



2020 Medicare Advantage Quality Incentive Program

51.07.800.1 (3/20)

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.

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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 in accordance with the Program, 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 pharmacist at least twice during the contract year, once during the first half of the calendar year and once during the second half of the calendar year, to review clinical pharmacy data and execute improvement actions for the population under shared management. Company and Group shall work together in good faith to schedule such meetings and attend them in order that Group may successfully fulfil this important obligation.

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 Health Inc. 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.

1.8 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 program 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 program year in which such member is attributed using the attribution methodology above, unless one of the following "change events" occurs: (a) the Group attributed member's coverage under Company's plan is terminated; or (b) the Group attributed member selects a participating provider outside of Group to be the member's PCP. In either of these events, such attributed Group member in question shall be un-attributed from Group as of the month following the change

event. Attributed members will be provided to 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 2020, Group shall implement the performance measures set forth below in **Domain 1**.

2020 QUALITY MEASURES – DOMAIN 1	Interim benchmarks*		
	Tier 1	Tier 2	Tier 3
1. Diabetes care – controlled HbA1c	82%	87%	91%
2. Diabetes medication adherence	86%	88%	89%
3. ACEI/ARB medication adherence	89%	90%	91%
4. Statin medication adherence	88%	90%	91%
5. Colorectal cancer screening	77%	81%	84%
6. Diabetes care – eye exam	76%	80%	83%
7. Statin therapy in persons with cardiovascular disease	87%	89%	91%
8. Statin use in diabetics	84%	85%	86%
9. Diabetes care – nephropathy screening	97%	98%	99%
10. Breast cancer screening	79%	83%	86%

*Final benchmarks noted here will be automatically revised to be identical to the final cut points released by CMS for the applicable contract year (e.g. the cut points published by CMS in October of 2021 are applicable to the 2020 contract year). Tier 1 will equal the 4 Star cut point, Tier 3 will equal the 5 Star cut point and Tier 2 will be the average between the Tier 1 and Tier 3 cut point.

For 2020, Group shall implement the performance measures set forth below in **Domain 2**.

Measures	Benchmark
1. Members with office visits	90%
2. Members with office visits – chronic disease	90%
3. 90-day Rx fill	90%
4. Plan all-cause readmissions	7%

2.1 Performance measure descriptions

DOMAIN 1			
Measure	Description	Source	Measure achieved by
1. Diabetes care – controlled HbA1c	Percentage of Quality Target Population ages 18–75 with diagnosis diabetes of who were continuously enrolled during the measurement year and whose most recent HbA1c test demonstrates control.	HEDIS®	Controlled HbA1c Level is <=9.0%. The absence of A1c testing equals poor control. Members in hospice are excluded.
2. Diabetes medication adherence	Percent of Quality Target Population with Part D coverage with a prescription for diabetes medication, over 12 months from January to December, who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. (Diabetes medication means a biguanide drug, a sulfonylurea drug, a thiazolidinedione drug, non-insulin injectable agents, SGLT2 inhibitor meds, or a DPP-IV inhibitor. Plan members who take insulin are not included.)	PDE Data	Continue to refill prescription for diabetes medication.

<p>3. ACEI/ARB medication adherence</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>4. Statin medication adherence</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>5. Colorectal cancer screening</p>	<p>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.</p>	<p>HEDIS</p>	<p>Appropriate screening: (any one of the tests listed below)</p> <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 <p>Members with a history of colon cancer or a total colectomy are excluded.</p> <p>Members in hospice are excluded.</p>
<p>6. 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</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</p>

	chart or photography of retinal abnormalities and evidence that the results were read by a qualified reading center.		who is a retinal specialist.
7. Statin therapy for persons with cardiovascular disease	Percentage of 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).	HEDIS	<p>A single fill of any high or moderate intensity statin allows the patient to “pass” this measure. This is captured through pharmacy claims.</p> <p>High intensity statins:</p> <ul style="list-style-type: none"> • Atorvastatin 40–80 mg • Rosuvastatin 20–40 mg • Simvastatin 80mg <p>Moderate intensity statins:</p> <ul style="list-style-type: none"> • Atorvastatin 10–20 mg • Rosuvastatin 5–10 mg • Simvastatin 20–40 mg • Pravastatin 40–80 mg • Lovastatin 40 mg

<p>8. Statin use in diabetics</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 and hospice members are excluded from the measure denominator.</p>	<p>PDE data</p>	<p>One fill of a statin medication.</p>
<p>9. Diabetes care — nephropathy 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>

10. 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 3-year time frame.	HEDIS	Members with bilateral mastectomies are excluded.
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DOMAIN 2			
Measure	Description	Source	Measure achieved by
1. 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	Quality Target Population members complete primary care physician visit during the contract year.
2. 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 follows: January–June and July–December.	Claims	Attributed members have at least one visit from January–June and July–December, during the contract year.
3. Rx 90-day supply	Percentage of prescriptions for renin-angiotensin system antagonists, statins or anti-diabetics that a claim was received	PDE data	Higher rate equals better performance.

	with a days' supply of 84 or greater for members with at least 2 fills of the medication.		
4. Plan all-cause readmissions	Quality Target Population members ages 18 years and older who had an acute inpatient stay(s) during the measurement year (January 1 to December 1) that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.	HEDIS	Lower rate equals better performance.

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.

Section 4: Frequently asked questions (FAQs)

Quality Incentive Program frequently asked questions

How can I join the Quality Incentive Program?

All you have to do is complete the participation form and send to the following email address: [AetnaMedicareValue BasedPrograms@Aetna.com](mailto:AetnaMedicareValueBasedPrograms@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/Coventry value-based contract or program.

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

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

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 program 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), which 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.

In Domain 1, what do the different tiers represent for each quality measure? The tier targets for each measure roughly reflect CMS' Medicare Stars thresholds. The tiers represent 4, 4.5 and 5 Star thresholds. Our goal in this program is to improve our performance in Stars to the benefit of our members — your patients.

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

We will provide you with a full reconciliation file and payment in the fall of the year following the program 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 that delivers greater clinical control and insights to medical practices, payers and more while adding efficiency, boosting care gap management and improving patient outcomes.

Will you provide any training?

Yes. If you would like to sign up for a pod training for you and/or your team, please send a request to AetnaDataLinkteam@Aetna.com.

What will happen after my pod training?

You will receive a next step email directly from the Aetna DataLink team post-pod training.

How do I obtain access?

We use the name(s) and email address(es) that you have provided to create a username and password.

How will I know what my username and password is?

You will receive a welcome email from DataLink to sign into the website for the first time, which will contain your username. You will set your password upon your initial login.

What if I experience an issue while using DataLink products?

If you experience any technical difficulties, please submit a ticket [here](#) or call **813-903-1091** to reach the DataLink Support desk.

Who do I contact for any other questions regarding DataLink?

If you have any further questions, please follow up with our Aetna DataLink team at AetnaDataLinkteam@Aetna.com.

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