Transforming Health Care:

A Proposal for Oklahoma's Future

November 21, 2014

Oklahoma Hospital Association

This presentation was developed in conjunction with Manatt Health and informed by discussions with multiple public and private stakeholders.

Elements of the Proposal

- The Case for Change
- Payment and Delivery System Reforms
- Broadening Coverage in Oklahoma

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The Case for Change

Forces Driving Reform of Health Care in Oklahoma

- To achieve a balanced budget, Oklahoma must **control state spending.**
  - Oklahoma spends approximately $5 B annually (36% of which is state funds) on the Medicaid program.
- Despite the state's investment in health care, more than 630,000 remain **uninsured (17% of the population**) in Oklahoma; **cost of that care is shifted to the private sector.**
- **Oklahoma has poor health outcomes**, as evidenced by high rates of smoking, obesity, and diabetes.
- The high rates of uninsurance and poor health status contribute to the **high cost of health care in Oklahoma.**

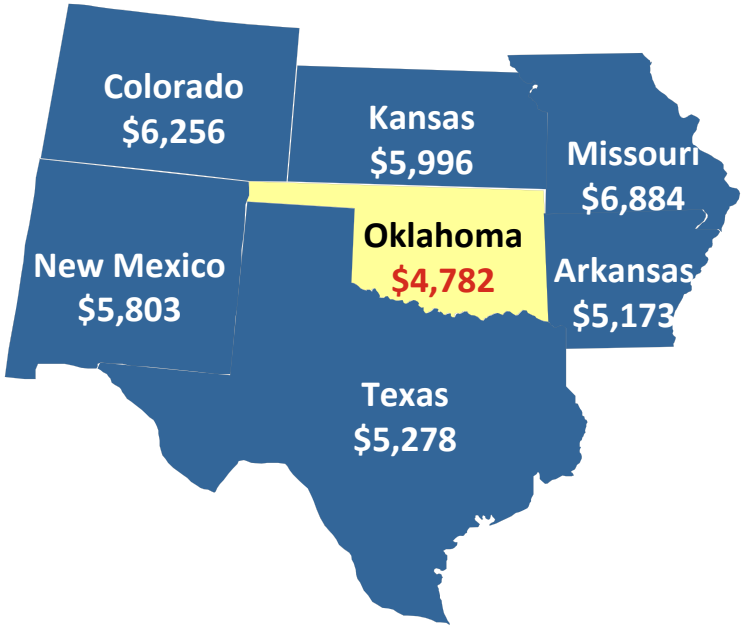
Sources: Bullet 2) Oklahoma Healthcare Authority; 3) Kaiser State Health Facts; 4) United Health Fund's America's Health Rankings® Dec. 2013; The Commonwealth Fund's Scorecard on State Health System Performance for Low-Income Populations, 2013

Oklahoma Must Become a Value-Based Purchaser

- Medicaid spending per beneficiary in Oklahoma is less than the national average and less than spending in neighboring states.

Even so….

- Oklahoma can become a more **prudent purchaser of care**, ensuring access and improving transparency, accountability and value.



National Average = $5,563

Sources: Kaiser State Health Facts; PHPC, "SoonerCare Choice Program Independent Evaluation," Sept. 2014

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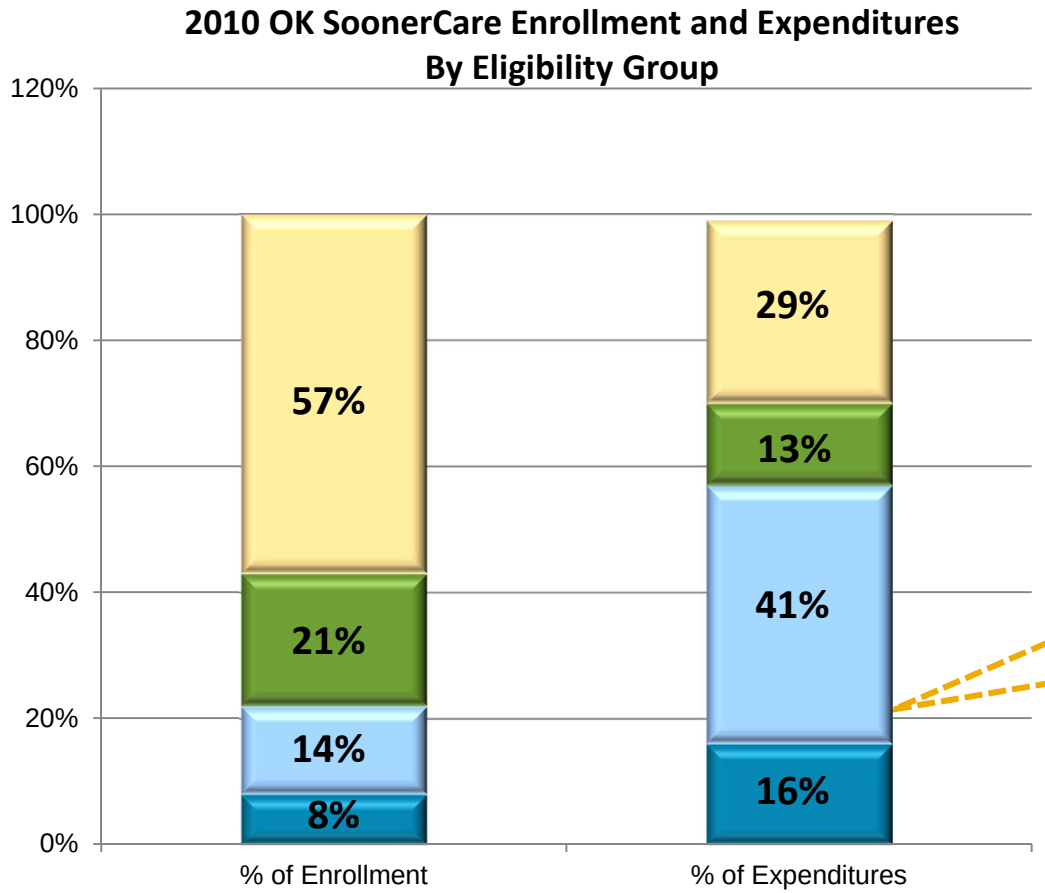
A Small Percentage of Beneficiaries Drive Costs

22% of beneficiaries account for 57% of program costs



Medicaid Payments per Aged and Disabled Enrollees are $10,085 *and* $13,820, *respectively, compared to $2,462 for children and $2,973 for adults.*

e: Kaiser State Health Facts, Oklahoma.

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Evaluations of SoonerCare Choice

SoonerCare Choice achieves mixed results on indicators of quality of care and health outcomes.

- **Preventive Screenings & Health Management:** Breast/cervical cancer screening rates, cholesterol management rates, and performance on all adult comprehensive diabetes measures are well below national average.
- **Emergency Department Utilization:** While the state has achieved some reductions, ED utilization rates remain high, especially for the disabled.

s: Leavitt Partners: "Covering the Low-Income, Uninsured in Oklahoma"; PHPC, "SoonerCare Choice Program Independent Evaluation," Sept. 2014

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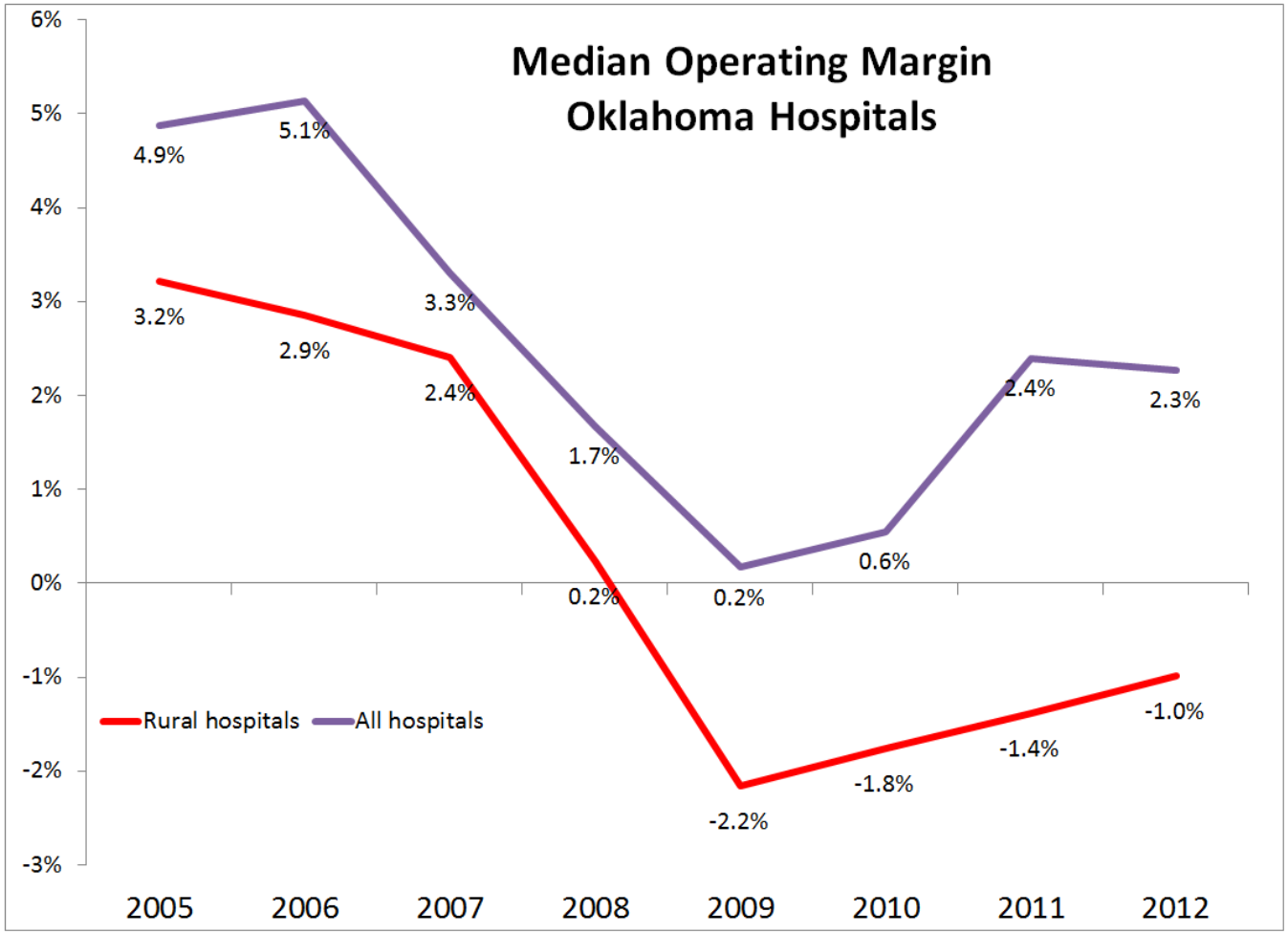
Broadening Coverage Reduces Uncompensated Care Costs

- In 2012, Oklahoma hospitals absorbed **$547 million in uncompensated care costs**, which represented 6.1% of Oklahoma hospitals' total expenses.
- The cost of treating **the uninsured disproportionately affects rural hospitals.**
  - Uncompensated care accounted for 10-17% of the expenses for 20 rural Oklahoma hospitals (compared to the 6.1% state average).
- **Rural hospitals are less able to shift costs** to insured patients given their payer mix.

Sources: American Hospital Association/OHA/OSDH Annual Cooperative Hospital Survey

Investment in Coverage Preserves Access in Rural Communities



Sources: CMS Healthcare Cost Report Information System

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Behavioral Health Is a Key Investment Area

Top 10 Diagnoses for Readmissions 2011

Medicaid
Mood disorders
Schizophrenia, other psychosis
Diabetes mellitus
Other complications of pregnancy
Alcohol-related disorders
Early or threatened labor
Congestive Heart Failure*
Septicemia (except labor)*
COPD and bronchiectasis*
Substance-related disorders

Four of the top 10 diagnoses related to readmissions are for behavioral health conditions.

Source: 2011, Data, Healthcare Cost and Utilization Project (HCUP). Agency for Healthcare Research and Quality (AHRQ). http://www.ahrq.gov/research/data/hcup/index.html

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Coverage Increases Resources for Behavioral Health

- **Federal dollars are available to pay for mental health and substance abuse services currently funded with state dollars.**
  - Increasing coverage would result in the federal government covering **$34 M** of **Department of Mental Health and Substance Abuse** expenditures annually.
  - The Department would then be able to use the freed up state dollars on other services that are not reimbursable by the federal government, e.g. social supports.
- The **Department of Corrections** would save **$11 M** in spending on prisoner hospitalizations.
  - Individuals discharged from prisons become eligible for Medicaid.
  - Access to physical and behavioral health services during transition could help prevent recidivism.

In addition to these savings, the state would save **$2.4 M** in **Department of Health** expenditures for a **total of $48.2 M in annual state savings.**

Source: OHCA, as described in Leavitt Partners: "Covering the Low-Income, Uninsured in Oklahoma";

Investing in Coverage Provides a High Rate of Return

- **An additional $8.6 B in federal funds** flows to the state over 10 years.
- **13,211* new jobs** in Oklahoma are created over 10 years.
- **$50 M** in state expenditures for health services are replaced by federal dollars annually, including a significant amount for behavioral health services.
- **Uncompensated care costs** for hospitals, physicians, and other providers **go down**, particularly benefiting rural communities.
- **Cost shifting** between payers and between the uninsured and the insured **is reduced.**

*Based on median coverage take-up rate.

Sources: Urban Institute; Leavitt Partners: "Covering the Low-Income, Uninsured in Oklahoma"

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Goals for Oklahoma's Investment in Health Care

- ✓ **Improve Quality, Outcomes, Value and Transparency**
- ✓ **Improve Access**
- ✓ **Contain Costs**
- ✓ **Improve Sustainability**

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Goals for the State's Health Care Investment

1. Improve quality, outcomes and value by holding providers accountable through value based purchasing models emphasizing care coordination and transparency.

2. Improve access by broadening coverage, identifying gaps in provider capacity and targeting resources more effectively.

3. Contain costs by targeting medically complex, high-cost populations (e.g. individuals with co-morbid physical and behavioral health conditions) and reducing unnecessary emergency department visits and potentially preventable admissions and readmissions.

4. Improve budget certainty and sustainability of the Medicaid program.

Building Blocks for an Oklahoma Plan

Payment & Delivery System Reform

- Improve quality & contain costs by moving from volume-based to value-based purchasing.
- Reduce unnecessary utilization, including ER visits and hospitalizations, through enhanced care coordination and access to primary care.
- Integrate services for high cost, high need beneficiaries with physical and behavioral health comorbidities.

Coverage Reform

- Build on Insure Oklahoma
- Engage the private sector
- Require personal responsibility
- Incent work and education
- Ensure sustainability

Enables budget predictability for the state

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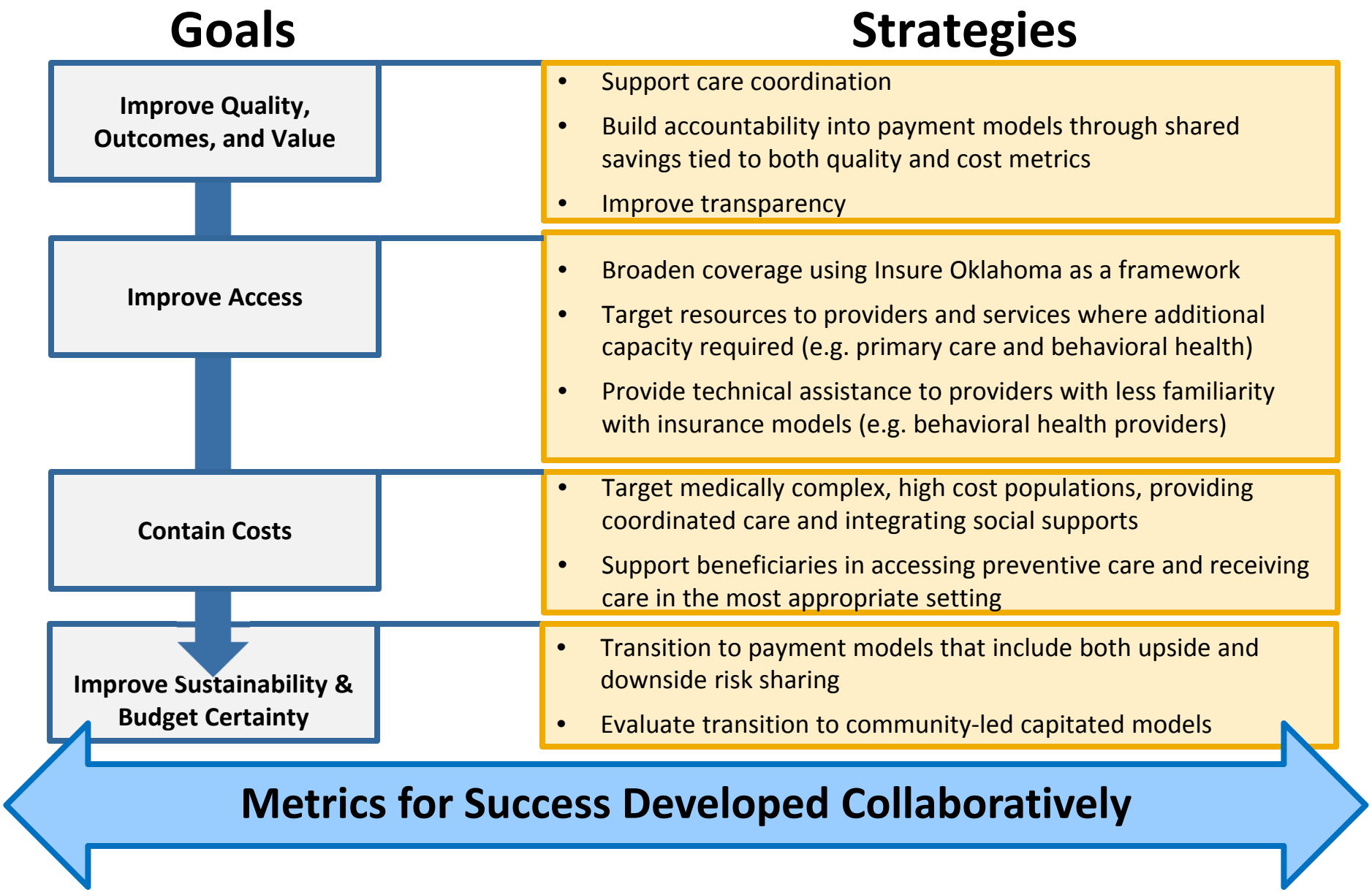
Payment & Delivery System Reforms

Oklahoma's Health Care Investment Goals & Strategies



Vehicles to Coordinate Care for Medicaid Beneficiaries

Patient-Centered *Medical* Homes

- A PCMH is a type of medical home that **centers around primary care physicians**, with incentives to coordinate patients' care across multiple providers (including hospitals, specialty, and community services and supports).
- States use various payment methodologies in PCMHs, including enhanced fee for service (FFS) rates, per member per month capitation rates, and shared savings.
- PCMHs may be implemented under the State Plan or under a waiver, depending on the features of the model.

Health Homes

- Medicaid Health Home **centers around the social service supports and care coordination** and targets Medicaid enrollees with chronic conditions or serious mental illness.
- Health homes provide:
  - Comprehensive care management and care coordination
  - Health promotion and patient education
  - Comprehensive transitional and follow-up care
  - Patient & family support
  - Referral to community & social supports
- States have flexibility in determining the payment methodology for health home services.
- States may receive 90% enhanced federal match for the first two years of health home services.

Proposed Building Blocks of Reform in Oklahoma

Medical Homes

- Expand patient-centered medical homes (PCMHs) to all Medicaid beneficiaries
- Establish linkages between and among PCMHs, hospitals and FQHCs
- Build on Health Access Networks to support medical home development
- PCMHs, partner hospitals and FQHCs eligible for shared savings

Health Homes

- Expand health homes for individuals with behavioral health conditions
- Establish health homes for individuals with chronic conditions
- Establish linkages with hospitals and FQHCs
- Health homes, partner hospitals and FQHCs eligible for shared savings

Community-Led Accountable Care Models

- Enroll beneficiaries in community-led accountable care models
- PCMHs and health homes provide care coordination and support services; foundation of accountable care
- Payment model developed over three years beginning with shared savings and transitioning to full capitation

Transition to Provider Risk-Bearing Models Over Time

Broaden Coverage in Oklahoma

Increased Coverage Facilitates Medicaid Reform

- Reduces churn between types of coverage and uninsurance
- Enables the management of care for individuals – directing them to preventive services and the most appropriate setting of care
- Reduces cost shifting across payers and employers
- Improves access to care and retains providers in the Medicaid delivery system
- Facilitates financial sustainability for providers who are particularly vulnerable to high rates of uninsured patients (e.g. rural providers)
- Enables Oklahoma to secure federal dollars to support transformation efforts

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Current Coverage Programs: SoonerCare

SoonerCare Choice is a primary care case management program where individuals are assigned to a medical home through which they receive primary care and care coordination services. High need beneficiaries receive additional care coordination and management support through Health Assistance Networks and the Health Management Program. Most children, parents, and many non-Medicare aged, blind and disabled (ABD) beneficiaries are enrolled in this program.

SoonerCare Traditional is a fee-for-service program that provides the standard Medicaid benefit package through a statewide network of providers. Individuals in long term care (LTC) facilities, dual eligibles, and LTC waiver populations are enrolled in this program. The primary difference between SoonerCare Choice and SoonerCare Traditional is that individuals in the Traditional plan are not enrolled in medical homes and physician visits are capped (children excluded).

Oklahoma Cares provides full SoonerCare benefits for women receiving treatment for breast and cervical cancer. Women who earn <185% Federal Poverty Level (FPL) and are less than 65 are eligible.

SoonerPlan covers only family planning services for men and women up to 133% FPL.

Current Coverage Programs: Insure Oklahoma

Insure Oklahoma offers **premium assistance for employer-sponsored insurance (ESI)** to individuals who make <200% FPL and work at eligible employers. Under this plan, employees, the state, and the employer all share in the cost of private health plan coverage for the employee.

Eligible individuals who make <100% FPL may purchase subsidized health insurance coverage through the Insure Oklahoma **Individual Plan (IP)**. Enrollees in the plan pay up to 20% of the premium on a sliding scale, which is subject to a cap of 4% of gross income. The Individual Plan is administered by the Oklahoma Health Care Authority.

The state's portion of Insure Oklahoma is financed by a sales tax on tobacco products; federal Medicaid matching funds cover the balance.

The program is authorized under an 1115 waiver. Without a waiver extension, it will end December 31, 2015.

Closing the Coverage Gap: Newly Eligible Adults

NEWLY ELIGIBLE ADULTS

- Childless adults with income below 138% FPL ($16,105)
- Parents with incomes between 42% - 138% FPL *(Example: family of two with parent and child, income between $6,606-$21,707)*
- Estimated 233,334 individuals would enroll in coverage over 10 years based on medium take-up rate

Source: Kaiser State Health Facts; Leavitt Partners: "Covering the Low-Income, Uninsured in Oklahoma"

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Covering the New Adults: Building on Insure Oklahoma

- Newly eligible adults with incomes up to 138% FPL with access to cost-effective employer-sponsored insurance (ESI) would be eligible for **Insure Oklahoma: ESI.**

- Newly eligible adults with incomes between 0-100% FPL without access to cost-effective ESI would be eligible for **Insure Oklahoma: Individual Plan.**

- Newly eligible adults with incomes between 100-138% FPL without access to cost-effective ESI would be eligible to enroll in commercial health plans on the individual market.

- Medically frail newly eligible adults with incomes up to 138% FPL would enroll in **Insure Oklahoma: Individual Plan**.

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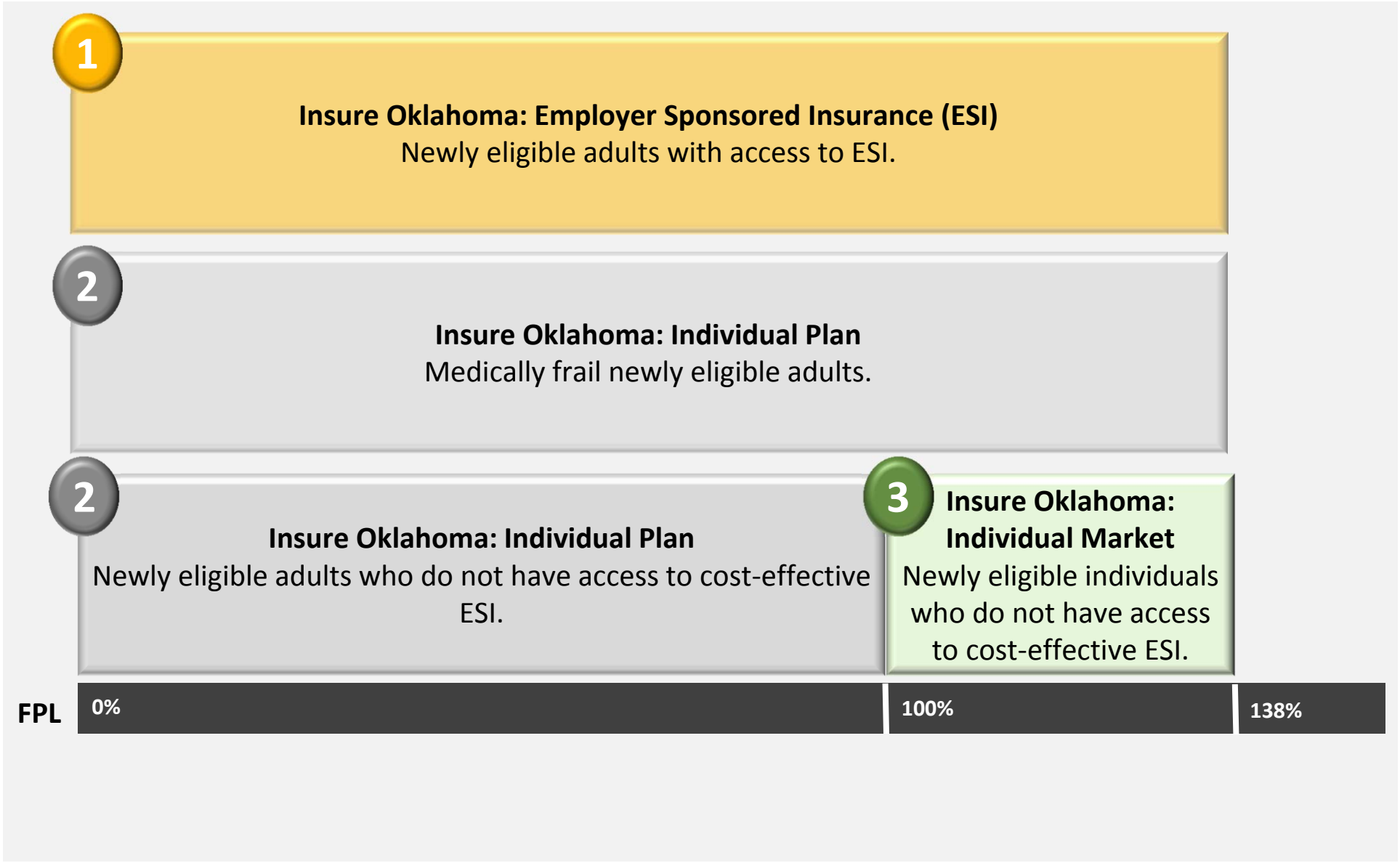
Insure Oklahoma: Proposed Coverage Solution



Coverage Proposal: Rationale and Considerations

Insure Oklahoma

1. **Insure Oklahoma: ESI** builds on the existing premium assistance program. Employer funding stays in the system.

2. **Insure Oklahoma: Individual Plan** builds on existing program and incorporates personal responsibility features for newly eligible adults, including cost sharing and non-coverage of non-emergent use of the ER, and payment and delivery system reforms holding providers accountable for improved quality and outcomes with a particular focus on high need beneficiaries.

3. **Insure Oklahoma: Individual Market** provides premium assistance to individuals enrolled in commercial health plans coupled with personal responsibility features including premiums and cost-sharing.

Examples of the Newly Insured Adults

Rachel

Single Working Mother
Annual Income: $12,584

Rachel is a single mom who works part-time for a large company. While pregnant, she was covered through SoonerCare Choice. However, 60 days post-partum her income exceeded the limit for SoonerCare Choice. Her employer is too large to participate in Insure Oklahoma and she cannot afford her employer's premiums. Her daughter, Anne, is enrolled in SoonerCare. (IO: ESI)

Rob, Janet, & Peter

Family with Working Parent
Annual Income: $17,811

Rob works full time making $9/hour for an employer in Texas that does not offer insurance. Janet stays at home with their 1-year-old son, Peter. Peter is enrolled in SoonerCare Choice. Rob and Janet are uninsured. Their income is too high to qualify for SoonerCare, and because Rob's employer is based out-of-state, he and Jan are not eligible for Insure Oklahoma. (IO:IP)

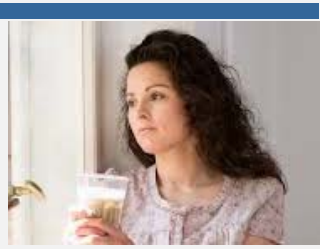
Jim

Working Adult
Annual Income: $11,086

Jim works for a small construction company. His employer used to offer health insurance for which employees paid 50% of the cost of the premiums. The company can no longer afford to offer insurance. If Jim's employer were enrolled in Insure Oklahoma, both Jim and his employer would receive assistance toward the cost of the premiums, with the state covering at least 60%. (IO: ESI)

Donna

Unemployed Adult
Annual Income: $0



Donna recently lost her job as a result of missed days due to treatments for liver cancer. Because of the illness, she is not currently looking for work. She is not eligible for SoonerCare due to her type of cancer (i.e., not breast or cervical cancer). Meanwhile, she is not eligible for Insure Oklahoma because she is not working or looking for work. (IO: IP)

Features of Oklahoma's Coverage Approach

Benefits. Alignment of the alternative benefit plan for newly eligible adults with the benefits offered by QHPs to the maximum extent possible.

Premiums and Cost-Sharing. Targeted use of premiums and cost sharing for individuals with incomes above 100% FPL.

Healthy Behavior Incentives. Incentives for meeting health or wellness standards, including elimination or reduction of co-pays or premiums.

Work and Education Referrals. Referrals to job training and placement programs (e.g., www.OKJobMatch.com) for unemployed individuals with incentives for participation.

State Protections. Use of a trust fund and a provider fee backstop to cover the non-federal share of the newly eligible; adoption of a provision to sunset coverage should the federal match rate go down.

States Cover ABP Benefits for New Adults at Enhanced Match

ALTERNATIVE BENEFIT PLAN (ABP)

- 10 Essential Health Benefits
  - Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Mental health and substance use disorder services, including behavioral health treatment
  - Prescription drugs
  - Rehabilitative and habilitative services and devices
  - Laboratory services
  - Preventive and wellness services and chronic disease management
  - Pediatric services, including oral and vision care
- Early Periodic Screening, Diagnosis, and Treatment (EPSDT) for 19 and 20 year olds
- Non-emergency medical transportation

YEAR	ENHANCED FEDERAL MATCHING RATE NEWLY ELIGIBLE ADULTS UP TO 138% FPL	
	State Share	*Federal Share*
2014	0%	100%
2015	0%	100%
2016	0%	100%
2017	5%	95%
2018	6%	94%
2019	7%	93%
2020+	10%	90%

Covered Benefits for Newly Eligible Adults

Coverage Vehicle

- Insure Oklahoma: ESI
- Insure Oklahoma: Individual Plan
- Insure Oklahoma: Individual Market

Benefit Package

- Alignment of benefits with QHPs to the maximum extent possible with no coverage of non-emergent use of the emergency department
- Medically frail new adults choose between the Insure Oklahoma Individual Plan benefit package and the traditional Medicaid benefit package
- Enhanced federal match for all covered services

Personal Responsibility: Premiums and Cost Sharing

Premiums

- Individuals with incomes 100% to 138% FPL subject to a premium up to 2% of household income
- Failure to pay premium for 90 days results in disenrollment
  - Re-enrollment not tied to repayment of back premiums
  - Unpaid premiums are a collectible debt
  - Consistent with PA's approach
- Individuals with incomes <100% FPL have no premium obligation

Cost Sharing

- Cost sharing consistent with federal rules for newly eligible adults 100-138% FPL (*see appendix*)
- Medicaid cost sharing for individuals >100% FPL generally aligns with QHP cost sharing for individuals <150% FPL

Incentives for Healthy Behaviors, Work Search & Education

Healthy Behavior Standards

- Reduction in cost sharing obligation or premiums for meeting healthy behavior standards, such as attending smoking cessation counseling or receiving all recommended preventive screenings

Work & Education Referrals

- Unemployed individuals referred to job training or work placement programs, e.g., www.OKJobMatch.com
- May include vouchers to reduce premiums or cost sharing for participation

Protections Used in Other States

Trust Fund

- Savings generated from increased coverage set aside to offset the State's share beginning in 2017.
- Sources of savings: cost of services for new adults currently funded with state dollars (e.g., mental health and substance abuse programs) and enhanced match for coverage of some existing eligibility groups e.g., Insure Oklahoma.

Provider Fee Backstop

- Revenue generated from provider fee may be used to cover a portion of the State's share for increased coverage if cost for new adults exceeds an established target.

Sunset Provision

- Termination of coverage for new adults if Congress reduces the federal share authorized by the Affordable Care Act (federal share is 100% through 2016 and decreases overtime until it reaches 90% in 2020).

Time Frame for Implementation of Proposals

Current	Phase 1 (2015-2016)	Phase 2 (2017-2020)
• Multi-stakeholder process to develop specific coverage and reform features and develop metrics for success.	• Expand Insure Oklahoma: ESI • Expand Insure Oklahoma: Individual Plan • Launch Insure Oklahoma: Individual Market • Expand PCMHs and develop shared savings program • Expand health homes and develop shared savings program • Develop provider-led accountable care model(s) and launch initially with FFS and shared savings	• Transition provider-led model(s) to capitated payments, potentially requiring a health plan or other state license.

Oklahoma's Investment in the Future

It is possible....

- ✓ For providers to transition from the 1st Curve to the 2nd Curve.
- ✓ For public/private partnerships to forge models for higher levels of health care services.
- ✓ To improve value and outcomes from Oklahoma's investment in health care.
- ✓ To broaden coverage and improve the health of all Oklahomans.

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Thank You…

Comments or Questions?

Appendix

Medicaid Premium & Cost-Sharing Rules

	< 100% FPL	100% - 149% FPL	≥ 150% FPL
Maximum Allowable Medicaid Premiums and Cost-Sharing			
Aggregate Cost-Sharing Cap	5% household income	5% household income	5% household income
Premiums	Not allowed	Not allowed	Permitted, subject to aggregate cap
Maximum Service-Related Co-pays/Co-Insurance			
Outpatient services	$4	10% of cost the agency pays	20% of cost the agency pays
Non-emergency ER	$8	$8	No limit
Rx Drugs	Preferred: $4 Non-Preferred: $8	Preferred: $4 Non-Preferred: $8	Preferred: $4 Non-Preferred: 20% of cost the agency pays
Institutional	$75 per stay	10% of total cost the agency pays for the entire stay	20% of total cost the agency pays for the entire stay

- Specific services are exempt from cost-sharing, including emergency services, family planning and pregnancy-related services
- Specific populations are exempt from cost-sharing requirements (e.g., pregnant women, spend-down beneficiaries, and individuals receiving hospice). However, exempt individuals may be charged cost-sharing for non-preferred drugs and non-emergency use of the emergency room
- Services may not be denied for individuals who fail to make co-payments if their income <100% FPL; services may be denied for those with incomes >100% FPL
- If non-preferred drugs are medically necessary, preferred drug cost sharing applies

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About Manatt Health

Our mission is to support clients transforming America's health system by increasing coverage and access and creating new ways of organizing, paying for and delivering care.

- **Interdisciplinary team of consultants and attorneys**
- **Thought leadership partnering with foundations, associations and policy makers**

What we are working on now:

- Medicaid transformation, including payment and delivery system reform and coverage solutions
- Multi-payer and payer/provider alignment
- Health reform opportunities (ACO, CMMI, Medicaid Waivers, Value-Based Purchasing, Duals Programs)
- Formation of next generation health care systems
- Population health management and sub-acute strategies
- Physical & behavioral health integration