

# Guide to Reading Your Pool Report



**This guide explains how to read your PCMH pool report and can help you with the following:**

- Find specific information in the report
- Understand the connection between sections of the report and program requirements

## **Things to know about your PCMH pool report**

- The report provides information based on current performance data
  - Data is displayed for a one year time period; exact timeframes are noted on each page
  - Data from all beneficiaries attributed to PCMHs in the pool is combined to determine performance on metrics and care categories
  - Practice support activities are assessed at the individual PCMH level
- Each PCMH will receive an individual report in addition to their pool report
  - The provider report should be used to assess the PCMH performance
  - The provider report may also be used to demonstrate each pooled PCMH's contribution to the pool provided in the shared performance entity report
  - All PCMHs, except standalone pools, will receive a shared performance entity report

The PCMH program seeks to reward primary care physicians for high-quality care that drives system-wide quality and efficiency. The PCMH program is part of the Arkansas Health Care Payment Improvement Initiative, a multi-payer collaboration between Arkansas Blue Cross Blue Shield, Arkansas Medicaid, Arkansas State and Public School Employees Plan, QualChoice of Arkansas, Arkansas Health and Wellness Solutions, United Healthcare and Walmart.

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**Visit us online to login to the portal and access PCMH resources**

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## **[www.paymentinitiative.org](http://www.paymentinitiative.org)**

Our website has the following:

- PCMH program details including the PCMH Program Policy Addendum and methodology used to calculate metrics
- Archived webinars on the PCMH program, guidance on interpreting reports and understanding shared performance
- Frequently asked questions, where to direct your questions, and links to resources

The website also has a link to the online portal. Use a secure username and password for the ability to perform the following:

- View your full report
- Submit required program data

Contact our knowledgeable provider support teams with questions and feedback

- Your Medicaid provider representative at Arkansas Foundation for Medical Care can be reached at 1-501-212-8600 or [PCMH@afmc.org](mailto:PCMH@afmc.org)
- DXC Technology Arkansas Health Care Payment Improvement Unit can be reached at 1-866-322-4696, locally at 1-501-301-8311, or via email at [ARKPII@dxc.com](mailto:ARKPII@dxc.com)

# Why do I get so many reports?

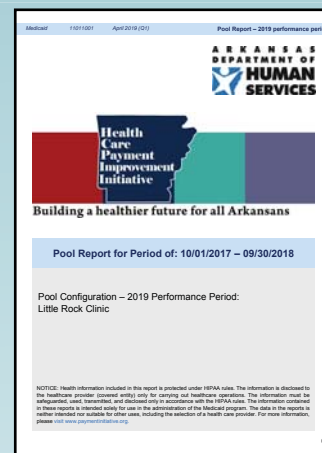
The Arkansas PCMH program runs on calendar years. Each calendar year, the program is refined a bit, with its own list of practice support activities and incentive, core, quality, and informational metrics.

Although each program spans one calendar year, claims processing takes time. More than 95% of claims are filed and processed within three months, but Medicaid rules give providers 365 days from the date of service to file claims, so each calendar year will continue to be processed for 12 further months. Therefore, a practice that is enrolled in the 2018 program will continue to receive reports for several quarters, and if that practice is also enrolled in the 2019 program, it will receive a separate report for that configuration.

Additionally, the Arkansas PCMH program requires at least 1,000 beneficiaries be attributed to a PCMH for at least six months in order for that PCMH to be eligible for shared performance payments. To help more practices qualify for these payments, PCMHs below that threshold may voluntarily pool with other PCMHs to reach the 1,000-beneficiary threshold, and any small PCMH not enrolled in a pool will be placed in either the statewide default pool or the petite pool for shared performance purposes. Each PCMH enrolled in a voluntary pool, the petite pool, or the statewide default pool will receive both a provider report that pertains only to that PCMH and a pool report (also called a shared performance entity report), which contains data from all PCMHs in the pool. Standalone PCMH practices that have at least 1,000 attributed beneficiaries will only receive a provider report. Starting in 2019, all practices with less than 300 beneficiaries may voluntarily pool with other PCMHs to reach the 1,000 minimum requirement.

Finally, though the Arkansas PCMH program runs on a calendar-year basis and metrics are processed quarterly, provider reports allow PCMHs to see how their performance compares to the state-wide average across a 12-month period. Because of the time required for claims processing, each report's 12-month time frame will end either about six months prior to when the report will be released or at the end of the configuration's calendar year. These reports are usually released near the end of each calendar quarter.

So near the end of the third quarter of 2019, for example, a PCMH that was enrolled in both the 2018 and 2019 versions of the program and was in a voluntary pool both years will receive a 2018 provider report and a 2018 pool report, which both will cover the period from January 1, 2018, to December 31, 2018, and a 2019 provider report and a 2019 pool report, which both will cover the period from April 1, 2018, to March 31, 2019.

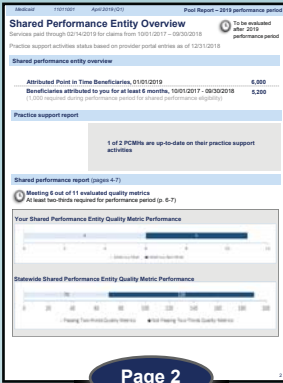


## What reports to expect in coming quarters

Report Run	Performance Period (2018)	Performance Period (2019*)	Report Delivery (Month Year)
Q2 2019	1/1/18 - 12/31/18	1/1/18 - 12/31/18	June 2019
Q3 2019	1/1/18 - 12/31/18	4/1/18 - 3/31/19	September 2019
Q4 2019	N/A	7/1/18 - 6/30/19	December 2019
Q1 2020	1/1/18 - 12/31/18	10/1/18 - 9/30/19	April 2020
Q2 2020	N/A	1/1/19 - 12/31/19	June 2020
Q3 2020	N/A	1/1/19 - 12/31/19	September 2020
Q1 2021	N/A	1/1/19 - 12/31/19	April 2021

\*Quality metrics – HPB PCP, Infant Wellness, Child Wellness, Adolescent Wellness, URI, HbA1c, COB, Tamiflu, Controlling BP, HbA1c Poor Control, Tobacco Use

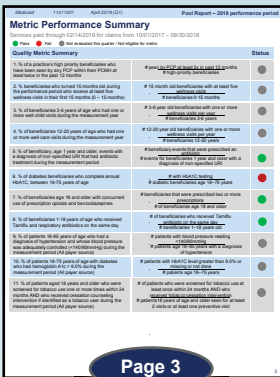
# Your report provides information on four areas



Page 2

## Summary Data (page 2 of report)

The summary page gives basic data for your pool overview as well as a summary of the requirements for practice support and shared performance payments once the performance period begins.



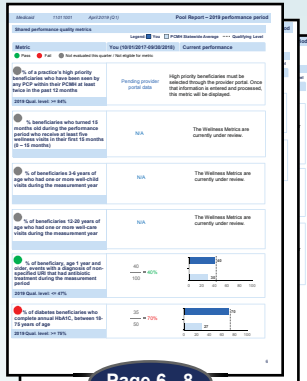
Page 3

## Metric Performance Data (page 3 of report)

The metric performance summary includes quality metric descriptions.



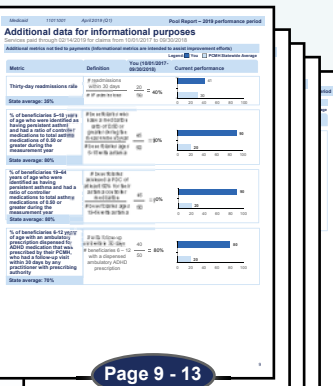
Page 4 - 5



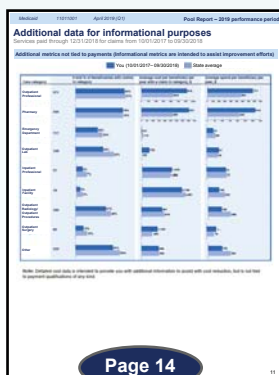
Page 6 - 8

## Shared Performance Data (pages 4 - 8 of report)

The shared performance report shows current performance on the quality metrics that will be tied to shared performance incentive payments during the performance period.



Page 9 - 13



Page 14

## Additional Data (pages 9 - 14 of report)




The additional data pages provide a current performance view on utilization metrics and cost of care by care category as well as a comparison to all participating PCMH practices. This information will not be tied to either practice support or shared performance payments, and is only for your planning purposes.




# How to interpret the legend for metrics charts<sup>1</sup>

## Legend for quality and core metrics

The legend below applies to the shared performance quality and core metrics (pages 6-8)

- These symbols indicate whether current performance data meets qualifying levels
- In instances where there are less than 25 beneficiaries, that metric will not be evaluated
  - For example, if two out of the seventeen quality metrics cannot be evaluated, the PCMH would have to meet two-thirds of the fifteen evaluated quality metrics

 Pass  Fail  Not evaluated this quarter / Not eligible for metric





<u>Symbol</u>	<u>Legend description</u>	<u>Details</u>
	Pass	The historical data in this report meets qualifying levels for the metric
	Fail	The historical data in this report does not meet qualifying levels for the metric
	Not evaluated this quarter/ Not eligible for metric	Metric data relies on data reported in the provider portal that is not yet due or the PCMH/Pool does not meet minimum eligibility criteria for the metric

## Legend for incentive metrics

The legend below applies to the shared performance incentive metrics (page 5)

- These symbols indicate the percentile rank of your current performance, if applicable
- For the incentive focus metric, in instances where there are less than 25 beneficiaries, the metrics will not be evaluated

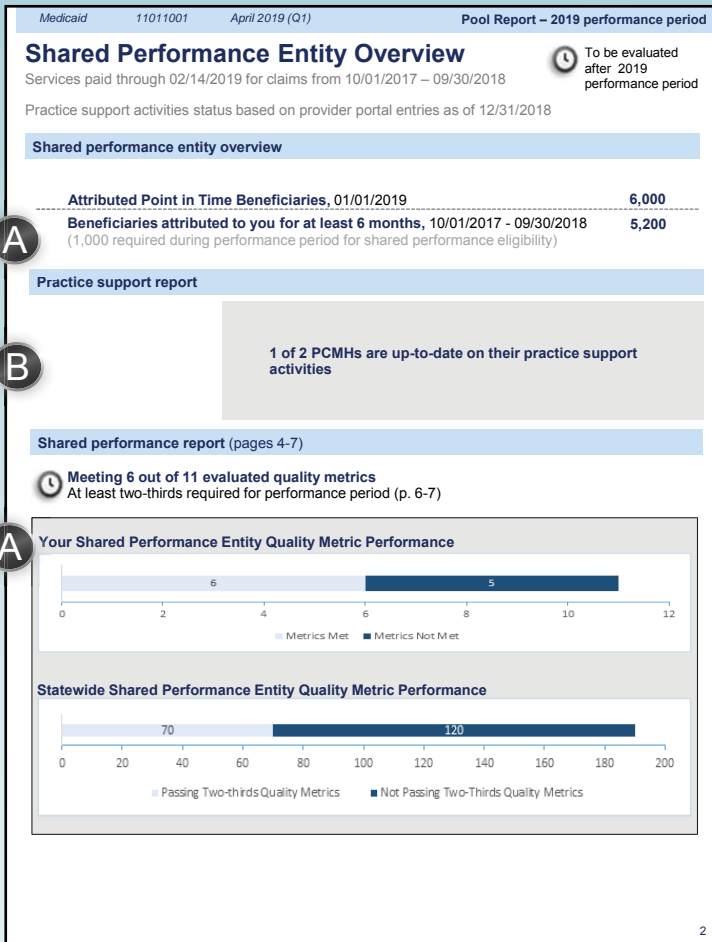
 1st – 10th percentile  11th – 35th percentile  36th + percentile  Not evaluated this quarter / Not eligible for metric

<u>Symbol</u>	<u>Legend description</u>	<u>Details</u>
	1st – 10th percentile	PCMH/Pool is currently at or below the 10th percentile for this metric.
	11th – 35th percentile	PCMH/Pool is currently between 11th - 35th percentile for this metric.
	36th + percentile	PCMH/Pool is currently above the 36th percentile for this metric.
	Not evaluated this quarter / Not eligible for metric	Metric is not evaluated this quarter or the PCMH/Pool did not meet the minimum denominator requirements to be measured for the metric.

<sup>1</sup> Relevant to charts and metrics for shared performance (pages 5 - 8)

# How to interpret your summary data

## Summary Page



A

### Shared performance entity overview

The overview gives basic facts about your pool as of the time periods specified

- “Attributed point in time beneficiaries” shows the number of beneficiaries that were attributed to PCMHs in your pool as of the month prior to the reporting quarter (i.e. January 1 for Q1)
- “Beneficiaries attributed to you for at least 6 months” counts only beneficiaries assigned to primary care physicians in PCMHs in your pool for at least 6 months in the report period

B

### Practice support progress report summary

This section indicates how many PCMHs within your pool are eligible for practice support

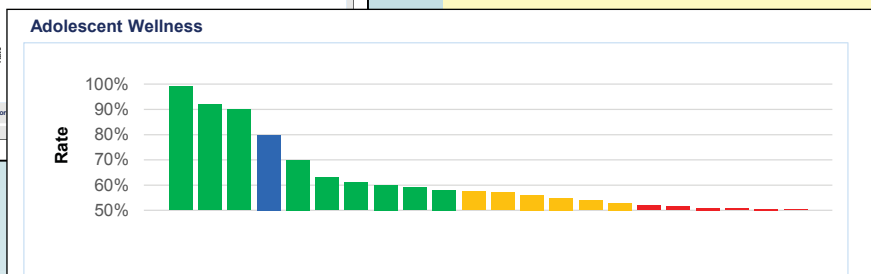
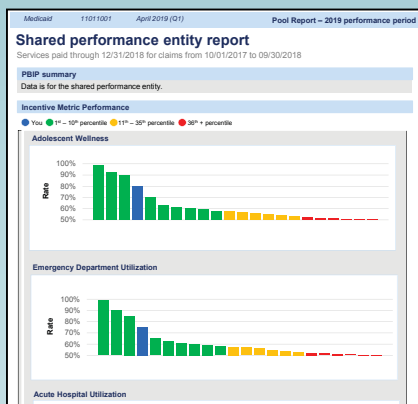
- Each PCMH’s practice support eligibility and data can be found in their PCMH report

# Performance Based Incentive Payments Summary

C

## Incentive Metric Performance

This page provides a population breakdown to provide PCMHs a graphical representation of their Focus and Incentive metric performance compared to the rest of the PCMHs/ Pools enrolled in the PCMH/Pool rankings as referenced below.

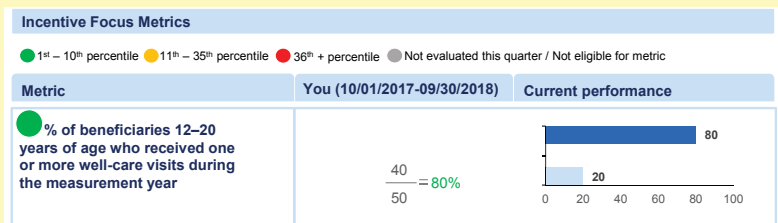


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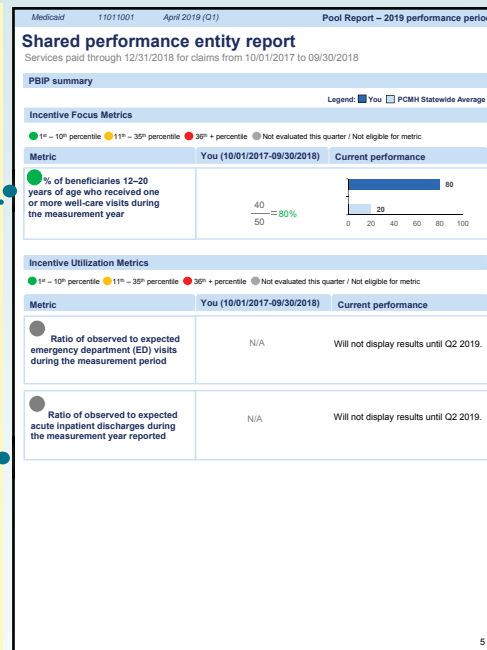
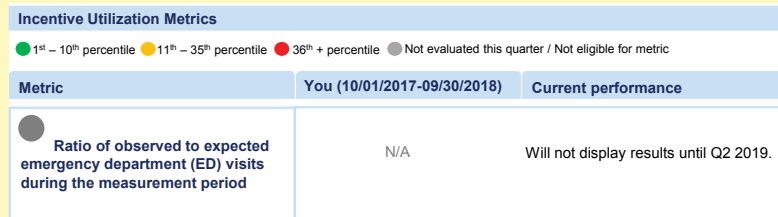
## PBIP Summary

This page is broken into two sections to assist PCMHs/ Pools in their PBIP metrics:

- Focus metric to determine a PCMH/Pool's ranking for potential incentive payments.



- Utilization metrics used to determine a PCMH/Pool's ranking for potential utilization payments.



# Understanding the status of your metric performance summary

## Metric Performance Summary

Legend: ● Pass ● Fail ● Not evaluated this quarter / Not eligible for metric

Medicaid 11011001 April 2019 (Q1)		Pool Report – 2019 performance period
<b>Metric Performance Summary</b> Services paid through 02/14/2019 for claims from 10/01/2017 – 09/30/2018 <span style="color: green;">●</span> Pass <span style="color: red;">●</span> Fail <span style="color: gray;">●</span> Not evaluated this quarter / Not eligible for metric		
Quality Metric Summary		Status
1. % of a practice's high priority beneficiaries who have been seen by any PCP within their PCMH at least twice in the past 12 months	$\frac{\# \text{ seen by PCP at least 2x in past 12 months}}{\# \text{ high-priority beneficiaries}}$	●
2. % beneficiaries who turned 15 months old during the performance period who receive at least five wellness visits in their first 15 months (0 – 15 months)	$\frac{\# \text{ 15 month old beneficiaries with at least five wellness visits}}{\# \text{ beneficiaries 0-15 months}}$	●
3. % of beneficiaries 3-6 years of age who had one or more well-child visits during the measurement year	$\frac{\# \text{ 3-6 year old beneficiaries with one or more wellness visits per year}}{\# \text{ beneficiaries 3-6 years}}$	●
4. % of beneficiaries 12-20 years of age who had one or more well-care visits during the measurement year	$\frac{\# \text{ 12-20 year old beneficiaries with one or more wellness visits per year}}{\# \text{ beneficiaries 12-20 years}}$	●
5. % of beneficiary, age 1 year and older, events with a diagnosis of non-specified URI that had antibiotic treatment during the measurement period	$\frac{\# \text{ beneficiary events that were prescribed an antibiotic}}{\# \text{ events for beneficiaries 1 year and older with a diagnosis of non-specified URI}}$	●
6. % of diabetes beneficiaries who complete annual HbA1C, between 18-75 years of age	$\frac{\# \text{ with HbA1C testing}}{\# \text{ diabetic beneficiaries age 18-75 years}}$	●
7. % of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines	$\frac{\# \text{ beneficiaries that were prescribed two or more prescriptions}}{\# \text{ of beneficiaries age 18 and older}}$	●
8. % of beneficiaries 1-18 years of age who received Tamiflu and respiratory antibiotics on the same day	$\frac{\# \text{ of beneficiaries who received Tamiflu antibiotic on the same day}}{\# \text{ beneficiaries 1-18 years old}}$	●
9. % of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period (All payer source)	$\frac{\# \text{ patients with blood pressure reading <140/90mmHg}}{\# \text{ patients age 18-85 years with a diagnosis of hypertension}}$	●
10. % of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period (All payer source)	$\frac{\# \text{ patients with HbA1C level greater than 9.0% or missing or not done}}{\# \text{ patients age 18-75 years}}$	●
11. % of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user during the measurement period (All payer source)	$\frac{\# \text{ of patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention}}{\# \text{ patients 18 years of age and older seen for at least 2 visits or at least one preventive visit}}$	●

3

### Pre-defined activities come from the PCMH Program Policy Addendum

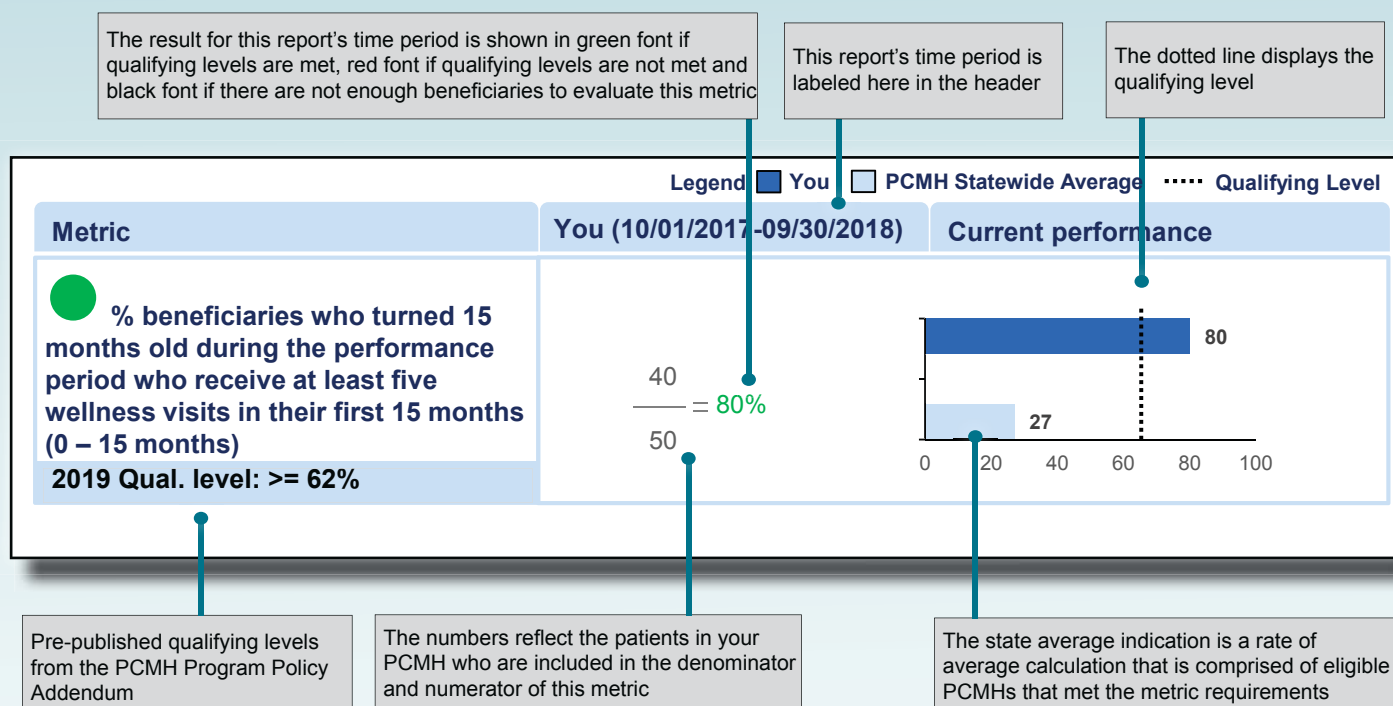
- The provider portal at <https://secure.ahin-net.com/ahin/logon.jsp> should be used to submit materials for completed activities. You can also link to the provider portal on [www.paymentinitiative.org](http://www.paymentinitiative.org).
- The status will show a green circle whenever the activity has been submitted, subject to verification. A red circle will be present if the activity was not submitted. Activities which are under validation or are required to be completed by a later date will be marked with a gray circle.

# How to read metrics charts<sup>1</sup>

## Metrics charts

The format of metrics charts are consistent across shared performance metrics (pages 5 - 8), and additional informational metrics (pages 9 - 14)

- Informational metrics do not show qualifying levels (known as 2019 targets) because they are not evaluated as part of the PCMH program requirements, but they do show the state average

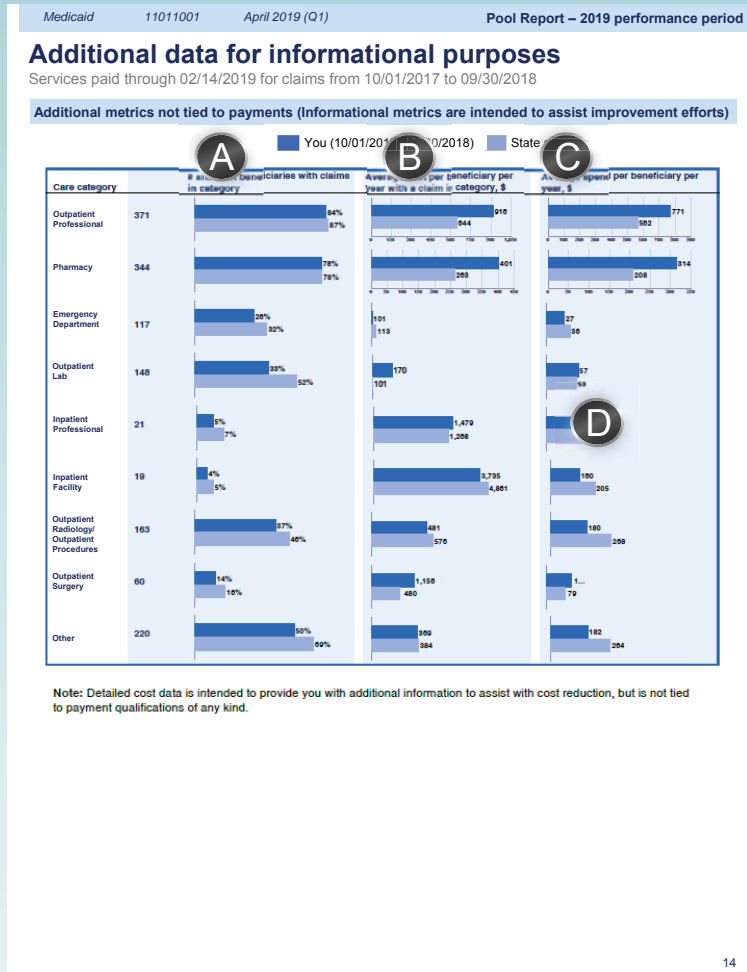


1 Relevant to charts and metrics for shared performance (pages 5 - 8), and additional informational data (pages 9 - 14) sections of the report



# Understanding your cost data

## Cost data by care category



Cost data by care category is displayed in the additional data section of the report (page 14)

**A** Number and percentage of beneficiaries with claims in the care category - enables you to understand the breadth of membership involved

**B** Average cost per beneficiary per year with a claim in the category - allows you to understand what the value is of an average patient

**C** Average spend in the care category per beneficiary per year (across all attributed beneficiaries) - allows you to see what the total value is of continued improvement in a category

**D** Statewide average - enables you to identify areas for improvement, i.e. where your performance is below that of your peers

### Cost information shows a comparison of your spend by care category to participating practices

- The data is intended to provide insight around where your spend occurs compared to your peers enabling you to focus on areas for improvement
- The care categories are the same categories used in Arkansas Health Care Payment Improvement Initiative (AHCPII) episode reports. Over time, these will be refined to highlight data particularly relevant to patient centered medical homes
- Care categories include: outpatient professional, pharmacy, emergency department, outpatient lab, inpatient professional, inpatient facility, outpatient radiology / outpatient procedures, outpatient surgery, and other
- The data is not tied to payment qualifications of any kind

Note: For additional detail on care categories refer to the "PCMH Program Policy Addendum" on the AHCPII website.