

**STATE OF CONNECTICUT**  
**State Innovation Model**  
**Practice Transformation Taskforce**

**Meeting Summary**  
**Tuesday, June 24, 2014**

**Members Present:** Lesley Bennett; Mary Boudreau; Claudia Coplein; Leigh Dubnicka; David Finn; Shirley Girouard; Bernadette Kelleher; Edmund Kim; Alta Lash; Michael Michaud; Rebecca Mizrachi; Douglas Olson; Rowena Rosenblum-Bergmans; Elsa Stone; Randy Trowbridge; Joseph Wankerl; Jesse White-Frese; Robert Zavoski

**Members Absent:** Heather Gates; Peter Holowesko; Tonya Wiley

**Other Participants:** Brody McConnell; Mark Schaefer; Marie Smith

Meeting was called to order at 6:06 p.m.

**Introductions**

Robert Zavoski served as the taskforce's temporary chairman. Group members and other participants introduced themselves. Marie Smith, Assistant Dean, and Brody McConnell, PharmD candidate, both from the University of Connecticut's School of Pharmacy, will serve as the taskforce's facilitators.

**House Rules/Executive Team**

The taskforce will operate under an aggressive timeline for the next six months. Members were asked to be involved as much as possible, to focus on what will be best for the state, to aim for consensus, to build on and share ideas, and to share the group's work with their respective constituents.

**Public Comment**

Ellen Andrews, Executive Director of the Connecticut Health Policy Project, provided written testimony ([see testimony here](#)). She spoke in favor of using NCQA as the standard for the Advanced Medical Home (AMH) as they had a track record of success. She also said that Connecticut did not have the time or money required to develop its own set of standards.

Gaye Hyre said she had done a great deal of reading on NCQA and that it appeared to be the best avenue to follow. She said she would rather see funds used for more patient centered activities.

Sheldon Toubman, a staff attorney with Greater New Haven Legal Aid, also spoke in favor of using NCQA standards. He said that the Department of Social Services has seen success in its person centered medical home (PCMH) program, in that providers have enrolled, quality has improved, and money has been saved. He said he was concerned that what is working in the Medicaid program could be harmed under the SIM proposal.

Shirley Girouard asked why the use of NCQA has become an issue and why the state decided to move from NCQA standards to state developed ones. Dr. Zavoski said that could be explained in the next part of the discussion.

### **SIM Background**

Members of each constituent group were asked to volunteer to serve on the taskforce's executive team. Executive team members would need to work with Dr. Smith and Mr. McConnell to organize the group's meetings and work. The executive team will comprise Lesley Bennett (consumer/advocate representative); Rebecca Mizrachi, APRN (provider representative); Joseph Wanklerl (payer representative); and Dr. Zavoski (state agency representative).

The taskforce reviewed the SIM work to date (pages 8-29 of the presentation [found here](#)). The group discussed the decision by the Care Delivery workgroup to pursue a state standard rather use NCQA or another standard (such as URAC or the Joint Commission). Mark Schaefer said the proposal to develop state specific standards would only impact providers who have not gone through the recognition process and did not impact those practices who have already gone through NCQA recognition. The taskforce could decide to uphold the proposal of the Care Delivery workgroup, adopt a specific standard such as NCQA, URAC, or the Joint Commission's, or choose one of those standards with the addition of state required standards such as CLAS (Culturally and Linguistically Appropriate Services Standards).

### **Practice Transformation Charter**

The taskforce reviewed the draft charter ([found here](#) and in pages 31-37 of the presentation [found here](#)). There may be a need for ad hoc groups to solicit feedback from other types of providers that are not currently represented on the taskforce (such as behavioral health, medication management, and oral health).

### **Advanced Medical Home Standards – National Recognition**

Taskforce members formed breakout groups to discuss a path forward with regard to the AMH standards. The breakout groups reported back to the whole taskforce on the following topics: (1) an advantage of using NCQA standards includes the fact that the standards are already developed and have been widely accepted; (2) NCQA standards (compared to state-developed standards) will not be subject to change based on any election/appointment of new state government leaders; and (3) discussions with NCQA staff members have indicated that they would be willing to work with the state to modify/enhance NCQA standards to align with state-specific requirements for its AMH Glide Path. There were several taskforce members who mentioned they were concerned that the process required for state-specific standards may be too random or unique, and the development process could be time-consuming and expensive.

There was consensus that the recommendation should be that the AMH standard follow the NCQA recognition process with the ability to add state-specific standards. Mr. McConnell said that NCQA could work with CT in two ways to expand upon the current 2014 NCQA standard: (1) NCQA can work with the state to determine additional standards for incorporation in their recognition process, and (2) the state will use the standard NCQA recognition process and data feed; but build additional required modules on its own. Some taskforce members asked how choosing NCQA as the standard would impact practices that had already gone through a recognition process. Dr. Schaefer clarified that practices that have already completed the recognition process would not be eligible for the AMH glide path program, and therefore, would not be impacted. They would continue to renew their recognition status as needed. The glide path program is open to practices that have no current PCMH recognition or credential.

Edmund Kim asked how many practices are currently not recognized by NCQA. The general number is 1,600 (this number excludes federally qualified health centers as many have pursued Joint Commission medical home recognition). There are an estimated 400 to 800 practices that may be interested in taking advantage of a no-cost practice transformation PCMH recognition process. The taskforce will need to discuss how to get buy-in from the targeted practices.

In terms of the SIM Model Test grant application, Dr. Schaefer said it could state that the intention is to tie the AMH Glide Path to the NCQA standards and require the NCQA recognition process. The taskforce would work to determine the program specifics. Alta Lash suggested the SIM Model Test funds, if awarded to CT, provide technical and financial resources to help practices with the heavy lift of transformation. Bernadette Kelleher expressed concern that the decision to use NCQA recognition process may be premature and that the thinking may be different in 2016 when the program is set to launch. Dr. Kim said that this recommendation was not in line with the recommendation of the Care Delivery work group, which was made after months of work. Jesse White-Frese asked whether the previous work group was concerned that additional practices would not sign on to NCQA. Dr. Kim said that it was. Elsa Stone said that with proper support the transformation process may not be as difficult and that the Medicaid glide path did encourage a significant number of practices to sign on.

Meeting adjourned at 8:30 p.m.