**CTC 2016-2017 Expansion: Milestone: Adult Rate Sheet: Per-Member-Per-Month Payments**

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| **Developmental Stage/Yr.** | **PMPM****Rates by contract year** | **Milestone Requirements** |
|  |  | **Care Management**Target 1 | **Planned Care for population Health**Target 2 | **Access and Continuity**Target 3 | **Patient Family Engagement**Target 4 | **Medical Home Coordination**Target 5 | **Quality Reporting**Target 6 | **Enhanced Payment for Practice Transformation**Target 7 |
| **Start up** **Year 1** 1/1/2017-12/31/17  | $3.00 base$2.50 NCM**Max: $5.50** | Hire Care Manager (end of 4 months) 1**Develop high risk registry and reportable fields for CM;** **report to health plans high risk**  | Selects has **work plan** to implement 1 care management strategy IBH OR Self-management support for risk condition OR Medication management and review (10 months)  | Submits empanelment report (10 months)provider panel report: accepting new patients (3rd next available appointment)(6 months)  | Submits patient panel for CAHPS survey **(3 months )**  | Submits 4 Compacts (9 months) Submits Transition of Care Policy and Procedure (12 months)  | Quality Report (6 months and quarterly thereafter)  | 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 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 | **Medical Home Coordination**Target 5 | **Quality Reporting**Target 6 | **Enhanced Payment for Practice Transformation**Target 7 |
|  | $3.00 Base$2.50 NCM$0.50 CM reporting and stable data **Max:$6** | Reports on CM activity with high risk patients and health plan specific report 1st month and quarterly thereafter  | Implements 1 care management strategy 6 months) IBH OR Self-management support for risk condition OR Medication management and review  |  Submits staffing plan: Before and After hours Protocol/Telephone response Expanded hours 4 hrs. over weekend, 2 hours AM or PM 3rd month  | Implements 1 option: Monthly surveyOr Quarterly PT/family advisory Or Quarterly survey/PFAC 2x Yr. Or Implements Open notes1st month  | Implements 1 option and submits f/u report high risk patients ED: 72 hours or IP: 72 hours 6 months 2 compacts 10 months  | Due quarterly  | 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.** | **PMPM****Rates/ contract year** | **Milestone Requirements** |
|  |  | **Care Management**Target 1 | **Planned Care Population Health**Target 2 | **Access and Continuity**Target 3 | **Patient Family Engagement**Target 4 | **Medical Home Coordination**Target 5 | **Quality Reporting**Target 6 | **Enhanced Payment**Target 7 |
| Performance I | $3.00 base$2.50 CM**$0.50 (Target 3 QM)** **$0.25 (Target 4 QM)** $0.50(Target Patient Experience) $1.25All Cause IP adm$0.75All Cause ED **Max: $8.75** | Reports on CM activity with high risk patients and health plan specific report 1st month and quarterly thereafter  | Implements 2 care management strategy 6 months) IBH Self-management support for risk condition OR Medication management and review 3rd month  | Submits empanelment report indicates 95% of patients assigned to PCP 1st month  | Identifies a priority condition, decision or test that would benefit from shared decision making and makes decision aid available to appropriate patients 3rd month  | Implements both option and submits f/u report high risk patients ED: 72 hours IP: 72 hours 6 months 2 compacts 10 months | Due quarterly  | 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  |