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OKLAHOMA HEALTH CARE AUTHORITY
AGED, BLIND AND DISABLED (ABD)
CARE COORDINATION STAKEHOLDER MEETING
4345 NORTH LINCOLN BLVD.
OKLAHOMA CITY, OKLAHOMA 73105
2:00 P.M. TO 4:00 P.M.

REPORTED BY: Lacy Antle, CSR, RPR

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

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

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

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

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

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

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

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

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

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

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

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

18 MS. NORTHRUP: Good morning.

19 Yes, it is afternoon, thank you.

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

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

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

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

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

19 SoonerCare Plus. Okay. And last but not
20 least, Sooner Align Plus.

21 AUDIENCE MEMBER: The first one.

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

25 Also, before I turn everything over to

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

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

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

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

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

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

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

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

25 So I always like to begin with this just

1 to remind us why we are all here today and why we're
2 not all off doing something else, and that is HB
3 1566, legislature which instructed OHCA to initiate
4 an RFP care coordination models for the ABD
5 populations with the persons or residents of
6 institutional settings coming into the facility.

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

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

1 needs, health needs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 move through the cycle?

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

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

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

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

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

1 person in the state.

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

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

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

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

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

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

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

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

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

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

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

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

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

25 So I think I've said this three or four

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

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

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

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

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

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

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

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

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

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

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

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

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

1 the model contract when I got up this morning was
2 300 pages, it's probably 301 just while I've been
3 talking to you here, it will continue to grow like a
4 tree in California. But you're not going to see
5 everything, so just because you don't see something,
6 even within a responsible recommendation, doesn't
7 mean that we don't have something that speaks to it,
8 it just means that I didn't squeeze it on this
9 particular slide. I wanted to get as much as I
10 could, without squishing it too much.

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

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

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

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

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

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

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

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

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

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

25 Behavioral health homes, which are a newer

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

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

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

25 The next step of the cycle is somebody has

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 So then we come to the last step in the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 MR. COHEN: I'm sorry, yeah.

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

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

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

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

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

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

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

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

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

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

21 So let me just take you a little bit
22 through the last part of the RFP document. So we've
23 been talking here up until now for the last, I guess
24 40 minutes or so, about the model contract, to the
25 extent that I'm able to talk about it in specifics.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 So these last two slides are just
7 acronyms.

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

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

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

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

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

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

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

15 MR. COHEN: That's my favorite
16 stakeholder.

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

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

1 MR. COHEN: You want me to answer that?

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

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

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

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

20 AUDIENCE MEMBER: Thank you.

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

1 that's working.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 MR. COHEN: Have to be careful here, the

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

4 AUDIENCE MEMBER: Oh, go ahead.

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

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

9 MS. HEATER: Do we have any further
10 questions?

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

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

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

23 MR. MEYER: Want me to ask people now?

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

1 next meeting we can provide.

2 MR. MEYER: Thank you.

3 MS. PERRY: Pam Perry with Amerigroup.

4 Will future stakeholders meetings be open to full
5 participation by a wide range of folks like today's
6 is and when -- what is the schedule for the next
7 stakeholders meetings?

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

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

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

20 Is there any other questions?

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

25 MS. NORTHRUP: Before you leave, if you

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

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

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1 CERTIFICATE

2 STATE OF OKLAHOMA)

3) SS:

4 COUNTY OF OKLAHOMA)

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

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

14

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Lacy Antle, CSR RPR

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