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| Managed Care Plan Name: | | | |  | | | | | | | | | | |
| Name of Person Completing Form: | | | |  | | | | | | | | | | |
| Phone Number: | | | |  | | | | | | | | | | |
| Email Address: | | | |  | | | | | | | | | | |
| 🞏 Initial Submission | | | | 🞏 Resubmission | | | | | | Date: |  | | | |
| **Section 1. Applicable Region(s)**  *Select all applicable regions.* | | | | | | | | | | | | | | |
| **Region:** | | 🞏 1 | 🞏 2 | 🞏 3 | 🞏 4 | 🞏 5 | | 🞏 6 | | 🞏 7 | 🞏 8 | 🞏 9 | 🞏 10 | 🞏 11 |
| **Section 2. Program Type**  *Select either IHP Incentive Program or AP Incentive Program (see instructions).* | | | | | | | | | | | | | | |
| 🞏 IHP Incentive Program | | | | | | | 🞏 AP Incentive Program | | | | | | | |
| **Section 3. Identified Providers- IHP ONLY. If AP, skip to Section 5.**  *Insert description below of all additional physicians to be included as Identified Providers* (see instructions). | | | | | | | | | | | | | | |
| **IHP Submission Requirement/Response** | | | | | | | | | | | | | | |
| **Response:** | | | | | | | | | | | | | | |
| **Section 4. Qualified Providers- IHP ONLY. If AP, skip to Section 5.**  *Complete the table below for each of the Qualified Provider types (see instructions).* | | | | | | | | | | | | | | |
| **Table (1) IHP Qualifications for Board-Certified Pediatricians** | | | | | | | | | | | | | | |
| **How measured:** | | | | | | | | | | | | | | |
| 🞏 | | Individual Level | | | | | | 🞏 | Site Level | | | | | |
| **Qualification / Measure** | | | | **Qualification / Measure Description** | | | | **Measurement Period** | | | **Benchmark to Qualify** | | | |
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| **Table (2). IHP Qualifications for Board-Certified Family Practitioners** | | | | | | | | | | | | | | |
| **How measured:** | | | | | | | | | | | | | | |
| 🞏 | | Individual Level | | | | | | 🞏 | Site Level | | | | | |
| **Qualification / Measure** | | | | **Qualification / Measure Description** | | | | **Measurement Period** | | | **Benchmark to Qualify** | | | |
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| **Table (3). IHP Qualifications for Board-Certified General Practitioners** | | | | | | | | | | | | | | |
| **How measured:** | | | | | | | | | | | | | | |
| 🞏 | | Individual Level | | | | | | 🞏 | Site Level | | | | | |
| **Qualification / Measure** | | | | **Qualification / Measure Description** | | | | **Measurement Period** | | | **Benchmark to Qualify** | | | |
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| **Table (4). IHP Qualifications for Board-Certified OB/GYNs** | | | | | | | | | | | | | | |
| **How measured:** | | | | | | | | | | | | | | |
| 🞏 | | Individual Level | | | | | | 🞏 | Site Level | | | | | |
| **Qualification / Measure** | | | | **Qualification / Measure Description** | | | | **Measurement Period** | | | **Benchmark to Qualify** | | | |
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| **Table (5). IHP Qualifications for Pediatric Specialists** | | | | | | | | | | | | | | |
| **How measured:** | | | | | | | | | | | | | | |
| 🞏 | | Individual Level | | | | | | 🞏 | Site Level | | | | | |
| **Specialist Type** | | | **Qualification / Measure** | | | **Qualification / Measure Description** | | | | **Measurement Period** | | **Benchmark to Qualify** | | |
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| **Table (6). IHP Qualifications for Other Physicians** | | | | | | | | | | | | | | |
| **How measured:** | | | | | | | | | | | | | | |
| 🞏 | | Individual Level | | | | | | 🞏 | Site Level | | | | | |
| **Physician Type** | | | **Qualification / Measure** | | | **Qualification / Measure Description** | | | | **Measurement Period** | | **Benchmark to Qualify** | | |
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| **Section 5. Payment Structure**  *Complete the table below to indicate the payment structure for both the IHP* ***and*** *AP for each of the applicable Provider Types as identified in Section 4 of this Submission Form.* | | | | | | | | | | | | | | |
| **IHP Submission Requirement/Response** | | | | | | | | | | | | | | |
| 🞏 **Regional Medicare rate in which site is located**  🞏 **Other (describe)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | |
| **IHP Provider Type** | | | | **FFS** | **Sub-capitated Prospective** | | | | **Sub-capitated Retrospective Reconciliation** | | | **Provider Contract Change? (Y/N)** | | |
| Pediatrician | | | |  |  | | | |  | | |  | | |
| Family Practitioner | | | |  |  | | | |  | | |  | | |
| General Practitioner | | | |  |  | | | |  | | |  | | |
| OB/GYN | | | |  |  | | | |  | | |  | | |
| Pediatric Specialist | | | |  |  | | | |  | | |  | | |
| Other Physician | | | |  |  | | | |  | | |  | | |
| **AP Submission Requirement/Response**  **Note: All Managed Care Plans Must Complete This Section** | | | | | | | | | | | | | | |
| 🞏 **Regional Medicare rate in which site is located**  🞏 **Other (describe)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | |
| **AP Provider Type** | | | | **FFS** | **Sub-capitated Prospective** | | | | **Sub-capitated Retrospective Reconciliation** | | | **Provider Contract Change? (Y/N)** | | |
| Pediatrician | | | |  |  | | | |  | | |  | | |
| Family Practitioner | | | |  |  | | | |  | | |  | | |
| General Practitioner | | | |  |  | | | |  | | |  | | |
| OB/GYN | | | |  |  | | | |  | | |  | | |
| Pediatric Specialist | | | |  |  | | | |  | | |  | | |
| Other Physician | | | |  |  | | | |  | | |  | | |
| **Section 6. Included Services**  *(See instructions).* | | | | | | | | | | | | | | |
| **Section 7. Estimated Value of Enhanced Reimbursement**  *Check all that apply- NOTE: Completion of Attachment IV for the AP Incentive Program is mandatory for all Managed Care Plans (See instructions).* | | | | | | | | | | | | | | |
| 🞏 | Attachment 5, Incentive Proposal Estimated Value Template Completed for IHP Incentive Program | | | | | | | 🞏 | | Attachment 5, Incentive Proposal Estimated Value Template Completed for AP Incentive Program | | | | |
| **Section 8. Provider Communications**  *(See instructions).* | | | | | | | | | | | | | | |