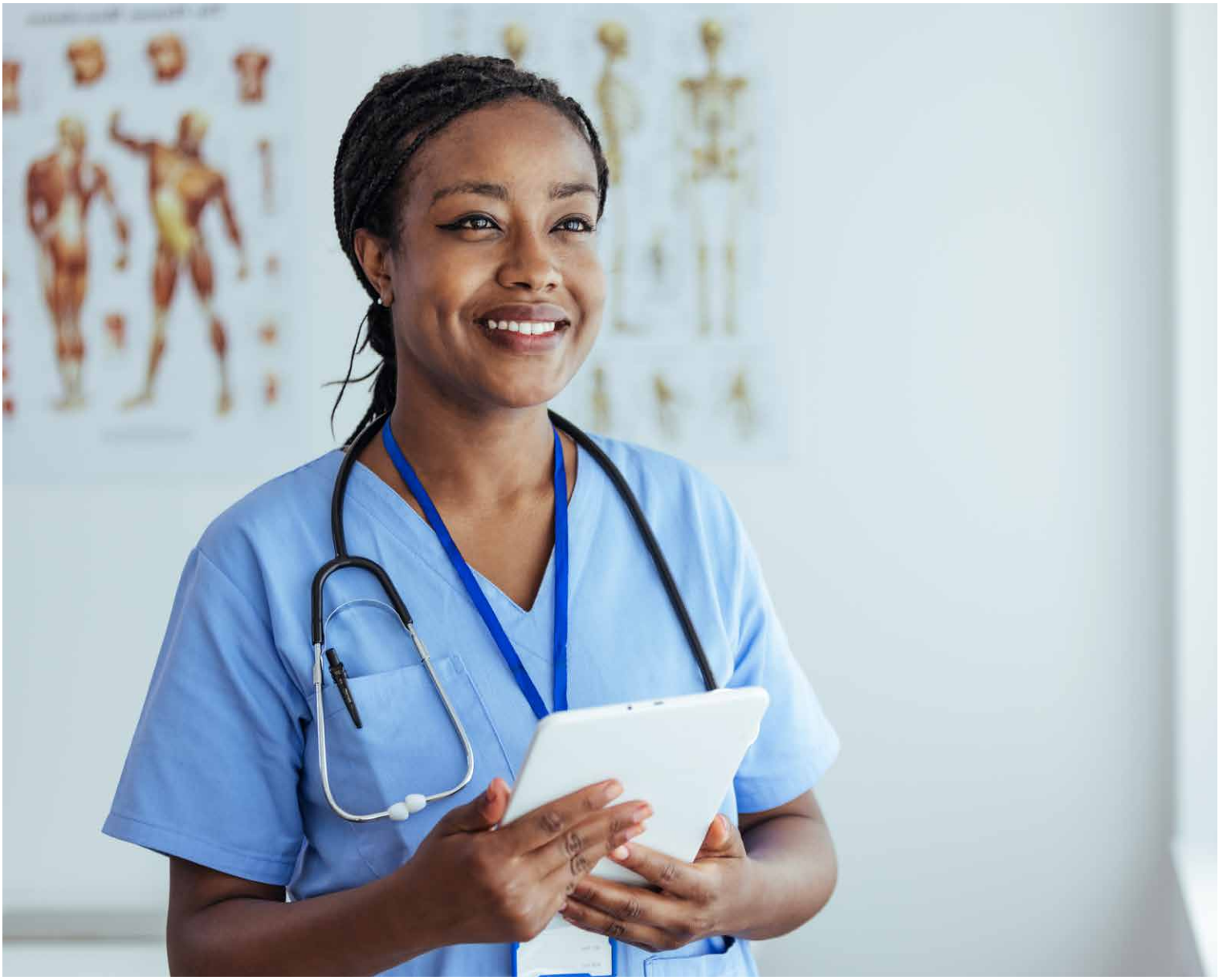

2024 Quality Incentive Program

EmblemHealth®

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Message From Our Senior Vice President, Medical Management

Dear Colleagues:

I am proud to share that 2023 was a great year of achievements for EmblemHealth that wouldn't be possible without your partnership, so thank you. We look forward to working with you in 2024.

I am deeply grateful for all your efforts to continue to help EmblemHealth deliver the best possible care to our members. We received numerous awards and recognitions including becoming the first plan in New York State to earn the Health Equity Accreditation from the National Committee for Quality Assurance (NCQA) across all lines of business. This award recognizes our dedicated efforts to reduce health disparity gaps, improve health outcomes, and ensure member satisfaction. These accomplishments are the results of the passion and dedication from you, our providers, and your employees.

We are excited to extend to you, once again, the opportunity to participate in our Quality Incentive Program. Our commitment to this program and our ongoing efforts to strengthen the partnership with our network providers continues to be at the center of our provider network and population health strategy. In 2023, we paid out $5.2 million to 40 different provider groups, representing a total of 2,768 individual providers in New York (21% achieved of total offered). In 2024, we anticipate an even more substantial payout, nearing $6.4 million.

We continue to simplify, streamline, and listen to our providers to help bring forward the most robust quality incentive program on the market. Our Quality Incentive Program is built on the following guiding principles:

- **Recognize and reward providers** with a highly competitive payout structure for exceptional care and improved health outcomes of their patients.
- **Shared commitment to help your patients get well, stay healthy, and live better lives.** By rewarding providers who prioritize preventive care, chronic disease health outcomes, and health equity, we collectively contribute to a healthier, more resilient population. Your dedication to deliver exceptional care remains the foundation of our vision for a robust and sustainable health care system.

Collaboration is pivotal to achieve our shared goals of delivering exceptional health care outcomes and improving the quality of care. This guide includes information on tools to help support you, including:

- Actionable data and reports such as member-level gaps in care reports, utilization data summary, medication adherence, and pharmacy reports.
- Dedicated support from our Provider Network team.
- Committed Quality Team to assist you.

For a full list of program resources, please see page 10.

We continue to work hard to provide exceptional quality health care for our members. However, there's still work that needs to be done to increase overall member satisfaction with EmblemHealth and our providers. As a team, we can make it a priority to provide our members with the highest level of care and customer service.

Thank you for your continued commitment to your patients and to EmblemHealth.

Abdou Bah

Abdou Bah
Senior Vice President, Medical Management & Chief Health Equity Officer

Program Overview

Eligibility and program requirements

Participation in the Quality Incentive Program (QIP) is extended to primary care providers at the group level (indicated as a Medical Center for EmblemHealth providers). Providers engaged in a delegated risk arrangement with EmblemHealth are ineligible for the QIP. Other value-based arrangements may restrict participation.

To confirm eligibility for the QIP and clarify existing contracts, we encourage you to talk with your Provider Network Manager. EmblemHealth, in its sole discretion, will determine eligibility and payout considerations including timing and amount to be paid, if any.

Other qualifications for the QIP include:

1. **Open panel**
   You must accept new EmblemHealth membership across your participating lines of business.

2. **Membership eligibility criteria**

   Line of business eligibility: Providers at the group level (indicated as a Medical Center by EmblemHealth) must have at least 50 members in Medicare or Medicaid/Child Health Plus (CHPlus)/Enhanced Care Plus (HARP)/Essential Plan to be eligible. Providers must meet this membership threshold to be eligible for each respective QIP. Panel sizes as of Dec. 31, 2024, will be used to determine program eligibility and payout. Only panels that meet the membership threshold will be eligible for payout.

   Measure eligibility: The denominator for each measure has a minimum size requirement of 15 members.

3. **Medical record access/supplemental data**

   Supplemental data: We understand you are committed to submitting accurate claims for your patients. However, there are instances when essential documentation is missing which leads to quality gaps. We encourage you to grant EmblemHealth authorization to view your patients' medical records, provide supplemental data, and share nonstandard data to ensure we capture all required patient information.

   Medical records: Authorization to view medical records must be provided to EmblemHealth, at no charge, for quality reviews related to this QIP, as well as for Healthcare Effectiveness Data and Information Set (HEDIS®) and other regulatory initiatives. Failure to do so will render you ineligible for the program.

Supplemental data files for 2024 dates of service will be accepted according to the table below:

Data Type	Standard Supplemental Data*	Non-Standard Data* (Medical Records)
Description	Aggregated patient data from a provider's electronic health records/electronic medical records (EHR/EMR) system in a required format. Supplemental data should be submitted monthly using the required format.	All other data which requires physical inspection such as patient charts and clinical summaries. May be submitted as proof of historical services, or services rendered by partnering or specialty providers only, to supplement compliance outside of claims and the standard supplemental file.
Submit To	**quality_data@emblemhealth.com** and copy your Provider Network Manager	**HEDISGroup@emblemhealth.com** and copy your Provider Network Manager
Submission Deadline	**Standard – first file:** Dec. 27, 2024 **Standard – other files:** Feb. 28, 2025 (First file must be received by Dec. 27, 2024)	Dec. 27, 2024

**Records only accepted starting April 1, 2024 for measurement year 2024.*

Resubmitted or corrected records will not be accepted for files sent after Dec. 20, 2024. See additional training material from your EmblemHealth Provider Network Manager on supplemental data templates and accepted measures.

Measures

Providers are evaluated on quality measures that are consistent with those published by the Centers for Medicare & Medicaid Services (CMS) and the New York State Department of Health (DOH). For a comprehensive list of measures included in the QIP and associated payment tiers, please refer to the **charts included in this brochure**, starting on page 8.

Measurement Period and Payment

Incentive payments will be made one time between April and June 2025.

- Payment is based on each eligible patient who receives services, or claims we receive for services rendered.
- Provider groups will be paid based on **membership as of Dec. 31, 2024**.
- Payments will be sent to the Independent Physician Association (IPA) or managing entity to disburse to individual providers.

Benchmark Targets

EmblemHealth's commitment to quality care is evident in our annual evaluation and updates of our program, methodology, measurement sets, and benchmarks. We align our programs with quality of care standards set by the National Committee for Quality Assurance (NCQA), CMS, DOH, and EmblemHealth's quality improvement priorities.

Benchmark methodology:

- EmblemHealth employs a robust methodology combining industry-standard criteria with our plan's historical performance and network provider track record.
- To set benchmark rates, we may adjust our QIP target based on our current standing. For example, if we fall below the 50th percentile or a Medicare Star Rating of 3, we may slightly reduce the benchmark. Similarly, if we go above the 75th benchmark or 4-star Medicare rating, we raise the benchmark to support continuous quality improvement.

We make our targets challenging and achievable, ensuring that our members receive the highest quality of care. This commitment drives us to exceed industry standards and continuously enhance the effectiveness of our programs.

Additional Incentive Opportunities

1. **Authorization to electronic medical records (EMRs)**
   EmblemHealth will provide an additional incentive to provider groups that grant us remote authorization to view their EMRs. This allows us to increase your rates, because it lets us capture services that may not be conventionally billed or have historically had claims processing issues. For every granted EMR system authorization, we will issue a $2,000 payment. This incentive is only available to new authorization arrangements.

2. **Risk adjustment reimbursements**
   EmblemHealth is committed to support our providers in identifying and managing our members' chronic conditions. This presents an opportunity for providers to earn additional reimbursements.

   Using our portal, providers can easily view member alerts that highlight emerging chronic conditions and existing conditions in need of attention. Responding to these alerts is streamlined through this online system, and allows providers to attach the necessary progress notes and documentation. Providers who actively engage in this process become eligible for reimbursement for each successfully completed alert. Additional reimbursements are offered for alerts completed in compliance with the program before July 1, 2024.

Reimbursement details:

- **$150** for each completed alert pertaining to a **Medicare** member
- **$40** for each completed alert pertaining to a **Medicaid** member
- **$100** for each completed alert pertaining to a **commercial** member

Summary of Changes From 2023 Program

EmblemHealth has made adjustments for 2024 to better align with our overarching objectives. We continue our commitment and remain dedicated partners to our health care providers. This involves continuous reporting, strategic targeting of quality improvement efforts, and expanding opportunities for incentives.

1. **Enhancements to incentive payments**
   - **Medicare** — Increased Tier 3 payments from $100 in 2023 to $125 in 2024 and increased Tier 2 payment for plan all-cause readmission from $75 to $100.
   - **Medicaid/Enhanced Care Plus (HARP)/Child Health Plus (CHPlus)/Essential Plan** — Increased Tier 3 payment from $100 in 2023 to $125 in 2024.

2. **Health disparity measures**
   In 2024, EmblemHealth is committed to further advancing health equity, with a dedicated emphasis on reducing health disparities prevalent among African American members.
   - **Control high blood pressure in African American population:** Building on the impact we made in 2023, when measures such as diabetes A1C control using the Healthcare Effectiveness Data and Information Set (HEDIS) and child and adolescent well-care visits were introduced to address health disparities, we are expanding our efforts by adding a metric focused on the African American population: controlling high blood pressure.
   - **Extension of diabetes A1C control measure to Medicare business:** Recognizing the importance of our impact, the diabetes A1C control measure — African American population — has been extended to the Medicare line of business. This increases our reach and effectiveness in promoting health and well-being across diverse populations.

3. **Measure Updates**
   Below is a summary of the measures we removed and those we added for 2024.

Population	Removed Measures	Added Measures
Medicare	**Transition of Care**	• Kidney health evaluation for patients with diabetes. • Statin therapy for patients with cardiovascular disease. • Follow-up after emergency department visit for people with multiple high-risk chronic conditions. • Health disparity measures. — Controlling High Blood Pressure – Health Disparity – African American population. — Blood Sugar Control – Health Disparity – African American population.
Medicaid/HARP/ CHPlus/Essential Plan	**Oral evaluation and dental services**	• Controlling high blood pressure – Health Disparity – African American population.

2024 Measures and Targets

Medicare

MEASURES	INCENTIVE TARGETS*			INCENTIVE PAYMENT**		
	TIER 1	TIER 2	TIER 3	TIER 1	TIER 2	TIER 3
Prevention						
Annual wellness visit	69%	75%	79%	$50	$75	$125
Breast cancer screening	69%	74%	82%	$50	$75	$125
Colorectal cancer screening	61%	71%	80%	$50	$75	$125
Social determinant of health screening	10%	15%	20%	$50	$75	$125
Controlling high blood pressure	65%	69%	72%	$50	$75	$125
Eye exam for patients with diabetes	64%	68%	75%	$50	$75	$125
Blood sugar control for patients with diabetes	65%	74%	77%	$50	$75	$125
Kidney health evaluation for patients with diabetes	43%	48%	56%	$50	$75	$125
Diabetes medication adherence	86%	89%	92%	$50	$75	$125
Hypertension medication adherence	86%	89%	92%	$50	$75	$125
Cholesterol medication adherence	86%	89%	92%	$50	$75	$125
Statin therapy for patients with cardiovascular disease	84%	87%	92%	$50	$75	$125
Plan all-cause readmission	10%	8%	6%	$50	$100	$125
Follow-up after emergency department visit for people with multiple high-risk chronic conditions	55%	60%	70%	$50	$75	$125
Health disparity – blood sugar control African American population	65%	72%	77%	$50	$75	$125
Health disparity – controlling high blood pressure in African American population	65%	69%	72%	$50	$75	$125

* Targets are based on Medicare Cut Points published by CMS, historical performance data, and additional industry-standard benchmarks.

** Once the Tier 1, Tier 2, or Tier 3 target is achieved, the provider will earn the respective incentive payment for each eligible member who received appropriate treatment.

Medicaid/CHPlus***/HARP†/Essential Plan

MEASURES	INCENTIVE TARGETS††			INCENTIVE PAYMENT†††		
	TIER 1	TIER 2	TIER 3	TIER 1	TIER 2	TIER 3
Adult Prevention						
Annual wellness visit	55%	60%	65%	$25	$50	$125
Breast cancer screening	65%	67%	72%	$25	$50	$125
Colorectal cancer screening	60%	62%	65%	$25	$50	$125
Social determinant of health screening	10%	15%	20%	$25	$50	$125
Cervical cancer screening	67%	71%	74%	$25	$50	$125
Chlamydia screening (composite rate)	70%	75%	80%	$25	$50	$125
Controlling high blood pressure	68%	71%	74%	$25	$50	$125
Blood sugar control for patients with diabetes	67%	70%	74%	$25	$50	$125
Well-child visits in the first 30 months of life; six or more visits in the first 15 months	70%	73%	83%	$25	$50	$125
Well-child visits in the first 30 months of life; two or more visits in months 15 through 30	78%	82%	84%	$25	$50	$125
Childhood immunization status (combination)	73%	76%	77%	$25	$50	$125
Child and adolescent well-care visits	70%	71%	74%	$25	$50	$125
Plan all-cause readmission	8%	6%	4%	$25	$50	$125
Transitions of care – patient engagement after inpatient discharge	55%	60%	65%	$25	$50	$125
Health disparity – blood sugar control African American population	67%	70%	74%	$25	$50	$125
Health disparity – child and adolescent well-care visits African American population	68%	71%	74%	$25	$50	$125
Health disparity – controlling high blood pressure in African American population	66%	71%	74%	$25	$50	$125

***Child Health Plus (CHPlus)
†Enhanced Care Plus (HARP)
†† Targets are based on benchmarks published by NYSDOH, historical performance data, and additional industry-standard benchmarks.
††† Once the Tier 1, Tier 2, or Tier 3 target is achieved, the provider will earn the respective incentive payment for each eligible member who received appropriate treatment.

Program Resources

1. **Emblemhealth provider portal and reporting**
   Tableau Tools: QIP is supported by real-time data reporting, providing a dynamic tool to monitor performance, identify opportunities for quality gap closure, and keep track of incentives earned. This resource is found in the provider portal and includes:

   - **Performance by line of business:** Includes the number of patients required to move to the next tier and current rate.
   - **Outreach list:** Patient-level detail data to act on care gaps.
   - **Snapshot of financial impact:** Summaries of total achieved incentive, total remaining incentive, and payment ratio.
   - **Primary care provider (PCP) and Provider Views:** Different views to support patient engagement which includes groupings by provider, PCP name, product line and incentive measure.

   If you do not have a portal account, you may apply for one at **emblemhealth.com/providers/resources/provider-sign-in**. Look for the box labeled "Request Provider Portal Account."

   Gaps-in-care report/utilization reports: We also provide you comprehensive gaps-in-care and utilization reports. This data can help you identify patients who may benefit from proactive outreach and intervention. Contact your Provider Network Manager for more information.

2. **In-home screening partners/vendors/partners**
   We recognize your commitment to our members' well-being and understand that treating patients in your office isn't always feasible. To complement your care, we've collaborated with in-home health care providers including DocGo, MyLaurel, and Matrix Medical. These providers offer an additional choice for patients to receive care in their homes at no extra cost. Our home care partners can do well-visits, post-hospital/care coordination check-ins, and screenings like lab tests or eye exams. Additionally, your patients can get home screenings such as A1C and FOBT/FIT kits through our vendor LetsGetChecked. All results from completed home visits and screenings will be promptly communicated to you by fax or letter.

3. **Rewards program for your patients**
   The EmblemHealth Medicare Member Rewards Program is designed to be sure patients get the medical care they need, including annual well-visits and preventive screenings. Members are rewarded for taking good care of their health. Your role remains unchanged — continue providing care including sending patients to receive important screenings such as mammograms.

   - To participate, Medicare members must sign-up for the EmblemHealth member portal at **my.emblemhealth.com**. They can also call Medicare Connect Concierge at **877-344-7364** (TTY: **711**).
   - **EmblemHealth Medicare Member Rewards website: emblemhealth.com/resources/medicare-member-resource-center/medicare-wellness-rewards.**

With the EmblemHealth Medicare Member Rewards Program, members can receive rewards for eligible services like:

	Reward	Member Type	Trigger for Reward	Value
ALL Medicare Members	Initial medicare annual well visit (90 days)	New	Completion of an Initial Medicare Annual Well Visit within 90 days of enrolling in Medicare	$50
	Initial health assessment (90 days)	New	Completion of Health Assessment (HA) within 90 days of enrollment	$50
	Bone mineral density (BMD) test	New and existing	Complete a BMD test to check for osteoporosis within six months after fracture.	$100
	Colorectal cancer screening	New and existing	Complete a fecal occult blood test (FOBT), flexible sigmoidoscopy, colonoscopy, fecal immunochemical test (FIT), DNA test, or colonography within the calendar year	$25
	Diabetes A1C test	New and existing	Complete one A1C blood test within the calendar year	$25
	Diabetes eye exam	New and existing	Complete a retinal or dilated eye exam by an eye care professional within the calendar year	$25
	Diabetes kidney health evaluation	New and existing	Complete an estimated glomerular filtration rate (eGFR) test and a urine albumin-creative ratio within the calendar year	$25
	Mammogram exam	New and existing	Complete a mammogram within the calendar year	$50
	EmblemHealth or ConnectiCare member portal registration	New and existing	Registration in the EmblemHealth or ConnectiCare Member portal in the calendar year	$25
	Sign-Up for Paperless	New and existing	Completion of sign-up for paperless	$25
DSNP Members	Annual health assessment	Existing	Completion of an HRA within the calendar year by a D-SNP Member	$50
	Comprehensive medication review (CMR)*	New and existing	Complete a CMR with EmblemHealth's medication therapy management (MTM) vendor	$10
	Cholesterol medication refill*	New and existing	Fill a 30-day, 60-day, or 90-day supply of a prescribed cholesterol medicine and complete a CMR.	$10 - 100**
	Diabetes medication refill*	New and existing	Fill a 30-day, 60-day, or 90-day supply of a prescribed oral diabetes medicine and complete a CMR.	$10 - 100**
	Hypertension medication refill*	New and existing	Fill a 30-day, 60-day, or 90-day supply of a prescribed blood pressure medicine and complete a CMR.	$10 - 100**

*Members in these contracts eligible for an CMR: H5991-010-000, H5991-012-001, H5991-012-002, H3276-001-000, H3276-003-000.

**Members earn $10 for a 30-day fill (monthly; maximum 10 times per year), $20 for a 60-day fill (bi-monthly; maximum five times per year), or $30 for a 90-day fill (quarterly; maximum three times per year).

Members are eligible to earn a reward after the provider completes a CMR.

The Member Rewards Program will also be extended to include the Medicaid/Health and Recovery Plan (HARP) population in 2024. The following rewards will be offered:

Medicaid/HARP adult members

- Adult annual well visit (an annual wellness visit or annual physical visit)..... $25
- Diabetes A1C Test (hemoglobin A1C (HbA1C) testing for diabetic members) $25
- Diabetes eye exam (retinal or dilated eye screening for diabetic members) $25
- Postpartum care visit (postpartum visit on or between seven and 84 days after delivery) $50

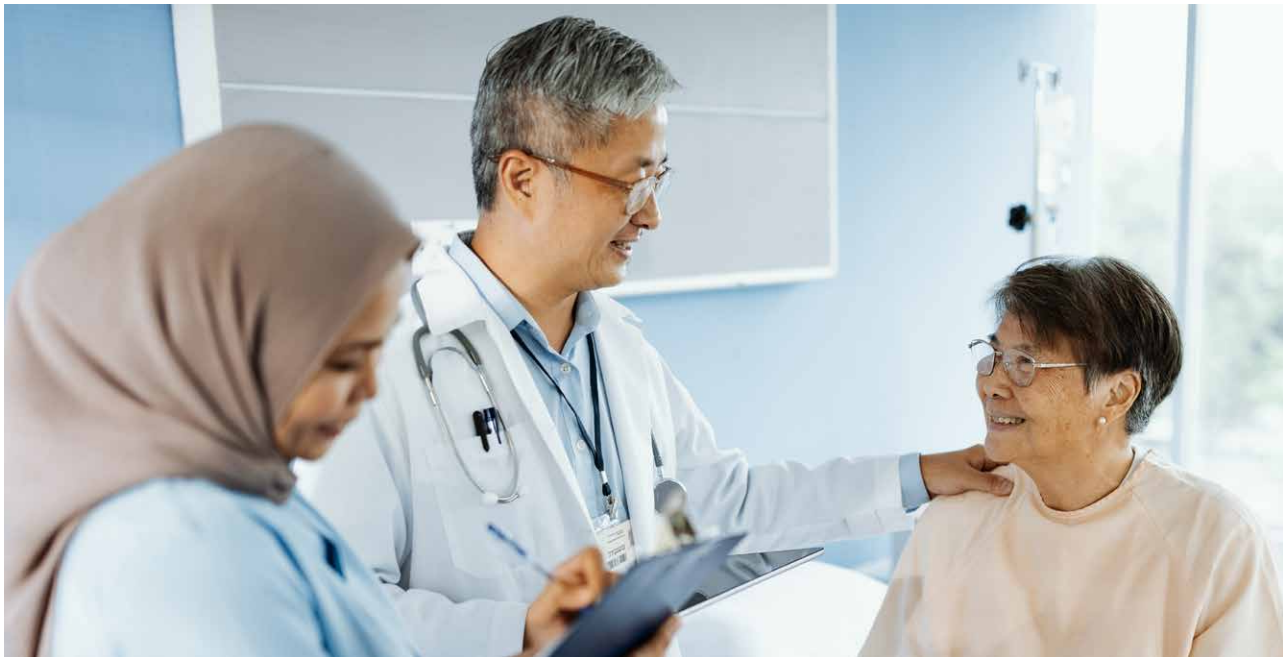
Medicaid/CHP Child Members

- Adolescent/child well annual visit (an annual well visit for children)..... $25
- Oral evaluation, dental services (comprehensive or periodic oral evaluation with a dental provider for children)..... $25

4. **Care Management**
   EmblemHealth provides a dedicated Care Management team comprised of nurses, social workers and community health workers to ensure continuous support for your patients' health care needs between doctor visits. This program is offered to your patients at no additional cost. Our team collaborates directly with you to develop a personalized care plan for each patient, tailoring our services to their unique needs. To learn more about the program:

   - **Email us at complexcasemgmt@emblemhealth.com**.
   - **Call us** at **800-447-0768**, 9 a.m. to 5 p.m., Monday through Friday.
   - Visit our provider resources page for more information: **emblemhealth.com/providers/resources/toolkit/Referral-Resources**.

5. **Quality Measure Resource Guide**
   The Quality Measure Resource guide is a valuable reference tool. It gives you detailed information including codes and actionable steps to close gaps in care. Find the guide at: **emblemhealth.com/providers/clinical-corner/quality** or request a copy from your Provider Network Manager.



For quick reference, here are brief descriptions of each measure you will find in the guide:

Annual wellness visit (AWV): An annual wellness visit or annual physical visit in the measurement year for patients 18 years and older. Visit includes physical assessment/physical exam, laboratory tests, immunizations, preventive screenings, and referrals.

Breast cancer screening (BCS): Mammogram screening that looks for signs of disease such as breast cancer before a person has symptoms; recommended for women 50-74 years old.

Colorectal cancer screening (COL): Colorectal cancer screening recommended for patients 45 – 75 years old, to detect early signs of colorectal cancer.

Social need screening and intervention (SNS-E): Screening to assess members social needs that may be affecting management of their health conditions.

Eye exam for patients with diabetes (EED): Retinal or dilated eye screening for diabetic retinal disease recommended for patients 18 – 75 years old with diabetes (type 1 or type 2).

Controlling blood pressure (CBP): Blood pressure management for patients 18 - 85 years old with a hypertension diagnosis of recommended pressure should be less than 140/90 mm Hg.

Chlamydia screening (CHL): At least one test for chlamydia during the current year for females 16 - 24 years old who were identified as sexually active.

Cervical cancer screening (CCS): Appropriate cervical cancer screening for women 21 - 64 years old.

Blood sugar control for patients with diabetes (HBD): Appropriate hemoglobin A1C rate for patients 18 – 75 years old with diabetes (type 1 or type 2). *A lower rate indicates better performance for this indicator (i.e., low rates of poor control indicate better care)*.

Kidney evaluation for patients with diabetes (KED): A kidney health evaluation for a diabetic patient that includes both an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR).

Well-child visits and adolescent well visits: Assessing physical, emotional, and social development of different stages of Children: first 15 months, 15 months – 30 months, and 3 - 21 years old.

Childhood immunization status (CIS): Administering recommended vaccines by patients' second birthday.

Plan all-cause readmission (PCR): Ensuring lower or no readmissions after acute inpatient and observation stays during the measurement year for patients 18 and older.

Transitions of care – patient engagement after discharge (TRC-E): Patient engagement (e.g., office visit, home visit, telehealth) within 30 days after discharge for patients 18 and older.

Medication adherence measures: Ensuring Diabetes/Hypertension/Cholesterol medicine adherence; enough to cover 80% or more of the time the patient is supposed to be taking the medication; measurement used for Medicare members.

Statin therapy for patients with cardiovascular disease (SPC): Prescribing and ensuring patients diagnosed with clinical atherosclerotic cardiovascular disease remain on at least one high-intensity or moderate-intensity statin medication for at least 80% of the treatment period during the measurement year.

Follow-up after emergency department visit for people with multiple high-risk chronic conditions (FMC): Follow-up within seven days of a patient's emergency department (ED) visit to avoid future ED visits: for patients 18 and older with two or more different high-risk chronic conditions.

Health disparities: Identifying conditions among the African American population that may be prevalent to improve health equity.

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For more information about the EmblemHealth Quality Incentive Program, please contact your provider relationship manager or visit the provider portal at **emblemhealth.com/providers.**

Delivering excellence to your patients

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