State of Connecticut
Healthcare Innovation Steering Committee

February 18, 2014
Meeting Summary

Members Present: Lt. Gov. Nancy Wyman (Chair); Tamim Ahmed; Patricia Baker; Jeffrey Beadle; Mary Bradley; Roderick Bremby; Patrick Charmel; Anne Melissa Dowling; Anne Foley; Kristi Gafford (for Frank Torti); Bernadette Kelleher; Suzanne Lagarde; Courtland Lewis; Robert McLean; Jane McNichol; Jewel Mullen; Thomas Raskauskas; Patricia Rehmer; Jan VanTassel; Michael Williams; Thomas Woodruff

Members Absent: Raegan Armata; Francis Padilla

The meeting was called to order at 2:05 p.m.

Introduction and welcome of new members

Mark Schaefer introduced new committee members who help bring additional provider voices to the table. Dr. Robert McLean is a primary care physician and rheumatologist who co-chaired the Care Delivery work group. Dr. Courtland Lewis is an orthopedist and served on the Payment Reform work group. Dr. Suzanne Lagarde is chief executive officer of the Fair Haven Community Health Center, one of the 14 federal qualified health centers in Connecticut. A gastroenterologist, she is also involved in Project Access in New Haven, which works to provide health care to low income, uninsured residents. Patrick Charmel is the president and chief executive officer of Griffin Hospital in Derby. Additionally, the Consumer Advisory Board recommended that Jeffrey Beadle be appointed to the steering committee. Mr. Beadle is a Consumer Advisory Board member and is the Executive Director of Windham Regional Community Council.

Update on SIM implementation

Dr. Schaefer provided an update on activities since the final Healthcare Innovation Plan was submitted to CMMI in December (see presentation here). There were many enhancements made to the plan based on the feedback received on the draft. For example, the University of Connecticut and Yale University worked to flesh out the evaluation strategy.

Since the plan was submitted the focus has been on setting up the program management office within the Office of the Healthcare Advocate (OHA). The program management office is working to prepare for the funding opportunity announcement by looking at the 2012 test grant announcement. The announcement has not yet been made. Dr. Schaefer indicated that the Healthcare Innovation Plan served as a deliverable for the State Innovation Model Design grant and is separate from the testing grant application. There has also been a focus on setting up the governance structure. Later in the meeting, the committee will discuss workgroup size, composition, and structure. Patricia Rehmer asked about the number of states applying for test grant funds. There were 15 states in addition to Connecticut that received design grants. Three states received pre-testing grants. All of these states are expected to apply for testing funds. In addition, the program management staff members have been reading other state's plans to help inform the application process.

SIM and the Governor's Budget

Governor Dannel Malloy's proposed budget adjustments for state fiscal year 2015 include $3.2 million within OHA to fund staff and vendors to work in support of the initiative regardless of

whether federal funding is received. It also includes $65,000 in the Office of the State Comptroller for a health care analyst and $1.9 million in capital funding for health information technology. Dr. Raskauskas asked what the timeframe to utilize these funds would be. The budget adjustments would be passed in May and take effect for the state fiscal year beginning July 1st. In terms of potential federal award funds, it is anticipated that there would be a nine month pre-implementation period and three years for implementation.

Jane McNichol asked who is determining how the funds are spent. Dr. Schaefer said that the program management office has worked with OPM to provide a preliminary sketch of the funding needed for the program management office and limited initial activities. The state funds are designated for nine permanent and 1.5 durational positions. It is anticipated that test funds would pay for some positions. There is also the consideration that certain activities may not be allowable expenditures under the test grant. The steering committee will be asked to provide input into the test grant budget.

Consumer Advisory Board & workgroup composition

The discussion focused on the Consumer Advisory Board and four of the five workgroups (excluding the Workforce Council which requires additional planning). The Consumer Advisory Board was newly reconstituted. The board is looking at ways to round out its membership and also how to involve advocates and consumers in the implementation process. Mr. Beadle, who serves on the Consumer Advisory Board, gave an update on activities so far. Their goal is to cast a wide net for consumer participation throughout the process, reaching out into all communities to get information out. They may conduct regional forums. They will be searching for the maximum venues possible to increase consumer participation.

Dr. Schaefer provided a high level summary of the workgroup composition guidelines. The narrative focuses on categories for participation (see draft guidelines here). Dr. Schaefer noted the recommendation for the CAB to engage more consumers in the CAB and workgroups, individuals whose primary credential is that they are using or have used the health system for a significant health condition. The CAB in particular will focus on recruiting consumers. With respect to the issue of workgroup size and composition, the guidelines note that workgroups function best when in the 9-12 member range, but recommend that the steering committee establish a target range of 14-16 members and an absolute maximum of 18 members given the number of stakeholders involved. The guidelines recommend roughly balanced or proportionate representation among the major categories of participants (consumer/advocate, provider, health plan and state agency), adjusted depending on the topic (e.g., more state agencies for the HIT Council and slightly more consumers/advocates for equity and access). The guidelines focus on the recruitment of individuals with expertise in the subject matter, such as physicians with experience in advanced primary care or care delivery systems. Similarly, the guidelines propose seeking a mix of health plan representatives, including some with expertise in statistics and quality measurement.

The steering committee discussed the recommendations for the workgroup composition guidelines, structure and composition. Jeff Beadle reported that several board members were at the meeting of the consumer advocates on January 27th and were aware of the recommendation for 51% consumers/advocates. The Consumer Advisory Board considered this recommendation in its most recent meeting and determined that the principle should be to achieve balance among the categories represented (or about 25%) and that consumer/advocate involvement should be significant, as is now reflected in the guidelines.

Ms. McNichol was concerned with the use of the phrase absolute maximum and stated a preference for softer terminology. Anne Foley suggested changing it to recommended maximum. All agreed to the change.

Dr. Raskauskas suggested that some among the 100,000 people who have purchased insurance through Access Health CT be represented. The guidelines will be modified to reflect this in addition to Medicare and Medicaid. Dr. Schaefer said that Arlene Murphy, Consumer Advisory Board co-chair, is an advisory member for Access Health CT. Mr. Beadle suggested reaching out to the Access Health CT advisory groups for crossover activities.

Dr. Schaefer said they are seeking members who have diverse backgrounds and expertise. One challenge is that the list of individual provider types is massive and could not realistically be fully represented in membership of the workgroups. The recommendation is that the charters of the workgroups include a plan for outreach to each stakeholder group that needs to be consulted in the detailed design. Those groups would be brought in or consulted with strategically to inform the process. Dr. Lewis suggested this be clearly articulated. Jan VanTassel suggested that the use of the word "expertise" could be off-putting, especially for consumers. She suggested including "experience" instead. All agreed to the change.

The solicitation process will take place over the internet and will be open for at least 10 days. Workgroup members would participate in monthly evening meetings (eventually moving to bi-monthly or quarterly as appropriate to provide ongoing oversight). The program management office is exploring the idea of a fixed stipend for consumer representatives. At this time there are no plans to form sub-groups as the program management office has limited staff resources. The goal is for Jeff Beadle to come back to the steering committee on March 24th with recommendations for additional members for the Consumer Advisory Board and workgroups so that the first meetings of each group can begin in April or early May. The Consumer Advisory Board will make recommendations on consumer members to the steering committee.

The steering committee discussed the specific recommended composition for each workgroup (see recommendation here). Patricia Baker expressed a concern that the recommended composition for the Practice Transformation Taskforce was not balanced. She said providers made up more than 25% of the workgroup and, that while she understood the reasoning, she was concerned that would impede the ultimate goal of partnership between providers and consumers. Dr. McLean said that because practice transformation focuses on practices, that many providers are needed at the table to impact change. If providers are underrepresented, there will be pushback. Dr. Lagarde said that each provider type will have a different perspective and that they should not be lumped together. Dr. Lewis said there was still a lot of work to do with the provider community to move ahead.

Ms. VanTassel expressed concern that there were not enough consumers on the Equity and Access Council and suggested adding one or two consumers if possible. Ms. McNichol suggested that consumers may need support in order to fully participate in the workgroups. Commissioner Rehmer said that the Department of Mental Health and Addiction Services had a great deal of experience coaching clients to be advocates in a variety of ways. Once they understand the jargon used, they can handle discussions. Dr. Schaefer suggested increasing the consumer/advocate representation on Equity and Access to "5 or 6." All agreed to the change.

Anne Melissa Dowling asked how the self insured would fit into the process. Dr. Schaefer said that CMMI and the PMO were tuned in to that challenge. One strategy to be pursued is the convening of

a substantial group of self-funded representatives for engagement with the help of Tom Woodruff from the Office of the State Comptroller

There was discussion on the size of the workgroups. Dr. Schaefer suggested that a hospital representative would not speak for all hospitals but that they could convene focus groups with other hospitals. There were suggestions to add Comptroller's Office representation to the Health Information Technology Council and Department of Children and Families representation to the Equity and Access Council. Dr. Schaefer noted that a special group would be convened for children's issues with DCF and the Office of Early Childhood and the Child Advocate.

There was discussion of the use of the word "champion" in the expectations of each workgroup members. Both Ms. McNichol and Ms. VanTassel said it may not be appropriate to expect people to champion recommendations that have not been made yet. Lt. Governor Wyman said different terminology will be used and sought recommendations for the terminology from the group.

Overview of Round 1 FOA and preliminary thoughts on strategy
Faina Dookh provided an overview of the 2012 State Innovation Model Test Grant announcement (see presentation here). Looking at the 2012 announcement can inform the strategy for the upcoming funding announcement. Some of the items that Connecticut will have to work on are firming up Medicaid's involvement, especially other CMS initiatives such as the dual eligible initiatives, waiver programs, and the Medicaid state plan. Additionally, the state will need to articulate Medicare participation, particularly with respect to advance payments and value-based insurance design. The state will also need to look at whether Medicare would entertain additional metrics.

Dr. Schaefer said that the state will need to do a better job of leveraging funds and looking at other potential funding streams. The more the state can point towards a fabric of supports, the more it will help its chances. Dr. Schaefer asked committee members to share any ideas they had for leveraging funding.

Dr. Schaefer explained further strategy items that need to be resolved. In practice transformation, that means looking at what the advanced medical home (AMH) model means for practices that are affiliated. Some of the questions that need answering include whether an AMH credential is needed; whether a self attestation process is created; and if there are incentives or consequences related to adopting standards. Additional discussion will be needed going forward.

Meeting adjourned at 4 p.m.

Next meeting: Monday, March 24, 2014 at 3 p.m. in the State Capitol Old Judiciary Room.