Priority Health

FINAL MANUAL

2023 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 2023 PIP incentives**. In this manual, we show you how.

2023 program updates

We update our PCP Incentive Program (PIP) annually to reflect current health care trends. Our 2023 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 and/or the HEDIS Provider Reference Guide.

Administrative changes

2023 Revised Measures

- Behavioral Health Collaborative Care (BHCC)

Retired Measures

- Care for Older Adults (COA)
- Osteoporosis Management in Women Who had a Fracture (OMW)
- Diabetes care: Controlled HbA1c≤8.0% (HBD)

Administrative changes

- ACN-level reporting and settlement
- Chronic Disease Management Focus Measures pre-payment
- ACN eligibility
- Monthly attestation in our Provider Roster Application (PRA) tool
- Filemart reporting

2023 program measure grid

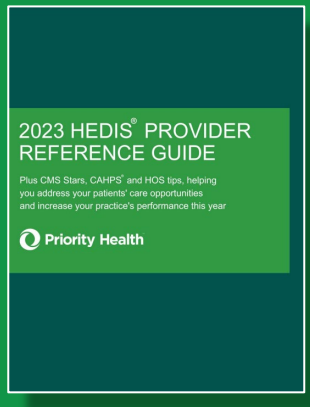
	90th percentile performance				75th percentile performance			
	Payout PMM (all products)	Commercial 90th percentile target	Medicare 90th percentile target	Medicaid 90th percentile target	Payout PMM (all products)	Commercial 75th percentile target	Medicare 75th percentile target	Medicaid 75th percentile target
HEDIS PREVENTIVE HEALTH PMM = per member meeting measure								
Lead Screening	$30			60%	$15			56%
Childhood Imms: Combo 3	$160	87%		61%	$80	84%		59%
Adolescent Immunizations	$100	44%		37%	$50	37%		34%
Well Child Visits: First 15 Months	$85	89%		68%	$43	85%		61%
Well Child Visits: 3-11 Years	$70	83%		61%	$35	75%		59%
Chlamydia Screening	$20			65%	$10			63%
Cervical Cancer Screenings	$20	80%		64%	$10	77%		59%
Breast Cancer Screening	$20	78%	80%	59%	$10	74%	77%	57%
Colorectal Cancer Screening	$20	72%	82%		$10	69%	78%	
HEDIS CHRONIC DISEASE MANAGEMENT Δ Chronic disease focus measure								
Hypertension: Controlled BP Δ	$130	73%	81%	79%	$75	67%	76%	65%
Diabetes Care: HbA1c≤9.0% Δ	$130	78%	87%	67%	$75	74%	84%	66%
Eye Exam for patients with Diabetes	$65	64%	83%	61%	$33	56%	79%	57%
Kidney Health Evaluation	$20	55%	62%	38%	$10	48%	52%	35%

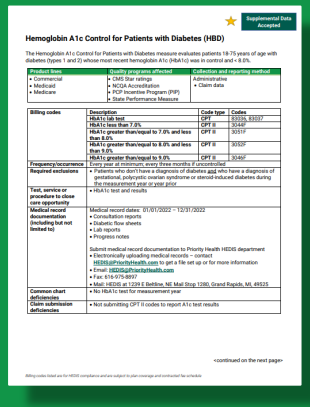
	5-Star Cut Point Performance		3-Star Cut Point Performance	
	Payout PMM	Medicare Cut Point Target	Payout PMM	Medicare Cut Point Target
MEDICARE 5-STAR CHRONIC DISEASE MANAGEMENT				
Statin Use for Patients w/Diabetes	$20	86%	$10	82%
Statin Therapy for Patients w/CVD	$20	89%	$10	81%
Medication Adherence – Diabetes	$20	92%	$10	85%
Medication Adherence – Hypertension	$20	91%	$10	86%
Medication Adherence – Cholesterol	$20	92%	$10	85%

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 by Jan. 1, 2023:

- ✓ **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 2023 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 ACN Requirements online (login required) for more information.

ACN payment rules

We'll make PIP payments directly to the participating ACN. These payments will 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

Starting in 2023, we'll require ACNs to attest to their providers in our PRA tool (login required) monthly. We'll use this monthly snapshot as our single source of truth to link PCPs to a PIP-participating ACN for their incentives and associated gaps in care reporting.

Cycle	Cycle Opens	Last Date to Attest (Cycle Closes)	Start Date	End Date
Dec	12/1/2022	12/15/2022	1/1/2023	1/31/2023
Jan	1/1/2023	1/16/2023	2/1/2023	2/28/2023
Feb	2/1/2023	2/15/2023	3/1/2023	3/31/2023
Mar	3/1/2023	3/15/2023	4/1/2023	4/30/2023
Apr	4/1/2023	4/17/2023	5/1/2023	5/31/2023
May	5/1/2023	5/15/2023	6/1/2023	6/30/2023
June	6/1/2023	6/15/2023	7/1/2023	7/31/2023
July	7/1/2023	7/17/2023	8/1/2023	8/31/2023
Aug	8/1/2023	8/15/2023	9/1/2023	9/30/2023
Sept	9/1/2023	9/15/2023	10/1/2023	10/31/2023
Oct	10/1/2023	10/16/2023	11/1/2023	11/20/2023
Nov	11/1/2023	11/15/2023	12/1/2023	12/31/2023
Dec	12/1/2023	12/15/2023	1/1/2024	1/31/2024

Therefore, ACNs must attest on behalf of their providers monthly. Failure to attest on a monthly basis 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.

What's new from an administrative perspective in 2023?

ACN-level reporting & settlement

We'll score performance and payout for incentives at the ACN-level (rather than the practice level). All reporting in Filemart will also be at the ACN level.

Chronic Disease Management pre-payment

Each quarter in 2023, your ACN will receive a guaranteed, estimated pre-payment for two measures based on a snapshot of your population (denominator) in the first quarter of 2023, reported through PRA attestation (ASO/PPO population will be excluded from denominator).

You'll receive quarterly pre-payments based on this estimate using the 75th percentile rate (see program measure grid).

ACN eligibility

An ACN must meet our eligibility requirements to participate in our PIP program.

Independent practitioners not affiliated with an eligible ACN won't be able to participate in our PIP program.

Monthly attestations

ACNs will need to attest to their PCP rosters monthly using our Provider Roster App (PRA) tool.

We'll match all ACN payments – including quarterly, ad hoc and year-end settlement – to the ACN's PRA-attested PCP roster. We'll use the last attestion for 2023 data, which is in Novemeber, for 2023 settlement.

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 assignment

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.

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 grid below). 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

Description	Deadline
2023 Settlement	June 2024
Supplemental data (Patient Profile, Report #70, MiHIN, HL7)	Jan. 31, 2024
Claims submission & adjudication	Feb. 28, 2024

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 budget 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)
- Patient Profile using the "Update Data" function
- Report #70 available in Filemart
- 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 deadline to submit supplemental data for the 2023 program year is Jan. 31, 2024.

Target rationale

Commercial targets for our HEDIS measures are based on HEDIS MY 2021 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 2021 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 Monday following the receipt of the MCIR file.
- **The MiHIN APS file** is delivered from MiHIN to Priority Health monthly.
- **Report #70**: Uploads submitted and processed on or prior to the last day of the month will have the submitted data reflected on the next month's Filemart report release.

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

Incentive details

Chronic Disease Management Focus Measure and payment

We'll provide an estimated pre-payment for the Hypertension: Controlled Blood Pressure measure and the Diabetes Care: HbA1c ≤ 9.0% measure in 2023. The prepayment will be made based on a snapshot of your ACNs population in these measures (denominator) in the first quarter of 2023 (ASO/PPO population will be excluded from denominator), as reported through PRA attestation.

You'll receive quarterly pre-payments based on this estimate using the 75th percentile rate noted below.

Measure	2023 75th percentile award	2023 90th percentile award	2022 90th percentile award
Hypertension	$75	$130	$60
A1c≤9.0%	$75	$130	$75

At year-end settlement, we'll review actual population and performance for these two measures and will either process additional payment or deduct overpayment from total ACN settlement reward. If your ACN doesn't achieve the 90th percentile for the performance year, we'll settle the difference from your year-end reward at the 75th percentile rate.

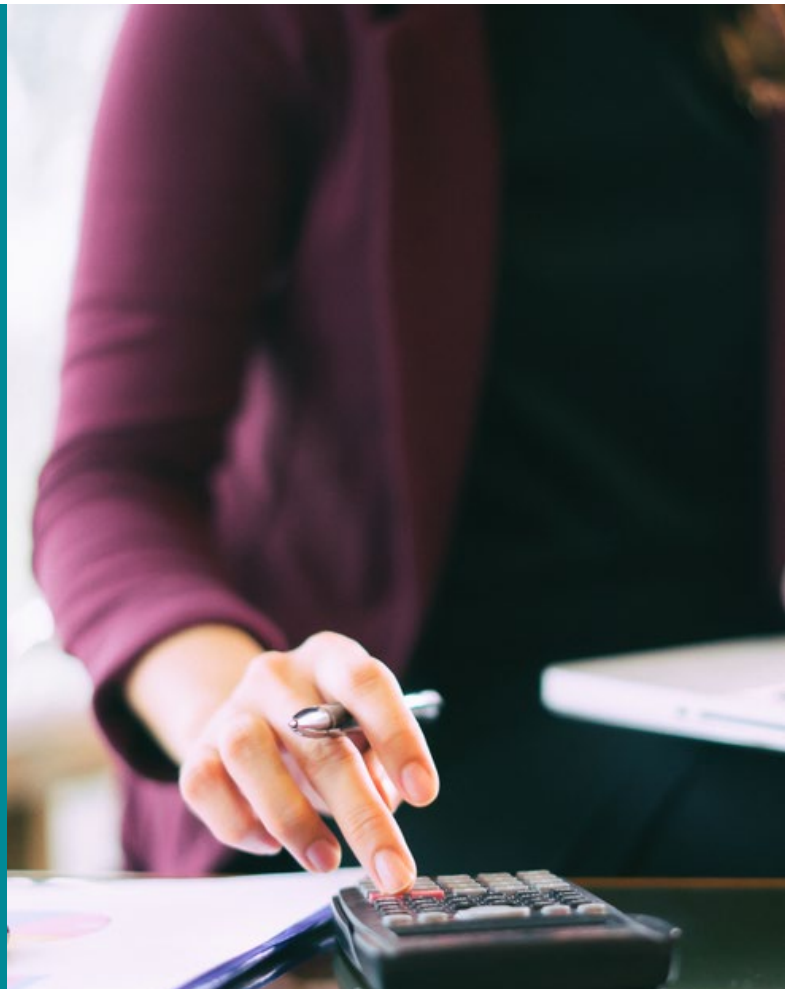
What does this look like?

Let's say Best ACN Ever has 1,000 members in its denominator for A1c ≤ 9% in the first quarter of 2023. The ACN would receive the following quarterly pre-payments:

- **Q1:** (1,000 members * $75) / 4 = $18,750
- **Q2:** (1,000 members * $75) / 4 = $18,750
- **Q3:** (1,000 members * $75) / 4 = $18,750
- **Q4:** (1,000 members * $75) / 4 = $18,750

By the end of 2023, Best ACN Ever achieves the 75th percentile for A1c ≤ 9% for the performance year. Here's how their settlement would work:

- **Focus measure pre-payments:**
  1,000 members * $75 = $75,000
- **Focus measure settlement:**
  750 members (numerator) * $75 = $56,250
- **Reduction to year-end settlement:**
  $75,000 - $56,250 = $18,750



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 qualified health professionals working as a care manager 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 and 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 documentation of education (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

Additional billing information can be found at:
priorityhealth.com/provider/manual/services/medical/care-management

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:

- one required measure assigned by Priority Health (varies by product and population), AND
- at least two additional unique measures

Comercial

- **Required (Adult):** Controlled HTN, or
- **Required (Pediatrics):** Childhood or Adolescent Immunizations, and
- **Two additional measures:** Childhood Imms: Combo 3, Adolescent Immunizations, Well Child Visits: First 15 mo, Well Child Visits: 3-11 years, Cervical Cancer Screening, Breast Cancer Screening, Colorectal Cancer Screening, Diabetes HbA1c ≤9.0%, Eye Exam for Patients with Diabetes, Kidney Health Evaluation for patients with Diabetes

Medicare

- **Required (Adult):** Controlled HTN, and
- **Two additional measures:** Breast Cancer Screening, Colorectal Cancer Screening, Diabetes HbA1c ≤9.0%, Eye Exam for Patients with Diabetes, Kidney Health Evaluation for patients with Diabetes, Statin Use Therapy for patients w/ Diabetes, Statin Therapy for patients w/ CVD, Medication Adherence – Diabetes, Medication Adherence – Hypertension, Medication Adherence - Cholesterol

Medicaid

- **Required (Adult):** Controlled HTN, or
- **Required (Pediatrics):** Childhood or Adolescent Immunizations, and
- **Two additional measures:** Lead Screening, Childhood Imms: Combo 3, Adolescent Immunizations, Well Child Visits: First 15 mo, Well Child Visits: 3-11 years, Chlamydia Screening, Cervical Cancer Screening, Breast Cancer Screening, Diabetes HbA1c ≤9.0%, Eye Exam for Patients with Diabetes, Kidney Health Evaluation for patients with Diabetes

Note: ACNs that include both adult and pediatric populations must meet either the adult or pediatric required measures by product.

Example

ABC PHO meets the following for their Commercial population:

- Components 1-3 for the care management measure
- Controlled HTN measure
- Well Child Visits: First 15 months
- Eye Exam for Patients with Diabetes

ABC PHO will meet their care management measure and be paid out their risk adjusted pmpm at year end settlement for their Commercial population. This ACN will receive payment for the individual quality measures where they meet or exceed targets.

ABC PHO meets the following for their Medicare population:

- Components 1-3 for the care management measure
- Breast Cancer Screening
- Eye Exam for Patients with Diabetes

But DOES NOT meet:

- Controlled HTN

ABC PHO will NOT meet their care management measure and be paid out their risk adjusted pmpm at year end settlement for their Medicare population. This ACN will receive payment for the individual quality measures where they meet or exceed targets.

ABC PHO meets the following for their Medicaid population:

- Components 1-3 for the care management measure
- Childhood Imms: Combo 3
- Well Child Visits: First 15 months
- Chlamydia Screening

ABC PHO will meet their care management measure and be paid out their risk adjusted pmpm at year end settlement for their Medicaid population. This ACN will receive payment for the individual quality measures where they meet or exceed targets.

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
The payment for care management 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.

Risk quartile	Individual/ACA	HMO/POS & ASO/PPO	Medicare	Medicaid
1 (lowest)	$0.25	$0.70	$0.85	$1.10
2	$0.60	$1.10	$1.25	$1.50
3	$2.50	$2.50	$2.56	$2.90
4 (highest)	$5.10	$5.10	$5.25	$5.50

Notes
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.

If a PCP changes from one ACN to another ACN, that PCP's care management touch points move with them to the new ACN.

Care management touch points will stay with the assigned/attributed PCP at the time of the care management visit.

If a member has two or more touchpoints with an assigned/attributed PCP, and that PCP retires or leaves the network, those touchpoints will be credited to the ACN where the assigned/attributed PCP was previously practicing.

Social Determinants of Health

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 and submit z-codes for identified 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 and report findings

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. Claims must be submitted and adjudicated by **Feb. 28, 2024,** for the 2023 program year.

SDoH measurement

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

Code type	Codes
ICD-10	Z55, Z55.0, Z55.1, Z55.2, Z55.3, Z55.4, Z55.5, 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, Z59, Z59.0, Z59.00, Z59.01, 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, Z62.29, Z62.3, Z62.6, Z62.8, Z62.81, Z62.810, Z62.811, Z62.812, Z62.813, Z62.819, Z62.82, Z62.820, Z62.821, Z62.822, Z62.89, Z62.890, Z62.891, 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 primary care provider in the measurement year.

Code type	Codes
CPT	99201, 99202, 99203, 99204, 99205, 99212, 99123, 99214, 99515, 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
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% / $0.50 pmpm Medicaid: 5% / $0.75 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 2024)	ACN	Claims data only. No supplemental data accepted.

Screening tools:
The comprehensive screening tools listed below are widely used. ACNs are free to use any screening tool they choose, as long as they address the areas listed under "2: Screen Members for SDoH and report findings" above.

- American Academy of Family Physicians screening tool
- Center for Health Care Strategies, Inc screening tool
- Centers for Medicare and Medicaid Services Accountable Health Communities 10-question screening tool
- Health Leads Social Needs screening tool
- PRAPARE screening tool

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 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

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 2024)	ACN	Claims data

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 the attributed PCP).
- ✓ Multiple BHCC claims billed in the same month will only count once per unique member.
- ✓ Claims must be submitted and adjudicated by Feb. 28, 2024.
- ✓ Target patient population includes those 12 years of age and older with moderate to severe depression and/or anxiety who can be managed by the PCP office with clinicians trained in addressing behavioral health issues and with medications that can be managed by a PCP.
- ✓ A PHQ-9 and / or GAD-7 score of 10 or more alerts the practitioner that collaborative care may be warranted for the patient.

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 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 2024)	ACN	MiHIN use case participation report.

Important notes:

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

Resources:

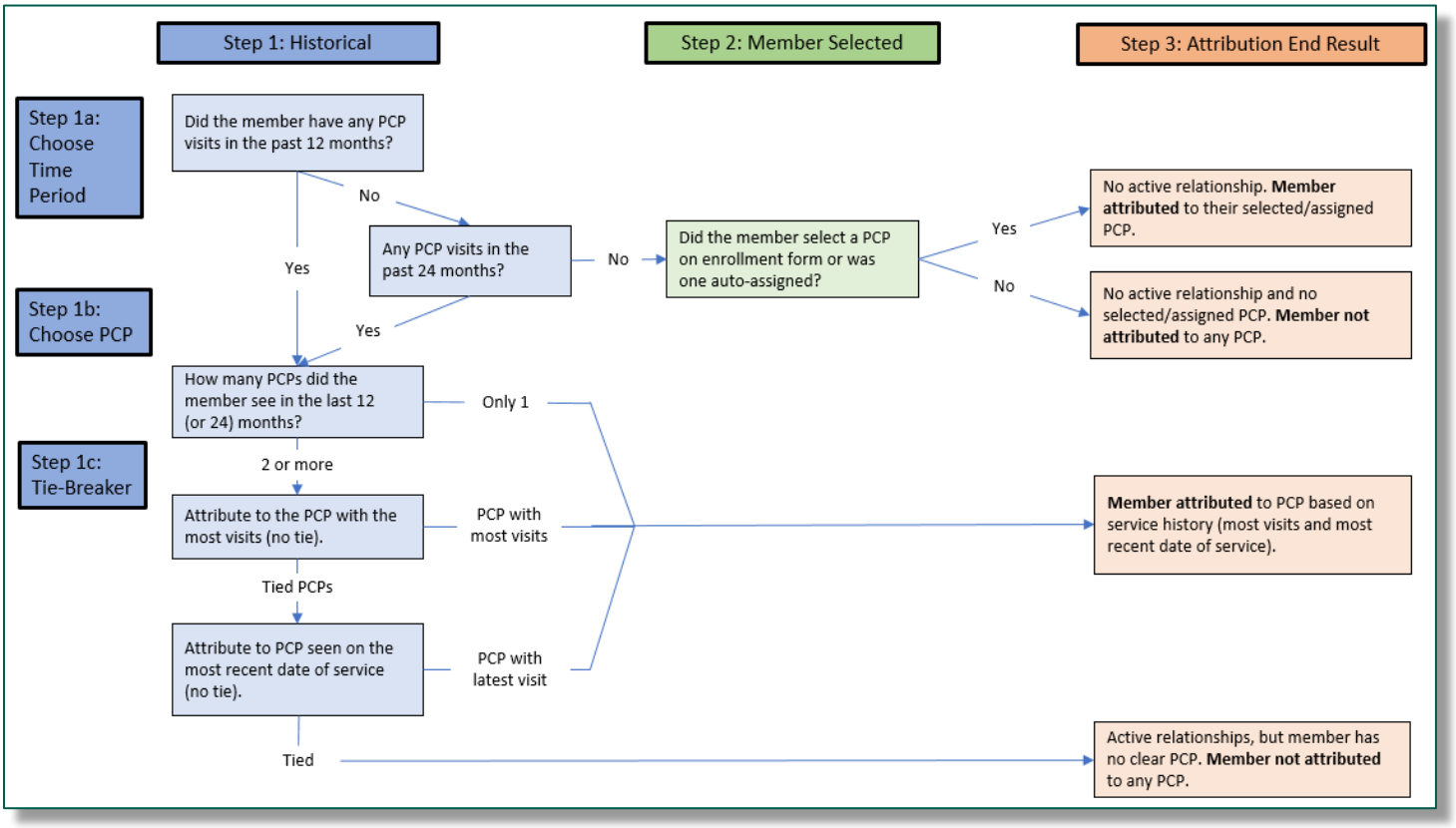
To learn more about participating in a use case with MiHIN, email *help@mihin.org*.

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:

- Member selected upon enrollment in a Priority Health plan, or
- Assigned upon enrollment in a Priority Health plan, or
- 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 will not be attributed to a PCP.

- Enrolled in a PPO with no claims history and no PCP selected
- A tie in claims for two or more PCPs with same number of services and 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: Supplemental data

We define supplemental data as anything submitted to us beyond what's included on a claim. There are four approved ways to submit supplemental data to us:

- All Payer Supplemental data transmitted via Michigan Health Information Network (MiHIN)
- EMR or patient registry data exchange (e.g., HL7 / APS file format)
- Patient Profile using the "Update Data" function
- Report #70

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

What's considered standard data?

Standard data is defined by NCQA as electronically generated files that come from service providers (provider who rendered the service).

Standard data we receive includes:

- HL7 or APS feeds (EMR and Lab)
- MCIR
- MiHIN

What's considered non-standard data?

Non-standard data is defined by NCQA as data used to capture missing service data not received through administrative sources (claims or encounters) or in the standard electronically generated files as described in the standard data source list above.

Non-standard data we currently accept includes:

- Patient Profile
- Report #70

Why do we audit non-standard data?

NCQA audits Priority Health on a sample of non-standard data as part of our accreditation process. Additionally, we're scrutinized regarding our internal auditing process related to non-standard supplemental data. If a medical record fails to match the submitted non-standard supplemental data source, NCQA has the discretion to penalize us by disallowing supplemental data, jeopardizing the integrity of Priority Health and our HEDIS accreditation.

We randomly audit non-standard data provided for the PIP program to ensure the accuracy of our program payouts and HEDIS compliance. This includes data submitted using Patient Profile and/or Report #70. Data submitted using either of these methods is considered non-standard because the submission isn't anchored to a medical record.

What's required when non-standard data is subject to audit?

Medical record documentation is required to validate any non-standard supplemental data. The medical record must provide the date on which the service was performed (rather than the date a test or result was reviewed with the patient), as well as the specific service (i.e., a colonoscopy vs a FOBT test). All supplemental (provider-reported) data is subject to audit.

Examples:

- ✓ **Cervical cancer screenings**: The collected date is required, not the result date or order date.
- ✓ **Colorectal cancer screenings**: The date of the procedure is required, not the result dates or order dates.
- ✓ **Hemoglobin A1c**: The collected date is required, not the result date or order date.

How we audit supplemental data

To perform an audit, Priority Health randomly selects records that were submitted using Patient Profile and Report #70 during the program year. Providers who failed an audit in the prior year are automatically subject to audit in the subsequent year. The number of records subjected to audit is proportional to the number of records submitted through the non-standard process as well as overall membership with the ACN.

On or around January 10 of following the program year, Priority Health will select a list of records to audit based on any non-standard supplemental data provided from January 1 to December 31 of the program year. Record requests will be based on the overall membership of the ACN and will not exceed the parameters noted below. If there are fewer records than the maximum allowed, all records will be subject to audit.

ACN audit tiering:

ACN membership	# of records audited
20,000+	200
10,000-19,999	150
5,000-9,999	100
< 5,000	50

Audit notification

We email audit notices to the ACN via secured email with instructions and the records that have been selected for an audit. ACNs will need to retrieve the audit details from their Priority Health secured email. We will follow-up with each ACN with a separate email notice that doesn't contain PHI and outlines the audit process.

ACNs' audit responsibilities

ACNs must return the medical record audits within two weeks of the audit delivery date.

If the medical record for a specific audit can't be located, we ask you to share that information with the returned record audit documentation and medical records, so we can investigate. If upon investigation we determine the service was provided or reported by a provider not associated with the ACN audit, we'll remove the member from the audit denominator.

Audit findings

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

An audit result of less than 95% accuracy will require a subsequent audit, in which we will audit the number of records according to these guidelines:

- An equal number of records based on the first audit; or
- If there is an insufficient number of additional records to audit, a minimum of 50 records will be required; or
- If there is less than 50 additional records to audit, we will audit all remaining records

Failure to reach a score of 95% or higher on the second audit will result in removal of all non-standard data submitted via Patient Profile and Report 70 along with a 10% payment penalty for each measure that had an audit failure.

Example: If the audit on cervical cancer screening and lead screening failed, Priority Health will calculate the earned reward for those 2 measures and reduce the payment by 10% for each measure met.

Egregious errors may result in additional sanctions against the ACN.

Notification of audit failures

ACNs that fail the first audit will be notified via their assigned Provider Strategy and Solutions Consultant via email. The notifications will include the audit score and breakdown of each record failure.

ACNs will receive a separate secured email with the second audit and return date.

ACNs that fail the second audit will be notified via their assigned Provider Strategy and Solutions Consultant via email. The notifications will include the audit score and breakdown of each record failure, and sanctions that apply.

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.

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 a Filemart Inventory section of this manual.

HEDIS
The National Committee for Quality Assurance (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 the Centers of Medicare and Medicaid Services (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.

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
The Centers for Medicare & Medicaid Services (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 weekly 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.

Patient Profile
Patient Profile is an online resource for providers to submit supplemental data. Ignore gaps in care result values and dates of service identified in Patient Profile. Use Filemart reports to identify accurate gaps in care information.

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 Global Risk Sharing Program (GRS).

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 Category 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.

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 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

Quality Measure	Indicator Description	CPT II Code	CPT II Description
			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 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

Quality Measure	Indicator Description	CPT II Code	CPT II Description
		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: Filemart report inventory

Report name	Report ID	Report detail
ACN HEDIS Report Card by Physician (TAB)	PIP_002C	Identifies performance for quality measures incentivized in the 2023 program year, by measure at the ACN level compared to the 90th percentile target. *PRA Group and Subgroup included.*
ACN HEDIS Report Card (TAB) - NEW	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. *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 have 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.*

Report name	Report ID	Report detail

PIP Care Management (PDF)	PIP_013_PDF	Includes member level detail for members who have 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 2023 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) - NEW	PIP_017	Includes member level detail for members who have received a Behavioral Health Collaborative Care service by PCP, by product, including BHCC code and DOS. Includes an indicator for 3+ BHCC visits w/in 6 months. *PRA Group and Subgroup included.*
Supplemental Data Worksheet (TAB)	PIP_070	Includes member level detail by measure and can be used to manually close quality gaps in care. *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.*

Appendix 6: Report #70 supplemental data reference guide

Purpose
Report #70 is a vehicle for providers to submit supplemental data for our PCP Incentive Program. We accept supplemental data to provide measure-related information that isn't received through claims, lab data interchange or registry data integration.

Distribution
Report #70 is updated monthly and represents year-to-date data received through the last day of the prior month. Reports can be generated at the ACN level.

When distributed via Filemart, Report #70 is generated in a TAB delimited file. This should be converted by your ACN into an Excel spreadsheet. We can accept the Excel file in either xls or xlsx format.

Completion
The completed Report #70 file should be returned to your ACN's Consultant using a secure email format.

Your Consultant will send the file to our decision support team who will then prepare an error report. Errors occur when data is provided in a format which does not match the report parameters. Your ACN will be notified of any errors so data entry can be corrected. Report parameters are below.

Data fields
The file you receive will contain the following data fields. The fields that may be updated are Data 1, Data 2 and Data 3.

Header	Field description
PIP Report Period Description	Report period year and month
Accountable Care Network(s)	ACN name
Prac Name	PCP name
Type II NPI	Group NPI number
PCP NPI	PCP NPI number
PRA Group Name	PRA Group Name (optional)
PRA Subgroup Name	PRA Subgroup Name (optional)
Member ID	PH unique member ID
Member Contract Number	Member contract number
Member Last Name	Member last name
Member First Name	Member first name
Member Middle Name	Member middle name
Member Birth Date	Member Date of birth
Supplemental Measure Description	Measure name
Supplemental Measure Value Message	Measure value identifier

Data requirements

- Each supplemental data entry must be accompanied by a measure date.
- The Data1 field must contain a value that matches the supplemental data language as listed in the table below. Any variation will cause an error that won't allow us to receive the data provided.
- The Data 2 field is designed for the two hypertension measures only.
- The Data 3 field is not used and should remain a blank field.
- Don't modify, add or delete columns included in Report #70.

Measure code	Corresponding PCP IP measures	Value domain	Data parameters	Data 1 format	Data 2 format	Data 3 format
MAM	Breast cancer screenings	V = Normal, Abnormal, Unk, N/A	Date during 2022 or 2023	See domain		
BILAT MAST	Breast cancer screenings	V = Y, N	Any date prior to Dec. 31, 2023	See domain		
CC SCREEN	Cervical cancer screenings	V = Normal, Abnormal, Unk	Date during 2021, 2022 or 2023	See domain		
SM_HPV_SCREEN	Cervical cancer screenings	V = Normal, Abnormal, Unk	Date during 2019, 2020, 2021, 2022 or 2023	See domain		
HYST (Total hysterectomy)	Cervical cancer screenings	V = Y, N	Any date prior to Dec. 31, 2023	See domain		
SM_WELL_CHILD (Well-child visits)	Well-child visits (15 months; 3-6 years)	V = Y, N	Any date prior to Dec. 31, 2023	See domain		
SM_CHLAMYDIA	Chlamydia screenings	V = Normal, Abnormal, Unk	Date during 2023	See domain		
LEAD (Lead Screen)	Lead screening in children	V = greater than 0	Date prior to patient's 2nd birthday	Integer		
BMI_PCT (BMI percentile)	Recorded BMI	Percent between 0 and 100	Date during 2023	Integer, decimal		
BMI	Recorded BMI	BMI must be between 12 and 99	Date during 2023	Integer		
PHQ-2 SCORE	Depression screening	Result between 0 and 6	Date during 2023	Integer		
PHQ-4 SCORE	Depression screening	Result between 0 and 12	Date during 2023	Integer		-
PHQ-9 SCORE	Depression screening	Result between 0 and 27	Date during 2023	Integer		
CR_COLO (Colonoscopy)	Colorectal cancer screenings	V = Normal, Abnormal	Date between 2014 and 2023	See domain		
CR_CANC (Colorectal cancer)	Colorectal cancer screenings	V = Y, N	Date prior to Dec. 31, 2023	See domain		
CR_FOB (Fecal occult blood test)	Colorectal cancer screenings	V = Normal, Abnormal	Date prior to Dec. 31, 2023	See domain		
CR_SIG (Flexible sigmoidoscopy)	Colorectal cancer screenings	V = Normal, Abnormal	Date between 2019 and 2023	See domain		
COLECT (Total colectomy)	Colorectal cancer screenings	V = Y, N	Date prior to Dec. 31, 2023	See domain		
SM_COLOGUARD (Cologuard)	Colorectal cancer screenings	V = Y, N	Date during 2020-2023			

Measure code	Corresponding PCP IP measures	Value domain	Data parameters	Data 1 format	Data 2 format	Data 3 format
HBA1C	Diabetes care: Controlled HbA1c (3 measures)	Value between 1.3 and 18.9	Date during 2023	Integer, decimal preferred		
SM_HBA1C_EXCL (HbA1c<7.0 Exclusions)	Diabetes care: Controlled HbA1c less than 7.0%	V = CHF, MI, CKD (stage 4)/ESRD, Dementia, Blindness, Amputation, No Exclusions, CABG, IVD, PCI, TAA	Any date prior to Dec. 31, 2023	See domain		
RET_EXAM	Diabetes care: Annual retinal exam	V = Normal, Abnormal, Unk	Date during 2022 or 2023	See domain		
MICROALB (Microalbumin test)	Diabetes care: Monitoring for nephropathy	V = Y, N	Date during 2023	See domain		
BP (Blood pressure)	Diabetes care: Controlled blood pressure Hypertension: Controlled blood pressure	Systolic between 40 and 300 / Diastolic between 40 and 200	Date during 2023	Integer (systolic)	Integer (diastolic)	