**CTC 2016-2017 Expansion: Milestone: Adult Rate Sheet: Per-Member-Per-Month Payments (Includes CPC+ requirements and payment identified in italics: Note timeframes for CPC+ milestones subject to change**

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| **Developmental Stage/Yr.** | **Adult Milestone Requirements** | | | | | | | | |
|  | **Care Management**  Target 1 | **Planned Care for population Health and Quality Reporting**  Target 2 | | **Access and Continuity**  Target 3 | **Patient Family Engagement**  Target 4 | | **Comprehensiveness**  **and Coordination**  Target 5 | | **Enhanced Payment for Practice Transformation**  Target 6 |
| **Start up**  **Year 1**  1/1/2017-12/31/17 | Hire Care Manager  (end of 4 months) 1  Develop high risk registry and reportable fields for CM;  6 months  Report to health plans high risk engagement  9 months  *Risk stratifies all empaneled patients*  *12 months* | Submits quality report (6 months and quarterly thereafter) | | *Submits empanelment report and organizes practice identified teams responsible for a specific identifiable panel of patients*  (10 months)  Submits  provider panel report: accepting new patients (3rd next available appointment)  (6 months) | Submits patient panel for CAHPS survey  **(3 months )**  *Convenes a Patient Family Advisory Council(PFAC) at least once in 2017 and implements recommendations*  *Assesses practice capacity and plans to support patients’ self-management* | | *Systematically identifies high volume and/or high cost specialists serving the patient populations and Submits 4 Compacts*  *(9 months)*  Submits Transition of Care Policy and Procedure  (12 months) | | Submits budget with staffing plan and use of funds to support care delivery model  (4 months)  NCQA PCMH Work plan due  9 months  PF meetings 1-2 a month |
| **Transition**  **Year 2**  1/1/2018-12/31/18 | **Care Management**  Target 1 | **Planned Care for population Health**  Target 2 | | **Access and Continuity**  Target 3 | **Patient Family Engagement**  Target 4 | | **Comprehensiveness**  **and Coordination**  Target 5 | | **Enhanced Payment for Practice Transformation**  Target 6 |
|  | *Provides targeted, proactive relationship based care management and reports on CM activity with high risk patients and health plan specific report*  *1st month and quarterly thereafter* | Submits quarterly quality data  *Uses feedback reports provided by CMS/other payers at least quarterly on at least 2 utilization measures at practice level and on at least 3 electronic quality measures derived from EHR at the practice and panel level to inform strategies to improve population health* | | Submits Before and After hours Protocol/Telephone response with patient access to 24/7 care team provider with real time access to EHR Expanded hours 4 hrs. over weekend, 2 hours AM or PM  3rd month | *Convenes a PFAC in at least 2 quarters and integrates recommendations into care as appropriate* | | *Identifies hospitals and ED’s responsible for majority of visits and assesses and improves timeliness of notification and information 1st month*  *Chooses and implements one option for integrated behavioral health*  2 compacts  10 months | | Submits budget with staffing plan and use of funds to support care delivery model  (1st months)  NCQA application submitted  9 months  PF 1x month |
| **Development Stage/Yr.** | **Adult Milestone Requirements** | | | | | | | | |
|  | **Care Management**  Target 1 | **Planned Care Population Health**  Target 2 | **Access and Continuity**  Target 3 | | | **Patient Family Engagement**  Target 4 | **Comprehensive-\_ness and Coordination**  Target 5 | **Enhanced Payment**  Target 6 | |
| Performance I | *Provides short team care management along with medication reconciliation to patients who have an ED or hospital admission/discharge/ transfer for high risk patients 1st month*  *Ensures patients with ED visit receive a follow interaction within 1 week of discharge 6th month*  *Contact at least 75% of patients who were hospitalized in target hospital within 2 business days 9 months*  Reports on CM activity with high risk patients and health plan specific report  1st month and quarterly thereafter | Submits quarterly quality data  Uses feedback reports provided by CMS/other payers at least quarterly on at least 2 utilization measures at practice level and on at least 3 electronic quality measures derived from EHR at the practice and panel level to inform strategies to improve population health | *Submits empanelment report Achieves 95% empanelment of patients assigned to PCP; organizes care by practice identified teams responsible for specific identifiable panel of patients*  *1st month* | | | *Continue implementation of patient/family strategy*  *Implements self-management support for at least 3 high risk conditions* | Implements both option and submits f/u report high risk patients  ED: 72 hours  IP: 72 hours  6 months  2 compacts  10 months | Submits budget with staffing plan and use of funds to support care delivery model  (1st months)  Achieves NCQA  1st month  Submits OHIC Care Management 80 % attestation by 9/30  PF 1x a quarter | |