Informational Purposes Only: Email Jennifer.Moorman@MolinaHealthcare.com for your patient list.

Molina Healthcare of Utah, Inc. DBA Molina Healthcare of Idaho

2024 Pay-For-Quality Gap Closure Bonus Program

I. P4C Bonus Program Overview.

Molina Healthcare of Utah, Inc. DBA Molina Healthcare of Idaho ("Health Plan") is committed to supporting primary care providers' ("PCPs"), and specialists serving as PCPs, efforts to provide the highest quality of care for Health Plan Members.

Health Plan's Pay-for-Quality Gap Closure Bonus Program ("P4C Program") is a quality bonus payment program that recognizes Eligible Providers who demonstrate the best quality of care for Health Plan Medicare Advantage P4C Program Members ("P4C Program Members"). This P4C Program is being implemented during the Contract Year in accordance with the provision in your Provider Services Agreement ("Agreement") titled "Quality Bonus Payment Program" or equivalent section thereof. All provisions in the Agreement will apply. If there is a conflict between this P4C Program and any other provision in the Agreement, the provisions in the P4C Program will control for the P4C Program.

The objective of this P4C Program is to reward Eligible Providers for their efforts in providing high-quality care to P4C Program Members to close quality care gaps and support optimal care coordination and treatment planning and show improved quality outcomes for Health Plan Members. Our P4C Program Members benefit from this P4C Program by receiving more regular and proactive assessments which help ensure proper care and care management.

The P4C Program achieves these goals by rewarding Eligible Providers based on their performance on the Quality Measures listed in Tables 1-3.

The Quality Measures are consistent with Contract Year NCQA, HEDIS®, and/or CMS national quality performance standards, as applicable.

II. Definitions.

Capitalized terms used in this P4C Program will have the same meaning ascribed to them in the Agreement unless otherwise set forth in this P4C Program.

A. **Administrative Data** means healthcare data captured in industry standard, structured formats such as claims data, inclusive of Current Procedural Terminology ("CPT") II and Social Determinant of Health ("SDOH") Z codes, encounters, or relevant clinical documents shared in Clinical Document Architecture ("CDA"), Continuity of Care Document ("CCD"), or Consolidated Clinical Data Architecture ("CCDA") format.
B. **Applicable Member** means an Assigned Member that meets the inclusion criteria (including but not limited to that the service is appropriate and Medically Necessary) for a specific Quality Measure during the Measurement Period.

C. **Assigned Member** means a Health Plan Medicare Advantage Member who is attributed by Health Plan to an Eligible Provider, either by assignment or selection, during the Contract Year.
D. **Bonus** means a bonus payment an Eligible Provider may be eligible to receive if the P4C Program requirements are met and Eligible Provider achieves the Quality Measure. A bonus will be paid for each Quality Measure that the Eligible Provider qualifies for during the Measurement Period.
E. **Contract Year** means the twelve (12) calendar month length of time between January 1, 2024 through December 31, 2024.
F. **Eligible Provider** means the assigned primary care provider ("PCP"), or specialist serving as a PCP for a P4C Program Member, who has an active Agreement with Health Plan. PCP's who are in practice together using the same tax identification number with an active Agreement with Health Plan are considered a PCP group and Eligible Providers.
G. **Government Agency** means the government authority such as Centers for Medicare & Medicaid Services ("CMS"), a State Medicaid Agency, State Department of Health, United States Department of Health and Human Services ("HHS"), or equivalent that presides over the administration and financing of a Product.
H. **HEDIS®** means the Healthcare Effectiveness Data and Information Set.
I. **Measurement Period** means September 1, 2024, through December 31, 2024, and is the time period for which Quality Measures for applicable P4C Program Members will be evaluated and each Bonus payment calculation is performed and processed by Health Plan.
J. **NCQA** means the National Committee for Quality Assurance.
K. **P4C Program Member** means an Assigned Member enrolled with the Health Plan, is linked through assignment or attribution to an Eligible Provider and qualifies for one or more Quality Measures during the Measurement Period.
L. Quality Measure means the quality care gap measures that are being evaluated during the Measurement Period as part of the P4C Program and that are listed in Table 1.

III. General Guidelines to be an Eligible Provider.

In addition to the definition of Eligible Provider, the Eligible Provider must meet the following requirements to be considered an Eligible Provider:

A. PCPs must be the assigned Eligible Provider for P4C Program Members included in the P4C Program.

B. To remain eligible for any Bonus payment under the P4C Program, Eligible Provider must have an active Agreement with Health Plan, be in compliance with their Agreement and be a Participating Provider with Health Plan at the time the Bonus under the P4C Program is issued to Eligible Provider, as determined by Health Plan.

IV. Health Plan Responsibilities.

A. Health Plan will supply Eligible Provider with a Medicare Comprehensive Care Gap Report with open quality care gaps of their Assigned Members related to the Quality Measures listed in Table 1. Health Plan will use best efforts to provide the

Comprehensive Care Gap Report to Eligible Provider within one (1) week of the start of the Measurement Period.

B. Health Plan will verify closed quality care gaps and use best efforts to provide an interim report to Eligible Provider no later than March 31, 2025. Eligible Provider will have thirty (30) days to review the interim report for accuracy and respond within said thirty (30) days from date of receipt of the interim report. If Health Plan does not receive a response within thirty (30) days, the interim report will be presumed accurate. Health Plan will subsequently issue a Final Report and any earned Bonus will be issued no later than May 31, 2025.

C. Eligible Provider will send evidence of quality care gap closures with dates of service ("DOS") during the Measurement Period to Health Plan via Administrative Data or other means accepted by Health Plan. Health Plan may pay Eligible Provider a Bonus for closing quality care needs as defined on the Medicare Comprehensive Care Gap Report specific to Eligible Provider and based on Eligible Provider's Applicable Members and Quality Measure performance results, using DOS during the Measurement Period, and also based on timely submission of Administrative Data, supplemental data files and/or other acceptable information to Health Plan.

D. The Parties acknowledge future Laws may require changes to the P4C Program. Additionally, changes to the P4C Program may be required by a Government Agency. If a change occurs, Health Plan agrees to provide notice of the change to Eligible Provider. Health Plan will use best efforts to minimize the impact of the change to the P4C Program.

V. Eligible Provider Responsibilities and Payment.

A. Eligible Providers will be eligible to earn a Bonus for each Quality Measure if: (1) Eligible Provider completes all actions, achieves requirements and specifications and then timely submits the required evidence for the Quality Measure, as set forth in Tables 1-3; and (2) all other requirements of the P4C Program are met. Eligible Provider will be paid for each Quality Measure they achieve for each Applicable Member.

B. Each Quality Measure is evaluated independently. For each quality gap that is closed and verified, the Health Plan will reimburse Eligible Provider per Quality Measure as listed in Table 1. Eligible Providers may be paid one Bonus for each Quality Measure for an Applicable Member, as set forth in Tables 2-3.

C. All HEDIS® Quality Measures follow the Contract Year HEDIS® technical specifications and requirements. All CMS Quality Measures follow the Contract Year CMS technical specifications and requirements.

D. Additionally, Eligible Provider will submit evidence of the quality gap closure to Health Plan, as listed in Tables 2-3. Specific actions and administrative requirements are listed in Tables 2-3.

E. Eligible Provider must submit Administrative Data, supplemental data files, medical records or other applicable information within thirty (30) days of the DOS, but in no event later than January 12, 2024. If providing evidence of gap closure to Health Plan

via supplemental data file(s), Eligible Provider is required to submit the last supplemental data file(s) no later than March 1, 2024. Eligible Provider recognizes and agrees that untimely submitted Administrative Data may be excluded from the Measurement Period P4C Program and its calculations, at Health Plan's sole discretion.

F. Health Plan may request additional documentation such as medical records if unable to verify information for Applicable Members using Administrative Data.

G. Data Sharing.

a. Eligible Provider shall deliver all relevant clinical documents electronically in a format stated in the Provider Manual or otherwise agreed to by Health Plan. This includes but is not limited to: Direct Remote EMR access, supplemental data files, CCDA files, sharing medical records information, and/or other data sharing methods for clinical quality information as agreed to.

b. Eligible Provider will participate in Health Plan's program to communicate clinical information using the format stated in the Provider Manual or otherwise agreed to by Health Plan.

c. Eligible Provider's mechanism for exchanging health information will comply with the Health Insurance Portability and Accountability Act ("HIPAA") and will be approved by the Office of the National Coordination of Health Information Technology ("ONC").

H. Earned Bonuses are paid to the Eligible Provider that is on record as the assigned provider for the P4C Program Member as of the end of the Measurement Period.

I. Earned Bonus payments will be made based on the current Tax ID information on file for the Eligible Provider. Per the Agreement, it is the Eligible Provider's responsibility to ensure that W-9 information is current with Health Plan prior to any Bonus payment distribution.

J. P4C Program Members are identified at the beginning of the Measurement Period and P4C Program Members are subject to change in future programs.

K. Eligible Provider shall only earn a Bonus for the provision of an appropriate and Medically Necessary service.

VI. Additional Conditions.

Additional conditions for Eligible Provider to receive a payment under this P4C Program are:

A. If Eligible Provider wishes to not participate in the P4C Program, Eligible Provider must notify Health Plan within thirty (30) days of receipt of this P4C Program.

~~**B.**~~ The P4C Program may be modified or canceled at any time and for any reason by Health Plan. Health Plan will have sole discretion in determining whether the P4C Program requirements are satisfied and the earned Bonus will be made solely at Health Plan's discretion. There is no right to appeal any decision made in connection with this P4C Program.

C. Eligible Provider's Agreement with Health Plan must have an effective date before the start of the P4C Measurement Period and remain active as of the end of the P4C Measurement Period and at the time any earned Bonus is distributed.

D. Any Bonus earned through this P4C Program will be in addition to the compensation arrangement set forth in Eligible Provider's Agreement, as well as any other Health Plan bonus program in which Eligible Provider may participate. At Health Plan's discretion, Eligible Providers who have a contractual or other quality arrangement with Health Plan, either directly or through another agreement, may be excluded from participation in this P4C program. For the avoidance of doubt, in no event will Eligible Provider be compensated twice for performing the same services and Eligible Provider will choose which quality program to participate in.

E. Health Plan reserves the right to fully or partially withhold the payment of any Bonus that may have otherwise been paid to Eligible Provider to the extent such Eligible Provider has received or retained an Overpayment, including any money to which Eligible Provider is not entitled. In the event Health Plan determines that Eligible Provider has received an Overpayment, Health Plan may offset any Bonus that may have otherwise been paid to Eligible Provider against the Overpayment, pursuant to the Offset provision or equivalent section(s) thereof, in the Agreement.

F. Quality Measure performance results must be substantiated by qualifying Current Procedural Terminology ("CPT") and International Classification of Diseases, Tenth Revision ("ICD-10") codes as defined by Contract Year HEDIS® and/or CMS technical specifications and requirements.

G. Legislation Regulating Provider Risk. Health Plan will comply with any applicable requirements under 42 C.F.R. § 422.208, 42 C.F.R. § 422.210 and any applicable state Laws. Notwithstanding any other provision in this Amendment, in no event will a Bonus be computed for an Eligible Provider which exceeds the amount that will be considered "Substantial Financial Risk" under 42 C.F.R. § 422.208, if the Eligible Provider is considered a physician or physician group under 42 C.F.R. § 422.208. Health Plan is not aware of any Laws, Government Program Requirements, administrative rulings or other position statements from applicable regulatory agencies that would subject Eligible Provider to insurance obligations for activities related to this P4C Program.

H. No Inducement to Reduce or Limit Medically Necessary Services. The terms in this P4C Program do not reduce or limit Medically Necessary Covered Services to any Member. This P4C Program does not provide incentives, monetary or otherwise, for withholding Medically Necessary Covered Services. If it is determined that Eligible Provider has reduced or limited Medically Necessary Covered Services to any Member, Eligible Provider will not be eligible to receive any Bonus under this P4C Program.

I. No Further Incentive Compensation. Except as provided herein, Eligible Provider may not seek additional reimbursement from a federal government program for the quality incentives covered herein.

Table 1: Quality Measures and Bonus Amounts

Quality Measure Name	Bonus Paid for each Quality Measure Achieved. *Refer to Tables 2 and 3 below for specifications and requirements.
Breast Cancer Screening ("BCS")	$100.00
Colorectal Cancer Screening ("COL")	$100.00
Eye Exams for Patients with Diabetes ("EED")	$100.00
Hemoglobin A1c Control for Patients with Diabetes (HbA1c ≤ 9.0) ("HBD")	$100.00
Controlling Blood Pressure (< 140/90 mm Hg) for Patients with Hypertension ("CBP")	$150.00
Statin Therapy for Patients with Cardiovascular Disease ("SPC")	$100.00
Statin Use for Persons with Diabetes ("SUPD")	$100.00
Medication Adherence for Diabetes Medications: 90-day Script ("MedAdh-Diab")	$75.00
Medication Adherence for Hypertension (RAS Antagonists): 90-day Script ("MedAdh-HTN)	$75.00
Medication Adherence for Cholesterol (Statins): 90-day Script ("MedAdh-Chol")	$75.00
Annual Preventive Visit ("APV")	$100.00

Table 2: Actions, Specifications and Evidence Required by Eligible Provider

Quality Measure Name	Actions and Specifications for Quality Measures (all quality care gaps must be closed during the stated relevant dates)	Evidence Required to earn a Bonus per Quality Measure
Breast Cancer Screening ("BCS")	Refer Applicable Member to imaging center. Follow up if mammogram isn't completed within one (1) month of Eligible Provider's referral. HEDIS measure assesses women aged 50-74 who had at least one mammogram to screen for breast cancer within the past two years.	• Submission of Administrative Data and/or medical record supporting evidence of completed mammogram, including date of completion and result (per specifications).

Quality Measure Name	Actions and Specifications for Quality Measures (all quality care gaps must be closed during the stated relevant dates)	Evidence Required to earn a Bonus per Quality Measure
	For the purpose of this P4C Program, completed and acceptable mammograms will include DOS from 09/01/2022 through 12/31/2024.	• Submission of Administrative Data and/or medical record within incentive timeframe showing evidence of referral and evidence of completed screening within Measurement Period.
Colorectal Cancer Screening ("COL")	Compliant colorectal cancer screening tools: 1. FOBT/FITs, 2. Flexible sigmoidoscopy, 3. Colonoscopy, 4. CT Colonography, 5. Stool DNA with FIT. If Applicable Member has completed a screening within acceptable time frames, submit evidence of screening to Health Plan's HEDIS Operations or submit the most correct CPT, HCPS, ICD-10, LOINC or SNOWMED code. Acceptable timeframes: 1. FIT/FOBT: completed during Measurement Period. 2. Flexible sigmoidoscopy: completed during Measurement Period or 4 years prior to Measurement Period. 3. Colonoscopy: completed during Measurement Period or 9 years prior to Measurement Period. 4. CT Colonography: completed during the Measurement Period or 4 years prior to Measurement Period. 5. Stool DNA with FIT: completed during the Measurement Period	• Submission of Administrative Data and/or medical record supporting evidence of completed Colorectal Cancer Screening, including date, type, and result (per specifications). • Submission of evidence of referral (medical record) AND evidence of completed screening within stated timeframe (Administrative Data or medical record).

Quality Measure Name	Actions and Specifications for Quality Measures (all quality care gaps must be closed during the stated relevant dates)	Evidence Required to earn a Bonus per Quality Measure
	or 2 years prior to the Measurement Period.	
Eye Exams for Patients with Diabetes ("EED")	Applicable Member must have completed a retinal or dilated eye exam or bilateral eye enucleation (exam performed by an eye care provider) during the Measurement Period.	• Eligible Provider is required to provide Health Plan of evidence of referral (Administrative Data or medical record) or evidence of completed test (Administrative Data or medical record). • Applicable Member must complete qualifying eye exam screening within the Measurement Period.
Hemoglobin A1c Control for Patients with Diabetes (HbA1c ≤ 9.0) ("HBD")	Applicable Member's most recent HbA1c test must be ≤ 9.0 to be considered in control.	• Eligible Provider is required provide Health Plan of evidence of referral (Administrative Data or medical record) or evidence of completed test with HgA1c in control (≤ 9.0) (Administrative Data or medical record). • Applicable Member's last A1c of Measurement Period must be ≤ 9.0.
Controlling Blood Pressure (< 140/90 mm Hg) for	Applicable Member's most recent blood pressure reading must be < 140/90 mm Hg to be considered controlled. If Administrative Data or medical	• Eligible Provider is required provide Health Plan evidence of blood pressure reading of < 140/90

Quality Measure Name	Actions and Specifications for Quality Measures (all quality care gaps must be closed during the stated relevant dates)	Evidence Required to earn a Bonus per Quality Measure
Patients with Hypertension (“CBP”)	record indicates multiple blood pressure readings on the same date of service, the lowest systolic and the lowest diastolic reading will be used as the representative blood pressure.	mm Hg (Administrative Data or medical record). • Applicable Member’s last representative blood pressure of Measurement Period must be < 140/90 mm Hg.
Statin Therapy for Patients with Cardiovascular Disease (“SPC”)	Applicable Member was dispensed at least one high-intensity or moderate-intensity statin medication.	• Eligible Provider is required to submit evidence of prescribing of a high-intensity or moderate-intensity statin (Administrative Data or medical record). • Applicable Member must be dispensed qualifying statin based on Administrative Data or pharmacy claims paid by Health Plan.
Statin Use for Persons with Diabetes (“SUPD”)	Applicable Member was dispensed at least one statin medication.	• Eligible Provider is required to submit evidence of a prescription for a statin (Administrative Data or medical record); and • Applicable Member must be dispensed qualifying statin based on Administrative Data or pharmacy claims paid by Health Plan.

Quality Measure Name	Actions and Specifications for Quality Measures (all quality care gaps must be closed during the stated relevant dates)	Evidence Required to earn a Bonus per Quality Measure
Medication Adherence for Diabetes Medications: 90-day Script ("MedAdh-Diab")	Applicable Member prescribed a 90-day prescription for diabetes medications (e.g., Glimepiride, Glipizide, Metformin, Pioglitazone) and dispensed a 90-day fill based on pharmacy claims paid by Health Plan.	• Provider required to submit evidence of a prescription (Administrative Data or medical record) for diabetes medications (Glimepiride, Glipizide, Metformin, Pioglitazone) for 90 days; and • Applicable Member must be dispensed 90-day fill of qualifying medication based on Administrative Data or pharmacy claims paid by Health Plan.
Medication Adherence for Hypertension (RAS Antagonists): 90-day Script ("MedAdh – HTN")	Applicable Member prescribed a 90-day prescription for RAS Antagonists (e.g., Benazepril, Lisinopril, Valsartan/HCTZ, Ramipril) and dispensed a 90-day fill based on pharmacy claims paid by Health Plan.	• Provider required to submit evidence of a prescription (Administrative Data or medical record) for RAS Antagonists (Benazepril, Lisinopril, Valsartan/HCTZ, Ramipril) for 90 days; and • Applicable Member must be dispensed 90-day fill of qualifying medication based on Administrative Data or pharmacy claims paid by Health Plan.
Medication Adherence for Cholesterol (Statins): 90-day Script	Applicable Member prescribed a 90-day prescription for a statin for Cholesterol management (e.g., Atorvastatin, Pravastatin, Simvastatin) and dispensed a 90-	• Eligible Provider is required to submit evidence of a prescription (Administrative Data

Quality Measure Name	Actions and Specifications for Quality Measures (all quality care gaps must be closed during the stated relevant dates)	Evidence Required to earn a Bonus per Quality Measure
("MedAdh-Chol")	day fill based on pharmacy claims paid by Health Plan.	or medical record) for a statin for Cholesterol management (Atorvastatin, Pravastatin, Simvastatin) for 90 days; and • Applicable Member must be dispensed 90-day fill of qualifying medication based on Administrative Data or pharmacy claims paid by Health Plan.
Annual Preventive Visit ("APV")	Applicable Member must complete an Annual Preventive Visit once every 12 months, DOS completed during the Measurement Period Annual Preventive Visits can be Annual Wellness Visits ("AWV") or annual physicals. • Annual Wellness Visits: Typically for Medicare beneficiaries: https://www.medicare.gov/coverage/yearly-wellness-visits • Annual Physical: Head-to-toe assessment which may include labs, physical tests, and vaccinations in addition to discussing medical and family histories, current and historical conditions, reviewing medications, addressing any concerns, address care gaps, and	• Eligible Provider must submit Administrative Data using appropriate CPT-10 or G code for IPPE, Annual Physical or AWV, or submit the medical record for the visit or EMR for verification.

Quality Measure Name	Actions and Specifications for Quality Measures (all quality care gaps must be closed during the stated relevant dates)	Evidence Required to earn a Bonus per Quality Measure
	creating or updating care plans.	

Table 3: Bonus Reimbursement Requirements

Quality Measure Name	Reimbursement Requirement
Breast Cancer Screening ("BCS")	Health Plan will only pay for 1 mammogram completed by Applicable Member during the time frame listed in Table 2. Required Eligible Provider activity: submit evidence of referral or completion of mammogram (Administrative Data or medical record).
Colorectal Cancer Screening ("COL")	Health Plan will only pay for 1 appropriate colorectal cancer screening completed by Applicable Member during the time frame listed in Table 2. Required Eligible Provider activity: submit evidence of referral or completion of screening (Administrative Data or medical record).
Eye Exams for Patients with Diabetes ("EED")	Health Plan will only pay for 1 appropriate exam completed by Applicable Member during the Measurement Period. Required Eligible Provider activity: submit evidence of referral or completion of screening (Administrative Data or medical record).
Hemoglobin A1c Control for Patients with Diabetes (HbA1c ≤ 9.0) ("HBD")	Health Plan will only pay Bonus if Applicable Member's most recent A1c is ≤ 9.0. Required Eligible Provider activity: submit evidence of A1c results (Administrative Data or medical record).

Quality Measure Name	Reimbursement Requirement
Controlling Blood Pressure (< 140/90 mm Hg) for Patients with Hypertension ("CBP")	Health Plan will only pay Bonus if Applicable Member's most recent BP is <140/90 mm Hg. Required Eligible Provider activity: submit evidence of BP reading (Administrative Data or medical record).
Statin Therapy for Patients with Cardiovascular Disease ("SPC")	Health Plan will only pay Bonus if Applicable Member is dispensed an appropriate statin. Health Plan will pay only 1 Bonus per Applicable Member. Required Eligible Provider activity: submit evidence of a 90-day prescription and dispensing of a 90-day supply of appropriate statin.
Statin Use for Persons with Diabetes ("SUPD")	Health Plan will only pay Bonus if Applicable Member is dispensed an appropriate statin. Health Plan will pay only 1 payment per Applicable Member. Required Eligible Provider activity: submit evidence of a 90-day prescription and dispensing of a 90-day supply of appropriate statin.
Medication Adherence for Diabetes Medications: 90-day Script ("MedAdh-Diab")	Health Plan will only pay Bonus if Applicable Member is dispensed an appropriate medication with a 90-day fill. Health Plan will pay only 1 payment per Applicable Member. Required Eligible Provider activity: submit evidence of a 90-day prescription. There must also be dispensing of a 90-day supply of the appropriate medication.
Medication Adherence for Hypertension (RAS Antagonists): 90-day Script ("MedAdh-HTN)	Health Plan will only pay Bonus if Applicable Member is dispensed an appropriate medication with a 90-day fill. Health Plan will pay only 1 payment per Applicable Member. Required Eligible Provider activity: submit evidence of a 90-day prescription. There must also be dispensing of the 90-day supply of the appropriate medication.
Medication Adherence for Cholesterol (Statins): 90-day Script ("MedAdh-Chol")	Health Plan will only pay Bonus if Applicable Member is dispensed an appropriate medication with a 90-day fill. Health Plan will pay only 1 payment per Applicable Member.

Quality Measure Name	Reimbursement Requirement
	Required Eligible Provider activity: submit evidence of a 90-day prescription. There must also be dispensing of a 90-day supply of the appropriate medication.
IPPE / Annual Preventive Visit ("APV")	Health Plan will only pay for 1 appropriate exam completed by Applicable Member during the Measurement Period. Required Eligible Provider activity: submit Administrative Data, medical record and/or EMR access.