Priority Health

PRELIMINARY MANUAL

2024 PCP Incentive Program (PIP)

An integrated program focused on patient-centered care

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Program overview

We're working together to deliver personalized health care made simple, affordable and exceptional.

For over 25 years, we've partnered with primary care providers (PCPs) to improve the quality, access and affordability of care for our members. Our goal is to work with our provider partners to deliver the right care, at the right time, in the right place and at the right cost.

Right care: We provide tools, programs and information that make it easier for you to improve the health outcomes of your Priority Health patients with integrated, patient-centered care.

Right time: Working to ensure access to care while supporting preventive care and ongoing chronic condition management gives those we serve the care they need, when they need it.

Right place: Our program encourages strong PCP-patient relationships, so our members have a medical home and coordinated care with high quality, cost-effective specialty and ancillary providers.

Right cost: We hold you accountable for using evidence-based medicine to reduce costs, and we reward you for achieving the best outcomes, ensuring our members continue to have access to excellent and affordable health care.

Together, through our PCP Incentive Program (PIP), we'll achieve our goal to improve outcomes and transform care delivery.

Achieving results

Working with our provider partners (you!), we've achieved outstanding results for Michigan communities year after year.

We're here to help you **maximize your 2024 PIP incentives**. In this manual, we show you how.

2024 program updates

We update our PCP Incentive Program (PIP) annually to reflect current health care trends. Our 2024 program aligns with our mission and goals to transform models of care and finance care delivery.

For complete details on these measure changes, refer to the individual measure specification pages in this manual and/or the HEDIS Provider Reference Guide.

Administrative changes

- Digital *First* Strategy, including the retirement of Report 70 and Patient Profile
- Focus measure pre-payment calculation, updated to ensure ACNs retain the full pre-payment amount at settlement

2024 Revised Measures

- Add two Pediatric chronic disease focus measures
- Care Management measure
  - ✓ Add CPT codes for touchpoint credit
  - ✓ Simplify the link to quality
- Added an additional Social Determinants of Health (SDoH) measure

Product payouts & targets will be included in the final 2024 PIP manual.

2024 program measure grid

	90th percentile performance				75th percentile performance			
	Payout PMM (all products)	Commercial 90th percentile target	Medicare 90th percentile target	Medicaid 90th percentile target	Payout PMM (all products)	Commercial 75th percentile target	Medicare 75th percentile target	Medicaid 75th percentile target
HEDIS PREVENTIVE HEALTH Δ Pediatric focus measure								
Lead Screening (LSC)								
Childhood Imms: Combo 3 (CIS)								
Adolescent Immunizations (IMA)								
Well Child Visits: First 15 Months (W30) Δ								
Well Child Visits: 3-11 Years (WCV) Δ								
Chlamydia Screening (CHL)								
Cervical Cancer Screenings (CCS)								
Breast Cancer Screening (BCS-E)								
Colorectal Cancer Screening (COL-E)								
HEDIS CHRONIC DISEASE MANAGEMENT Δ Chronic disease focus measure								
Controlling High Blood Pressure (CBP) Δ								
Diabetes Care: HbA1c≤9.0% (HBD) Δ								
Eye Exam for patients with Diabetes (EED)								
Kidney Health Evaluation (KED)								

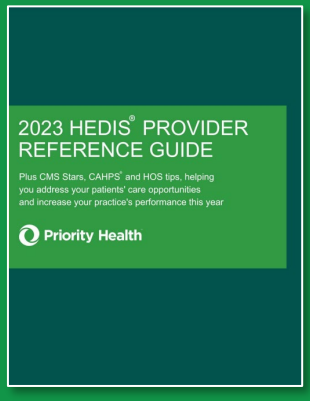
	5-Star Cut Point Performance		3-Star Cut Point Performance	
	Payout PMM	Medicare Cut Point Target	Payout PMM	Medicare Cut Point Target
MEDICARE 5-STAR CHRONIC DISEASE MANAGEMENT				
Statin Use for Patients w/Diabetes (SUPD)				
Statin Therapy for Patients w/CVD (SPC)				
Medication Adherence – Diabetes				
Medication Adherence – Hypertension				
Medication Adherence – Cholesterol				

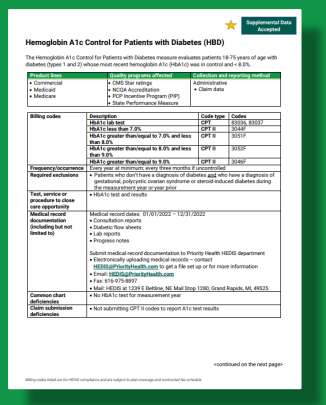
PMM = per member meeting measure

Access our HEDIS® Provider Reference Guide for detailed information on each measure direct from HEDIS, including:

- ✓ Billing codes
- ✓ Optional exclusions
- ✓ Services to close the care opportunity
- ✓ Medical record documentation
- ✓ Tips & best practices

Get the guide





Administrative details

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

ACN eligibility requirements

To be able to participate in our value-based programs, including PIP, 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.

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 PIP 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 PIP 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.

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 PIP-participating ACN for their incentives and associated gaps in care 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.

We'll match all ACN payments – including quarterly, ad hoc and year-end settlement – to the ACN's PRA-attested PCP

Our Digital *First* strategy

In 2024, our top priority is assisting you, our ACN partners, with implementing standardized data feeds for Priority Health.

This implementation replaces manual, nonstandard data delivery for quality gap closure.

Digital *First* leverages technological assets that exist within ACN cultures and features four primary goals:

1. **Prepare** for NCQA's ECDS roadmap.
2. **Retire** nonstandard data practices (Report #70, Patient Profile).
3. **Assist** ACNs with implementing standardized data feeds to Priority Health.
4. **Enhance** data confirmation reporting (HL7, MiHIN).

This strategy may impact the way your ACN submits supplemental data to us to close care gaps.

See full guidelines on submitting supplemental data in **Appendix 2** of this manual.

roster. We'll use the last attestation for 2024 data, which is in Novemeber, for 2024 settlement. See our PRA Manual for more information.

2024 PRA attestation cycles				
Cycle	**First date to attest**	**Last date to attest**	**Start date**	**End date**
January 2024	12/1/2023	12/15/2023	1/1/2024	1/31/2024
February 2024	1/2/2024	1/16/2024	2/1/2024	2/29/2024
March 2024	2/1/2024	2/15/2024	3/1/2024	3/31/2024
April 2024	3/1/2024	3/15/2024	4/1/2024	4/30/2024
May 2024	4/1/2024	4/15/2024	5/1/2024	5/31/2024
June 2024	5/1/2024	5/15/2024	6/1/2024	6/30/2024
July 2024	6/3/2024	6/17/2024	7/1/2024	7/31/2024
August 2024	7/1/2024	7/15/2024	8/1/2024	8/31/2024
September 2024	8/1/2024	8/15/2024	9/1/2024	9/30/2024
October 2024	9/3/2024	9/17/2024	10/1/2024	10/31/2024
November 2024	10/1/2024	10/15/2024	11/1/2024	11/30/2024
December 2024	11/1/2024	11/15/2024	12/1/2024	12/31/2024
January 2025	12/2/2024	12/16/2024	1/1/2025	1/31/2025

Health plans excluded from PIP

Most of our health plans are included in PIP. The exceptions are:

- Medigap
- Short-term individual plans
- Cigna wrap network
- Multiplan out-of-network wrap for Medicare Advantage
- Virtual Care Partners

Independent providers

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

Manual revisions

We reserve the right to make changes to our PIP program and rectify systematic errors at any time. The PIP 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.

You can always find the current, official PIP Manual linked on our PCP Incentive Program webpage (login required).

Measure rounding

We round preventive and chronic disease management measures up if the score is within 0.5% of the target.

Example: If the score is 89.4, it will round to 89. Alternatively, if the score is 89.5, it will round to 90. Find rounding details for the Transformation of Care measures in the measure specifications.

Member alignment

For program settlement, members are aligned to the PCP they're attributed to on December 31 of the measurement year. Measure case definitions provide a few exceptions to this rule.

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 diagnosis

Rarely, a newly diagnosed patient may appear in a measure denominator late in the year without having appeared on earlier reports due to lag or late diagnosis. For our PIP program, the attributed PCP will be measured on any patient who falls into the category within the calendar year.

Member discharge

We don't allow the discharge of members for the sole purpose of reaching PIP 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 PIP, 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.

Priority Health quality index scores

The quality index (QI) score is the sum of the numerators, divided by the sum of the denominators, of a subset of the PIP program clinical outcomes measures (see the table on the next page). The result is then divided by the weighted average of the targets (90th percentile) to determine the score.

The subset of measures is subject to change based on HEDIS adjustments. The QI score calculation uses the 90th percentile PIP measure targets from the current measurement year. We may use these year-end settlement QI scores to determine incentive payout in contractual risk arrangements and other value-based programs as applicable.

Measure name	HMO/POS	ASO/PPO	Medicare	Medicaid
Childhood Imms: Combo 3	✓	✓		✓
Adolescent Immunizations	✓	✓		✓
Well Child Visits: First 15 Mo	✓	✓		✓
Well Child Visits: 3-11 Years	✓	✓		✓
Chlamydia Screenings				✓
Cervical Cancer Screenings	✓	✓		✓
Breast Cancer Screenings	✓	✓	✓	✓
Colorectal Cancer Screening	✓	✓	✓	
Diabetes Care: HbA1c≤9.0%	✓	✓	✓	✓
Diabetes Care: Annual Eye Exam	✓	✓	✓	✓
Kidney Health Evaluation	✓	✓	✓	✓
Hypertension: Controlled BP	✓	✓	✓	✓

Program deadlines

Program deadline description	Deadline
Supplemental data (MiHIN, HL7)	Jan. 31, 2025
Claims submission and adjudication	Feb. 28, 2025
2024 Settlement	June 2025

Program funding

Our PIP program is funded with a per member per month (PMPM) accrual for HMO/POS, ASO/PPO, Medicare and Medicaid. The PMPM funding amount varies by each of these business categories. Forecasting is used to determine measure payout and measure availability by business category. Forecasting includes analysis of expected business category performance and measure member populations in the program year.

The ASO/PPO product category contains both self-funded (ASO) and fully funded (PPO) products. Although we settle the ASO and PPO products based on combined performance, the PMPM funding amount for each product will vary, and we use a total combined amount to determine a maximum budget amount for this business category. Program funding for all lines of business is subject to change and updating at any time during the program year. Product line payment won't exceed the budgeted amount. We'll index payment as needed.

Reporting

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

Secondary cardholders

We include members with primary insurance coverage through another health insurer in our PIP program.

Supplemental data

Submit supplemental data to us through any of these methods:

- All Payer Supplemental data transmitted via Michigan Health Information Network (MiHIN)
- EMR or patient registry data exchange (i.e., HL7 / APS file format)
- Michigan Care Improvement Registry (MCIR)

Supplemental data must provide the date the service was performed (rather than the date a test or result was reviewed with the patient). All supplemental (provider-reported) data is subject to audit.

The supplemental data submission deadline for the 2024 program year is Jan. 31, 2025.

Submit exclusions and more to our HEDIS team

You can submit medical record documentation directly to our HEDIS team for:

- **Measure denominator exclusions** (i.e., bilateral mastectomy, radical or total hysterectomy)
- **Certain measures to close gaps in care**, when all other gap closure measures have been exhausted (see our HEDIS Provider Reference Guide for details)

Ensure that...

- ✓ The patient's name and date of birth are on **every page** of the progress notes and lab results
- ✓ The physician, physician assistant or nurse practitioner has signed the progress notes **after each visit**

Where to send medical records

Email
HEDIS@priorityhealth.com

Fax
616.975.8897

Mail
1231 E. Beltline NE
Mail stop 1280
Grand Rapids, MI 49525

Electronic
Email to inquire

Note: There may be a delay with this reporting method. If we receive medical records before the last day of the previous month and approve them, compliant data will appear in your next monthly PIP reports.

Target rationale

Commercial targets for our HEDIS measures are based on HEDIS MY 2022 national performance at the 75th and 90th percentiles. Medicare 5-Star measure targets are based on Medicare 5 Star cut points. Medicaid HEDIS measure targets are set based on HEDIS MY 2022 Michigan performance at the 75th and 90th percentiles.

Uploading data & reporting schedule*

- **Data feeds (HL7/APS format)**: Data received and processed by the end of the month will be reflected in the following month's reporting.
- **Release of PIP Filemart reports**: Reports are released on or around the 15th of each month and include data received through the end of the previous month. Filemart reports will be available at the ACN-level only.
- **MCIR data** is typically received from the state between the 23rd and 25th of the month. Immunization values, dates or counts are updated on the Monday following the receipt of the MCIR file.
- **MiHIN APS files** are delivered from MiHIN to Priority Health monthly.

** These timelines assume all systems are refreshing properly and timely manner. Technical issues may result in delays.*

Incentive details

Focus measures and payment

In 2024, we'll provide an estimated pre-payment for the following measures:

- Controlling High Blood Pressure (CBP)
- Diabetes Care: HbA1c ≤ 9.0% (HBD)
- Well Child Visits 3-11 years (WCV)
- Well Child Visits 0-15 months (W30)

Regardless of performance, we won't take pre-paid dollars back from your ACN.

The prepayment will be made based on a snapshot of your ACNs population in these measures (denominator) in the first quarter of 2024 (ASO/PPO population will be excluded from denominator), as reported through PRA attestation.

You'll receive quarterly pre-payments based on 75% of the estimated denominator at the 75th percentile rate noted below.

Measure	2024 75th percentile award	2024 90th percentile award
Controlling High Blood Pressure (CBP)	TBD	TBD
Diabetes Care: HbA1c ≤ 9.0% (HBD)	TBD	TBD
Well Child 3-11 years (WCV)	TBD	TBD
Well Child 0-15 Months (W30)	TBD	TBD

At year-end settlement, we'll review your ACN's actual population and performance for these measures and pay any additional dollars earned.

What does this look like?

Say Best ACN Ever has 1,000 members in its denominator for HbA1c ≤ 9% in a snapshot taken during the 1st quarter of 2024. The ACN would receive the following pre-payments at 75% of the denominator:

- **Q1:** (750 members * $75) / 4 = $14,062.50
- **Q2:** (750 members * $75) / 4 = $14,062.50
- **Q3:** (750 members * $75) / 4 = $14,062.50
- **Q4:** (750 members * $75) / 4 = $14,062.50

By the end of 2024, Best ACN Ever achieves the 75th percentile for HbA1c ≤ 9% for their performance. Here's how their settlement would work:

- **Focus measure pre-payments:** 750 members * $75 = $56,250
- **Focus measure settlement:** 800 members (numerator) * $75 = $60,000
- **Payment at year-end settlement:** $60,000 (earned) - $56,250 (pre-paid) = $3,750 award at settlement

Transformation of Care measures

Care management

One of the primary goals of Priority Health's PIP program is to encourage appropriate care management and disease management of members with complex health care needs.

Program requirements:

- The care management program is built on the team-based model.
- Care management outreach to Priority Health members is based on a provider registry or EMR used for risk stratification or Priority Health population segmentation reports to identify patients for care management.
- The ACN supports integration with the Priority Health care management team. Integration is defined as communication, as needed, between Priority Health and point-of-care care managers to coordinate care.
- ACN must have a physician champion for their care management program.

ACNs may be audited to confirm measure compliance.

Priority Health recommends the Agency for Healthcare Research and Quality (AHRQ) and Case Management Society of America (CMSA) as resources to learn more about care management.

To be eligible for this incentive, ACNs must complete these components:

1 PCMH designation

PCPs must be practicing at a Patient Centered Medical Home (PCMH) designated practice in the program year to participate. This designation must be reported by the ACN in the PRA tool at any time during the program year. We honor the following designation programs: BCBSM, NCQA, URAC and Joint Commission.

PCMH designation status is a field in our PRA tool. We don't accept any other method for PCMH designation reporting.

If an ACN doesn't report in the PRA tool that a PCP is part of a PCMH-designated practice, we'll remove them from this measure (both numerator and denominator) at year-end settlement.

2 Care managers must be a trained QHP

QHP Licensure

Care managers must have qualified health professional (QHP) licensure. This requirement aligns with licensure required to bill care management codes and includes:

- Registered Nurse (RN)
- Nurse Practitioner (NP)

- Physician Assistant (PA)
- Licensed Master Social Worker (LMSW)
- Certified Diabetes Educator (CDE)
- Asthma Educator-Certified (AE-C)
- Pharmacist
- Respiratory Therapist (RT)
- Registered Dietician (RD)
- Registered Dietitian Nutritionist, Master's Level in Nutrition

Initial training for care managers

Priority Health requires all QHPs working as care managers to complete care management training under a recognized training program. Care managers must be trained within six months of providing and billing for care management services.

Initial training examples include:

- Case Management Society of America
- Health Services Institute
- Learning Action Network
- Michigan Center for Clinical System Improvement (MICCSI)
- Practice Transformation Institute
- State Innovation Model (SIM)
- MiCMRC Complex Care Management Course (prior to Jun. 30, 2020)
- Collaborative Care Model (provided by MICMT endorsed ACN trainer)
- Introduction to Team-Based Care (provided by MICMT endorsed ACN trainer)

Note: *MiCMRC PDCM* online course provides insufficient training for care management. This training won't satisfy the recognized training requirement.

Continuing education

Care managers must fulfill annual continuing education requirements. Beyond the initial training requirement for first year care managers, each care manager must document at least 8 hours of continuing education during the measurement year to qualify for the care management incentive.

Priority Health reserves the right to audit the credentials and education documentation (initial and continuing) for care managers providing care management services to Priority Health members.

3 Claims

ACNs must meet or exceed a 2% target of unique Priority Health members receiving care management services. This is a combined target for all active members assigned or attributed to the ACN.

Members need only be active on the date care management services are provided.

In order for a member to count towards the care management measure for the current measurement year, the member must have at least two care management interactions on different dates of service. Multiple claims billed on the same date of service will only count once towards the two billed care management claims per unique member requirement.

Claims with the following HCPCS and CPT codes will serve to identify members that have received care management services and will count toward the 2% target.

Code	Description
G0511	Care coordination services and payment for RHCs and FQHCs only
G9001	Coordinated care fee
G9002	Coordinated care fee
G9007	Coordinated care fee scheduled team conference
G9008	Coordinated care fee, physician coordinated care overnight services
99484	General behavioral health integration
99487	Complex chronic care management services
99490	Chronic care management services
99495	Transitional care management services
99496	Transitional care management services
98966	Non-face-to-face non-physician telephone services
98967	Non-face-to-face non-physician telephone services
98968	Non-face-to-face non-physician telephone services
98961	Education/training for patient self-management **(New)**
98962	Education/training for patient self-management **(New)**
S0257	End of life counseling **(New)**
99497	Advanced care planning **(New)**
99498	Advanced care planning **(New)**

Additional billing information can be found on our Provider Manual's Care Management page.

The Care Management measure score will be rounded to the tenth place. For instance, if an ACN scores 2.57, it will be rounded to 2.6.

4 Quality metric performance by product

ACNs must meet or exceed 90th percentile targets in three preventive health and/or chronic disease measures by product.

Care management measurement

Numerator

Two billed care management claims on different dates of service in current program year per unique member

Denominator

ACN assigned/attributed member months for current program year divided by 12

Level of measure

ACN

Product line

HMO/POS, ASO/PPO, Medicare, Medicaid

Method of measurement

Claims with dates of service in the program year and meeting or exceeding targets on quality measures.

Payout methodology

Payment for the care management measure is based on the illness burden of the Priority Health membership for the ACN. Each ACN will be assigned a unique standard per member per month (PMPM) payment value.

Membership is assigned to 4 risk quartiles. Risk scores are compiled at the ACN level, and average standard PMPMs are calculated for each ACN.

Notes

- ✓ The assigned or attributed PCP of the member on the date of the care management service will get the credit.
- ✓ Two or more touchpoints must be completed while the member is assigned/attributed to the same ACN's PCPs in the program year.
- ✓ Care management touch points stay with the assigned / attributed PCP at the time of the care management visit. If a PCP changes from one ACN to another ACN, that PCP's care management touchpoints move with them to the new ACN. If a PCP leaves the network, the PCP's care management touchpoints won't count.

Social Determinants of Health (SDoH) Screening

According to the Centers for Disease Control, social determinants of health (SDoH) are conditions in the places where people live, learn, work and play that affect a wide range of health and quality-of-life risks and outcomes. We provide an incentive to ACNs that screen for social care needs.

To be eligible for this incentive, ACNs must complete these components:

1 PCMH designation

PCPs must be practicing at a Patient Centered Medical Home (PCMH) designated practice in the program year to participate. This designation must be reported by the ACN in the PRA tool at any time during the program year. We honor the following designation programs: BCBSM, NCQA, URAC and Joint Commission.

PCMH designation status is a field in our PRA tool. We don't accept any other method for PCMH designation reporting.

If an ACN doesn't report in the PRA tool that a PCP is part of a PCMH-designated practice, we'll remove them from this measure (both numerator and denominator) at year-end settlement.

2 Screen members for SDoH

PCMH PCPs must use a comprehensive tool to screen patients for the presence of social care needs/SDoH. The tool should, at minimum, screen for the following areas:

- Access to food
- Housing
- Transportation

A screening compliance of 70% of the ACNs eligible population (identified by at least one E&M office visit code billed) is required for payout. Screening compliance is based exclusively on claims identifying the following codes:

- **G9920**: Screening Performed and Negative
- **G9919**: Screening Performed and Positive and Provision of Recommendations

SDoH screening measurement

Numerator: Patient from the denominator with at least one of the following codes reported in the calendar year:

- **G9920**: Screening Performed and Negative, or
- **G9919**: Screening Performed and Positive and Provision of Recommendations

Denominator: The eligible population includes all patients with at least one visit with a PCP in the measurement year.

Code type	Codes
CPT	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99441, 99448, 99443, 99444, 99484, 99487, 99488, 99489, 99490, 99492, 99493, 99494, 99495, 99496
HCPCS	G0402, G0406, G0407, G0408, G0438, G0439, G0463, G0511, G0512, G2214, G9001, G9002, T1015
Rev Codes	0500, 0509, 0510, 0514, 0517, 0519, 0520, 0521, 0522, 0523, 0524, 0525, 0528, 0529, 0770
Place of Service (POS) Codes	2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 19, 22, 50, 71, 72, OV
UB Facility Type ID	7

SDoH screening measure details

Product lines	Target / Payout	Eligible population
• Medicare • Medicaid	Medicare: 70% / $x.xx pmpm Medicaid: 70% / $x.xx pmpm	If the target is achieved, the payment will apply to the ACN's entire membership and paid on a pmpm basis.
Payout frequency	**Level of measurement**	**Collecting & reporting method**
Annual (June 2025)	ACN	Claims data only. No supplemental data accepted.

Screening tools:

The comprehensive screening tools* listed below are part of the HEDIS Social Needs Screening (SNS-e) measure. ACNs are free to use any screening tool they choose, as long as they address the areas listed under "2: Screen Members for SDoH above.

Some of these tools are proprietary. There may be a cost or licensing requirement associated with access and use.

- Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool
- American Academy of Family Physicians (AAFP) Social Needs Screening Tool
- Health Leads Screening Panel
- Hunger Vital Sign (HVS)
- Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]
- Safe Environment for Every Kid (SEEK)
- U.S. Household Food Security Survey [U.S. FSS]
- U.S. Adult Food Security Survey [U.S. FSS]
- U.S. Child Food Security Survey [U.S. FSS]
- U.S. Household Food Security Survey–Six-Item Short Form [U.S. FSS]
- We Care Survey
- WellRx Questionnaire
- Children's Health Watch Housing Stability Vital Signs™[1]
- Comprehensive Universal Behavior Screen (CUBS)
- PROMIS®[1]

Important notes:

- ✓ Payouts to the network won't exceed Priority Health's budgeted amount for this measure.
- ✓ Medicare and Medicaid populations will be scored separately.
- ✓ The SDoH measure score will be rounded to a whole number. For instance, if an ACN scores 66.7%, it will be rounded to 67%.
- ✓ Credit for screening will be given to the PCP billing the screening code.
- ✓ Supplemental data isn't accepted for this measure.

Resources:

Priority Health Connect is an online platform designed to connect individuals in the community with free and reduced-cost programs and critical social services. All our members can now connect themselves to resources at no cost by using Priority Health Connect.

Additional resources:

- Social Determinants of Health (AMA EdHub)

Social Determinants of Health (SDoH) z-code reporting

According to the Centers for Disease Control, social determinants of health (SDoH) are conditions in the places where people live, learn, work and play that affect a wide range of health and quality-of-life risks and outcomes. We provide an incentive to ACNs that submit z-codes for identified social care needs.

To be eligible for this incentive, ACNs must complete these components:

1 PCMH designation

PCPs must be practicing at a Patient Centered Medical Home (PCMH) designated practice in the program year to participate. This designation must be reported by the ACN in the PRA tool at any time during the program year. We honor the following designation programs: BCBSM, NCQA, URAC and Joint Commission.

PCMH designation status is a field in our PRA tool. We don't accept any other method for PCMH designation reporting.

If an ACN doesn't report in the PRA tool that a PCP is part of a PCMH-designated practice, we'll remove them from this measure (both numerator and denominator) at year-end settlement.

2 Report findings of positive screening

PCMH PCPs must use a comprehensive tool to screen patients for the presence of social care needs / SDoH. The tool should, at minimum, screen for the following areas:

- Access to food
- Housing
- Transportation

ACNs must provide at least one z-code on at least 5% of unique members seen (identified by at least one E&M office visit code billed) during the measurement year.

SDoH z-code reporting measurement

Numerator: Patient from the denominator with at least one of the following z-codes reported in the calendar year:

Positive screening z-codes *Indicate a social care need / SDoH was identified*	
Code type	**Codes**
ICD-10	Z55, Z55.0, Z55.1, Z55.2, Z55.3, Z55.4, Z55.5, Z55.6, Z55.8, Z55.9, Z56, Z56.0, Z56.1, Z56.2, Z56.3, Z56.4, Z56.5, Z56.6, Z56.8, Z56.81, Z56.82, Z56.89, Z56.9, Z57, Z57.0, Z57.1, Z57.2, Z57.3, Z57.31, Z57.39, Z57.4, Z57.5, Z57.6, Z57.7, Z57.8, Z57.9, Z58, Z58.6, Z58.8, Z58.81, Z58.89, Z59, Z59.0, Z59.00, Z59.01, Z59.10, Z59.11, Z59.12, z59.19, Z59.02, Z59.1, Z59.2, Z59.3, Z59.4, Z59.41, Z59.48, Z59.5, Z59.6, Z59.7, Z59.8, Z59.81, Z59.81, Z59.811, Z59.812, Z59.819, Z59.82, Z59.86, Z59.87, Z59.89, Z59.9, Z60, Z60.0, Z60.2, Z60.3, Z60.4, Z60.5, Z60.8, Z60.9, Z62, Z62.0, Z62.1, Z62.2, Z62.21, Z62.22, Z62.23, Z62.24, Z62.29, Z62.3, Z62.6, Z62.8, Z62.81, Z62.810, Z62.811, Z62.812, Z62.813, Z62.814, Z62.815, Z62.819, Z62.82, Z62.820, Z62.821, Z62.822, Z62.823, Z62.83, Z62.831, Z62.832, Z62.833, Z62.89, Z62.890, Z62.891, Z62.892, Z62.898, Z62.9, Z63, Z63.0, Z63.1, Z63.3, Z63.31, Z63.32, Z63.4, Z63.5, Z63.6, Z63.7, Z63.71, Z63.72, Z63.79, Z63.8, Z63.9, Z64, Z64.0, Z64.1, Z64.4, Z65, Z65.0, Z65.1, Z65.2, Z65.3, Z65.4, Z65.5, Z65.8, Z65.9

Denominator: The eligible population includes all patients with at least one visit with a PCP in the measurement year.

Code type	**Codes**
CPT	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99441, 99448, 99443, 99444, 99484, 99487, 99488, 99489, 99490, 99492, 99493, 99494, 99495, 99496
HCPCS	G0402, G0406, G0407, G0408, G0438, G0439, G0463, G0511, G0512, G2214, G9001, G9002, T1015
Rev Codes	0500, 0509, 0510, 0514, 0517, 0519, 0520, 0521, 0522, 0523, 0524, 0525, 0528, 0529, 0770
Place of Service (POS) Codes	2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 19, 22, 50, 71, 72, OV
UB Facility Type ID	7

SDoH measure details

Product lines	Target / Payout	Eligible population
• Medicare • Medicaid	Medicare: 5% / $x.xx pmpm Medicaid: 5% / $x.xx pmpm	If the target is achieved, the payment will apply to the ACN's entire membership and paid on a pmpm basis.
Payout frequency	**Level of measurement**	**Collecting & reporting method**
Annual (June 2025)	ACN	Claims data only. No supplemental data accepted.

Screening tools:

The comprehensive screening tools* listed below are part of the HEDIS Social Needs Screening (SNS-e) measure. ACNs are free to use any screening tool they choose, as long as they address the areas listed under "2: Screen Members for SDoH above.

Some of these tools are proprietary. There may be a cost or licensing requirement associated with access and use.

- Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool
- American Academy of Family Physicians (AAFP) Social Needs Screening Tool
- Health Leads Screening Panel
- Hunger Vital Sign (HVS)
- Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]
- Safe Environment for Every Kid (SEEK)
- U.S. Household Food Security Survey [U.S. FSS]
- U.S. Adult Food Security Survey [U.S. FSS]
- U.S. Child Food Security Survey [U.S. FSS]
- U.S. Household Food Security Survey–Six-Item Short Form [U.S. FSS]
- We Care Survey
- WellRx Questionnaire
- Children's Health Watch Housing Stability Vital Signs™[1]
- Comprehensive Universal Behavior Screen (CUBS)
- PROMIS®[1]

Important notes:

- ✓ Payouts to the network won't exceed Priority Health's budgeted amount for this measure.
- ✓ Medicare and Medicaid populations will be scored separately.
- ✓ The SDoH z-code measure score will be rounded to the tenth place. For instance, if an ACN scores 2.57, it will be rounded to 2.6.
- ✓ Supplemental data isn't accepted for this measure.
- ✓ An approved z-code billed on any professional or institutional claim will count toward the numerator for component 2.

Resources:
Priority Health Connect is an online platform designed to connect individuals in the community with free and reduced-cost programs and critical social services. All our members can now connect themselves to resources at no cost by using Priority Health Connect.

Additional resources:

- Social Determinants of Health (AMA EdHub)
- Z-Codes infographic (CMS)
- Resource on ICD-10-CM Coding for Social Determinants of Health (American Health Association)

Behavioral Health Collaborative Care (BHCC)

The Behavioral Health Collaborative Care (BHCC) model is an evidence-based care approach to integrating behavioral health into primary care based on a program developed by the University of Washington AIMS Center. The BHCC model supports the interaction of the behavioral health care manager, the PCP and the psychiatric consultant. Patients are first evaluated for moderate to severe depression or anxiety through use of an approved screening tool.

To be eligible for this incentive, ACNs must complete these components:

1 PCMH designation

PCPs must be practicing at a Patient Centered Medical Home (PCMH) designated practice in the program year to participate. This designation must be reported by the ACN in the PRA tool at any time during the program year. We honor the following designation programs: BCBSM, NCQA, URAC and Joint Commission.

PCMH designation status is a field in our PRA tool. We don't accept any other method for PCMH designation reporting.

If an ACN doesn't report in the PRA tool that a PCP is part of a PCMH-designated practice, we'll remove them from this measure (both numerator and denominator) at year-end settlement.

2 Provide BHCC services

We'll pay a $100 incentive per approved CPT/HCPCS code billed for each member considered as actively receiving BHCC services from a PCP.

Members are considered actively receiving BHCC services when at least three approved BHCC CPT and/or HCPCS codes are billed and adjudicated within six consecutive months of the calendar year.

We won't accept supplemental data for this second component. You must report this through claims.

Code type	Codes
CPT	99492, 99493, 99494
HCPCS	G0512, G2214

BHCC measure details

Product lines	Target / Payout	Eligible population
• HMO / POS • ASO / PPO • Medicare • Medicaid	$100 per eligible claim	Patients 12 years of age and older with at least 3 BHCC services billed and adjudicated in six consecutive months in the calendar year.
Payout frequency	**Level of measurement**	**Collecting & reporting method**
Annual (June 2025)	ACN	Claims data only. No supplemental data accepted.

Important notes:

- ✓ Payouts to the network won't exceed Priority Health's budgeted amount for this measure.
- ✓ PCP that billed the BHCC code(s) will be rewarded the incentive at year end settlement (not attributed PCP).
- ✓ Multiple BHCC claims billed in the same month will only count once per unique member.

Resources:

- Summary of the collaborative care model (APA video)
- MI-CCSI Upcoming Training Events
- MCCIST Collaborative Care
- Collaborative Care (University of Washington AIMS Center)
- Registry Tools (University of Washington AIMS Center)
- APA CoCare online course
- Behavioral Health Integration Services (CMS)
- Behavioral Health Integration Billing FAQ (CMS)
- myStrength member tool (Priority Health)
- The Collaborative Care Model (Medicaid.gov)
- When to report new behavioral health integration code (American Academy of Pediatrics)
- Best Practices for Systematic Case Review in Collaborative Care (Psychiatry Online)

Health Information Exchange Participation with MiHIN

ACNs must have active participation (file exchange in at least 8 of 12 months) in at least five of the following MiHIN use cases by December 1 of the program year:

- Admission, Discharge, Transfer (ADT)
- Active Care Relations Services (ACRS)
- Exchange C-CDA (formerly Medication Reconciliation)
- Quality Measure Information (QMI)
- Health Provider Directory (HPD)
- Common Key Service (CKS)
- Social Determinants of Health (SDoH)

Product lines	Target / Payout	Eligible population
• HMO / POS • ASO / PPO • Medicare • Medicaid	$0.05 pmpm	All attributed members on December 31 of the program year.
Payout frequency	**Level of measurement**	**Collecting & reporting method**
Annual (June 2025)	ACN	MiHIN use case participation report.

Important notes:
MiHIN will provide us a list of eligible ACNs annually. No attestation is required.

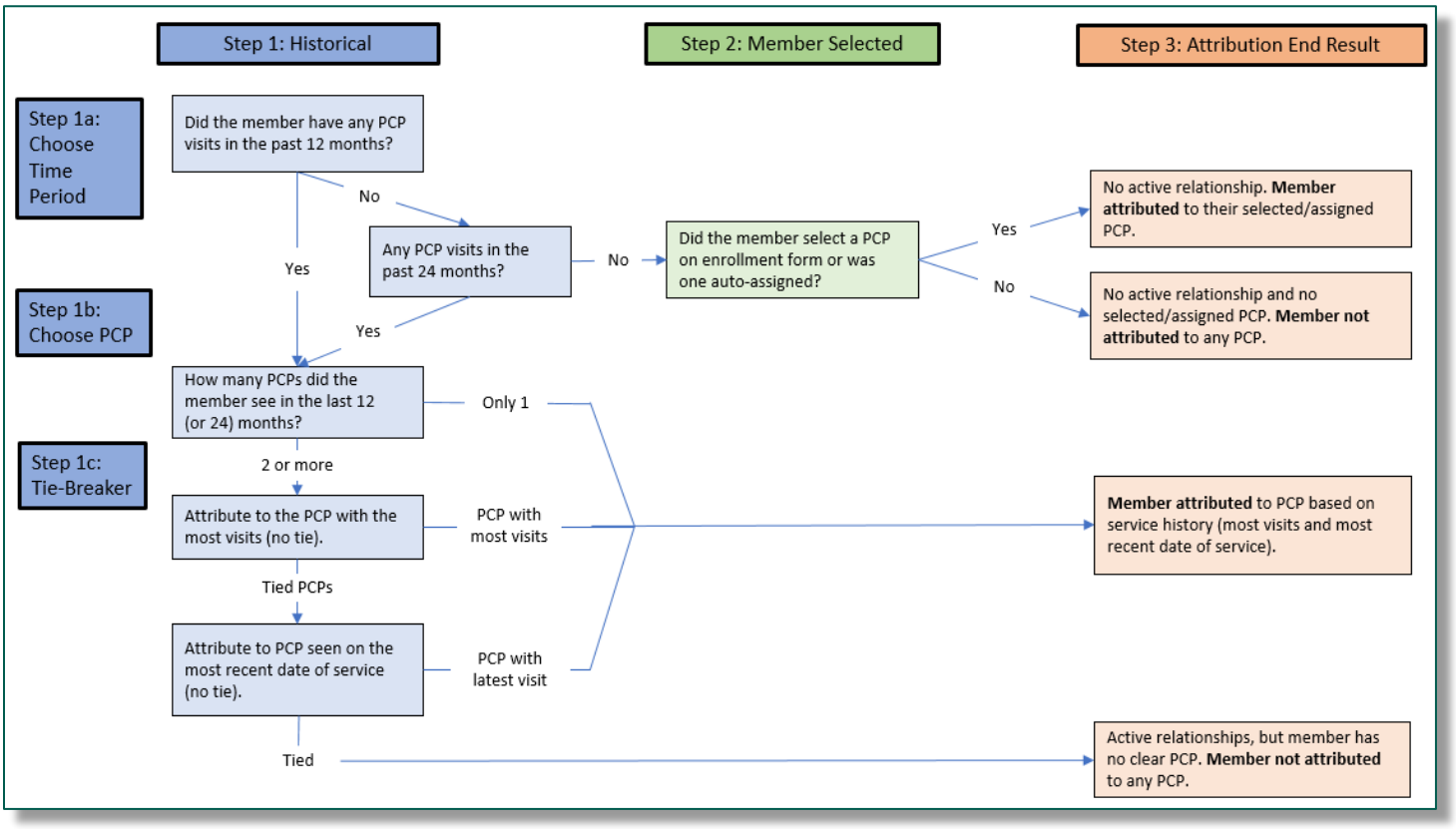
Resources:
To learn more about participating in a use case with MiHIN, email *help@mihin.org*.

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 to ensure that members enrolled in all health plans may be included in our PIP program. The PIP 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 PIP attribution model

PCP: We define a 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 Provided-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: Guidelines for reporting care gap closure

There are several data sources used to provide complete information about the quality of services delivered to our members.

To support our Digital *First* Strategy, which limits the burden of manual processes and costly medical record chasing, you must submit data for measure care gap closure through any of the following electronic/administrative methods:

1. Electronic health record (EHR)
2. Health information exchange (HIE) / clinical registry
3. Administrative (claims which include CPT II codes)
4. Medical record review using the HEDIS fax /email / mail with accompany medical record, which should be used when there is no electronic option to share the data (see page 11 of this manual for details).

We're here to help.

Do you need support transitioning from Patient Profile and/or the PIP_70 report to the data sources detailed here?

Our teams are here to help.

Contact your ACN's Provider Strategy & Solutions Consultant to get started.

We'll work with you to establish an electronic data feed (HL7 / APS), support you in making full use of CPT II codes and more.

Data audits

As part of our PIP program, we strive to ensure data accuracy. Data audits are an essential part of the process and maintain the integrity of Priority Health and our HEDIS accreditation.

Data source file feeds – such as EMR or patient registry data exchange feeds (i.e., HL7 / APS file format, Epic Payer Platform) – are subject to audit until our internal HEDIS auditor approves the data. This audit process could continue for years after the source is in place.

Audit process

During the annual HEDIS audit, the HEDIS auditor will conduct an inventory of the supplemental data sources. The auditor will determine if a source requires further investigation.

- **Standard supplemental data** are electronically generated files that come from service providers (providers who rendered the service).
- **Nonstandard supplemental data** is data used to capture missing service data not received through administrative sources (claims or encounters) or in the standard electronically generated files. Nonstandard data may be collected from sources on an irregular basis and could be in files or formats that aren't stable over time.

If the HEDIS auditor categorizes the supplemental data source as nonstandard, primary source validation (PSV) is required.

Primary Source Validation (PSV)

PSV is an audit where the health plan provides the HEDIS auditor with all the data points per supplemental data source that have been ingested by the HEDIS database and used for compliance. The HEDIS auditor will select a sample of those data points and require the health plan to provide proof-of-service documentation from the legal health record. The proof-of-service documentation must match the HEDIS database to pass PSV.

Supplemental data sources that don't pass all audit validation steps by the deadline can't be used to calculate HEDIS rates.

Priority Health reserves the right to request medical records to validate direct data feeds and remain compliant with NCQA standards.

Audit findings

Failure to return medical record documentation by the deadline will result in a 50% penalty for the program year's PIP payout.

Egregious errors may result in additional sanctions against the ACN.

Appendix 3: Glossary of terms

Accountable Care Network (ACN)
Recognized as a separate legal entity incorporated with an Employer Identification Number (EIN) that exists to bring together one or more group practices. In legal terms, it's recognized as a Clinically Integrated Network (CIN), a Physician Organization (PO) or a Physician Hospital Organization (PHO) that negotiates contracts on behalf of one or more group practices.

It's possible for a large primary care practice group or a multi-specialty practice group owned by a health system to be defined as an ACN by Priority Health.

We recognize ACNs through network agreements and hold an ACN entity accountable for executing and maintaining participation agreements with one or more group practices. We support ACNs in return for the ACN's work to manage the network, manage cost, gain efficiencies, distribute surplus dollars, take accountability for Advanced Health Assessment risk adjustment performance and improve quality through available incentives or value-based programs.

CMS
Centers for Medicare & Medicaid Services (CMS), the federal regulator of Medicare and Medicaid.

CMS cut points
The clustering algorithm identifies the "gaps" among the scores and creates four cut points resulting in the creation of five levels (one for each Star Rating). Star Rating levels 1 through 5 are assigned with 1 being the worst and 5 being the best.

Digital *First*
Assisting our ACN partners with implementing standardized data feeds for Priority Health is our top priority. This implementation replaces manual, nonstandard data delivery for quality gap closure. Digital *First* leverages technological assets that exist within ACN cultures.

1. **Prepare** for NCQA's ECDS roadmap
2. **Retire** nonstandard data practices (Report #70, Patient Profile)
3. **Assist** ACNs with implementing standardized data feeds to Priority Health
4. **Enhance** data confirmation reporting (HL7, MiHIN)

Electronic Clinical Data Systems (ECDS)
The National Committee for Quality Assurance (NCQA) defines Electronic Clinical Data Systems (ECDS) as a network of data containing a plan member's personal health information and records of their experiences within the health-care system. The HEDIS ECDS Reporting Standard provides health

plans a method to collect and report structured electronic clinical data for HEDIS quality measurement and quality improvement.

Filemart

A Priority Health application within our website's provider center, **prism**. Filemart is the application through which we deliver your standard incentive program and membership reports. A list of Filemart reports is included in the Filemart Inventory section of this manual.

HEDIS

NCQA developed and maintains the Healthcare Effectiveness Data and Information Set (HEDIS). It's one of the most widely used performance measure sets in managed care.

NCQA and CMS require health plans to conduct HEDIS reporting. They use this reporting for health plan accreditation, Star Ratings and regulatory compliance.

We collect HEDIS data through a combination of claims data, medical record audits and member surveys. This data provides information on customer satisfaction, specific health care measures and structural components that ensure quality of care.

HEDIS Provider Reference Guide

This is a comprehensive guide to help you better understand HEDIS and CMS Medicare 5-Star measures and their impact on your patients, your primary care providers and our health plan. The guide provides specific billing codes and medical record documentation tips to help ensure measure compliance.

MCIR

The Michigan Care Improvement Registry (MCIR) is an electronic immunization registry and is available to private and public providers for maintenance of immunization records for all citizens in the state of Michigan.

MCIR calculates a patient's age, provides an immunization history and determines which immunizations may be due. We receive monthly data downloads from the Michigan Department of Community Health (MDCH) and display this data within monthly reports.

Measurement Year

Unless stated otherwise within the measure description, the measurement year is January 1 through December 31. We use data from this 12-month time frame to score and settle PIP measures.

Medicaid

This includes members under Children's Special Health Care Services, the Healthy Michigan Plan and MIChild.

Medicare Star Rating Program
CMS uses a five-star quality rating system to measure the experiences Medicare beneficiaries have with their health plan and health care system. This is the Star Rating Program. Health plans are rated on a scale of 1 to 5 stars, with 5 being the highest. These ratings are then published for consumers to gauge a plan's quality rating, ease of access to care, provider and health plan experience and satisfaction.

Member Attribution
The member to PCP attribution model algorithm is available in Appendix 1 of this manual. This model aligns with industry standards and is used for this incentive program. We run attribution monthly and include it in PIP reporting.

MiHIN
The Michigan Health Information Network (MiHIN) is a public-private nonprofit collaboration dedicated to improving the health care experience, improving quality and decreasing cost for Michigan's people by supporting the statewide exchange of health information.

Participating PCP
A primary care provider (PCP) that's credentialed by and contracted with Priority Health to provide covered services to a member. PCPs must be claimed by an ACN using the Provider Roster Application (PRA) tool to be eligible for PIP payments.

PMM
Per member meeting measure.

PMPM
Per member per month (PMPM), identifies one member enrolled in the health plan for one month.

Provider Roster Application (PRA)
A tool where ACNs actively manage contracted primary care provider information simply and effectively for their participation in our value-based programs. This includes our PCP Incentive Program (PIP) and our Advanced Payment Model (APM) Risk Arrangements.

Appendix 4: CPT® II Codes

CPT II codes are **supplemental tracking codes that can be used for performance measurement**. The use of CPT II codes for HEDIS performance measures will decrease the need for record abstraction and chart review, and thereby minimize administrative burdens on physicians and other health care professionals.

They describe:

- ✓ Clinical components, such as those typically included in evaluation, management, or other clinical services,
- ✓ Results from clinical laboratory or radiology tests and other procedures; or
- ✓ Identified processes intended to address patient safety practices

Benefits of using CPT II codes

1. **Fewer medical record requests**
   When you add CPT II codes, we won't have to request charts from your office to confirm care you've already completed.

2. **Enhanced performance**
   With better information, we can work with you to help identify opportunities to improve patient care. This may lead to better performance on HEDIS measures for your ACN.

3. **Improved health outcomes**
   With more precise data, we can direct members to our programs that may be appropriate for their health situation to help support your plan of care.

4. **Less mail for members**
   With more complete information, we can avoid sending reminders to patients to get screenings they may have already completed.

The following table lists the HEDIS quality measure, indicator description and the CPT II codes that are recognized in the HEDIS specifications. Yellow highlight indicates a PIP measure.

Quality measure	Indicator description	CPT II code	CPT II description
Care for Older Adults	Advance Care Planning	1123F	Advance Care Planning discussed and documented advance care plan or surrogate decision maker documented in the medical record
		1124F	Advance Care Planning discussed and documented in the medical record, patient did not wish or was not able to name a surrogate decision

Quality measure	Indicator description	CPT II code	CPT II description
			maker or provide an advance care plan
		1157F	Advance care plan or similar legal document present in the medical record
		1158F	Advance care planning discussion documented in the medical record
	Functional Status Assessment	1170F	Functional status assessed
	Medication List	1159F	Medication list documented in medical record (must be billed with CPT II 1160F)
	Medication Review	1160F	Review of all medications by a prescribing practitioner or clinical pharmacist (such as, prescriptions, OTCs, herbal therapies, and supplements) documented in the medical record
	Pain Assessment	1125F	Pain severity quantified; pain present
		1126F	Pain severity quantified; no pain present
Controlling High Blood Pressure	Blood Pressure Control	3078F	Diastolic less than 80
		3079F	Diastolic between 80-89
		3080F	Diastolic greater than/equal to 90
		3074F	Systolic less than 130
		3075F	Systolic between 130-139
		3077F	Systolic greater than/equal to 140
Diabetes Care	Blood Pressure Control	3078F	Diastolic less than 80
		3079F	Diastolic between 80-89
		3080F	Diastolic greater than/equal to 90
		3074F	Systolic less than 130
		3075F	Systolic between 130-139
		3077F	Systolic greater than/equal to 140
	Hemoglobin A1c Control	3044F	HbA1c level less than 7.0%
		3051F	HbA1c level greater than or equal to 7.0% and less than 8.0%
		3052F	HbA1c level greater than or equal to 8.0% and less than or equal to 9.0%
		3046F	HbA1c greater than or equal to 9.0%
	Eye Exam with Evidence of Retinopathy	2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy
		2024F	7 standard field stereoscopic retinal photos with

The Controlling High Blood Pressure and Diabetes Care CPT II codes in this table will close gaps in care for the PIP program.

Quality measure	Indicator description	CPT II code	CPT II description
			interpretation by an ophthalmologist or optometrist documented and reviewed: with evidence of retinopathy
		2026F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy
	Eye Exam without Evidence of Retinopathy	2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
		2025F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
		2033F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy
		3072F	Low risk for retinopathy (no evidence of retinopathy in the prior year
Prenatal and Postpartum Care	Prenatal Visit	0500F	Initial prenatal care visit
		0501F	Prenatal flow sheet documented in medical record by first prenatal visit (documentation includes at minimum blood pressure, weight, urine protein, uterine size, fetal heart tones, and estimated date of delivery).
		0502F	Subsequent prenatal care visit
	Postpartum Visit	0503F	Postpartum care visit
Transition of Care	Medication Reconciliation Post-Discharge	1111F	Discharge medications reconciled with the current medication list in outpatient medical record

Appendix 5: Report inventory

Filemart reports

Report name	Report ID	Report detail
ACN HEDIS Report Card by Physician (TAB)	PIP_002C	Identifies performance for quality measures incentivized in the 2024 program year, by measure at the ACN level compared to the 90th percentile target. *PRA Group and Subgroup included.*
ACN HEDIS Report Card (TAB)	PIP_006B	Identifies performance for all HEDIS measures, by measure at the ACN level. *PRA Group and Subgroup NOT included.*
PCP Panel Status (TAB)	PIP_007	Identifies open and closed panel status by month, by product, by PCP. *PRA Group and Subgroup included.*
HEDIS Gaps in Care (TAB)	PIP_011C	Identifies member level detail by PCP, by product, by measure and gap closure indicator as well as the data source description and compliant date when available. *PRA Group and Subgroup included.*
PIP Diabetes Lab Result Worksheet (TAB)	PIP_011G	Identifies member level detail by PCP, by product, for members identified with diabetes. Includes last HbA1c lab date, value and source. *PRA Group and Subgroup included.*
PIP Hypertension Worksheet (TAB)	PIP_011H	Identifies member level detail by PCP, by product, for members identified with Hypertension. Includes last blood pressure date, BP result value and source and last office visit date. *PRA Group and Subgroup included.*
PIP Gaps in Care Immunizations (TAB)	PIP_011I	Includes member level detail for members who are in the incentivized immunization measures, by PCP, by product. Includes immunization status by required immunization series. *PRA Group and Subgroup included.*
Healthy Michigan Lab (TAB)	PIP_012	This is an incentive managed outside of PIP. Applicable to Healthy Michigan Medicaid member level data with HRA data, completion status and type of form submission. *PRA Group and Subgroup included.*

PIP Care Management (TAB)	PIP_013_TAB	Includes member level detail for members who've received a care management service by PCP, by product, including CM code and DOS. Includes an indicator for 2+ CM visits. *PRA Group and Subgroup included.*
PIP Care Management (PDF)	PIP_013_PDF	Includes member level detail for members who've received a care management service by PCP, by product, including CM code and DOS. *PRA Group and Subgroup NOT included in PDF.*
PIP SDoH (TAB)	PIP_014	Member level detail identifying members with billed SDoH z-code, by PCP, by product. Includes SDOH z-code, DOS. *PRA Group and Subgroup included.*
Quality Measure Opportunity Report (TAB)	PIP_015B	Identifies performance for quality measures incentivized in the 2024 program year, by measure, by product at the ACN level compared to the 90th percentile target. Includes earning opportunity detail. *PRA Group and Subgroup NOT included.*
BHCC (TAB)	PIP_017	Includes member level detail for members who've received a Behavioral Health Collaborative Care (BHCC) service by PCP, by product, including BHCC code and DOS. Includes an indicator for 3+ BHCC visits within 6 months. *PRA Group and Subgroup included.*
Member Eligibility (TAB)	PIP_075	Includes member level detail for all products with attributed PCP and member eligibility information. *PRA Group and Subgroup included.*
Membership Summary (TAB)	PIP_075A	Summary of member count by PCP, by product. *PRA Group and Subgroup included.*

Confirmation reports

MiHIN/HL7 confirmation reports

Your Provider Strategy & Solutions Consultant can send you this confirmation report monthly, upon request. It will include the following, as well as a message indicating a file wasn't received for this reporting period if applicable:

- HL7
- Disease Registry Extracts
- CCDA
- MiHIN PPQC data submission verification