STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 25-A: January 2025 Quarterly HIPAA Compliant Updates - Physician Office and Outpatient Fee Schedule, Physician Surgery, Physician Radiology, Independent Radiology, Laboratory Services, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedules/ Updates to the Autism Services, Adult Dental Services and Person-Centered Medical Home Plus

The State of Connecticut Department of Social Services (DSS) is submitting the Medicaid State Plan Amendment (SPA) 25-A to the Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS). Public comment information is at the bottom of this document.

Changes to Connecticut Medicaid State Plan

January 2025 Health Insurance Portability and Accountability Act (HIPAA) Updates:

Effective on or after January 1, 2025, this SPA will amend Attachment 4.19-B of the Medicaid State Plan to incorporate the January 2025 Healthcare Common Procedure Coding System (HCPCS) changes (additions, deletions, and description changes) to the physician office and outpatient, physician surgery, physician radiology independent radiology, laboratory services, autism services (ASD) and DMEPOS fee schedules. DSS is making these changes to ensure the fee schedules remain compliant with the Health Insurance Portability and Accountability Act (HIPAA).

Annual Review of Physician-Administered Drugs Reimbursement Rates:

In accordance with the existing federally approved methodology for physician-administered drugs in the Medicaid State Plan, this SPA will update the reimbursement methodology for various physician-administered drugs as detailed below. The purpose of these changes is to align with this federally required and approved methodology. For all applicable drugs, the rates will be updated to 100% of the January 2025 Medicare Average Sales Price (ASP) Drug Pricing file for physician-administered drugs, immune globulins, vaccines, and toxoids.

For procedure codes that are not priced on the January 2024 Medicare ASP Drug Pricing File and procedure codes that are described as “unclassified”, as set forth in the existing approved payment methodology in the Medicaid State Plan, the drug will be priced at the lowest of:

- The usual and customary charge to the public or the actual submitted ingredient cost;
- The National Average Drug Acquisition Cost (NADAC) established by CMS;
- The Affordable Care Act Federal Upper Limit (FUL); or
- Wholesale Acquisition Cost (WAC) plus zero (0) percent when no NADAC is available for the specific drug.

Addition of Select Services to Adult Dental Coverage:

Effective on or after January 1, 2025, SPA 25-A will amend Attachment 4.19-B of the Medicaid State Plan to expand dental services for eligible HUSKY Health members aged over 19 years old. The expanded dental services are the addition of fluoride application for adults, increasing the number of prophylaxis (dental cleanings) from one time to two times per calendar year, and the addition of periodontal treatment for adult HUSKY Health members with select medical diagnoses.

Newly added HCPCS codes to the adult dental fee schedule will be D0120 periodic examination, D110 Adult Prophylaxis, and D1208 Fluoride Application for the fluoride application and adult prophylaxis. Eligible adults who have both conditions (Gastroesophageal Reflux Disease in combination with Obstructive Sleep Apnea) eligible for periodontal treatment will be eligible for periodontal services which include D0120 - Complete Oral Examination *or* D0180 - Periodontal Examination, D4341 - Scaling & Root Planing Four or More Teeth, D4342 - Scaling & Root Planing Three or Less Teeth, D4355 - Full Mouth Debridement, and D4910 - Periodontal Maintenance.

Updates to the Person-Centered Medical Home Plus Program:

This SPA will amend Attachments 3.1-A, 3.1-B, and 4.19-B of the Medicaid State Plan to make updates to the Person-Centered Medical Home Plus (PCMH+) program coverage language and payment methodologies described below.

This SPA implements the updates detailed below to the PCMH+ program, which is codified in the Medicaid State Plan as an Integrated Care Model within section 1905(a)(30) of the Social Security Act (Act), which is the Medicaid benefit category for "any other medical care, and any other type of remedial care recognized under State law, specified by the [HHS] Secretary." PCMH+ involves shared savings payments and care coordination add-on payments for primary care case management (PCCM) services, as defined by section 1905(t) of the Act.

Specifically, this SPA updates the coverage pages for PCMH+ by changing specified performance measures; these updated performance measures are posted to DSS's website at: https://portal.ct.gov/DSS/Health-And-Home-Care/PCMH-Plus/Quality-Measure and select the measures in effect January 1, 2025. As part of these updates, among the performance measure changes are that the prior measures used as quality gates (previously Potentially Preventable Admissions (PPA) and Potentially Preventable Emergency Department Visits (PPV)) have been replaced with the Glycemic Status Assessment for Patients with Diabetes (GSD) and the Follow-up after ED Visit for Substance Use (FUA) measures. In order to receive individual pool and challenge pool shared savings, each PCMH+ Participating Entity (PE) must either: (1) be ranked within the top 30% of PEs for both of the quality gate measures (now GSD and FUA) in a performance year and/or (2) improve its year-over-year performance on both of those measures.

PEs will be eligible to qualify for shared savings payments for both the individual and challenge pools only if they meet at least one of these methods of meeting this updated quality gate for both GSD and FUA. All other requirements for potential eligibility for PCMH+ individual and challenge pools' shared savings payments continue to apply; the only change is to the quality gate for potential eligibility for such payments. The purpose of these changes is to reflect updated quality measures, improve transparency, and focus the financial incentives of PCMH+ on priority areas related to the updated quality measures, especially for the areas included in the quality gate measures.

As a cost-neutral way to help mitigate potential fluctuations in payment while remaining with

the existing annual funding cap for care coordination add-on payments to PCMH+ participating entities that are federally qualified health centers (FQHCs), this SPA updates the PCMH+ reimbursement language to change the Care Coordination Add-On Payment methodology so that the per-member per-month (PMPM) amount will be changed from $4.50 to $4.00 but adding a provision that if the total amount of funds for these payments (which remains $6.36 million) not be expended by the end of the performance year, DSS shall pay the remaining amount based on each FQHC's proportion of all FQHCs' member months. This SPA does not change the existing language that if this total pool of funds may be reached or exceeded in a calendar month, DSS shall reduce the PMPM amount for that month as necessary in order to remain within the total pool of funds and no PMPM payments will be made for any subsequent months in the performance year.

Fee schedules are published at this link: http://www.ctdssmap.com (select "Provider," then "Provider Fee Schedule Download," accept the terms and conditions, and select the applicable fee schedule).

Fiscal Impact

DSS does not anticipate that the HIPAA compliant updates to the physician office and outpatient, physician surgery, independent radiology, physician radiology, laboratory services, ASD services, and DMEPOS fee schedules will have any significant changes in annual aggregate expenditures.

The annual update of the reimbursement rates of physician-administered drugs listed on the physician office and outpatient fee schedule is estimated to have a gross fiscal impact of $991,784 in SFY 2025 and $2,415,984 in SFY 2026.

The addition of select HCPCS codes to the adult dental fee schedule will gross fiscal impact of $1,688,612 in SFY 2025 and $4,174,250 in SFY 2026.

DSS does not anticipate that the PCMH+ updates described above will result in any significant changes in the state's annual aggregate expenditures in SFY 2025 and SFY 2026.

Obtaining SPA Language and Submitting Comments

The proposed SPA is posted on the DSS website at this link: https://portal.ct.gov/DSS/Health-And-Home-Care/Medicaid-State-Plan-Amendments. The proposed SPA may also be obtained at any DSS resource center, at the Town of Vernon Social Services Department, or upon request from DSS (see below).

To request a copy of the SPA from DSS or to send comments about the SPA, please email: **Public.Comment.DSS@ct.gov** or write to: Department of Social Services, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105. Please reference "SPA 25-A: January 2025 Quarterly HIPAA Compliant Update - Physician Office and Outpatient Fee Schedule, Physician Surgery, Physician Radiology, Independent Radiology, Laboratory Services, and DMEPOS Fee Schedules/ Updates to the Autism Services, Adult Dental Services and PCMH+ Services".

Anyone may send DSS written comments about this SPA. Written comments must be received by DSS at the above contact information no later than **January 11, 2025.**

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(3) Other Laboratory and X-ray Services –

- Laboratory Services: Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of laboratory services. The agency's fee schedule rates were set as of January 1, ~~2024~~ 2025 and are effective for services provided on or after that date. All rates are published on the Connecticut Medical Assistance Program website: https://www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download." The Department reviews Medicare rate changes annually to ensure compliance with federal requirements.

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(3) Other Laboratory and X-ray Services (cont'd)

- X-ray Services provided by independent radiology centers: Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of x-ray services provided by independent radiology centers. The agency's fee schedule rates were set as of January 1, ~~2024~~2025. All rates are published on the Connecticut Medical Assistance Program website: https://www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download." Select the "Independent Radiology" fee schedule, which displays global fees, including both the technical and professional components of each fee.

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(5) Physician's services – Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of physician's services. The agency's fee schedule rates were set as of ~~October 1, 2024~~ January 1, 2025, and are effective for services provided on or after that date. All rates are published on the Connecticut Medical Assistance Program website: https://www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download," then select the applicable fee schedule.

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Home Health Services (Continued)

(d) Medical supplies, equipment and appliances suitable for use in the home – Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of medical supplies, equipment and appliances suitable for use in the home. The agency's fee schedule rates were set as of ~~October 1, 2024~~ January 1, 2025, and are effective for services provided on or after that date. All rates are published on the Connecticut Medical Assistance Program website: https://www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download," then select the applicable fee schedule. Over-the-counter products provided by pharmacies, including COVID-19 at-home test kits, are reimbursed at Average Wholesale Price (AWP) with no dispensing fee, except for blood glucose testing strips which are reimbursed at WAC (Wholesale Acquisition Cost) with no dispensing fee and alcohol prep pads which are reimbursed at a maximum amount of $6.00 per 100 prep pads with no dispensing fee. COVID-19 vaccines will be reimbursed at AWP + $1.00 with no dispensing fee.

Prescription products and devices provided by pharmacies, including continuous glucose monitoring (CGM) devices, are reimbursed at the device cost specified below plus the professional dispensing fee specified for pharmacies in section 12 of Attachment 4.19-B of the Medicaid State Plan, which is currently $10.75. Reimbursement for the device cost shall be the lowest of: (i) the usual and customary charge to the public or the pharmacy's actual submitted ingredient cost; (ii) the National Average Drug Acquisition Cost (NADAC) established by CMS; (iii) the Affordable Care Act Federal Upper Limit (FUL); or (iv) Wholesale Acquisition Cost (WAC) plus zero (0) percent when no NADAC is available for a specific drug.

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10. Dental Services:

(a) Dental Services Provided to Adults: Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of dental services provided to adults. The agency's fee schedule rates were set as of January 1, ~~2024~~ 2025 and are effective for services provided on or after that date. All rates are published on the Connecticut Medical Assistance Program website: https://www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download," then select the applicable fee schedule.

(b) Dental Services Provided to Children: Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of dental services provided to children. The agency's fee schedule rates were set January 1, 2024 and are effective for services provided on or after that date. All rates are published on the Connecticut Medical Assistance Program website: https://www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download," then select the applicable fee schedule.

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(b) Prosthetic devices

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of prosthetic devices. The agency's fee schedule rates were set as of ~~October~~ January 1, 20252~~024~~, and are effective for services provided on or after that date. All rates are published on the Connecticut Medical Assistance Program website: https://www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download," then select the applicable fee schedule.

(c) Eyeglasses

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of eyeglasses. The agency's fee schedule rates were set as of July 1, 2008, and are effective for services provided on or after that date. All rates are published on the Connecticut Medical Assistance Program website: https://www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download," then select the applicable fee schedule.

(d) Hearing Aids

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of hearing aids. The agency's fee schedule rates were set as of March 1, 2019, and are effective for services provided on or after that date. All rates are published on the Connecticut Medical Assistance Program website: https://www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download," then select the applicable fee schedule. The price allowed for hearing aids shall be the actual acquisition cost of the hearing aid(s) to the provider, not to exceed the applicable rates on the Hearing Aid/Prosthetic Eye fee schedule.

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13. c. Preventive Services

Services to Treat Autism Spectrum Disorders Pursuant to EPSDT

Fees for services to treat autism spectrum disorders pursuant to EPSDT were set as of ~~July 1, 2024~~ January 1, 2025 and are effective for services provided on or after that date. The fee schedules can be accessed and downloaded by going to the Connecticut Medical Assistance Program website: www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download" and select the fee schedule applicable to the qualified provider. Fees are the same for governmental and private providers.

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AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
CATEGORICALLY NEEDY GROUP(S): ALL

All Medicaid claim costs for covered services will be included in the shared savings calculations described in Attachment 4.19-B, except for: hospice; long-term services and supports (LTSS), including institutional and home and community-based services; and non-emergency medical transportation (NEMT) services. Participating Entities do not need to deliver all defined benefits; rather, the cost of all benefits provided to an assigned PCMH+ member, regardless of the specific provider that performed each service, will be included in the shared savings calculation.

III. Quality Measures

In addition to providing the Enhanced Care Coordination Activities (and for Participating Entities that are FQHCs, also the Care Coordination Add-On Payment Activities), in order to be eligible to receive shared savings payments, if applicable, each PCMH+ Participating Entity must also maintain and/or improve the quality of care and care experience for beneficiaries assigned to the Participating Entity, as measured by various quality measures. Specifically, in order to be eligible to receive shared savings payments, each PCMH+ Participating Entity must meet specified standards as described in Attachment 4.19-B. The PCMH+ quality measure set contains process and outcome measures that include measures of beneficiary experience. Of those measures, a specified subset of measures will be used in calculating various payments, as described in Attachment 4.19-B. All of the quality measures and applicable quality gates have been updated as of January 1, 20252~~4~~ and apply to ~~payments and~~ Performance Years beginning on or after that date and a description of those measures, including the use of each such measure in calculating shared savings payments, is posted to DSS's website at: https://portal.ct.gov/DSS/Health-And-Home-Care/PCMH-Plus/Quality-Measure, then select the applicable time period.

The quality measure set will be reviewed annually and updated as deemed necessary by DSS. Changes in the measure set will be derived from recommendations generated from the Program Evaluations for prior years.

IV.~~.~~ Measures to Prevent Under-Service

Participating Entities will be disqualified from receiving shared savings payments if they demonstrate repeated or systematic failure to offer medically necessary services or manipulate their member panel, whether or not there is evidence of intentionality. DSS uses a multi-pronged approach to identify and prevent under-service of PCMH+ members. The data points that DSS monitors under this approach include, but are not limited to: PCMH+ member grievances, provider performance on quality measures (particularly preventive care service measures),

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AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

All Medicaid claim costs for covered services will be included in the shared savings calculations described in Attachment 4.19-B, except for: hospice; long-term services and supports (LTSS), including institutional and home and community-based services; and non-emergency medical transportation (NEMT) services. Participating Entities do not need to deliver all defined benefits; rather, the cost of all benefits provided to an assigned PCMH+ member, regardless of the specific provider that performed each service, will be included in the shared savings calculation.

III. Quality Measures

In addition to providing the Enhanced Care Coordination Activities (and for Participating Entities that are FQHCs, also the Care Coordination Add-On Payment Activities) in order to be eligible to receive shared savings payments, if applicable, each PCMH+ Participating Entity must also maintain and/or improve the quality of care and care experience for beneficiaries assigned to the Participating Entity, as measured by various quality measures. Specifically, in order to be eligible to receive shared savings payments, each PCMH+ Participating Entity must meet specified standards, as described in Attachment 4.19-B. The PCMH+ quality measure set contains process and outcome measures that include measures of beneficiary experience. Of those measures, a specified subset of measures will be used in calculating various payments, as described in Attachment 4.19-B. All of the quality measures and applicable quality gates have been updated as of January 1, 20252~~4~~ and apply to ~~payments and~~ Performance Years beginning on or after that date and a description of those measures, including the use of each such measure in calculating shared savings payments, is posted to DSS's website at: https://portal.ct.gov/DSS/Health-And-Home-Care/PCMH-Plus/Quality-Measure, then select the applicable time period.

The quality measure set will be reviewed annually and updated as deemed necessary by DSS. Changes in the measure set will be derived from recommendations generated from the Program Evaluations for prior years.

IV. Measures to Prevent Under-Service

Participating Entities will be disqualified from receiving shared savings payments if they demonstrate repeated or systematic failure to offer medically necessary services or manipulate their member panel, whether or not there is evidence of intentionality. DSS uses a multi-pronged approach to identify and prevent under-service of PCMH+ members. The data points that DSS monitors under this approach include, but are not limited to: PCMH+ member grievances, provider performance on quality measures (particularly preventive care service measures),

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I. Shared Savings Payment Methodology: Individual Savings Pool and Quality Gates for Individual Savings Pool and Challenge Savings Pool

A. Individual Savings Pool Quality Measures and Quality Gates for Individual Savings Pool and Challenge Savings Pool

The quality measures and quality gates applicable to the payment methodology are described in Attachment 3.1-A and apply to ~~payments made~~Performance Years beginning on or after the effective date of the applicable language. Specifically, in order to receive Individual Savings Pool or Challenge Pool shared savings payments, the Participating Entity must meet both of the following quality gates:

(1) Improve on its Total Quality Score. To determine eligibility for this quality gate, each Participating Entity's Individual Savings Pool Quality Measures are averaged for the Prior Year and Performance Year, with each measure receiving equal weighting. Each Participating Entity whose Performance Year average is greater than the Prior Year average becomes eligible to participate in the Challenge Pool.

(2) For each of the ~~potentially preventable hospital admissions (PPA)~~ Glycemic Status Assessment for Patients with Diabetes (GSD) and the ~~potentially preventable hospital emergency department visits (PPV)~~ Follow-up after Hospital Emergency Department (ED) Visit for Substance Use (FUA) measures, each PE must either: (A) be ranked within the top 30% of PEs for that measure in a performance year and/or (B) improve ~~their score~~year-over-year performance on that measure ~~compared to the prior performance year~~. PEs will meet this quality gate only if they meet at least one of these methods of meeting this updated quality gate for both ~~PPA~~GSD and ~~PPV~~FUA.

B. Individual Savings Pool Total Quality Scoring

The Individual Savings Pool will be determined by the Participating Entity's Total Quality Score. The Total Quality Score will be developed based on the Participating Entity's quality scores (Absolute Quality) and improvement on quality scores (Improve Quality). Each quality measure can generate a maximum of two points - one point for the absolute level of quality achieved and one point for the year-over-year improvement in quality.

1. Absolute Quality: For each quality measure, a PCMH+ PE will earn a maximum of one point in accordance with the table below for its ability to reach Absolute Quality targets in the Performance Year. The ~~2020~~ Absolute Quality targets for each Performance Year will be derived from the 75th percentile of all PCMH+ PE quality scores from the performance year two years before the current Performance Year~~2018~~. ~~The 2021 targets will be derived from the 75th percentile of all PCMH+ PE quality scores from 2019. These targets will be shared with each PE.~~

Quality Performance Measured Against Quality Target	Points Awarded
Between 0.00% and 74.99%	0.00
75.00% or greater	1.00

2. Improve Quality: For each quality measure, a PCMH+ PE will earn a maximum of one point in accordance with the table below based on its year-over-year improvement compared to the improvement for all of the PCMH+ Performing Entities. The table for each measure will be derived from all Performing Entities for each Performance Year.

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VI. Care Coordination Add-On Payment Methodology (FQHCs Only)

DSS will make Care Coordination Add-On Payments prospectively to Participating Entities that are FQHCs (but not Advanced Networks that include one or more FQHCs) on a monthly basis using a per-member per-month (PMPM) amount for each beneficiary assigned to the FQHC, using the assignment methodology described above. DSS will factor the Care Coordination Add-On Payments in each FQHC's shared savings calculation. For the Performance Year for dates of service for calendar years ~~2017~~2025 and each Performance Year thereafter, except as otherwise provided below, the PMPM payment amount is $~~4.50~~4.00.

~~For the Performance Year for dates of service for calendar year 2017, the total pool of funds for making Care Coordination Add-On Payments is $5.57 million. For the Performance Year for dates of service for calendar year 2018, the total pool of funds for making Care Coordination Add-On Payments is $6.1 million. For the Performance Year for dates of service for calendar year 2019, the total pool of funds for making Care Coordination Add-On Payments is $6.6 million.~~ For the Performance Year for dates of service for calendar year 2020 and all subsequent calendar years, the total pool of funds for making Care Coordination Add-On Payments is $6.36 million. Notwithstanding the PMPM payment amount listed above, if DSS determines that this:

(1) total pool of funds will not be expended by the end of the performance year, DSS shall pay the remaining amount based on each FQHC's proportion of all FQHCs' member months; or

~~(1)~~(2) total pool of funds may be reached or exceeded in a calendar month, DSS shall reduce the PMPM amount for that month as necessary in order to remain within the total pool of funds and no PMPM payments will be made for any subsequent months in the performance year.

Attachment no. 1

PCMH+ W3 QUALITY MEASURE SET (effective January 1, 2025)

Scoring Measures	Measure Steward	National Quality Foundation #
Glycemic Status Assessment for Patients with Diabetes (GSD)*	NCQA	NA
Follow-up after ED Visit for Substance Use (FUA)*	NCQA	NA
Child and Adolescent Well-Care Visits (WCV)	NCQA	1516
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	NCQA	0058
Developmental screening in the first three years of life	CMS	NA
Ambulatory Care - ED Visits (AMB)	NCQA	NA
PCPCM Survey	ABFM	NA
Challenge Measures**	**Measure Steward**	**National Quality Foundation #**
Behavioral Health Screening 1–18	DSS	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics	NCQA	2800
Readmissions within 30 Days - Physical health and behavioral	DSS	NA
Prenatal and Postpartum Care (PPC)	NCQA	1517
Controlling High Blood Pressure (CBP)	NCQA	NA
Kidney Health Evaluation for Patients with Diabetes (KED)	NCQA	NA
Adult Immunization Status (AIS-E)	NCQA	NA
Immunization for Adolescents Combination 2 (IMA-E)	NCQA	NA
Reporting Only Measures	**Measure Steward**	**National Quality Foundation #**
Annual fluoride treatment ages 1-4	DSS	NA
Appropriate Treatment for Upper Respiratory Infection (URI)	NCQA	0069
Asthma Medication Ratio (AMR)	NCQA	1800
Breast Cancer Screening (BCS)	NCQA	2372
Cervical Cancer Screening (CCS)	NCQA	0032
Chlamydia Screening in Women (CHL)	NCQA	0033
Comprehensive Diabetes Care - Eye Exam (Retinal) Performed	NCQA	0055
Follow-Up Care for Children Prescribed ADHD Medication	NCQA	0108
Immunizations for Adolescents – HPV	NCQA	1407
Oral Evaluation, Dental Services	ADA	2517
Use of Imaging Studies for Low Back Pain (LBP)	NCQA	0052
Well-Child Visits in the First 30 Months of Life/Well-Child Visits in the First 15 Months) (W30)	NCQA	1392

* Denotes measures for which Participating Entities (PEs) ranked within the top 30% of PEs for an individual quality gate measure (GSD and FUA) at the end of the performance year will qualify for shared savings for that measure, irrespective of whether their score improved or declined compared to the previous year. PEs not ranked in the top 30% for a quality gate measure must demonstrate a year-over-year improvement to be eligible for shared savings. PEs would only qualify for shared savings when both quality gate measure requirements are met.

** The Challenge Pool Score will be based on a subset of four Challenge Pool quality measures selected by each PCMH+ PE from the list of all available Challenge Pool quality measures. The selection of measures will be subject to DSS approval and will be made prior to the start of the Performance Year.