that not -- did that not come through, the meaning?

AUDIENCE MEMBER: It came through. It was the wrong answer.

MS. HEATER: Do we have any further questions?

MR. MEYER: Brent Meyer with LeFlore. This is to Niko. I'm wondering if you all can post on the website the attendee list and contact information in hopes that this will connect providers or potential providers with potential bidders?

AUDIENCE MEMBER: Let me check and see if we can do that, I don't.

MR. COHEN: We have not done that in the past, because we really haven't asked people if they minded that we put their information out on the website.

MR. MEYER: Want me to ask people now?

MR. GOMEZ: I mean, I hear your question. Let us look into it and it may be something at the

next meeting we can provide.

MR. MEYER: Thank you.

MS. PERRY: Pam Perry with Amerigroup. Will future stakeholders meetings be open to full participation by a wide range of folks like today's is and when -- what is the schedule for the next stakeholders meetings?

MR. COHEN: Thank you for asking that because I was supposed to tell you and I didn't.

MS. NORTHRUP: The next stakeholder meeting is scheduled for September the 13th here in the Boardroom from 2:00 to 4:00 and it's open attendance, as this one was.

We are going to be having them every other month for the foreseeable future, mainly because with waiting for CMS approval, finishing up the RFP, getting the rates, we're just not going to have that much information to share to warrant having a meeting every single month.

Is there any other questions?

MR. COHEN: So you'll leave here, you'll go out, you'll talk to people about the Sooner Health Plus program and nobody will know what you're speaking about.

MS. NORTHRUP: Before you leave, if you

wouldn't mind staying put for just a couple minutes, our consultants with Westat are going to pass around a short survey to help us with our evaluation. And I want to thank everyone for attending. It's really, really heartening to see such a full crowd.

(MEETING CONCLUDED AT 3:20 P.M.)

CERTIFICATE

STATE OF OKLAHOMA)
) SS:
COUNTY OF OKLAHOMA)

I, Lacy Antle, Certified Shorthand Reporter within and for the State of Oklahoma, do hereby certify that the above and foregoing meeting was by me taken in shorthand and thereafter transcribed; and that I am not an attorney for nor relative of any of said parties or otherwise interested in the event of said action.

IN WITNESS WHEREOF, I have hereunto set my hand and official seal this 1st day of August, 2016.

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Lacy Antle, CSR RPR

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