2025 Quality Incentive Program

EmblemHealth®

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Message From Our Senior Vice President, Medical Management

Dear providers,

On behalf of our entire organization, I want to express our sincere gratitude for your continued partnership and support. The growth and success in our organization and quality results would not have been possible without the contributions of our provider partners. We are truly appreciative of your commitment, and we look forward to continuing our collaboration to deliver the best possible care and outcomes to our growing membership. Your dedication to exceptional care remains the foundation of our shared vision for a robust and sustainable health care system.

Here are some of the key highlights of those accomplishments for 2023-2024:

- EmblemHealth's provider incentive payout for 2023 measurement year was $6.9M, an increase of 33% from the previous year.
- We improved our Medicare Stars Quality performance from 3 to 3.5 Stars for both of our Medicare contracts.
- We maintained our NCQA Rating of 3.5 Stars for our Commercial HMO line of business.
- We have reimagined and simplified the preauthorization process for your practice by eliminating requirements for nearly 20% of codes. This has reduced the administrative burden and accelerated access to care.

While we have made significant strides, there's still work that needs to be done to increase overall access to care, care coordination, and member satisfaction based on your patients' feedback. Whether a patient is visiting one of your offices or contacting our customer service team, we must continue working together to deliver the highest level of care and service. In 2025, we will be restarting our member satisfaction with a provider survey to gather additional actionable insight to share with you.

2025 Program

We are excited to extend to you, once again, the opportunity to participate in our Quality Incentive Program. Our commitment to this program and our ongoing efforts to strengthen the partnership with our network providers continue to be at the center of our provider network and population health strategy.

EmblemHealth continues to simplify, streamline, and increase the value and payout opportunities of our Quality Incentive Program. While ultimately benefiting our members, these incentives also offer an opportunity to increase revenue to your office and are designed to foster partnerships with providers to improve clinical quality and patient outcomes.

Annually, we review our program using standardized, industry-accepted measures and best practices based on the following guiding principles:

- **Recognize and reward providers** with a highly competitive payout structure for exceptional care and improved health outcomes of their patients.
- **Shared commitment to help your patients get well, stay healthy, and live better lives.**

We continue to support our providers by providing:

- Actionable data and reports such as member-level gaps in care reports, utilization data summary, medication adherence, and pharmacy reports.
- A robust member rewards program for you to encourage your patients to complete activities that can help you improve your performance on these QIP measures.
- **New for 2025:** an enhanced dedicated provider quality team to work with your office on quality improvement activities and partnerships.

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

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

Program Overview

Eligibility and Program Requirements

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

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: Providers at the group level (indicated as a Medical Center by EmblemHealth) must have at least 50 members in Medicare or Medicaid/Child Health Plus (CHPlus)/ Enhanced Care Plus (HARP)/Essential Plan to be eligible. Providers must meet this membership threshold to be eligible for each respective QIP. Panel sizes as of Dec. 31, 2025, 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 in order to participate in the program.

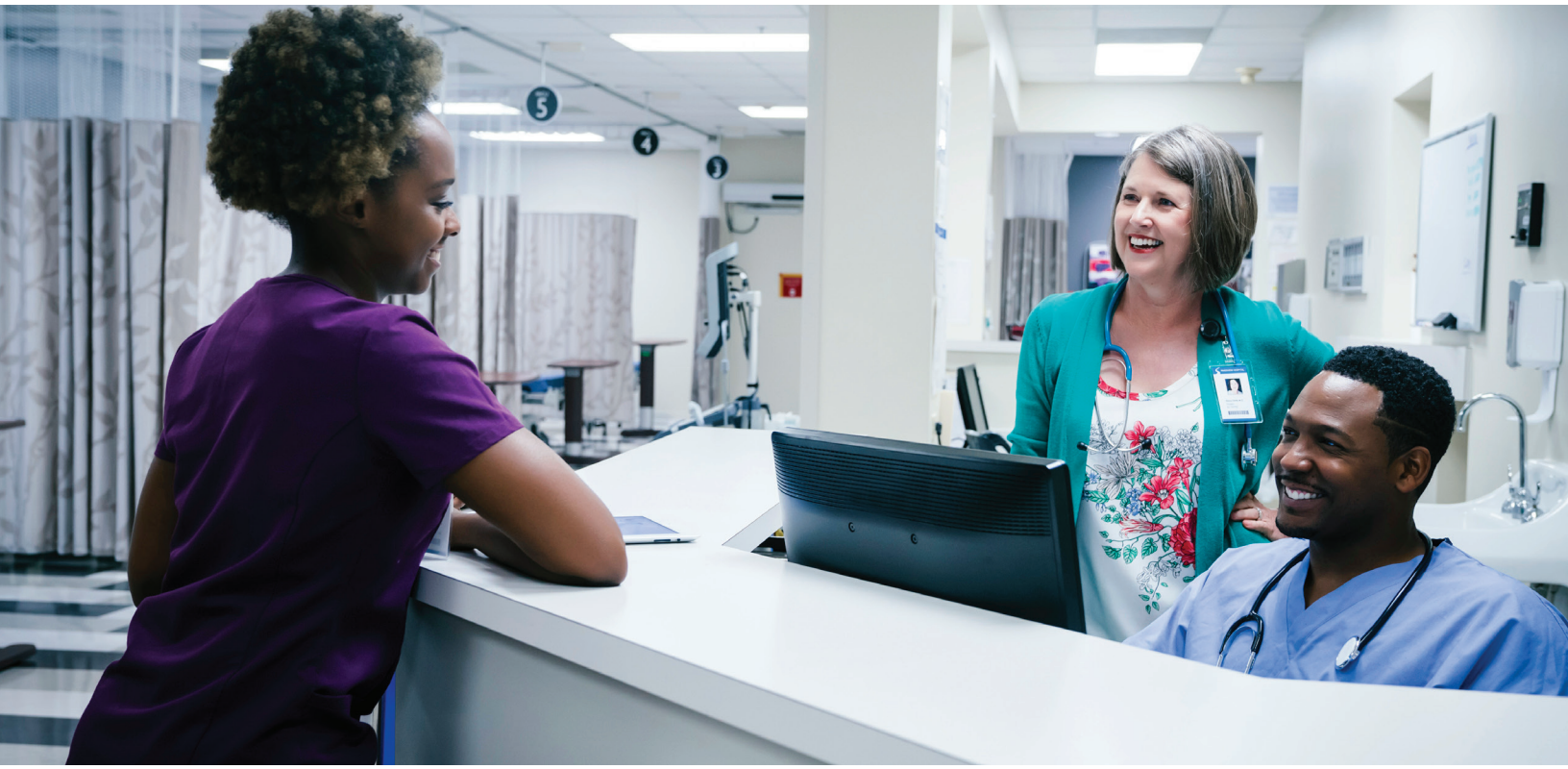
*Providers engaged in a delegated risk arrangement with EmblemHealth are ineligible for the QIP. Other value-based arrangements may restrict participation. EmblemHealth, in its sole discretion, will determine eligibility and payout considerations including timing and amount to be paid, if any.

Supplemental data files for 2025 dates of service will be accepted according to the table below:

Data Type	Standard Supplemental Data*	Non-Standard Data* (Medical Records)
Description	Aggregated patient data from a provider's electronic health records/electronic medical records (EHR/EMR) system in a required format. Supplemental data should be submitted monthly using the required format.	All other data which requires physical inspection such as patient charts and clinical summaries. May be submitted as proof of historical services, or services rendered by partnering or specialty providers only, to supplement compliance outside of claims and the standard supplemental file.
Submit To	**quality_data@emblemhealth.com** and copy your relationship manager	**hedisgroup@emblemhealth.com** and copy your relationship manager
Submission Deadline	**Standard – first file:** Dec. 26, 2025 **Standard – other files:** Feb. 27, 2026 (First file must be received by Dec. 26, 2025)	Dec. 26, 2025

**Records only accepted starting March 31, 2025, for measurement year 2025.*

See additional training material from your EmblemHealth relationship manager on supplemental data templates and accepted measures.



Measurement Period and Payment

Incentive payments will be made one time in the second quarter of 2026.

- 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, 2025**.
- Payments will be sent to the Independent Physician Association (IPA) or managing entity to disburse to individual providers.

Benchmark Targets

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

Benchmark methodology:

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

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

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 2025.

Population	Removed	Added
Medicare	• Plan All Cause Readmissions	• Controlling High Blood Pressure - <130/80
Medicaid/HARP/CHPlus/ Essential Plan	• Plan All Cause Readmissions • Transitions of Care	• Controlling High Blood Pressure - <130/80 • Eye Exam for Patients with Diabetes

Controlling High Blood Pressure <130/80 mm Hg: A new measure has been introduced based on new guidelines from the American Heart Association, the American College of Cardiology, and nine other health organizations, recommending a target blood pressure of **130/80 mm Hg** for all adults, including those with prehypertension and stage 1 hypertension. EmblemHealth believes that a **lower** blood pressure target ultimately results in fewer cardiovascular events and better health outcomes.

It's important to note that this custom measure is **not** a replacement for the existing and official NCQA's HEDIS measure (Controlling Blood Pressure) which continues to use <140/90 mm Hg as the standard for blood pressure control.

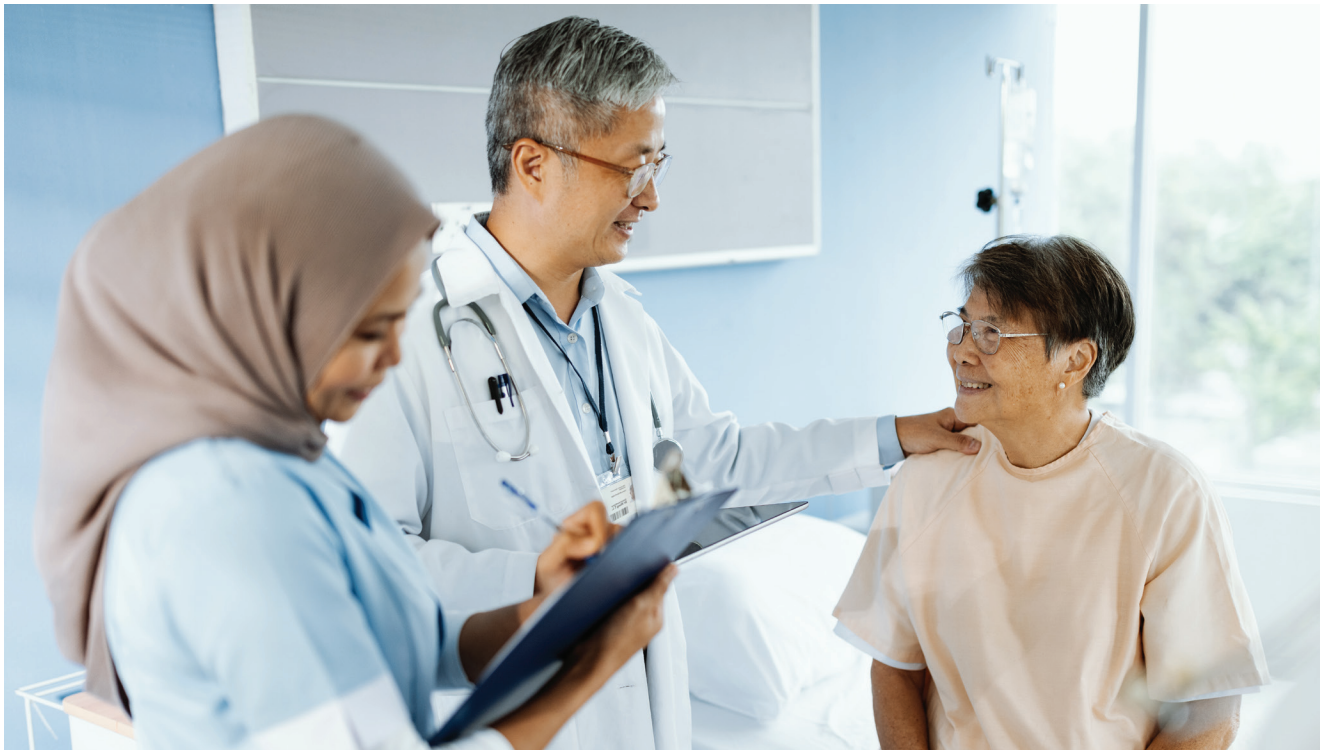
Additional Incentive Opportunities

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, 2025.

   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. ***NEW* CPT II code incentive**
   EmblemHealth will also offer a reimbursement for the utilization of CPT category II codes to address key quality measures. This incentive is available to primary care providers, with codes reimbursed through your regular claim payment process starting in March 2025. Reimbursement will include CPT II codes submitted from January 2025 onward.



Measure	CPT II Codes	Annual Frequency Allowed	Incentive
A1C	**3044F —** HbA1c less than 7.0 percent **3046F —** HbA1c greater than 9.0 percent **•3051F —** HbA1c greater than 7.0 percent and less than 8.0 percent **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) **2023F —** Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed: **without** evidence of retinopathy (DM) **2024F —** 7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed: **with** evidence of retinopathy (DM) **2025F —** 7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed: **without** evidence of retinopathy (DM) **2026F —** Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed: **with** evidence of retinopathy (DM) **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.** **Systolic Blood Pressure** **3074F —** blood pressure less than 130 mmHg **3075F —** blood pressure 130-139 mmHg **3077F —** blood pressure greater than or equal to 140 mmHg **Diastolic Blood Pressure** **3078F —** blood pressure less than 80 mmHg **3079F —** blood pressure 80-89 mmHg **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 **1160F —** Medication Review	1 time a year, per member	$10

2025 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	2025 QIP Tier 1 Benchmark	2025 QIP Tier 2 Benchmark	2025 QIP Tier 3 Benchmark	Tier 1 $	Tier 2 $	Tier 3 $
Annual wellness visit	69%	75%	79%	$50	$100	$175
Breast cancer screening	82%	83%	85%	$50	$100	$150
Colorectal cancer screening	65%	75%	83%	$50	$100	$150
Social determinant of health screening	8%	10%	15%	$50	$100	$150
Controlling high blood pressure - <130/80	74%	80%	85%	$25	$50	$100
Controlling high blood pressure - <140/90	74%	80%	85%	$50	$100	$175
Eye exam for patients with diabetes	70%	77%	83%	$50	$75	$100
Blood sugar control for patients with diabetes	72%	84%	90%	$50	$100	$175
Kidney health evaluation for patients with diabetes	43%	55%	60%	$50	$75	$100
Medication adherence — diabetes	87%	89%	92%	$50	$100	$200
Medication adherence — hypertension	87%	90%	92%	$50	$100	$200
Medication adherence — cholesterol	87%	89%	93%	$50	$100	$200
Statin therapy for patients with cardiovascular disease	85%	88%	92%	$50	$100	$125
Follow-up after emergency department visit for people with multiple high-risk chronic conditions	53%	60%	69%	$50	$100	$150
Health disparity — blood sugar control African Americans	72%	84%	90%	$50	$75	$100
Health disparity — controlling high blood pressure - African American	74%	80%	85%	$50	$75	$100

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

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

Measure	2025 QIP Tier 1 Benchmark	2025 QIP Tier 2 Benchmark	2025 QIP Tier 3 Benchmark	Tier 1 $	Tier 2 $	Tier 3 $
Annual wellness visit	55%	60%	65%	$50	$75	$125
Breast cancer screening	66%	68%	72%	$25	$75	$100
Colorectal cancer screening	50%	53%	54%	$25	$50	$100
Social need screening and intervention (sns-e)	8%	10%	15%	$50	$75	$100
Cervical cancer screening	68%	70%	72%	$25	$75	$100
Chlamydia screening (composite rate)	72%	77'%	81%	$25	$50	$100
Controlling high blood pressure - <130/80	69%	73%	75%	$25	$50	$75
Controlling high blood pressure - <140/90	69%	73%	75%	$50	$75	$100
Eye exam for patients with diabetes	60%	62%	69%	$25	$75	$100
Blood sugar control for patients with diabetes	71%	73%	74%	$25	$75	$100
Well-child visits in the first 30 months of life — composite	76%	80%	81%	$50	$100	$125
Childhood immunization status (combo3)	73%	78%	79%	$50	$75	$100
Child and adolescent well-care visits	71%	73%	76%	$50	$125	$175
Health disparity — blood sugar control African Americans	71%	73%	74%	$25	$50	$75
Health disparity child and adolescent well-care visits african americans	71%	73%	76%	$25	$50	$75
Health disparity — controlling high blood pressure - African American	69%	73%	75%	$25	$50	$75

***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 relationship manager 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, and Matrix Medical. These providers offer an additional choice for patients to receive care in their homes at no extra cost. Our home care partners can do well-visits, post-hospital care/coordination check-ins, and screenings like lab tests or eye exams. Additionally, your patients can get home screenings such as A1C and FOBT/FIT kits through our vendor LetsGetChecked. All results from completed home visits and screenings will be promptly communicated to you by fax or letter.

3. **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/toolkitw/referral-resources**.

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 relationship manager.

5. **Rewards program for your patients**
   The EmblemHealth Member Rewards Programs are designed to be sure 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

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

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

Reward	Member Type	Trigger for Reward	Value
Medicare and D-SNP Members			
Initial medicare annual well visit (90 days)	New	Complete an Initial Medicare Annual Well Visit within 90 days of enrolling in Medicare	$100
Initial health assessment (90 days)	New	Complete a Health Assessment (HA) within 90 days of enrollment	$50
Bone mineral density (BMD) test	New and existing	Complete a BMD test to check for osteoporosis in female members within six months after fracture	$100
Colorectal cancer screening	New and existing	Complete a fecal occult blood test (FOBT), flexible sigmoidoscopy, colonoscopy, fecal immunochemical test (FIT), DNA test, or colonography within the calendar year	$50
Diabetes A1C test	New and existing	Complete one A1C blood test within the calendar year	$50
Diabetes eye exam	New and existing	Complete a retinal or dilated eye exam by an eye care professional within the calendar year	$50
Diabetes kidney health evaluation	New and existing	Complete an estimated glomerular filtration rate (eGFR) test and a urine albumin-creative ratio within the calendar year	$50
Diabetes care completion bonus	New and existing	Complete all 3 diabetes care incentives: Diabetes A1C test, Diabetes eye exam, and Diabetes kidney health evaluation	$25
Mammogram exam	New and existing	Complete a mammogram within the calendar year	$100
EmblemHealth member portal registration	New and existing	Registration in the EmblemHealth Member portal in the calendar year	$25
Sign-up for paperless	New and existing	Complete sign-up for paperless	$50
DSNP Members			
Annual health assessment	Existing	Complete an HA within the calendar year by a D-SNP Member	$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**).

Medicaid/Health and Recovery Plan (HARP)/Child Health Plus (CHPlus)

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
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
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

Members may only be eligible for some of these activities. Age is determined by the member's age at the end of 2025.

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**).

Essential Plan

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

Reward	Trigger for Reward	Value
Social Determinants of Health (SDOH) Questionnaire	Complete a SDOH questionnaire within the calendar year	$25
Diabetes eye exam	Complete a retinal or dilated eye exam by an eye care professional within the calendar year	$25
Colorectal cancer screening	Complete a fecal occult blood test (FOBT), flexible sigmoidoscopy, colonoscopy, fecal immunochemical test (FIT), DNA test, or colonography within the calendar year	$25
Annual well visit	Complete an annual well visit with their PCP within the calendar year	$25

Members may only be eligible for some of these activities.

To participate, Essential Plan members must sign-up for the rewards program at **emblemhealthrewards.nationsbenefits.com**. They can also call Member Services at **888-447-7703** (TTY: **711).**

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

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

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

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

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

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

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

- <140/90 mm Hg.
- <130/80 mm Hg.
- <130/80 mm Hg has been add 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 (HBD): Appropriate hemoglobin A1C rate for patients 18 – 75 years old with diabetes (Type 1 or Type 2). A lower rate indicates better performance for this indicator (i.e., low rates of poor control indicate better care).

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

Well-child visits and adolescent well visits: Assessing physical, emotional, and social development of different stages of children: first 15 months, 15 – 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.

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

Delivering excellence to your patients

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