This Rhode Island Care Transformation Collaborative Initiative Agreement (the “Agreement”) is entered into this First day of January 2019, by and between HEALTHPLAN, (hereinafter “Plan”), andPROVIDER NAME.(hereinafter referred to interchangeably as the “Provider” or “Practice”).

W I T N E S S E T H:

 WHEREAS, the Plan and the Provider desire to enter into an agreement for the funding toward the Care Transformation Collaborative (“CTC-RI”) on the terms and conditions set forth herein; and

 WHEREAS, the Provider is a group of primary care providers (practitioners) or a solo practitioner in the Plan’s network pursuant to a Medical Group Participation Agreement or other substantially similar provider network participation agreement with Plan (hereinafter “Group Agreement”) and

WHEREAS, CTC-RI, a Multi-Payer Demonstration of the Patient-Centered Medical Home (“PCMH”), a model of primary care that will improve the care of chronic disease and lead to better overall health outcomes for Rhode Islanders.

 NOW, THEREFORE, in consideration of the mutual covenants, promises and undertakings hereinafter set forth and for other good and sufficient consideration, the receipt of which is hereby acknowledged, the parties hereto agree as follows:

**APPLICABILITY**

The provisions of this Appendix apply for services to be paid under this Agreement, rendered to Program Customers covered by commercial, Medicare Advantage and [RIte Care Subscribers Benefit Plans].

SECTION 1

Definitions

Unless otherwise defined in this Section 1, capitalized terms used in this Appendix have the meanings assigned to them in the underlying network participation Agreement between the parties (hereinafter “Agreement”) (or the meanings assigned in the Agreement to equivalent terms, such as “Benefit Contract” instead of “Benefit Plan”, “Member” instead of “Customer” (patients), “Payor” instead of “Payer” and “Health Services” instead of “Covered Services”). If any definition in this Appendix conflicts with another definition in the Agreement (including a definition of an equivalent term), the definition in this Appendix controls, with regard to Benefit Plans subject to this Appendix. Further, the definitions in this Appendix are independent of any other definition in any part of the Agreement outside this Appendix, of the same or similar terms.  Any definitions of those terms in any part of the Agreement outside this Appendix therefore have no bearing on the terms defined in this Appendix.

**Benefit Plan:** A certificate of coverage, summary plan description, or other document or agreement, whether delivered in paper, electronic, or other format, under which a Payer is obligated to provide coverage of Covered Services for a Customer.

**Care Delivery Requirements: Activities or measure results that Program Provider must complete or achieve for a given Measurement Period.** HEALTHPLAN**’s Care Delivery Requirements are described in the Care Delivery Requirements set forth online at www.ctc-ri.org.**

**Care Management Payment:** The payment made to Program Provider for meeting the Care Delivery Requirements.

**Comprehensive Primary Care Services:** Health care services, including but not limited to the following functions:

1. Care Management,
2. Planned Care: Population Health/Quality Reporting
3. Access and Continuity
4. Patient /family/caregiver Engagement, and
5. Comprehensiveness and Coordination
6. Practice Transformation

**Care Transformation Collaborative (CTC)**: The State of Rhode Island’s multi-payer patient centered medical home initiative.

**Customer/Patient:** A person eligible and enrolled to receive coverage from a Payer for Covered Services.

**Performance Payment:** The per member per month (pmpm) annual payment to Program Provider made to Program Provider retrospectively for performance of the CTC Service Delivery Requirements and as further described in this Appendix.

**Measurement Period or MP**: Each 12-month period during which the Program is in effect. Each Measurement Period will begin on January 1st and end on December 31st  of the applicable year.

**Member Month:** A month in which a Customer/Patient is a Program Customer/Patient under this Program.

**Payment Quarter:** A 3-month period with the 1st quarter starting on the 1st day of the Measurement Period. For example, the 1st Payment Quarter of an applicable Measurement Period runs from January 1st through March 31st. The 2nd Payment Quarter will run from April 1st through June 30th. The 3rd Payment Quarter will run from July1st through September 30th. The last Payment Quarter of an applicable Measurement Period will run from October 1st through December 31st.

**Payment Summary Report:** A report that identifies the number of Member Months for Program Customers and the Program Provider’s Care Management Payment for that applicable Payment Quarter.

**PCP or Primary Care Professionals Roster:** The list of Program Providers HEALTHPLAN NAME has identified as PCPs or Primary Care Professionals as defined below and attached as **Exhibit 3.**

**Performance Measure:** A metric upon which Program Provider’s performance will be measured.

**Performance Score:** The Program Provider’s actual score for the defined Measurement Period that is based on their aggregate practice performance for any Performance Measure as Program Provider reports it to or is determined by CTC.

**Primary Care Professionals or PCP a/ka/ Program Providers:** A physician, nurse practitioner, or physician assistant who is a Program Provider and who meets one of the following criteria:

1. All Program Providers must be under a network participation agreement with the Plan and be considered “in-network”; and credentialed by the Plan with a specialty in Pediatrics, or Family Practice (or any midlevel practitioners employed by the Geriatrics, Pediatrics, Internal Medicine or Family Practice providing primary care services) and listed in Exhibit 3.

HEALTHPLAN NAME reserves the right to make, but is not obligated to make, changes to the PCP Roster based on any changes HEALTHPLAN confirms are accurate (but the CTC list and/or HEALTHPLAN NAME’s system is inaccurate) with Program Provider even if they are not consistent with PCPs identified under (i) above.

With respect to subsection (i) above, a Program Provider Professional who is added to the Program Provider under the Agreement will be considered a Program Provider Professional for a given Payment Quarter only if Program Provider submitted the Program Provider Professional’s information to CTC and HEALTHPLAN NAME for inclusion in the Program Provider at least 60 days prior to the 1st day of the Payment Quarter if the acquisition or addition of new Program Providers will not increase the existing physician complement by more than 5% or Program Customers by 25%. To the extent the addition of Program Provider Professionals will result in an increase to the existing physician complement by more than 5% or Program Customers by 25%, the new Program Provider Professionals will become Program Provider Professionals only as mutually agreed in writing by HEALTHPLAN NAME, CTC and Program Provider.

A new Program Provider Professional’s information will not be considered submitted until that Program Provider Professional has successfully completed the credentialing process. PCP does not include any Program Provider Professional who is no longer listed in HEALTHPLAN NAME’s system as part of Program Provider.

**Program Customer/Patient:** A Customer/Patient who has been attributed to a Program Provider PCP in accordance with the Attribution Method **Exhibit 1** of this Appendix.

**Program Provider Professionals:** The medical group, physician, healthcare professional, federally qualified health center (FQHC) or any other provider that is a party to this Appendix.

**Program Provider Participating Location(s):** The list of Program Provider location(s) participating in this Program, as described in the Program Provider Participating Locations **Exhibit 3** of this Appendix.

HEALTHPLAN NAME**:** The affiliates or business units of HEALTHPLAN NAME Insurance Company that underwrite or manage those Benefit Plans that are subject to this Appendix.

**SECTION 2**

**Care Management Payment**

**2.1 Program Provider Eligibility.** In order to be eligible for consideration to receive a Care Management Payment under this Appendix, Program Provider must meet the following requirements:

1. Must employ a nurse care manager (or care coordinator for pediatric practice) dedicated to care coordination to support the implementation and maintenance of the Care Delivery Requirements as described online at www.ctc-ri.org.
2. Meet the Care Delivery Requirements in the Care Delivery Requirements set forth online at [www.ctc-ri.org](http://www.ctc-ri.org) in addition to CTC’s Program care delivery requirements. HEALTHPLAN may utilize CTC to assist with auditing a practice or HEALTH PLAN may audit Program Provider to determine Program Provider’s achievement of the Care Delivery Requirements.
3. Upon request, Program Provider will provide HEALTHPLAN NAME with the same information related to the Care Delivery Requirements as Program Provider disclosed to CTC.
4. Designate a contact person who will be responsible for receiving and distributing the reports provided by HEALTHPLAN NAME under this Appendix.
5. A Program Provider may not exceed one (1) year per each level of practice transformation. Movement to the next level is determined by CTC at the end of each one-year period. Program Provider must contact CTC prior to Care Management requirement delivery schedule as described online at [www.ctc-ri.org](http://www.ctc-ri.org) if Program Provider is unable to meet said requirements. Program Provider must request an extension no less than 30 days prior to the requirement due date as described online at www.ctc-ri.org and provide a corrective action plan as described in the CTC policy to request an extension. Such request is subject to CTC’s prior approval and monitoring for successful correction. If Program Provider fails to advance to next level of transformation within the 12-month period, continued participation in the CTC project will be reviewed and determined by voting members of the CTC board of directors.
6. If applicable, eligible RIte Care Subscriber payments will only be made to Program Provider with two hundred (200) or more Eligible Subscribers.

**2.2 Measurement Period and Care Management Payment Rate**. The applicable Measurement Period and Care Management Payment Rates for this Appendix are described in the Measurement Period Table:

**Measurement Period Table:**

|  |  |  |
| --- | --- | --- |
| **Measurement Period** | **Measurement Period** | **Care Management Base Payment Rate**  |
| MP 1 | 1-1-2019 through 12-31-19 | $ 3.50 |
| MP 2  | 1-1-2020 through 12-31-2020 | $ 3.00 |
| MP 3  | 1-1-2021 through 12-31-21 | $ 3.00 |

HEALTHPLAN NAME will provide to Program Provider the Care Management Payments no later than the last day of the 1st month of an applicable Payment Quarter.

**2.3 Care Management Payment Calculation.** The Care Management Payment for each Payment Quarter is calculated as follows:

**Care Management Payment =**

(Care Management Payment Rate X # Program Customers) X # of Program Months

For purposes of this Section, Program Months means the number of whole months in the applicable Payment Quarter during which this Appendix is in effect.

**2.4 Adjustment to Care Management Payment.**

1. If HEALTHPLAN determines a Care Management Payment for a prior Payment Quarter was inaccurate, then HEALTHPLAN reserves the right to determine the overpayment or underpayment resulting from the inaccuracy. Any overpayment or underpayment will be offset or paid in a future Care Management Payment. If HEALTHPLAN makes the determination after the final Care Management Payment under this Appendix, then HEALTHPLAN will pay any underpayment within 60 days of its determination or Program Provider will pay to HEALTHPLAN the overpayment within 60 days after HEALTHPLAN notifies Program Provider of the overpayment.
2. If at any time the Program Provider reasonably expects to be without a staff person for Care Coordination for a period of thirty (30) days or more, the Practice will notify the CTC Board of Directors and the Plan. If more than thirty (30) days passes and the Program Provider has not been able to replace the staff person for Care Coordination, the parties will attempt to reach a mutually agreeable alternative arrangement to perform the roles and responsibilities of Care Coordination as outlined in Attachment J. However, if a mutually agreeable alternative is not reached, the Plan will have the unilateral right to reduce or suspend the PMPM by an amount of no more than $2.50 which is the PMPM rate for the Care Manger or terminate this Agreement with the Program Provider.

**2.6 No Reconsideration.** Except as provided in Section 3.1(i) of this Appendix with respect to requests for review of the PCP Roster, no reconsideration will be available for HEALTHPLAN determination of the Care Management Payment, including but not limited to, attribution methodology or determination of Program Customers.

**SECTION 3**

**Reports**

**3.1 Program Provider Reports.** HEALTHPLAN will provide the following reports:

1. **High Risk Patient Lists**. HEALTHPLAN will provide quarterly High-Risk Patient Lists to practices six months after the start of the program and as agreed upon by CTC and the HEALTHPLAN
2. **Payment Summary Report.** HEALTHPLAN will provide the Payment Summary Report to Program Provider no later than the last day of 1st month of each Payment. This report includes a list of Program Provider’s Program Customers/Patients for whom HEALTHPLAN paid a Care Management Payment to Program Provider, the total number of Program Customers for each Program Provider PCP and the Care Management Payments paid for each Program Provider PCP’s Program Customers.
3. **Emergency Room and Inpatient Activity Reports.** HEALTHPLAN or its delegate will provide to Program Provider a report of Program Customers’ utilization each Payment Quarter.
4. **Attribution Report:** HEALTH PLAN or its delegate to provide to CTC quarterly attribution report based on receipt from CTC of practice panel information
5. **Additional Reports.** HEALTHPLAN may provide other reports as it determines in its sole discretion and/or by the CTC board of directors.

**3.2 Program Provider Reports.** Provider will provide the following reports to CTC as described online at www.ctc-ri.org:

1. Quality Metrics
2. Process and or Outcome Measures for the following:
3. After Hours Care Policy and Procedure which includes schedule demonstrating improved access
4. Transition of Care Policy and Procedure
5. Compacts established with specialists as defined in Service Delivery Requirements
6. Provider panel and 3rd next available appointment
7. Quality improvement reports (quality, customer experience, utilization)
8. Nurse Care Manager or Care Coordinator Engagement/FTE Report
9. Quality improvement Plan per OHIC requirements

**SECTION 4**

**Performance Incentive**

HEALTHPLAN will determine the Performance Incentive Bonus in accordance with the methodology set forth online at [www.ctc-ri.org](http://www.ctc-ri.org) and payment according to the Performance Incentive Exhibit 2 to this Appendix.

**4.1 Performance Incentive Bonus Due Date**. HEALTHPLAN will pay the Performance Incentive Bonus, if applicable, within 60 days after Healthplan receipt of results from CTC. If Plan makes a determination of an overpayment or underpayment after the final PMPM payment following the termination of this Agreement, then Plan will pay any underpayment within 60 days of its determination or Provider will pay to Plan the overpayment within 60 days after Plan notifies Provider of the overpayment. Notwithstanding the foregoing, Provider shall not be entitled to reimbursement for underpayment in circumstances where such underpayment resulted due to the failure of Provider to meet its notice requirements as set forth online at www.ctc-ri.org relating to updating its Practitioner listing.

**SECTION 5**

**Program Provider Responsibilities**

**5.1 Collaboration with** HEALTHPLAN and CTC**.** Program Provider will meet with HEALTHPLAN and/or CTC, upon HEALTHPLAN’s and/or CTC’s request, up to once a quarter. Program Provider agrees to cooperate with HEALTHPLAN to further the purposes of this Program. Discussions will include, but are not limited to:

1. Program Provider’s progress on the Care Delivery Requirements;
2. Reporting and Program Provider’s opportunities to improve Program Customer’s quality, total cost of care and health care;
3. Care management plans and care management services for Program Customers.

**5.2 Program Provider Data.** Program Provider agrees to provide data including, but not limited to, quality and utilization data for Program Customers, as specified by CTC in conjunction with CTC and other health plans participating in CTC’s Program that is determined to be necessary for the effectuation of the Program.

**5.3 PCP or Primary Care Provider Roster.** Program Provider agrees to provide CTC Quarterly Provider Roster due 45 days prior to the beginning of the Quarter. CTC will provide provider panel information to the HEALTH PLAN. Program Provider is responsible for adhering to HEALTH PLAN policy on notification of change of provider.

**5.4 Audits**. Program Provider will cooperate with HEALTHPLAN and/or CTC’s audits with respect to the Program, including, but not limited to, the achievement of the Care Delivery Requirements in the Care Delivery Requirements online at www.ctc-ri.org.

**SECTION 6**

**Term and Termination**

**6.1 Termination by HEALTHPLAN.** HEALTHPLAN may terminate this Appendix, without terminating the Agreement:

1. With at least 30 days prior written notice to Program Provider based on HEALTHPLAN’s determination that the Care Delivery Requirements are not met by Program Provider (inclusive of approved Request for Extension and plan of correction); or
2. Effective upon CTC’s termination of Program Provider’s participation in the CTC Program; or
3. With at least 30 days prior written notice to Program Provider if HEALTHPLAN terminates its participation in Program; or
4. Upon the Effective Date of Program Provider’s participation in a different incentive program with HEALTHPLAN. With at least 30 days prior written notice of the effective date and in accordance with the Agreement, Program Provider will notify HEALTHPLAN if they join a care delivery system that participates in an incentive program with HEALTHPLAN; or
5. With at least 30 days prior written notice to Program Provider, if Rhode Island Care Transformation Collaborative (CTC) determines that a Program Provider did not meet the Care Delivery Requirements.

Any termination of this Appendix pursuant to the reasons stated above will be effective on the last day of the Payment Quarter that ends at least 30 days after HEALTHPLAN provides notice to Program Provider.

**6.2 Termination by Either Party.** Either party may terminate this Appendix, without terminating the Agreement, as follows:

1. upon 60 days written notice to the other party of a material breach of this Appendix by the party receiving the notice, except that termination described in this clause will not take effect if the material breach is cured during the 60 days’ notice period. Termination under this Section will not be deferred during any dispute resolution process as described in the Agreement.
2. upon 90 days written notice if CTC terminates its participation in the CTC Program, so long as the notice is provided within 60 days of the effective date of CTC’s’ termination.

**6.3 Automatic Termination.** This Appendix will terminate automatically either on the effective date of termination of the underlying network participation Agreement between the parties for any reason or on the last day of Measurement Period 3.

**6.4 Effect of Termination on Care Management Payments.**

1. No Care Management Payments will be due or made to Program Provider after the effective date of termination. Except as otherwise provided in this Appendix, Program Provider will be entitled to Care Management Payments accrued prior to the effective date of termination.
2. In the event that this Appendix or the Agreement terminates due to a material breach by Program Provider, then Program Provider will not be entitled to a Care Management Payment for the Payment Quarter in which the termination becomes effective.
3. In the event that this Appendix terminates on any day other than the last day of a Payment Quarter due to any reason other than material breach by Program Provider, then Program Provider will be entitled to a Care Management Payment for the Payment Quarter in which the termination becomes effective.

**6.5 Effect of Termination on Performance Payments**. No Performance Payments will be due or made to Program Provider if Program Provider terminates this Program for any reason during the applicable Measurement Period. However, that Participating Program Provider’s data and Care Management Payments through the effective date of termination will be included in calculations of Performance Payments and may impact any Performance Payment made to the remaining Participating Program Providers.

 **ATTRIBUTION METHOD EXHIBIT 1**

**Payment Appendix – Care Transformation Collaborative of RI Program**

The following definitions will apply:

HEALTHPLAN attribution logic

**Performance Incentive Exhibit 2**

**Payment Appendix – Care Transformation Collaborative of RI Program**

The Program Provider agrees to fulfill CTC’s Performance Measures and Performance Score requirements, as described online at CTC’s Program care delivery requirements, as described online at www.ctc-ri.org.

Program Provider must achieve the Performance Measures and Performance Scores in order to earn a Performance Incentive Bonus PMPM for each Performance Measure as outlined in the Performance Incentive Table below. HEALTHPLAN will use the Performance Measure results provided by either CTC to determine Program Provider’s Performance Score.

**Performance Incentive Table**

|  |  |  |
| --- | --- | --- |
| **Measurement Period** | **Performance Measure** | **Performance Incentive Bonus PMPM** |
| **MP2** | Reducing ED visits/ meeting quality benchmarks | **$0.50** |
| **MP3** | Reducing ED visits/ meeting quality benchmarks | **$0.50** |

**PROGRAM PROVIDER PARTICIPATING LOCATIONS AND PROGRAM PROVIDER’S PRIMARY CARE PROFESSIONALS AND PCP EXHIBIT 3**

**Payment Appendix – Care Transformation Collaborative of RI Program**

If Program Provider adds any PCP during the term of this Appendix, then those PCPs will be added to this Appendix. If Program Provider adds a PCP not listed in the table below, Program Provider will provide CTC with a notice quarterly by the end of the 2nd month of the previous Quarter in order for PLAN to pay the CTC Payment for the next Quarter:

|  |
| --- |
| **PRACTICE LOCATIONS (complete one for each service location)** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Practice Location Name**  | **Provider Last Name** | **Provider First Name** | **Provider Type** **PCP, NP, AP** | **Provider NPI** |
|  |  |  |  |  |
| **Street Address** |  |  |  |  |
|  |  |  |  |  |
| **City** |  |  |  |  |
|  |  |  |  |  |
| **State and Zip Code** |  |  |  |  |
|  |  |  |  |  |
| **Phone Number** |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Practice Location Name**  | **Provider Last Name** | **Provider First Name** | **Provider Type** **PCP, NP, AP** | **Provider NPI** |
|  |  |  |  |  |
| **Street Address** |  |  |  |  |
|  |  |  |  |  |
| **City** |  |  |  |  |
|  |  |  |  |  |
| **State and Zip Code** |  |  |  |  |
|  |  |  |  |  |
| **Phone Number** |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Practice Location Name**  | **Provider Last Name** | **Provider First Name** | **Provider Type** **PCP, NP, AP** | **Provider NPI** |
|  |  |  |  |  |
| **Street Address** |  |  |  |  |
|  |  |  |  |  |
| **City** |  |  |  |  |
|  |  |  |  |  |
| **State and Zip Code** |  |  |  |  |
|  |  |  |  |  |
| **Phone Number** |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |