Response to Public Comments – First Draft - CCIP Report and Recommendations

As of October 6, 2015

Num.	Summary of Comments	PMO Response / Disposition
1	(1) Commenter believes that the three design principles of whole person centered care, health information availability to all, and accountability should be the core principles used to evaluate the standards and that should be noted clearly in the next draft.	(1) Comment addressed in the report.
	(2) Commenter believes that robust data collection should be required in the RFP for AN/FQHCs to analyze outcomes based on race, ethnicity, language etc.	(2) It is part of the CCIP standards that a minimum level of data collection and analytics is required by participants. The transformation vendor will provide technical assistance to participants to assist with robust data collection and analysis. Our plan and budget does not include PMO collection and analysis of participant data. Comment addressed in the report.
	(3) Commenter believes that CCIP's added design features should be more integrated structurally with the MQISSP program.	(3) PMO has engaged DSS in a discussion about integration issues. These issues are not addressed in the second draft of the report.
	(4) Commenter believes CCIP is a good bridge program to integrate social and clinical services, but long-term success will rely on some incentives from payers.	(4) Value-based payment will provide the incentive for improvement in these areas, especially (though not exclusively) where there is alignment with the quality scorecards. PMO anticipates that recommended scorecard will include measures associated with more effective management of complex populations

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		(readmission), health equity gaps, and access to behavioral health (new CAHPS measures).
	(5) Commenter supports the three target populations of core interventions	(5) No change required.
	(6) Commenter supports the focus on diabetes, asthma, and hypertension and believes that the networks should be limited initially to those focus areas.	(6) No change required.
	(7) Commenter supports CHWs as an integral part of the healthcare delivery in the future and believes that there should be a long-term strategy for the certification and recognition of CHWs in the report.	(7) The state's long-term strategy regarding the development of the CHW workforce will be addressed by UConn AHEC as part of the SIM funded CHW work stream.
	(8) Commenter is seeking clarification for how is the State/PMO plans to support real time data analytics to support population health objectives.	(8) SIM funding may support investment in shared analytic resources. The scope of SIM funded HIT investments is being developed in conjunction with the HIT Council. Note that many health systems are investing in these systems and will continue to do so without state support. Value-based payment provides some incentive to make such investments.
	(9) Commenter believes that the SIM budget needs to be revisited to incorporate other financial incentives for CCIP interventions beyond technical assistance.	(9) The PMO is examining the option of innovation awards or transformation grants to providers to support the development of CCIP capabilities.
	(10) Commenter believes that the draft would benefit from more clarity around the standards, whether they are required, and, if they are	(10) Comment addressed in the report.

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	required, what the baseline is and how they are linked to shared savings or other payment models.	
	(11) Commenter supports the Community Health Board concept but believes that it requires more clarity around what support it will receive and its structure so that it can be effective.	(11) Although this concept is introduced in the report, it will be developed further in the coming months. The PMO will work with stakeholders including DSS and DPH to ensure that this concept is coordinated and integrated with existing efforts. The second draft of this section of the report will be disseminated at a later date.
	(12) Commenter believes that the draft in general would benefit from more clarity around baseline requirements and accountability.	(12) PMO to seek clarification about what is intended by this comment and address if possible.
2	(1) Commenter noted that the report would benefit from a thorough fact checking, verification of references, and clarification of definition/terms.	(1) Comment addressed in the report.
	(2) Commenter would like more clarification about how CCIP aligns with the MQISSP and other SIM initiatives (e.g.; QC and workforce development workgroup), how many providers will be selected, and what the selection criteria will be.	(2) PMO has further addressed this comment in the report. The PMO is currently developing materials to better illustrate the relationship between the various initiatives.
	(3) Commenter would like more clarification around the transformation vendor(s), the number of them, and their roles/responsibilities.	(3) This has not yet been determined.
	(4) Commenter believes there should be more clarification about whether the program standards are required or optional.	(4) Comment addressed in the report.
	(5) Commenter believes that the sub-populations within the health equity intervention should be compared across all CCIP participants or between	(5) The Quality Council will examine the requirements for implementing health equity quality measures including the

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	CCIP participants and non-CCIP participants rather than just within a CCIP participating practice.	ability to generate appropriate state benchmarks against, which ANs/FQHCs can compare their performance.
	(6) Commenter believes there should be clarification around the three types of care plans referenced in the report, in particular whether they are referring to the same plan, and how these plans would be shared with the patient.	(6) The PMO has addressed this comment in report noting that the primary care plan will remain intact with components as needed to support comprehensive care management.
	(7) Commenter has additional feedback related to health IT.	(7) The PMO and DSS will continue to work with stakeholders to define CCIP related health information technology needs and to determine how these needs can be supported through technical assistance or SIM-funded technologies.
3	(1) Commenter would like to see provider focus expanded beyond FQHCs and Advanced Networks and to incorporate reproductive health providers.	(1) The PMO is investigating with DSS and other payers whether reproductive health providers can be a PCMH and a source of attribution under MQISSP.
	(2) Commenter would like to see women of color explicitly called out in the health equity standards as a target subpopulation as there is a demonstrated disparity in health outcomes both on the basis of gender and race.	(2) CCIP is focused on developing skills that can be applied to other sub-populations. To be most effective, the PMO believes that the transformation vendor will need to develop expertise in a limited set as specified in report, and in alignment with scorecard equity gap measures. The PMO will ensure that the transformation vendor provides education/training around other health equity areas that should be a focus including women of color.

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	(3) Commenter would like to see reproductive health explicitly called out as required training for CHWs as part of the health equity program.	(3) Comment addressed in the report. This recommendation has also been shared with the leadership of the SIM CHW initiative for consideration in their efforts to develop core competencies and curricula.
	(4) Commenter would like the CCIP standards to recognize that behavioral health screenings can be performed by other providers including OB/GYNs	(4) Comment addressed in the report.
4	(1) Commenter believes that there should be more clarification around the integration of CCIP with existing care coordination efforts, in particular with the PCMH program, to ensure that unnecessary duplication of efforts does not add an extra layer of burden on providers. Commenter believes that the CCIP and the SIM Advanced Medical Home Vanguard program are unintentionally undermining the PCMH program, in particular through the Comprehensive Care Teams outlined in the report.	(1) CCIP establishes minimum standards of capabilities among ANs/FQHCs. It is not intended to supplant activities that are already in place. The transformation vendor will conduct a gap analysis at the start in order to determine which standards or elements have already been met and which standards or elements have not been met. The transformation support will focus on those areas that have not been met. In this way, the CCIP should not disrupt existing care coordination efforts that a provider may have in place as a PCMH.
	(2) Commenter seeks more clarification around the plans to address health equity gaps, in particular how the standards/requirements will support PCMH's efforts in person-centeredness.	(2) Addressing health equity involves changes in the conduct of assessments and intervention methods and tools to help ensure that the entire process is more individualized and thus person-centered. The focus on health equity helps ensure that providers are specifically

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		attending to those individual needs that are related to factors such as race, ethnicity, culture and social determinant risks, in addition to other aspects of person-centered care such as consideration of values, preferences and individual goals.
	(3) Commenter believes that the behavioral health standards duplicate the assistance program begun by CHNCT for Medicaid practices.	(3) As above, if the provider has already addressed a behavioral health capability through assistance provided by CHNCT, it will not be identified as a gap and will not be a focus of CCIP support. In addition, if a provider is receiving CHNCT technical assistance in an area that overlap with CCIP, CCIP support will not be provided in this area.
	(4) Commenter believes that the Community Health Boards concept needs to be readdressed to determine how it can integrate with efforts underway by DPH and local health departments as well as the ACA-instituted non-profit hospital Community Health Needs Assessments.	(4) This concept of Community Health Boards (or collaboratives) is introduced in the report, but will be developed further in the coming months. The PMO will work with key partners including DSS and DPH to ensure that the concept is coordinated and integrated with existing efforts. A revised draft of this section will be provided at a later date.
	(5) Commenter is worried the standards are overly prescriptive in many areas and cites examples in e-consults (networks choose the specialty area, but networks will be expected to pay for services from CCIP's chosen source).	(5) The commenter may have misinterpreted the standards as it pertains to e-consult. Neither the PMO nor the transformation vendor will choose the source of specialty consultation services.

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	(6) Commenter would like SIM to take more time to coordinate with DSS.	(6) The PMO has engaged DSS to coordinate on areas highlighted by the public comments.
	(7) Commenter believes that all standards should be optional.	(7) The PTTF considered this issue and recommended that the standards be required as the core interventions are based on evidence and/or best practices from models around the country. The PMO has written the standards to allow flexibility in how the AN/FQHC chooses to meet the standards.
5	(1) Commenter believes that several terms and wording within the MTM standards would benefit from clarification and rewrites. Commenter has cited several examples within the PDF version of the standards.	(1) The PMO has accepted the commenter's suggestions on terms and wording.
	(2) Commenter advocates for the use of the term comprehensive medication management (CMM) rather than medication therapy management (MTM). Commenter notes that the terms are frequently confused, and CMM is more in line with the CCIP intervention.	(2) The PMO has reviewed the literature and agrees with the commenter's proposed edits, which are reflected in the second draft.
	(3) Commenter notes that the standard for CMM needs to convey the integration of medication therapy management in primary care workflows.	(3) Comment addressed in the report.
	(4) Commenter advocates for the JCPP Pharmacists' Patient Care Process practice model framework for the CMM standards.	(4) The PMO reviewed but did not adopt the JCPP framework at this time since our proposed standards incorporate most of

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		the elements of the framework as they are currently written.
	(5) Commenter advocates for the Collaborative Drug Therapy Management credentials, which is a CT state regulation addressing pharmacist competencies, to be considered as minimum credentials for the CCIP CMM standard.	(5) Although the PMO supports this as a minimum credential, the PMO is not specifying minimum credentials in the CCIP standards at this time.
	(6) Commenter advocates for the pharmacists' CMM recommendations for optimizing the medication regimen need to be shared with the patient/caregivers/ comprehensive care team members as part of a patient's longitudinal care plan -- not a stand-alone MTM action plan.	(6) Comment addressed in the report.
	(7) Commenter advocates for a sustainable reimbursement model needs to be established to assure the long-term integration of CMM services.	(7) SIM has generally taken the position that many new roles and functions can be integrated into practice and supported through shared saving in the same manner that medical assistants and nurses are currently non-reimbursable participants in the primary care team. This does not preclude the limited introduction of FFS or advanced payment solutions for select roles and functions. In some cases payers make such arrangements and net new expenses out of shared savings calculations. In other cases, it may be considered in conjunction with a provider assuming a greater degree of cost accountability.
	(8) Commenter advocates for the CT Medicaid Transformation MTM project to be a reference for a shared service integration model.	(8) This will be considered in a future revision.

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6	(1) Commenter advocates for CHW recruiting and training to start now.	(1) CHW training programs currently exist and will likely expand to meet demand, supported in part by the SIM funded, UConn AHEC led CHW workforce initiative.
	(2) Commenter advocates for patient navigator recruiting and training for CCIP to build off of existing efforts in the state and to start now.	(2) Patient navigator is one role that can be performed by a CHW, the workforce for which will be addressed as above.
	(3) Commenter advocates for pharmacist training for the expanded role outlined in the report to begin now.	(3) The PMO would reference comment number 5 of the CMM comments above and will investigate current numbers of CDTM credentialed pharmacist in the state.
	(4) Commenter requests additional clarity around the Community Health Boards and how local entities would establish them.	(4) This concept of Community Health Boards (or collaboratives) is introduced in the report, but will be developed further in the coming months. The PMO will work with key partners including DSS and DPH to ensure that the concept is coordinated and integrated with existing efforts. A revised draft of this section will be provided at a later date.
	(5) Commenter requests additional emphasis on the concept of Patient Responsibility for their care, such as monitoring of medications, reporting problems, using clinics rather than Emergency Departments.	(5) Although the importance of consumer engagement is discussed in the report, the PTTF did not come to agreement on including language re: patient responsibility. This issue will be reconsidered in the next revision of this report.
	(6) Commenter requests references and standards to care transitions to refer to all transitions of care including admission as well as discharge	(6) Comment addressed in the report.

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	from hospital, skilled nursing facility, rehabilitation or custodial facility all need recognition as flash points for error and confusion, with human and IT needs.	
	(7) Commenter requests additional clarity around how additional infrastructure will be funded.	(7) The PMO is examining the option of innovation awards or transformation grants to providers to support the development of CCIP capabilities.
	(8) Commenter requests additional clarity around how CCIP standards are not duplicative of other care coordination efforts.	(8) CCIP establishes minimum standards of capabilities among ANs/FQHCs. They are not intended to supplant activities that are already in place. The transformation vendor will conduct a gap analysis at the start in order to determine which standards or elements have already been met and which standards or elements have not been met. The transformation support will focus on those areas that have not been met. In this way, the CCIP should not disrupt existing care coordination efforts that a provider may have in place as a PCMH.
	(9) Commenter requests additional clarity around how health IT capabilities for CCIP will be supported.	(9) ANs/FQHCs vary in their ability to support CCIP capabilities with HIT. The PMO is examining options for developing state support HIT solutions that will support CCIP capabilities.
7	(1) Commenter encourages that the role of the caregiver be more strongly emphasized as a member of the comprehensive care team.	1) Comment addressed in the report.

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	(2) Commenter requests that the CCIP report include the recognition that knowledge and information will be freely shared between and among patients, care partners, physicians, and other caregivers, as designated by the patient.	2) Comment addressed in the report.
	(3) Commenter recommends that the Plan acknowledge the time and support that will be required for patients, caregivers, and their providers to engage in the necessary education and training that will be needed as they become active and engaged partners in their care and decision-making.	(3) Comment addressed in the report.
	(4) Commenter recommends that the Plan clearly describe and outline the target population and complex patient definition and suggests the Institute of Medicine's definition of serious and complex medical conditions.	(4) PMO referred this issue to the PTTF for consideration. The PTTF concluded that the IOM definition lacked person-centeredness and elected to retain the current definition of "complex patients" for the report.
	(5) Commenter recommends that the Plan have a mechanism by which providers can provide subjective data based on their experience with the patient.	(5) The PMO did not understand the intent or applicability of this recommendation.
	(6) Commenter encourages the State to proactively establish standards with regard to qualifications, training, specific functions performed, as well as a defined tool kit of interventions and recommends the creation of a Measurement Committee to define a minimum set of standardized information to be captured across practices and systems, and a determination of key performance indicators for the CHW role.	(6) As part of the SIM work plan, the CT AHEC CHW initiative is charged with creating a CHW Advisory Board that will be addressing the standards for CHWs, which many states have addressed through recognition of CHWs through certification or legislation. Connecticut has the opportunity to learn from other states, where they have embraced and incorporated CHWs as critical members of the health and human services team. Items for consideration include a widely

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		accepted CHW definition, the scope of work, the various roles that CHWs fulfill, the training that is required/recommended, and credentialing. The ultimate outcome is for CHWs to be recognized as valuable, sustainable members of health care and community teams. The importance of metrics and evaluation the impact of the CHW's intervention/s is critical, as CHA has discussed in the comments. The topic of measurement is also a concern at the national level. For example, the National Academy for State Health Policy (NASHP), supported by The Commonwealth Fund, is having "A Federal-State Discourse on the Role of Community Health Workers in the Wake of Health Care Reform" this month. It appears that this may also be a focus of the Patient Centered Outcomes Research Institute (PCORI). We will consider further the suggestion of establishing a Measurement Committee with the leadership of the CT AHEC CHW initiative.
	(7) Commenter notes the importance of the Community Care Team – integrated teams of hospital representatives and community partners who work together to address a patient's needs holistically.	(7) Comment noted.

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	(8) Commenter recommends that participating providers receive access to training and resources to support them in their quality improvements efforts.	(8) PMO will consider requiring that the transformation vendor identify or develop such training and resources.
	(9) Commenter recommends that participating providers receive credit for testing interventions utilizing cycle of change methodology (i.e., PDSA) to assess the effectiveness of an intervention prior to implementing, or spreading, the change. Providers should be given the necessary time to test adequately interventions prior to implementing change.	(9) The PMO has addressed this comment in the report and included this with the responsibilities of the transformation vendor.
	(10) Commenter recommends that testing a cycle of change be included in Section 3, and that at least one CHW is included in the Quality Improvement team that conducts the cycle of change.	(10) The PMO has further addressed this comment in the report and included this with the responsibilities of the transformation vendor.
	(11) Commenter recommends that providers also be given the support and training necessary to test and implement quality improvement interventions related to the elimination of healthcare disparities.	(11) The PMO has further addressed this comment in the report and included this with the responsibilities of the transformation vendor.
	(12) Commenter encourages the Practice Transformation Task Force to coordinate its efforts with the Department of Social Services with regard to care management.	(12) The PMO is working with DSS to coordinate our approach to promoting or providing care management.
8	(1) Commenter requests additional clarity around Medicaid reimbursement for e-consults and how reimbursement within CCIP program would function.	(1) The PMO will follow up with DSS to revisit the issue of e-consult reimbursement in Medicaid.
9	(1) Commenter raises concerns that CCIP will undermine care coordination efforts within Medicaid as many of the care coordination functions within CCIP overlap with existing PCMH functions.	(1) CCIP establishes minimum standards of capabilities among ANs/FQHCs. It is not intended to supplant activities that are already in place. The transformation vendor will conduct a gap analysis at the start in order to determine which standards or elements have already been

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		met and which standards or elements have not been met. The transformation support will focus on those areas that have not been met. In this way, the CCIP should not disrupt existing care coordination efforts that a provider may have in place as a PCMH. PMO has further addressed this in the report.
	(2) Commenter expresses concern that funding for CCIP will come from Medicaid, leading to further cuts in the program, and strongly disagrees with this approach, should it be adopted.	(2) The PMO is examining the option of SIM funded innovation awards or transformation grants to providers to support the development of CCIP capabilities.
	(3) Commenter expresses concern over the timeline of early October to provide meaningful changes to CCIP in order for it to be considered for inclusion into any Medicaid program.	(3) DSS and the PMO will seek a further extension of the MQISSP implementation date in order to allow additional time for planning.
10	(1) Commenter requests clarification around the inclusion of children with behavioral health needs in the SIM programs.	(1) The PMO will share this comment with DSS, which is responsible for determining the populations that will participate in MQISSP.
	(2) Commenter expresses concern that behavioral health and care coordination efforts of SIM do not meet the unique needs of children. In particular, commenter notes children with these conditions require greater access to the appropriate care, not just enhanced care coordination, and current proposed programs may duplicate this care and/or be too complex for patients and families to navigate.	(2) The PMO acknowledges that the proposed care management capabilities for complex populations are not designed to address the needs of children with serious behavioral health conditions. In such cases, the care management would not be duplicated, but rather we would recommend that providers refer to or coordinate with existing services and

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		supports that are available through the CT BHP, DCF, and DSS.