HEALTHCARE AUTHORITY STAKEHOLDER MEETING
ON SEPTEMBER 13TH, 2016 AT 2:00 P.M.
IN OKLAHOMA CITY, OKLAHOMA

REPORTED BY: Jessica L. Weathington, CSR

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UNIDENTIFIED SPEAKER: We've had a technical difficulties, so we apologize. And Buffy will begin to start.

BUFFY: Good afternoon everyone. Thank you very much for joining us this afternoon. Our last stakeholder meeting, I believe, was July of something like that. We were in this room, so I appreciate that as much as you do.

My name is Buffy Heater. I'm the chief strategy officer for the Healthcare Authority and the project lead for this effort. What I'm going to do is offer some introductory remarks and orient you to the agenda and then we'll get started going through our presentation.

We have a couple guest speakers that we're going to have addressing you today.

I did want to point out, though, that in your hands you have blue evaluation surveys that are very important to us, so make sure that you're filling those out after the meeting. You're welcome to either leave those in your chair or deposit them at the table at the sign-in whenever you first came into this room.

I wanted to point out that the remarks

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that you make on those forms are very important to us, so, for example, one of the things you told us in July is that you wanted to have more time and more interactive discussions, some Q and A, being able to dialogue back and forth. So one of the changes that we've made at today's meeting is making that time available. So we've reserved time at the end of this meeting to make sure that we have ample time to be able to talk about the form.

So we do take those to heart. We try to incorporate as many suggestions as you all give us and make these meetings more meaningful.

Okay. So for the agenda today, following myself you'll hear from Andy Cohen who is a familiar face to all of you from Pacific Health Policy Group. He'll be providing you an update on our progress towards the RFP. Following him, I've asked Mike Nordstrom, who is with Mercer. He is our actuarial consulting lead who has just begun to work with us.

So I have asked him to offer not a formal presentation to you, but just some generalized remarks on the approach and the plans that are being made to develop the rates and to be able

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to analyze data for this effort moving forward.

So understand that his remarks will be brief today. Think about your questions and things that you would like to know in additional detail from him because at a later stakeholder meeting we will be asking him to present a more comprehensive update on the plans moving forward.

Okay. One other update that I want to provide to you all, at last meeting there was a question, there have actually been several questions that have come up regarding if the State would be able to release the content of the RFP in draft form at the time that that article was to surface. So to ask really could we release a pre-released of the RFP comment prior to it on the street.

And I wanted to let you all know that the decision has been made. We're, of course, working with the Oklahoma Procurement Agency, which is OPS, and the decision has been made that we would not be able to release that content at this time. So what you'll want to especially key into as part of Mr. Cohen's presentation to look at that time line on when

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the RFP will be released on the street, because that will be the first opportunity that everyone will have to be able to take a look at the content, exactly what's in that document.

The last thing that I will point out today, unless someone tells me there's something else I'm forgetting, is the chat feature. So for those of you who are participating online, when we get to that portion of the agenda where we open it up for question and answer, we have made the chat feature available. And we recommend that you insert your questions and we will have staff actively monitoring that to be able to respond to those in the open forum. So even if you're not here physically, we want to make sure you are heard.

With that, I believe I will turn it over to Andy Cohen to take us through the presentation today.

MR. COHEN: Good afternoon. Thank you, Buffy. As Buffy said, the goods news we'll start out today is that I'm going to be brief. So, at least, by my standards I'm going to be brief. So hopefully good news for you.

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Probably good news for our translators who I have a tendency to wear out over the course of my presentation.

So I'm going to go ahead and get started. What I do want to do, even though I'm going to be up and down here pretty quickly, is to give you an update. We do have some new information that we can share with you while staying within the confines of what we're able to discuss given that we're approaching the point of being in an active procurement period. And so we agree that if we can share information with you, we want to do that. And that may help to derive some of the interactive part of the meeting later today so the discussion that we hope to have.

So as I always like to begin is what brought us all here originally. Let's move right to the status update on the RFP itself. We run that, please. We are, as Buffy indicated, at the point of being able to submit the model contract portion of the Sooner Health Plus RFP to the CMS, the federal government for their review. That's part of the steps that we have to go through before we can finalize the

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document.

And I think when we met in July, our target was end of August or beginning of September to do that. So we're a little, few days past that but I think we're going to have it ready to go in a few more days from now and get that over to them and they can get it to you.

So that's the model contract portion of the RFP. The other major component of the RFP is the portion that includes all the submission requirements for those organizations that are interested in participating as contractors. And that piece doesn't go to CMS, so we've not attempted to have that ready to go at the same time as the model contract, but instead will now working carefully in the coming weeks to pull that piece together as well as quotes from Mercer and OHCA will be collaborated with the capitation rates, which Mike is going to tell you a little bit more about that process in a few minute.

We have made some decisions since we met in July. And, again, to the extent that there are some of those that we can share with the

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group that will help you with your planning and with your understanding of the program as it's unfolding, we wanted to be able to do that. So I want to do that today.

And some of these changes really have been driven by the recommendations and the comments that we received from stakeholders throughout this process. So you may see evidence of that as I go through one by one.

And I want to start with some decisions that we've made around the covered populations. That is to say populations that would be included in the Sooner Health Plus program and would be receiving services through the managed care organization. So we're not just talking about covered populations in the sense of changing who's eligible for Soonercare, the overall program, because that's not changing. It's just around those that will be coming in under the RFP model contract.

And on of the populations that is going to be coming in are individuals with intellectual developmental disabilities, children and adults. And they fall in for purposes of what I want to talk about now. We're thinking about

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them in terms of two different groups.

We've got children and adults who today are in one of the three IVD waiver programs receiving care coordination and are receiving home and community based services and supports through those waiver programs. And that's about, roughly about 5,000 people total throughout the state. And they also get other Medicaid benefits as well.

And while these types of individuals have been enrolled in managed care from other states around the country, I believe the newest population to be served under managed care. And we know the service they receive and their needs are quite a bit different in many ways from other populations that will be coming in under Sooner Health Plus. Some similarities, but many things that make them different.

And we want to be as thoughtful as possible as we move toward the transition of bringing these folks into the program. And so we made the decision that we want to take extra time to do that. And so for those that are receiving waiver services today, so they're already getting a model of care coordination

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today, we're going to go ahead and enroll them effectively at the beginning of the year two of the program.

Now, at the same time the other group that we think of when we think of persons with IDD who are in Medicaid today and will be coming into Sooner Health Plus are those who are not in one of three homes and community base waivers but are in Medicaid, are in SooonerCare and received what we call state plan benefits. So these are the same benefits that are available to other folks that receive Soonercare.

In most cases or in many cases these are the individuals who are not necessarily receiving the kind of care coordination that we expect and will require of the managed care organizations for their members. And so we think it makes sense for those individuals to come into the program at the beginning so they can begin receiving the benefits associated with care coordination at the earliest possible opportunity. So change from one portion of the population of IDD and the other will come in as scheduled.

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Then the third bullet you see here refers to what I'm calling premium only Medicare/Medicaid dual eligible members. These are higher income individuals who receive, through Medicaid, not the actual full benefit of services but instead have their Medicare Part B premiums paid for them fully. Those costs are accounted for through the Medicaid program. And they are -- they go, for example, most of them are under specified for Medicare beneficiary.

And there really isn't a whole lot that we can ask managed kid care organizations to do for these people because they really are receiving their benefits through the Medicare program. They don't get wraparound Medicaid benefits that a so called full benefit that you see.

So this is something that we talked about internally for quite a while. And we finally came to the conclusion that it didn't make sense to bring these individuals into the program, because there really wasn't anything asked of the management organization to do for them. And so they -- we're going to leave them

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outside of the Sooner Health Plus program. It's about, we pulled the numbers on them just the last day or so. It's about 11,000 people. So it's a pretty small component of the total population, if you remember some of the numbers we looked at in the earlier meeting were 140, 170 in terms of the 170,000 people ultimately would be covered under Sooner Health Plus.

And then just a reminder of something we talked about in July. A couple of member types not based on their eligibility type, but based on the services they received who they are receiving these services would not be enrolled in Sooner Health Plus so long as they were, in fact, getting care coordination through these other venues. And those are individuals who are enrolled in behavior health home which would typically be persons with serious mental illness as well as persons who are enrolled in one of our case programs.

So then just a recap, what the enrollment phase looks like. In year one we have Soonercare choice Medicaid only members. These are individuals who don't have Medicare benefits. This is 50, 60,000 children and

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adults so still the full benefit to eligible members and then subsets within those first two groups, but just a reminder because they certainly take a lot of our focus as we work to develop a program.

Individuals who are enrolled in the advantage or the medical fragile waivers and they could be either Medicaid only or eligibles, they'll be coming into the program year one as well as I mentioned the IDD state panel only member.

Then in year two the IDD waiver members coming into the program. Year three pursuant to the statute, residence of nursing facilities and ICFIT or ICSID.

Second area to give you an update on is service areas. And so for folks who were at the meting in July, you may recall that we discussed then that the decision had been made not to require proposals to be statewide. But instead to allow organizations to propose for something less than the entire state.

At the time we were banding about the idea of even letting the organization define their own service areas. And we've backed off of

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that only because once we began to try to think about how we can do every operation like that and make that work in a way that wouldn't be overly complicated for members, for providers, for the state as an administrative organization or entity, and we didn't think it made a lot of sense.

What we did want to keep to the notion of allowing for something less than statewide as a way of maximizing the opportunity for organizations to participate so instead we're going ahead and going to define and we've got two, east and west with Tulsa unsurprisingly anchoring the east and Oklahoma City anchoring the rest region. We're finalizing those regions on a county base. Counties will be in one region or the other. And we're going to try and do it in a way that we're as close as possible in terms of having the same number of members in each region.

So in terms of counties, there will be more counties in the west than the east. We're not final on the actual groupings yet, but we're getting close on that.

Of course organizations will be free to in

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both regions which is safe to say state wide if they're able and that's what they want to do. Next area is capitations. So these are the payments that the managed care organizations will receive each month for the members that are enrolled with them.

And Mike is going to join us up here in a few minutes and talk about a bit more about capitation rates and the rates process. So I'll go quickly through this slide for you, but couple of points to make. OHCA and its actuary, Mike can help me, are targeting to development capitation rates that's appropriate, I would say realistic savings. We want to do something here through the program that does achieve savings for the, you know, for the state but we want to be realistic about that and careful and prudent about that for the first year and then beyond.

And in some states the approach that's been taken, I think we may have even talked about this in someone's question, has been to compel organizations that want to be in the program to propose capitation rates that they will be willing to accept. The idea of being

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sort of price be a driver, competitive point among potential awardians. And that is one way to go.

We've made the decision, though, we've got a population here that has complex needs. It's going to be a new program in the state. We don't want the price to be the determinant when we go to make our selection. Instead we want to be able to focus in on the things that we think are going to be critical for the program's success. And that is how well potential contractors can meet our standards and our expectations in areas such as providing accessible care, high quality care, and meeting all of the person and family centers care coordination requirements that would be defined in the model contract.

That's where we want to make our area of emphasis when we set up our partners amongst us. So this will allow us to do that. Like I say, Mike will talk more about the actual process.

Turning to the schedule quickly, the release of the RFP, that is putting it out on the street, that's going to be dependent on

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CMS's review once they have it in their hands. You can typically expect that might be up to about three months. So we're targeting November or I think maybe likely December that the RFP and all its compartments will be ready to be released. At that point it's available for everybody to be reviewing.

Now, that will happen, we think, in advance of the capitation rates themselves being ready because that process is just now getting started. And so we've got a date here on the slide. Everything's tentative, of January. So that means that the organizations that are thinking of responding, they're going to have all the technical requirements and submission instructions in advance of actually knowing what they would be paying for the program. Which is not always the way that we do this, but it's something that we've done in some other states when circumstances allow for it.

And I think what's important then when you have this kind of a phase release, is to allow enough time for organizations that might be to be able to review the rates, digest them

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to ask questions, to go through the supporting information around how those rates were developed and satisfy themselves that the rates were appropriate for what they're being asked to do.

And so in the RFP timeline I'll show you in the next slide, we're going to allow for that. So in essence what this will mean is that potential respondents can have more time than they otherwise might not have in order to go through and prepare thoughtful responses and think through how they would meet all the operational requirements that we need to lay out in the RFP. So that I think it is a positive for us to take our time and do it this way.

So here's our tentative schedule as it stands together. Submission of the RFP, IE the model contract, the CMS here in the coming days. And the CMS September, October, November we hope the end of November, maybe it will tip over into early December. We think they will be reviewed and we'll address any comments, concerns they may have and that then will allow us pretty quickly thereafter to release the RFP

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November or December. Capitation rates before then January. Proposals due sometime in February perhaps depending on what's happening with the preceding dates by March.

And then contract awards we think late spring. Readiness period which falls on that. And this is something that we talked about this some in our other stakeholder meeting. It's a federal requirement we would have done anyway. But once awards have been made, then we want to make certain that the organizations that have told us on paper what they are capable of doing, in fact, move forward to put in place the necessary systems and provider networks and structures and staffing to actually, in fact, do that. And that's what the readiness review period is devoted to reach whatever the point of saying we're ready to enroll people and entrust them to the organization to provide their care.

Assuming that all of that happens on schedule, then, as we come into the beginning of 2018, then members are given the opportunity to select a plan to enroll in. Members will have a choice months planned, regards of the

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region they're in and we want to, at the program outset members lots of time to give that choice so we're allowing two months. We don't want anybody to be rushed. And then services will begin in April of 2018.

Which those later dates I think have not moved from what we looked at in July. So we're staying on the same rollout schedule that we had in July. Some of these earlier dates may have moved a little bit.

I think that's all she wrote for me. So I'll -- I'm not going anywhere. I'm not leaving the room. So when we get to have our discussion, I'll be here if we need to go back through the slides, we can do that. But otherwise I think I'll just be talking about capitation while its fresh on your mind, go ahead and ask Mike to come up and share his thoughts with you. Everything you ever wanted to know about actuarial science or afraid to ask.

MR. NORDSTROM: Thank you, Andy. Really happy to be here today to get a chance to informally dialogue with everyone about capitation rates development process. Of

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course, I'm going to be battling the stereotype of the boring actuary. And I'm sure you've all heard the joke how do you know when you're talking with the precarious outgoing actuary, when he or she is looking at your shoes when they're speaking rather than their own.

So just to make sure we're all on the same page, I think it was mentioned earlier, Mercer is really been hired to help develop per member per month capitation rates that the state is going to pay for the health plans. That's different and separate than what the health plans are going to turn around and pay to individual providers for care. So just to make sure that everyone understands that aspect of it.

The process really starts with actuarial principles and practices. And there are things called actuary standards of practice. There are a list of documents that actuaries are required to follow. There are also requirements that CMS Medicare Medicaid services have. And so those two things are sort of the science part of it or in some cases the formula driven part of it.

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There are also components that require an awful lot of actuarial judgment and individual expertise. And those are some of the things that, and we'll talk about them in a little bit that tend to be somewhat controversial or a lot of back and forth dialogue.

So as things typically start out in actuarial work, the data and information analysis is a real key part of it. On slides four and five as we briefly mentioned, you know, the covered population as well as some of the excluded populations. So Mercer is going to take those covered populations and match them up with the claims that the members have incurred, right. So we're going to start out with the claim cost figures from prior periods and then we're going to be projecting those forward in a series of adjustments.

Within the eight categories, we might also further split those up in data analysis and we see that costs or what we call risks are materially different, so for example for the blind and disabled categories, we want to see different costs between children and adults. And so then we would set up separate rate cells

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or payment sales based on those things.

A lot of them will just really match to the individual eight categories, but this might be some further (inaudible).

So on slide number seven Andy mentioned the data book. And what a data book is it's really, again, it is data and information that's provided to prospective bidders to help them to better understand the cost of the populations that they're planning on bidding on. So, for example, and none of this is finalized as of yet, but we might look at in the data book calendar 2014 and separately calendar 2015 years of data, incurred costs or data service base costs. And so that's what the health plans will be responsible for is the -- is the claims, you know, incurred as of the time contract effective dates.

We'll look at the data book and develop a data book by the covered populations and the ratings. We'll do it by some of the regional splits that OHC finalizes. We'll provide information on the member month basis. And so that goes into that per member per month calculation that the capitation rates are based

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on.

So if someone in calendar '14, for example, or calendar '15, if they were covered for the full year, then they would -- they would represent 12 of the member months. If they were only covered for six months out of the year, they would only represent six of the member months. And that will match up, because if they were covered for six months of the year, then they're going to develop claims for just those six months. And so we want, you know, again, match the claims with the membership. And so we -- we show everything on a per member per month basis.

So we'll also, in addition to the member months, display utilization. And so utilization come in different forms. So for pharmacy or prescription drugs it will be the number of scrips. The average individuals had for emergency room emergency visits or if hospital in-patient days. And so each of those unitization statistics will look a little bit different, but we look to normalize them, you know, across all the different populations.

We'll also show the average unit cost.

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And so this isn't what, you know, one particular service or one particular provider is. In this sort of somewhat broad categories what we do is we take the total cost and then divide that by the units. And that gives the average unit cost. So it can give an indication of overall price for services within that broad category. Again, that doesn't mean any one particular service, you know, has (inaudible).

And then those two components, the utilization and the unit cost combined for a little mathematics into the per member per month cost. That's a starting point for the -- the claims. And so we're talking about the data book here, but there really also falls to the starting claim cost for rate development as well. So we're going to be looking within the data book. And then also likely within the capitation rate development to show those statistics on multiple categories of service as we would call them.

So, for example, hospital in-patient, hospital outpatient, emergency room, professional claims, behavior health, pharmacy,

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dental, nursing facility, home and community based services, supplies, for example, therapy, so that you can -- obviously you can get an incredible or an intense amount of detail. But we do need to roll them up into some sort of aggregate levels and would be working with OSCA in kind of what level of detail that is providing. But it will be pretty considerable.

And then of those, all those will sum up to people be able to say, this is what within historical period the cost of them for this population.

Also within the data book we'll communicate what we would call retrospective and then also prospective program changes. So within, again, I use the calendar '14 and calendar '15 as an example. Within that data time frame, there's been changes to the program, right. Different things of impact into the program and it's appeared in the base data that in the data book that people are going to want to know about what those are. So if the change from calendar '14 to calender '15 might indicate some trend level, is some of that related to changes in the program or is

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some of it related to changes in utilization or changes in average unit cost that are really independent of formal changes that the program is having at the time.

So we'll be looking to provide that information both on a, you know, say these are what the program changes and when they were effective. And certainly to the extent that we can, to also provide some estimates and sometimes those are driven, of course, by figures that we're able to get in working with as far as, you know, the estimates of what those program changes will be valued at.

So for a rate development purposes, again, we -- we look at the started base data. We may not use two years of data, depending if a calendar year or another annual period is what we call kind of fully credible, then we may not need to use the two years of data, which would be the most recent credible time period.

We're going to make some adjustments to that data again per the program changes or adjustment. Even if we're grabbing a very recent period, there typically is going to be what's called claim or run out indications, and

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so we'll need to make some adjustments. That's typically pumping the data out, up, because even if we're looking at calendar '15 service, for example, there are still going to be some claims that are paid today or tomorrow or a little bit into the future that go back to those original dates of service in calendar '15.

So it might be December of 2015 incurred claim, but it's not paid in the system until several months afterwards. So we need to account for that.

There also can be non-claims systems payments that we need to factor in. Sometimes they can be referred to as supplemental payments. And so to the extent that they impact the population as a part of Sooner Heath Plus, then we need to accommodate for those as well.

We talked a little bit about the program changes both retrospective so within the base data time periods and then prospective. So based on my example of 2015 as the starting claims base, then, of course, there's program changes that will happen after that. And if we

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know about any of that happening in the futures we're gong to look to estimate the impact of those as well out into the contract period.

Now, of course, one of the challenges is the effective dates are petty far out into the future. And there's likely to be some program changes that nobody here knows about at this point. And so we will need to make some adjustments for those down the road, but the rates that we will be developing will be sort of the best knowledge that we have at the time in working with OSCAA and anyone else to estimate those changes are.

So after we've taken the base data, adjusted for some program changes then we need to apply the claim cost trends. And those trends can be split out by utilization. So, for example, if there's a belief that people are taking more prescriptions on average in the future than they were in the calendar '15 time period, then we need to apply some trend factors to reflect positive utilization there.

If there's a belief that provider contract costs at the health plans are going to incur are going to increase, then we need to make

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some adjustments on the claim cost trend to that average unit cost. So, again, those two together will give us an overall per member per month claim cost trend to project forward.

One of the things in moving from a state administered program to an at risk Medicaid managed care program is based on different studies and experience there typically are some adjustments that get applied in that shift. And so in this case we would refer to those as managed care adjustments. They can definitely vary by population. And in some cases they might be rather small. Some cases they might be rather large. And so typical assumptions are in moving from the state administered program to the at risk managed care program are actually that, for example, primary care visits will increase. So there will be a utilization adjustment upward for primary care visits. There may be a utilization adjustment upward for pharmacy as well.

On the flip side, there are typically some pretty good adjustments downward on hospital in-patient, for example, or emergency room visits or even possible outpatient visits.

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Again, based on the previous experience and studies, the belief is that through some of those -- those managed care mechanisms that hospital in-patient days, for example, will reduce fairly significant.

And that will be one of the factors that hopefully will lead to the rather modest savings that we're targeting.

So the last couple of components that I really want to talk about are related to health plan administration. So all this stuff before was about the claim cost. And so heath plans, of course, have administrative costs as well. And those are legitimate costs and can be accounted for in the capitation enrollment process. And so we'll review the model contract. And when that's finalized and through reviewing our work with other states in similar populations and a whole bunch of other information we'll come up with a load or an adjustment for health plan administration.

And the final component I wanted to talk about, in sort of the sort of basic overview is what, for actuaries, is called the underwriting gain. And it's a little bit of an unusual

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term. What that accounts for is, of course, health plans have cost of capital. And so they -- they're making their investment into the program. They ship their funds elsewhere so they need to be paid somewhat for the cost of capital. Then they also have risks associated with the program.

So you might be familiar with that term and it's called underwriting gain. In the prior context people talked about it as risk or contingency or profit. They kind of all rolled up together, and it's still really kind of rolled up together, but within this actuary standards of practice it's underwriting gain.

So that's really kind of the final load within the basic capitation rate development.

I think at this point we're going to turn it over to the questions for anyone on the panel as they say.

BUFFY: Okay. So I'm sure as you all have been listening to the presenters, you've probably been jotting down some questions. Or some questions, perhaps, have come to mind. So this is the point in the agenda where we're going to open it up to some dialogue. We

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welcome any questions, no matter what the subject matter or content is. As Andy had pointed out earlier, if you're asking something related to procurement, we're not able to answer, we're going to say great question. We can't answer that. No offense there. We just want to make sure we stay on the legal side of things.

So at this time we would love to have any questions that you might have for myself or Andy or Mike.

MR. COHEN: If you don't we're going to start asking you questions.

UNIDENTIFIED SPEAKER: Please make sure to wait until you have the microphone and if you will state your name when you ask your question. Thank you.

MS. PERRY: Hi, Pam Perry, Amerigroup. Thank you very much for the confirmation of the geography modifications. We think that makes a lot of sense. My question is about the SIM Grand as far as the health that's currently developing and is getting underway. And it will address some of the Medicaid populations outside of this particular procurement.

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However, in many states when they started out with the managed care program to a limited population, given the success of that initiative, initial initiative tend to grow it, spread it to other populations in geographies, whatever the case may be, it seems that SIM Grand process that may impede that a bit. So, I just want to kind of get a sense from you all as to whether there may be opportunities in the future looking into the crystal ball to expand managed care to additional populations in Medicaid.

BUFFY: I don't know if it can come off speaker. Any how, I'll keep talking. I think it's going to be distracting to hear my own voice behind me as I was trying to answer. You wouldn't have gotten anything out of that.

So, yes, Oklahoma's been known for doing things the Oklahoma way, right. And so we recognize that here we think we're going to make a different approach from what other states have done in regards to proposals for managed care as well as other states that have been actively seeking and utilizing information to excel because Oklahoma's not able to get.

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Let me do a bit of a level set for everyone here just so you understand the full concept of what's going on related to the care coordination projects on the Health Plus and also the Sim networks. So effective July 1st this year, I personally have actually devoted 80 percent of my time to the HSS cabinet in Oklahoma to grapple with exactly that issue that you're talking about. So 20 percent of my time is still dedicated here to healthcare authority as of the CSO position. But the majority of my time, effective July first for this next calendar year, it is to wrestle with the identifying the common principal amount the SIMs, among grappling the waiver initiatives. We're also looking at the House Bill 1566 among other efforts. We know that there are health home initiatives going on with the Department of Mental Health. We know there's also substance abuse and use disorder waivers that are in development. Just a variety of invasions that are going on in Oklahoma.

And so the short answer to that is we don't know exactly how all these are going to intersect in the future. But what we have done

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is strategically and organizationally done a few very recent realignments to assure that among the HHS cabinet here in Oklahoma all those agencies are coming to the table to really put our best thoughts forward on how these efforts can be coordinated in the future.

I think at that, I really don't have any other details that I can share with you on what the time line might be in that effort, but know that that too is a great importance to secretary (inaudible).

MS. PEROT: Moreen Perot with Aetna. Also very impressed with information you shared today. Will those be defined and released prior to the RFP coming out?

BUFFY: So that's a good question. I typically say, of course, when the RFP is going to be released they would be made available. I think that's -- let us take that back. I'm not sure if there's an opportunity for us to release those ahead of time, but let us take that back and we'll bring it back as we come to the next meeting.

MS. PEROT: The second question I had is on your announcement today about the IDD

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population, the children and adults that will roll in year two. Do you have a number that currently falls in there?

MR. COHEN: For year two?

MS. PEROT: For the year two roll in.

MR. COHEN: It's about 5,000 people that are approximately in IDD waivers.

MS. PEROT: Okay. Thank you.

BUFFY: Something else that struck me today during the presentation, something we can make a promise to at our next stakeholder meeting. As Andy did a great job in that slide where it identifies the population coming in at different points in time, we can bring that back as a refresher slide next time on what the associated numbers are with each one of those populations that would be very helpful.

MR. HASA: Mike Hasa with Health Care Service Corporation. So quick question on provider directories. I realize that the Healthcare Authority has published Soonercare contracted provider directories for some provider specialties. Is there an opportunity for either Healthcare Authority or DHS to publish one for LTSS providers?

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BUFFY: I'd have to look to my DHS colleagues that may be in the room. If we don't have the right folks here, we can take that to them and provide you that answer. So to make sure I've got the request, you'd like to see a provider directory for LTSS providers?

MR. HASA: Correct.

BUFFY: That would be right now contract with Healthcare Authority. We will take that back.

MS. PERRY: Pam Perry, Amerigroup. Another interesting conversation at the last stakeholder meeting was an ombudsman function. And I think the state was envisioning having the MCOs manage that responsibility. Has there been any more thought to how that would be implemented and, you know, any feedback you might have to update us on that?

BUFFY: So if I remember the conversation from July, I might ask you to come address this, provide us an example.

MR. COHEN: Right. And this is -- I may end up saying what I said back in July, but (inaudible) but one of the recommendations that we receive when we were talking to the

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stakeholders as we went out around Oklahoma last fall, essentially late summer and fall was particularly coming from the members was the importance of having somebody who could help them navigate what's going to be a new world within the services and care management.

And so from that came the idea that we should have individuals within the managed care organization that while they are under employer contract by the managed care organization their mission really would be to support and advocate on behalf of the members who are enrolled in those organizations so it would be available to them as resources of questions. If they have a complaint and they want somebody to help them sort of navigate through how they get their complaint addressed.

And, you know, we use the term ombudsman in a very specific way when we talk about individuals who are receiving long-term care under Medicaid program. That's a state function. And so some extent we appropriated maybe we shouldn't have but we appropriated that term along with I think we ended up calling it a member advocate slash ombudsman.

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Because it does -- it does convey what we have in mind, which is to have somebody there who is really on network on behalf of the member or the family. That's what they do when they get up in the morning. That's their through job.

And so that is still, as it was when we presented it in July, that is still the vision to be a component of the program. But it doesn't that away from the statement.

MS. PERRY: May I just ask if you used any different state models? Is there a state that comes to mind that do have -- have you seen any -- have you used any best practices from other states or would be receptive to some states, examples of states that perform in that way?

MR. COHEN: Yes and yes. That is to say we did look at other states and so we're aware this is something that we weren't inventing. It has been done. And we thought the concept was a good one. We're always looking for best practices either now or in the case of obviously organization that might respond to the RFP when that comes out. That will be an organizations to talk about when they say best practices and how they would (inaudible).

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Couple opportunity for that. But what were the states that you looked at?

MS. PERRY: Yes. Georgia and Wisconsin.

UNIDENTIFIED SPEAKER: We've had several comments on the chat feature. If everyone could please try to speak up when they're on the microphone so that the people listening in on the webinar can hear clearly as well as I wanted to just let everyone know the PowerPoint slides will be loaded onto our website after the meeting today and there will also be a recording of the webinar itself that will be loaded up in the next couple of days.

BUFFY: We have two comments up here toward the front.

MS. TAYLOR: Karen Taylor. I'm a parent advocate. Using the Wisconsin example specifically, there's been a lot of discussion with families about really that ombudsman advocate role. And a big concern that we have is that if I'm having an issue with company A providing support for my son, the advocate who works and their paycheck is received from company A, that's not in my family's best interest.

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And so I think Wisconsin is a really good example of looking where the Ombudsman has advocates. Those advocates not only resolve issues, but they check the companies to make sure that they have some cultural sensitivity. That they resolve things in a way internally that's transparent and makes sense and all of that stuff.

Because the families that I was with at the July meeting, we all got very alarmed by the idea that the fox was going to watch that hen house.

UNIDENTIFIED SPEAKER: Absolutely.

BUFFY: And let me see if I can respond to that. So absolutely. And not to say that the Ombudsman that we would require an element of a managed care organization, not that would only be Ombudsman. So absolutely. It would be multifaceted. I think the intent there is to make sure that from the plan level that the two are responsible for being -- having firsthand knowledge the staff dedicated to that purpose and function and absolutely is not the one who recognizes some of those potential conflicts.

It's our responsibility (inaudible)

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engaged in that to make sure it best serves members.

ANN: I'm Ann from Integris. That brings up the second point. So the TEPRA kids are in the first group?

BUFFY: Yes.

ANN: I would ask about telehealth and telemedicine. When we talk about the capitation, is that part of the to be determined kinds of technologies that are going to be coming online before they are just assumed into the regular rates?

BUFFY: That's a good question. So there would be some expectation that we would expect to see in the proposals a plan of response to incorporate those technologies. Now, as far as a rate setting element, I'd ask Mike, to put you on the spot here a little bit, if there is specific adjustments or consideration as part of the administrative properties?

MR. NORDSTROM: Well, I think the telemedicine would typically fall into the claim cost portion of it. Because if it's really presumably, a substitute, right, for a physician (inaudible). And so some of the

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discussion around those actually are often results in, you know, well, do we factor in some savings for telehealth and telemedicine relative to an office and so, you know, to the extent that it is not within the base data, then it is a question of, you know is it going to result in savings. Basically the same cost or not.

ANN: Can I ask about remote monitoring, not just face to face. I'm asking about remote monitoring, if you have a physician that's monitoring the heart rate of the baby, it's not a face-to-face encounter.

MR. NORDSTROM: Sure. Again, you know, those are the -- what we would call the claim cost component of capitation rate. And are they essentially substitutes for an office visit or someone that they would care. And what are the relative costs of those, you know, typically most of those types of programs (inaudible) that they'll save some money and to providing more timely care and the enhancing access to the quality.

And so the cost considerations are certainly important, but almost secondary but I

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guess I would say, at a high level whether there inherent directly in the base cost or not, you know, I think they are part of the program and the contract.

MR. COHEN: One of the -- one of the advances potentially to a program like this, and it's something -- it's enough of an advantage we did recently release so called final rule for managed care. They went ahead and memorialized it. Understood all a long that they wanted to get it down in black and white. But sometimes in lieu of services. And it speaks to the fact that when you have somebody enrolled in a Medicaid program, let's say they're in state plan benefits, then what they're eligible to receive is defined chapter and verse in the regulations. So OHCA has a whole section on its website that goes through in great legalese and bureaucrats what services are covered and what circumstances and what prior authorization rules and so on and so on and so on. And you've got to fit, depending on your eligibility type, fit within the four corners of those prescribed servers.

And everybody may agree that OHCA or

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elsewhere that there might be something else that would make sense for a particular member to receive. It might be something that would first call other cost that would otherwise occur for that member, may be something that would help people safe in their home and prevent a hospitalization. But if it doesn't fit within those four corners, Medicaid won't pay for it.

What we get when we move to managed care is an opportunity to look to our partner in the manage care organization to find that the capitation of the set based on those historical costs at the same, but within them, within the program they have the opportunity to say, well, the state plan benefits are asked. That's what's in our contact, but it also says here CMS has said that in lieu of -- of services it limits here, there's something that makes s sense and state approves, then we can go ahead and deliver those services even though we can't find them chapter and verse.

And that's whether it's in-home monitoring or whatever it may be, that opportunity presents itself in a way that we don't have

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access to, you know, traditional fee for service benefits. That's one of the this that still gets me excited about programs moving to this type of structure because I know that that's one of the benefits that members and their families will see.

We want on the ground benefits that they'll see a difference tomorrow versus today when the transition does occur.

MS. HOUSER: Ester Houser representing the Alliance on Aging. The silverhaired legislatures and retired. I'm over it almost. Long term care, state long term care ombudsman. In the hope that that horse is not dead, that's just go back to the ombudsman component. The Oklahoma Aging Partnership this summer submitted a white paper related to many different aspects of the pointed care program. One of our recommendations was the inclusion of -- of some sort of ombudsman program that was independent.

Reflecting to the long term care ombudsman program federal law forbids such a program to be housed in or to be contracted to a provider organization because of the conflict of

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interest. And in this case whether it's real or apparent, if your aim is to have a patient navigator or a member navigator or member assistant, whatever, I would just hope that if it's -- if the -- if that entity is placed within the managed care according to care organization that it not be named in ombudsman so as to not spoil it for everybody else who is in ombudsman and is truly independent and advocating just for the member and not receiving a paycheck.

At the very least I would hope that you would, if you have an ombudsman program that you can back it out of those contract organizations and keep it in the healthcare authority.

MR. COHEN: Thank you for that. We'll keep that under advisement.

MS. PEROT: Hi. Moreen Perot again. Just a quick question on your amendment benefit, the transportation benefits currently administered separately through a contracted estate, will that be carved out or will that benefit be rolled in?

BUFFY: I think this is one of those where

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I have to pull the card that we'll have to release that information when the proposal comes out on the street. There's a comment toward the front.

GAYLE: Gayle Beaver from Senior Services in Tulsa. You guys have talked about the time line in terms of the RFP. What are you doing -- what are we going to do to help transition our clients and our members to this new program? That's kind of where I'm coming from. For some of our folks it's going to be a real shock, and so I know we -- we've -- we're talking about giving them time to enroll, but what -- how are we going to prepare them for the changes that are coming?

BUFFY: So thank you. Because you actually introduced one of the questions that I had for you as stakeholders. And so your question is spot on. Rather than perhaps the state providing a response to that, I'd like to turn that around and perhaps ask from the stakeholders perspective what are those elements that are critical. What are the opportunities that we have today to be able to begin transitioning populations?

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So while you're thinking about that, let me respond by saying, as part of the readiness review activities that also indicated on that time line, that's where those activities would occur, right. Not that it would be limited to that period of time, because we know that by having these open meetings, you know, every other month and to provide an audience of stakeholders is wishing to participate, we've already at least started to provide that awareness opportunity.

But I would like to perhaps hear from this group on what would be the critical elements of transition? What would be those opportunities that you would see as the best place to go as a first step or as a second or a third step. I know, for your organization, for other organizations that are dealing with members what materials is it, what is it that the state can provide you with to begin having those conversation with your members so that we can identify really from you what would be the best step to be able to begin having those conversations.

So see how I spun that question back

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around. It's back tag. You're it.

MS. TAYLOR: Erin Taylor again. I would just say those of us who get the privilege of working with children, educating parents on EPSCT, what that involves. What that provides for our children really is critical. Because it's going to be enough for us to explain to our new providers that things like vocational training, transportation and all that can be a Medicaid covered services. Most of our families don't even understand those non hard medical supports.

So that would be very, very helpful for me. And I would say that probably with the ton of our families we do 95 percent of our education online in a group. So however we can deliver it that way would be helpful for us.

MR. COHEN: Erin, do you have regularly scheduled forums online?

MS. TAYLOR: No. But, I mean, we have --

MR. COHEN: Q and A --

MS. TAYLOR: We have -- you know, there's 704 families, maybe 650. And I would say we have half of them in this group. But they check that account three or four times a day.

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So it needs to be something you can just repost. Something like that.

BUFFY: So let me ask from Life Services, from your perspective contrast that with the population you see. Would you see an online forum? Because it's not going to be a one size fits all. So I'd like to see --

UNIDENTIFIED SPEAKER: No. I don't -- work with the aging, the population of the aging, I don't think we're quite there yet. Now, you know, in ten years when you baby boomers are going through this, that will be a different story. But I would say the primary concern that our folks are going to have are they having to change their providers. And they've got these certain people that come in their world. And they want to know if that's going to have to change.

And so as much information, you know, the absence of information creates stories, right. People make things up. And so I think as soon as -- as soon as we know what the process is going to be, who the parties and providers are involved, then we have to just -- we just have to start initiating that.

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Part of it for us, as at Life, we have an advantage program. So what's going to happen to the advantage case managers? And they know then they can, they're the primary contact and connection along with the nursing ward, so, you know, I think we just have to really just start as soon as we know what's going to be like, start the information flow whether it's in person or we're some people are fine online and can do it that way. I think it's going to have to be done a variety of ways.

Not just -- for these folks probably online but for us we'll have to have brochures, pamphlets, talk to them. And whoever the primary providers are need to have people out on the phones.

MR. HASA: Mike Hasa Healthcare Service Corporation. And two quick questions to confirm or to help clarify some stuff I thought I heard today. First of which can you confirm that behavior health and pharmacy are going to be included in the RFP?

BUFFY: Well, I mean, I think -- I really don't want to speak to a service level inclusion to be fair to the question about

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emergency transportation. I'd rather not speak to level specifics.

MR. HASA: Okay. The second of which --

MR. COHEN: It was on the slide and that was something that we had discussed. So I'll quickly go through it again. Individuals who are receiving services who are aligned with a behavior health home, which is an initiative that is occurring in a lot of states and here under the omnibus of substance fee services. It's still in its fairly early days, but HSH is in the process of establishing behavior health. They're oriented toward individuals with serious mental illnesses. And so if somebody meets the clinical criteria for receiving integrated physical and behavioral health services through one of these settings then because they'll be getting care coordination in that setting, so long as they are receiving services in that setting, they would not be enrolled in the Sooner Health Plus program to a managed care organization even though they otherwise would quality.

And so that's -- that was the one piece of information that we at least discussed in July.

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I just put it on the slide again as (inaudible)that's what that was referring to.

MR. NORDSTROM: I probably should add, so I gave a laundry list of these categories of service that might be in the clinical data book, for example. And so that certainly wasn't meant to imply to each and every one of these services are going to be part of the program or not. It was really just more on an example of these are things that, you know, might typically be part of the book.

We're still working through that. There might be other things OHC wants to provide to potential bidders in that book as well. So if I led you down the wrong path on confirming different services, I apologize for that.

MR. HASA: No, thanks. That's helpful. The second question was, again, on the data book comments. So it was helpful to hear some of the logic that went into that. I thought you mentioned that there was a little bit of a markup for managed care MCO and admin costs that were going to be factored in.

But I thought I had heard at a previous meeting that as part of the procurement process

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that those are also going to have to set a little bit of their own admin costs permitting. Can somebody help clarify that?

MR. NORDSTROM: Yeah. I think that's one of the changes. So they're certainly one portion of possible RFP response and to have health plans bid rates into a range. And it might involve -- or kept secret, right. The approach that the state is using is that we're going to work with Mercer, obviously, and OHCA to develop a set capitation rate so that plans don't need to develop, you know, their own admin estimates or anything like that. You'll just need to once those are put forth, figure out, you know, do we think that we can do it for that level of capitation or not.

So you won't need to worry about that part of it.

MR. HASA: Okay. Thanks.

MS. BRUCE: My name's Jenny Bruce. I'm with the Oklahoma Family Network. And my question or suggestion maybe that goes back to how to get information to the individuals. And I would just say kind of ditto what the other two individuals said. But one of the things

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that we find often in the rural area is if you -- they like getting e-mails sometimes, but you just have to be really careful the way you send it. Because they may have real limited amounts of data.

And a lot of rural areas have to buy data. Like we use two minutes on our cell phones. And so however you give that information out, if it is electronically, that it be done in such a way that it will take as little data as possible.

And then my other suggestion is we have coalitions across the state. There are coalitions some that cover two counties, some that just cover one county. And that is a mechanism to really get a lot of good information out to the general population. And it may not be that, you know, Sam Q. Public is always there, but it might be their providers are there.

So I would just encourage you, you know, you know, you have your people out. You have people out in -- across the state, but if there were a way to get either to those coalitions or doing kind of an on the road, if you will, with

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information, that might be a good way to do it as well.

Because some people really do learn better where they can ask questions and interact versus just seeing it online.

BUFFY: So I think those are -- this is terrific feedback. Something that I might ask, there's two things. Number one is whenever you talk about the network of coalitions and grass roots efforts and local community based organizations as well as statewide or regional entities, as we approach that transition period, I think it will be helpful for all of us to utilize, as stakeholders, we also more broadly compile say a list, right, of, you know organizations where they're located, contact information. Perhaps that already existed that would be great to be able to share with potential venders after we get to that point.

Because those will be the connections that I think will be incumbent upon us at the state. We will help facilitate those connections. So that's kind of the first point. Let's make sure to remember that.

The other question that I was going to

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pose back to you all, so recognizing that it has to be a multifaceted outreach campaign using a variety of, you know, methods and some electronics, some paper, some face-to-face, things like that. Would you all find it useful when we got to that point as an element of the transition plan would there be some element of allowing a consumer or a family to choose yes, I want e-mail or, no, I want all postal mail or I really want to have calls to be able to have that where every consumer can self select and that they would like to have that outreach? That's great feedback.

UNIDENTIFIED SPEAKER: One of those feedback be video?

BUFFY: Video?

UNIDENTIFIED SPEAKER: You could have video to listen.

BUFFY: Absolutely. Yeah. Help us compile that list of what all those different methods may be. Yeah. I think we need a mic up here.

UNIDENTIFIED SPEAKER: I'm sure I could speak loudly enough for everyone.

BUFFY: For the folks online, I want to

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make sure they're hearing our --

GAYLE: Again, Gayle Beaver. When you guys did your on-the-road trips around the state, those were great. The only thing I would ask is that we did not have a enough time to get our consumers there. So please think in terms of giving us enough time so that if our folks want to attend, and also in a place large enough, I mean, where if we need to go pick them up or go do whatever we need to do to get them there, if they truly want to be there to hear the questions and ask questions and hear answers.

BUFFY: So Gayle, may I ask, is there a period of time that you might suggest? Are we talking about a 30 day notice, 60 day notice? Something like that?

GAYLE: Thirty days.

BUFFY: Thirty day notice, okay.

MR. HUGHES: Jeff Hughes with Progressive. So we've been meeting on this issue on Mondays so any time that you want to come down, we've got a group that is ready to go. We've been very much beat over the head with the managed care. So I'm very interested. Want to know

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how it's going to improve services. Welcome the Healthcare Authority to come down any time you want to. We'll get it coordinated. Just let me know. There are a lot of people who are obviously interested and want to know how this is going to shift. So just come on.

BUFFY: Thank you. Appreciate all the input you've already provided.

MR. COHEN: I think maybe when we get to the point of where we're able to go out and have sessions and answer and questions about what we are that maybe we can set up something where we can take invitation because we won't know (inaudible). I'm just saying I want to get out of Oklahoma City and back on the road.

UNIDENTIFIED SPEAKER: Tech question from Vickie. How is the RFP addressing IDD children that are in DHS custody?

BUFFY: So that is a question that has been brought up. And I can tell you that we don't have a definitive answer as of yet, but it is under discussion. And the thing that we know for children, you know, who are IDD, they do have that one year delay coming out year two. So we recognize the critical nature of

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that population and want to make sure that they're taking the advice from other states best practices.

There have been other states like the state of Florida that has done something separate in stage for their children in custody situations. And so not to say that's what we're doing here, but I'm just saying that we want to make sure that we're fully arming ourself with all the information on being pursued elsewhere before we make that decision.

UNIDENTIFIED SPEAKER: The second question from chat, Jonathan. What about those currently receiving successful care coordination to advantage waiver?

BUFFY: So we have been in talks with the Department of Human Services and the advantage waiver staff, which looking across the room, I was going to see if we had any advance in here. Okay. We have been in collaboration with OKDHs and the advantage care and looking at what the process was. We would like for members that are currently served by today's advantage program.

I can tell you there is not planned as for

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any other populations changes to eligibility enrollment processes that are happening outside and will remain in the same processes in there today that are outside of the RFP as well as available services and benefit that the members qualified for.

There will be no changes to those benefits that are available to those members. There's nothing substantial that needs to be changed as part of the managed care RFP.

What we do envision changing is the relationship between the contractual relationship between what is today the Healthcare Authority and advantage providers with the inference of a managed care organization. And we do anticipate that contractual relationship to change in that the Healthcare Authority now being contracted with the health plans and the managed care entity, it will be the responsibility of those managed care entities to then pursue the contracts with those advantage providers.

So from the providers there would be that change and those relationships would shift. However, we have to put in protections in RFP,

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but we put in consumer protections in the RFP to ensure that for a managed care entity that in year one of the program they must retain the same -- the same or more extensive network with advantage providers to make sure that we've got that continuity of care over that first year. I'm getting so --

UNIDENTIFIED SPEAKER: Too far in the weeds.

BUFFY: So, yes, we are looking at that taking that under consideration. I thought we had mentioned advantage. Other question? Other comments?

UNIDENTIFIED SPEAKER: Going on with the advantage program, BJ Mooney with Doc Services. We are -- we have been a long term provider of the advantage program. You know, it's been made very clear to us that you want to provide the member with choice. And with that being said, as a provider, are remittances and our billings, any issues that we have, are we going to have to be working with two or three different companies in weeding all of this out and having the problems with each company as before we were just able to go with the state.

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If we had a problem we knew directly who to talk to. And that may be too far, but I thought I would ask.

BUFFY: I'm willing to provide as much information as I can until someone gives me the -- anyhow, so that's a great point. Something seriously we'll take under consideration because we recognize consumer but for the provider side we want to make sure that there are protections in place as well to make sure your administrative burden doesn't increase as well.

So what I can say is part of that transition planning, we want to take a look at all positions and make sure that we've got appropriate controls, we will take a look at those specifically to make sure we understand what the impacts of our providers. So thank you.

MS. PERRY: Pam Perry, Amerigroup. How many plans do you anticipate contracting with by region or statewide?

BUFFY: So I think at this point, not able to -- not able to say that we have a definitive answer on how many that will be. Those are

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certainly things that we're considering certain elements. Not able to say at this time.

Other questions? All right. And I think actually the -- most of the questions that I had for you all you actually hit on. You've been asking the same questions that had come to my mind that we wanted feedback on. So I thank you for this dialogue and for this exchange today.

I'm going to ask everyone, I know we're making kind of those goodbye sounds we're gathering things.

UNIDENTIFIED SPEAKER: Please remember to fill out your surveys. Thank you.

BUFFY: Yes. We have someone at the table. Got somebody at the table to take those back so please take those blue evaluation forms. Leave those with us. I see no other questions or comments. Thank you all for your time this afternoon.

(Meeting was concluded at 3:23 p.m.)

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CERTIFICATE

STATE OF OKLAHOMA)
) SS:
COUNTY OF OKLAHOMA)

I, Jessica L. Weathington, CSR, do hereby certify that on SEPTEMBER 13TH, 2016 at the offices of Oklahoma Healthcare Authority Oklahoma City, Oklahoma, that the foregoing pages constitute a full, true, and correct transcript of the proceedings of said meeting on the date as indicated.

I do further certify that I am not counsel, attorney, or relative of either party, or otherwise interested in the event of this suit.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal at my office in Oklahoma City Oklahoma County, Oklahoma, this 23rd day of September, 2016.

Jessica L. Weathington

_____,

Jessica L. Weathington, CSR
CSR No. 1833