PCMH Program Policy Addendum

2020

Arkansas Medicaid

Arkansas Department of Human Services

Division of Medical Services

Change History

Description of Change	Date of Change
Added reconsideration period for Performance-Based Incentive Payment (PBIP) and Focus Measures to be performed during the Q2 2021 performance period. (237.000)	1/13/2020
Clarified Controlling High Blood Pressure metric denominator description, Oral Antibiotic Prescriptions metric numerator and denominator descriptions, and Care Category dental claim suppression, and Care Categories report generation (243.000)	2/24/2020
Deadline for Practice Support Activity A extended to 4/30/2020 (241.000)	3/20/2020
Deadline for Practice Support Activities B-G extended to 12/31/2020 (241.000)	5/14/2020
Updated Technical Specification for HIV Viral Load Informational Metric to clarify that denominator includes beneficiaries with an HIV diagnosis attributed in either the performance year or the year prior (243.000)	7/22/2020
Updated wording of sections 235.000 and 237.000 regarding calculations of PBIP payments	10/6/2020
Updated wording of section 237.000 to clarify that PBIP Payment amounts will be adjusted if total payouts exceed amount allocated to Medicaid	4/28/2021

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223.000 Explanation of Care Coordination Payments

Determination of Beneficiary Risk

- A Risk Utilization Band (RUB) score is calculated for all of the participating practices' 6-month attributed beneficiaries at the end of the preceding calendar year using the Johns Hopkins ACG® Grouper System, a tool for performing risk measurement and case mix categorization (http://acg.jhsph.org).
- For 6-month attributed beneficiaries with no claims history[1], a RUB score of 0 is assigned.

Per Beneficiary Per Month (PBPM) Amounts

- A per beneficiary per month (PBPM) amount is assigned based upon each beneficiary's RUB score in the table below.

RUB Score	PBPM Amount
0	$1
1	$1
2	$3
3	$5
4	$10
5	$30

- For attributed beneficiaries with fewer than 6 months of PCCM claims history (for whom no RUB is assigned), which is point-in-time attributed (PITA) beneficiaries, the PBPM amount will be equal to that of the average PBPM amount for that beneficiary's demographic cohort (based on age and sex).

[1] This will be based on the most recent inpatient, outpatient, and home health medical claims available.

- The care coordination payment for each practice equals the average of the PBPM amount for the practice's PITA beneficiaries multiplied by the practice's number of PITA beneficiaries.

232.000 Performance Based Incentive Payment (PBIP) Eligibility

PBIP Beneficiary Exclusions

- At this time, there are no changes to the definitions of those beneficiaries not counted toward the required 1,000 attributed beneficiaries. The requirement remains as currently defined in the 2019-2020 PCMH Provider Manual.

235.000 Performance Based Incentive Payment Methodology — Exclusions from the Calculation of Emergency Department Utilization and Acute Hospital Utilization

Emergency Department Utilization (EDU) — HEDIS[2] Exclusions

1. Emergency Department visits that result in an inpatient stay
2. A principal diagnosis of mental health or chemical dependency
3. Psychiatry
4. Electroconvulsive therapy
5. Hospice beneficiaries

Acute Hospital Utilization (AHU) — HEDIS Exclusions

1. Nonacute inpatient stay
2. A principal diagnosis of mental health or chemical dependency
3. A principal diagnosis of live-born infant
4. A maternity-related principal diagnosis
5. A maternity-related stay
6. Inpatient or observation stays with a discharge for death
7. Hospice beneficiaries

PCMH Program-specific Exclusions

1. Newborn Intensive Care Unit (NICU) stay
2. Provider types excluded from total cost of care
3. Medically Frail beneficiaries
4. Physician excluded beneficiaries
5. Unknown gender

[2] The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA). https://www.ncqa.org/hedis/measures/

236.000 Incentive Focus Metric

Metric #	Metric Name	Description	Minimum Attributed Beneficiaries
4	Adolescent Well-Care Visits	Percentage of beneficiaries 12-20 years of age who had one or more well-care visits during the measurement year	≥ 25

*Percentile of performance and incentive bonus

237.000 Performance Based Incentive Payment Amounts

Percentile of performance and incentive bonus[3]

- Acute Hospital Utilization (AHU)
    - Shared Performance Entities that are in the top 10th Percentile for lowest inpatient AHU rates can receive up to $12 times the number of attributed member months.
    - Shared Performance Entities that fall within the top 11th to 35th percentiles for lowest inpatient AHU rates can receive up to $6 times the number of attributed member months.
- Emergency Department Utilization (EDU)
    - Shared Performance Entities that are in the top 10th percentile for lowest EDU rates can receive up to $8 times the number of attributed member months.
    - Shared Performance Entities that fall between the top 11th to 35th percentiles for lowest EDU rates can receive up to $4 times the number of attributed member months.
- Focus Metric
    - Shared Performance Entities that are in the top 10th percentile for highest Focus Metric rates can receive up to $5 times the number of attributed member months.
    - Shared Performance Entities that fall within the top 11th to 35th percentiles for highest Focus Metric rates can receive up to $2.50 times the number of attributed member months.

Reconsideration for Performance-Based Incentive Payment (PBIP) and Focus Measures will be performed during Q3 of the 2021 performance period. The Q2 2021 quarterly report will identify providers' current standing and a special PHMR will identify those beneficiaries and events counted in these three measures. Requests for reconsideration on these measures will be accepted after Q2 2021 reports are posted to the PCMH Provider Portal, and such reconsideration requests must follow the guidance in the 2019-20 PCMH Provider Manual. (Sections 235.000, 236.000, 244.000)

[3] The total of Performance Based Incentive Payment (PBIP) amounts must not exceed Medicaid's allotted dollar amount for total payout. If the total of PBIP amounts exceed Medicaid's allotted dollar amount for total payout, all PBIP amounts will be adjusted accordingly.

241.000 Activities Tracked for Practice Support

Activities for the 2020 Performance Period

- All PCMHs must meet all activities by the following deadlines in order to be eligible for practice support:
- 3-month activities by 3/31/2020 – Note: Because of disruptions related to the COVID-19 pandemic, this deadline has been extended to 4/30/2020
- 6-month activities by 6/30/2020 – Note: Because of disruptions related to the COVID-19 pandemic, these deadlines have been extended to 12/31/2020
- 12-month activities by 12/31/2020
- For information on remediation, please refer to the 2019-2020 PCMH Provider Manual.

Activity	3-Month	6-Month	12-Month
A. Identify top 10% of high-priority patients	✓		
B. Make available 24/7 access to care.		✓	
C. Track same-day appointment requests.		✓	
D. Capacity to receive direct e-messaging from patients.		✓	
E. Childhood / Adult Vaccination Practice Strategy.		✓	
F. Join SHARE or participate in a network that delivers hospital discharge information to practice within 48 hours.		✓	

G. Medication Management		✓	
H. Care Plans for High Priority Patients			✓
I. Patient Literacy Assessment Tool			✓
J. Ability to receive patient feedback			✓
K. Care instructions for High Priority Patients			✓
L. 10-day Follow up after an Acute Inpatient Stay			✓
M. Developmental / Behavior Health Assessment for Children and Adolescents			✓

Details on Activities Tracked for Practice Support

Activity A: Identify top 10% of high-priority patients

Activity A Deadline: 3/31/2020 – Extended to 4/30/2020
1. Perform this by using: a. DMS patient panel data that ranks patients by risk at beginning of performance period; and/or, b. The practice's patient-centered assessment to determine which patients are high-priority. 2. Submit this list to DMS via the provider portal.

Activity B: Make available 24/7 access to care

Activity B Deadline: 6/30/2020 – Extended to 12/31/2020

1. Provide telephone access to a live voice (e.g., an employee of the primary care physician or an answering service) or to an answering machine that immediately pages an on-call medical professional 24 hours per day, 7 days per week.
    a. When employing an answering machine with recorded instructions for after-hours callers, PCPs should regularly check to ensure that the machine functions correctly and that the instructions are up to date.
    b. The on-call professional must:
        i. Provide information and instructions for treating emergency and non-emergency conditions,
        ii. Make appropriate referrals for non-emergency services, and
        iii. Provide information regarding accessing other services and handling medical problems during hours the PCP's office is closed.
2. Response to non-emergency after-hours calls must occur within 30 minutes. A call must be treated as an emergency if made under circumstances where a prudent layperson with an average knowledge of health care would reasonably believe that treatment is immediately necessary to prevent death or serious health impairment.
    a. PCPs must make the after-hours telephone number known by all patients; posting the after-hours number on all public entries to each site; and including the after-hours number on answering machine greetings.
3. Practices are to document completion of this activity via the provider portal, and attest that the described activity has been completed and that proper evidence of such can be provided upon request.

Activity C: Track same-day appointment requests

Activity C Deadline: 6/30/2020 – Extended to 12/31/2020
1. Perform this by: a. Using a tool to measure and monitor same-day appointment requests on a daily basis b. Recording fulfillment of same-day appointment requests 2. Provide a description of the tool used to track same-day appointment requests. 3. Practices are to document completion of this activity via the provider portal and attest that the described activity has been completed and that proper evidence of such can be provided upon request.

Activity D: Capacity to receive direct e-messaging from patients

Activity D Deadline: 6/30/2020 – Extended to 12/31/2020
1. Indicate if the practice has the capacity to use electronic messaging to communicate with patients. a. Indicate if the practice currently uses e-messaging and describe the method used. b. Indicate if the messaging system is secure. c. Indicate if the messaging system meets HIPAA guidelines. 2. If the practice does not use e-messaging, indicate if a plan has been developed to implement the use of e-messaging. 3. Practices are to document completion of this activity via the provider portal and attest that the described activity has been completed and that proper evidence of such can be provided upon request.

Activity E: Childhood/Adult Vaccination Practice Strategy

Activity E Deadline: 6/30/2020 – Extended to 12/31/2020
1. Indicate and describe the practice's implemented process to deliver immunization to both the pediatric and adult population leading into administration of immunization for the upcoming year. a. Indicate if there is an implemented process to identify vaccination gaps in care for both the pediatric and adult population. b. Indicate the ability to document historic immunization data into an EHR and review on each visit. c. Indicate the capability to submit data electronically to immunization registries or immunization information systems. 2. Practices are to document completion of this activity via the provider portal and attest that the described activity has been completed and that proper evidence of such can be provided upon request.

Activity F: Join SHARE or participate in a network that delivers hospital discharge information to practice within 48 hours

Activity F Deadline: 6/30/2020 – Extended to 12/31/2020
1. Indicate if the practice has joined SHARE. a. Indicate the ability to access inpatient discharge information via SHARE. b. Indicate the ability to access patient transfer information via SHARE. 2. If the practice has not joined SHARE, indicate if the practice participates in a network that delivers hospital discharge information to the practices within 48 hours of discharge.

Activity F Deadline: 6/30/2020 – Extended to 12/31/2020
3. Practices are to document completion of this activity via the provider portal and attest that the described activity has been completed and that proper evidence of such can be provided upon request.

Activity G: Medication Management

Activity G Deadline: 6/30/2020 – Extended to 12/31/2020
1. Define the practice's medication reconciliation process. For High Priority Beneficiaries, document updates to the active medication list in the EHR at least twice a year. a. Indicate if the medication list is updated on a timely basis from the last visit. b. Submit a short synopsis of the medication reconciliation process via the provider portal. 2. Practices are to document completion of this activity via the provider portal and attest that the described activity has been completed and that proper evidence of such can be provided upon request.

Activity H: Care Plans for High Priority Patients

Activity H Deadline: 12/31/2020
• At least 80% of high-priority patients have care plans and/or notes contained in the medical record that include the following elements: • Documentation of the patient's appropriate problem list • The problem list should include any active, significant clinical condition (chronic and/or acute)

Activity H Deadline: 12/31/2020
• Each visit related encounter should include a list of current problems (chronic and/or acute) • Assessment of progress to date • Documentation and assessment of each problem (stability or change of condition) • Each problem noted in the problem list must have an assessment as well as a status of the problem/diagnosis in the plan or in the note. For example, “diabetes well controlled based on HbA1c 6.7 and per patient’s compliance with prescribed medication” is sufficient. • If a problem noted in the problem list is no longer an active problem, a status such as “resolved” should be indicated. • If a specialist follows the patient, the most recent findings should be documented, if available. • Plan of Care • The documentation should include a specific plan of care related to the problem. For example, “continue Lisinopril 5mg daily”, “ordering labs”, “referral to OT/PT for evaluation and treatment”, “continue therapy sessions”, “prescribed Vyvanse 30 mg daily”, are acceptable. • Instruction for follow-up • The documentation should include the timing of future follow-up visits (related to the problem) • If multiples problems are addressed, a single clearly defined future visit (return to clinic date) is acceptable. For example, “return to office in 6 months” is acceptable; “return if no improvement or as needed” is not acceptable. • If problems/conditions are followed by a specialist, the timing of the follow up visit with the specialists should be noted. For example, “follow up with endocrinologist in 6 months” is acceptable; “follow up with endocrinologist” is not acceptable. • A minimum of two care plans should be completed within a 12-month period and submitted for validation review. • Documented update to the plan of care which would include active problems • For new patients: initial care plan and one update (in person or phone call)

Activity H Deadline: 12/31/2020
• For established patients: one care plan update must be completed by a face-to-face visit and one update may be completed via a phone call. • Addendums to the care plans are acceptable if completed within a reasonable period of no more than two weeks after the care plan has been created or updated. • Indicate if at least 80% of the top 10% of high-priority patients have a first and second care plan in the medical record. Each attested care plan includes all required elements listed in number 1. • For validation audit, 20% of the top 10% of high-priority patients with a first and second care plan, will be randomly selected for review of care plans. To pass this activity, at least 80% of the care plans must include all the required elements listed in number 1. • PCMHs that successfully pass two consecutive years of care plan validation audits without going into remediation will be eligible for a "Fast Track" audit. • The Fast Track audit includes: • Sample audit of five care plans • Sample audits will be conducted at the same time as regular care plan validation audits and for the same performance period • The PCMH must successfully pass the audit with at least an 80% total score • The scoring methodology will remain the same for the sample audit • If the practice passes the Fast Track audit, no further care plan audit will be required for the performance period. • If a practice fails the sample Fast Track audit, care plan validation will revert to the standard audit process and the PCMH will be required to submit the full 20% of care plans randomly selected for high-priority patients with a first and second care plan. • If the PCMH passes the secondary audit, the PCMH will remain in good standing and will be eligible for the Fast Track audit in the upcoming performance period.

Activity H Deadline: 12/31/2020

- If the PCMH does not meet the 80% target for the secondary audit, the PCMH will be required to follow the remediation process as stated in Section 242.000 of the 2019-2020 PCMH Provider Manual and will not be eligible for the Fast Track audit for the upcoming year.
- Scoring methodology:
- Each element of the care plan will be scored accordingly, with a total of eight possible points per High Priority Patient (HPP). The scoring methodology is the same for a regular care plan audit and a Fast Track audit.

Care Plan Element	Point Value (Care Plan 1)	Point Value (Care Plan 2)	Total Possible Points per HPP
Problem list	1	1	2
Assessment of problems	1	1	2
Plan of Care	1	1	2
Instruction for follow up	1	1	2
Total possible points per HPP	4	4	8

- Practices are to document completion of this activity via the provider portal and attest that the described activity has been completed and that proper evidence of such can be provided upon request.

Activity I: Patient Literacy Assessment Tool

Activity I Deadline: 12/31/2020
• Choose any health literacy tool and administer the screening to at least 75 beneficiaries (enrolled in the PCMH program) or their caregivers. Returning practices should select 75 beneficiaries that have not had a health literacy screening. • A list of health literacy tools suggested by the UAMS Center for Health Literacy may be obtained from the PCMHs AFMC Outreach Specialists. • Provide an example of the tool used to assess health literacy. • Provide a description of the overall results of the assessment. • Develop and describe a plan to help low health literacy beneficiaries to understand instructions and education materials. • Practices are to document completion of this activity via the provider portal and attest that the described activity has been completed and that proper evidence of such can be provided upon request.

Activity J: Ability to Receive Patient Feedback

Activity J Deadline: 12/31/2020
1. Indicate if the practice has implemented a process to obtain feedback from the patients. a. Describe: i. The method used to obtain feedback from patients (surveys, suggestion box, advisory council, etc.) ii. Who in the practice reviews the feedback

Activity J Deadline: 12/31/2020

iii. The capacity in which the feedback shared with other within the practice (staff, providers)

iv. How the feedback is used to make improvements in the practice

2. Practices are to document completion of this activity via the provider portal and attest that the described activity has been completed and that proper evidence of such can be provided upon request.

Activity K: Care Instructions for High Priority Patients

Activity K Deadline: 12/31/2020

1. Compile relevant and actionable information including: diagnosis, medication list, tests and results (if available), referral information (if applicable), and follow up instructions.
2. Create an after-visit summary of the information from patient's last visit.
3. The patient will receive a copy of the after-visit summary based on the patient's preferred method of delivery. Methods by which a patient may choose to receive their after-visit summary include the following:
    a. The patient will either receive a paper copy of the summary after their visit, prior to leaving the clinic.
    b. A copy of the summary will be mailed to the patient at the address listed in the record within three days of the visit, or completion of any lab test related to the visit
    c. An electronic copy of the summary will be made available to the patient via a patient portal
4. Practices are to document completion of this activity via the provider portal and attest that the described activity has been completed and that proper evidence of such can be provided upon request.

Activity L: 10-day Follow up after an Acute Inpatient Stay

Activity L Deadline: 12/31/2020
1. Attest that at least 40% of beneficiaries with an inpatient stay have had an in-person follow-up visit or a follow-up phone call with any provider within 10 business days of discharge but during the performance period being measured. a. Indicate if the practice has a written policy or process for monitoring follow-up visits/ phone calls within 10 business days of an inpatient stay. The practice will be able to produce documentation of an in-person follow-up visit or a follow-up phone call. b. Validation of this activity will occur by random selection of documentation from beneficiaries with an inpatient stay within the performance period. To pass this activity at least 40% of the selected documentation for review must include proof of an in-person follow-up visit or a follow-up phone call. 2. Practices are to document completion of this activity via the provider portal and attest that the described activity has been completed and that proper evidence of such can be provided upon request.

Activity M: Developmental/Behavior Health Assessment for Children and Adolescents

Activity M Deadline: 12/31/2020
1. Indicate and describe the practice's process to assess children and adolescents for developmental and behavioral health disorders. 2. Indicate the frequency of assessing children and adolescents for developmental and behavioral health disorders. 3. Indicate if a standardized developmental assessment tool is used by the practice. a. If a tool is used, indicate what type is used and how it is used to develop a plan of treatment. 4. If referrals are made for treatment outside of the practice, indicate if a mechanism is used to track progress.

Activity M Deadline: 12/31/2020
5. PCMHs may choose any developmental and behavior health assessment tool to administer to children and adolescent beneficiaries. a. The following links offer information and examples of tools to assist with implementing developmental and behavior health assessments: i. Centers for Disease Control and Prevention – Child Development: Development Monitoring and Screening: https://www.cdc.gov/ncbddd/childdevelopment/screening.html ii. American Academy of Pediatrics – Bright Futures: https://brightfutures.aap.org/materials-and-tools/tool-and-resource-kit/Pages/Developmental-Behavioral-Psychosocial-Screening-and-Assessment-Forms.aspx 6. Practices are to document completion of this activity via the provider portal and attest that the described activity has been completed and that proper evidence of such can be provided upon request.

Low Performance Core Metrics for the 2020 Performance Period

DMS will assess the following metrics for practice support starting on the first day of the performance period in which the practice is enrolled in the PCMH program, through the full calendar year (January through December). To be eligible for continued practice support, PCMHs must meet the target rate stated below. If a PCMH fails to achieve the stated target rate for the metric, then the PCMH must remediate performance to avoid suspension or termination of practice support. If the PCMH's denominator for a particular metric is less than the 25 minimum attributed beneficiaries, then the PCMH will not be considered for remediation due to this metric. If all of a PCMH's core-metrics denominators are less than the 25 minimum attributed beneficiaries, then the PCMH will not be considered for remediation at all (i.e. not penalized at all).

Metric	Description	Target Rate	Condition for Remediation	Minimum Attributed Beneficiaries
Core Metric 1: Well-Child Visits in the First 15 Months of Life (0 to 1 visit) (Low Performance) *Claims-based	The purpose of the well-child visits core metric is to identify low performers of infant wellness visits. The metric measures the percentage of beneficiaries who turned 15 months old during the performance period who only received zero to one wellness visit in their first 15 months (0 – 15 months)	15% or less of the patient panel, ages 0-15 months, having zero to one wellness visit	A PCMH will be placed in remediation for Core Metric 1 (Well-Child Visits in the First 15 Months of Life) tracked for Practice Support if more than 15% of the patient panel (0 – 15 months) have 0 – 1 wellness visits AND if the PCMH does not meet the target of 68% or greater for Quality Metric 2 (Infant Wellness)	≥ 25
Core Metric 2: Body Mass Index (BMI) (Low Performance)	The purpose of the BMI core metric is to identify low performers of BMI measurement. The metric measures the percentage of patients 3 – 17	At least 60% of the patient panel, ages 3-17 years, having evidence of BMI measurement during the measurement period.	A PCMH will be placed in remediation for the Core Metric 2 (BMI) tracked for Practice Support if less than 60% of the patient panel (3-17 years) have a BMI measurement.	≥ 25

*Self-reported by entering numerator and denominator data in the PCMH Provider Portal	years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had evidence of height, weight, and body mass index (BMI) percentile documentation during the measurement period.			
Core Metric 3: High Priority Beneficiary PCP Visits (Low Performance) *Claims-based	The purpose of the high priority beneficiary PCP visit core metric is to identify low performers of PCP visits with attributed PCMH. The metric measures the percentage of a practice's high priority beneficiaries who have been seen by any PCP within their PCMH at least twice in the past 12 months.	At least 60% of the practice's high priority beneficiaries with 2 of the selected visit types and criteria with their attributed PCMH.	A PCMH will be placed in remediation for Core Metric 3 (PCP Visits (Low Performance)) tracked for Practice Support if less than 60% of the practice's high priority beneficiaries who have been seen by any PCP within their PCMH at least twice in the past 12 months.	≥ 25
Core Metric 4: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c)	The purpose of the comprehensive diabetes care (HbA1c) core metric is to identify low performers of HbA1c testing. The metric measures the percentage of diabetes	At least 50% of the diabetic patient panel, ages 18-75 years, having completed an HbA1c test during the measurement period.	A PCMH will be placed in remediation for Core Metric 4 HbA1c (Low Performance) tracked for Practice Support if less than 50% of the patient panel (18-75 years) have an HbA1c test.	≥ 25

Testing (Low Performance) *Claims-based	beneficiaries who complete annual HbA1C, between 18-75 years of age.			

DMS will verify whether the PCMH has met the target for the Core Metrics by reviewing the PCMH reports issued during the third quarter following the completion of the measured performance period.

Failure to meet the targets will result in a "Notice of Failure to Meet Core Metrics Tracked for Practice Support." PCMHs that receive this notice will be subject to completion of a Quality Improvement Plan (QIP) and a 90-day remediation period.

- The PCMH will have 15 calendar-days to submit a sufficient QIP — failure to submit a sufficient QIP within 15 calendar-days of receiving the notice will result in suspension of practice support.
- PCMHs that receive a notice will have 90 calendar-days, from the date of the notice, to remediate performance of the metric.

Successful completion of remediation will be determined by DMS based on the Core Metric results reported in the monthly PCMH report, posted in the PCMH Provider Portal, the following month after remediation ends. If a PCMH fails to meet the deadlines or targets for the Core Metrics tracked for practice support within the specified remediation time, then DMS will suspend practice support.

The following is the timeline of milestones for the 2020 Core Quality Metrics tracked for practice support:

2020 Milestones	Description
June 2021	• Quarter 2 PCMH Report posted to PCMH Provider Portal (report includes data for January – December 2020) • DMS reviews reports and determines if targets, stated above, are met by PCMHs • Notice of Failure to Meet Core Metrics Tracked for Practice Support is issued to PCMHs that are deficient in meeting set targets
15 days from date notice received	Deadline for the PCMH to submit a sufficient QIP outlining a plan to correct the deficiency stated in the Notice of Failure to Meet Core Metrics Tracked for Practice Support
July – September 2021	90-day remediation period

October 2021	• DMS will review the results of the metrics posted in the PCMH's Population Health Monthly Report (PHMR) to determine successful remediation • PCMH will receive notice of remediation completion • If the PCMH fails to remediate performance, then DMS will suspend practice support

Technical Specifications for Low Performance Core Metrics

Well-Child Visits in the First 15 Months of Life (0 - 1 visits) (Low Performance)

Denominator	Numerator	Category	Measure Steward	Population Base
Denominator includes number of beneficiaries who turned 15 months old during the measurement year	Numerator includes number of beneficiaries who had 0 - 1 well-child visits during the first 15 months of life (0-15 months)	Core Metric: 0 - 1 wellness visits	NCQA	Child

Body Mass Index (BMI) (Low Performance)

Denominator	Numerator	Category	Measure Steward	Population Base
Denominator includes number of patients 3-17 years of age with at least one outpatient visit with a PCP or an OB/GYN during the measurement period (All payer source)	Numerator includes number of patients who had a height, weight, and BMI percentile recorded during the measurement period (All payer source)	Core Metric: BMI	eCQM (Community, Population and Public Health)	Child

High Priority Beneficiary PCP Visits (Low Performance)

Denominator	Numerator	Category	Measure Steward	Population Base
Denominator includes beneficiaries designated high priority by practices according to Section 241.000 and attributed to the PCMH for at least 6 months	Numerator includes the number of those high priority beneficiaries with 2 of the selected visit types and criteria with their attributed PCMH	Core Metric: PCP Visits	Homegrown	Child/Adult

Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (Low Performance)

Denominator	Numerator	Category	Measure Steward	Population Base
Denominator includes number of beneficiaries 18 to 75 years who have a diagnosis of diabetes	Numerator includes number of beneficiaries 18 to 75 years old with a diagnosis of diabetes who completed a HbA1c test during the measurement period	Core Metric: HbA1c	NCQA	Adult

243.000 Quality Metrics Tracked for Performance Based Incentive Payments

DMS assesses the following Quality Metrics tracked for Performance-Based Incentive Payments (PBIP) according to the targets below. The quality metrics are assessed only if the Shared Performance Entity has at least the minimum number of attributed beneficiaries in the category described for the majority of the performance period. To receive a PBIP, the Shared Performance Entity must meet at least two-thirds of the Quality Metrics on which the entity is assessed.

The Quality Metrics are assessed at the level of the shared performance entity for Voluntary pools and the Petite Pool. Quality Metrics for the default pool are assessed on an individual PCMH-level.

Achievement of targets for Quality Metrics 8, 9, and 10 can be calculated only if the required metric data is submitted through the PCMH Provider Portal. Failure to provide the required data by January 31, 2021 will cause failure to meet targets for Quality Metrics 8, 9, and 10.

Metric #	Metric Name	Description	Minimum Attributed Beneficiaries	2020 Target
Quality Metrics: Incentive Payment (Claims-Based)				
1	High Priority Beneficiary PCP Visits	Percentage of a practice's high priority beneficiaries who have been seen by any PCP within their PCMH at least twice in the past 12 months	≥ 25	≥ 85%
2	Well-Child Visits in the First 15 Months of Life (5+ Visits)	Percentage of beneficiaries who turned 15 months old during the performance period who receive at least five well-child visits in their first 15 months (0 – 15 months)	≥ 25	≥ 68%

Metric #	Metric Name	Description	Minimum Attributed Beneficiaries	2020 Target
Quality Metrics: Incentive Payment (Claims-Based)				
3	Well-Child Visits (Ages 3-6)	Percentage of beneficiaries 3-6 years of age who had one or more well-child visits during the measurement year	≥ 25	≥ 72%
4	Adolescent Well-Care Visits	Percentage of beneficiaries 12-20 years of age who had one or more well-care visits during the measurement year	≥ 25	≥ 53%
5	Appropriate Treatment for Unspecified URI	Percentage of beneficiary, age 1 year and older, events with a diagnosis of non-specified upper respiratory tract infection (URI) that had antibiotic treatment during the measurement period	≥ 25	≤ 45%
Quality Metrics: Incentive Payment (Claims-Based)				
6	Concurrent Use of Opioids and Benzodiazepines	Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines	≥ 25	≤ 30%
7	Tamiflu and Respiratory Antibiotics	Percentage of beneficiaries 1-18 years of age who received Tamiflu and respiratory antibiotics on the same day	≥ 25	≤ 18%

Metric #	Metric Name	Description	Minimum Attributed Beneficiaries	2020 Target
Quality Metrics: Incentive Payment (Claims-Based)				
eCQMs Quality Metrics: w/Target				
8	Controlling High Blood Pressure	Percentage of patients 18-85 years of age who had a diagnosis of hypertension overlapping the measurement period and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period (All payer source)	≥ 25	≥ 62%
9	Comprehansive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (> 9.0%)	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period (All payer source)	≥ 25	≤ 28%
10	Tobacco Use	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user during the measurement period (All payer source)	≥ 25	≥ 80%

Technical Specifications for Quality Metrics Tracked for PBIP

Metric 1: High Priority Beneficiary PCP Visits

Denominator	Numerator	Category	Measure Steward	Population Base
Denominator includes beneficiaries designated high priority by practices according to Section 241.000 and attributed to the PCMH for at least 6 months	Numerator includes the number of those high priority beneficiaries with 2 of the selected visit types and criteria with their attributed PCMH	Quality Metric: w/Target	Homegrown	Child/Adult

Metric 2: Well-Child Visits in the First 15 Months of Life (5+ Visits)

Denominator	Numerator	Category	Measure Steward	Population Base
Denominator includes number of beneficiaries who turned 15 months old during the measurement year	Numerator includes number of beneficiaries who had 5 or more wellness visits during first 15 months of life (0-15 months)	Quality Metric: w/Target	NCQA	Child

Metric 3: Well-Child Visits (Ages 3-6)

Denominator	Numerator	Category	Measure Steward	Population Base
Denominator includes number of beneficiaries 3 to 6 years old on the anchor (last) date of the measurement year	Numerator includes number of beneficiaries who had one or more wellness visits during the measurement year	Quality Metric: w/Target	NCQA	Child

Metric 4: Adolescent Well-Care Visits

Denominator	Numerator	Category	Measure Steward	Population Base
Denominator includes number of beneficiaries 12 to 20 years old on the anchor (last) date of the measurement year	Numerator includes number of beneficiaries who had one or more wellness visits during the measurement year	Quality Metric: w/Target; Incentive Focus	NCQA	Child

*Focus Metric for the 2020 Performance Period

Metric 5: Appropriate Treatment for Unspecified URI

Denominator	Numerator	Category	Measure Steward	Population Base
Denominator includes all events for attributed beneficiaries 1 year of age and older on the detail "from" date of service with a primary or secondary diagnosis of non-specified upper respiratory tract infection (URI) in combination with a CPT or HCPCS code	Numerator includes those beneficiary events that were dispensed a prescription for an antibiotic, at least one AHFS code, within twenty days from the initial event's start date	Quality Metric: w/Target	Homegrown EOC (URI Non-Specified)	Child/Adult

*American Hospital Formulary Service (AHFS); now AHFS Drug Information)

Metric 6: Concurrent Use of Opioids and Benzodiazepines

Denominator	Numerator	Category	Measure Steward	Population Base
Denominator includes number of beneficiaries age 18 and older on the anchor (first) date of the measurement year with an IPSD and with 2 or more prescriptions for opioids with unique dates of service, for which the sum of the days' supply is 15 or more	Numerator includes number of beneficiaries with two or more prescription claims for any benzodiazepine with unique dates of service and concurrent use of opioids and benzodiazepines for 30 or more cumulative days	Quality Metric: w/Target	Pharmacy Quality Alliance	Adult

Metric 7: Tamiflu and Respiratory Antibiotics

Denominator	Numerator	Category	Measure Steward	Population Base
Denominator includes number of beneficiaries 1-18 years old on the first date of the measurement period and received a Tamiflu prescription	Numerator includes number of beneficiaries who received Tamiflu and respiratory antibiotics on the same day	Quality Metric: w/Target	Homegrown	Child

Metric 8: Controlling High Blood Pressure

Denominator	Numerator	Category	Measure Steward	Population Base
Denominator includes number of patients 18-85 years of age who had a visit and diagnosis of essential hypertension overlapping the measurement period	Numerator includes number of patients whose most recent blood pressure is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period (All payer source)	Quality Metric: w/Target	eCQM (Effective Clinical Care)	Adult

Metric 9: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (> 9.0%)

Denominator	Numerator	Category	Measure Steward	Population Base
Denominator includes number of patients 18-75 years of age with diabetes with a visit during the measurement period (All payer source)	Numerator includes number of patients whose most recent HbA1c level (performed during the measurement period) is >9.0% (All payer source)	Quality Metric: w/Target	eCQM (Effective Clinical Care)	Adult

Metric 10: Tobacco Use

Denominator	Numerator	Category	Measure Steward	Population Base
Denominator includes number of patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period (All payer source)	Numerator includes number of patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user (All payer source)	Quality Metric: w/Target	eCQM (Community, Population and Public Health)	Adult

Incentive Utilization Metrics Tracked for PBIP

Metric #	Metric Name	Description
Incentive Utilization Metric: PBIP Payment (Claims-Based, Risk-Adjusted)		
1	Emergency Department Utilization	The ratio of observed to expected emergency department (ED) visits during the measurement period
2	Acute Hospital Utilization	The ratio of observed to expected acute inpatient or observation stay discharges during the measurement period

Technical Specifications for Incentive Utilization Metrics Tracked for PBIP

Metric 1: Emergency Department Utilization

Denominator	Numerator	Category	Measure Steward	Population Base
Denominator includes number of expected ED visits during the measurement period	Numerator includes number of observed ED visits during the measurement period	Incentive Utilization Metric: PBIP Payment	NCQA; GDIT	Child/Adult

*Percentile of performance and incentive bonus

Metric 2: Acute Hospital Utilization

Denominator	Numerator	Category	Measure Steward	Population Base
Denominator includes number of expected inpatient or observation stay discharges during the measurement period	Numerator includes number of observed inpatient or observation stay discharges during the measurement period	Incentive Utilization Metric: PBIP Payment	NCQA; GDIT	Child/Adult

*Percentile of performance and incentive bonus

Informational Metrics

DMS assesses the following informational metrics tracked for the PCMH program. The Informational Metrics are reported as "claims-based metrics" with at least the one minimum number of attributed beneficiaries in the category described for the majority of the performance period on the PCMH provider report. Breast Cancer Screening and Cervical Cancer Screening are collected as "Effective Clinical Care" metrics. All eCQM Informational Metrics are due through the PCMH Provider Portal by January 31, 2021.

Metric	Description
Informational Metrics: w/PCMH State Averages (Claims-Based)	
Asthma Medication Ratio (Ages 5-18)	Percentage of beneficiaries 5–18 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year
Asthma Medication Ratio (Ages 19-24)	Percentage of beneficiaries 19–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year
Follow-Up Care for Children Prescribed ADHD Medication	Percentage of beneficiaries 6-12 years of age with an ambulatory prescription dispensed for Attention-Deficit/Hyperactivity Disorder (ADHD) medication that was prescribed by their PCMH, who had a follow-up visit within 30 days by any practitioner with prescribing authority
Chlamydia Screening in Women Ages 16-20	The percentage of women 16-20 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period
Chlamydia Screening in Women Ages 21-24	The percentage of women 21-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period

Metric	Description
Informational Metrics: w/PCMH State Averages (Claims-Based)	
Comprehensive Diabetes Care: Eye Exam	Percentage of diabetic beneficiaries 18-75 years of age who had an eye exam (retinal) performed
PQI 01: Diabetes Short-Term Complications Admission Rate	Number of inpatient hospital admissions for diabetes short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 enrollee months for Medicaid beneficiaries age 18 and older
PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	Number of inpatient hospital admissions for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 enrollee months for beneficiaries age 40 and older

Metric	Description
Informational Metrics: w/PCMH State Averages (Claims-Based)	
Annual Monitoring for Patients on Persistent Medications	Percentage of beneficiaries 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent (angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB) or diuretics) during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year.
HIV Viral Load	Percentage of beneficiaries with a diagnosis of HIV with at least one HIV viral load test during the measurement year
Childhood Immunization Status	Percentage of children age 2 who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.
Breast Cancer Screening	Percentage of women 50–74 years of age who had a mammogram to screen for breast cancer
Cervical Cancer Screening	Percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria: Women age 21-64 who had cervical cytology performed every 3 years Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years
Oral Antibiotic Prescriptions (Rx) per 1,000 Attributed Beneficiaries	Number of oral antibiotic prescriptions per 1,000 attributed beneficiaries during the measurement period

Technical Specifications for Informational Metrics

Antibiotic Claims (Prescriptions) per 1,000 Attributed Beneficiaries

Denominator	Numerator	Category	Measure Steward	Population Base
Denominator is the number of 6-month attributed beneficiaries during the measurement period	Number of oral antibiotic prescriptions per 1,000 attributed beneficiaries during the measurement period	Informational Metric: w/PCMH State Average	Homegrown	Child/Adult

Asthma Medication Ratio (Ages 5-18 & Ages 19-64)

Denominator	Numerator	Category	Measure Steward	Population Base
Denominator includes number of beneficiaries 5 to 18 years of age with a diagnosis of persistent asthma	Numerator includes number of beneficiaries who have a medication ratio of 0.50 or greater during the measurement year	Informational Metric: w/PCMH State Average	NCQA	Child

Denominator	Numerator	Category	Measure Steward	Population Base
Denominator includes number of beneficiaries 19 to 64 years of age with a diagnosis of persistent asthma	Numerator includes number of beneficiaries who have a medication ratio of 0.50 or greater during the measurement year	Informational Metric: w/PCMH State Average	NCQA	Adult

Follow-Up Care for Children Prescribed ADHD Medication

Denominator	Numerator	Category	Measure Steward	Population Base
Denominator includes a modified HEDIS metric to determine the percent of patients between 6-12 years of age with a first ambulatory prescription dispensed for ADHD medication that was prescribed by their attributed PCMH. The intake period is modified from the HEDIS metric to be the first 11 months of the performance period	Numerator includes those ADHD patients who had one follow-up visit with any practitioner with prescribing authority during the 30 days following initiation of the prescription	Informational Metric: w/PCMH State Average	NCQA (Modified HEDIS metric)	Child

Chlamydia Screening In Women Ages 16-20 & Ages 21-24

Denominator	Numerator	Category	Measure Steward	Population Base
Denominator includes number of women ages 16 to 20 on the anchor (last) date of the measurement period	Numerator includes number of women with at least one chlamydia test during the measurement period	Informational Metric: w/PCMH State Average	NCQA	Child

Denominator	Numerator	Category	Measure Steward	Population Base
Denominator includes number of women ages 21 to 24 on the anchor (last) date of the measurement period	Numerator includes number of women with at least one chlamydia test during the measurement period	Informational Metric: w/PCMH State Average	NCQA	Adult

Comprehensive Diabetes Care: Eye Exam

Denominator	Numerator	Category	Measure Steward	Population Base
Denominator includes number of beneficiaries 18 to 75 years who have a diagnosis of diabetes	Numerator includes number of beneficiaries 18 to 75 years old with a diagnosis of diabetes who had an eye exam (retinal) performed	Informational Metric: w/PCMH State Average	NCQA	Adult

PQ01: Diabetes Short-Term Complications Admission Rate

Denominator	Numerator	Category	Measure Steward	Population Base
Denominator includes total number of months of enrollment for beneficiaries age 18 and older during the measurement period	Numerator includes all inpatient hospital admissions with ICD-10-CM principal diagnosis code for short-term complications of diabetes (ketoacidosis, hyperosmolarity, coma)	Informational Metric: w/PCMH State Average	Agency for Healthcare Research and Quality (AHRQ)	Adult

PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate

Denominator	Numerator	Category	Measure Steward	Population Base
Denominator includes total number of months of enrollment for beneficiaries age 40 and older during the measurement period	Numerator includes all non-maternal inpatient hospital admissions with an ICD-10-CM principal diagnosis code for COPD or Asthma	Informational Metric: w/PCMH State Average	AHRQ	Adult

Annual Monitoring for Patients on Persistent Medications

Denominator	Numerator	Category	Measure Steward	Population Base
Denominator includes number of beneficiaries 18 years of age and older who received at least 180 treatment days of ACE inhibitors or ARBs or diuretics, during the measurement year.	Numerator includes number of beneficiaries 18 years of age and older with at least one serum potassium and a serum creatinine therapeutic monitoring test in the measurement year.	Informational Metric: w/PCMH State Average	NCQA	Adult

HIV Viral Load

Denominator	Numerator	Category	Measure Steward	Population Base
Denominator includes number of beneficiaries with a primary or secondary diagnosis of HIV during the measurement year or year prior	Numerator includes number of beneficiaries with at least one HIV viral load test during the measurement year	Informational Metric: w/PCMH State Average	Homegrown	Child/Adult

Childhood Immunization Status

Denominator	Numerator	Category	Measure Steward	Population Base
Denominator includes number of children age 2 during the measurement year	Numerator includes number of children age 2 who had vaccines by their second birthday	Informational Metric: w/PCMH State Average	NCQA	Child

Breast Cancer Screening

Denominator	Numerator	eCQM Informational Metric Reference	Category	Measure Steward	Population Base
Denominator includes number of women 52-74 years of age on the anchor (last) date of the measurement year	Numerator includes number of women with one or more mammograms during the measurement year or the 15 months prior to the measurement year	https://ecqi.healthit.gov/ecqm/ep/2020/cms125v8 (All payer source)	Informational Metric: w/PCMH State Average	NCQA	Adult

Cervical Cancer Screening

Denominator	Numerator	eCQM Informational Metric Reference	Category	Measure Steward	Population Base
Denominator includes number of women 24-64 years of age with a visit during the measurement period	Numerator includes number of women with one or more screenings for cervical cancer. Appropriate screenings are defined by any one of the following criteria: -Cervical cytology performed during the measurement period or the two years prior to the measurement period for women who are at least 21 years old at the time of the test -Cervical cytology/human papillomavirus (HPV) co-testing performed during the measurement period or the four years prior to the measurement period for women who are at least 30 years old at the time of the test	https://ecqi.healthit.gov/ecqm/ep/2020/cms124v8 (All payer source)	Informational Metric: w/PCMH State Average	NCQA; eCQM (Effective Clinical Care)	Adult

Technical Specifications for Care Categories as Displayed in the PCMH Report

Anesthesia

Description of Anesthesia Category Logic
• Claim Type is professional (medical) claims or professional crossover claims • AND Detail Procedure Code is one of the following CPT codes (anesthesia): **CPT Codes** 00100 - 01999 Note that numeric ranges should only include numeric values

Dental

Description of Dental Category Logic
• Claim Type is dental claims (suppressed for PCMH program)

Durable Medical Equipment (DME)

Description of DME Category Logic

- Claim Type is NOT inpatient claims or inpatient crossover claims
- AND Detail Procedure Code is one of the following HCPCs codes (DME):

HCPCS Codes		
A4220 - A4236	A4714 - A4728	A9272 - A9286
A4280 - A4290	A4760 - A4766	A9900 - A9999
A4326 - A4353	A4860 - A4870	B4034 - B4088
A4357 - A4510	A5051 - A5093	B9000 - B9999
A4555 - A4557	A5102 - A5114	E0100 - E8002
A4563 - A4570	A5500 - A5514	K0001 - K0903
A4595	A6530 - A6550	L0112 - L4631
A4600 - A4604	A7000 - A7048	T5001 - T5999
A4611 - A4640	A7501 - A7527	
A4653 - A4670	A8000 - A8004	

Emergency Department (ED)

Description of Emergency Department Category Logic

Professional claims from ED:

- Claim Type is professional (medical) claims or professional crossover claims
- AND Detail Place Of Service is NOT 21 (not in an inpatient hospital)
- AND Detail Procedure Code is one of the following CPT codes:

CPT Codes
99281 - 99285

Facilities claims from ED:

- Claim Type is outpatient claims or outpatient crossover claims
- AND Header Billing Provider Type is '05' (hospital)
- AND Detail Revenue Code is NOT one of the following revenue codes (not free-standing clinic):

Revenue Codes
0520
0521
0524
0525

Description of Emergency Department Category Logic

- AND Either Header Condition Code_1 – 5 = 88 OR Detail Revenue code is one of the following revenue codes:

Revenue Codes
0450
0451
0452
0456
0459
0981

- AND Either (Detail Procedure Code NOT in one of HCPCS or CPT codes used for Care Categories: OP Lab, OP Imaging, OP Procedures, Pharm, OP Surgery, DME) OR Detail Procedure Code = NULL (blank)

Inpatient Facility (IP FAC)

Description of Inpatient Facility Category Logic

- Claim Type is inpatient claims or inpatient crossover claims
- AND Header Billing Provider Type = 05 (hospital)

Inpatient Professional (IP PROF)

Description of Inpatient Professional Category Logic

- Claim Type is professional (medical) claims or professional crossover claims
- AND Detail Place Of Service is 21 (inpatient hospital)
- AND Header Billing Provider Type is NOT to 49 (provider is not an FQHC)
- AND Detail Procedure Code is NOT one of the following CPT codes (not anesthesia):

CPT Codes
00100 - 01999

Note that numeric ranges should only include numeric values

- AND Detail Procedure Code is NOT one of the following HCPCS codes (DME):

HCPCS Codes		
A4220 - A4236	A4714 - A4728	A9272 - A9286
A4280 - A4290	A4760 - A4766	A9900 - A9999
A4326 - A4353	A4860 - A4870	B4034 - B4088

Description of Inpatient Professional Category Logic			
	A4357 - A4510	A5051 - A5093	B9000 - B9999
	A4555 - A4557	A5102 - A5114	E0100 - E8002
	A4563 - A4570	A5500 - A5514	K0001 - K0903
	A4595	A6530 - A6550	L0112 - L4631
	A4600 - A4604	A7000 - A7048	T5001 - T5999
	A4611 - A4640	A7501 - A7527	
	A4653 - A4670	A8000 - A8004	

Outpatient Imaging (OP IMAGING)

Description of Outpatient Imaging Category Logic

- Claim Type is NOT inpatient claims or inpatient crossover claims
- AND Detail Place of Service is NOT 21 (not in an inpatient hospital)
- AND Detail Procedure Code is one of the following HCPCS codes or CPT codes (imaging):

CPT Codes	**HCPCS Codes**	
70000 - 79999	C8900 - C8937	G0278 - G0279

Description of Outpatient Imaging Category Logic		
	C9744	G0288
	G0130	G0297
	G0219 - G0235	G0389
	G0252	S9024

Note that numeric ranges should only include numeric values

Outpatient Laboratory (OP LAB)

Description of Outpatient Laboratory Category Logic

- Claim Type is NOT inpatient claims or inpatient crossover claims
- AND Detail Place Of Service is NOT 21 (not in an inpatient hospital)
- AND Detail Procedure Code is one of the following HCPCS codes or CPT codes (lab):

CPT Codes	**HCPCS Codes**
80000 - 89999	Q0111 - Q0115
0001M - 0013M	Q0091
0001U - 0138U	S3620 - S3655

Description of Outpatient Laboratory Category Logic	
	S3800 - S3870
	G0141 - G0148
	P2028 - P7001
	G0123 - G0124
	G0416
	G0027
	G0306 - G0328
	G0431 - G0435

Note that numeric ranges should only include numeric values, and ranges ending with M only includes codes ending in M and ranges ending with U only includes codes ending with U

Outpatient Procedures (OP PROCEDURES)

Description of Outpatient Procedures Category Logic
• Claim Type is NOT inpatient claims or inpatient crossover claims • AND Detail Place of Service is NOT 21 (not in an inpatient hospital)

Description of Outpatient Procedures Category Logic

- AND Detail Procedure Code is one of the following HCPCS codes or CPT codes (procedures):

CPT Codes	**HCPCS Codes**		
90865 - 90880	C5271 - C5278	G0289	M0075 - M0301
90901 - 96020	C9600 - C9608	G0341 - G0365	P9010 - P9100
96360 - 96999	C9724 - C9743	G0403 - G0405	Q0035
97010 - 97799	C9745 - C9899	G0428 - G0429	Q0081 - Q0085
97810 - 98943	G0101 - G0106	G0448	S0199
99150 - 99157	G0117 - G0122	G0458	S0601
	G0127	G0460	S0630
	G0129	G0491 - G0492	S0800 - S0812
	G0166 - G0168	G0498	S2053 - S3005
	G0186	G0500	S3900 - S3904
	G0255 - G0269	G0516 - G0518	
	G0277	G6001 - G6017	

Outpatient Professional (OP PROF)

Description of Outpatient Professional Category Logic

Professional claims from physician's office for services performed outside hospital setting:

- Claim Type is professional (medical) claims or professional crossover claims
- AND Detail Place Of Service is NOT 21 (not inpatient hospital)
- AND Detail Procedure Code is one of the following HCPCS codes or CPT codes:

CPT Codes	HCPCS Codes
99201 - 99205	T1015
99241 - 99245	H0001 - H2037
99381 - 99404	G0402
99211 - 99215	G0463 - G0470
99429	G0245 - G0247
90791 - 90853	G0473
90885 - 90899	G0438 - G0447
96101 - 96161	S0610 - S0622
99217 - 99220	G0068 - G0087

Description of Outpatient Professional Category Logic

99224 - 99226	G2000 - G2015

Rural Health Clinic (RHC) claims:

- Claim Type is outpatient claims or outpatient crossover claims
- AND Header Billing Provider Type is 29 (RHC).
- AND Detail Revenue Code is one of the following revenue codes (free-standing clinic):

Revenue Codes
0520
0521
0524
0525

- AND Either (Detail Procedure Code NOT in one of HCPCS or CPT codes used for Care Categories: OP Lab, OP Imaging, OP Procedures, Pharm, OP Surgery, DME) OR Detail Procedure Code = NULL (blank)

Federally Qualified Health Center (FQHC) claims:

- Claim Type is professional (medical) claims or professional crossover claims
- AND Header Billing Provider Type is 49 (FQHC)
- AND Detail Procedure Code is one of the following HCPCS codes or CPT codes:

Description of Outpatient Professional Category Logic

CPT Codes	HCPCS Codes
99201 - 99205	T1015
99241 - 99245	H0001 - H2037
99381 - 99404	G0402
99211 - 99215	G0463 - G0470
99429	G0245 - G0247
90791 - 90853	G0473
90885 - 90899	G0438 - G0447
96101 - 96161	S0610 - S0622
99217 - 99220	G0068 - G0087
99224 - 99226	G2000 - G2015

Outpatient Surgery Facility (OP SURG FAC)

Description of Outpatient Surgery Facility Category Logic

- Claim Type is outpatient claims or outpatient crossover claims

Description of Outpatient Surgery Facility Category Logic
• AND Header Billing Provider Type is 05 or 28 (hospital or ambulatory surgical center (ASC)) • AND Detail Procedure Code is one of the following CPT codes (surgery): **CPT Codes** 10000 - 69999 Note that numeric ranges should only include numeric values

Outpatient Surgery Professional (OP SURG PROF)

Description of Outpatient Surgery Category Logic
• Claim Type is professional (medical) claims or professional crossover claims • AND Detail Place Of Service is NOT 21 (not inpatient hospital) • AND Detail Procedure Code is one of the following CPT codes (surgery): **CPT Codes** 10000 - 69999 Note that numeric ranges should only include numeric values

Pharmacy (PHARM)

Description of Pharmacy Category Logic

- Claim Type is pharmacy claims and compound drug
- OR Claim Type is NOT an inpatient claim or inpatient crossover claims
- AND [NOT (Claim Type is professional claims or professional crossover claims AND Detail Place of Service is 21)]AND Detail Procedure Code is one of the following HCPCS codes or CPT codes (pharmacy):

CPT Codes	**HCPCS Codes**	
90281 - 90399	J0120 - J9999	Q3027 - Q3028
90476 - 90756	C9014 - C9293	Q4074 - Q4082
	C9399 - C9497	Q5101 - Q5118
	Q0138 - Q0181	S0012 - S0197
	Q0515	S5550 - S5571
	Q2004 - Q2050	

Skilled Nursing Facility (SNF)

Description of Skilled Nursing Facility Category Logic
• Header Billing Provider Type is 11 (SNF) • AND Either (Detail Procedure Code NOT in one of HCPCS or CPT codes used for Care Categories: OP Lab, OP Imaging, OP Procedures, Pharm, OP Surgery, DME) OR Detail Procedure Code = NULL (blank)

Other

Description of Other Category Logic
• All other claims not tagged in a Care Category (claims not included or uniquely tagged in the Care Categories listed above). For example, Rehabilitation hospital claims and Psychiatric facility inpatient claims • OR When a claim is tagged by more than one Care Category

Care categories provide additional data for informational purposes in the full version of the PCMH report. The care categories of Anesthesia, Durable Medical Equipment, Emergency Department, Inpatient Hospital Facility, Inpatient Professional, Outpatient Imaging, Outpatient Lab, Outpatient Procedures, Outpatient Professional, Outpatient Surgery Facility, Outpatient Surgery Professional, Other and Pharmaceuticals are displayed in the PCMH report. Inpatient Psychiatric Facility, Inpatient Rehabilitation Facility, and Skilled Nursing Facility are included in Other Care Category. For each care category and across all care categories, the PCMH report displays the following information.

1. **Number of Beneficiaries with a Claim** – Number of beneficiaries with a paid claim within the care category
2. **Average Cost per Beneficiary with a Claim** – Average care category cost per beneficiary for beneficiaries with a paid claim within the care category

3. **Average Cost per Beneficiary** – Average care category cost per beneficiary across all 6-month attributed beneficiaries