PCMH Program Policy Addendum

2022

Arkansas Medicaid

Arkansas Department of Human Services

Division of Medical Services

Change History

Description of Change	Date of Change
Updated metric thresholds, retired, and moved metrics for 2022.	9/13/2021
Updated, retired, and added Practice Support Activities for 2022	10/27/2021

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223.000 Explanation of Care Coordination Payments

Determination of Beneficiary Risk

i. 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).

ii. For 6-month attributed beneficiaries with no claims history[1], a RUB score of 0 is assigned.

Per Beneficiary Per Month (PBPM) Amounts

iii. 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

iv. 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).

v. 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.

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

232.000 Performance Based Incentive Payment (PBIP) Eligibility

PBIP Beneficiary Exclusions

vi. 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 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[2] 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. 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 Measure

Metric #	Metric Name	Description	Minimum Attributed Beneficiaries
4	Adolescent Well-Care Visits (Age 12-20)	Percentage of non-pregnant beneficiaries 12-20 years of age who had at least one well-care visit during the measurement period.	≥ 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 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 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 within the top 11th to 35th percentiles for lowest EDU rates can receive up to $4 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 $5 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 $2.50 times the number of attributed member months

vii. Reconsideration for AHU, EDU, and Focus Measures will be performed during Q3 of the 2023 performance period. The Q3 2023 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 2023 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)

[3] The total of Performance Based Incentive Payment (PBIP) amounts must not exceed equal 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 2021 Performance Period

viii. 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 order to be eligible for practice support.

ix. 3-month activities by 3/31/2022

x. 6-month activities by 6/30/2022

xi. 12-month activities by 12/31/2022

xii. 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 – **New Activity**			✓
G. Care Plans for High Priority Patients			✓

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

Details on Activities Tracked for Practice Support

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

Activity A Deadline: 3/31/2022
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 QCI provider portal.

Activity B: Make available 24/7 access to care

Activity B Deadline: 6/30/2022
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 D Deadline: 6/30/2022
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.

Activity D Deadline: 6/30/2022
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: 6/30/2022
xiii. 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. xiv. Indicate if there is an implemented process to identify vaccination gaps in care for both the pediatric and adult population. xv. Indicate the ability to document historic immunization data into an EHR and review on each visit. xvi. Indicate the capability to submit data electronically to immunization registries or immunization information systems. xvii. 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: 6/30/2022
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 – New Activity

Activity F Deadline: 12/31/2022

1. Perform this activity by:

   xviii. 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)

   xix. Collect data:

   xx. On the same day of the week, once a week, sample all physicians.

   xxi. "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)

   xxii. Record fulfillment of the third next available appointment for physicians sampled.

   xxiii. 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.

Institute for Healthcare Improvement (IHI), (2021), *Third Next Available Appointment.* Retrieved from http://www.ihi.org/resources/Pages/Measures/ThirdNextAvailableAppointment.aspx

Activity G: Care Plans for High Priority Patients

Activity G Deadline: 12/31/2022
• 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)

Activity G Deadline: 12/31/2022
• 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.

Activity G Deadline: 12/31/2022

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

xxiv. 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: 12/31/2022

xxv. 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.

xxvi. A list of health literacy tools suggested by the UAMS Center for Health Literacy may be obtained from the PCMHs AFMC Outreach Specialists.

Activity H Deadline: 12/31/2022	
xxvii.	Provide an example of the tool used to assess health literacy.
xxviii.	Provide a description of the overall results of the assessment.
xxix.	Develop and describe a plan to help low health literacy beneficiaries to understand instructions and education materials.
xxx.	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 – New Activity

Activity I Deadline: 12/31/2022

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. *Note: if a PCMH has not established a process at this time, it *will not* cause a failure of this activity.
    a. Describe:
        i. The method used 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: 12/31/2022
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 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 – New Activity

Activity K Deadline: 12/31/2022
The purpose of this activity is to gather information regarding whether a PCMH screens their beneficiaries for Social Determinants of Health (SDOH). For the 2022 performance period, not screening for SDOH will not cause a PCMH to not pass this activity. The activity is primarily for informational purposes. A PCMH must respond to the following questions in the QCI provider portal: 1. Does your practice screen for social determinants of health?

Activity K Deadline: 12/31/2022
2. If yes, why type of screening tool is used? Can you provide a copy of the tool? If yes, 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, do you have 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.

Low Performance Core Metrics for the 2022 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: Oral Antibiotic Utilization (Low Performance)	The purpose of the oral antibiotic utilization metric is to identify low performers of oral antibiotic utilization. The metric measures the number of oral antibiotic prescriptions per 1,000 attributed beneficiaries during the measurement period.	1,600 oral antibiotic prescriptions or less per 1,000 attributed beneficiaries	A PCMH will be placed in remediation for Core Metric 1 (Oral Antibiotic Utilization) if its rate per 1000 patient panel antibiotic utilization is greater than 1,600.	≥ 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 beneficiaries who turned 15 months old during the	20% 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 20% of attributed beneficiaries (0 – 15 months) have 2 or fewer wellness visits AND if the PCMH does not meet the	≥ 25

*Claims-based	performance period who only received two or fewer wellness visits in their first 15 months (0 – 15 months)		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 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 for High Priority Beneficiaries (Low Performance)) tracked for Practice Support if less than 60% of the practice's high priority beneficiaries who were seen by their PCMH at least twice during the measurement year.	≥ 25
Core Metric 4: Comprehensive Diabetes Care: HbA1c Testing (Low Performance) *Claims-based	The purpose of the comprehensive diabetes care HbA1c testing core metric is to identify low performers of HbA1c testing. The metric measures the percentage of beneficiaries ages 18 to 75 with diabetes (type 1 and type 2) who had a hemoglobin A1c (HbA1c) test.	At least 60% of the diabetic patient panel, ages 18-75 years with a diagnosis of diabetes who completed an HbA1c test during the measurement period.	A PCMH will be placed in remediation for Core Metric 4 Comprehensive Diabetes Care: HbA1c Testing (Low Performance) tracked for Practice Support if less than 60% of the patient panel (18-75 years) have an HbA1c test.	≥ 25

Core Metric 5: 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.	27% 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 5 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 and benzodiazepines for 30 or more cumulative days.	≥ 25

Starting in July 2023, DMS will verify whether the PCMH has met the target for the Core Metrics by reviewing the PCMH reports issued in June 2023, 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.

xxxi. 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.

xxxii. 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 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, DMS will suspend practice support.

The following is the timeline of milestones for the 2022 Core Quality Metrics tracked for practice support:

2022 Milestones	Description
June 2023	xxxiii. Quarter 2 PCMH Report posted to portal (report includes data for January – December 2022) xxxiv.
July 2023	xxxv. DMS reviews reports and determines if targets for Core Metrics as stated above are met by PCMHs xxxvi. Notices of Failure to Meet Core Metrics Tracked for Practice Support ~~are~~ 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
August – October 2023	90-day remediation period

November 2023	xxxvii. DMS will review the results of the metrics posted in the PCMH's Population Health Monthly Report (PHMR) to determine successful remediation xxxviii. PCMH will receive notice of remediation completion xxxix. If the PCMH fails to remediate performance, then DMS will suspend practice support

Technical Specifications for Low Performance Core Metrics

Oral Antibiotic Utilization (Low Performance)

Denominator	Numerator	Category	Measure Steward	Population Base
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.	Core Metric: ABX	NCQA	Child/Adult

Well-Child Visits in the First 15 Months of Life (0-2 visits) (Low Performance)

Denominator	Numerator	Category	Measure Steward	Population Base
The number of beneficiaries who turned 15 months old during the measurement period	The number of beneficiaries who had 0 - 2 well-child visits during the first 15 months of life (0-15 months)	Core Metric: W15-2	NCQA	Child

PCP Visits for High Priority Beneficiaries (Low Performance)

Denominator	Numerator	Category	Measure Steward	Population Base
The number of beneficiaries designated high priority by practices according to Section 241.000	The number of those high priority beneficiaries with 2 of the selected visit types and criteria with their attributed PCMH	Core Metric: PCP	GDIT	Child/Adult

Comprehensive Diabetes Care: HbA1c Testing (Low Performance)

Denominator	Numerator	Category	Measure Steward	Population Base
The number of beneficiaries 18 to 75 years who have a diagnosis of diabetes	The number of beneficiaries 18 to 75 years old with a diagnosis of diabetes who completed an HbA1c test during the measurement period	Core Metric: HA1c	NCQA	Adult

Concurrent Use of Opioids and Benzodiazepines (Low Performance)

Denominator	Numerator	Category	Measure Steward	Population Base
The number of beneficiaries age 18 and older with 2 or more prescriptions for opioids with unique dates of service, for which the sum of the days supply is 15 or more during the measurement period.	The 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.	Core Metric: COB	PQA	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 10, 11, and 12 can be calculated only if the required metric data is submitted through the Provider Portal. Failure to provide the required data by January 31, 2023will cause failure to meet targets for Quality Metrics 10, 11, and 12 (eCQM).

Metric #	Metric Name	Description	Minimum Attributed Beneficiaries	2022 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	≥ 25	≥ 85%
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%

Metric #	Metric Name	Description	Minimum Attributed Beneficiaries	2022 Target
Quality Metrics: Incentive Payment (Claims-Based)				
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	≥ 60%
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 Antibiotic Utilization	Number of oral antibiotic prescriptions per 1,000 attributed beneficiaries during the measurement period.	≥ 25	≤ 1,164

Metric #	Metric Name	Description	Minimum Attributed Beneficiaries	2022 Target
Quality Metrics: Incentive Payment (Claims-Based)				
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	≥ 45%
8	Cervical Cancer Screening	Percentage of women ages 21 to 64 who were screened for cervical cancer using either of the following criteria: • Women ages 21 to 64 who had cervical cytology performed within the last 3 years • Women ages 30 to 64 who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years • Women ages 30 to 64 who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.	≥ 25	≥ 38%
9	Breast Cancer Screening	Percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	≥ 25	≥ 41%
eCQMs Quality Metrics: w/Target				
10	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	≥ 25	≥ 64%

Metric #	Metric Name	Description	Minimum Attributed Beneficiaries	2022 Target
Quality Metrics: Incentive Payment (Claims-Based)				
		period, and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period (All payer source).		
11	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	≤ 26%
12	Tobacco Use: Screening and Cessation Intervention	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 12 months AND who received cessation intervention counseling if identified as a tobacco user (All payer source).	≥ 25	≥ 80%

Technical Specifications for Quality Metrics Tracked for PBIP

Metric 1: PCP Visits for High Priority Beneficiaries

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

Metric 2: Well-Child Visits in the First 15 Months of Life (6+ Visits)

Denominator	Numerator	Category	Measure Steward	Population Base
The number of beneficiaries who turned 15 months old during the measurement period	The number of beneficiaries who had 6 or more well-child visits, on different dates of service, during their first 15 months of life (0-15 months)	Quality Metric: W15-6 w/Target	NCQA	Child

Metric 3: Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

Denominator	Numerator	Category	Measure Steward	Population Base
The number of beneficiaries 3-6 years old during the measurement period	The number of those beneficiaries who had at least one well-child visit during the measurement period	Quality Metric: W34 w/Target	NCQA	Child

Metric 4: Well-Child Visits in the Seventh, Eighth, Ninth, Tenth, and Eleventh Years of Life

Denominator	Numerator	Category	Measure Steward	Population Base
Number of beneficiaries 7 to 11 years old during the measurement period.	Number of beneficiaries who had one or more well-care visits during the measurement period.	Quality Metrics: WCV-7 w/Target	NCQA	Child

Metric 5: Adolescent Well-Care Visits (Age 12-20)

Denominator	Numerator	Category	Measure Steward	Population Base
The number of non-pregnant beneficiaries 12-20 years old during the measurement period	The number of those non-pregnant beneficiaries who had at least one comprehensive well-care visit during the measurement period	Quality Metric: AWC w/Target and Incentive Focus Metric*	NCQA	Child

*Incentive Focus Metric for the 2021 Performance Period

Metric 6: Oral Antibiotic Utilization

Denominator	Numerator	Category	Measure Steward	Population Base
The number of 6-month attributed beneficiaries during the measurement period.	The number of oral antibiotic prescriptions times 1,000.	Quality Metric: ABX w/Target	GDIT	Child/Adult

Metric 7: Chlamydia Screening in Women

Denominator	Numerator	Category	Measure Steward	Population Base
The number of women ages 16 to 24 who were identified as sexually active during the measurement period.	The number of women with at least one chlamydia test during the measurement period.	Quality Metric: CHL w/Target	Pharmacy Quality Alliance (PQA)	Child/Adult

Metric 8: Cervical Cancer Screening

Denominator	Numerator	Category	Measure Steward	Population Base
The number of women 24-64 years of age during the measurement period.	The number of women with one or more screenings for cervical cancer.	Quality Metric: CCS w/Target	GDIT	Adult

Metric 9: Breast Cancer Screening

Denominator	Numerator	Category	Measure Steward	Population Base
The number of women 50-74 years of age on the anchor (last) date of the measurement year.	The number of women with one or more mammograms during the measurement year or the 15 months prior to the measurement year.	Quality Metric: BCS w/Target	GDIT	Adult

Metric 10: Controlling High Blood Pressure

Denominator	Numerator	Category	Measure Steward	Population Base
The number of patients 18-85 years of age who had a visit and diagnosis of essential hypertension overlapping the measurement period or the year prior to the measurement period	The 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	Quality Metric: CBP w/Target	eCQM	Adult

Metric 11: Comprehensive Diabetes Care: HbA1c Poor Control

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

Metric 12: Tobacco Use: Screening and Cessation Intervention

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

*Percentile of performance and incentive bonus

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

*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 minimum number of attributed beneficiaries in the category described for the majority of the performance period on the PCMH provider report. All eCQM Informational Metrics are due through the Provider Portal by January 31, 2023

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
Well-Child Visits in the First 15-30 Months of Life	Percentage of children who turned 30 months old who had two or more well-child visits during the last 15 months.

Technical Specifications for Informational Metrics

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

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

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

Body Mass Index

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.	Numerator includes number of patients who had a height, weight, and BMI percentile recorded during the measurement period.	Informational Metric: BMI w/PCMH State Average	NCQA	Child

Diabetes Short-Term Complications Admission Rate

Denominator	Numerator	Category	Measure Steward	Population Base
The total number of months of enrollment for beneficiaries age 18 and older during the measurement period.	The number of all inpatient hospital admissions with ICD-10-CM principal diagnosis code for short-term complications of diabetes (ketoacidosis, hyperosmolarity, coma).	Informational Metric: PQI01 w/PCMH State Average	Agency for Healthcare Research and Quality (AHRQ)	Adult

COPD or Asthma in Older Adults Admission Rate

Denominator	Numerator	Category	Measure Steward	Population Base
The total number of months of enrollment for beneficiaries age 40 and older during the measurement period.	The number of all non-maternal inpatient hospital admissions with an ICD-10-CM principal diagnosis code for COPD or Asthma.	Informational Metric: PQI05 w/PCMH State Average	AHRQ	Adult

HIV Viral Load Test

Denominator	Numerator	Category	Measure Steward	Population Base
The number of beneficiaries with HIV.	The number of beneficiaries with at least one HIV viral load test during the measurement period.	Informational Metric: HVL w/PCMH State Average	GDIT	Child/Adult

Well-Child Visits in the First 30 Months of Life

Denominator	Numerator	Category	Measure Steward	Population Base
The number of children who turned 30 months old during the measurement period.	The number of children who had two or more well-child visits on different dates of service between the child's 15 month birthday plus 1 day and the 30 month birthday.	Informational Metric: W30 w/PCMH State Average	NCQA	Child

Technical Specifications for Care Categories as Displayed in the PCMH Report

Anesthesia

Description of Anesthesia Category Logic
xl. Claim Type is professional (medical) claims or professional crossover claims xli. AND Detail Procedure code is an anesthesia procedure code (Anesthesia CPT Value Set)

Dental

Description of Dental Category Logic
xlii. 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 a DME procedure code (DME HCPCS Value Set)

Emergency Department (ED)

Description of Emergency Department Category Logic
Professional claims from ED: xliii. Claim Type is professional (medical) claims or professional crossover claims xliv. AND Detail Place Of Service is NOT 21 (not in an inpatient hospital) • AND Detail Procedure code is an ED procedure code (Emergency Department CPT Value Set) Facilities claims from ED: xlv. Claim Type is outpatient claims or outpatient crossover claims xlvi. AND Header Billing Provider Type is '05' (hospital) xlvii. AND Detail Revenue code is NOT a free-standing clinic revenue code (Free-Standing Revenue Value Set) xlviii. AND Detail Revenue code is an ED revenue code (Emergency Department Revenue Code Value Set) xlix. AND Detail Procedure code is Null (blank) OR Detail Procedure code is NOT in one of HCPCS or CPT codes used for Care Categories: OP Lab, OP Imaging, OP Procedures, Pharm, OP Surgery, or DME

Inpatient Facility (IP FAC)

Description of Inpatient Facility Category Logic
l. Claim Type is inpatient claims or inpatient crossover claims li. AND Header Billing Provider Type = 05 (hospital)

Inpatient Professional (IP PROF)

Description of Inpatient Professional Category Logic
liii. Claim Type is professional (medical) claims or professional crossover claims liii. AND Detail Place Of Service is 21 (inpatient hospital) liv. AND Header Billing Provider Type is NOT to 49 (provider is not an FQHC) lv. AND Detail Procedure code is NOT an anesthesia procedure code (Anesthesia CPT Value Set) lvi. AND Detail Procedure code is NOT a DME procedure code (DME HCPCS Value Set)

Outpatient Imaging (OP IMAGING)

Description of Outpatient Imaging Category Logic
lvii. Claim Type is NOT inpatient claims or inpatient crossover claims lviii. AND Detail Place of Service is NOT 21 (not in an inpatient hospital) lix. AND Detail Procedure code is an imaging procedure code (Radiology HCPCS Value Set or Radiology CPT Value Set)

Outpatient Laboratory (OP LAB)

Description of Outpatient Laboratory Category Logic
lx. Claim Type is NOT inpatient claims or inpatient crossover claims lxi. AND Detail Place Of Service is NOT 21 (not in an inpatient hospital) lxii. AND Detail Procedure code is a lab procedure code (Laboratory HCPCS Value Set or Laboratory CPT Value Set)

Outpatient Procedures (OP PROCEDURES)

Description of Outpatient Procedures Category Logic
lxiii. Claim Type is NOT inpatient claims or inpatient crossover claims lxiv. AND Detail Place of Service is NOT 21 (not in an inpatient hospital) lxv. AND Detail Procedure code is an outpatient procedure code (Outpatient Procedures HCPCS Value Set or Outpatient Procedures CPT Value Set)

Outpatient Professional (OP PROF)

Description of Outpatient Professional Category Logic
Professional claims from physician's office for services performed outside hospital setting: lxvi. Claim Type is professional (medical) claims or professional crossover claims

Description of Outpatient Professional Category Logic
lxvii. AND Detail Place Of Service is NOT 21 (not inpatient hospital) lxviii. AND Detail Procedure code is an outpatient professional procedure code (Outpatient Professional HCPCS Value Set or Outpatient Professional CPT Value Set) Rural Health Clinic (RHC) claims: lxix. Claim Type is outpatient claims or outpatient crossover claims lxx. AND Header Billing Provider Type is 29 (RHC). lxxi. AND Detail Revenue code is a free-standing clinic revenue code (Free-Standing Revenue Value Set) ▪ AND Detail Procedure code is Null (blank) OR Detail Procedure code is NOT in one of HCPCS or CPT codes used for Care Categories: OP Lab, OP Imaging, OP Procedures, Pharm, OP Surgery, or DME Federally Qualified Health Center (FQHC) claims: lxxii. Claim Type is professional (medical) claims or professional crossover claims lxxiii. AND Header Billing Provider Type is 49 (FQHC) lxxiv. AND Detail Procedure code is an outpatient professional procedure code (Outpatient Professional HCPCS Value Set or Outpatient Professional CPT Value Set)

Outpatient Surgery Facility (OP SURG FAC)

Description of Outpatient Surgery Facility Category Logic
lxxv. Claim Type is outpatient claims or outpatient crossover claims lxxvi. AND Header Billing Provider Type is 05 or 28 (hospital or ambulatory surgical center (ASC)) AND Detail Procedure code is an outpatient surgery procedure code (Outpatient Surgery CPT Value Set)

Outpatient Surgery Professional (OP SURG PROF)

Description of Outpatient Surgery Category Logic
lxxvii. Claim Type is professional (medical) claims or professional crossover claims lxxviii. AND Detail Place Of Service is NOT 21 (not inpatient hospital) AND Detail Procedure code is an outpatient surgery procedure code (Outpatient Surgery CPT Value Set)

Pharmacy (PHARM)

Description of Pharmacy Category Logic
Pharmacy Claims lxxix. Claim Type is pharmacy or compound pharmacy claims Non-Pharmacy and Non-Inpatient Claims for Pharmaceuticals lxxx. Claim Type is NOT an inpatient, inpatient crossover, professional, or professional crossover claim OR Claim Type is a professional or professional crossover claim where Detail Place Of Service is NOT 21 (not inpatient hospital) lxxxi. AND Detail Procedure code is a pharmacy procedure code (Pharmacy CPT Value Set or Pharmacy HCPCS Value Set)

Skilled Nursing Facility (SNF)

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

Other

Description of Other Category Logic	
lxxxii.	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
lxxxiii.	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