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11 HEALTHCARE AUTHORITY STAKEHOLDER MEETING
ON SEPTEMBER 13TH, 2016 AT 2:00 P.M.
IN OKLAHOMA CITY, OKLAHOMA
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25 REPORTED BY: Jessica L. Weathington, CSR

1 UNIDENTIFIED SPEAKER: We've had a
2 technical difficulties, so we apologize. And
3 Buffy will begin to start.
4 BUFFY: Good afternoon everyone. Thank
5 you very much for joining us this afternoon.
6 Our last stakeholder meeting, I believe, was
7 July of something like that. We were in this
8 room, so I appreciate that as much as you do.
9 My name is Buffy Heater. I'm the chief
10 strategy officer for the Healthcare Authority
11 and the project lead for this effort. What I'm
12 going to do is offer some introductory remarks
13 and orient you to the agenda and then we'll get
14 started going through our presentation.
15 We have a couple guest speakers that we're
16 going to have addressing you today.
17 I did want to point out, though, that in
18 your hands you have blue evaluation surveys
19 that are very important to us, so make sure
20 that you're filling those out after the
21 meeting. You're welcome to either leave those
22 in your chair or deposit them at the table at
23 the sign-in whenever you first came into this
24 room.
25 I wanted to point out that the remarks

1 that you make on those forms are very important
2 to us, so, for example, one of the things you
3 told us in July is that you wanted to have more
4 time and more interactive discussions, some Q
5 and A, being able to dialogue back and forth.
6 So one of the changes that we've made at
7 today's meeting is making that time available.
8 So we've reserved time at the end of this
9 meeting to make sure that we have ample time to
10 be able to talk about the form.
11 So we do take those to heart. We try to
12 incorporate as many suggestions as you all give
13 us and make these meetings more meaningful.
14 Okay. So for the agenda today, following
15 myself you'll hear from Andy Cohen who is a
16 familiar face to all of you from Pacific Health
17 Policy Group. He'll be providing you an update
18 on our progress towards the RFP. Following
19 him, I've asked Mike Nordstrom, who is with
20 Mercer. He is our actuarial consulting lead
21 who has just begun to work with us.
22 So I have asked him to offer not a formal
23 presentation to you, but just some generalized
24 remarks on the approach and the plans that are
25 being made to develop the rates and to be able

1 to analyze data for this effort moving forward.
2 So understand that his remarks will be
3 brief today. Think about your questions and
4 things that you would like to know in
5 additional detail from him because at a later
6 stakeholder meeting we will be asking him to
7 present a more comprehensive update on the
8 plans moving forward.
9 Okay. One other update that I want to
10 provide to you all, at last meeting there was a
11 question, there have actually been several
12 questions that have come up regarding if the
13 State would be able to release the content of
14 the RFP in draft form at the time that that
15 article was to surface. So to ask really could
16 we release a pre-released of the RFP comment
17 prior to it on the street.
18 And I wanted to let you all know that the
19 decision has been made. We're, of course,
20 working with the Oklahoma Procurement Agency,
21 which is OPS, and the decision has been made
22 that we would not be able to release that
23 content at this time. So what you'll want to
24 especially key into as part of Mr. Cohen's
25 presentation to look at that time line on when

1 the RFP will be released on the street, because
2 that will be the first opportunity that
3 everyone will have to be able to take a look at
4 the content, exactly what's in that document.
5 The last thing that I will point out
6 today, unless someone tells me there's
7 something else I'm forgetting, is the chat
8 feature. So for those of you who are
9 participating online, when we get to that
10 portion of the agenda where we open it up for
11 question and answer, we have made the chat
12 feature available. And we recommend that you
13 insert your questions and we will have staff
14 actively monitoring that to be able to respond
15 to those in the open forum. So even if you're
16 not here physically, we want to make sure you
17 are heard.
18 With that, I believe I will turn it over
19 to Andy Cohen to take us through the
20 presentation today.
21 MR. COHEN: Good afternoon. Thank you,
22 Buffy. As Buffy said, the goods news we'll
23 start out today is that I'm going to be brief.
24 So, at least, by my standards I'm going to be
25 brief. So hopefully good news for you.

1 Probably good news for our translators who I
2 have a tendency to wear out over the course of
3 my presentation.
4 So I'm going to go ahead and get started.
5 What I do want to do, even though I'm going to
6 be up and down here pretty quickly, is to give
7 you an update. We do have some new information
8 that we can share with you while staying within
9 the confines of what we're able to discuss
10 given that we're approaching the point of being
11 in an active procurement period. And so we
12 agree that if we can share information with
13 you, we want to do that. And that may help to
14 derive some of the interactive part of the
15 meeting later today so the discussion that we
16 hope to have.
17 So as I always like to begin is what
18 brought us all here originally. Let's move
19 right to the status update on the RFP itself.
20 We run that, please. We are, as Buffy
21 indicated, at the point of being able to submit
22 the model contract portion of the Sooner Health
23 Plus RFP to the CMS, the federal government for
24 their review. That's part of the steps that we
25 have to go through before we can finalize the

1 document.
2 And I think when we met in July, our
3 target was end of August or beginning of
4 September to do that. So we're a little, few
5 days past that but I think we're going to have
6 it ready to go in a few more days from now and
7 get that over to them and they can get it to
8 you.
9 So that's the model contract portion of
10 the RFP. The other major component of the RFP
11 is the portion that includes all the submission
12 requirements for those organizations that are
13 interested in participating as contractors.
14 And that piece doesn't go to CMS, so we've not
15 attempted to have that ready to go at the same
16 time as the model contract, but instead will
17 now working carefully in the coming weeks to
18 pull that piece together as well as quotes from
19 Mercer and OHCA will be collaborated with the
20 capitation rates, which Mike is going to tell
21 you a little bit more about that process in a
22 few minute.
23 We have made some decisions since we met
24 in July. And, again, to the extent that there
25 are some of those that we can share with the

1 group that will help you with your planning and
2 with your understanding of the program as it's
3 unfolding, we wanted to be able to do that. So
4 I want to do that today.
5 And some of these changes really have been
6 driven by the recommendations and the comments
7 that we received from stakeholders throughout
8 this process. So you may see evidence of that
9 as I go through one by one.
10 And I want to start with some decisions
11 that we've made around the covered populations.
12 That is to say populations that would be
13 included in the Sooner Health Plus program and
14 would be receiving services through the managed
15 care organization. So we're not just talking
16 about covered populations in the sense of
17 changing who's eligible for Soonercare, the
18 overall program, because that's not changing.
19 It's just around those that will be coming in
20 under the RFP model contract.
21 And on of the populations that is going to
22 be coming in are individuals with intellectual
23 developmental disabilities, children and
24 adults. And they fall in for purposes of what
25 I want to talk about now. We're thinking about

1 them in terms of two different groups.
2 We've got children and adults who today
3 are in one of the three IVD waiver programs
4 receiving care coordination and are receiving
5 home and community based services and supports
6 through those waiver programs. And that's
7 about, roughly about 5,000 people total
8 throughout the state. And they also get other
9 Medicaid benefits as well.
10 And while these types of individuals have
11 been enrolled in managed care from other states
12 around the country, I believe the newest
13 population to be served under managed care.
14 And we know the service they receive and their
15 needs are quite a bit different in many ways
16 from other populations that will be coming in
17 under Sooner Health Plus. Some similarities,
18 but many things that make them different.
19 And we want to be as thoughtful as
20 possible as we move toward the transition of
21 bringing these folks into the program. And so
22 we made the decision that we want to take extra
23 time to do that. And so for those that are
24 receiving waiver services today, so they're
25 already getting a model of care coordination

1 today, we're going to go ahead and enroll them
2 effectively at the beginning of the year two of
3 the program.
4 Now, at the same time the other group that
5 we think of when we think of persons with IDD
6 who are in Medicaid today and will be coming
7 into Sooner Health Plus are those who are not
8 in one of three homes and community base
9 waivers but are in Medicaid, are in SooonerCare
10 and received what we call state plan benefits.
11 So these are the same benefits that are
12 available to other folks that receive
13 Soonercare.
14 In most cases or in many cases these are
15 the individuals who are not necessarily
16 receiving the kind of care coordination that we
17 expect and will require of the managed care
18 organizations for their members. And so we
19 think it makes sense for those individuals to
20 come into the program at the beginning so they
21 can begin receiving the benefits associated
22 with care coordination at the earliest possible
23 opportunity. So change from one portion of the
24 population of IDD and the other will come in as
25 scheduled.

1 Then the third bullet you see here refers
2 to what I'm calling premium only
3 Medicare/Medicaid dual eligible members. These
4 are higher income individuals who receive,
5 through Medicaid, not the actual full benefit
6 of services but instead have their Medicare
7 Part B premiums paid for them fully. Those
8 costs are accounted for through the Medicaid
9 program. And they are -- they go, for example,
10 most of them are under specified for Medicare
11 beneficiary.
12 And there really isn't a whole lot that we
13 can ask managed kid care organizations to do
14 for these people because they really are
15 receiving their benefits through the Medicare
16 program. They don't get wraparound Medicaid
17 benefits that a so called full benefit that you
18 see.
19 So this is something that we talked about
20 internally for quite a while. And we finally
21 came to the conclusion that it didn't make
22 sense to bring these individuals into the
23 program, because there really wasn't anything
24 asked of the management organization to do for
25 them. And so they -- we're going to leave them

1 outside of the Sooner Health Plus program.
2 It's about, we pulled the numbers on them just
3 the last day or so. It's about 11,000 people.
4 So it's a pretty small component of the total
5 population, if you remember some of the numbers
6 we looked at in the earlier meeting were 140,
7 170 in terms of the 170,000 people ultimately
8 would be covered under Sooner Health Plus.
9 And then just a reminder of something we
10 talked about in July. A couple of member types
11 not based on their eligibility type, but based
12 on the services they received who they are
13 receiving these services would not be enrolled
14 in Sooner Health Plus so long as they were, in
15 fact, getting care coordination through these
16 other venues. And those are individuals who
17 are enrolled in behavior health home which
18 would typically be persons with serious mental
19 illness as well as persons who are enrolled in
20 one of our case programs.
21 So then just a recap, what the enrollment
22 phase looks like. In year one we have
23 Soonercare choice Medicaid only members. These
24 are individuals who don't have Medicare
25 benefits. This is 50, 60,000 children and

1 adults so still the full benefit to eligible
2 members and then subsets within those first two
3 groups, but just a reminder because they
4 certainly take a lot of our focus as we work to
5 develop a program.
6 Individuals who are enrolled in the
7 advantage or the medical fragile waivers and
8 they could be either Medicaid only or
9 eligibles, they'll be coming into the program
10 year one as well as I mentioned the IDD state
11 panel only member.
12 Then in year two the IDD waiver members
13 coming into the program. Year three pursuant
14 to the statute, residence of nursing facilities
15 and ICFIT or ICSID.
16 Second area to give you an update on is
17 service areas. And so for folks who were at
18 the meting in July, you may recall that we
19 discussed then that the decision had been made
20 not to require proposals to be statewide. But
21 instead to allow organizations to propose for
22 something less than the entire state.
23 At the time we were banding about the idea
24 of even letting the organization define their
25 own service areas. And we've backed off of

1 that only because once we began to try to think
2 about how we can do every operation like that
3 and make that work in a way that wouldn't be
4 overly complicated for members, for providers,
5 for the state as an administrative organization
6 or entity, and we didn't think it made a lot of
7 sense.
8 What we did want to keep to the notion of
9 allowing for something less than statewide as a
10 way of maximizing the opportunity for
11 organizations to participate so instead we're
12 going ahead and going to define and we've got
13 two, east and west with Tulsa unsurprisingly
14 anchoring the east and Oklahoma City anchoring
15 the rest region. We're finalizing those
16 regions on a county base. Counties will be in
17 one region or the other. And we're going to
18 try and do it in a way that we're as close as
19 possible in terms of having the same number of
20 members in each region.
21 So in terms of counties, there will be
22 more counties in the west than the east. We're
23 not final on the actual groupings yet, but
24 we're getting close on that.
25 Of course organizations will be free to in

1 both regions which is safe to say state wide if
2 they're able and that's what they want to do.
3 Next area is capitations. So these are the
4 payments that the managed care organizations
5 will receive each month for the members that
6 are enrolled with them.
7 And Mike is going to join us up here in a
8 few minutes and talk about a bit more about
9 capitation rates and the rates process. So
10 I'll go quickly through this slide for you, but
11 couple of points to make. OHCA and its
12 actuary, Mike can help me, are targeting to
13 development capitation rates that's
14 appropriate, I would say realistic savings. We
15 want to do something here through the program
16 that does achieve savings for the, you know,
17 for the state but we want to be realistic about
18 that and careful and prudent about that for the
19 first year and then beyond.
20 And in some states the approach that's
21 been taken, I think we may have even talked
22 about this in someone's question, has been to
23 compel organizations that want to be in the
24 program to propose capitation rates that they
25 will be willing to accept. The idea of being

1 sort of price be a driver, competitive point
2 among potential awardians. And that is one way
3 to go.
4 We've made the decision, though, we've got
5 a population here that has complex needs. It's
6 going to be a new program in the state. We
7 don't want the price to be the determinant when
8 we go to make our selection. Instead we want
9 to be able to focus in on the things that we
10 think are going to be critical for the
11 program's success. And that is how well
12 potential contractors can meet our standards
13 and our expectations in areas such as providing
14 accessible care, high quality care, and meeting
15 all of the person and family centers care
16 coordination requirements that would be defined
17 in the model contract.
18 That's where we want to make our area of
19 emphasis when we set up our partners amongst
20 us. So this will allow us to do that. Like I
21 say, Mike will talk more about the actual
22 process.
23 Turning to the schedule quickly, the
24 release of the RFP, that is putting it out on
25 the street, that's going to be dependent on

1 CMS's review once they have it in their hands.
2 You can typically expect that might be up to
3 about three months. So we're targeting
4 November or I think maybe likely December that
5 the RFP and all its compartments will be ready
6 to be released. At that point it's available
7 for everybody to be reviewing.
8 Now, that will happen, we think, in
9 advance of the capitation rates themselves
10 being ready because that process is just now
11 getting started. And so we've got a date here
12 on the slide. Everything's tentative, of
13 January. So that means that the organizations
14 that are thinking of responding, they're going
15 to have all the technical requirements and
16 submission instructions in advance of actually
17 knowing what they would be paying for the
18 program. Which is not always the way that we
19 do this, but it's something that we've done in
20 some other states when circumstances allow for
21 it.
22 And I think what's important then when
23 you have this kind of a phase release, is to
24 allow enough time for organizations that might
25 be to be able to review the rates, digest them

1 to ask questions, to go through the supporting
2 information around how those rates were
3 developed and satisfy themselves that the rates
4 were appropriate for what they're being asked
5 to do.
6 And so in the RFP timeline I'll show you
7 in the next slide, we're going to allow for
8 that. So in essence what this will mean is
9 that potential respondents can have more time
10 than they otherwise might not have in order to
11 go through and prepare thoughtful responses and
12 think through how they would meet all the
13 operational requirements that we need to lay
14 out in the RFP. So that I think it is a
15 positive for us to take our time and do it this
16 way.
17 So here's our tentative schedule as it
18 stands together. Submission of the RFP, IE the
19 model contract, the CMS here in the coming
20 days. And the CMS September, October, November
21 we hope the end of November, maybe it will tip
22 over into early December. We think they will
23 be reviewed and we'll address any comments,
24 concerns they may have and that then will allow
25 us pretty quickly thereafter to release the RFP

1 November or December. Capitation rates before
2 then January. Proposals due sometime in
3 February perhaps depending on what's happening
4 with the preceding dates by March.
5 And then contract awards we think late
6 spring. Readiness period which falls on that.
7 And this is something that we talked about this
8 some in our other stakeholder meeting. It's a
9 federal requirement we would have done anyway.
10 But once awards have been made, then we want to
11 make certain that the organizations that have
12 told us on paper what they are capable of
13 doing, in fact, move forward to put in place
14 the necessary systems and provider networks and
15 structures and staffing to actually, in fact,
16 do that. And that's what the readiness review
17 period is devoted to reach whatever the point
18 of saying we're ready to enroll people and
19 entrust them to the organization to provide
20 their care.
21 Assuming that all of that happens on
22 schedule, then, as we come into the beginning
23 of 2018, then members are given the opportunity
24 to select a plan to enroll in. Members will
25 have a choice months planned, regards of the

1 region they're in and we want to, at the
2 program outset members lots of time to give
3 that choice so we're allowing two months. We
4 don't want anybody to be rushed. And then
5 services will begin in April of 2018.
6 Which those later dates I think have not
7 moved from what we looked at in July. So we're
8 staying on the same rollout schedule that we
9 had in July. Some of these earlier dates may
10 have moved a little bit.
11 I think that's all she wrote for me. So
12 I'll -- I'm not going anywhere. I'm not
13 leaving the room. So when we get to have our
14 discussion, I'll be here if we need to go back
15 through the slides, we can do that. But
16 otherwise I think I'll just be talking about
17 capitation while its fresh on your mind, go
18 ahead and ask Mike to come up and share his
19 thoughts with you. Everything you ever wanted
20 to know about actuarial science or afraid to
21 ask.
22 MR. NORDSTROM: Thank you, Andy. Really
23 happy to be here today to get a chance to
24 informally dialogue with everyone about
25 capitation rates development process. Of

1 course, I'm going to be battling the stereotype
2 of the boring actuary. And I'm sure you've all
3 heard the joke how do you know when you're
4 talking with the precarious outgoing actuary,
5 when he or she is looking at your shoes when
6 they're speaking rather than their own.
7 So just to make sure we're all on the same
8 page, I think it was mentioned earlier, Mercer
9 is really been hired to help develop per member
10 per month capitation rates that the state is
11 going to pay for the health plans. That's
12 different and separate than what the health
13 plans are going to turn around and pay to
14 individual providers for care. So just to make
15 sure that everyone understands that aspect of
16 it.
17 The process really starts with actuarial
18 principles and practices. And there are things
19 called actuary standards of practice. There
20 are a list of documents that actuaries are
21 required to follow. There are also
22 requirements that CMS Medicare Medicaid
23 services have. And so those two things are
24 sort of the science part of it or in some cases
25 the formula driven part of it.

1 There are also components that require an
2 awful lot of actuarial judgment and individual
3 expertise. And those are some of the things
4 that, and we'll talk about them in a little bit
5 that tend to be somewhat controversial or a lot
6 of back and forth dialogue.
7 So as things typically start out in
8 actuarial work, the data and information
9 analysis is a real key part of it. On slides
10 four and five as we briefly mentioned, you
11 know, the covered population as well as some of
12 the excluded populations. So Mercer is going
13 to take those covered populations and match
14 them up with the claims that the members have
15 incurred, right. So we're going to start out
16 with the claim cost figures from prior periods
17 and then we're going to be projecting those
18 forward in a series of adjustments.
19 Within the eight categories, we might also
20 further split those up in data analysis and we
21 see that costs or what we call risks are
22 materially different, so for example for the
23 blind and disabled categories, we want to see
24 different costs between children and adults.
25 And so then we would set up separate rate cells

1 or payment sales based on those things.
2 A lot of them will just really match to
3 the individual eight categories, but this might
4 be some further (inaudible).
5 So on slide number seven Andy mentioned
6 the data book. And what a data book is it's
7 really, again, it is data and information
8 that's provided to prospective bidders to help
9 them to better understand the cost of the
10 populations that they're planning on bidding
11 on. So, for example, and none of this is
12 finalized as of yet, but we might look at in
13 the data book calendar 2014 and separately
14 calendar 2015 years of data, incurred costs or
15 data service base costs. And so that's what
16 the health plans will be responsible for is
17 the -- is the claims, you know, incurred as of
18 the time contract effective dates.
19 We'll look at the data book and develop a
20 data book by the covered populations and the
21 ratings. We'll do it by some of the regional
22 splits that OHC finalizes. We'll provide
23 information on the member month basis. And so
24 that goes into that per member per month
25 calculation that the capitation rates are based

1 on.
2 So if someone in calendar '14, for
3 example, or calendar '15, if they were covered
4 for the full year, then they would -- they
5 would represent 12 of the member months. If
6 they were only covered for six months out of
7 the year, they would only represent six of the
8 member months. And that will match up, because
9 if they were covered for six months of the
10 year, then they're going to develop claims for
11 just those six months. And so we want, you
12 know, again, match the claims with the
13 membership. And so we -- we show everything on
14 a per member per month basis.
15 So we'll also, in addition to the member
16 months, display utilization. And so
17 utilization come in different forms. So for
18 pharmacy or prescription drugs it will be the
19 number of scrips. The average individuals had
20 for emergency room emergency visits or if
21 hospital in-patient days. And so each of those
22 unitization statistics will look a little bit
23 different, but we look to normalize them, you
24 know, across all the different populations.
25 We'll also show the average unit cost.

1 And so this isn't what, you know, one
2 particular service or one particular provider
3 is. In this sort of somewhat broad categories
4 what we do is we take the total cost and then
5 divide that by the units. And that gives the
6 average unit cost. So it can give an
7 indication of overall price for services within
8 that broad category. Again, that doesn't mean
9 any one particular service, you know, has
10 (inaudible).
11 And then those two components, the
12 utilization and the unit cost combined for a
13 little mathematics into the per member per
14 month cost. That's a starting point for the --
15 the claims. And so we're talking about the
16 data book here, but there really also falls to
17 the starting claim cost for rate development as
18 well. So we're going to be looking within the
19 data book. And then also likely within the
20 capitation rate development to show those
21 statistics on multiple categories of service as
22 we would call them.
23 So, for example, hospital in-patient,
24 hospital outpatient, emergency room,
25 professional claims, behavior health, pharmacy,

1 dental, nursing facility, home and community
2 based services, supplies, for example, therapy,
3 so that you can -- obviously you can get an
4 incredible or an intense amount of detail. But
5 we do need to roll them up into some sort of
6 aggregate levels and would be working with OSCA
7 in kind of what level of detail that is
8 providing. But it will be pretty considerable.
9 And then of those, all those will sum up
10 to people be able to say, this is what within
11 historical period the cost of them for this
12 population.
13 Also within the data book we'll
14 communicate what we would call retrospective
15 and then also prospective program changes. So
16 within, again, I use the calendar '14 and
17 calendar '15 as an example. Within that data
18 time frame, there's been changes to the
19 program, right. Different things of impact
20 into the program and it's appeared in the base
21 data that in the data book that people are
22 going to want to know about what those are. So
23 if the change from calendar '14 to calender '15
24 might indicate some trend level, is some of
25 that related to changes in the program or is

1 some of it related to changes in utilization or
2 changes in average unit cost that are really
3 independent of formal changes that the program
4 is having at the time.
5 So we'll be looking to provide that
6 information both on a, you know, say these are
7 what the program changes and when they were
8 effective. And certainly to the extent that we
9 can, to also provide some estimates and
10 sometimes those are driven, of course, by
11 figures that we're able to get in working with
12 as far as, you know, the estimates of what
13 those program changes will be valued at.
14 So for a rate development purposes, again,
15 we -- we look at the started base data. We may
16 not use two years of data, depending if a
17 calendar year or another annual period is what
18 we call kind of fully credible, then we may not
19 need to use the two years of data, which would
20 be the most recent credible time period.
21 We're going to make some adjustments to
22 that data again per the program changes or
23 adjustment. Even if we're grabbing a very
24 recent period, there typically is going to be
25 what's called claim or run out indications, and

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1 so we'll need to make some adjustments. That's
2 typically pumping the data out, up, because
3 even if we're looking at calendar '15 service,
4 for example, there are still going to be some
5 claims that are paid today or tomorrow or a
6 little bit into the future that go back to
7 those original dates of service in calendar
8 '15.
9 So it might be December of 2015 incurred
10 claim, but it's not paid in the system until
11 several months afterwards. So we need to
12 account for that.
13 There also can be non-claims systems
14 payments that we need to factor in. Sometimes
15 they can be referred to as supplemental
16 payments. And so to the extent that they
17 impact the population as a part of Sooner Heath
18 Plus, then we need to accommodate for those as
19 well.
20 We talked a little bit about the program
21 changes both retrospective so within the base
22 data time periods and then prospective. So
23 based on my example of 2015 as the starting
24 claims base, then, of course, there's program
25 changes that will happen after that. And if we

1 know about any of that happening in the futures
2 we're gong to look to estimate the impact of
3 those as well out into the contract period.
4 Now, of course, one of the challenges is
5 the effective dates are petty far out into the
6 future. And there's likely to be some program
7 changes that nobody here knows about at this
8 point. And so we will need to make some
9 adjustments for those down the road, but the
10 rates that we will be developing will be sort
11 of the best knowledge that we have at the time
12 in working with OSCAA and anyone else to
13 estimate those changes are.
14 So after we've taken the base data,
15 adjusted for some program changes then we need
16 to apply the claim cost trends. And those
17 trends can be split out by utilization. So,
18 for example, if there's a belief that people
19 are taking more prescriptions on average in the
20 future than they were in the calendar '15 time
21 period, then we need to apply some trend
22 factors to reflect positive utilization there.
23 If there's a belief that provider contract
24 costs at the health plans are going to incur
25 are going to increase, then we need to make

1 some adjustments on the claim cost trend to
2 that average unit cost. So, again, those two
3 together will give us an overall per member per
4 month claim cost trend to project forward.
5 One of the things in moving from a state
6 administered program to an at risk Medicaid
7 managed care program is based on different
8 studies and experience there typically are some
9 adjustments that get applied in that shift.
10 And so in this case we would refer to those as
11 managed care adjustments. They can definitely
12 vary by population. And in some cases they
13 might be rather small. Some cases they might
14 be rather large. And so typical assumptions
15 are in moving from the state administered
16 program to the at risk managed care program are
17 actually that, for example, primary care visits
18 will increase. So there will be a utilization
19 adjustment upward for primary care visits.
20 There may be a utilization adjustment upward
21 for pharmacy as well.
22 On the flip side, there are typically some
23 pretty good adjustments downward on hospital
24 in-patient, for example, or emergency room
25 visits or even possible outpatient visits.

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1 Again, based on the previous experience and
2 studies, the belief is that through some of
3 those -- those managed care mechanisms that
4 hospital in-patient days, for example, will
5 reduce fairly significant.
6 And that will be one of the factors that
7 hopefully will lead to the rather modest
8 savings that we're targeting.
9 So the last couple of components that I
10 really want to talk about are related to health
11 plan administration. So all this stuff before
12 was about the claim cost. And so heath plans,
13 of course, have administrative costs as well.
14 And those are legitimate costs and can be
15 accounted for in the capitation enrollment
16 process. And so we'll review the model
17 contract. And when that's finalized and
18 through reviewing our work with other states in
19 similar populations and a whole bunch of other
20 information we'll come up with a load or an
21 adjustment for health plan administration.
22 And the final component I wanted to talk
23 about, in sort of the sort of basic overview is
24 what, for actuaries, is called the underwriting
25 gain. And it's a little bit of an unusual

1 term. What that accounts for is, of course,
2 health plans have cost of capital. And so
3 they -- they're making their investment into
4 the program. They ship their funds elsewhere
5 so they need to be paid somewhat for the cost
6 of capital. Then they also have risks
7 associated with the program.
8 So you might be familiar with that term
9 and it's called underwriting gain. In the
10 prior context people talked about it as risk or
11 contingency or profit. They kind of all rolled
12 up together, and it's still really kind of
13 rolled up together, but within this actuary
14 standards of practice it's underwriting gain.
15 So that's really kind of the final load
16 within the basic capitation rate development.
17 I think at this point we're going to turn
18 it over to the questions for anyone on the
19 panel as they say.
20 BUFFY: Okay. So I'm sure as you all have
21 been listening to the presenters, you've
22 probably been jotting down some questions. Or
23 some questions, perhaps, have come to mind. So
24 this is the point in the agenda where we're
25 going to open it up to some dialogue. We

1 welcome any questions, no matter what the
2 subject matter or content is. As Andy had
3 pointed out earlier, if you're asking something
4 related to procurement, we're not able to
5 answer, we're going to say great question. We
6 can't answer that. No offense there. We just
7 want to make sure we stay on the legal side of
8 things.
9 So at this time we would love to have any
10 questions that you might have for myself or
11 Andy or Mike.
12 MR. COHEN: If you don't we're going to
13 start asking you questions.
14 UNIDENTIFIED SPEAKER: Please make sure to
15 wait until you have the microphone and if you
16 will state your name when you ask your
17 question. Thank you.
18 MS. PERRY: Hi, Pam Perry, Amerigroup.
19 Thank you very much for the confirmation of the
20 geography modifications. We think that makes a
21 lot of sense. My question is about the SIM
22 Grand as far as the health that's currently
23 developing and is getting underway. And it
24 will address some of the Medicaid populations
25 outside of this particular procurement.

1 However, in many states when they started out
2 with the managed care program to a limited
3 population, given the success of that
4 initiative, initial initiative tend to grow it,
5 spread it to other populations in geographies,
6 whatever the case may be, it seems that SIM
7 Grand process that may impede that a bit. So,
8 I just want to kind of get a sense from you all
9 as to whether there may be opportunities in the
10 future looking into the crystal ball to expand
11 managed care to additional populations in
12 Medicaid.
13 BUFFY: I don't know if it can come off
14 speaker. Any how, I'll keep talking. I think
15 it's going to be distracting to hear my own
16 voice behind me as I was trying to answer. You
17 wouldn't have gotten anything out of that.
18 So, yes, Oklahoma's been known for doing
19 things the Oklahoma way, right. And so we
20 recognize that here we think we're going to
21 make a different approach from what other
22 states have done in regards to proposals for
23 managed care as well as other states that have
24 been actively seeking and utilizing information
25 to excel because Oklahoma's not able to get.

1 Let me do a bit of a level set for
2 everyone here just so you understand the full
3 concept of what's going on related to the care
4 coordination projects on the Health Plus and
5 also the Sim networks. So effective July 1st
6 this year, I personally have actually devoted
7 80 percent of my time to the HSS cabinet in
8 Oklahoma to grapple with exactly that issue
9 that you're talking about. So 20 percent of my
10 time is still dedicated here to healthcare
11 authority as of the CSO position. But the
12 majority of my time, effective July first for
13 this next calendar year, it is to wrestle with
14 the identifying the common principal amount the
15 SIMs, among grappling the waiver initiatives.
16 We're also looking at the House Bill 1566 among
17 other efforts. We know that there are health
18 home initiatives going on with the Department
19 of Mental Health. We know there's also
20 substance abuse and use disorder waivers that
21 are in development. Just a variety of
22 invasions that are going on in Oklahoma.
23 And so the short answer to that is we
24 don't know exactly how all these are going to
25 intersect in the future. But what we have done

1 is strategically and organizationally done a
2 few very recent realignments to assure that
3 among the HHS cabinet here in Oklahoma all
4 those agencies are coming to the table to
5 really put our best thoughts forward on how
6 these efforts can be coordinated in the future.
7 I think at that, I really don't have any
8 other details that I can share with you on what
9 the time line might be in that effort, but know
10 that that too is a great importance to
11 secretary (inaudible).
12 MS. PEROT: Moreen Perot with Aetna. Also
13 very impressed with information you shared
14 today. Will those be defined and released
15 prior to the RFP coming out?
16 BUFFY: So that's a good question. I
17 typically say, of course, when the RFP is going
18 to be released they would be made available. I
19 think that's -- let us take that back. I'm not
20 sure if there's an opportunity for us to
21 release those ahead of time, but let us take
22 that back and we'll bring it back as we come to
23 the next meeting.
24 MS. PEROT: The second question I had is
25 on your announcement today about the IDD

1 population, the children and adults that will
2 roll in year two. Do you have a number that
3 currently falls in there?
4 MR. COHEN: For year two?
5 MS. PEROT: For the year two roll in.
6 MR. COHEN: It's about 5,000 people that
7 are approximately in IDD waivers.
8 MS. PEROT: Okay. Thank you.
9 BUFFY: Something else that struck me
10 today during the presentation, something we can
11 make a promise to at our next stakeholder
12 meeting. As Andy did a great job in that slide
13 where it identifies the population coming in at
14 different points in time, we can bring that
15 back as a refresher slide next time on what the
16 associated numbers are with each one of those
17 populations that would be very helpful.
18 MR. HASA: Mike Hasa with Health Care
19 Service Corporation. So quick question on
20 provider directories. I realize that the
21 Healthcare Authority has published Soonercare
22 contracted provider directories for some
23 provider specialties. Is there an opportunity
24 for either Healthcare Authority or DHS to
25 publish one for LTSS providers?

1 BUFFY: I'd have to look to my DHS
2 colleagues that may be in the room. If we
3 don't have the right folks here, we can take
4 that to them and provide you that answer. So
5 to make sure I've got the request, you'd like
6 to see a provider directory for LTSS providers?
7 MR. HASA: Correct.
8 BUFFY: That would be right now contract
9 with Healthcare Authority. We will take that
10 back.
11 MS. PERRY: Pam Perry, Amerigroup.
12 Another interesting conversation at the last
13 stakeholder meeting was an ombudsman function.
14 And I think the state was envisioning having
15 the MCOs manage that responsibility. Has there
16 been any more thought to how that would be
17 implemented and, you know, any feedback you
18 might have to update us on that?
19 BUFFY: So if I remember the conversation
20 from July, I might ask you to come address
21 this, provide us an example.
22 MR. COHEN: Right. And this is -- I may
23 end up saying what I said back in July, but
24 (inaudible) but one of the recommendations that
25 we receive when we were talking to the

1 stakeholders as we went out around Oklahoma
2 last fall, essentially late summer and fall was
3 particularly coming from the members was the
4 importance of having somebody who could help
5 them navigate what's going to be a new world
6 within the services and care management.
7 And so from that came the idea that we
8 should have individuals within the managed care
9 organization that while they are under employer
10 contract by the managed care organization their
11 mission really would be to support and advocate
12 on behalf of the members who are enrolled in
13 those organizations so it would be available to
14 them as resources of questions. If they have a
15 complaint and they want somebody to help them
16 sort of navigate through how they get their
17 complaint addressed.
18 And, you know, we use the term ombudsman
19 in a very specific way when we talk about
20 individuals who are receiving long-term care
21 under Medicaid program. That's a state
22 function. And so some extent we appropriated
23 maybe we shouldn't have but we appropriated
24 that term along with I think we ended up
25 calling it a member advocate slash ombudsman.

1 Because it does -- it does convey what we have
2 in mind, which is to have somebody there who is
3 really on network on behalf of the member or
4 the family. That's what they do when they get
5 up in the morning. That's their through job.
6 And so that is still, as it was when we
7 presented it in July, that is still the vision
8 to be a component of the program. But it
9 doesn't that away from the statement.
10 MS. PERRY: May I just ask if you used any
11 different state models? Is there a state that
12 comes to mind that do have -- have you seen any
13 -- have you used any best practices from other
14 states or would be receptive to some states,
15 examples of states that perform in that way?
16 MR. COHEN: Yes and yes. That is to say
17 we did look at other states and so we're aware
18 this is something that we weren't inventing.
19 It has been done. And we thought the concept
20 was a good one. We're always looking for best
21 practices either now or in the case of
22 obviously organization that might respond to
23 the RFP when that comes out. That will be an
24 organizations to talk about when they say best
25 practices and how they would (inaudible).

1 Couple opportunity for that. But what were the
2 states that you looked at?
3 MS. PERRY: Yes. Georgia and Wisconsin.
4 UNIDENTIFIED SPEAKER: We've had several
5 comments on the chat feature. If everyone
6 could please try to speak up when they're on
7 the microphone so that the people listening in
8 on the webinar can hear clearly as well as I
9 wanted to just let everyone know the PowerPoint
10 slides will be loaded onto our website after
11 the meeting today and there will also be a
12 recording of the webinar itself that will be
13 loaded up in the next couple of days.
14 BUFFY: We have two comments up here
15 toward the front.
16 MS. TAYLOR: Karen Taylor. I'm a parent
17 advocate. Using the Wisconsin example
18 specifically, there's been a lot of discussion
19 with families about really that ombudsman
20 advocate role. And a big concern that we have
21 is that if I'm having an issue with company A
22 providing support for my son, the advocate who
23 works and their paycheck is received from
24 company A, that's not in my family's best
25 interest.

1 And so I think Wisconsin is a really good
2 example of looking where the Ombudsman has
3 advocates. Those advocates not only resolve
4 issues, but they check the companies to make
5 sure that they have some cultural sensitivity.
6 That they resolve things in a way internally
7 that's transparent and makes sense and all of
8 that stuff.
9 Because the families that I was with at
10 the July meeting, we all got very alarmed by
11 the idea that the fox was going to watch that
12 hen house.
13 UNIDENTIFIED SPEAKER: Absolutely.
14 BUFFY: And let me see if I can respond to
15 that. So absolutely. And not to say that the
16 Ombudsman that we would require an element of a
17 managed care organization, not that would only
18 be Ombudsman. So absolutely. It would be
19 multifaceted. I think the intent there is to
20 make sure that from the plan level that the two
21 are responsible for being -- having firsthand
22 knowledge the staff dedicated to that purpose
23 and function and absolutely is not the one who
24 recognizes some of those potential conflicts.
25 It's our responsibility (inaudible)

1 engaged in that to make sure it best serves
2 members.
3 ANN: I'm Ann from Integris. That brings
4 up the second point. So the TEPRA kids are in
5 the first group?
6 BUFFY: Yes.
7 ANN: I would ask about telehealth and
8 telemedicine. When we talk about the
9 capitation, is that part of the to be
10 determined kinds of technologies that are going
11 to be coming online before they are just
12 assumed into the regular rates?
13 BUFFY: That's a good question. So there
14 would be some expectation that we would expect
15 to see in the proposals a plan of response to
16 incorporate those technologies. Now, as far as
17 a rate setting element, I'd ask Mike, to put
18 you on the spot here a little bit, if there is
19 specific adjustments or consideration as part
20 of the administrative properties?
21 MR. NORDSTROM: Well, I think the
22 telemedicine would typically fall into the
23 claim cost portion of it. Because if it's
24 really presumably, a substitute, right, for a
25 physician (inaudible). And so some of the

1 discussion around those actually are often
2 results in, you know, well, do we factor in
3 some savings for telehealth and telemedicine
4 relative to an office and so, you know, to the
5 extent that it is not within the base data,
6 then it is a question of, you know is it going
7 to result in savings. Basically the same cost
8 or not.
9 ANN: Can I ask about remote monitoring,
10 not just face to face. I'm asking about remote
11 monitoring, if you have a physician that's
12 monitoring the heart rate of the baby, it's not
13 a face-to-face encounter.
14 MR. NORDSTROM: Sure. Again, you know,
15 those are the -- what we would call the claim
16 cost component of capitation rate. And are
17 they essentially substitutes for an office
18 visit or someone that they would care. And
19 what are the relative costs of those, you know,
20 typically most of those types of programs
21 (inaudible) that they'll save some money and to
22 providing more timely care and the enhancing
23 access to the quality.
24 And so the cost considerations are
25 certainly important, but almost secondary but I

1 guess I would say, at a high level whether
2 there inherent directly in the base cost or
3 not, you know, I think they are part of the
4 program and the contract.
5 MR. COHEN: One of the -- one of the
6 advances potentially to a program like this,
7 and it's something -- it's enough of an
8 advantage we did recently release so called
9 final rule for managed care. They went ahead
10 and memorialized it. Understood all a long
11 that they wanted to get it down in black and
12 white. But sometimes in lieu of services. And
13 it speaks to the fact that when you have
14 somebody enrolled in a Medicaid program, let's
15 say they're in state plan benefits, then what
16 they're eligible to receive is defined chapter
17 and verse in the regulations. So OHCA has a
18 whole section on its website that goes through
19 in great legalese and bureaucrats what services
20 are covered and what circumstances and what
21 prior authorization rules and so on and so on
22 and so on. And you've got to fit, depending on
23 your eligibility type, fit within the four
24 corners of those prescribed servers.
25 And everybody may agree that OHCA or

1 elsewhere that there might be something else
2 that would make sense for a particular member
3 to receive. It might be something that would
4 first call other cost that would otherwise
5 occur for that member, may be something that
6 would help people safe in their home and
7 prevent a hospitalization. But if it doesn't
8 fit within those four corners, Medicaid won't
9 pay for it.
10 What we get when we move to managed care
11 is an opportunity to look to our partner in the
12 manage care organization to find that the
13 capitation of the set based on those historical
14 costs at the same, but within them, within the
15 program they have the opportunity to say, well,
16 the state plan benefits are asked. That's
17 what's in our contact, but it also says here
18 CMS has said that in lieu of -- of services it
19 limits here, there's something that makes s
20 sense and state approves, then we can go ahead
21 and deliver those services even though we can't
22 find them chapter and verse.
23 And that's whether it's in-home monitoring
24 or whatever it may be, that opportunity
25 presents itself in a way that we don't have

1 access to, you know, traditional fee for
2 service benefits. That's one of the this that
3 still gets me excited about programs moving to
4 this type of structure because I know that
5 that's one of the benefits that members and
6 their families will see.
7 We want on the ground benefits that
8 they'll see a difference tomorrow versus today
9 when the transition does occur.
10 MS. HOUSER: Ester Houser representing the
11 Alliance on Aging. The silverhaired
12 legislatures and retired. I'm over it almost.
13 Long term care, state long term care ombudsman.
14 In the hope that that horse is not dead, that's
15 just go back to the ombudsman component. The
16 Oklahoma Aging Partnership this summer
17 submitted a white paper related to many
18 different aspects of the pointed care program.
19 One of our recommendations was the inclusion of
20 -- of some sort of ombudsman program that was
21 independent.
22 Reflecting to the long term care ombudsman
23 program federal law forbids such a program to
24 be housed in or to be contracted to a provider
25 organization because of the conflict of

1 interest. And in this case whether it's real
2 or apparent, if your aim is to have a patient
3 navigator or a member navigator or member
4 assistant, whatever, I would just hope that if
5 it's -- if the -- if that entity is placed
6 within the managed care according to care
7 organization that it not be named in ombudsman
8 so as to not spoil it for everybody else who is
9 in ombudsman and is truly independent and
10 advocating just for the member and not
11 receiving a paycheck.
12 At the very least I would hope that you
13 would, if you have an ombudsman program that
14 you can back it out of those contract
15 organizations and keep it in the healthcare
16 authority.
17 MR. COHEN: Thank you for that. We'll
18 keep that under advisement.
19 MS. PEROT: Hi. Moreen Perot again. Just
20 a quick question on your amendment benefit, the
21 transportation benefits currently administered
22 separately through a contracted estate, will
23 that be carved out or will that benefit be
24 rolled in?
25 BUFFY: I think this is one of those where

1 I have to pull the card that we'll have to
2 release that information when the proposal
3 comes out on the street. There's a comment
4 toward the front.
5 GAYLE: Gayle Beaver from Senior Services
6 in Tulsa. You guys have talked about the time
7 line in terms of the RFP. What are you
8 doing -- what are we going to do to help
9 transition our clients and our members to this
10 new program? That's kind of where I'm coming
11 from. For some of our folks it's going to be a
12 real shock, and so I know we -- we've -- we're
13 talking about giving them time to enroll, but
14 what -- how are we going to prepare them for
15 the changes that are coming?
16 BUFFY: So thank you. Because you
17 actually introduced one of the questions that I
18 had for you as stakeholders. And so your
19 question is spot on. Rather than perhaps the
20 state providing a response to that, I'd like to
21 turn that around and perhaps ask from the
22 stakeholders perspective what are those
23 elements that are critical. What are the
24 opportunities that we have today to be able to
25 begin transitioning populations?

1 So while you're thinking about that, let
2 me respond by saying, as part of the readiness
3 review activities that also indicated on that
4 time line, that's where those activities would
5 occur, right. Not that it would be limited to
6 that period of time, because we know that by
7 having these open meetings, you know, every
8 other month and to provide an audience of
9 stakeholders is wishing to participate, we've
10 already at least started to provide that
11 awareness opportunity.
12 But I would like to perhaps hear from this
13 group on what would be the critical elements of
14 transition? What would be those opportunities
15 that you would see as the best place to go as a
16 first step or as a second or a third step. I
17 know, for your organization, for other
18 organizations that are dealing with members
19 what materials is it, what is it that the state
20 can provide you with to begin having those
21 conversation with your members so that we can
22 identify really from you what would be the best
23 step to be able to begin having those
24 conversations.
25 So see how I spun that question back

1 around. It's back tag. You're it.
2 MS. TAYLOR: Erin Taylor again. I would
3 just say those of us who get the privilege of
4 working with children, educating parents on
5 EPSCT, what that involves. What that provides
6 for our children really is critical. Because
7 it's going to be enough for us to explain to
8 our new providers that things like vocational
9 training, transportation and all that can be a
10 Medicaid covered services. Most of our
11 families don't even understand those non hard
12 medical supports.
13 So that would be very, very helpful for
14 me. And I would say that probably with the ton
15 of our families we do 95 percent of our
16 education online in a group. So however we can
17 deliver it that way would be helpful for us.
18 MR. COHEN: Erin, do you have regularly
19 scheduled forums online?
20 MS. TAYLOR: No. But, I mean, we have --
21 MR. COHEN: Q and A --
22 MS. TAYLOR: We have -- you know, there's
23 704 families, maybe 650. And I would say we
24 have half of them in this group. But they
25 check that account three or four times a day.

1 So it needs to be something you can just
2 repost. Something like that.
3 BUFFY: So let me ask from Life Services,
4 from your perspective contrast that with the
5 population you see. Would you see an online
6 forum? Because it's not going to be a one size
7 fits all. So I'd like to see --
8 UNIDENTIFIED SPEAKER: No. I don't --
9 work with the aging, the population of the
10 aging, I don't think we're quite there yet.
11 Now, you know, in ten years when you baby
12 boomers are going through this, that will be a
13 different story. But I would say the primary
14 concern that our folks are going to have are
15 they having to change their providers. And
16 they've got these certain people that come in
17 their world. And they want to know if that's
18 going to have to change.
19 And so as much information, you know, the
20 absence of information creates stories, right.
21 People make things up. And so I think as soon
22 as -- as soon as we know what the process is
23 going to be, who the parties and providers are
24 involved, then we have to just -- we just have
25 to start initiating that.

1 Part of it for us, as at Life, we have an
2 advantage program. So what's going to happen
3 to the advantage case managers? And they know
4 then they can, they're the primary contact and
5 connection along with the nursing ward, so, you
6 know, I think we just have to really just start
7 as soon as we know what's going to be like,
8 start the information flow whether it's in
9 person or we're some people are fine online and
10 can do it that way. I think it's going to have
11 to be done a variety of ways.
12 Not just -- for these folks probably
13 online but for us we'll have to have brochures,
14 pamphlets, talk to them. And whoever the
15 primary providers are need to have people out
16 on the phones.
17 MR. HASA: Mike Hasa Healthcare Service
18 Corporation. And two quick questions to
19 confirm or to help clarify some stuff I thought
20 I heard today. First of which can you confirm
21 that behavior health and pharmacy are going to
22 be included in the RFP?
23 BUFFY: Well, I mean, I think -- I really
24 don't want to speak to a service level
25 inclusion to be fair to the question about

1 emergency transportation. I'd rather not speak
2 to level specifics.
3 MR. HASA: Okay. The second of which --
4 MR. COHEN: It was on the slide and that
5 was something that we had discussed. So I'll
6 quickly go through it again. Individuals who
7 are receiving services who are aligned with a
8 behavior health home, which is an initiative
9 that is occurring in a lot of states and here
10 under the omnibus of substance fee services.
11 It's still in its fairly early days, but HSH is
12 in the process of establishing behavior health.
13 They're oriented toward individuals with
14 serious mental illnesses. And so if somebody
15 meets the clinical criteria for receiving
16 integrated physical and behavioral health
17 services through one of these settings then
18 because they'll be getting care coordination in
19 that setting, so long as they are receiving
20 services in that setting, they would not be
21 enrolled in the Sooner Health Plus program to a
22 managed care organization even though they
23 otherwise would quality.
24 And so that's -- that was the one piece of
25 information that we at least discussed in July.

1 I just put it on the slide again as
2 (inaudible)that's what that was referring to.
3 MR. NORDSTROM: I probably should add, so
4 I gave a laundry list of these categories of
5 service that might be in the clinical data
6 book, for example. And so that certainly
7 wasn't meant to imply to each and every one of
8 these services are going to be part of the
9 program or not. It was really just more on an
10 example of these are things that, you know,
11 might typically be part of the book.
12 We're still working through that. There
13 might be other things OHC wants to provide to
14 potential bidders in that book as well. So if
15 I led you down the wrong path on confirming
16 different services, I apologize for that.
17 MR. HASA: No, thanks. That's helpful.
18 The second question was, again, on the data
19 book comments. So it was helpful to hear some
20 of the logic that went into that. I thought
21 you mentioned that there was a little bit of a
22 markup for managed care MCO and admin costs
23 that were going to be factored in.
24 But I thought I had heard at a previous
25 meeting that as part of the procurement process

1 that those are also going to have to set a
2 little bit of their own admin costs permitting.
3 Can somebody help clarify that?
4 MR. NORDSTROM: Yeah. I think that's one
5 of the changes. So they're certainly one
6 portion of possible RFP response and to have
7 health plans bid rates into a range. And it
8 might involve -- or kept secret, right. The
9 approach that the state is using is that we're
10 going to work with Mercer, obviously, and OHCA
11 to develop a set capitation rate so that plans
12 don't need to develop, you know, their own
13 admin estimates or anything like that. You'll
14 just need to once those are put forth, figure
15 out, you know, do we think that we can do it
16 for that level of capitation or not.
17 So you won't need to worry about that part
18 of it.
19 MR. HASA: Okay. Thanks.
20 MS. BRUCE: My name's Jenny Bruce. I'm
21 with the Oklahoma Family Network. And my
22 question or suggestion maybe that goes back to
23 how to get information to the individuals. And
24 I would just say kind of ditto what the other
25 two individuals said. But one of the things

1 that we find often in the rural area is if
2 you -- they like getting e-mails sometimes, but
3 you just have to be really careful the way you
4 send it. Because they may have real limited
5 amounts of data.
6 And a lot of rural areas have to buy data.
7 Like we use two minutes on our cell phones.
8 And so however you give that information out,
9 if it is electronically, that it be done in
10 such a way that it will take as little data as
11 possible.
12 And then my other suggestion is we have
13 coalitions across the state. There are
14 coalitions some that cover two counties, some
15 that just cover one county. And that is a
16 mechanism to really get a lot of good
17 information out to the general population. And
18 it may not be that, you know, Sam Q. Public is
19 always there, but it might be their providers
20 are there.
21 So I would just encourage you, you know,
22 you know, you have your people out. You have
23 people out in -- across the state, but if there
24 were a way to get either to those coalitions or
25 doing kind of an on the road, if you will, with

1 information, that might be a good way to do it
2 as well.
3 Because some people really do learn better
4 where they can ask questions and interact
5 versus just seeing it online.
6 BUFFY: So I think those are -- this is
7 terrific feedback. Something that I might ask,
8 there's two things. Number one is whenever you
9 talk about the network of coalitions and grass
10 roots efforts and local community based
11 organizations as well as statewide or regional
12 entities, as we approach that transition
13 period, I think it will be helpful for all of
14 us to utilize, as stakeholders, we also more
15 broadly compile say a list, right, of, you know
16 organizations where they're located, contact
17 information. Perhaps that already existed
18 that would be great to be able to share with
19 potential venders after we get to that point.
20 Because those will be the connections that
21 I think will be incumbent upon us at the state.
22 We will help facilitate those connections. So
23 that's kind of the first point. Let's make
24 sure to remember that.
25 The other question that I was going to

1 pose back to you all, so recognizing that it
2 has to be a multifaceted outreach campaign
3 using a variety of, you know, methods and some
4 electronics, some paper, some face-to-face,
5 things like that. Would you all find it useful
6 when we got to that point as an element of the
7 transition plan would there be some element of
8 allowing a consumer or a family to choose yes,
9 I want e-mail or, no, I want all postal mail or
10 I really want to have calls to be able to have
11 that where every consumer can self select and
12 that they would like to have that outreach?
13 That's great feedback.
14 UNIDENTIFIED SPEAKER: One of those
15 feedback be video?
16 BUFFY: Video?
17 UNIDENTIFIED SPEAKER: You could have
18 video to listen.
19 BUFFY: Absolutely. Yeah. Help us
20 compile that list of what all those different
21 methods may be. Yeah. I think we need a mic
22 up here.
23 UNIDENTIFIED SPEAKER: I'm sure I could
24 speak loudly enough for everyone.
25 BUFFY: For the folks online, I want to

1 make sure they're hearing our --
2 GAYLE: Again, Gayle Beaver. When you
3 guys did your on-the-road trips around the
4 state, those were great. The only thing I
5 would ask is that we did not have a enough time
6 to get our consumers there. So please think in
7 terms of giving us enough time so that if our
8 folks want to attend, and also in a place large
9 enough, I mean, where if we need to go pick
10 them up or go do whatever we need to do to get
11 them there, if they truly want to be there to
12 hear the questions and ask questions and hear
13 answers.
14 BUFFY: So Gayle, may I ask, is there a
15 period of time that you might suggest? Are we
16 talking about a 30 day notice, 60 day notice?
17 Something like that?
18 GAYLE: Thirty days.
19 BUFFY: Thirty day notice, okay.
20 MR. HUGHES: Jeff Hughes with Progressive.
21 So we've been meeting on this issue on Mondays
22 so any time that you want to come down, we've
23 got a group that is ready to go. We've been
24 very much beat over the head with the managed
25 care. So I'm very interested. Want to know

1 how it's going to improve services. Welcome
2 the Healthcare Authority to come down any time
3 you want to. We'll get it coordinated. Just
4 let me know. There are a lot of people who are
5 obviously interested and want to know how this
6 is going to shift. So just come on.
7 BUFFY: Thank you. Appreciate all the
8 input you've already provided.
9 MR. COHEN: I think maybe when we get to
10 the point of where we're able to go out and
11 have sessions and answer and questions about
12 what we are that maybe we can set up something
13 where we can take invitation because we won't
14 know (inaudible). I'm just saying I want to
15 get out of Oklahoma City and back on the road.
16 UNIDENTIFIED SPEAKER: Tech question from
17 Vickie. How is the RFP addressing IDD children
18 that are in DHS custody?
19 BUFFY: So that is a question that has
20 been brought up. And I can tell you that we
21 don't have a definitive answer as of yet, but
22 it is under discussion. And the thing that we
23 know for children, you know, who are IDD, they
24 do have that one year delay coming out year
25 two. So we recognize the critical nature of

1 that population and want to make sure that
2 they're taking the advice from other states
3 best practices.
4 There have been other states like the
5 state of Florida that has done something
6 separate in stage for their children in custody
7 situations. And so not to say that's what
8 we're doing here, but I'm just saying that we
9 want to make sure that we're fully arming
10 ourself with all the information on being
11 pursued elsewhere before we make that decision.
12 UNIDENTIFIED SPEAKER: The second question
13 from chat, Jonathan. What about those
14 currently receiving successful care
15 coordination to advantage waiver?
16 BUFFY: So we have been in talks with the
17 Department of Human Services and the advantage
18 waiver staff, which looking across the room, I
19 was going to see if we had any advance in here.
20 Okay. We have been in collaboration with OKDHs
21 and the advantage care and looking at what the
22 process was. We would like for members that
23 are currently served by today's advantage
24 program.
25 I can tell you there is not planned as for

1 any other populations changes to eligibility
2 enrollment processes that are happening outside
3 and will remain in the same processes in there
4 today that are outside of the RFP as well as
5 available services and benefit that the members
6 qualified for.
7 There will be no changes to those
8 benefits that are available to those members.
9 There's nothing substantial that needs to be
10 changed as part of the managed care RFP.
11 What we do envision changing is the
12 relationship between the contractual
13 relationship between what is today the
14 Healthcare Authority and advantage providers
15 with the inference of a managed care
16 organization. And we do anticipate that
17 contractual relationship to change in that the
18 Healthcare Authority now being contracted with
19 the health plans and the managed care entity,
20 it will be the responsibility of those managed
21 care entities to then pursue the contracts with
22 those advantage providers.
23 So from the providers there would be that
24 change and those relationships would shift.
25 However, we have to put in protections in RFP,

1 but we put in consumer protections in the RFP
2 to ensure that for a managed care entity that
3 in year one of the program they must retain the
4 same -- the same or more extensive network with
5 advantage providers to make sure that we've got
6 that continuity of care over that first year.
7 I'm getting so --
8 UNIDENTIFIED SPEAKER: Too far in the
9 weeds.
10 BUFFY: So, yes, we are looking at that
11 taking that under consideration. I thought we
12 had mentioned advantage. Other question?
13 Other comments?
14 UNIDENTIFIED SPEAKER: Going on with the
15 advantage program, BJ Mooney with Doc Services.
16 We are -- we have been a long term provider of
17 the advantage program. You know, it's been
18 made very clear to us that you want to provide
19 the member with choice. And with that being
20 said, as a provider, are remittances and our
21 billings, any issues that we have, are we going
22 to have to be working with two or three
23 different companies in weeding all of this out
24 and having the problems with each company as
25 before we were just able to go with the state.

1 If we had a problem we knew directly who
2 to talk to. And that may be too far, but I
3 thought I would ask.
4 BUFFY: I'm willing to provide as much
5 information as I can until someone gives me
6 the -- anyhow, so that's a great point.
7 Something seriously we'll take under
8 consideration because we recognize consumer but
9 for the provider side we want to make sure that
10 there are protections in place as well to make
11 sure your administrative burden doesn't
12 increase as well.
13 So what I can say is part of that
14 transition planning, we want to take a look at
15 all positions and make sure that we've got
16 appropriate controls, we will take a look at
17 those specifically to make sure we understand
18 what the impacts of our providers. So thank
19 you.
20 MS. PERRY: Pam Perry, Amerigroup. How
21 many plans do you anticipate contracting with
22 by region or statewide?
23 BUFFY: So I think at this point, not able
24 to -- not able to say that we have a definitive
25 answer on how many that will be. Those are

1 certainly things that we're considering certain
2 elements. Not able to say at this time.
3 Other questions? All right. And I think
4 actually the -- most of the questions that I
5 had for you all you actually hit on. You've
6 been asking the same questions that had come to
7 my mind that we wanted feedback on. So I thank
8 you for this dialogue and for this exchange
9 today.
10 I'm going to ask everyone, I know we're
11 making kind of those goodbye sounds we're
12 gathering things.
13 UNIDENTIFIED SPEAKER: Please remember to
14 fill out your surveys. Thank you.
15 BUFFY: Yes. We have someone at the
16 table. Got somebody at the table to take those
17 back so please take those blue evaluation
18 forms. Leave those with us. I see no other
19 questions or comments. Thank you all for your
20 time this afternoon.
21 (Meeting was concluded at 3:23
22 p.m.)
23
24
25

1 CERTIFICATE
2 STATE OF OKLAHOMA)
3) SS:
4 COUNTY OF OKLAHOMA)
5 I, Jessica L. Weathington, CSR, do hereby
6 certify that on SEPTEMBER 13TH, 2016 at the offices
7 of Oklahoma Healthcare Authority Oklahoma City,
8 Oklahoma, that the foregoing pages constitute a
9 full, true, and correct transcript of the
10 proceedings of said meeting on the date as
11 indicated.
12 I do further certify that I am not
13 counsel, attorney, or relative of either party, or
14 otherwise interested in the event of this suit.
15 IN WITNESS WHEREOF, I have hereunto set my
16 hand and affixed my seal at my office in Oklahoma
17 City Oklahoma County, Oklahoma, this 23rd day of
18 September, 2016.
19
20
21 ______________________________,
22 Jessica L. Weathington, CSR
23 CSR No. 1833
24
25

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