Connecticut Diabetes Partnership Report

Status of Diabetes Advisory Council Recommendations

November 2018

Connecticut Department of Public Health

TABLE OF CONTENTS

DIABETES PARTNERSHIP COMMITTEE MEMBERS

First Name	Last Name	Organization
Bak	Leigh	Yale Health System
Berzins	Melanie	North Central Area Agency on Aging
Boisvert	Rebecca	Hartford YMCA
Bundy	Alan	Novo Nordisk
Burnham	Stephanie	Connecticut SIM Office
Camp	Anne	Fair Haven Community Health Center
Campbell	Donna	Consumer and NAACP
Chasse	Mark	Connecticut Optometrists Association
Cook	Michelle	Connecticut Legislature
Czunas	Sandra	Connecticut Office State Comptroller
Dalal	Mehul	Connecticut DPH
Darrow	Sally	Wallingford YMCA
Dookh	Faina	Connecticut SIM
Dowd	Elizabeth	Connecticut DPH
Dubois	Christine	Boehringer Ingelheim
Everette	Tekisa	Health Equity Solutions
Farrell	Maureen	Regional YMCA of Western Connecticut
Forbes	Venton	Faithworks
Galushko	Marylou	Wallingford YMCA
Genuario	Maryann	Riverbrook Regional YMCA
Gordon	Subira	Department of Economic Opportunity
Gould	Bruce	CHCACT
Habbe	Steve	American Diabetes Association
Jensen	Monica	Connecticut DPH
Kozak	Cindy	Connecticut DPH
Krikawa	Linda	Qualidigm
Lanza	Ann	Novo Nordisk
Leibovitz	Paula	Consultant
McAvoy	Karen	Yale New Haven Hospital
Nadolny	Barbara	Stamford Hospital
Ostrout	Sherry	CCCI
Poulin	Stephanie	Connecticut DPH
Robinson-Rush	Dana	Department of Social Services
Rosen	Debbye	West Hartford-Bloomfield Health Department
Snow	Kenneth	Aetna
Waite	Jessica	Southern Connecticut Area Agency on Aging

First Name	Last Name	Organization
Werner	Sharon	Novo Nordisk
Wessel	Joan	Senior Resources
Zavoski	Robert	Department of Social Services

INTRODUCTION

The Diabetes Partnership is a state wide coalition of multidisciplinary diabetes collaborators from across clinical, public health, industry, government and other sectors. It was convened in 2014 by the Department of Public Health (DPH) to address diabetes prevention, education and policy initiatives in Connecticut. The Partnership took on a voluntary role of overseeing progress on action steps developed by the Diabetes Advisory Council (DAC) which was convened in August of 2016 to begin work in response to Public Act 16-66, An Act Concerning Various Revisions to the Public Health Statutes, Section 51. This act established, within available appropriations, the DAC within the Connecticut DPH.

The DAC was charged to (1) analyze the current state of diabetes prevention, control, and treatment in Connecticut and (2) advise the Connecticut DPH on methods to achieve the federal Centers for Disease Control and Prevention's (CDC) goals in granting funds to the state for diabetes prevention and control. The bill required the DAC to make recommendations by May 2017 to enhance these efforts. To accomplish this, the DAC reviewed the following:

Strategies to identify and enroll individuals at risk of diabetes in prevention programs;

Strategies to identify and refer individuals with diabetes for enrollment in formal education classes and management programs;

The status of health care organizations reporting on clinical quality measures related to diabetes control;

Existing state programs that address prevention, control, and treatment; and

Evidence that supports the need for such programs.

The Council met on a monthly basis. Members also participated in one of three (3) workgroups: Diabetes Self-Management Education, Diabetes Prevention for Type 2 Diabetes, and Clinical Quality Measures. Staff members from DPH facilitated these workgroups through monthly conference calls held in between the DAC full council meetings. Each workgroup formulated recommendations in the form of long-term goals and one-year action steps to meet the goals. The full council discussed and voted on both the recommendations and final report. The DAC completed its findings in April of 2017 and submitted its report to the legislature.[1]

Upon the completion of the DAC meetings, the Diabetes Partnership resumed quarterly meetings to review, monitor and suggest actions to advance the work of the DAC recommendations. This report summarizes deliberations of the Diabetes Partnership and reviews progress made towards the DAC recommendations over the one year period from June 2017 to June 2018 .

SUMMARY OF THE STATUS OF DAC RECOMMENDATIONS AND ACTION STEPS

Rec. 1.1: Secure Medicaid coverage for Diabetes Self-Management Education and Support (DSME/S) at American Diabetes Association/ American Association of Diabetes Educators accredited programs.

[1] Connecticut Department of Public Health (DPH) (2017). Diabetes Advisory Council Final Report. Hartford, CT: DPH. Available online: https://portal.ct.gov/DPH/Health-Education-Management--Surveillance/Chronic-Disease-Prevention-and-Health-Promotion/Diabetes-Advisory-Council.

Action step 1.1.1: Between May 2017 and April 2018, the DPH will secure actuarial services and assess the cost-benefit analysis of DSME/S for the commercially insured population in Connecticut and share the results with key change agents (e.g. legislators).

DISCUSSION HIGHLIGHTS: Although budget limitations precluded DPH from securing formal actuarial services, DPH proposed conducting a similar analysis using data from the All-Payers Claims Database (APCD) in partnership with UConn Health. DPH identified federal resources through the CDC 1305 grant and worked closely with CDC officials to secure permission to use grant funds for this purpose. The Partnership members agreed to this approach and advised that the Office of the State Comptroller (OSC) and State Innovation Model (SIM) team be closely involved in reviewing and advising on the analysis due to its potential to impact Value-Based Insurance Design Policy.

STATUS AS OF JUNE 30, 2018: UConn Health anticipates receiving data from the APCD by July 16, 2018 then developing and proposing a detailed analysis plan to DPH/OSC/SIM by August 29, 2018. The final analysis and report are anticipated to be available by November 30, 2018. *NB: APCD data was received in August, 2018; the final report is on track for completion*.

Rec. 1.2 Devise a plan and seek financial support to increase Connecticut's pool of lay and professional diabetes educators who represent at-risk populations, including, but not limited to, minorities and those residing in low socioeconomic and rural areas.

Action step 1.2.1: Between May 2017 and April 2018, the DPH will convene stakeholders who have vested interest in seeing more culturally diverse educators develop, including workforce investment boards, to identify one or two organizations to spearhead this initiative.

DISCUSSION HIGHLIGHTS: Although no organization stepped forward to spearhead this initiative, rich discussions took place on ways to increase cultural diversity of the lay and professional diabetes educators. Some of the organizations contacted to assist with this include the Northern Connecticut Black Nurse Association, the Hispanic Nurses Association, Capitol Community College, Qualidigm, the Connecticut Alliance of Diabetes Educator, (CADE), and the Western Connecticut Area Agency on Aging.

STATUS AS OF JUNE 30, 2018: Qualidigm is hiring culturally diverse staff to conduct the evidence-based Live Well with Diabetes program in the community. Western Area Agency on Aging, with grant support from the Connecticut Community Foundation, is focusing efforts on recruiting Spanish speaking and African American lay leaders for this program. CADE will be introducing the concept of mentorship in the fall, 2018.

Rec. 1.3 Modify cost sharing of Diabetes Self-Management Education and Support (DSME/S) by reforming insurance plans to decrease barriers such that DSME/S is not subject to insurance deductibles and co-payments.

Action step 1.3.1: Between May 2017 and October 2017, CT Community Care (CCCI) will conduct a literature search on how cost, even with insurance coverage, affects accessing DSME/S and then share the results with key change agents (e.g. legislators).

DISCUSSION HIGHLIGHTS: CCCI provided an article on DSME/S cost sharing from the Center for Health Law and Policy at Harvard Law School.[2]

[2] Center for Health Law and Policy Innovation of Harvard Law School (2014). Reconsidering Cost-Sharing for Diabetes Self-Management Education: Recommendation for Policy Reform. Available online: http://www.diabetespolicy.org/wp-content/uploads/2014/06/6.11.15-Reconsidering-Cost-Sharing-for-DSME.pdf.

STATUS AS OF JUNE 30, 2018: Based on the literature which demonstrates nationally that co-pays and deductibles are deterrents to enrollments in DSME/S national legislation is being introduced to exclude DSME/S services from Part B cost-sharing and deductible requirements.

Action step 1.3.2: Between May 2017 and April 2018, the DPH will work with Office of the State Comptroller and the State Innovation Model (SIM) Project Management Office to formulate recommendations for Value-Based Insurance Design (VBID) to address financial barriers to DSME/S access in the self-funded and fully insured health insurance markets.

DISCUSSION HIGHLIGHTS: VBID work is underway.

STATUS AS OF JUNE 30, 2018: Awaiting results of the UConn analysis of the APCD as Connecticut specific information will be valuable in formulating recommendations.

Action step 1.3.3: Between January 2018 and June 2018, the Office of the State Comptroller, SIM Project Management Office, and DPH will convey recommended Value-Based Insurance Design policies to the SIM employer-led VBID consortium to be considered for inclusion in the updated VBID templates for the self-funded and fully insured health insurance markets.

DISCUSSION HIGHLIGHTS: Please see above

STATUS AS OF JUNE 30, 2018: Please see above

Rec. 1.4 Build statewide Diabetes Self-Management Education capacity with emphasis on culturally and linguistically appropriate standards, and improved access.

Action step 1.4.1: Between May 2017 and April 2018, Connecticut Community Care Inc. (CCCI) will convene interested diabetes education providers to pursue American Diabetes Association (ADA) / American Association of Diabetes Educators (AADE) recognition in Tolland County.

DISCUSSION HIGHLIGHTS: DAC members generated a list of organizations with potential interest in delivering ADA/AADE recognized diabetes education in Tolland County.

STATUS AS OF JUNE 30, 2018: CCCI has met with five Tolland county organizations. One, based in a grocery store with a pharmacist and a registered dietitian, has expressed interest in pursuing AADE accreditation.

Action step 1.4.2: Between May 2017 and April 2018, Connecticut Community Care, Inc. will conduct outreach regarding the Diabetes Self-Management Program (DSMP) to leaders through the Connecticut Healthy Living Collective.

DISCUSSION HIGHLIGHTS: The importance of continual engagement with leaders was emphasized. CCCI and the Area Agencies on Aging that are contracted to conduct the DSMP actively reach out to workshop leaders at least once a year.

STATUS AS OF JUNE 30, 2018: A data-base of all DSMP workshop leaders is maintained by CCCI and is used to facilitate communication. The cthealthyliving.org website (accessed at: http://cthealthyliving.org/) is operational and provides up-to-date information for leaders and participants including dates/locations for leader trainings and community workshops. A Leader Appreciation Day was held on May 2, 2018 with 64 attendees.

Rec. 2.1 Secure coverage through accountable care organizations, commercial, state employee and Medicaid health plans for CDC-recognized Diabetes Prevention Programs (DPP).

Added action step: State employees action step – Office of State Comptroller to issue a RFP to conduct Diabetes Prevention Program for Department of Transportation (DOT) employees.

DISCUSSION HIGHLIGHTS: In an effort to learn from other state health departments that have implemented the DPP for state employees, several conference calls were conducted. Valuable information on how best to operationalize the DPP in this population was acquired.

STATUS AS OF JUNE 30, 2018: Discussions with the Office of the State Comptroller (OSC), which coordinates the health benefit plan for 250,000 state and municipal employees and their dependents, led to a new (pilot) program for Connecticut DOT drivers. DOT was strategically selected for the Diabetes Prevention Program pilot because drivers who have diabetes and require insulin may be at risk of losing their commercial driver's license. Care Management Solutions (same vendor at the state employee Health Enhancement Program) was selected as the vendor. They have access to some data already. As of July 2018, the program has been implemented in 7 DOT garages enrolling more than 120 drivers (note the DOT universe is 1,300 employees). OSC anticipates expansion to 12 garages and may consider further expansion of the program to all state employees.

Rec 2.2 Establish as a standard of care, the referral of patients with prediabetes or at risk for type 2 diabetes to CDC-recognized DPP by medical providers, other health service providers, or by self-referral.

Action step 2.2.1: Between May 2017 and April 2018, the Connecticut YMCA DPP will hold a minimum of two (2) state-wide learning collaborative meetings among DPP Coordinators/educators and health care providers to share best practices and resources with respect to provider outreach and engagement, and patient recruitment, referral and retention.

DISCUSSION HIGHLIGHTS: YMCAs held one meeting with the CT DPP sites and Y-USA held a National Conference Call on 1/29/18 to outline the three options for YMCAs delivering the DPP Program: (1) Proceed with Medicare /Health Insurance; (2) Proceed as YMCA Chronic Disease Program with Self-Pay and Worksite Programs; and (3) Deliver a non-YMCA branded DPP Program locally. Connecticut YMCAs are deciding which route to pursue. Meanwhile other DPPs have been launched in various locations across the state with various outreach strategies. Although improving, provider outreach and engagement, and patient recruitment, referral and retention need ongoing attention.

STATUS AS OF JUNE 30, 2018: The number of DPPs has gone from a low of 5 in March 2014 up to 13 in January 2018. Behavioral Risk Factor Surveillance System survey findings from 2016, the midpoint of Connecticut's five-year initiative to increase pre-diabetes awareness, show a 2.1 percentage point increase in the percent of adults who reported being told they had prediabetes, an increase from 6.3% in 2013 to 8.4% in 2016.

Rec. 2.3: Build statewide DPP capacity with an emphasis on culturally and linguistically appropriate standards, and improved access.

Action step 2.3.1: By April 2018, the Department of Public Health will identify up to five (5) geographic areas in the state with a high prevalence of at-risk populations and work with the DPP network to identify the steps and funding needed to implement DPPs in up to three (3) of those areas.

DISCUSSION HIGHLIGHTS: BRFSS maps of areas that are significantly worse than the state for healthy weight were used as a proxy for areas with high risk for the development of type 2 diabetes. These would be appropriate places to target DPPs. Locations include: Hartford, Manchester, Vernon, New Britain, Meriden, Middletown, Waterbury, Bridgeport, West Haven, Orange and several towns in eastern

Connecticut along the Rhode Island border. DPH data on obesity as proxy for pre-diabetes indicates areas of eastern Connecticut, Hartford and Waterbury as greater risk than state overall.[3]

STATUS AS OF JUNE 30, 2018: In an effort to increase the number of strategically placed DPPs, the new DPH grant application to CDC includes a plan to offer DPP Coach training in Connecticut. If approved, this training will target the high risk areas listed above. In addition, scholarship funds and transportation for participants may be provided.

Rec. 3.1 Implement diabetes-related clinical quality measures as part of:

a. Statewide and regional health dashboards to monitor and report the effectiveness of diabetes control efforts, and

b. An all-payer scorecard of Advanced Network/Federally Qualified Health Centers' (FQHC) diabetes control performance, aligned with the measures recommended by the SIM Quality Council to enable quality improvement efforts.

Action step 3.1.1: Between May 2017 and April 2018, the Diabetes Partnership will track the progress of the SIM Program Management Office (PMO) in developing and maintaining statewide and regional dashboards and an all-payer scorecard.

DISCUSSION HIGHLIGHTS: Connecticut SIM, in collaboration with UConn Health, developed and published a data dashboard. This dashboard will house data and information on population health, healthcare costs, healthcare delivery, and health insurance transformation. The dashboard presents overall results for each measure and details on age, gender, race/ethnicity, income, insurance payer as the data allows. The dashboard also displays six population health measures: Adult Obesity, Adult Diabetes, Adult Smoking, Childhood Obesity, High School Youth Cigarette Smoking, and Premature Death due to Cardiovascular Disease.[4]

STATUS AS OF JUNE 30, 2018: UConn Health is working with the SIM Quality Council to review attribution methodology, benchmarks, user interface, information sourcing, and measure feasibility to begin the process of designing the public scorecard. Due to the delay in obtaining APCD data the scorecard will most likely be published in late summer of 2018.

Rec. 3.2: Reporting organizations and data administrators develop data systems to build analytic capabilities, stratify, and report clinical quality data by race and ethnicity.

Action step 3.2.1: By September 2017, Community Health Center Association of Connecticut (CHCACT) undertakes a review to determine whether CHCACT and its members' existing data systems are sufficient to undertake the process of meeting Community and Clinical Integration Program (CCIP) data collection and analytic standards.

DISCUSSION HIGHLIGHTS: The electronic medical records (EMRs) that are used by the Federally Qualified Health Centers (FQHCs) in Connecticut came into compliance with 2015 meaningful use requirements in November 2017, potentially allowing the collection of more robust race and ethnicity

[3] DPH (2017). Local Analysis of Selected Health Indicators in Connecticut, Results from the 2011-2015 Connecticut Behavioral Risk Factors Surveillance System (BRFSS). Hartford, CT: DPH. Available online: https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/BRFSS/BRFSSCTLocalAnalysis20112015pdf.pdf?la=en.

[4] The Connecticut SIM Data Dashboard is available online: http://www.publichealth.uconn.edu/sim_dash.html?ohriNav=%7C.

data; however, among the Connecticut FQHCs, seven different EMR systems are in use which may complicate data collection.

STATUS AS OF JUNE 30, 2018: Currently, the FQHCs report race and ethnicity data to the Health Resources and Services Administration's (HRSA) for the Uniform Data Set (UDS) as part of the HRSA Health Center Program's requirements. However, the UDS race and ethnicity categories are not the expanded categories recommended by Community and Clinical Integration Program (CCIP). Collecting the data for the expanded race and ethnicity categories is challenging, and, because FQHC funding has been decreasing, it is not likely that they will be able to devote the staff and time to collect this more detailed data.

Action step 3.2.2: By December 2017, the DPH meets with or convenes state agencies with health care authority including the Department of Social Services (DSS), Department of Children and Families (DCF), Department of Mental Health and Addiction Services (DMHAS), and Department of Developmental Services (DDS) to seek endorsement of the Community and Clinical Integration Program Health Equity Improvement data collection and analytic standards for race and ethnicity.

DISCUSSION HIGHLIGHTS: Action step 3.2.2 is under the purview of the DPH Office of Health Equity. The Office of Health Equity Director position was vacant for approximately six months.

STATUS AS OF JUNE 30, 2018: DPH hired a Director for the Office of Health Equity. He was made aware of action step 3.2.2; however, this action step was put on hold because of the likely change of DPH administration with the election of a new governor in November 2018.

Action step 3.2.3: By December 2017, the DPH and the SIM Program Management Office meet with the Department of Social Services to discuss making the CCIP Health Equity Improvement data collection and analytic standards for race and ethnicity as a requirement of FQHCs that are participating in Patient Centered Medical Home Plus (PCMH+), and not already subject to the standards.

DISCUSSION HIGHLIGHTS: The SIM Program Management Office (PMO) provides awards and learning collaborative opportunities to promote race and ethnicity data collection and address barriers within electronic health records (EHRs) as they pertain to capturing subpopulation data.

STATUS AS OF JUNE 30, 2018: SIM is offering PCMH+ FQHCs an opportunity to receive transformation awards specifically to address the health equity improvement standard. Current Wave 1 Participating Entities are participating in learning collaborative activities to provide support in determining how to assess and capture subpopulations and how to address barriers within electronic medical records (EMRs). The Office of Health Strategy (OHS) in SIM is currently assessing the need for additional supplemental awards to enhance capabilities of EMRs. Because of the difficulties of collecting expanded demographic data, a subgroup may be needed to look at the expanded data collection.

Action step 3.2.4: By May 2018, as a result of meeting with the DPH and the SIM Program Management Office, the Department of Social Services includes the CCIP Health Equity Improvement data collection and analytic standards for race and ethnicity as a requirement of Federally Qualified Health Centers that are participating in PCMH+, and not already subject to the standards.

DISCUSSION HIGHLIGHTS: Please see above.

STATUS AS OF JUNE 30, 2018: Please see above.

NEXT STEPS

DPH will continue to address diabetes and prediabetes through CDC grant #DP18-1815. This funding opportunity supports the implementation and evaluation of evidence-based strategies to prevent and manage cardiovascular disease and diabetes in high-burden populations in the state. The DP18-1815 diabetes related strategies include improving the care and management of people with diabetes through increasing access to and coverage for ADA-recognized/AADE-accredited diabetes self-management programs and increasing the use of pharmacist patient care processes that promote medication management therapy. Also, the funding opportunity supports improving access to, participation in, and coverage for the National Diabetes Prevention program lifestyle change program for people with prediabetes. These strategies align with several of the recommendations listed in this report. Additionally, DPH will convene a new, joint Diabetes-Cardiovascular Disease Advisory Board. This advisory board will provide subject matter expertise and advice on best practices to implement DP18-1815 strategies.

GLOSSARY OF SELECTED TERMS

All-Payer Claims Database (APCD): Claims data from a variety of sources both commercial and governmental. The APCD contains historical data back to 2012, and current data from 2016 forward. Currently, the APCD holds commercial data from various health insurance carriers covering Connecticut residents, including eligibility, medical and pharmacy claims data. Medicaid and Medicare data will be incorporated in the near future, along with dental claims data. The data submitted will also include provider databases, which will detail information on physician, facilities and hospitals.[i]

Certified diabetes educator: A registered nurse, registered dietitian, registered pharmacist or selected other health professionals who document at least 1000 hours of experience working with people with diabetes and then successfully pass an exam administered by the National Certification Board of Diabetes Educators.

Community & Clinical Integration Program (CCIP): Care delivery standards and technical assistance 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. The CCIP program is intended to complement the Medicaid Quality Improvement and Shared Savings Program (MQISSP) and its associated requirement elements. MQISSP builds on the great success of the Department of Social Services' PCMH program. The combined effect of the MQISSP 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.[ii]

Dashboard: A graphical summary of important measures to monitor an entity's performance and support quality improvement processes.

Educators: Lay people and professionals who instruct people with diabetes on how to manage diabetes.

Health equity: Equity in health refers to how uniformly services, opportunities and access are distributed across groups and places, according to the population group. Equity in health implies that ideally everyone could attain their full health potential and that no one should be disadvantaged from achieving this potential because of their social position or other socially determined circumstance. Efforts to promote equity in health are therefore aimed at creating opportunities and removing barriers to achieving the health potential of all people. It involves the fair distribution of resources needed for health, fair access to the opportunities available, and fairness in the support offered to people when ill. (Adapted from the World Health Organization Concept Paper as cited by the American Medical Student Association, n.d.).

Key change agent: An individual or organization that brings about, or helps bring about, change.

Person-Centered Medical Home Plus (PCMH+): PCMH+ will build on DSS' existing person-centered medical home (PCMH) model. PCMHs offer coordinated, comprehensive primary health care that is accessible, continuous, compassionate and culturally appropriate.[iii] PCMH+ builds on PCMH by incorporating new Enhanced Care Coordination Activities and Care Coordination Add-On Payment Activities related to the integration of primary care and behavioral health care, building provider competencies to support Medicaid beneficiaries with complex medical conditions and disability needs, and promoting linkages to community supports that can assist beneficiaries in utilizing their Medicaid

benefits. PCMH+ is open to federally qualified health centers (FQHCs) and advanced networks (networks including one or more primary care physician PCMH practices, which may also include one or more other specified types of providers in the network). These participating entities may receive shared savings if certain benchmarks are met and shared savings for members are demonstrated.[iv]

Scorecard: Graphical representation of progress made toward meeting specific goals or of trends in measures (e.g. clinical quality measures).

Stakeholder: Individuals or organizations with a vested interest in the policy, activity, or initiative being promoted.

Value-based insurance design: A cost sharing strategy in which incentives are aligned to promote appropriate use of high-value services and adherence to treatment regimens and healthy behaviors.[v]

ENDNOTES

[i] Analyze Health CT. About the Data. Available at https://www.analyzehealthct.com/about-the-data.html.

[ii] Connecticut State Innovation Model (SIM). Report of the Practice Transformation Taskforce on Community and Clinical Integration Program Standards for Advanced Networks and Federally Qualified Health Centers. Available at http://www.healthreform.ct.gov/ohri/lib/ohri/work_groups/practice_transformation/ccip_standards/ccip_report_4-13-16_final_approved_3_30_16.pdf.

[iii] Connecticut Health Policy Project. FAQs about patient-centered medical homes in CT. Available at http://www.ct.gov/sustinet/lib/sustinet/pcmh_ct_faqs_20110310.pdf.

[iv] State of Connecticut Department of Social Services (DSS). Notice of Intent to Adopt Regulations: Regulation 17-01 – Person-Centered Medical Home Plus (PCMH+) Program (PR 2016-087). Available at https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/OLCRAH/1701PR2016087NOIPCMH.pdf?la=en.

[v] Value-Based Insurance Design Consortium. Value-Based Insurance Design Fact Sheet. Available at http://www.healthreform.ct.gov/ohri/lib/ohri/initiatives/vbid/vbid_fact_sheet.pdf.