



CONNECTICUT HEALTHCARE INNOVATION PLAN



SUBMITTED
DECEMBER 30, 2013

Executive Summary

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INTRODUCTION

Connecticut's Healthcare Innovation Plan ("Innovation Plan") is the product of a shared vision of a broad range of stakeholders to establish primary care as the foundation of care delivery that is consumer and family centered, team based, evidence driven and coordinated, and in which value is rewarded over volume. We envision a healthcare system rooted in primary care and prevention, integrated with community resources, and truly accessible to our residents. We recognize that providers in the care delivery system are one among many community participants that must work together to achieve the broader goal of improved community health. Most importantly, achieving our goals of better health and better healthcare require the involvement of empowered and informed consumers who take an active role in the continuous pursuit of a healthier lifestyle and effective management of chronic conditions.

Our Innovation Plan is possible because, as we learned through many months of broad stakeholder engagement, many are already striving to improve health and our healthcare system. There is utility in combining our disparate efforts in support of the collective good. Connecticut's Innovation Plan leverages current public and private sector investments in healthcare reform initiatives, such as our state's health insurance marketplace, prevention efforts and value based payment reforms. Our plan is distinctive; it strongly promotes health equity throughout all its initiatives, ties provider payment to consumer experience, builds Health Enhancement Communities, leverages healthcare workforce development programs serving disparity populations in urban areas, and powers all through the effective use of health information technology.

We are forming a collaborative community of stakeholders across Connecticut for fulfilling this plan. We are ready to launch.

BACKGROUND

In March 2013, Connecticut received a \$2.8 million planning grant from the Center for Medicaid and Medicare Innovation (CMMI) to develop a State Healthcare Innovation Plan. CMMI's charge was to design a model for healthcare delivery supported by value-based payment methodologies tied to the totality of care delivered to at least 80% of our population within five years. Moreover, the Innovation Plan must promote the Triple Aim for everyone in Connecticut: better health while eliminating health disparities, improved healthcare quality and experience, and reduction of growth in healthcare costs.

Our Innovation Plan is the product of a model design process embracing broad stakeholder input and alignment. We conducted more than 25 consumer focus groups, an extensive survey comprising almost 800 individuals, and more than 45 multi-stakeholder meetings including

public and commercial payers, healthcare providers, employer purchasers, consumer and health equity advocates, and public agencies. These forums included wide-ranging discussions of our current healthcare system and barriers to community health improvement.

Core workgroups were also established to engage in focused deliberation, evaluation, development, and prioritization of options for innovation in care delivery, payment reform, health information technology, workforce development, and health equity. Along the way, we considered economic incentives driving care delivery decisions and the limitations of our healthcare workforce. Empowering Connecticut's healthcare consumers and recognizing the role community plays in health is vital to our plan. We learned that improving care delivery and the consumer experience of that delivery require the smart use of health information technology.

CONNECTICUT'S CURRENT HEALTH SYSTEM – “AS-IS”

Connecticut has a rich array of healthcare, public health, and support services. Despite this, healthcare in Connecticut falls short. For example, the state has high emergency department utilization rates, especially for non-urgent conditions, and a relatively high rate of hospital readmissions. Significant health inequities and socioeconomic disparities persist, keeping the state from achieving higher quality outcomes and a more effective and accountable care delivery system.

The state also faces the significant challenge of high healthcare costs in both the private and public sectors.¹ In 2012, healthcare spending in Connecticut was \$29 billion. That year, we ranked third highest among all states for healthcare spending per capita, at \$10,470. These figures raise concerns about continued affordability of healthcare coverage and access. High healthcare spending adversely impacts the competitiveness of our state's business community. Over the past several years, growth in healthcare spending has outpaced our economy's growth, meaning that each year fewer resources have been available to support education, housing, paying down consumer debt, or saving for the future.

Significant barriers prevent achievement of the Triple Aim, despite the resources that Connecticut devotes to healthcare. These barriers include barriers in access to care, a fragmented delivery system that often fails to educate and inform consumers, a lack of transparency about cost and performance, and payment methods that reward volume of service rather than quality, access and overall health improvement.

OUR VISION FOR THE FUTURE – “TO-BE”

Our vision is to establish a whole-person-centered health care system that improves community health and eliminates health inequities; ensures superior access, quality, and care experience; empowers

¹ NORC, Benchmark State Profile Report for Connecticut (2013)

individuals to actively participate in their health and healthcare; and improves affordability by reducing healthcare costs.

In the future providers, networks, and payers will work together on effective population health management. Our health workforce will be capable in whole-person-centered-care and population health, prepared to work as teams, and supported by the latest evidence-informed clinical decision making tools.

We will judge our efforts a success if primary care transformation, community health improvement, and consumer empowerment innovations have demonstrable positive impact on health outcomes, care quality, health equity, consumer experience, and costs.

EXHIBIT 1: State Innovation Model Goals

Better Health	<ul style="list-style-type: none">• Decrease the statewide rates of diabetes, obesity, tobacco use, asthma and falls
Alleviating and eventually eliminating health disparities	<ul style="list-style-type: none">• Close the gap between the highest and lowest achieving populations for each target measure impacted by health inequities
Better quality of care and consumer experience	<ul style="list-style-type: none">• Achieve top-quintile performance among all states for key measures of quality of care, increase preventative care and consumer experience and increase the proportion of providers meeting quality scorecard targets
Lower costs	<ul style="list-style-type: none">• Achieve a rate of healthcare expenditure growth no greater than the increase in gross state product (GSP) per capita, which corresponds to a 1-2% reduction in the annual rate of healthcare growth

GUIDING PRINCIPLES

To achieve our vision, innovation efforts will be logically integrated and our program decisions will be consistently aligned with a core set of guiding principles:

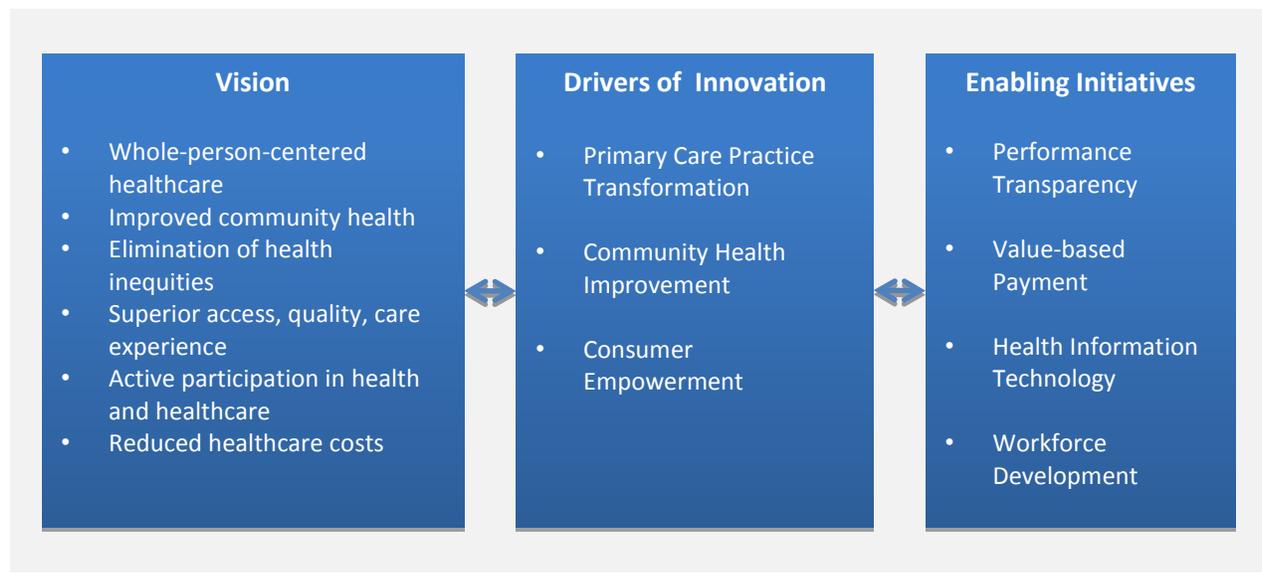
- Whole-person-centered care is more than the integration of medical, oral, and behavioral health. It is also the consideration of social, cultural, emotional, and economic contexts for wellbeing. It is team based, coordinated care for individuals with complex needs, and provided in the right setting at the right time.
- A healthy community is a strong community. Community health improvement requires attention to a community's particular healthcare needs and social determinants of health,

requires the collaboration of a wide range of community partners, and the expansion of a diverse and well-trained workforce that includes “non-traditional” providers such as community health workers.

- Every person has the right to be treated with respect, to receive culturally and linguistically appropriate whole-person-centered care, and to be fully informed and share in decisions that affect them and their families, regardless of socioeconomic status, race, ethnicity, language, gender/transgender, sexual orientation, geography, religion, ability/disability, or age.
- Health information technology powers primary care transformation, enabling point of care information and communications, continuous learning, and performance improvement. The use of technology for data collection and analytics provides for evidence-based approaches to care delivery, population health management, consumer access to cost and quality information, and tools to measure achievement of access, quality, equity, and cost goals.
- Healthcare economics must change so that providers are financially rewarded for whole-person-centered and evidence-based care, the continuous improvement of quality and care experience, and the reduction of unnecessary and avoidable costs, to improve affordability.
- Access to information that is culturally and linguistically appropriate is vital for improved health literacy to empower all patients to navigate the healthcare system, to choose their providers, to actively participate in their health and healthcare decisions, and to play an active role in their community and statewide health policy.
- Quality primary care is the bedrock of an effective healthcare delivery system. Access to primary care that is whole-person-centered, safe, effective, equitable, and based on the strongest clinical evidence is both fundamental and essential for improving health and healthcare outcomes.
- A highly-trained, well-equipped, and diverse primary care workforce with the capacity to meet the evolving needs of our population’s health and the demands of healthcare system reforms is crucial to the attainment of our vision.
- Affordability of healthcare will not be achieved at the expense of quality healthcare. We will not reward the achievement of cost savings through inappropriate means, including under-service of patients.
- For our healthcare delivery system transformation to be meaningful and sustainable, we must continuously engage our stakeholders, including consumers, advocates, employers, community organizations, providers, local and state officials, Medicaid, Medicare, and private health plans.
- The advancement of our vision requires a commitment to measuring the impact of transformation initiatives on health, access, quality, equity, and costs, and further, by establishing a mechanism for oversight and mid-course corrections.

OUR STATE INNOVATION MODEL AT-A-GLANCE

Exhibit 2



PRIMARY DRIVERS OF INNOVATION

In order to achieve the goals we have set forth and our vision for improved health and healthcare, three drivers of transformation are necessary:

- **Primary care practice transformation:** An Advanced Medical Home model will allow practices to manage effectively the total needs of a population of patients.
- **Community health improvement:** Designated Prevention Service Centers (“Prevention Service Centers”) and Health Enhancement Communities (HECs) will coordinate the efforts of community organizations, healthcare providers, employers, consumers and local public health entities.
- **Consumer empowerment:** Mechanisms for consumer input and feedback, incentives for positive care experience, and enhanced information will enable consumers to manage their own health and make informed choices regarding their care.

Primary Care Practice Transformation

A cornerstone of our Innovation Plan is supporting the transformation of primary care to the Advanced Medical Home (AMH), a care delivery model comprising five core elements:

- **Whole-person-centered care:** Care that addresses the full array of medical, social, behavioral health, oral health, cultural, environmental, and socioeconomic factors that contribute to a consumer’s ongoing health.
- **Enhanced access:**² an array of improvements in access including expanded provider hours and same-day appointments; e-consult access to specialists; non-visit methods for access

² Paulus RA, et al. Health Affairs 2008; Reforming the healthcare delivery system, Geisinger report , 2009

the primary care team; clear, easily accessible information; and care that is convenient, timely, and linguistically and culturally appropriate.

- **Population Health Management:** use of population-based data to understand practice sub-populations (e.g., race/ethnicity), panel and individual patient risk, and to inform care coordination and continuous quality improvement, and to determine which AMHs are impacting health disparities, for which conditions and for which populations.
- **Team-based coordinated care:**³ multi-disciplinary teams offering integrated care from primary care providers, specialists, and other health professionals. An essential element in what makes this work is the combination of behavioral healthcare with medical care, whether through co-location, referral linkages, or as part of a virtual team.
- **Evidence-informed clinical decision making:** Applying clinical evidence to healthcare decisions using electronic health record (EHR) decision support, shared decision making tools, and provider quality and cost data at the point-of-care to enable consumer directed care decisions.

Practices are in very different stages in terms of their ability to meet the advanced standards for becoming an Advanced Medical Home, so we designed the Glide Path program, which provides technical assistance and other support to facilitate the practice transformation process. When practices demonstrate readiness to coordinate care, payers (insurance companies, self-funded employers, Medicaid, Medicare) will begin to finance care coordination services and other advanced primary care activities. In time, providers will take responsibility for a broader array of quality and performance metrics, including offering a better care experience for their patients.

Community Health Improvement

While primary care transformation is essential, we recognize that effective prevention cannot be achieved by the care delivery system or by public health agencies acting alone. A major part of our transformation strategy is to foster collaboration among the full range of healthcare providers, employers, schools, community-based organizations, and public agencies to collectively work to improve the health of populations within their community. Our approach to community health improvement comprises two elements:

- **Designated Prevention Service Centers (DPSCs)** to strengthen community-based health services and linkages to primary healthcare.
- **Health Enhancement Communities (HECs)** to target resources and facilitate coordination and collaboration among multiple sectors to improve public health and reduce avoidable health disparities in areas with the highest disease burden, poorest indicators of socioeconomic status, and pervasive and persistent health disparities.

³ ACA Sec. 3502: Establishing Community Health teams to support the Patient Centered Medical Homes.

Consumer Empowerment

The delivery of whole-person-centered care requires a transformation in how payers and providers respect and enable consumers to be active participants in the management of their health. A person's values and preferences and the freedom to make informed decisions must be placed at the center of any efforts to achieve our vision.

Primary care practices will equip consumers with culturally and linguistically appropriate information, resources, and opportunities for them to play an active role in managing their health. As part of our plan for consumer empowerment, we include a three-pronged strategy detailed in the Innovation Plan:

- **Enhanced consumer information and tools** to enable health, wellness, and illness self-management, including shared decision making with providers.
- **Consumer input and advocacy** via decision-making roles in the SIM governance structure and through consumer care experience surveys that will directly affect provider payment.
- **Consumer incentives** to encourage healthy lifestyles and effective illness self-management through the promotion of value-based insurance designs (VBID) and employer incentive programs.

ENABLING INITIATIVES

Connecticut will enable our broad transformation through performance, cost and price transparency, value-based payment, health information technology, and workforce development. These initiatives, described in detail in the Innovation Plan, are highlighted here because of their role in achieving our vision.

Performance Transparency

Diverse groups of stakeholders have emphasized that increased transparency of quality, cost and price is a fundamental prerequisite to improving our health system. Transparency is essential for shaping our new care delivery and payment models, for informing consumer choice of health plans and providers, for guiding providers' own performance improvement efforts, and for identifying disparities in health and health outcomes. We will achieve this level of transparency with the following levers and focus areas:

- **Create a common scorecard** that reflects the AMH provider's ability to meet measures of health status, quality of care and consumer experience.
- **Track primary care performance** for quality, care experience, equity and cost measures, with the goal of future expansion to other parts of the healthcare system.
- **Combine data across payers** in order to be able to track a provider's true performance for their entire patient panel and to make reporting more efficient.

- **Ensure multiple levels of reporting** so that consumers, payers, providers and policy makers can access quality, cost, price, and equity information.

Value-based Payment

A key enabler of our transformation will be the shift from purely fee-for-service payment, which rewards providers for delivering a greater volume of services, to value-based payment, which rewards providers for delivering high-quality care and a positive consumer experience, while reducing waste and inefficiency. Value-based payment also reduces healthcare costs or better controls the growth in healthcare spending over time.

Implementing these payment changes across all payers strengthens the business case for providers to invest in advanced practice and performance improvement, while eliminating conflicting payer incentives. Based on the guidance from our workgroups and input from stakeholders, and our steering committee, we defined a strategy for value-based payment that comprises four components:

- **Two tracks for value-based payment:** In our Glide Path model, most providers who are new to value-based payment will begin in *Pay for Performance (P4P)*, which introduces rewards for performing well on quality and care experience targets. Eventually, all providers, as they achieve the scale and capabilities, will migrate to a *Shared Savings Program (SSP)*. A SSP introduces accountability for the overall cost of care for a panel of patients. A practice can share in savings when it provides more effective and efficient care or losses if care becomes less effective and efficient.
- **Alignment of payers to adopt similar reward structures tied to a common scorecard:** Payers will be encouraged to tie SSP and P4P programs to the same *common scorecard* for quality, care experience, health equity, and cost. This will reduce complexity for providers, increase the business case for investment in new capabilities, and sharpen providers' focus on specific measures of success supported by all payers.

Payers and providers will independently negotiate the level of outcomes-based bonus payments made under P4P. Similarly, payers and providers will be free to determine whether they want to share in gains and whether they want to share in losses under a SSP arrangement. Arrangements in which providers share in gains but not losses ("upside" arrangements) meet the minimum requirements of our Innovation Plan. Medicaid will establish an upside only shared savings program, although the timing has not been determined.

Health Information Technology

Health information technology plays a central and supporting role in every element of our proposed reforms. It is the means by which we develop our strategy, target our resources, measure our progress, manage continuous improvement, inform our care decisions, and communicate across individuals, providers, and systems. Our Innovation Plan defines a health information technology strategy that is based on four principles:

- **Advanced payer and provider analytic capabilities** to support improvements in care delivery and health, with the eventual introduction of cross-payer (“aggregate”) analytics made possible by Connecticut’s All Payer Claims Database (APCD) and advancements in health information exchange.
- **Creation of multi-payer portal for providers and consumers to allow easier access to** information and better decision making by providers and consumers.
- **Guidelines for care management tools.** Since Connecticut has a large number of small provider practices, we will establish shared guidelines rather than mandatory procedures for adopting care management tools.
- **Standardized approach to clinical information exchange** to accelerate providers’ use of direct messaging for secure communication and coordinated care delivery across different sites of care. Our plan begins with point to point communication and evolves to a comprehensive, statewide, health information exchange.

Health Workforce Development

For the Innovation Plan to succeed, it is essential that Connecticut has a healthcare workforce of sufficient size, composition and training to carry out the plan in both the short-term and long-term. With input from stakeholders and a workforce task force, we lay out six broad, multipurpose initiatives:

- **Health workforce data and analytics** will be collected in order to make informed decisions regarding training initiatives and regional needs.
- **Inter-professional education (IPE)**, a Connecticut Service Track will be created to promote team and population-health approaches to health professional training.
- **Training and certification standards for Community Health Workers** will ensure that community health workers with common core competencies become an integral part of the healthcare workforce.
- **Preparation of today’s workforce for care delivery reform** so providers are able to adapt to our advanced and accountable care delivery models.
- **Innovation in primary care Graduate Medical Education (GME) and residency programs** so that these efforts better align with our health and healthcare reforms.
- **Health professional and allied health professional training career pathways** to improve career flexibility, expand the pipeline of healthcare professionals, and promote workforce diversity.

WHAT MAKES OUR PLAN DISTINCTIVE?

All State Innovation Model designs are required to include new healthcare delivery and value-based payment models. Our plan meets these requirements, but is distinct in the following areas:

- Readiness to Launch with Extensive Stakeholder Support
- Promotion of Health Equity
- Equity and Access Council
- Designated Prevention Service Centers and Health Enhancement Communities
- Connecticut Service Track for Healthcare Workforce Development

Readiness to Launch with Extensive Stakeholder Support

Connecticut's Innovation Plan will launch quickly and successfully, with broad stakeholder support. Connecticut has a strong foundation of health reforms upon which to build. Existing innovations that complement our Innovation Plan are already improving access, integrating behavioral and mental healthcare, and addressing equity issues in communities, workplaces and schools. Medicaid and Commercial payers are implementing payment initiatives that support accountable care organization and medical home models.⁴ Stakeholders are eager to identify sustainable models that will support innovation on a greater scale.

Connecticut is tilled ground for maximizing federal investment to improve the health and healthcare of our residents. Our state health insurance marketplace, Access Health CT, has enrolled over 65,000 individuals into qualified health plans and Medicaid as of December 29, 2013 for coverage beginning January 1, 2014.

Promotion of Health Equity

Connecticut is one of the most racially, ethnically, and culturally diverse states in the country; in some counties Connecticut residents speak over 60 languages. Yet the state performs unacceptably on many population health and quality of care measures when one compares results by race, ethnicity, geography and income.

To achieve the Triple Aim for everyone, the state has committed to eliminating persistent barriers to health equity and will leverage current investments in this area as more fully described in the "Foundational Strengths and Initiatives" section.

During the design process we solicited advice through the formation of a health equity group to ensure inclusion of health equity's crosscutting influences on primary care practice transformation, community health improvement, consumer empowerment, performance transparency, value-based payment,

⁴ Patient-Centered Medical Home Program: Program description and guidelines, CareFirst, 2011.

workforce development, health information technology, and governance. Furthermore, our evaluation plan will examine our success in reducing health equity gaps in health and health care quality.

Our Innovation Plan is committed to promoting health equity through the elimination of health disparities in every aspect of the model. Although the promotion of health equity is a distinguishing feature of our plan, it is viewed not as a separate and distinct initiative, but rather inherent to all elements of the plan.

Equity and Access Council

Our value based payment reforms emphasize achievement of quality and care experience targets, while also recognizing the need for methods to guard against underservice. Through the establishment of an Equity and Access Council, Connecticut intends to be a national leader in the identification and deployment of advanced analytic methods that offer special protections for consumers as we migrate to value-based payment and to prevent providers from benefiting from unwarranted denials of care.

Consumer Empowerment

Consumer empowerment is one of the primary means of achieving our goals. It encompasses distinct initiatives and is also embedded throughout the plan as a means to achieving our goals. Consumer experience must matter to a much greater degree than it does today. For this reason, Connecticut intends to be among the first states to measure care experience statewide at the practice level and to factor care experience performance into our payment methods across all public and private payers. We will promote the widespread adoption of value-based insurance designs as a powerful means for rewarding healthy behavior. In addition, consumers will be represented in all of the key committees, councils and task forces that shape our SIM reforms over the next five years.

Designated Prevention Service Centers and Health Enhancement Communities

Community health improvement is a key component of our model—realizing that the goal of community health is in the value of our diverse communities. The states proposed Health Enhancement Communities (HECs) and Designated Prevention Service Centers (DPSCs) are innovative opportunities to foster an alignment among our Advance Medical Home providers and a diverse array of community participants. The proposed innovation will establish a structure that allows a bi-directional flow of information from providers to community based organizations and local health departments allowing for the planning and deployment of strategic investments in community health.

Connecticut Service Track for Healthcare Workforce Development

Connecticut will build upon its current program for community-based interprofessional education, UConn's Urban Service Track (UST), established to serve disadvantaged populations in urban settings through team-based care, cultural and linguistic appropriateness, and population health. The envisioned Connecticut Service Track (CST) extends beyond urban communities to include Connecticut's more rural counties—effectively covering all of Connecticut.

The CST program, as more fully described in the “Foundational Strengths and Initiatives” section, reaches across health professions schools, including nursing and allied health professions schools and additional community providers, increasing the number of participating schools, occupations, and community service locations.

MANAGING THE TRANSFORMATION

Governance Structure

The Lieutenant Governor will provide overall leadership for the Innovation Plan implementation. She will establish a Healthcare Innovation Steering Committee, a successor to the existing Steering Committee, with additional consumer, consumer and health equity advocate and provider representation. A Project Management Office will also be established to lead detailed design and implementation, oversee evaluation efforts, engage with stakeholders, manage vendors, and communicate progress to the public, state government, and CMMI. The Project Management Office will sit within Connecticut's Office of the Healthcare Advocate. The Steering Committee and Project Management Office will seek ongoing input and guidance from Connecticut's Healthcare Cabinet and Consumer Advisory Board.

Five specialized task forces and councils are envisioned focusing on provider transformation standards, support, and technical assistance; coordination of the various health information technology projects; quality, care experience, and health equity metrics and performance targets; methods for safeguarding equity, access, and appropriate levels of service; and workforce initiatives. Consumer membership in the task forces and councils will be facilitated through the statutorily created Consumer Advisory Board throughout the detailed design, pre-implementation and implementation phases of this initiative.

This structure is expected to be in place by February 2014.

EXHIBIT 3: Future Governance Structure



Transformation Roadmap

Our Innovation Plan will be implemented over five years, divided into four phases: 9-month detailed design beginning in January 2014; 9-month pre-implementation planning beginning in October 2014; Wave 1 implementation beginning in July 2015; and subsequent scale-up through successive waves of implementation in State Fiscal Years (SFY) 2017-2020.

- **Detailed Design (January 2014 to September 2014)**
- **Pre-implementation Planning (October 2014 to June 2015)**
- **Wave 1 Implementation (July 2015 to June 2016)**
- **Wave 2+ Scale-Up (July 2016 to June 2020)**

Evaluating our Innovation Plan

We will establish parallel evaluation tracks to measure the progress of our Innovation Plan; one track to monitor the *pace* of implementation and the other to monitor the *performance* of our initiatives and their associated impact on community health, quality of care, health equity, and costs.

Pace and performance dashboards, as discussed in detail in the Managing Transformation section of this plan, will be established by the Project Management Office and used to guide SIM efforts, report to stakeholders, and inform CMMI.

Baselines for population health, quality of care, health equity, and cost performance measures were developed in part using the Center for Disease Control and Prevention's **Behavioral Risk Factor Surveillance System (BRFSS)**, Connecticut's State Health Assessment and our financial analysis. Performance targets for population health, quality of care, and health equity are aligned with Connecticut Department of Public Health's Healthy Connecticut 2020 plan.

The SIM evaluation team will be established as a formal collaboration among Connecticut's institutions of higher learning through which the breadth and depth of expertise required for rigorous evaluation of SIM will be gained. The evaluation team will employ a multi-method approach, including quantitative research methods and sophisticated statistical modeling in combination with qualitative data.

Financial Analysis

Our Innovation Plan is projected to create more than \$3 billion in value over 5 years from State Fiscal Year (SFY) 2016 through SFY 2020. Research by the Institute of Medicine has suggested that approximately 30% of healthcare spending is unnecessary. The projected savings assumes that we will begin to eliminate some of this unnecessary spending through the initiatives proposed in our plan.

There are ample opportunities to generate value in Connecticut. We anticipate savings in healthcare spending attributed to poor healthcare outcomes, savings from improvements in prevention efforts, and reductions in excess costs such as duplicative or unnecessary tests and procedures. In Connecticut, an estimated 40% of our Medicaid enrollees with chronic conditions account for nearly 70% of our Medicaid spending, including spending on acute events that could have been prevented through more effective primary care. Connecticut has a 26% higher per capita use of hospital emergency departments than neighboring states and nearly 50% of those visits are for non-urgent care. We are among the highest cost states in spending per year per person in Medicaid, Medicare and private insurance.

Our financial projections for the potential impact of our Innovation Plan are based on achieving our aspiration that by SFY 2020 at least 90% of Connecticut's primary care providers will achieve AMH recognition and participate in shared savings plans. Additionally, we project about 50% of self-funded employers and 25% of fully-insured employers will adopt the AMH model for their employee benefit plans.

Achieving value will require meaningful investments in the care delivery systems. Projections assume that an average of 30-50% of savings achieved through implementation of the care delivery model will be paid to primary care providers in the form of bonus payments, net of increased spending on care coordination.

SUMMARY

Our Innovation Plan is the synthesis of our work groups' findings and recommendations, robust public commentary, deliberations by our steering committee and the Healthcare Cabinet, and

the broadly representative focus groups that vetted our emerging design. Moreover, this plan builds upon a foundation of innovations and reforms already underway in Connecticut. Our Innovation Plan will guide the development of the initiatives that will constitute our proposal for a CMMI model testing grant that we anticipate submitting in the Spring of 2014. In selecting initiatives and crafting our testing grant proposal we will continue to work with stakeholders to continuously improve the Innovation Plan as an effective roadmap for achieving a healthier Connecticut.