aetna®

Aetna Better Health® of Michigan

Building healthier communities

2025 Pay for Quality (P4Q) Program

AetnaBetterHealth.com/Michigan

PART A: Program Overview

Purpose

Aetna Better Health of Michigan ("Aetna"), is committed to advancing health equity, enhancing the patient experience, improving population health outcomes, prioritizing clinical well-being, and reducing costs. We understand that a key component of achieving superior health care and satisfaction for Members is the doctor-patient relationship. The Pay for Quality (P4Q) Program outlined in this handbook ("Handbook") seeks to enhance this relationship and support our Members in achieving the highest quality healthcare, as measured by national benchmarks.

Aetna's P4Q Program rewards Groups for meeting or exceeding specific quality goals. As a result of delivering the highest-quality health care to our Members, Groups are eligible to earn incentive payments.

Our P4Q Program supports your patients and our quality care initiatives by promoting:

- Care that improves quality and outcomes, thus resulting in a healthier population;
- Healthcare delivery consistency and adherence to evidence-based standards of care;
- Continuous quality improvement orientation; and
- Care coordination between providers and the health plan, and alignment of goals for our Members' health.

PART B: P4Q Program and Incentives

Program Incentives

Aetna has designed a menu outlining the P4Q Program (as defined in this Section 1) and other contractual features set forth in this Handbook. This program and contractual features may not be applicable to all Groups. A Group's Program Participation Form will outline the Program that applies to a Group for any given Program Year.

1. Pay for Quality ("P4Q") Program

a. The Program is applicable to Groups delivering care through PCPs with at least a 50 Member panel, subject to any additional terms and conditions of this Handbook.

b. The Program rewards such Groups for achieving a level of performance, as compared to defined targets, on selected HEDIS Measures ("Measure") applicable to the Group's Member panel, using the following methodology:

i. The top 10 HEDIS Measures (as outlined in Table 1 below) with the most Members who meet the clinical criteria to be included in the Measure's measurement pool, equal to or greater than 5, will be eligible for an annual P4Q incentive of up to $1.00 PMPM per measure (maximum P4Q Program payout for HEDIS performance of $10.00 PMPM). Groups will also be eligible for additional incentive for two (2) dental measures outside of the top 10 HEDIS Measures (outlined in Table 1 below) making the total maximum P4Q Program payout of $12.00 PMPM.

ii. Performance for each eligible measure will be calculated using claims data submitted up to ninety (90) days following the end of the Program Year. One cumulative score for each Measure will be determined per Group at the TIN level.

iii. Measure performance is measured against two targets, each based on the 2024 National Medicaid HEDIS 50th or 75th percentiles (or plan-defined targets when NCQA HEDIS national benchmarks were not available). A Group may be rewarded $0.50 PMPM for their entire assigned Member panel for each eligible measure for which Group meets or exceeds Target 1 (T1) and another $.50 PMPM incentive for each eligible measure for which Group meets or exceeds Target 2 (T2).

Table 1 – Eligible Measures

Measure Description	Measure Specification	Target 1	Target 2
Adults' Access to Preventive/Ambulatory Health Services (AAP)			
- Ages 20-44	HEDIS	69.69	74.69
- Ages 45-64	HEDIS	80.18	84.08
Asthma Medication Ratio – TOTAL (AMR)	HEDIS	65.61	70.82
Breast Cancer Screening (BCS)	HEDIS	52.20	58.35
Controlling High Blood Pressure (CBP)	HEDIS	61.31	67.27
Cervical Cancer Screening (CCS)	HEDIS	57.11	61.80
Chlamydia Screening in Woman - TOTAL (CHL)	HEDIS	56.04	62.90
Childhood Immunization Status – Combo 3 (CIS)	HEDIS	63.99	68.86
Eye Exam for Patients with Diabetes (EED)	HEDIS	52.31	59.37
Kidney Health Evaluation for Patients with Diabetes – TOTAL (KED)	HEDIS	33.52	41.49
Lead Screening in Children (LSC)	HEDIS	62.79	70.07
Child and Adolescent Well-Child Care Visits (WCV)			
- Ages 12-17	HEDIS	49.20	56.32
- Ages 3-11	HEDIS	55.66	62.89
Well-Child Visits in the First 30 Months of Life – First 15 Months (W30)	HEDIS	58.38	63.34
Preventive Dental Services (D1000-D1999)	MDHHS Dental Measure	17.0	24.0
Diagnostic Dental Services (D01000-D0999)	MDHHS Dental Measure	30.0	36.0

2. Program Reconciliation

a. Attribution

i. A Member shall be an Attributed Member to a Group if such Member is assigned to Group or Group Provider under their Plan.

b. Reporting

i. The following reports will be available to Groups, as applicable:

1. P4Q Performance Report: provides (i) Group and Group Provider level performance against Program Measures and Targets and (ii) highlights gaps in services that Members should have received and the actions required to successfully achieve program targets, (iii) an itemized list of all Members for whom the Measures apply, to assist with Group's outreach efforts.

2. Cumulative Year-End Report: Provides the calculation of earned incentive payments for the Program Year.

c. Aetna will provide reports to Group through our HIPAA compliant portal, secure file transfer protocol (SFTP) site, or other modality as agreed to by both parties.

d. Payment

    i. P4Q Program payments earned under this Handbook shall be issued not later than July 31st after the end of a Program Year.

PART C: Group Obligations

1) Group Obligations

a) Group must execute a Program Participation Form prior to start of the Program Year.

b) Group must comply with the terms and conditions of this Handbook throughout the Program Year. If Group fails to comply with such terms and conditions, Aetna may, at its own discretion, terminate Group's participation the Program and/or cause Group to forfeit of any incentives earned during the Program Year.

c) Group shall collaborate with Aetna in good faith in order that Group may succeed in the Program.

d) Group agrees to respond timely to email and telephonic outreach from Aetna, and provide requested information, including but not limited to TIN identification, EFT enrollment and an appropriate point of contact. Group agrees to meet at least quarterly with Aetna's Group engagement staff member, and other representatives (as necessary) throughout the calendar year to review performance, identify opportunities and potential strategies to resolve open gaps, share best practices, discuss data submission and coding issues, and evaluate opportunities to improve processes and workflows.

e) Aetna utilizes the Group Tax Identification Numbers (TINs) in performance tracking. Group agrees to confirm the accuracy of this full list of active TINs throughout the Program Year as follows:

   i) Group agrees to notify Aetna of any TIN changes, and effective dates within thirty (30) days of these changes. TIN changes received in accordance with this timeline will be reviewed and, if approved, reflected in the monthly membership reports beginning in the subsequent quarter. For example, TIN changes received by January 15th will be reflected in monthly membership reports beginning in April of that Program Year. Failure to notify Aetna of changes may result in decreased incentive payments.

f) Group must select a single TIN to receive all payments, and work with Aetna to enroll the banking information associated with this TIN in Aetna's Oracle EFT software such that payments can be made electronically (Aetna will inform Group if the TIN is already enrolled). Any and all Incentive payments for any and all TINs included in the P4Q Program will be paid electronically to the TIN selected by Group. Group is responsible to allocate incentive payments within its own organization.

g) Group agrees to work collaboratively with Aetna to identify, collect, and exchange, as needed, the data and information required to evaluate and report Group's performance under the Program. Group agrees to cooperate with Aetna's reasonable requests for performance data and information and shall submit the same to Aetna in an agreed upon format, which may be shared with Aetna's affiliates, vendors, and subcontractors.

h) Group agrees to use electronic health record technology to document and communicate clinical care and shall provide and transmit records to Aetna by this method, or other Aetna

approved method, no later than three (3) months after enrollment into the Program. Group must ensure Aetna receives all information and records upon request (on its own or through a designee) relating to Provider, Participating Providers, and Members, free of charge. For the avoidance of doubt, this obligation requires that Aetna receives any requested information and records, whether through access to an Electronic Health Record Technology, either in office or remotely, or alternatively, sent in reports or record extracts or in paper or any other form at no charge.

i) Group must comply with all federal and state laws related to the applicable 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 Michigan Medicaid program of the Plan. Moreover, and without limitation, Group shall comply with applicable terms of the State Contracts.

j) Group agrees to cooperate promptly, during and after each Program Year with reasonable and lawful requests from Aetna for information and records necessary for Aetna to comply with reporting requirements related to medical loss ratio ("MLR") requirements under the State Contract or applicable state statutes. In order for Aetna to comply with its MLR reporting requirements, Group agrees to cooperate with Aetna in differentiating costs that are medical expenses, costs that are administrative expenses, and costs that are expenses for quality improvement activities. Group shall submit any data required by Aetna electronically in a mutually acceptable format and shall maintain such MLR data for the longer of the time specified in Law or the State Contract.

k) Group agrees that in the event of any inconsistency between the terms of this Handbook and any other arrangements entered into between Group and/or Participating Providers, the terms of this Handbook shall control regarding the subject matter hereof.

l) Aetna has or shall seek contracts to serve beneficiaries of Government Programs. To the extent Aetna participates in such Government Programs, Group agrees, on behalf of itself and any Participating Providers or subcontractors acting on behalf of Provider, to be bound by all rules and regulations of, and all requirements applicable to, such Government Programs. With respect to Members of Government Programs, Group acknowledges that compensation under this Program for such Members constitutes receipt of state funds. Group agrees that all services and other activities performed by Group under this Program will be consistent and comply with the obligations of Aetna and/or Government Sponsor under its contract(s) with any applicable state or federal regulatory agency, to offer Government Program. Group further agrees to allow Government Sponsor or any applicable state or federal regulatory agency, and Aetna to monitor Provider's performance under this Program on an ongoing basis in accordance with applicable laws, rules, and regulations. Upon request, Group shall immediately provide to Aetna any information that is required by Aetna to meet its reporting obligations to Government Sponsor or any applicable state or federal regulatory agency. To the extent that Group generates and/or compiles and provides any data to Aetna that Aetna, in turn, submits to Government

Sponsor or any applicable state or federal regulatory agency, Group certifies, to the best of its knowledge and belief, that such data is accurate, complete, and truthful.

m) Group agrees that any dispute related to or arising from this Program shall be subject to the dispute resolution provisions in Group's Medicaid network participation agreement with Aetna.

n) Group agrees that participation in the Program or payment of Incentive Payments is not guaranteed. Group further agrees that Aetna may at any time during the Program Year, suspend or permanently discontinue this Program, remove Group from further participation in this Program or not include Group in this Program during subsequent Program Years. If Provider's participation in this Program terminates prior to the conclusion of the Program Year, for any reason, Group shall not be entitled to a pro-rated payment of any incentives earned prior to such termination.

o) Group agrees that in no event shall Aetna be liable for or have any obligation to pay any amounts, including without limitation any amounts arising from or related to the Program set forth in this Handbook, owed by Group to Group Providers under an agreement between such Group Providers and Group. Group agrees to indemnify Aetna and hold Aetna harmless from any and all claims, liabilities and causes of action brought by Group Providers against Aetna arising from or relating to the payment of any monies under this Handbook.

PART D: Definitions

1. The following shall be defined terms in this Handbook:

   Government Program: An arrangement with a state agency or other governmental entity authorized to offer, issue and/or administer one or more Plans, pursuant to a State Contract(s) to administer all or a portion of such Plan(s).

   Group: The Entity which executed a Program Participation Form to participate in the P4Q Program.

   HEDIS National Benchmark Percentile: A set of standardized performance measures developed and maintained by the National Committee for Quality Assurance (NCQA) specifically defined to allow for consistent comparison of health care plans.

   Member: Any person who is currently enrolled in a Plan, including, but not limited to, Attributed members.

   P4Q Program Payment: The total PMPM compensation earned by Group under the P4Q Program during a Contract Year.

   Plan: A Member enrolled in Aetna Better Health® of Michigan.

   Program Participation Form: The attestation executed by Group to acknowledge their participation in the P4Q Program included in Part E of this handbook.

   Program Year: A calendar year during which performance is tracked and measured, except that the first Contract Year may be a partial calendar year if this Addendum is executed after January 1 and the last Program Year may be a partial calendar year if this Addendum is terminated prior to December 31*st* , to the extent permitted under this Addendum.

   State Contract: Company's contract(s) to administer Plans, or Government Programs.