

# PCMH Program Policy Addendum

2025

Arkansas Medicaid

Arkansas Department of Human Services

Division of Medical Services

### Change History

Description of Change	Date of Change
Initial creation.	11/21/2024

## Table of Contents

Change History .....	i
Table of Contents.....	ii
<b>223.000 Explanation of Care Coordination Payments .....</b>	<b>1</b>
<i>Determination of Beneficiary Risk.....</i>	<i>1</i>
<i>Per Beneficiary Per Month (PBPM) Amounts.....</i>	<i>1</i>
<b>235.000 Performance Based Incentive Payment Methodology — Exclusions from the Calculation of Emergency Department Utilization and Acute Hospital Utilization .....</b>	<b>3</b>
<i>Emergency Department Utilization (EDU) — HEDIS Exclusions .....</i>	<i>3</i>
<i>Acute Hospital Utilization (AHU) — HEDIS<sup>2</sup> Exclusions.....</i>	<i>3</i>
<i>PCMH Program-specific Exclusions .....</i>	<i>3</i>
<b>236.000 Incentive Focus Measure .....</b>	<b>4</b>
<i>Technical Specifications for Incentive Utilization Metrics Tracked for PBIP .....</i>	<i>4</i>
Metric 1: Emergency Department Utilization .....	4
Metric 2: Acute Hospitalization Utilization .....	4
<b>237.000 Performance Based Incentive Payment Amounts .....</b>	<b>5</b>
<i>Percentile of performance and incentive bonus.....</i>	<i>5</i>
<b>241.000 Activities Tracked for Practice Support .....</b>	<b>6</b>
<i>Activities for the 2025 Performance Period.....</i>	<i>6</i>
<i>Details on Activities Tracked for Practice Support.....</i>	<i>7</i>
Activity A: Identify top 10% of high-priority patients.....	7
Activity B: Make available 24/7 access to care .....	8
Activity C: Capacity to receive direct e-messaging from patients.....	8
Activity D: Childhood/Adult Vaccination Practice Strategy .....	9
Activity E: Join SHARE or participate in a network that delivers hospital discharge information to practice within 48 hours .....	9
Activity F: Track third next available appointment.....	11
Activity G: Care Plans for High Priority Patients .....	12
Activity H: Patient Literacy Assessment Tool .....	14
Activity I: Patient and Family Engagement .....	15
Activity J: Care Instructions for High Priority Patients .....	16
Activity K: Social Determinants of Health .....	16
<i>Low Performance Core Metrics for the 2025 Performance Period.....</i>	<i>18</i>
<b>243.000 Quality Metrics Tracked for Performance Based Incentive Payments .....</b>	<b>22</b>
<i>Informational Metrics .....</i>	<i>26</i>

## 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<sup>1</sup>, 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).
- 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.

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<sup>1</sup> This will be based on the most recent inpatient, outpatient, and home health medical claims available.

- For practices that have completed training or are on track to achieve fidelity (certification) in a program approved by DHS to be an evidence-based pediatric practice transformation model defined in A.C.A. § 20-77-150 will receive an additional \$3.44 per month added to their PBPM for their beneficiaries ages 0-48 months.



ACT513.pdf

- A copy of the Act can be found here \_\_\_\_\_
  
- Current approved programs
  - HealthySteps

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

### **Emergency Department Utilization (EDU) — HEDIS<sup>2</sup> 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<sup>2</sup> Exclusions**

1. Nonacute inpatient stay
2. A principal diagnosis of mental health, chemical dependency, or intentional self-harm
3. A principal diagnosis of live-born infant
4. A maternity-related or specific weeks of gestation principal diagnosis
5. A maternity-related stay
6. Inpatient and 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. Physician selected excluded beneficiaries
4. Unknown gender

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<sup>2</sup> 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 Measure

Metric #	Metric Name	Description	Minimum Attributed Beneficiaries
5	<a href="#">Adolescent Well-Care Visits (Age 12-20)</a>	Percentage of non-pregnant beneficiaries 12-20 years of age who had at least one well-care visit during the measurement period.	≥ 25

### Technical Specifications for Incentive Utilization Metrics Tracked for PBIP

#### Metric 1: Emergency Department Utilization

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

#### Metric 2: Acute Hospitalization Utilization

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

[\\*PBIP percentile of performance and incentive bonus](#)

## 237.000 Performance Based Incentive Payment Amounts

### Percentile of performance and incentive bonus<sup>3</sup>

- [Emergency Department Utilization \(EDU\)](#)
  - Shared Performance Entities that are in the top 10th percentile for lowest EDU rates can receive up to \$9.50 times the number of attributed member months
  - Shared Performance Entities that fall within the top 11th to 35th percentiles for lowest EDU rates can receive up to \$4.75 times the number of attributed member months
- [Acute Hospital Utilization \(AHU\)](#)
  - Shared Performance Entities that are in the top 10th percentile for lowest AHU rates can receive up to \$6.50 times the number of attributed member months
  - Shared Performance Entities that fall within the top 11th to 35th percentiles for lowest AHU rates can receive up to \$3.25 times the number of attributed member months
- [Focus Measure](#)
  - Shared Performance Entities that are in the top 10th percentile for highest Focus Measure rates can receive up to \$4 times the number of attributed member months
  - Shared Performance Entities that fall within the top 11th to 35th percentiles for highest Focus Measure rates can receive up to \$2 times the number of attributed member months

Reconsideration for the 2025 EDU, AHU, and Focus Measures will be performed during Q4 of the 2026 calendar year. The Q3 2026 quarterly report will identify providers' current standing and a PBIP reconsideration application in the PCMH Provider Portal will identify those beneficiaries and events counted in these three measures. Requests for reconsideration on these measures will be accepted after Q3 2026 reports are posted to the PCMH portal, and such reconsideration requests must follow the guidance in the [PCMH Provider Manual](#). (Sections 235.000, 236.000, 244.000)

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<sup>3</sup> The Performance Based Incentive Payment (PBIP) amounts are based on previous payout amounts and those practices that qualified in each measure. The total of 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 2025 Performance Period

All PCMHs must meet all activities by the following deadlines, must complete the attestations and submit supporting documentation in the Quality Care Insight (QCI) provider portal in order to be eligible for practice support.

- 3-month activities by 3/31/2025
- 6-month activities by 6/30/2025
- 12-month activities by 12/31/2025

For information on remediation, please refer to the [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. Capacity to receive direct e-messaging from patients.		✓	
D. Childhood / Adult Vaccination Practice Strategy.		✓	
E. Join SHARE or participate in a network that delivers hospital discharge information to practice within 48 hours.		✓	
F. Track third available appointment			✓
G. Care Plans for High Priority Patients			✓

H. Patient Literacy Assessment Tool			✓
I. Patient and Family Engagement			✓
J. Care instructions for High Priority Patients			✓
K. Social Determinants of Health			✓

## Details on Activities Tracked for Practice Support

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

Activity A Deadline: 3/31/2025
<ol style="list-style-type: none"> <li>1. Perform this by using:             <ol style="list-style-type: none"> <li>a. DMS patient panel data that ranks patients by risk at beginning of performance period; and/or,</li> <li>b. The practice’s patient-centered assessment to determine which patients are high-priority.</li> </ol> </li> <li>2. Submit this list to DMS via the QCI provider portal.</li> </ol>

## Activity B: Make available 24/7 access to care

Activity B Deadline: 6/30/2025

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 QCI provider portal, and attest that the described activity has been completed and that proper evidence of such can be provided upon request.

## Activity C: Capacity to receive direct e-messaging from patients

Activity C Deadline: 6/30/2025

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 QCI provider portal and attest that the described activity has been completed and that proper evidence of such can be provided upon request.

### Activity D: Childhood/Adult Vaccination Practice Strategy

Activity D Deadline: 6/30/2025

- Indicate and describe the practice's implemented process to deliver immunization to both, when applicable, the pediatric and adult population leading into administration of immunization for the upcoming year.
- Indicate if there is an implemented process to identify vaccination gaps in care for both, when applicable, the pediatric and adult population.
- Indicate the ability to document historic immunization data into an EHR and review on each visit.
- Indicate the capability to submit data electronically to immunization registries or immunization information systems.
- Practices are to document completion of this activity via the QCI provider portal and attest that the described activity has been completed and that proper evidence of such can be provided upon request.

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

Activity E Deadline: 6/30/2025

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

## Activity F: Track third next available appointment

Activity F Deadline: 12/31/2025

1. Perform this activity by:

- Using either a manual or an electronic tool to track the third next available appointment for the following:
  - New patient appointment
  - Routine exam
  - Return visit exam

According to the Institute for Healthcare Improvement (IHI), "The data collection can be done manually or electronically. Manual collection means looking in the schedule book and counting from the "index" (day when the "dummy" appointment is requested) to the day of the third available appointment. Some electronic scheduling systems can be programmed to compute the number of days automatically."

An example of a tool may be found by clicking on the link: [Third Next Available Appointment: A Reference Guide \(h1ccp.com\)](http://h1ccp.com)

- Collect data:
- On the same day of the week, once a week, sample all physicians.
- "Count the number of days between a request for an appointment (e.g., enter dummy patient) with a physician and the third next available appointment for a new patient physical, routine exam, or return visit exam. Count calendar days (e.g. include weekends) and days off. Do not count any saved appointments for urgent visits (since they are "blocked off" on the schedule.)" (IHI, 2021)
- Record fulfillment of the third next available appointment for physicians sampled.
- Report the average number of days for physicians sampled. Practices are to document completion of this activity via the QCI provider portal and attest that the described activity has been completed and that proper evidence of such can be provided upon request.

## Activity G: Care Plans for High Priority Patients

Activity G Deadline: 12/31/2025

- 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)
- 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)

- 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.
  - 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 [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 QCI provider portal and attest that the described activity has been completed and that proper evidence of such can be provided upon request.

### Activity H: Patient Literacy Assessment Tool

Activity H Deadline: 12/31/2025

- 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 QCI 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 and Family Engagement

Activity I Deadline: 12/31/2025

The purpose of this activity is to establish proactive communication and partnered decision-making between providers, patients, families, and caregivers. It is about building a relationship that is based on trust and inclusion of individual values and beliefs.

1. Indicate if the practice has an established process for patient and family engagement.
  - a. Describe:
    - i. The method used to engage patients and families in decisions regarding the patient's care
    - ii. Provide examples of tools used in the practice to engage patients and families.
    - iii. If the practice does not have a current process for patient and family engagement, explain future plans to develop a process.
  - b. Information on patient and family engagement may be found on the CMS website at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/Person-and-Family-Engagement-Strategy-Summary.pdf>
2. Practices are to document completion of this activity via the QCI provider portal and attest that the described activity has been completed and that proper evidence of such can be provided upon request.

## Activity J: Care Instructions for High Priority Patients

Activity J Deadline: 12/31/2025

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 his/her after-visit summary include the following:
  - a. The patient may receive a paper copy of the summary after his/her visit, prior to leaving the clinic.
  - b. A copy of the summary may 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 may be made available to the patient via a patient portal
4. Practices are to document completion of this activity via the QCI provider portal and attest that the described activity has been completed and that proper evidence of such can be provided upon request.

## Activity K: Social Determinants of Health

Activity K Deadline: 12/31/2025

The purpose of this activity is to gather information regarding whether a PCMH screens its beneficiaries for Social Determinants of Health (SDOH). For the 2025 performance period, not screening for SDOH will cause a PCMH to not pass this activity.

A PCMH must respond to the following questions in the QCI provider portal:

1. Does your practice screen for social determinants of health?
2. If yes, what type of screening tool is used? Please upload a copy of the tool in the QCI provider portal
3. If yes to question 1, what is the process for analyzing the data received and how is it used?

4. If no to question 1, what are your plans to implement screening for social determinants of health?
5. Practices are to document completion of this activity via the QCI provider portal and attest that the described activity has been completed and that proper evidence of such can be provided upon request.
6. Do you as a practice feel confident or are you able to make appropriate referrals in those areas identified?

## Low Performance Core Metrics for the 2025 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, the PCMH will not be counted in this metric. If all of a PCMH's core-metrics denominators are less than the 25 minimum attributed beneficiaries, 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: Oral and Injectable Antibiotic Utilization (Low Performance)	The purpose of the oral and injectable antibiotic utilization metric is to identify low performers of oral and injectable antibiotic utilization. The metric measures the number of oral and injectable antibiotic prescriptions per 1,000 attributed beneficiaries during the measurement period	1,300 oral and injectable antibiotic prescriptions or less per 1,000 attributed beneficiaries	A PCMH will be placed in remediation for Core Metric 1 (Oral and Injectable Antibiotic Utilization) if its rate per 1000 patient panel antibiotic utilization is greater than 1,300.	≥ 25
Core Metric 2: Well-Child Visits in the First 15 Months of Life (0 to 2 visits) (Low Performance)	The purpose of the well-child visits core metric is to identify low performers of infant wellness visits. The metric measures the percentage of	16% or less of attributed beneficiaries, ages 0-15 months, having two or fewer wellness visits.	A PCMH will be placed in remediation for Core Metric 2 (Well-Child Visits in the First 15 Months of Life (0-2 Visits)) tracked for Practice Support if more than 18% of attributed beneficiaries (0 – 15	≥ 25

*Claims-based	beneficiaries who turned 15 months old during the performance period who only received two or fewer wellness visits in their first 15 months (0 – 15 months)		months) have 2 or fewer wellness visits AND if the PCMH does not meet the target of 56% or greater for Quality Metric 2 (Well-Child Visits in the First 15 Months of Life (6+ Visits))	
Core Metric 3: PCP Visits for High Priority Beneficiaries (Low Performance)  *Claims-based	The purpose of the PCP visits for high priority beneficiaries 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 were seen by their PCMH at least twice during the measurement year.	At least 70% 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 for High Priority Beneficiaries (Low Performance)) tracked for Practice Support if less than 67% of the practice's high priority beneficiaries who were seen by their PCMH at least twice during the measurement year.	≥ 25
Core Metric 4: Concurrent Use of Opioids and Benzodiazepines (Low Performance)  *Claims-based	The purpose of the concurrent use of prescription opioids and benzodiazepines core metric is to identify low performers. The metric measures the percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines.	25% or less 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.	A PCMH will be placed in remediation for Core Metric 4 Concurrent Use of Opioids and Benzodiazepines (Low Performance) tracked for Practice Support if more than 27% of beneficiaries with two or more prescription claims for any benzodiazepine with unique dates of service and concurrent use of opioids	≥ 25

			and benzodiazepines for 30 or more cumulative days.	
Core Metric 5: Adolescent Well-Care Visits (Ages 12-20) (AWC) (Low Performance)	The purpose of the adolescent well-care visits core metric is to identify low performers. The metric measures the percentage of beneficiaries 12-20 years of age who had one or more well-care visits during the measurement period.	At least 28% of the practice's beneficiaries 12-20 years of age with at least one well-care visit with their attributed PCMH during the measurement period.	A PCMH will be placed in remediation for Core Metric 5 Adolescent Well-Care Visits (Ages 12-20) (AWC) (Low Performance) tracked for Practice Support if less than 28% of attributed beneficiaries (12-20 years) have at least one wellness visit.	≥ 25
Core Metric 6: No HbA1c Test	The purpose of the HbA1c Test is to identify low performers. The metric measures the percentage of beneficiaries ages 18 to 75 with diabetes (type 1 and type 2) who did not have a hemoglobin A1c (HbA1c) test during the measurement period	25% or more of beneficiaries ages 18 to 75 who did not have a HbA1c test	A PCMH will be placed in remediation for Core Metric 6 No HbA1C Test (Ages 18-75) (Low Performance) tracked for Practice Support if more than 25% of attributed beneficiaries (18-75 years) with a diabetic diagnosis have not had a hemoglobin A1c (HbA1c) test during the measurement period.	≤25%

DMS will verify whether the PCMH has met the target for the Core Metrics by reviewing the PCMH reports issued in June 2026, at the end of the second 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 Population Health Management Report posted in the 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, the practice is subject to program suspension.



## 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 13, and 14 can be calculated only if the required metric data is submitted through the Provider Portal. Failure to provide the required data by January 31, 2026, will cause failure to meet targets for Quality Metrics 13, and 14 (eCQM).

Metric #	Metric Name	Description	Minimum Attributed Beneficiaries	2025 Target
Quality Metrics: Incentive Payment (Claims-Based)				
1	PCP Visits for High Priority Beneficiaries	Percentage of a practice’s high priority beneficiaries who were seen by their PCMH at least twice during the measurement year with dates of service at least 14 days apart	≥ 25	≥ 87%
2	Well-Child Visits in the First 15 Months of Life (6+ Visits)	Percentage of beneficiaries who turned 15 months old during the performance period and who had at least six well-child visits during their first 15 months of life (0 – 15 months)	≥ 25	≥ 56%

3	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Percentage of beneficiaries 3-6 who had one or more well-child visits during the measurement period	≥ 25	≥ 75%
4	Well-Child Visits in the Seventh, Eighth, Ninth, Tenth, and Eleventh Years of Life	Percentage of beneficiaries 7-11 years of age who had at least one comprehensive well-care visit during the measurement period.	≥ 25	≥ 65%
5	Adolescent Well-Care Visits (Age 12-20)	Percentage of non-pregnant beneficiaries ages 12-20 who had at least one comprehensive well-care visit during the measurement period	≥ 25	≥ 57%
6	Oral and Injectable Antibiotic Utilization	Number of oral and injectable antibiotic prescriptions per 1,000 attributed beneficiaries during the measurement period.	≥ 25	≤ 1,000
7	Chlamydia Screening in Women	Percentage of women ages 16-24 who were identified as sexually active and who had at least one test for chlamydia during the measurement period.	≥ 25	≥ 50%

8	Cervical Cancer Screening	<p>Percentage of women ages 21 to 64 who were screened for cervical cancer using either of the following criteria:</p> <ul style="list-style-type: none"> <li>• Women ages 21 to 64 who had cervical cytology performed within the last 3 years</li> <li>• Women ages 30 to 64 who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years</li> <li>• Women ages 30 to 64 who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.</li> </ul>	≥ 25	≥ 43%
9	Breast Cancer Screening	Percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	≥ 25	≥ 45%
10	Colorectal Cancer Screening	Percentage of beneficiaries 45–75 years of age who had appropriate screening for colorectal cancer.	≥ 25	≥ 33%
11	Well-Child Visits 15-30 Months 2+ Visits	Percentage of children who turned 30 months old who had two or more well-child visits during the last 15 months.	≥ 25	≥ 53%
12	Developmental Screening	<p>Percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool.</p> <ul style="list-style-type: none"> <li>• Any child under the age of 4 years old with a developmental, behavioral screening during the performance period based on the guidance provided in EPSDT II policy manual sections 215.310(J) and 215.320(K)</li> </ul>	≥ 25	≥ 21%

eCQMs Quality Metrics: w/Target				
13	Controlling High Blood Pressure	Percentage of patients 18-85 years of age who had a diagnosis of hypertension overlapping the measurement period or the year prior to the measurement period, and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period (All payer source).	≥ 25	≥ 64%
14	Comprehensive Diabetes Care: 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	≤ 25%

## 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 minimum number of attributed beneficiaries in the category described for the majority of the performance period on the PCMH provider report. All eQIM Informational Metrics are due through the Provider Portal by January 31, 2026.

Metric	Description
Informational Metrics: w/PCMH State Averages (Claims-Based)	
Asthma Medication Ratio (Ages 19-64)	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
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
Body Mass Index	Percentage of patients 3-17 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.
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 beneficiaries age 18 and older.
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)	
HIV Viral Load Test	Percentage of beneficiaries with HIV who received an HIV viral load test during the measurement period
Human Papillomavirus Vaccine	Percentage of children 9-13 years of age who initiated the human papillomavirus (HPV) vaccine series.
Tobacco Usage	Percentage of patients aged 12 years and older who were screened for tobacco use one or more times during the measurement period AND who received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period if identified as a tobacco user (All payer source).
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	The percentage of episodes for members 3 months of age and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event
Maternal Depression Screening	Percentage of those who have given birth in the past 12 months who have a paid Depression Screening claims billed either to the Mothers' Medicaid ID or the Child's Medicaid ID.
Lead Screening	The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday