

**CONNECTICUT  
HEALTHCARE  
INNOVATION PLAN  
ABBREVIATED SUMMARY  
FOR PROVIDERS**

Draft V1.1 FOR PUBLIC COMMENT  
NOVEMBER 2013

## Vision for the future

By 2020, Connecticut will establish a whole-person-centered health system that ensures superior healthcare quality and access, promotes value over volume, eliminates health inequities for all of Connecticut, and improves affordability.

### CONNECTICUT'S CURRENT HEALTH SYSTEM

Connecticut's residents are among the healthiest in the nation, and the state has an exceptionally rich array of healthcare, public health, and support services that provide a strong foundation for advancement. Despite this, the state must improve on indicators of healthcare quality. For example, Connecticut has high emergency department utilization rates, especially for non-urgent conditions, and it has a relatively high rate of hospital readmissions. Significant health inequities and socioeconomic disparities persist, keeping the state from achieving higher quality outcomes and a more effective and accountable care delivery system. The state also faces the significant challenge of high healthcare costs in both the private and public sectors.

In 2012, healthcare spending in Connecticut was \$29 billion. We rank third highest among all states for healthcare spending per capita, at \$10,470 in 2012. These figures raise concerns about continued affordability of healthcare coverage and the impact of healthcare spending on business competitiveness with other states. Just as importantly, over the past several years, growth in healthcare spending has outpaced our economy's growth, meaning that each year fewer resources have been available to support education, housing, paying down consumer debt, or saving for the future.

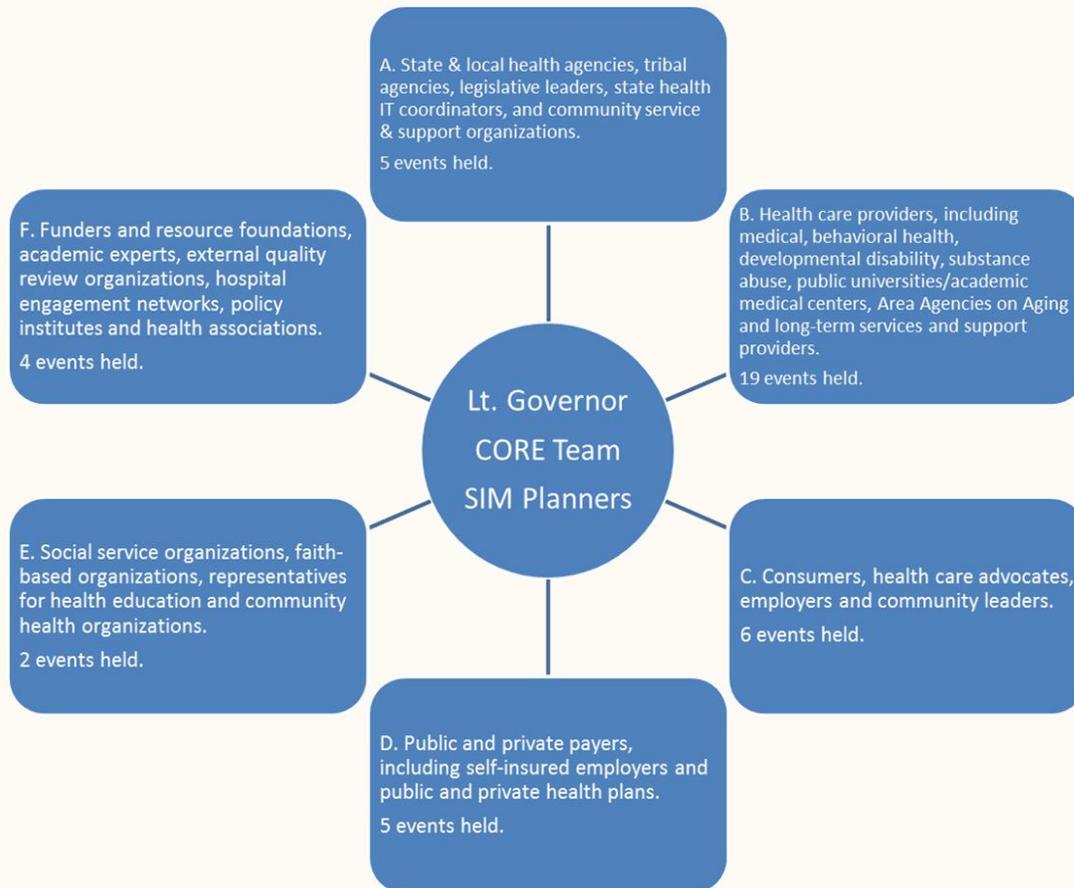
### OUR STATE INNOVATION MODELS INITIATIVE

In March 2013, the Governor's Office received a \$2.8 million planning grant from the Centers for Medicaid and Medicare Innovation (CMMI) to develop a State Healthcare Innovation Plan ("Innovation Plan"). Our Innovation Plan is Connecticut's vision for achieving the Triple Aim for everyone in Connecticut: better health, while eliminating health disparities, improved healthcare quality and experience, and lower healthcare costs. CMMI charged us with designing new healthcare delivery and payment models that would include value-based payment tied to the totality of care delivered to at least 80% of our population within five years.

Connecticut's Innovation Plan reflects the alignment of our payers (Medicaid, our state employees' plan, commercial plans, self-funded plans and hopefully Medicare), healthcare providers, employers, consumers, advocates and public agencies. The Innovation Plan also reflects our vision for building on ongoing innovations within our state that will bring best practices to scale on a statewide basis with the support of all payers. Connecticut is already home to many innovative healthcare organizations, public entities and community-based organizations that have made significant investments in improving health and healthcare. To date, however, these efforts have been mostly pilot programs, focused on single populations and/or select geographic regions within the state. Participants in our State Innovation Models initiative are eager to identify sustainable models that will support innovation on a greater scale.

This Innovation Plan is the product of broad stakeholder input, including more than 20 consumer focus groups and various forms of surveys comprising almost 800 individuals, and more than 25 multi-stakeholder meetings including payers, providers, employer

purchasers, and consumer advocates. In these forums, we surfaced issues within our current healthcare system and barriers to community health improvement. We then evaluated and prioritized options for innovation. We also established principles for value-based payment and health information technology that will be implemented on a multi-payer basis for the benefit all covered populations. In parallel, we developed an understanding of the current healthcare workforce and defined initiatives that will expand and align our workforce to address the needs identified through workgroups and consumer feedback.



Transparency and “two-way communication” were integral aspects of the model design and stakeholder engagement process. The project was governed by and compliant with state policies and procedures regarding public meetings. Throughout the project the state maintained a website dedicated to the SIM model design process at [www.healthreform.ct.gov](http://www.healthreform.ct.gov). All Steering Committee meetings and those of the four workgroups were publicly announced on Connecticut’s television network (CT-N), posted on the website, and accessible in person or by telephone.

Meeting agendas, materials, and summaries were made available on the website in an effort to ensure broad public visibility. A dedicated email address was established ([sim@ct.gov](mailto:sim@ct.gov)) and staffed to ensure that stakeholders who could not attend meetings or telephone in were able to send comments and questions.

## GOALS FOR HEALTH SYSTEM PERFORMANCE IMPROVEMENT

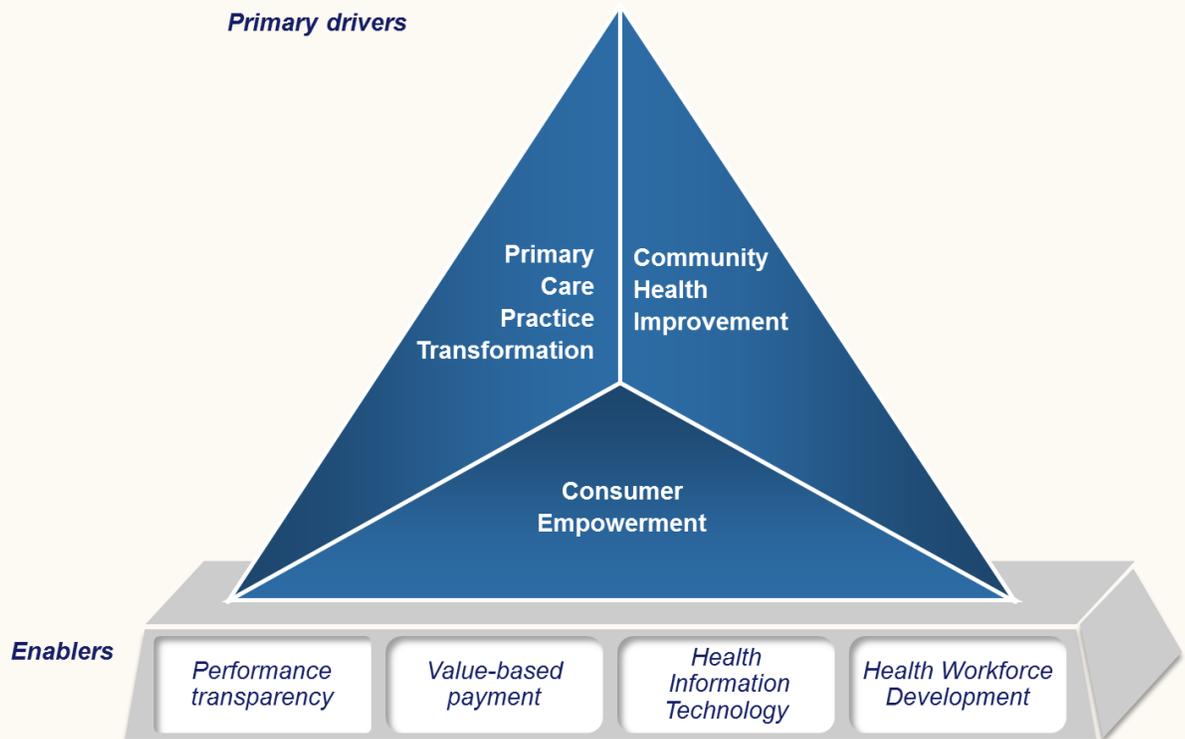
We will judge our efforts a success if the new care delivery model and enabling initiatives empower us to achieve our goals for health system performance, including:

- Better health and the elimination of health disparities for all of our residents
- Better healthcare by achieving superior quality of care and consumer experience
- A lower rate of growth in healthcare costs to improve affordability

### Primary drivers of transformation

Our State Healthcare Innovation Plan is based on three primary and equal drivers for health system transformation:

- I. **Primary care practice transformation** to manage the total needs of a population of patients
- II. **Community health improvement**, through the aligned efforts of community organizations, healthcare providers, and public health entities
- III. **Consumer empowerment** to manage their own health, access care when needed, and make informed choices regarding their care



### I. PRIMARY CARE PRACTICE TRANSFORMATION

A cornerstone of our Innovation Plan is supporting the transformation of primary care to the Advanced Medical Home (AMH), a care delivery model comprising five core elements:

1. Whole-person centered care
2. Enhanced access
3. Population health management
4. Team-based coordinated care
5. Evidence-informed clinical decision making

### **1. Whole-person centered care**

The AMH model will consider the full set of medical, social, behavioral health, oral health, cultural, environmental, and socioeconomic factors that contribute to a consumer's ongoing health. High-priority changes will include:

- Conducting whole-person assessments that identify consumer/family strengths and capacities, risk factors (e.g., history of trauma, housing instability, access to preventive oral health services), behavioral health and other co-occurring conditions (e.g., early childhood caries), and ability to self-manage care
- Supporting consumers with person-centered care planning, care coordination, and clinical interventions based on the whole-person assessment
- Identifying and assisting providers who need to find community-based entities and services that can help provide whole-person centered care

### **2. Enhanced access**

These changes will enable consumers that were excluded or had difficulty accessing the healthcare system with care that meets their needs. The model will also expand provider hours and even offer remote consultations. In order to reach previously underserved populations, it is essential to ensure that consumers have care that is convenient, timely, and consistent with the National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Health Care (e.g., primary care practices have care coordinators who speak the languages prevalent among the patient population). High-priority changes include:

- Improving access to primary care through: extended hours on evenings and weekends; convenient, timely appointment availability, including same-day access; and non-visit-based options including telephone, email, text, and video communication
- Enhancing specialty care access, e.g., by establishing eConsults between specialists and primary care providers
- Providing clear, easily accessible information on where consumers can go to meet their care needs (e.g., clearly communicated physician locations and hours)
- Taking reasonable steps to ensure meaningful access to care that is culturally and linguistically appropriate for patient populations and individuals (e.g., expanding communication and language assistance for limited English proficient (LEP) patients, addressing cultural norms regarding certain examinations)

### **3. Population health management**

Providers can determine which of their specific patient populations are at the greatest risk by analyzing and interpreting the data on the populations in their panel or geography (e.g., by placing consumers in a disease registry). They can then conduct early interventions to delay disease progression (e.g., place diabetics in diet and weight loss programs). Providers will collaborate with community-based organizations to deliver these interventions and adapt them so they provide reduce

health equity gaps for various racial/ethnic/cultural populations. High-priority changes include:

- Collecting and maintaining accurate and reliable demographic data, including race, ethnicity and other demographic data, to monitor health quality and outcomes and to inform service delivery
- Using population-based data to understand specific risks for one's own panel, key sub-populations (e.g., race/ethnicity) and individual patients
- Using risk stratification analyses to identify consumers who are at higher risk to inform and target support efforts
- Maintaining a disease registry
- Partnering with certified community-based entities and other social service and support entities to address clinical and support needs when necessary
- Aggregating de-identified data with State and payers to facilitate analyses, reporting and intervention

#### **4. Team-based coordinated care**

Multi-disciplinary teams offer integrated care from primary care providers, specialists, and other health professionals. An essential element in what makes this work is the combination of behavioral health care with medical care, whether through co-location or as part of a virtual team. High-priority changes include:

- Developing and implementing a whole-person centered treatment plan (see #1)
- Providing team-based care from a prepared, proactive and diverse team
- Integrating behavioral health, oral health, and primary care with "warm", coordinated hand-offs between practitioners (on-site, if possible)
- Coordinating all elements of a consumer's care (e.g., coordinate, track, and follow-up on laboratory tests, diagnostic imaging, and specialty referrals; reconcile or actively manage consumer medications at visits and post-hospitalization)
- Include community health workers as team members to better serve diverse populations when appropriate.

#### **5. Evidenced-informed clinical decision making**

Connecticut will encourage providers and patients to make clinical care decisions that reflect an in-depth, up-to-date understanding of the evidence regarding the clinical outcomes and cost-effectiveness of various treatments. High-priority changes include:

- Applying clinical evidence to target preventive care and interventions toward those patients for whom the intervention will be most effective
- Leveraging EHR decision support, shared decision making tools, and provider quality and cost data at the point-of-care to incorporate the most up-to-date evidence into clinical practice, so as to enable patient directed care decisions
- Incorporating clinical recommendations for disparity populations as available

#### **Roles needed to implement the new capabilities and processes**

Connecticut's AMH model will require a care team of various healthcare service and support providers. Primary care and behavioral health providers must collaborate closely for this to work. Each team will have a set of "core providers" who handle primary care (e.g., PCPs, APRNs, and care coordinators). Initially on a pilot basis and eventually more widely, we anticipate more fully integrated care teams with specialists, behavioral health providers,

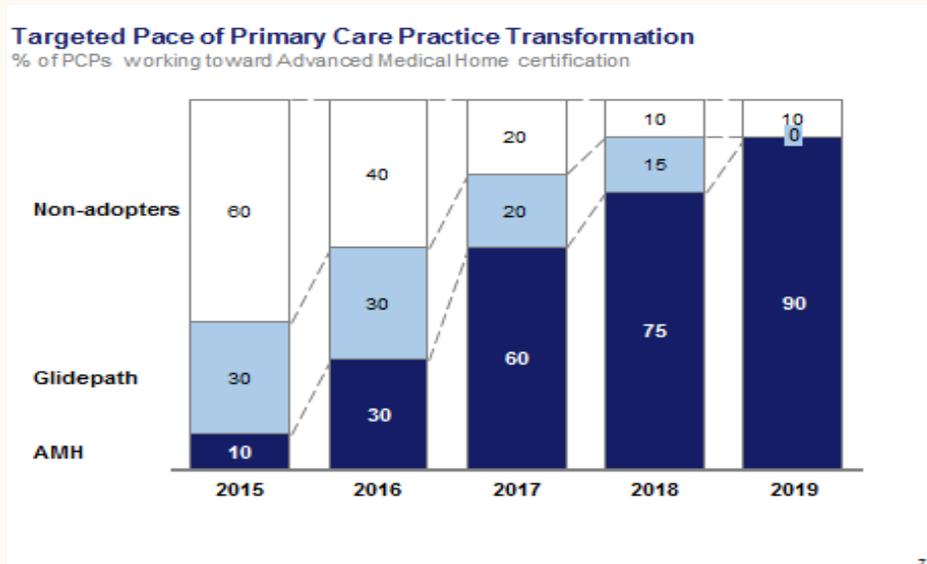
physician extenders, dietitians, pharmacists, oral health providers, and community health workers. Any other class of caregiver can also be included when deemed necessary.

The model's flexibility allows the consumer's health needs and desires and the structure of the practice or organization to shape the composition of care teams and the accountable provider. It also acknowledges that the leadership of the team may change. The State also encourages caregivers and support staff to collaborate across all types of providers – whether primary, acute, specialist, community, or social care – and leverages community health workers.

### Accreditation and performance paths for providers

The two ways providers will participate in the value-based payment system – as Advanced Medical Homes or as participants in the Glide Path who are working toward accreditation as an AMH – will evolve over time. The majority of providers will start either simply as PCPs or in the Glide Path, with only a small minority as AMHs; however, by Year 5 we aspire that the vast majority will be accredited AMHs (Exhibit 1).

### Exhibit 1: Growth in AMH as the Glide Path Providers Gain Accreditation



### Helping providers achieve the AMH accreditation

Because practices will be in very different stages in terms of their ability to meet the standards for becoming an AMH, Connecticut has designed a variety of programs to not only help providers but to make it easy for them to start the transformation.

We divide providers into two basic groups: those that are already nationally accredited as medical homes and those that are not. Accredited practices will not have to duplicate their accreditation, but may have to meet some additional standards. For all other providers, we created the Glide Path Program to facilitate the practice transformation process. Provider participants receive support as they adopt advanced practices like whole-person-centered care and care coordination. As they move forward, they are held accountable for meeting milestones and for achieving true practice transformation, thus ensuring that cost savings

are driven through quality improvements and more effective clinical decisions – not lower quality care.

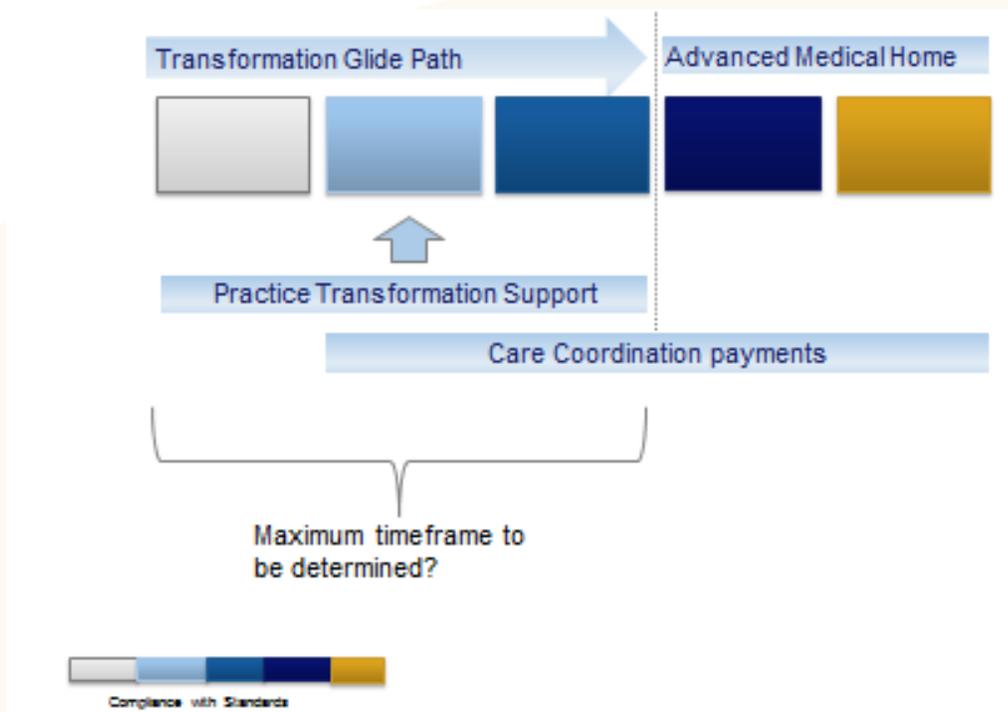
Providers who are already part of a network or group and participating in an advanced payment reform such as SSP may be given the option to assess existing practice gaps and to take advantage of practice transformation support through the Glide Path Program to achieve full AMH status. This option will in part be dependent on the availability of sufficient practice transformation resources.

The Glide Path holds practices accountable for achieving milestones for practice transformation as a condition for continuing to receive transformation support. Payers' willingness to fund care coordination fees may also be contingent on satisfactory progress against transformation milestones. More advanced practices and provider systems will need to take responsibility for a broader array of quality and performance metrics, responsibility for total cost care via participation in an SSP. These standards will increase in number and rigor as providers approach their accreditation (Exhibit 2).

Providers and payers in Connecticut now have several years of experience with national medical home standards. Many providers report that meeting national standards is both costly and administratively burdensome and that recognition or accreditation does not necessarily result in practice transformation. They have also indicated that the time and effort spent on the administrative requirements of a national accrediting body would be better spent on the transformation process. Payers in turn have established their own standards and this has, for providers, further complicated the transformation process.

Accordingly, Connecticut's payers will adopt a common set of accreditation standards for AMH, which will be defined by the Practice Transformation Taskforce. The standards may be drawn from NCQA, AAAHC, URAC, Joint Commission, Center for Medicare and Medicaid Innovation (CMMI) or other national/local standards, recognizing that each of the national standards today has strengths and weaknesses. A common set of AMH standards will simplify the transformation process.

## **Exhibit 2: Connecticut's Transformation Glide Path to AMH Status**



### Provider Aggregation to Achieve Scale and Capabilities

We anticipate that many independent PCPs will need to affiliate with one another in order to gain the scale necessary to efficiently adopt the new capabilities needed to achieve AMH status. They can use a variety of formal and informal clinical integration models to attain the scale they need (Exhibit 3). Their choice of a model will not affect their ability to participate in an SSP – only their performance against the standards does that. In order to protect consumer choice and affordability, the State will monitor for signs of market consolidation and consider legal and regulatory actions as appropriate.

### Exhibit 3: Clinical Integration Models to Attain Scale and Capabilities

<b>A</b> Integrated Delivery System	<ul style="list-style-type: none"> <li>Physicians and hospitals legally and financially integrated</li> <li>Capital, infrastructure, and clinical integration among physicians, hospitals, other providers</li> <li>Potential to distribute payment through employment agreements</li> </ul>
<b>B</b> Medical Group Practice	<ul style="list-style-type: none"> <li>Legally and financially integrated physician organization</li> <li>Capital, infrastructure, and clinical integration among physicians</li> <li>Potential to distribute payment through employment agreements</li> </ul>
<b>C</b> Clinically integrated network	<ul style="list-style-type: none"> <li>Formal contractual relationship among otherwise independent physicians, hospitals, other providers</li> <li>Capital, infrastructure, and clinical integration among physicians, hospitals, other providers</li> </ul>
<b>D</b> Strong IPA	<ul style="list-style-type: none"> <li>Physicians derive most or all of their revenue through IPA</li> <li>Capital, infrastructure, and clinical integration among physicians</li> </ul>
<b>E</b> Loose IPA	<ul style="list-style-type: none"> <li>Physicians and/or hospitals derive only part of their revenue through IPA</li> <li>Limited capital, infrastructure, or clinical integration among physicians</li> </ul>
<b>F</b> Regional cooperatives	<ul style="list-style-type: none"> <li>Regional cooperative provides clinical and technical resources</li> <li>Limited capital, infrastructure among participating physicians independently</li> <li>Regional cooperative <u>may or may not</u> be channel for distribution of risk sharing</li> </ul>

## II. COMMUNITY HEALTH IMPROVEMENT

The SIM initiative offers a unique opportunity to design a focused and coordinated approach to improving community health and reducing avoidable health disparities not easily addressed by the healthcare sector alone. A community health improvement approach is critical to the successful achievement of the state's aim of improving the health and healthcare quality of Connecticut's residents, eliminating health disparities, and improving care experience.

A major part of our transformation strategy is to foster collaboration among the full range of providers, employers, schools, community-based organizations, and public agencies to collectively work to improve the health of populations within their community. Our approach to community health improvement comprises two elements:

- 1. Establishing Health Enhancement Communities (HECs) in high-risk communities to target resources and facilitate coordination and collaboration among multiple sectors to improve public health and reduce avoidable health disparities**
- 2. Strengthening community-based health services and linkages to primary healthcare by establishing a Certified Community-Based Practice Support Entity**

### 1. Health Enhancement Communities

In formulating a strategy for community health improvement, the state recognized three essential considerations. First, the true measure of success in community health improvement lies in outcomes—a reduction in disease prevalence and complications and a reduction in health disparities. Second, holding healthcare providers accountable for such outcomes might result in their avoiding risky consumers, rather than taking on the challenge of prevention. Third, health outcomes are influenced by a multitude of factors, most of which lie beyond the influence of healthcare providers acting alone. The solution lies in elevating the goal of public health improvement, from healthcare provider specific accountability to that of the broader community, and its many participants.

The state proposes the adoption and designation of a geographically bounded region characterized as having a high level of health improvement opportunities and avoidable health disparities as Health Enhancement Communities (HECs). An HEC would have sufficient population to allow for reliable tracking of population health measures, contain a significant number of Advance Medical Homes and demonstrate capacity for multi-sector collaboration to address issues of health. The HECs would allow for coordinated and focused efforts from the public health, social service, education and private and non-profit sector to address key drivers of health impairment and avoidable health disparities through evidence-based approaches.

The state recommends the creation of three to five pilots, HECs that will be fully operational by the end of 2019. The pilot communities will be identified and selected by using rigorous criteria and valid measures that are in alignment with CMMI and CDC. The proposed Program Management Office will be the coordinating body for this initiative and will work with a multiple health and human service agencies to support design and implementation.

## **2. Certified Community-Based Practice Support Entity**

The State Department of Public Health (DPH) proposes the creation of several Certified Community-Based Practice Support Entities, herein referred to as Certified Entities. As the title suggests, Certified Entities would support a set of local Advanced Medical Homes with a specified package of evidence-based community services. This structure fosters alignment and collaboration between primary care providers, community-based services and State health agencies. It will also increase the impact of both AMH and community interventions as the literature has shown that a single intervention will not usually reduce an overall medical or behavioral burden or sustain preventative behavior.

Certified entities also provide a special opportunity to implement the Institute of Medicine's (IOM) best practices in integrating primary care and public health. The IOM recognizes that the degree of integration in communities/states may vary and offers several best practices to help primary care and public health providers decide on which community-based programs/activities to integrate.

### Proposed Certification Criteria

The proposed criteria for entity certification will help assure that high quality, coordinated services are available to clients.

Each Certified Entity would:

- Be responsible for the delivery of a core set of evidence-based community interventions – see the following section for selected interventions and rationale
- Enter into formal understanding or affiliations with primary care practices and share accountability for quality and outcomes
- Have a unique understanding of the community and population served and be able to deliver high quality, culturally and linguistically appropriate services
- Meet specified standards pertaining to the type, quality, scope and reach of services
- Have IT-enabled integrated communication protocols, including bi-directional referrals with affiliated primary care and other relevant providers and health agencies

- Employ community health workers for their services (Refer to Workforce Development section)

#### Certified Entity and Health Equity

Certified entities will help address health disparities through a targeted approach. They can deal with environmental quality issues in homes, health behavior modifications, and access to and quality of care. DPH will give priority to placement of certified entities and special attention to areas designated as a Health Professional Shortage Areas (HPSA) and regions/populations identified as high medical utilizers.

#### Financing Certified Entities

The State is currently evaluating several financial options to ensure that our Certified Entity model is financially sustainable. During the initial phase, we will explore the potential use of existing programmatic state funds and grants as a starting point.

### **III. CONSUMER EMPOWERMENT**

The delivery of truly whole-person-centered care requires transformation in how providers and payers respect and enable a person's right to be an active participant in the promotion and management of their own health.

In order for individuals to make the best health decisions for themselves and their families, a true working partnership must be developed between the individual and their provider. Every consumer has unique insights into the daily issues, both medical and non-medical, that can compromise their health. They also make daily decisions that contribute to their health and well-being. Providers possess the medical background to recognize and diagnose illness and suggest treatment options. Together, these two perspectives form the most effective partnership for making health-related decisions.

SIM provides a unique opportunity to transform the partnership model between consumers and providers today. The state will encourage providers to equip consumers with information, resources, and opportunities for them to play an active role in managing their health. The state will support participating payers' adoption of benefit plan designs that reward consumers who use these resources to understand and make informed healthcare decisions.

As part of our plan for consumer empowerment, we will encourage payers and providers to participate in a four-pronged strategy detailed in the Innovation Plan:

- 1. Implement formal mechanisms for on-going consumer input and advocacy**
- 2. Provide consumer information and tools to enable health, wellness, and illness self-management**
- 3. Introduce consumer incentives to encourage healthy lifestyles, high value healthcare choices and effective self-care**
- 4. Improve access to health services**

## **1. Mechanisms for consumer input and advocacy**

The impact of care delivery and payment transformation on both the experience of care and on outcomes will be a central concern in the implementation and continuous quality improvement of our AMH model.

Currently, care experience is not a factor used by commercial payers in their value based payment models. Participating payers will track the impact of the AMH model on the experience of care by implementing and collecting care experience surveys and linking pay for performance and shared savings program payment to scores on these surveys.

In addition, the SIM project management office will formally engage the Health Care Cabinet's Consumer Advisory Board to provide ongoing input into the design, implementation and future changes to the SIM program model. The board will also help to identify potential issues and concerns and craft resolutions.

AMH practice standards will also promote effective methods for engaging consumers in providing feedback to the practice in order to support the continuous improvement of care processes and care experience, including a focus on welcoming, engagement, communication, person centered care planning and shared decision making.

Finally, our Equity and Access Council will examine current opportunities for consumers to report concerns about denial of service or under-service and will make recommendations as to whether and how mechanisms additional or more user-friendly methods can be established.

## **2. Enhanced consumer information and tools to enable health, wellness, and illness self-management**

In order to partner effectively with their providers, consumers will need more and better health information in a timely manner. The SIM project will facilitate the expanded use of consumer portals with the integration of information from various provider settings.

Our practice transformation standards and technical assistance process will include elements that focus on person-centered care planning and the incorporation of decision support tools into the practice workflow. We will focus on the use of robust tools that meet minimum quality standards, e.g., that are evidence based, have high utility in practice settings, are adaptable for varying levels of health literacy, and can be tailored for culture, race, ethnicity, or disability status.

Selection of treatment settings and providers will be increasingly important as consumers become more sensitive to variations in quality and price for healthcare services. Accordingly, our health information technology reforms will focus on improving the measurement and dissemination of quality and cost information, initially focused on hospitals services and expanding from there to include services provided by specialists.

Finally, we will develop curricula designed to educate consumers about their role in a more person-centered, information rich, and transparent healthcare system. Payers and employers have specifically requested that SIM play a role in the development of these

materials, which we believe will also be of interest in community colleges and other adult education settings.

### **3. Consumer incentives to encourage healthy lifestyles and effective illness self-management**

There are few incentives today for consumers to invest the time and effort to make healthier lifestyle decisions and to partner with providers in proactively managing their health and illness. Connecticut intends to pursue two strategies that promise to improve consumer engagement in their healthcare and in nutritional awareness and purchasing.

#### **Value-Based Insurance Design (VBID)**

For many years employers have attempted to limit their health insurance costs, in many cases by shifting an increasing share of the costs to employees. While this strategy has limited employer cost, it has done little to slow the growth in spending. In many cases, because employees were required to pay higher deductibles and copayments, they put off needed care, which can lead to an increase in future cost for both employees and employers. VBID is one method to encourage consumer participation in health and wellness by providing incentives (positive and negative, dependent on program design) to choose high-value healthcare.

#### **Rewards for Nutritional Purchasing**

Food purchasing and diet are among the most difficult behaviors to influence and yet diet is widely recognized in the public health literature as one of the main contributors to chronic illness prevention and effective management. We believe that incentive based programs hold promise in changing food purchasing and eating habits and we intend to support several pilots during the two years of our SIM initiative using systems for indexing overall nutritional quality.

### **4. Improved access to health services**

A material barrier that prohibits a subset of consumers from participating in their care today is the lack of access: consumers have difficulty making appointments with their providers during regular business hours, and/or have difficulty securing transportation to the physician's office.

Providers (AMH and Glide Path) will be encouraged to decrease structural barriers to healthcare access. Accreditation standards and provider performance scorecards will measure providers' abilities to provide non-visit based options such as text messaging, emails, and phone calls. Providers will be required to open for extended hours and offer same-day appointment options to their panel of patients. In addition, payers and providers will encourage the adoption of non-visit based specialty consultation options such as e-consultation.

In addition, as detailed elsewhere, the State Department of Public Health (DPH) proposes the creation of several Certified Community-Based Practice Support Entities, which would partner with AMH's to provide improved access to evidence-based community services, such as diabetes prevention, in-home environmental assessments for asthma, and help in preventing falls among older adults or other individuals at-risk of falling as a result of health conditions.

Finally, an Equity and Access Council will be established to help ensure that the care delivery and payment reforms do not result in unintended reductions in access for particular populations or inappropriate reductions in service for particular populations, procedures or conditions.

## Enabling Initiatives

Connecticut will enable transformation through performance transparency, value-based payment, health information technology, and workforce development. These initiatives, described in detail in the Innovation Plan, are highlighted here because of their critical role in achieving our vision.

### PERFORMANCE TRANSPARENCY

Transparency will support our aims in multiple ways at different points in time: in shaping the design of new networks, payment models, and clinical interventions; as an input into consumer choice of health plan and network at the point of purchase of healthcare coverage; influencing consumer choice of provider at the point of care, as well as referral from one healthcare professional to another provider; and importantly to inspire and inform providers' own performance improvement efforts.

**1. Shaping program design.** In the near-term, comparative information regarding regional variation and provider performance variation on key health, quality and resource utilization measures will be informative to increasing the specificity of our multi-payer design of new care delivery and payment models. Similar information will also be instructive to payers in establishing pricing for new rewards. Longer term, the same comparative analyses will inform self-evaluation and continuous improvement to model designs.

**2. Input into consumer choice of health plan.** Currently, when consumers choose between health plans they have only limited information regarding network breadth; some may choose a network based on whether their current physician or their neighborhood hospital is in the network, but without information regarding how these providers compare to others in quality of care, consumer experience, and/or efficiency. As we gain greater insight into provider performance on these dimensions, this information will be made available to consumers (and other purchasers) at the point of choosing between health plans, whether on the Marketplace or in other venues.

**3. Point of care transparency.** Many have experienced the challenges and frustration of trying to identify accessible, high-quality providers at the point in time when symptoms develop and we need to access care. Even those who are under the care of a physician may be referred to another provider based on limited anecdotal experience of their referring physician, but without alternatives to choose from or objective data that consumers could use to participate in the referral decision. The progression of some providers toward AMH status and increased copays and deductibles among commercially insured consumers will likely fuel increased demand for transparency to inform point of care choice among treatment options, sites of care, and specific providers. At the same time, as primary care providers increasingly shoulder responsibility for the quality of care and resource utilization of other providers who care for their patients, PCPs also will increasingly demand information that they can use to inform those referral decisions.

**4. Provider performance improvement.** Providing comparative quality and cost information to providers will be critical to informing where they focus their efforts to improve care. Past experience with consumer transparency initiatives has suggested that even performance data that is only seldom accessed by consumers can have a significant impact on providers' own efforts to improve performance. Some industry experts have suggested that providers' own competitiveness as well as simply their commitment to excel in patient care has been as strong a motivating factor in driving provider performance improvement efforts tied to pay-for-performance than were the economic incentives themselves.

Our strategy for achieving this goal involves a common performance scorecard, beginning with primary care. It will use data that is aggregated across payers, with risk adjustment and exclusions as appropriate, and offering multiple reporting levels to inform a wide range of healthcare decision makers.

- **Common performance scorecard to increase consistency.** In the months ahead, a common performance scorecard will be established, including measures of health status, health equity gaps, quality of care, consumer experience, costs of care and resource utilization. Consistency of measures across payers will reduce business complexity and administrative costs for providers associated with reporting.
- **Beginning with primary care and moving outward.** The scorecard will initially focus on key process and outcomes measures related to quality, equity, care experience, cost, and resource efficiency within the primary care setting. Over time, additional data elements will be added to support our goals for community health improvement and consumer empowerment, in particular informed choice of specialists and hospitals.
- **Aggregation of data across payers to increase reliability of measures.** Data underlying the common scorecard will be aggregated across Medicaid, Medicare, and participating Commercial payers. Doing so will allow for larger "sample sizes" that will more reliably reflect a provider's true performance. Over time, we may also work toward consolidated reporting which will be more efficient for payers, and more practical for providers than accessing multiple payer reports.
- **Multiple levels of reporting to inform decision making.** Performance will be reported at multiple levels to inform decision making by consumers, providers, and payers at the point of care and point of purchase of health insurance, and as part of program development efforts. This will include: isolation of patient-level data; comparative analysis of population segments; provider-to-provider comparisons; plan-to-plan comparisons; and state and regional summaries.

## VALUE-BASED PAYMENT STRATEGY

Providers who meet specific thresholds on quality, cost, and equity metrics, or who improve their historical performance will be compensated for providing high-value care. Under all models, providers must achieve pre-determined thresholds for quality of care in order to earn shared savings or bonus payments.

## Shared Savings for Advanced Medical Homes

The State will allow Advanced Medical Homes to qualify immediately for shared savings program participation. They will possess:

- Accreditation under a set of standards for a medical home
- Clinical integration (e.g., an integrated IT platform, a physician portal, physician alignment, nursing collaboration, and governance structure)
- The ability to manage population health (e.g., predictive analytics, risk stratification, prevention, outcomes tracking, disease management, coordination with community programs, and concurrent review)
- Financial risk management (e.g., cost and utilization analytics/ benchmarking)

In some cases, provider organizations may already be adopting shared savings arrangements with Medicare and/or private payers though they have not yet achieved the level of capabilities associated with an Advanced Medical Home. The State does not wish to disrupt such arrangements; however, we will nonetheless encourage these providers to work toward AMH status and capabilities as a strategy for improving quality and care experience while succeeding under shared savings.

Shared savings payment models offer a range of benefits that will help increase the quality of care in Connecticut and reduce waste in the system. Value-based payment tightly aligns provider and consumer interests by rewarding primary care providers for considering the needs of the whole person and partnering with consumers to improve their health. This model also increases providers' accountability for high quality care that prevents disease exacerbation, readmissions, and redundant care (e.g., duplicate tests). Denial of necessary care is discouraged because providers are responsible for the downstream impact of withholding necessary care. In addition, we will adopt advanced analytics to identify outliers for underuse. In addition, as discussed in the performance management section, providers will be rewarded based on both their quality and efficiency performance.

Under the shared savings model, providers will take on accountability for total cost of care. Total cost of care is defined as the full set of healthcare costs associated with an individual's healthcare delivery, including: professional fees, inpatient facility fees, outpatient facility fees, pharmacy costs and ancillary costs (e.g., lab tests, diagnostics).

*Payers and providers may select from various risk levels when adopting the Shared Savings model:*

- Upside-only: where providers are eligible for smaller bonuses but do not share in risk), which physician-led ACOs with limited capital may favor. (Upside-only arrangements meet the requirements of our model.)
- Risk-sharing: where providers are eligible for a greater share of savings and a share of risk, which hospital-based ACOs may use to help offset lost margins associated with reductions in hospital volume

The Connecticut AMH model will include exclusions and adjustments to ensure that consumers with exceptional or unpredictable service needs do not unfairly affect providers' performance measures. Both payers and providers will have approved these adjustments.

For example, shared savings models typically exclude individuals who require organ transplants or who have experienced a significant traumatic injury. This makes sure that providers are held responsible only for those outcomes that they can manage effectively in their partnership with the patient.

Risk sharing will not be considered for the Medicaid program in the early phases of deploying value based payment reforms under SIM. Efforts subjecting Medicaid providers to downside risk will be informed by experiences of other SIM value based payment reforms on quality outcomes for patient participants. The rationale for this exclusion is to avoid negative quality outcomes for program participants and unintended contraction of the Medicaid provider network.

### **Pay for Performance Program**

Participation in shared savings tied to total cost of care typically requires a minimum patient panel size of 5,000 or more patients. Smaller providers may not meet these panel sizes, unless and until participating payers resolve how to aggregate performance for purposes of measurement and rewards. In the interim, many providers—especially those earlier in the development of AMH capabilities, may favor a pay-for-performance program structured around bonus payments tied to discreet measures of resource utilization in addition to the same measures of quality and consumer experience to which the Shared Savings Programs will be tied.

### **Up-Front Investment in Care Coordination**

Some providers lack the investment capital necessary to fund new capabilities and processes, or to weather the transition costs on practice productivity that can arise during a change in business models. In addition to the technical assistance that the State will provide through practice transformation support, payers will be encouraged to fund new responsibilities for care coordination through up-front fees, paid either on a per-member-per-month (PMPM) basis or through enhancements to the fee schedule. Such payments should be based on providers meeting mandatory pre-requisites (e.g. meaningful use of EMR) as well as progress milestones for practice transformation. In some cases, providers may elect to waive care coordination fees and practice transformation support in favor of higher levels of shared savings rewards.

### **Guidelines for Payer Reward Structures**

Each payer will determine their reward structure's specific targets, pricing, and risk levels. However, Connecticut provides a set of guiding principles for the structures' design:

- Both P4P and Shared Savings should deliver meaningful rewards that will support the capability building needed to transform the delivery system
- Both P4P and Shared Savings should reward both absolute performance and performance improvement
  - For select measures of quality and efficiency, providers will need to achieve a minimum level of performance in order to receive rewards
  - The level of the reward will be tied to the degree of performance or improvement beyond the minimum acceptable level
  - Providers that achieve distinctive performance may continue to earn rewards on a sustainable basis, without further improvements

- Glide Path providers should have an opportunity to earn rewards in the first year based on quality performance alone; rewards in subsequent years should require performance on both quality and cost savings

#### Data Aggregation to Measure Provider Performance

Given the market competition among Connecticut's payers, only the largest providers currently have patient panel sizes that are large enough to reliably measure total cost of care. Even resource utilization measures to be used in pay for performance programs may require patient panels that small practices can only meet for their largest payer. In order for pay-for-performance programs to gain adoption among smaller market share payers, it will be necessary for payers to aggregate data for performance measurement and reporting.

Defining the technical details of payer data aggregation will be among our key objectives in the months ahead to prepare for launch of the new payment models.

### HEALTH INFORMATION TECHNOLOGY

To achieve the full potential of the AMH transformation, Connecticut's payers and providers will need to deploy a wide range of HIT capabilities. These include payer analytics, consumer and provider portals, clinical healthcare information exchanges and provider-consumer care management tools.

Although Connecticut payers and large providers have significant capabilities today, e.g., advanced payer analytics and experience with PCMH pilots, obstacles remain. Smaller providers face technical challenges, the state's Health Information Exchange (HIE) is limited and the rollout of the APCD is in its preliminary stages. The State will leverage its existing capabilities as it accelerates HIT adoption.

The timeline for Connecticut's HIT strategy sequences the implementation of capabilities according to: their value to the AMH model, their current state of development, and the time needed to implement them and their interdependencies with other capabilities (Exhibit 4).

#### **Exhibit 4: Sequencing for Rolling Out the HIT Strategy**

Category	SIM Timeframe		Beyond SIM
	Stage 1 (1 year)	Stage 2 (2-3 years)	Stage 3 (3+ years)
<b>Payer analytics complemented by provider analytics</b>	Reporting based on foundational analytics (patient attribution, risk stratification, risk adjusted cost comparison, quality/utilization metrics)	Enhanced analytics that identify high priority patients for targeted intervention (care gaps analyses, alert generation)	System level public health/epidemic analyses; patient 360° view enabled by integration of claims and clinical data
<b>Provider-payer-consumer connectivity</b>	Multi-payer online portal for providers to receive static reports; basic consumer portal	Bi-directional provider-payer portal with data visualization; patient engagement/transparency tools	HIE-enabled bidirectional communication and data exchange
<b>Provider-patient care mgmt. tools</b>	Define provider workflow changes required to improve care coordination; provide manual/education that details options and applications for supporting technology	<ul style="list-style-type: none"> <li>Pre-qualify vendors and health information service providers with pre-negotiated, discounted pricing</li> <li>Potentially develop a shared-service model that providers can plug-into to avail of enhanced care management tools</li> </ul>	
<b>Provider-provider connectivity</b>	Promote point-to-point connectivity via scalable protocol such as direct messaging	Facilitate interoperability between local implementations of health information exchange solutions	Potentially integrate state-wide Health Information Exchange

In Year One, Connecticut will leverage existing stakeholder capabilities as it launches a broad array of fundamental payer-based components; these will include consumer attribution, risk stratification, performance reporting and specialist and facility analytics. The State will also create a provider and consumer portal. In years two and three, it will further develop provider care management tools and dramatically augment the portal and payer analytics.

**Payer analytics.** Payer analytics include tools that payers use to analyze claims data; these analyses then produce metrics that assess outcomes, quality and cost and can affect providers' reimbursement.

**Consumer-provider-payer connectivity.** Payers will establish portals where providers and consumers can access relevant information and submit data that is required to support the proposed reforms.

**Provider-consumer care management tools.** Care management tools will help care teams (physicians, care coordinators) identify care opportunities and prepare for consumer encounters.

**Provider-provider connectivity.** Provider-provider connectivity is the integrated exchange of clinical data between doctors, hospitals, and other healthcare providers through a secure, electronic network. Secure data exchange is a key enabler of population health.

## HEALTH WORKFORCE DEVELOPMENT

For the Innovation Plan to succeed, it is essential that Connecticut have a healthcare workforce of sufficient size, composition and training to carry out the plan in both the short-term and long-term. The demand for primary care services will increase with Connecticut's

aging population and a projected additional several hundred thousand covered lives resulting from the full implementation of the Affordable Care Act. This challenge is compounded by the fact, noted above; that the average professional clinician is middle aged with significant numbers of them over 60 years old. A virtually inevitable exodus of highly trained professionals during the coming decade will challenge our capacity to deliver services and to integrate behavioral health and primary care.

We lay out six broad, multipurpose initiatives based upon input from our health workforce taskforce:

**1. Health workforce data and analytics**

Over the next five years, Connecticut will work toward collecting and reporting real-time health workforce data, and will support the analyses necessary to interpret this data to estimate both current and future health workforce needs.

**2. Inter-professional education (IPE), the Connecticut Service Track**

Advanced Medical Homes are the foundation of care delivery under SIM. Inter-professional teams are integral to their success, as is expertise in population health. Historically, students of different clinical disciplines have rarely trained together beyond attending basic science courses together, and population health has not been central to clinical curricula. In developing its strategies, Connecticut will look to the Inter-professional Education Collaboration (IPEC), which was founded in 2009 when six national professional associations joined together to promote inter-professional education. These associations included allopathic and osteopathic medicine, dentistry, nursing, pharmacy and public health.

Connecticut will build upon its most effective program for community-based inter-professional training, UConn's Urban Service Track (UST), to establish a Connecticut Service Track (CST) that will cover more of Connecticut's communities, and will include more health professions and more of Connecticut's training programs.

**3. Training and certification standards for Community Health Workers**

Connecticut's Area Health Education Centers (AHEC) network will work together with Connecticut's Department of Public Health (DPH) to develop training and a certification process for Community Health Workers (CHW). Over the past decade, CT AHEC developed substantial expertise in developing and operating several small-scale programs and collaborating with other states in the development of their programs.

Our aim is not just to train community health workers in the essentials but also to train them to work as members of multi-professional primary care teams, which are the foundation of healthcare delivery as set forth in this plan. CHWs' value to these teams is their capacity to address the pervasive, persistent and expensive problem of health disparities in our state.

**4. Preparation of today's workforce for care delivery reform**

It will be many years before clinicians being trained today predominate in Connecticut's health workforce. Meanwhile, the success of healthcare reform depends on our existing health workforce, which was trained under different circumstances and for a care

delivery system that we hope to transcend. Our current health professionals and allied health professionals need varying degrees of retraining if they are to work effectively within new models of care and if these models are to succeed.

One lever is the requirement of health professionals and allied health professions to earn Continuing Education Units (CEUs) as a condition for maintaining their licenses to practice. The courses that confer CEUs should emphasize the knowledge and skills required to meet AMH care delivery standards.

The state will sponsor a survey of courses in Connecticut that grant CEUs to determine how often and how well they deal with these topics, and will work with our institutions of higher education to improve these offerings.

#### **5. Innovation in primary care Graduate Medical Education (GME) and residency programs**

If the healthcare reforms envisioned in this plan are to succeed, there must soon be an increase in the number of primary care clinicians in Connecticut: physicians, physician assistants, nurse practitioners and clinical pharmacists. Establishing primary care as the foundation of healthcare requires it, as do an increasing numbers of insured lives and an aging population. Since it is residencies that determine the discipline and the certification of a clinician and also often determine where clinicians settle to practice, Connecticut must work to enhance its primary care residency programs for all the healthcare professions.

The immediate issue is not a want of willingness by primary care group practices to participate in our state's primary care residency programs. We have a train-the-trainer problem. Many of our best prospects for faculty mentors in all the health professions, although first-rate clinicians were trained in another time and have been engaged in a paradigm of care delivery that we are in the process of transcending. We must construct a multidisciplinary faculty development program that enables our community-based faculty to become effective teachers and role models for the system of care described in our Innovation Plan. These mentors must be trained in a manner consistent with the AMH model.

#### **6. Health professional and allied health professional training career pathways**

Connecticut will build upon two ongoing initiatives to increase students' ability to accrue the credits and the capabilities needed to advance in the health and allied health professions, and also to increase the flexibility to change programs midstream or otherwise move from one health career to another.

The first is Governor Malloy's Science, Technology, Engineering and Mathematics (STEM) initiative. Connecticut's baccalaureate programs in both public and private colleges and universities are being encouraged to ensure that their STEM courses of study provide a sound foundation for both careers and technological advances that will strengthen Connecticut's economy.

The second initiative is the implementation of the Connecticut Board of Regents for Higher Education's comprehensive transfer and articulation agreement that enables students to transfer more easily across the 17 Connecticut State Colleges & Universities. This articulation policy applies to all subjects and all majors, and emphasizes seamlessness between associate degree programs and baccalaureate programs.

Each is designed to make significant contributions to developing a health workforce that will fulfill our state's plan for delivery system reform, and meet current and future needs for health services.

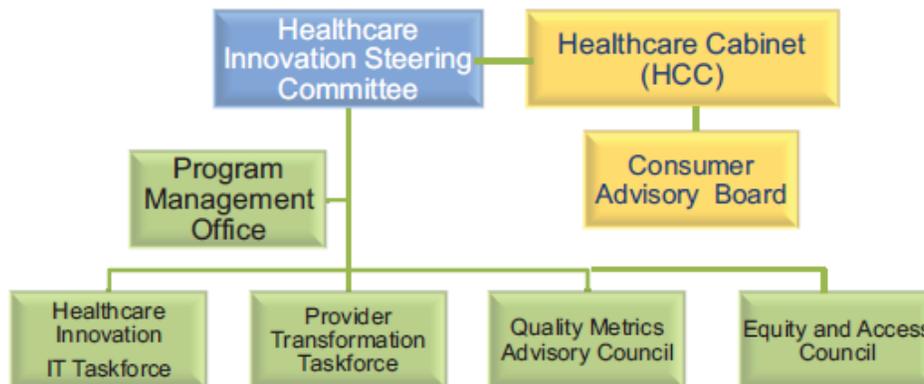
## Managing the transformation

### GOVERNANCE STRUCTURE

The Lieutenant Governor will provide overall leadership for the Innovation Plan implementation. She will establish a Healthcare Innovation Steering Committee by, a successor to the existing Steering Committee, with additional consumer, consumer advocate and provider representation. A Project Management Office will also be established to lead the detailed design and implementation, oversee evaluation efforts, engage with stakeholders, manage vendors, and communicate progress to the public, state government and CMMI.

Four specialized task forces and councils are envisioned focusing on provider transformation standards, support, and technical assistance; coordination of the various health information technology projects; quality and care experience metrics and performance targets; and methods for safeguarding equity, access, and appropriate levels of service. This structure is expected to be in place by January 2014.

The Steering Committee and Project Management Office will seek ongoing advice and guidance from Connecticut's Healthcare Cabinet Consumer input will be provided through the Consumer Advisory Board throughout the detailed design, pre-implementation and implementation phases of this initiative.



### TRANSFORMATION ROADMAP

Our Innovation Plan will be implemented over five years, divided into four phases: 9-month detailed design beginning in January 2014; 9-month implementation planning beginning in October 2014; Wave 1 Implementation beginning in July 2015; and subsequent scale-up through successful waves of implementation in State Fiscal Years (SFY) 2017-2020.

- 1. Detailed Design (January to September, 2014).** Pending stakeholder feedback and refinement of the Innovation Plan, the state will establish new governance structures and form a program management office (PMO). The PMO will have a small, dedicated staff that will rely on contracted support as necessary. The PMO will develop the more detailed technical design necessary to support our new models, including such activities as defining primary care practice transformation standards/ milestones and establishing common measures of quality, consumer experience, and resource utilization for the common scorecard.
- 2. Implementation Planning (October 2014 to June 2015).** Pending the award of the CMMI State Innovation Models Testing Grant and our securing other funding, we will initiate implementation planning targeted at a July 1, 2015 launch date for new multi-payer capabilities and processes.
- 3. Wave 1 Implementation (July 2015 to June 2016).** State Fiscal Year 2016 will mark the first year of operations of our multi-payer model for AMH as well as initiation of our new capabilities to support Workforce Development. Sample activities will include the capture of clinical data and transformation milestones through the multi-payer provider portal, quarterly payments of care coordination fees, and design of the Connecticut Service Track.
- 4. Wave 2+ Scale-Up (July 2016 to June 2020).** In State Fiscal Year 2017 and beyond, we will continuously improve the common scorecard, consumer/provider portal, data aggregation, and analytic and reporting capabilities. In addition, primary care providers will continue to be enrolled in the Glide Path and AMH model, and providers will continue to transition from P4P to SSP as they achieve the minimum necessary scale and capabilities over time. This period will also mark the major expansion of our Community Health Improvement and Workforce strategies, including establishment of Certified Entities and implementation of the Connecticut Service Track.