

**2019 MODEL HEALTH PLAN CONTRACT LANGUAGE**

**ON PAYMENT & DELIVERY REFORM**

***DISCLAIMER:*** *This Agreement is provided for informational purposes only. Before Purchaser makes any decisions as to whether to use this Agreement in whole or in part and to understand the legal implications of doing so, Purchaser should consult with a qualified legal professional for specific legal advice tailored to its situation.*

**Improving Value through Health Care Payment & Delivery Reform**

This Agreement is made and entered into this [#] day of [month], 2019, by and between [carrier or third-party administrator name], hereinafter called "Administrator," and [employer or other health care purchaser name], hereinafter called "Purchaser."

For the purposes of this Agreement, the term "Provider" shall refer to all health care providers for which there is health care spending.[[1]](#footnote-2) In addition, the term "Plan Participant" shall refer to Purchaser's covered population, such as employees, dependents and retirees, who are eligible to receive their health benefits under the group health plan (“Plan”).

1. **Introduction.** Purchaser sponsors a Plan under which eligible employees and retirees can enroll in health insurance coverage. Purchaser sponsors the Plan to ensure that Plan Participants have coverage for and access to comprehensive, high-value health care. Administrator provides third-party Plan administration services to Purchaser, which are described in the Administrative Services Agreement entered into between the parties effective on [fill in effective date of Addendum here]. To improve the delivery of health care, including its quality, efficiency, safety, patient-centeredness, coordination, and outcomes, there must be significant changes to existing health care payment and delivery structures and methodologies as well as to the environment in which administrators pay providers. This Agreement outlines Purchaser's expectations for how Administrator shall facilitate progress in both areas:
   1. Value-Oriented Payment and Delivery of Care. Administrator shall design and implement payment and delivery methodologies with its network Providers that are designed to cut waste, improve the quality of care, or both. Administrator shall report each individual program’s impact on quality outcomes, costs, and the savings generated, to Purchaser in a standardized way, on a quarterly basis (e.g., CPR’s Standard Plan Accountable Care Organization Report). For the purposes of this Agreement, payments designed to cut waste (e.g., a shared risk payment arrangement) are those that are intended to reduce unnecessary payments and unnecessary care, without compromising the quality of care. Payments designed to improve the quality of care may include payment for high-value services previously not covered (e.g., care coordination) or payments that rise or fall in a predetermined fashion, based on the provider’s performance on standard quality measures, utilization, and cost. Administrator shall use payment and delivery reforms to encourage adherence to clinical guidelines and to improve the value of care in the following clinical areas, including, but not limited to: maternity care, pharmacy, and behavioral health care. Value is defined as the level of the quality of care delivered compared to the amount of money paid to the Provider for delivering such care.
   2. Transparency. In order for those who purchase health care to judge its value, Administrator shall provide Plan Participants, Purchaser, and Providers with the information they need to understand the value of the care they seek, pay for, and provide.
   3. Market Competition. Administrator shall design contracting methodologies and payment options and administer Purchaser’s Plans in a manner that enhances competition among Providers and reduces unwarranted price and quality variation. For illustrative purposes only, such methodologies may include, but are not limited to: tiered and narrow networks; centers of excellence; reference pricing; support for purchaser-provider direct contracting; managed care/managed competition strategies; and price and quality transparency. To stimulate Provider competition further, Administrator shall establish programs, including some of those listed above, to engage Plan Participants in making informed choices and to select high-quality, evidence-based, and cost-effective care.
   4. Tracking Progress. Administrator shall provide Purchaser with updates on its implementation of health care payment and delivery reform programs and the impact of these programs on health care quality, cost, and utilization (e.g., CPR’s Reform Evaluation Framework(s) and / or CPR’s Standard Plan Accountable Care Organization Report). Administrator shall participate in CPR’s Scorecards on Payment Reform and CPR’s Health Plan User Group process (by invitation from CPR).

These contractual commitments are included to support and advance Administrator initiatives to develop a health care market in which (a) payment increasingly is designed to improve and reflect the effectiveness and efficiency with which Providers deliver care, and (b) Plan Participants are engaged in managing their health and selecting Providers and services with sensitivity to price and quality. The Administrator will use reasonable efforts to ensure that these commitments and initiatives apply to all benefits offered under the Plan and administered by the Administrator, as applicable, to the extent such implementation is supported by the Administrative Services Agreement and any Scope of Work related thereto. In order to facilitate broad consistency in payment and delivery reform efforts, Administrator should apply initiatives across all books and lines of business, including fully-insured, self-insured, public and private sector, as appropriate and permitted.

Purchaser will make best efforts to ensure benefit designs support the initiatives and commitments described in this Agreement. Unless otherwise specifically provided for herein, Administrator shall comply with the obligations set forth in this Agreement in accordance with the timelines established for each initiative described in this Agreement. Failure of the Administrator to materially meet these commitments by the applicable dates set forth in this Agreement will be considered grounds for non-renewal of the Agreement.

1. **Obligations of Administrator.** To advance the objectives stated above, Administrator shall promptly take the following actions.
   1. VALUE-ORIENTED PAYMENT AND DELIVERY OF CARE

Administrator shall implement health care payment and delivery strategies that reduce waste and improve the quality and coordination of care. Purchasers are particularly interested in methods that put providers at financial risk for the care of their populations. Administrator shall provide Purchaser with its strategy to make 20% of in-network payments to Providers through methods proven to improve value, by 2020. Such strategies shall include the following:

* + 1. **Modify the fee schedule to deliver a higher-value mix of services**
       1. **Pay for appropriate services that were not previously covered.** Administrator shall pay physicians to encourage the provision of appropriate services that were not previously covered. Such strategies include, but are not limited to, payment for care coordination and electronic communication with patients.
       2. **Pay appropriate relative amounts for services.** Administrator shall implement changes to the underlying fee schedule to establish relative amounts that encourage Providers to offer appropriate care. In particular, Administrator shall address potentially mis-valued services by adjusting payment for services that either exceed or come up short against the actual cost required to produce them.
       3. **Balance payment between primary and specialty care.** Administrator shall develop, pilot and implement successful strategies to increase and prioritize payment for primary care services, including strategies to reduce payment discrepancies between primary and specialty care. Such strategies may include, but are not limited to, performance-based incentive programs (e.g., shared savings and/or pay-for-performance), fee schedule adjustments (care coordination fees), partial or full capitation, and health care delivery system programs such as patient-centered medical homes (PCMH) and accountable care organizations (ACO). Irrespective of the payment method, delivery system programs should be structured to focus on improving the quality of care while also reducing total health care costs.
    2. **Pay according to performance and reinforce with benefit design.** Administrator shall implement successful approaches to payment that differentiate and reward Providers who meet or exceed regional or national standards for quality and efficiency. To the extent possible, Administrator shall include measures that assess Provider performance in the clinical areas with the highest variation for Purchaser, such as those listed in [CPR’s Employer-Purchaser Priority Measures Set](https://www.catalyze.org/product/cpr-employer-purchaser-guide-quality-measure-selection/). In the context of ACO arrangements, Administrator shall include measures from the [Integrated Healthcare Association-Pacific Business Group on Health ACO Measure Set](https://www.iha.org/our-work/accountability/value-based-p4p/measure-set) for greater consistency and alignment with other efforts. Payments to Providers should reflect their performance and result in market efficiencies and savings to Purchaser. Administrator shall be able to administer benefit designs to encourage Plan Participants to select effective and efficient Providers.
    3. **Use payment methods that cut waste and reduce unwarranted payment variation, without compromising the quality of care.** Administrator shall evaluate and implement successful approaches to payment that are designed to cut waste without compromising quality such as the approaches described below.
       1. **Methods that put Providers at risk.** Administrator shall develop, pilot and implement strategies in which Providers accept financial responsibility and risk for patient care, particularly through prospective payment arrangements. In such arrangements, Provider is financially liable for overspending or not meeting specified cost and quality targets. Examples include, but are not limited to warranties on discharges for patients who undergo procedures, bundled or episode-based payment, shared risk arrangements, partial- or condition specific-capitation, and full-capitation paired with quality incentives.
       2. **Non-payment for avoidable services.** Administrator shall not pay Providers for care that is deemed unnecessary or wasteful. Such strategies include but are not limited to non-elevated payment for hospital-acquired conditions, and, non-payment for all-cause readmissions within 30-days and non-payment for elective cesarean deliveries and/or elective inductions prior to 39 weeks of gestation.
    4. **Use health care payment and delivery methods that encourage adherence to clinical guidelines.** Administrator shall evaluate and implement approaches that successfully encourage adherence to clinical guidelines and the delivery of high-value health care services.
       1. **Maternity care**

An important priority for Purchaser is to encourage adherence to clinical guidelines for maternity care. Purchaser acknowledges that Plan Participant education and benefit design as well as Provider education and policy changes are important mechanisms to push maternity care to be more evidence-based. However, payment methods are an underutilized vehicle in driving positive change. Administrator will take the following steps with regard to payment for and evaluation of maternity care services:

* + - * 1. **Maternity care payment and certification.** Administrator shall implement payment strategies to reduce the rate of early elective deliveries and elective cesarean deliveries. Such strategies may include, but are not limited to, bundled payment for labor and delivery, blended single payment for cesarean delivery and vaginal births, and non-payment for early elective cesarean deliveries and/or inductions. Administrator shall certify and establish a payment process for alternative maternity care providers demonstrated to provide high-quality care at lower cost, such as certified nurse midwives, laborists, doulas, and free-standing non-hospital birth centers.
        2. **Change elective delivery rate.** Administrator shall require that Providers achieve a rate of 5% or less of early elective deliveries prior to 39 weeks. If a Provider does not achieve this rate, Administrator shall exclude Provider from the network, or report to Purchaser each year the rationale for continued contracting with Provider, and the efforts the Provider is undertaking to improve performance.
        3. **Change NTSV C-Section Rate.** Administrator shall contract only with hospitals that demonstrate they provide high-quality maternity care and promote the safety of Plan Participants during childbirth. Administrator shall either exclude hospitals that are unable to achieve The Joint Commission’s nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth (NTSV C-Section) rate below [23.9 percent](https://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-child-health/objectives) from Provider networks serving Plan Participants or document each year to the Purchaser the rationale for continued contracting; and
        4. **Measure and report results.** Administrator shall provide Purchaser and Plan Participants with information related to adherence to clinical guidelines for maternity care, and the quality of maternity care among Administrator's network Providers on an ongoing basis. Administrator shall measure and report on The Joint Commission’s NTSV C-Section measure. Administrator shall require that Providers that operate in states with a maternity data registry, such as the California Maternal Quality Care Collaborative Maternal Data Center, fully participate in the registry by reporting their data to it.
      1. **Pharmacy**

Another important priority for Purchaser is to address concerns about the rising cost and appropriate use of pharmaceuticals through health care payment and delivery reform.

**Formulary development.** Administrator shall describe how it considers value in its selection of medications for use in its formulary, including the extent to which it applies value assessment methodology developed by independent groups or uses independent drug assessment reports on comparative effectiveness and value to design benefits (e.g., value-based insurance design), negotiate prices, develop pricing for consumers, and determine formulary placement and tiering on its standard benefit designs. Administrator shall also describe how its construction of formularies is based on total cost of care rather than on drug cost alone.

**Payment reform.** Administrator shall implement payment reform strategies that address the cost and appropriate use of prescription drugs. Relevant strategies may include, but are not limited to, bundled payment and other population-based payments for the total cost of care, evidence-based incentive payments, non-payment policies, and pay-for-drug performance. Administrator shall report initiatives and results to Purchaser, quarterly.

**Delivery reform.** The setting in which a drug is administered can have a significant impact on the cost of the drug. Administrator shall implement strategies that ensure prescription drugs are delivered in the most cost-effective setting for Plan Participants.

**Appropriateness of care.** Administrator shall adhere to standard clinical and cost management strategies to help ensure appropriate drug use and minimize pharmaceutical costs. Relevant strategies may include, but are not limited to, prior authorization, step therapy, quantity limits, formulary management, exclusive formulary, and mandatory generic.

* + - 1. **Mental Health Conditions and Substance Use Disorders**

Administrator shall address Purchaser concerns about the rising costs of behavioral health care, provider access and quality challenges, and integration with medical services by experimenting with payment and delivery reforms. Strategies may include, but are not limited to, paying behavioral health providers adequately, expanding access by offering tele-behavioral health or computerized Cognitive Behavioral Therapy, integrating behavioral health providers with primary care, including behavioral health providers in accountable care organizations, and incorporating nationally-endorsed behavioral health quality measures that address the spectrum of behavioral health needs (i.e., needs for both lower- and higher-severity conditions) into payment and delivery reforms (e.g., evidence-based care, medication assisted treatment, etc.). Administrator shall report initiatives and results to Purchaser, quarterly.

If Administrator determines that the linkage between payment and adherence to clinical guidelines in any of these three areas results in meaningful improvement in value and clinical outcomes, Administrator shall report to Purchaser 1) plans to expand initiatives in the short term (1 year) and long term (3-5 years); and, 2) other clinical areas where current payment approaches create financial incentives to provide care that is not evidence-based, and where a change in payment methodology could instead provide incentives for evidence-based care.

* + 1. **Leverage network and benefit design strategies that encourage Plan Participants to seek high-value services or care from high-value Providers.** Moving Plan Participants to Providers who deliver higher quality, lower cost care will help Purchaser extract more value from the health care system. These strategies can send a signal to Providers that Purchaser will not support unwarranted variation in prices or below-standard quality.

Administrator shall help Purchaser develop and introduce new benefit designs and/or incentives, as well as communication strategies, that encourage Plan Participants to become active shoppers, helping them identify the highest-value services and Providers and limit out-of-pocket expenses. These steps include:

* + - 1. **Analyze price, cost, and quality data.** Administrator shall conduct an analysis of price, cost, and quality variation among its network Providers. Administrator shall share information with Purchaser indicating those procedures, regions, or market segments with the widest variation and greatest cost savings and quality improvement opportunities through network and benefit design strategies, on a quarterly basis.
      2. **Support benefit designs to shift Plan Participants to high-value services and Providers.** Administrator shall implement benefit designs that encourage consumers to seek high-value services or care from high-value Providers. Such strategies may include, but are not limited to, tiered and narrow networks; centers of excellence; reference pricing; value-based insurance design; and benefit designs encouraging the use of alternative sites of care.
      3. **Measure Plan Participant movement to high-value Providers**. Administrator shall measure and report the percent change from the prior year in Plan Participants selecting higher-value Providers for services, on an annual basis, and share, if possible, the impact on cost and quality.
      4. **Exclude Providers that do not meet cost and quality standards.** Administrator shall either exclude Providers from high-value networks if they do not meet cost or quality standards or report to Purchaser each year the rationale for continued contracting with each Provider who is identified as not meeting cost and quality standards, along with the efforts the Provider is undertaking to improve performance.
    1. **Provide Purchaser with Regular Information on the Impact of Payment and Delivery Reform Programs.** Administrator shall offer at least one payment and delivery reform program for formal evaluation by an external independent researcher and agree to external publication of the results. Administrator shall provide Purchaser with information on the performance of payment and delivery reform programs, as well as benefit designs, on a quarterly basis in an easy-to-digest fashion. Administrator shall provide such information in standard, ongoing reports, which shall provide the programs’ impact on cost, quality (e.g., the quality measures in [the CPR Employer-Purchaser Priority Measures Set (Table 2)](https://www.catalyze.org/product/cpr-employer-purchaser-guide-quality-measure-selection/)) and utilization. Reference tabs 6 and 7 in CPR’s [Reform Evaluation Framework(s)](https://www.catalyze.org/product/guide-evaluating-payment-reform-programs/), particularly the program outcomes questions in the embedded Excel file.

If Plan Participants are enrolled in or attributed to accountable care organization(s), Administrator shall use CPR’s [Standard Plan ACO Report](https://www.catalyze.org/product/sparc/) to report to Purchaser.

* 1. TRANSPARENCY

Administrator shall manage, maintain and/or make available to Plan Participants, Purchaser and Providers data and tools that enable price and quality comparisons among services and Providers.

* + 1. **For Plan Participants:** 
       1. **Incorporate the CPR Employer-Purchaser Priority Measures Set into consumer-facing transparency tools offered to Plan Participants.** Administrator shall incorporate [the CPR Employer-Purchaser Priority Measures Set (Table 2)](https://www.catalyze.org/product/cpr-employer-purchaser-guide-quality-measure-selection/) into its consumer price and quality transparency tool(s), with a goal of including all of the measures for which there are data available, as price and quality vary significantly for the clinical areas addressed by the measures and are of great concern to Purchaser. Tools should reflect quality and price information that is no older than 12 months. The disclosed information shall report the performance of Providers based on established quality metrics to facilitate Plan Participants' informed choice of treatment and care decisions.
       2. **Fully disclose prices to facilitate price comparisons of Providers and services by Plan Participants.** Administrator shall, where permitted, make transparent and available for use by Plan Participants (including those in high-deductible plans) Plan- and Purchaser-specific price information for services that represent at least 80% of Administrator’s medical spend in all markets, including full disclosure of the prices it is paying to Providers. Timely information on price shall be reported to Purchaser and Plan Participants on a quarterly basis. The disclosed information shall be based on the contracted price of specific procedures and services to facilitate Plan Participants' informed choice of treatment and care decisions.
       3. **Progress in all markets.** Administrator shall implement a strategy to make pricing and quality information available to Plan Participants in all markets in which Administrator operates and in which Plan Participants access Administrator’s proprietary network.
       4. **Meet Specifications in CPR’s “Comprehensive Specifications for the Evaluation of Transparency Tools.”** Administrator shall demonstrate to Purchaser that the Administrator’s transparency Tool meets the requirements outlined in CPR’s “Comprehensive Specifications for the Evaluation of Transparency Tools” document found [here](https://www.catalyze.org/product/evaluating-transparency-tool/). Administrator shall outline which specifications its Tool does not meet and share both those they do not meet and a timeline for meeting them with Purchaser.
    2. **For Purchaser:**

**Provide Purchaser with Regular Information on Price and Quality of Providers.** Administrator shall share Provider price and quality information with Purchaser on a regular basis (e.g., bi-annually or annually). The disclosed information shall report the performance of Providers based on established quality metrics and the contracted price of specific procedures and services.

* + 1. **For Providers:**
       1. **Disclose quality information to Providers.** Administrator shall provide Providers with their quality performance so that they can assess their care practices and identify where to improve. In addition, Administrator shall make available to Providers the quality performance of other Providers in Administrator’s network to help Providers make informed referrals.
       2. **Disclose price information to Providers.** Administrator shall make available for use by Providers the relative prices of other Providers in Administrator’s network to help them make informed referrals.
    2. **Phase out contract provisions that limit the use or release of price information.** Administrator shall implement a strategy to ensure that at least 99% of its network Providers (including physicians and facilities) provide data to the Administrator or its contracted third-party vendor to make prices available via a transparency tool. Administrator is expected either to exclude Providers from networks if they do not meet these standards or implement contract language that allows the Administrator to reduce reimbursement and prohibits the Provider from balance billing members,in addition to reporting to Purchaser each year the rationale for continued contracting with each Provider.
  1. MARKET COMPETITION
     1. **Identify markets with competitive issues.** Among the markets in which Administrator operates, Administrator shall identify markets with insufficient competition among Providers that may result in a negative impact on the cost and quality of care provided to Plan Participants. Among other factors, competition is insufficient when providers are concentrated to the point that consumer choices are limited (especially for non-specialized services), there are “gag clauses” that prevent Administrator from displaying cost and/or quality data, there are anti-steering contract provisions in place, there are barriers to entry for potential new providers in the market, and when there is a high rating for local providers on the Herfindahl Hirschman Index (HHI), a measure of market concentration.
     2. **Reform payment and other strategies to encourage competition.** Administrator shall implement programs to encourage competition and ameliorate the negative impacts of insufficient competition among providers identified in C.1. Approaches may include, but are not limited to:
        1. Increasing transparency about Provider quality and prices, including eliminating “gag clauses” that prevent Administrator from publishing this information;
        2. Implementing benefit designs that encourage competition, such as:
           1. Centers of excellence
           2. Reference pricing
           3. Tiered and/or narrow networks
           4. Incentives to use telehealth services;
        3. Eliminating anti-steering contractual provisions that would prohibit the above benefit designs or other strategies to encourage Plan Participants to select high value providers;
        4. Offering patient centered medical homes;
        5. Allowing accountable care organizations to reap savings only if they meet quality, cost, and efficiency standards, and limiting their ability to engage in exclusive contracts with providers; and
        6. Issuing RFPs for specific services.
     3. **Evaluate effects of value-based payment and benefit designs on Provider competition.** Administrator shall evaluate issues identified in C.1. and strategies implemented per C.2. of this section. Evaluation shall include an assessment of whether market competition has improved or declined based on these strategies.
     4. **Report to Purchaser.** Administrator shall report to Purchaser quarterly on the following:
        1. Assessment of the impact of competition in markets identified in C.1. on overall cost and quality to Purchaser during the prior calendar year; and
        2. Administrator's strategies from C.2. to encourage and ensure competition for the current calendar year.
  2. TRACKING PROGRESS
     1. **Report to Purchaser.** Administrator shall regularly report to Purchaser on its efforts to achieve the objectives of this Agreement according to the timelines set forth, including, but not limited to:
        1. The progress toward value-oriented payment and delivery initiatives imputed to the Purchaser’s annual spend for the preceding calendar year, using the format and calculation methodology in section one (“Tracking Administrator’s Progress on Payment Reform”) of CPR’s 2019 Health Plan RFI.
        2. The results of value-oriented payment and delivery initiatives imputed to the Purchaser’s annual spend for the preceding calendar year, using the format and calculation methodology in tabs 6 and 7 in CPR’s [Reform Evaluation Framework(s)](https://www.catalyze.org/product/guide-evaluating-payment-reform-programs/), particularly the program outcomes questions in the embedded Excel file. In the context of evaluating ACO arrangements, Administrator shall fill out all components of the [Standard Plan ACO Report](http://www.catalyze.org/product/sparc/) and provide it to Purchaser on a bi-annual basis. Results shall include how Administrator used and distributed care coordination and administrative services only (ASO) fees.
        3. Plan Participants’ utilization of the most effective and efficient Providers in the network, as designated by Administrator, quantifying, by specialty, the dollar variances on an episode basis of physicians designated high-quality and efficient, compared to non-designated physicians in Administrator's network; and
        4. Administrator's longer-term strategic plan (3-5-year horizon) with respect to movement toward value-oriented payment, delivery reforms, and payments designed to cut waste, as aligned with CPR’s 2020 goals.
     2. **Upon invitation from CPR, participate in Health Plan User Group meetings facilitated by CPR.**

Administrator is committed to collaborate with Purchaser and CPR to advance payment and delivery reform. Additionally, Administrator commits to transparency with Purchaser regarding its value-oriented payment strategies. Administrator will work with CPR to provide tri-annual updates on progress toward goals. Such updates include, but are not limited to, completion and sharing of the CPR Health Plan User Group progress report and participation in user group meetings by appropriate representatives of Administrator.

* + 1. **Provide data to CPR's Scorecards on Payment Reform** as relevant (e.g. Administrator does business in the geographic area where CPR is working on a national, state, or regional Scorecard) upon execution of this agreement.
       1. **The Scorecard.** When requested, the Administrator shall provide information to CPR about its approaches to paying Providers to support the implementation of its Scorecards on Payment Reform, hereinafter called "Scorecard." The Scorecard provides a view of progress on payment reform at the national as well as the state and regional level when the data collection allows.

**b. Data Submission for Scorecard**

* + - * 1. Data provided by Administrator for the Scorecard shall be aggregated with other submissions and de-identified, unless specifically agreed to otherwise and only as permitted by applicable law.
        2. Administrator shall provide data during the specified data collection period on an annual basis. Information will be for the most recent 12 months’ data available.
        3. CPR will review its Scorecard definitions and metrics regularly for relevance in the current marketplace and will clarify definitions and retire or add new metrics as appropriate. If CPR modifies definitions and/or adds new metrics to the Scorecard, CPR will consult with health plan Administrators on the feasibility of collecting the data to calculate any new metrics.
  1. ACKNOWLEDGEMENT [OPTIONAL SECTION. Include if the ASA does not address this issue generally.]

Administrator acknowledges that the Purchaser is relying on Administrator’s experience and expertise in providing the evaluative and analytic information described in this Agreement and that Administrator represents that it will use its best efforts to achieve the objectives set forth in this Agreement. Aside from the circumstance where Purchaser has established a direct contract with a Provider, Administrator and Purchaser agree that Administrator has full and complete responsibility for negotiation, execution and maintenance of the contracts governing its Provider network and that the Purchaser has no authority with respect to or control over the terms of such contracts, including methods and rates of payment and evaluation of Provider performance.

1. Including health systems, hospitals and other facilities, physicians, nurse practitioners, pharmacists and pharmacies, among others. [↑](#footnote-ref-2)