



# 2018 Medicare Advantage Quality Incentive Program

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## General Program Details and Requirements

1. **Duties of GROUP.** GROUP shall perform each of the following obligations, as applicable:
  - 1.1. Comply with all applicable federal and state laws related to this Quality Incentive Program (“Program”) and the services to be provided hereunder, including, but not limited to statutes and regulations related to fraud, abuse, discrimination, disabilities, confidentiality, self-referral, false claims and prohibition of kick-backs and all regulatory terms applicable to the Medicare Advantage program.
  - 1.2. GROUP will engage in care coordination, member engagement, education and data analytic services on behalf of Company.
2. **Payment Arrangements for GROUP Providers**
  - 2.1 GROUP agrees that in no event shall Company be liable for or have any obligation to pay any amounts, including without limitation any amounts arising from or related to the Incentive Arrangements set forth in this Handbook, owed by GROUP to GROUP Providers under any arrangements that may exist between Group and Group Providers.
  - 2.2 GROUP shall use its metrics and formulas to pass through payments GROUP receives through this Handbook to PCPs and Specialists equitably based upon achievement of the metrics and performance objectives. If requested by Company, GROUP will provide attestation that GROUP paid appropriate portions of the amounts earned hereunder to all applicable PCPs and Specialists.
3. **Term and Termination.** This Program shall be effective for an initial term of one (1) year commencing on the Effective Date (“Initial Term”). Thereafter, this Program shall automatically renew for one (1) year periods, unless terminated by either Party as provided in this Section of this Handbook. Also, the Parties agree that termination of the Medicare Advantage Agreement shall automatically cause the immediate and concurrent termination of this Program.
  - 3.1. **Termination without Cause.** Either Party may at its sole discretion and option terminate this Program by giving at least ninety (90) days’ notice in accordance with Section XX of this Handbook.
  - 3.2. **Termination for Breach.** This Program may be terminated at any time by either Party upon at least thirty (30) calendar days’ prior written notice of such termination to the other Party upon default or breach by such Party of one or more of its material obligations under this Program, unless such default or breach is cured within thirty (30) calendar days of the notice of termination.
  - 3.3. **Immediate Termination.** Notwithstanding the foregoing, if any of the following events shall occur with respect to either Party, the other Party may terminate the Program immediately upon notice:
    - a. The withdrawal, expiration or non-renewal of any state or local license, essential certificate, approval or authorization of either Party, which withdrawal, expiration or non-renewal may materially adversely affect the Party's ability to perform under the Handbook;
    - b. The bankruptcy or receivership of either Party, or an assignment by either Party for the benefit of creditors;
    - c. The loss of or limitation of either Party's general or professional liability insurance;
    - d. The debarment of either Party from participation in any government sponsored program that is necessary for execution of this Program; or

- e. The dissolution of either Party.

Company may terminate the Program immediately if Company determines that continuation of this Handbook could place the health or safety of Attributed Members in serious jeopardy.

### 3.4 Termination Due to Legal Events.

- a. Legal Events. If, during any Contract Year, any governmental authority adopts any law (including as a result of the establishment of a new law or the amendment, modification, codification, replacement or reenactment of any law that is in effect as of the Effective Date) (a “New Law”) that results in (A) a Party’s performance of its obligations hereunder causing, or its continued performance foreseeably causing, such Party to violate any provision of applicable New Law and such violation materially and adversely affects or jeopardizes (1) any Permit held by such Party that is required for such Party to conduct its business, or (2) such Party’s continued ability to participate in the Medicare Advantage program, (B) a material portion of the payments to GROUP not qualifying as Incurred Claims or as activities that improve health care quality, as defined in 42 C.F.R. §422.2430, where, as a result, Company does not satisfy the 85% MLR threshold as set forth in 42 C.F.R. § 422.2410 and is required to pay a MLR Rebate to CMS, or (C) a Party being subject to a material risk of criminal prosecution or civil monetary penalty (Clauses (A), (B), and (C) being referred to as “Legal Events”), then such affected Party (the “Noticing Party”) shall have the right to give the other Party notice of its intent to amend this Handbook in accordance with Section 9.4.b below.
- b. Notice Requirements. The Noticing Party shall give written notice to the other Party setting forth the following information:
  - (i) The Legal Event(s) underlying the notice;
  - (ii) The consequences of the Legal Event(s) as to the Noticing Party under this Program (including the specific provision and/or activity giving rise to such concern);
  - (iii) The Noticing Party’s intentions to amend this **Program** to address the Legal Event(s).

3.5 **Effect of Termination.** Termination of this Handbook shall not terminate the right of GROUP to receive payments earned in periods prior to the Contract Year in which such termination occurs. In the event of termination, Company shall perform a final reconciliation as set forth in Exhibit E, except that in the circumstance where reliable evidence of fraud or other similar fault exists, no payment shall be made to GROUP for the Contract Year in which such termination occurs and any monies earned by GROUP during that Contract Year and already paid to GROUP shall be re-paid to Company. Should such monies not be paid to Company timely, Company shall have the right to pursue any other recourse available under the Handbook or applicable law.

3.6 **Obligations Following Termination.** Upon expiration or termination of this Program where the Agreement remains in force, GROUP shall continue providing Covered Services as described in the Agreement. Termination of this Program shall have no impact on the underlying Agreement.

**4. Obligations.** The following data sharing and collaborative actions are paramount to the Parties’ ability to meet the goals they have set out, through this Program, to achieve. As such, the Parties agree that GROUP must successfully complete each of the following Obligations while this Program is in force. Failure to do so within the timing specified here will result in a forfeiture of any Quality Incentive Payments earned under this program.

4.1 Obligation #1 GROUP shall ensure that Company receives all Information and Records that it requests (on its own or through a designee) relating to GROUP, GROUP Providers and Attributed Members in accordance with this Handbook, free of charge. For the avoidance of doubt, this Obligation requires that Company receive any requested Information and Records, whether through access to a CEHRT (either in office or remotely), sent in reports or record extracts or in paper or any other form at no charge.

4.2 Obligation #2 Upon request by Company, GROUP shall meet with an Aetna Medicare pharmacist at least twice during the Contract Year, once during the first half of the calendar year and once during the second half of the calendar year to review clinical pharmacy data and execute improvement actions for the population under shared management. Company and GROUP shall work together in good faith to schedule such meetings and attend them in order that GROUP may successfully fulfil this important obligation.

5. **Dispute Resolution.** The Parties will attempt to resolve any controversy or claim arising out of or relating to this Handbook prior to the institution of arbitration or other permitted legal proceedings. Only after exhausting any and all internal dispute resolution processes available may the Parties pursue other dispute resolution mechanisms, except to the extent otherwise provided for specifically in this Handbook.

6. **Notices.** Any notice required to be given pursuant to the terms and provisions hereof shall be in writing and shall be effective when sent by certified or registered mail, overnight courier, or electronic mail to GROUP at the name and address provided by GROUP when enrolling in the Program.

and to Company at:

[Aetna  
Regional market head name  
Title  
Address]

## 7. Definitions

- 7.1 GROUP Provider** - A Primary Care Provider or Specialist that is contracted with Company to provide Covered Services to Members, affiliated with or contracted with GROUP and bound by GROUP to participate in the quality improvement activities set forth in this Handbook. GROUP Providers as of the Effective Date of this Handbook are identified in Exhibit F to this Handbook. After the Effective Date, GROUP shall provide a monthly GROUP Provider Participation File to update the list of GROUP Providers as described in this Handbook.
- 7.2 Attributed Member(s)** - Members who are attributed to the GROUP, as set forth in the methodology listed in Exhibit B.
- 7.3 CEHRT** - Electronic Health Record Technology certified by CMS and the Office of the National Coordinator (ONC) for use in the Medicare Electronic Health Record Incentive Programs.
- 7.4 Contract Year** - A calendar year, except that the last Contract Year may be a partial calendar year if the Program is terminated mid-year, to the extent permitted under the Agreement and this Handbook.
- 7.5 Covered Services** - Those health care services for which a Member is entitled to receive coverage under the terms and conditions of a Plan.
- 7.6 E&M Coded Service** - A service for which a GROUP Provider has accurately and appropriately coded the claim using the proper evaluation and management (“E&M”) code for the visit and services provided, which may/shall include one of the following E&M CPT and/or HCPCS Codes-office or other outpatient visit for E&M 99201-05, 99211-15; Home visit for E&M codes of a new patient 99341-45, established patient 99347-50; prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service; first hour 99354-55; prolonged E&M service before and/or after direct (face-to-face) patient care 99358-59; initial comprehensive preventive medicine evaluation and management 99381-87; periodic comprehensive preventive medicine reevaluation and management 99391-97; counseling and/or risk factor reduction intervention 99401-04; G Codes 0402, 0438, 0439. Company reserves the right to add or delete CPT and HCPCS codes from the definition of E&M Coded Service at any time at its sole discretion without providing notice to GROUP. However if changes to the CPT and/or HCPCS Codes made by Company materially impact the attribution methodology in Exhibit B, Company will provide advance written notice to GROUP. Changes described here shall not constitute amendments under the Program.
- 7.7 Government Officials.** Any federal governmental authorities with jurisdiction or their designees.
- 7.8 Incentive Arrangements** - The incentive arrangements set forth in Attachment 1, which represent a full spectrum of collaborative contracting programs made available by Company. The particular Incentive Arrangements agreed to by the Parties for any given Contract Year are memorialized in Exhibit F.
- 7.9 Medical Loss Ratio (MLR)** - Percentage of Premium revenue spent on medical care and services during the applicable measurement period (including but not limited to fee for service, pharmacy, etc.) and quality improvement by health insurance issuers calculated in accordance with the Affordable Care Act.

**7.10 Member** - Any person who is currently enrolled in a Plan, including, but not limited to, Attributed Members.

**7.11 Participating Provider** - Any provider who has entered into and continues to have a current valid contract with Company to provide Covered Services to Members.

**7.12 Plan** - Any Medicare Advantage plan offered by Company subject to this Handbook.

**7.13 PMPM** - Per Attributed Member per month.

**7.14 Primary Care Provider or PCP.** An GROUP Provider whose area of practice and training is family practice, general medicine, internal medicine or pediatrics, or who is otherwise designated as a Primary Care Physician by Company, and who has agreed to provide primary care services and to coordinate and manage all Covered Services for Members who have selected or been assigned to such GROUP Provider, if the applicable Plan provides for a Primary Care Provider. This term may also include a nurse practitioner and/or physician assistant practicing within the applicable scope of practice, provided such provider meets Company's standards.

**7.15 Specialist.** An GROUP Provider whose area of practice and training is Endocrinology, Oncology, Rheumatology, Pulmonary, Cardiology, Nephrology, Obstetrics/Gynecology or Gastroenterology.

## Member Attribution

For the purposes of calculating the compensation earned through GROUP's participation in the Aetna Medicare Quality Incentive Program, the following attribution rules shall apply:

1. A Member will become an "Attributed Member", if based solely on a review of Company's records the Member satisfies any of the following criteria in each Contract Year, in this order:
  - 1.1 The Member notified Company of his/her selection of GROUP as the Member's PCP, or
  - 1.2 If the Member has not selected a PCP, but GROUP has provided Covered Services to the Member, attribution will follow the following hierarchy:
    - a. PCP has provided a E&M Coded Service to the Medicare Member within the twelve months prior to the applicable program year (and if no PCP provided an E&M Coded Service within that period then Company will look back over the twelve months prior to that period). If Medicare Member had visits with multiple PCPs, then the Medicare Member will be assigned to the most recently seen PCP with at least 2 visits; or
    - b. If there are no PCP visits, then the Member will be assigned to a Specialist as defined in this Handbook who has provided an E&M Coded Service to the Member within the last twenty-four (24) months.
2. **Timing.** Company shall determine attribution using the above Attribution Methodology. Company shall identify Attributed Members within ninety (90) days of the Effective Date of the Contract. A Member shall be considered an Attributed Member for the duration of the program year in which such Member is attributed using the attribution methodology above, unless one of the following "Change Events" occurs: (a) the GROUP Attributed Member's coverage under Company's Plan is terminated; or (b) the GROUP Attributed Member selects a Participating Provider outside of Group to be the Member's PCP. In either of these events, such Attributed GROUP Member in question shall be un-attributed from GROUP as of the month following the Change Event. Attributed Members will be provided to Company in the monthly reporting package.
3. **Changes to Methodology**

Company may modify its methodology under this section by providing 90 days advance notice.



## Performance Measures and Benchmarks

For 2018, GROUP shall implement the quality Performance Measures set forth below in Domain 1.

Measures	Final Reconciliation Targets		
	Tier 1	Tier 2	Tier 3
1. Diabetes Care – Controlled HbA1c	76%	80%	84%
2. Diabetes Medication Adherence	81%	84%	86%
3. ACEI/ARB Medication Adherence	82%	84%	85%
4. Statin Medication Adherence	80%	83%	85%
5. Colorectal Cancer Screening	72%	77%	81%
6. Diabetes Care - Eye Exam	73%	77%	81%
7. Controlling High Blood Pressure	75%	81%	86%
8. Statin Use in Diabetics	78%	80%	82%
9. Medication Reconciliation Post Discharge	64%	71%	77%
10. Breast Cancer Screening	78%	81%	84%

For 2018, GROUP shall implement the quality Performance Measures set forth below in Domain 2.

Measures	Benchmark
1. Members with Office Visits	90%
2. Members with Office Visits – Chronic Disease	90%
3. Rx Generic Dispensing Rate	92%
4. Plan All-Cause Readmissions	8%

## Performance Measure Descriptions

Domain 1 Measure Descriptions			
Measure	Description	Source	Measure Achieved By
<b>1. Diabetes Care – Controlled HbA1c</b>	Percentage of Quality Target Population ages 18-75 with diagnosis diabetes of who were continuously enrolled during the measurement year and whose most recent HbA1c test demonstrates control.	HEDIS	<ul style="list-style-type: none"> <li>Controlled HbA1c Level = &lt;=9.0%</li> <li>The absence of A1c testing equals poor control</li> <li>Members in hospice are excluded</li> </ul>
<b>2. Diabetes Medication Adherence</b>	Percent of Quality Target Population with Part D coverage with a prescription for diabetes medication, over 12 months from January to December, who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. (Diabetes medication means a biguanide drug, a sulfonylurea drug, a thiazolidinedione drug, non-insulin injectable agents, SGLT2 inhibitor meds, or a DPP-IV inhibitor. Plan members who take insulin are not included.)	PDE Data	Continue to refill prescription for diabetes medication
<b>3. ACEI/ARB Medication Adherence</b>	Percent of Quality Target Population with Part D coverage with a prescription for a blood pressure medication, over 12 months from January to December, who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. (Blood pressure medication means an ACE (angiotensin converting enzyme) inhibitor or an ARB (angiotensin receptor blocker) drug.)	PDE Data	Continue to refill prescription for hypertensive medication
<b>4. Statin Medication Adherence</b>	Percent of Quality Target Population with Part D coverage with a prescription for a cholesterol medication (a statin drug), over 12 months from January to December, who fill their prescription often enough to cover 80% or more of the time they are supposed	PDE Data	Continue to refill prescription for cholesterol medication

	to be taking the medication.		
<b>5. Colorectal Cancer Screening</b>	Percentage of Quality Target Population ages 50-75 who continuously enrolled the measurement year and the year prior to the measurement year and had appropriate screening for colon cancer.	HEDIS	<p>Appropriate screening: (any one of the tests listed below)</p> <ul style="list-style-type: none"> <li>· Annual FOBT testing</li> <li>· FIT-DNA in the past 3 years</li> <li>· CT Colonography in the past 5 years</li> <li>· Flexible Sigmoidoscopy in the past 5 years.</li> <li>· Colonoscopy in the past 10 years.</li> </ul> <p>Members with a history of colon cancer or a Total Colectomy are excluded.</p> <p>Members in hospice are excluded</p>
<b>6. Diabetes Care - Eye Exam</b>	Percentage of Quality Target Population ages 18-75 with diagnosis of diabetes who were continuously enrolled during the measurement year and had annual diabetic retinal eye exam by an eye care professional (optometrist or ophthalmologist). A chart or photography of retinal abnormalities and evidence that the results were read by a qualified reading center.	HEDIS	<ul style="list-style-type: none"> <li>• An eye exam performed the prior year is also acceptable if the results are negative (No diabetic retinopathy).</li> <li>• Qualified reading center must operate under the direction of a medical director who is a retinal specialist.</li> <li>• Members in hospice are excluded</li> </ul>
<b>7. Controlling High Blood Pressure</b>	<p>Percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year based on the following criteria:</p> <ul style="list-style-type: none"> <li>• Members 18–59 years of age whose BP was &lt;140/90</li> <li>• Members 60–85 years of age with a diagnosis of diabetes whose BP was &lt;140/90</li> <li>• Members 60–85 years of age without a diagnosis of diabetes whose BP was &lt;150/90</li> </ul>	HEDIS	<ul style="list-style-type: none"> <li>• Documentation must include notation of the most recent BP in the medical record, as long as it was taken after the diagnosis of hypertension.</li> <li>• BPs taken during an acute inpatient stay, ER visit, an office visit with a procedure performed, surgical procedure, or major diagnostic procedure do not count.</li> </ul>

<p><b>8. Statin Use in Diabetics</b></p>	<p>Percent of Quality Target Population with Part D coverage between 40 and 75 years old who received at least two diabetes medication fills and one fill of a statin medication over 12 months from January to December. Members must be enrolled with the plan for atleast one month from Jan thru Dec and Hospice members are excluded from the measure denominator.</p>	<p>PDE Data</p>	<p>One fill of a statin medication</p>
<p><b>9. Medication Reconciliation Post Discharge</b></p>	<p>The percentage of Quality Target Population ages 65 and older who were discharged from January 1st –December 1st of the measurement year for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days). Quality Target Population must be continuously enrolled through 30 after discharge.</p>	<p>HEDIS</p>	<p>Medication reconciliation within 30 days of discharge</p> <ul style="list-style-type: none"> <li>• Members in hospice are excluded</li> </ul>
<p><b>10. Breast Cancer Screening</b></p>	<p>Percentage of Quality Target Population women ages 50-74 who were continuously enrolled two years prior to the measurement year through December 31st of the measurement year and had a screening mammogram over a 3 year timeframe.</p>	<p>HEDIS</p>	<p>Members with bilateral mastectomies are excluded.</p> <ul style="list-style-type: none"> <li>• Members in hospice are excluded</li> </ul>

Domain 2 Measure Descriptions			
Measure	Description	Source	Measure Achieved By
<b>1. Quality Target Population members with Office Visits</b>	Completion of an office visit for each Attributed Member in the Quality Target Population in the Contract Year.	Claims	Quality Target Population members complete Primary Care Physician visit during the Contract Year
<b>2. Quality Target Population members with Office Visits – Chronic Disease</b>	Completion of an office visit for each Attributed Member diagnosed with diabetes, CHF, or COPD at least once in each consecutive six month period of each calendar year as follows: January-June and July-December	Claims	Attributed Members have at least one visit from January - June and July - December, during the Contract Year
<b>3. Rx Generic Dispensing Rate</b>	Number of 30 day equivalent generic prescription paid claims (30 day equivalent prescription is defined as number of day supply of each prescription written divided by 30) divided by total number of 30 day equivalent prescriptions based on paid pharmacy claims for Attributed Members.	PDE Data	Higher rate equals better performance
<b>4. Plan All-Cause Readmissions</b>	Quality Target Population members ages 18 years and older who had an acute inpatient stay(s) during the measurement year (January 1st to December 1st) that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.	HEDIS	<ul style="list-style-type: none"> <li>• Lower rate equals better performance</li> <li>• Members in hospice are excluded</li> </ul>

## Reconciliation and Payment Administration

Company shall make best efforts to adhere to the timing set forth below, when performing reconciliations of those Incentive Arrangements and in making any payments to GROUP that may be earned in accordance with this Quality Incentive Program

**Quality Payment Reconciliation:** Reconciled on or about August 31 following end of Contract Year

**Quality Payment:** Paid on or about September 30 following end of Contract Year, taking into account Review Window

**Reconciliation Review Window** - GROUP will have thirty (30) calendar days from the date it receives a Quality Payment Reconciliation from Company during which to review Company's calculations in any applicable Quality Payment Reconciliation ("**Review Window**"). If Company does not receive written notice from GROUP of any disputes to the Quality Payment Reconciliation within the Review Window, such reconciliations shall be considered final. In the event GROUP raises a dispute during the Review Window, the Parties agree to work in good faith to resolve that dispute in a timely fashion. Company shall not make payment to GROUP of any monies that are the subject of a dispute until such dispute is resolved, and then, only to the extent mutually agreed upon by the Parties.

## Frequently Asked Questions

### Quality Incentive Program Frequently Asked Questions

#### **How can I join the Quality Incentive Program?**

All you have to do is complete the participation form and send to the following email address:

[AetnaMedicareValue\\_BasedPrograms@AETNA.com](mailto:AetnaMedicareValue_BasedPrograms@AETNA.com)

#### **What makes me eligible to participate in this program?**

You can participate in the Medicare Advantage Quality Incentive Program if you are a primary care physician with 50 -749 attributed Aetna Medicare Advantage members and are not currently participating in another Aetna/Coventry value based contract or program.

#### **Can I change any language or metrics in the participation form?**

Changes are not permitted to the program or the participation form.

#### **What is the last day to sign up for the program?**

You have until May 25<sup>th</sup>, 2018 to sign up for the program. Send your participation form to

[AetnaMedicareValue\\_BasedPrograms@AETNA.com](mailto:AetnaMedicareValue_BasedPrograms@AETNA.com)

#### **If I sign the participation form, when is my participation active?**

When you submit the participation form, you will be enrolled in the 2018 program. The 2018 program includes performance from January 1, 2018 to December 31, 2018.

#### **What will happen to my participation in 2019?**

Your participation will rollover to the next performance year unless you provide us , in accordance with the terms in the Quality Incentive Program Handbook, with written notice that you'd like to opt out.

#### **What time frame is used to calculate performance?**

The program is based on dates of service within the calendar year.

#### **How do I know how I am performing throughout the year?**

You will receive monthly performance reports that will be delivered to your Secure File Transfer Protocol (SFTP) site. After you sign your participation form, we will provide you with instructions on next steps including accessing your FTP site.

#### **In Domain 1, what to the different tiers represent for each quality measure?**

The tier targets for each measure roughly reflect CMS Medicare Stars thresholds. The tiers represent 4, 4.5, and 5 Star thresholds. Currently, 87% of our members are in a 4-star plan. Our goal in this program is to improve our performance in Stars to the benefit of our members, your patients.

#### **When will I receive payment for my performance in this program?**

After the calendar year, we will provide you with a full reconciliation file and payment as a result of the reconciliation towards the end of summer 2019.

#### **Need More Information?**

Send your question to [AetnaMedicareValue\\_BasedPrograms@AETNA.com](mailto:AetnaMedicareValue_BasedPrograms@AETNA.com)

## FTP Instructions

### FTP Instructions - Access your Monthly Collaboration Reports

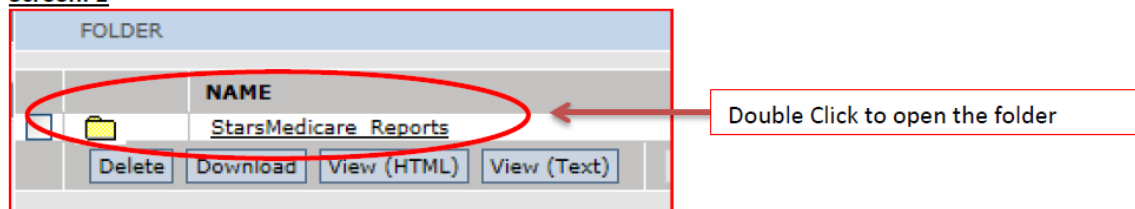
**What is FTP?** The File Transfer Protocol (FTP) is a standard network protocol used to transfer computer files between a client and a server on a computer network. In light of HIPPA, and PHI the sharing of information via email, even secure email, is no longer supported by Aetna. All performance reports that include PHI are sent via FTP and can be accessed after log on to the FTP site with a user ID and password.

Your group has been issued a user ID and password to access these reports. Reports will be available each month. Please send an email to [AetnaMedicareValue\\_BasedPrograms@AETNA.com](mailto:AetnaMedicareValue_BasedPrograms@AETNA.com) if you are not in receipt of this information.

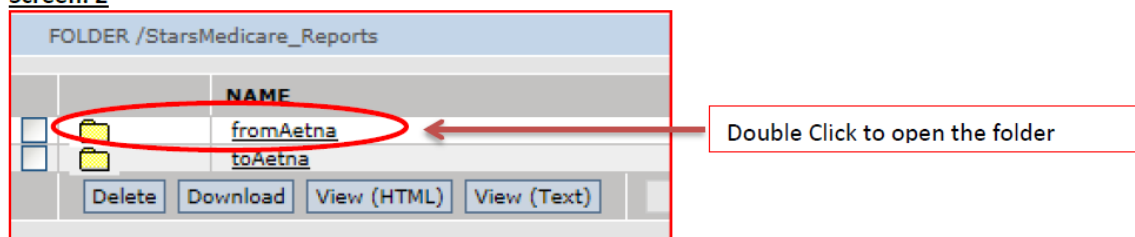
Follow below steps to download the files sent by Aetna:  
Login to <https://st1.aetna.com/> with your ID & password provided.  
Please note that both ID and the password are case sensitive.  
If you are not able to access the site, reach out to the Aetna team.

Upon login, you will see a folder "StarsMedicare\_Reports".  
This folder may have two subfolders – Please select **FromAetna**  
**FromAetna** - Any files (Quality report, Membership report) sent from the Medicare Stars team FTP site will be found in this folder each month.

#### Screen: 1



#### Screen: 2



#### Screen: 3 – Check the box and click download to download a file

