



# Connecticut State Innovation Model

STATE OF CONNECTICUT

SHIP Team Discussion  
April 30, 2013

# Agenda

Share context for Connecticut's State Innovation Models (SIM) design efforts	<i>10 min</i>
Share common themes and points of emphasis from key informant interviews	<i>10 min</i>
Review role of SHIP Steer Co and design project roadmap	<i>30 min</i>
Discuss vision for Connecticut's care delivery and payment model reform	<i>30 min</i>
Review next steps	<i>10 min</i>

## **Connecticut has a unique opportunity to address quality, access, and cost challenges today**

**Although Connecticut ranks at or above the national average on many indicators of health, there exists opportunity for improvement**

- Connecticut is among the top five states with the lowest rates of smoking, premature deaths, and poor mental health days and the highest rates of immunization coverage; is among the top quartile of states with the lowest obesity rates; and is among the top 50% of states with the lowest rates of preventable hospitalizations, diabetes, infant mortality, cardiovascular deaths, and cancer deaths
- Health disparities, however, continue to exist across racial and ethnic groups, illustrated by the variability in the infant mortality rate of non-hispanic black infants that is 3x that of non-hispanic white infants

**At the same time, Connecticut lacks a solution for the state to address the steep growth in state health expenditures**

- Connecticut faces a potential ~\$1B budget deficit in 2014 and 2015, driven in part by an increase in health care spending, which continues to grow at a rate higher than Connecticut's gross state product
- Inefficiencies in health care utilization continue to exist today, illustrated by the significant utilization of high-cost care settings (e.g., emergency department) for non-urgent visits

**While Connecticut has many payment and care delivery innovations underway, no common model is shared across Medicaid, Medicare, and Commercial insured populations**

**The funding and endorsement of the Center for Medicare and Medicaid Innovation (CMMI) as part of the State Innovation Models (SIM) initiative provides a unique opportunity for key stakeholders within the community to address these quality, access, and cost challenges in a statewide, multi-payer collaboration**

## Connecticut has received funding and endorsement from CMMI to innovate care delivery and payment model reforms

### CMMI guidance for State Innovation Models (SIM) design states

- Design care delivery and payment reform that touches **80% of state lives within 5 years**
- Roll-out across multiple payers' populations in a truly **multi-payer approach**
- Describe how “**broad-based accountability for outcomes, including total cost of care** for Medicare, Medicaid, and CHIP beneficiaries, is created”
- Test innovative payment and service delivery models that have the potential to “**lower costs,**” while “**maintaining or improving quality of care**”

# Connecticut's targeted aspirations for SIM are responsive to CMMI guidance for design states

## Aspirations

- Gain alignment around a common care delivery and payment model that is applicable across Medicare, Medicaid, and Commercial populations
- Define a solution that incorporates total cost of care accountability
- Maintain or improve leading indicators of health and patient experience under the new care delivery and payment model
- Establish timeline for rollout that will meaningfully curb health care spending growth within 3-5 years

## What we are hearing from key stakeholders

### Common themes

- Medical homes and accountable care organizations
- Public health and prevention
- Total cost of care accountability
- Focus on 3 or 4 superordinate goals

### Points of emphasis

#### *Care delivery*

- Health equity
- Primary care/ behavioral health integration
- Social determinants
- Consumer engagement

#### *Workforce*

- Rethink composition and capacity
- Improve physician retention
- Align education and training with new care delivery and business models
- Encourage and support phased transition to new models
- Align scope of practice acts and regulations
- Expand use of paraprofessionals
- UConn/ university/ college partnerships
- Accelerate change through multi-payer alignment

#### *Analytics*

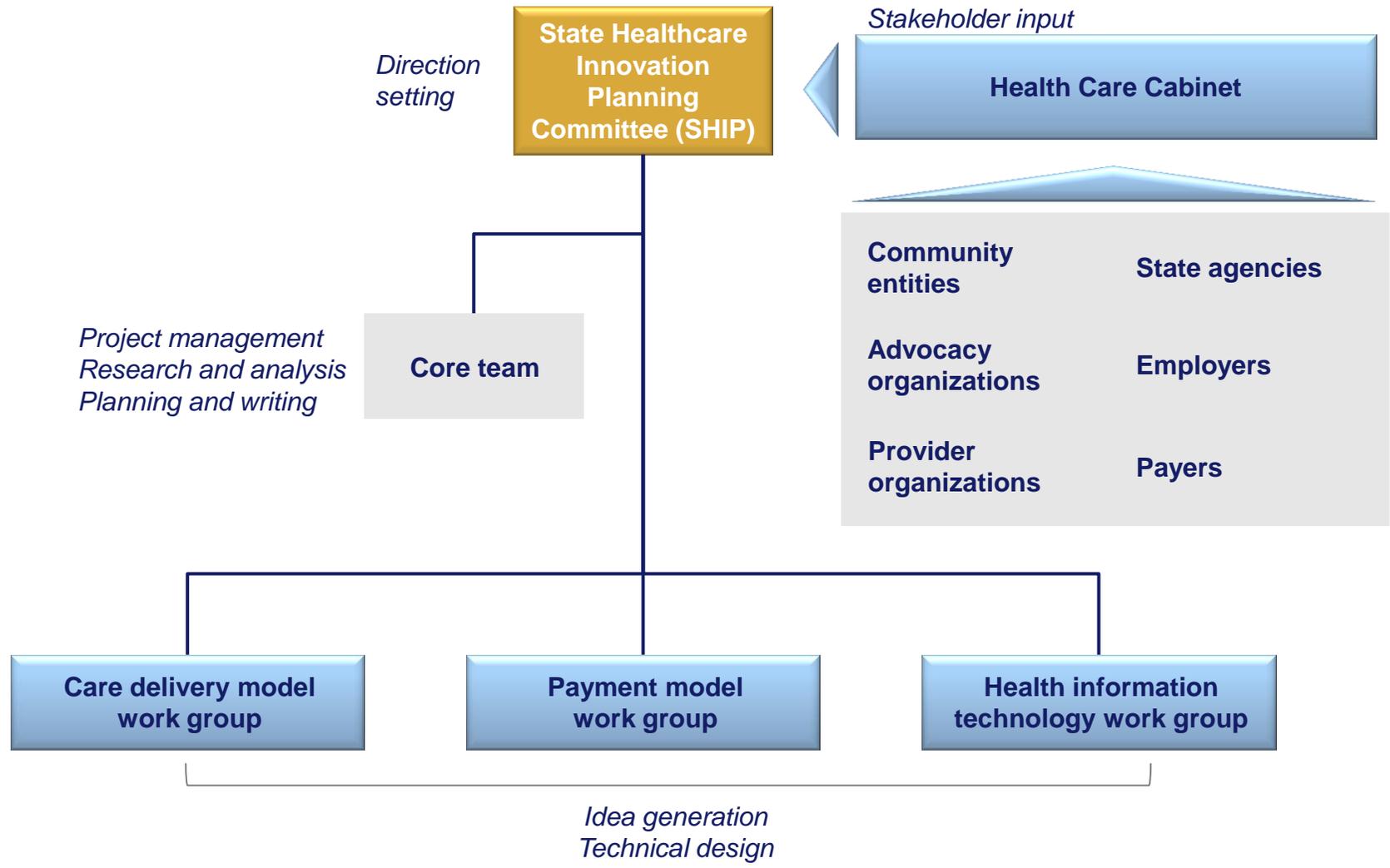
- Pricing transparency
- Provider clinical and business decision support
- Accountability for public health, health care outcomes and cost
- UConn/ university/ college partnerships
- Market dynamics/ opportunities
- Consumer engagement and decision-making
- Workforce capacity and gaps

# We will largely define and design the SIM care delivery and payment models by the end of July 2013

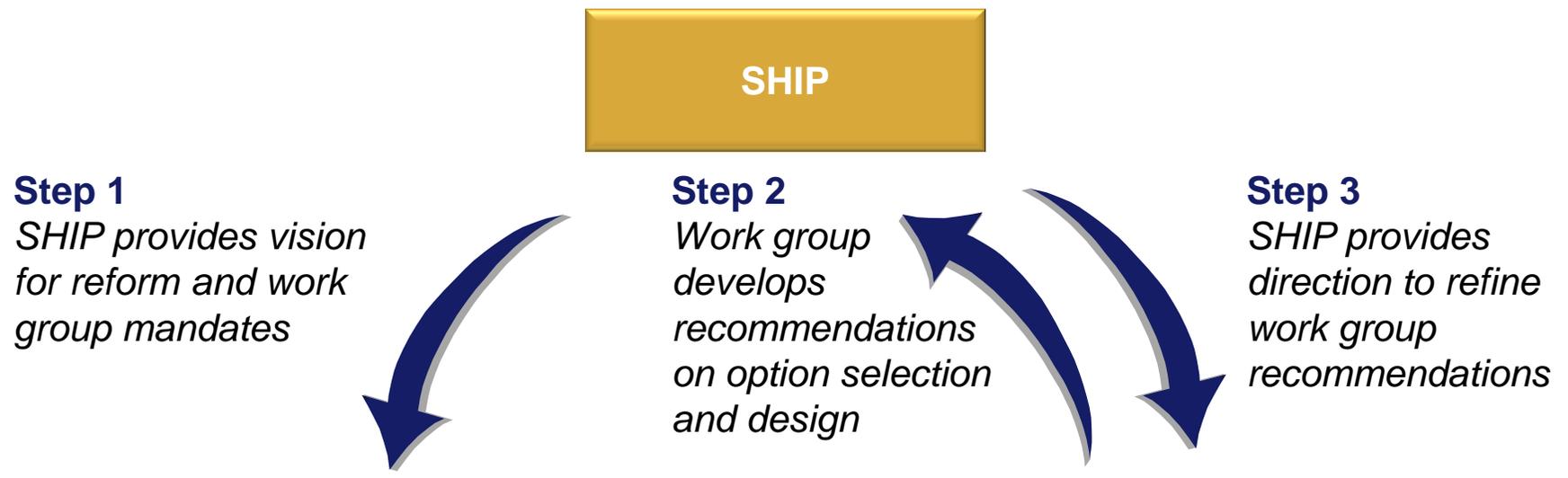


April	May	June	August
<b>Project set up and initial hypotheses</b>	<b>Current state, best practice, and options</b>	<b>Design and planning</b>	<b>Syndication</b>
<ul style="list-style-type: none"> <li>Understand current state</li> <li>Establish vision</li> <li>Identify target populations and sources of value</li> <li>Develop health care delivery system hypothesis</li> </ul>	<ul style="list-style-type: none"> <li>Pressure-test health care delivery system hypothesis</li> <li>Develop payment model hypothesis</li> <li>Align key stakeholders</li> </ul>	<ul style="list-style-type: none"> <li>Design detailed health care delivery system and payment model</li> <li>Develop implementation and roll-out plan</li> <li>Align on key quality metrics</li> </ul>	<ul style="list-style-type: none"> <li>Draft testing proposal</li> <li>Syndicate with key stakeholders</li> </ul>
			<b>Finalization</b>
			<ul style="list-style-type: none"> <li>Refine and submit testing proposal</li> </ul>

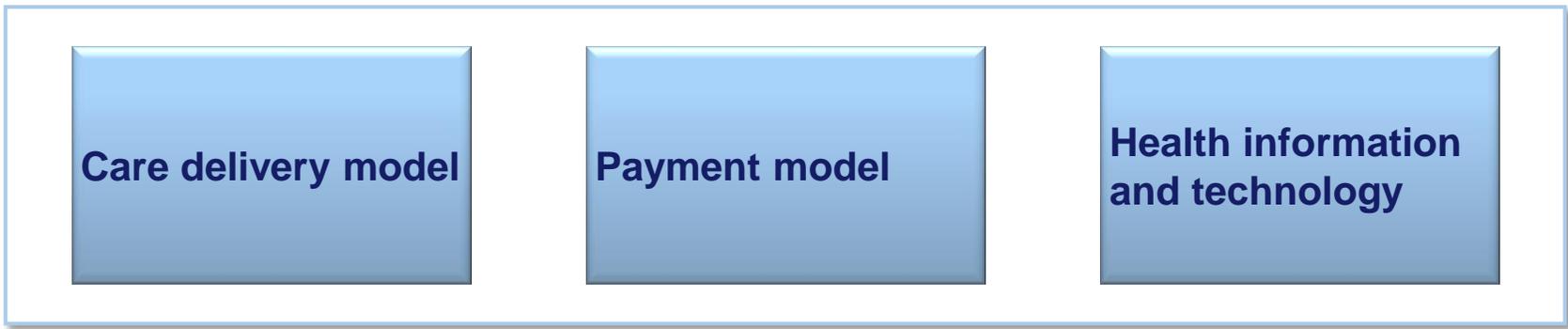
# SHIP will serve as the primary decision-making body with input from work groups, advisory boards, and the broader community



# SHIP will provide direction and feedback on recommendations that are developed by work groups



## Work groups



# What is the vision for change in Connecticut through SIM design effort?

## Care delivery model

- 1 What are the key sources of value to address within target populations?
- 2 What are the barriers to capturing these sources of value, and how should patient behavior, clinical practice patterns, and community involvement be changed to address them?
- 3 Care model: who are the specific types of stakeholders (e.g., providers, consumers, community members) who need to be involved to capture these sources of value?
- 4 Care model: what levers (e.g., education, policy) can be applied to support provider, consumer, and community entity behaviors that support capture of these sources of value?
- 5 Care model: how will providers, consumers, and community members be organized to promote the defined interaction model and changes to provider and consumer behaviors?
- 6 What is the current gap in workforce capacity and skills relative to the types of providers required, and what actions can close the gap?
- 7 What will be the pace of roll-out throughout the state, including population health programs?

## Payment model

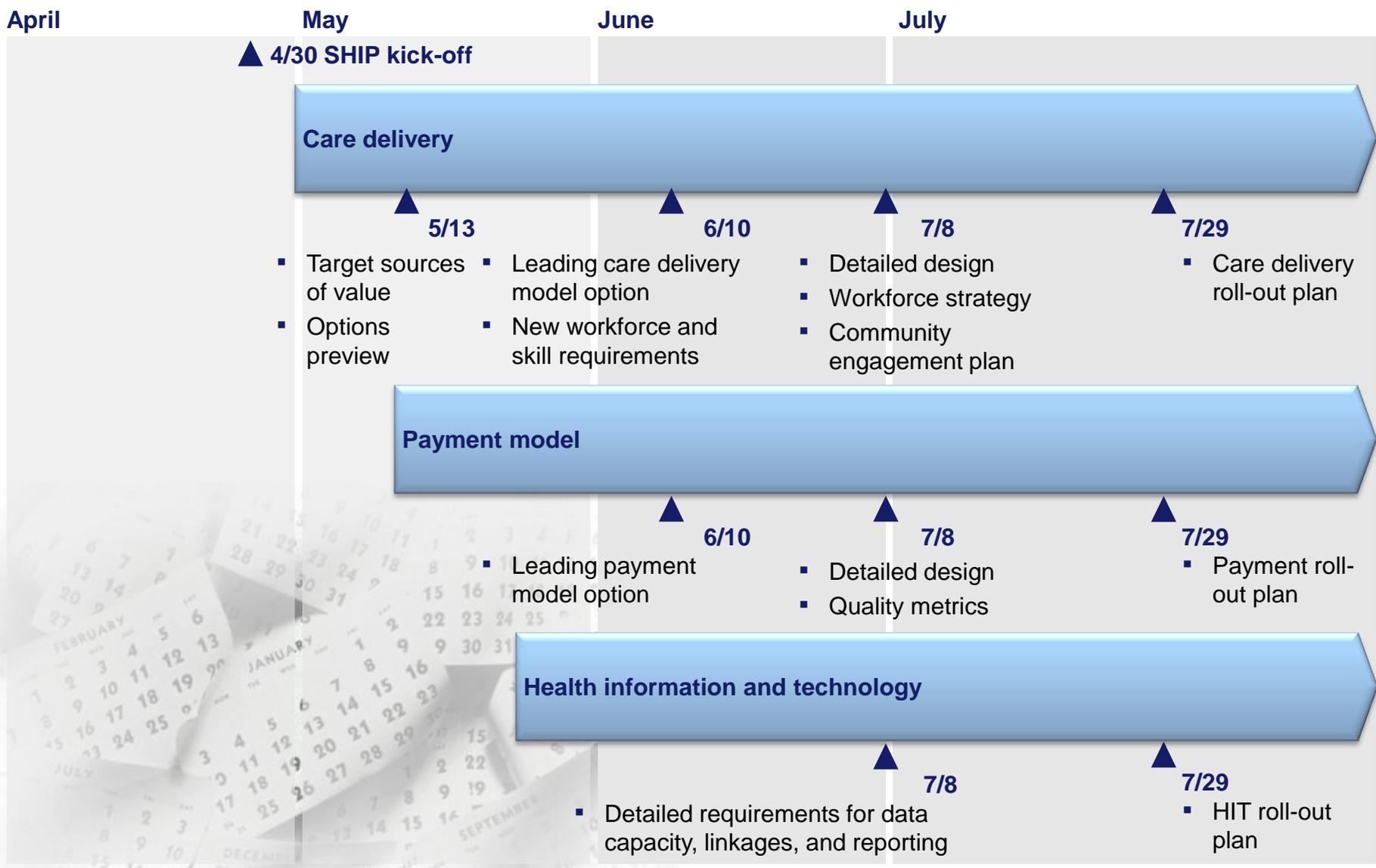
- 1 What are the target sources of value to promote under the new payment model?
- 2 What will be the key dimensions (e.g., structure, processes, outcomes) for which providers will be held responsible?
- 3 What payment/ qualification stipulations will be implemented to hold providers accountable for those structures, processes, and outcomes?
- 4 Who are the individuals who will be held accountable for those structures, processes, and outcomes?
- 5 What will be the technical design for how performance will be measured and reimbursed (e.g., pooled across providers)?
- 6 What are the specific metrics required to support the proposed payment model?
- 7 What will be the pace of roll-out throughout the state?

## Health information and technology

- 1 What capabilities are required across key stakeholders (e.g., payers, providers, community agencies)?
- 2 What are the current HIT capabilities of payers and within the statewide infrastructure?
- 3 What is the optimal level of payer infrastructure standardization across major components (e.g., data, reporting)?
- 4 What are the gaps in HIT capabilities that must be addressed?
- 5 What is the best strategy to develop the required HIT capabilities of individual providers?
- 6 What is the optimal capability roadmap and budget for developing the critical payer and statewide infrastructure for to implement the new care delivery and payment models?

# Work group and SHIP focus of efforts will be staged during design-period

▲ Recommendation to SHIP



# What is the vision for Connecticut’s SIM care delivery and payment reform?

**Purpose**

- Align on shared vision for Connecticut’s SIM care delivery and payment reform

**Approach**

- Write a newspaper headline describing the achievements of Connecticut’s new care delivery and payment innovation in 2016
- Break-out into groups of 3 and come up with one headline for the group
  - Include 3-5 concrete accomplishments that support the headline
- Come back in the larger group to share output

**Timing**

- 5 minutes:** Individual brainstorming
- 10 minutes:** Break out
- 15 minutes:** Report back and discuss as group



## Care delivery work group will assess and recommend sources of value to target as part of SIM care delivery and payment reform

	Description	Examples
<b>Primary prevention</b>	<ul style="list-style-type: none"> <li>Prevention of disease by removing root causes</li> </ul>	<ul style="list-style-type: none"> <li>Smoking cessation</li> </ul>
<b>Secondary prevention/ early detection</b>	<ul style="list-style-type: none"> <li>Early detection of disease while asymptomatic to prevent disease progression</li> </ul>	<ul style="list-style-type: none"> <li>Breast cancer screening</li> <li>Identification and management of patients at high risk for heart disease</li> </ul>
<b>Provider choice and setting</b>	<ul style="list-style-type: none"> <li>Utilizing highest value care settings and downstream providers</li> </ul>	<ul style="list-style-type: none"> <li>Phone consultation vs. in-person visit</li> </ul>
<b>Effective diagnosis and treatment selection</b>	<ul style="list-style-type: none"> <li>Evidence-informed choice of treatment method/intensity</li> </ul>	<ul style="list-style-type: none"> <li>Reduction in inappropriate utilization of c-section</li> </ul>
<b>Care coordination / chronic disease management</b>	<ul style="list-style-type: none"> <li>Ensuring patients effectively navigate the health system and adhere to treatment protocols</li> </ul>	<ul style="list-style-type: none"> <li>Care coordination, across specialties and care channels for chronic conditions (e.g., CHF, diabetes)</li> </ul>

## Next steps

- Refine and finalize vision statement

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- Convene during SHIP meeting week of May 13 to align on sources of value and to preview design options for care delivery model

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- Propose specific individuals to represent organizations on work groups

# APPENDIX

# Care Delivery work group charter

## Mandate

The care delivery work group will develop for recommendation to the State Health Care Innovation Plan steering committee a proposal on the design and plan for implementing a person-centered care delivery model. This model will promote the capture of prioritized sources of value (e.g., improved care coordination between primary and specialty care, primary prevention) within the target population. This work group will assess alternative care delivery design options and develop recommendations for the SHIP on key decisions, including those related to care delivery model; workforce development; and community outreach, education, and engagement

## Key questions for work group recommendation

- 1 What are the key sources of value to address within target populations?
- 2 What are the barriers to capturing these sources of value, and how should patient behavior, clinical practice patterns, and community involvement be changed to address them?
- 3 Care model: who are the specific types of stakeholders (e.g., providers, consumers, community members) who need to be involved to capture these sources of value?
- 4 Care model: what levers (e.g., education, policy) can be applied to support provider, consumer, and community entity behaviors that support capture of these sources of value?
- 5 Care model: how will providers, consumers, and community members be organized to promote the defined interaction model and changes to provider and consumer behaviors?
- 6 What is the current gap in workforce capacity and skills relative to the types of providers required, and what actions can close the gap?
- 7 What will be the pace of roll-out throughout the state, including population health programs?

## Key milestones

Date <i>(week of)</i>	Milestone
May 20	Development of hypotheses on care delivery model
June 3	Outline of new workforce capacity and skill requirements
July 1	Proposal on the design of new care delivery model; strategy for fulfilling new workforce requirements; required types of consumer involvement under new care delivery model
July 15	Final recommendation on care delivery model design, plan for workforce development, and plan for engaging community in testing and implementation of the state's care delivery model

## Interdependencies

- Payment work group: Types of behaviors to encourage, provider types to include, and metrics to track in new payment model
- Health Information Technology work group: Required systems capacity and capability to share data across providers and settings and to capture data

# Care delivery model work group meeting and key decision cadence

**Meeting (week of...)**

**Key decisions**

**May 6**

- Prioritize sources of value for target population based on impact, feasibility, and timing
- Identify set of care delivery model design decisions that target sources of value

**May 20**

- Develop hypothesis on leading options for key design decisions
- Prioritize proposed levers to capture prioritized sources of value

**June 3**

- Identify leading care delivery model option for each design decision
- Assess potential impact of leading care delivery model option
- Assess capabilities/ capacity required by provider type under new model

**June 17**

- Identify gaps in workforce capacity and capabilities
- Evaluate population health requirements and how care delivery model can improve population health

**July 1**

- Develop detailed design of care delivery model options
- Develop strategies to fill capacity and skill gaps in work force
- Develop approach to engaging and educating community to participate in delivery model

**July 15**

- Develop care delivery model roll-out plan
- Develop plan for improving work force capacity and skills, with timing
- Develop communication plan to reach out and engage consumers and community on the new care delivery model

# Payment work group charter

## Mandate

The payment work group will develop for recommendation to the State Health Care Innovation Plan steering committee a proposal on the design and plan for implementing a payment model that promotes value (i.e., the improvement of leading health indicators and delivery of quality outcomes and services relative to total cost); supports a person-centered care delivery model that integrates primary care, preventive care, specialty care, public health, and behavior health; enables the capture of prioritized sources of value within the target population; and ultimately holds providers accountable for total cost of care. This work group will assess key options for design of the payment model and propose to the SHIP

## Key questions for work group recommendation

- 1 What are the target sources of value to promote under the new payment model?
- 2 What will be the key dimensions (e.g., structure, processes, outcomes) for which providers will be held responsible?
- 3 What payment/ qualification stipulations will be implemented to hold providers accountable for those structures, processes, and outcomes?
- 4 Who are the individuals who will be held accountable for those structures, processes, and outcomes?
- 5 What is the appropriate level of risk sharing, and what risk adjustments (e.g., provider/ patient exclusions) will be put in place?
- 6 What are the specific metrics required to support the proposed payment model?
- 7 What will be the pace of roll-out throughout the state?

## Key milestones

Date (week of)	Milestone
May 27	▪ Alignment on hypothesis leading payment model option
July 1	▪ Agreement on design parameters of leading option, metrics to measure performance and reimburse providers under new care delivery and payment model
July 22	▪ Proposal on plan for implementing leading option; method to track key quality metrics

## Interdependencies

- Care delivery work group: Types of providers to include in new payment model, target behaviors of providers and consumers to enable under new payment model, metrics required to measure desired behaviors
- Health Information Technology work group: Key metrics that will be tracked under the new payment model, types of data and information required to support the new payment model, types of linkages across data required to support the new payment model, method to track key metrics

# Payment model work group meeting and key decision cadence

**Meeting (week of...)**

**Key decisions**

**May 13**

- Preview list of current payment models in Connecticut and in peer states
- List key design dimensions of payment model range and options for each
- Evaluate criteria for selecting leading options for design parameters

**May 27**

- Create benefits and limitations of case examples
- Align on hypothesis of leading payment model option

**June 10**

- Estimate financial impact of design option
- Develop hypothesis on detailed design of payment model
- Identify quality metrics being tracked in-state and in peer states

**June 24**

- Recommend detailed design of payment model
- Define key metrics to track quality and success of new care delivery and payment models

**July 8**

- Define boundaries for payment model roll-out plan (in concert with care delivery model work group)

**July 22**

- Develop payment model roll-out plan
- Create plan to gather new quality metrics

# Health Information Technology work group charter

## Mandate

The Health Information Technology work group will develop and recommend a plan for establishing the data, infrastructure, and processes/ protocols that will be required to support the care delivery and payment models proposed by the state as part of the State Innovation Model design project. The work group is responsible for developing a perspective on the data and systems that will be required by the new care delivery and payment models; identifying gaps in current data sources and systems capabilities/ capacity; and proposing a plan for updating the state’s data and systems to support the new care delivery and payment models.

## Key questions for work group recommendation

- 1 What capabilities are required across key stakeholders (e.g., payers, providers, community agencies) to implement the target care delivery and payment model?
- 2 What are the current HIT capabilities of payers and within the statewide infrastructure that are relevant to the new care delivery and payment model?
- 3 What is the optimal level of payer infrastructure standardization across each component (e.g., data, analytics, pooling, reporting, data visualization, portal)?
- 4 What is the best strategy to develop the required HIT capabilities?
- 5 What will be the pace of roll-out of the required capabilities throughout the state?
- 6 What is the required budget to develop these capabilities?
- 7 What is the best funding model to develop these capabilities?

## Key milestones

Date (week of)	Milestone
June 24	<ul style="list-style-type: none"> <li>▪ Align on capability requirements, current state capability landscape, strawman HIT standardization, approaches to develop required capabilities, sequencing of required capabilities, high level cost estimates of development and implementation</li> </ul>
July 22	<ul style="list-style-type: none"> <li>▪ Agreement on capability roadmap, strawman budget, potential funding sources</li> </ul>

## Interdependencies

- Payment work group: Metrics to track under the new payment model, types of data required to support the state’s proposed payment model
- Care delivery work group: Metrics to track to support the new care delivery model, linkages across settings and providers required to support the state’s proposed care delivery model

# HIT work group meeting and key decision cadence

## Meeting (week of...) Key decisions

**May 20** (given Memorial Day weekend)

- Agree on HIT capabilities that will be required across key stakeholders under new care delivery and payment models
- Develop criteria and approach to assess payor and health system capabilities

**June 10**

- Gain understanding of current capabilities and linkages of key stakeholders
- Develop initial view on potential models for HIT standardization
- Evaluate required health data sources required under new care delivery and payment models

**June 24**

- Create strawman for HIT standardization across key components
- Develop options to develop required capabilities (e.g., public utility vs. proprietary solutions, build vs. buy)
- Identify potential sequencing of required capabilities (e.g., feasibility, cost, day-one need)
- Conduct early assessment of costs of implementing required capabilities

**July 8**

- Create capability roadmap
- Estimate strawman budget
- Assess potential funding sources

**July 22**

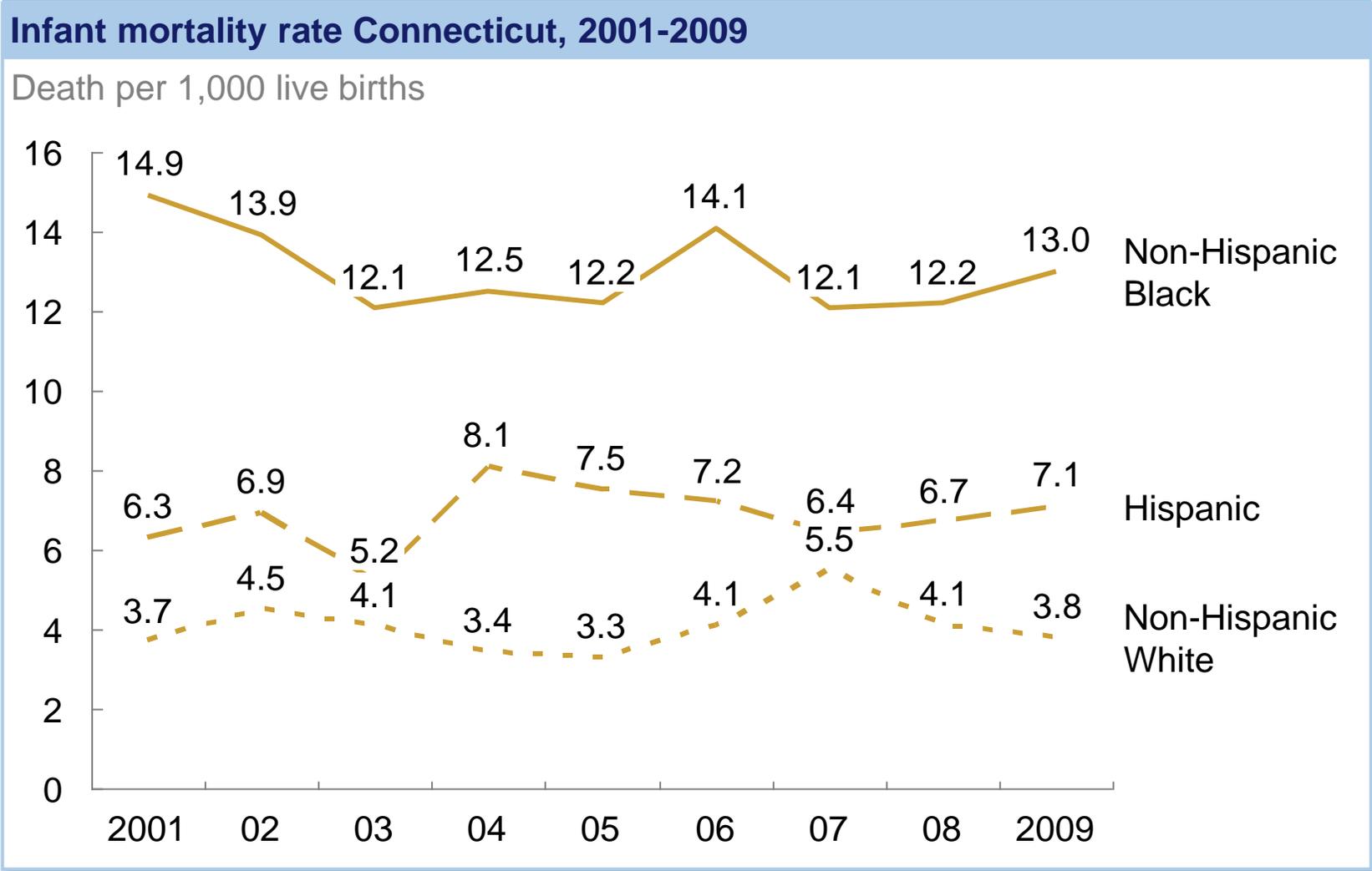
- Finalize budget
- Finalize funding sources

# Connecticut's public health profile ranks above national average on almost all indicators



Measure	2012 value	State rank
<i>Determinants</i>		
Smoking (Percent of adult population)	17.1%	5
Obesity (Percent of adult population)	24.5%	7
Immunization coverage (Per of children 19-35)	157.9	2
Preventable Hospitalizations (Per 1,000 Medicare enrollees)	60.4	23
<i>Health outcomes</i>		
Diabetes (Percent of adult population)	9.3%	19
Infant Mortality (Deaths per 1,000 live births)	5.8%	17
Cardiovascular Deaths (Deaths per 100,000 population)	239.2	17
Cancer Deaths (Deaths per 100,000 population)	176.4	15
Premature Death (Years lost per 100,000 population)	5943	5
Poor Mental Health Days (Number of days in last 30 days person indicates their activities are limited due to mental health difficulties)	3.6	5

# Opportunity exists, however, to improve health indicators and address health disparities



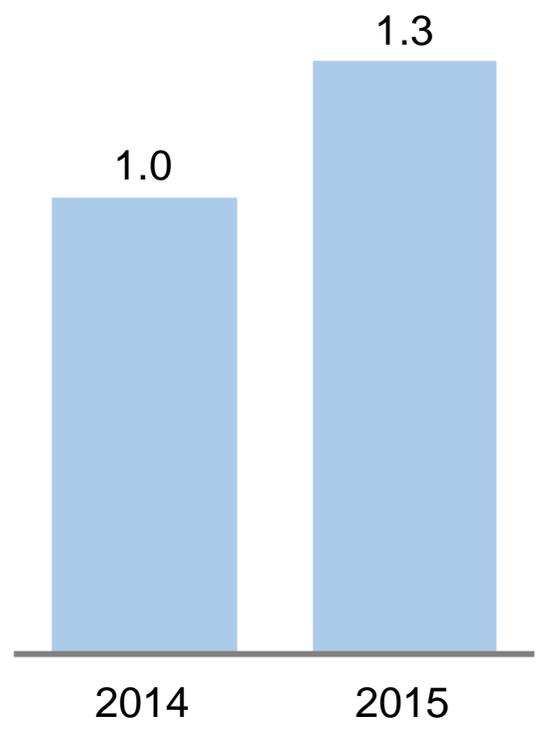
Note: Infant mortality defined as death within 1 year of birth

SOURCE: Connecticut Department of Public Health, Vital Statistics (Registration Reports), 2001-2009, Table 12

# At the same time, Connecticut will require a solution that addresses statewide cost challenges

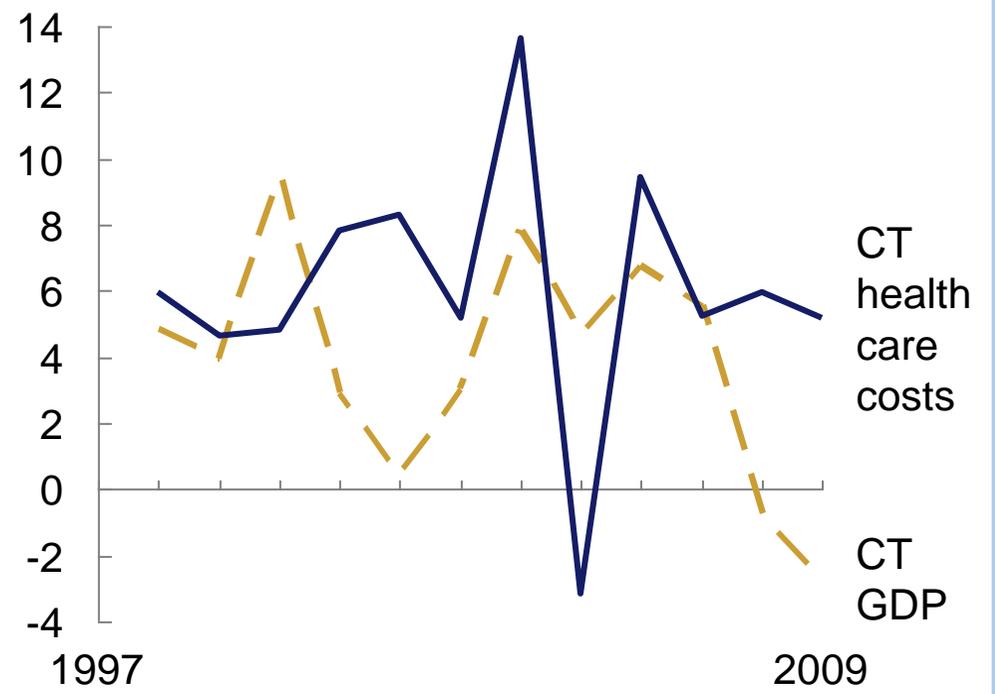
## Potentially significant budget deficits expected in FY 2014 - 2015

Projected deficit, as of April 6, 2013  
USD, billions



## Health care cost growth higher than state GDP growth

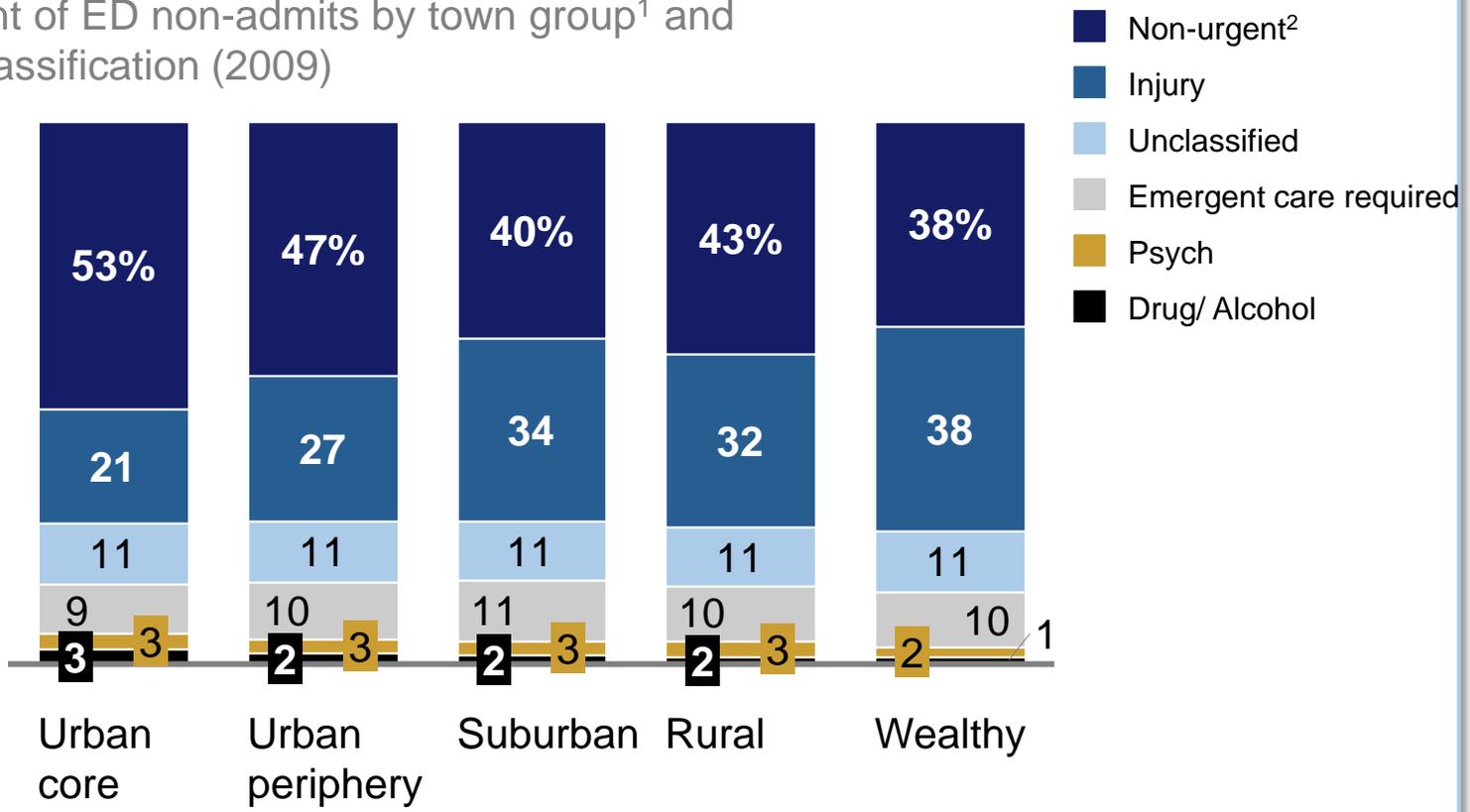
Annual growth rate, %



# Inefficient health care utilization is one among several drivers of high health care costs today

## 40-50% of ED non-admits were for non-urgent care in 2009

Percent of ED non-admits by town group<sup>1</sup> and visit classification (2009)



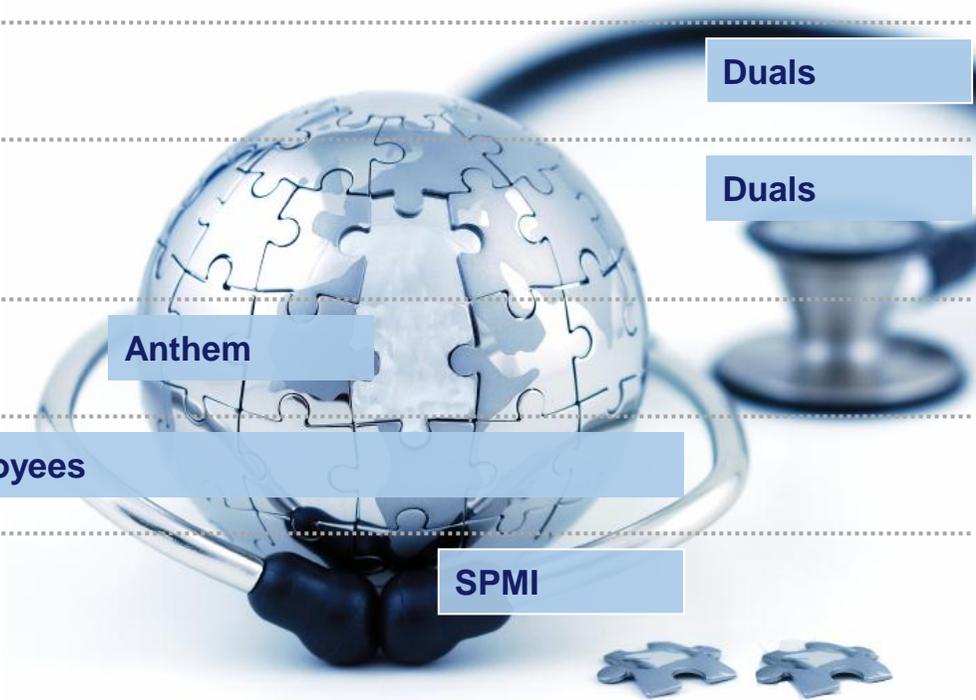
SOURCE: Connecticut Department of Public Health, OCHA. 2010. Profile in Emergency Department Visits Not Requiring Inpatient Admission to a Connecticut Acute Care Hospital Fiscal Year 2006-2009. Chart 8

1 Groupings of towns based on socioeconomic factors (CT State Data Center)

2 Non-urgent: The patient's presenting condition or symptoms at time of visit did not need immediate medical care within 12 hours

# CT has many payment and care delivery innovations, but no model shared across Medicaid, Medicare, and Commercial insured populations

	Children	Adult	Special needs <sup>1</sup>	Duals, elderly
<b>Patient-centered medical home</b> <i>Enhanced FFS performance payment, TCOC accountability (Anthem)</i>	Medicaid			
	Anthem			
<b>ACO</b> <i>ProHealth, Hartford Healthcare, St. Francis, Primed, Collaborative ACO</i>	Cigna			Medicare
<b>Integrated Care Initiative – ASO</b> <i>SSP with state</i>				Duals
<b>Integrated Care Initiative – Health Neighborhood</b> <i>TCOC SSP with providers</i>				Duals
<b>Episode-based payment</b> <i>Joint replacement pilot</i>		Anthem		
<b>Health enhancement program</b> <i>Consumer based incentives</i>	State employees			
<b>SPMI health homes</b> <i>Care coordination capitation</i>			SPMI	



<sup>1</sup> Includes LTSS, SPMI, and DD patients