ANNUAL REPORT CY 2014

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"OHA listened to me, stayed in touch and didn't back down. Your office obviously takes its mission seriously and gets results. "

ANNUAL REPORT

CY 2014

State of Connecticut
Office of the Healthcare Advocate

ANNUAL REPORT CY 2014

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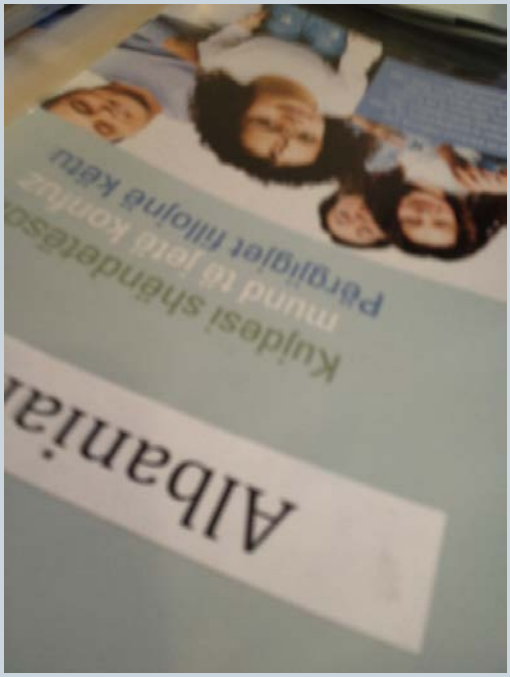


A Message from the Healthcare Advocate

Welcome to the Office of the Healthcare Advocate's (OHA's) 2014 Annual Report. Our staff continues to provide outstanding service to the residents of Connecticut. As of the date of this report, OHA has saved the consumers of Connecticut over $60 million since the office opened in 2001. We have worked with tens of thousands of policyholders, patients and families to explain their rights and responsibilities in their health plans, and to advocate for patients when they are denied coverage for treatment or denied reimbursement by their health plans. In CY 2014, OHA recovered $6,924,978 million for Connecticut consumers, taking 12,149 calls on our toll free line and handling 7,117 cases.

OHA has also taken on additional responsibilities for expanding and ensuring access to health coverage for Connecticut residents, recovering state funds, and engaging in systemic healthcare advocacy, all of which we highlight in the report. In sum, in CY 2014, OHA:

- Received a $442,863 Consumer Assistance Program (CAP) grant under the Affordable Care Act
- Conducted outreach to all 169 towns in Connecticut, including town halls, senior centers, libraries, social and youth services.
- Conducted 100 outreaches at health fairs and presentations
- Partnered with Access Health CT (AHCT) to implement the Navigator and Assisters Outreach Program, enrolling thousands of residents into healthcare coverage.
- Collaborated with partner agencies, advocates and consumers to identify opportunities for the creation of a sustainable, year-round consumer assistance program concerning enrollment and utilization of health insurance, to be implemented in coordination with AHCT and the Department of Social Services.
- Completed an evaluation of the Pay-for Performance Strategies under the Connecticut Behavioral Health Partnership in partnership with the Office of the Child Advocate.
- Continued to partner with the Department of Children and Families (DCF) to ensure that services for children whose parents have private health coverage are covered under private coverage before the state pays for services.
- Partnered with the Office of the Comptroller to enhance the clinical review of disability retirement applications, minimizing the risk of applications being returned for insufficient clinical documentation and the time to complete the review and determination process.

Developed two informational commercials airing on Hartford, New Haven and Bridgeport television stations; six radio appearances including streaming on websites; daily posts to OHA's Facebook and Twitter accounts.

We strive to empower Connecticut residents to become more informed consumers and effective self-advocates. Our website, Facebook, Twitter and YouTube accounts give timely information about consumer healthcare rights, through webcasts, links to timely news stories and policy developments.

If you have a specific question, or feel you have been incorrectly denied services by your health plan, please contact us by phone at (866) 466-4446 or by email at healthcare.advocate@ct.gov.

Victoria Veltri
State Healthcare Advocate

"Staff was excellent. Above and beyond my expectations."

What OHA Does

Managed Care is a health care system involving the active coordination of, and the arrangement for, the provision of health services and coverage of health benefits. Managed care usually involves three important components: oversight of the medical care provided, contractual relationships and organization of the providers giving care, and the covered benefits.

Managed Care continues to dominate the health care financing and delivery system in the United States. In Connecticut, most health plan consumers are enrolled in managed care plans. During the past several years, the individual and commercially insured, employer-sponsored segment of the Connecticut population has been joined by many Medicare beneficiaries who have enrolled in managed care plans.

The Office of the Healthcare Advocate helps individual Connecticut consumers enrolled in all types of health coverage, including private and public plans. While the office was created to promote and protect the interests of covered persons under MCO health plans in Connecticut, a major responsibility of the office involves educating consumers about their rights and how to advocate on their own behalf when they have a problem or concern about their healthcare plan. We can answer questions and assist consumers in understanding and exercising their rights to appeal a managed care plan's denial of a benefit or service.

By law, OHA is authorized to represent Connecticut residents in administrative matters, monitor implementation of state and federal laws, and facilitate comment on those laws.

On the state and national levels, OHA has been very active in promoting healthcare consumer interests in Medicaid and fully-insured and self-insured plans.

OHA pushes for systemic reforms based on data and health policy, and as the state's healthcare watchdog, OHA continues to push for accountability and transparency in healthcare costs, spending and quality of care. The Healthcare Advocate is also the Vice-Chair of the Access Health CT Board.

OHA's focus on implementation and enforcement of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and better access to needed behavioral health and preventive services for all Connecticut residents, and continues to work with national and state partners on legislative activities, hearings and task force efforts to address long-term remedies that must be implemented.

"Your response was exceptional, resolving a long standing issue in a few days. The best experience I've ever had with a state agency!"

Federal Involvement and Consumer Assistance Program

After passage of the Patient Protection and Affordable Care Act (ACA), OHA secured the first of four consumer assistance (CAP) grants from the Department of Health and Human Services' Center for Consumer Information and Insurance Oversight (CCIIO). The grants were the result of a concerted effort by the Connecticut congressional delegation and advocacy organizations to ensure that independent healthcare advocacy agencies like OHA would be adequately funded to assist consumers with healthcare issues.

> "Your office was extremely helpful and responsive. I very much appreciate the responsiveness and decisiveness and effectiveness of your staff."

In 2014, OHA received a Consumer Assistance Program (CAP) grant award for $442,863. This grant followed three previous grants awards of $127,967, $396,400 and $408,155. OHA recently replaced three previous grant positions and enhanced its data systems and reporting capabilities.

Under the ACA, all plans, whether self-funded or fully insured, are required to include OHA's contact information on every denial issued, informing consumers that OHA can assist with grievances and appeals. This requirement, in addition to Connecticut's similar law, led to 1,865 referrals to OHA in CYs 2012, 2013 and 2014.

OHA conducted two television spot campaigns, running spots in English and Spanish throughout the state. The office also conducted extensive outreach to towns throughout Connecticut and through media appearances and in-person outreach and education events in underserved markets.

OHA Nurse Consultant Jackie Murillo with WKND1480/WLAT910/WNEZ1230 Radio Station, East Hartford, CT

Collaborations

A. OHA and the Navigator and In-Person Assister Program

In 2014, OHA and Access Health CT, Connecticut's Health Insurance Marketplace, completed the rollout of the Navigator and In-Person Assister Program, enrolling tens of thousands of individuals into healthcare coverage with an aim of reduce disparities in healthcare coverage and access to care. The program, initially trained community assister organizations and six navigator organizations around the state, ultimately training over hundreds of community organizations, including health centers, hospitals and other community organizations committed to helping Connecticut residents get covered.

The NIPA program accommodated thirty two languages and provided regular newsletters to participants with timely information on updated enrollment information and materials for assisters and navigators. Because the program was dedicated to consumer engagement and empowerment deep into Connecticut's diverse communities, it allowed OHA to reach and assist more consumers than we reached prior to the establishment of the NIPA program.

OHA has partnered with community partners, Access Health CT and the Department of Social Services (DSS) to try to develop of a sustainable year round model of consumer assistance at the community level to ensure continued access to healthcare coverage and community engagement in statewide health reform efforts.

B. OHA and the Department of Children and Families

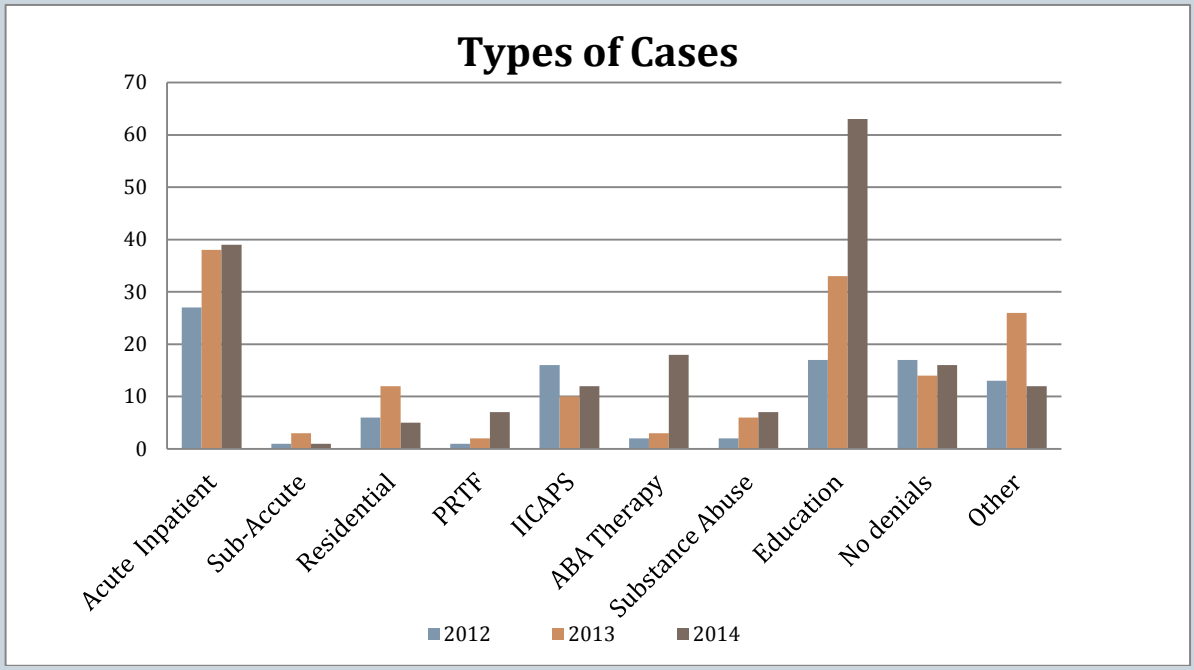
OHA and the Department of Children and Families (DCF) continued a successful collaboration in which families with private healthcare coverage seeking services from the DCF Voluntary Services Program are sent to OHA for assistance. Because of the success of the program, OHA the FY 15 budget revisions included a position for a mobile utilization review nurse to assist DCF facilities in obtaining needed approvals for services. The UR nurse came on board in October 2014.

Under the collaboration, OHA's dedicated staff:

- Counsels families on their rights under their health carrier, including the right to appeal denials of coverage and assists with these denials;
- Educates and assists families to navigate through the insurance system to obtain mental health and medical benefits per their plan;
- Educates DCF Voluntary Services team members about the proper use of primary healthcare coverage to prevent unnecessary state spending;

- Ensures that planning for children who need out of home placement on a temporary basis is done concurrently by a provider and the Connecticut Behavioral Health Partnership in collaboration with DCF Voluntary Services;
- Conducts internal and external appeals for medically necessary services for all types of healthcare coverage for referred families;
- Participates in ongoing planning and subsequent appeals for children and adolescents referred to OHA for a range of services from home-based and outpatient services to acute psychiatric services;
- Provides unique outreach presentations to Providers, DCF Voluntary Services, organizations and consumers to enhance knowledge on how the healthcare system works and the collaboration efforts between DCF and OHA to save money for state healthcare expenditures as applicable;
- Educates and counsels state facilities and providers to submit claims for private insurance coverage to increase state savings and reimbursements. Educates and counsels state facilities in the appeal and external review process;

Since its initiation, OHA's collaboration with DCF has saved over $4 million ($ 2.5 million in state savings and $1.5 million in consumer savings). OHA has handled 422 cases. Many of the cases OHA handles under the DCF project are for children who need acute levels of care. The project is a win-win in that it avoids cost-shifting of high-cost care to the state and allows OHA to educate Connecticut families about the value of their health coverage.



C. OHA and the Department of Developmental Services (DDS)

Based on the success of the DCF collaboration OHA is working with the Department of Developmental Services (DDS) to receive referrals for consumers who have contacted DDS for Autism Spectrum Disorder Services in order to maximize their utilization of all available private health plan reimbursement options.

D. OHA and the Office of the State Comptroller (OSC)

OHA partnered with the OSC to provide support to its Disability Retirement Unit (DRU) for the review and evaluation of disability applications. The process includes a significant clinical component for which OHA's clinical case management processes is ideally suited. OHA recruited a Nurse Consultant to be housed within the DRU, provided training in our case management processes, and continues to provide support for the position. This project has aided the DRU in increasing the volume and completeness of applications processed for review and determination by the Medical Examining Board.

E. Behavioral Health Clearinghouse (BHC)

P.A. 14-115 tasked OHA with the creation of "an information and referral service to help residents and providers receive behavioral health care information, timely referrals and access to behavioral health care providers". OHA conducted planning meetings with partner state and community agencies, advocates, behavioral health providers, health plans and others to promote comprehensive representation in the design and implementation process. Two UConn MSW interns began at OHA in September 2014 and OHA hired two budgeted project staff in October 2014. Since that time OHA has developed an exhaustive model for the BHC, including a comprehensive informational and referral consumer website and parameters for a consumer call center. Robust outreach efforts continue and include medical and behavioral health providers, consumers, advocate and state partners, with emphasis on the recruitment for and formation of workgroups to advise the development of the clearinghouse. The identification of possible funding sources for the BHC's components and development of a sustainable funding source is ongoing.

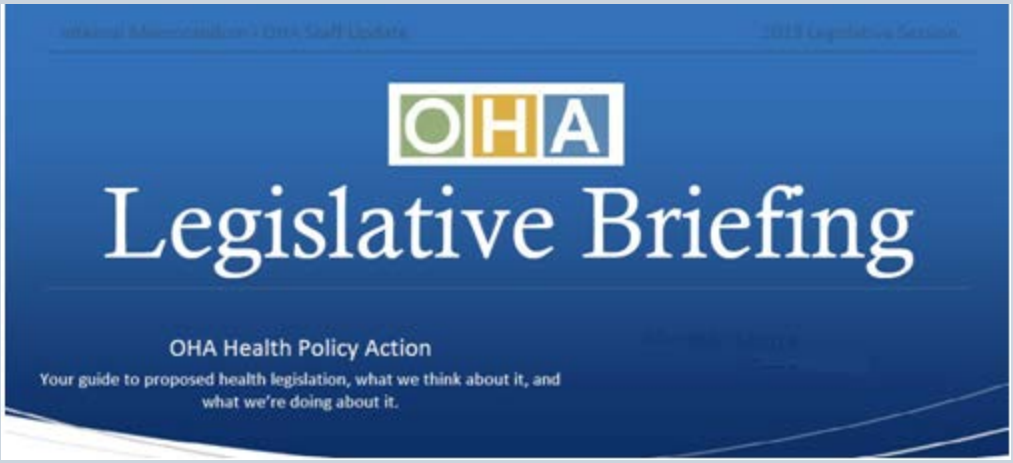
Legislative Summary

In 2014, OHA continued to receive extensive support to support its mission to assist Connecticut's healthcare consumers. In 2014, OHA testified on 30 bills to promote consumer protections and access to care, including support for the recommendations of the behavioral health task force and clinically appropriate reviews of requests for mental health and substance use services in commercial insurance plans. OHA also continued to advocate for legislation to improve transparency in healthcare pricing, improve quality and access to care. OHA successfully advocated for enhanced consumer notice requirements concerning liability for facility fees as well as a patient's status when in the hospital to ensure consumers are aware of the consequences of health coverage for being placed on observation status.

OHA appeared before the following committees during the 2014 legislative session: Insurance and Real Estate, Children's, Appropriations, Finance, Revenue and Bonding, Public Health, Labor and Public Employees, General Law and Human Services.

OHA expects to support: a) further initiatives to improve access to mental health and substance use preventive and treatment services, b) initiatives to increase transparency in healthcare costs, pricing and quality and c) efforts to promote alignment toward achieving the triple aim. (See Section on State Innovation Model Initiative.)

Click on the image below to read our legislative testimony.



Consumer Feedback:

"Your services are superlative and indispensable. I have never before encountered such an effective state agency"

"Your help may have saved my life."

"This agency is extremely important to help people.

"Wonderful, helpful, professional and caring. I appreciate all that they have done for me and continue to do."

"Careful, helpful and prompt with replies. Superb support!"

"Invaluable & professional service – great staff!"

Consumer Relations

In 2014, OHA fielded 12,149 calls on its toll free line from January through December 2014 and hundreds of additional calls or emails directly to staff.

The number of cases referred from legislators has steadily increased. We continue to encourage legislators and agencies to refer cases directly to OHA for high-quality real time services. Legislators, providers and consumers know that OHA operates in real time and via direct contact with consumers on: educational cases, medical and behavioral health issues and legal matters. Consumers are very satisfied with our services.

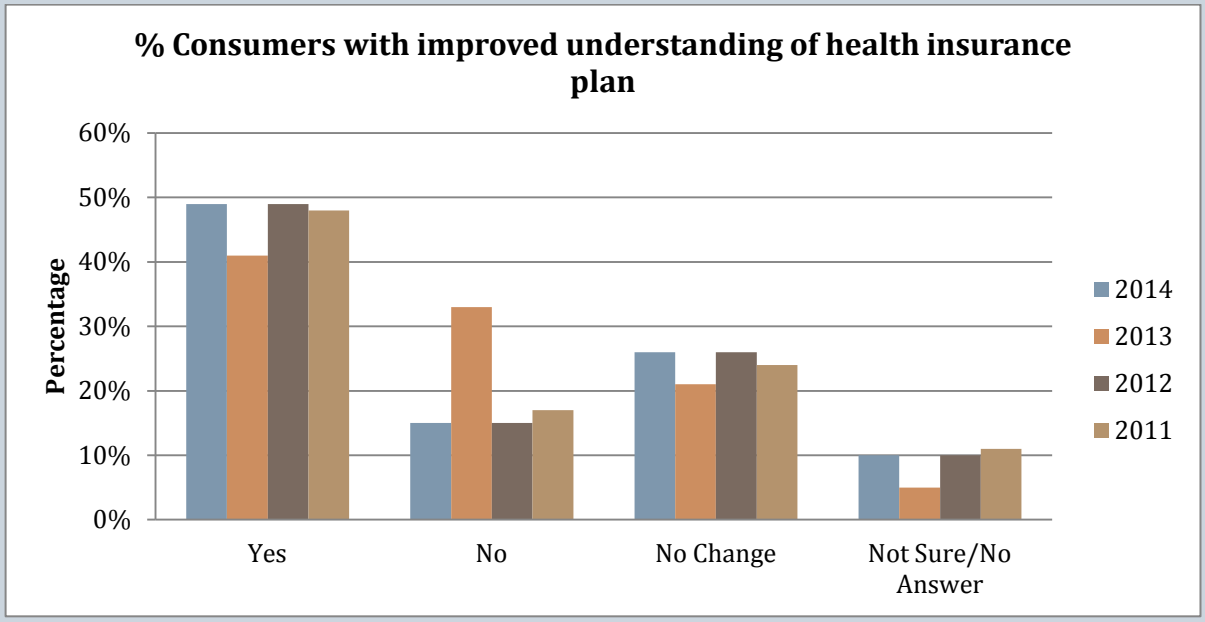
Though denials of services or treatment remains the highest category of complaints OHA receives, the number of cases involving education and counseling increased rapidly because of health reform activities.

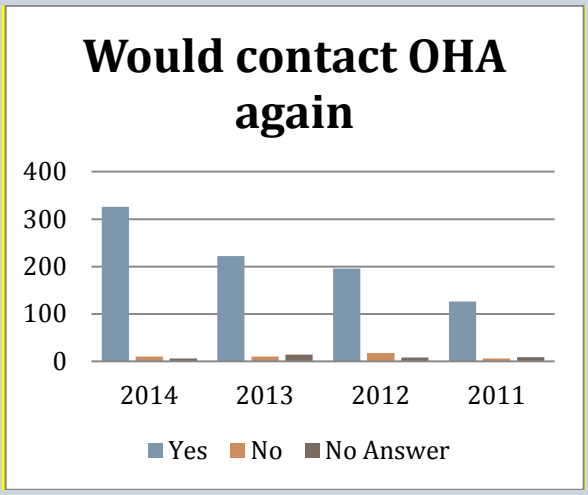
Mental health continues to be the biggest clinical category of cases OHA handles. Fortunately, OHA's advocacy resulted in reversals of denials of treatment or services that involve consumers needing treatment for serious, debilitating, or life-threatening illnesses.

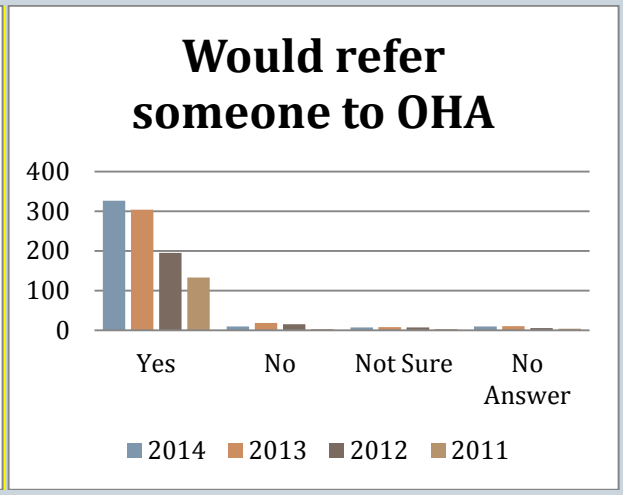
State Comptroller Kevin Lembo (and former Healthcare Advocate) and State Healthcare Advocate Victoria Veltri

OHA opened 7,117 cases in CY 2014. OHA closed 6,855 cases in 2014, an increase over CY 2013 levels of 1,434 cases opened and 3,258 cases closed, respectively.

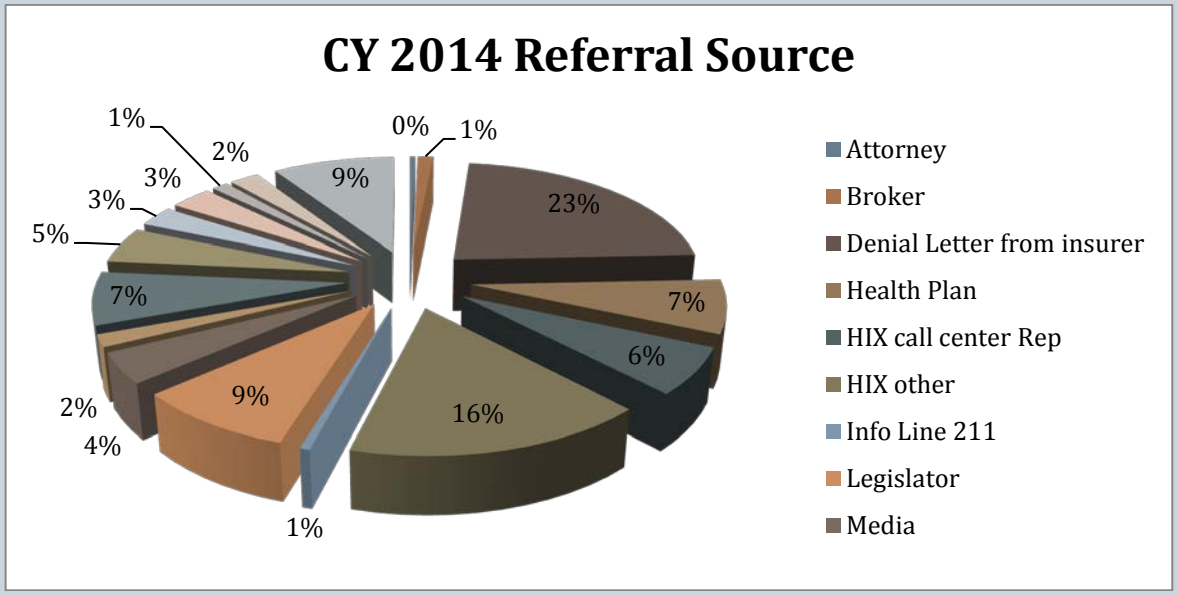
OHA's consumers continue to give OHA very high ratings. A very high percentage of customers would refer someone to OHA. OHA considers this measure the most important measure of OHA's services. The percentage of individuals reporting that they would refer a friend or family member to OHA and would contact OHA continues to increase. The percentage of individuals reporting that they have an improved understanding of their healthcare plan after contacting OHA continues to increase.



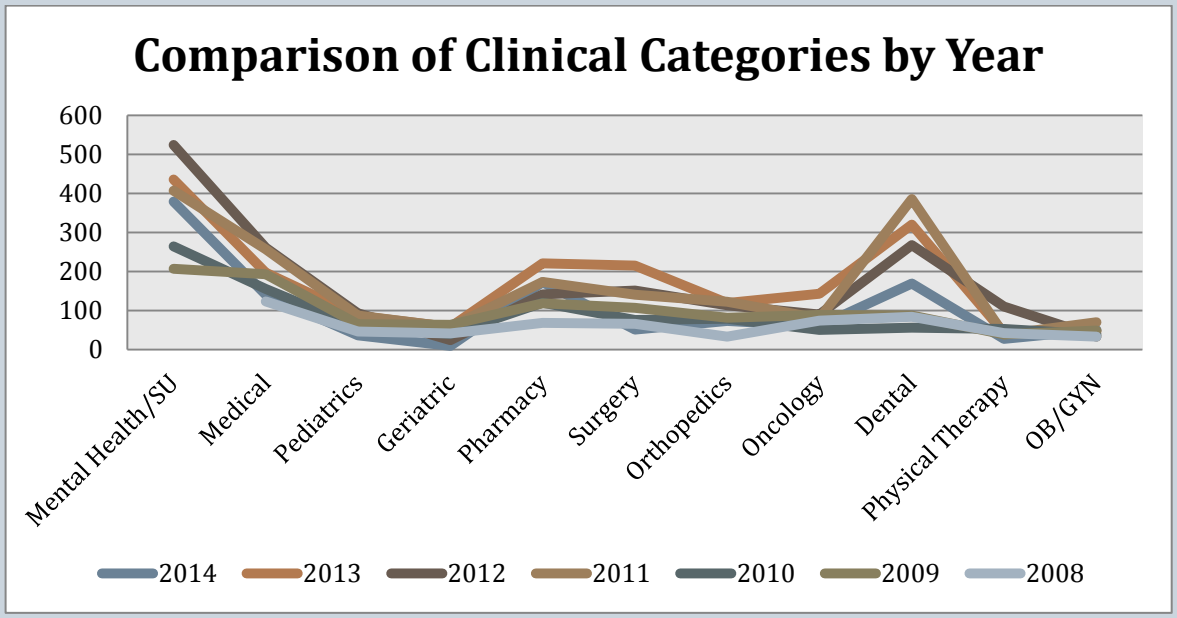


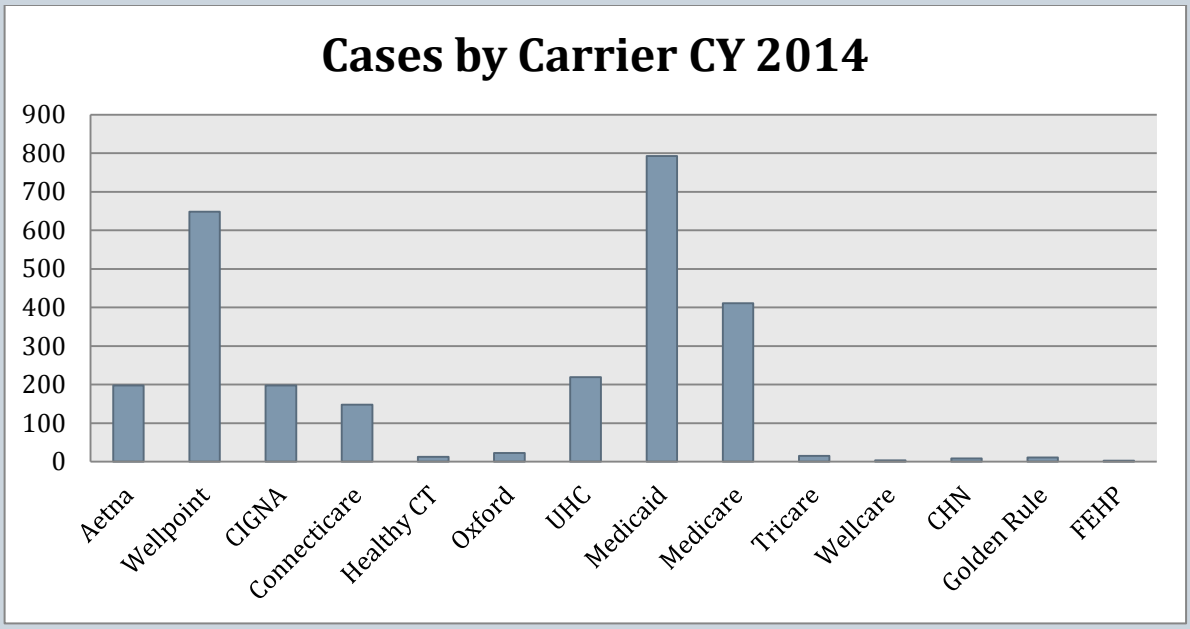


Cases continue to arrive to OHA from a variety of referral sources.

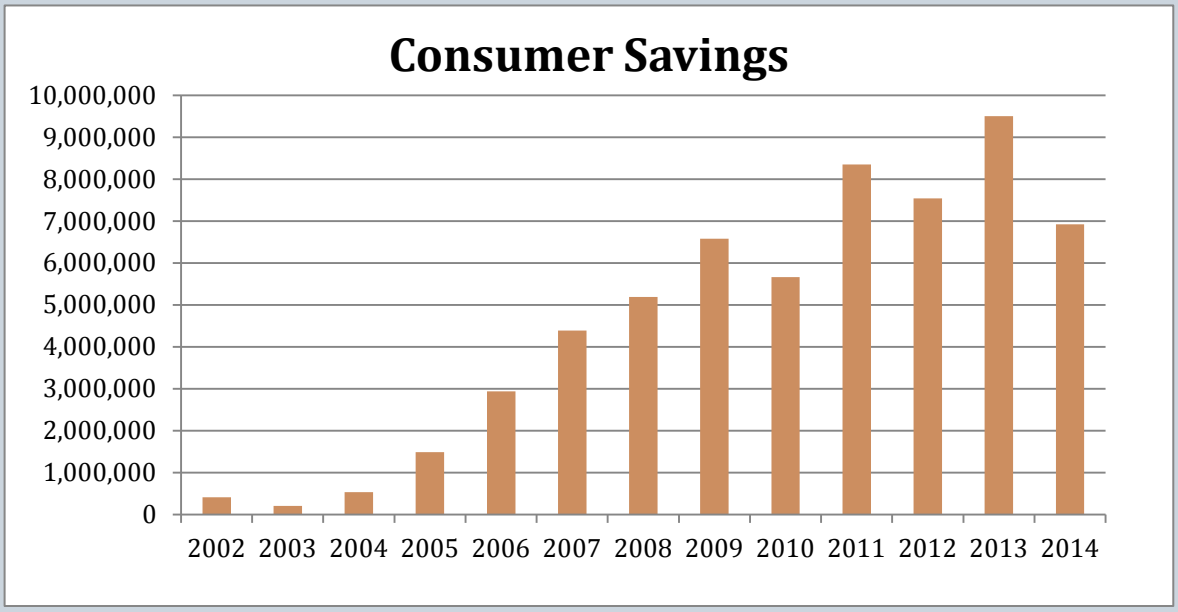


OHA continued to receive cases in a wide range of clinical categories, with mental health/substance use remaining the predominant area of need for assistance.

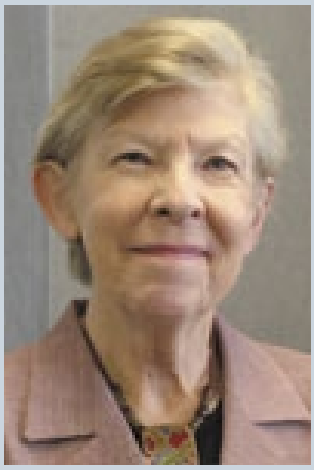




OHA's advocacy returned $6,924,978 million to the residents of Connecticut in 2014. Although this represents a decrease of $2,575,030 2013's savings, this reduction in savings is attributed to staff medical leaves, increased coaching/advice case volume and a considerable volume of cases related to Access Health CT and Medicaid enrollment issues. In addition, several cases in 2013 had very large savings of up to $1 million each.



Finally, Maureen Smith, OHA's longtime Director of Consumer Relations and a passionate and highly successful consumer advocate, retired in 2014 after 13 years with OHA. Maureen's knowledge and expertise helped OHA to become the agency it is today. Her legacy lives on in the office through the tremendous work of the staff she mentored.



Lt. Governor Nancy Wyman, State Healthcare Advocate Victoria Veltri and OHA Nurse Consultant Jackie Murillo

Consumer Stories

T.V. is a 54 year old woman whose health plan denied coverage for recurrent ovarian cancer chemotherapy medication ordered by her provider at Smilow Cancer Hospital. T.V. underwent many courses of chemotherapy since 2010, and unfortunately was diagnosed with a recurrence in the summer of 2011. Her health plan denied coverage for the course of treatment plan recommended by her treating physician, instead suggesting an alternate chemotherapy medication.

T.V.'s clinical history was quite complex. A CAT scan done in early 2014 demonstrated that prior treatments, which included the chemotherapy the health plan recommended, were unsuccessful treating her tumors. Instead, the scan showed a significant progression of her disease, with a 50% increase in the size of her tumors. T.V.'s provider recommended that she begin a new course of treatment with Abraxane, with which he had success with similar patients with in the past.

OHA intervened and, following exhaustive research and appeals, was successful getting the health plan to acknowledge T.V.'s history, including her failed intervention with the health plan's recommended chemotherapy. The health plan reversed its denial and agreed to cover her treatment with the medication prescribed by her doctor. Nine infusions were covered, saving T.V. $107,226 in out of pocket costs that she would have had to pay if her health plan had not covered the medication.

P.T. had a significant history including a bleeding disorder, stroke and a brain tumor. Her doctor could not operate on P.T.'s brain tumor until her heart was repaired. P.T.'s health plan denied coverage for a cardiac ablation, concluding that the procedure was experimental for her cardiac defect. However, the ablation was necessary because the only other procedure to correct the defect posed a greater risk for her, given her medical history. OHA filed an expedited appeal on P.T.'s behalf, the denial of coverage was overturned and the cardiac ablation was approved. As a result, the consumer saved$106,989.

A.W. is a 31 year old woman diagnosed with cervical and vaginal cancer, with extension into the parametrium. Based upon her history and presentation, her doctor prescribed a course of chemotherapy, followed by a radical hysterectomy. The health plan denied this treatment plan, citing alternate guidelines for the treatment of her cancer, recommending radiation and a different chemotherapy regimen. However, this course of treatment failed to account for a key clinical finding of A.W.'s disease, and would have been less effective than her doctor's recommendation.

An OHA case manager filed an expedited appeal of the health plan's decision to deny coverage for the recommended treatment plan. The case manager included peer reviewed studies of the benefits of the doctor's proposed treatment of A.W.'s condition that demonstrated a 14% higher 5 year survival rate than the health plan's recommendation.

Following the review of the clinical information and summary of A.W.'s history, the health plan overturned its initial denial and agreed to cover the doctor's proposed treatment, saving A.W. $57,000.

S.D. reached out to OHA for assistance getting coverage for her 11 year old son's Applied Behavioral Analysis (ABA) therapy under the family's self-funded health plan. The family requested 35 hours per week of school-based ABA services, as requested by the child's provider. However, the health plan partially denied the request, instead approving only 20 hours of ABA therapy and denying anything beyond that as not medically necessary.

The child attended a private day school specializing in educating children with autism spectrum disorder (ASD). The school required that each child with ASD have an ABA-trained provider with him at all times while in school. Without this level of therapeutic support, the school would not permit this child to remain enrolled. In order to ensure that their son received the most appropriate treatment and best education he could, his parents paid for the additional 15 hours of ABA therapy themselves.

OHA appealed the denial, unsuccessfully, throughout the internal appeal process. OHA then filed an external appeal for this child. The external reviewer wrote, "Based on the patient's symptoms, ABA is the treatment of choice for this patient. 35 – 40 hours weekly of ABA is the generally accepted standard of care. The fact that the patient has responded to a less intensive level is not a compelling argument that this treatment is satisfactory. On the contrary, it is an indication that the patient would likely have an even better response to a more intensive level of treatment." This refutation of the health plan's decision saved the family $46,506 and, most importantly, enabled the child to continue to his education and treatment in the most clinically appropriate and beneficial setting.

R. M. is a 58 year old male who contacted OHA for assistance clarifying his health insurance coverage options. In the beginning of 2014, he was covered under a health plan offered by his employer. Shortly thereafter, his employer eliminated his position and, for a variety of reasons, he ended up without healthcare coverage. Later in 2014, he had a significant medical condition, a duodenal perforation that required an emergency admission and surgery to repair the damage. Unfortunately, he experienced multiple post-operative complications and became critically ill, diagnosed with septic shock, acute respiratory failure, and acute renal failure.

R.M. remained hospitalized in the intensive care for several months and his doctors were unsure if he was going to survive. In addition to worrying about her husband's health and prognosis, R.M.'s wife was

overwhelmed by medical bills, the first of which was for $454,186, and the couple felt that the only option was to pursue bankruptcy.

OHA staff discovered that R.M. should have been offered the option to continue his employer-based healthcare coverage under COBRA. After significant research and intervention, OHA successfully had R.M.'s COBRA coverage reactivated, providing him with coverage for his treatment, with anticipated total costs well in excess of $1 million. R.M. is currently recovering at home, and OHA continues to assist him with coverage for the outstanding bills and costs.

C.R. is a 65 year old woman with a progressive history of increased weakness and debilitating pain beginning in 2008. She was no longer able to work and ultimately became disabled. She visited multiple doctors near and far, but none were able to diagnose the problem. C.R. consulted numerous neurologists, rheumatologists, psychiatrists, cardiologists, internists, neuroimmunologists, and pain management specialists (more than 25) in the past 5 1/2 years and was on more than 20 different medications in an attempt to manage her symptoms.

This quest for answers and a cure resulted in hundreds of thousands of dollars of medical services, and C.R. and her family exhausted most of their savings looking for treatment and diagnosis. Last year, she was referred to a specialist New York, who diagnosed her with chronic inflammatory demyelinating polyneuritis (CIPD) and started her on an aggressive course of treatment of plasmapheresis and IVIG. Within months her symptoms greatly improved and her pain significantly lessened, requiring fewer medications to manage her symptoms and greatly improving her quality of life.

However, C.R.'s specialist was an out of network provider. The family requested that the health plan cover the costs as if in-network, because of the lack of appropriate available in-network providers. In-network coverage was denied by the health plan. C.R. filed an initial appeal on her own and the health plan upheld the decision to deny coverage of the doctor in New York. OHA reviewed the case and filed an external appeal for one period of services that C.R. received to be covered as if in-network, with charges totaling $13,130. The external reviewer overturned the denial. OHA is appealing the remaining treatments with this provider.

M.R. is a 44 year old mother of three teenage boys. She was recently diagnosed with Stage III breast cancer and underwent a bilateral mastectomy. She completed 12 weeks of chemotherapy treatments and 6 weeks of radiation. She had reconstructive surgery and several weeks later received an Explanation of Benefits indicating that the surgery was denied because it was considered cosmetic. OHA intervened and was able to get the decision reversed and the reconstructive surgery covered saving M.R. $20,000.

Advocacy for Individuals with Mental Health and/or Substance Use Services Needs

Under Conn.Gen.Stat. § 38a-1041(e) shall, "establish a process to provide ongoing communication among mental health care providers, patients, state-wide and regional business organizations, managed care companies and other health insurers to assure: (1) Best practices in mental health treatment and recovery; (2) compliance with the provisions of sections 38a-476a, 38a-476b, 38a-488a and 38a-489; and (3) the relative costs and benefits of providing effective mental health care coverage to employees and their families. On or before January 1, 2006, and annually thereafter, the Healthcare Advocate shall report, in accordance with the provisions of section 11-4a, on the implementation of this subsection to the joint standing committees of the General Assembly having cognizance of matters relating to public health and insurance."

OHA's advocacy in this area is based on our extensive experience in advocating for consumers with complex behavioral health needs and our success in overturning denials of care in state-regulated and solely federally-regulated plans.

OHA participated with advocates, providers, state agencies, consumers and carriers on the legislative behavioral health task force created by P.A. 13-3 and on the task force established under P.A. 13-178, designed to establish of an effective behavioral health system for children

OHA continues to partner with the Parity Implementation Coalition, PIC, a national advocacy coalition, to ensure that the promise of the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is fully realized for all of Connecticut's residents, including those who are covered by self-funded health plans, that are regulated solely by the federal government.

Results of Connecticut Health Foundation grant study

Consistent with our mandate to ensure communication concerning best practices in mental health treatment and recovery, OHA received an $85,000 grant from the Connecticut Health Foundation to conduct an objective study of the effectiveness of the pay-for-performance (P4P) strategies of the Connecticut Behavioral Health Partnership (CTBHP) to determine whether such strategies, if effective, might be used to improve treatment and recovery models in private health plan models and/or be used more broadly within the CTBHP or elsewhere.

The finding of this study supports the P4P program's success contributing to a reduction in the length of stay as well as readmissions or increased emergency department utilization by program participants, which suggests that the P4P promoted better outcomes for consumers in the program and generated cost savings for the treatment.

Another salient finding that limited the study's conclusions was the challenge of accessing claims data for program participants. Sample sizes, delays in receipt and limitations of the information reported of the data

all contributed to limit the granularity with which the P4P could be studied. OHA is working with the Behavioral Health Partnership and DSS to ensure access to Medicaid program data could lead to more detailed studies of initiatives such as the P4P.

State Innovation Model Initiative (SIM)

The SIM is an initiative of the federal Center for Medicare and Medicaid Innovation (CMMI), created by the ACA, with a charge to participating states to design a plan for comprehensive reforms in healthcare delivery and payment that will reach 100% of the state's population within five years. Under the leadership of Lt Governor Nancy Wyman, Connecticut developed its plan to promote the "Triple Aim" for everyone in Connecticut: better health while eliminating health disparities, improved healthcare quality and experience, and reduction of growth in healthcare costs. An independent project management office (PMO) is housed in OHA, and continues coordinating SIM activities, including the build out of taskforces and councils on quality, practice transformation, workforce, health information technology, and equity and access.

In December 2014, CMMI awarded Connecticut a $45 million to implement its plan. Connecticut's Test grant application is the product of a shared vision of a broad range of stakeholders to establish primary care as the foundation of care delivery that is consumer and family centered, team based, evidence driven and coordinated, and in which value is rewarded over volume. Our approach is rooted in primary care and prevention, integrated community resources, and accessibility to our residents.

The grant award will enable us to test whether a comprehensive set of statewide transformation initiatives accelerates improvements in the performance of the healthcare system for all CT residents, while protecting against under-service. We will also determine whether a new Medicaid Quality Improvement and Shared Savings Program (QISSP) combined with a two part strategy to transform primary care will further accelerate the pace of change and performance of participating providers and that improvements in performance will be of particular benefit to Medicare, Medicaid, & CHIP consumers with chronic illnesses, significant care coordination needs, and social determinant risks. The two-part strategy includes an Advanced Medical Home program to strengthen the primary care foundation and a Community and Clinical Integration Program to develop special capabilities such as dynamic clinical teams. The initiative also focuses on population health planning, primary care transformation, value-based insurance design, aligning all payers around a common set of quality measures and payment reforms, health information technology, and workforce development.

The implementation of the grant will continue under a process embracing broad stakeholder input and alignment. The PMO works with taskforces and councils on quality, practice transformation, health information technology, and equity and access. The steering committee chaired by Lt Governor Nancy Wyman and comprised of providers, consumers, consumer advocates, state agencies, employer and payers will continue to guide the initiative. The Consumer Advisory Board provides support to the councils and advises the steering committee on key consumer issues such as the potential for under-service in value-based payment designs.

Denise Ramoutar, MPH, Outreach Coordinator/Data Analyst at Goodwin College Health Fair

Office of the Healthcare Advocate Biennial Budget

MCO39400

Position Summary Account	Actual FY 14	Original Appropriation FY 15	SIM FY 15
Permanent Full-Time – IF	17	20	9

Budget Summary Account	Actual FY 14	Original Appropriation FY 15	SIM FY 15
Personal Services	$1,339,621	$1,520,119	$ 580,708
Other Expenses	$ 326,267	$ 476,267	$2,225,000
Equipment	$ 5,000	$ 5,000	$ 10,000
Fringe Benefits	$ 947,599	$1,322,502	$ 396,567
Indirect Overhead	$ 27,229	$ 142,055	$0
Nonfunctional –Change to Accruals	**$ 12,157**	**$ 193,883**	**$0**
Agency Total – Insurance Fund	**$2,657,873**	**$3,659,826**	**$3,212,275**

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ANNUAL REPORT CY 2014

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