

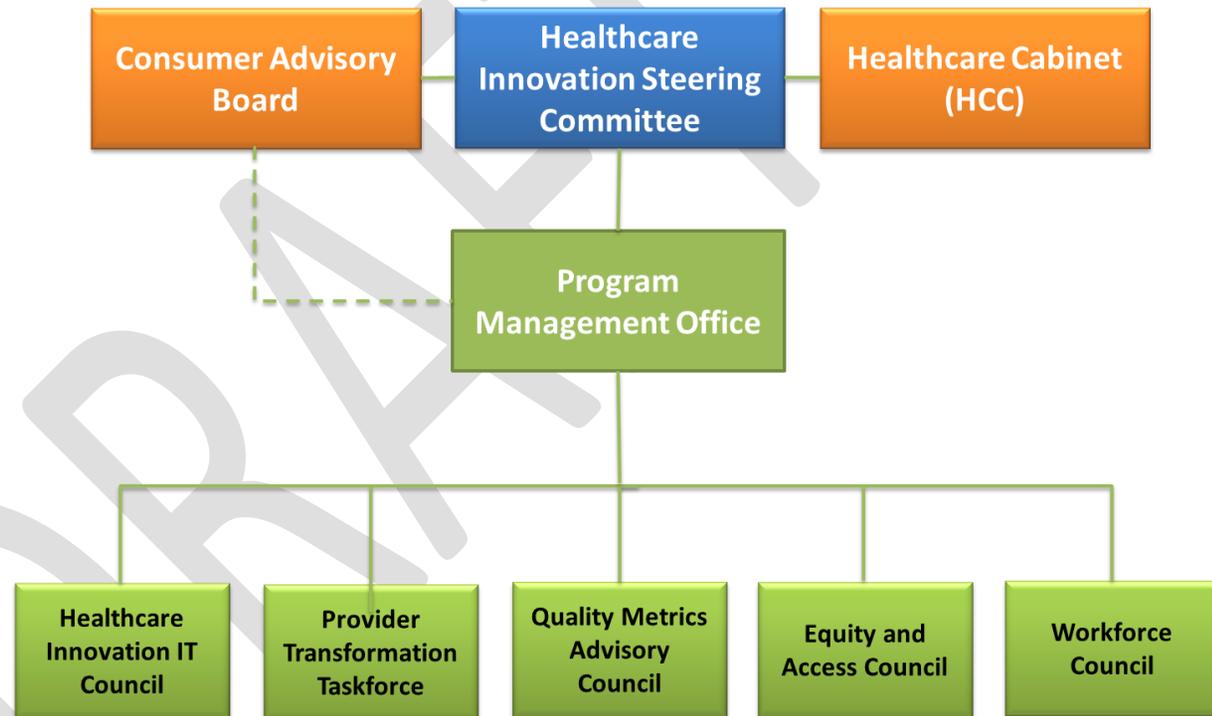
Connecticut State Innovation Model Initiative

Key issues pertaining to the State Healthcare Innovation Plan, Version 1.1

#1: Organization and Governance	
It is not clear where overall authority lies, and also where accountability lies for specific initiatives.	<p>Based on stakeholder feedback and public comment we are proposing the following clarifications and changes to SIM’s governing structure:</p> <p>Lieutenant Governor Nancy Wyman will provide the overall authority for the Connecticut Healthcare Innovation Plan (“Innovation Plan”). A Project Management Office will be established within the Office of the Healthcare Advocate (OHA) and every effort will be made to resource the office sufficiently to manage the project on an going basis. The Project Management Office (PMO) will be accountable for the conduct of specific initiatives, especially those that involve interagency collaboration, which do not fall within the purview of a single line agency or involve broader stakeholder involvement, such as task forces and councils. The PMO is also responsible for day to day management of the initiative, including fiscal and contract management. Accountability for certain other elements and initiatives of the Plan will reside within line agencies. These agencies will work closely with the PMO to implement aspects of the Plan and the designated line agency leads will participate on the SIM implementation team. During the next several weeks, we will determine which departments and individuals will have ownership and accountability over specific initiatives other than those that fall under the PMO.</p> <p>The promotion of Health equity through the elimination of disparities is embedded in virtually every aspect of the SIM model. We are currently making revisions to the Innovation Plan to incorporate broader recommendations from a number of stakeholders to ensure our commitment to health equity is more visible and achievable. Accountability for health equity will reside within the PMO. Health equity objectives and health equity solutions will be integrated into the work of the various councils and task forces.</p> <p>The Consumer Advisory Board will be directly linked to the Steering Committee and the Program Management Office for the purpose of providing advice and guidance. The Consumer Advisory Board will also be invited to arrange for consumer representation on each of the SIM taskforces and councils, as well as the steering committee. The Consumer Advisory Board will facilitate consumer participation at these meetings, provide the necessary guidance and support, and discuss issues brought back from</p>
The Consumer Advisory Board should have a more direct role in advising the PMO.	
Consumers should be represented on all task forces and councils.	
Consumer advocates should be represented on all task forces and councils.	
A much wider array of health professionals should have ongoing input into the SIM design and implementation (e.g., chiropractors, LCSWs, podiatrists, naturopaths, dentists, etc.)	
Health equity – Who will be accountable for health equity?	

the meetings with the larger group. The Consumer Advisory Board will solicit further input from the broader consumer community on an ongoing basis to be incorporated into each of the components of the SIM. This will reinforce consumers in every part of the planning process.

To the extent possible, decisions regarding the plan will be made in a collaborative process with the Program Management Office, the taskforces and councils, the Healthcare Cabinet and the Consumer Advisory Board, with the Lt. Governor being the ultimate decision maker.



During stakeholder feedback, a variety of healthcare professionals requested involvement in the SIM governance structure. We believe it is important to garner as many diverse perspectives as possible to create meaningful reform. We are evaluating the best mechanism, to ensure representation of the many different healthcare professionals we have in CT in our ongoing work—e.g., appointment to councils directly versus advising through a separate mechanism.

#2 Risk of under-service in shared savings programs	
<p>A number of respondents raised concerns that shared savings payment methods will incentivize providers to withhold necessary care. They asked what safeguards SIM will put into place to prevent this from happening. Some proposed the development of methods for monitoring under-service and an explicit principle that practitioners will be disqualified from receiving shared savings if they demonstrate under-service.</p>	<p>The Innovation Plan notes that it is important to establish program integrity functions that focus on these issues of risk avoidance and under-service, and that such functions should be separate and apart from quality measurement and continuous quality improvement activities. To this end, the Innovation Plan proposes to establish a separate Equity and Access 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 review the need for and recommend audit strategies and methods, both retrospective and concurrent, to help guard against these risks and to encourage payers to adopt such methods as they implement shared savings program arrangements. The state anticipates that payers will establish audit processes consistent with the recommendations of this Council.</p> <p>Several payers noted that under-service has been of relatively limited concern in their early payment reform efforts because they have been engaged with physicians who are self-selected and thus might be considered high performers. They are believed to be among the most advanced and focused on quality. In many cases, they have independently pursued medical home recognition. The NCQA PCMH recognition process reportedly requires that medical homes have methods for monitoring physician behavior and at least one payer reported that this is a requirement of their SSP contracts. We will examine the NCQA PCMH requirements as well.</p> <p>Several payers acknowledged that as cost accountable payment reforms such as shared savings programs become the default payment mechanism, methods for monitoring under-service may be of increasing importance.</p> <p>Payers also noted that NCQA health plan accreditation has required monitoring for under-service and over-service. We are in the process of soliciting more information about these NCQA required processes to determine whether they are consistent with the intent of the Council. One payer noted that these NCQA requirements have been phased out in favor of a portfolio of requirements that proactively address quality, safety, continuity, coordination, and gaps in care.</p> <p>Most payers expressed a willingness to engage on this topic through the Equity and Access Council. CMMI is also interested in this issue and is making efforts to provide for Medicare’s participation. One payer suggested that we involve the NQF as well.</p> <p>Several of the payers were willing to consider contractual methods for disqualifying practitioners from receiving shared savings if they are found to be engaging in systematic efforts to under-serve or to select or de-select patients based on quality or cost risks. However, there is at present insufficient</p>

	<p>consensus on this point to include it as a core principle. Consensus may emerge from further examination of this issue in the context of the Council including evaluation of the extent to which under-service might be an issue, and through the testing of various audit methods by payers. We intend to include providers and consumer advocates in this important area of inquiry.</p> <p>Medicaid expects that the SIM-associated process for selection of methods for monitoring of under-service and/or patient selection will, among payers, pose and settle the question of whether documentation of this type of behavior will be a disqualifying factor in assessment of eligibility for shared savings. DSS will participate in the Equity and Access Council and will not implement shared savings arrangements under the general Medicaid program until reasonable and necessary methods for monitoring under-services are in place. Whether documented under-service would disqualify providers under the Demonstration to Integrate Care for Medicare-Medicaid Enrollees would need to be determined in consultation with the Complex Care Committee.</p>
<p>#3 Advanced payments/care coordination payments</p>	
<p>Many providers indicated that care coordination payments or other advance payments are an important incentive to enter the AMH glide path. Some payers expressed concern that advance payments are difficult to administer and are not necessarily offset by savings. In addition, many self-funded employers are unwilling to support advance payments and other value based payment reforms.</p>	<p>Payers vary in terms of whether they consider advance payments to be care coordination fees, PCMH fees, or true advance payments, meaning an advance on shared savings. There appears to be an increasing preference among payers for advance payments because it implies continued payments are contingent on the continued generation of savings. There is also interest among one or two payers in phasing out PMPM payments for PCMH recognition, especially because such payments typically have not required demonstrated improvements in resource efficiency and utilization. Other payers are moving toward the elimination of advanced payments entirely in favor of rapid cycle (e.g., quarterly) shared savings payments. After an initial phase-in period, providers would have a continuing cycle of shared savings payments that can be flexibly applied. In theory, such payments can support the ongoing use of care coordinators, pharmacists, nutritionists, community health workers, or non-visit based care.</p> <p>In Medicaid, DSS is currently making advance payments in the form of fee differential payments to practices participating in the glide path and differential payments for practices that have qualified for PCMH status, depending upon their level of NCQA recognition.</p> <p>Under the proposed duals demonstration “health neighborhood” model, DSS is seeking approval from CMMI to make start-up payments, PMPM payments for care coordination, and also to make performance payments derived from a portion of any savings (Medicare, net of any increase in Medicaid expenditures) that are achieved.</p> <p><u>Recommendation:</u> Although it may not be possible to achieve 100% alignment on the issue of advance</p>

	<p>payments or care coordination payments, maximizing alignment remains our goal. The purpose of such payments is to help finance the costs associated with advanced primary care including care coordination. We recommend that payers offer advance payments to providers that have the potential to more than offset practice investments for high performing providers. We propose to revise the Innovation Plan to note that the majority of commercial payers and Medicaid will provide advanced payments during the glide path (once readiness is demonstrated) or once AMH recognition is achieved.</p> <p>We also intend to engage the employer community more widely to gauge their interest in advanced payments to ensure practice transformation, a mechanism that may ultimately propel the model forward and incentivize quality and savings over the long-term.</p>
<p>#4 Medicaid participation</p>	
<p>The Innovation Plan makes few specific references to Medicaid’s participation in the reforms. How will Medicaid participate?</p>	<p>Medicaid will align with other payers during the Innovation Plan test grant period by implementing an upside shared savings program for the general Medicaid population. Consideration of subjecting Medicaid providers to downside risk later in the test grant period will be informed by experience of other payers that have implemented downside risk and by metrics associated with patient access to care, experience of care and health outcomes. DSS will, based on the early experience of other payers with this approach, assess the need for protections for Medicaid beneficiaries and on this basis will determine how and when during the test grant period to implement downside risk. The rationale for this staged process is to avoid negative quality outcomes for program participants and unintended contraction of the Medicaid provider network.</p> <p>Prior to implementation of the Innovation Plan, DSS is proposing to limit its use of a shared savings approach in Medicaid to the activities proposed under the Demonstration to Integrate Care for Medicare-Medicaid Enrollees (“duals demonstration”). DSS is proposing to implement the duals demonstration at a point in time in 2014 to be determined by the pace of settling a Memorandum of Understanding with the Centers for Medicare and Medicaid Innovation (CMMI).</p> <p>Medicaid will plan to align its PCMH standards and quality/utilization metrics with other payers. Medicaid proposes both to retain its current recognition of PCMH practices that have achieved NCQA recognition and Joint Commission accreditation and additionally to recognize providers that have achieved AMH status. Although there has been much discussion of the basic concepts of AMH, the specific details of this model and how the AMH standards will compare to current PCMH standards are still to be completely clarified. At a minimum, Medicaid will be seeking to include the following in the AMH standards:</p>

	<ol style="list-style-type: none"> 1. expand the scope of support for patients within medical homes to more fully include measures to identify and address social determinants of health, behavioral health, oral health; 2. enable fuller adherence to the National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Health Care; 3. more fully incorporate data collection and analytics in support of a population health-based approach; and 4. expand the disciplinary range of the care team, both within and affiliated with the medical home. <p>To the extent that the above are not included in the core AMH standard set, DSS may establish these as additional standards applicable to providers that serve Medicaid.</p>
<p>#5 Health Information Technology - Portals</p>	
<p>Common provider portal; common consumer portal</p>	<p>Payers have made considerable investments in their provider portals. They believe this is one of the features that they offer that distinguishes them in the market. The functionality provided through such portals enables better patient care.</p> <p>Consequently, payers do not support pushing these capabilities to a common provider portal. They might consider pushing static reports, such as scorecards, health risk stratification information, and gaps/alerts to a common provider portal. Several of the payers would consider using a common provider portal with federated log-in such that a provider would have access to the portal of each payer without an additional log-in.</p> <p>Similarly, payers feel for the most part that a common consumer portal would not be of substantial value to consumers nor would it be in their business interests given the likely costs involved. When the idea of a single federate log-in was discussed with streamlined access to a payer specific portal, they acknowledged that it might be achievable, but cost would need to be assessed.</p> <p><u>Recommendation:</u> We recommend that we further examine the options of a common provider portal with static reports or a single portal with federated log-in. We recommend that we set aside payer participation in a common consumer portal at this time, pending further review.</p>
<p>#6 Tort Reform</p>	
<p>A number of physician providers, both primary care and specialty care, and their respective associations felt that tort reform was essential to</p>	<p>Physicians did not feel that they could reasonably be held accountable for costs, a portion of which is a result of practicing defensive medicine, unless there were real protections from malpractice lawsuits. They feel that they will experience additional malpractice exposure as a result of reducing unnecessary tests and procedures. There was particular interest in “safe harbor” malpractice reforms, which would</p>

<p>achieving the projected reductions in waste and cost under SIM.</p>	<p>protect physicians from malpractice lawsuits if providers follow specific utilization and appropriateness of testing guidelines, such as choosing wisely. Some physicians are concerned that there may be more adverse events if these guidelines are followed and that, without such protections, they will have exposure to additional liability. They also expressed concern that if guidelines establish a standard of care, and such guidelines are not followed, it exposes providers to liability.</p> <p><u>Recommendation:</u> The arguments for and against safe harbor laws are complex and beyond the scope of this response. However, the SIM planning team recommends that work begin with CSMS and liability carriers in the state to develop a program similar to those established by the Harvard Management Risk Foundation to identify risk reduction strategies for providers that will result in lower liability risk and reductions in premiums.</p>
<p>#7 Workforce – loan forgiveness</p>	
<p>Loan Forgiveness – Why doesn't the plan introduce much needed loan forgiveness to support careers in primary care, careers in Connecticut, and residence in health professional shortage areas?</p>	<p>Loan forgiveness is an obvious means for Connecticut to retain primary care clinicians. Over the next year, the state will review approaches to loan forgiveness and consider how such approaches might be funded and targeted. The Affordable Care Act calls for federal funding for loan forgiveness. Should such funding become available, Connecticut will seek to participate.</p>