



2021 Medicare Advantage Quality Incentive Program

51.07.800.1 A (3/21)

Introduction

This handbook sets forth the terms and conditions for the Medicare Advantage Quality Incentive Program (“Program”) and, by executing the participation form, you agreed to be bound by and comply with the terms outlined in this handbook.

Table of contents

Section 1: General program details and requirements

- 1.1 Duties of Group
- 1.2 Payment arrangements
- 1.3 Termination
- 1.4 Obligations
- 1.5 Dispute resolution
- 1.6 Notice
- 1.7 Definitions
- 1.8 Member attribution
- 1.9 Amendments
- 1.10 Superseding

Section 2: Performance measures descriptions and benchmarks

Section 3: Reconciliation and payment

Section 4: Frequently asked questions (FAQs)

Section 5: DataLink CareBook (Evoke 360) access and training FAQ

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company and its affiliates (Aetna).

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.

1.2 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 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.

1.3.4 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.

1.3.5 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 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.

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, 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.

Obligation #2: Upon request by Company, Group shall meet with an Aetna Medicare engagement staff member 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.

1.5 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.

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

1.7.2 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.

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

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 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.

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

1.7.8 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. 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.

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

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

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

1.7.12 PMPM — Per attributed member per month.

1.7.13 Primary care provider or 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.

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

1.7.15 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.

1.7.16 Composite Score – The weighted average of the Group’s overall Domain 1 performance, Section 2, subject to the CMS targets (cut points).

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

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

1.8 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:

1.8.1 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:

- a. The member notified Company of their selection of Group as the member’s PCP, or
- b. If the member has not selected a PCP, but 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 2 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.

1.8.2 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 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.

1.9 Amendments. Company may make changes, at its discretion, to this Program and the terms of this Program Handbook at any time by providing 90 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 45 days before the effective date of the amendment to the Program/Program Handbook.

1.10 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 2021, Group shall implement the performance measures set forth below in **Domain 1**. Composite score determined by a weighted average of “Stars” and “Weight.”

Measure	Weight	1-Star	2-Star	3-Star	4-Star	5-Star
Breast cancer screening	1	< 53%	53%	71%	79%	86%
Colorectal cancer screening	1	< 59%	59%	67%	77%	84%
Controlling high blood pressure	1	< 59%	59%	71%	79%	90%
Diabetes care - blood sugar controlled	3	< 43%	43%	72%	82%	91%
Diabetes care - eye exam	1	< 66%	66%	72%	76%	83%
Diabetes care - kidney screening	1	< 89%	89%	89%	97%	99%
Medication adherence: ACEI/ARB	3	< 82%	82%	86%	89%	91%
Medication adherence: diabetes	3	< 79%	79%	83%	87%	91%
Medication adherence: statin	3	< 79%	79%	87%	90%	92%
Osteoporosis management in women who had a fracture	1	< 36%	36%	50%	62%	83%
SNP – medication review	1	< 67%	67%	81%	91%	99%
SNP - pain screening	1	< 65%	65%	87%	95%	99%
Statin therapy for patients with CVD	1	< 79%	79%	83%	87%	91%
Statin use in diabetic persons	1	< 81%	81%	85%	87%	91%

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 2022 are applicable to the 2021 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
Breast cancer screening	Percentage of Quality Target Population women ages 50-74 who were continuously enrolled two years prior to the measurement year through December 31 of the measurement year and had a screening mammogram over a 2 ¼ -year timeframe.	HEDIS®	Members with bilateral mastectomies are excluded. Members in hospice are excluded.
Colorectal cancer screening	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®	Appropriate screening: (any one of the tests listed below) <ul style="list-style-type: none"> • Annual FOBT testing • FIT-DNA in the past 3 years • CT colonography in the past 5 years • Flexible sigmoidoscopy in the past 5 years • Colonoscopy in the past 10 years Members with a history of colon cancer or a total colectomy are excluded. Members in hospice are excluded.

<p>Controlling high blood pressure</p>	<p>Percentage of Quality Target Population 18–85 years of age who had a diagnosis of hypertension (HTN) and was adequately controlled (<140/90 mm Hg) during the measurement year.</p> <p>Members will be included if they were diagnosed with HTN x2 from January 1, 2019, through June 30, 2020, an outpatient visit including telephone and online assessments.</p>	<p>HEDIS®</p>	<p>Documentation must include notation of the most recent BP in the medical record, as long as it was taken after the diagnosis of hypertension.</p> <p>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.</p>
<p>Diabetes care - blood sugar controlled</p>	<p>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.</p>	<p>HEDIS®</p>	<p>Controlled HbA1c Level is <=9.0%.</p> <p>The absence of A1c testing equals poor control.</p> <p>Members in hospice are excluded.</p>

<p>Diabetes care - eye exam</p>	<p>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.</p>	<p>HEDIS®</p>	<p>An eye exam performed the prior year is also acceptable if the results are negative (no diabetic retinopathy). Qualified reading center must operate under the direction of a medical director who is a retinal specialist.</p>
<p>Diabetes care - kidney screening</p>	<p>Percentage of Quality Target Population ages 18–75 with a diagnosis of diabetes who were continuously enrolled during the measurement year and had annual nephropathy screening.</p>	<p>HEDIS®</p>	<p>Nephropathy screening:</p> <ul style="list-style-type: none"> • Visit with a nephrologist • Urine test for albumin or protein • Documentation of nephropathy care, for example, ESRD, CRK dialysis • Documentation of an ambulatory prescription for an ACEI/ARB <p>Members in hospice are excluded.</p>

<p>Medication adherence: ACEI/ARB</p>	<p>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.)</p>	<p>PDE data</p>	<p>Continue to refill prescription for hypertensive medication.</p>
<p>Medication adherence: diabetes</p>	<p>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.)</p>	<p>PDE data</p>	<p>Continue to refill prescription for diabetes medication.</p>

<p>Medication adherence: statin</p>	<p>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 to be taking the medication.</p>	<p>PDE data</p>	<p>Continue to refill prescription for cholesterol medication.</p>
<p>Osteoporosis management in women who had a fracture</p>	<p>Percentage of Quality Target Population women 67 to 85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture.</p>	<p>HEDIS®</p>	<p>Documentation in record showing evidence of BMD within 6 months of fracture or prescription for osteoporosis treatment.</p>
<p>SNP – medication review</p>	<p>Percentage of Quality Target Population Medicare Advantage Special Needs Plan enrollees 66 years and older (denominator) who received at least one medication review (Medication Review Value Set) conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record (Medication List Value Set) (numerator).</p>	<p>HEDIS®</p>	<p>Doctor or clinical pharmacist review of everything the member takes (prescription and non-prescription drugs, vitamins, herbal remedies, other supplements) at least once during the measurement year.</p>

<p>SNP - pain screening</p>	<p>Percentage of Quality Target Population Medicare Advantage Special Needs Plan enrollees 66 years and older (denominator) who received at least one pain assessment (Pain Assessment Value Set) plan during the measurement year (numerator).</p>	<p>HEDIS®</p>	<p>Pain screening at least once during the measurement year</p>
<p>Statin therapy for patients with CVD</p>	<p>Percentage of Quality Target Population males 21–75 years of age and females 40–75 years of age during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) (denominator) and were dispensed at least one high- or moderate-intensity statin medication during the measurement year (numerator)</p>	<p>HEDIS®</p>	<p>A single fill of any high or moderate intensity statin allows the patient to “pass” this measure. This is captured through pharmacy claims. High intensity statins: • Atorvastatin 40–80 mg • Rosuvastatin 20–40 mg • Simvastatin 80mg Moderate intensity statins: • Atorvastatin 10–20 mg • Rosuvastatin 5–10 mg • Simvastatin 20–40 mg • Pravastatin 40–80 mg • Lovastatin 40 mg</p>

<p>Statin use in diabetic persons</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 at least one month from January through December. Hospice members are excluded from the measure denominator.</p>	<p>HEDIS®</p>	<p>One fill of a statin medication</p>
<p>Quality Target Population members with office visits</p>	<p>Completion of an office visit for each attributed member in the Quality Target Population in the contract year.</p>	<p>Claims</p>	<p>Attributed Quality Target Population members complete primary care physician visit during the contract year.</p>
<p>Quality Target Population members with office visits — chronic disease</p>	<p>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.</p>	<p>Claims</p>	<p>Attributed Quality Target Population members have at least one visit from January–June and July–December, during the contract year.</p>
<p>Average members seen</p>	<p>Average of Quality Target Population members with office visits and Quality Target Population members with office visits chronic disease.</p>	<p>Claims</p>	<p>80%, 85% or 90% average completion rate to determine payment scale.</p>

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 examples

Measure	Star weight	Group pass rate	Stars	Weight %	Weighted value
Breast cancer screening	1	86%	5	4.55%	0.23
Colorectal cancer screening	1	77%	4	4.55%	0.18
Controlling high blood pressure	1	79%	4	4.55%	0.18
Diabetes care - blood sugar controlled	3	72%	3	13.64%	0.41
Diabetes care - eye exam	1	76%	4	4.55%	0.18
Diabetes care - kidney screening	1	100%	5	4.55%	0.23
Medication adherence: ACEI/ARB	3	89%	4	13.64%	0.55
Medication adherence: diabetes	3	91%	5	13.64%	0.68
Medication adherence: statin	3	92%	5	13.64%	0.68
Osteoporosis management in women w/fracture	1	62%	4	4.55%	0.18
SNP - medication	1	91%	4	4.55%	0.18
SNP - pain screening	1	95%	4	4.55%	0.18
Statin therapy for patients with CVD	1	91%	5	4.55%	0.23
Statin use in diabetic persons	1	87%	4	4.55%	0.18

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

Composite score	4.27
Composite score rounded	4.3
Average members seen	92%
PMPM opportunity	\$5.25
Member months	4,460
Total Quality Incentive Program payment value	\$23,415

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 with 50–749 attributed Aetna Medicare Advantage plan members and are not 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 will 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 will receive access to a web-based reporting solution, DataLink CareBook (soon to be known as 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 CareBook (Evoke360) access and training FAQ

What is DataLink CareBook (Evoke360)?

DataLink CareBook (soon to be known as Evoke 360) 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 will 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 to create a username and password.

How will I know what my username and password are?

You will receive a welcome email from DataLink to sign into the website for the first time. That message will contain your username. You will 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 **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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