

III. Project Narrative

A. State Health Care Innovation Plan (SHIP) Design Strategy: Connecticut seeks assistance under the State Innovation Models Initiative for a Model Design Grant to enable stewardship of its existing resources and thought leaders in support of health systems transformation. Connecticut brings significant capability to this effort that can be amplified immediately to produce actionable results. Critical examples of this capability include: 1) existing structures implemented by the Governor and the Legislature through which payers, providers and consumers are already working together in support of furthering common adoption of strategies toward reform; 2) strong leadership on population health initiatives; 3) specific, replicable examples of use of shared metrics, payment reform, and value-based initiatives; and 4) relationships with many leading private insurers. Notwithstanding these strengths, however, Connecticut also faces challenges, including: 1) extremely high health care cost trends; 2) barriers in utilization of and access to primary, preventative care that inhibit achieving the health outcomes and care experience that would otherwise be realized; and 3) limited experience with large-scale multi-payer efforts.

Connecticut's strengths are considerable. Connecticut has structures in place that will immediately support development of a strategic plan. These include: 1) the Governor's Health Care Cabinet which is charged with advising the Governor, the Lieutenant Governor, and the Office of Health Reform & Innovation (OHRI) on issues related to federal health reform implementation and the development of an integrated health care system for the state; 2) a fully constituted and active quasi-public Health Insurance Exchange; and 3) a cabinet-level Office of Health Care Reform and Innovation, which is charged with coordinating and implementing the State's responsibilities under state and federal health care reform. Further, Connecticut has a

lower overall incidence of obesity, tobacco use and depression as compared to other states [Healthy Connecticut 2010, Department of Public Health]. Additionally, Connecticut has already implemented smaller-scale examples of use of shared metrics (such as between Medicaid and State Employee Health Plan Patient/Person Centered Medical Home (PCMH) initiatives), payment reform (use of outcomes-based performance payments in the Medicaid PCMH initiative), and value-based design (implementation of a Health Enhancement Program for the state employee population). Finally, Connecticut is a corporate home for many major insurers, which provides proximity and opportunity to partner with key stakeholders needed to engage for multi-payer approaches.

Examples of Connecticut's constraints and challenges include high health care costs; inadequate access to primary, preventative care especially among those residents at disproportionate risk of disease; inappropriate use of emergency departments; and workforce capacity constraints. Health care costs are at an unsustainable level. Connecticut has the fourth highest level of health care expenditures at \$8,654 per capita, behind only the District of Columbia, Massachusetts, and Alaska; the ninth highest level of Medicare costs at \$11,086 per enrollee; and the highest level of Medicaid costs at \$9,577 per enrollee. In addition, the state's average annual growth health care costs are outpacing the national figure: 5.5% as compared with 5.3% [Kaiser State Health Facts, 2009 data]. Among populations in need, the cost profile of Connecticut's Medicare-Medicaid Eligibles (MMEs) is of particular concern, with per capita costs exceeding the national average by 55%. Additionally, adults do not use primary care as indicated, with 1) 12% of at-risk Connecticut residents not having visited a doctor within the two years previous to the study; 2) considerably fewer people of color having done so; and 3) only half of Connecticut adults over age 50 receiving recommended care [Commonwealth Fund,

2009]. A report from the Connecticut Hospital Association indicated that one-third of all emergency department visits are for non-urgent health issues, and that 64% occur between 8:00 a.m. and 6:00 p.m., suggesting that there are barriers to accessing primary care even during typical work hours [Connecticut Hospital Association, 2009]. Finally, there is serious concern about the capacity of Connecticut's primary care network to handle the demand that will arise under the Affordable Care Act's Medicaid expansion, as well as associated with value-based health initiatives that are incenting use of preventative care.

Connecticut's Strategic Vision: Connecticut is committed to ensuring that every resident has access to a high quality provider team that is responsible for delivering and coordinating the primary, preventive and specialty care that individuals need through a system in which: primary care, public health and community resources are aligned with innovative payment and delivery system strategies to optimize individual health and to reward value over volume; individuals will have access to care that is person-centered, informed by the social determinants of health and focused on prevention and keeping people healthy; we address the "whole" person and not just the disease; and we eliminate health disparities once and for all.

To achieve our vision, we will harness the collective power and potential of both public and private providers and payers to create broad transformation focused on improvement of individual and population health, prevention and appropriate treatment. The system we create will: promote individual and community wellness, prevention, detection, and intervention; work to reduce health disparities; assure access broadly; reward beneficiaries for acting as good health care consumers and providers for delivering value (health outcomes, care experience); be grounded in data, evidence and quality improvement; enable transparency; optimize use of public and private funds; and yield population-based improvements in health status.

By crafting a health care innovation plan with support from CMS, Connecticut will leverage its unique experience and motivated leaders to ensure health care delivery is integrated, collaborative, transparent, comprehensive and accountable. Within the six-month period of our cooperative agreement, we will develop models for testing that include payment mechanisms that reward value, quality, safety and positive health outcomes over volume. A diverse group of consumers will join representatives from each of the six major insurance companies and work with the Departments of Insurance (DOI), Mental Health and Addiction Services (DMHAS), Public Health (DPH), Social Services (DSS), the Comptroller's Office and other public and private stakeholders. We will ensure that a strong consumer perspective informs the planning process and that it weaves together the multiple initiatives already underway in our state.

Current Initiatives to Improve Delivery Systems, Increase Access to Care, Contain Costs and to Improve the Health of Connecticut's Citizens: Connecticut has already implemented a variety of means to address these issues, and is eager to explore how best to bring these efforts to scale across payers in a manner that will support our vision. Following are profiles of our current provider, payer and consumer initiatives:

Provider initiatives: Connecticut's work in this area has focused on two areas: 1) enhancement of the capacity and quality of primary care practices and 2) integration of primary care with other disciplines.

Enhancing the capacity and quality of primary care practices has involved two key elements: financial assistance and technical support in furtherance of being accredited as Patient/Person Centered Medical Homes (PCMH) and use of ACA funds in support of meaningful use of electronic health records (EHR). Effective January 11, 2011, the Office of the State Comptroller (OSC) contracted with two Administrative Services Organizations (ASO)

(Anthem and United Health Group) to participate in a PCMH initiative in support of the State's self-funded employee health plan covering 200,000 active and retired State employees and their dependents. The ASOs engaged with two large group practices that achieved Level 3 NCQA (National Committee for Quality Assurance) certification, and are using common metrics, providing enhanced compensation (through enhanced fee-for-service (FFS) and bonus payments for achieving identified outcomes), and engaging in data sharing. Over 45,000 state employee plan members are currently participating in the pilot. Paralleling the efforts of OSC, the Department of Social Services launched a Medicaid PCMH initiative on January 1, 2012, using common performance measures with those established for the state employee health plan PCMH, including required milestones, enhanced fee-for-service and performance payments. Recognizing that many smaller primary care practices had not yet started along the developmental curve toward PCMH status, the Medicaid PCMH initiative also included start-up payments to independent practices, "Glide Path" financial support, and technical support through the platform of the Medicaid medical Administrative Services Organization.

Another important aspect of enhancing the capacity of primary care is financial support for adoption of EHR. eHealth Connecticut is currently using a \$6.4 million federal grant to help providers, mainly primary care practices and health centers achieve meaningful use of EHR. Approximately 1,500 providers are enrolled.

Integration of primary care with other disciplines includes first stage efforts to integrate primary medical care with behavioral health services, long-term services and supports and community resources. These include efforts by Medicaid to support integration of medical and behavioral health care, SAMHSA-funded medical/behavioral health initiatives, partnerships in support of care transition, active Accountable Care Organizations (ACOs), and submission of an

application to CMMI in support of funding under the Demonstration to Integrate Care for Dually Eligible Individuals.

On January 1, 2012, Connecticut transitioned its Medicaid medical services from managed care organizations to a single, streamlined ASO that represents significant new capabilities in identifying those most in need of care coordination across a range of presenting needs through predictive modeling and data analytics. A critical element of this work is purposeful co-location of the staff of the Medicaid behavioral health ASO in the offices of the medical ASO to support an integrated, multi-disciplinary response for individuals who present with both physical and behavioral health needs. The Medicaid Behavioral Health Partnership (BHP), which is managed by Value Options, has also expanded its care coordination efforts under a partnership among DSS, DMHAS and the Department of Children and Families to include Medicare Medicaid Eligibles (MMEs). Finally, Medicaid provides enhanced reimbursement to enhanced Behavioral Health (BH) Clinics, which are certified by DMHAS based on their capacity to admit individuals who are not in crisis within specified time frames and to treat individuals with co-occurring disorders.

Connecticut's Primary Care/BH pilot integration initiatives, funded by SAMHSA and the Department of Mental Health and Addiction Services (DMHAS), integrate medical, psychiatric and substance abuse treatment, including co-location of services in local mental health agencies.

Several Connecticut entities received federal Care Transitions grants in support of collaborative efforts to identify best practices, enter care coordination agreements and reduce barriers associated with stable re-entry to the community following hospitalization or a rehabilitative stay in a nursing facility. Two Connecticut ACOs have already been recognized for

participation under the Medicare Shared Savings Initiative, and several more are actively under development.

Finally, Connecticut has submitted an application under the federal Demonstration to Integrate Care for Dually Eligible Individuals. The Connecticut proposal seeks to integrate Medicare and Medicaid long-term care, medical and behavioral services and supports, promote practice transformation, and create pathways for information sharing through key strategies including: 1) data integration and state of the art information technology and analytics; 2) Intensive Care Management (ICM) and care coordination in support of effective management of co-morbid chronic disease; 3) expanded access for MMEs to Person Centered Medical Home (PCMH) primary care; and 4) a payment structure that will align financial incentives (advance payments related to costs of care coordination and supplemental services, as well as performance payments) to promote value. The MME initiative will create new, multi-disciplinary provider arrangements called “Health Neighborhoods” through which providers will be linked through care coordination contracts and electronic means.

Payer Initiatives: Connecticut has implemented a number of promising payer initiatives in support of use of common performance metrics, payment reform, re-balancing of long-term care resources and liberalization of elements of the roles of members of the care team.

PCMH performance metrics includes a striking accomplishment by the employee health plan and Medicaid in which they have implemented common performance measures to evaluate primary care providers for achievement of health and consumer satisfaction outcomes.

PCMH payment reforms, associated with the above, in which both the state employee and Medicaid PCMH initiatives have adopted similar means of making performance payments to providers that achieve specified benchmarks on performance measures.

Long-term care rebalancing, demonstrated by Connecticut's Money Follows the Person (MFP) initiative that has led efforts toward systems change in long-term services and supports. In addition to its work in having transitioned over 1,000 individuals from nursing facilities to the community, Connecticut is implementing diverse strategies that support reform. The Governor has publicly committed to a significant expansion in the target for individuals transitioned, and ongoing, MFP will also 1) support nursing facilities in diversifying their services to include home and community-based services, through \$21 million in grants; 2) assist in effective discharge of hospitalized patients to home and community-based services through an expedited Medicaid eligibility determination process and a uniform web-based discharge tool; and 3) promote continuous quality improvement efforts across the care continuum.

Liberalization of aspects of roles of care team. In 2012, the Connecticut legislature enacted a public act that permits registered nurses to delegate administration of non-injectable medications to trained home health aides and personal care assistants. This act represents the collaborative work of a broad range of state agencies and stakeholders, led by the DSS Money Follows the Person initiative, and further flexibility for consumers as well as mindfulness about cost. Further, several of Connecticut's Medicaid home and community-based waivers are promoting the use of self-directed care through personal care assistants and support by fiscal intermediaries.

Consumer Initiatives: Illustrated by Connecticut expanding access to Medicaid coverage, the State has supported consumers in informed decision-making, and implementing innovative, value-based means of incenting and promoting consumer engagement in healthy behaviors.

Expansion of health insurance coverage for low-income individuals. Retroactive to April 1, 2010, Connecticut became the first state in the country to receive approval from the Centers

for Medicare and Medicaid Services (CMS) to cover a new eligibility group in Medicaid. This coverage, which is called Medicaid for Low-Income Adults, picks up individuals and couples who are over age 18 and under age 65, ineligible for coverage under Medicaid, Medicare and or CHIP, not covered by other health insurance, and whose incomes are no greater than 56% of the Federal Poverty Level (FPL). Additionally, Connecticut implemented new Affordable Care Act family planning coverage effective May, 2012.

Efforts to engage consumers in informed decision-making. Efforts to support consumers in self-directed decision-making about health care coverage include Connecticut's Office of the Healthcare Advocate (OHA), whose mission is, in part, to educate consumers about their rights under healthcare programs and to assist consumers with enrollment in health plans. (OHA is Connecticut's consumer assistance program under the Affordable Care Act.) The CHOICES program and Aging & Disability Resource Centers (ADRCs) also provide consumer assistance. Both work with older adults and individuals with disabilities to provide neutral, objective information about Medicare, Medigap, as well as supporting consumers with long-term care options counseling.

Value-based design to incent and promote consumer behavior. Connecticut's efforts to incentivize consumers' engagement in their own health include 1) the State employee health plan Health Enhancement Program (HEP); 2) the federally-funded Rewards to Quit initiative; 3) community-based prevention programs led by the Department of Public Health; and 4) chronic disease self-management education activities by the Medicaid medical ASO. The state employees' HEP represents a substantial commitment to improve patient engagement by providing strong incentives for obtaining preventive services and managing chronic conditions. HEP requires all participants to seek age-appropriate physicals and screenings and mandates that

participants with five identified conditions (asthma/COPD, diabetes, heart failure, hyperlipidemia and hypertension) participate in disease counseling and education programs. As of October 2011, 51,500 or 98% of active state employees enrolled in HEP. Under HEP 1) participants qualify for reduced premiums; and 2) those diagnosed with a chronic condition obtain a) reduced co-pays for condition-related medications and physician visits and b) an annual cash payment for participating in the condition counseling programs. HEP is expected to significantly influence participants' engagement with their physicians through more regular contact and enhanced care and counseling for chronic conditions and to positively influence health outcomes and ultimately to reduce costs through early identification of acute and chronic conditions.

The Department of Social Services is the recipient of a large federal grant in support of tobacco cessation activities. The "Rewards to Quit" program will partner with Federally Qualified Health Centers (FQHCs) and primary care practices to provide education, monitoring and incentives to beneficiaries in support of tobacco cessation.

Connecticut's consumer engagement efforts are supported by a Community Transformation Grant (CTG) that promotes healthy living in five rural counties emphasizing reducing disparities through policy, system and environmental changes. Programs aimed at personal behavior change include tobacco and substance abuse prevention and cessation, active living, injury prevention, pregnancy prevention, diabetes prevention, school-based healthy eating programs, and disease self-management for chronic conditions such as asthma and diabetes. Additional initiatives encourage screening and risk reduction, such as patient navigators to promote cancer screening, hypertension and cholesterol screening, enhanced HIV testing, and breast and cervical cancer screening. The State has also been engaged in infrastructure projects to expand laboratory and

immunization capacity. Connecticut has aligned activities with national efforts, including Healthy People 2020 (HP2020), the National Prevention Strategy and the National Quality Strategy, with formal assessment activities as part of the Department of Public Health's strategic planning. While engaging in efforts to promote wellness and prevention for all residents, Connecticut recognizes that there are health disparities within the population that require evidence-based interventions to advance health equity. DPH is taking steps to improve socio-demographic data and has also initiated interventions aimed at traditionally underinsured and high-risk populations.

Finally, the Medicaid medical ASO has built a substantial component of chronic disease self-education into its Intensive Care Management (ICM) program. ICM protocols, motivational interviewing training, goal-setting, scripts and supporting materials enable care managers to tailor their approach to individuals' unique health profiles.

In combination, Connecticut's substantial work to date sets a firm foundation for our work ahead in creating a collaborative plan for the future of our state's health care system. With CMS's financial and technical assistance at hand, we are ready to take our next steps into a concerted, organized and inclusive design planning process.

Design Process: Payment and service delivery models; policy levers and strategies.

Connecticut's process of developing its model design will be guided by the Institute of Medicine's essential principles for successful integration of primary care and public health: shared goal of population health improvement; community engagement in defining and addressing population health needs; aligned leadership; sustainability including shared infrastructure; and sharing and collaborative use of data and analytics. Consistent with these principles, Connecticut proposes to build upon the diverse elements of its current initiatives by

expanding them across payers, bringing them to scale among populations, and evaluating their effectiveness in achieving outcomes over time. Our project will concurrently examine payment models and care delivery models while developing the baselines and benchmarking information needed for an overall plan. We envision that our concurrent efforts will create a multi-faceted “change agenda” that focuses on payment models to drive change through aligned financial incentives and service delivery innovations that build effective care structures. These two major streams -- Payment and Service Delivery Models -- are described as follows:

Payment models:

Connecticut expects to focus upon the following elements for payment reform: 1) collaboration across public and private payers to promote greater consistency on quality and other performance metrics and reporting that will support broad-based development of person-centered advanced primary care practice; 2) financial support for integration of care across disciplines; 3) promotion of greater alignment on payment and contracting strategies that incentivize value over volume; and 4) harmonization of Medicaid’s reimbursement policies with those of other payers.

Performance Metrics and Reporting to Promote Advanced Primary Care. Connecticut’s current payment reform efforts have focused upon common use of performance payments associated with the State employee health plan and Medicaid PCMH initiatives that reward for value by establishing benchmarks of achievement on metrics associated with health outcomes and care experience. There is great value in having more consistent metrics that can more easily be acted upon by providers, and can serve as the basis for performance payments that incentivize quality care and service. Building upon current efforts, Connecticut has engaged the major commercial insurers to work with the state to promote consistent metrics as part of the planning process.

Financial support for integration of care across disciplines. Connecticut will seek to expand upon its plans under the Demonstration to Integrate Care for Dual Eligible Individuals by exploring other means of financing integration of care across disciplines. A notable example of potential means of doing so is Affordable Care Act health home funding.

Greater alignment on payment approaches. Payment policies must move away from strict fee-for-service methodologies and toward value based purchasing. Therefore, simultaneously, Connecticut will work with private and public payers to promote greater alignment on payment and contracting policies that incentivize providers to be more effective and efficient. The major commercial payers as well as the State Employee Health Plan and Medicaid have agreed to work together on the development of more consistent approaches. We expect that various models will inform our discussions, including the federal Shared Savings Program (premised on sharing Medicare savings), and proposed shared savings-related performance payments associated with the Demonstration to Integrate Care for Dually Eligible Individuals (premised on sharing Medicare savings, net of any increase in Medicaid).

Harmonization of Medicaid's payment policies with those of other payers. In light of the significant expansion in Medicaid eligibility that will occur in 2014, Connecticut expects to assess, evaluate and harmonize Medicaid's payment policies with those of other payers to create a roadmap for implementation. At present, Connecticut is one of only five states with a Medicaid program providing payment on a "target rate settlement" approach. Inpatient hospital claims are reimbursed on a per discharge basis, with no variation for length of stay or complexity. Outpatient hospital reimbursement is equally outdated, as some claims are paid based upon a partial cost-to-charges ratio, while others according to a partial fee schedule. Neither outpatient nor inpatient charges are based upon Diagnosis Related Group or Ambulatory Payment

Classifications. Medicaid generally reimburses physicians at less than 50 percent of Medicare rates. The design process will examine payment methods and payment levels as well as supplemental payments to ensure that Medicaid reimbursement policies are transparent and pay for quality, cost-effective care.

Building the Model Testing Financial Plan: Statistical and actuarial models will estimate the effects that proposed initiatives would have on utilization of health care for our state's various populations by attributing behavioral changes that affect utilization and/or intensity of care for various health conditions. The models will estimate the resulting changes for each segment of the population in the short term (1-2 years), mid-term (3-5 years) and longer term (6-10 years). These forecasts will be compared with results that would be expected without the initiatives. After adjusting for the costs associated with implementing these programs, the projected savings and the projected impacts will help guide our decisions on implementing payment and delivery system reforms.

Service delivery models: Connecticut expects to focus upon the following elements for reform of service delivery: 1) promotion of integrated care models; 2) implementation of means through which utilization data can be shared with providers and consumers; 3) use of the Health Insurance Exchange to inform and connect consumers to health insurance coverage; 4) means of expanding the supply of primary care physicians and other professionals; and 5) engagement among regulators, providers and consumers to examine practice acts in support of best use of the members of the care team.

Promotion of integrated care models: Connecticut will lead by example through existing models under which medical, behavioral health, long-term services and supports and community resources are integrated in support of multi-disciplinary, consumer-directed care planning.

Specifically, Connecticut will review means by which to integrate disciplines through a collaborative learning approach, means of connecting providers through common electronic portals, and incentives for collaboration. Further, as noted above, Connecticut will promote the use of common performance metrics, and to further the practice of developing measures to assess the success of coordinating care in transitions between primary care providers and specialists, and across care settings.

Implementation of means through which utilization data can be shared with providers and consumers. In 2012, the Connecticut legislature authorized the creation of an All-Payer Claims Database (APCD), which is expected to be operational on January 1, 2014. The Office of Health Reform & Innovation created and led a team comprised of all six of the State's major private insurers, who worked collaboratively with other state government leaders and a broad range of other stakeholders in initial planning and development activities. The APCD is anticipated to be the primary vehicle through which data will be shared 1) with providers, in support of improving practice and toward performance incentives; and 2) with consumers, in support of dissemination of information on health care costs that will permit consumers to make informed choices among providers.

Use of the Health Insurance Exchange to inform and connect consumers to health insurance coverage. Connecticut was among the first states to commit to the establishment of a Health Insurance Exchange. The Exchange was awarded a \$107 million Level II Establishment Grant to implement critical aspects of its work. Connecticut expects that when the Exchange is fully implemented it will support consumers in electing and accessing health insurance. In support of this, the Exchange has adopted principles that include emphasis on providing meaningful choice of high value plans; allowing consumers to access to high quality, diverse

networks, including providers with experience and capability in serving underserved populations and regions; and encouraging development of innovative products, including wellness promotion.

Implementing means of expanding the supply of primary care providers. Connecticut plans to engage physicians, academic centers and the medical schools to co-lead efforts to design a multi-faceted strategy to attract and train primary care providers who are equipped to practice within a person-centered, team-based model of primary care. This PCP may be a family practice physician, pediatrician, internist, a mid-level practitioner, or, for certain chronically ill individuals, a specialist, including mental health professional.

Engagement among regulators, providers and consumers to examine practice acts in support of best use of the members of the care team. Connecticut's Department of Public Health will bring together various provider associations (including, but not limited to, the Connecticut State Medical Society, the Connecticut Association of Home Care and Hospice, the Association of Health Care Facilities, AHEC (Area Health Education Center) and the Association of Homemaker-Companions), the practice boards, Federally Qualified Health Centers, community-based organizations and consumers to review the roles of various members of the care team (PCP, nurse, extenders, direct care staff, community health workers) and to examine means of conforming regulations to adapt practice to best meet the needs of consumers/patients. Further, Connecticut seeks to examine best practices from other states toward developing/adapting curricula for an effective mid-level professional Community Health Worker training and certification program.

Policy levers: Connecticut expects to use the following policy levers in support of reform: 1) forums including the Governor's Health Care Cabinet and the Health Insurance Exchange; 2)

leadership by the Office of Health Reform and Innovation, in partnership with the various state agencies that are charged with implementing elements of the Affordable Care Act; 3) regulatory authority of the Departments of Public Health and Insurance; 4) Medicaid oversight by the Department of Social Services; and 5) the purchasing power of the State employee health plan and Medicaid.

B. Stakeholders

The chart below illustrates the range of stakeholders involved in the SIM application process, those that provided letters of support expressing their commitment to the SIM planning process, and those Connecticut intends to engage as it moves forward with this initiative. Within the Executive Branch, the administration plans to coordinate the proposed effort across state agencies in order to employ all potential levers to effect maximal change. Furthermore, by engaging leadership at all levels, we intend to align federal policy and state legislative priorities and directives to optimize the impact of the State Plan.

Given that multi-payer collaboration and engagement is a priority and key to the achievement of system-wide change, public and private payers have been engaged in the development of this application and proposed project. In addition, consumer advocates and community organizations have been brought into our discussions to ensure they have opportunity to influence the creation of an effective patient/person-centered care system that improves health through high quality care, enhances access to services, and reduces social and economic barriers.

The participation of both individual and group practice providers representing the broad spectrum of practice levels, and specialty areas, is critical to developing new approaches to care delivery that are grounded in a value-based system that meets the needs of the community. The addition of large and small employers as partners in this effort will ensure the models we

create/adapt/test will have broad applicability to the companies and their employees. The large employers, which are mainly self-insured and often operate in diverse markets and settings, will provide a broad, more national perspective. Finally, we will partner with and draw from the State’s rich academic and research communities to take advantage of the best thinking in the public health, medical, pharmacy, and research sectors.

Figure 1: Stakeholder Participant Chart

Stakeholder Participant Chart: Involved in Application, Provided Letter, To Engage		
Involved in Application	Provided Letters of Support	To Engage
Government		
<ul style="list-style-type: none"> - Governor’s Office - Lt Governor’s Office - Dept. of Mental Health & Addiction Services - Dept. of Public Health - Dept. of Social Services - Health Insurance Exchange - Insurance Dept. - Office of Health Reform & Innovation - Office of Policy & Management - Office of the Healthcare Advocate - Office of the State Comptroller 	<ul style="list-style-type: none"> - Health Insurance Exchange - Department of Insurance - Department of Children and Families - Department Developmental Services - Dept. of Mental Health and Addiction Services - Dept. of Public Health - Dept. of Social Services - Office of the Healthcare Advocate - Office of the State Comptroller 	<ul style="list-style-type: none"> - CT Congressional Delegation - Local/Municipal Leaders
Public and Private Payers		
<ul style="list-style-type: none"> - CT Association of Health Plans - Aetna - Anthem BlueCross & BlueShield - CIGNA - ConnectiCare - United Health Group - WellCare 	<ul style="list-style-type: none"> - Aetna - Anthem BlueCross & BlueShield - CIGNA - ConnectiCare - United Health Group - WellCare 	<ul style="list-style-type: none"> - Other Payers and Third Party Administrators such as Medicaid Administrative Services Organization
Community and Consumer Organizations		
<ul style="list-style-type: none"> - CT Voices for Children 	<ul style="list-style-type: none"> - Christian Community Action - Community Health Center Association of CT 	<ul style="list-style-type: none"> - Community health organizations - Consumer organizations

III. Project Narrative

Involved in Application	Provided Letters of Support	To Engage
	<ul style="list-style-type: none"> - CT Association for - Community Action - CT Association of Nonprofits - CT Health Foundation - CT Voices for Children - Donahue Foundation - Interfaith Fellowship for - Universal Health Care - Latino Community Services - Mashantucket Pequot Tribe - MATCH Coalition Inc. - Mohegan Tribe - United Way of CT - Universal Health Care Foundation of CT 	<ul style="list-style-type: none"> - Community Action Agencies - Behavioral Health community organizations, such as National Alliance on Mental Illness of CT - Housing and Homeless organizations such as the CT Coalition to End Homelessness and Shelters and housing assistance programs, such as the Columbus House - Religious Institutions - Children’s Organizations - Organizations on Aging such as the CT Association of Area Agencies on Aging - Legal Assistance such as the GHLA - Chronic Illness Organizations
Providers and Provider Associations		
<ul style="list-style-type: none"> - CT Hospital Association - CT State Medical Society - Community Health Center Association of CT - Cornell Scott – Hill Health Center 	<ul style="list-style-type: none"> - CT Center for Primary Care - CT Children’s Medical Center - CT Hospital Association - CT State Medical Society - Primary Care Coalition of CT - Hartford Healthcare - Yale New Haven Health 	<ul style="list-style-type: none"> - State organizations for medical providers, including physicians and nurses. - State medical specialty societies, including primary care, family medicine, mental health, dentistry, and pharmacy. - Community provider associations, including school-based clinics, FQHCs, hospice, and nursing homes. - Community substance abuse and mental health centers, such as the Chrysalis Center
Employers and Business Sector		
<ul style="list-style-type: none"> - State Employees Health Plan 	<ul style="list-style-type: none"> - CT Business Group on Health 	<ul style="list-style-type: none"> - Employers and

Involved in Application	Provided Letters of Support	To Engage
	- CT Coalition of Taft-Hartley Health Funds	Employer Organizations such as United Technologies Corporation GE, Small Business for Healthy CT
Education and Research Organizations/Institutions		
	- University of Ct – School of Pharmacy - Yale School of Nursing - Yale University	- University of CT - Quinnipiac College - Saint Joseph College

C. Public and Private Payer Participation

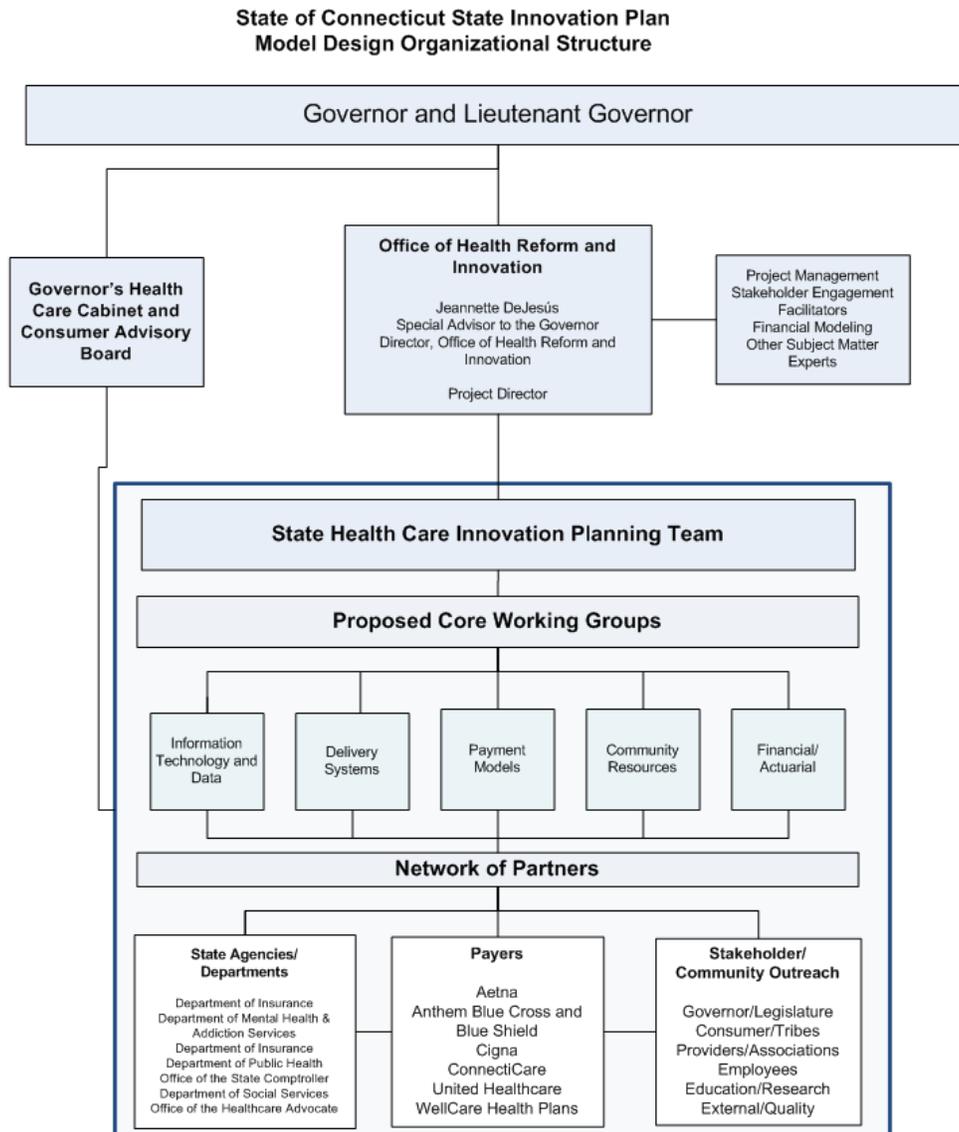
Recognizing the importance of multi-payer collaboration in achieving broad-based systems change, the Lieutenant Governor personally invited senior leaders from the key insurance companies in Connecticut (Aetna, Anthem Blue Cross & Blue Shield, CIGNA, ConnectiCare, United Health Care and WellCare) to participate in the model design effort. Together these companies cover the vast majority of the commercially insured population. Each of the companies has committed to work with the Office of Health Reform & Innovation to advance greater alignment on contracting and payment strategies that promote value over volume and greater consistency in quality and other performance metrics in support of expanded primary care. Each payer has designated a senior-level individual with responsibility for alternative payment strategies to participate in the application and planning process. In addition, if Connecticut’s application is successful they are committed to assigning additional staff and resources to the initiative. Like DSS and OSC, the private payers have been examining ways to provide support for practice-level care management activities and reimbursement strategies that support and incentivize quality and cost effective care. The Commissioner of the Department of Social Services, the interim Director of the state’s Medicaid Program and the Director of the State Employee Health Plan have served as key participants in the application process and will

continue to be involved in the model design process. Aligning incentives to advance our vision for a healthier Connecticut will require a complex set of conversations that will build upon efforts already underway in Connecticut as well as lessons learned by the national carriers in other states. We are confident that we have assembled the right mix of individuals, organizations, content expertise and experience to undertake a planning process that will result in an actionable plan. In achieving our goals, we will also benefit from the perspectives that the payers, most of which have large national workforces, bring as employers.

D. Project Organization

In September 2011, Governor Malloy convened the Connecticut Health Care Cabinet (The Cabinet) to advise on federal health reform implementation. Chaired by Lt. Governor Nancy Wyman, the Cabinet established operating principles that embrace improving the health care of all residents; promote equity in delivery and access; leverage the expertise in the public and private sectors; enhance transparency; and ensure consideration of a broad cross section of viewpoints. The Cabinet established work groups to address access, quality, cost, affordability of care, and technology needs. Separately, a Consumer Advisory Board was established by the legislature to ensure that the interests and needs of the consumer are represented in the programs and policies that are developed and implemented under health reform. For the proposed initiative, the Governor will appoint a State Healthcare Innovation Planning Team (Planning Team) comprised of state agency heads, consumers, payers, leaders from the provider community, and other stakeholders, to provide overall leadership and oversight of the planning process. The Cabinet and the Consumer Advisory Board will provide guidance and advice to the Planning Team.

The SIM Model Design and planning process will be directed and coordinated by the Office of Health Reform & Innovation (OHRI), an entity within the Lt. Governor’s Office, creating a clear line of authority and communication for the Model Design Process. In addition, OHRI Director Jeannette DeJesús is the Special Advisor to the Governor on Health Reform and as such reports directly to him and the Lt. Governor. She will coordinate all activities of the Planning Team and consultants, leveraging her previous experience as VP of the Connecticut Hospital Association and as President and CEO of the Hispanic Health Council.



As described in the SIM Model Design Work Plan section, the Planning Team will convene and be supported by five core working groups. In staffing the project, OHRI will benefit from the expertise of the academic, research and health care communities in Connecticut and will also engage national experts to assist on various aspects of the plan. As part of the state's in-kind contribution to the Model Design process, OHRI will provide office space and telecommunications support through conference call lines and technical assistance through multiple state agencies (OPM, BEST, DAS).

E. Provider Engagement

Given that providers are where “the rubber meets the road” in care delivery, their participation and input is critical in achieving Connecticut’s vision. While we can incentivize providers based on lowering costs and improving quality, these efforts will only prove successful with technical support, accurate and timely data analytics, electronic medical records, clinical support, shared learning opportunities, and access to evidence based practice. Key to avoiding burnout and allowing practitioners sufficient time to focus on patient needs is staffing practices adequately. While primary care practitioners are at the heart of many of the initiatives we have outlined, all providers play an important role in prevention and patient care. We share our providers’ concerns about building a qualified workforce capable of meeting Connecticut’s growing future health care needs.

Many provider groups offered letters in support of the Governor’s health reform efforts and this application, demonstrating their commitment to system transformation and willingness to participate in the initiatives outlined in this application. Our planning process will include providers who care for residents in facilities, hospitals, medical offices, community health

centers, behavioral health clinics, homes, or other community-based settings. The Planning Team's early efforts will draw on Connecticut's demonstrated success involving providers in innovative strategies, such as physician group transformation; alternative sites for non-urgent care; and programs supporting independent community living.

IV. SIM Project Plan and Timeline

At the outset of the project, the Governor’s Health Care Cabinet, Consumer Advisory Board and Planning Team will review the proposed 6-month work plan to make certain it demonstrates a clear path for our planning process. Through a collaborative process, we will: review critical milestones; create tracking and reporting mechanisms; identify deliverables; and create a management plan to serve as the “principal” planning document for monitoring the SIM process from start to finish. As an initial step, the Planning Team will conduct an in-depth review of state initiatives to explore questions such as: Where are we now? What is working? What are our levers? What are the short and long term options for filling the gaps we identify? What are the specific barriers to accomplishing our transformation even with all the levers at our disposal? How will we measure progress and success of our initiatives? Where do we want to be in two, five and ten years?

The Planning Team will gather data and conduct a high-level assessment via listening sessions across the state and a review of Connecticut’s current state and gaps via surveys and listening sessions with a cross-section of representative groups; two strategy sessions will be conducted with agency heads, providers, and payers in order to provide input into the strategic focus of delivery and payment system design and alignment.

The Planning Team will convene five working groups to assist in this comprehensive planning process:

- **Delivery Systems Working Group** will explore and make recommendations about payment reform and service delivery options that will enable Connecticut to provide the right care at the right time in the right place.

- **Information Technology and Data Working Group** will assess capability within communities; assess access to technology for specific populations; and review FQHC capability for EHR and other community based provider technologies to support payment reform.
- **Payment Models Working Group** will work cooperatively with payers and others to examine current models; identify additional models and best practices for potential testing, and determine the process and structures needed to support them.
- **Community Resources Working Group** will develop a comprehensive outreach strategy for conducting interviews and focus groups, and will seek guidance and insight from stakeholders on program innovation readiness and perceived strengths, weaknesses, opportunities and challenges.
- **Financial/Actuarial Working Group** will model the effects of Medicaid modernization options and conduct financial and actuarial analyses of short and long term potential impacts and interactions of selected models.
- **Legislative/Regulatory Working Group** will conduct a high-level assessment of legislative and regulatory statutes, such as scope of practice and other laws that may impede implementation of delivery and payment reforms.

At the conclusion of our planning process, we will have a roadmap with models to test that reflects our goal to create a highly coordinated and integrated health care delivery system that is supported by payment structures that are innovative, reward value over volume, are person/patient centered, lower costs and are economically sustainable over time. We will emerge with a clear role to provide leadership and innovative direction to ensure that our health reform efforts are grounded in the principals of health equity and that all CT residents have access to

team based advanced primary care.

Figure 3: Proposed Project Work Plan and Timeline –December 2012 – June 2013

Key Activity/Task	Dec	Jan	Feb	Mar	Apr	May	June
Model Design Cooperative Agreement Signed							
Subject matter experts/consultants in place							
SIM Planning Team High Level Agendas							
Meeting 1: Approve Work Plan; establish Working Groups (WG)							
Working Groups Meetings (WGM)1							
Planning Team Meeting 2: Strengths and Challenges							
WGM 2							
Planning Team Meeting 3: Promising Options							
WGM 3							
Planning Team Meeting 4: Model Selection							
WGM 4							
Planning Team Meeting 5: Financial Modeling							
WGM 5							
Planning Team Meeting 6: Review Roadmap & Operational Plan							
Consultant Deliverables (examples)							
Where we are now							
Other states' innovation experience and levers							
Quantifying CT goals and measuring progress							
Implementation timeline/milestones							
Draft Roadmap & Operational Plan							
Financial Modeling							
Current costs and trends							
Effects/Impacts of selected models							
Review against State goals							
Stakeholder and Public Meetings							
Interviews/ Focus Groups							
Strategy Session (s)							
Progress Report							
Joint Cabinet/Advisory Board Public Meeting/ Presenting and Confirming the Plan							
Deliver SHIP-Roadmap, Models to CMS							