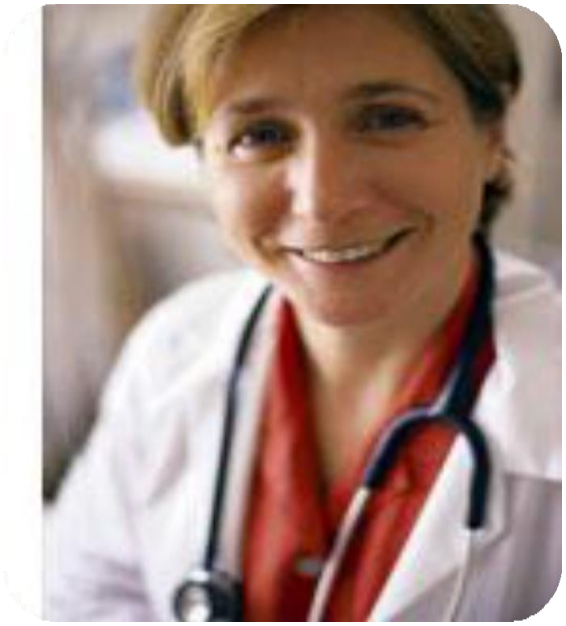
Harvard Pilgrim Health Care

Medicare STRIDE℠ Physician Quality Program 2019 Program Overview



Health Services- Managed by Network Medical Management

2019 Program

Medicare Advantage Quality Program

Program Overview

The Plan will support the efforts of the LCU and LCU Participating Providers in managing the needs of their patients to ensure they receive the highest quality care. Our Program is designed to encourage and reward greater focus on preventive health services, managing chronic conditions, and medication management that will result in improvements in clinical outcomes.

The Plan measures and funds LCU investments and improvements based on the LCU's Medicare Advantage Plan membership. Available funding for the Medicare Advantage Quality Program is more fully described below.

I. Medicare Advantage Quality Measures

The Plan's Medicare Advantage Quality Program rewards high levels of performance on clinical quality indicators taken from the domains of the CMS Five Star Quality Rating System for Medicare Advantage Plans.

The Plan will evaluate LCU's performance using a subset of the nationally accepted measures and/or other indicators of quality (such measure and quality indicators individually referred to as "Measure" or collectively as "Measures"). For each Measure, LCU will receive a per member per year ("PMPY") amount for each Medicare Advantage Member that meets the targets related to the Measures, as further described in this Attachment 1.

Section I describes the criteria for payment and the PMPY payment amount for the Medicare Advantage Quality Program for calendar year 2019.

On or about November 1 of each calendar year, the Plan will give written notice to LCU, pursuant to the notice provision of the Agreement, of the terms and criteria that will apply to the Medicare Advantage Quality Program for the subsequent calendar year.

Medicare Advantage Quality Measures Criteria

The Medicare Advantage Quality Program rewards performance in selected Measures for the Medicare Advantage patient population served by the practice. The LCU performance for 2019 will be determined based on verification of LCU Participating Providers' compliance with the Measures for each of their Medicare Advantage Members. As described in Table 1 below, the verification may be confirmed either via claims submission, chart review or attestations. The Plan may audit LCU medical records, as necessary, for purposes of monitoring the accuracy of the attestations and compliance with the Measures.

The Plan will calculate the LCU's performance based on verification of compliance of each LCU Participating Provider on the Measures attributed to their Medicare Advantage Members and any applicable medical records necessary to validate such compliance. For example, if LCU demonstrates that a Medicare Advantage Member met three Measures, LCU will receive a PMPY amount for each Measure.

No later than July 31st, of the current year (e.g. 2019), the Plan will send a reminder notice of the current year's Medicare Advantage Quality Program to the LCUs.

By December 15th, of the current year (e.g. 2019), the Plan will provide an updated Medicare Advantage Member roster ("Final Roster") to each LCU that identifies: (i) the LCU's Medicare Advantage Members, and (ii) the LCU Primary Care Provider for such Members. The Final Roster represents the baseline for performance and payment calculations.

By March 1st, of the following year (e.g. 2020), the Plan will send an Attestation Collection Tool which will include the LCU's Measurement Year Medicare Advantage Members to enable the LCU Participating Providers to complete the required attestations and submit any medical records requested by the Plan for Medicare Advantage Members that have met the Measures. As described in Table 2, such attestations and medical records must be submitted by LCU to the Plan by April 15th of the year subsequent to the measurement year (e.g. LCU must

submit attestations to the Plan by April 15, 2020 for Medicare Advantage Members that meet the Measures in calendar year 2019).

The Plan will calculate the LCU's performance based on the verification of compliance (claims submission and/or chart review or submission of attestations) by the LCU or the LCU Participating Provider showing that the Measures were met for their Medicare Advantage Members.

On or about ninety days (90) after the LCU's verification of compliance, the Plan will determine the LCU's performance on the Measures. The Plan will make payment to LCU in a PMPY amount for the Medicare Advantage Members as defined on the Final Roster for the applicable calendar year by August 1st.

If a Measure included in the Medicare Advantage Quality Program listed below is retired or substantially changed by CMS ("Modified Measure"), the Plan shall:

i. select a measure to replace the Modified Measure (the "Replacement Measure"); or
ii. redistribute the funding for the Modified Measure among the remaining Measures.

The Plan will provide notice of changes to the Modified Measure to the LCU as soon as feasible following the publication of such changes by CMS.

Table 1: Medicare Advantage Quality Program Measures and Targets

2019 Measures and Targets

Measure	Target	Primary Documentation of Performance	Secondary Documentation of Performance	Per Member Per Year Payment For each Measure Met
Annual Physical & Wellness Visits	Medicare Advantage Members age 20- and older who had an ambulatory or preventive care visit during the measurement year. The member is numerator compliant if they have been continuously enrolled during the Measurement Year and if the Annual Physical & Wellness Visit is billed with CPT Codes 99381 through 99397 in addition to HCPCS Codes G0402, G0438 and G0439	Claims submission	Not Applicable	$x.xx per Medicare Advantage Member with visit per year
Breast Cancer Screening	Medicare Advantage Female Members age 50-74 who had a mammogram to screen for breast cancer. The member is numerator compliant if she had one or more mammograms any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.	Claims submission	Not Applicable	$x.xx per Medicare Advantage Member with condition per year
Controlling Blood Pressure (<140/90)	Medicare Advantage Members who had a diagnosis of Hypertension and whose blood pressure (BP) is adequately controlled during the measurement year based on the following criteria: (1) Members 18–59 years of age whose BP was <140/90 mm Hg. (2) Members 60–85 years of age with a diagnosis of diabetes whose most recent BP was <140/90 mm Hg. (3) Members 60–85 years of age without a diagnosis of diabetes whose most recent BP was <150/90 mm Hg.	Claims submission or Medical Record Documentation	Physician Attestation which incorporate the outcome results	$x.xx per Medicare Advantage Member with condition per year
Diabetes Care – Blood Sugar Controlled-	Medicare Advantage Members with Diabetes who had an HbA1C test during the year that showed their average blood sugar is under control. The member is numerator compliant if the most recent HbA1c level is <8.0% in the measurement year. The member is not numerator compliant if the result for the most recent HbA1c test is ≥8.0% or is missing a result,	Claims submission or Medical Record Documentation	Physician Attestation which incorporate the outcome results	$x.xx per Medicare Advantage Member with condition per year

	or if an HbA1c test was not done during the measurement year.			
Diabetes Care – Eye Exam	Medicare Advantage Members with Diabetes who had an eye exam to check for damage from diabetes during the year. This includes diabetics who had one of the following: • A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year • A negative retinal or dilated exam (negative for retinopathy) by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year	Claims submission or Medical Record Documentation.	Physician Attestation	$x.xx per Medicare Advantage Member with condition per year
Diabetes Care – Medical Attention for Nephropathy	Medicare Advantage Members with Diabetes (type 1 and type 2) who had one of the following: • a nephropathy screening or monitoring test (urine protein test) • Evidence of treatment for nephropathy or ACE/ARB Therapy (filled prescription for an ACE/ARB) • Evidence of stage 4 chronic kidney disease. • Evidence of ESRD. • Evidence of a kidney transplant. • A visit with a nephrologist. • At least one ACE inhibitor or ARB dispensing event in the measurement year.	Claims submission or Medical Record Documentation	Physician Attestation	$x.xx per Medicare Advantage Member with condition per year
Medication Reconciliation within 30 days of discharge	Medicare Advantage Members with discharges from January 1–December 1 of the measurement year for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days). Medical record documentation that indicates the provider reconciled the current and discharge medications or a note indicating no medications were prescribed or ordered upon discharge is considered numerator compliant.	Claims submission or Medical Record Documentation	Not Applicable	$x.xx per Medicare Advantage Member per discharge per year

Table 2: Summary of Payment Requirements and Frequency for the 2019 Quality Measures	
Requirements for Payment	Verification of compliance (Claims submission and/or Chart Review or Submission of Attestations) by LCU certifying compliance with the Measures described in Table 1 above for each of their Medicare Advantage Members.
LCU Deadlines	April 15, 2020
Funding	As indicated in your contract
Payment Frequency	Annually, by August 1st

*****On an annual basis, the Plan will pay a maximum amount of per Medicare Advantage Member per Measure if such member has met one or more of the targets noted in Table 1. For example, if a Medicare Advantage Member meets the following three Measures – Breast Cancer Screening, Annual Physical and Controlling Blood Pressure -- the LCU will be reimbursed $x.xx per Measure for this Medicare Advantage Member for Breast Cancer Screening and Annual Physical and $x.xx for Controlling Blood Pressure, for a total of $x.xx for the applicable calendar year.

II. Accurate Clinical Documentation

The Plan supports engagement with Medicare Advantage patients that have chronic conditions and encourages complete coding of patient conditions to aid in understanding the true health risk of the LCU's Medicare Advantage Members and enabling appropriate population health management. The Plan supports this by providing a framework for providers to:

a. Schedule an appointment for their patient,
b. Provide follow up care for the condition(s)
c. Submit a claim coded with the chronic condition diagnosis.

Measurement: The Plan will provide a list to the LCU of Medicare Advantage Members with chronic conditions submitted through previous years claims and conditions reported by CMS, who have not yet been seen for this condition in 2019 (as documented via receipt of a claim coded with that condition). This is defined as a "Coding Gap."

If appropriate, the provider engages the Medicare Advantage patient to follow-up on the chronic condition(s) by December 31, 2019 and submits a claim with the diagnosis code(s) by February 28, 2020. Chronic conditions must be monitored, evaluated, assessed or treated through a face-to-face encounter. Documentation in the EMR must show that condition was monitored, evaluated, assessed or treated.

The Plan will provide the LCU with:

- An Initial List by February 15th of the current year (e.g. 2019) that identifies the LCU's Medicare Advantage Members that have chronic conditions
- Updated Lists by May 15th of the current year and August 15th of the current year (e.g. 2019)
- A Final List by October 15th of the current year (e.g. 2019). This list will be updated to remove members who have already been seen by their provider for the chronic condition.

Target: Close at least 70% of the Coding Gaps.

Payment:
Payment will be made annually as noted in Table 3.

Table 3: Summary of Payment Requirements and Frequency for the Accurate Clinical Documentation

Requirements for Payment	Close at least seventy (70%) percentage of the Coding Gaps. Verification of compliance will be based on claims submitted to the Plan for care provided to Medicare Advantage Members for the identified chronic condition.

Close Gap %	Per Member Per Year $$
0 – 69.9%	$x.xx
70.0 – 74.9%	$x.xx
75.0- 89.9%	$x.xx
90.0%+	$x.xx

LCU Deadlines	Follow-up on chronic condition(s) by December 31, 2019
Payment Frequency	Annually, by August 1st