Priority Health

2024 MANUAL

Disease Burden Management Program

Improving patient care with complete, accurate chronic condition recapture and management.

For Priority Health Medicare Advantage (MAPD), including D-SNP and Commercial ACA members

Have questions?
Contact your ACN's Provider Strategy & Solutions Consultant.

Inside this manual

Overview

We're working together to improve patient care through complete, accurate chronic condition recapture and management.

Our Disease Burden Management (DBM) program has two ways for you to track your patients' conditions and earn incentives.

Incentive #1: Chronic condition (HCC) recapture

To earn this incentive, an ACN must demonstrate an increased recapture rate for chronic hierarchical condition categories (HCC) codes for their eligible Priority Health patients during the performance year. The per member per month (PMPM) payout tiers range from $0 to $6 depending on the recapture rate increase over the previous year.

ACNs meeting the program requirements will receive a one-time settlement payment for this incentive program for the 2024 performance year in April 2025.

Get details on page 10 of this manual.

HCC code recapture
Updating a patient's HCC codes during the current calendar year

Incentive #2: PCP visits

This incentive offers ACNs $1 PMPM for all eligible Priority Health patients who receive an appropriate evaluation and management (E/M) visit during the performance year once the program's thresholds are met.

The incentive will be paid in two installments – with a preliminary payment in August 2024 and a settlement payment in April 2025 – based on performance.

Get details on page 12 of this manual.

Why did we create a Disease Burden Management program?

We heard you. The S-code used in the Advanced Health Assessment (AHA) program was a burden to your staff.

To help streamline your administrative workflow, we've reimagined our programs with new coding requirements more aligned to industry standards and to help close care gaps.

The new Disease Burden Management program includes elements of both our former AHA and Persistency programs (both retired effective Dec. 31, 2023) and is designed to assess a member's full burden of illness more effectively through an emphasis on capturing and managing all chronic conditions. The S-code will not be required.

Administrative details

Understanding the details is key to your successful participation in our DBM program.

ACN eligibility requirements

To be able to participate in our value-based programs, including DBM, ACNs must meet the following requirements:

- **Have 30 practitioner members** that practice and are credentialed as primary care providers as defined in our Determination of Practitioners for Primary Care Practitioner Status, **or**
- **Have 2,500 attributed members** across all lines of business.

Medical records: Providers must send attributed members' medical records to Priority Health. See "Submitting medical records" below for more information.

ACNs involved in a full-risk alternative payment model (APM) aren't eligible for participation for the full-risk lines of business. However, their lines of business not in a full-risk APM are still eligible. For example, if an ACN is in a full risk APM for Medicare Advantage, they may not participate in the DBM program for the Medicare Advantage line of business, but they can participate in the DBM program for the commercial ACA line of business.

For an ACN to become eligible during the 2024 calendar year, they must:

1. **Attain** the minimum membership or PCP thresholds outlined above between February and September; and
2. **Notify** Priority Health that they met the threshold; and
3. **Attest** to their PCP roster in our PRA tool to become DBM eligible the following month and each month thereafter through the end of the calendar year.

See our ACN Requirements online (login required) for more information.

ACN payment rules

We'll make DBM payments directly to the participating ACN. These payments encompass program settlement for the providers the ACN has attested to in PRA. ACNs are responsible for distributing these settlement funds to their providers at their discretion.

Should an ACN wish to dispute a settlement payment, contact your Provider Strategy & Solutions Consultant.

Attesting to PCPs monthly in PRA

ACNs must attest monthly to their PCPs in our PRA tool (login required). We use this monthly snapshot as our source of truth to link PCPs to a DBM-participating ACN for their incentives and associated reporting. Failure to attest monthly will affect the accuracy of your value-based program reporting and payment. We require monthly roster submission, regardless of whether there are network changes, to maintain data integrity. To minimize confusion and make it easier for you to participate in all our programs with less administrative work, this is the same process used in our PCP Incentive Program (PIP).

We'll match ACN payments – including preliminary and year-end settlement – to the ACN's PRA-attested PCP roster. PRA attestation is forward looking, i.e., an ACN attests in May to its June roster.

For the preliminary DBM payment, the PRA data used for payment calculation will be taken from the January attestation of February rosters. For the year-end settlement payment, the PRA data used for payment calculation will be taken from the June attestation of July rosters. See our PRA Manual for more information.

Plans included in the DBM program

Only our Medicare Advantage (MAPD), D-SNP and commercial ACA plans are included in the DBM program.

Independent providers

We require independent providers to align with a DBM-eligible ACN to participate in our DBM program. PCPs not contracted through and claimed by an ACN in PRA won't be eligible to receive DBM incentive payments.

Manual revisions

We reserve the right to make changes to our DBM program and rectify systematic errors at any time. The DBM Manual available on our website is considered to be the official version at any given time. We'll let you know of any updates to the manual through news items posted to our online Provider Manual.

Member attribution

For program settlement, members are aligned to the PCP they're attributed to in the measurement year. See the incentive program specifications in this manual for attribution snapshot timelines.

Official member counts include 90 days of retroactivity. Employers have 30 days to request retroactive member enrollment or termination. However, an employer may request to review 90-day retroactivity.

Member discharge

We don't allow the discharge of members for the sole purpose of reaching DBM program measure targets. Review our member discharge criteria online and process through our online provider center, **prism** (login required).

PCP eligibility

To be eligible for inclusion in an ACN's roster for DBM, a PCP must be:

- Reported as a PCP by a contracted, Priority Health-recognized ACN and attested to in the PRA tool
- An MD, DO, Nurse Practitioner or Physician Assistant credentialed as a PCP, in good standing with Priority Health and practicing in a primary care setting as defined by a TIN
- The rendering physician on a claim
- Board certified in Internal Medicine, Internal Medicine and Pediatrics, Family Medicine, Pediatrics, Geriatrics, General Practice or OB/GYN

No minimum membership is required at the PCP-level.

Program deadlines

Program deadline description	Deadline
Preliminary payment claims submission and adjudication (for January – May 2024 dates of service)	July 31, 2024
2024 preliminary payment	August 2024
Settlement payment claims submission and adjudication (for all 2024 dates of service)	Mar. 31, 2025
2024 settlement payment	April 2025

Reporting

We'll make our standard reporting available for ACNs. We won't build or create custom reports for ACNs or practices for our DBM program.

We strongly encourage ACNs to set up Secure File Transfer Protocol (SFTP) with us if they haven't already, to receive these standard monthly reports. If SFTP isn't feasible, our teams will send the reports by secure email.

Reports will be made available on the 15th of each month, and ACNs using SFTP are responsible for retrieving them.

Monthly reports will include the following information:

- Member eligibility lists
- Member demographic detail (name, DOB, etc.)
- PCP visit status flag for each member (member seen or not yet seen by PCP)
- All HCC chronic condition gaps for eligible members, based on 2023 enrollment
- All HCC chronic condition gaps addressed in 2024
- Suspected diagnoses (informational only – not included in 2024 incentive. Address these conditions as appropriate, for potential inclusion for the 2025 incentive program.)
- Summary reports showing the following:
    - PCP visits YTD vs target
    - Chronic condition recapture YTD vs target
    - Other summary reports to assist in targeting members with open chronic gaps

Claims data received, processed and approved by the end of the month will be reflected in the following month's reporting. Final reports will be sent after three months of runout on the year. Membership count for payment for the measurement year will include:

- attributed membership for Medicare Advantage and
- a high-risk subset of the attributed membership for commercial ACA

Reconciliation

A comparison of results included in the monthly activity reports should be performed against your records. If the results don't align, please send an inquiry to your Provider Strategy & Solutions Specialist for review.

Submitting medical records

To ensure complete and accurate disease burden documentation, Priority Health will send participating ACNs requests for medical records throughout the calendar year to conduct post-encounter chart reviews. Participating ACN's are required to provide records **within 30 days** of each request.

The Centers for Medicare and Medicaid Services (CMS) and Health and Human Services (HHS) require health plans participating in the Medicare Advantage (MA) program and/or the Affordable Care Act (ACA) to submit health status documents from diagnoses contained in claims and the member's medical record. CMS requires that we submit complete and accurate diagnostic data each year for each member. The diagnostic data submitted is used to predict the relative health risk status of individuals during the next calendar year and must be supported by valid documentation within the patient's medical record. In accordance with your provider contract's Record Keeping section, the provider is required to provide the requested documents.

Medical records can be submitted by:

- Epic Payer Platform (see below)
- Remote EMR access (see below)
- SharePoint electronic upload – email *riskadj@priorityhealth.com* for access
- Secure email to *riskadj@priorityhealth.com*
- Fax to 616.975.8823
- Mail to: Priority Health, 1241 East Beltline Ave NE, Grand Rapids, MI 49525, Mail Stop 2235, Attn: Risk Adjustment

Medical records must be submitted at no charge for coding review. **Failure to return medical record documentation by the deadline will result in a 50% penalty for the program year's final settlement payout.**

Epic Payer Platform (EPP) & Remote EMR access
To reduce the impact of your staff pulling medical records for this program, we're happy to partner with you through Epic Payer Platform (EPP) or Remote EMR access.

- **EPP**: For Epic users, EPP can create a streamlined connection for electronic data to be exchanged in real time. One feature of this platform is Clinical Document Exchange (CDE). CDE allows Priority Health to efficiently pull encounter data without a strain on your resources.
- **Remote EMR access** allows Priority Health access to your EMR through a secure connection. This allows our Health Information Management (HIM) coordinators to retrieve the medical records and documentation we need from your EMR directly and securely without placing a burden on your practices.

Contact your Provider Strategy & Solutions Specialist to get started with either EPP or Remote EMR access.

Incentive details

Chronic condition (HCC) recapture

To earn this incentive, an ACN must demonstrate an increased recapture rate for chronic hierarchical condition categories (HCC) codes for their eligible Priority Health patients during the performance year.

For the Medicare Advantage (MAPD), this incentive program is based on CMS's V28 coding model.

Program requirements	In addition to the requirements outlined in the Administrative Details section of this manual, the following are required for incentive payment: • A minimum recapture rate of 70%. We'll establish each ACN's baseline recapture rate in April 2024 and this rate will be included in monthly performance reports. • A recapture rate increase based on the thresholds outlined in the Payment Rules on page 11.
Member targeting & outreach	• Medicare Advantage (MAPD) and D-SNP members*. • A subgroup of commercial ACA members determined to be high-risk by Priority Health based on past illness burden and other risk factors.* For each ACN, we'll pull a snapshot of member attribution at the end of January 2024 as initial targets. ACNs will receive their member attribution lists for preliminary targets in March 2024. Final targets will be based on member attribution at the end of July 2024 and sent to the ACNs in August 2024. The member lists will be sent via SFTP or secure email. Members from the list attributed to the ACN in July 2024 will be counted for settlement calculation. **Members without an HCC chronic condition recorded in the prior year will be removed from the calculation.*
Program measurements	• **Numerator**: Includes all chronic HCC conditions that were coded and accepted by CMS by any provider (not just those coded by the PCP office), with payment through March 2025. These HCCs include only those from the denominator below. • **Denominator**: Includes HCCs based on 2023 chronic conditions. The initial list of eligible HCCs will be included in the March 2024* reporting based on February 2024 member eligibility and ACN attributions status. **Note: Member eligibility and HCC chronic condition lists will be provided to ACNs monthly throughout 2024. Most members attributed to an ACN in early 2024 will remain with the ACN throughout the year. Therefore, ACNs can work throughout the year in addressing chronic conditions. The final member settlement date in August, based on July attribution, is meant to provide more than four months to schedule and address conditions for any new or newly attributed members to the ACN in 2024 to date.*

Because the DBM program is based on performance improvement over the prior year, any new members are attributed to an ACN after February 2024 will be communicated to the ACN monthly. However, these additional members won't be included in the final settlement calculation.

We still highly encourage PCP offices to see these members in 2024.

Payment rules

ACNs meeting the program requirements will receive a one-time settlement payment for this incentive program for the 2024 performance year in April 2025.

Below are the recapture rate thresholds which will determine an ACN's PMPM for this incentive. These increase rates apply to the ACN's full eligible member panel:

Recapture rate increase from previous year	Incentive amount
6.00% or greater	$6 PMPM
4.00% - 5.99%	$4 PMPM
2.00% - 3.99%	$2 PMPM
Less than 2.00%	$0

PCP visits

This incentive offers ACNs a $1 PMPM for all eligible Priority Health patients who receive an appropriate evaluation and management (E/M) visit during the performance year.

We strongly encourage our PCPs to see our members, their patients, at the beginning of the year to fully assess their chronic conditions. Therefore, we're paying this incentive in two installments – with a preliminary payment in August 2024 and a settlement payment in April 2025 – based on performance.

Program requirements	In addition to the requirements outlined in the Administrative Details section of this manual, the following are required for incentive payment: • At least 70% of eligible members see their PCP by May 31, 2024, to be eligible for the preliminary payment. • At least 95% of eligible members see their PCP during the performance year to be eligible for the final settlement payment. • At least 70% recapture rate in the Chronic Condition (HCC) Recapture incentive to be eligible for the final settlement payment.
Member targeting & outreach	• Medicare Advantage (MAPD) and D-SNP members. • A subgroup of commercial ACA members determined to be high-risk by Priority Health based on past illness burden and other risk factors. For each ACN, we'll pull an initial snapshot of member attribution at the end of February 2024. ACNs will receive these member attribution lists in March 2024. The final member list will be sent in August 2024 based on the end of July 2024 member attribution. These lists will serve as the ACN's baseline attributed member lists for the entirety of the program. For the preliminary payment, those initial members still active and assigned to the ACN as of May 2024 will be included in the calculation. For the settlement payment, those initial members still active and assigned to the ACN as of July 2024 will be included.
Program measurements	• **Numerator**: Includes completed PCP visits incurred during the 2024 calendar year with claims runout through March 2025. • **Denominator**: Includes all targeted members assigned to the ACN as of February 2024 for the preliminary payment and July 2024 for final settlement.

Billing requirements

The types of visits eligible include all office, virtual and home-based visits, both preventive and non-preventive, paid on a claim. These must be risk-adjusted eligible codes and accepted by CMS/HHS to count.

Office visits: The set of procedure codes indicating a PCP visit on which attribution is made.

Approved CPT codes for DBM visits				
99202	99212	99381	99391	99495
99203	99213	99382	99392	99496
99204	99214	99383	99393	99502*
99205	99215	99384	99394	G0402
		99385	99395	G0438
		99368	99396	G0439
		99387	99397	
**99502 only applies to ACA individual members. This code links to a home visit for a newborn care assessment.*				

Place of service (POS): The POS is where a member receives service from a provider. The POS codes considered in the attribution model include:

Eligible POS code	POS description
2	Virtual services performed with a patient who's in a location other than their home*
3	School
4	Homeless shelter
5	Indian Health Service Free-Standing facility
6	Indian Health Service Provider-based facility
7	Tribal 838 Free-Standing Facility
8	Tribal 638 Provider-based facility
10	Virtual services performed with a patient who's in their home*
11	Office
12	Home
19	Off Campus-Outpatient Hospital
22	On Campus-Outpatient Hospital
50	Federally Qualified Health Center
71	Public Health Clinic
72	Rural Health Clinic
OV	Office Visit

**Virtual visits must include a video component and cannot be audio only.*

Revenue center codes: These codes are used to identify office visits for members receiving care from a Federally Qualified Health Center (FQHC), Rural Health Center (RHC) or Tribal Health Center (THC). The revenue center codes considered in our attribution model are:

Revenue code	Revenue description
0500	Outpatient services-general classification
0509	Outpatient services – other
0510	Clinic-general classification
0514	Clinic-OB/GYN
0517	Clinic-family practice clinic
0519	Clinic-other
0520	Free standing clinic-general classification
0521	Free standing clinic-Clinic visit by a member to RHC/FQHC
0522	Free standing clinic-family practice

0523	Free standing clinic-family practice
0524	Free standing clinic-visit to RHC/FQHC practitioner by member in a covered Part A stay at a SNF
0525	Free standing clinic-visit by RHC/FQHC practitioner to a member in a SNF (not covered Part A stay) or NF or ICF MR or other residential facility
0528	Visit by RHC/FQHC practitioner to other non RHC/FQHC site (e.g., scene of accident)
0529	Freestanding clinic-other

UB facility type ID	UB facility type description
7	Clinic or hospital based ESRD facility

Payment rules

ACNs which meet the requirements will receive two payments as follows:

Preliminary payment		
Dates of service	**Target**	**Payment timeline**
January through May 2024	70% of eligible population receives appropriate E/M visits (as defined below) by May 31	August 2024*
*Claim runout is through July 31, 2024.		

Settlement payment If preliminary payment is achieved		
Dates of service	**Target**	**Payment timeline**
June through December 2024	• 95% of eligible population receives appropriate E/M visits (as defined below) during the performance year, AND • At least 70% recapture rate in the Chronic Condition (HCC) Recapture incentive	April 2025*
*Claim runout is through Mar. 31, 2025.		

Even if the preliminary payment target isn't achieved, an ACN will still be eligible for final settlement on the full performance year if the final target is achieved.

	Settlement payment If preliminary payment is not achieved

Dates of service	Target	Payment timeline
January through December 2024	• 95% of eligible population receives appropriate E/M visits (as defined below) during the performance year, AND • At least 70% recapture rate in the Chronic Condition (HCC) Recapture incentive	April 2025*
*Claim runout is through Mar. 31, 2025.		

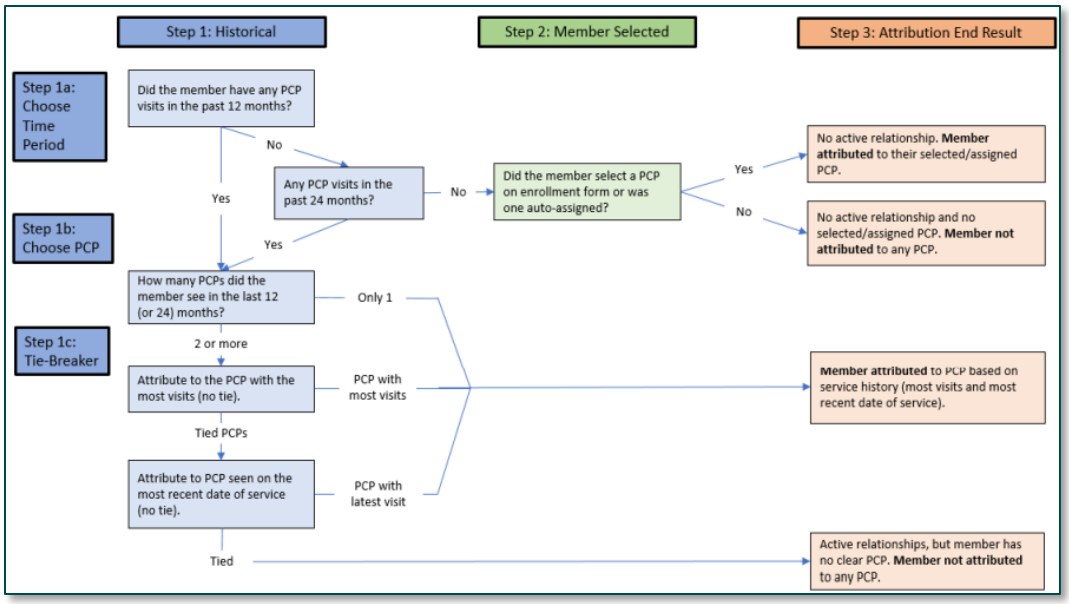
Separate measurements and payments will be made for Medicare Advantage and commercial ACA members.

Appendices

Appendix 1: Member attribution

How our value-based programs attribution model works

We're committed to providing a medical home for all our members for all products. Our value-based programs attribution model is primarily based on utilization. This attribution model is updated monthly and is run on the first business day of the month.



Description of our value-based programs attribution process

Step 1a: Historical 12 months

A review of claims is completed to identify if a member had a visit with a PCP in the past 12 months. If claims are found, the patient is attributed to the PCP identified on the claims unless the member saw more than one PCP during the 12-month period. See Step 1c.

Step 1b: Historical 24 months

If no PCP claims are found in the past 12 months, a review of claims is completed for the past 24 months. If claims are found, the patient is attributed to the PCP identified on the claims unless the member saw more than one PCP during the 24-month period. See Step 1c.

Step 1c: Historical tiebreaker

If a member sees more than one PCP during a 12-month or 24-month period, then claims are reviewed for the PCP with the greatest number of visits for that member (attribute the member to the PCP) or, if there is a tie in the number of PCP visits between the two PCPs, attribute the member to the PCP with the most recent visit.

Step 2: Assignment/member declared

There are three ways a member is matched to a PCP:

1. Member selected upon enrollment in a Priority Health plan, or
2. Assigned upon enrollment in a Priority Health plan, or
3. Attributed based on claims history. Attribution will override assigned or member selected PCP

Step 3: End result of attribution

The ways in which a member is attributed to a PCP by Priority Health:

- Attribution based on claims
- Member-selected; confirmed through attribution
- Member-selected/assigned (without claims history)

Some members won't be attributed to a PCP:

- Enrolled in a PPO plan with no claims history and no PCP selected
- A tie in claims for two or more PCPs with the same number of services and the same most recent date of service

Variables included in our attribution model

PCP: We define primary care physician (PCP) as one of the following: Internal Medicine, Pediatrics, Internal Medicine/Pediatrics, Family Medicine, General Practice, Geriatric Medicine or Obstetrics/Gynecology.

POS: Place of service (POS) is the location in which a member receives a service from a provider. The POS codes considered in the attribution model include:

POS code	POS description
2	Virtual services performed with a patient who's in a location other than their own home
3	School
4	Homeless Shelter
5	Indian Health Service Free-Standing Facility
6	Indian Health Service Provider-Based Facility
7	Tribal 638 Free-Standing Facility
8	Tribal 638 Provider-Based Facility
10	Virtual services performed with a patient who's in their own home
11	Office
12	Home
19	Off Campus-Outpatient Hospital
22	On Campus-Outpatient Hospital
50	Federally Qualified Health Center
71	Public Health Clinic
72	Rural Health Clinic
OV	Office Visit

Office visits: The set of procedure codes indicating a PCP visit on which attribution is made.

CPT					HCPCS
99201	99245	99384	99403	99494	G0402
99202	99341	99385	99404	99495	G0406
99203	99342	99386	99441	99496	G0407
99204	99343	99387	99442		G0408
99205	99344	99391	99443		G0438
99212	99345	99392	99444		G0439
99213	99347	99393	99484		G0463
99214	99348	99394	99487		G0511
99215	99349	99395	99488		G0512
99241	99350	99396	99489		G2214
99242	99381	99397	99490		G9001
99243	99382	99401	99392		G9002
99244	99383	99402	99493		T1015

Revenue center codes: Used to identify office visits for members receiving care from a Federally Qualified Health Center (FQHC), Rural Health Center (RHC) or Tribal Health Center (THC). The revenue center codes considered in our attribution model are:

Revenue center code	Description
0500	Outpatient services-general classification
0509	Outpatient services-other
0510	Clinic-general classification
0514	Clinic-OB-GYN
0517	Clinic-family practice clinic
0519	Clinic-other
0520	Free-standing clinic-general classification
0521	Free-standing clinic-Clinic visit by a member to RHC/FQHC
0522	Free-standing clinic-family practice
0523	Free-standing clinic-family practice
0524	Free-standing clinic - visit by RHC/FQHC practitioner to a member in a covered Part A stay at the SNF
0525	Free-standing clinic - visit by RHC/FQHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility
0529	Free-standing clinic-other

Appendix 2: Acute vs. chronic conditions

The Disease Burden Management Program will recognize and reward physicians who consistently achieve industry benchmark Hierarchical Condition Category (HCC) capture rates.

The Chronic Condition (HCC) recapture incentive is based on the coding and documentation of patients' medical conditions defined to be chronic. The recapture of members' acute conditions doesn't increase the percentage for the incentive metric.

Listed below are the Medicare Advantage and ACA chronic conditions eligible for inclusion in the recapture incentive measurement.

Medicare Advantage Chronic Condition (HCC) descriptions

HCC	HCC description
HCC001	HIV/AIDS
HCC017	Cancer Metastatic to Lung, Liver, Brain, and Other Organs; Acute Myeloid Leukemia Except Promyelocyte
HCC018	Cancer Metastatic to Bone, Other and Unspecified Metastatic Cancer; Acute Leukemia Except Myeloid
HCC019	Myelodysplastic Syndromes, Multiple Myeloma, and Other Cancers
HCC020	Lung and Other Severe Cancers
HCC021	Lymphoma and Other Cancers
HCC022	Bladder, Colorectal, and Other Cancers
HCC023	Prostate, Breast, and Other Cancers and Tumors
HCC035	Pancreas Transplant Status
HCC037	Diabetes with Chronic Complications
HCC038	Diabetes with Glycemic, Unspecified, or No Complications
HCC048	Morbid Obesity
HCC049	Specified Lysosomal Storage Disorders
HCC050	Amyloidosis, Porphyria, and Other Specified Metabolic Disorders
HCC051	Addison's and Cushing's Diseases, Acromegaly, and Other Specified Endocrine Disorders
HCC062	Liver Transplant Status/Complications
HCC063	Chronic Liver Failure/End-Stage Liver Disorders
HCC064	Cirrhosis of Liver
HCC065	Chronic Hepatitis
HCC068	Cholangitis and Obstruction of Bile Duct Without Gallstones
HCC077	Intestine Transplant Status/Complications
HCC079	Chronic Pancreatitis
HCC080	Crohn's Disease (Regional Enteritis)
HCC081	Ulcerative Colitis
HCC092	Bone/Joint/Muscle/Severe Soft Tissue Infections/Necrosis
HCC093	Rheumatoid Arthritis and Other Specified Inflammatory Rheumatic Disorders
HCC094	Systemic Lupus Erythematosus and Other Specified Systemic Connective Tissue Disorders
HCC107	Sickle Cell Anemia (Hb-SS) and Thalassemia Beta Zero
HCC108	Sickle Cell Disorders, Except Sickle Cell Anemia (Hb-SS) and Thalassemia Beta Zero; Beta Thalassemia
HCC109	Acquired Hemolytic, Aplastic, and Sideroblastic Anemias
HCC111	Hemophilia, Male

HCC112	Immune Thrombocytopenia and Specified Coagulation Defects and Hemorrhagic Conditions
HCC114	Common Variable and Combined Immunodeficiencies
HCC115	Specified Immunodeficiencies and White Blood Cell Disorders
HCC125	Dementia, Severe
HCC126	Dementia, Moderate
HCC127	Dementia, Mild or Unspecified
HCC137	Drug Use Disorder, Moderate/Severe, or Drug Use with Non-Psychotic Complications
HCC138	Drug Use Disorder, Mild, Uncomplicated, Except Cannabis
HCC139	Alcohol Use Disorder, Moderate/Severe, or Alcohol Use with Specified Non-Psychotic Complications
HCC151	Schizophrenia
HCC152	Psychosis, Except Schizophrenia
HCC153	Personality Disorders; Anorexia/Bulimia Nervosa
HCC154	Bipolar Disorders without Psychosis
HCC155	Major Depression, Moderate or Severe, without Psychosis
HCC180	Quadriplegia
HCC181	Paraplegia
HCC182	Spinal Cord Disorders/Injuries
HCC190	Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease, Spinal Muscular Atrophy
HCC191	Quadriplegic Cerebral Palsy
HCC192	Cerebral Palsy, Except Quadriplegic
HCC193	Chronic Inflammatory Demyelinating Polyneuritis and Multifocal Motor Neuropathy
HCC195	Myasthenia Gravis with (Acute) Exacerbation
HCC196	Myasthenia Gravis without (Acute) Exacerbation and Other Myoneural Disorders
HCC197	Muscular Dystrophy
HCC198	Multiple Sclerosis
HCC199	Parkinson and Other Degenerative Disease of Basal Ganglia
HCC200	Friedreich and Other Hereditary Ataxias; Huntington Disease
HCC201	Seizure Disorders and Convulsions
HCC221	Heart Transplant Status/Complications
HCC222	End-Stage Heart Failure
HCC223	Heart Failure with Heart Assist Device/Artificial Heart
HCC224	Acute on Chronic Heart Failure
HCC225	Acute Heart Failure
HCC226	Heart Failure, Except End-Stage and Acute
HCC227	Cardiomyopathy/Myocarditis
HCC238	Specified Heart Arrhythmias
HCC253	Hemiplegia/Hemiparesis
HCC254	Monoplegia, Other Paralytic Syndromes
HCC264	Vascular Disease with Complications
HCC267	Deep Vein Thrombosis and Pulmonary Embolism
HCC276	Lung Transplant Status/Complications
HCC277	Cystic Fibrosis
HCC278	Idiopathic Pulmonary Fibrosis and Lung Involvement in Systemic Sclerosis
HCC279	Severe Persistent Asthma

HCC280	Chronic Obstructive Pulmonary Disease, Interstitial Lung Disorders, and Other Chronic Lung Disorder
HCC298	Severe Diabetic Eye Disease, Retinal Vein Occlusion, and Vitreous Hemorrhage
HCC300	Exudative Macular Degeneration
HCC326	Chronic Kidney Disease, Stage 5
HCC327	Chronic Kidney Disease, Severe (Stage 4)
HCC328	Chronic Kidney Disease, Moderate (Stage 3B)
HCC329	Chronic Kidney Disease, Moderate (Stage 3, Except 3B)
HCC379	Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone
HCC380	Chronic Ulcer of Skin, Except Pressure, Through to Bone or Muscle
HCC381	Pressure Ulcer of Skin with Full Thickness Skin Loss
HCC382	Pressure Ulcer of Skin with Partial Thickness Skin Loss
HCC383	Chronic Ulcer of Skin, Except Pressure, Not Specified as Through to Bone or Muscle
HCC387	Pemphigus, Pemphigoid, and Other Specified Autoimmune Skin Disorders
HCC409	Amputation Status, Lower Limb/Amputation Complications
HCC454	Stem Cell, Including Bone Marrow, Transplant Status/Complications
HCC463	Artificial Openings for Feeding or Elimination

ACA Chronic Condition (HCC) descriptions

HCC	HCC description
HCC001	HIV/AIDS
HCC002	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock
HCC003	Central Nervous System Infections, Except Viral Meningitis
HCC004	Viral or Unspecified Meningitis
HCC006	Opportunistic Infections
HCC008	Metastatic Cancer
HCC009	Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia
HCC010	Non-Hodgkin's Lymphomas and Other Cancers and Tumors
HCC011	Colorectal, Breast (Age < 50), Kidney, and Other Cancers
HCC012	Breast (Age 50+) and Prostate Cancer, Benign/Uncertain Brain Tumors, and Other Cancers and Tumors
HCC013	Thyroid Cancer, Melanoma, Neurofibromatosis, and Other Cancers and Tumors
HCC018	Pancreas Transplant Status/Complications
HCC019	Diabetes with Acute Complications
HCC020	Diabetes with Chronic Complications
HCC021	Diabetes without Complication
HCC023	Protein-Calorie Malnutrition
HCC026	Mucopolysaccharidosis
HCC027	Lipidoses and Glycogenosis
HCC028	Congenital Metabolic Disorders, Not Elsewhere Classified
HCC029	Amyloidosis, Porphyria, and Other Metabolic Disorders
HCC030	Adrenal, Pituitary, and Other Significant Endocrine Disorders
HCC034	Liver Transplant Status/Complications
HCC035	End-Stage Liver Disease
HCC036	Cirrhosis of Liver

HCC037	Chronic Hepatitis
HCC371	Chronic Viral Hepatitis C
HCC372	Chronic Hepatitis, Except Chronic Viral Hepatitis C
HCC038	Acute Liver Failure/Disease, Including Neonatal Hepatitis
HCC041	Intestine Transplant Status/Complications
HCC042	Peritonitis/Gastrointestinal Perforation/Necrotizing Enterocolitis
HCC045	Intestinal Obstruction
HCC046	Chronic Pancreatitis
HCC047	Acute Pancreatitis/Other Pancreatic Disorders and Intestinal Malabsorption
HCC048	Inflammatory Bowel Disease
HCC054	Necrotizing Fasciitis
HCC055	Bone/Joint/Muscle Infections/Necrosis
HCC056	Rheumatoid Arthritis and Specified Autoimmune Disorders
HCC057	Systemic Lupus Erythematosus and Other Autoimmune Disorders
HCC061	Osteogenesis Imperfecta and Other Osteodystrophy's
HCC062	Congenital/Developmental Skeletal and Connective Tissue Disorders
HCC063	Cleft Lip/Cleft Palate
HCC064	Major Congenital Anomalies of Diaphragm, Abdominal Wall, and Esophagus, Age < 2
HCC066	Hemophilia
HCC067	Myelodysplastic Syndromes and Myelofibrosis
HCC068	Aplastic Anemia
HCC069	Acquired Hemolytic Anemia, Including Hemolytic Disease of Newborn
HCC070	Sickle Cell Anemia (Hb-SS)
HCC071	Thalassemia Major
HCC073	Combined and Other Severe Immunodeficiencies
HCC074	Disorders of the Immune Mechanism
HCC075	Coagulation Defects and Other Specified Hematological Disorders
HCC081	Drug Psychosis
HCC082	Drug Dependence
HCC087	Schizophrenia
HCC088	Major Depressive and Bipolar Disorders
HCC089	Reactive and Unspecified Psychosis, Delusional Disorders
HCC090	Personality Disorders
HCC094	Anorexia/Bulimia Nervosa
HCC096	Prader-Willi, Patau, Edwards, and Autosomal Deletion Syndromes
HCC097	Down Syndrome, Fragile X, Other Chromosomal Anomalies, and Congenital Malformation Syndromes
HCC102	Autistic Disorder
HCC103	Pervasive Developmental Disorders, Except Autistic Disorder
HCC106	Traumatic Complete Lesion Cervical Spinal Cord
HCC107	Quadriplegia
HCC108	Traumatic Complete Lesion Dorsal Spinal Cord
HCC109	Paraplegia
HCC110	Spinal Cord Disorders/Injuries
HCC111	Amyotrophic Lateral Sclerosis and Other Anterior Horn Cell Disease

HCC112	Quadriplegic Cerebral Palsy
HCC113	Cerebral Palsy, Except Quadriplegic
HCC114	Spina Bifida and Other Brain/Spinal/Nervous System Congenital Anomalies
HCC115	Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy
HCC117	Muscular Dystrophy
HCC118	Multiple Sclerosis
HCC119	Parkinson's, Huntington's, and Spinocerebellar Disease, and Other Neurodegenerative Disorders
HCC120	Seizure Disorders and Convulsions
HCC121	Hydrocephalus
HCC122	Non-Traumatic Coma, Brain Compression/Anoxic Damage
HCC125	Respirator Dependence/Tracheostomy Status
HCC127	Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes
HCC128	Heart Assistive Device/Artificial Heart
HCC129	Heart Transplant
HCC130	Congestive Heart Failure
HCC131	Acute Myocardial Infarction
HCC132	Unstable Angina and Other Acute Ischemic Heart Disease
HCC135	Heart Infection/Inflammation, Except Rheumatic
HCC137	Hypoplastic Left Heart Syndrome and Other Severe Congenital Heart Disorders
HCC138	Major Congenital Heart/Circulatory Disorders
HCC139	Atrial and Ventricular Septal Defects, Patent Ductus Arteriosus, and Other Congenital Heart/Circulatory Disorders
HCC142	Specified Heart Arrhythmias
HCC145	Intracranial Hemorrhage
HCC146	Ischemic or Unspecified Stroke
HCC149	Cerebral Aneurysm and Arteriovenous Malformation
HCC150	Hemiplegia/Hemiparesis
HCC151	Monoplegia, Other Paralytic Syndromes
HCC153	Atherosclerosis of the Extremities with Ulceration or Gangrene
HCC154	Vascular Disease with Complications
RXC001	Anti-HIV Agents
RXC002	Anti-Hepatitis C (HCV) Agents
RXC003	Antiarrhythmics
RXC004	Phosphate Binders
RXC005	Inflammatory Bowel Disease Agents
RXC006	Insulin
RXC007	Anti-Diabetic Agents, Except Insulin and Metformin
RXC008	Multiple Sclerosis Agents
RXC009	Immune Suppressants and Immunomodulators
RXC010	Cystic Fibrosis Agents
RXC011	Ammonia Detoxicants
RXC012	Diuretics, Loop, and Select Potassium-Sparing
HCC156	Pulmonary Embolism and Deep Vein Thrombosis
HCC158	Lung Transplant Status/Complications

HCC159	Cystic Fibrosis
HCC160	Chronic Obstructive Pulmonary Disease, Including Bronchiectasis
HCC161	Asthma
HCC162	Fibrosis of Lung and Other Lung Disorders
HCC183	Kidney Transplant Status
HCC184	End Stage Renal Disease
HCC187	Chronic Kidney Disease, Stage 5
HCC188	Chronic Kidney Disease, Severe (Stage 4)
HCC217	Chronic Ulcer of Skin, Except Pressure
HCC251	Stem Cell, Including Bone Marrow, Transplant Status/Complications
HCC253	Artificial Openings for Feeding or Elimination
HCC254	Amputation Status, Lower Limb/Amputation Complications

Appendix 3: FAQ

When will the Disease Burden Management program go into effect?
The new disease burden program will begin Jan. 1, 2024.

Are providers still able to earn incentives through the AHA and Persistency programs?
The AHA and Persistency programs will retire on Dec. 31, 2023. Providers will no longer be able to participate in these programs.

Why are the AHA and Persistency programs being replaced?
The new Disease Burden Management program will have elements of both AHA and Persistency and is designed to assess a member's full burden of illness more effectively through an emphasis on capturing and managing all chronic conditions.

We want to make capturing essential information about your patients easier and more efficient so providers can focus their time on what matters most – their patients, our members. We're reimagining our programs to help streamline your administrative workflow with new coding requirements that are more aligned to industry standards.

Will providers still be paid for AHA and Persistency incentives earned in 2023?
The final 2023 AHA program incentives will be processed and paid out as with prior years. The claims runout period is through Feb. 29, 2024. AHA visits will then be reconciled with the final incentive payment in March 2024.

The 2023 Persistency program settlement will be calculated using final reporting outcomes in May 2024, with settlement payments to be made in June 2024.

Which providers are eligible for this new DBM incentive program?
Providers attributed to an eligible ACN (see criteria on pages 5-6). The eligible ACN may not participate in a full risk alternative payment model (APM) within the line of business. For example, if an ACN is in a full risk APM for Medicare Advantage, they may not participate in the DBM program for the Medicare Advantage line of business, but they can participate in the DBM program for the commercial ACA line of business.

What members are included in this program?
Medicare Advantage, D-SNP and commercial ACA. Consistent with the previous AHA program, members will be targeted based on past illness burden and other risk identification factors.

Separate measurements and payments will be made for Medicare Advantage (including D-SNP) and commercial ACA.

What if a practice or provider's attribution differs from our records?
There can be instances that members are "attributed" to a provider, but your understanding may be the patient isn't under your care / you haven't seen. We would advise outreach to these patients to determine some of these variables (e.g., they still need to establish care, they were attributed due to a provider leaving, etc.). In some cases, a patient may need to be directed to Priority Health Customer Service at 800.942.0954 so they can update their member information correctly.

What about access barriers, given the PCP visit incentive is asking our teams to see a high percentage of Priority Health attributed patients each year?
Priority Health highly encourages that every Medicare Advantage and high-risk ACA member be seen at least one time per year by their primary care physician / advanced practice provider, to maintain continuity in care and review chronic conditions they may have. It's the provider's discretion to determine what's medically necessary for their patient.

Currently, ACNs across our network are seeing an average of 88-96% of their attributed patients each year.

Does a visit have to be an Annual Wellness Visit (AWV) or Physical (CPE) to qualify for the PCP Visit incentive?

No. Any visit that falls under approved CPT codes (annual wellness, general wellness evaluation and management (E/M) and similar visits) is eligible to earn incentives. See pages 18 & 19 of this manual for a list of approved CPT codes.

Can a patient be seen for an acute concern in addition to chronic conditions?
Yes. Follow standard E/M coding to reflect this.

Do virtual visits qualify for the PCP Visit incentive?
Yes, CMS-compliant visits eligible for risk adjustment will qualify for the incentive. The visits must be both audio and video. See pages 18 & 19 of this manual for a list of approved CPT codes.

Are providers still required to use an S code to document visits, as was required with AHA?
No, the S Code will no longer be a required component of coding for any visit or incentive under this new program.

Who will receive credit for the completion of a PCP visit if an attributed member is seen by another provider in their ACN?
For the PCP visit incentive, any/all qualified providers may see the patient; however, the PCP attributed to the member will receive credit for the PCP incentive visit.

Who will receive credit for the recapture of chronic conditions if an attributed member is seen by another provider in their ACN?
For the Chronic Condition (HCC) Recapture incentive, the attributed PCP will be credited for HCC capture regardless of another provider or specialist closing a chronic condition care gap.

Will the recapture rate be impacted by changes to providers within an ACN (for example, if a provider leaves mid-year)?
The recapture rate will be based on ACN attribution status as of July 31, 2024. At this date, the providers within an ACN are considered locked in for the final calculation of the incentive results.

Does the Chronic Condition (HCC) Recapture incentive for Medicare Advantage (MAPD) follow the V24 or V28 model for risk adjustment?
For Medicare Advantage (MAPD) and D-SNP, this incentive program is based on the CMS V28 coding model. Education on the new CMS model will be provided to help understand the differences in recapture rate between V24 and V28.

What documentation are PCPs or practices required to provide to be eligible to earn incentives through the Disease Burden Management program? For example, chart notes, forms, etc.?
Medical records must be sent to Priority Health or be available for access upon request. It's recommended to document to the highest level of specificity for chronic conditions and follow ICD-10 coding guidelines ensuring proper documentation of MEAT.

Does the Chronic Condition (HCC) Recapture incentive include new chronic conditions (HCCs) addressed in the program year?
For 2024, we're not including the new conditions within the metric but strongly encourage the incorporation of suspecting diagnoses within your practice workflow. We'd like to work with practices throughout this year to ensure infrastructure and workflows are all set up and configured to be successful for inclusion of suspecting into an incentive in the future.

Does a minimum percentage of chronic conditions (HCCs) need to be recaptured to be eligible for a PCP incentive and/or the Chronic Condition (HCC) Recapture payments?
Yes, for the final incentive calculation, a minimum of 70% of chronic conditions need to be recaptured to be eligible for either incentive.