Print Form

Name of Advanced Network: _____

STATE OF CONNECTICUT
OFFICE OF THE HEALTHCARE ADVOCATE
STATE INNOVATION MODEL PROGRAM MANAGEMENT OFFICE
REQUEST FOR APPLICATIONS (RFA) FOR THE ADVANCED MEDICAL HOME VANGUARD PROGRAM

PART 1 of 3
ADVANCED NETWORK PROFILE

This form should be completed by the Advanced Network.

Advanced Networks are defined as independent practice associations, large medical groups, clinically integrated networks, and integrated delivery system organizations that have entered into shared savings plan (SSP) arrangements with at least one payer. This definition includes entities designated as Accountable Care Organizations for the purpose of participating in the Medicare SSP.

GENERAL INFORMATION

Date: _____ Name of Advanced Network: _____

Administrative Office Location

Street Address: _____ City and Zip: _____

Phone: _____ Fax: _____

Contact Person

Name & Title of Single Point of Contact for Organization: _____

E-mail address of Contact Person: _____

Telephone Number of Contact Person: _____

What best describes the relationship among the healthcare providers in your organization?

- ☐ Group practice
- ☐ Network of individual practices (IPA)
- ☐ Hospital / healthcare provider partnership or joint venture
- ☐ Hospital contracted healthcare providers
- ☐ Employer contracted healthcare providers
- ☐ Healthcare provider-health plan partnership

Which Connecticut hospital(s) is part of your organization?

_____

Which of the following types of patients does your organization provide care to?

- ☐ Medicare
- ☐ Medicaid
- ☐ Commercial
- ☐ Self-pay/Uninsured

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OTHER INFORMATION

Estimated number of the following employed by or affiliated with your organization:

Primary Care MD: _____ Primary Care RN: _____

Primary Care APRN: _____ Specialty MD: _____

Please indicate if the organization expects to make changes in any of the following areas over the next year:

☐ Organization ownership / closure ☐ Electronic health record system

☐ Administrative office location ☐ Practice management software

If yes, please explain:

Does your organization currently participate in the Medicare Shared Savings Program (SSP)?	☐ YES ☐ NO
Does your organization currently have a Shared Savings Program (SSP) relationship with any commercial payers?	☐ YES ☐ NO
Is the organization capable of performing risk stratification to identify patients in need of care management?	☐ YES ☐ NO
Does your organization provide care coordination resources to the practices in its network? **If YES, please describe:**	☐ YES ☐ NO
Are the practices you propose to be in the pilot able to provide quarterly clinical performance data from the office EHR or registry during the 15-month Transformation Phase? **If NO, please explain:**	☐ YES ☐ NO

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CERTIFICATION OF APPLICATION

Statement of Acceptance: *The terms and conditions contained in the SIM AMH Request for Applications for the Advanced Medical Home Vanguard Program constitute a basis for this procurement. These terms and conditions, as well as others so labeled elsewhere in this document are mandatory for the resultant contract. The Office of the Healthcare Advocate is solely responsible for rendering decisions in matters of interpretation on all terms and conditions.*

My signature below, for and on behalf of _____*(Name of Advanced Network)*, certifies and indicates acceptance of the following:

1. I have the authority to submit this application on behalf of the Advanced Network.

2. I hereby certify that the statements contained in the responses to this application are true to the best of my knowledge and belief.

3. I am committed to following all program guidelines and completing all components of the Advanced Medical Home Vanguard Program as laid out in the State Innovation Model Advanced Medical Home Vanguard Program Request for Applications (RFA).

4. I agree to accept the Section VI: General Provisions as set forth in the Office of the Healthcare Advocate State Innovation Model Program Management Office's Request for Applications for the Advanced Medical Home Vanguard Program.

_____

Signature of Authorized Official

_____

Name of Authorized Official

_____

Date