Commonwealth of Massachusetts
Executive Office of Health and Human Services

Request for Responses (RFR)
for
Multi-payer Patient-Centered Medical Home Services

Document #: 1LCEHSMEDICALHOMES

Issued: July 9, 2010

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Section 1. Introduction and Procurement Requirements

A. Overview

The Commonwealth of Massachusetts Executive Office of Health and Human Services (EOHHS) seeks primary care practice sites comprised of licensed physicians (internal medicine, general medicine, pediatric, and family practice specialists) and other licensed health care professionals to participate in the Massachusetts Patient-Centered Medical Home Initiative (PCMHI). The PCMHI is a three-year, multi-payer initiative to implement the Patient-Centered Medical Home (PCMH) model in selected primary care practice sites. The PCMH is an alternative approach to the delivery of primary care services that promises better patient experience and better results than traditional care.[1] The PCMHI seeks to implement the model in a diverse group of practices in terms of primary care specialty (internal medicine, general medicine, pediatric, and family practice), practice structure and size, practice affiliation, clinical setting, geographic location, and payer mix in order to evaluate the effectiveness of this transformation.

EOHHS will select primary care practice sites that currently have a contract with EOHHS to participate in the MassHealth Primary Care Clinician (PCC) Plan or that have a contract with one or more of managed care organizations (MCOs) that hold a MassHealth contract at the time of PCMHI Contract award[2]. EOHHS (through the PCC Plan) and the MCOs for individuals under age 65 will amend existing provider contracts with practice sites that currently participate in their networks to establish the contract requirements for selected practices. To the extent that any selected practice site also participates in the network of any of the other participating payers (see **Section 1.B** for a list of participating payers), it is anticipated that these payers will also amend their contracts with the selected practice sites to carry out this procurement.

The selected primary care practice sites (“Practices”) will work with EOHHS individually and with one another collectively to transform their Practices over at least a three-year period by participating in a learning collaborative[3] and working with a medical home facilitator[4]. A Practice Site or Practice is defined as the single physical location at which a practice would make its medical home transformation. In their RFR response, Providers who have more than one physical location must choose and identify to EOHHS a single Practice Site for the PCMHI transformation. Organizations that wish to have multiple Practice Site participation must submit a separate application for each Practice Site and each application will be considered individually. Practices will be required to transform internal processes for planning, delivering and measuring the impact of care on their patients, using a patient registry and other mechanisms. Practices will also be

[1] For more information on the PCMH, see www.pcpcc.net/files/PCMH_Vision_to_Reality.pdf.

[2] MassHealth’s contracted MCOs include Boston Medical Center HealthNet Plan, Fallon Community Health Plan, Health New England, Neighborhood Health Plan, and Network Health.

[3] A learning collaborative is a process pioneered by the Institute for Healthcare Improvement whereby clinical teams join clinical teams from other organizations to learn in order to generate performance improvement. Practice teams meet a few times face-to-face over the course of at least 12 months and learn from teachers and from one another.

[4] A medical home facilitator is an individual who is learned in the PCMH and in performance improvement and works with primary care practices to support their efforts to transform into a PCMH.

required to obtain National Committee of Quality Assurance (NCQA) Physician Practice Connections-Patient Centered Medical Home (PPC-PCMH) recognition (see **Section 2.E**).

Subject to terms and conditions described herein and in the contracts with participating payers, one group of participating Practices for which MassHealth, its contracted MCOs and the Health Safety Net represent a significant proportion of practice revenue (Technical Assistance-Plus Practices), will be paid for performing certain start-up activities, will be paid per-member-per-month (PMPM) payments for performing various medical home activities and for Clinical Care Management activities, and may receive payments for shared cost savings, as more fully described in **Section 3**. A second group of practices (Technical Assistance-Only Practices) will not receive any additional compensation for their participation in the PCMHI.

B. PCMHI Background and Role of EOHHS

EOHHS is the Massachusetts secretariat responsible for administering a number of state-sponsored human services programs that serve the financially and medically needy. A key responsibility of the EOHHS Office of Medicaid is serving as the single state agency responsible for administering the Medicaid program and the Children's Health Insurance Program within Massachusetts (collectively, "MassHealth"), pursuant to M.G.L. c.118E, Title XIX of the Social Security Act (42 U.S.C. § 1396 et seq.), Title XXI of the Social Security Act (42 U.S.C. § 1397aa et seq.), and other applicable laws and waivers.

EOHHS is also required under Chapter 305 Section 30 of the Acts of 2008 (An Act to Promote Cost Containment, Transparency and Efficiency in the Delivery of Quality Health Care) to establish a medical home demonstration project within the Office of Medicaid. Among other things, the legislation requires EOHHS to: (1) include restructuring of its payment system to support primary care practices that use a medical home model, and (2) to undertake a program to support primary care practices' efforts to develop an organizational structure that allows them to provide a medical home. The Secretary of EOHHS is authorized under M.G.L. c. 6A to enter into agreements with private individuals, firms, corporations, associations and other entities on behalf of the Executive Office and its agencies. Consistent with the MassHealth Medical Home demonstration mandate, the public policy interest in transforming primary care practices to improve medical quality and costs for all Massachusetts residents, and the Secretary's authority to enter into agreements to support the goals and objectives of EOHHS, the Secretary invited a wide range of stakeholders to participate in designing the multi-payer PCMHI. Accordingly, the Patient-Centered Medical Home Initiative Council was established in June 2009. The Secretary co-chairs the Council, which has as its purpose the design and implementation of a public-private multi-payer PCMH Initiative. EOHHS will continue to provide active oversight of the PCMHI activities.

In February 2009, EOHHS and the Massachusetts League of Community Health Centers were awarded grant funding to support the transformation of 14 Community Health Center sites (CHCs) into patient-centered medical homes over a four-year period (the Commonwealth Fund/Qualis Safety Net Medical Home Initiative (SNMHI) practice sites). In accordance with the State Fiscal Year 2011 General Appropriations Act Section 182B, EOHHS is required to include in the PCMHI all SNMHI practice sites that submit

a qualifying response to this Request for Responses (RFR). This same legislation authorizes EOHHS to selectively contract with additional practice sites.

EOHHS is administering this procurement on behalf of the MassHealth program and also on behalf of the other public and private payers that we expect to participate in the PCMHI. Practices selected by EOHHS as a result of this RFR, including both Technical Assistance-Plus and Technical Assistance-Only Practices, will be required to execute amendments to any contracts they currently have with the MassHealth PCC Plan and, as directed by other participating payers, will need to separately execute amendments to their current contracts with those payers.

The payers/purchasers that currently intend to participate by lines of business include:

Payer/Purchaser	MassHealth	Commonwealth Care	Health Safety Net	Commercial
Blue Cross Blue Shield of Massachusetts				Yes[5]
Boston Medical Center HealthNet Plan	Yes	Yes		
Celticare		Yes		
Health Safety Net administered by Division of Health Care Finance & Policy			Yes	
Fallon Community Health Plan	Yes	Yes		
Group Insurance Commission				Yes[6]
Health New England	Yes			
MassHealth Primary Care Clinician (PCC) Plan[7]	Yes			
Neighborhood Health Plan[8]	Yes	Yes	Yes	Yes

[5] BCBSMA participation will be limited to primary care clinicians enrolled in BCBSMA's Primary Care Physician Incentive Program (PCPIP), and to commercial, non-Medicare Advantage and non-indemnity members who are covered by that program. BCBSMA will fund its PCMHI practice payments with PCPIP funds to clinicians at participating PCMHI sites. For clinicians practicing at more than one practice site, payments will be made to the site designated by the clinician.

[6] As of the date of the release of this RFR, the payers that will participate under the Group Insurance Commission are: Harvard Pilgrim Health Care, Neighborhood Health Plan, and UniCare.

[7] The PCC Plan is MassHealth's self-administered managed care plan.

Payer/Purchaser	MassHealth	Commonwealth Care	Health Safety Net	Commercial
Network Health	Yes	Yes		
Unicare				Yes

The federal Medicare program may also participate in the PCMHI. EOHHS intends to submit an application in August in response to the CMS Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration Solicitation. Should CMS select Massachusetts, EOHHS anticipates that CMS would participate in the PCMHI as an additional payer for Medicare beneficiaries enrolled in the traditional Medicare fee-for-service program. While EOHHS anticipates that CMS would participate in the PCMHI consistent with the terms of this RFR, EOHHS will also need to adhere to any stipulations made by CMS as a condition of participating in the MAPCP demonstration, and may need to amend the Contracts accordingly.

In addition, additional payers beyond those listed above may choose to participate in the PCMHI after the release of this RFR. Information about participating payers will be posted on the Commonwealth's procurement web site, Comm-PASS (see **Section 6.B** for information on Comm-PASS), as it becomes available.

C. Objectives of the PCMHI

The objectives of the PCMHI are:

1. to implement and evaluate the PCMH model as a means to achieve accessible, high quality primary care, for all patients including persons with disabilities;
2. to attract and retain primary care clinicians into practice in Massachusetts by increasing resources available to practices and improving their quality of work life; and
3. to demonstrate cost-effectiveness in order to justify and support the sustainability and spread of the model.

Additional detailed information regarding the PCMHI can be found in **Appendices A** and **B.**

D. Primary Care Practice Pre-Qualifications

In order to be selected, primary care practice candidates must, at a minimum, currently:

- participate as a Primary Care Clinician in the MassHealth PCC Plan or have a primary care provider contract with at least one of the MassHealth MCOs, and
- possess broadband Internet access.

[8] Neighborhood Health Plan will participate on behalf of its MassHealth and Commonwealth Care members and its commercially insured members, including those covered by the Group Insurance Commission.

E. General Procurement Requirements

EOHHS is issuing this RFR to solicit applications from Massachusetts primary care practices, qualified as described in **Section 1.D** above and wishing to participate in the PCHMI. The provisions of 801 CMR 21.00 will apply where applicable. Words used in this RFR shall have the meanings defined in 801 CMR 21.00. Unless otherwise specified in this RFR, all communications, responses, and documentation must be in English, all measurements must be provided in feet, inches, and pounds and all cost proposals or figures in U.S. currency. All responses must be submitted in accordance with the specific terms of this RFR.

EOHHS makes no guarantee that a Contract will result from this RFR, with any or all of the participating payers, including MassHealth.

EOHHS anticipates that the initial term of Contracts resulting from this RFR will be approximately three years, with an anticipated start date of October 15, 2010, and end date on or about February 28, 2014. EOHHS expects that BCBSMA contracts with selected participating practices will have an anticipated start date of January 1, 2011 and an end date of December 31, 2013. In addition, EOHHS may, at its sole option, decide to extend any or all PCC Plan Contracts resulting from this RFR in increments determined by EOHHS for up to five additional years, subject to the availability of funding, all necessary approvals, successful performance by the Practices, and any additional provisions negotiated by the parties. Any extension of a contract with any other participating payer is at the sole discretion of that participating payer.

EOHHS reserves the right to reopen this procurement to new Applicants at specified times throughout the duration of the Contract. If it exercises that option, EOHHS will announce on Comm-PASS that it is accepting new applications from additional primary care practice sites seeking to participate in the PCMHI. Such applications will be expected to meet the requirements set forth in **Section 4** of this RFR along with any other application instructions that are posted on Comm-PASS at that time. Applications will be reviewed in the manner described in **Section 5**.

For any Practices that execute a PCMH Contracts as a result of a subsequent reopening of this RFR, their Contracts shall expire no later than February 28, 2018.

EOHHS reserves the right to amend this RFR at any time prior to the date the responses are due. Any such amendment will be posted to Comm-PASS. Practices are cautioned to check this site regularly, as this will be the sole method used for notification of changes. (See also **Section 6.G**.)

All responses must be submitted in accordance with specifications in **Section 4: Response Requirements**.

F. Procurement Timetable

Unless otherwise specified, the time of day for the following events shall be between 8:00 a.m. and 4:30 p.m., Eastern Time (ET).

EOHHS may adjust this schedule as it deems necessary. Notification of any adjustment to the RFR Timetable shall be posted on Comm-PASS.

1.	RFR Issued	July 9, 2010
2.	Deadline for Written Inquiries (see **Section 1.G**)	July 20, 2010
3.	**Practices' Responses due**	**August 12, 2010**
4.	EOHHS Anticipated Contract Start Date[9]	October 15, 2010

G. RFR Inquiries

Prospective Applicants may make written inquiries concerning this RFR until no later than the date and time specified in **Section 4.F**. Written inquiries must be sent to Geraldine Sobkowicz at the address listed in **Section 4.F**, by fax to (617) 573-1893 or by e-mail to Geraldine.Sobkowicz@state.ma.us.

Inquiries received after the deadline may be disregarded. EOHHS will review inquiries received before the deadline and at its discretion prepare written responses to questions which EOHHS determines to be of general interest and that help to clarify the RFR. Any written response will be posted on Comm-PASS. Only written responses will be binding on EOHHS.

H. Informational Sessions

Prospective Applicants are invited to attend general web-based Informational Sessions. At these sessions EOHHS will entertain questions of general interest that help to clarify the RFR. Oral responses will be given when possible. Written responses will be prepared as determined appropriate by EOHHS and posted on Comm-PASS. Only written responses will be binding on EOHHS. These webinars will take place at the dates and times below:

[9] Other than for EOHHS' MassHealth PCC Plan, start dates for participating payers and selected practices in their provider networks will be determined by their contracting process.

Date	July 19, 2010
Time	8:00 AM
Reserve your Webinar seat now at:	https://www1.gotomeeting.com/register/546983160
Date	July 20, 2010
Time	12:00pm
Reserve your Webinar space now at:	https://www1.gotomeeting.com/register/624753385

In addition, EOHHS will sponsor an Information Session presentation by a primary care practice from another state that has been participating in a PCMH initiative similar to that planned for Massachusetts. The practice will describe its experience transforming to a Patient-Centered Medical Home.

Date	July 21, 2010
Time	12:00pm
Reserve your Webinar space now at:	https://www1.gotomeeting.com/register/418363560

Section 2: Scope of Services

Selected Practices will work with EOHHS individually and with one another collectively to transform their Practices over a three-year period by fulfilling the following responsibilities. Failure to meet these responsibilities will be cause for suspension of Practice medical home payments and/or termination of the MassHealth PCC Plan contract amendments that are expected to be executed with the Practices, and will result in EOHHS notifying the other participating payers of the failure.

This section describes substantially the activities selected Practices will be required to engage in and the responsibilities they will fulfill under any agreement resulting from this RFR. Agreements resulting from this RFR are contingent on federal Centers for Medicare and Medicaid Services (CMS) approval. The requirements set forth in this section are subject to change should the CMS select Massachusetts as a pilot for its forthcoming Advanced Primary Care demonstration or for another related CMS pilot or demonstration, and should there be language in this RFR that is objectionable to CMS. These requirements may also be informed or modified by any additional requirements negotiated between EOHHS and the Practices.

A. Learning Collaborative and Medical Home Facilitators

Practices shall participate in a PCMH learning collaborative in the following fashion. The Practice shall:

- attend nine days of learning collaborative meetings, including seven days between February 2011 and January 2012, and two days between February 2012 and January 2013. A senior clinician within the Practice, another clinician, and a non-clinician member (e.g., practice manager or practice administrator) of the primary care Core Practice Team shall attend the Learning Collaborative meetings;
- participate with one or more members of the Core Practice Team in monthly one-hour learning collaborative conference calls or webinars;
- meet, face-to-face and telephonically, with EOHHS-contracted medical home facilitators, upon request by the medical home facilitators and/or EOHHS;
- submit the data reports specified in **Section 2.G**, below; and
- participate in ad hoc, time-limited EOHHS-convened topical work groups (e.g., primary care and behavioral health integration) as requested by EOHHS.

B. Internal Practice Team Meetings

Practices shall convene regular internal Practice Team meetings to plan and implement PCMH transformation over the course of the Contract period.

C. Patient Registries

Practices shall create and maintain patient registries, either using electronic health record (EHR) software or a stand-alone registry. A patient registry is a system for tracking information EOHHS has determined is critical to the management of the health of a primary care practice's patient population, including dates of delivered and needed services, laboratory values needed to track a chronic condition, and other measures of health status. The Practice's registry shall be used for:

- patient tracking;
- patient risk stratification;
- analysis of patient population health status and individual patient needs; and
- reporting, as specified in **Section 2.G**, below.

Technical assistance, by EOHHS e, will be provided to all Practices to assist them with meeting the functionality requirements prescribed by EOHHS for their registries. A stand-alone registry will be provided to Practices, if necessary.

Additional technical assistance is available to practices from the Massachusetts eHealth Institute through Regional Extension Centers. For more information go to http://www.maehi.org/.

D. Mastery of the Required Medical Home Core Competencies[10]

Practices shall transform how they operate in order to become a PCMH. Transformation entails mastery of 12 PCMH core competencies, to be taught through the learning collaborative and by medical home facilitators, and defined as follows:

1. Patient/family/peer/advocate/caregiver-centeredness[11]: This means that longitudinal care is delivered with transparency, individualization, recognition, respect, linguistic and cultural competence, and dignity.[12] Such care also provides patients/families/caregivers with choice in all matters and possesses an ongoing focus on consumer service, with bi-directional feedback.
2. Multi-disciplinary team-based approach to care: This is a model for care delivery that is less physician-centric or hierarchical than is found in traditional primary care practice and is one that requires effective team communication, collaboration and role definition.
3. Planned visits and follow-up care: In contrast to episodic, reactive care, this manner of primary care delivery tracks patients on an ongoing basis so that the practice is informed and ready to address the patient's needs holistically whenever the patient makes contact, and follows up with patients after encounters, as necessary.
4. Population-based tracking and analysis with patient-specific reminders: To support planned visits and follow-up care, a practice needs information tracking capacity in the form of a freestanding or EHR-based patient registry with reporting functionality.
5. Care coordination[13] across settings, including referral and transition management: Practices assume responsibility for tracking and assisting patients as they move across care settings, and for coordinating services with other service providers including behavioral health and social service providers.
6. Integrated Clinical Care Management[14] services focused on high-risk patients: For the most clinically at-risk patients in a practice, a care manager is either a) based in the practice or b) residing outside of the practice but otherwise tightly integrated with the Practice Team.
7. Patient and family education: The Practice Team educates patients and family members both on primary preventive care, and on self-management of chronic illness (i.e., secondary preventive care).

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[10]Some core competencies lend themselves to condition-specific changes (e.g., self-management support), while others require practice-wide change (e.g., patient-centeredness). For those core competencies requiring condition-specific changes, EOHHS has adopted the idea that initial technical support would focus on a limited number of common conditions for the practices, with the pediatric practices focusing on different conditions than primary care practices treating an adult population. The specific clinical focus recommendations are described in **Appendix A, Section A**.

[11] "Patient/family/caregiver" recognizes that in pediatric care and in care for some adults, family members and caregivers play a primary role in identifying and communicating the health needs of a patient and in self-management activities.

[12] Berwick DM. "What 'Patient-centered' Should Mean: Confessions of An Extremist". *Health Affairs* 28, no. 4, w555-565, published online May 19, 2009.

[13] See **Appendix B** for definitions of "care coordination" and "Clinical Care Management Services."

[14] See **Appendix B** for definitions of "care coordination" and "Clinical Care Management Services."

8. Self-management support by members of the Practice Team: Extending beyond education, self-management support assists the patient and/or family/peer/advocate/caregiver with the challenges of ongoing self-management, directly and/or through referral.
9. Involvement of the patient in goal setting, action planning, problem solving and follow-up: Patient-centered primary care requires care planning and related activities focused on a patient's specific circumstances, wishes and needs.
10. Evidence-based care delivery, including stepped care protocols: Care should be evidence-based wherever evidence exists, and follow stepped protocols for treatment of illness.
11. Integration of quality improvement strategies and techniques: Practices should utilize the improvement model emphasized by the Institute for Healthcare Improvement to measure performance, identify opportunities for improvement, test interventions, and reassess performance.
12. Enhanced access: Another hallmark of patient-centered primary care is the availability of easy and flexible access to the Practice Team, including alternatives to face-to-face visits, such as e-mail and telephone[15] and 24 hours per day/seven days per week practice coverage.

E. National Committee of Quality Assurance (NCQA) Recognition

Practices shall obtain no less than NCQA Physician Practice Connections-Patient Centered Medical Home (PPC-PCMH) "Level 1 Plus" recognition. "Level 1 Plus" recognition is defined for purposes of this procurement as meeting NCQA Level 1 standards, plus recognition for achieving the following NCQA PPC-PCMH standards at the specified levels of performance:

- Standard 3C - 75%
- Standard 3D - 100%
- Standard 4B - 50%[16]

Practices shall submit the National Committee of Quality Assurance (NCQA) Physician Practice Connections-Patient Centered Medical Home (PPC-PCMH) recognition application to NCQA by July 31, 2012, using the PPC-PCMH standards in effect as of August 1, 2011, and submit documentation to EOHHS, as specified by EOHHS, demonstrating that the Practice has achieved no less than NCQA Level 1 recognition and have been recognized by NCQA for meeting Standards 3C, 3D and 4B at the levels specified above.

[15] Other use of technology, such as to improve medication compliance and provide remote behavior coaching, represents additional means for enhancing access.

[16] NCQA is currently revising its PPC-PCMH standards. Should requirements 3C, 3D and 4B be renamed, this requirement will be applied to the renamed standards. Should the requirements be modified, EOHHS will decide whether these three requirements should be maintained or removed. The current NCQA PPC-PCMH standards can be obtained at www.ncqa.org/tabid/631/Default.aspx.

F. Clinical Care Management Services

Practices shall provide Clinical Care Management Services, as further defined in **Appendix B**. Clinical Care Management entails the identification of high-risk patients, and intensive monitoring, follow-up, and clinical management of such patients. These activities generally include frequent patient contact, clinical assessment, medication review and reconciliation, communication with treating clinicians, and medication adjustment by protocol.

Practices shall ensure and document that Clinical Care Management Services funding is used exclusively to provide Clinical Care Management Services. Selected Practices may collaborate in provision of Clinical Care Management Services, and EOHHS, may facilitate efforts across Practice sites that have interest in collaborating to share a Clinical Care Manager.

G. Data Reporting

Practices shall submit to EOHHS the following reports, as further specified by EOHHS, within the time frames specified below:

- monthly narrative practice reports that describe the Practice's efforts and progress to implement PCMH practices;
- monthly clinical quality indicator reports utilizing clinical data contained within the Practice's patient registry;
- periodic submission of Medical Home Implementation Quotient (MHIQ) survey[17] scores, as specified by EOHHS;
- allocation of Clinical Care Manager time, twice per calendar year; and
- other reports, as specified by EOHHS.

H. Notification of Primary Care Practice Changes

Practices are required to notify EOHHS within five working days of the following changes:

- the employment or contract of a Clinical Care Manager terminates subsequent to the initiation of Clinical Care Management payments; and
- any substantive changes in Practice ownership or composition, including:
  - the Practice is acquired by another practice;
  - the Practice merges with another practice; and
  - the Practice acquires another practice.

I. Participation in Evaluation

Practices shall participate in an evaluation of the PCMHI, to be performed by the University of Massachusetts Medical School's Department of Commonwealth Medicine (University). Participation shall minimally entail responding to surveys and requests for

[17] The MHIQ 2.0 evaluation tool is accessible at: www.transformed.com/MHIQ/welcome.cfm.

interviews of Practice staff and patients. Practices shall provide all requested information to the University in a timely fashion. Practices shall also participate in an evaluation conducted by CMS for its MAPCP demonstration, in the event that the Massachusetts application to CMS is successful.

Section 3. Payment

Subject to all required state and federal approvals, EOHHS has developed the following payment structure for contracted Technical Assistance-Plus Practices. Except as described below for BCBSMA, EOHHS expects PCMHI participating payers to use the payment methodology and amounts described below when calculating payments. However, a Technical Assistance-Plus Practice will not receive payment from those payers with which it does not have a contract, and may not receive payment from those payers with which it has an existing capitation or other alternative payment arrangement that supports medical home practice infrastructure and/or provides the Technical Assistance-Plus Practice with the opportunity to share or reap savings through effective and efficient care delivery. EOHHS expects that BCBSMA payments will be limited to primary care clinicians enrolled in BCBSMA's Primary Care Physician Incentive Program (PCPIP), and to commercial, non-Medicare Advantage and non-indemnity coverage members who are covered by that program. BCBSMA will fund its PCMHI Practice payments with available PCPIP funds to clinicians at participating PCMHI sites. For BCBSMA clinicians practicing at more than one practice site, payments will be made to the practice site designated by the clinician. BCBSMA payments under **Sections 3.B and 3.C** may be a different payment amount or methodology.

No payments will be made to any Technical Assistance-Plus Practice until the calendar month immediately following the first learning collaborative session, and all payments are contingent on the Technical Assistance-Plus Practice meeting the requirements set forth in this RFR, as determined by EOHHS.

The anticipated payment methodology for Technical Assistance-Plus Practices is as follows:
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Type of Payment	Payment Amount
A. <u>Start-up infrastructure payment</u>: Payment per practice site for start-up and infrastructure development practice costs during Year One[18] and Year Two. Payment will be based on the percentage of each participating payer's patients attributed to the Practice. A Practice will be paid the Year One or Year Two maximum payment amount only if all of its contracted payers choose to participate in the PCMHI.	<u>Year One</u>: up to $15,000 <u>Year Two</u>: up to $3,500
B. <u>Payment for Medical Home activities</u>: PMPM payment for activities including, but not limited to,	$1.50 PMPM

[18] Year One is defined as the twelve-month period starting with the month of the first learning collaborative session.

development of patient care plans, managing care transitions, provision of care coordination, provision of patient self-management education and self-management support, and other activities to be taught in the course of the learning collaborative sessions.	
C. Payment for Clinical Care Management Services: PMPM payment for such services provided by a care manager who has been hired or contracted by the Technical Assistance-Plus Practice, either alone or in partnership with one or more other Practices (as described in **Appendix B**). Payment will begin only once the Technical Assistance-Plus Practice demonstrates to EOHHS' satisfaction that the Technical Assistance-Plus Practice has hired or contracted a Clinical Care Manager.	$0.60 PMPM – children under 18 years $1.50 PMPM – adults ages 18-64 years $6.00 PMPM – adults ages 65 and older
D. Payment for Shared Savings and Quality: If EOHHS determines that a grouping of EOHHS-determined like Practices has generated cost savings relative to a control group of primary care practices, after subtracting payment amounts made under **Sections 3.A, B** and **C**, and if the Technical Assistance-Plus Practice meets quality of care performance thresholds to be determined by EOHHS, the Technical Assistance-Plus Practice shall share with the payers in the cost savings consistent with a methodology to be defined by EOHHS.	The amount of any shared savings in the first year will not be determined or paid to the Practices until after the end of the second year. The amount of any second year and third year savings will be determined after the end of the second and third years, respectively.

Subject to EOHHS's determination that the Technical Assistance-Plus Practices have performed their obligations under the PCMHI agreement, payments for PCC Plan members will be made as follows:

- For Year One, EOHHS shall pay Technical Assistance-Plus Practices quarterly for payments described in **Sections 3.A-C.**
- For Year Two, EOHHS shall pay Technical Assistance-Plus Practices a one-time payment for the payment described in **Sections 3.A** and **3.D**. and monthly for payments described in **Sections 3.B** and **3.C**.
- For Year Three, EOHHS shall pay Technical Assistance-Plus Practices a one-time payment for the payment described in **Section 3.D** and monthly for payments described in **Sections 3.B** and **3.C**.

Payments described in **Sections 3.B** and **3.C** will be based on EOHHS' count of the PCC Plan members assigned to the Technical Assistance-Plus Practice on a date certain each month. For Year One, EOHHS will calculate a monthly payment amount, and then sum the monthly payment amounts each quarter. For non-PCC Plan members, each participating payer shall calculate payments based on their respective members attributed to each Practice.

EOHHS anticipates that participating payers will use a common patient attribution methodology to determine the primary care practice for members not required to designate a primary care provider.

Should experience reveal to EOHHS that elements of the payment methodology will not function, or are not functioning, as EOHHS expects, EOHHS reserves the right to make changes to the payment methodology after consultation with participating PCMHI Technical Assistance-Plus Practices and payers, and all required federal approvals.

Section 4. Response Requirements

A. General Submission Instructions

Responses must be submitted by the date listed in the Procurement Timetable, **Section 1.F**, no later than 3:00 pm ET. A follow-up hard copy of the responses must be postmarked by due date for any e-mailed responses, and delivered by mail or hand-delivered to:

Geraldine Sobkowicz, Procurement Coordinator
Executive Office of Health and Human Services Legal Unit
One Ashburton Place, 11th floor
Boston, MA 02108
e-mail: Geraldine.sobkowicz@state.ma.us

B. Contents of the Submission

The Applicant must submit:

- a completed application form, found in **Appendix C**, attached to this RFR; and
- **a cover letter** that clearly states the name of the applicant organization and the name of the applicant's contact person. The letter must be signed by an individual authorized to bind the applicant.

Section 5. Response Evaluation Process

A. Response Review and Evaluation

1. Compliance with Submission Instructions

All responses will be reviewed by EOHHS to determine compliance with the response submission instructions described in **Section 4**. For those responses that comply with the response submission instructions, including meeting the pre-qualification requirements defined in **Section 1.D** and the submission of a complete response to the application contained in **Appendix C**, an Evaluation Committee designated by EOHHS will review the responses.

2. Evaluation Criteria for the PCMHI

a. The following identifies the criteria by which EOHHS will evaluate responses from each SNMHI practice:

- the Practice demonstrates that it meets the practice pre-qualifications identified in **Section 1.D**; and
- the Practice submits a complete and timely application contained in **Appendix C**.

Each SNMHI practice that meets these criteria above shall be selected as a Technical Assistance-Plus practice.

b. The following identifies, in descending order of importance, the criteria by which EOHHS will evaluate each non-SNMHI practice's response for selection as a Technical Assistance-Plus Practice:

- the quality of the responses to the questions in **Appendix C** in accordance with the following criteria: comprehensiveness, feasibility, appropriateness, clarity, effectiveness, innovation, and responsiveness to the needs of EOHHS and the goals of the PCMHI;
- the extent to which the practice demonstrates leadership commitment and basic capabilities that will allow it to effectively engage in the PCMHI and in practice transformation activity;
- the extent to which the practice demonstrates that it contributes toward EOHHS selection of a group of primary care practices which, taken together, are diverse in terms of:
    - primary care specialty (internal medicine, pediatric, and family practice);
    - practice structure (e.g., solo, group, Community Health Center, etc.);
    - practice size;
    - practice affiliation (e.g., independent, hospital-owned);
    - geographic location;
    - patient mix, as defined by racial and ethnic composition;
    - payer mix; and
- reference information provided by participating payers. By submitting an application for the PMCHI, the Applicant grants permission to EOHHS to contact any participating payer for reference information.

In addition, for Applicants seeking to participate as Technical Assistance-Plus Practices, the extent to which MassHealth, MassHealth MCOs and the Health Safety Net collectively represent a significant proportion of calendar year 2009 practice revenue.

Finally, EOHHS may consider any relevant information about the practice known to EOHHS.

c. The following identifies, in descending order of importance, the criteria by which EOHHS will evaluate each Applicant that is a non-SNMHI practice and that is not selected as a Technical Assistance-Plus response but which seeks to participate as a Technical Assistance-Only Practice:

- the quality of the responses to the questions in **Appendix C** in accordance with the following criteria: comprehensiveness, feasibility, appropriateness, clarity, effectiveness, innovation, and responsiveness to the needs of EOHHS and the goals of the PCMHI;
- the extent to which the practice demonstrates leadership commitment and basic capabilities that will allow it to effectively engage in the PCMHI and in practice transformation activity;
- the extent to which the practice demonstrates that it contributes toward EOHHS selection of a group of primary care practices which, taken together, are diverse in terms of:
    - primary care specialty (internal medicine, pediatric, and family practice);
    - practice structure (e.g., solo, group, Community Health Center, etc.);
    - practice size;
    - practice affiliation (e.g., independent, hospital-owned);
    - geographic location;
    - patient mix, as defined by racial and ethnic composition;
    - payer mix; and
- reference information provided by participating payers. By submitting an application for the PMCHI, the Applicant grants permission to EOHHS to contact any participating payer for reference information.

Finally, EOHHS may consider any relevant information about the practice known to EOHHS.

3. Qualifying Proposals

EOHHS reserves the right to reject a practice's response at any time during the evaluation process if the Applicant:

- fails to demonstrate to EOHHS's satisfaction that it meets all RFR requirements, including having a contract with EOHHS to participate in the MassHealth PCC Plan and/or having a contract with one or more of the MassHealth-contracted MCOs;
- fails to submit all required information or otherwise satisfy all Response requirements in **Section 4**; or

- rejects or qualifies its agreement to any of the mandatory provisions of the RFR or the Commonwealth's standard Contract Terms and Conditions.

The Evaluation Committee may determine non-compliance with an RFR requirement is insubstantial. In such cases, the Committee may seek clarification, allow the Applicant to make minor corrections, apply appropriate penalties in evaluating the Response, or apply a combination of all three remedies.

4. Clarifications

The Evaluation Committee may determine some element of an Applicant's response requires clarification to verify its responsiveness to the RFR or facilitate a fair comparison with competing proposals. In such cases, the Committee may seek clarification from the Applicant. All practices will be accorded fair and equal treatment with respect to any opportunity for clarification.

B. Recommendation for Award

After the Committee completes its evaluation, comparison and ranking of all proposals, the Committee may recommend to the Medicaid Director practices with which to enter into Contract negotiations. The Medicaid Director's decision shall be based on the Committee's recommendation and on the best interests of the Commonwealth. EOHHS is under no obligation to award any Contracts pursuant to this RFR.

Section 6. Additional Terms and Conditions

A. Issuing Office

Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

B. Comm-PASS

This RFR has been distributed electronically using the Commonwealth of Massachusetts Procurement Access and Solicitation System (Comm-PASS). Attachments referenced in the RFR are available on the Operational Services Division (OSD) web site at www.mass.gov/osd and clicking on the "OSD Forms" link; or available from EOHHS upon request.

Applicants are solely responsible for obtaining and completing required attachments that are identified in this RFR and for checking Comm-PASS for any addenda or modifications that are subsequently made to this RFR or attachments. The Commonwealth and its subdivisions accept no liability and will provide no accommodation to applicants that fail to check for amended RFRs and submit inadequate or incorrect responses. Applicants are advised to check the "last change" field on the summary page of RFRs for which they intend to submit a response to ensure that they have the most recent RFR files. Applicants may not alter (manually or electronically) the RFR language or any RFR component files. Modifications to the body of the RFR,

specifications, terms and conditions, or which change the intent of this RFR are prohibited and may disqualify a response.

C. Reasonable Accommodation

Applicants with disabilities or hardships that seek reasonable accommodation, which may include the receipt of RFR information in an alternative format, must communicate such requests in writing to the contact person. Requests for accommodation will be addressed on a case-by-case basis. An applicant requesting accommodation must submit a written statement that describes the applicant's disability and the requested accommodation to the contact person for the RFR. EOHHS reserves the right to reject unreasonable requests.

D. RFR Copies

Applicants may request a copy of the RFR, or any of its components, by contacting Geraldine Sobkowicz through any of the following methods:

- in writing at the Issuing Office specified under **Section 6.A** above;
- by e-mail to: Geraldine.Sobkowicz@state.ma.us
- by facsimile: 617-573-1893; or
- by telephone: 617-573-1678.

E. Amendment or Withdrawal of RFR

If EOHHS decides to amend or clarify any part of this RFR, any written amendment will be posted on Comm-PASS. Applicants are cautioned to check this site regularly, as this will be the sole method used for notification of changes. EOHHS reserves the right to amend the RFR at any time prior to the deadline for submission of responses and to terminate this procurement in whole or in part at any time before or after submission of responses.

F. Costs

The Commonwealth will not be responsible for any costs or expenses incurred by applicants responding to this RFR.

G. Closing Date

Responses received after the Response due date and time specified in **Section 1.F** of this RFR will be rejected. Individual requests for extension of the time for submitting responses will be denied. All responses become the property of the Commonwealth of Massachusetts.

H. Acceptance of Response Content

The entire contents of the applicant's response shall be binding on the Applicant. The specifications and contents of a successful applicant's response may be incorporated into the Contract.

I. Public Records

All responses and related documents submitted in response to this RFR are public records and are subject to the Massachusetts Public Records Law, M.G.L. c. 66, § 10 and M.G.L. c. 4, § 7 subsection 26. Any statements in submitted responses that are inconsistent with these statutes will be disregarded.

J. Response Duration

The applicant's response shall remain in effect until any Contract with the Applicant is executed or the Applicant withdraws its proposal.

K. Confidentiality

Applicants shall comply with all state and federal laws and regulations relating to confidentiality and privacy.

L. Incorporation of RFR

This RFR and the selected Applicant's response may be incorporated into any Contract awarded as a result of this RFR to that Applicant.

M. Option to Modify Scope of Work

EOHHS reserves the right, at its sole discretion and at any time after release of the RFR and during the Contract term, to modify, increase, reduce or terminate any requirements under the Contract, whenever EOHHS deems necessary or reasonable to reflect any change in policy or program goals. EOHHS additionally reserves the right, at its sole discretion and at any time after release of the RFR and during the Contract term, to amend the Contract to implement state or federal statutory or regulatory requirements, judicial orders, settlement agreements, or any state or federal initiatives or changes affecting EOHHS agencies. In the event of a change in the scope of work for any Contract tasks or portions thereof, EOHHS will provide written notice to the Contractor and will initiate negotiations with the Contractor. EOHHS reserves the right to amend the Contract accordingly, including payments under, or maximum obligation of the Contract.

N. Debriefing

Upon notification of EOHHS's award decision, any non-selected Applicant may make a written request for debriefing. A debriefing meeting provides the Applicant an opportunity to discuss the evaluation of its response. A request for debriefing must be received by EOHHS at the Issuing Office specified under **Section 6.A,** within 14 calendar days after the postmark of EOHHS's award decision notification to the Applicant. Debriefing meetings shall be held at the discretion of EOHHS.

O. Authorizations and Appropriations

Any Contract awarded under this RFR is subject to all necessary federal and state approvals, as applicable, including the Office of the Comptroller and is subject to appropriation of sufficient funding, as determined by EOHHS.

P. Byrd Anti-Lobbying Amendment

If a Contractor receives $100,000 or more of federal funds through a contract, by signing that contract it certifies it has not and will not use federal appropriated funds to pay any person or organization for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress or an employee of a Member of Congress in connection with obtaining any federal contract, grant or any other award covered by 31 U.S.C. 1352. A Contractor shall disclose any lobbying with non-federal funds that takes place in connection with obtaining any federal award.

Q. Electronic Communication/Update of Applicant's/Contractor's Contact Information

It is the responsibility of the Applicants and selected Practices to keep current the email address of a contact person and prospective Contract manager, if awarded a Contract, and to monitor that email inbox for communications from the Evaluation Committee, including requests for clarification. The Evaluation Committee and the Commonwealth assume no responsibility if an Applicant's/selected Practice's designated e-mail address is not current, or if technical problems, including those with the bidder's/selected Practice's computer, network or internet service provider (ISP) cause email communications sent to/from the bidder's/selected Practice's and the Evaluation Committee to be lost or rejected by any means including e-mail or spam filtering.

R. Restriction on the Use of the Commonwealth Seal

Applicants and Contractors are not allowed to display the Commonwealth of Massachusetts Seal in their bid package or subsequent marketing materials if they are awarded a contract because use of the coat of arms and the Great Seal of the Commonwealth for advertising or commercial purposes is prohibited by law.

S. Environmental Response Submission Compliance

In an effort to promote greater use of recycled and environmentally preferable products and minimize waste, all responses submitted should comply with the following guidelines:

- All copies should be printed double-sided.
- All submittals and copies should be printed on recycled paper with a minimum post-consumer content of 30% or on tree-free paper (i.e., paper made from raw materials other than trees, such as kenaf). To document the use of such paper, a photocopy of the ream cover/wrapper should be included with the response.
- Unless absolutely necessary, all responses and copies should minimize or eliminate use of non-recyclable or non-re-usable materials such as plastic report

covers, plastic dividers, vinyl sleeves and GBC binding. Three-ringed binders, glued materials, paper clips and staples are acceptable.

- Applicants should submit materials in a format which allows for easy removal and recycling of paper materials.
- Applicants are encouraged to use other products which contain recycled content in their response documents. Such products may include, but are not limited to, folders, binders, paper clips, diskettes, envelopes, boxes, etc. Where appropriate, bidders should note which products in their responses are made with recycled materials.
- Unnecessary samples, attachments or documents not specifically asked for should not be submitted.

T. Executive Order 504

All contracts entered into by state agencies after January 1, 2009, shall contain provisions requiring Contractors to certify that they have read Executive Order 504, that they have reviewed and will comply with all information security programs, plans, guidelines, standards and policies that apply to the work they will be performing for their contracting agency, that they will communicate these provisions to and enforce them against their subcontractors, and that they will implement and maintain any other reasonable and appropriate security procedures and practices necessary to protect personal information to which they are given access as part of the contract from unauthorized access, destruction, use, modification, disclosure or loss. The provisions shall be enforced through EOHHS and the Operational Services Division. Any breach shall be regarded as a material breach of the contract that may subject the Contractor to appropriate sanctions.

U. Subcontracting Policies

Prior approval of the department is required for any subcontracted service of the Contract. Contractors are responsible for the satisfactory performance and adequate oversight of its subcontractors. Human and social service subcontractors are also required to meet the same state and federal financial and program reporting requirements and are held to the same reimbursable cost standards as contractors.

Appendix A

Clinical Focus of Initial Practice Transformation
and
Patient Engagement

As describe in **Section 1.B**, the Patient-Centered Medical Home Initiative Council was convened in June 2009 to advise EOHHS on the design and implementation of the PCMHI. As part of this process, the Council developed a “Framework for Design and Implementation” in November, 2009. This document outlines content on which to organize the PCMHI and included the two topics excerpted below.

Section A describes the clinical focus approach for initial practice transformation that is anticipated as part of the learning collaborative curriculum for selected Practices in the first year. Section B provides the recommendations from the Council’s Consumer Engagement Work Group, which was comprised of a subset of Council members. The recommendations describe anticipated activities of the Practices as part of their efforts to engage patients and also identify activities that will be implemented by the University of Massachusetts Medical School's Department of Commonwealth Medicine, which is collaborating with EOHHS on several activities to support Practices.

A. Clinical Focus of Initial Practice Transformation

Some of the PCMH core competencies defined in **Section 2.C** lend themselves to condition-specific changes (e.g., self-management support), while others require practice-wide change (e.g., patient-centeredness). For those core competencies requiring condition-specific changes, the initial practice transformation support will focus on a limited number of common conditions for the practices, with the pediatric practices focusing on a different condition(s) than primary care practices treating an adult population. This initial narrow condition focus will be time-limited in order to ensure that transformation for *all* patients eventually occurs, and that the transformation will result in change for the entire practice.

EOHHS currently anticipates that the clinical focus detailed below would be applicable in the first 12 months of the PCMHI. Once the new processes are learned and in place, providers will be in a position to spread the care model more broadly. The envisioned clinical focus may change, however, prior to the contract start date.

<u>Adult Population:</u>

- *Condition focus*: people with diabetes, including their co-morbidities
- *Spread in Year 1*: once the practices have grasped the new care processes working with patients with diabetes, move quickly to include in the population of focus all high-risk patients, regardless of disease or condition
- *Preventive care*: incorporate prevention services into planned care <u>for the above two targeted populations</u>, focusing on mammography, colon cancer screening, Pap smears, and flu shots

Pediatric Population:

- *Condition focus*: patients with asthma and Attention Deficit Hyperactivity Disorder (ADHD), including their co-morbidities
- *Spread in Year 1*: once the practices have grasped the new care processes working with patients with asthma and ADHD, include all high-risk patients regardless of disease or condition
- *Preventive care*: focus on obesity prevention among children at–risk for obesity, and specified preventive services (e.g., vaccinations for children at two years of age) for children with asthma, ADHD or at risk for obesity.

B. Patient Engagement

An important PCMH concept, derived from the Chronic Care Model, is that a prepared, proactive practice team productively interacts with an informed, activated patient who is participating in the management of his/her care as much as is possible.[19] EOHHS seeks to ensure that efforts at patient engagement occur both in the practice setting and in the community, outside of the practice setting. EOHHS has adopted the following strategy for patient engagement:

Priority #1: Involve Patients at the Participating Practice Level to Assure Patient-Centered Practices

Include in provider contract amendments the requirements that practice redesign teams:

- actively involve patients in the practice redesign process, including patients with disabilities, through use of mechanisms such as, by way of example, having a patient serve on the practice redesign team, creating a patient advisory committee, or using patient surveys;
- obtain patient input on a regular basis as PCMH changes are implemented to determine their effectiveness in meeting patient-centeredness goals;
- obtain patient input as to patient needs regarding culturally[20] and linguistically appropriate access and physical/communication access to PCMH sites, and
- identify resource(s) in the practice that will be responsible for identifying and establishing strong working relationships with medical and non-medical community-based resources.

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[19] Consumer engagement is a term also used to refer to insurance benefit designs that encourage patients to use health care services more effectively. Creating new benefit designs is beyond the scope of this initiative.

[20] Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. (Adapted from Cross, 1989).

Priority #2: Promote Involved Patients by Educating Patients on Roles and Responsibilities

The University of Massachusetts Medical School will develop consumer educational materials for patients, families and caregivers that convey to consumers the following key messages:

- each individual consumer is vital to the PCMH primary care team;
- a PCMH provides team-based care, which benefits the patient by providing comprehensive care that looks at the patient from a holistic perspective;
- the primary care team is your first contact point for getting health care services and it is important to understand the roles of the team members;
- patients have an important role to play as self-advocates and need to assume responsibility for being their own self-advocates;
- patients have an opportunity to partner with providers around self-management of their health;
- developing and following a care plan with the assistance of your primary care team is a very important step in managing your own health care needs;
- by changing to a PCMH, your providers are recognizing the need to improve the practice experience for you and invite your participation and feedback, and

The University of Massachusetts Medical School will conduct focus groups in order to identify consumer priorities, understanding of PCMH concepts and terminology and the role of patients, which will be used to develop consumer materials that convey a consistent message across cultures and languages and statewide.

Priority #3: Develop Consumer Engagement Skills at the Practice Level among the Care Teams

To help care teams develop these skills:

- The University of Massachusetts Medical School will design and develop a training curriculum for medical home facilitators around fostering consumer engagement in practice redesign, and
- EOHHS will include training centered around best practices to meet the requirements of Priority 1 (involving consumers at the practice level) during the pre-work phase and at the first Learning Collaborative session.

Priority #4: Develop Stakeholder Educational Materials to Build an Involved, Supportive Community

The University of Massachusetts Medical School will develop educational materials for community agencies such as social service agencies, group homes, ASAPs, home health agencies, Independent Living and Recovery Learning Centers, Aging and Disability Resource Consortia, community health workers and medical interpreters, that:

- explain a PCMH and the role of community resources;
- explain the rights and responsibilities of the care team and the patient/family/caregivers, and

- identify methods to improve communication and collaboration and better manage transitions between community-based resources and a PCMH.

Priority #5: Increase the PCMH's Use of Existing Community-based Resources

The University of Massachusetts Medical School will:

- create a directory of key, existing referral systems/resources (such as www.800AgeInfo.com, MA Aging and Disability Locator www.madil.org , www.massaccesshousingregistery.org, etc.) and post the directory on the PCMHI website, available to providers and consumers;
- work with existing organizations, such as ASAPs, Independent Living and Recovery Learning Centers, Aging and Disability Resource Consortia, and health home agencies that currently have an Information and Referral capability to develop proposals for PCMH practices to access these community-based resources located within their geographic area, and
- work with EOHHS and the Department of Public Health (DPH) to develop links between DPH's peer support program (based on the Stanford Model) and participating practices and to educate providers on the value and role of peer support programs as a key component of patient engagement.

Priority #6: Encourage PCMHs to Integrate Existing Payer and Employer Consumer Incentive Programs and Wellness Benefits into Care Plans

To encourage use of existing consumer incentive and wellness programs by PCMHs:

- the University of Massachusetts Medical School will include within the responsibilities of the medical home facilitators the routine collection of information about consumer incentives and wellness benefits from DPH, and local health plans, including MassHealth, and provide this information to PCMH practice care coordinators, and
- EOHHS will include within the Learning Collaborative sessions care team information on the availability of consumer incentives/wellness benefits and how they might be incorporated into a patient's care plan.

Appendix B

General Functional Definitions of
Care Coordination and Clinical Care Management Services

(adapted from definitions developed by Ed Wagner, MD[21])

Care Coordination

A core function of primary care and PCMHs is the delivery of a set of care coordination activities, assuring that patients receive timely, high quality and efficient health care and support services within and outside of the medical home through the development and implementation of a care plan and development of patient self-management skills. Services may be identified either by the practice by referral or by the patient or other providers to maintain or improve the well being of the patient and includes clinical services, clinical and non-clinical support services available within the community, and facility-based services. To coordinate care effectively, this role involves activities to:

- identify available community resources;
- assure that referrals made by the practice for external services result in timely appointments, timely two-way transmission of useful patient information, and address patient and practice concerns without duplication of services or provision of inappropriate services;
- obtain reliable and timely information about external services not initiated by the practice such as emergency, patient-initiated, or other provider-initiated care, as well as case management in order to provide and receive patient information, and to assure safe and effective transitions, and
- interface with case management or disease management staff functioning on behalf of insurers, disease management companies, publicly funded programs, state agencies, including schools, etc. to assure that services are consistent with the PCMH's care plan.

Clinical Care Management

The Clinical Care Manager has several unique functions, some of which can only be performed by a licensed nurse. The unique activities of the clinical care management role are the identification of high-risk patients, and their more intensive monitoring, follow-up, and clinical management. These activities generally include:

- frequent patient contact;
- clinical assessment;
- medication review and reconciliation;
- communication with treating clinicians, and
- medication adjustment by protocol.

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[21] Personal communications with Judith Schaefer, MacColl Institute, September 2009.

Self-management support is also a critical element in this role. While Clinical Care Managers often take on some of the activities described in the care coordination role, especially related to transitions, their role is primarily clinical rather than administrative. The Clinical Care Manager can reside within the practice setting or be contracted through a community-based agency. In either situation, the Clinical Care Manager must be closely integrated within the practice primary care team.

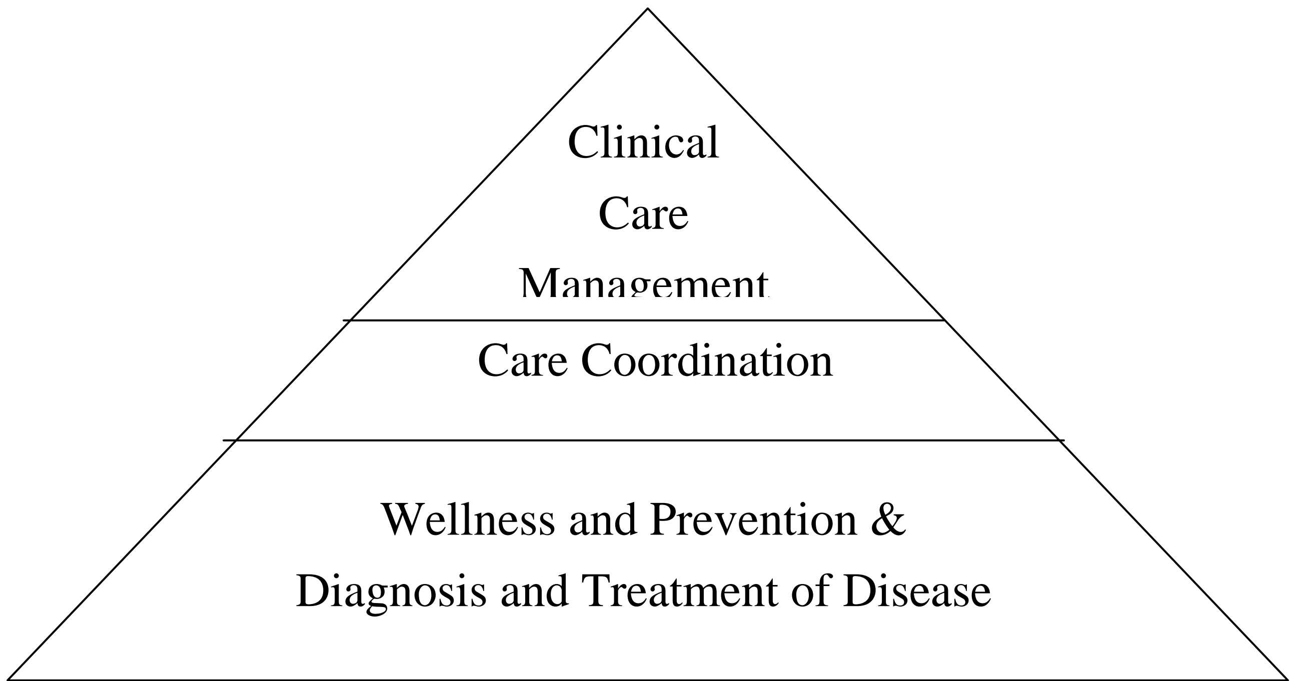
Note: The terms "Case Management" and "Disease Management" were consciously not used, because both terms are so closely linked to payer-based functions and as such differ from the practice-based functions described here. In addition, Case Management is a term that has specific meanings within several publicly funded health and human service programs. If successfully implemented and operated within the practice setting, Care Coordination and Care Management have the potential for eliminating the need for at least some public and private payer-based Case Management and Disease Management functions once practices are capable of assuming some or all of these responsibilities.

Patients Who May Be in Need of Care Coordination and Clinical Care Management

	Patients Who May Be in Need of Care Coordination	**Patients Who May Be in Need of Clinical Care Management**
Description	Patient or family with low to moderate level of self-actualization who has a current medical condition and/or risk factors needing services or is healthy, but in need of services to prevent diminution of health status.	Patient with complex condition or multiple co-morbidities that places him or her at high risk for a future inpatient medical or behavioral health admission.
Duration of Services	Temporary, intermittent, or on-going, depending on nature of need	On-going until sufficient reduction in risk
Examples	45-year old patient recently diagnosed with cancer who is going to be laid off in 2 weeks and cannot afford COBRA 8-year old recently diagnosed with autism who needs educational, social, behavioral health and family support	Patient with uncontrolled diabetes
Provider Type	May be provided by trained layperson (parent, family advocate, community health worker), or a health care provider	Must be provided by a licensed nurse
Goal of Services	Goal: to take action to assist the patient to remain as healthy as possible by accessing culturally appropriate and necessary care and community-based services and by using services appropriately.	Goal: to take action to keep the person safely cared for within the patient-centered medical home or across a system of care, community, preventing ER visits, hospitalization, reduce unnecessary facility admissions, and minimize nursing facility lengths of stay.

<table>
<tr><th></th><th>Patients Who May Be in Need of Care Coordination</th><th>Patients Who May Be in Need of Clinical Care Management</th></tr>
<tr><td>Focus of Services</td><td>Broadly focusing on medical, psychosocial, educational needs and providing linkage to community services</td><td>Primarily a medical focus</td></tr>
<tr><td>Relationship to Medical Home</td><td>Physically or virtually located within the practice. Care Coordinator is a member of the PCMH care team.*</td><td>Physically or virtually located within the practice. Clinical Care Manager is a member of the PCMH care team.*</td></tr>
<tr><td>Key Service Functions</td><td>o Care Coordination and follow-up
  o Development of multi-disciplinary care plan, created jointly by the individual or family and the care team, and which the individual or family has access to at all times
  o Support/facilitate care transitions
  o Provides linkages to needed community-based services, e.g., behavioral health services
  o Maintain continuous communication and documentation to assure care team's knowledge of activities/decisions/issues
  o Manage/track tests, referrals and outcomes
  o Assist patient/family with identifying barriers and problem solving solutions
  o Function as system navigator
o Coach patients/families on self-management skills
o Participate in QI activities at the level of the PCMH or broader system of care</td><td>o Coordinates care among providers and across continuum of care
o Population Management – identifies high risk patients in need of care management and pro-active outreach
o Intense medical and medication management
o Intense transition management
o Care review and planning:
  o Complete/analyze medical, biopsychosocial support and self-management support assessments;
  o Update as necessary
  o Develops and maintains care plan
o Provides Care Coordination services to patients receiving Clinical Care Management
o Oversees care coordination activities delegated to other team members
o Trains team members in care coordination and self-management support</td></tr>
</table>

*Practices might share resources, which could be either dedicated resources or contracted resources from a community agency, such as Independent Living and Recovery Learning Centers for Care Coordination and/or a home health agency, home care agency or Aging Services Access Point (ASAP) for Clinical Care Management.



Application of Care Management and Care Coordination
by Population

Appendix C

Application to Participate in the Massachusetts Patient-Centered Medical Home Initiative

Section A: Practice Site Information

1. Contact Information

a. Name of person completing application:	Title:
b. Name of Practice:	
c. Address of Practice site at which the medical home transformation will occur[22]:	
d. Name of contact person:	Title: E-mail: Phone:
e. Practice's Federal Tax Identification Number:	
f. Practice's Medicaid/MassHealth Provider Number (if applicable):	
g. Practice's contracts with the MassHealth PCC Plan and Medicaid MCOs (check all that apply): ___ BMC HealthNet Plan ___ Fallon Community Health Plan ___ Health New England	 ___ Neighborhood Health Plan ___ Network Health ___ PCC Plan
h. If the Practice site is part of a larger organization that is submitting applications for other practice sites as well, please identify the name of the larger organization: ____	
i. Is the practice site participating in the Safety Net Medical Home Initiative ? Yes ___ No ____	

2. Desired Participation

Does the Applicant wish to be considered for selection to serve as a:		
a. Technical Assistance-Plus Practice?	___ Yes	___ No
b. Technical Assistance-Only Practice?	___ Yes	___ No

[22] If the Practice's organization is interesting in having multiple sites participate in the PCMHI, a separate application must be submitted for each site and each application will be considered individually.

3. Practice Site Characteristics

a. What best describes the person or entity that owns the Practice Site? i. ___ Individual physician ii. ___ Group Practice (Multiple physician partners or shareholders) iii. ___ Hospital or health system iv. ___ Federal, state or local government v. ___ Practice is an independent non-profit organization (other than a hospital) vi. Community Health Center vii. ___ Other (please describe)	b. Type of Practice (Please check all that apply, and indicate with a '*' the characteristic that best describes the practice) i. ___ solo practice (one physician) ii. ___ single-site, single specialty group practice iii. ___ multi-site, single specialty group practice iv. ___ single-site, multi-specialty group practice v. ___ multi-site, multi-specialty group practice vi. ___ residency or academic practice vii. ___ community health center viii. ___ other (please describe)
c. Specialty (check all that apply) i. ___ Pediatrics ii. ___ Family Medicine iii. ___ Internal Medicine iv. ___ General Practice	d. How many years has this Practice Site been in operation? ____ years
e. How many unduplicated patients did the Practice Site see during 2009? Use your best estimate if the practice is unable to provide an accurate count. _______	

f. During the past 12 months, about what percentage of all the patients that the practice site saw were in the following groups? (Your best estimate is fine.)

American Indian/Alaska Native	_______% of all patients
Asian	_______% of all patients
Black	_______% of all patients
Hispanic/Latino/Black	_______% of all patients
Hispanic/Latino/White	_______% of all patients
Hispanic/Latino/Other	_______% of all patients
Native Hawaiian or Other Pacific Islander	_______% of all patients
White	_______% of all patients
Other Race	_______% of all patients
Total (should be close to 100%)	_______% TOTAL

4. Practice Site Clinicians with Patient Panels: Please provide totals in full-time equivalences (FTEs) and subtotals by category of clinician in number of people filling those positions, to the extent that the practice has such personnel and whether the positions are staffed or vacant:

a. Total Physician FTEs with patient panels ____	b. Total Nurse Practitioner (NP) FTEs with patient panels ____
i. # of staffed full time physicians ____ ii. # of staffed part-time physicians ____ iii. # of vacant full-time physician positions ___ iv. # of vacant part-time physician positions ____	i. # of staffed full time NPs ____ ii. # of staffed part-time NPs ____ iii. # of vacant full-time NPs with ____ iv. # of vacant part-time NPs ____
c. Do individual Practice primary care clinicians each have defined panels of patients? ___ Yes ___ No	

5. Payer Mix: Please provide the information requested in the table below for each source of practice site revenue, inserting copies of 2009 1099 forms as supporting documentation. If no 1099 is available, explain why. To automatically calculate the TOTAL, enter all dollar amounts requested; place the cursor in the TOTAL $ column over the "0"; right click and select "update field."

Payer Name	**Total Payments Received for Calendar Year 2009**
Aetna	$
Blue Cross Blue Shield of Mass.	$
Boston Medical Center HealthNet Plan	$
Celticare	$
CIGNA	$
Fallon Community Health Plan	$
Harvard Pilgrim Health Care	$
Health New England	$
MassHealth PCC Plan[23]	$
MassHealth Fee-for-service (non-PCC Plan and non-MCO)	$
Medicare (traditional)[24]	$
Neighborhood Health Plan	$
Network Health	$
Tufts Health Plan	$
UniCare (GIC)	$
UnitedHealthcare	$
Health Safety Net	$
patient private pay	$
other[25] (please identify):	$
other (please identify):	$
TOTAL	$0
% of Total Annual Practice Revenue Represented by Sources Above	%

Each participating payer will also provide EOHHS with expenditure information for practices.

[23] Excludes MassHealth payments for beneficiaries not enrolled in the PCC Plan and payments by Medicaid managed care plans under contract with MassHealth.
[24] Excludes payments by Medicare supplemental policy insurers and by Medicare Advantage product insurers.
[25] Identify only payers who accounted for 5% or more of practice revenue in 2009.

6. Additional Practice Site Information

a. For each practice site position below, provide the number of total FTEs for each position and the number of vacant positions:
   i. Physician Assistants
      Total FTEs______ vacant positions _____
   ii. Clinical staff without patient panels (RNs, LPNs, Medical Assistants, etc.)
      Total FTEs______ vacant positions _____
   iiii. Clinical support staff (social workers, Clinical Care Managers, educators, etc.)
      Total FTEs______ vacant positions _____
   v. Practice Administrator
      Total FTEs______ vacant positions _____
   vi. Office manager
      Total FTEs______ vacant positions _____
   vii. Front office administrative staff
      Total FTEs______ vacant positions _____

b. As of the date of completing this application, when a patient calls for an acute visit, what is the current wait time for getting an appointment at the practice site? _____

7. Computer-based or Web-based Functionalities: Please indicate which of the following computer-based or web-based functionalities the practice site currently has, if any (check all that apply):

a. ______Patient scheduling	i. _____Coordination of care software
b. ______Financial data management	j. _____Patient e-mail
c. ______Electronic claims submission	k. _____General clinical information retrieval
d. ______Medical records	l. _____Network server
e. ______Patient registry	m. _____Website practice site information (e.g., web page)
f. ______Electronic prescribing	n. _____Broadband/wi-fi/high-speed Internet access
g. ______Referral request submission	o. _____None of the above
h. ______Electronic transmission of lab results	

8. Medical Records

a. Approximately what percent of the Practice Site's medical records are currently (percentages should total 100%):
   i. ______% Handwritten
   ii. ______% Typed
   iii. ______% Electronic

b. If the Practice Site uses an electronic health record (EHR), when was it implemented? ______

d. If the practice site uses an EHR, please check if the EHR is:
   i. ____ Used in the exam room during patient visits
   ii. ____ Used to exchange data with external systems (e.g., lab, referral providers)
   iii. ____ Used for 100% of patient record keeping

c. If the Practice Site does not use an EHR, does the Practice Site have plans to implement an EHR: In 2010? ____ Yes ____ No In 2011? ____ Yes ____ No	

Section B: Medical Home Transformation

9. Explain in one page or less why the applicant is interesting in participating and why it believes it would be a good Practice Site to implement a PCMH. Describe how transformation to a PCMH will enable the Practice to advance opportunities to deliver care and address common chronic conditions such as diabetes, depression, and asthma.

10. Describe in one page or less the experience of the individual(s) who will be providing Practice Site leadership should the practice be selected for the PCMHI (note: Community Health Center applicant practices must include, at a minimum, their Medical Director), why such experience/leadership is relevant to PCMH implementation, and his or her understanding of the challenges inherent in practice transformation.

11. List the names and titles of the members of the Practice Site's proposed Core Practice Team, including one primary care physician or nurse practitioner holding a senior leadership position, another clinician and a non-clinician member of the primary care Core Practice Team (e.g., practice manager or practice administrator). A Core Practice Team must be either pediatric only or adult-plus (internal medicine, family practice, etc.) focused.

a.

Name	Title/Position

b.

Is the Core Practice Team pediatric-only or adult-plus focused? (please check only one)	Pediatric ____ Adult + ____

12. In one page or less, describe and provide examples of how the Practice will involve patients, families and/or caregivers in the process of defining the elements of a "patient-centered practice."

13. In one page or less, if the Applicant is other than an independent, single-site practice, describe in detail the manner in which the larger corporate entity will support the Practice Site meeting the goals of the PCMHI, including:

a. ensuring that supplemental payments made available through PCMHI/ participation will pass through to the practice site, should the practice site be selected as a Technical Assistance-Plus Practice;
b. provision of staff or other resources (including at a minimum, information technology staff for activities such as EHR programming, data analysis); and
c. provision of resources to ensure spread of the PCMH model to other care teams that are not part of the PCMHI Practice Team.

14. If the Applicant is not selected as a Technical Assistance-Plus Practice and would wish to be considered for participation as a Technical Assistance-Only Practice, explain in one page or less how the Practice will meet the requirements set forth in **Section 2** without additional compensation.

15. In one page or less, describe how the Applicant will coordinate care across the continuum of services and ongoing challenges for which you would appreciate technical assistance from the PCMHI. This information will help EOHHS understand each Applicant's current approach to care coordination and potential technical assistance needs. [Response will not be considered in final consideration of Applicant's response.]