

Quality Measure Resource Guide

2026

EmblemHealth®

Table of Contents

2026 Quality Measure Resource Guide 1

Prevention

Annual Wellness/Preventive Visit (AWV) 3
Breast Cancer Screening (BCS) 4
Colorectal Cancer Screening (COL) 5
Cervical Cancer Screening (CCS-E) 7
Chlamydia Screening (CHL) 8
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) 9
Social Needs Screening and Intervention (SNS-E) 10

Chronic Disease Care

Controlling Blood Pressure (CBP) 12
Eye Exam for Patients With Diabetes (EED) 14
Glycemic Status Assessment for Patients With Diabetes (GSD) 16
Kidney Evaluation for Patients With Diabetes (KED) 18

Pediatric Care

Well-Child Visits in the First 30 Months of Life (WC30), Child and Adolescent Well-Care Visits (WCV) 20
Childhood Immunization Status (CIS-E) 22

Maternity

Prenatal Care (PPC1) 24
Prenatal Immunization Status (PRS-E) 26
Postpartum Depression Screening and Follow-Up (PDS-E) 27
Postpartum Care (PPC2) 29

Medication Adherence

Statin Use in Persons With Diabetes (SPD) 33

Utilization

Plan All-Cause Readmission (PCR) 35
Transitions of Care — Patient Engagement after Discharge (TRC-E) 36
Transitions of Care — Medication Reconciliation Post-Discharge (TRC-MR) 37
Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC) 38

Mental Health/Substance Abuse

Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA) 40
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence (POD-N) 42

HIV/AIDS

Viral Load Suppression 43

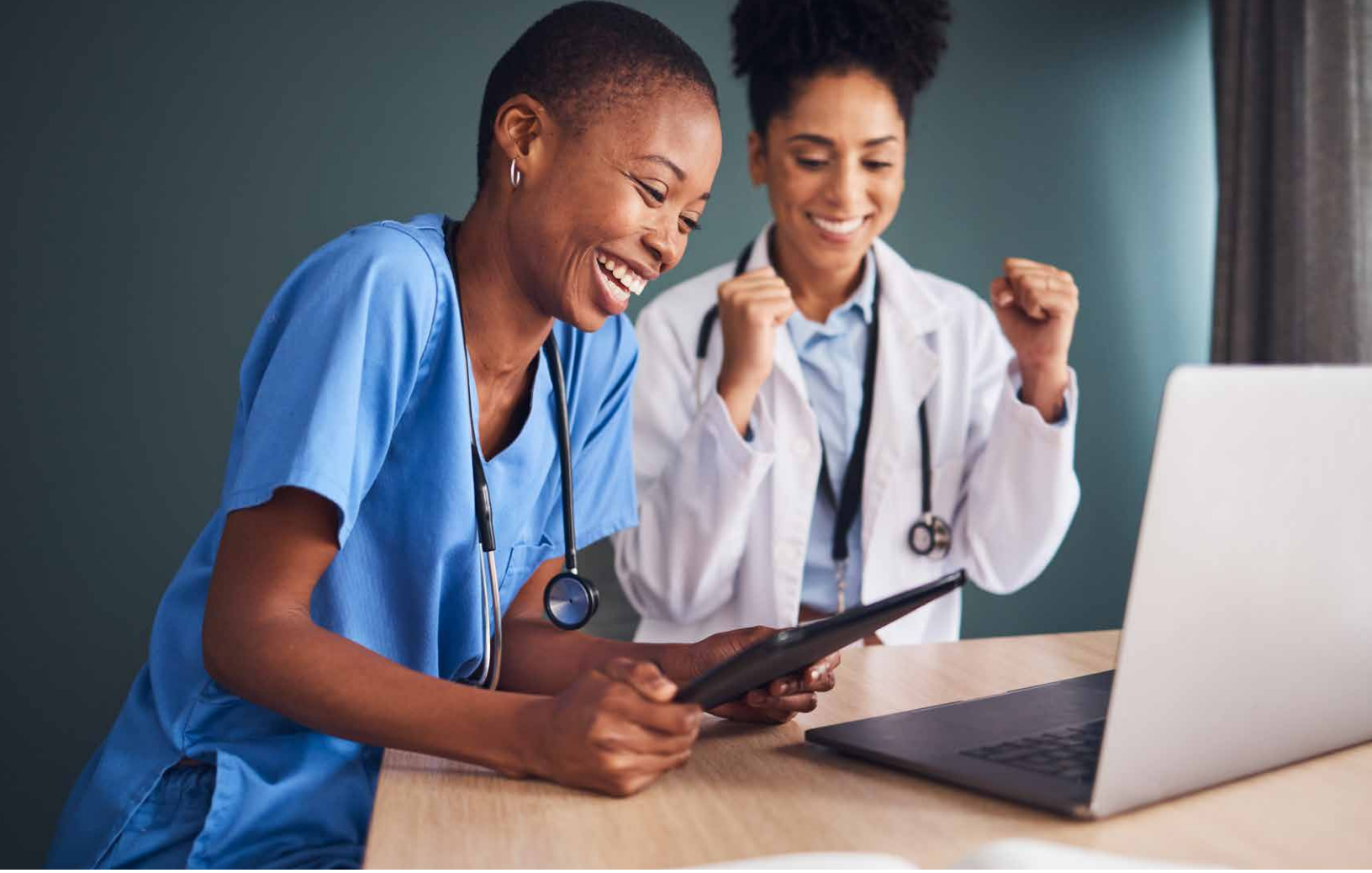
2026 Quality Measure Resource Guide

EmblemHealth is dedicated to delivering high-quality service to our valued members. The Quality Measure Resource Guide provides a brief overview of national and state quality measures* that evaluate various domains of preventive, acute, and chronic care for our members.

Our updated 2026 Quality Measure Resource Guide provides details of quality measures, descriptions of documentation/coding, best practices, and steps to close care gaps.



*The information contained in this guide was compiled in March 2026 and is subject to change as the sources update their specifications. Measures included in this guide are sourced from the National Committee for Quality Assurance (NCQA) — **ncqa.org**, Centers for Medicare & Medicaid Services (CMS) — **cms.gov**, and New York State Department of Health (NYSDOH) — **health.ny.gov**. NCQA HEDIS® specifications and New York state Value Set Directory can be viewed at **ncqa.org/hedis/measures**. Please confirm with your EmblemHealth Engagement Strategist that suggested codes are payable per your specific contract.



Provider Benefits and Incentives for Meeting Compliance Measures

Quality Incentive Programs

Through participation in our quality incentive programs (QIPs), providers may earn incentive payments tied to measures that improve meaningful health outcomes.

Measures included in this Quality Measure Resource Guide, like the Annual Wellness/Preventive Visit (AWV) and Depression Screening and Follow-up Bonus (DSF-E), which are NEW Bonus Measures for 2026, and others, offer additional bonuses for qualifying providers who meet these measures and document them according to listed requirements.

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

For a QIP program overview, including benchmark targets, state-sponsored programs, and additional incentive opportunities, read our Quality Incentive Program 2026 booklet.

Annual Wellness/ Preventive Visit (AWV)

Annual wellness visits or physicals help prevent and detect diseases early.

Who's included in the measure?

Patients 18 years of age and older who had an annual wellness visit or annual physical visit in the measurement year.

Actions needed for compliance:

An annual wellness visit or annual physical visit in the current measurement year for patients 18 years of age and older. An annual wellness visit includes physical assessment/physical exam, laboratory tests, immunizations, preventive screenings, and referrals.

Documentation/coding requirements

- **G0402:** During the first 12 months a patient is enrolled in Medicare, they are eligible for the Medicare welcome visit.
- **G0438:** After a patient has been enrolled in Medicare for 12 months. Includes initial wellness visit and annual wellness visit.
- **G0439:** All subsequent Medicare annual wellness visits that occur after the initial AWV (G0438). Includes annual wellness visit and subsequent wellness visits.
- **G0468:** Annual wellness visits for federally qualified health clinics.
- For Medicare, when billing an annual wellness visit and annual physical exam on the same day, using the modifier code 25 for the annual physical exam.

All lines of business: Annual physical exam during the measurement year.

- 99344 – 99348
- 99381 – 99387.
- 99391 – 99397.

Telehealth

A telehealth appointment is not sufficient to complete this screening.

Steps for closing care gaps

1. Use the Gap in Care report to identify patients to schedule for a wellness visit, if not yet arranged. You can also use the Gap in Care report to identify patients who are not compliant for this measure. Filter for measure name and "Non-Compliant" using the "Compliant Status" column.
2. Schedule early in the year to maximize benefit: needed preventive screenings can be assessed and scheduled.
3. Send appointment reminders prior to the scheduled appointment date.
4. Review office workflow to ensure addressing of gaps.
5. Consider offering blocked scheduling days or hours for this specific appointment type to maximize availability to patients.
6. Develop tools/checklist for annual wellness exams and continuously evaluate opportunities to close gaps every time a patient is seen.
7. Ensure process is in place for submitting either coding or supplemental data.

Breast Cancer Screening (BCS)

A mammogram screening that looks for signs of disease such as breast cancer before a person has symptoms.

Who's included in the measure?

Women 40 – 74 years of age who have had one or more mammograms between Oct. 1 two years prior to the measurement year and Dec. 31 of the measurement year.

Actions needed for compliance:

A mammogram to screen for breast cancer for women 40 – 74 years of age.

Documentation/coding requirements

- Documentation of the screening date. If the patient is not sure of the exact date, document the closest time frame (month/year).
- Use correct billing codes and ensure timely submission of claims. Electronic data collection method only measure.
- **CPT codes:** 77061 – 77063, 77065 – 77067.

Telehealth

- A telehealth appointment is not sufficient to complete this screening. Telehealth can be used only to review and document history of screenings.
- **CPT codes:** 98966, 98967, 98968, 99441, 99442, 99443.

Steps for closing care gaps

1. Use the Gap in Care report to identify patients to schedule for a wellness visit, if not yet arranged. You can also use the Gap in Care report to identify patients who are not compliant for this measure. Filter for measure name and "Non-Compliant" using the "Compliant Status" column.
2. During the visit, highlight the importance of preventive screenings and early detection. Discuss common fears about testing. Inform the patient that currently available testing methods are less uncomfortable and require less radiation.
3. Create a standing order for ease of screening completion.
4. Share a list of mammogram facilities with the patient or assist with scheduling.
5. Conduct telephonic outreach to non-compliant patients (despite receipt of an order/prescription) by using monthly Gap in Care report.

Exclusion criteria

- Patients with bilateral mastectomy can be excluded from the measure.
- Patients receiving hospice or palliative care at any time during the measurement year.

Colorectal Cancer Screening (COL)

Regular colorectal cancer screening, beginning at age 45, is key to preventing colorectal cancer and finding it early. About nine out of every 10 people whose colorectal cancers are found early and treated appropriately are still alive five years later (cdc.org, 2023).

Who's included in the measure?

Patients 45 – 75 years of age.

Actions needed for compliance:

Appropriate screening (as defined below) for colorectal cancer for patients 45 – 75 years of age:

- **Fecal occult blood test (FOBT):** during the current year.
- **Flexible sigmoidoscopy:** current year or four years prior (five years).
- **Colonoscopy:** current year or nine years prior (10 years).
- **CT colonography:** current year or four years prior (five years).
- **Stool DNA (FIT):** current year or two years prior (three years).

Documentation/coding requirements

- A pathology report that indicates the type of screening and the date the screening was performed.
- Patient-reported colorectal cancer screenings are acceptable if the screening is documented in the patient's medical history. It must include at a minimum the type of screening and year the screening was completed.
- Note: In-office digital rectal exam (DRE) and/or occult blood is not acceptable.
- Use the correct billing codes shared below and ensure timely submission of claims:
  - **Colonoscopy CPT:** 44388 – 44392, 44394, 44401 – 44408, 45379 – 45382, 45398.
  - **HCPCS:** G0105, G0121 ICD9: 45.22, 45.23, 45.25, 45.42, 45.43.
  - **FOBT CPT:** 82270, 82274 HCPCS: G0328.
  - **Stool DNA (FIT) CPT:** 81528.
  - **CT Colonography CPT:** 74261–74263.
  - **Flexible Sigmoidoscopy CPT:** 45330–45335, 45337–45338, 45340 – 45342, 45346 – 45347, 45349 – 45350.
  - **HCPCS:** G0104 ICD9: 45.24.

Telehealth

A telehealth appointment is not sufficient to complete this screening.

Steps for closing care gaps

1. Use the Gap in Care report to identify patients to schedule for a wellness visit, if not yet arranged.
2. Ensure that the patient's history is updated annually regarding prior colorectal cancer screening test(s) and look for evidence of compliance (colonoscopy completed within nine years of date or an exclusion as defined below).
3. Identify and schedule patients early in the year who may need a colorectal cancer screening.
   a. Use the Gap in Care report to identify patients who are not compliant. Filter for measure name and "Non-Compliant" using the "Compliant Status" column.
   b. Refer to the Last Completion Date column to understand the last time patient had the test completed. *Conduct outreach to patients to encourage colorectal cancer screening (consider letters and post cards).*

4. During visit, highlight importance of preventive routine screenings and benefits of screening for colorectal cancer. Discuss all options for screening, including FOBT and Stool DNA, for patients who may not want a colonoscopy. Encourage patients to take advantage of kits sent to their home for screening.
5. Create a relationship with a local gastroenterologist. Provide order and/or referral for screening.

Exclusion criteria

- Patients receiving hospice or palliative care at any time during the measurement year.
- Patients with evidence of colorectal cancer or total colectomy.

Cervical Cancer Screening (CCS-E)

Using the Pap test (or Pap smear), this screening looks for precancers — cell changes on the cervix that might become cervical cancer if they are not treated appropriately.

Who's included in the measure?

Women 21 – 64 years of age who had a proper screening for cervical cancer in the required time frame.

Actions needed for compliance:

Cervical cancer screening for women 21 – 64 years of age, following the required time frames:

- **Women 21 – 64 years of age:** Cervical cytology during the current year or two years prior to the current year (every three years).
- **Women 30 – 64 years of age:** Cervical high-risk human papillomavirus (hrHPV) testing performed during the current year or four years prior to the current year (every five years).
- **Women 30 – 64 years of age:** Cervical cytology/HPV co-testing during the current year or four years prior to the current year (every five years).

Documentation/coding requirements

- Documentation of the date (month, year) that the cervical cytology was performed and the results or findings.
- Use the correct billing codes shared below and ensure timely submission of claims:
  - **Cervical cytology CPT:** 88141 – 88143, 88147, 88148, 88150, 88152 – 88153, 88164 – 88167, 88174, 88175.
  - **HCPCS:** G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091.
  - **HPV test CPT:** 87624, 87625.
  - **HCPCS:** G0476.

Telehealth

A telehealth appointment is not sufficient to complete this screening, only to review and document history of screenings. **Use CPT codes:** 98966, 98967, 98968, 99441, 99442, 99443 with telehealth modifier 95.

Steps for closing care gaps

1. Use the Gap in Care report to identify patients to schedule for a wellness visit, if not yet arranged. You can also use the Gap in Care report to identify patients who are not compliant for this measure. Filter for measure name and "Non-Compliant" using the "Compliant Status" column.
2. During visit, highlight the importance of early detection, review barriers, and stress importance of preventive screenings.
3. Place reminders in patients' charts for when next screening is due, and reminder calls for scheduling.
4. Flag charts of patients after screening is performed to ensure timely follow-up of results and data capture for compliance.
5. Request to have cervical cytology results sent to you if done at an OB/GYN office.

Exclusion criteria

- Patients with a hysterectomy with no residual cervix, cervical agenesis, or acquired absence of the cervix.
- Patients receiving hospice or palliative care at any time during the measurement year.

Chlamydia Screening (CHL)

A chlamydia test detects the bacteria that causes chlamydia, a sexually transmitted infection (STI). This screening can be performed through urine collection or vaginal swab.

Who's included in the measure?

Females 16 – 24 years of age who were identified as sexually active.

Actions needed for compliance:

At least one test for chlamydia during the current year for females 16 – 24 years of age who were identified as sexually active.

Documentation/coding requirements

- Documentation must include date (month, year) of test and results.
- Use correct billing codes and ensure timely submission of claims.
  CPT: 87110, 87270, 87320, 87490 – 87492, 87810, 0353U.

Telehealth

- A telehealth appointment is not sufficient to complete this screening, only to review and document history of screenings.
- **Use CPT codes:** 98966, 98967, 98968, 99441, 99442, 99443 with modifier 95 for telehealth.

Steps for closing care gaps

1. Use the Gap in Care report to identify patients to schedule for a wellness visit, if not yet arranged. You can also use the Gap in Care report to identify patients who are not compliant for this measure. Filter for measure name and "Non-Compliant" using the "Compliant Status" column.
2. During visit, discuss safe sex practices and STIs with patients and highlight the importance of early detection.
3. Review and confirm all preventive health screenings at each visit.
4. Consider universal screening or opt in approach as a method to help prevent gaps in testing and unidentified sexually active women.

Exclusion criteria

- Female patients' pregnancy test and prescription for isotretinoin and a diagnostic radiology order on the date of the pregnancy test or six days after the pregnancy test.
- Patients receiving hospice or palliative care at any time during the measurement year.

Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

Routine depression screening supports early identification to help members receive timely, appropriate behavioral healthcare across the enterprise.

Who's included in the measure?

Adolescents age 12 – 17 and adults age 18+ who were screened for clinical depression using a standardized tool and received appropriate follow-up care if the screening result was positive. For positive screening results, the patient needs follow-up care on or within 30 days of the screening.

Actions needed for compliance:

- Use a **standardized, age-appropriate, validated** depression screening tool for patients **12 years of age and older**.
- Document the score or result in the note (a statement like "screen completed" is not enough).
- Complete the screening during the **measurement period**.
- If the screening is **positive**, document follow-up care **on or within 30 days** (for example: an office/telehealth visit to assess symptoms and plan care, a referral, or treatment started).

Documentation/coding requirements

A standard assessment instrument that has been normalized and validated for the appropriate patient population. Eligible screening instruments with thresholds for positive findings include:

Patient Health Questionnaire (PHQ-9)	44261-6	Total score ≥10
Patient Health Questionnaire Modified for Teens (PHQ-9M)	89204-2	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2)*	55758-7	Total score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS)*,**	89208-3	Total score ≥8
Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)	89205-9	Total score ≥17
Edinburgh Postnatal Depression Scale (EPDS)	71354-5	Total score ≥10
PROMIS Depression	71965-8	Total score ≥60

Exclusion criteria

- Patients receiving hospice/palliative care.
- Patients with a history of bipolar disorder.
- Patients with existing depression in the prior year.

Social Needs Screening and Intervention (SNS-E)

Social determinants of health (SDOH) are the conditions in the environment where people are born, live, learn, work, play, worship, and age that affect a wider range of health-functioning and quality-of-life outcomes. Patients with unmet social needs are more likely to have difficulties self-managing chronic health conditions, have repeat no-shows to medical appointments, and be frequent emergency department users. Your partnership is an important element to capture this data to positively impact the quality of life of our members.

Who's included in the measure?

Patients within the following age ranges. This applies to commercial, Medicare, and Medicaid patients:

- 17 years old and younger.
- 18 – 64 years old.
- Age 65 and older.

Actions needed for compliance:

Screen patients using a prespecified standardized tool at least once during the measurement period for unmet food, housing, and transportation needs, and provide a corresponding intervention if a patient screens positive.

We use the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool. Please see the example below of how to submit screening codes and respective findings using this tool.

For measure compliance, submit:

1. LOINC codes (both screening code **and** finding code as shown below) OR
2. Supplemental data (please ask your Provider Network Manager for a supplemental data template for SDOH).

Screening	Question	Screening Code	Answer	Finding Code
Housing	What is your living situation today?	71802-3	I have a steady place to live.	LA31993-1
			I have a place to live today, but I am worried about losing it in the future.	LA31994-9
			I do not have a steady place to live. (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park.)	LA31995-6
Food	Within the past 12 months, have you been worried that your food would run out before you got money to buy more?	88122-7	Often true.	LA28397-0
			Sometimes true.	LA6729-3
			Never true.	LA28398-8

Screening	Question	Screening Code	Answer	Finding Code
Transportation	In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?	93030-5	Yes.	LA33-6
			No.	LA32-8

SDOH screening tools

The four tools below are evidence-based tools that work for the SNS-E HEDIS quality measure.

Assessment Tool	Link to Tool
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	**The AHC Health-Related Social Needs Screening Tool (cms.gov)**
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	**Social Needs Screening Tool (aafp.org)**
Health Leads Screening Panel® *	**The Health Leads Screening Toolkit — Health Leads (healthleadsusa.org)**
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences [PRAPARE]® *	**Homepage — PRAPARE**

* Proprietary; may have a cost/licensing requirement if used.

Key SDOH strategy considerations

1. Are you asking your members about SDOH? If so, what tools do you use? Select an evidence-based screening tool based on the needs of your member population.
2. If a member screens positive for SDOH, are you linking them to appropriate resources for assistance?
3. Do you have a playbook of community resources by SDOH type?
4. Is your practice submitting claims with SDOH codes when assessments are completed, and interventions performed? Is your practice capturing survey data results in a reportable system?
5. What successes/difficulties are you experiencing in your office when billing and documenting in your electronic medical records (EMR)? Document the completion of SDOH assessments with appropriate coding.

How can EmblemHealth support you?

- Partner to define an SDOH strategy.
- Selection of an SDOH screening tool.
- Develop further understanding of the new quality measure.
- Share data on new HEDIS measure.
- Develop playbook of community resources.

Controlling Blood Pressure (CBP)

Controlling blood pressure is an important step in preventing heart attack, stroke, kidney disease, and in reducing the risk of developing other serious conditions.

EmblemHealth is dedicated to reducing health disparities for the African American population. As part of this effort, a specific measure has been included for this population. The prevalence of high blood pressure among African American people in the United States is among the highest in the world. Black people also have disproportionately high rates of more severe high blood pressure, and it develops earlier in life. Historical and systemic factors play a major role in these statistics (heart.org, 2023).

Who's included in the measure?

Patients 18 – 85 years of age who had at least two visits on different dates of service with a diagnosis of hypertension on or between Jan. 1 of the year prior to the measurement year and June 30 of the measurement year.

Actions needed for compliance:

Documentation/coding requirements

- Use the most recent blood pressure reading during the measurement year, which must be taken on or after second diagnosis of hypertension.
- Use the correct billing codes shared below and ensure timely submission of claims:
  - **Diastolic Blood Pressure CPT II:**
    - 3078F – blood pressure less than 80 mmHg.
    - 3079F – blood pressure 80 – 89 mmHg.
  - **Systolic Blood Pressure CPT II:**
    - 3074F – blood pressure less than 130 mmHg.
    - 3075F – blood pressure 130 – 139 mmHg.

Telehealth

A telehealth appointment can be used for compliance if a patient reported blood pressure values and the information is documented and stored in the patient's medical record by a PCP or specialist (if the specialist is providing a primary care service related to the condition being assessed). Use CPT codes from above.

Steps for closing care gaps

1. Use the Gap in Care report to identify patients to schedule for a wellness visit, if not yet arranged.
2. Identify and schedule patients early in the year who may need a blood pressure screening.
   a. Use the Gap in Care report to identify patients who are not compliant. Filter for measure name and "Non-Compliant" using the "Compliant Status" column.
   b. Refer to the Last Completion Date column to determine the date of the last blood pressure reading.
3. During visit, perform blood pressure check within first 20 minutes as patients often become anxious with long wait times. If blood pressure is over 140/90, perform recheck (digital or manual). Never use ranges.
   a. Submit CPT II codes for the lower of each reading set. Readings performed during the same day can be combined to obtain a compliant result (<140/90).
   b. Attempt to refrain from administering systemic medications such as Albuterol and antibiotics.
   c. Review diet, medications, exercise regimen, and treatment adherence with the patient at each visit.
   d. If patient is hypertensive during the visit, review medication history and consider modifying treatment plan.
5. Blood pressure readings that are patient-reported and/or taken with a remote digital monitoring device are reportable and count for compliance.

6. Provide enough medication to cover the time frame in between appointments.
7. Ensure next appointment is scheduled for patient prior to patient leaving the office.

Exclusion criteria

- Patients receiving hospice or palliative care at any time during the measurement year.
- Patients 66-80 with 2+ frailty and advanced illness diagnoses.
- Patients 81 years of age and older with a diagnosis of frailty.
- Patients diagnosed with end-stage renal disease.

Eye Exam for Patients With Diabetes (EED)

Diabetes-related eye disease typically causes few or no symptoms until it is severe. For this reason, annual dilated eye exams are recommended for all diabetic patients (diabetes.org, 2023).

Who's included in the measure?

Patients 18 – 75 years of age with diabetes (Type 1 or Type 2).

Actions needed for compliance:

Retinal or dilated eye screening for diabetic retinal disease, for a diabetic patient:

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) during the year.
- A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year. Negative eye exams can be conducted annually or every other year, while positive eye exams must be conducted annually.
- Bilateral eye enucleation any time during the patient's history through Dec. 31 of the measurement year.

Documentation/coding requirements

- Note or letter prepared by a healthcare professional indicating that an ophthalmoscopic exam was completed by an eye care professional (optometrist or ophthalmologist), the date when the procedure was performed, and the results.
- Chart or photograph indicating the date the fundus photography was performed and one of the following:
  - Evidence that an eye care professional (optometrist or ophthalmologist) reviewed the results.
  - Evidence results were read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.
  - Evidence that results were read by a system that provides an artificial intelligence (AI) interpretation.
- Use correct billing codes and ensure timely submission of claims. Codes can be submitted by any provider type.
  - **Eye exam with evidence of retinopathy:** 2022F, 2024F, 2026F.
  - **Eye exam without evidence of retinopathy:** 2025F, 2023F, 2033F.

Telehealth

A telehealth appointment is not sufficient to complete this screening, but documentation in telehealth visit of prior screening will count for compliance. Collect and document history of diabetes care.

Steps for closing care gaps

1. Use the Gap in Care report to identify patients to schedule for a wellness visit, if not yet arranged.
2. Identify and schedule patients early in the year who may need a diabetic eye exam.
   a. Use the Gap in Care report to identify patients who are not compliant. Filter for measure name and "Non-Compliant" using the "Compliant Status" column.
   b. Refer to the Last Completion Date column to understand the last time patient had the test completed. If patient hasn't completed the test within the calendar year, place an order or referral for retinal screening. *Conduct outreach to patients to make them aware of the referral and locations they can visit to have testing performed.*
3. During visit, highlight importance of preventive routine screenings and benefits of screening for diabetic retinopathy. Explain the risk of impaired vision caused by diabetes and the importance of retinal eye exams.
4. Refer non-compliant patients to local optometrist/ophthalmologist that can conduct a dilated fundus exam (DFE). Indicate on referral request for the report to be shared with the PCP.

Exclusion criteria

- Patients receiving hospice or palliative care at any time during the measurement year.
- Patients age 66 and older as of Dec. 31 of the measurement year who meet both frailty and advanced illness criteria.
- Patients who did not have a diagnosis of diabetes and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes, or steroid-induced diabetes.

Glycemic Status Assessment for Patients With Diabetes (GSD)

Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.

The former Hemoglobin A1C (HbA1c) Control for Patients With Diabetes (HBD) measure was revised to Glycemic Status Assessment for Patients With Diabetes (GSD). EmblemHealth is dedicated to reducing health disparities for the African American population. As part of this effort, a specific measure has been included for this population.

Who's included in the measure?

Patients 18 – 75 years of age with diabetes (Type 1 or Type 2).

Actions needed for compliance:

Appropriate hemoglobin HbA1c (A1C) rate OR glucose management indicator (GMI) for a diabetic patient. A lower rate indicates better performance for this indicator (low rates of poor control indicate better care).

Documentation/coding requirements

- Glucose management indicator (GMI) was added as an option to meet numerator criteria. Continuous glucose monitoring (CGM) data is acceptable.
- GMI values must include documentation of the CGM data date range used to derive the value.
- Documentation must include screening results AND date of service when the A1C or GMI test was performed. The most recent result is the ONLY result that is used to determine compliance.
- Documentation must include screening results and date of service when the A1C test was performed. The most recent result is the ONLY result that is used to determine compliance.
- If the A1C result is >8.0 or missing, the patient will not be compliant for this measure.
- Use the correct billing codes shared below and ensure timely submission of claims.
  - **HbA1c lab test via CPT:**
    - 83036, 83037.
  - Submit A1C test results via CPT II codes.
    - **3044F:** most recent A1C level less than 7.0%.
    - **3051F:** most recent A1C level greater than or equal to 7.0% and less than 8.0%.
    - **3052F:** most recent A1C level greater than or equal to 8.0% and less than or equal to 9.0%.
    - **GMI:** LOINC code: 97506-0

Telehealth

A telehealth appointment is not sufficient to complete the screening, but documentation in telehealth visit of prior screening will count for compliance. Collect and document history of diabetes care.

Steps for closing care gaps

1. Use the Gap in Care report to identify patients to schedule for a wellness visit, if not yet arranged.
2. Identify and schedule patients early in the year who may need A1C testing.
   a. Use the Gap in Care report to identify patients who are not compliant. Filter for measure name and "Non-Compliant" using the "Compliant Status" column.
   b. Refer to the Last Completion Date column to understand the last time patient had the test completed. If the patient hasn't completed the test within the calendar year, place an order for A1C testing. Conduct outreach to patients to make them aware of the order and locations they can visit to have testing performed.
   c. Review patient chart to find evidence of lab result value or date or exclusion (gestational or steroid-induced diabetes).

3. Identify and schedule patients who may need medical intervention due to non-controlled value >9. During visit, assure appropriate medical management of these patients, which includes starting on medication, adjustment in medication, discussing medication adherence, seeking specialist, care management referral, etc.
4. During visit, highlight importance of preventive screenings, educate member on the A1C target and the CGM goals, and review diabetic services needed at each office visit.
5. Considerations for testing:
    a. Complete hemoglobin A1C test quarterly. Consider using scheduled timeline: January, April, July, October.
    b. Consider ordering tests prior to the holiday season with the last test scheduled to be performed in October.

Exclusion criteria

- Patients receiving hospice or palliative care at any time during the measurement year.
- Patients age 66 and older as of Dec. 31 of the measurement year who meet both frailty and advanced illness criteria.
- Patients with a diagnosis of polycystic ovarian syndrome, gestational diabetes, or steroid-induced diabetes.

Kidney Evaluation for Patients With Diabetes (KED)

Diabetes is the leading cause of chronic kidney disease (CKD). Approximately one in three adults with diabetes has CKD. As many as 90% of people with CKD do not know they have it, because it often has no symptoms. CKD gets worse over time and can lead to heart disease, stroke, and kidney failure. For these reasons, annual monitoring of kidney health is crucial for people with diabetes (ncqa.org, 2023).

Who's included in the measure?

Patients 18 – 75 years of age with diabetes (Type 1 or Type 2).

Actions needed for compliance:

A kidney health evaluation (both screenings below) for a diabetic patient:

- Estimated glomerular filtration rate (eGFR).
- A urine albumin-creatinine ratio (uACR) identified by either of the following:
  Both a Quantitative Urine Albumin test and a Urine Creatinine test with service dates four days or less apart OR a uACR test.

Documentation/coding requirements

- Documentation must include the date of service, screening performed, and the result of the screening.
- Use the correct billing codes shared below and ensure timely submission of claims:
  - **eGFR testing CPT:** 80047, 80048, 80050, 80053, 80069, 82565.
  - **uACR testing CPT:** ensure that the albumin/creatinine ratio is being measured and reported, and both codes are being billed:
    - 82043 Quantitative Urine Albumin Lab Test.
    - 82570 Urine Creatinine Lab Test.

Telehealth

Telehealth is not sufficient to complete screening, but documentation in the telehealth visit of prior screening will count for compliance. Collect and document history of diabetes care.

Steps for closing care gaps

1. Use the Gap in Care report to identify patients to schedule for a wellness visit, if not yet arranged.
2. Identify and schedule patients early in the year who may need kidney health screening.
   a. Use the Gap in Care report to identify patients who are not compliant. Filter for measure name and "Non-Compliant" using the "Compliant Status" column.
   b. Refer to the Last Completion Date column to understand the last time patient had the test completed. If patient hasn't completed the tests within the calendar year, place an order for both eGFR and uACR testing prior to patient appointment. Conduct outreach to patients to make them aware of the order and locations they can visit to have testing performed.
3. During visit, highlight the importance of preventive routine screenings and medication adherence, and review diabetic services needed at each office visit. Educate member that kidney disease often develops slowly. Consequently, many are unaware until the disease is advanced and requires dialysis or a kidney transplant.
4. Considerations for testing:
   a. Ensure labs are ordered at least annually, preferably at the beginning of the year.
   b. Complete kidney health evaluation when patient is fasting.
   c. Consider ordering along with hemoglobin A1C test.

Exclusion criteria

- Patients receiving hospice or palliative care at any time during the measurement year.
- Patients age 66 and older as of Dec. 31 of the measurement year who meet both frailty and advanced illness criteria.
- Patients who did not have a diagnosis of diabetes and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes, or steroid-induced diabetes.

Well-Child Visits in the First 30 Months of Life (WC30), Child and Adolescent Well-Care Visits (WCV)

Well-child visits play a critical role in monitoring physical, emotional, and social development throughout childhood and adolescence. These visits support early identification of concerns, delivery of preventive care, and guidance for parents and caregivers to promote healthy growth and development.

EmblemHealth is dedicated to reducing health disparities for the African American population. As part of this effort, a specific well-care visit measure has been included for this population.

Who's included in the measure?

Children: first 15 months of life, 15 months – 30 months, and 3 - 21 years of age.

Actions needed for compliance:

Providers should ensure well-child visits are completed within the required time frames below:

- **Well-Child Visits in the First 15 Months of Life:** Children who turn 15 months old during the measurement year must have six or more well-child visits with a PCP. All visits must occur before the child reaches 15 months of age.
- **Well-Child Visits for Ages 15 – 30 Months:** Children who turn 30 months old during the measurement year must have at least two well-child visits with a PCP between 15 months and 30 months of age.
- **Child and Adolescent Well-Care Visits (Ages 3 – 21 Years):** Members 3 through 21 years of age must have at least one comprehensive well-care visit annually with a PCP or OB/GYN provider.

Documentation/coding requirements

- Well-child visits must occur with a PCP (assigned or unassigned).
- Well-child visits must include a physical exam. If the visit was originally for a sick visit, the physical must be comprehensive, and not just about the reason for the sick visit.
- A health history must be included with an assessment of the patient's history of disease or illness and family health history.
- A physical development history must be included with an assessment of the patient's specific age-appropriate physical development milestones.
- A mental development history must be included with an assessment of the patient's specific age-appropriate mental development milestones.
- Health education/anticipatory guidance must be given in anticipation of emerging issues that a child/family may face and to whom received the information.
- Include the date when a health and developmental history and physical exam was performed, and health education/anticipatory guidance was given in the medical record.
- Use the correct billing codes shared below to ensure timely submission of claims:
  - **CPT codes:** 99381 – 99385, 99391 – 99395, 99461
  - **HCPCS:** G0438, G0439, S0302
  - **ICD-10:** Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z02.5, Z76.1, Z76.2

Telehealth

A telehealth appointment is not sufficient to complete the screening.

Steps for closing care gaps

1. Use the Gap in Care report to identify patients to schedule for a wellness visit, if not yet arranged. You can also use the Gap in Care report to identify patients who are not compliant for these measures. Filter for measure(s) name and "Non-Compliant" using the "Compliant Status" column.
2. Take advantage of school breaks and holidays (summer and winter breaks) and offer extended/weekend hours.
3. Be sure to document all required elements of the wellness visit as described above.
4. Preschedule the next wellness visit before the patient leaves the office.
5. Conduct or schedule well-care visits when patients present for illness or other events (sport physical) as this might be the only time you see this member during the measurement year. Add modifier 25 to turn a sick visit into a well-child visit.
6. Take the opportunity to check and administer vaccines that are due at every visit.

Exclusion criteria

Patients receiving hospice or palliative care at any time during the measurement year are excluded.

Childhood Immunization Status (CIS-E)

Immunizations are a critical part of preventive care and help protect children from serious vaccine-preventable diseases.

Who's included in the measure?

Children, between their first and second birthday.

Actions needed for compliance:

Recommended vaccines that must be completed on or before the child's second birthday, with certain vaccines required to be administered between the child's first and second birthday according to HEDIS requirements, which include:

- Four DTaP (diphtheria/tetanus/acellular pertussis) vaccines.
- Four PCV (pneumococcal conjugate) vaccines.
- Three IPV (polio) vaccines.
- Three HiB (haemophilus influenza type B) vaccines.
- Three HepB (hepatitis B) vaccines or history of hepatitis illness.
- One VZV (chicken pox (VZV varicella zoster vaccine)* or history of varicella zoster illness.
- One MMR (measles/mumps/rubella) vaccine* or a history of measles, mumps, or rubella.

*Must occur between the child's first and second birthday.

Combination Vaccinations for Childhood Immunization Status										
	DTaP	IPV	MMR	HiB	HepB	VZV	PCV	HepA	RV	Influenza
Combo 3	X	X	X	X	X	X	X			
Combo 10**	X	X	X	X	X	X	X	X	X	X

**Combo 10 indicates that child received all the vaccines required for the Childhood Immunization Status (CIS) measures by their second birthday.

Documentation/coding requirements

- Documentation must include vaccine name and date of the immunization.
- There must be a note indicating the date of a seropositive test result or a documented history of illness, which must have occurred by the member's second birthday.
- Children who had a contraindication for a specific vaccine, (anaphylactic reaction, communal deficiency) are excluded.
- Use the correct billing codes shared and ensure timely submission of claims:
  - **DTaP CPT codes:** 90697, 90698, 90700, 90723.
  - **IPV CPT codes:** 90697, 90698, 90713, 90723.
  - **MMR CPT codes:** 90707, 90710.
  - **HIB CPT codes:** 90644, 90647, 90648, 90697, 90698, 90748.
  - **Hep B CPT:** 90697, 90723, 90740, 90744, 90747, 90748; HCPCS: G0010.
  - **VZV CPT:** 90710, 90716.
  - **Pneumococcal CPT:** 90670
  - **Hep A CPT:** 90633, 90634.
  - **RV 2 Dose CPT:** 90681.
  - **RV 3 Dose CPT:** 90680.
  - **Influenza CPT:** 90655 – 90658, 90611, 90674, 90685 – 90689, 90756.
  - **HCPCS:** G0008, G0009, G0010.

Telehealth

A telehealth appointment is not sufficient to complete immunizations.

Steps for closing care gaps

1. Use the Gap in Care report to identify patients to schedule for a wellness visit, if not yet arranged. You can also use the Gap in Care report to identify patients who are not compliant for this measure. Filter for measure name and "Non-Compliant" using the "Compliant Status" column.
2. Take advantage of school breaks and holidays (summer and winter breaks) and offer extended/weekend hours.
3. Begin vaccination conversations as early as prenatal appointments.
4. Administer vaccinations during already scheduled appointments.
5. During visit, review immunization records and encourage the opportunity to catch up on missing immunizations.
    a. Present vaccination as the default option, presuming parents and/or guardians will immunize.
    b. Educate parents on vaccination side effects and address common fears.
    c. Advise parents on the importance of completing each vaccine series.
    d. Provide handouts on the diseases the vaccines prevent.
6. Use electronic medical record (EMR) alerts to stay on schedule.
7. Schedule the next appointment at the time of checkout and use any office visit as an opportunity to vaccinate.

Exclusion criteria

Patients receiving hospice or palliative care at any time during the measurement year are excluded.

Patients who had a severe combined immunodeficiency, severe disorder of the immune system, human immunodeficiency virus (HIV), malignant neoplasm of lymphatic tissue, or intussusception on or before their second birthday are also excluded.

Prenatal Care (PPC1)

Prenatal care is most effective when it begins during the first trimester (within the first 12 weeks of pregnancy). Early engagement in prenatal care allows providers to monitor maternal and fetal health, address potential risks, and support positive outcomes throughout pregnancy.

Who's included in the measure?

Women who had a live birth on or between Oct. 8 of the year prior to the measurement year and Oct. 7 of the measurement year are included in this measure.

Actions needed for compliance:

Timely prenatal care for women who had a live birth on or between Oct. 8 of the year prior to the measurement year and Oct. 7 of the measurement year.

Documentation/coding requirements

- Prenatal care visit to an OB/GYN or other prenatal care practitioner or PCP meets the requirements. For visits to a PCP, a diagnosis of pregnancy must be present. Documentation in the medical record must include a note indicating the date when the prenatal care visit occurred and evidence that the patient is pregnant or references the pregnancy. Examples include:
  - Documentation in a standardized prenatal flow sheet.
  - Documentation of the last menstrual period (LMP), estimated due date (EDD), or gestational age.
  - A positive pregnancy test result.
  - Documentation of gravidity and parity.
  - Documentation of complete obstetrical history.
  - Documentation of prenatal risk assessment and counseling/education.
- A basic physical obstetrical examination that includes auscultation for fetal heart tone, or a pelvic exam with obstetric observations, or measurement of fundus height (a standardized prenatal flow sheet may be used).
- Evidence that a prenatal care procedure was performed, such as:
  - Screening test in the form of an obstetric panel including all of the following: hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, and Rh and ABO blood typing.
  - A TORCH antibody panel on its own.
  - A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing.
  - Ultrasound of a pregnant uterus.
- Use the correct billing codes shared below and ensure timely submission of claims:
  - Global / Bundled OB Care: Use CPT codes: 59400, 59510, 59610, 59618
  - Antepartum (Prenatal-Only Bundles): Use CPT codes: 59425, 59426
  - Standalone Prenatal Visits (E/M): Use CPT codes: 99202 – 99205, 99211 – 99215, 99241 – 99245
  - Prenatal Quality Reporting Codes (HEDIS / CPT II): Use CPT II code: 0500F for the initial prenatal visit, 0501F for the prenatal care visit, and 0502F for the postpartum visit.
  - Prenatal Care Support Services / Education: Use HCPCS code: H1000 for prenatal care and at-risk assessment, H1001 – H1004 for prenatal care education/support services, and H1005 for prenatal care enhancement services.
  - Use a pregnancy diagnosis code, including: Z34 for a normal pregnancy, O09 for a high-risk pregnancy, and ICD-10 or other pregnancy-related codes as needed.
  - Telehealth Prenatal Visits: Make sure appropriate modifiers are used like 95 and GT, and check that the visit meets prenatal care criteria.

Telehealth

A telehealth appointment and asynchronous e-visits can be used for compliance.

Steps for closing care gaps

1. Conduct outreach to pregnant members to help schedule their first prenatal visit with a provider during the first trimester whenever possible. Consider flexible scheduling or overbooking options for patients entering care later in pregnancy.
2. Coordinate with obstetric providers to ensure prenatal and postpartum visits are scheduled in a timely manner.
3. Use each visit as an opportunity for education. Discuss the importance of early and ongoing prenatal care, routine prenatal screenings, and maternal health. Educate patients on recognizing signs and symptoms of perinatal depression that may occur during or after pregnancy.
4. Remind patients receiving care from Maternal-Fetal Medicine (MFM) that they should continue routine visits with their OB/GYN provider in addition to specialty care.
5. Encourage patients to schedule future prenatal visits in advance to support adherence to recommended prenatal care schedules.
6. Promote completion of the postpartum visit between 7 and 84 days after delivery.

Exclusion criteria

- Patients receiving hospice or palliative care at any time during the measurement year are excluded.
- Patients who died any time during the measurement year are excluded.

Prenatal Immunization Status (PRS-E)

Physiologic and immune changes during pregnancy increase the risk of severe illness and hospitalization from influenza. Vaccination during pregnancy helps protect both the mother and infant and is an important component of preventive prenatal care.

Who's included in the measure?

Deliveries in the measurement year (Jan. 1 through Dec. 31) in which patients received influenza and tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccinations.

Actions needed for compliance:

Influenza vaccinations must be received on or between July 1 of the year prior to the measurement year and the delivery date.

Tdap vaccinations must be received during the pregnancy (including the delivery date).

Documentation/coding requirements

Tdap vaccinations must be received during the pregnancy (including the delivery date). Use appropriate CPT codes including: 90630, 90653, 90654, 90656, 90658, 90661, 90662, 90673, 90674, 90682, 90686, 90688, 90689, 90694, 90756.

For anaphylaxis due to diphtheria, tetanus, or a pertussis vaccine and encephalitis due to diphtheria, tetanus, or a pertussis vaccine, use an appropriate CPT code including: CPT 90715.

Telehealth

A telehealth appointment and asynchronous e-visits cannot be used for compliance with this measure.

Steps for closing care gaps

1. Offer vaccinations during prenatal visits or when patient is admitted for delivery.
2. Educate patient on the importance of vaccinations and how vaccinations protect both patient and baby.
3. Address patient anxiety and fear regarding vaccinations during pregnancy.
4. Outreach to patients who cancel appointments and assist them with rescheduling as soon as possible.
5. Set flags, if available, in the electronic health record (EHR), or develop alternative method for tracking patients who need vaccinations.
6. Document all vaccinations in the patient EMR, claims processing system, and state registry.

Exclusion criteria

- Patients receiving hospice or palliative care at any time during the measurement year.
- Patients who died any time during the measurement year.

Postpartum Depression Screening and Follow-Up (PDS-E)

Depression and anxiety rank among the most prevalent complications during pregnancy, even more commonplace than diabetes and high blood pressure — two complications that are regularly screened for by doctors.

Who's included in the measure?

Deliveries during the measurement period where the member also meets the criteria for participation of 28 days prior to the delivery date through the delivery date.

Actions needed for compliance:

Depression screening: the percentage of deliveries in which members were screened for clinical depression during the postpartum period using a standardized instrument and if screened positive, received follow-up care.

Follow-up on positive screening: the percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.

Documentation/coding requirements

A standard assessment instrument that has been normalized and validated for the appropriate patient population should be used. Eligible screening instruments with thresholds for positive findings include:

Instruments for Adolescents (≤17 years of age)	Total Score LOINC Codes	Positive Finding
Patient Health Questionnaire (PHQ-9)	44261-6	Total score ≥10
Patient Health Questionnaire Modified for Teens (PHQ-9M)	89204-2	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2)*	55758-7	Total score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS)*,**	89208-3	Total score ≥8
Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)	89205-9	Total score ≥17
Edinburgh Postnatal Depression Scale (EPDS)	99046-5	Total score ≥10
PROMIS Depression	71965-8	Total score ≥60

Instruments for Adults (18+ years of age)	Total Score LOINC Codes	Positive Finding
Patient Health Questionnaire (PHQ-9)	44261-6	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2)*	55758-7	Total score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS)*,**	89208-3	Total score ≥8
Beck Depression Inventory (BDI-II)	89209-1	Total score ≥20
Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)	89205-9	Total score ≥17
Duke Anxiety-Depression Scale (DUKE-AD)**	90853-3	Total score ≥30
Edinburgh Postnatal Depression Scale (EPDS)	99046-5	Total score ≥10
My Mood Monitor (M-3)	71777-7	Total score ≥5
PROMIS Depression	71965-8	Total score ≥60
Clinically Useful Depression Outcome Scale (CUDOS)	90221-3	Total score ≥31

*Brief screening instrument. All other instruments are full-length.
**Proprietary; may be cost or licensing requirement associated with use.

Not an all-inclusive list.

Telehealth

Telehealth appointment and asynchronous e-visits can be used for compliance for follow-up on positive screen.

Steps for closing care gaps

1. Educate the patient about the importance of follow-up and adherence to treatment recommendations.
2. Coordinate care with behavioral health practitioners by sharing progress notes and updates.
3. Outreach patients who cancel appointments and assist them with rescheduling as soon as possible.
4. Consider telemedicine visits when in-person visits are not available.
5. Discuss the importance of follow-up with a mental health provider.
6. Develop outreach internal team and/or assign care/case managers to members to ensure members keep follow-up appointments or reschedule missed appointments.
7. Set flags if available in electronic health records (EHR) or develop tracking method for patients who may need screenings and follow-up visit.

Exclusion criteria

- Exclude deliveries that occurred at less than 37 weeks gestation.
- Patients receiving hospice or palliative care at any time during the measurement year are excluded.
- Patients who died any time during the measurement year.

Postpartum Care (PPC2)

Timely postpartum care between seven and 84 days is essential to monitor a mother's recovery and identify potential physical and mental health concerns following childbirth.

Who's included in the measure?

Women with a live birth on or between Oct. 8 of the year prior to the measurement year and Oct. 7 of the measurement year.

Actions needed for compliance:

Timely postpartum care (between seven and 84 days after delivery) for women with a live birth on or between Oct. 8 of the year prior to the measurement year and Oct. 7 of the measurement year.

Documentation/coding requirements

- Documentation must include the date when a postpartum visit occurred and one of the following:
  - A pelvic exam.
  - Evaluation of weight, blood pressure, breasts, and abdomen — all four must be documented:
    - Notation of postpartum care, which includes documenting the visit as "postpartum care," "PP care," "PP check," or a "six-week check." Also, a preprinted Postpartum Care form where information was documented during the visit works for documenting postpartum care.
  - A perineal or cesarean incision/wound check.
  - Screening for depression, anxiety, tobacco use, substance use disorder, or preexisting mental health disorders.
  - A glucose screening for women with gestational diabetes.
- Documentation of any of the following topics:
  - Infant care or breastfeeding.
  - Resumption of intercourse, birth spacing, or family planning.
  - Sleep/fatigue.
  - Resumption of physical activity.
  - Attainment of healthy weight.
- Use the correct billing codes shared below and ensure timely submission of claims:
  - **CPT codes:** 58300, 59430, 99501.
  - **CPT ll codes:** 0503F.
  - **ICD-10 CM codes:** Z01.411, Z01.419, Z30.430, Z39.1, Z39.2.
  - **HCPCS codes:** G0101.
  - **Postpartum Bundled Services, CPT codes:** 59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622, or any of the cervical cytology codes listed in the cervical cancer screening measure above.

Telehealth

Telehealth and asynchronous e-visits can be used for compliance. A telehealth, telephone, e-visit, or virtual check-in appointment with a postpartum visit or cervical cytology code within seven to 84 days from delivery meets compliance for this measure.

Steps for closing care gaps

1. Conduct outreach to help patients schedule the postpartum visit before the patient delivers.
2. Explain the importance of and encourage attendance for postpartum visit.
3. Support the mother by reminding her to schedule a postpartum checkup during the baby's first well-child visit.
4. During visit, educate patients on recognizing the signs and symptoms of perinatal depression, which can occur during or after pregnancy.

Exclusion criteria

- Patients receiving hospice or palliative care at any time during the measurement year are excluded.
- Patients who died any time during the measurement year.

Medication Adherence

Adherence to medications for chronic conditions is an important factor for keeping your patients healthy and to optimize health outcomes. This is especially important for patients who take medications for hypertension, hyperlipidemia, and diabetes.

	Diabetes	**Hypertension**	**Cholesterol**
	Fight diabetes through medication adherence. Prevent heart disease and stroke complications.	Hypertension is a major risk factor for stroke, heart disease, and kidney disease.	Statins decrease cardiovascular events, including mortality.
Who's included in the measure?	Medicare members 18 years of age and older with at least two filled prescriptions for diabetes medications during the contract year.	Medicare members 18 years of age and older with at least two filled prescriptions for a blood pressure medication during the contract year.	Medicare members 18 years of age and older with at least two statin prescriptions for cholesterol filled during the contract year.
Actions needed for compliance	For Medicare members. **Diabetes medication** adherence, enough to cover 80% or more of the time patient is supposed to be taking the medication.	For Medicare members. **Hypertension medication** adherence, enough to cover 80% or more of the time patient is supposed to be taking the medication.	For Medicare members. **Cholesterol medication** adherence, enough to cover 80% or more of the time patient is supposed to be taking the medication.
Documentation/ coding requirements	Data from this measure comes from PDE data submitted by drug plans to Medicare. Only final-action PDE claims are used to calculate this measure. Medications: biguanides, sulfonylureas, thiazolidinediones, dipeptidyl peptidase (DPP)-4 inhibitors, GLP-1 receptor agonists, meglitinides, and sodium glucose cotransporter 2 (SGLT2) inhibitors.	Data from this measure comes from PDE data submitted by drug plans to Medicare. Only final-action PDE claims are used to calculate this measure. Medications: RAS antagonist medications only from one or more of the following drug classes: ARBs, or ACE inhibitors, or direct renin inhibitors.	Data from this measure comes from PDE data submitted by drug plans to Medicare. Only final-action PDE claims are used to calculate this measure. Medications: Only statin medications qualify: • Pitavastatin. • Fluvastatin. • Rosuvastatin. • Pravastatin. • Atorvastatin (+/- amlodipine). • Simvastatin (+/- ezetimibe, niacin). • Lovastatin (+/- niacin).
Exclusions	• Members receiving palliative/hospice care services. • Members with an ESRD diagnosis or dialysis coverage dates. • Members with one or more prescriptions for insulin.	• Members receiving palliative/hospice care services. • Members with an ESRD diagnosis or dialysis coverage dates. • One or more prescriptions for sacubitril/ valsartan (Entresto).	• Members receiving palliative/ hospice care services. • Members with an ESRD diagnosis or dialysis coverage dates.

Steps for closing care gaps

1. Identify non-compliant patients by using the Medication Adherence list. Conduct outreach to discuss compliance.
2. Key points to consider:
   a. **PDC Rates**: <80% = non-adherent
   b. **Medication run-out dates**
   c. **Previous fill/PDC history**
3. During visit with patient (face to face/virtual), educate patients and their caregivers on the importance of medication adherence. Discuss with patient common medication side effects and when to call the provider.
4. Remind patients to ask for medication to be run through their insurance benefit.
5. Adherence/reminder tools:
   a. Encourage 90-day fills for maintenance medications (during visit and/or through telephonic outreach).
   b. Compliance packaging tools: **free EmblemHealth pillbox**, digital reminders, auto refills, etc.
   c. Medication delivery or mail order pharmacy (Express Scripts or Sortpak Pharmacy), Amazon Pharmacy, and PillPack Pharmacy (compliance packaging pharmacy) powered by Amazon Pharmacy.
6. Address barriers:
   a. Cost, side effects, coordination of refills, transportation, doctor appointments.
   b. Clinical education.
7. Routinely arrange follow-up visits before the patient leaves the office.
8. Inform patients that you are working in collaboration with us (their insurance company) to ensure they get the most out of their treatment therapy and that we will frequently follow up with them via phone, text, or email.

Statin Use in Persons With Diabetes (SPD)

Statins are recommended for primary prevention of cardiovascular disease in patients with diabetes as they have an increased prevalence of lipid abnormalities, which contributes to their increased risk of cardiovascular disease.

Who's included in the measure?

Patients 40 – 75 years of age with diabetes during the measurement year who do not have clinical atherosclerotic cardiovascular disease (ASCVD).

Actions needed for compliance:

Patients who were prescribed and remained on at least one statin medication of any intensity for at least 80% of the treatment period during the measurement year.

Documentation/coding requirements

Compliance can only be achieved through prescription drug event (PDE) data. Claims that are filled through pharmacy discount programs will not result in compliance and patients may pay more for the statin than if they used their prescription drug coverage. Only final-action PDE claims are used to calculate this measure.

Eligible medications:

High-Intensity Statin Therapy

- Atorvastatin 40 – 80 mg.
- Amlodipine-atorvastatin 40 – 80 mg.
- Rosuvastatin 20 – 40 mg.
- Simvastatin 80 mg.
- Ezetimibe-simvastatin 80 mg.

Moderate-Intensity Statin Therapy

- Atorvastatin 10 – 20 mg.
- Amlodipine-atorvastatin 10 – 20 mg.
- Rosuvastatin 5 – 10 mg.
- Simvastatin 20 – 40 mg.
- Ezetimibe-simvastatin 20 – 40 mg.
- Pravastatin 40 – 80 mg.
- Lovastatin 40 mg.
- Fluvastatin 40 – 80 mg.
- Pitavastatin 1 – 4 mg.

Low-Intensity Statin Therapy

- Ezetimibe-simvastatin 10 mg.
- Fluvastatin 20 mg.
- Lovastatin 10 – 20 mg.
- Pravastatin 10 – 20 mg.
- Simvastatin 5 – 10 mg.

Telehealth

Telehealth can be used for compliance.

Steps for closing care gaps

1. Use the Gap in Care report to identify patients to schedule for a wellness visit, if not yet arranged. You can also use the Gap in Care report to identify patients who are not compliant for this measure. Filter for measure name and "Non-Compliant" using the "Compliant Status" column.
2. During visit, educate patients with diabetes of their increased risk of cardiovascular disease and the benefits of statin medication to prevent cardiovascular disease. Identify and resolve patient-specific adherence barriers (cost, refills, side effects). Remind patients to use their ID card at the pharmacy.
3. Consider prescribing a 90-day supply when appropriate.
4. Schedule follow-up visits to check progress.
5. Refer to specialist if appropriate.
6. Build quality care alerts in your electronic medical record (EMR).
7. Document in the medical record patient conditions that exclude them from taking a statin.

Exclusion criteria

Patients who fall under the below conditions are excluded:

- End-stage renal disease (ESRD).
- Cirrhosis.
- Myalgia, myositis, myopathy, or rhabdomyolysis.
- Pregnancy and IVF.
- Dispensed at least one prescription for clomiphene.
- Polycystic ovarian syndrome.
- Gestational diabetes.
- Steroid-induced diabetes.
- Patients discharged from an inpatient setting with a myocardial infarction.
- Patients who had coronary bypass graft surgery (CABG).
- Patients who had percutaneous coronary intervention (PCI).
- Patients who had any other revascularization procedure.
- IVD diagnosis.
- Patients receiving hospice or palliative care.

Plan All-Cause Readmission (PCR)

A high rate of patient readmissions may indicate inadequate quality of care in the hospital and/or a lack of appropriate post-discharge planning and care coordination. Unplanned readmissions are associated with increased mortality and higher healthcare costs. Unplanned readmissions can be prevented by standardizing and improving coordination of care after discharge and increasing support for patient self-management (ncqa.org, 2023).

Who's included in the measure?

Patients 18 years of age and older who had acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.

Actions needed for compliance:

Lower rate or no readmissions after acute inpatient and observation stays during the measurement year for patients 18 years of age and older.

Telehealth

A telehealth appointment can be used for follow-up care coordination and medication reconciliation.

Steps for closing care gaps

1. Partner with facility to improve care coordination upon discharge.
2. Contact patient within three days (72 hours) after discharge to schedule patient for follow-up with PCP/surgeon visit/virtual visit within seven days of patient discharge.
3. During visit, ensure patient's discharge information is comprehensive and complete. Review discharge summary with patient and caregivers, including medication regimen. Ensure they understand diagnosis, care plan, and patient has all medications and can take as prescribed.
4. Document medication reconciliation (discharge medications reconciled with current medication list) in the patient's medical record.
5. Consider a patient referral to Care Management if high-risk patient and need coordination of care. For more information and/or for your referrals, call our Care Management department at **800-447-0768** from 9 a.m. to 5 p.m., Monday through Friday.

Exclusion criteria

Medicare patient exclusions:

- Died during the stay.
- Received hospice care at any time during the measurement period.

Medicaid patient exclusions:

- Have a primary diagnosis of pregnancy.
- Had a primary diagnosis of a condition that originated in the perinatal period.
- Hospice in MY, four or more hospital stays Jan. 1 — Dec. 1 of MY, non-acute inpatient stays, hospital stays for select diagnoses or that meet specified admission/discharge date criteria, or if member died during the stay, readmissions for select diagnoses.

Transitions of Care — Patient Engagement After Discharge (TRC-E)

Transitioning from the inpatient (hospital) setting back to home often results in poor care coordination, including communication lapses between inpatient and outpatient (a setting other than a hospital) providers; intentional and unintentional medication changes; incomplete diagnostic workups; and inadequate patient, caregiver, and provider understanding of diagnoses, medication, and follow-up needs (ncqa.org, 2023).

Who's included in the measure?

Patients 18 years of age and older who were discharged from an acute or non-acute inpatient setting.

Actions needed for compliance:

Evidence the patient had an encounter (outpatient visit [office/home], call, telehealth, etc.) within 30 days of the inpatient discharge.

Documentation/coding requirements

- Care gaps for this measure are closed through claims data only.
- Outpatient visit.
- Use the correct billing codes shared below and ensure timely submission of claims:
  - **CPT codes:** 99202 – 99205, 99211 – 99215, 99241 – 99245, 99341 – 99345, 99347 – 99350, 99381 – 99387, 99391 – 99397, 99401 – 99404, 99411 – 99412, 99429, 99455, 99456, 99483.
  - **HCPCS codes:** G0402, G0438, G0439, G0463, T1015.
  - **Telephone visit: CPT codes:** 98966 – 98968, 99441 – 99443.
  - **Transitional care management services CPT codes:** 99495, 99496.
  - **Virtual visit/online assessment CPT codes:** 98969 – 98972, 98980, 98981, 99421 – 99423, 99444, 99457 – 99458.
  - **HCPCS codes:** G2061 – G2063.

Transitional care management codes will close care gaps for both patient engagement and medication reconciliation with proper documentation.

Telehealth

A telehealth appointment can be used for compliance.

Steps for closing care gaps

1. Partner with a care facility to improve care coordination upon discharge.
2. Contact patient within three days (72 hours) after discharge to schedule patient for follow-up with PCP/surgeon visit/virtual visit within seven days.
3. During the visit, ensure patient's discharge information is comprehensive and complete. Review discharge summary with patient and caregivers, including medication regimen. Ensure they understand diagnosis and care plan, and patient has all medications and can take as prescribed.

Exclusion criteria

Patients receiving hospice or palliative care at any time during the measurement year are excluded.

Transitions of Care — Medication Reconciliation Post-Discharge (TRC-MR)

Transitioning from the inpatient (hospital) setting back to home often results in poor care coordination, including communication lapses between inpatient and outpatient (a setting other than a hospital) providers; intentional and unintentional medication changes; incomplete diagnostic workups; and inadequate patient, caregiver, and provider understanding of diagnoses, medication, and follow-up needs (ncqa.org, 2023).

Who's included in the measure?

Patients 18 years of age and older who were discharged from an acute or non-acute inpatient setting.

Actions needed for compliance:

Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist, physician assistant, PCP, or registered nurse on the date of discharge through 30 days after discharge for patients.

Documentation/coding requirements

- Documentation in the outpatient medical record must include evidence of medication reconciliation and the date when it was performed. This meets the intent of the measure. An outpatient visit is not required.
- Use the correct billing codes shared below and ensure timely submission of claims:
  - Transitional care management CPT codes: 99495, 99496.
  - Cognitive assessment and care plan services CPT codes: 99483.
  - Discharge medications were reconciled with current medication list in outpatient medical record CPTII: 1111F (indicates that appropriate documentation exists in the patient's outpatient medical record). Submit 1111F code as a zero-dollar claim.

Telehealth

A telehealth appointment can be used for compliance.

Steps for closing care gaps

1. Partner with facility to improve care coordination upon discharge.
2. Contact patient within three days (72 hours) after discharge to schedule patient for follow-up with PCP/surgeon visit/virtual visit within seven days.
3. Secure medication reconciliation completed on the day of hospital discharge, review, and include as part of patient's outpatient medical record within 30 days of discharge from hospital. There must be evidence that the discharge summary with discharge medication(s) was filed in the medical record within 30 days of discharge.
4. During visit, ensure patient's discharge information is comprehensive and complete. Review discharge summary with patient and caregivers, including medication regimen. Ensure they understand diagnosis, care plan, and patient has all medications and can take as prescribed.
5. If medication reconciliation from hospital/discharge summary was not obtained, complete a thorough medication reconciliation of hospital discharge medications and update medical record. Documentation includes:
   - Evidence that provider reconciled the current and discharge medications.
   - Review of current medications along with a reference to discharge medications (that includes that they were reviewed, there are no changes, discharge medications will be discontinued, etc.).
   - If no medications were prescribed upon discharge, provide documentation with a note showing that.

Exclusion criteria

Patients receiving hospice or palliative care at any time during the measurement year are excluded.

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 visit (18 years of age and older with multiple chronic health conditions) helps to avoid any future re-visits to the emergency department.

Who's included in the measure?

Patients 18 years of age and older with two or more different high-risk chronic conditions that had an emergency department visit between Jan. 1 and Dec. 24 of the measurement year.

Actions needed for compliance:

A patient must have a follow-up service within seven days after the emergency department visit. Visit types may include an office visit, virtual visit, behavioral health visit, transitional care or case management, etc.

Chronic health conditions include (diagnosed prior to emergency department visit during the measurement year or year prior):

- Chronic respiratory conditions: chronic obstructive pulmonary disease (COPD), asthma, unspecified bronchitis.
- Alzheimer's disease and related disorders.
- Chronic kidney disease.
- Depression.
- Heart failure (chronic heart failure, heart failure diagnosis).
- Acute myocardial infarction.
- Atrial fibrillation.
- Stroke and transient ischemic attack (visit with a principal diagnosis of encounter for other specified aftercare not included).

Note: If a patient has more than one emergency department visit, they could be in the measure more than once.

Documentation/coding requirements

Patients must have at least two qualifying high-risk chronic conditions and a documented follow-up visit with a healthcare professional within seven days of the emergency department visit.

Telehealth

A telehealth appointment can be used for compliance. Telehealth follow-ups are encouraged as they allow for easy connection just after an emergency department visit when it may be difficult for patients to travel.

Steps for closing care gaps

1. Establish relationships with area hospitals to develop a notification process for emergency department visits.
2. Create a daily process to schedule patients that have been discharged from the emergency department or an inpatient stay.
3. Contact patient to schedule post-emergency department follow-up visit (PCP/surgeon visit/virtual visit) as soon as emergency department admission or discharge notification is received.
4. During follow-up visit, discuss the discharge summary and verify understanding of instructions and that all new prescriptions were filled. Complete a thorough medication reconciliation with the patient/caregiver.

5. Encourage patients to have regular office visits to monitor and manage chronic conditions.
6. Provide a visit summary of what was discussed during the PCP visit with clear instructions on changes that need immediate attention.
7. Encourage patients to call PCP's office/after-hours line when condition changes.
8. Submit claims timely and include the appropriate codes for diagnosis, health conditions, and the services provided. A provider type requirement is not defined in the FMC measure specification.

Exclusion criteria

Patients who fall under the below conditions are excluded:

- Patients in hospice or using hospice services anytime during the measurement year.
- Patients who died any time during the measurement year.
- Any emergency department visit that results in an inpatient admission on the day of, or within seven days following, the emergency department visit, regardless of the principal diagnosis for admission.
- Emergency department visits occurring within the same eight-day period.
- Principal diagnosis of encounter for other specified aftercare.
- Any diagnosis of concussion with loss of consciousness (LOC) or fracture of vault of skull.

Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)

Medication adherence reduces the risk of relapse or hospitalization in individuals with schizophrenia.

Who's included in the measure?

Patients 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed two or more anti-psychotic medications.

Actions needed for compliance

A patient must remain on an antipsychotic medication for at least 80% of their treatment period.

Documentation/coding requirements

Compliance can only be achieved through a prescription drug event (PDE) and medical claims data. Eligible medications include:

- **Oral medications:**
  - Aripiprazole
  - Asenapine
  - Brexpiprazole
  - Cariprazine
  - Clozapine
  - Haloperidol
  - Iloperidone
  - Loxapine
  - Lurasidone
  - Molindone
  - Olanzapine
  - Paliperidone
  - Quetiapine
  - Risperidone
  - Ziprasidone
- **Phenothiazine antipsychotics (oral):**
  - Chlorpromazine
  - Fluphenazine
  - Perphenazine
  - Prochlorperazine
  - Thioridazine
  - Trifluoperazine
- **Psychotherapeutic oral combinations:**
  - Amitriptyline-perphenazine
- **Thioxanthenes (oral):**
  - Thiothixene
- **Long-acting injections:**
  - Aripiprazole
  - Fluphenazine decanoate
  - Haloperidol decanoate
  - Olanzapine
  - Paliperidone palmitate
  - Risperidone

Telehealth

A telehealth appointment is not sufficient for compliance. This measure is based on pharmacy fills/claims. Visits (in-person or telehealth) support adherence but do not, by themselves, close the gap.

Steps for closing care gaps

1. Use the Gap in Care report to identify patients to schedule for a wellness visit, if not yet arranged. You can also use the Gap in Care report to identify patients who are not compliant for this measure. Filter for measure name and "Non-Compliant" using the "Compliant Status" column.
2. Coordinate care with patients' behavioral health specialist.
3. During visit, educate patients and their caregivers on the importance of medication adherence. Discuss patients' common medication side effects and when to call the provider. Consider prescribing a 90-day supply.
4. Consider long-acting injectable medications for eligible patients with a history of medication non-compliance.
5. Routinely arrange follow-up visits before the patient leaves the office.

Exclusion criteria

Patients who fall under the below conditions are excluded:

- Diagnosis of dementia.
- Patients receiving hospice or palliative care at any time during the measurement year.
- Patient did not have at least two antipsychotic medication dispensing events.
- Patients with Medicare, 66 years of age or older, are either enrolled in an institutional special needs plan (I-SNP) or are living long-term in an institution.
- Patients 66 – 80 years of age with frailty AND advanced illness.
- Patients 81 years of age and older with frailty.
- Patient who died any time during the measurement period.

Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence (POD-N)

Evidence suggests that pharmacotherapy can improve outcomes for individuals with opioid use disorder (OUD) and that continuity of pharmacotherapy is critical to prevent relapse and overdose.

Who's included in the measure?

Patients 18 years of age and older with a diagnosis of opioid use disorder (OUD).

Actions needed for compliance:

Initiate pharmacotherapy with at least one prescription or visit for opioid treatment medication within 30 days following a diagnosis of opioid dependence.

Documentation/coding requirements

- Compliance can also be met via medical/visit-based medication administration data (claims), e.g. if member goes in for a visit for the injection to be administered. Claims that are filed through pharmacy discount programs will not result in compliance, and patients may pay more for the medication than if they used their prescription drug coverage. Only final-action PDE claims are used to calculate this measure.
- Eligible medications include:

Naltrexone	Buprenorphine	Buprenorphine/naloxone
— Oral tablet	— Sublingual tablet	— Sublingual tablet
— Injectable	— Injection	— Buccal film
	— Implant	— Sublingual film

Telehealth

A telehealth appointment is not sufficient for compliance.

Steps for closing care gaps

1. Use the Gap in Care report to identify patients to schedule for a wellness visit, if not yet arranged. You can also use the Gap in Care report to identify patients who are not compliant for this measure. Filter for measure name and "Non-Compliant" using the "Compliant Status" column.
2. Ensure pharmacotherapy treatment is started upon diagnosis.
3. During the visit, discuss medication use with your patients, including:
   a. Possible medication side effects and how to manage them, including when to notify the provider.
   b. Potential interactions, including interactions with other controlled substances.
   c. Importance of medication adherence and the dangers of discontinuing suddenly.
4. Help patients manage stressors and identify triggers that can return them to illicit opioid use.
5. Encourage patients to combine medication treatment with behavioral counseling or therapy.
6. Encourage follow-up visits. Schedule their appointment at the end of the visit.
7. Coordinate care with patients' behavioral health specialist.

Exclusion criteria

- Patients who had an index visit with a diagnosis of opioid abuse or dependence during the 60 days before the index episode start date are excluded.

Viral Load Suppression

Getting and keeping an undetectable viral load is the best thing people with HIV can do to stay healthy. Another benefit of reducing the amount of virus in the body is that it prevents transmission to others through sex or syringe sharing, and from mother to child during pregnancy, birth, and breastfeeding (cdc.gov, 2023).

Who's included in the measure?

Patients two years of age and older who are HIV-positive.

Actions needed for compliance:

An HIV viral load less than 200 copies/mL at last viral load test in the current year for patients two years of age and older.

Telehealth

A telehealth appointment is not sufficient for this measure. Telehealth visits can be used for counseling and ordering labs, but compliance requires a viral load lab result on file.

Steps for closing care gaps

1. Use Gap in Care report to identify patients to schedule for a wellness visit, if not yet arranged. You can also use the Gap in Care report to identify patients who are not compliant for this measure. Filter for measure name and "Non-Compliant" using the "Compliant Status" column.
2. Complete these actions during the visit:
   a. Share information with your patients about the research on treatment as prevention and then ask them open-ended questions to start the conversation.
   b. Talk about the benefits of achieving and maintaining an undetectable viral load, including not being able to sexually transmit HIV to others.
   c. Emphasize that while treatment as prevention is a highly effective prevention strategy, its success depends on achieving and maintaining an undetectable viral load. Note that if a patient's viral load increases, so does their risk of transmitting HIV to their HIV-negative partners through sex.
   d. Discuss the prevention steps your patients are taking to help them adhere to their treatment regimen and maintain an undetectable viral load.
   e. Use the information your patients share with you to identify barriers they may have to adhering to antiretroviral therapy (ART) and regular, ongoing care that may make it difficult for them to achieve and maintain viral suppression.

Exclusion criteria

Patients with two or fewer HIV claims, no HIV diagnosis in the past two years, no viral load results/claims, no current HIV medication regimen, and no current claims from an infectious disease provider are excluded.

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



EmblemHealth Plan, Inc., EmblemHealth Insurance Company, and Health Insurance Plan of Greater New York (HIP) are EmblemHealth companies. EmblemHealth Services Company, LLC and EmblemHealth Connecticut, LLC provide administrative services to the EmblemHealth companies.

EMB_PR_BRO_71352_QualityResourceMeasureGuide 10/26