2024 Quality Care Plus (QCP)

Primary Care Physician Incentive Program

Jefferson Health Plans

Jefferson Health Plans is the marketing name for Health Partners Plans, Inc., and includes the following lines of business: Jefferson Health Plans (Individual and Family Plans); Jefferson Health Plans (Medicare); Health Partners (Medicaid); and KidzPartners (CHIP). If information in a communication pertains to a specific line of business, Jefferson Health Plans will specify within the content.

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

Message from Our CEO

Jefferson Health Plans is committed to the health and well-being of all our members, providers and the communities we serve. I want to thank you for your continued partnership and support.

It has been an exciting year of change and growth. On July 1, 2023, our Corporate Marketing name officially changed to Jefferson Health Plans, and we have continued to become an integral part of "One Jefferson," alongside the health and university arms of the business.

In 2024, we are excited to continue to replicate and expand our model of success across Pennsylvania and to welcome new Medicaid members statewide. We're also excited to be offering nine Medicare Advantage and seven ACA plans in Pennsylvania and New Jersey and expanding our geography in New Jersey to include two new counties: Atlantic and Mercer.

We're proud to have been named the #15 top employer on the Philadelphia Inquirer's 2023 Top Workplaces list. This award was particularly meaningful because it's based on the feedback of Jefferson Health Plans employees, who help build and maintain our special culture focused on our commitment to the communities we serve and on our growth as people and professionals.

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

I am 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.

Sincerely,

Denise Napier

Denise Napier, RN, MHA
President & CEO
Jefferson Health Plans

Summary of Our 2023 Performance

RECOGNITIONS FROM THE NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA)

NCQA Plan Rating

Jefferson Health Plans received a 4 out of 5 Stars rating from NCQA for our Medicaid plan. Jefferson Health Plans is one of 7 plans in Pennsylvania to receive this high rating for 2023 and remains among the top 54 (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 1,886 rated plans (Medicaid, Medicare, Exchange, and Commercial/Private) in 2023, only 362 plans (19%) received a top rating of 4, 4.5 or 5 and Jefferson Health Plans is proud to be one of these plans.

Health Equity Accreditation

In 2023, Jefferson Health Plans 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.

In 2011 Health Partners Plans was the first plan in the country to earn the NCQA Multicultural Health Care Distinction and maintained this distinction through 2023, the most recent reassessment year.

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 2023). This is a drop from the 4 Star rating we received the last two years. Industry success continues to raise the bar and it has become more difficult to achieve 4 Stars at the measure level for nearly half of the Stars program measures, but Jefferson Health Plans is aggressively working on improvement strategies to better position ourselves to return to a 4+ Star rating.

Overview of the QCP Program

WHAT IS QCP?

Quality Care Plus (QCP) is Jefferson Health Plans' 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
- Jefferson Health Plans' goals and priorities

This manual provides details on what you need to know about our 2024 QCP program and opportunities to maximize your incentive payments.

"Practice group" will be referenced throughout this manual. Practice group is defined by Jefferson Health Plans as 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 50 members at the practice group level and 100 members at the tax identification number (TIN) level for each product line (Medicare, Medicaid and CHIP) for 12 consecutive months during the measurement period.
- **Modified:** Have a minimum of 30 members in the individual measure's denominator to qualify and to receive any payment for that measure.
- See at least 25% of paneled Medicaid members during the 2024 measurement year to participate and earn any incentive dollars for Medicaid measures beginning with the May 2025 payment cycle. Additional details can be found in the 2024 QCP Program Updates section on page 8.*

***In calendar year 2025, this rate will increase to 30%.** Jefferson Health Plans will continue to provide advanced notice to any practices that may be at risk of not meeting this eligibility requirement.*

- Accept new Jefferson Health Plans members (unless Jefferson Health Plans has restricted your panel).

The acceptance of new membership must continue during the payment period and will be monitored monthly by Jefferson Health Plans. If a practice group and/or TIN discontinues the acceptance of new Jefferson Health Plans membership, the practice group and/or TIN becomes ineligible to participate in QCP. Bonus payments through the program will cease upon notification. 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).

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 considered by Jefferson Health Plans to continue the bonus payments to participants:

- 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 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 group locations that close and transfer membership to multiple practice groups and/or multiple TINs will be excluded from the QCP bonus.

Practice groups that voluntarily close their panel permanently will no longer be eligible for QCP reimbursement. Jefferson Health Plans 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.

Note: Capitated and fee-for-service practices are eligible to participate. A practice group may not be eligible for the QCP program if they have another VBP contractual arrangement with Jefferson Health Plans.

Jefferson Health Plans calculates and incentivizes practice groups for both operational measures and Healthcare Effectiveness Data and Information Set (HEDIS) measures within the QCP Program. 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 is based on the average membership of the practice during the 12-month measurement period (membership calculated bi-annually).

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.

Measurement Period

Jefferson Health Plans uses 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.

Jefferson Health Plans recalculates membership on a bi-annual basis:

- Membership will be recalculated for the **May 2024 payment**, based on membership and performance from January 1, 2023 to December 31, 2023. Payments reflecting this recalculation will be made from May 2024 to October 2024.
- Membership will be recalculated again for the **November 2024 payment**, based on membership from July 1, 2023 to June 30, 2024 and performance from January 1, 2023 to December 31, 2023. Payments reflecting this recalculation will be made from November 2024 to April 2025. 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

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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 Jefferson Health Plans' agreement with DHS, exhibit B(3), Section III, D.

2024 QCP Program Updates

All QCP-participating offices were sent a 2024 QCP Updates letter in October 2023 that provided an initial notification of updates to the 2024 QCP program. These updates are described in greater detail in this manual. Most updates listed below will not affect QCP payments until the 2025 recalculation, with reimbursement beginning in May 2025 (measurement period: January 2024-December 2024).

Here are the updates to our 2024 QCP program:

1. Eligibility Requirement
Effective for the 2024 measurement period, providers will continue to be required to see at least 25% of paneled Health Partners Medicaid Members during the 2024 measurement year in order to participate and earn any incentive dollars for Medicaid measures beginning with the May 2025 payment cycle. 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. We plan to increase this eligibility requirement to 30% for measurement year 2025.

Please see below for the place of service and servicing provider specialties Jefferson Health Plans 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. Measure Denominator Minimum
To continue to promote statistical significance, Jefferson Health Plans will increase the minimum number of Members in the individual measure's denominator from 20 to 30 Members for all lines of business. This means that your practice must have 30 Members in the individual measure's denominator to qualify and to receive any payment for that measure.

3. QCP Measure Changes

Jefferson Health Plans is making changes to the following measures for the January 2024 to December 2024 measurement period (to be reflected in the payments beginning in May 2025). Details of all new, updated and existing measures are included in this manual.

- **Care of Older Adults:** This Medicare measure was previously measured as a combo measure

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(Pain, Functional Status and Medication Review). In 2024, to continue to align with the CMS Medicare Stars Program more closely, Care of Older Adults – Pain Assessment and Care of Older Adults – Medication Review will be included as separate, stand-alone measures for Medicare only. Benchmarks for these measures will align with the most recently available Stars benchmarks released in October 2023.

- **Plan All-Cause Readmissions:** This measure will continue to be included for both Medicare and Medicaid, but the measurement logic will differ by line of business. For Medicaid, Jefferson Health Plans will continue to use the ratio of observed/expected readmissions (no changes). For Medicare, Jefferson Health Plans will align with the CMS Medicare Stars Program measurement, which assesses the percentage of hospital stays during the measurement year that were followed by an unplanned readmission within 30 days.
- **Glycemic Status Assessment for Patients with Diabetes (>9.0%) replacing Hemoglobin A1c Control for Patients with Diabetes - HbA1c Poor Control (>9.0%):** This new Medicaid measure will look at the percentage of members 18-75 years of age with diabetes (type 1 and type 2) whose most recent glycemic status (hemoglobin A1c or glucose management indicator) was greater than 9%. This replacement was mandated by DHS. Hemoglobin A1c Control for Patients with Diabetes - HbA1c Poor Control (>9.0%) will remain a Medicare measure.
- **Oral Evaluation, Dental Services replacing Annual Dental Visit:** This new Medicaid measure will look at the percentage of members under 21 years of age who received a comprehensive or periodic oral evaluation with a dental provider during the measurement year. This replacement was mandated by DHS. Please contact your Network Market Manager for more information.
- **Member Satisfaction Measures (Provider and Office Staff):** These measures will now be Medicaid-only QCP measures. Providers will no longer be measured or reimbursed for the Medicare LOB. Instead, Jefferson Health Plans has elected to introduce a separate Mock CAHPS survey for our Medicare population this year which will not be associated with our QCP Program.

4. PCMH Bonus Removed

Jefferson Health Plans will no longer offer a quality bonus to PCMH participating practices in the QCP Program. Further details will be shared with the PCMH participating practices.

5. HOS Bonus Removed

Jefferson Health Plans will remove the HOS bonus from QCP, but we will continue to share resources related to key HOS measures throughout 2024. Educational materials, including Jefferson Health Plans' Provider Resource Guide: Improving Patient Experience – A Guidebook to CAHPS, HOS and Quality Resources, can be found online on Jefferson Health Plans' Quality and Population Health webpage.

6. Improvement Incentive Opportunity

Effective for the 2024 measurement period, Jefferson Health Plans will introduce a new improvement incentive in our QCP Program. Providers will be eligible to earn a $0.05 PMPM incentive payment if they improve their baseline rate (MY2023 rate) by 5% for each of the below five Medicaid measures:

- Child and Adolescent Well-Care Visits (Total)
- Controlling Blood Pressure

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- Developmental Screening in the First Three Years of Life
- Glycemic Status Assessment for Patients with Diabetes (>9%)
- Lead Screening in Children

To be eligible for the improvement incentive, practices must have qualified for QCP during the previous measurement period (MY2023).

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, Jefferson Health Plans 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 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 17 of this manual for detailed benchmark and PMPM information for each of these measures.*

ELECTRONIC QUALITY MEASURE BONUS (MEDICAID)

Jefferson Health Plans 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 Jefferson Health Plans 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, Jefferson Health Plans 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 (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.

Jefferson Health Plans will continue to implement this program in 2024. 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

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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 fifteen practices below that were recognized and rewarded as high performers in 2023 based on their HEDIS measure performance in QCP MY 2022.

Practice Name	Address	City	State	Zip Code	Practice Type
Esperanza Health Center – Hunting Park	4417 N 6th St	Philadelphia	PA	19140-2319	Family Practice
Esperanza Health Center – Allegheny Avenue	861 E Allegheny Ave	Philadelphia	PA	19134-2401	Family Practice
Health Center #6	321 W Girard Ave	Philadelphia	PA	19123-1531	Internal Medicine
Jonathan B. Levyn; DO, PC	3402 F Street	Philadelphia	PA	19134-1225	Family Practice
Jonathan B. Levyn; DO	4031 Sheffield Street	Philadelphia	PA	19136-3101	Family Practice
Maria De Los Santos Health Center	401 W Allegheny Ave	Philadelphia	PA	19133-3644	Family Practice
The Pediatric and Adolescent Medicine Center of Philadelphia	105 W School House Ln	Philadelphia	PA	19144-3348	Pediatric
The Pediatric and Adolescent Medicine Center of Philadelphia	5249 Cedar Ave, Suite C	Philadelphia	PA	19143-1524	Pediatric
Temple Family Medicine at Elkins Park	8380 Old York Rd, Suite 100	Elkins Park	PA	19027-1539	Family Practice
Temple General Internal Medicine Associates	8380 Old York Rd, Suite 100	Philadelphia	PA	19140-5185	Internal Medicine
Temple Physicians At Hunting Park – Adult Medicine	133 W Hunting Park Ave, Suite 300-A	Philadelphia	PA	19140-2717	Family Practice
Temple Physicians At Hunting Park – Pediatrics	133 W Hunting Park Ave, Suite 300-B	Philadelphia	PA	19140-2717	Pediatric
Temple Physicians At Rockledge	8 Huntingdon Pike, Suite 100	Rockledge	PA	19046-4351	Family Practice
TPI Internal Medicine – Lehigh	100 E Lehigh Ave, CHC 1	Philadelphia	PA	19125-1012	Internal Medicine
TPI Pediatrics – Lehigh	100 East Lehigh Avenue, CHC 1	Philadelphia	PA	19125-1012	Pediatric

2024 QCP Measures

Below are measures included in our QCP program for 2024. Specific details of each measure are provided in this manual — including measure descriptions, requirements, tips for improvement, benchmarks and PMPMs.

2024 Measures	Medicare	Medicaid	CHIP
Adult Population			
Breast Cancer Screening	✓	✓	
Care of Older Adults – Pain Assessment	✓		
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%)		✓	
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)		✓	
Social Determinants of Health (SDoH)		✓	
Pediatric & Adolescent Population			
Oral Evaluation, Dental Services		✓	
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 2024 measure descriptions, requirements and tips for improvement.

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
- **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 the Medication Reconciliation Post-discharge brochure that Jefferson Health Plans released in September 2019. If you would like additional copies, please contact your Provider Relations Representative. You can also visit the Medication Management page on Jefferson Health Plans' site at **HPPlans.com/providers/quality-and-population-health/medication-management** for more information.

MEMBER SATISFACTION (MEDICAID)

Jefferson Health Plans continues to measure our Medicaid members' satisfaction with the care that they are receiving from our network providers. In 2024, 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 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, practice group and individual provider levels. Results will be recalculated beginning with the May 2025 payment (based on January 2024 – December 2024 measurement period).

The following benchmarks will be used for the member satisfaction measures. These benchmarks were set based on Jefferson Health 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.

Jefferson Health Plans will continue to provide practice groups with blinded member level open-ended responses and feedback per request, in addition to the TIN, practice group and provider 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.

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

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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.

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

SOCIAL DETERMINANTS OF HEALTH (MEDICAID)

Social determinants of health (SDoH) are the conditions in which people are born, grow, work, live and age. This measure assesses the percentage of your patients for whom Jefferson Health Plans receives SDoH-based codes via claims at least once during the measurement period (January 2024 - December 2024). Jefferson Health Plans will compare the rate (the percentage of members with completed SDoH screenings) to predefined benchmarks set by Jefferson Health Plans. All our patients enrolled with QCP-participating practice groups are eligible if they have been enrolled with Jefferson Health Plans 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 SDoH assessment is completed and positive (barriers identified), submit HCPCS Code **G9919** AND the appropriate SDoH Diagnosis Code(s) listed in Exhibit B on **pages 19 and 20**.
2. If the SDoH assessment is completed and negative (no barriers identified), submit HCPCS Code **G9920**.

Jefferson Health Plans recommends all patients be screened for SDoH 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.

Jefferson Health Plans encourages 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. For providers with their own platform of FindHelp, Jefferson Health Plans is actively working to identify how to integrate results and reporting between various FindHelp platforms.

Exhibit A: Measure Specific Benchmarks and Payments

Jefferson Health Plans utilizes a benchmark methodology that was created using a combination of NCQA industry-standard benchmarks, historical performance and clustering of our network performance. Jefferson Health Plans 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. Jefferson Health Plans continues to update these benchmarks.

Medicare	Benchmarks			PMPM		
Measure	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3
Breast Cancer Screening	63.00%	71.00%	79.00%	$0.50	$1.75	$2.50
Care of Older Adult – Medication Review	84.00%	93.00%	98.00%	$1.00	$2.50	$4.25
Care of Older Adult – Pain Assessment	83.00%	91.00%	96.00%	$1.00	$2.50	$4.25
Colorectal Cancer Screening	61.00%	71.00%	80.00%	$0.50	$1.75	$2.00
Controlling High Blood Pressure	68.00%	74.00%	82.00%	$0.75	$2.00	$2.75
Diabetes: Eye Exam	68.00%	73.00%	81.00%	$0.50	$1.00	$1.50
Diabetes: HbA1c Control (<9%)	72.00%	80.00%	87.00%	$0.50	$2.00	$2.75
Medication Adherence for Cholesterol	86.00%	88.00%	91.00%	$0.75	$1.75	$2.00
Medication Adherence for Diabetes	86.00%	88.00%	92.00%	$0.75	$1.75	$2.00
Medication Adherence for Hypertension	84.00%	86.00%	90.00%	$0.75	$1.75	$2.25
Medication Reconciliation Post-Discharge	52.00%	68.00%	82.00%	$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	11.00%	10.00%	8.00%	$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	73.00%	80.00%	87.00%	96.00%	$0.50	$0.75	$0.85	$1.00
Child and Adolescent Well-Care Visits	80.00%	86.00%	92.00%	95.00%	$0.25	$0.50	$1.00	$1.50
Childhood Immunization Status	33.00%	36.00%	39.00%	42.00%	$0.20	$0.40	$0.60	$1.00
Lead Screening in Children	74.00%	78.00%	82.00%	88.00%	$0.20	$0.40	$0.60	$0.80
Well-Child Visits for First 15 Months of Life	63.50%	68.00%	74.00%	79.00%	$0.15	$0.40	$0.85	$1.50
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	60.00%	65.00%	70.00%	75.00%	$0.25	$0.50	$0.75	$1.00
Child and Adolescent Well Care Visits (Total)	65.00%	72.00%	80.00%	90.00%	$0.25	$0.50	$1.00	$1.50
Childhood Immunization Status	46.00%	53.00%	57.00%	60.00%	$0.50	$0.75	$1.25	$1.50
Comprehensive Diabetes Care: Eye Exam	58.00%	63.00%	69.00%	76.00%	$0.10	$0.25	$0.50	$0.75
Controlling High Blood Pressure	60.00%	70.00%	80.00%	90.00%	$0.75	$1.00	$1.75	$2.00
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%)	63.00%	68.00%	76.00%	86.00%	$1.00	$1.50	$2.00	$2.75
Lead Screening in Children	80.00%	85.00%	90.00%	95.00%	$0.25	$0.50	$0.75	$1.50
Member Satisfaction (Provider)	94.00%	95.50%	97.00%	98.50%	$0.20	$0.40	$0.60	$1.00
Member Satisfaction (Office Staff)	95.00%	96.00%	97.00%	98.00%	$0.20	$0.40	$0.60	$1.00
Oral Evaluation, Dental Services	50.00%	58.00%	65.00%	70.00%	$0.05	$0.10	$0.50	$0.75
Plan All-Cause Readmissions	1.00	0.92	0.82	0.75	$0.25	$0.50	$1.00	$1.50
Social Determinants of Health (SDoH)	25.00%	35.00%	40.00%	50.00%	$0.25	$0.50	$1.00	$1.25
Well-Child Visits in the First 15 Months of Life	70.00%	75.00%	85.00%	90.00%	$0.25	$0.50	$1.50	$2.25
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 SDoH Diagnosis Codes

Please submit the following appropriate diagnosis code(s) AND HCPCS code G9919 if you complete an SDoH 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 SDoH 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)
Z59.7	Insufficient social insurance and 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

Jefferson Health Plans suggests working with your leadership team at your practice to identify a set of universally agreed upon SDoH ICD-10 codes.

Exhibit C: Measure Descriptions, Compliant Codes, 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 Jefferson Health Plans' fee schedule, unless specified. Codes that are included on a Jefferson Health Plans' 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 provided by Jefferson Health Plans. Additionally, please ensure claims and encounter data are submitted quickly and accurately. Please note that unless indicated, no supplemental data files will be accepted by Jefferson Health Plans 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.

	Oral Evaluation, Dental Services
Measure Description	The percentage of patients under 21 years of age who received a comprehensive or periodic oral evaluation with a dental provider during the measurement year.
Product Line	Medicaid
Eligible Patients	Based on age only. All members ages 0-21 years old as of December 31 of the measurement year that are continuously enrolled for 180 days during the measurement year with no gaps in enrollment.
Exclusions	• Members in hospice or using hospice services anytime during the measurement year. • Members who died during the measurement year.
Telehealth Allowance	None.
Tips to Improve Performance	• Educate parents on the importance of routine dental care for their child. • Identify and refer patients to dental providers close to your office and to where your patients live. • Use the Dental Provider Directory on Jefferson Health Plans' website to identify dental providers in close proximity to your office. • Review all open care gaps for the patient and attempt to close all gaps (e.g., patients might also be due for a Well-Care Visit). • Prioritize outreach efforts by targeting patients within the same household to achieve a greater impact. • Segment your population by age groups to identify your biggest opportunities. • Leverage our member incentive programs. • Remind parents and caregivers that preventive dental care and medically necessary services are covered under the health plan
Codes for Compliance	Any claim with a comprehensive or periodic oral examination code (D0150, D0145, or D0120) billed by a dental provider as identified through the provider taxonomy code.

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 Line	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.
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 provided by Jefferson Health Plans 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.

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Asthma Medication Ratio			
Medications for Compliance (Please note that some medications may be available only as certain brand name drugs or certain formulations on Jefferson Health Plans' 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 Jefferson Health Plans' formulary.*

Breast Cancer Screening	
Measure Description	The percentage of patients 50–74 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 10/1/22 and 12/31/24 to count for the 2024 measurement period [1/1/24–12/31/24]). *Note: All types and methods of mammograms (screening, diagnostic, film, digital or digital breast tomosynthesis) qualify for compliance.*
Product Line	Medicare and Medicaid
Eligible Patients	Patients 52 to 74 years of age. Patients who turn 52 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.

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<table>
<tr><th colspan="4">Breast Cancer Screening</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 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 44 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">• 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.
• 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.</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 Jefferson Health Plans' fee schedule, but will count toward the measure.*

<table>
<tr><th colspan="4">Care of Older Adult</th></tr>
<tr><td>Measure Description</td><td colspan="3">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.</td></tr>
<tr><td>Product Line</td><td colspan="3">Medicare (D-SNP Only)</td></tr>
<tr><td>Eligible Patients</td><td colspan="3">Based on age only. Patients who turn 66 years old during the measurement year are included.</td></tr>
<tr><td>Exclusions</td><td colspan="3">• Members in hospice or using hospice services anytime during the measurement year.
• Members who died during the measurement year.</td></tr>
<tr><td>Telehealth Allowance</td><td colspan="3">Patient-reported outcomes during telehealth visits and/or telephone phone assessments are permissible for functional status and pain assessments.</td></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 to Jefferson Health Plans, 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>
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Care of Older Adults – Pain Assessment			
Measure Description	The percentage of patients 66 years and older who had a pain 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. • Include documentation in the patient's medical chart to include evidence of a complete pain assessment (positive or negative findings of pain) and the date on which the assessment was performed.		
Codes for Compliance	Pain Assessment	CPT II	1125F, 1126F
	Transitional Care Management Services (TCM)	CPT	99495, 99496

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. Telehealth visits will count toward the measure.*
Product Line	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	Telehealth visits will count toward the measure. Please note that telehealth visits must be conducted via video. Please use the following telehealth modifier code and/or telehealth place of service (POS) code in addition to the traditional codes. • **Telehealth Modifier:** 95, GT, or GQ • **Place of Service:** 02
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.

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Child and Adolescent Well-Care Visits (Ages 3-21)			
Tips to Improve Performance	• Prioritize outreach efforts by targeting patients within the same household to achieve a greater impact. • Review all open care gaps for the patient and attempt to close all gaps (e.g., patients might also be due for an Annual 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 Jefferson Health Plans 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.		
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, Z76.1, Z76.2

**Code not on Jefferson Health Plans' 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 Line	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.
Telehealth Allowance	None

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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 an Annual 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
	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 • **HCPCS**: G0010* • **ICD10CM:** B16.0-B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11 • **ICD10PCS:** 3E0234Z
	Haemophilus Influenza Type B (HiB)	• **CPT:** 90644*, 90647, 90648, 90697, 90698, 90748 • **CVX:** 0120, 0146, 0148, 17, 46-51
	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 • **HCPCS:** G0008
	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 • **CVX:** 0109, 0133, 0152, 0215 • **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 Jefferson Health Plans' 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.

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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 Jefferson Health Plans' 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 Line	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.

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<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 44 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 social determinant of health.
• 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.
• 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 the Jefferson Health Plans' 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 Healthy Kids 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. • Bilateral eye enucleation anytime during the patient's history through the measurement year.
Product Line	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	• 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.

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<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 44 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">Diabetic Retinal Screening</td><td>CPT</td><td>67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92201, 92202, 92227-92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245</td></tr>
<tr><td>HCPCS</td><td>S0620, S0621, S3000</td></tr>
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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
	Unilateral Eye Enucleation	CPT	65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114

**Code not on Jefferson Health Plans' 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.

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<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 44 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. Jefferson Health Plans automatically receives 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.</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 lower than 9%. *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 44** 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. Jefferson Health Plans automatically receives this data from Quest; however, please document the results in the member's chart.

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Diabetes: Glycemic Status Assessment (>9%)			
Tips to Improve Performance	• 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.		
Codes for Compliance	HbA1c Test	CPT	83036, 83037
	HbA1c Result	CPT II	**Most recent HbA1c level < than 7.0%:** 3044F
			Most recent HbA1c level ≥7.0% and < than 8.0%: 3051F
			Most recent HbA1c level ≥ 8.0% and ≤ 9.0%: 3052F
			Most recent HbA1c level > than 9.0%: 3046F

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 Line	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 an Annual 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 12/31/24.	
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 Jefferson Health Plans' 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 Jefferson Health Plans' 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 12/31/24.	
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 Jefferson Health Plans' 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

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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 Jefferson Health Plans' 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 Jefferson Health Plans' formulary.*

Medication Adherence for Hypertension Medications			
Measure Description	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.		
Product Line	Medicare		
Eligible Patients	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.		
Exclusions	• 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 12/31/24.		
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. • 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.		
Medications for Compliance *(Please note that some medications may be available only as certain brand name drugs or certain formulations on Jefferson Health Plans' formulary or may require prior authorization.)*	ACE Inhibitors	• Amlodipine-Benazepril • Amlodipine-Perindopril* • Benazepril • Benazepril-HCTZ • Captopril • Captopril-HCTZ* • Cilazapril* • Cilazapril-HCTZ* • Enalapril • Enalapril-HCTZ • Enalaprilat* • Fosinopril • Fosinopril-HCTZ	• Lisinopril • Lisinopril-HCTZ • Moexipril • Moexipril-HCTZ* • Perindopril • Perindopril-Indapamide* • Quinapril • Quinapril-HCTZ • Ramipril • Ramipril-HCTZ* • Trandolapril • Trandolapril-Verapamil

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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 Jefferson Health Plans' 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 Jefferson Health Plans' 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 Line	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	Telehealth visits will count toward the measure. Please note that telehealth visits **must** be conducted via video. Please use the following telehealth modifier code and/or telehealth place of service (POS) code **in addition** to the traditional codes: • **Telehealth Modifier:** 95, GT, or GQ • **Place of Service:** 02		
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 Jefferson Health Plans to hold block scheduling events. • Connect patients to our Healthy Kids Program, KidzPartners. • 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, 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 Line	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	Telehealth visits will count toward the measure. Please note that telehealth visits **must** be conducted via video. Please use the following telehealth modifier code and/or telehealth place of service (POS) code **in addition** to the traditional codes: • **Telehealth Modifier:** 95, GT, or GQ • **Place of Service:** 02		
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 Jefferson Health Plans to hold block scheduling events. • Connect patients to our Healthy Kids Program, KidzPartners. • 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, Z76.1, Z76.2

Exhibit D: Exclusion Codes for Palliative Care, Advanced Illness and Frailty

Please refer to the exclusion codes below for Palliative Care, Advanced Illness and Frailty. These codes apply to the following five measures:

- Breast Cancer Screening
- 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, M1017* **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, F01.51, 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, F02.81, 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, F03.91, 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, J84.17, 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, K74.0, 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,

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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, 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

**Code not on Jefferson Health Plans' fee schedule, but will count towards the measure.*

Frequently Asked Questions

Q: HOW IS THE QCP MONTHLY INCENTIVE PAYMENT CALCULATED?

A: Jefferson Health Plans uses 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 Jefferson Health Plans' 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, 2024.

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 Jefferson Health Plans that are beyond the providers' control or previously communicated technical issues. 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 MQCP scores are released. Appeals will only be considered in the event of errors made by Jefferson Health Plans 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 CPT2 codes, that will meet the measure requirements. CPT2 codes capture important health outcomes information that closes care gaps without chart reviews and/or submission of additional data files.
- 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 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, CPT2, and/or ICD-10 codes. Jefferson Health Plans also has 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. Please note that no supplemental data files will be accepted, with the exception of errors made by Jefferson Health Plans that are beyond the providers' control.

Q: CAN I FIND MORE INFORMATION ABOUT JEFFERSON HEALTH PLANS' QUALITY-RELATED PROGRAMS ONLINE?

A: Yes! Jefferson Health Plans has an entire section of its 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 SDOH guides, medication management resources, chronic disease management information and related guides, and much more. The link is: **HPPlans.com/providers/quality-and-population-health**.

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

Jefferson Health Plans

Jefferson Health Plans

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

JeffersonHealthPlans.com

Jefferson Health Plans

@jeffersonhealthplans

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