PROJECT NARRATIVE

Connecticut (CT) is seeking to establish a whole-person-centered healthcare system that improves population health and eliminates health inequities; ensures superior access, quality, and care experience; empowers individuals to actively participate in their healthcare; and improves affordability by reducing healthcare costs. CT's Model Test is the vehicle for achieving this vision. It is the product of two years of planning, including input from 25 consumer focus groups, an extensive survey of approximately 800 consumers, and more than 60 multi-stakeholder meetings. ***Our Model Test drives accountability, consumer engagement and high quality of care, featuring: 1) development of a comprehensive evidence-based plan for improving population health; 2) initiatives to strengthen primary care and integrate community and clinical care; 3) value-based payment and insurance design; and 4) multi-payer alignment on quality, health equity, and care experience measures.***

I. Plan for improving population health

Background: The Plan for Improving Population Health ("Plan") will utilize and build upon the Department of Public Health's (DPH) recent State Health Assessment, State Health Improvement Plan (*Healthy Connecticut 2020)* and the state Chronic Disease Prevention Plan. These plans are characterized by a dual emphasis on state-wide population health improvement and achievement of specific health equity objectives. Plan Lead: 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.

***Stakeholder Engagement and Governance*:** A health systems workgroup was 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 for the purposes of: 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. Priority-setting of health improvement areas will be accomplished using a modified Hanlon method used in *Healthy Connecticut 2020*, supplemented by state-specific local data, financial and disease burden analyses and guided by CDC technical assistance. Barriers to improving health in prioritized areas will be identified by root cause analyses related to the social determinants of health (e.g., Frieden's Health Impact Pyramid) focusing on barriers most likely to contribute to health inequities. Evidence-based strategies from expert sources will be selected (e.g. Guide to Community Preventive Services).

***Key data sources*:** Enhanced Behavioral Risk Factor Surveillance Survey (BRFSS) sampling will provide baseline and ongoing capability to conduct small area analyses for tobacco, obesity and diabetes and other identified health priorities. Other data sources include mortality data, hospital and ED discharge data and existing community health needs assessments. The state will consider expanding the state's reportable diseases database to include chronic disease indicators for population health activities once a fully-functioning statewide Health Information Exchange (HIE) system is available.

Policy, Sustainability and Implementation: Design and implementation of two sustainable primary population health enabling structures will be considered: 1) Prevention Service Centers (PSCs), community-based entities offering evidence-based community preventive services in

affiliation with providers, and 2) Health Enhancement Communities (HECs) in areas with the greatest disparities, targeting resources and facilitating local coordination and accountability among providers, local public health departments, nonprofits, schools, housing authorities and others through innovative financing strategies (e.g., wellness trusts) and multi-sector governance solutions (e.g., local coalitions led by a fiduciary agent). Evidence-based policies and strategies will be linked with reimbursement innovations to address social determinants of health and health equity (e.g., reimbursement for healthy homes assessments and community health workers). A proposed timeline is: Year 1: Complete population health assessment; prioritize health conditions and identify interventions; Year 2: Develop PSC and HEC concept and plan; identify additional population health and health equity metrics for evaluation and monitoring; Year 3: Implement plan for PSC and complete detailed design of HEC proposal; Year 4: Implement PSC demonstration and finalize HEC proposal.

II. Health Care Delivery System Transformation Plan

Advanced primary care practice is the foundation for a high-performance healthcare system. CT consumers, providers, and other stakeholders believe that strong primary care is a strategic health policy goal and requires redesigned primary care practices with accountability measures for performance on patient outcomes, care experience, and resource utilization that are linked to a new payment reform approach. The CT Model Test prioritizes **five core elements to move toward advanced primary care practice**: 1) whole-person-centered care; 2) enhanced access without disparity; 3) population health management; 4) dynamic, team-based coordinated care; and 5) evidence-informed clinical decision making. **These core elements -- plus quality measure alignment, value-based insurance design, robust data infrastructure, payment**

innovation, and an enhanced workforce --will collectively support achievement of the "triple aim" of better health, better care and reduced costs.

Our Model 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. These initiatives involve nearly all payers, providers, and a diverse array of stakeholders. They include activities in the aforementioned areas of quality measure alignment, value-based insurance design, health information technology, payment reform and workforce development and they are intended to benefit **the entire care delivery system and all CT residents statewide.**

Our Model Test also introduces a targeted, three-part strategy to transform primary care in CT: 1) an Advanced Medical Home Glide Path; 2) the Community and Clinical Integration Program; and 3) Statewide Learning Collaboratives. **These programs will focus on a subset of providers that participate in a newly established Medicaid Quality Improvement and Shared Savings Program (Medicaid QISSP)** that will be described in the Payment and Service Delivery Model section. We hypothesize that our three part strategy outlined below to transform primary care, combined with the Medicaid Quality Improvement and Shared Savings Program, will further accelerate the pace of change and performance of participating providers relative to non-participants, and that the improvement in performance will be of particular benefit to Medicare, Medicaid and CHIP beneficiaries who have chronic illnesses, significant care coordination needs, and/or social determinant risks. We intend to implement this three part strategy in three waves, two of which will occur during the test grant. Over the course of five years, a substantial majority of the state's primary care community will participate in Medicaid QISSP and will have the proposed advanced primary care capabilities.

Statewide Interventions	Targeted Interventions
Plan for Improving Population Health	Medicaid QISSP
Quality Measure Alignment	Advanced Medical Home Glide Path Program
SSP based on Care Experience/Quality	Community & Clinical Integration Program
Value Based Insurance Design	Innovation Awards
Workforce Development	Learning Collaboratives
HIT / Analytics / Performance Transparency	

Primary Care Transformation: CT has approximately 3,300 primary care physicians, 1,200 primary care advanced practice registered nurses (APRNs), and 1,000 physician assistants (PAs). These figures include an estimated 280 primary care providers (PCPs) in 14 federally qualified health centers (FQHCs) who care for more than 340,000 individuals each year. Nearly 3,400 PCPs are estimated to work in 15-17 *Advanced Networks* –which we define 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. Many of these Advanced Networks include one or more anchor hospitals. More than 1,900 PCPs are in unaffiliated, independent practice settings.

All of CT's FQHCs will be nationally recognized as medical homes under NCQA 2011 standards or Joint Commission standards by the end of this year. Although many independent practices and those affiliated with Advanced Networks have pursued practice advancement, only about 600-700 PCPs in CT have achieved or maintained NCQA 2011 medical home standards. **Many practices are prepared to pursue medical home recognition, but lack the resources and support necessary to begin that process. Similarly, many Advanced Networks with a strong advanced practice foundation want to move to the next level but lack the funding**

and technical expertise necessary to re-engineer their processes, incorporate new technologies, or develop more sophisticated clinical and community integration capabilities. Our three-part strategy to transform primary care addresses these needs.

Advanced Medical Home (AMH) Glide Path: In 2012, DSS established a glide path program to provide practical, on-site technical support to facilitate practice transformation towards medical home recognition. The PMO will leverage this DSS program to establish a multi-payer AMH Glide Path. The PMO will enroll a total of 500 primary care practices, with 250 practices in each of two waves during Years 1 and 3 of the test period. AMH Glide Path support will be offered first to Advanced Networks that are participating in the Medicaid QISSP and who have practices that are not yet recognized as medical homes. AMH Glide Path support will be available to non-participating primary care practices within available resources. The AMH Glide Path will utilize NCQA standards and additional CT-specific standards to be developed by the Practice Transformation Taskforce comprised of state Medicaid officials, representatives from all five of CT's major health plans, employers, providers and consumers. Participating practices will be required to achieve NCQA recognition in order to complete the Glide Path. The PMO will contract with vendors to provide practice transformation support over 9 to 18 months. 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.

Community and Clinical Integration Program (CCIP): The CCIP will offer Targeted Technical Assistance (TTA) and Innovation Awards to Advanced Networks and FQHCs, selected to participate in Medicaid QISSP. CCIP will accelerate advancement and spur investments in the following priority areas: 1) integrating behavioral health and oral health integration, 2) providing

medication therapy management services, 3) building dynamic clinical teams, 4) expanding e-consults between primary care providers and specialists, 5) incorporating community health workers as health coaches and patient navigators, 6) closing health equity gaps, 7) improving the care experience for vulnerable populations, 8) establishing community linkages with providers of social services, long term supports and services (LTSS), and preventive health; and 9) identifying "super utilizers" for community care team interventions. FQHCs have identified two additional priority areas: 1) enhancing primary care provider/staff skills in quality improvement methods and analytics; and 2) producing actionable quality improvement reports. The PMO will contract with vendors to provide TTA across the 11 CCIP priority areas listed above.

Finally, CCIP will include a competitive Innovation Awards program to support transformational demonstration pilots that align with CCIP priorities. The PMO will establish an Innovation Awards advisory committee to establish award criteria and processes. These awards may include matching or in-kind requirements for larger Advanced Networks, which will not be required for FQHCs.

*Learning Collaboratives (LCs)**:*** 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.

Healthcare Workforce Development: Our Model Test includes a healthcare workforce component to address the need for training in newer models of multi-disciplinary and coordinated care. The Model Test includes three workforce initiatives in support of this goal:

Inter-professional education (IPE): The Area Health Education Center (AHEC) will work with all CT health professions schools/programs to develop and incorporate inter-professional, team-based curricula and sponsor IPE training sites throughout the state.

Community health worker training: CT's Model Test anticipates that CHWs will be integrated into primary care teams as health coaches and patient navigators, and will also provide prevention services in a variety of settings. AHEC has partnered with three community colleges to provide basic and specialty CHW training programs that are tailored to the needs of diverse consumers and prospective employers.

Primary care capacity: The CT Teaching Health Center Coalition (comprised of eight FQHCs) and the Community Health Center Association of CT (CHCACT) propose to develop and operate two or more primary care medical residency programs. Model Test funding will support the design of residency programs, with input from health centers and hospitals statewide; longer-term funding support will be sought through a Teaching Health Center grant from the Health Resources and Services Administration.

III. Payment and Service Delivery Model

CT's payment and service delivery model will demonstrate that performance and value can be increased through (1) primary care accountability for quality, care experience and total cost under shared savings programs; and 2) value-based insurance design (VBID) that engages consumers and reduces barriers to critical prevention and treatment services.

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, modeled upon the Medicare SSP.

In the past two years, considerable market consolidation has resulted in an estimated 65% of CT's PCPs employed by or affiliated with a provider organization that is participating in at least one SSP contract, and this percentage is growing. The CT State Medical Society is working to establish a statewide Medicare SSP network for the remaining PCPs that do not yet have such affiliations.

Medicaid QISSP: In the above context, DSS seeks to establish and test a complementary SSP, which will improve care and reduce costs for vulnerable populations. DSS will undertake a competitive procurement of advanced networks and FQHCs to participate in the Medicaid QISSP. Selection criteria will be established through an intensive stakeholder engagement and design process to conclude in early 2015. Criteria may include demonstrated commitment, experience and capacity to serve Medicaid beneficiaries; ability to meet identified standards for clinical and community integration; 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. The selection process will prioritize providers who are participating in Medicare and commercial SSP arrangements to maximize multi-payer alignment, practicing in areas of critical need in the state for the Medicaid population, as evidenced by disease burden, disparities and cost of care.

DSS will include an estimated 200,000 to 215,000 beneficiaries in the first of two waves conducted during the test period. The wave one procurement will occur in 2015, with the performance period beginning January 1, 2016. The second wave procurement will occur in 2017, with the performance period beginning January 1, 2018. DSS will implement advance payments for participants in the Medicaid QISSP 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. DSS will use its current PCMH retrospective attribution methodology to evaluate performance and determine eligibility for upside-only SSP payments. 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. This will reduce complexity for providers and confusion for consumers, while increasing the business case for investment in new capabilities to achieve specified targets.

The Medicaid QISSP does not address the challenge of individual FQHCs not having sufficient attributed members with private payers or Medicare to enter into SSP arrangements. To maximize statewide impact of valued-based payment reform, the PMO will offer support to FQHCs to pool their panels and enter into SSP contracts with private payers and to form an ACO for the purpose of participating in the Medicare SSP, both by the final year of the test period.

DSS relies on Administrative Services Organization (ASO) agreements to manage medical, behavioral health, dental and transportation benefits. Its medical ASO provides customer service, data analytic, quality improvement and intensive care management (ICM) functions for all of the state's Medicaid beneficiaries. The care coordination and analytic capabilities of Medicaid QISSP participating Advanced Networks and FQHCs will be supplemented as necessary by the medical ASO's federated data analytic and ICM supports to improve their performance.

Under-service Monitoring: CT acknowledges that providers in SSP arrangements may seek savings through under-service, which might include reducing necessary access, inappropriate patient selection, cost shifting, withholding appropriate care or inappropriate referral practices. CT has established an **Equity and Access Council** comprised of physicians, consumer advocates, payers, and researchers from the state's public academic health center to develop

methods that will help guard against such risks. DSS will not implement the Medicaid QISSP until reasonable and necessary methods for monitoring under-service are in place, and will make ongoing adjustments to these methods as appropriate. All payers commit to 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. Additionally, the state will leverage the dispute resolution role of its Office of the Healthcare Advocate to adjudicate consumer complaints of suspected under-service.

Participation Projections: Table 1 summarizes the number of PCPs that are projected to participate in one or more SSP reforms during the next five years. Table 2 illustrates the number of beneficiaries that are projected to obtain their care from a PCP who is accountable for the quality of their care, care experience and total cost. Provider participation rates for the Medicaid QISSP and three-part strategy are contained in the operational plan.

Table 1: PCP Participation in SSP

PCP Type	Base	2016	2017	2018	2019	2020
APRN	803	880	957	1034	1111	1173
PA	654	717	780	843	906	956
Physician	2135	2340	2545	2750	2955	3120
Total	**3592**	**3937**	**4282**	**4627**	**4972**	**5249**

Table 2: Number of Beneficiaries with PCP in SSP

Coverage Category (000's)	2015	2016	2017	2018	2019	2020
ASO (excluding State Employees)	336.6	453.7	630.7	753.6	879.1	1,007.2
Fully insured	260.1	350.6	487.3	582.3	679.2	778.2
State employees, exc. Medicare Supp.	40.7	54.8	76.2	91.0	106.2	121.6

Coverage Category (000's)	2015	2016	2017	2018	2019	2020
Medicare	175.4	240.8	340.8	414.5	492.3	574.3
Medicaid/CHIP*	0.0	204.9	209.7	429.1	439.1	636.5
Total	812.8	1,304.8	1,744.7	2,270.5	2,595.9	3,118.0

*Includes approximately 137,000 single adults enrolled in the Medicaid Expansion

Value-Based Insurance Design (VBID): CT's largest employers and healthplans 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. **The PMO will undertake extensive VBID adoption efforts**, convening employers, business groups such as CT's Business and Industry Association, healthplans, 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 practices to accelerate the adoption of VBID plans. With respect to specific programmatic activities, the PMO will: 1) establish a VBID baseline; 2) conduct a VBID/ACO comparative effectiveness study; 3) establish an employer-led consortium with core interest sub-groups (e.g. clinical, wellness, administration) and linkages to regional and national forums such as CMMI's VBID learning cluster to enable peer-to-peer sharing of best practices; 4) develop VBID template(s) and implementation toolkits; 5) convene an annual learning collaborative, including panel discussions with nationally recognized experts and technical assistance; and 6) facilitate a workforce health outcomes pilot. In addition, subject to board approval, Access Health CT will implement VBID in Year 2 of the Model Test. CT's Medicaid program currently features VBID with its grant-funded Rewards to Quit tobacco cessation incentive. DSS will consider the

implementation of additional incentives in alignment with the development of the state's population health plan.

IV. Leveraging Regulatory Authorities

Connecticut has demonstrated that it is **committed to using legislative and regulatory authority to support healthcare delivery and payment reform**. Recent legislative initiatives include: 1) establishing the CT Health Insurance Exchange (Access Health CT) (PA11-53); 2) expanding Medicaid (PA11-44); 3) establishing an All-Payer Claims Database (APCD) (PA13-247); 4) requiring DPH to develop a chronic disease prevention and reduction plan consistent with the Innovation Plan (PA14-148); 5) transferring responsibility for HIT and the Health Information Exchange (HIE) coordination to DSS (PA 14-217); 6) permitting APRNs who have been licensed for at least three years to practice independently, enabling practice at the top of the license and improved access to primary care (PA14-12); 7) enabling licensed behavioral health clinics to provide "off-site" services in physician offices and other healthcare settings, removing a longstanding barrier to the integration of primary care and behavioral health (PA14-211); 8) informing consumers about hospital facility fees (PA14-145); 9) reducing state employee healthcare costs associated with facility fees (PA14-217); 10) expanding CT's False Claim Act to encompass all health and human service agencies, programs, and employees/retirees (PA14-217); 11) disclosing observation status to patients (PA14-180); 12) ensuring competitive healthcare markets by giving the Attorney General notification and information regarding material changes to the business or structure of physician group practices (PA14-168); 13) requiring a certificate of need for transfers of ownership of certain physician group practices to any entity other than physicians or physician groups (PA14-168); 14) requiring annual filing of hospitals, systems, and physician groups affiliation (PA14-168); 15) requiring online license

renewals for physicians, dentists, and APRNs; 16) establishing the CT Institute for Primary Care, a cooperative venture of the state's public academic medical center and St. Francis Hospital for the purposes of advancing primary care transformation (PA 10-104); and 17) providing funding to sustain the PMO (PA 14-217).

During the Model Test, the state is committed to continuing to leverage its statutory and regulatory authority to influence the structure and performance of the state's healthcare system to support the aims of SIM. The following policy actions are planned or under consideration: 1) Amending insurance regulations to enable health plans to provide consumers with provider quality and cost information so that they can make informed decisions regarding high value care and to enable health plans to establish tiered networks based on provider value; 2) Including VBID in the next procurement of Qualified Health Plans (effective with the 2016 benefit year) and establishing plan designs to encourage integration of behavioral and oral health, by Access Health CT pending approval by its board; 3) Reviewing same day service barriers, such as coverage limitations that prohibit reimbursement for medical and behavioral health services provided on the same day, which helps to enable integrated care; and 4) Using loan forgiveness programs to support the retention of residents in primary care.

V. Health Information Technology

HIT and HIEs have the potential to accelerate improvements in population health and innovations in healthcare delivery and payment reform, if positioned and leveraged in a meaningful way. To achieve the full potential of health system transformation, CT payers and providers will need to deploy a wide range of HIT capabilities, including data analytics, health information exchanges and care management tools. CT's Model Test seeks to provide HIT targeted solutions to assist implementation of each component of the proposal.

***Current State of HIT Adoption*:** As of May 2014, the state has received over $260 million through the EHR incentive program. Over 5,300 providers and all hospitals have received payments for adoption of EHRs, of whom 60% have attested to achieving Meaningful Use Stage 1. The 2013 HIE evaluation found that 68-74% of physicians are either using EHRs or are in the process of implementing EHRs; 96% of pharmacies are able to process e-prescriptions; 62% of prescribers are e-prescribing; 63% of hospitals are sharing lab results electronically, and 50% of independent labs are sending lab results electronically. Currently, CT does not have an operational statewide HIE.

Governance: Effective July 1, 2014, the role of HIT Coordinator and full responsibilities for HIT were transferred to DSS through legislative action. DSS will build upon the existing HIT Strategic and Operational Plan, and recommendations from the technology work group on adoption of industry standards for data exchange; efficient and effective data sharing; person-centric focus; interoperability, integration and an open architecture; and secure data exchange.

DSS and the PMO will establish a HIT Council, including health and human service delivery agencies, providers, health plans and advocates, to participate in a one-year planning process. The planning process will result in an update of the three-year HIT strategic plan by

August 2015 to incorporate Model Test needs. In the final year of the Model Test, the HIT plan will be updated again to reflect the changes within and evolved needs of the state as a result of implementing the Model Test and related activities. The HIT Council will be chaired by the Commissioner of DSS and facilitated by the HIT Coordinator, who will report to the Steering Committee on a quarterly basis. DSS and PMO will work closely together during the planning process and the Model Test implementation to coordinate efforts across programs, ensuring that all HIT assets are used optimally and any redundancies are identified early and avoided.

Policy: CT will execute the Model Test in the context of several ongoing transformational initiatives, such as the APCD, which will help guide and support the Model Test innovations. The Model Test will promote use of HIT and data analytics through its healthcare delivery system and payment reforms, but also statewide through a number of data-related policy levers needed for implementation of the Model Test: 1) the PMO, with guidance from the HIT Coordinator, will finalize a standard Data-Use and Reciprocal Support Agreement across agencies and public-private enterprises to support data sharing and analyses; 2) all agencies/organizations participating in the Model Test will be asked to deploy edge-servers to index clinical and other health databases to support care delivery and analytics; and 3) all stakeholders, including payers, will be asked to make relevant data available for population-based analytics to help identify groups that can benefit from intensive clinical and community-based services.

Infrastructure: CT's overall HIT/HIE strategies aim to move the state from simply identifying and integrating available data to using such data and analytical tools to drive transformational change. Investments in these areas support **increased communication between providers, care coordination and integration across settings, population health assessments, improved care**

delivery and quality measurement and reporting. Several existing HIT assets will support the quality data infrastructure that is essential for enhanced care delivery and payment reform, including: 1) standards based Health Provider Directory; 2) Enterprise Master Patient Index; 3) Health Information Service Provider service for Direct Messaging (DM); and 4) APCD. These assets are also building blocks for operating a statewide HIE, and with exception of the APCD, managed by DSS. The Model Test will support additional HIT and data analytic related infrastructure needs, including the following:

Consent registries: DSS will expand procurement for a consent registry that can be queried by Model Test participants in order to assess consumer consent status with respect to sharing of information. State bond funds have already supported core procurement of the registry.

Direct Messaging (DM): DSS is promoting the use of DM protocols to send messages between providers and/or systems, allowing secure exchange of clinical documents, such as discharge summaries, orders, and continuity of care documents. Additionally, DM can be used to generate health alerts and reminders to improve care, especially for patients with chronic conditions. As of January 2015, most certified EHRs will be enabled with DM. Model Test funds will be used to provide DM addresses to providers that are not eligible for the CMS EHR incentive program, including behavioral health, long-term care, and home-health agencies.

Quality measurement: DSS will use Quality Reporting Document Architecture Category III and Category I standards for receiving eClinical Quality Measures (eCQMs) as one option in the EHR incentive program. With respect to the Model Test, this mechanism will be repurposed to help collect the quality measures recommended by the Quality Council and produce the cross-payer provider performance scorecard.

Expanded uptake of Personal Health Records (PHRs): DSS is working with CMS to initiate a project to provide PHRs to all Medicaid beneficiaries. The same PHR will be made available to commercial and Medicare beneficiaries who do not otherwise have access to a PHR.

Promoting access to data and analytics: DSS will create provider, organization, and state-level data reports enabled by edge-server based indexing technology that allows both large and small providers to access data and analytics equally, irrespective of resource constraints. These reports will improve healthcare delivery interventions, such as identifying populations in need of intensive services, as well as monitoring and evaluation. Existing state bond funding and CMS funding will jointly support the license for this technology and development costs, which will be supplemented by Model Test funding in Years 3 and 4.

SIM funds will enhance existing HIT capabilities by supplementing existing funds to increase capacity and procure the following: 1) disease registries to support population health planning analyses and interventions; 2) mobile medical applications for improving care management; and 3) certified technologies for providers, using the Software-As-A-Service model, that do not have access to federal funding targeted for increasing HIT adoption. All existing state HIT assets will be available for the Model Test initiative for re-use through a shared cost arrangement. All HIT solutions are scalable and ready to be deployed within an enterprise.

Technical Assistance: HIT technical assistance (TA) will be provided by the HIT Coordinator and staff across the range of Model Test initiatives, particularly for AMH Glide Path and CCIP participants. In addition to general TA, this group also conducts outreach and provides education about DM, meaningful use measures, and quality improvement as it relates to eCQMs.

VI. Stakeholder Engagement

CT has established a governance structure that includes a broad range of stakeholders with direct and ongoing involvement in SIM design, implementation and evaluation. The governance structure includes the following:

Healthcare Innovation Steering Committee: This advisory Steering Committee is chaired by Lieutenant Governor and is responsible for providing overall oversight of the Innovation Plan and Model Test. Participants include private foundations; consumer advocates; representatives of hospitals, Advanced Networks, home health, physicians and APRNs; health plans; and employers. Additionally, the Comptroller's office is included as well as line agency Commissioners with responsibility for public health, Medicaid, behavioral health, health insurance exchange, APCD, and child welfare. The Steering Committee facilitates ongoing alignment of payment reforms through the use its ad hoc Finance Work Group, including all major health plans. The Steering Committee will 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.

Consumer Advisory Board (CAB): A 16 member independent consumer advisory board provides 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.

SIM Work Groups: A number of Councils and Task Forces have been established to undertake detailed design and oversight across a range of areas including Practice Transformation, Quality, Equity and Access, HIT, and Workforce Development. There are four broad categories of balanced representation on workgroups: consumer/advocate, payer, provider, and state agency.

Each workgroup charter requires a plan for stakeholder engagement to ensure that additional stakeholders are consulted on the development of specific work products.

Medical Assistance Program Oversight Council (MAPOC): CT law established the MAPOC as the legislative oversight body for the Medicaid/CHIP programs. The MAPOC will designate a committee to review and comment on each aspect of the design of the 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. The PMO and the CAB will support **consumer engagement** that meaningfully integrates consumer perspective and provides outreach and education for consumers about how innovation will change their experience of healthcare. Programmatic activities include consumer-led learning collaboratives, issue-driven focus groups, and targeted communications. Consumer outreach will leverage the extensive regional network of our state's navigators and in-person assistors that enabled the state to double its enrollment goal in Access Health CT.

***Provider Engagement*:** The PMO's **provider engagement** activities have 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 SIM governance structure, including the MAPOC and its committees.

All of CT's healthplan**s** have provided input into the Model Test and all have expressed support for the outlined reforms. Notably, healthplans agreed to a broad-based annual assessment

of $3.2 million in support of the PMO. **Healthplans are involved in all aspects of planning and oversight for the proposed reforms.** In addition to representation on the Steering Committee, all healthplans with more than 5% market share participate on the Practice Transformation, Quality, and Equity and Access work groups.

Employer engagement: Employers are fundamental to achieving care delivery and payment reforms and 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. These employers are members of the Steering Committee, and participate in workgroups charged with design and implementation of the Model Test. The PMO will convene an annual Innovators Conference for all stakeholders involved in SIM governance and workgroups.

VII. Quality Measurement Alignment

All of CT's major health plans and Medicaid have committed to quality measure alignment including the following: 1) a core quality measurement set for primary care providers, select specialists, and hospitals; 2) a common cross-payer measure of care experience tied to value based payment; and 3) a common provider scorecard. Health plans recognize that this unified approach will reduce the administrative burden on providers, enabling them to organize their performance improvement efforts around common expectations, rather than the fragmented business rules and reporting requirements that exist today. It will also provide consistent incentives, standardized reporting, and multi-payer clinical reports on quality and cost metrics.

Quality, care experience and cost measures will be developed by the Quality Council, which is comprised of the five major health plans, one large employer, six consumer advocates, three

state agencies, six practicing physicians, one FQHC and one hospital. Health plan representatives include medical directors, statisticians and measurement experts. The Council will propose a core set of measures for use in the assessment of primary care, specialty care, including behavioral and oral health, and hospital provider performance and will reassess measures on a regular basis to identify gaps and incorporate new national measures to keep pace with clinical and technological practice. The Council will begin meeting in July 2014 and will complete its recommendations regarding primary care by December 2014. Health plans will modify systems and contracts in 2015 and implement the new measurement set and scorecard in 2016. Measures of specialty care and hospital performance will be recommended by the Council in 2015 with implementation scheduled for the 2017 measurement year. The state will compute and post cross-payer provider performance data for consumer and provider review.

Quality Measures: The Quality Council will prioritize measures that are recommended by CMMI, align with existing Medicare performance measurement initiatives, and established or endorsed by the Healthcare Effectiveness Data and Information Set (HEDIS), National Quality Foundation, Agency for Healthcare Research and Quality, or U.S. Preventive Services Task Force. The following measures may be considered:

Care Experience: getting timely care, appointments, and information; how well your doctors communicate; patients' rating of doctor, access to specialists; health promotion and education; shared decision making; health status/functional status

Prevention/Screening: well child visits, mammograms (women > 50), colorectal cancer screening (adults > 50), influenza immunization, pneumococcal vaccination, hypertension (HTN), depression, fall risk and addiction screening, tobacco use assessment and cessation intervention, weight screening and follow-up.

Chronic Illness Management: diabetes, asthma, hypertension, hyperlipidemia, congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, chronic pain, sickle cell

Care Coordination/Patient Safety: hospitalizations for ambulatory care sensitive conditions, readmissions for avoidable complications, medication reconciliation, asthma ED visits, hospitalization due to falls

Resource Efficiency: Duplicative testing, generic prescribing, use of lower-cost providers.

Health equity gaps for each measure will be considered for inclusion in the core quality measurement set.

Care Experience Survey: The most important means to improve consumer experience is to measure care experience, publish results, and link results to payment. 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.

The PMO will contract with a vendor for the administration of care experience surveys with sufficient statistical reliability and validity at the level of the Advanced Network or FQHC to support the inclusion of care experience scores in the performance scorecard and as a factor in calculating SSP rewards. The sample will be drawn from attributed patients of Advanced Networks and FQHCs participating in SSP. This represents the first effort among payers to use cross-payer pooled performance data. During the Model Test, the vendor will oversample for Medicaid recipients in order to assess the extent to which there are health equity gaps in care

experience, care experience survey results will be included in provider performance scorecard tied to SSP calculations.

Providers will have the option to arrange and finance the care experience survey themselves, provided they use the recommended survey tool and methods. For the first two years of the Model Test, the PMO will co-source the conduct of the survey free of charge on behalf of those providers that do not wish to undertake the survey themselves. Combining the purchasing power of participating providers will significantly reduce the cost per completed survey. By the third year of the Model Test, providers will be charged a fee sufficient to cover the administration and conduct of the survey. The state will explore with CMMI the option of combining this survey with that of Medicare's ACO survey.

VIII. Monitoring and Evaluation Plan

Overall Approach: We will monitor and report on the impact of the Model Test on 1) population health; 2) health care quality; and 3) per capita healthcare spending. Our evaluation approach includes the 1) collection of real-time data to promote and support continuous quality improvement; 2) use of advanced statistical methods to analyze complex data and account for nonrandomized designs when conducting assessments of specific innovations, such as VBID; and 3) collection of qualitative data to better understand the context of reform efforts. Data on Model Test targets will be compiled quarterly and reported to the PMO, Rapid Response Team and CMMI at specified intervals, to facilitate rapid-cycle evaluation of reform efforts and identify areas for mid-course corrections.

Reports: The team will prepare a *Dashboard* that presents summaries of a core set of measures, corresponding to Model Test targets, to 1) monitor the pace of implementation and performance of key program initiatives; and 2) provide data on changes in health outcomes and health spending to inform short time-cycle program adjustments. Dashboard measures will be refined in conjunction with CMS during pre-implementation.

Strengthening Population Health: The team will report to CMMI about progress developing the Population Health Plan, including 1) identifying priorities, barriers and interventions; 2) completing a population health assessment; 3) implementation of a PSC demonstration; and 4) finalization of the Health Enhancement Community (HEC) design. The Dashboard will include measures for statewide population health targets contained in the states' Healthy CT 2020 plan including tobacco use, obesity, and diabetes prevalence. New measures will be selected that align with the priority areas identified in the Population Health Plan.

Transforming the Health Care Delivery System: We will monitor the pace and impact of

delivery system changes by tracking policy and structure changes, such as the adoption by practice groups of HIT and team-based care, and measures of potential impact, such as the percentage of residents attributed to a PCP that are reimbursed under a SSP. Program accountability measures include 1) number of providers completing AMH Glide Path; 2) achievement of targeted technical assistance capabilities and impact; and 3) use of patient care experience data to help determine shared savings. Changes in the delivery system over the Model Test period are expected to allow the State to achieve the access and quality targets below.

Category/Measure	Base	2016	2017	2018	2019	2020
% of adults w/ regular source of care	83.9	85.7	87.5	89.4	91.2	93.0
Risk - std. all condition readmissions	15.9	15.3	14.8	14.2	13.7	13.1
Amb Care Sensitive Cond Admissions	1448.7	1398.0	1347.3	1296.5	1245.8	1195.1
Children well-child visits for at-risk pop	62.8	64.1	65.3	66.6	67.8	69.1
Mammogram for women >50 last 2 years	83.9	84.7	85.4	86.2	87.0	87.7
Colorectal screening - adults aged 50+	75.7	77.2	78.8	80.3	81.9	83.6
Colorectal screening - Low income	64.9	65.6	66.2	66.9	67.5	68.2
Optimal diabetes care - 2+ annual Alc tests	72.9	74.3	75.7	77.1	78.6	80.1
ED use - asthma as primary dx (per 10k)	73.0	71.2	69.4	67.6	65.8	64.0
ED use - asthma as primary dx (Hispanics)	170.5	168.0	165.5	163.0	160.5	158.0
% of adults with HTN taking HTN meds	60.1	62.0	63.9	65.7	67.6	69.5
Premature death-CVD adults (per 100k)	889.0	819.2	749.4	679.6	609.8	540.0
Premature death-CVD black adults (/100k)	1737.6	1562.1	1386.6	1211.0	1035.5	860.0

Quality measures and targets related to hospitalizations will be calculated using the AHRQ Prevention Quality Indicators (PQIs), 14 measures of conditions managed in ambulatory settings.

Additional measures and targets, including behavioral health and oral health are under review.

Equity: A major goal of the Model Test is to improve equity in access and quality. We will monitor equity gaps for the core Dashboard measures and target selected areas for improvement.

Costs of Health Care: Major operational plan milestones include 1) Medicaid QISSP implementation, 2) percent increase in providers/beneficiaries in SSPs; 2) percent of employers adopting VBID; 3) percent of consumers with access to price information via performance scorecards. Additionally, the State has established the following PMPM cost targets:

Cost (PMPM)	2014	2015	2016	2017	2018	2019	2020
ASO/Fully insured	$457	$478	$501	$525	$550	$576	$603
State employees w/o Medicare	$547	$573	$600	$629	$658	$690	$722
Medicare	$850	$887	$926	$966	$1,007	$1,051	$1,096
Medicaid/CHIP, incl. expansion	$390	$408	$426	$446	$466	$487	$509
Average	$515	$539	$565	$591	$619	$649	$679

Data Sources: CT has many existing data sources to support evaluation and monitoring, including the CT BRFSS data and claims data from CT's APCD, which will be used to monitor the extent to which CT is achieving annual quality, cost and population health targets. CT's APCD includes eligibility data; medical, pharmacy, and dental claims; and provider information since 2008. For the 14 large primary care practice groups in CT (representing 65% of PCPs in the state and 55% of state employees) two large insurance plans have agreed to differentially assign 1) insurance design and 2) payment strategy, so that we can assess the independent and synergistic effects of benefit design and payment arrangements.

Collection of new data: We will compile or collect quantitative and qualitative data to supplement the BRFSS and APCD data. The evaluation team has extensive experience

developing and administering patient, provider, and population surveys. To assess consumer experiences with care, we will use Consumer Assessment of Healthcare Providers and Systems (CAHPS) data which are collected annually from representative samples of Medicare beneficiaries, hospitalized patients, and individuals in accredited health plans. To enable generalization about ambulatory care experiences to the CT population as a whole, we will conduct a statewide survey about consumer engagement and care experiences that will include Medicaid and other individuals not in accredited health plans in Year 2. We will conduct a statewide survey of providers in Year 3 that will allow us to assess changes in barriers to system changes and provider activities and practice patterns assessed in a statewide survey of 1,200 CT physicians conducted in fall 2014. Finally, semi-structured interviews with key stakeholders will provide critical information on the pace of delivery system transformation, barriers to change, and changes in the ability to provide high quality, efficient care.

Focused Analyses of the Impact of Reform Efforts: The differential adoption by practice groups of new benefit and payment models will allow rigorous assessments of, for example, the impact of employee benefit plans (e.g. VBID) and provider reimbursement (e.g. SSP) on care patterns, costs, and health outcomes. Assessment of the impact of different delivery, benefit, and payment models will use statistical methods that account for non-random assignment to conditions and the clustering of patients within sites and sites within larger organizations. For example, we will use hierarchical regression models to account for correlation among patients within clinics and allow for differential changes across sites and propensity score matching to account for non-random assignment. Changes in outcomes across groups of sites can be estimated using an interaction term between measurement period and groups (e.g. adopters vs. non-adopters of an innovation).

IX. Alignment with State and Federal Innovation

The state is currently engaged in a range of innovations that complement the Model Test:

Integrated Care Demonstration for Medicare/Medicaid Eligibles (ICD): Medicaid is scheduled to implement this demonstration in early 2015, testing a unique approach to bundled care management and support services, care coordination contracts and electronic messaging tools that will inform our multi-payer reforms beyond the test period. One component of the ICD will support Medicaid beneficiaries through federated analytics and intensive care management associated with Medicaid's medical ASO. The other component of ICD will introduce local multi-disciplinary networks known as "health neighborhoods", which may align with the HEC. Our model test will not introduce duplicative services or payment.

Behavioral Health Homes (BHH): The BHH model aims to improve care and reduce costs for Medicaid recipients with serious and persistent mental illness. BHH assess, identify and coordinate the physical and mental healthcare needs. Local mental health authorities will receive a fee for care management and coordination, assistance with transitions, and referrals to community supports. Payment for BHH services will not duplicate payments made under Medicaid for covered services, including those associated with the model test. The BHH will provide valuable experience in serving a special population that is not a primary focus of our model test, but will inform SIM related multi-payer innovations in the future

WrapAround New Haven: CMMI recently awarded a $9.7 million, 3-year grant to Clifford Beers Clinic for an intensive care coordination intervention targeting children at risk for trauma and their families. Working with a health center, public schools and DSS, the program seeks to improve health outcomes through integration of behavioral health and medical care as well as payment reforms that supports care coordination for high-risk beneficiaries.