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*State of Connecticut Healthcare Innovation Planning Team*

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Dear Core Planning Team:

The Connecticut Healthcare Innovation Plan Draft 1.1 ("the Plan") builds on reform work of an existing CT system that has been active for many years. What is proposed lofty and ambitious and, for this, the authors are to be congratulated.

I have consulted with national healthcare policy experts at AARP and I am happy to provide comment on the Plan on behalf of AARP CT. Additionally, I want to thank the authors for consulting with AARP CT and our members in the development of the Plan. I hope that the input from our Shelton Chapter and Advocacy Leadership Council was valuable.

Connecticut is clearly different in many ways from more traditional models as it plans to build on the recent organization of medical homes and a more community-based model. While the Plan is designed to include many relevant organizations at the local level, a very positive design feature, it will be challenging to develop the management and coordinated infrastructure that this type of plan needs to be successful.

The Plan has the potential to work well for consumers and deliver more coordinated, less costly care. While it is still a little early to comment specifically on details that have not yet been well-developed, it is a good time to stress some very important principles the authors are encouraged to keep front and center as the design progresses.

The comments below are made at a very high level, but AARP CT wants state decision-makers to know the areas that we will be monitoring and advocating for throughout the design and implementation process.

Robert G. Romasco, President  
Addison Berry Rand, Chief Executive Officer

### Consumer Involvement

It is vitally important that there be organized and respected consumer involvement in the design process and in the implementation phases of the SIM plan. The inclusion of an active consumer advisory council is a good first step. In addition, we recommend that there be strong and active consumer representation on the majority of the plan design committees.

Consumers should have access to active participation at all strategic meetings, not just relegated to their own advisory committee. The question of how any design decision will impact consumers should be an uppermost concern. AARP CT supports consumer involvement during the initial phases of plan implementation and on key advisory committees during the operational stages of the implementation.

### Continuity of Care and Individualized Plan of Care

Whether or not the plans end up instituting voluntary enrollment, AARP CT believes it is vital that sufficient attention is directed to individuals who are transitioning into a new delivery system and/or to a new primary care physician/new providers. If enrollment in a plan results in a change of primary care physician, AARP urges a face-to-face assessment of need with the new participant. Telephonic engagement is not sufficient for individuals with more complex needs and health plans must get to know first-hand the needs of these individuals. To achieve the goals of better care with lower costs, it is essential that plans and providers understand not only the health needs of plan participants, but functional and other adult daily living needs as well.

AARP CT believes that plans need to engage not only with their new members, but also with built-in support systems in order to help achieve both individual goals and the goals of the Plan. This means, at a minimum, an initial face-to-face engagement with the individual and support system in developing a plan of care for the health and well-being of the individual. While this may not be necessary for all individuals, it should become engrained as standard procedure for assessing need, developing a plan and ensuring involvement by stakeholders, such as family caregivers, local health and human services providers (nutrition, transportation, social, etc.) and others who can assist in implementing the plan of care.

### Monitoring Service Delivery and Care Transitions

AARP CT feels strongly that there must be robust methods for monitoring the health and well-being of all program participants. Frequency of direct contact with the plan participant should be included in any plan of care. While one cannot prevent every acute care need, we encourage developing a care system with a built-in expectation that there is sufficient involvement with the plan participant for avoiding potential acute care occurrences. Additionally, if a plan participant is hospitalized there must be clear accountability on which entity will be responsible for an effective transition back to the home or to a rehab facility (and subsequently home). Care transitions need to be closely monitored and measured, and plans held accountable via reward and/or penalization, for ensuring the best outcome for the consumer.

Data and Performance Benchmarks

Health plans and other coordinating entities are becoming familiar with increased demands for financial and care benchmark data. AARP CT is very concerned that plans not be given financial incentives to withhold care. Data must be collected and benchmarks set to reward plans and other coordinating entities based on health outcomes for the consumers they serve. AARP CT opposes any payment system that monetarily rewards plans solely on a per member per month basis. That system inevitably leads to withholding care and/or denials of legitimate claims. AARP urges the use of best practices methodologies that reward plans for specific performance and to consider penalizing plans that do not meet accepted performance standards. This can be approached in different ways, but plans should understand that there are defined indicators that can reveal whether defined outcomes are being achieved.

Thank you for the opportunity to provide input and this and additional junctures in the process.

Regards,

A handwritten signature in black ink, appearing to read 'Nora Duncan', with a long horizontal line extending to the right.

Nora Duncan  
State Director