CONNECTICUT HEALTHCARE INNOVATION PLAN

State Innovation Model Update

Presentation to the Healthcare Cabinet

January 13, 2015

SIM Grant Award

- Connecticut awarded $45 million over four years
- We are in the company of many other innovative states….

SIM Model Test Round 1 Awards

State	Award Amount	Population
Arkansas	$42,000,000	2,959,373
Maine	$33,000,000	1,328,302
Massachusetts	$44,000,000	6,745,408
Minnesota	$45,000,000	5,457,173
Oregon	$45,000,000	3,970,239
Vermont	$45,000,000	626,562

SIM Model Test Round 2 Awards

State	Award Amount	Population	Round 1 Status
New York	$99,900,000	19,651,127	Pre-Test
Ohio	$75,000,000	11,570,808	Design
Michigan	$70,000,000	9,895,622	Design
Colorado	$65,000,000	5,268,367	Pre-Test
Tennessee	$65,000,000	6,495,984	Design
Washington	$64,900,000	6,971,406	Pre-Test
Connecticut	$45,000,000	3,596,080	Design
Iowa	$43,100,000	3,090,416	Design
Idaho	$40,000,000	1,612,136	Design
Delaware	$35,000,000	917,092	Design
Rhode Island	$20,000,000	1,050,292	Design

SIM Model Design Round 2 Awards

State	Award	State	Award
American Samoa (AS)	$750,000	New Jersey (NJ)	$3,000,000
Arizona (AZ)	$2,500,000	New Mexico (NM)	$1,999,988
California (CA)	$3,000,000	CW of N. Mariana Islands	$750,000
District of Columbia (DC)	$1,000,000	Oklahoma (OK)	$2,000,000
Hawaii (HI)	$1,500,000	Pennsylvania (PA)	$3,000,000
Kentucky (KY)	$2,000,000	Puerto Rico (PR)	$1,944,740
Illinois (IL)	$3,000,000	Utah (UT)	$2,000,000
Maryland (MD)	$2,500,000	Virginia (VA)	$2,589,792
Montana (MT)	$999,999	West Virginia (WV)	$1,939,705
Nevada (NV)	$2,000,000	Wisconsin (WI)	$2,494,290
New Hampshire (NH)	$2,000,000	Texas (TX)	NA

Legend	Color	Legend	Color
New applicant for design	(black)	New applicant for test	(green)
Rnd 1 applicant for test	(red)	Rnd 1, no app for Rnd 2	(tan)
Rnd 1 applicant for design	(blue)		

SIM Grant Award

- Connecticut awarded $45 million over four years
- Pre-implementation
  - February 1, 2015 – January 31, 2016
  - Initial authorization - $7,332,846
- Model Test
  - February 1, 2016 – January 31, 2019

Pre-implementation Budget

- $6.03 million is contractual
- All contractual funds restricted pending approval of contractor, method of selection, scope of work, etc.

Near Term Priorities (2/2015)

- Launch Advanced Medical Home Pilot
- Continue hiring positions for PMO
- Expand project plan and project management tools
- Business processes for administering cooperative agreement, federal reporting, MOAs/contracts, and subcontracts

Near Term Priorities (2/2015)

- Prepare & execute Memoranda of Agreement with state agency partners
  - DPH – population health planning
  - DSS - MQISSP planning & pre-implementation
  - DSS – HIT planning & pre-implementation
  - UConn – evaluation

Mid-Term Priorities (4/2015)

- Prepare & execute Memoranda of Agreement with state agency partners
  - UConn – community health workers
- Prepare & execute contracts
  - VBID consultation support
  - Consumer outreach and engagement coordinator
  - Focus group and listening sessions facilitator

Long term Priorities (8/2015)

- Prepare & execute Memoranda of Agreement with state agency partners
  - DSS – Administration of AMH Glide Path
- Prepare and execute contracts
  - AMH vendors
  - CCIP vendor(s)

Quality Council

Quality Council

- First meeting – 9/3/14, six full council meetings to date
- Executive team
  - Dr. Mehul Dalal, DPH (co-chair)
  - Deborah Dauser Forrest, Connecticare
  - Meryl Price, consumer advocate
  - Dr. Steve Wolfson, physician (co-chair)

Guiding Principles

1. Maximize alignment with the Medicare Shared Savings Program ACO measure set.

2. Recommend additional measure elements that address the most significant health needs of Connecticut residents, the needs of non-Medicare populations (e.g., pediatrics, reproductive health), and areas of special emphasis such as behavioral health, health equity, patient safety, and care experience.

3. Wherever possible, draw from established measures such as those already established by the National Quality Forum and those that comprise the Medicaid Adult and Child Health Care Quality Measures, the Physician Quality Reporting System, CMS Meaningful Use Clinical Quality Measures, NCQA measures, and the CMMI Core Measure Set.

Guiding Principles

4. Balance comprehensiveness and breadth with the need to prioritize and focus for the purpose of enabling effective and continuous quality improvement.

5. Promote measures and methods with the aim of maximizing impact, accuracy, validity, fairness and data integrity.

6. Promote credibility and transparency in order to maximize patient, employer, payer, and provider engagement.

7. Assess the impact of race, ethnicity, language, economic status, and other important demographic and cultural characteristics important to health equity. Leverage the output of this analysis to identify potential reportable metrics for inclusion in the scorecard. (Draft…referred to Health Equity Design Group)

Guiding Principles

8. Recommend measures that are accessible with minimal burden to the clinical mission; should draw upon established data acquisition and analysis systems; should be both efficient and practicable with respect to what is required of payers, providers, and consumers; and should make use of improvements in data access and quality as technology evolves and become more refined and varied over time.
9. Maximize the use of clinical outcome measures and patient reported outcomes, over process measures, and measure quality at the level of the organization.
10. Use measurement to promote the concept of the Rapidly Learning Health System.

Defining Council Outputs

- All payer measure set vs. commercial/Medicaid only?
- If all-payer, we would retain all Medicare measures
- If commercial/Medicaid, we would retain only those measures relevant to commercial/Medicaid
  - Example: If base rate of falls is very low in commercial and Medicaid populations, we might eliminate "Falls: screening for future fall risk"

Pre-decisional – for discussion only

Defining Council Outputs

- Draft assumptions
  - Include all measures that are a high priority for any payer/population
  - Include even those measures that may not be appropriate for some providers or populations
  - Example: Commercial contract with provider with low base rate of COPD might not include COPD measures

Pre-decisional – for discussion only

Defining Council Outputs

- Draft assumptions
  - Assuming the above, measure set is actually a menu of measures
  - No payer-provider contract would include all measures in all value-based contracts
  - However, when payer focuses on a condition that is included in the measure set, they must use the measure and specifications as defined in the measure set

Pre-decisional – for discussion only

Defining Council Outputs

- If core measure set is a menu, how we would we ensure achievement of SIM objectives?
  - Certain domains and measures could be deemed *mandatory* or *essential* measures
  - Status would be recommended by Council
  - Other measures would be *optional*

Pre-decisional – for discussion only

Sample Measure Set

ACO #	Measure title	NQF #	Essential vs Optional	Data source	Pediatric/ Adult	Reporting vs. Payment		
						2016	2017	2018
Domain: patient/caregiver experience								
1	xxxxx	0123	E	Survey	P/A	P	P	P
2	xxxxx	0123	E	Survey	P/A	P	P	P
3	xxxxx	0123	E	Survey	P/A	P	P	P
4	xxxxx	0123	E	Survey	P/A	P	P	P
5	xxxxx	0123	E	Survey	P/A	P	P	P
6	xxxxx	0123	E	Survey	P/A	R	R	R
Domain: care coordination/patient safety								
9	xxxxx	0123	E	Claims	A	P	P	P
10	xxxxx	0123	E	Claims	A	R	P	P
11	xxxxx	0123	O	Claims	A	R	P	P
12	xxxxx	0123	E	Claims	P	P	P	P
13	xxxxx	0123	O	Claims	A	P	P	P
14	xxxxx	0123	O	Claims	P	P	P	P
Domain: preventive health								
15	xxxxx	0123	E	Claims	A	P	P	P
16	xxxxx	0123	E	EHR	A	P	P	P
17	xxxxx	0123	O	EHR	A	R	R	P
18	xxxxx	0123	E	Claims	A	P	P	P
19	xxxxx	0123	O	EHR	P	P	P	P
20	xxxxx	0123	O	EHR	P	P	P	P
Domain: at-risk population								
Asthma								
21	xxxxx	0123	E	EHR	P/A	R	R	P
22	xxxxx	0123	O	EHR	A	P	P	P

Key Challenges

- Even if a domain or measure is mandatory, how do we ensure it has sufficient weight in scoring?
- How do we ensure the integrity of EHR or self-reported data?
- Who is responsible for producing new measures? Which measures should be produced by the state?
- How do we handle base rate limitations?

Key Challenges

- Some measures may not be ready for implementation in 2016, even for reporting purposes
- Such measures could be included in the core measure set, or as a supplemental set, and projected for implementation at a later time
- Accordingly, we could consider staging our efforts, with 2016 measures proposed as Stage 1 measures and other measures as Stage 2 measures

Measure Comparison

- 33 Medicare ACO measures (2012 – 2014)
- New Medicare ACO measures proposed for 2015
- All measures currently in use by Connecticut's largest commercial payers – claims based
- All measures currently in use by Connecticut Medicaid for the PCMH Program
- More than 100 measures under review

Pre-decisional – for discussion only

Measure Comparison

- Pediatric design group recommended 12 measures including additional measures from the Children's Health Insurance Program Reauthorization Act (CHIPRA) recommended measure set (CTAAP)
- Recommendations pending:
  - Health equity design group
  - Behavioral health design group
  - Care Experience design group
  - Supplemental Medicaid measures (DSS/MAPOC Care Management Committee)

Questions

Acronyms

Acronym	
ACO	Accountable care organization
AMH	Advanced Medical Home
DPH	Department of Public Health
DSS	Department of Social Services
EHR	Electronic health record
HEC	Health Enhancement Community
HIT	Health Information Technology
MQISSP	Medicaid Quality Improvement & Shared Savings Program
PCMH	Patient centered medical home
PMO	Program Management Office
RFP	Request for Proposals