2022 Medicare Advantage Quality Incentive Program

876365-01-01

Introduction

This handbook sets forth the terms and conditions for the Medicare Advantage Quality Incentive Program ("Program"). You've agreed to be bound by and comply with the terms outlined in this handbook by executing the participation form.

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Section 1: General program details and requirements

1.1 **Duties of Group.** Group shall perform each of the following obligations, as applicable:

1.1.1 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, prohibition of kickbacks and all regulatory terms applicable to the Medicare Advantage program.

1.1.2 Group will engage in care coordination, member engagement, education and data analytic services on behalf of Company.

1.1.3 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, free of charge. For the avoidance of doubt, this obligation requires that Company receive any requested information and records, whether through access to a Certified Electronic Health Record Technology (CEHRT), either in office or remotely, sent in reports or record extracts or in paper or any other form at no charge.

1.1.4 Upon request by Company, Group shall meet with an Aetna Medicare engagement staff member, or a representative from Company's HIPAA compliant data exchange portal 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 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.

1.2 **Payment arrangements for Group providers**

1.2.1 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 quality incentive arrangements set forth in this handbook, owed by Group to Group Providers under any arrangements that may exist between Group and Group Providers.

1.2.2 Group shall use its metrics and formulas to pass through payments Group receives through the Program to primary care physicians (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.

1.3 **Term and termination.** This Program shall be effective for an initial term of one (1) year commencing on the effective date as set forth in the executed participation form ("Initial Term"). Thereafter, this Program shall automatically renew for one (1) year periods, unless terminated by either party as provided in this section. Also, the parties agree that termination of the base Provider/Group Agreement shall automatically cause the immediate and concurrent termination of this Program.

1.3.1 **Termination without cause.** Either party may, at its sole discretion and option, terminate the Program by giving at least ninety (90) days' prior written notice.

1.3.2 **Termination for breach.** The 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 the program, unless such default or breach is cured within thirty (30) calendar days of the notice of termination.

1.3.3 **Effect of termination.** Termination of the Program shall not terminate the right of the 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 Section 3, below 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 repaid 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.

1.3.4 **Obligations following termination**. Upon expiration or termination of this Program where the base Provider/Group agreement remains in force, Group shall continue providing covered services. Termination of this Program shall have no impact on the base Provider/Group agreement.

1.4 **Dispute resolution**. The parties will attempt to resolve any controversy or claim arising out of or relating to the Program by exhausting any and all internal dispute resolution processes available first, and then may pursue other dispute

resolution mechanisms, provided for in the base Provider/Group agreement except to the extent otherwise provided for specifically in this handbook.

1.5 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 through the participation form, **and to Company at: AetnaMedicareValue_BasedPrograms@Aetna.com**

1.6 Definitions

1.6.1 Group — Entity who executed the participation form to participate in the Program.

1.6.2 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 the Program. Group providers, as of the effective date of the Program, is identified by the tax identification numbers (TINs) on the participation form. Thereafter, Group is required to confirm the appropriate TINs appear on the monthly data reports. Any discrepancies are to be reported immediately to the Company.

1.6.3 Attributed member(s) — Members who are attributed to the Group, as set forth in the methodology listed in Section 1.8.

1.6.4 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.

1.6.5 Company — Aetna® Network Services, LLC on behalf of itself and its affiliates.

1.6.6 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 participation form and this handbook.

1.6.7 Covered services —Those health care services for which a member is entitled to receive coverage under the terms and conditions of a plan.

1.6.8 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

1.6.9 . 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 Section 1.8, Company will provide advance written notice to Group.

1.6.10 **Member** — Any person who is currently enrolled in a plan, including, but not limited to, attributed members.

1.6.11 **Participating provider** — Any provider who has entered into and continues to have a current valid contract with Company to provide covered services to members.

1.6.12 **Plan** — Any Medicare Advantage plan offered by Company subject to this Program.

1.6.13 **PMPM** — Per attributed member per month.

1.6.14 **Primary care provider (PCP)** — A 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.

1.6.15 **Specialist** — A Group provider whose area of practice and training is endocrinology, oncology, rheumatology, pulmonary, cardiology, nephrology, obstetrics/gynecology, or gastroenterology.

1.6.16 **Quality Target Population** — To determine whether Group has achieved the Quality Payments, Company shall assess the performance measures against the members that were or would have been attributed to the Group providers as of April 1 of the applicable contract year, regardless of whether this addendum was effective on such date (Quality Target Population). Such Quality Target Population shall be used only to determine if the performance measures are met. Quality Payments, if applicable and earned in a contract year, shall be based on total attributed members throughout the applicable contract year.

1.6.17 **Composite Score** — The weighted average of the Group's overall Domain 1 performance, Section 2, subject to the CMS targets (cut points).

1.6.18 **Stars** — Based on measure Star rating (1–5) as defined by CMS targets (cut points) and used to determine Composite Score.

1.6.19 **Weight** — Based on the single-or triple star weighted designation assigned by CMS used to determine Composite Score.

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

1.7.1 A member will become an "attributed member," if based solely on a review of the Company's records the member satisfies any of the following criteria in each contract year, in this order:

a. The member notified the Company of their selection of the Group as the member's PCP, or

b. If the member has not selected a PCP, but the Group has provided covered services to the member, attribution will follow the following hierarchy:

i. PCP has provided an E&M coded service to the Medicare member within the 12 months prior to the applicable Contract Year (and if no PCP provided an E&M coded service within that period then Company will look back over the 12 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 visits; or

ii. 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 24 months.

1.7.2 **Timing**. Company shall determine attribution using the above attribution methodology. Company shall identify attributed members

within 90 days of the effective date of the Program. A member shall be considered an attributed member for the duration of the Contract Year in which such member is attributed using the attribution methodology above, unless one of the following “change events” occurs: (a) Group provides Company with written notice that a member should not be designated as a Group Attributed Member by July 1 of the contract year and Company, upon review, agrees with Group; (b) the Group attributed member’s coverage under Company’s plan is terminated; or (c) 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 unattributed from Group as of the month following the change event. Attributed members will be provided to Group in the monthly reporting package.

1.8 **Amendments.** Company may make changes, at its discretion, to this Program and the terms of this program handbook at any time by providing 30 days' notice to Group. In the event Company notifies Group of an amendment pursuant to this section, Group shall have the option to terminate the Program by providing Company notice of termination no less than 15 days before the effective date of the amendment to the Program/program handbook.

1.9 **Superseding.** The Program participation form along with this program handbook, including any amendments, exhibits or schedules thereto, constitutes the complete and sole agreement between the parties regarding the subject matter described herein. Participation in this Program supersedes and voids Group’s participation in any other value based or alternative financial arrangement and/or program that provides incentives for primary care physicians meeting quality performance measures that exist at the time of signature of the participation form.

Section 2: Performance measures and benchmarks

For 2022, Group shall implement the performance measures set forth below in **Domain 1.** Composite score determined by a weighted average of "Stars" and "Weight."

Measure	Star weight	1-Stars	2-Stars	3-Stars	4-Stars	5-Stars
Medication adherence for diabetes medications	3	< 84%	84%	89%	91%	95%
Medication adherence for cholesterol (statins)	3	< 82%	82%	87%	91%	95%
Medication adherence for hypertension (RAS antagonists)	3	< 79%	79%	87%	91%	94%
Diabetes care — blood sugar controlled	3	< 43%	43%	63%	74%	86%
Diabetes care — eye exams	1	< 57%	57%	67%	75%	81%
Colorectal cancer screening	1	< 51%	51%	64%	75%	82%
Breast cancer screening	1	< 47%	47%	66%	74%	81%
Plan all-cause readmissions (PCR)	1	> 10%	10%	8%	7%	3%
Statin use in persons with diabetes	1	< 80%	80%	84%	87%	91%
Statin therapy for patients with cardiovascular disease	1	< 81%	81%	86%	89%	94%
Follow-up after ED visit (FMC)	1	< 46%	46%	54%	62%	72%
Osteoporosis in women who had a fracture	1	< 32%	32%	43%	52%	70%
Care for older adults — pain assessment	1	< 60%	60%	81%	89%	98%
Care for older adults — medication review	1	< 53%	53%	76%	89%	97%
Diabetes care — kidney disease monitoring	1	< 84%	84%	90%	97%	99%

Annual reconciliation of Domain 1 performance is based upon the cut points released by CMS for the applicable contract year (e.g., the cut points published by CMS in October of 2023 are applicable to the 2022 contract year). Company shall pay Group the PMPM payment at the applicable Composite Score in Section 2.1, if applicable, in a contract year.

If any Domain 1 Performance Measure should be converted to "display only" by CMS during a contract year, that measure will be removed from the Final Reconciliation — Quality Payment. Any such Performance Measure will not contribute to Group's Composite Score. If CMS adds a Performance Measure during a contract year, the measure will be added automatically to Domain 1 for the then current contract year and will be included in Group's Composite Score and Final Reconciliation — Quality Payment.

2.1 Domain 1 Opportunity

Payment of Quality Payments is based upon the successful achievement of Performance Measures contained in Domain 1 (Section 2) in a given contract year as follows.

Stars composite score	80% average members seen	85% average members seen	90% average members seen
5.0	$6.00	$7.50	$10.00
4.9	$5.63	$7.04	$9.39
4.8	$5.26	$6.57	$8.76
4.7	$4.88	$6.10	$8.13
4.6	$4.51	$5.63	$7.51
4.5	$4.13	$5.17	$6.89
4.4	$3.30	$4.13	$5.50
4.3	$3.15	$3.94	$5.25
4.2	$3.00	$3.75	$5.00
4.1	$2.85	$3.56	$4.75
4.0	$2.70	$3.38	$4.50
3.9	$1.66	$2.07	$2.76
3.8	$1.51	$1.88	$2.51
3.7	$1.35	$1.69	$2.25
3.6	$1.21	$1.51	$2.01
3.5	$0.90	$1.13	$1.50
3.4	$0.76	$0.95	$1.26
3.3	$0.61	$0.76	$1.01
3.2	$0.45	$0.56	$0.75
3.1	$0.31	$0.38	$0.51
<= 3.0	$0.00	$0.00	$0.00

2.2 Performance measure descriptions

Domain 1			
Measure	**Description**	**Source**	**Measure achieved by**
Medication adherence for diabetes medications	Quality Target Population Medicare Part D beneficiaries 18 years and older who adhere to their prescribed drug therapy across classes of diabetes medications: • Biguanides, • Sulfonylureas, • Thiazolidinediones, • Dipeptidyl Peptidase (DPP)-4 Inhibitors • GLP-1 receptor agonists • Meglitinides • Sodium glucose cotransporter 2 (SGLT2) inhibitors. Does not include insulin.	CMS and PQA	Percent of plan members with a prescription for non-insulin diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.
Medication adherence for cholesterol (statins)	Quality Target Population Medicare Part D beneficiaries 18 years and older who adhere to their prescribed drug therapy for statin cholesterol medications.	CMS and PQA	Percent of plan members with a prescription for a statin medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.
Medication adherence for hypertension (RAS antagonists)	Quality Target Population Medicare Part D beneficiaries 18 years and older who adhere to their prescribed drug therapy for renin angiotensin system (RAS) antagonists: • Angiotensin converting enzyme inhibitor (ACEI)	CMS and PQA	Percent of plan members with a prescription for a RASA blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.

	• Angiotensin receptor blocker (ARB) • Direct renin inhibitor medications		
Diabetes care — blood sugar controlled	Quality Target Population members 18–75 with diagnosis of Type 1 or 2 diabetes who had an A1C lab test during the year that showed their average blood sugar is under control.	HEDIS®	1. The last HbA1c Level = <=9.0% during the current year
Diabetes care — eye exams	Quality Target Population members 18–75 with a diagnosis of Type 1 or 2 diabetes who had an eye exam (retinal) performed during the measurement year.	HEDIS®	Any of the following: 1. Retinal/dilated eye exam during the current year 2. Negative (retinopathy) retinal or dilated eye exam year prior to the current year by an optometrist or ophthalmologist 3. Bilateral eye enucleation 4. Automated eye exam by any provider during the current year.
Colorectal cancer screening	Quality Target Population Members 50–75 who had appropriate screening for colon cancer	HEDIS®	Any of the following: 1. Annual FOBT testing 2. FIT-DNA in the past three years 3. CT Colonography in the past five years 4. Flexible Sigmoidoscopy in the past five years

			5. Colonoscopy in the past 10 years
Breast cancer screening	Quality Target Population Women ages 50–74 who had a mammogram	HEDIS®	1. Mammogram performed in the past 27 months
Plan all-cause readmissions (PCR)	Quality Target Population Members 18 years of age and older with acute inpatient and observation stays followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.	HEDIS®	<u>VIA CLAIMS ONLY</u> 1. An unplanned acute readmission for any diagnosis within 30 days. *Lower rate is better
Statin use in persons with diabetes	The percent of Quality Target Population plan members with diabetes who take a statin medication.	CMS and PQA	Percent of Medicare Part D beneficiaries 40-75 years old who were dispensed at least two diabetes medication fills and received a statin medication fill during the measurement period.
Statin therapy for patients with cardiovascular disease	Quality Target Population Males 21–75 and females 40–75 years of age who are identified as having clinical ASCVD and met the following criteria: Received Statin therapy, dispensed at least one-high intensity or moderate-intensity statin	HEDIS®	<u>Received therapy</u> 1. Dispensed a statin

	medication during the current year.		
Follow-up after ED visit (FMC)	Quality Target Population Members 18 years as of emergency department (ED) visit and older who have high-risk chronic conditions and were seen in the ED and had a follow up service within seven days of the visit (total eight days)	HEDIS®	VIA CLAIMS ONLY 1. An outpatient visit within seven days of an emergency department discharge
Osteoporosis in women who had a fracture	Quality Target Population Women 67–85 years of age who suffered a fracture and either a bone mineral density (BMD) test or prescription to treat osteoporosis within six months of the fracture (excludes fractures to the finger, toe, face, and skull)	HEDIS®	1. Bone mineral density test six months after fracture 2. Osteoporosis medication therapy six months after fracture
Care for older adults — pain assessment	Quality Target Population Members 66 years and older and part of the Dual-Eligible Special Needs Population who received at least one pain assessment	HEDIS®	1. Pain assessment during the current year

Care for older adults — medication review	Quality Target Population Members 66 years and older and part of the Dual-Eligible Special Needs Population who received at least one medication review	HEDIS®	1. Medication review completed by a prescribing practitioner or clinical pharmacist during the current year
Diabetes care — kidney disease monitoring	Quality Target Population of diabetic MA enrollees 18–75 with a diagnosis of Type 1 or Type 2 diabetes who had medical attention for nephropathy during the measurement year.	HEDIS®	Any of the following during the current year: 1. Visit with a nephrologist 2. Urine test for albumin or protein 3. Treatment for nephropathy 4. ACEI/ARB therapy 5. End-stage renal disease 6. Dialysis 7. Nephrectomy
Quality Target Population members with office visits	Completion of an office visit for each attributed member in the Quality Target Population in the contract year.	Claims	Attributed Quality Target Population members complete primary care physician visit during the contract year.
Quality Target Population members with office visits — chronic disease	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	Claims	Attributed Quality Target Population members have at least one visit from January–June and July–

	follows: January–June and July–December.		December, during the contract year.
Average members seen	Average of Quality Target Population members with office visits and Quality Target Population members with office visits chronic disease.	Claims	80%, 85% or 90% average completion rate to determine payment scale.

Section 3: Reconciliation and payment administration

- Company shall make best efforts to adhere to the timing set forth below, when performing reconciliations of the quality incentive arrangements and in making any payments to Group that may be earned in accordance with this quality incentive program

Quality incentive payment reconciliation: Reconciled on or about October 31 following end of contract year.

Quality incentive payment: Paid on or about November 30 following end of contract year, taking into account the review window.

Reconciliation review window: Group will have 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.

3.1 Quality incentive program payment example

Measure	Star weight	Group pass rate	Stars	Weight %	Weighted value
Medication adherence for diabetes medications	3	97%	5	13.04%	0.65
Medication adherence for cholesterol (statins)	3	84%	2	13.04%	0.26
Medication adherence for hypertension (RAS antagonists)	3	95%	5	13.04%	0.65
Diabetes care — blood sugar controlled	3	86%	5	13.04%	0.65
Diabetes care eye exams	1	72%	3	4.35%	0.13
Colorectal cancer screening	1	85%	5	4.35%	0.22
Breast cancer screening	1	80%	4	4.35%	0.17
Plan all-cause readmissions (PCR)	1	6%	4	4.35%	0.17
Statin use in persons with diabetes	1	93%	5	4.35%	0.22
Statin therapy for patients with cardiovascular disease	1	96%	5	4.35%	0.22
Follow-up after ED visit (FMC)	1	50%	2	4.35%	0.09
Osteoporosis in women who had a fracture	1	83%	5	4.35%	0.22
Care for older adults — pain assessment	1	92%	4	4.35%	0.17
Care for older adults — medication review	1	98%	5	4.35%	0.22
Diabetes care — kidney disease monitoring	1	95%	3	4.35%	0.13

Members with office visits	93%
Members with office visits — chronic disease	91%
Average members seen	92%

Composite score	4.17
Composite score rounded	4.2
Average members seen	92%
PMPM opportunity	$5.00
Member months	4,460
Total quality incentive program payment value	$22,300.00

Section 4: Frequently asked questions (FAQs)

How can I join the quality incentive program?
All you have to do is complete the participation form and send to **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. You must have at least 50 attributed Aetna Medicare Advantage plan members and aren't currently participating in another Aetna® 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.

If I sign the participation form, when is my participation active?
When you submit the signed participation form, you'll be enrolled in the program as of the effective date indicated on the form. The program includes performance from effective date to December 31 of the contract year.

What will happen to my participation next year?
Your participation will roll over 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 terminate your participation.

How do I know how I am performing throughout the year?
You'll receive access to a web-based reporting solution, DataLink Evoke360. It will provide you with access to information to support your efforts to improve quality of care, monitor performance and much more. After you sign your participation form, we will provide you with instructions on how to obtain access and training for this solution.

When will I receive payment for my performance in this program?
We will provide you with a full reconciliation file and payment in the fall of the year following the contract year close.

Need more information?

Send your question to **AetnaMedicareValue_BasedPrograms@Aetna.com**

Section 5: DataLink Evoke360 access and training FAQ

What is DataLink Evoke360?
DataLink Evoke360 (formerly known as CareBook) is a robust, web-based population health management and point-of-care software. It delivers greater clinical control and insights to medical practices, payers and more. It also adds efficiency, boosting care gap management and improving patient outcomes.

Will you provide any training?
Yes. If you would like to sign up for training for you and your team, send a request to **AetnaDataLinkteam@Aetna.com**

What will happen after my training?
You'll receive a next steps email directly from the Aetna® DataLink team after your training.

How do I obtain access?
We use the name(s) and email address(es) you provide on our Evoke360 enrollment form to create a username and password. Please use your business email address.

How will I know what my username and password are?
You'll receive a welcome email from DataLink to sign into the website for the first time. That message will contain your username. You'll set your password at your initial log in.

What if I have an issue while using DataLink products?
If you experience any technical difficulties, submit a ticket here. You can also call **1-813-903-1091** to reach the DataLink Support desk.

Who do I contact for any other questions about DataLink?
If you have any further questions, follow up with our Aetna DataLink team at **AetnaDataLinkteam@Aetna.com**

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