Summit Health

Medicare Advantage Primary Care Incentive Program (MAPCIP)

Program Guidelines and Structure

Plan Year 2024

Provider Eligibility & Payment

To be eligible for participation in the MAPCIP program, providers will:

- Be certified by the Oregon Health Authority as a PCPCH Tier 1-5.
- Perform one of the three required data submission activities. Further details are included below.
- Have a Medicare Advantage contract through **Summit Health** that is active and in good standing at the time incentives are disbursed. Note: “Good standing” includes participating in required compliance or Quality Program activities (e.g., timely submission of requested medical records for HEDIS risk adjustment reviews). If we receive any notification of a provider group's intent to terminate the agreement, that provider group will be ineligible to receive any incentive payment.

Incentive Categories

The Medicare Advantage Primary Care Incentive Program (MAPCIP) payment components include:

- **Care Gap Incentive Payment (CGIP)** - performance based payment made to Provider, based on annual performance on quality measures, patient experience of care measures and/or utilization measures, as further defined below.

- **Access to Care Incentive Payment (ACIP**) - performance based payment made to Provider, based on annual performance of MAPCIP members having completed an annual physical and/or annual wellness visit during the Settlement Period, as further defined below.

- **PCPCH Capitation** - a risk stratified per member-per month capitation-based payment made to Provider based on the PCPCH tier designation by the Oregon Health Authority (OHA) and published on the OHA website.

Additional MAPCIP payment principles may be added in subsequent program years.

Member Eligibility and Attribution

Summit Health eligible members who select or are attributed to a Participating MAPCIP Provider as their primary care provider will be automatically included in the MAPCIP program.

Membership for Medicare Advantage Care Gap Incentive Payments-

Participating primary care providers will be paid incentives for providing care for MAPCIP members. Calculations for attributed members will be based on Summit Health defined attribution methodologies. Details on our attribution methodology are available upon request.

Payment Model Specifications

1. Patient Centered Primary Care Home (PCPCH) Capitation Payments

Primary care practices will be eligible for a Patient Centered Primary Care Home payment based on the practice's PCPCH tier designation by the Oregon Health Authority (OHA) and published on the OHA website.

The PCPCH payments are intended to support clinic efforts in achieving the incentive program targets noted below and to account for the additional administrative complexities inherent within a Medicare Advantage program such as responding to medical record requests for purposes of completing risk adjustment reviews for Summit Health Members.

Practices will receive higher capitation rates for members with a higher health risk score, as calculated by the Optum Symmetry risk score calculator.

Capitation rates for each risk quartile are shown in the table below. Quartile 1 represents members with the lowest health risk, and quartile 4 represents members with the highest health risk.

Risk Quartile	PCPCH Tier 1	PCPCH Tier 2	PCPCH Tier 3	PCPCH Tier 4	PCPCH Tier 5
1	$0.00	$0.00	$1.50	$3.50	$5.50
2	$0.00	$0.00	$2.25	$5.25	$8.25
3	$0.00	$0.00	$3.75	$8.75	$13.75
4	$0.00	$0.00	$4.50	$10.50	$16.50

Such payments shall be calculated as of the Member's enrollment on the 15th day of the month, with payments remitted to Provider at the end of each calendar month. Tier changes must be published on the OHA website by the 15th of the month. Changes after the 15th of the month will be updated for the next month's payment.

2. Care Gap Incentive Payment (CGIP)

Summit Health shall pay a Care Gap Incentive Payment (CGIP) to Provider to reward performance for quality care. The incentive will be based on the total number of members who meet the numerator criteria for each of the quality measures below (all numerators summed together), divided by the total number of members in the denominators (all denominators summed together). This calculation shall be the 'Gap Closure Percentage'. Measurement will be based on a calendar year, beginning with January 1, 2024. Summit Health will provide a quality measure reporting package, including attributed members, identified care gaps and progress toward gap closure.

For each Settlement Period, the participating primary care provider will be held accountable to members attributed to them for at least nine months during the Settlement Period. If a gap is closed by a provider who is not a member's attributed provider, gap closure credit goes to the attributed provider no matter who closed the gap.

The quality measures set is as follows:

Quality Measure	Measure Requires Clinical Data
Breast Cancer Screening (BCS)	N
Colorectal Cancer Screening (COL)	Y
Controlling High Blood Pressure (CBP)	Y
Diabetes care – HbA1c poor control (>=9)	Y
Statin Therapy for Patients with Diabetes - Received Therapy	N
Statin Therapy for Patients with Cardiovascular Disease (SPC) - Received Therapy	N
Transitions of Care – Patient Engagement after Inpatient Discharge (TRC-Patient Engagement within 30 days)	N

The quality measures in the table above follow the Healthcare Effectiveness Data and Information Set (HEDIS) Technical Specifications. Quality measures with historic lookback periods may be met by submitting data through the defined Provider Data Exchange (PDE), Arcadia population health management tool, Novillus Care Gap Management Application (CGMA), and/or supplemental data file source as defined by Summit Health.

The CGIP amount per member will be based upon total Gap Closure Percentage at the end of each calendar year for all measures.

	Gap closure %		
Incentive level	Greater than or equal to…	But less than…	PMPM Bonus
1		65%	$0.00
2	65%	75%	$4.00
3	75%	85%	$8.00
4	85%	N/A	$20.00

3. Access to Care Incentive Payment (ACIP)

Provider may earn an incentive of $100 to $200 per member for annual Access to Care services. We ask providers to perform a comprehensive assessment of all active and chronic health conditions and submit a claim with all diagnosis codes impacting patient condition complexity to inform the best quality care and services to our members.

Visit types closing this gap include annual physical exams, initial preventive physical examination (IPPE or "Welcome to Medicare" visit), Annual Wellness Visit (AWV) initial or subsequent. Annual physical and wellness visit codes include the following:

G0402, G0438, G0439, G0468, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397

Incentive Amount	Benchmark to Earn Incentive
$200.00 per Member	Member has an annual physical and/or annual wellness visit with any of the above codes by 6/30 of the measurement period.
$100.00 per Member	Member has an annual physical and/or annual wellness visit with any of the above codes between 7/1 and 12/31 of the measurement period.

Participating primary care providers can earn the ACIP for any eligible Summit Medicare member, regardless of attribution status. The ACIP can only be earned once per member per calendar year, and only the first provider to conduct the AWV during the calendar year will receive the ACIP.

Summit Health Medicare Advantage members have a Welcome to Medicare visit, AWV, and Annual Physical Exam covered at no cost once per calendar year. Summit Medicare plans do not require a wait

of 11 months between visits. A Welcome to Medicare visit or AWV can be completed at the same visit as a Physical Exam.

Data Sharing Options for Eligibility

Provider will be inferred as participating in the MAPCIP programs when one of the following actions is undertaken:

- Connection with Summit Health Provider Data Exchange (PDE) or Arcadia Analytics, where clinical data files extracted from EHR are transferred monthly. Please contact ValueBasedDataSharing@modahealth.com for instructions on connecting with the Provider Data Exchange as well as the current file layout details.
- Submission of clinical quality measure data through other methods, as approved in advance by Summit Health
- Utilization of Care Gap Management Application (CGMA) by Novillus

Provider shall comply with requests to share clinical, quality, EMR and other data to facilitate care coordination. Information that will be shared may include, but is not limited to, medical records, investigation of complaints, utilization review, quality assessment, preventive health care, outcome studies and data collection from monitoring and evaluation of health care service and delivery for MAPCIP members. Data sharing will be handled in accordance with all federal and state requirements regarding security for personal health information, pricing, and other confidential business information.

Accurate coding of member conditions on claims and documentation within medical records is imperative to ensure appropriate funding from CMS to account for individual member risk based on their medical conditions. Periodically, medical records will be requested for patients seen in Provider's office to perform risk adjustment reviews to confirm documented member conditions. Providers participating in the MAPCIP program shall timely respond to medical record requests from Summit Health for risk adjustment reviews or provide remote EMR access to Summit Health staff.

Term and Payment

The program period will be the calendar year 2024. The CGIP and ACIP amounts will be calculated three months after the Settlement Period ends to allow for claims run-out. Payments will be made by June 30 of each year for the prior year's Settlement Period.

Reporting

Summit Health will provide a reporting package to assist Participating Providers in managing MAPCIP members' care. Participating Provider will identify and provide to Summit Health point(s) of contact for delivery of the reporting package and are required to notify Summit Health of any modifications to reporting point(s) of contact or point(s) of contact information. Participating Provider will make best efforts to use Summit Health's electronic report delivery system and to access reports electronically where possible.

If clinics report monthly or quarterly to Summit Health, the data can be included in the provider reporting package to track measure performance. This includes data files, direct EHR access, or HIE connector.

Program Changes

Summit Health retains the right to make program changes with 30-day notice.

Example Calculations

CGIP Calculation Example:

A provider has 49 attributed Medicare members and submits data through an approved method. Performance on the quality measure set is as follows:

Quality Measure	Reported Rate	Numerator	Denominator
Breast Cancer Screening (BCS)	78%	18	23
Colorectal Cancer Screening (COL)	75%	6	8
Controlling High Blood Pressure (CBP)	57%	4	7
Diabetes care – HbA1c poor control (>=9)	67%	4	6
Statin Therapy for Patients with Diabetes - Received Therapy	67%	4	6
Statin Therapy for Patients with Cardiovascular Disease (SPC) - Received Therapy	80%	8	10
Transitions of Care – Patient Engagement after Inpatient Discharge (TRC-Patient Engagement within 30	80%	4	5
Total	73.8%	45	65

Following the chart above, 73.8% gap closure % equates to a $4 PMPM bonus. Assuming the provider had all 49 members assigned for a full 12 months they would be awarded a payment based on the following calculation:

49 members * $4 PMPM * 12 months = $2,352 bonus

ACIP Calculation Example:

A provider has 49 attributed Medicare members and performed comprehensive annual physicals throughout the year for 45 unique members. Performance on the access to care measure set is as follows:

Qualifying Service Rendered	**Member Count**	**Incentive Rate**	**Incentive Total**
January 1 – June 30	35	$200	$7,000
July 1 – December 31	10	$100	$1,000
Total	**45**		**$8,000**

The provider receives an incentive based on the first qualifying service rendered per unique member.