The Connecticut State Innovation Model

October 1, 2014
# Connecticut Participants

<table>
<thead>
<tr>
<th>Nancy Wyman</th>
<th>Patricia Checko</th>
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<tbody>
<tr>
<td>Lieutenant Governor</td>
<td>SIM Consumer Advisory Board</td>
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<tr>
<td>Roderick L. Bremby</td>
<td>Paul Cleary</td>
</tr>
<tr>
<td>Department of Social Services</td>
<td>Yale School of Public Health</td>
</tr>
<tr>
<td>Jewel Mullen</td>
<td>Jill Hummel</td>
</tr>
<tr>
<td>Department of Public Health</td>
<td>Anthem Blue Cross and Blue Shield</td>
</tr>
<tr>
<td>Mark Schaefer</td>
<td>Suzanne Lagarde</td>
</tr>
<tr>
<td>Director of Healthcare Innovation</td>
<td>Fair Haven Community Health Center</td>
</tr>
<tr>
<td>Victoria Veltri</td>
<td>Katharine K. Lewis</td>
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<tr>
<td>State Healthcare Advocate</td>
<td>Department of Public Health</td>
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<tr>
<td>Robert Aseltine</td>
<td>Kate McEvoy</td>
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<tr>
<td>UConn Health Center</td>
<td>Department of Social Services</td>
</tr>
<tr>
<td>Mary Bradley</td>
<td>Robert McLean</td>
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<tr>
<td>Pitney Bowes</td>
<td>Connecticut Medical Group</td>
</tr>
<tr>
<td>Patrick Charmel</td>
<td>Michael Michaud</td>
</tr>
<tr>
<td>Griffin Hospital</td>
<td>Dept. of Mental Health &amp; Addiction Services</td>
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## Connecticut Participants

<table>
<thead>
<tr>
<th>Name</th>
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<tr>
<td>Ron Preston</td>
<td>UConn Health Center</td>
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<tr>
<td>Marie Smith</td>
<td>UConn School of Pharmacy</td>
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<tr>
<td>Robin Lamott Sparks</td>
<td>Bridgeport Child Advocacy Coalition</td>
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<tr>
<td>Kristin Sullivan</td>
<td>Department of Public Health</td>
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<tr>
<td>Minakshi Tikoo</td>
<td>State Health IT Coordinator</td>
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<tr>
<td>Thomas Woodruff</td>
<td>Office of the State Comptroller</td>
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Vision

Establish a whole-person-centered healthcare system that improves population health and eliminates health inequities; ensures superior access, quality, and care experience; empowers individuals to actively participate in their healthcare; and improves affordability by reducing healthcare costs.
Vision

Establish a whole-person-centered healthcare system that improves population health and eliminates health inequities; ensures superior access, quality, and care experience; empowers individuals to actively participate in their healthcare; and improves affordability by reducing healthcare costs.
## Today’s Agenda

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<td>Commissioner Mullen</td>
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<td>Population health plan</td>
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<td>Mark Schaefer</td>
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<tr>
<td>Payment reform: Alignment with Medicare SSP</td>
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<tr>
<td>Tom Woodruff</td>
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<td>Value-based Insurance Design</td>
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<td>Commissioner Bremby</td>
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<td>Health Information Technology</td>
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<th>Targeted Initiatives</th>
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<tr>
<td>Kate McEvoy</td>
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<tr>
<td>Medicaid Quality Improvement &amp; Shared Savings Program</td>
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<td>Mark Schaefer</td>
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<tr>
<td>Primary Care Transformation</td>
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<tr>
<td>• Advanced Medical Home Glide Path</td>
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<tr>
<td>• Community and Clinical Integration Program</td>
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<tr>
<td>Governance</td>
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<td>Why Connecticut?</td>
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Statewide Initiatives
Improved Population Health
Population Health Improvement Pathway

**ASSETS**

- **Plans:**
  - Healthy CT 2020
  - SHA
  - SHIP
  - Chronic Disease Plan

- **Partners**
  - Healthy CT Coalition
    - (150+ members)

- **Data**
  - BRFSS, Mortality
  - Hospital /ED discharge
  - CHNA’s
  - Performance Dashboard

**ACTIVITIES**

- **Pop Health Planning**
  - Enhance existing coalition (payers, non-traditional)
  - Focus on SDH and Equity
  - Identify State priority conditions
  - Identify barriers
  - Identify Interventions
  - Design and develop PSC and HECs
  - Make recommendations to PMO and councils for integrating efforts

- **Enhanced Data Collection/Analysis**
  - BRFSS oversampling
  - Integrating CHNA’s
  - Small Area Estimation
  - Expand reportable conditions

**VEHICLES**

- **Prevention Service Centers (PSC)**

- **Health Enhancement Communities (HEC)**

- **Other Mechanisms**
  - Coalitions and Partnerships

**VEHICLES**

- **Community Integrated Health Systems (Health System 3.0)**

**VEHICLES**

- **Improved Pop Health**

- **Reduced Disparity**
  - (Triple Aim)
## Improved Population Health

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Healthy CT 2020 Target</th>
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<tbody>
<tr>
<td><strong>Diabetes: undiagnosed Type II</strong></td>
<td></td>
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<tr>
<td>Connecticut overall</td>
<td>93,000</td>
<td>88,350</td>
</tr>
<tr>
<td><strong>Smoking Rates</strong></td>
<td></td>
<td></td>
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<tr>
<td>Students in grades 6-8</td>
<td>2.9%</td>
<td>2.2%</td>
</tr>
<tr>
<td>Students in grades 9 - 12</td>
<td>14.0</td>
<td>10.5%</td>
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<tr>
<td><strong>Obesity Rates</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults 18 years of age and older</td>
<td>25.6%</td>
<td>24.3%</td>
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Payment Reform
Value-Based Payment

• SIM design process spurred a multi-payer commitment to value-based payment

• Accelerated the organization of providers to accept accountability for quality and total cost of care

• Under our model test grant, payers further committed to alignment with the Medicare Shared Savings Program (SSP)
Value-Based Payment

• Today, 13 major provider organizations are participating in the Medicare SSP as ACOs, what we refer to as *Advanced Networks*

• Three additional Advanced Networks will participate by January 2015

• Connecticut State Medical Society established an ACO option for *independent physicians*

• The ACO structure is becoming the *default standard* in Connecticut
Value-Based Payment

• Federally Qualified Health Centers are seeking opportunities to assume accountability for quality and total cost of care

• Medicaid’s participation, combined with SIM funded technical assistance, will enable FQHCs to develop these capabilities

• And it will enable Advanced Networks to achieve a predominance of SSP arrangements
Opportunities for Alignment with Medicare SSP

- Conditions of participation
- Governance
- Leadership and management structure
- Program integrity & compliance plan
- Marketing, beneficiary information & notification
- Quality Measures
- Shared savings methodology
Quality Measure Alignment

• Improve efficiency, reduce complexity
• Improve focus, support quality improvement
• Make care experience matter
• Measure and reward health equity gains
Quality Council

• Maximize alignment with the Medicare Shared Savings Program ACO measure set

• Add measures to address:
  – Gaps, e.g., pediatrics, reproductive health
  – Areas of emphasis such as behavioral health, health equity, and care experience.

• Wherever possible, draw from established measures

• Accelerate migration to outcome-based measures

• Commitment to transparency
## Shared Savings Program

### Participation Projections

<table>
<thead>
<tr>
<th>Year</th>
<th>Beneficiaries</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>1,305,000</td>
<td>38%</td>
</tr>
<tr>
<td>2017</td>
<td>1,745,000</td>
<td>50%</td>
</tr>
<tr>
<td>2018</td>
<td>2,270,000</td>
<td>64%</td>
</tr>
<tr>
<td>2019</td>
<td>2,596,000</td>
<td>73%</td>
</tr>
<tr>
<td>2020</td>
<td>3,117,000</td>
<td>88%</td>
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</tbody>
</table>
Value-Based Insurance Design
Value-Based Insurance Design

• Value-based payment most effective when paired with an insurance design that rewards positive health behavior
  – Self-management of chronic conditions
  – Participation in preventative services
  – Healthy lifestyle
Value-Based Insurance Design

**Goals**

Develop prototype VBID plan designs that align supply and demand while enabling streamlined administration

Provide a mechanism for employers to share best practices to accelerate the adoption of VBID plans
Value-Based Insurance Design

Key Partners

- Connecticut Business and Industry Association
- Connecticut Business Group on Health
- Northeast Business Group on Health
- Office of the State Comptroller (state employee health plan)
Value-Based Insurance Design Plan Components

- Establish employer-led consortium with core interest sub-groups (e.g. clinical, wellness, administration) and linkages to regional and national forums such as CMMI’s VBID learning cluster to enable peer-to-peer sharing of best practices.
- Develop VBID template(s) and implementation toolkits;
- Convene an annual learning collaborative, including panel discussions with nationally recognized experts and technical assistance; and
- Facilitate a workforce health outcomes pilot.
- Subject to board approval, Access Health CT will implement VBID in Year 2 of the Model Test.
# Value-Based Insurance Design Accountability Metrics

<table>
<thead>
<tr>
<th>Year</th>
<th>Percent adoption</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>44%*</td>
</tr>
<tr>
<td>2017</td>
<td>53%</td>
</tr>
<tr>
<td>2018</td>
<td>65%</td>
</tr>
<tr>
<td>2019</td>
<td>74%</td>
</tr>
<tr>
<td>2020</td>
<td>85%</td>
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*Estimate – will establish empirical baseline 2015
Health Information Technology
**Input/Resources**
- HIT Council
- Other SIM workgroups

**Proposed SIM HIT Assets**
- Direct Health Information
- Service provider
- Consent Registry
- Analytics - Edge Servers
- Disease Registries
- Personal Health Record

**Other HIT Assets**
- Provider Directory
- Enterprise Master Patient Index
- All payers claims data
- Integrated Eligibility System
- Care Analyzer (risk stratification tool used by Medicaid Medical ASO)
- Alert/notification Engine based on ADT feeds

**Activities**
- Meetings with Stakeholders

**HIT Interventions**

**Person-level**
- Personal Health Records/Patient portal to provide patient access to EHRs (Use Blue Button)
- Self-management programs
- Use of mobile technology

**System level**
- Identifying High-risk population using LACE Index/care analyzer
- Predicting readmissions using disease specific algorithms
- Monitoring system health through Performance Measures
- Data mining to identify patterns

**Provider Level**
- Alert Notification
- Community Support Resources
- Medication Reconciliation
- Care Coordination - Use of Secure messaging for document transport (Direct message)

**Outputs**

**Short-term**
- Increased capacity to process data
- Increased capacity to analyze integrated data
- Use of Standards for exchange of information
- Use of standard terminologies and vocabularies
- Harmonized systems and procedures

**Long-term Outcome**
- Published Results based on the domains and quality measures selected to demonstrate value. For example
  - Reduction in Hosp. readmission
  - Reduction in maternal depression
  - Increased Diabetes control
  - Enhanced rate of age-appropriate screenings

**Impact**
- Improvement in 2020 Population Health indicators
- Lower per capita costs
Health Information Technology

Direct Messaging

• Allow secure exchange of clinical documents, such as discharge summaries, orders, and continuity of care documents.

• Generate health alerts and reminders to improve care, especially for patients with chronic conditions.

• As of January 2015, most certified EHRs will be enabled with Direct Messaging.

• Model Test funds will be used to provide Direct Messaging addresses to providers that are not eligible for the CMS EHR incentive program, including behavioral health, long-term care, and home-health agencies.
Health Information Technology
Consent Registry

• Managing patient consent is a burden on providers and interferes with efficient and timely communication

• Consent registry can be queried to assess consumer consent status with respect to sharing of information

• State bond funds have already supported core procurement of the registry

• SIM funds will be used to further enhance the Consent Registry
Health Information Technology

**Analytics/Edge Server**

- DSS will create provider, organization, and state-level data reports enabled by edge-server based indexing technology that allows both large and small providers to access data and analytics equally, irrespective of resource constraints.

- These reports will provide actionable data to improve healthcare delivery interventions.

- Existing state bond funding and CMS funding will jointly support the license for this technology and development costs, which will be supplemented by Model Test funding in Years 3 and 4.
Health Information Technology

Disease Registry

• Disease Registries will be procured based on the population’s identified needs through crowd sourcing
Patient access to personal health record empowers them to be informed decision makers with their providers.

DSS is working with CMS to initiate a project to provide PHRs to all Medicaid beneficiaries.

Same PHR will be made available to commercial and Medicare beneficiaries who do not otherwise have access to a PHR.
Targeted Initiatives
Medicaid Quality Improvement and Shared Savings Program (MQIISSP)
Medicaid QISSP

Procurement

• DSS will procure FQHCs and Advanced Networks to participate in Medicaid QISSP

• Selection based on:
  – demonstrated commitment, experience and capacity to serve Medicaid beneficiaries;
  – ability to meet identified standards for clinical and community integration;
  – willingness to invest in special capabilities such as data analytics, quality measurement and rapid cycle improvement;
  – 5,000 attributed single-eligible Medicaid beneficiaries.
Medicaid QISSP Procurement

• Priority given to:
  
  – Participation in Medicare and commercial SSP arrangements to maximize multi-payer alignment,

  – Situated in areas of critical need in the state for the Medicaid population, as evidenced by disease burden, disparities and cost of care.
Medicaid QISSP
Planning & Oversight

• SIM related Medicaid planning integrated with longstanding Medicaid advisory structure

• Medical Assistance Program Oversight Council (MAPOC)
  – Care Management/PCMH committee will advise re: the development of Medicaid QISSP
  – SIM consumer advocates will participate
  – MAPOC representatives will be participate with SIM workgroups
Medicaid QISSP Protections

• Upside only SSP

• Implement only when reasonable and necessary methods for monitoring under-service are in place

• New patient advocate position in the Office of the Healthcare Advocate
Medicaid QISSP Implementation

• Two waves during the grant period
  – January 2016
  – January 2018

• Third wave projected 2020

• Estimate 200 to 215,000 beneficiaries in the first wave
# Medicaid QISSP Participation Projections

<table>
<thead>
<tr>
<th>Year</th>
<th>Beneficiaries</th>
<th>%</th>
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<tbody>
<tr>
<td>2016</td>
<td>205,000</td>
<td>30%</td>
</tr>
<tr>
<td>2017</td>
<td>210,000</td>
<td>30%</td>
</tr>
<tr>
<td>2018</td>
<td>429,000</td>
<td>60%</td>
</tr>
<tr>
<td>2019</td>
<td>439,000</td>
<td>61%</td>
</tr>
<tr>
<td>2020</td>
<td>636,000</td>
<td>89%</td>
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Primary Care Transformation
Advanced Medical Home Glide Path

*Building the Foundation*

- Practice transformation support
- Modeled after existing Medicaid Person Centered Medical Home (PCMH) Glide Path program
- Accountability for meeting milestones
- Targeted to practices affiliated with Advanced Networks
  - Offered more widely within available resources
- On-site validation
Advanced Medical Home Glide Path

• NCQA standards & recognition
  – Establish additional “must pass” elements or factors or consider “new” elements if they align with our vision, e.g., health equity analysis & quality improvement
  – Consider alignment with CPCI capabilities

• Learning Collaborative
  – open to PCPs, staff, and practice administrators to facilitate peer-to-peer learning and interdisciplinary networking for primary care transformation
<table>
<thead>
<tr>
<th>Year</th>
<th>Primary Care Practices</th>
<th>Target</th>
<th>Percentage</th>
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<tr>
<td>2015</td>
<td>Population N</td>
<td>500</td>
<td></td>
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<tr>
<td></td>
<td>1st Quarter</td>
<td>0</td>
<td>0%</td>
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<tr>
<td></td>
<td>2nd Quarter</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>3rd Quarter</td>
<td>50</td>
<td>10%</td>
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<tr>
<td></td>
<td>4th Quarter</td>
<td>100</td>
<td>20%</td>
</tr>
<tr>
<td>2016</td>
<td>Population N</td>
<td>500</td>
<td></td>
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<tr>
<td></td>
<td>1st Quarter</td>
<td>150</td>
<td>30%</td>
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<tr>
<td></td>
<td>2nd Quarter</td>
<td>250</td>
<td>50%</td>
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<tr>
<td></td>
<td>3rd Quarter</td>
<td>250</td>
<td>50%</td>
</tr>
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<td></td>
<td>4th Quarter</td>
<td>250</td>
<td>50%</td>
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<tr>
<td>2017</td>
<td>Population N</td>
<td>500</td>
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<td></td>
<td>1st Quarter</td>
<td>250</td>
<td>50%</td>
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<td></td>
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<tr>
<td></td>
<td>3rd Quarter</td>
<td>325</td>
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<td>4th Quarter</td>
<td>400</td>
<td>80%</td>
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<tr>
<td>2018</td>
<td>Population N</td>
<td>500</td>
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<td>1st Quarter</td>
<td>500</td>
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<td>3rd Quarter</td>
<td>500</td>
<td>100%</td>
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<td></td>
<td>4th Quarter</td>
<td>500</td>
<td>100%</td>
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Community and Clinical Integration

*Enabling the Enterprise*

- **Targeted Technical Assistance**
  - Focus on identified priority areas, opportunities for significant quality and/or cost improvement; **major emphasis** on building bridges to the community to address social determinants

- **Innovation Awards**
  - Competitive grant process will foster innovations that align with our vision and strategy. PMO will establish an Innovation Awards advisory committee to establish award criteria and processes.

- **Learning collaboratives**
  - Two dedicated collaboratives, one tailored to FQHCs and the other to Advanced Networks
Community and Clinical Integration

For participating Advanced Networks and FQHCs

1) integrating behavioral health and oral health,
2) providing medication therapy management services,
3) building dynamic clinical teams,
4) expanding e-consults between PCPs and specialists,
5) incorporating community health workers,
6) closing health equity gaps,
7) improving the care experience for vulnerable populations,
8) establishing community linkages
9) identifying “super utilizers” for community care teams
Community and Clinical Integration

Additional assistance areas for FQHCs

1) enhancing primary care provider/staff skills in quality improvement methods and analytics; and

2) producing actionable quality improvement reports.
SIM Governance Structure

Consumer Advisory Board (CAB) → Healthcare Innovation Steering Committee → Healthcare Cabinet (HCC)

Program Management Office (PMO)

Health Information Technology Council
Practice Transformation Task Force
Quality Council
Equity and Access Council
Workforce Council

* * *
SIM Governance Structure

• Balanced and proportionate representation
  – Consumer advocates, providers, state agencies, payers

• More than 40 consumer advocates

• Substantial physician participation including:
  – President, CT State Medical Society,
  – Governor, CT Chapter of the American College of Physicians,
  – President, CT Academy of Family Physicians
  – Former President, CT Chapter of the Academy of Pediatrics

• Integration with the Medical Assistance Program Oversight Council
Why Connecticut?
- Unprecedented collaboration across diverse partners
- Strong record of success & commitment to sustain
- Intent to lead the nation:
  - Empowering consumers
  - Making care experience matter
  - Putting health equity into the value equation
  - Integrating behavioral health
  - Consumer safeguards
- Demonstrated commitment among all of Connecticut’s commercial payers
- Ensure success of Medicare ACO model
Questions