AHEAD MODEL APPLICATION
CONNECTICUT

Commissioner Deidre S. Gifford

OFFICE OF HEALTH STRATEGY

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Acronym Glossary

AHEAD	States Advancing All-Payer Health Equity Approaches and Development
APCD	All-Payer Claims Database
APM	Alternative payment model
CHIP	Children's Health Insurance Program
CHNA	Community Health Needs Assessment
CMMI	The Center for Medicare and Medicaid Innovation
CT	Connecticut
DSS	Department of Social Services
DPH	Department of Public Health
FQHCs	Federally Qualified Health Centers
FFS	Fee-for-service
HCC	Health Care Cabinet
HIE	Health Information Exchange
HHS	Health and Human Services
HRSN	Health-Related Social Needs
OHS	Office of Health Strategy
OSC	Office of the State Comptroller
OPM	Office of Policy and Management soc
PMPM	Per Member Per Month
PCMH	Person-Centered Medical Home
PCMH+	Person-Centered Medical Home Plus
PCPAC	Primary Care Program Advisory Committee
SIM	State Innovation Model
SMA	State Medicaid Agency
SNAP	Supplemental Nutritional Assistance Program
SOCT PCI	OSC's Primary Care Initiative
TCOC	Total cost of care

I. Organizational Capacity

The Connecticut (CT) Office of Health Strategy (OHS) is the lead applicant and the Department of Social Services (DSS), the state Medicaid agency (SMA), is a subrecipient. OHS Executive Director Dr. Deidre Gifford is the immediate past DSS Commissioner and is the Governor's Health and Human Services (HHS) Senior Advisor. The DSS Commissioner is Andrea Barton Reeves.

In CT, nine HHS agencies provide services to millions of residents ranging from healthcare, services for older adults and people with disabilities, food assistance, childcare, mental health and addiction services, services for veterans and much more. An HHS Commissioners' Cabinet facilitates feedback, alignment, and collaborative decision-making supporting cross-cutting agency priorities. CT's Office of Policy and Management (OPM) is the Governor's staff agency and is responsible for the state budget and overall executive branch policy. The Governor's Office and OPM Health and Human Services Policy and Planning Division work closely with HHS agencies to set policy priorities. OHS and DSS also have strong working relationships with key legislators and committees to facilitate alignment on key initiatives, including the state's cost-growth benchmark, improving behavioral health, and increasing primary care capacity and investment. The Office of the State Comptroller (OSC) Healthcare Policy and Benefit Services Division administers health benefits for over 200,000 state employees, dependents, and retirees. OSC is working to expand opportunities for municipalities and non-profits to procure healthcare in coordination with the state. OSC coordinates closely with DSS and OHS on health reform, including Healthcare Cost Containment efforts and increased primary care investments and competencies.

Finally, the statutorily authorized Health Care Cabinet, established in 2011, consists of stakeholders from industry, providers, government, and advocates to advise the Governor on healthcare reform, and is proposed to play a critical role in States Advancing All-Payer Health Equity Approaches and Development (AHEAD) (see Model Governance). Taken together, CT benefits

from a strong and collaborative intergovernmental structure to advance the Governor's priorities around high- quality, high-value affordable healthcare.

OHS, the lead agency, has oversight over the state's health system planning and implementation, promoting effective health planning and quality healthcare provision to ensure access to cost effective healthcare services, and improving service availability and financial stability of such services in the state. OHS has extensive experience in collection, analysis and reporting of payment and quality data. The OHS team includes data analysts, healthcare administrators, cost and quality experts, and IT professionals. The work is conducted through four units: Health Data and Analysis, Health Innovation and Strategy, Health Systems Planning and Health Equity.

- Health Innovation Strategy – administers CT's Cost Growth and Quality Benchmarks and Primary Care Target and convenes the Quality Council and the Cost Growth Benchmark Steering Committee.
- Health Systems Planning - administers the Certificate of Need program, develops the Statewide Health Care Facilities and Services Plan and reviews financial data to assess hospitals' financial status, stability and sustainability.
- Health Data and Analysis - administers the Health Information Exchange (HIE) to facilitate coordination across care settings and the All-Payer Claims Database (APCD) which collects healthcare information to help assess costs, quality and efficiency; convenes the APCD Advisory Group and Data Release Committee and the Health information Technology Advisory Council; and guides the implementation of Race, Ethnicity and Language data collection.
- Health Equity – oversees the Community Benefit Hospital reporting, including Community Health Needs Assessment (CHNA) findings, works on evaluation and sustainability planning for CT's Universal Home Nurse Visiting Program, develops the State's Health Improvement

Plan, oversees the Community Health Workers Advisory Body and participates in statewide Health Equity initiatives.

DSS provides health and social services to nearly a third of CT's population with a strong focus on population health and health equity. DSS administers Medicaid and Children's Health Insurance Program (CHIP), also known as HUSKY Health, covering almost one million lives and social services supports addressing Health-Related Social Needs (HRSN) including food assistance through the Supplemental Nutrition Assistance Program (SNAP), and financial and utility assistance for individuals and families with low incomes. DSS has over 1,800 staff and an annual budget of $9 billion (state and federal funds).

Connecticut's Medicaid program is well-situated to successfully implement all aspects of the AHEAD model. The SMA operates the Medicaid program, unique among states, on a managed fee-for-service (FFS) model without managed care contracts. This structure helps CT implement the program efficiently and consistently statewide. For example, we have leveraged this model to roll out a state-wide quality-gated primary care shared savings program called PCMH+, later described in detail. We have one rate setting team in the SMA that will design, implement and negotiate directly with hospitals the global budget methodology.

OHS and DSS coordinate closely on healthcare reform and innovation efforts, including during the last OHS-led State Innovation Model (SIM) (2015-2020) where DSS actively worked on governance, technical design (Quality Measures Council) and implementation (current Medicaid primary care shared savings initiative, Person-Centered Medical Home Plus (PCMH+)). Some additional examples include:

- Both agency heads participate in the Governor's Health and Human Services Cabinet, coordinating policy and program implementation across agencies.

- Co-lead interagency hospital workgroup to vet policy issues related to hospitals, including Medicaid payments and hospital financial stability.
- Expanding health coverage through the Covered CT program which provides no-cost health insurance through the state-based Health Insurance Exchange to individuals not eligible for Medicaid below 175% of federal poverty level (FPL). DSS administers the program and OHS provides grants to community organizations for targeted enrollment outreach.
- OHS and DSS are improving race, ethnicity, and language data collection using American Rescue Plan Act (ARPA) funds to upgrade OHS and DSS data systems.
- Partner on administering an equity-focused maternal/infant health improvement program including universal nurse home visiting and Community Health Worker (CHW) support.
- Collaborate closely on primary care expansion and investment to align Medicaid and commercial efforts

Roles of the agencies in AHEAD

OHS will lead AHEAD research, reporting and planning; development, implementation and oversight of the Commercial Hospital Global Budget; align and oversee Statewide Accountability Targets in conjunction with the Healthcare Benchmarks Initiative; coordinate and manage AHEAD tasks across multiple agencies; support the Model Governance Structure and lead state Health Equity Plan development.

DSS will develop and implement the Medicaid Hospital Global Budget and align primary care recruitment with PCMH+ and further Medicaid primary care payment reform (including the DSS Primary Care Advisory Committee).

OHS and DSS will co-lead hospital and primary care recruitment and retention and the Model Governance Structure.

Organizational Structure – OHS and DSS

Dr. Deidre Gifford, OHS Executive Director, has extensive experience overseeing contracts, grants and program implementation, and will have overall project accountability as the Interim Project Director. Dr. Gifford's role will be to provide strategic direction, ensure coordination between all involved state agencies, participate in key CMS meetings, and serve as the public face in recruitment efforts. Elisa Neira, OHS Senior Director of Health Equity, reports directly to OHS' Executive Director, and will oversee new staff added to round out the existing agency expertise. This includes the AHEAD Durational Project Manager (DPM) and Lead Planning Analyst (LPA) to be hired under the model. The DPM joins the existing teams overseeing cost, quality and primary care efforts at OHS, and will oversee and coordinate all aspects of AHEAD, convene an AHEAD interagency workgroup to develop project plans, track action steps and ensure progress according to established timelines. Once a DPM is hired, the DPM will transition into the Project Director role and serve as the main contact to all notifications from CMS, as well as assuming oversight of the day-to-day activities of the program. The DPM and LPA will also provide leadership and support to the Health Care Cabinet subcommittee which will be the Model Governance Structure. Other key team members include Alex Reger, Cost Growth Benchmark Manager, Hanna Nagy, Lead Planning Analyst for Cost Growth/Quality Benchmark and Primary Care, and Olga Armah, Manager of Research and Planning. A Data Scientist, to be hired under the model, will coordinate data collection, measure/metrics estimation, track Model performance.

DSS will actively participate in in the model design, implementation, recruitment, monitoring and evaluation. State Medicaid Director, Gui Woolston, PhD will be the DSS lead. Bradley Richards MD, Medicaid Medical Director will lead DSS's AHEAD primary care initiatives, Ms. Nicole Godburn, Director of Certificate of Need/Rate Setting, Roland Claudomir, Principal Cost

Analyst and two additional Principal Cost Analysts and one Associate Accountant to be hired under the model will serve as the global budget payment team, and Mehul Dalal MD, Chief Policy Advisor will participate in the Model Governance Structure and support hospital recruitment.

As stated above, OHS will hire a DPM through a direct hire mechanism to expedite the recruitment process. OHS has already started to identify potential candidates. The DPM will be responsible for the hiring of all OHS AHEAD positions with input from the HE & SDH Director, Manager of Research and Planning and Fiscal Administrative Supervisor. Where possible, OHS and DSS will use direct hiring opportunities or other mechanisms that allow the state to also recruit outside of state government to grow the pool of potential candidates. The state posts all job opportunities through Jobs.CT.Gov as well as through professional networks, stakeholder lists and social media platforms. The state's goal is to recruit and onboard these key personnel no later than December 1, 2024, prioritizing the DPM to start shortly after the award.

AHEAD complements the work already underway in DSS and OHS, much of which is required by CT law, ensuring its continuation. This initiative will be embedded in the ongoing work and priorities of existing staff with leadership support. Between OHS and DSS a percentage of approximately 19 in-kind FTEs will be assigned to the project, breakdown outlined in a chart in the Budget Narrative. By in large our use of contractors will build on existing capabilities and experience in ways we have effectively utilized in the past, for example the proposed contractor for primary care outreach has been engaged in primary care recruitment in alternative payment models launched under CT's State Innovation Model and has worked effectively under the current supervisory and contract management structure.

Vendor Support

OHS and DSS plan to engage with existing and new vendors to accomplish this work, specifically on the front end/build up of structures and resources to prepare for roll out in 2027. As

stated above, some of these vendors have long-existing relationships with the state agencies and work hand in hand with state staff. Contracts include language that requires the vendors to support transition of any relevant activities to existing state structures and teams. OHS and DSS will lead this work through assigned staff that will support, and guide vendor work and under the supervision of state leadership, including the Project Director.

OHS has a contract with Bailit Health for analytical, technical and policy support on the Cost Growth Benchmark, quality benchmarks and primary care spending targets and technical expertise on primary care delivery system and payment models. Bailit has also supported OHS to develop a primary care roadmap to achieve primary care investment targets for commercial, Medicare and Medicaid payers. This on-going, state-funded activity will continue at least until 2026, and OHS looks to leverage this contract to support AHEAD. To support other AHEAD activities, OHS will also look to engage additional vendor(s) in developing the Hospital Global Budget Model policy and scope; evaluating quality measure structure and content; and supporting an expanded primary care strategy.

The SMA will leverage and expand existing contracts in the following ways: 1) our Medical Administrative Services Organization (ASO) will continue to support primary care practice recruitment, retention, and technical assistance and 2) to design and implement the Medicaid Hospital Global budget, the SMA intends to leverage existing contractors under a current or amended Advance Planning Document (APD), contingent on CMS approval.

Organizational charts are included in Appendix A, explaining roles and reporting relationships.

II. Description of Region

Connecticut has 3.3 million residents, comprised of 63% White non-Hispanic, 18% Hispanic or Latino, 12% Black, 5% Asian. Over the last decade, the state has been actively engaged in

healthcare delivery system redesign to address diverse population health needs and disparities. The state's initiatives focus on improving quality, outcomes, and cost.

The CT hospital system is comprised of 27 acute care hospitals employing over 51,000 people, and earning more than $15 billion in annual revenue, with net assets of $10 billion. CT averages roughly one hospital per 100 square miles. There are 9,420 total licensed hospital beds. Yale New Haven Health System (2,556 beds) and Hartford Healthcare (2,488 beds) are the two largest systems. Other health systems include Nuvance Health (916 beds) and Trinity Health New England (1,162 beds). There are 7 independent hospitals in the state.

According to DataHaven's 2023 Health Equity in Connecticut Report, CT is one of the healthiest states but has significant health disparities. Black and Hispanic residents are more likely to have poorer health outcomes than their white counterparts. These disparities include higher rates of asthma, diabetes, cancer, and infant mortality. A Universal Health Care Survey of 1,300 CT residents found that about 55% of Connecticut adults faced one or more healthcare affordability burdens in the past year, including lacking insurance due to high premium costs, delaying or forgoing healthcare due to expenses, and struggling to pay medical bills. Additionally, 24% of adults encountered challenges paying medical bills, including dealing with collection agencies, depleting savings, accumulating credit card debt, and facing financial hardships. Notably, 78% of respondents expressed worry about affording healthcare in the future.

As a result, CT has taken a multi-level systemic approach to improve healthcare delivery and better control healthcare cost growth. Established programs include a statutorily-established Healthcare Benchmark initiative that includes Cost, Quality and Primary Care Investment components; a Medicaid Person-Centered Medical Home (PCMH) established in 2012 based on a widely adopted national model with enhanced rates and a per member per month (PMPM) quality-

based payment; and Person-Centered Medical Home Plus (PCMH+) in 2017 that builds on PCMH with enhanced care coordination (PMPM add-on for FQHCs) and total cost of care shared savings/quality payments. OSC has vigorously pursued value-based payment strategies for the state employee health plan, including several bundled payment initiatives, an advanced primary care payment program and a Center of Excellence model.

To secure support from key entities for the healthcare service delivery model governance structure, our engagement plan is targeted and focuses on collaboration. We will initiate targeted outreach to hospitals, primary care practices, and local government, highlighting the benefits of helping to shape healthcare delivery reform. We will organize personalized meetings and informational sessions to articulate the shared vision, emphasizing how each entity's expertise and input are integral to the model's success. We will actively seek input, address concerns, and foster a sense of ownership among stakeholders. We will establish strong communication channels, such as regular updates, feedback mechanisms, and collaborative workshops to ensure ongoing engagement and adaptability. This approach will build a strong coalition committed to advancing healthcare delivery.

III. State-Wide Accountability Targets

Description of plan for Measurement of TCOC and Primary Care Spending:

CT has a well-developed, codified, and broadly supported Cost Growth Benchmarking System. CT began measuring statewide total cost of care (TCOC) and primary care spending in 2020, beginning with spending in calendar years 2018 and 2019. The program was initiated through an Executive Order in 2020 and put into state law in 2022. CT measures and publicly reports total healthcare expenditures (including insurance costs), per person total medical expenditure (TME),

selected measures of healthcare quality, and primary care spending annually, under the Cost Growth Benchmark Initiative.

Five insurers (with over 90% of the state's commercially insured and Medicare Advantage markets) annually report TME and primary care spending to OHS. DSS also annually reports Medicaid TME and primary care program spending. CT measures and reports (1) TME at the state and insurance market (i.e., commercial, Medicaid and Medicare) levels, and at the payer and large provider entity levels by market and (2) primary care spending as a percent of total spending at the state and insurance market levels and at the payer level by market.

OHS's most recent Healthcare Cost Growth Benchmark Results and the Primary Care Spending Target Results for 2020-2021 are as follows:

- Statewide healthcare costs grew by 6%, exceeding the 3.4% benchmark. Commercial healthcare costs grew 18.8%; Medicare costs grew 1.4% and Medicaid costs grew 0.8%.
- All five commercial payers and three out of four Medicare Advantage payers exceeded the benchmark for that period.
- Statewide primary care spending was 5.1% of total spending, achieving the 5% primary care target. Total spending breakdown by payer as follows: Medicaid 8.3%, commercial 3.9% and Medicare Advantage 3.5%.
- Two out of five commercial payers achieved the primary care target. None of the four Medicare Advantage payers achieved the target.

Data Collection - Medicaid and Commercial TCOC and Primary Care Spending:

CT annually obtains TCOC and primary care spending data from each applicable payer: (1) commercial: five largest commercial payers, (2) Medicaid and CHIP: DSS, (3) state employee plan: Office of the State Comptroller, (4) incarcerated residents: the Connecticut Department of Correction, (5) U.S. Veterans Affairs for its patients, and (6) Medicare : from the U.S. Centers for

Medicare & Medicaid Services (CMS). CT maintains an implementation manual for all data submitters, updated annually. Data are submitted in standard file formats by August 15th of each year and CT engages with data submitters in a data validation process.

Codifying TCOC and primary care investment targets in state executive order, statute, and/or regulation: CT's benchmark was established in 2020 by Executive Order. OHS established the benchmark with goals to slow spending growth and make healthcare more affordable while maintaining or improving quality and equity. The benchmark is the targeted year-to-year increase in healthcare spending per person. OHS set CT's benchmark in November 2020, for calendar years 2021-2025 based on a blend of forecasted per capita potential gross state product (PGSP) and forecasted median income growth. Formulas were developed and established with the advice of OHS advisory bodies. The detailed cost growth benchmark methodology is in the Healthcare Benchmark Initiative Implementation Manual. The per person spending growth target benchmark was set at 3.4% for 2021, 3.2% for 2022, and 2.9% for 2023, 2024 and 2025.

The primary care spending target is a supplemental strategy in CT to encourage increased primary care investment that can lead to better patient outcomes, lower costs, and improve patient experience. OHS is required to set primary care spending targets, as a share of total healthcare spending, for each year through 2025. OHS developed the definition of primary care providers and spending with the input of its advisory bodies. The definition built on a methodology established in collaboration with the six New England states (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont). Primary care spending targets are 5% for 2021, 5.3% for 2022, 6.9% for 2023, 8.5% for 2024 and 10% for 2025. The primary care spending targets are codified in state law. The law requires the Office of Health Strategy executive director to establish annual primary care spending targets in five-year increments. By July 1, 2025, she must establish the

benchmarks for the calendar years 2025-2030 (CGS § 19a-754g(b)(1)(A)), but the requirement that OHS set targets does not expire.

In 2022, Executive Order No. 5's provisions were codified into statute and introduced new annual reporting requirements for CT's cost growth benchmark and primary care spending target. Conn. Gen. Stat. § 19a-754 requires:

- Payers to annually report TCOC and primary care spending data to OHS.
- OHS to annually prepare and post a report on TCOC and primary care spending by payer and provider entity.
- OHS to submit a report to the legislature annually with spending trends, any unintended consequences or impacts to quality, and recommendations on strategies to increase the efficiency of the state's healthcare system; and
- OHS to hold an annual informational hearing on these results.

The statute also authorizes OHS to require any payer or provider entity found to be a significant contributor to healthcare cost growth or that failed to meet the primary care spending target, to participate in the hearing and provide testimony.

<u>Anticipated policy levers to increase primary care spending by commercial payers and Medicaid:</u> CT uses multiple levers to increase primary care spending by commercial payers and Medicaid to attain the primary care spending target. First, the state uses public transparency, annually reporting payer performance on primary care spending, to its Healthcare Benchmark Initiative Steering Committee, at an annual public hearing, in meetings with legislators and in its annual legislative report.

Second, OHS has held periodic private meetings with insurers to obtain their commitment to meeting the primary care spending target. Third, OHS, DSS and OSC meet periodically to coordinate on primary care policy. OSC has adopted many of the OHS recommendations for Advanced Primary Care payment and has implemented an Advanced Payment Model in the state

employee plan. OSC is committed to ensuring that state employees have access to high quality, equitable primary care as part of a comprehensive cost and quality improvement strategy.

In the 2024 legislative session, the Governor has proposed adding "Performance Improvement Plans" (PIPs) to the benchmark initiative. The legislation, if enacted, would allow OHS to impose a PIP on an entity that exceeded the benchmark or significantly contributed to the state exceeding the benchmark. Such PIPs would allow OHS to work with insurers and providers to expand investments in primary care to meet their PIP expectations. CT intends to continue to use these levers during Model implementation.

The 2024 Performance Improvement plan legislation is still being considered by the legislature. If the legislation does not pass this session, which ends on May 8, 2024, OHS will take the following steps to enforce root causes of exceeding the cost growth benchmarks:

- Continue to publicly report on root causes of excessive cost growth utilizing the current statutory authority to the fullest extent possible.
- Provide transparency and data regarding cost growth drivers in the state; and
- Continue to pursue legislation to enhance enforcement, such as performance improvement plans.

Engage stakeholders, including legislators, in understanding cost drivers and policy solutions to excessive cost growth.

Under current statute, OHS can require payers, providers and other entities that were determined to be significant contributors during the performance year to participate in an informational public hearing regarding growth in total health care expenditures and performance against the benchmark. During the hearing, entities will answer questions related to their contributions to unsustainable healthcare cost growth. OHS will utilize the information discovered

during the hearing to help inform the required annual report to the legislature, which can include legislative recommendations from OHS's Executive Director.

OHS is also considering additional mechanisms to increase primary care investment. DSS has made various investments in Medicaid and CHIP primary care, including in 2012, launched PCMH (described above) to improve access and quality of primary care; in 2013, increased primary payments under the Affordable Care Act, continued in modified form after federal requirements expired 12/31/14; and in 2017, launched PCMH+ (described above). Collectively, these represent significant investments in primary care, with some practices participating in multiple programs. DSS complies with federal Medicaid requirements for annual adjustments to FQHC prospective payment system rates, which also increases primary care spending. Finally, DSS continues to actively investigate future improvements to primary care both internally and with multiple stakeholders through its Primary Care Program Advisory Council.

<u>Regulatory and policy levers the applicant intends to use to achieve or enforce TCOC cost growth targets across payers:</u> CT has applied many of the same levers to achieve its TCOC target (cost growth benchmark) as it has for increasing primary care spending. First, the state used public transparency, publicly reporting payer performance relative to the TCOC benchmark annually to its Healthcare Benchmark Initiative Steering Committee, at an annual public hearing, in meetings with legislators and in its annual legislative report. Second, OHS periodically meets with insurers and the state's largest health systems to obtain their commitment to the TCOC benchmark. In its first legislative report on TCOC benchmark performance in October 2023, CT recommended phasing in performance improvement plans (PIP) with entities that exceed the benchmark and allowing application of a civil penalty if an entity willfully neglects to file a PIP. As described above, this recommendation is under consideration in the CT legislature in the 2024 session.

Known gaps in state TCOC and primary care spending reporting: According to CT's assessment, there are some minor but no significant gaps in state TCOC and primary care spending reporting. DSS is able to report some, but not all, spending stratified by provider entity (DSS cannot report spending for dually eligible population stratified by provider entity). Currently, CMS is unable to report to Connecticut TCOC in service categories consistent with the state's commercial payers and Medicaid, nor is CMS able to report primary care spending in alignment with CT's definition of primary care (CT can only report primary care spending for Medicare Advantage). We look forward to partnering with CMS to improve alignment. Finally, one insurer has been reluctant to provide Medicare Advantage spending data (representing less than 5% of the state's Medicare Advantage market), and one national commercial insurer has been unwilling to report a portion of self-funded commercial business. CT uses payer reported aggregate data to conduct the Cost Growth Benchmark and Primary Care Spending Target Analyses. CT also has in-house databases (All-Payer Claims Data Base, hospital discharge and Emergency Department data) for additional drill-down of statewide cost drivers.

Except for traditional Medicare data, CT currently includes TCOC and primary care data for FQHCs and dual-eligible populations. CT has always included payments to FQHCs in both TCOC and primary care spending calculations for the commercial, Medicaid and Medicare Advantage markets, and understands CMS to include FQHC payments in the TCOC spending data it provides CT for traditional Medicare. CT has always included payments on behalf of dual-eligible populations in both TCOC and primary care spending calculations for the Medicaid and Medicare Advantage markets and understands CMS to include payments made on behalf of the dual-eligible population in the TCOC spending data it provides CT for traditional Medicare. CT currently does not receive any primary care spending data from CMS for traditional Medicare for the dual-eligible population, FQHCs, or for the broader Medicare-only population. However, CT is hopeful that

under the AHEAD model, CMS will begin to provide CT with service category-level spending for traditional Medicare, inclusive of Medicare-covered spending for dual-eligibles, that will match the service category data that CT gathers from all other payers.

Proposed State Legislation to Address Healthcare Affordability

Recently, Governor Lamont introduced House Bill 5054 "An Act Addressing Healthcare Affordability", which among other things, proposes the following:

- establishes a Cost Growth Benchmark Oversight Commission,
- adds Performance Improvement Plans (PIPs) to the cost growth benchmark and allows OHS to impose civil penalties for failure to implement a PIP,
- provides subpoena power to compel participation in the annual Cost Growth Benchmark hearing, and
- establishes a new process whereby OHS would assess commercial insurer rate increase requests against a standard of affordability, in concert with CT Insurance Department.
- Allows OHS to conduct a Cost and Market Impact Review (CMIR) for entities that exceed the benchmark.

The above items, if passed by the state legislature and signed into law by the Governor, will directly enhance OHS's ability to collect and report on healthcare spending and empower OHS to implement concrete improvement strategies for Cost Growth Benchmark non-compliance.

IV. Hospital Recruitment Plan

In recruiting hospitals to participate in the AHEAD global budget, the state will build upon our existing collaborative relationships with hospitals to improve the healthcare system. As context, there are 27 acute care hospitals in the state of which 23 are non-profit, three are for profit, and one

is a state-operated hospital. Of the 23 non-profit hospitals, seven are independent. See map in Appendix B of all acute care hospitals, location, and affiliation with multi-hospital health systems.

The state and the hospitals work collaboratively in multiple areas, with ongoing dialogue and coordination. The state engaged with the Connecticut Hospital Association (CHA) and individual hospitals in developing current Medicaid inpatient and outpatient payment systems that launched in 2015 and 2016, respectively, as documented here. In 2019, the state and privately operated acute care hospitals entered a seven-year settlement agreement that provides predictability for Medicaid hospital reimbursement. OHS is currently working with CHA and CT commercial insurers on an administrative simplification Task Force aimed at reducing the burden of prior authorization for providers, payers and consumers. OHS has monthly meetings with CHA Leadership to discussing on-going issues of mutual interest.

In 2020-2022, the state and hospitals worked closely together on many fronts to help address the COVID-19 pandemic, including the state adding licensing flexibilities, paying higher Medicaid rate for COVID-19 hospital admissions, allocating Coronavirus Relief Fund (CRF) dollars to hospitals to help mitigate hospitals' costs related to COVID-19, establishing effective infection prevention strategies, and partnering to implement statewide testing and vaccination programs during the height of the pandemic. More recently, the state and hospitals collaborated on state legislation in 2023, Public Act 23-171, which, among other things, tasks DSS with preparing a report on the state's Medicaid program, including consulting with hospitals and exploring opportunities for improvement. CHA has extensively participated in the state's stakeholder engagement for Medicaid payment reform, especially primary care and maternity services. Leadership from CHA and the state's largest health systems serve on OHS's Healthcare Benchmark Initiative Steering Committee, and actively participate in quality, primary care and health IT advisory bodies.

The timing of AHEAD cohort 2 aligns perfectly with the settlement agreement, which expires June 30, 2026, and, with current payment changes typically being made at the beginning of each calendar year, January 1, 2027, is the logical time to begin a new Medicaid payment framework under AHEAD. Once the agreement has expired, there is more flexibility to explore mutually beneficial payment reform with the hospitals. The state has been discussing benefits of AHEAD with CHA and individual hospitals/systems. This collaboration and dialogue are key to recruiting hospitals to participate in AHEAD.

OHS and DSS conducted an initial assessment of CT's hospitals for AHEAD, reviewing financial status, payer mix, net patient revenue by payer type, geography and commitment to population health, health equity, and addressing HRSN. Based on this assessment, we held one-on-one conversations with three independent hospitals and two hospital systems. One hospital system, Trinity Health, has experience with TCOC and global budgets in Maryland. Two independent hospitals (Bristol and Day Kimball) have faced financial struggles that resulted in state allocations to help the hospitals maintain essential services. These hospitals expressed an interest in further conversations with OHS and DSS about participation in the model, but were clear that they will need further clarification of model details for Medicaid and Commercial payers, and further collaboration in order to make a firm commitment. Together, these hospitals represent 44 percent of the state's Medicare net patient revenue, as follows:

Hospital	**Affiliation**	**Medicare net patient revenue 2022***	**% of CT Medicare**	**Medicaid net patient revenue****
Bristol Hospital	Independent	$59,481,500	1.2%	$26,511,592
Day Kimball Hospital	Independent	$44,935,476	0.9%	$47,850,189
Griffin Hospital	Independent	$81,588,979	1.6%	$29,684,614

Trinity Health System (three hospitals)	Hospital System	$468,366,964	9.3%	$219,330,461
Hartford Healthcare (seven hospitals)	Hospital System	$1,586,866,669	31.4%	$604,771,127
TOTAL		$2,241,239,588	44.4%	

*Based on hospital self-reported data from 2022 CT OHS Fiscal Stability Reports. The figures represent total Medicare revenue, the hospitals do not report MA and FFS separately. In 2022, MA covered approximately 52% of the CT Medicare population.
** Not inclusive of Medicaid supplemental payments

Below is an illustrative example of the percent of hospital services and percent of statewide net patient revenue for care received by residents in the state that could be under a global budget in the AHEAD model.

Hospital or Health System	Inpatient & Outpatient Equivalent Discharges 2022*	% of Total Inpatient & Outpatient Equivalent Discharge - 2022*	Hospital Net Patient Revenue 2022*#	Statewide Net Patient Revenue % - 2022*
Bristol Hospital	16,206	2%	$145,811,299	1%
Day Kimball Hospital	12,600	1%	$106,511,797	1%
Griffin Hospital	19,708	2%	$218,699,686	1%
Trinity Health System (three hospitals)	81,286	9%	$1,201,262,904	8%
Hartford Healthcare (seven hospitals)	210,700	24%	$3,977,915,847	27%
TOTAL	**340,500**	**39%**	**$5,650,201,533**	**39%**

*Based on hospital self-reported data from 2022 CT OHS Financial Stability Reports and Hospital Reporting System.
Not inclusive of Medicaid supplemental payments

OHS does not have access to TCOC data by hospital or health system. (OHS uses "Advanced Networks" in monitoring TCOC for the benchmark program, which is similar but not identical to hospitals and health systems.) For purposes of this application, OHS and DSS believe that TCOC percentages would roughly align with Net Patient Revenue percentages, such that the

hospitals we have approached would represent roughly 39% of statewide TCOC. Hospitals generally expressed interest in learning more about AHEAD and the state's plans for implementation. At this early stage of program development, before making any firm commitments to participate, hospitals are looking for detailed information about the model in order to analyze how it could potentially align with their missions, business plans and community health needs. OHS and DSS are encouraged by the conversations and intend to continue regular conversations with these and other hospitals and stakeholders.

Recruitment Timeline

CT will approach recruitment as a total package of benefits of AHEAD participation tailored to individual hospitals or systems. We will highlight the financial and operational benefits of participation inclusive of Medicare, Medicaid, and commercial hospital global budgets, and AHEAD primary care, as well as the opportunity to meet healthcare benchmark targets through AHEAD participation. The 30-month planning period will allow time for discussions with hospitals and commercial payers and allow hospitals to conduct their own financial assessments as additional details about the various payers' global budget methodologies are developed and shared.

While early recruitment will be broad with the goal of onboarding any eligible hospital ready to start in Wave 1 (given the incentives available in the first 2 years), the state anticipates that some larger health systems will be more apt to participate later after seeing other hospitals' experience. The state will highlight incentives available for early sign-on such as the Transformation Incentive Adjustment while also leveraging the state's additional flexibility to adjust the Medicaid hospital payment methodology after the end of the state's settlement agreement with the hospitals. In addition to the broad recruitment efforts, the state's strategy is to also focus conversations and outreach with the seven independent hospitals as their needs vary significantly from larger health

systems and the state is already providing funding to some of those hospitals. As Wave 1 recruitment unfolds, the state is ready to re-strategize recruitment efforts to add an additional targeted and meaningful Wave 2 round of recruitment. For example: first wave focusing on the cohort of hospitals and systems listed above and any additional hospitals ready to sign on and targeting 10% Medicare FFS participation by PY1. The second wave will focus on any safety net hospital not signed on to Wave 1 and broader health system participation targeting 30% Medicare FFS participation by PY3. Below is the recruitment timeline:

2024 Quarters 3 & 4 through 2025 Quarter 1 *July 2024-March 2025*	Ongoing engagement, education, and targeted recruitment (wave 1)	• OHS and DSS will continue dialogue with the hospitals already identified in preliminary conversations, including the seven independent hospitals. • OHS and DSS will perform a more thorough assessment of hospitals to identify additional hospitals for targeted recruitment due to their financial sustainability, leadership priorities, geographic location, population served and alignment with AHEAD. • Host webinars for education about AHEAD for all eligible hospitals and 1:1 technical assistance and support for interested hospitals exploring feasibility of model. • Continue to define potential partnerships with the CHA and their role in supporting member hospital participation. • Once a contractor for Hospital Global Budget Policy Development is on board, DSS and OHS will engage with all eligible hospitals and other interested parties on the Medicaid and Commercial global budget methodology development.
2025 Quarter 2 *April 2025 – June 2025*	Joint commitment to proceed with negotiations	OHS and DSS will negotiate with hospitals where there is joint commitment to work towards agreement for a January 2027 launch.

	(wave 1)	Identify teams in OHS and DSS to proceed with hospital negotiations. Parties will work on timeline to draft scope and terms, review and sign agreements before implementation.
2025 Quarters 3 & 4 *July 2025 – December 2025*	Medicaid/Medicare substantive engagement with participating hospitals (wave 1)	Make technical assistance and support available to hospitals to work on global budgets, scope, quality and equity measures, payments, administration, and monitoring and reporting. Engage with federal partners on recruitment supports, strategies and questions that may come up regarding Medicare.
2026 Quarters 1 & 2 *January 2026 – June 2026*	Finalize negotiations on Medicare FFS and Medicaid HGB and finalize agreement drafts for review Wave 2 recruitment	Wrap up outstanding open questions regarding budgets, scope, payments, overall administration and expectation regarding monitoring and reporting. Finalize agreements to start final reviews before execution. Officially launch wave 2 recruitment
2026 Quarter 3 & 4 *July 2026 – December 2026*	Hospital agreements fully executed (wave 1)	Execute agreements. Host initial pre-implementation meetings after
Jan 2027-Jan 2029	Wave 2 discussions and negotiations Wave 1 - retention	Follow recruitment, discussion and negotiation steps as listed above with wave 2 hospitals and systems. Closely monitor wave 1 participant performance, co-develop risk and mitigation plans to support ongoing retention

There are no critical access or rural hospitals in the state. There are seven hospitals in CT that are considered safety net hospitals – Bridgeport, Yale New Haven, St. Francis, Waterbury, Saint Vincent's, Hartford, and Danbury Hospitals (all are part of health systems). Two of these hospitals are part of the health systems the state has already connected with and plans to continue engagement. All will be approached as part of broader engagement efforts for Wave 1 and using the Transformation Incentive adjustment to facilitate participation in the first 2 years. The state will leverage existing partnerships described above for recruitment and potential participation. Some of

these hospitals, have existing partnerships with the state and we anticipate early engagement. As mentioned, several CT hospitals are currently receiving intermittent financial assistance from the State, the receipt of which is governed by agreements between the state and the receiving facilities. Should hospitals continue to request such aid the state could engage in conversations regarding the Hospital Global Budgets. For example, Bridgeport and St. Vincent's Hospital has a partnership with the state's Office of Early Childhood/OHS/DSS to implement CT's first Universal Nurse Home Visiting program. This partnership is looking to improve infant and maternal health outcomes and address HRSN through CHW interventions.

As described, CT's settlement agreement with hospitals expires July 2026. This timing presents a unique opportunity for AHEAD implementation as DSS is beginning to explore alternative payment models that could be used for hospital payment after the settlement agreement and coordinated with AHEAD global budget payments. First, the settlement agreement enabled the state and the hospitals participating in the settlement (all in-state non-governmental short-term general hospitals, but not including other hospitals, such as the state's public university hospital or the separately licensed children's hospital) to come to agreement on payment methodology. During the settlement negotiations, among other topics, the state and the hospitals discussed the general need for and benefit of exploring alternative payment methodologies to enhance incentives to improve outcomes for members and value for the state, especially for behavioral health services. The settlement agreement itself provided a framework for further discussions to inform hospital value-based payment. Pursuant to that language, the state and hospitals had an initial conversation about hospital value-based payment shortly after the agreement was finalized in early 2020, but our collective focus on responding to the COVID-19 pandemic and other priorities delayed any significant follow-up on those conversations, although in recent months, the state and the Connecticut Hospital Association have had some brief conversations about hospital value-based

payment. The Connecticut Hospital Association has also actively participated in DSS's advisory councils for other (non-hospital) value-based payment approaches, including the proposed maternity bundled payment and further primary care payment reform. The state will use a collaborative approach to continue engaging with the hospitals and seeking their input to help inform the state's design of the Medicaid AHEAD hospital global budget payment methodology. Second, the expiration of the settlement agreement effective July 1, 2026 will enable the state to have more flexibility in updating the Medicaid payment methodology for hospitals, including the AHEAD hospital global budget for participating hospitals.

The state's existing cost growth benchmark also serves as a tool to engage hospitals in advanced payment models and enhanced primary care investment. To strengthen this tool, Governor Lamont proposed legislation to address Health Care Affordability as detailed above. OHS has identified hospital costs, both inpatient and outpatient, as primary drivers of cost growth in CT. The AHEAD model presents an opportunity for hospitals to engage in strategies that will address cost growth concerns while meeting quality and equity targets.

Recruitment Goals

CT's recruitment goals are to meet PY 1 milestones through the participation of an initial set of interested hospitals as described in the recruitment timeline constituting at least 10% of CT's Medicare FFS Net Patient Revenue. To achieve 30% Medicare FFS by PY3, beginning in the pre-implementation period, we will target recruitment with larger health systems, including safety net hospitals not part of Wave 1. While expressing interest in continued engagement and conversations, based on initial engagement, some areas for continued development of detail were identified including:

- Hospitals emphasized needing more details about AHEAD, specifically global budget methodologies (Medicare GB became available in February and most conversations happened

earlier). DSS has alleviated some of those concerns by explaining the state's strategy to apply for Cohort 2, creating more time to develop the Medicaid global budget model.

- Hospitals raised concerns around alignment with their existing ongoing efforts to improve quality and reduce cost and utilization and how those can be incorporated into this work.
- Hospitals expressed the need to account for certain volatile and high-cost services in the global budget methodology and are interested in discussing methods to preserve access, such as excluding certain services from the global budget.
- Based on on-going efforts and experience, some hospitals also raised concerns about HRSN screening and referrals, and the community's ability to meet these needs without significant investments. This will be critical for the Health Equity plan development for both the state and participating hospitals as well as representation of social services agencies in the MSG.

CT is well positioned to meet the milestones in the AHEAD model given the timing of the state's Medicaid payment settlement with the hospitals and the existing work happening in CT. The state welcomes the support of CMS with hospital engagement as it will greatly support and enhance state efforts and conversations with the hospitals. Early engagement on the above issues, and early monitoring and reporting will be important to address concerns/challenges and unintended consequences. Early success will help future recruitment and retention.

CT will use existing policy and regulatory levers for recruitment and retention efforts including:

- Public Act 22-118 which requires OHS to set an annual health care cost growth benchmark and primary care spending target which is adjusted every five years. The next adjustment will happen in 2025 for the next five years.

- AHEAD also compliments the current primary care spending target, which encourages payers to spend a minimum percentage of healthcare dollars on primary care services. This additionally helps payers, providers, and other entities to meet the cost growth benchmark.

V. Hospital Global Methodology Development

DSS has experience with implementing major changes in Medicaid payment methodologies and is uniquely positioned as a non-Managed Care state to implement a standardized AHEAD payment model working directly with provider partners without the need for an MCO intermediary. For example, it implemented Medicaid inpatient and outpatient hospital reimbursement modernization from 2013-2016 referenced above (and see this DSS webpage: Medicaid Hospital Reimbursement--Related Resources (ct.gov). DSS worked with staff across multiple units, its Medicaid Management Information System (MMIS) vendor and ASOs, and expert consultants to develop and refine the reforms, as well as OPM, and CMS (for federal Medicaid approval). DSS also engaged extensively with CHA, individual hospitals, and other stakeholders. Similar to AHEAD, this work involved detailed modeling and projections, stakeholder engagement, and governing documents (including federal Medicaid authority application, legislation, bulletins, and others). Additionally, DSS has worked extensively with a stakeholder advisory council (which included active CHA participation) on the design and implementation of our HUSKY Maternity Bundle as part of our focus on health equity and overall move towards value-based payments. The system is currently in the technical design and testing stage, with an anticipated launch in fall 2024.

Using the CMS Medicare global budget methodology as a starting point, DSS will use a similar stakeholder engagement and design approach for the AHEAD model and hospital global budget methodology.

Leveraging our single state ASO contract to assist, DSS also has experience in implementing value-based payment methodologies, especially PCMH+, described above, which builds on PCMH. Practices that generate savings and meet quality standards can share in savings achieved; unearned savings can be earned based on quality performance by other participating providers. Additionally, as described further in the primary care vision section, DSS launched a Primary Care Redesign initiative to review care delivery and alternative payment options as successors to the PCMH and PCMH+ models.

As noted above, CT's Medicaid managed FFS structure is an advantage for AHEAD, since the SMA has more direct control over hospital payment without Medicaid managed care organizations (MCOs) intermediaries. DSS has direct oversight of coverage, reimbursement, and provider qualifications, leveraging ASOs to administer day-to-day program operations. CT expects to use a Medicaid state plan amendment (SPA) and/or an 1115 waiver to implement the changes to the program for AHEAD. CT has significant experience using the Medicaid state plan to implement innovative payment approaches, including PCMH+. CT has two approved 1115 demonstration waivers and is actively working to expand one of its 1115 demonstrations.

Regulatory Approach. The state proposes to use the most streamlined regulatory approach feasible, leveraging DSS's experience with hospital modernization. The state agencies will work together, with the input of hospitals and other stakeholders to put forward legislative proposals that can support AHEAD if needed. (CT statute requires legislative committee approval of 1115 demonstration proposals and legislative notification for SPAs, but it is not clear that additional statutory changes would be needed to implement AHEAD). Consistent with CT Medicaid's managed FFS structure described above, the multi-agency team will also work together on a Medicaid State Plan Amendment to the full extent feasible based on the model and will prepare and request an 1115 waiver as necessary to enable any portion of the global budget model not

approvable in the state plan. If a Medicaid State Plan Amendment is not sufficient by itself to obtain federal authority to claim federal Medicaid matching funds for the hospital global budget and a section 1115 waiver is needed, we will be prepared to submit a formal 1115 waiver on or before January 1, 2026, consistent with Model milestone "submit full detailed methodology to CMS for review and approval 12 months prior to the start of PY1" on page 122 of the NOFO. Based on our previous experience with CT's two currently approved 1115 waivers, provided there is opportunity for informal dialogue before formal submission (which we regularly seek with CMCS on significant projects), 12 months is anticipated to be sufficient. We anticipate ongoing dialogue with CMS, both CMMI and CMCS, prior to our submission, including submitting an initial proposal 18 months prior to the start of PY1 consistent with the NOFO Model Milestones. We understand that CMS is currently processing a high volume of 1115 waivers and we would welcome further discussion around ways to expedite CMCS's review of our application.

See table below from the AHEAD Notice of Funding Opportunity's Appendix XII with CT's added deadlines and comments.

Interim Milestones	**Timeline of Activities and Deadlines**
Submit initial proposal for any regulatory pathway/change needed for Medicaid hospital global budgets to CMS (note that this is a requirement under the AHEAD model and not a requirement for authority application from CMCS)	By July 1, 2025 (18 months prior to the start of PY1)
Submit full, detailed methodology to CMS for review and approval	By January 1, 2026 (12 months prior to the start of PY1)
CMS approval for the regulatory pathway/change needed for Medicaid Hospital Global Budget Implementation	By July 1, 2026 (6 months prior to the start of PY1)
Obtain CMS approval on full, detailed methodology	By July 1, 2026 (6 months prior to the start of PY1)
Demonstrate readiness for Medicaid Hospital Global Budget Implementation, as evidenced by finalized methodology and hospital recruitment	By October 1, 2026 (90 days prior to the start of PY1)

Final Milestone	**Timeline of Activities and Deadline**
Implementation of Medicaid Hospital Global Budget(s)	By December 31, 2026 (end of PY1)

DSS and OHS will engage with stakeholders including PY 1 hospitals and other interested hospitals in the development of the global budget methodology for Medicaid (DSS) and commercial insurance (OHS) during the first phase of the Pre-Implementation period between July 2024 and March 2025). This engagement will be supported by the Global Budget Policy and Stakeholder Outreach vendor which we anticipate can be on board between six to eight months after award. Additionally, OHS and DSS will convene the Health Care Cabinet, CHA, and other advisory bodies with vested interest and in-depth expertise on hospital payments. Based on preliminary conversations, hospitals have expressed they would like to understand in much more detail the Medicaid hospital global methodology in order to assess the financial implications. At least one hospital expressed that the development of the methodology should be a collaborative process. Additionally, hospitals have asserted that they believe Medicaid payment levels should be higher and have requested that the hospital global budget design should address their concerns regarding the overall payment level. DSS is separately analyzing the rates of hospitals and other providers. DSS's preliminary analysis indicates that Medicaid payment level is reasonable and adequate, particularly in light of the significant increases in rates and related factors, plus increased supplemental payment, most of which were implemented pursuant to the settlement agreement between the state and the hospitals referenced above. We anticipate building on long-standing relationships and foundational principles built with stakeholders that have been engaged in payment reform conversations, most recently with the DSS Primary Care Program Advisory Committee (PCPAC) described below in

"vision for primary care transformation) including addressing any services that need to be excluded from the global payment methodology to preserve access and quality.

In regards to the Medicare FFS Methodology, the state does not anticipate any major challenges, although, DSS anticipates wanting to tweak the Medicare FFS methodology to address the specific concerns of the Medicaid population and Medicare program. Some of the potential issues that we are working through – if selected:

- Cash flow for hospitals. In general, global budgets will *improve* cash flow positions for hospitals. It is possible, however, that in some cases, some hospitals in particular circumstances might experience some cash flow constraints, since payments are to be made to hospitals in biweekly increments, but patient volume and acuity are not level throughout the year.
- Weighting of years. Another issue may result from the third-year data collected as hospitals may feel year three may not be representative of future periods, particularly since year three is weighted at 60%.
- Transparency to hospitals. Lastly, hospitals may be hesitant to enroll due to the adjustments reflected in the hospital performance i.e., Quality Adjustment, and Health Equity Improvement Bonus which may be difficult to predict at the beginning of the program. We would work with our hospitals to provide as much clarity on their performance as early as possible.

If awarded, the state will need to address these challenges with our various partners and stakeholders to develop future solutions. We anticipate and welcome the opportunity to work closely with CMS and hospital awardees to solve for these issues. We view these issues as very solvable.

Regarding any particular incentives that might benefit the Medicaid population that the State anticipates building into Medicaid HGB methodologies. Depending on the exact details of the Medicare FFS methodology, for any particular item, we may not need to make a tweak.

If selected, Connecticut would also look forward to getting advice from other states, including Maryland and Pennsylvania and Vermont, as well as Connecticut-based stakeholders.

Long term care. Medicaid covers more long-term care than does Medicare. Hospital discharge planning plays a large role in helping Medicaid members either return to home or go to a nursing home. Since Medicaid is often the majority payor for long-term and nursing home services, Medicaid will want the hospital global budget to encourage hospitals to coordinate discharge planning to encourage "discharge to home" planning. We will want to ensure that the Medicaid global budget encourages this careful discharge planning, including as it relates to long term care.

- Patient churn. Medicaid members are more likely to come in and out of coverage than Medicare members; we look forward to carefully reviewing the details of the Medicare global budget to understand if we need to tweak the approach to members who have left the program.
- Behavioral health and Serious and persistent mental illness. BH and SPMI services are especially important to Medicaid populations, and the model will need to address how continued access to these services can be maintained; for example, risk adjustment, hospital units that primarily serve patients with these conditions, etc. When the Medicare details become available, we look forward to reviewing and determining if we need to make any tweaks.

VI. Vision for Primary Care Transformation

Leveraging its transition to a managed fee-for-service model in 2012, DSS has actively invested in APMs and primary care transformation for Medicaid beneficiaries. A complementary set of efforts to contain primary care costs, increase primary care spend, and improve patient care have been supported by the Governor's Office, OHS, and OSC. Lessons from these efforts put CT Medicaid in an ideal position to align with the AHEAD model on enhanced primary care payments, quality and performance measures, and create accountability for well-coordinated, person-centered care. As DSS continues to evaluate Medicaid primary care and develop its vision for the next iteration of primary care payment, the state is in an ideal position to shape the vision to align with AHEAD primary care.

Current Medicaid Primary Care Initiatives and Goals

PCMH and PCMH+ Programs. As described above, DSS currently has two primary care programs with distinct requirements and payment models: PCMH and PCMH+.

PCMH, established in 2012, is based on a widely adopted national model with around an enhanced FFS rate and PMPM quality performance-based payment. Practices must obtain National Committee for Quality Assurance (NCQA) PMCH recognition to participate, with a glide path program of technical assistance for practices seeking to become PCMH practices. 56% of CT Medicaid's PCPs are with a PCMH recognized practice and 55% of all CT Medicaid members are attributed to a PCMH practice.

PCMH+ was established in 2017 and builds on PCMH by enhancing care coordination with a care coordination PMPM add-on for FQHCs and a quality gated upside-only total cost of care shared savings payment. The established PCMH+ quality measure set includes scored and reporting measures and is broadly aligned with AHEAD goals and measures.

Care Management in Primary Care. In addition to our two primary care programs, DSS uses ASOs to help oversee and deliver behavioral, medical, and care management services and to address HRSN

for our members. Community Health Network of Connecticut (CHNCT) has been our medical ASO since 2012. CHNCT and DSS developed an Intensive Care Management (ICM) and Targeted Care Management (TCM) program. CHNCT's ICM and TCM programs focus on the complex care management of members with multi-morbid conditions (i.e., high risk perinatal, chronic health conditions, neonatal intensive care unit program, sickle cell disease), barriers to optimal care, and psychosocial needs. Using a multi-disciplinary, person-centered approach, ICM provides comprehensive case management services to increase member engagement with a primary care provider (PCP), decrease potentially avoidable hospitalizations, and reduce health disparities. In 2022, DSS's new contract with CHNCT improves service delivery to better meet members' needs and align further with our primary care programs. Initially, ICM focused on nurses providing care coordination and case management services via telephone and connecting complex members with CHWs. Now, the ICM reduced the number of nurses providing care coordination/case management services to members via telephone and significantly increasing the number of CHWs in CHNCT. This change acknowledges CHWs' integral role in addressing HRSN as liaisons between individuals, communities, and health/social services to facilitate access and improve quality and cultural responsiveness. CHWs help identify and connect members with a primary care provider in addition to assessing for other needs.

OSC's Primary Care Initiative. OSC, which manages the state employee health plan, launched its Primary Care Initiative (SOCT PCI) in 2022 to improve healthcare coordination, quality and outcomes while reducing overall cost. The TCOC model creates a reimbursement structure with upside and downside risk for cost targets on medical and pharmacy services, provides additional funding, enhanced reporting, dedicated staff and other resources, to participating advanced primary care groups. This structure is intended to drive improvements in key areas identified by the CT OHS Primary Care Road Map, which lays out strategies to ensure that increased primary care investments

yield meaningful and measurable benefits. Quality bonus payments are paid to participating providers for performance on quality measures from OHS's standard measure set. Enhanced care coordination funds (CCF) are invested in some, or all of the 11 target areas identified in the roadmap to improve high-quality primary care. Participating CT PCI providers must annually report to OSC, describing how CCF funding was spent toward further mastery across the 11 target areas. The payment model is designed to better align incentives of the state as a payer and providers to achieve the above objectives, creating a partnership in which each entity can use the tools at its disposal to work toward common objectives. As a state led model, this program is ideally suited to promote further commercial payer engagement with AHEAD.

Vision for Medicaid Primary Care Transformation:

Primary Care Redesign Initiative: Since 2022, DSS has been actively evaluating its existing primary care programs and articulating a future vision. In 2022, DSS evaluated existing primary care programs (PCMH and PCMH+), performed a landscape analysis of other states and payors' approaches to primary care, and conducted stakeholder focus groups to identify opportunities for the future of CT's Medicaid primary care. In 2023, DSS formed the PCPAC, including patients, providers (including CHA), community organization leaders, advocates and other state agencies. PCPAC members bring their perspectives and meet monthly to discuss various topics. To date, the committee has done extensive data review, identified care delivery transformation focus areas, and discussed performance measurement and payment model tools to support the care transformation goals the committee has established.

Goals and Strategies. DSS is pursuing Primary Care Redesign with the overarching goal to improve its members' health and well-being, especially for the most disadvantaged members and in a way that reduces inequities and racial disparities. Based on this evaluation and stakeholder input, DSS and the PCPAC have identified and aligned on key opportunities guiding primary care redesign efforts. Key

opportunities are outlined below, followed by strategies under consideration. Opportunities for direct alignment with AHEAD are identified with a (*).

Opportunity: Invest more in primary care as a percent of total spend with the intent to increase preventive care spending and decrease acute care spending.

Strategies under consideration to increase Medicaid primary care investment

- *Enhanced payment for care transformation activities**: DSS is considering expansion of enhanced payment for primary care practices to support care transformation, subject to available state funding. DSS envisions aligning the structure of this payment with the AHEAD Enhanced Primary Care Payment, using a similar approach to clinical and social risk adjustment, quality performance adjustment, and attribution.
- *Alignment with the state's primary care spending target**: DSS is fully aligned with achieving the primary care spending target currently overseen and monitored by OHS and integrated in AHEAD through the Primary Care Investment Target.
- *Total cost of care shared savings/risk APM model*:* DSS anticipates adopting a performance-based payment model in the new program design with provider-level incentives to reduce unnecessary hospital utilization, rebalancing investment towards primary care prevention and management strategies. This model would align provider level incentives with the AHEAD TCOC Growth Target.
- *Primary care rates:* DSS is comprehensively reviewing all Medicaid rates through a Medicaid Rate Study required by state statute in Public Act 23-186, including primary care, which will inform the approach to primary care rates, subject to available state funds.

Opportunity: Ensure members have easy and timely access to care and address the range of barriers that make it challenging for members to access care.

Strategies under consideration to increase primary care access.

- *Care transformation requirements*:* Under the Primary Care re-design program DSS is reviewing various requirements for advanced primary care, including same-day appointments, telehealth capability, evening/weekend hours, and cultural and linguistic competence training.
- *Access related quality measures*:* DSS anticipates adopting access-related process measures and access-sensitive outcomes measures as part a broader performance measurement strategy.

Opportunity: Drive care transformation and support the delivery of high-quality person-centered care, with a focus on strengthening care coordination/management, enhancing team-based care, integrating behavioral health, and better identifying and addressing members' HRSN.

DSS and the PCPAC have identified five priority care delivery focus areas aligned with this goal, including: (1) care management (including BH and chronic conditions), (2) care accessibility, (3) HRSN screening and community supports, (4) data infrastructure and sharing, and (5) team-based care. DSS is considering various measures, requirements, and payment models to drive transformation in these focus areas.

Policy Tools and Strategies under consideration to drive care transformation:

- *Care transformation requirements and quality measures*:* Given the close alignment with the AHEAD's care transformation focus areas, there is a clear opportunity for alignment of requirements and measures. DSS is well positioned to adopt an aligned measure set, as we identified six of the seven measures in the AHEAD Primary Care in DSS' initial Primary Care Redesign engagements.
- *Payment Model:* DSS is considering a hybrid FFS/population-based payment (PBP) model to support practices with flexibility and predictability to advance care transformation. Since January 2023, DSS has been part of a learning collaborative to develop and implement PBP models in Medicaid. DSS received technical assistance and peer-to-peer learning from other states. DSS is

finalizing the preliminary design phase of the primary care model with stakeholders in May before beginning technical design work. At this time further details are subject to change and DSS anticipates being able to share more detailed information in the coming months. To date, DSS' Primary Care Program Advisory Committee has considered the strengths and limitations of a primary care population-based payment, and discussed creating program tracks that give providers the option to transition to a population-based payment model for an array of primary care services. More discussion about included services and the structure of the payment is anticipated as part of the upcoming technical design work. Details of discussions to date can be found on DSS' Primary Care Redesign webpage. Specifically, the April 2024 stakeholder meeting materials outlines the preliminary payment structure to date. DSS would be happy to provide additional details to CMS as they are defined in the next phase of work. There may be a longer-term opportunity to align this component with AHEAD if CMS implements a primary care capitated track in 2027, as described in the NOFO.

Opportunity: Incorporate health equity as a guiding principle for system change and address disparities in outcomes.

Tools and Strategies for incorporating health equity into the primary care system

- *FQHC participation and engagement*:* Recognizing that FQHCs disproportionately serve our most historically disadvantaged members, DSS prioritized FQHC engagement in our Primary Care Redesign initiative and established an FQHC Subcommittee in PCPAC with representatives from every CT FQHC. DSS is committed to working with FQHCs to facilitate participation in the new program.
- *Medical and social risk adjustment*:* DSS anticipates integrating medical and social risk adjustment within base and performance payments to ensure payments adequately support member needs.

DSS is currently developing a social risk adjustment strategy leveraging area deprivation index (ADI) for a new maternity bundled payment program.

- *Collection of race, ethnicity, language, and disability data:* Improved demographic data collection will support measurement to identify and address disparities in care and outcomes,

Plans for Alignment with Primary Care AHEAD. DSS has prioritized multi-payer alignment as a critical success factor in primary care transformation and has been working closely with partner agencies and providers to maintain a multi-payer perspective. DSS has leveraged the OHS Quality Council Aligned Measure Set and OHS Primary Care Roadmap, which articulate expectations for commercial insurers. DSS also coordinates closely with OSC to ensure alignment with the State Employee Health Plan primary care initiative and is tracking Medicare program developments and experience of primary care providers and health systems in the state.

DSS has a unique opportunity to leverage the current redesign process and framework to engage a diverse array of stakeholders in the design and launch of the AHEAD-aligned program. In early 2024, DSS anticipates having the necessary elements of the redesigned primary care program structure identified to move forward with detailed design and implementation, which includes identifying additional financial resources that needed to carry out the redesign. This timeline dovetails perfectly with the AHEAD model timeline, allowing adequate time to align the new program with AHEAD during the Pre-Implementation Period, and ensuring a successful launch by the beginning of Program Year 1.

VII. Primary Care Practice Recruitment Plan

As discussed in the transforming primary care section, DSS has extensive prior experience operating value-based payment (VBP) primary care programs, including PCMH and PCMH+, in

which 74% of Connecticut's Medicaid primary care providers participate. DSS has remained invested in building upon and refining PCMH and PCMH+ as part of broader Medicaid primary care redesign. There is ample time to further align the redesign with AHEAD requirements, putting Connecticut in an ideal position to participate in the second AHEAD cohort. DSS's efforts dovetail with primary care transformation and cost containment initiatives in OHS and OSC. Further, the OSC State Employee Plan Primary Care Initiative Pilot will plan to align itself with AHEAD requirements, which could create an opportunity to more easily recruit and transition pilot participants into the AHEAD program.

Primary Care Practice Recruitment Logistics

To help manage recruitment, OHS intends to bring in a primary care recruitment contractor. OHS and DSS intend to explore a contract with CHNCT, DSS' medical ASO, to provide primary care recruitment services because CHNCT already provides those services for DSS in engaging providers to participate in Medicaid PCMH. CHNCT currently engages in primary care provider engagement, recruitment, and outreach to help manage the practices participating in PCMH. Given CHNCT's existing relationships with many providers in the state, their involvement would increase the efficiency of the relatively short practice recruitment period.

To start the recruitment process, CHNCT and the DPM will outline the primary care recruitment goals and objectives. CHNCT would use its existing data sources and additional sources available through DSS to identify and recruit primary care practices into Primary Care AHEAD. Given the high level of primary care provider participation in PCMH and PCMH+, recruitment efforts would likely start by targeting participants in those programs. There are no rural health centers (RCHs) in CT. By the beginning of PY1, we would aim to recruit 15% of practices and FQHCs currently participating in PCMH or PCMH+ into the AHEAD model.

In addition, CHNCT would consult with the Department of Public Health (DPH) Primary Care Office, DSS, and OSC to map the existing system, gaps and areas to leverage, and stakeholders. Upon culling a list of practitioners, the contractor will outreach through various modes of communication including direct mailing, phone calls and in-person meetings. CHNCT will draft materials such as frequently asked questions (FAQs), and one-pagers, in consultation with DPH, OHS, and DSS to explain the AHEAD project to prospective practitioners.

These materials will be used as recruitment tools and provided to practitioners one to one, in webinars, and resource library formats. CHNCT upon identifying system gaps would convene and facilitate a group of agency representatives and stakeholders to problem solve under the Primary Care AHEAD. The DPM will be responsible for the ongoing plan implementation.

CHNCT would host virtual events similar to past PCMH and PCMH+ recruitment webinars advertised and developed in collaboration with stakeholders. The webinars will be tailored to specific groups, e.g., FQHCs, independent practices, and practices that are part of larger health systems. CHNCT, in consultation with OHS and DSS, would also connect with clinically integrated networks like Privia Health of New England to gauge their interest, given their previous participation in state APM primary care programs. Throughout the recruitment process, CHNCT would also be expected to provide assistance to practices interested in participating in AHEAD primary care.

In addition to DSS's extensive activities in engaging primary care, both OHS, and the Office of the State Comptroller have years-long partnerships with the CT primary care community. OHS works annually with the state's largest physician groups (so-called "Advanced Networks") to review their performance in the healthcare benchmark program. OHS reviews data and performance, receives feedback, and engages in policy-focused improvement strategies with the Ans. In addition to leveraging these relationships, in recruiting practices to participate in Primary Care AHEAD,

OHS will engage members of their Primary Care Advisory Group, and the Physician Practice Workgroup, two bodies that were instituted to advise OHS on policies and programs related to primary care. OSC will also assist in recruiting by engaging those Advanced Networks with which it has established value-based contracts that are significantly aligned with the structure and goals of AHEAD.

Overall, the State is well positioned to align with the AHEAD model's approach to enhanced primary care payments, quality and performance measures, and aligned accountability for well-coordinated, person-centered care. The State intends to align both the Medicaid Primary Care APM being developed through DSS' Primary Care Redesign Initiative and OSC's State Employee Health Plan primary care initiative with the AHEAD model. The State anticipates that close alignment between these programs will reduce the burden on providers participating in multiple programs. The State's provider recruitment efforts will highlight the alignment between the various models, demonstrating how the models are supportive of a consistent approach to care delivery and compensation. For a more comprehensive recruitment of primary care providers, including primary care practices, FQHCs and SNHs, timeline is available in the table below.

Time	**Milestone**	**Description**
2024 Quarters 3 & 4 through 2025 Quarter 1 *July 2024-March 2025*	Ongoing engagement, education, and targeted recruitment (Wave 1)	• CHNCT meets with OHS and DSS and OSC to discuss goals and objectives for initial recruitment • CHNCT will begin dialogue with primary care providers that are already involved in PCMH and PCMH+. (inclusive of FQHCs) • Host webinars for education about AHEAD for primary care providers and make time available for 1:1 technical assistance and support for smaller practices exploring feasibility of model. • State AHEAD team facilitates initial participation discussions with clinically integrated networks.

2025 Quarter 2 *April 2025 – June 2025*	Additional Outreach	• CHNCT uses existing data sources to identify additional primary care providers that have not yet signed up to participate. • CHNCT conducts direct outreach to identified providers. • Create online clearing house of educational resources for those interested in participating in AHEAD primary care. • OSC and OHS ensure alignment with existing primary care programs and participants
2025 Quarters 3 & 4 *July 2025 – December 2025*	Additional recruitment and signing federal agreements (Wave 1)	• Make technical assistance and support available to eligible primary care providers as they work through the technical aspects of establishing the AHEAD model in their practices. • Coordinate with CMMI on getting primary practices to begin signing participation agreements.
2026 Quarters 1 & 2 *January 2026 – June 2026*	Finalize Wave 1 participation agreements	• Last members of Wave 1 sign participation agreements with CMS. • Wave 2 of recruitment begins. • Assess progress on goal of recruiting 15% of primary care providers and FQHCs participating in PCMH/PCMH+ to participate in AHEAD by January 1, 2027.
2026 Quarter 3 & 4 *July 2026 – December 2026*	Begin Wave 2	• Host pre-implementation meetings • Evaluate gaps in recruitment process, and apply that knowledge to Wave 2 recruitment
January 2027 – January 2029	Wave 2: Discussions and Negotiations Wave 1: Retention	• Follow recruitment steps as listed above with Wave 2 primary care providers. • Monitor Wave 1 participant performance, offer additional technical assistance as needed to support retention. • Assess progress on goal of recruiting 35% of primary care providers and FQHCs participating in PCMH/PCMH+ to participate in AHEAD by January 1, 2029.

Anticipated Challenges

- **Quick Turnaround Period.** Given the relatively short time between execution of the state agreement and PY1, the recruitment contractor and state stakeholders will need to work

efficiently to explain AHEAD to potential participants and assist with executing agreements between these providers and CMMI.

- **Health Information Technology.** Historically, some practices interested in participating in VBP programs have struggled with required changes to their electronic health records (EHRs) and health information exchange requirements. Challenges of updating EHRs to incorporate new quality measures may affect interest in AHEAD.
- **Apprehension about re-aligning with AHEAD requirements.** Practices currently participating in PCMH and PCMH+ may have concerns about how participation in AHEAD would further shift care delivery and compensation.

VIII. Description of State Data/Health IT Infrastructure

CT has access to a rich array of data systems and infrastructure to support the AHEAD model implementation. These systems allow for the collection, analysis, reporting and, measurement that will permit evaluation of key performance against the quality and cost growth benchmarks essential to the success of the model. These databases include:

Data	Source	Outcomes Measures
APCD	OHS	Statewide, provider, payer, healthcare service category cost growth
Hospital Inpatient Discharge Data	OHS	AHRQ Quality Indicators Emergency Department Utilization
CT Healthcare Cost Growth Benchmark Initiative	OHS	State all-payer total cost of care (TCOC) growth target
Licensed healthcare provider electronic medical (or health) Record (EMR/EHR); Admission/Discharge/Transfer; Continuity of Care Documents; Lab and Radiology Reports; and transcribed notes	Connie (Health Information Exchange), overseen by OHS	Electronic clinical quality measure (eCQM)
Connecticut Behavioral Risk Factor Surveillance System (BRFSS) and other public health surveillance and health equity data	DPH	Public health and health equity improvement

Medicaid program claims/Medicaid Management Information System	DSS	Medicaid utilization, population health status, Budget savings measures and quality reporting
State employee/retiree health plan	Office of State Comptroller	Utilization, health status, Budget savings measures and quality reporting

Data access/infrastructure for Model

OHS anticipates that based on the above, the applicant agencies already have access to much of the data that will be necessary for the evaluation and monitoring of the AHEAD model implementation. Access to non-public data not readily available to OHS or DSS will be facilitated with a memorandum of agreement and/or data use agreement among Model partner agencies and participants.

Under CT statute, OHS administers the Healthcare Cost Growth Benchmark Initiative, which has already established data collection strategies and process relevant to AHEAD from all payers. These include: for the Healthcare Cost Growth Benchmark, primary care spending target and quality benchmarks programs, as well as the adoption of alternative payment models in the State across payers and providers. OHS also administers the state's All-Payer Claims Database (APCD) which comprises commercial, Medicaid and Medicare eligibility/enrollment and administrative medical and pharmacy claims, and related provider data, as well as the hospital inpatient discharge and emergency department databases. All data are readily available to support Model activities as allowed by state and federal statute.

As part of OHS' health system planning work, OHS is also responsible for receiving, storing, maintaining, sharing and using patient identifiable data from hospitals and other healthcare providers, member identifiable enrollment and claims data from payers, and data on payments and quality measures from both payers and healthcare providers that are accountable to the healthcare

benchmarks. OHS has well defined policies and compliance monitoring standards on data privacy, data sharing, data use agreements and transparency measures.

OHS Healthcare Cost Growth Benchmark Initiative

The Healthcare Cost Growth Benchmark Initiative includes all-payer and advanced network total cost of care growth targets, raising primary care spending as a percentage of total healthcare expenditures to 10% by 2025, and developing quality benchmarks across all public and private payers. As part of the program, OHS collects data from all payers to calculate performance against the benchmarks and primary care spending target. All payers submit healthcare and primary care spending and quality data to OHS each performance year. Spending data is aggregated by large service categories and does not include claims-level information. OHS's Quality Council has recommended 29 aligned measures of clinical quality, patient safety, consumer experience and benchmarks that insurers select for use in new value-based contracts with private and public payers.

OHS has administrative oversight of Connie, the state's official Health Information Exchange (HIE), which connects healthcare providers such as doctors' offices, hospitals and laboratories to enable electronic sharing of clinical information; assist in care coordination among providers; reduce preventable costs; support public health reporting, research and population health analytics; promote standards and interoperability; and provide patient access to their information. Connie is overseen by an appointed board of directors chaired by the state's health information technology officer, who also has statutory oversight of the APCD, and is part of OHS leadership. Connie data includes electronic health records and will be implementing electronic clinical quality measures (eCQM) to support provider portal and directory enhancements in FFY25.

The state mandated that all licensed healthcare providers in the state begin the process of connecting and participating in Connie by May 2023. To date, all hospitals and a significant number

of physician groups are connected to Connie and sharing data on its patient panel, admission/discharge/transfer (ADT), continuity of care documents (CCD), laboratory result, radiology reports and transcribed notes. Additionally, a significant number of EHR vendors in the state are either connected to or working with Connie to connect and participate.

Organizations under consideration to partner and/or participate in this Model will be connected and participating in Connie or are in the process of connecting and participate. OHS will leverage this capability as well as OSC's experience with the Primary Care Initiative TCOC payment Model and DSS's experience and expertise along with other partners' and participants' experience to meet Model requirements.

Department of Public Health

DPH authorizes the Connecticut Behavioral Risk Factor Surveillance System (CT BRFSS) that may be available on the U.S. Centers for Disease Control and Prevention (CDC) website, and other public health surveillance and health equity data. DPH works with state agencies to provide BRFSS and other public health related data specific to their needs. OHS will partner with DPH to identify the information needed for the Model.

State Employee Health Plan: Commercial

The state employee health plan medical and pharmacy administrative claims data are warehoused by the state's contracted medical carrier, its pharmacy benefit manager, and OSC-contracted benefits consulting firm which provides utilization, trend and cost reporting on medical and pharmacy services dating from 2011. The state's medical carrier provides direct administrative support for the Primary Care Initiative (PCI) and provides reporting to OSC for the TCOC contracted participating groups in the CT PCI.

The state employee health plan's current medical carrier has been engaged in value-based contracting for nearly a decade, and with TCOC contracting through the PCI with OSC since 2022.

OSC funds staff at the medical carrier to provide analytic support for reporting, administrative support and dedicated nurse consultants to review detailed utilization and quality reports (based on the CT OHS Quality Council aligned measure set) with engaged provider groups and the state covering nearly 100,000 attributed members. Nurse consultants meet regularly with provider groups' population health and care management teams to advise on opportunities for care delivery improvement and cost containment.

DSS offers financial incentives to primary care practices in PCMH program to reimburse them for the enhanced primary care services required by the program. DSS's PCMH per member per month performance-based payments are based on select adult and pediatric health measures for Medicaid members attributed to the practice during the performance year. Additionally, to improve its Medicaid clients' health outcomes, as initially funded through section 9817 of the American Rescue Plan Act (ARPA), DSS is providing pay-for-performance payments as part of a value-based payment for home and community-based providers based on clearly defined outcomes that align payment with value.

OHS will leverage this capability, OSC's experience with the PCI TCOC payment Model and DSS's experience and expertise along with other partners' and participants' experience to meet Model requirements.

DSS is mandated to deliver, fund, and oversee a wide range of programs and services, including administering the state's Medicaid program and CHIP. OSC has oversight authority over state employee and retiree benefits, including healthcare benefits. Leveraging these authorities and experiences across Model partner agencies and with a master agreement, OHS is able to become a health oversight agency for the purposes of data sharing by the start of PY1.

IX. Description of Current and Planned Health Equity Activities

CT is committed to advancing Health Equity by promoting better health outcomes, reducing disparities, and addressing HRSN for all residents, particularly those who have been historically underserved. The state has taken several steps and actions to embed health and racial equity initiatives, measures, and requirements across its health and human services platforms. One priority area is to focus on equity-oriented data – Race, Ethnicity, and Language (REL) – to identify disparities in health outcomes. In 2021 a standardization of REL data collection law was enacted requiring uniform collection of REL from any state entity or contracted provider delivering healthcare or public health services with the goal to use such data to inform policies and interventions to address long-standing health disparities and inequities.

The AHEAD model presents a great opportunity for CT to enhance health equity strategies and align equity targets among state agencies, healthcare providers and insurers. Below are strategies already in place used to identify disparities, population health focus areas and HRSN as well as structures that inform the design and implementation of population health activities that can be leveraged to support the Health Equity planning and alignment.

State Health Improvement Plan (SHIP) and State Health Assessment (SHA)

For several years, Connecticut has led a comprehensive approach in developing its SHIP. The most recent one, Healthy Connecticut 2025, was developed with a focus on Health Equity and HRSN. The 5-year plan released in 2021 involved diverse teams and advisory groups and outlined several strategies and goals targeting social drivers of health. DPH plans to conduct the next SHA this year, which will provide information and data to inform the next SHIP. The next SHIP will be integrated with the State's Facilities and Services Plan (FSP). The FSP primarily looks at the availability and utilization of acute hospital care, hospital emergency care, specialty hospital care, outpatient surgical care, primary care and clinic care and geographic areas that may be underserved and serves as a tool to inform decisions and planning for various healthcare service needs. The goal

is to produce a more comprehensive plan that ties in population health status, social needs health drivers, and availability of healthcare facilities. The FSP, which will be published as a draft document on June 30, and will be open for public comment, is meant to serve as a tool to guide ongoing and future decisions impacting access to care. The state is planning community and stakeholder engagement on this plan for a 90-day period before finalizing the document. Once finalized, the state looks to use this as a tool to inform policy, legislative and financial decisions regarding health care systems and equity planning and prioritizing interventions and policies that will tackle any identified unmet needs. The plan will also be integrated into the statewide health equity planning required as part of AHEAD.

Community Benefit Reporting Requirements

In 2023, CT enacted a law defining community benefit as prevention and interventions aimed at reducing health disparities and addressing the cost and economic burden of poor health. It also required hospitals to submit status reports to OHS including information from their CHNA regarding community health needs and target populations and the hospital's actions to address identified needs including community benefit investments. In 2024, the OHS will produce the first Community Benefit Report, which will analyze Hospital Community Benefit spending, identified community health needs by the hospitals, and ways hospitals are addressing those needs. This report will help inform state health policy.

This analysis will also provide information on statewide healthcare and HRSN identified in the CHNAs. Data from 2021/2022 CHNAs shows that hospitals across the board identified some of the same needs, which included behavioral health, access to care, HRSN, healthcare costs and coverage, and chronic disease. Hospitals primarily coordinate CHNAs with local public health departments. Through hospital status reporting, OHS identified that all CT hospitals in the state have programs or actions in place to address behavioral health.

Other efforts include the Health Enhancement Communities grant program to enhance local efforts to address health disparities that contribute to poor health outcomes by bringing together organizations and community members. Through this model, HECs invest in communities by employing trusted community members as ambassadors to give insight, engage, and be a part of discussions and interventions. As of 2024, OHS has invested over $4 million in nine HECs working to improve minority maternal health, food security and homelessness prevention.

Health Care Cabinet (HCC)

The HCC advises OHS on issues related to federal health reform implementation and development of an integrated healthcare system. The Cabinet includes representation from hospital systems, primary care practices, FQHCs, insurance, and state HHS agencies. It makes recommendations from healthcare provider payment reforms to advancing equity in healthcare delivery and reducing disparities based on race, ethnicity, gender and sexual orientation. The Model Governance Structure section describes how the HCC will assume that role.

Agency specific strategies

DSS – using dashboards – collects race and ethnicity data by category of expense, membership, and risk scores to identify membership trends and mitigate disparities in Medicaid eligibility. It has convened an Equity Workgroup to review analysis of trends and identify targeted interventions to racial disparities in health outcomes. Its focus areas are: (1) reducing health disparities for behavioral health follow-up for hospitalization for Black adults; (2) increasing rates of well-child visits, immunizations, and vaccinations for Black youth; and (3) reducing maternal adverse outcomes during the postpartum for Black women.

Legislative Structures

The Executive Branch has strong legislative partners that support health equity initiatives. In 2021, the legislature declared racism a public health crisis contributing to health disparities and

inequities and established a Commission on Racial Equity in Public Health to examine and identify health disparities and inform policies to advance health equity. The Commission produces annual reports to the legislature about racial and ethnic health disparities to inform policy decisions.

Health and Quality Measures

The AHEAD model quality strategy includes three sets of quality measures with a health equity focus. To support performance on these measures, CT will use its existing Healthcare and Quality Benchmarks structures. CT is the second state to establish statewide benchmarks through an OHS Quality Council. Quality benchmarks are annual measures and target values that all public and private payers, providers, and the State must work to achieve to improve healthcare quality, including chronic conditions such as asthma, diabetes, and high blood pressure. The Council has also recommended 29 Aligned Measures from which OHS requests insurers select measures for use in value-based contracts. Core Measures are those that OHS asks insurers to use in all new value-based contracts, and Menu Measures are optional for use. The measures include care coordination/readmissions, chronic conditions, prevention, behavioral health and health equity. By aligning quality measures in use by commercial insurers and Medicaid through an Aligned Measure Set reduces the administrative burden on providers associated with operating under multiple, non-aligned contractual measure-sets while focusing efforts on quality metrics that the State deemed a priority.

There is overlap between CT's and AHEAD's measures, which can guide the state's measure selection and help evaluate the quality of services while maintaining alignment with the AHEAD model. The table below demonstrates the overlaps:

AHEAD Core and Optional Measures*	**CT Core Set Aligned Measures**	**CT Menu Set Aligned Measures**	**CT Quality Measure**
Controlling High Blood Pressure	x		x
Hemoglobin A1c Control for Patients with Diabetes: HbA1c Poor Control	x		x

Colorectal Cancer Screening		x	
Breast Cancer Screening		x	
Use of Pharmacotherapy for Opioid Use Disorder		x	
Screening for Depression and Follow-up Plan		x	
Colorectal Cancer Screening		x	
Breast Cancer Screening		x	
Use of Pharmacotherapy for Opioid Use Disorder		x	
Prenatal and Postpartum Care*	x		
Follow-Up After Hospitalization Visit for Mental Illness (7-day)			x
Prevalence of Obesity*			x

In addition, below are some examples of new, existing, and ongoing health equity strategies and interventions that the state can leverage to support the Quality and Population Health Strategy and align with the priorities of the State Health Equity Plan to be developed as part of AHEAD.

Enhancing person-centered care management and coordination to address HRSN and support chronic disease management.

DSS' Hypertension Program uses a person-centered approach with the goal of connecting unattributed or high-risk/complex Black members with hypertension to care with a primary care provider. Interventions include condition-specific coaching by nurses, promoting family/caregiver participation in coaching, diet counseling, medication management support, care transitions to support positive outcomes, and working with members to address barriers to engaging in care with a provider such as communication or transportation needs.

Strengthening CHWs workforce to address HSRN through access and linkages to services.

CHWs are trusted community members with lived experience trained to bridge gaps that address HRSN. Connecticut has completed significant work in promoting, professionalizing, and expanding the CHW Workforce. CT defined CHWs in state statute (Public Act 19-117) and

developed an optional certification program administered by DPH. OHS chairs the CHW Advisory Body to support educational and certification requirements for the four training programs in the state. The CHW Association is statewide and works to promote the community's voice within the healthcare system, champions the advancement of CHWs through policy, education, research, and leadership, and serves as a forum to share resources and strategies.

Connecticut does not currently reimburse CHWs through Medicaid; however, a recent law requires DSS to design and implement a plan for Medicaid reimbursement for certified CHWs. Under the statute, reimbursable services would include but are not limited to (1) Coordination of medical, oral and behavioral healthcare services and social supports; (2) connection to and navigation of health systems and services; (3) prenatal, birth, lactation and postpartum supports; and (4) health promotion, coaching and self-management education. This presents a great opportunity for the state to align with AHEAD's goals under Primary Care and Hospital's Health Equity Plans requirement to conduct HRSN screenings and referrals.

Currently, CHWs are integrated in many health-related initiatives through various state and community partnerships to identify and make proper HRSN referrals. For example, in the Family Bridge Pilot, certified CHWs are integrated into a universal nurse home visitation pilot. As described above, DSS and CHNCT have redesigned the Medicaid Primary Care ICM program by significantly increasing the number of CHWs providing care coordination and case management to members via telephone, which were historically provided mostly by registered nurses. This change highlights the critical role CHWs play in addressing HRSN while serving as liaisons between individuals, communities, and health/social services to facilitate access to care and improve the quality and cultural responsiveness and linguistically adequate service delivery.

Increasing support, quality, and interventions to address disparities in minority infant and maternal health.

Addressing disparities in infant and maternal health outcomes is a priority issue in CT. DSS has taken several actions to enhance prenatal and postpartum benefits under Medicaid, which covers over 40% of births in CT with around 70% of those concentrated in urban and underserved areas. As part of these efforts to reduce disparities in infant and maternal health, DSS is developing a Medicaid maternity bundled payment.

DSS plans to shift to paying for maternity care in Medicaid using a bundled payment, rather than FFS. This plan is part of DSS' overarching goal to move toward paying for equitable care in a value-based way and is anticipated to launch in September 2024. Equity is at the center of this plan to address and remedy disparities in access, utilization, and outcomes for disproportionally affected women including pregnant women, target women of color, women with substance use disorders, and women with a high social vulnerability index. The bundle will include and integrate elements that promote equitable access to care and support such as doulas and breastfeeding supports. The additional high-valued services aim to bridge the equity gaps for historically marginalized birthing people, including those with substance use disorders.

DSS has also significantly expanded benefits by offering prenatal care benefits to undocumented women at the same eligibility level for Medicaid-eligible pregnant women, providing state-funded post-partum coverage to undocumented women for 12 months after birth who would otherwise qualify for Medicaid if not for their immigration status and overall postpartum coverage for 12 months for all Medicaid members. Over the last several years, Medicaid has implemented several relevant interventions to reduce the rate of cesarean sections and incidence of neonatal abstinence syndrome (NAS), among other benefits. These include 1) an obstetrics pay-for-performance (P4P) initiative; 2) Intensive Care Management supports; and 3) strict prior authorization requirements for prescribed opioids.

Through a multi-agency collaboration, OEC, OHS and DPH, have established an evidence-based Universal Nurse Home Visiting and Community Health Worker Pilot in the greater Bridgeport area where there is a high percentage of minorities living in poverty. The goal is to expand the program, named Family Bridge, statewide. The program, implemented by Bridgeport Hospital, aims to address significant unidentified and unmet behavioral, mental, social, and physical health needs for mothers, infants, and families in the prenatal and postnatal periods. While the program traditionally includes specially trained Registered Nurses (RN), the CT model also uses CHWs in this intervention. The program offers universal home visits to families with new babies in greater Bridgeport to identify, intervene, and address HRSN through community outreach and maternal support services that impact maternal/child health and strengthen public health infrastructure.

Improving health outcomes through coordinated care for individuals with behavioral health and other serious health conditions.

Connecticut Housing Engagement and Support Services (CHESS), launched in 2021, combines Medicaid coverage of various supportive services with a range of non-Medicaid housing services for state residents struggling with homelessness and chronic health issues. This innovative Medicaid benefit, one of the first to receive federal approval, aligns various Medicaid supports overseen by DSS (in coordination with the Department of Mental Health and Addiction Services) with the Coordinated Access Network and housing subsidy programs administered by the Department of Housing (DOH). Medicaid-covered housing engagement and support services include chronic disease management and wellness education, in addition to pre-tenancy supports (help with locating and securing housing), tenancy sustaining supports (help with maintaining successful tenancy), and non-medical transportation. Housing subsidies, administered by DOH were prioritized for CHESS participants that are homeless and on the by-name list. CHESS

provider staff will help a participant apply for the housing voucher. In addition, CHESS uses an algorithm developed by DSS's behavioral health ASO to help identify potentially Medicaid eligible members experiencing homelessness, who are most likely to show improvement in their health and wellbeing (and potentially reduce unnecessary Medicaid expenditures) once they are housed.

Reducing avoidable Emergency Department visits for vulnerable groups.

DSS' Medical ASO developed interventions to address specific disparities such as Emergency Department Utilization for non-emergent services among Hispanic members residing in Bridgeport and New Britain. Bridgeport and New Britain were two cities in the state where Medicaid enrolled Hispanics were using the emergency room more frequently than the non-Hispanic for non-emergent services.

In 2023, a team identified opportunities to reduce this disparity gap through interventions focused on member education on when to use the emergency department, how to find a primary care provider, and use of the medical ASO's 24/7 Nurse Helpline, as well as exploring opportunities to improve access to translation services for Spanish speaking members at Urgent Care/Walk-Ins and provider practices through partnerships with community organizations centered around Hispanic communities in these two cities. Geo-targeting is also being used to direct information campaigns to members residing in high ED utilization zip codes in Bridgeport and New Britain. Members were able to access a link about where to seek care for non-emergent symptoms through these targeted advertisements. These efforts are ongoing to increase primary care utilization which aligns with AHEAD priorities.

In addition to the health equity activities mentioned above, the state is also focused on enhancing health IT systems to identify and address health-related social needs across healthcare providers. The state established an annual Statewide Health IT Plan with six priority focus areas

including improving healthcare delivery, increasing coordination of healthcare and social services, and implementing systems to address health disparities and HRSN.

Connie, CT's HIE, is responsible for connecting healthcare providers to enable sharing of clinical information electronically; assisting in care coordination among providers; reducing preventable costs; supporting public health reporting, research, and population health analytics; promoting standards and interoperability; and providing patient access to their information. This year, Connie is developing a closed-loop referral service for HRSN to capture identified needs, which along with clinical health data, will result in more informed treatment and care coordination. As part of this system enhancement and by collecting HRSN, referrals to appropriate social services agencies could be facilitated and make it easier for provider-to-provider feedback to close the loop on these referrals.

Connie is also working closely with healthcare providers and community-based organizations (CBOs) and social service agencies to improve the coordination of care and social services. As a result, it has created a roadmap for interoperability for a Community Information Exchange (CIE) and the HIE. A CIE would offer resource directory services and software solutions to enable electronic referrals to be sent directly from an Electronic Health Record (EHR) to a CBO, based on an individual's needs. Currently, Connie is working with DSS to offer electronic closed loop referrals between hospitals, skilled nursing facilities, healthcare practices, and home and community-based providers for Medicaid beneficiaries.

In 2021, state legislation was enacted to require standardized collection and reporting of race, ethnicity, and language (REL) data. These efforts, already underway, will support AHEAD's enhanced demographic data collection goals to identify health disparities and monitor impact to patient outcomes. This mandate is required for any state agency, board, or commissioner that directly or under contract collects REL data in the context of healthcare or for the provision or

receipt of healthcare or public health services. These agencies include HHS agencies, clinical, behavioral, community and public health services. Healthcare providers that have electronic health record (EHR) systems are required to connect to and participate in Connie and must collect in their EHR system patient self-reported REL data in alignment with the state's standards. OHS will work and support AHEAD participating providers as they work through this implementation to meet the goals of AHEAD.

The law required OHS to develop REL data collection standards in alignment with the U.S. Office of Management and Budget (OMB) race and ethnicity standards as well as an implementation plan. The REL standards document enumerates how to uniformly collect and code self-reported race, ethnicity, and language by clients/patients. The information is self-reported by the client/patient. Clients/patients are not required to provide REL data to receive care or services; however, entities mandated to collect REL data must do so in alignment with the OHS REL Data Collection Standards where applicable. OHS periodically reviews census data and updates the REL categories as necessary such as potential changes to race and ethnicity questions for the 2030 census as being proposed at the federal level.

The goal is to get to full implementation of quality REL data that is self-reported using the detailed standards OHS has developed. Availability of REL data will support development of targeted interventions to reduce racial disparities, and augment healthcare providers' continuous efforts to provide high quality, effective, timely, person-centered, equitable care to all patients, in the state. In addition, this data is shared with the Commission on Racial Equity in Public Health to inform annual reporting of race disparities and efforts to reduce these disparities.

CT's efforts to advance Health Equity and address HRSN impacting our residents is a whole-of-government approach with key and important partnerships with the legislature and the private and non-profit sector, as demonstrated in the examples in this section. As a result of this

work over the past several years, the state is in a great position to implement AHEAD and leverage it to continue to improve health outcomes for all residents, targeting efforts to those with the most disparate health outcomes. The State specifically looks to use AHEAD to:

- Leverage the Model Governance Structure's statewide health equity plan to coordinate and align health equity activities as they relate to the AHEAD goals and objectives.
- Find opportunities to align hospital equity plans with other hospital efforts to address HRSNs, i.e. Community Benefit, CHNAs.
- Leverage hospital global budget payments to make more investments in Primary Care and improve performance on disparity-focused measures which will promote more focus on prevention, address root causes of poor health, community investments to support individuals and improved technology to coordinate care more seamlessly.
- Align AHEAD Primary Care goals with the state's Medicaid and multi-payer primary care transformation efforts focused on advancing health equity, addressing HRSNs, providing high quality person-centered care, integrating medical and social risk adjustments and paying based performance on quality measures.
- Advance REL data collection and Connie's HRSN screening and referral efforts by requiring participating hospitals and primary care practices to fully implement demographic data collection and reporting and integrate HRSN screenings and linkages through the HIE.
- Require participating providers to enhance the role of CHWs and establish partnerships with community organizations to address the root causes of poor health around health equity goals and quality measures that the State and providers agree on through their Health Equity Plans.

X. Proposed Model Governance Structure

CT will leverage the statutorily created Health Care Cabinet (HCC) to serve as the AHEAD Model Governance Structure (MGS). HCC was created in 2011 and is a committee of healthcare policy experts who advise OHS on issues related to federal health reform implementation and development of an integrated healthcare system. The Cabinet convenes working groups, which include volunteer healthcare experts, to make recommendations concerning development and implementation of service delivery and payment reforms, including multi-payer initiatives, medical homes, EHRs, pharmaceutical pricing, and evidenced-based healthcare quality improvement. The group's operating principles include equity in healthcare delivery and access. HCC makes recommendations on reducing disparities based on race, ethnicity, gender and sexual orientation. The membership includes representation from hospital systems, primary care practices, community health centers, insurance, and various state agencies.

Specifically, for AHEAD, CT proposes creating a subcommittee of HCC to serve as the MGS. The subcommittee will include members of the HCC and expand to additional stakeholders to meet AHEAD-specific needs and priorities. OHS will support the subcommittee and have primary responsibility for coordinating MGS activities, facilitating participation of diverse stakeholders, setting agendas and timelines, and ensuring MGS deliverables are met.

Composition of Model Governance Structure

The MGS will be co-chaired by the OHS Executive Director, or designee and the DSS Commissioner or designee. DPH will be closely consulted on matters related to population data, public health, and health equity. The HCC meets once a month and is chaired by the OHS Executive Director and is comprised of 16 appointed public members representing providers, payers and consumers and 11 ex-officio members representing state agencies.

MGS membership will include participation from community-based organizations serving and representing underserved communities, including, but not limited to, behavioral health

providers, housing and homelessness services providers, Community Action Agencies, food assistance programs and United Ways. MGS recruitment will include organizations offering statewide perspectives such as Health Equity Solutions, a statewide advocacy group promoting policy solutions to advance health equity, CT Coalition to End Homelessness, CT Foodshare (CT's food bank), the Office of Rural Health and CT Association of CHWs all have expressed interest in MGS participation, and we will offer avenues to participate in the initial planning stages. Some of these statewide organizations serve as coalitions that include membership from CBOs representing underserved communities. For example, Health Equity Solutions leads a Health Equity for the People by the People Coalition that includes Make the Road CT (an immigrant rights organization), Ministerial Health Fellowship, and CT Students For a Dream. In addition, the MGS will also include leadership and participation from tribal governments, community-based organizations, and other entities representing or advocating for underserved communities in CT. During the Performance Years, as the footprint of participating hospitals and primary care practices emerges, we anticipate expanding the MGS with additional local representation as appropriate and in alignment with identified priorities (e.g., local providers, CBOs, etc.).

Model Governance Structure and Model Implementation

We envision a central role for the MGS as the state's primary forum to gain diverse and critical input on AHEAD's vision and direction. The HCC's longstanding expertise in healthcare reform paired with new community perspectives highlighting equity will facilitate diverse and grounded feedback and guidance. The MGS is well positioned to play the lead role in developing the state-wide health equity plan. In recent years, CT has conducted numerous assessments and recommendations related to health equity and the MGS can leverage and incorporate existing plans, such as the SHIP, CHNAs, and others in developing the health equity plan. We envision the state-wide health equity plan will serve as a basis and guide for which the MGS can advise on population

health metrics, quality measures, equity targets including state-wide cost, and quality targets. The MGS will also play a role in reviewing hospital health equity plans and provide input on use of funding.

XI. Commercial Payer Alignment

The State Employee Health Plan

The state employee health plan has taken a leading role in driving state-wide healthcare reform and population health improvement efforts in CT and will be a commercial participant in the state's implementation of the AHEAD model. In recent years the State Employee health plan has aligned its benefits structure, programs, member supports and reimbursement models to meet statewide health policy goals. The plan has a rich benefit structure that incentivizes preventive care and screenings, recently implemented an advanced primary care payment model and has several programs and contract provisions that seek to retain cost growth.

The state established health policy goals, initially through Governor's Executive Order No. 5 and later codified through Connecticut Public Act 22-118 that seek to: limit healthcare cost growth to sustainable levels through the healthcare cost growth benchmark; increase primary care investment and standardize quality metrics across payers and improve health equity.

OSC coordinates with OHS to incorporate these initiatives into the administration of the state employee health plan through value-based reimbursements and benefit design:

OSC Primary Care Initiative (PCI): Primary Care investment and Total Cost of Care accountability:

The PCI, an OSC-run program, launched in calendar year 2023 with the aim of improving healthcare coordination, quality and outcomes while reducing overall cost. The model provides meaningful care coordination payments to participating PCP groups ($18 PMPM on average – more

than 5 times the typical commercial care coordination payments in CT). Groups are required to spend the enhanced care coordination funds on improving their capacities in eleven focus areas. Groups report annually to the state on how the funding was spent across the designated areas. Participating groups are also held accountable to total cost of care targets that include shared risk, both upside and downside, for performance against a prospective cost trend. Beginning in year three of the program, the trend target will be equivalent to the state's healthcare cost growth benchmark, meaning that when provider groups hold cost growth under the benchmark, they will be rewarded with shared savings, and will incur financial costs when they fail to meet the benchmark. The program also includes a robust quality bonus program in which participating groups can earn additional PMPM payments for performance on certain quality metrics. The quality metrics used in the program align with those established for statewide alignment by OHS's Quality Council. Finally, the program is supported by dedicated staff that work with provider groups to identify opportunities and gaps, while sharing cost and quality data crucial to successful management. The PCI is designed to better align incentives of the state as a payer and providers to achieve the above objectives; creating a partnership in which each entity can use the tools at its disposal to work toward common objectives.

Value-based insurance design: Affordability and control cost growth

The state employee plan includes value-based insurance design features that seek to incentivize members to engage in preventive care and screenings and leverage high quality efficient providers. The state employee plan's Health Enhancement Program (HEP) provides reduced premiums and cost sharing for members who receive age-appropriate screenings and preventive care. The program has resulted in cancer screening rates that are 10–20% above commercial market norms. Over performance is consistent across all races and ethnicities, helping reduce health disparities. The plan also offers financial incentives for members to receive care from high performing specialists for

common procedures like colonoscopies and joint replacements. These programs combined with aggressive contracting and transparent pharmacy pricing helped the state employee plan achieve more sustainable healthcare cost growth trends in recent years including a 2.6% trend in state fiscal year 2023.

The state employee plan does not require special authorization to participate in the AHEAD model, however a specific endorsement of participation through legislation may be sought. OSC's existing authority (Conn. Gen. Stat. § 5-259) to contract for the administration of medical and pharmacy services on behalf of state employees and members of the Partnership plan would be used to contract a third-party administrator to implement required components of the model.

Total Cost of Care (TCOC Accountability): The Healthcare Cost Growth Benchmark

In order to slow the quickly growing costs of healthcare spending, CT established the Healthcare Cost Growth Benchmark under the Healthcare Benchmarks Initiative work, as is discussed in more detail in Section 3: Statewide Accountability Targets. Through the Benchmark initiative, OHS has extensive contact with the states commercial insurers on quality, cost and primary care data and policy. Commercial insurers submit aggregate data to OHS for the benchmark calculations, resulting in significant collaboration around these issues throughout the year. These relationships will serve as a foundation for the recruitment and alignment of commercial payers to the AHEAD model in addition to the State Employee Plan. Commercial payers also serve on the Benchmark Steering Committee and actively participate in the feedback on and development of policies aimed at cost control and quality improvement.

The first Healthcare Cost Growth Benchmark report was published in March 2023, which showed healthcare spending growth exceeded the benchmark target. OHS identified several entities that significantly contributed to cost growth, including insurers, hospitals, and pharmaceutical

manufacturers. On June 28, 2023, OHS held a public hearing reporting on the results and engaged representatives from these industries on potential drivers and policy solutions. In October 2023, using information from the analysis, report, and hearing, OHS made recommendations to the Legislature in four general areas that support commercial payer alignment with AHEAD:

1. Institute Enforcement Mechanisms for the Healthcare Cost Growth Benchmark
    a. Adopt a requirement for performance improvement plans (PIPs) for entities exceeding the cost growth benchmark
    b. Consider insurer use of the cost growth benchmark as a factor in rate filings review.
2. Address Provider Price Growth
    a. Institute out-of-network price caps to reduce market pressure by providers who do not participate in insurer networks.
    b. Expand the cost and market impact review (CMIR) trigger criteria to include hospitals and health systems that are identified as a significant contributor to healthcare cost growth or that exceed the benchmark.
    c. Increase transparency of group practice acquisitions by requiring a certificate of need application for any transfer of ownership of large group practices including to private equity entities, insurers or other non-physician owners.
3. Address Insurers' Role in Healthcare Cost Growth
    a. Create affordability standards for Connecticut commercial insurers and incorporate the standards into the annual review of commercial insurers' rate filings.
4. Pursue Strategies to Slow Pharmacy Price Growth
    a. Increase pharmacy benefit manager price transparency.

These recommendations are intended to enhance accountability through enforcement and strategies to address significant cost growth drivers. As OHS continues the Cost Growth Benchmark, more data and insights into the healthcare landscape will focus longer term strategies.

This existing body of work serves as the basis for the policy levers that OHS and DSS will use to encourage private payers to participate in the AHEAD model. In addition to annually reporting payer performance on primary care spending using multiple channels, holding periodic private meetings with insurers to obtain their commitment to meeting the primary care spending target, and using OSC state employee plan purchasing strategy, CT will utilize the "Performance Improvement Plans" (PIPs) as proposed in 2024 legislation to work with commercial payers to expand investments in primary care. It will also consider 2025 legislation to add enforcement power to its current primary care spending target.

Commercial Payer Recruitment Plan

CT is in regular dialogue with the five largest commercial payers in the state. The senior market executives for three payers (ConnectiCare, Elevance and UnitedHealthcare) sit on the OHS Steering Committee of the Healthcare Benchmarks Initiative, and the two other payers (Aetna and Cigna) participate sit on the OHS Quality Council. In addition, OSC meets regularly with Elevance, its third-party plan administrator. Finally, OHS periodically meets individually with the payers to discuss their activities to advance the Healthcare Benchmarks Initiative objectives, including value-based payment adoption and the primary care spend target.

Recognizing that the success of the AHEAD hospital global budget and primary care models will be influenced by commercial payer adoption, CT will undertake several commercial payer recruitment and retention activities if selected for AHEAD. In Fall 2024, CT will host an educational webinar for commercial payers, with an in-depth discussion of hospital global budgets,

their benefits, and commercial payer experience in other states. Ideally, CT will involve one of the Pennsylvania-participating payers, since some operate in Connecticut. Throughout Fall 2024 and Winter 2025, OHS and DSS will also meet with the executives from each of the five largest commercial payers in Connecticut to solicit their participation in the hospital global budget and primary care models. As recruitment progresses, OHS and DSS will also evaluate whether to strengthen the primary care spend statute by introducing legislation with enforcement authority. Throughout this entire process, OHS and DSS will encourage AHEAD participating hospitals to request commercial payer participation in hospital global budgets as a way of applying additional pressure for payer participation, and so that hospitals need not operate under conflicting payment models. A more detailed timeline for commercial payer recruitment is available below.

2024 Quarters 3 & 4 through 2025 Quarter 1 *July 2024-March 2025*	Ongoing engagement, education, and recruitment	• OHS and DSS will continue dialogue with the commercial payers already identified in preliminary conversations. • OHS and DSS will perform a more thorough assessment to identify additional commercial payers for targeted recruitment due to their market share, leadership priorities, enrollee populations served, and alignment with AHEAD. • Host webinars for any interested commercial payers and conduct private meetings with targeted commercial payers to provide additional background on the AHEAD model • Provide technical assistance and support for payers exploring feasibility of participating in the model. • Continue to define potential partnerships with the Connecticut Association of Health Plans and their role in supporting members. • Once a contractor for Hospital Global Budget Policy Development is on board, DSS and OHS will engage with

		commercial payers on commercial global budget methodology development.
2025 Quarters 2 - 4 *April 2025 – December 2025*	Medicaid/Medicare substantive engagement with participating commercial payers (wave 1)	• Make technical assistance and support available to commercial payers to help with alignment on global budgets, scope, quality and equity measures, payments, administration, and monitoring and reporting. • Engage with federal partners on recruitment supports, strategies and questions that may come up regarding Medicare Advantage.
2026 Quarters 1 & 2 *January 2026 – June 2026*	Finalize initial collaborations with commercial payers Wave 2 recruitment	• Wrap up outstanding open questions regarding budgets, scope, payments, overall administration and expectation regarding monitoring and reporting. • Officially launch wave 2 recruitment
2026 Quarter 3 & 4 *July 2026 – December 2026*	Payer agreements fully executed (wave 1)	• Communicate with private payers regarding negotiations with hospitals and primary care providers. • Host initial pre-implementation meetings.
Jan 2027-Jan 2029	Wave 2 discussions and negotiations Wave 1 - retention	Follow recruitment, discussion and negotiation steps as listed above with wave 2 commercial payers. Closely monitor wave 1 participant performance, co-develop risk and mitigation plans to support ongoing retention

The greatest obstacle that CT will face in achieving robust commercial payer alignment is that the four largest insurers in the Connecticut commercial market are national companies that are reticent to customize their operations at the state level. This barrier might be overcome if a) CMS requires AHEAD model adoption by its contracted Medicare Advantage plans, and b) there are a sufficient number of AHEAD-participating states such that the national insurers see a compelling case for adopting hospital global budget arrangements and increasing their support for primary care.

Final Thoughts

The AHEAD model provides an opportunity for OHS to continue its current efforts, in collaboration with DSS, OSC, DPH, and other agencies and stakeholders, in controlling costs by prioritizing improving population health and health equity.