

Connecticut State Innovation Model

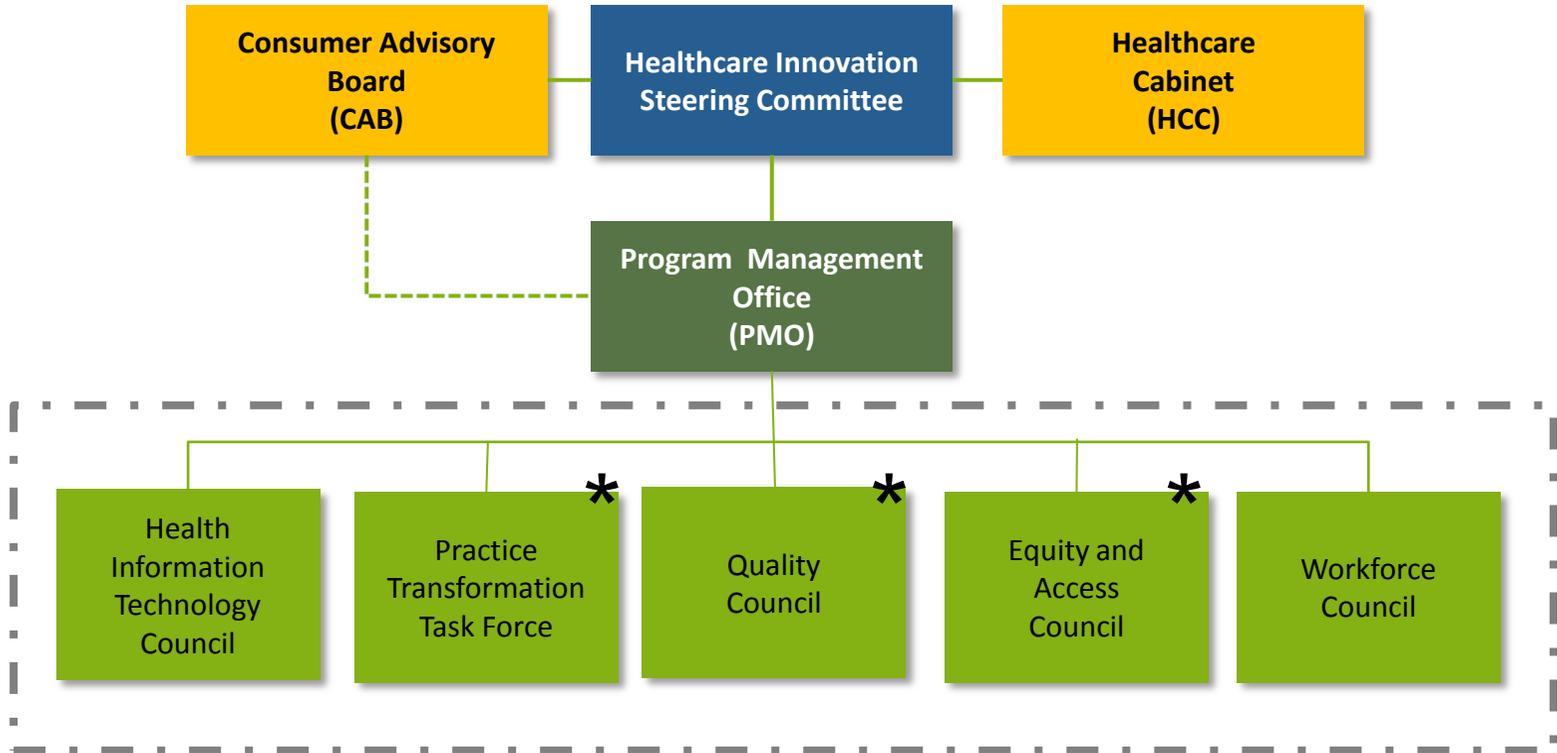
Workgroup **Charters**

3.0

Presented at the Consumer Advisory Board Meeting

05/27/14

SIM WORKGROUPS



* Draft charters attached

PRACTICE TRANSFORMATION TASK FORCE

Charter

This Task Force will develop for recommendation to the Healthcare Innovation Steering Committee, a proposal for the implementation of the Advanced Medical Home (AMH) model under the Connecticut Healthcare Innovation Plan (SHIP). The AMH Model has five core components: (1) whole-person-centered care; (2) enhanced access; (3) population health management; (4) team-based coordinated care; (5) evidence-informed clinical decision making. This work group will develop the advanced medical home standards, detail the design of a “glide path” program in which providers are offered practice transformation support services for a limited period of time, advise on the process for vendor selection for practice transformation support and practice certification, and coordinate with interdependent workgroups and initiatives. The Task Force will identify key stakeholder groups whose input is essential to various aspects of the Task Force’s work and formulate a plan for engaging these groups to provide for necessary input. The Task Force will convene ad hoc design teams to resolve technical issues that arise in its work.

Key questions this work group needs to answer

Standards

1. What are the medical home standards in use today by the national accrediting bodies and Connecticut’s health plans?
2. Which of these standards align with and would best achieve the AMH core components (listed above)?
3. What additional standards should be considered that are not in use today? (e.g., oral health; NCLAS)
4. What standards should be established for coordinating with behavioral health homes and prevention service centers?
5. Of the above standards, which standards represent core capabilities that are achievable for small practices and essential for improving value?
6. Should the standards be applied uniformly, or should there be adjustments based on practice characteristics?
7. Should such standards be applied by site or by group?

Transformation Process

1. What are the criteria that a practice must meet to qualify for the glide path?
2. What readiness tools exist today and which among them should be adapted for use in the Advanced Medical Home program?
3. What are the milestones that correspond to major achievements in the glide path?
4. Which milestones are recommended as a qualification for advance payments?
5. What are the requirements for certification as an Advanced Medical Home?
6. What process should be used to support practice transformation? On-site assistance? Learning collaboratives?
7. How will this taskforce support the transformation pace and process?
8. What technical assistance should be provided to assist practices with selection, implementation, adoption of EHR?

Transformation Vendor Procurement

1. Should there be a single vendor or multiple vendors? Should they be regional or statewide? Should they be funded fixed grant, flat fee per practice, or paid per successful applicant?
2. Should the level of support and pricing depend upon the practice readiness assessment? For example, should there be tiered levels of support based on level of readiness/gaps or the presence or absence of an EHR?

QUALITY COUNCIL

Charter

This work group will develop for recommendation to the Healthcare Innovation Steering Committee, a proposal for a core set of measures for use in the assessment of primary care, specialty, and hospital provider performance. This workgroup will develop a common provider scorecard format for use by all payers and reassess measures on a regular basis to identify gaps and incorporate new national measures to keep pace with clinical and technological practice. SIM aims to achieve top-quintile performance among all states for key measures of quality of care, and increase the proportion of providers meeting quality scorecard targets. The Council will identify key stakeholder groups whose input is essential to various aspects of the Council's work and formulate a plan for engaging these groups to provide for necessary input. The Council will convene ad hoc design teams to resolve technical issues that arise in its work.

Key questions this work group needs to answer

Measures

1. What are the structure, process, patient engagement and experience, efficiency, disparities-sensitive, outcome, and cost measures that are in use today by national quality bodies and CT's health plans? (e.g. NQF, AHRQ, NCQA, CAPHS)
2. Which of these measures should be adopted to measure provider performance, taking into consideration the target conditions identified in the Innovation Plan?
3. Which of these measures should be adopted to measure provider performance, taking into consideration the prevention goals identified in the Innovation Plan?
4. What other measures could be used as indicators for whole-person-centered care, enhanced access, and coordinated care (e.g. behavioral health, oral health)?
5. What measures could be used as indicators of workforce productivity/timely return to work?

Metrics

1. What are the metrics for each of the measures and how will they be calculated?
2. What methods will be used for risk adjustment and exclusions?

Common Performance Scorecard

1. What are the best examples of performance scorecards currently in use?
2. What will Connecticut's common scorecard across all health plans look like?
3. What is the process for all health plans to implement the common scorecard?
4. How will cross-payer analytics be integrated for a given practice profile, including commercial and public payers?
5. Is there a recommended frequency and schedule that could be adopted across payers?
6. How will the common performance scorecard be integrated with value-based payment calculations?
7. How will the scorecards be made available to the public?

Common Care Experience Survey

1. What are the best examples of care experience surveys currently in use?
2. Is there one survey that would best align with the goals of the Innovation Plan? Are there supplemental questions that should be considered?
3. What is the process for all health plans to implement the common care experience survey?
4. One what schedule should the common care experience survey be administered?
5. How will the common care experience survey be integrated with value-based payment calculations?
6. How will the results of care experience surveys be made available to the public?

EQUITY AND ACCESS COUNCIL

Charter

This work group will develop for recommendation to the Healthcare Innovation Steering Committee a proposal for retrospective and concurrent analytic methods to ensure safety, access to providers and appropriate services, and to limit the risk of patient selection and under-service of requisite care; recommend a response to demonstrated patient selection and under-service; and define the state's plan to ensure that at-risk and underserved populations benefit from the proposed reforms. The Council will identify key stakeholder groups whose input is essential to various aspects of the Council's work and formulate a plan for engaging these groups to provide for necessary input. The Council will convene ad hoc design teams to resolve technical issues that arise in its work. Patient selection refers to efforts to avoid serving patients who may compromise a provider's measured performance or earned savings. Under-service refers to systematic or repeated failure of a provider to offer [evidence-based] medically necessary services in order to maximize savings or avoid financial losses associated with value based payment arrangements. A finding of failure shall not require proof of intentionality or a plan.

Key questions this work group needs to answer – Phase I – Design & Implementation

Setting Context

1. Equity includes assurance that underserved populations aren't subjected to targeted under-service and patient selection. Disparities in quality, outcomes, and care experience will be within the scope of the Quality Council.

Assessing Risk

1. What evidence is available today regarding patient selection and under-service in total cost of care payment arrangements (e.g. ACO, shared savings plan)?
2. Have public or private payers undertaken studies to examine the risk of patient selection or under-service that could inform this council's work?

Guarding against under-service

1. What are the current methods utilized by private and public payers for detecting under-service?
2. Can standard measures and metrics be applied for the detection of under-service?
3. What are the program integrity methods in use today by Medicare / Medicaid and how might such methods be applied to detect under-service?
4. Who will monitor, investigate, and report suspected under-service and what steps should be taken if under-service is suspected?
5. What are the criteria and processes that a payer might use to disqualify a clinician from receipt of shared savings due to demonstrated under-service?
6. What are the mechanisms for consumer complaints of suspected under-service?
7. Given the above, what is the Council's recommended approach for Connecticut's public and private payers to monitor for and respond to under-service?

Guarding against patient selection

1. What are the current methods utilized by private and public payers for monitoring of patient selection?
2. Can standard measures and metrics be applied for the monitoring of patient selection?
3. What are the program integrity methods in use today by Medicare / Medicaid and how might such methods be applied to detect patient selection?
4. What other methods might be available to monitor for patient selection (e.g., mystery shopper)?
5. Who will monitor, investigate, and report suspected patient selection and what steps should be taken if patient selection is suspected?
6. What are the criteria and processes that a payer might use to disqualify a clinician from shared savings arrangements due to patient selection?
7. What are the mechanisms for consumer complaints of suspected patient selection?
8. Given the above, what is the Council's recommended approach for Connecticut's public and private payers to monitor for and respond to patient selection?

Questions this work group may opt to consider – Phase II

1. Network adequacy, provider participation, Medicaid specialty care, timely and necessary services?
2. Care variations and standardization, evidence-based standards?