Alternative Payment Methodology & Measurement-Based Care
December 15, 2021
9am-10am

Meeting Minutes:

1. **Welcome & Introductions:**
   Jeff Vanderploeg welcomed the group to the final APM meeting. The workgroup goals have remained the same since the beginning of this workgroup in June. The draft of the workgroup report was sent via email for participants to review. There are plans to continue workgroup activity into the next year in different forms of participation.

2. **Overview of Workgroup Goals, Anticipated Deliverables and Timeline:**
   Tim Marshall welcomed the group and informed everyone that Bill Halsey who was originally planning on making a presentation had a conflict. As a reminder the workgroup goal was to review the underlying components and principles of an APM model and look at measurement-based care with different platforms. The report is focused on those aspects. The draft will be sent out within the next week or two. Vanderploeg informed the group that Bill Halsey will be joining about 30 minutes late and may be able to update the workgroup.

3. **Draft Report and Workgroup Recommendations:**
   A number of presentations were listened to over the past 6 months. Most noticeably was the 1115 Waiver and the Integrated Care for Kids (InCK), which has been working on a demonstration project for New Haven. In addition to those presentations, this group has also heard from three different state models and learned a lot from those states (PA, OR, and NY). This group identified that at minimum an APM needs to include goals, target population(s), strategies, provider technical assistance and outcomes/metrics. It's important to note that CT remains in a "learning mode". This group was charged with developing guidance on future development efforts, rather than a fully articulated APM program.

   Some important APM components for the goals section included selecting goals that incentivize health equity and reducing disparities and ensuring family/consumer participation. Overall, eight goal areas were identified as most important in an APM. They are listed in the PowerPoint as well as identified in the draft report. There was some crossover between this group and the data integration workgroup, such as the series of accountability metrics, ED rates, and system level measures to gauge how the system as a whole is doing.

   A participant questioned the inclusion of increased continuity of care with a single provider since many providers aren't able to assist with all levels of care.
   Another participant clarified that it was meant to be within the same level of care, so an individual isn't jumping around to different providers. It was noted that this would be made more clear in the report. Marshall reflected on the APM presentation that occurred with PA; the provider stated that the structure of their APM resulted in being more attuned to individuals' needs. The APM model allowed them the resources to provide the appropriate level of care at any time or place.

Later in the meeting a participant raised further concern regarding this priority; they were concerned regarding referencing a single provider because mid-level agencies don't necessarily have larger support. They recommended expanding the bullet in the report to make sure we are referring broadly to the continuity of care. It's important for children and families to have a supportive transition vs. a drop off. The importance of care management/care coordination could be a way to address the concerns.

A participant noted that it should be explicitly stated that the goal is client health outcomes. Vanderploeg mentioned that there is some references to higher levels of goals, but there is definitely space in this document to make the child/family goals more present.

A participant commented they were confused regarding the references to adults/adult services.
Marshall asked for a few examples to understand better. The participant referenced the 1115 waiver and CCBHC, both are primarily adult levels of care. Marshall stated that the 1115 waiver mainly impacts the adult residential services, however there was also an adolescent facility section. The primary reason for including these was learning from the alternative payment models of different varieties are already being used in Connecticut. CCBHC is primarily an adult-based model but it does call for addressing children's mental health. Marshall noted the report would be clear in referring to certain principles of APM in these settings. Any of the lessons learned from the adult based initiatives would need to be thoughtfully applied to child and family populations.

One of the objectives was to integrate primary care with behavioral health care; it is a big ambition. The participants want to make sure this process is being done in a strategic way due to the lack of supply of behavioral health providers vs. primary care providers. Primary Care has seen a shortage as well lately. Vanderploeg noted that it is a good point to remember that all of the workgroups have common themes of need for funding, rates, and direct investment to the pipeline.

A participant further discussed the integration of behavioral and primary care; there are models that integrate, however the collaborative model is not reimbursable under Medicaid. Bringing behavioral health care into primary care brings an added cost. Need to understand that after nearly two years of the pandemic, there is a new reality of the workforce that needs to be addressed. It may be more accurate to develop a goal around sustaining a capable workforce. It's about being able to hire and keep staff members so the people we are servicing are not constantly changing providers. The focus in CT has been primarily about behavioral health going into primary care and enhancing access, but not on bringing primary care into behavioral health systems. This is critical to youth with high needs that do not have their basic medical needs met by primary care providers.

The target population selection should reflect the overarching goal of reducing health disparities and increasing equity. Vanderploeg asked about any additional high need target populations that could be a focus of an APM strategy.

A participant asked about integrating engagement with the caregiver population.
Often the high utilizers are impacted by additional challenges being experienced by the caregiver. In the target population it may be helpful to consider a multi-generational approach. It's important to not ignore the needs of other members of the family such as the parent or siblings.

Vanderploeg continued the discussion. Risk categories refers to the way to structure the payment approach and the risk attribution. From the discussions the workgroup heard from other states, they mainly focused on upside and downside risks. There were a number of categories listed on the PowerPoint slide. A participant stated that they would not support including full risk capitation models as a recommendation, but the other options are worth considering in the CT system. Vanderploeg confirmed that there is not a recommendation that supports the full risk capitation model.

Bill Halsey joined the group and discussed that this group could be a good pool of individuals to help with providing feedback for an APM for the entire behavioral health system with different measures for adults and children, including a possible expansion of additional workgroups. Currently exploring a few different models, and currently looking at certified community behavioral health care model; it's not a payment model but the CCBHC model does have a lot of good qualities. Halsey reported that there was feedback from New Jersey regarding how care coordination might look like at the youth level.

A participant suggested including the term "funded" to recommendation number 5 in regards to data collection.
The participant noted that agencies are constantly asked to report on data types or change how and when they collect the information but very little funding is given to support these needs and changes. Vanderploeg noted that including an area about readiness is important to this document, ensure proper infrastructure before implementing an APM.

4. **Finalize Recommendations & Next Steps**
Marshall stated that he is hopeful that this is the last meeting for this group however there is an opportunity for the work to continue in a different capacity. Many participants were supportive of future work. If there are additional comments or questions, they can be emailed to either chair. Marshall informed the participants to be on the lookout for additional materials or invitations for future work.