Person-Centered Medical Home (PCMH)
Glide Path Renewal Instructions and Application

Revision B – 06.01.2025

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GLIDE PATH RENEWAL APPLICATION INSTRUCTIONS

I. Glide Path Renewal Application Requirements

Your practice will be required to complete a gap analysis in collaboration with your Community Practice Transformation Specialist (CPTS) within 30 days of this application submission. If you have any questions, please contact the PCMH Program Administrator at 203.949.4194 or **pcmhglideapplication@chnct.org**.

To Complete a Glide Path Renewal Application:

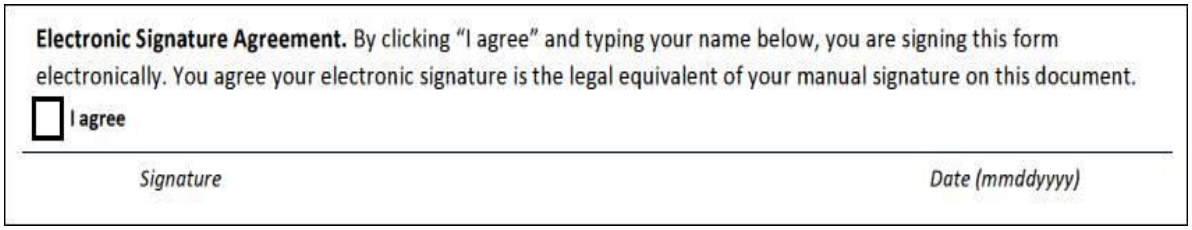
1. It is important to download and save the form before entering data. Save the application using the convention:

   PracticeName_PCMHGlidePathRenewal_mm-dd-yyyy.pdf.

   The form was created using Adobe® Acrobat® 10 Pro Version 10.1.16. It has been tested using Adobe® Acrobat® Reader 11 and Microsoft Internet Explorer® 11.0.
   The form should be submitted using an Adobe® Acrobat® application using Internet Explorer®.

2. Complete the application by entering data directly in the form fields provided on the application. As you enter data be sure to periodically save the form.

3. The last section of the application is the electronic signature agreement. By clicking "I agree" and signing below, you are signing the agreement electronically. You agree your electronic signature is the legal equivalent of your manual signature on the agreement.



4. Upon completion, save the form. Contact your assigned Community Practice Transformation Specialist (CPTS) to review the draft of your application prior to submission.

5. Once approved, click the **SUBMIT** button on the last page to transmit the data to the Medical Administrative Service Organization (ASO). You will automatically receive a **Message Received** reply with a tracking number. Save this for future reference. You can expect to be contacted by the ASO within three business days.

A complete description of the Glide Path Renewal Application requirements and detailed data field descriptions are included in the Application on pages 7 to 11.

II. Additions or Changes to the Glide Path Renewal Application

Open your original, saved Glide Path Renewal Application and make appropriate additions or changes, making sure to reference the Glide Path Renewal **tracking number**. An individual authorized to act as a signatory for the practice must re-sign the application when it is re-submitted. In doing so, the signatory certifies that all updated information provided on the application is accurate.

Once your application is updated and signed, follow the Electronic Submission instructions on page 11.

Please direct any questions regarding the PCMH Glide Path Renewal Application process to your Community Practice Transformation Specialist or the PCMH Program Administrator at 203.949.4194 or pcmhglideapplication@chnct.org.

III. Summary of Glide Path Renewal Application Submission Requirements

SUMMARY OF SUBMISSION REQUIREMENTS		
GLIDE PATH PRACTICE MUST PROVIDE:	**INCLUDING:**	**THE INFORMATION MUST BE PROVIDED:**
Glide Path Renewal applicants must complete the following requirements.		
A. Grant access to the practice's NCQA Q-PASS account	Contributor user access rights to the practice's NCQA Q-PASS account	At the time the applicant submits the Glide Path Renewal Application.
B. A complete Glide Path Renewal Application.	Practice Information specific to NCQA requirements, Glide Path Program requirements, Glide Path Summary Timeline and Signatures. The Glide Path Application can be found at http://www.huskyhealthct.org/providers/PCMH/PCMH-Documents/PCMH_Glide_Path_Instructions_and_Application.pdf	At the time the applicant submits the Glide Path Renewal Application. Follow submission directions below. **PLEASE NOTE:** The change in enhanced reimbursement rate effective date will be the day of the Practice's current NCQA expiration date.
If awarded Glide Path Renewal Practice status, your practice will receive a letter from the DSS PCMH program. Once you receive this letter of approval, please complete the following requirements.		
C. A completed CHNCT PCMH Gap Analysis Checklist.	The series of questions to determine the practice's current status in the NCQA PCMH Renewal Process.	To complete an initial gap analysis in collaboration with their Community Practice Transformation Specialist (CPTS) within 30 days of the application submission.
D. A revised CHNCT PCMH Gap Analysis Checklist	A revised CHNCT PCMH Gap Analysis Checklist	Every three months that the practice is in the Glide Path Renewal process to monitor the practice's progress.

IV. Detailed Description of Glide Path Renewal Application Requirements

This section describes how to complete the Glide Path Renewal Application in detail.

A. PRACTICE INFORMATION	
Field Number and Name	**Description**
Practice Name	Enter the legal name of the practice.
Individual responsible for Glide Path Renewal requirements	Enter the name of the individual who will be working directly with the Medical ASO staff to ensure that all Glide Path Renewal requirements are met.
Connecticut Medical Assistance Program (CMAP) numbers under which the practice bills primary care services for all Primary Care Providers (PCPs) listed in the Practice's PCMH Application	Enter all applicable billing CMAP provider ID numbers used by the practice to bill the Department of Social Services ("the Department" or DSS) for care provided to HUSKY Health program recipients. CMAP provider numbers are sometimes referred to as "AVRS IDs" on CMAP remittance advice. Typically, a practice will have different CMAP numbers (which may map to one or multiple NPI's) maintained for different specialties, such as Internal Medicine, Family Practice, Pediatrics, and Nurse Practitioners. All relevant CMAP billing provider numbers should be included.
Address Line 1	Enter the number and street name of the practice's primary site address. **This cannot be a P.O. Box**.
Address Line 2	Enter the second line of the practice's primary site street address, if necessary.
Practice City	Enter the city name of the practice's primary site address.
Practice State	Enter the state name or its abbreviation of the practice's primary site address.
Practice Zip Code	Enter the 5-digit zip code of the practice's primary site address.
Practice Telephone Number	Enter the telephone number of the practice's primary site.
Practice Fax Number	Enter the fax number of the practice's primary site.

B. NCQA Q-PASS ACCOUNT AND REQUIRED CRITERIA	
Field Number	Description
NCQA Q-PASS ACCOUNT	Enter the NCQA Q-PASS account number. Glide Path Practices must provide the Department's Medical ASO with access to their NCQA Q-PASS account by registering the Medical ASO as a contributor. If a Q-PASS account has not been established, enter the projected Phase, which would be either Phase 1 or Phase 2.
NCQA CORE CRITERIA	Listed are the required core criteria that the practice will be completing. Practice will select "yes" for the criteria that are met or "no" for any criteria that is not yet met.
NCQA ELECTIVE CRITERIA	Check the box to attest that the practice will complete the required NCQA elective criteria with the selection of at least 25 credits across five of the six concepts as mandated by NCQA.
PCMH DISTINCTION MODULES	Check the boxes if your practice has achieved any of PCMH Distinctions in addition to 2017 PCMH Recognition (check all that apply)

C. Glide Path Renewal Timeline

Glide Path Renewal Timeline	Completion Date	Required Documentation
Three Months	mm/dd/yyyy	CHNCT PCMH Gap Analysis Checklist
Six Months	mm/dd/yyyy	CHNCT PCMH Gap Analysis Checklist
Nine Months	mm/dd/yyyy	CHNCT PCMH Gap Analysis Checklist

D. Glide Path Renewal Deliverables

The Glide Path Renewal Application requires applicants to complete all required documentation.

Practices must complete the entire Glide Path Renewal in no more than nine months. In the event that a practice does not complete the Glide Path Renewal within the nine month period, DSS will be notified and the practice's ability to continue the DSS PCMH Program and obtain reimbursements will be determined.

E. Requirement for Glide Path Renewal Completion

- A copy of the Notification of Recognition Decision email from NCQA, denoting the practice has been granted recognition.
- A copy of the NCQA PCMH Certificate of Recognition.

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Save this form periodically while completing or editing your application. Any data not saved will be lost.

A. Practice Information

Field Number and Required Information		Practice Response	
*A.1	**Practice Name**		
*A.2	**Individual Contact responsible for Glide Path Renewal requirements**		
A.3	**Connecticut Medical Assistance Program (CMAP) Group ID numbers.** *These are the ID numbers under which the practice bills primary care services for all Primary Care Providers (PCPs) listed in Section E of the PCMH Application. Enter CMAP Group ID numbers only.*	1.	
		2.	
		3.	
		4.	
		5.	
*A.4	**Practice Address Line 1**		
A.5	**Practice Address Line 2**		
*A.6	**Practice City**		
*A.7	**Practice State**		
*A.8	**Practice Zip Code**		
*A.9	**Practice Telephone Number**		
A.10	**Practice Fax Number**		

Please complete all required fields marked by an asterisk (*)

Please Note: If the practice has multiple sites, complete an application for each site with different addresses. You may incorporate the name of the practice with its location. For example: "ABC Practice – South Street."

B. NCQA Q-PASS Account

Field Number and Name	Description	
NCQA Q-Pass Account	Enter the NCQA Q-PASS account number. Glide Path Renewal Practices must provide the Department's Medical ASO with Contributor user access rights to their Q-PASS account. If a Q-PASS account has not been established, enter the projected date that this will occur.	

C. NCQA REQUIRED CORE CRITERIA

Below is a listing of **required core criteria** that a practice must complete in addition to the **CHNCT PCMH Gap Analysis Checklist** with your assigned Community Practice Transformation Specialist (CPTS). **Please note:** if you do not have an assigned CPTS, please contact the PCMH Program Administrator at 203.949.4194 or pcmhglideapplication@chnct.org.

Concepts	Required Core Criteria	Met
Team-Based Care and Practice Organization (TC)	**Competency A** **TC 01: PCMH Transformation Leads**	☐ Yes ☐ No
	TC 02: Structure and Staff Responsibilities	☐ Yes ☐ No
	Competency B **TC 06: Individual Patient Care Meetings/Communication**	☐ Yes ☐ No
	TC 07: Staff Involvement in Quality Improvement	☐ Yes ☐ No
	Competency C **TC 09: Medical Home Information**	☐ Yes ☐ No
Knowing and Managing Your Patients (KM)	**Competency A** **KM 01: Problem Lists**	☐ Yes ☐ No
	KM 02: Comprehensive Health Assessment	☐ Yes ☐ No
	KM 03: Depression Screening	☐ Yes ☐ No
	Competency B **KM 09: Diversity**	☐ Yes ☐ No
	KM 10: Language	☐ Yes ☐ No
	Competency C **KM 12: Proactive Reminders**	☐ Yes ☐ No
	Competency D **KM 14: Medication Reconciliation**	☐ Yes ☐ No
	KM 15: Medication Lists	☐ Yes ☐ No
	Competency E **KM 20: Clinical Decision Support**	☐ Yes ☐ No
	Competency F **KM 21: Community Resource Needs**	☐ Yes ☐ No

Patient-Centered Access and Continuity (AC)	**Competency A** **AC 01: Access Needs and Preferences** **AC 02: Same-Day Appointments** **AC 03: Appointments Outside Business Hours** **AC 04: Timely Clinical Advice by Telephone** **AC 05: Clinical Advice Documentation**	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
	Competency B **AC 10: Personal Clinician Selection** **AC 11: Patient Visits with Clinician/Team**	☐ Yes ☐ No ☐ Yes ☐ No
Care Management and Support (CM)	**Competency A** **CM 01: Identifying Patients for Care Management** **CM 02: Monitoring Patients for Care Management**	☐ Yes ☐ No ☐ Yes ☐ No
	Competency B **CM 04: Person-Centered Care Plans** **CM 05: Written Care Plans**	☐ Yes ☐ No ☐ Yes ☐ No
Care Coordination and Care Transitions (CC)	**Competency A** **CC 01: Lab and Imaging Test Management**	☐ Yes ☐ No
	Competency B **CC 04: Referral Management**	☐ Yes ☐ No
	Competency C **CC 14: Identifying Unplanned Hospital and ED Visits** **CC 15: Sharing Clinical Information** **CC 16: Post-Hospital/ED Visit Follow-Up**	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
Performance Measurement and Quality Improvement (QI)	**Competency A** **QI 01: Clinical Quality Measures** **QI 02: Resource Stewardship Measures**	☐ Yes ☐ No ☐ Yes ☐ No

	QI 03: Appointment Availability Assessment	☐ Yes ☐ No
	QI 04: Patient Experience Feedback	☐ Yes ☐ No
	Competency B **QI 08: Goals and Actions to Improve Clinical Quality Measures**	☐ Yes ☐ No
	QI 09: Goal and Actions to Improve Resource Stewardship Measures	☐ Yes ☐ No
	QI 10: Goals and Actions to Improve Appointment Availability	☐ Yes ☐ No
	QI 11: Goals and Actions to Improve Patient Experience	☐ Yes ☐ No
	Competency C **QI 15: Reporting Performance within the Practice**	☐ Yes ☐ No

D. NCQA REQUIRED ELECTIVE CRITERIA

Elective Criteria	**By checking the box to the right, you agree to complete the required elective criteria with the selection of at least 25 credits across five of the six concepts as mandated by NCQA.**	☐
PCMH Distinction Modules **(check all that apply)**	**Behavioral Health Integration – (BHI)** **Electronic Quality Measures Reporting – (eCQM)** **Patient Experience Reporting – (PEX)** **Not Applicable**	☐ ☐ ☐ ☐

E. GLIDE PATH RENEWAL TIMELINE

Glide Path Renewal Timeline	Completion Date: MMDDYYYY *(The start date is the same date that the application is submitted)*
Three Months	
Six Months	
Nine Months	

F. GLIDE PATH RENEWAL DELIVERABLES

Refer to page 5 of the Glide Path Renewal Requirements in the instructions for information.

G. REQUIREMENTS FOR GLIDE PATH RENEWAL COMPLETION

- Copy of the email from NCQA, recognizing the practice as a Level 2 or Level 3 PCMH Practice is required to achieve full PCMH qualification from the Department.
- The practice must submit a copy of the NCQA PCMH Certificate of Recognition, Level 2 or Level 3, to the Medical ASO when it is received from NCQA.

H. SIGNATURE

The information provided in this PCMH GLIDE PATH RENEWAL APPLICATION is true and correct to the best of my knowledge as an individual authorized by the practice.

An individual authorized to act as a signatory for the practice must also provide an electronic signature on the application. In doing so, the signatory certifies that all information provided in the application is accurate.

Provider Entity Name (doing business as)

Name of Authorized Representative

Electronic Signature Agreement. By clicking "I agree" and typing your name below, you are signing this application electronically. You agree your electronic signature is the legal equivalent of your manual signature on this document.

☐ *** I agree**

**Signature* **Date (mm/dd/yyyy)*

Click the **SUBMIT** button on this page to send this application to the Medical ASO. You will automatically receive a **Message Received** reply with a tracking number. Save these for future reference. You can expect to be contacted by the Medical ASO within 3 business days.

SUBMIT

If you have any questions about this Glide Path Renewal application, contact the PCMH Program Administrator at **203.949.4194** or pcmhglideapplication@chnct.org.