Connecticut State Health Innovation Model Program Management Office Response to Public Comments

We are inspired by the level of engagement in our state's healthcare innovation efforts. We have synthesized public comments received in response to Draft 1.1 of the Connecticut Healthcare Innovation Plan ("the Plan"). While many of the public comments supported the Plan's vision, goals, and initiatives, some called out the need for further expansion, clarification, and consideration of some of the facets of the Plan. We provide highlights of the latter below, along with our reply. Our state's submission of the Plan to CMMI on 12/30/13 and the planned submission of a Test Grant to CMMI in the upcoming months were significantly strengthened by these broad public comments across diverse stakeholders.

What we heard	***How this influenced the Plan - PRIMARY CARE PRACTICE TRANSFORMATION***
1. Why doesn't the Plan build on the success of the PCMH model that many early adopter providers have already established and received certification for?	The Plan builds on Medicaid's PCMH model by incorporating the glide path program in the multi-payer Advanced Medical Home model and incorporating advance payments among most of the payers. The target practices for the AMH model are not the early adopters, but those practices that have, for the most part, not adopted advanced primary care reforms. Several health plans and the state employee plan are building on their PCMH initiatives and are moving a number of them to ACO-like arrangements.
2. How will the state engage and support small practices?	Small and independent primary care medical practices represent upwards of 40% of all primary care medical practices in Connecticut. Practice reform in Connecticut will not succeed without their participation. The proposed Advanced Medical Home program and practice transformation supports are targeted at small and independent primary care medical practices. SIM funded practice transformation support will make it possible for many practices to advance that otherwise would not have the resources to invest in technical assistance. In addition, these same practices will qualify for performance payments and, in many cases, advance payments, which will further engage and reward these practices. The **Practice Transformation Task Force** will be charged with continued consideration of issues regarding small practices for the purpose of delivery and payment innovations. The state will be conducting a physician survey to help inform our strategy for practice transformation support.

3. Can small practices provide high quality, coordinated care (which likely means additional staff and possibly less patient visits) and still "break even" financially?	Other states, such as Vermont, have had considerable success in working with and supporting solo and small group practices in becoming financially viable medical homes. So we know it can be done, and we will draw upon the experiences of these states. Under the final Plan, the **Practice Transformation Task Force** will be charged with continued consideration of issues regarding small practices for the purpose of delivery and payment innovations. Practice transformation support and technical assistance for small and independent practices are included in the Plan. There will be modest requirements for receiving this help, e.g., commitment to reform and practice gap analysis. Payers will introduce pay for performance (P4P), which offers the opportunity to generate financial rewards that meet or exceed the investments required of practices. However, small group practices will be limited in their ability to advance population health based care, team based care and coordinated care, and to assume responsibility for the cost of care, which is required for participation in shared savings programs— unless they organize or affiliate with other practices or systems. As a result, providers will be encouraged to organize or affiliate to develop such capabilities by promoting options for affiliation that will allow practices to remain independent and that will not foster the sort of market consolidation that simply drives up prices without a proportionate improvement in value. During the development of the Plan, both payers and providers supported provider transformation support for primary care practices that have not thus far pursued transformation and which are, for the most part, small and independent. All of the major payers have had experience in working to foster practice transformation. Among the cautionary lessons learned: a) investments in small practices can fail to transform them when there is a lack of motivation, resources or leadership, b) encouraging practices to affiliate may help them in terms of scale and capabilities but may also promote the consolidation of market power, driving up prices, and c) practices' meeting medical home requirements will not necessarily result in better outcomes or savings. Both investments and financial incentives must be carefully targeted at activities that will have a direct demonstrable positive effect on better outcomes and reduced costs.
4. There needs to be clarification on the minimal standards to achieve AMH status.	The minimum standards for achieving AMH status will be recommended by the **Practice Transformation Task Force**. We hope to receive recommendations from this task force by October or November, 2014.

5. Why focus on 80% of Connecticut's residents when the great majority of healthcare costs are the result of 5% with the greatest burden of illness? How will SIM address the needs of the most costly 5%?	CMMI requires that within three years of the start of implementation, care delivery and payment reforms must impact the care of 80% of Connecticut's residents. CMMI is committed to innovations that improve health (i.e., prevention) as this is where the greatest public benefit and long term cost savings will be seen. Focusing on 80% helps ensure that preventive care and public health are part of the plan. In its emphasis on care coordination and team-based care, the Plan does address the needs of the 5% of us who have the greatest needs. These individuals will be better served by practices that are more advanced, e.g. have access to care coordination; health risk stratification data (to identify those most in need of care coordination); nutritionists to address the special dietary needs that such individuals may have; behavioral health supports for high need individuals, and pharmacists to help optimize the medication regimen for those who take a large amount of medication. The payment reforms will measure the quality of care provided to individuals with complex health care needs, and reward providers for providing them with higher value care.
6. The state should not require AMHs to be certified.	The State has not finalized its policy on AMH certification. The benefits and costs are under consideration and will be examined by the Healthcare Innovation Steering Committee.
7. How will the Plan address lack of access to Medicaid providers?	Medicaid has already seen a steady increase in providers as a result of the increase in primary care reimbursement. We expect that Medicaid's expanded approach to value-based payment will also serve as an incentive. Also, new primary care delivery practices such as e-Consult are intended to help address specialty care access issues for Medicaid beneficiaries while other ways enhance their access progress.
8. How will this initiative impact specialty care physicians?	The Plan focuses on the enhancement of primary care as the foundation of delivery system reform. Changes in primary care and the migration to value based payment will impact other aspects of care delivery, including physician specialty care. We cannot predict the overall positive or negative impact on specialty care but we can speak to some of the factors that may impact practice. Although the Plan focuses on primary care reforms, it does not take a position on whether more specialists will be required in the years ahead in general or by specialty. Many factors will influence this, including changes in care delivery, technology and demographics. There is no question that specialists will continue to play an essential role in improving healthcare outcomes. The Plan provides for increased transparency regarding quality and outcomes for a range of providers, including hospitals and specialists. This comes at a time when new insurance designs are making consumers more price sensitive, Consequently, we expect that consumers will wish to be better informed regarding decisions based on quality and price. Additionally, employers are providing the

	information to employees and capping amounts to be paid (sometimes referred to as reference pricing). The remainder will be out of pocket expenses for the patient. Quality and cost information (including out of pocket expenses) will be made available to consumers to inform their choice of care setting and provider. As a result, specialists with lower costs, higher quality or both may see increased volume. A small number of providers are almost exclusively primary care and will accept accountability for quality and total cost of care. These providers may increasingly refer to specialists who demonstrate lower costs, higher quality, or both. Other providers, such as clinically integrated networks, will be comprised of a mix of primary care and specialty practices, as well as other provider types, including hospitals and home health care providers. We envision continuing opportunities for specialists to participate in these networks. This will enable specialists to participate more meaningfully as members of the healthcare team for more complex patients, as well as possibly share in savings. Some specialists may serve as the primary care providers for complex patients for whom this would be most efficient. Specialists will have opportunities to diversify their relationships with primary care practices, e.g., by offering e-consultation services, education or other cognitive services. The Plan does not propose bundled or episode based payment methods, although these were identified by the workgroups as a potential overlay in the future. In such arrangements, specialists are often the lead provider and beneficiary of savings that result from improvements in outcomes and efficiency.
9. OBGYNs should be considered primary care providers.	In Connecticut, the legislatively mandated Statewide Primary Care Access Authority (SPCAA), in its 2010 report to the General Assembly, defined primary care practitioners to include physicians certified in family practice, internal medicine, pediatrics, obstetrics and gynecology, homeopathic medicine and naturopathy, as well as advance practice registered nurses, licensed nurse midwives and physician assistants. This is consistent with the Connecticut State Medical Society's recommendations. The **Practice Transformation Task Force** will be charged with consideration of issues regarding definitions of primary care providers for the purpose of delivery and payment innovations. The state recognizes that OBGYNs are not among the providers who qualify for primary care payment incentives under Medicaid or Medicare. Consideration of this issue will include Connecticut's fully insured and self-funded payers and Medicaid.
10. What is the role of dental medicine in primary care? Can the concept of a primary care Dental	Oral health is essential to overall health, and general dentistry services are integral to primary health care. We anticipate that the **Practice Transformation Task Force** will recommend oral health screening and prevention services (e.g., dental varnish) as among the core capabilities of an AMH. It is also

Home be linked to the AMH?	essential that AMHs work closely with dental practices to ensure that needs for preventive and primary dentistry are being met. Similarly, it is important for dental practices to work closely with AMHs to ensure that overall health needs are being met since general health is also critical to dental health. We recognize the evidence linking oral health conditions with other medical conditions. We also recognize the availability of protocols that might provide for the ongoing management of conditions like early childhood caries in primary care pediatric settings, in much the same way as pediatricians currently manage asthma, diabetes, and other common chronic illnesses. We have added language to the Plan on screening and referral for oral health conditions. The Practice Transformation Task Force will consider whether chronic care for certain oral health conditions such as early childhood caries and periodontal disease should be among the initial standards established for AMHs. Oral health metrics will also be considered for inclusion in the core quality metric set and value based payment.
11. The Plan should incorporate spiritual care benefits and providers in recognition of whole-person-centered care.	The Plan does not propose changes in benefits covered by public or private payers. Instead, the Plan proposes to foster a market for value in which providers are incentivized to invest in services and supports (e.g., medication therapy management) that are not covered on a fee for service basis, but that will improve outcomes and reduce costs. The services of spiritual care providers are among the options that providers might pursue to improve value.
12. How does this plan address the issue of primary care providers not being reimbursed by Medicaid for care coordination with Behavioral Health Homes?	The Plan proposes that payers provide advance payment to AMHs and accountable care systems. These advance payments are intended to cover the cost of care coordination, including coordination with behavioral health homes. The DMHAS behavioral health home model seeks to embed APRNs in LMHAs and these health homes will be charged with coordinating care with primary care providers including medical homes.
13. The Plan will make it more difficult to access mental health care, for example for traumatic brain injury.	The Plan is intended to improve access by rewarding providers for a better care experience and timely service that helps avoid poor consumer outcomes or the use of the wrong services at the wrong time (e.g., emergency department for non-emergent conditions). SIM is not proposing to change the scope of Medicaid behavioral health coverage.

14. How does this plan address the issue of primary care providers not being reimbursed for telephonic consults with behavioral health specialists?	The Plan proposes that payers provide advance payment to AMHs and accountable care systems. These advance payments are intended to cover the cost of care coordination and non-visit based care activities such as telephonic consults with behavioral health services. We also intend to pilot an e-Consult service that will facilitate and formalize consultations, while overcoming the logistical challenges of phone-based consultations.
15. A number of physician providers, both primary care and specialty care, and their respective associations felt that tort reform was essential to achieving the projected reductions in waste and cost under SIM.	The SIM Program Management Office recognizes the significance of medical liability concerns, although tort reform is not a component of the state's healthcare innovation plan. The Program Management Office will further discuss the potential liability risk associated with the proposed reforms with liability carriers and the medical society.
16. How will input from practicing medical, dental, and naturopathic providers be elicited? Will there be a medical advisory panel?	The workgroups proposed in the Plan will be focused on the production of technical work products. The workgroups will undertake considerable technical material review (e.g., medical home standards, quality metric sets); they will need to exercise judgment about scope, pacing, and feasibility; and they will need to solve problems. Balancing the need for an efficient group process with the considerable number of stakeholders that must be represented, the steering committee proposes to aim for 14-16 members, but set a recommended maximum of 18 members on any workgroup. Although the proposed workgroup size is large for the kind of work it will be doing, it is not large enough to include the diverse array of health care service and support providers who play a role in effective care delivery. In order to address this issue, each workgroup will be asked to consider which stakeholders need to be consulted in order to support the development of their work products. Accordingly, as part of each workgroup charter, workgroups will be asked to develop a plan for stakeholder engagement. Consulting with a larger stakeholder community will help ensure that a variety of perspectives and needs are considered with respect to design and implementation. It will allow for fuller consideration of intended and unintended consequences as well feasibility issues. We expect to enable a broader community of health care service and support providers in this way. Workgroups will also consider the "design team" concept when problems emerge that require a mix of experts from within and outside of the workgroup, or across workgroups. For example, a practice transformation standard involving coordination of care and requiring a particular health information technology solution might require a HIT/Practice Transformation design team with outside participants. Such teams would be convened as needed. They would undertake one or more problem-solving sessions, always task focused and time limited.

17. Will the SIM facilitate the development of care coordination and cost management model for AMHs?	The AMH standards and associated practice transformation strategy will support the implementation of care coordination as well as other practice improvements, which will improve outcomes and which should in turn help practices to reduce unnecessary costs. It has not yet been determined whether the practice transformation support will include a specific focus on cost management, although the measurement and tracking of costs of care is expected to be among the areas examined by the Quality Council and potentially part of the common scorecard.
18. The Plan uses data that underestimates the number of practicing primary care physicians and overestimates those practicing in large group structures.	We acknowledge the uncertainty regarding these estimates and intend to undertake a physician survey to obtain more up-to-date results to inform our practice transformation strategy.
19. Health insurance companies should pay for practice transformation to the AMH model; they already create expensive administrative burdens on small physician practices.	The Governor has proposed in his budget that health insurance companies cover a share of the costs of the State Innovation Model initiative. However, we do not propose at this time to ask health insurance companies to directly subsidize the cost of practice transformation.
20. How will this Plan monitor provider shortages created by small and solo practices that can't or don't want to transition to the new model?	It is not clear why a decision not to transition to the new model would result in provider shortages. We have not proposed making the transition to an AMH model a condition for practicing in Connecticut.
21. The Plan doesn't explain how hospitals will factor into care delivery transformation.	Coordination with hospitals is an important aspect of caring for individuals with serious acute or complex chronic conditions. We anticipate that coordination with hospitals will be among the standards developed by the Practice Transformation Task Force. Medicaid will be seeking applied partnerships with hospitals including such features as real time sharing of ED data and direct collaboration in care coordination for high utilizers and on behalf of those experiencing care transitions.
22. How will the Plan address the potential that the development/expansion of large integrated health care systems will increase health care costs?	The AMH model and other elements of the plan provide a pathway to advancement to small and mid-size practices that do not want to become part of a larger integrated health care system. Thus, the plan potentially mitigates this trend and the associated costs.
23. AMHs should not function as	The Plan does not propose that AMH providers would function as gatekeepers.

"gatekeepers"; the model should recognize the need for patients to directly access other providers and specialists, particularly for sexual and reproductive services.	
24. A strong public option should be part of delivery system transformation. Can the State employee plan be made available to more employers, beyond municipalities?	Healthcare coverage options are not among the areas covered by the Plan at this time. It should be noted that Municipal Employees Health Insurance Program was legislated in July 1, 1996 to help cities and towns provide health coverage for municipal employees. The plan requires no additional state funding, as all costs are paid through members' premiums. After its adoption in 1996, the Comptroller's office secured legislation to open MEHIP to nonprofit organizations and community action agencies with public contracts, thus expanding the availability of Traditional MEHIP. Beginning in July, 2012, the legislature authorized the Comptroller's office to offer the state employee plan to non-state public employers, including its Value Based Insurance Design (VBID) features called the Health Enhancement Program (HEP). This program has saved these public employers significant funds due to its purchasing power as well as a degree of risk pooling with its relatively large population. The public employee unions have embraced the HEP as a way of promoting greater member engagement in the management of their health.
25. How will this Plan address behavioral health licensure obstacles for co-location within an AMH? DPH regulations need to be modified.	The state acknowledges this barrier. As a result of the SIM planning process, DPH is removing potential barriers to the integration of primary care and behavioral health services by revising the regulations for the multiple types of behavioral health providers. These revisions will streamline the licensing process by compressing five behavioral health license types into one. The revisions will also allow services to be delivered at sites other than the licensed provider address. The goal is to integrate medical and behavioral health services for the benefit of the patient. Any off-site service locations will be noted in the treatment plan for the individual patient. These changes will allow co-location of behavioral health clinic providers in the primary care practice's location.

What we heard	***How this influenced the Plan – COMMUNITY HEALTH IMPROVEMENT***
1. Will an investment be made in community health centers and specifically mental health at	Most of the proposed investments will be in the areas of primary care transformation focused primarily on small to mid-sized practices and on health information technology. Other proposed investments would focus on consumer empowerment, employer engagement, workforce development, and community health improvement. None of the investments specifically target community health centers or mental health at

community health centers?	community health centers. However, we believe that our focus on integration of primary care and behavioral health, coordination with behavioral health, and perhaps measurement of behavioral health related quality outcomes will be broadly benefit consumers with behavioral health needs.
2. Will an investment be made in community health centers and specifically mental health at community health centers?	The integration of behavioral health in primary care settings will be a focus, although the plan does not propose direct investments in community health centers.
3. Will the SIM undertake an inventory of community and statewide community health initiatives?	This recommendation will be considered during the detailed design phase, in particular, when we undertake planning for the Community Health Improvement initiatives.
4. How can Local health directors and districts be involved in the design, implementation, and governance of the SIM?	We anticipate that local health directors will be involved the design of the health enhancement community program and will be consulted in other aspects of the proposed reforms, such as the design of the prevention service centers.
5. How will Community Health Workers be reimbursed under this plan?	The migration to value-based payment and shared savings programs will produce in the market a demand for services that will better enable providers to deliver value to the consumers they serve. We anticipate that providers will fund the services of community health workers based on these new incentives for value, combined with the measurement of their performance, particularly as it relates to disparity populations. We intend to educate providers with regard to the value of including community health workers in their care teams, or coordinating closely with them. We will also reduce some of the barriers to hiring community health workers by ensuring core competencies (through a certification and training program) and also by facilitating more effective communication among community health workers and care teams, e.g., by exploring the use of direct messaging. We also anticipate encouraging payers to include the costs associated with community health workers in their advance payments on a pilot basis. This will provide practices with the funding they need to begin to employ this workforce. Other financing mechanisms may need to be examined.

6. How will this plan address access to care issues in the state's rural areas?	The Plan proposes to put into place a structure to collect and analyze health workforce capacity in Connecticut, which should support the development of solutions for areas (rural or otherwise) where a workforce shortage is affecting capacity. For example, it could set the stage for loan forgiveness programs that are targeted at certain geographic areas and professions. In addition, the Plan will support the introduction or dissemination of methods for improving communication and remote access to care, whether direct messaging to support team based care including outlying providers, or e-consult, to provide rapid access to specialist consultation services. e-Consult could be of particular value for primary care providers who are practicing in rural areas.
7. How does this plan address issues of undocumented and uninsured patients?	The Plan does not address limitations on coverage.
8. What is the role for school-based health centers?	The **Primary Care Transformation Task Force** will define the practice and provider types that will be permitted to receive AMH recognition. We anticipate that eligible practices and providers will include those led by internists, family physicians, pediatricians, and APRNs with necessary collaboration agreements in place. We anticipate eligible practices will also include school-based health centers, an essential means of access to primary care services for children in Connecticut, although as in Medicaid's PCMH program, there may be some restrictions. School-based health centers will be beneficiaries of investment in health information technology and connectivity and they will increasingly be accountable for performance.
9. What is the role of home care agencies?	The Plan does not envision a role for home care agencies that is substantially different from the role they play today. Home care agencies will remain essential providers within the care delivery system for individuals with complex acute and chronic care needs, which include many of the individuals served by Medicaid's waiver programs. Our efforts to improve coordination and communication will apply to home care agencies as will our efforts to foster performance transparency. Our work with providers on the glide path will include coordination with home care agencies and other key community providers. We intend to encourage and support the adoption of Direct messaging by home care agencies in order to support the secure, efficient flow of information between primary care providers, home care providers and hospitals, to the extent permitted by patient consent. We anticipate that home care agencies might diversify their portfolio of services and offer these services (e.g., care coordination, telemonitoring) to newly accountable care entities such as AMH providers or

	accountable care organizations. We do not envision modifying coverage for home care. The financing for any new services that are offered would likely need to come from other provider partners.
10. What is the role of social work services in the Plan? It should be included in the list of core providers of the care team for the AMH model, and a loan forgiveness program should be implemented.	Social workers are referenced in the primary care transformation section of the plan as part of the care team. In addition, loan forgiveness is being considered as an option in the workforce development section. We recognize the role of licensed clinical social workers as providers of behavioral health services within primary care settings or otherwise as members of the care team, as well as masters level social workers serving other roles and functions including support for the coordination of care and linkage to necessary non-health community services and supports.
11. There should be strong indication of integration between this plan and existing rebalancing projects such as Money Follows the Person, etc.	This important area is one that we are interested in expanding in the test grant and the next revision of the Plan. A key aspect of rebalancing is supporting consumer choice of setting and mode of long term supports and services, both of which can effectively be promoted through an integrated person-centered planning process. The Money Follows the Person initiative is characteristic of this approach as are other of the Department of Social Service's waiver programs. We will be working with the Department of Social Services to explore opportunities to introduce additional standard related to integration with rebalancing efforts and with long term supports and services.
12. Expand the Diabetes Prevention Program and the Asthma Home Assessment Program; ensure they are "covered services" for provider reimbursement.	The Prevention Services Center should help to increase the supply of entities that are qualified to provide evidence based diabetes prevention and asthma in home assessment programs. As with other essential services that are not eligible for fee for service reimbursement, such as care coordination, we anticipate that the migration to value-based payment will create a market for providers of these services. Advanced Medical Homes and care delivery systems may contract for these services in order to achieve quality targets related to these conditions. We will also explore whether payers would factor such costs into their advance payment programs, so that providers have the resources to support the use of these services before shared savings payments are received.
13. How will the financial needs of community based organizations supporting Health Enhancement Communities be considered?	We anticipate that the detailed design work on Health Enhancement Communities will not begin until early 2015. We will consider the issue of financial support for Health Enhancement Communities at that time.
14. The Plan should address cross-sectoral support to resolve the issues of neighborhoods without access to	Our aim for Health Enhancement Communities is to create an alignment of incentives around health goals that would reward cross-sector support for solutions such as access to healthy foods.

healthy foods, including DOT, DECD, DOA.	
15. What is the role of public health experts in the Plan?	Representatives from the Department of Public Health will participate as members of several work groups and subject matter experts from the Department of Public Health will be available for consultation on an as needed basis. In addition, we anticipate including public health experts from the community in ad hoc design teams to support the work groups. Finally, the development of Health Enhancement Communities will likely require its own work group to include state and community public health experts.
16. The Plan should be shared more broadly with "real people", such as the Parent Councils in public schools and via Town Halls.	This recommendation will be considered by the Consumer Advisory Board, which will help with our strategy for broader sharing of the plan with the general public.
17. What specific health conditions will the Plan be focused on for achieving improvements?	The plan will be focused on ambulatory care sensitive conditions such as diabetes, asthma, various cardiovascular conditions, and sickle cell anemia. The plan will also focus initially on tobacco cessation, falls prevention and diabetes prevention.
18. Is Community Health Improvement as high of a priority in the Plan as Practice Transformation and Payment Reform?	Community health improvement and prevention are as important as practice transformation and payment reform. We recognize that most of the costs of healthcare are associated with disease prevalence rather than healthcare quality. However, the proposed practice and payment reforms lay the foundation for reforms that will ultimately encompass public health goals and require collaborative partners outside of the care delivery system. Accordingly, our near term priority is on practice transformation and payment reform.
19. How will input from non-medical community, including advocacy organizations and people affected by the Plan be elicited? Especially for programs for nutrition rewards, SNAP?	Consumers and advocates will play a major role in governance. They will comprise the Consumer Advisory Board and also play a significant role in each of the proposed work groups and Steering Committee. A plan for consumer input outside of these work groups will be developed during the detailed design phase.
20. How do existing programs such as Diabetes Prevention, Asthma Home Environmental Assessment, and Falls Prevention factor into the Plan? How are they integrated with primary care practice transformation and whole-	Providers of Diabetes Prevention, Asthma Home Environmental Assessment and Falls Prevention services will be a resource for providers that will increasingly be held accountable for outcomes that depend on these interventions. Over time these outcomes will be rewarded by our payment reforms. The methods for linking transformed practices with these services will be a focus of the Practice Transformation Task Force.

person-centered care?	
21. What is the difference between the existing "public health worker" and the Plan's "Community Health Worker"?	There is likely some overlap between the terms public health worker and community health worker, although the definition of the latter continues to evolve. The purpose of establishing the term and a method of certification is to help ensure a supply of such individuals with core competencies to participate in or support health care teams.

What we heard	***How this influenced the Plan – CONSUMER EMPOWERMENT***
1. How will consumer input be incorporated into continuous quality improvement?	The most direct means of making consumer experience a focus for continuous quality improvement is to measure consumer care experience and tie the results to value-based payment. The Plan proposes to align all payers around a common methodology for measuring care experience and applying care experience performance to reimbursement at the level of the practice and/or care delivery system. Most health plans currently collect data for the Consumer Assessment of Health Plans Survey (CAHPS) as a condition of NCQA accreditation. However, this information is not adequate to assess consumer experience at the practice level. In addition, some payers note that providers conduct care experience surveys as a condition for more advanced value based contracts (P4P, SSP). However, even when they require the collection of such data, payers do not factor the results into their payment methodologies. During the development of this plan, health plans supported the concept of linking care experience to value based payment, and noted this is a key element of the triple aim. Health plans acknowledge that co-sourcing a statewide provider care experience survey, statistically valid at the level of the panel rather than the practice, could be cost-efficient and they are willing to explore a common approach. There are technical challenges, in that such an approach presumes the ability to identify each practice's and each physician's panel in a reliable manner. The selection of consumer care experience measures and methods for the collection and application of such measures to payment will be the responsibility of the Quality Council.
2. What is the plan for independent consumers to be included on all SIM committees, workgroups, and councils?	The current plan is to include consumers and consumer advocates on all governance bodies, including the Healthcare Innovation Steering Committee, Consumer Advisory Board and the various workgroups. The composition of the various committees, workgroups and councils, and the extent of consumer representation will be determined by the Steering Committee.
3. The state should utilize FQHCs for	This is a good suggestion for consideration by the **Consumer Advisory Board** as it outlines its plan for

eliciting consumer input.	engaging the broader consumer community in the coming months.
4. FQHCs can play a role in the Equity and Access Council to ensure patients aren't under-served by AMHs.	The current approved composition of the Equity and Access Council does not include FQHC representation. However, the Equity and Access Council will be charged with soliciting broader input in the course of formulating its recommendations.
5. The state needs a stronger strategy for engaging employers and employees.	Self-funded employers make up to 85% of the business of Connecticut's health plans. The state recognizes that health plans cannot support innovations in care delivery without the support of these employers. The state will further define its proposed strategy for employer engagement in our application for a State Innovation Model Testing Grant, including initiatives to increase uptake of Value Based Insurance Design benefit plans offered to employees.
6. Should patients bear some financial risk related to costs and appropriate health behaviors such as screenings and responsible chronic illness management?	There has been a growing trend among fully insured and self-funded health plans to have beneficiaries bear more of the cost of care through deductibles, co-payments and cost sharing. Value Based Insurance Designs (VBID) support high value care by focusing on financial incentives for positive health behavior, such as screenings and participation in chronic care management. The Plan proposes to promote financial rewards and penalties that incentivize beneficiaries to engage in appropriate health behaviors such as screenings and responsible chronic illness management. The Office of the State Comptroller will engage Connecticut's employers and the health plans in a review of VBID programs in Connecticut and other states. They will model a menu of VBID options that health plans can offer to employers on either an insured or self-insured basis, and explore the needed infrastructure and support they companies may require to participate in VBID programs. The goal is to increase the adoption of VBIDs by demonstrating to employers that a well-designed and implemented VBID program can improve health and lower costs for people who are incentivized to actively participate in their health care. The Department of Social Services is not presently able to use these strategies in Medicaid, with the exception of financial incentives to quit smoking under the grant-funded Rewards to Quit program.
7. Why is Medicaid excluded from Value Based Insurance Designs?	Under federal law, Connecticut's Medicaid program is limited in the extent to which it can impose premiums, deductibles or significant cost-sharing. Moreover, studies have shown that such costs can serve as barriers to coverage and access to care or use of services for individuals with extremely limited economic means (e.g., not taking prescribed medications due to cost-sharing). Accordingly, the Plan does not include Value Based Insurance Design for Connecticut's Medicaid program. DSS has implemented the Rewards to Quit program to provide financial rewards for smoking cessation and it will consider similar opportunities to reward positive health behavior in other areas to the extent that

	such incentives would be coverable under Medicaid and cost-effective. The Rewards to Quit program is funded under a federal grant. Such incentives are otherwise not an option broadly available to Medicaid beneficiaries.
8. What is the plan for public health consumer curriculum?	Options for developing a consumer curriculum may be considered during the design phase.
9. The Plan should mandate that all AMHs provide medical interpretation services and evidence of contract with interpreter service. AMHs should be reimbursed by payers for the cost of interpreter services.	We recognize the importance of interpreter services. The Plan emphasizes the incorporation of national Cultural and Linguistic Appropriateness Standards as part of AMH. However, it will leave questions as to whether all practices should be required to retain interpreter services to the Practice Transformation Task Force. The Plan does not propose changes in coverage for interpreter services.
10. Consumer's values and preferences must drive decision-making, e.g. informed consent. AMHs must fully inform consumers in plain language about risks and benefits related to treatment options.	This comment is consistent with the Plan and its focus on person-centered care as well as the adoption of decision aids that provide more reliable, complete, and evidence-based information about diagnostic and treatment options. The specific standards related to person-centered care will be developed by the **Practice Transformation Task Force**.
11. Consumers should be equipped with culturally and linguistically appropriate information and resources.	This is a generally held principle; various aspects of the Plan include the proposed application of NCLAS standards as part of the AMH model.
12. It is not reasonable for payers to override consumer selection of primary care provider by assigning members to the provider that has given them most of their primary care; this is at cross purposes of the true working partnership ideal between patients and their providers.	This method is intended to make assignment more closely match a patient's choice. In the past, members selected a primary care provider and the information became outdated when the patient decided to go somewhere else. The use of actual patient care information helps ensure that the health plan is connecting the patient with the provider that the patient has actually decided to use. The patient can change the assignment (also called "attribution") simply by going somewhere else. The assignment serves the purpose of attributing accountability for quality and outcomes that are connected to payment. It is important to use this kind of information so that a provider the patient didn't use isn't held accountable for the care provided. It also helps ensure that the health plan is using the most

	up to date information about where the patient is going for care when helping to coordinate care.
13. Educational efforts must include how to negotiate the healthcare system – e.g. when to contact a primary care physician, what to do with a referral.	These are good suggestions that will be taken into consideration in planning for consumer empowerment initiatives.
14. Independent consumer advocates should be properly skilled and trained and be accessible to patients by phone.	The plan does not propose additional means of access to independent consumer advocates than already exist in Connecticut.
15. How will the Plan address issues of health literacy and patient education?	The specific Advanced Medical Home standards related to health literacy and patient education will be developed by the **Practice Transformation Task Force**.
16. The SIM should provide employers with a health insurance procurement template consistent with SIM goals.	We anticipate that this will be part of our Employer Engagement Strategy.
17. The Plan is vague on specifically how consumers will be able to access price information to make healthcare decisions.	Under its APCD initiative, Access Health Connecticut is in the process of developing they methods by which it will make price information available to consumers. In addition, our Advance Medical Home standards will likely include patient education about sources for price information. There are many different sources of cost information already available to consumers, including specific cost information available through individual health plans. If they are not already aware of these, consumers could be educated during a primary care visit.
18. The Plan should include a patient ombudsman, such as an expanded role for the Office of the Healthcare Advocate for consumer appeals of provider decisions.	We will consider this idea during the detailed design phase.

What we heard	*How this influenced the Plan – HEALTH EQUITY*
1. What place does health equity have in the Plan?	The Plan identifies health equity as one of four program aims, "Close the gap between the highest and lowest achieving populations for each target measure impacted by health inequities." Optimal population health cannot be achieved without the elimination of health disparities. Quality measures that are the foundation of both performance and shared savings payment methodologies must include metrics to assess health disparities and to assess progress in addressing them. **The Quality Council** will develop measures, metrics, and a common performance scorecard that will be used to identify the gap between the highest and lowest achieving populations for each targeted measure.
2. Health Equity needs to be woven into the fabric of graduate medical education and continuing medical education; including the integration of CLAS and multicultural clinical skills.	This is consistent with the revised workforce development strategy outlined in the Plan, including training of Community Health Workers and the CT Service Track curriculum. Additionally, the **Practice Transformation Task Force** will determine standards for Advanced Medical Homes (AMHs), including the incorporation of CLAS standards along the AMH glide path.
3. The Plan should mandate signage (multiple languages) at medical care sites encouraging patients to call if they've been denied care.	The **Equity and Access Council** will determine mechanisms for consumer complaints of suspected underservice.
4. The Plan should commit health insurers to make investments in concerted efforts to collect REL data at the point of enrollment.	According to AHIP, many health insurers already collect race, ethnicity, and language data at the point of enrollment. While there is currently no federal requirement mandating the completion of REL data fields during the enrollment process, research suggests that consumers would more readily self-report this data if they are asked for it and if they are advised what the data would be used for. The **Quality Council** will determine measures and metrics for cost, quality, experience, and equity for use across payers. Part of this deliberation will encompass data collection necessary to fulfill common performance scorecard reporting.

5. The Plan doesn't identify specific goals on achieving measurable health care disparity reductions for specific health conditions.	The Plan identifies health equity as one of four program aims, "Close the gap between the highest and lowest achieving populations for each target measure impacted by health inequities." The Plan was also revised to include population health measures for tobacco use, diabetes, obesity, diabetes, asthma, falls, hypertension, child oral health, preventable hospital visits, cancer screening stratified by race and ethnicity. Specific goals on achieving measurable health care disparity reductions for specific health conditions will be considered by **Quality Council** and SIM Program Evaluators.
6. The Plan frequently references cost, quality, and care experience. Equity should similarly be embedded throughout the Plan.	The Plan now embeds health equity throughout. Additionally, promotion of health equity is identified as one of five areas of distinction for CT's Plan.
7. How does the SIM define underserved disparity populations?	The Plan takes a broad view of disparity populations and recognizes that many factors may lead to inequitable healthcare, including: socioeconomic status, race, ethnicity, language, age, gender, sexual orientation, disability, geography, and religion.
8. Recommend that SIM expands cultural competency training to all licensed healthcare providers.	By promoting CLAS standards, the Plan promotes the standard: "Educate and train governance, leadership, and workforce in culturally and linguistically appropriate services on ongoing basis." Furthermore, the principal standard of CLAS is: "Provide effective, equitable, understandable, respectful quality care responsive to diverse cultural health beliefs, preferred language, and health literacy." We envision that practices will use these standards to address the gaps in their strategy to address health disparities, including the level of cultural competency among their staff.
9. How will SIM approach the implementation of CLAS?	Work is already underway through DPH's grant-funded Multicultural Health Partnership to promote the adoption of CLAS by targeted healthcare organizations. The Practice Transformation Task Force will consider the implementation of CLAS standards consistent with the Advanced Medical Home glide path standards and transformation support services. This is an area for potential integration of efforts between the practice transformation support vendor and the CT Multicultural Health Partnership that is in the process of developing a baseline survey to identify level of adoption and curricula for statewide trainings.
10. The SIM should consider existing services such as Area Agencies on Aging (long term supports, education), Patient Navigation Program (health coaching), and Interpreters and Translators Inc.	We recognize and anticipate that organizations such as these, the **Consumer Advisory Board**, the navigators and in-person assisters working with OHA and AHCT, and others will play a vital role in our new delivery system.

11. The SIM should ensure interpreters are of high quality.	By promoting the implementation of CLAS standards, SIM promotes the language standard of "ensure the competence of individuals providing language assistance."
12. Education on health equity should be woven into medical education. Culturally competent training should include multicultural clinical interviewing, health literacy and motivational interviewing.	The Plan includes a CT Service Track program, which is aimed at developing a workforce to serve disparity populations, including the urban poor and rural communities. Cultural and linguistic appreciation, population health, and public health are among the core competencies stressed in the curricula. Additionally, cultural competency for Community Health Workers will be further developed as part of training and certification envisioned in the Plan.
13. Prevention Service Centers should have a clear, explicit and direct focus on health disparities.	Community Health Improvement is one of three drivers of innovation envisioned in the Plan. The creation of Prevention Service Centers (PSCs) is one of the community health improvement initiatives. PSCs will provide care-coordinated, evidence-based, and culturally and linguistically appropriate prevention services. The health conditions targeted by the SIM, and targeted to the extent available for PSC intervention are tobacco use, diabetes, asthma, obesity, and falls – all conditions for which health disparities are prevalent.
14. How will race data be collected and standardized?	The specifics of race/ethnicity data collection will be considered during Phase 1. The Quality Council will be proposing health equity measures and, with the HIT Council, will propose a source of standardized data to permit the calculation and application of these measures.
15. How will the Plan improve continuous coverage, especially for the most vulnerable, children and families?	The Plan does not address the issue of continuous coverage or coverage issues in general. CMMI funded state innovation models focus on care delivery and payment reforms rather than access to private or public health insurance programs.
16. Population Health Management: Suggest adding: Population-based data will also be used to determine which AMHs are impacting health disparities, for which conditions, for which populations.	The Plan now notes that population-based data will be used to understand the risks for one's own panel, key sub-populations (e.g., race/ethnicity) and individual patients and using that information to guide care coordination and continuous quality improvement.
17. Will the Equity and Access Council determine methods to guard against under-service *and* disparities in care	The **Equity and Access Council** will develop for recommendation to the Healthcare Innovation Steering Committee a proposal for retrospective and concurrent analytic methods to (1) ensure safety, access to providers and appropriate services, and to limit the risk of patient selection and under-service of requisite care, including assurance that underserved populations aren't subjected to targeted under-service and

and outcomes across populations?	patient selection; (2) recommend a response to demonstrated patient selection and under-service; and (3) define the state's plan to ensure that at-risk and underserved populations benefit from the proposed reforms. Disparities in quality, outcomes, and care experience will be taken up by the **Quality Council**.
18. How does this Plan address DSS issues of reimbursement of LogistiCare/medical cab for appointments with chiropractors and other non-medical care providers, eyeglasses, and lack of an up-to-date list of participating doctors?	The Plan does not address Medicaid program specific coverage issues and the availability of accurate program materials. These issues are best directed to the Department of Social Services.

What we heard	***How this influenced the Plan – PERFORMANCE TRANSPARENCY***
1. There should be greater emphasis on price and performance transparency.	We recognize the extraordinary importance of price and performance transparency and will provide greater emphasis on this in the final version of the Plan. Transparency is essential to consumer empowerment, which in turn is essential to a healthcare market that rewards value, which means better quality at lower cost. Key to achieving this transparency is a comprehensive all-payer claims database (APCD), which is currently under development in Connecticut. Claims data must be analyzed, packaged and made available so that valid comparisons can be made by consumers, providers, payers, and policy makers. Connecticut is developing an APCD that will lay out findings over the web in formats that enable consumers to readily compare providers. Connecticut is working hard to implement its APCD and will supplement the APCD with accessible information about outcomes and consumer satisfaction beyond what other states have done.
2. Complex Care/Health Neighborhoods need to be considered when developing performance metrics.	The **Quality Council** will review and recommend common performance measures currently in use. The Quality Council will consider the measures proposed for use in the Department of Social Services' Integrated Care Demonstration (i.e., Health Neighborhood initiative for Medicare/Medicaid dual eligibles). While full alignment among payers is a goal, we recognize that Medicaid and Medicare may need additional measures that reflect the special health needs and circumstances of their consumers.
3. Pain management should be included as a performance metric.	The **Quality Council** will review and recommend common performance measures for use by all of Connecticut's payers. We will ask them to consider pain management measures.

4. The state could use UDS for practice report cards and common performance standards.	The **Quality Council** will review and recommend common performance measures for use by all of Connecticut's payers. We will ask them to consider the use of UDS for practice report cards and common performance standards.
5. Dilated eye exams for the detection of diabetes should be included as a performance metric.	The **Quality Council** will review and recommend common performance measures for use by all of Connecticut's payers. We will ask them to consider dilated eye exams for the detection of diabetes.
6. There is currently no consensus on definition of high value medical care - high quality, clinically important, low cost care.	We recognize that defining and measuring value is a relatively new focus in healthcare and that in many areas, perhaps most areas, there is no consensus. The purpose of the SIM is to help develop greater consensus on ways to define and measure value.
7. Physicians need to be involved in defining quality performance.	The **Quality Council** will review and recommend common performance measures for use by all of Connecticut's payers. The Quality Council will include physician members.
8. Physician rating systems need to be further explained; these could have a profound impact on care delivery.	We appreciate the significance of efforts to measure or rate physician performance. The **Quality Council** will review and recommend common performance measures for use by all of Connecticut's payers. Physicians will be actively involved in this council and there will be an emphasis on transparency of methods.
9. Performance on quality should be considered before performance on cost; and co-morbidities need to be factored into ratings.	Payers are already measuring and rewarding quality and cost performance. The **Quality Council** will review and recommend common performance measures for use by all of Connecticut's payers, including methods for risk adjustment (e.g., related to co-morbidities).
10. The Plan has no detail on the inclusion of national quality measures and metrics in performance rating.	Quality measures have not yet been selected. The **Quality Council** will review and recommend common performance measures for use by all of Connecticut's payers during the detailed design phase.
11. CT should not adopt the MA model of tiering for rating providers.	The **Quality Council** will review and recommend common performance measures for use by all of Connecticut's payers during the detailed design phase.
12. Will the Plan include the designation of Centers of Excellence or Tiered networks?	These ideas are not currently elements of the Plan. However, this does not preclude payers from independently adopting these models.
13. Insurance provider networks should not be narrowed based on	The **Quality Council** will review and recommend common performance measures for use by all of Connecticut's payers during the detailed design phase. These measures will likely including measures of

performance rankings.	access. The plan does not take a position on narrow networks.
14. The Plan doesn't say how performance and quality metrics will be determined, by whom, and when.	The **Quality Council** will review and recommend common performance measures for use by all of Connecticut's payers during the detailed design phase.
15. The Plan identifies generic prescription substitution as an example of a performance metric. What are all the performance metrics?	The **Quality Council** will review and recommend common performance measures for use by all of Connecticut's payers during the detailed design phase.
16. What is the role of the Practice Standards entity?	There is no practice standards entity proposed. However, we do envision establishing a Practice Transformation Task Force. Preliminarily, we anticipate that this Task Force will develop for recommendation to the Healthcare Innovation Steering Committee, a proposal for the implementation of the Advanced Medical Home (AMH) model under the Plan. The AMH Model has five core components: (1) whole-person-centered care; (2) enhanced access; (3) population health management; (4) team-based coordinated care; (5) evidence-informed clinical decision making. This work group will develop the advanced medical home standards, detail the design of a "glide path" program in which providers are offered practice transformation support services for a limited period of time, advise on the process for vendor selection for practice transformation support and practice certification, and coordinate with interdependent workgroups and initiatives. The Task Force will identify key stakeholder groups whose input is essential to various aspects of the Task Force's work and formulate a plan for engaging these groups to provide for necessary input. The Task Force will convene ad hoc design teams to resolve technical issues that arise in its work.
17. Performance metrics should include HEDIS measures for Chlamydia and cervical cancer screenings and discussion of birth control use in young adult populations.	The **Quality Council** will review and recommend common performance measures for use by all of Connecticut's payers during the detailed design phase.
18. The Plan should include a provider ombudsman role for issues with quality metrics and evidence-	We will consider this idea during the detailed design phase.

based protocols.	
19. Will the SIM consider HRSA quality and cost metrics for AMHs, such as used by FQHCs today?	The **Quality Council** will review and recommend common performance measures for use by all of Connecticut's payers during the detailed design phase. It is likely that measures will be drawn from those already endorsed by the National Quality Foundation. We have included an FQHC on the Quality Council in part to ensure consideration of the issue of HRSA quality and cost metrics.
20. Will performance metrics be applied at the physician or clinic level?	The **Quality Council** will review and recommend common performance measures for use by all of Connecticut's payers during the detailed design phase, including perhaps, levels of analysis and accountability.

What we heard	***How this influenced the Plan – VALUE BASED PAYMENT***
1. Is the plan proposing to replace the current fee for service payment system?	The Plan does not propose to replace the current fee for service payment system. However, it does recommend the introduction of payments based on the value of services provided—value being quality divided by cost. Under the plan, traditional fee for service payments are expected to account for a smaller share of a provider's overall revenue once value based payment methodologies are established. Measured performance including quality and care experience will account for an increasing share of a provider's overall revenue.
2. Who will set quality measures and targets? This should be done by an independent committee and apply to all contracts.	Of great importance to the success of Connecticut's innovation model are: (1) the development of a valid set of core measures of the performance of AMHs, specialists, hospitals, and care delivery systems; (2) the broad adoption of these measures by practices and payers; (3) the development of processes by which data on these measures are gathered, stored, made available for analysis, and analyzed—including by researchers, and (4) the development of processes and formats by which findings are made available and useful to all interested parties, including consumers, providers, and payers. The development of core measures themselves cannot be done effectively without consideration of the other three actions. It is our goal to promote the adoption of a common set of core measures applied to all payer contracts, but individual payers must agree to do so. Achieving this consensus among payers is in itself a critical objective. For this reason, and also because developing valid measures requires considerable expertise and broad input from stakeholders, the process will include participation by consumers, experts in metrics and representatives of providers, payers and governmental agencies. The **Quality Council** will be charged with recommending quality measures in support of care delivery and payment innovations.

3. How do we ensure providers aren't penalized by quality measures that are negatively skewed by complex patients, leading to unfair performance assessments or incentives to discharge high-risk patients?	The shared savings program model will include adjustments for case mix—that is, to the overall severity of illness among a practice's patients. Also, certain patient populations will not be counted for shared savings, such as persons who are seriously and persistently mentally ill. These adjustments will help ensure that providers are held accountable for those healthcare results that are within their control, and protected from the risk associated with populations whose costs are generally higher or highly unpredictable. This will help diminish the likelihood that providers will try to improve their performance by avoiding or discharging more complex patients. The **Equity and Access Council** will recommendation methods for monitoring provider utilization to help ensure that these safeguards are working.
4. How can we monitor AMHs for under-service, stinting, and patient selection, and disqualify or sanction providers who demonstrate a pattern of intentional under-service from shared savings and other financial rewards?	In response to concerns about under-service, payers initially cited NCQA accreditation and requirements for monitoring under-service and over-service, consistent with the comments submitted on their behalf by CAHP. When pressed, several payers acknowledged that NCQA focuses on under-service relative to established quality metrics. They apparently do not monitor for under-service using the more flexible program integrity audits. NCQA does require monitoring for patient abandonment but notes 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 as among those most focused on quality. In many cases, these clinicians have independently pursued medical home recognition. In addition, NCQA recognition requires that physicians have internal monitoring of physician behavior in place and at least one payer reported that this is a requirement of their SSP contracts. Most payers acknowledge that as cost accountable payment reforms become more prevalent, monitoring for under-service will become more important. They expressed a willingness to participate in the **Equity and Access Council**, which will examine and recommend under-service safeguards. It is important to note that one or more of Connecticut's health plans and Medicare have already implemented shared savings contracts with Connecticut providers. We are not proposing to interfere with existing contracts or delay these payers' entry into new contracts. However, Medicaid will not enter into shared savings agreements until program integrity functions have been established for detecting under-service and also policies that preclude practitioners from receiving shared savings related incentives when they have demonstrated under-service or when practitioners have been found to have selected patients so as to avoid those whose care can be expected to be more costly.
5. Will there be an appeals process for consumers that believe they've been under-served?	All consumers currently have access to complaint procedures through their source of coverage, whether a fully insured plan, self-funded plan, Medicare, or Medicaid. Whether additional avenues for appeal are necessary will be considered by the **Equity and Access Council**.

6. Who will monitor how AMH cost savings are achieved and if they are achieved for withholding care?	The **Equity and Access Council** will make recommendations for monitoring for under-service (i.e., withholding necessary care) for adoption by the various payers. The plan does not propose to establish methods for monitoring under-service independent of the payers. The state may, however, consider an examination of this question as part of its evaluation.
7. What is the reason for proposing a shared savings payment arrangement for AMHs and how is this different from a pay for performance arrangement?	Shared Savings Program (SSP) The plan aims to incentivize AMHs to work with their patients and with the rest of the health care delivery system to curb the overall cost of care for their patients by giving a share of any savings to those AMHs that meet quality targets. We will do this by projecting how much it should cost to provide health services to an AMH's patients for one year. This is akin to establishing an annual budget; however, providers will continue to be paid fee-for-service. The projected budget will be higher for patients who whose care is likely to be more expensive. In a process called risk adjustment, healthcare utilization data will be used to group patients into different levels of risk that correspond to different projected budgets. Although the provider is paid fee-for-service, the costs for their panel of patients are tracked relative to the projected budget. The budget includes all costs of care including hospitalizations, lab/diagnostic imaging and specialty care. The provider earns a share of the savings if the overall costs for their panel of patients for the year are less than was projected by the payer. This is referred to as a Shared Savings Program (SSP). Some providers also choose an arrangement in which their reimbursement is reduced if their costs exceed the projected budget. This is called a "downside" risk arrangement. Usually a provider with such an arrangement also gets a greater share of savings when costs are less than the projected budget. However, undertaking a "downside" risk arrangement is a decision between payers and providers and is not a condition of participation in our model. Quality of care and patient satisfaction (or care experience) will be measured for providers in shared savings programs. Importantly, providers are only able to share in savings if they meet quality of care and patient satisfaction targets. In addition, we will recommend that providers not be permitted to share in savings if there is evidence that these savings were achieved in inappropriate ways (see below). Providers will typically try to achieve savings by providing higher quality care more efficiently. For example, there may be savings if they improve the timeliness and accuracy of their diagnoses, and provide the right care at the right time thereby avoiding unnecessary hospitalizations. Practices may also achieve savings by eliminating unnecessary and duplicative services. Pay for Performance Program (P4P) Although our focus in SIM is on promoting SSP arrangements, we recognize that many providers are not prepared to take on this level of responsibility for quality, care experience, utilization and efficiency

	targets. They need time to develop the requisite skills and capacities. Also, many independent AMHs do not have a panel of patients large enough for payers to reliably project cost. For these reasons, we have proposed a pay for performance (P4P) track in which providers will receive financial rewards if they meet certain quality, resource efficiency and care experience targets. Our expectation is that this track with be transitional, and that, over the course of five years, the great majority of AMH providers will have SSP arrangements. With the P4P track, providers will be offered practice transformation support for developing new practice protocols, skills, and tools to help them meet performance targets and improve their performance over time. Although P4P is an excellent way to help providers learn how to measure and improve their performance, in the long run, it is not as effective as SSP. This is because P4P only rewards targeted areas of ineffective or inefficient care, whereas SSP arrangements reward all areas of ineffective or inefficient care.
8. There should be no downside risk for Medicaid providers.	The Department of Social Services recognizes concerns raised by consumer advocates about downside risk in Medicaid. The Department of Social Services is planning to focus on the development of upside only shared savings programs under the Plan. The Department of Social Services will not implement downside risk during the test grant period.
9. What about the idea of Medicaid ACOs?	The Accountable Care Organization or ACO is a term used by Medicare for the provider organizations that participate in Medicare's shared savings program. Medicaid law does not recognize ACOs, except with respect to a narrow new authority to establish pediatric ACOs. The term ACO is now used more widely including among several of Connecticut's health plans to refer to any provider organization that enters into a shared savings program arrangement. Medicaid is planning to focus on the development of upside only shared savings programs under the Plan. The use of Medicaid ACOs was not considered in the development of the Plan.
10. FQHCs should be eligible for value based payment arrangements, especially for commercially insured patients.	FQHCs that have achieved PCMH recognition are not currently eligible to receive performance payments of any kind under the Medicaid program. The State will review whether FQHCs may be permitted to receive pay for performance or shared savings incentives under SIM during the detailed design phase of this initiative. FQHCs with sufficient covered lives are expected to be eligible to participate in shared savings payment arrangements with fully insured and self-funded payers.
11. What is the commitment of health insurers to the Plan, especially to using common standards to evaluate physician performance?	We have a commitment from the health plans (all or nearly all) to participate in the development of common measures to evaluation physician performance. We hope to maintain this commitment during the detailed design phase, but this will likely depend on the final recommendations issued by the Quality Council.

12. Health insurance carrier participation in this plan should be voluntary.	The participation of fully insured and self-funded payers in the proposed reforms is voluntary, except that the Governor's budget proposes that all payers share in the cost of program management and many SIM related program investments.
13. This plan should not disrupt on-going medical home and ACO arrangements already underway between carriers and providers.	The design of the Plan is intended to complement existing medical home and ACO arrangements. However, the Plan does require modification to these arrangements, such as alignment around common quality measures and provider scorecards.
14. How will the Plan ensure there is no incentive duplication with SSPs?	Each payer administers its own shared savings program arrangement, so there should be no duplication of incentives.
15. Payer funding to practices should be based on transition to medical home and pre-defined metrics rather than as upfront investments.	Many independent practices and also larger groups and systems lack the capital necessary to fund new capabilities and processes or to weather the transition costs on productivity that can arise during a change in business models. In addition to the technical assistance that the State will provide through practice transformation support, payers will be encouraged to fund new capabilities such as care coordination, which is essential to achieving improvements in care for individuals with complex care needs. Funding is typically implemented through up-front fees, paid either on a monthly (PMPM) or quarterly (PMPQ) basis or through enhancements to the fee or reimbursement schedule. Payments will be based on providers meeting mandatory pre-requisites (e.g. meaningful use of EHR) as well as milestones for practice transformation. The majority of Connecticut's health plans and Medicaid will provide advanced payments, beginning either during the Glide Path (once readiness is demonstrated) or once AMH recognition is achieved. Payers' willingness to provide advance payments or care coordination fees may be contingent on satisfactory progress against transformation milestones and demonstrated savings over time. In some cases, providers may elect to waive care coordination fees and practice transformation support in favor of higher levels of shared savings rewards.
16. Risk sharing for health systems (hospitals + physicians) is not detailed in the plan.	The Plan does not propose to align the specific shared savings program arrangements, which will continue to be negotiated between provider and payer.
17. The SIM should eliminate gag clauses in reimbursement contracts between insurers and providers.	The Plan does not propose to eliminate gag clauses.
18. The SIM should require health insurers to release price and reimbursement information for cost-	We anticipate that the APCD will undertake cross-payer analytics to produce pricing transparency and make this information available to consumers and providers.

effective referrals.	
19. The SIM should require insurers to develop consumer-facing comprehensive price transparency plans.	See above.
20. How will a patient's care experience be factored into physician reimbursement?	The strategies and mechanisms which outlay the cost, collection, and design of patient experience surveys will be considered in more detail during Phase 1. Note: The question of how care experience surveys will be administered to allow statistically valid care experience data has not been resolved. Currently, payers invest in care experience surveys that are required under NCQA, but such surveys only have to be statistically valid for their entire membership statewide. Practices are required to undertake some consumer experience surveys, required in some cases by NCQA or payers, and to undertake quality improvement activities related to the feedback. At present, none of Connecticut's health plans use care experience survey data at the practice level to confer value based payment. Care experience performance is currently not a factor in determining whether a practice qualifies for a financial reward or how much they receive. This is a unique differentiator envisioned by the SIM. The SIM assumes that capturing meaningful care experience is paramount to the value equation and must be included in the payment method. CT health insurers/payers have committed to examining cost effective ways that this can be accomplished. One method that is under consideration is the co- sourcing of the survey vendor who would provide statistically valid care experience survey data at the practice level.
21. Providers should not be penalized for patient admissions to higher cost facilities given geographic limitations and reduced choice due to market consolidation.	The state recognizes the threat presented by marked consolidation. The Attorney General's office intends to monitor this issue more closely in the future.
22. The Plan should allow physicians in independent practices to collectively negotiate with insurers to determine cost savings and payment rates, in order to achieve quality	The state will consider regulatory provisions that might enable solo and small practices to accurately and efficiently share clinician and cost information real time with their peers across the system (and across practices). The State will evaluate how this could be achieved with consideration of anti-trust restrictions, potentially by allowing the collaborative sharing of such information as monitored by a state actor such as the health care advocate's office.

improvements and cost savings.	
23. Primary care physician reimbursement rates should be increased and specialty physician reimbursement rates should be decreased.	Primary care physicians will have the opportunity to generate higher revenue through advanced payment arrangements such as shared savings rather than through increased fee for service reimbursement. Specialty physician service pricing may be affected by greater pricing transparency and the new market incentives, which will make consumers and primary care providers more sensitive to specialty physician cost and quality.
24. How does the Plan address health care costs associated with compensation, monopolization, and lack of volume purchasing?	The state recognizes the threat presented by marked consolidation. The Attorney General's office intends to monitor this issue more closely in the future. We believe that payment reforms that emphasize value, along with a wide array of price transparency tools, will impact compensation and may promote volume purchasing.
25. Will there be a common method for insurance companies to reimburse AMHs for care coordination?	The Plan will encourage the use of advance payments for care coordination and other elements of advanced primary care and, perhaps a high level alignment of methods. However, the state does not intend to focus on the specific of advance payments, such as how such payments are calculated and administered.
26. SIM should adopt the Catalyst for Payment Reform tool to measure the pace of VBP transformation.	The state will consider the Catalyst for Payment Reform tool or similar tools to measure the pace of value based payment transformation.
27. What about "reference based pricing"?	Reference based pricing will be among the insurance designs that are considered as part of our employer engagement strategy related to value based insurance designs and payment reforms.

What we heard	***How this influenced the Plan – HEALTH INFORMATION TECHNOLOGY***
1. How will the Plan address the issue of many competing EMR systems that have already been established? There is no one method of interoperability that is suggested to progress coordination of care.	Direct messaging is the primary focus for facilitating coordination of care among unaffiliated clinicians and systems. The long term solution for health information exchange will take longer to develop. There are ongoing challenges related to health information technology, meaningful use and inter-operability that will be considered by the Health Information Technology Council.

2. How will the Plan address the issue of thousands of care sites and primary care physicians not having financial or staffing resources to extend health information technology beyond their care delivery site?	Direct messaging is the primary focus for facilitating coordination of care among unaffiliated clinicians and systems. The long-term solution for more widespread health information technology adoption and exchange will take longer to develop. There are ongoing challenges related to health information technology, meaningful use and inter-operability that will be considered by the Health Information Technology Council.
3. How will the APCD be integrated with the SIM initiatives?	Initially, the APCD will be a source for pricing transparency and the use of this tool and similar tools will be the focus of our efforts to advance primary care and consumer empowerment. The final version of the plan includes considerably more information about the potential role of the APCD over the longer term.
4. How will the HIE be integrated with the SIM initiatives?	Direct messaging is the primary focus for facilitating coordination of care among unaffiliated clinicians and systems. The long-term solution for more widespread health information technology adoption and exchange will take longer to develop. There are ongoing challenges related to health information technology, meaningful use and inter-operability that will be considered by the Health Information Technology Council.
5. The SIM supports the continued development of the HIE and the APCD. What steps will be taken to ensure health information security and privacy?	Questions of security and privacy in sharing health data have received significant attention and discussion.[1] There is not a "one size fits all" model that can be applied in all circumstances. There are, however fundamental data use concepts: • Consumer Empowerment, • Protocols for when people are incapacitated and require immediate lifesaving care, • Fraud, Waste and Abuse Prevention, and • Outcomes Reporting and Analysis <u>HIE</u> **Consumer Empowerment** and Primary Care Practice Transformation are two of three drivers of innovation identified in the Plan. Both envision improved provider to provider and provider to patient communications. Patients will be empowered through the active and continual collection of their consent to share their protected health information (PHI). An individual's health records are owned by that individual. Service providers, payers and other custodians have access to these records based on established need and permissions, but the base premise is they can be shared only with the individual's consent. As we advance the concept of Integrated Eligibility for Human Service programs, we envision

[1] http://www.healthit.gov/policy-researchers-implementers/advancing-privacy-and-security-health-information-exchange

	ongoing updates to a "consent registry". It will record when a patient has provided permission to share data, for how long and for what purpose. Patients must be informed in advance about the benefits of sharing the information, to themselves, their providers and their communities. **Incapacitated, Lifesaving Care** – Clinicians who must give lifesaving care when a patient cannot provide information due to incapacitation should have access to the patient's health information until the emergency has passed. **Fraud, Waste and Abuse Prevention** – While the vast majority of patients and providers use the medical system for its intended purpose, instances of fraud and abuse are real and detrimental. Fraud and abuse must be identified and addressed. Data from various sources should be available for this purpose, but this data must not be diverted to other purposes. We also recognize that various types of research involving 'treatments and coordination of care' by non-public health state projects/agencies may require patient consents as a prerequisite for data use. APCD Performance transparency is one of four enabling initiatives identified in the Plan. Capturing data and performing associated outcomes reporting and other data analytics will allow identification of cost, quality, equity, and care experience issues essential for Connecticut to achieve the triple aim and to evaluate the impact of SIM initiatives. Reporting and analysis will be based on de-identified data, not PHI. Connecticut is in the process of formulating APCD policies and procedures regarding data use, privacy and security. It is contemplated the APCD will be able to share data with various entities both private and public, as allowable under the strict guidelines of HIPAA regulations. Under the allowable guidelines, we can use both de-identified and limited data sets for various research activities and cost transparency reporting, provided the member identification is never compromised.
6. The Plan should provide for telemedicine.	The telemedicine related priority under SIM is e-consult, particularly due to the likely improvement in specialty care access for Medicaid recipients. However, the SIM Program Management Office will be assessing whether and how it can support other telemedicine activities.
7. The Plan should include eConsults for specialty care, and virtual visits and case-based distance learning.	See above. Also, Project Echo was examined as an option for case-based distance learning; however, a complete analysis of this initiative with respect to its impact on quality and cost has not been completed.
8. The Plan should consider additional telehealth innovations such as diabetic retinal screening.	The telemedicine related priority under SIM is e-Consult, particularly due to the likely improvement in specialty care access for Medicaid recipients. However, the SIM Program Management Office will be assessing whether and how it can support other telemedicine activities.
9. The Plan should include expanded use of the Health Equity Index as a	The Health Equity Index is not currently included in the Plan. However, we would consider further assessment in the future.

tool to understand community and population health and to designate HECs based on scoring.	
10. The Plan should encourage commercial payers to provide portals that identify patient-specific gaps in care to clinicians.	We believe that all of the payers are planning to introduce payer specific analytics to support patient specific identification of gaps and provider alerts within the next couple of years. The state will also be developing cross-payer analytic capabilities that will eventually allow for the identification of gaps based on cross-payer claims analysis.
11. With the uncertainty of HITE-CT, the state is still in need of a robust HIE infrastructure for secure messaging of PHI between providers and patients.	In the next three years, SIM will focus on the expanded use of direct messaging, including investment in a consent registry to simplify the consent process and ensure that consumers have the ability to segment the information that is shared and with whom it is shared.
12. How can physicians achieve connectivity and interoperability of quality and cost information across systems in light of anti-trust concerns and limitations by the FTC and DOJ?	The state will consider regulatory provisions that might enable solo and small practices to accurately and efficiently share clinician and cost information real time with their peers across the system (and across practices). The State will evaluate how this could be achieved with consideration of anti-trust restrictions, potentially, by allowing the collaborative sharing of such information as monitored by a state actor such as the health care advocate's office.
13. The Plan should consider Choosing Wisely guidelines for consumer decision support tools.	The state will consider the use of Choosing Wisely to support consumer decision making.

What we heard	***How this influenced the Plan – WORKFORCE DEVELOPMENT***
1. How does the plan address developing a health workforce that can meet the needs of specific populations, such as children, seniors, or persons with certain illnesses such as diabetes?	We agree that strategies must be developed to meet the needs of specific populations. Our primary focus for the Plan was to outline what is needed to assure a workforce capable of meeting the needs of Connecticut's residents for primary care that is based on Advanced Medical Homes.
2. The workforce section barely	Yale University, Quinnipiac University, and Connecticut State Colleges and Universities reviewed the draft

covered the potential contributions of our state's universities other than UConn.	plan in November and December, along with a number of our teaching hospitals and Federally Qualified Health Centers. Their input is reflected in the final submission. In addition, Appendix E summarizes a number of the innovative programs and training activities of the state's universities and institutions. Going forward, we anticipate broad participation in healthcare workforce development by our institutions of higher education.
3. Why didn't the workforce section emphasize the recruitment and retention of primary care clinicians?	We acknowledge the importance of recruitment and retention, but they are mostly driven by what clinicians are paid, how they are paid, and what their conditions of practice are. In short, concerns of payment reform and practice redesign are key to recruitment and retention. Going forward, we expect the Healthcare Workforce Council to work with the other taskforces and councils and with the Healthcare Innovation Steering Committee to achieve payment methodologies and practice designs that will aid in the recruitment and retention of primary care clinicians. In addition, we will be examining other opportunities to attract clinicians to primary care and health professional shortage areas, such as loan forgiveness programs.
4. What about targeted loan forgiveness as a means inducing more clinicians in training to go into primary care? The state could receive matching federal funds for Health Professional Shortage Areas which would help attract and retain primary care physicians.	The Plan calls for an evaluation of loan forgiveness that addresses its potential usefulness and feasibility, identifies potential sources of funding and assesses how it should be targeted.
5. Concern was expressed that November's healthcare workforce section was too focused on physicians relative to the other clinical professions: dental medicine, nursing, pharmacy and social work.	The final submission provides somewhat greater attention to other members of the workforce, including community health workers.

6. There were differing views on whether the scopes of practice (SOP) of the clinical professions should be reviewed. Some favored this consideration; some did not.	The healthcare workforce taskforce determined that it would be too difficult and consuming to address this topic in the plan. In its charge, the upcoming health workforce council is given latitude to consider scopes of practice if it deems it essential to practice redesign and the needs of Connecticut for quality health services but the council can also decide that a consideration of scopes of practice is unwarranted. If it decides that consideration is warranted, the council must recommend a process for addressing scopes of practice.
7. Support was strong for training and certifying Community Health Workers; however, a number of comments noted that the role of Community Health Workers must be carefully worded so that it is clear that it supports a team approach to healthcare and that it does not conflict with the roles of healthcare professionals and other allied health professionals.	The Community Health Worker training and certification initiative in the final Plan submission was described to address these concerns.
8. A number of comments stressed that a healthcare workforce must be developed that can meet the labor needs of Connecticut's healthcare providers, particularly its non-profit healthcare providers.	The health workforce data initiative is meant to provide the knowledge of supply and demand that can guide students in their choice of occupations and schools in their offerings and curricula and to support workforce planning in all healthcare settings.
9. Instilling cultural competency and ending health disparities were recurrent themes in comments on the health work force.	Our expectation is that all six of the healthcare workforce initiatives outlined in the plan will address both cultural competency and health disparities. Healthcare workforce data must track indicators of whether a workforce is being developed that is capable of addressing both. For Community Health Workers, an ability to address both is central to their mission. Interprofessional education and innovative residencies must instill competence in both. Constructing better career pathways is meant, in part, to assist students from minority and disadvantaged backgrounds to become better represented in the healthcare workforce, particularly in the clinical professions.

10. How does this plan support the collection of workforce data and analysis of workforce diversity and adequacy? Is this the role of DPH?	The Plan proposes to modify the information that is collected on-line during the application renewal process, provide for the storage of that data at the state or UConn, and provide for foundational analytics through UConn, while also making the data available publicly.
11. The plan should consider funding for training beyond medical residencies.	The proposed Workforce Council will examine training beyond medical residency. The source of any required funds will need to be considered as the needs are specified.
12. How does this Plan address the shortage of psychiatrists? Allowing psychologists and other mental health providers the training to prescribe psychotropics would be beneficial for access to care issues.	The plan does not specifically take up the issue of access to psychotropic prescribing, except that improved integration of primary care and behavioral health may improve the treatment of patients with psychiatric conditions in primary care settings, including psychopharmacology.
13. It is important to distinguish between Patient Navigators (that coordinate care), Integrative Health Coaches (that facilitate lifestyle changes), and the broad category of CHWs.	We agree that there is work to be done in better defining the roles and functions of community health workers.
14. There should be a strong focus on community based primary care training and FQHCs/Teaching Health Centers.	This remains an area of interest and options will be explored during the detailed design phase.

What we heard	*How this influenced the Plan – GOVERNANCE*
1. How will the process going forward ensure transparency?	The Lieutenant Governor will ensure high standards for transparency including: 1. Posted meeting date, location, and agenda on the SIM website (www.healthreform.ct.gov) 24 hours in advance of any steering committee, council, or taskforce meeting. In addition, we will make every effort to post meeting materials in advance of the meetings. 2. Notice to the Secretary of State's office of the same. 3. Posting of meeting materials and summaries within 7 days of the meeting date.
2. The Governance process should be guided by input from patients, practicing physicians and others with relevant clinical expertise.	We agree with this recommendation. The final Plan creates a governance structure that includes a number of workgroups that will be essential to the detailed design and implementation of SIM and its various work streams: Consumer Advisory Board, Health Information Technology Council, Practice Transformation Taskforce, Quality Council, Equity and Access Council, and Workforce Council. The Healthcare Innovation Steering Committee will approve the composition of each of the workgroups and its members. The composition of the work groups will include consumers, consumer advocates, practicing physicians, health plans, state agencies, and other stakeholders for broadly informed decision making.
3. The Consumer Advisory Board of the Healthcare Cabinet is fairly small and, according to the organization chart, has no direct relation to the decision-making structure of the SIM. Will this Board be expanded and incorporated more fully into the SIM structure? Will its duties in relation to the SIM process be defined?	The SIM governance structure was revised in the Plan. The **Consumer Advisory Board** now has a direct advisory relationship with the Healthcare Innovation Steering Committee and a dotted line advisory relationship with the Program Management Office. In addition, one member of the Consumer Advisory Board has been appointed to the Healthcare Innovation Steering Committee. The composition and membership of the Consumer Advisory Board is determined by the Healthcare Innovation Steering Committee. The Consumer Advisory Board nominates consumers and advocates to the Steering Committee, the Consumer Advisory Board and the work groups. The Consumer Advisory Board may elect to propose changes in composition to the Healthcare Innovation Steering Committee at any time. The Healthcare Innovation Steering Committee recently approved an expansion of membership at the request of the Consumer Advisory Board. The Program Management Office will work with the Consumer Advisory Board to help define its scope during the first six months of 2014.
4. Who will appoint the head of the Program Management Office? To	The Lieutenant Governor appointed the Director of the Program Management Office. The Director reports to the Lieutenant Governor.

whom will the head of the Program Management Office be responsible?	
5. Is there a difference between task force, an advisory council and a council? How will appointments to these bodies be made?	The Plan uses the terms "council" and "task force" to describe five distinct but interdependent workgroups charged with making recommendations for the detail design and implementation of SIM initiatives. The term council is used to refer to bodies that will likely have an ongoing role. The term task force is used for bodies that have a defined task and which may disband after completing the task. Appointments will be made by the Steering Committee.
6. How do these entities relate to the Program Management Office?	The Program Management Office provides the day to day management of the SIM project and coordinates the activities of the councils and taskforce in support of the overall project. The recommendations of the councils and task force will be subject to the review and recommendation of the Healthcare Innovation Steering Committee. The councils and taskforce will provide the necessary expertise and content knowledge in their specific fields in order to provide recommendations, guidance, and insight into the further development and implementation of the Plan. Furthermore, these entities house important stakeholders, such as providers and consumers, whose input is critical to guiding initiatives forward in a meaningful way.
7. How will the SIM and the SIM Program Management Office be adequately resourced? Will it be managed within a government agency that resembles the former Office of Healthcare Reform and Innovation under the leadership of Lt. Governor and Advisory Councils?	The SIM Program Management Office will be housed within the Office of the Healthcare Advocate for administrative purposes. The SIM resource plan will continue to evolve; the Program Management Office intends to use a combination of hired staff within the Program Management Office and contracted expertise to facilitate the Plan's progress toward stated goals. In addition, SIM program activities may be housed within state agencies. These agencies will be accountable for implementing certain aspects of the Plan.
8. A Cost Council should be added to the Governance Structure.	The Plan currently focuses on those councils and taskforces that are essential for designing and implementing SIM initiatives. The Program Management Office anticipates health system economic analytics will be addressed upon fuller development and implementation of the APCD and other analytical tools. The Program Management Office may determine a need for a cost council in subsequent phases of program implementation.
9. The SIM should develop a more sophisticated marketing effort to engage consumers.	The **Consumer Advisory Board** will recommend consumer engagement strategies to the Program Management Office and Healthcare Innovation Steering Committee.