Preliminary view of model that achieves goals of coverage and care

I) Creation of Quasi Public Trust charged with:

Administration of coverage programs in which state of Ct. has an investment in managing value

a. data collection and analysis
b. Monitor risk segmentation and address adverse selection, as needed
c. Health Planning
d. Establishing standards
e. Establishing timing for phase in of coverage and system changes
f. Portfolio to include state employee plans, charter oak, newly created coverage options; option to include Husky/SAGA/Medicaid/Medicaid PCCM in future
g. Serve as liaison with plans outside of this portfolio
h. Monitor directly or indirectly progress towards reduction of racial and ethnic health disparities
i. Appointments to Trust to represent broad stakeholders group

II) Quality improvement and cost containment

a. Improving quality through transformation of delivery system
(* indicates potentially cost-saving initiatives)
   i. Achieving "medical home" status: process and rewards*
   ii. Chronic disease management, care coordination, care management, and case management: subset of the Trust, community based if unable to do at the practice level*
   iii. Health Promotion and prevention, with incentives for individual responsibility*
   iv. Value based plan design that incorporates evidence based medicine*
   v. Integration of primary care with oral and behavioral health*
   vi. Patient safety standards*
   vii. Data collection and transparency
   viii. Electronic Medical records: accelerating adoption, incentives and support*
   ix. Achieving 100% e-prescribing across Ct.*
   x. Auto-enrollment in Medicaid at point of licensure for providers
   xi. Incrase Medicaid rate to 100% of Medicare
   xii. Include CHC and school based clinics*
   xiii. Auto-screening and enrollment in Medicaid for uninsured at point of service as well as on-line screening for eligibility
   xiv. Workforce development (reference Tonya Court report)

xv. Public education on living wills*

b. Cost Containment (** indicates potentially quality improving initiatives)
   i. Pooling of risk
   ii. Self Insurance
   iii. Minimum medical loss ratio
   iv. Pay for performance**
   v. Reduce cost shifting for uncompensated care
   vi. Value based plan design**
   vii. Expanded IT**
   viii. Medical Malpractice
   ix. Revise consumer protections and insurance mandates to align with evidence based and value benefit design under aegis of Trust
   x. Care coordination**
   xi. Reduce admissions for ambulatory care sensitive conditions
   xii. Universal
   xiii. CON

III) Coverage
   a. Satisfied customers can keep existing coverage
   b. CT Health Partnership (state employee pool)
      i. Provide parallel options to individuals and businesses
      ii. Make options attractive by incorporating Value based design (public, transparent process)
      iii. Expand benefits to include oral health and mental health
   c. Maximize federal participation-- convert SAGA to Medicaid (CMS waiver required)
   d. Enrollment in coverage
      i. Through Trust for new coverage options
      ii. Automatic enrollment in HUSKY, SAGA at point of service for eligibles
   e. Shared responsibility as the underlying principle: individuals, employers, and government all play a role in achieving our goals.

IV) Financing based on shared responsibility
   a. Business Contribution: employer share of health costs of individuals
   b. Individual contribution: share of health costs based on sliding scale and affordability index

c. Government contribution to support affordability
    i. Existing revenue streams
    ii. Sin taxes
    iii. Bonding for specific initiatives
    iv. Additional federal funds