PRELIMINARY MANUAL

2026 PCP Incentive Program (PIP)

An integrated program focused on patient-centered care

Priority Health

TABLE OF CONTENTS

Note: the following appendices, updated for 2026, will be released with the final 2026 PIP Manual, on or around Dec. 5, 2025:

- *Appendix 4: CPT® II codes*
- *Appendix 5: Report inventory*
- *Appendix 6: Medicare 5-Star Chronic Disease (Part D) measure tip sheets*

01

Program overview

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

For over 38 years, we've partnered with primary care providers (PCPs) to improve the quality, access and affordability of care for our members. Our goal is to work with our provider partners to deliver the right care, at the right time, in the right place and at the right cost.

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

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

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

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

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

Achieving results

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

We're here to help you maximize your 2026 PIP incentives. In this manual, we show you how.

2026 PROGRAM UPDATES

We update our PIP program annually to reflect current health care trends. Our 2026 program aligns with our mission and goals to transform models of care and finance care delivery. For complete details on these measure changes, refer to the individual measure specification pages in this manual and the HEDIS Provider Reference Guide (to be updated for 2026 later this year).

2026 administrative changes

- New reporting vendor
- ACA and commercial plans will be used for categorizing and payout instead of separating HMO/POS and ASO/PPO
- Medicaid percentile target for HEDIS measures updated to 75th

2026 revised measures

- Care Management (CM)
  - Target increase from 2% to 4%
  - Annual questionnaire and narrative required with details outlining care management model and how incentive dollars are used
  - Both touchpoints required for incentive credit can be telephone codes
- Behavioral Health Collaborative Care (BHCC)
  - Three approved BHCC CPT and/or HCPCS codes must still be billed and adjudicated before a member can be considered as actively receiving BHCC services from a PCP and be eligible for incentive dollars. However, these codes no longer need to be billed within six consecutive months of the calendar year.
  - Added 99494 as an approved BHCC measure CPT code
- Well Child Visits (WCV) measure will be broken into three age ranges:
  - WCV 3-11 years
  - WCV 12-17 years
  - WCV 18-21 years
- Breast Cancer Screening (BCS-E) member age range for denominator inclusion updated from 50-74 to 40-74 years of age to align with NCQA guidelines.

2026 retired measures

- Disparity of Care
- Health Information Exchange Participation with MiHIN

2026 new measures

- HEDIS preventive health & chronic disease management
  - Adult's Access to Preventive/Ambulatory Health Services- 20-44 years (AAP-2044)
  - Follow up for ED Visit for High-Risk Multiple Chronic Conditions (FMC)
  - Follow up for ED Visit for Mental Illness (FUM) – Report Only
  - Osteoporosis Management in Women (OMW)
  - Pneumococcal Vaccination Status for Older Adults (PNU)– Report Only
- Medicare 5-Star chronic disease management
  - Concurrent Use of Opioids and Benzodiazepines (COB)
  - Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH)
- Data Quality Collaborative

2026 PROGRAM MEASURE GRIDS

**Commercial and ACA are measured independently but have the same payout.*

⁺per compliant member

	Percentile performance						
	Commercial 90th percentile target	ACA 90th percentile target	Commercial & ACA payout* (pcm⁺)	Medicare 90th percentile target	Medicare payout (pcm)	Medicaid 75th percentile target	Medicaid payout (pcm)
	HEDIS PREVENTIVE HEALTH MEASURES						
Adult's Access to Preventive/Ambulatory Health Services - 20-44 years (AAP-2044)						TBD	TBD
Breast Cancer Screening (BCS-E)	TBD	TBD	TBD	TBD	TBD	TBD	TBD
Cervical Cancer Screenings (CCS)	TBD	TBD	TBD			TBD	TBD
Childhood Immunizations: Combo 3 (CIS)	TBD	TBD	TBD			TBD	TBD
Chlamydia Screening (CHL)				TBD	TBD		
Colorectal Cancer Screening (COL-E)	TBD	TBD	TBD	TBD	TBD		
Follow-up for ED Visit for High-Risk Multiple Chronic Conditions (FMC)				TBD	TBD		
Follow-up for ED Visit for Mental Illness (FUM)						Report only	
Immunizations for Adolescents: Combo 2 (IMA)	TBD	TBD	TBD			TBD	TBD
Lead Screening (LSC)						TBD	TBD
Osteoporosis Management in Women (OMW)				TBD	TBD		
Pneumococcal Vaccine (PNU)				Report only			
Social Needs Screening & Intervention (SNS-E)	Report only						
Statin Therapy for Patients w/CVD (SPC)				TBD	TBD		
Well Child Visits: First 15 Mo (W30)	TBD	TBD	TBD			TBD	TBD
Well Child Visits: 15-30 Mo (W30)	TBD	TBD	TBD			TBD	TBD

Well Child Visits: 3-11Yrs (WCV)	TBD	TBD	TBD			TBD	TBD
Well Child Visits: 12-17 Yrs (WCV)	TBD	TBD	TBD			TBD	TBD
Well Child Visits: 18-21 Yrs (WCV)	TBD	TBD	TBD			TBD	TBD
	HEDIS CHRONIC DISEASE MANAGEMENT MEASURES						
Controlling High Blood Pressure (CBP)	TBD	TBD	TBD	TBD	TBD	TBD	TBD
Eye Exam for Patients with Diabetes (EED)	TBD	TBD	TBD	TBD	TBD	TBD	TBD
Glycemic Status Assessment for Patients with Diabetes HbA1c ≤ 9.0% (GSD)	TBD	TBD	TBD	TBD	TBD	TBD	TBD
Kidney Health Evaluation (KED)	TBD	TBD	TBD	TBD	TBD	TBD	TBD

	Medicare 5-Star cut point performance	
	Payout PCM	Medicare cut point target
	MEDICARE 5-STAR CHRONIC DISEASE (PART D) MEASURES	
Concurrent use of opioids and benzodiazepines (COB)	TBD	TBD
Statin Use for Patients w/Diabetes (SUPD)	TBD	TBD
Medication Adherence – Diabetes	TBD	TBD
Medication Adherence – Hypertension	TBD	TBD
Medication Adherence – Cholesterol	TBD	TBD
Polypharmacy: use of multiple anticholinergic medications in older adults (Poly-ACH)	TBD	TBD

Access our HEDIS Provider Reference Guide (to be updated for 2026 later this year) for detailed information on each measure direct from HEDIS, including billing codes, optional exclusions, services to close the care opportunity, medical record documentation and more.

ADMINISTRATIVE DETAILS

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

ACN eligibility requirements

To participate in our value-based programs, including PIP, ACNs must meet the following requirements:

- **Have 30 practitioner members** that practice and are credentialed as primary care providers (PCPs) as defined in our Determination of Practitioners for Primary Care Practitioner Status, **or**
- **Have 2,500 attributed members** across all lines of business.

For an ACN to become eligible during the 2026 calendar year, they must:

1. **Attain** the minimum membership or PCP thresholds outlined above between February and September; **and**
2. **Notify** Priority Health that they met the threshold; **and**
3. **Attest** to their PCP roster in our Provider Roster App (PRA) tool to become PIP eligible in the month following attestation (i.e., attest in August to September's roster and become eligible in September) and each month thereafter through the end of the calendar year.

See our ACN Requirements online (login required) for more information.

ACN payment rules

We'll make PIP payments directly to the participating ACN. These payments encompass program settlement for the providers based on the Groups / Subgroups the ACN has attested to in PRA. ACNs are responsible for distributing these settlement funds to their providers at their discretion.

Discrepancies with settlement payments must be brought to the attention of your Provider Network Management Consultant within two weeks of settlement reporting.

Attesting to PCPs monthly in PRA

ACNs must attest monthly to their PCPs in our PRA tool (login required). We use this monthly snapshot as our source of truth to link PCPs within their Groups / Subgroups to a PIP-participating ACN for their incentives and associated gaps in care reporting. Failure to attest monthly will affect the accuracy of your value-based program reporting and payment. We require monthly roster submission, regardless of whether there are network changes, to maintain data integrity.

ACNs must leverage the Group / Subgroup feature in our PRA tool (login required) to organize individual practitioners by provider group and practice. This Group / Subgroup data is pulled into columns in several of our PIP reports, adding a layer of filterability at the practice level. See our PRA Manual for instructions on using the Group / Subgroup feature. **ACNs which fail to add the Group / Subgroup information in PRA will forfeit settlement of practice level measures.**

We'll match all ACN payments – including quarterly, ad hoc and year-end settlement – to the ACN's PRA-attested PCP roster. We'll use the **2026 12 DEC** attestation cycle, attested to in November (see schedule below), for 2026 settlement. As a reminder, provider changes made within PRA don't automatically update enrollment and credentialing. The standard process for updating a provider's credentialing must be completed. See our PRA Manual for more information.

2026 PRA attestation schedule
Note: The first day to attest for any given cycle is always the 1st of the month.

Cycle name	Last date to attest	Cycle start date	Cycle end date
2026 02 FEB	1/15/2026	2/1/2026	2/28/2026
2026 03 MAR	2/16/2026	3/1/2026	3/31/2026
2026 04 APR	3/16/2026	4/1/2026	4/30/2026
2026 05 MAY	4/15/2026	5/1/2026	5/31/2026
2026 06 JUN	5/15/2026	6/1/2026	6/30/2026
2026 07 JUL	6/16/2026	7/1/2026	7/31/2026
2026 08 AUG	7/15/2026	8/1/2026	8/31/2026
2026 09 SEP	8/17/2026	9/1/2026	9/30/2026
2026 10 OCT	9/15/2026	10/1/2026	10/31/2026
2026 11 NOV	10/15/2026	11/1/2026	11/30/2026
2026 12 DEC	11/16/2026	12/1/2026	12/31/2026
2027 01 JAN	12/15/2026	1/1/2027	1/31/2027

Digital First strategy

In 2026, our top priority is assisting our ACN partners with implementing standardized data feeds for Priority Health. This implementation replaces manual, nonstandard data delivery for quality gap closure.

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

1. Prepare for NCQA's ECDS roadmap
2. Disallow nonstandard data practices
3. Help ACNs implement standardized data feeds to Priority Health
4. Enhance data confirmation reporting (HL7, MiHIN)

This strategy may impact the way your ACN submits supplemental data to us to close care gaps. See the full guidelines on submitting supplemental data in Appendix 2 of this manual.

Health plans excluded from PIP

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

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

Independent providers
We require independent providers to align with a PIP-eligible ACN to continue their participation in our PIP program. PCPs not contracted through and claimed by an ACN in PRA by the **2026 12 DEC** attestation cycle, which happens in November, won't be eligible to participate. See the 2026 PRA attestation calendar on page 9 of this manual for details.

Manual revisions
We reserve the right to make changes to our PIP program and rectify systematic errors at any time. The PIP Manual and new Reports Data Dictionary available on our website is the official version at any given time. We'll let you know of any updates to the manual through our biweekly PriorityActions for Providers email digest and via news items posted to our Provider Manual.

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

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

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

Member diagnosis
Rarely, a newly diagnosed patient may appear in a measure denominator late in the year without having appeared on earlier reports due to lag or late diagnosis. For our PIP program, the attributed PCP as of October 31 will be measured on any patient who falls into the category within the calendar year.

Membership lock date
For program settlement, members are locked to the PCP they're attributed to as of October 31 of the measurement year. Members must remain active through December 31 to be included in the measure rewards.

For example: Member A is attributed to Dr. Smith as of October 31. In November, Member A has multiple visits with Dr. Jones. Member A's attribution will move to Dr. Jones; however, Member A's PIP settlement stays with Dr. Smith. If Dr. Smith moves ACNs, their locked membership will move with them, impacting the ACNs' numerators and denominators.

Measure case definitions provide a few exceptions to this rule. See measure definition for our Transformation of Care measures (i.e., Care Management and Behavioral Health Collaborative Care).

Official member counts include 90 days of retroactivity. Employers have 30 days to request retroactive member enrollment or termination. However, an employer may request to review 90-day retroactivity.

PCP eligibility

To be eligible for inclusion in an ACN's roster for PIP, a PCP must be:

- Reported as a PCP by a contracted, Priority Health-recognized ACN and attested to in the PRA tool
- An MD, DO, Nurse Practitioner or Physician Assistant credentialed as a PCP, in good standing with Priority Health and practicing in a primary care setting as defined by a TIN
- The rendering provider on a claim
- Board certified in Internal Medicine, Internal Medicine and Pediatrics, Family Medicine, Pediatrics, Geriatrics, General Practice or an OB/GYN credentialed as a PCP

No minimum membership is required at the PCP level.

Priority Health quality index scores

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

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

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

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

Quality Index (QI) = QS / WT

By way of example and with a sample of measures, the calculation would be completed as follows:

A	B	C	D = B x C	E	F = E / D	G = D - E
QI measure	**Target***	**# Eligible members**	**# Members to meet target**	**# Members who met target**	**Met / Target**	**Gap**
Cervical Cancer Screenings	75%	4,000	3,000	2,500	0.833	500
Well Child Visits: 3-11 Yrs	60%	2,500	1,500	1,200	0.800	300
Controlling High BP	67%	1,200	800	600	0.750	200
TOTAL	**69%**	**7,700**	**5,300**	**4,300**	**0.811**	**1,000**
**Target based on PIP benchmarks established by NCQA and Medicare 5-Star*						

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

Measure name	HMO/POS	ASO/PPO	Medicare	Medicaid
Childhood Immunizations: Combo 3 (CIS)	✓	✓		✓
Adolescent Immunizations: Combo 2 (IMA)	✓	✓		✓
Well Child Visits: First 15 Mo (W30)	✓	✓		✓
Well Child Visits: 15-30 Mo (W30)	✓	✓		✓
Well Child Visits: 3-11 Yrs (WCV)	✓	✓		✓
Well Child Visits: 12-17 Yrs (WCV)	✓	✓		✓
Well Child Visits: 18-21 Yrs (WCV)	✓	✓		✓
Chlamydia Screenings (CHL)				✓
Cervical Cancer Screenings (CCS)	✓	✓		✓
Breast Cancer Screenings (BSC-E)	✓	✓	✓	✓
Colorectal Cancer Screening (COL-E)	✓	✓	✓	
Glycemic Status Assessment for patients with Diabetes: HbA1c≤9.0% (GSD)	✓	✓	✓	✓
Diabetes Care: Annual Eye Exam (EED)	✓	✓	✓	✓
Kidney Health Evaluation (KED)	✓	✓	✓	✓
Controlling High Blood Pressure (CBP)	✓	✓	✓	✓
Statin Use for Patients with Diabetes (SUPD)			✓	
Statin Use for Patients with CVD (SPC)			✓	
Medication Adherence – Diabetes			✓	
Medication Adherence – Hypertension			✓	
Medication Adherence – Cholesterol			✓	

Program deadlines

Program deadline description	Deadline
PCMH attestation in PRA	Oct. 15, 2026 attestation for Nov. 1 effective date
Supplemental data (including MiHIN, APS, HL7, EPP and medical records submitted via fax, mail or SharePoint) **for dates of service between Jan. 1 – June 30, 2026**	Nov. 1, 2026
PRA attestation including Group and Subgroup designations for PCPs	Nov. 16, 2026 attestation for Dec. 1 effective date
Addition of formerly independent providers	

Supplemental data (including MiHIN, APS, HL7, EPP and medical records submitted via fax, mail or SharePoint) **for dates of service between July 1 – Dec. 31, 2026**	Jan. 31, 2027
Claims submission and adjudication	Feb. 28, 2027
2026 Settlement	June 2027

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

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

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

Supplemental data
Submit supplemental data to us through any of these methods:

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

Supplemental data must provide the date the service was performed (rather than the date a test or result was reviewed with the patient). All supplemental (provider-reported) data is subject to audit. For MiHIN, sending **only** the service type code **won't** close the care gap. You **must also** send the appropriate procedure, LOINC, diagnosis or revenue code to close the care gap.

The supplemental data submission deadlines for the 2026 program year are outlined on pages 13-14 of this manual.

Target rationale
Commercial and Medicare targets for our HEDIS measures are based on HEDIS MY 2024 national performance at the 90th percentile. Medicare 5-Star measure targets are based on Medicare 5-Star cut points. Medicaid HEDIS measure targets are set based on HEDIS MY 2024 Michigan performance at the 90th percentile.

Uploading data & reporting schedule*

- **Data feeds (HL7/APS format)**: Data received and processed by the end of the month will be reflected in the following month's reporting.

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

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

Submit exclusions and more to our HEDIS team

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

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

Ensure that:

- ✓ The subject line of your submission says **PIP Gaps in Care** to ensure timely processing
- ✓ The patient's name and date of birth are on **every page** of the progress notes and lab results
- ✓ The physician, physician assistant or nurse practitioner has signed the progress notes **after each visit**

Where to send medical records

Email
HEDIS@priorityhealth.com

Fax
616.975.8897

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

Electronic
Reach out to our HEDIS team via email (see above) to set up a secure SharePoint site for medical record submissions. Gain insights into this process, including file naming conventions – watch this webinar recording.

Provider registry
Contact *kennedy.rogers@priorityhealth.com* to get started.

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

02

Incentive details

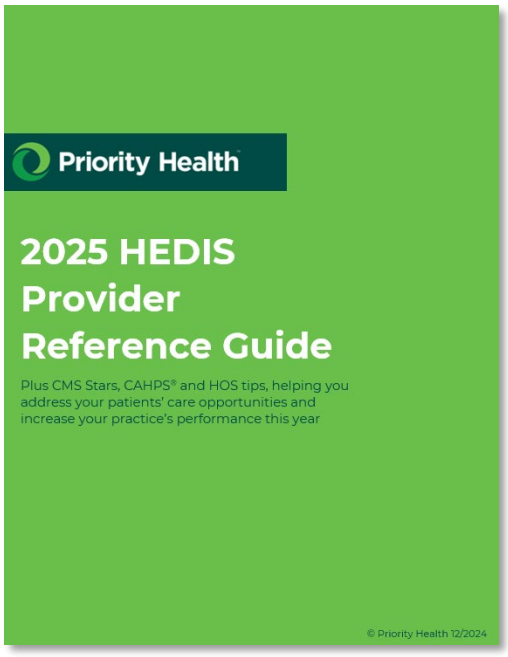
HEDIS PREVENTIVE HEALTH, HEDIS CHRONIC DISEASE MANAGEMENT & MEDICARE 5-STAR MEASURES

Practice level measures

Reference our HEDIS Provider Reference Guide for detailed information on each of our 2026 PIP HEDIS preventive health, HEDIS chronic disease management and Medicare 5-Star measures, direct from HEDIS.

The HEDIS Provider Reference Guide includes:

- Product lines
- Collection and reporting method
- Numerator compliance
- Billing codes
- Frequency / occurrence
- Required or optional exclusions
- Tests, services or procedures to close the care opportunity
- Medical record documentation
- Tips and best practices
- And more



NOTE: The HEDIS Provider Reference Guide will be updated for 2026 in December 2025 and released with the final 2026 PIP Manual.

TRANSFORMATION OF CARE MEASURES

ACN level measures

Care management

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

PROGRAM REQUIREMENTS

- The care management program is built on the team-based model.
- The ACN supports integration with the Priority Health care management team. Integration is defined as communication, as needed, between Priority Health and point-of-care care managers to coordinate care.
- The ACN must have a physician champion for their care management program.

ACNs may be audited to confirm measure compliance.

Priority Health recommends The Michigan Center for Clinical Systems Improvement (Mi-CCSI), Case Management Society of America (CMSA) and National Committee for Quality Assurance (NCQA) as resources to learn more about care management.

ELIGIBILITY

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

1

PCMH designation

PCPs must be practicing at a Patient Centered Medical Home (PCMH) designated practice in the program year to participate. This designation can be reported by the ACN in the PRA tool any time during the program year, however, Priority Health will use the **2026 11 NOV** attestation of PCMH, which takes place in October to settle PIP and update our Find a Doctor website directory (see PRA attestation cycle on page 9 of this manual). We honor the following designation programs: BCBSM, NCQA, URAC and Joint Commission.

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

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

2

Training for clinical staff providing care management services

A clinical staff member is a person who works under the supervision of a physician, NP or PA and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specified

professional service, but who doesn't individually report that professional service.

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

Initial training examples include:

- Case Management Society of America
- Michigan Center for Clinical System Improvement (MICCSI)
- Practice Transformation Institute
- Collaborative Care Model (provided by MICMT endorsed ACN trainer)
- Introduction to Team-Based Care (provided by MICMT endorsed ACN trainer)
- ACMA: Compass Directional Training
- CCMC's Case Management Body of Knowledge (CMBOK)

Continuing education
Clinical staff providing care management services must fulfill annual continuing education requirements. Beyond the initial training requirement, each clinical staff providing care management services must document at least eight hours of continuing education during the measurement year to qualify for the care management incentive.

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

3

Claims

ACNs must meet or exceed a 4% target of unique Priority Health members receiving care management services by product line (Commercial, ACA, Medicare and Medicaid) with a minimum of two touchpoints.

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

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

Claims with the following HCPCS and CPT codes will serve to identify members that have received care management services and will count toward the 4% target.

NOTE: The care management code set for 2026 PIP will be added to this manual at a later date.

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

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

4

Care Management questionnaire and narrative

New in 2026, each ACN must have three or more practices fill out our annual care management questionnaire and narrative. The goal of this questionnaire is to have a better understanding of how care management is being delivered within each practice, how incentive dollars are utilized, as well as the best practices that have been observed. Obtaining this information will help our value-based team with determining the direction of our Care Management incentive and how we can best support this work.

Questionnaires will be distributed by your Provider Network Management consultant at the beginning of 2026. Complete them by Dec. 31, 2026.

MEASURE DETAILS

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

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

Level of measurement
ACN

Product lines
Medicare, Medicaid, commercial and ACA

Collection & reporting method
Claims with dates of service in the program year

Payout
Priority Health will pay $TBD PMPM to ACNs (paid at annual settlement) for providing care management services to our members.

NOTES

- The assigned or attributed PCP of the member on the date of the care management service will get the credit.
- Two or more touchpoints must be completed while the member is assigned / attributed to the same ACN's PCPs in the program year.

- Care management touchpoints stay with the assigned / attributed PCP at the time of the care management visit. If a PCP changes from one ACN to another ACN, that PCP's care management touchpoints move with them to the new ACN. If a PCP leaves the network, the PCP's care management touchpoints won't count.

Behavioral Health Collaborative Care (BHCC) measure

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

ELIGIBILITY

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

1

PCMH designation

PCPs must be practicing at a Patient Centered Medical Home (PCMH) designated practice in the program year to participate. This designation can be reported by the ACN in the PRA tool any time during the program year, however, Priority Health will use the **2026 11 NOV** attestation of PCMH, which takes place in October to settle PIP and update our Find a Doctor website directory (see PRA attestation cycle on page 9 of this manual). We honor the following designation programs: BCBSM, NCQA, URAC and Joint Commission.

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

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

2

Provide BHCC services

We'll pay a $TBD incentive per approved CPT / HCPCS code billed for each member considered as actively receiving BHCC services from a PCP participating in our PIP program.

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

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

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

MEASURE DETAILS

Product lines	Target / payout	Eligible population
• Commercial • ACA • Medicare • Medicaid	$TBD per eligible claim	Patients 12 years of age and older with at least three BHCC services billed and adjudicated in the calendar year.
Payout frequency	**Level of measurement**	**Collecting & reporting method**
Annual (June 2027)	ACN	Claims data only. No supplemental data accepted.

NOTES

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

RESOURCES

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

Data Quality Collaborative incentive

To ensure our PIP reporting accurately reflects data ingestion, we've introduced this new incentive aimed at clearer care gap reporting and data feed improvements. Your participation in this initiative will allow us to more effectively pinpoint areas where data ingestion processes may benefit from improvement, ultimately driving more reliable and actionable reporting.

ACNs must meet the following requirements to be eligible:

- Must attest to PIP participation for providers within our PRA tool.
- Participate in 2 out of 4 offered meetings with Priority Health data analysts.
- Send three to five care gaps quarterly to our HEDIS team to be assessed (process outlined in the notes section below). These should include gaps in care where data has been sent to Priority Health, but the gap is still showing as open in our PIP reporting. **Note: allow 60 days from the time the data is submitted to Priority Health to see the gap reflected as closed within the reporting.**
- Adhere to our supplemental data submission deadlines: Nov.1, 2026 for dates of service between Jan. 1 – June 30, 2026, and Jan. 31, 2027, for dates of service between July 1 – Dec. 31, 2026.

INCENTIVE DETAILS

Product lines	**Payout**	**Collection & reporting method**
• Commercial • ACA • Medicare • Medicaid	$5,000 per ACN	Secure SharePoint folder (see Notes section for details)
Payout frequency	**Level of measurement**	
Annual (June 2027)	ACN	

NOTES

To submit your gaps in care, please follow the following process:

1. Access your ACN's Priority Health supplemental data SharePoint folder, or request for one to be set up for you.
2. Locate the "Data Quality Collaborative" folder and drop your files into the appropriate folder for the quarter (i.e., the "Quarter 1" folder would house the examples you're submitting for dates of service from Jan. 1 – Mar. 31).

You'll receive an email from *HEDIS@priorityhealth.com* with Priority Health's findings and any action requested to improve the supplemental data process.

03

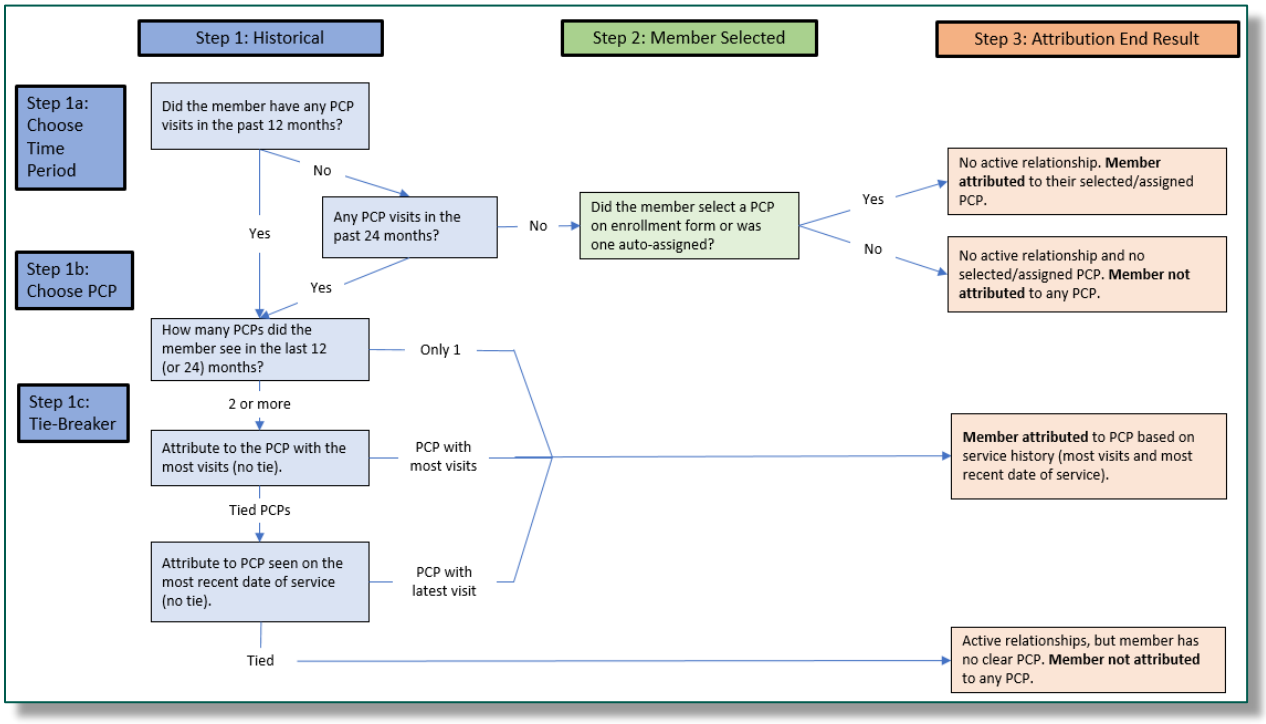
Appendices

APPENDIX 1: MEMBER ATTRIBUTION

How Priority Health's member attribution model works

We're committed to providing a medical home for all our members, for all products. Our member attribution model is primarily based on utilization to ensure that members enrolled in all health plans may be included in our PIP program. The member attribution model is updated monthly and is run on the 1st business day of the month.

Note: If a member is newly assigned and / or attributed on or after Nov. 1, 2026, they won't be included in any measure denominator.



Description of our value-based programs attribution process

Step 1a: Historical 12 months

A review of claims is completed to identify if a member has had a visit with a PCP in the past 12 months. If claims are found, the patient is attributed to the PCP identified on the claims unless the member saw more than one PCP during the 12-month period. In this case, see Step 1c.

Step 1b: Historical 24 months

If no PCP claims are found in the past 12 months, a review of claims is completed for the past 24 months. If claims are found, the patient is attributed to the PCP identified on the claims unless the member saw more than one PCP during the 24-month period. In this case, see Step 1c.

Step 1c: Historical tiebreaker

If a member sees more than one PCP during a 12-month or 24-month period, then claims are reviewed for the PCP with the greatest number of visits for that member

(attribute the member to the PCP) or, if there's a tie in the number of PCP visits between the two PCPs, attribute the member to the PCP with the most recent visit.

Step 2: Assignment/member declared

There are three ways a member is matched to a PCP:

1. Member selected upon enrollment in a Priority Health plan, or
2. Assigned upon enrollment in a Priority Health plan, or
3. Attributed based on claims history. Attribution will override assigned or member-selected PCP.

Step 3: End result of attribution

The ways in which a member is attributed to a PCP by Priority Health:

- Attribution based on claims
- Member-selected; confirmed through attribution
- Member-selected/assigned (without claims history)

Some members won't be attributed to a PCP:

- Enrolled in a PPO plan with no claims history and no PCP selected
- A tie in claims for two or more PCPs with the same number of services and the same most recent date of service

Variables included in our member attribution model

PCP: We define a primary care physician (PCP) as one of the following: Internal Medicine, Pediatrics, Internal Medicine/Pediatrics, Family Medicine, General Practice, Geriatric Medicine or OB/GYN when credentialed as a PCP.

POS: Place of Service (POS) is the location in which a member receives a service from a provider. The POS codes considered in the attribution model include:

POS code	POS description
2	Virtual services performed with a patient who's in a location other than their own home
3	School
4	Homeless Shelter
5	Indian Health Service Free-standing Facility
6	Indian Health Service Provider-based Facility
7	Tribal 638 Free-standing Facility
8	Tribal 638 Provided-based Facility
10	Virtual services performed with a patient who's in their own home
11	Office
12	Home
19	Off Campus-Outpatient Hospital
22	On Campus-Outpatient Hospital
50	Federally Qualified Health Center
71	Public Health Clinic
72	Rural Health Clinic
OV	Office Visit

Office visits: The set of procedure codes indicating a PCP visit on which attribution is made

CPT					HCPCS
99201	99245	99384	99403	99494	G0402
99202	99341	99385	99404	99495	G0406
99203	99342	99386	99441	99496	G0407
99204	99343	99387	99442		G0408
99205	99344	99391	99443		G0438
99212	99345	99392	99444		G0439
99213	99347	99393	99484		G0463
99214	99348	99394	99487		G0511
99215	99349	99395	99488		G0512
99241	99350	99396	99489		G2214
99242	99381	99397	99490		G9001
99243	99382	99401	99392		G9002
99244	99383	99402	99493		T1015

Revenue center codes: Used to identify office visits for members receiving care from a Federally Qualified Health Center (FQHC), Rural Health Center (RHC) or Tribal Health Center (THC). The revenue center codes considered in our attribution model are:

Revenue center code	Description
0500	Outpatient services-general classification
0509	Outpatient services-other
0510	Clinic-general classification
0514	Clinic-OB-GYN
0517	Clinic-family practice clinic
0519	Clinic-other
0520	Free-standing clinic-general classification
0521	Free-standing clinic-Clinic visit by a member to RHC/FQHC
0522	Free-standing clinic-family practice
0523	Free-standing clinic-family practice
0524	Free-standing clinic - visit by RHC/FQHC practitioner to a member in a covered Part A stay at the SNF
0525	Free-standing clinic - visit by RHC/FQHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility
0529	Free-standing clinic-other

APPENDIX 2: GUIDELINES FOR REPORTING GAP CLOSURE

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

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

1. Electronic health record (EHR)
2. Health information exchange (HIE) / clinical registry
3. Administrative (claims which include CPT II codes)
4. Medical record review using the HEDIS fax / email / SharePoint / mail with accompanying medical record, which should be used when there is no electronic option to share the data (see page 14 of this manual for details).

Data audits

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

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

Audit process

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

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

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

Primary Source Validation (PSV)

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

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

Electronic Clinical Data Systems (ECDS)

Priority Health has a data quality audit program that audits both traditional and ECDS measures. The data quality program selects a combination of members and measures per data source. Data points sent to us per data source are validated against the medical record to ensure the data is accurate.

For more information, refer to our HEDIS ECDS Provider Guide.

Audit findings

Failure to return medical record documentation by the deadline will result in a 50% penalty for the program year's PIP payout. If the data points don't match the record, Priority Health will inform the provider of the errors and work with them to resolve the issue. Once resolved, the changes will be reviewed in the subsequent data run. If the errors remain unresolved, the data points will be removed from the HEDIS and PIP databases and a 10% penalty will be imposed specific to that measure at settlement.

Egregious errors may result in additional sanctions against the ACN.

We're here to help

Do you need support transitioning to the data sources listed here? Our teams are here to help. **Contact your ACN's Provider Network Management Consultant to get started.**

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

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

APPENDIX 3: GLOSSARY OF TERMS

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

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

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

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

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

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

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

Electronic Clinical Data Systems (ECDS)
The National Committee for Quality Assurance (NCQA) defines Electronic Clinical Data Systems (ECDS) as a network of data containing a plan member's personal health information and records of their experiences within the health care system. The HEDIS ECDS Reporting Standard provides health plans a method to collect and report structured electronic clinical data for HEDIS quality measurement and quality improvement. For more information, refer to our HEDIS ECDS Provider Guide.

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

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

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

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

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

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

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

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

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

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

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

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

PCM
Per compliant member.

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

Provider Roster Application (PRA)
A tool where ACNs actively manage contracted PCP information simply and effectively for their participation in our value-based programs. This includes our PCP Incentive Program (PIP), Disease Burden Management program and Advanced Payment Model (APM) risk arrangements.