2026 Medicare Advantage Quality Incentive Program

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Introduction

This Quality Incentive Program Handbook ("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 Quality Incentive Program Participation Form ("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 obligations 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 and Group Providers shall use certified electronic health record technology (CEHRT, as defined in 42 CFR §414.1305) to document and communicate clinical care and shall provide and transmit records to Company by this method, or other Company approved method, no later than three (3) months after Program enrollment.

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, or alternatively, 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 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 fulfill 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 a Group Provider under any arrangements that may exist between Group and Group Providers. Group agrees to indemnify Company and hold Company harmless from any and all claims, liabilities and causes of action brought by Group Providers

against Company arising from or relating to the payment of any monies under this agreement.

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 metrics and performance objectives. Company may request that Group or Group Providers provide an attestation confirming compliance with the obligations set forth in this Section 1.2.2.

1.3 **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. Also, the parties agree that termination of the Base 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' written notice prior to the end of Initial Term, or any subsequent Contract Year then in effect. Such termination shall void any participation for Initial Term, or for terminations in subsequent Contract Years, shall become effective on the last day of last fully completed Contract Year.

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 5 below. In a 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.

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 Agreement except to the extent otherwise provided for specifically in this Handbook.

1.5 **Par status.** If Group's participation in Company's network (for Medicare products) terminates or expires for any reason, participation in this Program shall simultaneously terminate.

1.6 **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 through the Participation Form, and to Company at: **AetnaMedicareValue_BasedPrograms@Aetna.com**

1.7 **Definitions**

1.7.1 **Annual wellness visit ("AWV") completion rate** — Determined by calculating the number of Quality Target Population members who receive an AWV (as indicated by claims submitted using one of the following codes, as appropriate for the attributed member: G0402, G0438, G0439, G0468, G0506, 99387, 99397) during the applicable calendar year, including six (6) months of claims run out thereafter.

1.7.2 **Attributed Member(s)** — Members who are attributed to the Group, as set forth in Section 1.7.

1.7.3 **Base Agreement** — A contract between Company and Group whereby a Group provides or arranges for the provision of Covered Services to Members.

1.7.4 **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.

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

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

1.7.7 **Contract year** — A calendar year to the extent permitted under the Participation Form and this Handbook.

1.7.8 **Covered services** — Those benefits provided under a Plan, including services, devices or items for which a Member is entitled to receive

coverage under the terms and conditions of such Plan, including specifically, all Supplemental Benefits.

1.7.9 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 99202-05, 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 99417; 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 Section 1.8, Company will provide advance written notice to Group.

1.7.10 Effective Date — The date set forth in the Participation Form, labeled as "Date" or "Effective Date."

1.7.11 Group — Entity who executed the Participation Form to participate in the Program.

1.7.12 Group Provider — A primary care provider or specialist that is (a) contracted with Company to provide Covered Services to Members who is and (b) affiliated with or otherwise 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, are identified by the tax identification numbers (TINs) on the Participation Form ("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.

1.7.13 Incentive Arrangements —The incentive arrangements set forth in Section 2 and Section 3, which represent all of the potential care coordination, quality and care management programs and other contractual features made available by Company. The particular Incentive Arrangements agreed to by the Parties for any given Contract Year are outlined in Section 4.

1.7.14 Member — Any person who is currently enrolled in a Plan, including, but not limited to, Attributed Members.

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

1.7.16 Plan — Any Medicare Advantage plan (which may be a Medicare only or a Medicare plan with Part D or a D-SNP plan) offered by Company subject to this Program.

1.7.17 PMPM — Per Attributed Member Per Month.

1.7.18 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.

1.7.19 Program Performance Year— The Contract Year will be from January 1 until December 31 unless Program Participation is terminated prior to such date in accordance with the terms of this Handbook.

1.7.20 Quality Target Population — Members that were attributed to or would have been attributed to Group providers as of April 1 of the applicable Contract Year, regardless of whether the Program was effective on such date, used to assess performance in Performance Measures for the given Contract Year. Refer to Section 2 for more information.

1.7.21 Specialist — A Group provider whose area of practice and training includes but is not limited to endocrinology, oncology, rheumatology, pulmonary, cardiology, nephrology, obstetrics/gynecology or gastroenterology.

1.7.22 Stars — A 1–5 rating scale based on Star ratings, as defined by CMS targets (cut points) and used to determine Composite Score.

1.7.23 Supplemental Benefits – An item or service covered by the Plan that is not covered by Medicare Part A or Part B.

1.7.24 Weight — A statistical factor based on the single- or triple-star weighted designation by CMS that is used to determine the Composite Score.

1.8 Member attribution. For the purposes of calculating Group's Quality Incentive Payment(s) under the Program, the following Member attribution rules shall apply:

1.8.1 A Member will become an "Attributed Member," if based solely on Company's review of its 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. If a PCP has provided an outpatient E&M Coded Service (including office, home, telemedicine or other outpatient location) to the Medicare Member within the twelve (12) months prior to the applicable Contract Year. If Medicare Member had visits with multiple PCPs, then the Medicare Member will be assigned to the PCP with the most visits; or

ii. If there are no visits within the last 12 months, then the Member will be assigned to a PCP who has provided an outpatient E&M Coded Service to the Member within the last twenty-four (24) months.

iii. If there are no PCP visits within the last 24 months, then the Member will be assigned to a Specialist as defined in this Section 1.8 who has provided an outpatient E&M Coded Service to the Member within the last 12 months.

iv. If there are no Specialist visits within the last 12 months, then the Member will be assigned to a Specialist as defined in this Section 1.8 who has provided an outpatient E&M Coded Service to the Member within the last 24 months.

1.8.2 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 Group Attributed Member in question shall be unattributed from Group as of the month following the change event. A listing of Attributed Members will be provided to Group in the monthly reporting package.

1.8.3 Changes to Methodology. Company may modify its methodology in this Section 1.9 by providing 90 days advance written notice to Group.

1.9 Amendments. Company may make changes, at its discretion, to this Program and the terms of this 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 or this Handbook.

1.10 Superseding. The Participation Form along with this Handbook, including any amendments, exhibits or schedules thereto, constitutes the complete and sole agreement between the Company and Group 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 Company and/or any Company program that provides incentives for Primary Care Physicians meeting quality Performance Measures that exist at the time of signature of the Participation Form.

1.11 Data reporting

1.11.1 Engagement meetings may be used as a forum to discuss and share specific datasets in support of this Program and discuss performance improvement activities undertaken by Group to achieve the goals of the Program.

1.11.2 The initial set of reports generally will be available to Group 2–3 months following Company's receipt of executed Participation Form for Program participation.

1.11.3 Company will provide reports to Group through Company's HIPAA compliant portal, or, if necessary, Secure File Transfer Protocol (SFTP) site, as agreed to by the Parties.

1.11.4 The following is a list of reporting resources to be provided by Company. Frequency may vary depending on how the report is provided. Reporting resources can be adjusted at any time.

a. Membership
b. Quality
c. Pharmacy
d. Office visits
e. Risk adjustment
f. Clinical programs

1.11.5 Company representative will provide final reconciliation report to Group directly. Using calculations set forth in Section 2 of this Handbook, final reconciliation reports detail calculation of payments earned by Group for the Contract Year.

1.12 **Enrollment updates.** Company and Group agree that the Tax Identification Numbers (TINs) included in executed Form for Program participation represent a complete list of participating TINs at the time of execution. Group agrees that any subsequent changes to this TIN list must be submitted by the 15th of October by electronic mail to Company at: **AetnaMedicareValue_BasedPrograms@Aetna.com**. TIN changes received in accordance with this timeline will be effective January 1st of the following Contract Year. Failure to notify Company of changes may result in inaccurate or insufficient reported data to Group.

Section 2: Incentive arrangements

This Section 2 contains a description of Incentive Arrangement calculations. Section 3 shall set forth, for any given Contract Year, the Performance Measures and benchmarks designated by Company. Section 4 shall set forth the compensation that Group may have the opportunity to earn. Section 5 shall set forth the reconciliation and payment schedule applicable to any Incentive Arrangement set forth in this Section 2.

The Parties' goal is for the Group to improve the coordination, clinical performance and cost of care through a number of initiatives as described in this Handbook. In consideration for participating in various care coordination and quality programs, as designated in Section 4, Company will compensate Group for the improved clinical performance and efficiency of the care provided pursuant to the terms of this Handbook.

2.1 **Quality payments.** As set forth in Section 3, certain performance measures ("Performance Measures") are grouped into a domain ("Domain 1"). The Parties agree that the:

2.1.1 Annual reconciliation of Domain 1 performance ("Final Reconciliation – Quality Payment") will be calculated based upon the cut points released by CMS for the measurement year that corresponds with the applicable Contract Year ("Final Reconciliation Benchmarks") (e.g., the cut points published by CMS in October of 2026 are applicable to the 2025 Contract Year). Company shall pay Group the PMPM payment at the applicable Composite Score in Section 4 Table 1 and the AWV Completion Rate in Section 4 Table 2, if applicable, in a Contract Year.

2.1.2 If CMS makes any substantive changes to a Performance Measure, including an addition or retirement, or changes in technical specifications, or a conversion to "display only" during a Contract Year, that measure may be (i) modified, or (ii) removed from the Final Reconciliation – Quality Payment (as applicable). Any removal of a Performance Measure will cause that Performance Measure to not contribute to Group's Composite Score. If a Performance Measure is removed, Company may modify the Performance Measures and benchmarks in Section 3 of this Handbook in accordance with the substantive change by providing thirty (30) days advance written notice or as soon as practicable after CMS provides notice of such change, in accordance with Section 1.10 of this Handbook.

2.1.3 To determine the Final Reconciliation – Quality Payment, Company shall assess the Performance Measures in accordance with Section 3. The Quality Target Population or Total Population, as applicable, shall be used to determine if the Performance Measures are met. Final Reconciliation – Quality Payments, if applicable and earned in a Contract Year, shall be

based on total Attributed Members throughout the applicable Contract Year.

2.2 Triple Weighted Performance Measures payment. To further emphasize its commitment to improved quality of care, Company will offer a payment opportunity for certain Performance Measures that CMS has deemed triple weighted ("Triple Weighted Performance Measures") for the measurement year that corresponds with the applicable Contract Year. Triple Weighted Performance Measures are grouped into a domain (Domain 2). The Triple Weighted Performance Measures are outlined in Section 3 of this Handbook. The payment opportunity is outlined in Section 4 of this Handbook.

2.2.1 The Domain 2 payment opportunity will only be paid in the event the Group achieves a 4-star rating or greater star score in all Tripled Weighted Performance Measures. Achieving a star score of 4-star rating or greater in less than all Triple Weighted Performance Measures will result in zero dollars ($0.00) Domain 2 payment opportunity.

If any Triple Weighted Performance Measure(s) should be converted to "display only" by CMS during a Contract Year, or is changed mid-year to single weighted, that measure will be removed from the Final Reconciliation – Triple Weighted Performance Measures, and will not contribute to the Domain 2 incentive opportunity.

2.2.2 Any Triple Weighted Performance Measures Payment will be calculated during Final Reconciliation and paid in conjunction with Final Reconciliation – Quality Payments, described in Section 2.1 of this Section 2.

Section 3: Performance measures and benchmarks

3.1 **Domain 1.** Group and Group Providers shall implement the quality Performance Measures and benchmarks set forth below in Domain 1, Section 3 Table 1. Measures may be modified in accordance with Section 2.1 of this Handbook. Domain 1 Performance Measure descriptions are set forth in Section 3 Table 4.

Section 3 Table 1 — Domain 1 Performance Measures and benchmarks

Domain 1 Performance Measures	Star weight	2-Star	3-Star	4-Star	5-Star
Breast Cancer Screening (BCS)	1	62%	73%	78%	85%
Care for Older Adults – Functional Status Assessment	1	51%	70%	84%	95%
Colorectal Cancer Screening (COL)	1	53%	63%	73%	80%
Concurrent Use of Opioids/Benzos (COB)	1	20%	13%	9%	5%
Controlling Blood Pressure via Electronic Data (CBP)	3	69%	76%	81%	87%
Eye Exam for Patients with Diabetes (EED)	1	60%	73%	81%	87%
Follow-up after ED Visit for People with Multiple High Risk Chronic Conditions (FMC)	1	53%	62%	69%	80%
Glycemic Status Assessment for Patients With Diabetes (GSD)	3	60%	81%	89%	92%
Kidney Health Evaluation for Patients with Diabetes (KED)	1	47%	58%	68%	79%
Medication Adherence for Diabetes Medications with Risk Adjustment (ADH-Diabetes RA)	1	84%	88%	91%	93%
Medication Adherence for RAS Antagonists with Risk Adjustment (ADH-RAS RA)	1	85%	89%	92%	94%
Medication Adherence for Statins with Risk Adjustment (ADH-Statins RA)	1	87%	89%	92%	94%
Osteoporosis in Women who had a fracture (OMW)	1	38%	45%	56%	70%
Plan All-Cause Readmissions (PCR)	3	10%	9%	8%	6%
PolyRx Multi-anticholinergics (Poly-ACH)	1	14%	9%	6%	5%
Statin Use in Persons with Diabetes (SUPD)	1	83%	87%	91%	94%

Section 3 Table 2 — Domain 1 additional opportunity

Qualifying event	Benchmark
Annual wellness visits completed	50% or more

3.2 **Domain 2.** Group and Group Providers shall implement the Performance Measures and benchmarks set forth below in Domain 2, Section 3 Table 3. Measures may be modified in accordance with Section 2.2 of this Handbook. Domain 2 Performance Measure descriptions are set forth in Section 3 Table 4.

Section 3 Table 3 — Domain 2 Weighted Performance Measures and benchmarks

Domain 2 Performance Measures	Interim 4-star benchmark
Controlling Blood Pressure via Electronic Data (CBP)	81%
Glycemic status assessment for patients with diabetes (GSD)	89%
Plan all-cause readmissions (PCR)	8%

Section 3 Table 4 — Performance Measure descriptions

Measure	Measure Description	Measure achieved by
Breast Cancer Screening (BCS-E)	Quality Target Population: Women ages 50–74 who had a mammogram.	Mammogram performed in the past 27 months.
Care for Older Adults – Functional Status Assessment (COA-FSA)	Quality Target Population: Members ages 66 and older who are part of the Dual-Eligible Special Needs Population (D-SNP) that received at least one functional status assessment.	One functional status assessment performed in an outpatient setting during the measurement year.
Colorectal Cancer Screening (COL-E)	Quality Target Population: Members ages 45 -75 who had appropriate screening for colon cancer.	Any of the following tests: 1. FOBT during measurement year 2. Stool DNA (sDNA) with FIT test in measurement year or two years prior 3. CT Colonography in measurement year or four years prior 4. Flexible sigmoidoscopy in the measurement year or four years prior 5. Colonoscopy in the measurement year or nine years prior

Measure	Measure Description	Measure achieved by
Concurrent use of Opioids and Benzodiazepines (COB)	Quality Target Population: Medicare Part D beneficiaries ages 18 and older with concurrent use of prescription opioids and benzodiazepines.	Percent of plan members with concurrent use of opioids and benzodiazepines for 30 or more cumulative days, including at least two separate prescription claims for benzodiazepines and two for opioids (each with different dates of service), and a minimum cumulative opioid supply of 15 days. *Lower rate is better.
Controlling Blood Pressure via Electronic Data (CBP)	Quality Target Population: Members ages 18-85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.	Adequately controlled blood pressure readings (<140/90) from the current measurement year submitted via CPTII claim codes or approved electronic data file submission.
Eye Exam for Patients with Diabetes (EED)	Quality Target Population: Members 18–75 with a diagnosis of Type 1 or 2 diabetes who had an eye exam (retinal) performed.	Any of the following: 1. Retinal/dilated eye exam by an optometrist or ophthalmologist during the measurement year. 2. Negative for retinopathy — retinal/dilated eye exam by an optometrist or ophthalmologist the year *prior* to the measurement year. 3. Retinal imaging with interpretation and reporting by a qualified reading center during the measurement year. 4. Automated eye exam during the measurement year (code 92229).

Measure	Measure Description	Measure achieved by
Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)	Total population: Percentage of emergency department (ED) visits for members ages 18 and older who have multiple high-risk chronic conditions and had a follow up service within 7 days or on the day of the ED visit (total 8 days).	Any of the following within 7 days or on the day of (total 8 days) an emergency department visit: 1. Outpatient visit. 2. Telephone visit. 3. E-visit/virtual check-in. 4. Outpatient/Telehealth behavioral health visit. 5. Transitional care management services 6. Case management visits. 7. Complex care management services 8. Intensive outpatient encounter or Partial hospitalization. 9. Community mental health center visits with POS code 53. 10. Electroconvulsive therapy with one of the following POS codes- 24, 52, 53 11. Telehealth visit with telehealth POS code. Substance use disorder service or substance abuse counseling and surveillance.
Glycemic Status Assessment for Patients With Diabetes (GSD)	Quality Target Population: Members ages 18–75 with diagnosis of Type 1 or 2 diabetes who had an A1C or glucose management indicator test during measurement year that resulted in a controlled value.	Last HbA1c Level $\leq$9.0% in the measurement year.

Measure	Measure Description	Measure achieved by
Kidney Health Evaluation for Patients with Diabetes (KED)	Quality Target Population: Members ages 18–85 with a diagnosis of Type 1 or 2 diabetes who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR).	1. One Estimated Glomerular Filtration Rate Lab Test (eGFR) during the measurement year, AND 2. One Urine Albumin-Creatinine Ratio (uACR) during the measurement year *or* one quantitative urine albumin test *and* one urine creatinine lab test (with dates of service four days or less apart) during the measurement year. *Both eGFR and uACR must be performed during the measurement year.
Medication Adherence for Diabetes Medications with Risk Adjustment (ADH-Diabetes RA)	Quality Target Population: Medicare Part D beneficiaries ages 18 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 and sodium glucose cotransporter 2 (SGLT2) inhibitors. Does not include insulin.	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 RAS Antagonists with Risk Adjustment (ADH-RAS RA)	Quality Target Population: Medicare Part D beneficiaries ages 18 and older who adhere to their prescribed drug therapy for renin angiotensin system (RAS) antagonists: angiotensin converting enzyme inhibitor (ACEI), angiotensin receptor blocker (ARB) or direct renin inhibitor medications.	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.

Measure	Measure Description	Measure achieved by
Medication Adherence for Statins with Risk Adjustment (ADH-Statins RA)	Quality Target Population: Medicare Part D beneficiaries ages 18 and older who adhere to their prescribed drug therapy for statin cholesterol medications.	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.
Osteoporosis in women who had a fracture (OMW)	Total population: Women ages 67–85 who suffered a fracture and received either a bone mineral density (BMD) test or prescription to treat osteoporosis. *Excludes fractures to the finger, toe, face and skull.	Bone mineral density test or dispensed a prescription to treat osteoporosis on the day of fracture or in the 180 days after a fracture. Measurement period is July 1, 2025, to June 30, 2026.
Plan All Cause Readmissions (PCR)	Total population: Members ages 18 and older, the number of unplanned acute readmissions for any diagnosis within 30 days after an inpatient or observation stay and the predicted probability of an acute readmission.	An unplanned acute readmission for *any* diagnosis within 30 days after an acute inpatient or observation stay. *Lower rate is better.
Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH)	Quality Target Population: Medicare Part D beneficiaries ages 65 and older with concurrent use of 2 or more unique anticholinergic medications.	Percent of plan members with ≥2 prescription claims on different dates for ≥2 unique anticholinergic medications, and the different anticholinergic medications overlap for ≥30 cumulative days. *Lower rate is better.

Measure	Measure Description	Measure achieved by
Statin Use in Persons with Diabetes (SUPD)	Quality Target Population: The percent of Medicare Part D beneficiaries ages 40-75 with diabetes medications who take a statin medication.	The percent of plan members who were dispensed at least two diabetes medication fills and received a statin medication fill during the measurement period.

References/resources:

2025–2026 Quality Reference Guide (formerly HEDIS® Reference Tool) produced by Aetna® based on notifications received and specifications determined by the following organizations:

- National Committee for Quality Assurance (NCQA)
- Centers for Medicare and Medicaid Services (CMS)
- Pharmacy Quality Alliance (PQA)

Section 4: Incentive arrangement requirements

4.1 Domain 1 opportunity. Payment of Quality Payments is based upon the successful achievement of Performance Measures contained in Domain 1 (Section 3.1) in a given Contract Year as outlined in Section 4 Table 1 below.

4.2 Domain 1 additional opportunity. If the Group's AWV Completion Rate is equal to or greater than the AWV threshold, then the Domain 1 Opportunity PMPM, in Table 4.1 below, shall be multiplied by the factor below, Section 4 Table 2, for each Contract Year.

Section 4 Table 1 — Domain 1 incentive opportunity PMPM

Domain 1 Stars composite score	Domain 1 opportunity Annual wellness visits < 50% completed	Domain 1 opportunity Annual wellness visits >=50% completed
5.0	$12.00	$14.40
4.9	$11.50	$13.80
4.8	$11.00	$13.20
4.7	$10.50	$12.60
4.6	$10.00	$12.00
4.5	$9.50	$11.40
4.4	$9.00	$10.80
4.3	$8.50	$10.20
4.2	$8.00	$9.60
4.1	$7.50	$9.00
4.0	$7.00	$8.40
3.9	$4.00	$4.80
3.8	$3.75	$4.50
3.7	$3.50	$4.20
3.6	$3.25	$3.90
3.5	$3.00	$3.60
3.4	$1.75	$2.10
3.3	$1.50	$1.80
3.2	$1.25	$1.50
3.1	$1.00	$1.20
<= 3.0	$0.00	$0.00

Section 4 Table 2 — Domain 1 additional opportunity

Domain 1 additional opportunity qualifying event	AWV Factor
Annual wellness visit (AWV) completion rate (50% or more)	1.20x

4.3 Domain 2 opportunity. All Triple Weighted Performance Measures contained in Domain 2 (Section 3.2) must be individually greater than or equal to a star score of 4.0 in order for the Triple Weighted Performance Measures Payment opportunity to be achieved. Domain 2 payment opportunity for each Contract Year is outlined in Section 4 Table 3 below.

Section 4 Table 3 — Domain 2 opportunity

Domain 2 qualifying event	Domain 2 incentive opportunity PMPM
All Triple Weighted Performance Measures >= 4-Star rating	$1.00

Section 5: Reconciliation and payment administration

Company shall make best efforts to adhere to the timing set forth below, when performing reconciliations and in making any required payments.

5.1 **Final reconciliation quality.** Reconciled on or about October 31 following end of Contract Year.

5.2 **Final reconciliation Triple Weighted Performance Measures.** Reconciled on or about October 31 following end of Contract Year.

5.3 **Quality payment and Triple Weighted Performance Measures payment.** Paid on or about December of the following end of Contract Year, taking into account the Review Window.

5.4 **Reconciliation review window.** Group will have thirty (30) calendar days from the date it receives a Quality Payment Reconciliation and a Triple Weighted Performance Measures Reconciliation, during which to review Company's calculations in such reconciliation(s) ("**Review Window**"). If Company does not receive written notice from Group of any disputes to the reconciliation(s) within the Review Window, such reconciliation(s) 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 such dispute in a timely fashion. Company may 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.

Example reconciliation provided on next page, Section 5 Table 1.

Section 5 Table 1 — Program reconciliation example

Domain 1 performance measures	Final pass rate	Star Rating	Star Weight	Weighted value
Breast cancer screening (BCS)	90%	5	1	5
Care for older adults – functional status assessment	98%	5	1	5
Colorectal cancer screening (COL)	62%	2	1	2
Concurrent use of opioids and benzodiazepines (COB)	14%	3	1	3
Controlling blood pressure	84%	4	3	12
Eye exam for patients with diabetes (EED)	72%	3	1	3
Follow-up after emergency department visit for people with multiple high-risk chronic conditions (FMC)	53%	2	1	2
Glycemic status assessment for patients with diabetes (GSD)	88%	4	3	12
Kidney health evaluation for patients with diabetes (KED)	30%	2	1	2
Medication adherence for diabetes medication	96%	5	1	5
Medication adherence for cholesterol (statins)	93%	4	1	4
Medication adherence for hypertension (RAS antagonists)	91%	4	1	4
Osteoporosis in women who had a fracture (OMW)	80%	5	1	5
Plan all-cause readmissions (PCR)	6%	5	3	15
Polypharmacy: use of multiple anticholinergic medications in older adults (Poly-ACH)	9%	3	1	3
Statin use in persons with diabetes (SUPD)	92%	4	1	4
Stars composite score calculation = Total Weighted Value ÷ Total Star Weight			22	86

Stars composite score	3.9
Domain 1 score	3.9

Domain 1 additional opportunity	Final rate	Met goal
Annual wellness visits completed	58%	Yes

Domain 2 performance measures	Star rating	Met goal
Glycemic Status Assessment for Patients with Diabetes (GSD)	4 Star	Yes
Plan all-cause readmissions (PCR)	5 Star	
Controlling Blood Pressure	4 Star	

Program component	Incentive PMPM	Member months	Incentive payment
Domain 1 earned with 1.20 AWV factor applied	$4.80	4,800	$23,040.00
Domain 2 earned	$1.00		$4,800.00
Total incentive earned	**$5.80**		**$27,840.00**

Section 6: Frequently asked questions (FAQs)

1. **How can I join the quality incentive program?**
   All you must do is complete the Participation Form and send to **AetnaMedicareValue_BasedPrograms@Aetna.com**

2. **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.

3. **Can I change any language or metrics in the Participation Form?**
   Changes are not permitted to the Handbook or the Participation Form.

4. **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 you signed the Participation Form. The program includes performance from the program performance year: 1/1/2026–12/31/2026, also indicated on the Participation Form.

5. **What will happen to my participation next year?**
   Your participation will roll over to the next Contract 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.

6. **How do I know how I am performing throughout the year?**
   You'll work with an Aetna Engagement Manager to gain access to our reports. Our reports will provide you with access to information to support your efforts to improve quality of care, monitor performance and much more. After you submit your executed Participation Form, we will provide you with instructions on how to obtain access and training.

7. **When will I receive payment for my performance in this program?**
   We will provide you with a full reconciliation file and payment at the end of the year following the Contract Year close.

8. **Need more information?**

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

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