Partners in Performance

2015 PCP Incentive Program

An integrated program focused on patient-centered care.

PriorityHealth®
A healthier approach to health care®

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2015 Program updates

The PCP Incentive Program is updated annually to reflect current health care trends. Below are this year's program updates. For complete details, refer to the measure specification pages.

Administrative changes

We've realigned our measurement categories according to the Triple Aim goal: to eliminate avoidable cost while improving quality and ensuring the best patient experience. Medicare parity is achieved on all measure payouts.

2014 Category	2015 Category
Preventive health	Clinical outcomes
Disease management	Clinical outcomes
Infrastructure	Efficiency and care transformation
Efficiency measures	Efficiency and care transformation
New	Experience and access

Clinical outcomes

Measures unchanged from 2014
Cervical Cancer Screenings
Childhood Immunizations
Adolescent Immunizations
Well-Child Visits in the First 15 Months of Life
Well-Child Visits 3-6 Years
Chlamydia Screenings
Lead Screening
Colorectal Cancer Screening
Diabetes Care: Controlled HbA1c less than 7.0%
Diabetes Care: Controlled HbA1c less than 8.0%
Diabetes Care: Controlled HbA1c less than or equal to 9.0%
Diabetes Care: Annual Retinal Eye Exam—increased payout
Diabetes Care: Monitoring for Nephropathy
Diabetes Care: Hypertension Medication Therapy

Revised measures
Depression Screening—added PHQ4
Hypertension: Controlled Blood Pressure—integrated Diabetes Controlled Blood Pressure
Pediatric Obesity—full 12-month measure
Optimal Diabetes Care—retired two subset measures
Senior Care Education—provider education focus—attestation

Experience and access

Healthy Michigan Plan Access and Health Risk Assessment (HRA)—NEW
CG CAHPS

Efficiency and care transformation

Follow-up Visits Post Hospital Discharge
Care Management
PCMH Recognition
ED Visits: PCP Treatable Care

2014 Retired measures

Diabetes Tiers (for Accountable Care Networks)	Cardiovascular Care: Cholesterol Management Therapy
Diabetes Care: Cholesterol Medication Therapy	Asthma Care Management
Diabetes Care: Controlled Blood Pressure	HL7 Data Submission
Annual Lab Monitoring for Patients on Persistent Meds	Advanced Care Planning
Triple Aim Grant Program	

Partners in Performance

Helping you thrive in a changing world

For 18 years, we've partnered with PCPs to improve the quality, access and affordability of care for our members.

Our goal is to:

- **Optimize health.** 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.
- **Ensure the best care experience.** We engage your Priority Health patients and hold them accountable for their health.
- **Eliminate avoidable costs.** We hold you accountable for using evidence-based medicine to reduce costs and we reward you for achieving the best outcomes.

We're focused on five foundational elements:

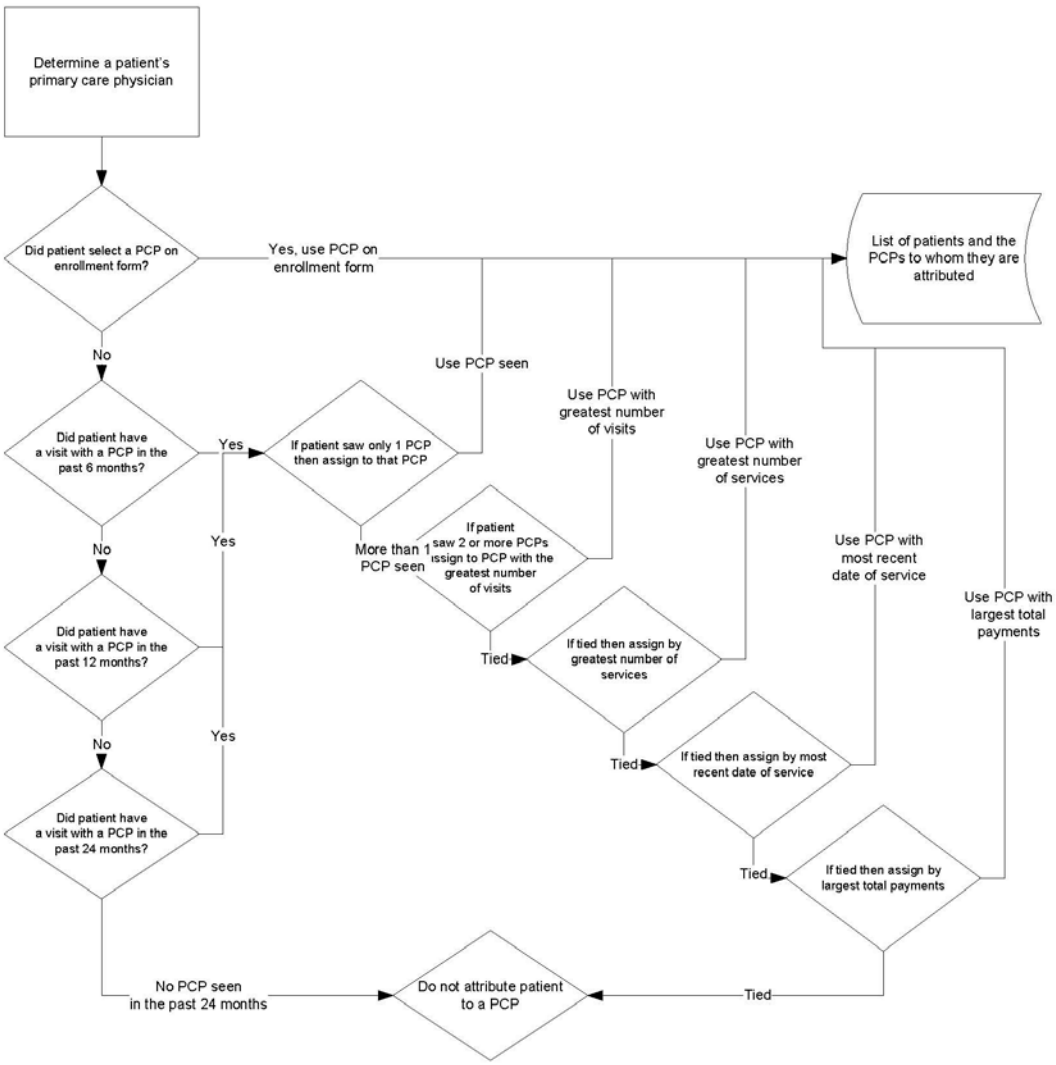
- **Clinical collaboration.** *We work with you*: Building from our combined clinical resources, we'll work together with you to implement transformative programs that meet the needs of your patient population.
- **Access and experience.** *We're committed:* We work with you to ensure that patients have access to exceptional care, in all settings—primary care, specialty care and facility services. In addition, we're committed to assisting you in improving the patient experience by providing actionable information and program support.
- **Fair and transparent cost.** *We're transparent:* We work with you to collect performance data on fair cost of services, usage, quality and experience. We then share this data with Priority Health patients and employers so they can make informed health care decisions.
- **Continuous quality improvement.** *We evaluate and innovate*. Continuous improvement is the hallmark of great organizations and great partnerships. Through our unique tool set, we collect, monitor and share with you opportunities to improve the cost, quality and/or experience of care (Triple Aim). More importantly, we'll work with you to determine which opportunities are achievable and align with our mutual priorities and available resources.
- **Economic alignment.** *We pay for value over volume.* We work with you to transform the way health care is delivered. By collaborating on reimbursement strategies, we can help you successfully transition from a pay-for-volume business model to a pay-for-value one, minimizing economic impact.

Working together, Priority Health and our primary care physician partners have produced outstanding results for Michigan communities year after year. We're here to help your practice maximize its 2015 PCP incentives. Contact your Provider Account Representative for practice resources and programs to support your efforts.

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 in 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 submitted to Priority Health beyond what is included on a claim form. There are three approved methods of submitting supplemental data:

1. HL7 supplemental health data exchange
2. Patient profile
3. Report #70

How we audit supplemental data

Random 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 process procedure:

- Audit notices are hand-delivered or mailed.
- 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 2015 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 set of 50 records will result in ineligibility for the 2015 payout.
- Revised PCP Incentive Program scores will also be used to determine Apple quality ratings as displayed within the Priority Health Find a Doctor tool.
- 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/PHO) or professional groups defined as one entity for reporting and performance measurement purposes. The pay for performance (PFP) group serves as the system template for creation of ACN groups and ACN reporting.

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 4.

Filemart
A Priority Health application within our online Provider Center, Filemart is the mechanism through which you can receive standard Incentive Program and membership reports.

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 are revised in 2015, Priority Health will update measures based upon these revisions. If a HEDIS revision impacts our PCP Incentive Program, we will provide written notification to the network and update the online manual 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 and in Patient Profile.

Non-adherence
A status defined as a "member 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.
- Non-adherence requests can be submitted using the Patient Profile tool. A provider may request exclusion of a member at any point prior to Nov. 13, 2015 for the 2015 program year. Each request for exclusion will be granted for the current program year only.
- Manual processing of non-adherence member exclusions won't take place until the 2015 settlement process in the first quarter of 2016.

Patient Profile
This online resource is designed to assist PCPs with patient management. Data is based on information gathered through medical claims, lab files submitted by hospitals and independent laboratories, pharmacy claims, HL7 files and physician-supplied data.

Patient Profile features include:

- Patient search: Practices can conduct a search for individual patients and review reports for individualized care needs.
- Health condition search: Searches are available for an entire patient population. Variables may be selected to tailor the search to your practice's specific interests.
- Resource list: Clinical practice guidelines and printable patient education tools.

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.
- PCP Incentive Program indicator icons are updated with the monthly PIP report refresh.
- MCIR data is received once monthly, usually between the 23rd and 25th of the month.

Pay for Performance (PFP) group
A Pay for Performance group is a contracted PO, PHO or large medical group.

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

Prescribing provider
Captured from pharmacy claims, this is the provider recorded as prescribing the filled prescription. Incorrect attributions must be discussed with the dispensing pharmacy.

Priority Health Standard of Excellence
Is defined as 75th percentile practice group performance or 90% adherence for patient care processes measured at the point of care.

Administrative details

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

Demographic changes
Demographic information characterizes an individual by such things as PCP assignment, age or gender. Demographic changes for age or gender must be requested prior to Dec. 31, 2015, for the 2015 PCP Incentive Program.

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

ICD-10 conversion
ICD-10 has a planned implementation date of Oct. 1, 2015. PCP IP relevant care, billed under an ICD-10 code, will be converted back by Priority Health to the most appropriate ICD-9 code.

Manual revisions
If revisions are made to the technical manual throughout the calendar year, the updated online version will be considered the official version rather than the printed one. The online version will be dated to identify the most current version. We'll alert you of manual revisions via news articles.

Medicaid
Includes members under Children's Special Health Care Services, 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, 2015. 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 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 criteria as listed in the Provider Manual located in the Provider Center of *priorityhealth.com.* See member discharge information here.

Minimum settlement check amount
Practices earning less than $50 won't receive a PCP Incentive Program settlement payout.

Pay for Performance (PFP) Audits
Fourth quarter Pay for Performance (PFP) group audits are required. PFP groups must review physician (PCP) inclusion to ensure physicians are correctly assigned to the appropriate PFP group. This validation process is critical to the PCP Incentive Program settlement. PFP groups that fail to complete this audit according to deadlines are at risk for incorrect settlement payments.

PCP Incentive Program eligibility
It is easy to participate in PCP IP. You are eligible if you:

- Participate with Priority Health as a PCP on Dec. 31, 2015.
- Submit claims within 45 days of service
- Participate with the Priority Health Clinical Quality Improvement Program

The Emergency Department Visits: PCP Treatable measure includes all data and experience for terminated physicians, PCPs that become specialists and terminated members throughout the calendar year 2015.

PHO/PO pay-to rules
Contracted PHO/POs will receive program settlement for all member providers in one check at year-end settlement in April 2016. These PHO/POs are responsible for distributing settlement funds to providers at their discretion.

Post-settlement review
Requests for review of final 2015 settlement performance and financial payout must be submitted in writing by May 15, 2016. For details regarding appeal request requirements and to submit an appeal, contact your practice's Provider Account Representative (PAR).

Priority Health apple designation
Apples are awarded annually to PCPs whose performance meets or exceeds threshold targets for preventive care and treatment of chronic illnesses. These quality ratings are illustrated by red apple icons published on the PCP's page in our "Find a Doctor" tool at *priorityhealth.com*. An overall rating is awarded based on the average for all measures.

PCPs earning a score of:

Four apples:	meet or exceed the target
Three apples:	are in the top third of the target
Two apples:	are in the middle third of the target
One apple:	are in the lowest third of the target

Priority Health Quality Awards
The physicians and groups selected for annual Priority Health Quality Awards have achieved the highest overall scores for ensuring patients receive preventive care, control chronic disease and have a good experience. 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.

Program deadlines

Post settlement review 2014	May 13, 2015
Care management attestation form	June 1, 2015
CG CAHPS attestation form	June 1, 2015
Senior care education attestation form	June 1, 2015
Self-reported data for care management	June 15, 2015 and Dec. 15, 2015
PCMH	Aug. 15, 2015
Non-adherence	Nov. 13, 2015
Special exceptions	Jan. 31, 2016
Supplemental data	Jan. 31, 2016
Claims submission	Feb. 28, 2016

Reporting
No custom reports will be built or provided to PO/PHOs or practices for the 2015 PCP Incentive Program.

Report #70
Report #70 is an Excel file made available by Priority Health for PCP practices to compile and provide data to Priority Health. Practices enter member-specific data into the file and return the file electronically to their PAR who routes it to the correct department within Priority Health for data downloading.

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

Settlement
Settlement for the PCP Incentive Program occurs at year-end. No prospective payments will be distributed.

Settlement entities
Settlement will be attributed to the participating primary care provider (PCP) assigned as of Dec. 31, 2015, unless otherwise specified, and paid to the physicians' primary contracted physician hospital organization (PHO) or physician organization (PO). Physicians participating in multiple PHO/POs will be asked to select a primary affiliation for purposes of the PCP Incentive Program. PHO/POs will only receive incentive payment for contracted product lines. If a physician has a contract for any product directly with Priority Health outside of the PHO/PO contract, Priority Health will distribute those non-contracted funds directly to the same entity his/her claims are paid 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, 2015 deadline. Manual processing of special exceptions won't take place until the 2015 settlement process in the first quarter of 2016.

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

- Patient Profile using the "Update Data" function
- PIP Report #70, Supplemental Data Extract available via FileMart. To learn more, contact your Provider Account Representative.
- EMR or Patient Registry data exchange (e.g. HL7 file format)
- Michigan Care Improvement Registry (MCIR)

Supplemental data must provide the date on which the service is performed not the date a test or result was reviewed with the patient. All supplemental (provider-reported) data is subject to audit. For details regarding the audit process, refer to page 5.

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 approximately by 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. The release of reports corresponds with the "opportunity" indicators in Patient Profile.
- Opportunity indicators: These update the Monday following the release of the reports. If the 15th falls on a weekend or Monday, opportunity indicator updates will display the following Monday.
- MCIR data is received from the state typically between the 23rd and 25th of the month. Immunization values, dates or counts are updated Monday following the receipt of the MCIR file.

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

Clinical outcomes
Cervical Cancer Screenings

Source	HEDIS
Target source	2014 HEDIS 90th percentile
Identified measure	The percentage of women 21–64 years of age with a cervical cancer screening according to the following schedule: • 30-64 years of age: with negative HPV screen, within 4 days of a cervical cancer screen in 2011, 2012, 2013, 2014 or 2015 **and** who were 30 years or older on the date of both tests or • 21-64 years of age: cervical cancer screen in 2013, 2014 or 2015
Case definition	Women must be continuously enrolled with Priority Health in 2013, 2014 and 2015 with no more than a 45-day gap in coverage each year. Women must be members of Priority Health on Dec. 31, 2015.
Age criteria	24–64 years of age as of Dec. 31, 2015. The measured age range for women with a negative HPV screen is 30-64.
Exclusionary criteria	Women who have had a hysterectomy on or before Dec. 31, 2015. If Priority Health has not 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, 2015
Level of measure	Practice group
Minimum members	1 per practice group
Applicable product line	HMO/POS, ASO/PPO and Medicaid
Method of measurement	Claims data processed by Feb. 28, 2016, and provider supplemental data by Jan. 31, 2016
Provider data input	Supplemental data for hysterectomy history may be provided until Jan. 31, 2016. Supplemental data for non-billed cervical cancer screenings may be provided until Jan. 31, 2016. Supplemental data includes: • HL7 • Patient Profile • Report #70 Supplemental data is subject to audit.
Target: HMO/POS, ASO/PPO	82%
Target: Medicaid	77%
Payout	$10 per measured member

Clinical outcomes
Childhood Immunizations

Source	HEDIS Combination 3
Target source	2014 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 • **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 • **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 a 45-day gap in coverage. Children must have active enrollment and be assigned to a participating PCP on their second birthday. Member/PCP assignment: PCP assigned on the member's second birthday
Age criteria	Two years of age as of Dec. 31, 2015
Exclusionary criteria	Children who are documented in MCIR as having certain health conditions for which vaccines are contraindicated.
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 waiver form is required as documentation for these cases. The parent or guardian must sign the immunization waiver form yearly and a copy must be saved in the patient's medical record. History of a member's immunization 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 immunization waiver templates: • Michigan Department of Community Health • American Academy of Pediatrics • Alliance for Immunization in Michigan
Numerator	The number of children with completed vaccinations as defined above
Denominator	The number of children two years of age as of Dec. 31, 2015
Level of measure	Practice group
Minimum members	1 per practice group
Applicable product line	HMO/POS, ASO/PPO and Medicaid
Method of measurement	Claims data processed by Feb. 28, 2016. MCIR data is downloaded from the State of Michigan monthly. MCIR immunization history must be entered by Jan. 31, 2016. 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	For the 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	87%
Target: Medicaid	81%
Payout	$170 per measured member

Clinical outcomes
Adolescent Immunizations

Source	HEDIS
Target source	2014 HEDIS 90th percentile
Identified measure	The percentage of adolescents 13 years of age who had the following vaccines: • **Meningococcal**: One meningococcal conjugate or meningococcal polysaccharide vaccine between the 11th and 13th birthdays • **Tdap or Td**: One tetanus and diphtheria toxoids and acellular pertussis or tetanus diphtheria vaccine between the 10th and 13th birthdays * **Cases of pertussis have been increasing in Michigan. It is recommended that providers choose the Tdap vaccine for revaccination.*
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. Member/PCP assignment: PCP assigned on the members 13th birthday
Age criteria	13 years of age as of Dec. 31, 2015
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.
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 waiver form is required as documentation for these cases. The parent or guardian must sign the immunization waiver form yearly and a copy must be saved in the patient's medical record. History of a member's immunization 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 immunization waiver templates: • Michigan Department of Community Health • American Academy of Pediatrics • Alliance for Immunization in Michigan
Numerator	The number of adolescents with completed immunizations as defined above
Denominator	The number of adolescents 13 years of age as of Dec. 31, 2015
Level of measure	Practice group
Minimum members	1 per practice group
Applicable product line	HMO/POS, ASO/PPO and Medicaid
Method of measurement	Claims data processed by Feb. 28, 2016. MCIR data is downloaded from the State of Michigan monthly. MCIR immunization history must be entered by Jan. 31, 2016. 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	All immunization data must be updated in MCIR by Jan. 31, 2016.
Target: HMO/POS, ASO/PPO	86%
Target: Medicaid	86%
Payout	$50 per measured member

Clinical outcomes

Well-Child Visits in the First 15 Months of Life

Source	HEDIS
Target source	2014 HEDIS 90th percentile
Identified measure	Infants turning 15 months of age in 2015 who had at least six well-child visits 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 a 45-day gap in coverage. The infant must be enrolled and assigned to a PCP on the day of their 15th month of age. Fifteen months of age is defined as the 90th day following the infant's first birthday. Member/PCP assignment: PCP assigned to the infant on the date the infant reaches 15 months of age.
Age criteria	15 months of age during 2015
Exclusionary criteria	None
Numerator	Infants with at least six well-child visits before turning 15 months of age
Denominator	Infants turning 15 months of age during 2015
Level of measure	Practice group
Minimum members	1 per practice group
Applicable product line	HMO/POS, ASO/PPO and Medicaid
Method of measurement	Claims data processed by Feb. 28, 2016
Provider data input	Supplemental data includes: • HL7 • Report #70 Supplemental data is subject to audit.
Target: HMO/POS, ASO/PPO	90%
Target: Medicaid	77%
Payout	$75 per measured member

Physical exams (well-child visits)

Here's how often children should have complete physicals (well-child exams.)

Age	Recommendation
Newborn	1 visit 3-5 days after discharge
0-2 years	1 visit at 2, 4, 6, 9, 12, 15, 18 and 24 months
3-6 years	1 visit at 30 months and 1 visit every year for ages 3-6
7-10 years	1 visit every 1-2 years
11-18 years	1 visit every year

Clinical outcomes
Well-Child Visits 3–6 Years

Source	HEDIS
Target source	2014 HEDIS 90th percentile
Identified measure	Children 3–6 years of age who received one or more well-child visits with a PCP in 2015
Case definition	Children must be continuously enrolled with Priority Health during 2015 with no more than a 45-day gap in coverage. Children must be members of Priority Health and assigned to a participating PCP on Dec. 31, 2015.
Age criteria	3-6 years of age as of Dec. 31, 2015
Exclusionary criteria	None
Numerator	The number of children with at least one well-child visit in 2015
Denominator	The number of children 3-6 years of age as of Dec. 31, 2015
Level of measure	Practice group
Minimum members	1 per practice group
Applicable product line	HMO/POS, ASO/PPO and Medicaid
Method of measurement	Claims data processed by Feb. 28, 2016
Provider data input	Supplemental data includes: • HL7 • Report #70 Supplemental data is subject to audit.
Target: HMO/POS, ASO/PPO	87%
Target: Medicaid	83%
Payout	$60 per measured member

Physical exams (well-child visits)

Here's how often children should have complete physicals (well-child exams.)

Age	Recommendation
Newborn	1 visit 3-5 days after discharge
0-2 years	1 visit at 2, 4, 6, 9, 12, 15, 18 and 24 months
3-6 years	1 visit at 30 months and 1 visit every year for ages 3-6
7-10 years	1 visit every 1-2 years
11-18 years	1 visit every year

Clinical outcomes
Chlamydia Screening

Source	HEDIS
Target source	2014 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 2015.
Case definition	Women must be continuously enrolled with Priority Health in 2015 with no more than a 45-day gap in coverage. Women must be enrolled with Priority Health and assigned to a participating PCP on Dec. 31, 2015.
Age criteria	16–24 years of age as of Dec. 31, 2015
Exclusionary criteria	A billed pregnancy test during 2015 followed within 7 days by a filled prescription for isotretinoin (Accutane) or an X-ray. Submit a special exception in Patient Profile for women with a pregnancy test conducted pre-surgery.
Numerator	Women with at least one or more Chlamydia tests during 2015.
Denominator	Sexually active women 16-24 years old
Level of measure	Practice group
Minimum members	1 per practice group
Applicable product line	HMO/POS, ASO/PPO and Medicaid
Method of measurement	Pharmacy and medical claims processed by Feb. 28, 2016. Physician reported data submitted by Jan. 31, 2016. Sexual activity is identified through billed diagnosis codes, procedure codes and pharmacy claims.
Provider data input	Documented Chlamydia screening may be supplied as supplemental data through Jan. 31, 2016. Supplemental data includes: • HL7 • Patient Profile • Report #70 Supplemental data is subject to audit.
Target: HMO/POS, ASO/PPO	62%
Target: Medicaid	67%
Payout	$15 per measured member

Clinical outcomes
Lead Screening in Children

Source	HEDIS
Target source	2014 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. Member/PCP assignment: PCP assigned to the child on their second birthday
Age criteria	Two years of age as of Dec. 31, 2015
Exclusionary criteria	None
Numerator	One or more capillary or venous blood tests to screen for lead poisoning on or before the child's second birthday.
Denominator	All children turning age two in 2015
Level of measure	Practice group
Minimum members	1 per practice group
Applicable product line	Medicaid
Method of measurement	Claims data processed by Feb. 28, 2016. Physician reported data submitted by Jan. 31, 2016. Lead screenings noted within MCIR will also be downloaded to supplement claims data. The MCIR lead file from the State of Michigan does not include MIChild or Healthy Michigan Plan members, or Children's Special Health Care; 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, 2016. Supplemental data includes: • HL7 • Patient Profile • Report #70 Supplemental data is subject to audit.
Target	86%
Payout	$15 per measured member

Clinical outcomes
Pediatric Obesity

Source	Priority Health standard of excellence
Identified measure	The percentage of members 3-17 years of age who had a preventive evaluation and management visit with a PCP or OB/GYN and who had a BMI percentile documented and billed with ICD-9 code V85.51-V85.54. The evaluation timeframe will be Jan. 1 – Dec. 31, 2015.
Case definition	Members continuously enrolled in 2015, with no more than a 45-day gap in coverage. Members must be active as of Dec. 31, 2015.
Age criteria	3-17 years as of Dec. 31, 2015.
Exclusionary criteria	None
Numerator	Unique members with a billed preventive evaluation and management (E&M) visit between Jan. 1 and Dec. 31, 2015. These members must have a billed diagnosis code of V85.51-V85.54 on any PCP claim in 2015.
Denominator	Unique members 3-17 years of age with a billed preventive evaluation and management (E&M) visit between Jan. 1 and Dec. 31, 2015
Level of measurement	Practice group
Minimum members	1 per practice group
Applicable product lines	HMO/POS, ASO/PPO and Medicaid
Method of measurement	Claims data processed by Feb. 28, 2016 and supplemental data entered on or before Jan. 31, 2016
Provider data input	Supplemental data includes: • HL7 • Patient Profile • Report #70 Supplemental data is subject to audit.
Combined product Target	90%
Payout	$0.25 pmpm for all members newborn through 17 years of age. Payout will be for the full 12 months.

Clinical outcomes
Depression Screening

Source	Priority Health standard of excellence
Identified measure	The percentage of members 12 years of age and older with PHQ2, PHQ4 or PHQ9 conducted during a PCP evaluation and management (E&M) visit in 2015. The evaluation timeframe is Jan. 1 – Dec. 31, 2015.
Case definition	Members must be active as of Dec. 31, 2015.
Age criteria	12 years and older as of Dec. 31, 2015.
Exclusionary criteria	None
Numerator	The number of members represented in a random audit with a documented PHQ2, PHQ4 or PHQ9 in 2015. Members included in the audit will have had a billed E&M visit with a PCP between Jan. 1 – Dec. 31, 2015.
Denominator	Fifty randomly selected members for each practice group. Member lists will be available fourth quarter 2015 by accessing monthly FileMart reports and/or Patient Profile. If a practice does not have a minimum of 50 members with a billed E&M visit, the denominator will become the total number of members with a billed E&M visit.
Level of measure	Practice group
Minimum members	100 combined members—in any month between Jan. 1 and June 30, 2015—within all applicable product lines
Applicable product lines	HMO/POS, ASO/PPO, Medicare and Medicaid
Method of measurement	PHQ2, PHQ4 and PHQ9 data are captured through registry data submission, HCPCS billing codes, Patient Profile and Report #70. Practices will have access to their member lists via FileMart or Patient Profile during the fourth quarter of 2015. Practices must provide PHQ2, PHQ4 or PHQ9 data for members selected for this measure by Jan. 31, 2016. No member audit lists will be mailed or distributed in a manner outside of standard monthly Filemart reporting or Patient Profile. Documented PHQ2, PHQ4 and PHQ9 can occur during any office visit in 2015. Practices have the opportunity to conduct depression screenings within office visits scheduled after the release of their member audit list but before Dec. 31, 2015. Following the release of the member audit list, the measure denominator is adjusted when members change PCPs or a PCP terminates participation with Priority Health.
HCPCS billing codes	G8431 – Positive screen for clinical depression, follow-up plan documented G8510 – Negative screen for clinical depression documented, follow-up plan not required G8511 – Positive screen for clinical depression using an age appropriate standardized tool documented, follow-up plan not documented, reason not specified.
Provider data input	PHQ2, PHQ4 and PHQ9 must be provided by Jan. 31, 2016.
Combined product target	90%
Payout	$0.15pmpm applies to entire member population; all ages.

Clinical outcomes
Colorectal Cancer Screening

Source	HEDIS
Target source	2014 HEDIS 90th percentile
Identified measure	The percentage of members 50-75 years of age who had appropriate screening for colorectal cancer
Case definition	Members continuously enrolled in 2014 and 2015, with no more than a 45-day gap in coverage. Members 51-75 years of age as of Dec. 31, 2015.
Age criteria	51-75 years
Exclusionary criteria	Members with a diagnosis of colorectal cancer or total colectomy
Numerator	One or more screenings for colorectal cancer: • Fecal occult blood test (FOBT) during 2015 • Flexible sigmoidoscopy anytime during 2011 – 2015 • Colonoscopy anytime during 2006 – 2015
Denominator	Eligible members between 51-75 years of age
Level of measurement	Practice group
Minimum members	1 per practice group
Applicable product lines	HMO/POS, ASO/PPO, Medicare and Medicaid
Method of measurement	Claims data processed by Feb. 28, 2016. Physician reported data submitted by Jan. 31, 2016.
Provider data input	Supplemental data may be provided until Jan. 31, 2016 Supplemental data includes: • HL7 • Patient Profile • Report #70 Supplemental data is subject to audit.
Target: HMO/POS, ASO/PPO	74%
Target: Medicare	78%
Target: Medicaid	58%
Payout	$10 per measured member

Clinical outcomes

Diabetes Care: Controlled HbA1c Less Than 7.0%

Source	HEDIS
Target source	2014 HEDIS 90th percentile
Identified measure	The percentage of members with diabetes with an HbA1c <7.0%. This measure considers the most recent lab conducted in 2015. If no HbA1c was conducted during 2015, the level is considered to be greater than or equal to 7.0%
Case definition	A member with diabetes is defined by: • Two face-to-face encounters with a diagnosis of diabetes: o On different dates of service o In an outpatient setting o In 2014 or 2015, or • One face-to-face encounter with a diagnosis of diabetes: o In an acute inpatient or emergency department setting o In 2014 or 2015, or • Insulin or oral hypoglycemic/antihyperglycemic filled script with diagnosis of diabetes during 2014 or 2015. Members must be continuously enrolled in 2015 with no more than a 45-day gap in coverage. Members must be active with Priority Health and assigned to a participating PCP on Dec. 31, 2015.
Age criteria	18–64 years of age as of Dec. 31, 2015
Exclusionary criteria	• Coronary artery bypass graft (CABG): Members discharged alive for CABG in 2014 or 2015 • Percutaneous Cornonary Intervention (PCI): Members who had at least one encounter, in any setting, with any code to identify PCI in 2014 or 2015 • Ischemic vascular disease (IVD): Members with either of the following in 2014 or 2015: o At least one outpatient visit with an IVD diagnosis, or o At least one acute inpatient visit • Chronic heart failure (CHF): Members who had at least one encounter, in any setting, with any code to identify CHF • Thoracic aortic aneurysm: Members who had at least one outpatient visit or one acute inpatient visit with any code to identify thoracic aortic aneurysm • Prior myocardial infarction (MI): Members who had at least one encounter, in any setting, with any code to identify MI • Chronic renal failure (CRF)/end-stage renal disease (ESRD): Members who had at least one encounter in any setting with any code to identify ESRD • Dementia: Members who had at least one encounter, in any setting, with any code to identify dementia • Blindness: Members who had at least one encounter, in any setting, with any code to identify blindness • Amputation: Members who had at least one encounter, in any setting, with any code to identify lower extremity amputation • Polycystic ovary disease: Members with polycystic ovary disease who did not have any face-to-face encounters with diagnosis of diabetes, in any setting, in 2014 and 2015 • Gestational or steroid-induced diabetes: Members with gestational or steroid-induced diabetes who did not have any face-to-face encounters with diagnosis of diabetes, in any setting, in 2014 or 2015
Numerator	The number of members with diabetes with an HbA1c <7.0%. This measure considers the most recent lab conducted in 2015. If no HbA1c was conducted during 2015, the level is considered to be greater than or equal to 7.0%
Denominator	All members with diabetes as defined above
Level of measure	Practice group

Minimum members	1 per practice group
Applicable product line	HMO/POS, ASO/PPO and 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, 2016.
Provider data input	Documented lab values may be provided as supplemental data through Jan. 31, 2016. Supplemental data includes: • HL7 • Patient Profile • Report #70 Providers may exclude any member they determine to be incorrectly defined as diabetic by submitting data through the *Update Data* function in Patient Profile. The deadline for data submission is Jan. 31, 2016. Supplemental data is subject to audit.
Target: HMO/POS, ASO/PPO	47%
Target: Medicaid	44%
Payout	$25 per measured member

Clinical outcomes

Diabetes Care: Controlled HbA1c Less Than 8.0%

Source	HEDIS
Target source	2014 HEDIS 90th percentile
Identified measure	The percentage of members with diabetes with an HbA1c <8.0%. This measure considers the most recent lab conducted in 2015. If no HbA1c was conducted during 2015, the level is considered to be greater than or equal to 8.0%.
Case definition	A member with diabetes is defined by: • Two face-to-face encounters with a diagnosis of diabetes: o On different dates of service o In an outpatient setting o In 2014 or 2015, or • One face-to-face encounter with a diagnosis of diabetes: o In an acute inpatient or emergency department setting o In 2014 or 2015, or • Insulin or oral hypoglycemic/antihyperglycemic filled script with diagnosis of diabetes during 2014 or 2015. Members must be continuously enrolled in 2015 with no more than a 45-day gap in coverage. Members must be active with Priority Health and assigned to a participating PCP on Dec. 31, 2015.
Age criteria	18–75 years of age as of Dec. 31, 2015
Exclusionary criteria	Polycystic ovary disease: Members with polycystic ovary disease who did not have any face-to-face encounters with diagnosis of diabetes, in any setting, in 2014 and 2015 Gestational or steroid-induced diabetes: Members with gestational or steroid-induced diabetes who did not have any face-to-face encounters with diagnosis of diabetes, in any setting, in 2014 or 2015
Numerator	The number of members with diabetes with an HbA1c <8.0%. This measure considers the most recent lab conducted in 2015. If no HbA1c was conducted during 2015, 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
Applicable product line	HMO/POS, ASO/PPO, Medicare and 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, 2016.
Provider data input	Documented lab values may be provided as supplemental data through Jan. 31, 2016. Supplemental data includes: • HL7 • Patient Profile • Report #70 Providers may exclude any member they determine to be incorrectly defined as diabetic by submitting data through the *Update Data* function in Patient Profile. The deadline for data submission is Jan. 31, 2016. Supplemental data is subject to audit.
Target: HMO/POS, ASO/PPO	69%
Target: Medicare	78%
Target: Medicaid	59%
Payout	$30 per measured member

Clinical outcomes

Diabetes Care: Controlled HbA1c Less Than or Equal to 9.0%

Source	HEDIS
Target source	2014 HEDIS 90th percentile
Identified measure	The percentage of members with diabetes with an HbA1c ≤9.0%. This measure considers the most recent lab conducted in 2015. If no HbA1c was conducted during 2015, the level is considered to be greater than 9.0%.
Case definition	A member with diabetes is defined by: • Two face-to-face encounters with a diagnosis of diabetes: o On different dates of service o In an outpatient setting o In 2014 or 2015, or • One face-to-face encounter with a diagnosis of diabetes: o In an acute inpatient or emergency department setting o In 2014 or 2015, or • Insulin or oral hypoglycemic/antihyperglycemic filled script with diagnosis of diabetes during 2014 or 2015. Members must be continuously enrolled in 2015 with no more than a 45-day gap in coverage. Members must be active with Priority Health and assigned to a participating PCP on Dec. 31, 2015.
Age criteria	18–75 years of age as of Dec. 31, 2015
Exclusionary criteria	Polycystic ovary disease: Members with polycystic ovary disease who did not have any face-to-face encounters with diagnosis of diabetes, in any setting, in 2014 and 2015 Gestational or steroid-induced diabetes: Members with gestational or steroid-induced diabetes who did not have any face-to-face encounters with diagnosis of diabetes, in any setting, in 2014 or 2015
Numerator	The number of members with diabetes with an HbA1c ≤ 9.0%. This measure considers the most recent lab conducted in 2015. If no HbA1c was conducted during 2015, 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
Applicable product line	HMO/POS, ASO/PPO, Medicare and 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, 2016
Provider data input	Documented lab values may be provided as supplemental data through Jan. 31, 2016. Supplemental data includes: • HL7 • Patient Profile • Report #70 Providers may exclude any member they determine to be incorrectly defined as diabetic by submitting data through the *Update Data* function in Patient Profile. The deadline for data submission is Jan. 31, 2016. Supplemental data is subject to audit.
Target: HMO/POS, ASO/PPO	81%
Target: Medicare	87%
Target: Medicaid	70%
Payout	$25 per measured member

Clinical outcomes
Diabetes Care: Annual Retinal Eye Exam

Source	HEDIS
Target source	2014 HEDIS 90th percentile
Identified measure	The percentage of members with diabetes and a retinal eye exam in 2015
Case definition	A member with diabetes is defined by: • Two face-to-face encounters with a diagnosis of diabetes: o On different dates of service o In an outpatient setting o In 2014 or 2015, or • One face-to-face encounter with a diagnosis of diabetes: o In an acute inpatient or emergency department setting o In 2014 or 2015, or • Insulin or oral hypoglycemic/antihyperglycemic filled script with diagnosis of diabetes during 2014 or 2015. Members must be continuously enrolled in 2015 with no more than a 45-day gap in coverage. Members must be active with Priority Health and assigned to a participating PCP on Dec. 31, 2015.
Age criteria	18–75 years of age as of Dec. 31, 2015
Exclusionary criteria	Polycystic Ovary Disease: Members with polycystic ovary disease who did not have any face-to-face encounters with diagnosis of diabetes, in any setting, in 2014 and 2015. Gestational or steroid-induced diabetes: Members with gestational or steroid-induced diabetes who did not have any face-to-face encounters with diagnosis of diabetes, in any setting, in 2014 or 2015.
Numerator	The number of members with diabetes with a retinal eye exam performed in 2015 or a negative retinal eye exam in 2014
Denominator	All members with diabetes as defined above
Level of measure	Practice group
Minimum members	1 per practice group
Applicable product line	HMO/POS, ASO/PPO, Medicare and Medicaid
Method of measurement	Claims data processed by Feb. 28, 2016. Supplemental data submitted by Jan. 31, 2016
Provider data input	Documented retinal eye exams may be provided as supplemental data through Jan. 31, 2016. Supplemental data includes: • HL7 • Patient Profile • Report #70 Providers may exclude any member they determine to be incorrectly defined as diabetic by submitting data through the *Update Data* function in Patient Profile. The deadline for data submission is Jan. 31, 2016. Supplemental data is subject to audit.
Target: HMO/POS, ASO/PPO	74%
Target: Medicare	82%
Target: Medicaid	68%
Payout	$15 per measured member

Clinical outcomes
Diabetes Care: Monitoring for Nephropathy

Source	HEDIS
Target source	2014 HEDIS 90th percentile
Identified measure	The percentage of members with diabetes who have had one of the following: • A microalbuminuria lab during 2015 • Diagnosis of or treatment for nephropathy in 2015 • Pharmacy claim for ACE/ARB therapy during 2015 • Visit with a nephrologist in 2015 • Evidence of kidney transplant
Case definition	A member with diabetes is defined by: • Two face-to-face encounters with a diagnosis of diabetes: o On different dates of service o In an outpatient setting o In 2014 or 2015, or • One face-to-face encounter with a diagnosis of diabetes: o In an acute inpatient or emergency department setting o In 2014 or 2015, or • Insulin or oral hypoglycemic/antihyperglycemic filled script with diagnosis of diabetes during 2014 or 2015. Members must be continuously enrolled in 2015 with no more than a 45-day gap in coverage. Members must be active with Priority Health and assigned to a participating PCP on Dec. 31, 2015.
Age criteria	18–75 years of age as of Dec. 31, 2015
Exclusionary criteria	Polycystic ovary disease: Members with polycystic ovary disease who did not have any face-to-face encounters with diagnosis of diabetes, in any setting, in 2014 and 2015 Gestational or steroid-induced diabetes: Members with gestational or steroid-induced diabetes who did not have any face-to-face encounters with diagnosis of diabetes, in any setting, in 2014 or 2015
Numerator	Members with diabetes who have had one of the following: • A microalbuminuria lab during 2015 • Diagnosis of or treatment for nephropathy in 2015 • Pharmacy claim for ACE/ARB therapy during 2015 • Visit with a nephrologist in 2015
Denominator	All members with diabetes as defined above
Level of measure	Practice group
Minimum members	1 per practice group
Applicable product line	HMO/POS, ASO/PPO, Medicare and Medicaid
Method of measurement	Claims data processed by Feb. 28, 2016. Supplemental data submitted by Jan. 31, 2016
Provider data input	Documented microalbuminuria labs may be provided as supplemental data through Jan. 31, 2016. Supplemental data includes: • HL7 • Patient Profile • Report #70 Providers may exclude any member they determine to be incorrectly defined as diabetic by submitting data through the Update Data function in Patient Profile. The deadline for data submission is Jan. 31, 2016. Supplemental data is subject to audit.
Target: HMO/POS, ASO/PPO	91%
Target: Medicare	96%
Target: Medicaid	87%
Payout	$10 per measured member

Clinical outcomes
Hypertension Medication Therapy

Source	Joint National Committee 8
	Priority Health standard of excellence
Identified measure	The percentage of members with diabetes and hypertension who had at least one billed prescription for an ACE/ARB, calcium channel blocker or hydrochlorothiazide during 2015
Case definition	A member with diabetes is defined by: • Two face-to-face encounters with a diagnosis of diabetes: o On different dates of service o In an outpatient setting o In 2014 or 2015, or • One face-to-face encounter with a diagnosis of diabetes: o In an acute inpatient or emergency department setting o In 2014 or 2015, or • Insulin or oral hypoglycemic/antihyperglycemic filled prescription with diagnosis of diabetes during 2014 or 2015. A member with hypertension is defined by: • One outpatient encounter between Jan. 1 and June 30, 2015, and • Billed diagnosis of 401.x during the outpatient encounter • Members must be continuously enrolled with both medical and prescription coverage in 2014 with no more than a 45-day gap in coverage. Members must be active with Priority Health on Dec. 31, 2015.
Age criteria	18–75 years of age as of Dec. 31, 2015
Exclusionary criteria	End-stage renal disease Pregnancy diagnosis billed in 2015 Non-acute inpatient treatment Polycystic Ovary Disease: Members with polycystic ovary disease who did not have any face-to-face encounters with diagnosis of diabetes, in any setting, in 2014 and 2015. Gestational or steroid-induced diabetes: Members with gestational or steroid-induced diabetes who did not have any face-to-face encounters with diagnosis of diabetes, in any setting, in 2014 or 2015.
Numerator	The number of members with diabetes and hypertension who had a least one billed prescription for an ACE/ARB, calcium channel blocker or hydrochlorothizide during 2015
Denominator	All members with diabetes and hypertension as defined above
Level of measure	Practice group
Minimum members	1 per practice group
Applicable product lines	HMO/POS, ASO/PPO, Medicare and Medicaid
Method of measurement	Claims data processed by Feb. 28, 2016
Provider data input	None
Targets: HMO/POS, ASO/PPO and Medicaid	TBD
Targets: Medicare	TBD
Payout	$ 40 per measured member

Clinical outcomes
Optimal Diabetes Care

Source	Extrapolated from HEDIS Diabetes Care measures
Identified measure	The percentage of patients with diabetes who have met all standards defined in each of the following measures: • Diabetes Care: Controlled HbA1c Less Than 7.0% (if applicable, based on co-morbidities and age) • Diabetes Care: Controlled HbA1c Less Than 8.0% • Diabetes Care: Annual Retinal Eye Exam • Diabetes Care: Monitoring for Nephropathy
Case definition	A member with diabetes is defined by: • Two face-to-face encounters with a diagnosis of diabetes: o On different dates of service o In an outpatient setting o In 2014 or 2015, or • One face-to-face encounter with a diagnosis of diabetes: o In an acute inpatient or emergency department setting o In 2014 or 2015, or • Insulin or oral hypoglycemic/anti-hyperglycemic filled script with diagnosis of diabetes during 2014 or 2015. Members must be continuously enrolled in 2015 with no more than a 45-day gap in coverage. Members must be active with Priority Health on Dec. 31, 2015.
Age criteria	18–75 years of age as of Dec. 31, 2015 (Exception: Diabetes Care: Controlled HbA1c Less than 7.0% measure age range is 18–64 years)
Exclusionary criteria	Polycystic ovary disease: Members with polycystic ovary disease who did not have any face-to-face encounters with diagnosis of diabetes, in any setting, in 2014 and 2015. Gestational or steroid-induced diabetes: Members with gestational or steroid-induced diabetes that did not have any face-to-face encounters with diagnosis of diabetes, in any setting, in 2014 or 2015.
Numerator	The number of members with diabetes that met each of the standards in the following diabetes measures: • Diabetes Care: Controlled HbA1c Less Than 7.0% (if applicable, based on co morbidities and age) • Diabetes Care: Controlled HbA1c Less Than 8.0% • Diabetes Care: Annual Retinal Eye Exam • Diabetes Care: Monitoring for Nephropathy
Denominator	All members with diabetes as defined above
Level of measure	Practice group
Minimum members	1 per practice group
Applicable product lines	HMO/POS, ASO/PPO, Medicare and Medicaid
Method of measurement	Claims data processed by Feb. 28, 2016. Supplemental data submitted by Jan. 31, 2016.
Provider data input	None
Targets: HMO/POS, ASO/PPO and Medicaid	20-24%, 25-29%, and 30% and above
Targets: Medicare	25-29%, 30-34%, 35% and above
Payout:HMO/POS, ASO/PPO and Medicaid	$75 per member measured for performance of 20-24% $125 per member measured 25-29% $200 per member measured 30% and above
Payout: Medicare	$75 per member measured for performance of 25-29% $125 per member measured 30-34% $200 per member measured 35% and above

Clinical outcomes
Hypertension: Controlled Blood Pressure

Source	HEDIS
Target source	2014 HEDIS 90th percentile
Identified measure	The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year based on the following criteria: • Members 18–59 years of age whose BP was <140/90 mm Hg. • Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg. • Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg. The most recent BP reading during the measurement year. 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. If no BP is recorded during the measurement year, assume that the member is "not controlled."
Case definition	A member with hypertension is defined by: • One outpatient encounter between Jan. 1 and June 30, 2015, and • Billed diagnosis of 401.x during the outpatient encounter A member with diabetes is defined by: • Two face-to-face encounters with a diagnosis of diabetes: o On different dates of service o In an outpatient setting o In 2014 or 2015, or • One face-to-face encounter with a diagnosis of diabetes: o In an acute inpatient or emergency department setting o In 2014 or 2015, or • Insulin or oral hypoglycemic/antihyperglycemic filled script with diagnosis of diabetes during 2014 or 2015. The following members in the eligible population should not be considered to have diabetes: Polycystic ovary disease: Members with polycystic ovary disease who did not have any face-to-face encounters with diagnosis of diabetes, in any setting, in 2014 and 2015 Gestational or steroid-induced diabetes: Members with gestational or steroid-induced diabetes who did not have any face-to-face encounters with diagnosis of diabetes, in any setting, in 2014 or 2015 Members must be continuously enrolled with Priority Health in 2015 with no more than a 45-day gap in coverage. Members must be active with Priority Health on Dec. 31, 2015
Age criteria	18–85 years of age as of Dec. 31, 2015
Exclusionary criteria	• Exclude from the eligible population all members with evidence of end-stage renal disease (ESRD) or kidney transplant on or prior to Dec. 31, 2015. • Exclude from the eligible population all members with a diagnosis of pregnancy during 2015. • Exclude from the eligible population all members who had a nonacute inpatient admission during 2015.

Numerator	The number of members in the denominator whose most recent BP (both systolic and diastolic) is adequately controlled during the measurement year based on the following criteria: • Members 18–59 years of age as of December 31 of the measurement year whose BP was <140/90 mm Hg, using the latest PCP office visit in 2015 • Members 60–85 years of age as of December 31 of the measurement year and flagged with a diagnosis of diabetes whose BP was <140/90 mm Hg, using the latest PCP office visit in 2015 • Members 60–85 years of age as of December 31 of the measurement year and flagged as not having a diagnosis of diabetes whose BP was <150/90 mm Hg, using the latest PCP office visit in 2015
Denominator	Hypertensive patients as defined above
Level of measure	Practice group
Minimum members	1 per practice
Applicable product lines	HMO/POS, ASO/PPO, Medicare and Medicaid
Method of measurement	Physician reported data submitted by Jan. 31, 2016
Provider data input	Documented blood pressure may be provided as supplemental data through Jan. 31, 2016. Supplemental data includes: • HL7 • Patient Profile • Report #70 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, 2016 Supplemental data is subject to audit. BPs must be documented by a health care provider and saved within the member's medical record.
Special note for members with no PCP visit in 2015	Monthly 2015 reporting includes members who have a billed diagnosis of hypertension by any physician. If a member does not have a PCP office visit during 2014, the member will be removed from the measure denominator at year-end. As an option to keep these members in your measure denominator—and potentially the measure numerator—practices may obtain medical records of a blood pressure recorded during a specialist office visit. With this documentation, practices may submit the blood pressure and apply it as supplemental data. 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.
Target: HMO/POS, ASO/PPO	TBD
Target: Medicare	TBD
Target: Medicaid	TBD
Payout	$80 per measured member

Clinical outcomes
Senior Care Education

Source	Priority Health Standard of Excellence
Identified measure	An incentive is provided for practices that have implemented routine discussions/counseling using the outline below with all Priority Health Medicare patients during annual wellness visits or a comprehensive physical exam. Recommended exams and tests □ Annual flu shot □ Pneumonia vaccine □ Bone density test to check for osteoporosis □ Annual glaucoma test □ Shingles vaccination □ Colon cancer screening (age 50 – 86) □ Mammogram (women age 50 – 74) □ Diabetes screening Patient questionnaire/discussion points: When Medicare patients are polled about their experience with providers during annual wellness visits or comprehensive physical exams, they are asked if you've discussed: • How to stay physically active and the importance of exercise • Ways to prevent falls and problems with balance or walking • How to improve bladder control • What they can do if they have feelings of sadness, worry or loneliness • What they can do if they have feelings of confusion or forgetfulness • Risks of high cholesterol • Risks of high blood pressure • Body or joint pain they may be experiencing • Proper use of medications including importance of adherence (comprehensive medication reviews are available at no cost to them) • Risks of substance abuse (alcohol, tobacco, pain killers) In addition to reviewing the discussion points during patient visits, providers must attest to reviewing provider education on the elements outlined above. Content will be made available on the provider portal on *priorityhealth.com.*
Age criteria	64 years of age and older
Exclusionary criteria	None
Level of measure	Practice group
Minimum members	1 Medicare member per practice group
Applicable product line	Medicare
Method of measurement	Implementation of measure specifications by March 31, 2015, completion of the PH provider education webcast (located on the provider portal of *priorityhealth.com*), and completion of the measure attestation survey by June 1, 2015
Payout	$0.25 pmpm for Medicare membership

Experience and access
Healthy Michigan Plan: HRA Completion and Open Access

Identified measure	For calendar year 2015, primary care providers are eligible for a $25 incentive for proper completion of a health risk assessment (HRA) and billing of code 99420, and an additional $25 if they are open to new Medicaid members on the date of service. **$25 incentive for HRA completion** Priority Health will pay a $25 incentive to participating PCPs only when the PCP (physician or mid-level primary care provider) completes the HRA form properly and timely. To receive the incentive, the PCP must: 1. Conduct an "initial visit" with the Healthy Michigan Plan member within 150 days of the member's enrollment date 2. Bill an E&M code for the initial visit. Use code 99420 to indicate that the form was completed during the initial visit; bill with zero dollar charges as payment will occur with all other measures at settlement in April 2016 3. Use the age-appropriate preventive health V-code as the diagnosis with 99420 4. Within 30 days of the initial visit OR the patient's effective date with Priority Health, whichever is later, fax the entire completed HRA to Priority Health at 616.942.0616. Incomplete forms will be returned to you for completion. Complete and fax back to Priority Health within 10 days. Failure to complete the form properly will result in ineligibility for the incentive. To be considered, the HRA must include results of all questions and the provider attestation information. Handwritten forms must be legible. **$25 additional incentive for PCPs open to new Medicaid members** PCPs open to new Medicaid members can earn an additional $25 per completed HRA form. To receive the additional incentive, PCPs must meet the criteria above for earning the $25 HRA incentive, AND be open to new Medicaid members on the date of service on which the visit occurred. If a practice is currently closed to new Medicaid members, use the Participating Provider Change Form to inform Priority Health that you will open your practice to new members. We will use the date the form is received as the effective date of "open" status. Both incentive payments will be processed annually. Federally Qualified Health Clinics and Rural Health Clinics are eligible for this incentive.
Case definition	Members with coverage under the Healthy Michigan Plan. PCPs must be open to new members under their Priority Health Medicaid contract to receive the additional $25 payout.
Age criteria	19-64 years of age
Exclusionary criteria	None
Level of measure	Practice level
Minimum members	1 per practice
Applicable product lines	Healthy Michigan Plan
Method of measurement	Billed claims with CPT 99420 for dates of service in 2015, received and processed by Feb. 28, 2016 AND completed HRA faxed.
Provider data input	Complete and fax HRA within 30 days of the initial visit date of service, and bill code 99420 for the initial visit. Refer to notes above regarding completion status.
Payout	$25 per measured member for faxing of completed HRA and billing of CPT 99420 within criteria $25 per measured member for Open Access on date of service.

Experience and access
CG CAHPS

<table>
<tr><td>Identified measure</td><td>An incentive is available to practices that have conducted the CG Consumer Assessment Healthcare Providers and Systems (CAHPS) patient experience survey.

CG CAHPS is promoted by the Michigan Patient Experience of Care (MIPEC) initiative. However, practices do not need to participate with the MIPEC initiative to receive an incentive.

Practices eligible for this incentive must conduct a minimum number of surveys as identified in the chart below. The chart was developed by the Agency for Healthcare Research and Quality (AHRQ). Practices are identified by Priority Health facility site ID. The minimum survey count applies to any patients, not just Priority Health members.

<table>
<tr><td># of Providers per practice site</td><td>Required # of completed surveys</td></tr>
<tr><td>1</td><td>50</td></tr>
<tr><td>2</td><td>100</td></tr>
<tr><td>3</td><td>150</td></tr>
<tr><td>4-9</td><td>175</td></tr>
<tr><td>10-13</td><td>200</td></tr>
<tr><td>14+</td><td>250</td></tr>
</table>

To be considered for the incentive, practices must:
1. Complete an attestation (online survey)
2. Submit practice-level performance data by each GC CAHPS measure via flat ASC II or excel to PH by Jan. 31, 2016.
Based on the need for comparable, reliable and bias-free survey methodology and results, Priority Health reserves the right to require use of a certified vendor to conduct the CG-CAHPS survey.</td></tr>
<tr><td>Level of measurement</td><td>Practice group</td></tr>
<tr><td>Minimum members</td><td>No minimum member requirement</td></tr>
<tr><td>Applicable product lines</td><td>HMO/POS, ASO/PPO, Medicare and Medicaid</td></tr>
<tr><td>Method of measurement</td><td>Initiate CG CAHPS survey processes by May 1, 2015.

To demonstrate intent, we require completion of attestation with supporting documentation by June 1, 2015.

ACNs may complete one attestation (online survey) on behalf of all member practices. A list of practices with Priority Health’s facility site ID is also required.

The attestation (online survey) and supporting documentation are required in one PDF. We will not accept multiple files.</td></tr>
<tr><td>Payout</td><td>$0.10 pmpm</td></tr>
</table>

Efficiency and care transformation
Follow-up PCP Visits Post-Hospital Discharge

Identified measure	Priority Health provides a claims-based incentive to primary care practices when members receive PCP home- or office-based care within seven calendar days post-discharge from inpatient hospitalization.* The intent of the measure is that the patient is seen within seven days of discharge and the measure is claims-based only. Inpatient hospitalizations included in this measure are defined by claim admit type. Admit types include: • Emergent • Urgent • Trauma Inpatient claim admit types not included in this measure are obstetrics, newborn and preplanned surgery. **The visit may be with any PCP within the member's primary care practice. For PPO plans without PCP assignment, the visit may be with any network PCP.* Payout is provided to the participating PCP assigned/attributed on the date of discharge. Members with chronic conditions yield a higher payout for the practice. Chronic conditions eligible for the enhanced payout: • Cardiovascular disease • Diabetes • Asthma
Age criteria	All ages
Exclusionary criteria	Obstetrics, newborn and preplanned surgery admissions
Level of measure	Practice group
Minimum members	1 per practice group
Applicable product line	HMO/POS, ASO/PPO, Medicare and Medicaid
Method of measurement	Priority Health facility and medical claims processed by Feb. 28, 2016
Target	This measure does not include a target for achievement. An incentive is paid for each member that meets measure criteria
Payout	$135 for members with chronic conditions identified above, $70 for all other members. A portion of the incentive dollars were added to reimbursement of CPT codes 99495 and 99496 for transitional care management.

Efficiency and care transformation
Patient-Centered Medical Home Recognition

Identified measure	Priority Health provides an incentive for all practices with active patient-centered medical home recognition. Priority Health is honoring three recognition programs: BCBS of Michigan, NCQA and URAC. **BCBS PGIP PCMH recognition** Practices are required to resubmit proof of PCMH renewal through BCBS by Aug. 15, 2015. This process aligns with BCBS' annual announcement of PGIP PCMH recognized practices. Practices that lose BCBS PCMH recognition July 2015 will have monthly pro-rated recognition end September 2015. Practices that are newly recognized by BCBS in July 2015 will have recognition begin October 2015. Failure to submit proof of recognition by Aug. 15, 2015 will stop existing PCMH recognition in September 2015. **NCQA recognition** Practices with existing NCQA recognition are requested to submit proof of recognition status during fourth quarter 2015. Practices that are newly recognized should submit proof of recognition as soon as it is granted. **URAC** Practices with existing URAC recognition are requested to submit proof of recognition status during fourth quarter 2015. Practices that are newly recognized should submit proof of recognition as soon as it is granted.
Level of measure	Practice group
Minimum members	1 per practice group
Applicable product line	HMO/POS, ASO/PPO, Medicare and Medicaid
Method of measurement	Practices must have active patient-centered medical home recognition. Priority Health is honoring three recognition programs: BCBS of Michigan, NCQA and URAC. **BCBS of Michigan** The BCBS PHO/PO notification spreadsheet is required as proof of recognition status. Priority Health facility site IDs are required for those practice groups that received BCBS PGIP PCMH designation. Priority Health will require practices to submit the Priority Health facility site ID with the BCBS documentation. **NCQA** Newly-recognized practices must provide documentation of recognition status. A letter from NCQA or certificate is appropriate documentation. Priority Health requires practices to submit the Priority Health facility site ID with the NCQA documentation. **URAC** Practices must provide documentation of recognition status. A letter or certificate from URAC is appropriate documentation. Priority Health requires practices to submit the Priority Health facility site ID with the URAC documentation.
Payout	$1.00 per member per month Practices are eligible for either PCMH incentive or the Care Management incentive but not both. If a PCMH practice qualifies for the Care Management incentive the higher Care Management incentive will be paid. With each practice measured separately, an ACN will receive incentives for each member practice based on their PCMH and/or Care Management incentive status.

Efficiency and care transformation
Practice Transformation: Care Management

Identified measure	An incentive is available for primary care practices that have implemented a care management program which includes Priority Health members. Care management programs must include a minimum of one part- or full-time care manager assigned to the practice and actively working with Priority Health members. To receive the care management incentive, practices must meet/provide the following in 2015: • Billed claims for care management services • Self-reported data • Attestation form **Claims** Practices must meet or exceed a 2% target of unique Priority Health members receiving care management services. This is a combined target for all active members assigned or attributed to the practice. Member continuous enrollment criteria does not apply. Members need only be active on the date care management services were provided. The measure denominator is defined as the practice's assigned/attributed 2015 member months divided by 12. Claims with the following HCPCS and CPT codes will serve to identify members that have received care management services: • 99495-99496 • G9001-G9002 • G9007-G9008 • 98966-98968 • 99487 • 99489 • Gxxx1 (code to be released by CMS late 2014) **Self-reported data** Self-reported data is requested as a means to fill in gaps in information not represented through claims activity. Between claims and self-reported data, we hope to better integrate care management services between the health plan and primary care. Self-reported data will be requested two times per year and will follow a standardized format. The self-reported data procedure is documented and available outside of the PCP Incentive Program Manual. The requested fields are: • Number of unique members • Number of encounters • Intervention counts for telephonic services • Intervention counts for in person services • Number of care managers in the practice • Methods for identifyng patients for CM • Number of physicians and advance practice professionals in the practice **Attestation** Practices will also be required to attest to care management program details. The following details will be addressed in an attestation survey. Each of these items is required to receive the incentive.

	Care management program requirements:
	• Full- or part-time equivalent care manager(s) in the practice
	• Care management staff trained under program models consistent with nationally-recognized programs. Examples include:
	  o Geisinger
	  o Care Management Society of America
	  o Michigan Primary Care Transformation (MiPCT)
	  o Michigan Center for Clinical System Improvement (MICCSI)
	  o Learning Action Network
	  o Health Services Institute
	  o Practice Transformation Institute
	• Care managers must have the licensure of a qualified health professional. This requirement aligns with licensure required to bill care management codes (RN, RD, MSW, CDE, CAE, Pharmacist, PA, NP)
	• The practice's care management program is built on the team-based model
	• Registry use for risk stratification or population segmentation to identify patients for care management
	• The practice supports integration with Priority Health's care management team which may include use of Priority Health population segmentation to identify potential patients for care management
	• Practice written protocol or policy regarding patient populations selected for care management.
	The attestation will also request a sample plan of care, developed by the care manager that includes input by the PCP, patient, caregiver, specialists and other relevant input by the care team.
	
	Practices may be audited to confirm compliance with measure criteria.
	
	Priority Health recommends the Agency for Healthcare Research and Quality (AHRQ) and Care Management Society of America (CMSA) as resources to learn more about care management.

Level of measure	Practice group
Minimum members	1 per practice group
Applicable product lines	HMO/POS, ASO/PPO, Medicare and Medicaid
Method of measurement	Self-reported data provided two times per year, June 15, 2015 and Dec. 15, 2015. Claims activity to measure 2% unique member target. Attestation via a completed survey, due by June 1, 2015.
Target: HMO/POS, ASO/PPO, Medicare and Medicaid	Of all active members attributed or assigned to the practice, 2% or greater unique members must have a billed care management claim for a 2015 date of service.
Payout	$3.25 pmpm Practices are eligible for either the PCMH incentive or Care Management incentive, but not both. If a PCMH practice qualifies for the Care Management incentive, the higher Care Management incentive will be paid. With each practice measured separately, an ACN will receive incentives for each member practice based on their PCMH and/or Care Management incentive status.

Efficiency and care transformation
Emergency Department Visits: PCP Treatable Care

<table>
<tr><td>MiPCT</td><td>Aligned with MiPCT</td></tr>
<tr><td>Case definition</td><td>Emergency department utilization of PCP treatable care as identified through ICD-9/10 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) a target of TBD ED PCP treatable visits per thousand, or
• Experience improvement from year-end 2014 to year-end 2015 and have a year-end 2015 rate between TBD and TBD ED PCP treatable visits per thousand.</td></tr>
<tr><td>Age criteria</td><td>All ages</td></tr>
<tr><td>Exclusionary criteria</td><td>ED visits resulting in an inpatient admission</td></tr>
<tr><td>Numerator</td><td>Number of PCP treatable ED visits with a PCP-treatable defined primary diagnosis.</td></tr>
<tr><td>Denominator</td><td>Member months affiliated with an ACN</td></tr>
<tr><td>Level of measure</td><td>Accountable Care Network (ACN)</td></tr>
<tr><td>Minimum members</td><td>A minimum of 12,000 annual member months at the ACN level in 2015.

ACNs with fewer than 12,000 annual member months in 2014 who reach more than 12,000 annual member months in 2015 will only be eligible for the target measurement. No improvement criteria will apply.</td></tr>
<tr><td>Applicable product lines</td><td>HMO/POS</td></tr>
<tr><td>Method of measurement</td><td>Claims data submitted by Feb. 28, 2016</td></tr>
<tr><td>Calculation</td><td>PCP treatable ED visits x 12,000
Total member months</td></tr>
<tr><td>Target, improvement and shared savings</td><td>Each ED PCP treatable visits is valued at $TBD pmpm for each per thousand increment.

<table>
<tr><td>Target/Improvement</td><td>Share of Savings</td></tr>
<tr><td>Rate that exceeds (lower than) TBD</td><td>50% savings share for each ED PCP treatable unit below TBD</td></tr>
<tr><td>Experience improvement from 2014 to 2015 and have a rate between TBD and TBD</td><td>25% savings share for each ED PCP treatable unit between TBD and TBD</td></tr>
</table>
</td></tr>
</table>

Measure code sets

ICD-10 conversion

ICD-10 has a planned implementation date of Oct. 1, 2015. PCP IP relevant care, billed under an ICD-10 code, will be converted back by Priority Health to the most appropriate ICD-9 code.

Measure codes for Cervical Cancer Screenings

Cervical cancer screenings

CPT		HCPCS		UB Rev Code
88141-88143	88152-88154	G0123	G0147	0923
88147	88164-88167	G0124	G0148	
88148	88174	G0141	Q0091	
88150	88175	G0143-G0145	P3000	
			P3001	

HPV Screening

CPT
87620
87621
87622

Hysterectomy exclusion

CPT		ICD-9
51925	58270	618.5
56308	58275	752.43
57540	58280	V88.01
57545	58285	V88.03
57550	58290-58294	
57555	58548	
57556	58550-58554	
58150	58570-58573	
58152	58951	
58200	58953	
58210	58954	
58240	58956	
58260	59135	
58262		
58263		
58267		

Measure codes for Adolescent Immunizations

Vaccines

Meningococcal	Tdap/ Td
90733	90715
90734	90714
	90718
	90703
	90719

Measure codes for Childhood Immunizations

Vaccines

DTaP	IPV	MMR	HIB	HepB	Varicella	Pneumo-coccal Conjugate
90698 90700 90721 90723	90698 90713 90723	90704 (mumps) 90705 (measles) 90706 (rubella) 90707 90708 (measles and rubella) 90710 055 (measles) 072 (mumps) 056 (rubella)	90645-90648 90698 90721 90748	90723 90740 90744 90747 90748 G0010 070.2-070.23 070.3-070.33 V02.61	90710 90716 053 053.10-053.14 053.19-053.22 053.29 053.71 053.79-053.9	90669 90670 G0009

Measure codes for Well-Child Visits in the First 15 Months of Life

Well-Child visits

CPT	HCPCS	ICD-9
99381-99385 99391-99395 99461	G0438 G0439	V20.2 V20.31 V V70.0 V70.3 V70.5 V70.6 V70.8 V70.9

Measure codes for Well-Child Visits 3–6 Years

Well-Child visits

CPT	ICD-9	
99382	V20.2	V70.6
99383	V70.0	V70.8
99392	V70.3	V70.9
99393	V70.5	

Measure codes for Chlamydia Screenings

Chlamydia screening

CPT
87110
87270
87320
87490-87492
87810

Sexually active women

CPT		UB Rev Code	ICD-9	HCPCS
11976	59820	0112	042	G0101
57022	59821	0122	054.10	G0123
57170	59830	0132	054.11	G0124
58300	59840	0142	054.12	G0141
58301	59841	0152	054.19	G0143-G0145
58600	59850-59852	0720-0722	078.11	G0147
58605	59855-59857	0724	078.88	G0148
58611	59866	0729	079.4	H1000
58615	59870	0923	079.51-079.53	H1001
58970	59871	0925	079.88	H1003-H1005
58974	59897		079.98	P3000
58976	59898		091-097	P3001
59000	59899		098.0	Q0091
59001	76801		098.10	S0199
59012	76805		098.11	S4981
59015	76811		098.15-098.17	S8055
59020	76813		098.19	
59025	76815-76821		095.19	
59030	76825-76828		098.2	
59050	76941		098.30	
59051	76945		098.31	
59070	76946		098.35-098.43	
59072	80055		098.49-098.53	
59074	81025		098.59	
59076	82105		098.6	
59100	82106		098.7	
59120	82143		098.81 – 098.86	
59121	82731		098.89	
59130	83632		099-099.41	
59135	83661-83664		099.49-099.56	
59136	84163		099.59	
59140	84702-84704		099.8	
59150	86592		099.9	
59151	86593		131.01-131.03	
59160	86631-86632		131.9	
59200	87110		302.76	
59300	87164		339.82	
59320	87166		614-615	
59325	87270		615.1	
59350	87320		615.9	
59400	87490-87492		622.3	
59409	87590-87592		623.4	
59410	87620-87622		625	
59412	87660		626.7	
59414	87661		628.0-628.4	
59425	87808		628.8	
59426	87810		628.9	
59430	87850			
59510	88141-88143		795.0-795.19	
59514	88147		796.70-796.79	
59515	88148		996.32	
59525	88150		V01.6	
59610	88152-88155		V02.7	
59612	88164-88167		V02.8	
59614	88174		V08	
59618	88715		V15.7	
59620	88235			
59622	88267		V24.0-V24.2	
59812	88269		V25.01-V25.04	
			V25.09	
			V25.11-V25.13	
			V25.2-V25.3	
			V25.40-V25.43	
			V25.49	
			V25.5	
			V25.8-V25.9	

		V26.0- V26.1 V26.21 V26.22 V26.29 V26.31 – V26.35 V26.39 V26.41 V26.42 V26.49 V26.51 V26.81 V26.82 V26.89 V26.9 V27.0 – V27.7 V27.9 V45.51 V45.52 V45.49 V61.5-V61.7 V69.2 V72.31 V72.32 V72.40 – V72.42 V73.81 V73.88 V73.98 V74.5 V76.2 69.01 69.02 69.51 69.52 69.7 72.0 72.1 72.21 72.29 72.31 72.39 72.4 72.51-72.54 72.6 72.71 72.79-72.9 73.01 73.21 73.22 73.3-73.4 73.51 73.59 73.6 73.8 73.91-73.94 73.99 -74.4 74.91 74.99-75.2 75.31-75.38 75.4 75.50-75.52 75.61-75.62 75.69 75.7 75.8 75.91-75.94	

		75.99 88.78 97.24 97.71 97.73	

Pregnancy tests (when billed with Diagnostic Radiology)

CPT	Rev Code
81025 84702 84703	0925

Diagnostic radiology

CPT	Rev Code
70010-76499	032x

Exclusion for prescription retinoid (lostretinoin) identified by National Drug Code

Oral contraceptive prescriptions to determine sexual activity identified by National Drug Code

Measure codes for Lead Screening in Children

Lead tests

CPT
83655

Measure codes for Colorectal Cancer Screening

Colonoscopy

CPT	HCPCS	ICD-9
44388 - 44394	G0105	45.22
44397	G0121	45.23
45355		45.25
45378 – 45387		45.24
45391		45.43
45392		

Colorectal cancer

ICD-9	HCPCS
153.0	G0213
153.1	G0214
153.2	G0215
153.3	G0231
153.4	
153.5	
153.6	
153.7	
153.8	
153.9	
154.0	
154.1	
154.2	
154.3	
197.5	
V10.05	
V10.06	

Flexible sigmoidoscopy

CPT	HCPCS	ICD-9
45330-45335	G0104	45.24
45337-45339		
45340-45342		
45345		

FOBT

CPT	HCPCS
82270	**G0328**
82274	

Total colectomy

CPT	ICD-9
44150-44153	45.81
44155-44158	45.82
44210-44212	45.83

Measure codes for Diabetes Care Measures

Diabetes

ICD-9
250
357.2
362.0
366.41
648.0

Exclusion codes: Polycystic ovary disease (256.4), steroid-induced diabetes (249, 251.8, 962.0) and gestational diabetes (648.8) exclusions

Exclusion codes: End-stage renal disease (ESRD) exclusion
Available by request

Measure codes for Diabetes Care: Controlled HbA1c Measures

HbA1c lab codes

CPT	CPT II
83036	3044F
83037	3045F
	3046F

Diabetes Care: Controlled HbA1c Less Than 7.0% – myocardial infarction exclusion

ICD-9
410
412

Diabetes Care: Controlled HbA1c Less Than 7.0% – blindness exclusion

ICD-9	
369.0	369.4
369.1	369.6
369.2	369.7

Diabetes Care: Controlled HbA1c Less Than 7.0% – lower extremity amputation exclusion

CPT		ICD-9
27290	27884	
27295	27886	84.10 -84.19
27590-27592	27888	
27594	27889	
27596	28800	
27598	28805	
27880	28810	
27881	28820	
27882	28825	

Diabetes Care: Controlled HbA1c Less Than 7.0% – thoracic aortic aneurysm

ICD-9
441.01
441.03
441.1
441.2
441.6
441.7

Diabetes Care: Controlled HbA1c Less Than 7.0% – IVD exclusion

ICD-9	
411	433-
413	434
414.0	440.1
414.01	440.2
414.02	440.4
414.03	444
414.04	445
414.05	
414.06	
414.07	
414.2	
414.8	
414.9	
429.2	

Diabetes Care: Controlled HbA1c Less Than 7.0% - CABG exclusion

CPT	HCPCS	ICD-9
33510-33514 33516-33519 33521-33523 33533-33536	S2205-S2209	36.10-26.19 36.2

Diabetes Care: Controlled HbA1c Less Than 7.0% – PTCA exclusion

CPT
33140
2980
92982
92995

Diabetes Care: PCI exclusion

CPT	HCPCS	ICD-9
92933	G0290	00.66
92937		36.06
92941		36.07
92943		
92980		
92982		
92995		

Diabetes Care: Controlled HbA1c Less Than 7.0% – dementia, organic brain syndrome, Alzheimer's disease, frontotemporal dementia, dementia with Lewy bodies exclusions

ICD-9	
290	294.0
291.2	294.10
292.82	294.11
	294.20
	294.21
	331.0
	331.82

Diabetes Care: Controlled HbA1c Less Than 7.0% – CHF exclusion

ICD-9
425
428

Measure codes for Diabetes Care: Annual Retinal Eye Exam

Retinal eye exam

HCPCS	CPT	CPT II
S0620 S0621 S0625 S3000	67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92014, 92015, 92018, 92019, 92134, 92225-92228, 92230, 92235, 92240, 92250 99203-99205 99213-99215, 99242-99245, 92260	2022F 2024F 2026F 3072F

Measure Codes for Diabetes Care: Monitoring for Nephropathy

Microalbuminuria and treatment

CPT	CPT II	ICD-9
82042 82043 82044 84156	3060F (microalbuminuria) 3061F (microalbuminuria) 3062F (micoralbuminuria) 3066F (treatment of nephropathy) 4010F 4009F (ACE/ARB treatment)	250.40-250.43 403 404 405 580 581 582 583 584 585 586 587 588 753 791.0

Kidney Transplant

CPT	HCPCS	ICD-9
50300 50320 50340 50360 50365 50370 50380	S2065	V42.0 55.61 55.69

Measure Codes for Hypertension: Controlled Blood Pressure

Blood pressure

CPT II
Systolic • 3074F – Most recent systolic blood pressure < 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

Pregnancy Exclusion

ICD-9
630-679
V22
V23
V28

Kidney Transplant Exclusion

CPT	HCPCS	ICD9
50300	S2065	V42.0
50320		55.61
50340		55.69
50360		
50365		
50370		
50380		

ESRD Exclusion

CPT	HCPCS	ICD9
90969-90970	G0257	585.5-585.6
90989	S9339	V45.11
90993		V45.12
90997		38.95
90999		39.27
99512		39.42-39.43
		39.53
		39.93-39.95
		54.98

Measure codes for Follow-up PCP Visits Post-Hospital Discharge

PCP office visit

CPT	Revenue Code
99201-99205 99212-99215 99241-99245 99381-99387 99391-99397 99495 (transitional care) 99496 (transitional care) 99304 (skilled nursing facility)	510 Clinic 514 Clinic OB/GYN 517 Clinic Family Practice 521 Free-standing clinic rural health 522 Free-Standing clinic rural health home 524 Visit by RHC/FQHC provider to skilled nursing facility (Medicare Part A) 525 Visit by RHC/FQHC provider to a skilled nursing facility, nursing facility or other residential facility

PCP home visit

CPT
99341-99345 99347-99350

Measure codes for Care Management

CPT
G9001 G9002 G9007 G9008 98966 98967 98968 99487 99489 99495 99496

Emergency Department Visits: PCP Treatable Care

We've adopted the New York University (NYU) emergency department utilization code set as our standard. Access the list of ICD-9 codes that are part of this measure. You'll find the list as a bullet in the "Overview" section.