

# Stakeholder Engagement Plan

Connecticut State Innovation Model Test Grant  
April 3, 2015

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## I. Introduction

Connecticut’s stakeholders are committed to producing better health, better and more equitable care, and lower costs through implementation of our Connecticut State Innovation Model Test Grant. Our State Innovation Model (SIM) test will determine whether a comprehensive set of statewide transformation initiatives will accelerate improvements in the performance of the health care system for all of Connecticut residents. It includes activities in the areas of quality measure alignment, value-based insurance design, health information technology, payment reform, and population health initiatives. For this ambitious healthcare delivery system transformation to be meaningful and sustainable, we must continuously engage our stakeholders, including consumers, advocates, employers, community organizations, providers, local and state officials, Medicaid, Medicare, and private health plans.

Connecticut’s State Innovation Model Test Grant builds on and expands stakeholder engagement efforts that began in the design and planning phases. We are undertaking pre-implementation activities with broad stakeholder support. The following Stakeholder Engagement Plan details how Connecticut intends to continue to engage a variety of stakeholders during the State Innovation Model pre-implementation and test period.

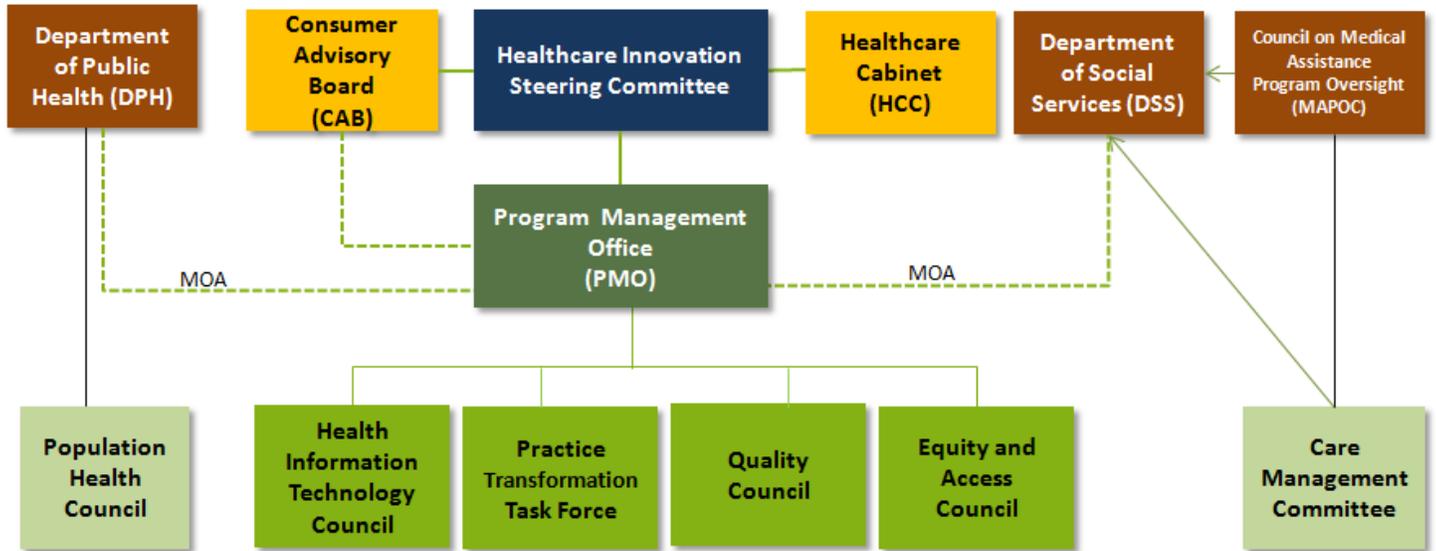
Our stakeholder engagement strategy reflects the following **core values**:



## II. State Innovation Model Governance Structure

The CT SIM Test Grant was designed to be implemented with significant public input, and facilitated by clear plans for governance, management, and communication. Our governance structure is one of the primary methods for engaging and empowering a broad array of stakeholders and formalizes stakeholder involvement across a variety of interests.

**Exhibit A: SIM Governance Structure & Related Advisory Committees**



The SIM governance structure includes:

1. Healthcare Innovation Steering Committee
2. Program Management Office (PMO)
3. Consumer Advisory Board (CAB)
4. Healthcare Cabinet (HCC)
5. Four workgroups:
  - a. Health Information Technology Council
  - b. Practice Transformation Taskforce
  - c. Quality Council
  - d. Equity and Access Council

A fifth workgroup, Workforce Development Council, remains under consideration. In addition, the PMO will collaborate and work closely with the Department of Social Services (DSS), which administers Medicaid, and the Department of Public Health (DPH), along with input from the following advisory committees:

1. Council on Medical Assistance Program Oversight (MAPOC), and their Care Management Committee
2. Population Health Council, overseen by the Department of Public Health

The Office of the State Comptroller (OSC) will play a lead role in the engagement of employers on Value-Based Insurance Design. The OSC and PMO will establish an employer-led consortium and an annual learning collaborative.

## **1. Healthcare Innovation Steering Committee**

This Healthcare Innovation Steering Committee is responsible for providing oversight of the Innovation Plan and Model Test. Participants include private foundations; consumer advocates; representatives of a hospital anchored health system, physicians; health plans; and employers. Additionally, the Comptroller's office and health insurance exchange are represented as well as line agency Commissioners with responsibility for public health, insurance, Medicaid, behavioral health, and child welfare. The Office of Policy and Management (OPM) with responsibility for the state budget is also a member.

The Steering Committee is chaired by Lieutenant Governor Nancy Wyman. The Lieutenant Governor is a former healthcare provider and healthcare purchaser in her former role as State Comptroller, and advocate for improving healthcare access and affordability. She has provided overall leadership, ensuring participation from a broad range of public and private entities.

The Steering Committee will continue to meet monthly, providing advice and guidance on SIM design and implementation, while addressing key strategic, policy, and programmatic concerns. Our plan provides for ongoing alignment of payment reforms through the use of an ad hoc Finance Work Group, which we anticipate will include all major health plans. The Steering Committee will also designate a multi-payer Rapid Response Team to work directly with our evaluator to review and respond to information regarding pace and performance of our reforms.

## **2. Program Management Office (PMO)**

The SIM Program Management Office (PMO) is located within the Connecticut Office of the Healthcare Advocate (OHA) and is responsible for administering the Connecticut State Innovation Model Grant. The PMO will be accountable for the conduct of specific SIM initiatives and will work closely with state agencies and stakeholders that hold accountability for components of the plan. The PMO will communicate SIM progress to the public and state government, engage with stakeholders, and provide staff support to SIM. The PMO administers a SIM Core Team comprised of representatives from the DSS, DPH, OSC, OPM, the Department of Mental Health and Addiction Services (DMHAS), the UConn Health evaluation team, State Health Information Technology (HIT) Coordinator and other representatives of the UConn Health HIT technical team, Access Health CT/APCD, and the Consumer Advisory Board. The SIM Core Team supports overall program management and coordination amongst the various lead entities.

### 3. Consumer Advisory Board (CAB)

The CAB is a 16 member independent advisory board that will continue to provide advice and guidance directly to the Steering Committee (on which it has a seat) and the PMO. The CAB is racially and ethnically diverse, with members involved in advocacy and community development, health services, and housing. The Consumer Advisory Board provides advice and guidance to the PMO and the Steering Committee, on which it has a seat.

The Consumer Advisory Board (CAB) is the main vehicle in the governance structure to ensure community and consumer stakeholder engagement. The CAB's mission statement is:

*“The mission of the Consumer Advisory Board is to advocate for and facilitate strong public and consumer input to inform policy and operational decisions on health care reform in Connecticut.”*

The CAB's mission is supported by the following strategies:

- Providing a forum for consumers, their advocates and the public to provide oral and written input on health care reform.
- Serving as a catalyst to engage consumers and solicit their input on specific health care reform issues.
- Helping to educate and engage consumers and the public about state and federal health care reform laws and health care reform policies and regulations as they are proposed and implemented.
- Informing policymakers about the importance of addressing healthcare disparities and consumer needs.
- Offering advice and feedback to the state's PMO and other health care policy leaders on best practices for implementing consumer assistance and consumer access systems.

### 4. Health Care Cabinet

Connecticut's Healthcare Cabinet was established in 2011 to advise Governor Dannel P. Malloy and Lieutenant Governor Nancy Wyman on issues related to implementation of federal health reform and the development of an integrated healthcare system for the state. The Cabinet consists of both voting and non-voting members, is chaired by the Lieutenant Governor and includes nine state offices or departments: OHA, OSC, OPM, DPH, OSC, DSS, DMHAS, the Department of Children and Families (DCF), the Connecticut Insurance Department (CID) the Department of Developmental Disabilities (DDS) as well as the Non-Profit Liaison to the Governor. Other representatives are appointed by legislative leadership and represent home health care, small businesses, hospitals, faith communities, HIT industry, primary care physicians, advanced practice registered nurses, consumer advocates, labor, oral health services, community health centers, the healthcare industry and insurance producers. Two members- at-large also participate. The Healthcare Cabinet is charged with improving the physical, mental and oral health of all state residents while reducing health disparities by maximizing the state's leveraging capacity and making the best use of public and private opportunities.

SIM staff will continue to regularly present to the Healthcare Cabinet on a monthly basis to solicit input on various aspects of SIM implementation.

## 5. Workgroups

Four workgroups have been established to ensure that the necessary stakeholders and technical experts are continually engaged and actively involved in the implementation of the SIM grant. There are four broad categories of representation on these workgroups: consumer/advocate, payer, provider, and state agency. The workgroups participate in detailed planning, and provide oversight across a range of areas including Practice Transformation, Quality, Equity and Access, and Health Information Technology (HIT). In addition, each workgroup charter requires a plan for stakeholder engagement to ensure that additional stakeholders are consulted on the development of specific work products.

The meeting frequency varies depending on the requirements of SIM design. Meetings currently occur as often as twice a month, but will likely occur on a monthly or quarterly basis as we move from planning to implementation. When necessary, design groups are established to consider special issues and to engage additional external stakeholders who may have the expertise and knowledge necessary to inform the planning. **For the meeting schedule, minutes, and workgroup membership and charters please visit <http://healthreform.ct.gov/ohri/cwp/view.asp?a=2765&q=333596&ohriNav=|>.**

### a. Practice Transformation Task Force

The Task Force is comprised of consumer and health equity advocates, physicians, a provider of behavioral health services, a Federally Qualified Health Center, APRN, health plans, and state agencies. To date this taskforce has recommended the Connecticut Advanced Medical Home standards, which the state is preparing to pilot prior to full implementation under the test grant. The MAPOC has designated two additional representatives to represent the interests of Medicaid beneficiaries. The Task Force has established design groups with additional representation and expert consultation in the areas of health equity, behavioral health, and oral health. Despite its name, the Task Force will also advise on broader care delivery reform activities. The Task Force is currently charged with developing the strategy for the Community and Clinical Integration Program (CCIP).

### b. Quality Council

The Quality Council is comprised of consumers, consumer advocates, a health equity advocate, physicians, health plans, OSC, DMHAS and the DPH chronic disease director. Physicians other than those represented are consulted in the measure development process as the need arises. The Council also includes two representatives from the MAPOC, one of whom also represents the Connecticut Hospital Association. The Council has established design groups with additional representation and expert consultation in the areas of care experience, health equity, behavioral health, and pediatrics. The MAPOC's Care Management Committee will recommend supplemental measures that address the needs of the Medicaid program.

The Quality Council is in the process of developing a core measurement set for use in the assessment of primary care, specialty and hospital provider performance and the overall evaluation of the Connecticut health and healthcare systems. The council may develop a common provider scorecard format for use by all of the payers. The measurement set will be reassessed on a regular basis to identify gaps, to incorporate new national measures as they become available, and to keep pace with changes in technology and clinical practice.

### **c. Health Information Technology (HIT) Council**

Members of the HIT Council cover an array of skills and experience from business processes and policy to business analytics and information technology. Membership includes consumer advocates, payers, health information technology and analytics staff from hospitals and Advanced Networks<sup>1</sup>, consumers, a Federally Qualified Health Center, the state medical society, OSC and DMHAS. A design group has been established to focus on the production of performance measures. The combined membership of the HIT Council is such that it has formal authority or the ability to influence public or private HIT systems and technical HIT expertise. The Council will, among other things:

- set HIT priorities and develop payer and provider education materials;
- provide input and expertise regarding the creation of the HIT Strategic Plan;
- define standards for system interoperability and consistent formats for reports and portals; and
- coordinate with HIE, HIX, other HIT-intensive initiatives

### **d. Equity and Access Council**

This council is comprised of consumer and health equity advocates, representatives of the physician, advanced network and FQHC communities, and health plans with a commitment to ensuring long-term, systemic provision of appropriate care and access, especially to typically underserved communities.

Design work groups have been established to engage the council participants and the public in more focused conversations on what recommendations to make to protect against under-service and patient selection as value based payment reforms are implemented. Four design groups have been developed to focus the group, two of which focus on value based payment design elements and two that focus on supplemental safeguards. The four design groups are follows:

1. Group One: Patient Attribution and Cost Benchmark Calculation
2. Group Two: Payment Calculation and Distribution
3. Group Three: Rules, Communications and Enforcement
4. Group Four: Detection and Monitoring – Concurrent and Retrospective

The council, along with the design groups, will:

- recommend retrospective and concurrent analytic methods to ensure safety, access to providers and appropriate services, and to limit the risk of under-provision of requisite care;
- recommend a response to demonstrated patient selection and under-service; and
- define Connecticut's plan to ensure the AMH model systematically includes at-risk populations

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<sup>1</sup> Advanced Networks are defined as independent practice associations, large medical groups, clinically integrated networks, and integrated delivery system organizations that have entered into shared savings plan (SSP) arrangements with at least one payer. This definition includes entities designated as Accountable Care Organizations for the purpose of participating in Medicare's SSP.

### III. Governance Processes

All meetings will continue to be governed by and compliant with state policies and procedures regarding public meetings. Agendas are posted in advance of all meetings. Minutes are published on the SIM website along with meeting materials.

Membership for the four work groups, and the CAB was done in a deliberate and inclusive. Composition, membership criteria and roles were approved by the Steering Committee. A public solicitation was undertaken by the PMO in partnership with the CAB. All nominations for membership were approved by the Steering Committee. When members need to be added or replaced for the workgroups, the personnel subcommittee of the Steering Committee meets as needed to advise regarding the method and criteria for member solicitation. This subcommittee reviews applications and presents a recommendation to Steering Committee, which votes on proposed appointments.

All governing bodies are advisory in nature. They do not have authority regarding matters of budget, but may make recommendations to the PMO. Members of the governance structure may from time to time participate in procurements administered by the PMO. However, such participants are subject to strict conflict of interest and confidentiality rules as outlined at [http://www.healthreform.ct.gov/ohri/lib/ohri/sim/steering\\_committee/2015-02-05/sim\\_conflict\\_of\\_interest\\_protocol\\_final\\_draft.pdf](http://www.healthreform.ct.gov/ohri/lib/ohri/sim/steering_committee/2015-02-05/sim_conflict_of_interest_protocol_final_draft.pdf).

**For information about work group composition, criteria, and roles of workgroup members, see APPENDIX A.**

Other committees, work groups, and councils may be formed as the need arises. For example, a group may be established to advise on the Community Health Worker (CHW) training and certification process and to facilitate discussions about CHW sustainability models.

**The following table inventories the organizations currently represented in the Steering Committee and the four work groups.** This does not include the members that will be convened for the Population Health Council or that comprises the Healthcare Cabinet or MAPOC/CMC, whose membership information is detailed in upcoming sections and in **APPENDIX B.**

For a complete listing of the individuals represented in the Steering Committee and the four work groups, refer to **APPENDIX B.**

**Exhibit B: Stakeholders engaged through SIM Governance**

Federal, State and Local Governmental Stakeholders	Community and Consumer Stakeholders, Employers	Payers	Providers
<ul style="list-style-type: none"> <li>— Department of Public Health</li> <li>— Department of Social Services</li> <li>— Department of Mental Health &amp; Addiction Services</li> <li>— Office of the Healthcare Advocate</li> <li>— Department of Children and Families</li> <li>— Access Health (CT’s Health Exchange)</li> <li>— Connecticut Insurance Department</li> <li>— Office of Policy and Management</li> <li>— University of Connecticut Health Center</li> <li>— Office of the State Comptroller</li> <li>— Yale School of Medicine</li> <li>— Bureau of Enterprise Systems Technology</li> <li>— CT State Senate</li> <li>— CT House of Representatives</li> <li>— APCD</li> <li>— MAPOC/CMC</li> <li>— Office of the State Comptroller</li> </ul>	<ul style="list-style-type: none"> <li>— 16 unaffiliated consumer advocates</li> <li>— United Technologies Corporation</li> <li>— Pitney Bowes, Inc.</li> <li>— Connecticut Health Foundation</li> <li>— Windham Regional Community Council</li> <li>— Bridgeport Child Advocacy Coalition</li> <li>— Connecticut Legal Rights Project</li> <li>— Small Business for a Healthy Connecticut</li> <li>— Christian Community Action, Inc</li> <li>— Khmer Health Advocates</li> <li>— Connecticut Voices for Children</li> <li>— PATH Parent to Parent/Family Voices of CT</li> <li>— Latino Community Services, Inc.</li> <li>— United Way of Connecticut</li> <li>— Partnership for Strong Communities</li> <li>— Connecticut Health Policy Project</li> <li>— Connecticut Legal Services</li> <li>— Legal Assistance Resource Center of Connecticut</li> <li>— Universal Healthcare Foundation of Connecticut</li> <li>— Harris Forbes Associates</li> <li>— American Cancer Society - New England Division</li> <li>— National Association of Social Workers - CT Chapter</li> <li>— Eastern Area Health Education Center</li> <li>— Project Access</li> <li>— National Cambodian-American Health Initiative</li> <li>— United Connecticut Action for Neighborhoods</li> <li>— Health Policy Matters</li> <li>— Connecticut Oral Health Initiative</li> <li>— NAMI Connecticut</li> <li>— Connecticut Center for Patient Safety</li> <li>— Optum Government Solutions</li> </ul>	<ul style="list-style-type: none"> <li>— Medicaid</li> <li>— State Employee Health Plan</li> <li>— Anthem Blue Cross &amp; Blue Shield</li> <li>— Aetna</li> <li>— Cigna</li> <li>— United Healthcare</li> <li>— Connecticare</li> <li>— HealthyCT</li> </ul>	<ul style="list-style-type: none"> <li>— Connecticut Hospital Association</li> <li>— Griffin Hospital</li> <li>— Fair Haven Community Health Center</li> <li>— Orthopedic Associates of Hartford</li> <li>— Connecticut Medical Group, LLC</li> <li>— Yale New Haven Health System</li> <li>— Connecticut State Medical Society</li> <li>— Radiological Society of Connecticut</li> <li>— Norwalk Hospital</li> <li>— Community Health Center Association of Connecticut</li> <li>— Community Medical Group IPA</li> <li>— Hartford Healthcare</li> <li>— Saint Mary’s Hospital</li> <li>— Saint Francis Center for Health Equity</li> <li>— St. Vincent’s Health Partners</li> <li>— Family Medicine Center at Asylum Hill</li> <li>— Norwalk Community Health Center</li> <li>— ProHealth Physicians</li> <li>— Pediatrics Plus</li> <li>— Connecticut Association of School Based Health Centers</li> <li>— Stamford Hospital</li> <li>— Community Health Center, Inc.</li> <li>— American College of Physicians - CT Chapter</li> <li>— Cardiology Associates of New Haven PC</li> <li>— Connecticut Institute for Clinical and Translational Science at UConn</li> <li>— Robert D. Russo MD and Associates Radiology</li> <li>— Burgdorf Health Center</li> <li>— Southwest Community Health Center, Inc.</li> <li>— ConnectiCare, Inc. &amp; Affiliates</li> <li>— Western Connecticut Health Network</li> <li>— Team Rehab</li> <li>— Medical Analytics Department, ConnectiCare, Inc.</li> <li>— Westwood Women’s Health</li> <li>— ENT &amp; Allergy Associates LLC</li> <li>— Community Health Resources</li> </ul>

## IV. Other Advisory Committees

### 1. Medical Assistance Program Oversight Council (MAPOC) - Care Management Committee

CT law established the MAPOC as the legislative oversight body for the Medicaid/CHIP programs. The MAPOC has designated the Care Management Committee to review and comment on each aspect of the design of the Medicaid Quality Improvement and Shared Savings Program (Medicaid QISSP), including the establishment of consumer protections and implementation activities. Committee membership will be supplemented by members of the Steering Committee and CAB. Additionally, MAPOC has designated up to two members to participate in each SIM work group and the Steering Committee.

### 2. Population Health Council

The Population Health Council is responsible for developing the Population Health Plan during the SIM test period, including: 1) identifying additional state health priorities relevant to the Model Test (e.g. child wellness); 2) identifying barriers to population health improvement; and 3) recommending specific evidence-based strategies to address tobacco, obesity, diabetes and other identified priorities.

In developing its statewide Health Improvement Plan, Healthy Connecticut 2020, Connecticut engaged 150 organizations in developing a broad population health improvement framework that addresses chronic disease and its risk factors; infectious diseases; injury and violence; mental health, alcohol and substance abuse; environmental health; maternal, infant and child health; and health system issues such as access to care, health financing, health workforce, health information technology, quality of care and public health. From this stakeholder base, we intend to draw representatives from sectors that have a role in health improvement and the shared values of prevention, wellness and reducing health disparities, to reconvene into the Population Health Council.

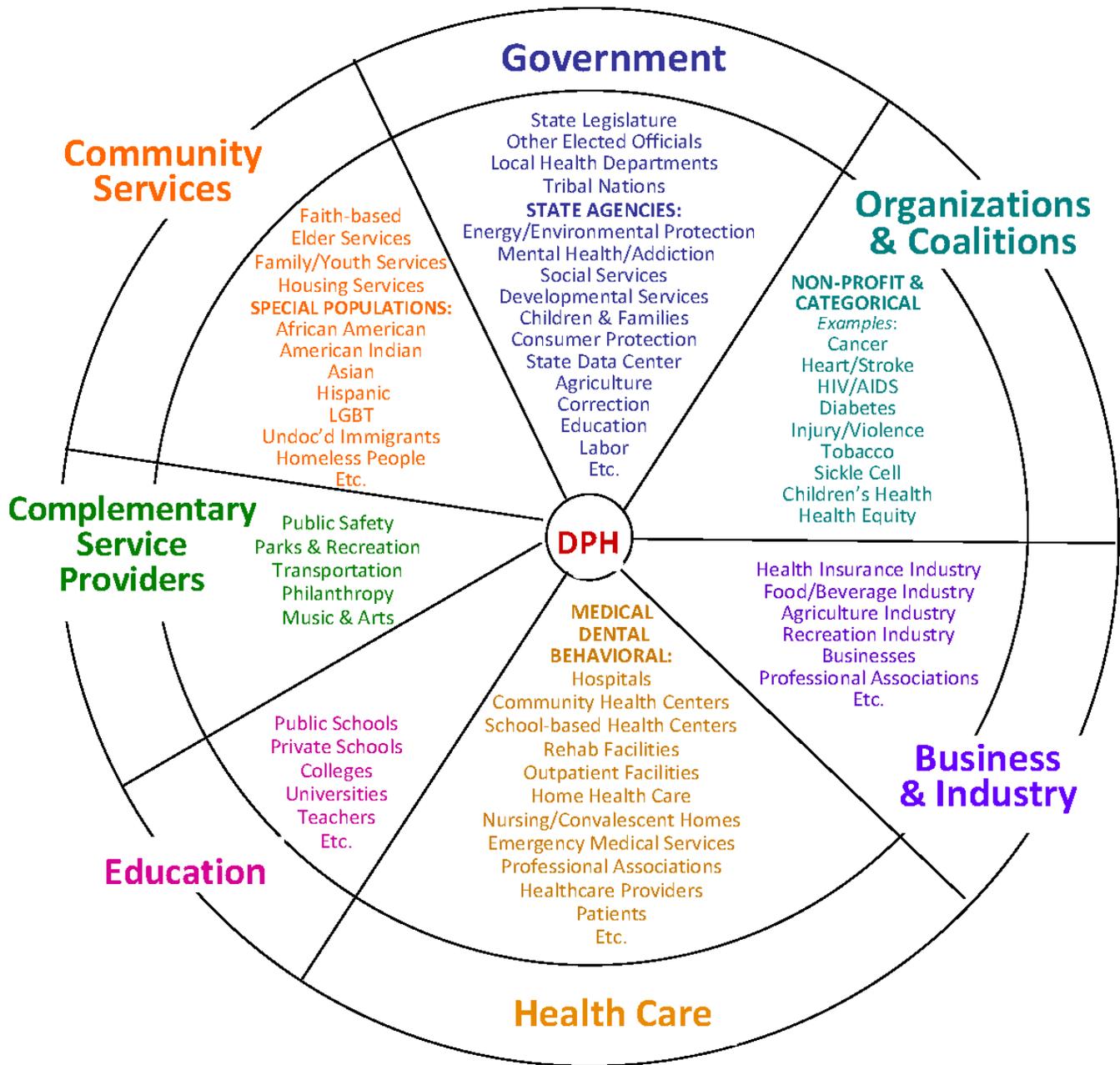
To address gaps in payer, provider and business participation from the previous council, we will draw from SIM governance stakeholders. To the extent possible, Connecticut seeks to widen the circle of involvement with new partners and representatives in order to facilitate grass roots participation and enhance creativity and innovation in solving health challenges. Planning and thinking around stakeholder engagement will continue to evolve and may benefit from additional input and advice from the newly convened Healthy Connecticut 2020 Advisory Council [HCT 2020 Council]. The goal of the HCT 2020 Council is to implement all focus areas including Health Systems and Chronic Disease which together encompass many of the SIM goals. Coalition members already conducting work in these areas were identified via survey. From this list, Lead Conveners, to coordinate partners to work toward health improvement goals in these focus areas were nominated by the Advisory Council according to several criteria (capacity, credibility, trusted entity etc.). This may provide the basis for Population Health Council membership. The below **Stakeholder Wheel** can be reviewed to ensure broad based representation from all relevant sectors, including business, payers, providers and partners. This includes key agencies and offices with potential influence over social determinants of health (SDH) to be included on the Population Health Council. Illustrative examples include the Office of Early Childhood,

Department of Housing, Insurance, Social Services and other payers. This Council will also be comprised of representatives from key sectors and health stakeholders including hospitals and community health centers, Departments of Education, Transportation, and Environmental Protection, various community coalitions, and philanthropies. CDC will be consulted for technical assistance.

A Charter for the Council will be developed that lays out structure, roles and responsibilities of members, and key qualifications. Additional input may be sought from the Healthy Connecticut 2020 Advisory Council about ways to link and leverage these efforts and capture the current momentum of activity. An executive committee initially comprising DPH, DSS and PMO is in place to establish the Council, and may be broadened to ensure links to the social determinants of health.

We also seek to extend our relationship with Health Resources in Action (HRiA) for consultation and assistance with stakeholder and community engagement processes and techniques. General engagement methods with the Council may include but are not limited to: regular communications (website, email, webinars); structured meetings (facilitated discussions, use of key questions, group priority setting methods, voting, surveys, reporting successes); and stakeholder tasks based on area of expertise. If the opportunity is available, the Council may consider community discussions, hearings, and/or a public comment period for wider engagement and input on components of the Plan.

**Exhibit C: Sector and Stakeholder Wheel for Population Health Planning**



The Population Health Council will engage additional stakeholders when it begins planning for both the **Prevention Service Centers (PSCs)** and **Health Enhancement Communities (HECs)**.

#### **a. Prevention Service Centers (PSCs)**

Prevention Service Centers are community-placed organizations that would meet criteria for the provision of evidence-informed, culturally and linguistically appropriate community prevention services. Prevention Service Centers may be new or existing local organizations, providers (e.g., FQHCs), non-profits or local health departments. Prevention Service Centers will foster alignment and collaboration between primary care providers, community-based services and State health agencies. Their workforce will include existing workers providing similar services (e.g. local health department staff, Area Agencies on Aging, FQHC staff) and the emerging cadre of community health workers envisioned as part of our healthcare workforce development strategy.

#### **b. Health Enhancement Communities (HECs)**

During Year 3 of the test grant planning will begin for HECs in areas with the greatest disparities, targeting resources and facilitating local coordination and accountability among local stakeholders in a specified region(s). At this time local stakeholders will be engaged in the Council's work including local providers, public health departments, nonprofits, schools, housing authorities and others. One of the main purposes of regional HECs is to stimulate stakeholder engagement and collaboration in SIM models of payment and quality care that will increase accountability for healthcare equity, quality, and cost. The HECs will be collaborative multi-sector partnerships—alliances among people and organizations from multiple sectors working together to improve conditions and outcomes related to health and well-being of entire communities. We anticipate that Prevention Service Centers would be among the multi-sector participants.

One example of an effective collaborative partnership that HECs will try to model is a health and wellness district jointly sponsored by Charter Oak Communities, City of Stamford and Stamford Hospital. The vision is not only to revitalize the economic health and well-being of Stamford's West Side residents but also to ensure a health and wellness destination that can improve the quality of life for the entire city. Stakeholders engaged include experts with regard to improving access to healthier food, fitness opportunities, and preventive health and medical care as well as job training and workforce development. Informed by a local Community Health Needs Assessment (CHNA) and a collaborative strategic planning process, the initiative is well underway and has achieved a number of accomplishments.

Within the Population Health Council, a five to six member executive committee will be formed to inform and guide the work of the Council. Participants of the executive committee will collaborate closely and share decision making authority. Led by DPH, the committee will include, for example, representatives from DSS, the PMO, and key entities and organizations with specialized knowledge and expertise in SDH.

To ensure that Population Health planning engages stakeholders involved in the other SIM reforms, the Medicaid QISSP, CCIP, and VBID leads will be requested to submit and/or present quarterly progress

updates to the Population Health Council. The CCIP in particular, will be well positioned to assess, from the primary care practice perspective, gaps and needs in community-based preventive services that could inform the design of population health initiatives. The DPH-based Population Health Planning leads will participate in SIM Core Team meetings to ensure that the practice transformation and payment reform initiatives are current with developments and recommendations of the Population Health Council. In addition DSS will consult on a regular basis with DPH Population Health Planning leads regarding Medicaid QISSP design, implementation and monitoring. Finally, DPH, DSS, and the PMO will execute Memoranda of Agreement that detail their joint planning and administrative responsibilities.

## V. Stakeholder Engagement Methods

CT's State Innovation Model will ensure transparency and the availability of information throughout the test period. All Steering Committee and work group meetings will be publicly announced on Connecticut's television network (CT-N), posted on the website, and accessible in person or by telephone. They will continue to be public meetings, with a public comment period designated at the beginning of each meeting.

The state will maintain its website (<http://healthreform.ct.gov/ohri/site/default.asp>) dedicated to disbursing information about SIM work group meetings, PowerPoints, narratives, and other critical information. Meeting agendas, materials, and summaries will be made available on the website in an effort to ensure broad public visibility. A dedicated email address was established ([sim@ct.gov](mailto:sim@ct.gov)) and staffed to ensure that stakeholders who could not attend meetings or telephone in were able to send comments and questions.

Besides the governance structure and the availability of information, the testing period will involve a variety of other engagement methods including: conferences, forums, learning collaboratives, dissemination of information tailored to specific stakeholders (e.g., reports, data, etc.), and presentations.

**The following table outlines the main engagement methods we aim to utilize during the testing phase.**

**Exhibit D: Engagement Methods**

Stakeholder	Engagement Method			
	Inform	Consult & Involve	Engage & Empower	
<b>Federal, State and Local Government Stakeholders</b>	Information posted on CT SIM website	MOAs, Core Team	Internal Core Team meetings with the PMO	<b>Public SIM governance meetings (in person and by phone):</b>  Steering Committee (monthly)  Health Information Council (monthly)  Practice Transformation Task Force  Quality Council  Equity and Access Council  Healthcare Cabinet (HCC)  <b>Other Advisory Committees:</b>  MAPOC – Care Management Committee  DPH’s Population Health Council
<b>Community and Consumer Stakeholders, Employers</b>	Community Stakeholder Presentations	Comments and questions via sim@ct.gov  Care Experience Survey  Public Comment	Consumer Advisory Board	
	Materials and presentations to employers		Annual Employer Innovators Conference	
	Dissemination of quality and cost information		VBID Learning Collaborative	
	Information posted on CT SIM website			
<b>Payers</b>	Information posted on CT SIM website	Email correspondence	Ad hoc individual and group meetings	
<b>Providers</b>		Comments and questions via sim@ct.gov		
	Information posted on CT SIM website	Provider Survey  Provider Forums	Advanced Medical Home Vanguard and Glide Path Programs	
	Reports about quality and cost	CHW annual conference	Community and Clinical Integration Program	
	AMH GP - Practice Transformation curriculum	Comprehensive physician licensing questions  Public Comment  Site-visits	Learning Collaboratives  Targeted Technical Assistance	

## VI. Engagement Details by Work stream

The following three sections represent core work streams of the CT SIM Test Grant:

- 1. Care Delivery Transformation**
- 2. Payment Reform**
- 3. Population Health Plan**

For each of the three work streams, key stakeholder outputs & deliverables are inventoried, along with the stakeholders that will be engaged, and the target dates. Stakeholders are divided into the following categories: federal, state and local government entities; consumer, community and employers; payers; and providers.

For each stakeholder category that will be engaged, the following information is detailed:

- Stakeholder information
- Rationale for engagement
- Method for engagement
- Timeframe for stakeholder engagement
- Roles and responsibilities
- Potential risks

## 1. Care Delivery Transformation

Advanced Medical Home Glide Path						
<i>Output/Deliverable</i>	<i>Government</i>	<i>Consumer Community Employer</i>	<i>Payers</i>	<i>Providers</i>	<i>Target Date</i>	
Establish and endorse standards for AMH.	X	X	X	X	Y1, Q1	
Practices enroll into the Advanced Medical Home Glide Path from Advanced Networks for Wave 1 / and Wave 2.	X			X	Y1, Q3 / Y3, Q3	
185 practices transformed to AMH status. Begin recruiting Wave 2 practices.	X			X	Y3, Q2	
370 practices transformed to AMH status.				X	Y4, Q4	
Share best practices and experiences with AMH Glide Path.				X	Y1-Y4	
Provide operational support for AMH Glide Path Program.	X				Y1-Y3	
Clinical and Community Integration Program (CCIP)						
<i>Output/Deliverable</i>	<i>Government</i>	<i>Consumer Community Employer</i>	<i>Payers</i>	<i>Providers</i>	<i>Target Date</i>	
Establish and endorse detailed program design.	X	X	X	X	Y1, Q1	
Practices enroll in CCIP.	X			X	Y1, Q3 / Y3, Q3	
Share best practices and experience with CCIP.		X		X	Y1-Y4	
Provide operational support to CCIP practices.	X				Y1, Q3- Y4, Q4	
Workforce Development						
<i>Output/Deliverable</i>	<i>Government</i>	<i>Consumer Community Employer</i>	<i>Payers</i>	<i>Providers</i>	<i>Target Date</i>	
Enhance capabilities and integration of Community Health Works.	X	X		X	Y1, Q3- Y4, Q4	
Health Information Technology / Analytics / Performance Transparency						
<i>Output/Deliverable</i>	<i>Government</i>	<i>Consumer Community Employer</i>	<i>Payers</i>	<i>Providers</i>	<i>Target Date</i>	
Statewide HIT and analytic capability, including direct messaging and consent registry.	X	X	X	X	Y1, Q1- Y4, Q4	

<b>Federal, State and Local Governmental Stakeholders:</b>		
<b>Stakeholder Information:</b>	<ul style="list-style-type: none"> <li>– Department of Public Health</li> <li>– Department of Social Services</li> <li>– Department of Mental Health &amp; Addiction Services</li> <li>– Office of the Healthcare Advocate</li> <li>– Department of Children and Families</li> <li>– Access Health (CT’s Health Exchange)</li> <li>– Connecticut Insurance Department</li> <li>– Office of Policy and Management</li> <li>– APCD</li> </ul>	<ul style="list-style-type: none"> <li>– University of Connecticut Health Center</li> <li>– Office of the State Comptroller</li> <li>– Yale School of Medicine</li> <li>– Bureau of Enterprise Systems Technology</li> <li>– CT State Senate</li> <li>– CT House of Representatives</li> <li>– MAPOC</li> <li>– SIM Program Management Office</li> </ul>
<b>Rationale for Engagement:</b>	<p>In order for the cross-cutting scope of CT’s State Innovation Model to be successful, a multitude of government stakeholders must coordinate and be involved in its implementation. Streamlined policy and program development processes will maximize the effectiveness and impact of the AMH Glide Path, CCIP, and workforce development.</p> <p>For example, CCIP will include initiatives that span multiple state agencies, including the Department of Social Services, Department of Mental Health &amp; Addiction Services, the Office of the Healthcare Advocate, and local governmental health entities. These government stakeholders must coordinate and be involved in CCIP’s implementation for it to be successful.</p>	
<b>Method for Engagement:</b>	<p><b><u>Committees &amp; Workgroups</u></b></p> <p>The PTF has representation from the Department of Social Services and the Department of Mental Health &amp; Addiction Services.</p> <p>The Health Information Technology Council, which includes membership from DSS, DPH, DMHAS, Office of the State Comptroller and the Bureau of Enterprise Systems Technology, is tasked with advising on the development of a statewide HIT strategy that supports SIM work.</p> <p>In addition, the Healthcare Innovation Steering Committee will continue to meet monthly to discuss grant implementation topics, including the AMH Glide Path, workforce development, and CCIP. The Committee acts as a forum to share updates, obtain feedback, and make streamlined decisions regarding SIM concerns. These meetings have seen active commitment from line agency Commissioners with responsibility for public health, Medicaid, behavioral health, insurance, APCD, and child welfare, as well as OPM and the Comptroller’s office.</p>	

	<p><b><u>Contractual</u></b> DSS and the PMO are finalizing a Memorandum of Agreement (MOA), which will engage DSS in a targeted way to perform specific services in regard to initiatives including the MQISSP, HIT, CCIP, and AMH Glide Path.</p> <p><b><u>Management – Individual Engagement &amp; Core Agency Meetings</u></b> The PMO acts as the main coordinating body of SIM initiatives and will continue to hold regular internal meetings with the relevant agencies in regards to the AMH Glide Path, CCIP, and workforce development. In addition, a bi-weekly core team will be convened that is comprised of the state agencies who are administering SIM services/outputs.</p>
<b>Timeframe for Stakeholder Engagement</b>	CCIP, the AMH Glide Path, and workforce development initiatives will require ongoing involvement of the mentioned agencies throughout the life of the grant.
<b>Roles and Responsibilities:</b>	<p>The role of government entities includes the outputs of the Practice Transformation Taskforce (PTTF). PTTF has finalized the development of AMH standards, and they will be an advisory body that oversees the implementation of these standards. The PTTF is also tasked with developing the details of the CCIP. After the details are finalized, the PTTF will be an advisory body that oversees its implementation.</p> <p>The launch of the SIM AMH Glide Path requires that it is aligned with DSS’s glide path program. The PMO will contract with vendors to provide practice transformation support over 9 to 18 months while DSS will provide operational support for the AMH Glide Path Program, including providing health plans with information regarding AMH Glide Path enrollment, achievement of milestones, and designation status. In addition, those practices that meet the eligibility requirements for DSS’s glide path will be eligible for enhanced fees as part of the program. DSS will also play a major role in the implementation of CCIP, as practices involved will likely be those that participate in MQISSP. Other agencies play an advisory role in providing feedback through the SIM workgroups and committees. This includes state agencies providing subject matter expertise on CCIP topics.</p> <p>UConn Health will play a critical role in the workforce development initiative to train and certify Community Health Workers, so that they may be integrated into the care team.</p> <p>Finally, The Department of Social Services is the lead for HIT deliverables. The HIT Council will advise and provide input into the creation of these outputs. State agencies will share detailed information on existing infrastructure and HIT capabilities within each department, including the potential to integrate or expand on existing systems. This includes for the work of increasing direct messaging capabilities, and the development of a consent registry.</p>

<b>Potential Risks:</b>	Without the collaboration across state agencies, practices enrolled in the AMH Glide Path and CCIP, and CHWs involved in our workforce development initiatives will not receive support and services that are standardized and coordinated. Our stakeholder engagement efforts will mitigate this risk.
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<b>Community and Consumer Stakeholders, Employers</b>	
<b>Stakeholder Information:</b>	<ul style="list-style-type: none"> <li>– 16 unaffiliated consumer advocates</li> <li>– Pitney Bowes, Inc.</li> <li>– Connecticut Health Foundation</li> <li>– Windham Regional Community Council</li> <li>– Bridgeport Child Advocacy Coalition</li> <li>– Connecticut Legal Rights Project</li> <li>– Small Business for a Healthy Connecticut</li> <li>– Christian Community Action, Inc</li> <li>– Khmer Health Advocates</li> <li>– Connecticut Voices for Children</li> <li>– PATH Parent to Parent/Family Voices of CT</li> <li>– Latino Community Services, Inc.</li> <li>– United Way of Connecticut</li> <li>– Partnership for Strong Communities</li> <li>– Neighborhoods</li> <li>– Health Policy Matters</li> <li>– Connecticut Oral Health Initiative</li> <li>– MAPOC/CMC</li> <li>– Optum Government Solutions</li> <li>– Connecticut Health Policy Project</li> <li>– Connecticut Legal Services</li> <li>– Legal Assistance Resource Center of Connecticut</li> <li>– Universal Healthcare Foundation of Connecticut</li> <li>– Harris Forbes Associates</li> <li>– American Cancer Society - New England Division</li> <li>– National Association of Social Workers - CT Chapter</li> <li>– Eastern Area Health Education Center</li> <li>– Project Access</li> <li>– National Cambodian-American Health Initiative</li> <li>– United Connecticut Action for</li> <li>– NAMI Connecticut</li> <li>– Connecticut Center for Patient Safety</li> </ul>
<b>Rationale for Engagement:</b>	Consumer advocates must be involved to ensure that the practice transformation methods utilized to advance primary care practices in Connecticut will have a positive impact on the consumers using those services. The input of community organizations is critical because of their understanding of local needs and opportunities and because they may likely serve as partners with healthcare practices for the CCIP initiative.
<b>Method for Engagement:</b>	<p><b><u>Committees &amp; Workgroups</u></b></p> <p>The Practice Transformation Taskforce (PTTF), which is the main work group in the governance structure responsible for AMH standards and the development of</p>

	<p>CCIP, has representation from a variety of consumer and community stakeholders, including from the United Connecticut Action for Neighborhoods, the Connecticut Oral Health Initiative, School Based Health Centers, and Family Voices of CT.</p> <p>The Healthcare Innovation Steering Committee will continue to meet monthly to discuss grant implementation topics, such as the AMH Glide Path and CCIP. The Committee acts as a forum to share updates, obtain feedback, and make streamlined decisions regarding SIM concerns. These meetings have seen active commitment from community and consumer advocates.</p> <p>The Consumer Advisory Board (CAB) is the main vehicle in the governance structure to ensure community and consumer stakeholder engagement. The CAB has established consumer representation on each of the SIM taskforces and councils, as well as the Steering Committee. The Consumer Advisory Board will facilitate consumer participation at these meetings, provide the necessary guidance and support, and discuss issues brought back from the meetings with the larger group. This will reinforce consumers in every part of the implementation process. The Board will solicit further input from the broader consumer community on an ongoing basis. The Consumer Advisory Board will also coordinate participation of consumer organizations and networks, including the navigator and assister network created through Access Health CT.</p> <p><b><u>Community Stakeholder Presentations</u></b></p> <p>The PMO will reach out to nonprofit organizations, foundations, and community-based organizations to present at their meetings or serve on panels on a regular basis.</p>
<p><b>Timeframe for Stakeholder Engagement</b></p>	<p>Consumer and community stakeholders will be engaged in an ongoing way, including during the planning phases and throughout implementation to ensure corrections are made that ensure consumer satisfaction with reforms is met.</p>
<p><b>Roles and Responsibilities:</b></p>	<p>The role of consumer and community stakeholders include the outputs of the PTF. The PTF is tasked with developing the details of this program aimed to accelerate advancement and spur investments in priority areas including: closing health equity gaps; improving the care experience for vulnerable populations; and establishing community linkages with providers of social services, long term supports and services (LTSS), and preventive health. These areas, in particular, require substantial input from consumer and community stakeholders. As do the practice transformation methods that affect consumer choice, literacy, care experience, communication, access, and others.</p> <p>Consumers play a vital role in the development and roll-out of AMH standards, and CCIP, and ensuring that both initiatives are patient-centered and drive outcomes. They will help define changes required in provider-patient interactions, and will be actively empowered to create the details that will create the framework for CCIP.</p>

	<p>Stakeholders will act as the subject matter experts to the most effective methods to bridge clinical and community systems.</p> <p>Their role will be ongoing as they play an advisory role throughout the test grant to give feedback on how the transition of practices to medical homes that are integrated clinically and with the community is impacting their healthcare experience. Their task will be to oversee this pilot and ensure that the standards chosen will lead to outcomes that most benefit consumers.</p>
<b>Potential Risks:</b>	<p>Failing to engage consumers may lead to outcomes that do not improve their healthcare experience or outcomes. Collaborating with them ensures that their needs and barriers are met.</p>

<b>Payers</b>													
<b>Stakeholder Information:</b>	<ul style="list-style-type: none"> <li>– DSS, Medicaid</li> <li>– OSC, State Employee Health Plan</li> <li>– Anthem Blue Cross &amp; Blue Shield</li> <li>– Aetna</li> </ul>												
	<ul style="list-style-type: none"> <li>– Cigna</li> <li>– United Healthcare</li> <li>– Connecticare</li> <li>– HealthyCT</li> <li>– Harvard Pilgrim</li> </ul>												
<p>We define Connecticut’s major commercial payers as those with over 5% market share. These payers include the following based on 2013 coverage data:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Commercial Payer</th> <th style="text-align: right;">Market Share</th> </tr> </thead> <tbody> <tr> <td>Aetna</td> <td style="text-align: right;">12.7%</td> </tr> <tr> <td>Anthem</td> <td style="text-align: right;">48.2%</td> </tr> <tr> <td>Cigna</td> <td style="text-align: right;">23.8%</td> </tr> <tr> <td>Connecticare Insurance Company, Inc</td> <td style="text-align: right;">7.6%</td> </tr> <tr> <td>UnitedHealthCare Insurance Company</td> <td style="text-align: right;">7.6%</td> </tr> </tbody> </table> <p>In addition, we have been working closely HealthyCT, which in 2014 began offering individual coverage on our health insurance exchange, and Harvard Pilgrim, which is also entered the Connecticut market.</p>		Commercial Payer	Market Share	Aetna	12.7%	Anthem	48.2%	Cigna	23.8%	Connecticare Insurance Company, Inc	7.6%	UnitedHealthCare Insurance Company	7.6%
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<b>Rationale for Engagement:</b>	Payers are engaged in practice transformation support so that they can contribute their practice transformation expertise, standards, gap analysis or readiness assessment tools, and practice support methods currently in use.
<b>Method for Engagement:</b>	<p><b><u>Committees &amp; Workgroups</u></b></p> <p>The Practice Transformation Taskforce has had the following health plan members: Aetna, United HealthCare, Cigna, Anthem, Connecticare, and DSS.</p> <p>Payers will also continue to be involved in the Steering Committee to advise on care delivery transformation. The PMO also participates in individual payer meetings and group meetings on invitation.</p>
<b>Timeframe for Stakeholder Engagement</b>	Payers will be engaged on an ongoing basis throughout the test grant period through PTTF, and the Steering Committee.
<b>Roles and Responsibilities:</b>	<p>The role of the health plans is to provide their expertise on practice transformation, standards, gap analysis or readiness assessment tools, and practice support methods currently in use.</p> <p>Payers will also play the role of serving as change agents to roll-out task-force recommendations with providers.</p>
<b>Potential Risks:</b>	Engaging payers is critical to ensure that the best and most current knowledge in the field of care transformation is utilized.

<b>Providers</b>		
<b>Stakeholder Information:</b>	<ul style="list-style-type: none"> <li>– Connecticut Hospital Association</li> <li>– Griffin Hospital</li> <li>– Fair Haven Community Health Center</li> <li>– Orthopedic Associates of Hartford</li> <li>– Connecticut Medical Group, LLC</li> <li>– Yale New Haven Health System</li> <li>– Connecticut State Medical Society</li> <li>– Radiological Society of Connecticut</li> <li>– Norwalk Hospital</li> <li>– Community Health Center Association of Connecticut</li> </ul>	<ul style="list-style-type: none"> <li>– ProHealth Physicians</li> <li>– Pediatrics Plus</li> <li>– Connecticut Association of School Based Health Centers</li> <li>– Stamford Hospital</li> <li>– Community Health Center, Inc.</li> <li>– American College of Physicians - CT Chapter</li> <li>– Cardiology Associates of New Haven PC</li> </ul>

	<ul style="list-style-type: none"> <li>– Community Medical Group IPA</li> <li>– Hartford Healthcare</li> <li>– Saint Mary's Hospital</li> <li>– Saint Francis Center for Health Equity</li> <li>– St. Vincent's Health Partners</li> <li>– Family Medicine Center at Asylum Hill</li> <li>– Norwalk Community Health Center</li> <li>– Medical Analytics Department, ConnectiCare, Inc.</li> <li>– ENT &amp; Allergy Associates LLC</li> </ul>	<ul style="list-style-type: none"> <li>– Connecticut Institute for Clinical and Translational Science at UConn</li> <li>– Robert D. Russo MD and Associates Radiology</li> <li>– Burgdorf Health Center</li> <li>– Southwest Community Health Center, Inc.</li> <li>– ConnectiCare, Inc. &amp; Affiliates</li> <li>– Western Connecticut Health Network</li> <li>– Team Rehab</li> <li>– Westwood Women's Health</li> <li>– Community Health Resources</li> </ul>
<p><b>Rationale for Engagement:</b></p>	<p>Active provider engagement in our planning and implementation efforts of primary care transformation through the Advanced Medical Home Glide Path, CCIP, and workforce development will ensure that the unique needs of the provider workforce in our state are met and that their strengths, skills, and interests are optimized.</p> <p>Spreading awareness and information about our reforms will ensure that there is a broad and adequate foundation of interested providers, practices, and networks that will participate in and champion SIM initiatives. Engaging providers so they are knowledgeable and confident about the Advanced Home program, CCIP, and workforce development initiatives will spur their active commitment to and involvement in initiatives aiming to achieve improved healthcare quality, reduced cost and increased satisfaction with the practice of primary care medicine.</p>	
<p><b>Method for Engagement:</b></p>	<p><b><u>Committees &amp; Workgroups</u></b></p> <p>Providers currently represented on the PTF include FQHCs, Advanced Networks, pediatricians, primary care physicians, behavioral health practitioners, school based health centers and others. Additional providers and provider groups will be regularly incorporated during break-out design groups and the addition of home health agencies, long term services and supports providers and hospitals is under consideration.</p> <p>The Healthcare Innovation Steering Committee will continue to meet monthly to discuss grant implementation topics, such as the AMH Glide Path, CCIP, and workforce development. The Committee acts as a forum to share updates, obtain feedback, and make streamlined decisions regarding SIM concerns. The Steering Committee and associated work groups have seen active commitment from providers, including members of the CT State Medical Society, CT Chapter of the College of Physicians, CT Academy of Family Physicians, Community Health Center Association of CT, CT Chapter of the American Academy of Pediatrics, and the CT Hospital Association. More than fifty providers and trade associations are engaged in the Healthcare Innovation Steering Committee, and all other councils and task</p>	

forces associated with the SIM governance structure, including the MAPOC and its committees.

A new advisory group is being considered for the Community Health Worker (CHW) initiative and to facilitate discussions about CHW sustainability models, and will include provider representation such current CHWs.

#### **Forums & Conferences**

The SIM PMO is partnering with physicians who are engaged in the SIM governance structure to undertake an extensive campaign to raise physician awareness and, importantly, to participate in forums that allow physicians to directly engage on the issues that cause them greatest concerns. We will do this work in collaboration with the various professional associations including the CT State Medical Society, CT Chapter of the American College of Physicians, CT Academy of Family Physicians, and the CT Chapter of the Academy of Pediatrics.

Additional forums will be held specifically to engage Community Health Worker leaders and organizations in the production and launch of the CHW training curriculum and certification program. In Yr 4, Q1-4, an annual conference will be held for CHWs and interested stakeholders to convene and share learning and experience regarding the CHW certification program.

#### **Advanced Medical Home Learning Collaborative**

The PMO will establish three learning collaboratives. The first will focus on practices enrolled in the AMH Glide Path. This LC will foster continuous learning through webinars, workshops, an online collaboration site, and phone support. Practices will be expected to actively share resources, tools, and strategies with each other in the LC. LC participants will report quarterly progress on achieving milestones to track transformation.

#### **Comprehensive Physician Licensing**

Incorporating sustainable processes that regularly collect information about the physicians in our state will ensure that their experience and perspective is included in any health reform initiatives. During the SIM test period we will expand the current physician licensing process to include survey questions that better capture the experience of health care providers in our state. Questions will expand the scope of the current survey to include topics such as racial and ethnic information, timeline for retirement, and provider satisfaction. The state will engage the Council for State Boards of Nursing (NCSBN), and health professional associations at both the state and federal levels to develop survey questions. We will also collaborate broadly with pertinent boards and commissions and the state's institutions of higher education to identify the real-time data necessary to better align current healthcare education with provider needs and demographics.

#### **Physician Survey**

In order to engage physicians on a broad scale, the SIM evaluation team conducted a statewide physician survey in November 2014 reaching more than 3400 healthcare providers including primary care physicians and several specialist

	<p>groups. This survey provides a baseline assessment of the State’s physician workforce and physician’s experiences with and perspectives on healthcare transformation efforts. Survey information collected includes:</p> <ul style="list-style-type: none"> <li>• Physicians’ attitude and concerns regarding care coordination and medical home or advanced primary care principles;</li> <li>• Physicians ‘ attitudes and concerns regarding larger coordinating entities such as clinically integrated health systems or Advanced Networks;</li> <li>• The types of support and resources that physicians would be interested in to help them change the way they provide primary care services to complex patients;</li> <li>• Willingness to accept new patients and patients with different types of insurance (e.g., Medicaid, Medicare).</li> <li>• Amount of primary care currently provided and any anticipated changes in the relative amount of primary care provided;</li> <li>• Availability and/or use of a formal care coordinator and/or ability to coordinate care, and to attract staff to help address complex care needs;</li> <li>• Ownership and organization of practices and affiliations with larger care systems/organizations such as networks, Independent Practice Associations (IPAs), or Accountable Care Organizations (ACOs), as well as anticipated new affiliations or arrangements;</li> </ul> <p>Recently released findings will be used to inform primary care transformation efforts and tailor quality improvement efforts to suit the needs of providers in our state. In addition, the survey questions will inform the development of questions for the expanded physician licensing survey described previously. The physician survey could then be used as a baseline or starting point to evaluate whether our reforms are impacting provider concerns.</p>
<p><b>Timeframe for Stakeholder Engagement</b></p>	<p>Providers will be engaged throughout the test grant on an ongoing basis, in terms of high level feedback from the Committees and Workgroups, but also from the practices involved directly in the reforms as participants.</p>
<p><b>Roles and Responsibilities:</b></p>	<p>The role of consumer and community stakeholders include the outputs of the PTF, described previously. CCIP will span numerous priority areas that target healthcare providers, such as: behavioral health and oral health integration; building dynamic clinical teams and; expanding e-consults between primary care providers and specialists. Providers on the taskforce are tasked with representing the experience of providers in a way that will ensure that the program can be implemented within a range of practices.</p> <p>As members of the PTF physicians are tasked with gathering broad input from a diverse set of physicians such as hospital-employed physicians and rural physicians. They will also: outline the clinical processes, systems, and infrastructure that needs to be modified to transition the majority of physicians to CT’s defined AMH model; provide insight into potential barriers for change and</p>

	<p>suggestions for overcoming them; and promote taskforce recommendations within the physician community.</p> <p>Behavioral health providers that are members of the PTF are tasked with providing insight into the needs of behavioral health patients that require additional modifications in provider practices ranging from screening, assessment, brief treatment, health behavior, and linkage to behavioral health affiliates. They will also help brainstorm potential solutions and promote taskforce recommendations within the behavioral health community.</p> <p>Hospitals will share insights on changes required to administrative, and clinical processes, systems and budgeting for hospitals to play a role in the new care delivery model. They will help the taskforce define a plan for implementing recommendations with hospitals.</p> <p>Healthcare providers play the critical role of participating in and championing the SIM practice improvement initiatives of the Advanced Medical Home Glide Path, CCIP, and workforce development.</p>
<p><b>Potential Risks:</b></p>	<p>In order to reach our goal of transforming 370 practices to AMH status we must be able to engage and interest them in such transformation. This begins with including them in the planning processes, and to adapt to and anticipate their needs and strengths. Slow or unbalanced provider and practice staff enrollment will be mitigated by working closely with leadership of Advanced Networks and FQHCs to optimize and balance practice and participant enrollment.</p> <p>The ability to address providers' challenges quickly and adapt our methods to suit their needs will target our efforts effectively to drive real change. Providers have identified challenges or barriers to the success of the care delivery and payment reforms. Physicians note that there remains among many physicians a lack of knowledge about the reforms, or skepticism that such reforms will achieve promised improvements in quality, cost or satisfaction with the practice of primary care medicine. Unaddressed this may diminish physicians' willingness to participate in offered practice transformations support services or to participate with the Advanced Networks that are already involved in such reforms. Our stakeholder methods will mitigate these risks.</p>

## 2. Value-Based Payment and Insurance Reform

SSP based on Care Experience/Quality						
<i>Output/Deliverable</i>	<i>Government</i>	<i>Consumer Community Employer</i>	<i>Payers</i>	<i>Providers</i>	<i>Target Date</i>	
Collaborative model where provider organizations are rewarded based on quality and cost	X	X	X	X	Y1-Y4	
Reasonable and necessary methods for monitoring under-service and make ongoing adjustments to these methods as appropriate.	X	X	X	X	Y2, Q1-Q4	
Ensure provider organizations have the tools and information required to be successful in a value based payment environment.	X		X		Y1-Y4	
Quality Measure Alignment						
<i>Output/Deliverable</i>	<i>Government</i>	<i>Consumer Community Employer</i>	<i>Payers</i>	<i>Providers</i>	<i>Target Date</i>	
Common Performance Measure Set.	X	X	X	X	Y2, Q1	
Care Experience Survey tied to SSP.	X	X	X	X	Y4, Q4	
Value-based Insurance Design (VBID)						
<i>Output/Deliverable</i>	<i>Government</i>	<i>Consumer Community Employer</i>	<i>Payers</i>	<i>Providers</i>	<i>Target Date</i>	
Implement effective value-based insurance design products.	X	X			Y1-Y4	
Health Information Technology / Analytics / Performance Transparency						
<i>Output/Deliverable</i>	<i>Government</i>	<i>Consumer Community Employer</i>	<i>Payers</i>	<i>Providers</i>	<i>Target Date</i>	
Statewide HIT and analytic capability, including cross-payer analytics	X	X	X	X	Y1, Q1-Y4, Q4	

Federal, State and Local Governmental Stakeholders:		
<b>Stakeholder Information:</b>	<ul style="list-style-type: none"> <li>– Department of Public Health</li> <li>– Department of Social Services</li> <li>– Department of Mental Health &amp; Addiction Services</li> <li>– Office of the Healthcare Advocate</li> <li>– Department of Children and Families</li> <li>– Access Health (CT’s Health Insurance Exchange)</li> <li>– Connecticut Insurance Department</li> <li>– Office of Policy and Management</li> <li>– APCD</li> <li>– Office of the State Comptroller</li> </ul>	<ul style="list-style-type: none"> <li>– University of Connecticut Health Center</li> <li>– Office of the State Comptroller</li> <li>– Yale School of Medicine</li> <li>– Bureau of Enterprise Systems Technology</li> <li>– CT State Senate</li> <li>– CT House of Representatives</li> <li>– SIM Program Management Office</li> <li>– MAPOC/CMC</li> </ul>
<b>Rationale for Engagement:</b>	<p>In order for the cross-cutting scope of CT’s State Innovation Model to be successful, a multitude of government stakeholders must coordinate and be involved in its implementation. Streamlined policy and program development processes and leveraged regulatory authorities will maximize the effectiveness and impact of the Medicaid Quality Improvement and Shared Savings Program (MQISSP), quality measure alignment, VBID, and HIT initiatives.</p>	
<b>Method for Engagement:</b>	<p><b><u>Committees &amp; Workgroups</u></b></p> <p>Stakeholder engagement for the development of MQISSP and overseeing its launch will be primarily done through the MAPOC, which is the legislative oversight body for the Medicaid/CHIP programs. The MAPOC has designated the Care Management Committee to review and comment on each aspect of the design of the Medicaid Shared Savings Program (Medicaid QISSP), including the establishment of consumer protections and implementation activities. Committee membership will be supplemented by members of the Steering Committee and CAB. Additionally, MAPOC will designate up to two members to participate in each SIM work group.</p> <p>The Quality Council is the method of engagement for the development of the common scorecard and includes membership of the Department of Social Services, the Office of the State Comptroller and an epidemiologist from DPH, all of whom have technical expertise and experience with measurement of health, quality, equity, and consumer experience.</p> <p>The Equity and Access Council, tasked with developing methods to monitor under-service also engage government stakeholders, including public health experts from Medicare, DSS, and academic institutions.</p>	

	<p>The Health Information Technology Council, which includes membership from DSS, DPH, DMHAS, Office of the State Comptroller and the Bureau of Enterprise Systems Technology, is tasked with advising on the development of a statewide HIT strategy that supports SIM work.</p> <p>Finally, the Healthcare Innovation Steering Committee will continue to meet monthly to discuss grant implementation topics, such as the common scorecard and SSP models. The Committee acts as a forum to share updates, obtain feedback, and make streamlined decisions regarding SIM concerns. These meetings have seen active commitment from line agency Commissioners with responsibility for public health, Medicaid, behavioral health, insurance, APCD, and child welfare, as well as OPM and the Comptroller’s office.</p> <p><b><u>Contractual</u></b></p> <p>DSS and the PMO are finalizing a Memorandum of Agreement (MOA), which will engage DSS in a targeted way to perform specific services in regard to SIM initiatives.</p> <p><b><u>Management – Individual Engagement &amp; Core Agency Meetings</u></b></p> <p>The PMO acts as the main coordinating body of SIM initiatives and will continue to hold monthly internal meetings with the relevant agencies in regards to MQISSP and the Common Performance Scorecard. In addition, a bi-weekly Core Team will be convened that is comprised of the state agencies who are administering SIM services/outputs.</p>
<p><b>Timeframe for Stakeholder Engagement</b></p>	<p>The planning phases of the common scorecard, care experience survey details, and MQISSP will entail intensive engagement with state agencies, particularly the Department of Social Services and the Department of Public Health.</p> <p>Following the launch of these and other initiatives, this engagement will remain ongoing for oversight, administration of services, and iterative adjustments.</p>
<p><b>Roles and Responsibilities:</b></p>	<p>The Quality Council, which has state agency representation from DPH and the Office of the State Comptroller, is developing the core measurement set for use in the assessment of primary care, specialty and hospital provider performance and the overall evaluation of the Connecticut health and healthcare systems. The council will develop a common provider scorecard format for use by all of the payers. The measurement set will be reassessed on a regular basis to identify gaps, to incorporate new national measures as they become available, and to keep pace with changes in technology and clinical practice. The Quality Council is also tasked with recommending a tool to be used for the Care Experience Survey. The DPH epidemiologist will share what health metrics, surveillance data, and vital statistics are being tracked by DPH and other community organizations today; and will help identify and prioritize metrics to be used to track improvements in public health.</p>

	<p>The Equity and Access Council, with representatives DSS and DPH is responsible for developing methods that monitor potential under-service in shared savings arrangements. The state will leverage the dispute resolution role of its Office of the Healthcare Advocate to adjudicate consumer complaints of suspected under-service.</p> <p>The MAPOC has designated the Care Management Committee to review and comment on each aspect of the design of the Medicaid Quality Improvement and Shared Savings Program (Medicaid QISSP), including the establishment of consumer protections and implementation activities. Consistent with its commitments to transparency and stakeholder engagement, the Department of Social Services, which administers the Medicaid program, will present the Medicare Shared Savings Program ACO measure set, as well as additional measure elements proposed by the SIM Quality Council, to the relevant committee of its statutorily established stakeholder group, the Medical Assistance Program Oversight Council, for review and consideration as component elements of the QISSP Request for Proposals.</p> <p>The Department of Social Services is the lead for HIT deliverables. The HIT Council will advise and provide input into the creation of these outputs. State agencies will share detailed information on existing infrastructure and HIT capabilities within each department, including the potential to integrate or expand on existing systems. They will also define the need for new systems and outline a plan for integration. Access Health CT will outline their existing infrastructure and the capabilities of CT’s public exchange and All Payer Claims Database that can be leveraged to support CT SIM. They will also share learnings to implementing HIT innovation in CT based on their experience with the exchange and APCD.</p>
<p><b>Potential Risks:</b></p>	<p>Fostering collaboration across state agencies will ensure that the practices participating in payment reform in a coordinated manner. For example, DSS, the state agency that administers Medicaid, has a critical role to ensure that the MQISSP program is launched effectively. Their engagement in the vision and aims of SIM is, therefore, a priority to achieve increased healthcare quality, health equity, reduced cost, and improved population health.</p>

<p><b>Community and Consumer Stakeholders, Employers</b></p>		
<p><b>Stakeholder Information:</b></p>	<ul style="list-style-type: none"> <li>– 16 unaffiliated consumer advocates</li> <li>– Connecticut Health Foundation</li> <li>– Windham Regional Community Council</li> <li>– Bridgeport Child Advocacy Coalition</li> <li>– Connecticut Legal Rights Project</li> <li>– Small Business for a Healthy Connecticut</li> <li>– Christian Community Action, Inc</li> </ul>	<ul style="list-style-type: none"> <li>– Connecticut Health Policy Project</li> <li>– Connecticut Legal Services</li> <li>– Legal Assistance Resource Center of Connecticut</li> <li>– Universal Healthcare Foundation of Connecticut</li> <li>– Harris Forbes Associates</li> </ul>

	<ul style="list-style-type: none"> <li>– Khmer Health Advocates</li> <li>– Connecticut Voices for Children</li> <li>– PATH Parent to Parent/Family Voices of CT</li> <li>– Latino Community Services, Inc.</li> <li>– United Way of Connecticut</li> <li>– Partnership for Strong Communities</li> <li>– Neighborhoods</li> <li>– Health Policy Matters</li> <li>– Connecticut Oral Health Initiative</li> <li>– MAPOC/CMC</li> <li>– Connecticut Center for Patient Safety</li> </ul>	<ul style="list-style-type: none"> <li>– American Cancer Society - New England Division</li> <li>– National Association of Social Workers - CT Chapter</li> <li>– Eastern Area Health Education Center</li> <li>– Project Access</li> <li>– National Cambodian-American Health Initiative</li> <li>– United Connecticut Action for</li> <li>– NAMI Connecticut</li> <li>– Optum Government Solutions</li> </ul>
<p><b>Rationale for Engagement:</b></p>	<p>SIM healthcare reforms must address the needs of the populations they aim to serve. Statewide reforms will aim to reach the entire CT population. Targeted initiatives will also shift healthcare models for broad populations. For example, MQISSP will include an estimated 200,000 to 215,000 beneficiaries during the first of two waves of the test period. Consumer input and active engagement is needed to align efforts with the barriers and challenges that consumers experience. Formal and consistent solicitation of community and consumer input will create effective strategies of reform implementation and enhanced community confidence in SIM initiatives.</p>	
<p><b>Method for Engagement:</b></p>	<p><b><u>Committees &amp; Workgroups</u></b>  The Equity and Access Council is the vehicle to engage consumer and community advocates in developing methods to monitor under-service. The Council has numerous consumer and community advocates as members, including from the Connecticut Health Policy Project, Project Access, Connecticut Legal Services, and unaffiliated consumers.</p> <p>Consumer and community engagement is also represented through their membership on the Care Management Committee of the MAPOC, the HIT Council, the Quality Council, Steering Committee, and the CAB, described previously.</p> <p><b><u>Community Stakeholder Presentations</u></b>  The PMO will reach out to nonprofit organizations, foundations, and community-based organizations to present at their meetings or serve on panels.</p> <p><b><u>Dissemination of Quality and Cost Data</u></b>  In order to actively engage in their own healthcare and partner effectively with their providers, consumers will need more and better health information in a timely manner. Our State Innovation Model will increase transparency and access to information through the leveraging of HIT to disseminate quality and cost data.</p> <p>The Quality Council is also responsible for establishing a plan for consumer education and access to scorecard data.</p>	

	<p><b>Care Experience Survey</b></p> <p>One of the most effective methods to improve consumer engagement in healthcare practice policies and procedures is to incorporate their experiences in the quality improvement efforts of practices and Advanced Networks. As part of our Model Test, all health plans and Medicaid will require a care experience survey for providers participating in SSP arrangements as of the 2016 contract year, using a survey tool recommended by the Quality Council. The survey results will be used to assess the performance of each provider for the purpose of determining whether and to what extent a provider qualifies for shared savings. Similar to the provider performance scorecard, the state will post cross-payer care experience survey results to ensure transparency for consumers.</p>
<p><b>Timeframe for Stakeholder Engagement</b></p>	<p>The planning phases of the common scorecard, methods for monitoring under-service, care experience survey details, and MQISSP will entail intensive engagement with consumer and community advocates. However, engaging consumers throughout the model test is important to evaluate whether methods are working, gauge satisfaction with reforms, and make necessary changes.</p>
<p><b>Roles and Responsibilities:</b></p>	<p>Consumer and community stakeholders on the Quality Council are tasked with providing input on aspects of quality measurement that pertains to outcomes and care experience, as well as helping to prioritize root issues that need to be addressed by metrics. Consumers and other stakeholders participating in the Quality Council will need to recommend a care experience survey for providers participating in SSP arrangements as of the 2016 contract year.</p> <p>Consumer and community stakeholders role is to maintain active engagement in the Equity and Access Council to recommend retrospective and concurrent analytic methods to ensure safety, access to providers and appropriate services, and to limit the risk of under-provision of requisite care; recommend a response to demonstrated patient selection and under-service; and define Connecticut’s plan to ensure the AMH model systematically includes at-risk populations. Consumer and community stakeholders on the Equity and Access Council are tasked with providing input on under-service safeguards from a consumer perspective; and gauging the reasonableness and adequacy of such safeguards.</p> <p>On the HIT Council, consumer and community stakeholders are tasked with providing inputs on aspects of health information that relate to consumer/provider communication, performance transparency, privacy, security and shared decision making tools.</p> <p>Their role also includes maintaining active membership and engagement in the Care Management Committee of the MAPOC, in the development and oversight of the launch of MQISSP; the Quality Council; Steering Committee; and the CAB. They will provide feedback to ensure that reforms are consumer-centered.</p>

<p><b>Potential Risks:</b></p>	<p>Failing to engage consumer and community stakeholders may lead to outcomes that do not improve their healthcare experience or outcomes. Collaborating with them ensures that their needs and barriers are met.</p> <p>In addition, a perceived risk of under-service may lead consumers to be wary of practices participating in value-based models. These risks will be mitigated by sophisticated methods for monitoring under-service; detailed reporting and analysis of provider performance; and the inclusion of a Nurse Consultant in the Office of the Healthcare Advocate, who will provide information related to these concerns.</p>	
<p><b>Employers</b></p>		
<p><b>Stakeholder Information:</b></p>	<ul style="list-style-type: none"> <li>– United Technologies Corporation</li> <li>– Pitney Bowes, Inc.</li> <li>– CT Business Group on Health</li> <li>– Northeast Business Group on Health</li> <li>– Connecticut Business and Industry Association</li> </ul>	
<p><b>Rationale for Engagement:</b></p>	<p>Engaging employers is crucial to implement value-based insurance design (VBID) that engages consumers and reduces barriers to critical prevention and treatment services.</p> <p>CT’s largest employers and health plans recognize the importance of demand side levers such as VBID to increase consumer engagement in health improvement and reduce barriers to effective self-management of chronic illness. Employers are fundamental to achieving care delivery and payment reforms.</p>	
<p><b>Method for Engagement:</b></p>	<p><b><u>Committees &amp; Workgroups</u></b></p> <p>The SIM governance structure and programmatic activities establish formal mechanisms for on-going employer engagement. Notably, representatives from the state’s largest employers and early adopters of value based insurance design (VBID), a critical component of the Model Test, are actively committed to the implementation of the SIM. One major employer participates in the Steering Committee.</p> <p><b><u>Other</u></b></p> <p>The OSC and PMO will undertake extensive VBID adoption efforts, convening employers, business groups such as CT’s Business and Industry Association, health plans, providers and consumers to provide input on VBID design; develop prototype VBID plan designs that align supply and demand while enabling streamlined administration; and provide a mechanism for employers to share best</p>	

	<p>practices to accelerate the adoption of VBID plans. Specific employer engagement methods will include:</p> <ul style="list-style-type: none"> <li>• The OSC and PMO will also convene an annual VBID Innovators Conference for all stakeholders involved in SIM governance and workgroups.</li> <li>• Establish an employer-led consortium with core interest sub-groups (e.g. clinical, wellness, administration);</li> <li>• Establish linkages to regional and national forums such as CMMI’s VBID learning cluster to enable peer-to-peer sharing of best practices;</li> <li>• Employer portal on the SIM website;</li> <li>• Develop VBID template(s) and implementation toolkits; and</li> <li>• Convene an annual learning collaborative, for all stakeholders involved in SIM governance and workgroups, which will include panel discussions with nationally recognized experts and technical assistance.</li> </ul> <p>Additionally, the OSC and PMO will include staff responsible for employer engagement with the support of a contractor. These staff will develop materials to make the business case to employers and provide employers with a health insurance procurement template that contains elements consistent with SIM goals. The staff will do this work in collaboration with the Connecticut Business Group on Health, the Northeast Business Group on Health, and the Connecticut Business and Industry Association.</p>
<p><b>Timeframe for Stakeholder Engagement</b></p>	<p>Steering Committee meetings will be monthly throughout the life of the test grant. The employer-led consortium with core interest sub-groups (e.g. clinical, wellness, administration) and annual learning collaborative will also be ongoing.</p>
<p><b>Roles and Responsibilities:</b></p>	<p>A number of Connecticut’s self-funded employers are contracting with their carriers in a manner consistent with our proposed care delivery and payment reforms. Employers’ role is to implement VBID that empower consumer choice and reduce cost.</p>
<p><b>Potential Risks:</b></p>	<p>Failing to engage employers will limit the scope and depth of critical value-based payment reforms. Given that self-funded employers comprise 60 to 85% of the commercial carriers’ business, engagement of these employers is of primary importance. In addition, failing to engage employers in the adoption of VBID will weaken the impact of care delivery and payment reforms, e.g., by creating barriers to obtaining essential chronic care or engaging in health and wellness activities.</p>

<b>Payers</b>													
<b>Stakeholder Information:</b>	<ul style="list-style-type: none"> <li>– Medicaid</li> <li>– State Employee Health Plan</li> <li>– Anthem Blue Cross &amp; Blue Shield</li> <li>– Aetna</li> </ul> <ul style="list-style-type: none"> <li>– Cigna</li> <li>– United Healthcare</li> <li>– Connecticare</li> <li>– HealthyCT</li> </ul> <p>We define Connecticut’s major commercial payers as those with over 5% market share. These payers include the following based on 2013 coverage data:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="background-color: #d9e1f2;">Commercial Payer</th> <th style="background-color: #d9e1f2;">Market Share</th> </tr> </thead> <tbody> <tr> <td>Aetna</td> <td style="text-align: right;">12.7%</td> </tr> <tr> <td>Anthem</td> <td style="text-align: right;">48.2%</td> </tr> <tr> <td>Cigna</td> <td style="text-align: right;">23.8%</td> </tr> <tr> <td>Connecticare Insurance Company, Inc</td> <td style="text-align: right;">7.6%</td> </tr> <tr> <td>UnitedHealthCare Insurance Company</td> <td style="text-align: right;">7.6%</td> </tr> </tbody> </table> <p>In addition, we have been working closely HealthyCT, which in 2014 began offering individual coverage on our health insurance exchange, and Harvard Pilgrim, which is also preparing to enter the Connecticut market.</p>	Commercial Payer	Market Share	Aetna	12.7%	Anthem	48.2%	Cigna	23.8%	Connecticare Insurance Company, Inc	7.6%	UnitedHealthCare Insurance Company	7.6%
Commercial Payer	Market Share												
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UnitedHealthCare Insurance Company	7.6%												
<b>Rationale for Engagement:</b>	<p>Engagement of payers is critical to ensuring the effective implementation of several SIM initiatives, notably the development and roll out of a common set of metrics for all payers to use with Advanced Networks participating in shared savings programs. SIM initiatives, such as these, aim to align payers in order to reduce the fragmentation many providers and consumers experience. To illustrate, Anthem has arrangements with provider organizations that cover 56% of primary care physicians in the State of Connecticut. These organizations include hospital owned physician groups, large independent physician groups as well as some smaller medical practices. Maintaining engagement with payers like Anthem will catalyze a broad foundation of primary care practices in Connecticut to adopt patient-centered and value-based care models.</p>												

	<p>In addition, aligning with Medicare, and across payers is critical to reduce the fragmentation consumers and providers currently experience.</p>
<p><b>Method for Engagement:</b></p>	<p><b><u>Committees &amp; Workgroups</u></b></p> <p>Health plans are and will remain involved in all aspects of planning and oversight for CT SIM. In addition to representation on the Steering Committee, all health plans with more than 5% market share, and Medicaid, participate on the Practice Transformation, Health Information Technology Council, Quality, and Equity &amp; Access work groups. Anthem is the largest carrier in the State of Connecticut and an administrator of the Connecticut State Employee and Retiree Healthcare Plan and actively participates in all of the above forums. These forums will continue to provide formal mechanisms for payers to remain actively engaged in the implementation of the SIM grant.</p>
<p><b>Commitment</b></p>	<p>All of CT’s health plans, Medicaid, and the state employee health plan have committed to implementing value-based payment arrangements through shared savings programs (SSP) for providers with sufficient scale and capabilities, that is broadly aligned with Medicare SSP. Anthem has already begun to change its relationships with providers, moving to a collaborative model where provider organizations are rewarded based on quality and cost and given tools the tools and information required to be successful in a value based payment environment. Specifically, Anthem has entered into shared savings models where provider organizations are allowed to share in a portion of the savings (e.g., actual total costs for providing care to the defined population are less than projected total costs) provided they meet the quality threshold. In addition, the percentage of savings providers are eligible to receive, up to cap, increases as performance against the quality metrics increases. Anthem’s model aligns with our proposed efforts and Anthem has committed to continue and expand its efforts.</p> <p>All of Connecticut’s payers have made commitments to critical aspects of initiatives that affect them. This includes:</p> <ul style="list-style-type: none"> <li>• Strong endorsement of a transition from volume to value-based payment as evidenced in their letters of support.</li> <li>• Specific endorsement of broad alignment with the Medicare SSP.</li> <li>• The principle that providers be disqualified from receiving shared savings if they demonstrate repeated or systematic failure to offer medically necessary services, whether or not there is evidence of intentionality.</li> <li>• Developing a common set of quality metrics.</li> </ul> <p>Refer to <b>APPENDIX C</b> to view excerpts from their letters of support emphasizing their commitment.</p> <p>Features relating to organizational structure, measure set and shared savings methodology will require further review by the relevant stakeholder groups associated with the SIM and Medicaid to recognize the current stage of development and readiness in Connecticut as well as the need for additional population-specific measures.</p>

<b>Timeframe for Stakeholder Engagement</b>	<p>Engagement of payers will be ongoing throughout the life of the SIM Test Grant.</p>
<b>Roles and Responsibilities:</b>	<p>Payers’ role includes maintaining active engagement in all work groups and the Steering Committee, described below.</p> <p>Health Plans on the HIT Council are tasked with providing information on existing infrastructure and HIT capabilities across a diverse set of private payers. They will also liaise with internal executives to share taskforce recommendations and gather input. Lastly they will determine the feasibility of integrating systems across payers.</p> <p>Representatives from health plans on the Equity and Access Council are tasked with helping the council identify potential issues in program design that could negatively impact delivery of appropriate care and access. They will lead the taskforce’s efforts to define and execute a plan to identify outliers in care delivery and payments. Those health plan members focused on program integrity will consider methods for identifying patterns of under-service, risk avoidance, or patient abandonment. They will lead the council’s efforts to define and execute a plan to identify and investigate outliers.</p> <p>Representatives from health plans on the Quality Council will share what measures are being tracked and help assess the feasibility for payers to track recommended common measure set with their network providers. They will also consider the merits of transitioning to a “common provider scorecard” across payers and will serve as liaison with internal executives to gather feedback and to recommended metrics. Representatives experts will facilitate the selection of a core set of measures that include a mix of process, outcome, efficiency, and patient engagement and experience metrics. They will outline data requirements (e.g., minimum patient panel size for statistical validity of prioritized metrics); outline risk adjustment and exclusion methods; and help the taskforce select measures that are ambitious, but feasible to implement.</p> <p>Other roles are outlined below.</p> <p><b>Moving to a model that rewards providers based on quality and cost:</b>  Medicaid and health plans will tie their SSP payment calculations to the achievement of performance targets using a common scorecard for access, quality, care experience, health equity, and cost. As active participants in the Quality Council, all of Connecticut’s major commercial health plans, including Anthem, strongly support the development of a common set of metrics for all payers to use with Advanced Networks and FQHCs participating in shared savings programs and other providers who are eligible to receive payment rewards. Payers are encouraged to replace the existing quality measures in use in their shared savings</p>

programs with the all payer measures developed to support Connecticut’s proposed efforts. Payers understand that alignment of quality measures across payers will help providers focus on those metrics that are most meaningful and impactful, increasing the likelihood that they will be able to improve performance against these measures over time.

**Medicaid Quality Improvement and Shared Savings Program (MQISSP):**

Medicaid will launch its own Shared Savings program as part of SIM. There are a variety of outputs associated with the launch of this program, including:

- a) The development of a shared savings methodology with its actuarial contractor, Mercer;
- b) Administration of a beneficiary attribution methodology by CHN that is the same as or substantially similar to the methodology currently in use for the PCMH initiative;
- c) Assessment of eligibility for shared savings payment by CHN; and
- d) Distribution of shared payments by HP using business processes similar to those employed for distribution of performance payments.

In addition, as part of this program, Medicaid may implement advance payments for participants in MQISSP using an established Medicaid Management Information System (MMIS) based payment methodology that ties enhanced fees to specific primary care services, depending on the level of medical home recognition.

**Providing tools and information to provider organizations:**

We encourage payers to continue to provide participating providers with resources and tools designed to support their successful transformation to a proactive and coordinated care model in a way that augments any resources or tools provided on an all-payer basis during SIM test grant implementation.

**Incorporate the Care Experience Survey as a condition for participating in a value-based payment arrangement:**

All of Connecticut’s payers will require a statistically valid and sufficient consumer survey as a condition for participating in a value-based payment arrangement as of the 2016 contract year, using a care experience survey tool recommended by the Quality Council and approved by the Steering Committee. The results of such survey will be used to assess the performance of each Advanced Network or FQHC for the purpose of determining qualification to receive shared savings. The sample will be drawn from each entity’s attributed patients, without regard to payer or source of coverage, except that in the initial years, we will oversample for Medicaid in order to quantify the Medicaid/commercial health equity gap as it pertains to care experience.

**Information to the PMO:**

The SIM PMO requires certain information in order to execute several aspects of the test grant. This includes:

	<p>a) The Care Experience Survey requires that payers provide the PMO a list of provider organizations participating in SSP arrangements. The PMO’s vendor will then use this list contact each provider organization so that they can have the choice of participating in the PMO administered survey process, which will reduce providers’ costs of conducting the survey.</p> <p>b) Data regarding physician participation in FFS and SSP, &amp; beneficiaries in VBID.</p> <p><b>Comparative effectiveness study of VBID plans and Accountable Care Organizations:</b>  Anthem and its analytic team at HealthCore, a research subsidiary, have committed resources to undertake a comparative effectiveness study of VBID plans and Accountable Care Organizations study with the State Employee and Retiree Healthcare Plan and several control groups. The goal of the study is to evaluate the effectiveness of VBID and value-based payment models alone and in concert with one another to see which is more effective and whether synergies can be achieved by offering the member incentive (VBID) and provider incentives in combination.</p>
<p><b>Potential Risks:</b></p>	<p>The development of a common set of metrics is crucial to establish cross-payer alignment on quality measures for providers participating in shared savings arrangements. A potential risk arises if major payers implement the common measure set that the Quality Council endorses in an uneven way. This may create confusion and fragmentation in implementation of the scorecard. To mitigate this risk the Quality Council will include major payers during all discussion and decisions relating to the quality measures set, and facilitate agreement.</p> <p>In addition, payer engagement is crucial to ensure payer analytics and data reporting align with SIM goals. Risks to the timeline are associated with dependencies that all payers and providers are ready to launch technologies and allow indexing. Early engagement of providers/health plans will aid to mitigate this concern.</p>

<p><b>Providers</b></p>		
<p><b>Stakeholder Information:</b></p>	<ul style="list-style-type: none"> <li>– Connecticut Hospital Association</li> <li>– Griffin Hospital</li> <li>– Fair Haven Community Health Center</li> <li>– Orthopedic Associates of Hartford</li> <li>– Connecticut Medical Group, LLC</li> <li>– Yale New Haven Health System</li> <li>– Connecticut State Medical Society</li> <li>– Radiological Society of Connecticut</li> </ul>	<ul style="list-style-type: none"> <li>– ProHealth Physicians</li> <li>– Pediatrics Plus</li> <li>– Connecticut Association of School Based Health Centers</li> <li>– Stamford Hospital</li> <li>– Community Health Center, Inc.</li> <li>– American College of Physicians - CT Chapter</li> </ul>

	<ul style="list-style-type: none"> <li>– Norwalk Hospital</li> <li>– Community Health Center Association of Connecticut</li> <li>– Community Medical Group IPA</li> <li>– Hartford Healthcare</li> <li>– Saint Mary's Hospital</li> <li>– Saint Francis Center for Health Equity</li> <li>– St. Vincent's Health Partners</li> <li>– Family Medicine Center at Asylum Hill</li> <li>– Norwalk Community Health Center</li> <li>– Medical Analytics Department, ConnectiCare, Inc.</li> <li>– ENT &amp; Allergy Associates LLC</li> </ul>	<ul style="list-style-type: none"> <li>– Cardiology Associates of New Haven PC</li> <li>– Connecticut Institute for Clinical and Translational Science at UConn</li> <li>– Robert D. Russo MD and Associates Radiology</li> <li>– Burgdorf Health Center</li> <li>– Southwest Community Health Center, Inc.</li> <li>– ConnectiCare, Inc. &amp; Affiliates</li> <li>– Western Connecticut Health Network</li> <li>– Team Rehab</li> <li>– Westwood Women's Health</li> <li>– Community Health Resources</li> </ul>
<p><b>Rationale for Engagement:</b></p>	<p>Engaging providers so they are knowledgeable and confident about reforms will spur their active commitment to and involvement in initiatives aiming to achieve improved healthcare quality, reduced cost and satisfaction with the practice of primary care medicine. Over the course of five years, a substantial majority of the state’s primary care community will participate in Medicaid Shared Savings arrangement (MQISSP) and its associated components, as well as be affected by the common performance scorecard, and statewide HIT initiatives. For this reason it is critical that their input and experience is sought through our engagement methods.</p> <p>Active provider engagement in our planning and implementation efforts will also ensure that the unique needs of the provider workforce in our state are met and that their strengths, skills, and interests are optimized.</p>	
<p><b>Method for Engagement:</b></p>	<p><b><u>Committees &amp; Workgroups</u></b></p> <p>The SIM test phase will build on engagement efforts that occurred during the development phase. These activities included a wide variety of providers in the development of the Model Test, including members of the CT State Medical Society, CT Chapter of the College of Physicians, CT Academy of Family Physicians, Community Health Center Association of CT, CT Chapter of the American Academy of Pediatrics, CT Hospital Association, the CT Association for Healthcare at Home and members of the LTSS community. More than fifty providers and trade associations are engaged in the Healthcare Innovation Steering Committee, and all other councils and task forces associated with the SIM governance structure, including the MAPOC and its committees.</p> <p>Providers hold active membership in the Quality Council, which is developing the core measure set for the Common Performance Scorecard, and physicians representing all types of physician practices will be consulted in the metrics development process.</p>	

Providers also have membership on the Equity & Access Council, and the HIT Council, in which they will provide input to identify new needs as the status of HIT acquisition and operations changes over the test period.

**Forums**

The SIM PMO is partnering with physicians who are engaged in the SIM governance structure to undertake an extensive campaign to raise physician awareness and, importantly, to participate in forums that allow physicians to directly engage on the issues that cause them greatest concerns. We will do this work in collaboration with the various professional associations including the CT State Medical Society, CT Chapter of the American College of Physicians, CT Academy of Family Physicians, and the CT Chapter of the Academy of Pediatrics.

**Advanced Medical Home Learning Collaborative**

The PMO will establish three learning collaboratives. The first will focus on practices enrolled in the AMH Glide Path. The second and third LCs will be tailored to FQHCs and Advanced Networks participating in QISPP. LCs will foster continuous learning through webinars, workshops, an online collaboration site, and phone support. Practices will be expected to actively share resources, tools, and strategies with each other in the LC. LC participants will report quarterly progress on achieving milestones to track transformation.

**Targeted Technical Assistance**

Providers that participate in MQISSP will receive Targeted Technical Assistance, which will assist and engage them in establishing this value based model in their practice.

**Site Visits**

Site visits will be conducted for practices participating in MQISSP to review detailed reporting and drill down analyses by provider, provider group, and consumer.

**Physician Survey**

In order to engage physicians on a broad scale, the SIM evaluation team conducted a statewide physician survey in November 2014 reaching more than 3400 healthcare providers including primary care physicians and several specialist groups. This survey provides a baseline assessment of the State’s physician workforce and physician’s experiences with and perspectives on healthcare transformation efforts. Survey information collected includes:

- Physicians ‘ attitudes and concerns regarding larger coordinating entities such as clinically integrated health systems or Advanced Networks;
- Willingness to accept new patients and patients with different types of insurance (e.g., Medicaid, Medicare).
- Amount of primary care currently provided and any anticipated changes in the relative amount of primary care provided;
- Availability and/or use of a formal care coordinator and/or ability to coordinate care, and to attract staff to help address complex care needs;

	<ul style="list-style-type: none"> <li>Ownership and organization of practices and affiliations with larger care systems/organizations such as networks, Independent Practice Associations (IPAs), or Accountable Care Organizations (ACOs), as well as anticipated new affiliations or arrangements;</li> </ul> <p>Recently released findings will be used to inform implementation of SIM initiatives. In addition, the survey questions may inform the development of questions for the expanded physician licensing survey described previously. The physician survey could then be used as a baseline or starting point to evaluate whether our reforms are impacting provider concerns.</p>
<p><b>Timeframe for Stakeholder Engagement</b></p>	<p>Providers will be engaged throughout the test grant on an ongoing basis, in terms of high level feedback from the Committees and Workgroups, but also from the practices involved directly in the reforms as participants.</p>
<p><b>Roles and Responsibilities:</b></p>	<p>During the SIM test period healthcare providers will participate in the SIM governance structure in order to provide feedback on any issues raised during implementation. Secondly, healthcare providers play the critical role of participating in SIM practice improvement initiatives, including moving towards value based payment arrangements.</p> <p>Primary care providers, specialists, and hospitals on the <b>Quality Council</b> will share what metrics are and should be tracked and help assess the feasibility of tracking new metrics within the clinical setting, such as changes to systems and clinical processes. Hospitals will also help to assess and identify and help resolve duplicative, conflicting, and unnecessary measurement mandates.</p> <p>Behavioral health providers on the <b>Quality Council</b> are tasked with identifying and helping to prioritize behavioral-health and health behavior related metrics for inclusion on scorecard. They will share behavioral-specific metrics that are being tracked and help assess the feasibility of tracking new metrics. In addition, they will promote scorecards within the behavioral health community.</p> <p>Physicians &amp; hospitals on the <b>Equity &amp; Access Council</b> will define and oversee the plan to systematically gather input from a broad range of physicians to identify potential changes to provider practices that may compromise the system’s ability to provide appropriate care and access to care.</p> <p>Advanced Networks on the <b>HIT Council</b> will help the taskforce understand new systems, capabilities, and infrastructure that will be required for providers to transition into an ACO clinically integrated model. They will support prioritization and sequencing of planned changes that will maximize impact while minimizing disruption to provider workflows.</p> <p>Hospitals on the <b>HIT Council</b> will share insights on existing systems being used by CT hospitals that can be leveraged or best practices that can be adopted. They will</p>

	<p>support the prioritization and sequencing of planned changes that will maximize consumer and provider benefit while minimizing disruption to provider systems and workflow.</p> <p>Physicians on the <b>HIT Council</b> will help the council understand new systems, capabilities, and infrastructure that will be required for independent practice providers to utilize new HIT tools and infrastructure. They will help identify and prioritize required changes to existing systems; provide insight into potential barriers for change and make suggestions for overcoming barriers; support the identification of and vetting of preferred vendors; and provide estimation of required financial investment.</p> <p>In addition, the providers will also have the following roles:</p> <p><b>Adoption of value-based payment models, including MQISSP:</b> Advanced networks, FQHCs and primary care practices participating in SIM initiatives including Medicaid QISSP and the Advanced Medical Home Glide Path will be responsible for meeting the criteria and program guidelines established, such as: demonstrated commitment, experience and capacity to serve Medicaid beneficiaries; ability to meet identified standards for clinical and community integration, like integrating the use of community health workers; a willingness to invest in special capabilities such as data analytics, quality measurement and rapid cycle improvement efforts; and a minimum of 5,000 attributed single-eligible Medicaid beneficiaries.</p> <p><b>Financing the Care Experience Survey:</b> For the first two years (2015 baseline, and 2016 performance year), the state has proposed to use SIM funding to subsidize the cost of the care experience survey. The PMO will co-source the conduct of the survey on behalf of all payers and provider organization participating in SSP arrangements. We believe that combining the purchasing power in this way will reduce the cost per completed survey. As of the 2017 performance year, each provider organization will have the option to arrange for and finance the care experience survey themselves, provided they use the survey tool and methods approved by the Steering Committee, and to have their performance reported to the PMO and each payer. Provider organizations that do not enter into an agreement with the PMO’s vendor to co-source the survey will be required by payers to provide a qualifying survey in order to receive a shared savings distribution.</p>
<p><b>Potential Risks:</b></p>	<p>Wave 1 of MQISSP aims for an enrollment of 200,000 beneficiaries into SSP. There is a risk of insufficient participation that will be mitigated by intensive stakeholder engagement.</p> <p>Risks to the timeline are associated with dependencies that all payers and providers are ready to launch technologies and allow indexing. Early engagement of providers/health plans will aid to mitigate this concern.</p>

The ability to address provider challenges quickly and adapt our methods to suit their needs will target our efforts effectively to drive real change. Providers have identified challenges or barriers to the success of the care delivery and payment reforms. Physicians note that there remains among many physicians a lack of knowledge about the reforms, or skepticism that such reforms will achieve promised improvements in quality, cost or satisfaction with the practice of primary care medicine. Unaddressed this may diminish physicians' willingness to participate in offered practice transformations support services or to participate with the Advanced Networks that are already involved in such reforms.

Additionally, patient centered medical home models must incorporate provider input on how to meet their challenges to achieving this goal for their practice. We are challenged by the high percentage of independent physicians in 2-4 person size groups and not in larger practices/networks and a lower percentage of these independent physicians in various risk-sharing or alternative payment models. The Connecticut State Medical Society is directly addressing this issue by providing an Advanced Network options and the SIM practice transformation support may be available for these providers. Our efforts at quality measure alignment should also make participation more efficient and practicable for these smaller scale arrangements.

Collaborating with a broad array of providers allows us to address unique challenges. For instance, Connecticut's FQHCs have expressed special challenges with building the data and analytic infrastructure necessary to support high performance in a quality and cost accountable environment. Moreover, they believe that they need support in develop continuous quality improvement process that will enable them to make progress as performance improvement opportunities are identified. Our Community and Clinical Integration Program and its associated Learning Collaborative will pay special attention to overcoming these challenges in the support they provide to the FQCH community participating in the Medicaid QISSP.

## **Data Collection and Evaluation Coordination**

Sufficient commitment has been obtained to support the data collection and evaluation coordination requirements established in the cooperative agreement terms and conditions.

Connecticut Medicaid has extremely strong analytic capacity and expertise. Since 2012, Connecticut Medicaid has had the benefit of a fully integrated set of claims data across all categories of Medicaid services. The Department's medical ASO, CHN, maintains this data within the Utilization & Cost Analyzer (UCA) system, an analytical and data discovery tool that includes Medicaid claims, member eligibility, and provider data. UCA utilizes QlikView software and is uploaded monthly with claims, member eligibility, and provider data directly from CHN's data warehouse specific to the Connecticut Medicaid

program. The data warehouse is populated with data that is received from the Department and its claims processing partner, HP. The Department anticipates that the data extracts necessary to support the federal evaluation will be produced by CHN. As noted above, the Department will enter into data use agreements (DUA) with CMS or the federal contractor for purposes of sharing the minimum necessary identifiable data.

With respect to the APCD, if the statutory language permitting the disclosure of identifiable data from the APCD to CMMI for the purposes of SIM evaluation is not successful, the SIM PMO will work with the individual commercial payers to provide for direct submission of the minimum identifiable dataset necessary to achieve the purposes of the evaluation. We are also prepared to directly engage self-funded employers to the extent that this is necessary to ensure authorization for the provision of necessary data. The proposed HIPAA rule change appears to resolve questions that emerged in our discussions with commercial payers as to the permissibility of such disclosures under HIPAA. There are no state laws that otherwise would prohibit their disclosure, other than potential limitations on the disclosure of behavioral health information (CGS 52-14 b, c, d, e and f), which we intend to address with the above referenced changes to the APCD enabling legislation.

### 3. Population Health Plan

Population Health Plan					
<i>Output/Deliverable</i>	<i>Government</i>	<i>Consumer Community Employer</i>	<i>Payers</i>	<i>Providers</i>	<i>Target Date</i>
Detailed design of population health initiatives.	X	X	X	X	Y1-Y4
Innovative financing strategies and alignment with care delivery and payment reform models.	X	X	X	X	Y4
Establish effective partnership between provider and community entities.	X	X	X	X	Y3, Y4

Federal, State and Local Governmental Stakeholders:		
<b>Stakeholder Information:</b>	<ul style="list-style-type: none"> <li>– Department of Public Health</li> <li>– Department of Social Services</li> </ul>	<ul style="list-style-type: none"> <li>– <i>Potentially:</i></li> <li>– Department of Housing</li> <li>– Office of Early Childhood</li> </ul>

	<ul style="list-style-type: none"> <li>– Department of Mental Health &amp; Addiction Services</li> <li>– Office of the Healthcare Advocate</li> <li>– Department of Children and Families</li> <li>– Access Health (CT’s Health Exchange)</li> <li>– Connecticut Insurance Department</li> <li>– Office of Policy and Management</li> <li>– CT State Senate</li> <li>– CT House of Representatives</li> <li>– SIM Program Management Office</li> <li>– Office of the State Comptroller</li> <li>– CDC</li> </ul>	<ul style="list-style-type: none"> <li>– Local health departments</li> <li>– Department of Aging</li> <li>– Department of Transportation</li> <li>– Department of Environment and Energy</li> <li>– Department of Education</li> <li>– Department of Labor</li> </ul>
<p><b>Rationale for Engagement:</b></p>	<p>There is a multitude of local governmental health and human service agencies with a deep and unique understanding of the communities they serve, that must be engaged to deliver a model that can improve population health.</p> <p>The Plan will include initiatives that span multiple state agencies, such as, the Department of Social Services, Department of Mental Health &amp; Addiction Services, the Office of the Healthcare Advocate, Department of Children and Families, and local governmental health entities. These government stakeholders must coordinate and be involved in the Plan’s implementation for it to be successful.</p> <p>Furthermore, collaboration between local government stakeholders will be required for the launch of Prevention Service Centers (PSCs) and Health Enhancement Communities (HECs). At this time, local public health departments, schools, and local social service organizations will be among the governmental authorities brought together. DPH will maintain its strong relationships to CT’s eight local health districts, which may play a role in fiduciary oversight and program coordination among community coalitions.</p>	
<p><b>Method for Engagement:</b></p>	<p><b><u>Committees &amp; Workgroups</u></b></p> <p>State agencies will be active members on the Population Health Council. The Steering Committee will receive regular updates from DPH and will play an advisory role as described in the SIM Governance section of this plan. Agencies who may not have been engaged previously will be sought out during the test phase, such as the Department of Housing and the Office of Early Childhood.</p> <p><b><u>Contractual</u></b></p> <p>DPH and the PMO will execute an initial Memorandum of Agreement to provide support for early planning activities. This MOA will be expanded to include DSS and will detail their joint planning and administrative responsibilities in regards to the development of the HEC and other initiatives related to the Plan.</p>	

	<p><b>Management – Internal Meetings &amp; Core Agency Meetings</b></p> <p>The DPH-based Population Health Planning leads will participate in SIM Core Team meetings to ensure that the practice transformation and payment reform initiatives are coordinated with developments and recommendations of the Population Health Council.</p>
<p><b>Timeframe for Stakeholder Engagement</b></p>	<p>The Council will be established Y1, Q1 and will be ongoing through the test period.</p>
<p><b>Roles and Responsibilities:</b></p>	<p>Plan development will be led by DPH in collaboration with the Department of Social Services (DSS), which administers the CT’s Medicaid program, and the State Innovation Model Program Management Office (PMO), which will ensure integration of population health interventions with the care delivery and payment innovations of the Model Test.</p> <p>To successfully deliver this plan, DPH will also need to analyze multiple data sources including Behavioral Risk Factor Surveillance Survey (BRFSS), mortality data, hospital and ED discharge data and existing community health needs assessments. Some of DPH’s outputs, such as finding ways to expand the state’s reportable diseases database to include chronic disease indicators for population health activities, requires work of other agencies such as with DSS in its efforts to create a fully-functioning statewide Health Information Exchange (HIE).</p> <p>DPH is also responsible for multiple outputs including identifying public health priorities based on criteria of burden and cost; conducting root cause and barrier analyses for tobacco, obesity and diabetes and other priority areas; researching evidence-based interventions; and conducting a trend analysis.</p> <p>Other engaged agencies will serve as subject matter experts to guide the development of an effective model.</p>
<p><b>Potential Risks:</b></p>	<p>Failure to coordinate and collaborate across state agencies could result in misalignment and the failure to take advantage of mutually reinforcing initiatives and authorities.</p>

<b>Community and Consumer Stakeholders, Employers</b>		
<b>Stakeholder Information:</b>	<ul style="list-style-type: none"> <li>– Pitney Bowes, Inc.</li> <li>– Connecticut Health Foundation</li> <li>– Windham Regional Community Council</li> <li>– Bridgeport Child Advocacy Coalition</li> <li>– Legal Assistance Resource Center of Connecticut</li> </ul>	<ul style="list-style-type: none"> <li>– United Connecticut Action for Neighborhoods</li> <li>– Connecticut Legal Rights Project</li> <li>– Universal Healthcare Foundation of Connecticut</li> </ul> <p><i><b>Note:</b> Many more to be included once Council is established – see Section IV. Other Advisory Committees</i></p>
<b>Rationale for Engagement:</b>	<p>The SIM initiative offers a unique opportunity to design a focused and coordinated approach to improving community health and reducing avoidable health disparities not easily addressed by the healthcare sector alone. A community health improvement approach is critical to the successful achievement of the state’s aim of improving the health and healthcare quality of Connecticut's residents, eliminating health disparities, improving care experience, and promoting population health.</p> <p>Connecticut has a rich array of community-based organizations and local non-governmental health and human service agencies with a deep and unique understanding of the communities they serve. These entities administer community-based programs that share a common objective with clinical practices – preventing illness or injury, managing chronic illness and improving the health of consumers. Unfortunately, these programs face multiple obstacles in achieving this goal. Engaging them in the development of this new model will ensure their sustainability and integration into the broader healthcare system.</p>	
<b>Method for Engagement:</b>	<p><b><u>Committees &amp; Workgroups</u></b> Community and consumer advocates will be active members on the Population Health Council, and the Steering Committee, described in the SIM Governance section of this plan.</p> <p><b><u>Convening of Organizations</u></b> Organizations interested in providing PSC services will be convened during the process of selecting 2-3 demonstration sites for the PSC initiative.</p> <p><b><u>Community Stakeholder Presentations</u></b> DPH and its partners will reach out to nonprofit organizations, foundations, and community-based organizations to present at their meetings or serve on panels.</p>	

<b>Timeframe for Stakeholder Engagement</b>	Consumer and community advocates were critical during the development of the Plan and will be engaged during Y1-Y4 when details are developed. Community organizations will also be engaged as participants during the launch of PSCs.
<b>Roles and Responsibilities:</b>	Consumer advocate and community stakeholders will be responsible for providing expertise regarding regional services, needs, gaps, and opportunities. Community organizations will also have the opportunity to become PSCs.
<b>Potential Risks:</b>	<p>The Plan will need to partner with a variety of community organizations to develop actionable initiatives that will improve population health. Community based organizations that address the social determinants of health will be critical to creating the evidence-based strategies to address tobacco, obesity, diabetes and other identified priorities; and to identifying barriers to population health improvement.</p> <p>Failing to engage consumers may lead to solutions that are not supported by the community and that do not reflect consumer values and priorities. This will limit our ability to achieve proposed improvements in health. Collaboration will help ensure that their needs are well understood and barriers are addressed.</p>

<b>Payers</b>									
<b>Stakeholder Information:</b>	<ul style="list-style-type: none"> <li>– DSS, Medicaid</li> <li>– OSC, State Employee Health Plan</li> <li>– Anthem Blue Cross &amp; Blue Shield</li> <li>– Aetna</li> </ul>	<ul style="list-style-type: none"> <li>– Cigna</li> <li>– United Healthcare</li> <li>– Connecticare</li> <li>– Harvard Pilgrim</li> <li>– HealthyCT</li> </ul>							
	<p>We define Connecticut’s major commercial payers as those with over 5% market share. These payers include the following based on 2013 coverage data:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Commercial Payer</th> <th style="text-align: right;">Market Share</th> </tr> </thead> <tbody> <tr> <td>Aetna</td> <td style="text-align: right;">12.7%</td> </tr> <tr> <td>Anthem</td> <td style="text-align: right;">48.2%</td> </tr> <tr> <td>Cigna</td> <td style="text-align: right;">23.8%</td> </tr> </tbody> </table>		Commercial Payer	Market Share	Aetna	12.7%	Anthem	48.2%	Cigna
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<p><b>Rationale for Engagement:</b></p>	<p>In addition, we have been working closely HealthyCT, which in 2014 began offering individual coverage on our health insurance exchange, and Harvard Pilgrim, which is also preparing to enter the Connecticut market.</p> <p>In order to move towards models that improve the health for populations, there must be accountability for the healthcare quality and cost for those populations, as well as mechanisms that formalize and sustain partnerships across entities. Current data suggests that the need for high quality community services far outstrips their availability. However, many community-based services rely on grant funding, leaving even the highest quality services vulnerable to funding cycles and thus unsustainable.</p> <p>Health Enhancement Communities (HECs), an initiative to be developed as part of the Plan for Improving Population Health, will aim to enhance coordination local coordination and accountability among providers, local public health departments, nonprofits, schools, housing authorities and others. In order to ensure sustainability and accountability, as well as alignment with value-based payment models, payers must be engaged to develop innovative financing strategies.</p>					
<p><b>Method for Engagement:</b></p>	<p><b><u>Committees &amp; Workgroups</u></b>  Payers will be brought together with other stakeholders to create and agree on possible innovative financing strategies (e.g., wellness trusts) and what their relationships will be to multi-sector governance solutions (e.g., local coalitions led by a fiduciary agent).</p> <p>Health plans will be engaged with the Population Health Council. They will also be engaged on an ongoing one-on-one basis to offer insight and input.</p>					
<p><b>Timeframe for Stakeholder Engagement</b></p>	<p>Payers will be engaged on monthly periodic basis throughout the test grant period through the Council.</p>					
<p><b>Roles and Responsibilities:</b></p>	<p>Medicaid will review all available options for State Plan and waiver authority in support of HECs, for example, by enabling reimbursement for community health workers and bundled payments for trauma-informed wrap-around interventions for children and families.</p> <p>All health plans will have the role of providing expertise in the development of new financing strategies.</p>					

<b>Potential Risks:</b>	<p>Engaging payers is critical to ensure viability and sustainability of the Plan. New reimbursement innovations will rely on payer willingness to, for example, implement evidence-based policies and strategies that are linked with reimbursement innovations to address social determinants of health and health equity (e.g., reimbursement for healthy homes assessments and community health workers).</p> <p>Payer engagement is also crucial to ensure the sustainability for financing of PSCs and potentially HEC. To mitigate this risk we will engage private and public payers for sustainable financing of PSCs. For HECs, reserve fund/wellness trust based on expected savings or other sustainable financing mechanism will be designed and established.</p>
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<b>Providers</b>			
<b>Stakeholder Information:</b>	<table border="1" style="width: 100%;"> <tr> <td style="width: 50%;"> <ul style="list-style-type: none"> <li>– Griffin Hospital</li> <li>– Fair Haven Community Health Center</li> <li>– Orthopedic Associates of Hartford</li> </ul> </td> <td style="width: 50%;"> <ul style="list-style-type: none"> <li>– Connecticut Medical Group, LLC</li> <li>– St. Vincent's Health Partners</li> </ul> <p><i><b>Note:</b> Many more to be included once Council is established – see Section IV. Other Advisory Committees</i></p> </td> </tr> </table>	<ul style="list-style-type: none"> <li>– Griffin Hospital</li> <li>– Fair Haven Community Health Center</li> <li>– Orthopedic Associates of Hartford</li> </ul>	<ul style="list-style-type: none"> <li>– Connecticut Medical Group, LLC</li> <li>– St. Vincent's Health Partners</li> </ul> <p><i><b>Note:</b> Many more to be included once Council is established – see Section IV. Other Advisory Committees</i></p>
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<b>Rationale for Engagement:</b>	<p>In order to ensure effective clinical linkages with other entities that care for a given population, providers and provider organizations must be informed and engaged. The planning for population health models that achieve the Triple Aim must incorporate their input and expertise.</p>		
<b>Method for Engagement:</b>	<p><b><u>Committees &amp; Workgroups</u></b>  The Population Health Council is responsible for developing the Population Health Plan during the SIM test period. An Advisory Council and Health Systems Work Group were established previously under a broader 150-member, multi-sector Healthy Connecticut 2020 planning coalition. This workgroup will be reconvened as the Population Health Council and enhanced to include payers and health care providers. This Council will meet monthly.</p> <p><b><u>Contractual</u></b>  DPH will facilitate the development of formal agreements between primary care sites and PSCs.</p>		

	<p><b>Forums</b></p> <p>DPH will partner with physicians who are engaged in the SIM governance structure to undertake raise physician awareness and, importantly, to participate in forums that allow physicians to directly engage on the issues that cause them greatest concerns. DPH will do this work in collaboration with the various professional associations including the CT State Medical Society, CT Chapter of the American College of Physicians, CT Academy of Family Physicians, and the CT Chapter of the Academy of Pediatrics.</p>
<p><b>Timeframe for Stakeholder Engagement</b></p>	<p>Providers will be engaged throughout the test grant on an ongoing basis, in terms of high level feedback from the Committees and Workgroups, but also from the practices involved directly in the reforms as participants.</p>
<p><b>Roles and Responsibilities:</b></p>	<p>Providers and provider organizations will be responsible for providing expertise regarding health related topics, as well as the clinical landscape, needs, gaps, and opportunities in specific regions.</p> <p>Practices will establish formal ties with PSCs and will ultimately be participants in HECs.</p>
<p><b>Potential Risks:</b></p>	<p>If providers are not engaged in the Plan, their healthcare expertise, strengths, and the challenges they face in providing holistic care will not be addressed. Providers have specific challenges and barriers to providing comprehensive care and creating linkages within the healthcare field and with community entities. If their perspectives are not included, the Plan will not be actionable or practical. Our engagement efforts will mitigate this risk.</p>

## APPENDIX A:

Roles, composition, and criteria for the four SIM governance work groups.

### COMPOSITION AND HIGH-LEVEL CRITERIA FOR WORKGROUP PARTICIPATION

	Composition	High-Level Criteria
Health Information Technology Council	<ul style="list-style-type: none"> <li>▪ 3 consumers/advocates</li> <li>▪ 2 physicians/CSMS</li> <li>▪ 2 health plans</li> <li>▪ 1 HIT coordinator</li> <li>▪ 1 AHCT/APCD</li> <li>▪ 1 hospital</li> <li>▪ 1-2 ACO/clinically integrated network</li> <li>▪ 8 DSS, DMHAS, DPH, DCF, DOC, OPM, BEST, OSC</li> <li>▪ 1 Academic health center</li> </ul>	<ul style="list-style-type: none"> <li>▪ Authority or ability to influence</li> <li>▪ Technical expertise with provider and payer systems, health information technology and/or analytics</li> </ul>
Practice Transformation Taskforce	<ul style="list-style-type: none"> <li>▪ 4 consumers or advocates</li> <li>▪ 2 DSS, DMHAS</li> <li>▪ 4 primary care/specialty providers inc APRN</li> <li>▪ 1 behavioral health provider</li> <li>▪ 1 FQHC</li> <li>▪ 1 hospital</li> <li>▪ 5 all health plans with &gt;5% market share</li> <li>▪ 1 employer</li> <li>▪ 1 school-based health center</li> </ul>	<ul style="list-style-type: none"> <li>▪ Authority or ability to influence</li> <li>▪ Commitment to shared aspirations</li> <li>▪ Direct experience with advanced primary care, clinical integration, practice transformation</li> </ul>
Quality Council	<ul style="list-style-type: none"> <li>▪ 4 consumers or advocates</li> <li>▪ 3 physicians</li> <li>▪ 1 hospital</li> <li>▪ 1 FQHC</li> <li>▪ 5 all health plans with &gt;5% market share</li> <li>▪ 4 DSS, DMHAS, DPH, OSC</li> </ul>	<ul style="list-style-type: none"> <li>▪ Authority or ability to influence</li> <li>▪ Technical expertise and experience with measurement of health, quality, resource efficiency, and consumer experience</li> </ul>
Equity and Access Council	<ul style="list-style-type: none"> <li>▪ 6 consumers or advocates</li> <li>▪ 3 DSS, DPH, OHA</li> <li>▪ 5 all health plans with &gt;5% market share</li> <li>▪ 3 physicians</li> <li>▪ 1 hospital</li> <li>▪ 1 FQHC</li> </ul>	<ul style="list-style-type: none"> <li>▪ Commitment to appropriate care and access</li> <li>▪ Experience with access &amp; underservice issues</li> <li>▪ Ability to understand claims-level data analysis</li> <li>▪ Understanding of underserved populations</li> </ul>

## PRACTICE TRANSFORMATION TASKFORCE

### Role Description

#### Consumers & Advocates

- Provide input on aspects of practice transformation that affect consumer choice, literacy, care experience, communication, access, etc. Help **define changes required** in provider-patient interactions
  - **Qualifications:** Experienced health conditions such as cardiovascular disease, diabetes, asthma, arthritis, psychiatric illness, or substance use; diverse and balanced mix of participants, considering life experience, individual circumstances, source of coverage, race/ethnicity, and health conditions; good synthesis abilities; creative problem-solving abilities; relationships with other consumers preferred.
- 

#### Physicians

- Gather broad input from diverse set of physicians, e.g., hospital-employed physicians, rural physicians
  - Outline the **clinical processes, systems, and infrastructure** that need to be modified to transition majority of physicians to Connecticut's defined AMH model
  - Provide insight into **potential barriers for change** and suggestions for overcoming
  - **Promote** taskforce recommendations within the physician community
  - **Qualifications:** Strong presence in CT's physician community, serving in an advanced practice or clinically integrated setting, understanding of underlying systems / infrastructure of practices, time and ability to gather data across diverse set of physicians, creative problem-solving
- 

#### Behavioral Health Provider

- Provide insight into **needs of behavioral health patients** that require additional modifications in provider practices ranging from screening, assessment, brief treatment, health behavior, linkage to BH affiliate
  - Help **brainstorm potential solutions**
  - **Promote** taskforce recommendations within behavioral health community
  - **Qualifications:** Strong presence in behavioral health community, expertise in primary care/behavioral health integration, familiarity with current state / transformational needs of diverse set of behavioral health providers, creative and open-minded approach to brainstorming solutions
- 

#### Hospital

- Share insight on changes required to **administrative and clinical processes, systems and budgeting** for hospitals to play a role in new care delivery model
  - Help taskforce define **plan for implementing** recommendations with hospitals
  - **Promote** taskforce recommendations within the hospital community
- 

#### Health Plans

- Share practice transformation expertise, standards, gap analysis or readiness assessment tools, and practice support methods currently in use
- Be prepared to serve as change agents to **roll-out taskforce recommendations** with network providers
- **Qualifications:** Strong relationships with network physicians, support from internal payer executives who are open to providing feedback through their medical director, creative and open-minded approach to brainstorming, familiarity with innovative care delivery and payment models at existing payer and other payers in state; represent a diversity of roles within health plan related practice transformation, e.g., medical director, medical home director, practice transformation support specialist, etc.

## QUALITY COUNCIL

### Role Description

#### Consumers & Advocates

- Provide input on aspects of quality measurement that pertain to outcomes and care experience, help prioritize **root issues** that need to be addressed by metrics
  - **Qualifications:** Experienced health conditions such as cardiovascular disease, diabetes, asthma, arthritis, psychiatric illness, or substance use; diverse and balanced mix of participants, considering life experience, individual circumstances, source of coverage, race/ethnicity, and health conditions; good synthesis abilities; creative problem-solving abilities; comfortable asserting views; relationships with other consumers preferred
- 

#### Primary Care Providers & Specialists

- Share what metrics are and should **be tracked** and help assess the **feasibility of tracking new metrics** within clinical setting, e.g., required changes to systems, clinical processes
  - **Promote** performance measurement and provider scorecards within physician community
  - **Qualifications:** Strong, recognized presence in physician community; ability and time to gather input from broad set of physicians regarding metrics currently being tracked; good grasp of requirements to track metrics within clinical setting (e.g., impact on clinical process / flow)
- 

#### Behavioral Health Provider

- Identify and help prioritize **behavioral-health and health behavior related metrics** for inclusion on scorecards
  - Share behavioral-specific metrics that are being tracked and help assess **feasibility of tracking new metrics**
  - **Promote** scorecards within behavioral health community
  - **Qualifications:** Strong, recognized presence in behavioral community; familiarity with behavioral health metrics being tracked in-state and elsewhere; understanding of technical requirements to reliably track metrics
- 

#### Hospitals

- Share metrics currently tracked and help assess the **feasibility of tracking new metrics** within clinical settings, e.g., required changes to systems, clinical processes; identify and help resolve duplicative, conflicting, and unnecessary measurement mandates
- **Promote** performance measurement and provider scorecards within provider community
- **Qualifications:** Strong, recognized presence among hospital medical directors and quality managers, ability to solicit detailed information from other hospital medical directors and quality measurement staff as needed to understand feasibility of tracking new metrics; familiarity with state and national measurement sets and requirements

## QUALITY COUNCIL (cont.)

### Role Description

#### Health plan medical directors

- Share what metrics are being tracked and help assess the **feasibility for payers to track new metrics** with their network providers;
  - Consider feasibility of transitioning to a **“common provider scorecard”** across payers
  - Serve as **liaison** with internal executives to gather feedback on recommended metrics
  - **Qualifications:** Commitment from payer executives to provide feedback through medical director, familiarity with metrics being tracked by payer in CT and in other regions, ability to comfortably problem-solve with private payer statisticians on statistical viability of metrics and methods for risk adjustment and exclusions
- 

#### Health plan statisticians & measurement experts

- Facilitate selection of core set of measures; mix of process, outcome, efficiency, and patient engagement and experience metrics
  - Outline data requirements, e.g., minimum patient panel size for statistical validity of prioritized metrics
  - Outline risk adjustment and exclusion methods
  - Help taskforce select measures that are ambitious, but feasible to implement
  - **Qualifications:** Strong statistical analysis capabilities; creative and open-minded problem-solver; familiarity with diverse set of metrics including national measurement sets (e.g., AHRQ, NQF, NCQA, Medicare SSP), and statistics
- 

#### DPH Epidemiologist

- Share what health metrics, surveillance data, and vital statistics are being tracked by DPH and other community organizations today; familiarity Healthy People 2020 measures, targets, and statistics
  - Help identify and prioritize metrics to be used to track improvements in **public health**
  - **Qualifications:** Familiarity with population-health metrics being implemented in CT and in other best practice settings to measure public health
-

## EQUITY AND ACCESS COUNCIL

### Role Description

#### Consumer Advocates

- Provide input on under-service safeguards from consumer perspective; gauge reasonableness and adequacy of such safeguards
  - **Qualifications:** Experienced health conditions such as cardiovascular disease, diabetes, asthma, arthritis, psychiatric illness, or substance use; diverse and balanced mix of participants, considering life experience, individual circumstances, source of coverage, race/ethnicity, and health conditions; good synthesis abilities; creative problem-solving abilities; relationships with other consumers preferred
- 

#### Health plans – medical directors

- Help taskforce identify **potential issues in program design** that could negatively impact delivery of appropriate care and access
  - Lead taskforce's efforts to **define and execute plan to identify outliers** in care delivery and payments
  - **Qualifications:** Strong relationships with network physicians, support from internal payer executives who are open to providing feedback through their medical director, creative and open-minded approach to brainstorming, familiarity with innovative payment models; familiarity with safety, quality, & outlier monitoring
- 

#### Health plans - program integrity

- Consider methods for identifying patterns of under-service, risk avoidance, or patient abandonment
  - Lead taskforce's efforts to **define and execute plan to identify and investigate outliers**
  - **Qualifications:** Prior experience in managing program integrity and surveillance; commitment to ensuring long-term, system provision of appropriate care and access; scenario modeling capabilities a plus
- 

#### Academics

- Provide **input from academic research** on potential design facets that could compromise ability to provide appropriate care and access to care
  - Work with PI specialists to understand **statistical requirements** to gather reliable data that will support identification of outliers
  - **Qualifications:** Commitment to ensuring long-term provision of appropriate care and access; familiarity with academic research on program integrity and surveillance; statistical analysis capabilities
- 

#### Physicians/ Hospitals

- Define and oversee plan to systematically gather input from broad range of physicians to identify potential changes to provider practices that may **compromise the system's ability to provide appropriate care and access to care**
- **Qualifications:** Commitment to ensuring long-term system provision of appropriate care and access; familiarity with under-service risks and needs of underserved populations

## HEALTH INFORMATION TECHNOLOGY COUNCIL

### Role Description

#### Consumers & Advocates

- Provide input on aspects of health information that relate to consumer/provider communication, performance transparency, privacy, security, and shared decision making tools
  - **Qualifications:** Experienced health conditions such as cardiovascular disease, diabetes, asthma, arthritis, psychiatric illness, or substance use; diverse and balanced mix of participants, considering life experience, individual circumstances, source of coverage, race/ethnicity, and health conditions; good synthesis abilities; creative problem-solving abilities; relationships with other consumers preferred.
- 

#### Health Plans

- Provide information on **existing infrastructure and HIT capabilities** across diverse set of private payers
  - Liaise with internal executives to share taskforce recommendations and gather input
  - Determine **feasibility of integrating systems across payers**
  - **Qualifications:** Strong relationships with counterparts at other insurers, commitment from payer executives to provide input through representative, familiarity with or ability to gather data on HIT systems and infrastructure across diverse set of insurers, authority and ability to negotiate with counterparts at other insurers regarding potentially integrating systems / processes
- 

#### State Agencies<sup>1</sup>

- Share detailed information on **existing infrastructure and HIT capabilities within each department**, including potential to integrate or expand on existing systems
  - Define need for **new systems introductions** and outline plan for integration
  - **Qualifications:** Familiarity with existing infrastructure and systems across departments, prior involvement in CT HIT-related initiatives, e.g., SIM, CT Data Collaborative, EHR incentive program, Direct messaging, Medicaid Information Technology Architecture (MITA)
- 

#### ACO / Clinically Integrated Network

- Help taskforce understand **new systems, capabilities, and infrastructure** that will be required for providers to transition into an ACO or other clinically integrated model
- Support **prioritization and sequencing of planned changes** that will maximize impact while minimizing disruption to provider workflow
- **Qualifications:** Familiarity with HIT requirements associated with transitioning to an AMH-like model, personal experience implementing HIT changes in physician, hospital, and other ambulatory care settings

## HEALTH INFORMATION TECHNOLOGY COUNCIL (cont.)

### Role Description

#### Access Health CT

- Outline **existing infrastructure / capabilities** of CT's **public exchange and All Payer Claims Database** that can be leveraged to support CT SIM
  - Share **learnings** on implementing HIT innovation in CT based on experience with the exchange and APCD
  - **Qualifications:** Ability to gather input / feedback from wide range of individuals at Access Health CT to provide comprehensive perspective on existing systems and capabilities; approval authority / ability to secure approval to share systems / infrastructure with CT SIM effort
- 

#### Hospitals

- Provide information on **unique systems and HIT capabilities** that will be required to support needs of diverse set of hospital patients and clinically integrated care
  - Share insights on **existing systems being used by CT hospitals** that can be leveraged or best practices that can be adopted
  - Support prioritization and sequencing of planned changes that will maximize consumer and provider benefit while minimizing disruption to provider systems and workflow
  - **Qualifications:** Relationships with other hospitals serving broad array of patients; familiarity with hospital-based information technology including electronic health records, health information exchange, analytics, and care management tools; familiarity with other HIT demands such as ICD-10
- 

#### Physicians and/or CSMS

- Help taskforce understand new systems, capabilities, and infrastructure that will be required for independent practice providers to utilize new health information technology tools and infrastructure
- Support prioritization and sequencing of planned changes that will maximize consumer and provider benefit while minimizing disruption to provider systems and workflow
- Help identify and prioritize required **changes to existing systems / infrastructure**
- Provide insight into potential barriers for change and suggestions for overcoming
- Support identification of and vetting of **preferred vendors**
- Provide **estimation** of required financial investment
- **Qualifications:** Familiarity with HIT requirements associated with transitioning to an AMH-like model, personal experience implementing HIT changes at practice. Familiarity with best practice HIT changes that are in existence today and with new HIT innovations, practical experience with seeing HIT systems and infrastructure being used by physicians

## APPENDIX B:

Complete listing of stakeholders currently participating in the SIM governance structure, followed by a listing of MAPOC membership.

Stakeholder Category	Role in SIM Governance	Name	Organization
Community and Consumer Stakeholders	Steering Committee	Patricia Baker	Connecticut Health Foundation
Community and Consumer Stakeholders	Steering Committee	Jeffrey G. Beadle	Windham Regional Community Council
Community and Consumer Stakeholders	Steering Committee	Robin Lamott Sparks	Bridgeport Child Advocacy Coalition
Community and Consumer Stakeholders	Steering Committee	Alta Lash	United Connecticut Action for Neighborhoods
Community and Consumer Stakeholders	Steering Committee	Jan VanTassel	Connecticut Legal Rights Project
Community and Consumer Stakeholders	Consumer Advisory Board	Dr. Patricia Checko	Consumer Advocate
Community and Consumer Stakeholders	Consumer Advisory Board	Alice Ferguson	Consumer Advocate
Community and Consumer Stakeholders	Consumer Advisory Board	Michaela I Fissel	Consumer Advocate
Community and Consumer Stakeholders	Consumer Advisory Board	Kevin Galvin	Small Business for a Healthy Connecticut
Community and Consumer Stakeholders	Consumer Advisory Board	Bonita Grubbs	Christian Community Action, Inc.
Community and Patient Stakeholders	Consumer Advisory Board	Theanvy Kuoch	Khmer Health Advocates
Community and Patient Stakeholders	Consumer Advisory Board	Sharon D. Langer	Connecticut Voices for Children
Community and Patient Stakeholders	Consumer Advisory Board	Nanfi Lubogo	PATH Parent to Parent/Family Voices of CT
Community and Patient Stakeholders	Consumer Advisory Board	Fernando Morales	Latino Community Services, Inc.
Community and Patient Stakeholders	Consumer Advisory Board	Arlene Murphy	Consumer Advocate
Community and Consumer Stakeholders	Consumer Advisory Board	Richard J. Porth	United Way of Connecticut
Community and Consumer Stakeholders	Consumer Advisory Board	Alicia Woodsby	Partnership for Strong Communities

Community and Consumer Stakeholders	Equity and Access Council	Dr. Ellen Andrews	Connecticut Health Policy Project
Community and Consumer Stakeholders	Equity and Access Council	Alice Ferguson	Consumer Advisory Board
Community and Consumer Stakeholders	Equity and Access Council	Kristen Hatcher	Connecticut Legal Services
Community and Consumer Stakeholders	Equity and Access Council	Gaye Hyre	Consumer Advocate
Community and Consumer Stakeholders	Equity and Access Council	Roy Lee	Consumer Advocate
Community and Consumer Stakeholders	Health Information Technology Council	Dr. Patricia Checko	Consumer Advocate
Community and Consumer Stakeholders	Steering Committee	Jane McNichol	Legal Assistance Resource Center of Connecticut
Community and Consumer Stakeholders	Steering Committee	Frances Padilla	Universal Healthcare Foundation of Connecticut
Community and Consumer Stakeholders	Consumer Advisory Board	Jeffrey G. Beadle	Windham Regional Community Council
Community and Consumer Stakeholders	Consumer Advisory Board	Cheryl Harris Forbes	Harris Forbes Associates
Community and Consumer Stakeholders	Consumer Advisory Board	Bryte Johnson	American Cancer Society - New England Division
Community and Consumer Stakeholders	Consumer Advisory Board	Stephen Karp	National Association of Social Workers - CT Chapter
Community and Consumer Stakeholders	Consumer Advisory Board	Robert Krzys	
Community and Consumer Stakeholders	Equity and Access Council	Maritza Bond	Eastern Area Health Education Center
Community and Consumer Stakeholders	Equity and Access Council	Darcey Cobbs-Lomax	Project Access
Community and Consumer Stakeholders	Health Information Technology Council	Theanvy Kuoch	National Cambodian-American Health Initiative
Community and Consumer Stakeholders	Practice Transformation Taskforce	Lesley Bennett	Consumer Advocate
Community and Consumer Stakeholders	Practice Transformation Taskforce	Alta Lash	United Connecticut Action for Neighborhoods
Community and Consumer Stakeholders	Practice Transformation Taskforce	Nanfi Lubogo	Consumer Advisory Board
Community and Consumer Stakeholders	Quality Council	Arlene Murphy	

Community and Consumer Stakeholders	Quality Council	Meryl Price	Health Policy Matters
Community and Consumer Stakeholders	Health Information Technology Council	Crystal Emery	Consumer Advocate
Community and Consumer Stakeholders	Health Information Technology Council	Jenn Whinnem	Connecticut Health Foundation
Community and Consumer Stakeholders	Practice Transformation Taskforce	Mary Boudreau	Connecticut Oral Health Initiative
Community and Consumer Stakeholders	Practice Transformation Taskforce	Tonya Wiley	Consumer Advocate
Community and Consumer Stakeholders	Quality Council	Daniela Giordano	NAMI Connecticut
Community and Consumer Stakeholders	Quality Council	Jean Rexford	Connecticut Center for Patient Safety
Federal, State and Local Government Stakeholders	Steering Committee	Catherine F. Abercrombie	CT House of Representatives
Federal, State and Local Government Stakeholders	Steering Committee	Tamim Ahmed	Access Health Analytics
Federal, State and Local Government Stakeholders	Steering Committee	Roderick L. Bremby	Department of Social Services - Commissioner
Federal, State and Local Government Stakeholders	Steering Committee	Anne Melissa Dowling	Connecticut Insurance Department - Deputy Commissioner
Federal, State and Local Government Stakeholders	Steering Committee	Anne Foley	Office of Policy and Management
Federal, State and Local Government Stakeholders	Steering Committee	Terry Gerratana	CT State Senate
Federal, State and Local Government Stakeholders	Steering Committee	Dr. Jewel Mullen	Department of Public Health - Commissioner
Federal, State and Local Government Stakeholders	Steering Committee	Patricia Rehmer	Department of Mental Health & Addiction Services- Commissioner
Federal, State and Local Government Stakeholders	Steering Committee	Dr. Frank Torti	University of Connecticut Health Center
Federal, State and Local Government Stakeholders	Steering Committee	Victoria Veltri	Office of the Healthcare Advocate
Federal, State and Local Government Stakeholders	Steering Committee	Michael Williams	Department of Children and Families - Deputy Commissioner
Federal, State and Local Government Stakeholders	Steering Committee	Dr. Thomas C. Woodruff	Office of the State Comptroller
Federal, State and Local Government Stakeholders	Equity and Access Council	Dr. Margaret Hynes	Department of Public Health

Federal, State and Local Government Stakeholders	Equity and Access Council	Kate McEvoy	Department of Social Services
Federal, State and Local Government Stakeholders	Equity and Access Council	Dr. Erica Spatz	Yale School of Medicine
Federal, State and Local Government Stakeholders	Equity and Access Council	Victoria Veltri	Office of the Healthcare Advocate
Federal, State and Local Government Stakeholders	Health Information Technology Council	Dr. Thomas Agresta	UConn Health Center
Federal, State and Local Government Stakeholders	Health Information Technology Council	Roderick L. Bremby	Department of Social Services - Commissioner
Federal, State and Local Government Stakeholders	Health Information Technology Council	Vanessa Kapral	Department of Public Health
Federal, State and Local Government Stakeholders	Health Information Technology Council	Michael Michaud	Department of Mental Health and Addiction Services
Federal, State and Local Government Stakeholders	Health Information Technology Council	Joshua Wojcik	Office of the State Comptroller
Federal, State and Local Government Stakeholders	Practice Transformation Taskforce	Michael Michaud	Department of Mental Health and Addiction Services
Federal, State and Local Government Stakeholders	Practice Transformation Taskforce	Dr. Robert Zavoski	Department of Social Services
Federal, State and Local Government Stakeholders	Quality Council	Dr. Mehul Dalal	Department of Public Health
Federal, State and Local Government Stakeholders	Quality Council	Karin Haberlin	Department of Mental Health and Addiction Services
Federal, State and Local Government Stakeholders	Quality Council	Dr. Thomas Woodruff	Office of the State Comptroller
Federal, State and Local Government Stakeholders	Health Information Technology Council	Mark Raymond	Bureau of Enterprise Systems Technology
Payers	Steering Committee	Raegan M. Armata	Cigna
Payers	Steering Committee	Mary Bradley	Pitney Bowes, Inc.
Payers	Steering Committee	Bernadette Kelleher	Anthem Blue Cross Blue Shield
Payers	Equity and Access Council	Peter Bowers	Anthem Blue Cross & Blue Shield
Payers	Equity and Access Council	Deborah Hutton	Cigna
Payers	Equity and Access Council	Dr. Donna LaLiberte O'Shea	United Healthcare
Payers	Equity and Access Council	Dr. Robert S. Willig	Aetna

Payers	Practice Transformation Taskforce	Leigh C. Dubnicka	United Healthcare
Payers	Practice Transformation Taskforce	David J. Finn	Aetna
Payers	Practice Transformation Taskforce	Bernadette Kelleher	Anthem Blue Cross and Blue Shield
Payers	Practice Transformation Taskforce	Joseph Wankerl	Cigna
Payers	Quality Council	Aileen Broderick	Anthem Blue Cross and Blue Shield
Payers	Quality Council	Elizabeth Krause	Connecticut Health Foundation
Payers	Quality Council	Dr. Donna Laliberte O'Shea	United Healthcare
Payers	Quality Council	Gigi Hunt	Cigna
Payers	Quality Council	Todd Varricchio	Aetna Northeast Region
Payers	Health Information Technology Council	Mike Miller	Optum Government Solutions
Payers	Practice Transformation Taskforce	Peter Holowesko	United Technologies Corporation
Providers	Steering Committee	Patrick Charmel	Griffin Hospital
Providers	Steering Committee	Suzanne Lagarde	Fair Haven Community Health Center
Providers	Steering Committee	Courtland G. Lewis	Orthopedic Associates of Hartford
Providers	Steering Committee	Robert McLean	Connecticut Medical Group, LLC
Providers	Health Information Technology Council	Dr. Anne Camp	Fair Haven Community Health Center
Providers	Health Information Technology Council	Anthony Dias	Connecticut Hospital Association
Providers	Health Information Technology Council	Ed Fisher	Yale New Haven Health System
Providers	Health Information Technology Council	Matthew Katz	Connecticut State Medical Society

Providers	Health Information Technology Council	Dr. Alan Kaye	Radiological Society of Connecticut
Providers	Health Information Technology Council	Stephen O'Mahony	Norwalk Hospital
Providers	Health Information Technology Council	Philip Renda	Community Health Center Association of Connecticut
Providers	Health Information Technology Council	Dr. Craig Summers	Community Medical Group IPA
Providers	Health Information Technology Council	Moh Zaman	Hartford Healthcare
Providers	Practice Transformation Taskforce	Dr. M. Alex Geertsma	Saint Mary's Hospital
Providers	Practice Transformation Taskforce	Dr. Edmund Kim	Family Medicine Center at Asylum Hill
Providers	Practice Transformation Taskforce	Rebecca Mizrachi	Norwalk Community Health Center
Providers	Practice Transformation Taskforce	Dr. Douglas Olson	Norwalk Community Health Center
Providers	Practice Transformation Taskforce	Dr. H. Andrew Selinger	ProHealth Physicians
Providers	Practice Transformation Taskforce	Dr. Elsa Stone	Pediatrics Plus
Providers	Practice Transformation Taskforce	Jesse White-Frese	Connecticut Association of School Based Health Centers
Providers	Quality Council	Dr. Rohit Bhalla	Stamford Hospital
Providers	Quality Council	Kathleen Harding	Community Health Center, Inc.
Providers	Quality Council	Dr. Robert Nardino	American College of Physicians - CT Chapter
Providers	Quality Council	Dr. H. Andrew Selinger	ProHealth Physicians
Providers	Quality Council	Dr. Steve Wolfson	Cardiology Associates of New Haven PC
Providers	Steering Committee	Dr. Thomas A. Raskauskas	State Vincent's Health Partners

Providers	Equity and Access Council	Dr. Linda Barry	Connecticut Institute for Clinical and Translational Science at UConn
Providers	Equity and Access Council	Dr. Barbara Headley	
Providers	Equity and Access Council	Dr. Robert Russo	Robert D. Russo MD and Associates Radiology
Providers	Equity and Access Council	Dr. Keith vom Eigen	Burgdorf Health Center
Providers	Equity and Access Council	Katherine S. Yacavone	Southwest Community Health Center, Inc.
Providers	Practice Transformation Taskforce	Dr. Claudia Coplein	ConnectiCare, Inc. & Affiliates
Providers	Practice Transformation Taskforce	Dr. Shirley Girouard	
Providers	Practice Transformation Taskforce	Rowena Rosenblum Bergmans	Western Connecticut Health Network
Providers	Practice Transformation Taskforce	Dr. Randy Trowbridge	Team Rehab
Providers	Quality Council	Dr. Deb Dauser Forrest	Medical Analytics Department, ConnectiCare, Inc.
Providers	Quality Council	Dr. Mark DeFrancesco	Westwood Women's Health
Providers	Quality Council	Dr. Kathy Lavorgna	
Providers	Quality Council	Dr. Steve Levine	ENT & Allergy Associates LLC
Providers	Quality Council	Rebecca Santiago	Saint Francis Center for Health Equity
Providers	Health Information Technology Council	Michael Hunt	St. Vincent's Health Partners
Providers	Practice Transformation Taskforce	Heather Gates	Community Health Resources

**MAPOC and subcommittee membership:**

takeholder Category	Role in SIM Governance	Name	Category	Organization/ position
Federal, State and Local Government Stakeholders	MAPOC			General Assembly
Providers	MAPOC	Tracy Wodatch	Home care	CAHCH (Home care)
Providers	MAPOC	Dr. Cliff O'Callahan	PCMH	Primary Care Medical Home provider
Community and Patient Stakeholders	MAPOC	Marjorie Eichler		Advocate for DCF foster families
Providers	MAPOC	Mark Maselli	Business	CHC Inc.
Federal, State and Local Government Stakeholders	MAPOC	Rep. Susan Johnson		General Assembly
Providers	MAPOC	Beth Cheney	FQHC	APRN, Columbia
Providers	MAPOC	Stephen Frayne	Hospital	CT Hospital Association
Providers	MAPOC	Jesse White Frese	School based health center	School based health center
Community and Patient Stakeholders	MAPOC			Husky recipient
Providers	MAPOC	Suzanne Lagarde	Medicaid physician	Physician who serves Medicaid clients
Community and Patient Stakeholders	MAPOC	Kristen Hatcher J.D.	Medicaid low income adults advocate (LIA)	Connecticut Legal Services
Providers	MAPOC	Joyce Hess (WCHN)	Hospital	WCHN
Federal, State and Local Government Stakeholders	MAPOC	Marie Allen, SW	Business community - cost efficiency management	Agency on Aging

Community and Patient Stakeholders	MAPOC	Heather Greene	Substance abuse	
Providers	MAPOC	Jeff Walter	Dental	Medicaid dental provider
Community and Patient Stakeholders	MAPOC	Raymond Wilkens	Nursing home	For-profit nursing home industry
Community and Patient Stakeholders	MAPOC	Sheila Admur	Disabilities	Advocate for persons with disabilities
Community and Patient Stakeholders	MAPOC	Cynthia DeFavero	Medicaid dual eligible	Recipient of Medicaid Dual Eligible program
Providers	MAPOC	Mag Morelli	Nursing home (not-for-profit)	Leading Age CT
Providers	Subcommittee on Cost Savings	Mark Maselli	Business community - cost efficiency management	Community Health Center, Inc.
Providers	Subcommittee on Cost Savings	Stephen Frayne, MD	Physician serving Medicaid	Fair Haven Health Center
Providers	Subcommittee on Cost Savings	Susan Lagarde		
Federal, State and Local Government Stakeholders	Subcommittee on Cost Savings	Marie Allen, SW	Business community - cost efficiency management	Southwest Agency on Aging
Providers	Subcommittee on Cost Savings	Mag Morelli	Nursing home (not-for-profit)	Leading Age CT
Providers	Subcommittee on Cost Savings	Raymond Wilkens	Nursing home (for-profit)	
Federal, State and Local Government Stakeholders	Subcommittee on Cost Savings	Alex Geertsma, MD	Commission on Children	Commission on Children
Providers	Subcommittee on Cost Savings	Molly Rees Gavin	LTSS	Long-Term Care Advisory Council representative

## **APPENDIX C:**

Excerpts from the letters of support from Connecticut's payers showing commitment to specific SIM initiatives:

### **CT Association of Health Plans**

*The Connecticut Association of Health Plans (CTAHP) and its member companies, Aetna, Anthem, Cigna, ConnectiCare, United, and Harvard Pilgrim, are pleased to submit this letter in support of Connecticut's State Innovation Model (SIM) Test Grant Application that is being submitted by the Office of the Healthcare Advocate to the Center for Medicare and Medicaid Innovation (CMMI).*

*CTAHP represents all of the major health insurance carriers in the state as well as the 2 million plus members that they serve. Connecticut's carriers range from national large companies, to those whose primary focus is Connecticut specific and the Association is inclusive of both for-profit and not-for-profit organizations.*

*... As has been demonstrated throughout the implementation of the ACA, the commercial industry has not only embraced a value centered philosophy, but has acted upon it. Connecticut's carriers have made substantial investments in the accountable care organization (ACO) and medical home models envisioned under SIM and the carriers are experienced leaders in supporting provider practices that have demonstrated their commitment to transforming into high value and efficient primary care settings that employ care teams and practice population management. As such, the industry is very supportive of any SIM elements that build upon these efforts without compromising any of the reforms already underway by the carriers.*

### **Aetna**

*Aetna is also a leader in advancing integrated value-based products as successors to outmoded fee-for-service models – including value-based insurance design (VBID), patient-centered medical homes (PCMHs), and accountable care organizations (ACOs).*

*Therefore, we share Connecticut's SIM vision to:*

- *Establish primary care as the foundation of a care delivery system that is patient and family centered, coordinated, and evidence driven, and which rewards value over volume.*

*... We look forward to a continued active participation in the development of various committees' work plans, including:*

*... The development of a shared savings program (SSP) arrangements similar to those employed in the Medicare SSP and which gives carriers and providers the flexibility to determine the specific terms.*

### **Anthem**

*Our Enhanced Personal Health Care program allows us to maximize collaboration with our provider network. Some important elements of this program include: actionable data transfer, so physicians can*

*better manage the health care of their patients; care management tools; and transformation resources. A central facet of this program is payment redesign, moving from payment based on volume to payment based on value. Practices are reimbursed for care coordination activities and also have an opportunity to earn shared savings upon reaching quality targets.*

*... We recognize the importance of value-based payment methods and we will participate in both the Equity and Access Council and Practice Transformation Council in order to align efforts and create standards for a successful multi-payer Advanced Medical Home model.*

### **Cigna**

*... As has been demonstrated throughout the implementation of the ACA, Cigna has not only embraced a value-centered philosophy, but has acted upon it. We have made substantial investments in our Collaborative Accountable Care models, which combine elements of the accountable care organization (ACO) and medical home models envisioned under SIM and the carriers are experienced leaders in supporting provider practices that have demonstrated their commitment to transforming into high value and efficient primary care settings that employ care teams and practice population management. Cigna has several ACO relationships throughout Connecticut, including the Greenwich Physicians Association, Integrated Care Partners/Hartford Healthcare, New Haven Community Medical Group, ProHealth Physicians, Inc., Saint Francis HealthCare Partners and others. As such, we are very supportive of any SIM elements that build upon these efforts without compromising any of the programs or standards we have already implemented.*

*... Cigna also recognizes the importance of value-based payment methods that hold primary care providers accountable for quality, care experience and total cost of care. We support applying our best efforts to financially align with other payers in the adoption of shared savings program (SSP) arrangements similar to those employed in the Medicare SSP.*

### **ConnectiCare**

*... By means of this letter, ConnectiCare is declaring its support for the Connecticut State Innovation Model Test. Specifically, ConnectiCare is committed to:*

- Work with the SIM Steering Committee and other stakeholders in the State towards a goal of achieving better alignment of payment and contracting strategies that reward value over volume; ...*
- Offer alternative risk-based reimbursement models that may include shared savings program (SSP) arrangements similar to those employed in the Medicare SSP, pay for performance, and global or capitated payments designed to meet the needs of our customers and provider partners;...*

### **Harvard Pilgrim**

*... At its core, the SIM initiative seeks to transition from a volume-based health care delivery system to value-centered approach focused on the individual. By doing so, important advancements are proposed, including: new value-based payment methodologies; enhanced collaboration with providers in the*

*community through practice transformation initiatives; and consumer empowerment through increased transparency.*

*Harvard Pilgrim recognizes the importance of value-based payment designs as a tool to improve the quality of care for members. We support the importance placed on these payment designs in the SIM test grant, and as a company hold significant experience with alternative payment methodologies. As you are undoubtedly aware, Massachusetts has undertaken its own initiative in payment reform. Harvard Pilgrim embraced the goals outlined in this effort, and the company currently employs a number of risk-based (both upside and downside risk) contracts with providers throughout New England. We have found that these arrangements provide enormous value to our members because their care now focuses on health outcomes and places primary care providers at the center of a larger care management team.*

### **HealthyCT**

*... HealthyCT shares the vision outlined in the application to establish primary care as the foundation of a care delivery system that is consumer and family centered and which rewards value over volume.*

*... Finally, our A-PMPM program aligns nicely with the SIM grant proposal in supporting the transition to value-based payment methods which should help drive a much needed change in focus from volume to value.*

### **UnitedHealth Group**

*... That is why we are pleased to provide this letter of support for the general concepts and principals outlined in the State of Connecticut's State Innovation Model Plan – Model Test Grant application that is part of the State's Center for Medicare and Medicaid Innovation (CMMI) – State Innovation Model Grant.*

*... UnitedHealth Group continues to work collaboratively with many varied stakeholders across the country to test and sustain new payment and service delivery models ... These important collaborations include...value-based payment reform programs. Our deliberate evaluation of these programs proves that they are successful and have meaningful outcomes for quality and cost.*

*... UnitedHealth Group hopes to continue to work with the State to assist in implementing Connecticut's State Innovation Plan and its Model Test Grant application. Our experience is extensive in working with primary care practices and other providers across the country...to create successful value-based and incentive based provider payment programs to increase the quality of care for our members and reduce costs, and we have sophisticated and well used member transparency tools for both cost and provider performance information.*