

PCMH Program Policy Addendum

2026

Arkansas Medicaid

Arkansas Department of Human Services

Division of Medical Services

Change History

Description of Change	Date of Change

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223.000 Explanation of Care Coordination Payments

Determination of Beneficiary Risk

A Risk Utilization Band (RUB) score is calculated for all of the participating practices' 6-month attributed beneficiaries at the end of the preceding calendar year using the Johns Hopkins ACG® Grouper System, a tool for performing risk measurement and case mix categorization (<http://acg.jhsph.org>).

Per Beneficiary Per Month (PBPM) Amounts

A per beneficiary per month (PBPM) care coordination payment 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 beneficiaries attributed to the PCMH for at least six months but have no Medicaid claims history^[1], a RUB score of 0 is assigned.

Beneficiaries attributed to the PCMH less than six months and have less than 6 months of Medicaid claims history are known as point-in-time attributed (PITA) beneficiaries. The PBPM amount for PITA beneficiaries will be equal to that of the average PBPM amount for that beneficiary's demographic cohort (based on age and sex).

Existing Medicaid claims history is used to calculate a RUB score for all other beneficiaries attributed to the PCMH.

^[1] 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 ACT 513 of 2023 will receive \$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) — HEDIS¹ 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) — HEDIS² 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

¹ 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	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

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 bonus²

- [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 the 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 the highest Focus Measure rates can receive up to \$2 times the number of attributed member months.

² The Performance Based Incentive Payment (PBIP) amounts are based on previous payout amounts and those practices that qualified in each measure. The total calculated PBIP payments must not exceed Medicaid's allotted dollar amount for total payout. If the total calculated PBIP payments exceed Medicaid's allotted dollar amount for total payout, all PBIP amounts will be adjusted accordingly.

Practices may request reconsideration of the 2026 EDU, AHU, and Focus Measures if they believe there is an error in the calculation, or they have additional documentation supporting the need for a revised calculation. Reconsiderations will be performed during Q4 of the 2027 calendar year. The Q3 2027 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 2027 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)

241.000 Activities Tracked for Practice Support (PBPM Care Coordination Payment)

Activities for the 2026 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 PBPM care coordination payments.

- 3-month activities by 3/31/2026
- 6-month activities by 6/30/2026
- 9-month activities by 9/30/2026
- 12-month activities by 12/31/2026

For information on remediation, please refer to the [PCMH Provider Manual](#).

Activity	3-Month	6-Month	9-Month	12-Month
A. Identify top 10% of high-priority patients	✓			
B. Identify Focus Area for Improvement	✓			
C. Make Available 24/7 Access to Care	✓			
D. Prescription Drug Monitoring Program (PDMP) Questions	✓			
E. Capacity to Receive Direct E-Messaging from Patients		✓		
F. Childhood/Adult Vaccination Practice Strategy		✓		
G. Join SHARE or Participate in Network		✓		
H. Model Fidelity/Healthy Steps Participation			✓	
I. Patient Literacy Assessment Tool			✓	
J. Patient and Family Engagement			✓	
K. Care Instructions/After Visit Summary			✓	

L. Social Determinants of Health			✓	
M. Model Fidelity/HealthySteps Practice Performance				✓
N. Care Plans for High Priority Beneficiaries				✓
O. Identify Focus Area for Improvement-Follow Up				✓

Details on Activities Tracked for Practice Support (PBPM care Coordination Payments)

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

Activity A Deadline: 3/31/2026
<ol style="list-style-type: none"> 1. Perform this by using: <ol style="list-style-type: none"> 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: Identify Focus Area for Improvement

Activity B Deadline: 3/31/2026 Identify Focus Area for Improvement
<ol style="list-style-type: none"> 1. Identify a minimum of 1 focus area for improvement <ol style="list-style-type: none"> a. If new to the PCMH program review the current PCMH Manual and Addendum <ul style="list-style-type: none"> * Choose either an Activity or Metric that may be an obstacle for your practice * Meet with practice staff members to identify this area and develop goals and a quality improvement strategy. * Define the process for monitoring progress, barriers, and expected outcomes b. If re-enrolling in the PCMH program <ul style="list-style-type: none"> * Choose an existing area that has shown itself to be an obstacle for your practice in previous performance periods.

- * Meet with practice staff members to identify this area and develop goals and a quality improvement strategy.
 - * Define the process for monitoring progress, barriers, and expected outcomes
2. Submit these focus areas and goals via the QCI provider portal.

Activity C: Make Available 24/7 Access to Care

Activity C Deadline: 3/31/2026 Make Available 24/7 Access to Care

1. Provide telephone access to a live voice (e.g., an employee of the primary care provider or an answering service) or to an answering service that immediately pages an on-call medical professional 24 hours per day, 7 days per week.
 - a. When employing an answering service 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:
 - * Provide information and instructions for treating emergency and non-emergency conditions,
 - * Make appropriate referrals for non-emergency services, and
 - * 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.
 - * PCPs must make the after-hours telephone number known to 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 must document completion of this activity via the QCI provider portal and attest the described activity has been completed and proper evidence of such can be provided upon request.
- *Validation of this Activity may occur at anytime during the performance period by after hour calls.***

Activity D: Prescription Drug Monitoring Program (PDMP) Questions

Activity D Deadline: 3/31/2026 PDMP Questions

- As of October 1, 2021, all providers permitted to prescribe controlled substances and participate in Medicaid are required by Section 5042 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, to query qualified prescription drug monitoring programs (PDMPs) before prescribing controlled substances to most Medicaid beneficiaries, unless the beneficiary is receiving inpatient hospice care or long-term residential facility care. (This is required reporting for the State).**
1. Review the 3 required questions through the QCI Portal with each of your PCMH providers and anyone with prescribing rights and the possible answers a-f
 2. Enter the answers collectively as a practice.

Example: If the practice has 5 providers and 3 of them answered (a), 1 answered (b), and 1 answered (f) you would enter those numbers by each answer.

Submitted answers will be for the previous PCMH performance period. For this submission, answer for the 2025 performance period. Example of Questions: [PDMP survey provider questions](#)

Activity E: Capacity to Receive Direct E-messaging From Patients

Activity E Deadline: 6/30/2026 Capacity to Receive Direct E-messaging from Patients

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 the 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: Childhood/Adult Vaccination Practice Strategy

Activity F Deadline: 6/30/2026 Childhood/Adult Vaccination Practice Strategy

1. Indicate whether the practice has a childhood/adult vaccination practice strategy and describe the implemented process to deliver immunizations to both the pediatric and adult population leading into the upcoming year (2027).
2. Indicate if the practice has an implemented process to identify vaccination gaps in care for both the pediatric and adult population.
3. Indicate if the practice has the ability to document historic immunization data into an EHR and review on each visit.
4. Indicate the ability to submit data electronically to immunization registries or immunization information systems.
5. Practices must 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: Join SHARE or Participate in Network

Activity G Deadline: 6/30/2026 Join SHARE or Participate in Network

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 H: Model Fidelity/ACT 513 Participation

Activity H Deadline: 9/30/2026 Model Fidelity/Healthy Steps Participation

This Activity is only for practices recognized as having completed training and are on track to achieve or have achieved model fidelity as defined in ACT 513.

Currently the only model recognized for the 2026 performance period is HealthySteps

1. Attest that your practice participates in the above recognized program model.
2. Upload the annual site report the practice must submit to HealthySteps to the QCI portal.

Activity I: Patient Literacy Assessment Tool

Activity I Deadline: 9/30/2026 Patient Literacy Assessment Tool

1. 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 previously.
2. A list of health literacy tools suggested by the UAMS Center for Health Literacy may be obtained from the PCMHs AFMC Outreach Specialists.
3. Provide an example of the tool used to assess health literacy.
4. Provide a description of the overall results of the assessment.
5. Develop and describe a plan to help low health literacy beneficiaries understand instructions and education materials.
6. Practices must 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: Patient and Family Engagement

Activity J Deadline: 9/30/2026 Patient and Family Engagement

1. Indicate if the practice has an established process for patient and family engagement.
 - a. Describe
 - * The method used to engage patients and families in decisions regarding the patient's care
 - * Provide examples of tools used in the practice to engage patients and families in the patients' care.
 - * If the practice is new to the PCMH program and does not have a current process for patient and family engagement, explain how a process will be developed, including time line to achieve within the first year.

- b. Information on patient and family engagement may be found on the CMS website at:
<https://www.cms.gov/Medicare/QualityInitiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/Person-and-Family-Engagement-StrategySummary.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 K: Care Instructions/After Visit Summary

Activity K Deadline: 09/30/2026 Care Instructions/After Visit Summary

1. Create an after-visit summary from the patient's last visit. The summary should include relevant and actionable information, including diagnosis, medication list, tests and results (if available), referral information (if applicable), and follow up instructions
2. Provide the patient 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 after the 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
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 L: Social Determinants of Health

Activity L Deadline: 09/30/2026 Social Determinants of Health

- 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 including a timeline to implement in the first year?
 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 feel confident as a practice or are you able to make appropriate referrals in those areas identified?

Activity M: Model Fidelity/Act 513 Practice Performance

Activity M Deadline: 12/31/2026 Model Fidelity/Health Steps Practice Performance

If a practice is not recognized or on track to achieve model fidelity as defined in ACT 513, the practice is exempt from this activity.

Currently the only model recognized for the 2026 performance period is HealthySteps

1. Attest to receiving from the Program Model the report documenting how the practice performed against Activities tracked for Fidelity.
2. Upload a copy of the report to the QCI Portal.

Activity N: Care Plans for High Priority Beneficiaries

Activity N Deadline: 12/31/2026 Care Plans for High Priority Beneficiaries

Develop care plans for at least 80% of high-priority patients. Care plans and/or notes contained in the medical record must include the following elements:

1. Documentation of the patient's appropriate problem list
2. The problem list should include any active, significant clinical condition (chronic and/or acute).
3. Each related visit encounter should include a list of current problems (chronic and/or acute).
4. Assessment of progress to date
5. Documentation and assessment of each problem (stability or change of condition)
6. 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.
7. If a problem noted in the problem list is no longer an active problem, a status such as "resolved" should be indicated.
8. If a specialist follows the patient, the most recent findings should be documented, if available, including name of specialist.
9. 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.
10. A minimum of two care plans should be completed within a 12-month period and submitted for validation review.
11. Documented update to the care plan, which would include active problems
12. For new patients: initial care plan and one update (in person or phone call).
13. 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.

14. 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.
15. 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.
16. For validation audit, 20% of the top 10% of high-priority patients 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.
17. PCMHs that successfully pass two consecutive years of care plan validation audits without going into remediation will be eligible for a “**Fast Track**” audit.
18. 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 PCMH does not meet the 80% target for the secondary audit, the PCMH will be required to follow the remediation process as stated in Section 242.000 of the 2019-2026 PCMH Provider Manual and will not be eligible for the Fast Track audit for the upcoming year.
19. 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
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20. Practices must document completion of this activity via the QCI portal.

Activity O: Identified Focus Area for Improvement Follow Up from Activity B

Activity O Deadline: 12/31/2026 Identified Area of Focus Follow-Up from Activity B

1. Attest that the PCMHs has been actively participating in a quality improvement strategy related to the focus area of improvement identified in Activity B
2. Through the QCI portal describe if these goals were met and list successes and/or challenges the practice may have faced this performance period

Low Performance Core Metrics for the 2026 Performance Period

DMS will assess the following metrics for PBPM care coordination payments 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 PBPM care coordination payments, PCMHs must meet the target rate stated below. If a PCMH fails to achieve the stated target rate for the metric, the PCMH must remediate performance to avoid suspension or termination of PBPM care coordination payments. If the PCMH’s denominator for a particular metric is less than the 25 minimum attributed beneficiaries, 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, 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 1,000 patient panel antibiotic utilization is greater than 1,300.	≥ 25
Core Metric 1: 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 performance period who only received zero to one wellness visit in their first 15 months (0 – 15 months)	12% or less of the patient panel, ages 0-15 months, having two or fewer wellness visits.	A PCMH will be placed in remediation for Core Metric 1 (Well-Child Visits in the First 15 Months of Life (0-1 Visits)) tracked for PBPM care coordination payments if more than 12% of the patient panel (0 – 15 months) have 0 – 2 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))	≥ 25

Metric	Description	Target Rate	Condition for Remediation	Minimum Attributed Beneficiaries
Core Metric 3: PCP Visits for High Priority Beneficiaries (Low Performance)	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 73% 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 PBPM care coordination payments if less than 73% of the practice's high priority beneficiaries were seen by their PCMH at least twice during the measurement year.	≥ 25
Core Metric 4: Concurrent Use of Opioids and Benzodiazepines (Low Performance)	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.	23% 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 PBPM care coordination payments if more than 23% 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

DMS will verify whether the PCMH has met the target for Core Metrics by reviewing the PCMH reports issued in June 2027, 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 PBPM care coordination payments.” 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 PBPM care coordination payments.
- 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 PBPM care coordination payments 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 ≥25 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, 2027, 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 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	≥57%
4	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%

Metric #	Metric Name	Description	Minimum Attributed Beneficiaries	2026 Target
Quality Metrics: Incentive Payment (Claims-Based)				
5	Developmental Screening	Percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool.	≥25	≥21%
		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)		
6	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	≥ 67%
7	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	≥ 58%
8	Oral and Injectable Antibiotic Utilization	Number of oral and injectable antibiotic prescriptions per 1,000 attributed beneficiaries during the measurement period.	≥ 25	≤ 1,000
9	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%
10	Cervical Cancer Screening	Percentage of women ages 21 to 64 who were screened for cervical cancer using either of the following criteria:	≥ 25	≥ 43%
		• 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.		
11	Breast Cancer Screening	Percentage of women 40–74 years of age who had a mammogram to screen for breast cancer.	≥ 25	≥ 45%

Metric #	Metric Name	Description	Minimum Attributed Beneficiaries	2026 Target
12	Colorectal Cancer Screening	Percentage of beneficiaries 45–75 years of age who had appropriate screening for colorectal cancer.	>=25	>=35%
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 providers report. All eCQM informational metrics are due through the QCI Portal by January 31, 2027.

Metric	Description
Informational Metrics: w/PCMH State Averages (Claims-Based)	
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.
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.
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.
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 (Child)	The percentage of episodes for members 3 months-17 years of age with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Adult)	The percentage of episodes for members ages 18-64 years with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event
Lead Screening	The percentage of children 2 years of age who had one or more capillaries or venous lead blood test for lead poisoning by their second birthday
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.
Respiratory Syncytial Virus Vaccine Rate	Percentage of beneficiaries 2 years of age who had at least one RSV vaccine by their second birthday
Syphilis Screening in Women	Percentage of women ages 16-24 who were identified as sexually active and who had at least one test for syphilis during the measurement period
Contraceptive Care	Percentage of women ages 15-44 provided a most effective or moderately effective method of contraception

