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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).*  |