Appendix A:

Care Transformation Requirements

Comprehensive Primary Care Functions of Advanced Primary Care	Care Transformation Requirement	Practice Track Requirement
Access and Continuity	1.1 Empanel attributed beneficiaries to practitioner or care team.	Track 1 + 2
	1.2 Ensure attributed beneficiaries have 24/7 access to a care team or practitioner with real-time access to the EHR.	Track 1 + 2
	1.3 Ensure attributed beneficiaries have regular access to the care team or practitioner through at least one alternative care strategy.	Track 2 only
Care Management	2.1 Ensure all empaneled, attributed beneficiaries are risk stratified.	Track 1 + 2
	2.2 Ensure all attributed beneficiaries identified as increased risk and likely to benefit receive targeted, proactive, relationship-based (longitudinal) care management.	Track 1 + 2
	2.3 Ensure attributed beneficiaries receive a follow-up interaction from your practice within one week for ED discharges and two business days for hospital discharges.	Track 1 + 2
	2.4 Ensure targeted, attributed beneficiaries who have received follow-up after ED, hospital discharge, or other triggering events receive short-term (episodic) care management.	Track 1 + 2
	2.5 Ensure attributed beneficiaries in longitudinal care management are engaged in a personalized care planning process, which includes at least their goals, needs, and self-management activities.	Track 2 only
	2.6 Ensure attributed beneficiaries in longitudinal care management have access to comprehensive medication management.	Track 2 only
Comprehensiveness and Coordination across the Continuum of Care	3.1 Ensure coordinated referral management for attributed beneficiaries seeking care from high-volume and/or high-cost specialists as well as EDs and hospitals.	Track 1 + 2
	3.2 Ensure attributed beneficiaries with behavioral health needs have access to care consistent with at least one option from a menu of options for integrated behavioral health supplied to attributed beneficiaries by the Practice	Track 1 + 2
	3.3 Facilitate access to resources that are available in your community for beneficiaries with identified health-related social needs	Track 2 only
Beneficiary & Caregiver Experience	4.1 Convene a Patient-Family/ Caregiver Advisory Council (PFAC) at least annually and integrate PFAC recommendations into care and quality improvement activities.	Track 1 + 2
	4.2 Engage attributed beneficiaries and caregivers in a collaborative process for advance care planning	Track 2 only
Planned Care for Health Outcomes	5.1 Continuously improve your performance on key outcomes, including cost of care, electronic clinical quality measures, beneficiary experience, and utilization measures.	Track 1 + 2

Appendix B:

CTO Services/Personnel Offered and Practice Selection

Package A (50%)

Service Category	Care Requirement & Quality Measure	Description	Staff Type	Ratio of staff (FTE) to practice
Behavioral Health Integration (BHI)	Comprehensiveness & Coordination 3.2, NQF 0004	Linking to services; AGH or Health Department	Care Coordination/Manager	1:2 per practice
Medication Management	Care Management 2.6	Link to services & MTM program	Care Coordination/Manager	1:2 per practice
Social Determinants Screening & Referral	Comprehensiveness & Coordination 3.3	Manage and refer to Health Department	Care Coordination/Manager	1:2 per practice
Alternative Care (e.g., Telehealth, home visits)	Access & Continuity 1.3	N/A	Care Coordination/Manager	1:2 per practice
Transitional Care Management (TCM)	Care Management 2.2, 2.3, 2.4, 2.5, 2.6	Work in conjunction with AGH case managers	Care Coordination/Manager	1:2 per practice
Care Planning & Self-Management Support	Care Management 2.5, Beneficiary & Caregiver Experience 4.2	Work in conjunction with AGH case managers	Care Coordination/Manager	1:2 per practice
Population Health Management & Analytics	Planned Care for Health Outcomes 5.1, eCQMs, Utilization	Execute follow-up based upon reports/outcomes	Care Coordination/Manager	1:2 per practice
Clinical & Claims Data Analysis	Care Management 2.1-2.4, Utilization	HCC based upon claims data & reports thru CRISP	Care Coordination/Manager	1:2 per practice
Patient Family Advisory Councils (PFACs)	Beneficiary & Caregiver Experience 4.1	Future development	Care Coordination/Manager	1:2 per practice
Quality & Utilization Performance	Planned Care for Health Outcomes 5.1, eCQMs	Execute follow-up based upon reports/outcomes	Care Coordination/Manager	1:2 per practice
24/7 Access	Access & Continuity 1.2	Provided by individual practice	Care Coordination/Manager	1:2 per practice
Referral Management	Comprehensiveness & Coordination 3.1	Hospital and community based care coordination	Care Coordination/Manager	1:2 per practice
Other				