PriorityHealth

PRELIMINARY MANUAL

2023 PCP Incentive Program (PIP)

An integrated program focused on patient-centered care

2022 © Priority Health 10/2022

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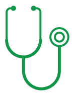
Program overview

Why we partner with you

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.

But we know we can do even better, which is why **we've redesigned our PIP program for 2023**.

We're here to help you **maximize your 2023 PIP incentives**. In this preliminary manual, we show you how.

A whole new PIP program

We've redesigned and rebuilt PIP from top to bottom for 2023, ushering in more opportunities to earn incentive payments more frequently throughout the year.

2023 PIP program components

1 Push Measures

Push Measures are **specific quality performance measures** to be completed against a **benchmark** within a **short period of time**.

Each quarter in 2023, we'll release new push measures along with their PMM (per member meeting measure) payout. Make sure to get your claims in during the Push Measure timeframe to maximize your incentive earning potential.

High-value targets

- ✓ 5-Star Medicare measures
- ✓ Triple-threat Medicaid measures
- ✓ Chronic condition measures

Push Measures offer the opportunity to be **more deeply engaged** in a specific set of measures through **more targeted data**, which our Accountable Care Networks (ACNs) track towards a goal. Get more details on page 10 of this manual.

35% of PIP budget

Quarterly payments to ACNs

Focus on measures that need improvement

Amplify Stars

2 Quality Index score

An ACN's quality index (QI) score is a composite quality score based on the results of their performance throughout the PIP program year on the subset of the HEDIS® clinical outcomes measures outlined on page 12 of this manual.

Targets for these measures are determined by HEDIS 90th percentile performance for the previous program year by measure and by product.

40% of PIP budget

Year-end payments to ACNs

3 Transformation measures

Integrating behavioral health into primary care settings and tracking social determinants of health can truly transform the care we provide for our communities – meeting them where they are, as they are and with the care they need.

Submitting your data electronically with MiHIN can help improve care delivery with respect to safety, quality, cost and efficiency.

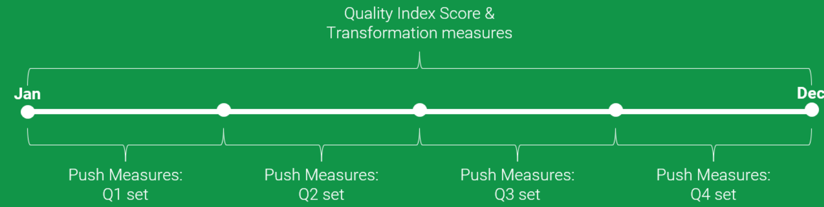
25% of PIP budget

Year-end payments to ACNs

What this looks like in action

From January to December 2023, your ACN's PCPs will earn incentive dollars for their performance in the subset of HEDIS measures listed on page 14 of this manual. We'll payout these **Quality Index Score** earnings at your annual settlement.

Also, throughout the year, your ACN's PCPs will earn incentive dollars for their participation in our **Transformation measures** described on pages 15-22 of this manual. We'll payout these earnings to your ACN at your annual settlement.



On top of this, each quarter, we'll announce **Push Measures** for that quarter. During the quarter, your PCPs will have the opportunity to double down on those specific measures to earn additional incentive dollars. We'll payout these Push Measures quarterly.

Introducing our HEDIS Provider Reference Guide

This comprehensive guide draws directly from the official HEDIS Manual. In it, for each measure, you'll find:

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

We update this guide annually to reflect any updates HEDIS makes to their own manual.

Use this HEDIS Provider Reference Guide to support your Quality Index Score performance.

Get the guide

2022 HEDIS® PROVIDER REFERENCE GUIDE

Plus CMS Stars, CAHPS® and HOS tips, helping you address your patients' care opportunities and increase your practice's performance this year

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 Practioner 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 incentive payments directly to the participating ACN. These payments will encompass program settlement for the providers the ACN has attested to in PRA. ACNs are then 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.

We'll match all ACN payments – including quarterly, ad hoc and year-end settlement – to the ACN's PRA-attested PCP roster. Therefore, it's critical that ACNs attest on behalf of their providers monthly. ACNs that don't attest during every monthly PRA cycle won't be eligible for their year-end settlement payment, approximately 50% of their reward opportunity.

What's new from an administrative perspective in 2023?

ACN-level reporting & settlement

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

You'll receive your ACN's via secure email from your Provider Strategies & Solutions Consultant.

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.

Additionally, failure to include a PCP in an attestation isn't appealable – unless the omission was due to a Priority Health error.

Health plans included in 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 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).

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've revised our criteria for 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 (as is required at the ACN-level).

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. We use forecasting 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 includes 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.

Provider Roster Application (PRA) tool

ACNs must use our PRA tool to manage their PCP roster for our PIP program. ACNs attest to the accuracy and alignment of their PCPs on a monthly basis. We use these attestations as the source of truth for PIP incentive payments. ACNs that don't attest during every monthly PRA cycle won't be eligible for their year-end settlement payments. We'll use the rosters that ACNs attest to during the last attestation cycle of the program year for our year-end PIP settlement. Because of this, any PCPs added to an ACN's roster following the final attestation closing date won't count towards their settlement for the program year. For additional PRA information, see "PCP attestation in PRA" above and visit our PRA webpage (login required).

Here's our anticipated 2023 attestation schedule:

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

Reporting

We'll make our standard reporting available for ACNs. We'll no longer provide reporting at the practice group level. 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

Supplemental data can impact the results of your Quality Index Scores and therefore your year-end PIP incentive payout.

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.

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. If the 15th falls on a weekend, reports are released the following Monday. 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 Filemart report release.

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

Incentive details

Push Measures

Claims data only
ACN rewarded quarterly

A Push Measure is a specific quality performance measure to be completed against a benchmark within a short period of time. We will pull from HEDIS, Medicare 5-Star and/or State of Michigan Medicaid measures to create our Push Measures. Each quarter will feature new Push Measures, some of which may require a care management touchpoint component.

You cannot appeal incentive payments for Push Measures. We'll include claim submission and adjudicating timelines in our quarterly Push Measure announcements. Make sure you're billing in a timely manner to maximize your earning potential.

Product lines	Target / Payout	Eligible population
• HMO / POS • ASO / PPO • Medicare • Medicaid	We'll provide target and payout information specific to each Push Measure as they're released quarterly. Announcements will be made 30 days in advance of the Push Measure.	We'll provide specific patient population eligibility with each measure as released quarterly.
Payout frequency	**Level of measurement**	**Collecting & reporting method**
Quarterly	ACN	Claims data only. No supplemental data accepted.

Important notes:

- Payouts to the network won't exceed Priority Health-budgeted amounts for the measure.
- Priority Health will communicate Push Measures quarterly.
- Push Measures may be line-of-business specific.
- Push Measures will follow standard HEDIS measure specifications.
- Priority Health will provide specific data points to ACNs to "push" performance within two-month sprint cycles to close gaps in care.
- Priority Health will round preventive and chronic disease management measures up if the score is within 0.5% of the target. Rounding is only applicable to HEDIS and Medicare 5-Star measures. Example: If the score is 89.4 it will round to 89. Alternatively, if the score is 89.5 it will round to 90.
- Performance will be measured with claims data. No supplemental data will be accepted (including direct data feeds or MiHIN).

Resources:

- Reference our HEDIS Provider Resource Guide for HEDIS and Medicare 5-Star quality measure specifications.
- See Appendix 4: CPT II Codes at the end of this manual.

Push Measure details continue on the next page

The contents of this page are for example only.

Here's how Push Measures can align under a focus area

Focus Push Measure: Chronic condition management of diabetes

Sub-measures settled as a single incentive:

1. Medication adherence
2. A1c < 9%
3. Retinal eye exam
4. Care management touchpoints

Here are two Push Measure examples

Measure	Denominator	Numerator goal	Payment
Adult Access to Care 21-64 years	400	85% 75% 70-74% <70%	$125 pmm $100 pmm $50 pmm $0 pmm
Pediatric Well Child 3-11 years	150	80% 75% 70-74% <70%	$125 pmm $100 pmm $50 pmm $0 pmm

We'll set denominators based on the appropriateness of the time interval and in conjunction with our members' history.

In this example, we're setting the goal at 85% of the denominator for the highest payout and offer a tiered payout through 70% of the denominator. If you were to fall below 70%, no payment would be made for this push.

Efforts in these measures are never in vain. They help boost your scores for the final settlement under the Quality Index Scores (see the next page of this manual). A reward in the Push Measure simply means that particular measure was given a high priority for completion.

We'll announce actual Push Measures quarterly.

Quality Index Scores

Accepts Claims &
Supplemental data
ACN rewarded annually

An ACN's Quality Index (QI) score is a composite quality score based on the results of their performance throughout the measurement year on a subset of HEDIS clinical outcome measures. Targets are determined by HEDIS 90th percentile performance for the previous program year – by measure and by product.

The measures we're focusing on for the 2023 PIP program year are outlined in the grid below. This subset of measures is subject to change based on HEDIS adjustments.

Product lines	Target / Payout	Eligible population
• HMO / POS • ASO / PPO • Medicare • Medicaid	Tiered payout. We'll share details in the official manual which comes out in January 2023. Payout = Risk adjusted PMPM (by ACN)	See HEDIS measure specifications.
Payout frequency	**Level of measurement**	**Collecting & reporting method**
Annual (June 2024)	ACN	• Claims data • MiHIN, APS and/or direct data feed • Supplemental data

2023 QI measures

Measure	HMO/POS	Self-funded 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 Screening	✓	✓	✓	✓
Colorectal Cancer Screening	✓	✓	✓	
Diabetes Care: HbA1c <8.0%	✓	✓	✓	✓
Diabetes Care: HbA1c ≤9.0%	✓	✓	✓	✓
Diabetes Care: Annual Eye Exam	✓	✓	✓	✓
Kidney Health Evaluation			✓	
Hypertension: Controlled BP	✓	✓	✓	✓

Quality Index Score details continue on the next page

How your ACN's QI will be calculated

Measure	Numerator	Denominator	Target
A	A_N	A_D	A_T
B	B_N	B_D	B_T
C	C_N	C_D	C_T

Quality Score (QS) = $(A_N + B_N + C_N) / (A_D + B_D + C_D)$

Weighted Target (WT) = $[(A_D \times A_T) + (B_D \times B_T) + (C_D \times C_T)] / (A_D + B_D + C_D)$

Quality Index (QI) = QS / WT

Important notes:

- Payouts to the network won't exceed Priority Health's budgeted amounts for the measure.
- The Quality Index Score will be rounded to the thousandths place.

Resources:

- Reference our HEDIS Provider Resource Guide for HEDIS and Medicare 5-Star quality measure specifications.

Transformation measures

Claims data only
ACN rewarded annually

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 practices that screen for social care needs and submit z-codes for identified needs.

To be eligible for this incentive practices 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. We honor the following designation programs: BCBSM, NCQA, URAC and Joint Commission.

Proof of PCMH designation is required annually. 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 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 complete and report the screening of 90% of their population for incentive payout. Screening compliance is based exclusively on claims containing one of two reporting methods:

1. G9920: Screening Performed and Negative
2. Appropriate z-code (see below) for positive screening indicating social care need / SDoH identified

SDoH details continue on the next page

SDoH measurement

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

- G9920: Screening Performed and Negative, or
- Appropriate z-code for positive screening indicating social care need / SDoH identified

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, Z59.812, Z59.819, Z59.82, 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 details continue on the next page

SDoH measure details

Product lines	Target / Payout	Eligible population
• Medicare • Medicaid	Medicare: 90% / $0.50 pmpm Medicaid: 90% / $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. Practices 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.
- ✓ 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.
- ✓ Continuous member enrollment criteria doesn't apply.

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)

Claims data only
MiHIN APS / direct data feed
ACN rewarded annually

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 practices 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. We honor the following designation programs: BCBSM, NCQA, URAC and Joint Commission.

Proof of PCMH designation is required annually. 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 an approved BHCC CPT and / or HCPCS code is billed and adjudicated for at least three 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

3 Submit GAD-7 and PHQ-9 scores

ACNs must report GAD-7 and / or PHQ-9 scores electronically via direct data feed (HL7/APS format) or MiHIN APS, each month for members actively receiving BHCC services.

We'll pay an incentive of $0.05 pmpm when 90% of GAD-7 and/or PHQ-9 scores are received.

BHCC details continue on the next page

Measurement

Numerator: Patients in the denominator with a GAD-7 and/or PHQ-9 score submitted for each month that they're considered actively receiving BHCC services from a PCP.

Denominator: All patients 12 years of age and older with a BHCC service billed for at least three consecutive months in the calendar year. Each eligible service billed and adjudicated will count as one in the denominator.

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

BHCC measure details

Product lines	Target / Payout	Eligible population
• HMP / POS • ASO / PPO • Medicare • Medicaid	**Component 2**: $100 per eligible claim	**Component 2**: Patients 12 years of age and older with a BHCC service billed and adjudicated for at least three consecutive months in the calendar year.
	Component 3: 90% = $0.05 pmpm	**Component 3**: If achieved, the payment will apply to the ACNs entire membership (12 and older).
Payout frequency	**Level of measurement**	**Collecting & reporting method**
Annual (June 2024)	ACN	Claims data, MiHIN APS and / or direct data feed.

Important notes:

- ✓ Payouts to the network won't exceed Priority Health's budgeted amount for this measure.
- ✓ Claims must be submitted and adjudicated by Feb. 28, 2024
- ✓ Data must be submitted electronically by direct data feeds and / or MiHIN by Jan. 31, 2024.
- ✓ Non-standard supplemental data isn't accepted (Patient Profile, Report #70).
- ✓ The BHCC measure will be rounded up if the score is within 0.5% of the target. I.e., If the score is 89.4 it will round to 89. Alternatively, if the score is 89.5, it will round to 90.
- ✓ 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

BHCC details continue on the next page

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.
- ✓ Continuous member enrollment criteria doesn't apply.

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)

MiHIN report
ACN rewarded annually

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.

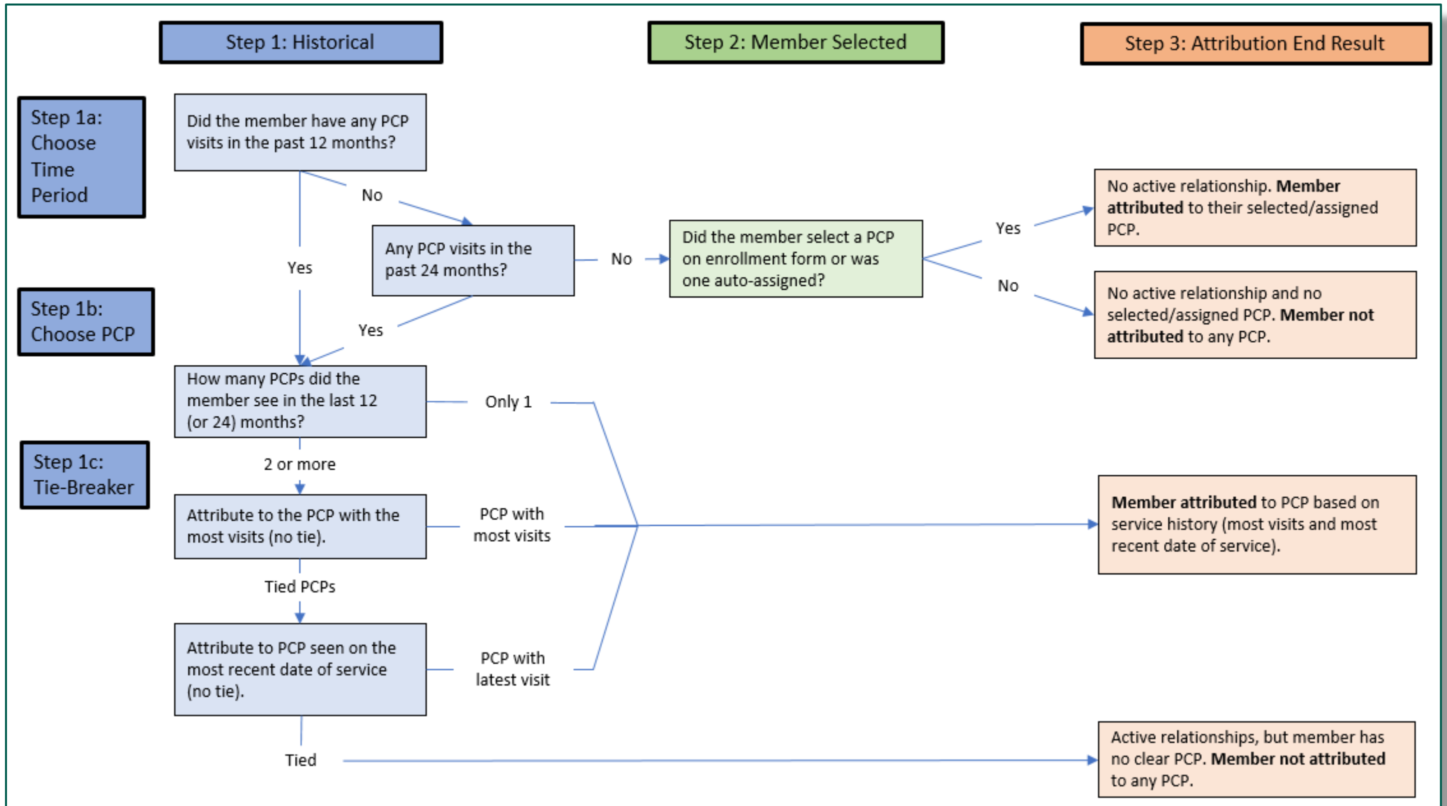
Resources:
To learn more about participating in a use case with MiHIN, email *help@mihin.org*.

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.



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

Appendix 1 continues on the next page

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

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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.

How we audit supplemental data

We audit the supplemental data provided for the PIP program measure requirements to ensure the accuracy of our PIP program payouts. This annual audit randomly selects submitted supplemental data pieces.

At year-end, we give each audited ACN a partial list of the supplemental data provided to us. ACNs must return a copy of the medical record that documents each supplemental data piece.

I.e., If lab value data was supplied, the ACN would submit a printed copy of office visit notes with the lab value.

Audit procedure:

1. We email audit notices to the ACN.
2. ACNs must respond to the audit within two weeks of the delivery date.

Important notes about these audits:

- ✓ Failure to return results by the deadline will result in ineligibility for the program year payout.
- ✓ If a medical record is unavailable, we'll recalculate audit results to determine a compliance score with the audit.
- ✓ An audit result of less than 95% accuracy will require an additional audit.
- ✓ Failure to reach a score of 95% or higher on the second audit will result in ineligibility for the program year payout.
- ✓ Additional sanctions against the practice may also be considered based on audit results.

Appendix 3: Glossary of terms

Accountable Care Organization (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.

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 will be included in a Filemart Inventory section in the official 2023 PIP Manual to be released in January 2023. If you'd like to learn more about Filemart reporting, contact your Provider Strategy & Solutions Consultant.

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 practice and our health plan.

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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. This 12-month time frame is where data is collected for submission during the reporting year.

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 attribution model algorithm is available in Appendix 1 on page 24 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.

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Patient Profile

Patient Profile is an online resource for providers to submit supplemental data.

- Patient demographic information is updated nightly.
- Supplemental data provided by primary care practices and network providers is scheduled for a weekly update administered each weekend.

Please 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).

Push Measure

A push measure is a specific quality performance measure to be completed against a benchmark within a short duration of time. Any of our push measures may also have a care management touchpoint component. Learn more about Push Measures on page 12 of this manual.

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 practice.

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

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Quality Measure	Indicator Description	CPT II Code	CPT II Description
		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 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

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Quality Measure	Indicator Description	CPT II Code	CPT II Description
	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