OLR RESEARCH REPORT

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HEALTHCARE INNOVATION PLAN

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You asked for a summary of the draft plan to implement the state's healthcare innovation grant. The plan is available at http://healthreform.ct.gov/ohri/lib/ohri/CT_SHIP_Draft1_10242013.pdf.

SUMMARY

In March 2013, the state received a $2.8 million grant from the federal Centers for Medicaid and Medicare Innovation (CMMI) to develop a State Healthcare Innovation Plan. State agencies, with the assistance of a steering committee representing various stakeholder groups, developed the draft plan, which was released in October 2013. The draft plan seeks to:

1. transform primary care practice to manage the total needs of the patients a practice serves;

2. improve community health through the coordinated efforts of community organizations, health care providers, employers, and public health entities; and

3. empower consumers to manage their own health, access care when needed, and make informed choices regarding their care.

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To achieve these goals, the plan proposes initiatives in healthcare provider performance transparency, value-based payment, health information technology, and workforce development. The plan seeks to increase transparency by creating a healthcare provider performance scorecard, including measures of patient health status, quality of care, consumer experience, cost of care, and resource utilization. It proposes to shift from a purely fee-for-service payment system, which rewards providers for delivering a greater volume of products and services, to value-based payment, which rewards providers for delivering high-quality care and a positive consumer experience. Among other things, the plan's health information technology strategy calls for implementing an all payer claims database and creating a multi-payer portal to give consumers and providers easier access to information and help them make better decisions. The plan also seeks to expand and improve the state's health workforce by, among other things, enhancing health workforce data and analytics and developing career pathways for health and allied health professionals.

The draft plan will be refined and submitted to CMMI by the end of December. The final plan will be implemented over five years starting in January 2014.

BACKGROUND

In March 2013, the state received a $2.8 million grant from CMMI to develop the plan. CMMI charged the state with designing new health care delivery and payment models that would include value-based payment tied to the care delivered to at least 80% of the state's population within five years.

The plan notes that Connecticut's residents are among the healthiest in the nation. On the other hand, significant health inequities and socioeconomic disparities persist, keeping the state from achieving better outcomes and a more effective and accountable care delivery system.

According to the plan, Connecticut has many innovative health care organizations, public entities, and community-based organizations that have made significant investments in improving health and health care. But these efforts have been mostly pilot programs, focused on specific populations or regions.

The plan notes that the state also faces the challenge of high health care costs. In 2012, health care spending was $29 billion, the third highest per capita spending ($10,470) in the country. These figures raise concerns about the affordability of health care coverage and the impact

of health care spending on business competitiveness with other states. Growth in health care spending has outpaced the economy's growth, leaving fewer resources to support education, housing, paying down consumer debt, or saving for the future.

DRAFT PLAN

Development

The plan was developed by representatives of the Office of the Healthcare Advocate, Department of Social Services, and Department of Mental Health and Addiction Services, with the healthcare advocate providing overall project direction. This group was advised by a steering committee with representatives of relevant state agencies, insurance companies and other payers, hospitals, employers, and foundations, as well as the dean of the UConn School of Medicine.

The plan had input from more than 20 consumer focus groups, surveys of almost 1,600 individuals, and more than 25 meetings with payers, providers, employers, and consumer advocates.

Goals

The plan seeks to

1. improve the health of all residents and eliminate health disparities,
2. improve healthcare in terms of quality of care and consumer experience, and
3. reduce the rate of growth in health care costs to improve affordability.

To accomplish these goals, the plan seeks to:

1. transform primary care practice to manage the total needs of the patients a practice serves;
2. improve community health through the coordinated efforts of community organizations, health care providers, employers and public health entities; and
3. empower consumers to manage their own health, access care when needed, and make informed choices regarding their care.

Primary Care Practice. A cornerstone of the plan is to support the transformation of primary care to the advanced medical home model, which among other things calls for coordinating care among teams of providers and making clinical decisions based on the evidence.

Community Health. Another key element of the plan is fostering collaboration among providers, employers, schools, community-based organizations, and public agencies to work to improve the health of populations within their communities. The plan calls for establishing health enhancement communities in high-risk communities to target resources and facilitate coordination and collaboration among multiple sectors to improve public health and reduce avoidable health disparities. It also seeks to strengthen community-based health services and linkages to primary health care by establishing certified community-based practice support entities. These entities would foster collaboration between primary care providers, community-based services, and state health agencies.

Consumer Empowerment. The plan seeks to equip consumers with information, resources, and opportunities to play an active role in managing their health. Specifically, it seeks to promote:

1. consumer input and advocacy;

2. enhanced consumer information and tools to enable health, wellness, and illness self-management;

3. consumer incentives for healthy lifestyles and effective illness self-management; and

4. improved access to health services.

Enabling Initiatives

The plan seeks to transform the health care system through performance transparency, value-based payment, health information technology, and workforce development.

Transparency. Stakeholders in the planning process stated that increased transparency of costs and quality is essential to improving the system. The plan seeks to increase transparency by creating a common provider performance scorecard, including measures of health status, quality of care, consumer experience, cost of care, and resource utilization.

To assure the accuracy of the scorecard, the state will:

1. aggregate data across payers to increase reliability of measures to allow for sample sizes that reliably reflect a provider's true performance;

2. use tools such as risk adjustment to lessen the risk that any single provider would be disadvantaged because of the composition of their patient population; and

3. require multiple levels of reporting to inform decision making by consumers, providers, and payers.

Value-based Payments. The plan proposes to shift from purely fee-for-service payments, which reward providers for delivering a greater volume of products and services, to a value-based payment system. This system is designed to reward providers for delivering high-quality care and a positive consumer experience. The plan asserts that value-based payment will also control the growth in health care spending over time.

The value-based payment strategy has four components:

1. creating Pay for Performance and Shared Savings Programs, in which payers provide incentives for provider's absolute performance and improvements in performance;

2. encouraging payers to tie the programs to a common scorecard for quality, experience, and resources utilization to (a) reduce complexity for healthcare providers, (b) increase the case for them investing in new capabilities, and (c) sharpen provider focus on specific measures of success that all providers support;

3. ensuring provider and payer independence in setting risk parameters and levels of outcomes-based payments; and

4. helping providers aggregate to assist them achieve the scale and capabilities necessary to effectively manage a population of patients.

Health Information Technology. The plan's health information technology strategy calls for:

1. implementing an all payer claims database to aggregate performance measurement for quality and resource utilization;

2. creating a multi-payer portal for consumers and providers to allow easier access to information and better decision making;

3. developing guidelines for care management tools; and

4. developing a standardized approach to clinical data exchange to accelerate providers' use of direct messaging for secure communication to other providers and to ensure coordinated care delivery across different sites of care.

Health Workforce. The plan lays out initiatives in six areas:

1. health workforce data and analytics;

2. inter-professional education;

3. training and certification standards for community health workers;

4. preparing today's workforce for care delivery reform;

5. primary care graduate medical education and residency programs; and

6. health professional and allied health professional training career pathways.

For example, under the plan, the state will collect and report real-time health workforce data, and will support the analyses necessary to interpret this data to estimate both current and future health workforce needs. Under the second initiative, the state will work with medical schools to train future caregivers together, particularly in subjects that pertain to population health and patient centered care, and to have much of this training tied to the direct care of consumers in clinical settings outside of institutions.

Implementation Schedule

The draft plan will be refined based on further stakeholder feedback and public comment. It will be submitted to CMMI by the end of December. Early next year, the final plan will guide the development of a proposal for a CMMI model testing grant that the state anticipates submitting next spring.

The final plan will be implemented over five years. A nine-month detailed design will begin in January 2014; a nine-month implementation planning process will begin in October 2014; Wave 1 Implementation will begin in July 2015; and implementation of successive waves will occur in fiscal years 2017-2020.

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