Clover

2018 Provider Quality Incentive Program Guidelines

Introduction

Thank you for your participation in the Clover Physician Quality Incentive Program which includes the Clinical Quality Initiative, and Partners for Care (collectively, the "**Clover Physician Quality Incentive Program"** or the "**Program**"). At Clover, we believe that working closely with physicians like you results in our members—your patients—receiving the best possible care. Below you will find the criteria applicable to each incentive program that is part of the Clover Physician Quality Incentive Program.

These 2018 Provider Quality Incentive Program Guidelines (the "**Guidelines"**) are effective as of January 1, 2018 and shall remain in effect until either (a) the Quality Amendment is terminated, or (b) they are revised by new guidelines. Clover reserves the right to make periodic edits to these Guidelines. Notice of any changes to the Guidelines will be communicated electronically 60 days prior to the effective date of the new guidelines. You may opt-out of participating in the Clover Physician Quality Incentive Program as set-out in the Quality Amendment.

Program Overview

As part of the Physician Quality Incentive Program and in exchange for the quality payments set forth in these Guidelines, you agree to provide quality care management of Clover members and coordinate their care across the healthcare continuum in accordance with these Guidelines. Participating in the Program will require providers to meet with Clover as requested, but no more than once per week, regarding progress towards satisfying the Quality Measures set-out in Appendix A.

Member Attribution

Members will be attributed to a Participating Provider (as defined in the **Amended and Restated Addendum)**, and thereby eligible to be included for purposes of calculating quality payments as follows:

- Performance Year Attribution: Any member that Clover determines (via claims data) has received Evaluation and Management, or Wellness Visit Services from a Participating Provider in a given quarter will be attributed to that provider. Attribution will be effective in the quarter in which a member visits a provider office and will continue for the remainder of the year (subject to the payment provisions below).

- Attribution Exclusion: Clover will exclude from attribution any member that has been prescribed medications for the treatment of Diabetes, Hypertension or Cholesterol, but was not prescribed such medication by the provider who performed the Evaluation and Management or Wellness Visit (i.e. these medications are prescribed and managed by a third party physician).
- Overlap: In the event a member is attributed to more than one provider (e.g., a Participating Provider and a third-party provider), Clover and the provider agree to mutually determine which is the provider responsible for the completion of the Quality Measures described

Quality Payments

Clover will pay Participating Providers the per member amounts set forth below

Clover Quality Initiative

- Twenty-five dollars ($25) per quarter for each member attributed to a Participating Provider by Clover in a given quarter for which a provider completes between 80 to 99% of the Quality Measures (set-out in Appendix A) that are applicable to a given Member and fifty dollars ($50) per quarter for each member attributed to a provider by Clover in a given quarter for which a provider completes 100% of any of the Quality Measures applicable to a given member

Partners for Care

- Seventy-five dollars ($75) per quarter for each member attributed to a Participating Provider by Clover in a given quarter for which a provider completes between 80 to 99% of the Quality Measures applicable to a given Member and one hundred dollars ($100) per quarter for each member attributed to a provider by Clover in a given quarter for which a provider completes 100% of any of the Quality Measures applicable to a given member
- Participating providers must agree to accept payment for evaluation and management (CPT 9920x and 9921x) and annual wellness visit (CPT G0438 and G0439) services at a rate of 75 % of the Medicare Allowable rate applicable to the geographic area in which the Covered Service is rendered, as of the date Covered Services are rendered, less Member Expenses (as defined in the PSA).

Chronic Condition Bonus

- For both the Clinical Quality Initiative and Partners for Care programs Clover will make an additional payment of $25 per quarter for each member attributed to a Participating Provider by Clover in a given quarter for the management of Members who are identified as having four (4) or more of the specific chronic conditions set forth below; provided that the provider has, to Clover's satisfaction, accurately diagnosed, confirmed and is managing the chronic condition(s).

- Chronic conditions for which Clover will reimburse providers are as follows:
    - Chronic Obstructive Pulmonary Disease
    - Congestive Heart Failure
    - Diabetes with Complications (counts as 2 conditions)
    - Diabetes without complication
    - Stroke
    - Peripheral Vascular Disease
    - Myocardial Infarction
    - Atrial Fibrillation
    - Chronic Kidney Disease
    - Asthma
    - Hypertension
    - Morbid Obesity
    - Rheumatoid Arthritis
- Confirmation of chronic conditions requires documentation during a 2018 face-to face encounter with a specified treatment plan (documentation from 2017 or earlier is not valid).

Payment

- Providers must also complete and return to Clover appropriate documentation demonstrating the fulfillment of such Quality Measures, as specified by us.
- Quality payments will be calculated by Clover based on all of the data submitted by a provider in a given quarter, inclusive of the last day in a given quarter.
- Clover will calculate and remit payment to the provider within sixty calendar days after the last day of the quarter in which the quality payments were earned. Program enrollment (and hence subsequent payment) will begin in the quarter following execution of the Agreement.
- Payments are paid directly to the group practice. The group practice is responsible for distributing payments to providers.
- In the event a member is attributed to more than one Participating Provider in a group practice, Clover will remit payment to the Participating Provider for whom the member last had an evaluation and management (CPT 9920x and 9921x) or annual wellness visit with.

Progress Reports

Clover will provide Participating Providers financial and quality reporting monthly, beginning within ninety (90) days after the Effective Date, Such report shall include but is not limited to financial information detailing calculations of quality payments and quality measures completed.

APPENDIX A

Clinical Quality Initiative and Partners for Care Quality Measures

Measure	**Eligible Population**	**Requirement**	**Allowed data sources to satisfy measure requirement** (a minimum of one allowed source is required to satisfy each measure)
Breast cancer screening	Female members 52-74	Mammogram performed every two years	• Claim for mammogram
Colorectal cancer screening	Members 50-75	Colonoscopy every ten years; OR Sigmoidoscopy every 5 years; OR FOBT performed annually	• Claim for colonoscopy/sigmoidoscopy/FOBT • Colonoscopy/sigmoidoscopy/FOBT procedure and date performed recorded in chart
Adult BMI Assessment	Members 18-74	BMI calculated annually	• Claim for documented BMI • Value recorded in chart
Diabetes - Eye exam	Members with Diabetes	Exam performed by eye care provider Annually if screening is positive for retinopathy; OR Every two years if negative for retinopathy or if result is unknown	• Claim for eye exam procedure, date performed, and result recorded in chart • While a claim indicates the

			exam has occurred, the positive or negative finding for retinopathy may only be submitted via the chart. If the chart is missing or does not contain this information, the retinopathy finding is unknown.
Diabetes - Kidney disease monitoring	Members with Diabetes	Urine protein test performed OR treatment with ACE or ARB therapy OR visit with a nephrologist, once per year	• Claim for microalbumin test/visit with nephrologist/ACE or ARB prescription • Microalbumin test recorded in chart • Microalbumin result from integration with laboratory
Diabetes - HbA1c under <9%	Members with Diabetes	HbA1c performed with results <9% If the test is performed multiple times during the year, only the result from the most recent test can satisfy the measure requirement.	• Lab result value from chart • Lab result value from integration with performing laboratory

Controlling blood pressure	Members 60-85	Blood pressure is controlled (<140/90 for diabetics or <150/90 for non-diabetics). If blood pressure is recorded in an outpatient setting multiple times during the year, only the measurement from the most recent recording can satisfy the measure requirement.	• Blood pressure values recorded in chart
Rheumatoid Arthritis	Members with Rheumatoid Arthritis	2018 fill for a DMARD	• Pharmacy claim for DMARD
Medication Adherence - Diabetes	Members with medications for Diabetes	Ongoing adherence (95%) or a 90+ day script is filled	• Pharmacy claim for diabetes medication
Medication Adherence - Hypertension (RAS antagonists)	Members with medication for Hypertension	Ongoing adherence (95%) or a 90+ day script is filled	• Pharmacy claim for hypertension medication
Medication Adherence - Cholesterol (statins)	Members who are on medications for Hypercholesterolemia	Ongoing adherence or a (95%) 90+ day script is filled	• Pharmacy claim for cholesterol lowering medication