

Maine Patient Centered Medical Home Pilot
Memorandum of Agreement for Participation
Maine PCMH Pilot Expansion & MAPCP Demonstration

Introduction: In 2009, The Dirigo Health Agency's Maine Quality Forum, Quality Counts, and the Maine Health Management Coalition convened a multi-stakeholder effort to implement and evaluate the Maine Patient Centered Medical Home (PCMH) Pilot as the first step in achieving statewide implementation of the PCMH model. The Pilot was launched in January 2010 with 26 practices from across the state, initially planned as a 3-year effort to implement the PCMH model in a set of primary care practices. In November 2010, Maine was selected as one of eight sites to participate in the Medicare Multipayer Advanced Primary Care Practice (MAPCP) demonstration project, bringing in Medicare as a payer in the Pilot.

As a requirement of participation in the MAPCP demonstration, the original timeline of the Maine PCMH Pilot has been extended to match the MAPCP timeline (i.e. January 1, 2012 through December 31, 2014), and the participating commercial payers and Medicaid have agreed to extend their participation through this time. In addition, the Pilot is being expanded to include 20 new adult primary care practices in January 2013.

Practices applying for participation in the Maine PCMH Pilot expansion are asked to commit to full participation in the Pilot and the MAPCP demonstration. This Memorandum of Agreement serves as a formal agreement to meet the expectations of participation in the Pilot and MAPCP demo through this time period.

Mission: The Maine Patient Centered Medical Home (PCMH) Pilot will develop and implement patient centered delivery system and payment models that will provide and support effective, efficient, and accessible health care.

Vision: The Patient Centered Medical Home model will provide effective, efficient, and accessible health care supported by appropriate payment, and will deliver sustainable value to patients, providers, purchasers, and payers.

Benefits of Participation

The Maine PCMH Pilot offers an opportunity for primary care practices to make significant improvements in their systems of care for all patients in their practice, and to test a new payment model that recognizes the value of the PCMH model. Participants in the Pilot receive the following benefits:

- Recognition as a practice committed to improving primary care and a leader in transforming care to the PCMH model
- Opportunity to participate in an alternative payment model for primary care services, including PCMH payments from commercial payers and Medicaid.
- Support for transforming practice to the PCMH model through the PCMH Learning Collaborative, project staff and consultants, and collaborative learning with other practices participating in the Pilot
- Category I CME credits for attendance at PCMH Collaborative Learning Sessions
- Patient and provider tools to improve care
- Assistance in managing complex, high-needs patients from a partnering Community Care Team

Expectations of Participating Practices – Primary care practice sites selected for participation in the Maine PCMH Pilot and MAPCP demonstration are asked to commit to the following:

1. Support the Mission, Vision, and Guiding Principles of the Maine PCMH Pilot (see Appendix A), and commit to preserving access to primary care services.
2. Participate in the full duration of the Pilot and MAPCP demonstration, including a 3-month post-Pilot practice reassessment as part of the overall Pilot evaluation. Participation of Pilot practice sites means active participation of all healthcare professionals and staff in the practice site, and agreement to continually assess and improve care processes and structures within the practice, working in partnership with Pilot staff.
3. Fully implement the PCMH model as defined by the Maine Pilot, including fully implementing and maintaining *all* PCMH Pilot “Core Expectations” (see Appendix B). Practices newly entering the Pilot will be required to participate in an on-site assessment to evaluate the status of their Core Expectation implementation prior to entering the Pilot, with the practice assuming the costs of this assessment.
4. Maintain Patient Centered Medical Home recognition using the National Committee for Quality Assurance Patient Centered Medical Home 2011 Standards (NCQA PCMH 2011), maintaining or improving practice’s current NCQA PCMH recognition level.
5. Submit updated provider information (provider names, tax ID numbers) to Pilot staff on a quarterly basis, or as otherwise requested, to support the process of attributing patients to the practice which is required for payers to make appropriate payments to practices.
6. Explicitly identify and use the PCMH payments from participating payers specifically to implement the PCMH model and improve systems of care within the practice.
7. Maintain a “Leadership Team” within the practice to serve as champions for PCMH improvement efforts and to attend PCMH Learning Collaborative Learning Sessions. The Leadership Team at your practice must include (at a minimum) a lead primary care physician or nurse practitioner, practice administrator, and a clinical support staff.
8. Participate in the PCMH Learning Collaborative, including consistent attendance by all members of the practice Leadership Team at 1-day Learning Sessions three times per year for the duration of the Pilot and MAPCP demonstration. A minimum of three Leadership Team members are required to attend all PCMH Learning Sessions, and practices may be required to pay a fee for attendance to help defray costs.
9. Participate actively in collaborative learning with other Pilot practices through sharing learning with other teams in Learning Sessions and participation of at least one Leadership Team member in monthly Leadership Team conference calls. Pilot practices are required to participate as a faculty/guest presenter in at least one PCMH team call or Learning Session per year.
10. Work with a PCMH Pilot-recognized Community Care Team to coordinate care and collaboratively manage the most high-needs, high-cost patients in the practice.
11. Fully participate in the Pilot and MAPCP evaluations, including the following:
 - Submit required authorizations for release of claims data to PCMH Pilot staff and evaluation team for analysis of cost and quality measures, both at baseline and over the course of the Pilot.

- Track full set of Pilot clinical quality measures using the practice’s electronic medical record or registry, and report the full set of these clinical outcomes at baseline and quarterly to PCMH Pilot.
- Complete additional tools assessing practice culture as determined by the Pilot evaluation team – e.g. Practice Staff Questionnaire, Microsystems Assessment Tool.
- Participate in surveys and interviews with evaluation team, to be completed within three months of completion of the Pilot.

By signing below, I acknowledge my understanding of the goals and expectations of the Maine PCMH Pilot and MAPCP demonstration, and commit to full participation in the Pilot and MAPCP demonstration as defined by agreement to fulfill the expectations outlined above. I further understand that PCMH Pilot staff will periodically communicate our practice’s adherence to these expectations to the participating Pilot payers, and that these payers may choose to discontinue PCMH payments if we do not fully adhere to these expectations.

Practice name: _____

Practice Address (site): _____

➤ **Physician or Nurse Practitioner Leader:**

Signed: _____ Date: _____

(Name): _____

➤ **Practice Manager or lead Administrator:**

Signed: _____ Date: _____

(Name): _____

➤ **Practice Senior Leader** (*Practices that are owned by a parent organization, hospital, or health system must obtain signature of the CEO/President of the parent organization that is responsible for operations of the practice*):

Signed: _____ Date: _____

(Name): _____

**Please print and return completed MOA (Pgs 1-3) to Maine Quality Counts by March 31, 2012
PO Box 190, Manchester, ME 04351-0190, or FAX 622.3332**

Maine Patient Centered Medical Home Pilot Memorandum of Agreement for Participation

Appendix A:

Mission & Vision, Guiding Principles of the Maine PCMH Pilot

Mission: The Maine Patient Centered Medical Home (PCMH) Pilot will develop and implement patient centered delivery system and payment models that will provide and support effective, efficient, and accessible health care.

Vision: The Patient Centered Medical Home model will provide effective, efficient, and accessible health care supported by appropriate payment, and will deliver sustainable value to patients, providers, purchasers, and payers.

Definitions of Success - The Patient Centered Medical Home will:

- **Improve the health, well-being, and experience of care for all patients and families by...**
 - Transforming the experience of care for all patients in the practice, and strengthening the caring relationship between patients and their healthcare provider
 - Providing quality care that is safe, timely, effective, equitable, efficient, and patient-centered
 - Providing care that recognizes and integrates all of the patient's healthcare needs, including integrating behavioral and physical health needs
 - Educating and empowering patients to work in partnership with the practice team to achieve optimal health and promote preventive care
 - Giving patients more opportunities to be active and engaged in improving their care and their health (e.g. e-visits, group visits, community supports) without creating barriers to needed care
 - Connecting patients and families with community resources that support improved care and healthy behaviors, and are linked to Maine's emerging public health infrastructure (e.g. HMPs)
- **Sustain & revitalize primary care by...**
 - Encouraging primary care practices to take responsibility for the health needs of the entire population of patients in the practice who have agreed to partner with the practice team to receive care.
 - Enabling primary care providers to serve as leaders of practice change and advocates for their patients in a system of patient-centered care (i.e. not "gatekeepers")
 - Improving the efficiency of the practice and the satisfaction of the entire practice team
 - Providing a sustainable payment model that appropriately recognizes the value of primary care, supports the infrastructure and systems needed to deliver high quality care, rewards cost effective care, positive patient experiences and desired outcomes, and can be expanded statewide
 - Redefining the job of primary care and demonstrating how primary care can be an attractive form of practice that encourages medical students to choose training in primary care
 - Highlighting pilot practices as "best practice showcases" to help other practices learn how to transform to the medical home model and to promote spread of the model statewide
- **Promote an efficient integrated system of care by...**
 - Creating a system that enables people to be healthier and more productive.
 - Working with payers and purchasers to develop benefit designs and payment methodologies that support the mutual goals of the medical home
 - Bringing community stakeholders (e.g. primary care, specialists, hospitals) together to work towards shared goals and community benefit
 - Reducing overall costs of care (or at a minimum slowing the rate of healthcare cost increases) by reducing inappropriate utilization (e.g. avoidable Emergency Department use & hospitalizations) and decreasing unwarranted variations in care
 - Measuring outcomes that demonstrate the value (ROI) of the new model, broadly defined in terms of quality, experience of care, and costs/resource use

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Appendix A:

Mission & Vision, Guiding Principles of the Maine PCMH Pilot

Guiding Principles for Maine Patient Centered Medical Home

The stakeholders of the Maine Multi-Payer Pilot of the Patient Centered Medical Home (PCMH) model endorse the “Joint Principles of the Patient-Centered Medical Home” as outlined by the American Academy of Family Physicians (AAFP), American College of Physicians (ACP), American College of Pediatrics (AAP), and American Osteopathic Association (AOA) in defining the medical home model – see attached.¹

In addition to the AAFP-ACP-AAP-AOA Joint Principles, the stakeholders of the Maine Multi-Payer PCMH Pilot also identify the following additional principles that define implementation of the PCMH model in Maine:

- Given the unique geographic and demographic characteristics of the state and the need to take an inclusive approach to primary care practice, we envision a patient-centered medical home model that is delivered by practice teams that may be broad and varied in their composition but are held to a common set of expectations and consistent standard of care.
- We recognize that nurse practitioners and physician assistants are an integral part of the primary care system, and are important members of the primary care practice team.
- We consider references in the AAFP-ACP-AAP-AOA Joint Principles to “the personal physician” to be too narrow, and use the broader definition of the “personal primary care provider”. Similarly, we more broadly define references to the “Physician directed medical practice” to include “primary care practice”.
- We expand the description of “whole person orientation” in the Joint Principles to include a responsibility of the primary care team to recognize and integrate the patient’s entire healthcare needs, including integration of behavioral and physical health needs.
- We recognize that payment for the medical home must appropriately recognize the added value provided to patients, but also must be balanced by savings from improved efficiencies and decreased costs achieved by reducing inappropriate utilization (e.g. avoidable Emergency Department use and hospitalizations, diagnostic testing not supported by evidence based guidelines) and decreasing unwarranted variations in care.

We further recognize that some stakeholders believe the definition of the Patient-Centered Medical Home as defined by the Joint Principles, and as further defined by the NCQA Physician-Practice Connection-PCMH (PPC-PCMH) standards, are limited, and/or in need of further refinement. As with any relatively new process, we are committed to continually reviewing the Joint Principles and standards, and consider them subject to potential future revision. Today, however, we recognize that they stand as the current national consensus definitions of a Patient-Centered Medical Home and endorse them as the core principles for the PCMH model when considered together with those noted above.

¹ Joint Principles of the Patient Centered Medical Home, AAFP, AAP, ACP, AOA – March 2007
January 2012

**American Academy of Family Physicians (AAFP)
American Academy of Pediatrics (AAP)
American College of Physicians (ACP)
American Osteopathic Association (AOA)**

**Joint Principles of the Patient-Centered Medical Home
March 2007**

Introduction

The Patient-Centered Medical Home (PC-MH) is an approach to providing comprehensive primary care for children, youth, and adults. The PC-MH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.

The AAP, AAFP, ACP and AOA, representing approximately 333,000 physicians, have developed the following joint principles to describe the characteristics of the PC-MH.

Principles

Personal physician - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician directed medical practice – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation – the personal physician is responsible for providing for all the patient's medical needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; end of life care.

Care is coordinated and/or integrated across all domains of the health care system (e.g. subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g. family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:

- Practice advocates for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family
- Evidence-based medicine and clinical decision-support tools guide decision making
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met

- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication
- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.
- Patients and families participate in quality improvement activities at the practice level

Enhanced access to care through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and office staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

- It should reflect the value of physician and non-physician staff work that falls outside of the face-to-face visit associated with patient-centered care management.
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- It should support adoption and use of health information technology for quality improvement;
- It should support provision of enhanced communication access such as secure e-mail and telephone consultation;
- It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).
- It should recognize case mix differences in the patient population being treated within the practice.
- It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
- It should allow for additional payments for achieving measurable and continuous quality improvements.

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APPENDIX B – Maine PCMH Pilot Core Expectations

Introduction: The Maine Patient Centered Medical Home (PCMH) Pilot is a multi-stakeholder effort convened by the Dirigo Health Agency’s Maine Quality Forum, Maine Quality Counts, and the Maine Health Management Coalition to implement and evaluate the PCMH model as the first step in achieving its statewide implementation. Practices participating in the Pilot confirm their commitment through a written “Memorandum of Agreement”, which outlines the anticipated benefits and expectations for primary care practice sites participating in the Pilot, and includes a set of “Core Expectations”, listed below. Pilot practices commit to achieving and maintaining these Core Expectations during the course of the Pilot. (NB: Expectation #10, HIT, was added July 09).

1. **Demonstrated leadership**

- The practice can identify at least one primary care physician or nurse practitioner as a leader within the practice who visibly champions a commitment to improve care and implement the PCMH model. The primary care leader(s) takes an active role in working with other providers and staff in the practice to build a team-based approach to care, continually examine processes and structures to improve care, and review data on the performance of the practice. The primary care leader also participates as a member of the practice Leadership Team and participates in all aspects of the PCMH Learning Collaborative.

2. **Team-based approach to care**

- The practice uses a team-based approach to care delivery that includes expanding the roles of non-physician providers (e.g. nurse practitioners, physician assistants, nurses, medical assistants) to improve clinical workflows.
- The practice has committed redesigning primary care practice in a way that utilizes non-physician staff to improve access and efficiency of the practice team in specific ways, such as through greater use of planned visits, integrating care management into clinical practice, delegating some types of patient testing or exams (e.g., ordering of routine screening tests, diabetic foot exams) to non-physicians; expanding patient education; and providing greater data support to physicians to enhance the quality and cost-effectiveness of their clinical work.
- Members of the practice team identify themselves as part of the practice team, and can identify their specific role and responsibilities within the team.

3. **Population risk stratification and management**

- The practice has adopted a process for proactively identifying and stratifying patients across their population who are at risk for adverse outcomes, and direct resources or care processes to help reduce those risks.
- “Adverse outcomes” is intended to mean adverse clinical outcomes and/or avoidable use of healthcare services such as hospital admissions, emergency department visits, or non-evidence based use of diagnostic testing or procedures.

4. **Practice-integrated care management**

- The practice has a clear process for providing care management services, and has identified specific individuals to work closely with the practice team to provide care management for patients at high risk for experiencing adverse outcomes, including patients with chronic illness who are complex or fail to meet multiple treatment goals;

patients identified at risk for avoidable hospitalization or emergency department use; and patients at risk for developing avoidable conditions or complications of illness.

- Care management staff have clear roles and responsibilities, are integrated into the practice team, and receive explicit training to provide care management services.
- Care management staff have defined methods for tracking outcomes for patients receiving care management services.

5. Enhanced access to care

- The practice commits to preserving access to their population of patients.
- The practice has a system in place that ensures patients have same-day access to their healthcare provider using some form of care that meets their needs – e.g. open-access scheduling for same-day appointments, telephonic support, and/or secure messaging.
- Time to 3rd next available appointment is consistently tracked and measured at zero.

6. Behavioral-physical health integration

- With the assistance of PCMH Pilot staff and consultants, practice participates in a baseline assessment of their current behavioral-physical health integration capacity
- Using results from this baseline assessment, practice has taken steps to make one or more specific improvements to integrate behavioral and physical health care– e.g.
 - Implement a system to routinely conduct a standard assessment for depression (e.g. PHQ-9) in patients with chronic illness
 - Incorporate a behavioralist into the practice to assist with chronic condition management
 - Co-locate behavioral health services within in the practice

7. Inclusion of patients & families in implementation of PCMH model

- With the assistance of PCMH Pilot staff and consultants, practice has identified at least two patients or family members to be part of the practice Leadership Team
- Practice is using one or more mechanisms for routinely soliciting input from patients and families on how well the practice is meeting their needs

8. Connection to community – local Healthy Maine Partnership

- With assistance from PCMH Pilot staff, practice connects with their local Healthy Maine Partnership (HMP) to better understand community resources available to their patients
 - Practice can identify their local Healthy Maine Partnership
 - Practice leadership meets at least once with HMP staff

9. Commitment to reducing unnecessary healthcare spending, reducing waste, and improving cost-effective use of healthcare services

- The practice makes a clear and firm commitment to reduce wasteful spending of healthcare resources and improving the cost-effective use of healthcare services by targeting at least 1-3 specific waste reduction initiatives – i.e. practice commits specific resources or processes in the practice towards... (e.g.)
 - Reducing avoidable hospitalizations
 - Reducing avoidable emergency department visits
 - Reducing non-evidence-based use of expensive imaging – e.g. MRI for low back pain or headache
 - Working with specialists to develop new models of specialty consultation that improve patient experience and quality of care, while reducing unnecessary use of services
 - Directing referrals to specialists who consistently demonstrate high quality and cost efficient use of resources

10. **Integration of health information technology (HIT):**

- Practice is working towards use of integrated HIT (e.g. registry, electronic medical record, personal health records, health information exchange, provider-patient secure messaging) to support improved communication with and for patients, and to assure patients get care when and where they need and want it in a culturally and linguistically appropriate manner.

**Please print and return completed MOA (Pgs 1-3) to Maine Quality Counts by December 15, 2011
PO Box 190, Manchester, ME 04351-0190, or FAX 622.3332**