Working Group Name: Healthcare Working Group

List the priorities of your working group in the appropriate areas below…

PRIORITY INITIATIVES: Things that should be addressed during the 2011 budget/legislative process

	Policy Initiative	**Immediate Fiscal Impact**
1.	Incorporate SustiNet board recommendations into health care planning and implementation.	We need to see final recommendations of Sustinet Board due January 7th 2011. Assuming they recommend opening state employee health insurance pool to municipalities (which has been discussed), the fiscal impact would be potentially significant savings to municipalities.
2.	Assure access to prenatal care for all women.	See Recommendations Report.
3.	Establish Office of Health Care Reform Implementation.	No fiscal impact. Proposal is to establish office with existing resources and positions currently used to support Governor Rell's Health Care Reform Cabinet (Executive Order No. 43, April 2010).

SHORT-TERM INITIATIVES: Things that should be addressed by 2012/2013

	Policy Initiative	**Short Term Fiscal Impact**
1.	Invest in nursing and allied health faculty.	See Recommendations Report.
2.	Expand community health centers.	See Recommendations Report: Masselli "Community Health Centers" paper.
3.	Expand school-based health clinics.	See Recommendations Report.

LONG-TERM INITIATIVES: Things that should be considered beyond 2013

	Policy Initiative	**Long Term Fiscal Impact**
1.	Reform the medical liability system to promote quality and following of evidence-based guidelines.	See Recommendations Report: Andrews "Payment Reform" paper.
2.	Expand Medicaid coverage of childless adults to 185% of federal poverty level.	See Recommendations Report.
3.	Create public option to be offered in the health insurance exchange.	Potential long-term savings. Divergent views and opinions.

On items in which there was not consensus, please append any dissenting opinions.

To: Malloy/Wyman

TRANSITION STEERING COMMITTEE

HEALTH CARE WORKING GROUP RECOMMENDATIONS

Co-Chairs

Juan A. Figueroa
President
Universal Health Care Foundation of CT.

Tory Westbrook, M.D.
Family Physician
Community Health Center, Inc.

December 2010

INTRODUCTION
HEALTHCARE WORKING GROUP

Statement of the Issue
The availability of affordable, quality health care is one of the most important issues facing Connecticut's children and families. It is also a crucial issue for Connecticut's employers. Access to health care is a moral issue, a quality of life issue and an economic issue.

The health care system is not currently meeting the needs of many residents in Connecticut. Many concerns were identified in the following Malloy/Wyman Campaign Policy briefs:

- Health Care
- Supporting Connecticut's Seniors
- Center for Autism and Developmental Disabilities
- ABC: A Bioscience Connecticut

The health care system challenges facing our state include:

- The number of uninsured in Connecticut is growing. According to the US Census bureau, the number of uninsured increased from 326,000 in 2007 to 343,000 in 2008 to 418,000 in 2009.
- Chronic disease rates are high. Some portion of conditions such as diabetes, cancer, and heart disease, could be prevented or could be managed in a way that avoids costly health care resources. Our current medical care system and public health system are often not able to provide people with the resources and support they need to prevent and manage their illnesses. Instead, people with chronic, potentially preventable conditions are consuming an increasing amount of expensive health care resources.
- Rates of tobacco use and obesity, while lower than those of many other states, are still high and contribute to the burden of chronic disease in Connecticut.
- Ethnic and racial disparities in health status persist and, in some instances, are growing.
- Health care costs are rising much faster than wages. A study conducted by Families USA found health insurance premiums for families in Connecticut skyrocketed over 80.7% from 2000-2007, while wages during the same time period increased by only 9.9%.

Given increased demand and rising health care costs, it is not surprising the portions of the state budget devoted to health care expenditures are also growing rapidly.

- Medicaid is the single largest line item in the state budget. The same Fiscal Accountability Report estimates that Medicaid costs could exceed $4.3 billion in FY 2011 and could grow by as much as 13% by FY 2013. At the same time that need is growing and expenditures are rising, support received from the federal government through the stimulus package will not be available beginning in FY 2012.
- The largest proportion of Medicaid expenses is attributable to long-term care. With baby-boomers beginning to reach their 60's, the needs of a growing senior population will continue to increase and put further demands on the Medicaid budget.

- State employee and retiree health care costs are growing rapidly. The Fiscal Accountability Report issued by OPM in November projects that state employee and retiree health care costs, already over $1 billion, could increase by over 20% from FY 2011 to FY 2013.

Even as Medicaid costs skyrocket, it has been well-documented that the rates Medicaid pays to providers in many cases do not cover the cost of care. When the state does not pay its fair share of costs, providers raise prices to private payers. This shifting of costs is one of the reasons for the high insurance premiums that many employers and individuals in our state must pay, and has a negative impact on Connecticut's business climate. Lower Medicaid rates are also one factor impacting the ability of providers to provide decent benefits and wages to their employees. Finally, low Medicaid rates also limit the number of providers willing to accept Medicaid, thus further reducing access to care. Adults in Medicaid face many access challenges, to specialty care and dental care. Children's access to mental health care is yet another area of concern.

While Medicaid expenses are growing, this report provides several examples where Connecticut has not taken full advantage of sharing costs with the federal government. Medicaid expenses are generally split 50/50 with the federal government. Yet some programs continue to be operated in Connecticut with 100% state dollars that could potentially be shifted into the Medicaid program. New opportunities to receive enhanced federal match are also presented in some of the grants and state plan amendment opportunities offered by the Affordable Care Act (ACA). Therefore, several proposals on ways to increase funding to the Medicaid program are included.

With health care reform pending that will enable more people in our state to become insured, there is a renewed focus on the health care workforce. Health care reform will be a job creator. Another potential source of jobs will be the growing bioscience industry in Connecticut. But we must insure there will be enough trained people ready and able to meet the needs of the newly insured and to perform well in the highly technical bioscience field. Concern is particularly focused on the adequacy of the primary care workforce. Fortunately there are resources available through the ACA devoted to workforce planning and development. Maximizing these resources and determining the right investment strategy will be necessary in order to assure the well-trained workforce needed to revive the economy and meet the health care needs of our residents.

Proposed Action

This is a time of great challenge, but also a time of great promise. In March of this year, the Affordable care Act, the federal government's health care reform plan, became law. At the state level, many individuals and organizations have been working to finalize recommendations on how to implement SustiNet, Connecticut's own health care reform law. Other efforts are underway to maximize federal revenues and shore up important programs.

In the spirit of addressing the problems identified above and moving the state forward on the crucial issue area of health care, the Healthcare Working Group would like to offer the Transition Team a total of 46 short briefing papers. These papers contain a multitude of recommendations ranging from short term actions that will reap immediate savings or bring in new revenues to medium term and longer term strategies that will improve health care system efficiency and effectiveness and lead to long term savings.

The document is divided into the following sections:

- Health Care Reform
- Stakeholder Perspectives on Health Care Reform and Health System Redesign
- Medicaid
- Public Health, Population Health, Wellness, Health Equity
- Mental Health and Autism Care
- Long-Term Care and Chronic Disease
- Oral Health
- Healthcare and Bioscience Jobs

It is important to note that some individual papers actually address issues in more than one section. An outline listing each of the papers included in this document is attached.

Working Group Membership and Process

The Healthcare Working Group reached out to a variety of stakeholders to receive their input on policy proposals. All proposals included in this document were sent to all members of the group, allowing them the opportunity to review and comment on them. In several cases, email conversations resulted. A list of the members of the group is attached. Members were asked to send in submissions based on an outline supplied by the Malloy/Wyman Transition Team. In most cases the submissions use that format. In a few cases, due to the extremely short timeline, several of the papers are in a different format. Several other individuals and organizations also supplied information to the group. The papers in this document have been held to the standard set by the Transition Team of brevity, although in a few cases the requested 2-3 pages was exceeded.

The co-chairs have been in touch with two other working groups: Human Services and Children's Services. Those two groups have included significant sections on health care, so there will be some overlap with the issues covered by our group.

Conclusion

We would like to thank the Malloy/Wyman Transition Team for the opportunity to submit this document. We would also like to thank the members of the Healthcare Working Group for their hard work they put in to making this document a reality. All very busy professionals, they were able to contribute despite the very short timeline of the process. Finally, we want to acknowledge the invaluable support provided by Universal Health Care Foundation staff member Jill Zorn and intern Matthew Ashby as well as by the staff at Community Health Center.

The members of the Healthcare Working Group are ready and willing to provide additional assistance to the Transition Team, as the new administration moves forward. Please don't hesitate to contact us if you have any questions.

Juan A. Figueroa	Tory Westbrook, MD
Co-Chair	Co-Chair

HEALTHCARE WORKING GROUP
OUTLINE

Health Care Reform

- Implementation of Health Care Reform in Connecticut, Juan Figueroa and Tory Westbrook, MD, Co-Chairs
- Strategic Health Care Plan for Connecticut, Jack Reed, ProHealth Physicians
- SustiNet, excerpt from Universal Health Care Foundation of Connecticut briefing paper previously submitted to the Governor
- Legislative Briefing on SustiNet, excerpts from presentation made on December 15, 2010
- Patient-Centered Medical Homes, Ellen Andrews, Connecticut Health Policy Project
- Health Information Technology, Ellen Andrews, Connecticut Health Policy Project
- Payment Reform and All-Payer Initiatives, Ellen Andrews, Connecticut Health Policy Project
- Development of State Exchanges, Jerald Gooden, Aetna
- Planning and Implementation the Health Insurance Exchange, excerpt from Universal Health Care Foundation of Connecticut briefing paper previously submitted to the Governor

Stakeholder Perspectives on Health Care Reform and Health System Redesign

- Health System Reform, Eric George, CBIA
- Healthcare System Change, Bob Rinker, CSEA SEIU Local 2001
- Health System Reform, David Katz, MD, Connecticut State Medical Society
- Optimizing the State Health Care System, Susan Davis, St. Vincent's Medical Center
- Community Health Centers, Mark Masselli, Community Health Center, Inc.
- Home Health Perspective, Joanne Walsh, Constellation Health Services
- Small Business Perspective, Sean Moore, Greater Meriden Chamber of Commerce
- Healthcare Delivery System Change, Fred McKinney, PhD, Greater New England Minority Supplier Development Council

Medicaid

- Suggestions for Administrative and Policy Improvements to Medicaid and HUSKY, Jane McNichol Legal Assistance Resource Center of Connecticut and Co-Chair, Medicaid Strategy Group
- Developing a Collaboration Between UConn Health Centers and DSS, Cato Laurencin, MD, University of Connecticut
- Medicaid Family Planning Expansion, Planned Parenthood of Southern New England
- Inmate Inpatient Care and Medicaid, Cato Laurencin, MD, University of Connecticut

Public Health, Population Health, Wellness, Health Equity

- Public Health and Prevention, Katherine Lewis, University of Hartford
- Women's Health, Natalie Achong, MD
- Wellness Programs, Ellen Andrews, Connecticut Health Policy Project

- Creation of Connecticut Health and Human Service Agency to Improve Health Outcomes, Marie Spivey, Capitol Workforce Partners and Chair, Connecticut Commission on Health Equity
- Creation of HEALTH Agency that Promotes Population Health and Drives Health Outcomes, Patricia Baker, Connecticut Health Foundation
- Racial and Ethnic Health Disparities, Patricia Baker, Connecticut Health Foundation

Mental Health and Autism Care

- Mental Health Policy, Dominique Thornton, Mental Health Association of Connecticut
- Children's Mental Health, Patricia Baker, Connecticut Health Foundation
- Children's Mental Health Prevention System, Patricia Baker, Connecticut Health Foundation
- Center for Autism and Developmental Disabilities, Lynn Ricci, Hospital for Special Care
- The Life-Time Effects of Trauma and Violence on Children, Cynthia Rojas, Clifford W. Beers Guidance Clinic
- Mental Health Needs of Older Adults, Kate McEvoy, Agency on Aging of South Central Connecticut

Long-Term Care and Chronic Disease

- Streamline and Improve Access to Medicaid Home and Community-Based Long-Term Care Services, Kate McEvoy, Agency on Aging of South Central Connecticut
- Equipping Consumers to Make Informed Long-Term Care Choices, Kate McEvoy, Agency on Aging of South Central Connecticut
- Reform Connecticut's Long-Term Care System Now!, Long Term Care Advisory Council
- Home Health Aide Workforce, Joanne Walsh, Constellation Health Services
- Alzheimer's Issue Paper
- Coverage for Clinical Trial Routine Care Expenses, Martin Looney, Senate Majority Leader

Oral Health

- Oral Health, Patricia Baker, Connecticut Health Foundation
- Oral Health for All, Connecticut Oral Health Initiative

Health Care and Bioscience Jobs

- Workforce Development: Primary Care Physicians, Cato Laurencin, MD, University of Connecticut
- Diversity in the Health Professions and Health Disparities, Cato Laurencin, MD, University of Connecticut
- The Connecticut Institute for Clinical and Translational Science at the University of Connecticut, Cato Laurencin, MD, University of Connecticut
- University of Connecticut Health Center, Cato Laurencin, MD, University of Connecticut
- A Healthy Connecticut? Allied Health Workforce Faces Critical Challenges Ahead, Connecticut Allied Health Workforce Policy Board

Healthcare Working Group Members

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Health Care Reform

IMPLEMENTATION OF HEALTH CARE REFORM IN CONNECTICUT

Juan Figueroa (Co-Chair)
President
Universal Health Care Foundation of CT

Tory Z. Westbrook, MD (Co-Chair)
Community Health Center, Inc.

Statement of Issue

Federal health care reform, the Affordable Care Act (ACA), and State health reform, SustiNet, seek the same results:

- Improve access to health care
- Improve health status
- Improve the efficacy of the health care system so that we are receiving quality and value for our health care dollars
- Bend the health care cost curve, to ease the burden on government budgets and residents' pocketbooks

ACA regulations and funding opportunities are released constantly by the Health and Human Services Department (HHS), and require careful monitoring followed by rapid mobilization of the state's response. The SustiNet legislation, if it is passed by the legislature, will also require immediate attention. Implementation of these important initiatives will require actions that cross many departmental lines within state government, making it all the more challenging and complex. They will also require a transparent process that allows for stakeholder and consumer input, to assure that Connecticut develops health reform programs that are well-run, address the needs of residents, and meet the goals listed above.

Immediate Action Area

Faced with critical tasks to phase in SustiNet as well as the need to plan how to put key aspects of the ACA into operation, Connecticut should establish a structure to integrate their planning and implementation. This could be done by establishing an Office of Health Care Reform Implementation (Office) using many of the existing resources and positions currently used to support Governor Rell's Health Care Reform Cabinet (Executive Order No. 43, April 2010). The Office would have a direct line to the Governor to insure that the structures of state government are working in concert to efficiently and effectively implement federal reform and SustiNet. The Office would also move forward any legislative initiatives required for federal and state health care reform implementation. Finally, it would focus on maximizing federal ACA grant funding as well as private sector support to move these initiatives forward. The Office will conduct its work in a manner that allows for regular input from consumers and key stakeholders.

Health Insurance Exchange

The ACA gives each state the opportunity to establish two health insurance exchanges; one to serve individuals and one to serve small employers of up to 100 employees, to begin full operation in 2014.

Planning and start up costs are covered through ACA grants, therefore there will be no cost to the state in the next biennium. However, by 2015, one year after the exchange is fully operational; exchanges must be financially self-sustaining and no longer reliant on federal funding. During 2013 HHS will make a final determination if the exchange is ready for operation. In order to meet that goal, extensive planning is required now and, in fact, is already underway. An exchange planning grant of $1 million has already been received and the next grant application related to exchange planning will be due as soon as the spring of 2011.

Insurance Rate Review

The Department of Insurance received a grant of $1 million to provide additional actuarial and other resources to the insurance rate review process. The grant is also intended to improve the transparency of the rate review process. However, to fully insure a process that balances the needs of insurance companies with the needs of their customers, rate review legislation is likely to be filed in the 2011 session by the Office of Healthcare Advocate. This legislation, which has been filed in previous years but not passed, will include provisions to:

- Require that the insurance departments post complete rate-filings from the insurers online
- Requiring public hearings on any rate requests that exceed a certain percentage, e.g. ten percent
- Allow the participation of the Offices of the Healthcare Advocate and the Attorney General as interveners with the right to cross-examine insurers on all issues relevant to the rate request
- Require the Insurance Department to consider certain factors in determining whether a rate request is excessive, including the insurer's financial information, e.g., its arrangements with a parent company, its profits/losses, etc.

Given that the funding from the ACA is intended to cover improved transparency of the rate review process, there should be little or no cost associated with these changes in the rate review process. And the potential for more transparent process to help with moderating rate increases will be beneficial to individuals and employers, who have continued to experience large, often double digit increases.

Restructuring of Enrollment and Eligibility Functions within Medicaid

States will be required by the ACA to implement a “No Wrong Door” enrollment system for individuals seeking health insurance, whether through Medicaid or through the Exchange. Eligibility standards are also going to change significantly, in an effort to achieve a much more streamlined application process. This will require huge changes to the current enrollment and eligibility processes and culture, as well as significant upgrades to the current Medicaid information system. HHS has already stated that it will cover 90% of the costs of the computer system upgrade. There are also national efforts underway to provide additional funding for these efforts. For example, Families USA, along with several other key partners is organizing Enroll America. The Office of Health Care Reform Implementation can stay abreast of potential funding sources as well as assure the necessary coordination between exchange and Medicaid enrollment planning.

Maximizing Federal Reform and Private Philanthropy Grant Dollars

Significant grant funding is available from the ACA in such categories as:

- Delivery system reforms
- Public health programs
- Health care workforce
- Health care reform implementation
- Support for community-based wellness, chronic care and long term care programs

A partial list of grant opportunities is listed in the Health Care Briefing Paper provided as a separate attachment to this submission.

Given the momentum and innovation occurring in Connecticut around health care reform, it may also be possible to attract large grants from national foundations. In addition, local health foundations have shown a willingness to fund health care reform efforts. The funding collaborative formed in 2009 that supported technical assistance to SustiNet included two local and two national foundations:

- Connecticut Health Foundation
- Universal Health Care Foundation of Connecticut
- Jesse B. Cox Trust
- Robert Wood Johnson Foundation

SustiNet

SustiNet, Connecticut's health care reform law, passed in 2009. The SustiNet Health Partnership board of directors will be releasing their report to the Connecticut General Assembly in early January, 2011. A wealth of information can be found in the board minutes and presentations and task force and committee reports found on the website: www.ct.gov/sustinet. While the board's recommendations have not yet been finalized, consensus has been reached on many action items including several with immediate implementation:

- Pooling of health care purchasing at the state level to maximize the state's purchasing power and enable municipalities, small businesses, non-profits and individuals to benefit from that leverage
- Delivery system reform efforts that benefit, at a minimum Medicaid recipients and the state employee health care plan, but in many cases could benefit other state residents as well.
    - Patient Centered Medical Home (PCMH), including the Primary Care Case Management (PCCM) program already operated by Medicaid and the pilot PCMH program being implemented by Pro-Health Physicians for the state employee health plan
    - Health information technology/health information exchange
    - Payment reform

(Note: see separate papers on each of these key delivery system reforms included in this submission for more specific information as well as several other papers which also mention the importance of one or more of these reforms.)

- Medicaid restructuring. As mentioned earlier, the Medicaid enrollment and eligibility processes will undergo significant change in the next few years in order to assure that the state is ready for ACA implementation. Other, more imminent changes to Medicaid include:
    - Ending the overpayments to Managed Care Organizations (MCOs) and shifting the operation of the HUSKY program to Administrative Service Organizations (ASOs) and/or PCCM. (Note: the Connecticut Health Foundation is supporting the Medicaid Managed Care Council's workgroup regarding the restructuring of Medicaid. The study will examine different means of administering the Medicaid program from MCOs, ASOs, PCCM, ACOs, and others. Other states are being examined to inform best practices. Some of the states to be interviewed are North Carolina, Illinois, Oklahoma, Massachusetts, and Minnesota. This report is to be presented to the Medicaid work group the first of January. The researcher is developing recommendations keeping in mind national and state health reform.)
    - Pursuing ACA funding opportunities specific to improving care and lowering the cost of care for Medicaid recipients. (Addressed by several papers in this submission).

A. Prioritization Schedule and Timeline

Given the momentum behind health care reform in the state, the complexity of implementation, and the pending deadlines, establishment of the Office of Health Care Reform Implementation should occur as soon as possible.

B. Fiscal Impacts

The Rell Administration appointed a Special Advisor for Health Care Reform to coordinate Connecticut's response to federal reform and convened a Health Care Cabinet, consisting of some, but not all, of the state agencies with responsibility for health care. This paper proposes a more robust, comprehensive approach, through the creation of an Office of Health Care Reform Implementation. The Office can utilize existing state government positions and resources but the Malloy administration will want to carefully consider the size and staffing of the Office, and insure it has the authority to move the state forward as quickly and effectively as possible. A good portion of the work of the Office can be funded by ACA and perhaps private foundation grants, written directly by the Office, or coordinated by the Office. For example, in the short run, exchange planning grants will fund the planning and implementation of the exchange. In the longer run, the implementation of delivery system reforms will generate cost savings.

C. Job Impacts

As stated in the Malloy/Wyman health care policy proposal, the availability of quality affordable health care will make Connecticut "a more business-friendly state" and is, overall, a "job creator". More people with access to health care will mean more health care jobs. Delivery system reforms will also create new positions, such as those related to care coordination and electronic health records, for example.

D. Tie-in to Malloy/Wyman Campaign Policy

The Malloy/Wyman health care policy proposal lauds the passing of federal reform legislation. SustiNet is also strongly supported as an "important step closer to achieving quality, affordable healthcare for every Connecticut resident. In fact Nancy Wyman has served as co-chair of the SustiNet board. It also includes specific support for many of the policies discussed in this paper as well as the other papers in the health care reform section of the Healthcare Working Group's submission to the Transition Team including:

- Pooling the state government's "purchasing power and large number of covered lives to help drive down costs for municipalities and boards of education-as well as other employers."
- Connecting "all providers with electronic medical records" and changing "the way we pay for healthcare services in the State."
- Ending the overpayment of HUSKY HMO's and expanding PCCM
- Providing leadership to create Patent Centered Medical Homes
- Training more primary care physicians, nurses and other providers
- Investment in public health and primary care to avoid the exorbitant costs of preventable illness

E. Benchmark state(s)

- Oregon is planning a public health insurance option that is intended to ultimately compete in the health insurance exchange. Information can be found on the web site of the Oregon Health Policy Board.
- Massachusetts has implemented a health insurance exchange, California has passed legislation and Oregon recently released an exchange plan. Utah has also piloted a statewide exchange for small businesses and individuals.
- Massachusetts, Vermont and Maine are states who have already implemented state-based reform and now are organizing to implement federal reform.

F. People/Organizations in Connecticut Who are Knowledgeable/Supportive

All those contributing to the Healthcare Working Group policy document support achieving access to quality, affordable health care for all Connecticut residents. While there may be some disagreement regarding exactly how to get there, there is significant consensus regarding the need to achieve delivery system re-design, a focus on public health and prevention, and paying for value. Other supportive organizations include members of the SustiNet Board, Task Forces and Advisory Committees, participants in the healthcare4every1 coalition, Small Business for a Healthy Connecticut, the Interfaith Fellowship for Universal Health Care and many other individuals and organizations throughout the state.

G. Dissenting opinions/organizations

As stated above, there is much agreement among stakeholders and consumers. Disagreement largely lies in finding the right balance between the role of government and the role of the private sector in achieving the goals of reform.

Long Term Needs/Vision

- Connecticut leads the way in implementation of health care reform that provides access AND addresses cost and quality.
- Connecticut maximizes funding from the ACA and promotes delivery system innovation.
- Connecticut assures that public dollars are spent in the most efficient, effective way possible to maximize health care outcomes and minimize waste and duplication.
- Even after the initial intensive years of health care reform implementation, Connecticut continues to coordinate health system change and improvement within the public sector and between the public and private sectors.
- Connecticut establishes targets and measures progress toward assuring access to quality, affordable health care for its residents and employers, and toward becoming the healthiest state in the United States of America.

Strategic Health Care Plan for Connecticut

Jack Reed
President and CEO
ProHealth Physicians

Statement of Issue:
We have a mandate to provide strong direction to our national and state health care crisis. Resolution of the issues will not be limited to the short term redesign of financing models, benefit plans, or awkward legislation. While we must address the immediate health care needs for our residents whether that be for chronic disease management, access to primary care or acute care, the core resolution will be to look at our health care system requirements in much longer time intervals and accept the reality that it took us decades to arrive at this crises and it will take more than a generation to move beyond it.

As a result, we must continue to follow a course that shapes and refines policies for the each major strategic category of need. For example:

I. Planning for Success:
Given the enormous cost of health care and further the consequences of an inadequate health care system we must have a strong and empowered infrastructure to create change. The quality of ideas won't matter nor will we ever achieve the level of success that is possible if we fail to organize ourselves for success. Given the magnitude of opportunity and complexity of the change process, we should appoint a commissioner level position to drive improvements in the state's health care system. A position that is not part of existing departments, but can cut across all regulatory agencies and purchasers of health care both public and private, with the specific objective of addressing those tactics to meet short needs and plan for longer term outcomes. This position must be complemented by a non-partisan board of industry and public leaders from all sectors who will not only address legislative issues, but consistently review data and tactics to improve the health of our residents and lead to a more competitive environment for the purchasers of health care. Both functions will be very proactive to ensure that the State actively competes for those federal dollars that supporting change.

II. Access:

a. Continued investment and expansion of community health centers to serve the areas of the state demonstrating the greatest areas of need is critical to addressing access and having an impact on resulting costs. Communicating the known gap in the delivery system, continued provision of incentives to support expansion of the centers, development of incentives to support high clinical, operating and service outcomes within the centers is all necessary. The cost of poor access to care is known; therefore the ROI model for such an effort is easily determined. However, if the state decides to support such an effort, clear expectations must be set.
b. Expansion of school based clinics need to be reassessed. It is without dispute that a large percentage of inner city students who have little access to routine health care needs can strongly benefit from school based clinics through the term of their education. This must include primary care, dental care and behavioral health. The operating models for the clinics

can include management by the community health centers, hospitals, medical group practices or the school districts. Linking the clinics electronically to other providers will greatly enhance their capabilities.

Creation of a social networking strategy to communicate with student as they mature will also be of value to set forth a foundation for a long term life style for health.

A template for information on the delivery of care within every school in the state should be created (if not already in existence) to determine areas of improvement.

c. As a State we also need to recognize that enhancing the health of our residents, reducing the long term cost of care, and improving the management of chronic disease also includes access to an appropriate food supply. The State needs to investigate with the major grocery store chains or alternative provider the potential of establishing grocery stores in each of our inner cities to ensure that our residents can routinely access food that meets their nutritional needs, begin to impact obesity, and may offer opportunities to improve their health status. It may require grants, tax rebates and other forms of creative, unconventional thinking to accomplish this objective. As CVS and Walgreens demonstrated the stores may also become a site for primary care services.

d. Primary care manpower development is a critical issue for our delivery system. We need to communicate broadly to all system participants the number of providers required to meet current and future demand and also redesign how we deliver primary care to increase the capacity of those sites to manage patients.

- ✓ Much focus has been placed on creating incentives for medical students to select primary care as their career focus. It is an important component of fulfilling demand and the State through the School of Medicine should encourage models that meet this objective, such as tuition rebates for selecting primary care for specific time frames. While there may be a state sponsored tuition waiver we may also consider incentives for existing health care organizations to implement incentives to physicians to retire their medical school tuition debt in exchange for a commitment towards a primary care service.
- ✓ Existing primary care providers must be incented to be a part of the educational process of medical students. At the present time, while they are an integral part of the educational process. They are highly depended upon to provide an educational experience to medical students which may lead to that student's decision to become a primary care provider. But the financial incentive is grossly inadequate other than a professional interest to continue in a preceptor role. The pressures of reimbursements, the economy, and E HR are major impediments to continue in that role.
- ✓ We need to also create similar incentives to support the development of incentives to encourage primary care commitments for nurse practitioners and physician assistants.
- ✓ Medical assistants play a major role in the primary care settings, but their impact is limited by the restrictions that are placed on the scope of services that they can provide, training requirements, and licensure. It would be a wise decision to evaluate the expansion of the role of MA's in primary care settings, the required training, cost of licensure, increased cost on the benefits of increased capacity for patient care at primary care offices.
- ✓ We need to responsibly change the reimbursement levels in the State Medicaid program for providers to make it possible for them to provide services to these patients. If we did this, it may be possible to identify the cost savings that will result

from increase primary care access, care coordination and improved disease management.

III. Health Information Technology:

a. A strong statement to the public, our state's health care organizations, and industry leaders is required regarding our future vision on HIT inclusive of electronic health records adoption, development of interfaces among providers and payers, and patient/consumer portals for health care information. With that statement will be a commitment to an organizational process through which we intend to achieve it. There are several pieces in place, but we need to demonstrate conviction to achieve what is possible.
b. We require a full commit towards the comprehensive development of a state wide Health Information Exchange to ensure that providers and health care organizations who have implemented EHR, patient portals and other information technologies can use that information to support the improvement in health care delivery. As a State we must assertively support efficient access to health care information for all elements of the health care system inclusive of consumers. Incentives should be considered to encourage participation given the benefits that it will eventually provide. Community based providers require support to deploy these sophisticated systems, and generally do not have the capabilities to do so. A key resource that the State can evaluate is the firm commitment to develop a utility type of function to facilitate acquisition, planning, implementation, and use of these systems.
c. Continued encouragement of the growth of the electronic health records among providers is critical. There are several incentives in place from the federal government and the hospitals, although additional consideration should be made towards incentives to cause providers to adopt the technology. For community based providers, it is an expensive undertaking not solely from the upfront costs and ongoing costs, but also the impact on daily productivity. Perhaps the state could consider a payment differential in Medicaid if providers were using an EHR and participating in the HIE or had demonstrated interfaces with other major health care organizations.

IV. A Focus on Wellness and Prevention:

a. We need to put into place a strong public awareness process to ensure that the residents of Connecticut have a firm understanding of their role and responsibility in managing their health care. Without a sense of public understanding that we are in effect the cause of the health care crisis through our unrelenting demand and need for services (the result of our lifestyles) the crisis may never subside.
b. This starts at the elementary school level and continues through high school. It includes an expanded role for school based clinics, health education, availability of appropriate food for breakfast programs and lunches, and possibly a strong social networking communication program.
c. In our inner cities and for individuals with public assistance health care plans
    1. we might consider leveraging the school based clinics to adult care in the evenings and weekends for primary care level services, flu vaccines etc.;
    2. We need to engage the Churches within the inner city to communicate to our residents the need and value for all disease prevention behaviors and wellness

exams. The State will need to be an active partner in ensuring that there is adequate access for diagnostic testing to address early detection of disease inclusive of cancers and heart disease;

d. As a State we need to have several very aggressive campaigns to address the drivers of disease namely obesity, smoking, and sedentary life styles.
e. Employers and Payers need to embrace their role in Wellness and Prevention as a higher level. As high deductible health plans have increased the number of office visits to primary care providers have declined. Patients (consumers) in increasing numbers are misunderstanding their benefit plans and avoiding routine office visits or diagnostic testing for early detection. This may result in future issues if left unaddressed.

V. Health Care Financing:

a. Connecticut needs to continue our efforts to plan for the Health Insurance Exchange to ensure that we can offer health insurance to all residents. We must demonstrate a commitment to this process as one of the tools we use to ensure access to health care insurance.
b. Refining how a public option plan is incorporated into this initiative or as a standalone remains an important undertaking. The pubic option will be not be a sustainable approach if the reimbursement levels are set at current State/Medicaid levels.
c. There should be an industry wide undertaking with all payers and providers to address how their collaboration can reduce the continued administrative barriers within the health care industry which reduces productivity, limits access to providers and is very costly. A commission with convener level status should be considers to investigate this opportunity.
d. We need to create incentives for clinical and cost performance within Medicaid so that providers can realize improved reimbursements based on their ability to generate increased clinical outcomes and care coordination results.

SUSTINET

Juan Figueroa
Co-Chair, Healthcare Working Group

In July, 2009, the Connecticut General Assembly overrode Governor Rell's veto and passed the SustiNet law. The law appointed the SustiNet Health Partnership board of directors and empowered them to "design and establish implementation procedures to implement the SustiNet Plan."

RESULTS

The law charges the SustiNet Plan to achieve the following results:

- Improve the health of state residents
- Improve the quality of health care and access to health care
- Provide health insurance coverage to Connecticut residents who would otherwise be uninsured
- Increase the range of health care insurance coverage options available to residents and employers
- Slow the growth of per capita health care spending both in the short-term and in the long-term
- Implement reforms to the health care delivery system that will apply to all SustiNet Plan members

In addition to the cost, quality and access results listed above, the law recommends that action plans to achieve measurable objectives be established regarding:

- Management of chronic illness
- Preventive care
- Reducing racial and ethnic disparities as related to health care and health outcomes

These results would be achieved through a well-managed health plan that promotes delivery system reform including:

- Participating providers will utilize interoperable electronic medical records
- SustiNet members will have access to a patient-centered medical home, with priority given to members with chronic health conditions. The medical home concept includes the following:
    - Care coordination
    - Providing support, assistance and education to patients to enable them to safeguard and improve their own health
    - Providing improved access to care through telephone and email contact as well as more evening and weekend or same-day appointment access
- Systematic implementation of evidence-based clinical care and safety protocols, including providing ongoing measurement and feedback regarding provider performance
- Offering a benefits package that provides coverage for preventive and chronic disease management
- An overall emphasis on promoting health equity and reducing health disparities

- An approach to reimbursement that provides incentives for quality and value over volume and that supports prevention and the maintenance of medical homes

These approaches would not only improve health status, but they would also lead to cost savings through avoiding inpatient hospitalizations and emergency room visits. Additionally, they would prevent or slow the progression of costly chronic illnesses.

SustiNet Plan Membership

Achieving delivery system change is a challenging goal. Nevertheless, if the SustiNet Plan has a large enough membership, it can use its leverage with providers to push for change. SustiNet Plan membership is proposed to start with two large groups for which the state of Connecticut already funds health insurance costs: Medicaid recipients (funding shared with the federal government) and state employees and retirees. Improving the health status of these populations through a health plan that emphasizes prevention and chronic care management will help to moderate the steep growth in health costs the state has had to shoulder.

Starting with these two large populations would give SustiNet a critical mass of close to 700,000 covered lives. The size of the plan could then be increased by offering SustiNet coverage to small businesses, non-profits, municipalities, and the uninsured. This would make a quality, affordable option available in the small group and individual markets where insurance costs have skyrocketed and coverage has generally become less comprehensive.

In this way, a state-based public option would lead the way in innovation to improve quality and lower costs, as well as provide access for those in the most troubled sectors of the current insurance marketplace.

Board, Committees and Task Forces

The SustiNet board has been meeting since September, 2009. Minutes from board meetings and materials discussed at the meetings can be found at www.ct.gov/sustinet. Board meetings are broadcast on CTN, and previous board meetings can be found in their video archives at http://www.ctn.state.ct.us/ondemand.asp.

The legislation also established five committees and three task forces:

SustiNet Committees

1. Health Information Technology Advisory Committee
2. Patient-Centered Medical Home Advisory Committee
3. Health Disparities and Equity Advisory Committee
4. Preventive Healthcare Advisory Committee
5. Healthcare Quality and Provider Advisory Committee

SustiNet Task Forces

1. Tobacco and Smoking Cessation Task Force
2. Childhood and Adult Obesity Task Force
3. Healthcare Work Force Task Force

Over 160 volunteers participated in the committee process. Committee and Task Force reports were submitted on June 30, 2010 and can be reviewed at www.ct.gov/sustinet.

60 Day Analysis

60 days after federal reform passed, the SustiNet law required that the board submit a preliminary analysis of the new law's impact on SustiNet. That report, produced in late May, can also be found on the SustiNet web site.

SUSTINET-RELATED PILOT PROGRAMS

Several efforts are currently underway in the state that relate to SustiNet.

Primary Care Case Management

Primary Care Case Management (PCCM) is a pilot program within the state's HUSKY program that offers a medical home model to enrollees. The program offers participating providers an additional $7.50 per member per month (pm/pm) to manage the care of members. Thirty other states offer similar programs as part of their Medicaid options. Cost savings from this approach have been documented in diverse states, including Oklahoma and North Carolina.
http://www.chcs.org/usr_doc/EPCCM_Full_Report.pdf

Connecticut's program, opened in February, 2009, is currently operating in four areas of the state. Enrollment is low, at approximately 500 people. Advocates argue that DSS has stymied enrollment by not marketing the program and by providing limitations on where it is offered. These complaints are echoed by the Connecticut State Medical Society:
https://www.csms.org/upload/files/PDF/10-06-10%20DSS-AAP-HUSKY%20jointletter.pdf

State Employee Medical Home Pilot

When the state employee health plan was put out to bid in 2009, the Comptroller's office requested a strong medical home component. Pro-Health Physicians, a statewide multi-site primary care group, has agreed to provide medical home services to state employees and retirees who receive care at one of their practice sites. United Healthcare and Anthem, the insurance carriers for state employees, have agreed to provide extra reimbursement for medical home services.
http://www.ct.gov/sustinet/lib/sustinet/committeeinformation/medical_home/pcmh_report_final.pdf

Building on this project, the state has now applied for an ACA grant to expand this pilot to include Medicare, Medicaid and privately insured patients.
http://www.cthealthpolicy.org/briefs/issue_brief_54.pdf

Healthcare Workforce Planning Grant

The Connecticut Employment and Training Commission (CETC) has received a $150,000 grant to produce a statewide health care workforce plan. The need for such a plan has been highlighted in many studies throughout the years. The state already has documented workforce shortages in key areas. With a rapidly aging population and increases in coverage due to health care reform, these shortages are likely to become more acute.

Resources on the health care work force include:
http://www.cwealf.org/files/media/Resource/AHWPB_2010.pdf
http://www.ct.gov/sustinet/cwp/view.asp?a=3822&q=450070
https://www.csms.org/index.php?option=com_content&task=view&id=2590&Itemid=222

Health Information Technology/Health Information Exchange

The federal government has provided significant funding under the stimulus package (American Resource and Recovery Act) to help states move forward with the implementation of health information technology. The Department of Public Health is coordinating the planning and implementation of a Health Information Exchange in Connecticut. Beginning in January, 2011, this responsibility will be transferred to a quasi-public agency, Health Information Technology Exchange-Connecticut (HITE-CT), overseen by a governing board. The Department of Public Health produced a strategic and operational plan in September, 2010. The plan documents that dissemination of electronic medical records at the physician-practice level is still in its infancy in Connecticut. Furthermore, the large variety of different systems on the market means there is little to no ability to communicate information between practice settings.
http://www.ct.gov/dph/lib/dph/research_&_development/ct_hite_strategic__operational_plan_sept2010.pdf

A second grant of $4.75 million was received by ehealthCT to provide support and assistance to providers implementing electronic medical records. http://www.ehealthconnecticut.org/REC.aspx

Department of Public Health Planning Process

A planning process is underway to link risk-factor reduction (smoking, poor nutrition, lack of physical activity, etc.) to the prevention of multiple chronic diseases (heart disease, stroke, diabetes, cancer, asthma). This approach is illustrative of the need to break down silos that have historically existed among different disease prevention efforts. As this planning process moves forward, it can be connected more deliberately to SustiNet.

Potential Federal Funding Related to SustiNet

The Affordable Care Act (ACA) also provides significant opportunity for Connecticut to implement programs to improve the efficiency and effectiveness of our health care system. While the federal government will set overall regulatory parameters, innovation at the state level is encouraged. Funding of state-based innovations will be available to states that are organized to seize the initiative.

The SustiNet Framework enables Connecticut to apply for ACA future funding opportunities. Categories of grant funding include:

- Public health, prevention and wellness programs
- Delivery system innovations
- Payment reform initiatives all-payer efforts (grant application has been filed)
- Payment reform initiatives for dually eligible; for Medicaid
- Addressing ethnic and racial health disparities

- Health care workforce
- Community health centers and school-based health centers

Two PowerPoint presentations given at the September 8 and September 22 SustiNet board meetings include lists of possible ACA grant opportunities:

Preventive Care

- 10 state wellness demonstration projects (Secs. 1201 and 4206)
- Grants for incentive programs to help Medicaid recipients quit smoking, control/reduce weight, lower cholesterol and blood pressure (Sec. 4108)
- Grants for community preventive health activities (Sec.4201)
- Pilots to promote healthy aging (Sec.4202)
- Demonstration to increase immunization of high-risk populations (Sec. 4204)
- Support community-based collaborative care networks of providers to provide comprehensive coordinated and integrated health care services for low-income populations (Sec. 10333)
- Workplace wellness grants for small employers (Sec. 10408)

Delivery System Reform

- Planning Grants to Provide Health Homes for Chronically Ill Patients (Sec. 2703)
- Establish Community Health Teams to Support Patient-Centered Medical Homes (Sec. 3502)
- Pediatric ACO Demonstration (Sec. 2706)
- Medicare Shared Savings Program, ACOs (Sec. 3022)
- Co-locating primary and specialty care in community-based mental health settings (sec. 5604)
- Community-based Care Transitions Program (sec. 3026)
- Extension of Rural Community Hospital Demonstration (Sec. 3123)
- Medicare Hospice Concurrent Care Demonstration Project (Sec. 3140)
- Grants or contracts to implement medication management services in treatment of chronic diseases (Sec. 3503)

Payment Reform

- Demonstration project to evaluate integrated care around a hospitalization, bundled payments (sec. 2704)
- Medicaid Global Payment Demonstration (Sec. 2705)
- Value-based purchasing demonstration programs (Sec. 3001)
- National Pilot Program on Medicare Payment Bundling (Sec. 3023)
- Medicare demonstration based on the study of home health agencies (Sec. 10315)

It will be important to monitor and attempt to block any possible efforts of the U.S. House of Representatives to de-fund some of the ACA grants. Close contact with Connecticut's Congressional delegation will be essential.

Legislative Briefing on SustiNet

Below are several slides excerpted from a presentation made on December 16, 2010 by Stan Dorn of the Urban Institute, who has worked as a consultant to the SustiNet Board. The Board has not yet completed its work. Their final report will be submitted to the General Assembly the first week in January. This presentation summarizes a general sense of where the Board seems to be headed. It also summarizes some of the results of the economic modeling presented to the Board at their November 18 meeting.

A copy of the entire presentation can be found at www.ct.gov/sustinet Click on "SustiNet Health Partnership Briefings" under "Latest News" to find this and other materials used in the two public briefings and the legislative briefing held during the second week in December. A presentation on cost and coverage estimates can be found by clicking on Board of Directors on the menu to the left and then scrolling down to the November 18 meeting.

Board process

- Members appointed by Governor and Legislature
- 5 committees and 3 task forces addressed key issues
  - More than 160 volunteer participants
  - By July 1, 2010, reported detailed recommendations to the SustiNet Board and the Legislature
- Board action
  - 19 open meetings, 2 hearings for public testimony
  - May 30: "60-day" report analyzed impact of federal reform
    - Many common elements with SustiNet and federal reform
  - Dr. Jonathan Gruber of MIT modeled cost and coverage effects
  - Final report will make legislative recommendations

What will the Board propose?

- Nothing is final
- What follows reflects a general sense of where the Board seems to be headed
- General areas of proposal
  - What is the SustiNet plan?
  - Who is in the SustiNet plan?
  - How does the proposal achieve its goals?

What is the SustiNet plan?

- A publicly-administered plan, applying the country's best thinking about reforming health care delivery to slow cost growth while improving quality
  - Patient-centered medical homes
  - Health information technology
  - Incentives for evidence-based medicine
  - Payment reforms
- Administered by independent authority
  - Time-limited step: use current staff within an existing agency
  - Can adjust delivery system/payment reforms based on new evidence
- Areas of focus include chronic illness and racial/ethnic disparities

Who is in SustiNet?

- Phase I: current state-sponsored populations
  - Categories
    - Medicaid and HUSKY
    - State employees and retirees
  - Approach
    - Short-term goal: slow cost growth
    - Common platform for delivery system reforms
    - Important differences (e.g., benefits, legal constraints, payment rates)
- Phase II: an option for municipalities, small firms, non-profits
  - Before 2014, if feasible
- Phase III: an option for other employers and residents
  - Starting 1/1/2014
  - Offered both inside the exchange and in other venues

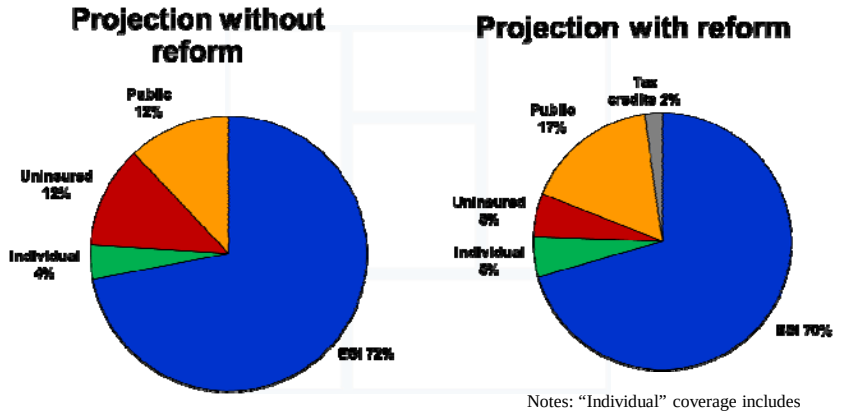
SustiNet as an option in commercial markets

- Commercial-style benefits
  - Must meet state benefit requirements
- Follow applicable market rules, to prevent adverse selection
  - Premium rating rules for individual and small group markets
  - For employers large enough to self-insure, can experience-rate premiums
- Will require preparation – e.g.:
  - Need insurance license to be sold in the exchange
  - Business plan, feasibility study

Goal #1: covering the uninsured

- Before 2014, HUSKY covers all adults up to 185 percent of the federal poverty level (FPL)
  - ***Depends on finding resources***. Could cover 60,000 people, creating net state costs of $100 to $150 million a year. Just until 2014.
- Starting in 1/1/14, much more federal money.
  - HUSKY to 133% FPL. Federal Medicaid dollars pay 90-100% of costs for newly eligible adults.
  - HUSKY for adults at 133-200% FPL. Federal Basic Health Program (BH) dollars pay 100% of all costs.
- Net results (2017):
  - 200,000 fewer uninsured, a 55% drop
  - Among small firms:
    - Employer-sponsored insurance (ESI) falls by 9-10%, saving firms $410-$415 million
    - Most employees leaving small-group ESI shift to the exchange

Coverage of residents under age 65, with and without SustiNet plus federal reform: 2017



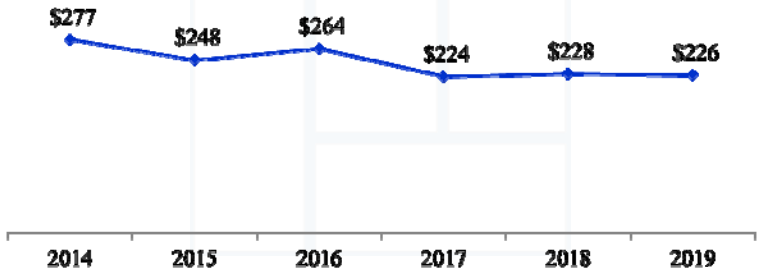
Source: Gruber Microsimulation Model, November 2010.

Notes: "Individual" coverage includes unsubsidized coverage in the exchange.

Effect on state budget, 2014 and beyond

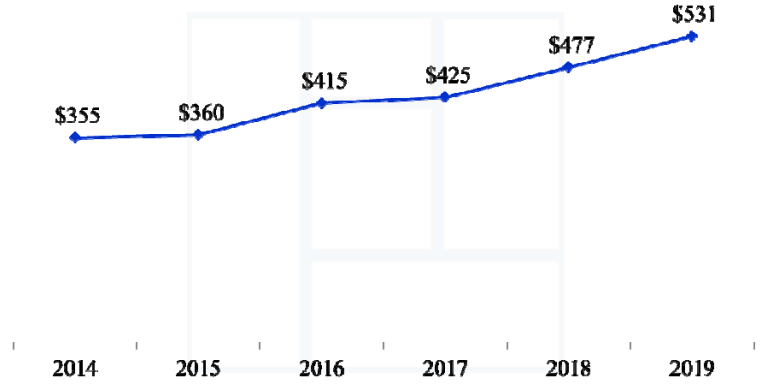
- Ongoing savings
  - Federal funds substitute for state spending
    - Federal government pays >95% of SAGA costs
    - Some HUSKY parents shift from 50/50 Medicaid to 100% federally-funded BH
  - If SustiNet slows cost growth, additional savings
    - Pessimistic scenario: no effect on cost growth
    - Optimistic scenario: cost growth slows by 1 percentage point per year
- Ongoing costs
  - More enrollment in current HUSKY categories
  - Starting in 2017, state must pay some costs for newly eligible Medicaid adults

Net state budget savings, pessimistic scenario: 2014-2019 (millions)



Source: Gruber Microsimulation Model, November 2010.

Net state budget savings, optimistic scenario: 2014-2019 (millions)



Source: Gruber Microsimulation Model, November 2010.

Goal #2: slowing health care cost growth while improving quality

- How SustiNet sparks broad reform of health care delivery
  - Leading by example
  - Leading by competing
  - Business case for savings
  - Cooperating in multi-payer efforts
  - As enrollment rises, more leverage to implement reforms

Estimated SustiNet enrollment, outside state-sponsored groups: 2017

	Small firm enrollment		Large firm enrollment		Individual enrollment	
	Covered lives	Share of small firm coverage	Covered lives	Share of large firm coverage	Covered lives	Share of individual market
Pessimistic scenario	136,000	24%	126,000	8%	32,000	14%
Optimistic scenario	164,000	29%	165,000	10%	33,000	15%

Source: Gruber Microsimulation Model, November 2010.

Other policy elements

- Insurance company discrimination addressed by other features of federal law
- Gradually raise Medicaid/HUSKY payment to Medicare levels
  - Part of more comprehensive Medicaid payment realignment
    - Some payments will not rise
    - Some payments may fall
    - For some populations, Medicare not the right model
  - In 2012, budget-neutral adjustments
  - Legislature and state agencies will work together to find resources that fund further increases
- Public health investments: obesity, tobacco, prevention, workforce

Patient-Centered Medical Homes

Ellen Andrews, PhD
Executive Director
Connecticut Health Policy Project

Issue Paper: Implement patient-centered medical homes for every member of state coverage plans

I. Statement of issue:

Patient-centered medical homes (PCMHs) coordinate fragmented services and give patients the tools and support they need to improve and maintain their own health. PCMHs reduce the need for specialty care, improve access, reduce duplicate tests, reduce unnecessary and conflicting medications, keep patients out of emergency rooms, and improve patient safety by strengthening the patient-provider relationship and by emphasizing primary care and prevention.[1] Two years ago, CT's HUSKY program initiated a PCMH pilot (Primary Care Case Management) but enrollment has been low due to a lack of state support. Under the leadership of the Comptroller's Office, Connecticut has implemented a PCMH pilot to include Medicaid and state employees; efforts to grow this initiative and expand to Medicare and other payers should be supported. CT needs to build on the momentum created by our recent Medicare PCMH application[2], and the strong Congressional delegation support, to access federal funds.[3] Connecticut has recently joined with the other New England states (and a few others) in a PMCH evaluation and learning collaborative allowing CT to benefit from private foundation funding.

II. Immediate Action Areas (6 months to 2 years)

a. Schedule and timeframe: The state employee PMCH program will be operational early next year and could be expanded to new sites by the end of 2011. Statewide PCCM could be operational in 6 to 8 months, particularly if the advocacy and provider communities are productively engaged in the effort.
b. Fiscal impacts: The state could potentially save $71 to $530 per person per year[4], eventually reaching approximately 850,000 people covered by state programs totaling $250 million or more in annual savings. National health reform includes several significant funding opportunities for states to implement and support patient-centered medical homes, within Medicaid and for larger communities.[5]
c. Job impacts: Patient centered medical homes refocus the health care system on primary care teams and care coordination. CT is facing a serious shortage of primary care providers which will be difficult and expensive to remedy. Stress, poor quality of life and lower pay have been cited as causes.[6] Building a team of professionals to care for patients through PCMHs eases stress on primary care doctors, provides quality of life

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[1] Patient Centered Medical Homes: The Fix for Our Health Care System?, CT Health Policy Project, June 2009, http://www.cthealthpolicy.org/medicalhome/patient_centered.pdf
[2] Connecticut's Patient Centered Medical Home Medicare Application, CT Health Policy Project Policymaker Issue Brief No. 54, September 2010, http://www.cthealthpolicy.org/briefs/issue_brief_54.pdf.
[3] CT Congressional delegation letter to CMS Administrator Berwick, October 8, 2010.
[4] D. Fields et. al., Driving Quality Gains and Cost Savings through Adoption of Medical Homes, Health Affairs 29:819-826, 2010.
[5] Patient Centered Medical Homes in the Patient Protection and Affordable Care Act, CT Health Policy Project, May 2010, http://www.cthealthpolicy.org/medicalhome/20100516_pcmh_and_federal.pdf
[6] SustiNet Health Care Workforce Task Force Report, July 2010.

relief, increased pay, and has been linked to higher primary care physician job satisfaction and retention. It allows doctors to "get off the treadmill" of 15 minute visits and long hours at the office.[7]

PCMHs also create and expand new job categories, most notably care managers. These positions require less educational investment than many health professions and will likely be a significant future driver of job creation in CT.

d. Tie in to Malloy/Wyman campaign policies: The Policy Project includes creation of all-payer PCMHs for every state resident and expansion of Primary Care Case Management to every HUSKY family (p. 51).
e. Benchmark states: VT, ME, MN, CO
f. People/organizations in CT who are knowledgeable/supportive: CT Health Policy Project, New Haven Legal Assistance, Office of State Comptroller, ProHealth Physicians
g. Dissenting opinions/organizations: Some payers are skeptical of savings. Some provider groups are skeptical that their primary care members will receive a fair share of the savings they generate through the PCMHs, and specialty groups are concerned that increases in resources to primary care will come out of their rates. Concerns of nurse practitioners and physician assistants that they would be left out of PCMHs were addressed recently by national PCMH accrediting bodies who have qualified them as lead clinicians. In CT as elsewhere, chiropractors have lobbied for qualification to lead PCMHs, however there is virtually no support and a great deal of resistance to this from other providers, consumer groups, accrediting bodies and from reviews of the research literature. An array of other provider groups have lobbied to be included in PCMH teams, within practices and/or within community PCMH support structures.

III. Long-term Needs/Actions

To support sustainable PCMHs the state must create a new, coordinating authority to guide development of medical homes in Connecticut. It is critical that the authority be independent of any provider group; no current state agency or authority has the necessary credibility to undertake this project. One of the most important tasks for the authority is to coordinate payment structures and evaluation standards across payers. Practices now have to navigate a dizzying array of incentives that vary between plans and payers, making the incentives too small and hard to access to be meaningful for small practices. However, a state convening authority and likely some legislative change is needed to provide anti-trust protection to payers and plans that wish to collaborate. The authority should also be responsible for conducting an independent, solid evaluation of PCMHs in CT, identifying best practices, challenges and solutions. The authority should also provide a learning collaborative for busy providers to learn new PCMH skills and share resources.[8]

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[7] R. Aseltine, M Katz and A Geragosian, Adoption of the Medical Home in Connecticut, CT Medicine 74:601-607, November/December 2010, B Darves, Patient Centered Medical Home Debuts, May 2009, New England J Medicine.

[8] SustiNet Patient-Centered Medical Home Advisory Committee Report, July 2010.

Health Information Technology

Ellen Andrews, PhD
Executive Director
Connecticut Health Policy Project

Issue Paper: Promote and require the use of health information technology tools

I. Statement of issue:

Moving patient records from paper to electronic files that can be shared is an important innovation in health care systems in Connecticut and across the US. It is one of the few health care reforms that most everyone agrees with. Electronic records will improve the quality and timeliness of care, reduce medical errors, save money, reduce duplicate testing, and generate data on the health of our state. If you show up unconscious at an emergency room, you want the doctor there to have all the information he needs to make you well and safely treat you. The state needs to foster the transition of medical records from paper to electronic formats, including provider electronic medical records and consumer personal health records, using the leverage of state coverage programs. Connecticut must develop a secure, private, user-friendly health information exchange for all state residents. Strong privacy protections, including opt-in consumer consent policies, are critical to the integrity of health information exchange and a viable statewide system.[9] Competence in health information technology is gaining interest as a component of physician licensure and renewal standards.[10] Unfortunately Connecticut is behind other states, in part due to our large proportion of smaller practices and a lack of state leadership on the issue.

II. Immediate Action Areas (6 months to 2 years)
   a. Schedule and timeframe: Development of a plan for a statewide health information exchange has been fractious. The pieces are in place, but it is unlikely that funding can be secured in the next year. Public education about the need for, and the risks of, health information technology has been non-existent. eHealthConnecticut's health information exchange Medicaid pilot is now operational, but without continued funding it will likely end within months.
   b. Fiscal impacts: Significant funding for these initiatives are available to purchase electronic medical record systems is available to physicians and hospitals directly from the federal government through Medicaid and Medicare. eHealthConnecticut has won a federal grant to train practices in the use of electronic records. DPH has won a federal grant to develop an interoperable health information exchange.

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[9] Public comment submitted to the CT Health Information Technology and Exchange, CT Health Policy Project, June 23, 2010, http://www.cthealthpolicy.org/pdfs/20100623_eHealth_DPH_plan_testimony.pdf

[10] H Chaudry, Federation of State Medical Boards: Maintenance of Licensure and Health IT, Health Affairs Blog, August 5, 2010, http://healthaffairs.org/blog/2010/08/05/fed-of-state-medical-boards-maintenance-of-licensure-and-health-it, K Weiss and S. Horowitz, American Board of Medical Specialties: Aligning Maintenance of Certification and Meaningful Use, Health Affairs Blog, August 5, 2010, http://healthaffairs.org/blog/2010/08/05/amer-board-of-med-specialties-aligning-maintenance-of-certification-and-meaningful-use

c. Job impacts: Jobs for Medical Record and Health Information Technicians in CT are projected to grow by 18% from 2004 to 2014.[11] Connecticut is home to a growing health information technology industry – many of the largest players in the field have corporate headquarters in our state.
d. Tie in to Malloy/Wyman campaign policies: The Policy Project references reducing health costs as a critical part of making Connecticut more business-friendly (p.39) and includes creation of all-payer patient-centered medical homes for every state resident (p. 51). Health information technology is critical to those goals.
e. Benchmark states: VT, NY, MA
f. People/organizations in CT who are knowledgeable/supportive: eHealthCT, HITE-CT
g. Dissenting opinions/organizations: There is little contention over the need for health information technology development, but great dissention over control of the information and exchange. A great deal of money and strong players are involved and the state has played a weak, even disruptive role. Cooperation has been difficult to achieve.

III. Long-term Needs/Actions

State leaders, at a high level, need to make this a priority and use their influence to bring parties together. Development of health information technology and exchange is critical to coordinating care through patient-centered medical homes, reducing medical errors, paying for quality, improving efficiency, reducing duplication of services, improving health outcomes, comparing/rewarding providers based on performance, fraud detection, and collecting the data necessary for essential public health functions as well as intelligent health system planning. Getting this right is critical to most health reform goals.

[11] Connecticut's Industries and Occupations Forecast 2014, CT Dept. of Labor, Summer 2006.

Payment Reform and All-Payer Initiatives

Ellen Andrews, PhD
Executive Director
Connecticut Health Policy Project

Issue Paper: Implement payment reform for all state health care purchasing and support all-payer initiatives to reduce overutilization and pay for quality

I. Statement of issue:

This includes a variety of initiatives implemented in other states such as pay-for performance for both providers and managed care plans, paying for episodes, or bundles, of care in one payment across the care continuum rather than paying fees for each individual service, and eventually making global care payments for individuals, risk adjusted to account for varying levels of need. The state should incorporate Value Based Insurance Design into coverage programs providing consumers with personalized incentives to improve their health, i.e. remove copays on blood pressure medications to improve compliance. While preserving competition and recognizing anti-trust concerns, the state should take a lead role among payers in developing Accountable Care Organization arrangements in our state to align incentives for efficiency among providers across the care continuum.

II. Immediate Action Areas (6 months to 2 years)
   a. Schedule and timeframe: CT lags other states in developing payment reform pilots, in both government and private employer programs. Some provisions can be implemented quickly, i.e. reducing copays for high value services. Some will take longer, i.e. creating contractual and structural accountability relationships, and the financial/data systems to support them, will take several years.
   b. Fiscal impacts: CT could save $126 million in Medicaid[12] annually. National health reform includes several funding opportunities for implementation of payment reform models.[13]
   c. Job impacts: This provision has the best hope of long term reducing health benefit costs which will ease pressure on wages and hiring in CT.
   d. Tie in to Malloy/Wyman campaign policies: The Policy Project references reducing health costs as a critical part of making Connecticut more business-friendly (p.39) and a significant driver of the cost of covering the uninsured (p. 48).
   e. Benchmark states: Maine and Minnesota have led states in bringing together employers with government payers to align standards and incentives, share oversight resources, improve the quality of care and reduce rising costs.[14]
   f. People/organizations in CT who are knowledgeable/supportive: Office of State Comptroller, CSG/ERC, CT Health Policy Project

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[12] $300 to 400 savings estimate per Medicare enrollee (E. Fisher, et. al., Fostering Accountable Health Care: Moving Forward in Medicare, Health Affairs 28:w219-231, January 2009), 90% proportional pmpm spending Medicare to Medicaid for CT (Kaiser State Health Facts), 400,000 estimated enrollment current

[13] Patient Protection and Affordable Care Act, (P.L. 111-148) Title II, Subtitle I.

[14] Value over Volume, Council of State Governments/Eastern Regional Conference, February 2010, www.valueovervolume.org.

g. Dissenting opinions/organizations: Anti-trust concerns have been raised by health plans and some large payers. Providers have expressed concerns that they will be held financially responsible for performance lapses they do not control, i.e. community doctors lose money when their patients experience a medical error in a hospital setting and conversely, hospitals lose money if community providers do not follow up with patients after discharge and patients are readmitted. There is some skepticism that payment rates will be accurately risk adjusted – that rates will reflect the varying health needs across the patient population.

III. Long-term Needs/Actions

Connecticut needs to develop an entity to take leadership, within government, coordinating and incubating payment reform pilots. Much value based purchasing is in its infancy and it is not clear what pilots will work in Connecticut. A trusted entity must provide guidance, evaluation, convening power to engage competitors across the health care system and foster collaboration while maintaining a competitive environment to limit skyrocketing health costs, using best practices from other states and systems.

Development of State Exchanges

Jerald Gooden,
Northeast Region President
Aetna

Statement of Issue:

I. The *Affordable Care Act* (ACA) requires each state to establish an Exchange for the individual and small group markets by 2014.

II. Immediate Action Areas (between 6 months and 2 years)

A. Prioritization schedule and timeline

Connecticut must balance the requirement to establish an Exchange by 2014 with the fact that HHS guidance on Exchanges will be evolving throughout 2011. Connecticut should consider delaying legislation until federal guidance is firm, or alternatively, Connecticut could move to pass Exchange authorization but not prescriptive legislation. In this way, Connecticut will avoid enacting a law that is inconsistent with the final federal guidance. Any Exchange should be market based, provide consumers with a choice of products and facilitate competition.

B. Fiscal impacts: Cost savings? Implementation costs?

CMS has awarded grants to states to facilitate Exchange planning and development, however, the cost of the Exchange will ultimately be borne by the state and is anticipated to be in the millions of dollars. There are no cost savings to state government resulting from Exchange development.

C. Job impacts

If Exchanges are not implemented effectively, it could lead to higher costs for health insurance and subsequently have negative consequences on employers and economic growth in Connecticut.

D. How does it tie-in to Malloy/Wyman campaign policy?

Exchange development is consistent with the Malloy/Wyman campaign policy to implement the relevant state provisions of the ACA. Exchanges, if implemented correctly, can serve to increase consumer choice and bring down cost. However, if done inappropriately, could result in unintended negative consequences.

E. Benchmark state(s)

Utah and Massachusetts.

F. People/organizations in CT who are knowledgeable/supportive

Insurance companies like Aetna offer unparalleled expertise in how insurance premiums and products are developed as well as how consumers make value-based decisions. Aetna would be happy to share this expertise with Governor Malloy and his team as they develop recommendations on the Exchange design.

G. Dissenting opinions/organizations

None identified.

III. Long-term Needs/Vision

The establishment of Exchanges is one of the most critical implementation activities in the Affordable Care Act. We would like to partner with the Administration as well as the States to assure that Exchanges streamline the process by which individuals can effectively and efficiently evaluate available

health plan offerings, while enhancing competition and preserving choice. To achieve these goals, it is important that:

Exchanges should:

A) Use market-based prices and not "negotiate" premiums with health plans:
Otherwise, Exchanges would result in de facto premium price controls for the entire market since ACA requires the same premiums inside and outside of Exchanges. In addition, premium "negotiation" would result in reduced choice as only very tightly managed networks would be offered in the market.

B) Allow the market to meet consumer's product needs outside of the Exchange:
Small employers and individuals have a wide spectrum of preferences in how to obtain their health insurance coverage. We should preserve this choice of distribution options. Similarly, affordability is a huge issue for individuals and small businesses who may not qualify for a subsidy. Allowing consumers to select affordable products that are suited to their needs are important considerations that should be maintained.

C) Set transparent standards and accept all insurers that meet such criteria:
Standards that are developed as part of closed-door contractual negotiations would limit competition and choice. Insurers need advance notice to develop the product, plan design, and other related capabilities that an Exchange may require.

D) Recognize that enrollment criteria will play a major role in the health of the risk pool within Exchanges:
There are a number of criteria for enrollment that will ensure the actuarial soundness of the product offerings within the Exchange. These include: annualized enrollment periods, penalties for dropping annual coverage, and waiting periods. Without these criteria in place, the Exchange's insurance participants will be challenged to offer affordable products.

E) Be limited to small employers only:
Opening the Exchange to larger employers would create adverse selection problems. Larger employers with sicker or older employees would find it advantageous to participate while healthier employers would choose to self-fund. This could create higher premiums for the very small employers the Exchange is intended to assist.

F) Explore initiatives that maximize flexibility for small employers to help employees buy coverage – while maintaining the stability of the market:
Exchanges should assure that they immediately provide services to small employers that ease the purchase of insurance. It is important to recognize that the Massachusetts Exchange's struggle with employee choice delayed small employer access to the Exchange for several years.

G) Establish nationally consistent systems and technical specifications for insurers to interface with Exchanges:
Exchanges should help make the health system more efficient and reduce administrative costs. State-by-state technical standards would increase administrative costs unnecessarily and reduce competition in the Exchanges. The ability of Exchanges to bring value and simplicity to small employers and individual consumers will depend on certain threshold implementation decisions made by state and federal policymakers.

PLANNING AND IMPLEMENTATION OF THE HEALTH INSURANCE EXCHANGE

Juan Figueroa
Co-chair Healthcare Working Group

Although the access benefits from federal reform will not accrue to the state until 2014, the planning process is already underway for implementation of the health insurance exchange. Proper planning and opening of the exchange will be an enormous undertaking for state government. Because the exchange is so crucial to the successful implementation of health reform, an overview is provided here.

Each state is given the option to establish two health insurance marketplaces, known as exchanges, one to serve individuals (American Health Benefits Exchange) and one to serve small employers of up to 100 employees (Small Business Health Options Program or SHOP Exchange). An exchange can be operated by a government agency or by a non-profit entity "established by the state." The state can choose to operate a single exchange for individuals and small employers. Multi-state exchanges or regional exchanges within a state are also permitted. If a state elects not to establish an exchange, the federal government will operate it.

While the individual and small group markets will not be replaced by the exchanges, the same market rules will apply inside and outside the exchanges to ensure that adverse selection does not occur within the exchanges. Premium subsidies, available from the federal government to individuals and families with incomes up to 400% of federal poverty, will only be offered to people that enroll in health plans that operate within the exchanges.

KEY EXCHANGE FUNCTIONS

- Implement procedures for certification, recertification, and decertification of Qualified Health Plans (QHPs)
- Maintain website where QHPs are presented in a standardized format and can be easily compared; details on quality, price and enrollee satisfaction must be included in this information
- Operate toll-free call center to respond to consumer inquiries
- Assign ratings to each QHP based on relative quality and price (in accordance with criteria to be developed by HHS)
- Inform individuals of eligibility requirements for Medicaid and CHIP and enroll individuals in those programs
- Calculate actual cost of coverage (premiums) after tax credits and cost-sharing are applied
    - HHS will provide a model web-based template for a calculator
    - Federal government subsidies will NOT cover state-mandated benefits that are outside of the essential benefits package

- Certify individuals who are exempt from the individual mandate and share that information with the IRS
- Share information with the federal government needed to enforce employer responsibility penalties for those employers that have 50 or more employees and do not offer health insurance
- Establish a Navigator program
    - Award grants to organizations that can do "fair and impartial" public education and outreach about the exchange, facilitate enrollment, and refer people to the Office of the Health Care Advocate if they have insurance complaints. Navigators can be trade and professional organizations, community and consumer-focused nonprofit groups, chambers of commerce, unions, or licensed agents or brokers

Timeline – Key Milestone Dates

January, 2013 (on or before)	HHS determines that state will be ready to operate the exchange properly. If not, HHS will assume responsibility to operate the state's exchange
Fall, 2013 *January, 2014*	Exchange starts marketing plans and its first open enrollment period (Initial open enrollment period will be announced by HHS by 7/1/2012) Coverage through the exchange begins
January, 2015	Exchange must be financially self-sustaining, likely through assessing user fees to participating health plans

Planning Decisions and Measures Required in 2011

- Write and submit enabling legislation
- Determine governance (state department, quasi-public entity, other non-profit) and governing board composition and appoint governing board
- Determine staffing requirements and hire initial staff
- Determine what functions will be kept "in house" and what functions may need to be contracted out
- Decide if Connecticut will operate its exchanges, share an exchange with other state(s), or allow HHS to operate
- Decide whether to operate 2 separate exchanges (one for individuals and one for small groups) or combine them

- Determine IT requirements and what IT upgrades are needed to do eligibility, enrollment and communication to federal government re: individual mandate exemptions and employers who will be assessed shared responsibility payments (note: specifications about what will be required have not yet been developed by HHS)
- Obtain input from key stakeholders on exchange design/operations/goals
- Project budget, plan accounting and reporting systems (HHS will have strict annual reporting requirements and the GAO will be studying the operation and administration of state exchanges)
- Apply for next exchange planning/establishment grant (available annually if "State is making sufficient progress toward establishing an exchange")

The governance of the exchange must be carefully protected from undue influence by entities which stand to financially benefit from their operation. For this reason, exchange planning should be conducted in an inclusive and transparent manner.

RESOURCES

Federal Register, 45 CFR Part 170, Vol. 75, No. 148, Tuesday, August 3, 2010; Department of Health and Human Services, Office of Consumer Information and Insurance Oversight, Planning and Establishment of State-Level Exchanges and Exchange planning grant application:
http://www.ct.gov/dph/lib/dph/ohca/hcrcabinet/ct_exchange_planning_application.pdf

Commonwealth Fund Timeline for Health Care Reform Implementation, Health Insurance Provisions:
http://www.commonwealthfund.org/~/media/Files/Publications/Other/2010/Timeline_Coverage_818_v4.pdf

Health insurance Exchanges, Key Issues for State Implementation
http://www.statecoverage.org/files/Carey-ExchangesKeyIssues.pdf

Implementing Health Insurance Exchanges: A Guide to State Activities and Choices
http://www.familiesusa.org/assets/pdfs/health-reform/Guide-to-Exchanges.pdf

Massachusetts and Utah both operate exchanges, although they are quite different in their structure and function.

Draft health insurance exchange legislation is being prepared by the National Association of Insurance Commissioners and by the National Academy of Social Insurance. In addition,
California passed legislation this year.

Stakeholder Perspectives on Health Care Reform and Health System Redesign

Health System Reform

Eric George
Associate Counsel
CBIA

We absolutely need to change our healthcare system in a way that emphasizes/puts a premium on wellness, chronic disease management, technology and data transparency. I also support those proposals that would promote improvements to our long-term care system, including "money follows the person."

I do feel that one of the most daunting barriers facing us is in the area of state Medicaid reimbursements. We all know that in order to increase reimbursement rates, we will have to look at reforming other areas of our healthcare system to help pay for this.

This working group should recommend that Governor-elect Malloy start a dialogue, and begin working, with the state employee union on the issue of redesigning the current state employee health plans so that they are more focused on being "value-added." They need to better promote wellness, chronic disease management and other value-added goals. This recommendation would be in alignment with (and should mirror as closely as possible) the recommendations of Mr. Michael Critelli, past president of Pitney Bowes, that he has communicated countless times (most notably when he sat on the legislature's HealthFirst Connecticut Authority several years ago). Using the concepts under the "value-based" healthcare philosophy, Mr. Critelli revolutionized health care at Pitney Bowes and significantly improved the quality of care his employees (and their dependents) received. He even lowered their overall costs as well.

The potentially significant cost savings that would result from this recommendation could then be used to increase Medicaid rates. Not only would this result in more doctors caring for Medicaid patients (thereby increasing access to care), it would also result in reducing the current cost shift to private payers (thereby increasing access to insurance).

This reform recommendation is critical given Connecticut's dire fiscal and economic situation as well as its long term health care liabilities.

This reform recommendation (as well as all of the reforms we should be reporting to the Governor elect) would be a "win/win" scenario for everyone involved.

Healthcare System Change

Bob Rinker
Executive Director
CSEA SEIU Local 2001

Much of what has been written and offered by other members on the sub-committee I agree with in regard to changing our healthcare system to focus on:

- Wellness
- Chronic Disease Management
- Technology – Electronic Medical Records
- Data Transparency
- Long term care – including the creation of a quality homecare workforce to take care of citizens in their homes, where appropriate, instead of nursing homes. A task force should be created to address the care of the growing population of Alzheimer patients and its cost to our healthcare system.

With regard to the healthcare plan for state employees, retirees and their dependents (214,000 lives), I would offer the following:

- Open the State healthcare plan to municipalities, non-profits and small business. My organization has 25 employees and is paying $13,000 per year more for family health coverage than the State healthcare plan which has more comprehensive healthcare benefits.
- Allow the Medicaid covered lives to use the State's employees' prescription drug program. This would provide savings to Medicaid program and to the State healthcare plan. The State's health care plan receives greater discounts from its PBM based upon the number of participants in the plan. The plan has recently accepted retired teachers and the City of Hartford's municipal employees.
- Include state employees who are receiving care under the State's Worker's Compensation program in the State's healthcare plan. It is not efficient to have two health care provider systems running parallel to each other when the future focus will be on patient centered medical homes.
- Continue to implement the patient centered medical homes delivered through primary care physicians that have implemented Electronic Medical Records system.
- Implement a valued based plan design with a valued based reimbursement system

The State of Connecticut spends nearly $7 billion on healthcare through a number of state agencies. The State healthcare plan for state employees, retiree and dependents accounts for over $1 billion of spending. This fragmented system should be coordinated through one agency or convening authority.

Legislation should be passed that allows for transparency of data between providers, primary care doctors, health care purchasers and insurance companies. Currently reimbursement rates to providers are considered proprietary information of the healthcare insurance companies. Employers, especially

self-insured plans, should know the reimbursement rates for procedures from health insurance companies to providers not only to incent employees to less expensive care, but to those providers that have better outcomes. In other words, that competition as currently mandated by federal and state antitrust laws should be supplanted by a regulatory program to permit and encourage cooperative agreements between hospitals, healthcare purchasers, or other health care providers when the benefits outweigh the disadvantages caused by their potential adverse effects on competition.

Finally, current expenditures by insurance companies for disease management should be pooled and provided directly as monetary incentives to primary doctors that have agreed to be patient centered medical home to provide disease management. A call from your primary doctor is more effective tool for chronic disease management than a call from an insurance company.

If you would like to discuss my ideas further, please feel free to call me at 860-951-6614.

Health System Reform

David S. Katz, M.D., F.A.C.S.
President C.S.M.S.

Connecticut State Medical Society
Comments on Transition Paper Outline
Health System Reform

The Connecticut State Medical Society (CSMS) welcomes the opportunity to provide comments on the Transition Team Outline on Health System Reform. We believe these comments can augment the outline to ensure that the most comprehensive and effective document possible is produced. In addition to the comments below, we have attached several documents that we feel can assist the committee regarding issues of physician workforce, establishing individual health care policy and the CSMS Outline for Universal Access to Quality Patient Care in Connecticut. You will notice that a majority of our recommendations are consistent with ideas already contained in the Transition Team documents and we believe, support efforts to establish a more unified and connected health care system in Connecticut while preserving the community-based medicine that characterizes our state.

Comprehensive health system reform must be built on four pillars if it is to be successful in providing access to quality medical care at an affordable level:

- **Transparency** in all transactions related to patient care and reimbursement.
- **Access** must be available statewide and services and benefits fairly distributed.
- **Quality** medical care must be delivered. Prevention and disease management must be cornerstones.
- **Funding.** Comprehensive quality patient care must be fully funded and allow funding to follow the patient resulting in enhanced portability.

Transparency

Recent reform measures such as the establishment of Accountable Care Organizations (ACO), the need for interoperable Health Information Technology (HIT), and consolidation within the insurance market make it critical that all transactions, communications and activities within the system be subject to a high level of transparency. Furthermore, the ability to communicate more freely within the system and that establishment of standards for interactions within the system must by increased. To accomplish this goal, it is imperative that the following recommendations be included and passed as appropriate.

- Enact state exemptions from federal laws to allow physicians to negotiate as a group to strengthen their position in contracting. Benefits would include the ability to seek opportunities to implement electronic medical record systems, establish ACOs, cover increased liability insurance costs and support recruitment of new physicians. (Model legislation attached)
- Establish stronger statutory guidelines for acquisitions and mergers of health insurance companies and other entities offering access to medical care.
- Establish a statutory definition of network adequacy and strengthen provider directory adequacy requirements.
- Guarantee that rating systems and performance measures are based on sound medical standards rather than economic factors, with physicians and other health professionals who provide the care making informed decisions and setting policies.

Additionally, the same protections and transparency should be extended to any state program such as those administered through the Department of Social Services, in which contracts with managed care organizations (MCOs) are established, patients are enrolled and physicians are asked to provide services.

Access

CSMS remains steadfast in its position that health system reform focused only on providing access the health insurance will provide limited benefit to Connecticut residents. Reform must instead place a primary focus on addressing issues of access to health care itself. This includes addressing physician workforce shortages, reimbursement, barriers to care, health care disparities, health care infrastructure and the *proper* use of all members of the health care delivery team.

Workforce- CSMS has aggressively worked with supporting foundations to identify workforce issues plaguing physicians and negatively impacting the recruitment and retention of physicians. Today, and in the coming years, Connecticut will be competing against all other states to maintain an adequate physician workforce while a limited supply exists and demand is increasing nationally. This makes it imperative that Connecticut enact policy creating a favorable and attractive environment for physicians. This includes:

- Reducing regulations that impede physician services such as those required by the Certificate of Need process;
- Establishing student loan forgiveness/forbearance and insurance-premium assistance programs for new physicians;
- Continuing to address emergency room overcrowding and boarding issues;
- Preserving and expanding the graduate medical education and teaching system. The state's academic medical centers continue to be an essential part of Connecticut's medical system, as do community care sites were additional training is provided for medical students, residents, fellows and other health care professionals.

Proper use of the health care team- CSMS continues to support implementation and expansion of the "team" approach to the delivery of health care to reduce duplication of services and ensure that proper care is received by the proper professional at the proper time. This includes such programs at the Primary Care Home Model (PCHM) and the Primary Care Case Management (PCCM) model that currently exists in the Medicaid program.

Connecticut residents deserve the highest quality of health care delivered by trained and skilled professionals. Additionally, increased access to health insurance coverage will place an even greater demand on the already strained health care work force. Therefore, we must work to ensure that non-physician health care providers are able to practice to the fullest of their ability. To ensure quality and safety, education and experience -- in addition to need -- must be reviewed and adjudicated prior to expanding use of ancillary personnel. An administrative review process such as that recently recommended by the Program Review and Investigations Committee of the Connecticut General Assembly would ensure that professions expected to be involved in the delivery of team care work in a coordinated effort to ensure that statutory scopes of practice allow professionals to practice to the fullest extent of their education and training.

Reimbursements- CSMS supports recommendations made by the Transition Team in Section 2 of its outline. This section refers to the "phase in" of SustiNet. Therefore, we echo key agreements of the SustiNet Board directly related to this issue:

- Realign and restructure Medicaid and HUSKY payment levels.
- Incentives for evidence-based care that leave room for individual clinical judgment.
- Payment Reforms - refocus incentives on promoting health outcomes.

Quality

Under the auspices of quality, such issues as prevention and disease management must serve as a cornerstone. A focus on quality exists to some extent with efforts to develop Health Information Technology (HIT) systems and to implement Electronic Medical Records (EMR). Future efforts must include involvement from practicing physicians and understand the need for such a transition to be financially supported and incentivized in such a way that provides up-front funding and back-end support of physicians and their practices, the vast majority of which, in Connecticut, are small offices with less access to this kind of support. This would include funding for physicians to purchase and maintain systems and connect to the Health Information Exchange (HIE) and other such entities designed and developed to improve access to medical information.

Additionally, we offer that to truly increase the quality of care in Connecticut and recognize tremendous cost savings, we must address a liability system that often stifles advancement. The current punitive system must be transformed into one in which health care professionals meeting established guidelines can deliver high-quality care without concern for their livelihood and professional future. To accomplish this goal, we recommend the following:

- Establishment of liability safe-harbors for professionals following established practice guidelines established and maintained by physicians;
- Establishment of quality and practice guideline initiatives previously recommended by the Universal Health Care Foundation in the original SustiNet legislation;
- Establish special health courts currently proposed by national organizations such as Common Good, the American Medical Association and the American Hospital Association. Such courts with expertise in medical liability cases would ensure appropriate adjudication;
- Increased immunity for physicians providing volunteer or pro-bono services;
- Expand protections for physicians providing mandated care such as services required under the Emergency Medical Treatment and Labor Act (EMTALA);
- Review and strengthen peer review laws to ensure that professionals can review system breakdowns and weaknesses to properly address them in an unfettered and protected manner.

Funding

Initial investment and funding in health system reform will provide tremendous future cost savings allowing for the expansion of services and increased benefits. At a more basic level, it is imperative that funding for services provided by physicians within such programs be established at acceptable levels that ensure access. Reimbursements must be tied to appropriate formularies ensuring appropriate adjustments and maximize federal matching funds.

Optimizing the State Health Care System

Susan Davis, RN, EdD
President and CEO
St. Vincent's Medical Center

OPTIMIZING THE STATE HEALTHCARE SYSTEM

1. Hospitals must be included in the Health System policy statement. They are the safety net for our communities; are available 24-7 and provide care to anyone in need regardless of their ability to pay

2. There must be a shift from payment for illness to providing payment and incentives for prevention and wellness.

3. The policy needs to create opportunities and incentives for improving access to primary care for the poor and underserved. Physician payment for services must cover the cost of care.

4. The funding for Home Care and Nursing Home care needs to be examined and a policy developed that pays for the cost of care provided by these low cost providers.

5. Medicaid payment to Hospitals needs to move from cost based reimbursement to a DRG system that provides incentives for improving care and efficiencies.

6. Create a 'Workforce Council' for the growing home care industry so that workers can have a voice in the development of care requirements and job standards.

7. Create a legislative committee to work with providers in the state to maximize federal Medicaid and Medicare reimbursement.

8. Work with the federal government and medical schools in the state to train more primary care physicians, nurses and other providers who will remain in the state to meet the healthcare needs of our residents.

Medicaid payment to providers is the biggest challenged to improving access to healthcare in our state. There is a growing Medicaid population in the state and the continued gap between cost and payment only puts providers at risk and raises the likelihood of limited access for our residents.

Community Health Centers

Mark Masselli
President and CEO
Community Health Center, Inc.

The role of Connecticut's federally qualified health centers in improving quality and safety, driving value, and controlling costs in health care

Community Health Centers are an important part of the health care landscape in the United States and in the State of Connecticut, and have been so since the first health centers opened in 1965. As health care reform has taken center stage in the American political debate, growing numbers of Americans are uninsured or are insured with minimal or no access to primary health care services. Health centers have penetrated communities around the nation, providing primary and preventive health care, lab services, dental and behavioral health care, and case management to meet the needs of those they serve. Though each health center is an independent entity they share common regulations on scope of service and quality of health care, and provide services to all patients, regardless of ability to pay. Governed by consumer-dominated boards of directors, health centers focus on meeting the primary health care needs of their respective communities, including those that are traditionally disenfranchised from health care, such as low income and uninsured, linguistically isolated, homeless persons, residents of public housing, and migrant farm workers. 1,250 health centers provide essential primary care to 20 million Americans, and this includes 14 federally qualified health centers in Connecticut, who serve approximately 300,000 patients. Approximately 70% of these patients live in poverty and nearly one-third of health center patients in Connecticut do not have insurance. As health care costs continue to rise, the US population ages and develops more chronic diseases, and economic challenges threaten the ability to maintain insurance, the need for primary health care services grows rapidly. This is manifest by the $18 billion a year that is wasted on unnecessary hospital emergency room visits for care that could have been provided by a health center or prevented by the application of preventive services (NACHC).

Targeting, identifying, preventing and treating many of the modifiable risk factors of CVD and other chronic diseases is at the core of the mission of health centers, which have the capability to be models of improved access, effectiveness in reducing disparities, cultural and linguistic competence, coordinated care and cost-effective care. The efficient and effective care delivered in health centers, as well as other high performance health care systems, has been shown to improve preventive care, reduce costs, and reduce disparities. (Commonwealth Fund Report: Beal, A. et al: "Closing the divide: how medical homes promote equity in health care: Results from the Commonwealth Fund 2006 Health Care Quality Survey, June 27, 2007, Volume 62)

There are currently 14 federally qualified health centers in Connecticut, up from 10 in 2008. Combined, these centers serviced 242,000 people in 2008 (UDS 2008) and now serve close to 300,000 individuals. They serve a population that is overwhelmingly low income, publicly insured

(50%) or uninsured (24%) , and disproportionately representative of ethnic and racial minorities (45% Hispanic, 22% African American) and linguistically isolated (34% spoke a primary language other than English.). All health centers in Connecticut have been expanding in capacity with the support of stimulus funding for physical, clinical, and service expansion, as well as funding to create "new access points". They range from relatively new organizations such as the Community Health Center of Greater Danbury, to the largest and only state-wide health Center, Community Health Center, Inc. The unique benefits available to federally qualified health centers, among them FTCA malpractice coverage at no charge, participation in the 340b pharmacy program, access to health professionals through the national health service corps scholars and loan repayment programs, and an all-inclusive, prospective payment system under Medicaid, make them a strong, essential, and scalable foundation for addressing quality, cost, and effectiveness of health care in Connecticut.

References:

www.chcact.org

www.chc1.com

http://www.hrsa.gov/data-statistics/health-center-data/StateData/2008/CT/2008_ct_summary.pdf

Recommendations, measures of success, and supporting references

Community Health Center, Inc. specifically recommends the following actions to strengthen the community health infrastructure, improve efficiency, access, and quality, and improve the health of individuals and communities served by health centers.

Recommendation #1: All Connecticut FQHCs shall achieve NCQA or comparable recognition as Level 3 patient centered medical home by January 2012

All federally qualified health centers should prioritize achieving NCQA Level 3 recognition as a Patient Centered Medical Home (PCMH). This recognition confirms that the health center has adequately demonstrated that it has developed the clinical, technology, and business infrastructure, systems, and processes to provide the most effective and efficient care possible. Currently, no health center in Connecticut holds this recognition and only one private practice has achieved it. CHC, Inc. has submitted its application and supporting documentation for its entire network of practices and is awaiting the outcome of the NCQA review. Studies have documented improved clinical outcomes, patient satisfaction, provider satisfaction, and reduced costs in practices that have implemented the PCMH. These standards include critical elements like enhanced access to care, care coordination across healthcare settings, automated prompts for preventive services, integration of behavioral health and primary care, chronic disease patient registries, and continuous clinical quality improvement based on actionable data.

Barriers to pursuing NCQA recognition have included 1) substantial fees and 2) lack of technical

assistance for practice transformation in order to meet the standards. In November, 2010, HRSA and the Bureau of Primary Care announced a collaboration with NCQA under which federally qualified health centers would not have to pay the fees (similar to what HRSA has done for FQHCs seeking Joint Commission Accreditation) and that it was launching an intensive program of technical assistance for FQHCs to help them achieve PCHM status.

Measure of success: Achievement of NCQA Level 3 recognition by January 2012

References:

Reid, R., Fisheman, R, Yu, O, Ross, T, Tufano, J.. Patient Centered Medical Home Demonstration Project: A prospective, quasi-experimental, before and after evaluation. American Journal of Managed Care, (2009), 15 (9), e71-79.

Grunbach, K; Bodenheimer, T; Grundy, P. Outcomes of Implementing Patient Centered Medical Home: Review of evidence on quality, access, and costs from recent prospective evaluation studies. Report, Patient Centered Medical Home Collaborative, August, 2009.

Recommendation #2: **All Connecticut FQHCs shall meets ONC standards for "meaningful use" of health information technology by July, 2012**

The Obama administration and the Office of the National Coordinator have issued the standards for meaningful use of electronic health information technology and with it, a financial incentive program that offers health centers both the opportunity to be reimbursed for past and current HIT expenses, and to invest in future HIT developments. Converting from paper to electronic health records is the critical first step, and most health centers in Connecticut either have accomplished this or are in the planning and implementation phases. Meaningful use goes beyond merely converting from paper to electronic documentation. It requires interfaces with lab and pharmacy, communication with ERs, hospitals, and specialists, and use of HIT data to drive clinical performance and decision-making. Thus, it is completely consistent with recommendation #1, and provides the financial resources to do this. **Every FQHC qualifies to draw down $64,000 per physician, nurse practitioner, nurse midwife, and dentist regardless of whether the individual works full or part time, is directly employed or contracted by the FQHC.** CHC, Inc. conservatively estimates that Connecticut's federally qualified health centers can draw down approximately $20m in financial support of meaningful use of health information technology.

Measure of success: Every FQHC in Connecticut will draw down at least an initial payment from the ONC by December 2011 and will complete the process by July 2012.

References

http://www.hrsa.gov/data-statistics/health-center-data/StateData/2008/CT/2008_ct_summary.pdf

Recommendation #3: Adopt an Evidence-Based Drug Formulary Based on the Veterans

Administration Drug Model for adults enrolled in Medicaid

The adoption of drug formularies is often a contentious subject, and rightly so. Too often, drug formularies are based on preferred pricing offered by pharmaceutical companies and the benefit managers, which are based on business, not clinical, rationale. The Veterans Administration is an exception to this. Their drug formulary is developed by clinicians, for clinicians, with clinical rigor and a focus on achieving the desired clinical outcomes in the most cost-effective manner. Generic drugs are used where their clinical effectiveness is confirmed, but non-generics are included where no appropriate generic substitute is available. The appropriateness and effectiveness of the VA formulary is reflected in the VA's clinical outcomes, which are superior to those in virtually any other health care system. They achieve this despite a population that is older and sicker than the population at large. Adopting the VA formulary for adult Medicaid enrollees would likely save millions of dollars annually, although we (CHCI) do not have access to the dataset, which would allow precise estimates. A secondary benefit of adopting the VA formulary would be the achievement of control over one of the most vexing problems faced by clinicians in FQHCs: the demand for brand name narcotic prescription medication and the potential for abuse and diversion of these drugs.

Measure of success: Adoption of VA formulary for adult patients by all FQHCs. Reduced per capita spending for pharmaceuticals for Medicaid enrollees in Connecticut.

Reference: Aspinall, S; Chester, G; Glassman, P, Valentino, M. The Evolving Use of Cost-Effectiveness Analysis in Formulary Management Within the Department of Veterans Affairs. Medical Care, July 2005, Vol 43, #7, p.20-26

Recommendation #4: Increase access to specialist care for patients seen in FQHCs through implementation of "eConsults" and virtual visits, with appropriate reimbursement by Medicaid.

Lack of access to specialty care is a major problem for Medicaid enrollees. FQHCs face the same barriers in securing specialty care for their patients as other Medicaid providers. These barriers include low participation in Medicaid by specialists, and patient-centered barriers such as language and transportation, often to distant cities. The San Francisco Healthy Access Project has demonstrated virtual or "eConsults" can significantly increase access to specialist consultation for the primary care provider and reduce the need for patients to travel to a specialist for an "in person" consultation. Dr. Mitch Katz, MD, Health Director for San Francisco County came to Connecticut at the invitation of the Community Health Center, Inc. and presented on this topic at the Legislative Office Building and at CHC's Weitzman Symposium in 2008. Community Health Center, Inc. has been working to implement such a system for the past two years, and now has a formal contract with the University Of Connecticut Health Center to implement "eConsults" with cardiology, with is the single highest volume specialty referral in our system. Under this system, a Community Health Center primary care provider initiates a consult request for a specific purpose, provides appropriate patient information

including labs, diagnostic tests, and history, and submits the consult question and information electronically through a secure portal to the University of Connecticut Health Center. UCHC cardiology specialists retrieve the consult requests electronically and respond within 48 hours, again through a secure portal. The response may include direction on changes to the treatment plan including additional medications or further diagnostic testing, or reassurance and support for continuing the current plan, or a directive to have the patient seen in person by a specialist either in the community or at UCHC. This system can and should be expanded to all other major specialty areas, specifically endocrinology, neurology, gastroenterology, and dermatology.

Measure of Success: eConsult MOA in place with all specialties at the UCHC or other institutions/practice groups by July 2011.

Reference: Chen, A., Kushel, M, Grunbach, K. A Safety Net System Gains Efficiencies through "eReferrals" to Specialists. Health Affairs, 2010, Volume 29 (5), pp 969-971.

Recommendation #5: Adopt new strategies to improve pregnancy outcomes

Despite enormous effort and focus, too many communities in Connecticut still show very high rates of late entry to prenatal care and poor pregnancy outcomes, particularly low birth weight, and most dramatically for African-Americans. Health insurance is a barrier for undocumented immigrants, but virtually all other low-income populations have access to Medicaid. A two –pronged effort is called for:

1) Provide funding support for prenatal care for women who do not/can not qualify for Medicaid until the 9th month of pregnancy.
2) Expand access to prenatal care in community health centers
3) Implement new models of prenatal care which have been demonstrated to be effective at reducing pre-term birth/low birth weight and may offer a more culturally appropriate, supportive model that yields positive effects in the postpartum and parenting phase as well as prenatally.

Specifically, Community Health Center, Inc. recommends that all FQHCs develop the capacity to provide prenatal care with full integration with obstetrical services directly or indirectly. CHCI further recommends that the Centering Pregnancy model be adopted as a standard of prenatal care in all FQHCs.

Measure of success: All FQHCs will provide routine prenatal care by July 2012, using the Centering Pregnancy model.

References:

Rising, S, Ickovics, J et al. Group Prenatal Care and Preterm Birth Weight: Results from a matched cohort study at public clinics. Obstetrics and Gynecology, November 2008, Vol. 102, #5, Part 1, p. 1051-1057

Recommendation #6: Create an environment in which all healthcare professionals practice to the top of their license. Remove restrictions to effective and efficient clinical practice. Adopt the recommendations of the IOM report with regard to scope of practice barriers and residency training for new APRNs.

The patient-centered medical home is based on continuous, personal relationships between a patient and the primary care provider, supported by a cohesive, prepared team that can work as a unit to ensure that all preventive, treatment, chronic disease, and care management needs are attended to. Currently, there are several impediments to this. These include licensure restrictions for APRNs, legislation prohibiting the administration of medication by non-licensed personnel (medical assistants), and lack of access to residency training for new APRNs entering practice in the complex setting of FQHCs. The Institute of Medicine has just issued its evidence-based recommendations, which include a recommendation to state legislatures to eliminate scope of practice barriers and to support the development of residency training for new APRNs and new RNs, among other recommendations.

CHC, Inc. supports elimination of legislation preventing non-licensed personnel (medical assistants) from administering medications and vaccines under the direction of a licensed prescriber (MD, APRN, PA, and CNM). With proper training, supervision, and oversight, such tasks as administering routine immunizations (influenza, pneumococcal, tetanus, etc) can be safely delegated, thus freeing up valuable nursing capacity to attend to critical elements of the patient centered medical home such as complex care coordination.

Community Health Center, Inc. has already developed the national model for nurse practitioner residency training, and is now in its 4th year of training new family nurse practitioners to practice as primary care providers in the highly complex setting of community health centers. CHC, Inc. could expand its capacity for residency training to ten residents per year, and is prepared to support other FQHCs in Connecticut in developing residency training for new NPs/APRNs in primary care.

Measure of success: Elimination of legislation prohibiting administration of medications by non-licensed personnel and adoption of models in use in other states. Expansion of CHCI NP residency training program to 12 residents per year. Development of at least two other FQHC based NP residency training programs in Connecticut.

http://www.iom.edu/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing- Health.aspx

http://jama.ama-assn.org/content/291/10/1246.abstract

http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume102005/No3Sept05/tpc28_516029.aspx

Recommendation #7: Identify cohort of highest health care utilizers with corresponding highest health care expense in the Medicaid population and develop appropriately intensive, target care management intervention strategy.

Currently, clinicians practicing in community health centers have no access to global utilization or cost data for their patients, including those enrolled in Medicaid. Further, we presume that many of the highest risk/sickest/highest utilizing Medicaid enrollees are not engaged with a FQHC at all. Studies have

shown that up to 80% of Medicaid costs are accounted for by 20% of Medicaid enrollees. We recommend that DSS identify the highest utilizing cohort of patients in terms of expenditure, and convene a multidisciplinary panel including medicine, nursing, pharmacy, substance abuse, housing, and behavioral health specialists to review this cohort and identify targeted strategies to improve health and reduce expenditures for this population.

Measure of success: Identification of highest risk/utilize Medicaid enrollees, reduction of global cost pre-post intervention, development of model strategy for intervention in highest need Medicaid population.

Reference:
http://www.csh.org/index.cfm?fuseaction=page.viewPage&pageID=4501&nodeID=81 (Frequent users of public services: Ending the institutional circuit)

Report: Designing and Implementing Medicaid Disease and Care Management Programs. Agency for Healthcare Research and Quality. No.7 (08) #0063, March, 2008.

Home Health Perspective

Joanne Walsh
President and CEO
Constellation Health Services

Forwarded to Healthcare Working Group by Joanne Walsh, Constellation Health Services

MEMORANDUM
To: Governor-Elect Malloy Human Services Policy Working Group
Ron Cretaro, Co-chair, Exec. Dir. CT Assoc. of Non Profits
Terry Edelstein, Co-chair, Pres., CT Community Providers Association
Toni Fatone, Co-chair, Past Exec. VP, CT Assoc. for Healthcare Facilities

From: Deborah R. Hoyt
President and CEO
CT Association for Home Care & Hospice

Date: December 14, 2010

Subject: Input from CT Home Health and Hospice Industry for Malloy Transition Team

Statement of Issue:
A stable and sustainable home health care industry in CT holds the promise of dramatically cutting CT's health care costs, balancing the state budget, and meeting the growing health care needs of aging state residents.

Home care is the high quality, cost effective solution to ensure Connecticut residents are getting the care they need and deserve. The provision of health care in the home is customer preferred, makes economic sense, creates better health outcomes, reduces readmissions to costlier care settings, and allows families to remain connected and be part of the care process.

Home health has already demonstrated that it can create significant cost savings for the state of Connecticut. The Connecticut Home Care Program for Elders saved the state an average of $100 million each year from 2006 to 2008.

The Federal Government reimburses Connecticut's Medicaid home care program with a 60 percent match. The expansion of home care allows state government to expand services while reducing the burden on state tax revenues.

Home care offers a cost-effective alternative at $135 per visit, vs. $622 per day for skilled nursing facilities and $6,200 per day for inpatient hospital care (source: NAHC 2009 Medicare charge data www.nahc.org)

Challenges/Obstacles:
Home care's ability to help state government heal the budget crisis is seriously undermined by chronic underfunding to agency providers and burdensome state and federal regulation. Public access to our 90 licensed home care and hospice agencies are already being jeopardized due to funding and regulatory issues.

Home health agencies in Connecticut are paid roughly 70 cents by Medicaid — funded primarily by Connecticut taxpayers — for every dollar they spend delivering patient care, resulting in an estimated annual loss of $42 million. Connecticut's inadequate Medicaid rates are preventing the expansion of home care in Connecticut.

Today, Medicaid payments are 30 percent below costs for home health agencies. Home care received a nominal 3 percent increase in 2007 and no increased in the past 4 years. Over the last 14 years, the state's Medicaid home care rates have increased by an average of only 1 percent a year preventing providers from even meeting the costs of inflation.

The combination of federal health care reform, along with proposed regulatory changes, will reduce Medicare revenues to Connecticut home care agencies by an estimated $50 million a year once they are fully implemented. This is on top of Medicare cuts totaling 8.5 percent over the past three years.

A properly funded home care sector can and will save hundreds of millions of dollars, however, continued cuts to provider reimbursement, coupled with increased regulatory and reporting requirements are seriously undermining this valuable safety net and system of care.

Proposed Action:
Develop a long-term comprehensive solution to sustain an adequately funded, cost-effective, affordable health care integrated delivery system in CT that includes effective transitions of care from inpatient to skilled nursing to home care.

1. Establish an adequate reimbursement system to enable CT's home care industry to expand in order for the State of CT to reap cost savings benefit.

- Stabilize current state funding for home care and increase reimbursement to equal the cost of providing such care to support agency viability and growth.
- Address inadequate Medicaid rates and restructure existing programs to maximize federal funding for home care.
- Create an environment which will enable home health agencies to prepare for Medicaid expansion as a result of national health reform and the addition of 40,000 CT residents into the system.
- Reassess provider reimbursement to expand the Money Follows the Person (MFP) initiative to move patients from higher cost to lower cost care settings to enable the State to reap additional cost savings.

2. Create a policy and regulatory environment that fosters patient safety and enhances quality of health care services that is not onerous, burdensome or cost-prohibitive to home health providers.

- Address Third Party Liability (TPL) practices to create a workable long-term resolution to replace the demonstration project.
- Develop a long-range strategy for care and payment of dual eligibles (Medicare and Medicaid) frail and elderly patients.
- Address regulations and licensure requirements that impede the ability of home health providers to focus less on administrative burden and more on patient care.

3. Support initiatives that ensure home cares ability to appropriately manage human resources to meet ever-changing patient care needs and grow CT's workforce.

- Clarify the supervisory roles of registered nurses and home care workers, including non-employed, non-licensed caregivers (Personal Care Attendants – PCAs) privately employed and providing care in the home, in order for home care agencies to match employee roles to care delivery.
- Institute comprehensive background checks for all personnel that perform care in the home as one part of the strategy to protect patients, ensure safety, and guarantee the highest level of quality patient care.

Long-term Needs

- Advance the development of a statewide health information exchange that includes home care and leverages technology including telehealth and electronic medical records.
- Develop initiatives that focus the Department of Public Health's oversight with evidence-based practices and quality improvement.
- Align the state's commercial insurance and Medicaid program with federal healthcare reform with a focus on the establishment of the Connecticut exchange and expanding access to home care.

Jobs Impact & Other Benefits

- The growth of CT's home health care industry is linked directly to a significant increase in the state's workforce over the next ten years if home health care providers are delivering care in an adequately funded and fairly regulated environment.

Small Business Perspective

Sean Moore
President
Greater Meriden Chamber of Commerce

Issue

Work to ensure maximum participation from the **private sector businesses, especially small businesses,** as they are the insurance partners who contribute real money to the cause while struggling with the issues of affordability and complexity. Businesses must remain as active participants in all health care solutions. They will participate if there is a business decision that makes sense to them like saving money or retaining healthy employees who are on the job and working productively.

- The portion of the insurance premium paid by businesses is expensive and premiums are rising too fast
- Plan options are often very confusing, especially to small businesses without an HR professional on staff. Individuals might be able to make the simple decision to buy their insurance from a web site but businesses need agents to serve as the trusted advisors when there is a lot of money and decisions on the table.
- Businesses will participate in education, wellness and prevention programs as a direct cost reduction and productivity enhancement measure.

Action Steps

Utilize chambers of commerce, professional, business and trade associations as insurance distribution channels and to engage their membership in education and wellness programs to control costs.

Other Observations

Prevention, Public Health and Wellness Programs are continuous education initiatives that could start with the Early Childhood Education programs as referenced in the Malloy Policy Project and could be linked to the universal access to pre-school.

Governor-Elect's Policy recommendation #11 should add the Community Colleges to the list of medical trainers.

Healthcare Delivery System Change

Fred McKinney, PhD
President and CEO
Greater New England Minority Supplier Development Council

For the most part policy makers have viewed the problem of increasing healthcare cost as the result of a flawed financing system. Third party reimbursement, the cost of insurance, the cost of malpractice insurance, the number of uninsured citizens are all symptoms and causes for health care cost growing at unsustainable rates. But without adequate attention to the healthcare delivery system's fundamental inefficiencies and a serious look at nutrition, solving the financial problem will prove illusive at best. The healthcare delivery model of healthcare being funneled almost exclusively through highly trained and talented physicians does not leverage the opportunities for healthcare consumers to use information technology, nutrition, and the power of markets to lower the total cost to consumers, taxpayers and the system as a whole.

We must not lose track of the goal of an improved healthcare system is improved health for the citizens of the state. From the perspective of reducing morbidity and mortality, the existing healthcare delivery system is part of the process. But fixing the financing, i.e. the insurance system, provides no guarantee that health outcomes will improve.

Without going into great detail, the Governor Elect has a unique opportunity to change the healthcare delivery system in ways that can lower cost, increase access to quality care and improve health outcomes. Here are my recommendations:

1. Change state law that would allow greater independence of nurse practitioners and physician assistants, so that they can practice independently from physicians.

2. Using the Community Colleges, train unemployed and underemployed workers to work in the homes of the frail and sick elderly.

3. Set up chronic care community resource centers that deal exclusively with diabetes, HIV/AIDS, asthma, and obesity. These centers can be housed in existing community based organizations.

4. Tax non generic drugs and the physicians who prescribe them.

5. "Pay" unemployed workers with healthcare backgrounds to work in community resource centers.

6. Invest in a statewide patient information system whereby patients and providers will have easy access to their important patient history. Smart card systems like those in France, Japan and S. Korea could work here in CT.

7. Allow physician practices and hospitals to advertise and compete for customers on the basis of price as well as quality.

8. Start an anti-obesity campaign along the lines of the anti-smoking campaign and tax foods and drinks that contain “large” amounts of sugar and “bad” fats. The grocery store and fast food restaurants are in the health care delivery value chain!

Obviously, there would be challenges to these recommendations from powerful special interest groups who will not accept a conflict between their narrow economic interests and the interests of the community. It may be the appropriate role of government to encourage this debate so that ultimately the taxpayers and consumers decide and not simply the providers and the experts.

Medicaid

Suggestions for Administrative and Policy Improvements to Medicaid and HUSKY

Jane McNichol
Executive Director
Legal Assistance Resource Center of CT

The public health coverage programs provide essential health care coverage for over 545,000 children and low-income adults in Connecticut. About one in seven Connecticut residents rely on publicly financed health insurance. These programs are vitally important for the covered individuals and for policy makers seeking to ensure that all residents of Connecticut have access to adequate health care.

	# of participants
Medicaid[15]	
HUSKY A (children, parents and caregivers, pregnant women)	396,977
Low-Income Adults (formerly SAGA)	53,306
Other Medicaid (typically elderly and/or disabled)	79,762

The federal government generally pays 50% of Medicaid costs; under the enhanced FMAP formula, the federal government is now paying about 62% of Medicaid costs.

Children's Health Insurance Program[16]	
HUSKY B (*children only* in families with incomes over 185% of federal poverty level)	14,977

65% of HUSKY B costs are paid by the federal government

Medicaid is one area of the budget that presents an opportunity to maximize federal funds. The administration should explore increasing federal reimbursement for Medicaid costs as an alternative to restricting access to or cutting essential health care for vulnerable residents in order to reduce state expenditures for health care. The Departments of Mental Health and Addiction Services, Developmental Services and Corrections submitted budget options proposing that expanded community mental health services, community services for DDS clients and inpatient inmate medical care may be eligible for Medicaid reimbursement. Services for people in supportive housing and alternatives to nursing home care may also be eligible for Medicaid reimbursement.

Medicaid and HUSKY, along with federally-funded Medicare, serve as the foundation for any system of universal health care coverage. Maintaining a strong Medicaid program is crucial for the health of

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[15] From Department of Social Services "Active Assistance Units Report for September 2010", issued October 14, 2010. HUSKY Enrollment Reports, available at www.huskyhealth.com, indicate that over 250,000 children participated in the HUSKY A program in September, 2010.

[16] From HUSKY Enrollment Reports, available at www.huskyhealth.com, (September 2010).,

low-income families and children and is consistent with the goals of SustiNet and the Affordable Care Act. Specific proposals include:

1. **Implement common sense legislation already on the books that promotes good health and can save the state money,** including:

    - family planning services to individuals at risk of needing Medicaid once they become pregnant
    - smoking cessation services for all populations on Medicaid (Currently, Connecticut only covers the full-range of such services for pregnant women and children.)
    - medical interpretation services covered by Medicaid, which increases patient compliance with prescribing and reduces medical errors
    - presumptive eligibility for HUSKY B which enables children in HUSKY B to get coverage sooner. By implementing this simplification strategy Connecticut will become eligible for federal bonus dollars. DSS has begun planning for its implementation. It needs to be instituted by April 1, 2011 in order for the State to qualify for the bonus money.

2. **Reorganize and re-invigorate the Department of Social Services (DSS)** to ensure that:

    - applications for health care assistance are accepted and processed in a timely manner with minimal burden on families and individuals
    - DSS is utilizing Medicaid and CHIP state plan amendments, waivers and grant opportunities that will enhance the state's health care system and bring in federal funding (some specific proposals are listed in section 1 above)
    - agency policies and actions are transparent to consumers and stakeholders. For example, issuing regulations in a timely manner and publishing them in a searchable format on the DSS website.
    - organizations contracting with DSS are monitored and held to high standards of service and transparency
    - Connecticut is prepared for the "No Wrong Door" approach for Medicaid and the Health Insurance Exchange eligibility determinations and enrollment, required by the Affordable Care Act by 2014, through continuing the information technology improvements already in progress. These improvements should re-engineer eligibility, enrollment, and renewal processes, eliminate repetitive requests for information, and provide new avenues for accessing applications and information.

3. **Actively pursue alternatives to MCOs** as administrators of HUSKY A and B, including the use of an Administrative Services Organization in combination with a statewide primary care case management (PCCM) system. If this were done, health plans would no longer be paid on a risk basis, increasing transparency and accountability in providing access to quality and timely care. PCCM can improve access to preventive care, thereby helping patients avoid expensive medical complications.

4. **Adopt changes to Medicaid and HUSKY B which close gaps and equalize coverage.** Too often, these programs set limits on eligibility based on specific health care needs or family composition. The result is gaps in access to preventive health care and higher costs to the health care system. We should:

- adopt a Medicaid state plan amendment for long-term care so that people needing long-term care receive services in their homes or communities to prevent inappropriate institutionalization. This will ensure that low-income seniors and people with disabilities who are now eligible for nursing home care under Medicaid have access to home care when appropriate. Helping individuals remain in their homes will help drive down long-term care costs.

- explore options for maintaining affordable, quality coverage for parents with incomes between 133% and 185% of the federal poverty level, who are currently covered in HUSKY A, as federal health care reform is implemented, and, to the extent possible, continue to match eligibility levels for parents and children in Medicaid.

- increase provider rates so that sufficient numbers of all categories of providers are willing to participate in the Medicaid program, for both primary and specialty care, as well as therapies and home care.

- eliminate current restrictions on Medicaid-funded access to podiatrists, and physical, speech and occupational therapists

- eliminate unaffordable drug co-pays for dual-eligible Medicare/Medicaid enrollees

Developing a Collaboration Between UConn Health Centers and DSS

Cato Laurencin, MD, PhD.
Vice President for Health Affairs
Dean of the School of Medicine, UConn

Statement of Issue

Bottom line: Connecticut's implementation ofMedicaid and Healthcare Reform need critical expertise and funding to help pay for this expertise. UCHC can assist with both through a UCHC/Medicaid formal collaboration that will also provide the basis for the participation of the broader University.

As both Medicaid and Healthcare Reform have driven states' need for clinical, analytic and subject expertise, states have developed formal collaborations between their universities and their Medicaid programs to provide this expertise, and to assist in its funding. Federal Medicaid rules provide significant financial (federal Medicaid claiming) advantages to Medicaid/Public University collaborations. Four New England states have long established collaborations, a fifth, Rhode Island, is developing one, and for nearly a year, UCHC has had a team working on developing a suitable design for Connecticut. In consultation with DSS, this team has learned the mechanics required of this collaboration and has agreed on a recommended approach.

Immediate Action Areas

A. Prioritization schedule and timeline
   Spring 2011

- **Interagency Service Agreement (ISA):** For CT to claim federal Medicaid match for the administrative services UCHC performs for CT Medicaid, there must be a formal agreement between the two that defines the collaboration. States have crafted these ISAs in various ways but Maine provides a good model with a global agreement that expressly balances the interests and contributions of the university and Medicaid. Separate cooperative agreements clearly delineate each project.

- **Pass through authority:** CT must establish a mechanism for transferring to UCHC the federal Medicaid match for the Medicaid administrative services that UCHC performs. Every state with a University/Medicaid collaboration has established such a mechanism, which may require rule making or state legislation. An approach suitable to CT must be developed with the relevant parties (the Governor, CT General Assembly, Office of Policy and Management etc.).

  December 2011

- **Money on the table:** Since the missions of UCHC and Medicaid overlap, UCHC already does significant training, analysis and consultation that benefit the administration of Medicaid. If UCHC had an agreement with DSS, all the costs UCHC incurs in this work, including its indirect costs, become the basis for obtaining federal dollars. Federal Medicaid match for the administrative benefits UCHC is already providing can result in hundreds of thousands of dollars to jumpstart a greater collaboration. Also, starting with what UCHC is already doing positions a UCHC/Medicaid collaboration to build on the current strengths and activities of multiple centers within UCHC.

B. Fiscal impacts: cost savings? implementation costs?

Savings and revenue depend on the scope of the operation established. UMass' large collaboration generates @$50 million a year in Federal Medicaid match, whereas UMaine's generates @$24 million. It takes time to build up a collaboration. If CT moves forward, it could expect to net several million dollars next year. Implementation costs are small. To receive federal Medicaid match, UCHC must maintain proper accounting procedures and records. Initially, the staff resources required will likely be modest. This activity is comparable to what UCHC must already perform for federal grants. The same units that perform this work can be assigned to handle the Medicaid collaboration with the staff devoted to this collaboration growing as the collaboration itself grows.

C. Job impacts

As opposed to turning to out-of-state consulting firms, turning to UCHC for necessary expertise keeps professional jobs and support staff within CT, and develops programs within UCHC that can better train a professional workforce for the state. The federal Medicaid dollars and also the soft money that UCHC can draw for collaborative projects enhance the money available for CT jobs.

D. Malloy/Wyman Campaign Policy Tie In

Malloy/Wyman have advocated implementing SusiNet and ACA, establishing efficiencies within CT Medicaid, improving long-term care, payment and delivery system reforms, and seeking additional sources of federal funding. Under a formal agreement with DSS, UCHC is well positioned to help with these initiatives.

E. Benchmark state(s)

Maine & Massachusetts. Both have long-established and successful collaborations (ME 1989/MA 1996). Both offer lessons for CT. UCHC's 2010 TRIPP Visiting Professor was instrumental in developing these collaborations and has been part of UCHC's team.

F. People/organizations in CT who are knowledgeable/supportive

UCHC team is knowledgeable: Dr. Judith Fifield, Dr. Robert Trestman, Dr. Ann Ferris, Dr. Ron Preston, and Dr. Judith Meyers. UCHC leadership has supported the team's purpose and work. DSS's Dr. Mark Schaefer and Dr. Robert Zavoski have also participated, as has

Dr. Marie Smith (School of Pharmacy). Throughout, the Child Health & Development Institute (CHDI) has supported the initiative.

G. Dissenting opinions/organizations
None.

Long-term Needs/Vision

- Establish a mechanism by which the state can enhance and readily draw on UCHC's (UConn's) resources to assist the development and administration of Medicaid and Healthcare Reform.
- Build capacity, centers of excellence and perhaps even institutes within UCHC (UConn) devoted to providing analytics and expertise necessary to advance Medicaid and healthcare reforms.

Medicaid Family Planning Expansion

Planned Parenthood of Southern New England

Of the concerns facing Connecticut's schools, dropout rates loom large. Yet as federal, state, and local officials, community and business leaders, social entrepreneurs, and philanthropists develop strategies that will help reduce these alarming dropout rates, an important piece of the puzzle—too-early pregnancy and parenthood—is often neglected.

Teen pregnancy/parenthood and school dropout are closely associated:

- Fully 30 % of teen girls cite pregnancy or parenthood as a key reason for dropping out of high school; rates are even higher for African American and Latino girls.
- Only 40 % of teen moms finish high school and the crisis extends to postsecondary institutions as well.
- Less than 2% of teen moms finish college by age 30, and
- 61% of women who have children after enrolling in community college fail to finish their degree—a rate 65% higher than the rate for those who didn't have children.

Too few Connecticut public schools are prepared to induce pregnant teens to stay in school or young mothers to return to school by offering child care and other supportive services.

About 50% of American high school students are sexually active by the time they reach senior year, according to the Youth Risk Behavior Survey. Preventing pregnancy (and disease) by preparing students with the comprehensive, medically accurate information and reproductive health care they need is critically important. Again, Connecticut schools have an inconsistent record around implementation of comprehensive health education, including sex education. And only a handful of school based health centers make full reproductive health exams *and contraceptives* available to students.

Clearly, sexually active adolescents need access to low or no-cost sexual health care, including family planning (contraceptive) services. An expansion of Connecticut's Medicaid family planning program could accomplish this goal at relatively low up-front cost to the state. What's more, similar programs in others states have been shown to save millions in state and federal Medicaid payments annually.

Proposed Action:

In 2005, the Connecticut General Assembly passed legislation requiring DSS to apply for a Medicaid Family Planning Expansion Waiver based on the fact that the federal match for such services is 90 cents for every 10 cents a state spends. Despite almost constant prodding from legislators and advocates since 2005, this waiver application was never completed or submitted to CMS.

Twenty seven other states have saved significant state dollars through family planning expansions. With passage of the federal Affordable Care Act in 2010, states have been encouraged to expand their Medicaid family planning programs via a State Plan Amendment (rather than a waiver) …a far simpler route.

We propose that Connecticut join the 27 states which save $4 for every $1 of public money spent on family planning, and that we reap the benefits of the 90-10 federal match on family planning services.

Prioritization Schedule:

Since this issue has been in the planning/discussion phase for over 5 years, there should be comparatively little effort required to apply for a Family Planning State Plan Amendment. It is our recommendation that DSS move swiftly to apply for a SPA. From the CMS point of view, the initial process, summarized, is as follows:

To amend its plan, a state must submit a draft SPA to the regional CMS office, using CMS Form 179 (Transmittal and Notice of Approval of State Plan Material). In yet another distinct difference from the waiver route, federal regulations specify a timeline for the review and approval of amendments. Once the regional office receives a SPA, the amendment is considered approved if CMS neither disapproves it nor makes a formal request for additional information within 90 calendar days.

Fiscal Impact:

Research has consistently shown over time that for every dollar state and federal governments spend on family planning, they reap at least $4 due to the cost savings from pregnancies averted. Savings would likewise accrue to Connecticut from the family planning expansion (see chart below.)

- $8,072,501: estimated total cost of family planning/contraception to eligible users, 90% reimbursed by the federal government.
- $807,250: CT investment
- $46,000,000: estimated possible savings from births averted (prenatal care, labor and delivery, inclusive of Medicaid costs to cover newborn and mother.)

Connection to Malloy-Wyman campaign policy:

Implementation of the family planning expansion addresses the incoming Administration's priorities on at least two levels .

1. A more comprehensive approach to reproductive health care/pregnancy prevention for sexually active adolescents *will contribute to school reform by contributing to the decrease in dropout rates.*
2. Making family planning available to adolescents and other eligible women of reproductive age (not otherwise categorically eligible for the full set of Medicaid services) *is proven to save state dollars*. Twenty seven states with experience operating family planning waivers are now transitioning to the SPA expansions, having reaped the fiscal benefits of an investment in family planning that is heavily subsidized by federal dollars.

Long Term Needs/Vision:

Family planning is among those basic preventive strategies that Connecticut should adopt more consistently. Just as with other early childhood interventions that avoid significant health or mental health costs at a later point, an investment in family planning and a

more realistic commitment to the sexual health of our citizens will also help to avert both the costs and the heartache of sexually transmitted infection (which is rampant among young people, and leads to infertility) and the incidence of HIV-AIDS, which, sadly, is growing among young adults.

	Women	***Men***	***total***	***Notes***
under 20 and uninsured	*12,295*	*606*	*12,901*	*This number could increase with outreach and as a result of efforts related to teen pregnancy prevention.*
20-44 under 100FPL	*6,290*	*814*	*7,103*	*Some in bracket may already be covered by Medicaid, but are not currently accessing FP services.*
20-44 101% to 249% FPL	*17,294*	*2208*	*19,502*	*Some in this bracket may be or have been covered by Medicaid (e.g. Healthy Start) for a time.*
Total	***35,878***	***3,628***	***39,506***	

Based on calculations provided by The Guttmacher Institute	**# of clients served (female only)**	**Pregnancies averted**	**Births averted**	**Abortions averted**
Currently served by publicly funded centers (such as PPSNE)	80,110	16,600	7,400	6,900
Estimate served by FP Expansion	35,878	7,434	3,314	3,090

Estimation of cost savings with Medicaid family planning expansion

	Avg. cost per Medicaid Birth	**Cost of Medicaid birth (Avg. cost X births averted)**	**FP costs per person***	**Total FP costs**	**State FP costs (**90% of total costs reimbursed by federal gov't)	**Total savings**
Calculation A	$14,307	$47,415,372	$225	$8,072,501	$807,250	$46,608,122
Calculation B	$ 4,576	$15,165,495	$225	$8,072,501	$807,250	$14,358,245

Calculation A: The cost of a Medicaid-funded birth is defined here to include costs for prenatal care, delivery, postpartum care and medical care of the infant for one year.
Calculation B: The cost of prenatal care, delivery and postpartum care.
* Family planning costs include supplies, 1.7 visits a year per person on average)

Inmate Inpatient Care and Medicaid

Cato Laurencin, MD, PhD
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Dean of the School of Medicine, UConn

Generally, the federal government, via the Centers for Medicare and Medicaid Services does not reimburse states for inmate medical care under the Medicaid program. An exception, however, is permitted when inmates are treated in a hospital not under the control of the state's correction system. UCHC has been working with DOC and DSS to change the current arrangement of having all inpatient services billed to UCHC/CMHC and paid from the DOC allocation budget allocation for inmate medical services and instead to have John Dempsey Hospital and the other outside hospitals bill Medicaid for the inpatient charges for inmates. This change requires hospitals to process applications to establish eligibility and enroll inmates once they have had an inpatient stay. This will then enable them to bill the Medicaid program. The benefit will be that these inpatient Medicaid eligible costs will meet the requirement for the Federal match for Medicaid services. The costs for inpatient services in Fiscal Year '10 were approximately $8.5 million, $8.0 million paid to John Dempsey Hospital and total of $.5 million paid to a variety of other hospitals. It is estimated that this change in practice, given the federal match, will likely yield a savings to the state of $3-4 million dollars.

Public Health, Population Health, Wellness, Health Equity

Public Health and Prevention

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Healthcare Working Group
Public Health and Prevention

I. *Context:* The health of Connecticut residents depends upon a robust public health infrastructure, and prevention efforts that occur "upstream" where they have the most impact on the social determinants of health. The 'social determinants' of health are best addressed by public health, defined as "…what we do as a society to assure the conditions in which people can be healthy."[17] Only about 10% of the health of populations is associated with access to health care: by far the biggest determinant of health is behavior (40%), which occurs within and is dependent upon environmental (5%) and social circumstances (15%).[18] Public health is primarily the responsibility of federal, state and local government entities,[19] but budget cuts are threatening public health infrastructure and workforce capabilities to meet current and emerging public health concerns.[20]

II. *Immediate Action Areas*:

A. Over the next six months, assure that public health infrastructure and workforce spending remains constant: during 2010, Connecticut's funding to local public health dropped 26-50%; [20]

B. Continue to invest in evidence-based prevention programs that will, in the long run, reduce health care spending and morbidity/mortality; and

C. Over the next two years, *increase* spending on public health and prevention programs, public health workforce and infrastructure, particularly during times of budget neutrality or excess.

D. Fiscal impacts:

a. Cuts to public health spending can actually increase health care costs, since spending on local public health is inversely related to health care costs;[21]

b. Evidence-based public health and prevention programs in Connecticut have the potential to reduce health care costs by more than $231 million over five years;[22] and

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[17] Institute of Medicine (2002). *The future of the public's health in the 21st century*. Washington DC: National Academies Press
[18] MGinnis, J., Williams-Russo, P., & Knickman, J. 2002. *The case for more active policy attention to health promotion*. Health Affairs, 21(2): 78-93.
[19] Turnock, B. (2009). *Public health: What it is and how it works*. Boston: Jones and Bartlett.
[20] National Association of City and County Health Officials [NACCHO]. (2010). *Local health department job losses and program cuts: Findings from January/February 2010 survey.*
[21] Mays, g., 7 Smith, S. (2009). Geographic variation in public health spending: Correlates and consequences. *Public Health Services and Systems Research.*

c. Evidence-based smoking cessation programs for Medicaid recipients could reduce smoking rates among the Medicaid population by as much as 10% per year; currently smoking-related health care costs for Medicaid recipients are more that $5 million annually.[23]

E. Job impacts:

a. Funding cuts to Connecticut's local health departments and districts has resulted in job losses in 26 – 50 % of those departments/districts.[20]

F. How does it tie-in to Malloy/Wyman campaign policy?

a. Benchmark state(s): Massachusetts has successfully reduced smoking rates by 10% per year among its Medicaid recipients by offering evidence-based smoking cessation programs to that population; Connecticut is one of only four states in country not offering comprehensive smoking cessation programs to Medicaid beneficiaries.[23] Connecticut is one of only five states that does not track diseases using a Centers for Disease Control and Prevention (CDC) system.[24]

b. Organizations in Connecticut that are knowledgeable about and supportive of public health strategies and solutions: (this is only a partial list and I have not contacted these organizations for specific comments/feedback): Connecticut Public Health Association; Connecticut Association of Directors of Health; Connecticut Association of Public Health Nurses; schools of public health; public health coalitions; others (?)

c. Dissenting opinions and/or organizations: those who are unaware of the potential impact of not having a robust public health infrastructure; those who have not been educated on the impact of the social determinants of health on population health; entities and organizations focused "downstream" on acute care, rather than "upstream" on prevention.

III. Long-term Needs/Vision: the Institute of Medicine (IOM) recently reported that, despite spending more than any other nation on health care, the U.S. is not healthier on average than many, less affluent countries and in fact ranks 49th in the world for life expectancy. The IOM argues that this is in part due to inefficient, inadequate means to communicate and share individual and population health data, including the underlying "social determinants" of health. Policymakers can only make good decisions when good data are available. For a number of important reasons, the administration should look at health information technology exchanges and public health communication strategies that will enhance their ability to make policy decisions that will actually improve the public's health.[25]

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[22] Trust for America's Health. (2008). *Prevention for a healthier America: Investments in disease prevention yield significant savings, stronger communities.*

[23] Cooney, J., Cohen, J., Checko, P., Grant, C., & Lewis, KK. (2010). *Examining tobacco use, consequences and Policies in Connecticut: Smoke and Mirrors?* Connecticut Public Health Policy Institute: Issue Brief presented at the Connecticut Legislative Office Building, January 19, 2010.

[24] Trust for America's Health. (2010). *Shortchanging America's health: A state-by-state look at how public health dollars are spent.* Available at http://healthyamericans.org/report/74/federal-spending-2010

[25] Institute of Medicine. (2010). *For the public's health: The role of measurement in action and accountability*.

Women’s Health

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National Medical Association

Women are the drivers of healthcare delivery for their families and therein healthcare overall.

Regarding Women’s healthcare in our state, I would highlight certain issues. In terms of women's health, we have not met a number of national benchmarks.

1. Focusing on women as a mechanism to reduce health care disparities. It is key to deliver and implement healthcare that is culturally and linguistically competent. In Connecticut, issues of particular concern are cardiovascular disease, hypertension, diabetes, infant mortality, sexually transmitted infection and lung cancer prevention.

2. We should focus on women without health insurance, especially between 18-44 years. Support and improve access to community and hospital and based-programs for wellness and prevention especially for underserved women for hypertension, diabetes as well as PAP smear and mammogram screening and comprehensive prenatal services. As pointed out already, elements of health reform, consumer centered medical home, prevention and electronic health record are means to facilitate continuity of care.

3. With patient education as the ultimate strategy of disease prevention, we should support reform form that creates affordable, efficient and importantly, culturally sensitive and competent medical, mental and oral health services for women.

Wellness Programs

Ellen Andrews, PhD
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Connecticut Health Policy Project

Issue Paper: **Build robust wellness programs for state coverage plans**

I. Statement of issue:

The best way to reduce medical costs is to avoid them. Workplace wellness programs, to support consumers in assessing health risks and links to treatment, are becoming common among employers; 48% of all US workers in large and medium private establishments participated in a wellness program last year.[26] Wellness programs are very popular; 82% of employed Americans view them positively.[27] A new study of wellness programs found that every dollar spent returned $3.27 on the investment in reduced medical costs and $2.73 in reduced absenteeism.[28] As the state employee plan recently converted to self-insurance, the state will keep the savings from investing in wellness for the plan's 200,000 members. The move of HUSKY from capitation to a self-insured ASO model, included in this year's budget, will allow the state to retain wellness program savings in that program serving another 400,000 state residents. The previous administration was not open to any wellness programs that included incentives to consumers to improve their health or even take a risk assessment. Successful programs emphasize consumer incentives over penalties. The new administration should allow consumer rewards for risk assessments and healthy behaviors into state wellness programs.

II. Immediate Action Areas (6 months to 2 years)
   a. Schedule and timeframe – The Comptroller's Office could quickly build on existing programs for state employees to include incentives. DSS could solicit bids and award contracts for wellness programs for HUSKY families within six months.
   b. Fiscal impacts: Annually the state could save $43 million for state employees alone[29] and potentially far more in the $800 million/year HUSKY program. Several sections of the Accountable Care Act include support for wellness programs.[30]
   c. Job impacts: Workplace wellness programs have demonstrated effectiveness in reducing absenteeism, improving the efficiency of CT's businesses and state government.

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[26] EBRI Databook on Employee Benefits, Ch. 4, April 2010, Employee Benefit Research Institute.
[27] How do Americans View Wellness Programs?, Oct. 30, 2007, Employee Benefit Research Institute.
[28] K Baicker, et. al., Workplace Wellness Programs Generate Savings, Health Affairs 29:1-8, 2010.
[29] $214 per person annual savings medical costs (see above) X 200,000 state employee plan members.
[30] ACA Sec. 4002 establishes a Prevention and Public Health Investment Fund to support wellness programs, among others, authorized by the Public Health Service Act, Sec. 4202 creates a program of CDC grants to states and local health dept.s for pilot wellness programs to improve the health of pre-Medicare eligible consumers, and Sec. 4303 provides research, educational campaigns and technical assistance to support workplace wellness programs. The recent HHS regulation defining allowable quality expenses by health plans for purposes of medical loss ratio reporting includes the cost of wellness programs. The ACA permits employers to offer rewards of up to 30% (and to 50% in some cases) of the cost of coverage to workers for participation in wellness programs. The Act establishes a 10-state pilot program of wellness rewards in the individual market. The Act also creates grants to small businesses for wellness programs to begin in 2011.

d. Tie in to Malloy/Wyman campaign policies: The Policy Project focuses on prevention and wellness programs as an important strategy to reduce health costs (p. 49).
e. Benchmark state: RI, MA, VT
f. People/organizations in CT who are knowledgeable/supportive: Comptroller's Office
g. Dissenting opinions/organizations: None that I know of.

III. Long-term Needs/Actions

It is critical to evaluate each program with a robust study. Too many wellness programs are ineffective marketing tools and do little to improve health. It is difficult to know what will work before it is implemented, but it is critical to measure impact and modify policy and purchasing in response.

Creation of Connecticut Health and Human Service Agency to Improve Health Outcomes

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Capitol Workforce Partners Chair, CT Commission on Health Equity

I. Statement of issue:

Consolidation of public health and social service agencies in the State of Connecticut into a *Connecticut Health and Human Service Agency* will improve health outcomes and determine the following efficiencies:

- Streamlined administrative/operational costs.
- Transparency in financial and performance reporting.
- Reduced healthcare costs and fraud.
- Collaborative planning among public health, social service state and local agencies, community health centers, and employers to project and monitor trends in disparities, costs and savings.
- Common data systems

Changes to be implemented:

1. Results-based accountability report card to track the accessibility, affordability, safety and quality of care for all.
    a. Concerns: Striving to eliminate health disparities and inequities of the health status of the multiple populations in our state, regardless of race, ethnicity, culture or linguistic differences deserves careful examination, deliberation and determination to solve the manner in which we view the delivery of quality health care.
2. Education and training in culturally competent care is provided <u>for</u> all health care providers.
    a. Concerns: time commitment and cost (redistribution of resources necessary)
    b. Expectation: Incentives for providers tbd.
3. Creation of a *health care collaborative* comprised of local public health agencies, health education institutions, acute care/long term care/ home care facilities, community health centers and <u>employers</u> to work together to plan for reduction of duplicated services and improvements in the delivery of health care to improve the quality of life for all residents.
    a. Concerns: Focused and skillful leadership required; plan to redesign the infrastructure required; policies and procedures reviewed, rewritten, and implemented.

II. Immediate action (between 6 months and 2 years):

A. Under the workforce shortage faced by some state departments, now and in the near future, the Malloy/Wyman-administration could assign representatives to an internal Conversion

Team to plan personnel redeployment and programmatic redesign- within departments, and across departmental borders. Availability of data to determine disease trends and costs for treatment is essential to this process; trends in health disparities and social determinants of health affecting specific population groups in urban and rural areas will determine the need for a strategic redesign.

B. Medicaid incentives to recipients of services for smoking cessation and weight reduction will only work if incentivized negotiations are implemented for grocery stores/chains to locate products cost effectively in food deserts.
C. This process will meet with some resistance from those who wish to keep the status quo. Bargaining units should be brought into the process early on to influence responsible, collaborative work on the change elements required.
D. Within the next two years, affordable health insurance coverage for entrepreneurial seekers will aid in job creation.

III. Short and Long-term Needs

Communication Plan among the Partnership members.

Quarterly Progress Reports to the community-at-large for the first two years – then annually.

IV. Vision: CT has an efficient, effective healthcare system responsive to the health needs of all of its residents.

Creation of HEALTH Agency that Promotes Population Health and Drives Health Outcomes

Patricia Baker
President and CEO
Connecticut Health Foundation

Policy Action: Creation of HEALTH Agency that promotes population health and drives health outcomes

Issue: The Department of Public Health and the Department of Social Services operate separately. Rarely over the last 20 years have there been coordinated efforts to improve health outcomes; rather, they have often been at cross purposes. This bifurcation can reduce the impact of each's agenda. DPH is charged with the monitoring and tracking of health data and improvement of the state population health. DSS is a significant payer for the Medicaid eligible population in CT. 1 out of every 4 babies born in our state is covered by Medicaid. Given the economy, this number is nearing 1 out of 3. Connecticut cannot afford to have these operating in separate silos. CT residents cannot afford it. There must be specific goals and clearly aligned financial incentives to drive outcomes and accountability.

Immediate action:

- Consider interim leadership for the departments rather than appointing Commissioners. This interim leadership should not be tied to existing Commissioners. The desire to protect the status quo could inhibit innovative thinking and the ability to engage in a rigorous examination.
- Leadership work group assigned to articulate goals and expectations of the merger that are health outcome driven using the payer system to improve outcomes and promote quality and value. The team is charged with the implementation planning over the next year. The team must be clear that the purpose is not cost cutting via merger, but the appropriate reallocation of dollars to create the greatest return on the state's investment.
- Identify essential services, what works and doesn't.
- Reallocate resources to maximize investments and let go of what does not work.
- Conduct national search to ensure the level of leadership required to lead this new department.

Long Term:

- Statewide health goals established with resources from prevention to payment for services aligned to accomplish goals.
- Continuous Quality Improvement function established to assure best practices and evidence is driving investment
- Establish Health Planning function that engages the community
- Create a culture of accountability to the public by reporting out results
- Centralize and coordinate health data report to provide accurate, timely, and accessible data from which both the Executive Branch and Legislative Branch can use for decision-making as well as the community.

Racial and Ethnic Disparities

Patricia Baker
President and CEO
Connecticut Health Foundation

Connecticut's most widespread public health problem -- health disparities (*avoidable* differences in health status) -- disproportionately impact Connecticut communities of color regardless of socio-economic status or health insurance coverage. Racial and ethnic health disparities have been extensively documented throughout Connecticut and our nation, and present a complex challenge for health care and public health systems, and society at large.

While there is no simple remedy to address this long-standing and complicated public health challenge, health disparities can be reduced over time with sustained leadership from all sectors – public, private and non-profit. Government can promote policy changes that can make measurable differences in the health outcomes of populations of color in Connecticut. As a member of the Connecticut Health Foundation's (CT Health) 2003 Policy Panel on Racial and Ethnic Health Disparities, Governor-Elect Dan Malloy approved a series of specific public policy recommendations designed to reduce health disparities by changing systems interconnected with health (see enclosed *Pathways to Equal Health: Eliminating Health Disparities in Connecticut* or visit our website, www.cthealth.org). In addition, CT Health believes policy-makers could make a significant impact in the following areas:

- Ensure those most impacted by racial and ethnic health disparities actively participate in the policy-making process.
- Implement state health reform in a way that increases access to health care and promotes quality care with a goal to reduce racial and ethnic health disparities. All health reform plans should support this goal via 1) enhancing the patient-provider relationship; 2) expanding the culturally/linguistically competent health care work force; 3) requiring evidence-based best diagnosis and treatment practices; 4) collecting and evaluating health indicators that measure health disparities; and 5) demonstrating transparency and accountability in the policy-making process.
- Require all state agencies to collect racial, ethnic and language preference data to accurately measure health outcomes and quality improvement efforts. The Department of Public Health already has developed a racial/ethnic health data collection policy that includes an annual reporting requirement (see enclosed excerpt or visit www.ct.gov/dph).
- Fund Commission on Health Equity to build its capacity to carry out its legislative mandate to collect and analyze racial and ethnic health indicators across all state agencies.
- Amend state Medicaid plan to include medical interpretation services (including face-to-face, teleconference, language telephone, etc.) as a covered expense under Medicaid (see Public Act No. 07-185) and include in "basic health plan" under SustiNet. Under the federal Children's Health Insurance Reauthorization Act, Connecticut could receive a 75 percent reimbursement rate for medical interpretation services for children insured under Medicaid. According to a CT Health Foundation 2006 report, *Estimates for the Cost of Interpretation Services for Connecticut Medicaid Recipients* (see attached or visit www.cthealth.org), language barriers can lead to poor health outcomes and substandard care among patients with limited English proficiency.

Aside from commissioning several public policy reports around racial and ethnic health disparities, CT Health also has invested in the development of the next generation of advocates through our Health

Leadership Fellows, a year-long knowledge and skill-building program designed to raise awareness and public action to reduce racial and ethnic health disparities. To date, 100 Fellows have graduated from the program and are leading state and local efforts to reduce racial and ethnic health disparities.

Mental Health and Autism Care

Mental Health Policy

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Mental Health Association of CT, Inc.

Mental Health Policy Outline

I. Statement of Issue:

With the exception of group homes, Connecticut has traditionally paid for the majority of mental health services with 100% state funded dollars. Until recently, Connecticut has not applied for much in the way of federal Medicaid dollars that could have paid for these services. Some progress was made recently when Connecticut was granted Home and Community Based Services Mental Health (HCBS) Waiver and Money Follows the Person (MFP) Program, but much more can be done to maximize federal dollars and to substitute federal dollars for state dollars for the provision of mental health services. For example, Connecticut became the first state in the country to expand Medicaid coverage under the Affordable Care Act. The State Administered General Assistance Program (SAGA) was discontinued and individuals formerly covered under SAGA are now being covered under Medicaid effective April 1, 2010. This change transfers the 45,000 single, low-income adults covered by SAGA into the Medicaid program. These adults will now have access to the fee-for-service Medicaid health care benefit package **which includes mental health care,** having a positive impact on the state budget because it will now receive federal reimbursement for services that were previously paid for by entirely all state expenditures under SAGA. **However, Connecticut must do more to ensure that the federal government is billed for these services if we are to maximize the costs of mental healthcare to Medicaid under the new Section 1915(i) "state plan option," which does not require institutional care as a condition for the receipt of Medicaid dollars.**

II. Immediate Action Areas

A. Prioritization

Maximize Medicaid billings for outpatient services. Federal revenue can be maximized by assuring that outpatient services provided by state operated and contracted providers are billed to Medicaid to the fullest extent allowed. Services provided by state operated programs and facilities are billed through the Department of Administrative Services not DMHAS. DMHAS and other state agencies that deliver mental healthcare such as DOC do not direct bill, nor are their budgets dependent upon any income generated thereby. The state should determine if standards regarding productivity, timely and accurate billing and targets related to income recovery to maximize what the state does collect for its billable services.

B. Fiscal Impact

Expand Medicaid reimbursement. An actuarial study conducted by the Mercer Consulting Group for the Department of Social Services (DSS) identified in their February 2004 published study the following new federal revenue for these existing DMHAS services as Medicaid rehabilitation services:

Assertive Community Treatment Teams (ACT)	$10,554,692
Supervised Housing (services only)	11,141,684
Supported Housing (services only)	7,074,768
Mobile Crisis	6,167,272

Total estimated	$34,938,416[31]
Targeted Case Management current cost	(7,000,000)
NET NEW FEDERAL FUNDS	**$27,938,416[32]**

Continue to expand federal revenue under the Mental Health Home and Community-Based Services (HCBS) Waiver designed for adults with serious mental illness who may be discharged or diverted from expensive nursing home care with appropriate community support. This waiver is now authorized will now prevent another loss of last year's estimated $7.5 million of Medicaid reimbursement because the number of persons with mental illness in some nursing homes exceeded the federal limit. Approximately 72 persons were discharged or diverted from nursing home care since the Waiver began April 1, 2009.

Expand Money Follows the Person (MFP). The goal of MFP is to rebalance Connecticut's long-term care systems with an emphasis on home and community-based services rather than nursing home care. MFP provides services to a broad range of persons with disabilities including persons with **mental illness.** MFP funded services for persons who have a mental illness include a) home and community based services identical to those available under the Mental Health Waiver discussed above, b) services otherwise authorized by the Medicaid State Plan and c) demonstration services not authorized under any waiver. Once an MFP participant with mental illness has received MFP services for 365 days, the participant will automatically transition to the Mental Health Waiver program again supplanting state nursing home expenses with federal dollars for services in the community.

Expand Alternatives to Incarceration. Currently, almost 20% of persons incarcerated in CT prisons and jails have been diagnosed with a mental illness. Since 2000, the number of inmates with moderate to serious mental illnesses rose from 2,200 to over 3,700. Along with homelessness and nursing home admissions, this is a stark example of the deterioration of our basic mental health system. Department of Corrections officials confirm that an estimated 1,428 persons with moderate to serious mental illnesses are incarcerated for low-level, non-violent offenses.[33] This represents a substantial number of non-violent offenders with mental illnesses who could safely live in the community, if they had housing and services. Instead of providing services and housing, the state spends approximately $40,000 to $60,000 per person to incarcerate people. Although it may not be possible to do a "one on one" closure of prison beds for every person we can take out of prison or divert from prison, over time we will reduce the number of prison beds. State staff who are no longer deployed to state institutions could form the core of new community supervised placements for diverting and discharging people from prisons who do not need to be there.

C. Job Impacts

Waiver services are provided face to face, in the participant's home or in other community settings (non-office/non-institutional setting). Individualized assessment, Recovery Plan development, and service

[31] Group homes are excluded since DMHAS and DCF are already proceeding with coverage of their services under the Rehab Option.

[32] Mercer Government Consulting Group, ***Estimate of the Budget Neutrality of the Connecticut Behavioral Health Partnership, Technical Appendix,*** Feb. 2004, Appendix J.5.

[33] As of October 2007, the Department of Corrections (DOC) reported that of the 3,897 inmates with mental health issues classified as level 3, 4 and 5, 1,741 were not convicted of, or on bond for, a violent or serious offense (46%). The DOC reports the Mental Health level 3 numbers to be inflated by approximately 20% because they include inmates with problems that are probably not directly attributable to serious psychiatric illness. This still leaves 1,428 inmates with moderate to serious mental illnesses who are in prison for low level offenses.

delivery emphasize participant strengths and assets, utilization of natural supports and community integration. DSS and DMHAS have already developed service definitions and a rate-setting methodology for services to be covered under the current waiver. Two of these, assertive community treatment and community support services (included as ACT in the Mercer study), could be covered by the Medicaid state plan. By increasing opportunities for community integration for those with mental illnesses the state can shift funds from costly criminal justice settings, nursing facilities and crisis services, to more cost-effective and evidence-based community options. The state can utilize available federal Medicaid funding to preserve critically needed community mental health services. This will save the state money and sustain state funds necessary for the support services and rental assistance (RAP certificates) that are not Medicaid billable but central components of community care. The most promising option is a state plan amendment under 1915(i) to allow the state to bill for Community Support Program (CSP), Assertive Community Treatment (ACT), Peer Support, Supported Employment, Recovery Assistant, Short Term Crisis Stabilization, and Transitional Case Management, among other potential services. Any state workers displaced could be transferred to provide the community treatment and support as was done when state hospitals were closed. The state's long term gain is in reducing institutional costs, gaining Medicaid payment for inpatient care, expanding resources for community integration without jeopardizing jobs, and reducing emergency room costs.

D. **Malloy/Wyman Campaign**

Invest in Cost-Effective Housing and Community Services. Transferring some intermediate inpatient care services to private hospitals could both alleviate the gridlock in the state's institutional mental health system and create an opportunity to transfer resources from inpatient settings to the community. It is well documented that the lack of adequate funds for housing and community services and supports for persons with psychiatric disabilities contributes to the utilization of more expensive care in nursing homes, prisons, shelters, emergency rooms and hospitals at a significant cost to the taxpayers. Community options, particularly **supportive housing**, reduce hospitalizations, **increase employment** and education, and contribute to **increasing neighborhood property values.**

E. **Benchmark state(s).** Connecticut is a pioneer in health care. It was the first to be granted federal Medicaid reimbursement under the new federal healthcare reform for Low Income Adults and the first to pass its own public option. However, Oregon has done a much better job of rebalancing its institutional versus community long term care costs and maximize federal reimbursement.

F. **People/organizations in CT who are knowledgeable/supportive**
NAMI and the CT Legal Rights Project; Keep the Promise Coalition would be both supportive of increased federal Medicaid and opposed to reform without vital community supports, services and housing to put into place to ensure the continuum of care. They would also oppose any cost cutting around psychiatric medications.

G. **Dissenting opinions/organizations.** Consolidation of large multi-service agencies as advised by CBIA will threaten the delivery of specialized mental health services and be strongly opposed by mental health advocates. However, back office functions can be consolidated. Front door eligibility applications can be standardized.

H. **Long Term Vision.** Many of these measures require planning and oversight. The state has an existing strategic planning body that could oversee this process and present a report to the Governor and the Legislature by June 1, 2011—the Community Mental Health Strategy Board. Chaired by the Commissioner of DMHAS, the DCF Commissioner and a representative of OPM also sit as voting members of the Board, and

other relevant state agencies have non-voting seats. Hospitals and advocacy groups also are members. There are currently vacancies on the Board to which union, consumer and family, and community provider representatives could be appointed to assure that that mental illness is treated as any other preventable, treatable, chronic illness.

Children's Mental Health

Patricia Baker
President and CEO
Connecticut Health Foundation

Mental health disorders affect 1 in 20 young people. Data indicates that between 5 percent and 9 percent of children and youth experience serious emotional problems that can hinder a child's ability to live a full and productive life. Unfortunately, many low-income children and children of color do not have access to the array of mental health services. National research indicates that up to 80 percent of children of color who have mental health issues do not have access to treatment.

In an effort to expand access to these services, the Connecticut Health Foundation (CT Health) has made investments in:

- Kidcare, the state's comprehensive, community-based, family-centered, cultural and linguistic competent program.
- Child Health and Development Institute of Connecticut to develop a baseline assessment of the children's mental health delivery system so the Department of Children and Families could evaluate the shift to local systems of care.
- The Center for Effective Practice, which pioneered the use of a proven mental health treatment intervention specifically for children in Connecticut's juvenile justice system.

Many experts agree that early identification, assessment, and intervention of children with emotional and behavioral problems can help prevent more serious and costly problems in the future, most state dollars provide services for a small number of children. About 70 percent of the state's financial investment in children's mental health serves about 30 percent of children who suffer from severe mental health problems.

While these children require a more intense investment, the state can reduce the need for more intense and expensive mental health services in the future by investing a majority of its resources in prevention and earlier stage services. Data also reveals that children of color often do not receive mental health services until they enter the juvenile justice system, creating significant racial and ethnic mental health disparities.

CT Health modified its children's mental health strategic objectives in 2007 to reduce the number of at-risk children ages 6 to 14 from entering the most intensive mental health treatment and/or the juvenile justice system due to their mental health problems. In an effort to achieve our strategic goal, CT Health has invested in both grant-making and health policy research:

- The foundation will invest about $4.75 million over five years to create a prevention system of early intervention on the local level. Four communities – Waterbury, Manchester, Derby and Middletown – are eligible to receive CT Health funding to implement local mental health prevention systems. The results of this demonstration initiative may guide decision-makers to reallocate state children's mental health resources into more efficient and effective local systems of children's mental health care.

- CT Health will assess the public policy implications of a school-based system of early identification and assessment of children exhibiting signs of behavioral or mental health issues.

Children's Mental Health Prevention System

Patricia Baker
President and CEO
Connecticut Health Foundation

Policy Action: Investment in community based culturally competent prevention system that supports early identification, assessment, and intervention for children at risk of mental health issues.

Issue: 80% of the children's mental health resources are concentrated on children of extremely high need which need the state's support. The agencies, advocates, and parents and families in the community have repeatedly stated that this reality coupled with the lack of support for secondary prevention has resulted in children at risk not receiving the attention they need when they need it. This often means those at risk can either find themselves entering deep end treatment or juvenile justice system. Adding to this troubling reality is that our state finds great disparity with children of color often not receiving mental health services until they enter the juvenile justice system.

Immediate action:

- Inclusion of a children's mental health expert on the leadership team at DCF.
- Increased value placed on the mental health function at DCF.
- Assessment of data and dollars at DCF – where is the state investing for what return including an actuarial analysis to understand costs and return on investment which can inform a redesigned
- Engage the communities most affected to discuss the issue of early identification and implications.
- Create partnership between Department of Ed and CSSD to foster a seamless prevention system that supports local communities
- Diagnose the data issues that impede the ability of the state and communities to follow children and families and provide the needed accountability and data to improve outcomes.
- Ensure that mental health parity is honored in any health reform and be actively engaged in planning so this concept of secondary prevention can be supported
- Support electronic health record that is inclusive of comprehensive prevention and care model including mental health.
- Conduct actuarial analysis to have the data to understand costs and return on investment and to inform realignment of financial incentives.

Long Term:

- Secondary prevention is supported with state dollars resulting in early identification of children at risk gaining appropriate support and intervention to optimize their mental health outcomes. This investment in early identification can be supported by eventual savings from the most costly care, deep end treatment and juvenile justice.
- Data systems will support tracking and outcome based results.
- Full integration in the health delivery system
- Bundle payments to follow child rather than the continued support of categorical funding so the needs of child from the simple to complicated are supported.

Center for Autism and Developmental Disabilities

Lynn Ricci
Senior Vice President
Hospital for Special Care

I. Statement of Issue

This proposal is in direct response to the Governor-elect's campaign policy announced in New Britain on September 30, 2010.

"As the incidence of autism continues to grow at both state and national levels, the disorder is and will continue to be one of our state's most critical and costly issues in the years ahead. This is often a condition that requires significant resources from families, school districts, social services agencies and the medical system at large. Although autism affects all ethnic social and economic demographics, clearly those families which are in the middle and lower income categories have a much more difficult time navigating the health care system."[34]

II. Proposed Action

"Create a Center for Autism and Developmental Disabilities housed within the state's private, non-profit system. The Center would serve four primary functions: diagnostic services, outpatient treatment, in-patient treatment and care coordination. The Center would also house a state wide Policy Council to continuously monitor and report on advancements in research, diagnoses and treatment. The Policy Council would consist of parents, medical doctors, researchers, advocates and experts that will both guide the Center and make policy recommendations to state."

Hospital for Special Care (HSC) is uniquely qualified to provide leadership, development and coordination of services necessary to appropriately serve the ASD population. They are well positioned to coordinate these services based on their history of providing care for chronic and complex patient populations. First, HSC began working to identify the needs and stresses of the current system over two years ago. Second, HSC has the premier complex medical pediatric inpatient service in the State, directed by a well respected developmental pediatrician. Third, HSC has extensive experience in designing and providing a unique and specialized behavioral program for individuals with acquired brain injuries. Fourth, HSC has developed a medical home approach for children with muscular dystrophy and related neuromuscular issues and operated it successfully for over two years.

Hospital for Special Care has presented a plan to this working group that captures the Governor's intent on this issue and practically brings it to fruition. It concludes that "all too often both government and the health care industry engage in the costly and time-consuming endeavor of duplicating efforts. In this instance, however, we all can avoid that. At a time when revenues and resources are scarce, and at the dawn of a new State administration that has vowed to change the way Connecticut does business, both Hospital for Special Care and Governor-elect Malloy find themselves uniquely able to work together to help solve the serious problem of caring for one of our State's most vulnerable populations – children affected with Autism Spectrum Disorder."[35]

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[34] Malloy policy proposal – 9/30/2010
[35] Hospital for Special Care white paper

A. Prioritization Schedule

1. February 2011: Governor Malloy re-allocates existing bond funds to the Hospital for the planning and construction of the Center for Autism and Developmental Disabilities.

2. March 2011: Governor Malloy presides over the inaugural meeting of the CT Autism Policy Council.

3. November 2011: Governor Malloy breaks-ground on the Center for Autism and Developmental Disabilities

4. Summer 2012: Governor Malloy officially opens the Center.

B. Fiscal Impacts

1. There will be zero fiscal impact on the current State operating budget. First, many of the envisioned inpatient services are currently being provided at out-of-state facilities and the Center as envisioned will bring these children home to be nearer to their parents and their communities while not spending additional Medicaid dollars. Second, "as a private non-profit entity, the Center would operate under a 'Fee-for-Service' model"[36] and not as part of the State operating budget.

2. The state would provide the Hospital with the capital funds to plan and build the Center. According to the Malloy policy statement: "Any initial capital outlay for the Center would be directed from previously authorized bond funds; no additional bonding is being requested and no additional pressure on the bond cap is being created."[37] Estimated cost options are as follows:

   - $14 Million to achieve the goals set-forth in the initial Malloy/Wyman proposal to provide the inpatient, outpatient diagnostic and medical home services in the newly created Bioscience Enterprise Zone in New Britain.

   - $28 Million to build the single best Center in New England which would include the above as well a state-of-the-art school and day program based on the Cleveland Clinic model.

   - $40 Million to build the above as well a series of satellite facilities around the State of Connecticut.

C. How does it tie-in to Malloy/Wyman campaign policy?

1. This proposal is the realization of a major, stand-alone policy initiative introduced publicly by the Malloy/Wyman team on September 30, 2010.

III. Long-term Needs/Vision

HSC proposes to develop three major components of the overall continuum and rehabilitation services, namely a diagnostic and evaluation service for young children, outpatient medical services built on a medical home model, and a short-term intensive inpatient service for those children who are at risk due to

[36] Malloy Policy – 9/30/2010
[37] Malloy Policy – 9/30/2010

self-injurious or aggressive behaviors. The goal of each of these programs is to enable these children to live safely in the community and minimize the need for placement in out-of-state long term residential settings.

The first component would be the provision of diagnostic, assessment and evaluation services. These begin with the initial diagnosis as young as one or two years of age. Throughout childhood, adolescence and teenage years, the team will be available for periodic assessments as needs and issues evolve.

The second component is the provision of primary care and coordination of specialty care in a medical home model. These services and the assessments completed are also utilized to assure coordination between educational, vocational, medical and family support teams.

The third component to be developed at HSC will be a pediatric behavioral inpatient unit for individuals on the ASD spectrum and/or with developmental disabilities. Currently these children are being placed out-of-State in psychiatric settings which are often not designated for the treatment of ASD.

Ultimately, a series of satellites around the State would be coordinated by the Center for Autism and Developmental Disabilities and would provide support and consultation to parents, providers and advocates.

IV. Jobs Impact & Other Benefits

- Approximately 100 construction jobs for local companies with union labor
- Long-term establishment of 75 new positions for entry level and professional staff
- State Medicaid dollars to remain in Connecticut vs. out-of-state
- Provision of coordinated early intervention and intensive services which has been shown to reduce log term costs

V. Dissenting Opinions & Other Relevant Items

HSC has already met with numerous provider, advocacy, State and parent representatives, all of which have communicated support and enthusiasm for this concept.

Hospital for Special Care

Services for Children with Autism Spectrum Disorders: Responding to Community Need

December 10, 2010

Introduction

Hospital for Special Care has always been known by its commitment to one particular concept in its Mission:

> We will anticipate and be responsive to changing needs of our communities and a changing healthcare environment by creating an innovative, fiscally sound, cost effective system of care.

In keeping with the hospital's history, we at Hospital for Special Care (HSC) have been examining the ongoing healthcare needs of a growing segment of our community, namely persons with Autism Spectrum Disorders. In Connecticut, over 5,000 children under the age of 21 have been identified as exhibiting this disorder. That is about 1 in 100 children, and 1 in 70 are boys. Unfortunately, it seems the prevalence rate is growing.

As seen in the attached Policy Statement, Autism Spectrum Disorders (ASD) have been identified by Governor-Elect Malloy as a significant issue for our State. Governor-elect Malloy recognized that if this issue is not addressed in a more comprehensive and coordinated manner, the costs of caring for these individuals will increase exponentially as they age. In addition, the Policy Statement on Autism specifically noted that sending our most compromised children out-of-state also sends both money and jobs out of the State while separating children from their families and communities.

What makes this, in part, a difficult population to serve is that ASD "remains a diagnosis that is defined completely on the basis of behavior"[1] making even basic diagnosis and intervention complex and expensive. In Connecticut, the Children's Behavioral Health Advisory Committee has observed that "there are inadequate resources."[2] The report goes on to note that even though the primary provider of services for children with autism is the school system, schools are only mandated to provide educational services.[3] HSC has observed that though there are many agencies and groups providing specific services, there is little coordination between health care and other components, such as education, vocation and family support.

Need

In establishing the most pressing needs of the community and those that could be addressed by HSC, services for ASD were studied from three vantage points, namely, (1) a formal needs analysis by a respected healthcare analyst, (2) a wide sweep of interviews with providers, advocates, parents and State officials in Connecticut, and (3) a sampling of nationally recognized programs and reports. The fields of education, housing, healthcare and family support were all included.

A full listing of over 40 people who were interviewed as part of this analysis is attached as Exhibit II. In each case, we not only asked about current services but also explored with participants the gaps they saw and challenges that lay in the way of achieving the goals of improving access, availability and timeliness of services for individuals with ASD. HSC came away from these interviews with three major findings that validate the observations presented in the Governor-elect's own policy statement:

- There is an unreasonably long waiting time for most diagnostic and evaluation services, up to six months in many cases;
- There are no inpatient services for children with ASD in Connecticut, and as State statistics indicate, an estimated 70 or more children with ASD are placed out-of-state at any given time; and
- It is very difficult to find comprehensive medical services and medical services that are coordinated with educational, social, and family services.

The market analysis prepared for HSC by Bober and Associates indicates a definite need in Connecticut for inpatient services. For a complete copy of the analysis see Exhibit III. Earlier this year, Connecticut DCF alone had placed approximately 77 youth in out-of-state facilities. The report cited another study in Pennsylvania which showed that over 10% of children with ASD would be hospitalized at least once for behavioral issues.

Response

HSC proposes to develop three major components of the overall continuum of services for ASD, namely (1) a diagnostic and evaluation service for young children, (2) an outpatient medical service built on a medical home model, and (3) a short-term intensive inpatient service for those children who are at risk due to self-injurious or aggressive behaviors. The goal of each of these programs is to enable these children to live safely in the community.

Attached to this summary, as Exhibit IV, is a conceptualization of the eight major components of the continuum of services for people with ASD. The three areas HSC proposes to address are highlighted.

The first component would be the provision of diagnostic, assessment and evaluation services. These begin with the initial diagnosis at ages as young as one or two years of age. Throughout the child's journey through childhood, adolescence and teenage years, the team would be available for periodic assessments as needs and issues evolve.

The second component is the provision of primary medical care and coordination of specialty care in a medical home model. These services and the assessments completed would also be utilized to assure coordination between educational, vocational, medical and family support teams.

The third component proposed to be developed at HSC is a pediatric behavioral inpatient unit for individuals on the Autism spectrum and/or with significant developmental disabilities. The program would be modeled on HSC's successful and unique inpatient neurobehavioral program. Currently, these children are being placed out-of-state in psychiatric settings that often do not provide programs dedicated to their specific needs.

Next Steps

Hospital for Special Care has committed staff and consultant resources to develop these three proposed program initiatives. HSC is in discussions with existing Connecticut providers and advocates assisting in both the planning and provision of these services. State advocacy groups that have been consulted include the Autism Spectrum Resource Council, Autism Speaks, and Disability Resource Network. In addition, HSC has reached out to national leaders from the Cleveland Clinic, Seven Hills Foundation in Massachusetts and others in its effort to build on the most successful approaches to treatment of ASD.

We see Governor-elect Malloy's passion for properly caring for these children and their families as an opportunity to merge our ongoing efforts with his vision. HSC is asking the State to consider providing the capital financing necessary for the design and construction of a world class inpatient facility with space for the outpatient, research and educational components of a Center for Autism Care. HSC envisions funding, through operations and fundraising, the appropriate staff and related costs of launching and operating this Center.

We believe with the support of the State, we can create an exemplary program, which will provide three essential components on the continuum of services for people with ASD and their families in a manner which we believe will reduce costs over the long run and create jobs today. Together with the State, we can fulfill Governor-elect Malloy's promise and commitment to these young citizens.

HSC is uniquely suited to achieve these objectives. First, HSC began working to identify the needs and stresses of the current system related to treatment of ASD over two years ago. Second, HSC has the premier complex medical pediatric inpatient service in the State, directed by a well respected developmental pediatrician. Third, HSC is experienced in designing and providing a unique and specialized behavioral program for individuals with acquired brain injuries. Fourth, HSC has developed a medical home approach for children with muscular dystrophy and related neuromuscular issues and has operated it successfully for over two years. This medical home model of coordinating care can be replicated for children with ASD.

All too often, both government and the health care industry engage in the costly and time-consuming endeavor of duplicating efforts. In this instance, however, we all can avoid that. At a time when revenues and resources are scarce, and at the dawn of a new State administration that has vowed to change the way Connecticut does business, both Hospital for Special Care and Governor-elect Malloy find themselves uniquely able to work together to help solve the serious problem of caring for one of our State's most vulnerable segments – children affected with Autism Spectrum Disorder.

Attachments:

Exhibit I – Healthcare Policy Statement from Governor-Elect Dannel Malloy; *Center for Autism and Developmental Disabilities.*

Exhibit II – List of Interviewees

Exhibit III – Need Analysis prepared by Bober and Associates

Exhibit IV – Continuum of Care for ASD

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[1] Social Policy Report from the Society for Research in Child Development, titled "Autism Spectrum Disorders: Diagnosis, Prevalence and Services for Children and Families" (Volume 24, Number 2, 2010)
[2] Children's Behavioral Health Advisory Committee Recommendations for the State Advisory Council on Children and Families (November 5, 2010), p. 3
[3] Children's Behavioral Health Advisory Committee Recommendations for the State Advisory Council on Children and Families (November 5, 2010), p. 3

The Life-time Effects of Trauma and Violence on Children

Cynthia Rojas
Director of Strategic Advancement
Clifford W. Beers Guidance Clinic

Statement of the Issue: In order for adults to live truly health lives, a synergy between mental and physical health must exist. The current model dividing physical and mental health has failed to see the link between the two and how one affects the other. However, simply adding mental health to healthcare reform is not the answer. Primary care physicians must and should be screening for mental health issues or issues that make an individual at risk of mental health issues. These ideas are based on the research by Drs. Robert Anda and Vincent Felitti conducted in collaboration with Kaiser Permanente in San Diego and the CDC. It's the largest study of its kind (18,000 adults) and its findings clearly show a relationship between adverse childhood experiences (traumatic experiences) and organic disease (later in adult life). Understanding the link between trauma and disease means that if we are to save health care costs in the long term we will have to address mental health issues within primary care settings. Today, many children in our urban areas and suburban as well are exposed to multiple complex traumatic stressors (adverse childhood experiences) such as traumatic loss, domestic violence, sexual abuse and community violence. Research has shown that a childhood filled with exposure to more than three traumatic life experiences can have lifelong physical and behavioral health consequences. The effects of untreated traumatic exposure can result in cancer, heart disease, diabetes, obesity, lifelong mental health difficulties, incarceration, violence and early death. Traumatic stress can cause disruptions in children's ability to finish school and hold a job. It can interfere with peer relationships and cause a lifetime of health and social impairment. Connecticut needs to be a state that takes the effects of trauma and violence seriously and takes steps to ensure we have a trauma-informed safety net of effective and accessible mental health care within its healthcare reform movement.

1. Immediate Action Areas

   Integrate Trauma-Informed Care In the Healthcare Reform Process: (Costs integrated into the costs of Health Care Reform)

   - Integrate mental health and physical health work groups focusing on healthcare reform to ensure that both are considered.
   - Create opportunities to incorporate trauma-informed care within primary care setting, for example mandate that primary care physicians assess for trauma during physicals or regular office visits (including pediatric care).
   - Incorporate data collection (of mental health assessments) in any Health care reform initiatives in the State.
   - Create a data collection mandate to assess for trauma exposure in the Medicaid Electronic Health Record Meaningful Use initiative.
   - Data collection systems should be able to highlight at risk individuals for adult disease and incorporate this information into a client's patient-centered medical home
   - Create a mandate for youth and families with chronic traumatic stress to receive priority for the Health Care Homes Initiative on Health Care reform.

   Integrate Trauma-Informed Care into all Health and Human Services (see costs listed below)

   - Support Learning Collaboratives throughout the state in evidence based treatments for treating trauma and violence for children and families in both primary care and mental health settings. ($600,000 per year, per collaborative)
   - Increase Medicaid rates for providers offering trauma assessment and evidenced based trauma informed care in primary and mental health settings (Increased Medicaid Rates/State share)

- Create a maternal health screening for mothers at high risk for trauma and create programs that incorporate trauma and violence prevention in home visiting programs ($1,000,000 per year estimate)
- Educate the child welfare, juvenile justice, police, emergency care providers and firefighters and court support staff on the effects of trauma and violence exposure and make available information on trauma informed resources available in the community (Integrate specialty training into current training dollars)

Train service providers in trauma-informed care: (Use current training dollars to by trauma-informed training)

- Train healthcare providers on trauma informed care and how to conduct assessments.
- Educate the child welfare, juvenile justice, police, emergency care providers and firefighters and court support staff on the effects of trauma and violence exposure and make available information on trauma informed resources available in the community (Integrate specialty training into current training dollars)
- Create specialized trauma focused coursework for educators and mental health practitioners in trauma-informed care in all institutions of higher learning throughout the State.
- All teachers and principals are trained on the effects of trauma and violence in children and how exposure effects behavior and health (including obesity)
- Support school based mental health initiatives
- Incorporate stress management techniques in life skills curriculum

Fiscal Impact: Obviously any healthcare model that focuses on holistic care and includes mental as well as physical health will save costs in the long term. We would expect to see a reduction in chronic disease among very vulnerable populations. The focus would be on preventative measures as opposed to managing chronic disease. This proposal would need an initial investment upfront in order to save costs later.

Tie into the Malloy Wyman Campaign: A Trauma-informed approach to health and wellness will create a healthier Connecticut and a more cost effective system of care. It will change our fiscal focus from paying exorbitant costs of chronic disease to prevention, early detection and treatment, thus saving lives as well as resources while making mental health care the priority it should be, but still isn't. (Dan Malloy, Policy Book, 2010) Children can lead happy, successful adult lives, free from the long term mental and physical effects of trauma.

Those On Board with Concept: DCF, DHMAS, DPH, Senator Toni Harp, Rep. Toni Walker, Yale, UCONN, CHDI, Child Guidance
Clinics, No More Crumbs Coalition, Managed Medicaid Council, Private Providers.

Dissenting Voices: People who believe that it is not the government's domain to take care of people's personal issues– people should take care of themselves, government should stay out of their lives.

3. Long-term Needs/Vision: Connecticut is a Trauma-Informed State that includes public and private service providers, educators, and primary and mental health care professionals.

√ Implement Effective Trauma-Informed Interventions across the State: Strategies that promote prevention, early intervention, treatment

√ Strong Partnerships: Across service systems, partnerships and networks that facilitate knowledge exchange

√ Access to Tools and Training: Create a learning community that shares data, assessment and trainings across the state

√ Implement Trauma-Informed Policies that promotes these efforts

Challenges for Long Term Change: We run risks when we promote public policy based on simple linear associations, for example, chronic adverse childhood experiences equals a lifetime of health consequences. Rather, the perspective should be that there is a dynamic complexity to our lives and that trauma interventions work. Our focus on health through life course is not about our limits, but rather about opportunities.

Mental Health Needs of Older Adults

Kate McEvoy, Esq.
Deputy Director
Agency on Aging of South Central CT

Statement of the Issue:

Connecticut should examine the high self-report of mental health needs among older adults and people with disabilities, identify the degree to which needs are currently unmet, and establish strategies for overcoming barriers to service. The Connecticut Long-Term Care Needs Assessment provides startling data on mental needs of older adults and people with disabilities. Generally, there was a high report of mental health needs among respondents, with almost one-third, or 27%, reporting that they often felt down, depressed or hopeless and 23% reporting little interest or pleasure in doing things. Almost half (48%) of the low-income group reported that they had experienced feelings of depression or hopelessness over the month prior to completing the survey. This compared to 17% of those in top three income categories. This key indicator of mental health status ranged across ethnicity, with 43% of Latinos reporting feeling down, depressed or hopeless in last month as compared with 33% of Blacks and 25% of Whites. Further, 31% of respondents used some kind of mental or behavioral health service three or more times in past year and 21% used those services six or more times in that period.

Long-Term Care and Chronic Disease

Streamline and Improve Access to Medicaid Home and Community-Based Long-Term Care Services

Kate McEvoy, Esq.
Deputy Director
Agency on Aging of South Central CT

Statement of the Issue:

Connecticut should streamline and improve access to Medicaid home and community-based long-term care services (HCBS) by directing the Department of Social Services (DSS) to seek, pursuant to Section 1915(i) of the Social Security Act, authorization from the Centers for Medicare and Medicaid of an amendment of the Connecticut Medicaid state plan.

Such amendment shall be designed to achieve the objective of improving access to home and community-based services (HCBS) by:

- **overcoming "silos"** by utilizing non-financial eligibility criteria that relate to functional limitations as opposed to age, diagnosis, condition or disability;
- **expanding coverage** for otherwise eligible individuals who are currently waitlisted for service; and
- **enhancing federal match** for individuals whose services are currently funded exclusively out of state funds.

Home and community-based long-term care services are cost effective and reflect consumer preferences concerning care setting.

- **Cost effectiveness:** A key example of the cost savings that have been achieved is DSS's analysis of expenditures under just one of Connecticut's Medicaid "waiver" programs, the Connecticut Home Care Program for Elders (CHCPE). In its report on the SFY'08 program year (latest published data), DSS presents a net CHCPE savings figure of $101,931,462, which represents the difference between total costs for services plus administrative costs plus Old Age Assistance benefits as compared with the costs that would have been incurred had participants entered nursing facilities.[38]
- **Consumer preference:** Consistent with the results of national surveys, almost 80% of Connecticut respondents to the Connecticut Long-Term Care Needs Assessment indicated that they would prefer to remain at home as they age, with or without home modifications.[39]

Connecticut's current means of providing Medicaid-funded HCBS is fractured and presents many barriers to consumers. As a result of capacity constraints, many otherwise eligible individuals have been waitlisted and endure long wait times for service. Consumers and professionals alike are challenged by the "silo" effect of Medicaid "waivers", each of which are associated with distinct age, diagnostic or disability-specific eligibility criteria. Further, Connecticut is supporting many

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[38] Connecticut Home Care Program for Elders Annual Report to the Legislature SFY'08, p. 9, *available at: http://www.ct.gov/dss/lib/dss/pdfs/annual_report/chcpereport2008.pdf*

[39] Connecticut Long-Term Care Needs Assessment, University of Connecticut School of Medicine Center on Aging, 2007, *available at: http://www.cga.ct.gov/coa/incl_longtermcare.htm*

individuals exclusively through state funding, the cost of whose services could be eligible for Federal Medical Assistance Payment (FMAP).

Immediate Action Areas:

A. Prioritization schedule and timeline

Pursuing a 1915(i) Medicaid state plan amendment should be prioritized because of the opportunity to expand coverage to individuals who are currently waitlisted for HCBS and to garner federal match for individuals who are currently served exclusively through state funding.

The state plan amendment process has historically originated within DSS with the Director of Medicaid, and involves dialogue with and feedback from CMS and ideally also community stakeholders. A group of advocates was convened in late Spring, 2010 to study this option and is in process of producing draft enabling legislation with specific language addressing eligibility requirements.

B. Fiscal impacts

Consistent with efforts to optimize use of federal revenue, the 1915(i) option affords Connecticut an opportunity to garner FMAP for populations that are currently served exclusively through state funding. A non-exclusive list of examples of these include:

- participants of the state-funded tiers (Levels 1 & 2) of the CHCPE who are financially eligible for Medicaid but cannot currently meet the functional requirements for participation in a "waiver"; and
- individuals served by the Department of Mental Health & Addiction Services (DMHAS) through state grants.

The 1915(i) option does fundamentally alter the means by which the state would cover individuals, shifting from the current system in which each Medicaid "waiver" is associated with a participation cap to a system in which the state would be required to serve all individuals who met financial and functional eligibility criteria. Any expansion of costs associated with serving additional individuals is, however, anticipated to be:

- at least partially offset by receipt of FMAP for the above populations; and
- limited by the terms of participating in Medicaid that have always influenced consumer eligibility and willingness to accept benefits, among them:
    - low asset eligibility limits (generally, no more than $1,600 in liquid assets over and above "exempt" assets such as the recipient's house);
    - the requirement that participants with incomes in excess of 200% of the Federal Poverty Level (FPL) contribute toward the costs of their care ("applied income"); and
    - the right of the state to recoup benefits paid upon the death of the recipient ("estate recovery").

C. Job impacts

Use of a 1915(i) state plan amendment would expand opportunities to serve individuals in the community, necessitating a larger pool of available direct care workers. Further, the state plan amendment permits use of a "self-directed" care model that would allow participants to hire their

own "personal care attendants" (PCA's) to support their needs on a flexible and individually-tailored basis. This option is consistent with federal policy preference and also presents opportunities to expand the community-based long-term care workforce.

D. Tie-in to Malloy/Wyman campaign policy

Use of the 1915(i) option is consistent with Governor-elect Malloy's policy statement "Supporting Connecticut Seniors". Specifically, page 2 of that statement provides:

> *I will work to support home care and other services that give seniors choices in where and how they will receive care. And, I will advocate for expanding access to those programs by reviewing and reforming eligibility requirements so that they more fairly reflect cost of living and other factors impacting our senior population.*

Please note: page 2 of the "Supporting Connecticut Seniors" statement unfortunately provides some potentially misleading information about the CHCPE. The CHCPE contains two related components: 1) a Medicaid "waiver", eligibility for which is determined using <u>both</u> income and asset eligibility requirements; and 2) a state-funded component, eligibility for which is determined using <u>only</u> an asset requirement. The statement seems to suggest that it is problematic to determine eligibility for the state-funded component solely on the basis of assets, but in fact it was a welcome development that via Public Act 00-2, June Special Session, the Connecticut Legislature liberalized access to the program by removing the income limits, affording access to program benefits to additional individuals who historically could not qualify because their incomes exceeded the prior limit.

E. Benchmark states

According to Diane Justice of the National Academy for State Health Policy, five states adopted a 1915(i) state plan amendment prior to adoption of ACA. These states include: Iowa, Nevada, Washington, Wisconsin and Colorado.

F. Knowledgeable parties/supporters

Commission on Aging; Connecticut Long-Term Care Advisory Council (statutorily established group representing all major stakeholder associations in service and advocacy with and for older adults and individuals with disabilities); DSS Money Follows the Person and Alternate Care Unit staff.

G. Dissenting opinions

Reasonable concerns have been expressed concerning expenditures under a 1915(i) state plan amendment given that it shifts from the current system in which each Medicaid "waiver" is associated with a participation cap to a system in which the state would be required to serve all individuals who met financial and functional eligibility criteria. As stated above, however, any expansion of costs associated with serving additional individuals is, however, anticipated to be:

- at least partially offset by receipt of FMAP for the above populations; and
- limited by the terms of participating in Medicaid that have always influenced consumer eligibility and willingness to accept benefits, among them:
  - low asset eligibility limits (generally, no more than $1,600 in liquid assets over and above "exempt" assets such as the recipient's house);
  - the requirement that participants with incomes in excess of 200% of the Federal Poverty Level (FPL) contribute toward the costs of their care ("applied income"); and
  - the right of the state to recoup benefits paid upon the death of the recipient ("estate recovery").

Equipping Consumers to Make Informed Long-Term Care Choices

Kate McEvoy, Esq.
Deputy Director
Agency on Aging of South Central CT

Statement of the Issue:

Connecticut should implement a public education campaign to equip consumers to make informed long-term care choices. Elements of this campaign should include:

- expansion of the current Aging & Disability Resource Center (ADRC) pilots to a statewide Single Point of Entry (SPE) system for providing information;
- promotion of the new Community Living Assistance Services and Supports (CLASS) program that will be established by the Affordable Care Act (ACA); and
- continued promotion of Connecticut Partnership long-term care insurance options.

Education of consumers regarding financial planning, the limited scope of public benefits, and available home and community-based options will be a key component of Connecticut's efforts to rationalize and rebalance its long-term care spending. Consumers do not plan ahead for their long-term care needs, have an over-reliance on the extent to which public sources, notably Medicare, will cover services, and are not familiar with the costs of long-term care.

A successful ongoing education campaign could instrumentally influence the degree to which consumers make rational, planful use of their own resources and avoid or delay need for public assistance through the Medicaid program.

The Connecticut Long-Term Care Needs Assessment indicates:

> *People have limited resources set aside for long-term care and have done little in the way of long-term care planning. Some people continue to erroneously believe long-term care costs will be paid by Medicare or private health insurance.*
>
> *Finances and lack of knowledge about services are the primary barriers to receiving services.*[40]

Further, the Connecticut Long-Term Care Plan states:

[40] Connecticut Long-Term Care Needs Assessment, University of Connecticut School of Medicine Center on Aging, 2007, *available at: http://www.cga.ct.gov/coa/incl_longtermcare.htm*

Individuals often do not seek information about long-term care until they are in a crisis situation and need immediate help. At that point it is difficult to navigate the complex systems to get needed information so that supports can be secured quickly.

Minority families are even less likely to have information about available supports due to cultural assumptions that such supports should be provided by families. Often this lack of information leads individuals to assume that institutional placements are their only option.[41]

Immediate Action Areas:

H. Prioritization schedule and timeline

This initiative could be implemented immediately through existing departmental/program structure.

I. Fiscal impacts

A public education campaign could without significant preparatory steps utilize existing staff of the Office of Policy & Management (OPM) Partnership for Long-Term Care, Department of Social Services (DSS) Aging Services Division and Alternate Care Unit, CHOICES and ADRC staff of the Agencies on Aging, and community partners including municipal agents and senior centers. There is a natural fit between this agenda and use of the existing Connecticut long-term care web site: http://www.ct.gov/longtermcare/site/default.asp

Expansion of the current Aging & Disability Resource Center (ADRC) pilots to a statewide Single Point of Entry (SPE) system for providing information merits investment of state funds because it will serve cost-saving functions of:

- educating consumers and caregivers to use their resources more rationally and to prevent the need to tap public sources; and
- accessing all available federally-funded benefits including the Medicare D Low-Income Subsidy and the Medicare Savings Programs (QMB, SLMB, QI)

The three existing ADRC pilots in Connecticut are currently funded exclusively through federal demonstration grant funds, and the Connecticut CHOICES program exclusively through other federal sources. CHOICES has had a significant role in saving money for the State of Connecticut. A key example is CHOICES benefits counseling work. In SFY'10, CHOICES made 21,236 contacts with consumers that related to the Medicare Cost Sharing Programs. CHOICES directly assisted 4,219 consumers with MSP applications, and another 150 consumers with LIS applications. Beyond these immediately attributable statistics, CHOICES staff and volunteers were also instrumental in helping many more of the 28,417 additional Connecticut residents who were added to MSP participation over the course of the year.

Estimated cost savings achieved by CHOICES are as follows:

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[41] Connecticut Long-Term Care Plan: A Report to the General Assembly, January 2010, *available at: http://www.cga.ct.gov/coa/PDFs/Reports/LTC%20Plan%20-%202010%20PDF.pdf*

Medicare D cost that would otherwise be paid by the state of Connecticut	Annual Cost per Individual		# of individuals affected (MSP plus LIS applications)	Cost Savings
Benchmark premium	$414.84	x	4,369	$1,812,436
Deductible	$310.00	x	4,369	$1,354,390
Drug coverage during "gap"	$839.19[42]	x	4,369	$3,666,421
			TOTAL	$6,833,247

J. Job impacts

Educating consumers and caregivers to make rational and planful long-term care decisions has a direct relationship to supporting families in retaining employment. It has been well documented that urgent, unanticipated scenarios in which an older adult or individual with a disability requires additional support interfere with caregivers' employment, in many cases even to the point of causing them to leave work entirely. Supporting both populations in making informed choices can help to support a stable, consistent and mentally focused workforce.

K. Tie-in to Malloy/Wyman campaign policy

Use of a public long-term care education campaign is consistent with Governor-elect Malloy's policy statement "Supporting Connecticut Seniors". Specifically, page 2 of that statement provides:

I will work to support home care and other services that give seniors choices in where and how they will receive care.

L. Benchmark states

The Administration on Aging and the Lewin Group have partnered to pilot ADRC work across the country and represent good information sources on states that are ahead of Connecticut in ADRC development and public long-term care education plans. Another good source is the federal Health and Human Services Administration National Clearinghouse for Long-Term Care Information web site section on state campaign materials, available at:

http://www.longtermcare.gov/LTC/Main_Site/Planning_LTC/Campaign/State/index.aspx

M. Knowledgeable parties/supporters

Commission on Aging; staff of DSS Aging Services Division; Agencies on Aging; Centers for Independent Living

N. Dissenting opinions

[42] Based on State of Connecticut Department of Social Services ConnPACE Semi-Annual Report data, assuming each ConnPACE participant received 1.12 prescriptions per month at an average cost per claim of $62.44.

The one potential pushback of which I am aware is a feeling in certain quarters that the responsibility for promoting the federal CLASS program does not primarily rest with states. In that participation in CLASS is intended to provide a per diem cash benefit to those who develop a disability or condition that limits their functional ability, it is, however, in the state's interest to promote the program as an alternative to people being forced instead to utilize Medicaid benefits.

Reform Connecticut's Long-Term Care System Now!

Long Term Care Advisory Council

We urge the Governor and the Legislature to reform the Long-Term Care (LTC) System so that it:

~ honors individual choice,
~ upholds the US Supreme Court Olmstead Decision,
~ maximizes available federal revenue, and
~ achieves significant cost savings.

The Long-Term Care Advisory Council respectfully urges the Executive and Legislative Branches to take the following actions this session:

1) **Establish a Sound Home and Community-Based (HCBS) Infrastructure**
   - Seek authorization for a 1915 (i) Medicaid State Plan Amendment
   - Maintain state funding for the CT Home Care Program for Elders & CT Home Care Program for Persons with Disabilities
   - Develop a robust long-term care workforce
   - Re-structure oversight of long-term care within the Department of Social Services

2) **Maximize Federal Funding Opportunities Provided by the Affordable Care Act (federal health care reform)**
   - Pursue the Community First Choice Option for self-directed services
   - Pursue the State Balancing Incentive Payments Program
   - Broaden Money Follows the Person Eligibility

3) **Establish a Plan to Modernize and Diversify Services Provided by Nursing Homes**

4) **Capture and Reinvest Cost Savings Across the Long-Term Care Continuum**
   - Implement the Long-Term Care Reinvestment Account
   - Implement global budgeting in use of Medicaid funds

5) **Encourage People to Plan for Their Own Long-Term Care Needs and Educate Them about Options**
   - Partner with the federal government to strengthen and promote the CLASS Act (Community Living Assistance Services and Supports)
   - Establish a statewide Single Point of Entry

In making these recommendations, the Connecticut Long-Term Care Advisory Council affirms the following Guiding Principles:

- Connecticut should achieve parity among age groups, across disabilities, and between programs by allocating funds equitably among people who require long-term care services and supports based on their functional need as opposed to their age, diagnosis or disability.
- Connecticut should break down silos that exist within and among state agencies and programs to improve access and coordination and to avoid redundant expense.

Established in the Long-Term Care Needs Assessment (mandated by PA 06-188) and reiterated in the LTC Plan 2010 (mandated by CGS 17b-337).

The Long-term Care Advisory Council and other organizations respectfully urge the Executive and Legislative Branches to take the following reform-related action:

1) Establish a sound home and community-based (HCBS) infrastructure by:

a) Directing the Department of Social Services to seek authorization from the Centers for Medicare and Medicaid Services (CMS) for a 1915(i) Medicaid State Plan amendment.

The Affordable Care Act provides new options for offering home and community-based services through a Medicaid state plan amendment. This new option will:

- *address the historical fragmentation of the Medicaid "waivers," which are associated with specific age and diagnostic eligibility criteria;*
- *preserve the state's ability to serve individuals with incomes up to 300% of the maximum SSI payment and to maintain an expansive service array;*
- *allow for presumptive eligibility; and*
- *possibly benefit the state financially as DSS will be able to move additional participants from exclusively state funded supports to Medicaid, which will qualify these services for a 50% federal match.*

b) Continuing to appropriate funding for the state-funded CHCPE & CHCPD, integrating the two programs by removing age and diagnostic criteria, and repealing the CHCPE cost-share.

CT has through general funds historically supported two programs that provide care management and home and community-based services to those with slightly higher income and assets levels than are permitted under a Waiver or State Plan Amendment (including the proposed 1915(i)): The state-funded CT Home Care Program for Elders serves approximately 4,300 people 65 years of age; and the state pilot CT Home Care Program for Disabled Adults serves up to 50 people under age 65 who have neurodegenerative conditions.

Unfortunately, program capacity constraints and cost-sharing have limited participation in these programs. The CHCPD pilot is limited to serving no more than 50 people and currently has a waitlist of 56 people. Separately, in 2009, the Legislature imposed new cost sharing requirements on the state-funded clients of the CHCPE. Though cost sharing was in the 2010 session reduced from 15% to 6% this requirement has forced several hundred people off the

program and put many of them at risk of much more costly Medicaid-funded nursing home placement.

c) **Directing the Departments of Social Services and Labor, in partnership with stakeholders, to establish clear state priorities and goals for long-term care services and supports workforce needs, and to assist those who are receiving LTC services but also wish to work in gaining in meaningful employment.**
In order to prepare and respond to the dramatically shifting demographics and to honor consumer preference Connecticut must build and support a robust long term services and supports workforce that is sustainable, respected and skilled. This workforce will support the dignity, choice and autonomy of individuals with disabilities and older adults. It is expected that over the next 4 years CT will need approximately 9,000 NEW direct care workers, primarily home health aides and Personal Care Attendants (PCA's). At the same time, many folks with disabilities in the community desire and would benefit from employment and the state will benefit from the taxes their income generates.

d) **Directing the Department of Social Services to re-structure its oversight of long-term care services consistent with best practices that streamline access, eliminate redundant work and ensure effective utilization.**
The state should design and implement *a state departmental structure for long-term care, with the Department of Social Services (Connecticut's Medicaid agency) as the hub, that:*
- *integrates and coordinates the delivery of DSS LTC services and supports;*
- *provides easy access for residents;*
- *maximizes federal funding;*
- *achieves greater efficiency within state government; and*
- *is consistent with national research on Best Practices.*

Further, the structure shall coordinate the administration, policy and funding of all long-term care services across state agencies.

2) Maximize Federal Funding Opportunities Provided by the Affordable Care Act (federal health care reform) by:

a) **Directing the Department of Social Services to seek authorization from the Centers for Medicare and Medicaid Services for the Community 1st Choice Option.**
The Affordable Care Act established the Community First Choice Option in Medicaid to provide personal care attendant services to individuals with disabilities who would absent that support require an institutional level of care. As an incentive, this option provides states with an enhanced federal match rate of an additional six percentage points for reimbursable expenses. This option sunsets after five years. (Effective October 1, 2011)

b) **Directing the Department of Social Services to seek authorization from the Centers for Medicare and Medicaid Services for enhanced federal match under the State Re-Balancing Payment Program.**
The Affordable Care Act created the State Balancing Incentive Program to provide enhanced federal match payments to eligible states to increase the proportion of their spending on home and community-based services and supports. (Effective October 1, 2011 through September 30, 2015)

c) **Directing Department of Social Services to reduce the requirement for eligibility for Money Follows the Person (MFP) from 6 months in an institution to 90 days.**
The Affordable Care Act extends MFP Rebalancing Demonstration Program to 2016 and also allows states to opt to reduce the minimum time eligible individuals must have resided in an institution from 6 months to 90 days, giving additional individuals the opportunity to participate.

3) Establish a Plan to Modernize and Diversify the Services Provided by Nursing Homes by:

Directing the Departments of Social Services and Public Health to help foster innovative solutions, provide incentives and technical support to providers of institutional level care to develop and implement short and long-term plans for modernization and diversification.
Connecticut has a goal of balancing the long-term care system so that it offers individuals the services and supports of their choice in the least restrictive, preferred setting. To succeed in providing consumers with choice, Connecticut must make available a full continuum of quality service option. In support of this goal the state should encourage providers of institutional level care to modernize and diversify their services.

4) Capture and Reinvest the Cost Savings Across the Long-Term Care Continuum by:

a) **Implementing the Long-Term Care Reinvestment Account.**
Connecticut Public Act 08-180 and 09-5 established the Long Term Care Reinvestment Account. This Act directs that any funds resulting from the enhanced federal medical assistance percentage (FMAP) received by the state under the Money Follows the Person demonstration project must be deposited in the account. The savings contained in the account will be reinvested into a broad range of services and supports across the continuum of care. Unfortunately, this account has not yet been implemented due to legislative deferrals.

b) **Directing the Department of Social Services to immediately implement global budgeting.**
Research has demonstrated that long-term care dollars have been far more efficiently spent in states that have utilized flexible budgeting authority. Flexible budgeting permits states to easily transfer Medicaid dollars between institutional care and an array of home and community-based services, based on the projected needs and preferences of the population and in response to budget drivers such as inflation. Safeguards should be put in place to ensure that individuals with significant care needs are afforded equitable access to services and supports in the community regardless of the extent of their functional impairment. DSS has acknowledged that it already has the authority to implement global budgeting but has not chosen to do so.

5) Encourage Folks to Plan for Their Own LTC Needs and Educate Them about Options by:

a) **Directing the Office of Policy and Management to comment on draft federal regulations and then lead a public education campaign in support of CLASS.**

The Affordable Care Act established a new, national, voluntary cash benefit program for long-term care services called Community Living Assistance Services and Supports (CLASS). Presently, many people cannot afford private long-term care insurance. Even those who are able to bear the cost may by reason of having health conditions still be foreclosed from coverage due to stringent medical underwriting standards. The major "Insurance" plan by default for long-term care services is Medicaid, which serves the impoverished and has limited options for personal choice. Following a five-year vesting period, CLASS will provide working individuals with functional limitations a cash benefit of approximately $50 per day to purchase services and supports. The program will be financed through voluntary payroll deductions for all working adults, unless they choose to opt-out.

b) **Directing DSS to create a Statewide Single Point of Entry (ADRC)*.***
The long-term care system is highly complex, difficult to navigate and access and institutionally-biased. A *Single Point of Entry (ADRC) creates efficiencies and helps older adults and persons with disabilities by providing one place through which to receive information and referral, to evaluate long-term care options and to be screened for and receive support in accessing/applying for benefits, services and supports.* There are presently three ADRC pilots in Connecticut.

Home Health Aide Workforce

Joanne Walsh
President and CEO
Constellation Health Services

Statement of Issue:

Home Health Care is widely accepted as a cost-effective alternative to institutional care, specifically nursing home care and extended hospital care. People prefer to remain at home in familiar surroundings, and oftentimes with limited outside support, quality of life is enhanced for the "patient" as well as their family caregivers, whether nearby or far away. As it is in nursing homes with CNAs (certified nurse aides), the overwhelming majority of the hands-on care provided to home health care patients is delivered by certified home health aides. **The fact that in CT certified home health aides are undercompensated is an issue that is largely unreported but must be addressed in any health care overhaul that looks to home health care as part of a cost-effective and patient-centered health care delivery plan.** The home health industry has reported that 2010 Medicaid payments are 30% below costs, despite the fact that from 2006-08 the CT Home Care Program for Elders reported annual savings of $100 million due to home health service provision.

Home health aides work primarily on a per diem basis earning an average hourly rate of $12.95 with only state and federally legislated benefits. In contrast, certified nurse aides that provide similar support to the nursing home industry, receive health insurance, sick time, vacation and holiday pay as well as retirement benefits.

I. **Immediate Action Areas:**

- Home health agencies must receive funding from the Medicaid Program that allows them to fairly compensate, manage, supervise and train home health aides. Innovative programs like Money Follows the Person cannot deliver the promised results unless there is an adequate work force of qualified, motivated home health aides available.
- The uninformed public needs to be educated about the pitfalls of relying on unlicensed, non-medical home care providers, registries and other unregulated "outfits" for lower cost, higher risk services in the unsupervised home environment: comprehensive background checks must be required for any worker working privately providing care in a home environment.

II. **Long-term Needs/Vision:**

Connecticut will be the premier provider of innovative, compassionate, cost-effective home health care for every resident for whom home health care is a safe and viable option.

Alzheimer's Issue Paper

Alzheimer's Association

I. **Statement of Issue**:

With the aging baby boom generation, the number of Americans age 65 and over with Alzheimer's is expected to explode. Today, 5.3 million Americans aged 65 and over are living with the disease. By mid-century this number is expected to reach 13.5 million and could be as high as 16 million. In Connecticut, there are over 70,000 people aged 65 and older with Alzheimer's and other dementias. Alzheimer's is a crisis, and places an enormous burden on individuals and families. However, there is an economic toll as well, necessitating immediate action: Individuals with Alzheimer's are high users of health care, long-term care, and hospice services.

- Average annual Medicare payments for individuals with Alzheimer's disease and other dementias are three times higher than for those without the conditions.
- Medicaid payments for those with Alzheimer's and other dementias are, on average, nine times higher.

II. Immediate Action Areas

A. Timeline: (between 6 months and 2 years)

Establish a Task Force to develop a State Alzheimer's Plan by Executive Order; Appoint Task Force members from a diverse group of interests; Members will identify policy objectives and formulate recommendations.

B. Fiscal Impacts:

According to the *2010 Alzheimer's disease Facts and Figures* report, nearly one-third of Medicare beneficiaries aged 65 and over with Alzheimer's disease or other dementia are also Medicaid beneficiaries. Furthermore, half of all nursing home residents in the United States have a diagnosis of Alzheimer's disease or other dementia in their medical records, and about half of those rely on Medicaid to help pay for their nursing home care. As a result, Medicaid nursing home costs for people with Alzheimer's disease are substantial.

The task force itself will be entirely volunteers. However, the final report will include policy recommendations to respond to the growth in Alzheimer's disease offering potential savings for Connecticut.

C. Job Impacts:

American businesses incur high costs due to lost productivity, missed work and replacement expenses for employees who are caring for a person with Alzheimer's or other dementia and have to reduce their hours, take time off or completely quit working because of the demands of caregiving. One study estimated the cost to U.S.

businesses for employees who are caregivers of people with Alzheimer's and other dementias was $36.5 billion. [43]

In addition, the Institute of Medicine predicts that there is a severe shortage of healthcare personnel who are trained to care for older adults, including those with dementia, in the healthcare and long-term care systems. There is a critical need for training the health and long-term care workforce in dementia care and geriatric medicine and opportunity exists to address this need through targeted training and certification requirements for relevant professional groups.

Finally, the Connecticut Long Term Care Needs Assessment predicts there will be a demand for over 9,000 jobs in the health care industry over the next five years to serve the growing aging population. Given that the long-term care industry employs more than nearly any other industry, and direct-care jobs are the employment core of this industry and are among the nation's fastest-growing occupations, there is opportunity for job creation. In addition, the biomedical and stem cell fields provide promising research and job growth.

D. Tie-in to Malloy/Wyman campaign policy:

As the incidence of Alzheimer's continues to grow, the disease is and will continue to be one our state's most costly issues. A shift in focus to detection, cure or delay can disrupt the projected growth of the disease which is unsustainable. Bringing together stakeholders and early intervention is crucial to confronting the challenges of Alzheimer's.

Alzheimer's patients cannot protect themselves and the person close to them cannot lobby because they're home taking care of them. Long-term care safety-net programs for these individuals are essential.

E. Benchmark states:

Since 2006, at least 25 states have taken concrete action towards developing an Alzheimer's state plan. In fact, Congress just unanimously passed, and President Obama is expected to sign the National Alzheimer's Project Act. The bill establishes a council within the Department of Health and Human Services to coordinate and evaluate all federal efforts on research, care and treatment of Alzheimer's.

F. Supportive Organizations:

The Alzheimer's community consists of many knowledgeable people and organizations that support Alzheimer's disease from people with Alzheimer's (particularly younger-onset) family and professional caregivers, health professionals, residential and

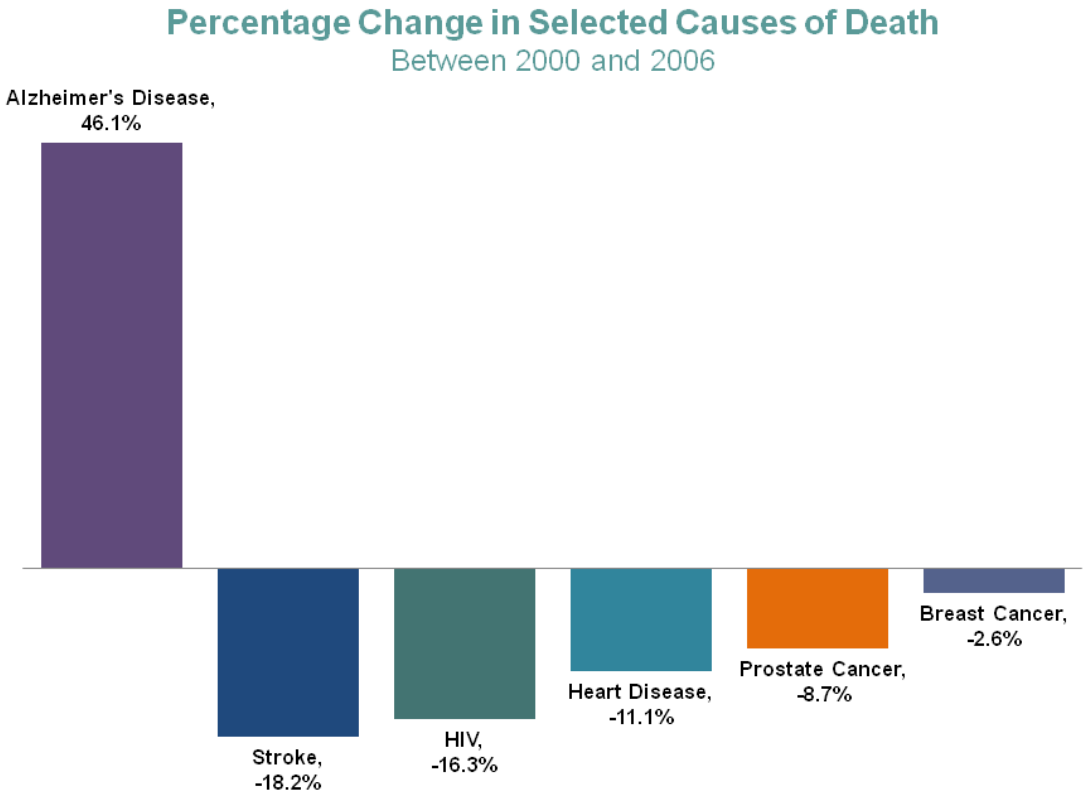
[43] Koppel, R. Alzheimer's disease: The Costs to U.S. Businesses in 2002 (Washington, D.C.: Alzheimer's Association, June 2002).

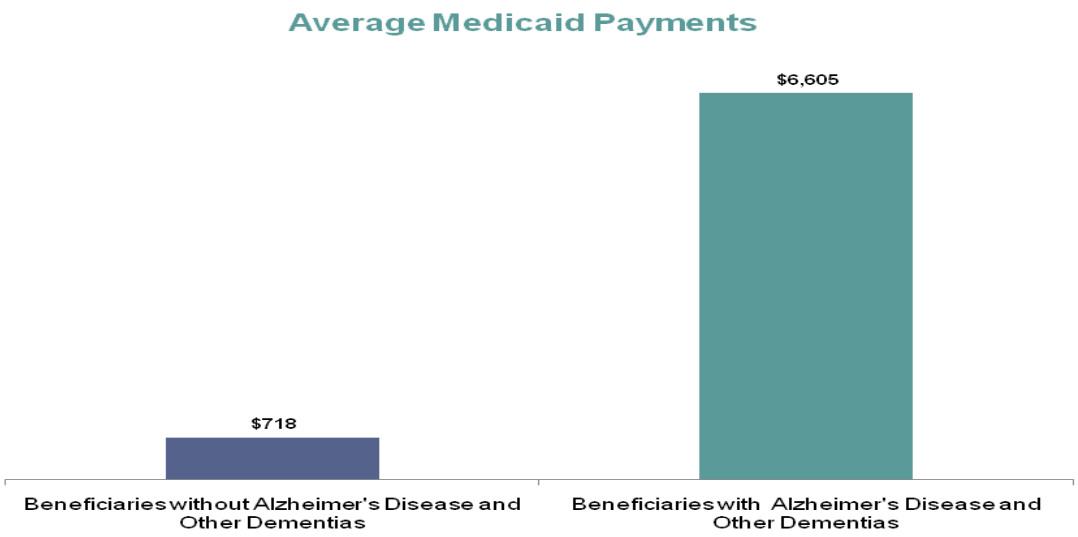
community care providers and Connecticut's Alzheimer's Association's staff and volunteers.

G. Dissenting opinion/organizations: None

III. Long-term Needs/Vision:

Translate the task force recommendations into actual public policy. This consensus-built document will formulate legislation and regulations to prevent, halt or delay the course of Alzheimer's disease and improve the early diagnosis and coordination of the care and treatment of citizens with Alzheimer's. Improve the delivery of adequate care from primary prevention to end-of-life care. A comprehensive state strategy to address the needs of persons with Alzheimer's provides a mechanism to consider all of these issues collectively.




Average Medicaid Payments
$718
$6,605
Beneficiaries without Alzheimer's Disease and Other Dementias
Beneficiaries with Alzheimer's Disease and Other Dementias

alzheimer's association

Connecticut

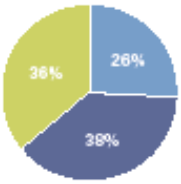
Alzheimer Statistics

In the United States, 5.3 million people are living with Alzheimer's disease, and a new individual is diagnosed with the disease every 70 seconds. Unless something is done, by 2050, up to 16 million Americans will have Alzheimer's, and a new case will be diagnosed every 33 seconds.

Number of People Aged 65 and Older with Alzheimer's and Other Dementias by Age

Year	65–74	75–84	85+	Total	% change from 2000
2000	3,600	35,000	30,000	68,000	
2010	2,800	30,000	37,000	70,000	3%
2020	3,600	29,000	38,000	70,000	3%
2025	3,900	34,000	38,000	76,000	12%

Cognitive Impairment in Nursing Home Residents, 2008



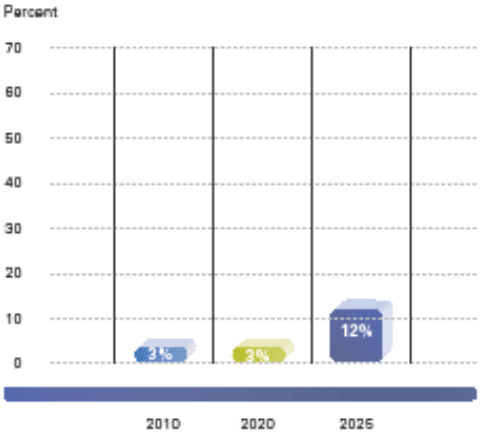
Total Nursing Home Residents
63,238

Level of Cognitive Impairment
- severe/moderate
- mild/very mild
- none

Number of Alzheimer and Dementia Caregivers, Hours of Unpaid Care, and Economic Value of Care

Year	Number of Caregivers	Total Hours of Unpaid Care	Total Value of Unpaid Care
2007	112,782	97,353,432	$1,029,999,306
2008	113,074	97,605,554	$1,093,421,654
2009	125,758	143,213,279	$1,646,952,695

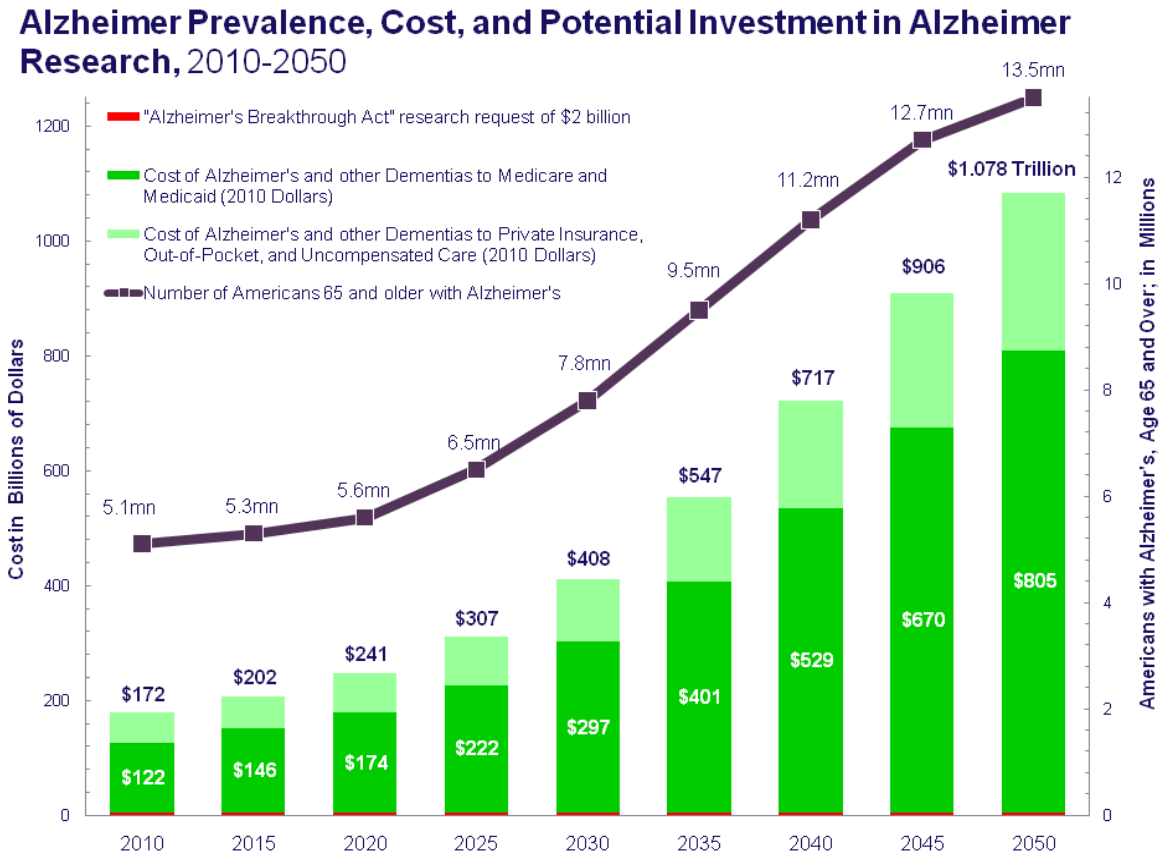
Percentage Change in Number with Alzheimer's Disease Compared to 2000



Number of Deaths Due to Alzheimer's Disease in 2006

728

For more information, view the *2010 Alzheimer's Disease Facts and Figures* report at **alz.org/facts**.



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For information contact Laurie Julian, Director of Public Policy, Alzheimer's Association, CT Chapter, 860) 828-2828 or laurie.julian@alz.org

Coverage for Clinical Trial Routine Care Expenses

SENATOR MARTIN M. LOONEY
MAJORITY LEADER

Eleventh District
New Haven & Hamden

State of Connecticut
SENATE

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www.SenatorLooney.cga.ct.gov

December 2, 2010

Governor-elect Dannel Malloy
State Capitol, room 416
Hartford, CT 06016

Dear Governor-elect Malloy:

I write to ask for your help regarding an issue on which I have worked for several years: expanding insurance coverage of routine patient care costs for clinical trial patients. This is a matter of health equity without an associated cost to the state.

The Connecticut General Assembly passed legislation in 2001 to require this coverage but only for cancer clinical trials. While this was a positive step, it was not the most rational option. Cancer trials were often already covered by insurers, and there are often a sufficient number of cancer patients so that drug development for oncology is often profitable enough for pharmaceutical companies to move forward. Patients with rare diseases can be left out of this coverage and thus out of potential drug development. There is no logic in requiring insurers to sustain their responsibility to patients and to cover routine care in cancer trials but not in clinical trials for other serious, life-threatening, chronic or disabling diseases.

Under President Clinton, Medicare made the common sense change to cover routine patient care costs for clinical trial patients. The Medicare coverage is, sensibly, not limited by disease. The recently passed landmark Affordable Care Act requires coverage of routine patient care costs but only in trials for cancer or other life-threatening diseases. It then provides an extraordinarily narrow definition for 'life-threatening' which does not include the majority of chronic and disabling diseases. This is in conflict with the thoughtful policy developed by the Centers for Medicare & Medicaid Services. While I am also advocating an expansion in the federal legislation with members of Congress, I believe that state action is likely necessary and desirable.

The clinical trial legislation that I am proposing does not ask insurance companies to cover more than they should expect to pay. It requires that insurance companies cover standard of care treatment for patients who are enrolled in clinical trials as they would for patients who are not enrolled in clinical trials. Routine patient care is care which would otherwise be covered if such services were not rendered pursuant to a clinical trial. The insurers would not be required to cover the experimental drug, but rather the patient's regular routine care only. Evidence suggests that routine care costs for clinical trial patients are only marginally higher than for patients not in a clinical trial[1]. In a number of cases, the insurer's cost will be reduced because the patient will cease treatment with the already approved drug for which the insurer would have to pay and begin treatment with the experimental drug for which the trial sponsor will pay. In many cases this will more than offset the incremental increase in the cost of routine patient care.

Insurers vary significantly in policies regarding coverage of these costs (for example AETNA followed the lead of Medicare in offering coverage for routine patient care costs not limited by disease or condition). This small change would create a more equitable outcome for clinical trial patients who are taking a risk to help others who share their particular condition. These patients deserve our encouragement and support. They should not be billed for procedures that their insurers would otherwise cover if they were not participants in a clinical trial. I look forward to working with you on this important matter of health equity and fundamental fairness.

Sincerely,

Marty

Martin M. Looney
State Senator, Eleventh District

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[1] Bennet *et al.*, *Evaluating the Financial Impact of Clinical Trials in Oncology: Results from a Pilot Study From the Association of American Cancer Institutes/Northwestern University Clinical Trials Costs and Charges Project*, 18 J. OF CLINICAL ONCOLOGY 15, 2805-10 (2000).
Bruce H. Firemen, et al., *Cost of Care for Patients in Cancer Clinical Trials*, 92 J. THE NAT'L CANCER INST. 7, (2000.).
Wagner, et al., *Incremental Costs of Enrolling Cancer Patients in Clinical Trials: A Population Based Study*, 91 JNCI 10, 847-53 (1999).
Goldman et. al, *Incremental Treatment Costs in National Cancer Institute-Sponsored Clinical Trials*, 289 J. OF THE AM. MED. ASSOC. 22, 2970-77 (June 11, 2003). Note that the date used in this study was compiled before Medicare began paying routine patient care costs in clinical trials

Oral Health

Oral Health

Patricia Baker
President and CEO
Connecticut Health Foundation

Tooth decay continues to be the single most common chronic disease among U.S. children. This problem persists despite the fact that it is preventable through early and consistent family interventions. Decay is five times more common than asthma and 80 percent of dental disease is found in about one-quarter of children. Unfortunately, low-income children and their families are much more likely to suffer from this disease, but also are much less likely to obtain dental care.

Over the past ten years, the Connecticut Health Foundation (CT Health) has made progress in expanding access to and use of oral health services for low-income children by:

- Commissioning a blueprint of action steps designed to improve oral health and access to dental care (*Elements of Effective Action to Improve Oral Health & Access to Dental Care for Connecticut's Children & Families*).
- Supporting efforts to increase Medicaid reimbursement for children's dental services, which expanded the number of participating providers.
- Funding community-based collaboratives in several Connecticut communities to expand capacity or an integrated, community-based system of oral health care.
- Establishing and supporting the Connecticut Oral Health Initiative, the leading statewide oral health advocate.
- Commissioning a multi-year evaluation of the effectiveness of increasing Medicaid reimbursement rate for oral health services provided to children insured under HUSKY as a method of improving access.
- Developing a model for federally qualified health centers (FQHCs) to use when contracting with private dentists who provide oral health services. This contracting model was included in the federal Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009.

While the results of our work over the past decade are promising, in 2010 we realigned our strategic grant-making priorities to focus on prevention and ensuring patients establish a "dental home," a source of ongoing, comprehensive dental care no later than age one (see enclosed Executive Summary of the 2007-2017 Strategic Plan).

More specifically, our future investments will focus on the integration of health, education and human service systems into oral health and the promotion of oral health among pregnant women. Research illustrates that mothers may pass on tooth decay-causing bacteria as well as unhealthy nutrition that can lead to oral disease. Mothers without regular dental care are less likely to seek dental care for their children.

In September of 2010, CT Health issued two requests for proposal that are designed to identify low-income pregnant women or women contemplating pregnancy, promote oral health, and provide pathways to establish an ongoing "dental home." Outcomes of these grant initiatives may have public policy implications in connection with SustiNet and federal health reform implementation, Medicaid managed care restructuring and the potential development of a primary or elementary school dental screening requirement.

Oral Health for All

December 13, 2010

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Juan Figueroa, Co-Chair
Healthcare Policy Working Group

Tory Westbrook, M.D., Co-Chair
Healthcare Policy Working Group

Dear Mr. Figueroa and Dr. Westbrook:

The Connecticut Oral Health Initiative (COHI), a leader in oral health advocacy, is writing to convey our desire to assist the Healthcare Working Group on key oral health issues.

As you are undoubtedly aware, the preservation of the healthcare safety net for Connecticut residents is critical for our neediest population. One of the major findings of the Surgeon General's 2000 report on oral health stated that "oral diseases and disorders in and of themselves affect health and well-being throughout life." From that perspective, we support the premise that oral health is fundamental to overall health, yet it is often overlooked in the shuffle of healthcare issues. Dental care remains the single greatest unmet health care need for children, while tooth decay is the most common childhood disease: five times more prevalent than asthma. It's presence in children affects their ability to eat, speak and learn.

Additionally there is definitive correlation between dental disease and low-weight birth rates. Oral health has an impact on chronic conditions in adults, including diabetes, heart disease, stroke and cancer. Dental disease can adversely affect an individual's ability to perform basic activities: employed adults lose more than 164 million hours of work each year due to oral health pain and disease. Unlike many medical conditions that run their course without treatment, dental conditions worsen and become more costly to treat without intervention.

As Governor-Elect Malloy and his transition team grapple with prioritizing services and resources in the face of budgetary shortfalls, **we strongly urge that state budget reductions do no health harm.** COHI asks you, as co-chair of the Healthcare Policy Working Group, to share with Governor-Elect Malloy the following recommendations:

1. **Incorporate preventive dental services in the state's health exchange medical plan (SustiNet) and ensure that the Connecticut health exchange plans include dental services in parity with similar private and public health coverage for oral health.**
   a. Preventive dental services should be included in the health exchange medical plans as well as all commercial health plans. Preventive services may consist of an annual dental exam and dental cleanings at six-month intervals for children and adults, as well as topical fluoride application, fluoride varnish and sealants for children and topical fluoride application for adults who are undergoing head and neck radiation for treatment of disease.
   b. Additional preventive, restorative and other non-preventive dental services should be offered as tier-based benefits with appropriate and affordable pricing.
   c. A licensed dentist (DDS or DMD) must be included in all Exchange workgroup benefits discussions.
   d. Adoption of electronic health records (EHR) in care delivery settings is essential to the future of quality, cost-effective healthcare, and systems should be designed to integrate documentation of both medical and dental patient visits and clinical data

2. **Support a revenue option for Connecticut on soda and other sweetened beverages.**
   a. Establish a state tax on soda and other sweetened beverages and dedicate those resources for public health and education programs.
   b. Prohibit the use of CT SNAP (Supplemental Nutrition Assistance Program) benefits for the purchase of soda and other sweetened beverages.

3. **Support preventive and restorative dental services delivered in school based health centers.**
   a. Dental hygienists should continue to provide oral screening examinations, dental cleanings, fluoride treatment and sealant applications at the school sites and make referrals to dentists when additional treatment needs are identified.
   b. Dentists should continue to review assessments and provide restorative treatment at school sites where appropriate equipment is available.

In support of these measures, allow us to provide additional discourse:

1. **Incorporate preventive dental services in the state's health exchange medical plan (SustiNet) and ensure that the Connecticut health exchange plans include dental services in parity with similar private and public health coverage for oral health.**

Oral health is a critical component of health and must be included in the provision of health care and the design of community programs.[1]

The arguments in favor of both national health reform and Connecticut's SustiNet plan (Public Act No. 09-148) have been grounded in prevention and cost-effectiveness. The importance of good oral health care has been cited at the federal and state levels. With preventive care, Connecticut residents have a better opportunity to live free from pain and disease. This includes oral health, as a healthy mouth is functionally vital to personal well-being throughout the age spectrum. This

[1] U.S. Department of Health and Human Services."Oral Health in America: A Report of the Surgeon General." *Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.*

action would be a forward-thinking achievement and a progressive example for health reform across the nation:

- Estimates reveal a savings of 7.3% from regular screening and early intervention with identified oral disease.[2]
- Prevention of dental disease ranks above HIV screening and influenza immunization in cost savings[3]
- Oral cancer screening is effective and cost effective; if cancer is detected in a pre-cancerous state, the disease itself can be prevented.

The Sustinet Board Partnership Board of Directors, Task Forces and Advisory Committees underscore the importance of oral health and the historical lack of parity with medical services. This recognition is evinced in the language of Public Act No. 09-148, Section 1. (2) (G): *Dental care coverage that is comparable in scope to the median coverage provided to employees by large employers in the Northeast states; provided, in defining large employers, consideration shall be given to the capacity of available data to yield, without substantial expense, reliable estimates of median dental coverage offered by such employers.*

Most mid-size to large employers, State of Connecticut employees and federal employees are offered dental coverage under their respective health benefits plans. The dental benefits premiums may be subsidized by the employer or, as with the Federal Employees Health Benefits Program (FEHBP), on an enrollee-pay-all basis. The bargaining power of large employers and state and federal governments, a result of the number of eligible enrollees, allows coverage to be purchased on a group basis, resulting in lower premiums and no pre-existing condition limitations. To honor the Public Act language and respect that oral health is imperative to overall health, the Exchange workgroup should require that all plans in the Connecticut health exchange offer preventive dental services as well as an array of tier-priced dental benefits packages at appropriate and affordable costs.

2. Support a revenue option for Connecticut on soda and other sweetened beverages.

In 2009 there was a spate of articles in the media about the possibility of a soda tax. Most of the articles and news clips centered around beverages infused with sugar, high-fructose corn syrup and fruit-juice concentrate and its effect on obesity. In an article from the LA Times, October 6, 2009, Kelly Brownell (director of the Rudd Center for Food Policy and Obesity at Yale University) and David Ludwig (associate professor of pediatrics at Harvard Medical School) noted that a one penny per ounce tax added to the cost of sugared beverages could generate about $150 billion annually over the next 10 years. The story also notes that the average American consumes 50 gallons of sugared beverages per year. If the one cent per ounce tax was applied in Connecticut, it would produce no less than $225 million in additional annual revenue.[4] The authors recommend that the resultant revenue be spent on needed programs.

A key consideration absent from these discourses is the impact of soda and other sugary beverages on the incidence of dental caries. The continual presence of sugars and acids in the mouth creates

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[2] Zavras AI et al, "Health *Care Savings from Microbiological Caries Risk Screening of Toddlers: a Cost Estimation Model". Journal of Public Health Dentistry. Summer 2000. 60(3) pp. 182-8.*

[3] Oral Healthcare: Essential to Health Care Reform Policy Statement, American Dental Education Association

[4] Based on 7/1/09 U.S. Census population data for CT (3,518,288) x average of sugared beverages consumed annually by average American (50 gallons) x number of ounces per gallon (128)

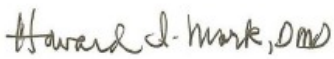
an environment more prone to dental decay. Research indicates that increased soda consumption, regular powdered beverages and 100% fruit juice is associated with increased caries risk.[5] Although the American Academy of Pediatrics recommends that children ages 1-5 consume no more than 4 to 6 ounces of fruit juice per day, greater than 10% of U.S. preschoolers drink 2-3 times more than the recommended daily amount.[6]

According to recent data, there are more than 300,000 Connecticut residents receiving benefits under the Supplemental Nutrition Assistance Program (SNAP). [7] Tobacco products and alcoholic beverages are among prohibited purchases with SNAP benefits; soda and other sugared beverages are allowed. In October 2010, the New York City Department of Health and Mental Hygiene, along with Mayor Michael Bloomberg, made a formal request to the United States Department of Agriculture to authorize a demonstration program to remove sugar-sweetened beverages from the list of allowable purchases through SNAP. Their premise is based on the increased risk of obesity and Type II diabetes from the caloric consumption of such beverages.[8] A July 2010 news article noted that a supermarket executive advised that carbonated soft drinks accounted for 6.2% of SNAP recipient's grocery bills. If 2010 SNAP estimates are accurate, that would amount to $4 billion in taxpayer money spent on SNAP soda purchases (based on estimated $65 billion for SNAP grocery benefits in 2010).[9]

We kindly ask that you review these recommendations as improvements to public health and view them for their potential revenue savings and revenue enhancements, respectively.

Thank you in advance for your consideration. The staff and members of COHI's Board of Directors stand ready to assist the Healthcare Policy Working Group: please do not hesitate to contact us with any questions regarding this information or on oral health issues and policy.

Sincerely,



Lisa Belisle
Executive Director

Howard I. Mark, DMD
President

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[5] Marshall et al, "Dental Caries and Beverage Consumption in Young Children" *PEDIATRICS Vol. 112 No. 3 September 2003, pp. e184-e191*

[6] Dye et al, "The relationship between healthful eating practices and dental caries in children aged 2–5 years in the United States, 1988–1994", J Am Dent Assoc, Vol. 135, No 1, 55-66.

[7] http://www.cahs.org/programs-snap.asp

[8] Removing SNAP Subsidy for Sugar-Sweetened Beverages *How New York City's proposed demonstration project would work, and why the City is proposing it,* http://www.nyc.gov/html/doh/downloads/pdf/cdp/cdp-snap-faq.pdf

[9] Michael Jacobson, "Big soda deserves taxes, not subsidies", *The Huffington Post, July 16, 2010*

Health Care and Bioscience Jobs

Workforce Development: Primary Care Physicians

Cato Laurencin, MD, PhD.
Dean of the School of Medicine
University of Connecticut

Statement of Issue

The Connecticut 2009 Primary Care Survey: Physician Satisfaction, Physician Supply and Patient Access to Medical Care commissioned by the Connecticut State Medical Society, revealed that Connecticut's primary care capacity is already stretched very thin: 28% of internists and 26% of family physicians were not accepting new patients. In addition, on average, new patients faced a wait of 18 days for a routine office visit. The addition of currently un- and underinsured patients to the patient load would be expected to stretch urban area physicians and overwhelm those in rural areas if structural issues are not addressed. This report tells us that Connecticut has a limited capacity to care for more patients who require primary care services. Half of the respondents reported that obtaining referrals to specialists for their patients had become more difficult over the past three years. Health plan restrictions were the most significant reason cited for this difficulty, followed by the supply of physicians in specialty areas.

It is widely known that lower salaries are a disincentive to medical students choosing Primary Care careers. Students list a number of factors that influence their career choice. According to the Association of American Medical Colleges (AAMC), the majority of medical students cited the content of the specialty, its fit with personal interests and skills, and mentor or role model influence as the three most important factors in career choice. Their decisions are directly affected by:

- Educational Debt Load: Average Medical Student debt load climbed to $141,751 according to the 2008 Association of American Medical Colleges (AAMC) Graduate Questionnaire (GQ). Historically, this level of debt has pushed many students to higher paying specialties.
- Salary Expectations: Historically, procedural specialties have enjoyed far higher reimbursement levels when compared to primary care. Both for life style considerations and their ability to pay off their educational debts, students may be drawn to higher paying specialties.
- Life Style Considerations: Students may be drawn to specialties perceived as having more predictable work hours, less harried work environments and more controllable lifestyles. Primary care, with its inherent responsibility for coordinating all aspects of patient care, long hours and unpredictable (and potentially unscheduled) patient needs, as well as relatively poor reimbursement, is perceived by many students as not competitive with other specialties (e.g. dermatology).
- Role Model Influence: A majority of medical students cite the influence of a mentor or role model. Unfortunately, physicians, primary care or not, are seldom trained in career counseling and mentoring of students and physicians in training.
- Personal Characteristics: Gender, age, major in college, etc., have all been correlated at times with career choice. It would appear that women and somewhat more mature students tend to track into primary care careers.

What we're doing: 35% of UConn Medical School Graduates practice in the state of Connecticut. Approximately 50% of all trainees/residents-in-training at UC are training in primary care. Through

numerous University-sponsored educational pipeline programs that focus on training health professions, thousands of students statewide (from middle school, high school, undergraduates and masters) are exposed to health careers, often in urban centers. For example, the Health Center's Urban Service Track Program allows students from the University's Schools of Medicine, Dental Medicine, Pharmacy and Nursing to learn and serve in urban health care settings.

Immediate Action Areas

A. Prioritization Schedule and Timeline

The following are three approaches that in the immediate, intermediate and long-term would increase the number of primary care physicians practicing in the state.

Immediate Impact: Develop a loan repayment assistance program for medical school loans for individuals who complete a residency program in primary care in exchange for committing no less than four years of service in the state. Preference should be given to those who will practice in medically underserved areas.

Intermediate Impact: Fund a full tuition and fee scholarship program for students enrolled at the UConn Medical School who will pursue careers in primary care. In exchange for the scholarships, students shall provide at least four years of service within the state in primary care with preference given to practice in underserved areas.

Long Term Impact: Provide funding to expand existing "Pipeline Programs" sponsored by the University of Connecticut Health Center to increase the number of students who will pursue careers in medicine and other health professions. Expanding these pipeline programs will enhance diversity and reduce disparities in the health care professions (see attachments).

B. Fiscal Impact: cost savings? implementation costs?

Immediate: Primary Care Residency Loan Repayment Assistance Program: $124,220 (cost of four years of UConn Medical School for in-state students) per resident.

Intermediate: Medical School Scholarship Program: $124,220 (cost of tuition and fees for four years per medical student).

Long term: The attached documents provide the additional resources required to increase the numbers of students served in the pipeline programs, total impact approx. $2.33 million.

C. Jobs Impact:

Encouraging, mentoring and providing additional support to prospective and current medical students increase the likelihood that students will enter the field of primary care and/or serve in under-served areas, thereby increasing access to quality healthcare for the residents in the state of Connecticut.

D. Malloy/Wyman Campaign Policy Tie-In:

The shortage of primary care physicians in the state of Connecticut will soon reach crisis proportions. Individuals, particularly the elderly, are currently having difficulty finding physicians who will accept new patients. Efforts to increase access for Connecticut citizens factors in directly with the campaign statement to "Work with the federal government and

medical schools in the state to train more primary care physicians, nurses and other providers who will remain in the state to meet the needs of our residents."

For additional information see attachments:
Diversity in Health Professions and Health Disparities
Support of Primary Care Workforce

Long Term Needs/ Vision

With incentives to enter the field of primary care, more medical students and residents in training will practice primary care in Connecticut, thereby increasing the citizens' access to care.

Diversity in the Health Professions and Health Disparities

Cato Laurencin, MD, PhD.
Dean of the School of Medicine
University of Connecticut

The Issue: Diversity in the Health Professions and Health Disparities

What we are doing: The University of Connecticut Health Center, in collaboration with its partner school district and colleges, implemented the Health Professions Partnership Initiative *HPPI (now called Aetna HPPI)* in June, 1996. The goal of the Aetna *HPPI* is to increase the applicant pool of Connecticut underrepresented minorities, low income and first generation college students to medical school, dental school, graduate programs in biomedical research, allied health professions and pharmacy. In recent years, other activities have been added in an effort to be more comprehensive and effective in achieving the goal. The Great Explorations Program for middle school students and the activities at the Sport and Medical Sciences Academy for high school students were implemented to serve as feeders into the Health Professions Jumpstart, Junior and Senior Doctors Saturday Academy. Students in middle school are exposed to the sciences and health professions. This provides a foundation for them as they move to high school where activities continue to expose them to health issues in their community as well as provide them with a 'college ready' curriculum. As they matriculate to college, they are given the opportunity to become involved in more sophisticated issues such as conducting health research in the community. The exposure and involvement serves as a basis on which they can develop a commitment to serve in their community as primary health care providers. The current programs target students in the Hartford area. Our vision is that replication of the programs at another area of the state such as the Stamford area will enable a cadre of individuals to develop a similar sense of serving in the community as primary care physicians and dentists once they are similarly exposed.

The current programs are all revenue neutral because of the support of several entities including the Aetna Foundation, the Connecticut Department of Higher Education ConnCAP Grant, the Fisher Foundation and the University of Connecticut Health Center. The main educational enrichment and support activities are described below:

Great Explorations: Designed to raise college and health professions career awareness among Hartford students enrolled in grades 6-8, the program serves 225 students annually and provides services to participants in the form of science exposure activities, after-school tutoring and enrichment activities and a 4-week summer academic enrichment program. (Jumpstart Program).

Sport and Medical Sciences Academy: Enrichment programs in the health professions are provided to students at this school. Activities include visits to universities and the health center, lectures by various health professionals, an epidemiology course taught by health center professionals and students serving as teen patients for preparing medical students to interact with teen patients.

Saturday Academy (Jumpstart, Juniors and Senior Doctors Academy): A six-week summer program and 20-week academic year Saturday Academy for 100 high school students (grades 9-12) from the Hartford area schools who expressed an interest in medicine, dental medicine or biomedical research. This program held on the campus of the University of Connecticut Greater Hartford provides students with a review of algebra, geometry, science, language arts and proven test-taking strategies to increase CAPT, PSAT, SAT and other scores. Enrichment activities with presentations by Health Center staff and the colleges, field trips, and parent/student activities are also scheduled.

High School Student Research Apprentice Program: A six-week summer program for high school students who have completed their junior or senior year and have indicated an interest in medicine, dental medicine or biomedical research. This program provides the students with a research experience in one of the basic science or clinical laboratories at the University of Connecticut Health Center, or Central Connecticut State University.

High School Mini Medical/Dental School Program: A series of eight to ten weekly lectures/demonstrations presented by faculty members of the Health center to high school students. The lectures are also broadcast live to sites around the state.

Parental Development Program: Programs are planned during the academic school year that involve parental participation that will ultimately help foster and strengthen the role of the parent to promote and mentor their child's interest in the health professions. Activities such as tours of the University of Connecticut Health Center; series of educational lectures on health topics; computer literacy; health professions career guidance, and college financial aid for high school students.

Pre College Enrichment Program: A six week summer program for college pre-freshmen at The University of Connecticut, Storrs. The purpose of this program is to enhance the preparation and to increase the retention of freshmen already admitted to college. Most of the participants are students from the Saturday Academy mentioned above.

College Enrichment Program: A six-week summer program for college freshmen and sophomores at the University of Connecticut, Storrs. The purpose of this program is to increase the retention of freshmen and sophomores admitted to college.

Medical/Dental Preparatory Program (MDPP): A six-week summer program for students who expect to apply to professional schools of medicine and dental medicine. The purposes of the program are to (a) facilitate the entry of these students into professional school by improving their performance on admissions tests and (b) to increase the retention of successful matriculants to professional school through early exposure to professional education.

Summer Research Fellowship Program (SRFP): A ten-week program designed to provide a research enrichment experience and exposure to clinical medicine or dental medicine to undergraduate college students.

Clinical Summer Research Fellowship Program: A six week program where participants are

placed at one of several clinical sites in the community to conduct research. The students targeted for this program are college students who have participated in the Saturday Academy. Conducting clinical research and exposure to health issues in the community where they were raised may have a positive impact on the decision to practice in that community when they have completed their health profession training.

In addition to the structured programs described above, the Health Center has several other initiatives in place. The Bridge to the Future Science Mentorship Program (BFSMP) is a program in which medical, dental, graduate, nursing and allied health students serve as mentors to college students, who have expressed an interest in a career in the health professions. The college students in turn serve as mentors to high school students in the program. A network is established which includes the middle school through professional school educational community, all sharing an interest in science or health professions. The program provides an opportunity for college and high school students to seek advice from medical, dental, graduate, nursing and allied health students and gain insights into successful preparation for an application to professional schools. Thus, the program is aimed at meeting the long-term objective of increasing diversity in health professions programs. Among a number of strategies formulated to meet this objective is development of mentoring programs for high school and college students that involve students from the academic Health Center's professional schools.

What we propose: Replication of the Health Professions Saturday Academy at the UCONN Stamford campus with 50 high school students. These students will then be eligible to participate in our other Health Professions Pipeline programs as they matriculate and move through college.

Schedule: June 20- July 29, 2011: Summer component of the Saturday Academy
September 2011 – June 2012: Academic Year component of the Saturday Academy (20 Saturdays)

Fiscal Impact: The current programs are all revenue neutral because of the support of several entities as stated previously. Total cost of current programs = $1.5 million. However, additional funds for replicating the Saturday Academy at Stamford will be required as follows: two Education Specialists, 6 teachers, educational supplies, transportation costs, and student meals.

Total additional funds needed= $330,000 (approximately)

Long-term Needs/Vision: Increasing the number of students in the Saturday Academy at Stamford from 50 to 100; the provision of financial support for those students who matriculate in health professional schools.

Jobs Impact and other Benefits: Jobs for 2 educational specialists, 1 administrative assistant, 6 teachers (full time during the summer and part time during the academic year); The Economics of providing educational supplies, transportation and meals for the students – vendors providing the services; Potential of producing more diverse health care providers from the Stamford area.

The Connecticut Institute for Clinical and Translational Science at the University of Connecticut

Cato Laurencin, MD, PhD.
Dean of the School of Medicine
University of Connecticut

Statement of Issue

Nationally, health research is undergoing a paradigm shift to accelerate the direct application of scientific discovery and evidence in healthcare practice and the community. The new paradigm is focused on the translation of bench research to the bedside in clinical trials (T1) and from the bedside to the clinic and community (T2). All across the translational continuum, multidisciplinary teams of researchers, clinicians, and policy makers are being formed and infrastructure support systems are being designed to support the new approach to research and science. ***Academic Health Centers must be prepared to engage in this paradigm shift to remain competitive in research, training and care delivery***. The National Institutes of Health (NIH) have made translational research a top priority, launching the Clinical and Translational Science Award (CTSA) program in 2006, and more recently announcing plans to realign resources to establish a new Center devoted to advancing translational science.

The University of Connecticut, in partnership with five regional hospitals, state agencies, and three community health care organizations, has created the Connecticut Institute for Clinical and Translational Science (CICATS), headquartered at UCHC, to transform the way science is conceived, conducted and disseminated in Connecticut. The partnership has been actively seeking an NIH CTSA award and has a strong application pending review. A decision is expected early in 2011. If awarded, approximately one-third of the cost of CICATS would be covered by the award. CICATS organizes the University and its partners into a single functioning research partnership with substantial new infrastructure, staff and expertise located across the region and primarily supported by the University. The mission of CICATS is to *transcend traditional boundaries of a university and incorporate community researchers and practitioners into the research process.* This will be accomplished through: leveraging existing assets and collaborations in and across its partners; encouraging biomedical and health-related discoveries and expediting their translation into products, treatments, and interventions to improve people's lives; educating and nurturing new scientists; increasing the number of clinical and translational research projects conducted at the Health Center, regional hospitals, the Storrs campus of the University, and other healthcare organizations throughout the greater Hartford metropolitan area; and working collaboratively with regional stakeholders to improve healthcare disparities in the region and the nation.

Immediate Action Areas

A. Prioritization schedule and timeline

CICATS operations are limited and funded by the University, while awaiting an NIH review in February 2011. If funded, the 5-year award would begin in July 2011. The award would increase CICATS operations by funding a large education and training component. However, two-thirds of the operational cost of the Institute will remain as a University obligation ($46 million over 5 years).

B. Fiscal impacts: cost savings? implementation costs?
We project a substantial return on investment (ROI) associated with this investment, however, to be sustained, we request one-third of the cost in new State funds ($22 million over 5 years), one-third in existing University funds and one-third from the federal grant.

C. Jobs Impacts
We project that 68 additional staff and faculty will be required to provide growth in infrastructure and to staff new grants and projects over the next five years.

Today, the UCONN R&D Corp is managing five firms emanating from medical innovations. The Technology Incubation Program at UCHC is currently supporting five firms from outside of the university; two engaged in drug discovery, two medical device firms and an Information Technology (IT) firm to develop a system to support compliance with federal health care mandates. Four firms with ten jobs are located at our new incubator co-located with the stem cell core lab and four others are in the various stages of our application process. Each has the potential to utilize CICATS to support company job growth.

We project that 68 new grants across the partner institutions will result from CICATS supported pilot studies (6/year), K-12 scholars (10 over 5 years), Multidisciplinary research teams (20 over 5 years) and from a minimum of one additional grant from each partnering institution. These grants (primarily NIH funded) will range from small R03 awards at $50,000/year to large R01 awards at $350,000/year for up to 5 years. With overhead rates ranging from 20-54%, the region will benefit over the five years at $13,600,000/year in directs and up to $7,344,000 in overhead for a total of $21 million per year.

D. Malloy/Wyman Campaign Policy Tie In
CICATS is precisely what is needed to assist Governor Malloy in achieving his stated goals of having A Bioscience Connecticut (ABC) and affordable, quality health care. At the T1 end of the translational continuum, vibrant CTSA Centers where innovation and fast-track translational science is being conducted will attract the kind of trainees, scientists and bio-technology firms that ABC will need to be a success. At the T2 end of the continuum, innovative primary care models, effective HIV, obesity and diabetes prevention programs, as well as cutting-edge technology solutions that will have immediate practical benefit for healthcare and health status in Connecticut.

E. Benchmark state(s)

NIH plans to fund 60 CTSA applications leaving approximately half of the Academic Health Centers in the U.S. without funding. UConn should not be in the unfunded half. In the northeast the only other State University with a currently funded CTSA is at UMass. The other centers are all large, private institutions including 3 in Boston, 1 in New Haven, CT and 7 in New York City.

F. People/organizations in CT who are knowledgeable/supportive

UConn has partnered with Hartford Hospital, Saint Francis Hospital, CT. Children's, Hospital of Central CT, the Hospital for Special Care and three community organizations including the Hispanic Health Council and the Institute for Community Research. The leaders and scientists from each partner organization have been involved in CICATS development from its inception and are deeply involved in its operations. In addition we have the support of our Congressional Delegation, the Commissioner of DPH, the National Medical Association and many other regional stakeholders.

G. Dissenting opinions/organizations

It is doubtful that there is a dissenting opinion about the value of CICATS to the region. There are other organizations with similar missions with whom CICATS would seek to establish, or has already developed, a collaborative relationship. These include Metro Hartford Alliance, which is conducting a business planning effort to create a regional clinical trials supersite to attract clinical trials work to Central Connecticut. CICATS and Metro Hartford have met to discuss opportunities to collaborate. Yale has a funded CTSA, however, its mission is more in line with the mission of a private University with less focus on the state and local impact for the citizens of the State of CT.

Long-term Needs/Vision

CICATS must continue with its current level of funding throughout the next five years and must receive additional support for the projected growth in infrastructure as investigators, trainees and research activity increase.

University of Connecticut Health Center

Cato Laurencin, MD, PhD.
Dean of the School of Medicine
University of Connecticut

With tremendous state support through 21st Century UConn, sustained and enhanced appropriations and, most recently, bond funds for the UConn Health Network and Biosciences Initiative, the University of Connecticut Health Center is moving forward in all aspects of its integrated educational, research and clinical care mission.

The UConn Health Center is the state's only public academic medical center. It is home to three schools: the UConn School of Medicine, the UConn School of Dental Medicine, and the Graduate School. All schools are highly competitive, with the vast majority of students coming from Connecticut. Clinically, the UConn Health Center is home to the UConn Medical Group, the region's largest multi-specialty practice; University Dentists and dental clinics which provide a full range of dental services, for all patients regardless of their ability to pay, and the John Dempsey Hospital, the state's only public acute care hospital. Each of these clinical services provides educational and clinical training opportunities for students, residents, fellows and faculty. In fact, UCHC is the major source of physicians and dentists who practice in the state and annually sponsors nearly 700 UCHC residents (medical and dental) who train throughout Connecticut driving millions of dollars to the area hospitals from federal Graduate Medical Education dollars. The UCHC academic programs contribute mightily to the state's physician and dental workforce (35% of School of Medicine graduates and 46% of School of Dental Medicine graduates practice within the state.)

As a publicly supported facility, UCHC is committed to providing health care to all residents regardless of ability to pay. In addition to its immediate service area, UCHC provides critically needed care throughout the state, particularly for vulnerable, underserved populations, through a collaborative network of teaching affiliates and community health centers. As a result, JDH ranks among the top hospitals in the state for providing healthcare services to the indigent and medically underserved, and patients who are recipients of Medicaid comprise a significant proportion of faculty practice visits. Similarly, UCHC's School of Dental Medicine is by far the largest provider of oral health care services for the under- and uninsured in the state and for people with developmental disabilities. Furthermore, UCHC provides all medical and dental services to the more than 19,000 persons in the custody and care of the State Department of Correction, and UCHC is the primary provider of healthcare to a significant population of migrant laborers who work on Connecticut's farms each year.

UConn Health Center's robust research enterprise garnered a record $100 million in extramural support in 2010 and is a national leader in areas including immunology, stem cell research and genetics. The state of Connecticut has shown extraordinary leadership in the area of stem cell research, positioning our researchers for significant breakthroughs and advances in the near future.

In addition, with more than 5,300 employees, including highly skilled employees and internationally renowned experts, the UConn Health Center is a major economic force in the region, generating nearly $1 billion in gross state product annually.

Its active research environment fosters and encourages discoveries that will lead to new cures and treatments, as well as new jobs. Through the years, Health Center researchers have laid the groundwork for more than 75 patents that today are helping to diagnose glaucoma, fight cancer, lessen the burden of orthodontic care with improved composites and wire, and more.

Earlier this year, UConn Health Center moved four of its major research components into a new, state-of-the-art facility, the Cell and Genome Sciences Building in Farmington, which was supported by UConn 21st Century. Here, collaboration among researchers from UConn, Yale and Wesleyan and entrepreneurs is encouraged; the building also houses incubator space for start-up bioscience companies.

Moving forward, the Health Center will work with all regional hospitals and many health organizations, to implement the innovative components of the UConn Health Network and Biosciences Initiative. This forward-thinking package was approved by the General Assembly and signed into law by Governor M. Jodi Rell in the spring of 2010. It will go far to create new and sustainable jobs in healthcare, research and biosciences and at the same time, address a wide range of pressing issues from ongoing health disparities to current and expected shortages of primary care physicians. A critical component of the UConn Health Network is the renewal of John Dempsey Hospital, through vast upgrades and the addition of 50 medical surgical beds for the region. The Health Center has applied for a federal grant from the U.S. Department of Health and Human Services to support these efforts; without grant, it will seek other sources of non-state dollars to keep all projects moving forward.

In all, these elements, as estimated by the Connecticut Center for Economic Analysis, 2010, are expected to produce tangible economic impacts: creating 5,000 new jobs by 2020 and 7,400 by 2040 (not including 2,100 construction jobs), generating $1.5 billion annually in new personal income in 2040, producing $1 billion annually in new output, and contributing $1.1 billion in new state tax revenue by 2040.

Implementing the UConn Health Network and Connecticut Bioscience initiative is critical to the state's and region's economy. It is also essential to the Health Center's continuing ability to provide the state's core public medical and dental education, to meet the state's current and future need for doctors and dentists, provide clinical care to Connecticut residents and to grow research activities and jobs .

A Healthy Connecticut?

Connecticut's allied health workforce is facing critical challenges stemming from shortages of qualified professionals but no shortage of patients. Today, key allied health professions face workforce shortages and the need for services is expected to rise over the next two decades as the number of patients and their needs grow and change. In order to address these challenges, Connecticut must develop workforce pipelines to ensure we have enough appropriately trained and culturally competent workers in a relatively short period of time.

here is how we will solve this problem, *together*

Introduction

Over 3,400,000 people live in Connecticut. This population is very diverse with many different needs. There are over half a million people age 62 and older. This "baby boomer" generation is aging and stressing the resources for medical treatment. In 2011, the first "baby boomers" will turn 65. In the next 20 years, the aging population is expected to double. According to AARP, at least eighty percent (80%) of seniors have one chronic health problem. Additionally, the workforce is facing shortages because many qualified workers are retiring or will retire in the next few years.

In addition to the aging population, Connecticut's diversity is increasing exponentially. By 2025, the number of White non-Hispanic residents will decrease from 82% to 69% of the population. The Hispanic/Latino population is projected to grow from 7.5% to 15.4%; African-Americans will grow from 8.4% to 11.1%; and the Asian and Island Pacific population will grow from 1.9% to 4.3%[1]. The allied health professions currently do not reflect this diversity and will need to develop a culturally competent workforce to address the needs of these growing populations.

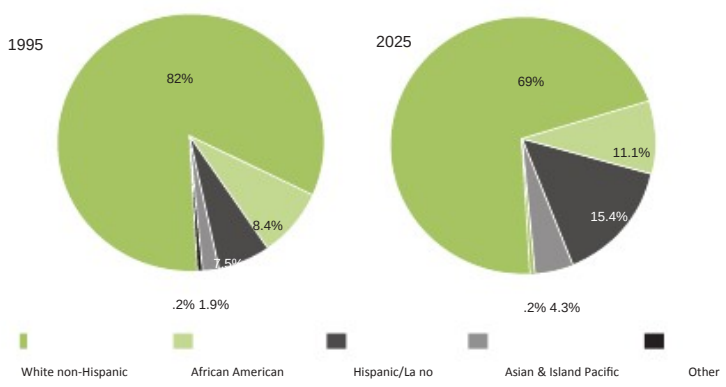
The importance of addressing the need in the allied health fields cannot be overstated. There is a high demand for allied health professionals in Connecticut. A pool of individuals exists in our state right now who, with the right combination of education and training, can fill this need. However, there must be multiple strategies to address the needs. This will require broad support among legislators, educators and employers.

Fortunately, much of the work has already beenstarted.Alliedhealthprofessionals, universities and colleges, workforce investment boards,community-basedorganizations,and labor unions have made numerous efforts to expand the health field in Connecticut to meet the high demands of the diverse and aging population. Additionally, in 2004, Connecticut's legislature established the Connecticut Allied Health Workforce Policy Board (AHWPB) (Public Act 04-220)[2] to conduct research and planning activities related to the allied health workforce.

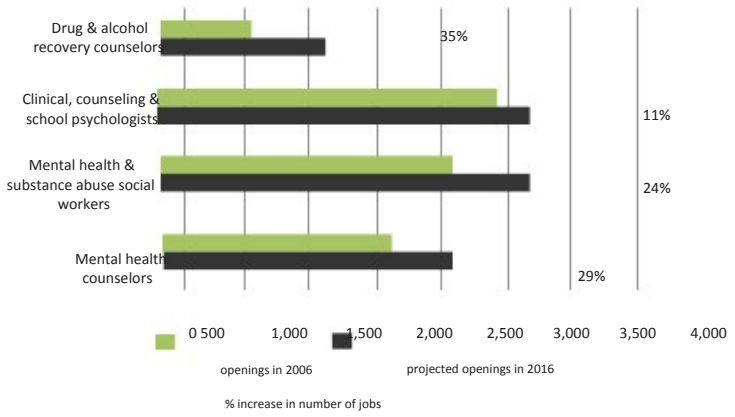
For the past six years, the AHWPB has convened experts in the allied health fields to share their expertise, data and knowledge about why shortages exist and to make recommendations on how to address this crisis. The AHWPB stands ready to lead future efforts to address allied health workforce shortages in our state.

The following information illustrates the occupations in demand, the challenges in addressing these shortages, and recommendations on how Connecticut can ensure that we have the workforce needed to meet our changing demographics.

US Census Bureau - Connecticut change in demographics 1995 - 2025



CTDOL Projected Job Growth in Behavioral Health Occupations



Data and Trends

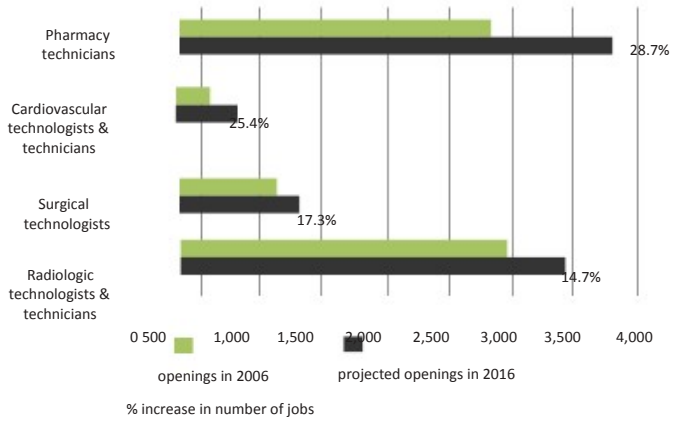
Connecticut Department of Labor Data

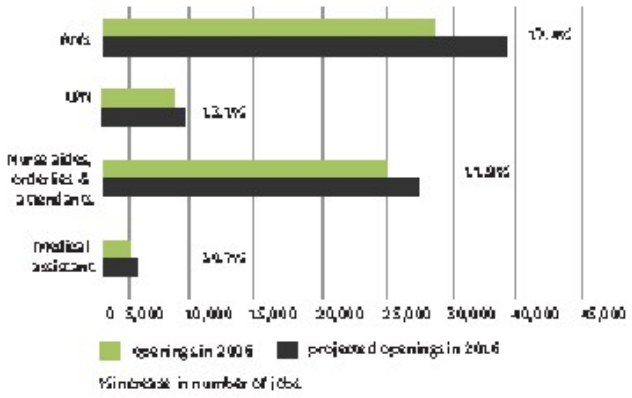
Data from the Connecticut Department of Labor (CT DOL) indicates that the estimate of total employment levels for health-related occupations, including doctors and dentists, for 2006 was 147,230, while the employment level for 2016 is expected to be 170,900, a 16.1% increase for the ten-year period. The allied health occupation with the highest employment level is registered nurses (RNs) with 32,840 jobs in 2006, and a projected 38,560 jobs for 2016 (17.4% increase). The CT DOL projects that the state will need to average 1,114 new registered nurses each year through 2016 to fill expected job openings. Behaviorial health and other allied health occupations are also experiencing significant shortages.

Shortages in these occupations are not unique to Connecticut. According to the Health Resources and Service Administration (HRSA), the adequacy of nurse supply varies geographically throughout the nation, with a general consensus that at the national level currently a moderate shortage of registered nurses (RN) exists. The findings of HRSA's analysis suggest that the current RN shortage will continue to grow in severity during the next 20 years if current trends prevail, and that some states face a more severe shortage than do others. The growth and aging of the population, along with the nation's continued demand for the highest quality of care, will create a surging demand for the services of RNs over the coming two decades.

Vacancy rate information from the hospitals in the Connecticut Hospital Association (CHA) shows continued shortages for registered nurses, unlicensed assistive personnel, ultrasound technologists, pharmacists, physical therapists, medical technologists, medical records coders, and surgical technologists. However, these occupations are all experiencing lower vacancy rates than at any point over the last 10 years. CHA contends that it is important to note that the recession has driven vacancy rates downward due to delayed retirements, increases in part-time employee hours, and employees returning to work due to job loss of a spouse. Though the 4.6 % vacancy rate for RNs appears low, it represents 628 open positions at 25 Connecticut hospitals. Furthermore, this persistent shortage exists despite the production of approximately 1,100 nurses by Connecticut's institutions of higher education in response to projections of labor market need.

CTDOL Projected Job Growth in Allied Health Occupations





Challenges

In order to lessen workforce shortages in allied health, a number of challenges must be addressed. These issues range from the systemic to the individual level. Though specific professions may experience some challenges to a greater or lesser extent, the ones listed below have been found to cut across all the allied health fields.

Connecticut's talent pipeline for allied health careers is in particularly poor shape because:

- Many applicants to certificate and degree programs lack fundamental skills in literacy, math, science, and English, and require substantial developmental education to enter a post-secondary allied health program.
- High school students have only a limited understanding of the availability of, and range of opportunities in, allied health careers, and do not connect their high school experience to their college plans.
- There is a significant under-representation of minorities pursuing careers in allied health professions.

Another key issue affecting the future of the allied health workforce is an insufficient supply of college faculty, particularly nursing faculty, to provide academic and clinical training.The current faculty workforce is aging and few individuals are pursuing graduate degrees in nursing and allied health. One reason for this shortage is that salary levels of teaching professionals, in allied health and nursing fields in particular, are significantly less than salaries for practitioners. In addition, many bachelor's and graduate programs are full-time, and few current employees are in a position to stop working to advance their careers. These individuals may also have difficulty securing financial aid or scholarships to support their educational programs if they can only attend college part time or if they earn too much money, even working reduced hours, to qualify for financial aid.

Recommendations

Addressing these challenges will require collaboration and investments among a variety of stakeholders, including state agencies, colleges and universities, labor unions, and employers, as well as capitalizing on the federal funding opportunities. Current ongoing efforts in allied health training, taking place across high schools and post-secondary institutions as well as state agencies and Workforce Investment Boards in Connecticut, are making a difference. However, we need to attack these challenges in a more systemic fashion.

Based on the challenges and examples of best practices found within our state, the following is a list of recommendations to help deal with the shortages in our allied health fields.

Recommendation 1: Develop a State Strategic Health Care Workforce Plan

Connecticut must develop a long-term plan for the allied health workforce, outlining the needs of employers over the next ten years and the current and predicted supply of skilled workers. The plan should identify the gap between demand and supply and the capacity of the state's colleges, universities, and other training providers to educate the needed workforce. In addition, the plan should outline how the barriers to career advancement outlined above will be addressed to ensure that state investments in training are efficient and effective.

The AHWPB, based on its membership and years of work, was recently awarded a grant with the Connecticut Employment and Training Commission to lead a strategic planning process.

The planning process, funded by HRSA, will include a broad range of healthcare related occupations and will build on and incorporate other planning efforts that have taken place in the past, such as the Hospital Task

The need for health care practitioners and technical occupations will increase 15.6% by 2016.

Force and the planning under the SustiNet Board. The report will also focus on the behavioral health workforce and the planning work being done by the Connecticut Workforce Collaborative for Behavioral Health. With this information, the AHWPB can set forth a plan for the state that positions the legislature to make decisions related to both short- and long-term investments in the state's allied health workforce and ensure that these disparate planning efforts are coordinated.

Recommendation 2: Provide Student Support Services and Academic Remediation

Numerous studies and pilot projects in Connecticut have shown that embedded tutoring, case management, and academic counseling services directly affect student program completion. Most colleges and universities, as well as the Technical High School system, have very limited funding for program-specific student services. Colleges should consider a variety of proven strategies to improve student success, including shrinking class sizes to provide students with more instructional contact, streamlining developmental courses to allow students to focus on their learning gaps and accelerate their progress, and supporting learning communities that provide for cohort development. We recommend that resources for these supports be included in future state appropriations for public educational institutions in order to ensure student success.

We also recommend that the legislature authorize the use of state financial aid provided to the state's public and private colleges and universities for students who are pursuing non-credit certificate programs in our state's training programs in particular, EMT and paramedic training and short-term programs in medical billing and coding and phlebotomy to help address workforce shortages. Currently no state funding is available for training in these short-term occupational areas that support the state's health care infrastructure.

Recommendation 3: Coordinate Statewide Allied Health Outreach Campaign

While many training programs exist within the state, some of those programs and careers, such as nuclear medical technologists or laboratory technicians, go virtually unnoticed by prospective students, both youth and adults. A coordinated statewide outreach campaign, designed with input from all stakeholders, including Area Health Education Centers, the Nursing Career Center, Connecticut Works One Stop Career Centers, Connecticut League for Nursing and the state's secondary and post-secondary institutions, is needed.

This campaign should include general marketing of nursing, behavioral health and allied health careers. The campaign should target unemployed adults with college degrees, teachers and guidance counselors, and parents and students, particularly minority students, providing information on career opportunities and the location of and educational requirements for allied health programs. Current funding in each of these agencies' budgets can be leveraged to start this effort.

Recommendation 4: Invest In New Faculty

Nearly every Connecticut degree program within nursing and allied health fields is vulnerable to current or anticipated faculty shortages. Colleges and universities sought out 27 waivers for nursing faculty from the Nurse Board of Examiners in 2009. Where sufficient faculty exists, it is recognized that securing replacements will be difficult. It is therefore in the best interests of the state to create a proactive plan to develop instructor talent and provide the resources to prepare more professionals to become faculty members. One example is the Scholarship-for-Service model, which has been used successfully in government and the armed forces to produce employeesforareasofneed.Connecticut should provide funding for Scholarship-for-Service opportunities for graduate level education to colleges and universities to support expansion of these new scholarship models.These resources will help the state meet its need for allied health faculty and ensure that we are able to continue training the future workforce.

Recommendation 5: Improve Clinical Contracting Process

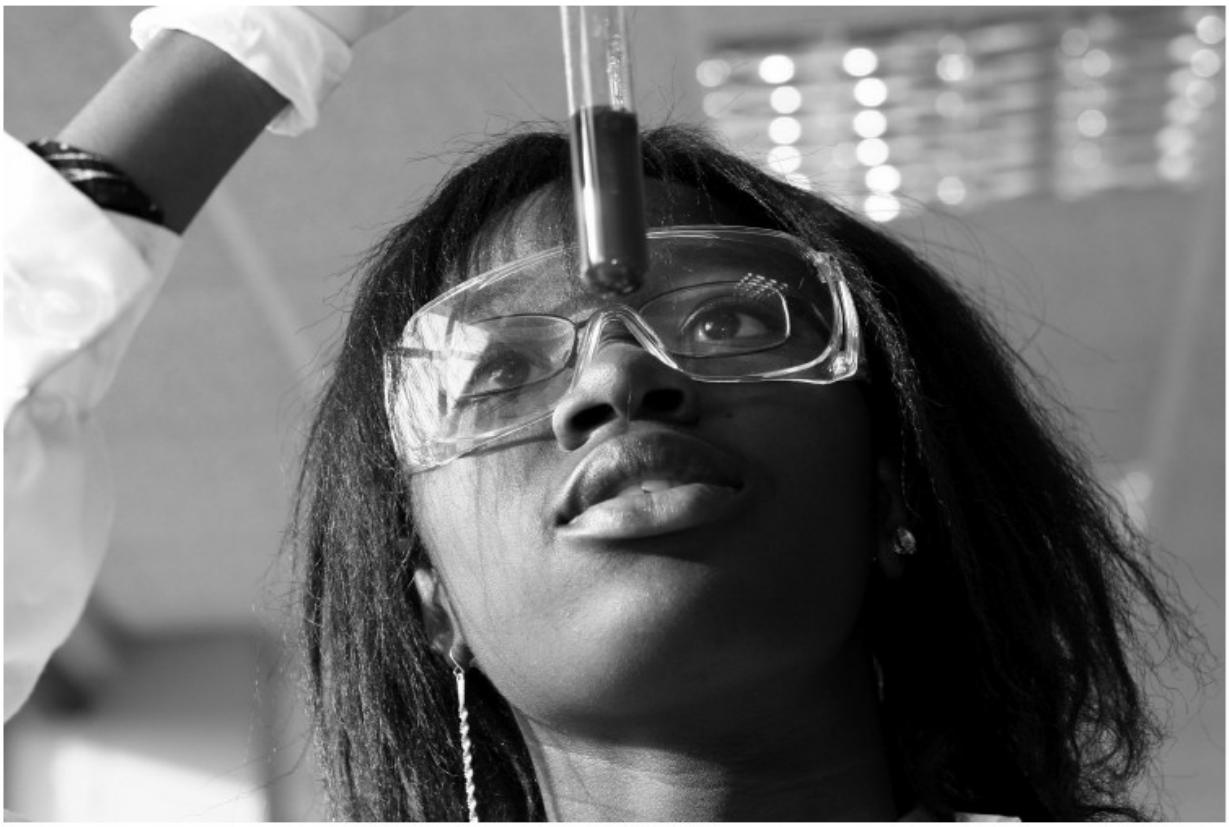
The contracting process is cited by employers, particularly hospitals, colleges and universities, and high schools as a barrier to providing students with clinical placements. The issues arise in multiple ways: contract requirements and rules change frequently; parent companies that reside outside of the state may follow rules that conflict with Connecticut's; and the length of time to complete contracts jeopardizes securing placements. Stakeholders call for clearer direction from the state, particularly the Attorney General's office, on contract requirements and increased support in getting these important contracts in place for the school year.

Recommendation 6: Expand Allied Health Programs

In order to meet the demand for allied health professionals, the state must expand its program offerings at the secondary, post-secondary, and graduate degree levels. In addition, new training opportunities for students and faculty need to be developed in on-line and simulated formats to promote greater access to education programs. The faculty plan commissioned by the AHWPB in 2007 outlined a number of key areas (e.g., Respiratory Care, Medical/Clinical Research Technology, Medical Laboratory Technology) in which program expansion is necessary to meet labor force demands. It is imperative that the faculty resources allocated in the 2011 budget to the state's colleges and universities be maintained to support the expansion of allied health programs to meet state workforce demands.

Recommendation 7: Support Employer-Sponsored Training

Having employers offer education classes to their own employees addresses several of the barriers that entry-level workers, particularly recent immigrants, face in terms of accessing basic skills and language skills training. Barriers include transportation, work and family obligations, the cost of training and difficulty locating courses. Employer-sponsored courses have the added benefit of enabling employers to develop curricula that focus on the



specific skill development and language needs of workers in the health care industry. It is recommended that current state investments in summer youth employment be maintained to support the paid allied health internships that have been developed statewide. Furthermore, the state must continue its current investment for incumbent worker training through the Department of Labor and Workforce Investment Boards in order to support the continued viability of hospitals, medical offices and laboratories, and long-term care facilities. During the 2008-2009 fiscal year, the WIBs spent approximately $1.5 million providing individual training accounts to individuals training for health care professions. An additional $300,000 was spent on incumbent worker training with $445,000 contributed by employer partners.

Conclusion

The AHWPB has identified much of the work that needs to be done both to coordinate efforts and to implement the activities that will position Connecticut to create the necessary pipelines to fill the allied health professions. It is critical, in this time of scarce resources, for the state to utilize this Policy Board rather than duplicating its efforts. This committed group has investigated, studied and piloted many best practices, and is undertaking planning work to position the state for future federal investments.

The AHWPB calls on the state to target resources to allied health careers. The AHWPB will work with state agencies, colleges and universities, Workforce Investment Boards, and other partners to ensure that these investments are strategically implemented, monitored, and replicated throughout the state.

Acknowledgments

The Office for Workforce Competitiveness would like to thank the following members of the Connecticut Allied Health Workforce Policy Board for their support of this effort.

Elizabeth Beaudin, Connecticut Hospital Association

Patricia Bouffard, Connecticut State Board of Examiners for Nursing

Patricia Ciccone, Connecticut Technical High School System

Amy Dent, Health Care Consumer

Margaret Flinter, Connecticut Health Center

Michael Hahn, Allergan, Inc.

Mary Ann Hanley, Chair, Office for Workforce Competitiveness

Merle Harris, Retired President, Charter Oak State College

Tricia Harrity, Northwestern AHEC

Kathleen Hiatt, Retired

Sherry Ostrout, Connecticut Community Care, Inc.

Deb Parker, Eastern Connecticut Health Network

Patricia Santoro, State Department of Higher Education

Betsey Smith, Quinnipiac University/Connecticut Conference of Independent Colleges

Kristin Sullivan, State Department of Public Health

We would also like to thank the representatives from Connecticut's universities, colleges, regional Workforce Investment Boards, state agencies, advocates, and many others who participate in our meetings, and shared in our deliberations throughout the year.

Alice Pritchard, Executive Director of the Connecticut Women's Education and Legal Fund, serves as an advisor to the Board. For more information on the Board's activities, contact Dr. Pritchard at 860-247-6090 or apritchard@cwealf.org.

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[1] Population Projections for States, by Age, Sex, Race and Hispanic Origin: 1995 to 2025, Report PPL-47, US. Bureau of the Census, Population Division.

[2] PA 04-220 stated that "allied health workforce" and "allied health professionals" means professionals or paraprofessionals who are qualified by special training, education, skills and experience in providing health care, treatment and diagnostic services, under the supervision of or in collaboration with a licensed practitioner, and includes but is not limited to, physician assistants, registered nurses, licensed practical nurses, certified nursing assistants, home health aides, radiological technologists and technicians, medical therapists and other qualified technologists and technicians.