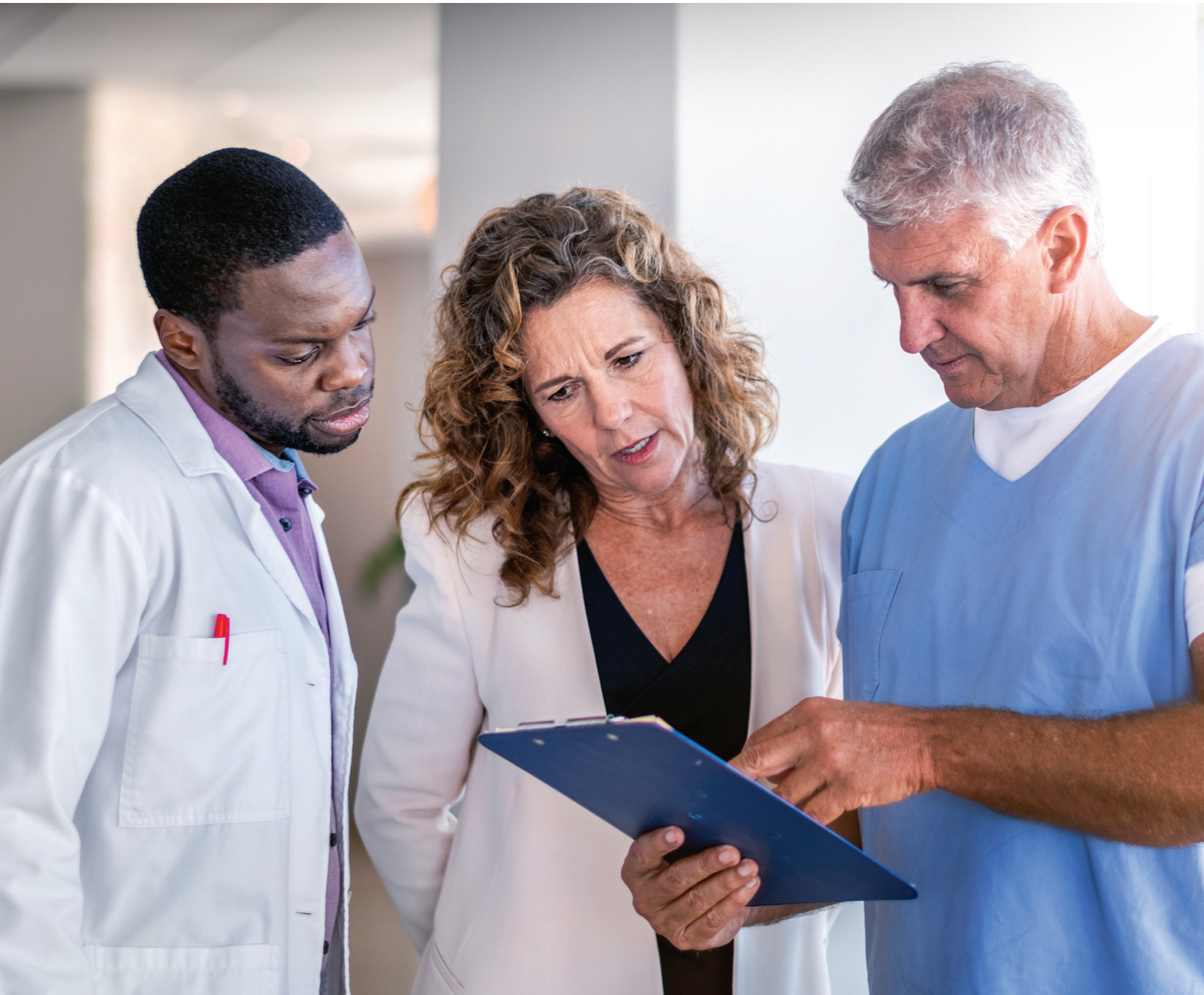
ConnectiCare®

2023 Quality Incentive Program



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Message From Our Chief Medical Officer (CMO)

Dear colleagues:

ConnectiCare is committed to helping our members stay healthy, get well, and live better lives. Our provider network plays an integral role in this effort, and we know you share the same commitment to delivering excellent care to your patients.

As part of the ConnectiCare provider network, you have an opportunity to earn incentive payments for the work you do. Our Quality Incentive Program (QIP) focuses on measures that impact and improve important health outcomes for members.

Our QIP strives to improve the following key outcomes for our shared members:

1. Engagement in Preventive Care.

   We value investment in preventive care. Many important measures, including annual well visits and cancer screenings, are included in our incentive program to ensure members get the important routine care they need to stay healthy.

2. Coordination of Care.

   Coordination of care ensures that responsibilities for care and service transitions are orderly and promote the highest quality of care possible. We have included measures to focus on transition of care post-discharge and screening for social determinants of health.

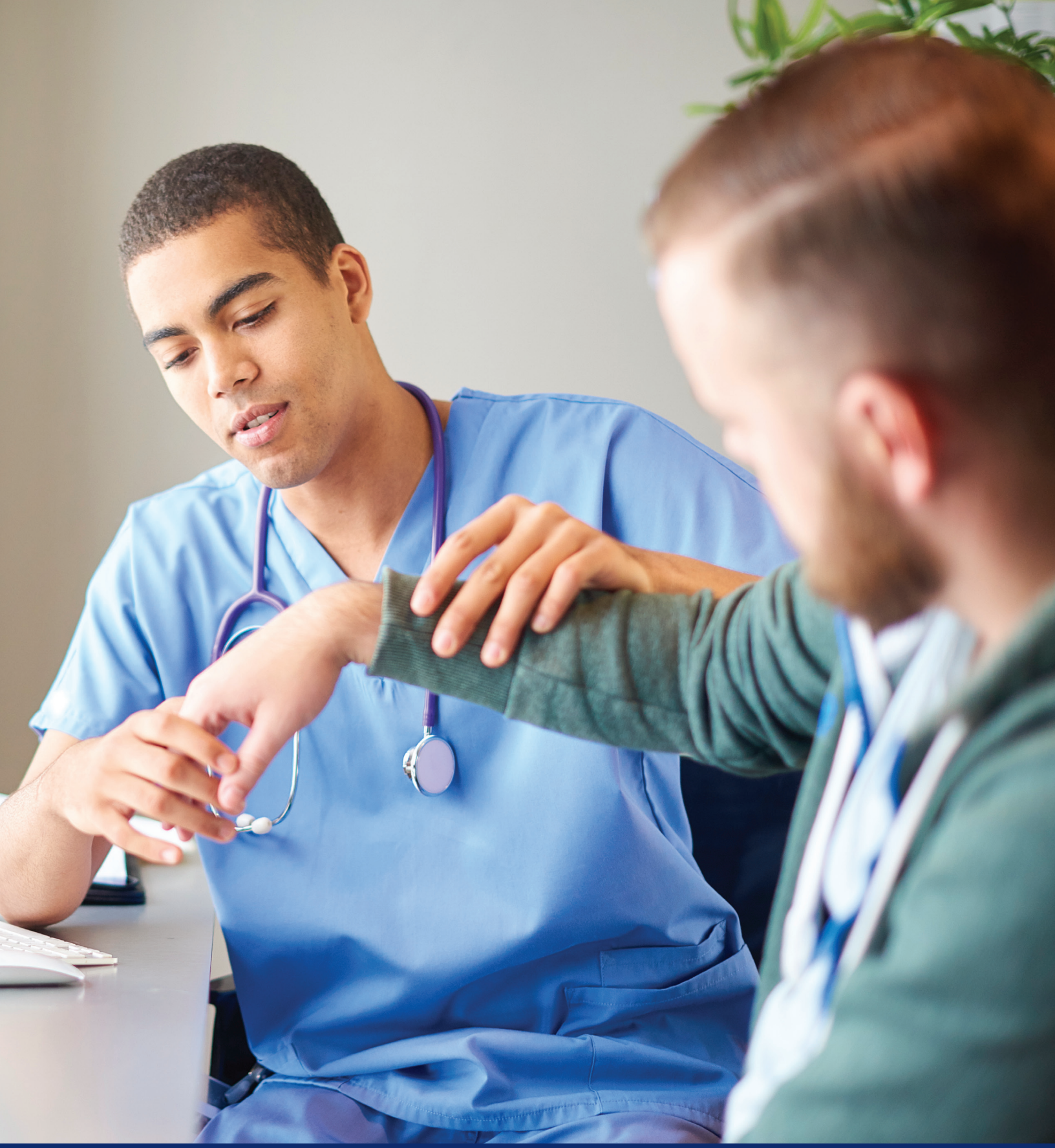
3. Chronic Disease Health Outcomes.

   It is also very important to our health plan that our members with chronic conditions, such as diabetes and heart disease, get the help and support they need to best manage their conditions. Therefore, we included measures in this program that aid members with high-risk health conditions in obtaining the assessments and treatments they need to stay well.

We thank you for your support and dedication in helping our members receive the preventive and chronic care needed to keep them healthy. We hope that this program supports you in your efforts.

Sincerely,

Richard Dal Col, MD, MPH
Enterprise Chief Medical Officer



Program Overview

Eligibility and Program Requirements

Primary care providers (PCPs) participate in the QIP at the group level. Providers participating in a delegated risk arrangement with ConnectiCare are not eligible for the QIP. Additionally, there may be other value-based arrangements that prohibit participation. Please speak to your ConnectiCare Relationship Manager if you have questions about your eligibility for the QIP and existing contracts with ConnectiCare. Eligibility and payout determinations shall be made by ConnectiCare in its sole discretion.

Further qualifications for the ConnectiCare QIP include the following:

1. **Open Panel.** To participate, you must accept new ConnectiCare membership across your participating line/s of business.
2. **Membership Eligibility Criteria.** Providers at the group level must have at least 50 members in Medicare to be eligible. Providers must meet this membership threshold to be eligible for each respective QIP. Panel sizes as of Dec. 31, 2023, will be used to determine program eligibility and payout; only panels that meet the membership threshold will be eligible for payout. Additionally, there is a minimum denominator size requirement in place for each measure (of 15 members).
3. **We know you do your best to submit respective claims for your patients,** but sometimes we don't have the required documentation needed to help close critical quality gaps. We encourage you to provide ConnectiCare access to your patients' medical records, supply supplemental data, and share nonstandard data to ensure we capture all needed information regarding your patients. You must provide ConnectiCare with access to medical records, 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.

   Supplemental data files for 2023 dates of service will be accepted according to the table below:

Data Type	Description	Submit to:	Submission Deadline:
Standard Supplemental data*:	Aggregated member data from a provider's EHR/EMR system in a required format. *Supplemental data should be submitted monthly, using the required format*	**quality_data@emblemhealth.com**	Feb. 28, 2024, if a prior submission was received by Dec. 29, 2023
Non-standard data* (medical records):	All other data which requires physical inspection e.g. member charts, 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.*	**HEDISGroup@emblemhealth.com** *and copy Relationship manager*	Dec. 29, 2023 *Records only accepted starting Apr. 1, 2023 for measurement year 2023.* **Resubmitted or corrected records will not be accepted for files sent after Dec. 22, 2023.*

*See additional training material from your ConnectiCare Account Manager on supplemental data templates and accepted measures.

Measures

Providers will be evaluated on quality measures that are consistent with those published by the Centers for Medicare & Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA). For a list of measures that are included in the ConnectiCare QIP, as well as the related payment tiers, please see the **chart included in this brochure**.

Measurement Period

Provider groups will be paid based on their panel membership as of Dec. 31, 2023. Payment is based on each eligible member receiving services, or claims received for services rendered. Incentive payments will be made in Quarter 2 2024. Payments will be sent to the IPA/managing entity to disburse and not to individual providers.

Benchmark Targets

ConnectiCare evaluates and updates our program, methodology, measurement sets, and benchmarks annually. In addition, we ensure that our various programs align with the quality-of-care standards defined by the National Committee for Quality Assurance (NCQA), Centers for Medicare & Medicaid Services (CMS), and ConnectiCare's quality improvement priorities.

In establishing benchmark rates, ConnectiCare employs a methodology that primarily follows official industry-standard criterion in combination with the historical performance of our plan and our network providers. For example, ConnectiCare may slightly reduce the QIP target benchmark if we are currently below the 50th percentile or 3 Medicare Star rating; similarly, if the plan is above the 75th benchmark or 4 Star rating, we may increase the benchmark to support continuous quality improvement, while keeping our targets as achievable as possible.

Additional Incentive Opportunities

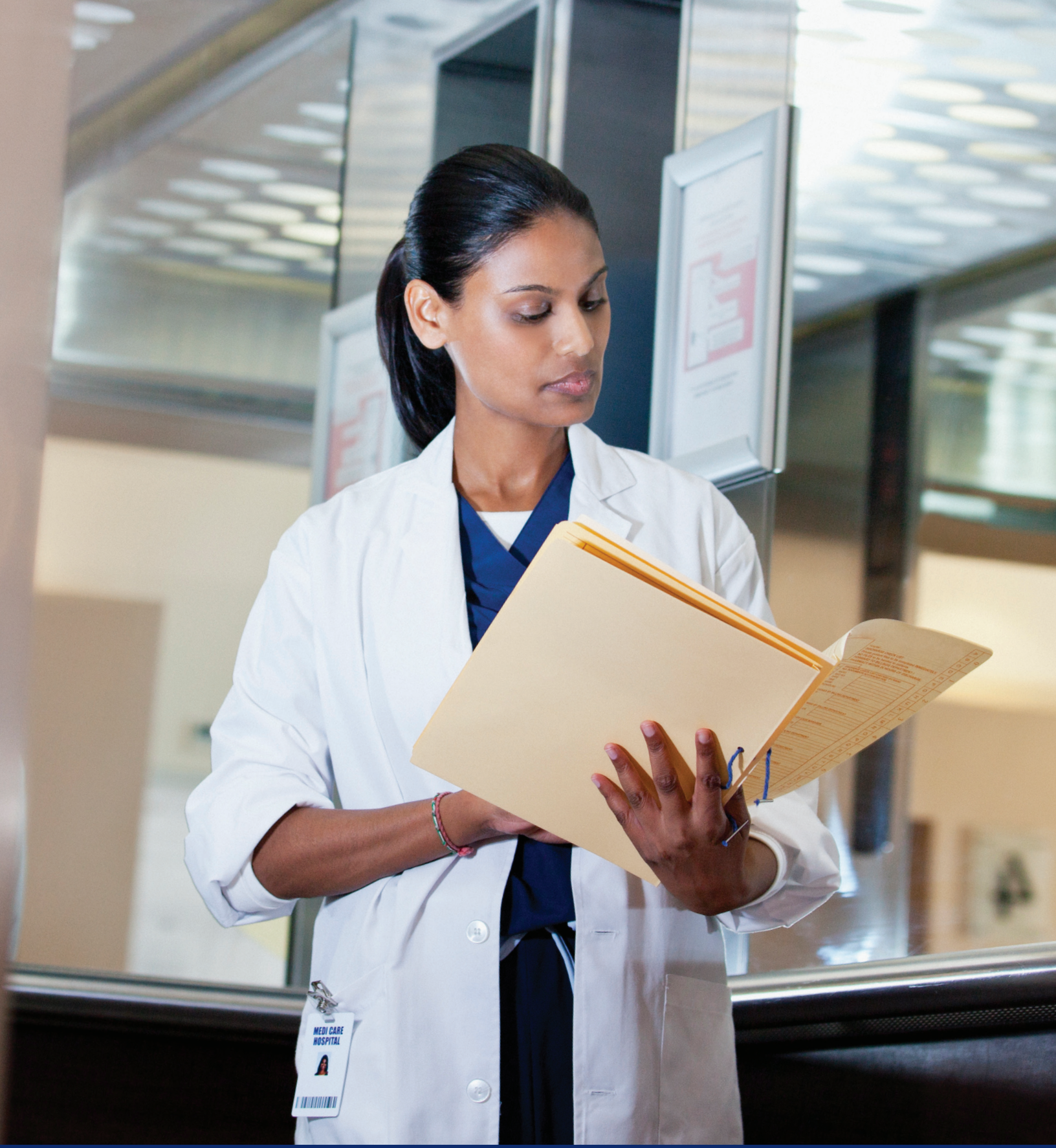
1. **Access to Electronic Medical Records (EMRs)**
   ConnectiCare will offer an additional incentive payment for provider groups that grant remote access to their electronic medical records (EMRs). Allowing this access can help increase your rates, as it will assist us to capturing services that are not typically billed for, or historically have trouble showing up through claims. Each EMR system access granted to ConnectiCare will result in a payment of $2,000. Please note this is a one-time incentive for new access only.

2. **Risk Adjustment Reimbursements**
   ConnectiCare is committed to assisting our providers in identifying and managing our members' chronic conditions. This is also an area where providers can earn additional reimbursements.

   Providers can conduct office visits with our members and utilize the Vatica Health™ (our vendor) portal to address emerging chronic and existing conditions that require treatment. Providers who utilize the Vatica portal can receive a reimbursement for each compliant visit. Contact Vatica at **network@vaticahealth.com** with questions or to implement the tool.

   Reimbursement for each completed Vatica visit $150 per Medicare or Commercial member:

   $150 per Medicare member, $40 per Medicaid member, $100 per commercial member.



2023 Measures and Targets

Medicare

MEASURES	INCENTIVE TARGETS[1]			INCENTIVE PAYMENT[2]		
	TIER 1	TIER 2	TIER 3	TIER 1	TIER 2	TIER 3
Prevention						
Annual Wellness/Preventive Visit	50%	55%	60%	$50	$75	$100
Breast Cancer Screening	62%	70%	77%	$50	$75	$100
Colorectal Cancer Screening	60%	66%	71%	$50	$75	$100
Social Determinants of Health	10%	15%	20%	$50	$75	$100
Chronic Disease Care						
Eye Exam for Patients With Diabetes	61%	66%	71%	$50	$75	$100
Blood Sugar Control for Patients With Diabetes	62%	69%	75%	$50	$75	$100
Controlling High Blood Pressure	63%	68%	73%	$50	$75	$100
Medication Adherence						
Medication Adherence for Diabetes	85%	88%	92%	$50	$75	$100
Medication Adherence for Hypertension	86%	89%	91%	$50	$75	$100
Medication Adherence for Cholesterol	85%	88%	92%	$50	$75	$100
Utilization						
All Cause Readmission	92%	94%	96%	$50	$75	$100
Transition of Care – Patient Engagement After Discharge	80%	85%	90%	$50	$75	$100
Transition of Care – Medication Reconciliation	57%	63%	69%	$50	$75	$100

[1] Targets are based on Medicare Cut Points published by CMS, historical performance data, and additional industry-standard benchmarks.

[2] 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. In-home screening partners/ vendors/partners

We know you take great care of our members but do understand that it's not always possible to get your patients into the office to be seen. We have partnered with several in-home vendors to provide an additional way for members to be seen in the comfort of their home and at no additional cost. We also provide your patients opportunities for home screenings (e.g. A1c and FOBT/FIT kits). All results of completed home visits and screenings will be communicated to you through fax or letters.

2. Rewards Program

The ConnectiCare Member Rewards Program is designed to ensure members get needed medical care such as their annual well-visit and selected preventative screenings. Members are rewarded for taking good care of their health. All you need to do is provide care as you always do, including referring your patient for necessary screenings such as mammograms.

- Members must sign-up for the Medicare Member Rewards Program at **connecticare.com** (https://www.connecticare.com/resources/medicare-member-resources-center/medicare-wellness-rewards) to participate in this program.
  - Call ConnectiCare Customer Service at the number on their member ID card.
  - Please submit claims to us as soon as possible, but no later than Dec. 31, 2023.

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

- Initial Medicare Annual Well Visit (90 days)
- Initial Health Assessment (90 days)
- Annual Visit with PCP
- Reward Portal Registration
- ConnectiCare Member Portal Registration
- Sign-Up for Paperless
- Diabetes A1c Test
- Diabetes Eye Exam
- Annual Health Assessment*
- Colorectal Cancer Screening
- Mammogram Exam
- Kidney Health Evaluation

* D-SNP members only.

For more information visit **connecticare.com** (connecticare.com/resources/medicare-member-resources-center/medicare-wellness-rewards).

3. Access to ConnectiCare Provider Portal.

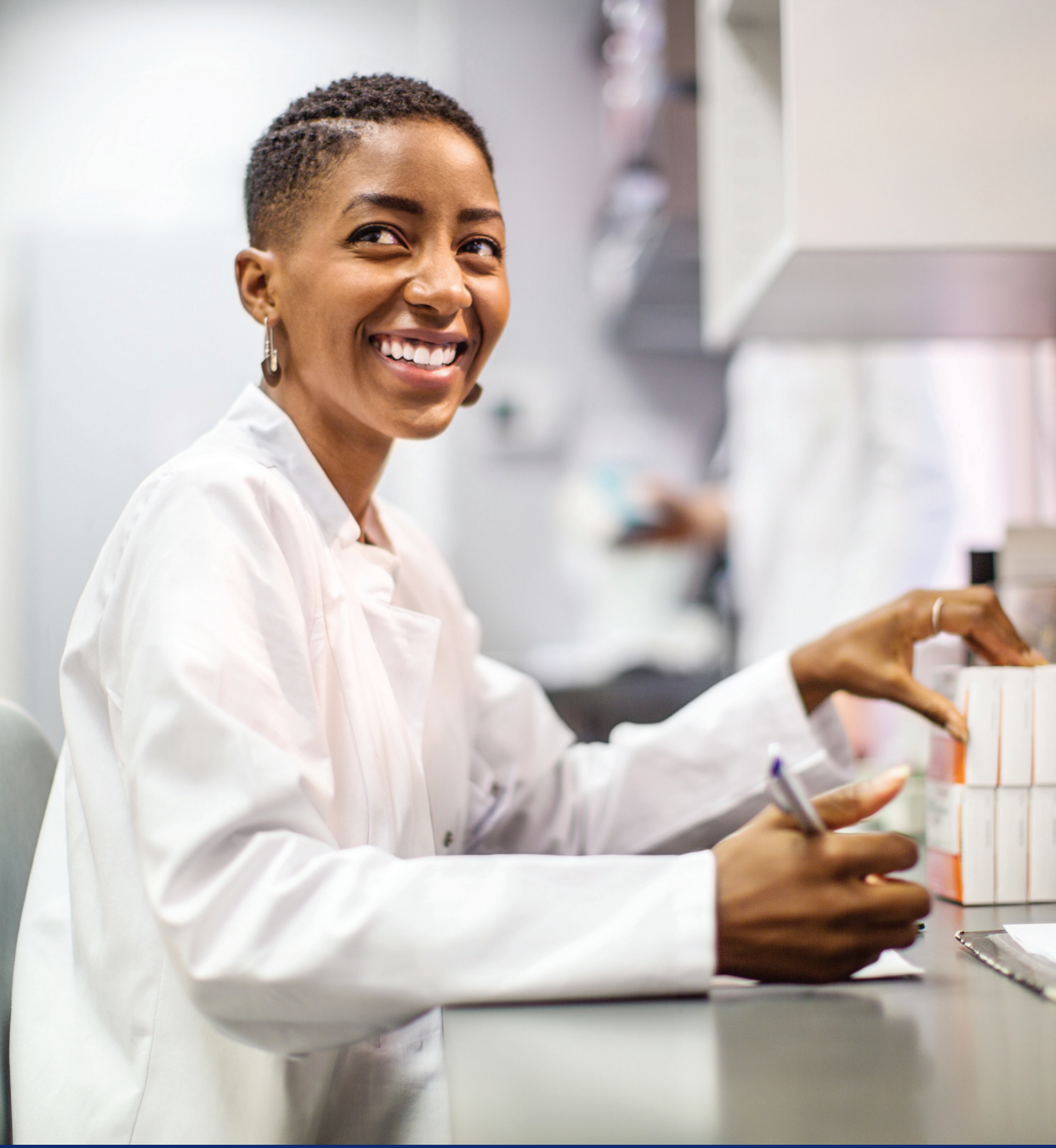
The portal will have information on the QIP, gaps in care, and your best opportunities for incentive payments. If you do not have an account, you may sign up at **provider.connecticare.com** (https://provider.connecticare.com/cciprovider/providerlogin?ec=302&startURL=%2Fcciprovider%2Fs%2F)

4. Care Management

ConnectiCare offers a dedicated Care Management team staffed by nurses and social workers to support your patients' healthcare needs between doctor visits. This program is offered to your patient at no additional cost. We will work directly with you to develop a care plan for your patient.

Providers can learn more about the ConnectiCare Care Management program at: **connecticare.com/providers** (https://www.connecticare.com/providers/resources/news/refer-patients-to-our-care-management-team)

Please call us Monday, Thursday, and Friday 8 a.m. to 4 p.m. or Tuesday and Wednesday 8 a.m. to 7:30 p.m. at **800-390-3522** (TTY: **711**), or email **hmpreferrals@connecticare.com**.



Measure Specification and Tips

All Cause Readmission (PCR)

For patients 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were not followed by an unplanned acute readmission for any diagnosis within 30 days.

Numerator/Denominator

Numerator: Patients in the denominator with an acute inpatient or observation stay who did not have an unplanned acute inpatient or observation readmission for any diagnosis within 30 days after discharge.

Denominator: Patients 18 years of age and older with an acute inpatient or observation stay with a discharge on or between Jan. 1 and Dec. 1 of the measurement year.

Exclusion Criteria:

- Died during the stay.
- Received hospice care at any time during the measurement period.
- Have a primary diagnosis of pregnancy.
- Had a primary diagnosis of a condition that originated in the perinatal period.

Additional Measure Information

Post-discharge planning and care coordination are essential in preventing unplanned readmissions. This measure is based on discharge events.

Telehealth

Medication reconciliation may be done over the phone.

HELPFUL TIPS

- **Identify high utilizers and populations at risk.**
- **Partner with facility to improve care coordination upon discharge.**
- **Keep open appointments so patients can be seen promptly upon discharge.**
- **Work with patients and caregivers to ensure they understand discharge care plan, including their new medication regimen.**
- **Obtain hospital discharge summary and use to schedule post-discharge appointments.**
- **Contact patients within three days of discharge.**
- **Document medication reconciliation (discharge medications reconciled with current medication list) in the member's medical record.**
- **Refer 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 800-829-0696 (TTY: 711) from 8 a.m. to 4 p.m., Monday through Friday.**

Annual Wellness/Preventive Visit (AWV)

The percentage of patients ages 18 and older who had an annual physical exam in the measurement year.

Numerator/Denominator

Numerator: Patients in the denominator who had an annual wellness exam in the measurement year.

Denominator: Patients ages 18 and older.

Additional Measure Information

Visit includes:

- Physical assessment
- Physical exam
- Laboratory tests
- Immunizations
- Preventive screening
- Referrals
- Counseling

Codes/Medications for Compliance

Applicable Codes
Well visit: HCPCS code: • G0438 (Initial Medicare Preventative Visit) • G0439 (Subsequent Annual Wellness Visit) • G0468 • G0402

Applicable Codes
Annual Physical Exam: CPT codes: • 99381-99387 • 99391-99397 • 99402-99404

Documentation Requirements

For Medicare, when billing an annual wellness visit and annual physical exam on the same day, use a modifier code of 25 for the annual physical exam.

Telehealth

Telehealth can be used for compliance.

HELPFUL TIPS

- Send reminders prior to the scheduled appointment date.
- Consider expanding early morning, evening, and weekend hours.
- Provide patient education regarding the importance of preventive health visits and completing the annual wellness visit.
- Utilize visit to address behavioral health needs and social determinants of health.
- Visits can be done annually based on calendar year in conjunction with an annual physical exam.
- Telehealth resources may be utilized to reach patients unable to schedule an in- office appointment. See the ConnectiCare Quality Measures and Risk Adjustment Telehealth Tip Sheet for more information: **connecticare.com/providers/resources/clinical-information/quality-improvement** (scroll to bottom of page, under Telehealth).
- Review office workflow to ensure time efficiencies.
- Offer block scheduling and/or annual wellness visit-specific appointment days.
- Provide patient education and resources regarding management of health conditions.

Blood Sugar Control for Patients With Diabetes (HBD)

The percentage of patients 18-75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year: HbA1c control (<=9.0%).

ConnectiCare is focused on driving the improvement of health disparities for this measure for the African American population and therefore has included a separate measure specific to this race.

Numerator/Denominator

Numerator: HbA1c control: Patients in the denominator who have an HbA1c level <=9.0% in the measurement year (most recent HbA1c level is used).

Denominator: Members between ages 18-75 who have diabetes, as evidenced by one acute inpatient encounter or two outpatient encounters or were dispensed insulin or hypoglycemics/ antihyperglycemics in the measurement year or year prior.

Exclusion Criteria:

- Patients receiving hospice or palliative care at any time during the measurement year.
- Members ages 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.

Codes/Medications for Compliance

Applicable Codes
HbA1c Lab Test: CPT: 83036, 83037
HbA1c Test Results: CPT II:
• 3044F Most recent HbA1c level less than 7.0%
• 3051F Most recent HbA1c level greater than or equal to 7.0% and less than 8.0%
• 3052F Most recent HbA1c level greater than or equal to 8.0% and less than or equal to 9.0%

Documentation Requirements

Documentation must include screening results and date of service when the HbA1c test was performed. The most recent result is the ONLY result that is used to determine compliance. If the HbA1c result is >9.0 or missing the member will not be compliant for this measure.

Telehealth

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

HELPFUL TIPS

- **Identify early in the year who may need A1c testing. Frequency of visits should depend on level of A1c control. Members with elevated A1c levels need to be seen more frequently.**
- **Emphasize importance of medication and insulin adherence in managing blood glucose.**
- **Adjust therapies to improve levels and recommend follow-up visits to monitor results.**
- **Create a diabetes checklist in your EMR/patient chart to monitor if patients are up to date with recommended screenings.**
- **The date of the latest A1c of the added "measurement" should be submitted (CPT and CPT II codes).**

Breast Cancer Screening (BCS)

The percentage of women ages 50-74 years who have had a mammogram to screen for breast cancer.

Numerator/Denominator

Numerator: Patients in the denominator who have had one or more mammograms between Oct. 1 two years prior to the measurement year and Dec. 31 of the measurement year.

Denominator: Women ages 50-74.

Exclusion Criteria:

- Patients with bilateral mastectomy.
- Patients receiving hospice or palliative care at any time during the measurement year.
- Do not count MRIs, ultrasounds, or biopsies toward the numerator. Although these procedures may be indicated for evaluating women at higher risk for breast cancer or for diagnostic purposes, they are performed as an adjunct to mammography and do not alone count toward the numerator.

Codes/Medications for Compliance

Codes
CPT: 77061-77063, 77065-77067
Exclusion Codes
Z90.13, All palliative care codes

Documentation Requirements

Date of screening and results in medical record. If patient is not sure on exact date, document closest possible timeframe (i.e., month/year).

Telehealth

CPT 98966, 98967, 98968, 99441, 99442, 99443: Telehealth not sufficient to complete screening; only to review and document history of screenings.

HELPFUL TIPS

- **Highlight the importance of early detection.**
- **Discuss common fears about testing. Inform them that currently available testing methods are less uncomfortable and require less radiation.**
- **Place a reminder in the patient's chart for when the next screening is due.**
- **Create "Standing Order" for ease of access.**
- **Share list of mammogram facilities with the patient.**

Colorectal Cancer Screening (COL)

The percentage of members ages 45-75 who have had an appropriate screening for colorectal cancer in required time frame (depends on screening type).

Numerator/Denominator

Numerator: Members in the denominator with colorectal cancer screening in required time frame (varies by type of screening).

Appropriate screenings for colorectal cancer:

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

Denominator: Members between ages 45-75.

Exclusion Criteria:

- Patients with evidence of colorectal cancer or total colectomy.
- Patients receiving palliative or hospice care are not included in the measure.

Codes/Medications for Compliance

Applicable Codes
Colonoscopy: **CPT:** 44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398 **HCPCS:** G0105, G0121 **ICD9:** 45.22, 45.23, 45.25, 45.42, 45.43

Applicable Codes
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

Documentation Requirements

- Report that indicates type of screening (test name), the date the screening was performed, and result.
- Member-reported colorectal cancer screenings are acceptable if the screening is documented in the patient's medical history.

Telehealth

Telehealth not sufficient to complete screening. Collect and document history of screenings.

HELPFUL TIPS

- **Ensure that the patient's history is updated annually regarding prior colorectal cancer screening test(s).**
- **Discuss all options for screening, including FOBT and Stool DNA, for patients who may not want colonoscopy.**
- **Provide order for testing.**
- **Highlight the importance of early detection.**
- **Review/confirm all preventive health screenings at each visit.**
- **Place a reminder in the patient's chart for when the next screening is due.**

Controlling High Blood Pressure (CBP)

The percentage of patients ages 18-85 diagnosed with hypertension whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.

Numerator/Denominator

Numerator: Patients in the denominator with a blood pressure reading of <140/90 Hg during the measurement year.

Denominator: Patients ages 18-85 diagnosed with hypertension at two or more visits between Jan. 1 of the year prior to the measurement year and June 30 of the measurement year.

Exclusion Criteria:

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

Codes/Medications for Compliance

Applicable Codes
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
3077F - blood pressure greater than or equal to 140 mmHg

Additional Measure Information

Blood pressure readings that are Member-reported and/or taken with remote digital monitoring device are reportable.

Documentation Requirements

Utilize the most recent blood pressure (BP) reading during the measurement year, which must be taken on or after second diagnosis of hypertension

Telehealth

Telehealth can be used for compliance.

HELPFUL TIPS

- If blood pressure reading is high when the patient arrives, re-check at the end of the visit.
- If patient is hypertensive during visit, review medication history and consider modifying treatment plan.
- Schedule a follow-up visit once treatment plan has been initiated.
- Record exact systolic and diastolic values; do not round a result.
- Review diet, medications, exercise regimen, and treatment adherence with the patient at each visit
- Conduct outreach to patients with hypertension who have not had a follow-up appointment.
- Partner with patients to help identify any barriers to effective management.
- Connect patients with care coordinators or other practice staff for available resources.
- Encourage patients to use the mail order pharmacy service to save on the cost of medications.
- Prescribe a digital device for these members and discuss how self-monitoring at home may help them lower their blood pressure.
- Members can report their blood pressure verbally during a telehealth (telephone, e-visit, virtual) or office visit and that will help close the gap.

Eye Exam for Patient With Diabetes (EED)

The percentage of members ages 18-75 with diabetes (type 1 or 2) who had a retinal eye exam.

Numerator/Denominator

Numerator: Members in the denominator who had a retinal or dilated eye exam during the measurement year or a negative retinal eye or dilated eye exam (negative for retinopathy) in the measurement year or year prior.

Denominator: Members between ages 18-75 who have diabetes, as evidenced by one or two acute inpatient encounters or were dispensed insulin or hypoglycemics/antihyperglycemics in the measurement year or year prior.

Exclusion Criteria:

- Members who do not have a diagnosis of diabetes.
- Members in hospice or using hospice services any time during the measurement year.
- Members receiving palliative care.

Codes/Medications for Compliance

Applicable Codes
Diabetic Retinal Screening:
CPT: 67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92201, 92202, 92225-92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99214, 99215, 99242-99245.
HCPCS: S0620, S0621, S3000
NOTE: These codes must be billed with an eye doctor specialty.

Applicable Codes
Eye Exam with Retinopathy:
CPT II: 2022F, 2024F, 2026F, 92229
Eye Exam without Retinopathy:
CPT II: 2023F, 2025F, 2033F
Diabetic Retinal Screening Negative:
CPT II: 3072F
NOTE: These codes may be billed by any provider type.

Documentation Requirements

- Documentation must include screening results and date of service.
- Eye exams can be performed by an optometrist or ophthalmologist.
- A bilateral eye enucleation counts for numerator compliance.
- Eye exams read by artificial intelligence system count for compliance.

Telehealth

- Members can get into denominator with telehealth visits. Telehealth not sufficient to complete screening. Collect and document history of diabetes care

HELPFUL TIPS

- **Explain the risk of impaired vision caused by diabetes and the importance of retinal eye exams.**
- **Ensure results are read by optometrist or ophthalmologist.**
- **Create a diabetes checklist in your EMR/ patient chart to monitor if patients are up to date with recommended screenings.**

Medication Adherence for Cholesterol

The percentage of Medicare members with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.

Numerator/Denominator

Numerator: Members in the denominator who fill their cholesterol medication at least 80% or more of the time they are supposed to be taking the medication in the year.

Denominator: Medicare members with at least two statin cholesterol prescriptions filled (on unique dates of service) during the year.

Exclusion Criteria:

Members receiving palliative care and members with end stage renal disease (ESRD) are excluded from measure.

Codes/Medications for Compliance

Applicable Codes
ConnectiCare and Affiliates use medication National Drug Codes (NDCs) from pharmacy data to calculate the rates. **Only statin medications qualify.**

Medications
• Fluvastatin • Pitavastatin • Rosuvastatin • Pravastatin • Atorvastatin (+/- Amplodipine) • Simvastatin (+/- Ezetimibe, Niacin) • Lovastatin (+/- Niacin)

Documentation Requirements

Data from this measure comes from prescription drug event (PDE) data submitted by drug plans to Medicare. Only final action PDE claims are used to calculate this measure.

Telehealth

Telehealth is not sufficient to close quality care gap for this measure.

HELPFUL TIPS

- **Stress the importance of remaining on statin medication to lower blood cholesterol and reduce the risk of cardiovascular disease.**
- **Consider prescribing a 90-day supply when appropriate and educate patient on pharmacy auto-refill program.**
- **Schedule follow-up visits to check progress.**
- **Discuss medication adherence barriers and ask open-ended questions about concerns related to health benefits, side effects, and cost.**

Medication Adherence for Diabetes

The percentage of Medicare members with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.

Numerator/Denominator

Numerator: Members in the denominator who fill their diabetes medication at least 80% or more of the time they are supposed to be taking the medication in the year.

Denominator: Medicare members with at least two filled prescriptions for diabetes medications (on unique dates of service) during the year.

Exclusion Criteria:

- Members receiving palliative/hospice care services.
- Members with an ESRD diagnosis or dialysis coverage dates.
- Members with one or more prescriptions for insulin.

Codes/Medications for Compliance

Applicable Codes
ConnectiCare and Affiliates use medication National Drug Codes (NDCs) from pharmacy data to calculate the rates.
Medications
• ACEI/ARB/direct renin inhibitor • ACEI/ARB/direct renin inhibitor combination

Documentation 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.

Telehealth

No benefits or inclusions around telehealth.

HELPFUL TIPS

- **Stress the importance of remaining on diabetes medication to control blood glucose and reduce the risk of diabetes- related illnesses.**
- **Consider prescribing a 90-day supply when appropriate and educate patient on pharmacy auto-refill program.**
- **Schedule follow-up visits to check progress.**
- **Discuss medication adherence barriers and ask open-ended questions about concerns related to health benefits, side effects, and cost.**

Medication Adherence for Hypertension

The percentage of Medicare members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.

Numerator/Denominator

Numerator: Members in the denominator who fill their hypertension medication at least 80% or more of the time they are supposed to be taking the medication in the year.

Denominator: Medicare members with a prescription for a blood pressure medication.

Exclusion Criteria:

- Members receiving palliative/hospice care services.
- Members with an ESRD diagnosis or dialysis coverage dates.
- Members with one or more prescriptions for sacubitril/valsartan.

Codes/Medications for Compliance

Applicable Codes
• ConnectiCare and Affiliates use medication National Drug Codes (NDCs) from pharmacy data to calculate the rates. **Only renin-angiotensin-system (RAS) antagonists qualify.**

Medications
• ACEI/ARB/direct renin inhibitor • ACEI/ARB/direct renin inhibitor combination

Documentation 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.

Telehealth

No benefits or inclusions around telehealth.

HELPFUL TIPS

- **Stress the importance of remaining on RAS antagonists to treat hypertension and proteinuria and reduce the risk of renal and heart disease.**
- **Consider prescribing a 90-day supply when appropriate and educate patient on pharmacy auto-refill program.**
- **Schedule follow-up visits to check progress.**
- **Discuss medication adherence barriers and ask open-ended questions about concerns related to health benefits, side effects, and cost.**

Transitions of Care — Patient Engagement Post Inpatient Discharge (TRC)

The percentage of discharges for patients 18 years of age and older who had patient engagement within 30 days after discharge.

Numerator/Denominator

Numerator: Patient engagement after inpatient discharge within 30 days after discharge (office visit, telehealth, home visit).

Denominator: Members ages 18 and older who had an acute or nonacute inpatient discharge on or between Jan. 1 and Dec. 1 of the measurement year.

Exclusion Criteria:
Members in hospice or using hospice services.

Codes/Medications for Compliance

Applicable Codes
Outpatient Visit:
CPT Codes: 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99429, 99455, 99456, 99483
HCPCS: G0402, G0438, G0439, G0463, T1015

Applicable Codes
Telephone Visit
CPT: 98966-98968, 99441-99443
Transitional Care Management Services: **CPT:** 99495, 99496
Virtual Visit/Online Assessment: **CPT:** 98969-98972, 99421-99423, 99457, 99458
HCPCS: G0071, G2010, G2012, G2061-G2063, G2250-G2252

Additional Measure Information

Care coordination is important when transitioning from the hospital setting back to home to ensure clear understanding of follow-up needs.

Documentation Requirements

- Documentation of patient engagement (e.g., office visit, visit to the home or telehealth visit) provided within 30 days after discharge.
- **Note:** Do not include patient engagement that occurs on the same date of discharge.

Telehealth

Telehealth visit, telephone visit, e-visit, or virtual check-in count for compliance in patient engagement after inpatient discharge.

HELPFUL TIPS

- **Ensure patient's discharge information is comprehensive and complete.**
- **Ensure patient has a follow-up visit within 30 days of discharge.**
- **Review discharge summary, including new medication regimen, with patients and caregivers to ensure they understand diagnosis and care plan.**
- **Contact patient within three days of discharge.**
- **Ensure patient has all medications and can take as prescribed.**
- **Partner with facility to improve care coordination upon discharge.**

Transitions of Care — Medication Reconciliation Post Discharge (TRC)

The percentage of inpatient discharges for members ages 18 and older who had a medication reconciliation within 30 days of inpatient discharge.

Numerator/Denominator

Numerator: Patients discharge medications were reconciled with the most recent medication list in the outpatient record on the date of discharge through 30 days after discharge.

Denominator: Members ages 18 and older who had an acute or nonacute inpatient discharge on or between Jan. 1 and Dec. 1 of the measurement year.

Codes/Medications for Compliance

Applicable Codes
Transitional Care Management: **CPT:** 99495, 99496
Cognitive Assessment and Care Plan Services: **CPT:** 99483 **CPTII:** 1111F – Discharge medications were reconciled with current medication list in outpatient medical record.

Additional Measure Information

- Care coordination is important when transitioning from the hospital setting back to home to ensure clear understanding of medication changes, diagnostic testing, and follow-up needs.
- Transitional care management visits using CPT codes 99495, 99496, and 99483 count as numerator compliance for patient engagement after discharge and medication reconciliation.
- Medication reconciliation can be conducted by a prescribing practitioner, clinical pharmacist, physician assistant, or registered nurse.

Documentation Requirements

Documentation in the outpatient medical record must include evidence of medication reconciliation and the date it was performed. Member does not need to be present.

Telehealth

Telehealth may be used for this measure.

HELPFUL TIPS

- **Ensure patient's discharge information is comprehensive and complete and used to schedule post-discharge appointments.**
- **Ensure patient has a follow-up visit within 30 days of discharge.**
- **Review discharge summary, including new medication regimen, with patients and caregivers to ensure they understand diagnosis and care plan. Ensure patient has all medications and can take as prescribed.**
- **Contact patient within three days of discharge.**
- **Partner with facility to improve care coordination upon discharge.**

Social Need Screening and Intervention (SNS-E)

The percentage of patients who were screened using prespecified tools, at least once during the measurement period for unmet food, housing, and transportation needs, and received a corresponding intervention if they screened positive.

Numerator/Denominator

Numerator: Members who were screened in the measurement year.

Denominator: Medicare members.

Documentation Requirements

Social determinants of health (SDOH) data must be documented using the prespecified screening tool and submitted claims.

Telehealth

No current benefits or inclusions around telehealth.

Codes for Compliance

Applicable Codes
See separate SDOH material.

Quality Measure — 2023 New HEDIS SDOH Measure

There are 6 separate metrics that are part of the new HEDIS SDOH Measure looking at screening and intervention.

Food Screening	Housing Screening	Transportation Screening	Food Intervention	Housing Intervention	Transportation Intervention
The percentage of members who were screened for food insecurity.	The percentage of members who were screened for housing instability, homelessness, or housing inadequacy.	The percentage of members who were screened for transportation insecurity.	The percentage of members who received a corresponding intervention within one month of screening positive for food insecurity.	The percentage of members who received a corresponding intervention within one month of screening positive for housing instability, homelessness, or housing inadequacy.	The percentage of members who received a corresponding intervention within one month of screening positive for transportation insecurity.

HELPFUL TIPS

- **Link members to behavioral health and/or other social service providers.**
- **Discuss/understand intersection between SDOH and preventive and chronic disease care.**
- **Keep track of and monitor social needs expressed by members that impact treatment adherence and health outcomes.**
- **At ConnectiCare Centers, you can get in-person help understanding and using your plan from one of our friendly associates. We also offer health and wellness events. Call 877-523-6837 (TTY: 711) for appointments or assistance. For more information, go to connecticare.com/about/care-centers.**

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

What is CAHPS?

Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a survey designed to capture member experiences with their doctors and health plan. It is conducted by a certified and approved vendor on behalf of the Centers for Medicare & Medicaid Services (CMS), the New York State Department of Health (NYSDOH), and the National Committee for Quality Assurance (NCQA). The survey is sent to a random sample of Medicare, commercial, and exchange members in the spring, and Medicaid members in the fall.

Why is CAHPS Important?

The CAHPS survey helps us gain a better understanding of our members' experiences when using their health care benefits so we can drive continuous improvement. CAHPS helps inform whether members are satisfied with the care they receive from our provider partners. The data collected from CAHPS helps us track and trend results year to-year, giving us the opportunity to proactively plan and target key areas for improvement. CAHPS also provides a standardized comparison between health plans so that consumers may make informed decisions when selecting providers and health plans. We look forward to collaborating with all our network providers to improve patient experience.

5 Ways to Improve Member Satisfaction Scores

You know your patients best and what works for your office. We compiled some evidence-based tips to help you increase your patients' (our members), satisfaction.

1. Two-way communication: Make sure your patients feel heard. Some ways to do that are to: engage in shared decision making, ask for feedback, practice cultural sensitivity, communicate in plain language, ask about social needs, discuss care and treatment received by other doctors, and use a multi-channel approach to communicate (e.g., text, email, interactive voice response (IVR), phone, in person).
2. Equip patients with tools: Confirm your understanding of a patient's needs and link them to appropriate resources. You can do this by providing materials about health conditions (handouts, posters, information sheets), letting patients view their health records, implementing reminder systems, and empowering patients with other tools, including those from our health plan.
3. Assess the need for increased appointment availability: Some ways to enhance availability include offering same-day appointments, accommodating patients on evenings and weekends, offering a nurse line for after hours, using virtual visits (if appropriate), partnering with other providers for specialty referrals, and offering online scheduling.
4. Consider timeliness: A few ideas to consider around timeliness are to limit telephone hold times, keep patients informed if you are running behind schedule, limit wait time to under 15 minutes, and try to schedule well visits/routine physicals within four weeks and non-urgent sick visits within 48 to 72 hours of request.
5. Create a welcoming environment: Set the tone for a good visit by ensuring cleanliness around the office and waiting areas, communicating service standards to staff, and providing empathy and a personalized experience. You may also consider offering magazines, television, water, or other items in the waiting area to create a pleasant experience.

See our complete CAHPS guide on the ConnectiCare website: **connecticare.com/providers/resources/clinical-information/quality-improvement**.

NOTES

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For more information about the ConnectiCare Quality Incentive Program, please contact your provider account manager or visit the provider portal.

Delivering Excellence to Your Patients.

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