**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) 1Develop 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 9/30PF 1x a quarter  |