Connecticut Healthcare Cabinet Recommendations Preliminarily Approved on November 1, 2016

November 2, 2016

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Introduction

This document contains the written detail of the recommendations that the Cabinet approved on November 1, 2016. These recommendations are being made available for public stakeholder comment and review. The November 15, 2016 meeting of the Healthcare Cabinet will be dedicated to public comment on these recommended strategies for cost containment.

I. Delivery System and Payment System Transformation Strategies

1A. Provide More Coordinated, Effective and Efficient Care Through CCOs
1B. Build on the SIM Agenda and Current Success in the Medicaid Program
1C. Create Community Health Teams to Address Complex Health Care Needs

1A. Provide More Coordinated, Effective and Efficient Care through CCOs

Goal of Strategy: Reduce costs in the health care system by promoting delivery system and payment reform, through models that engage providers to provide services in a more coordinated, effective and efficient manner; that address issues of underuse, overuse, misuse and ineffective use, and that reduce the impacts of social determinants of health and health inequities.

Recommendation: The Legislature should require the Medicaid program and the Office of the State Comptroller (OSC) to pursue a Consumer Care Organization (CCO) strategy that includes the use of independent but aligned purchasing strategies, including contract language, with entities that are each accountable for the cost of a comprehensive set of services (e.g., "total cost of care") for an attributed population using an approach that holds providers accountable for their quality performance on outcomes, patient access and efficiency.

Rationale: This recommendation seeks to build upon the shared savings programs being launched by Medicaid (PCMH+) and the OSC (ACO-type) by requiring providers to organize themselves in such a way that would allow better care coordination across the continuum of multiple providers and increase accountability among all providers, and in particular, among the highest cost providers (e.g., hospitals and specialists). This recommendation seeks to introduce shared-risk over time to give providers greater incentives to change the way they deliver care than shared savings programs have, and to emphasize care coordination for those most in need. Since this recommendation affects all state-purchased health care, it sends a clear and coordinated message to the provider community, making it easier for providers to adapt to this change. (*Please see Strategy #3B Office of Health Strategy for more information on how this strategy can be made multi-payer.*) Importantly, this recommendation keeps consumers at the center of the health care delivery system and provides strong protections for their active participation in the business decisions of the health care system.

The strategy to utilize shared risk arrangements is in keeping with national trends among states that contract directly with providers for Medicaid. Of the 11 states with active ACO programs in Medicaid, eight utilize shared risk or intend to use shared or full risk.[1]

To be successful under a total cost of care model, the CCOs must 1) identify and better manage high-cost, high-need patients who will benefit from intensive care management services, 2) better manage transitions of care between inpatient and community-based organizations, 3)

[1] Medicaid Accountable Care Organizations: State Update. Center for Health Care Strategies, September 2016.

quickly identify and better manage ambulatory patients with poorly managed chronic diseases or conditions that could lead to the use of high-cost services, and 4) address social determinants of health through forging close service connections with community-based organizations.

Finally, a total cost of care model that includes providers along the continuum of care is the model being aggressively pursued by Medicare and by private insurers in other states. Connecticut's top insurers have also publicly stated their desire to move to value-based contracts, including risk-based contracts with willing providers.[2] By participating in the CCO model, providers would benefit directly by having opportunities to earn savings and to potentially exempt them from the Medicare MIPS reporting and performance requirements, which would make providers eligible for Medicare rate increases.[3]

What are Consumer Care Organizations? Consumer Care Organizations (CCOs) would be a collection of providers that voluntarily come together to coordinate a comprehensive set of services for an attributed population. An ACO, or Advanced Network, could be a CCO if it meets the requirements stated below. Consumer Care Organizations would be regulated by the State for financial solvency and operational capacity, and if qualified, comply with Preferred Provider Network regulations enforced by the CID.

Aligned Requirements: The Medicaid program and the Office of the Comptroller should each include in their contracts requirements that:

- CCOs have a governing body that is representative of the provider-types that make up the CCO, with the providers being Connecticut-based;
- consumers are meaningfully represented on the governing body across its lines of business;
- a separate consumer advisory board be formed with a direct advisory relationship to the CCO governing body;
- CCOs meaningfully participate in Community Health Collaboratives;
- in order to address health inequities and social determinants of health, CCOs meet the Community and Clinical Integration Program (CCIP) standards set forth in the SIM program, and[4,5]
- CCOs meet minimum requirements and undergo a readiness review, as defined by the State, to participate in the shared risk model. Such requirements could include

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[2] Anthem: www.beckershospitalreview.com/payer-issues/anthem-makes-nearly-40b-shift-from-fee-for-service-medicine-to-value-based-pay.html; Aetna: www.strategy-business.com/blog/Aetna-Frugal-Healthcare-Strategy?gko=432ba

[3] Under MACRA, providers that participate in a "qualifying" value-based payment model will be eligible for a 5 percent increase in rates, and will be exempt from participating in the MIPS quality program, which has the potential of a 9 percent rate increase, and a 9 percent rate reduction over a four-year period. The CCO model, as described in this proposal, could be a "qualifying" value-based payment model in the "Other APM" category starting in 2019. See footnote 8 for incidences in which the CCO model would not be considered a "qualifying APM." The PCMH+ model is not a qualified model under the final MACRA rule.

[4] For more information on the CCIP program standards, see: www.healthreform.ct.gov/ohri/lib/ohri/work_groups/practice_transformation/ccip_standards/ccip_report_4-13-16_draft_5_14.pdf

[5]CCIP standards are intended to apply to all payers/populations. .

substantive progress made toward acquiring and utilizing new health analytics technology, and making operational connections with social service and community-based organizations.

Nonaligned Requirements: The Medicaid program and the Office of the Comptroller may have additional requirements that are not aligned, including, for example:

- the number of attributed lives that a CCO must have before assuming risk;
- provider types that are required to be part of a CCO;
- social service agencies that are required to be part of a CCO; and
- the suite of health care services for which the CCO is responsible (so long as it is a comprehensive set of services).[6]

Requirements Specific to Medicaid: The Legislature should recommend that Medicaid require its providers to develop the capacity to assume clinical and financial responsibility for dental and long-term support and services within three years of the start of the contract.

How CCOs are Paid: In keeping with the goals of the SIM program, and aligned with the goals of the Cabinet to move hospitals, specialists and other providers to value-based payment models (see recommendation #2), Consumer Care Organizations should be paid using a value-based payment model. For the Medicaid program, the model should include accountability for medical and behavioral health services, and within three years include dental and long-term services and supports. For the Office of the Comptroller, it should include all covered medical and behavioral health care services.

Generally, the payment model should adhere to the following principles, with the design and operational details to be fleshed out by the Department of Social Services and the Office of the Comptroller, under the direction of the Office of Health Strategy. The payment model should be consistent, to the extent possible, with the SIM Care Management Committee and Equity and Access Council recommendations.

Total Cost of Care

- CCOs will be held accountable for a total cost of care (TCOC) target that includes the broadest range of services possible.
- A TCOC target should be based on historical analysis of the TCOC for the patients of the primary care providers (and subspecialists functioning as PCPs for patients with certain conditions, such as cancer or complex diabetes) that make up the CCO with a trend rate that is no greater than the cost growth target set by the state (see Recommendation #2).
- In order to provide incentives for providers to care for individuals with illnesses that result in high costs, the TCOC target will be risk-adjusted, and high-cost outlier cases will be truncated at a predetermined threshold.[7]

[6] For example, the Medicaid program may wish to include dental providers as a required provider for CCOs, but the Office of the Comptroller may not.

[7] Currently, risk adjusters do not adequately account for social determinant risk factors. When and if there is a risk adjuster that takes into account social determinant risk factors, it should be considered for inclusion in this program.

Risk Model

- All CCOs, unless otherwise willing and capable of demonstrating readiness, should begin in a shared-savings model. The opportunity to share in savings should be greater than what is being offered at the time in the PCMH+ program to encourage provider participation in the CCO model.
- Within 3 years, CCOs should be expected to move into shared-risk models where providers share in savings and in risk with the state. The shared savings portion of this opportunity will be greater in this model than in the shared savings-only model to encourage providers to adopt shared risk. Risk caps should be employed such that the risk is meaningful, but CCOs are not exposed to catastrophic risk. Risk caps should be set no lower than 1% and no higher than 5% of the total cost of care on a per member per month basis.[8] Higher risk caps and higher potential savings percentages, similar to the Medicare Next Gen model, could be considered for qualified CCOs.
- The risk cap may vary between the Medicaid program and the state employee health program.

Quality Model

- CCOs should be focused upon improving the health status of the Connecticut population, with special attention to reducing health disparities based on race, ethnicity, gender, and sexual orientation, reducing the impact of negative social determinants of health, and reducing barriers to care for those most vulnerable. The State should specifically incorporate quality performance measures addressing these desired outcomes.
- Performance on quality process and outcome measures should affect the portion of shared savings for which a CCO is eligible, and the amount of risk for which a CCO is responsible, with the levels being determined by the State.
- Quality measures to which CCOs are held accountable should be consistent with the core measurement set recommended by the SIM Quality Council. In accordance with the recommendations of the Council, the scorecard should include measures of health equity gaps in order to ensure that CCOs drive reduction in such gaps. Measures should target opportunities for performance improvement, as well as ensure that there is no diminishment in access to services. Additional quality measures will be necessary to measure the performance of non-primary care providers, and to adequately measure outcomes as previously described. Any additional quality measures that the state Medicaid program or Office of the Comptroller wish to include should be decided with input from CCOs, providers that make up CCOs, and consumers, and in coordination with the Office of Health Strategy, which will lead efforts to align quality measures with other payers.
- To address the risk of potential underservice, the State should consider utilizing "secret shoppers" and consumer experience of care surveys as part of its quality measurement system.

[8] Under the final regulations for MACRA, to be exempt from MIPS, providers must participate in a "qualifying APM' which includes accepting at least 3% risk for total expenditures which the provider is responsible for within the model. If a risk cap is set lower than 3%, as this strategy allows, it will not be a qualifying APM.

Primary Care Bundles

- Primary care payment should be modified to support primary care practices' ability to diversify the care team and to deliver care using currently non-reimbursable modalities, including through the use of upfront payment. Care team diversification may include but would not be limited to patient navigators and community health workers. New care modalities may include telephone, e-visits and video visits, as well as remote monitoring.

Timeline for Implementation of CCOs: The work of the Medicaid program has fastidiously laid the groundwork for the development of CCOs through its focus on primary care transformation, high-risk and high-need population-based programs, and the PCMH+ shared savings program. Some of the providers that may wish to become a CCO have been gaining experience in value-based payment models, including in enhanced medical home and pay-for-performance models, and as of January 1, 2017 will through the PCMH+ shared savings model. Other providers will have had experience in shared savings and shared risk models offered by Medicare[9] and commercial payers, while some providers will have had no experience.

When considering the timeline for implementing the CCO model, it must be recognized that Medicaid must work with stakeholders to develop program detail, including but not limited to CCO performance standards, expectations regarding how to address social determinants of health, and details regarding the payment methodology. It will therefore important to and ensure the availability of Medicaid staff and contracting resources top perform this work.

To account for the variation in experience in value-based payment in the state and the administrative capacity of the Medicaid Department, the following timeline should be utilized for implementation of CCOs, unless the Office of Health Strategy adjusts the timeline to better align existing and ongoing initiatives:

- Begin contracting with CCOs on January 1, 2019.
- All CCOs start in a shared savings model, which could be nearly identical to the PCMH+ model, with the exception that CCOs would be provided the opportunity to share in additional savings, from January 1, 2019 to December 31, 2019. CCOs that are comprised of a substantial number of providers that are participating in PCMH+, or that have participated in any Medicare or commercial shared savings model, move into a shared risk arrangement on January 1, 2020. This is in keeping with the State's commitment to not require Medicaid providers to move risk-based contracts under the PCMH+ program during the SIM initiative.
- CCOs that did not exist in any form prior to January 1, 2019 or did not have prior experience with shared risk, move into shared risk on January 1, 2021.

Technical Assistance: To be successful in population management and assuming risk, providers will need to build the necessary infrastructure to collect and analyze both claims and

[9] There are currently five Connecticut-based ACOs participating in the Medicare Shared Savings Program. Another six New York-based ACOs count some Connecticut counties as part of their service area. See https://data.cms.gov/ACO/2016-Medicare-Shared-Savings-Program-Organizations/5kdu-cnmy.

clinical data. Moreover, CCOs will need to develop delivery system processes, including a strong care management system, that supports population management models. Infrastructure development will necessarily occur at practice, facility and CCO levels. To facilitate the development of needed infrastructure, the State should provide opportunities for providers to participate in learning collaboratives that will enable participants to learn from the experiences of providers who have successfully developed needed infrastructure and to participate in peer learning on aspects of CCO performance that are critical to success. This technical assistance can be provided in concert with a Delivery System Reform Incentive Payment (DSRIP) program, if the State applies for one to CMS.

The following table summarizes key differences between the current PCMH+ initiative and the proposed CCO model.

Model Feature	PCMH+	CCO
Providers eligible to earn shared savings	PCPs	PCPs, specialists, hospitals, "downstream providers," such as SNFs, VNAs, and participating social service agencies
Covered Patient Populations	All Medicaid patients attributed to a PCP	All Medicaid patients, and state employees attributed to a PCP
Budget upon which savings are determined	All Medicaid claims costs for covered benefits, except: • Hospice • LTSS, including institutional and community-based services • Non-emergency medical transportation	For Medicaid: All Medicaid claims costs for medical and behavioral health services. Within 3 years the addition of dental and LTSS For OSC: All employee claims costs for medical and behavioral health services
Quality Measures	PCP-oriented, including clinical quality and access measures	Measures would be included for services provided by PCPs, medical specialists, behavioral health clinicians, and hospitals. When LTSS and dental are added to Medicaid CCOs, measures for dental and LTSS providers would be added.
Payment Model	Shared savings	Shared risk
Goal	Improve the health of the attributed population through a focus on strengthening primary care services by providing	Provide strong incentives to improve the health of the attributed population by engaging the full spectrum of providers in becoming more

Model Feature	PCMH+	CCO
	incentives to PCPs to better coordinate care and implement patient-centered care models.	efficient and effective in providing person-centered care.
Consumer Involvement	Continue to participate at the state policy level through MAPOC and SIM. No direct input into delivery model with providers unless provider creates consumer advisory group.	Consumers are involved at the provider level by sitting on the CCOs' boards of directors and by participating in CCO consumer advisory groups.
Limitations	Focuses on PCPs and not the entire continuum of care. Does not address rising pharmacy costs.	Requires previously unrelated entities to formally join together to change their care delivery model. Does not address rising pharmacy costs.
Potential Impact on Health Care Costs	Minimal because of PCP focus	Potentially significant because of focus on full continuum of care
LAN Category	3A (APMs with upside gainsharing)	3B (APMs with upside gainsharing/downside risk)

1B. Build on the SIM Agenda and Current Success in the Medicaid Program

Goal of Strategy: Reduce costs in the health care system by promoting delivery system and payment reform, through models that engage providers to provide more services in a more coordinated, effective and efficient manner; that address issues of underuse, overuse, misuse and ineffective use, and that reduce the impacts of social determinants of health and health inequities.

Recommendation: (1) Continue with the SIM agenda in its focus on care delivery reforms, development of a common quality framework, and cross-payer alignment around use of Medicare ACO SSP shared savings arrangements, as those features contribute to cost containment. (2) (a) Continue to optimize the current Medicaid care delivery reform initiatives; including ASO-based intensive care management, person-centered medical homes, behavioral health homes, and the long-term services and supports re-balancing plan; and (b) implement targeted new interventions that address and improve outcomes for high need, high cost Medicaid members.

Rationale: The SIM agenda has set important strategic aims for multi-payer alignment on care delivery and payment reform strategies that require time to be implemented, to mature, and to be properly evaluated.

Connecticut Medicaid's program has proven success in improving:

- **member access to services** through increased participation of primary care providers, behavioral health providers, and dentists;
- **health outcomes**, including sustained reductions in emergency department visit rates, overall admissions, and utilization of emergent medical visits, as well as improvements in results on many health measures related to chronic conditions;
- **care experience**, as evidenced by results on CAHPS and use of mystery shopper reviews; and
- **per member per month costs**, which have decreased by 1.9% from SFY 2012 through SFY 2016.

Further, the program is actively engaged in launching, and developing additional, new health care delivery and payment innovations.

Continue with SIM Agenda:
The Connecticut State Innovation Model (SIM) is a multi-payer approach to promote improved health care delivery. SIM was established as a means to ensure that health care reform initiatives are informed by the diversity and expertise that exists within Connecticut's stakeholder community – consumers, consumer advocates, employers, health plans, providers, and state agencies. SIM promotes alignment on methods and requirements where alignment makes sense, while also promoting flexibility and innovation.

There are four major strands of SIM work that have bearing on Medicaid. These include:

- **Advanced Medical Home (AMH):** Connecticut's SIM initiative emphasizes the importance of investing in primary care transformation. Through the AMH program, SIM will provide technical assistance to support the advancement of 300 primary care practices statewide to achieve NCQA PCMH recognition, while emphasizing health equity and patient-centered care. NCQA PCMH recognition allows practices to meet the current eligibility requirements to participate in the PCMH+ program. The AMH program is expected to conclude in 2019.

- **PCMH+:** DSS' goal with PCMH+ is to continue to improve health and satisfaction outcomes for Medicaid beneficiaries currently being served by Federally Qualified Health Centers (FQHCs) and "advanced networks" (e.g., Accountable Care Organizations, integrated practices), which have been competitively selected by the department via a request for proposals. Both FQHCs and certain ACOs are currently providing a significant amount of primary care to Medicaid beneficiaries.

  PCMH+ represents an opportunity for Connecticut Medicaid to build on, but not supplant, its existing and successful Person-Centered Medical Home initiative, and Intensive Care Management (ICM) initiatives. As of October, 2016, 108 practices (affiliated with 435 sites and 1,518 providers) were participating in PCMH, serving 328,169 beneficiaries (over 43% of Medicaid members). The Medicaid PCMH model is a strong premise from which to start in that PCMH practices have demonstrated year-over-year improvement on a range of quality measures (e.g., adolescent well care, ambulatory ED visits, asthma ED visits, LDL screening, readmissions, well child visits)

and also have received high scores on such elements as overall member satisfaction, access to care, and courtesy and respect. Connecticut Medicaid's ICM initiatives have also demonstrated exciting initial results.

While PCMH will remain the foundation of care delivery transformation, PCMH+ will build on current efforts by incorporating new requirements by incorporating additional requirements for care coordination, focusing upon integration of behavioral and physical health care, children with special health care needs, health equity, and competency in care for individuals with disabilities, as well as linkages to the types of community supports that can assist beneficiaries in utilizing their Medicaid benefits.

- **Clinical and Community Integration Program (CCIP):** As part of the SIM grant, approximately $3 million dollars has been devoted to providing technical assistance, peer learning support and financial awards to providers that are participating in the PCMH+ initiative to help them achieve best practice standards in improving care for individuals with complex health needs, introduce new care processes to reduce health equity gaps, and to improve access to and integration of behavioral health services. Technical assistance will also be provided on e-consults, comprehensive medication management, and oral health integration. The standards emphasize social determinants of health, integrating community health workers into primary care teams, community linkages, and a range of capabilities intended to improve the effectiveness of FQHCs and Advanced Networks that are accountable for quality and cost of care. In addition, a pool of $5.5 million has been established to support awards of up to $500,000 for CCIP participating entities that are not participating in the Practice Transformation Network (PTN) initiative. Funds will help support the costs associated with working toward achievement of the standards. SIM funding for this initiative concludes in 2019.

- **Population Health Planning:** The Population Health Planning activities are led by the Department of Health and focus on two major sub-initiatives, which focus primarily on community health improvement objectives (i.e., primary and secondary prevention). Notably, there is not yet a solution for financing the implementation of these initiatives nor for sustaining them over time:
    - Health Enhancement Communities (HEC): Accountable Health Community models are coming to the forefront as a promising strategy to improve health outcomes and meet health-related needs, such as food insecurity or unstable housing. These models differ from state to state, but often include the linkage of clinical and community services, strategies to address both health and social needs, an accountability structure, and a financing strategy. HECs in combination with PSCs will be the Connecticut-specific model of an ACH. HECs will administer target resources and facilitate both local coordination and accountability among providers, local public health departments, municipalities, 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 to innovative reimbursements and to strategies that address social determinants of health and health equity (e.g., sustainable financing for healthy

homes assessments and community health workers). These enhanced agency partnerships and capacity building, which relies on both traditional and nontraditional partners, will strengthen the ability of the community to intervene social determinants of health. The resulting alignment between health care and public health will additionally reframe conventional strategies and broaden targeted groups.

- Prevention Service Centers (PSCs): PSCs are community-placed organizations or consortiums that would meet criteria for the provision of evidence- informed, culturally and linguistically appropriate community prevention services. PSCs may be new or existing local organizations, health care providers (e.g., PCMH, FQHCs), non-profit agencies or local health departments. These centers will be an integral part of the community interagency consortiums seeking designation as an HEC. The State anticipates that the PSCs will initially focus on environmental quality issues in homes and promoting positive health behavior (e.g., asthma home environmental assessments, diabetes prevention programs, and hypertension screening and control). PSCs will also 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 the SIM health care workforce development strategy.

Continue to Optimize Existing Care Delivery Reform Initiatives and Refine Proposed Initiatives:

In addition to the above referenced PCMH+ initiative, Connecticut HUSKY Health (Medicaid) has an established and successful reform agenda that centers around the following elements:

Streamlining and optimizing administration of Medicaid through . . .	• a self-insured, managed fee-for-service structure that contracts with Administrative Services Organizations • unique, cross-departmental collaborations including administration of the Connecticut Behavioral Health Partnership (DSS, DCF, DMHAS), LTSS rebalancing plan (DSS, DMHAS, DDS, DOH) and the new ID Partnership (DDS and DSS)
Improving access to primary, preventative care through . . .	• extensive new investments in primary care (PCMH payments, primary care rate bump, Electronic Health Record payments)

	• comprehensive coverage of preventative behavioral health and dental benefits
Coordinating and integrating care through . . .	• ASO-based Intensive Care Management (ICM) • Cross-ASO collaboration • PCMH practice transformation • DMHAS-led behavioral health homes • Money Follows the Person "housing + supports" approach and Innovation Accelerator Program • PCMH+ shared savings initiative
Re-balancing long-term services and supports (LTSS) through . . .	A multi-faceted Governor-led re-balancing plan that includes: • Extensive collaboration by DSS, DMHAS, DDS, DOH • State Balancing Incentive Program (BIP) activities • LTSS waivers (DSS, DMHAS, DDS) • Nursing home "right sizing" • Workforce initiatives • My Place consumer portal
Moving toward Value-Based Payment approaches through . . .	• Hospital payment modernization • Pay-for-performance (PCMH, OB) • PCMH+ shared savings initiative • Exploration of use of episodes

Medicaid care delivery and payment reform strategies that are adopted should align with the following value statements:

1) **Do no harm to Connecticut Medicaid members**.

   Model design, structure and Medicaid authority must promote the rights and interests of members, meaningfully contribute to improvement of their health outcomes and care experience, and anticipate and safeguard members from denial of service or under-service.

2) **Build upon existing, proven care delivery interventions in Connecticut Medicaid that have already contained costs**.

   Use of data analytics to risk stratify and predictively model the needs of Medicaid members with complex health profiles, as well as ASO-based Intensive Care Management and embedded Person-Centered Medical Home care management, have established a foundational structure upon which DSS is building enhanced PCMH+ care coordination activities, and should continue to be the basis of any regional, provider network model that emerges.

3) **Take the time to develop and mature the elements of vertical and horizontal integration and provider capacity that are necessary prerequisites for a regional, multi-disciplinary provider model and that will be furthered under PCMH+.**

   Investigate means of financing, and enable, the following tools and supports:

   - Health Information Exchange and associated tools;
   - data analytic capacity;
   - cross-disciplinary relationships among health and social services providers; and
   - means of financing or offsetting up-front costs of care coordination and infrastructure investments made by providers.

Medicaid should also continue to use Connecticut Medicaid claims data to design and implement targeted new care delivery and payment initiatives focusing on high cost, high need Medicaid members, including initiatives to:

- optimize Medicaid claiming and care access /continuity for justice-involved individuals re-entering communities;
- develop a health home for children with complex trauma;
- develop a 1915(i) state plan amendment to cover transition and tenancy-sustaining supports under Medicaid, to address and support the need for housing stability as it contributes to improved health outcomes;
- address the care coordination needs of children with complex medical needs (e.g., with sickle cell) who present to the hospital;
- increase the use of standards-based telemedicine;
- launch "Safe to Wait" consumer intervention around self-triage and use of the ED;
- address, with hospitals, the needs of individuals presenting to ED because of pain; and
- develop bundled payments (e.g., for maternity care).

1C. Create Community Health Teams to Address Complex Health Care Needs

Goal: Continue to support delivery system transformation initiatives designed to deliver comprehensive, well-coordinated care and improve health outcomes while controlling costs for patients with complex medical conditions or challenging socioeconomic situations.

Recommendations: Develop all-payer, multi-disciplinary community health teams composed of, at a minimum, a team manager, a nurse care manager, a behavioral health clinician, a social worker, a community health worker and a pharmacist. The community health team should serve primary care providers and patients within a specific geographic community by offering individual care coordination, health and wellness coaching, and behavioral health counseling. It should connect patients to social and economic support services and perform community outreach to support public health initiatives.

The community health teams should be designed to support PCPs who are participating in PCMH+. The community health teams could also provide services to newly formed CCOs until

they have built their own infrastructure to provide these services. This would enable a broad range of providers to participate in the CCO strategy.

Under this proposal, the key functions of the community health team include:
Care managers follow up with patients who are overdue for appointments or tests, manage short-term care for patients with high needs, check that patients are filling prescriptions and taking their medications appropriately, and follow up with patients on their personal health management goals.

Behavioral health providers help providers identify patients with untreated depression or substance abuse, and provide brief behavioral health interventions, when necessary.
Community health workers help patients fill out insurance applications, follow treatment plans, manage stress, and work toward their personal wellness or disease-management goals, accompany patients to appointments and help them find transportation or child care.
Pharmacists work with primary care physicians on medication management for patients taking multiple prescriptions and/or with chronic conditions that can be well managed with effective drug adherence, and assist with medication reconciliation when patients transition from inpatient to outpatient settings.

Social workers help patients connect to social service agencies and to public health initiatives that are designed to address the negative impact of social determinants of health.
Other service specialists, such dieticians, would be engaged as needed.

All team members would work with patients on improving self-management of their health and behavioral health conditions.

Funding sources to make this an all-payer initiative need to be identified. Possible sources of funds could be legislative funding, insurer payments or through other sources identified by the legislature. The cost of each community health team would vary based on the region covered, the number of primary care practices served, and the composition of the team. It is estimated minimum support for a team would be $500,000 annually.

Rationale: This strategy is based on the success experienced in Vermont with its community health teams which are an integral component of Vermont's Blueprint for Health. Vermont's Blueprint for Health, which is built on a model of PCMH plus community health teams and data-sharing infrastructure, has demonstrated significant savings and improved quality.[10] By being an all-payer model, PCMH providers are able to meet the needs of all high-risk, high-cost patients using a single, coordinated model.

A community health team with its multi-disciplinary resources is able to support primary care practices that do not have the internal resources needed to become mature patient-centered medical homes and is aligned with the current Medicaid PCMH+ strategy. The community health team strategy is also consistent with the CCO strategy in two regards. First, community health teams could provide necessary care management services to a newly formed CCO until it is able to build its own infrastructure. Second, for providers who are not aligned with a CCO,

[10] Blueprint for Health 2015 Annual Report, published January 31, 2016

the community health teams would provide needed delivery system support so that they can become mature PCMHs.

II. Directly Reduce Cost Growth

2A. Adopt Statewide Health Care Cost Growth Target
2B. Set Statewide Targets for Value-Based Payment

2A & B: Directly Reduce Cost Growth

Goal of Strategy: Reduce cost growth by setting a target on annual increases; setting targets for adoption of Alternative Payment Models (APMs), and developing mechanisms to 1) track and assure adherence to the cost growth target and APM target and 3) make data transparent to the public.

Recommendation: The Legislature should A) adopt a state-wide health care cost growth target and B) set targets for value-based payment for all payers in the state.

Rationale: Setting a cost growth target will focus the attention of all providers and payers on containing costs, which will necessarily consider both service prices and utilization of services. A cost growth target, applicable to both the public and private sector is consistent with SIM's goals of limiting Connecticut's health care cost increases to sustainable levels. Setting a target for APM adoption will further move providers and payers towards payment models that reward a more coordinated, efficient and higher quality care model.

The Connecticut health care market place is rapidly evolving into a limited number of large hospital-based integrated systems that include primary care, specialists and "downstream" providers. Work by economists, such as Professor Zack Cooper, has demonstrated that this type of consolidation leads to higher unit prices. By developing and implementing payment models that fits with the structure of an integrated health care system, but creates financial consequences for efficiency and quality performance, this strategy , when combined with the cost growth target, counters the ability of large providers to dictate price to employer purchasers.

Strategy 2a (state-wide health care cost growth target) was not voted upon during the November 1, 2016 meeting. The Cabinet has requested modifications to this strategy to articulate a "glide path" toward implementing a cost growth target, but not implementing one immediately. A "glide path" would include identifying the data needed to establish baseline spending and then measure cost growth, establishing a concrete plan for identifying a target, and defining an implementation timeline. In addition, the revised strategy will not include any penalties or sanctions for noncompliance. The Cabinet will review the restated strategy and vote upon it December 13, 2016.

2A. State-wide health care cost growth target: The Legislature should require that the State of Connecticut annually adopt a state-wide health care cost growth target that is based either on the projected gross state product or upon another external economic indicator, such as the Urban Consumer Price Index. The goal is to establish a cost growth rate target that is reasonable and results in more affordable health care. This is consistent with SIM's goal to "achieve a rate of healthcare expenditure growth no greater than the increase in gross state product (GSP)."

The responsibility for developing the methodology for determining the annual target should lie with the newly created, semi-independent Office of Health Strategy. Please see the separate discussion of the Office of Health Strategy for more details regarding its roles and responsibilities (Strategy #3B).

Obtaining required data to implement a cost growth target: Having appropriate data is key to implementing a cost growth target. Until the State's All-Payer Claims Database (APCD) or other database is fully functional, the State should pursue the following incremental strategies for collecting needed data and implementing the cost growth target:

- The CID should annually collect per member per month information from all health insurers selling products in Connecticut. Data should be submitted using definitions developed by and in the manner required of CID and should cover all insured products.
- The Comptroller's Office should collect data using the same format and time periods that CID is using.
- Medicaid should also use its robust database to continue to calculate per member per month growth rates and to the extent possible analyze data in a manner that is consistent with CID and the Comptroller's Office.

Once the APCD or other database is operational, data from the APCD should be used to assess compliance at the insurer and Advanced Network and FQHC levels on a per capita basis that includes all health care costs and by key cost drivers. These data should be available for use by researchers, while protecting patient privacy.

Implementation and enforcement of a cost growth target: The cost growth target should be implemented over several years' time, both in terms of its scope of impact and in term of regulatory consequences for not meeting the target.

Scope. Until the APCD, or other database is operational:

- The target should be applied to commercial insurance plans.
- The Comptroller's Office should apply the cost growth target to its insurer contracts.
- Medicaid should also apply the cost growth target to any CCOs with which it contracts.
- The Office of Health Strategy should urge large employers and employer coalitions to adopt the health care cap for its self-insured products.

Once the APCD or other database is operational, the target should be expanded to include Advanced Networks with sufficient attributed lives to impact health care costs in Connecticut. At this stage of implementation, the cost growth target will be directly applicable to all providers participating in an Advanced Network. In light of the rapid consolidation occurring in Connecticut, Advanced Networks could represent a significant portion of the health care market.

Regulatory Approach. It is recommended that for the first two years sanctions for non-compliance be minimal and that sanctions be increased over time for any entity subject to the target.

Specifically, for the first two years Advanced Networks and/or insurers that are subject to and exceed the per capita cost growth target should be required to a) submit a plan of correction

detailing steps they will take to reduce their cost growth rates, and b) come before the Office of Health Strategy to explain why they exceeded the target and what steps they are taking to reduce their growth rate. The Office of Health Strategy should have the authority to accept, reject or modify the plan of correction. Any insurer or Advanced Network that fails to submit a plan of correction would be subject to a daily fine until the plan is submitted.

Beginning in Year 3 of being subject to the cost growth target, insurers should be subject to regulatory sanctions from the CID if the cost growth target is not met. The CID will also be responsible for periodically reviewing insurer-provider contracts to confirm that provider contracts are consistent with the cost growth target. The Office of Comptroller should also build in penalties into its contracts with its insurers for failing to meet the cost growth target by year 3.

At this stage of implementation, the state agency implementing the CON would consider the cost growth target as integral to the CON review process.

The CID, Medicaid, the Comptroller's Office and the agency implementing the CON should be expected to submit information to the Office of Health Strategy for inclusion in its annual report to the public and to the legislature. It is essential that cost growth data be reported in a robust and transparent manner to the public in order to bring attention to cost growth issues and change the public conversation and expectations regarding the need to contain costs.

In all cases, the regulatory and /or contracting agency would be using the state-wide per capita cost growth target as the limit on how much per capita costs could go up for the population for which they are responsible. By applying the cost growth target to large entities – insurers, large Advanced Networks – it is reasonable to expect them to keep costs below the target by implementing delivery system and payment reforms that reward efficiency and quality.

2B. Set targets for and adopt value-based payment models

In 2015, the U.S. Department of Health and Human Services set a goal that 30% of U.S. health care payments would be in value-based payment models by 2016 and 50% in 2018. These standards were developed out of recognition that the fee-for-service health care payment system rewards volume over value of services, leading to overuse, misuse and the devaluing of lower-priced services like primary care and mental health. By changing the health care payment system to one that rewards the quality of care provided and the efficiency with which it is provided, it is expected that the health care system will save money, while at the same time, improving the quality of care provided. To track progress to the HHS goals, the Health Care Payment Learning Action Network (HCP-LAN), a national collaborative body, was created and was charged with creating a "framework for categorizing value-based payment models and establishing a standardized and national accepted method to measure progress in the adoption of [value-based payment] across the U.S. health care system."[11]

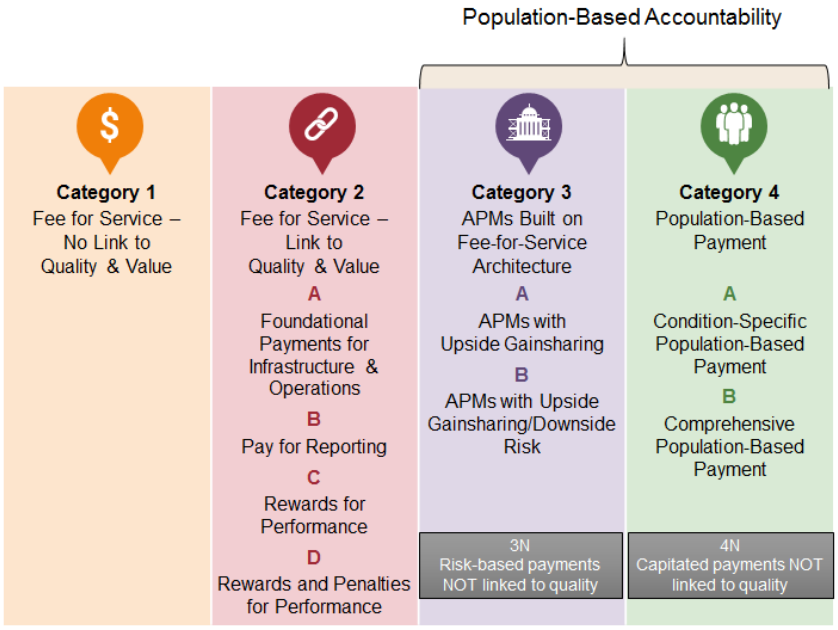
[11] Alternative Payment Model (APM) Framework. January 12, 2016. https://hcp-lan.org/groups/apm-fpt/apm-framework/

Similarly, one of the goals of Connecticut's SIM model is to promote payment models that reward improved quality, care experience, health equity and lower cost. The Connecticut SIM initiative has set a goal to have 89% of Medicaid beneficiaries in the PCMH+ program, and 88% of the Connecticut population going to a primary care provider responsible for the quality and cost of their care by 2020.

In support of the existing SIM goals for primary care providers and to further advance payment reform beyond primary care, the Office of Health Strategy should **set payment reform adoption targets for all payers in the state, including primary care and non-primary care providers.** Targets should be set by the Office of Health Strategy in coordination with its stakeholder advisory committee. Targets for payment reform adoption should be set with consideration for plan enrollment, geographic concentration of enrollment and current levels of adoption. Targets should be set using the "Alternative Payment Model" Framework established by the HCP-LAN (see page 7), and encourage more provider participation in Categories 3 and 4.

On an annual basis, commercial payers with a specified minimum number of covered lives and Medicaid should submit data to the Office of Health Strategy on their use of value-based payment models. The Office of Health Strategy should annually report on the progress each payer is making toward the value-based payment model targets. Any insurer that fails to meet the goal will be required to submit a public plan of correction to the Office of Health Strategy, identifying action steps being taken to come into full compliance with the targets. The diagram below outlines the HCP-LAN framework for categorizing alternative payment models.

HCP-LAN Framework for APMs



Source: https://hcp-lan.org/groups/apm-fpt/apm-framework/

III. Coordinate and Align State Strategies

~~3A. Create a Health Policy Council~~
3B. Create an Office of Health Strategy

~~3A &B~~. Coordinate and Align State Strategies

~~Strategy 3A: "Create a Health Policy Council" was not approved by the Cabinet.~~

Goal: Provide the infrastructure for coordinating and aligning state strategies across state agencies and with the private sector.

Recommendations: The legislature should ~~A) create a Health Policy Council which would report to the Governor and work to implement health care reform strategies in a coherent and~~

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~~consistent manner across the state and across all payers, and B)~~ create an~~d~~ Office of Health Strategy that would effectively develop and implement key components of the state's cost containment strategy.

Rationale: ~~Currently state agencies collaborate on numerous initiatives, such as reducing homelessness among Medicaid beneficiaries. However, there is no formal infrastructure for the agencies to develop shared priorities and strategic responses. To be effective in marshaling its resources to have maximum impact, there needs to be a clearly identified entity that is accountable for addressing health care delivery and cost issues in the state, through a Health Policy Council.~~

~~In a supporting manner,~~ T~~t~~he Office of Health Strategy would create the infrastructure necessary to implement key cost containment strategies, such as the cost growth ~~cap~~target, and provide an entity to be accountable for developing and implementing a coordinated state cost containment strategy. By having clear accountability, there is the opportunity to maximize state programs to drive cost saving initiatives within both the public and private sectors.

~~**A. Health Policy Council:** To implement health care purchasing and regulatory strategies in a coherent and consistent manner across Connecticut agencies, the Legislature should create a Health Policy Council which would report to the Governor. The Health Policy Council would be composed of the leaders of all health-related agencies, the Health Care Advocate, the Insurance Commissioner, the Comptroller, the Office of Health Strategy as well as the SIM PMO and Access Health CT Director. The Council's mission would be to coordinate the design and implementation of purchasing and regulatory strategies to manage spending on health care, as well as further other policy objectives related to population health, access and health care quality.~~

~~At the Council's discretion, representatives from the private sector, including leaders from key insurers, employers, and providers and consumer groups, may be invited to join internal Council meetings to assist with the development of coordinated and aligned strategies which are intended to be applicable to the private sector.~~

~~When considering new strategies, the Health Policy Council should obtain feedback from consumer advisory bodies, including but not limited to MAPOC and the SIM Consumer Advisory Board and obtain input from both consumers and consumer advocates. The goal is to create a coordinated process for hearing stakeholder input as aligned strategies are developed across the state.~~

~~The Council should meet on a regular and frequent basis to develop a health care vision for the State, to identify common cost drivers and to develop and implement coordinated responses.~~

~~B.~~ **Office of Health Strategy:** To effectively develop and implement key components of the state's cost control strategy, the Legislature should enact legislation to create an Office of Health Strategy that reports to the Governor and which would have seven key responsibilities:

1. Work with the ~~Health Policy Council and other~~ appropriate Task Forces, Councils, Cabinets, including those supported through the SIM project, and consumers, to develop a comprehensive and cohesive health care vision for the state.

2. Develop and implement the cost growth target, which will require close collaboration with CID, Medicaid, the Comptroller's Office and the agency implementing the CON and budget review processes.

3. Track and report on the progress all payers are making toward value-based payment, utilizing the HCP-LAN Alternative Payment Model framework as guidance.

4. Study and then, based on the results of the study, consider developing, as appropriate, other payment and delivery system reform models, including a global payment model that is based on the total cost of care paid by all payer. The Office of Health Strategy should study the feasibility of Connecticut implementing a rate-setting process based on a total cost of care model. In collaboration with the CID, it should also study whether and how consumer affordability can be incorporated into CID rate review process.

5. Create forums within state government[12] and with external stakeholders to discuss health care issues in a manner that develops trust and leads to the development of effective health care cost and quality strategies. The Healthcare Cabinet shall serve as an advisory board to the Office of Health Strategy. To assure effective stakeholder representation the Healthcare Cabinet should be modified in statue to more accurately reflect public and private health care stakeholders, including primary care physicians, integrated provider organizations, health plans, and long-term care providers. ~~for creating a stakeholder advisory board with representatives from consumers, providers, payers and employers, economists and health care policy experts.~~ The Office of Health Strategy ~~It~~ may also create or seek input from existing consumer input groups to obtain the views of health care consumers in the state, but specifically those insured through Medicaid, the state employee health benefit plan, and through commercial insurers. The goal is to create a coordinated process for hearing stakeholder input as aligned strategies are developed across the state.

6. Fulfill the requirements of section 19 of PA 15-146 to study the rising health care costs. Annually publish a report that reports compliance (or non-compliance) patterns, cost drivers, and recommendations for meeting the cost growth target, if it is not achieved. Every two years, report on price variation among Connecticut providers, including variation by most frequent and most high-cost services, and report on any changes since the prior report.

7. Initiate efforts to improve multi-payer alignment regarding delivery system and payment reform models, quality measurement and any other payment or delivery

[12] If the Cabinet recommends against creating a Health Policy Council, the Office of Health Strategy would be responsible for creating forums within state government to assist in the development of effective health care cost and quality strategies.

system reform strategies that benefit from consistency across payers. The Office of Health Strategy should work closely with SIM to accomplish these goals.

The OHS could be staffed by 5-6 individuals. The staff would consist of an (1) executive director ($150,000); (3-4) health care analysts ($100,000 each); and (1) administrative professional ($70,000). In addition, the Cabinet recommends the Office of Health Strategy have access to $200,000 additional funds for the purposes of procuring external outside expertise (e.g., that of an economist or consultant). The total annual budget is projected to be $820,000. Given the state fiscal crisis, the Cabinet recommends that $400,000 of the annual budget come from the reallocation of existing state staff who are qualified to support the Office of Health Strategy.

IV. Support Market Competition by Expanding the Attorney General's Powers to Monitor Health Care Market Trends

4. Support Market Competition by Expanding the Attorney General's Powers to Monitor Health Care Market Trends

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Goal: Give the Attorney General additional investigative and reporting powers to identify causes of cost increases that cannot be determined through publicly available data.

Recommendation: The legislature should give the Attorney General the necessary authority and funds to monitor health care market trends by collecting information from any provider, provider organization, private health care payer or public health care payer through document production, answering interrogatories and providing testimony under oath with regard to health care costs and cost trends , the factors that contribute to cost growth within the state's health care system and the relationship between provider costs and payer premium rates.

The Attorney General, in collaboration with the Office of Health Strategy, should be required by the legislature to hold a public hearing at which providers and representatives from provider organizations, private health care payers and public health care payers testify and answer questions regarding health care market trends, including but not limited to health care costs and cost trends , the factors that contribute to cost growth within the state's health care system and the relationship between provider costs and payer premium rates. Participants would also be expected to provide testimony regarding any specific topics identified in advance by the Attorney General or the Office of Health Strategy.

In anticipation of the annual public hearing, the Attorney General should be required by the legislature to publish a report on key topics relevant to health care market trends, such as, but not limited to: price disparities for health care services, relationship between price and quality of services provided, effectiveness of payment reform to reduce costs and improve quality, health service disparities by race and ethnicity, the behavioral health care market, and pharmaceutical costs. The report should detail the market practices that impact costs without identifying providers unless the practice is publicly known to be followed by a specific market place participant. For example, if a leading commercial payer was pursuing a total cost of care strategy with downside risk and publicly promoted this practice as a market differentiator, and the Attorney General chose to investigate the effectiveness of this contracting strategy on containing costs, the Attorney General could name the payer in its report, if it were important to the findings to do so.

The Attorney General, who currently has authority to challenge mergers and acquisitions under Connecticut's anti-trust laws, could use any of the information provided to pursue an anti-trust case, if illegalities were uncovered.

Rationale: The role of the Attorney General as investigator and reporter is one of the keys to assuring data and information transparency. While other state agencies have the authority to

collect and report on health care market trends, the Attorney General, as an independent office, would have the ability to investigate and report on politically-sensitive marketplace issues independently. Working with the Office of Health Strategy on an annual public hearing, the Attorney General's Office would help continually make these issues more transparent.

Once a new issue is disclosed and better understood because of the Attorney General's work, other state agencies would be in a better position to maintain on-going oversight by collecting and reporting on data similar to that initially collected and reported on by the Attorney General and by implementing strategy initiatives to address concerning practices. In this role, the Attorney General would serve as the state's investigative probe.

By working collaboratively with the Office of Health Strategy and other state agencies, the Attorney General would be 1) furthering the State's understanding of the underlying causes of health care cost increases, 2) providing information and policy recommendations for an aligned state health care policy and 3) working with other state agencies to systematize oversight of and transparency regarding important health care market issues.

Operational Considerations. To assure that the Attorney General was collecting appropriate data and correctly interpreting it, the Attorney General should seek consulting services from people with detailed familiarity with the Connecticut marketplace. Their expertise might include detailed understanding of network contracting, clinical quality measurement, financial analysis, actuarial analysis, health care economics, pharmaceutical pricing, data analysis, and behavioral health service delivery. The specific expertise needed might vary with the specific market practice or market segment under investigation.

By producing an annual report and by participating in an annual public hearing, the Attorney General should be held accountable publicly, and unable to pursue "fishing expeditions." Moreover, the areas of inquiry should be guided by outside experts with in-depth knowledge of the Connecticut health care marketplace.

Cost: The Attorney General will need to determine what personnel resources its office requires to fulfill this requirement, and the legislature would need to appropriate such funds. Based on the experience in Massachusetts the funding for additional consulting services is between $200,000 and $500,000, depending on the areas of investigation the office wishes to pursue.

V. Support Provider Transformation

5A. Augment Existing Funds and Programs to Support Provider Transformation through Applying for Federal DSRIP Funds
5B. Support Provider Transformation through Existing Funds and Programs

5A. Augment Existing Funds and Programs to Support Provider Transformation Through Applying for Federal DSRIP Funds

Goal of Strategy: Implementing delivery system reform in a manner that improves health care and reduces costs requires significant upfront provider investment to support new technology, technical assistance and ongoing learning for providers. This strategy would provide frontline providers the needed technical support and financial investment to change and improve their care delivery models and thereby be more effective under new value-based payment models.

Recommendation: Provide new capital and support to continue the acceleration of practices achieving improved health outcomes efficiently, while reducing the growth of health care spending. The State should study and then seriously consider pursuinge a five-year Delivery System Reform Incentive Payment (DSRIP) program that would allow the State to access new federal funds for Medicaid provider infrastructure development, system redesign, clinical outcome improvements and population-focused improvements. Funds to providers are tied to meeting state-defined milestones and metrics. These funds would augment the existing funds available through DSS's Person Centered-Medical Home Program, the Electronic Health Record Incentive Program, the Behavioral Health Homes, and the SIM program.

Rationale: The rapid transformation of the health care system from episodic care to a value-based payment system that is cost-effective requires providers to deliver health care in a new manner, utilize new technology (e.g., population health analytic tools and electronic medical records), and hire new staff (e.g., care managers, community health workers). Providers need financial and technical support to build required infrastructure.

CMS is providing states with significant funding through DSRIP programs to support Medicaid provider transformation. To date, individual states have received between $34 million and $6.5 billion in support.[13] Utilizing an 1115 Waiver, states negotiate special terms and conditions which outline key design elements for DSRIP programs and provide a conceptual framework, including performance reporting and outcome requirements. All DSRIP programs intend to achieve the Triple Aim. Participating provider organizations earn DSRIP incentive payments by demonstrating implementation of projects or development of infrastructure that focus on management of health and wellness for a designated population. Each state's DSRIP program reflects its own Medicaid program and delivery system needs and a state-defined strategy.

Connecticut could use the funds to support provider engagement in any existing delivery system reform initiative, or Health Care Cabinet proposed initiative, including to assist providers in transforming into CCOs. It could also assist providers through programs that DSS

[13] Delivery System Reform Incentive Payment (DSRIP): State Program Tracking. Center for Health Care Strategies, Inc. October 2016. www.chcs.org/media/DSRIP-State-Program-Tracking-102016-FINAL.pdf

is considering, including for community reintegration of justice-involved individuals, or health homes for children with complex trauma.

Operational Considerations: In order to pursue a DSRIP program, selected state staff would need to be dedicated to the operations of developing and applying for an 1115 Waiver and developing a proposal for a DSRIP program. The state staff should come under the direction of DSS leadership.

When developing a proposal for an 1115 Waiver and DSRIP program, the State should be inclusive and transparent, allowing for stakeholder input in the design of the program and the source of the state matching funds. DSRIP programs require the State to identify funds that the federal government would match to make up the incentive payments that are distributed to providers. States have identified many different sources of matching funds, including state general revenue, designated state health programs, intergovernmental transfers from public entities, and provider taxes. Connecticut would first need to identify a source (or sources) of revenues to receive matching funds, and should build into the proposal, like many states have, that a portion of the DSRIP funds go to the state to administer the program.

Designing a DSRIP Program: DSRIP programs across the country are focusing on issues that are most important to their Medicaid program, including behavioral health integration, electronic medical record adoption, workforce development, community integration of justice-involved individuals, improving care for foster children, and general infrastructure development for providers to participate in delivery and payment system reform, to name a few. DSS should consider building upon the SIM CCIP Transformation Awards to support activities including social determinant assessments, care coordination, community support connections, health technology investment and data integration for population health analytics.

For example, Washington recently announced that it will receive $1.125 billion from the federal government for its DSRIP program focused on health systems capacity building (e.g., workforce development, system infrastructure technology and tools), care delivery redesign (e.g., integrated physical and behavioral health care services, recovery support), and prevention and health promotion.

Mitigating Risk of an 1115 Waiver: DSRIP funding can only be obtained through an 1115 Waiver. Stakeholder concerns have been raised about how 1115 Waivers have been proposed in other states, and that waivers must be budget neutral to the federal government. To mitigate these concerns, when developing the 1115 Waiver to request DSRIP program funds, the State should ensure the Waiver not reduce services, scope of the program or eligibility. Specifically, the 1115 Waiver should not institute premium assistance vouchers, eliminate benefits, waive retroactive eligibility, place premiums and copayments on the near-poor or poor, lock beneficiaries out for nonpayment of premiums, institute work requirements, place lifetime limits on coverage, eliminate wraparound benefits for children or restrict family planning care.

Regarding budget neutrality, over the course of the Waiver, federal Medicaid expenditures must not be greater than they would have been without the Waiver. Medicaid programs can accomplish this in one of two ways. First, budget neutrality can be achieved by reducing state costs, which Connecticut is actively pursuing, including via initiatives described in strategy 1B

"Build on the SIM Agenda and Current Success in the Medicaid Program." In addition, the Health Care Cabinet is considering numerous other cost savings strategies. Second, states may reallocate funds. For example, Colorado, is proposing to utilize existing hospital provider fees and repurposing them for use in a DSRIP program, and thereby not need to offset new federal money with cost savings.

5B. Support Provider Transformation through Existing Financial Support Programs

Goal of Strategy: In recognition that implementing delivery system reform in a manner that improves health care and reduces costs is very difficult for providers, provide them with financial, infrastructure and technical support needed to change their care delivery models

Recommendation: Continue to utilize existing financial support programs to assist providers with delivery system reforms, including through existing support available through the Person-Centered Medical Home program, the electronic health record incentive program, Behavioral Health Homes and the SIM programs.

Rationale: Providers across the country, and the State of Connecticut, are moving toward new delivery system and payment reform models by federal, state and commercial payers. This rapid transformation of the health care system requires providers to deliver health care in a new manner, utilize new technology (e.g., population health analytic tools and electronic medical records), and hire new staff (e.g., care managers, community health workers). Providers need financial and technical support to operate in this new manner.

Description of Current Financial Support for Provider Transformation Activities:

DSS's Person-Centered Medical Home Program (PCMH)
DSS' PCMH initiative supports eligible primary care practices (independent private practices and hospital-based outpatient clinics) with:

- a "glide path" and no-cost multi-disciplinary coaching to enable practices to become recognized, and to renew recognition, as NCQA or JCAHO medical homes;
- enhanced fee-for-service payments, both during an 18-24 month "glide path" as practices work toward recognition, and ongoing after recognition is received; and
- for practices that achieve recognition, performance and year-over-year improvement payments that are based on quality measures.

The PCMH initiative also provides no-cost multi-disciplinary practice coaching to Federally Qualified Health Centers, in support of their recognition as medical homes by NCQA or JCAHO.

DSS' medical Administrative Services Organization (ASO), the Community Health Network of Connecticut, Inc. (CHN-CT), provides the multi-disciplinary coaching. Coaching is led by a Community Practice Transformation Specialist, in consultation with a team that includes clinical, administrative and legal expertise.

Practices receive enhanced FFS payments[14] for 18-24 months while practices are working toward achieving recognition, and enhanced FFS ongoing when practices are recognized by NCQA at Levels 2 or 3.

Additionally, practices recognized at NCQA Levels 2 or 3 are eligible for performance and year-over-year improvement payments based on quality measures. These quality measures were adopted in common with those used by the State Employee Health Plan. See this link for the involved measures:
www.huskyhealthct.org/pathways_pcmh/pcmh_postings/PCMH_Quality_Performance_Measures_2016.pdf

See this link for information on the performance and improvement payments:
www.huskyhealthct.org/pathways_pcmh/pcmh_postings/PCMH_Performance-Based_Payment_Program.pdf

These payments make the PCMH program a Learning and Action Network (LAN) Category 2C Alternative Payment Model (APM) (fee-for-service with rewards for performance).

As of October, 2016, 108 practices (affiliated with 435 sites and 1,518 providers) were participating in the DSS PCMH Program, serving 328,169 beneficiaries (over 43% of Medicaid members).

DSS's Electronic Health Record Incentive Program
The Medicaid EHR Incentive Program provides financial incentive payments for Medicaid participating physicians, dentists, nurse practitioners, and certified nurse-midwives to adopt and use certified electronic technology. DSS administers the program with federal support from CMS. Eligible providers[15] may be entitled up to $63,750 in incentive payments over a six-year period for participating in the program. The incentive payment is a fixed amount each year for adoption, implementation or upgrading to a certified EHR technology system. Payments in subsequent years are $8,500.

DMHAS's Behavioral Health Homes
DMHAS invested $9,000,000 in 14 designated Behavioral Health providers to enable them to hire diverse staff with medical knowledge and expertise to augment existing traditional behavioral health staff. Together, the Behavioral Health Home (BHH) team works with individuals with a diagnosis of severe mental health and co-occurring medical conditions, a traditionally underserved population. An additional $1,000,000 financed an Administrative Services Organization to provide technical support and assistance to designated providers as they expand their expertise to work with the "whole" person. There is an enhanced FMAP 90% for the first 8 quarters, which reverts to 50% thereafter. The project is initially front-loaded by grant dollars, although payment methodology may transform over time. There are very specific

[14] FQHCs are not eligible for enhanced FFS payments.
[15] To be eligible a Medicaid provider must have 30% or more Medicaid patient volume, or 20% for pediatricians, are not hospital-based, and are in good standing with the state and federal government agencies.

outcome measures attached to the project, some required by CMS, such as reducing hospital readmissions and others specific to Connecticut, such as increasing the number of tobacco users who received cessation intervention.

SIM's Advanced Medical Home Initiative (AMH)
As part of the overall SIM grant, funds were made available so that primary care practices were able to receive free transformation services offered by Qualidigm and Planetree. Services included interactive learning collaborative, practices facilitation visits, and a variety of evidence-based quality improvement interventions.

SIM's Community and Clinical Integration Program (CCIP)
As part of the overall SIM grant, $5.5 million dollars has been devoted to providing technical assistance, peer learning support and financial awards to Medicaid providers that are participating in the PCMH+ initiative to help them achieve best practice standards in improving care for individuals with complex health needs, introduce new care processes to reduce health equity gaps, and to improve access to and integration of behavioral health services. Technical assistance will also be provided on e-consults, comprehensive medication management, and oral health integration. SIM funded technical assistance and peer learning support in the form of a learning collaborative are the primary means by which organizations will be supported in achieving the these best practice standards. In addition, awards of up to $500,000 will also be made available to CCIP participants to help support the costs associated with working toward achievement of the standards.

VI. Support Policy Makers with Data

6. Support Policy Makers with Data

6. Support Policy Makers with Data

Goal of Strategy: Build the data and clinical information infrastructure necessary to support delivery system and payment reform at the provider level and to inform good state policy-making.

Recommendations: Ensure that the Health Information Technology Officer equips the Office of Health Strategy with data necessary to fulfill the requirements of section 19 of PA 15-146 to examine the health care cost trends in the state, and to appropriately set the cost growth targets.

Public Act 16-77 called for the development of a statewide HIE, and for the Lieutenant Governor to designate an individual to serve as the Health Information Technology Officer (HITO), responsible for coordinating all state health information technology initiatives, including overseeing the development and implementation of the statewide HIE, which would support providers with data. The HITO should be required to work with the Office of Health Strategy to ensure that the Office of Health Strategy has the data necessary to examine the health care cost trends in the state, and to appropriately set the cost growth targets.

Rationale: Data are essential for the State to make informed policy decisions, set strategy, and track progress toward goals of health care reform. Given the State is actively pursuing the completion of its APCD and the building of its HIE, this recommendation is focused on how those data can be used to inform the health care reform policy agenda, and is solely focused on ensuring the Office of Health Strategy can complete its recommended work.

VII. Incorporate Use of Evidence into State Policy Making

7. Incorporate Use of Evidence into State Policy Making

7. Incorporate Use of Evidence into State Policy Making

Goal of Strategy: Incorporate the use of comparative effectiveness evidence into policy making decisions to reduce overuse and misuse of health care services.

Recommendations: The Department of Social Services and the Office of the State Comptroller should access outside resources through a new Health Technology Assessment Committee to review and incorporate comparative effectiveness research into policy making and coverage decisions in an effort to reduce unnecessary and costly services.

Rationale: Research indicates that overuse and misuse of health care services are costly problems deserving of attention for both quality of care and cost concerns. Experts estimate that perhaps one-third of all U.S. health care spending produces no benefit to the patient – and some of it produces clear harm.[4] For example, unexplained variation in the use and intensity of end-of-life care, CABG surgery and angioplasty may cost the health care system approximately $600 billion a year in avoidable costs.[5] Angioplasty is inappropriate in about 1 in 10 patients according to experts, and another third may be questionable.[6] Misuse of drugs and treatments may cost $52.2 billion and overuse of antibiotics for respiratory infections may cost $1.1 billion.[7] Use of double CT scans, a common practice in some hospitals, can unnecessarily expose patients to radiation equal to that of about 350 x-rays.[8]

Operational Considerations. A state Health Technology Assessment Committee to be should be formed within the Department of Public Health to determine the safety and effectiveness of medical devices, procedures and tests and make their recommendations to DSS and the Office of the State Comptroller.

Unless appropriated, the Health Technology Assessment Committee should not conduct de novo research, but instead leverage the work of well-established medical evidence review organizations, such as the federal Agency for Healthcare Research and Quality (AHRQ), England's National Institute for Health and Care Excellence and the Scottish Intercollegiate Guidelines Network. Two of the most long-standing, collaborative state efforts to reduce overuse and misuse include the Medicaid Evidence-based Decisions (MED) Project and the Drug Effectiveness Review Project (DERP), both operated out of the Oregon Health and Science University's Center for Evidence-Based Policy, for which participating states pay dues. These two multi-state efforts use comparative effectiveness research to answer policy-related research questions and inform benefit coverage considerations with a particular focus on state Medicaid programs. Currently, 19 states are participating in the MED program and 13 states participate in the DERP. Most, but not all, of the involved states participate in both. Connecticut is not participating in either.

The Health Technology Assessment Committee could review the guidelines and research from these external organizations, if they become members, and use that information to make a recommendation regarding under what circumstances and for what conditions the service would be a covered benefit for the respective beneficiaries, or whether a drug should be on the

preferred drug list. Careful consideration, however, should be given to limitations of comparative effectiveness research, in particular when research does not adequately study the impact of a service or drug on specific subpopulations or if the analysis does not adequately cover alternative treatment options.

Stakeholder Input. The state Health Technology Assessment Committee should conduct these reviews in a public manner, with ample input from stakeholders, including consumers. Consumers and other stakeholders should be allowed to make suggestions on what services or drugs should be reviewed. In addition, consumers and stakeholder feedback on the impact on removing any covered benefits or prescription drugs from the preferred drug list should be considered before any final policy decision is made.