# 2026 Quality Incentive Program

EmblemHealth®

# Table of Contents

# Message From Our Senior Vice President, Medical Management and Chief Health Equity Officer

Dear providers,

On behalf of EmblemHealth, thank you for your continued partnership and the exceptional care you provide for our members. Your engagement in our quality efforts contributed to the early success and meaningful improvement of key measures. This includes our Medicare contract's improvement from 3.5 to 4.0 Stars in 2024 as announced October 2025. These results reflect your dedication and the strong collaboration across our provider network.

As we move into the next program year, we remain focused on strengthening access, care coordination, and the overall patient experience. With a newly expanded Quality Provider Engagement team, we will continue working closely with your practices to identify and remove barriers, support outreach, offer training, education, and monthly webinars to help you succeed in priority measures. In addition to this Quality Incentive Program we are also introducing our Behavioral Health and Maternity incentive programs, efforts designed to support our entire provider network and further solidify whole care collaboration and high-quality coordination of care.

### 2026 Program

We are excited to launch another year of our enhanced Quality Incentive Program. This year's updates are formed by provider feedback, early program outcomes, and our shared commitment to improving clinical quality and patient health. These incentives are designed to reward providers for delivering high-quality care while supporting continuous improvement across our network.

Our program is grounded in the following principles:

- **Recognizing and rewarding providers** with a competitive payout structure tied to meaningful improvements in patient outcomes.
- **Partnering with practices through actionable data**, including member-level gaps in care, utilization trends, and medication adherence insights.
- **Supporting patient engagement** through a robust member rewards program that encourages completion of activities that positively impact your performance.

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

Warm regards,

Abdou Bah

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

# Program Overview

## Eligibility and Program Requirements

### Participation in the Quality Incentive Program (QIP) is extended to primary care providers at the group level (indicated as a Medical Center for EmblemHealth providers).*

To confirm eligibility for the QIP and clarify existing contracts, we encourage you to talk with your relationship manager.

Qualifications for the QIP include:

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

2. **Membership eligibility criteria**
   **Line of business eligibility:** To be eligible, providers at the group level (indicated as a Medical Center by EmblemHealth) must have at least 50 members in Medicare or Medicaid/Child Health Plus (CHPlus)/Enhanced Care Plus (HARP)/Essential Plan to be eligible. Panel sizes as of Dec. 31, 2026, will be used to determine program eligibility and payout. Only panels that meet the membership threshold will be eligible for payout.

   **Measure eligibility:** Each measure requires a minimum of 15 members to report on the measure.

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

   **Supplemental data:** Providers are required to submit supplemental data a minimum of 4 times per program year in order to participate in the program. *(Our preference is quarterly submissions.)*

*Providers engaged in a delegated risk arrangement with EmblemHealth are ineligible for the QIP. Other value-based arrangements may restrict participation. EmblemHealth, in its sole discretion, will determine eligibility and payout considerations including timing and amount to be paid, if any.

Supplemental data files for 2026 dates of service will be accepted according to the table below:

| Data Type | Standard Supplemental Data* | Non-Standard Data* (Medical Records) |
|---|---|---|
| **Description** | Aggregated patient data from a provider's electronic health records/electronic medical records (EHR/EMR) system in a required format.<br>Supplemental data should be submitted monthly using the required format. | All other data which requires physical inspection such as patient charts and clinical summaries.<br>May be submitted as proof of historical services, or services rendered by partnering or specialty providers only, to supplement compliance outside of claims and the standard supplemental file. |
| **Submit To** | **quality_data@emblemhealth.com** and copy your Quality Engagement Strategist. | **hedisgroup@emblemhealth.com** and copy your Quality Engagement Strategist. |
| **Submission Deadline** | **Standard - 4th quarter file:** Dec. 24, 2026<br>**Standard – other files:** Feb. 26, 2027 | Dec. 24, 2026 |

**Records only accepted starting March 31, 2026, for measurement year 2026.*

*See additional training material from your EmblemHealth Quality Engagement Strategist on supplemental data templates and accepted measures.*

## Measurement Period and Payment

**Incentive payments will be made one time in the second quarter of 2027.**

- Payment is based on each eligible patient who receives services, or claims we receive for services rendered.
- Provider groups will be paid based on **membership as of Dec. 31, 2026**.
- Payments will be sent to the Independent Physician Association (IPA) or managing entity to disburse to individual providers.

## Benchmark Targets

EmblemHealth evaluates and updates our program, methodology, measure sets, and benchmarks annually. In addition, we ensure that our various programs align with the quality-of-care standards defined by the Centers for Medicare and Medicaid Services (CMS), National Committee for Quality Assurance (NCQA), Department of Health requirements, and our quality improvement priorities. EmblemHealth utilizes a benchmark methodology that uses a combination of the official NCQA/CMS industry-standard benchmarks for individual Lines of Business (LOBs), the historical measure trend performance of our plan, projected forward cut points, and clustering of our network performance. The industry-standard benchmarks follow a clustering methodology where the benchmarks are created based on the results of the entire industry (every health plan).

**Summary of benchmark methodology:**

EmblemHealth uses a combination of the following factors to establish projected benchmarks:

- Latest official CMS, NYDOH, or NCQA cut points (usually 2-year lagging).
- 3-year historical trend of cut point movement and projected forward trend.
- Latest network performance.
- EmblemHealth quality goals.

Benchmarks are set to achieve and/or maintain competitive high-quality results in our market. This commitment drives us to exceed industry standards and continuously enhance the effectiveness of our programs.

# Summary of Changes From Previous Program Year

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

**Measure Updates**

Below is a summary of the measures we removed and those we added for 2026.

| Population | Removed | Added |
|---|---|---|
| **Medicare** | • Annual Wellness Visit | • Annual Wellness Visit Bonus |
| **State Sponsored Plans** | • Annual Wellness Visit | • Annual Wellness Visit Bonus<br>• Depression Screening Bonus |

Bonus Activities:

1. Annual Wellness Visit Bonus — Measured quarterly, Q1 $100, Q2 $75, Q3 $50, Q4 $25 to be paid out annually.
2. Depression Screening Bonus — Screenings with results submitted via supplemental data files, $10/per member to be paid out annually.
3. Required to submit supplemental data file at least 4x per year and grant access to EHR.

# Additional Incentive Opportunities

1. **Risk adjustment reimbursements**
   EmblemHealth is committed to supporting our providers in identifying and managing our members' chronic conditions. This presents an opportunity for providers to earn additional reimbursements. Using our portal, providers can easily view member alerts that highlight emerging chronic conditions and existing conditions in need of attention. Responding to these alerts is streamlined through this online system, and allows providers to attach the necessary progress notes and documentation. Providers who actively engage in this process become eligible for reimbursement for each successfully completed alert. Additional reimbursements are offered for alerts completed in compliance with the program before July 1, 2026.
   **Reimbursement details:**
   - **$150** for each completed alert pertaining to a **Medicare** member.
   - **$40** for each completed alert pertaining to a **Medicaid** member.
   - **$100** for each completed alert pertaining to a **Commercial** member.

2. **CPT II code incentive**
   EmblemHealth offers a reimbursement for the utilization of CPT category II codes to address key quality measures. This incentive is available to primary care providers. While there has been a delay in setup, please rest assured that starting in March 2026, providers will be reimbursed through the regular claim payment process for a full year of CPT II code submissions made in 2025, as well as for CPT II codes submitted from January 2026 onward.

3. ***NEW* Bonus Measures**
   **Annual Wellness Bonus (AWV)** — Measured Quarterly, Paid out annually at Q1 $100, Q2 $75, Q3 $50, Q4 $25.
   **Depression Screening and Follow up Bonus (DSF-E)**— Screenings performed and positive results follow up with in 30 days. Results submitted via supplemental data files. Paid out $10/per member annually.

| Measure | CPT II Codes | Annual Frequency Allowed | Incentive |
|---|---|---|---|
| **A1C** | **3044F —** HbA1c less than 7.0 percent<br>**3046F —** HbA1c greater than 9.0 percent<br>**3051F —** HbA1c greater than 7.0 percent and less than 8.0 percent<br>**3052F —** HbA1c greater than or equal to 8.0 percent and less than or equal to 9.0 percent | One of these codes (as applicable) can be used up to 4 times per year, per member. | $10 (up to 4 times, i.e. $40 max) |
| **Retinal Eye Exam** | **2022F —** Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed: **with** evidence of retinopathy (DM)<br>**2023F —** Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed: **without** evidence of retinopathy (DM)<br>**2024F —** 7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed: **with** evidence of retinopathy (DM)<br>**2025F —** 7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed: **without** evidence of retinopathy (DM)<br>**2026F —** Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed: **with** evidence of retinopathy (DM)<br>**2033F —** Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed: **without** evidence of retinopathy (DM) | 1 time a year, per member | $10 |
| **Blood Pressure** | **Both codes must be present for the incentive to be paid.**<br>**Systolic Blood Pressure**<br>**3074F —** blood pressure less than 130 mmHg<br>**3075F —** blood pressure 130-139 mmHg<br>**3077F —** blood pressure greater than or equal to 140 mmHg<br>**Diastolic Blood Pressure**<br>**3078F —** blood pressure less than 80 mmHg<br>**3079F —** blood pressure 80-89 mmHg<br>**3080F** — blood pressure greater than or equal to 90 | One of these sets of codes, systolic **and** diastolic (as applicable), can be used up to 4 times per year, per member. | $10 (up to 4 times, i.e. $40 max) |
| **Functional Status Assessment** | **1170F —** Functional status assessed | 1 time a year, per member | $10 |
| **Medication Review** | **1159F —** Medication list documented in medical record<br>**1160F —** Medication Review | 1 time a year, per member | $10 |

# 2026 Measures and Targets

Providers are evaluated on quality measures that are consistent with those published by the Centers for Medicare & Medicaid Services (CMS) and the New York State Department of Health (DOH). Below is a list of measures included in the QIP and associated payment tiers.

## Medicare

| Measure | 2026 QIP Tier 1 Benchmark | 2026 QIP Tier 2 Benchmark | 2026 QIP Tier 3 Benchmark | Tier 1 $ | Tier 2 $ | Tier 3 $ |
|---|---|---|---|---|---|---|
| Social Determinants of Health | 10% | 15% | 20% | $25 | $50 | $75 |
| Breast Cancer Screening (BCS-E) | 87% | 88% | 90% | $50 | $100 | $150 |
| Colorectal Cancer Screening (COL-E) | 86% | 87% | 88% | $50 | $100 | $150 |
| Controlling High Blood Pressure (CBP) <140/90 | 81% | 84% | 90% | $50 | $100 | $200 |
| Glycemic Status Assessment for Patients With Diabetes (GSD) | 86% | 87% | 93% | $50 | $100 | $200 |
| Eye Exam for the Patient with Diabetes (EED) | 86% | 88% | 91% | $50 | $100 | $150 |
| Kidney Health Evaluation for Patients With Diabetes (KED) | 72% | 75% | 78% | $50 | $100 | $150 |
| Controlling High Blood Pressure (CBP) <130/80 | 81% | 84% | 90% | $20 | $40 | $50 |
| Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC) | 66% | 71% | 76% | $50 | $100 | $150 |
| Statin Therapy for Patients with Cardiovascular Disease (SPC) | 89% | 92% | 95% | $50 | $100 | $125 |
| Part D Medication Adherence — Oral Diabetes Medications | 91% | 92% | 94% | $50 | $100 | $200 |
| Part D Medication Adherence — Hypertension | 91% | 92% | 94% | $50 | $100 | $200 |
| Part D Medication Adherence — Cholesterol | 91% | 92% | 94% | $50 | $100 | $200 |

Targets are based on Medicare Cut Points published by CMS, historical performance data, and additional industry-standard benchmarks. Once the Tier 1, Tier 2, or Tier 3 target is achieved, the provider will earn the respective incentive payment for each eligible member who received appropriate treatment.

# State Sponsored Programs

## Medicaid/CHPlus*/HARP+/Essential Plan

| Measure | 2026 QIP Tier 1 Benchmark | 2026 QIP Tier 2 Benchmark | 2026 QIP Tier 3 Benchmark | Tier 1 $ | Tier 2 $ | Tier 3 $ |
|---|---|---|---|---|---|---|
| Breast cancer screening | 75% | 77% | 79% | $25 | $75 | $100 |
| Cervical cancer screening | 77% | 78% | 80% | $25 | $75 | $100 |
| Chlamydia Screening in Women | 77% | 78% | 82% | $25 | $50 | $100 |
| Colorectal Cancer Screening | 62% | 65% | 68% | $25 | $50 | $100 |
| Controlling high blood pressure — <140/90 | 65% | 70% | 75% | $75 | $100 | $125 |
| Eye Exam for Patients With Diabetes | 64% | 66% | 69% | $25 | $75 | $100 |
| Glycemic Status Assessment for Patients With Diabetes | 65% | 70% | 75% | $75 | $100 | $125 |
| Social Need Screening and Intervention (Combo-Total) | 20% | 22% | 25% | $50 | $75 | $100 |
| Child and Adolescent Well-Care Visits (WCV) | 71% | 75% | 78% | $50 | $100 | $125 |
| Childhood Immunization Status (CIS) Combo 3 | 73% | 78% | 79% | $50 | $100 | $125 |
| Well-Child Visits in the First 30 Months of Life (W30) | 74% | 79% | 84% | $50 | $100 | $125 |
| Health Disparity — Glycemic Status Assessment for Patients With Diabetes African Americans | 65% | 70% | 75% | $25 | $40 | $50 |
| Health Disparity — Child and Adolescent Well-Care Visits African Americans | 71% | 75% | 78% | $25 | $40 | $50 |
| Controlling High Blood Pressure — <130/80 | 65% | 70% | 75% | $25 | $40 | $50 |
| Health Disparity — Controlling High Blood Pressure African American | 65% | 70% | 75% | $25 | $40 | $50 |

*Child Health Plus (CHPlus)

† Enhanced Care Plus (HARP)

Targets are based on benchmarks published by NYSDOH, historical performance data, and additional industry-standard benchmarks. Once the Tier 1, Tier 2, or Tier 3 target is achieved, the provider will earn the respective incentive payment for each eligible member who received appropriate treatment.

# Program Resources

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

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

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

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

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

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

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

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

5. **Rewards program for your patients**
   The EmblemHealth Member Rewards Programs are designed to ensure patients get the medical care they need, including preventive screenings. Members are rewarded for taking good care of their health. Your role remains unchanged — continue providing care including sending patients to receive important screenings such as mammograms.

## Medicare Member Rewards Program

**EmblemHealth Medicare Member Rewards website: emblemhealth.com/resources/medicare-member-resource-center/medicare-wellness-rewards.**

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

| Medicare and D-SNP Members | | | | |
|---|---|---|---|---|
| **Reward** | **Member Type** | **Frequency** | **Trigger for Reward** | **Value** |
| Welcome to Medicare Exam | New | 1 / lifetime | Completion of the Welcome to Medicare Exam within 90 days of enrolling in Medicare | $100 |
| Health Risk Assessment — Initial | New | 1 / lifetime | Completion of the Health Risk Assessment within 90 days of enrollment | $50 |
| Bone Mineral Density Test | New & Existing | 1 / year | Bone mineral density test (BMD) to check for osteoporosis for women age 67 – 85 within six months after fracture | $250 |
| Colorectal Cancer Screening | New & Existing | 1 / year | Fecal occult blood test (FOBT), flexible sigmoidoscopy, colonoscopy, FIT DNA test, or colonography | $50 |
| Diabetes A1c Test | New & Existing | 1 / year | A1c blood test | $25 |
| Diabetes Eye Exam | New & Existing | 1 / year | Retinal or dilated eye exam by an eye care professional | $50 |
| Diabetes Kidney Health Evaluation | New & Existing | 1 / year | Estimated glomerular filtration rate (eGFR) test and a urine albumin-creatinine ratio | $25 |
| Diabetes Care Completion Bonus | New & Existing | 1 / year | Complete all 3 diabetes care incentives: Diabetes A1C test, Eye Exam and Kidney Health Evaluation | $100 |
| Mammogram Exam | New & Existing | 1 / 2 years | Mammogram | $50 |
| Paperless Communication | New & Existing | 1 / lifetime | Completion of the Sign-Up for paperless communication preference | $100 |
| Annual Wellness Visit | New & Existing | 1 / year | Completion of an Annual Wellness Visit with PCP | $15 |
| Inpatient Admission Follow-up | New & Existing | 1 / event | Follow-up with a PCP or Specialist within 30-days of an inpatient admission | $25 |
| Emergency Department Follow-up | New & Existing | 1 / event | Follow-up with a PCP or Specialist within 7-days after discharge from emergency department for members with multiple high-risk chronic conditions | $50 |
| **DSNP Members ONLY** | | | | |
| Health Risk Assessment — Annual | Existing | 1 / year | Completion of the Health Risk Assessment | $50 |

Members may only be eligible for some of these activities.

To participate, Medicare members must sign-up for the rewards program on the EmblemHealth member portal at **my.emblemhealth.com**. They can also call Medicare Connect Concierge at **877-344-7364** (TTY: **711**).

## State Sponsored Programs

With the EmblemHealth Medicaid/HARP/CHPlus Member Rewards Program, members can receive rewards for eligible services like:

| Reward | Plan | Trigger for Reward | Value |
|---|---|---|---|
| Adult annual well visit | Medicaid/ HARP | Members age 22+ complete an annual wellness visit or annual physical visit within the calendar year | $25 |
| Postpartum checkup | Medicaid | Women complete a postpartum visit on or between seven and 84 days after delivery within the calendar year | $50 |
| Child/adolescent well-care visit | Medicaid/ CHPlus | Children 3-21 years old complete an annual well visit within the calendar year | $25 |
| Child/adolescent dental visit | Medicaid/ CHPlus | Children under 21 years old complete a comprehensive or periodic oral evaluation with a dental provider within the calendar year | $25 |
| Diabetes eye exam | Medicaid/ HARP | Diabetic members age 18-64 complete a retinal or dilated eye exam by an eye care professional within the calendar year | $25 |
| Diabetes A1C test | Medicaid/ HARP | Diabetic members age 18-75 complete an A1C blood test within the calendar year | $25 |

Members may only be eligible for some of these activities. Age is determined by the member's age at the end of 2026.

To participate, Medicaid/HARP/CHPlus members must sign-up for the rewards program at **emblemhealthrewards.nationsbenefits.com**. They can also call Member Services at **855-283-2146** (TTY: **711**).

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

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

**Breast cancer screening (BCS):** Mammogram screening that looks for signs of disease such as breast cancer before a person has symptoms; recommended for women 40 – 74 years old.

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

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

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

**Controlling blood pressure (CBP):** Blood pressure management for patients 18 – 85 years old with a hypertension diagnosis and whose most recent blood pressure was at the following levels during the measurement period:

- <140/90 mm Hg.
- <130/80 mm Hg has been added as an additional target during the measurement period. Evidence shows that a lower blood pressure target ultimately results in fewer cardiovascular events.

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

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

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

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

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

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

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

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

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

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

**Depression Screening and Follow-up for Adolescents and Adults Bonus:** Screening for depression using a standardized tool and ensuring members with positive results receive follow-up care within 30 days.

55 Water Street, New York, NY 10041-8190 | emblemhealth.com

EmblemHealth®

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

## Delivering excellence to your patients



EMB_PR_BRO_70659_QualityIncentiveProgram 12/25