CT State Innovation Model (SIM) – Frequently Asked Questions

Overview	
What is SIM?	The State Innovation Model Initiative (SIM) is an initiative of the Center for Medicare and Medicaid Innovation (CMMI). CMMI was created under the Affordable Care Act to address the need for healthcare innovation to improve the quality of care delivered in the U.S. and to contain increasing healthcare costs. Under the SIM initiative, CMMI awarded model design grants to Governors to align multiple stakeholders, including providers, consumers, employers, payers and state leaders around healthcare reforms that improve access to care, improve population health and reduce or contain healthcare costs. CT's model design grant requires the state to produce a state healthcare innovation plan (SHIP) and a model of healthcare delivery and payment reforms that will reach 80% of Connecticut's residents within 3-5 years. Connecticut received the design grant award in March 2013. Award funds have supported an intensive model design and stakeholder engagement process, which will conclude in December 2013 with the submission of our State Healthcare Innovation Plan (SHIP). We anticipate that CMMI will release in January 2014 a competitive funding opportunity announcement for up to $45 million in additional funds to help us implement and test our model. If Connecticut is awarded test grant funds, it is anticipated that implementation would begin in late 2014 or early 2015. Connecticut's grant application and related documents are available at www.healthreform.ct.gov.
Why is CT engaged in the SIM?	Connecticut spends higher than average amounts on healthcare while producing uneven quality of care for individuals and persistent health disparities. For example, Connecticut has relatively high hospital readmission rates and high infant mortality rates among Black and Hispanic populations (13% and 7.1% respectively) as compared to the white population (3.8%). CT is also falling behind other states in terms of primary care innovation. For example, as of December 2012, CT had one of the lowest rates of Electronic Health Record (EHR) adoption in the nation. EHRs are one essential component to transforming primary care practice. The primary care network will face new challenges in 2014 when a new wave of Medicaid enrollees enters the network through the Affordable Care Act. CT has the fourth highest level of health care expenditures and the highest level of Medicaid costs per enrollee in the nation. The per capita costs for Medicare/Medicaid enrollees are 55% higher than the national average. Furthermore, the state's annual growth of health care costs of 5.3% exceeds the national rate. Like many other states, Connecticut continues to reward practices for volume instead of value (detailed information on pp 4-5), and inefficiencies in access and service delivery lead to one third of costly emergency room visits being for non-urgent health issues. Opportunities exist in Connecticut to enhance the quality of care, improve health, reduce costs, and enhance health equity. The SIM planning grant dollars are supporting Connecticut in its efforts to develop a roadmap of how to improve the State's health care delivery system and to compete for a $45 million testing grant. This current SIM planning process will produce an actionable plan of a health delivery and payment system that is aligned and sustainable. The proposed model builds upon existing health reform efforts including medical home, accountable care organization (ACO) and primary care/behavioral health integration initiatives. The model also seeks to align primary

	care, public health and community resources to produce a health care system that is person-centered, and focuses on prevention, transparency, collaboration and cost effectiveness.
What are the common barriers and themes identified by consumers?	Consumer focus groups, meetings and electronic surveys were the primary vehicle we used to understand the current experience of care. We conducted numerous focus groups and attended many community-based meetings seeking consumers' perceptions of issues, barriers and solutions. Their personal stories were powerful and sometimes difficult to hear, but they spurred us to a higher level of awareness and aspiration. A sampling of the issues and barriers identified through this process follows: 1. Unaffordability – the number one barrier consumers identified was cost for coverage, premiums, co-pays, prescriptions and deductibles 2. Barriers to access - this took many forms, including long wait times, inconvenient hours, need for prior authorizations, distant locations, a lack of providers and a sense, especially among Medicaid recipients, that they are not welcome. 3. Poor care experience –A pervasive sense exists among most consumers of Medicaid that providers do not treat them with dignity; more specifically, the input we received included many statements by consumers that many providers in all plan types do not listen, respect consumers as patients, trust patients' reports of symptoms or understand patients as a whole person. Medicaid recipients widely reported being treated with a lack of dignity and respect. 4. Barriers to engagement – Consumers find it difficult to actively participate in their own treatment because they are not equipped with education and information about treatment options and the costs of healthcare, or the tools to assist in communication with their providers. Consumers also remarked that do not have the tools to understand the quality of care differences among providers. 5. Fragmented care system – The fragmentation makes communication, coordination and continuity of care extremely difficult Privacy concerns – While consumers understand the need to share data across practices and providers, concerns about privacy and security exist and must be considered.
What barriers do providers and employers identify?	Many of the concerns stated above also resonate with healthcare providers and employers. For instance, providers are frustrated with the current fragmented healthcare system such as the unavailability of patient data, and tools and mechanisms to help manage and coordinate patient care. In addition, providers desire support for meaningful practice transformation, as well as implementing an effective HIT strategy and expanding their Electronic Health Records. They also noted the following: 1. Concern about the current low desirability of primary care physician practice and the belief that the current system has a shortage of primary care physicians. 2. A need expressed by some for a larger role for APRN's and non-traditional providers (e.g., Community Health Workers). 3. A wish to spend more time with their patients and provide more holistic care. 4. A need to consider the social, emotional, environmental, and economic contexts of health 5. Frustration with worrying about malpractice and having to practice defensive medicine. 6. Frustration with the administrative burdens of practice and lack of support for coordination and population health management. 7. A need for more clarity and coherence around existing initiatives (e.g., PCMH, health neighborhoods, etc.). 8. A need for mechanisms to eliminate the existing gap between new knowledge and implementation. Employers feel that the failures of the health system, including poor quality or ineffective care, directly affect employee attendance, morale and productivity in the workplace. They see their employees (and businesses) suffering. Employers worry about the affordability of healthcare for them and for their employees, who sometimes cannot afford to purchase the coverage offered by their employers. Employers are also seeking affordable plans that allow them to incentivize prevention and employee empowerment. Some employers also

	expressed concern about the security of EHR data. Employers expressed other concerns as follows: 1. Employers voice dissatisfaction with unnecessary tests and procedures. Employers say that doctors should be paid based on how healthy they keep the population. 2. Employers would like someone other than the provider to be able to help with coordination of care. 3. Employers want to help with consumer engagement but often lack the materials (e.g., expertise and educational curricula) to do so.
What are the common barriers and themes identified by community organizations?	More integration of social determinants of health (poverty, access to healthy foods, race, access to transportation, cultural and linguistic needs, violence in families and neighborhoods, food security, housing, etc). 1. SIM should consider the social, emotional, environmental, and economic contexts of health. 2. A focus on preventative services, such as by emphasizing diet and nutrition. 3. Focus and reimbursement of non-traditional providers such as Community Health Workers, case managers and navigators, as well as social workers. 4. Sustainability and longevity of the ability of Community Health Workers at nonprofits to affect outcomes and the affect on non-profits that resource those workers because nonprofits depend on grant funding. 5. Reaching people in their communities and throughout the lifecycle, including transitions of care and lifestyle management services dealing with obesity and stress. 6. Accountability should be created through focusing on metrics that carry through the lifecycle and share costs and benefits proportionally among financial stakeholders. 7 Integration of behavioral health and primary care 8. Improvement in access to healthcare. 9. Improvement in coordination among the various health providers. 10. Creation of proactive and concrete measures to address health disparities.
Care Delivery Reform	
What is the proposed care delivery reform under SIM?	A cornerstone of our SIM State Healthcare Innovation Plan (SHIP) is supporting the transformation of primary care to the Advanced Medical Home (AMH). The AMH approach builds on various medical home initiatives undertaken by commercial and public payers in Connecticut in recent years. It adds important elements that should strengthen and accelerate the reform process, and make it more responsive to consumers and providers. For example, it places greater emphasis on the use of a common set of standards and quality metrics by all payers, substantial investments in facilitating practice transformation and validating change, and introducing various enabling initiatives that will be detailed in the SHIP. The AMH care delivery model is comprised of five core standards outlined below. 1. Whole-person centered care. Under the new model, primary care providers will complete comprehensive health assessments and develop treatment plans that consider and address all of the patient's medical, social, behavioral health, cultural, environmental, and socioeconomic needs and risks. 2. Enhanced access. Providers working toward AMH certification will ensure that longer office hours are available and are able to understand and navigate any cultural and language factors influencing the care process.

	3. Population health management. Providers gather and analyze information about their patient populations and identify particular sub-populations' health patterns and improvement opportunities. They will apply insights to continually improve care delivery. 4. Team-based coordinated care. Patients will receive integrated care from multi-disciplinary teams that will eventually include primary care providers, allied health professionals, specialists, care coordinators, oral and behavioral health practitioners, and community support providers to the extent such individuals are supported within plan coverage limits. The integration of behavioral health care with medical care at pivotal points of treatment is one the key strengths of this approach. 5. Evidence-informed clinical decision making. Providers and patients will make better clinical care decisions that reflect in-depth, up-to-date understanding of the effectiveness and affordability of various treatments. Consumers will be engaged and informed about their conditions, health and treatment at the point of care and beyond. Culturally and linguistically appropriate service elements will be woven into these standards, ensuring that meaningful progress is made in eliminating health disparities. We will also be encouraging AMH practices to form organized groups or to affiliate with larger groups of providers. This will allow them to share in the investments required to build the infrastructure and capabilities necessary to provide coordinated, integrated care and to continuously improve quality.
Why aren't you requiring patient centered medical home (PCMH) recognition by one of the national accrediting bodies like NCQA, Joint Commission, or URAC?	Providers and payers in Connecticut now have several years of experience with the NCQA PCMH recognition process. Many providers report that meeting NCQA or other 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 such as NCQA would be better spent on the transformation process. Payers for the most part share this view. In response, they have developed their own standards and tools for assessing a provider's "readiness" to function as a medical home--to provide better integrated and coordinated care and to enter into contracts that hold the provider accountable for quality of care and care experience. Each payer has its own standards, many of which are similar to those of national accrediting bodies such as NCQA. Under SIM, we are proposing to introduce a common set of standards that would be adopted by all payers. Providers will have an easier time undertaking transformation if there is a common set of standards that all payers use or recognize. We do not intend to dilute the existing standards used by Medicaid in its PCMH program. Instead we propose to establish "best of breed" standards that draw from existing national standards, recognizing that each of the national standards today has strengths and weaknesses. For example, one of the most widely used medical home standard sets is weaker in the area of population health management. In this area, we might decide to base our population health management standard on those of another accrediting body. We might then enhance this standard to ensure that it allows for the identification of health equity gaps among various race/ethnic groups. Our SIM plan includes the provision of practice transform support services to help providers meet the AMH standards. We envision that the practice transformation support vendors will also assess readiness through a validation survey. Payers would have the option of accepting this validation survey or continue to rely on their own readiness assessment. In either case, the practice only has to demonstrate compliance with a single set of standards established under the SIM multi-payer alignment process.

Value Based Payment Reform	
How are you proposing to change payment methods under SIM?	<u>Shared savings Program</u> Our primary payment reform under SIM is to move toward holding AMH providers responsible for the overall cost of care for their patients and to reward them with a share of any savings *if they meet quality targets*. We will do this by projecting how much it should cost for the AMH provider to serve their patients for one year. This is similar to establishing an annual budget. However, it is actually a *virtual* budget, because the provider will continue to be paid fee-for-service. The projected budget will be higher for patients with chronic illnesses, because these patients typically require more services. This process is called risk adjustment--the use of healthcare utilization data to group patients into different levels of risk that correspond to different projected budgets. Although the provider is paid fee-for-service, the costs for their panel of patients are tracked relative to the projected budget. The budget includes all costs of care including hospitalizations, lab/diagnostic imaging, and specialty care. The provider earns a share of the savings if the overall costs for their panel of patients for the year are less than was projected by the payer. This is referred to as a Shared Savings Program (SSP). Some providers also choose an arrangement where they return funds to the payer if their costs exceed the projected budget. This is called a risk arrangement. Usually a provider in this kind of arrangement also has an opportunity to earn more shared savings. However, undertaking this kind of arrangement is a decision between payers and providers and is not a condition of participation in our model. Quality of care and patient satisfaction (or care experience) is always measured for providers in shared savings programs. Importantly, providers are only able to share in savings if they meet quality of care *and* patient satisfaction targets. In addition, we will recommend that providers are not permitted to share in savings if there is evidence that there savings were achieved in inappropriate ways (see below). Providers will typically try to achieve savings by providing high quality care and more efficient care. For example, there may be savings if they improve their ability to quickly find the right diagnoses for a patient, and to provide the right care the first time so as to avoid hospitalizations. However, they may also achieve savings by eliminating wasteful and duplicative services. <u>Pay for Performance Program</u> Although our focus in SIM is on promoting SSP arrangements, we recognize that many providers are not prepared to take on this level of responsibility for quality, care experience, utilization and efficiency targets. They need time to develop the skills and capabilities within their practice to continuously manage and improve their performance. In addition, many independent AMH's do not have the scale required for payers to reliably project cost. For these reasons, we have proposed a transitional "pay for performance" track in which providers will receive financial rewards if they meet certain quality and care experience targets. Providers receiving practice transformation support services will receive assistance in developing new practice protocols, skills and tools to help them meet these targets and improve their performance over time. Although pay for performance is an excellent way to help providers learn how to measure and improve their performance, it has important limitations as a long term strategy, which we discuss further below.

What is wrong with the way we currently pay for health care services?	The most common way of paying for health care services today is called fee-for-service. In a fee-for-service arrangement (without a shared savings component), providers are paid for every service or procedure that they do, and the use of any equipment and supplies There are many negative consequences of these types of fee-for-service reimbursement methods. Fee-for-service is inherently inflationary because it rewards volume above all else (Gawande, 2009). It incentivizes services and procedures not all of which are clearly evidence-based and some of which might even be unnecessary. This clearly contributes to over-utilization and inefficiency. Moreover it creates a market that rewards the emergence and application of new medical technologies without regard to their benefits relative to existing technologies and often with unknown long term risks. The current fee-for-service market is one of the reasons that healthcare is perhaps the only industry where advances in technology increase rather than decrease costs. Fee-for-service payment without accountability for quality or costs contributes to a health care system that is increasingly unaffordable for individual patients, employers and both commercial and public payers. It contributes to the cost to employers of adding jobs or encroaches on potential wage increases. It also crowds out taxpayer dollars that could otherwise be spent on providing necessary healthcare to uninsured as well as other uses for public funding like essential investments such as education. Less well known, but of even greater importance, is the impact on consumers. Most fee-for-service systems have inadequate mechanisms to prevent duplicative or unnecessary tests and procedures. They also pay for all delivered care. Whether inappropriate care, ineffective care, or care resulting in medical errors, providers are actually paid for the consequences of poor health care—longer episodes of care with additional, sometimes costly services. Importantly, there is then no incentive for a healthcare practice or system to make the substantial investments that are required to improve quality and outcomes. Nor are they rewarded for effective preventive care. This failure to improve over time translates into decades of lost benefits to the general public. The payment system must be changed in order to align the incentives to provide preventive and when needed high value care, not high volume care. The impact on consumers is not simply the burden of illness poorly treated, lost time at work or the inconvenience of unnecessary or additional tests and procedures. It is the often unrecognized risks and health consequences of various services and procedures, whether clearly needed or maybe unnecessary. For example, every hospitalization exposes an individual to risk of infection from specific bacteria residing there like VRE (vancomycin-resistant enterococcus) or MRSA (methicillin-resistant staphylococcus aureus), hence the preponderance of contact precautions and gown use requirements for staff and visitors in hospitals across the country. Frequent antibiotic use fosters the development of resistant bacteria, leading to more challenging treatment options, as well as allowing other infections like "C. Diff" gastroenteritis to emerge (Clostridium difficile). CT scans and other radiologic procedures expose individuals to radiation that increases the risk of later malignancies. Over the years, the use of radiologic medical imaging procedures has increased dramatically, and many now express concern that potential harms of some tests and procedures might outweigh short term diagnostic and therapeutic benefit when not clearly necessary (Topol, 2012). In sum, more healthcare testing and treatment is not necessarily better or safer healthcare. Medicare, Medicaid and to a lesser extent commercial payers have made substantial investments to counter the excessive utilization that occurs in our current fee-for-service payment system. The focus of these activities, commonly referred to as audit or program integrity, is on a broad range of excess service issues. Payers rely on administrative data and advanced analytics to identify billing outliers (providers whose patterns of service activity differ from their peers) or unusual trends in utilization that might signify inappropriate services by major provider systems or segments (e.g,. home health care, personal care) of the market. Although payers run standard reports to identify issues, they also adapt their analyses to the changing market. They may focus and drill down more deeply on particular sectors of the

	market where data trends suggest excessive or inappropriate service. Notably, program integrity and audit divisions are entirely separate from program divisions, which tend to focus on improving quality rather than routing out unnecessary or inappropriate service.
Won't this new payment method reward providers for withholding necessary care? What safeguards will SIM put into place to prevent this from happening?	Connecticut's SIM program, like numerous other care delivery, payment, and health information technology (HIT) reforms across the country (e.g., Medicare SSP and SIM Test Grant states), introduces shared savings payment arrangements that are intended to reduce over-service, improve quality, and reduce costs by holding primary care networks and larger clinically integrated networks responsible for the cost of care of the individuals they serve. While this will not entirely eliminate incentives for over-utilization among some players in the health care system, it will begin to impact the current volume-focused culture. There will instead be an increasing mindfulness of "value" among primary care providers and their partners, which will set in motion ongoing efforts to evaluate what quality care is delivered at what cost. This approach will improve health, health care outcomes at both the individual and population levels, and affordability. As Connecticut's consumer advocates have made clear, there is the possibility that a few unscrupulous providers might seek savings through inappropriate methods. These include reducing necessary access, risk selection, lowering quality of care, cost shifting, withholding appropriate care or inappropriate referral practices. For instance, a provider might avoid new clients or discharge existing clients who are at higher risk or who have more serious and potentially costly conditions or might fail to order necessary tests or procedures. Quality metrics will help guard against this for target conditions (e.g., diabetes, asthma). However, they may not prevent more systematic efforts to under-serve, particularly for uncommon conditions, or any conditions that are outside the scope of quality improvement metrics. We believe that it is essential to establish program integrity functions that focus on these issues of risk avoidance and under-service. Moreover, we believe that these functions should be separate and apart from quality measurement and continuous quality improvement activities, which should focus on targeting opportunities for improvement and expanding the core measurement set. To this end, Connecticut proposes to establish a separate Equity, Access and Appropriateness Council, comprised of consumer advocates, payer-based experts in audits and advanced analytics, and clinical experts and researchers from the state's academic health centers. The task of this Council will be to recommend an audit strategy and methods, both retrospective and concurrent, that will help guard against these risks and to encourage payers to adopt such methods on or before implementation. The state anticipates that payers will expand or repurpose existing audit resources to support the recommendations of this Council. The Council may also recommend circumstances under which the findings of audit processes might result in disqualification from value-based payment rewards such as shared savings, de-credentialing or other penalties or sanctions.
Will providers be at risk in these new arrangements?	We are proposing that our payment reforms incentivize providers to be more mindful of value, and make efforts to improve outcomes eliminate wasteful, duplicative, inefficient and ineffective services. Shared savings arrangements in which providers share in savings, but not losses, meet our requirements for payment reform. That said, payers and providers may choose to introduce "downside" arrangements, in which providers share in losses as well as gains, but such arrangements will be determined by the payer and the provider.

The Medicaid PCMH model is a pay for performance based payment reform that is working well. Why not simply expand on this model?	Pay for performance has an important role to play in developing providers' skills in managing performance on quality measures. For this reason, pay for performance has been an important element of several of the state's current medical home initiatives (e.g., Medicaid's PCMH program) and it is proposed as a transitional payment method in our SIM plan. Pay for performance programs, however, have important limitations as a long term approach to payment reform. Such programs are substantially less likely to improve consumer value (quality and total cost) than payment reforms that measure and reward the overall value of services provided to a population. These programs require careful analysis to find targeted opportunities to eliminate waste, duplicative care, inefficiency care and ineffective care. Each opportunity has to be carefully defined, measurement specifications and data collection methods must be established, and providers must be benchmarked. Only then can performance rewards be implemented. Pay for performance programs can slow the pace of change because providers are only incentivized to focus on the opportunities for improvement selected by the payer. It does not encourage providers to innovate—to find new opportunities to improve quality and care experience, while driving down avoidable and unnecessary costs. We will learn more, and learn faster if providers are given the latitude to use their insights and ingenuity to solve the innumerable quality and cost challenges that exist today. Finally, only value-based payment reforms that introduce accountability for total cost change the market. In a pay for performance system, there is still a strong incentive for every supplier of every service, supply, and procedure to drive up the price. In a cost accountable market, cost will be transparent, the system will naturally incentivize quality and economy, and providers of services, supplies and procedures will be focused on delivering value in a market that competes on value.
Is this sort of payment reform required by CMMI?	We met with CMMI to consider this question on October 17th. CMMI remains strongly committed to payment models as they are defined in the Funding Opportunity Announcement. Our proposed shared savings program model is a total cost of care model. CMMI is not permitted to comment on requirements that might be included in a future Funding Opportunity Announcement (grant solicitation), including the second round funding opportunity for SIM. Although we cannot be certain what CMMI will require in the next round, we anticipate that it will require or strongly favor payment models of this type.
Other	
What is the plan to ensure quality measures are in place before holding providers accountable?	The SIM Project Management Office will convene a Quality Council with the aim of recommending a core measurement set for adoption by all payers. The measurement set will include quality process and outcome measures, care experience measures, and health equity measures. It is anticipated that the Council may also recommend what metrics and what level of performance a provider must meet in order to qualify for financial rewards. The Council may recommend additional measures that should be adopted for payers with special populations and health service challenges, such as Medicaid. The initial measurement set will be based primarily on CMMI recommended measures and other NQF endorsed measures. The availability of quality metrics that are reliable, valid and feasible to collect will improve over time, especially as the state and payers develop methods expanding measures to those that are derived from EHRs, including measures related to the "meaningful use" of these new EHR systems. The recommended measurement set will become more comprehensive over the 5-year time frame for this initiative.

What is the timeline?	Our current estimated timeline is as follows: • November 1st – State Healthcare Innovation Plan (SHIP) published for comment on www.healthreform.ct.gov • November 1-December 10th – public forum, re-engagement with focus groups and stakeholders • December 31st – SHIP submitted to CMMI • January 31st – Estimated date when CMMI will release Funding Opportunity Announcement, requesting that state submit a model testing grant application. We anticipate that the grant application will be due approximately 60 days from release and that funds will be awarded by fall of 2014. Pre-implementation activities are expected to conclude around June 2015, after which the initiative will begin. These dates are estimates
Is the SIM model design process completed?	No. We will continue to engage a wide variety of stakeholders to give us feedback on our proposals through the end of November. We will finalize and submit the plan by December 31, 2013.
What is your plan for further stakeholder engagement?	We intend to publish a draft State Healthcare Innovation Plan on November 1st. The public will be invited to comment on the plan. In addition, we will convene at least one public forum plus a series of meetings with consumers, providers, employers, advocates and other stakeholders in order to get their feedback on the plan. After submission of the SHIP to CMMI, we plan to include stakeholders in the task forces and councils that will advise on the implementation. We will also consult on an ongoing basis with the Consumer Advisory Board of the Health Care Cabinet. This process will begin by January 2014. We will continue to present at stakeholder forums to raise awareness and solicit feedback on the pre-implementation and implementation process. Check our calendar on to www.healthreform.ct.gov to track our stakeholder engagement activities.
Where can I go to get more information or to ask questions?	Check our website at www.healthcarereform.ct.gov for all posted materials, meeting minutes, etc. You may e-mail sim@ct.gov with any questions.

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