

TPHO PROVIDER MANUAL 2024



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About TPHO

What is TPHO?

The TriHealth Physician Hospital Organization (TPHO) is a value-driven and clinically integrated organization committed to surprisingly human care. Within TPHO are employed and independent physicians. These members participate in joint hospital and physician contracting and align economic incentives for improvements. With access to physicians across the full spectrum of care, our large and easy-to-access TPHO network provides common care management models and shared information infrastructure to deliver on the triple aim of better care, better health, and better value for every patient we serve. Through value add and patient centered solutions, TPHO manages financial and performance risk leading to better health and higher quality of life for our community.

TPHO Mission Statement

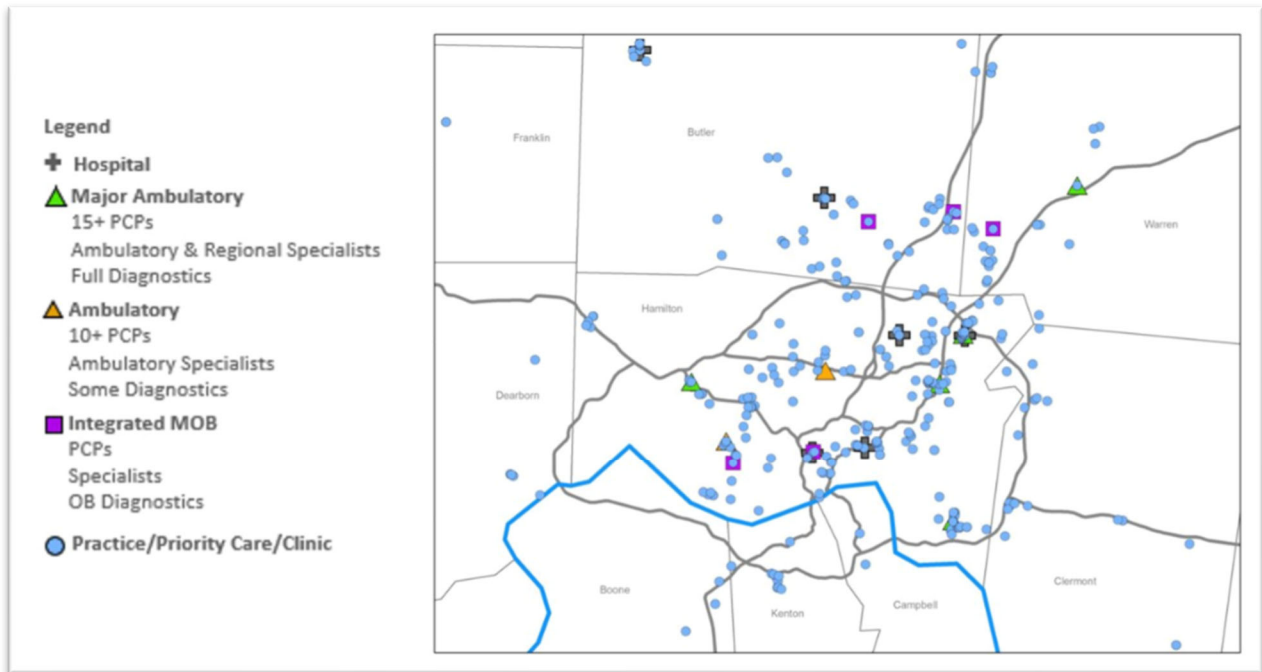
The mission of the TriHealth Population Health Organization (TPHO) is to understand the needs and challenges of each patient and improve the every-day well-being of people in our community. We are getting healthcare right by ensuring our patients feel respected, connected, and deeply cared for. As members of TPHO, we are confident we can change how our patients think about healthcare for the better due to our unwavering commitment to patient-centered and value-based care.

Benefits of TPHO Membership

- Provides a vehicle for participating physicians, facilities, and ancillary partners to manage population health and better coordinate care across the continuum.
- Drives high-quality, cost-effective care delivery through the promotion of evidence-based care standards and decision support tools and the reduction of unnecessary variation and utilization.
- Provides an attractive model for participating physicians under a common infrastructure (e.g. quality, efficiency, care management)
- Allows participating physicians to align economic incentives for improvements in cost, quality, and efficiency for the evolving reimbursement models.
- Establish referral relationships with other high-value network providers that are committed to providing the highest quality, coordinated care for patients.

TPHO Network

Today, TPHO is the region's largest, most-complete and best-positioned network, with a proven track record for managing total cost of care. By leveraging the high-value providers in the network – the TPHO has demonstrated an ability to bend the cost curve. Today, there are over 70 groups and 1,600 individual providers associated with the TPHO network.



The online directory of TPHO in-network PCPs and Specialists can be located on the TriHealth and TPHO Websites.

- www.TriHealth.com
- www.trihealthpho.com/

Click the link for 'Find a TPHO Doctor' (<https://directory.trihealthpho.com/>)

Membership Participation Requirements and Processes

Contracting Process

New Group TIN to TPHO

1. If TPHO membership is requested, please reach out to the TPHO Network Operations and Development team at TPHOProviders@trihealth.com
2. TPHO will provide TPHO Contract documents (Participating Provider Agreement and Business Associate Agreement), provider roster, and Group Profile form to be completed by requesting provider. Provider must return all documentation and include a current copy of the W-9 form for the office.
3. TPHO will validate Medical Staff Office appointment as well as board certification status for providers. If the providers associated with the new Group-TIN are not privileged at a TriHealth facility, they will be directed to the TriHealth Medical Staffing Office to begin that standalone process.
4. All newly executed agreements for TPHO membership requests must be presented to the Quality Access/Clinical Integration Committee for membership approval. Effective TPHO membership date is the date of final approval by the QA/CI. The TPHO QA/CI Committee as well as the TPHO Board of Directors meet quarterly in 2024.
5. TPHO will notify provider designee of TPHO approval or denial. TPHO will provide countersigned copies of the TPHO contract documents along with Welcome Packet which includes pertinent TPHO information.

Individual Provider Credentialing Requirements

Provider (Employed or Independent physician) of a contracted TIN, wishes to request TPHO membership.

1. **Notification:** TPHO must be notified that a new provider (employed or independent) is requesting TPHO membership.
2. **MSO Requirement:** Does the provider have a TriHealth Medical Staffing Office appointment for privileges at a TriHealth facility?
 - a. Yes: Provider will follow traditional TPHO membership process. Please continue to step 3.
 - b. No: Provider will follow the Alternate Credentialing Process described below.
3. **Board Certified Requirement:** Is the provider board certified?
 - a. Yes: Provider will follow traditional TPHO membership process. Please continue below.
 - i. In Examination: If applicant is not board certified due to being in process of taking the board exams, the applicant must be presented at the QA/CI Committee to recommend membership to TPHO. Please continue below.
 - b. No: Please reference the section below specific to the Alternate Credentialing Process.

Credentialing Process for Individuals in Existing TPHO Groups

New Individual Provider of a contracted TIN, requests membership (Existing provider groups include both splitter and non-splitter groups)

1. If TPHO membership is requested, please reach out to the TPHO Network Operations and Development team at TPHOProviders@trihealth.com with a Provider Add/Term/Change form.
2. TPHO will validate Medical Staff Office appointment as well as board certification status.
3. If the provider is not in a splitter group and meets TPHO qualifications, he/she is able to be approved for immediate TPHO membership without Committee approval.
4. If the provider is in a splitter group, all TPHO membership requests must be presented to the Quality Committee for membership approval. Effective TPHO membership date is the date of final approval by the QA/CI.
5. TPHO will notify provider designee of TPHO approval or denial.

New Providers requesting TPHO Membership via the Alternate Credentialing Process

1. Notification: Provider (Employed or Independent physician) wishes to request TPHO membership as described above.
2. Requirements: Does provider have MSO appointment?
 - a. Yes: Provider will follow traditional TPHO membership process above.
 - b. No: Follow below process for Alternate Credentialing with TPHO.

TPHO Alternate Credentialing Process

1. Alternate Credentialing Process is for providers who are not seeking hospital privileges at a TriHealth facility. The likely participant in this process would be for employed or independent Advanced Practice Providers.
2. TPHO will provide an alternate credentialing application that will need to be completed and returned to the email address above.
3. TPHO will then supply application to the TriHealth Medical Staffing Office for credentialing verifications. (Education, License verification, OIG verification, etc.)
4. Once all credentialing verifications and security checks have been completed, the Medical Staff Office will return paperwork to TPHO.
5. The application and returned source documentation will then be reviewed by the TPHO Network Participation & Realignment Committee to determine a recommendation to the TPHO Quality Access & Clinical Integration Committee.
6. All TPHO providers utilizing the alternate credentialing process must have their applications presented to the TPHO Quality Access & Clinical Integration Committee for full TPHO Membership approval. Once TPHO receives the completed application from the Medical Staff Office, the application will then be presented to the QA/CI Committee. The TPHO QA/CI Committee meets on a quarterly basis, and therefore expect the process for full TPHO membership approval to require a maximum of 3 months.

Member Responsibilities

Ensuring a high-performing network requires that participating providers agree to responsibilities that are outlined in the TPHO Participant Agreement as well as the TPHO Network Participation and Realignment policy. The Agreement outlines these responsibilities in detail and a summary of these are outlined below. The Participating Provider is accountable for the quality, cost, and overall care of TPHO attributed patients.

Membership Responsibilities

- Maintain a valid, unrestricted license to practice medicine.
- Maintain in good standing all required and applicable federal and state licenses and certifications.
- Never have been convicted of health care fraud, crime, suspended, etc.
- No direct ownership or controlling interest of 5% or more of a 'sanctioned entity' convicted of an offense.
- Maintain appropriate medical staff privileges at one or more TriHealth hospitals except for those providers who are accepted to TPHO through the Alternate Credentialing Process as described above.
- Maintain professional liability insurance.
- Not be subject to any agreement that restricts, limits, or prohibits the participation in TPHO.
- For Primary Care Providers - not be a member of or participating provider in any other physician-hospital organization, accountable care organization, preferred provider organization, health maintenance organization, managed care organization or similar clinically integrated network that is deemed by TriHealth or the TPHO (in its sole discretion) to be in competition with TriHealth or any of its subsidiaries or affiliates including TPHO.

Engagement and Performance Responsibilities

TPHO has Performance Standards outlined in the TPHO Network Participation and Realignment Policy available in the Appendix of this manual. The policy outlines criteria to measure clinical quality, as well as resource utilization and cost effectiveness. The Participating Provider agrees to comply with such performance standards and programs as TPHO shall from time to time establish, including quality improvement, patient safety, disease management, reporting, data sharing and utilization management programs, processes, and procedures.

Additionally, all primary care physicians are required to attend annual POD meetings. Incentive distribution eligibility requires at least 75% attendance to annual meetings.

In-Network Referrals Responsibilities

As referenced in the Participating Provider Agreement, that is signed by each TPHO group prior to membership – TPHO members are required to refer to providers within the TPHO network. Referring in the network ensures that patients are utilizing high-value providers that have committed to collaborating and adhering to the principles of value-based care. The most current version of the TPHO network can always be found here: <https://directory.trihealthpho.com/>. Exceptions for referring outside the TPHO network are mentioned in the Provider Agreement and include:

1. Services are not offered in the TPHO network.
2. Patient preference
3. Referral to non-TPHO provider is required by the Payor.

See the Care Compact in the Appendix of this manual for details.

Electronic Connectivity and Data Sharing Responsibilities

Consistent with the commitment to communication and collaboration with other TPHO members, to provide the best care for patients, TPHO members agree to maintain, or participate in, information systems that contribute to providing high-value care.

More information can be provided by the TPHO team. The following are examples of tools that TPHO members can use to better collaborate with other members:

- **EpicCare Link:** web-based access to Epic to be able to review patient information in Epic as well as provider notes from previous patient encounters.
- **Voalte:** HIPAA-compliant messaging app that can allow communication between providers and consults with specialists.

In order to achieve TPHO network goals to meet payor quality and utilization targets set in value-based contracts, we rely on data sharing across our employed and independent network of providers. For those providers not on an EMR that is interoperable with EPIC, it is the provider's responsibility to allow TPHO Network Operations associates or Population Health Managers into their office for a review of value-based attributed members upon request. Further, it is the provider's responsibility to submit data as requested using secure processes that are outlined by TPHO Network Operations. Failure to do so inhibits the ability of the network to achieve contracted goals and could result in a provider entering a Performance Improvement Plan. Failure to correct deficiencies could result in further action by the TPHO Network Participation & Realignment Committee, including the removal of a provider from certain value-based contracts or termination from the TPHO network.

Engagement & Support

TPHO Staff

The TPHO organization is composed of a multi-disciplinary team to support TPHO members in their pursuit of value-based care. The leadership group comprises Dr. Raymond Metzger, TPHO President, Patrick Wright, VP of Population Health at TriHealth, and Tom Boggs, VP Client Partner at Lumeris.

TPHO Website

The TPHO website (www.trihealthpho.com) is a great resource for learning about TPHO and a place for quick access to resources. The website includes helpful topics including, but not limited to:

- TPHO Overview
- Key Contacts
- Governance Members
- Membership requirements
- Clinical Integration
- Education Library
- PHO Communications
- Network Directory link

POD Meetings

POD meetings are held on a quarterly basis and are a requirement for all TPHO PCPs. POD meetings are held on a quarterly basis. The purpose of POD meetings is to:

- Provide performance and contractual updates.
- Cascade best practices
- Provider support, resources, and tools
- Provide network updates.
- Collaborative discussions of how TPHO can best support our partners through the population health journey.
- Opportunity to create relationships with other physicians and support staff.

TPHO Governance

The TPHO organization was formed with several governing bodies, each listed and described below, and meets on a quarterly basis. These governing bodies oversee the TPHO organization and the value-based contracts in which members can participate.

Quality Assurance & Clinical Integration Committee

The Quality Assurance and Clinical Integration Committee (QA/CI) shall have the responsibility of ensuring the quality of care, and clinical integration by participating providers. They may also evaluate and recommend providers to the Board for membership, ongoing monitoring, evaluation of quality and provision of care. Dr. Lee Niemeyer, MD is the current Chair of QA/CI.

Payor Contracting & Financial Operations Committee

The Payor Contracting and Financial Operations Committee shall have the responsibility of overseeing the financial condition of TPHO. They may make recommendations to the Executive Committee and Board concerning financial matters, including, without limitation, investments. TriHealth CFO Andrew DeVoe is the current Chair of the Payor Contracting & Financial Operations Committee.

Board of Directors

The Board of Directors is the governing body for TPHO. The Board oversees strategy, contracting, operations, clinical integration, infrastructure and resources. Dr. Bryan Strader, MD, is the current Chair of the TPHO Board of Directors.

Incentive Distribution

The physician-led TPHO Board has developed and approved a methodology to distribute any value-based revenue/savings with eligible, participating primary care providers, via their Tax Identification Number (TIN). The Board considered specific criteria when developing this methodology. These include TPHO members who:

- Enhance the TPHO vision of providing better care, better health, and better value for our patients.
- Be fair and equitable in providing payment for measurable outcomes achieved.
- Maintain a process that is transparent.

Eligibility Requirements for Incentives

To participate in the annual distribution of earned 'shared savings,' the following eligibility requirements must be met:

- Physician – specialty of Internal Medicine, Family Medicine, Pediatrics, Geriatric Medicine + practicing in the capacity of a primary care physician (e.g. not urgent care, dual specialty and practicing as a specialist) or...
- Nurse Practitioner / Physician Assistant – practicing in an adult primary care capacity in a primary care office with attributed lives.
- Value-Based Member Months attributed to the provider.
- Active member in TPHO, in good standing (e.g., meet credentialing requirements and have attended 75% of POD meetings)
- Active TPHO member on **12/31** of the performance year in which the funds are earned.

2024 Measures

For PY2024, the TPHO Board of Directors approved an updated incentive distribution approach that enhances the alignment of TPHO PCPs with the key tenants of value-based care. In addition to updating the measures and associated targets, the Board created five performance domains that are critical for successfully performing in value-based care arrangements: 1) Quality Performance 2) Access to Care 3) Chronic Documentation and Coding 4) Care Consolidation and 5) Utilization.

The below incentive measures were approved by the TPHO Board of Directors on December 5, 2023.

2024 Performance Year
Access to Care KPI (20%) Individual
Access to Care: Adult (MA and MSSP/ACO Reach for 20 years and older)
Yearly Primary Care Provider Visit for patients with chronic condition (Comm)
Quality KPI (30%) Individual
Breast Cancer Screening (All VB 50-74 years)
Colorectal Cancer Screening (All VB 45-75 years)
Diabetes: A1C ≤ 9 (MA and MSSP/ACO Reach 18-75 years)
Diabetes: A1C < 8 (Commercial and Medicaid 18-75 years)
Diabetes: KED (MA and Commercial 18-85 years)
Hypertension: BP Control (All VB for 18-85 years)
Documentation & Coding (30%) Individual
Chronic Condition Refresh (MA and MSSP/ACO Reach)
Care Consolidation (10%) POD
Use of Preferred Network (Non-DHS Encounters only, All LOB)
Utilization (10%) POD
Outpatient ED Visits/1000 (Commercial)
Outpatient ED Visits/1000 (MA, ACO Reach, MSSP)

Value-Based Contracts

To be eligible for participation in a TPHO value-based contract, you must first hold a fee-for-service agreement for the payor and associated line of business. The list below outlines the current value-based agreements held by TPHO:

- Anthem Medicare Advantage
- Anthem Commercial
- Aetna Medicare Advantage
- Aetna Commercial
- Cigna Commercial
- CMS: Medicare Shared Savings Program (MSSP)
- CMS: ACO REACH
- Humana Medicare Advantage
- Humana Commercial
- MMO Medicare Advantage
- MMO Commercial
- UnitedHealthcare Commercial
- UnitedHealthcare Medicare Advantage
- Buckeye Medicaid
- Buckeye AMBetter
- Buckeye MA
- CareSource
- Essence MA

Attribution

Why is Attribution Important?

Payor attribution is important because it is the financial mechanism used by the payors to determine ownership of their members and our patients, within our value-based contracts.

TPHO earns value-based care (VBC) dollars based upon the payor's attribution model and the quality and cost outcomes for the patients attributed within this model.

When a payor attributes a patient to a provider, they are communicating that the provider is responsible for managing all the patient's care, including cost and quality, regardless of where and by whom, the patient's medical treatment is rendered.

Payor Methodology

Payors can attribute a patient to a provider for various reasons, but the initial hierarchy generally looks like:

1. Patient selection at time of enrollment - whether they've previously seen the provider or not.
2. History – if there's previous claims history; specialists are often assigned using this method.
3. Family relationship – if another age-appropriate member of the family currently sees this provider under the same plan.
4. Quality – some plans have a quality filter that finds high quality providers that match geo-assignment or claims diagnosis history.
5. Geo-assignment – based on address of patient and provider available. While the last in most payor assignment hierarchies, this is often the most common way payors assign PCPs.

After initial assignment, payors may re-assign based on the following:

1. Claims attribution – a regularly scheduled review of claims history to identify who the patient is receiving primary care services from, if different than initial assignment. Many plans follow a rule of 3 consecutive visits.
2. Patient requests – most of the plans in our value-based contracts allow a patient to change their officially designated PCP through the payor's member service contact center. Some payors allow changes through their secured online member portal.

Impacts of Attribution

Specialists - Patients can be assigned to specialists, including OB-GYN, or in some cases Cardiologists and Oncologists. Many payors allow this as a member selection at time of enrollment, or through their claim's attribution process based on plurality of visits, in absence of a Primary Care visit.

APPs – Many payors, including Aetna, United, the MSSP program, and others allow primary care APPs to have attributed patients. Our payor files indicate significant panels for APPs embedded in our primary care offices, and these providers are eligible for the annual incentive distribution.

Incentive Distribution – Payor attributed patients form the basis of maximum incentive distribution earned for eligible primary care providers. The more value-based (VB) patients a provider has assigned by the payor, the higher earning potential is for the Performance Year. This also means that the TPHO provider is responsible for the care and outcomes of that patient, even if they are not seeing the payor attributed provider.

Annual Roster Verification & Demographic Updates

TPHO completes an annual roster verification process each year to ensure that the data we house on our network for providers is accurate and up to date. Each year you will be supplied with a roster of data from TPHO and asked to validate the accuracy of the data. Any modifications, deletions or additions to the data will need to be communicated back to TPHOProviders@trihealth.com.

Accurate data and timely updates to provider data is a critical component of the operational work performed by TPHO. Provider data is used for a variety of workstreams, including but not limited to payor rosters, in network referral options, provider finder directory, funds distribution, communication cascades, etc. Failure to respond to the annual roster verification and subsequent outreach efforts could lead to exclusion from value-based contract referrals or termination from the network.

Provider roster updates, demographic, and point of contact changes can be made at any time by reaching out to the TPHO Network Operations and Development team at TPHOProviders@trihealth.com. It may be necessary to complete a provider or group profile form to update the provider or group demographics.

APPENDIX

Care Compact: Physician-to-Physician Commitments

By signing the Participating Agreement – TPHO members agree to be bound by and adhere to the commitments in this Compact. The Care Compact is a set of peer commitments, and it outlines how members will work together as a member of the TPHO network.

Mission

The mission of the TriHealth Population Health Organization (TPHO) is to understand the needs and challenges of each patient and improve the every-day well-being of people in our community. We are getting healthcare right by ensuring our patients feel respected, connected, and deeply cared for. As members of TPHO, we are confident we can change how our patients think about healthcare for the better due to our unwavering commitment to patient-centered and value-based care.

Preamble to the Commitments

TPHO, together with all the professionals within the Clinically Integration Network (CIN), is committed to achieving the “*quadruple aim*” of improvement in care; improvement in health outcomes; improvement in the efficiency and effectiveness of resource management; *and improvement in the professional experience of those providing the care*. In doing so, TPHO will lead the local market into the value-based reimbursement environment.

The following set of commitments represents the foundation of the professional relationships among the clinicians within TriHealth Population Health Organization.

Peer Commitments:

To operate within a successful and mutually beneficial CIN, TPHO professionals agree to:

■ **Conduct clinical activities with professionalism, personal accountability, and integrity.**

Meaning...

- Conducting interactions with colleagues, staff, and patients with honesty, personal responsibility, and the highest ethical standards
- Demonstrating trustworthiness in interactions with peers, staff, and patients
- Treating all patients, regardless of personal attributes or circumstances, with the respect and dignity with which each of us wants to be treated.
- Avoiding economic conflicts of interest
- Completing tasks for which you are professionally accountable in a timely fashion.

- Avoiding speaking disparagingly about a patient, professional colleague, or staff member in front of others
- **Support a team approach to caring for patients while always recognizing the physician's leadership role within the clinical delivery team.**

Meaning...

- Encouraging, fostering, and supporting a comfortable, collaborative, and safe working environment.

TPHO Peer-to-Peer Commitments

- Recognizing the contributions of all members of the clinical work team and showing respect and gratitude for those efforts
- Demonstrating clarity within communications, setting clear expectations, and being responsive to colleague referrals
- Participating in activities that advance our group's mission, vision, and values.
- Offering and accepting constructive feedback to staff and colleagues falling short of meeting these commitments in a responsible and respectful manner
- Being responsive to patients' needs and engaging patients in shared decision-making.
- When necessary, allow for effective co-management of patients.

- **Maintain the competence required to care for the community of patients we serve together.**

Meaning...

- Maintaining the capacity, knowledge, and clinical skills necessary to contribute to the care of our patients.
- Complying with internal and external certification requirements
- Maintaining professional curiosity and embracing an environment of lifelong learning, seeking to broaden personal and organizational knowledge and skills.
- Mentoring and teaching the next generation of caregivers

- **Be responsible stewards of our shared resources.**

Meaning...

- Providing the right care at the right time in the right clinical environment
- Striving to balance the needs of the patient, the community, TPHO, and TriHealth
- Endeavoring to achieve the "*quadruple aim*" of improving care; improving clinical outcomes; improving the utilization of resources; *and improving the professional experience of those providing care.*
- Contributing to the coordination and integration of care across time, place, and discipline, all central to TPHO's mission of population health management
- Utilizing professionals in our system with whom we share responsibility for the care of our patients and who support our goals and honor our standards.

- **Practice to the highest contemporary standards of evidence-based care established by TPHO**

Meaning...

- Setting the highest standards of clinical care, quality, and service as personal priorities
- Operating using evidence-based models of care and practicing to evidence-based standards, utilizing clinical guidelines and protocols adopted by the group.
- Responsibly requesting assistance when the help of others is needed.
- Making certain that handoffs are comprehensive and complete.
- Honoring all confidentiality that are intrinsic to our professional work environment.

TPHO Participation & Realignment Policy

The following policy was approved by the TPHO Board of Directors on June 6, 2023.

Purpose:

TriHealth CIPHO, Inc. (dba TriHealth Population Health Organization and hereinafter “TPHO” or “Network”) operates a clinically integrated network comprised of Participating Providers (defined below) that have agreed to participate in one or more value-based products through the Network for the purpose of providing high-quality, cost-efficient care to members, while creating a high degree of care coordination amongst the Network’s providers.

The purpose of this Network Participation & Realignment Policy (“Policy”) is to outline certain requirements that providers must meet for network selection into and ongoing participation in the Network. There may be additional payor specific credentialing requirements for participation based on the specific payor program or payor agreement addressed outside of this document. This Policy supersedes and replaces the TPHO Provider Advisory Committee Policy. However, in the event there is a direct conflict between any of the provisions contained in this Policy and the terms of the applicable TPHO Participation Agreement (as defined below), the terms of the applicable TPHO Participation Agreement will control. Capitalized terms not defined herein shall have the meanings given to them in the TPHO Provider Manual (as defined below).

Policy Statement:

Participating Providers must meet a minimum set of credentialing and enrollment requirements set forth in the TPHO Participation Agreement and TPHO Provider Manual. In addition to basic membership requirements outlined in the participation agreement and TPHO Provider Manual, certain Performance Requirements defined and outlined within the following attachments (Attachment A and Attachment B) shall be required to continue participation after initial selection into the Network.

Failure to meet Performance Requirements may lead to a Performance Improvement Plan and/or termination from the Network. Primary Care Participating Provider Performance Requirements are outlined in Attachment A. Specialists Participating Provider Performance Requirements are outlined in Attachment B. Both attachments may be updated within the Provider Manual from time to time as approved by the appropriate TPHO governance body.

Definitions:

“Credentialing Requirements” means requirements of payor with which the Network contracts that a Participating Provider must meet and comply with.

“Participating Provider” means any Participating Health Care Professional, Participating Physician, Participating Hospital, or other health care professional or facility engaged in the delivery of health care, which or who has been selected into the Network to provide Covered Services to Covered Persons.

“TPHO Participation Agreement” means a participating provider agreement between Participating Provider and TPHO.

“TPHO Provider Manual” means a supplemental document, given to a Participating Provider, that provides additional operational detail about items mentioned in the TPHO Participation Agreement. The Provider Manual will also codify decisions, and related detail, for topics such as credentialing requirements, the incentive distribution model and performance management and realignment. The TPHO Provider Manual shall be updated annually to include updates to Network Performance Requirements required for continued Network participation.

“Membership Participation Requirements and Processes” means basic membership requirements and processes to be met for initial acceptance into the Network outlined and updated from time to time in the TPHO Participation Agreement and Provider Manual.

“Performance Requirements” means those performance requirements for Network participation set forth on Attachments A and/or B (as applicable) and as amended by the Network from time to time.

“Realignment Plan” means a written plan approved by the Network participation and Realignment committee, TPHO President, or delegate for specific purpose of developing a Participating Provider driven action plan with a timeframe for improvement that holds Participating Providers accountable, aligned with the incentive distribution metrics to improves access, quality and/or cost outcomes.

“Network Participation and Realignment Committee” is a monthly committee chaired by the TPHO President and consists of the Senior Vice President, Client Partner Executive, TPHO Network Director, and delegated Analytics Leader. This committee reviews current data and reconciles against the Performance Requirements. This group is responsible for initiating and monitoring the Realignment pathway.

Network Participation

The following requirements have been adopted by TPHO in support of the Network’s efforts to implement its value-based programs and to achieve its Network objectives for better care, better health, better value and better experience.

1. Participating Providers must satisfy the Membership Participation Requirements and Processes, agree to and at all times abide by the terms of the TPHO Participation Agreement and the TPHO Provider Manual, and be approved for admittance into the Network by the Quality Assurance & Clinical Integration (QA/CI) Committee.
2. Participating Providers who fail to satisfy the Membership Participation Requirements and Processes may be subject to realignment and/or termination from the Network.
3. Participating Providers must comply with the Performance Requirements and with the Credentialing Requirements of any applicable payor with which the Network contracts. Failure to meet Performance Requirements and/or Credentialing Requirements may lead to realignment and/or termination from the Network and/or from a payor/product.

Network Participation and Review of Realignment/Termination Decisions

The Network Participation and Realignment Committee shall provide ongoing monitoring, oversight, and review of Participating Providers. Specifically, and without limitation, the Network Participation and Realignment Committee shall monitor and review ongoing compliance with Network and payor credentialing criteria and TPHO Performance Requirements (Exhibits A & B).

Participating Providers shall be bound by the realignment and termination decisions made by the TPHO board and any TPHO board committees that have been delegated board authority, including but not limited to, the Quality Assurance/Clinical Integration Committee regarding Participating Provider’s participation in TPHO.

Any request for review of decisions for realignment and/or termination from TPHO may be made to the attention of: TPHO President and TPHO Board Chair within 15 days of receiving communication from TPHO about the realignment and/or termination from TPHO. A follow up response from TPHO will occur within 15 days. Additional details on the review process are outlined in the TPHO Provider Manual.

Network Participation & Realignment

Attachment A

Performance Requirements

Primary Care Providers

The TPHO value-based network development and performance strategy is centered around supporting high quality and affordable access to care. The following provides the criteria and process for primary care providers to continue to be a Participating Provider.

Performance Requirements	Definition	Provider Requirement
Electronic Health Record/Medical Chart Access	Providers are willing to grant access to Medical Charts for the purposes of documentation and quality reporting outcomes requirements	Access Upon Request, as needed to support performance reporting. <ul style="list-style-type: none"> Submission of EHR name and edition to TPHO Network
Priority Metrics (as defined in Provider Manual)	Provider meets or exceeds minimum performance levels in the Primary Care Priority Performance metrics, scoring 2 or > in all domains of the 1-5 scoring methodology	Based on prior year results Provider shall have a minimum of 20 attributed patients in any one priority metric denominator to be included in the scoring domain methodology
Attributed Lives Collaboration	Provider agrees to: <ul style="list-style-type: none"> Utilize network resources when available to coordinate with clinical and non-clinical staff in lowering cost and improving quality unless an exception in the Participation Agreement exists. Utilize evidence-based practice guidelines/clinical workflows made available to Providers 	<ul style="list-style-type: none"> Adhere to Primary Care Provider Care Consolidation minimum standards (included in Priority Metrics aligned incentives) Adhere to minimum standards as approved by TPHO QA/CI
Citizenship	Attendance at 75% of Pod meetings is a requirement to be eligible for fund distribution.	Attend 3 out of 4 Pod Meetings annually

Attributed Lives Co-Management	Acceptable use of centralized technology and resources to manage patient population effectively	Monitor and track performance utilizing technology provided. Promote use of centralized resources to conduct attributed patient outreach
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Network may use Participating Providers' ability to meet or not meet the above Performance Requirements to group Participating Providers for value-based purposes utilizing performance information to determine high outcomes, appropriate lower cost utilization, and/or high interoperability to determine participation in increasing levels of value-based risk arrangements with payors. Measures used to define priority metrics will align with incentive distribution measures approved annually by the TPHO Board.

Failure of a Participating Provider to satisfy any of the Performance Requirements may result in the termination of the Participating Provider's participation in a value-based product and/or in the Network. Performance Requirements shall be updated annually, or as needed, in accordance with TPHO Board approvals, and/or payor program changes.

If a Participating Provider does not satisfy any of the above Performance Requirements, then in effect for the applicable program year, then no later than ninety (90) days after the date on which Network notifies Participating Provider of the deficiency, and no later than thirty (30) days prior to the date on which Network submits its Participation Provider roster to CMS or applicable payor for the next performance year, Participating Provider must develop, in conjunction with the applicable Network Participation and Realignment Committee, TPHO President, or defined delegate, and satisfactorily execute a time bound Performance Improvement Plan for each of the deficient Performance Requirements. Participating Provider must obtain approval of his/her Performance Improvement Plan from the applicable Network Participation and Realignment Committee, TPHO President, or defined delegate. Failure to complete the Performance Improvement Plan will result in removal from the Network.

Network Participation & Realignment

Attachment B

Performance Requirements

Specialists & Other Value-Based Providers Participation

The TPHO value-based network development and performance strategy is centered around supporting high quality and affordable access to care. The following provides the criteria and process for specialty care providers to continue to be a Participating Provider.

Performance Requirements	Definition	Provider Requirement
Quality	Adhere to minimum quality Service Line standards as	Participate in programmatic initiatives that drive standards adherence and improvement of

	determined by Evidence Based Standards process	quality outcomes as illustrated in the TPHO Provider Manual
Cost	Adhere to minimum cost standards as determined by Evidence Based Standards process where applicable	Participate in programmatic initiatives that drive standards adherence and reduction of unnecessary cost and utilization as illustrated in the TPHO Provider Manual
Attributed Lives Collaboration	Provider agrees to: <ul style="list-style-type: none"> Utilize network resources when available to coordinate with clinical and non-clinical staff in lowering cost and improving quality Utilize evidence-based practice guidelines/clinical workflows made available to Providers 	<ul style="list-style-type: none"> Adhere to Care Consolidation Steering minimum standards defined and approved by the TPHO Board Adhere to minimum standards as approved by TPHO QA/CI
Citizenship	Provider roster management is a key driver of payor performance reporting that must be updated regularly	Provider agrees to send at least quarterly updated provider group roster inclusive of full provider names, NPIs, primary provider office location.
Access & Availability	Address patient access to care issues, due to provider capacity and/or wait times	Adherence to the access/availability standards approved by TPHO QA/CI

Network may use Participating Providers ability to meet or not meet the above Performance Requirements to group Participating Providers for value-based purposes utilizing performance information to determine high outcomes, appropriate lower cost utilization, and/or high interoperability to determine participation in increasing levels of value-based risk arrangements with payors. Measures used to define priority metrics will align with incentive distribution measures approved annually by the TPHO Board.

Failure of a Participating Provider to satisfy any of the Performance Requirements may result in the termination of the Participating Provider's participation in a value-based product and/or in the Network. Performance Requirements shall be updated annually, or as needed in accordance with TPHO Board approvals, and/or payor program changes.

If a Participating Provider does not satisfy any of the above Performance Requirements, then in effect for the applicable program year, then no later than ninety (90) days after the date on which Network notifies Participating Provider of the deficiency, and no later than thirty (30) days prior to the date on which Network submits its Participation Provider roster to CMS or applicable payor for the next performance year, Participating Provider must develop, in conjunction with the applicable Network Participation and Realignment Committee, TPHO President, or defined delegate, and satisfactorily execute a time bound

Performance Improvement Plan for each of the deficient Performance Requirements. Participating Provider must obtain approval of his/her Performance Improvement Plan from the applicable Network Participation and Realignment Committee, TPHO President, or defined delegate. Failure to complete the Performance Improvement Plan will result in removal from the Network.