2025 Quality Care Plus (QCP)

Primary Care Physician Incentive Program

Jefferson Health Plans | Health Partners Plans

Thank you for being a valued provider for members in one or more of our health plans: Health Partners Plans Medicaid, Health Partners Plans CHIP, Jefferson Health Plans Medicare Advantage, and/or Jefferson Health Plans Individual and Family Plans. All communications will specify the impacted lines of business within the content of the message.

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This manual and other quality-related information can be found on our website: **healthpartnersplans.com/home/providers/clinical-resources/quality-and-population-health**

Message from the Health Plan

Health Partners Plans, Inc. is committed to the health and wellbeing of our members, providers, and the communities we serve. Thank you for your continued partnership and support as we've continued to integrate with the Jefferson enterprise.

Effective August 1, 2024, Jefferson and Lehigh Valley Health Network (LVHN) officially joined to become one health system. With a combined 325 years of experience, our health system is now among the top 15 not-for-profit health systems in the U.S. with 65,000 colleagues, 32 hospitals, and more than 700 sites of care in Pennsylvania and New Jersey. Together, we will increase patient access to high-quality and affordable care, clinical trials, and health plan offerings while addressing health inequities for our most vulnerable populations.

The growth and success we've experienced recently and over the years could not have been accomplished without our provider partnerships.

We are truly grateful for your commitment and support and look forward to continuing to work together to deliver the best possible care to our growing network.

Summary of Our 2024 Performance

RECOGNITIONS FROM THE NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA)

NCQA Plan Rating

Health Partners Plans Medicaid received a 4 out of 5 Stars rating from NCQA. We are one of 6 plans in Pennsylvania to receive this high rating for 2024 and remain among the top 59 (5, 4.5 and 4 stars combined) plans in the entire country. On average, NCQA rates more than 1,800 health insurance plans in the country each year on a scale from 0 to 5 based on the combined HEDIS and CAHPS scores and NCQA Accreditation status. Of the 1,484 rated plans (Medicaid, Medicare, Exchange, and Commercial/Private) in 2024, only 344 plans (23%) received a top rating of 4, 4.5, or 5, and we are proud to be one of these plans.

Health Equity Accreditation

In 2011, we were the first plan in the country to earn the NCQA Multicultural Health Care Distinction which has transitioned to the full Health Equity Accreditation. In 2023, we successfully completed the Health Equity Accreditation Survey. This accreditation is awarded every three years to organizations that aim to reduce health care disparities and engage in efforts to improve culturally and linguistically appropriate services by addressing diversity, inclusivity and equity in hiring and promoting internal staff, as well as racial, ethnic, linguistic, gender identity and sexual orientation disparities in health care.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) MEDICARE STAR RATING

Every year, CMS uses a five-star scale to rate a plan's quality performance and member satisfaction with the plan. Jefferson Health Plans Medicare received 3.5 out of 5 stars in the most recent CMS star rating (released in October 2024). With the explosion of new four-star plans due to relaxed program rules during the pandemic, Jefferson Health Plans being one of those who benefited, CMS continues to make market corrections through their regulatory changes. With the most recent scoring release, individual star measure thresholds (cut points) increased dramatically, making 60% of the Stars program more challenging to achieve success at the measure level compared to last year. Although our overall score remained unchanged since last year, our raw score did increase, and we continue to improve. We are outpacing industry improvement in certain areas and positioning ourselves to return to a 4+ Star rating.

Overview of the QCP Program

WHAT IS QCP?

Quality Care Plus (QCP) is our primary care physician incentive program for our Medicare, Medicaid, and CHIP health plans. It is a transparent tool that is designed to recognize and reward your practice's performance in delivering quality services throughout the year. Through standardized industry accepted measures and our unique quality performance initiatives, QCP supports our shared mission of improving the health of our members and the communities we serve.

Every year, we refine the QCP program based on:

- Updates to NCQA measures
- Pennsylvania Department of Human Services (DHS) and the Centers for Medicare and Medicaid Services (CMS) requirements and priorities for managed care organizations
- Our goals and priorities

This manual provides details on what you need to know about our 2025 QCP program and opportunities to maximize your incentive payments.

"Practice group" will be referenced throughout this manual. Practice group is a single location with a corresponding supplier location ID.

PREREQUISITES

Practices must meet the following prerequisites to participate in the QCP program:

- Average at least 100 members at the tax identification number (TIN) level for any one or more product lines (Medicare, Medicaid, and CHIP) for 12 consecutive months during the measurement period.
- Have a minimum of 30 members in the individual measure's denominator to qualify and to receive any payment for that measure.
- **Modified:** See at least 30% of paneled Medicaid members during the 2025 measurement year to participate and earn any incentive dollars for Medicaid measures beginning with the May 2026 payment cycle. Additional details can be found in the 2025 QCP Program Updates section on page 8.*

  **We will continue to provide advanced notice to any practices that may be at risk of not meeting this eligibility requirement.*
- Accept new Health Partners Plans Medicaid, Health Partners Plans CHIP, and Jefferson Health Plans Medicare members (unless we have restricted your panel).

Please refer to the grid on the following page to review how changes to your practice composition affect your QCP program eligibility and incentive payments.

Practice groups that close during the payment period will be considered ineligible for QCP participation and bonus payments will cease upon notification. There are exceptions we consider to continue the bonus payments to participants.

Continued on next page

Practice Scenario	Scoring and Payment Impact
Practice Merger – Same TIN	Practice groups that close and transfer the full membership to another site within the same TIN will continue to receive the same QCP bonus payments as prior to practice group closure.
Practice Merger – Different TIN	Practice groups that close and transfer the full membership to a different TIN but primary care physicians remain the same and continue to follow membership will continue to receive the same QCP bonus payments as prior to practice group closure.
Practice Closure	Practice group locations that close and transfer membership to multiple practice groups and/or multiple TINs will be excluded from the QCP bonus.
Panel Closure	Practice groups that voluntarily close their panel permanently will no longer be eligible for QCP reimbursement. We may allow select high-performing practice groups that request to temporarily close their panels to remain in the program with a 50% deduction to the practice group's total QCP reimbursement. If during the payment period the practice group(s) decide to re-open their panel, full QCP reimbursement will be reinstated upon notification. Retroactive payment will not be considered for the months the panel closure was in place.
Termination of Provider Agreement	If notified of termination of your Participating Agreement with us, participation in the QCP program and payments made to you in the program will end 90 days prior to the termination date or immediately upon notification if within 90 days of termination date.
Participation in Value-Based Contract	A practice group is not eligible for the QCP program if they participate in another value-based contract or quality arrangement with us. Practices will be ineligible for QCP participation and associated payments for the measurement year in which they enter into a VBC or quality arrangement. Practices will be paid in full according to the QCP payment cycle for the most recent measurement period in which they were eligible for QCP, **per the practice scenarios listed above**.

Note: Capitated and fee-for-service practices are eligible to participate.

Note: If the practice group and/or TIN is eligible in more than one line of business for the program, the individual line of business will be considered for eligibility (i.e., if the practice group has discontinued acceptance of Medicaid members but continues to accept new Medicare members and is eligible for the QCP bonus in both lines of business, only bonus payments for the Medicaid line of business will be discontinued).

Payments are based on the percentage of members meeting each measure's specifications during the 12-month measurement period. The incentives will be paid using a per member per month (PMPM) calculation, which will be based on the current paneled membership of the practice each month.

Measurement Period

We use the date range of January 1 through December 31 for consideration with all measures included in the QCP program. Payments are made monthly, based on the benchmark methodology. Results are recalculated (based on January 1 – December 31 performance measurement of the prior year) to determine new monthly payments, which are issued beginning in May of the recalculation year.

Membership is calculated monthly based on the current paneled membership.

By participating in the QCP program, provider organizations agree that 80% of the Medicaid incentive payment will be dispersed to the provider and/or care team that completed the QCP requirements and/or cared for the members and no more than 20% of those funds will be used for general administrative purposes, per the terms outlined in Health Partners Plans, Inc. agreement with DHS, exhibit B(3), Section III, D.

2025 QCP Program Updates

All QCP-participating offices were sent a 2025 QCP Updates letter in November 2024 that provided an initial notification of updates to the 2025 QCP program. These updates are described in greater detail in this manual. Most updates listed below will not affect QCP payments until the 2026 recalculation, with reimbursement beginning in May 2026 (measurement period: January 2025 – December 2025), although there are some exceptions.

Here are the updates to our 2025 QCP program:

1. Eligibility Requirement
Effective for the 2025 measurement period, providers will now be required to see at least 30% of paneled Health Partners Plans Medicaid Members during the 2025 measurement year in order to participate and earn any incentive dollars for Medicaid measures beginning with the May 2026 payment cycle. This is a 5% increase from the previous years' eligibility requirement; however, providers were given advanced notice of this planned increase as outlined in the 2024 QCP Manual and communicated throughout the year. Only Members enrolled for at least 10 months at the site during the measurement year and remaining enrolled as of December 31 of the measurement year will be included in the rate calculation. Telehealth visits are allowed and will count toward the visit rate. The member must see a primary care provider associated with the Tax ID of their PCP within the measurement year. This requirement impacts the Medicaid line of business only and will not affect the Medicare or CHIP lines of business.

Please see below for the place of service and servicing provider specialties we will use to identify PCP visits.

- Place of Service is one of the following: Federally Qualified Health Center, Independent Clinic, Off Campus-Outpatient Hospital, Office, On Campus-Outpatient Hospital, Patient's Home, Rural Health Clinic, Telehealth Provided in Patient's Home, Telehealth Services.
- Provider Specialty is one of the following: Adolescent Medicine, Advanced Practice Nurse, Certified Registered Nurse Practitioner, Clinic/Center Federally Qualified Health Center, Clinic/Center Rural Health, Family Practice, General Practice, Geriatric Medicine, Internal Medicine, Pediatric Development, Pediatrics, Physician Assistant.

2. Payment Calculation at the TIN Level
Effective for the 2024 measurement period (payments beginning in May 2025), providers will be measured and paid at the overall TIN level rather than the individual supplier location level. Providers will no longer need to meet a supplier location minimum membership threshold of 50 members. Only the TIN minimum membership threshold of 100 members must be met in order to participate.

3. PMPMs Based on Monthly Membership
Effective for the 2024 measurement period (payments beginning in May 2025), incentives will be paid using a per member per month (PMPM) calculation, which is based on the current paneled membership of the practice every month.

4. QCP Measure Changes

We are making changes to the following measures for the January 2025 to December 2025 measurement period (to be reflected in the payments beginning in May 2026). Details of all new, updated and existing measures are included in this manual.

- **Care of Older Adults:** In 2024, we included Medication Review and Pain Assessment as separate, stand-alone measures. In 2025, Functional Status Assessment will replace Pain Assessment. Functional Status Assessment and Medication Review will continue to be measured separately as stand-alone measures for Medicare only. Official CMS cut points are not available since Functional Status Assessment is a returning measure to the Stars program. Benchmarks will be based on historical network performance.
- **Annual Wellness Visit:** This new Medicare measure will look at the percentage of Medicare members who had their annual wellness visit (preventive visit covered by Medicare) completed during the measurement year. Since this is not a Stars measure, we created custom benchmarks for this measure based on historical network performance.
- **Kidney Health Evaluation for Patients with Diabetes:** This new Medicare measure will look at the percentage of members 18-85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year. Please note that members must complete both tests to be considered compliant for this measure.
- **Oral Evaluation, Dental Services:** This Medicaid only measure will be removed from the QCP program effective measurement year 2025. Dental providers will continue to be incentivized via our Dental P4P Program.

QCP Bonus Opportunities

Your practice will continue to have the opportunity to earn additional QCP payments for the following:

HEALTH DISPARITY BONUS (MEDICAID)

As part of an ongoing effort to address health disparities, we will continue to offer a bonus payment specific to the African American population on three disparity measures: (1) **Well-Child Visits - First 15 Months of Life**; (2) **Glycemic Status Assessment for Patients with Diabetes (>9%)**; and/or (3) **Controlling Blood Pressure**. Medicaid sites/practice groups will have the opportunity to earn a bonus payment for each eligible measure, in addition to their payment received for the measure for the entire population.

Practice groups must hit either the Tier 3 or the Tier 4 benchmark for only their African American members to receive a $1 PMPM bonus for each of the three disparity measures. The $1 PMPM bonus will only be for the practice group's African American population for each specific measure and not the entire panel. *Please refer to Exhibit A on page 16 of this manual for detailed benchmark and PMPM information for each of these measures.*

ELECTRONIC QUALITY MEASURE BONUS (MEDICAID)

We will continue to offer an Electronic Quality Measure incentive for two quality measures: (1) **Glycemic Status Assessment for Patients with Diabetes (>9%)** and (2) **Controlling Blood Pressure**. Medicaid practice groups that submit A1c results values and blood pressure readings to us through electronic medical record (EMR) feeds will be able to earn $1 PMPM. Payment will be based on the total number of members in the denominator for each measure, not on the total average membership at the practice group.

HIGH PERFORMER RECOGNITION PROGRAM

In 2023, we implemented a high performer recognition program for high performing sites in the Quality Care Plus (QCP) program. The goal is to acknowledge the practice groups that have an overall commitment to high quality care. Individual practice locations are recognized for high quality performance based on HEDIS measure performance. High performers are identified as the top 10th percentile of all eligible sites. The program is specific to our Medicaid line of business. All PCP practice locations with 500 or more Health Partners Plans Medicaid members and those currently participating in the QCP program are eligible.

Please note: This program is designed to recognize performance related to HEDIS quality measures in the QCP program **only** and is not related to any other type of performance within the network.

We will continue to implement this program in 2025. The top performing sites will be calculated by the total number of closed care gaps over the total number of eligible care gaps. The total rate of completed care gaps is assigned a percentile rank as compared to all other eligible sites. All High Performer sites will be recognized with a certificate of recognition to display at your office and a High Performer logo in our Provider Directory.

Congratulations to the fourteen practices below that were recognized and rewarded as high performers in 2024 based on their HEDIS measure performance in QCP MY 2023.

Practice Name	Address	City	Practice Type
Aria Health Physician Services DBA Tillman Family	3220 Tillman Dr Ste 101	Bensalem	Family Medicine
Clinical Care Associates	7133 Roosevelt Blvd	Philadelphia	Internal Medicine
Esperanza Health Center, Inc.	861 E Allegheny Ave	Philadelphia	Family Medicine
Esperanza Health Center, Inc.	4417 N 6th St	Philadelphia	Family Medicine
Fair Hill Community Physicians – Lehigh	100 E Lehigh Ave	Philadelphia	Family Medicine
Fair Hill Community Physicians – Hunting Park	133 W Hunting Park Ave	Philadelphia	Family Medicine
Jonathan B Levyn DO PC	3402 F St	Philadelphia	Family Medicine
Jonathan B Levyn DO PC	4031 Sheffield Ave	Philadelphia	Family Medicine
Murali Pediatrics LLC	1337 Cottman Ave Ste B	Philadelphia	Pediatrics
Pizzica Pediatrics	100 E Lehigh Ave	Philadelphia	Pediatrics
The Ped & Adol Med Centers of Philadelphia	5249 Cedar Ave Ste C	Philadelphia	Pediatrics
Temple Physicians, Inc.	8 Huntingdon Pike Ste 100	Jenkintown	Family Medicine
Temple Physicians, Inc.	8380 Old York Rd Ste 100	Elkins Park	Family Medicine
Temple Physicians, Inc.	9331 Old Bustleton Ave Ste 201	Philadelphia	Family Medicine

2025 QCP Measures

Below are measures included in our QCP program for 2025. Specific details of each measure are provided in this manual — including measure descriptions, requirements, tips for improvement, benchmarks and PMPMs.

2025 Measures	Medicare	Medicaid	CHIP
Adult Population			
Annual Wellness Visit	✓		
Breast Cancer Screening	✓	✓	
Care of Older Adults – Functional Status	✓		
Care of Older Adults – Medication Review	✓		
Colorectal Cancer Screening	✓		
Controlling High Blood Pressure	✓	✓	
Diabetes: Eye Exam	✓	✓	
Diabetes: HbA1c Control (<9%)	✓		
Glycemic Status Assessment for Patients with Diabetes (>9%)		✓	
Kidney Health Evaluation for Patients with Diabetes	✓		
Medication Adherence for Cholesterol Medications	✓		
Medication Adherence for Diabetes Medications	✓		
Medication Adherence for Hypertension Medications	✓		
Medication Reconciliation Post-Discharge	✓		
Patient Engagement After Inpatient Discharge	✓		
Plan All-Cause Readmissions	✓	✓	
Adult & Pediatric Population			
Asthma Medication Ratio		✓	✓
Member Satisfaction (Provider)		✓	
Member Satisfaction (Office Staff)		✓	
Health-Related Social Needs (HRSN)		✓	
Pediatric & Adolescent Population			
Child and Adolescent Well-Care Visits (Ages 3-21)		✓	✓
Childhood Immunization Status		✓	✓
Developmental Screening in the First Three Years of Life		✓	
Lead Screening in Children		✓	✓
Well-Child Visits in the First 15 Months of Life		✓	✓
Well-Child Visits for Age 15 Months - 30 Months		✓	✓

Description of Measures

Please refer to Exhibit C on **page 21** for additional 2025 measure descriptions, requirements and tips for improvement.

MEDICARE ANNUAL WELLNESS VISIT (MEDICARE)

The Medicare Annual Wellness Visit (AWV) is a preventive visit covered by Medicare at no cost to patients. An AWV is an opportunity to connect with patients and focus on issues that may be overlooked during other visits (i.e. sick visits, follow-up visits).

Performance measurement will be based on the submission of the appropriate codes.

G0402: Welcome to Medicare Visit. Must be done in first 12 months of Part B coverage.

G0438: Initial Medicare Annual Wellness Visit. Patients are eligible after the first 12 months of Part B coverage and they must not have already completed a Welcome to Medicare visit in the past 12 months.

G0439: Subsequent Medicare Annual Wellness Visit. This applies to all AWVs after a patient's initial AWV. Patients must not have had an AWV already completed in the past 12 months.

Since this is not a Stars measure, we created custom benchmarks for this measure based on historical network performance.

For additional tips about this measure and how to improve performance, please reference the **Annual Wellness Visits Provider Fact Sheet**, available on our website.

MEDICATION RECONCILIATION POST-DISCHARGE (MEDICARE)

Medication reconciliation is the process of comparing a patient's medication orders after an acute discharge to all the medications the patient had been taking prior to hospitalization. This measure assesses the percentage of discharges from January 1 – December 1 of the measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days). The denominator for this measure is based on total discharges, not total patients. This means that a patient may be in the denominator more than once.

If the discharge is followed by a readmission or a direct transfer to an acute or non-acute inpatient care setting on the date of discharge through 30 days after discharge (31 total days), only the last discharge will be counted. If no medications were prescribed or ordered upon discharge, this must be notated in the medical record.

An outpatient visit is not required to conduct medication reconciliation, although documentation that it was performed must be in the outpatient chart to meet the intent of this measure. Medication reconciliation **must** be conducted by a prescribing practitioner, clinical pharmacist, or registered nurse (RN).

Your patients do **not** need to be present for you to meet the requirement for this measure, but the 1111F CPT II code must be billed, and the criteria below must be documented in your patients' medical records. You may also bill the transition of care codes listed below if you have a face-to-face visit with your patients.

Codes for Medication Reconciliation:

- **CPT Transition of Care Codes**: 99495, 99496, 99483
- **CPT II**: 1111F

Documentation in the medical record must include all of the following:

- The date of the review and reconciliation, as well as the credentials of the person completing the reconciliation.
- Evidence of medication review and reconciliation or that no medications were prescribed or ordered upon discharge.

Exclusions for this measure:

- Patients in hospice or using hospice services any time during the measurement year.
- Patients who died during the measurement year.

For additional information, tips, and best practices regarding this measure, please reference our Medication Reconciliation Post-Discharge Tip Sheet released in 2024, available on our **Medication Management and Adherence webpage**.

MEMBER SATISFACTION (MEDICAID)

We continue to measure our Medicaid members' satisfaction with the care that they are receiving from our network providers. In 2025, we will continue to use two survey questions to be included as Medicaid-only measures in QCP:

- How would you rate your provider's ability to explain things in a way that was easy to understand?
- How would you rate the ability of the clerks and receptionists at this provider's office to treat you with courtesy and respect?*

**This question will not count for any visits conducted via telehealth since members may only interact with their provider during telehealth visits.*

Response options for these questions include the following: Excellent, Very Good, Good, Fair, Poor, and Not Ascertained.

The survey targets Medicaid members who have completed a visit with their attributed PCP for all QCP practice groups with more than 300 total Health Partners Plans Medicaid members (at the practice group level). A minimum of 30 completed surveys per practice group are required in order to be included in this measure. Members will only be included in the sample on a bi-annual basis (January – June and July – December). Surveys will only be conducted a maximum of two times per year for members with multiple visits to avoid bias and survey fatigue (this is only applicable if the survey is completed). Surveys will be conducted via text and live phone calls.

Providers will be measured at the practice group level and will receive bi-monthly report cards from their Provider Relations Representatives, available at the TIN and practice group levels. Results will be recalculated beginning with the May 2026 payment (based on January 2025 – December 2025 measurement period).

The following benchmarks will be used for the member satisfaction measures. These benchmarks were set based on Jefferson Health Plans/Health Partners Plans providers' historical performance on like measures. Scores will be based on the combination of Very Good and Excellent member responses.

Medicaid Measures	Tier 1	Tier 2	Tier 3	Tier 4
How would you rate your provider's ability to explain things in a way that was easy to understand?	94.00%	95.50%	97.00%	98.50%
How would you rate the ability of the clerks and receptionists at this provider's office to treat you with courtesy and respect?	95.00%	96.00%	97.00%	98.00%

Please note that rates are not rounded up for any performance measures.

We will continue to provide practice groups with blinded member level open-ended responses and feedback per request, in addition to the TIN and practice group level report cards that are also issued bi-monthly based on our satisfaction survey responses.

PATIENT ENGAGEMENT AFTER INPATIENT DISCHARGE (MEDICARE)

This measure is considered one of the four sub-measures of the Transitions of Care (TRC) HEDIS measure. The measure assesses the percentage of discharges for members ages 18 and older who had patient engagement provided within 30 days after discharge. Patient engagement on the date of discharge does not count.

The following meet criteria for patient engagement:

- An outpatient visit, including office visits and home visits
- A telephone visit
- Transitional care management services
- An e-visit or virtual check-in

If the member is unable to communicate with the provider, interaction between the member's caregiver and the provider meets criteria.

The denominator for this measure is based on total discharges, not total patients. This means that a patient may be in the denominator more than once. If the discharge is followed by a readmission or a direct transfer to an acute or non-acute inpatient care setting on the date of discharge through 30 days after discharge (31 total days), only the last discharge will be counted.

Exclusions for this measure:

- Patients in hospice or using hospice services anytime during the measurement year.
- Patients who died during the measurement year.

For additional information, tips, and best practices regarding this measure, please reference our Transitions to Care Tip Sheet released in 2024, available on our **Quality and Population Health webpage**.

PLAN ALL-CAUSE READMISSIONS (MEDICAID & MEDICARE)

This measure rewards your practice for providing quality care, support for self-management and appropriate post-discharge planning and care coordination to your patients ages 18 and older during the measurement year. Please note that this measure is based on the number of discharges, not patients. This means that a patient may be included in the denominator more than once.

For Medicaid, we will be measuring the observed readmission over expected readmission ratio. This measure assesses the number of acute inpatient or observation stays for patients ages 18 and older during the measurement year (January 1 to December 1) that were followed by an

unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. The measure calculates the count of 30-day observed readmissions divided by the count of 30-day expected readmissions, which is referred to as the observed/expected ratio. Qualifying readmissions must have a service date within 30 days of the previous index discharge date. The readmission can be to the same hospital or to a different hospital, and for the same condition or for a different condition.

For Medicare, we will be measuring the observed readmission rate. This measure assesses the number of acute inpatient or observation stays for patients ages 18 and older during the measurement year (January 1 to December 1) that were followed by an unplanned acute readmission for any diagnosis within 30 days. The measure calculates the observed readmission rate by the count of observed readmissions within 30 days divided by the count of initial acute stays.

For both Medicaid and Medicare, the measure includes acute discharges from any type of facility (including behavioral health care facilities). For discharges with one or more direct transfers, the last discharge is used. A direct transfer is when a discharge date from the initial stay precedes the admission date to a subsequent stay by one calendar day or less. Inpatient and observation stays in which the previous discharge and the readmission date are two or more calendar days apart are considered distinct inpatient stays. Direct transfers that take place within the same institution and to the same service category (but to different levels of care) count as one admission. A direct transfer between acute inpatient and observation does not count as a readmission. Your practice must have at least 30 individual discharges in order to be eligible for this measure and receive a payout.

Exclusions for this measure:

- Denied claims
- Patients in hospice
- Planned hospital stays in which the admission date is the same as the discharge date
- Hospital stays involving the following:
  - Patients who passed away during the stay
  - Patients with a principal diagnosis of pregnancy on a discharge claim
  - A principal diagnosis of a condition originating in the perinatal period on the discharge claim

HEALTH-RELATED SOCIAL NEEDS (MEDICAID)

Social determinants of health (SDOH) refers to factors that may create barriers to health and well-being beyond access to medical services at a community level. However, the specific factors that impact individuals directly are called “health-related social needs” (HRSN). Health providers can take steps to address HRSN by screening patients and referring them to community-based services.

This measure assesses the percentage of your patients for whom we receive HRSN-based codes via claims at least once during the measurement period (January 2025 – December 2025). We will compare the rate (the percentage of members with completed HRSN screenings) to predefined benchmarks we've set. All our patients enrolled with QCP-participating practice groups are eligible if they have been enrolled in our network for at least 10 months during the measurement period. Claim submissions will not be restricted to attributed providers and will be accepted from any PCP or Specialist.

The following codes must be submitted via claims to count for compliance:

1. If the HRSN assessment is completed and positive (barriers identified), submit HCPCS Code **G9919** AND the appropriate HRSN Diagnosis Code(s) listed in Exhibit B on **pages 19 and 20**.
2. If the HRSN assessment is completed and negative (no barriers identified), submit HCPCS Code **G9920**.

We recommend all patients be screened for HRSN at least once per year. Identified barriers should be addressed by referral to appropriate community resources and revisited during subsequent visits. Appropriate codes should continue to be submitted.

We encourage providers to access our premium version of FindHelp (**hpp.findhelp.com**), a web-based social care network that helps connect members to social services in their communities. With this tool, community resources can be identified to address the following DHS-priority social barriers: Financial Resource Strain, Food Insecurity, Housing Instability, Transportation, Health Care/Medical Access/Affordability, Childcare, Employment, Utilities and Clothing. Additionally, referrals to community resources can be made, received and tracked through FindHelp.

Exhibit A: Measure Specific Benchmarks and Payments

We utilize a benchmark methodology that was created using a combination of NCQA industry-standard benchmarks, historical performance and clustering of our network performance. We also followed the clustering methodology CMS uses for its Medicare Star Rating Program where the benchmarks are created based on the results of all participating plans. For 2023, CMS implemented a Tukey outlier deletion method when calculating the Medicare Stars cut points. In order to counteract favorable regulatory changes CMS made during the Public Health Emergency (PHE), this change in methodology increased cut point thresholds. In 2024, CMS continued to make market corrections through their regulatory changes and individual star measure thresholds (cut points) increased dramatically, with 60% of the Stars program becoming harder to achieve success at the measure level compared to last year.

Medicare	Benchmarks			PMPM		
Measure	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3
Annual Wellness Visit	45.00%	55.00%	65.00%	$0.50	$1.50	$2.50
Breast Cancer Screening	67.00%	75.00%	82.00%	$0.50	$1.75	$2.50
Care of Older Adult – Functional Status	85.00%	92.00%	97.00%	$0.80	$1.50	$3.00
Care of Older Adult – Medication Review	80.00%	92.00%	98.00%	$1.00	$2.00	$3.50
Colorectal Cancer Screening	65.00%	75.00%	83.00%	$0.50	$1.75	$2.00
Controlling High Blood Pressure	74.00%	80.00%	85.00%	$0.75	$2.00	$2.75
Diabetes: Eye Exam	70.00%	77.00%	83.00%	$0.50	$1.00	$1.50
Diabetes: HbA1c Control (<9%)	72.00%	84.00%	90.00%	$0.50	$2.00	$2.75

Medicare	Benchmarks			PMPM		
Measure	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3
Kidney Health Evaluation for Patients with Diabetes	51.00%	58.00%	65.00%	$0.50	$1.00	$1.50
Medication Adherence for Cholesterol	85.00%	89.00%	93.00%	$0.75	$1.75	$2.00
Medication Adherence for Diabetes	85.00%	87.00%	91.00%	$0.75	$1.75	$2.00
Medication Adherence for Hypertension	87.00%	90.00%	92.00%	$0.75	$1.75	$2.25
Medication Reconciliation Post-Discharge	57.00%	73.00%	87.00%	$0.25	$1.25	$1.50
Patient Engagement After Inpatient Discharge	77.00%	86.00%	93.00%	$0.75	$1.75	$2.00
Plan All-Cause Readmissions	0.12	0.10	0.08	$0.50	$1.75	$3.50

CHIP	Benchmarks				PMPM			
Measure	Tier 1	Tier 2	Tier 3	Tier 4	Tier 1	Tier 2	Tier 3	Tier 4
Asthma Medication Ratio	68.00%	73.00%	80.00%	87.00%	$0.50	$0.75	$0.85	$1.00
Child and Adolescent Well-Care Visits	60.00%	65.00%	75.00%	85.00%	$0.20	$0.40	$0.75	$1.00
Childhood Immunization Status	29.00%	36.00%	39.00%	42.00%	$0.20	$0.40	$0.60	$1.00
Lead Screening in Children	56.00%	67.00%	78.00%	88.00%	$0.20	$0.40	$0.60	$0.80
Well-Child Visits for First 15 Months of Life	50.00%	60.00%	70.00%	80.00%	$0.10	$0.30	$0.75	$1.25
Well-Child Visits for Age 15 Months – 30 Months	73.00%	78.00%	83.00%	87.00%	$0.25	$0.50	$0.75	$1.00

Medicaid	Benchmarks				PMPM			
Measure	Tier 1	Tier 2	Tier 3	Tier 4	Tier 1	Tier 2	Tier 3	Tier 4
Asthma Medication Ratio	68.00%	72.00%	79.00%	86.00%	$0.50	$1.00	$1.75	$2.50
Breast Cancer Screening	58.00%	65.00%	70.00%	75.00%	$0.10	$0.30	$0.75	$1.00
Child and Adolescent Well Care Visits (Total)	61.00%	70.00%	75.00%	85.00%	$0.15	$0.65	$1.00	$1.50
Childhood Immunization Status	42.00%	50.00%	53.00%	60.00%	$0.25	$0.50	$1.25	$1.50
Comprehensive Diabetes Care: Eye Exam	57.00%	63.00%	69.00%	70.00%	$0.10	$0.25	$0.50	$0.75
Controlling High Blood Pressure	58.00%,	65.00%	75.00%	88.00%	$0.50	$1.00	$1.50	$2.00

Medicaid	Benchmarks				PMPM			
Measure	Tier 1	Tier 2	Tier 3	Tier 4	Tier 1	Tier 2	Tier 3	Tier 4
Developmental Screening in the first Three Years of Life	60.00%	67.00%	85.00%	92.00%	$0.25	$0.50	$1.00	$1.50
Glycemic Status Assessment for Patients with Diabetes (>9%)	39.50%	37.00%	33.50%	28.00%	$0.25	$0.75	$1.25	$1.75
Lead Screening in Children	75.00%	85.00%	90.00%	95.00%	$0.25	$0.50	$0.75	$1.50
Member Satisfaction (Provider)	92.00%	94.00%	95.50%	98.50%	$0.20	$0.40	$0.60	$1.00
Member Satisfaction (Office Staff)	94.00%	95.00%	96.00%	98.00%	$0.20	$0.40	$0.60	$1.00
Plan All-Cause Readmissions	0.99	0.79	0.59	0.39	$0.25	$0.50	$1.00	$1.50
Health-Related Social Needs (HRSN)	25.00%	35.00%	40.00%	50.00%	$0.10	$0.30	$0.50	$1.25
Well-Child Visits in the First 15 Months of Life	61.00%	72.00%	80.00%	85.00%	$0.25	$0.50	$1.00	$1.75
Well-Child Visits for Age 15 Months-30 Months	70.00%	75.00%	85.00%	90.00%	$0.25	$0.50	$1.25	$1.50

Please note: In alignment with the HEDIS and Stars calculation methodology, performance rates are not rounded up for any performance measures.

Exhibit B: Descriptions of HRSN Diagnosis Codes

Please submit the following appropriate diagnosis code(s) **AND** HCPCS code **G9919** if you complete an HRSN screening assessment and identify barriers. **Additionally, please ensure that you are using the specific, billable diagnosis code(s), not the non-billable header codes (e.g., Z55, Z56, Z56.8, etc.)**.

For assessments completed in which no barriers have been identified, submit HCPCS code **G9920** only. (Submission of this code will still count toward the HRSN measure since the screening has been completed.)

Problems related to education and literacy (Z55)	
Z55.0	Illiteracy and low-level literacy
Z55.1	Schooling unavailable and unattainable
Z55.2	Failed school examinations
Z55.3	Underachievement in school
Z55.4	Educational maladjustment and discord with teachers and classmates
Z55.8	Other problems related to education and literacy
Z55.9	Problems related to education and literacy, unspecified

Problems related to employment and unemployment (Z56)	
Z56.0	Unemployment, unspecified
Z56.1	Change of job
Z56.2	Threat of job loss
Z56.3	Stressful work schedule
Z56.4	Discord with boss and workmates
Z56.5	Uncongenial work environment
Z56.6	Other physical and mental strain related to work
Z56.9	Unspecified problems related to employment
Other problems related to employment (Z56.8)	
Z56.81	Sexual harassment on the job
Z56.82	Military deployment status
Z56.89	Other problems related to employment

Occupational exposure to risk factors (Z57)	
Z57.0	Occupational exposure to noise
Z57.1	Occupational exposure to radiation
Z57.2	Occupational exposure to dust
Z57.4	Occupational exposure to toxic agents in agriculture
Z57.5	Occupational exposure to toxic agents in other industries
Z57.6	Occupational exposure to extreme temperature
Z57.7	Occupational exposure to vibration
Z57.8	Occupational exposure to other risk factors
Z57.9	Occupational exposure to unspecified risk factor
Occupational exposure to other air contaminants (Z57.3)	
Z57.31	Occupational exposure to environmental tobacco smoke
Z57.39	Occupational exposure to other air contaminants

Problems related to housing and economic circumstances (Z59)	
Z59.00	Homelessness unspecified
Z59.01	Sheltered homelessness
Z59.02	Unsheltered homelessness
Z59.1	Inadequate housing
Z59.2	Discord with neighbors, lodgers and landlord
Z59.3	Problems related to living in residential institution
Z59.41	Food insecurity
Z59.42	Other specified lack of adequate food
Z59.5	Extreme poverty (100% FPL or below)
Z59.6	Low income (200% FPL or below)
Insufficient social insurance and welfare support (Z59.7)	
Z59.71	Insufficient health insurance coverage
Z59.72	Insufficient welfare support
Z59.81	Housing instability, housed
Z59.811	Housing instability, housed, with risk of homelessness
Z59.812	Housing instability, housed, homelessness in past 12 months
Z59.819	Housing instability, housed unspecified
Z59.89	Other problems related to housing and economic circumstances
Z59.9	Problem related to housing and economic circumstances, unspecified

Problems related to social environment (Z60)	
Z60.0	Problems of adjustment to life-cycle transitions
Z60.2	Problems related to living alone
Z60.3	Acculturation difficulty
Z60.4	Social exclusion and rejection
Z60.5	Target of (perceived) adverse discrimination and persecution
Z60.8	Other problems related to social environment
Z60.9	Problem related to social environment, unspecified

Problems related to upbringing (Z62)	
Z62.0	Inadequate parental supervision and control
Z62.1	Parental overprotection
Z62.3	Hostility toward and scapegoating of child
Z62.6	Inappropriate (excessive) parental pressure
Z62.9	Problem related to upbringing, unspecified
Upbringing away from parents (Z62.2)	
Z62.21	Child in welfare custody
Z62.22	Institutional upbringing
Z62.29	Other upbringing away from parents
Other specified problems related to upbringing (Z62.8) & Personal history of abuse in childhood (Z62.81)	
Z62.810	Personal history of physical and sexual abuse in childhood
Z62.811	Personal history of psychological abuse in childhood
Z62.812	Personal history of neglect in childhood
Z62.813	Personal history of forced labor or sexual exploitation in childhood
Z62.819	Personal history of unspecified abuse in childhood
Parent-child conflict (Z62.82)	
Z62.820	Parent-biological child conflict
Z62.821	Parent-adopted child conflict
Z62.822	Parent-foster child conflict
Other specified problems related to upbringing (Z62.89)	
Z62.890	Parent-child estrangement not elsewhere classified
Z62.891	Sibling rivalry
Z62.898	Other specified problems related to upbringing

Other problems related to primary support group, including family circumstances (Z63)	
Z63.0	Problems in relationship with spouse or partner
Z63.1	Problems in relationship with in-laws
Z63.4	Disappearance and death of family member
Z63.5	Disruption of family by separation and divorce
Z63.6	Dependent relative needing care at home
Z63.8	Other specified problems related to primary support group
Z63.9	Problem related to primary support group, unspecified
Absence of family member (Z63.3)	
Z63.31	Absence of family member due to military deployment
Z63.32	Other absence of family member
Other stressful life events affecting family & household (Z63.7)	
Z63.71	Stress on family due to return of family member from military deployment
Z63.72	Alcoholism and drug addiction in family
Z63.79	Other stressful life events affecting family and household

Problems related to certain psychosocial circumstances (Z64)	
Z64.0	Problems related to unwanted pregnancy
Z64.1	Problems related to multiparity
Z64.4	Discord with counselors

Problems related to other psychosocial circumstances (Z65)	
Z65.0	Conviction in civil and criminal proceedings without imprisonment
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to release from prison
Z65.3	Problems related to other legal circumstances
Z65.4	Victim of crime and terrorism
Z65.5	Exposure to disaster, war and other hostilities
Z65.8	Other specified problems related to psychosocial circumstances
Z65.9	Problem related to unspecified psychosocial circumstances

Problems related to life management difficulty (Z73)	
Z73.3	Stress not elsewhere classified

Personal history of psychological trauma, not elsewhere classified (Z91.4)	
Z91.42	Personal history of forced labor or sexual exploitation
Personal history of adult abuse (Z91.41)	
Z91.410	Personal history of adult physical and sexual abuse
Z91.411	Personal history of adult psychological abuse
Z91.412	Personal history of adult neglect
Z91.419	Personal history of unspecified adult abuse

Diagnosis of patient's intentional underdosing of medication regimen due to financial hardship	
Z91.120	Patient's intentional underdosing of medication regimen due to financial hardship

Encounter for screening, unspecified	
Z13.9	Encounter for screening, unspecified

We suggest working with your leadership team at your practice to identify a set of universally agreed upon HRSN ICD-10 codes.

Exhibit C: Measure Descriptions, Codes for Compliance, and Best Practices

These measure descriptions, requirements, codes and calculations are defined, maintained and updated annually by NCQA. Your practice scores will be determined by your HEDIS performance. The Medication Adherence measures are adapted from the Medication Adherence-Proportion of Days Covered measure developed and endorsed by the Pharmacy Quality Alliance. The adherence measures are also endorsed by the National Quality Forum.

All CPT and HCPCS codes listed in this section are on our fee schedule, unless specified. Codes that are included on a fee schedule do not guarantee payment for services rendered but will count toward the measure. Also included are tips that can help you improve your rates on each of these quality measures. As always, please make sure you are appropriately documenting and coding using the codes we've provided. Additionally, please ensure claims and encounter data are submitted quickly and accurately. Please note that unless indicated, we will not accept supplemental data files under any circumstances except in the event that there is an error in our data/unless otherwise requested.

If any participating provider groups encounter extenuating circumstances, please submit an appeal in writing, but we can make no guarantees that the request will be accommodated.

Asthma Medication Ratio	
Measure Description	The percentage of patients 5–64 years of age who were identified as having persistent asthma and had a ratio of .50 or higher of controller medications to total asthma medications during the measurement year.
Product Lines	Medicaid and CHIP
Eligible Patients	• Patients ages 5-64 as of December 31 of the measurement year are included. • Patients are identified as having persistent asthma when they meet at least one of the following criteria during the measurement year and the year prior to the measurement year (criteria need not be the same across both years): – At least one ED visit with a principal diagnosis of asthma. – At least one acute inpatient encounter with a principal diagnosis of asthma without telehealth. – At least one acute inpatient discharge with a principal diagnosis of asthma on the discharge claim. – At least four outpatient visits, observation visits, telephone visits or e-visits/virtual check-ins on different dates of service with any diagnosis of asthma and at least two asthma medication dispensing events for any controller or reliever medication (visit type need not be the same for four visits). – At least four asthma medication dispensing events for any controller or reliever medication
Exclusions	• Members who had a diagnosis that requires a different treatment approach than members with asthma any time during the patient's history through December 31 of the measurement year including, but not limited to, acute respiratory failure, chronic respiratory conditions due to fumes or vapors, COPD, cystic fibrosis, emphysema or other emphysema, or obstructive chronic bronchitis. • Members who had no asthma controller or reliever medications dispensed during the measurement year. • Members in hospice or using hospice services any time during the measurement year. • Members who died any time during the measurement year.

Asthma Medication Ratio			
Telehealth Allowance	None		
Tips to Improve Performance	• Discuss medication adherence during all visits and incorporate as part of pre-visit checklist. • Ensure patients are accurately diagnosed with persistent asthma. • Educate your patients and their family members about self-management, identifying triggers and the importance of adhering to the medication instructions. • Evaluate members before approving requests for refills of rescue inhalers. • Schedule regular follow-up visits for your patients with persistent asthma. • Document patients' medication lists and the date medications were prescribed. • Assess patients use of rescue inhalers versus controller medications at each visit. • Ask your Provider Relations Representative about installing an on-site mobile dispensing unit in your office. • Leverage pharmacies that provide in-home delivery services. • Review and work the AMR worklists we provide which include members with multiple fills of rescue inhalers but no controller medications. • Review our member level reports in our provider portal to identify noncompliant members.		
Medications for Compliance *(Please note that some medications may be available only as certain brand name drugs or certain formulations on our formulary or may require a prior authorization.)*	Antibody Inhibitor	• Omalizumab	
	Anti-interleukin-4	• Dupilumab*	
	Anti-interleukin-5	• Benralizumab • Mepolizumab	• Reslizumab* • Tezepelumab
	Inhaled Corticosteroids	• Beclomethasone • Budesonide • Ciclesonide*	• Flunisolide* • Fluticasone • Mometasone
	Inhaled Steroid Combinations	• Budesonide-Formoterol • Fluticasone-Salmeterol • Fluticasone-Vilanterol*	• Mometasone-Formoterol • Fluticasone-umeclidinium-vilanterol
	Leukotriene Modifiers	• Montelukast • Zafirlukast*	• Zileuton*
	Methylxanthines	• Theophylline	
	Short-acting, inhaled beta-2 agonists	• Albuterol	• Levalbuterol

**Medication is not on our formulary.*

Breast Cancer Screening	
Measure Description	The percentage of patients 40–74 years of age who had a mammogram to screen for breast cancer in the past 27 months before the end of the measurement period (e.g., screening must be completed between 10/1/23 and 12/31/25 to count for the 2025 measurement period [1/1/25 - 12/31/25]). *Note: All types and methods of mammograms (screening, diagnostic, film, digital or digital breast tomosynthesis) qualify for compliance.*
Product Lines	Medicare and Medicaid
Eligible Patients	Patients 42 to 74 years of age. Patients who turn 42 years old during the measurement year are included.
Exclusions	• Patients with bilateral mastectomy at any time during the patient's history through December 31 of the measurement year. Any of the following meet criteria: – Bilateral mastectomy – Unilateral mastectomy with a bilateral modifier (including mastectomy found in clinical data) – History of bilateral mastectomy – Mastectomy on both the left and right side (on the same or different dates of service) • Patients receiving palliative care or who had an encounter for palliative care during the measurement year. • Patients in hospice or using hospice services anytime during the measurement year. • Patients who died during the measurement year. • Patients who had gender-affirming chest surgery with a diagnosis of gender dysphoria any time during the member's history through the end of the measurement period. • Patients 66 years of age and older with frailty and advanced illness. Patients must meet both of the following to be excluded: – At least two indications of frailty with different dates of service during the measurement period. – Any of the following during the measurement year or the year prior: o Two outpatient visits, observation visits, ED visits, telephone visits, e-visits/virtual check-ins or nonacute inpatient encounters/discharges on different dates of service, with an advanced illness diagnosis. o One acute inpatient encounter with an advanced illness diagnosis. o At least one acute inpatient discharge with an advanced illness diagnosis. o Dispensed dementia medication. Please refer to Exhibit D: Exclusion Codes for Palliative Care, Advanced Illness and Frailty on **page 45** for exclusion codes.
Telehealth Allowance	None
Tips to Improve Performance	• Address barriers that might prevent your patient from getting a mammogram (e.g., transportation or fear of discomfort during the screening). • Be proactive in writing scripts for patients who are overdue for screenings to reduce administrative burden. • Document the appropriate date(s) in the patient's medical record if the patient has already had a breast cancer screening or a bilateral mastectomy. • Utilize walk-in hours available at screening locations.

<table>
<tr><th colspan="4">Breast Cancer Screening</th></tr>
<tr><td>Tips to Improve Performance</td><td colspan="3">• Partner with a mobile mammogram van (e.g., Fox Chase, Jefferson) to hold screening events at your sites/practice groups.
• Review our member level reports in our provider portal to identify members due for a mammogram and make outreach efforts to schedule them for a mammogram.
• Leverage our member incentive programs.
• Submit the 3014F Breast Cancer Screening CPT II code to indicate that a breast cancer screening was completed, documented, and reviewed. This can help identify charts for medical record review and may lead to a HEDIS "hit" and care gap closure.</td></tr>
<tr><td>Codes for Compliance</td><td>Mammogram</td><td>CPT</td><td>77061-77063, 77065-77067</td></tr>
<tr><td>Exclusion Codes</td><td>Bilateral Mastectomy</td><td colspan="2"><u>Bilateral Mastectomy</u>
• ICD10PCS: 0HTV0ZZ

<u>Unilateral Mastectomy (Left and Right)</u>
• Unilateral Mastectomy (CPT): 19180. 19200. 19220. 19240, 19303, 19304*, 19305-19307
• Left (ICD10PCS): 0HTU0ZZ
• Right (ICD10PCS): 0HTT0ZZ

<u>History of Bilateral Mastectomy</u>
• ICD10CM: Z90.13

<u>Absence of Breast (Left and Right)</u>
• Left Breast (ICD10CM): Z90.12
• Right Breast (ICD10CM): Z90.11</td></tr>
</table>

**Code not on our fee schedule, but will count toward the measure.*

Care of Older Adults – Functional Status			
Measure Description	The percentage of patients 66 years and older who had a functional status assessment completed during the measurement year. • Services rendered during a telephone visit, e-visit/virtual check in will count for compliance.		
Product Line	Medicare (D-SNP Only)		
Eligible Patients	Based on age only. Patients who turn 66 years old during the measurement year are included.		
Exclusions	• Members in hospice or using hospice services anytime during the measurement year. • Members who died during the measurement year.		
Telehealth Allowance	Patient-reported outcomes during telehealth visits and/or telephone phone assessments are permissible for functional status and pain assessments.		
Tips to Improve Performance	• Complete the medication review, functional status assessment and pain assessment during the same visit. Do this annually for all eligible patients. • Make sure all three elements are completed and appropriately documented. Utilize all touchpoints by your clinical team to complete these assessments (e.g., telephonic and face-to-face outreach). • Implement a standard screening process for your patients, starting at age 65. • Create a checklist to make sure all criteria for each assessment are captured. • Review our member level reports in our provider portal to identify noncompliant members.		
Codes for Compliance	Functional Status Assessment	CPT	99483
		CPT II	1170F
		HCPCS	G0438, G0439
	Transitional Care Management Services (TCM)	CPT	99495, 99496

Care of Older Adult – Medication Review	
Measure Description	The percentage of patients 66 years and older who had a medication review completed during the measurement year. • Patients are not required to be present for the medication review. • The medication review must be completed by a prescribing practitioner or clinical pharmacist.
Product Line	Medicare (D-SNP Only)
Eligible Patients	Based on age only. Patients who turn 66 years old during the measurement year are included.
Exclusions	• Members in hospice or using hospice services anytime during the measurement year. • Members who died during the measurement year.
Telehealth Allowance	Patient-reported outcomes during telehealth visits and/or telephone phone assessments are permissible for functional status and pain assessments.

<table>
<tr><th colspan="4">Care of Older Adult – Medication Review</th></tr>
<tr><td>Tips to Improve Performance</td><td colspan="3">• Complete the medication review, functional status assessment and pain assessment during the same visit. Do this annually for all eligible patients.
• Make sure all three elements are completed and appropriately documented. Utilize all touchpoints by your clinical team to complete these assessments (e.g., telephonic and face-to-face outreach).
• Implement a standard screening process for your patients, starting at age 65.
• Create a checklist to make sure all criteria for each assessment are captured.
• Review our member level reports in our provider portal to identify noncompliant members.
– If a patient is not taking any medications, then documentation noting this and the date it was noted will count for compliance.
– In order to receive credit through claims data for the medication review; two codes must be submitted, one for a medication list and one for a medication review on the same date of service for the member to be compliant through claims.</td></tr>
<tr><td rowspan="5">Codes for Compliance</td><td rowspan="2">Medication List</td><td>CPT II</td><td>1159F</td></tr>
<tr><td>HCPCS</td><td>G8427</td></tr>
<tr><td rowspan="2">Medication Review</td><td>CPT</td><td>90863, 99483, 99605, 99606</td></tr>
<tr><td>CPT II</td><td>1160F</td></tr>
<tr><td>Transitional Care Management Services (TCM)</td><td>CPT</td><td>99495, 99496</td></tr>
</table>

Child and Adolescent Well-Care Visits (Ages 3-21)	
Measure Description	The percentage of patients 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB-GYN during the measurement year. *Note: Well visits completed by a non-PCP or non-OB-GYN do not count toward the measure.*
Product Lines	Medicaid and CHIP
Eligible Patients	Based on age only. Members who turn 3 years old during the measurement year are included.
Exclusions	• Members in hospice or using hospice services anytime during the measurement year. • Members who died during the measurement year.
Telehealth Allowance	None. **Please note that per NCQA, telehealth is no longer allowed for well visits.**
Tips to Improve Performance	• If a patient comes in for a sick visit or a sports physical and is due for a well-care visit, try to complete all services of a well-care visit. Well-care preventive services count toward the measure, regardless of the primary intent of the visit. • Remind your staff that **your patients are eligible for a well-child visit once every year, even if 365 days have not yet passed since their last well-child visit in the prior calendar year**. Providers will be reimbursed as long as it is a new calendar year. • Prioritize outreach efforts by targeting patients within the same household to achieve a greater impact.

Child and Adolescent Well-Care Visits (Ages 3-21)			
Tips to Improve Performance	• Review all open care gaps for the patient and attempt to close all gaps (e.g., patients might also be due for a dental visit). • If the patient comes into the office as a walk-in, complete the well-care visit during that time. • Leverage our member incentive programs. • Partner with us to hold block scheduling events. • Review our member level reports in our provider portal to identify noncompliant members. • If possible, send reminders of scheduled visit dates and time via calls or texts. • Review and work the WCV worklists we've provided which includes members who are noncompliant for their well visits.		
Codes for Compliance	Well-Care Visit/ Encounter for Well-Care	CPT	99381-99385, 99391-99395, 99461
		HCPCS	G0438, G0439, S0302*, S0610*, S0612*, S0613*
		ICD10 CM	Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, Z02.5, Z02.84, Z76.1, Z76.2

**Code not on our fee schedule, but will count toward the measure.*

Childhood Immunization Status	
Measure Description	The percentage of patients who had all of the following vaccines by their second birthday: • Four Diphtheria, Tetanus and Acellular Pertussis (DTaP) • One Hepatitis A (Hep A) • Three Hepatitis B (Hep B) • Three Haemophilus Influenza Type B (HiB) • Two Influenza* (flu) • Three Polio (IPV) • One Measles, Mumps and Rubella (MMR) • Four Pneumococcal Conjugate (PCV) • Two or three Rotavirus (RV) • One Chicken Pox (VZV) *To be compliant, all vaccines must be administered on or before the child's second birthday. Please note that the HEDIS specifications require that the codes be billed according to the dose that each member receives. The HEDIS specification does not allow them to be interchangeable (i.e. Rotavirus 2 Dose Schedule vs. Rotavirus 3 Dose Schedule. The vaccine product should be consistent throughout the entire series).* **One of the two influenza vaccinations can be an LAIV vaccination; however, LAIV vaccination must be administered on the child's second birthday (LAIV vaccination administered before the child's second birthday does not count).*
Product Lines	Medicaid and CHIP
Eligible Patients	Based on age only. Patients who turn 2 years old during the measurement year are included.
Exclusions	• Members in hospice or using hospice services anytime during the measurement year. • Members who died during the measurement year. • Members who had a contraindication to a childhood vaccine on or before their second birthday (this includes organ and bone marrow transplants).
Telehealth Allowance	None

Childhood Immunization Status		
Tips to Improve Performance	• Schedule in advance. Educate office staff to schedule appointments prior to the patient's second birthday. Any vaccines administered after age 2 will not be counted toward the measure. • Document all administered shots and the dates of the shot visits. • Send reminders to parents to avoid missed appointments and dosages. • Document name of vaccination and number of doses for rotavirus vaccine. • Review all open care gaps for the patient and attempt to close all gaps together (e.g., patients might also be due for a dental visit). • Prioritize outreach efforts by targeting patients within the same household to achieve a greater impact. • Take advantage of all visits, including walk-ins, to administer the vaccines. • Review our member level reports in our provider portal to identify noncompliant members.	
Vaccines Administered for Compliance	Diphtheria, Tetanus and Acellular Pertussis (DTaP)	**CPT:** 90697, 90698, 90700, 90723 **CVX:** 0110, 0120, 0146, 20, 50, 106, 107, 198
	Hepatitis A (Hep A)	**CPT:** 90633 **CVX:** 31, 83, 85 **ICD10CM:** B15.0, B15.9
	Hepatitis B (Hep B)	**CPT:** 90697*, 90723, 90740*, 90744, 90747, 90748* **CVX:** 0110, 0146, 08, 44, 45, 51, 198 **HCPCS**: G0010* **ICD10CM:** B16.0-B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11
	Haemophilus Influenza Type B (HiB)	**CPT:** 90644*, 90647, 90648, 90697, 90698, 90748 **CVX:** 0120, 0146, 0148, 17, 46-51, 198
	Influenza	**CPT:** 90655*, 90657*, 90660, 90661*, 90672, 90673*, 90674, 90685-90688, 90689*, 90756 **CVX:** 88, 111, 140, 141, 149, 150, 153, 155, 158, 161, 171, 186
	Polio (IPV)	**CPT:** 90697, 90698, 90713, 90723 **CVX:** 0110, 0120, 0146, 10, 89
	Measles, Mumps and Rubella (MMR)	**CPT:** 90707, 90710 **CVX:** 03, 94 **ICD10CM:** B05.0-B05.4, B05.81, B05.89, B05.9, B06.00-B06.02, B06.09, B06.81, B06.82, B06.89*, B06.9, B26.0-B26.3, B26.81-B26.85, B26.89, B26.9
	Pneumococcal Conjugate (PCV)	**CPT:** 90670, 90671, 90677 **CVX:** 0109, 0133, 0152, 0215, 216 **HCPCS:** G0009
	Rotavirus (RV)	**CPT:** 90680, 90681 **CVX:** 0116, 0119, 0122
	Chicken Pox (VZV)	**CPT:** 90710, 90716 **CVX:** 21, 94 **ICD10CM:** B01.0, B01.11, B01.12, B01.2, B01.81, B01.89, B01.9, B02.0, B02.1, B02.21-B02.24, B02.29-B02.34, B02.39, B02.7-B02.9

**Code not on our fee schedule, but will count toward the measure.*

Colorectal Cancer Screening	
Measure Description	The percentage of patients 45–75 years of age who had appropriate screening for colorectal cancer. Any of the following types of screenings during the measurement year meet criteria: • Fecal occult blood test (FOBT) • FIT-DNA test (or two years prior to the measurement year) • Flexible sigmoidoscopy (or 4 years prior to the measurement year) • CT Colonography (or 4 years prior to the measurement year) • Colonoscopy (or 9 years prior to the measurement year)
Product Line	Medicare
Eligible Patients	Based on age only. Patients who turn 46 years old during the measurement year are included.
Exclusions	• Patients with colorectal cancer or total colectomy anytime during the patient's history. • Patients in hospice or using hospice services anytime during the measurement year. • Patients who died anytime during the measurement year. • Patients receiving palliative care during the measurement year. • Patients 66 years of age and older who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. – Living long-term in an institution any time during the measurement year. • Patients 66 years of age and older with frailty and advanced illness. Patients must meet both of the following to be excluded: – At least two indications of frailty with different dates of service during the measurement year – Any of the following during the measurement year or the year prior: o Two outpatient visits, observation visits, ED visits, telephone visits, e-visits/virtual check-ins or nonacute inpatient encounters/discharges on different dates of service, with an advanced illness diagnosis. o At least one acute inpatient encounter with an advanced illness diagnosis. o At least one acute inpatient discharge with an advanced illness diagnosis. o A dispensed dementia medication.
Telehealth Allowance	None
Tips to Improve Performance	• Educate your patients about the importance of early detection. • Educate and offer alternative tests besides a colonoscopy that are non-invasive, such as a FOBT or FIT-DNA test, which may better suit your patient's needs. Contact your lab provider for kits, which may be available at no additional cost. • Follow up with your patients to ensure that they have completed their screening. • If a patient reports having had a colonoscopy, ask the patient for a copy of the results/report or the location of the screening and add that to the patient's medical record. Document results of colorectal screening in your patient's medical record. The documentation should: – include where and when the exam was performed and that an attempt to obtain the original record is in process (this information is in the assessment section of the medical record); – use CPT II code 3017F (colorectal cancer screening results documented and reviewed) with colorectal cancer screening code Z12.11. • Leverage our member incentive programs. • Review our member level reports in our provider portal to identify noncompliant members.

Colorectal Cancer Screening			
Codes for Compliance	Colonoscopy	CPT	44388-44392, 44394, 44401-44408, 45378-45382, 45384-45386, 45388-45393, 45398
		HCPCS	G0105, G0121
	CT Colonography	CPT	74261-74263
	FIT-DNA	CPT	81528
		HCPCS	G0464*
	Flexible Sigmoidoscopy	CPT	45330-45335, 45337, 45338, 45340-45342, 45346, 45347, 45349, 45350
		HCPCS	G0104
	FOBT	CPT	82270, 82274
		HCPCS	G0328
Exclusion Codes	Colorectal Cancer	**ICD-10CM:** C18.0-C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048	
	Total Colectomy	**CPT:** 44150, 44151, 44152*, 44153*, 44155-44158, 44210-44212 **ICD10PCS:** 0DTE0ZZ, 0DTE4ZZ, 0DTE7ZZ, 0DTE8ZZ	

**Code not on our fee schedule, but will count toward the measure.*

Controlling High Blood Pressure	
Measure Description	The percentage of patients 18–85 years of age who had a diagnosis of hypertension and whose most recent blood pressure (BP) reading was adequately controlled during the measurement year. Adequate control is defined as BP < 140/90 mm Hg. **BP readings must be taken using a digital device** and can be taken during an outpatient visit, telephone visit, e-visit/virtual check-in, nonacute inpatient encounter or remote monitoring event. **Results can be taken by the member** and reported to the provider **verbally** over the phone. Medical record documentation must **clearly** state that the reading was taken by a digital device. *Note: This measure uses the most recent BP reading (as long as it occurred on or after the date of the second diagnosis of hypertension). If there is no BP recorded during the measurement year, or if the reading is incomplete, the patient is considered not compliant. If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.*
Product Lines	Medicare and Medicaid
Eligible Patients	Patients who turn 18 years old during the measurement year are included. Patients are identified as hypertensive if there have been at least two visits on different dates of service with a diagnosis of hypertension in the first six months of the measurement year and the year prior to the measurement year. Visit type need not be the same for both visits.
Exclusions	• Patients in hospice or using hospice services any time during the measurement year. • Patients who died any time during the measurement year. • Patients receiving palliative care during the measurement year. • Patients with evidence of end-stage renal disease (ESRD), dialysis, nephrectomy or kidney transplant any time during the patient's history on or prior to December 31 of the measurement year.

<table>
<tr><th colspan="4">Controlling High Blood Pressure</th></tr>
<tr><td>Exclusions</td><td colspan="3">• Patients with a diagnosis of pregnancy any time during the measurement year.
• Medicare patients 66 years of age and older who meet either of the following:
– Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
– Living long-term in an institution any time during the measurement year as identified by the LTI flag in the monthly membership detail data file.
• Patients 66-80 years of age with frailty and advanced illness. Patients must meet both of the following to be excluded:
– At least two indications of frailty with different dates of service during the measurement year.
– Any of the following during the measurement year or the year prior:
o Two outpatient visits, observation visits, ED visits, telephone visits, e-visits/virtual check-ins, or nonacute inpatient encounters/discharges on different dates of service, with an advanced illness diagnosis.
o One acute inpatient encounter with an advanced illness diagnosis.
o At least one acute inpatient discharge with an advanced illness diagnosis.
o A dispensed dementia medication.
• Patients 81 years of age and older with at least two indications of frailty with different dates of service.

Please refer to Exhibit D: Exclusion Codes for Palliative Care, Advanced Illness and Frailty on page 45 for exclusion codes.</td></tr>
<tr><td>Telehealth Allowance</td><td colspan="3">Patient-reported blood pressure readings during telehealth visits and/or telephone phone assessments are permissible.</td></tr>
<tr><td>Tips to Improve Performance</td><td colspan="3">• Confirm the diagnosis using readings and tests and do not code for hypertension based on member reported information.
• Take a second reading during your patient's visit if the initial reading is not controlled.
• If multiple readings are recorded on the same date, use the lowest reading.
• Schedule follow-up visits for your patients to have their BP rechecked as needed.
• Review your patient's adherence to hypertension medications. Ask and address any barriers that prevent them from being compliant, such as medication cost or transportation concerns.
• If barriers impacting adherence are identified (transportation, financial, etc.), refer your patients to available community resources that may help. Also, be sure to submit the appropriate ICD-10 CM codes to indicate the appropriate health-related social needs.
• Review your patient's treatment plan for uncontrolled BP (e.g., lifestyle modifications, adherence to treatment recommendations).
• Review our member level reports in our provider portal to identify noncompliant members.
• Review and work the A1c and CBP mini missed opportunity reports we provide which include members who are noncompliant for diabetes and/or blood pressure.
• Request that a blood pressure cuff be mailed to your patient's home so they can self-manage their hypertension (for details, see the Quality and Population Health Programs section or the Form and Supply Requests page of our provider website).
• If during a telehealth visit your patient reports a blood pressure reading that they took using a digital blood pressure device at home, document it in the progress notes as self-reported.</td></tr>
<tr><td rowspan="5">Codes for Compliance</td><td rowspan="5">Blood Pressure Results</td><td rowspan="5">CPT II</td><td>Diastolic < 80 mm Hg: 3078F</td></tr>
<tr><td>Diastolic 80-89 mm Hg: 3079F</td></tr>
<tr><td>Diastolic ≥ 90 mm Hg: 3080F</td></tr>
<tr><td>Systolic < 140 mm Hg: 3074F, 3075F</td></tr>
<tr><td>Systolic ≥ 140 mm Hg: 3077F</td></tr>
</table>

Developmental Screening in the First Three Years of Life			
Measure Description	The percentage of patients 0-3 years of age who were screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life. *Please note that this measure includes three age-specific indicators assessing whether children are screened by their first, second or third birthday.*		
Product Line	Medicaid		
Eligible Patients	Based on age only. Patients who turn 3 years old during the measurement year are included.		
Exclusions	None		
Telehealth Allowance	None		
Tips to Improve Performance	• Ensure that you are using a standardized, validated screening tool. • When billing with CPT code 96110, ensure that your documentation includes confirmation that the screening was completed using a standardized tool, the results and any actions taken. • Connect patients to our Pediatric Care Coordination program. • Review our member level reports in our provider portal to identify noncompliant members.		
Codes for Compliance	Developmental testing, with interpretation and report	CPT	96110

Diabetes: Eye Exam	
Measure Description	The percentage of patients 18–75 years of age with diabetes (Type 1 and Type 2) who had one of the following during the measurement year: • Retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year. • Negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.
Product Lines	Medicare and Medicaid
Eligible Patients	Patients who turn 18 years old during the measurement year are included. Patients may be identified as having diabetes during the measurement year or the year prior to the measurement year. A patient only needs to be diagnosed with diabetes by one of the following two methods to be included in the measure: • By claims/encounter data (one acute inpatient encounter with a diagnosis of diabetes without telehealth; one acute inpatient discharge with a diagnosis of diabetes on a discharge claim; or two outpatient visits, observation visits, telephone visits, e-visits/virtual check-ins, ED visits, nonacute inpatient encounters or nonacute inpatient discharges on different dates of service with a diagnosis of diabetes) • By pharmacy data (patients who were dispensed insulin or hypoglycemics/antihyperglycemics) *Note: Patients identified as having diabetes will remain in your denominator for two years thereafter.*
Exclusions	• Bilateral eye enucleation any time during the patient's history through December 31 of the measurement year. • Patients in hospice or using hospice services any time during the measurement year. • Patients who died any time during the measurement year. • Patients receiving palliative care or who had an encounter for palliative care during the measurement year.

<table>
<tr><th colspan="4">Diabetes: Eye Exam</th></tr>
<tr><td>Exclusions</td><td colspan="3">• Patients 66 years of age and older with frailty and advanced illness. Patients must meet both of the following to be excluded:
– At least two indications of frailty with different dates of service during the measurement year
– Any of the following during the measurement year or the year prior:
o Two outpatient visits, observation visits, ED visits, telephone visits, e-visits/virtual check-ins, or nonacute inpatient encounters/discharges on different dates of service, with an advanced illness diagnosis.
o One acute inpatient encounter with an advanced illness diagnosis.
o At least one acute inpatient discharge with an advanced illness diagnosis.
o A dispensed dementia medication.
• Medicare patients 66 years of age and older who meet either of the following:
– Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
– Living long-term in an institution any time during the measurement year as identified by the LTI flag in the monthly membership detail data file.

Please refer to Exhibit D: Exclusion Codes for Palliative Care, Advanced Illness and Frailty on page 45 for exclusion codes.</td></tr>
<tr><td>Telehealth Allowance</td><td colspan="3">None</td></tr>
<tr><td>Tip to Improve Performance</td><td colspan="3">• Refer your patients to an eye care specialist. Exams must be completed by an eye care professional (optometrist or ophthalmologist) to count.
• Train your staff to review the patient's chart prior to the visit to identify if a patient is overdue for an eye exam.
• Educate patients that a diabetic eye exam is a covered benefit under their medical plan (not vision insurance).
• Remember to use appropriate exclusion coding for steroid induced or gestational diabetes.
• Document exclusions that may prevent the member from completing the exam, such as blindness.
• Leverage our member incentive programs.
• Consider purchasing a retinal eye camera or partnering with an imaging center to take the pictures.
• Review our member level reports in our provider portal to identify noncompliant members.
• Effective 1/1/2022, Digital Diabetic Retinopathy Screening (92227) and Fundus Photography (92250) are eligible for reimbursement consideration one time per calendar year. Please refer to the communication released January 14, 2022, for additional details (Re: Diabetic Retinopathy Screening and Fundus Photography).</td></tr>
<tr><td rowspan="3">Codes for Compliance</td><td>Diabetes Mellitus without Complications</td><td>ICD-10 CM</td><td>E10.9, E11.9, E13.9</td></tr>
<tr><td rowspan="2">Retinal Eye Exams</td><td>CPT</td><td>92002, 92004, 92012, 92014, 92018, 92019, 92134, 92201, 92202, 92230, 92235, 92250, 99203-99205, 99213-99215, 99242-99245</td></tr>
<tr><td>HCPCS</td><td>S0620, S0621, S3000</td></tr>
</table>

Diabetes: Eye Exam			
Codes for Compliance	Diabetic Retinal Screening Negative in Prior Year	CPT II	3072F
	Eye Exam with Evidence of Retinopathy	CPT II	2022F, 2024F, 2026F
	Eye Exam Without Evidence of Retinopathy	CPT II	2023F, 2025F, 2033F
	Retinal Imaging	CPT	92227, 92228
	Unilateral Eye Enucleation	CPT	65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114

**Code not on our fee schedule, but will count toward the measure.*

Diabetes: HbA1c Control (< 9%)	
Measure Description	The percentage of patients 18–75 years of age with diabetes (Type 1 and Type 2) whose most recent HbA1c level is lower than 9%. *Note: Patients who are not tested during the measurement year are considered non-compliant. In addition, if your office utilizes point-of-care testing, you will need to use the CPT II code for both the test and the results.*
Product Line	Medicare
Eligible Patients	Patients who turn 18 years old during the measurement year are included. Patients may be identified as having diabetes during the measurement year or the year prior to the measurement year. A patient only needs to be diagnosed with diabetes by one of the following two methods to be included in the measure: • By claims/encounter data (one acute inpatient encounter with a diagnosis of diabetes without telehealth; one acute inpatient discharge with a diagnosis of diabetes on a discharge claim; or two outpatient visits, observation visits, telephone visits, e-visits/virtual check-ins, ED visits, nonacute inpatient encounters or nonacute inpatient discharges, on different dates of service with a diagnosis of diabetes) • By pharmacy data (patients who were dispensed insulin or hypoglycemics/antihyperglycemics) *Note: Patients identified as having diabetes will remain in your denominator for two years thereafter.*
Exclusions	• Patients in hospice or using hospice services any time during the measurement year. • Patients who died any time during the measurement year. • Patients receiving palliative care during the measurement year. • Patients 66 years of age and older with frailty and advanced illness. Patients must meet both of the following to be excluded: – At least two indications of frailty with different dates of service during the measurement year – Any of the following during the measurement year or the year prior: o Two outpatient visits, observation visits, ED visits, telephone visits, e-visits/virtual check-ins, or nonacute inpatient encounters/discharges on different dates of service, with an advanced illness diagnosis. o One acute inpatient encounter with an advanced illness diagnosis. o At least one acute inpatient discharge with an advanced illness diagnosis. o A dispensed dementia medication.

<table>
<tr><th colspan="4">Diabetes: HbA1c Control (< 9%)</th></tr>
<tr><td>Exclusions</td><td colspan="3">• Medicare patients 66 years of age and older who meet either of the following:
– Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
– Living long-term in an institution any time during the measurement year as identified by the LTI flag in the monthly membership detail data file.

Please refer to Exhibit D: Exclusion Codes for Palliative Care, Advanced Illness and Frailty on page 45 for exclusion codes.</td></tr>
<tr><td>Telehealth Allowance</td><td colspan="3">None</td></tr>
<tr><td>Tips to Improve Performance</td><td colspan="3">• Request tests to be completed prior to your patient's visit so that test results can be reviewed with your patient during the visit.
• Do not submit diabetes diagnosis codes for patients identified as only pre-diabetic. This will identify the member as being diabetic, per NCQA guidelines, and will count the member in your denominator but not your numerator, which would then decrease your rate and payout. (The R73.03 code can be used to identify a member as pre-diabetic).
• When tests have been conducted by Quest, do not submit CPT or CPT II HbA1c testing and result codes. We automatically receive this data from Quest; however, please document the results in the member's chart.
• Establish a process for obtaining lab results that were ordered by other providers (specialists, ED, urgent care centers, etc.).
• Analyze why your patients are noncompliant for this measure:
– A1c value is >9; therefore, the member should be retested.
– Order was written but member did not complete the blood draw; therefore, remind the member to complete the test.
– Order was never written for the member; therefore, create a standing order for the member in the system.
• Review your patient's adherence to diabetes medications and make modifications as needed.
• Review our member level reports in our provider portal to identify noncompliant members.
• Review and work the A1c and CBP mini missed opportunity reports we provide which includes members who are noncompliant for diabetes and/or blood pressure.</td></tr>
<tr><td rowspan="5">Codes for Compliance</td><td>HbA1c Test</td><td>CPT</td><td>83036, 83037</td></tr>
<tr><td rowspan="4">HbA1c Result</td><td rowspan="4">CPT II</td><td>Most recent HbA1c level < than 7.0%: 3044F</td></tr>
<tr><td>Most recent HbA1c level ≥ 7.0% and < than 8.0%: 3051F</td></tr>
<tr><td>Most recent HbA1c level ≥ 8.0% and ≤ 9.0%: 3052F</td></tr>
<tr><td>Most recent HbA1c level > than 9.0%: 3046F</td></tr>
</table>

Diabetes: Glycemic Status Assessment (>9%)	
Measure Description	The percentage of patients 18–75 years of age with diabetes (Type 1 and Type 2) whose most recent HbA1c level is greater than 9%. This is an inverse measure. *Note: Patients who are not tested during the measurement year are considered noncompliant. In addition, if your office utilizes point-of-care testing, you will need to use the CPT II code for both the test and the results.*
Product Line	Medicaid
Eligible Patients	Patients who turn 18 years old during the measurement year are included. Patients may be identified as having diabetes during the measurement year or the year prior to the measurement year. A patient only needs to be diagnosed with diabetes by one of the following two methods to be included in the measure: • By claims/encounter data (members who had at least 2 diagnoses of diabetes on different dates of service during the measurement year or the year prior to the measurement year). • By claims/encounter data (members who had at least 2 diagnoses of diabetes on different dates of service during the measurement year or the year prior to the measurement year). *Note: Patients identified as having diabetes will remain in your denominator for two years thereafter.*
Exclusions	• Patients in hospice or using hospice services any time during the measurement year. • Patients who died any time during the measurement year. • Patients receiving palliative care during the measurement year. • Patients 66 years of age and older with frailty and advanced illness. Patients must meet both of the following to be excluded: – At least two indications of frailty with different dates of service during the measurement year – Any of the following during the measurement year or the year prior: o Two outpatient visits, observation visits, ED visits, telephone visits, e-visits/virtual check-ins, or nonacute inpatient encounters/discharges on different dates of service, with an advanced illness diagnosis. o One acute inpatient encounter with an advanced illness diagnosis. o At least one acute inpatient discharge with an advanced illness diagnosis. o A dispensed dementia medication. Please refer to Exhibit D: Exclusion Codes for Palliative Care, Advanced Illness and Frailty on **page 45** for exclusion codes.
Telehealth Allowance	None
Tips to Improve Performance	• Request tests to be completed prior to your patient's visit so that test results can be reviewed with your patient during the visit. • Do not submit diabetes diagnosis codes for patients identified as only pre-diabetic. This will identify the member as being diabetic, per NCQA guidelines, and will count the member in your denominator but not your numerator, which would then decrease your rate and payout. (The R73.03 code can be used to identify a member as pre-diabetic). • When tests have been conducted by Quest, do not submit CPT or CPT II HbA1c testing and result codes. We automatically receive this data from Quest; however, please document the results in the member's chart.

<table>
<tr><th colspan="4">Diabetes: Glycemic Status Assessment (>9%)</th></tr>
<tr><td>Tips to Improve Performance</td><td colspan="3">• Establish a process for obtaining lab results that were ordered by other providers (specialists, ED, urgent care centers, etc.).
• Analyze why your patients are noncompliant for this measure:
– A1c value is >9; therefore, the member should be retested.
– Order was written but member did not complete the blood draw; therefore, remind the member to complete the test.
– Order was never written for the member; therefore, create a standing order for the member in the system.
• Review your patient's adherence to diabetes medications and make modifications as needed.
• Review our member level reports in our provider portal to identify noncompliant members.
• Review and work the A1c and CBP mini missed opportunity reports we provide which includes members who are noncompliant for diabetes and/or blood pressure.</td></tr>
<tr><td rowspan="5">Codes for Compliance</td><td>HbA1c Test</td><td>CPT</td><td>83036, 83037</td></tr>
<tr><td rowspan="4">HbA1c Result</td><td rowspan="4">CPT II</td><td>Most recent HbA1c level < than 7.0%: 3044F</td></tr>
<tr><td>Most recent HbA1c level ≥7.0% and < than 8.0%: 3051F</td></tr>
<tr><td>Most recent HbA1c level ≥ 8.0% and ≤ 9.0%: 3052F</td></tr>
<tr><td>Most recent HbA1c level > than 9.0%: 3046F</td></tr>
</table>

Kidney Health Evaluation for Patients with Diabetes (KED)	
Measure Description	The percentage of members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) ***and*** a urine albumin-creatinine ratio (uACR), during the measurement year.
Product Line	Medicare
Eligible Patients	Patients who turn 18 years old during the measurement year are included. Patients may be identified as having diabetes during the measurement year or the year prior to the measurement year. A patient only needs to be diagnosed with diabetes by one of the following two methods to be included in the measure: • By claims/encounter data (members who had at least 2 diagnoses of diabetes on different dates of service during the measurement year or the year prior to the measurement year). • By pharmacy data (members who were dispensed insulin or hypoglycemics/ antihyperglycemics during the measurement year or the year prior to the measurement year and have at least one diagnosis of diabetes during the measurement year or the year prior to the measurement year).
Exclusions	• Patients with a diagnosis of ESRD • Patients who had dialysis. • Patients in hospice or using hospice services any time during the measurement year. • Patients who died any time during the measurement year. • Patients receiving palliative care during the measurement year. • Patients 66 years of age and older as of December 31 of the measurement year who meet either of the following: - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. - Living long-term in an institution any time during the measurement year. - Patients 66–80 years of age as of December 31 of the measurement year with frailty and advanced illness.

Kidney Health Evaluation for Patients with Diabetes (KED)			
Telehealth Allowance	None		
Tips to Improve Performance	• Make sure you perform both the eGFR and the uACR tests for your patients. • Document in the patient's medical record on both the eFGR and the uACR separately. • Follow up with your patients if their labs show abnormal results. • Review your patient's adherence to diabetes medications and make modifications as needed. • Review our member level reports in our provider portal to identify noncompliant members. • Review the KED Tip Sheet available on our website.		
Codes for Compliance	Estimated Glomerular Filtration Rate Lab Test	CPT	80047, 80048, 80050, 80053, 80069, 82565
	Quantitative Urine Albumin Lab Test	CPT	82043
	Urine Creatinine Lab Test	CPT	82570

Lead Screening in Children			
Measure Description	The percentage of patients who had one or more lead poisoning tests (capillary or venous lead blood test) **on or before** their second birthday.		
Product Lines	Medicaid and CHIP		
Eligible Patients	Based on age only. Patients who turn 2 years old during the measurement year are included.		
Exclusions	• Members in hospice or using hospice services any time during the measurement year. • Members who died any time during the measurement year.		
Telehealth Allowance	None		
Tips to Improve Performance	• Educate office staff to schedule appointments prior to the patient's 2nd birthday. Any lead screening tests after the age of 2 will not count. • Be aware that a lead risk questionnaire/assessment does not count for this measure. • Document both the date the test was performed and the result or finding. • Review all open care gaps for the patient and attempt to close all gaps together (e.g., patients might also be due for a dental visit or well visit). • Avoid missed opportunities by taking advantage of every office visit (including sick visits and walk-in visits) to administer the test. • If there is no phlebotomist on site, schedule your patients at a local Quest lab or have Quest lab phone numbers and addresses available for your patients.		
Codes for Compliance	Lead Tests	CPT	83655

Medication Adherence for Cholesterol Medications		
Measure Description	The percentage of patients 18 years or older who are at least 80% adherent (throughout the year) to their prescribed cholesterol medications (statin drugs).	
Product Line	Medicare	
Eligible Patients	Medicare patients 18 years and older who fill two or more prescriptions for cholesterol medication (on unique dates of service). Patients who turn 18 years old during the measurement year are included.	
Exclusions	• Patients diagnosed with end-stage renal disease (ESRD). • Patients in hospice. • Patients whose first fill of their medication occurs < 90 days before 12/31/25.	
Telehealth Allowance	None	
Tips to Improve Performance	• Discuss medication adherence during all visits and incorporate as part of pre-visit checklist. • When appropriate, consider a 90-day prescription for chronic conditions, which can save patients time and money. • Ask your patients if their medication is causing negative side effects and if there are financial issues or other barriers impacting adherence. For patients struggling with transportation issues, ask them to consider a pharmacy with home delivery services or a mail order pharmacy. • If barriers impacting adherence are identified (transportation, financial, etc.), refer your patients to available community resources that may help. • Define the lifestyle treatment goal and method for achieving it. • Remind your patients to take medications at the same time(s) each day by setting up a reminder alarm, or link dosing with another routine task, like brushing teeth. • Encourage your patients to sign up for refill reminders at their pharmacy, if available. • Leverage our member incentive programs. • Review our member level reports in our provider portal to identify noncompliant members.	
Medications for Compliance *(Please note that some medications may be available only as certain brand name drugs or certain formulations on our formulary or may require a prior authorization.)*	Statin Drugs	• Atorvastatin • Amlodipine-Atorvastatin • Ezetimibe-Simvastatin • Ezetimibe-Rosuvastatin* • Fluvastatin* • Lovastatin • Lovastatin-Niacin* • Niacin-Simvastatin* • Pitavastatin* • Rosuvastatin • Simvastatin

**Medication is not on our formulary.*

Medication Adherence for Diabetes Medications		
Measure Description	The percentage of patients aged 18 or older who are at least 80% adherent (throughout the year) to their prescribed oral diabetes medications, including: Biguanide drugs, DiPeptidyl Peptidase - 4 [DPP-4] inhibitors, GLP-1 receptor agonists, Meglitinide drugs, sodium glucose cotransporter 2 (SGLT2) inhibitors, Sulfonylurea drugs, and Thiazolidinedione drugs.	
Product Line	Medicare	
Eligible Patients	Patients 18 years and older who fill two or more prescriptions for any diabetes medication (on unique dates of service). Patients who turn 18 years old during the measurement year are included.	
Exclusions	• Patients who have one or more prescriptions filled for insulin • Patients diagnosed with end-stage renal disease (ESRD) • Patients in hospice • Patients whose first fill of their medication occurs < 90 days before 12/31/25.	
Telehealth Allowance	None	
Tips to Improve Performance	• Discuss medication adherence during all visits and incorporate as part of pre-visit checklist. • When appropriate, consider a 90-day prescription for chronic conditions, which can save patients time and money. • Ask your patients if their medication is causing negative side effects and if there are financial issues or other barriers impacting adherence. For patients struggling with transportation issues, ask them to consider a pharmacy with home delivery services or a mail order pharmacy. • Define the lifestyle treatment goal and method for achieving it. • If barriers impacting adherence are identified (transportation, financial, etc.), refer your patients to available community resources that may help. • Remind your patients to take medications at the same time(s) each day by setting up a reminder alarm or link dosing with another routine task, like brushing teeth. • Encourage your patients to sign up for refill reminders at their pharmacy, if available. • Leverage our member incentive programs. • Review our member level reports in our provider portal to identify noncompliant members.	
Medications for Compliance *(Please note that some medications may be available only as certain brand name drugs or certain formulations on our formulary or may require a prior authorization.)*	Biguanide Drugs	• Alogliptin-Metformin • Canagliflozin-Metformin* • Dapagliflozin-Metformin* • Empagliflozin-Metformin • Ertugliflozin-Metformin* • Glipizide-Metformin • Glyburide-Metformin • Linagliptin-Metformin • Metformin • Pioglitazone-Metformin • Repaglinide-Metformin* • Rosiglitazone-Metformin* • Saxagliptin-Metformin* • Sitagliptin-Metformin • Empagliflozin-Linagliptin-Metformin

Medication Adherence for Diabetes Medications			
Medications for Compliance *(Please note that some medications may be available only as certain brand name drugs or certain formulations on our formulary or may require a prior authorization.)*	DPP 4 Inhibitors	• Alogliptin • Alogliptin-Metformin • Alogliptin-Pioglitazone • Linagliptin • Linagliptin-Metformin • Linagliptin-Empagliflozin • Empagliflozin-Linagliptin-Metformin	• Saxagliptin* • Saxagliptin-Metformin* • Saxagliptin-Dapagliflozin* • Sitagliptin • Sitagliptin-Metformin • Sitagliptin-Ertugliflozin*
	GLP-1 Receptor Agonists	• Albiglutide* • Dulaglutide • Exenatide	• Liraglutide • Lixisenatide* • Semaglutide
	Meglitinide Drugs	• Nateglinide • Repaglinide	• Repaglinide-Metformin*
	SGLT2 Inhibitors	• Canagliflozin* • Canagliflozin-Metformin* • Dapagliflozin • Dapagliflozin-Metformin • Dapagliflozin-Saxagliptin* • Empagliflozin	• Empagliflozin-Linagliptin • Empagliflozin-Metformin • Ertugliflozin* • Ertugliflozin-Metformin* • Ertugliflozin-Sitagliptin* • Empagliflozin-Linagliptin-Metformin
	Sulfonylurea Drugs	• Chlorpropamide* • Glimepiride • Glipizide • Glyburide • Metformin-Glipizide	• Metformin-Glyburide • Pioglitazone-Glimepiride • Tolazamide* • Tolbutamide*
	Thiazolidinedione Drugs	• Alogliptin-Pioglitazone* • Glimepiride-Pioglitazone • Metformin-Pioglitazone	• Pioglitazone • Rosiglitazone * • Rosiglitazone-Metformin*

**Medication is not on our formulary.*

<table>
<tr><th colspan="4">Medication Adherence for Hypertension Medications</th></tr>
<tr><td>Measure Description</td><td colspan="3">The percentage of patients aged 18 or older who are at least 80% adherent (throughout the year) to their prescribed blood pressure medications, including: angiotensin converting enzyme inhibitor (ACEI), angiotensin receptor blocker (ARB), or direct renin inhibitor medications.</td></tr>
<tr><td>Product Line</td><td colspan="3">Medicare</td></tr>
<tr><td>Eligible Patients</td><td colspan="3">Patients 18 years and older who fill two or more prescriptions for hypertension medication (on unique dates of service). Patients who turn 18 years old during the measurement year are included.</td></tr>
<tr><td>Exclusions</td><td colspan="3">• Patients with one or more claims for Sacubitril/Valsartan
• Patients diagnosed with end-stage renal disease (ESRD)
• Patients in hospice
• Patients whose first fill of their medication occurs < 90 days before 12/31/25.</td></tr>
<tr><td>Telehealth Allowance</td><td colspan="3">None</td></tr>
<tr><td>Tips to Improve Performance</td><td colspan="3">• Discuss medication adherence during all visits and incorporate as part of pre-visit checklist.
• When appropriate, consider a 90-day prescription for chronic conditions, which can save patients time and money.
• Define the lifestyle treatment goal and method for achieving it.
• Ask your patients if their medication is causing negative side effects and if there are financial issues or other barriers impacting adherence. For patients struggling with transportation issues, ask them to consider a pharmacy with home delivery services or a mail order pharmacy.
• If barriers impacting adherence are identified (transportation, financial, etc.), refer your patients to available community resources that may help.
• Remind your patient to take medications at the same time(s) each day by setting up a reminder alarm or link dosing with another routine task, like brushing teeth.
• Encourage your patient to sign up for refill reminders at their pharmacy, if available.
• Leverage our member incentive programs.
• Review our member level reports in our provider portal to identify noncompliant members.</td></tr>
<tr><td>Medications for Compliance
(Please note that some medications may be available only as certain brand name drugs or certain formulations on our formulary or may require prior authorization.)</td><td>ACE Inhibitors</td><td>• Amlodipine-Benazepril
• Amlodipine-Perindopril*
• Benazepril
• Benazepril-HCTZ
• Captopril
• Captopril-HCTZ*
• Cilazapril*
• Cilazapril-HCTZ*
• Enalapril
• Enalapril-HCTZ
• Enalaprilat*
• Fosinopril
• Fosinopril-HCTZ</td><td>• Lisinopril
• Lisinopril-HCTZ
• Moexipril
• Moexipril-HCTZ*
• Perindopril
• Perindopril-Indapamide*
• Quinapril
• Quinapril-HCTZ
• Ramipril
• Ramipril-HCTZ*
• Trandolapril
• Trandolapril-Verapamil</td></tr>
</table>

Medication Adherence for Hypertension Medications			
Medications for Compliance *(Please note that some medications may be available only as certain brand name drugs or certain formulations on our formulary or may require prior authorization.)*	ARB Drugs	• Amlodipine-Olmesartan • Amlodipine-Telmisartan • Amlodipine-Valsartan • Amlodipine-Valsartan-HCTZ • Azilsartan* • Azilsartan-Chlorthalidone* • Candesartan • Candesartan-HCT • Eprosartan* • Eprosartan-HCTZ* • Irbesartan	• Irbesartan-HCTZ • Losartan • Losartan-HCTZ • Nebivolol-Valsartan* • Olmesartan • Olmesartan-HCTZ • Olmesartan-Amlodipine-HCTZ • Sacubitril-Valsartan • Telmisartan • Telmisartan-HCTZ • Valsartan • Valsartan-HCTZ
	Direct Renin Inhibitors	• Aliskiren	• Aliskiren-HCTZ*

**Medication is not on our formulary.*

Well-Child Visits, First 15 Months of Life			
Measure Description	The percentage of patients who had six or more well-child visits with a PCP on or before turning 15 months.		
Product Lines	Medicaid and CHIP		
Eligible Patients	Based on age only. Members who turn 15 months during the measurement year are included.		
Exclusions	• Members in hospice or using hospice services any time during the measurement year. • Members who died any time during the measurement year.		
Telehealth Allowance	None. **Please note that per NCQA, telehealth is no longer allowed for well visits.**		
Tips to Improve Performance	• Educate office staff to schedule appointments prior to the patients turning 15 months. Visits scheduled after 15 months will not count. • Send appointment reminders via live calls, text or email. • Schedule multiple visits at once, if possible. • If a patient comes in for a sick visit and is due for a well-child visit, try to complete all services of a well-child visit. Well-child preventive services count toward the measures regardless of the primary intent of the visit. • If the patient comes into the office as a walk-in, complete the well visit during that time. • Partner with us to hold block scheduling events. • Connect patients to our Pediatric Care Coordination department. • Review our' member level reports in our provider portal to identify noncompliant members. • If possible, send reminders of scheduled visit dates and time via calls or texts.		
Codes for Compliance	Well-Care Visit	CPT	99381-99385, 99391-99395, 99461
		HCPCS	G0438, G0439, S0302, S0610, S0612, S0613
		ICD-10 CM	Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, Z02.5, Z02.84, Z76.1, Z76.2

Well-Child Visits for Age 15 Months-30 Months			
Measure Description	The percentage of patients 15-30 months old who had two well-child visits by their 30-month birthday. *Note: Two or more well-child visits need to be completed **between** the patient's 15-month and 30-month birthday (one day after the patient turns 15 months up to and including the day the patient turns 30 months old).*		
Product Lines	Medicaid and CHIP		
Eligible Patients	Based on age only. Members who turn 30 months during the measurement year are included.		
Exclusions	• Members in hospice or using hospice services any time during the measurement year. • Members who died any time during the measurement year.		
Telehealth Allowance	None. **Please note that per NCQA, telehealth is no longer allowed for well visits.**		
Tips to Improve Performance	• Educate office staff to schedule appointments prior to the patients turning 30 months old. Visits scheduled on or before 15 months, and visits scheduled after 30 months will not count. • Send appointment reminders via live calls, text or email. • If a patient comes in for a sick visit and is due for a well-child visit, try to complete all services of a well-child visit. Well-child preventive services count toward the measures regardless of the primary intent of the visit. • If the patient comes into the office as a walk-in, complete the well visit during that time. • Partner with us to hold block scheduling events. • Connect patients to our Pediatric Care Coordination department. • Review our member level reports in our provider portal to identify noncompliant members. • If possible, send reminders of scheduled visit dates and time via calls or texts.		
Codes for Compliance	Well-Care Visit	CPT	99381-99385, 99391-99395, 99461
		HCPCS	G0438, G0439, S0302, S0610, S0612, S0613
		ICD-10 CM	Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, Z02.84, Z76.1, Z76.2

Exhibit D: Exclusion Codes for Palliative Care, Advanced Illness, Frailty and Organ and Bone Marrow Transplants

Please refer to the exclusion codes below for Palliative Care, Advanced Illness, Frailty, and Organ and Bone Marrow Transplants. These codes apply to the following six measures:

- Breast Cancer Screening
- Childhood Immunization Status
- Colorectal Cancer Screening
- Controlling High Blood Pressure
- Diabetes: Eye Exam
- Glycemic Status Assessment for Patients with Diabetes (>9%)/Diabetes: HbA1c Control (<9%)

Codes for Exclusion	
Palliative Care	**HCPCS:** G9054 **ICD10CM:** Z51.5
Advanced Illness	**ICD10CM:** A81.00, A81.01, A81.09, C25.0-C25.4, C25.7-C25.9, C71.0- C71.9, C77.0-C77.5, C77.8, C77.9, C78.00-C78.02, C78.1, C78.2, C78.30, C78.39, C78.4-C78.7, C78.80, C78.89, C79.00-C79.02, C79.10, C79.11, C79.19, C79.2, C79.31, C79.32, C79.40, C79.49, C79.51, C79.52, C79.60-C79.63, C79.70- C79.72, C79.81, C79.82, C79.89, C79.9, C91.00, C91.02, C92.00, C92.02, C93.00, C93.02, C93.90, C93.92, C93.Z0, C93.Z2, C94.30, C94.32, F01.50, F01.511, F01.518, F01.52,-F01.54, F01.A0, F01.A11, F01.A18, F01.A2-F01.A4, F01.B0, F01.B11, F01.B18, F01.B2-F01.B4, F01.C0, F01.C11, F01.C18, F01.C2-F01.C4, F02.80, F02.811, F02.818, F02.82-F02.84, F02.A0, F02.A11, F02.A18, F02.A2-F02.A4, F02.B0, F02.B11, F02.B18, F02.B2-F02.B4, F02.C0, F02.C11, F02.C18, F02.C2-F02.C4, F03.90, F03.911, F03.918, F02.92-F02.94, F03.A0, F02.A11, F03.A18, F03.A2-F03.A4, F03.B0, F03.B11, F03.B18, F03.B2-F03.B4, F03.C0, F03.C11, F03.C18, F03.C2-F03.C4, F04, F10.27, F10.96, F10.97, G10, G12.21, G20, G30.0, G30.1, G30.8, G30.9, G31.01, G31.09, G31.83, G35, I09.81, I11.0, I12.0, I13.0, I13.11, I13.2, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30-I50.33, I50.40- I50.43, I50.810-I50.814, I50.82-I50.84, I50.89, I50.9, J43.0- J43.2, J43.8, J43.9, J68.4, J84.10, J84.112, J84.170, J84.178, J96.10- J96.12, J96.20- J96.22, J96.90-J96.92, J98.2, J98.3, K70.10, K70.11, K70.2, K70.30, K70.31, K70.40, K70.41, K70.9, K74.00, K74.01, K74.02, K74.1, K74.2, K74.4, K74.5, K74.60, K74.69, N18.5, N18.6
Frailty	**Frailty Device** **HCPCS:** E0100, E0105, E0130, E0135, E0140, E0141, E0143, E0144, E0147-E0149, E0163, E0165, E0167, E0168, E0170*, E0171*, E0250, E0251, E0255, E0256, E0260, E0261, E0265, E0266, E0270*, E0290-E0297, E0301-E0304, E0424, E0425, E0430, E0431, E0433, E0434, E0435*, E0439-E0444, E0462*, E0465, E0466, E0470-E0472, E1130, E1140, E1150, E1160, E1161, E1170-E1172, E1180, E1190, E1195, E1200, E1220, E1240, E1250, E1260, E1270, E1280, E1285, E1290, E1295-E1298 **Frailty Diagnosis** **ICD10CM:** L89.000-L89.004, L89.006, L89.009-L89.014, L89.016, L89.019-L89.024, L89.026, L89.029, L89.100-L89.104, L89.106, L89.109-L89.114, L89.116, L89.119-L89.124, L89.126, L89.129-L89.134, L89.136, L89.139-L89.144, L89.146, L89.149-L89.154, L89.156, L89.159, L89.200-L89.204, L89.206, L89.209-L89.214, L89.216, L89.219- L89.224, L89.226, L89.229, L89.300-L89.304, L89.306, L89.309-L89.314, L89.316, L89.319-L89.324, L89.326, L89.329, L89.40-L89.46, L89.500-L89.504, L89.506, L89.509-L89.514, L89.516, L89.519-L89.524, L89.526, L89.529, L89.600-L89.604, L89.606, L89.609-L89.614, L89.616, L89.619-L89.624,

Codes for Exclusion	
Frailty	L89.626, L89.629, L89.810-L89.814, L89.816, L89.819, L89.890-L89.894, L89.896, L89.899-L89.96, M62.50, M62.81, M62.84, R29.6, W01.0XXA, W01.0XXD, W01.0XXS, W01.10XA, W01.10XD, W01.10XS, W01.110A, W01.110D, W01.110S, W01.111A, W01.111D, W01.111S, W01.118A, W01.118D, W01.118S, W01.119A, W01.119D, W01.119S, W01.190A, W01.190D, W01.190S, W01.198A, W01.198D, W01.198S, W06.XXXA, W06.XXXD, W06.XXXS, W07.XXXA, W07.XXXD, W07.XXXS, W08.XXXA, W08.XXXD, W08.XXXS, W10.0XXA, W10.0XXD, W10.0XXS, W10.1XXA, W10.1XXD, W10.1XXS, W10.2XXA, W10.2XXD, W10.2XXS, W10.8XXA, W10.8XXD, W10.8XXS, W10.9XXA, W10.9XXD, W10.9XXS, W18.00XA, W18.00XD, W18.00XS, W18.02XA, W18.02XD, W18.02XS, W18.09XA, W18.09XD, W18.09XS, W18.11XA, W18.11XD, W18.11XS, W18.12XA, W18.12XD, W18.12XS, W18.2XXA, W18.2XXD, W18.2XXS, W18.30XA, W18.30XD, W18.30XS, W18.31XA, W18.31XD, W18.31XS, W18.39XA, W18.39XD, W18.39XS, W19.XXXA, W19.XXXD, W19.XXXS, Y92.199, Z59.3, Z73.6, Z74.01, Z74.09, Z74.1-Z74.3, Z74.8, Z74.9, Z91.81, Z99.11, Z99.3, Z99.81, Z99.89 **Frailty Encounter** **CPT:** 99504, 99509 **HCPCS:** G0162, G0299, G0300, G0493, G0494, S0271, S0311, S9123, S9124, T1000-T1005, T1019-T1022, T1030, T1031 **Frailty Symptom** **ICD10CM:** R26.2, R26.89, R26.9, R53.1, R53.81, R54, R62.7, R63.4, R63.6, R64
Organ and Bone Marrow Transplants	**CPT:** 32850-32856, 33927-33930, 33933, 33935, 33940, 33944, 33945, 44132, 44133, 44135-44137, 44715, 44720, 44721, 47133, 47135, 47136, 47140-47147, 48160, 48550-48552, 48554, 48556, 50360, 50365, 50380 **HCPCS:** S2053, S2054, S2055, S2060, S2061, S2065, S2152

**Code not on our fee schedule, but will count towards the measure.*

Frequently Asked Questions

Q: HOW IS THE QCP MONTHLY INCENTIVE PAYMENT CALCULATED?

A: We use a benchmark methodology to determine your payout, which allows us to truly reward practices for high performance, rather than making payments based on peer ranking using a percentile calculation methodology. In the benchmark model, payments are made monthly based on membership and our benchmarks.

Q: WHEN DO I RECEIVE THE QCP INCENTIVE PAYMENT?

A: A separate incentive payment is issued monthly for each TIN based on your performance on the program measures.

Q: HOW DO I RECEIVE THE QCP INCENTIVE PAYMENT?

A: You can receive QCP payments via check or you can elect to receive payment via electronic funds transfer (EFT). While EFTs are the preferred method of payment, incentive checks are issued for practices that have not yet enrolled for EFT.

Q: HOW DO I REGISTER FOR EFT PAYMENTS?

A: You can register for EFT payments through ECHO Health, Inc.
Visit **www.echohealthinc.com** and select "Provider Links." Then click on "Connecting to the ECHO Payer Network for EFT/ERA." Use the first digits of your tax ID as your enrollment code. If you have any questions, contact the provider EFT enrollment specialists at ECHO at **EDI@echohealthinc.com** or **1-844-586-7463**.

Q: WHAT IS THE LAG TIME ON RESULTS BEING INCLUDED IN OUR QCP SCORES?

A: Since January 2020, QCP scores have been recalculated once per year, with updated reimbursement beginning in May. Since most of the measures depend on claims data, the measure recalculation will only incorporate data received through February 15, 2025.

Q: WHAT SHOULD I DO IF I BELIEVE THAT MY SCORES ARE INCORRECT?

A: Please contact your Provider Relations Representative as soon as you identify potential incorrect scores and/or payments. All appeals must be made in writing and submitted no later than 90 days after QCP scores are released. Appeals will only be considered in the event of errors made by us that are beyond the providers' control or previously communicated technical issues.

Q: HOW CAN I IMPROVE MY PERFORMANCE?

A: Here are some tips for performance improvement:

- Review and work the monthly gap-in-care reports that we provide via our provider portal.
- Leverage the report cards available in our provider portal to gain more insight into your QCP performance and opportunities.
- Ensure that you are using the appropriate billing codes, including CPT II codes, that will meet the measure requirements. CPT II codes capture important health outcomes information that closes care gaps without chart reviews and/or submission of additional data files. Review the CPT II Codes Tip Sheets on the Quality and Population Health Programs website on the CPT II Codes tab.

- Request your "Missed Opportunities Report" from your Provider Relations Representative and review your list of members that had multiple visits during the year but had a number of care gaps left open.
- Consider telehealth when appropriate and allowed.
- Review our **Provider Reporting Calendar** on our website to ensure your staff are working on the various quality reports shared throughout the year.
- Review the requirements for the type of providers allowed to bill the codes that count toward compliance.
- Utilize proper documentation in your charts.
- Review the "Tips to Improve Performance" suggestions listed for each quality measure detailed in this manual.
- Work with your Provider Relations Representative.

Q: HOW DO I GET CREDIT FOR CLOSING A CARE GAP?

A: The quickest and most accurate way to close a care gap is to submit a claim with the required CPT, CPT II, and/or ICD-10 codes. An updated list of CPT II Codes and a CPT II Code Tip Sheet is available on our website: **www.healthpartnersplans.com/home/providers/clinical-resources/disease-and-medication-management**. We also have a relationship with a vendor to set up an automated EMR data feed process. Please reach out to your Provider Relations Representative for more information. Lastly, our Quality Management team can work with your practice to close care gaps, either via record retrieval from your EMR, via a portal, fax, or secure email. You can forward information to the attention of Pearl Taylor, our main point of contact for chart submission, using the contact information below. At minimum, please include Member Name, Member DOB, Measure (put in subject line), Date of Service, and Section/Page of record.

Jefferson Health Plans
Quality Management Department/Attention Pearl Taylor
1101 Market Street, Suite 3000
Philadelphia, PA 19107

Phone: 215-991-4283
Fax: 215-967-9230
Email: **caregap_records@hpplans.com**

Ciox/Datavant Smart Request Portal ID#1336327

Q: WHAT IS THE DIFFERENCE BETWEEN SDOH AND HRSN?

A: Per CMS, the way communities and individuals experience health and health care is not just based on access to medical services. It is also impacted by other factors that may support or create barriers to health and well-being. At a community level, these factors are referred to as "social drivers of health" (SDOH) and may also be referred to as "social determinants of health." Examples of SDOH include economic stability, access to quality education and health care, and the neighborhood and built environment.

The specific factors that impact individuals directly are called "health-related social needs" (HRSN). Examples of HRSN include lack of stable or affordable housing and utilities, financial strain, lack of access to healthy food, personal safety, and lack of

access to transportation. SDOH and HRSN can coincide and overlap, for instance, in the case of a household with income below the federal poverty line (an individual-level HRSN) in an area with poor economic conditions (a community-level SDOH). Health providers can take steps to address HRSN by understanding the needs of their patients and referring them to community-based services.

SDOH and HRSN are what commonly lead to health disparities — that is, different health outcomes in different groups of people. Addressing SDOH and HRSN is an important component of efforts to overcome disparities and achieve health equity for individuals and communities.

Q: CAN I FIND MORE INFORMATION ABOUT QUALITY-RELATED PROGRAMS ONLINE?

A: Yes! We have an entire section of our website dedicated to Quality and Population Health Programs. The most up to date QCP Manual is available as well as other quality-related information like HRSN guides, medication management resources, chronic disease management information and related guides, and much more. The link is: **healthpartnersplans.com/home/providers/clinical-resources/quality-and-population-health**.

As always, please contact your Provider Relations Representative for any questions about this program.

Jefferson Health Plans | Health Partners Plans

Jefferson Health Plans/Health Partners Plans

1-888-991-9023 (Provider Services Helpline)

JeffersonHealthPlans.com

Jefferson Health Plans

@jeffersonhealthplans

Health Partners Plans, Inc. (HPP), uses Jefferson Health Plans as the marketing name for some of its lines of business. Current lines of business are: Jefferson Health Plans Individual and Family Plans, Jefferson Health Plans Medicare Advantage, Health Partners Plans Medicaid, and Health Partners Plans CHIP. All communications will specify the impacted line of business within the content of the message.

PC-521QM-6247 1/2025