

Preliminary view of model that achieves goals of coverage and care

- I) Creation of Quasi Public Trust charged with:
 - Administration of coverage programs in which state of Ct. has an investment in managing value
 - a. data collection and analysis
 - b. Monitor risk segmentation and address adverse selection, as needed
 - c. Health Planning
 - d. Establishing standards
 - e. Establishing timing for phase in of coverage and system changes
 - f. Portfolio to include state employee plans, charter oak, newly created coverage options; option to include Husky/SAGA/Medicaid/Medicaid PCCM in future
 - g. Serve as liaison with plans outside of this portfolio
 - h. Monitor directly or indirectly progress towards reduction of racial and ethnic health disparities
 - i. Appointments to Trust to represent broad stakeholders group

- II) Quality improvement and cost containment
 - a. Improving quality through transformation of delivery system (* indicates potentially cost-saving initiatives)
 - i. Achieving "medical home" status: process and rewards*
 - ii. Chronic disease management, care coordination, care management, and case management: subset of the Trust, community based if unable to do at the practice level*
 - iii. Health Promotion and prevention, with incentives for individual responsibility*
 - iv. Value based plan design that incorporates evidence based medicine*
 - v. Integration of primary care with oral and behavioral health*
 - vi. Patient safety standards*
 - vii. Data collection and transparency
 - viii. Electronic Medical records: accelerating adoption, incentives and support*
 - ix. Achieving 100% e-prescribing across Ct.*
 - x. Auto-enrollment in Medicaid at point of licensure for providers
 - xi. Increase Medicaid rate to 100% of Medicare
 - xii. Include CHC and school based clinics*
 - xiii. Auto-screening and enrollment in Medicaid for uninsured at point of service as well as on-line screening for eligibility
 - xiv. Workforce development (reference Tonya Court report)

- xv. Public education on living wills*
- b. Cost Containment (** indicates potentially quality improving initiatives)
 - i. Pooling of risk
 - ii. Self Insurance
 - iii. Minimum medical loss ratio
 - iv. Pay for performance**
 - v. Reduce cost shifting for uncompensated care
 - vi. Value based plan design**
 - vii. Expanded IT**
 - viii. Medical Malpractice
 - ix. Revise consumer protections and insurance mandates to align with evidence based and value benefit design under aegis of Trust
 - x. Care coordination**
 - xi. Reduce admissions for ambulatory care sensitive conditions
 - xii. Universal
 - xiii. CON

III) Coverage

- a. Satisfied customers can keep existing coverage
- b. CT Health Partnership (state employee pool)
 - i. Provide parallel options to individuals and businesses
 - ii. Make options attractive by incorporating Value based design (public, transparent process)
 - iii. Expand benefits to include oral health and mental health
- c. Maximize federal participation-- convert SAGA to Medicaid (CMS waiver required)
- d. Enrollment in coverage
 - i. Through Trust for new coverage options
 - ii. Automatic enrollment in HUSKY, SAGA at point of service for eligibles
- e. Shared responsibility as the underlying principle: individuals, employers, and government all play a role in achieving our goals.

IV) Financing based on shared responsibility

- a. Business Contribution: employer share of health costs of individuals
- b. Individual contribution: share of health costs based on sliding scale and affordability index

- c. Government contribution to support affordability
 - i. Existing revenue streams
 - ii. Sin taxes
 - iii. Bonding for specific initiatives
 - iv. Additional federal funds