PriorityHealth

2021 PCP Incentive Program

An Integrated Program Focused on Patient-Centered Care

Updated May 2021

Contents

Why we partner with you

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

For over 24 years, we've partnered with 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 and 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.

We'll achieve our commitment by collaborating with you on our prevention, chronic condition, transformation of care, and efficiency and utilization measures in our PCP Incentive Program.

Achieving results
Working with you, we've achieved outstanding results for Michigan communities year after year. We're here to help your practice maximize its 2021 PCP incentives. Contact your Provider Performance Specialist for practice resources and programs to support your efforts.

2021 Program updates

The PCP Incentive Program is updated annually to reflect current health care trends. The 2021 program aligns with our mission and goals for transformation of models of care and financing of care delivery.

For complete details on these measure changes, refer to the individual measure specification pages.

Administrative changes

2021 New Measures

- Childhood Immunizations: Combo 10 (Report only)
- Well Child Visits 15 – 30 Months (Report only)
- Kidney Health Evaluation for Patients with Diabetes (Report only)
- Social Determinates of Health (SDoH)
- Health Information Exchange Participation with MiHIN
- Behavioral Health Collaborative Care

2021 Revised Measures

- Well Child Visits 3 – 11 Years
- Optimal Diabetes Care
- Care Management
- Medication Therapy Management (MTM)
- Healthy Michigan Plan (HRA)
- Acute Hospital Utilization (AHU) (Report only)
- Emergency Department Utilization (EDU) (Report only)

Retired Measures

- Depression Screening and Follow up
- Medicaid Patient-Centered Medical Home (PCMH)
- Risk Adjustment
- CG CAHPS

2021 Program measure grid

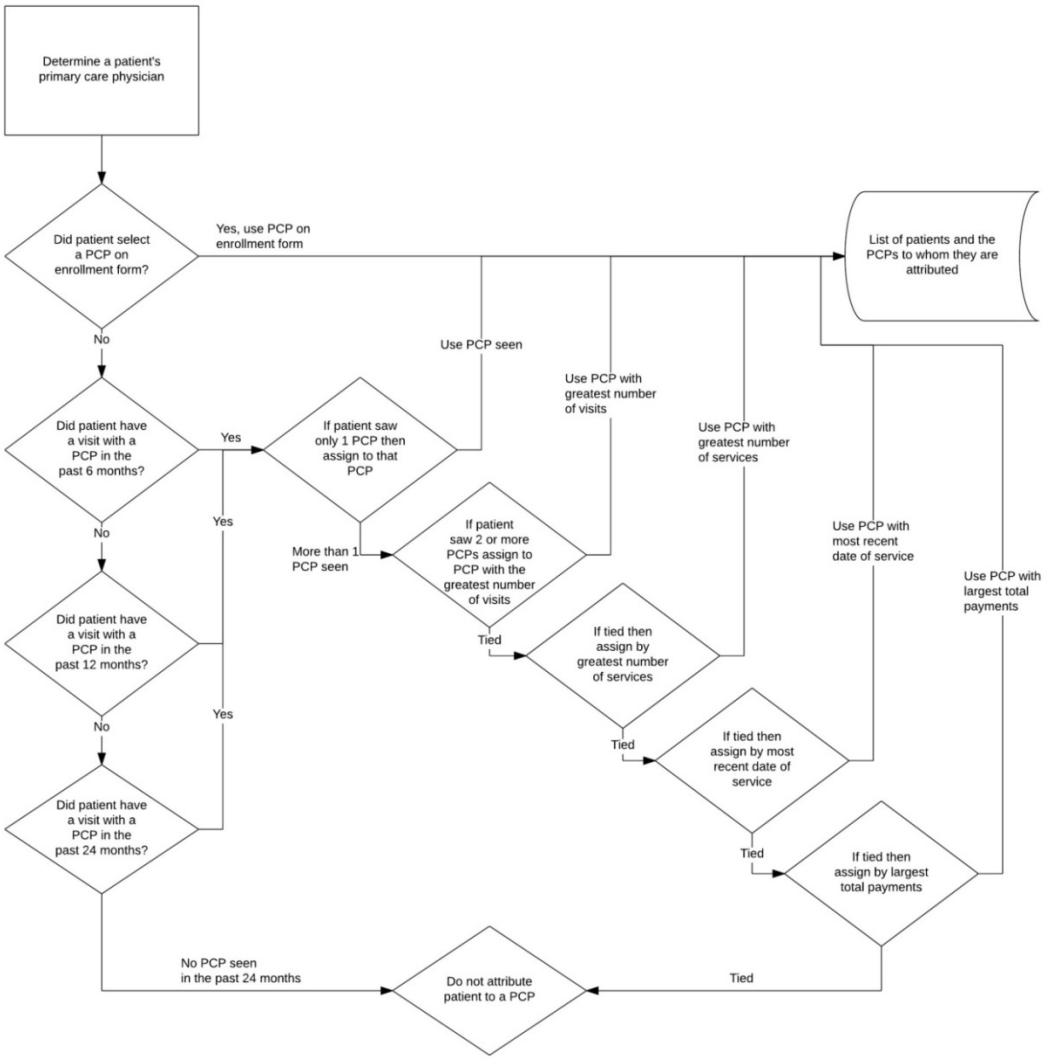
	HMO/POS & ASO/PPO Payout	HMO/POS & ASO/PPO Target	Medicare Payout	Medicare Target	Medicaid Payout	Medicaid Target
Prevention						
Lead Screening Δ					$40	87%
Childhood Imms: Combo 3	$175	88%			$180	79%
Childhood Imms: Combo 10	Report only					
Adolescent Immunizations	$100	43%			$75	51%
Well Child Visits: First 15 Mo	$85	91%			$85	77%
Well Child Visits: 15-30 Mo+	Report only					
Well Child visits: 3-11 Years Δ	$70	79%			$70	62%
Chlamydia Screenings					$35	71%
Cervical Cancer Screenings	$15	84%			$20	73%
Breast Cancer Screening	$15	81%	$25	85%	$20	69%
Colorectal Cancer Screening*	$20	77%	$20	84%		
Opioid Utilization (report only)	Report only					
Chronic Disease Management						
Diabetes Care: HbA1c <8.0%	$60	68%	$60	79%	$50	61%
Diabetes Care: HbA1c ≤9.0%*	$60	80%	$75	89%	$30	72%
Diabetes Care: Annual Eye Exam*	$40	70%	$75	85%	$50	70%
Diabetes Care: Nephropathy			$40	98%		
Kidney Health Evaluation for Patients with Diabetes (report only) +	Report only					
Optimal Diabetes Care	$75/$125/$200	20/30/35%			$75/$125/$200	20/30/35%
Statin Therapy for Patients w/ Diabetes*			$35	91%		
Statin Therapy for Patients w/ CVD* (No payout for ASO/PPO)	$35	88%	$35	91%		
Medication Adherence- Diabetes			$20	91%		
Medication Adherence- Hypertension			$20	91%		
Medication Adherence- Cholesterol			$20	91%		
Hypertension: Controlled BP	$45	76%	$45	86%	$45	73%
Transformation of Care						
Care Management Δ	Payout: Risk adjusted PMPM Requirements: Achievement of Practice-Specific Targets and Proof of PCMH recognition					
Social Determinants of Health +	Requirements: Proof of PCMH recognition, Attestation, Z-code claims submission					
			$0.50 PMPM	5% members seen	$1.00 PMPM	5% members seen
Medication Therapy Management (MTM) Δ	$75 per CMR		$75 per CMR			
Health Information Exchange Participation with MiHIN +	$0.05 PMPM		$0.05 PMPM		$0.05 PMPM	
Healthy Michigan Plan: HRA Completion Δ					$70 Champs $15 Fax	
Behavioral Health Collaborative Care+	$0.25 PMPM		$0.25 PMPM		$0.25 PMPM	
Efficiency and Utilization						
ED Visits- PCP Treatable					Shared Savings	See tech spec
Acute Hospital Util. (AHU)	Report only					
Emergency Department Util. (EDU)	Report only					

Key
+ = *new measure* Δ = Changes to measure * 5 Star Challenge Measure

How our attribution model works

We're committed to providing a medical home for all Priority Health members.

We use an attribution model to ensure that members enrolled in health plans with no PCP assignment are included in the PCP Incentive Program. This includes members in self-funded and fully funded PPO plans as well as Medicare PPO plans.



Visits are determined using claims information. Valid E&M codes: 99201-99205, 99212-99215, 99241-99245, 99381-99387, 99391-99397. Valid place of service locations: school, homeless shelter, Indian Health Service free-standing facility, Indian Health Service provider-based facility, Tribal 638 free-standing facility, Tribal 638 provider-based facility, office, patient's home, outpatient hospital, federally qualified health center. state or local public health clinic and rural health clinic.

Supplemental data

Priority Health defines supplemental data as anything that is submitted to Priority Health beyond what is included on a claim form. There are four approved methods of submitting supplemental data:

- HL7
- Patient profile
- Report #70
- All Payer Supplemental (APS) File via Michigan Health Information Network Shared Services (MiHIN)

How we audit supplemental data

Audits ensure the accuracy of our PCP Incentive Program payouts.

Priority Health audits the supplemental data provided by practices for the PCP Incentive Program measure requirements. This annual audit randomly selects practices throughout the network.

At year end, each audited practice is given a partial list of supplemental data provided to Priority Health. Practices are required to return a copy of the medical record that documents the supplemental data piece. Example: If lab value data was supplied, the practice would submit a printed copy of office visit notes with the lab value.

Audit procedure:

- Audit notices are emailed to the practice group and ACN if applicable.
- Providers are required to respond to the audit within two weeks of the delivery date. Failure to return results by the deadline will result in ineligibility for the program year payout.
- If a medical record is unavailable, audit results will be recalculated to determine a compliance score with the audit. An audit result of less than 95% accuracy will require an additional audit of 50 medical records.
- Failure to reach a score of 95% or higher on the second audit of 50 records will result in ineligibility for the program year payout.
- Additional sanctions against the practice may also be considered based upon audit results.

Glossary

Accountable Care Network (ACN)
Accountable Care Networks are contracted physician organizations/physician hospital organizations (PO/PHOs) or professional groups defined as one entity for reporting and performance measurement purposes.

Attribution model
Our attribution model matches a primary care physician with a patient enrolled in a Priority Health plan that does not require an assigned PCP. See our attribution model on page 7.

D-SNP
A dual-eligible special needs plan (D-SNP) is a type of special needs plan specifically designed to address the unique care needs of beneficiaries who are entitled to both Medicare and Medicaid. D-SNPs offer the opportunity to provide members with enhanced benefits by combining those available through both programs and coordinating care

Priority Medicare D-SNP is a type of Medicare Advantage plan and shares the same network and formulary as our other Medicare Advantage products.

Facility site ID
The administrative number Priority Health assigns to your practice for purposes of identification and payment. The facility site ID is a four to eleven-digit number included on each PIP report.

FileMart
A Priority Health application within our website's provider center. FileMart is the available mechanism to receive standard incentive program and membership reports. A list of FileMart reports are in the FileMart Inventory section included at the end of this manual. If you would like to learn more about FileMart reporting, please contact your Provider Performance Specialist at priorityhealth.com/provider/center/contact-us/representatives

Health plan inclusion
All Priority Health plans, except our Medigap and short-term individual plans, are included in the PCP Incentive Program.

HEDIS
The Healthcare Effectiveness Data and Information Set (HEDIS) is the most widely used set of performance measures in the health care industry. HEDIS is developed and maintained by the National Committee for Quality Assurance (NCQA), a not-for-profit organization committed to assessing, reporting, and improving the quality of care provided by organized delivery systems. If HEDIS definitions/targets are revised throughout the measurement year, Priority Health will update measures based on those revisions. If a HEDIS revision impacts our PCP Incentive Program, we will provide written notification to the network and update the manual online as appropriate.

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. Priority Health receives monthly data downloads from the Michigan Department of Community Health (MDCH) and displays this data within monthly reports.

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.

Non-adherence
Non-adherence is defined as “Members refusing to follow provider recommendations for care”.

- Providers can request that non-adherent members be excluded from PIP measure denominators.
- It is the intent of the Non-Adherent Member Exclusion Procedure to identify members who have been counseled at least three times on recommended care and who have made the personal choice not to seek care, for any reason. The three outreach attempts must be a minimum of one week apart and must take place in the measurement year.
- Non-adherence requests will only be accepted using the Patient Profile tool. A provider may request exclusion of a member at any point prior to Nov. 5, 2021 for the measurement year. Each request for exclusion will be granted for the current measurement year only.
- Non-adherent members are removed from all approved PCP IP measures not just the measure for which he or she is non-adherent.
- Manual processing of non-adherent member exclusions take place during the 2021 settlement process in the first quarter of 2022. Find additional information about the non-adherent exclusion process at *priorityhealth.com/provider/center/incentives/pip/nonadherent-members* (login required).

Participating PCP
A primary care provider that is credentialed by and contracted with Priority Health to provide Covered Services to a member.

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

- 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.

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

PMM
Per member meeting measure (PMM)

Administrative details

Understanding the details is key to successful participation in our PCP Incentive Program.

ACN pay-to rules
Contracted ACNs will receive program settlement for all member providers in one check at year end settlement. These ACNs will be responsible for distributing settlement funds to providers at their discretion.

Comprehensive Primary Care Plus (CPC+)
CPC+ is an alternative payment model (APM) introduced by the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. Participation in CPC+ supports development of an advanced medical home (AMH) model, facilitated by multi-payer collaboration. We consider CPC+ a program under Partners in Performance, along with our standard PCP Incentive Program. Specific to the care management measure, practices may participate in either program, but not both. Practices participating in CPC+ should refer to the care management CPC+ measure specifications.

Demographic changes
The Centers for Medicare & Medicaid Services (CMS) has issued requirements for payer online directories to ensure that members have access to accurate information about contracted providers including location, hours of operations, contact information, and whether the provider is accepting new patients. Under the requirement CMS requires the following:

- Require contracted providers to inform the plan of any changes to street address, phone number and office hours or other changes that affect availability.

To become fully compliant with this requirement, Priority Health will make the PIP_099 Physician Audit and PIP_007 Open/Closed and Peak Membership reports available to all providers. We expect providers to review these reports monthly for accuracy and to contact us immediately if their open/closed status has changed. Providers are contractually obligated to provide 60 days prior written notice of closing to new members. Providers that need to make changes, including to location, contact information, office hours, etc., can inform us using the Provider Information Form located at priorityhealth.com/provider/manual/forms. Correct physician alignment and demographic information facilitates accurate PIP settlement.

If a PCP has demographic changes they should submit a Provider Information Form to *PH-PELC@priorityhealth.com*.

Earned members
Earned members are based on assignments to a practice on the 15th of each month, considering retroactivity.

Manual revisions
Priority Health reserves the right to make changes to the PCP Incentive Program at any time. If revisions are made to the technical manual throughout the calendar year, the updated online version is considered the official version. Check the date on the online manual to identify the most current version. We'll alert you of manual revisions via news articles.

Measure rounding
PIP measures are rounded 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.

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

Member assignment
For most measures, member assignment for program settlement aligns with the participating PCP assigned or attributed on Dec. 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, 90-day retroactivity may be requested by an employer for review.

Member diagnosis
Rarely, a newly diagnosed patient may appear in practice reporting during the calendar year. The PCP will be measured on this patient for the PCP Incentive Program.

Member discharge
Discharging members for the sole purpose of reaching PCP Incentive Program measure targets is not allowed. Member discharges are reviewed by Priority Health and must meet the following criteria as listed in the online Provider Manual at http://www.priorityhealth.com/provider/manual/standards/provider-patient-relationship/discharge

Minimum settlement check amount
Practices earning less than $50 will not receive a PCP Incentive Program settlement payout.

Outcomes MTM
OutcomesMTM® is a Cardinal Health company and a vendor we use for the delivery and administration of Medication Therapy Management programs.

PCP incentive program eligibility
It's easy to participate in our PCP Incentive Program. You're eligible if you:
- Participate with Priority Health as a PCP on Dec. 31 of the measurement year
- Submit claims within 45 days of service
- Participate with Priority Health clinical quality improvement programs

The ED visits: PCP treatable measure includes all data and experience for terminated physicians, PCPs that become specialists, and terminated members throughout the performance year.

Some of the measures are paid out at the Accountable Care Network level. Practices who are not contracted through a participating ACN are not eligible for payment in these measures. Details can be found in each measure specification.

Post-settlement review
Priority Health will review and consider appeals to settlement data related to health plan errors or omissions only. Each individual appeal submission must meet a minimum dollar threshold of $2,000 and be submitted for review within 15 days of settlement payment. For details and submission criteria for post-settlement review request requirements, contact your practice's Provider Performance Specialist. Refer to program deadlines for specific deadline dates.

PPACA
The Patient Protection and Affordable Care Act (PPACA), which is also known as The Affordable Care Act (ACA), is considered healthcare law. Some of our measures have applicable product lines listed as PPACA. This line of business can include individual and small group lines of business.

Priority Health quality awards
The practice groups selected for annual Priority Health Quality Awards have achieved the highest overall scores for ensuring patients receive preventive care and control chronic disease. Quality award results are based on performance of a combined quality index score of 1.0 and greater, plus minimum membership of 100 Priority Health members. The quality index (QI) is the sum of the numerators, divided by the sum of the denominators, of each PCP Incentive Program clinical outcomes measures. The result is then divided by the weighted average of the targets to determine the recipients.

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 PCP Incentive Program clinical outcomes measures (see grid below). The result is then divided by the weighted average of the targets to determine the recipients. The subset of measures is subject to change based on HEDIS adjustments. The quality index score calculation uses the same PIP measure targets from the measurement year. Target sources are identified in the measure specs annually.

MEASURE NAME	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	✓	✓	✓	✓
Diabetes Care: Nephropathy			✓	
Hypertension: Controlled BP	✓	✓	✓	✓

Program Deadlines

Description	Deadline
2021 Settlement	June 1, 2022
Medication therapy management (MTM) attestation survey and signed collaborative practice agreement https://www.priorityhealth.com/provider/center/incentives/pip/mtm-incentive-measure	Mar. 12, 2021
Social Determinates of Health (SDoH) attestation survey	May 28, 2021
Behavioral Health Collaborative Care survey attestation	Dec. 3, 2021
Discharge/Transfers – https://www.priorityhealth.com/provider/manual/standards/provider-patient-relationship/discharge	Oct. 31, 2021
Non-adherence www.priorityhealth.com/provider/center/incentives/pip/nonadherent-members	Nov. 5, 2021
Special exceptions www.priorityhealth.com/provider/center/incentives/pip/special-exceptions	Jan. 31, 2022
Supplemental data	Jan. 31, 2022
Claims submission and adjudication	Feb. 28, 2022
Post settlement review 2021	June 15, 2022

Program funding

The PCP Incentive 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 2021. The ASO/PPO product category contains both self-funded (ASO) and fully funded (PPO) products. Although the ASO and PPO products will be settled based upon combined performance, the PMPM funding amount for each product will vary and a total combined amount will be used 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 will not exceed budget amount. Priority Health will index payment as needed.

Report only
Report only measures do not have a monetary incentive tied to performance. These measures are included to determine plan performance, allow for providers to familiarize, and operationalize process and forecasting for the plan.

Reporting
Custom reports won't be built or provided to ACNs or practices for the 2021 PCP Incentive Program.

Report #70 – Supplemental data worksheet
PIP_070 – Supplemental Data Worksheet is an Excel file made available by Priority Health for PCP practices to compile and provide data to us. Practices enter member-specific data into the file and return the file electronically to their Provider Performance Specialist who routes it to the correct department within Priority Health for data downloading. Report #70 instructions are included at the end of this manual.

Secondary cardholders
Members with primary insurance coverage through another health insurer are included in the PCP Incentive Program.

Settlement
For practices participating in standard PIP (not CPC+), all settlement payments will be paid at year-end settlement (June following the program year). Prospective payments won't be distributed for Standard PIP practices.

For practice sites participating in a CPC+ track, prospective payments will be distributed quarterly for the care management measure only. All other measures will be paid at year-end settlement (June following the program year). Refer to the CPC+ care management measure specifications.

Settlement entities
Settlement will be attributed to the participating primary care provider (PCP) assigned as of Dec. 31 of the measurement year, unless otherwise specified, and paid to the physicians' primary contracted accountable health network (ACN). Physicians participating in multiple ACNs will be asked to select a primary affiliation for purposes of the PCP Incentive Program. ACNs will only receive incentive payment for contracted product lines. If physicians have a contract for any product directly with Priority Health outside of the ACN contract, we will distribute those non-contracted funds directly to the same entity his/her claims are paid to for primary care services.

Special exceptions
Special exceptions are only accepted for measures with performance targets. They must be entered in the patient profile tool and must be submitted online by the Jan. 31, 2022 deadline. No other reasons for exclusion or method of submitting your request will be accepted. Manual processing of special exceptions will take place with the 2021 settlement process in the first quarter of 2022. To learn more about special exceptions go to *priorityhealth.com/provider/center/incentives/pip/special-exceptions* (login required).

Supplemental data
Supplemental data may be submitted to Priority Health through these methods:

- Patient Profile using the "Update Data" function
- PIP_070 – Supplemental Data Worksheet is available via FileMart.
- EMR or Patient Registry data exchange (e.g. HL7 file format)
- Michigan Care Improvement Registry (MCIR)
- All Payer Supplemental data transmitted via Michigan Health Information Network (MiHIN)

To learn more about these methods, contact your Provider Performance Specialist.

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.

Supplemental data upload schedule – HL7 data, Patient Profile, and Report #70

- Demographic data: Data transactions including address and benefits are updated nightly.
- Supplemental data: The bulk of Patient Profile data comes from supplemental data elements from claims, HL7 files and provider updates: This update is administered each weekend.
- Release of PIP FileMart reports: Reports are released by approximately 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.
- 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.
- 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.
- The MiHIN APS file is delivered from MiHIN to Priority Health monthly.

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

Prevention

Lead screening in children

Source	HEDIS
Target source	HEDIS 90th percentile
Identified measure	The percentage of children two years of age who had one or more capillary or venous blood screenings for lead poisoning before their second birthday
Case definition	Children must be continuously enrolled for 12 months prior to their second birthday with no more than a 45-day gap in coverage. Children must have active coverage and be assigned to a participating PCP on their second birthday. PCP assigned/attributed on the member's second birthday is credited if measure is met
Age criteria	2 years of age as of Dec. 31 of the measurement year
Exclusionary criteria	Members in hospice or using hospice services any time during the measurement year
Numerator	One or more capillary or venous blood tests to screen for lead poisoning on the child's second birthday
Denominator	All children turning age two in the measurement year
Level of measure	Practice group
Minimum members	1 per practice group
Product line	Medicaid
Method of measurement	Claims data processed by Feb. 28 of the following measurement year. Physician reported data submitted by Jan. 31 of the following measurement year. Lead screenings noted within MCIR will also be downloaded to supplement claims data. The MCIR lead file from the State of Michigan doesn't include MIChild, Healthy Michigan Plan, or Children's Special Health Care Services (CSHCS) members. Therefore, some practices may notice members not meeting the lead screening measure even though the member may have had the service completed. Providers should enter these screenings as supplemental data.
Provider data input	Documented lead screenings may be supplied as supplemental data through Jan. 31 of the following measurement year. Supplemental data includes: • APS • HL7 • Patient Profile • Report #70 Supplemental data is subject to audit.
Target	87%
Payout	$40 per member meeting the measure
Reporting	PIP_011A – PIP Measure Worksheet PIP_011C – PIP Measure Worksheet (TAB)

Prevention
Childhood immunizations: Combination 3

Source	HEDIS
Target source	HEDIS 90th percentile
Identified measure	Immunization set combination 3: • **Four DTaP/DTP**: All at least 42 days after birth, with different dates of service, and on or before the second birthday • **Three Hepatitis B**: On or before the second birthday, with different dates of service. Or history of hepatitis illness • **Three H Influenza Type B (HIB)**: All at least 42 days after birth, with different dates of service, and on or before the second birthday • **One MMR**: On or before the second birthday (the "14-day rule" does not apply) • **Three IPV**: All at least 42 days after birth, with different dates of service, and on or before the second birthday • **One Varicella**: On or before second birthday, or history of disease on or before the second birthday • **Four Pneumococcal Conjugate**: All at least 42 days after birth, with different dates of service, and on or before the second birthday
Case definition	Children continuously enrolled with Priority Health for a 12-month period preceding their second birthday, with no more than one gap in enrollment of up to 45-days during the 12 months prior to the child's second birthday. Children must have active enrollment and be assigned to a participating PCP on their second birthday. PCP assigned/attributed on the member's second birthday is credited if measure is met All events except for MMR must be at least 14 days apart. Following HEDIS criteria, numerator events such as HIB vaccines must be at least 14 days apart to count as two separate events. If two of the same numerator events (i.e. two HIB vaccines) happen within 14 days of each other, we will credit only the first one. For example, if the service date was Feb. 1, then the service date for the second visit must be on or after Feb.15.
Age criteria	2 years of age as of Dec. 31 of the measurement year
Exclusionary criteria	Children who are documented in MCIR as having certain health conditions for which vaccines are contraindicated. Members in hospice or using hospice services any time during the measurement year.
Immunization waivers	The PCP Incentive Program also allows members to be excluded from this measure when parents choose not to vaccinate their child. An immunization refusal or waiver form is required as documentation for these cases. The parent or guardian must sign the immunization refusal or waiver form yearly and a copy must be saved in the patient's medical record. The date of a member's immunization refusal or waiver needs to be submitted through the Update Data function in Patient Profile. These members are removed from the measure denominator. Priority Health requires the use of one of the following templates: • Michigan Department of Community Health • American Academy of Pediatrics
Numerator	The number of children with completed vaccinations as defined above

Denominator	The number of children 2 years of age as of Dec. 31 of the measurement year
Level of measure	Practice group
Minimum members	1 per practice group
Product line	HMO/POS, ASO/PPO, Medicaid
Method of measurement	Claims data processed by Feb. 28 of the following measurement year MCIR data downloaded from the State of Michigan monthly MCIR and Priority Health match member records using a point system. We aren't always able to make a perfect match. Check monthly reporting for non-matches and provide the member's MCIR number to Priority Health through Patient Profile or Report #70.
Provider data input	Immunizations must be entered into MCIR by Jan. 31, of the following measurement year For the MMR, Hepatitis B and varicella vaccine, history of illness or seropositive test should be entered in MCIR as a "documented immunity" (e.g., a child with chicken pox history would be noted as having a documented immunity to the varicella vaccine).
Target: HMO/POS, ASO/PPO	88%
Payout: HMO/POS, ASO/PPO	$175 per member meeting the measure
Target: Medicaid	79%
Payout: Medicaid	$180 per member meeting the measure
Reporting	PIP_011A – PIP Measure Worksheet PIP_011C – PIP Measure Worksheet (TAB) PIP_011I – PIP Immunization Worksheet

Prevention
Childhood immunizations: Combination 10 – Report only

Source	HEDIS
Target source	HEDIS 90th percentile
Identified measure	Immunization set combination 10: • **Four DTaP/DTP**: All at least 42 days after birth, with different dates of service, and on or before the second birthday • **Three Hepatitis B**: On or before the second birthday, with different dates of service. Or history of hepatitis illness • **Three H Influenza Type B (HIB)**: All at least 42 days after birth, with different dates of service, and on or before the second birthday • **One MMR**: On or before the second birthday (the "14-day rule" does not apply) • **Three IPV**: All at least 42 days after birth, with different dates of service, and on or before the second birthday • **One Varicella**: On or before second birthday, or history of disease on or before the second birthday • **Four Pneumococcal Conjugate**: All at least 42 days after birth, with different dates of service, and on or before the second birthday • **One Hepatitis A**: On or between the child's first second birthdays, or history of disease • **Rotavirus**: All at least 42 days after birth, with different dates of service, and on or before the second birthday ▪ At least two doses of the two-dose rotavirus vaccine ▪ At least three doses of the three-dose rotavirus vaccine ▪ At least one dose of the two-dose rotavirus vaccine and at least two doses of the three-dose rotavirus vaccine • **Two Influenza**: At least 180 days after birth, with different dates of service, and on or before the second birthday
Case definition	Children continuously enrolled with Priority Health for a 12-month period preceding their second birthday, with no more than one gap in enrollment up to 45-days during the 12 months prior to the child's second birthday. Children must have active enrollment and be assigned to a participating PCP on their second birthday. PCP assigned/attributed on the member's second birthday is credited if measure is met All events except for MMR must be at least 14 days apart. Following HEDIS criteria, numerator events such as HIB vaccines must be at least 14 days apart to count as two separate events. If two of the same numerator events (i.e. two HIB vaccines) happen within 14 days of each other, we will credit only the first one. For example, if the service date was Feb. 1, then the service date for the second visit must be on or after Feb.15.
Age criteria	2 years of age as of Dec. 31 of the measurement year
Exclusionary criteria	Children who are documented in MCIR as having certain health conditions for which vaccines are contraindicated. Members in hospice or using hospice services any time during the measurement year.
Immunization waivers	The PCP Incentive Program also allows members to be excluded from this measure when parents choose not to vaccinate their child. An immunization refusal or waiver form is required as documentation for these cases. The parent or guardian must sign the immunization refusal or waiver form yearly and a copy must be saved in the patient's medical record.

	The date of a member's immunization refusal or waiver needs to be submitted through the Update Data function in Patient Profile. These members are removed from the measure denominator. Priority Health requires the use of one of the following templates: • Michigan Department of Community Health • American Academy of Pediatrics
Numerator	The number of children with completed vaccinations as defined above
Denominator	The number of children 2 years of age as of Dec. 31 of the measurement year
Level of measure	Practice group
Minimum members	1 per practice group
Product line	HMO/POS, ASO/PPO, Medicaid
Method of measurement	Claims data processed by Feb. 28 of the following measurement year MCIR data downloaded from the State of Michigan monthly MCIR and Priority Health match member records using a point system. We aren't always able to make a perfect match. Check monthly reporting for non-matches and provide the member's MCIR number to Priority Health through Patient Profile or Report #70.
Provider data input	Immunizations must be entered into MCIR by Jan. 31, of the following measurement year For the MMR, Hepatitis B, varicella and Hepatitis A vaccine, history of illness or seropositive test should be entered in MCIR as a "documented immunity" (e.g., a child with chicken pox history would be noted as having a documented immunity to the varicella vaccine).
Target: HMO/POS, ASO/PPO	Reporting only
Payout: HMO/POS, ASO/PPO	Reporting only
Target: Medicaid	Reporting only
Payout: Medicaid	Reporting only
Reporting	PIP_011A – PIP Measure Worksheet PIP_011C – PIP Measure Worksheet (TAB) PIP_011I – PIP Immunization Worksheet
	For Influenza: • Do not count a vaccination administered prior to 6 months (180 days) after birth. • One of the two vaccinations can be an LAIV administered <u>on</u> the child's second birthday. Do not count an LAIV vaccination administered before the child's second birthday.

Prevention
Adolescent immunizations

Source	HEDIS
Target source	HEDIS 90th percentile
Identified measure	Immunization set combination 2: Percentage of adolescents 13 years of age who had the following vaccines: • **Meningococcal**: One meningococcal conjugate between the 11th and 13th birthdays • **Tdap**: One between the 10th and 13th birthdays • **HPV**: Two or three human papilloma virus vaccines between the 9th and 13th birthdays at least 146 days apart. For example, if the service date for the first vaccine was Mar. 1, then the service date for the second vaccine must be after July 25.
Case definition	Adolescents must be continuously enrolled with Priority Health for a 12-month period preceding their 13th birthday with no more than a 45-day gap in coverage. Adolescents must have active enrollment and be assigned to a participating PCP on their 13th birthday. PCP assigned/attributed on the member's 13th birthday is credited if measure is met
Age criteria	13 years of age as of Dec. 31 of the measurement year
Exclusionary criteria	Refer to the CDC guidelines regarding health history, which may result in contraindication for a vaccine. The health history must be noted in MCIR. Members in hospice or using hospice services any time during the measurement year.
Immunization waivers	The PCP Incentive Program also allows members to be excluded from this measure when parents choose not to vaccinate their child. An immunization refusal or waiver form is required as documentation for these cases. The parent or guardian must sign the immunization refusal or waiver form yearly and a copy must be saved in the patient's medical record. The date of a member's immunization refusal or waiver needs to be submitted through the Update Data function in Patient Profile. These members are removed from the measure denominator. Priority Health requires the use of one of the following templates: • Michigan Department of Community Health • American Academy of Pediatrics
Numerator	The number of adolescents with completed immunizations as defined above
Denominator	The number of adolescents 13 years of age as of Dec. 31 of the measurement year.
Level of measure	Practice group
Minimum members	1 per practice group
Product line	HMO/POS, ASO/PPO, Medicaid
Method of measurement	Claims data processed by Feb. 28 of the following measurement year MCIR data downloaded from the State of Michigan monthly MCIR and Priority Health match member records using a point system. We aren't always able to make a perfect match. Check monthly reporting for non-matches and provide the member's MCIR number to Priority Health through Patient Profile or Report #70.

Provider data input	Immunizations must be entered into MCIR by Jan. 31, of the following measurement year
Target: HMO/POS, ASO/PPO	43%
Payout: HMO/POS, ASO/PPO	$100 per member meeting the measure
Target: Medicaid	51%
Payout: Medicaid	$75 per member meeting the measure
Reporting	PIP_011A – PIP Measure Worksheet PIP_011C – PIP Measure Worksheet (TAB) PIP_011I – PIP Immunization Worksheet

Prevention
Well-Child visits in the first 15 months of life

Source	HEDIS
Target source	HEDIS 90th percentile
Identified measure	Infants turning 15 months of age in the measurement year who had at least six well-child visits with a PCP by 15 months of age
Case definition	Continuously enrolled with Priority Health from 31 days of age to 15 months of age with no more than one gap in enrollment of up to 45 days during the continuous enrollment period The infant must be enrolled and assigned to a PCP on the day of their 15th month of age. 15 months of age is defined as the 90th day following the infant's 1st birthday. PCP assigned/attributed on the date the infant reaches 15 months is credited if measure is met Following HEDIS criteria, numerator events such as a well-child visit must be at least 14 days apart to count as two separate events. If two of the same numerator events (i.e. two well-child visits) happen within 14 days of each other, we will credit only the first one. For example, if the service date was Feb. 1, then the service date for the second visit must be on or after Feb. 15.
Age criteria	15 months of age during the measurement year
Exclusionary criteria	Members in hospice or using hospice services any time during the measurement year
Numerator	Infants with at least six well-child visits before turning 15 months of age
Denominator	Infants turning 15 months of age during the measurement year
Level of measure	Practice group
Minimum members	1 per practice group
Product line	HMO/POS, ASO/PPO, Medicaid
Method of measurement	Claims data processed by Feb. 28 of the following measurement year. Supplemental data for well child visits that were not billed but are documented in the medical record can be submitted via report 70.
Provider data input	Supplemental data includes: • APS • HL7 • Report #70 Supplemental data is subject to audit.
Target: HMO/POS, ASO/PPO	91%
Payout: HMO/POS, ASO/PPO	$85 per member meeting the measure
Target: Medicaid	77%
Payout: Medicaid	$85 per member meeting the measure
Reporting	PIP_011A – PIP Measure Worksheet PIP_011C – PIP Measure Worksheet (TAB)

Notes	Documentation from the medical record must include a visit with a PCP Well-child visits completed via telehealth are considered numerator compliant when billed with a GT or 95 modifier or place of service (POS) 02. Services rendered during an inpatient or ED visit don't count

Prevention
Well-Child visits in the first 15 to 30 months of life – Report only

Source	HEDIS
Target source	HEDIS 90th percentile
Identified measure	Children turning 30 months of age in the measurement year who had at two or more well child visits with a PCP by 30 months of age
Case definition	Continuously enrolled with Priority Health from 15 months plus 1 day – 30 months of age with no more than one gap in enrollment of up to 45 days during the continuous enrollment period Children must be enrolled and assigned to a PCP on the day of their 30 months of age. 30 months of age is defined as the 180th day following the child's 2nd birthday. PCP assigned/attributed on the date the child reaches 30 months is credited if measure is met Following HEDIS criteria, numerator events such as a well-child visit must be at least 14 days apart to count as two separate events. If two of the same numerator events (i.e. two well-child visits) happen within 14 days of each other, we will credit only the first one. For example, if the service date was Feb. 1, then the service date for the second visit must be on or after Feb. 15.
Age criteria	30 months of age during the measurement year
Exclusionary criteria	Members in hospice or using hospice services any time during the measurement year
Numerator	Children with at least two well-child visits on different dates of service between the child's 15-month birthday plus 1 day and the 30-month birthday
Denominator	Children turning 30 months of age during the measurement year
Level of measure	Practice group
Minimum members	1 per practice group
Product line	HMO/POS, ASO/PPO, Medicaid
Method of measurement	Claims data processed by Feb. 28 of the following measurement year Supplemental data for well child visits that were not billed but are documented in the medical record can be submitted via report 70.
Provider data input	Supplemental data includes: • APS • HL7 • Report #70 Supplemental data is subject to audit.
Target:	Reporting only
Payout:	Reporting only
Reporting	PIP_011A – PIP Measure Worksheet PIP_011C – PIP Measure Worksheet (TAB)
Notes	Documentation from the medical record must include a visit with a PCP Well-child visits completed via telehealth are considered numerator compliant when billed with a GT or 95 modifier or place of service (POS) 02. Services rendered during an inpatient or ED visit don't count

Prevention
Well-Child visits 3–11 years

Source	HEDIS
Target source	2020 Health Plan 75th Percentile Performance
Identified measure	Children 3–11 years of age who received one or more well-child visits with a PCP in the measurement year
Case definition	Children must be continuously enrolled with Priority Health during the measurement year with no more one gap in enrollment of more than 45-day Children must be members of Priority Health and assigned/attributed to a participating PCP on Dec. 31 of the measurement year
Age criteria	3-11 years of age as of Dec. 31 of the measurement year
Exclusionary criteria	Members in hospice or using hospice services any time during the measurement year
Numerator	The number of children with at least one well-child visit during the measurement year
Denominator	The number of children 3-11 years of age as of Dec. 31 of the measurement year
Level of measure	Practice group
Minimum members	1 per practice group
Product line	HMO/POS, ASO/PPO, and Medicaid
Method of measurement	Claims data processed by Feb. 28 of the following measurement year Supplemental data for well child visits that were not billed but are documented in the medical record can be submitted via report 70.
Provider data input	Supplemental data includes: • APS • HL7 • Report #70 Supplemental data is subject to audit.
Target: HMO/POS, ASO/PPO	79%
Payout: HMO/POS, ASO/PPO	$70 per member meeting the measure
Target: Medicaid	62%
Payout: Medicaid	$70 per member meeting the measure
Reporting	PIP_011A – PIP Measure Worksheet PIP_011C – PIP Measure Worksheet (TAB)
Notes	Target is based on the 75th percentile of 2020 network performance Target to be communicated to the network Q2 2021 Documentation from the medical record must include a visit with a PCP Well-child visits completed via telehealth are considered numerator compliant when billed with a GT or 95 modifier or place of service (POS) 02. Services rendered during an inpatient or ED visit don't count

Prevention
Chlamydia screening

Source	HEDIS
Target source	HEDIS 90th percentile
Identified measure	The percentage of women 16–24 years of age who were identified as sexually active with one or more chlamydia screenings during the measurement year
Case definition	Women must be continuously enrolled with Priority Health with no more than one gap in enrollment of up to 45-days during the measurement year Women must be enrolled with Priority Health and assigned to a participating PCP on Dec. 31 of the measurement year
Age criteria	16–24 years of age as of Dec. 31 of the measurement year
Exclusionary criteria	A billed pregnancy test during the measurement year and a filled prescription for Isotretinoin (Accutane) An X-ray on the same day as the pregnancy test or six days after the pregnancy test Members in hospice or using hospice services any time during the measurement year
Numerator	Women 16-24 years of age with at least one or more chlamydia tests during the measurement year
Denominator	Sexually active women 16-24 years old
Level of measure	Practice group
Minimum members	1 per practice group
Product line	Medicaid
Method of measurement	Pharmacy and medical claims processed by Feb. 28 of the following measurement year Physician reported data submitted by Jan. 31 of the following measurement year Sexual activity is identified through billed diagnosis codes, procedure codes and pharmacy claims (see measure code sets)
Provider data input	Documented chlamydia screening may be supplied as supplemental data through Jan. 31 of the following measurement year. Supplemental data includes: • APS • HL7 • Patient Profile • Report #70 Supplemental data is subject to audit.
Target: Medicaid	71%
Payout	$35 per member meeting the measure
Reporting	PIP_011A – PIP Measure Worksheet PIP_011C – PIP Measure Worksheet (TAB)

Prevention
Cervical cancer screening

Source	HEDIS
Target source	HEDIS 90th percentile
Identified measure	The percentage of women 21–64 years of age with a cervical cancer screening according to the following schedule: • Women 21–64 years of age who had cervical cytology performed within the last 3 years. • Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years. • Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.
Case definition	For commercial only - Women must be continuously enrolled during the measurement year and the two years prior to the measurement year with no more than one 45-day gap in coverage during each year of continuous enrollment. For ACA Individual (HMO/POS) and Medicaid, women must be continuously enrolled with Priority Health in the measurement year with no more than one gap in enrollment of up to 45 days during the measurement year Women must be members of Priority Health on Dec. 31 of the measurement year
Age criteria	24–64 years of age as of Dec. 31 of the measurement year
Exclusionary criteria	Women who have had a complete, total or radical abdominal or vaginal hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during the member's history through Dec. 31 of the measurement year. Member in hospice, using hospice services or palliative care any time during the measurement year. If Priority Health hasn't received claims data regarding this history, providers may supply through supplemental data options.
Numerator	The number of women who received cervical cancer screening as defined above
Denominator	The number of women who reached the age of 24-64 years as of Dec. 31 of the measurement year
Level of measure	Practice group
Minimum members	1 per practice group
Product line	HMO/POS, ASO/PPO, Medicaid
Method of measurement	Claims data processed by Feb. 28 of the following measurement year Provider supplemental data by Jan. 31 of the following measurement year
Provider data input	Supplemental data for complete, total or radical abdominal or vaginal hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix, may be provided until Jan. 31 of the following measurement year. Supplemental data for non-billed cervical cancer screenings and/or HPV co-testing may be provided until Jan. 31 of the following measurement year. Supplemental data includes: • APS

	• HL7 • Patient Profile • Report #70 Supplemental data for non-billed hrHPV screenings Report #70 and patient profile Supplemental data is subject to audit.
Target: HMO/POS, ASO/PPO	84%
Payout: HMO/POS, ASO/PPO	$15 per member meeting the measure
Target: Medicaid	73%
Payout: Medicaid	$20 per member meeting the measure
Reporting	PIP_011A – PIP Measure Worksheet PIP_011C – PIP Measure Worksheet (TAB)

Prevention
Breast cancer screening

Source	HEDIS
Target source	Commercial and Medicaid: HEDIS 90th percentile Medicare: CMS Medicare 5 Star cut point plus a predictive factor
Identified measure	One or more mammograms any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year
Case definition	**Continuous enrollment** October 1 two years prior to the measurement year through December 31 of the measurement year. **Allowable gap** No more than one gap in enrollment of up to 45 days for each full calendar year of continuous enrollment (the measurement year and the year prior to the measurement year). Medicaid: member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled) during each year of continuous enrollment.
Age criteria	50-74 years of age as of Dec. 31 of the measurement year
Exclusionary criteria	Members that had a bilateral mastectomy any time during the member's history Members in hospice, using hospice services or palliative care any time during the measurement year Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: • Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. • Living long-term in an institution any time during the measurement year Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty ***and*** advanced illness. Members must meet ***BOTH*** of the following frailty and advanced illness criteria to be excluded (includes telephone visits, e-visits and virtual check-ins)
Numerator	The number of women 50-74 years of age who received mammogram any time between October 1 two years prior to the measurement year and December 31 of the measurement year
Denominator	The number of women who reached the age of 50-74 years as of Dec. 31 of the measurement year
Level of measure	Practice group
Minimum members	1 per practice group
Product line	HMO/POS, ASO/PPO, Medicare, Medicaid
Method of measurement	Claims data processed by Feb. 28 of the following measurement year Provider supplemental data by Jan. 31 of the following measurement year
Provider data input	Supplemental data for bilateral mastectomy history may be provided until Jan. 31 of the following measurement year Supplemental data includes: • APS • HL7 • Patient Profile

	• Report #70 Supplemental data is subject to audit.
Target: HMO/POS, ASO/PPO	81%
Payout: HMO/POS, ASO/PPO	$15 per member meeting the measure
Target: Medicare	85%
Payout: Medicare	$25 per member meeting the measure
Target: Medicaid	69%
Payout: Medicaid	$20 per member meeting the measure
Reporting	PIP_011A – PIP Measure Worksheet PIP_011C – PIP Measure Worksheet (TAB)
Notes	All types and methods of mammograms (screening, diagnostic, film, digital or digital breast tomosynthesis) qualify for numerator compliance MRIs, ultrasounds, thermograms, or biopsies do not count towards the numerator

Prevention
Colorectal cancer screening

Source	HEDIS
Target source	Commercial and Medicaid: HEDIS 90th percentile Medicare: CMS Medicare 5 Star cut point plus a predictive factor
Identified measure	The percentage of members 50-75 years of age who had appropriate screening for colorectal cancer
Case definition	Members continuously enrolled in in the measurement year and the year prior, with no more than one gap in continuous enrollment of up to 45 days during each year of continuous enrollment Members 51-75 years of age as of Dec. 31 of the measurement year
Age criteria	51-75 years of age as of Dec. 31 of the measurement year
Exclusionary criteria	Members with a diagnosis of colorectal cancer or total colectomy any time during the member's history Members in hospice, using hospice services or palliative care any time during the measurement year Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: • Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. • Living long-term in an institution any time during the measurement year Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty ***and*** advanced illness. Members must meet ***BOTH*** of the following frailty and advanced illness criteria to be excluded (includes telephone visits, e-visits and virtual check-ins)
Numerator	One or more screenings for colorectal cancer: • Fecal occult blood test (FOBT) during the measurement year • Flexible sigmoidoscopy anytime during the measurement year or four years prior to the measurement year • Colonoscopy anytime during the measurement year or nine years prior to the measurement year • FIT-DNA (Cologuard) anytime during the measurement year or the two years prior to the measurement year • CT colonography anytime during the measurement year or the four years prior to the measurement year
Denominator	Eligible members between 50-75 years of age
Level of measurement	Practice group
Minimum members	1 per practice group
Product Line	HMO/POS, ASO/PPO, Medicare
Method of measurement	Claims data processed by Feb. 28 of the following measurement year Physician reported data submitted by Jan. 31 of the following measurement year Measure is scored based on evidence of procedure via supplemental data or claims, not the result of the procedure
Provider data input	Supplemental data may be provided until Jan. 31 of the following measurement year. Supplemental data includes: • APS

	• HL7 • Patient Profile • Report #70 If member had any of these services defined below completed prior to enrollment with Priority Health, enter that date of service and result in Patient Profile or Report #70 • Fecal occult blood test (FOBT) • Flexible sigmoidoscopy • Colonoscopy • CT colonography • FIT-DNA (Cologuard) Supplemental data is subject to audit
Target: HMO/POS, ASO/PPO	77%
Target: Medicare	84%
Payout: HMO/POS, ASO/PPO Medicare	$20 per member meeting the measure
Reporting	PIP_011A – PIP Measure Worksheet PIP_011C – PIP Measure Worksheet (TAB)

Prevention
Opioid utilization- Report only

Source	HEDIS – Developed by Pharmacy Quality Alliance (PQA)
Identified measure	The proportion of members 18 years and older, receiving prescription opioids for ≥15 days during the measurement year at a high dosage (average milligram morphine dose [MME] ≥90 mg) The proportion will be calculated and displayed as a permillage (multiplied by 1,000) instead of a percentage in reports.
Case definition	Members must be continuously enrolled with Priority Health in the measurement year.
Age criteria	18 years of age and older during the measurement year
Exclusionary criteria	• Members who had only a single opioid medication dispensing event • Members with a diagnosis of cancer or sickle cell disease • Members receiving palliative care during the measurement year
Numerator	The number of members who's average MME was ≥90 mg MME during the treatment period
Denominator	Members 18 years and older as of January 1, of the measurement year with • At least two or more opioid dispensing events on different dates of service (HDO-A Opioid Medications List) *AND* • ≥15 total days covered by opioids
Level of measure	Practice level
Minimum members	1 per practice
Product line	HMO/POS, ASO/PPO, Medicare, Medicaid
Method of measurement	Claims data processed by Feb. 28 of the following program year
Reporting	Opioid utilization report
Notes	Measure title in HEDIS is Use of Opioids at High Dosage A lower rate indicates better performance Opioid Medications include: • Butorphanol • Codeine • Dihydrocodeine • Fentanyl • Hydrocodone • Hydromorphone • Meperidine • Methadone • Morphine • Opium • Oxycodone • Oxymorphone • Pentazocine • Tapentadol • Tramadol Methadone for the treatment of opioid use disorder is excluded from this measure.

Chronic disease

Diabetes care: Controlled HbA1c less than 8.0%

Source	HEDIS
Target source	Commercial and Medicaid: HEDIS 90th percentile Medicare: HEDIS 90th percentile plus a predictive factor
Identified measure	The percentage of members 18 to 75 years of age with diabetes with an HbA1c <8.0%
Case definition	A member with diabetes is defined by: Claim/encounter and pharmacy data • Two face-to-face encounters with a diagnosis of diabetes: ▪ On different dates of service. ▪ In an outpatient setting, observation visit, telephone visit, online assessment, ED visit, non-acute inpatient encounter, or non-acute inpatient discharges in the year prior or measurement year. ▪ Visits may be an outpatient telehealth, telephone visit or virtual check-in, OR • One face-to-face encounter with a diagnosis of diabetes: ▪ In an acute inpatient encounter without telehealth in the year prior or measurement year. ▪ One acute inpatient discharge with a diagnosis of diabetes on the discharge claim. OR • Pharmacy data, insulin or oral hypoglycemic/antihyperglycemic filled script with diagnosis of diabetes during the year prior or measurement year. **Continuous enrollment/allowable gap** Members must be continuously enrolled in the measurement year with no more than one gap in enrollment of up to 45-days during the measurement year. Members must be active with Priority Health and assigned/attributed to a participating PCP on Dec. 31 of the measurement year. Medicaid: member may not have more than a 1-month gap in coverage
Age criteria	18–75 years of age as of Dec. 31 of the measurement year
Exclusionary criteria	Members in hospice, using hospice services or palliative care any time during the measurement year Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: • Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. • Living long-term in an institution any time during the measurement year Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty ***and*** advanced illness. Members must meet ***BOTH*** of the following frailty and advanced illness criteria to be excluded (includes telephone visits, e-visits and virtual check-ins) Members who do not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and

	who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes in any setting during the measurement year or the year prior or measurement year.
Numerator	The number of members with diabetes with an HbA1c <8.0% This measure considers the most recent lab conducted in the measurement year. If no HbA1c was conducted during measurement year, the level is considered to be greater than or equal to 8.0%
Denominator	All members with diabetes as defined above
Level of measure	Practice group
Minimum members	1 per practice group
Product line	HMO/POS, ASO/PPO, Medicare, Medicaid
Method of measurement	HbA1c values are sent electronically to Priority Health by many network hospitals and independent labs. Supplemental data submitted by Jan. 31 of the following measurement year
Provider data input	Documented lab values may be provided as supplemental data through Jan. 31 of the following measurement year. Supplemental data includes: • APS • HL7 • Patient Profile • Report #70 Supplemental data is subject to audit. Providers may exclude any member they determine to be incorrectly defined as diabetic by submitting data through the Update Data function located in the diabetic status dropdown in Patient Profile. The deadline for data submission is Jan. 31 of the following measurement year.
Target: HMO/POS, ASO/PPO	68%
Payout: HMO/POS, ASO/PPO	$60 per member meeting the measure
Target: Medicare	79%
Payout: Medicare	$60 per member meeting the measure
Target: Medicaid	61%
Payout: Medicaid	$50 per member meeting the measure
Reporting	PIP_011A – PIP Measure Worksheet PIP_011C – PIP Measure Worksheet (TAB) PIP_011D – PIP Diabetes Worksheet PIP_011G – PIP Diabetes Lab Result Worksheet
Notes:	Rarely, a newly diagnosed patient may appear in practice reporting during the calendar year. The PCP will be measured on this patient for the PCP Incentive Program.

Chronic disease
Diabetes care: Controlled HbA1c less than or equal to 9.0%

Source	HEDIS
Target source	Commercial and Medicaid: HEDIS 90th percentile Medicare: CMS Medicare 5 Star cut point plus a predictive factor
Identified measure	The percentage of members 18 to 75 years of age with diabetes with an HbA1c ≤9.0%
Case definition	A member with diabetes is defined by: Claim/encounter and pharmacy data • Two face-to-face encounters with a diagnosis of diabetes: ▪ On different dates of service. ▪ In an outpatient setting, observation visit, telephone visit, online assessment, ED visit, non-acute inpatient encounter, or non-acute inpatient discharges in the year prior or measurement year. ▪ Visits may be an outpatient telehealth, telephone visit or virtual check-in, OR • One face-to-face encounter with a diagnosis of diabetes: ▪ In an acute inpatient encounter without telehealth in the year prior or measurement year. ▪ One acute inpatient discharge with a diagnosis of diabetes on the discharge claim. OR • Pharmacy data, insulin or oral hypoglycemic/antihyperglycemic filled script with diagnosis of diabetes during the year prior or measurement year. **Continuous enrollment/allowable gap** Members must be continuously enrolled in the measurement year with no more than one gap in enrollment of up to 45-days during the measurement year. Members must be active with Priority Health and assigned/attributed to a participating PCP on Dec. 31 of the measurement year. Medicaid: member may not have more than a 1-month gap in coverage
Age criteria	18–75 years of age as of Dec. 31 of the measurement year
Exclusionary criteria	Members in hospice, using hospice services or palliative care any time during the measurement year Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: • Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. • Living long-term in an institution any time during the measurement year Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty ***and*** advanced illness. Members must meet ***BOTH*** of the following frailty and advanced illness criteria to be excluded (includes telephone visits, e-visits and virtual check-ins) Members who do not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes in any setting during the measurement year or the year prior or measurement year.
Numerator	The number of members with diabetes with an HbA1c ≤ 9.0%

	This measure considers the most recent lab conducted in the measurement year. If no HbA1c was conducted in the measurement year, the level is considered to be greater than 9.0%.
Denominator	All members with diabetes as defined above
Level of measure	Practice group
Minimum members	1 per practice group
Product line	HMO/POS, ASO/PPO, Medicare, Medicaid
Method of measurement	HbA1c values are sent electronically to Priority Health by many network hospitals and independent labs. Supplemental data submitted by Jan. 31 of the following measurement year
Provider data input	Documented lab values may be provided as supplemental data through Jan. 31 of the following measurement year. Supplemental data includes: • APS • HL7 • Patient Profile • Report #70 Supplemental data is subject to audit. Providers may exclude any member they determine to be incorrectly defined as diabetic by submitting data through the Update Data function located in the diabetic status dropdown in Patient Profile. The deadline for data submission is Jan. 31 of the following measurement year.
Target: HMO/POS, ASO/PPO	80%
Payout: HMO/POS, ASO/PPO	$60 per member meeting the measure
Target: Medicare	89%
Payout: Medicare	$75 per member meeting the measure
Target: Medicaid	72%
Payout: Medicaid	$30 per member meeting the measure
Reporting	PIP_011A – PIP Measure Worksheet PIP_011C – PIP Measure Worksheet (TAB) PIP_011D – PIP Diabetes Worksheet PIP_011G – PIP Diabetes Lab Result Worksheet
Notes	Rarely, a newly diagnosed patient may appear in practice reporting during the calendar year. The PCP will be measured on this patient for the PCP Incentive Program.

Chronic disease
Diabetes care: Annual retinal eye exam

Source	HEDIS
Target source	Commercial and Medicaid: HEDIS 90th percentile Medicare: CMS Medicare 5 Star cut point plus a predictive factor
Identified measure	The percentage of members 18 to 75 years of age with diabetes and: • A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year • A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year • Eye exam results read by a system that provides an artificial intelligence (AI) interpretation meet criteria • Bilateral eye enucleations any time during the member's history through Dec. 31 of the measurement year
Case definition	A member with diabetes is defined by: Claim/encounter and pharmacy data • Two face-to-face encounters with a diagnosis of diabetes: ▪ On different dates of service. ▪ In an outpatient setting, observation visit, telephone visit, online assessment, ED visit, non-acute inpatient encounter, or non-acute inpatient discharges in the year prior or measurement year. ▪ Visits may be an outpatient telehealth, telephone visit or virtual check-in, OR • One face-to-face encounter with a diagnosis of diabetes: ▪ In an acute inpatient encounter without telehealth in the year prior or measurement year. ▪ One acute inpatient discharge with a diagnosis of diabetes on the discharge claim. OR • Pharmacy data, insulin or oral hypoglycemic/antihyperglycemic filled script with diagnosis of diabetes during the year prior or measurement year. **Continuous enrollment/allowable gap** Members must be continuously enrolled in the measurement year with no more than one gap in enrollment of up to 45-days during the measurement year. Members must be active with Priority Health and assigned/attributed to a participating PCP on Dec. 31 of the measurement year. Medicaid: member may not have more than a 1-month gap in coverage
Age criteria	18–75 years of age as of Dec. 31 of the measurement year
Exclusionary criteria	Members in hospice, using hospice services or palliative care any time during the measurement year Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: • Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. • Living long-term in an institution any time during the measurement year Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty ***and*** advanced illness. Members must meet ***BOTH*** of the following frailty and advanced illness

	criteria to be excluded (includes telephone visits, e-visits and virtual check-ins) Members who do not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes in any setting during the measurement year or the year prior or measurement year.
Numerator	The number of members with diabetes with a retinal or dilated eye exam performed in the measurement year or a documented negative retinal eye exam performed in the year prior to the measurement year
Denominator	All members with diabetes as defined above
Level of measure	Practice group
Minimum members	1 per practice group
Product line	HMO/POS, ASO/PPO, Medicare and Medicaid
Method of measurement	Claims data processed by Feb. 28 of the following measurement year Supplemental data submitted by Jan. 31 of the following measurement year
Provider data input	Documented retinal eye exams may be provided as supplemental data through Jan. 31 of the following measurement year. Supplemental data includes: • APS • HL7 • Patient Profile • Report #70 Supplemental data is subject to audit. Providers may exclude any member they determine to be incorrectly defined as diabetic by submitting data through the Update Data function located in the diabetic status dropdown in Patient Profile. The deadline for data submission is Jan. 31 of the following measurement year. Supplemental data submission measure result entered as unknown for the year prior to the measurement year will not count towards the numerator.
Target: HMO/POS, ASO/PPO	70%
Payout: HMO/POS, ASO/PPO	$40 per member meeting the measure
Target: Medicare	85%
Payout: Medicare	$75 per member meeting the measure
Target: Medicaid	70%
Payout: Medicaid	$50 per member meeting the measure
Reporting	PIP_011A – PIP Measure Worksheet PIP_011C – PIP Measure Worksheet (TAB) PIP_011D – PIP Diabetes Worksheet PIP_011Z – PIP Diabetes Retinopathy Evaluation Form
Notes:	Rarely, a newly diagnosed patient may appear in practice reporting during the calendar year. The PCP will be measured on this patient for the PCP Incentive Program.

Chronic disease
Diabetes care: Monitoring for nephropathy

Source	HEDIS
Target source	CMS Medicare 5 Star cut point
Identified measure	The percentage of members 18 to 75 years of age with diabetes who have had one of the following during the measurement year: • A microalbuminuria lab in the measurement year • Diagnosis of or treatment for nephropathy or ACE/ARB therapy in the measurement year • Pharmacy claim for ACE/ARB therapy in the program year • Visit with a nephrologist in the measurement year • Evidence of nephrectomy or kidney transplant • Evidence of ESRD or dialysis • Evidence of stage 4 chronic kidney disease
Case definition	A member with diabetes is defined by: Claim/encounter and pharmacy data • Two face-to-face encounters with a diagnosis of diabetes: ▪ On different dates of service. ▪ In an outpatient setting, observation visit, telephone visit, online assessment, ED visit, non-acute inpatient encounter, or non-acute inpatient discharges in the year prior or measurement year. ▪ Visits may be an outpatient telehealth, telephone visit or virtual check-in, OR • One face-to-face encounter with a diagnosis of diabetes: ▪ In an acute inpatient encounter without telehealth in the year prior or measurement year. ▪ One acute inpatient discharge with a diagnosis of diabetes on the discharge claim. OR • Pharmacy data, insulin or oral hypoglycemic/antihyperglycemic filled script with diagnosis of diabetes during the year prior or measurement year. **Continuous enrollment/allowable gap** Members must be continuously enrolled in the measurement year with no more than one gap in enrollment of up to 45-days during the measurement year. Members must be active with Priority Health and assigned/attributed to a participating PCP on Dec. 31 of the measurement year.
Age criteria	18–75 years of age as of Dec. 31 of the measurement year
Exclusionary criteria	Members in hospice, using hospice services or palliative care any time during the measurement year Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: • Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. • Living long-term in an institution any time during the measurement year Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty ***and*** advanced illness. Members must meet ***BOTH*** of the following frailty and advanced illness

	criteria to be excluded (includes telephone visits, e-visits and virtual check-ins) Members who do not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes in any setting during the measurement year or the year prior or measurement year.
Numerator	Members with diabetes who have had one of the following: • A microalbuminuria lab during the measurement year • Diagnosis of or treatment for nephropathy during the measurement year • Pharmacy claim for ACE/ARB therapy during the measurement year • Visit with a nephrologist in the measurement year • Evidence of ESRD • Evidence of stage 4 chronic kidney disease • Evidence of kidney transplant
Denominator	All members with diabetes as defined above
Level of measure	Practice group
Minimum members	1 per practice group
Product line	Medicare
Method of measurement	Claims data processed by Feb. 28 of the following measurement year Supplemental data submitted by Jan. 31 of the following measurement year
Provider data input	Documented microalbuminuria labs may be provided as supplemental data through Jan. 31 of the following measurement year. Supplemental data includes: • APS • HL7 • Patient Profile • Report #70 Supplemental data is subject to audit. Providers may exclude any member they determine to be incorrectly defined as diabetic by submitting data through the Update Data function located in the diabetic status dropdown in Patient Profile. The deadline for data submission is Jan. 31 of the following measurement year.
Target: Medicare	98%
Payout: Medicare	$40 per member meeting the measure
Reporting	PIP_011A – PIP Measure Worksheet PIP_011C – PIP Measure Worksheet (TAB) PIP_011D – PIP Diabetes Worksheet
Notes:	Rarely, a newly diagnosed patient may appear in practice reporting during the calendar year. The PCP will be measured on this patient for the PCP Incentive Program.

Chronic Disease
Kidney Health Evaluation for Patients with Diabetes – Report only

Source	HEDIS
Identified measure	The percentage of members 18-85 years of age with diabetes (type 1 and 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin creatinine ratio (uACR), during the measurement year
Case definition	A member with diabetes is defined by: Claim/encounter and pharmacy data • Two face-to-face encounters with a diagnosis of diabetes: ▪ On different dates of service. ▪ In an outpatient setting, observation visit, telephone visit, online assessment, ED visit, non-acute inpatient encounter, or non-acute inpatient discharges in the year prior or measurement year. ▪ Visits may be an outpatient telehealth, telephone visit or virtual check-in, OR • One face-to-face encounter with a diagnosis of diabetes: ▪ In an acute inpatient encounter without telehealth in the year prior or measurement year. ▪ One acute inpatient discharge with a diagnosis of diabetes on the discharge claim. OR • Pharmacy data, insulin or oral hypoglycemic/antihyperglycemic filled script with diagnosis of diabetes during the year prior or measurement year. **Continuous enrollment/allowable gap** Members must be continuously enrolled in the measurement year with no more than one gap in enrollment of up to 45-days during the measurement year. Members must be active with Priority Health and assigned/attributed to a participating PCP on Dec. 31 of the measurement year. Medicaid: member may not have more than a 1-month gap in coverage
Age criteria	18-85 years of age as of Dec. 31 of the measurement year
Exclusionary criteria	Members in hospice, using hospice services or palliative care any time during the measurement year Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: • Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. • Living long-term in an institution any time during the measurement year Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty ***and*** advanced illness. Members must meet ***BOTH*** of the following frailty and advanced illness criteria to be excluded (includes telephone visits, e-visits, and virtual check-ins) Members 81 years of age and older as of December 31 of the measurement year (all product lines) with frailty Members who do not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-

	induced diabetes in any setting during the measurement year or the year prior or measurement year Members with evidence of ESRD or dialysis any time during the member's history on prior to Dec. 31 of the measurement year
Numerator	Members who received both of the following during the measurement year on the same or different dates of service: • At least one eGFR • At least one uACR identified by both a quantitative urine albumin test and a urine creatinine test with service dates four or less days apart For example, if the service date for the quantitative urine albumin test was Dec. 1 of the measure year, then the urine creatinine test must have a service date on or between Nov. 27 and Dec. 5 of the measurement year.
Denominator	All members with diabetes as defined above
Level of measure	Practice level
Minimum members	1 per practice
Product line	HMO/POS, ASO/PPO, Medicare, Medicaid
Method of measurement	Claims data processed by Feb. 28 of the following program year
Reporting	TBD
Notes	Rarely, a newly diagnosed patient may appear in practice reporting during the calendar year. The PCP will be measured on this patient for the PCP Incentive Program.

Chronic Disease
Optimal diabetes care

Source	Extrapolated from HEDIS Diabetes Care measures
Identified measure	The percentage of patients 18 to 75 years of age with diabetes who have met all standards defined in each of the following measures: • Diabetes care: Controlled HbA1c less than 8.0% • Diabetes care: Annual retinal eye exam • Diabetes care: Controlled blood pressure
Case definition	A member with diabetes is defined by: Claim/encounter and pharmacy data • Two face-to-face encounters with a diagnosis of diabetes: ▪ On different dates of service. ▪ In an outpatient setting, observation visit, telephone visit, online assessment, ED visit, non-acute inpatient encounter, or non-acute inpatient discharges in the year prior or measurement year. ▪ Visits may be an outpatient telehealth, telephone visit or virtual check-in, OR • One face-to-face encounter with a diagnosis of diabetes: ▪ In an acute inpatient encounter without telehealth in the year prior or measurement year. ▪ One acute inpatient discharge with a diagnosis of diabetes on the discharge claim. OR • Pharmacy data, insulin or oral hypoglycemic/antihyperglycemic filled script with diagnosis of diabetes during the year prior or measurement year. **Continuous enrollment/allowable gap** Members must be continuously enrolled in the measurement year with no more than one gap in enrollment of up to 45-days during the measurement year. Members must be active with Priority Health and assigned/attributed to a participating PCP on Dec. 31 of the measurement year. Medicaid: member may not have more than a 1-month gap in coverage
Age criteria	18–75 years of age as of Dec. 31 of the measurement year
Exclusionary criteria	Members in hospice, using hospice services or palliative care any time during the measurement year Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: • Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. • Living long-term in an institution any time during the measurement year Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty ***and*** advanced illness. Members must meet ***BOTH*** of the following frailty and advanced illness criteria to be excluded (includes telephone visits, e-visits and virtual check-ins) Members who do not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes in any setting during the measurement year or the year prior or measurement year.
Numerator	The number of members with diabetes that met each of the standards in the following diabetes measures:

	• Diabetes care: Controlled HbA1c less than 8% • Diabetes care: Annual retinal eye exam • Diabetes care: Controlled blood pressure
Denominator	All members with diabetes as defined above
Level of measure	Practice group
Minimum members	1 per practice group
Product Line	HMO/POS, ASO/PPO, Medicaid
Method of measurement	Claims data processed by Feb. 28 of the following measurement year Supplemental data submitted by Jan. 31 of the following measurement year
Provider data input	None
Targets: HMO/POS, ASO/PPO and Medicaid	20-29%, 30-34%, 35% and above
Payout: HMO/POS, ASO/PPO and Medicaid	$75 per member measured for performance of 20-29%, $125 per member measured for performance of 30-34% $200 per member measured for performance of 35% and above
Reporting	PIP_011A – PIP Measure Worksheet PIP_011C – PIP Measure Worksheet (TAB) PIP_011D – PIP Diabetes Worksheet
Notes:	Rarely, a newly diagnosed patient may appear in practice reporting during the calendar year. The PCP will be measured on this patient for the PCP Incentive Program.

Chronic Disease
Statin therapy for patients with diabetes

Source	CMS Medicare 5 Star
Target Source	CMS Medicare 5 Star cut point plus a predictive factor
Identified measure	Medicare members 40-75 years of age during the measurement year who were dispensed at least two diabetes medication fills who received a statin medication fill during the measurement year
Case definition	A member with diabetes is defined by having at least two diabetes medication fills during the measurement year. The percentage is calculated as the number of members 40-75 years old who received a statin medication fill during the measurement period (numerator) divided by the number of members 40-75 years old with at least two diabetes medication fills during the measurement period (denominator).
Age criteria	Members 40-75 years of age as of Dec. 31 of the measurement year
Exclusionary criteria	Members in hospice Members with ESRD diagnosis
Numerator	Members that had at least one dispensing event for a high-intensity, moderate intensity, or low-intensity statin medication during the measurement year
Denominator	Members 40-75 years old with at least two diabetes medications fill during the measurement period All members with diabetes as defined above
Level of measure	Practice group
Minimum members	1 per practice group
Product Lines	Medicare
Method of measurement	Claims data processed by Feb. 28, of the following measurement year
Provider data input	This measure is based on billed pharmacy claims. No supplemental data will be accepted.
Target: Medicare	91%
Payout: Medicare	$35 per member meeting the measure
Reporting	PIP_011A – PIP Measure Worksheet PIP_011C – PIP Measure Worksheet (TAB)
Notes	This measure is based on billed pharmacy claims. This measure is calculated using the National Drug Code (NDC) lists updated by the PQA.

Chronic Disease
Statin therapy for patients with cardiovascular disease

Source	HEDIS
Target Source	Commercial: HEDIS 90th percentile Medicare: CMS Medicare 5 Star cut point plus a predictive factor
Identified measure	The percentage of male members 21-75 years of age and female members 40-75 years of age during the measurement year that were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year
Case definition	Members with cardiovascular disease by the following event or diagnosis during the year prior to the measurement year: • Discharged from an inpatient setting with a myocardial infarction (MI) • Members who had a coronary artery bypass grafting (CABG), percutaneous coronary intervention (PCI), or revascularization procedure in any setting. *Diagnosis of ischemic vascular disease (IVD) and one of the following in the measurement year and the year prior to the measurement year:* • At least one outpatient visit, telephone visit, or online assessment with an IVD diagnosis. • At least one acute inpatient encounter with an IVD diagnosis without telehealth. • At least one acute inpatient discharge with a principle diagnosis of IVP. **Continuous enrollment/allowable gap** Members must be continuously enrolled in the measurement year with no more than one gap in enrollment of up to 45-days during the measurement year. Members must be active with Priority Health and assigned/attributed to a participating PCP on Dec. 31 of the measurement year.
Age criteria	Male members 21-75 years of age as of Dec. 31 of the measurement year Female members 40-75 years of age as of Dec. 31 of the measure year
Exclusionary criteria	*Diagnosis. During the measurement year or the year prior:* • Members diagnosed as having end-stage renal disease (ESRD) or Cirrhosis. • Diagnosis of pregnancy or In vitro fertilization. • Dispensed at least one prescription for clomiphene. • Myalgia, myositis, myopathy or rhabdomyolysis during the measurement year. Members in hospice, using hospice services or palliative care any time during the measurement year Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: • Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. • Living long-term in an institution any time during the measurement year Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty ***and*** advanced illness.

	Members must meet ***BOTH*** of the following frailty and advanced illness criteria to be excluded (includes telephone visits, e-visits and virtual check-ins)
Numerator	Members who had at least one dispensing event for a high-intensity or moderate intensity statin medication during the measurement year
Denominator	All members with ASCVD as defined above
Level of measure	Practice group
Minimum members	1 per practice group
Product Line	HMO/POS, Medicare
Method of measurement	Claims data processed by Feb. 28 of the following measurement year
Provider data input	This measure is based on billed pharmacy claims. No supplemental data will be accepted.
Target: HMO/POS	88%
Target: Medicare	91%
Payout: HMO/POS, Medicare	$35 per member meeting the measure
Reporting	PIP_011A – PIP Measure Worksheet PIP_011C – PIP Measure Worksheet (TAB)
Notes	This measure is based on billed pharmacy claims.

Chronic Disease
Medication Adherence for Diabetes Medications

Source	CMS Medicare 5 Star
Target Source	CMS Medicare 5 Star cut point plus a predictive factor
Identified measure	The percentage of members 18 years of age and older with a billed prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication
Case definition	This measure is defined as the percent of Medicare members 18 years and older who adhere to their prescribed drug therapy across classes of diabetes medications: • Biguanides • Sulfonylureas • Thiazolidinediones • DePedtidyl Peptidase (DPP)-Inhibitors • Incretin mimetics • Meglitinides • Sodium glucose cotransporter (SGLT2) inhibitors
Age criteria	Members 18 years of age and older
Exclusionary criteria	• Members with one or more fills of insulin with a service date in the measurement year • Members with ESRD • Members enrolled in inpatient or skilled nursing facilities within the measurement year • Members in hospice
Numerator	18 years and older, with a proportion of days covered (PDC) at 80 percent or higher across the classes of diabetes medications during the measurement period
Denominator	18 years and older, with at least two fills of diabetes medication(s) on unique dates of service during the measurement period. Members must have two fills no later than Oct 1, 2021.
Level of measure	Practice group
Minimum members	1
Product Line	Medicare
Method of measurement	Pharmacy Drug Encounter (PDE)
Provider data input	This measure is based on billed pharmacy claims. No supplemental data will be accepted.
Target: Medicare	91%
Payout: Medicare	$20 per member meeting the measure
Reporting:	PIP_011M – Medication Adherence
Notes:	This measure was adapted from the Medication Adherence - Proportion of Days Covered measure that was developed and endorsed by the Pharmacy Quality Alliance (PQA). The proportion of days covered (PDC) is the percent of days in the measurement period “covered” by prescription claims for the same medication or another in its therapeutic class category. The medication adherence timeframe begins the same day as the indexed prescription start date (IPSD) which is the same day as one of the first two prescription fills.

	Members are only included in the measure if the first fill of their medication occurs at least 91 days before the end of the enrollment period. Members must have two fills no later than Oct 1, 2021. Days supply that extend into the beginning of the measurement year from a fill from the previous year aren't included in the count of percent of days covered. See the case definition section for the list of medications for this measure. The Medication Adherence rate is calculated using the National Drug Code (NDC) list and obsolete NDC data methodology maintained by the PQA. The complete NDC list in the measure calculation if their obsolete dates as reported by PQA are within the period of measurement or within six months prior to the beginning of the measurement year. Medicare 5 stars 2021 manual

Chronic Disease
Medication Adherence for Hypertension

Source	CMS Medicare 5 Star
Target Source	CMS Medicare 5 Star cut point plus a predictive factor
Identified measure	The percentage of members 18 years of age or older with a prescription for blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication
Case definition	Medicare members 18 years and older that adhere to their prescribed drug therapy for blood pressure medications: • Renin angiotensin system (RAS) antagonist • Angiotensin converting enzyme (ACE) inhibitor • Angiotensin receptor blocker (ARB) • Direct renin inhibitor
Age criteria	Members 18 years of age and older
Exclusionary criteria	• Members in hospice. • Members enrolled in inpatient or skilled nursing facilities within the measurement year • Members with ESRD diagnosis • Members with one or more prescriptions for sacubitril/valsartan
Numerator	18 years and older, with a proportion of days covered (PDC) at 80 percent or higher for blood pressure medication(s) during the measurement period
Denominator	18 years and older with at least two fills of blood pressure medication(s) on unique dates of service during the measurement period. Members must have two fills no later than Oct 1, 2021.
Level of measure	Practice group
Minimum members	1
Product Line	Medicare
Method of measurement	Pharmacy Drug Encounter (PDE)
Provider data input	This measure is based on billed pharmacy claims. No supplemental data will be accepted.
Target: Medicare	91%
Payout: Medicare	$20 per member meeting the measure
Reporting:	PIP_011M – Medication Adherence
Notes:	This measure was adapted from the Medication Adherence - Proportion of Days Covered measure that was developed and endorsed by the Pharmacy Quality Alliance (PQA). The proportion of days covered (PDC) is the percent of days in the measurement period “covered” by prescription claims for the same medication or another in its therapeutic class category. Members are only included in the measure if the first fill of their medication occurs at least 91 days before the end of the enrollment period. Members must have two fills no later than Oct. 1, 2021. Days supply that extend into the beginning of the measurement year from a fill from the previous year aren’t included in the count of percent of days covered. See the medication list for this measure. The Medication Adherence rate is calculated using the National Drug Code (NDC) list and obsolete NDC data methodology maintained by the PQA. The complete NDC list in the measure calculation if their obsolete dates as reported by PQA are within

	the period of measurement or within six months prior to the beginning of the measurement year. Medicare 5 stars 2021 manual

Chronic Disease
Medication Adherence for Cholesterol

Source	CMS Medicare 5 Star
Target Source	CMS Medicare 5 Star cut point plus a predictive factor
Identified measure	The percentage of members 18 years of age and older with a billed prescription for cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication
Case definition	Medicare members 18 years and older that adhere to their prescribed drug therapy for statin cholesterol medications
Age criteria	Members 18 years of age and older
Exclusionary criteria	• Members with ESRD • Members enrolled in impatient or skilled nursing facilities within the measurement year • Members in hospice
Numerator	18 years and older, with a proportion of days covered (PDC) at 80 percent or higher for statin cholesterol medication(s) during the measurement period
Denominator	18 years and older with at least two billed statin cholesterol medication(s) on unique dates of service during the measurement period. Members must have two fills no later than Oct 1, 2021.
Level of measure	Practice group
Minimum members	1
Product Line	Medicare
Method of measurement	Pharmacy Drug Encounter (PDE)
Provider data input	This measure is based on billed pharmacy claims. No supplemental data will be accepted.
Target: Medicare	91%
Payout: Medicare	$20 per member meeting the measure
Reporting:	PIP_011M – Medication Adherence
Notes:	This measure was adapted from the Medication Adherence- Proportion of Days Covered measure that was developed and endorsed by the Pharmacy Quality Alliance (PQA). The proportion of days covered (PDC) is the percent of days in the measurement period “covered” by prescription claims for the same medication or another in its therapeutic class category. Members are only included in the measure if the first fill of their medication occurs at least 91 days before the end of the enrollment period. Members must have two fills no later than Oct. 1, 2021. Days supply that extend into the beginning of the measurement year from a fill from the previous year aren’t included in the count of percent of days covered. See the medication list for this measure. The Medication Adherence rate is calculated using the National Drug Code (NDC) list and obsolete NDC data methodology maintained by the PQA. The complete NDC list in the measure calculation if their obsolete dates as reported by PQA are within the period of measurement or within six months prior to the beginning of the measurement year. Medicare 5 stars 2021 manual

Chronic disease
Hypertension: Controlled blood pressure

Source	HEDIS
Target Source	Commercial and Medicaid: HEDIS 90th percentile Medicare: CMS Medicare 5 Star cut point plus a predictive factor
Identified measure	The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled during the measurement year on or after the date of the second diagnosis of hypertension. Adequate control is defined as: • Members 18–85 years of age whose BP was <140/90 mm Hg. Priority Health uses the BP value of the most recent billed outpatient visit to determine if BP is controlled. BPs taken during telehealth visits and/or by member on the date of the PCP visit with any digital device is acceptable. The BP results don't need to be digitally stored and transmitted to the provider. All blood pressure readings must be documented in the medical record. Do not take BP readings taken by the member using a non-digital device, such as with a manual blood pressure cuff and stethoscope.
Case definition	A member with hypertension is defined by: • Two visits on different dates of service with a diagnosis of hypertension during the first six months of the measurement year and the year prior to the measurement year. • In an outpatient setting with any diagnosis of hypertension. • A telephone visit or an online assessment with any diagnosis of hypertension. • An e-visit or virtual check-in with any diagnosis of hypertension. **Continuous enrollment/allowable gap** Members must be continuously enrolled in the measurement year with no more than one gap in enrollment of up to 45-days during the measurement year. Members must be active with Priority Health and assigned/attributed to a participating PCP on Dec. 31 of the measurement year. Medicaid: member may not have more than a 1-month gap in coverage
Age criteria	18–85 years of age as of Dec. 31 of the measurement year
Exclusionary criteria	Exclude from the eligible population all members with: • Evidence of end-stage renal disease (ESRD), dialysis, nephrectomy or kidney transplant on or prior to Dec. 31 of the measurement year • A diagnosis of pregnancy during the measurement year • A non-acute inpatient admission during the measurement year Members in hospice, using hospice services or palliative care any time during the measurement year Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: • Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.

	• Living long-term in an institution any time during the measurement year Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty ***and*** advanced illness. Members must meet ***BOTH*** of the following frailty and advanced illness criteria to be excluded (includes telephone visits, e-visits and virtual check-ins) Members 81 years of age and older as of December 31 of the measurement year (all product lines) with frailty
Numerator	The number of members in the denominator whose most recent BP (both systolic and diastolic) is adequately controlled during the measurement year on or after the second diagnosis of hypertension based on the following criteria: • Members 18–85 years of age as of Dec. 31 of the measurement year whose BP was <140/90 mm Hg
Denominator	Hypertensive patients as defined above
Level of measure	Practice group
Minimum members	1 per practice
Product Line	HMO/POS, ASO/PPO, Medicare, Medicaid
Method of measurement	Physician reported data submitted by Jan. 31, of the following measurement year
Provider data input	Documented BP year. Supplemental data includes: • APS • HL7 • Patient Profile • Report #70 Supplemental data is subject to audit. Providers may exclude any member they determine to be incorrectly defined as hypertensive by submitting data through the Update Data function in Patient Profile by Jan. 31 of the following measurement year. BPs must be documented by a health care provider and saved within the member's medical record.
Reporting	PIP_011A – PIP Measure Worksheet PIP_011C – PIP Measure Worksheet PIP_011H – PIP Hypertension Worksheet
Target: HMO/POS, ASO/PPO	76%
Target: Medicare	86%
Target: Medicaid	73%
Payout: HMO/POS, ASO/PPO, Medicare and Medicaid	$45 per member meeting the measure
Notes:	If multiple BP measurements occur on the same date or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. The systolic and diastolic results don't need to be from the same reading. If no BP is recorded during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing) assume that the member is "not controlled."

	All eligible BP measurements recorded in the record must be considered. If an organization cannot find the medical record, the member remains in the measure denominator and is considered noncompliant for the numerator. Digital blood pressure readings: • Can be reported without a visit as long as it is recorded in the chart • Can be called in by a member • Recorded by a mobile app and documented in medical record • Can't be taken with a manual blood pressure cuff and stethoscope • HEDIS does require the BP to the most recent visit date during the measurement year Monthly reporting includes members who have a billed diagnosis of hypertension by <u>any</u> physician. Within reporting, you may see BP history unfamiliar to your practice. Health systems using a shared patient registry submit BP data from all visits, including specialists. This measure requires reporting of the last billed face-to-face visit of the measurement year. If a BP is taken after that visit but not at a billed face-to-face visit (i.e. nurse visit, telehealth visit) we will accept the BP from the non-billed visit as long as it is documented in the medical record and taken with a digital device.

Medicare 5-star challenge

Historically, the Priority Health provider network has displayed high levels of performance on quality measures, exceeding national benchmarks. In recent years, national performance has surged while regional performance appears to have plateaued. Priority Health aims to incentivize continued advancement of performance through a new incentive model.

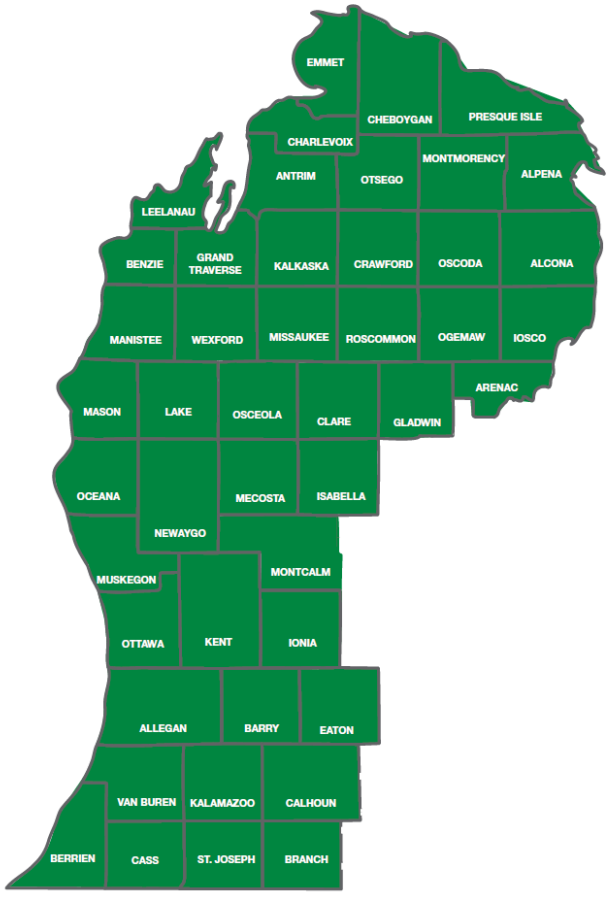
In addition to the practice level measures, there is an ACN-level incentive available to qualifying ACNs for a subset of Medicare 5-Star measures. These measures include:

- Colorectal cancer screening
- Diabetes care: Annual retinal eye exam
- Diabetes care: Controlled A1c <= 9.0%
- Statin therapy for diabetes
- Statin therapy for cardiovascular disease

The specifications for the measures are the same for both the practice and ACN levels.

Participation in the Medicare 5-Star Challenge will be divided between two regions, West/North and East. Descriptions of the challenge by region are outlined below.

West and north regions



<table>
<tr><td>Source</td><td>CMS Medicare 5 Star</td></tr>
<tr><td>Target Source</td><td>CMS Medicare 5 Star cut point plus a predictive factor</td></tr>
<tr><td>Identified measure</td><td>ACN level performance on a subset of Medicare 5 Star quality measures:
Colorectal cancer screening
Diabetes care: Annual retinal eye exam
Diabetes care: Controlled A1c <= 9.0%
Statin therapy for diabetes
Statin therapy for cardiovascular disease</td></tr>
<tr><td>Case definition</td><td>Qualified Accountable Care Networks (ACNs) will receive an incentive for meeting ACN level targets</td></tr>
<tr><td>Age criteria</td><td>See individual measure specifications</td></tr>
<tr><td>Exclusionary criteria</td><td>See individual measure specifications</td></tr>
<tr><td>Level of measure</td><td>Accountable Care Network (ACN)</td></tr>
<tr><td>Minimum members</td><td>Contracted ACNs with a minimum of 3,000 Medicare members on Jan. 31 of the measurement year</td></tr>
<tr><td>Product Lines</td><td>Medicare</td></tr>
<tr><td>Method of measurement</td><td>Claims and lab data processed by Feb. 28 of the following measurement year
Supplemental data submitted by Jan. 31 of the following measurement year</td></tr>
<tr><td>Provider data input</td><td>See individual measure specifications</td></tr>
<tr><td>Target and Payout</td><td>Targets are tiered with a unique payout for each, applied to the numerator once the target is met.
<table>
<tr><td>sure</td><td>Tier 1 Target</td><td>Tier 1 Payout</td><td>Tier 2 Target</td><td>Tier 2 Payout</td></tr>
<tr><td>Colorectal Cancer Screening</td><td>87%</td><td>$20</td><td>84%</td><td>$8</td></tr>
<tr><td>Diabetes Care: Eye Exam</td><td>85%</td><td>$40</td><td>82%</td><td>$20</td></tr>
<tr><td>Diabetes Care: Controlled A1c <= to 9.0%</td><td>91%</td><td>$40</td><td>88%</td><td>$20</td></tr>
<tr><td>Statin Therapy for Diabetes</td><td>91%</td><td>$30</td><td>88%</td><td>$20</td></tr>
<tr><td>Statin Therapy for Cardiovascular Disease</td><td>91%</td><td>$30</td><td>88%</td><td>$20</td></tr>
</table></td></tr>
<tr><td>Reporting:</td><td>Priority Health will provide monthly status reports comparing performance across participating ACNs</td></tr>
</table>

East region

Source	HEDIS
Target Source	Historical performance
Identified measure	ACN level performance on a subset of Medicare 5 Star quality measures: • Colorectal cancer screening • Diabetes care: Annual retinal eye exam • Diabetes care: Controlled A1c <= 9.0% • Statin therapy for diabetes • Statin therapy for cardiovascular disease
Case definition	Qualified Accountable Care Networks (ACNs) will receive an incentive for every 5-percentage point improvement over the previous year end performance by measure. If previous year baseline performance is less than 40% for an individual measure, the 5% improvement does not apply until a rate of 40% is reached.
Age criteria	See individual measure specifications
Exclusionary criteria	See individual measure specifications
Level of measure	Accountable Care Network (ACN)
Minimum members	Contracted ACNs with a minimum of 1,000 Medicare members on January 31 of the measurement year
Product Lines	Medicare
Method of measurement	Claims and lab data processed by Feb. 28 of the following measurement year Supplemental data submitted by Jan. 31 of the following measurement year
Provider data input	See individual measure specifications
Target and Payout	A PMPM reward will be assigned by measure for every 5-percentage point increase over previous program year performance. Improvement of 10 percentage points would result in a payout of 2 times the reward value. 15 percentage points results in a payout 3 times the reward value.

<table>
<tr><td></td><td>
<table>
<tr><th>Measure</th><th>Payout by 5% improvement</th></tr>
<tr><td>Colorectal Cancer Screening</td><td>$0.40 PMPM</td></tr>
<tr><td>Diabetes Care: Eye Exam</td><td>$0.40 PMPM</td></tr>
<tr><td>Diabetes Care: Controlled A1c <= to 9.0%</td><td>$0.50 PMPM</td></tr>
<tr><td>Statin Therapy for Diabetes</td><td>$0.30 PMPM</td></tr>
<tr><td>Statin Therapy for Cardiovascular Disease</td><td>$0.30 PMPM</td></tr>
</table>
</td></tr>
<tr><td>Reporting:</td><td>Priority Health will provide monthly status reports comparing performance across participating ACNs</td></tr>
</table>

Transformation of care

Care management – Standard PIP practices

Identified measure	One of the primary goals of Priority Health's PCP Incentive Program is to encourage appropriate care management and disease management of members with complex health care needs. Program requirements: • The practice's 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 practice supports integration with the Priority Health care management team. Integration is defined as communication, as needed, between Priority Health and practice care managers to coordinate care. • Practice or ACN must have a physician champion for their care management program. If the practice is a member of an ACN and the physician champion for care management covers all practice sites, this meets criteria. Independent practices must designate a physician lead for care management. To be eligible for this incentive (see additional details for each component below): • Practice groups must be PCMH recognized in the program year • Practice groups must include a minimum of one part- or full-time care manager assigned to the practice and actively working with Priority Health members. • Care managers must be trained prior to providing and billing for care management services • Care managers must fulfill annual continuing education requirements • Submit claims for care management services (list of codes provided below) Practices 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.
	Component 1: PCMH Recognition Practice groups must be PCMH recognized in the program year. Priority Health honors the following recognition programs: BCBSM, NCQA, URAC and Joint Commission. Proof of PCMH recognition is required annually. For the 2021 program year proof of recognition is based solely on responses submitted to Priority Health on the network assessment survey requested and submitted in 2020. Deadline for network assessment survey for this program year was Sept. 18, 2020. No other method of submission for PCMH recognition is accepted. Future measure year participation will require proof of recognition to be submitted annually through the Priority Health network assessment survey.

	<u>Component 2:</u> Qualified Health Professional (QHP) licensure requirements Practice groups must include a minimum of one part- or full-time care manager assigned to the practice and actively working with Priority Health members. Care managers must have qualified health professional 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 Priority Health reserves the right to audit the credentials of care managers providing care management services to Priority Health members.
	<u>Component 3:</u> 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. **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. Priority Health reserves the right to audit records of documented training of care managers providing care management services to Priority Health members.
	<u>Component 4:</u> Continuing education Care managers must fulfill annual continuing education requirements. Beyond the initial training requirement for first year care managers, each care manager must be able to 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 documentation of continuing education for care managers providing care management services to Priority Health members.

<table>
<tr><td></td><td><u>Component 5:</u> Claims
Practices must meet or exceed a risk adjusted target of unique Priority Health members receiving care management services. This is a combined target for all active members assigned or attributed to the practice. Continuous member enrollment criteria don’t apply.

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 risk adjusted care management billing threshold.
<table>
<tr><th>Codes</th><th>Description</th></tr>
<tr><td>G0511</td><td>Care coordination services and payment for RHCs and FQHCs only</td></tr>
<tr><td>G0512</td><td>Care coordination services and payment for RHCs and FQHCs only</td></tr>
<tr><td>G9001</td><td>Coordinated care fee</td></tr>
<tr><td>G9002</td><td>Coordinated care fee</td></tr>
<tr><td>G9007</td><td>Coordinated care fee scheduled team conference</td></tr>
<tr><td>G9008</td><td>Coordinated care fee, physician coordinated care oversight services</td></tr>
<tr><td>98961</td><td>Group education and training, 2-4 patients, each 30 min</td></tr>
<tr><td>98962</td><td>Group education and training, 5-8 patients, each 30 min</td></tr>
<tr><td>99078</td><td>Physician educational services rendered in a group setting</td></tr>
<tr><td>99484</td><td>General behavioral health integration</td></tr>
<tr><td>99487</td><td>Complex chronic care management services</td></tr>
<tr><td>99490</td><td>Chronic care management services</td></tr>
<tr><td>99492</td><td>Psychiatric collaborative care management services</td></tr>
<tr><td>99493</td><td>Psychiatric collaborative care management services</td></tr>
<tr><td>99494</td><td>Psychiatric collaborative care management services</td></tr>
<tr><td>99495</td><td>Transitional care management services</td></tr>
<tr><td>99496</td><td>Transitional care management services</td></tr>
<tr><td>98966</td><td>Non-face-to-face non-physician telephone services</td></tr>
<tr><td>98967</td><td>Non-face-to-face non-physician telephone services</td></tr>
<tr><td>98968</td><td>Non-face-to-face non-physician telephone services</td></tr>
</table>
Additional billing information can be found at
prioritythealth.com/provider/manual/services/medical/care-management

We offer FileMart report “PIP_013 Care Management”, which provides additional detail around care management claims and practice-level performance. For information on this report or to receive an electronic version, please contact your Provider Performance Specialist.</td></tr>
<tr><td>Numerator</td><td>Two billed care management claims on different dates of service in current program year per unique member</td></tr>
<tr><td>Denominator</td><td>Practice’s assigned/attributed member months for the current program year divided by 12</td></tr>
</table>

<table>
<tr><td>Level of measure</td><td>Practice group</td></tr>
<tr><td>Minimum members</td><td>1 per practice group</td></tr>
<tr><td>Product line</td><td>HMO/POS, ASO/PPO, Medicare, Medicaid</td></tr>
<tr><td>Method of measurement</td><td>Claims activity to measure risk adjusted practice group target</td></tr>
<tr><td>Target and payout methodology</td><td>
The target and payment for care management is based on the illness burden of the Priority Health membership for the practice. Each practice will be assigned a 2%, 3%, or 4% target along with a unique standard per member per month (PMPM) payment value.

Membership is assigned to 4 risk quartiles, risk scores are compiled at the practice level, and average standard PMPMs are calculated for each practice.
<table>
<tr><th>Risk Quartile</th><th>Individual/ACA</th><th>HMO/POS & ASO/PPO</th><th>Medicare</th><th>Medicaid</th></tr>
<tr><td>1 (Lowest)</td><td>$0.25</td><td>$0.70</td><td>$0.85</td><td>$1.10</td></tr>
<tr><td>2</td><td>$0.60</td><td>$1.10</td><td>$1.25</td><td>$1.50</td></tr>
<tr><td>3</td><td>$2.50</td><td>$2.50</td><td>$2.65</td><td>$2.90</td></tr>
<tr><td>4 (Highest)</td><td>$5.10</td><td>$5.10</td><td>$5.25</td><td>$5.50</td></tr>
</table>

Practice Standard PMPMs are allotted to ranges as shown below and care management targets are assigned to each practice.
<table>
<tr><th>Target</th><th>Standard PMPM</th></tr>
<tr><td>2%</td><td><$1.70</td></tr>
<tr><td>3%</td><td>$1.70 - $2.60</td></tr>
<tr><td>4%</td><td>>$2.60</td></tr>
</table>

The following table and calculations demonstrate an example calculation for a practice.
<table>
<tr><th>Risk Quartile</th><th>Member Months (12 months)</th><th>Standard PMPM per Quartile</th><th>Total Payout</th></tr>
<tr><td>1</td><td>600</td><td>$1.10</td><td>$660</td></tr>
<tr><td>2</td><td>1200</td><td>$1.50</td><td>$1,800</td></tr>
<tr><td>3</td><td>3600</td><td>$2.90</td><td>$10,440</td></tr>
<tr><td>4</td><td>1200</td><td>$5.50</td><td>$6,600</td></tr>
<tr><td>Total</td><td>6600</td><td>N/A</td><td>$19,500</td></tr>
</table>

<u>Calculating the total payout:</u>
• Quartile 1: 600 member months x $1.10
• Quartile 2: 1200 member months x $1.50
• Quartile 3: 3600 member months x $2.90
• Quartile 4: 1200 member months x $5.50
Total payout: $19,500

<u>Calculating the estimated practice standard PMPM:</u>
$19,500 total funds / 6600 member months = $2.95 practice PMPM

The estimated standard PMPM of $2.95 results in a target of 3% for this practice.

Reporting:
Each practice in the network has a defined target and estimated standard PMPM opportunity. This information is provided via email. If your practice or ACN has not received this information, contact your Provider Performance Specialist.
</td></tr>
</table>

Reporting	**RPX** PIP_013 – PIP Care Management PIP_013 – PIP Care Management (TAB)
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 practice group's PCPs in the program year. Examples – assume a member has two PCPs throughout the year – Dr A and Dr B, both initially in the same practice group. • The member has two touch points with Dr A. The practice group gets to count the member because it has two touch points with its current PCPs. • The member has a touch point with Dr A, switches to Dr B, and has another touch point. The practice group gets to count the member because it has two touch points with its current PCPs. • The member has a touch point with Dr A, and then Dr A leaves the practice for another group. Member switches to Dr B, and has another touch point. Neither practice group gets to count the member because each only had one touch point for that member. • The member has two touch points with Dr A, and then Dr A leaves the practice for another group. Member switches to Dr B, and has two more touch points. Both practice group gets to count the member because each has two touch points for that member. If a PCP changes from one practice group to another practice group, that PCP's care management touch points move with them to the new practice group. 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 practice group where the assigned/attributed PCP was previously practicing. If two care management visits are completed by the assigned/attributed PCP and the member transfers to a different practice, care management visits stay with the previously assigned PCP/practice group.

Transformation of care
Care management – CPC+ practices

Identified measure	One of the primary goals of Priority Health's CPC+ program is to encourage appropriate care management and disease management of members with complex health care needs. Program requirements: • The practice's 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 practice supports integration with the Priority Health care management team. Integration is defined as communication, as needed, between Priority Health and practice care managers to coordinate care. • Practice or ACN must have a physician champion for their care management program. If the practice is a member of a ACN and the physician champion for care management covers all practice sites, this meets criteria. Independent practices must designate a physician lead for care management. To be eligible for this incentive (see additional details for each component below): • Practice groups must be identified as a CPC+ track 1 or track 2 practice from CMS • Practice groups must be PCMH recognized in the program year • Practice groups must include a minimum of one part- or full-time care manager assigned to the practice and actively working with Priority Health members. • Care managers must be trained prior to providing and billing for care management services • Care managers must fulfill annual continuing education requirements • Submit claims for care management services (list of codes provided below) Practices 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.
	Component 1: PCMH Recognition Practice groups must be PCMH recognized in the program year. Priority Health honors the following recognition programs: BCBSM, NCQA, URAC and Joint Commission. Proof of PCMH recognition is required annually. For the 2021 program year proof of recognition is based solely on responses submitted to Priority Health on the network assessment survey requested and submitted in 2020. Deadline for network assessment survey for this program year was Sept. 18, 2020. No other method of submission for PCMH recognition is accepted. Future measure year participation will require proof of recognition to be submitted annually through the Priority Health network assessment survey.

	<u>Component 2:</u> Qualified Health Professional (QHP) licensure requirements Practice groups must include a minimum of one part- or full-time care manager assigned to the practice and actively working with Priority Health members. Care managers must have qualified health professional 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 Priority Health reserves the right to audit the credentials of care managers providing care management services to Priority Health members.
	<u>Component 3:</u> 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. **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. Priority Health reserves the right to audit records of documented training of care managers providing care management services to Priority Health members.
	<u>Component 4:</u> Continuing education Care managers must fulfill annual continuing education requirements. Beyond the initial training requirement for first year care managers, each care manager must be able to 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 documentation of continuing education for care managers providing care management services to Priority Health members.

<table>
<tr><td></td><td><u>Component 5:</u> Claims
Practices must meet or exceed a risk adjusted target of unique Priority Health members receiving care management services. This is a combined target for all active members assigned or attributed to the practice. Continuous member enrollment criteria don’t apply.

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 risk adjusted care management billing threshold.
<table>
<tr><th>Codes</th><th>Description</th></tr>
<tr><td>G0511</td><td>Care coordination services and payment for RHCs and FQHCs only</td></tr>
<tr><td>G0512</td><td>Care coordination services and payment for RHCs and FQHCs only</td></tr>
<tr><td>G9001</td><td>Coordinated care fee</td></tr>
<tr><td>G9002</td><td>Coordinated care fee</td></tr>
<tr><td>G9007</td><td>Coordinated care fee scheduled team conference</td></tr>
<tr><td>G9008</td><td>Coordinated care fee, physician coordinated care oversight services</td></tr>
<tr><td>98961</td><td>Group education and training, 2-4 patients, each 30 min</td></tr>
<tr><td>98962</td><td>Group education and training, 5-8 patients, each 30 min</td></tr>
<tr><td>99078</td><td>Physician educational services rendered in a group setting</td></tr>
<tr><td>99484</td><td>General behavioral health integration</td></tr>
<tr><td>99487</td><td>Complex chronic care management services</td></tr>
<tr><td>99490</td><td>Chronic care management services</td></tr>
<tr><td>99492</td><td>Psychiatric collaborative care management services</td></tr>
<tr><td>99493</td><td>Psychiatric collaborative care management services</td></tr>
<tr><td>99494</td><td>Psychiatric collaborative care management services</td></tr>
<tr><td>99495</td><td>Transitional care management services</td></tr>
<tr><td>99496</td><td>Transitional care management services</td></tr>
<tr><td>98966</td><td>Non-face-to-face non-physician telephone services</td></tr>
<tr><td>98967</td><td>Non-face-to-face non-physician telephone services</td></tr>
<tr><td>98968</td><td>Non-face-to-face non-physician telephone services</td></tr>
</table>
Additional billing information can be found at
priorityhealth.com/provider/manual/services/medical/care-management

We offer FileMart report “PIP_013 Care Management”, which provides additional detail around care management claims and practice-level performance. For information on this report or to receive an electronic version, please contact your Provider Performance Specialist.</td></tr>
<tr><td>Numerator</td><td>Two billed care management claims on different dates of service in current program year per unique member</td></tr>
<tr><td>Denominator</td><td>Practice’s assigned/attributed member months for the current program year divided by 12</td></tr>
</table>

<table>
<tr><td>Level of measure</td><td>Practice group</td></tr>
<tr><td>Minimum members</td><td>1 per practice group</td></tr>
<tr><td>Product line</td><td>HMO/POS, ASO/PPO, Medicare, Medicaid</td></tr>
<tr><td>Method of measurement</td><td>Claims activity to measure risk adjusted practice group target</td></tr>
<tr><td>Target and payout methodology</td><td>
The target and payment for care management is based on the illness burden of the Priority Health membership for the practice. Each practice will be assigned a 2%, 3%, or 4% target along with a unique standard per member per month (PMPM) payment value.

CPC+ Track 1 CM Targets and Payouts
Membership is assigned to 4 risk quartiles, risk scores are compiled at the practice level, and average Standard PMPMs are calculated for each practice.
<table>
<tr><th>Risk Quartile</th><th>Individual/ACA</th><th>HMO/POS & ASO/PPO</th><th>Medicare</th><th>Medicaid</th></tr>
<tr><td>1 (Lowest)</td><td>$0.25</td><td>$0.70</td><td>$0.85</td><td>$1.10</td></tr>
<tr><td>2</td><td>$0.60</td><td>$1.10</td><td>$1.25</td><td>$1.50</td></tr>
<tr><td>3</td><td>$2.50</td><td>$2.50</td><td>$2.65</td><td>$2.90</td></tr>
<tr><td>4 (Highest)</td><td>$5.10</td><td>$5.10</td><td>$5.25</td><td>$5.50</td></tr>
</table>
Practice Standard PMPMs are allotted to ranges as shown below and care management targets are assigned to each practice.
<table>
<tr><th>Target</th><th>Standard PMPM</th></tr>
<tr><td>2%</td><td><$1.70</td></tr>
<tr><td>3%</td><td>$1.70 - $2.60</td></tr>
<tr><td>4%</td><td>>$2.60</td></tr>
</table>
CPC+ Track 2 CM Targets and Payouts
CPC+ Track 2 practices are assigned a “stretch” care management goal, which is a percentage point beyond their “standard” goal. For example: a CPC+ Track 2 practice with an assessed illness burden corresponding with a 4% CM target will have a stretch CM target of 5%. To incentivize practices to reach this higher target, an additional stretch PMPM is offered beyond the Standard PMPM. Track 2 practices meeting only their lower care management target (standard) will receive the Standard PMPM, while Track 2 practices meeting their higher, or stretch care management target will receive the Stretch PMPM.

In either case, the Standard PMPM will be paid out to CPC+ Track 2 practices prospectively, while practices earning the Stretch PMPM will receive this additional funding during year-end settlement.

Standard Track 2 PMPMs, the payment values if the standard care management target is met by CPC+ Track 2 practices:
<table>
<tr><th>Risk Quartile</th><th>Individual/ACA</th><th>HMO/POS & ASO/PPO</th><th>Medicare</th><th>Medicaid</th></tr>
<tr><td>1 (Lowest)</td><td>$0.50</td><td>$0.95</td><td>$1.10</td><td>$1.35</td></tr>
<tr><td>2</td><td>$0.85</td><td>$1.35</td><td>$1.50</td><td>$1.75</td></tr>
<tr><td>3</td><td>$2.75</td><td>$2.75</td><td>$2.90</td><td>$3.15</td></tr>
<tr><td>4 (Highest)</td><td>$5.35</td><td>$5.35</td><td>$5.50</td><td>$5.75</td></tr>
</table>
</td></tr>
</table>

Stretch Track 2 PMPMs, the payment values if the stretch care management target is met by CPC+ Track 2 practices:

Risk Quartile	Individual/ACA	HMO/POS & ASO/PPO	Medicare	Medicaid
1 (Lowest)	$0.75	$1.45	$1.60	$1.85
2	$1.35	$1.85	$2.00	$2.25
3	$3.25	$3.25	$3.40	$3.65
4 (Highest)	$5.85	$5.85	$6.00	$6.25

Example Calculation – CPC+ Track 1
The following table and calculations demonstrate an example calculation for a CPC+ Track 1 practice.

Risk Quartile	Member Months (12 months)	PMPM per Quartile	Total Payout
1	600	$1.10	$660
2	1200	$1.50	$1,800
3	3600	$2.90	$10,440
4	1200	$5.50	$6,600
Total	**6600**	**N/A**	**$19,500**

Calculating the total payout
- Quartile 1: 600 member months x $1.10
- Quartile 2: 1200 member months x $1.50
- Quartile 3: 3600 member months x $2.90
- Quartile 4: 1200 member months x $5.50

Total payout: $19,500

Calculating the estimated practice PMPM:
$19,500 total funds / 6600 member months = **$2.95 practice PMPM**
The estimated Standard PMPM of $2.95 results in a target of 3% for this practice.

Reporting:
Each practice in the network has a defined target and estimated PMPM opportunity. This information is provided via email. If your practice or ACN has not received this information, contact your Provider Performance Specialist.

Reporting

RPX
PIP_013 – PIP Care Management
PIP_013 – PIP Care Management (TAB)

Notes

Prospective payments for care management are intended to enable practice-level transformation of care delivery while providing ongoing capital to invest in providing longitudinal care management to our members. Our CPC+ care management measure is an outcomes-based incentive. Targets are based on risk scores at the practice level. Any unearned, prospectively paid funds provided to practices that don't meet their 2020 performance targets must be paid back. Providers that were paid prospective payments and didn't meet their risk adjusted care management target, will receive an invoice for recovery, sent to the location to which payment processed to.

To protect ACNs and practices from ongoing and excessive recovery experiences, practices that have missed their care management risk adjusted target for two consecutive years will no longer be eligible to receive prospective payments in the following performance year.

	CPC+ practices must meet a minimum membership of 100 members combined across all products as of Dec. 15 of the previous measurement year in order to be eligible for quarterly prospective payments. 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 practice group's PCPs in the program year. Examples – assume a member has two PCPs throughout the year – Dr A and Dr B, both initially in the same practice group. • The member has two touch points with Dr A. The practice group gets to count the member because it has two touch points with its current PCPs. • The member has a touch point with Dr A, switches to Dr B, and has another touch point. The practice group gets to count the member because it has two touch points with its current PCPs. • The member has a touch point with Dr A, and then Dr A leaves the practice for another group. Member switches to Dr B, and has another touch point. Neither practice group gets to count the member because each only had one touch point for that member. • The member has two touch points with Dr A, and then Dr A leaves the practice for another group. Member switches to Dr B, and has two more touch points. Both practice group gets to count the member because each has two touch points for that member. If a PCP changes from one practice group to another practice group, that PCP's care management touch points move with them to the new practice group. 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 practice group where the assigned/attributed PCP was previously practicing. If two care management visits are completed by the assigned/attributed PCP and the member transfers to a different practice, care management visits stay with the previously assigned PCP/practice group.

Transformation of care
Social Determinants of Health (SDoH)

Identified measure	According to the Center 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. Priority Health provides an incentive to practices that screen patients and submit information on Social Determinants of Health (SDoH). To be eligible for this incentive practices must (see additional details for each component below): • Have PCMH recognition in the program year • Screen members for SDoH • Submit a survey attestation • Submit z-codes for SDoH determined by screening
	Component 1: PCMH Recognition Practice groups must be PCMH recognized in the program year. Priority Health honors the following recognition programs: BCBSM, NCQA, URAC and Joint Commission. Proof of PCMH recognition is required annually. For the 2021 program year proof of recognition is based solely on responses submitted to Priority Health on the network assessment survey requested and submitted in 2020. Deadline for network assessment survey for this program year was Sept. 18, 2020. No other method of submission for PCMH recognition is accepted. Future measure year participation will require proof of recognition to be submitted annually through the Priority Health network assessment survey.
	Component 2: Screening for SDoH Practice groups must use an approved tool to screen patients seen by the practice during the performance year for the presence of SDoH. **Approved screening tools:** **American Academy of Family Physicians** https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/hops19-physician-form-sdoh.pdf **Center for Health Care Strategies, Inc.** https://www.chcs.org/media/AccessHealth-Social-Determinant-Screening_102517.pdf **Centers for Medicare & Medicaid Services Accountable Health Communities' 10-question** https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf **Health Leads Social Needs Screening** https://healthleadsusa.org/wp-content/uploads/2018/10/Health-Leads-Social-Needs-Screening-Toolkit-1.pdf **PRAPARE** https://www.chcs.org/media/Redwood-PRAPARE-Questions_102517.pdf) **State Innovation Model (SIM) Screening Tool** **Community Health Innovation Region (CHIR) Screening Tool** **EPIC Screening Tool (EMR embedded)**

	If practices would prefer to use a screening tools that isn't listed above, they can submit to Priority Health for consideration with their attestation prior to May 28, 2021.
	Component 3: Survey attestation Complete the Social Determinants of Health (SDoH) survey attestation and submit to PH-PartnersinPerformance@priorityhealth.com by **May 28, 2021.** ACNs can complete the attestation survey on the behalf of multiple practice sites. The attestation survey and additional SDoH information is available at *priorityhealth.com* (login required). **Attestation survey fields:** Practice name Facility site ID Screening tool (y/n) Approved screening tool name SDoH contact person's name SDoH contact person's email address SDoH contract person's phone number Sample of completed attestation survey can be found at *priorityhealth.com* (login required).
	Component 4: Z-codes Identified z-codes submitted on claims for all SDoH discovered during screening. Practices 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 **February 28, 2022** for the 2021 program year. Continuous member enrollment criteria don't apply. For access to a list of approved Z-codes, applicable E/M office visit codes, and their definitions, go to *priorityhealth.com* (login required).
Numerator	# of unique members from the denominator with at least one z-code billed
Denominator	# of unique members in the practice with at least one billed evaluation and management code (E&M) in the performance year
Level of measure	Practice group
Minimum members	1 per practice group
Product line	Medicare and Medicaid
Method of measurement	Claims with 2021 dates of service and Z-codes submitted by February 28, 2022
Target: Medicare and Medicaid	5% Medicare 5% Medicaid
Payout: Medicare	$0.50 PMPM
Payout: Medicaid	$1.00 PMPM
Reporting	**TBD**

Notes	For questions about the network assessment survey submitted for the program year please contact your Provider Performance Specialist. Payouts to the network will not exceed Priority Health budgeted amounts for this measure. Medicare and Medicaid populations will be scored separately. Supplemental data is not accepted. An approved z-code billed on any professional or institutional claim will count toward the numerator. 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 Priority Health members can now connect themselves to resources at no cost by using Priority Health Connect.

Transformation of Care
Medication therapy management (MTM)

Source	CMS Medicare 5-Star Measure
Identified measure	The percentage of patients identified by OutcomesMTM are eligible to receive a comprehensive medication review (CMR) by a point of care pharmacist. To be eligible for this incentive, practice groups aligned with an ACN are required to complete the following by **Mar. 12, 2021**: **Component 1:** Submit completed MTM point of care attestation survey **Component 2**: Submit signed collaborative practice agreement annually for each attested practice for the current program year between physician and pharmacist(s) **Priority Health will not accept any late attestation or signed practice collaborative agreement submissions.** Refer to the notes section for the attestation and signed collaborative agreement requirements.
Case definition	Members who meet eligibility criteria for a CMR and are identified for targeting in the OutcomesMTM platform. CMR eligibility criteria: • Commercial: at least 18 years old and 4 or more chronic or maintenance drugs filled in the last 6 months. • Medicare: 3 or more out of the following health conditions: o Asthma o CHF o COPD o Diabetes o Dyslipidemia o HTN AND, taking 8 or more chronic or maintenance drugs and the total costs of your drugs must be at least the current annual CMS defined threshold. Members must be continuously enrolled in the measurement year with no more than a 45-day gap in coverage and active on Dec. 31 of the measurement year. Members must be eligible for the CMR service greater than 60 days before Dec. 31 of the measurement year.
Age criteria	18 years and older as of Dec. 31 of the measurement year.
Exclusionary criteria	None
Numerator	The number of patients in the denominator that have received one or more comprehensive medication reviews (CMRs) during the measurement year by a point of care pharmacist.
Denominator	Patients 18 years and older as of the last day of the measurement year who met eligibility criteria for a CMR in OutcomesMTM by Nov. 1, 2021. OR

	Patient received a comprehensive medication review (CMR) that was documented in Outcomes MTM during the measurement year by a point of care pharmacist.
Level of measure	Practice groups aligned with an ACN
Minimum members	1 per practice group
Product lines	HMO/POS, ASO/PPO, Medicare
Method of measurement	CMR completed by point of care pharmacist billed by OutcomesMTM processed by Feb. 28, of the following measurement year.
Provider data input	Complete the MTM point of care attestation survey by Mar. 12, 2021 AND Submit signed collaborative practice agreement annually for each attested practice for the current program year between physician and pharmacist(s) by Mar. 12, 2021
Payout:	Practices earn a total payment of $171 per completed CMR • $96 dollars paid per completed CMR monthly via the OutcomesMTM enhanced fee schedule rate • $75 dollars paid per completed CMR awarded at year-end settlement
Reporting:	Practice groups must access the OutcomesMTM platform to identify eligible members. The OutcomesMTM platform provides reliable, real time, and accurate identification of eligible targeted members. Priority Health will no longer generate PIP_011J and PIP_011K reporting through filemart for the MTM measure. ACNs are encouraged to register for an OutcomesMTM pharmacy administrator account via https://secure.outcomesmtm.com/index.cfm?event=register to track CMR completion by participating pharmacists throughout the performance year. Access may take up to 1-5 business days. An OutcomeMTM account will deactivate after 60 days of inactivity. The pharmacy administrator role in the OutcomesMTM Connect Platform provides users with reporting capabilities to monitor pharmacy engagement, pharmacist activity and progress toward MTM goals and overall MTM program performance. Once your ACN is registered and a username and password is approved, email clinics@outcomesmtm.com and provide the following: • User first and last name • OutcomesMTM registered user account name • Location name(s) where the pharmacist(s) is registered with OutcomesMTM • Pharmacy National Council of Prescription Drug Program (NCPDB) practice number(s) Providing the above detail will grant your ACN access to reporting capabilities.
Notes	The MTM attestation survey will be available on the MTM web landing page in early Jan. 2021 https://www.priorityhealth.com/provider/center/incentives/pip/mtm-incentive-measure?LoginChecked=true#/provider (login required). **MTM attestation requirements:**

	Pharmacist(s) hired, trained, and registered in OutcomesMTM • All questions must be answered. Enter data as unique and separate rows. Do not combine multiple pharmacist data as one-line item. • Data must be submitted in the required format. Data returned in any other format will not be accepted and will be returned to the sender. • ACNs can submit one survey attestation for all practices. MTM survey attestation and signed practice collaborative agreements must be emailed to PH-PartnersInPerformance@priorityhealth.com. Priority Health does not provide a practice collaborative agreement template. If needed, collaborative practice agreements are available from a variety of web resources. *Enhanced fee schedule* In April 2021, OutcomesMTM will receive the list of 2021 attested / eligible practices and will apply the enhanced fee schedule rate of $96 per completed CMR. Additional information about Medication Therapy Management and OutcomesMTM can be found at https://www.priorityhealth.com/provider/center/incentives/pip/mtm-incentive-measure?LoginChecked=true#/provider (login required). Priority Health defines a point of care pharmacist as a pharmacist that is serving as a member of the care team as evidenced by access to the practice's EHR and an established collaborative practice agreement. The pharmacist(s) can serve multiple practices sites. A visiting pharmacist or centralized (i.e. brick and mortar pharmacy) model is acceptable as long as the pharmacist is serving as an active member of the care team with EHR access and a collaborative practice agreement is established with the practice(s)' physicians.

Transformation of care

Health Information Exchange Participation with MiHIN

Identified measure	Participate in at least 4 of the following 6 MiHIN use cases: • Admission, Discharge, Transfer (ADT) • Active Care Relations Services (ACRS) • Medication Reconciliation • Quality Measure Information (QMI) • Health Provider Directory (HPD) • Common Key Service
Level of measure	ACN
Minimum members	1 per practice group
Product line	HMO/POS, ASO/PPO, Medicare, Medicaid
Method of measurement	ACN must have active participation in at least 4 out of 6 of the above MiHIN use cases by Dec. 1 of the current program year
Payout	$0.05 per member per month
Notes	The list of eligible ACNs will be provided by MiHIN annually No supplemental data required

Transformation of care

Healthy Michigan Plan: HRA completion

<table>
<tr><td>Identified measure</td><td>
Priority Health credentialed participating primary care providers and mid-level providers, billing under the credentialed participating supervising physician are eligible for a tiered incentive for proper completion and submission of the annual health risk assessment (HRA).

Tiered incentive for annual HRA completion
Priority Health will pay a tiered incentive to Priority Health participating credentialed PCPs only when the PCP (physician or mid-level primary care provider) completes an annual HRA form properly and timely. To receive the incentive, the PCP must:
• Conduct a visit with the Healthy Michigan Plan member within the measurement year.
• Complete Healthy Michigan Health Risk Assessment with member during visit.
Completed HRA form submitted by a mid-level provider (billing under the member's credentialed participating Primary Care Physician) is eligible for a tiered incentive for proper completion and submission. The mid-level provider completing the HRA doesn’t need to be credentialed. Credit will be applied to the member's PCP on the date of the completed HRA.

Submission method options:
<table>
<tr><th>Submission Method</th><th>Action</th><th>Incentive Amount</th></tr>
<tr><td>CHAMPS</td><td>1. Log into CHAMPS
2. Access Profile, Provider HRA section
3. Enter HRA information</td><td>$70</td></tr>
<tr><td>FAX</td><td>1. Option one – fax to Priority Health directly 616.942.0616
2. Option two – fax to MDHHS at 517.763.0200</td><td>$15</td></tr>
</table>
Incomplete forms will be faxed to the office for completion. Complete and return the form back to Priority Health. Failure to complete the form properly will compromise the eligibility for the incentive.
</td></tr>
<tr><td>Case definition</td><td>Members with coverage under the Healthy Michigan Plan</td></tr>
<tr><td>Age criteria</td><td>19-64 years of age</td></tr>
<tr><td>Exclusionary criteria</td><td>None</td></tr>
<tr><td>Level of measure</td><td>Practice level</td></tr>
<tr><td>Minimum members</td><td>1 per practice</td></tr>
<tr><td>Product line</td><td>Healthy Michigan Medicaid (HMI)</td></tr>
<tr><td>Method of measurement</td><td>Completed HRA form within the measurement year</td></tr>
<tr><td>Payout</td><td>
<table>
<tr><th>Submission Method</th><th>Incentive Amount per eligible completed HRA</th></tr>
</table>
</td></tr>
</table>

<table>
<tr><td></td><td><table><tr><td>CHAMPS</td><td>$70</td></tr><tr><td>FAX</td><td>$15</td></tr></table></td></tr>
<tr><td>Reporting</td><td>PIP_012 – PIP Healthy Michigan Plan
PIP_012 – PIP Healthy Michigan Plan (TAB)</td></tr>
<tr><td>Notes</td><td>Healthy Michigan members are identifiable by HMI indicated on the ID card

The annual health risk assessment (HRA) will be paid out for the measurement year only; it will not be paid out for subsequent years.

To be considered for the incentive, the HRA must be signed and include the provider attestation information. Handwritten forms must be legible. HRAs must be listed as “Completed” or “Completed – Waiting for Health Plan Review” in CHAMPS.

CHAMPS Provider HRA Domain Training document:
https://www.michigan.gov/documents/mdhhs/Provider_Instructions_for_Completing_the_Health_Risk_Assessment_620500_7.pdf

Healthy Michigan Plan information for providers:
https://www.priorityhealth.com/provider/manual/plans-benefits/medicaid-programs/healthy-michigan-plan

Healthy Michigan Plan HRA form submission and incentive
https://www.priorityhealth.com/provider/manual/plans-benefits/medicaid-programs/healthy-michigan-plan/hra-and-incentive

HRA form - Word or PDF
https://www.michigan.gov/mdhhs/0,5885,7-339-71547_2943_66797-325070--,00.html

Michigan Department of Health & Human Services (MDHHS) HRA completion and submission videos
Completing the HRA
Submitting the HRA
Overview Health Behaviors Incentive Program</td></tr>
</table>

Transformation of care
Behavioral Health Collaborative Care

Source	The Behavioral Health Collaborative Care 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.
Identified measure	The behavioral health collaborative care (BHCC) incentive is designed to engage PCP practices in evaluating their readiness to develop and implement a behavioral health collaborative care program. The behavioral health collaborative care model supports the interaction of the behavioral health care manager, the PCP, and the psychiatric consultant. Patients are first evaluated for mild to moderate depression or anxiety through use of an approved screening tool. To be eligible for this incentive practices must (see additional details for each component below): • Have PCMH recognition in the program year • Attend at least 1 BHCC learning event in the program year • Attend at least 3 quarterly Priority Health sponsored meetings to discuss BHCC
Age criteria	Members 12 years of age and older
	Component 1: PCMH Recognition Practice groups must be PCMH recognized in the program year. Priority Health honors the following recognition programs: BCBSM, NCQA, URAC and Joint Commission. Proof of PCMH recognition is required annually. For the 2021 program year proof of recognition is based solely on responses submitted to Priority Health on the network assessment survey requested and submitted in 2020. Deadline for network assessment survey for this program year was Sept. 18, 2020. No other method of submission for PCMH recognition is accepted. Future measure year participation will require proof of recognition to be submitted annually through the Priority Health network assessment survey.
	Component 2: BHCC education and attestation Participating ACNs will make BHCC learning events available to contracted PCP practices with several dates and times to choose from. Acceptable learning events and literature for creating learning events can be found in the notes section below. Attendance at one learning event is required by (but not limited to) at least 1 behavioral health care manager or provider representing the practice: • Registered Nurse (RN) • Nurse Practitioner (NP) • Physician Assistant (PA) • Licensed Master Social Worker (LMSW) • Primary Care Physician (PCP) *Attendance by a Licensed Practical Nurse (LPN) or Medical Assistant (MA) representing the practice doesn't qualify as meeting component 2.* Courses provided by Mi-CCSI and MCCIST as part of the BCBSM CoCM program may also be credited as training for the Priority Health BHCC program. ACNs will complete the BHCC survey attestation on behalf of their contracted provider groups and submit to PH-PartnersinPerformance@priorityhealth.com by **Dec. 3, 2021.** **Attestation survey fields:**

	Practice name Facility site ID Name of screening tool used Name of learning event Date of learning event attended Credentials of attendee ACN contact name ACN contact email address ACN contract phone number Sample of completed attestation survey can be found at *priorityhealth.com* (login required).
	<u>Component 3: Priority Health meeting attendance</u> Practices interested in earning the incentive for this measure must attend at least 3 out of 4 quarterly virtual meetings to discuss collaborative care activities, share best practices and discuss barriers to implementation. These meetings will be held: • Feb. 2021 • May 2021 • Sept. 2021 • Nov. 2021 Meeting details will be communicated no less than two weeks prior to the meeting date. Attendance is required by (but not limited to) at least 1 behavioral health care manager representing the practice: • Registered Nurse (RN) • Nurse Practitioner (NP) • Physician Assistant (PA) • Licensed Master Social Worker (LMSW) • Primary Care Physician (PCP) • ACN care management leader *Attendance by a Licensed Practical Nurse (LPN) or Medical Assistant (MA) representing the practice doesn't qualify as meeting component 3.* Information and best practices learned at these meetings should be shared with others on the practice care management team, used for implementing a BHCC program in the ACN, and/or recruiting behavioral health collaborating partners. Priority Health will document attendance at these events for measure credit.
Level of measure	Practice groups contracted through an CAN
Minimum members	1 per practice group
Product line	HMO/POS, ASO/PPO, Medicare, Medicaid
Method of measurement	Practice group level
Payout	$0.25 pmpm
Notes	The attestation survey and additional BHCC information is available at *priorityhealth.com* (login required). Target patient population includes those with mild to moderate depression and 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 practice; patients with severe and complex needs may need to be managed by Care Managers and/or a psychiatrists. Behavioral health collaborative care procedure codes are reimbursed at a fee-for-service rate (varies by product and fee schedule) and count toward the care

	management touchpoints that impact a practice's performance relative to its annual risk-adjusted target. These procedure codes include: • **99492:** First 70 minutes in the first calendar month for behavioral health care manager activities • **99493:** First 60 minutes in a subsequent month for behavioral health care manager activities • **99494:** Each additional 30 minutes in a calendar month of behavioral health care manager activities listed above For PHQ9 and GAD7 a score of 10 or more alerts the practitioner that collaborative care may be warranted for the patient. **Summary of the collaborative care model – APA Video:** https://www.youtube.com/watch?v=zXZTgq3GyPw **Education and literature resources:** MICMT education: https://micmt-cares.org/event/mccist-collaborative-care University of Washington AIMS Center: https://aims.uw.edu/collaborative-care APA CoCare online course: https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care Centers for Medicare & Medicaid Services: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes Study: https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/hh-irc-collaborative-5-13.pdf

Efficiency and utilization

Acute hospital utilization – Report only

Source	HEDIS
Identified measure	For members 18 years of age and older, the risk-adjusted ratio of observed to expected acute inpatient and observation stay discharges during the measurement year.
Case definition	This measure uses a risk-adjustment methodology to predict how many discharges each member may have during the measurement year, given age, gender and presence or absence of a comorbid condition. The risk-adjustment method is based on Hierarchical Condition Categories (HCCs). An incentive will be provided to an ACN that: • Exceeds (lower than) the product-specific targets for the observed/expected ratio of acute hospital discharges. In the event of an acute-to-acute direct transfer, the last discharge is used. A direct transfer is when the discharge date from the first stay precedes the admission date to a subsequent stay by one calendar day or less. Members must be continuously enrolled with Priority Health in the measurement year and year prior with no more than 45-day gap in coverage.
Age criteria	18 years of age and older as of Dec 31 of the measurement year.
Exclusionary criteria	Members in hospice or using hospice any time during the measurement year. Medicare members with four or more inpatient or observation stay discharges during the measurement year Commercial members with three or more inpatient or observation stay discharges during the measurement year The following inpatient or observation discharges are excluded: • Principal diagnosis of mental health or chemical dependency • Principal diagnosis of live-born infant • Maternity-related principal diagnosis • Maternity-related stay • Discharge for death
Numerator	Number of observed acute inpatient and observation stay discharges in the measurement year.
Denominator	Number of expected acute inpatient and observation stay discharges in the measurement year.
Level of measure	Contracted Accountable Care Network (ACN)
Minimum members	ACNs with the minimum number of members as of Jan. 31 of the measurement year are eligible for this measure HMO/POS: 2,000 members ASO/PPO: 2,000 members Medicare: 1,000 members
Applicable product line	HMO/POS, ASO/PPO, Medicare
Method of measurement	Claims data processed by Feb. 28, 2022
Provider data input	None
Reporting	Reporting quarterly for ACNs meeting membership threshold by product

Notes	The targets for the AHU and EDU measures will be established based on peer ACN performance percentiles calculated based on the performance period. CMS includes this utilization measure in CPC+. Member months are defined as the eligible population.

Efficiency and utilization

Emergency department utilization – Report only

Source	HEDIS
Identified measure	For members 18 years of age and older, the risk-adjusted ratio of observed to expected emergency department (ED) visits during the measurement year.
Case definition	This measure uses a risk-adjustment methodology to predict how many ED visits each member may have during the measurement year, given age, gender and presence or absence of a comorbid condition. The risk-adjustment method is based on Hierarchical Condition Categories (HCCs). An incentive will be provided to an ACN that: • Exceeds (lower than) the product-specific targets for the observed/expected ratio of ED visits Members must be continuously enrolled with Priority Health in the measurement year and year prior with no more than 45-day gap in coverage.
Age criteria	18 years of age and older as of Dec 31 of the measurement year.
Exclusionary criteria	Members in hospice or using hospice any time during the measurement year. The following ED visits are excluded from the measure: • ED visits that result in an inpatient stay • ED visits with a principal diagnosis of mental health or chemical dependency • Psychiatry • Electroconvulsive therapy
Numerator	Number of observed ED visits in 2021
Denominator	Number of expected ED visits in 2021
Level of measure	Contracted Accountable Care Network (ACN)
Minimum members	ACNs with the minimum number of members as of Jan. 31 of the measurement year are eligible for this measure. HMO/POS: 2,000 members ASO/PPO: 2,000 members Medicare: 1,000 members
Applicable product line	HMO/POS, ASO/PPO, Medicare
Method of measurement	Claims data processed by Feb. 28, 2022
Provider data input	None
Reporting	Contact your Provider Performance Specialist for ACN reporting
Notes	The targets for the AHU and EDU measures will be established based on peer ACN performance percentiles calculated based on the performance period. The AHU and EDU measures are set on a fixed budget. If performance exceeds the budget for the measure, the measure payout will be adjusted to the budget amount. CMS includes this utilization measure in CPC+. Member months are defined as the eligible population.
Reporting	Reporting quarterly for ACNs meeting membership threshold by product
Notes	The targets for the AHU and EDU measures will be established based on peer ACN performance percentiles calculated based on the performance period.

	CMS includes this utilization measure in CPC+. Member months are defined as the eligible population.

Efficiency and utilization
ED visits: PCP treatable care

Case definition	Emergency department utilization of PCP treatable care as identified through ICD-10 coding. PCP treatable care is based on the NYU code set. Performance is measured in a PCP treatable ED rate per 1,000 members. A shared savings incentive will be provided to primary care practices that: • Exceed (lower than) the product-specific target ED PCP treatable visits per thousand for the 50% shared savings, or • Experience improvement from year-end 2020 to year-end 2021 and have a year-end 2021 rate between the product-specific thresholds for the 25% shared savings.
Age criteria	All ages
Exclusionary criteria	ED visits resulting in an inpatient admission
Numerator	Number of PCP treatable ED visits with a PCP treatable defined primary diagnosis.
Denominator	Member months affiliated with an ACN
Level of measure	Accountable Care Network (ACN)
Minimum members	ACNs with a minimum of 12,000 annual Medicaid member months at the ACN level as of Jan. 31 of the measurement year are eligible for this measure. ACNs with fewer than 12,000 annual Medicaid member months in the measurement year, who reach more than 12,000 annual member months in the measurement year, will only be eligible for the target measurement. No improvement criteria will apply.
Product line	Medicaid
Method of measurement	Claims data submitted by Feb. 28 of the following measurement year
Provider data input	PCP treatable ED visits x 12,000 Total member months
Target and Payout	Contact your Provider Performance Specialist for ACN eligibility and specific targets annually. Payout is based on shared savings.
Reporting	PIP_019 – ED visits per Thousand Members PIP_019 – ED visits per Thousand Members (TAB)
Notes	ACN targets will be available in Q2 2021. This measure is based on member demographics, and Priority Health utilizes data from the mid-year point of the previous program year.

Measure code sets

Lead test

CPT
83655

Childhood Immunizations

DTaP		IPV		MMR	
CPT	CVX	CPT	CVX	CPT	CVX
90698	20	90698	10	90707	03
90700	50	90713	89	90710	07
90723	106	90723	110	90704	94
	107		120	90705	
	110				
	120				

MMR ICD10CM			
B26.0	B26.82	B26.9	B06.81
B26.1	B26.83	B06.00	B06.82
B26.2	B26.84	B06.01	B06.89
B26.3	B26.85	B06.02	B06.9
B26.81	B26.89	B06.09	B05.89
			B05.9

Varicella						
CPT	CVX	ICD10CM				
90710	21	B01.0	B01.89	B02.22	B02.31	B02.7
90716	94	B01.11	B01.9	B02.23	B02.32	B02.8
		B01.12	B02.0	B02.24	B02.33	B02.9
		B01.2	B02.1	B02.29	B02.34	
		B01.81	B02.21	B02.30	B02.39	

HIB		HepB			
CPT	CVX	CPT	CVX	HCPCS	ICD10CM
90644	17	90723	08	G0010	B16.0
90645	46	90740	44	3E0234Z	B16.1
90646	47	90744	45		B16.2
90647	48	90747	51		B16.9
90648	49	90748	110		B17.0
90698	50				B18.0
90748	51				B18.1
	120				B19.10
	148				B19.11

Pneumococcal Conjugate	
CPT	CVX
90669	133
90670	152

Hepatitis A Immunization		
CVX		
31	83	85

Hepatitis A Vaccine Procedure
CPT
90633

Hepatitis A
ICD10CM
B15.0
B15.9

Rotavirus (3 Dose Schedule) Immunization	
CVX	
116	122

Rotavirus (3 Dose Schedule) Immunization Procedure
CPT
90680

Influenza Immunization	
CVX	
88	153
140	155
141	158
150	161

Influenza Vaccine Procedure		
CPT		HCPCS
90655	90686	G0008
90657	90687	
90661	90688	
90673	90689	
90685		

Influenza Virus LAIV Immunization	
CVX	
111	149

Influenza Virus LAIV Vaccine Procedure	
CPT	
90660	90672

Anaphylactic Reaction

ICD10CM
T80.52XA
T80.52XD
T80.52XS

Encephalopathy

ICD10CM
G04.32
T50.A15A
T50.A15D
T50.A15S

Disorders of the Immune System

ICD10CM			
D80.0	D81.2	D82.9	D89.811
D80.1	D81.4	D83.0	D89.812
D80.2	D81.6	D83.1	D89.813
D80.3	D81.7	D83.2	D89.82
D80.4	D81.89	D83.8	D89.89
D80.5	D81.9	D83.9	D89.9
D80.6	D82.0	D84.0	
D80.7	D82.1	D84.1	
D80.8	D82.2	D84.8	
D80.9	D82.3	D84.9	
D81.0	D82.4	D89.3	
D81.1	D82.8	D89.810	

HIV **HIV Type 2**

ICD10CM	
B20	B97.35
Z21	

Lymphoreticular cancer, multiple myeloma or leukemia

ICD10CM					
C81.00	C82.12	C83.04	C84.16	C85.28	C92.30
C81.01	C82.13	C83.05	C84.17	C85.29	C92.31
C81.02	C82.14	C83.06	C84.18	C85.80	C92.32
C81.03	C82.15	C83.07	C84.19	C85.81	C92.40
C81.04	C82.16	C83.08	C84.40	C85.82	C92.41
C81.05	C82.17	C83.09	C84.41	C85.83	C92.42
C81.06	C82.18	C83.10	C84.42	C85.84	C92.50
C81.07	C82.19	C83.11	C84.43	C85.85	C92.51
C81.08	C82.20	C83.12	C84.44	C85.86	C92.52
C81.09	C82.21	C83.13	C84.45	C85.87	C92.60
C81.10	C82.22	C83.14	C84.46	C85.88	C92.61
C81.11	C82.23	C83.15	C84.47	C85.89	C92.62
C81.12	C82.24	C83.16	C84.48	C85.90	C92.90
C81.13	C82.25	C83.17	C84.49	C85.91	C92.91
C81.14	C82.26	C83.18	C84.60	C85.92	C92.92
C81.15	C82.27	C83.19	C84.61	C85.93	C92.A0
C81.16	C82.28	C83.30	C84.62	C85.94	C92.A1
C81.17	C82.29	C83.31	C84.63	C85.95	C92.A2
C81.18	C82.30	C83.32	C84.64	C85.96	C92.Z0

Lymphoreticular cancer, multiple myeloma or leukemia

ICD10CM					
C81.19	C82.31	C83.33	C84.65	C85.97	C92.Z1
C81.20	C82.32	C83.34	C84.66	C85.98	C92.Z2
C81.21	C82.33	C83.35	C84.67	C85.99	C93.00
C81.22	C82.34	C83.36	C84.68	C86.0	C93.01
C81.23	C82.35	C83.37	C84.69	C86.1	C93.02
C81.24	C82.36	C83.38	C84.70	C86.2	C93.10
C81.25	C82.37	C83.39	C84.71	C86.3	C93.11
C81.26	C82.38	C83.50	C84.72	C86.4	C93.12
C81.27	C82.39	C83.51	C84.73	C86.5	C93.30
C81.28	C82.40	C83.52	C84.74	C86.6	C93.31
C81.29	C82.41	C83.53	C84.75	C88.2	C93.32
C81.30	C82.42	C83.54	C84.76	C88.3	C93.90
C81.31	C82.43	C83.55	C84.77	C88.4	C93.91
C81.32	C82.44	C83.56	C84.78	C88.8	C93.92
C81.33	C82.45	C83.57	C84.79	C88.9	C93.Z0
C81.34	C82.46	C83.58	C84.90	C90.00	C93.Z1
C81.35	C82.47	C83.59	C84.91	C90.01	C93.Z2
C81.36	C82.48	C83.70	C84.92	C90.02	C94.00
C81.37	C82.49	C83.71	C84.93	C90.10	C94.01
C81.38	C82.50	C83.72	C84.94	C90.11	C94.02
C81.39	C82.51	C83.73	C84.95	C90.12	C94.20
C81.40	C82.52	C83.74	C84.96	C90.20	C94.21
C81.41	C82.53	C83.75	C84.97	C90.21	C94.22
C81.42	C82.54	C83.76	C84.98	C90.22	C94.30
C81.43	C82.55	C83.77	C84.99	C90.30	C94.31
C81.44	C82.56	C83.78	C84.A0	C90.31	C94.32
C81.45	C82.57	C83.79	C84.A1	C90.32	C94.80
C81.46	C82.58	C83.80	C84.A2	C91.00	C94.81
C81.47	C82.59	C83.81	C84.A3	C91.01	C94.82
C81.48	C82.60	C83.82	C84.A4	C91.02	C95.00
C81.49	C82.61	C83.83	C84.A5	C91.10	C95.01
C81.70	C82.62	C83.84	C84.A6	C91.11	C95.02
C81.71	C82.63	C83.85	C84.A7	C91.12	C95.10
C81.72	C82.64	C83.86	C84.A8	C91.30	C95.11
C81.73	C82.65	C83.87	C84.A9	C91.31	C95.12
C81.74	C82.66	C83.88	C84.Z0	C91.32	C95.90
C81.75	C82.67	C83.89	C84.Z1	C91.40	C95.91
C81.76	C82.68	C83.90	C84.Z2	C91.41	C95.92

Lymphoreticular cancer, multiple myeloma or leukemia

ICD10CM					
C81.77	C82.69	C83.91	C84.Z3	C91.42	C96.0
C81.78	C82.80	C83.92	C84.Z4	C91.50	C96.2
C81.79	C82.81	C83.93	C84.Z5	C91.51	C96.20
C81.90	C82.82	C83.94	C84.Z6	C91.52	C96.21
C81.91	C82.83	C83.95	C84.Z7	C91.60	C96.22
C81.92	C82.84	C83.96	C84.Z8	C91.61	C96.29
C81.93	C82.85	C83.97	C84.Z9	C91.62	C96.4
C81.94	C82.86	C83.98	C85.10	C91.90	C96.9
C81.95	C82.87	C83.99	C85.11	C91.91	C96.A
C81.96	C82.88	C84.00	C85.12	C91.92	C96.Z
C81.97	C82.89	C84.01	C85.13	C91.A0	
C81.98	C82.90	C84.02	C85.14	C91.A1	
C81.99	C82.91	C84.03	C85.15	C91.A2	
C82.00	C82.92	C84.04	C85.16	C91.Z0	
C82.01	C82.93	C84.05	C85.17	C91.Z1	
C82.02	C82.94	C84.06	C85.18	C91.Z2	
C82.03	C82.95	C84.07	C85.19	C92.00	
C82.04	C82.96	C84.08	C85.20	C92.01	
C82.05	C82.97	C84.09	C85.21	C92.02	
C82.06	C82.98	C84.10	C85.22	C92.10	
C82.07	C82.99	C84.11	C85.23	C92.11	
C82.08	C83.00	C84.12	C85.24	C92.12	
C82.09	C83.01	C84.13	C85.25	C92.20	
C82.10	C83.02	C84.14	C85.26	C92.21	
C82.11	C83.03	C84.15	C85.27	C92.22	

Adolescent Immunizations

Meningococcal		Tdap		HPV	
CPT	CVX	CPT	CVX	CPT	CVX
90734	108	90715	115	90649	62
	114			90650	118
	136			90651	137
	147				165
	167				

Anaphylactic reaction due to vaccination

ICD10CM
T80.52XA
T80.52XD
T80.52XS

Encephalopathy due to vaccination

ICD10CM
G04.32

Vaccine causing adverse effect

ICD10CM
T50.A15A
T50.A15D
T50.A15S

Well-Child visits

CPT	HCPCS	ICD10CM	MODIFIER	POS MODIFIER
99381	G0438	Z00.00	95	2
99382	G0439	Z00.01	GT	
99383	S0302	Z00.110		
99384		Z00.111		
99385		Z00.121		
99391		Z00.129		
99392		Z00.2		
99393		Z00.3		
99394		Z02.5		
99395		Z76.1		
99461		Z76.2		

Chlamydia screenings

CPT	
87110	87491
87270	87492
87320	87810
87490	

Sexually active women

CPT					HCPCS
11976	59150	59841	80055	87624	G0101
57022	59151	59850	80081	87625	G0123
57170	59160	59851	82105	87660	G0124
58300	59200	59852	82106	87661	G0141
58301	59300	59855	82143	87808	G0143
58600	59320	59856	82731	87810	G0144
58605	59325	59857	83632	87850	G0145
58615	59350	59866	83661	88141	G0147
58970	59400	59870	83662	88142	G0148
58974	59409	59871	83663	88143	G0475
58976	59410	59897	83664	88147	G0476
59000	59412	59898	84163	88148	H1000
59001	59414	59899	84704	88150	H1001
59012	59425	76801	86592	88152	H1003
59015	59426	76805	86593	88153	H1004
59020	59430	76811	86631	88154	H1005
59025	59510	76813	86632	88164	P3000
59030	59514	76815	87110	88165	P3001
59050	59515	76816	87164	88166	Q0091
59051	59525	76817	87166	88167	S0199
59070	59610	76818	87270	88174	S4981
59072	59612	76819	87320	88175	S8055
59074	59614	76820	87490	88235	
59076	59618	76821	87491	88267	
59100	59620	76825	87492	88269	
59120	59622	76826	87590		
59121	59812	76827	87591		
59130	59820	76828	87592		
59135	59821	76941	87620		
59136	59830	76945	87621		
59140	59840	76946	87622		

Sexually active women

ICD10CM						
A34	A52.77	A56.11	N71.1	Z30.011	Z32.2	Z3A.08
A51.0	A52.78	A56.19	N71.9	Z30.012	Z32.3	Z3A.09
A51.1	A52.79	A56.2	N93.0	Z30.013	Z33.1	Z3A.10
A51.2	A52.8	A56.3	N94.1	Z30.014	Z33.2	Z3A.11
A51.31	A52.9	A56.4	N96	Z30.018	Z34.00	Z3A.12
A51.32	A53.0	A56.8	N97.0	Z30.019	Z34.01	Z3A.13
A51.39	A53.9	A57	N97.1	Z30.02	Z34.02	Z3A.14
A51.41	A54.00	A58	N97.2	Z30.09	Z34.03	Z3A.15
A51.42	A54.01	A59.00	N97.8	Z30.2	Z34.80	Z3A.16
A51.43	A54.02	A59.01	N97.9	Z30.40	Z34.81	Z3A.17
A51.44	A54.03	A59.03	O94	Z30.41	Z34.82	Z3A.18
A51.45	A54.09	A59.09	T38.4X1A	Z30.42	Z34.83	Z3A.19
A51.46	A54.1	A59.8	T38.4X1D	Z30.430	Z34.90	Z3A.20
A51.49	A54.21	A59.9	T38.4X1S	Z30.431	Z34.91	Z3A.21
A51.5	A54.24	A60.00	T38.4X2A	Z30.432	Z34.92	Z3A.22
A51.9	A54.29	A60.03	T38.4X2D	Z30.433	Z34.93	Z3A.23
A52.00	A54.30	A60.04	T38.4X2S	Z30.49	Z36	Z3A.24
A52.01	A54.31	A60.09	T38.4X3A	Z30.8	Z37.0	Z3A.25
A52.02	A54.32	A60.1	T38.4X3D	Z30.9	Z37.1	Z3A.26
A52.03	A54.33	A60.9	T38.4X3S	Z31.0	Z37.2	Z3A.27
A52.04	A54.39	A63.0	T38.4X4A	Z31.41	Z37.3	Z3A.28
A52.05	A54.40	A63.8	T38.4X4D	Z31.42	Z37.4	Z3A.29
A52.06	A54.41	A64	T38.4X4S	Z31.430	Z37.50	Z3A.30
A52.09	A54.42	B20	T38.4X5A	Z31.438	Z37.51	Z3A.31
A52.10	A54.43	B97.33	T38.4X5D	Z31.440	Z37.52	Z3A.32
A52.11	A54.49	B97.34	T38.4X5S	Z31.441	Z37.53	Z3A.33
A52.12	A54.5	B97.35	T38.4X6A	Z31.448	Z37.54	Z3A.34
A52.13	A54.6	B97.7	T38.4X6D	Z31.49	Z37.59	Z3A.35
A52.14	A54.81	F52.6	T38.4X6S	Z31.5	Z37.60	Z3A.36
A52.15	A54.82	F53	T83.31XA	Z31.61	Z37.61	Z3A.37
A52.16	A54.83	G44.82	T83.31XD	Z31.62	Z37.62	Z3A.38
A52.17	A54.84	N70.01	T83.31XS	Z31.69	Z37.63	Z3A.39
A52.19	A54.85	N70.02	T83.32XA	Z31.81	Z37.64	Z3A.40
A52.2	A54.86	N70.03	T83.32XD	Z31.82	Z37.69	Z3A.41
A52.3	A54.89	N70.11	T83.32XS	Z31.83	Z37.7	Z3A.42
A52.71	A54.9	N70.12	T83.39XA	Z31.84	Z37.9	Z3A.49
A52.72	A55	N70.13	T83.39XD	Z31.89	Z39.0	Z64.0
A52.73	A56.00	N70.91	T83.39XS	Z31.9	Z39.1	Z64.1
A52.74	A56.01	N70.92	Z20.2	Z32.00	Z39.2	Z72.51

Sexually active women

ICD10CM						
A52.75	A56.02	N70.93	Z21	Z32.01	Z3A.00	Z72.52
A52.76	A56.09	N71.0	Z22.4	Z32.02	Z3A.01	Z72.53
						Z79.3
						Z92.0
						Z97.5
						Z98.51

Sexually active women

ICD10CM
Z79.3
Z92.0
Z97.5
Z98.51

Pregnancy codes
Contact your provider performance specialist for the list of codes

Pregnancy tests

CPT
81025
84702
84703

Diagnostic radiology

CPT
70010-76499

Pregnancy test exclusion

CPT
84702
84703

Retinoid Medications

Description	Prescription
Retinoid	Isotretinoin

Contraceptive Medications

Description	Prescription	
Contraceptives	• Desogestrel-ethinyl estradiol • Dienogest-estradiol (multiphasic) • Drospirenone-ethinyl estradiol • Drospirenone-ethinyl estradiol-levomefolate (biphasic) • Ethinyl estradiol-ethynodiol • Ethinyl estradiol-etonogestrel • Ethinyl estradiol-levonorgestrel • Ethinyl estradiol-norelgestromin	• Ethinyl estradiol-norethindrone • Ethinyl estradiol-norgestimate • Ethinyl estradiol-norgestrel • Etonogestrel • Levonorgestrel • Medroxyprogesterone • Mestranol-norethindrone • Norethindrone
Diaphragm	• Diaphragm	
Spermicide	• Nonoxynol 9	

Cervical Cancer Screenings

CPT			HCPCS	
88141	88150	88165	G0123	G0145
88142	88152	88166	G0124	G0147
88143	88153	88167	G0141	G0148
88147	88154	88174	G0143	P3000
88148	88164	88175	G0144	P3001
				Q0091

High risk HPV lab test result or finding

CPT
87620
87621
87622
87624
87625

Absence of cervix

CPT
Q51.5
Z90.710
Z90.712

Hysterectomy Exclusion

CPT			ICD10CM
51925	58267	58570	0UTC0ZZ
56308	58270	58571	0UTC4ZZ
57540	58275	58572	0UTC7ZZ
57545	58280	58573	0UTC8ZZ
57550	58285	58951	
57555	58290	58953	
57556	58291	58954	
58150	58292	58956	
58152	58293	59135	
58200	58294		
58210	58548		
58240	58550		
58260	58552		
58262	58553		
58263	58554		

Mammography

CPT		HCPCS
77055	77063	G0202
77056	77065	G0204
77057	77066	G0206
77061	77067	
77062		

Bilateral Mastectomy

ICD10 PCS
0HTV0ZZ

History of Bilateral Mastectomy

ICD10CM
Z90.13

Unilateral Mastectomy

CPT			ICD10PCS	LEFT MODIFIER	RIGHT MODIFIER
19180	19303	19307	0HTU0ZZ	LT	RT
19200	19304		0HTT0ZZ		
19220	19305				
19240	19306				

Absence of left breast

ICD10CM
Z90.12

Absence of right breast

ICD10CM
Z90.11

Frailty

CPT	HCPCS					ICD10CM
99504	E0100	E0260	E0433	E1161	T1000	R26.0
99509	E0105	E0261	E0434	E1240	T1001	R26.1
	E0130	E0265	E0435	E1250	T1002	R26.2
	E0135	E0266	E0439	E1260	T1003	R26.89
	E0140	E0270	E0440	E1270	T1004	R26.9
	E0141	E0290	E0441	E1280	T1005	R41.81
	E0143	E0291	E0442	E1285	T1019	R53.1
	E0144	E0292	E0443	E1290	T1020	R53.81
	E0147	E0293	E0444	E1295	T1021	R53.83
	E0148	E0294	E0462	E1296	T1022	R54
	E0149	E0295	E0465	E1297	T1030	R62.7
	E0163	E0296	E0466	E1298	T1031	R63.4
	E0165	E0297	E0470	G0162		R63.6
	E0167	E0301	E0471	G0299		R64
	E0168	E0302	E0472	G0300		
	E0170	E0303	E0561	G0493		
	E0171	E0304	E0562	G0494		
	E0250	E0424	E1130	S0271		
	E0251	E0425	E1140	S0311		
	E0255	E0430	E1150	S9123		
	E0256	E0431	E1160	S9124		

Outpatient

CPT				HCPCS	UBREV	
99201	99242	99381	99397	G0402	510	523
99202	99243	99382	99401	G0438	511	526
99203	99244	99383	99402	G0439	512	527
99204	99245	99384	99403	G0463	513	528
99205	99341	99385	99404	T1015	514	529
99211	99342	99386	99411		515	982
99212	99343	99387	99412		516	983
99213	99344	99391	99429		517	
99214	99345	99392	99455		519	
99215	99347	99393	99456		520	
99241	99348	99394			521	
	99349	99395			522	
	99350	99396				

Observation

CPT
99217
99218
99219
99220

ED

CPT	UBREV
99281	450
99282	451
99283	452
99284	456
99285	459
	981

Nonacute inpatient stay

CPT	
99304	99324
99305	99325
99306	99326
99307	99327
99308	99328
99309	99334
99310	99335
99315	99336
99316	99337
99318	

Advanced illness

ICD10CM						
A81.00	C78.2	C93.Z0	G31.09	I50.811	J96.21	N18.5
A81.01	C78.39	C93.Z2	G31.83	I50.812	J96.22	N18.6
A81.09	C78.4	C94.30	I09.81	I50.813	J96.90	
C25.0	C78.5	C94.32	I11.0	I50.814	J96.91	
C25.1	C78.6	F01.50	I12.0	I50.82	J96.92	
C25.2	C78.7	F01.51	I13.0	I50.83	J98.2	
C25.3	C78.89	F02.80	I13.11	I50.84	J98.3	
C25.4	C79.00	F02.81	I13.2	I50.89	K70.10	
C25.7	C79.11	F03.90	I50.1	I50.9	K70.11	
C25.8	C79.19	F03.91	I50.20	J43.0	K70.2	
C25.9	C79.2	F04	I50.21	J43.1	K70.30	
C71.9	C79.31	F10.27	I50.22	J43.2	K70.31	
C77.0	C79.32	F10.96	I50.23	J43.8	K70.40	
C77.1	C79.49	F10.97	I50.30	J43.9	K70.41	
C77.2	C91.00	G10	I50.31	J68.4	K70.9	
C77.3	C91.02	G12.21	I50.32	J84.10	K74.0	
C77.4	C92.00	G20	I50.33	J84.112	K74.1	
C77.5	C92.02	G30.0	I50.40	J84.17	K74.2	
C77.8	C93.00	G30.1	I50.41	J96.10	K74.4	
C77.9	C93.02	G30.8	I50.42	J96.11	K74.5	
C78.00	C93.90	G30.9	I50.43	J96.12	K74.60	
C78.1	C93.92	G31.01	I50.810	J96.20	K74.69	

Acute Inpatient

CPT			
99221	99232	99251	99255
99222	99233	99252	99291
99223	99238	99253	
99231	99239	99254	

Dementia Medications

Description	Prescription		
Cholinesterase inhibitors	• Donepezil	• Galantamine	• Rivastigmine
Miscellaneous central nervous system agents	• Memantine		
Dementia combinations	• Donepezil-memantine		

Palliative Care

HCPCS	ICD10CM
G9054	Z51.5
M1017	

Colonoscopy

CPT				HCPCS
44388	44403	45381	45391	G0105
44389	44404	45382	45392	G0121
44390	44405	45383	45393	
44391	44406	45384	45398	
44392	44407	45385		
44393	44408	45386		
44394	45355	45387		
44397	45378	45388		
44401	45379	45389		
44402	45380	45390		

FIT-DNA

CPT	HCPCS
81528	G0464

CT colonography

CPT		
74261	74262	74263

Fecal occult blood test (FOBT)

CPT	HCPCS
82270	G0328
82274	

Flexible sigmoidoscopy

CPT				HCPCS
45330	45334	45339	45345	G0104
45331	45335	45340	45346	
45332	45337	45341	45347	
45333	45338	45342	45349	
			45350	

Colorectal cancer

HCPCS	ICD10CM		
G0213	C18.0	C18.7	C78.5
G0214	C18.1	C18.8	Z85.038
G0215	C18.2	C18.9	Z85.048
G0231	C18.3	C19	
	C18.4	C20	
	C18.5	C21.2	
	C18.6	C21.8	

Total colectomy

CPT		ICD10PCS
44150	44157	0DTE0ZZ
44151	44158	0DTE4ZZ
44152	44210	0DTE7ZZ
44153	44211	0DTE8ZZ
44155	44212	
44156		

Inpatient stay

UBREV						
0100	0121	0134	0148	0164	0193	0210
0101	0122	0136	0149	0167	0194	0211
0110	0123	0137	0150	0169	0199	0212
0111	0124	0138	0151	0170	0200	0213
0112	0126	0139	0152	0171	0201	0214
0113	0127	0140	0153	0172	0202	0219
0114	0128	0141	0154	0173	0203	1000
0116	0129	0142	0156	0174	0204	1001
0117	0130	0143	0157	0179	0206	1002
0118	0131	0144	0158	0190	0207	
0119	0132	0146	0159	0191	0208	
0120	0133	0147	0160	0192	0209	

Diabetes

ICD10CM					
E10.10	E10.3393	E10.3541	E10.620	E11.3219	E11.3499
E10.11	E10.3399	E10.3542	E10.621	E11.329	E11.351
E10.21	E10.341	E10.3543	E10.622	E11.3291	E11.3511
E10.22	E10.3411	E10.3549	E10.628	E11.3292	E11.3512
E10.29	E10.3412	E10.3551	E10.630	E11.3293	E11.3513
E10.311	E10.3413	E10.3552	E10.638	E11.3299	E11.3519
E10.319	E10.3419	E10.3553	E10.641	E11.331	E11.3521
E10.321	E10.349	E10.3559	E10.649	E11.3311	E11.3522
E10.3211	E10.3491	E10.36	E10.65	E11.3312	E11.3523
E10.3212	E10.3492	E10.37X1	E10.69	E11.3313	E11.3529
E10.3213	E10.3493	E10.37X2	E10.8	E11.3319	E11.3531
E10.3219	E10.3499	E10.37X3	E10.9	E11.339	E11.3532
E10.329	E10.351	E10.37X9	E11.00	E11.3391	E11.3533
E10.3291	E10.3511	E10.39	E11.01	E11.3392	E11.3539
E10.3292	E10.3512	E10.40	E11.10	E11.3393	E11.3541
E10.3293	E10.3513	E10.41	E11.11	E11.3399	E11.3542
E10.3299	E10.3519	E10.42	E11.21	E11.341	E11.3543
E10.331	E10.3521	E10.43	E11.22	E11.3411	E11.3549
E10.3311	E10.3522	E10.44	E11.29	E11.3412	E11.3551
E10.3312	E10.3523	E10.49	E11.311	E11.3413	E11.3552
E10.3313	E10.3529	E10.51	E11.319	E11.3419	E11.3553
E10.3319	E10.3531	E10.52	E11.321	E11.349	E11.3559
E10.339	E10.3532	E10.59	E11.3211	E11.3491	
E10.3391	E10.3533	E10.610	E11.3212	E11.3492	
E10.3392	E10.3539	E10.618	E11.3213	E11.3493	

Diabetes

ICD-10CM						
E11.359	E11.628	E13.3292	E13.3512	E13.37X1	E13.69	O24.82
E11.3591	E11.630	E13.3293	E13.3513	E13.37X2	E13.8	O24.83
E11.3592	E11.638	E13.3299	E13.3519	E13.37X3	E13.9	
E11.3593	E11.641	E13.331	E13.3521	E13.37X9	O24.011	
E11.3599	E11.649	E13.3311	E13.3522	E13.39	O24.012	
E11.36	E11.65	E13.3312	E13.3523	E13.40	O24.013	
E11.37X1	E11.69	E13.3313	E13.3529	E13.41	O24.019	
E11.37X2	E11.8	E13.3319	E13.3531	E13.42	O24.02	
E11.37X3	E11.9	E13.339	E13.3532	E13.43	O24.03	
E11.37X9	E13.00	E13.3391	E13.3533	E13.44	O24.111	
E11.39	E13.01	E13.3392	E13.3539	E13.49	O24.112	
E11.40	E13.10	E13.3393	E13.3541	E13.51	O24.113	
E11.41	E13.11	E13.3399	E13.3542	E13.52	O24.119	
E11.42	E13.21	E13.341	E13.3543	E13.59	O24.12	
E11.43	E13.22	E13.3411	E13.3549	E13.610	O24.13	
E11.44	E13.29	E13.3412	E13.3551	E13.618	O24.311	
E11.49	E13.311	E13.3413	E13.3552	E13.620	O24.312	
E11.51	E13.319	E13.3419	E13.3553	E13.621	O24.313	
E11.52	E13.321	E13.349	E13.3559	E13.622	O24.319	
E11.59	E13.3211	E13.3491	E13.359	E13.628	O24.32	
E11.610	E13.3212	E13.3492	E13.3591	E13.630	O24.33	
E11.618	E13.3213	E13.3493	E13.3592	E13.638	O24.811	
E11.620	E13.3219	E13.3499	E13.3593	E13.641	O24.812	
E11.621	E13.329	E13.351	E13.3599	E13.649	O24.813	
E11.622	E13.3291	E13.3511	E13.36	E13.65	O24.819	

Diabetes Medications

Description	Prescription		
Alpha-glucosidase inhibitors	• Acarbose	• Miglitol	
Amylin analogs	• Pramlintide		
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Dapagliflozin-metformin • Empagliflozin-linagliptin	• Empagliflozin-metformin • Glimepiride-pioglitazone • Glipizide-metformin • Glyburide-metformin • Linagliptin-metformin	• Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone • Metformin-saxagliptin • Metformin-sitagliptin
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin degludec • Insulin detemir • Insulin glargine • Insulin glulisine	• Insulin isophane human • Insulin isophane-insulin regular • Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human • Insulin human inhaled	
Meglitinides	• Nateglinide	• Repaglinide	
Glucagon-like peptide-1 (GLP1) agonists	• Dulaglutide • Exenatide	• Albiglutide • Liraglutide (excluding *Saxenda*®)	

Description	Prescription		
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin	• Dapagliflozin	• Empagliflozin
Sulfonylureas	• Chlorpropamide • Glimepiride	• Glipizide • Glyburide	• Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin	• Saxagliptin • Sitagliptin	

HbA1C lab codes

CPT	CPT-CAT-II	
83036	3044F	3051F
83037	3045F	3052F
	3046F	

If a CPT II code is billed, for example 3051F, we will look for any value that was provided to us during the measurement year. If no value is found, we assume the value is just below 9, so 8.9.

Telehealth Modifier

CPT Modifier
95
GT

Telehealth POS

POS
2

Diabetes exclusions

E08.00	E08.3412	E08.3592	E08.9	E09.3411	E09.3591	E09.8
E08.01	E08.3413	E08.3593	E09.00	E09.3412	E09.3592	E09.9
E08.10	E08.3419	E08.3599	E09.01	E09.3413	E09.3593	O24.410
E08.11	E08.349	E08.36	E09.10	E09.3419	E09.3599	O24.414
E08.21	E08.3491	E08.37X1	E09.11	E09.349	E09.36	O24.415
E08.22	E08.3492	E08.37X2	E09.21	E09.3491	E09.37X1	O24.419
E08.29	E08.3493	E08.37X3	E09.22	E09.3492	E09.37X2	O24.420
E08.311	E08.3499	E08.37X9	E09.29	E09.3493	E09.37X3	O24.424
E08.319	E08.351	E08.39	E09.311	E09.3499	E09.37X9	O24.425
E08.321	E08.3511	E08.40	E09.319	E09.351	E09.39	O24.429
E08.3211	E08.3512	E08.41	E09.321	E09.3511	E09.40	O24.430
E08.3212	E08.3513	E08.42	E09.3211	E09.3512	E09.41	O24.434
E08.3213	E08.3519	E08.43	E09.3212	E09.3513	E09.42	O24.435
E08.3219	E08.3521	E08.44	E09.3213	E09.3519	E09.43	O24.439
E08.329	E08.3522	E08.49	E09.3219	E09.3521	E09.44	O24.911
E08.3291	E08.3523	E08.51	E09.329	E09.3522	E09.49	O24.912
E08.3292	E08.3529	E08.52	E09.3291	E09.3523	E09.51	O24.913
E08.3293	E08.3531	E08.59	E09.3292	E09.3529	E09.52	O24.919
E08.3299	E08.3532	E08.610	E09.3293	E09.3531	E09.59	O24.92
E08.331	E08.3533	E08.618	E09.3299	E09.3532	E09.610	O24.93
E08.3311	E08.3539	E08.620	E09.331	E09.3533	E09.618	
E08.3312	E08.3541	E08.621	E09.3311	E09.3539	E09.620	
E08.3313	E08.3542	E08.622	E09.3312	E09.3541	E09.621	
E08.3319	E08.3543	E08.628	E09.3313	E09.3542	E09.622	
E08.339	E08.3549	E08.630	E09.3319	E09.3543	E09.628	
E08.3391	E08.3551	E08.638	E09.339	E09.3549	E09.630	
E08.3392	E08.3552	E08.641	E09.3391	E09.3551	E09.638	
E08.3393	E08.3553	E08.649	E09.3392	E09.3552	E09.641	
E08.3399	E08.3559	E08.65	E09.3393	E09.3553	E09.649	
E08.341	E08.359	E08.69	E09.3399	E09.3559	E09.65	
E08.3411	E08.3591	E08.8	E09.341	E09.359	E09.69	

Telephone Visit

CPT
98966
98967
98968
99441
99442
99443

Online Assessments

CPT	
98969	G2010
99444	G2012
98971	G2061
98972	G2062
99421	G2063
99422	
99423	
99444	
99458	

Urine protein tests

CPT	CPT II
81000	3060F
81001	3061F
81002	3062F
81003	3066F
81005	4010F
82042	
82043	
82044	
84156	

Nephropathy treatment

ICD10CM				
E08.21	N01.0	N04.3	N07.6	Q60.2
E08.22	N01.1	N04.4	N07.7	Q60.3
E08.29	N01.2	N04.5	N07.8	Q60.4
E09.21	N01.3	N04.6	N07.9	Q60.5
E09.22	N01.4	N04.7	N08	Q60.6
E09.29	N01.5	N04.8	N14.0	Q61.00
E10.21	N01.6	N04.9	N14.1	Q61.01
E10.22	N01.7	N05.0	N14.2	Q61.02
E10.29	N01.8	N05.1	N14.3	Q61.11
E11.21	N01.9	N05.2	N14.4	Q61.19
E11.22	N02.0	N05.3	N17.0	Q61.2
E11.29	N02.1	N05.4	N17.1	Q61.3
E13.21	N02.2	N05.5	N17.2	Q61.4
E13.22	N02.3	N05.6	N17.8	Q61.5
E13.29	N02.4	N05.7	N17.9	Q61.8
I12.0	N02.5	N05.8	N18.1	Q61.9
I12.9	N02.6	N05.9	N18.2	R80.0

I13.0	N02.7	N06.0	N18.3	R80.1
I13.10	N02.8	N06.1	N18.4	R80.2
I13.11	N02.9	N06.2	N18.5	R80.3
I13.2	N03.0	N06.3	N18.6	R80.8
I15.0	N03.1	N06.4	N18.9	R80.9
I15.1	N03.2	N06.5	N19	
N00.0	N03.3	N06.6	N25.0	
N00.1	N03.4	N06.7	N25.1	
N00.2	N03.5	N06.8	N25.81	
N00.3	N03.6	N06.9	N25.89	
N00.4	N03.7	N07.0	N25.9	
N00.5	N03.8	N07.1	N26.1	
N00.6	N03.9	N07.2	N26.2	
N00.7	N04.0	N07.3	N26.9	
N00.8	N04.1	N07.4	Q60.0	
N00.9	N04.2	N07.5	Q60.1	

Stage 4 Chronic Kidney Disease

CPT
N18.4

End Stage Renal Disease (ESRD)

CPT		HCPCS	ICD10CM	ICD10PCS
36147	36833	G0257	N18.5	3E1M39Z
36800	90935	S9339	N18.6	5A1D00Z
36810	90937		Z99.2	5A1D60Z
36815	90945			5A1D70Z
36818	90947			5A1D80Z
36819				5A1D90Z
36820				
36821				
36831				
36832				

Dialysis procedure

CPT	HCPCS	ICD10PCS
90935	G0257	3E1M39Z
90937	S9339	5A1D00Z
90945		5A1D60Z
90947		5A1D70Z
90997		5A1D80Z
90999		5A1D90Z
99512		

Nephrectomy

CPT	ICD10PCS	ICD10PCS
50340	0TB00ZX	0TB10ZZ
50370	0TB00ZZ	0TB13ZX
	0TB03ZX	0TB13ZZ
	0TB03ZZ	0TB14ZX
	0TB04ZX	0TB14ZZ
	0TB04ZZ	0TB17ZX
	0TB07ZX	0TB17ZZ
	0TB07ZZ	0TB18ZX
	0TB08ZX	0TB18ZZ
	0TB08ZZ	
	0TB10ZX	

Kidney transplant

CPT	HCPS	ICD10CM	ICD10PCS			
50340	S2065	Z94.0	0TY00Z0	0TB00ZX	0TB07ZX	0TB13ZX
50360			0TY00Z1	0TB00ZZ	0TB07ZZ	0TB13ZZ
50365			0TY00Z2	0TB03ZX	0TB08ZX	0TB14ZX
50370			0TY10Z0	0TB03ZZ	0TB08ZZ	0TB14ZZ
50380			0TY10Z1	0TB04ZX	0TB10ZX	0TB17ZX
			0TY10Z2	0TB04ZZ	0TB10ZZ	0TB17ZX
						0TB17ZZ
						0TB18ZX
						0TB18ZZ

ACE Inhibitor and ARB Medications

Description	Prescription
Angiotensin converting enzyme inhibitors	• Benazepril • Captopril • Enalapril • Fosinopril • Lisinopril • Moexipril • Perindopril • Quinapril • Ramipril • Trandolapril
Angiotensin II inhibitors	• Azilsartan • Candesartan • Eprosartan • Irbesartan • Losartan • Olmesartan • Telmisartan • Valsartan
Antihypertensive combinations	• Amlodipine-benazepril • Amlodipine-hydrochlorothiazide-valsartan • Amlodipine-hydrochlorothiazide-olmesartan • Amlodipine-olmesartan • Amlodipine-perindopril • Amlodipine-telmisartan • Amlodipine-valsartan • Azilsartan-chlorthalidone • Benazepril-hydrochlorothiazide • Candesartan-hydrochlorothiazide • Captopril-hydrochlorothiazide • Enalapril-hydrochlorothiazide • Fosinopril-hydrochlorothiazide • Hydrochlorothiazide-irbesartan • Hydrochlorothiazide-lisinopril • Hydrochlorothiazide-losartan • Hydrochlorothiazide-moexipril • Hydrochlorothiazide-olmesartan • Hydrochlorothiazide-quinapril • Hydrochlorothiazide-telmisartan • Hydrochlorothiazide-valsartan • Sacubitril-valsartan • Trandolapril-verapamil

MI

ICD10CM			
I21.01	I21.3	I22.2	I23.4
I21.02	I21.4	I22.8	I23.5
I21.09	I21.9	I22.9	I23.6
I21.11	I21.A1	I23.0	I23.7
I21.19	I21.A9	I23.1	I23.8
I21.21	I22.0	I23.2	I25.2
I21.29	I22.1	I23.3	

CABG

CPT	HCPCS	ICD10PCS				
33510	S2205	210083	02100A3	02110A8	02120A9	02130AC
33511	S2206	210088	02100A8	02110A9	02120AC	02130AF
33512	S2207	210089	02100A9	02110AC	02120AF	02130AW
33513	S2208	210093	02100AC	02110AF	02120AW	02130J3
33514	S2209	210098	02100AF	02110AW	02120J3	02130J8
33516		210099	02100AW	02110J3	02120J8	02130J9
33517		211083	02100J3	02110J8	02120J9	02130JC
33518		211088	02100J8	02110J9	02120JC	02130JF
33519		211089	02100J9	02110JC	02120JF	02130JW
33521		211093	02100JC	02110JF	02120JW	02130K3
33522		211098	02100JF	02110JW	02120K3	02130K8
33523		211099	02100JW	02110K3	02120K8	02130K9
33533		212083	02100K3	02110K8	02120K9	02130KC
33534		212088	02100K8	02110K9	02120KC	02130KF
33535		212089	02100K9	02110KC	02120KF	02130KW
33536		212093	02100KC	02110KF	02120KW	02130Z3
		212098	02100KF	02110KW	02120Z3	02130Z8
		212099	02100KW	02110Z3	02120Z8	02130Z9
		213083	02100Z3	02110Z8	02120Z9	02130ZC
		213088	02100Z8	02110Z9	02120ZC	02130ZF
		213089	02100Z9	02110ZC	02120ZF	
		213093	02100ZC	02110ZF	021308C	
		213098	02100ZF	021208C	021308F	
		213099	021108C	021208F	021308W	
		021008C	021108F	021208W	021309C	
		021008F	021108W	021209C	021309F	
		021008W	021109C	021209F	021309W	
		021009C	021109F	021209W	02130A3	
		021009F	021109W	02120A3	02130A8	
		021009W	02110A3	02120A8	02130A9	

PCI

CPT	HCPS	ICD10PCS				
92920	C9600	270346	2714000000	027134Z	02723DZ	02733GZ
92924	C9602	270356	2723000000	027135Z	02723EZ	02733T6
92928	C9604	270366	2724000000	027136Z	02723F6	02733TZ
92933	C9606	270376	2733000000	027137Z	02723FZ	02733Z6
92937	C9607	270446	2734000000	02713D6	02723G6	02733ZZ
92941		270456	027034Z	02713DZ	02723GZ	027344Z
92943		270466	027035Z	02713EZ	02723T6	027345Z
		270476	027036Z	02713F6	02723TZ	027346Z
		271346	027037Z	02713FZ	02723Z6	027347Z
		271356	02703D6	02713G6	02723ZZ	02734D6
		271366	02703DZ	02713GZ	027244Z	02734DZ
		271376	02703EZ	02713T6	027245Z	02734EZ
		271446	02703F6	02713TZ	027246Z	02734F6
		271456	02703FZ	02713Z6	027247Z	02734FZ
		271466	02703G6	02713ZZ	02724D6	02734G6
		271476	02703GZ	027144Z	02724DZ	02734GZ
		272346	02703T6	027145Z	02724EZ	02734T6
		272356	02703TZ	027146Z	02724F6	02734TZ
		272366	02703Z6	027147Z	02724FZ	02734Z6
		272376	02703ZZ	02714D6	02724G6	02734ZZ
		272446	027044Z	02714DZ	02724GZ	
		272456	027045Z	02714EZ	02724T6	
		272466	027046Z	02714F6	02724TZ	
		272476	027047Z	02714FZ	02724Z6	
		273346	02704D6	02714G6	02724ZZ	
		273356	02704DZ	02714GZ	027334Z	
		273366	02704EZ	02714T6	027335Z	
		273376	02704F6	02714TZ	027336Z	
		273446	02704FZ	02714Z6	027337Z	
		273456	02704G6	02714ZZ	02733D6	
		273466	02704GZ	027234Z	02733DZ	
		273476	02704T6	027235Z	02733EZ	
		2703000000	02704TZ	027236Z	02733F6	
		2704000000	02704Z6	027237Z	02733FZ	
		2713000000	02704ZZ	02723D6	02733G6	

Other Revascularization

CPT				
37220	37224	37226	37228	37230
37221	37225	37227	37229	37231

IVD

ICD10CM						
I20.0	I63.50	I70.229	I70.369	I70.529	I70.669	T82.856A
I20.8	I63.511	I70.231	I70.391	I70.531	I70.691	T82.856D
I20.9	I63.512	I70.232	I70.392	I70.532	I70.692	T82.856S
I24.0	I63.513	I70.233	I70.393	I70.533	I70.693	
I24.8	I63.519	I70.234	I70.398	I70.534	I70.698	
I24.9	I63.521	I70.235	I70.399	I70.535	I70.699	
I25.10	I63.522	I70.238	I70.401	I70.538	I70.701	
I25.110	I63.523	I70.239	I70.402	I70.539	I70.702	
I25.111	I63.529	I70.241	I70.403	I70.541	I70.703	
I25.118	I63.531	I70.242	I70.408	I70.542	I70.708	
I25.119	I63.532	I70.243	I70.409	I70.543	I70.709	
I25.5	I63.533	I70.244	I70.411	I70.544	I70.711	
I25.6	I63.539	I70.245	I70.412	I70.545	I70.712	
I25.700	I63.541	I70.248	I70.413	I70.548	I70.713	
I25.701	I63.542	I70.249	I70.418	I70.549	I70.718	
I25.708	I63.543	I70.25	I70.419	I70.55	I70.719	
I25.709	I63.549	I70.261	I70.421	I70.561	I70.721	
I25.710	I63.59	I70.262	I70.422	I70.562	I70.722	
I25.711	I65.01	I70.263	I70.423	I70.563	I70.723	
I25.718	I65.02	I70.268	I70.428	I70.568	I70.728	
I25.719	I65.03	I70.269	I70.429	I70.569	I70.729	
I25.720	I65.09	I70.291	I70.431	I70.591	I70.731	
I25.721	I65.1	I70.292	I70.432	I70.592	I70.732	
I25.728	I65.21	I70.293	I70.433	I70.593	I70.733	
I25.729	I65.22	I70.298	I70.434	I70.598	I70.734	
I25.730	I65.23	I70.299	I70.435	I70.599	I70.735	
I25.731	I65.29	I70.301	I70.438	I70.601	I70.738	
I25.738	I65.8	I70.302	I70.439	I70.602	I70.739	
I25.739	I65.9	I70.303	I70.441	I70.603	I70.741	
I25.750	I66.01	I70.308	I70.442	I70.608	I70.742	
I25.751	I66.02	I70.309	I70.443	I70.609	I70.743	
I25.758	I66.03	I70.311	I70.444	I70.611	I70.744	
I25.759	I66.09	I70.312	I70.445	I70.612	I70.745	
I25.760	I66.11	I70.313	I70.448	I70.613	I70.748	
I25.761	I66.12	I70.318	I70.449	I70.618	I70.749	
I25.768	I66.13	I70.319	I70.45	I70.619	I70.75	

I25.769	I66.19	I70.321	I70.461	I70.621	I70.761
I25.790	I66.21	I70.322	I70.462	I70.622	I70.762
I25.791	I66.22	I70.323	I70.463	I70.623	I70.763
I25.798	I66.23	I70.328	I70.468	I70.628	I70.768
I25.799	I66.29	I70.329	I70.469	I70.629	I70.769
I25.810	I66.3	I70.331	I70.491	I70.631	I70.791
I25.811	I66.8	I70.332	I70.492	I70.632	I70.792
I25.812	I66.9	I70.333	I70.493	I70.633	I70.793
I25.82	I67.2	I70.334	I70.498	I70.634	I70.798
I25.83	I70.1	I70.335	I70.499	I70.635	I70.799
I25.84	I70.201	I70.338	I70.501	I70.638	I70.92
I25.89	I70.202	I70.339	I70.502	I70.639	I75.011
I25.9	I70.203	I70.341	I70.503	I70.641	I75.012
I63.20	I70.208	I70.342	I70.508	I70.642	I75.013
I63.211	I70.209	I70.343	I70.509	I70.643	I75.019
I63.212	I70.211	I70.344	I70.511	I70.644	I75.021
I63.213	I70.212	I70.345	I70.512	I70.645	I75.022
I63.219	I70.213	I70.348	I70.513	I70.648	I75.023
I63.22	I70.218	I70.349	I70.518	I70.649	I75.029
I63.231	I70.219	I70.35	I70.519	I70.65	I75.81
I63.232	I70.221	I70.361	I70.521	I70.661	I75.89
I63.233	I70.222	I70.362	I70.522	I70.662	T82.855A
I63.239	I70.223	I70.363	I70.523	I70.663	T82.855D
I63.29	I70.228	I70.368	I70.528	I70.668	T82.855S

IVF

HCPCS				
S4015	S4016	S4018	S4020	S4021

Estrogen Agonists Medications List

Description	Prescription
Estrogen agonists	• Clomiphene

Cirrhosis

ICDCM				
K70.30	K71.7	K74.4	K74.60	P78.81
K70.31	K74.3	K74.5	K74.69	

Muscular Pain and Disease

ICD10CM	
G72.0	M60.861
G72.2	M60.862
G72.9	M60.869
M60.80	M60.871
M60.811	M60.872
M60.812	M60.879
M60.819	M60.88
M60.821	M60.89
M60.822	M60.9
M60.829	M62.82
M60.831	M79.1
M60.832	M79.10
M60.839	M79.11
M60.841	M79.12
M60.842	M79.18
M60.849	
M60.851	
M60.852	
M60.859	

High, Moderate and Low-Intensity Statin Medications

Description	Prescription	Medication Lists
High-intensity statin therapy	• Atorvastatin 40-80 mg	Atorvastatin High Intensity Medications List
High-intensity statin therapy	• Amlodipine-atorvastatin 40-80 mg	Amlodipine Atorvastatin High Intensity Medications List
High-intensity statin therapy	• Rosuvastatin 20-40 mg	Rosuvastatin High Intensity Medications List
High-intensity statin therapy	• Simvastatin 80 mg	Simvastatin High Intensity Medications List
High-intensity statin therapy	• Ezetimibe-simvastatin 80 mg	Ezetimibe Simvastatin High Intensity Medications List
Moderate-intensity statin therapy	• Atorvastatin 10-20 mg	Atorvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Amlodipine-atorvastatin 10-20 mg	Amlodipine Atorvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Rosuvastatin 5-10 mg	Rosuvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Simvastatin 20-40 mg	Simvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Ezetimibe-simvastatin 20-40 mg	Ezetimibe Simvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Pravastatin 40-80 mg	Pravastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Lovastatin 40 mg	Lovastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Fluvastatin 40-80 mg	Fluvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Pitavastatin 1–4 mg	Pitavastatin Moderate Intensity Medications List
Low-intensity statin therapy	• Ezetimibe-simvastatin 10 mg	Ezetimibe Simvastatin Low Intensity Medications List
Low-intensity statin therapy	• Fluvastatin 20 mg	Fluvastatin Low Intensity Medications List
Low-intensity statin therapy	• Lovastatin 10-20 mg	Lovastatin Low Intensity Medications List
Low-intensity statin therapy	• Pravastatin 10–20 mg	Pravastatin Low Intensity Medications List
Low-intensity statin therapy	• Simvastatin 5-10 mg	Simvastatin Low Intensity Medications List

Estimated Glomerular Filtration Rate Lab

CPT	
80047	80053
80048	80069
80050	82565

Quantitative Urine Albumin lab

CPT
82043

Urine Creatinine lab

CPT
82570

Diabetic retinal screening

CPT					HCPCS	CPT II
67028	67108	67227	92228	99242	S0620	2022F
67030	67110	67228	92230	99243	S0621	2024F
67031	67112	92002	92235	99244	S3000	2026F
67036	67113	92004	92240	99245		2023F
67039	67121	92012	92250			2025F
67040	67141	92014	92260			2033F
67041	67145	92018	99203			3027F
67042	67208	92019	99204			
67043	67210	92134	99205			
67101	67218	92225	99213			
67105	67220	92226	99214			
67107	67221	92227	99215			

Measure codes for Diabetes Care: Unilateral eye enucleation

CPT	
65091	65105
65093	65110
65101	65112
65103	65114

Bilateral modifier

50

Unilateral Eye Enucleation Left

ICD10PCS
08B1XZZ

Unilateral Eye Enucleation Right

ICD10PCS
08B0XZZ

Diabetes mellitus without complications

ICD10CM		
E10.9	E11.9	E13.9

Pregnancy
For the list of codes, contact your Provider Performance Specialist

Dementia

ICD10CM		
F01.50	F10.97	F19.97
F01.51	F13.27	G30.0
F02.80	F13.97	G30.1
F02.81	F18.17	G30.8
F03.90	F18.27	G30.9
F03.91	F18.97	G31.83
F04	F19.17	
F10.27	F19.27	

Inpatient stay

UBREV				
0100	0130	0152	0193	1002
0101	0131	0153	0194	
0110	0132	0154	0199	
0111	0133	0156	0200	
0112	0134	0157	0201	
0113	0136	0158	0202	
0114	0137	0159	0203	
0116	0138	0160	0204	
0117	0139	0164	0206	
0118	0140	0167	0207	
0119	0141	0169	0208	
0120	0142	0170	0209	
0121	0143	0171	0210	
0122	0144	0172	0211	
0123	0146	0173	0212	
0124	0147	0174	0213	
0126	0148	0179	0214	
0127	0149	0190	0219	
0128	0150	0191	1000	
0129	0151	0192	1001	

Essential hypertension

ICD10CM
I10

Blood pressure

CPT II
Systolic
3074F - Most recent systolic blood pressure less than 130 mm Hg
3075F - Most recent systolic blood pressure 130-139 mm Hg
3077F - Most recent systolic blood pressure greater than or equal to 140 mm Hg
Diastolic
3078F - Most recent diastolic blood pressure less than 80 mm Hg
3079F - Most recent diastolic blood pressure 80-89 mm Hg
3080F - Most recent diastolic blood pressure greater than or equal to 90 mm Hg

Remote blood pressure monitoring

CPT		
93784	99091	99473
93788	99453	99474
93790	99454	
	99457	

History of kidney transplant

ICD010CM
Z94.0

Outpatient Without UBREV

CPT					HCPCS
99201	99241	99347	99387	99403	G0402
99202	99242	99348	99391	99404	G0438
99203	99243	99349	99392	99411	G0439
99204	99244	99350	99393	99412	G0463
99205	99245	99381	99394	99429	T1015
99211	99341	99382	99395	99455	
99212	99342	99383	99396	99456	
99213	99343	99384	99397	99483	
99214	99344	99385	99401		
99215	99345	99386	99402		

Care management

CPT				
G0511	G9007	99078	99492	99496
G0512	G9008	99484	99493	98966
G9001	98961	99487	99494	98967
G9002	98962	99490	99494	98968

Social Determinants of Health

ICD10CM						
Z55.0	Z56.6	Z57.7	Z60.0	Z62.6	Z62.891	Z63.8
Z55.1	Z56.81	Z57.8	Z60.2	Z62.81	Z62.898	Z63.9
Z55.2	Z56.82	Z57.9	Z60.3	Z62.810	Z62.9	Z64.0
Z55.3	Z56.89	Z59.0	Z60.4	Z62.811	Z63.0	Z64.1
Z55.4	Z56.9	Z59.1	Z60.5	Z62.812	Z63.1	Z64.4
Z55.8	Z57.0	Z59.2	Z60.8	Z62.813	Z63.31	Z65.0
Z55.9	Z57.1	Z59.3	Z60.9	Z62.819	Z63.32	Z65.1
Z56.0	Z57.2	Z59.4	Z62.0	Z62.82	Z63.4	Z65.2
Z56.1	Z57.31	Z59.5	Z62.1	Z62.820	Z63.5	Z65.3
Z56.2	Z57.39	Z59.6	Z62.21	Z62.821	Z63.6	Z65.4
Z56.3	Z57.4	Z59.7	Z62.22	Z62.822	Z63.71	Z65.5
Z56.4	Z57.5	Z59.8	Z62.29	Z62.89	Z63.72	Z65.8
Z56.5	Z57.6	Z59.9	Z62.3	Z62.890	Z63.79	Z65.9

SDoH

CPT						HCPCS
98966	99213	99271	99348	99392	99442	G0406
98967	99214	99272	99349	99393	99443	G0407
98968	99215	99273	99350	99394	99444	G0408
99058	99241	99274	99381	99395	99487	G0425
99201	99242	99275	99382	99396	99488	G0426
99202	99243	99341	99383	99397	99489	G0427
99203	99244	99342	99384	99401	99495	G0463
99204	99245	99343	99385	99402	99496	G0463
99205	99261	99344	99386	99403		G2012
99211	99262	99345	99387	99404		T1015
99212	99263	99347	99391	99441		

Mental and behavioral disorders

Contact your Provider Performance Specialist for the list of codes

Deliveries Infant Record

ICD10CM			
Z38.00	Z38.31	Z38.63	Z38.69
Z38.01	Z38.4	Z38.64	Z38.7
Z38.1	Z38.5	Z38.65	Z38.8
Z38.2	Z38.61	Z38.66	
Z38.30	Z38.62	Z38.68	

Maternity diagnosis

Contact your provider performance specialist for the list of codes

Maternity

UBREV	UBTOB				
0112	0720	0841	0847	084I	084X
0122	0721	0842	0848	084J	084Y
0132	0722	0843	084F	084K	084Z
0142	0724	0844	084G	084M	
0152	0840	0845	084H	084O	

Surgery

UBREV				
0360	0361	0362	0367	0369

ED

CPT		UBREV	
99281	99284	0450	0456
99282	99285	0451	0459
99283		0452	0981

ED procedure

Contact your Provider Performance Specialist for a list of codes

ED POS

POS
23

Psychiatry

CPT					
90785	90834	90840	90853	90869	90882
90791	90836	90845	90863	90870	90885
90792	90837	90846	90865	90875	90887
90832	90838	90847	90867	90876	90889
90833	90839	90849	90868	90880	90899

Electroconvulsive therapy

CPT	ICDPCS	
90870	GZB0ZZZ	GZB3ZZZ
	GZB1ZZZ	GZB4ZZZ
	GZB2ZZZ	

UOD Opioid Medications

UOD Opioid Medications			
• Butorphanol	• Hydrocodone	• Methadone	• Oxymorphone
• Codeine	• Hydromorphone	• Morphine	• Pentazocine
• Dihydrocodeine	• Levorphanol	• Opium	• Tapentadol
• Fentanyl	• Meperidine	• Oxycodone	• Tramadol

Malignant Neoplasm

Contact your Provider Performance Specialist for the list of codes

Sickle cell anemia and HB-S disease

ICD10CM			
D57.00	D57.211	D57.412	D57.812
D57.01	D57.212	D57.419	D57.819
D57.02	D57.219	D57.80	
D57.1	D57.40	D57.811	
D57.20	D57.411		

ED visits: PCP treatable care

wagner.nyu.edu/faculty/billings/nyued-background

Report #70 supplemental data reference guide

Purpose
Report #70 is a vehicle for providers to submit supplemental data for the PCP Incentive Program. Supplemental data is required measure-related information that is not 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 for an individual practice, physician organization or physician hospital organization.
When distributed via FileMart, Report #70 is generated in a TAB delimited file. This should be converted by your practice 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 practice's Priority Health Provider Performance Specialist using a secure email format.
Your Provider Performance Specialist 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 practice 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
PFP_RPT_PERIOD_DESC	Report period
PAY_FOR_PERF_GRP_NAME	PFP group
FAC_SITE_NAME	Practice group
PRAC_NAME	Physician
MBR_ID	PH unique member ID
MBR_CONTR_EXT_ID	Contract number
MBR_LAST_NAME	Member last name
Header	**Field description**
MBR_FIRST_NAME	Member first name
MBR_MIDDLE_NAME	Member middle initial
MBR_BIRTHDATE	Date of birth
SUPP_MEAS_CD	Measure code
SUPP_MEAS_VALUE_MSG	Measure description
MEASURE_DATE	Date of service
DATA1	Service value
DATA2	Service value
DATA3	Service value

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 Priority Health 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.
- Please do not modify, add or delete columns included in Report #70.

Measure code	Corresponding PCP IP measure	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 2020 or 2021	See domain		
BILAT MAST	Breast cancer screenings	V = Y, N	Any date prior to Dec. 31, 2021	See domain		
CC SCREEN	Cervical cancer screenings	V = NORMAL, ABNORMAL, UNK	Date during 2019, 2020, or 2021	See domain		
SM_HPV_SCREEN	Cervical cancer screenings	V = NORMAL, ABNORMAL, UNK	Date during 2017, 2018, 2019, 2020 or 2021	See domain		
HYST (Total hysterectomy)	Cervical cancer Screenings	V = Y, N	Any date prior to Dec. 31, 2021	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, 2021	See do main		
SM_CHLAMYDIA	Chlamydia screenings	V = NORMAL, ABNORMAL, UNK	Date during 2021	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 2021	Integer, decimal		
BMI	Recorded BMI	BMI must be between 12 and 99	Date during 2021	Integer		
PHQ- 2 SCORE	Depression screening	Result between 0 and 6	Date during 2021	Integer		
PHQ-4 SCORE	Depression screening	Result between 0 and 12	Date during 2021	Integer		
PHQ-9 SCORE	Depression screening	Result between 0 and 27	Date during 2021	Integer		
CR_COLO (Colonoscopy)	Colorectal cancer screenings	V = NORMAL, ABNORMAL	Date between 2012 and 2021	See domain		
CR_CANC (Colorectal cancer)	Colorectal cancer screenings	V = Y, N	Date prior to Dec. 31, 2021	See domain		

CR_FOB (Fecal occult blood test)	Colorectal cancer screenings	V = NORMAL, ABNORMAL	Date prior to Dec. 31, 2021	See domain		
CR_SIG (Flexible sigmoidoscopy)	Colorectal cancer screenings	V = NORMAL, ABNORMAL	Date between 2017 and 2021	See domain		
COLECT (Total colectomy)	Colorectal cancer screenings	V = Y, N	Date prior to Dec. 31, 2021	See domain		
SM_COLOGUARD (Cologuard)	Colorectal cancer screenings	V = Y, N	Date during 2018 – 2021			
HBA1C	Diabetes care: Controlled HbA1c (3 measures)	Value between 1.3 and 18.9	Date during 2021	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, DIMENTIA, BLINDNESS, AMPUTATION, NO EXCLUSIONS, CABG, IVD, PCI, TAA	Any date prior to Dec. 31, 2021	See domain		
RET_EXAM	Diabetes care: Annual retinal exam	V = NORMAL, ABNORMAL, UNK	Date during 2019 or 2021	See domain		
MICROALB (Microalbumin test)	Diabetes care: Monitoring for nephropathy	V = POSITIVE, NEGATIVE, UNK	Date during 2021	See domain		
NEPHR (Nephropathy status)	Diabetes care: Monitoring for nephropathy	V = Y, N	Date during 2021	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 2021	Integer (systolic)	Integer (diastolic)	

FileMart report inventory

Report category	Report ID	Report title	Description
Partners in Performance (PIP) incentive program reports	PIP_002	Key Indicators by Physician	All PCP in ACN, roll-up (percents, no num/denom) by ACN, PFP, or PG
Partners in Performance (PIP) incentive program reports	PIP_002A	Key Indicators by Practice Group	Practice Groups in ACN roll-up (percents & num/denom) by ACN, PG, PFP
Partners in Performance (PIP) incentive program reports	PIP_002C	Key Indicators by Physician and Practice	Practice KIR *in the PFP group* with Individual PCP numerator and denom, plus percent for each measure
Partners in Performance (PIP) incentive program reports	PIP_002C	Key Indicators by Physician and Practice (PG)	Practice KIR with Individual PCP numerator and denom, plus percent for each measure (will include all practitioners in the practice, regardless of their PFP affiliation). Products are displayed on separate pages.
Partners in Performance (PIP) incentive program reports	PIP_002C	Key Indicators by Physician and Practice (TAB)	Practice KIR with Individual PCP numerator and denom, plus percent for each measure (will include all practitioners in the practice, regardless of their PFP affiliation). Tab delimited report format can be saved as spreadsheet by the user.
Partners in Performance (PIP) incentive program reports	PIP_007	Open/Closed and Peak Membership	Landscape report. Open = O, Closed = X, with each month's peak membership by physician. Products listed on separate pages.
Partners in Performance (PIP) incentive program reports	PIP_007	Open/Closed and Peak Membership (TAB)	Landscape report. Open = O, Closed = X, with each month's peak membership by physician. Products listed on separate pages. Tab delimited report format can be saved as spreadsheet.
Partners in Performance (PIP) incentive program reports	PIP_008B	PIP_008B - Daily Inpatient Census	Lists current patients in the hospital or discharged in the last 7 days by Provider. Can be selected for Practice and/or PFP group. Includes Facility, admit date, expected discharge, admitting physician, Dx, product line

Partners in Performance (PIP) incentive program reports	PIP_008B	Daily Inpatient Census (TAB)	Same as 008B in Tab-delimited format
Partners in Performance (PIP) incentive program reports	PIP_011	Patient detail Worksheets by PIP Measure	Member in measures detail report: all, Diabetes, Asthma, Diabetes, lab, Hypertension, Imms, Retinopathy, etc.
Partners in Performance (PIP) incentive program reports	PIP_011	PIP Measure Worksheet (TAB)	Member in measures detail report, can select measures included on report. Tab delimited report format can be saved as spreadsheet by the user.
Partners in Performance (PIP) incentive program reports	PIP_011D	Diabetes Worksheet	All members in all products all diabetes measures, displayed in landscape format
Partners in Performance (PIP) incentive program reports	PIP_011G	PIP Diabetes Lab Result Worksheet	Landscape report. Format can be used to manually collect/note Diabetes lab results for Supplemental data entry.
Partners in Performance (PIP) incentive program reports	PIP_011H	PIP Hypertension Worksheet	Landscape Report. Format allows space to manually collect/note BP results for Supplemental data entry. Prompts on needed results display on report.
Partners in Performance (PIP) incentive program reports	PIP_011I	PIP Immunization Worksheet	Landscape report. Displaying each PCP on separate page(s). Indicates members not meeting measure by displaying an X beneath the Imms headers of: Dtap, Hep B, Hib, MMR, IPV, VZV, PNC
Partners in Performance (PIP) incentive program reports	PIP_011M	PIP Medication Adherence	Tab delimited file, lists patient information, PCP, practice name, medication adherence measure, result
Partners in Performance (PIP) incentive program reports	PIP_011Z	PIP Diabetes Retinopathy Evaluation Form	Pre-populated form for PCP to share with members or Optometrists to get Retinopathy exam results.

Partners in Performance (PIP) incentive program reports	PIP_012	PIP Healthy Michigan Plan	Members previous HRA date, survey source and Healthy Michigan status
Partners in Performance (PIP) incentive program reports	PIP_012	PIP Healthy Michigan Plan (TAB)	Members previous HRA date, survey source and Healthy Michigan status
Partners in Performance (PIP) incentive program reports	PIP_013	PIP Care Management	Billed care management codes, touch point criteria, product line, PCP on date of visit
Partners in Performance (PIP) incentive program reports	PIP_013	PIP Care Management (TAB)	Billed care management codes, touch point criteria, product line, PCP on date of visit
Partners in Performance (PIP) incentive program reports	PIP_015	PIP Reward for Primary Care Physicians	Year-end report of rewards by measure by physician
Partners in Performance (PIP) incentive program reports	PIP_015B	PIP Opportunity	Earnings opportunity on PIP quality measures by practice group
Partners in Performance (PIP) incentive program reports	PIP_015B	PIP Opportunity (TAB)	Earnings opportunity on PIP quality measures by practice group. Tab delimited report version
Partners in Performance (PIP) incentive program reports	PIP_019	ED visits per Thousand Members	Landscape Report. Lists patients by Provider. Can be selected for Practice and/or ACN and Product line. Includes Facility, Dx, product line and whether the visit was a PCP-treatable DX (avoidable)
Partners in Performance (PIP) incentive program reports	PIP_019	ED visits per Thousand Members (TAB)	Same as 019 in Tab-delimited format

Partners in Performance (PIP) incentive program reports	PIP_019A	Emergency Department Utilization - Frequent Patients	ER frequent flyers, rolling six months. Sorted descending frequency (highest frequency first) by PCP
Partners in Performance (PIP) incentive program reports	PIP_021	PIP Acute Hospital Utilization (TAB)	Tab delimited file, lists patient information, facility, discharge date, primary diagnosis and DRG description
Partners in Performance (PIP) incentive program reports	PIP_070	Supplemental Data Worksheet (TAB)	Tab delimited file can contain only members not meeting measures **or** all members in all measures. Providers save as Spreadsheet, populate needed data and return to PAR. PAR sends to Measurement and Evaluation staff for loading. *Separate procedure available.*
Partners in Performance (PIP) incentive program reports	PIP_070A	Supplemental Data Error Extract (TAB)	Run/used by PNP staff to help Providers identify data in the supplemental data spreadsheet (070) that didn't load due to format errors.
Partners in Performance (PIP) incentive program reports	PIP_075	Member Eligibility (TAB)	All members, all products. Can be date sensitive/selected. Will run for membership on date report requested (requested 9-7-10 = members on 9-7-2010). Can select at practice, risk group, hospital network, PFP group level or ACN.
Partners in Performance (PIP) incentive program reports	PIP_075A	Membership Summary	Summary of member count by physician by business category
Partners in Performance (PIP) incentive program reports	PIP_075A	Membership Summary (TAB)	Summary of member count by physician by business category. This report is in a tab delimited format.
Partners in Performance (PIP) incentive program reports	PIP_075B	Membership Detail	Summary of member count by physician by business category, less detail regarding member than 075A report
Partners in Performance (PIP) incentive program reports	PIP_099	Physician Audit	List of physicians assigned to pfp group, used to ask PHO/PO to verify their membership for settlement. Can also be run to verify docs at individual, practice, risk group, region, sub-region, etc. level. Includes MM for each product.

Partners in Performance (PIP) incentive program reports	PIP_099	Physician Audit (TAB)	Variation of the 99, but includes practice information, address, city, state, zip and NPI for PFP groups to use to match for settlement prep

2021 Incentive program quick reference guide

PriorityHealth
THINK SMART. LIVE SMART.

Working together to improve the quality, access and affordability of care to our members.

Prevention		
Lead screening in children **Medicaid only** 2 years of age as of 12/31 of the measurement year Target: 87% Payout: $40 Per member meeting the measure	**Childhood immunizations Combo 3** Complete by second birthday **HMO/POS, ASO/PPO** Target: 88% Payout: $175 Per member meeting the measure **Medicaid** Target:79% Payout: $180 per member meeting the measure	**Childhood immunizations Combo 10 - Report only** Complete by second birthday
Adolescent immunizations Complete by 13th birthday **HMO/POS, ASO/PPO** Target: 43% Payout: $100 per member meeting the measure **Medicaid** Target: 51% Payout: $75 per member meeting the measure	**Well-child visits first 15 months** 6 visits before 15 months of age **HMO/POS, ASO/PPO** Target:91% Payout: $85 per member meeting the measure **Medicaid** Target: 77% Payout: $85 per member meeting the measure	**Well-child 15-30 months – report only** 2 visits before 30 months of age
Well-child 3-11 years HMO/POS, ASO/PPO Target:: TBD Payout: $70 per member meeting the measure **Medicaid** Target: TBD Payout: $70 per member meeting the measure	**Chlamydia screening** Female; 16-24 years **Medicaid** Target: 71% Payout: $35 per member meeting the measure	**Cervical cancer screening** Female; 21-64 years -1 screening/5years for 30-64 years with hrHVP screen every 5 years -1 screening/3 years for 21-64 years **HMO/POS, ASO/PPO** Target: 84% Payout: $15 per member meeting the measure **Medicaid** Target: 73% Payout: $20 per member meeting the measure
Breast cancer screening Female; 50-74 years One or more mammograms on or between Oct 1 two years prior to the measurement year and Dec 31 of the measurement year **HMO/POS, ASO/PPO** Target: 81% Payout: $15 per member meeting the measure **Medicare** Target: 85% Payout: $25 per member meeting the measure **Medicaid** Target: 69% Payout: $20 per member meeting the measure	**Colorectal cancer screening** 50-75 years Compliance is evidenced via supplemental data or claims **HMO/POS, ASO/PPO** Target: 77% **Medicare** Target: 84% Payout: $20 per member meeting the measure	**Opioid utilization – reporting only** 18 years and older

continued >

Chronic Disease		
Controlled HbA1c less than 8.0% 18-75 years **HMO/POS, ASO/PPO** Target: 68% Payout: $60 per member meeting the measure **Medicare** Target: 79% Payout: $60 per member meeting the measure **Medicaid** Target: 61% Payout:$50 per member meeting the measure	**Controlled HbA1c less than 9.0%** 18-75 years **HMO/POS, ASO/PPO** Target: 80% Payout: $60 per member meeting the measure **Medicare** Target: 89% Payout: $75 per member meeting the measure **Medicaid** Target: 72% Payout: $30 per member meeting the measure	**Diabetes Annual retinal eye exam** 18-75 years **HMO/POS, ASO/PPO** Target: 70% Payout: $40 per member meeting the measure **Medicare** Target: 85% Payout: $75 per member meeting the measure **Medicaid** Target: 70% Payout: $50 per member meeting the measure
Diabetes Monitoring for nephropathy 18-75 years **Medicare** Target: 98% Payout: $40 per member meeting the measure	**Kidney Health Evaluation for patients with Diabetes – Report only** 18-85 years -One eGFR -One uACR at least four or less days apart	**Optimal diabetes care** 18-75 years -Controlled HbA1c less than 8.0% Annual eye exam -Controlled blood pressure **HMO/POS, ASO, Medicaid** Target: 20-29% Payout: $75 per member meeting the measure Target: 30-34% Payout: $125 per member meeting the measure Target: 35% and above Payout: $200 per member meeting the measure
Statin therapy for patients with diabetes 40-75 years **Medicare only** Target: 91% Payout: $35 per member meeting the measure	**Statin therapy for patients with cardiovascular disease** Male; 21-75 years, Female; 40-75 years **HMO/POS** Target:88% Payout: $35 per member meeting the measure **Medicare** Target: 91% Payout: $35 per member meeting the measure	**Medication adherence for diabetes medications** 18 years and older **Medicare only** Target: 91% Payout: $20 per member meeting the measure
Medication adherence for hypertension 18 years and older **Medicare only** Target: 91% Payout: $20 per member meeting the measure	**Medication adherence for cholesterol** 18 years and older **Medicare only** Target: 91% Payout: $20 per member meeting the measure	**Hypertension: Controlled blood pressure** 18 – 85 years BP <140/90 mm Hg. **HMO/POS, ASO/PPO** Target: 76% **Medicare** Target: 86% **Medicaid** Target: 73% Payout: $45 per member meeting the measure (all products)

continued >

Transformation of care		
Care management **HMO/POS, ASO/PPO, Medicare, Medicaid** Risk adjusted target based on illness burden Payout: varies	**Social determinants of Health (SDOH)** **Medicare, Medicaid** -PCMH recognized -Survey attestation -Screen 5% or more of Priority Health patients -Billed Z-codes during the measurement year Target: 5% Medicare payout: $0.50 PMPM Medicaid payout: $1.00 PMPM	**Medication therapy management (MTM)** **HMO/POS, ASO/PPO, Medicare** -Eligible members identified by OutcomesMTM -Survey attestation -Signed practice collaborative agreement
Health Information Exchange Participation with MiHIN ACN level incentive **HMO/POS, ASO/PPO, Medicare, Medicaid** Payout: $0.05 PMPM	**Healthy Michigan Plan: HRA completion** 19-64 years **Healthy Michigan Plan Members (HMI) only** Completed HRA form submission via CHAMPS or Fax Payout: CHAMPS $70 Fax $15	**Behavioral health collaborative care** **HMO/POS, ASO/PPO, Medicare, Medicaid** -PCMH recognized -Attend 1 BHCC learning event -Attend a minimum 3 out of 4 quarterly behavioral health virtual learning sessions Payout: $0.25 PMPM
Acute Hospital and Emergency Department Utilization – Report only **HMO/POS, ASO/PPO, Medicare** 18 years and older Observed to expected acute inpatient and observation stay discharges Minimum ACN membership applies: HMO/POS: 2,000 ASO/PPO: 2,000 Medicare: 1,000	**Emergency Department Utilization – Report only** **HMO/POS, ASO/PPO, Medicare** 18 years and older Observed to expected emergency department (ED) visits during the measurement year Minimum ACN membership applies: HMO/POS: 2,000 ASO/PPO: 2,000 Medicare: 1,000	**ED visits: PCP treatable care** All ages ACN level incentive **Medicaid only** Payout: shared savings
ED visits: PCP treatable care All ages **Medicaid only** Payout: shared savings		

Complete PCP Incentive Program and CPC+ program manuals are available at *priorityhealth.com/provider/center*. Select **Incentive programs**. You need to be logged in to the Provider Center to view this information.