State Innovation Model Operational Plan

State of Connecticut

August 1, 2016

SIM connecticut state innovation model

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Acronyms

ACO Accountable Care Organization

ACH Accountable Communities for Health

AHCT Access Health CT

AMH Advanced Medical Home

AN Advanced Network

APCD All-Payers Claims Database

ASO Administrative Services Organization

BRFSS Behavioral Risk Factor Surveillance System

CAB Consumer Advisory Board

CCIP Clinical & Community Integration Program

CDC Center for Disease Control and Prevention

CHW Community Health Worker

CMC Care Management Committee

CMMI Center for Medicare & Medicaid Innovations

CMS Centers for Medicare and Medicaid Services

CTG Community Transformation Grant

DMHAS Department of Mental Health and Addiction Services (CT)

DPH Department of Public Health (CT)

DSS Department of Social Services

EAC Equity and Access Council

EHR Electronic Health Record

FQHC Federally Qualified Health Center

HEC Health Enhancement Community

HIE Health Information Exchange

HISC Healthcare Innovation Steering Committee

HIT Health Information Technology

HPA Health Program Assistant

ICM Intensive Care Management

LC Learning Collaborative

MAPOC Medical Assistance Program Oversight Council

PCMH+ Person Centered Medical Home +

MSSP Medicare Shared Savings Program

NCQA National Committee for Quality Assurance

NQF National Quality Forum

OSC Office of the State Comptroller

PCMH Patient Centered Medical Home

PCP Primary care provider

PIP Pre-implementation period (SIM grant)

PMO Program Management Office (SIM)

PSC Prevention Service Center

PTTF Practice Transformation Task Force

PY1-3 Performance year 1-3 (SIM grant)

QC Quality Council

RFP Request for Proposals

SIM State Innovation Model

SSP Shared Savings Program

TA Technical Assistance

VBID Value-based Insurance Design

VBP Value-based payment

A. Project Summary

1. Connecticut State Innovation Model Project Summary

The State Innovation Model (SIM) program is a Center for Medicare & Medicaid Innovation (CMMI) initiative to support the development and implementation of state-led, multi-payer healthcare payment and service delivery model reforms that will promote healthier people, better care, and smarter spending in participating states. As part of this program, Connecticut released its State Healthcare Innovation Plan (SHIP) articulating a shared vision to transform healthcare:

Vision: *Establish a whole-person-centered healthcare system that improves community health and eliminates health inequities; ensures superior access, quality, and care experience; empowers individuals to actively participate in their health and health care; and improves affordability by reducing healthcare costs.*

In 2014 Connecticut received a $45 million State Innovation Model (SIM) grant from CMMI to implement its plan for achieving this vision over a four year period (2015-2019).

Improve Population Health

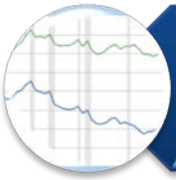
Reduce the statewide rates of diabetes, obesity, and tobacco use

Despite the resources Connecticut devotes to healthcare, consumers often face an uncoordinated and fragmented system. This system does not consistently perform well, as is witnessed by our high emergency department utilization rates, especially for preventable conditions; high hospital readmissions rates and; significant racial, ethnic and economic health disparities.

Improve Health Care Outcomes

Improve performance on key quality measures, including preventative care and care experience

In addition, growth in healthcare spending has outpaced the growth of our economy. In 2012, healthcare spending in Connecticut was $29 billion, the third highest per capita among all states. These outcomes raise concerns about access to care and the long-term affordability of healthcare coverage. High healthcare costs also strain the resources available for other governmental programs such as education and housing, and threaten the ability of government to sustain social services and Medicaid benefits. Increasingly, employers pass on the costs of insurance to employees and customers; and the competitiveness of Connecticut's business community is endangered.



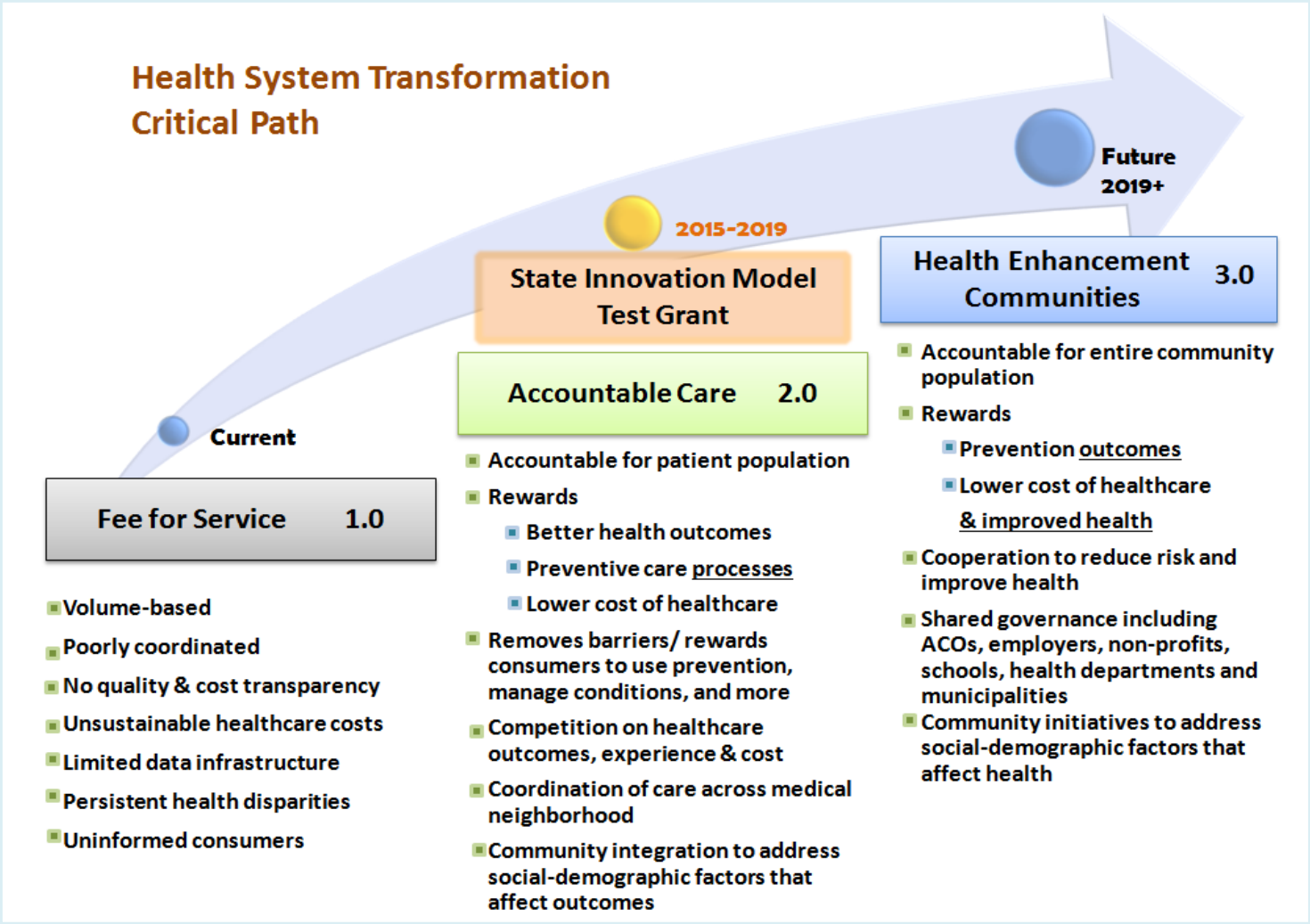
Promote Health Equity

Close the health disparity gap between the highest and lowest achieving populations for key quality measures

Reduce Healthcare Costs

Achieve a 1-2% reduction in the annual rate of healthcare growth

Connecticut's SIM moves Connecticut's health care system along a path of transformation:



Connecticut's SIM proposes a multi-pronged strategy to transform Connecticut's healthcare system for the majority of residents. We promote a transition away from paying for volume of services towards payments based on whether people receive care that leads to better healthcare and lower growth in costs. We will provide technical assistance and supports to healthcare providers that want to succeed in these new payment models, so that they can connect individuals to community and behavioral supports, deploy community health workers, use data to track and improve their performance, and more.

Simultaneously, we will engage consumers by promoting insurance plans that remove financial barriers to, or introduce rewards for preventive care, medication adherence, chronic disease management, and high-quality provider selection. Lastly, we will create a Population Health Plan that combines innovations in clinical healthcare delivery, payment reform, and population health strategies to improve health as a community approach, rather than one focused solely on patient panels.

Connecticut intends to continue these efforts beyond the Model Test period. By 2020 CT will achieve goals that include:

- **Improved rates of diabetes, obesity, and tobacco use, with reduced health disparities.**
- **Improved health care outcomes on measures including preventable ED admissions, hospital readmissions, cancer screenings, cardiovascular deaths, diabetes care, child well-visits and others; with reduced health disparities.**
- **88% of the Connecticut population goes to a healthcare provider that is accountable for quality and total cost of care (SSP Models).**
- **1,364 providers in 16 Advanced Networks & 1 Federally Qualified Health Center, and 300 primary care practices undergo a transformation program to improve care delivery.**
- **87% of the commercially insured population has a value-based insurance plan that removes financial barriers/has rewards for preventative care, chronic condition management, and more.**

Connecticut's SIM is being implemented with a broad array of stakeholder involvement and input. The Lieutenant Governor provides overall leadership and oversight for SIM. SIM initiatives are being executed in collaboration by multiple agencies and organizations: Department of Social Services (DSS), Department of Public Health (DPH), Office of the State Comptroller (OSC), Access Health Connecticut (AHCT), and UConn Health. The SIM Program Management Office (PMO), within the Office of the Healthcare Advocate (OHA), is leading implementation, coordinating efforts with key partners and executing select initiatives directly.

In addition, SIM is engaging more than 150 stakeholders through a number of advisory groups that focus on particular components of SIM such as health information technology, quality measurement, and practice transformation. These work groups are comprised of consumers, employers, healthcare providers, community organizations, and subject matter experts. Our Model Test also includes the participation of all seven of Connecticut's commercial payers, Medicare and Medicaid.

Our Operational Plan outlines the strategy that we will execute over the next three years of the SIM test grant, with a focus on the next performance year (October 1, 2016 – September 30, 2017). This document is consistent with the approach set forth in our Test Grant Application and is supplemented with plans developed since the application was submitted. It outlines model goals, supporting strategies, accountability targets, and allocation of funding among project components. This Operational Plan will govern the business relationship between Connecticut and CMMI, and establish accountability for proposed strategies. Based on feedback from the recent CMMI site visit, the PMO is meeting with key work stream leads to further evolve our proposed strategies to optimize alignment in support of three to five target conditions/populations priorities. While each work stream will retain a broader strategy, we will seek to ensure that each work stream specifically enable improvement in these target areas, better deploy resources, and reduce provider/stakeholder burden.

2. Driver Diagram

Connecticut is striving to achieve challenging yet attainable goals for population health, healthcare outcomes, health equity and cost reduction. The grant is also meant to accelerate state-wide transformation efforts towards value-driven and sustainable models in healthcare. Achieving our goals requires a multi-faceted approach with multiple interventions being leveraged at once to impact the majority of those living in Connecticut. Instead of applying singular reforms or interventions, we apply multiple levers simultaneously to drive change, such as changes to payment incentives, healthcare delivery standards, consumer-driven reforms, health information technology infrastructure, and regulatory levers.

Although SIM funds support many initiatives directly, we also coordinate with other major initiatives such as the Medicare Shared Savings Program (SSP), the Department of Social Services' person-centered medical home (PCMH) and administrative service organization (ASO) initiatives, and the CMMI funded Practice Transformation Network (PTN) initiative.

A *Driver Diagram* was developed to illustrate how SIM initiatives connect with one another and our hypothesis about which drivers will enable us to achieve our aims. The diagram also creates the high-level framework that guides this Operational Plan.

Our Driver Diagram reflects principles and strategies identified in the 2013 Connecticut State Healthcare Innovation Plan, as well as the refinements and new plans developed since then in collaboration with our key partners. The diagram provides a shared vision of our scope of work. It illustrates where we are focusing our interventions and which targets we use for monitoring our progress. It will remain an iterative document, requiring updates as lessons are learned and milestones are met.

Please see Driver Diagram on the next page.

Exhibit: State Innovation Model Driver Diagram

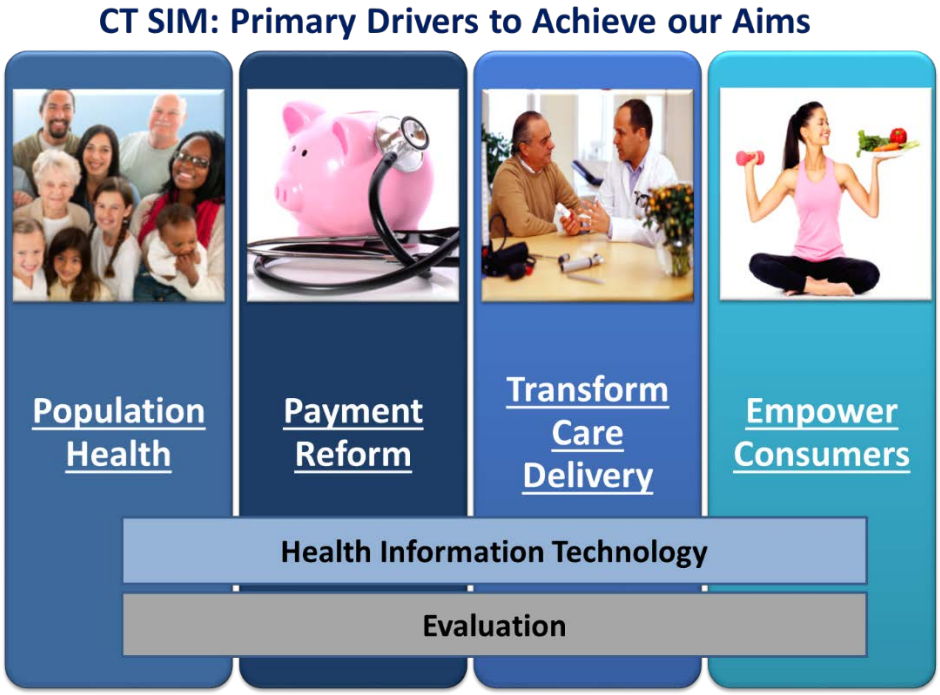
Aim	*Primary Driver*	*Secondary Driver*	*Accountability Target*
By 6/30/2020 Connecticut will: **Healthier People While Promoting Health Equity** Reduce statewide rates of diabetes, obesity, and tobacco use **Better Care While Promoting Health Equity** Improve performance on key quality measures, increase preventative care and consumer experience, and increase the proportion of providers meeting quality scorecard targets **Reduce Healthcare Costs** 1-2% percentage point reduction in annual healthcare spending growth	Promote policy, systems, & environmental changes, while addressing **socioeconomic factors that impact health**	**Engage** local and state health, government, and community stakeholders to produce a population health plan	• Develop Population Health Assessment by Q1 PY1 • Develop Population health plan by Q4 PY1 (to include community health measures and PSC detailed design)
		Identify **reliable & valid measures** of community health improvement	• Community health measures identified for target communities by Q1 PY1
		Develop detailed design for Health Enhancement Communities (HECs) and Prevention Service Centers (PSC)s that include financial incentive model to reward communities for health improvement	• Updated Pop Health Plan that includes HEC detailed design by Q4 PY3
		Build community structures and capabilities to improve health	• Demonstration for 2-3 PSCs launched by Q1 PY3 • Launch 1-2 HECs in 2019 (outside of grant period)
	Engage consumers in healthy lifestyles, preventive care, chronic illness self-management, and healthcare decisions	Promote the use of **Value-Based Insurance Designs (VBID)** that Incentivize healthy choices by engaging employers and others	• 87% of insured population in a VBID health plan by 2020 • Introduce VBID prototypes & learning collaborative Q1 PY1
		Provide transparency on cost and quality by creating a public **common scorecard** to report provider performance, and deploying CAHPs	• Public provider scorecard launched Q4, PY1 • Conduct cross-payer care experience survey linked to value-based payment for commercial/Medicaid payers – Q1 PY1
		Hold public meetings, focus groups, listening tours, and other outreach strategies for healthcare consumers	• Twelve public meetings held by Q4, PY3
		Support **data analytics** and deploy **HIT tools** that engage consumers	• Deploy mobile applications by Q4, PY3
	Promote payment models that reward improved quality, care experience, health equity and lower cost	All payers in CT use financial incentives to reward improved quality and reduced cost: launch **Medicaid Quality Improvement & Shared Savings Program** (PCMH+)	• 89% of Medicaid beneficiaries in Medicaid Quality Improvement & Shared Savings Program (PCMH+) by 2020
		Engage payers to increase proportion of CT population with a primary care provider responsible for quality and total cost of care	• 88% of CT population goes to a primary care provider responsible for the quality and cost of their care by 2020
		Recommend a statewide multi-payer **core quality measure set** for use in value-based payment models to promote quality measure alignment	• Increase alignment on core quality measures by 2019
		Support **data analytics** and deploy **HIT tools**, including a multi-payer solution for the extraction, integration, and reporting of eCQMs	• Implement health information technology solution to produce EHR-based, outcome, health equity measures – Q4 PY2
	Strengthen capabilities of Advanced Networks and FHQCs to delivery higher quality, better coordinated, community integrated and more efficient care	**Community & Clinical Integration Program (CCIP):** Provide technical assistance & awards to PCMH+ participating entities to achieve best-practice standards in: comprehensive care management; health equity improvement; & behavioral health integration	• 1,364 providers participate in CCIP by Q4 PY3
		Promote use of Community Health Workers (CHWs) through developing policy framework, outreach, and toolkit	• Develop a policy framework for the CHW workforce (by Q4, PY1) and toolkit for utilization (by Q3 PY2), & then implement
		Establish a statewide **health information exchange**	• Phase in operations of statewide HIE by Q1 PY2
		Coordinate HIT initiatives & execute broad stakeholder engagement	• Complete HIT stakeholder engagement by Q3 PY1
		Establish infrastructure for sending **alerts** to providers and caregivers	• Deploy alert notification system with PCMH+ Q4 PY1
		Advanced Medical Home (AMH) Program: Provide support to primary care practices, within PCMH+ participating entities, that are not medical homes, to become AMHs	• 300 primary care practices become Advanced Medical Homes (AMH) by 2019

Logical Flow

The Driver Diagram identifies the following: *project aims, primary drivers, secondary drivers, and accountability targets*.

The ***aims*** are the overall goals of our work. We strive to achieve the "Triple Aim" of healthier people, better care, and smarter spending. However, improving health and healthcare performance can be accomplished without reducing the significant healthcare disparities that exist in our state. For this reason we emphasize closing healthcare disparity gaps within each of our aims of better health and better care. All of our measures will be tracked for the entire state population by our evaluation team. More detail about measures and project evaluation is provided in Section A.3. Core Progress Metrics and Accountability Targets and Section C.6. Program Monitoring and Reporting.

The four ***primary drivers*** are those higher level categories of activity that contribute directly to achieving our aims:



Secondary drivers are those lower-level actions or interventions necessary to achieve the primary drivers. These work streams contribute to one or more of the primary drivers. Many of these activities overlap and are not meant to be implemented in silos. For example, the Community & Clinical Integration Program (CCIP) targets the same healthcare entities as the Medicaid Person Centered Medical Home + (PCMH+) program. Similarly, some of the work streams may have a targeted population focus, but many are statewide.

Accountability targets have been set for all of the drivers and serve as milestones for the work. These accountability targets will be updated as the transformation work unfolds, milestones are reached and new targets are set. Targets may be further developed to reflect target conditions/populations that are a focus of cross-work stream alignment.

3. Core Progress Metrics and Accountability Targets

The SIM has identified key core metrics that will be used to track progress towards goals under SIM, identify trends in progress, potential best practices and critical gaps, and barriers to implementation. Measures are grouped into two categories: "Performance measures" are measures that measure progress toward our aims or the impact of our model on the state's population. "Pace measures" represent measures that are process oriented and track milestones such as percentage of beneficiaries impacted by and providers participating in reforms.

The following performance measures will monitor the impact of the proposed model:

- **Improve population health:** Reduce statewide rates of diabetes, obesity, and tobacco use while reducing **health disparities**
- **Improve healthcare outcomes:** Improve statewide performance on key quality measures, including: adults with a regular source of care; ambulatory care sensitive condition admissions; child well-visits for at-risk populations; mammograms for women ages 50+; colorectal screening; optimal diabetes care- annual A1c tests ; asthma ED utilization; percent of adults with hypertension taking hypertension medication; all-condition readmissions; and premature deaths. Improve quality of care while reducing **health disparities** on key measures.
- **Reduce healthcare costs:** 1-2% percentage point reduction in annual healthcare spending growth.

The following pace of reform metrics will also be tracked:

- **Shared Savings Program:** Provider and beneficiary participation in Shared Savings Programs in Connecticut.
- **Person Centered Medical Home+:** Provider and beneficiary participation in the new Medicaid shared savings model.
- **Community and Clinical Integration Program:** Provider penetration in CCIP.
- **Advanced Medical Home Glide Path Program** - Provider participation in AMH model.
- **Value-Based Insurance Design:** Beneficiary participation in VBID

SIM Component	Test Grant Pace Targets
SSP	• 88% of insured population participates in any SSP by 2020 (including Medicaid, Medicare, and commercial SSP) • 5753 PCPs participate in any SSP by 2020
PCMH+	• 89% of Medicaid beneficiaries in PCMH+ by 2020. • 2072 PCPs in 14 FQHCs and 16 Advanced Networks in PCMH+ by 2020.
Community and Clinical Integration Program	1,364 providers participate in CCIP by Q4 2018
Advanced Medical Home Program	300 non-medical homes become AMH practices by 2019
Value-Based Insurance Design	84% of insured population is in a VBID plan by 2020

For complete information on performance and pace measure specifics, benchmarks, data sources, and exact targets please see Section C.6. Program Monitoring and Reporting.

4. Master Timeline for SIM

The following Master Timeline provides an overview of the rollout of SIM components over the three year performance period. It also includes a Project Lead, who will lead the implementation of the activity, identify risks and issues, and track progress towards milestones. This is meant to serve as a high level guide. More detailed and complete operational components can be found in **Appendix F: Operational Components.**

The SIM test grant funds activities from February 2015 to September 30, 2019. A pre-implementation period (PIP) from February 2015 to September 30, 2016 is not included in the Master Timeline. During the PIP additional planning details were developed, councils were established, and select implementation activities took place. The timeline focuses on the three performance years of the grant:

- The first performance year (PY1) runs from October 1, 2016 – September 30, 2017.
- The second performance year (PY2) runs from October 1, 2017 – September 30, 2018.
- The final performance year (PY3) runs from October 1, 2018 – September 30, 2019.

Please note that test grant quarters do not line up with calendar year quarters. Quarter one of the test grant begins on October 1st of each year.

The reforms in the Connecticut SIM are intended to be transformative and sustainable past the test grant period. Therefore, many metrics have a goal set beyond the test grant period.

Table 1: Master Timeline Gantt Chart for Performance Years 2016-2019

Master Timeline Gantt Chart for Performance Years 2016-2019														
SIM Component/Project Area	Component/Project Lead	Performance Year 1 2016-2017				Performance Year 2 2017-2018				Performance Year 3 2018-2019				Milestone(s) with Due Dates
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Plan for Improving Population Health														
Identify funding options & federal authority to support PSCs and HECs	HPA													9/30/2018
Conduct statewide scan to identify entities that can provide prevention services	HPA													1/31/2017
Establish community health improvement measures, gather data, conduct analyses, and set improvement targets	Anitha Nair													4/30/2018
Design PSCs	Mario Garcia													9/30/2017
PSC demonstration	DPH SIM Staff, Pop. Health Council & PSC Stakeholders													PY3, Q1
Develop detailed design and designation standard for HECs	See above													PY3, Q4
Medicaid QISSP (PCMH+)														
Develop & execute provider contracts with common performance measures	DSS and Mercer													PY1, Q1
Go live with Wave 1	DSS and Mercer													PY1, Q2 (1/1/2017)
Update performance measures and SSP requirements	DSS and Mercer													PY2, Q1
Develop Wave 2 RFP for provider entry	DSS and Mercer													PY2, Q1

Master Timeline Gantt Chart for Performance Years 2016-2019														
SIM Component/Project Area	Component/Project Lead	Performance Year 1 2016-2017				Performance Year 2 2017-2018				Performance Year 3 2018-2019				Milestone(s) with Due Dates
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Go live with Wave 2	DSS and Mercer													PY2, Q2 (1/1/2018)
Under-service monitoring	DSS and Mercer													PY1 Q2-Ongoing
Coordinate evaluation, data monitoring, and contract monitoring	DSS and Mercer													PY1 Q2-Ongoing
Advanced Medical Home Program														
Enroll practices from ANs for Wave 1	Shiu-Yu Kettering (PMO), Care Delivery Reform Lead (TBH)													PY1, Q1
Wave 1: Provide transformation support	See above													PY1, Q1
Enroll practices from ANs for Wave 2	See above													PY1, Q3
Wave 2: Provide transformation support	See above													PY2, Q1
Clinical & Community Integration Program														
Enroll practices from ANs & FQHCs for Wave 1	Mark Schaefer (MS), Faina Dookh (FD) (PMO)													PY1, Q1
Provide transformation support for Wave 1 participants	See above													Begin support PY1, Q1
Enroll ANs & FQHCs for Wave 2	See above													PY2, Q1
Provide transformation support for Wave 2 participants	See above													Begin support PY2, Q2

Master Timeline Gantt Chart for Performance Years 2016-2019														
SIM Component/Project Area	Component/Project Lead	Performance Year 1 2016-2017				Performance Year 2 2017-2018				Performance Year 3 2018-2019				Milestone(s) with Due Dates
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Complete evaluation report														Due 9/30/19
CCIP Transformation Awards														
Wave 1 Performance Period: Core Transformation Activities Occur	MS, FD (PMO)													PY1 Q2
Wave 2 Performance Period: Core Transformation Activities Occur	**See Above**													
Health Information Technology														
Establish HIT PMO	HITO (TBH)													PY1, Q1
Stakeholder Engagement/ HIT Landscape Assessment	HITO (TBH)													PY1, Q3
HIE RFP Process and Operations	HITO (TBH)													PY2, Q1
HIE Implementation	HITO (TBH)													Ongoing
Alert Notification	HITO (TBH)/ DSS													PY1, Q4
Support data analytics and deployment of health IT Tools (e.g. mobile apps, edge servers)	HITO (TBH)/ DSS													Ongoing
Value-Based Insurance Design (VBID)														
Recommend and launch VBID products	OSC, PMO													PY1, Q1
Periodic update of VBID templates, with semi-annual meetings of the Consortium														Ongoing
Convene VBID Learning Collaboratives (LCs)	OSC, PMO													Ongoing

Master Timeline Gantt Chart for Performance Years 2016-2019													
SIM Component/Project Area	Component/Project Lead	Performance Year 1 2016-2017				Performance Year 2 2017-2018				Performance Year 3 2018-2019				Milestone(s) with Due Dates
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Work with Commercial Market and AHCT to encourage VBID adoption	OSC, PMO													Commercial Adoption: PY1: 44%, PY2 53%, PY3 65%,; Adoption by AHCT
Consumer Engagement														
Develop tools and types of communication forums	PMO, CAB													PY1 Q1
Conduct issue-driven online or in-person forums, focus groups, and listening sessions	See above													Ongoing
Conduct outreach and provide education to consumers and advocates, community organizations and stakeholder groups	See above													Ongoing
SIM Evaluation, Data Collection, Sharing & Reporting														
Produce pace dashboards and quarterly cost, quality, outcomes dashboards	Robert Aseltine (UConn Health)													Ongoing: Quarterly
Care Experience Survey	Paul Cleary (Yale)													PY1,Q3
Physician Survey	Robert Aseltine (UConn Health)													Analysis by PY2,Q2
Commence Rapid Response Team: Ad hoc team reviews dashboard data as issues arise	Robert Aseltine (UConn Health)													Quarterly dashboard reviews begin PY1, Q1
Community Health Worker Initiative														

Master Timeline Gantt Chart for Performance Years 2016-2019														
SIM Component/Project Area	Component/Project Lead	Performance Year 1 2016-2017				Performance Year 2 2017-2018				Performance Year 3 2018-2019				Milestone(s) with Due Dates
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Develop CHW policy framework	UCONN/ Southwestern AHEC (SWAHEC)													PY1 Q1
Engage stakeholders to promote CHW integration and employment opportunities	SWAHEC													PY1 and ongoing
Identify TA needs of employers by creating and distributing "an employer/supervisor survey" and provide TA	SWAHEC													Implemented PY1 and completed PY3
Initiate identification and development of CHW apprenticeships	SWAHEC													End of PY1
Quality Measure Alignment														
Promote voluntary adoption across payers of recommended quality measures for use in VBP contracts	MS (PMO)													Ongoing
Payers begin to incorporate measures into VBP contracts	MS, FD (PMO)													PY3, Q1
DSS HIT/analytics design and programming for cross-payer performance analytics	MS, FD (PMO)													PY2
Public Common Scorecard														
Publish first online scorecard	MS, FD (PMO)													PY1
Quality Council establishes and rolls out plan for consumer education and access to scorecard data	MS, FD (PMO)													PY2
Review performance scorecard analytics, and measures and make periodic changes and refinements	MS, FD (PMO)													Ongoing

Master Timeline Gantt Chart for Performance Years 2016-2019													
SIM Component/Project Area	Component/Project Lead	Performance Year 1 2016-2017				Performance Year 2 2017-2018				Performance Year 3 2018-2019				Milestone(s) with Due Dates
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Assess and deploy other capabilities, features, or broaden scope (e.g., common performance scorecard measures for additional specialists and hospitals)	MS, FD (PMO)													PY3, Q1
SIM Evaluation, Data Collection, Sharing & Reporting														
Produce pace dashboards and quarterly cost, quality, outcomes dashboards	Robert Aseltine (UConn Health)													Ongoing: Quarterly
Physician Survey	Robert Aseltine (UConn Health)													PY3
Commence Rapid Response Team: Ad hoc team reviews dashboard data as issues arise	Robert Aseltine (UConn Health)													Qty dashboard reviews begin PY1, Q1
Identify attributed members, sampling frame	Paul Cleary (Yale), Mark Schaefer (PMO)													Q1 of each PY
Conduct care experience survey	PL (Yale), MS (PMO)													Q2 of each PY
Analysis & reporting of results to health plans for SSP calculations	PL (Yale), MS (PMO)													Q2-3 of each PY
Establish survey fee collection procedures and collect fees	PL (Yale), MS (PMO)													Q3-4, PY3

5. Budget Summary Table

The following budget summary table provides a summary of projected funding needs for each state SIM initiative component for the upcoming funding period (PY1: October 1, 2016 – September 30, 2017).

SIM Test Grant Request	Performance Year 1 10/01/16-09/30/17
Plan for Improving Population Health	**$ 1,666,411**
Care Delivery/Payment Reform	
PCMH+	**$ 2,034,087**
Community & Clinical Integration Program	**$ 1,190,170**
CCIP Transformation Awards	**$ 2,356,380**
Advanced Medical Home Program	**$ 1,440,000**
Health Information Technology	**$ 2,476,979**
Workforce Development (CHW Initiative)	**$ 274,664**
Value-based Insurance Design	**$ 36,394**
Consumer Engagement	**$ 93,592**
Program Evaluation	**$ 946,433**
OHA - under-service	**$ 66,169**
PMO Administration	**$ 1,200,881**
Total	**$ 13,782,161**

B. Detailed SIM Operational Plan

Our Model Test will determine whether a comprehensive set of statewide and targeted transformation initiatives will accelerate improvements in the performance of the health care system for all of Connecticut residents. These initiatives involve nearly all payers, providers, and a diverse array of stakeholders. They include activities in the aforementioned areas of population health planning, care delivery reform, quality measure alignment, value-based insurance design, health information technology, payment reform and workforce development and they are intended to benefit the entire care delivery system and all Connecticut residents statewide.

Statewide Interventions	Targeted Interventions
Plan for Improving Population Health	PCMH+
Quality Measure Alignment	Advanced Medical Home Glide Path Program
Promote Community Health Workers	Community & Clinical Integration Program, including Transformation Awards
Value Based Insurance Design	
Consumer Engagement	
Quality Performance Transparency	
HIT / Analytics / Performance Transparency	

The below sections provide detailed information on specific operational components of SIM:

1. **Plan for Improving Population Health**
2. **Payment and Care Delivery Model**
    a. Strengthen health care delivery
        i. Advance provider capabilities through CCIP and Transformation Awards
        ii. Transform Primary Care through AMH program
    b. Promote Payment Models that Incentivize Value: PCMH+
3. **Quality Measure Alignment**
    a. Recommended Core Quality Measure Set for SSP
    b. Care Experience Survey for SSP
4. **Health Information Technology**
5. **Community Health Worker Promotion**
6. **Consumer Empowerment**
    a. Value-Based Insurance Design
    b. Consumer Communication Strategy
    c. Public Scorecard featuring Advanced Networks and FQHCs

1. Plan for Improving Population Health

Background

With the passage of the Affordable Care Act (ACA) in 2010, Congress mandated the testing of innovative payment and service delivery models to reduce health care costs while enhancing the quality of care for Medicare and Medicaid beneficiaries. Therefore, health reforms have gone beyond the expansion of insurance coverage to attempt to reform systems of care and address the quality of public health care services to improve health outcomes.

Towards these ends, the ACA added new requirements that hospital organizations must satisfy in order to be qualify under IRS rules as a charitable organization. Among other requirements, hospitals are required to conduct a community health needs assessment (CHNA) and adopt an implementation strategy. Connecticut communities are actively engaged with all of the state's non-profit hospitals to conduct these collaborative assessments focused on health priorities. This represents an unprecedented level of community participation and hospital outreach and coordination with local agencies.

Additionally, the ACA provided funding for the National Public Health Improvement Initiative in which all state public health agencies received a grant to improve the quality, efficiency and effectiveness of public health services. This provided an opportunity for Connecticut to assess its current activities against nationally recognized standards of public health practice, and to put in place key initiatives such as a Statewide Health Assessment and a Health Improvement Plan, to begin to address population health improvement. For this purpose, Connecticut assembled a statewide coalition, put in place a Public Health performance management system with the ability to monitor health improvement targets, and a State Public Health Agency strategic and quality plan with the purpose of obtaining national public health accreditation. The significance of seeking accreditation is to establish a continuous improvement approach to improving population health. Connecticut's activities as part of the National Public Health Improvement Initiative have been concurrent with participation in the State Innovation Model initiative and the preparation of the State Health Care Innovation Plan in 2013. These initiatives provide the opportunity to strengthen the Connecticut's health system from the perspective of both clinical care delivery and prevention intervention capacity. Alignment of objectives and the creation of synergies between these two statewide initiatives has become imperative to effectively improve health by addressing underlying structural factors and social and economic determinants of health.

As Connecticut implements the SIM Test grant to address issues of quality of care, reduction of cost and improvement of population health outcomes, the SIM Population Health Plan will entail conducting activities leading to strengthening community health capabilities. They include a system of population health indicators and community accountability metrics, along with designing and implementing two sustainable community health enabling structures: Prevention Service Centers (PSCs) and Health Enhancement Communities (HECs) models.

With this background in mind and with the goal of becoming an avenue for alignment of public health and health care objectives, the SIM Population Health work stream will develop, over the grant period, a

plan applicable to any community in the State to improve its population's health. The plan will utilize and build upon the State Health Improvement Plan (*Healthy Connecticut 2020)* and the State Chronic Disease Prevention Plan *(Live Healthy Connecticut)* issued by the Department of Public Health (DPH) in March and May of 2014 respectively. These plans are characterized by an emphasis on state-wide population health improvement and they aim particularly at achieving specific health equity objectives. Goals and objectives of both plans are based on the findings of the State Health Assessment.

Strategic Policy, Sustainability and Implementation

The design and implementation of two sustainable community health enabling structures will be the main accountability target of the SIM Population Health work stream. The state seeks to demonstrate a PSC model where community-based entities offer evidence-based community preventive services in affiliation with providers. The state also seeks to design and test an HEC model in areas with the greatest disparities. HEC's will target resources and facilitate 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 with reimbursement innovations to address social determinants of health and health equity (e.g., sustainable financing for healthy homes assessments and community health workers).

Population Health Metrics System

Population Health Plan data collection methods will be led by DPH in collaboration with the Department of Social Services (DSS), which oversees the state's Medicaid program, and the SIM Program Management Office (PMO). DPH utilizes existing surveillance and current reports to propose a set of population health based indicators to the Population Health Council. Using expertise from DPH, the Population Health Council will consider and endorse appropriate population health indicators and improvement targets that align with the priority areas identified in the Population Health Plan. These indicators will be part of the tool kit for PSCs and HECs to assess their ability to improve health status in their communities. While overall health status indicators are generally recognized, health data systems and data sources in Connecticut are multiple and complex. A Population Health Indicators System that effectively gauges progress towards meeting improvement targets requires a selective use of measures that ensure sustainable and improved platforms for both data sharing and visualization. In contrast, community accountability metrics are not widely available and therefore they require standardization and a good measure of innovation. In defining accountability measures, variability of community capacity and unique public health needs would need to be considered.

The DPH is developing a SIM oriented health assessment based on the review of the 2013 State Health Assessment (SHA), existing surveillance and epidemiology reports, and available local and regional CHNAs. This assessment will be introduced to the Population Health Council in its September 22nd meeting and it will continue to be expanded through the span of the project with new data, demographic methods and trends analysis. Other data sources include the State's births and deaths data along with hospital and ED discharge data. Public health data relies mostly on self-reported and behavioral information. Therefore, it is imperative that a fully functioning statewide HIT system

considers linking health records of injury and chronic disease with public health analytic methods which are essential for population health tracking.

The Connecticut Behavioral Risk Factors Surveillance System (CT BRFSS) is a phone survey conducted of adult residents in the state and is managed within Connecticut by DPH. The survey is part of a larger effort managed by the U.S. Centers for Disease Control and Prevention of all states in the country to monitor health status, health risk and protective behaviors, and chronic conditions of adults and children. The SIM initiative supports this effort to complete the health assessment and to inform the population health indicators. The survey design was modified during the SIM pre-implementation period not only to expand the sample size, but also to include questions about the built environment, housing and food insecurity. These additional questions address the SIM primary drivers to promote systems and environmental changes, and the secondary drivers to identify reliable and valid measures of community health improvement. The CT BRFSS is the only available source in the state for key health indicators such as tobacco use, obesity, and diabetes diagnosis, indicators that are also required for SIM. Many programs within DPH use results of the CT BRFSS to inform program activity and identify emerging public health issues. State programs outside DPH also depend on results of the CT BRFSS, including the Medicaid program managed through the DSS, as well as the Office of Early Childhood.

Recognizing the potential of the CT BRFSS for addressing other key topics of interest, a core team involved in SIM within CT successfully advocated for inclusion of a set of questions into the CT BRFSS. These questions were included in the 2015 and current 2016 surveys, and will provide additional valuable information about neighborhood safety and walkability, as well as food and housing insecurity. The SIM team will continue to participate in annual discussions of state-specific questions for the CT BRFSS to ensure that topics of interest to the grant are included in the survey.

Due to a modest sample size, the CT BRFSS has been limited in its ability to assess racial and ethnic disparities in health indicators, and estimates of health indicators in sub-state regions were also not possible. The recent increase in sample size made possible, in part, by SIM funds is expected to allow more robust assessment of health disparities by race/ethnicity. In addition, the increase in sample size makes possible exploration of a methodology for sub-state estimates, particularly in towns of possible high need for SIM activity. The SIM Plan will continue supporting the increased sample size for the CT BRFSS to allow sub-state geographic estimates and more robust assessment of racial/ethnic disparities. DPH relies heavily on the Behavioral Risk Factors Surveillance System (BRFSS) to document health status. Therefore, the SIM operational plan proposes continued support of the annual survey to ensure that the added questions and increased sample size meet the selected Population Health Indicators.

DPH has also contracted expertise in demographic analysis from the Data Center of the University of Connecticut to develop a small area estimation demographic model to allow a CT-specific town-level population estimates for breakdowns of health indicators. This model will require uninterrupted testing and implementation, which will be conducted in PY1 by a SIM supported Epidemiologist housed at the Health Statistic section in the DPH.

Table 1. Data sources and applications in small area population projection

Dataset	Population Component	Town	5-year Age Groups * Sex	Race/Ethnicity
Bridged 7/1/2010 POP	All	Y	Y	Y
FSCPE Annual TOWN Estimates	All	Y	N	N
NCHS Annual ASRH Estimates	All	N	Y	Y
Births	Youth	Y	Y	Y
Deaths	Elderly	Y	Y	Y
Household Population	All	Y	Y	N
Group Quarters	All	Y	Y	N
School Enrollment	Youth	Y	Y	Y
DMV	Adults	Y	Y	N
Medicare	Elderly	N	Y	Y
Utility	All	N	N	N
IRS	Employed	N	N	N
Voter Registration	Adult	Y	Y	N

Note: FSCPE represents The Federal-State Cooperative for Population Estimates;
NCHS represents National Center for Health Statistics

Population data is a key component for health statistics, governmental planning, and resource allocations at national, state, and local levels. The US Census Bureau provides county-level population estimates annually that include demographic identifiers, such as age, sex, race, and Hispanic origin. While the majority of the states in the U.S. use county as the principal geographic level for local governance, Connecticut and a few others states rely on towns or cities. Currently, the only reliable source for town-level population data with demographic identifiers for Connecticut is the decennial census that occurs every 10 years. As the demographic distributions within each town evolve over time, the decennial counts become outdated and may insufficiently represent the true town populations. Connecticut must wait 10 years for an updated population distribution from the next decennial census. An alternative option is to develop an in-house process to estimate the demographic distribution of each town on an annual basis. With no comprehensive resource for inter-census population counts in Connecticut, this task requires both identifying and accessing reliable resources and developing a model that accurately estimates population distributions.

Data sources and providers have been identified and a workflow developed to generate yearly population estimates by combining multi-sources datasets. In addition to developing models of conversion from ZIP code to town level, the predictive value of data sources has been tested. Birth and infant death data, school enrollment counts, DMV licenses/non-driver ID, residential utility customer data, and Medicare data are examples of multi-source data set use to estimate population counts in 2011-2014 by town-age-sex-race/ethnicity.

Root Causes and Barrier Analysis of Population Health Priority Indicators

The Population Health Plan will focus on identifying local geographical areas with highest burden of morbidity, mortality and cost of care to prioritize health improvement initiatives. In addition to a health assessment, this effort also requires conducting a root cause and barrier analysis of near term health

priorities such as diabetes, hypertension and asthma, as well as tobacco use, overweight and obesity. A root cause analyses will aid in defining the underlying barriers to improving health and contribute to the definition of priorities for intervention. To determine what the highest burden areas are, an experienced strategic planning consultant will facilitate discussions among council members to understand current data for health priorities such as such as diabetes, hypertension and asthma and to identify population health priorities to be the focal points for planning. Setting priorities for health improvement will be accomplished using a modified Hanlon method (used in HCT 2020) supplemented by state-specific local data, financial and disease burden analyses, and guided by CDC technical assistance. It is also anticipated that burden of cost and capacity for prevention implementation will be included in the analysis of priorities.

The consultant will facilitate a root cause and barrier analysis on the identified priorities for addressing and improving health outcomes. True root causes are not easily identifiable which requires using multiple quality improvement tools to separate the root cause from the symptoms of the problem. The consultant will facilitate discussion focusing on "upstream" factors such as the social determinants of health (i.e., Frieden's Health Impact Pyramid) and on barriers that are likely to contribute to health inequities. The consultant facilitator will also assist by ensuring the analysis is conducted within the scope of the Council's charter and by keeping the discussion informed by the available data. The analysis will focus on discerning the contributing factors that make unfavorable health outcomes persist while exploring the underlying process and system issues that may require change.

As a result, the Population Health Council may identify additional state health priorities relevant to SIM, identify barriers to population health improvement and recommend specific evidence-based strategies to address diabetes, hypertension, asthma and other priorities (i.e., Guide to Community Preventive Services).

High Burden of Disease Areas and Community Prevention Institutional Capacity

The burden of chronic diseases is not just a public health challenge, but a major public policy challenge that threatens the health of individuals and communities along with Connecticut's future economic prosperity. The State has alarming rates of risk factors for chronic diseases including diabetes, asthma, hypertension, obesity, tobacco usage, alcohol abuse and poor nutrition. The priority areas with the highest burden of disease will be identified by using the current statewide tracking and surveillance systems in place, along with community assessments and available epidemiological reports. Those systems will provide the data and evidence-based rationale for selection of priority areas. The geographic identification of where those health priorities intersect the populations at risk is the starting point of discerning which communities can be designated to implementation the SIM enabling strategies proposed in the Population Health Plan. Building Population Health capabilities in communities in need will also require a minimum institutional capacity to conduct effective interagency collaborations. Therefore, priority areas will also be designated as a result of demonstrable ability to sustain interagency community-wide projects by characterizing whether existing and/or new infrastructures will be utilized to implement selected health interventions or initiatives.

Health Enhancement Communities

Accountable Health Community (AHC) 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.

It is clear that optimal health outcomes are determined by multiple factors beyond the provision of health care alone. Health disparities result from limited access to resources that promote healthy conditions and behaviors. In addition to addressing the improvement of health care quality and reduction of costs, the SIM proposes mechanisms to address community-based factors and socio-economic determinants of health that impact individuals at home, schools, worksites and neighborhoods. The Population Health Plan will aim at prioritizing investments and commitments to community-wide prevention services and to sustain multiagency collaboratives for health by developing a coordinated community and social service care model.

The HEC model will assess and leverage strategies established by other States and communities across the country that are implementing, or planning to implement and ACH model. The purpose of this initiative is to introduce synergies and improve coordination of community resources to improve health in areas with the highest disease burden, worst indicators of socioeconomic status and pervasive and persistent health disparities. This model of coordinated community and social service care will include an advanced stage of the Community Health Collaboratives initiated under the SIM Community and Clinical Integration Program. A community designation as an HEC will indicate a shift from a health care system accountable to a patient panel into a community collaborative accountable to the total population. There will be evidence that the scope of preventive interventions has expanded beyond clinical services to include community-wide interventions. Optimally, an HEC will have an enabling infrastructure such as information technology, reimbursement systems and legal and fiduciary mechanisms.

Prevention Service Centers Design and Prevention Services Menu

PSCs are community-placed organizations 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-profits agencies or local health departments. These centers will be an integral part of the community interagency consortiums seeking designation as an HEC. We anticipate 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 healthcare workforce development strategy.

Early in the development of the Population Health Plan, the scope and role of PSCs will be established with respect to community prevention interventions. This will require research on evidence-based community interventions that fit the identified priorities. To know if there is an evidence-based intervention that can address the selected priority, the planning process will consult with subject matter experts and technical assistance, search existing compendiums of evidence-based practices (e.g. CDC Community Guide, county health rankings, AHRQ), and search peer-reviewed or grey literature.

Special emphasis will be made to accelerate action by pursuing the CDC 6-18 initiative. Specifically, we will focus initially on three of the six high burden health conditions that are costly and preventable—asthma, diabetes, and hypertension. This together with the implementation of the associated evidence based interventions that have proven to be scalable and likely to be addressed together with payers and providers. This process will be further informed by an environmental scan conducted in consultation with partners and subject matter experts to assess the extent to which these type of interventions are already underway.

Any proposed intervention through the steps above will be scrutinized for appropriateness and adoptability of interventions. This will be accomplished by determining existing capacity to implement interventions, recognizing what new capacities are needed to implement interventions, and establishing whether the intervention is culturally appropriate and otherwise acceptable to populations/sub-populations of interest.

In order to facilitate coordination with ongoing public health initiatives, PSCs will be required to determine the relationship of possible prevention interventions with other local and state-wide initiatives to avoid duplication or possible conflicts. Similarly, PSC's will need to determine whether/how proposed interventions support or create synergies and efficiencies with similar initiatives within their defined geographic boundaries.

Clinical Primary Prevention services conducted in community settings and community-wide prevention interventions will constitute the scope of opportunities for both early detection and identification of health problems and addressing root causes of disease. The categories and individual interventions will be drawn out from recognized sources of evidence-base solutions. They will be included in a menu of services that will serve as reference for the PSCs.

Baseline Assessment of Provider Capacity for Community-Prevention Services and Community Collaboration

The DPH will utilize consultant expertise to conduct a Connecticut baseline and environmental scan of community based networks for the purpose of identifying entities able to provide evidence-based community-prevention services and determine their capacity for non-clinical delivery of preventive services. These include primary prevention services that extend individual care outside of the clinical setting (i.e. community-based chronic disease management programs) and population-based interventions that aim to improve the health of all community-dwellers (e.g. smoke-free ordinances, complete streets).

The scan will characterize existing institutions and related-networks by their administrative capacity, legal ability to enter into contracts, funding streams and governance structures. This project is intended

to identify strengths and weaknesses across the state that could be addressed in the process of implementing an ACH Model specific to Connecticut's demographic and institutional characteristics.

The work of the consultant will be carried out under the direction of the DPH Office of Public Health Systems Improvement and in close consultation with the State Chronic Disease Director's office. The project will both survey and make direct inquiries with existing networks of not-for-profit organizations as well as with regional human services and councils of governments. These inquiries will aim at identifying community collaborative models that are operational, or being planned, including formalized ACH models, ACH-like models and any other ACH precursors (e.g. existence of an integrator organization).

Findings will be interpreted in context with national ACH models and subsequently compiled and presented to the Population Health Council. This project will also serve as linkage to the SIM Community and Clinical Integration Program and its learning collaborative effort. A survey of community collaborative efforts may prove useful to a consultant that the PMO is procuring to offer technical assistance to CCIP participants. This information will also be instrumental for the CCIP consultant to convene partners and mobilize partnerships (Community Health Collaboratives).

Cooperation and coordination of community stakeholders with CCIP providers will be foundational for the implementation of the SIM Population Health Strategies which includes PSCs and HECs as proposed in the test grant.

Concurrently and through the Medicaid reform initiatives (SIM supported PCMH+), the state DSS is proposing to promote the development of Health Neighborhoods composed of Patient Centered Medical Homes (PCMH) practices, specialties, CHW's and non-medical services that can be supported by additional value-based payment strategies such as enhanced fees and performance payments and shared savings arrangements. While long term financial options for community collaboratives and the HEC model require further consideration, the Departments for Social Services and Public Health and the PMO have begun to outline essential components of the PSCs. Those include defining a basic metrics system for population health improvement and community performance, and characterizing clinical and community based preventions interventions that are feasible and consistent with health problems in specific communities. Therefore, the development of the HEC model by the Population Health work stream will be carried out in direct coordination and alignment with both the *Community Health Collaboratives* of the Clinical and Community Integration Program and the *Health Neighborhoods* of the Medicaid program.

Health Enhancement Communities - Considerations

We envision that a community-based agency will operate as an **integrator** and administrator of a **portfolio** of prevention interventions. Among the functions of the community integrator agency would be maintaining accountability for improved health and reduction of disparities of the total population in a defined geographic area, while bringing together clinical care, public health, and community services. As a backbone organization, the community integrator will play a central role in coordinating partners for specific interventions and selecting financing vehicles. Therefore, the connector agency must prove to be neutral, legally operational entity capable of contracting and characterized by broad based

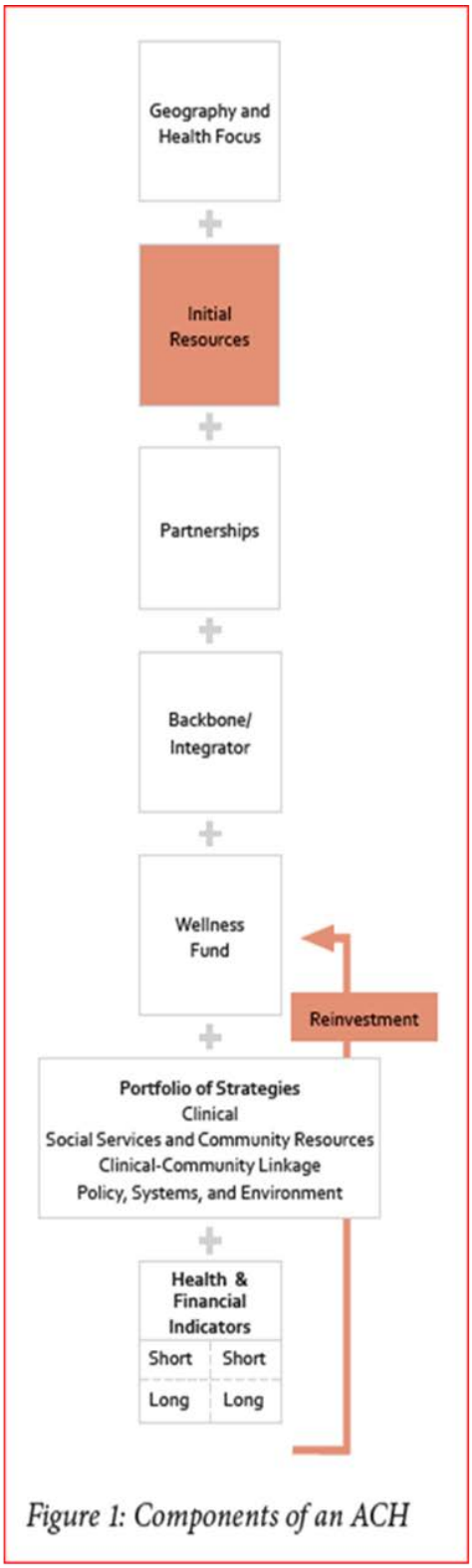


Figure 1: Components of an ACH

Cantor, J. et. al. Accountable Communities for Health. *Strategies for Financial Sustainability*. JSI,Inc. May 2015

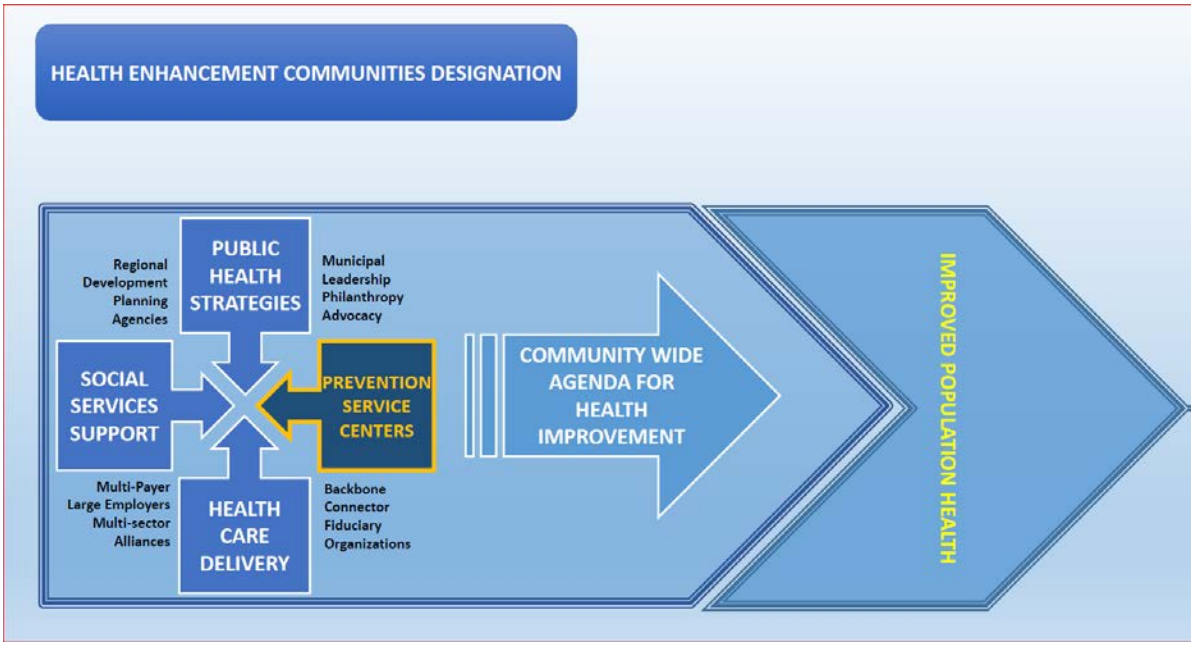
governance. Its authority and credibility will steam from a broad inclusion of community stakeholders, therefore, this agency also convenes, coordinates health assessments, and defines health priorities for intervention.

Advanced Networks and FQHCs can potentially play an important role as backbone organizations as they expand better links between community and clinical preventive services. It is expected that Advanced Networks and FQHCs in selected HECs will serve as partners in addition to other stakeholder entities. To facilitate integration and coordination of effort, the common scorecard and value based payment system may incorporate community-wide population health measures that are common to the HEC and SSP initiatives. The measures are based on the total population, which may include individuals attributed to healthcare providers participating in an SSP. The DPH will coordinate with the SIM PMO and the DSS, which will lend their expertise, resources and authorities to support the integration effort. The DPH will assist with the design, implementation and evaluation of community interventions. It is important to highlight that high quality local data together with reliable IT infrastructure are critical in this design. DPH will support local data analysis, including coordination with other health and human services agencies, to the extent that data sources and IT infrastructure are available.

The Population Health Plan will use the findings from the State Health Assessment, the recommendations from the Healthy Connecticut 2020 and the Coordinated Chronic Disease Prevention and Health Promotion Plan to inform this effort. Although priorities of the HEC's will be expected to reflect local health concerns and assets in the selected communities, the Population Health Plan will propose focus areas for which evidence-based interventions and measures are tested for tracking and reporting of population health outcomes. Core topic areas will be asthma, hypertension, diabetes, tobacco use, and obesity along with indicators that relate to

community characteristics, health care factors and overall health system performance especially as it pertains to health equity.

We anticipate that HECs will be urged to design interventions that relate to policy, system-level and environmental actions that can improve community health. Policy interventions can be institutional or statutory such introduction of financial incentives for re-alignment or behavior change. Systems-level interventions will address processes and quality improvements that strengthen networks, especially between inter-sectoral organizations. Environmental interventions should aim at modifying interactions



between individuals and detrimental physical and psychological exposures. A designation criteria will be developed as part of the Population Health Plan and they will include evidence of sponsorship with in-kind or financial support by a local public-private consortium that includes at least one local health department within the target community. The HEC must comprise a contiguous geographic area defined either by zip codes or census tracts with demonstrable poor health outcomes and economic disadvantage.

Communities seeking designation as a HEC should have a specific focus on improving health related disparities and must define clear and measurable target improvements. Any proposed intervention for community based prevention should be evidence-based and the community must demonstrate that it has the necessary assets to implement it. Prevention interventions will be expected to complement local clinical and community-based interventions and avoid duplication of effort.

As discussed in the next section, the Population Health Plan will address sustainability concerns by exploring legislative opportunities to establish a framework for HEC designation. Incentive options will be explored through possible state allocations, payers' global budgets, pooling of funds through braided mechanisms and the creation of wellness funds. Informed by the evaluation of a pilot HEC, this initiative may encompass more geographic areas or to address more complex challenges.

A variety of governance solutions will be considered by the Population Health Council during the HEC design phase. The planning process will include a survey of emerging national models such as those in use in Washington (Accountable Care Organizations), Oregon (Coordinated Care Organizations), and Minnesota (Hennepin County). Connecticut experimented with a Lead Fiduciary Model in 2011 when DPH implemented the CDC's Community Transformation Grant in five of eight counties. Because CT lacks a county government structure, one health district from each county was charged with fiduciary oversight and program coordination through establishing county-wide multi-sector, community coalitions and developing and executing local plans to implement policy, environmental, and infrastructure changes related to the CTG strategic areas (smoking, healthful living and preventive services). Such a coalition-based model could be focused and modified to serve the governance needs of HECs.

Opportunities for Financial Sustainability of PSCs and HECs

Financial sustainability of the PSC/HEC model will be a major consideration of this initiative. Observations of similar experiences in other jurisdictions show that possible avenues include state allocations, global budgets, pooling of funds through braided mechanisms and the creation of wellness funds. In the initial phase of model design, Connecticut may seek State Appropriations for startup costs in SFY 18/19 with particular focus on maximizing the use of prevention funds. Community Health Collaboratives applying for HEC designation may be urged to have established dedicated wellness trust funds, which could also be used to capture a portion of any anticipated savings from the provision of health care services. Shared Savings could potentially be estimated through assessments by entities realizing or most likely to realize savings from the implementation of HECs (e.g. payers, healthcare organizations). Entities realizing such savings may develop a business-case and be willing to provide up-front, and ongoing, financial commitment to a wellness trust fund. This assumes that shared savings rewards could be linked to community-wide performance in areas that are a direct focus of HEC efforts.

Traditional categorical funding tends to create specialized entities that build redundant overhead to secure their revenue stream which leads to larger administrative burden on the overall system. Competitive access to funding decreases a desirable and expected spirit of community collaboration. Therefore to counteract this, other possible approach to financial sustainability is the alignment of grant funded programs around interventions lead by a HEC. For example, Stamford, CT has already harnessed Department of Housing and Urban Development (HUD) and US Environmental Protection Agency (EPA) resources to help fund a Health and Wellness District initiative http://vitastamford.com/about-vita/. Similarly, numerous disease prevention and control initiatives funded by the CDC and administered by DPH, offer the opportunity to align funding streams as they are implemented at the local level by a HEC (e.g. healthy food retail, local active transportation initiatives, screening programs, medication therapy management, etc.). Block grants to states were an early attempt to break down silos and let states use federal funds more flexibility, though they still came with restrictions.

Blended or braided funding could be an effective solution through the pooling of funds by public-private partnerships to ensure support of the health portfolio strategies. The alignment of different funding

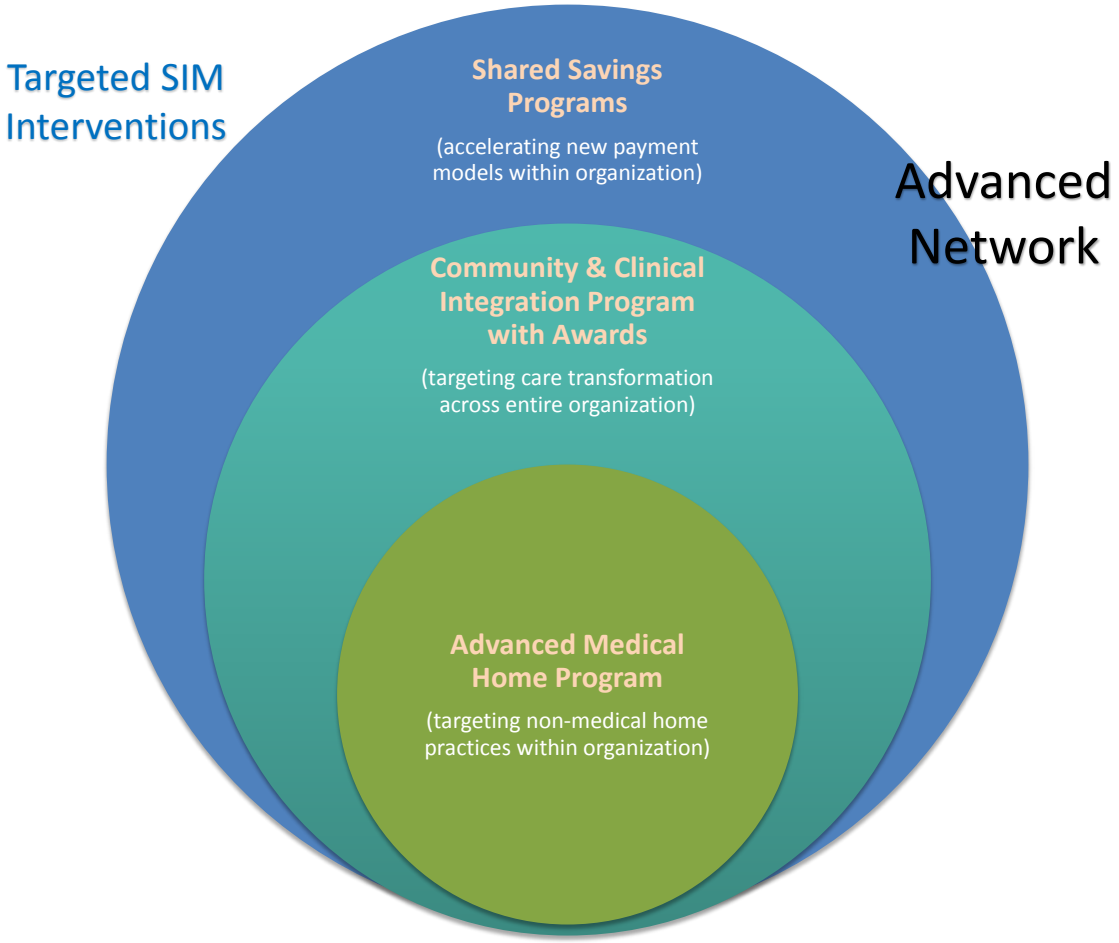
streams would support services, projects and infrastructure that could not be supported by a single stream. However, costs still would be tracked by individual funding source.

The model design will include a request to DSS to review all available options for State Plan and waiver authority in support of HECs. For example, by enabling reimbursement for community health workers for preventive services, or by providing bundled payments for wrap-around interventions for children and families. The SIM Population Health Plan will take advantage of the opportunities for blending funding to connect the public health and community development fields when tackling the social determinants of health.

The alignment of community based initiatives from human services agencies and hospitals while addressing findings of local Health Needs Assessments, represents a clear opportunity to material hospital community benefits and community health improvement plans. This funding option could be led by the health systems in cooperation with municipal agencies, in particular health departments, to support the PSC's models.

2. Health Care Delivery System Transformation Plan/Payment and care delivery model

Connecticut's Model Test includes a set of targeted initiatives that leverage the shift towards Shared Savings Programs and combines this with care delivery transformation supports so that providers can succeed in these new models of integrated care. Our initiatives focus on ***Advanced Networks*** –which we define as independent practice associations, large medical groups, clinically integrated networks, and integrated delivery system organizations that have entered into shared savings plan (SSP) arrangements with at least one payer. Our targeted supports will increase the SSP arrangements that these Advanced Networks have with payers; give them technical assistance, peer-learning support, and transformation awards as part of the CCIP; and enable their non-medical home practices to become AMHs. Our initiatives also focus on FQHCs, which will have the opportunity to begin participating in SSP arrangements with DSS through PCMH+. However, for most FQHCS the transformation of their care delivery systems will be supported by a Practice Transformation Network (PTN) grant.



Connecticut's SIM initiatives focus primarily on three payer populations: Medicare beneficiaries, members of commercially insured or employer-funded health plans, and Medicaid beneficiaries.

Medicare beneficiaries in Connecticut have been substantially involved in value-based payment reform and SSPs through the Medicare Shared Savings Program (MSSP). Commercially insurers have also been active in introducing shared savings with providers throughout Connecticut. The larger commercial payers report that more than half of the beneficiaries with a usual source of primary care are attributed to a primary care provider who is accountable for quality and total cost of care. In 2012 the Department of Social Services introduced the successful PCMH initiative for its Medicaid and CHIP programs. This pay-for-performance initiative has accelerated the advancement of primary care in Connecticut and has contributed to gains in quality performance and reductions in total cost of care. As part of Connecticut SIM, the PCMH initiative will serve as a platform for a new SSP initiative referred to as **PCMH+**.

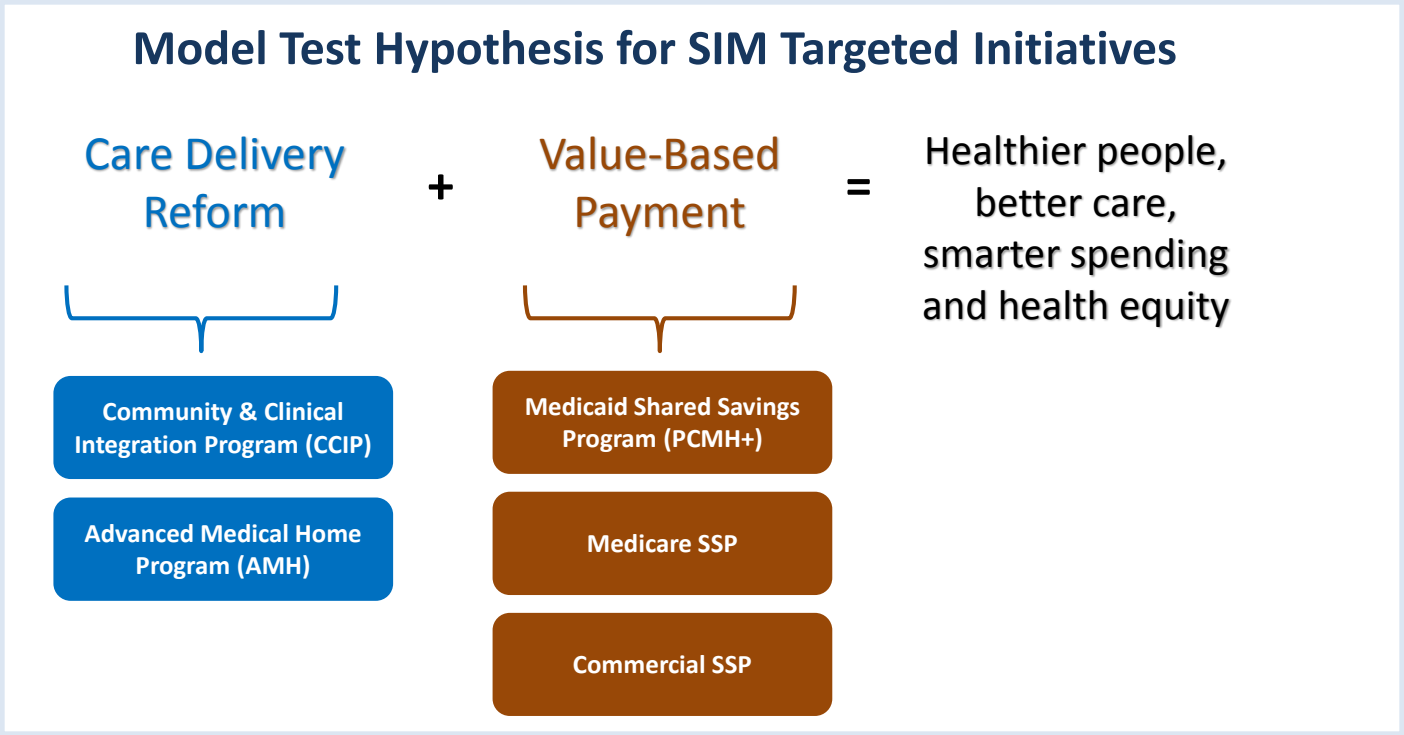
Commercial payers and Medicare in Connecticut are rapidly implementing shared savings plan contracts with provider entities. However, these Advanced Networks have difficulty fully transitioning to genuine value-based care when some of their payer contracts are in fee-for-service, and only a few are in value-based payment arrangements. This prevents them from fully transitioning towards preventative care, care coordination, and population health management because they have to continue to focus on the provision of more and more services. It also prevents them from making investments in the culture change and data analytics necessary to succeed in shared savings arrangements. Additionally, they may develop new capabilities or deploy greater supports for one payer population, such as Medicare beneficiaries, and not others.

Medicaid insures more than 20% of the Connecticut population. Leveraging Medicaid's market power through PCMH+ will help move Advanced Networks in Connecticut to a point where they are accountable for the cost and quality of a great majority of their patient population. This will make it financially feasible for networks to scale innovative care delivery strategies such as medical homes, health information technology, and community health workers. PCMH+ will also provide FQHCs an on-ramp to SSP focused on the more than 60% of their population that qualifies for Medicaid.

Advanced Networks and FQHCs may need help in developing the capabilities necessarily to improve quality and efficiency under these new payment models. The following care delivery transformation programs will focus on those Advanced Networks and FQHCs that are participating in PCMH+ (excluding those that are participating in a PTN):

1) **Advanced Medical Home Program**
2) **Community and Clinical Integration Program, with Transformation Awards**

Pairing care delivery support with value-based payment reform aligns resources to support a shift in favor of efficiency, prevention, and continuous quality improvement. This approach leverages the interest of providers that are expanding their participation in shared savings plan models. These providers have strong incentives to perform well on quality measures and improve the overall efficiency and effectiveness of patient care processes.



We hypothesize that our strategy outlined below to transform care delivery, combined with payment reforms, will further accelerate the pace of change and performance of participating providers relative to non-participants, and that the improvement in performance will be of particular benefit to Medicare, Medicaid and CHIP beneficiaries who have chronic illnesses, significant care coordination needs, and/or social determinant risks.

We intend to implement this targeted strategy in three waves, two of which will occur during the test grant. The first wave of technical assistance and transformation awards will launch by January 2017. Over the course of five years, our goal is that 89% of Medicaid beneficiaries receive their care from PCMH+-participating healthcare entities. We also aim to have 1,364 providers in 12 Advanced Networks and 15 FQHCs; and 300 primary care practices undergo a transformation program to improve care delivery.

The care delivery and payment reforms featured in our test grant and operational plan were strongly influenced by reforms at the national level, especially those promulgated by CMS, such as the Medicare Shared Savings Program, and initiatives undertaken by CMMI and the Healthcare Payment Learning and Action Network (HCPLAN). As we conclude our planning for PY1, it has become apparent that more recent developments at the federal level should be considered and perhaps leveraged as we consider how best to continue to evolve our care delivery and payment models.

Foremost among these developments is that of the Quality Payment Program (QPP) introduced under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The QPP contains two components, the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APM). In the near term, most of Connecticut's physician community will participate in MIPS. By emphasizing the importance of investments in practice improvement, we believe that MIPS will provide

a substantial incentive for provider participation in the SIM funded AMH and CCIP initiatives. The PMO will be developing educational materials that highlight the relationship between AMH/CCIP capabilities and those that are the focus of MIPS. In addition, the PMO may consider further adjustments to AMH/CCIP to optimize alignment.

In addition to participating in MIPS in the near term, we believe that many providers will be interested in a pathway that would enable them to meet the APM participation thresholds for their Medicare, commercial and Medicaid populations. We recognize that APMs that qualify under the QPP must be more advanced than the payment models that are in widespread use in Connecticut today. For this reason, we intend to educate our payer partners in both the private and public sector to ensure that they understand how their payment models can potentially support providers' ability to maximize incentives under Medicare. This education and opportunity for dialogue will be extended to our broader stakeholder community. As with the Medicare SSP, we believe that CMS has provided Connecticut with important opportunities to create synergies among payers, while also providing useful next generation payment reform models, with the Next Generation and CPC+ being among the most prominent examples.

A. Strengthen health care delivery

Historical models of care delivery in Connecticut can be fragmented and difficult to navigate. Both individual primary care practices and accountable healthcare organizations have room to improve the way healthcare is delivered and how patients are engaged in their care. Many practices are prepared to pursue medical home recognition, but lack the resources and support necessary to begin that process. Similarly, many Advanced Networks with a strong advanced practice foundation want to move to the next level but lack the funding and technical expertise necessary to re-engineer their processes, incorporate new technologies, or develop more sophisticated clinical and community integration capabilities.

To achieve better outcomes at a more affordable cost, the way care is delivered needs to change. Shifting from volume-based payment to value-based payment is an essential catalyst to incent and sustain the requisite changes in care delivery. However, payment reform alone cannot achieve the state's vision. SIM pairs the shift from volume-based payment to value-based payment **with healthcare delivery initiatives** so that providers, with our support, are able to make and sustain investments in patient-centered, coordinated, and effective care. These healthcare delivery initiatives include the following:

1. **Community and Clinical Integration Program (CCIP):** Provides technical assistance, learning collaborative support and **CCIP Transformation Awards** so that Advanced Networks and FQHCs achieve CCIP standards in comprehensive care management, health equity interventions, behavioral health integration, across their organization. Community Health Collaboratives will bring together clinical and community stakeholders to develop consensus protocols for coordinated care and community linkages.

2. **Advanced Medical Home Program (AMH):** Provides a guided program with webinars and on-site support to non-medical homes within Advanced Networks so that they can achieve patient-centered medical home standards.

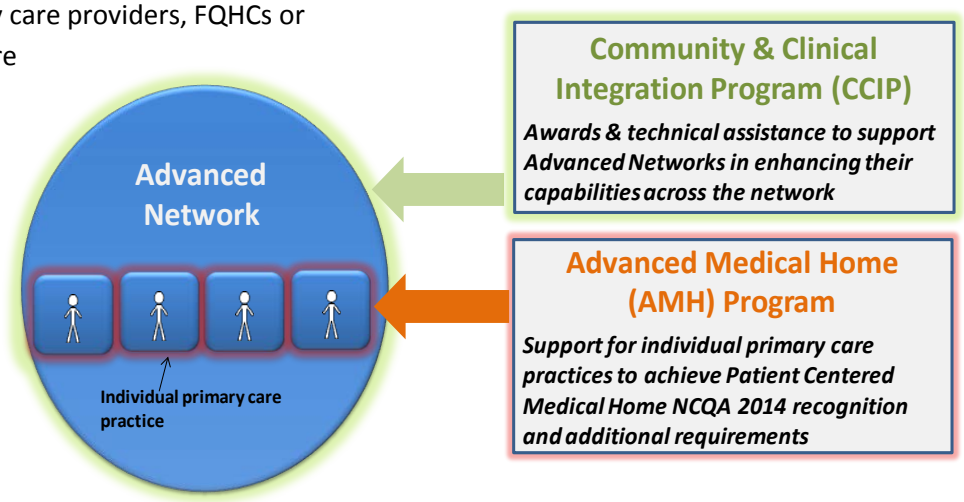
i. Introduction to AMH and CCIP

Connecticut has approximately 3,300 primary care physicians, 1,200 primary care advanced practice registered nurses (APRNs), and 1,000 physician assistants (PAs). These figures include an estimated 280 primary care providers (PCPs) in 15 federally qualified health centers (FQHCs) who care for more than 340,000 individuals each year. Approximately 3,400 PCPs are estimated to work in 16-20 Advanced Networks. Many of these Advanced Networks include one or more anchor hospitals. More than 1,900 PCPs are in unaffiliated, independent practice settings. Transforming care to be truly person-centered is a process that takes place at multiple levels. SIM healthcare delivery initiatives aim to address the gaps at the individual primary care practice level and at the organizational level.

The envisioned transformation will ensure that the patient – and, where applicable, family and caregivers – are the center of healthcare delivery processes and systems. This is known as person-centeredness. Person-centered healthcare engages patients as partners in their healthcare and relies on teams of healthcare and other workers to address the range of medical and socio-economic factors that influence good health.

The medical home approach to primary care constitutes an essential building block for a person-centered healthcare system. Medical homes utilize a team-based approach to deliver comprehensive, coordinated, accessible primary care and preventive services to patients. To encourage medical homes, the SIM developed the AMH Program to help practices create the infrastructure required for transformation. The AMH Program builds aligns with and builds on the exceptionally successful PCMH program administered by DSS.

In addition to transforming care at the practice level, SIM seeks to transform care at the "network" level. Many of the services and resources that need to be incorporated in a truly person-centered healthcare delivery system lie outside of the individual primary care office. Some of these services exist or could be built into large groups of primary care providers, FQHCs or networks comprised of healthcare facilities and providers. In particular, healthcare networks that are organizing to take financial responsibility for clinical quality, total cost of care, and patient health outcomes are well-positioned to adopt this broader approach to health services. We refer to these organizations as



"Advanced Networks." SIM seeks to support the development of the processes to support patient needs at the network or FQHC level through the launch of CCIP. CCIP will support these networks and FQHCs in the development of new capabilities and will complement patient-centered medical home activities to effectively integrate non-clinical community services with traditional clinical care into a set of comprehensive, person-centered primary care services that support patient goals.

Both of these delivery system initiatives are complementary to PCMH+. CCIP has been included as a component of the procurement for PCMH+. Those Advanced Networks and FQHCs selected to participate in PCMH+ will be required to work toward or achieve the CCIP core program standards, unless they are participating in PTN. The AMH program will increase the number of practices that achieve medical home capabilities enabling them to excel in shared savings programs.

Pairing care delivery support with value-based payment reform aligns resources to support a shift in favor of efficiency, prevention, and continuous quality improvement. This approach leverages the interest of providers that are expanding their participation in shared savings plan models. These providers have strong incentives to perform well on quality measures and improve the overall efficiency and effectiveness of patient care processes:

ii. Community & Clinical Integration Program: Building Essential Capabilities

The Community and Clinical Integration Program (CCIP) deploys evidence-based care delivery standards that participants will receive support to achieve over a 15-month performance period. CCIP promotes care delivery transformation across the entire network and patient population to deliver better care that results in better health outcomes at lower costs for Medicare, Medicaid, and commercial plan enrollees. CCIP participating entities will receive free technical assistance, as well as peer support through a Learning Collaborative so that they can achieve CCIP standards.

CCIP is intended to support Participating Entities by providing them with technical assistance and peer learning support to a) improve care for individuals with complex health needs, b) introduce new care processes to reduce health equity gaps, and c) improve access to and integration of behavioral health services. In each of these areas, there are sizable opportunities to improve care, especially by helping care teams to identify cultural, language, and social factors that are barriers to care and address these barriers through community linkages and new team members such as Community Health Workers (CHWs).

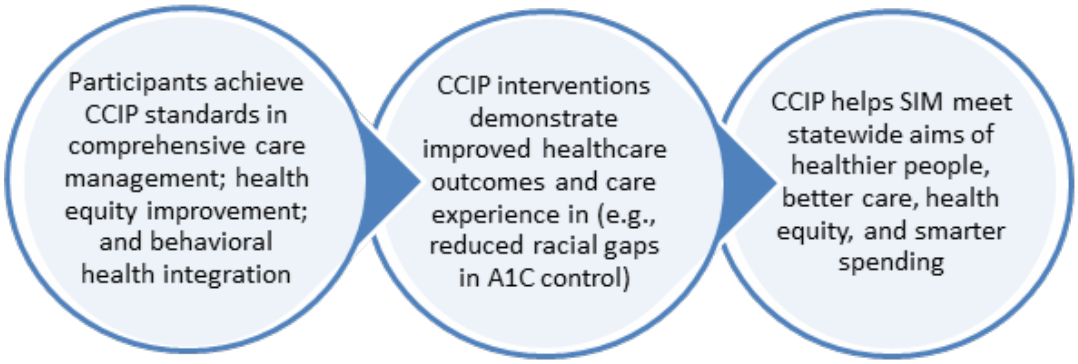
Our care delivery strategy, including CCIP and its technical assistance support, aligns with the overall aims of SIM of healthier people, better care, smarter spending, and health equity.

Please refer to the CCIP Report for a full description of the program, the CCIP standards, process of developing them, and further context.

CCIP Components

The primary goal of the CCIP program is to ensure that Participating Entities have the capabilities necessary to effectively support individuals with complex health care needs, to identify and reduce health equity gaps, and to better identify and support individuals with behavioral health needs. These

CCIP capabilities are reflected in the core standards. Participating Entities will track quality measures to ensure that new activities and care processes result in demonstrated improvements in healthcare outcomes, in turn contributing to the achievement of SIM's statewide aims.



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 core and elective capabilities. Transformation awards of up to $500,000 will also be made available to CCIP Participating Entities to help support the costs associated with working toward achievement of the standards. The SIM PMO will administer the Transformation Awards. Finally, Community Health Collaboratives will provide a vehicle for developing consensus protocols for coordination and the use of shared resources for the benefit of all Participating Entities and their clinical and community partners.

Exhibit: Core supports provided to CCIP Participating Entities

The CCIP implementation process will be overseen by the PMO. The SIM PMO will procure one CCIP Transformation Vendor to administer the technical assistance, learning collaborative, and Community Health Collaboratives.

CCIP Standards

The CCIP standards build on existing medical home and care coordination programs in Connecticut. They are based on local and national best practices that have been shown to improve health care outcomes, improve health equity, and reduce costs. There are three required core standards on which Participating Entities must focus and three elective standards that they can voluntarily request assistance in meeting.

The three core standards include:

1. **Comprehensive care management:** These standards establish a person-centered process for identifying and managing the care of individuals with complex health care needs, including using multi-disciplinary comprehensive care teams. They will enable the effective identification of individuals who would benefit from comprehensive care management, engage those individuals, and coordinate services by using an expanded care team that includes community-based service and support providers.
2. **Health equity improvement:** Part 1 of these standards focus on continuous health equity gap improvement including analytic capabilities to routinely identify disparities in care, conduct root

cause analyses to identify the best interventions, and develop the capabilities to monitor the interventions. Part 2 specifies an intervention that uses a community health worker to address an identified equity gap.

3. **Behavioral health integration:** These standards incorporate best-practice processes to identify individuals with unidentified behavioral health needs in the primary care setting and addressing the need.

Technical assistance will also be available for three additional elective standards to Participating Entities that seek to improve care in the following areas:

4. **E-Consults:** E-consults are a telehealth system in which primary care providers consult with a specialist reviewer electronically prior to referring an individual to a specialist for a face to face non-urgent care visit. This can improve the quality of primary care management, enhance the range of conditions that a primary care provider can effectively treat in primary care, and reduce avoidable delays and other barriers (e.g., transportation) to specialist consultation.
5. **Comprehensive Medication Management (CMM):** This intervention is intended to improve care for patients with complex therapeutic needs who would benefit from a comprehensive personalized medication management plan. CMM is a system-level, person-centered process of care provided by credentialed pharmacists to optimize the complete drug therapy regimen for a patient's given medical condition, socio-economic conditions, and personal preferences. The model depends on pharmacists working collaboratively with physicians and other healthcare professionals to optimize medication use in accordance with evidence-based guidelines.
6. **Oral Health Integration:** These standards provide best-practice processes for the primary care practices to routinely perform oral health assessments with recommendations for prevention, treatment and referral to a dental home.

Each CCIP standard contains elements and their respective criteria.

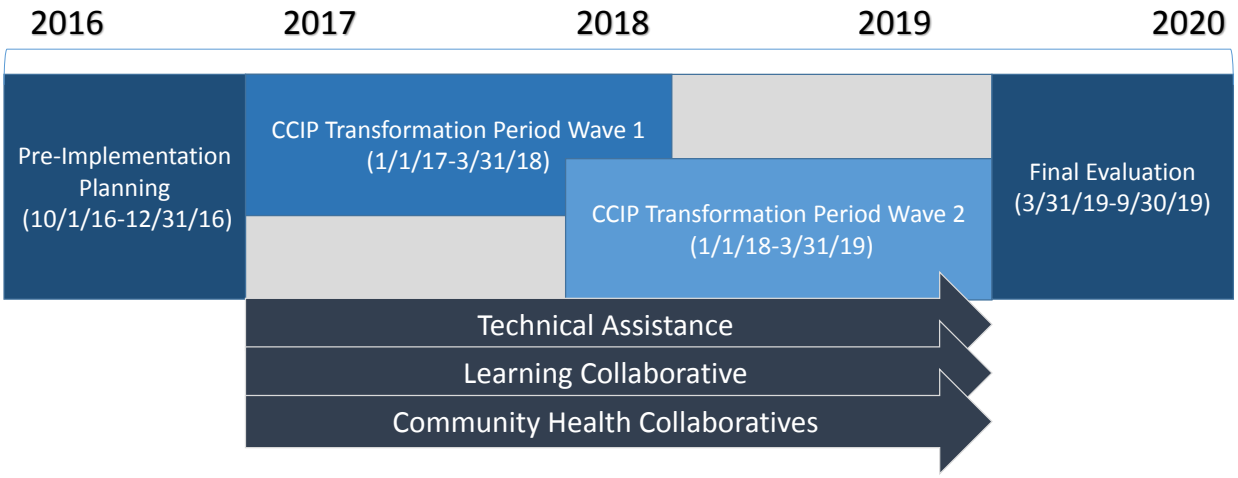
Community Health Collaboratives

The Transformation Vendor will also be charged with establishing or engaging **Community Health Collaboratives** in three or more regions of the state. The purpose of these collaboratives is to facilitate more efficient coordination among healthcare providers and community organizations or other community entities in the service of better healthcare outcomes. The vendor will work with these collaboratives to develop standardized protocols for linking community resources with clinical service providers in a geographic area.

Projected Enrollment Numbers

The SIM PMO is estimating that approximately 15 Participating Entities (14 Advanced Networks & 1 FQHC) will be supported through CCIP, encompassing about 1,400 primary care providers. CCIP will be implemented in two waves. Estimated Participating Entities and intervention period for each wave are provided in the table below:

Exhibit: CCIP Timeline



Participating Entities

Only Advanced Networks and FQHCs that participate in PCMH+ will be eligible for CCIP transformation support. Advanced Networks and FQHCs that are participating in the Transforming Clinical Practices Initiative (TCPI), a separate federal practice transformation grant awarded to some practices and FQHCs, are not eligible to participate in CCIP. DSS has embedded requirements related to CCIP standards within the PCMH+ Request for Proposals (RFP). All entities selected to participate in CCIP will be those that also participate in PCMH+.

The CCIP program is intended to complement PCMH+ and its associated requirement elements. PCMH+ builds on the successes of the DSS' PCMH program and harmonizes with other DSS initiatives such as the Intensive Care Management (ICM) program, the medical and behavioral health ASOs, and the Health Home initiative all of which contribute to a record of quality improvement and cost savings. The combined effect of the PCMH+ required elements and the CCIP standards is to strengthen the capabilities of our increasingly accountable provider community with an emphasis on care coordination, team-based care, health equity, social determinant risks, community integration, community health worker supports, behavioral health integration, and the care of special populations.

Testing the Standards

DSS and the SIM PMO agree that it will be useful to test the CCIP standards. Therefore, in the first wave of PCMH+ procurement for the project period starting January 1, 2017, DSS and the SIM PMO have agreed to permit PCMH+ applicant entities to choose whether or not they will be bound by the CCIP standards. The DSS PCMH+ RFP for Wave 1 offers two tracks, from which applicant entities must choose:

- Track 1 will require PCMH+ Participating Entities to participate in CCIP technical assistance, engage in the transformation process, and make progress towards achieving CCIP standards but will not require demonstrated achievement of the CCIP standards as a condition for continued participation in PCMH+.

- Track 2 will enable PCMH+ Participating Entities to indicate that they agree to be bound by CCIP standards. These Participating Entities must achieve the core CCIP standards within 15 months of the PCMH+ start date. *Only Track 2 Participating Entities will be eligible for transformation awards*.

Over the course of the PCMH+ performance period for Wave 1, the experience of Participating Entities will be reviewed and the standards may be adjusted. For the Wave 2 PCMH+ procurement, achievement of the CCIP standards, as revised, will be a condition for all PCMH+ Participating Entities, including those entities that were exempt during the first wave.

Participating Entities may request accommodations, such as if CCIP requirements conflict with the needs of the patient population. More information about the two track approach and accommodations can be found in the CCIP Report.

CCIP Transformation Awards

The SIM PMO will make CCIP Transformation Awards of up to $500,000 available to Participating Entities to meet the CCIP standards and requirements. Transformation awards will only be available to PCMH+ Wave 1, Track 2 participants or Wave 2 participants. The awards are intend to provide direct funding to Participating Entities so that they can make investments to achieve CCIP standards in order to improve the quality of care and reduce costs across their network.

Proposed allowable costs for CCIP Transformation Awards include, but are not limited to the following activities provided such activities are not otherwise provided by the PMO contracted technical assistance vendor(s):

- Business process analysis and requirement system analysis.
- Redesigning internal clinical workflows and staff training to implement new workflows.
- Contractors or staff to facilitate and support meeting model aims including the following:
    - learning and improvement activities based on the CCIP standards (e.g., webinars, meetings, workgroups),
    - Providing non-clinical guidance, expertise, and support across practices and the organization with regard to operational, financial and business process redesign, and broad quality improvement; and
    - Providing clinical guidance, expertise, and support within the organization and among affiliated practices
- Temporary funding for additional employed or contracted staff needed to meet CCIP standards, including direct service staff such as CHWs.
- Sub-contracts to support new clinical processes (e.g., care coordination, patient navigation, social determinant assessment, community support referral tracking and follow-up).
- Data integration and analytics to support health risk stratification, predictive modeling, and sub-population performance analysis.
- Clinical data, drill down capability to the provider and patient-level data and the ability to compare a provider to aggregate measure outputs.

- Health information technology investments to facilitate or enable collection, analysis, sharing of data for clinical providers and practices across the clinical and community continuum.
- Health information technology investments to enable care management and evidence-based decision support.
- Investments needed to improve quality performance measurement, analysis, and dissemination. For example, clinical quality measures, calculated for providers and presented through a web-based interface with drill down capability to the provider and patient-level data and the ability to compare a provider to aggregate measure outputs. Providing monthly detail and aggregate data to the entities clinical providers/partners.
- Costs associated with reporting of quality data to the SIM PMO.
- Costs associated with the tracking and analysis of measures outside of the PCMH+ measure set.

Participation Goals

The PMO aims to support 1,364 providers at least 12 Advanced Networks and 1 FQHC through CCIP across the two waves of PCMH+. The goal is that all of these entities enhance their care delivery capabilities and meet the CCIP standards.

CCIP work stream lead: The CCIP implementation process will be overseen by the SIM PMO with the assistance of one or more transformation vendors that will provide technical assistance to participating Advanced Networks and FQHCs and support them in meeting the CCIP standards. The SIM Practice Transformation Taskforce (PTTF) will serve as an advisory body to this work stream.

ii. Advanced Medical Home Program: Transforming Primary Care

Advanced primary care practice is the foundation for a high-performance healthcare system. Connecticut consumers, providers, and other stakeholders believe that strong primary care is a strategic health policy goal and requires redesigned primary care practices with accountability measures for performance on patient outcomes, care experience, and resource utilization that are linked to a new payment reform approach.

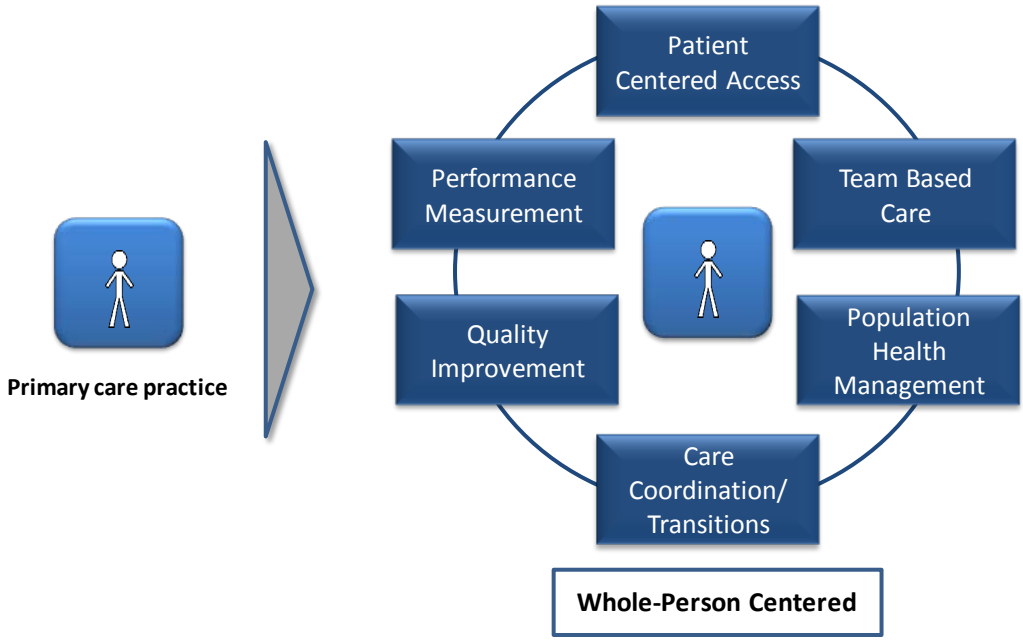
Today's health care environment presents enormous challenges to primary care practices, including new payment models that place greater responsibility on practices to manage quality and costs. At the same time practices need to master electronic health records and complex administrative requirements such as ICD-10 to be competitive. Although many independent practices and those affiliated with Advanced Networks have pursued practice advancement, only about 900 PCPs in CT have achieved or maintained NCQA 2011 medical home standards. **Many practices are prepared to pursue medical home recognition, but lack the resources and support necessary to begin that process.**

The SIM Test Grant funds the launch of the **AMH Program** to support the advancement of 300 primary care practices statewide to achieve these core elements. The goal of the AMH Program is to ease the burden of transformation of individual primary care practices within Advance Networks, while improving the primary care experience for patients and every member of the primary care team.

The PMO will contract with one or more transformation vendors to provide practice transformation support in two waves of up to 15 months each, with 3 months of evaluation. The SIM PMO is also working with health plans to provide them with information regarding AMH Program enrollment, achievement of milestones, and designation status.

Advanced Medical Home Program

Webinars, peer learning & on-site support for individual primary care practices to achieve Patient Centered Medical Home NCQA 2014 accreditation as well as additional required criteria.



Advanced Medical Home Model

Components of the AMH model targeted at primary care practices include:

- 15-months of transformation services from experienced transformation vendors. Through this they can master evidence-based processes to improve clinical outcomes and patient care and be better positioned to excel in new care delivery and payment models, such as shared savings programs**;**
- Interactive learning collaborative, practice facilitation visits, and a variety of evidence-based Quality Improvement (QI) interventions;
- Support to achieve **AMH Designation**: NCQA PCMH 2014 standards level II or III with additional required elements and factors;
- Eligibility for discounted NCQA application fees;
- Facilitation for AMH participants to qualify and enroll in the Medicaid PCMH program and thereby qualify for enhanced fees and quality of care incentive payments (Pay for Performance)

The AMH model is based on the National Committee for Quality Assurance's (NCQA) patient-centered medical home (PCMH) program, which has been shown to improve healthcare coordination and quality.

In a medical home, a primary care provider works closely with a team to coordinate care for their patient panel. The approach also emphasizes the holistic assessment of patient treatment and support needs, shared decision making, and continuous quality improvement. The NCQA recognition credential will enable MIPS participating physicians to obtain full credit for investments clinical practice improvement activities.

Participating practices will be required to achieve NCQA recognition in order to achieve the AMH designation. The AMH Program also requires additional Connecticut-specific standards that were identified by the SIM Practice Transformation Taskforce. These additional criteria take previously voluntary NCQA criteria and make them mandatory for the AMH program. The program also introduces additional areas of emphasis that comprise a portion of the transformation curriculum. Together, these required criteria and areas of emphasis reflect the importance of health equity, prevention, person-centered care, behavioral health and oral health.

For a full list of AMH standards, criteria, and elements, click here.

AMH Pilot and Planetree Recognition

The PMO has undertaken a pilot of the AMH Program in which practices also receive support to achieve **Planetree Patient-Centered Bronze Recognition** for excellence in patient-centered care. Organized around eleven core dimensions of patient-centered care, including structures necessary for culture change; human interactions; promoting patient education, choice and responsibility; family involvement; and healthy communities, the criteria uniquely capture the depth and scope of what it takes to implement and maintain a patient-centered culture. The criteria focus on the patient experience, as well as the experiences of family member, practice staff and care teams.

Planetree recognition is conferred based on a variety of factors, including performance on traditional quality indicators, review of policy documents and, most importantly, how patients, their loved ones, and staff assess the organization's patient-centered culture. Fundamental to the recognition assessment process are focus groups or interviews with patients and family members, as well as staff.

For the purposes of the AMH program pilot, achievement of PCMH recognition through NCQA and recognition as an AMH will serve as proxy validation for 29 of the 35 criteria required for Bronze Planetree recognition. In order to minimize redundancy, no additional documentation or validation will be required to substantiate fulfillment of those overlapping Bronze recognition criteria.

The PMO will solicit feedback from AMH program pilot participants and confer with the PTTF and Healthcare Innovation Steering Committee before determining whether the Planetree Recognition will be included as part of SIM funded AMH support.

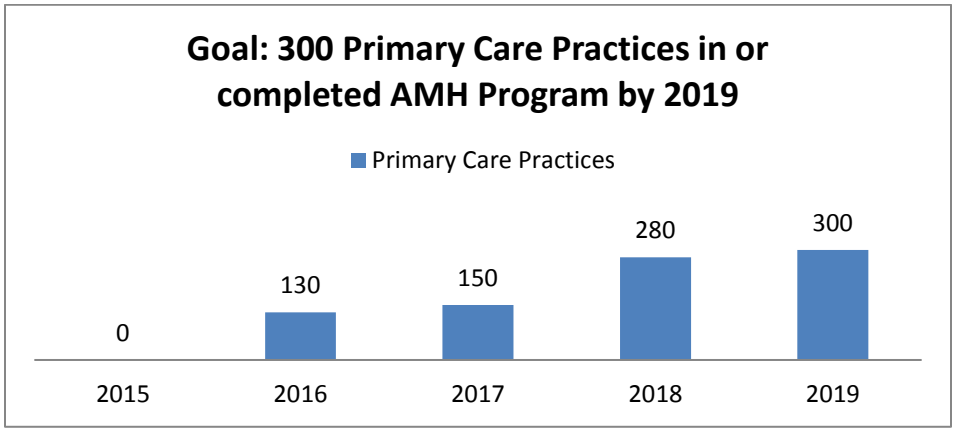
In 2012, DSS established a glide path program to provide practical, on-site technical support to facilitate practice transformation towards medical home recognition. The PMO is coordinating with this DSS program to implement the AMH Program. The AMH program will provide facilitation for AMH participants to qualify and enroll in the Medicaid PCMH program and thereby qualify for enhanced fees

and quality of care incentive payments. Note that currently, 109 practices (affiliated with 381 sites and 1,386 providers) are participating in the DSS Medicaid PCMH Program, serving over 312,777 beneficiaries (over 40% of Medicaid members).

Participation Goals

The PMO aims to enroll a total of 300 primary care practice sites, with 150 practices in each of two waves during Years 1 and 2 of the test period. It is anticipated that practices will be recruited into the program over a period of several months. AMH support will be offered first to Advanced Networks that are participating in PCMH+ and who have practices that are not yet recognized as medical homes. AMH support may be available to non-participating primary care practices within available resources.

Exhibit: AMH Provider Participation Goals



AMH work stream lead: AMH administration will be led by the SIM PMO. The SIM PTTF will serve as an advisory body to this work steam.

B. Promote Payment Models that Incentivize Value

A core strategy Connecticut has adopted in pursuit of its vision is to **shift from paying for volume ("fee for service") to paying for value.** Value-based payment rewards provision of care that is higher-quality and lower-cost. This shift, already underway in Connecticut and across the United States, is a response to the fact that healthcare in the U.S. is nearly twice as expensive as in any other country, but falls short on most measures of quality and access. Connecticut has also been lagging in healthcare performance, with respect to both quality and cost; performing more poorly than most other states on healthcare outcomes, such as readmission and measures of health equity, yet spending more per capita on healthcare than all but three states. These results are in large part a product of the way the U.S. has historically financed healthcare. Volume-based payment has stimulated the provision of more care, but not better care or more affordable care.

Value-based payment, and particularly shared savings programs, are intended to bring about changes in care delivery that yield better clinical outcomes, keep people healthier, and make healthcare more affordable and sustainable. It seeks to align provider organizations' economic incentives with the

outcomes they achieve for their patients and their communities. This alignment, largely absent historically, will encourage providers, payers, and other healthcare stakeholders to coordinate across time and settings and engage patients as better partners in good health. So many adverse health outcomes currently experienced are caused by a lack of coordination and a failure to engage patients. Aligning around coordinated care and care management has been shown to improve overall quality, strengthen provider skills in care management, promote engagement between providers and patients, optimize the efficient use of resources, and streamline delivery for an improved patient experience.

The shift to value-based payment and associated transformation of care delivery systems is well underway. Over the past several years, Connecticut's commercial payers, Medicare and Medicaid have partnered with providers to accelerate the adoption of these transformative payment models. At the federal level, the Department of Health and Human Services (HHS) is working in concert with stakeholders in the private, public, and non-profit sectors to transform the nation's health system to emphasize value over volume. HHS has set a goal of tying 50 percent of Medicare fee-for-service payments to quality or value through alternative payment models by 2018. To support these efforts, HHS has launched the Health Care Payment Learning and Action Network to help advance the work being done across sectors to increase the adoption of value-based payments and alternative payment models. This network recently released a White Paper[1] to create a clear and understandable alternative payment model framework, provide a deeper understanding of payment models, and to provide case studies. In this report, they outline goals to move public (Medicare and Medicaid) and private (commercial health plans) spending away from a fee-for-service model towards alternative and population based payment models.

One of the principal vehicles through which value-based payment is occurring is the advent of ACOs in which networks of providers agree to take responsibility for the quality and total of care for a given patient population. Approximately 750 ACOs have emerged as of March 2015[2] with many reporting impressive results, including within Connecticut.

Shared Savings Program: *A form of a value based payment that incents networks of providers to manage healthcare spending and improve quality for a defined patient population by sharing with those organizations a portion of the net savings realized as a result of their efforts. Savings are typically calculated as the difference between actual and expected expenditures, and then shared between payer and providers. Shared savings programs typically require providers to meet defined targets with respect to quality metrics in order to qualify for shared savings.*

The introduction of **shared savings programs (SSP)** to the market in Connecticut is already well underway. Nearly 20 organizations have existing shared savings contracts with Medicare and/or commercial payer(s). In the past two years, considerable market consolidation has resulted in an

[1] https://hcp-lan.org/groups/apm-fpt/apm-framework/

[2] Leavitt Partners, as cited in "Growth And Dispersion Of Accountable Care Organizations In 2015," Health Affairs Blog, March 31, 2015.

estimated 65% of CT's PCPs employed by or affiliated with a provider organization that is participating in at least one SSP contract, and this percentage is growing. All of CT's health plans, Medicaid, and the state employee health plan have committed to implementing value-based payment arrangements through SSP for providers with sufficient scale and capabilities, modeled upon the Medicare SSP.

Alignment with Medicare Payment Models:

SIM is seeking to support this continued transformation from volume-based to value-based reimbursement by promoting **multi-payer alignment** around a common framework for value-based payment. The framework it has chosen is the Medicare Shared Savings Program (MSSP), which introduced the term ACO. All Connecticut payers have committed to a payment model that is broadly aligned with the MSSP. Features relating to organizational structure, measure set and shared savings methodology will require further review by the relevant stakeholder groups associated with the SIM and Medicaid to recognize the current stage of development and readiness in Connecticut as well as the need for additional population-specific measures.

SSP Participation Projections

The SIM has set a goal of 88% of the Connecticut population obtaining their care from a PCP who is accountable for the quality of their care, care experience and total cost by 2020. **See next page for the following targets by year:**

1. **Primary Care Provider Participation in any SSP**
2. **Number of Beneficiaries (in thousands) with a PCP in any SSP**
3. **Number of Beneficiaries (in thousands) with a PCP in Multi-Payer SSP with PCMH+**
4. **Provider Participation in PCMH+**

Provider and beneficiary participation assumptions are further detailed in Appendix C, Pace Measures.

Exhibit*: *Primary Care Provider Participation in any Shared Savings Program

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

***Exhibit*: Number of Beneficiaries (in thousands) with a Primary Care Provider in any SSP**

Coverage Category (000's)	2015	2016	2017	2018	2019	2020
ASO (excluding State Employees)	336.6	453.7	630.7	753.6	879.1	1,007.2
Fully insured	260.1	350.6	487.3	582.3	679.2	778.2

Coverage Category (000's)	2015	2016	2017	2018	2019	2020
State employees, exc. Medicare Supp.	40.7	54.8	76.2	91.0	106.2	121.6
Medicare	175.4	240.8	340.8	414.5	492.3	574.3
Medicaid/CHIP*	0	0	210.0	429.1	439.1	636.5
Total	**812.8**	**1,099**	**1,745.0**	**2,270.5**	**2,595.9**	**3,118.0**

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

***Exhibit*: Number of Beneficiaries (in thousands) with a PCP in Multi-Payer SSP with PCMH+**

Coverage Category (000's)	2016	2017	2018	2019	2020
Commercial/Medicare beneficiaries	0	580.8	1,510.0	1,812.0	2,400.0
Medicaid (PCMH+) beneficiaries	0	210.0	429.0	439.0	636.0
Total	**790.8**	**1,939.0**	**1,939.0**	**2,251.9**	**3,036.0**

***Exhibit*: Provider Participation in PCMH+**

Coverage Category (000's)	Base	2016	2017	2018	2019	2020
Advanced Networks	16	0	3	12	12	16
Federally Qualified Health Centers	14	0	9	14	14	14
Primary Care Providers	2072	0	516	1,624	1,624	2,072

Person Centered Medical Home + (PCMH+)

Overview

In the above context, DSS seeks to establish and test a new, upside-only shared savings initiative entitled PCMH+. DSS' goal with PCMH+ is to build upon its successful Intensive Care Management (ICM) and Person-Centered Medical Home (PCMH) initiatives to improve health and satisfaction outcomes for individuals currently being served by Federally Qualified Health Centers (FQHCs) and "advanced networks" (e.g., ACOs), both of which are currently providing a significant amount of primary care to Medicaid beneficiaries. DSS has chosen an upside-only model because this is the first ever application of shared savings within Connecticut Medicaid, and it will be important to gain experience with protecting beneficiary interests and rights, and to enable providers to operate effectively within this structure.

PCMH+ Participating Entities will be competitively selected by the Department via a Request for Proposals.

PCMH+ represents an opportunity for Connecticut Medicaid to build on, but not supplant, its existing and successful PCMH and Intensive Care Management initiatives. Currently, 109 practices (affiliated with 381 sites and 1,386 providers) are participating, serving over 312,777 beneficiaries (over 40% of Medicaid members). Connecticut's 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 Intensive Care Management initiative has also demonstrated exciting initial results. In a year over year comparison of SFY'15 and SFY'14, the Medicaid medical Administrative Services Organization has:

- for those members who received ICM, **reduced emergency department (ED) usage** by **22.72%** and **reduced inpatient admissions by 43.87%**
- for those members who received Intensive Discharge Care Management (IDCM) services, **reduced readmission rates by 28.08%**

Over SFY'15, through a range of strategies (Intensive Care Management, behavioral health community care teams) and in cooperation with the Connecticut Hospital Association, the Connecticut Medicaid Emergency Department visit rate was reduced by:

- 4.70% for HUSKY A and B
- 2.16% for HUSKY C
- 23.51% for HUSKY D

Further, over SFY'15:

- Overall admissions per 1,000 member months (MM) **decreased by 13.2%**
- Utilization per 1,000 MM for emergent medical visits **decreased by 5.4%**
- Utilization per 1,000 MM for all other hospital outpatient services **decreased by 5.3%**

DSS regards PCMH+ as an opportunity to begin migrating its present, federated, ASO-based model of ICM to a more local basis.

While PCMH will remain the foundation of care delivery transformation, and ICM will continue to be a resource to high need, high cost beneficiaries, PCMH+ will incorporate new requirements related to integration of primary care and behavioral health care, as well as linkages to the types of community supports that can assist beneficiaries in utilizing their Medicaid benefits. Typical barriers that inhibit the use of Medicaid benefits include housing instability, food insecurity, lack of personal safety, limited office hours at medical practices, chronic conditions, and lack of literacy. Enabling connections to

organizations that can support beneficiaries in resolving these access barriers will further DSS' interests in preventative health. Further, partnering with providers on this will begin to re-shape the paradigm for care coordination in a direction that will support population health goals for individuals who face the challenges of substance abuse and behavioral health, limited educational attainment, poverty, homelessness, and exposure to neighborhood violence.

An important next stage in the discussion of PCMH+ care coordination will be to examine and synthesize PCMH+, existing Intensive Care Management strategies overseen by the Medicaid Administrative Services Organizations, the SIM CCIP, and the CMMI TCPI in which the Community Health Center Association of Connecticut will be participating as a PTN.

MQISSP is slated to be rolled out in two waves. The first wave will serve 200,000 to 215,000 beneficiaries. MQISSP will focus upon single-eligible Medicaid beneficiaries. Certain populations (e.g. those served by long-term services and supports waivers, nursing home residents) will not participate in MQISSP. The Department has proposed to use its current Person-Centered Medical Home attribution model to identify where beneficiaries have sought care, and to prospectively assign beneficiaries to those practices under PCMH+. Beneficiaries will continue to have the right to seek care from any Medicaid provider, and will have the right to opt out of PCMH+.

PCMH+ will also enable progress on the payment reform curve toward cross-payer value-based payment by encouraging providers to:

- focus less on billed volume
- invest in expanding care teams to include health coaches and navigators
- universalize their approaches across all patients, irrespective of payer

PCMH+ participating entities will receive Medicaid-funded care coordination payments (**FQHCs only**) and, on the condition that they meet benchmarks on identified quality measures (including measures of under-service), a portion of any savings that are achieved (**FQHCs and Advanced Networks**).

All elements of PCMH+ model design that have been proposed to date have been reviewed through an intensive stakeholder engagement and design process that is described below. This process will continue through and beyond implementation.

Program Design Process

DSS has worked in conjunction with Mercer consulting to propose PCMH+ model design features to its lead stakeholder body: the Care Management Committee (the Committee) of the MAPOC. At the inception of the project, DSS worked with the Committee and the SIM PMO to develop and finalize a PCMH+ "primer" document that introduced the premise for model design, as well as outlining the various aspects of model design that would be reviewed. DSS also worked with the Committee and the SIM PMO to articulate a protocol for interaction with, as well as review and comment by, SIM-affiliated councils. DSS and Mercer presented material at and supported discussion:

- at [nine] regularly scheduled monthly meetings of the Committee;
- via [three] webinars on a proposed quality set, proposed care coordination elements, attribution/assignment, and shared savings methodology; and
- monthly work sessions on the elements of the shared savings methodology, the proposed framework for under service monitoring, attribution/assignment, and member communications.

Model design was at every turn based upon environmental scans of best practices, and premised in values that were articulated at the inception point of discussion of each element. DSS also participated in the SIM Quality, PTTF and Equity & Access Councils, and presented PCMH+ material to the same.

Guiding Principles

At each interval point in making recommendations on model design, DSS and Mercer articulated a set of values that informed decision-making and acted as a litmus test for supporting the rights and interests of Medicaid beneficiaries.

Care Coordination Principles

The premise of the PCMH+ care coordination elements proposed by DSS is that they will build on existing standards for FQHCs under the Health Resource and Standards Administration (HRSA) as well as PCMH Standards for ambulatory entities established by the NCQA or The Joint Commission (TJC). On DSS' behalf, Mercer scanned each of those standards, and also examined national best practices as well as model design and experience in many states (Alabama, Maine, Ohio, Rhode Island, Wisconsin, and Washington) that have incorporated PCMH or health home-based care delivery model designs within Medicaid reform efforts.

Quality Measure Principles

The PCMH+ quality measures proposed by the Department were selected with a lens toward:

- leveraging the current DSS PCMH reporting
- measures that are primarily claims based
- measures that are nationally recognized
- measures that use common CPT and HCPCS billing codes
- measures that do not have extended look-back periods
- measures that are relevant to Medicaid population:
- advance DSS' emphasis on preventative and primary care
- focus on conditions highly prevalent in Medicaid populations
- measures recommended by the SIM Quality Council, where aligned with PCMH+ goals
- measures that support identification and elimination of under-service

Shared Savings Model Principles

In proposing these aspects of model design, DSS and Mercer were guided by these values:

- Only participating entities that meet identified benchmarks on quality standards and measures of under-service will be eligible to participate in shared savings
- Quality improvement (not just absolute quality ranking) will factor into the calculation of shared savings
- Higher quality scores will allow a Participating Entity to receive more shared savings
- Participating Entities that demonstrate losses will not be required to share in losses
- Participating Entities will be benchmarked for quality and cost against a comparison group devised from in-State, non-participating Entities as well as national benchmarks

Overview of Model Design Recommendations

Timing and Means of Affiliating Beneficiaries

DSS will include an estimated 200,000 to 215,000 beneficiaries in the first of two waves conducted during the test period. The wave one procurement will occur in 2016, with the performance period beginning January 1, 2017. The second wave procurement will occur in 2017, with the performance period beginning January 1, 2018.

DSS has proposed to use its current PCMH attribution model to identify where beneficiaries have sought care, and to prospectively assign beneficiaries to those practices under PCMH+. Beneficiaries will continue to have the right to seek care from any Medicaid provider, and will have the right to opt out of PCMH+.

Care Coordination/Quality Management Elements

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

The proposed PCMH+ care coordination elements focus upon the following:

- Behavioral and physical health integration:
    - Care coordinator training and experience
    - Use of screening tools
    - Use of psychiatric advance directives
    - Use of Wellness Recovery Action Plans (WRAPs)
- Culturally competent services
    - Training
    - Expansion of the current use of CAHPS to include the Cultural Competency Item Set
    - Incorporation of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) standards

- Care coordinator availability and education
- Supports for children and youth with special health care needs
    - Advance care planning discussions and use of advance directives
    - Incorporation of school-related information in the health assessment and health record (e.g. existence of IEP or 504)
- Competence in providing services to individuals with disabilities
    - Assessment of individual preferences and need for accommodation
    - Training in disability competence
    - Accessible equipment and communication strategies
    - Resource connections with community-based entities
- Provider report cards

Quality Measures

See next page for proposed quality measures.

PCMH+ Quality Measure Set

MQISSP Measure Number	Scoring Measures	Potential Means to Identify Under-Service	Measure Steward	National Quality Foundation #
1	Adolescent well-care visits	*	NCQA	NA
6	Avoidance of antibiotic treatment in adults with acute bronchitis		NCQA	0058
11	Developmental screening in the first three years of life	*	OHSU	1448
13	Diabetes HbA1c Screening	*	NCQA	0057
15	Emergency Department (ED) Usage		NCQA	NA
19	Medication management for people with asthma	*	NCQA	1799
25	Prenatal care and Postpartum care	*	NCQA	1517
27	Well-child visits in the first 15 months of life	*	NCQA	1392

MQISSP Measure Number	Challenge Measures	Potential Means to Identify Under-Service	Measure Steward	National Quality Foundation #
7	Behavioral Health Screening 1–17	*	DSS	NA
20	Metabolic Monitoring for Children and Adolescents on Antipsychotics	*	NCQA	NA
22	PCMH CAHPS	*	AHRQ	NA
23	Readmissions within 30 Days		MMDN	NA
24	Post-Hospital Admission Follow up	*	DSS	NA

MQISSP Measure Number	Reporting Only Measures	Potential Means to Identify Under-Service	Measure Steward	National Quality Foundation #
2	Annual fluoride treatment ages 0<4	*	DSS	NA
3	Annual monitoring for persistent medications (roll-up)	*	NCQA	2371
4	Appropriate treatment for children with upper respiratory infection		NCQA	0069
5	Asthma Medication Ratio	*	NCQA	1800
8	Breast cancer screening	*	NCQA	2372
9	Cervical cancer screening	*	NCQA	0032
10	Chlamydia screening in women	*	NCQA	0033
12	Diabetes eye exam	*	NCQA	0055
14	Diabetes: medical attention for nephropathy	*	NCQA	0062
16	Follow-up care for children prescribed ADHD medication	*	NCQA	0108
17	Frequency of Ongoing Prenatal Care[1]	*	NCQA	1391
18	Human Papillomavirus Vaccine (HPV) for Female Adolescents	*	NCQA	1959
21	Oral evaluation, dental services	*	ADA	2517
26	Use of imaging studies for low back pain		NCQA	0052
28	Well-child visits in the third, fourth, fifth and sixth years of life	*	NCQA	1516

Notes:

1. This measure will be removed from the list of Reporting Only quality measures and will not be tracked as part of MQISSP.

Strategies to Prevent and Address Under-Service

The most recent aspect of model design that has been discussed with the Committee is a multi-pronged framework for monitoring for under-service to beneficiaries. These aspects of model design will be discussed and refined more extensively over Fall 2016, but presently include the following prongs:

- **Preventative and Access to Care Measures** – 22 of the proposed PCMH+ quality measures track preventative care rates and monitor appropriate clinical care for specific health conditions
- **Member Surveys** – use of the CAHPS PCMH survey and consideration of the use of the CAHPS Cultural Competency Supplemental Item Set
- **Member Education and Grievance Process –** specific, affirmative education for beneficiaries on PCMH+ as well as their grievance and appeal rights
- **Secret Shopper** – expansion of the Department's current secret shopper approach to gauge access to care as well as experience in seeking care
- **Elements of Shared Savings Model Design –** various elements of the shared savings model for PCMH+ (use of a savings cap, decision not to include a minimum savings rate, upside-only approach, high cost claims truncation, and concurrent risk adjustment claims methodology) were selected with a lens toward protecting beneficiary rights

Provider Qualifications

Key features of qualifications for PCMH+ Participating Entities that have been proposed by DSS include the following:

- Participating Entities must have a minimum of 2,500 attributed Medicaid beneficiaries
- All practices that participate in PCMH+ shared savings arrangements must already be recognized as person-centered medical homes by either NCQA or TJC
- Participating Entities must be enrolled as Medicaid providers
- Participating entities can be:
    - A FQHC, or
    - An "advanced network", defined as:
        - A single DSS PCMH program participant
        - A DSS PCMH program participant plus specialists
        - A DSS PCMH program participant plus specialists and hospital(s) or
        - A Medicare ACO

DSS has also sought review and comment on proposed features of leadership and advisory structure (with a particular emphasis on consumer representation), as well as requirements for connections with a range of community providers.

Other criteria will likely focus upon demonstrated commitment, experience and capacity to serve Medicaid beneficiaries; ability to meet identified standards for clinical and community integration; and capacity to effectively oversee quality measurement functions.

Shared Savings Model

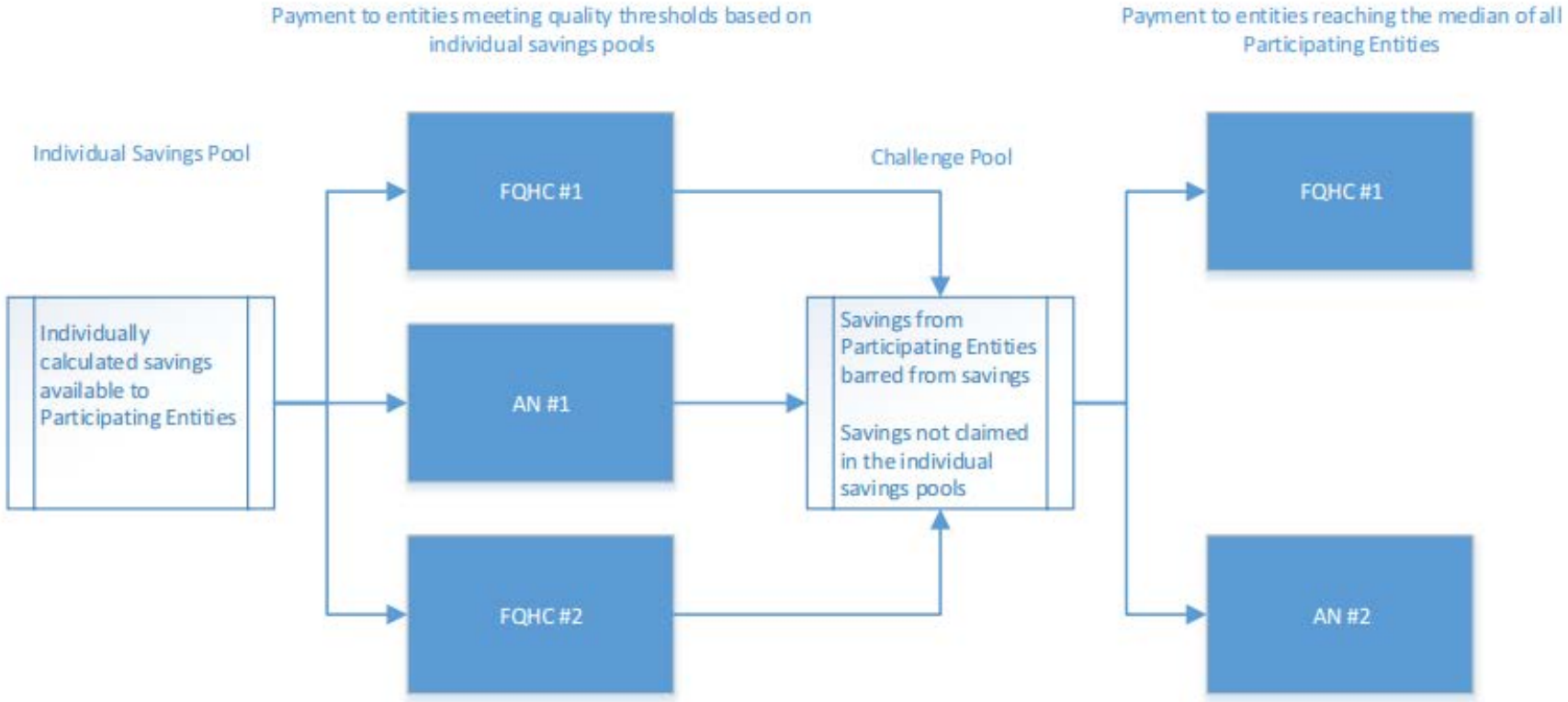
DSS and Mercer have proposed to create a hybrid savings pool consisting of both:

- an **individual savings pool** (where savings are pooled separately and accessible individually for each Participating Entity); and
- **a secondary savings pool** that will aggregate all savings not realized individually due to failing to meet identified benchmarks on quality standards and measures of under-service

Important features of the proposed shared savings methodology include the following:

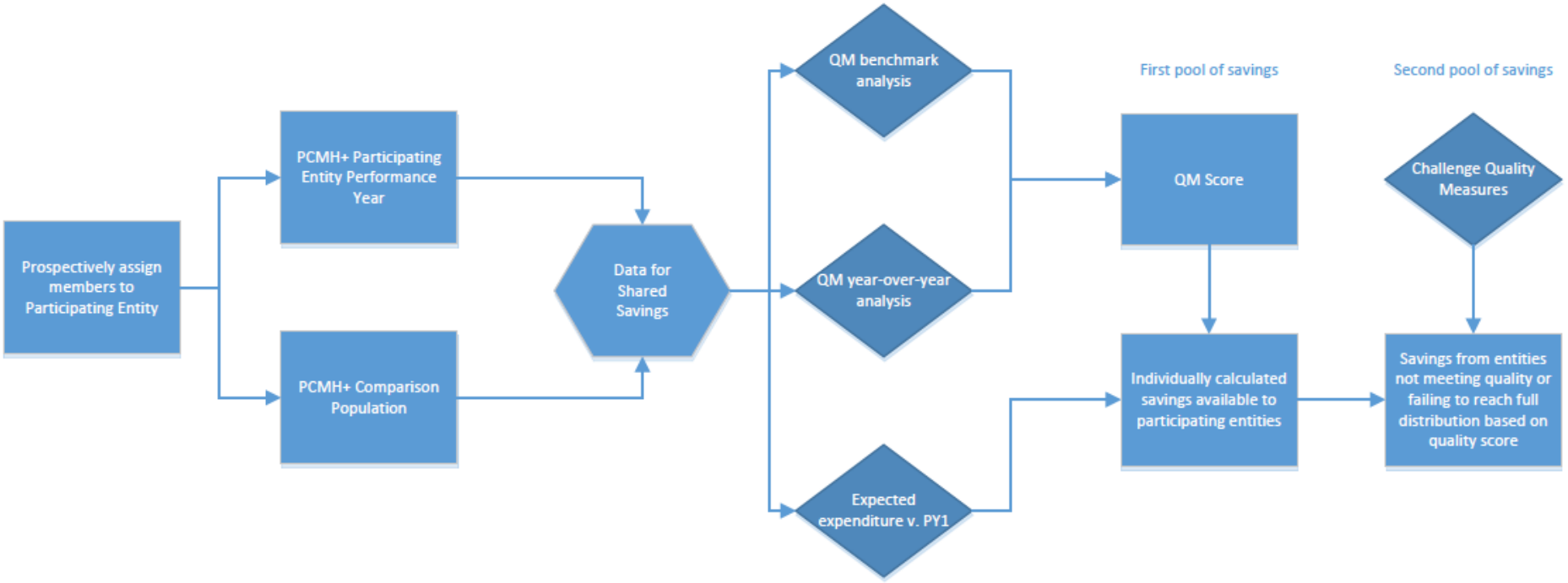
- Calculation of shared savings for a Participating Entity will be separate for each entity and will be based on quality measurement thresholds and scores, including measures of under-service
- Quality measures used to determine savings distribution in the first performance year will be limited to claims-based measures that are currently being reported.

Draft Shared Savings Payment Diagram



Draft PCMH+ Shared Savings Pathway – 1/1/2017 Implementation

This diagram is intended to illustrate the proposed PCMH+ model design and identify areas that have been informed by committee discussion and direction.



Wave 1 Performance Yr 1

Principles of Model Design

Participating Entity requirements
Target population
Minimum number of assigned members
Retrospective attribution for prospective assignment

Analysis

Principles of Model Design

Comparison group approach
Concurrent risk adjustment methodology
Truncation of high cost claims
Benefits included in the shared savings calculation
Meeting identified quality and improvement

Results

Principles of Model Design

Hybrid savings pool to distribute shared savings
Absolute quality and improvement factors
Upside only model
No MSR and a savings cap of 10%

PCMH+ Participation Goals

The goal is that 89% of Medicaid beneficiaries receive their care from PCMH+-participating healthcare entities by 2020. Provider participation targets can be found in Appendix C.

PCMH+ Lead: The PCMH+ will be developed and implemented by the DSS, the single state Medicaid agency, under the guidance of the Care Management Committee of the MAPOC in a manner consistent with the best interests of Medicaid enrollees, in accordance with the protocol between the SIM PMO and DSS.

3. Quality Measure Alignment

Quality measures play an essential role within shared savings programs and other value-based payment arrangements. Payers generally use quality measures to establish expectations, evaluate performance, and reward attainment of value – improvements in clinical quality and health outcomes and/or reductions in the total cost of care.

The advent of quality measurement is not without its challenges. One of which is that, as multiple payers increasingly use value-based contracts to pay provider organizations; the **number of quality measures** has begun to spiral out of control. Implementation of disparate measures can create so much administrative and clinical complexity that it undermines our goals. This lack of alignment is particularly counterproductive when several measures that address the same clinical condition with small or minimal variations are developed and maintained by different organizations.

A. Multi-Payer Quality Measure Set

SIM proposed to address the challenges of the current system of fragmented performance measurement by developing a recommended **core quality measure set,** and work with all payers in Connecticut to voluntarily align around the recommended measures in their value-based payment contracts. Connecticut views such a measure set as a key enabler of the shift to more comprehensive, person-centered, and accountable care and a means to drive continuous quality improvement.

The SIM core measure set is intended to:

- Support continuous quality improvement by focusing health care providers on a single set of measures that are recognized by all payers and
- Reduce provider and payer burden, cost, and inefficiency that is caused by measures that are too numerous or misaligned.

Health plans recognize that this unified approach will reduce the administrative burden on providers, enabling them to organize their performance improvement efforts around common expectations, rather than the fragmented business rules and reporting requirements that exist today. It will also provide

consistent incentives, standardized reporting, and multi-payer clinical reports on quality and cost metrics.

Quality Council and Measure Selection Process

The SIM PMO convened the Quality Council in July of 2014 to propose a uniform and aligned set of quality measures to be voluntarily adopted by payers in Connecticut to assess and reward the quality of services delivered under value-based payment arrangements. The Council is comprised of the five major health plans, one large employer, six consumer advocates, three state agencies, six practicing physicians, one FQHC and one hospital. Health plan representatives include medical directors, statisticians and measurement experts. The Quality Council's charter specifically sets the objective of proposing a core set of quality measures for use in the assessment of primary care, specialty, and hospital provider performance in the State of Connecticut.

The selection of quality measures must reflect the needs of the population to which the measures will be applied. The MSSP has already defined a set of 33 quality measures for Medicare beneficiaries that are tuned to the health needs and conditions of individuals over 65 years of age. Medicare's measure set is the product of extensive research and public input and thus represents the standard of quality measurement for older adults. Recognizing this, the Quality Council focused its efforts on the commercial and Medicaid populations, particularly children and adults under age 65 years of age. The Quality Council established a collaborative process to incorporate the views of four major stakeholder groups in Connecticut: consumers, payers, providers, and government agencies. The Council convened during the fourth quarter of 2014 and thereafter every two to four weeks. It began by framing the work and developing a common understanding of the topic to inform its work. The Council devised a set of Guiding Principles to guide its work and evaluate quality measures. One of the key principles throughout the Quality Council's work has been alignment with existing quality promotion activities in Connecticut and across the U.S. The Quality Council built on existing work with sufficient flexibility to align stakeholders.

To harness the expertise of its members, the Quality Council created three breakout groups and five design groups. The breakout groups were organized around three of the stakeholder groups: providers, payers, and consumer advocates. Government officials self-selected into whichever breakout group most aligned with their professional affiliation or state agency's role. The design groups focused on particular dimensions of the quality measure development process, including care experience, health equity, behavioral health, pediatrics, and obstetrics.

The Quality Council surveyed several sources for potential measures to include in its measure set. In accordance with its guiding principles, the Council first looked at the MSSP measures and at quality measures that were already used in commercial contracts in Connecticut. The Council consulted with a variety of outside experts including national non-profit organizations such as the National Committee for Quality Assurance (NCQA), National Quality Forum (NQF), and Center for Outcomes Research and Evaluation (CORE) at Yale University. The Council ultimately considered over 100 measures for incorporation into the measure set.

The Council reviewed measures using a three level process, to narrow the list to approximately 60 measures. The Council then embarked on a process to prioritize and tier the measures. This led to the development of three categories of measures: (1) a core measure set that is recommended for value-based payment; (2) a set of measures that reflect areas of clinical importance, but which require significant development before they can be recommended for payment; and (3) a set recommended for reporting only. These measure sets, have been released for public comment. Input and feedback will then be incorporated before a final recommended set of measures is published. These Executive Summary contains a list of the recommended measures that have been released for comment.

Process of Multi-Payer Alignment

The State is encouraging public and private payers to consider adopting recommended measures in one of two ways: (1) as part of a standard measure set for all value-based payment contracts or (2) as part of a suite of measures that are included in value-based payment contracts when there is an opportunity for performance improvement. The State recognizes that there are measures in the core set that may not be applicable to all plans or all providers.

The core measure set will be finalized in 2016 following a public comment period, after which we will encourage payers to use the measure set as a reference when negotiating or re-negotiating value-based payment contracts. Quality measures that can be calculated using claims or other administrative data (referred to in this report as "claims-based measures" will be the initial focus of alignment along with state-administered measures of care experience. Quality measures that require the collection of data from electronic health records (EHRs) or registries (referred to in this report as EHR-based measures) will require additional lead time as payers do not currently have the means for efficient, automated collection of these measures. The Quality Council recommended to the SIM Health Information Technology Council that a technology solution be developed to support the production of these measures on behalf of all payers.[3] Responsibility for advising the State with regard to this solution will be transferred to the State Health Information Technology Advisory Council in June 2016.

Quality measure alignment activities such as the Core Quality Measures Collaborative (CQMC), initiatives with quality measurement implications such as the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), and efforts to introduce new measures or improve existing measures will have implications for our alignment activities in Connecticut. Accordingly, the Quality Council intends to evaluate the core measure set annually.

For more information on the core measure set, the Quality Council's role, approach to measure selection, and alignment plan please see SIM Report of the Quality Council on a Multi-Payer Quality Measure Set for Improving Connecticut's Healthcare Quality.

[3] http://www.healthreform.ct.gov/ohri/lib/ohri/work_groups/hit/2015-04-17/presentation_-_hit_council_-_4_17_15_-_final.pdf, slides 12-14

B. Care Experience Survey

The most important means to improve consumer experience is to measure care experience, publish results, and link results to payment. The PMO is asking health plans to consider including consumer experience measures in their value-based payment contracts once they have been provided with acceptable provider performance and statewide benchmark information.

The PMO is planning to contract with a vendor for the administration of the PCMH CAHPS with sufficient statistical reliability and validity at the level of the ACO to support the inclusion of care experience targets in value-based payment contracts as a factor in calculating SSP rewards. It is anticipated that Medicaid will administer a version of the PCMH CAHPS that is the same as or similar to that recommended by the Quality Council for inclusion as a payment measure in PCMH+. Accordingly, the PMO is only proposing to undertake care experience surveys for the private health plans.

The goals of collecting CAHPS survey data include providing data that will be used by:

a) Health plans assessing and rewarding consumer experience performance under SSP contracts;
b) SIM evaluators in assessing the impact of SIM related reforms on care experience during the period of the test grant; and
c) SIM for the production of a public scorecard displaying the performance of each Advanced Network.

Care experience surveys are costly to administer, in part because of the large number of surveys that must be collected for each provider to achieve statistically significant results. For this reason, the PMO is proposing to draw the sample of members to be surveyed for each provider from the combined attributed populations across health plans. This means that the PCMH CAHPS survey measures would be payer agnostic—they would reflect each provider's overall performance for their attributed commercially insured population.

Representatives of health plans operating in Connecticut have met several times with the SIM Evaluation Team to discuss how to most efficiently compile information needed by the Evaluation Team and health plans to evaluate these new initiatives in CT and to include consumer experience in SSP arrangements. Discussions have focused on the information about insured individuals that will be necessary and procedures for administering consumer experience surveys.

Based on those discussions, below we summarize an approach to data collection.

Instrument

The CT SIM will be assessing consumer experiences using a version of the CAHPS survey. We propose using the CG-CAHPS survey with supplemental PCMH questions and some questions about behavioral health access.

Design

The main analyses will be at the level of the Advanced Network, without regard to health insurance plan. However, health plan specific analysis may be undertaken to examine the extent to which the variance on any measure is explained by provider vs. source of insurance. We will then identify the consumer experience measures on which there is significant health plan variation within Advanced Networks and provide data to allow health plans to determine whether to take this into account for incentive payments. This information will help determine whether we recommend certain measures for use in SSP scorecards, e.g., we might not recommend measures where all or most of the variance is a function of health plan. We propose to suppress this information as to payer before presenting it to the networks.

Variability of provider performance on care experience measures by health plan may mean that: 1) The Advanced Network treats consumers insured by different health plans differently and/or; 2) There are unique barriers associated with different health plans that inhibit a provider's ability to perform well on a consumer experience measure. This survey is not intended to directly measure either of these factors; however, we plan to analytically assess variation in consumer experience that can be attributed to the Advanced Network as opposed to that variation which is a function either of health plan or consumer characteristics. We will then identify the consumer experience measures on which there appears to be significant plan variation and provide data to allow health plans to determine whether to take this into account for incentive payments.

The CT SIM team anticipates collecting, and distributing the results of, consumer experience surveys every 12-18 months to assess changes in consumer experiences.

Below we describe the process for collecting consumer experience data, the data that will be requested from health plans to permit the collection of such data, the expected timeline for these activities, and the resulting data that will be provided to participating health plans.

Sample

As indicated above, the key evaluation question that will be asked using care experience data is what types of practice arrangements are related to better care experiences and specifically if the experiences of consumers cared for by clinicians in an Advanced Network differ from those cared for by clinicians not in such an organization.

It has been estimated that between approximately 60 and 75 percent of commercially insured consumers cared for by a clinician in an Advanced Network are covered by a SSP. We are interested in whether experiences of consumers who are and are not part of a SSP differ, but we do not intend to sample for covered and non-covered consumers in each Advanced Network. Rather, we would like to determine the proportion of consumers in each Advanced Network who are part of a shared savings program and assess analytically whether the penetration of SSPs is related to care experiences across Advanced Networks.

To assess each Advanced Network, we will follow NCQA sampling guidelines for PCMH CAHPS. NCQA guidelines for PCMH CAHPS differ depending on the number of physicians in the entity being assessed as shown in the table below.

Number of Clinicians	Sample Size
1	128
2-3	171
4-9	343
10-13	429
14-19	500
20-28	643
29+	686

We will treat each Advanced Network as a single organization. There are currently 18 commercial Advanced Networks in CT. If we assume that most Advanced Networks have approximately 20 physicians, we would need approximately 643 consumers per Advanced Network. Thus, to develop a single estimate for each ACO would require a total of approximately 11,574 surveys. We also will collect surveys from a sample of non-ACO consumers sufficient to detect differential trends in ACO and non-ACO. We will refine our sample estimates once we are able to collect more information about the Advanced Networks in Connecticut.

Process

All CAHPS surveys will be administered by a third party survey vendor, to be selected by a competitive bidding process. The RFP for the data collection vendor will specify adherence to NCQA protocols and require TCPA compliance.

The survey vendor will need to have the names and addresses of the sampled individuals. Thus, the selected vendor will need to have or establish a formal Business Associate Agreement (BAA) with the participating health plans. The BAA will include detailed specifications of outreach and follow-up strategies, especially for IVR, if used.

The approach tentatively agreed upon is that the vendor will receive complete lists of covered consumers from each participating commercial health plan and will draw the samples necessary for the SIM evaluation. The vendor would not share any PHI with the SIM Evaluation Team, but would conduct the surveys, de-identify the resulting files and provide de-identified data to the team for analysis.

In discussion with health plans we have determined that it will not be practical to remove individuals who also have been sampled for a Health Plan CAHPS survey. Given the relatively small number of consumers in the Health Plan CAHPS and SIM CAHPS surveys, however, the probability of overlap is very small. We will, however, ask the vendors to select only one individual per household.

We will ask the vendors to draw a sample proportional to the health plan's representation in each Advanced Network.

Health Plan Request

We would request that each health plan create a list of all adult covered lives in Connecticut, with enough information so that the vendor can de-duplicate within families. If available and feasible we would like the health plans to include in the member file the member ID, physician ID (NPI) of the primary physician with whom the member has had the preponderance of use (and to whom the consumer is attributed for SSP purposes), and the Advanced Network affiliation of the physician.

No socio-demographic data are essential. It would be desirable, however, if we had some basic information to assess, and perhaps adjust for, potential non-response bias. The information that would help us do that are consumer age, gender and zip code.

We will provide more detailed specifications once we receive the member file layouts that health plans currently use and discuss what other types of information are available and easy to provide.

Draft Timeline

We anticipate that the baseline survey will be conducted in late 2016 or early 2017 for the purpose of provide a baseline performance year.

The recommended measures and performance results will be distributed to payers that have agreed to begin to incorporate these measures in their value-based payment contracts. The results will include statewide benchmark performance of all ACOs. This data should provide the information necessary to support the negotiation of consumer experience targets in value-based payment contracts.

The PMO intends to conduct performance surveys annually beginning in the first quarter of calendar year 2018 for the 2017 performance year. We anticipate that the resulting data will be provided to participating payers so that the results can be factored into the payment calculations for future payment distribution cycles. Payers with asynchronous performance periods may wish to reference the most recently available performance data for the purpose of calculating shared savings distributions.

August 1, 2016	Health plans reach agreement with SIM team on intent to participate in consumer experience survey, processes to be followed, and data that would be made available to vendor.
	Health plans provide sample file layouts used for Health Plan CAHPS.
	Alert potential survey vendors to forthcoming RFP
September 1, 2016	Health plans obtain employer approval
September 9, 2016	SIM team and health plans agree on CAHPS data report content and format.
	Health plans specify policies for excluding individuals from the file or sample, such as those on a company specific “do not contact list.” Some health plans (e.g., Anthem) review their member lists for compliance against the no-call federal database before they give the member data to vendors. We will solicit comparable information from other health plans if they have not already removed these members and ask the vendor to do so.
	SIM team provides list of Advanced Networks to health plans.
September 16, 2016	SIM team issues RFP for a survey vendor
October 14, 2016	Due date for RFP responses from survey vendors
October 28, 2016	Selection of vendor

November 25, 2016	Vendor defines file specifications for sample data from plans
December 9, 2016	BAAs between health plans and vendor finalized.
	Health plans provide files for sampling and survey administration to vendor
	The SIM PMO will send an information sheet to Advanced Networks in advance of the survey. The information sheet will describe the purpose, process and timetable. The PMO recommends that health plans communicate their intent to begin to incorporate care experience targets into their scorecards and that this state-administered survey will provide the baseline data necessary to do so.
January 2, 2017	Survey starts
March 1, 2017	Vendor provides data and survey summary report to Evaluation Team
June 30, 2017	Report of CAHPS data analyses to SIM PMO and health plans
	The SIM PMO will provide the following consumer experience information to participating plans:
	CT means scores on each CAHPS composite and rating and/or single reporting item
	Mean scores for individuals with commercial health plans in each Advanced Network operating in CT

Quality Alignment work stream lead: Quality measure alignment and care experience work streams will be led by the SIM PMO, in collaboration with the SIM Evaluation Team. The SIM Quality Council will serve as an advisory body to this work stream.

4. Health Information Technology

Rationale

Health Information Technology (HIT) and Health Information Exchange (HIE) have the potential to accelerate improvements in population health, innovations in health care delivery and payment reform and improve the state's capacity for data analytics. Connecticut plans to utilize SIM funds to make strategic investments in HIT infrastructure to build a statewide HIE, support hospitals, providers, SIM participants and laboratories to connect to the HIE, improve EHR interoperability, engage consumers in their care coordination and management, and boost aggregation of data across payers and providers.

Connecticut will leverage existing investments such as the Provider Directory, Enterprise Master Patient Index, the state's Health Information Service Provider and Direct Secure Messaging as building blocks to create a long-term vision of data interoperability. The state will also invest in cutting edge technologies such as mobile applications and support clinical quality measure collection. Together these technologies will make the "right data" available to the "right people" at the "right time" across organizations. SIM will support the state by making strategic investments in the HIT infrastructure to improve EHR interoperability, connect more providers to HIEs, and boost aggregation of data across payers and providers. The State believes that these investments will build towards a level of interoperability that is essential for payment and care delivery reform. Investments in these areas support increased communication between providers, care coordination and integration across settings, population health assessments, improved care delivery and quality measurement and reporting. Connecticut's plan recognizes and leverages existing HIT assets and state specific strategies while proposing new services and/or applications to act as enablers for the SIM Drivers, these are:

Table 1: Connecticut's Current Technology Assets & Proposed Technology Needs

EXISTING ENTERPRISE ASSETS
All Payer Claims Database (APCD):): is a database that contains eligibility and claims data (medical, pharmacy and dental) that will be used to report cost, use and quality information for payers, including private health insurers, Medicaid, children's health insurance, state employee health benefit programs, prescription drug plans, dental insurers, self-insured employer plans and Medicare.
Care Analyzer: is a reporting tool that continuously measures, monitors and manages performance measures, evaluates physician care effectiveness, and identifies gaps in care through health risk stratification. The Medicaid agency has procured the DST Health Solutions (DSTHS) CareAnalyzer, a web-based tool that combines elements of patient risk, care opportunities, and provider performance. The tool supports predictive modeling and data analytic capabilities of the Medicaid agency's Administrative Service Organization (ASO). The tool is currently updated on monthly bases with Medicaid Claims, member eligibility, provider data and lab results. The CareAnalyzer includes NCQA HEDIS certified quality measures and the Adjusted Clinical Group system; it also contains a series of reports designed to provide information and provider effectiveness (quality of care) and provider efficiency (cost of care). SIM may leverage the CareAnalyzer for initiatives around payment reform and care delivery transformation.
Direct Secure Messaging (DM): is a national encryption standard for securely exchanging health information between health care entities (e.g. primary care physicians, specialists, hospitals, laboratories, long term care facilities) in a trusted network. It is easy to use, inexpensive and functions like regular email with additional security measures. Direct messaging allows the secure exchange of clinical documents such as discharge

summaries, orders, and continuity of care documents. DM can be used to generate health alerts and reminders to improve care, especially for patients with chronic conditions. DSS has provisioned DM for the Medicaid EHR Incentive Program. DM is currently being used to communicate between providers, hospitals, labs, and long term care facilities. There are approximately 71 users of DM that Medicaid has offered. Medicaid has also provided an option to use DM to facilitate electronic scripts for Durable Medical Equipment (DME) between providers and suppliers. Medicaid and SIM plan to promote and expand DM to exchange secure clinical documents through a variety of initiatives including PCMH+, PCMH and facilities that do not have a certified EHR.
Enterprise Master Person Index (EMPI): is a database that is used across a healthcare organization to maintain consistent, accurate and current demographic and essential medical data on persons. Each person is assigned a unique identifier that is used to refer to him or her across enterprises. The main objective is to ensure that each patient is represented only once across all technology systems. Essential data includes name, gender, date of birth, race and ethnicity, social security number, current address and contact information, insurance information, current diagnoses, etc. This is an enterprise asset, through NextGate, that will be gradually scaled for the entire state. Medicaid and initiatives within SIM will utilize the EMPI.
Health Information Service Provider (HISP): The HISP is the organization that manages security and transport for health information exchange among health care entities and individuals using Direct. The state has provisioned Secure Exchange Solutions (SES) to be the state's HISP. SES HISP is fully accredited and is a member of the DirectTrust[4].
Provider Directory (PD): supports the management of healthcare provider information in a directory structure. It classifies Individual Providers (e.g. physician, nurse, pharmacist, etc.) and Organizational Providers (e.g. organizations that provide healthcare services such as hospitals, HIEs, managed care, etc.) by provider type, specialties, credentials, demographics and service locations. This is an enterprise asset, through NextGate, that offers a single provider ID for consistent enterprise use. The Medicaid Agency and SIM promote the use of the NextGate solution to simplify and consolidate the management of provider information.
PROPOSED NEW TECHNOLOGIES ASSETS
Alert Notifications Engine: is real-time notifications for care coordination and quality improvement purposes when patients are admitted, discharged, or transferred to, from or within a hospital. SIM will work with DSS to leverage the alert notification engine to promote secure communication through DM.
Consent Registry: a registry that allows patients to provide consent to share their medical information. This information is then used to control access to medical data and provides the ability to share medical information with non-medical providers not covered under HIPAA. DSS has procured a consent registry that can be expanded for the use of SIM initiatives in order to assess consumer consent status with respect to sharing information. State bond funds have already supported core procurement of the registry. SIM intends to work with DSS to leverage the consent registry so that patients can manage their consent as it pertains to support the.
Disease Registries: are collections of data related to patients with a specific diagnosis, condition, or procedure. This is also known as patient registries. DPH maintains several vital registries including Vital Statistics, Immunization, Syndromic Surveillance, Cancer and electronic laboratory reporting. At this time these registries do not collect data electronically. The HIT PMO will work with the Population Health Council to identify priority disease registries to promulgate promoting population health interventions.
Edge Servers: Provides the ability to capture data from EHRs and other database applications, file systems or websites and creates normalized indexes of data that are maintained by the original data source. Authorized users can then query, retrieve, extract, navigate, analyze and report across application data silos. Edge server technology will be used to create an expandable data overlay and integration platform on selected eCQMs across

[4] DirectTrust is a collaborative non-profit association of 145 Health IT and health care provider organizations to support secure, interoperable health information exchange via Direct message protocols. DirectTrust activities are consistent with the governance rules for the Direct Project and the NwHIN promulgated by HHS, ONC, and the mandates of the HITECH act.

SIM Model Test Participants. This technology provides data normalization and aggregation across systems, and is non-disruptive to existing production data systems. It leverages existing data collection and analysis systems to deliver global views across all application repositories. The platform enables reuse of existing application repositories, the ability to plug in new analysis tools for new views, and interoperability among the index nodes spanning multiple databases and other information system applications. Due to the use of edge servers for collection and analysis, data will be available on a timely basis and is capable of providing continuous, real-time integration. A standards-based mechanism will be used to transport data. Unstructured data will be captured in its native format and represented within the appropriate location of the standardized documents. The state plans to further review the use of edge servers to index eCQMs. This is one of the two methods the State plans to analyze quality measures. DSS is considering using QRDA standards to collect eCQMs for the Medicaid EHR Incentive Program. SIM proposes examining the use of edge servers to index quality measures identified by the Quality Council as well examining its use for VBP and/or the scorecard.
EHR Software as a Service (SaaS): Provides access to an EHR for entities who do not have a Certified EHR Technology (CEHRT). The state plans to execute a broad-based stakeholder engagement process that will include assessing the technology landscape. This will aid in assessing the need of, use of, and amount of this technology needed by healthcare providers/organizations in the state.
Mobile Applications: these are to be determined smartphone and tablet applications to provide access for patients to be alerted through mobile applications for reminders such as medicine refills, glucose tests, etc. This technology offering would support patient care coordination and chronic illness self-management.

The following Connecticut SIM HIT Drivers are critical for the success of the Connecticut SIM Model. Without interoperability, participants will not have the necessary information to support the model and transform healthcare in the state at an accelerated pace.

Table 2: SIM Health IT Secondary Drivers and Accountability Targets for Performance Year 1

Driver 1:	**Coordinate and connect various HIT initiatives throughout the state** **1.1** Designate a Health Information Technology Officer and an HIT Program Management Office to coordinate HIT initiatives throughout the state **1.2** Leverage federal funds awarded to the state to enhance access to and the rate of exchange of health information resulting in a person centered health care system **1.3** Establish and facilitate the statewide Health IT Advisory Council **1.4** Develop an HIT/HIE Roadmap for the state
Driver 2:	**Execute a broad-based stakeholder engagement process** **2.1.** Execute an RFP process to procure a vendor to perform the stakeholder engagement **2.2.** Identify and engage stakeholders (e.g. consumers, providers, healthcare organizations, payers, etc.) to determine current health IT needs, gaps and future direction **2.3.** Incorporate results of the engagement process into the Health IT landscape/ needs assessment
Driver 3:	**Leverage technical infrastructure for sending alerts to providers and caregivers using Direct Secure Messaging** **3.1** Participate and leverage the Provider Directory to enable sending alerts and notifications based on the ADT feed. **3.2** Extend the use of the HISP and DM to build the alert notification infrastructure **3.3** Extend the use of the alert notification engine **3.4** Provide technical assistance to organizations to utilize the alert notification engine
Driver 4:	**Establish a statewide health Information exchange** **4.1** Execute an RFP process to procure HIE Solutions **4.2** Leverage current Health IT Assets **4.3** Administer the HIE for the state per Public Act 16-77

In order to achieve the aforementioned drivers, there are four areas of investments that need to occur in Performance Year 1 to enable health information exchange, promote health information technologies to improve care coordination and lays the groundwork to support eCQMs. SIM will:

1. Establish the Health Information Technology Officer and the HIT Program Management Office to coordinate HIT Initiatives and leverage federal awards to support viable, long-term investments for the state.
2. Initiate a robust and broad-based stakeholder engagement process to assess and prioritize health information technologies needs in the state. This will entail HIT landscape and gap analysis and the development of the HIT/ HIE strategic plan that will assess and prioritize the SIM technologies needed to transform healthcare delivery system; establish the value proposition and a sustainable business model for the Health Information Exchange. The SIM identified technologies will provide the foundation for the HIE to be sustainable.
    a. Leverage current Health IT assets as well as procure technologies to achieve the "triple aim."
    b. Guide the RFP process to procure an HIE Solution(s)
3. Establish the statewide Health Information Exchange by doing the following:
    a. Leverage the Provider Directory and Enterprise Master Person Index
    b. Procure and implement the alert notification engine
    c. Accelerate alert notification utilization through Medicaid and SIM initiatives
    d. Procure and implement solutions to enable electronic data exchange for disease registries to support population health, planning, analyses and interventions.
    e. Acquire and establish technology and infrastructure to support interoperability by capturing patient data and report on clinical quality measures
4. Invest and provide technology solutions for SIM participants to meet the Triple AIM, including investing in transforming diseases registries to accept electronic submissions.

The above investments will enable the success of SIM Drivers that HIT will enable in Performance Years 2 and 3, identified in the below table.

Table 3: SIM Health IT Secondary Drivers and Accountability Targets for Performance Years 2-3

Driver 5:	**Support Data Analytics** **5.1** Examine and develop a multi-payer shared utility solution for the extraction, integration, and reporting of eCQMs, such as through the use of edge servers **5.2** Offer CareAnalyzer to support predicative modeling and data analytics
Driver 6:	**Deployment of Health IT Tools** **6.1** Mobile Applications **6.2** Electronic Disease Registries - develop interfaces for bi-directional electronic data submission (Begins in Performance Year 1). **6.3** EHR SaaS to entities who do not have a certified EHR technology **6.4** Other Health IT Technologies identified through the Stakeholder Engagement Process (e.g. telehealth, e-consults)

Governance

Organizational Structure and Decision-Making Authority related to Health IT

Effective on May 2, 2016, the Connecticut General Assembly passed Public Act 16-77 (P.A. 16-77), "*An Act Concerning Patient Notices, Designation of a Health Information Technology Officer, Assets Purchased for the State-Wide Health Information Exchange and Membership of the State Health Information Technology Advisory Council*." Sections 4 through 7 of the Act modify coordination of HIT related policy and activities for health reform initiatives in Connecticut and allow the state to build upon existing assets acquired and developed by the Department of Social Services (DSS) the state's Medicaid agency. The Public Act requires Lt. Governor Nancy Wyman, the state's lead on health reform initiatives, to designate a Health Information Technology Officer (HITO), who will report to her, to coordinate all state HIT initiatives. This officer is responsible for coordination all state health information technology initiatives in the state and will lead the effort to actualize a statewide HIE to be developed as a non-profit or public benefit organization, similar to other successful HIEs throughout the nation.

The HITO also will lead a project management office (PMO) that brings together various HIT initiatives in the state to coordinate HIT activities related to health reform, including Medicaid, SIM HIT supports, the All Payer Claims Database, the Department of Public Health's population health work stream, and other CMMI funded efforts directed to state entities, such as the Transforming Clinical Practice Initiative, among others. DSS continues to play a key role in HIT, including responsibility for human services technology alignment, launching of an alert engine and enhancing our EMPI and a provider directory in project year 1. DSS will work in partnership with the HITO to ensure coordination of efforts.

State Health IT Advisory Council

The current Governance structure builds upon the 2012 recommendations of the Health Technology Workgroup (HTWG) of the Connecticut Health Care Cabinet[5]. The HTWG recommended the creation of Technology Officer who reports directly to the Governor or the Lieutenant Governor, a Health IT Office and a steering committee who represents the various stakeholders in Connecticut. These recommendations are realized by Public Act 16-77.

With the passage of P.A. 16-77, the SIM HIT efforts have been incorporated into the legislatively mandated State Health Information Technology (Health IT) Advisory Council ("Health IT Council"), in which the SIM PMO is a standing member. The act also authorizes the appointment of three additional members to the Health IT Council with expectation that three legacy SIM HIT Council members may transition to the Health IT Council. The consolidation of the two councils will enable the SIM initiative to be closely aligned with the statewide HIT infrastructure that is being developed.

The Health IT Council includes clinical and administrative stakeholders from hospitals, physician practices, ambulatory care providers, health information technology leaders, state agencies and importantly consumers/ consumer advocates (See Table X: Health IT Council). The Health IT Council is charged with developing (1) recommendations to advance the state's health information technology and HIE efforts and goals; (2) implementing the state HIT plan and standards; (3) implementing the state HIE; (4)

[5] http://www.healthreform.ct.gov/ohri/lib/ohri/HealthTechnologyWorkGroupFinalReportRecommendations.pdf

appropriate governance, oversight and accountability measures to ensure success in achieving the state's HIT and HIE goals. The Office of the National Coordinator for Health Information Technology (ONC) notes that a strong governance body adds value in providing clarity and transparency of the roles of the stakeholders and processes for oversight, engagement, and accountability[6].

The Health Information Technology Officer (HITO) will chair the Health IT Council and will report to the Lieutenant Governor. The HITO will lead the effort to standup the statewide HIE as well as the efforts to coordinate various HIT Initiatives within the state. To coordinate the HIT efforts, the HITO will require both technology and administrative staff, which will be funded through federal and state resources within the SIM initiative.

Table 2: Health IT Advisory Council

Health Information Technology Officer -Chair

Roderick Bremby Commissioner of Social Services	Demian Fontanella Acting Healthcare Advocate	*To be Appointed* Provider of home health care services
Miriam Delphin-Rittmon Commissioner of Mental Health and Addiction Services	Kathleen DeMatteo Representative of a health system that includes more than one hospital	*To be Appointed* *Health care consumer or a health care consumer advocate*
Fernando Muñiz Deputy Commissioner of Children and Families	David Fusco Representative of the health insurance industry	Patrick Charmel Representative of an independent community hospital
Cheryl Cepelak Deputy Commissioner of Correction	Nicolangelo Scibelli Expert in health information technology	Ken Yanagisawa, MD Physician who provides services in a multispecialty group and who is not employed by a hospital
Raul Pino, MD Commissioner of Public Health	Patricia Checko Health care consumer or consumer advocate	Joseph L. Quaranta, MD (Co-Chair) Primary care physician who provides services in a small independent practice
Morna Murray Commissioner of Developmental Services	Bob Tessier An employee or trustee of a plan established pursuant to subdivision (5) of subsection © of 29 USC 186	Alan D. Kaye, MD Expert in health care analytics and quality analysis
Mark Raymond Chief Information Officer	*To be Appointed* Representative of a federally qualified health center	President Pro Tempore of Senate or designee
James Wadleigh CEO of the CT Health Insurance Exchange	Jeannette DeJesus Provider of Behavioral Health Services	Speaker of the House of Representatives or designee
Mark Schaefer Director of State Innovation Model Initiative Program Management Office	*To be Appointed* *Representative of the Connecticut State Medical Society*	Jennifer Macierowski Designee for Minority Leader of the Senate

[6] https://www.healthit.gov/sites/default/files/GovernanceFrameworkTrustedEHIE_Final.pdf

Jon Carroll CIO of UConn Health Center	*To be Appointed* *Technology expert who represents a hospital system*	Prasad Srinivasan, MD Designee for Minority Leader of the House of Representatives

Leveraging Existing Assets to Align with Federally-funded Programs & State Enterprise IT

The State of Connecticut maintains a number of technology solutions that were procured by the state and are being deployed by the Bureaus of Enterprise Systems and Technology (BEST), such as the Enterprise Master Person Index (EMPI), Healthcare Provider Directory (PD), Health Information Services Providers (HISP), and Direct Secure Messaging (DM). An additional asset is the All Payer Claims Database (APCD), maintained by Access Health CT, the quasi-public agency managing the state's health insurance exchange. These enterprise assets are fundamental to building a robust health IT infrastructure that will enhance care delivery, payment reform and implementing a statewide HIE. Connecticut's plan recognizes and leverages the aforementioned existing Health IT assets and state specific strategies while proposing new services and/or applications to act as enablers for the SIM drivers (see Table 1 in Rationale).

A key driver for investment in electronic health records adoption and health information exchange is the need to meet the Meaningful Use program requirements in order to qualify for incentive payments. Meaningful Use Stage 1 sets the foundation for the Medicare and Medicaid EHR Incentive Program by establishing requirements for the electronic capture of clinical data (either person- or aggregate- level data). Stage 2 Rules for Meaningful Use expanded upon this with a focus on ensuring that the meaningful use of EHRs supports the aims and priorities of the National Quality Strategy it also encourages the use of health IT for continuous quality improvement at the point of care and the exchange of information in the most structured format. Meaningful Use Stage 3 will begin in 2017 as an option for eligible professionals/hospitals and will be required in 2018. Stage 3 focuses on improved outcomes through advance use of health information exchange functionality and continuous quality improvement.

Meaningful Use already increased the requirements that health information technology vendors must follow, therefore Connecticut does not plan to place additional rules on providers to dictate how they must store or exchange data. Rather, SIM introduces a value proposition – if providers are paid for value, they will adopt the health information technology that helps them meet healthy, quality and cost goals. To strengthen the value proposition, Connecticut will leverage our current technologies to build a flexible and agile HIE. Once the HIE is operational, current policy levers require hospitals, clinical laboratories, and providers to participate in the statewide HIE.

As the first step in building the state's Health Information Exchange, SIM will support the Medicaid Agency's implementation of the Alert Notification in federally qualified health centers (FQHCs) and Advanced Networks (ANs) that participate in PCMH+. The state was approved through the February 2016 Implementation Advance Planning Document (IAPD) to build an alert notification system for Medicaid beneficiaries. The state will leverage the current work of the Medicaid Agency and will provide the fair share funding to support the non-Medicaid beneficiaries (please see the Section on Infrastructure for additional information).

Concurrently, the state will begin a stakeholder engagement process to assess existing technology landscape, identify additional HIT needs of the community to shape the development and implementation of an HIE. Note the state will support establishment of an HIE; however the HIE will not be a state-run entity. The state may continue to support the operations of the HIE. Moreover, a report from the Healthcare Information and Management Systems Society's (HIMSS) State Advisory Roundtable[7] indicated that state exchanges would evolve and change their business models as government policies promote the transition from fee-for-service to value-based reimbursement. With this in mind, Connecticut has the ability to learn from its successful predecessors and build a model where the HIE will facilitate care coordination. Connecticut's legislative policy levers are the building blocks that promote this transition.

Policy

The State is making a concerted effort to accelerate standards-based HIT adoption to improve care through policy and legislation. Beginning in 2014 the Connecticut General Assembly enacted three pieces of legislation to support the development of health information exchange in a strategic manner. These include:

- Public Act 14-217 (§ 169-175 & 259): This act transferred certain responsibilities to the Commissioner of DSS the responsibility to (1) implement a statewide health information technology plan; (2) establish electronic data standards to facilitate the development of integrated electronic health information systems for use by health care providers and institutions that receive state funding (in consultation with DPH and DMHAS). By law, the statewide plan must include electronic data standards and general standards and protocols for health information exchange for use throughout state agencies (DCF, DDS, DMHAS, DOC and DPH).
- Public Act 15-146 (§ 20-27): This act built upon Public Act 14-217 and created the 28-member State Health IT Advisory Council that began work in August 2015 to advise the DSS Commissioner on developing priorities and policy recommendations for advancing HIT and HIE efforts. The act (1) established authority for a statewide health information exchange, and gave DSS administrative authority over the HIE; (2) provided DSS the authority to develop uniform management information, terminology and Health IT standards across agencies and coordinate federally-funded programs in human services agencies; (3) requires participation for all hospitals and clinical laboratories to connect to the HIE no later than one year following its launch with the condition that the connection will be bi-directional between other hospitals and providers with an EHR capable of exchanging records. In addition it also requires participation of providers with EHRs to connect no later than two years following the HIE launch; and (4) to develop a statewide HIE plan. The act also included provisions related to the following:
    - Health Care Spending, Cost Containment and Disclosing Cost Information: (1) Health Care Cost Study - the Insurance Commissioner to convene a workgroup to study rising health care costs and examine increases in prices charged for health care services; variation in provider charges impact of these prices and variations on health insurance reimbursement rates and the impact of provider price variation on the state's health care spending as both a payer and

[7] http://www.himss.org/

provider of health care services, insurance premiums and consumer out-of-pocket expenses. (2) Health Care Cost Containment Models - the state's Health Care Cabinet to study health care costs containment models in other states and report its finding and recommendations to the legislature including methods to monitor and control health care costs; promote the use of high-quality health care providers with low total medical expense and prices; improve health care cost and quality transparency and improve quality of care and health outcomes. (3) Disclose Cost Information - each health carrier to disclose information about in and out of network costs to consumers. It also requires Access Health CT, the state's health insurance exchange to post information regarding information about each carrier for their respective health plan offering through the HIX as well as to post online tools available to help consumers compare and evaluate health insurance policies and plans.

- Health Information Blocking - The act makes "health information blocking" an unfair trade practice, and specified that a hospital, health system or seller of EHR systems that engage in health information blocking is subject to certain civil penalties under the unfair trade practices law. It defines health information blocking as knowingly interfering with or engaging in business practices of other conduct reasonably likely to interfere with the ability of patients, providers or other authorized persons to access, exchange or use EHRs or using EHR system to both steer patient referrals to affiliated providers and prevent or unreasonably interfere with referrals to nonaffiliated providers. It also makes it an unfair trade practice for a seller of an EHR system to make a false, misleading or deceptive representation that the system is certified by ONC.

- Public Act 16-77 (§ 4-7): The act, signed by the Governor on June 2, 2016, requires the Lieutenant Governor to designate a Health Information Technology Officer (HITO) for the State. As mentioned in the Governance section, this officer is responsible for coordinating all state health information technology initiatives. The act transfers various existing responsibilities from the DSS commissioner to the HITO, such as the authority over the statewide health information exchange and implementing and revising the statewide health information technology plan. The act also adds three more members to the State Health IT Advisory Council. During the transition to the HITO, the Lieutenant Governor and her advisors, the DSS Commissioner, and the SIM PMO will work together to support executing the state's Health IT plans. This act also supersedes certain provisions in PA 15-146.

SIM Health IT Alignment with other State, Federal and External Health IT Efforts

The State of Connecticut is engaged in multiple federally supported health care innovation activities, representing a considerable investment in the state. The SIM PMO, with the advice of the Healthcare Innovation Steering Committee, will ensure that SIM funding does not duplicate or supplant current initiatives and aligns SIM objectives consistent with other federal investments and CMMI initiatives within the state. It is expected and required by law that the newly designated HITO will coordinate HIT and HIE activities across state agencies and other stakeholders as well as foster growth of HIT activities in the state.

Other State Health IT Efforts

The following activities are currently underway within the State and will influence HIT and HIE activities in the next 5 years:

Strategic HIT Planning

A strategic planning process is underway to create a shared vision of exchanging health information in the state in an interoperable manner. Once the HITO is on board, the officer with the advice of the Health IT Council will begin an extensive stakeholder engagement process, establish a governance structure and build a strategic plan to support an interoperable HIT/HIE infrastructure in the state. Stakeholders include state agencies, payers, hospitals, health care provider organization/societies, consumers, and businesses. As part of the strategic planning process, the state will also perform an environmental scan and a gap analysis. This will identify current technology needs and gaps within the market that the statewide health information exchange can fulfill and help ensure that technology investments are not duplicative. It is anticipated that the stakeholder engagement is the first part of the strategic planning process, which will begin when the HITO is on boarded.

Department of Social Services HIT/ HIE related activities

Medicaid is a key partner in transforming the health information technology landscape in the state. DSS is working to put systems in place to help residents qualify for services easily and timely. Additionally, DSS holds a wealth of data – claims, member eligibility and provider data that can be analyzed to improve care. DSS is working with their Administrative Services Organizations (ASOs) to: help beneficiaries utilize their medical, behavioral health and dental benefits and as well as connecting with their providers; integrate medical and behavioral health care; enable people who need long-term services and supports to receive them in the community; utilize claims data to identify and monitor the needs of beneficiaries; help inform policy decisions; and shift to a value based payment method. Two areas of interest are the Medicaid EHR Incentive Payment Program and the Testing Experience & Functional Tools Grant (TEFT):

DSS offers the **Medicaid Electronic Health Record (EHR) Incentive Program**, which provides incentive payments to Medicaid-enrolled hospitals and "eligible professionals." The program utilizes 100% federal funding for the incentive payments and 90% for administration as authorized by Section 4201 of the *American Recovery and Reinvestment Act of 2009* (ARRA). As of April 2016, CMS has accounted for a total of 6,432 eligible professionals and 28 eligible hospitals paid through the Medicare and Medicaid EHR Incentive program[8]. The CT Medicaid EHR Incentive program collaborates with other Region 1 states on a quarterly basis to share information. In addition, it is part of a 13 state Medical Assistance Provider Incentive Repository (MAPIR) collaborative.

Eligible Professionals and Hospitals attest to meeting a specific set of meaningful use measures and must report on clinical quality measures. DSS has proposed the use of Quality Reporting Document Architecture (QRDA) Category III and I standards for receiving electronic Clinical Quality measures

[8] https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/April_2016_Unique_Of_Providers_By_State.pdf

(eCQMs)[9]. This is another option the state may pursue outside the edge serve technology SIM is considering to analyze clinical quality measures.

Recently CMS published the State Medicaid Director's letter (SMD #16-003) that provides the availability of HITECH administrative matching funds to support HIT and HIE efforts. As mentioned earlier, the Medicaid agency has received approval to begin alert notification for Medicaid beneficiaries. SIM funding will augment the scope of DSS' current activities to support non-Medicaid beneficiaries. For the upcoming submission of the IAPD and moving forward, the HITO will work with the Commissioner of Social Services and the EHR Incentive Program to coordinate and apply for HITECH administrative funds to support the HIE. As required by Public Act 16-77, all "applications, proposals, planning documents or other requests seeking federal grants, matching funds or other federal support" require review and comments from the state Health IT Advisory Council.

DSS was also awarded the **Testing Experience & Functional Tools Grant** (TEFT) in 2014. Connecticut is one of six states awarded funding for all four-grant components. The expected outcomes of the TEFT grant program includes testing the usability of PHRs and automating transport of an eLTSS care plan, which are the two HIT components of the TEFT grant. TEFT will support Money Follows the Person (MFP) and the Balancing Incentive Program (BIP).

Community Health Network of Connecticut (CHNCT) – Alert Notifications

CHNCT receives automated HL7 messages for inpatient and emergency department (ED) ADT information from hospital EHRs. This allows CHNCT to identify CT Medicaid members at the point of care who have recent history of ED utilization and a targeted medical diagnosis in order to connect them with follow-up primary care and/or community resources. The CHNCT ED Care Managers collaborate with the hospital EDs to identify and address medical, functional, social and emotional needs that increase the members risk for inappropriate use of the emergency department. The HITO will work with CHNCT and the other ASOs around their use of alert notifications.

Practice Transformation Initiatives – Central Data Repository

Community Health Center Association of Connecticut (CHCACT) has been working with CHNCT since 2012 to develop a central data repository for FQHC Clinical data. The data that is transmitted from the FQHC EHRs to the data warehouse using Continuity of Care Documents (CCDs). As part of the HIT landscape analysis, the State will identify efforts like these that aim to make clinical data actionable. This information will be used to inform the strategy that will promote an infrastructure for eCQMs.

[9] Clinical Quality Measures (CQM) are tools that help measure and track the quality of health care services provided by providers and hospitals. These measures use data associated with providers' ability to deliver high-quality care and measure aspects of patient care including health outcomes, clinical processes, patient safety, efficient use of health care resources, care coordination, patient engagement, population and public health, and adherence to clinical guidelines. ONC and the electronic CQM (eCQM) community have developed electronic specifications, which include human readable descriptions and XML files.

Prescription Drug Monitoring Program (PDMP)

The PDMP is overseen by the Department of Consumer Protection and collects prescription data for Schedule II through Schedule V drugs into a central database, the Connecticut Prescription Monitoring and Reporting System (CPMRS), which can then be used by providers and pharmacists in the active treatment of their patients. CPMRS presents a complete picture of a patient's controlled substance use, including prescriptions by other providers so that providers can properly manage the patient's treatment including the referral of a patient to services offering treatment for drug abuse or addiction. CPMRS receives data once a week from dispensing pharmacies and practitioners. PDMP serves a number of functions including assisting in patient care, providing early warning signs of drug epidemics and detecting drug diversion and insurance fraud. Providers and pharmacies have the ability to have the CPMRS integrated into their EHR technology. Otherwise they can log in through the portal. The CT PDMP currently shares information with 20 other states through the Alliance of States with Prescription Monitoring Programs (ASPMP). The PDMP interface with the Health Information Exchange is an option that SIM and the state may consider in the future.

Regional Extension Center (REC)

eHealthCT (eHCT), the designated Regional Extension Center (REC) for Connecticut, received a $7.3 million award from ONC to help the providers select, implement, and achieve Meaningful Use of CEHRTs. The REC enrolled over 1,500 primary care providers and reached its targeted goal of 1,308 primary care providers by the end of 2015. Additionally, the REC has integrated their MU assistance program with PCMH training and recognition program for 100 primary care providers.

Beyond the work covered by the original Cooperative Agreement with ONC, eHCT continues to provide HIT and Practice Transformation Services. eHCT serves as a subcontractor for Community Health Center of Connecticut (CHCACT) and UConn Health / UMass Medical School for their respective CMS Transforming Clinical Practice Initiative (TCPI) grants. They are leading ongoing popHealth workgroups and provide direction, both technical and organizational, to the open source governance body and provide implementation support work to Connecticut FQHCs and other entities. In addition, they are participating in a DPH CDC funded grant award, "State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health" (SHAPE) by assisting in the collection of data from large ambulatory settings on diabetes and blood pressure quality measures. The REC is a stakeholder in Connecticut's landscape and will part of the engagement process.

All Payer Claims Database (APCD) Policies

The Connecticut APCD was established in 2012. With the passage of Public Act 13-247, the Connecticut General Assembly authorized Access Health CT (Connecticut's health insurance exchange) to:

"(A) Oversee the planning, implementation and administration of the all-payer claims database program for the purpose of collecting, assessing and reporting health care information relating to safety, quality, cost-effectiveness, access and efficiency for all levels of health care;
(B) ensure that data received from reporting entities is securely collected, compiled and stored in accordance with state and federal law; and
(C) conduct audits of data submitted by reporting entities in order to verify its accuracy."

PA 13-247 further directs Access Health CT to

"(A) Utilize data in the all-payer claims database to provide health care consumers in the state with information concerning the cost and quality of health care services that allows such consumers to make economically sound and medically appropriate health care decisions; and
(B) make data in the all-payer claims database available to any state agency, insurer, employer, health care provider, consumer of health care services or researcher for the purpose of allowing such person or entity to review such data as it relates to health care utilization, costs or quality of health care services. Such disclosure shall be made in accordance with subdivision (2) of subsection (b) of section 38a-1090 of the general statutes, as amended by this act. The exchange may set a fee to be charged to each person or entity requesting access to data stored in the all-payer claims database." [10]

In June 2016, DSS and Access Health CT signed a Memorandum of Agreement to make Medicaid data available to the state's insurance exchange to improve the health of the population through transparency, informed decision making, and support health reform activities. Medicaid data may be made available to the extent the permitted data use conforms with State and Federal laws. The recent Supreme Court Ruling[11] is being carefully reviewed to better understand the implications and opportunities for states. Since the Access Health CT sits on the state Health IT Advisory Council, SIM and the HITO may pursue broader analytics capabilities between APCD, DSS and SIM.

Public Health Disease Registries

The Department of Public Health (DPH) collects health information to prevent and contain outbreaks, analyze population health trends, and educate and promote healthy choices. There are many important registries that DPH currently maintains including: Annual Registration Report of Vital Statistics, Connecticut Immunization Registry and Tracking System (CIRTS), Infectious Disease/ Syndromic Surveillance, STD, Lyme Disease, Food-Borne Illness, Connecticut Tumor Registry (CTR); Lead Poisoning Surveillance, and Birth Defects Surveillance. Additionally, DPH collects data on Health Behavior such as

[10] http://apcdcouncil.org/state/connecticut

[11] March 2016 the U.S. Supreme Court issued a ruling regarding a Vermont law requiring health insurance plans to provide certain claims information to state agencies for the purpose of compiling a database that consumers use to compare health care prices. The Court ruled that Employee Retirement Income Security Ace (ERISA) plans were exempt from the Vermont law and insurance companies are not required to provide claims information from ERISA plans to the state. (For more information please see Gobeille v. Liberty Mutual Insurance Company)

the Behavioral Risk Factor Surveillance System, Mother and Child Health Indicators (collects birth weights, prenatal care, birth outcomes), Family Health Indicators (pregnancy prevention activities), and Connecticut Health Check (a periodic survey of students in grades 6-12). Currently, providers report to these registries by paper therefore data entry into the registries is manual. The HITO will work with the DPH, the SIM Population Health committee and through the stakeholder engagement process to identify possible registries and develop a plan to support registries to permit bi-directional electronic data submission.

Other Federal Health IT Efforts

At the federal level, the Health Information Technology for Economic and Clinical Health (HITECH) provisions created a crucial foundation for restructuring health care delivery and for realizing key goals of improving health care quality, reducing costs, and increasing access through better methods of storing, analyzing, and sharing health information. The HITECH Act sought to improve patient care and make it patient centric through the creation of a secure nationwide information network. The act established the EHR Incentive Program that incentivized the health care delivery system to adopt and meaningfully use electronic health records. It also funded the regional extension centers, supported the development and use of clinical registries, and linked health outcomes research networks - all of which are critical to carrying out the comparative clinical effectiveness research that is expanded under health reform.

Methods to Improve Transparency, Encourage Innovative Uses of Data, Promote Patient Engagement and Shared Decision Making

For innovation to occur and health information exchange to succeed, strong leadership is needed. The Health Information Technology Officer will enhance the state's ability to provide direction, oversight and transparency on activities as well as directly leading the HIE efforts and leveraging state infrastructure and finances. Moreover, as Connecticut's HIE business model matures, the State and its stakeholders will need to recognize that the HIE will evolve to become a major tool to facilitate health care coordination, supporting the state and its partners as it substantially expands payment reform and care delivery transformation. Additionally, as required by PA-16-77, all "applications, proposals, planning documents or other requests seeking federal grants, matching funds or other federal support" require review and comments from the Health IT Council. Since the meetings are open to the public and all documentation is posted on the webpage, this will improve transparency and buy-in for transformation efforts.

To further improve communication with stakeholders as well as to identify innovative technology and its use, the broad-based stakeholder engagement planned for Performance Year 1 will provide the opportunity for the HITO and staff to understand the current landscape and innovation happening within the state that is transforming the delivery of care, leverage innovation and ensuring no duplicative activities occur with technology funds.

The below table depicts an initial list of stakeholders that the state plans to engage.

Table 3: Draft Stakeholder Engagement

Hospitals & Health Systems	➢ All Hospital systems ➢ YNHHS ➢ Hartford ➢ St. Francis	➢ L & M ➢ Griffin ➢ Western CT ➢ Middlesex	➢ St Vincent's ➢ WCHN ➢ CHA
Physician Groups	➢ CSMS and County Societies ➢ NEMG ➢ YMG	➢ St Vincent's PHO ➢ St Francis PHO ➢ Western CT PHO ➢ ProHealth	➢ Hartford Hospital ICP ➢ Middlesex IPA ➢ Starling ➢ CMG
Patient Advocacy Groups	➢ State Agencies involved with Health and Human Services	➢ Community Organization	➢ CT Community Nonprofit Alliance
Providers	➢ Community Providers ➢ Behavioral Health Providers	➢ Independent practitioners ➢ APRNs ➢ Non-Profit Providers	➢ CNMs ➢ Long-Term Services ➢ Others
Lab Providers	➢ Quest ➢ Lab Corp	➢ Hospital labs	➢ Independent labs
Large Independent Radiology Groups	➢ Advanced Radiology	➢ Jefferson Radiology	
Other	➢ Patients ➢ Consumers ➢ Possibly the HIT membership ➢ Nonprofits for hospitals, primary care ➢ FQHC Clinics ➢ REC ➢ EHR Vendors	➢ Small, medium and large ambulatory providers not employed by hospital networks ➢ Insurance companies ➢ Pharmacy/ PMB data ➢ EHR & analytic platform vendors	➢ Community and facility based long-term care organizations ➢ Skilled Nursing Facilities ➢ Visiting Nurse Agencies ➢ Home Health Care

The following table drills down on the Health IT levers as they support the SIM Primary Drivers:

Table 4: HIT Driver Diagram Drill Down

SIM Primary Driver	HIT Secondary Driver	Functionality/Output	Health IT Levers
Primary Care Transformation: Strengthen capabilities of Advanced Networks and FHQCs to delivery higher quality, better coordinated, community integrated and more efficient care	**Driver 1** Coordinate and connect various HIT initiatives throughout the state	• Per PA 16-77, the HITO shall be responsible for coordinating all state health information technology initiatives and may seek private and federal funds for staffing to support such initiatives • The HITO will also coordinate the state's health information technology and health information exchange efforts to ensure consistent and collaborative cross-agency planning and implementation	Legislation to establish HITO and coordination of HIT activities

	Driver 3 Establish a technical infrastructure for sending alerts to providers and caregivers using Direct Secure Messaging	• Statewide, secure and interoperable health information exchange
		  • Statewide hospital notifications to ANs, health plans, ANs/FQHCs when their patients are seen in the ED, are admitted to inpatient care, discharged from the hospital, or transferred to a nursing facility
		  • Timely, secure, and patient-consented access to the relevant and appropriate health and/or other information of patients (Medicaid, Medicare and commercially insured) as they move across health care and community systems, to appropriate clinical providers and community organizations, to improve health outcomes, avoid duplication, and improve convenience for the patient. For example: ability of primary care ANs to access the necessary data on their patients if their patient has received care from a different AN or has been admitted to a hospital, etc.)
			• ADT
			• DM
			• PD/EMPI
			• HISP
			• EHR SaaS

	Driver 4 Establish a statewide health Information exchange	• Statewide, secure and interoperable health information exchange (linkages across ANs, across ANs and clinical and non-clinical community partners, and across ANs and consumers)
		• Comprehensive care teams comprised of patients, other supports, members of the primary care team, and appropriate clinical and non-clinical community services and supports work together to better support patients' achievement of care goals
		  • Electronic connectivity among all members of the care team enables efficient one-to-many communication to support coordination, care plan adjustments, and problem solving.
		  • Shared care plans exist that allow full consumer access and supports efficient care team communication and consent based access for other members of the care team.
		• Clinical and community linkages through efficient referral and tracking
		  • ANs are able to efficiently refer and track follow-up with their patients (e.g., e-referrals to in-network and out-of-network providers with ability for bi-directional communication and follow-up tracking)
			HIE
			• PD
			• EMPI
			• HISP
			• DM
			• Consent Registry
			• EHR SaaS Other technologies

		• ANs are able to access an up-to-date resource list and efficiently refer and track follow-up with their patients, including only relevant, patient authorized data in pre-identified fields • ANs access consumer consent data to support care coordination and referrals.	

Payment Reform: Promote payment models that reward improved quality, care experience, health equity and lower cost
 	
(Performance Year 2 and 3 HIT activities)
	Driver 5 Support Data Analytics	• Payers and ANs have access to a shared utility for the production of clinical quality measures to support value-based payment; automated data capture is an improvement over self-reported data and allows the information to be stratified by payer, AN, and patient characteristics such as race/ethnicity.
		• Statewide performance/continuous quality improvement analytics for those participating in and administering new and existing value-based payment models. Reliable, secure, timely, and actionable information created from clinical quality data to support health care ANs, public health agencies, and health plans' ability to deploy targeted strategies to improve population health, including public reporting.
		  • Payers access CQMs from clinical systems in automated way
		  • Ability of payers to use clinical-data based quality measures to track and reward AN performance. This means enabling data to be stratified by AN and by health plan.
		  • Ability of ANs and consumers to have timely and secure access to this data (by a portal, web interface, dashboard, etc.), and promote streamlined reporting. Access to data allows ANs to stratify data by payer and aggregate data across payer so ANs can see their performance on quality measures for their entire panel. Ability for ANs to analyze data by race/ethnicity and other sub-population characteristics such as income, languages spoken, geography/neighborhood, and sexual orientation/gender identify.
		  • Ability to streamline AN reporting requirements.
		  • Ability to combine information from a variety of sources, including claims and lab data, in order to inform a comprehensive view of the patient, population, and performance on a quality measure. Includes the ability to combine data from various sources as patients move across the health system (in-network and out-of-network ANs)
			• Edger Servers
			• CareAnalyzer

	Driver 6 Deployment of Health IT Tools		• EHR SaaS • Electronic Disease Registries • Other Health Information Technologies (TBD)
Consumer Empowerment: Engage consumers in healthy lifestyles, preventive care,	**Driver 2** Execute a broad-based stakeholder engagement process	• Public scorecard: Consumers have public access to the performance of Advanced Networks & FQHCs to inform their decisions regarding choice of AN; • Patients have access to their health or other relevant information even as they move across health ANs;	• Engage stakeholders to determine Health IT needs

chronic illness self-management, and healthcare decisions	**Driver 6** Deployment of Health IT Tools	• ANs have the capability of efficient consultation with specialists and bi-directional engagement with consumers (e.g. remote monitoring, consumer data automatically transmitted to AN) to increase consumer access to ANs, and engagement and timeliness of care.	• Mobile Applications • Scorecard • Other HIT (e-consult, telehealth)

Multi-Payer Strategies to Enable and Expand the Use of Health IT

Payer engagement is critical to achieve data reporting and payer analytics that align with SIM goals. Health plans, employers and Medicaid are and will remain involved in all aspects of planning and oversight for Connecticut SIM. In addition to representation on the Steering Committee, private and public payers participate on the Health IT Council as well as the Practice Transformation, Quality, CHW, and Equity & Access work groups. Anthem is the largest carrier in the State of Connecticut and one of the administrators of the Connecticut State Employee and Retiree Healthcare Plan and have actively participated in nearly all of the above forums. These forums will continue to provide formal mechanisms for payers to remain engaged in the implementation of the SIM grant. The HITO and the HIT PMO will foster multi-payer strategies to enable and expand the use of Health IT within the state. A Broad-based stakeholder engagement process is a critical next step.

Infrastructure

Background

Connecticut is starting from a place of strength. All hospitals in the state as well as over 6,400 providers have received an incentive payment through either the Medicare or Medicaid EHR Incentive Payment Program. We believe that close to 75% of all medical professionals (i.e. physicians, dentists, APRNs, & certified nurse midwives) are using certified EHR technology which will help providers integrate their EHRs with the HIE when it is operational.

Public Act 16-77,

Vision for the statewide HIE:

"There shall be established a State-wide Health Information Exchange to empower consumers to make effective health care decisions, promote patient-centered care, improve the quality, safety and value of health care, reduce waste and duplication of services, support clinical decision-making, keep confidential health information secure and make progress toward the state's public health

The State Medicaid Agency is promoting Directed Exchange since it is one of the three key forms of health information exchange promoted by the ONC. It provides the ability to send and receive secure information electronically between care providers to support coordinated care – such as discharge summaries, laboratory orders and results, or patient referrals. This form of information exchange enables coordinated care. Directed exchange can also be used for sending immunization data to public health or to report quality measures. Since the Directed Exchange is standards-based, this can be incorporated into the statewide HIE. Similar to other states, the state's Health IT Infrastructure follows a "network of network" approach that links entities through a standard set of "core services" and allows one entity to share data with one another and provides the ability to access data from across institutions, States, and repositories. Connecticut's Health IT infrastructure is a network of networks: Medicaid Management Information System (MMIS), integrated delivery networks, payer networks, e-prescribing infrastructure, vendor networks, and an evolving Directed Exchange Health Information Exchange (HIE) Model.

Public Act 16-77 cites the following goals for the statewide HIE:

Allow real-time, secure access to patient health information and complete medical records across all health care provider settings;

(1) Provide patients with secure electronic access to their health information;
(2) Allow voluntary participation by patients to access their health information at no cost;
(3) Support care coordination through real-time alerts and timely access to clinical information;
(4) Reduce costs associated with preventable readmissions, duplicative testing, and medical errors;
(5) Promote the highest level of interoperability;
(6) Meet all state and federal privacy and security requirements;
(7) Support public health reporting, quality improvement, academic research, and health care delivery and payment reform through data aggregation and analytics;
(8) Support population health analytics;
(9) Be standards-based; and
(10) *Provide for broad local governance that (A) includes stakeholders, including, but not limited to, representatives of DSS, hospitals, physicians, behavioral health care providers, long-term care providers, health insurers, employers, patients, and academic or medical research institutions, and (B) is committed to the successful development and implementation of a statewide Health Information Exchange.*

The goals of the statewide HIE can be met by assuring a meaningful stakeholder engagement process (Goal 11), followed by implementing a secure and standards-based interoperable infrastructure (Goals 6, 7 and 10), that allows for alert notification (Goals 1, 4, 5), is cost-effective and supports value based outcomes (Goals 8 and 9) and empowers the person through the use of a Personal Health Records (PHR) [12](Goals 2 and 3).

SIM Health IT Drivers for Performance Year 1

Driver 1: Coordinate and connect various HIT initiatives throughout the state

1.1 Designate a Health Information Technology Officer and an HIT Program Management Office to coordinate HIT initiatives throughout the state
1.2 Leverage federal funds awarded to the state to enhance access to and the rate of exchange of health information resulting in a person centered health care system
1.3 Establish and facilitate the statewide Health IT Advisory Council
1.4 Develop an HIT/HIE Roadmap for the state

Driver 2: Execute a broad-based stakeholder engagement process

2.1. Execute an RFP process to procure a vendor to perform the stakeholder engagement
2.2. Identify and engage stakeholders (e.g. consumers, providers, healthcare organizations, payers, etc.) to determine current health IT needs, gaps and future direction
2.3. Incorporate results of the engagement process into the Health IT landscape/ needs assessment

Driver 3: Leverage technical infrastructure for sending alerts to providers and caregivers using Direct Secure Messaging

3.1 Participate and leverage the PD to enable sending alerts and notifications based on the ADT feed
3.2 Extend the use of the HISP and DM to build the alert notification infrastructure
3.3 Extend the use of the alert notification engine
3.4 Provide technical assistance to organizations to utilize the alert notification engine

Driver 4: Establish a statewide HIE

4.1 Execute an RFP process to procure HIE solutions
4.2 Leverage current Health IT Assets
4.3 Administer the HIE for the state per Public Act 16-77

[12] DSS has received a 4 year grant through a CMS funded grant, Testing Experience and Functional Assessment Tools (TEFT) which provides PHRs to Medicaid Beneficiaries. Additional information can be found at http://www.ct.gov/dss/cwp/view.asp?a=3922&q=562672

The State Innovation Model Health IT objectives, as mentioned in the Rationale, are aligned and augment the state's vision and goals. In Performance Year 1, the HITO in conjunction with SIM will complete a robust and broad-based stakeholder engagement process that will identify key state needs to implement an interoperable infrastructure and planning for SIM technologies. Additionally, SIM will build upon the alert notification infrastructure that Medicaid is currently developing. In Program Years 2 and 3, SIM will support building the statewide HIE infrastructure, however the Health IT may focus on strengthening quality improvement and data analytics.

Investments in these areas support increased communication between providers, care coordination and integration across settings, population health assessments, improved care delivery and quality measurement and reporting. Connecticut's plan recognizes and leverages existing HIT assets and state specific strategies while proposing new services and/or applications to act as enablers for the SIM Drivers.

This strategy begins with the establishment of the HITO and the HIT PMO. It is anticipated that the HITO will be designated prior to the start of FFY 17. In this capacity, the HITO will establish a HIT PMO, chair the Health IT Council, and procure a vendor to perform a stakeholder engagement process.

The HITO's management of the broad-based stakeholder engagement process will verify if the technology SIM offers will substantially enable transformation and reform. SIM will have the ability to reassess, identify, and invest in technologies that are scalable, enterprise solutions. And provide value to the state through its development of the Health Information Exchange.

This stakeholder engagement process will determine which technologies the state should invest in to support care coordination, data analytics and quality improvement over the next several years. At this time, SIM anticipates the following HIT and data analytic needs:

Consent registry: Fund the expansion of the consent registry procured by DSS so that SIM participants can query and assess patient consent status with respect to sharing of information.

Direct Messaging: In Program Year 1, DM will be used to send messages between providers and/or systems allowing for the secure exchange of clinical documents (e.g. discharge summaries, CCDs). The use of DM can be expanded to generate health alerts and reminders to improve care and/or to submit data into disease registries (e.g. Immunization, Cancer, or a Chronic Disease Registry). DM will also be offered to providers who are not eligible for the CMS EHR Incentive Program, including behavioral health, long-term care, and home health agencies. SIM may explore the new initiative, Partnership for Patients Program (P4PP) that utilizes DM to improve communication between patients and their providers.

Quality Measurements: Quality Reporting Document Architecture (QRDA) Category III and Category I are standards for receiving electronic Clinical Quality Measures (eCQMs). This is an option that the state Medicaid EHR Incentive Program is exploring. If this mechanism to collect CQMs is successful, SIM can repurpose it to assist in collecting quality measures recommended

by the Quality Council and support the production of the cross-payer performance scorecard. A second option is to pilot indexing technology through edge servers. Medicaid is currently piloting this edge server technology. SIM will evaluate Medicaid's success for collection of quality measurements and for data analysis through this technology.

Alert Notification: Concurrently, the state will implement an alert notification service to support the health care delivery system by providing real-time or near real-time information about patients and their health care services, accelerating the ability of ANs and FQHCs to provide immediate care coordination. The state was approved, through the February 2016 Implementation Advance Planning Document (IAPD) to build an alert notification system for Medicaid beneficiaries. DSS is in the pre-implementation of the ADT infrastructure with the Medicaid ASOs. SIM will leverage the ADT infrastructure and expand this program to provide funding to support the non-Medicaid beneficiaries who receive services at FQHCs and ANs that participate in PCMH+.

The ANs and FQHCs participating in PCMH+ and other value based payment arrangements is the perfect environment to test the alert notification; it supports providers, care coordination and provides needed transparency in data sharing. Provider organizations are interested in real-time reporting that leads to improved efficiency, better quality and a lower total cost of care.

The Master Timeline outlines the activities for the life of the initiative. For Performance Year 1, The SIM technology investment in the state's alert notification system allows the delivery system to use HIT to:

1. Coordinate transitions of care with entities outside of their own system
2. Receive timely information from systems outside of their own internal systems
3. Improve health outcomes of individual patients that have the potential to both improve overall population health and lower potentially avoidable events.

SIM funds have been proposed to enable the following activities in Performance Year 2 and 3:

1. Mobile Applications for improving care management and health tracking. The stakeholder engagement will identify the types of applications that consumers would be interested in to track key health issues.
2. EHR SaaS to support targeted providers who do not have certified EHR including behavioral health care providers, long-term health care agencies and home health agencies.

Analytical Tools, Data-Driven, Evidence Based Approaches

The SIM PMO is currently monitoring and reporting on the impact of the SIM on 1) population health; 2) health care quality; and 3) per capita healthcare spending as it pertains to the entire Connecticut population. Health disparities are also tracked, to ensure that the Model Test is promoting health equity while it is improving population health and health care quality.

The core Health IT components, PD and EMPI, provide the foundation for the integration of data to be used for data analytics. The availability of DM provided by the HISP and DM addresses available through the Provider Directory address gaps in exchange. ADT alerts will also be supported through DM. This overall infrastructure approach is flexible enough to support innovative solutions to exchange health information such as open Application Programming Interface (APIs) and Fast Healthcare Interoperability Resources (FHIR) as exchange solutions continue to evolve. By building a flexible infrastructure, the state is building a scalable platform that will not only enhance interoperability but will advance data analytic services.

The potential use of edge servers will allow for data analysis without having to move and secure large datasets. Additionally, health plans and most stakeholders worry about security and privacy, and edge server technology allows the owners of the data to retain total control of their data, with knowledge that copies of their data are not being reviewed and analyzed. Lastly, this allows for reports to run against the most updated information in local provider databases and/or clinical systems.

Connecticut's evaluation approach includes:

1. Collection of real-time data to promote and support continuous quality improvement
2. Use of advanced statistical methods to analyze complex data and account for nonrandomized designs when conducting assessments of specific innovations, such as VBID
3. Collection of qualitative data to better understand the context of reform efforts

Since 2012, Medicaid has had the benefit of a fully integrated set of claims data across all categories of Medicaid services. The Department's medical ASO, CHNCT, maintains this data within the Utilization & Cost Analyzer (UCA) system, an analytical and data discovery tool that includes Medicaid claims, member eligibility, and provider data. UCA utilizes QlikView software for visualization that is uploaded monthly with claims, member eligibility, and provider data directly from CHNCT's data warehouse specific to the Connecticut Medicaid program. **UCA is a tool that can be leveraged for PCMH+ participants.** The data warehouse is populated with data from DSS and its claims processing partner, Hewlett Packard Enterprise (HPE). UCA provides a simple, rapid, and comprehensive means of assessing medical cost and utilization trends in various cuts of the claims, member eligibility and provider data with multiple layers of investigative analysis, to the claim, member, and provider level.

Plans to Utilize Telehealth and Perform Remote Patient Monitoring

P.A. 15-88 requires certain health insurance policies to cover medical services provided through telehealth to the extent that they cover the services through in-person visits between an insured person and a health care provider. It also establishes requirements for health care providers who provide medical services through the use of telehealth. SIM and the HIT PMO will advocate for the use of telehealth and will identify additional barriers or obstacles through SIM initiatives that may require statutory changes. In addition, the SIM PMO is offering assistance with implementing e-consult solutions on an elective basis as part of the CCIP.

Plans to Use Standards-Based Health IT to Enable Electronic Quality Reporting

Public Act 15-146 established and Public Act 16-77 retained the following health information exchange goals: (1) Allow real-time, secure access to patient health information and complete medical records across all health care provider settings; (2) Provide patients with secure electronic access to their health information; (3) Allow voluntary participation by patients to access their health information at no cost; (4) Support care coordination through real-time alerts and timely access to clinical information; (5) Reduce costs associated with preventable readmissions, duplicative testing, and medical errors; (6) Promote the highest level of interoperability; (7) Meet all state and federal privacy and security requirements; (8) Support public health reporting, quality improvement, academic research, and health care delivery and payment reform through data aggregation and analytics; (9) Support population health analytics; (10) Be standards-based; and (11) Provide for broad local governance that (A) includes stakeholders, including, but not limited to, representatives of DSS, hospitals, physicians, behavioral health care providers, long-term care providers, health insurers, employers, patients, and academic or medical research institutions, and (B) is committed to the successful development and implementation of a statewide Health Information Exchange.

The State will adhere to the legislative mandate to endorse a standards based exchange that enables electronic quality reporting. Additionally, the HITO and the SIM PMO will work with federal agencies including CMS, CMMI and ONC to monitor federal activity regarding IT standards, and disseminate any new regulations or standards to stakeholder organizations, payers, and practices. SIM will also work to ensure alignment of SIM-related HIT activities with federal stands and guidance.

To ensure reporting on quality measurement, the Medicaid EHR Incentive Program is currently planning to provide eligible professionals and hospitals the opportunity to pilot edge server technology and or the option to utilize QRDA Category I and QRDA Category III standards to submit eCQMs. After these mechanisms have shown success, they can be repurposed to assist in collecting quality measures recommended by the Quality Council to support value-based payment and to produce the cross-payer provider performance scorecard.

Public Health IT Systems Integration and Electronic Data to Drive Quality Improvement

The Department of Public Health's State Health Improvement Plan outlines the agency's commitment to align state and local health with health care reform efforts to increase access to high quality and affordable healthcare services for all residents of the state. One strategy for achieving this goal involves standardizing and connecting public health data systems to allow for appropriate electronic public health and clinical data exchange through the use of an HIE. Specifically, once the stakeholder engagement process occurs, the state can identify priority public health data systems that should be interoperable with the HIE or would be enhanced by the use of technology solutions to improve quality. It is anticipated that the HITO, SIM PMO, and DPH will partner to plan to how appropriate electronic data can be exchanged between the HIE and DPH.

Additionally, the Medicaid EHR Incentive Program requires eligible professionals to submit data electronically to public health registries. DPH and DSS are working to support building the infrastructure to support electronic data submission. Once the HITO is on board and the HIT/HIE strategic and operational plan is complete, the HITO will work in conjunction with the state agencies and the SIM PMO to see how the HIE can accelerate electronic data submission since this will drive quality improvement activities. Medicaid is leveraging providers, hospitals and the Medicaid ASO to support ADT notifications to exchange clinical documents. This solution can be leveraged to support public health system and connections to identified registries. The construction of eCQMs from automatically submitted CCDs will enable point-of-care quality improvement for Connecticut providers. This will serve as a more real-time and specific view of performance than can be achieved through claims data.

Technical Assistance

Health IT Technical Assistance will be provided by the HIT PMO and/or by the UCONN HIT staff across the range of initiatives. UCONN HIT staff is providing HIT Technical assistance as it relates to EMPI, PD, and the alert notification engine. They will educate participants on the technologies, perform testing to assess accuracy of the alerts, model data across payers, and answer day-to-day questions. In addition, UCONN HIT currently conducts outreach and provides education about Direct Messaging, meaningful use measures and quality improvement as it relates to eCQMs to eligible providers throughout the state.

The HITO and the HIT PMO will continue to engage Connecticut practices to understand their technical needs and enable connectivity to the HIE and other Health IT technologies. They will also extend resources (e.g. EHR SaaS and DM) to providers and organizations that do not receive Medicaid/Medicare Meaningful Use Incentive Payments.

Health IT to Support Fraud and Abuse Prevention, Detection and Correction

DSS is taking measures to ensure that the implementation of PCMH+ takes into account potential new forms of fraud and abuse[13]. DSS will not implement the PCMH+ until reasonable and necessary strategies for monitoring under-service are in place, and will make ongoing adjustments to these strategies as appropriate. The most recent progress towards the design for monitoring under-service follows a multi-pronged framework consisting of five strategies. The design of these strategies took into consideration and incorporated various elements of beneficiary protections that were recommended by the SIM Equity and Access Task Force. These aspects of model design will be discussed and refined more extensively over time, but presently include the following:

1. **Preventative and Access to Care Measures** – Twenty-two of the proposed PCMH+ quality measures track preventative care rates and monitor appropriate clinical care for specific health conditions
2. **Member Surveys** – use of the CAHPS PCMH survey and consideration of the use of the CAHPS Cultural Competency Supplemental Item Set
3. **Member Education and Grievance Process –** specific, affirmative education for beneficiaries on PCHM+ including their grievance and appeal rights

[13] SIM Operational Plan, State of Connecticut, March 1, 2016, page 130

4. **Secret Shopper** – expansion of DSS's current secret shopper approach to gauge access to care as well as experience in seeking care
5. **Elements of Shared Savings Model Design –** various elements of the shared savings model for PCHM+ were selected with a lens toward protecting beneficiary rights including:
    a. Use of a savings cap
    b. Decision not to include a minimum savings rate
    c. Upside-only approach
    d. High cost claims truncation
    e. Concurrent risk adjustment claims methodology

At this time none of these components are in need of federal SIM funding and have no related technology requests.

Overarching Health IT Needs and Challenges

Health IT infrastructure needs must be addressed in terms of Connecticut's SIM governance, policy and legal agreements, technical architecture, business and technical operations, and financing, for the overall successful implementation and functioning of these systems. There are substantial Health IT assets controlled by both the state and private stakeholders. The SIM funding will allow these assets to be leveraged and integrated to support population health and new payment models.

The principal challenge to financing the Health IT infrastructure is the commitment from stakeholders during and after the grant period. Existing SIM Health IT challenges are related to legal authority, financing, available incentives to change, and political and practical realities. The authority for establishing and supporting a Health IT infrastructure for the CT SIM period has been established through P.A. 16-77. In addition, recent legislation and policy initiatives create opportunities for integration for the SIM activities to be supported by the reuse and expansion of the existing Health IT infrastructure. This will be addressed directly by statute, such as the possibility of requiring participation in the Directed Exchange and by requiring participation in various initiatives such as the PCMH+.

In summary, to achieve the full potential of health system transformation, Connecticut payers and providers will need to deploy a wide range of Health IT capabilities, including data analytics, HIEs and care management tools. Connecticut's SIM seeks to provide Health IT targeted solutions to assist implementation of each component of the proposal.

5. Community Health Worker Promotion

Community health workers (CHWs) are recognized by national and local health leaders, as well as in the ACA, as important members of the health care workforce, and are increasingly being used as integral members of primary health care teams. CHWs serve as an extension of the healthcare team into an individual's community or home. They can address cultural, linguistic, health-literacy-level, and social-determinant-based barriers that deter individuals from receiving the healthcare services they need. CHWs provide health education and coaching, identify resources, assist with adherence to treatment plans, and ensure that individuals get the health and social services they need. They also provide informal counseling and social support, advocate for individuals and communities, provide direct services (such as basic first aid), administer health screening tests, and build individual and community capacity.

The evidence shows that they help improve health care access and outcomes, play a critical role on health care teams, produce a return on investment, and enhance the quality of life for people in disadvantaged communities.

The SIM provides funding to promote the use of CHWs along the healthcare continuum, to help prepare this workforce to become members of inter-professional primary care teams, and to play key roles in improving population health. By engaging national and regional experts, the SIM will focus on stakeholder engagement, development of infrastructure, policy and sustainability development, as well as education and community integration.

Activities

Approximately $1 million in SIM test grant funds will support the following activities of the CHW initiative over the test grant period:

Community Health Workforce Development

- **CHW needs assessment:** Develop and implement a survey to identify the needs of CHWs.
- **Apprenticeships:** Work with the CT Department of Labor to identify, develop and implement community-based CHW placements and protocols for apprenticeships.
- **CHW resources:** Identify resources available to CHWs and disseminate the information for CHW use.
- **Technical assistance:** Survey the needs of employers and provide relevant technical assistance.

Infrastructure & Policy

- **Research on best models:** Research and interviews with subject matter experts on the best models for CHW integration
- **CHW Advisory Committee:** Will provide guidance and recommendations on CHW initiatives.
- **Healthcare Innovation Steering Committee** Will provide oversight of all SIM CHW initiatives. The SIM Consumer Advisory Board will be informed of CHW initiative.

Education & Community Integration

- **Update curricular materials:** Develop materials to support CHW workforce development.
- Meet with stakeholders to discuss and promote CHW integration into communities and healthcare settings and promote opportunities for employment.
- **Assist in Coordinating state-wide meeting** of current and potential CHW employers and other stakeholders for continued workforce development

In addition, the CHW Initiative will engage and complement the CHW efforts of other work streams:

- **Community & Clinical Integration Program (CCIP):** CCIP has incorporated CHWs into its standards. These standards and technical assistance will be part of the Request for Proposals to select ANs and FQHCs that will be part of PCMH+.
- **Advanced Medical Home Program:** SIM funding promotes the advancement of primary care practices to become AMHs, an enhanced version of the team-based patient-centered medical home model. Practices and provider entities will be looking at new care delivery models and team compositions to improve quality, including the potential use of CHWs.
- **Population Health Plan:** SIM is funding the development of a Population Health Plan, which includes PSCs and HECs. The inclusion of CHWs in the Population Health Plan and especially PSCs will be critical to adequately addressing population health.

The proposed activities will build on work done during the pre-implementation period, which includes:

- Establishing a CHW Advisory Committee in coordination with the SIM Consumer Advisory Board
- Meetings with stakeholders representing employers, payers, consumers, academic and workforce partners, professional organizations, and others to identify interest and opportunities
- Securing national and regional experts to provide technical assistance in developing the necessary components for CHW workforce infrastructure, policy and sustainability
- Inventory of national CHW initiatives, focused particularly on core competencies, scope of work, models of certification and training, and mechanisms of payment
- Development of SIM CHW Initiative At A Glance document

Community Health Worker initiative lead: The SIM PMO has contracted with the University of Connecticut Health Center (UConn Health) to implement the CHW initiatives outlined above. UConn Health has subcontracted with Southwestern Area Health Education Center (AHEC) to help support this work. AHEC has experience and expertise in workforce development and community collaboration. The CHW Advisory Committee will serve as an advisory body to this work steam.

6. Consumer Empowerment

Healthcare reform will be most effective if it can leverage both “supply” and “demand” -side reforms. Supply-side mechanisms of improving healthcare include enabling clinicians to deliver better-quality care more efficiently through medical home models, shared savings arrangements, and enhanced health

information technology. However, engaging consumers on the demand side is critical to ensure that initiatives are tuned to the needs of the CT population and that are active and able participants in a healthcare systems that is aiming to be more person-centered care. The following three levers will be implemented to engage and empower consumers:

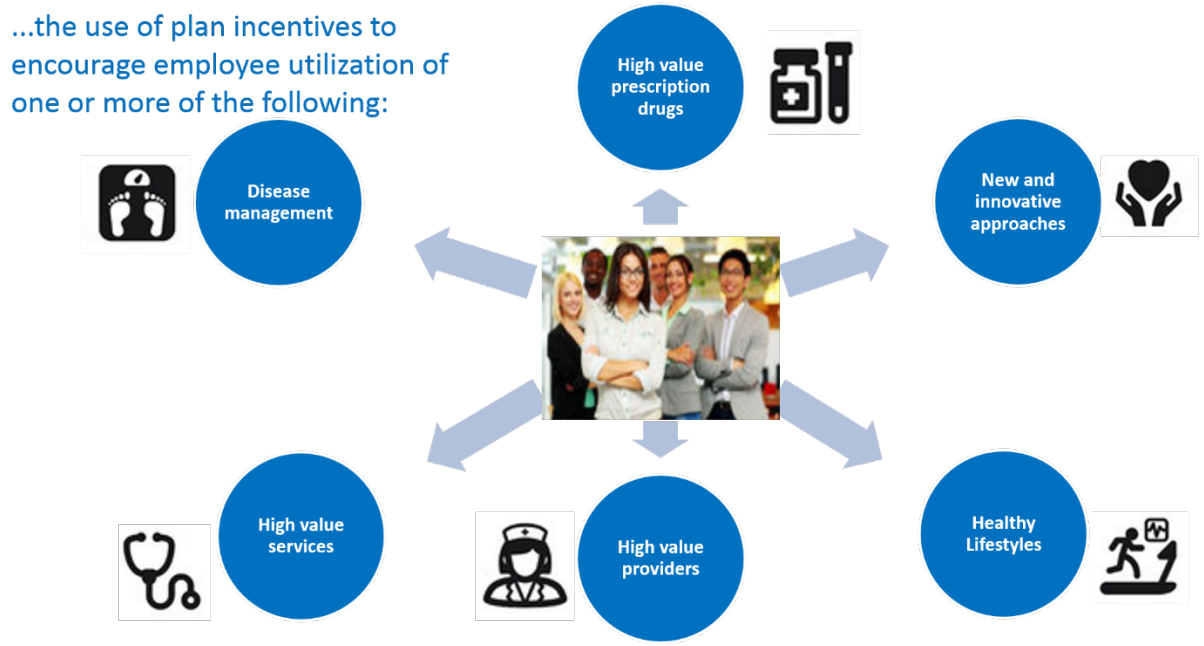
A. **Value-Based Insurance Design:** Activate demand-side reforms by engaging employers to adopt VBID health plans, thereby removing barriers for essential, effective services.
B. **Consumer Engagement Strategy:** Provide outreach and education to consumers, such as forums and listening sessions, to receive feedback about the healthcare system and care delivery reforms and to educate them about the changing role of the consumer.
C. **Quality Performance & Cost Transparency:** Stand up a public dashboard with data about SIM progress, as well as a public scorecard of Advanced Networks & FQHC performance information.

A. Value Based Insurance Design (VBID)

Definition

Value Based Insurance Design (VBID) is a cost-effective employee benefit plan approach used by small and large, fully- and self-insured employers to lower or eliminate financial barriers to, or introduce rewards for preventive care, medication adherence, chronic disease management, and high-quality provider selection.

Value Based Insurance Design…



Objective

A critical component of the SIM initiative is promoting VBID to employers. Such designs are fundamental to achieving care delivery and payment reforms. SIM aims to empower consumers to make healthier lifestyle decisions and engage in effective illness self-management through VBID. The VBID initiative aims to increase the adoption of VBID programs among Connecticut employers as part of SIM's goals to improve residents' health outcomes while reducing unnecessary and potentially harmful healthcare utilization and spending. Our goal is to engage employers in proposed care delivery and payment reforms such that the substantial majority of self-funded employers throughout Connecticut adopt such reforms in their benefit administration arrangements with health plans.

This initiative will produce VBID prototypes of recommended VBID plans and practices, with strategies and tools for employers to select and promote these plans. These deliverables are meant to encourage adoption of VBID programs by self and fully-insured employers, commercial health plans, and the health insurance exchange.

AHCT, Connecticut's health insurance exchange, will play a large role in promoting VBID plans to the small group and individual markets. It is anticipated that as a result of increased employer uptake of VBID plans, commercial health insurers in the state will be encouraged to offer these value-based products and shift plan designs towards incentivizing consumers and providers to utilize high value, lower cost services and reduce utilization of costly services with little clinical value.

Activities

We will continue our extensive VBID adoption efforts, with the participation of employers, business groups such as CT's Business and Industry Association, health plans, providers and consumers to continue the development of our prototype VBID plan designs that align supply and demand while enabling streamlined administration; and providing a mechanism for employers to share best practices to accelerate the adoption of VBID plans.

The VBID work will be comprised of the following activities and deliverables, building on the work completed during the Pre-Implementation Period:

- **SIM VBID Consortium:** During the pre-implementation period, a Consortium was established, bringing together health plans, consumers, employers, employer associations, providers, and state agencies to advise on all aspects of the VBID initiative, including recommended benefit plans, the effectiveness and feasibility of implementing various VBID principles and mechanisms, aligning consumer incentives with payment side reforms, and how their products may align with this initiative. The Consortium will continue to meet occasionally for the remainder of the test grant to advise on strategies for engaging employers and to provide feedback on future iterations of the VBID prototype templates and employer guidance.
- **VBID Learning Collaborative**: An annual learning collaborative will be facilitated, including panel discussions with nationally recognized experts and technical assistance to engage fully-insured and self-insured employers in the Connecticut market, disseminate best practices in innovative

plan design, and help form a network of stakeholders engaged in healthcare reform efforts in the state. The Learning Collaborative Kickoff will take place in the fall of Performance Year 1 and evolve to address the needs of employers implementing VBID. Smaller, more targeted presentations and meetings will likely be utilized to effectively engage the fully-insured employer community.

- **VBID Prototypes:** During the pre-implementation period, the Consortium advised on the development of two prototype VBID templates: one targeting fully-insured employers and another targeting self-insured employers. These templates will be used as part of the Implementation Guide, allowing employers to implement VBID plans directly from the templates. The templates will be highlighted during the Learning Collaborative Kickoff, and will be shared with health plans and brokers in order to develop insurance products for fully-insured employers.
- **VBID Implementation Guide: During the pre-implementation period, a** VBID Implementation Guide for employers was developed. The Implementation Guide includes the VBID Prototype templates, as well as advice, guidance, and considerations for implementation. The Implementation Guide will also be highlighted at the Learning Collaborative Kickoff and will serve as one of the main vehicles for facilitating VBID implementation among employers. Like the prototype templates, separate Implementation Guides have been developed for self-insured and fully-insured employers to address their unique needs and considerations in the adoption of VBID.

Goals

1. Develop prototype VBID plan designs that align the interests of consumers and providers

2. Provide a mechanism for employers to share best practices to accelerate the adoption of VBID plans

In addition, subject to board approval, AHCT may implement VBID in Year 3 of the Model Test. DSS may consider the implementation of incentives in alignment with the development of the state's population health plan.

Context

The uptake in VBIDs nationally and in Connecticut has been gradual. Some barriers to accelerated uptake of VBIDs include the capacity for employers to quantify clinical and economic return on investment, measure outcomes, accurately determine the value of specific services through comparative effectiveness research, and perform actuarial analysis to set copayments. Additionally, employers that offer their employees enrollment choice across multiple health plans may not be able to implement one standard VBID, as each health plan may have unique VBID products and administrative capabilities. This creates an additional layer of employee education and administrative burden on the employer.

Some large Connecticut-based employers, including the State of Connecticut, have already embraced and are managing successful VBID programs for their employees. Connecticut's SIM initiative seeks to promote the statewide adoption and integration of VBID by building on the experience and lessons learned by these employer groups. For example, the State of Connecticut's OSC successfully implemented the state Health Enhancement Program (HEP) in 2011. In exchange for lower member premium shares, the program requires employees and their dependents that elect to participate to undergo preventive care (e.g. annual preventive visit, dental cleaning, cholesterol screening, vision exams, etc. as determined by age). Those participants having one or more chronic conditions are required to participate in a care management program, whereby the copayment for the medication to manage the chronic condition may be reduced or waived.

VBID Participation Goals

SIM sets a goal that 84% of the total insured population in Connecticut will be in a value-based insurance design plan by 2020.

Exhibit: **Number of Beneficiaries (in thousands) with a VBID insurance plan**

Coverage Category (000's)	2016	2017	2018	2019	2020
ASO (excluding State Employees)	453.7	589.9	766.8	881.8	1,014.1
Fully insured	350.6	420.7	525.9	631.0	757.3
State employees, exc. Medicare Supp.	134.0	136.0	137.0	137.0	137.0
Total	**938.3**	**1,146.6**	**1,429.7**	**1,549.9**	**1,908.4**

VBID initiative lead: The VBID initiative will be led by the OSC, in collaboration with the SIM PMO. The VBID Consortium will serve as an advisory body to this work stream. The SIM PMO and OSC have engaged Freedman HealthCare, LLC, a leading consulting firm in healthcare systems improvement to implement this initiative. Together with their partners Drs. Mark Fendrick and Michael Chernew, nationally renowned VBID experts, and Dr. Bruce Landon, health policy expert, this team will assist the State in promoting VBID among CT employers, health plans, and consumers.

B. Consumer Communication Strategy

SIM healthcare reforms must address the needs of the populations they aim to serve. Statewide SIM reforms will impact the entire CT population. Targeted initiatives will also shift healthcare models for broad populations. For example, PCMH+ will include an estimated 200,000 to 215,000 beneficiaries in the first of two waves of the test period and an additional 200,000 to 215,000 beneficiaries in the second wave. Consumer input and active engagement is needed to understand and address the barriers and challenges that consumers experience as providers transform. The input of community organizations is also critical because of their understanding of local needs and opportunities because they may serve as partners with healthcare practices for many SIM initiatives. Formal and consistent solicitation of community and consumer input will create effective strategies of reform implementation and enhanced community confidence in SIM initiatives.

The Consumer Advisory Board (CAB) is the main vehicle in the governance structure to ensure community and consumer stakeholder engagement. The CAB has established consumer representation on each of the SIM taskforces and councils, as well as the Steering Committee. The CAB will facilitate consumer participation at these meetings, provide the necessary guidance and support, and discuss issues brought back from the meetings with the larger group. This will reinforce consumers in every part of the implementation process. The Board will solicit further input from the broader consumer community on an ongoing basis.

In addition, the CAB will launch a **consumer engagement communication plan and strategy.** They have identified goals and objectives for this work and the SIM PMO is in the process of hiring a Consumer Engagement vendor to provide assistance. The CAB has identified four areas of preliminary focus that members plan to explore using this comprehensive approach. The focus areas are:

1. Population health,
2. Behavioral health,
3. Health equity, and
4. Workforce.

Objectives

The following objectives have been identified:

1. The multichannel engagement and communication plan will incorporate in-person and web-based strategies:
    a. Web-based meeting support to coordinate and/or conduct consumer engagement activities across the CT SIM Governance structure (e.g., monthly meetings, hosted webinars) and with members of the broader consumer community.
    b. Social media to engage a broad audience (e.g., Twitter, Facebook, Instagram)

c. Interactive Information support to be used by and for consumers, consumer representatives, providers, and general public for all communications, including disseminating information and collecting feedback on all consumer activities across SIM and engagement that supports the role of consumers in healthcare today.

d. Community Conversations to explore challenges and solutions related to the four priority areas identified by the CAB.
e. Listening Forums to receive feedback from consumers on various topics related to the CT SIM innovations and outcomes.
f. Educational Forums to provide information on implementation of SIM in populations of special interest and addressing health inequities caused by social determinants of health.
g. Focus Groups with targeted consumer groups on specific topics to evaluate whether SIM strategies are leading to positive health outcomes, identifying gaps and barriers, along with identifying inequities between populations.

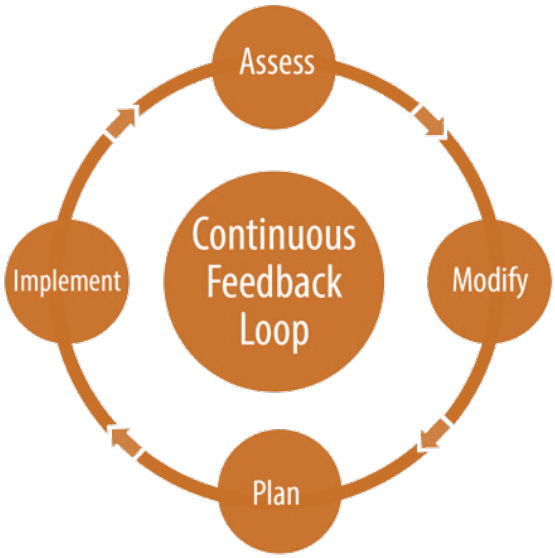
2. Coordinate communication and activities between consumer representatives across the CT SIM Governance Workgroups.

3. Develop and implement a process for the review of selected informational materials developed by the SIM PMO prior to distribution or publication to allow for the revision of such materials or the production of consumer facing versions of SIM information materials. The purpose will be to ensure that information is accessible to the lay consumer and also linguistically and culturally relevant. This means that plain language is used, that complex terminology is simplified, and delivered in a clear and concise format. The CAB acknowledges that language and cultural differences can be barriers to successful communication and understanding of systems. Documents need to be written using language, terminology, and images that make sense to everyone – including spoken formats.

4. Identify, secure, and maintain partnerships with community-based organizations and cross-sector stakeholder groups to promote active participation of consumers statewide. The CAB believes that we are all in this together and wants to assure that no one is left out so that the most benefit can be realized for everyone.

The CAB will provide outreach and education to consumers about how the planned innovations identified in the CT SIM will change their experience with the healthcare system. To achieve these broad goals the overall engagement and communication framework should encompass at least four primary work streams that include:

- Development of a comprehensive multichannel engagement and communication plan that encompasses both internal and external processes;
- Implementation of consumer engagement and communication strategies for sharing, collecting, and disseminating information within the existing SIM governance structure and consumer populations(s) statewide;
- Establishment of a Continuous Feedback Loop to plan, implement, assess, and modify current strategies in the areas of CT SIM reform, consumer engagement, and related outcomes; and
- Creation of outreach strategies that include everyone and every community in this process.



Programmatic activities include consumer-led learning collaboratives, issue-driven focus groups, and targeted communications. The CAB will build on work done during the pre-implementation period, including hosting both a Rural Health Listening Forum, and a Southeast Asian Community Event. Feedback from these events will continue to inform SIM progress and reforms.

Consumer Engagement Initiatives lead: The Consumer Advisory Board (CAB) and the SIM Program Management Office (PMO) will lead this work stream with the support of the Consumer Engagement Coordinator (North Central Regional Mental Health Board).

C. Public Common Scorecard

In order to actively engage individuals in decisions about their choice of provider, consumers will need access to reliable data about the performance of Connecticut's Advanced Networks and FQHCs. Our SIM will increase transparency and access to information about provider performance through the leveraging of Health Information Technology to disseminate quality and cost data through a public common scorecard.

The SIM Quality Council is in the process of developing a core measure set for use in the assessment of primary care, specialty and hospital provider performance and the overall evaluation of the Connecticut health and healthcare systems. Data from payers on the performance of Advanced Networks & FQHCs on the measures from the core quality measure set will be collected and displayed on a public

scorecard, beginning with claims and survey-based measures. The Quality Council is responsible for establishing a plan for consumer education and access to scorecard data. The state is currently engaging health plans to gauge their level of support for the production of a statewide quality scorecard that reflects provider performance across payers.

Scorecard lead: The SIM PMO will be the lead for this work stream. The Quality Council and Health IT Council will serve as advisory bodies to this work.

C. General SIM Operational and Policy Areas

1. SIM Governance, Management Structure and Decision-making Authority

Connecticut's SIM is being implemented with a broad array of stakeholder involvement and input. The Lieutenant Governor provides overall leadership and oversight for SIM. The Lieutenant Governor is a former healthcare provider, a healthcare purchaser in her former role as State Comptroller, and an advocate for improving healthcare access and affordability. She has provided overall leadership, ensuring participation from a broad range of public and private entities.

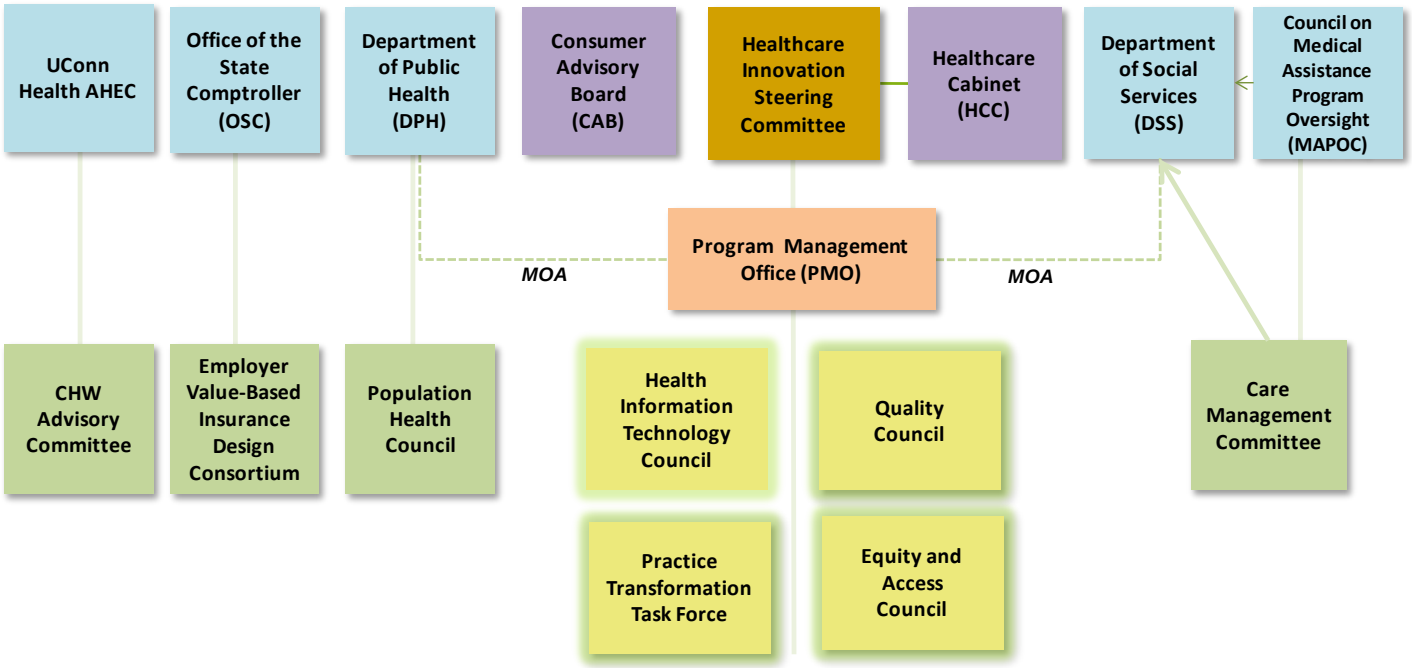
SIM initiatives will be executed in collaboration with multiple agencies and organizations including the DSS, DPH, OSC, AHCT and UConn Health. The SIM PMO, within the OHA, is leading the implementation. The PMO coordinates activities across work streams, oversees the evaluation, engages stakeholders, manages vendors, executes care delivery reform initiatives, and communicates progress to the public.

The PMO has engaged more than 100 stakeholders through a number of advisory work groups that focus on particular components of SIM such as health information technology, quality measurement, and practice transformation. These work groups are comprised of consumers, employers, healthcare providers, community organizations, and subject matter experts. Our Model Test also includes the participation of all five of Connecticut's major commercial payers, Medicare and Medicaid. Work groups will inform the HISC, which will provide key guidance and recommendations regarding SIM initiatives. Our work groups are supported by the SIM PMO and partner agencies.

Workgroup/Committee Structure

CT has established a workgroup and committee structure that includes a broad range of stakeholders with direct and ongoing involvement in SIM design, implementation and evaluation.

Exhibit: SIM Workgroup/ Committee Structure



This engagement structure includes the following committees and work groups:

1. Healthcare Innovation Steering Committee
2. **Program Management Office (PMO)**
3. Consumer Advisory Board (CAB)
4. Healthcare Cabinet (HCC)
5. State Health IT Advisory Council (Health IT Council)
6. **Six SIM workgroups:**
    a. ***Practice Transformation Taskforce***
    b. ***Quality Council***
    c. ***Equity and Access Council***
    d. ***CHW Advisory Committee (led by UConn Health AHEC)***
    e. ***Employer VBID Consortium (led by Office of the State Comptroller)***
    f. ***Population Health Council (led by Department of Public Health)***
7. ***Care Management Committee (advisory to the Department of Social Services)***

1. Healthcare Innovation Steering Committee (HISC)

The HISC is chaired by Lieutenant Governor and serves as the key advisory body for the implementation of the Model Test. Participants include private foundations; consumer advocates; representatives of hospitals, Advanced Networks, home health, physicians and APRNs; health plans; and employers. Additionally, the Comptroller's office is included as well as line agency Commissioners with responsibility

for public health, Medicaid, behavioral health, health insurance exchange, APCD, and child welfare. The OPM with responsibility for the state budget is also a member.

The HISC will continue to meet monthly, providing advice and guidance on SIM design and implementation, while addressing key strategic, policy, and programmatic concerns. The HISC has also designated a multi-stakeholder Rapid Response Team process, which will be mobilized as need to review and respond to information regarding pace and performance of our reforms.

2. Program Management Office (PMO)

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

3. Consumer Advisory Board (CAB)

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

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

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

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

- Providing a forum for consumers, their advocates and the public to provide oral and written input on health care reform.
- Serving as a catalyst to engage consumers and solicit their input on specific health care reform issues.
- Helping to educate and engage consumers and the public about state and federal health care reform laws and health care reform policies and regulations as they are proposed and implemented.
- Informing policymakers about the importance of addressing healthcare disparities and consumer needs.

- Offering advice and feedback to the state's PMO and other health care policy leaders on best practices for implementing consumer assistance and consumer access systems.

4. Health Care Cabinet

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

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

5. State Health Information Technology Advisory Council (Health IT Council)

In 2015, a 28-member State Health Information Technology Advisory Council (Health IT Council) was created through Public Act 15-146, *"An Act Concerning Hospitals, Insurers, and Health Care Consumers*." The council's purpose was to advise on: (1) developing priorities and policy recommendations to advance the state's health information technology and health information goals; (2) develop and implement the statewide health information technology plan, data and technology standards, and the statewide health information exchange; and (3) develop appropriate governance, oversight, and accountability measures to ensure success in achieving the state's HIT and HIE goals. In May of 2016, the state enacted Public Act 16-77, "*An Act Concerning Patient Notices, Designation of a Health Information Technology Officer, Assets Purchased for the State-Wide Health Information Exchange and Membership of the State Health Information Technology Advisory Council*." This act makes various changes to requirements for health information technology, hospitals, health systems, and health carriers enacted in PA 15-146. Changes about the health information technology include (1) designation of a Health Information Technology Officer (HITO) by the Lieutenant Governor, (2) transfers various responsibilities from DSS Commissioner to the HITO; and (3) adds additional members to the state Health IT Advisory Council. Additional details can be found within the Health Technology Section. As a result of P.A. 16-77 and the onboarding of a HITO, the advisory process for P.A. 16-77 and the former SIM HIT Council have been consolidated under the Health IT Council.

6. MAPOC - Care Management Committee

CT law established the Medical Assistance Program Oversight Council (MAPOC) as the legislative oversight body for the Medicaid/CHIP programs. The MAPOC leadership designated the Care

Management Committee of the MAPOC to review and comment on each aspect of the design of the PCMH+ program, including the establishment of consumer protections and implementation activities. Committee membership was supplemented by members of the Steering Committee and CAB. Additionally, MAPOC has designated up to two members to participate in each SIM work group and the Steering Committee.

7. SIM Workgroups

Six workgroups ensure that the necessary stakeholders and technical experts are continually engaged and actively involved in the implementation of the SIM grant. There are four broad categories of representation on these workgroups: consumer/advocate, payer, provider, and state agency. The workgroups participate in detailed planning, and provide oversight across a range of areas.

When necessary, work groups establish design groups to consider special issues and to engage additional external stakeholders who may have the expertise and knowledge necessary to inform the planning. **For the meeting schedule, minutes, and workgroup membership and charters please visit** http://healthreform.ct.gov/ohri/cwp/view.asp?a=2765&q=333596&ohriNav=|**.**

a. Practice Transformation Task Force (PTTF)

The PTTF is comprised of consumer and health equity advocates, physicians, a provider of behavioral health services, a FQHC, APRN, health plans, and state agencies. To date this taskforce has recommended the Connecticut Advanced Medical Home standards, which the state is preparing to pilot prior to full implementation under the test grant. The MAPOC has designated two additional representatives to represent the interests of Medicaid beneficiaries. The PTTF has established design groups with additional representation and expert consultation in the areas of health equity, behavioral health, and oral health. Despite its name, the PTTF will also advise on broader care delivery reform activities. The Task Force has completed the design of the AMH program and the CCIP. The Task Force will continue to meet as needed to provide advice to the PMO regarding the implementation of these initiatives.

b. Quality Council

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

The role of the Quality Council is to recommend a set of quality measures that payers will be encouraged to use to assess the quality of services delivered under value-based payment arrangements. The Quality Council's charter sets the objective of proposing a core set of quality measures for use in the assessment of primary care, specialty, and hospital provider performance in the State of Connecticut.

The Quality Council will reassess the core measure set on a regular basis to identify gaps, to incorporate new national measures as they become available, and to keep pace with changes in technology and clinical practice. The Council has recently begun to provide advice regarding the development of a public provider scorecard.

d. Equity and Access Council

This council is comprised of consumer and health equity advocates, representatives of the physician, advanced network and FQHC communities, and health plans with a commitment to ensuring long-term, systemic provision of appropriate care and access, especially to typically underserviced communities. Design work groups have been established to engage the council participants and the public in more focused conversations on what recommendations to make to protect against under-service and patient selection as value based payment reforms are implemented. Four design groups were developed to focus the group, two of which focus on value based payment design elements and two that focus on supplemental safeguards. The four design groups are follows:

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

The council, along with the design groups, has recommended retrospective and concurrent analytic methods to ensure safety, access to providers and appropriate services, and to limit the risk of under-provision of requisite care. They have released the Report of the Equity and Access Council on Safeguarding Against Under-Service and Patient Selection in the Context of Shared Savings Payment Arrangements.

e. Community Health Worker Advisory Committee (led by UConn Health AHEC)

The Community Health Worker (CHW) Advisory Committee was officially formed in February, 2016. The Committee consists of community health workers, providers, state agencies, consumers/advocates, health plans, and employers. The role of the Committee is to develop recommendations for the Healthcare Innovation Steering Committee with respect to the training, promotion, utilization and certification of CHWs. They will also advise on a framework for sustainable payment models for CHW compensation. The Committee will examine critical issues for employers with regard to hiring, supervising and technical support of CHWs. Specific recommendations and deliverables may include: a definition and scope of work for CHWs, a process for certification, and recommendations for sustainable payment.

f. Employer led Value-Based Insurance Design (VBID) Consortium (supported by the Office of the State Comptroller)

The VBID Consortium provides advice and guidance on all aspects of the VBID initiative. The Consortium consists of consumers, providers, CT state agencies, Accountable Care Organizations (ACOs), employers, employer associations and health plans that work collaboratively to encourage the uptake of VBID benefit plans throughout the state. The Consortium has developed and continues to develop

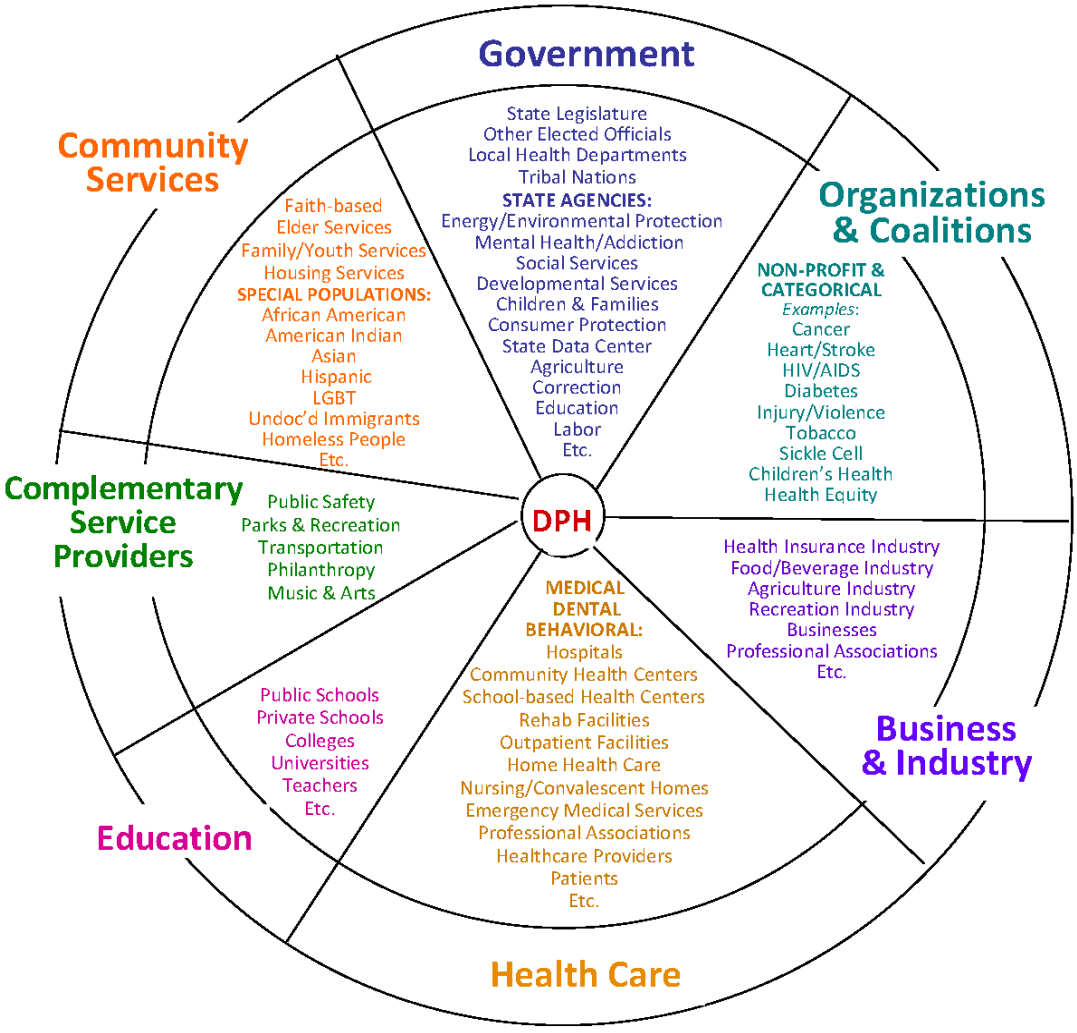
recommendations to the HISC with respect to the promotion and adoption of value based insurance design models for use by self-insured employers, fully insured employers and private and public health insurance exchanges. To date, the Consortium advised on the development of VBID prototypes and an implementation guide for employers seeking to implement VBID plans. They will continue to provide recommendations on: identifying and engaging stakeholders and establishing the program design for a VBID learning collaborative.

g. Population Health Council (supported by the Department of Public Health)

The Population Health Council is responsible for providing advice regarding the development of the Population Health Plan. The Council will develop a vision for improving Population Health in the context of payment, insurance and practice reforms, and community integration and innovation. The Council will also leverage existing resources and will build on the framework established in the State Health Improvement Coalition to advance population health planning and establish a long term public health strategy.

The Council ensures broad based representation from all relevant sectors and agencies with potential influence over social determinants of health (SDH). Council members include representatives from key sectors such as healthcare providers, health plans, large and small employers, consumers, behavioral health community, education among various community coalitions and philanthropies. State Agencies directly involved in the design of HEC's will function as ex-officio and will include the DPH, the DCF, the DMHAS, the DSS and the OSC.

The Council will make recommendations regarding three strategic areas, a) the appropriate indicators and monitoring systems of population health improvement, b) the establishment of Community Prevention Service Centers (PSCs), and c) the designation of Health Enhancement Communities (HECs). More specifically, the council will recommend to the HISC a strategy to maintain a system of population health data, overall health improvement monitoring, and community accountability metrics. In addition, the council will assess community health capabilities in order to recommend an extension model of prevention services outside of the clinical settings. Lastly and more importantly, the Council will recommend guiding principles and a sustainability strategy for the designation of structured community-wide collaborations with a multisector agenda for HECs. Overall, the Council will focus on addressing root causes of disease by defining priorities based on burden of disease and health cost, identifying barriers to health improvement and recommending specific evidence based strategies to reduce health inequities and improving overall population health.



Risk Mitigation Strategy

The PMO promotes a purposeful and collaborative approach to large scale systems change and anticipate and manages risks and issues crucial to success. Identifying risks and creating risk mitigation plans will be an ongoing process throughout the implementation of the grant. Risks will be reported by each work stream on an ongoing basis to ensure early detection and discussion and identify the need for escalation through the Governance structure. The SIM PMO will manage a risk log on the SharePoint site across all work streams, and it will be updated by all relevant leads in real time as next steps are pursued and updates are needed. This information will be used to update work groups and committees as well as CMMI.

Through a thoughtful process each work stream determined their risks and mitigation strategies for performance year one. Each work stream first delineated their accountability targets and objectives. For each accountability target, the likelihood of failure was identified for each related objective. Risk factors were determined based on the likelihood of failure. For example, if the accountability target was to receive data from a particular state agency, the likelihood of failure might be low, and a potential risk

factor would be that the data file is not ready for release. This process was completed for all accountability objectives.

Each risk factor was then prioritized based on the likelihood of failure. Using this prioritization, work streams identified potential risk mitigation options, feasibility of resources, and the potential impact on SIM progress. Taking into account all factors, an overall priority level was assigned to each risk factor. Those risk factors that were most likely to have the greatest impact on overall SIM progress were then detailed, including the risk mitigation strategies, priority level, lead person, relevant work groups, next steps, and timeline.

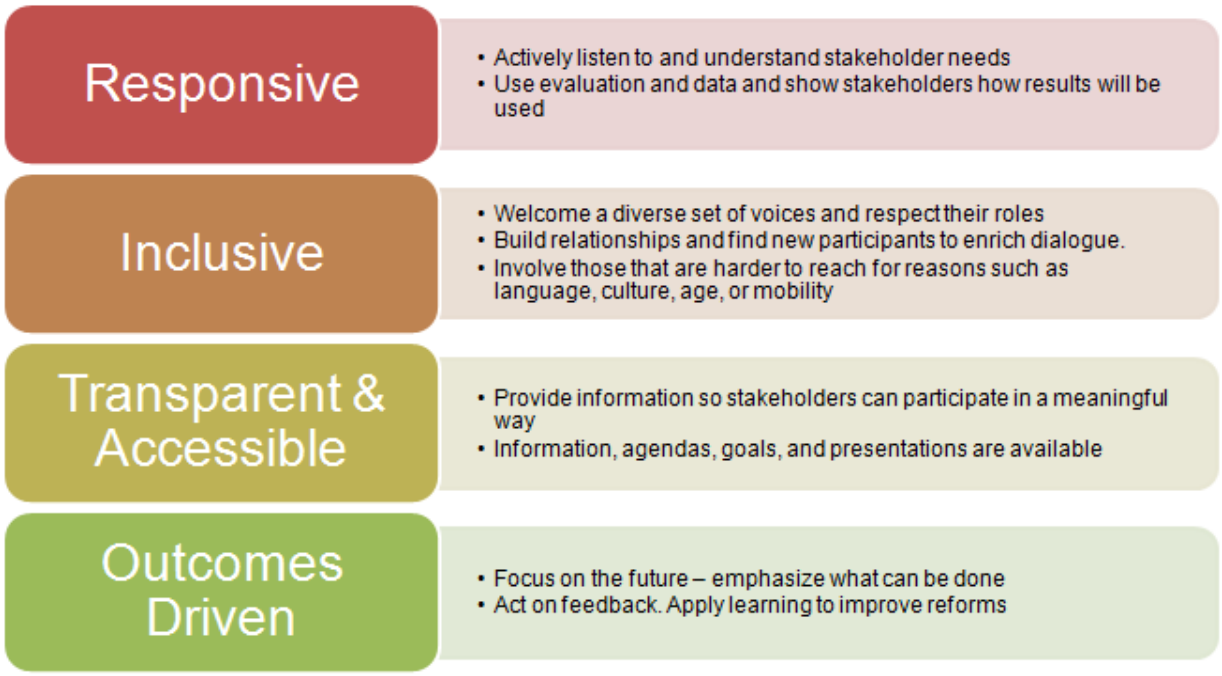
Appendix E contains a risk log for performance year one. Each risk will associate a relevant time frame, a description, a priority level, mitigation plan, and next steps. The mitigation of risks and the collaborative approach to finding solutions is an important accountability process that will occur on a continuous basis.

Supporting document available: Appendix E - SIM Risk Log

2. Stakeholder Engagement

Connecticut's stakeholders are committed to producing better health, better and more equitable care, and lower costs through implementation of our Connecticut SIM Test Grant. For our healthcare delivery system transformation to be meaningful and sustainable, we must continuously engage our stakeholders, including consumers, advocates, employers, community organizations, providers, local and state officials, Medicaid, Medicare, and private health plans.

Connecticut's SIM Test Grant builds on and expands stakeholder engagement efforts that began in the design and planning phases. Our stakeholder engagement strategy reflects the following **core values**:



Our governance and work group structure, described in the previous section, is one of the primary methods for engaging and empowering a broad array of stakeholders and formalizes stakeholder involvement across a variety of interests.

CT's SIM will ensure transparency and the availability of information throughout the test period. All Steering Committee and work group meetings will be posted on the website and accessible in person or by telephone. They will continue to be public meetings, with a public comment period designated at the beginning of each meeting.

The state will maintain its website (http://healthreform.ct.gov/ohri/site/default.asp) dedicated to disbursing information about SIM work group meetings, PowerPoints, narratives, and other critical information. Meeting agendas, materials, and summaries will be made available on the website in an effort to ensure broad public visibility. A dedicated email address was established (sim@ct.gov) and

staffed to ensure that stakeholders who could not attend meetings or telephone in were able to send comments and questions.

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

You may refer to our **SIM Stakeholder Engagement Plan** for more information on our SIM stakeholder engagement plans, including key stakeholder outputs & deliverables, target dates, and the stakeholders that will be engaged for key SIM work streams.

The stakeholder engagement strategy includes engaging the following categories:

1. Federal, State and local government stakeholders
2. Community and Consumer stakeholders, employers
3. Payers
4. Healthcare providers

Information about payer and provider engagement is outlined below. Consumer engagement efforts are detailed in Section B.6. Consumer Engagement, and government officials' engagement is detailed in the Stakeholder Engagement Plan.

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

Exhibit: Stakeholder Engagement Methods during the Model Test

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

Participating Payers and Key SIM Activities

CT's five largest health plans, Medicaid, and the state employee health plan are implementing value-based payment arrangements through shared savings programs (SSP) for providers with sufficient scale and capabilities, that are broadly aligned with Medicare SSP. To illustrate, Anthem has arrangements with more than fifteen Advanced Networks that cover more than 60% of primary care physicians in the State of Connecticut. These organizations include hospital owned physician groups, large independent physician groups as well as some smaller medical practices. Maintaining engagement with payers like Anthem will continue to catalyze a broad foundation of primary care practices in Connecticut to adopt patient-centered and value-based care models. In addition, aligning with Medicare, and across payers is critical to reduce the fragmentation consumers and providers currently experience. This is especially important as it relates to the work of the Quality Council on quality measure alignment, which is critical to improving efficiency, more effectively driving improvement, and reducing the burden of SSP participation on providers

All of the above Connecticut's commercial payers are participating in one or more of our work groups. These include the following:

Commercial Payer	**Market Share (2015)**
Aetna	14.4%
Anthem	49.0%
Cigna	17.7%
Connecticare Insurance Company, Inc	7.5%
Harvard Pilgrim	
HealthyCT	
UnitedHealthCare Insurance Company	7.7%

Additionally, in order to move towards models that improve the health for populations, there must be accountability for the healthcare quality and cost for all populations, whether or not they are attributed to an Advanced Network or FQHC, as well as mechanisms that formalize and sustain partnerships across entities. Current data suggests that the need for high quality community services to address social determinant risks that contribute to poor health and healthcare outcomes. Demand for such services far outstrips their availability. However, many community-based services rely on grant funding, leaving even the highest quality services vulnerable to funding cycles and thus unsustainable.

HECs, an initiative to be developed as part of the Plan for Improving Population Health, will aim to enhance local coordination and accountability among providers, local public health departments, nonprofits, schools, housing authorities and others. In order to ensure sustainability and accountability,

as well as alignment with value-based payment models, payers must be engaged to develop innovative financing strategies.

Payer Engagement Methods & Roles

Health plans are and will remain involved in all aspects of planning and oversight for CT SIM. In addition to representation on the HISC, all health plans with more than 5% market share, and Medicaid, participate on the Practice Transformation, Health Information Technology Council, Quality, CHW, and Equity & Access work groups. Anthem is the largest carrier in the State of Connecticut and an administrator of the Connecticut State Employee and Retiree Healthcare Plan and actively participates in all of the above forums. These forums will continue to provide formal mechanisms for payers to remain actively engaged in the implementation of the SIM grant.

The role of health plans includes maintaining active engagement in all work groups and the Steering Committee, described below.

- The role of the health plans on the **Practice Transformation Task Force** is to provide their expertise on practice transformation, standards, gap analysis or readiness assessment tools, and practice support methods currently in use. Payers will also play the role of serving as change agents to roll-out task-force recommendations with providers.
- Representatives from health plans on the **Equity and Access Council** are tasked with helping the council identify potential issues in program design that could negatively impact delivery of appropriate care and access.
- Representatives from health plans on the **Quality Council** will share what measures are being tracked and help assess the feasibility for payers to track recommended common measure set with their network providers. They will also consider the merits of transitioning to a "common provider scorecard" across payers and will serve as liaison with internal executives to gather feedback and to recommended metrics. Representatives will lend their expertise to facilitate the selection of a core set of measures that include a mix of process, outcome, efficiency, and patient engagement and experience metrics. They will outline data requirements (e.g., minimum patient panel size for statistical validity of prioritized metrics); outline risk adjustment and exclusion methods; and help the taskforce select measures that are ambitious, but feasible to implement.

Other roles are outlined below.

Moving to a model that rewards providers based on quality and cost:
As active participants in the Quality Council, Connecticut's large commercial health plans support the development of a core quality measure set for all payers to use as a reference in their SSP contracts with Advanced Networks and FQHCs. Payers understand that alignment of quality measures across payers will help providers focus on those metrics that are most meaningful and impactful, increasing the likelihood that they will be able to improve performance against these measures over time.

Person Centered Medical Home Program + (PCMH+)*:*
Medicaid will launch its own SSP as part of SIM. There are a variety of outputs associated with the launch of this program, outlined in the Section B.2.A. PCMH+.

Providing tools and information to provider organizations*:*
We encourage payers to continue to offer participating providers resources and tools to support their successful transformation to a proactive and coordinated care model in a way that augments any resources or tools provided on an all-payer basis during SIM test grant implementation.

Incorporate the Care Experience Survey in value-based payment arrangements:
The SIM PMO is working with health plans in the state to implement a consumer experience survey in their value-based payment arrangements. More information can be found in Section C.7. Data Collection, Sharing & Evaluation.

Information to the PMO:
The SIM PMO requires certain information in order to evaluate performance under the test grant (e.g., VBID and SSP pace metrics) and to execute aspects of the test grant such as data necessary to administer a care experience survey on behalf of commercial health plans. The SIM PMO is working with health plans to be able to obtain this data.

Comparative effectiveness study of VBID plans and Accountable Care Organizations:
Anthem and its analytic team at HealthCore, a research subsidiary, have committed resources to undertake a comparative effectiveness study of VBID plans and Accountable Care Organizations study with the State Employee and Retiree Healthcare Plan and several control groups. The goal of the study is to evaluate the effectiveness of VBID and value-based payment models alone and in concert with one another to see which is more effective and whether synergies can be achieved by offering the member incentive (VBID) and provider incentives in combination.

Risks of Not Engaging Payers
Cross-payer alignment on quality measures is important for providers participating in shared savings arrangements. A potential risk arises if improved alignment does not occur due, e.g., to resource considerations or health plan specific efforts to align internally across states. To mitigate this risk the Quality Council will include health plans in discussions and decisions relating to the quality measures set, especially as it pertains to implementation process, in order to facilitate agreement.

Engaging payers is necessary to ensure viability and sustainability of the payment reforms and the SIM Population Health Plan. New reimbursement innovations will depend in part on health plans' willingness to, for example, link reimbursement innovations with evidence-based policies and strategies to address social determinants of health and health equity (e.g., reimbursement for healthy homes assessments and community health workers). Payer engagement may play a role in ensuring sustainability financing of PSCs and potentially HECs. To mitigate this risk we will engage private and public payers for sustainable financing of PSCs and HECs, while also seeking to diversify the potential sources of sustainability.

Participating Providers and Key SIM Activities

Engaging providers so they are knowledgeable and confident about reforms will spur their active commitment to and involvement in initiatives aiming to achieve improved healthcare quality, reduced cost and satisfaction with the practice of primary care medicine. Over the course of five years, a substantial portion of the state's primary care community is projected to participate in PCMH+ and its associated components, as well as be affected by the common performance scorecard, and statewide HIT initiatives. Active provider engagement in our planning and implementation efforts of primary care transformation through the AMH Program, CCIP, and workforce development will ensure that the unique needs of the provider workforce in our state are met and that their strengths, skills, and interests are optimized. For these reasons it is critical that their input and experience is sought through our engagement methods.

Provider Engagement Methods & Roles

The SIM test phase will build on engagement efforts that occurred during the development phase. These activities included a wide variety of providers in the development of the Model Test, including members of the CT State Medical Society, CT Chapter of the College of Physicians, CT Academy of Family Physicians, Community Health Center Association of CT, CT Chapter of the American Academy of Pediatrics, CT Hospital Association, the CT Association for Healthcare at Home and members of the LTSS community. More than fifty providers and trade associations are engaged in the Healthcare Innovation Steering Committee, and all other councils and task forces associated with the SIM governance structure, including the MAPOC and its committees.

The following methods will be used to engage providers during the test period:

Forums

The SIM PMO is partnering with physicians who are engaged in the SIM governance structure to undertake extensive efforts to raise physician awareness and, importantly, to participate in forums that allow physicians to directly engage on the issues that cause them greatest concerns. We will do this work in collaboration with the various professional associations including the CT State Medical Society, CT Chapter of the American College of Physicians, CT Academy of Family Physicians, and the CT Chapter of the Academy of Pediatrics. We will also partner with DSS as it pertains the interdependent initiatives including AMH, CCIP and PCMH+.

Learning Collaborative

The AMH Program includes a learning collaborative and interactive website to promote peer learning and collaboration. Practices will be expected to actively share resources, tools, and strategies with each other in the learning collaborative. The CCIP learning collaborative will be tailored to Advanced Networks and FQHCs participating in PCMH+. The learning collaborative will foster continuous learning through webinars, workshops, an online collaboration site, and phone support.

Technical Assistance

Providers that participate in CCIP will receive technical assistance, which will assist and engage them in establishing advanced care capabilities across their network.

Physician Survey

In order to engage physicians on a broad scale, the SIM evaluation team conducted a statewide physician survey in November 2014 reaching more than 3400 healthcare providers including primary care physicians and several specialist groups. More information can be found in Section C.5 Workforce Capacity Monitoring.

SIM Governance and Workgroup Structure

During the SIM test period healthcare providers will participate in the SIM governance structure in order to provide feedback on issues that emerge during implementation. In addition, healthcare providers play the critical role of participating in SIM practice improvement initiatives, including moving towards value based payment arrangements.

Providers are members of the Quality Council, which is recommending the core measure set for value-based payment and the public scorecard, and physicians representing all types of physician practices will be consulted in the measure review process. Providers also have membership on the Equity & Access Council, and Health IT Council. As part of the Health IT Council they will provide input regarding the need for HIT solutions and advice regarding the design and implementation of HIT solutions during the test period. Providers currently represented on the PTTF include FQHCs, Advanced Networks, pediatricians, primary care physicians, behavioral health practitioners, school based health centers, home health agencies, cultural health organizations, housing support providers, hospitals and others.

- As members of the **PTTF** physicians are tasked with gathering broad input from a diverse set of physicians such as hospital-employed physicians and rural physicians. They will also provide insight into potential barriers for change and suggestions for overcoming them and promote taskforce recommendations within the physician community.
- Behavioral health providers that are members of the **PTTF** are tasked with providing insight into the needs of behavioral health patients that require additional modifications in provider practices ranging from screening, assessment, brief treatment, health behavior, and linkage to behavioral health affiliates.
- Hospitals will share insights on changes required to administrative, and clinical processes, systems and budgeting for hospitals to play a role in the new care delivery model. They will help the taskforce define a plan for implementing recommendations with hospitals.
- Primary care providers, specialists, and hospitals on the **Quality Council** will share what metrics are and should be tracked and help assess the feasibility of tracking new metrics within the clinical setting, such as changes to systems and clinical processes. Hospitals will also help to assess and identify and help resolve duplicative, conflicting, and unnecessary measurement mandates.
- Behavioral health providers on the **Quality Council** are tasked with identifying and helping to prioritize behavioral-health and health behavior related metrics for inclusion on scorecard. They will share behavioral-specific metrics that are being tracked and help assess the feasibility of tracking new metrics. In addition, they will promote scorecards within the behavioral health community.

- Advanced Networks on the **Health IT Council** will help the HITO and PMO understand new systems, capabilities, and infrastructure that will be required for providers to transition into an ACO clinically integrated model. They will support prioritization and sequencing of planned changes that will maximize impact while minimizing disruption to provider workflows.
- Hospitals on the **Health IT Council** will share insights on existing systems being used by CT hospitals that can be leveraged or best practices that can be adopted. They will support the prioritization and sequencing of planned changes that will maximize consumer and provider benefit while minimizing disruption to provider systems and workflow.
- Physicians on the **Health IT Council** will help the council understand new systems, capabilities, and infrastructure that will be required for independent practice providers to utilize new HIT tools and infrastructure. They will help identify and prioritize required changes to existing systems; provide insight into potential barriers for change and make suggestions for overcoming barriers; support the identification of and vetting of preferred vendors; and provide estimation of required financial investment.
- The newly established **Community Health Worker (CHW) Advisory Committee** includes community health workers and other providers. The committee will facilitate discussions about CHW sustainability models, and includes provider representation.

The HISC will continue to meet monthly to discuss grant implementation topics, such as the AMH Program and CCIP. The Committee acts as a forum to share updates, obtain feedback, and make streamlined decisions regarding SIM concerns. The HISC and associated work groups have seen active commitment from providers, including members of the CT State Medical Society, CT Chapter of the College of Physicians, CT Academy of Family Physicians, Community Health Center Association of CT, CT Chapter of the American Academy of Pediatrics, and the CT Hospital Association. More than fifty providers and trade associations are engaged in the HISC and other councils and task forces associated with the SIM governance structure, including the MAPOC and its committees.

In addition, providers will also have the following roles:

Adoption of value-based payment models, including PCMH+:
Advanced networks, FQHCs and primary care practices participating in SIM initiatives including PCMH+, the AMH Program and CCIP will be responsible for meeting the program requirements.

Financing the Care Experience Survey*:*
For the first two years (2015 baseline, and 2016 performance year), the state has proposed to use SIM funding to subsidize the cost of the care experience survey. The PMO will co-source the conduct of the survey on behalf of all payers and provider organization participating in SSP arrangements. We believe that combining the purchasing power in this way will reduce the cost per completed survey.

Risks of Not Engaging Providers
Providers have identified challenges or barriers to the success of the care delivery and payment reforms. For example, there remains among many physicians a lack of knowledge about the reforms, or skepticism that such reforms will achieve promised improvements in quality, cost or satisfaction with

the practice of primary care medicine. If left unaddressed, physicians may not be willing to participate in offered practice transformations support services or to participate with the Advanced Networks that are already involved in such reforms. Our stakeholder engagement methods will mitigate these risks.

In order to reach our goal of transforming 300 practices to AMH status as well as goals of including 215,000 Medicaid beneficiaries in PCMH+ in the first wave, we must be able to engage and interest providers in transformation. Our mitigation plan includes the following:

- Conduct a qualitative evaluation of the AMH Vanguard Program pilot to enable adjustments to the program design prior to implementing federally funded AMH recruitment
- Recruit champions from the pilot to encourage their peers to join the program
- Convene with DSS one or more AMH engagement forums, beginning in October 2016 to build enthusiasm for their program. Emphasize benefits with respect to enhanced Medicaid fees, the opportunity to participate in PCMH+, streamlined NCQA PCMH administrative requirements, the value of PCMH recognition with respect to MIPS, and the impact on performance improvement.

Payers & Providers: Data Collection and Evaluation Coordination

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

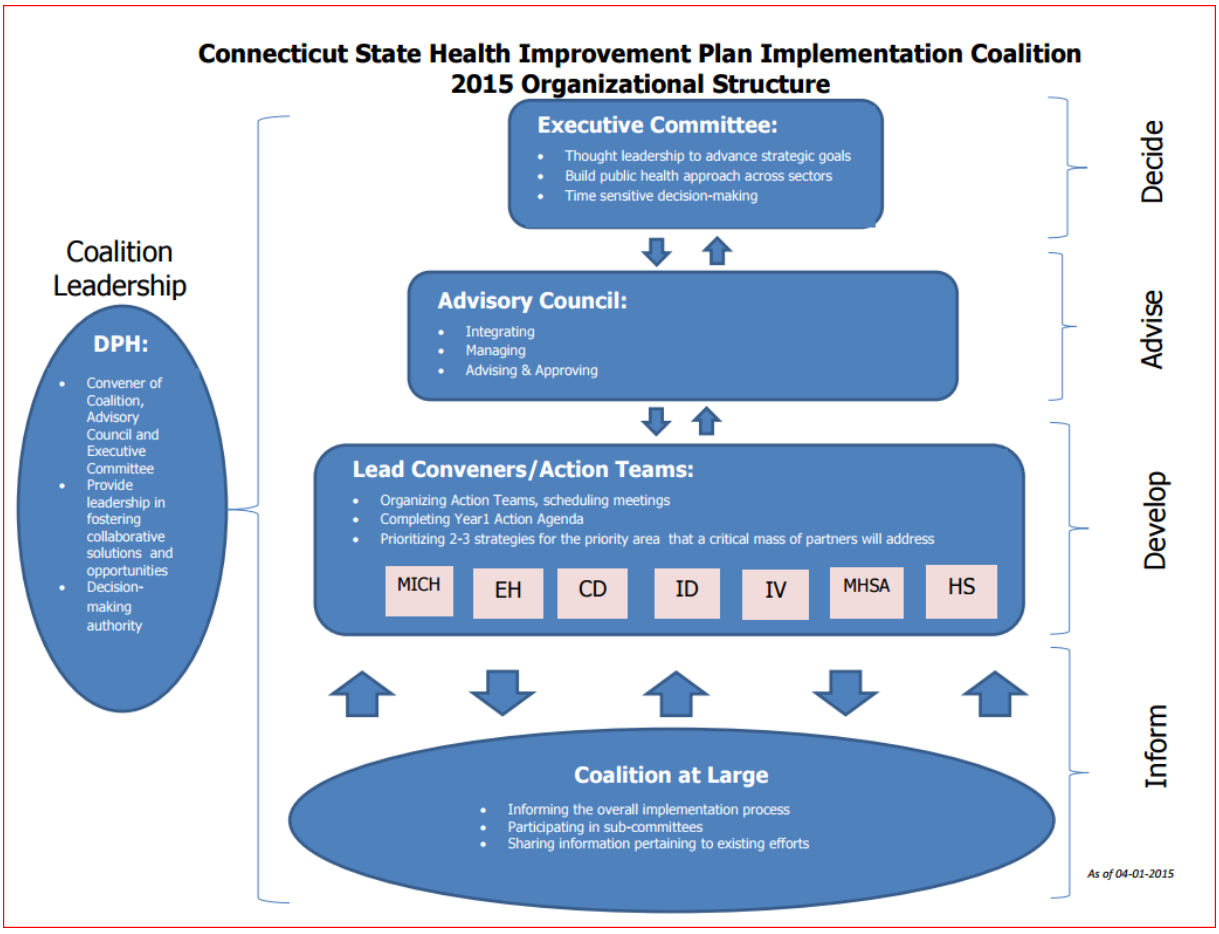
Connecticut Medicaid has strong analytic capacity and expertise. Since 2012, Connecticut Medicaid has had the benefit of a fully integrated set of claims data across all categories of Medicaid services. The Department's medical ASO, CHN, maintains this data within the Utilization & Cost Analyzer (UCA) system, an analytical and data discovery tool that includes Medicaid claims, member eligibility, and provider data. UCA utilizes QlikView software and is uploaded monthly with claims, member eligibility, and provider data directly from CHN's data warehouse specific to the Connecticut Medicaid program. The data warehouse is populated with data that is received from the Department and its claims processing partner, HP. The Department anticipates that the data extracts necessary to support the federal evaluation will be produced by CHN. As noted above, the Department will enter into data use agreements (DUA) with CMS or the federal contractor for purposes of sharing the minimum necessary identifiable data.

Participating Public Health Sector and Key SIM Activities

To develop the Statewide Health Improvement Plan (SHIP or *Healthy Connecticut 2020)*, Connecticut engaged over 150 organizations around a Statewide Health Improvement Coalition in designing and advancing a health improvement framework. This planning framework addresses chronic disease and its risk factors; infectious diseases; injury and violence; mental health, alcohol and substance abuse; environmental health; and maternal, infant and child health. From this stakeholder base and beyond, DPH draw representatives from sectors that have a role in health improvement and that share values of prevention, wellness and reducing health disparities, to participate in the Population Health Council.

The State health improvement coalition involves a broad based representation from relevant sectors, including business, payers, providers and multiple partners from community coalitions, human services providers and the educational sector among others. The coalition is organized around seven action teams addressing priority areas defined in the SHIP. Action teams through their lead conveners report to the SHIP Advisory Council, which in turn is assisted by an executive committee.

To the extent that Population Health planning becomes more inclusive, Connecticut seeks to widen the circle of involvement with new partners and representatives (stakeholder wheel) in order to facilitate grassroots participation and enhance creativity and innovation in solving health challenges. New partnerships should ensure broad based representation from all relevant sectors, including businesses, payers, providers and partners. This also includes key agencies and offices with potential influence and funding mechanisms over social determinants of health (SDH) such as Office of Early Childhood, Department of Housing, Insurance, Social Services and healthcare payers. Planning and thinking around stakeholder engagement will continue to evolve and may benefit from additional input from the SHIP Advisory Council. The goal of this Council is to manage implementation of strategies that will improve health in focus areas such as Health Systems and Chronic Disease, which together encompass many of the SIM goals. The SIM Population Health Director will engage as a lead convener of the HCT2020 Health Systems workgroup to coordinate goals toward health improvement. Healthy Connecticut 2020



Statewide Health Improvement Coalition is coordinated by DPH with decisions made through a 5

member Executive Committee and activity management by a 25 member Advisory Council. Each of 7 Focus Area Teams have co-leads to work on implementing priority strategies and interventions to improve health in 21 key priority areas. Executive, Advisory and leads are credible leaders and stakeholders drawn from the Coalition.

Risks of Not Engaging Public Health Sector Stakeholders

Attempting to impact the larger Population Health Issues necessarily involves the participation of the Public Health Sector as it is clearly established that health outcomes are the result of multiple social determinants. The Public Health sector has a broad spectrum of practice that ranges from the direct delivery of field and community based services to the planning and design of health policy and reforms. Within the same spectrum, there are researchers, clinicians, social service workers, administrators, legal experts, data analyst, environmentalists and many other fields interested in all factors defined as social determinants of health. In contrast with the Healthcare industry, the public health system is not adequately resourced to accomplish its mission and it is and not optimally equipped to utilize the resources it does receive. More importantly, the public health system is not adequately linked to the healthcare delivery system and its workforce capacity does not adequately meet current and future needs.

Despite of these weaknesses, public health practitioners are a key resource to assist care providers in assuring that patients receive appropriate services outside the clinical setting to promote health and prevent disease in addition to receiving diagnosis and treatment. The Public Health sector has solid experience identify quality measures and incentives that yield better health outcomes and control costs. They can also provide evidence of effective preventive interventions as defined by national standards and tested over many years of grant funded initiatives. In reforming the healthcare delivery sector, the Public Health experience represents an opportunity to bring proven interventions to scale if such experience is made part of the payment reform and new value based health plans design. More importantly, traditional public health interventions can be made a natural complement to traditional health care treatment by implementing community-oriented population health measures.

3. Leveraging Regulatory Authority

Connecticut has demonstrated that it is **committed to using legislative and regulatory authority to support healthcare delivery and payment reform**. Recent health care related legislative initiatives include: 1) broad healthcare bill addressing health information exchange, facility fees, healthcare cost containment, certificates of need, hospital conversions, transparency on quality and cost information and other consumer protections, including protections against surprise billing (P.A. 15-146); establishing the CT Health Insurance Exchange (Access Health CT) (P.A. 11-53); 2) expanding Medicaid (P.A. 11-44); 3) reducing state employee healthcare costs associated with facility fees (P.A. 14-217); 4) expanding CT's False Claim Act to encompass all health and human service agencies, programs, and employees/retirees (P.A. 14-217); 5) disclosing observation status to patients (P.A. 14-180); and 6) establishing the CT

Institute for Primary Care, a cooperative venture of the state's public academic medical center and St. Francis Hospital for the purposes of advancing primary care transformation (P.A. 10-104).

In June of 2015 the state enacted Public Act 15-146: An Act Concerning Hospitals, Insurers and Health Care Consumers[14]. This public act creates broad and expansive changes to the health care landscape that promote many of SIM's goals. In particular, this act:

- Requires that the CT health insurance exchange (Access Health CT) provides consumer information on their website, with information comparing quality, price and cost of health care services, and factors consumers should consider when choosing an insurance product or provider group, including provider network. Also says the exchange may consider adding quality measures to the website as recommended by the SIM PMO.
- The health insurance exchange must also offer tiered health care provider network plans that have different cost-sharing rates for different provider tiers and reward enrollees for choosing low-cost, high quality health care providers by offering glower copayments, deductibles or other out-of pocket expenses.
- Requires the Healthcare Cabinet to study cost trends, and promote high quality health care providers. They will produce a report in 2016 with recommendations for changes that will monitor cost growth (may include state-wide or provider benchmarks or limits on health care cost growth); identifying providers that exceed benchmarks; and mitigate factors that contribute to cost growth, including delivery system reforms to promote value-based care.
- Establishes a working group consisting of Insurance Commissioner, Comptroller, DPH Commissioner and Healthcare Advocate to study rising cost of health care.
- Establishes a health information exchange. Requires that no later than two years after, each provider with an EHR that can connect to the HIE must begin the process to connect to the HIE. Establishes a state HIT Advisory Council to advise the state's HIT and HIE efforts, of which the Director of SIM is a member.
- States that each hospital shall, to the extent possible, use its EHR system to enable bidirectional connectivity between other hospitals and providers that has an EHR capable of exchanging record.
- Requires that contracts between providers and health carriers cannot prohibit disclosure of any data to the APCD.
- Requires that State of CT Health and Educational Facilities Authority shall consider financing options to enable community hospitals to advance analytics; providing CLAS services; supporting infrastructure investment is health care facilities that are necessary for the transition to APMs; improving the affordability and quality of care, by increasing coordination between hospitals and community-based health care providers and other community organizations.
- Establishes requirements regarding facility fees notices, and notices of mergers and acquisitions.
- States that health information blocking shall be an unfair trade practice.
- Limits allowable facility fees.

[14] https://www.cga.ct.gov/asp/cgabillstatus/cgabillstatus.asp?selBillType=Bill&which_year=2015&bill_num=sb+811

- Adds factors that the Department of Public Health and Office of Health Care Access (OHCA) must consider when reviewing certificate of need (CON) application for a hospital transfer of ownership. Places certain conditions on its approval of a CON application involving a hospital ownership transfer. Also requires OHCA to conduct a cost and market impact review for certain hospital ownership transfers.
- Requires notices to patients including of costs for nonemergency services, about covered benefits, the network status of providers, and surprise bills.
- Requires the insurance commissioner to evaluate health insurers', HMOs', fraternal benefit societies', and hospital and medical service corporations' compliance with the federal Affordable Care Act (ACA).

In May of 2016 the state enacted Public Act 16-77: An Act Concerning Patient Notices, Designation of a Health Information Technology Officer, Assets Purchased for the State-Wide Health Information Exchange and Membership of the State Health Information Technology Advisory Council. This act makes various changes to requirements for health information technology, hospitals, health systems, and health carriers enacted in PA 15-146. Changes about the health information technology include (1) designation of an Health Information Technology Officer (HITO) by the Lieutenant Governor, (2) transfers various responsibilities from DSS Commissioner to the HITO; and (3) adds additional members to the state Health IT Advisory Council. Additional details can be found within the Health Technology Section.

Additional recent legislative and policy initiatives align with our objectives under SIM and create opportunities for integration with our ongoing SIM program design and implementation activities. Several examples are as follows:

- Public Act (PA) 14-217, the budget implementer bill established funding for the PMO, which enables the PMO to play an ongoing role in the coordination and integration of state agency, provider, payers, and stakeholder activities, including beyond the period of performance for the SIM grant.
- P.A. 15-88 requires certain health insurance policies to cover medical services provided through telehealth to the extent that they cover the services through in-person visits between an insured person and a health care provider. It also establishes requirements for health care providers who provide medical services through the use of telehealth.
- P.A. 15-34 requires acute care hospitals to ensure that interpreter services are available to patients whose primary language is spoken by at least 5% of the population residing in the hospital's geographic service area. Current law requires hospitals to do so only to the extent possible.
- P.A. 14-148 requires DPH to develop a chronic disease prevention and reduction plan consistent with the Innovation Plan, which provides the opportunity to integrate DPH's overarching chronic disease prevention and reduction plan with specific systemic changes in community governance, accountability and health care financing as envisioned as part of the Health Enhancement Community concept. SIM will bring greater focus on maximizing the use of public and private health financing levers to reward providers and other community entities for achieving population health goals.

- P.A. 13-247 established the All-Payer Claims Database (APCD), which will be the primary source for data to enable evaluation of SIM related care delivery and payment reforms.
- P.A. 14-168 helps ensure competitive healthcare markets by requiring Attorney General notification and the submission of information regarding material changes to the business or structure of physician group practices. This law also requires annual filing of hospital, system, and physician group affiliation to enable the state to better monitor the impact on competition and price as providers organize and consolidate to assume accountability under SIM related payment reforms. The inclusion of new certificate of need requirements regarding transfers of ownership of certain physician group practices to any entity other than physicians or physician groups will provide the state with additional control over such consolidation. These activities are important in light of evidence nationally that the gains in waste reduction and quality achievable in larger systems (and enabled by CT's SIM initiative) can be countered by reductions in competition and associated increases in pricing.
- P.A. 14-12 permits APRNs who have been licensed for at least three years to practice independently. The implications of this change will be considered by the Practice Transformation Task Force as it considers the role of APRNs within health care teams and the context of medical home recognition.
- P.A. 14-211 enables licensed behavioral health clinics to provide "off-site" services in physician offices and other healthcare settings, removing a longstanding barrier to the integration of primary care and behavioral health. This new flexibility will be a consideration for the Practice Transformation Task Force in the development of integrated behavioral health standards and will provide additional flexibility in our efforts to provide technical assistance for practice transformation in this important area.
- P.A. 14-217 which transfers responsibility for HIT and the Health Information Exchange (HIE) coordination to DSS will better enable the integration of SIM HIT initiatives, especially as it pertains to information exchange and analytics, and with DSS HIT initiatives within Medicaid such as the administration of the EHR incentive program.
- P.A. 14-145 requires that consumers be informed of hospital facility fees, which will empower consumers to take cost into consideration when making decisions about where to go for care.
- New requirements for online license renewals for physicians, dentists, and APRNs is enabling us to integrate workforce survey questions so that we can more easily gather timely information about capacity distribution and changes in provider capabilities (e.g., EHR adoption, extended hours, etc.). DPH and the PMO are currently developing physician survey questions. PMO workforce analytic resources will enable the analysis of this data to inform our primary care investments and track progress over time.

During the Model Test, the state is committed to continuing to leverage its statutory and regulatory authority to influence the structure and performance of the state's healthcare system to support the aims of SIM. The following policy actions are planned or under consideration:

1. Amending insurance regulations to enable health plans to provide consumers with provider quality and cost information so that they can make informed decisions regarding high value care and to enable health plans to establish tiered networks based on provider value. This focus on

performance transparency is an essential companions to VBID reforms and insurance design changes that make consumers more price sensitive;

2. Potentially Including VBID in the next procurement of Qualified Health Plans (effective with the 2018 benefit year) and establishing plan designs to encourage integration of behavioral and oral health, by Access Health CT pending approval by its board. This will contribute to our overall efforts to accelerate VBID penetration.
3. Reviewing same day service barriers, such as coverage limitations that prohibit reimbursement for medical and behavioral health services provided on the same day, which helps to enable integrated care; and
4. Using loan forgiveness programs to support the retention of residents in primary care. This would better enable the state to incentive primary care retention in primary care shortage areas.

4. SIM Alignment with State and Federal Initiatives

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

1. Behavioral Health Homes
2. Department of Social Services Medicaid PCMH Program and Intensive Care Management Initiatives
3. *WrapAround New Haven*
4. State Health Improvement Plan, Healthy CT 2020
5. Connecticut's Coordinated Chronic Disease and Health Promotion Plan
6. Regional health improvement collaboratives
7. Community benefit programs sponsored by non-profit hospitals/businesses
8. Local public health department activities
9. Local health education activities
10. Community needs assessment completed by not for profit hospitals and health systems
11. Other key local initiatives sponsored by city, county or regional public health commissions/agencies, foundations, large employers, academic institutions, community organizations, etc.
12. Practice Transformation Network grant initiative
13. Medicare SSP

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

that is not a primary focus of our model test, but will inform SIM related multi-payer innovations in the future.

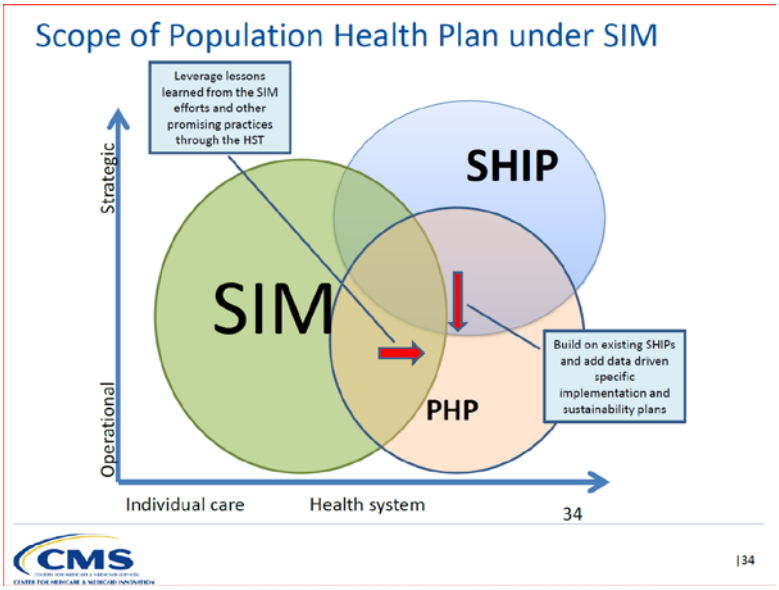
Department of Social Services Medicaid PCMH Program and Intensive Care Management Initiatives: Through this program primary care practices are eligible for enhanced fee-for-service as well as quality performance and improvement payments once they become recognized by NCQA as a patient-centered medical home.

PCMH+ represents an opportunity for Connecticut Medicaid to build on, but not supplant, its successful PCMH Program and Intensive Care Management initiatives. Currently, 109 practices (affiliated with 381 sites and 1,386 providers) are participating, serving over 312,777 beneficiaries (over 40% of Medicaid members). Connecticut's 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 Intensive Care Management initiative has also demonstrated exciting initial results.

In 2012, DSS established a glide path program to provide practical, on-site technical support to facilitate practice transformation towards medical home recognition. The PMO will coordinate with this DSS program to implement the Advanced Medical Home Program. The AMH program will provide facilitation for AMH participants to qualify and enroll in the Medicaid PCMH program and thereby qualify for enhanced fees and quality of care incentive payments.

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

State Health Improvement Plan, Healthy CT 2020: The Department of Public Health developed a comprehensive, multi-year state health plan that comprises assessments of the health status of CT's population and the availability of health facilitates. This plan is designed to be an integrated framework for agencies, coalitions, organizations, groups and individuals to use in leveraging resources, coordinating and aligning efforts, and sharing data and best practices to improve the health of CT residents in a focused and purposeful way.

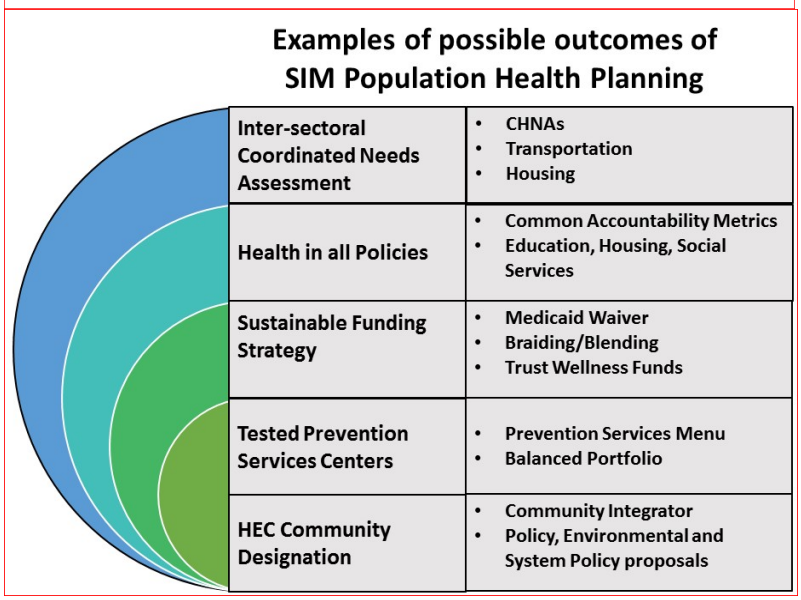


The SIM Population Health Plan work builds on and coordinates with the Healthy CT 2020 Plan. The SIM Population Health Council leverages the existing governance and stakeholder engagement bodies that were created to implement Health CT 2020 and aims to use many of these stakeholders to both populate the council and engage in other ways to obtain their input. Additionally, prioritization and barriers identification will be made based on assessments available through CT2020.

The SIM Population Health initiative is led by the State Department of Public Health in close cooperation with the Office of the Health Advocate and the State Department of Social Services. As an integral part of the State Innovation Model, the Population Health work stream collaborates with multiple other agencies and organizations such as the office of the State Comptroller, Access Health Connecticut and UConn Health. The SIM Program Management Office supports the implementation of the Population Health Work stream by coordinating efforts, overseeing evaluation, engaging stakeholders, managing vendors, executing select initiatives, and communicating progress to the public.

Alongside its leading role in the SIM Population Health Planning, the State Department of Public Health also leads the implementation of the State Health Improvement Plan (SHIP). The DPH/SIM Population Health director sits as lead of the SHIP Health Systems Workgroup to inform about progress around the State Innovation Model and how it contributes to the SHIP strategic objectives. Through its coordination with SHIP stakeholders, the SIM Population Health work stream draws from the experience of multi sector representatives with whom it shares values of prevention, wellness and health disparities reduction. Conversely, the SHIP initiative also benefits from this coordination addressing gaps in payer, provider and business participation by drawing from SIM governance stakeholders.

Although the SHIP has a strong and strategic focus on traditional public health approaches, the SHIP Health Systems workgroup is also concerned with issues such as access to care, health financing, health workforce, health information technology, quality of care and public health infrastructure. The goal of the SHIP Advisory is to implement all focus areas including Health Systems and Chronic Disease which together encompass many of the SIM goals.



Connecticut's Coordinated Chronic Disease and Health Promotion Plan: Nested within the broader Healthy CT 2020 framework, the CDC-funded "Live Healthy Connecticut" Connecticut's Coordinated Chronic Disease and Health Promotion Plan, identifies ambitious yet achievable goals in 12 chronic disease priority areas aligned around three portfolios of disease prevention and control: 1) Policy and environmental strategies to support and reinforce healthful behaviors 2) Health system strategies to improve use and delivery of preventive intervention and 3) Strengthening clinical-community linkages to better utilize community resources. The plan details state-wide strategies to address top CT SIM priorities such as obesity, diabetes, tobacco and asthma which has already informed SIM pop health planning. Using the plan and with the direct engagement of chronic disease staff, the SIM Pop Health Council will build on, and coordinate with ongoing efforts to address chronic disease.

Regional health improvement collaborative: While building community health capabilities, the population health component of SIM is beginning to establish the current level of activity and structure of existing community based collaboratives. Project staff are making personal contacts and exploratory visits with recognized initiatives in the state in order to begin assessing their service delivery capacity and/or their ability to convene multisector discussions.

http://gethealthyct.org/

http://vitastamford.com/

In Bridgeport for example, an oral health collaborative aims to double access and utilization of oral health services among HUSKY children within the next 5 years. In Waterbury a community based planning consortium works with the Ryan White Planning Council and its very active consumer advisory group organizing HIV testing and outreach events. The Department of Health & Human Services in Hartford launched a Health Hartford wellness campaign. This campaign was designed to increase the availability of health related information and have the community discussions about health behaviors like physical activity, proper eating, and other aspects of disease prevention. This wellness initiative also designed interactive activities targeting specific demographic groups throughout Hartford's 17 neighborhoods.

Community benefit programs sponsored by non-profit hospitals/businesses: The SIM population health component is led by the Department of Public Health, which by statute must require all hospital systems to file with the Department the community benefits reports. This creates an opportunity for the program to receive direct reports of all community benefits initiatives funded through the Connecticut health systems. In addition to the breakdown of costs for services reported by non-profit hospitals, there are reporting elements that provide qualitative descriptions of the added value that hospitals' investments place in the community. The community benefits report, in supplement with the community health needs assessments, provide key information to the SIM program to build on already tailored initiatives. Findings in the community benefits reports provide an opportunity to characterize feasible interventions (i.e. educational, community support, leadership development, coalition building etc.), which can be used for multisector engagement and community health improvement planning purposes.

Local public health department activities: State statutes require the Commissioner of the Department of Public Health to host a semi-annual meeting with all local health directors to exchange experiences. While the Commissioner learns about priorities and challenges at the municipal level, the Department also provides guidance on statewide programs. Typically, subjects of discussion include sessions such as *Overview of Programs in the Office of Injury Prevention, Infectious Diseases, Accreditation tips, tools and management, State Innovation Model and Community Water Fluoridation.* The SIM program has also a direct opportunity to work with health directors to educate them on the progress of health reform in the state. With several local health districts seeking to become accredited health departments, initiatives like SIM provide alternatives for strengthening their community coalitions.

Local health education activities: Through the identification of high-risk conditions and areas of unmet need, the SIM Population Health Council will be well positioned to better guide efforts/initiatives at the local level. Investments in local prevention services for some chronic disease self-management programs could be more confidently place if priorities and barriers are clearly identified. For example, diabetes management clinics with low enrollments could open different areas. Currently, some clinics provide up to 150 diabetics with self-management skills and clinical care. They meet once a week (in various locations) to develop treatment plans for new patients and collaborate on existing patients. Similarly, local health assessments have identified specific segments of the population and geographical areas with transportation barriers for receiving health care. In the Waterbury area *Be Well Bus* has completed 4,170 transports to and from medical appointments. Other local health education experience that the SIM project has become aware of is the *Better Breathers Club* in the town of Middlesex. This program support groups to learn how to better cope with COPD. This group meets regularly and feature educational presentations on a wide range of relevant topics including exercise, breathing techniques and home health care.

Community needs assessment completed by not for profit hospitals and health systems: SIM funds have allowed the State to supplement the data that already exists with newly highlighted local level perspectives and updated information. This blend of data driven and self-identified views on health and health outcomes, are essential for impacting the population at the community level. Evaluating the statewide status of health indicates, that while Connecticut fairs well nationally with health targets, locally there exists much disparity in health outcomes. The SIM Population Health Assessment can elaborate on those disparities and focus on areas that require more integrated care and services to improve overall state health outcomes.

SIM directed efforts provide an ability to strategically target areas (identified through the community health needs assessments) for improvement. Linking the areas of high risk, with its' cost burden and declaring existing gaps in care and prevention, can assist policymakers and agencies on how to strategize efforts to lower per capita costs, while improving the overall patient experience of care. By implementing interventions for targeted communities, the focus of resources can be concentrated on those most-at-risk and those most likely to demonstrate an impact benefit. The intentional assignment and demonstration of PSCs and HECs require that the selected areas of need care capable of displaying the capacity to show improvement over time.

Other key local initiatives sponsored by city, county or regional public health commissions/agencies, foundations, large employers, academic institutions, community organizations, etc. : The Population Health Council will represent a diverse group of people that represent the various public health commissions/agencies, foundations, community organizations and academic institutions that will have great influence over the SIM directives, while incorporating a great range of expertise. It is through their

Practice Transformation Network (PTN) grant initiative: Health systems in Connecticut were recently recipients of grants to support practice transformation under the CMMI's PTN grants. SIM and PTN both include a focus on practice transformation and technical assistance. CMMI has instructed SIM and PTN grant recipients to work together to coordinate the administration of these programs with the aim of promoting harmonization and ensuring that duplication is avoided. The SIM PMO and DSS have worked with CT's PTN grantees to formulate key principles for coordinating the two programs. The principles below are based on discussions with Community Health Center Association of Connecticut (CHCACT), the lead agency for Connecticut's FQHC participants, and UConn Health, as a participant of the Southern New England PTN.[15]

Key Principles of Coordination: SIM and PTNs

1. The SIM and the PTN programs emphasize related capabilities focused on team-based care management, population based analytics and performance improvement, and integrated behavioral health. In order to avoid duplication and maximize the total number of clinicians in Connecticut that can be supported by these transformation initiatives, providers shall not be permitted to participate in both SIM and PTN funded transformation support in these overlapping core content areas. SIM funded technical assistance and transformation awards with this focus shall be limited to entities/clinicians that are not participating in PTN.
2. The SIM program also focuses on content areas related to e-consultation and the use of Community Health Workers in support of clinical care, navigation and access to community supports. Neither e-consultation nor Community Health Workers are content areas within the CHCACT PTN program. Accordingly, SIM funded technical assistance and the SIM CHW initiative may be available to support interested entities/clinicians that are participating in PTN. SIM and CHCACT PTN program leads agree to make good faith efforts to examine the extent to which this can be achieved to mutual advantage and within available resources. UConn Health does include e-consultation as a content area and will not duplicate any technical assistance provided under SIM. UConn Health is also developing an initiative to bring geriatric expertise both to primary and a specialty practices, for which there is no counterpart SIM, but which might help inform SIM's transformation initiatives.
3. Statewide transformation efforts should present a unified approach and should not create silos amongst practices. The SIM and PTN program administrators will work to promote harmonization in the design of these programs. The PTN program administrators will work in

[15] Discussions have also been held with VHA/UHC, however, the VHA/UHC clinician recruitment plan does not currently include Connecticut-based clinicians.

collaboration with the SIM PMO to review the SIM Community and Clinical Integration Program (CCIP) standards and consider whether and to what extent these standards could be incorporated into the PTN change package in a manner that will advance the programs' mutual aims and without adding undue burden on the program participants. The SIM PMO will do the same with the PTN standards and change package to the extent such information is available timely.

4. SIM and PTN should adopt a strategy that avoids unnecessary burden on the provider. Transformation assistance should be tailored to focus on the gaps in participants' capabilities, rather than a "one-size-fits-all" approach that requires all providers to participate in all aspects of the change package.
5. The Medicaid Quality Improvement and Shared Savings Program (PCMH+) is a SIM related initiative that is intended to build on current success with the Medicaid PCMH and Intensive Care Management initiatives by incorporating advanced care coordination elements within a shared savings model. None of the principles outlined above are intended to preclude PTN providers from applying to participate in PCMH+ if they otherwise meet DSS's eligibility requirements. DSS and the PMO encourage FQHCs and other PTN participants to consider applying to participate in PCMH+ and recognize that PTN resources may better enable PTN participants to achieve PCMH+ care improvement goals.

Medicare Shared Savings Program: SIM is seeking to build on the leadership of to support the continued transformation from volume-based to value-based reimbursement, and aims to promote multi-payer alignment around a common framework for value-based payment, based on the Medicare Shared Savings Program (MSSP). For more information, see Section B.2.A. Promote Payment Models that Incentivize Value, Alignment with Medicare Payment Models.

5. Workforce Capacity Monitoring

The following strategies will be implemented during the SIM grant period to address the future health care workforce requirements of our proposed SIM:

1. include participation of academic medical centers, professional associations and trade groups in stakeholder engagement plans;
2. Assess and track physician burnout: Physician Survey, AMH Program;
3. Implement Community Health Worker initiative; and
4. Leverage regulatory authorities.
5. Establish a Work Group on Workforce Development of the Consumer Advisory Board

Stakeholder Engagement Plans

The SIM stakeholder engagement strategy includes participation of academic medical centers, professional associations and trade groups. Engaging providers so they are knowledgeable and confident about reforms will spur their active commitment to and involvement in initiatives aiming to achieve improved healthcare quality, reduced cost and satisfaction with the practice of primary care medicine. Active provider engagement in our planning and implementation efforts of primary care transformation through the AMH Program, CCIP, and workforce development will ensure that the unique needs of the provider workforce in our state are met and that their strengths, skills, and interests are optimized. For these reasons it is critical that their input and experience is sought through our engagement methods.

The SIM test phase will build on engagement efforts that occurred during the development phase. These activities included a wide variety of providers in the development of the Model Test, including members of the CT State Medical Society, CT Chapter of the College of Physicians, CT Academy of Family Physicians, Community Health Center Association of CT, CT Chapter of the American Academy of Pediatrics, CT Hospital Association, the CT Association for Healthcare at Home and members of the LTSS community. More than fifty providers and trade associations are engaged in the Healthcare Innovation Steering Committee, and all other councils and task forces associated with the SIM governance structure, including the MAPOC and its committees.

For more information, see Section C.2 Stakeholder Engagement.

Assessing physician burnout: Physician Survey, AMH Program

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

- Physicians ' attitudes and concerns regarding larger coordinating entities such as clinically integrated health systems or Advanced Networks;

- Willingness to accept new patients and patients with different types of insurance (e.g., Medicaid, Medicare).
- Amount of primary care currently provided and any anticipated changes in the relative amount of primary care provided;
- Availability and/or use of a formal care coordinator and/or ability to coordinate care, and to attract staff to help address complex care needs;
- Ownership and organization of practices and affiliations with larger care systems/organizations such as networks, Independent Practice Associations (IPAs), or Accountable Care Organizations (ACOs), as well as anticipated new affiliations or arrangements;

These findings will be used to inform implementation of SIM initiatives. In particular, some of these questions have already been incorporated into the AMH program. The pre and post assessment of practices that receive transformation services to become medical homes includes questions such as:

- In the last 12 months, how often have you considered reducing your panel size?
- In the last 12 months, how often have you felt burned out from your work?
- What kind of effect do you think an EHR system has on each of the following outcomes? (Reducing healthcare costs; quality of healthcare; quality of patient-physician communication; efficiency of providing care)

In addition, the survey questions may inform the development of questions for the expanded physician licensing survey described previously. The physician survey could then be used as a baseline or starting point to evaluate whether our reforms are impacting provider concerns.

Community Health Worker Initiative

Community health workers are widely recognized as critical healthcare providers in new and innovative healthcare payment and service delivery models. They have been shown to improve access and outcomes, and are an important component to a healthcare workforce strategy that is able to meet the needs of the individuals it serves. SIM is investing in a comprehensive CHW initiative which includes establishing a CHW Committee that includes CHWs and other providers, develop marketing materials and CHW integration toolkits, and analyzing the CHW workforce in the state. For more information see Section B.4 Community Health Worker Promotion.

Leveraging Regulatory Authorities

As stated in Section C.3 Leveraging Regulatory Authority, the following regulatory action may be considered:

> Using loan forgiveness programs to support the retention of residents in primary care. This would better enable the state to incentive primary care retention in primary care shortage areas.

Other regulatory options will be compiled and considered.

Work Group on Work Force Development

A Work Group on Workforce Development of the Consumer Advisory Board is currently being established to examine workforce capacity issues. Composition of the workforce work group may include consumers, private payers, representatives from providers of services, a labor economist, the State Department of Labor, the US DOL, the state DOE, DPH, UConn Health Center, the Board of Regents, labor organizations representing members in health care occupations and others who come forward and demonstrate a particular expertise in workforce issues.

This work group may focus on the following: compiling data on the existing healthcare workforce; analyzing current demand for services; reviewing the current educational pathways for training; and the ability of current workforce to meet the demands of the healthcare system.

6. Program Monitoring & Reporting

Overall Approach

We are monitoring and reporting on the impact of the Model Test on 1) population health; 2) health care quality; and 3) per capita healthcare spending as it pertains to the entire Connecticut population. Health disparities are also tracked, to ensure that the model test is promoting health equity while it is improving population health and health care quality. Our evaluation approach includes:

1. Collection of real-time data to promote and support continuous quality improvement;
2. Use of advanced statistical methods to analyze complex data and account for nonrandomized designs when conducting assessments of specific innovations, such as VBID; and
3. Collection of qualitative data to better understand the context of reform efforts.

Data on Model Test targets will be compiled quarterly and reported to the PMO, Rapid Response Team and CMMI at specified intervals, to facilitate rapid-cycle evaluation of reform efforts and identify areas for mid-course corrections.

More detailed information regarding measure definitions, populations, measure types, and other can be found in Appendix B, performance measures and Appendix C, pace measures.

Dashboard

The team has prepared a *Dashboard* that presents summaries of a core set of measures, corresponding to Model Test targets, to 1) monitor the pace of implementation and performance of key program initiatives; and 2) provide data on changes in health outcomes and health spending to inform short time-cycle program adjustments. Alignment of dashboard measures with CMS guidance is underway.

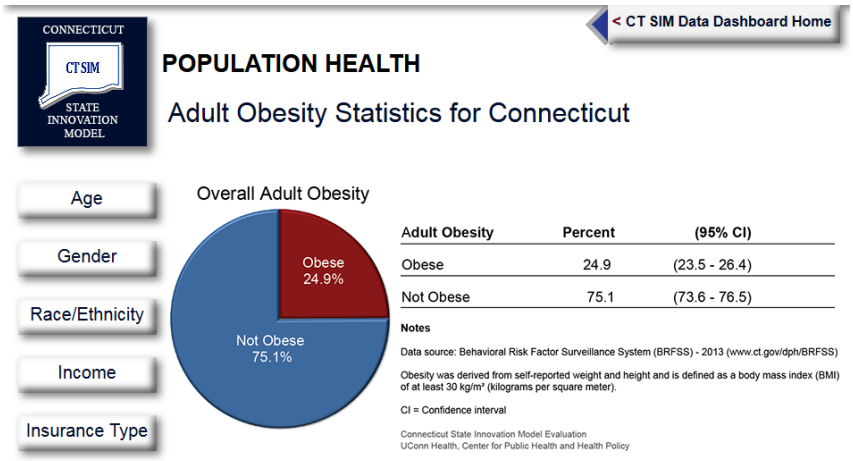
Through the SIM Evaluation Dashboard, information provides the public with a powerful tool with which to investigate the changing healthcare landscape under SIM and to assess how well we are meeting our SIM goals.

Results are calculated from data obtained by Connecticut State Agencies and span a variety of topics from population health and healthcare delivery to healthcare costs and health insurance transformation. This dashboard is being produced and maintained by our Evaluation Team at the UConn Health, Center for Public Health and Health Policy (CPHHP).

The dashboard displays tables and graphs of overall results and by gender, race/ethnicity, income, insurance payer, and age as the data allows. It will ultimately consist of approximately 30 core measures identified in the SIM grant.

The first dashboard publication is based on data from the Behavioral Risk Factor Surveillance System (BRFSS-2013-2014) and Youth Tobacco Survey (YTS-2013) obtained from Department of Public Health (DPH) and focuses on five population health measures: Childhood Obesity, High School Student Smoking, Adult Obesity, Adult Smoking, and Adult Diabetes.

Exhibit: Example display of Dashboard information



In the future additional measures from DPH's Death Records and Hospital Inpatient Discharge Data (HIDD) will be added, as well as updated current measures. Displays with baseline values and yearly targets under SIM will also be added. Thereafter, population health measures are expected to have yearly updates while most healthcare delivery, healthcare costs and health insurance transformation measures will be updated quarterly. Measures based on data from public and private sources and insurance payers will be added as they become available.

To access the first iteration of the dashboard please visit:
http://www.publichealth.uconn.edu/sim_dash.html.

(1) Strengthening Population Health

The team will report to CMMI about progress developing the Population Health Plan, including 1) identifying priorities, barriers and interventions; 2) completing a population health assessment; 3) implementation of a PSC demonstration; and 4) finalization of the Health Enhancement Community (HEC) design. The Dashboard includes measures for statewide population health targets contained in the states' Healthy CT 2020 plan including tobacco use, obesity, and diabetes prevalence. The plan for improving population health utilizes and builds upon the DPH's recent State Health Assessment, State Health Improvement Plan (Healthy Connecticut 2020) and the state Chronic Disease Prevention Plan. The measures presented in Table 5 and three of the measures in table 6 (Percent of adults with a regular source of care; frequency of well-child visits, especially for at-risk populations; and premature death due to cardiovascular disease among adults) are the population health measures that we are monitoring over the course of the project. The population health measures listed in Table 5 and 6 are all derived from population-level datasets (e.g. BRFSS, YTS, HIDD, Vital Statistics).

In addition, the State Chronic Disease Plan has established population measures with baselines and targets for obesity, tobacco and diabetes, which are delineated in Table 5 below. These measures will serve as a baseline for anticipated interventions targeting these three conditions.

Note that the baseline and target values for population health and care delivery are in the process of being rebased as the values listed in the grant were based on data from 2012. Observed values for 2014 differed from the initial projections and rebasing is required to produce appropriate targets. The Evaluation Team has worked closely with the CT Department of Public Health to begin to produce updated targets. Historical data has been analyzed through 2014 and projected values based on expectations without SIM programming have been calculated for 2015-2020. SIM targets have been set off of a 2015 baseline value with a 5% improvement by 2020, taking secular trends into account. The data in the tables below will be updated using this method. Appendix B includes some updated measures, however, the majority are listed as TBD and will be calculated with targets through 2020 once data becomes available.

Exhibit: Improving Population Health Measures

Category/Measure	Data Source	Base	2016	2017	2018	2019	2020
Adult Obesity	CT DPH: Behavioral Risk Factor Surveillance System (BRFSS)	24.50%	23.65%	23.48%	23.30%	23.13%	**22.95%**
Childhood Obesity	BRFSS	18.80%	18.15%	18.03%	17.90%	17.78%	**17.65%**
Adult Smoking	BRFSS	17.10%	15.60%	15.30%	15.00%	14.70%	**14.40%**
Youth Smoking (high school)	CT DPH: Youth Tobacco Survey	14.00%	13.28%	13.14%	13.00%	12.85%	**12.72%**
Adult Diabetes	BRFSS	8.50%	8.14%	8.07%	8.00%	7.93%	**7.86%**

Additional population health priorities, measures and targets (e.g. child wellness, vaccines and infant mortality), may be identified by the Population Health Council during the development of the population health plan in Year 2 of the Test Grant. Baselines for population health measures will include overall population totals and stratified totals by age, race and ethnicity, and payer (Medicare, Medicaid, commercially insured), all of which are available in the source data (e.g., HIDD, BRFSS, YTS, Vital Statistics Registry).

(2) Transforming the Health Care Delivery System

We are monitoring the pace and impact of delivery and payment system changes as follows:

Pace Measures

Major operational plan milestones include Medicaid Quality Improvement and Shared Savings Program (Medicaid QISSP) implementation, involvement in the Community and Clinical Integration program, percent of primary care providers and beneficiaries in shared savings programs (SSPs)(Table 1; Test Model submission and Tables 6-12 of this response).

The following pace of reform metrics will be tracked:

SIM Component	What is Tracked	Test Grant Pace Targets
PCMH+	Provider and beneficiary participation in Medicaid shared savings model	• 89% of Medicaid beneficiaries in PCMH+ by 2020. • 2072 PCPs in 14 FQHCs and 16 Advanced Networks in PCMH+ by 2020.
Value-Based Payment	Provider and beneficiary participation in any VBP in Connecticut	• 88% of insured population participates in any SSP by 2020 (including Medicaid, Medicare, and commercial SSP) • 5753 PCPs participate in any SSP by 2020
Community and Clinical Integration Program	Provider Penetration in CCIP	1,364 providers participate in CCIP by Q4 2018
Advanced Medical Home Program	Provider Participation in AMH model	300 non-medical homes become AMH practices by 2019
Value-Based Insurance Design	Beneficiary Participation in VBID	84% of insured population is in a VBID plan by 2020

Yearly targets can be found in the corresponding section in this Operational Plan. Yearly and quarterly information can be found in the spreadsheet in **Appendix C, Pace Measures.**

As part of the Test Model evaluation process we will monitor the measures described in Appendix B and C. In addition, the differential adoption by practice groups of new benefit and payment models will allow rigorous assessments of, for example, the impact of employee benefit plans (e.g. VBID) and provider reimbursement (e.g. SSP) on care patterns, costs, and health outcomes. Assessment of the impact of different delivery, benefit, and payment models will require information on rates of adoption.

In anticipation of potential Model Test implementation, the evaluation team conducted a state wide survey of primary care and specialist physicians in Connecticut (N=1082) to assess the readiness of the physician workforce in the state to assume financial risk and provide services consistent with the advanced medical home model. Results of this survey will contribute to the development of next physician survey which the SIM evaluation team will launch in year two of the Model Test implementation. The second survey instrument will be reviewed by the Steering Committee prior to its being moved into the field. Results of the survey are expected to be compiled and delivered to the State by March 31, 2018.

Thus to collect data that will allow us to assess the pace and impact of test model changes, we are using three general strategies. Each quarter we will elicit information on rates of participation available from

the 5 major CT insurers, Medicare, and Medicaid (e.g., percent of primary care providers in shared savings arrangements). For some aspects of program pace (e.g., implementation of the Community and Clinical Integration Program), we will conduct quarterly surveys of the CT Advanced Networks (currently 17) and FQHCs. For those aspects of the program in which we elicit information about participation from the Advanced Networks, we also will conduct a survey of a sample of 1,000 health care providers not in Advanced Networks. That information will allow us to determine the extent to which providers in the Advanced Networks are making changes that are greater than other providers in CT.

Survey strategy

The major insurers have agreed to designate a contact person for providing information for the quarterly reports. To collect information from the Advanced Networks and in the annual survey of providers, we will identify a clinical and administrative head to provide the information required. The surveys of Advanced Network representatives and non-affiliated providers will be conducted by mail with a telephone follow-up to non-responders. Survey development will include pilot testing to insure questions are clear and consistently understood. Data collection will be conducted by professional survey firms that will bid on specific projects and activities. The first CT physician survey was being conducted by the Center for Survey Research (CSR) at the University of Massachusetts-Boston. An example of another firm that we may solicit bids form is the Survey Research Center at the University of Michigan. Both are University based survey research organizations with the staff and resources to carry out all phases of multi-mode survey research and have significant experience conducting dual-language surveys, Spanish/English in particular. Drs. Aseltine and Cleary have extensive experience in working with both organizations on numerous large-scale projects.

Performance Measures

Changes in the delivery system over the Model Test period are expected to allow the State to achieve the access and quality targets identified below:

Exhibit: Improving Healthcare Outcomes Measures

Category/Measure	Data Source	Base	2016	2017	2018	2019	2020
Adults with Regular Source of Care	CT All Payer Claims Database (APCD)	83.9	85.7	87.5	89.4	91.2	93.0
Plan All-Cause Ambulatory Sensitive Care Condition	DPH: Hospital Inpatient Discharge Database	15.9	15.3	14.8	14.2	13.7	13.1
Ambulatory Care Sensitive Condition Admissions	DPH: Hospital Inpatient Discharge Database	1448.7	1398.0	1347.3	1296.5	1245.8	1195.1
Mammogram for women >50 last 2 years	APCD	83.9	84.7	85.4	86.2	87.0	87.7

Colorectal Screening	APCD	75.7	77.2	78.8	80.3	81.9	83.6
Diabetes care: 2+ annual A1c tests	APCD	72.9	74.3	75.7	77.1	78.6	80.1
ED use - asthma as primary dx (per 10k)	**APCD**	73.0	71.2	69.4	67.6	65.8	64.0
Hypertension control :% of adults with HTN taking HTN meds	APCD	60.1	62.0	63.9	65.7	67.6	69.5
Premature death: CVD adults (per 100k)	CT DPH: Death Records	889.0	819.2	749.4	679.6	609.8	540.0

*Quality measures and targets related to hospitalizations will be calculated using the AHRQ Prevention Quality Indicators (PQIs), 14 measures of conditions managed in ambulatory settings.
**Additional measures and targets, including behavioral health and oral health are under review.

Connecticut Medicaid collects and reports a full array of quality measures across its clinical programs. With some notable exceptions, these measure sets are complete since the beginning of calendar year 2012, when the Department transitioned entirely to an administrative services model of care. These include an annual Consumer Assessment of Healthcare Providers and Systems surveys of both adult and child members, a complete panel of HEDIS and CHIPRA measures, as well as several measures of special interest to the Department and its stakeholders. Examples of these 'home grown' measures are the incidence of sexually transmitted infections in males (not just in females, which is the HEDIS measure) and a more detailed measure of 30 day hospital readmissions which includes all ages and diagnoses.

Health Equity

A major goal of the Model Test is to improve equity in access and quality. We are monitoring equity gaps for the core Dashboard measures as data allows and target selected areas for improvement. Please see the following two exhibits on the next page for measure specifics.

Exhibit: Population Health Equity Measures

Population Health						
Measure Number	Measure	Reporting Frequency	Data Source	Health Disparities		
				Race/ Ethnicity?[1]	Income?[1]	Subgroup Target
1	Percent of adults who are obese	Yearly	DPH: BRFSS	Y	Y	None
2	Percent of children who are obese	Yearly	DPH: BRFSS	Y	Y	Low Income
3	Percent of adults who currently smoke	Yearly	DPH: BRFSS	Y	Y	Low Income
4	Percent of youth (high school) who currently smoke	Yearly	DPH: YTS	Y	N	None
5	Percent of adults with diabetes	Yearly	DPH: BRFSS	Y	Y	Low Income
6	Premature death- CVD adults (per 100k)	Yearly	DPH: Death Records	Y	N	African American

1. Some categories will be suppressed because they do not meet requirements for publication

Exhibit: Healthcare Outcomes Equity Measures

Healthcare Delivery						
Measure Number	Measure	Reporting Frequency	Data Source	Health Disparities		
				Race/ Ethnicity?	Income?	Subgroup Target
1	Percent of adults with regular source of care	Quarterly	APCD	N[2]	N	None
2	Risk- std. all condition readmissions	Quarterly	HIDD	Y	N	None
3	Amb Care Sensitive Cond Admissions	Quarterly	HIDD	Y	N	None
4	Children well-child visits for at-risk pop	Quarterly	APCD	N[2]	N	None
5	Mammogram for women >50 last 2 years	Quarterly	APCD	N[2]	N	None
6	Colorectal screening- adults aged 50+	Quarterly	APCD	N[2]	N	Income
7	Optimal diabetes care- 2+ annual A1c tests	Quarterly	APCD	N[2]	N	None
8	ED use- asthma as primary dx (per 10k)	Quarterly	APCD	N[2]	N	Hispanic
9	Percent of adults with HTN taking HTN meds	Quarterly	APCD	N2	N	None

2. We hope to be able to add these in 2017

(3) Costs of Health Care

Major operational plan milestones include 1) Medicaid QISSP implementation, 2) percent increase in providers/beneficiaries in SSPs. Additionally, the State has established the following PMPM cost targets:

Exhibit: Cost Targets

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

Data Sources

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

Collection of new data

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

Focused Analyses of the Impact of Reform Efforts

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

7. Data Collection, Sharing & Evaluation

The collection and sharing of data is critical to the implementation, evaluation and sustainability of the SIM initiative. We will cooperate with CMS and its efforts to conduct the federal evaluation of our initiative. The federal evaluation is independent, federally funded, and statutorily mandated. The below information reflects how we have addressed the following data collection and sharing requirements.

***Ability to provide current identifiable, individual Medicaid claims data to the federal evaluator/CMS*:**

Connecticut Medicaid has extremely strong analytic capacity and expertise. Since 2012, Connecticut Medicaid has had the benefit of a fully integrated set of claims data across all categories of Medicaid services. The Department's medical ASO, CHN, maintains this data within the Utilization & Cost Analyzer (UCA) system, an analytical and data discovery tool that includes Medicaid claims, member eligibility, and provider data. UCA utilizes QlikView software and is uploaded monthly with claims, member eligibility, and provider data directly from CHN's data warehouse specific to the Connecticut Medicaid program. The data warehouse is populated with data that is received from the Department and its claims processing partner, HP. UCA provides a simple, rapid, and comprehensive means of assessing medical cost and utilization trends in various cuts of the claims, member eligibility and provider data with multiple layers of drillable investigative analysis, down to the claim, member and provider level.

The Department anticipates that the data extracts necessary to support the federal evaluation, including baseline and historical data from the three years prior to the project period, will be produced by CHN. As noted above, the Department will enter into data use agreements (DUA) with CMS or the federal contractor for purposes of sharing the minimum necessary identifiable data.

Ability to provide individual-level commercial claims data to the federal evaluator/CMS:

The All-Payer Claims Database (APCD) that Access Health CT (AHCT) is developing will have commercial data with member identifiers. All of Connecticut's health plans have indicated their support for the APCD as evidenced in each of their letters of support for SIM. Moreover, they have all recently

reaffirmed their commitment to use the APCD as the primary and preferred source for the production of commercial health plan data and reports to meet the needs of the state and federal evaluation of the SIM program, including the submission of historical data from three years prior to the project period that are needed to calculate baselines.

The SIM PMO will convene a SIM Program Monitoring team comprised of APCD officials, participating health plans, and state and federal evaluators in order to further specify the requirements of the federal and state evaluations and to determine whether all required elements for the evaluation are addressed in the approved Data Submission Guidelines and, if not addressed, appropriate steps will be taken to modify these guidelines including necessary approvals. The SIM Program Monitoring Team will further determine the level of data identification necessary to achieve the purposes of the state and federal evaluations.

The APCD data infrastructure will be managed by an outside data and analytics vendor with capabilities of maintaining and operating a robust data ETL process, transformation of this data from various data submitters into an equivalent data base structure and maintain historical data of eligibility, medical and pharmacy claims, and provider information.

There will be two environments in this data infrastructure.

i. Production environment – will be used to generate healthcare costs and utilization reports on the web, to be primarily used and accessed by the data analytic vendor, and
ii. Managed Hosting environment – with an enclave style access management primarily for internal and external users, e.g., SIM analysts, CMS and the federal evaluator.

The Managed Hosting server will be accessible via secured VPN connectivity. Users will have access to permissible directories via a Data Enclave environment. The environment will be firewalled from outside intrusion, and is only accessible to authorized users. Researchers and analysts involved with SIM will have access to analytic tools in secure environment to work with the data, including such applications as SQL, SAS, and other applications. Data can be accessed to generate member and provider list for relevant ACOs and FQHCs; reports can be run for risk-adjusted costs and utilization reports by various participating entities; evaluate pre- and post-intervention effects due to SIM initiative; develop ID and Stratification based on clinical groupers for members in the ACO or FQHC groups; and, various other reports on claims-based compliance and other quality indicators.

The vendor for data intake and integration was originally targeted to be in place at the beginning of 4th quarter 2014, however it has taken longer than expected to accomplish the security audits. The current timeline for data intake and integration are as follows:

Exhibit: Timeline for Data Intake and Integration

Activities	Target Date
1. Develop data intake infrastructure for commercial and public (Medicare) payers	12/15/2014
2. Test for stability and efficiency of data ETL process	1/15/2015
3. Receive and upload test data	1/31/2016
4. Data Quality validation a. Ensure files received from data submitters are accurate b. Ensure data contents from various files are accurate c. Ensure files are transmitted are complete – control total d. Ensure data files conform to general benchmarks	 2/15/2016 2/28/2016 3/15/2016 3/15/2016
5. Data warehouse completed and tested	4/15/2016
6. Historical data in-take	6/15/2016
7. Analytic environment tested	7/1/2016
8. Production Environment tested	7/15/2016
9. Production Environment deployed	8/1/2016

Ability to provide Medicare identifiers to the federal evaluator/CMS for beneficiaries affected by SIM:

The plan for Connecticut's APCD includes the collection of Medicare fee-for-service data from CMS. The data set will have Medicare beneficiaries' information with claims level details. If allowed by CMS, that data can be used to support SIM initiative. We intend to collect monthly files from CMS. If not available then we can at least collect information at quarterly time intervals. Part D of Medicare will also be available. As part of the collection effort, the APCD intends to collect Part C Medicare data as well from health insurance carriers. Data collected from Medicare program will be maintained in the same data infrastructure as discussed in 8(b) above. As such, the APCD will be a source of linked and de-duplicated individual claims level data, inclusive of Medicare.

Connecticut will compile and share information about the identity of the Advanced Networks and FQHCs that are participating in the PCMH+ in each of the two waves and receiving AMH Glide Path and CCIP support. We believe that CSM would be the most reliable source of information about Medicare beneficiaries attributed to and benefiting from their participation with these providers. We would request that CMS share information about Medicare attributed beneficiaries with the state evaluators to support our rapid cycle learning and evaluation.

Laws and/or regulations preventing the disclosure of necessary records or data to the federal contractor performing the evaluation of SIM:

Medicaid: Federal Medicaid law provides that state Medicaid agencies must restrict the use and disclosure of information concerning Medicaid applicants and recipients "to purposes directly connected with administration of the plan." 42 U.S.C. § 1396a(a)(7); 42 C.F.R. § 431.300(a). More specifically, the federal regulation defines "purposes directly related to plan administration" as including "(a)

establishing eligibility; (b) determining the amount of medical assistance; (c) providing services for beneficiaries; and (d) conducting or assisting an investigation, prosecution or civil of criminal proceeding related to administration of the plan." 42 C.F.R. § 431.302.

State law, specifically section 17b-90(b) of the Connecticut General Statutes, similarly provides that, except for purposes directly connected with the administration of the Department of Social Services programs, disclosure of information about persons applying for or receiving assistance from the Department, or persons participating in the Department's programs, is prohibited. State regulations provide that "purposes directly connected with" the Department's programs includes "an audit or similar activity conducted in connection with the administration of the program by any governmental entity authorized by law to conduct such audit or activity." Section 1020.10 of the Uniform Policy Manual.

The Connecticut Department of Social Services will regard disclosure of necessary records or data to the federal contractor performing evaluation of SIM to be for purposes directly connected with administration of the plan. Assuming the federal contractor has a business associate agreement with CMS, the Department will enter into data use agreements (DUA) with CMS or the federal contractor for purposes of data sharing. These DUAs will parallel those into which the Department has entered with CMS in support of data sharing for the Demonstration to Integrate Care for Medicare-Medicaid Enrollees.

APCD: APCD enabling legislation permits the sharing of de-identified, individual level data for commercial payers. Medicare data sharing will be governed by CMS rules particularly supporting CMMI funded demonstration projects. However, it does not permit the sharing of data on identifiable members to external entities such as state or federal agencies and their respective evaluators. The SIM PMO will convene a team comprised of APCD officials, participating health plans, and state and federal evaluators in order to further specify the requirements of the federal and state evaluations and to determine whether the purposes of the evaluation can be achieved with an individual level, de-identified data set or whether a limited data set with date of service and zip code will be required. If the latter is necessary to achieve the purpose of the evaluation, the state will propose legislation that will enable the APCD to share the limited data set for the purpose of the SIM evaluation. We anticipate that such legislation can be achieved by June of 2015. If a more complete set of identifiers is required, additional research will be necessary to determine whether an amendment to the APCD legislation would be sufficient for this purpose.

In summary, with respect to commercial data, Connecticut's APCD enabling legislation does not permit the sharing of data on identifiable members to external entities such as state or federal agencies and their respective evaluators. The state will propose legislation in the 2015 legislative session that will enable the APCD to share the limited data set with the federal and state evaluation contractors for the narrow purpose of enabling the SIM evaluation. We anticipate that such legislation can be achieved by June of 2015. If the statutory language permitting the disclosure of identifiable data from the APCD to CMMI for the purposes of SIM evaluation is not successful, the SIM PMO will work with the individual commercial payers to provide for direct submission of the minimum identifiable dataset necessary to

achieve the purposes of the evaluation. We are also prepared to directly engage self-funded employers to the extent that this is necessary to ensure authorization for the provision of necessary data. The proposed HIPAA rule change appears to resolve questions that emerged in our discussions with commercial payers as to the permissibility of such disclosures under HIPAA. There are no state laws that otherwise would prohibit their disclosure, other than potential limitations on the disclosure of behavioral health information (CGS 52-14 b, c, d, e and f), which we intend to address with the above referenced changes to the APCD enabling legislation.

General/HIPAA: SIM is in compliance with the HIPAA/HITECH rules effective September 22, 2014. We recognize that covered entities must bring all of their Business Associate Agreements ("BAAs") into compliance with the Rules and that the Rules also apply this requirement to Business Associates' agreements with their covered subcontractors. While the Rules in some respects represent a major departure from the existing HIPAA and HITECH requirements, many of the new provisions accept without change the requirements that the HHS had previously proposed in the interim final HITECH Breach Notification Rule, in October 2009, and in the proposed Privacy, Security and Enforcement Rules updates in July 2010 (the "Interim Rules"). ***Providing CMS and its Contractors with identifying information for beneficiaries who receive services under the model to examine patient care experience under this initiative***

Cooperation with the contractor performing the federal evaluation:

The state will fully cooperate with the contractor performing the federal evaluation. The state will provide informant in a timely manner that will allow CMS to review and comment on methods and results from the state evaluation before publication of results.

The SIM Evaluation Team is committed to meeting with CMS and its external evaluator as frequently as is necessary to inform and monitor program implementation and to allow for external oversight and evaluation. Drs. Aseltine and Cleary and their evaluation teams will coordinate the quarterly reporting relevant to SIM program pace and performance monitoring and periodic outcome assessments and be responsible for meeting with the Steering Committee and federal evaluation contractor every other week for the first 6 months of the project, and monthly thereafter. The Evaluation Team will contribute to the meetings with the SIM Rapid Response Team on pace and performance monitoring and to the meetings with CMMI and/or the federal evaluation contractor. Meetings with CMS and the federal evaluation contractor will also provide opportunities for CMS to review and comment on methods and results from the state evaluation prior to publication and dissemination of findings.

Cooperating with primary data collection efforts such as, but not limited to, surveys, focus groups, and key informant interviews

The Evaluation team will fully cooperate with primary data collection efforts as described in this document and as allowed by Connecticut and Federal laws and regulations.

Agreeing not to receive additional reimbursement for providing data or other reasonable information to CMS or another government entity or contractor

The state agrees to not seek to receive any additional reimbursements for providing data or other reasonable information to CMS or another government entity or contractor as a part of carrying out the terms of this project as described in this report.

8. Fraud & Abuse Monitoring, Detection, & Correction

Monitoring Sub-recipients

Sub-recipients who spent at least $500,000 in federal funds from all federal sources during their fiscal year must have an audit performed in accordance with OMB Circular A-133. The A-133 compliant audit must be completed within 9 months of the end of the sub-recipient's fiscal year. For those Transformation Award sub-recipients that meet this threshold requirement, the PMO will require the sub-recipient to provide the State with a copy of their completed A-133 compliant audit including:

- The auditor's opinion on the sub-recipient's financial statements;
- The auditor's report on the sub-recipient's internal controls;
- The auditor's report and opinion on compliance with laws and regulations that could have an effect on major programs;
- The schedule of findings and questioned costs;
- And the sub-recipient's corrective action plan (if any).

The PMO will issue a management decision on audit findings within 6 months after receipt of the sub-recipient's A-133 compliant audit report.

If a sub-recipient's schedule of findings and questioned costs did not disclose audit findings relating to the Federal awards provided by the PMO and the summary schedule of prior audit findings did not report the status of audit findings relating to Federal awards provided by the PMO, the sub-recipient may opt not to provide the A-133 compliant audit report to the PMO. In this case, the PMO will verify that there were no audit findings utilizing the Federal Audit Clearinghouse database.

Any sub-recipient that, because it does not meet the $500,000 threshold or because it is a for- profit entity, does not receive an audit performed in accordance with OMB Circular A–133 may at its option and expense have an independent audit performed. The independent audit should be performed to obtain reasonable assurance about whether the sub-recipient's financial statements are free of material misstatement. The independent audit should also take into consideration the sub-recipient's internal control, but does not necessarily have to contain the auditor's opinion on the agency's internal control. If the sub-recipient elects to have an audit report that covers more than the sub-recipient's financial statements, the PMO may request that the entirety of the auditor's report be provided to the PMO.

If the sub-recipient chooses not to have an independent audit and the sub-recipient will receive at least $10,000 during the current fiscal year, they may be subject to on-site monitoring during the award period. Sub-recipients who are individual contractors will not be subject to on-site monitoring based solely on the lack of an independent audit.

Desk Reviews

All sub-recipients who are estimated to receive $10,000 or more during the fiscal year will undergo a desk review at least once during the grant period. If a sub-recipient receives less than $10,000, the PMO may

at its discretion opt to conduct a desk review. During a desk review, sub- recipients might be expected to provide:

- Adequate source documentation to support financial requests including but not limited to an income statement, payroll ledgers, cancelled checks, receipts ledgers, bank deposit tickets and bank statements, and timesheets.
- If salary is funded under the award and if the staff whose salary is funded under the award is charged to other funding sources, time distribution records to support the amounts charged to federal funding provided by the State.
- A statement verifying that the organization has a system in place for maintaining its records relative to federal funding provided by the State for the amount of time as specified in the sub-award document.
- Adequate documentation to support required match, if any.

Monitoring Contractors

The SIM PMO has assigned a contract coordinator to each executed contract and each Memorandum of Agreement. The responsibilities of the contract coordinator may include, but are not limited to, the following:

- coordinating the flow of information between the SIM PMO and the contractor;
- responding to requests from the contractor;
- authorizing contractor payments against the contract's budget;
- monitoring progress against work schedules or milestones;
- reviewing and approving deliverables;
- taking corrective action when a contractor's or key partner's performance is deficient;
- resolving disputes in a timely manner; and
- maintaining appropriate records.

Each contract coordinator assigned to the project must ensure that the contractor meets the requirements of the contract and that the financial (and other) interests of the State and of CMMI are protected. The contract manager is well versed in both the contract and the operational components of the work stream that the contractor supports. The contract manager works closely with the contractors and the PMO's fiscal administrator to ensure payments are aligned with the work set forth in the contract.

Under-Service Monitoring

Shared savings programs are an increasingly central feature of the U.S. healthcare landscape since the Centers for Medicare and Medicaid Services (CMS) launched the Medicare Shared Savings Program (MSSP) in 2012. Given their relative youth, there is limited evidence available that these types of payment arrangements do or do not lead to under-service or patient selection. However, the rapid growth in these programs' popularity and the potential for adverse responses to financial incentives has

motivated Connecticut to proactively evaluate how these programs can be designed and monitored to ensure that all populations benefit.

Equity and Access Council

The SIM PMO formed the Equity and Access Council (EAC) to help ensure that as SIM reforms are implemented, at-risk and underserved populations benefit from, and are not harmed by, reforms. Within that broader scope, the EAC's initial charge was to ensure that, as value-based payment becomes the prevailing method of financing healthcare in the state, appropriate safeguards are adopted to protect against under-service and patient selection. These phenomena are defined in the EAC's charter:

- **Under-service** refers to the systematic or repeated failure of provider to offer medically necessary services in order to maximize savings or avoid financial losses associated with value based payment arrangements.
- **Patient selection** refers to efforts to avoid serving patients who may compromise a provider's measured performance or earned savings.

The EAC explored how the incentives inherent in shared savings payment design features can be structured, how they might impact an ACO's or a provider's behavior, and the extent and nature of the risk of under-service and patient selection. It also explored what supplemental safeguards might be layered on top of a program's internal structure to further minimize the risks of under-service and patient selection.

The EAC's intent in articulating a perspective about payment design features was not to prescribe a single standard shared savings contract model for all-payer adoption. While Connecticut expects that all payers will align broadly around shared savings programs, it does not expect that they will adopt a uniform approach to many of the design choices addressed in the EAC's considerations.

The EAC issued recommendations related to patient attribution; cost target calculation; payment calculation and distribution; rules, monitoring, and accountability; and communication. Its recommendations are intended to inform the actions of policymakers as well as those who purchase, provide, insure, administer, and utilize healthcare in Connecticut. They are not binding on the executive branch of government, on any of the EAC's members, or on the organizations they represent. The EAC, like other components of the SIM workgroup structure, exists to surface effective solutions and to create alignment among key stakeholders in support of the goals established in Connecticut's State Healthcare Innovation Plan.

For a list of the EAC's recommendations and further information on context and process, please see the Final Report of the Equity and Access Council on Safeguarding Against Under-Service and Patient Selection in the Context of Shared Savings Payment Arrangements.

PCMH+ and Under-service Monitoring

DSS is taking measures to ensure that the implementation of PCMH+ takes into account potentially new forms of fraud and abuse. DSS will not implement the PCMH+ until reasonable and necessary strategies for monitoring under-service are in place, and will make ongoing adjustments to these strategies as appropriate. The most recent progress towards the design for monitoring under-service follows a multi-pronged framework consisting of five strategies. The design of these strategies took into consideration and incorporated various elements of beneficiary protections that were recommended by the SIM Equity and Access Task Force. These aspects of model design will be discussed and refined more extensively over the fall of 2016, but presently include the following prongs:

- **Preventative and Access to Care Measures** – 22 of the proposed PCMH+ quality measures track preventative care rates and monitor appropriate clinical care for specific health conditions
- **Member Surveys** – use of the CAHPS Person-Centered Medical Home survey and consideration of the use of the CAHPS Cultural Competency Supplemental Item Set
- **Member Education and Grievance Process –** specific, affirmative education for beneficiaries on PCMH+ as well as their grievance and appeal rights
- **Secret Shopper** – expansion of the Department's current secret shopper approach to gauge access to care as well as experience in seeking care
- **Elements of Shared Savings Model Design –** various elements of the shared savings model for PCMH+ (use of a savings cap, decision not to include a minimum savings rate, upside-only approach, high cost claims truncation, and concurrent risk adjustment claims methodology) were selected with a lens toward protecting beneficiary rights

All payers have previously committed to the principle that providers be disqualified from receiving shared savings if they demonstrate repeated or systematic failure to offer medically necessary services, whether or not there is evidence of intentionality. Additionally, the state will leverage the dispute resolution role of its Office of the Healthcare Advocate to adjudicate consumer complaints of suspected under-service.

APPENDIX A: BUDGET NARRATIVE

CONNECTICUT STATE INNOVATION MODEL

GRANT NUMBER: 1G1 CMS331404-01-00

PERFORMANCE YEAR 1

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We attest that requested federal funding will not supplant any other funding sources.

A. PERSONNEL

Please refer to the budget cost tables for salary breakdowns, including annual salary, the percentage of time budgeted for the program, the total months of salary budgeted, and total salary requested.

Annual salary estimates are based on mid-salary range of current state employee compensation plans. Annual amounts are increased 5% in Years 2-4 to account for estimated contractual increases.

Table 1: Personnel Title and Role Descriptions

Population Health – Department of Public Health		
Position Title	**Name**	**Role**
Organizational Development Specialist	Joan Ascheim	Works with the Population Health Council to ensure performance, accountability and quality of public health services as proposed for the PSCs and HECs. The position advises on best practices for monitoring health improvement and health outcomes. In addition to advising on strategic planning direction and goal/priority setting for population health improvement planning, this position also provides foundational guidance toward organizational effectiveness and meeting national standards for prevention services and community activation as required for population health improvement.
Epidemiologist 2	TBH	This position is assigned to the Health Statistics and Surveillance section to conduct data analyses of populations and sub-populations, behavioral risks, health status, and prevalence of obesity, diabetes, and tobacco use. These data originate in the Behavioral Risk Factors Surveillance System (BRFSS) survey conducted annually by the Department of Public Health. Although the position was vacated in February, it will be hired by the start of the first performance year. The position will support enhanced use of the BRFSS. The epidemiologist will support a) administrative functions with the survey's contractor; b) ensure that the targeted number of interviews are completed and conduct any mid-course corrections, if needed; c) conduct quality control on end-of-year survey datasets; and d) analyze and generate summary reports of survey results, including possible small area analysis. In addition, the epidemiologist will assist with special reports on key population health indicators, particularly among vulnerable populations, to inform public health strategies and interventions. This position will increase capacity of the BRFSS team to generate and disseminate information about key indicators, such as health indicators and health-seeking behaviors, as well as health outcomes and current health status.
Health Program Associate	TBH	Provides support to DPH-SIM Population Health Director in developing the population health plan with a specific focus on researching and analyzing evidence-based approaches needed to address identified priorities. This position assists the program leadership with

		coordination and communication activities between participating agencies. The Health Program Associate conducts research and develops program content for the deliberations of the Population Health Council. This position works with all program staff in the preparation and submission of monthly, quarterly, operational plan and budgetary reports.
Epidemiologist 3	TBH	The position will maintain and annually update a model-based town-level population estimation system. The person will also develop computer programs to calculate associated age-adjusted indicators.
Secretary 2	Yolanda Perez	Provides clerical and administrative support to DPH-SIM Population Health Director, Epidemiologist 3, Health Program Associate, and Primary Prevention Services Coordinator positions. This position assists the program with filing of monthly and quarterly reports in the SharePoint website and provides clerical support to the planning of the Population Health council. This position started on June 17, 2016.
Health Program Assistant 2	TBH	Facilitates targeted engagement of local health agencies and their community partners whose activities address the social determinants of health; reviews community health needs including local input to assist in the up keep of local and regional health assessments. This position also has administrative responsibilities to secure internal reviews of contracts and fiscal processes. The Health Program Assistant 2 will maintain communications protocols between the program staff, population health council, partner agencies and the state and local level and with the Program Management Office (PMO)
Primary Prevention Services Coordinator	TBH	Aligns and coordinates statewide activities addressing obesity, tobacco use, diabetes, and other priority chronic diseases. This position will provide subject matter expertise and content development regarding prevention services centers and Health Enhancement Communities. The prevention services coordinator will work directly with a contractor conducting the environmental scan of local collaboratives and community based prevention programs. The position supports the alignment efforts between the State Health Improvement Plan, the State Chronic Disease Plan and the SIM population Health Plan.
PCMH+ – Department of Social Services		
Position Title	**Name**	**Role**
Health Program Assistant 2	TBH	Provides support to population health planning by researching and formulating, under the direction of the Director of the Integrated Care Unit, Medicaid policy and reimbursement mechanisms to address identified priorities within the plan.
Health Program Assistant 2	TBH	Supports activities relating to PCMH+, including coordination with the actuarial contractor, aligning attribution methodology, and developing provider requisites and RFPs.
Associate Accountant	TBH	Provides financial support to PCMH+, including budget development and analysis; financial modeling; and detailed development and review of shared savings calculations.

Accountant (Trainee)	TBH	Supports the financial reporting requirements of both PCMH+ and potential waivers and state plan amendments; supports Associate Accountant to meet workload demands.
SIM PMO		
Position Title	Name	Role
Durational Project Management Support Specialist	Jenna Lupi	Administers project management efforts; promotes functional knowledge management; administers SharePoint site; supports vendor management oversight; assists with maintaining the PMO Standard Operating Procedures; implements and evaluates project management related goals and objectives; oversees, tracks, reports and monitors implementation; serves as liaison with state agency collaborators.
State Innovation Model Specialist (care delivery reform lead)	TBH	Manages staff /operations of primary care transformation; oversees AMH Glide Path and CCIP implementation, learning collaborative and targeted technical assistance and Transformation Awards.
State Innovation Model Specialist (quality lead)	TBH	Manages staff /operations related to quality measure alignment, care experience surveys, and the public scorecard.
Health Program Associate **Health Program Associate**	TBH TBH	Each position will be responsible for the respective implementation, facilitation, and tracking of the following primary care transformation initiatives: (1) AMH Glide Path and Learning Collaborative and (2) CCIP Targeted Technical Assistance, Learning Collaboratives and Transformation Awards.
Nurse Consultant	TBH	OHA- Handles disputes/complaints related to potential under-service from providers and consumers related to new payment models. The title of "Nurse Consultant" is a classified position title in the State of CT. It is not a contractual arrangement for consultation services, but a new state employee hire. Follow this link to see a description of the classified position: Class Code 5904, Nurse Consultant (Healthcare Advocate), Pay Plan HC-28, Step 6.
Health Information Technology Officer	TBH	It is anticipated that the HITO will begin in September 2016. This position will lead an effort focusing on standing up the statewide HIE and SIM funded technologies, some of which support the statewide HIE. The HITO will lead the HIT Project Management Office (located within the Office of the Lieutenant Governor), which will coordinate various HIT initiatives in the state related to Health Care Reform, Medicaid, SIM, All Payer Claims Database, Population Health work and other federally funded efforts directed to state entities.
Program Manager	TBH	It is anticipated that the HIT Program Manager will begin in October 2016. This position will provide leadership and drive the technical development activities ensuring alignment with state and federal laws to support the development and implementation of the Health Information Exchange. Will also provide strategic planning, software development management, and the technical expertise to lead large scale enterprise systems design, vendor selection, gap analysis, implementation and deployment of technologies.

B. Fringe Benefits

Please refer to the budget cost tables for fringe cost breakdowns by position.

The FICA, Medicare, Unemployment, and Retirement components of the fringe benefit formula are based on the Connecticut State Comptroller's FY 2017-2018 fringe benefit rate calculations that went into effect July 1, 2016. The life and medical insurance are estimates based on the average state employee health and group life insurance costs during FY 2017.

Table 2: Fringe Benefit Formula

Fringe Benefit Formula	
Component	**% Salary**
FICA	6.20%
Medicare	1.45%
Unemployment	0.06%
Retirement	54.99%
Life (estimate)	0.21%
Medical (estimate)	19.40%
TOTAL	**82.31%**

One of the major contributors to Connecticut's high fringe benefit rate is the retirement component rate. This rate consists of employer contributions for retirement (including normal costs and unfunded liability), retiree health insurance costs, and retirement administration costs. Connecticut's large unfunded pension liability and its contribution to retiree health insurance costs are the drivers behind this high rate. In previous years, the pension ARC calculation included adjustments which artificially reduced the State's contribution to the fund and were significant contributors to the system's underfunding. During the current administration, these adjustments were eliminated and more conservative actuarial assumptions were adopted. These adjustments are reflected in the new proposed budget.

C. TRAVEL

Please refer to the budget cost tables for travel cost breakdowns, including distance, mileage reimbursement rates, airfare costs, and other.

Revised travel estimates are based on U.S. Average Domestic Itinerary Fares for the first quarter of 2016 as reported by the U.S. Department of Transportation, Bureau of Transportation Statistics; the 2016 lodging/MIE per diem rates from the US General Services Administration (GSA); and the 2016 GSA mileage reimbursement guidelines.

Table 3: Travel Justifications

Travel Activity	Description
In-State Mileage Reimbursement	
Coordinating and Informational Meetings and Presentations	It is anticipated that all the DPH positions and the one DSS position listed on the grant will be asked to attend coordinating or informational meetings and presentations to further SIM project goals and to participate in discussions that support development of the population health plan. It is further anticipated that most meetings will be held in the Hartford area, however coordination with health system stakeholders may occur in any other location of the state. Standard estimates for in-state travel are included based on experience with grant and statewide coordinating activities.
Out-of-State Mileage Reimbursement	
DPH- National Meeting	The DPH-SIM Population Health Director will travel to a Population Health related national meeting at least once during the first year implementation to stay current with the evidence base and innovations in addressing population health equity. Specific meeting has not yet been identified, but as they occur annually; potential opportunities include the National Network of Public Health Institutes Annual Conference, the National Academy for State Health Policy Annual Conference and the Centers for Disease Control and Prevention among others.
DPH – BRFSS Conference	The Epidemiologist 2 will attend a 5-day Behavioral Risk Factor Surveillance System (BRFSS) conference annually to stay current with modeling, analysis and interpretation of results.
PMO - SIM Conferences	Costs support travel for SIM staff/representatives to attend SIM workshops and conferences as specified in the funding announcement on page 30. As those conferences have not yet been scheduled or formally announced, estimates are based on the 2016 GSA lodging and MIE guidelines for Washington, DC and revised round trip airfare estimates are based on U.S. Average Domestic Itinerary Fares for the first quarter of 2016, as reported by the U.S. Department of Transportation, Bureau of Transportation Statistics.

D. EQUIPMENT

There are no costs projected for equipment at this time.

E. SUPPLIES

Please refer the budget cost tables for supplies cost breakdowns.

Supplies will be used to carry out daily activities related to the SIM grant and will be used 100% for SIM-related program objectives.

Table 4: Supplies Description

Supplies	Description
General Office Supplies (DPH)	Costs support general office supplies including paper, pens and staples for 8 DPH staff and contracted personnel. Estimated costs are $25/month and are adjusted for inflation for Performance year 2 and 3.
PC Monitors (DPH)	Costs support additional monitors for the 3 staff positions in Performance Year 1. The computers are used to assist with analyses, data reviews, and presentations so that both written information and data and analyses can be viewed and crossed checked at the same time.
Computers and Software (DPH /PMO/OHA)	Costs support computers and software for the grant-funded PMO positions in Performance Year 1, the OHA nurse, DPH staff, HIT staff (Pre-implementation period) and contracted personnel to carry out daily functions related to SIM grant.
Software Licenses (DPH)	Costs support funding for SAS, ArcGIS, Instant Atlas, and Adobe Professional licenses for DPH staff and contracted personnel (in PY1) for data and stratification analysis needed for identification of high-risk populations. Data management and visualization software are essential tools for communicating results of health indicators to larger audiences.
Laptops (PMO)	Cost supports a laptop for CAB offsite meeting presentations, focus groups, listening sessions, and other consumer engagement activities. Cost supports a laptop for the HIT work stream to support office activities such as group webinars and presentations, in addition to field operations such as council meetings and other off site workshops.
General Office Supplies (Evaluation)	Costs support general office supplies for the entire Performance Year 1 & 2. Performance Year 3 covers only 7 months of costs. The list of general office supplies are listed as the following: pens, pencils, paper, ink cartridges, staples, clips, tape, and pads to be used by the Evaluation staff to carry out their daily activities.

F. CONTRACTUAL

Please refer to the budget cost tables for contractual cost breakdowns, including contractual personnel costs, equipment costs, and other.

Consultants and contractors engaged in SIM initiatives that are not currently under contract or classified as state vendors will be secured via competitive bid / RFP process and will be held accountable by procuring agency via standard progress reporting. When the contractors are formally selected, the following required information will be provided for the contracts: all contract staff positions dedicated to the SIM program included annual salary, percentage of time budgeted for, and total number of months; a clear statement of the tasks and deliverables; the expected rate of compensation, and indirect cost rates.

Table 5: Overview of Contracts

CT SIM Initiative	Contract/Consultant
Population Health	• **HRIA** • **ICF International** • **TriCom**
PCMH+	• **Mercer** • **CHNCT**
AMH	• **TBD**
CCIP – Technical Assistance Vendor	• **TBD**
CCIP – Transformation Awards	• **TBD**
VBID	• **Freedman**
Health Information Technology	• **UConn (sub-contractor for DSS)** • **HTS (sub-contractor for UConn)**
Community Health Worker Initiative	• **UConn Health** • **Southwest Area Health Education Center (sub-contract)** • **University of Massachusetts, Center for Health Policy & Research (sub-contract)** • **Walker Systems (sub-contract)**
Program Evaluation	• **UConn Health** • **Yale University (sub-contract)** • **Greg Matthews (sub-contract)**

CONTRACTUAL BUDGET JUSTIFICATIONS BY SIM WORK STREAM

Please refer to the budget cost tables for detailed contractual cost breakdowns.

Population Health

The Department of Public Health is utilizing the following contracts in support of SIM work:

1. **Health Resource in Action (HRiA):** The consultant will develop, process and facilitate monthly meetings of the Population Health Council; provide all documentation including agenda, meeting summaries and meeting materials (electronic files of agendas and handout materials); facilitate development of public health priorities; assist the Council in identifying root causes and barriers to health improvement; and facilitate a selection process of evidence-based interventions. The consultant will also conduct a statewide scan of community prevention services in order to aid with the Council's development of recommendations for the operation of Prevention Service Centers and Health Enhancement Communities. The consultant will also carry out a scan of national initiatives related to population-based accountability models. In addition to assisting with identifying relevant environmental, policy, and systems changes, the consultant will also facilitate the analysis of most appropriate funding options and federal authority to support community prevention services and health enhancement community models.
2. **ICF International:** a consultant to develop and test a statistical modeling system that uses currently available data to create a consistent series of annual post-censal, town-level population estimates. DPH will use its existing contract with ICF Macro International to double the CT BRFSS sample size for sufficient statistical power to generate small area estimates for population subgroups. Funds have also been included to hire consultant services for the purposes of conducting baseline research about current community based capabilities for non-clinical delivery of preventive services. Consultants will survey and make direct inquiries with existing networks of non for profit organizations as well as with regional human services and councils of governments. This initial screening will characterize the institutional networks, administrative capacity, legal ability to enter into contracts, funding streams and governance structures. The goal of this project will be to identify strengths and weaknesses across the state that can be targeted in the process of implementing accountable health community models.
3. **Tri-Com**: DPH uses an existing contract with a staffing firm (Tri-Com) to retain a physician-level project manager and an epidemiologist/analyst.
4. **Special Projects**: DPH will engage consultancy services to provide financial and operational analysis to strengthen the planning of the Health Enhancement Community model. While several financing options such as waivers, shared savings, trust funds and/or philanthropic investments have been proposed, the feasibility of implementation in the context of particular communities in the State requires specific analysis. Similarly, operational frameworks for multiagency consortiums and governance systems will require special considerations according to each local or regional context.

Person Centered Medical Home + (PCMH+)

DSS will expand existing contracts with:

1. **Mercer Consulting** to perform various activities related to the establishment and implementation of PCMH+, including environmental scans, development of issue briefs, decision support and stakeholdering on major elements of model design (e.g. care coordination strategies, quality measures, shared savings model); development of an RFP for selection of FQHCs and Advanced Networks; program evaluation; and actuarial support. General services include performing analyses and facilitating MAPOC CMC monthly meetings and work sessions. Model construction tasks have focused upon development of the upside only shared savings arrangement. Shared savings model actuarial support includes receiving, cleaning and validating data and developing an expenditure benchmark.
2. **Community Health Network of Connecticut (CHN-CT)** to develop and implement under-service monitoring tools.

Primary Care Transformation

Advanced Medical Home (AMH) Program

PMO will procure a **practice transformation support vendor** to help practices achieve AMH status. The transformation process will be approximately a 12-month average duration. For the AMH pilot program, the state conducted a competitive procurement for a transformation vendor, including the costs of both the Technical Assistance (TA) and the learning collaborative. That cost assumption was used as the basis for the revised projection for the federally funded waves 1 and 2 of the AMH Program.

Clinical & Community Integration Program

PMO will procure a **CCIP transformation vendor** to provide technical assistance and learning collaborative support for healthcare provider networks (Advanced Networks and FQHCs), for the purposes of supporting CCIP. Services include developing a transformation curriculum to enable the achievement of CCIP standards, deploying a comprehensive change management strategy tailored to each network, convening or engaging Community Health Collaboratives to develop consensus coordination protocols, and conducting evaluation and monitoring. This will be done in conjunction with PCMH+, and will be implemented in two 15-month waves.

The Community Health Center Association of Connecticut, which includes all but one of Connecticut's FQHCs, was awarded a $17 million Practice Transformation Network (PTN) grant. Southern New England PTN, which includes UConn Health, was also awarded a PTN grant. PTN participating FQHCs and practices are prohibited from receiving CCIP technical assistance (with possible limited exceptions), so that the PTN and SIM funds dedicated to care delivery reform can reach the maximum number of providers. This strategy was formulated with CMMI input and approval.

The detail regarding priority areas and the nature and extent of support is the focus of a recent report by the Practice Transformation Task Force, which can be found in the latest CCIP report on the CT SIM website.

Clinical & Community Integration Program – Transformation Awards

PMO will issue **CCIP transformation awards** to eligible CCIP participants, to support them in achieving CCIP standards. It is anticipated that two waves of awards will be distributed, coinciding with the launch of the two PCMH+ waves, to support an estimated twelve Advanced Networks and one FQHC. The estimated average award amount is approximately $400,000 - $450,000--the amount may vary considerable depending on network size, feasibility of approach, and level of organizational commitment and strength of proposal. We anticipate that no awards will exceed $750,000. CCIP will target 1,364 providers by Quarter 4 of 2018.

Health Information Technology

SIM funds will support the HITO and the HIT Project Management Office to coordinate various HIT initiatives in the state related to Health Care Reform, Medicaid, APCD, Population Health, SIM and other federally funded efforts.

Additionally, through a DSS MOA, UConn is subcontracted to provide subject matter expertise and project/ technical management for the procurement and implementation of the Medicaid Alert Notification infrastructure that will begin with the Medicaid ASO and will be expanded to support the non-Medicaid beneficiaries of the PCMH+ program. UConn will also provide day-to-day management, data analytic capabilities and technical assistance to SIM participants utilizing the alert notification engine (including PD and EMPI).

- SIM will also provide financial support to procure or utilize the following technology solutions:
- Care Analyzer (DSS to acquire/implement)
- Consent Registry
- Disease Registries & Mobile Medical Applications
- EMPI-Nextgate
- Provider Directory-NextGate
- Direct Messaging/ADT
- Edge Servers/Indexing/eCQM
- EHR-SaaS
- Funds to support hosting technologies at the state technology agency, Bureau of Enterprise Systems and Technology (BEST)
- Funds to support Crowd-sourcing

Community Health Worker (CHW) Initiative

The PMO contracted with **UConn Health Center AHEC,** which subcontracted with **Southwest AHEC** to implement the CHW initiative. Together, they will support: CHW workforce development efforts through a CHW needs assessment, apprenticeship development with the Department of Labor, the identification of CHW resources, and technical assistance; Infrastructure and policy efforts through research on CHW models, coordination of the CHW Advisory Committee, and the development of recommendations for a CHW policy model; and Education and Community Integration through the development of curricular materials, stakeholder engagement, and the coordination of a statewide meeting.

UConn Health Center has also subcontracted with the **University of Massachusetts, Center for Health Policy & Research, Mass AHEC** to provide technical assistance in developing and executing an evaluation plan for the CHW workforce development initiative.

UConn Health Center has also subcontracted with **Walker Systems** to provide technical assistance and support in the development of an online resource/website for the CHW workforce development initiative.

Value Based Insurance Design

The PMO contracted with Freedman Healthcare LLC (FHC) to convene and facilitate meetings of the VBID Consortium and to provide limited support to the conduct of the Learning Collaborative. The Learning Collaborative may consist of several meetings, the distribution of educational materials, maintenance of the website, or other initiatives intended to engage self-insured employers in the V-BID process, as determined by the Learning Collaborative Design group. In addition to the Learning Collaborative, the PMO may work with FHC on an engagement strategy for fully-insured employers. Further, the PMO will work with FHC on a plan for future meetings of the Consortium, which may meet annually or semi-annually to provide further insight on encouraging the use of VBID plans across Connecticut. The PMO has not yet determined whether it will extend the Freedman contract beyond October 2016 to continue support for this initiative.

Consumer Engagement

Working with the state-funded consumer engagement coordinator, the Consumer Advisory Board will work to develop a Consumer Engagement Plan. The Plan will determine the communication, outreach, and education strategy to be employed. The Plan will include focus groups, forums, and listening sessions for which expert panelists and sign language interpreters may be utilized. Additional engagement activities may be determined to be necessary through the planning process in order to achieve the consumer engagement goals.

Program Evaluation

The PMO contracted with **UConn Health** to work on the program evaluation. UConn Health subcontracted with **Yale** to undertake all program evaluation activities. The Evaluation team will be accountable for the care experience survey, which will enable us to undertake a consolidated survey process that uses the same tool and data for the evaluation and for use by health plans for SSP contracts. This approach provides for a more cost-effective use of resources and should enable us to undertake surveys in each of three years.

G. OTHER

Please refer to the budget cost tables document for detailed cost breakdowns.

"Other" costs will support SIM-related program objectives. The round trip airfare estimated costs were revised to reflect the U.S. Average Domestic Itinerary Fares for the first quarter of 2016, as reported by the U.S. Department of Transportation, Bureau of Transportation Statistics.

Table 7: "Other" Description

Supplies	Description
Telephone Installation (DPH)	DPH will install telephones for program staff at an anticipated $40 cost for Performance Year 1.
Copier Expense (DPH)	An administrative printer/copier expense is included for maintenance associated with everyday printing/copy costs for 9 DPH staff and contracted personnel assigned to this project. Standard estimates are based on average costs/ staff usage
License Renewal (DPH)	Software license renewals are included for each of the Epidemiologists positions or contracted personnel associated with the need for SAS, ArcGIS and Instant Atlas. Data management and visualization tools are required for processing population health indicators data and develop the necessary breakdowns to illustrate and communicate changes in health indicators and disparities. All of these software packages require a license fee.

I. Total Direct Costs

Please refer to the budget cost tables document for detailed cost breakdowns.

*Total Modified Direct Costs refers to the total direct costs less equipment and sub-recipient charges (after the first $25,000).

A. Personnel

Position Title (Name)		Annual Salary	Time %				Months				$ Requested				TOTAL
			PIP	PY1	PY2	PY3	PIP	PY1	PY2	PY3	PIP	PY1	PY2	PY3	
											02/01/15-09/30/16	10/01/16-09/30/17	10/01/17-09/30/18	10/01/18-09/30/19	
Organizational Development Specialist - J.Ascheim	DPH	$94,179	50%				12	12	12	8	47,090	49,444	51,916	36,341	184,792
Epidemiologist 2 (Health Stats) - TBD	DPH	$67,604	100%				7	12	12	8	39,436	70,984	74,533	52,173	237,127
Health Program Associate	DPH	$70,813	90%	100%			12	12	12	9	63,732	74,354	78,071	61,481	277,638
Epidemiologist 3 (Vital Stats) - TBD	DPH	$85,368	100%				3	12	12	8	21,342	89,636	94,118	65,883	270,979
Secretary 2 - TBD	DPH	$54,099	100%				5	12	12	9	22,541	56,804	59,644	46,970	185,959
Health Program Assistant 2 - TBD	DPH	$59,929	100%				3	12	12	9	14,982	62,925	66,072	52,031	196,011
Primary Prevention Services Coordinator - TBD	DPH	$88,593	100%				3	12	12	8	22,148	93,023	97,674	68,372	281,216
Health Program Assistant 2	DSS/ DPH	$59,929	100%				0	12	12	12	0	62,925	66,072	69,375	198,372
Health Program Assistant 2	DSS	$59,929	100%				0	12	12	12	0	62,925	66,072	69,375	198,372
Associate Accountant	DSS	$85,918	100%				0	9	12	12	0	67,660	94,725	99,461	261,846
Accountant trainee	DSS	$51,862	100%				0	9	12	12	0	40,841	57,178	60,037	158,056
Durational Project Management Support Specialist J. Lupi	PMO	$65,000	100%				10	12	12	7	54,167	68,250	71,663	43,893	237,972
State Innovation Model Specialist (care delivery) - TBD	PMO	$87,298	100%				0	12	12	7	0	91,663	96,246	58,951	246,860
Health Program Associate D - TBD	PMO	$69,796	100%				0	12	12	7	0	73,286	76,950	47,132	197,368
Health Program Associate E - TBD	PMO	$69,796	100%				0	12	12	7	0	73,286	76,950	47,132	197,368
Nurse Consultant - TBD	OHA	$84,024	100%				0	9	12	12	0	66,169	92,636	97,268	256,074
Health Information Technology Officer	HITO Office	$185,100	100%	100%	100%	100%	4	12	12	7	61,700	186,951	188,821	111,247	548,718
HIT Program Manager	HITO Office	$125,000	100%	100%	100%	100%	3	12	12	7	31,250	128,750	132,613	79,678	372,291
										Personnel Grand Total:	**378,387**	**1,419,877**	**1,541,953**	**1,166,801**	**4,507,019**

B. Fringe

Position Title (Name)		Pre-Implementation 02/01/15-09/30/16	Performance Year 1 10/01/16-09/30/17	Performance Year 2 10/01/17-09/30/18	Performance Year 3 10/01/18-09/30/19	Total
Organizational Development Specialist - J.Ascheim	DPH	36,386	40,697	40,116	28,081	145,280
Epidemiologist 2 (Health Stats) - TBD	DPH	30,472	58,427	57,592	40,314	186,805
Health Program Associate - D. Yeager	DPH	49,245	61,200	60,326	47,507	218,278
Epidemiologist 3 (Vital Stats) - TBD	DPH	16,491	73,780	72,725	50,908	213,903
Secretary 2 - TBD	DPH	17,418	46,755	46,087	36,294	146,554
Health Program Assistant 2 - TBD	DPH	11,577	51,794	51,054	40,205	154,629
Primary Prevention Services Coordinator - TBD	DPH	17,114	76,567	75,473	52,831	221,984
Health Program Assistant 2	DSS/DPH	0	51,794	51,054	53,606	156,454
Health Program Assistant 2	DSS	0	51,794	51,054	53,606	156,454
Associate Accountant	DSS	0	55,691	73,194	76,853	205,738
Accountant trainee	DSS	0	33,616	44,181	46,390	124,188
Durational Project Management Support Specialist J. Lupi	PMO	41,855	56,177	55,374	33,916	187,321
State Innovation Model Specialist (care delivery) - TBD	PMO	0	75,448	74,369	45,551	195,368
Health Program Associate D - TBD	PMO	0	60,322	59,459	36,419	156,200
Health Program Associate E - TBD	PMO	0	60,322	59,459	36,419	156,200
Nurse Consultant - TBD	OHA	0	54,464	71,580	75,159	201,203
Health Information Technology Officer	HITO Office	50,594	153,300	154,833	91,222	449,949
Program Manager	HITO Office	25,625	105,575	108,742	65,336	305,278
Program Manager	HITO Office	0	0	0	0	0
Executive Assistant	HITO Office	0	0	0	0	0
Fringe Grand Total		**296,776**	**1,167,722**	**1,206,671**	**910,618**	**3,581,788**

C. Travel

Description	Program	Agency	Justification/Calculation	$ Requested				Total
				Pre-Implementation	Performance Year 1	Performance Year 2	Performance Year 3	
				02/01/15-09/30/16	10/01/16-09/30/17	10/01/17-09/30/18	10/01/18-09/30/19	
Mileage reimbursement DPH staff	Population Health	DPH	(8 Staff in yr 1, 9 staff yrs 2-4) * 40mi per month* 12 months * .56 a mile. 10 months in year 1.	$ 2,189	$ 2,419	$ 2,419	$ 2,419	$ 9,447
National Meeting	Population Health	DPH						
Epidemiologist 3			Airfare	$ 309	$ 324	$ 431		$ 1,064
			Hotel: 3 nights	$ 657	$ 750	$ 825		$ 2,232
			Per Diem (Meals): 4 days	$ 284	$ 284	$ 284		$ 852
			Transportation					
Physician 2			Airfare	$ 309	$ 324	$ 431		$ 1,064
			Hotel: 3 nights	$ 657	$ 750	$ 825		$ 2,232
			Per Diem (Meals): 4 days	$ 284	$ 284	$ 284		$ 852
			Transportation					
5 - Day BRFSS Conference	Population Health	DPH						
Epidemiologist 2			Airfare		$ 380	$ 380		$ 760
			Hotel: 3 nights		$ 780	$ 780		$ 1,560
			Per Diem (Meals): 4 days		$ 330	$ 330		$ 660
			Transportation		$ 75	$ 75		$ 150
			Fees: Registration, Baggage		$ 1,150	$ 1,150		$ 2,300
Required SIM Workshops/Conferences	SIM PMO	PMO						
4 Staff			Airfare	$ 2,420	$ 4,560	$ 4,560	$ 4,560	$ 16,100
			Hotel: 3 nights	$ 2,628	$ 2,628	$ 2,628	$ 2,628	$ 10,512
			Per Diem (Meals): 4 days	$ 852	$ 852	$ 852	$ 852	$ 3,408
			Transportation	$ 100				$ 100
			Travel Grand Total:	**$ 10,689**	**$ 15,889**	**$ 16,254**	**$ 10,459**	**$ 53,292**

D. Equipment

There are no costs projected for equipment at this time.

Description			Calculation	$ Requested				
				PIP	PY1	PY2	PY3	Total
				02/01/15-09/30/16	10/01/16-09/30/17	10/01/17-09/30/18	10/01/18-09/30/19	
				0	0	0	0	

E. Supplies

Description			Calculation	$ Requested PIP 02/01/15-09/30/16	$ Requested PY1 10/01/16-09/30/17	$ Requested PY2 10/01/17-09/30/18	$ Requested PY3 10/01/18-09/30/19	Total
General Office Supplies	DPH	Pop Health	Year 1 - $25/staff/month X 8 staff X 10 months Year 2-4 - $25/staff/month X 9 staff X 12 months (2% increase years 3 and 4)	$ 2,991	$ 2,400	$ 2,448	$ 2,497	$ 10,336
Extra PC monitor for Epi positions	DPH	Pop Health	Year 1 - $120/monitor X 2 epidemiologist positions Year 2 - $120/monitor X 1 epidemiologist position	$ 699	$ 120	$ -	$ -	$ 819
3 PC's including software	DPH	Pop Health	Year 1 - $1010/computer X 0 staff Year 2 - $1010/computer X 3 staff	$ -	$ 3,030	$ -	$ -	$ 3,030
Statistical Analytical Software	DPH	Pop Health	Year 1 - $1,500/package X 2 epidemiologist position Year 2 - $1,500/package X 1 epidemiologist position	$ -	$ 1,500	$ -	$ -	$ 1,500
Instant Atlas Software/Arc GIS License	DPH	Pop Health	Year 1 - $1,225/license X 2 epidemiologist position Year 2 - $1,225/license X 1 epidemiologist position	$ 1,472	$ 3,028	$ -	$ -	$ 4,500
Arc GIS license	DPH	Pop Health	Year 1 - $1,500/license X 2 epidemiologist position Year 2 - $1,500/license X 1 epidemiologist position	$ -	$ -	$ -	$ -	$ -
Adobe Professional	DPH	Pop Health	Year 1 - $303/package X 2 epidemiologist position Year 2 - $303/package X 1 epidemiologist position	$ -		$ -	$ -	$ -
Laptop for DPH	DPH	Pop Health		$ 1,300	$ -	$ -	$ -	$ 1,300
								$ -
4 PCs including software	PMO	SIM PMO	$1010/computer X 4 staff	$ -	$ 4,040	$ -	$ -	$ 4,040
								$ -
Laptop for use at CAB meetings/focus groups	PMO	Consumer	$1,300/laptop	$ 1,300	$ -	$ -	$ -	$ 1,300
1 Desktop computer	OHA	Consumer	$1010/computer X 1 staff	$ -	$ 1,010	$ -	$ -	$ 1,010
								$ -
General Office Supplies	Eval	Evaluation	$137/month	$ -	$ 1,644	$ 1,644	$ 959	$ 4,247
External Hard Drives	Eval	Evaluation	$728/hard drive X 3 hard drives	$ -	$ -	$ -	$ -	$ -
Desktop computers	Eval	Evaluation	$910/computer X 3 computers	$ -	$ -	$ -	$ -	$ -
General Office Supplies		HIT		$ -	$ -	$ -	$ -	$ -
Network Printer		HIT		$ -	$ -	$ -	$ -	$ -
3 computers (@ 877.60 each)	PMO	HIT		$ 2,633	$ -	$ -	$ -	$ 2,633
Laptops	PMO	HIT		$ 2,600	$ -	$ -	$ -	$ 2,600
			Supplies Grand Total:	**$ 12,995**	**$ 16,772**	**$ 4,092**	**$ 3,456**	**$ 37,315**

F. Contractual

Consumer Engagement		PIP	PY1	PY2	PY3	Total
		02/01/15-09/30/16	10/01/16-09/30/17	10/01/17-09/30/18	10/01/18-09/30/19	
Community Outreach and Engagement Program	5 community organizations X $2000 X 4 per year - to assist in feedback and engagement loops	$ -	$ 40,000	$ 40,000	$ 40,000	$ 120,000
Focus Group & Listening Sessions Facilitator	$5,000 per focus group and listening sessions * 4 each per Year; travel to focus groups and listening sessions - 8 sessions @ $50 each	$ 23,391	$ 53,592	$ 53,592	$ 53,592	$ 184,167
Sign language and language interpreters for meetings	interpreter services for focus groups, listening sessions and CAB meetings - $200*20; 20 meetings x $50 per meeting	#REF!	$ 5,000	$ 5,000	$ 5,000	#REF!
4 Expert Panelists	1 panelists quarterly * $1,500/honorarium + $380/flight and $168/per diem (Hartford GSA - $112 lodging and $56 MIE)	#REF!	#REF!	#REF!	#REF!	#REF!
	Total	**#REF!**	**#REF!**	**#REF!**	**#REF!**	**#REF!**

Population Health		PIP	PY1	PY2	PY3	Total
		02/01/15-09/30/16	10/01/16-09/30/17	10/01/17-09/30/18	10/01/18-09/30/19	
Development of Population Health Plan - HRiA	$960/day X 102 days X 2 years	$ 83,438	$ 83,437	$ -	$ -	$ 166,875
Creation of Population Estimates (CT State Data Center)	$160/hr X 62.5 days	$ 80,000	$ -	$ -	$ -	$ 80,000
BRFFS Consultant - ICF International	Conduct telephone interviews: 2,000 land line interviews @ $50/interview and 3,000 cell phone interviews @ $81/interview	$ 493,000	$ 343,000	$ 343,000	$ 193,000	$ 1,372,000
Personnel Consultant-Tri-Com		$ 289,813	$ 314,496	$ 330,221	$ 260,049	$ 1,194,578
Special Projects - HRiA		$ 51,815	$ -	$ -	$ -	$ 51,815
	Total	**$ 998,066**	**$ 740,933**	**$ 673,221**	**$ 453,049**	**$ 2,865,268**

Medicaid Quality Improvement & Shared Savings Program (PCMH+)		PIP	PY1	PY2	PY3	Total
		02/01/15-09/30/16	10/01/16-09/30/17	10/01/17-09/30/18	10/01/18-09/30/19	
Mercer	DSS Sub-contractor	$ 2,811,667	$ 1,159,666	$ 1,859,333		$ 5,830,667
CHN - Under Utilization of Services		$ 307,088	$ 447,172	$ 391,974	$ 403,852	$ 1,550,086

Primary Care Transformation		PIP	PY1	PY2	PY3	Total

F. Contractual

		02/01/15-09/30/16	10/01/16-09/30/17	10/01/17-09/30/18	10/01/18-09/30/19	
Advanced Medical Home Glide Path, Level 1 and 2 Practices	300 practices * 12,000 = $3,600,000 Year 1: 0practices; Year 2: 120 practices; Year 3: 120 practices; Year 4: 60 practices	$ -	$ 1,440,000	$ 1,440,000	$ 720,000	$ 3,600,000
Community and Clinical Integration Targeted Technical Assistance	Will help sites implement the 9 targeted technical assistance functions in 2 - 18 month phases.	$ 385,382	$ 1,190,170	$ 1,322,412	$ 352,643	$ 3,250,607
CCIP Transformation Awards		$ -	$ 2,356,380	$ 2,618,200	$ 698,187	$ 5,672,767
	TOTAL:	**$ 385,382**	**$ 4,986,551**	**$ 5,380,612**	**$ 1,770,830**	**$ 12,523,374**

Value Based Insurance Design		**PIP**	**PY1**	**PY2**	**PY3**	**Total**
Freedman Healthcare LLC		**02/01/15-09/30/16**	**10/01/16-09/30/17**	**10/01/17-09/30/18**	**10/01/18-09/30/19**	
Employer VBID consortium and learning collaboratives	Planning, design, facilitation of employer VBID consortium and learning collaboratives, Template & Toolkit development	$ 245,250	$ 30,250	$ 30,250	$ 15,250	$ 321,000
Panelists for Learning Collaboratives (3)	3 * $1,500/honorarium * $380/flight and $168/per diem (Hartford GSA - $112 lodging and $56 MIE) * 4 years	$ 6,144	$ 6,144	$ 6,144	$ 6,144	$ 24,576
	TOTAL:	**$ 251,394**	**$ 36,394**	**$ 36,394**	**$ 21,394**	**$ 345,576**

Department of Social Services		**PIP**	**PY1**	**PY2**	**PY3**	**Total**
Health Information Technology (HIT)		**02/01/15-09/30/16**	**10/01/16-09/30/17**	**10/01/17-09/30/18**	**10/01/18-09/30/19**	
HIT Budget		$ 473,002	$ 439,779	$ 456,354	$ 287,084	$ 1,656,220

UConn Evaluation		**PIP**	**PY1**	**PY2**	**PY3**	**Total**
		02/01/15-09/30/16	**10/01/16-09/30/17**	**10/01/17-09/30/18**	**10/01/18-09/30/19**	
Evaluation Budget		$ 1,016,702	$ 944,789	$ 927,173	$ 596,695	$ 3,485,358

UConn		**PIP**	**PY1**	**PY2**	**PY3**	**Total**
Community Health Worker		**02/01/15-09/30/16**	**10/01/16-09/30/17**	**10/01/17-09/30/18**	**10/01/18-09/30/19**	
CHW Budget		$ 311,310	$ 274,664	$ 282,653	$ 124,049	$ 992,676

G. Other

Description of Item Requested			Calculation	$ Requested				
				PIP	PY1	PY2	PY3	Total
Telephone Installation	DPH	Pop. Health	$63.44/phone * 9 staff	$ 571	$ 40			$ 611
Copier Expense	DPH	Pop. Health	50pg per wk * 9 staff * 52 wks * .02	$ -	$ 468	$ 477	$ 487	$ 1,432
License Renewal-Software Maint.	DPH	Pop. Health	Epi SAS, Atlas, Arch (2 in year 2; 3 in year 3 and 4))	$ -	$ 652	$ 978	$ 998	$ 2,628
Office Configuration	DPH	Pop. Health		$ 3,425	$ -	$ -	$ -	$ 3,425
Other Grand Total:				**$ 3,996**	**$ 1,160**	**$ 1,455**	**$ 1,485**	**$ 8,096**

I. Total Direct Costs

Contractual Budget Indirect Costs

Contract/ Consultant	Rate	PIP 02/01/15-09/30/16	PY1 10/01/16-09/30/17	PY2 10/01/17-09/30/18	PY3 10/01/18-09/30/19	Total
UConn Health (HIT)	10 % of direct costs	$31,161	$39,980	$41,487	$26,099	$138,726
UConn Health (Program Evaluation)	10% of modified direct costs*	$58,473	$54,127	$52,526	$35,927	$201,052
UConn and CT Area Health Education Center (CHW)	10% of modified direct costs*	$11,156	$8,606	$9,332	$6,732	$35,826

*Total Modified Direct Costs refers to the total direct costs less equipment and sub-recipient charges (after the first $25,000).

Indirect costs have been adjusted to reflect changes in the current projected budgets for these contracts including the extension period.

Appendix B. Performance Measures

Metric Title	Data Source	Reporting Frequency (How often will the data be submitted to CMMI? Quarterly, Annual, Biannual)	Definition	Numerator Definition	Denominator Definition	Measure Population (e.g., Statewide Population, Providers, Patient Group)	Measure Type (Process, Outcome, Structure, Balance, Composite)	Measure Value/Record Type (Currency, Percentage, Binary (Y/N), Date, Count)	Measure Group (Performance, Clinical, Cost/Utilization)	National Quality Strategy Priority Area	Baseline	Target Goal by end of Project Year 1	Target Goal by end of Project Year 2	Target Goal by end of Project Year 3	Target Goal by end of Project Period (January 2019)
Adult Obesity	CT DPH: Behavioral Risk Factor Surveillance System	Yearly	Percentage of CT residents 18+ years of age who are obese	Weighted Number of respondents with a BMI of 30 kg/m2 or greater based on self reported weight and height	CT population aged 18 years and older	Statewide Population	Outcome	Percentage	Performance	Performance_Population Health	25.3	25.2	25	24.9	24.7
Childhood Obesity	CT DPH: Behavioral Risk Factor Surveillance System	Yearly	percentage of CT residents under 18 years of age who are obese	Weighted number of surveyed children with a BMI at or above 95th percentile for children of the same sex and age based on reported weight and height	CT population aged under 18 years	Statewide Population	Outcome	Percentage	Performance	Performance_Population Health	TBD	TBD	TBD	TBD	TBD
Adult Smoking	CT DPH: Behavioral Risk Factor Surveillance System	Yearly	Percentage of CT residents 18+ years of age who currently smoke	Number of respondents who reported smoking some days or every day	CT population aged 18 years and older	Statewide Population	Outcome	Percentage	Performance	Performance_Population Health	14.7	14.2	13.7	13.2	12.7
Youth Smoking	CT DPH: Youth Tobacco Survey	Yearly	Percentage of CT high school students who currently smoke	Number of high school students who reported that they smoked cigarettes at least once in the past 30 days	CT high school population	Statewide Population	Outcome	Percentage	Performance	Performance_Population Health	TBD	TBD	TBD	TBD	TBD
Adult Diabetes	CT DPH: Behavioral Risk Factor Surveillance System	Yearly	Percentage of CT residents 18+ years of age who have been given a diagnosis of diabetes	respondents age 18+ years who reported that a doctor, nurse or other health professional ever told them that they had diabetes (excluding during pregnancy)	CT population aged 18 years and older	Statewide Population	Outcome	Percentage	Performance	Performance_Population Health	9.5	9.4	9.2	9.1	9
Premature Death: CVD	CT DPH: Death Records	Yearly	The number of CT residents per 100k who died of cardiovascular disease before age 75 years.	Number of CT residents who died in the measurement year of with causes of death listed as ICD 10 codes I11,I20-I25 or I160-169	Population of CT aged under 75 years in the measurement year	Statewide Population	Outcome	Rate	Performance	Performance_Population Health	TBD	TBD	TBD	TBD	TBD
Risk- All Condition Readmissions	DPH: Hospital Inpatient Discharge Database	Yearly	Readmissions for PQI 90 (overall composite)	CT Readmissions for any ASC diagnosis within 30 days of the Index Discharge Date.	All CT ambulatory sensitive care admissions for persons aged	Statewide Population	Outcome	Percentage	Performance	Performance_Utilization	TBD	TBD	TBD	TBD	TBD
Ambulatory Care Sensitive Condition Admissions	DPH: Hospital Inpatient Discharge Database	Yearly	Prevention Quality Indicators Overall Composite	PQI overall composite per 100k population aged 18 years and older.	Population ages 18 and older in metropolitan areas or	Statewide Population	Outcome	Rate	Performance	Performance_Utilization	TBD	TBD	TBD	TBD	TBD
Adults with Regular Source of Care	CT All Payer Claims Database	Quarterly	NQMC 9851. Percentage of members 20 years and older who had an ambulatory or preventive care visit. Medicaid and Medicare members who had an ambulatory or preventive care visit during the measurement year Commercial members who had an ambulatory or preventive care visit during the measurement year or the two years prior to the measurement year	Medicaid/Medicare: One or more ambulatory or preventative visit during the measurement year Commercial: One or more ambulatory or preventative care visit during the measurement year or the two years prior to the measurement year.	Number of members aged 20 years or older	CT insured Population	Outcome	Percentage	Performance	Performance_Utilization	TBD	TBD	TBD	TBD	TBD

Appendix B. Performance Measures

Well Child Visits- Low Income	CT All Payer Claims Database	Quarterly	NCMC 9059. Children and adolescents' access to primary care practitioners: % of members 1-19 years who had a visit with a pcp	Ages 1-6 years: One or more visits to a pcp during the measurement year. Ages 7-19 years: One or more visits to a pcp during the measurement year or the prior year	Number of CT children aged 1-19 covered by Medicaid	CT Population Insured by Medicaid	Outcome	Percentage	Performance	Performance_Utilization	TBD	TBD	TBD	TBD	TBD
Mammograms	CT All Payer Claims Database	Quarterly	NQF 2372. The percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.	Number of women who received a mammogram to screen for breast cancer in the measurement year	Women aged 52-74 as of end of the measurement year	CT insured Population	Outcome	Percentage	Performance	Performance_Utilization	TBD	TBD	TBD	TBD	TBD
Colorectal Screening	CT All Payer Claims Database	Quarterly	NQF 0034 The percentage of patients 50-75 years of age who had appropriate screening for colon cancer during the measurement year (fecal occult blood test, flexible sigmoidoscopy, colonoscopy). Excludes patients with a diagnosis of colorectal cancer or total colectomy.	Patients with one or more screenings for colorectal cancer	Patients 51-75 years of age as of the end of the measurement year	CT insured Population	Outcome	Percentage	Performance	Performance_Utilization	TBD	TBD	TBD	TBD	TBD
Diabetes care	CT All Payer Claims Database	Quarterly	NQF 0057. The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year.	Patients who had an HbA1c test performed during the measurement year.	Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.	CT insured Population	Outcome	Percentage	Performance	Performance_Utilization	TBD	TBD	TBD	TBD	TBD
ED use-Asthma as Primary Diagnosis	CT All Payer Claims Database	Quarterly	Visits to the Emergency Department with a primary diagnosis of asthma per 10k CT residents.	Number of ED visits with a primary diagnosis of asthma.	Population of CT in the year of measurement.	CT Population	Outcome	Rate	Performance	Performance_Utilization	TBD	TBD	TBD	TBD	TBD
Percent of adults with HTN taking HTN meds	CT All Payer Claims Database	Quarterly	The percentage of patients 18-75 years of age with diagnosis of HTN who are filling prescriptions for HTN	Number of patients aged 18-75 years of age with a diagnosis of HTN who are filling prescriptions for HTN	Patients 18-75 years of age by the end of the measurement year who had a diagnosis of hypertension	CT insured Population	Outcome	Percentage	Performance	Performance_Population Health	TBD	TBD	TBD	TBD	TBD

Appendix B. Performance Measures

Follow-Up Emergency Department for Mental Health or Alcohol or other Drug	CT All Payer Claims Database	Quarterly	NQF 2605: The percentage of discharges for patients 18 years of age and older who had a visit to the emergency department with a primary diagnosis of mental health or alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence within 7- and 30-days of discharge.	The percentage of discharges for patients 18 years of age and older who had a visit to the emergency department with a primary diagnosis of mental health or alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence within 7- and 30-days of discharge.	Patients who were treated and discharged from an emergency department with a primary diagnosis of mental health or alcohol or other drug dependence on or between January 1 and December 1 of the measurement year.	CT insured Population	Outcome	Percentage	Performance	Performance_Population Health					
Follow-Up after Hospitalization for Mental Illness	CT All Payer Claims Database	Quarterly	NQF # 0576:The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: -The percentage of discharges for which the patient received follow-up within 30 days of discharge and -The percentage of discharges for which the patient received follow-up within 7 days of discharge	30-Day Follow-Up: An outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge. 7-Day Follow-Up: An outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge.	Patients 6 years and older as of the date of discharge who were discharged from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness during the first 11 months of the measurement year	CT insured Population	Outcome	Percentage	Performance	Performance_Population Health					

Appendix B. Performance Measures

Antidepressant Medication Management	CT All Payer Claims Database	Quarterly	NQF 0105:The percentage of members 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported. a) Effective Acute Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks). b) Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180	a) Effective Acute Phase Treatment: At least 84 days (12 weeks) of continuous treatment with antidepressant medication (Table AMM-C) during the 114-day period following the Index Prescription Start Date (IPSD) (115 total days). The continuous treatment allows gaps in medication treatment up to a total of 30 days during the 115-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. Regardless of the number of gaps, there may be no more than 30 gap days. Count any combination of gaps (e.g., two washout gaps of 15 days each, or two washout gaps of 10 days each and one treatment gap of 10 days). b) Effective Continuation Phase Treatment: At least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-C) during the 232-day period following the IPSD. Continuous treatment allows gaps in medication treatment up to a total of 51 days during the 232-day period. Gaps can include either	Patients 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication.	CT insured Population	Outcome	Percentage	Performance	Performance_Population Health					
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	CT All Payer Claims Database	Quarterly	NQF # 0004: The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following.- Initiation of AOD Treatment. The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.- Engagement of AOD Treatment. The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	Initiation of AOD Dependence Treatment: Initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the index episode start date. Engagement of AOD Treatment: Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive).	Patients age 13 years of age and older who were diagnosed with a new episode of alcohol or other drug dependency (AOD) during the first 10 and ½ months of the measurement year.	CT insured Population	Outcome	Percentage	Performance	Performance_Population Health					

Appendix B. Performance Measures

Cost of Outpatient Care	CT All Payer Claims Database and Payers	Yearly	Total charges and co-pays per enrollee for outpatient care	Total outpatient charges and co-pays for covered individuals	Covered individuals	TBD-prefer all individuals with insurance; need to determine if covered individuals who do not use services included in commercial and Medicaid data.	Process	Dollars	Cost	State Health Care Landscape	TBD	TBD	TBD	TBD	TBD
Cost of Inpatient Care	CT All Payer Claims Database and Payers	Yearly	Total charges and co-pays per enrollee for inpatient care	Total inpatient charges and co-pays for covered individuals	Covered individuals	TBD-prefer all individuals with insurance; need to determine if covered individuals who do not use services included.	Process	Dollars	Cost	State Health Care Landscape	TBD	TBD	TBD	TBD	TBD
Percent of consumers with access to price info via performance scorecards	CT Insurance Payers	Yearly	Percent of consumers with access to price info via performance scorecards	Number of insured individuals in CT (Medicaid, Medicare, plus commercially insured) who have access to information about he cost of ambulatory services	Number of insured individuals in CT (Medicaid, Medicare, plus commercially insured)	Statewide insured population	Structure	Percent	Pace	State Health Care Landscape_Beneficiaries	TBD	TBD	TBD	TBD	TBD

APPENDIX C: PACE OF REFORM ACCOUNTABILITY MEASURES

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Measure Details

Metric Title	Data Source	Reporting Frequency (How often will the data be submitted to CMMI? Quarterly, Annual, Biannual)	Definition	Numerator Definition	Denominator Definition	Measure Population (e.g., Statewide Population, Providers, Patient Group)	Measure Type (Process, Outcome, Structure, Balance, Composite)	Measure Value/Record Type (Currency, Percentage, Binary (Y/N), Date, Count)	Measure Group (Performance, Clinical, Cost/Utilization)	National Quality Strategy Priority Area
Provider Participation in Adv. Med. Home Glide Path Program- Percent	PMO	4thQ 2016; 4thQ 2017	Percent of PCPs in Glide Path Program	Number of clinically active CT PCPs in a Glide Path Program	Number of clinically active CT PCPs	CT Clinically active PCPs	Structure	Percent	Pace	State Health Care Landscape_Providers
Provider Participation in a Community and Clinical Integration Program	PMO	4thQ 2016; 4thQ 2017	Percent of PCPs in a CCIP	Number of clinically active CT PCPs in a CCIP	Number of clinically active CT PCPs	CT Clinically active PCPs	Structure	Percent	Pace	State Health Care Landscape_Providers
Beneficiary Participation in Medicaid QISSP (PCMH+)	Medicaid	Yearly	Percent of Medicaid covered individuals in a QISSP program	Number of Medicaid covered individuals in a QISSP program	Number of Medicaid covered individuals in a QISSP program	Individuals in CT covered by Medicaid for more than 6 months in denominator year	Structure	Percent	Pace	State Health Care Landscape_Beneficiaries
Provider Participation in Medicaid QISSP (PCMH+)	Medicaid	Yearly	Percent of providers in FQHCs or Advanced Networks in MQISSP	Number of clinically active CT providers in FQHCs or Advanced Networks in MQISSP	Number of clinically active CT Medicaid providers	clinically active CT Medicaid providers	Structure	Percent	Pace	State Health Care Landscape_Providers
Beneficiary Participation in VBID- Percent	CT Insurance Payers	Yearly	Percent of commercially covered lives with a VBID insurance plan	Number of commercially covered lives with a VBID insurance plan	Number of commercially covered lives plan	TBD-prefer all individuals with commercial insurance; need to determine if covered individuals who do not use	Structure	Percent	Cost/utilization	State Health Care Landscape_Beneficiaries
Beneficiary participation in Shared Savings Plan (SSP)	CT Insurance Payers	Yearly	Percent of covered individuals with a PCP in an SSP	Number of covered individuals with a PCP in an SSP	Number of covered individuals with a PCP in CT	TBD-prefer all individuals with commercial insurance; need to determine if covered individuals who do not use	Structure	Percent	Pace	State Health Care Landscape_Beneficiaries
PCP participation in Shared Savings Plan (SSP)	CT Insurance Payers	Yearly	Percent of clinically active PCPs with more than 10% of their patient population in a SSP	Number of clinically active PCPs with more than 10% of their patient population in a SSP	Number of clinically active PCPs	Active PCPs in CT	Structure	Number	Cost/utilization	State Health Care Landscape_Providers

Table 1: Advanced Medical Home Glide Path Program - Provider Participation

Year		Primary Care Practices		Grant Period	
		Target # in or completed	Percentage of Target Total		
	Target Total	**370**			
2015	1st Quarter	0	0%	Q1	**PIP**
	2nd Quarter	0	0%	Q2	
	3rd Quarter	0	0%	Q3	
	4th Quarter	0	0%	Q4	
2016	1st Quarter	0	0%	Q5	
	2nd Quarter	0	0%	Q1	**PY1**
	3rd Quarter	0	0%	Q2	
	4th Quarter	185	50%	Q3	
2017	1st Quarter	185	50%	Q4	
	2nd Quarter	185	50%	Q1	**PY2**
	3rd Quarter	185	50%	Q2	
	4th Quarter	370	100%	Q3	
2018	1st Quarter	370	100%	Q4	
	2nd Quarter	370	100%	Q1	**PY3**
	3rd Quarter	370	100%	Q2	
	4th Quarter	370	100%	Q3	
2019	1st Quarter	370	100%	Q4	

Note 1: Targets are cumulative totals

Note 2: AMH target practices may extend beyond PCMH+

Note 3: Performance year quarters begin and end one month later than calendar quarters

Table 2: Community and Clinical Integration Program - Provider and Beneficiary Penetration

Year		Advanced Networks		FQHCs		PCPs*			Grant Period
		Target	Percentage	Target	Percentage	Target	Percentage		
	Target Total	**16**		**14**		**2,072**			
2015	1st Quarter	0	0%	0	0%	0	0%	Q1	**PIP**
	2nd Quarter	0	0%	0	0%	0	0%	Q2	
	3rd Quarter	0	0%	0	0%	0	0%	Q3	
	4th Quarter	0	0%	0	0%	0	0%	Q4	
2016	1st Quarter	0	0%	0	0%	0	0%	Q5	
	2nd Quarter	0	0%	0	0%	0	0%	Q1	**PY1**
	3rd Quarter	0	0%	0	0%	0	0%	Q2	
	4th Quarter	3	19%	1	7%	356	17%	Q3	
2017	1st Quarter	3	19%	1	7%	356	17%	Q4	
	2nd Quarter	3	19%	1	7%	356	17%	Q1	**PY2**
	3rd Quarter	3	19%	1	7%	356	17%	Q2	
	4th Quarter	12	75%	1	7%	1,364	66%	Q3	
2018	1st Quarter	12	75%	1	7%	1,364	66%	Q4	
	2nd Quarter	12	75%	1	7%	1,364	66%	Q1	**PY3**
	3rd Quarter	12	75%	1	7%	1,364	66%	Q2	
	4th Quarter	12	75%	1	7%	1,364	66%	Q3	
2019	1st Quarter	12	75%	1	7%	1,364	66%	Q4	
	2nd Quarter	12	75%	1	7%	1,364	66%		
	3rd Quarter	12	75%	1	7%	1,364	66%		
	4th Quarter	12	75%	1	7%	1,364	66%		

Note 1: PCP counts include those PCPs employed by or affiliated with Advanced Networks and FQHCs

Note 2: Targets are cumulative totals

Note 3: Performance year quarters begin and end one month later than calendar quarters

Table 3: Provider Participation in PCMH+

Year		Advanced Networks		FQHCs		PCPs*		Grant Period	
		Target	Percentage	Target	Percentage	Target	Percentage		
	Target Total	**16**		**14**		**2,072**			
2015	1st Quarter	0	0%	0	0%	0	0%	Q1	**PIP**
	2nd Quarter	0	0%	0	0%	0	0%	Q2	
	3rd Quarter	0	0%	0	0%	0	0%	Q3	
	4th Quarter	0	0%	0	0%	0	0%	Q4	
2016	1st Quarter	0	0%	0	0%	0	0%	Q5	
	2nd Quarter	0	0%	0	0%	0	0%	Q1	**PY1**
	3rd Quarter	0	0%	0	0%	0	0%	Q2	
	4th Quarter	0	0%	0	0%	0	0%	Q3	
2017	1st Quarter	3	19%	9	64%	516	25%	Q4	
	2nd Quarter	3	19%	9	64%	516	25%	Q1	**PY2**
	3rd Quarter	3	19%	9	64%	516	25%	Q2	
	4th Quarter	3	19%	9	64%	516	25%	Q3	
2018	1st Quarter	12	75%	14	100%	1,624	78%	Q4	
	2nd Quarter	12	75%	14	100%	1,624	78%	Q1	**PY3**
	3rd Quarter	12	75%	14	100%	1,624	78%	Q2	
	4th Quarter	12	75%	14	100%	1,624	78%	Q3	
2019	1st Quarter	12	75%	14	100%	1,624	78%	Q4	
	2nd Quarter	12	75%	14	100%	1,624	78%		
	3rd Quarter	12	75%	14	100%	1,624	78%		
	4th Quarter	12	75%	14	100%	1,624	78%		
2020	1st Quarter	16	100%	14	100%	2,072	100%		
	2nd Quarter	16	100%	14	100%	2,072	100%		
	3rd Quarter	16	100%	14	100%	2,072	100%		
	4th Quarter	16	100%	14	100%	2,072	100%		

Note 1: PCP counts include those PCPs employed by or affiliated with Advanced Networks and FQHCs

Note 2: Targets are cumulative totals

Table 4: Beneficiary Participation in Targeted Reforms*

Year		Comm/Medicare Beneficiaries		Medicaid Beneficairies		Total		Grant Period	
		Target	Percentage	Target	Percentage	Target	Percentage		
2016	**Population N**	**2,751,723**		**683,018**		**3,434,741**			
	1st Quarter	0	0%	0	0%	0	0%	Q1	**PIP**
	2nd Quarter	0	0%	0	0%	0	0%	Q2	
	3rd Quarter	0	0%	0	0%	0	0%	Q3	
	4th Quarter	0	0%	0	0%	0	0%	Q4	
2017	**Population N**	**2,792,947**		**698,920**		**3,491,867**			
	1st Quarter	580,750	21%	210,000	30%	790,750	23%	Q5	
	2nd Quarter	580,750	21%	210,000	30%	790,750	23%	Q1	**PY1**
	3rd Quarter	580,750	21%	210,000	30%	790,750	23%	Q2	
	4th Quarter	580,750	21%	210,000	30%	790,750	23%	Q3	
2018	**Population N**	**2,834,947**		**715,192**		**3,550,139**			
	1st Quarter	1,510,000	53%	429,000	60%	1,939,000	55%	Q4	
	2nd Quarter	1,510,000	53%	429,000	60%	1,939,000	55%	Q1	**PY2**
	3rd Quarter	1,510,000	53%	429,000	60%	1,939,000	55%	Q2	
	4th Quarter	1,510,000	53%	429,000	60%	1,939,000	55%	Q3	
2019	**Population N**	**2,877,741**		**731,843**		**3,609,584**			
	1st Quarter	1,812,000	64%	439,000	61%	2,251,000	63%	Q4	
	2nd Quarter	1,812,000	64%	439,000	61%	2,251,000	63%	Q1	**PY3**
	3rd Quarter	1,812,000	64%	439,000	61%	2,251,000	63%	Q2	
	4th Quarter	1,812,000	64%	439,000	61%	2,251,000	63%	Q3	
2020	**Population N**	**2,921,347**		**748,882**		**3,670,229**		Q4	
	1st Quarter	2,400,000	85%	636,000	89%	3,036,000	86%		
	2nd Quarter	2,400,000	85%	636,000	89%	3,036,000	86%		
	3rd Quarter	2,400,000	85%	636,000	89%	3,036,000	86%		
	4th Quarter	2,400,000	85%	636,000	89%	3,036,000	86%		

*Based on estimates of beneficiaries receiving services from Advanced Networks participating in both PCMH+ and Comm/Medicare SSP or FQHCs participating in PCMH+ alone

Table 5: Beneficiary Participation in Any Shared Savings Program

Year		ASO (exc State Emp)		Fully Insured		State Employees (exc Medicare Supp)		Medicare (exc duals)		Medicaid/CHIP (exc duals)		Total	
		Target	Percent	Target	Percent	Target	Percent	Target	Percent	Target	Percent	Target	Percent
2016	**Population N**	**1,134,339**		**876,450**		**136,989**		**601,929**		**683,018**		**3,432,725**	
	1st Quarter	453,735	40%	350,580	40%	54,796	40%	240,771	40%	0	0%	1,099,882	32%
	2nd Quarter	453,735	40%	350,580	40%	54,796	40%	240,771	40%	0	0%	1,099,882	32%
	3rd Quarter	453,735	40%	350,580	40%	54,796	40%	240,771	40%	0	0%	1,099,882	32%
	4th Quarter	453,735	40%	350,580	40%	54,796	40%	240,771	40%	0	0%	1,099,882	32%
2017	**Population N**	**1,146,794**		**886,074**		**138,494**		**619,569**		**698,920**		**3,489,851**	
	1st Quarter	630,737	55%	487,341	55%	76,171	55%	340,763	55%	210,000	30%	1,745,012	50%
	2nd Quarter	630,737	55%	487,341	55%	76,171	55%	340,763	55%	210,000	30%	1,745,012	50%
	3rd Quarter	630,737	55%	487,341	55%	76,171	55%	340,763	55%	210,000	30%	1,745,012	50%
	4th Quarter	630,737	55%	487,341	55%	76,171	55%	340,763	55%	210,000	30%	1,745,012	50%
2018	**Population N**	**1,159,385**		**895,803**		**140,014**		**637,726**		**715,192**		**3,548,120**	
	1st Quarter	753,601	65%	582,272	65%	91,009	65%	414,522	65%	429,000	60%	2,270,404	64%
	2nd Quarter	753,601	65%	582,272	65%	91,009	65%	414,522	65%	429,000	60%	2,270,404	64%
	3rd Quarter	753,601	65%	582,272	65%	91,009	65%	414,522	65%	429,000	60%	2,270,404	64%
	4th Quarter	753,601	65%	582,272	65%	91,009	65%	414,522	65%	429,000	60%	2,270,404	64%
2019	**Population N**	**1,172,115**		**905,639**		**141,552**		**656,416**		**731,843**		**3,607,565**	
	1st Quarter	879,087	76%	679,229	76%	106,164	76%	492,312	77%	439,000	61%	2,595,792	73%
	2nd Quarter	879,087	76%	679,229	76%	106,164	76%	492,312	77%	439,000	61%	2,595,792	73%
	3rd Quarter	879,087	76%	679,229	76%	106,164	76%	492,312	77%	439,000	61%	2,595,792	73%
	4th Quarter	879,087	76%	679,229	76%	106,164	76%	492,312	77%	439,000	61%	2,595,792	73%
2020	**Population N**	**1,184,985**		**915,583**		**143,106**		**675,653**		**748,882**		**3,668,209**	
	1st Quarter	1,007,238	87%	778,245	87%	121,640	87%	574,305	90%	636,000	89%	3,117,428	88%
	2nd Quarter	1,007,238	87%	778,245	87%	121,640	87%	574,305	90%	636,000	89%	3,117,428	88%
	3rd Quarter	1,007,238	87%	778,245	87%	121,640	87%	574,305	90%	636,000	89%	3,117,428	88%
	4th Quarter	1,007,238	87%	778,245	87%	121,640	87%	574,305	90%	636,000	89%	3,117,428	88%

Table 6: PCP Participation in Any SSP

Year		PCP Type			Total PCP
		APRN	PA	Physician	
2016	Population N	1,200	1,000	3,300	5,500
	Percent	67%	65%	65%	65%
	Base N	**803**	**654**	**2,135**	**3,592**
	1st Quarter	822	669	2,185	3,675
	2nd Quarter	841	685	2,235	3,761
	3rd Quarter	860	701	2,287	3,848
	4th Quarter	880	717	2,340	3,937
2017	Population N	1,200	1,000	3,300	5,500
	Percent	67%	65%	65%	65%
	Base N	**957**	**780**	**2,545**	**4,282**
	1st Quarter	979	798	2,604	4,381
	2nd Quarter	1,002	817	2,664	4,483
	3rd Quarter	1,025	836	2,726	4,587
	4th Quarter	1,049	855	2,790	4,693
2018	Population N	1,200	1,000	3,300	5,500
	Percent	67%	65%	65%	65%
	Base N	**1,034**	**843**	**2,750**	**4,627**
	1st Quarter	1,058	863	2,814	4,734
	2nd Quarter	1,083	883	2,879	4,844
	3rd Quarter	1,108	903	2,946	4,957
	4th Quarter	1,133	924	3,014	5,072
2019	Population N	1,200	1,000	3,300	5,500
	Percent	67%	65%	65%	65%
	Base N	**1,111**	**906**	**2,955**	**4,972**
	1st Quarter	1,137	927	3,024	5,087
	2nd Quarter	1,163	949	3,094	5,205
	3rd Quarter	1,190	971	3,165	5,326
	4th Quarter	1,218	993	3,239	5,450
2020	Population N	1,200	1,000	3,300	5,500
	Percent	67%	65%	65%	65%
	Base N	**1,173**	**956**	**3,120**	**5,249**
	1st Quarter	1,200	978	3,192	5,371
	2nd Quarter	1,228	1,001	3,266	5,495
	3rd Quarter	1,257	1,024	3,342	5,623
	4th Quarter	1,286	1,048	3,420	5,753

Table 7: Beneficiary Participation in Value Based Insurance Design

Year		ASO (exc State Emp)		Fully Insured		State Employees (exc Medicare Supp)		Total	
		Target	Percent	Target	Percent	Target	Percent	Target	Percent
2016	**Population N**	**1,134,339**		**876,450**		**136,989**		**2,147,778**	
	1st Quarter	453,735	40%	350,580	40%	134,000	98%	938,315	44%
	2nd Quarter	453,735	40%	350,580	40%	134,000	98%	938,315	44%
	3rd Quarter	453,735	40%	350,580	40%	134,000	98%	938,315	44%
	4th Quarter	453,735	40%	350,580	40%	134,000	98%	938,315	44%
2017	**Population N**	**1,146,794**		**886,074**		**138,494**		**2,171,362**	
	1st Quarter	589,856	51%	420,696	47%	136,000	98%	1,146,552	53%
	2nd Quarter	589,856	51%	420,696	47%	136,000	98%	1,146,552	53%
	3rd Quarter	589,856	51%	420,696	47%	136,000	98%	1,146,552	53%
	4th Quarter	589,856	51%	420,696	47%	136,000	98%	1,146,552	53%
2018	**Population N**	**1,159,385**		**895,803**		**140,014**		**2,195,202**	
	1st Quarter	766,812	66%	525,870	59%	137,000	98%	1,429,682	65%
	2nd Quarter	766,812	66%	525,870	59%	137,000	98%	1,429,682	65%
	3rd Quarter	766,812	66%	525,870	59%	137,000	98%	1,429,682	65%
	4th Quarter	766,812	66%	525,870	59%	137,000	98%	1,429,682	65%
2019	**Population N**	**1,172,115**		**905,639**		**141,552**		**2,219,306**	
	1st Quarter	881,834	76%	631,044	70%	137,000	98%	1,649,878	75%
	2nd Quarter	881,834	76%	631,044	70%	137,000	98%	1,649,878	75%
	3rd Quarter	881,834	76%	631,044	70%	137,000	98%	1,649,878	75%
	4th Quarter	881,834	76%	631,044	70%	137,000	98%	1,649,878	75%
2020	**Population N**	**1,184,985**		**915,583**		**143,106**		**2,243,674**	
	1st Quarter	1,014,109	87%	757,253	85%	137,000	98%	1,908,362	87%
	2nd Quarter	1,014,109	87%	757,253	85%	137,000	98%	1,908,362	87%
	3rd Quarter	1,014,109	87%	757,253	85%	137,000	98%	1,908,362	87%
	4th Quarter	1,014,109	87%	757,253	85%	137,000	98%	1,908,362	87%

Appendix F

Operational Plan Components
Performance Year 1

8/1/2016

Activity	PY1 Quarters	Target Date
Population Health Planning		
Develop Population Health Assessment	Q1	10/1/16-12/31/2016
Community health measures identified for target communities	Q1	10/1/16-12/31/2016
Provide data and enabling methods to select and maintain metrics of Population Health	Q1-Q4	10/1/16-3/31/2019
Conduct a root cause and barrier analysis of population health priority indicators	Q1-Q4	10/1/16-9/30/2017
Define trends and improvement targets for tobacco use, obesity and diabetes and other selected population health indicators	Q1-Q4	10/1/16-9/30/2017
Identify priority areas with highest burden of disease and community institutional capacity to implement prevention initiatives	Q1	10/1/16- 12/31/2016
Conduct statewide scan to identify entities able to provide evidence-based community-prevention services	Q1-Q2	10/1/16-1/31/2017
Design Prevention Service Centers, research evidence -based interventions and finalize PSC's service menu	Q1-Q4	10/1/16-9/30/2017
Identify funding options & federal authority to support Prevention Service Centers and Health Enhancement Communities	Q2-Q4	1/1/17-9/30/2018
Conduct research and develop conceptual model of HEC	Q1-Q4	10/1/16-10/30/2017
Establish a planning team and guiding principles for Health Enhancement Communities (HEC's)	Q4	2/28/2018
Advanced Medical Home		
Enroll practices from Advanced Networks for Wave 1	Q1	10/1/16- 11/30/16
Finalize Contracts & Launch AMH Program	Q1	11/1/16-1/31/17
Monthly conference calls	Q1-Q4	Beginning 12/1/16
Continuous LC webpage updates & milestone reporting	Q1-Q4	Beginning 12/1/16
LC webinars	Q1-Q4	Beginning 12/1/16
Continue enrollment for future cohorts	Q2-Q4	1/1/17-9/30/17
Clinical and Community Integration Program: Technical Assistance		
Procure CCIP TA vendor(s)	Q1	10/1/2016
Contract with Advanced Networks for Wave 1 participation	Q1	8/1/16-10/31/16
CCIP Vendor Primplementation Planning- Develop Implementation Package, Community Health Collaborative scan and planning	Q1	10/1/16-11/30/16
Roll out Wave 1 technical assistance support, including developing transformation plans, conducting core TA activities, care delivery interventions, and assessments	Q2-Q4	1/1/17-9/30/17
Conduct Learning Collaborative	Q2-Q4	1/1/17-9/30/17
Convene and facilitate Community Health Collaboratives	Q2-Q4	1/1/17-9/30/17
Clinical and Community Integration Program: Transformation Awards		
Awards Issued	Q1	9/1/16-10/31/16
Performance Period Begins for Wave 1	Q2	1/1/2017

Performance Period: Core Transformation Activities Occur	Q2-Q4	1/1/17-9/30/17
PCMH+		
Develop provider contracts for MQISSP participation that include common performance measures; up-side only risk agreement, and; reporting requirements to MQISSP data aggregator and population health management entity	Q1	5/1/16-10/31/16
Complete assessment of provider compatibility with Medicaid requirements for participation in MQISSP.	Q1	5/1/16-10/31/16
Go live with Wave 1, targeting 200,000-215,000 beneficiaries	Q2	By 1/1/2017
Commence on-going TTA to providers	Q1-Q2	11/1/16-1/31/17
Receive, clean, and validate data related to the target population (all sources). Develop expenditure benchmark with calculation. Link quality score and shared saving loss percentages.	Q1-Q4	10/1/16-9/30/17
Commence under-service monitoring, with detailed reporting and drill down analyses by provider, provider group and patient	Q3-Q4	11/1/16-9/30/17
Conduct provider site visits to review findings	Q1-Q4	11/1/16-9/30/17
Provide reports to PMO and Equity and Access Council	Q1-Q4	11/1/16-9/30/17
Coordinate evaluation and data reporting activities	Q1-Q4	11/1/16-9/30/17
Perform contract monitoring of participating providers	Q1-Q4	11/1/16-9/30/17
Conduct clinical staff translation of criteria into appropriate service codes to run investigative software	Q1-Q2	11/1/16-1/31/17
Prepare baseline reports for comparison of utilization changes occurring after the implementation of the SIM program for Medicaid beneficiaries	Q1-Q2	11/1/16-1/31/17
Commence on-going staff training and transition of post-implementation and sustainability responsibilities	Q2-Q4	2/1/17-9/30/17
Quality Measure Alignment		
Promote voluntary adoption across payers of recommended quality measures for use in VBP contracts	Q1-Q4	10/1/16-9/30/17
Evaluate and develop measures on the Development Set	Q1-Q4	10/1/16-9/30/17
Assess payer interest in specialty and hospital specific measures sets in conjunction with alternative payment models	Q1-Q3	10/1/16-6/30/17
Periodic reevaluation of measure set by Quality Council	Q1-Q4	10/1/16-9/30/17
Community Health Workers		
Work with CHW consultants to develop and implement a CHW Workforce Development Plan incorporating the input of the CHW Advisory Committee, CHWs, and other stakeholders.	Q1-Q4	10/1/16 – 12/31/18
Meet with stakeholders to discuss and promote CHW integration into communities and healthcare settings and promote opportunities for employment.	Q1-Q4	10/1/16 – 12/31/18

Develop and implement a survey to identify the TA needs of CHW employers and supervisors in order to assess knowledge about the utilization of the CHW workforce, apprenticeships, and the movement of healthcare reform toward value-based payment and population health	Q1-Q4	10/1/16 – 12/31/17
Provide TA to CHW employers and supervisors that addresses the specific needs identified in the TA-needs survey (2.2).	Q1-Q4	10/1/16 – 12/31/18
Explore pathways for the award of credits toward healthcare-related degree programs for prior learning assessment (e.g., AHEC's CHW "boot camp") and prior experience working in a CHW capacity.	Q1-Q4	10/1/16 – 12/31/18
Create a CHW toolkit based on best practices of CHW workforce development and integration.	Q4	7/1/17 – 12/31/18
Work with the CHW Advisory Committee to provide guidance to the SIM Steering Committee on creating a sustainable policy framework for CHWs in CT.	Q1-Q4	10/1/16 – 12/31/18
Engage CHW consultant to provide guidance on CHW curriculum and training best practices by incorporating the C3 Project recommendations.	Q1-Q4	10/1/16 – 12/31/18
Health Information Technology		
Establish the HIT Program Management Office		
HITO to chair the State Health IT Advisory Council	Q1-Q4	9/1/2016 - Ongoing
Identify vendor to perform facilitation services for the State Health IT Advisory Council	Q1	9/1/2016 -10/1/16
Stakeholder Engagement/ HIT landscape Assessment		
Prepare stakeholder engagement RFP	Q1	7/1/16- 9/1/16
Issue RFP for stakeholder engagement for HIT activities	Q1	9/1/2016
Solicit proposals for stakeholder engagement RFP	Q1	9/1/16-10/1/16
Evaluation of stakeholder engagement RFP	Q1	10/1/16-10/15/16
Vendor negotiation and contract execution	Q1	10/15/16-11/1/16
Stakeholder Engagement	Q1-Q3	11/1/16-4/30/17
HIE RFP Process, Operations & Implementations		
Prepare RFP for the HIE	Q1-Q2	11/1/16-3/1/17
Issue RFP for the HIE	Q2	3/15/2017
Vendor responses	Q2-Q3	3/15/17-4/15/17
Vendor negotiation and contract execution	Q3	4/15/17-6/1/17
Phase in operations for statewide HIE	Q3-PY2	6/1/17-12/31/17
*Hospital and Clinical Laboratory Connection to the HIE	PY2	12/31/2018
*Provider Connection to the HIE	PY3	12/31/2019
Leveraging Enterprise Assets		
Enterprise Master Person Index Go-Live and Production (Medicaid beneficiaries data)	Q2	3/7/16-Ongoing
Prepopulate Provider Directory with MMIS and Licensure data	Q2-Q3	3/7/16-5/2/16
Alert Notification		
1. Alert Notification with Medicaid ASOs		

Implement Provider Directory with an ASO	Q2-Q3	3/7/16-5/2/16
Sign DURSA with [an] ASO[s]	Q2-Q3	3/7/16-5/2/16
Procure an Alert Notification Engine	Q2-Q3	5/1/16-6/1/16
Build Alert Notification Infrastructure with an ASO (Pre-Implementation)	Q3-Q4	5/2/16-10/1/16
Test Alerts between ASO and DSS	Q1	10/1/16-11/1/16
Pilot Alert Notification System with ASO	Q1	11/1/16-12/1/16
Deploy Alert Notification System and provide TA with **all** ASOs in the State (?)	Q1-Q2	12/1/16-3/1/17
*Alert Notification with Medicaid ASO funded by 90/10 and state appropriations		
2. Alert Notification with PCMH+ Participants		
PCMH+ NCE and Performance Year 1 timeline supporting ADT pilot	Q1	7/1/16-12/31/17
Develop Use Case Scenario for PCMH+ participants	Q1	7/1/16-9/1/16
Expand Alert Notification with identified PCMH+ Participants, Health Plans and execute DURSAs (Patient Consent?)	Q1-Q2	10/1/16-3/1/17
Load Provider and Patient Panel	Q1	10/1/16-12/31/16
Securely transmit a file of patients for which it is subscribing to receive alerts (monthly basis minimum)	Q2	1/1/17-3/1/17
Pilot Alert Notification	Q2-Q3	3/1/1/7-4/1/17
Deploy Alert Notification System	Q3-Q4	4/1/17-7/1/17
Provide TA	Q3	4/1/17-Ongoing
Reporting Requirements		
Health IT Strategic Roadmap for the State	Q2-Q4	12/1/16-7/1/17
Annual Report on Health IT activities to the CT General Assembly	Q2	1/1/17-2/1/17
Value Based Insurance Design		
Conduct baseline VBID survey (Evaluation team)	Q1	10/1/16-12/31/16
Begin VBID/ACO actuarial evaluation study	Q1	10/1/16-12/31/2016
Launch employer section on SIM website	Q1	10/1/16-10/31/16
Convene 1st VBID learning collaborative	Q1	10/1/16-10/31/16
Continue VBID/ACO actuarial study	Q2-Q4	1/1/16-9/30/17
Engage self-insured employers through learning collaborative	Q1-Q4	10/1/16-9/30/17
Engage fully-insured employers using engagement plan developed during Preimplementation Period	Q1-Q4	10/1/16-9/30/17
Continue working with Access Health CT on strategies to implement VBID on the health insurance exchange	Q1-Q4	10/1/16-9/30/17
Engage VBID Consortium in the implementation process through monthly updates	Q1-Q4	10/1/16-9/30/17
Consumer Engagement		
Develop tools and types of communication forums for use with each consumer segment including platforms for online social media communications	Q1	10/1/16-10/31/16
Develop platforms for online and social media communications	Q1-Q4	10/1/16-9/30/17

Conduct issue-driven online or in-person forums, focus groups, and listening sessions and report on the findings	Q1-Q4	10/1/16-9/30/17
Conduct outreach and provide education to consumers and advocates, community organizations and stakeholder groups.	Q1-Q4	10/1/16-9/30/17
Compile and share results with CAB and PMO	Q1-Q4	10/1/16-9/30/17
Continue CAB monthly meetings	Q1-Q4	10/1/16-9/30/17
Common Scorecard		
Select measures and rating system	Q1	6/1/16-11/15/16
Determine website functionality	Q1	9/1/16-11/15/16
Obtain and analyze data, Finalize results	Q1-Q3	10/1/16-6/30/17
Select web development vendor and develop website with test data	Q1-Q13	10/1/16- 5/1/17
Publish first online scorecard	Q4	by 9/30/17