BlueCross BlueShield of North Carolina

Quality Incentive Program

DESCRIPTION

This policy contains the applicable terms and conditions for the Blue Cross and Blue Shield of North Carolina ("Blue Cross NC") Medicare Advantage Quality Incentive Program ("MAQIP"). All Qualifying Providers, as defined below, will be notified of their ability to participate in the MAQIP under the terms and conditions in this policy for a given Measurement Year. Qualifying Providers that participate in the MAQIP under the terms and conditions of this policy will have the opportunity to earn the additional payment incentives outlined below. There is no penalty to Qualifying Providers that choose not comply with the terms and conditions for the MAQIP under this policy.

POLICY

1. MAQIP Qualification & Policy Application.

1.1. Qualifying Provider (as defined and meeting the Attributed Member threshold in Section 2.15 below) (also referred to herein as "Provider") is eligible to participate in the MAQIP under this policy as Provider's Medicare Advantage ("MA") quality incentive program with Blue Cross NC for any applicable calendar year that the MAQIP and this policy are effective for the MA plans offered by Blue Cross NC. The MAQIP is an upside-only program, with quality incentives offered to Provider pursuant to the terms of this policy.

1.2. Qualifying Provider does not participate in any other quality incentive program offered by Blue Cross NC during the same Measurement Year in which the Provider participates in MAQIP under this policy. Any Qualifying Provider that enters any other quality incentive program with Blue Cross NC for a given Measurement Year (either through other applicable policy or by separate agreement with Blue Cross NC) will be removed from the MAQIP and this policy will no longer apply to Provider for that Measurement Year. The other applicable policy or agreement terms for the other quality incentive program offered by Blue Cross NC would then apply to Provider.

2. Definitions:

2.1. **"Attributed Member"** shall mean an individual who satisfies the attribution logic set forth in Section 7, below.

2.2. **"Chronic Condition"** shall mean a health condition that (1) has been associated with a Qualified Member, (2) is chronic and persistent in nature, (3) would be expected to remain present over an extended or indefinite period of time (e.g., diabetes), and (4) has been assigned a specific Hierarchal Condition Categories as defined in Section 2.5, for purposes of one or more risk adjustment processes.

2.3. **"CMS Metric"** shall mean the "Metric" that the Centers for Medicare and Medicaid Services ("CMS") uses to measure a MA plan's performance on a MA Star Measure. The CMS Metrics for specific MA Star Measures are published by CMS annually in the "Part C & D Star Rating Technical Notes."

2.4. **"Contract Star Rating"** shall mean the overall Star rating assigned to Provider by Blue Cross NC for a Measurement Year based on how Provider performs on a set of defined quality measures

during that Measurement Year. The Contract Star Rating shall be expressed as a number between 1.0 and 5.0 with 0.5 intervening increments (i.e., 1.0, 1.5, 2.0, 2.5, etc.). Blue Cross NC will assign a new Contract Star Rating for each Measurement Year in which Provider participates in the MAQIP.

2.5. **"Hierarchical Condition Categories"** shall mean a roll up of ICD-9 and ICD-10 codes that CMS and the U.S. Department of Health and Human Services ("HHS") has ruled shall be used for risk adjustment purposes in the MA program.

2.6. **"Medicare Advantage Star Measure"** shall mean an individual performance measure that CMS uses to determine the Part C & D Star Ratings displayed on the Medicare Plan Finder at http://www.medicare.gov. MA Star Measures are published by CMS annually in the "Part C & D Star Rating Technical Notes."

2.7. **"Measurement Year"** shall mean a calendar year that begins on January 1 and ends on December 31. For the sake of clarity and to avoid confusion, each calendar year that this policy is effective, and the Provider qualifies for the MAQIP shall constitute a separate and distinct "Measurement Year."

2.8. "**Medical Chart**" shall mean any clinical and/or claims data or information for a Blue Cross NC MA Member who receives or has received services from Provider that is needed by Blue Cross NC to satisfy its reporting obligations to the National Committee for Quality Assurance ("NCQA"), CMS, or any other accreditation or regulatory entity. The term "Member Data" shall be inclusive of all data regardless of whether such data is stored by Provider in an electronic format or in paper records. For the sake of clarity and to avoid confusion, Member Data shall not be limited to data on only those Blue Cross NC Members who are Blue Cross MA Members but shall include data any Blue Cross NC Member who received services from Provider.

2.9. **"Primary Care Physician"** shall mean a physician or advanced care practitioner participating in the Blue Cross NC MA network under a MA Provider Agreement whose individual primary specialty reported to Blue Cross NC by Provider is one of the following: family medicine, internal medicine, obstetrics & gynecology, pediatrics, general practice, or geriatric medicine.

2.10. **"Persistency Rate"** shall mean the percentage of Chronic Conditions that are coded in the Prior Year and Measurement Year, and that shall be calculated as set forth in Section 5 below.

2.11. **"Prior Year"** shall mean a calendar year that immediately precedes a Measurement Year.

2.12. **"Program Star Measure"** refers to the individual MA Star Measures that Blue Cross NC will use to assess Provider's performance under this policy during any Measurement Year and that appear in Schedule 1 to this policy.

2.13. **"Program Star Rating"** shall mean the Star Rating that Blue Cross NC assigns to Provider for an individual Program Star Measure for a Measurement Year based on Provider's performance during that Measurement Year.

2.14. **"Qualified Member"** shall mean a Blue Cross MA Member who had a visit with a Primary Care Provider in the applicable Provider's practice or health system in both the Measurement Year and the Prior Year.

2.15. **"Qualifying Provider"** (also referred to herein as "Provider") shall mean any practice or health system that, as of the March 15 cutoff of the applicable Measurement Year, has at least one

hundred (100) attributed Blue Cross NC MA Members based on visits to an affiliated Primary Care Physician of the practice or health system. For purposes of clarity, no practice or health system participating in any other quality incentive or value-based program with Blue Cross NC, either through policy or by separate agreement with Blue Cross NC, meets the definition of Qualifying Provider or Provider under the terms of this policy.

2.16. **"Requested Medical Chart"** shall mean a Medical Chart that Blue Cross NC requests from the Provider for an individual Blue Cross NC MA Member for a specific date of service or range of dates (e.g., January 1through December 31 of any applicable Measurement Period).

2.17. **"Timely Medical Chart"** shall mean a Requested Medical Chart that was supplied by Provider to Blue Cross NC in full within the timeframe set forth in "Chart Response" section of this policy.

3. MAQIP Reimbursement

3.1. For the applicable Measurement Year, Blue Cross NC will pay the Provider a fixed Per-Member-Per Year ("PMPY") fee for each Attributed Member who was attributed to Provider at the end of the Measurement Year (the "Quality Incentive Program Fee") as set forth in Section 3.2.

3.2. Blue Cross NC will determine the PMPY fee that will be used to calculate the Quality Incentive Program Fee for a Measurement Year using the following chart and based on the intersection of the Contract Star Rating and Risk Rating that Provider achieved for the applicable Measurement Year:

QUALITY INCENTIVE PROGRAM –PMPY						
	Contract Star Rating					
Risk Rating	2.5	3.0	3.5	4.0	4.5	5.0
Tier 1	$0.00	$50.00	$75.00	$150.00	$200.00	$250.00
Tier 2	$0.00	$25.00	$50.00	$125.00	$175.00	$225.00
Tier 3	$0.00	$0.00	$25.00	$100.00	$150.00	$200.00
Tier 4	$0.00	$0.00	$0.00	$75.00	$125.00	$175.00

For example, if Provider is assigned a Risk Rating of Tier 1 and a Star Rating of 4.5 for a Measurement Year, Blue Cross NC would reimburse Provider two hundred dollars ($200.00) PMPY for each Attributed Member that was attributed to Provider during the Measurement Year.

Blue Cross NC will calculate the final Risk Rating and Contract Star Rating for the Measurement Year no later than May 31 of the year immediately following the Measurement Year and will notify Provider of the results of such calculations and any resulting Quality Incentive Program Fee that Provider is owed no later than June 15 of the year immediately following the Measurement Year. If Provider believes that Blue Cross NC did not properly account for care gaps that were addressed during the Measurement Year and for which documentation had been supplied to Blue Cross NC by the applicable deadline, Provider shall have fifteen (15) calendar days to appeal the results and submit any relevant information to Blue Cross NC for consideration. During this appeal process, Blue Cross NC will not accept new electronic or paper records for the

Measurement Year that were not previously supplied to Blue Cross NC before the applicable deadline.

3.3. Any Quality Incentive Program Fee due to Provider under this policy and the MAQIP are in addition to any other fees due to the Provider under any other agreement (including any other attachments or addenda thereto), and will not reduce, modify, or offset any such fees.

4. CONTRACT STAR RATING

4.1. For each Measurement Year that Provider participates in the MAQIP under this policy, Blue Cross NC will assign Provider a Contract Star Rating based on Provider's overall performance on the Program Star Measures. Each Program Star Measure corresponds to a MA Star Measure used by CMS to assign Part C & D Star Ratings to MA Organizations and will be assessed by Blue Cross NC using the same standards and requirements that are used by CMS for the corresponding MA Star Measure.

4.2. The following measures are the 2021 Program Measures and the corresponding 2020 MA Star Measures from CMS.

4.3. For any applicable Measurement Year, Blue Cross NC will assess Provider's performance on each Program Star Measure using the cutpoints for the corresponding MA Star Measure published by CMS during the year immediately preceding the beginning of the Measurement Year. If cutpoints were not available in the year immediately preceding the beginning of the Measurement Year, the most recent cutpoints issued prior to that date will apply.

Program Star Measure	Corresponding 2020 MA Star Measure	Measure weight for 2021 MAQIP
Breast Cancer Screening	C01 – Breast Cancer Screening	1
Colorectal Cancer Screening	C02 – Colorectal Cancer Screening	1
Diabetes Care – Blood Sugar Controlled	C15 – Diabetes Care – Blood Sugar Controlled	3
Controlling Blood Pressure	DMC17 – Controlling Blood Pressure	1
Plan All-Cause Readmissions	C20 – Plan All-Cause Readmissions	0
Medication Adherence for Diabetes	D10 – Medication Adherence for Diabetes	3
Medication Adherence for Hypertension	D11 – Medication Adherence for Hypertension	3
Medication Adherence for Cholesterol	D12 – Medication Adherence for Cholesterol	3
Statin Use in Persons with Diabetes	D14 – Statin Use in Persons with Diabetes (SUPD)	1
Statin Therapy for Patients with Cardiovascular Disease	C21 – Statin Therapy for Patients with Cardiovascular Disease	1

4.4. Blue Cross NC will calculate the Contract Star Rating for each Measurement Year using the following methodology:

4.4.1. **STEP ONE**: Blue Cross NC will determine Provider's performance on each Program Star Measure using the applicable CMS Metric. For example, for the "Breast Cancer Screening" Program Star Rating Blue Cross NC would divide the number of Attributed Members who are female and between the ages of 50 and 74 by the number of those Attributed Members who had a mammogram to screen for breast cancer during the Measurement Year.

4.4.2. **STEP TWO**: Using the calculations from step one above, Blue Cross NC will assign a whole-number Program Star Rating of 1 – 5 for each Program Star Measurement based on cutpoints published by CMS during the year immediately preceding the beginning of Measurement Year.

4.4.3. **STEP THREE**: Blue Cross NC will multiply the Program Star Rating assigned to each Program Star Measure by the applicable Weighting Value for that Program Star Measure and sum the resulting values. This number will then serve as the numerator in the calculation performed in Step Five, below.

4.4.4. **STEP FOUR**: Blue Cross NC will sum the numerical value of the applicable Weighting Value for each Program Star Measure. This number will then serve as the denominator in the calculation performed in Step Five, below.

4.4.5. **STEP FIVE**: Blue Cross NC will divide the results of Step Three by the results of Step Four to determine the Provider's Contract Star Rating for the Measurement Year in question (any

fractional results will be rounded to the nearest half-star rating, i.e., 4.375 would round up to 4.5, 4.125 would round down to 4.0).

The following is a representative example of this calculation for demonstration purposes only:

A. <u>STEPS ONE (calculate performance on Provider Performance Metrics) & TWO (calculate points for each Provider Performance Metrics):</u>

Program Star Measure	Provider Performance Based on CMS Metric	Program Star Rating	Measure Weight
Rheumatoid Arthritis Management	91	5	1
Medication Adherence for Cholesterol	85	5	3
Plan All-Cause Readmissions (lower is better)	8	4	3
Statin Use in Persons with Diabetes	78	3	1

B. **<u>STEP THREE (calculate numerator for Contract Star Rating)</u>**:

(1*5) + (3*5) + (3*4) + (1*3) = 35

C. **<u>STEP FOUR (calculate denominator for Contract Star Rating)</u>**:

1 + 3 + 3 + 1 = 8

D. **<u>STEP FIVE (calculate Contract Star Rating)</u>**:

35 / 8 = 4.375 = Contract Star Rating of 4.5

5. RISK RATING

5.1. Risk Tier Assignment

5.1.1. For the Measurement Year, Blue Cross NC will assign Provider to one of four Risk Rating "tiers" (i.e., Tiers 1 – 4) based on Provider's performance on two metrics: Chart Response Rate and Coding Persistency Rate. Blue Cross NC will measure Provider's performance on each metric using the criteria set forth in Sections 5.2 and 5.3 below and will assign points based on such measurement in accordance with the applicable chart in each section. Based on the total number of points assigned to Provider for these two metrics for a Measurement Year, Blue Cross NC will assign Provider to a Risk Rating tier in accordance with the following chart:

Risk Rating	Total Points
Tier 1	14-17
Tier 2	11-13
Tier 3	8-10
Tier 4	0-7

5.2. Chart Response

5.2.1. Provision of Medical Charts

5.2.1.1. As part of its obligation under the terms of the MAQIP and this policy, Provider shall supply Blue Cross NC with all Requested Medical Chart within thirty (30) calendar days of receiving a request for such records from Blue Cross NC and/or a representative on behalf of Blue Cross NC.

5.2.1.2. If Provider is unable to supply Blue Cross NC with a complete copy of a Requested Medical Chart within the timeframe set forth above, Provider must respond to Blue Cross NC within fifteen (15) calendar days of receiving such request by either:

(a) delivering to Blue Cross NC those portions of the Requested Medical Chart that are available and providing an explanation of why the remaining portions of the Requested Medical Chart cannot be provided;

(b) acknowledging receipt of the request and providing a specific date by which the Requested Medical Chart will be delivered to Blue Cross NC;

(c) acknowledging receipt of the request and notifying Blue Cross NC of any additional information needed to process the request: or

(d) acknowledging receipt of the request and providing Blue Cross NC with an explanation of why the Requested Medical Chart cannot be provided.

5.2.2.Provision of Medical Charts – Governmental Audit

5.2.2.1. If Blue Cross NC receives a request from CMS or another governmental agency for information in connection with an audit or review related to the risk adjustment process ("Governmental Audit") that requires Blue Cross NC to produce Requested Medical Charts that correspond to services that Provider supplied to a Blue Cross NC MA Member, Provider must supply one hundred percent (100%) of the Requested Medical Charts that Blue Cross NC requests in connection with such audit or review within thirty (30) calendar days of receiving a request from Blue Cross NC.

5.2.2.2. If Provider fails to supply one hundred percent (100%) of the Requested Medical Charts requested by Blue Cross NC in connection with a Governmental Audit, Provider will be lowered one (1) Risk Rating "tier" for the applicable Measurement Year in which the request for the Requested Medical Charts was made by Blue Cross NC. For example, if a request from Blue Cross NC for Requested Medical Charts from Provider in connection with a Governmental Audit in the Measurement Year in which Provider would have otherwise been assigned to Risk Rating Tier 1, and Provider fails to return one hundred percent (100%) of those Requested Medical Charts to Blue Cross NC, Provider would be lowered from a Tier 1 to a Tier 2 Risk Rating for that Measurement Year.

5.2.3.Chart Response Rate

5.2.3.1. For an applicable Measurement Year, Blue Cross NC will calculate a Chart Response Rate based on the number of Requested Medical Charts that Provider supplied to Blue Cross NC within the required timeframe.

5.2.3.2. The Chart Response Rate will be calculated by dividing the number of Timely Medical Charts for the Measurement Year by the number of Requested Medical Charts for the Measurement Year. using the following formula:

$$Chart\ Response\ Rate = \frac{Timely\ Medical\ Charts}{Requested\ Medical\ Charts}$$

5.2.3.2.1. The denominator of this formula (the Requested Medical Charts) will be determined based on the total number of Requested Medical Charts from by Blue Cross NC to Provider during the Measurement Year.

5.2.3.2.2. The numerator of this formula (the Timely Medical Charts) will be determined based on the number of Requested Medical Charts that were supplied by Provider to Blue Cross NC within the required timeframe. Blue Cross NC will not include any Requested Medical Chart in the numerator of the formula that is not supplied to Blue Cross within the required timeframe.

5.2.4.Chart Response Rate Scoring

5.2.4.1. In determining the applicable Risk Rating tier for Provider, Blue Cross NC will assign Provider points based on the Chart Response Rate achieved for a Measurement Year using the following chart:

Chart Response Rate	Points

95% - 100%	4
85% - 94.9%	3
75% - 84.9%	2
65% - 74.9%	1
Below 65%	0

5.3. Coding Persistency

5.3.1. Coding of Chronic Conditions

5.3.1.1. Provider agrees to use commercially reasonable efforts to ensure that the Chronic Conditions for the Qualified Members who receive primary care services from a Primary Care Provider in Provider's practice or health system are consistently coded in the Measurement Year if a qualified health care provider applying his or her independent professional judgment and based on a face-to-face encounter during the Measurement Year determines that such individual suffers from such Chronic Condition.

5.3.1.2. Provider agrees to refrain from taking any action either directly or indirectly that would (or could be construed to) override or otherwise interfere with the independent professional judgment of a health care provider within Provider's practice or health system with respect to the diagnosis, documentation, or coding of a Chronic Condition.

5.3.1.3. Provider agrees that all Chronic Conditions that are reported on a claim submitted to Blue Cross NC in connection with this policy or the MAQIP are accurate and truthful, and resulted from a face-to-face encounter between a qualified health care provider and an Attributed Member.

5.3.2. Calculation of the Persistency Rate:

5.3.2.1. For any applicable Measurement Year, Blue Cross NC will calculate a Persistency Rate for Qualified Members.

5.3.2.2. The Persistency Rate will be calculated by dividing the number of Chronic Conditions for Qualified Members that are coded in the Prior Year into the number of Chronic Conditions for Qualified Members that are subsequently coded in the applicable Measurement Year using the following formula:

$$Persistency\ Rate = \frac{Measurement\ Year\ \ Chronic\ Conditions}{Prior\ Year\ \ Chronic\ Conditions}$$

5.3.2.2.1. The denominator of this formula (the Prior Year Chronic Conditions) will be determined by adding the total number of Chronic Conditions that were reported on a claim for a Qualified Member submitted during the Prior Year by an applicable Primary Care Provider.

5.3.2.2.2. The numerator of this formula (the Measurement Year Chronic Conditions) will be determined by adding the total number of Chronic Conditions that are reported on a risk adjustable claim for an Qualified Member who had a Prior Year Chronic Condition and that have a severity level that is either equal to or more severe than the code reported for that Chronic Condition for the same Qualified Member in the Prior Year. However, if the Prior Year Chronic Condition is a Chronic Condition with an acute element, a lower severity Measurement Year Chronic Condition will be accepted and included within the numerator of the Persistency Rate formula (e.g. "Diabetes with Acute Complications" will be recaptured with "Diabetes with No Complications").

5.3.2.2.3. On a monthly basis during a Measurement Year, Blue Cross NC will supply Provider with a report that contains preliminary information on how Provider is performing with respect to the Persistency Rate for the applicable Measurement Year.

5.3.2.2.4. The Provider has the right to question the status of any particular patient. Blue Cross NC and the Provider will work in good faith to resolve the differences.

5.3.3. Persistency Rate Scoring

5.3.3.1. For the purposes of determining the applicable Risk Rating tier for Provider, Blue Cross NC will assign Providers point based on the Persistency Rate achieved for the applicable Measurement Year using the following chart:

Persistency Rate	Points
90% - 100%	14
85% - 89.9%	10
80% - 84.9%	7
75% - 79.9%	4
Below 75%	0

6. Data Exchange

6.1. Provider agrees to supply all Requested Medical Charts (paper records) to Blue Cross NC for the applicable Measurement Year no later than November 15 of the Measurement Year.

6.2. All Requested Medical Charts will be supplied to Blue Cross NC by Provider at no cost to Blue Cross NC.

6.3. To the extent that Requested Medical Charts are stored electronically in an electronic health record or other electronic system (collectively "EHR") by Provider, Provider must provide Blue Cross NC such Requested Medical Charts through a final data extract from such EHR in Blue Cross NC's standard EHR extract format no later than February 5 of the year immediately following the applicable Measurement Year. Provider must send to Blue Cross NC the first EHR test file no later than June 7 of the applicable Measurement Year and the first production file no later than August 2 of the applicable Measurement Year. Provider otherwise must supply medical records to satisfy

Blue Cross NC requests for Requested Medical Charts in BlueCross NC standard EHR format. If Provider supplies Blue Cross NC with a Requested Medical Chart as part of an EHR extract and Blue Cross NC requires an additional copy of such Requested Medical Chart in a non-EHR format, Provider agrees to supply Blue Cross NC with that additional copy of the Requested Medical Chart within the timeframes above.

6.4. Provider shall agree to one (1) of the following: a) furnish Blue Cross NC the details and credentials to the Provider's secure FTP server or b) agree to use existing Blue Cross NC MFT portal.

6.4.1. By agreeing to one (1) of the above scenarios Blue Cross NC will have the ability to transfer files containing member data back to the Provider relating to EHR data (i.e., error reports, performance reports, etc.).

7. Attribution

7.1. Attribution identifies the target population of patients and Members under the care of Provider. A Provider's pool of Attributed Members identifies the Blue Cross NC Members for whom the Provider may receive an incentive payment under the MAQIP program, if certain requirements under this policy are satisfied. A Member is an Attributed Member for Provider if that Member meets the applicable attribution criteria herein for the applicable Measurement Year.

7.2. Eligibility for Attribution

7.2.1. A Member is eligible to become an Attributed Member for the Provider if the Member is actively enrolled in a Blue Cross NC MA health plan;

7.3. Attribution Criteria

7.3.1. Members that meet all the following criteria will be attributed to a Provider and will become part of Provider's population of Attributed Members for purposes of evaluating performance under the MAQIP and this policy:

7.3.2. The Member has met the eligibility criteria outlined in Section 7.2 above, and

7.3.2.1. The Member self-selects a PCP associated with the Provider, or

7.3.2.2. The Member did not self-select a PCP during the initial enrollment period by the policy effective date of coverage and is assigned by Blue Cross NC to a PCP affiliated with the Provider. Blue Cross NC uses the following hierarchy for auto-assignments:

- The Member will be assigned to the first PCP (and therefore, Provider) identified within the Member's zip code.
- If **no** PCP (and therefore, no Provider) is identified within the Member's zip code, Blue Cross NC will contact the Member to select a PCP.
- If Blue Cross NC is unable reach the Member, Blue Cross NC will assign a PCP (and therefore, Provider) and will notify the Member of this assignment.

7.4. Attribution Period

7.4.1. The period during which a Member is attributed to a specific Provider ("Attribution Period") begins on the first day of the first month after the month in which the Member self-selects a PCP associated with a Provider, is assigned to such a PCP, or otherwise satisfies applicable attribution criteria. The Attribution Period ends on the last day of the month in which the Member self-selects a PCP that is not associated with the Provider or otherwise fails to satisfy the attribution criteria set forth above. For example, if a Member self-selects a PCP associated with a Provider on March 3rd, the Member would be attributed to the Provider for purposes of MAQIP on April 1st.

7.4.2. Members may select a new PCP at any time during a Measurement Year. MAQIP quality performance calculations will be based on attribution at the end of the Measurement Year.

EFFECTIVE DATE: January 1, 2021