Guide to Reading Your PCMH Report

Health Care Payment Improvement Initiative

Building a healthier future for all Arkansans

This guide explains how to read your PCMH 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 report

- The report provides information based on current performance data
  - — Data is displayed for a one-year time period. The exact timeframe is noted on each page.
- The report shows information about your PCMH practice
  - — For pooled practices, the information for your shared performance entity will be provided in the shared performance entity report (see "Guide to Reading Your Pool Report")
  - — All PCMHs who are associated with a pool 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.

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

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

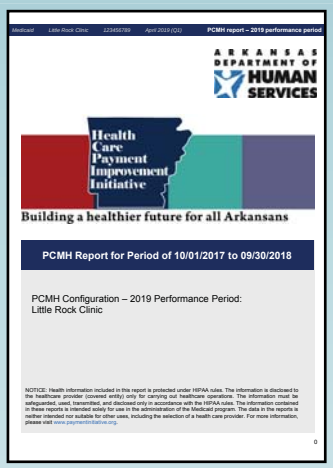
The website also has a link to the online portal. Use a secure username and password for the ability to perform the following:

- 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
- 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

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.

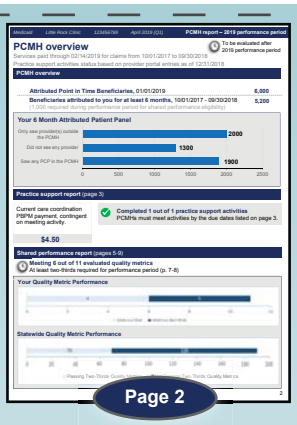
Finally, though the Arkansas PCMH program runs on a calendar-year basis and metrics are processed quarterly, provider reports allow PCMHs to see how their performance compares to the state-wide average across a 12-month period. Because of the time required for claims processing, each report's 12-month 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 ranging from January 1, 2018, to December 31, 2018, and a 2019 provider report and a 2019 pool report, which both will cover the period ranging 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

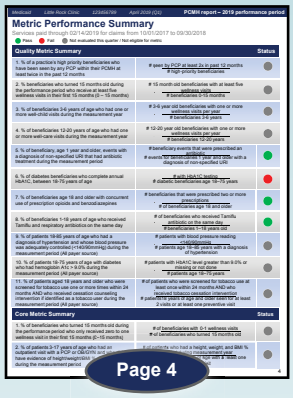
**Quality metrics – HPB PCP, Infant Wellness, Child Wellness, Adolescent Wellness, URI, HbA1c, COB, Tamiflu, Controlling BP, HbA1c Poor Control, Tobacco Use*

Your report provides information on four areas



Summary Data (page 2 of report)

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

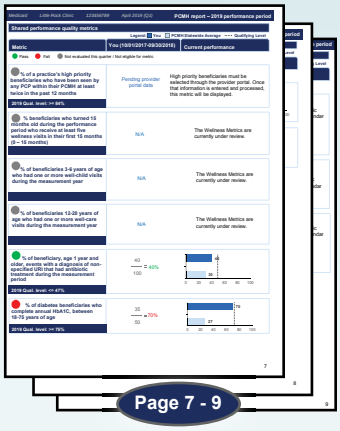


Practice Support Data (page 3 of report)

The practice support report includes progress report on activities. This element will be tied to practice support payments (PMPM) during the performance period.

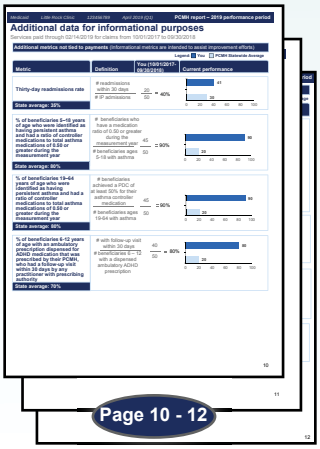
Metric Performance Data (page 4 of report)

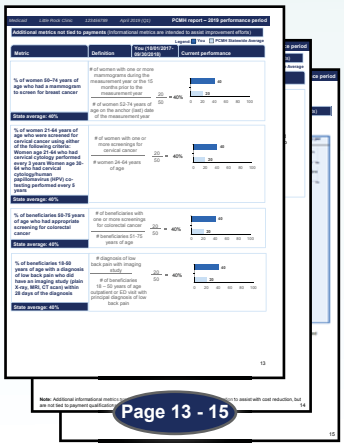
The metric performance summary includes quality and core metric descriptions.



Shared Performance Data (page 5 - 9 of report)

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





Additional Data (page 10 - 15 of report)

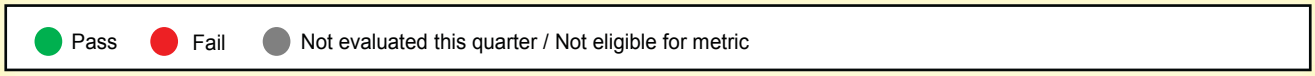
The additional data pages provide current performance on informational metrics and cost of care by care category as well as a comparison to all participating PCMH practices. This information will not be tied to either practice support or shared performance payments, and is only for your planning purposes.

How to interpret the legend for metrics charts[1]

Legend for quality and core metrics

The legend below applies to the shared performance quality and core metrics (pages 6-9)

- These symbols indicate whether current performance 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

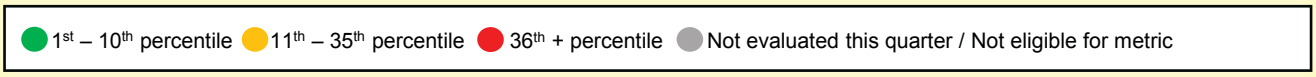


Symbol	Legend description	Details
	Pass	The current performance in this report meets qualifying levels for the metric
	Fail	The current performance in this report does not meet qualifying levels for the metric
	Not evaluated this quarter/ Not eligible for metric	Metric data relies on data reported in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

Legend for incentive metrics

The legend below applies to the shared performance incentive metrics (page 6)

- 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 metric will not be evaluated



Symbol	Legend description	Details
	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.

1 Relevant to charts and metrics for shared performance (pages 5 - 9)

How to interpret your summary data

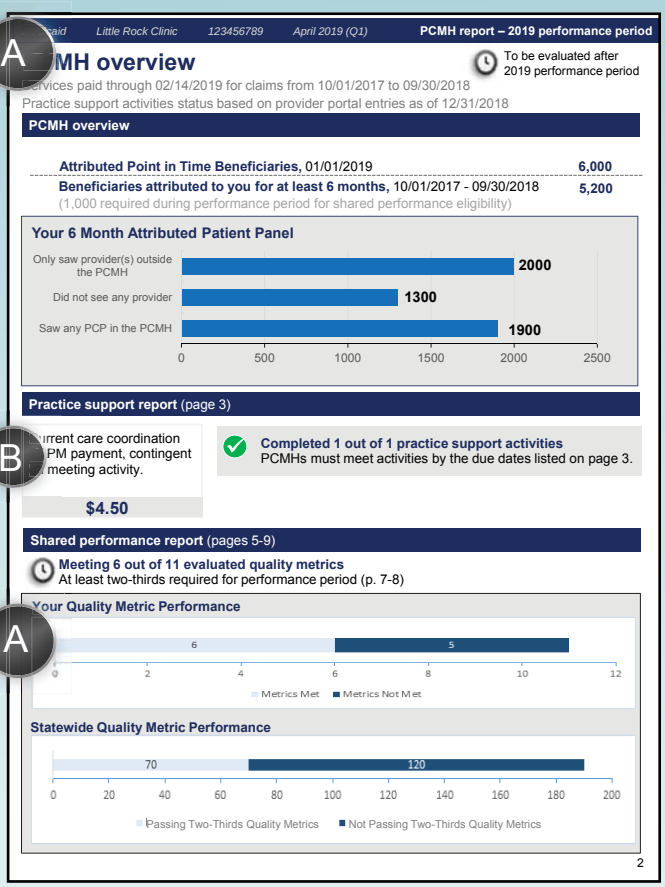
Summary Page

A

PCMH Overview

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

- "Attributed point in time beneficiaries" shows the number of beneficiaries that were attributed to your PCMH as of the start of the performance period (i.e. January 1 for Q1)
- "Beneficiaries attributed to you for at least 6 months" counts only beneficiaries assigned to primary care physicians in your PCMH for at least 6 months in the report period
- The 6 Month Attributed Patient Panel is broken down into three categories to assist population management. The three categories are:
  - — Only saw provider outside the PCMH
  - — Did not see any provider
  - — Saw any PCP in the PCMH
- Two graphs are provided to assist PCMHs in their quality metric performance and how it compares to all PCMHs enrolled in the program.
  These two graphs are:
  - — Your Quality Metric Performance
  - — Statewide Quality Metric Performance



B

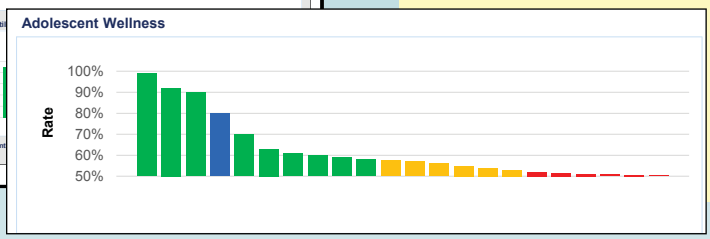
Practice Support Report Summary

This section provides two main data points of estimated care coordination payments and requirement to continue receiving practice support, including payments.

- Care coordination estimates are based on historical numbers and the risk profile of patients
- In order to continue receiving practice support, including payments, practices must meet all activities by the required due dates

Completed 1 out of 1 practice support activities
PCMHs must meet activities by the due dates listed on page 3.

Performance Based Incentive Payments Summary



C

Incentive Metric Performance

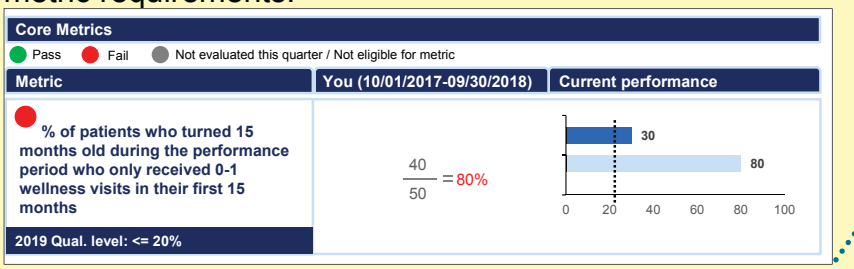
This page provides a population breakdown to provide PCMHs a graphical representation of their Focus and Incentive metric performance compared to the rest of the PCMHs/Pools enrolled in the PCMH/Pool rankings as referenced below.

D

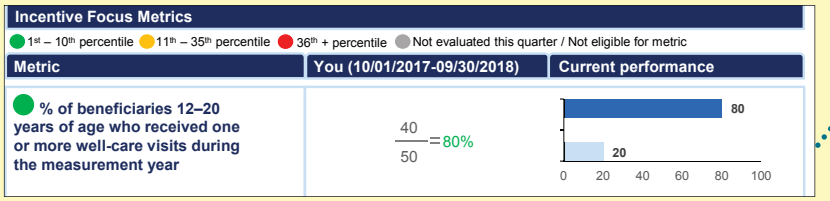
PBIP Summary

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

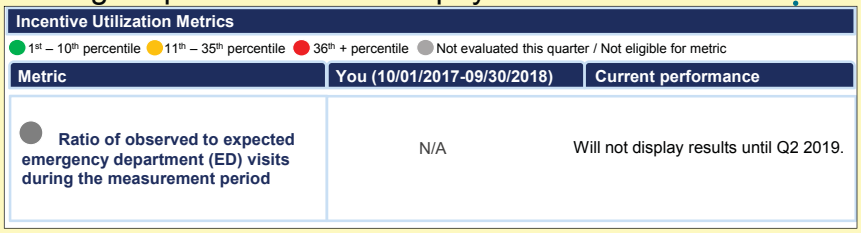
- Core metrics that determine if PCMHs are meeting minimum metric requirements.

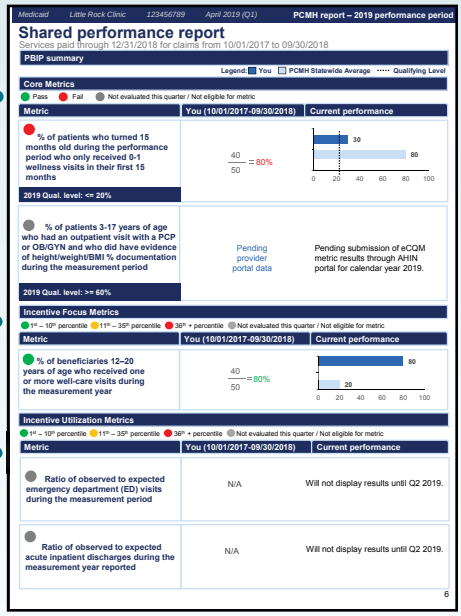


- Focus metric to determine a PCMH/Pool's ranking for potential incentive payments.



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





Understanding the status of your practice support activities

Practice Support Report

Legend: Pass Fail Not evaluated this quarter / Under validation

Medicaid *Little Rock Clinic* *123456789* *April 2019 (Q1)* **PCMH report – 2019 performance period**

Practice support report

Practice support activities status based on provider portal entries as of 09/30/2018

Pass Fail Not evaluated this quarter / Under validation

Practice support activity	Due date	Status
A. Identify top 10% of high-priority patients (including behavioral clients)	03/31/2019	
B. Make available 24/7 access to care.	06/30/2019	
C. Track same-day appointment requests	06/30/2019	
D. Capacity to receive direct e-messaging from the patients	06/30/2019	
E. Childhood / Adult Vaccination Practice Strategy	06/30/2019	
F. Join SHARE or participate in a network that delivers hospital discharge information to practice within 48 hours	06/30/2019	
G. Medication Management	06/30/2019	
H. Care Plans for High Priority Patients	12/31/2019	
I. Patient Literacy Assessment Tool	12/31/2019	
J. Ability to receive patient feedback	12/31/2019	
K. Care instructions for High Priority Patients	12/31/2019	
L. 10-day Follow up after an Acute Inpatient Stay	12/31/2019	
M. Developmental / Behavior Health Assessment for Children and Adolescents	12/31/2019	

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.
- 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.

Understanding the status of your metric performance summary

Metric Performance Summary

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

Medicaid *Little Rock Clinic* *123456789* *April 2019 (Q1)* **PCMH report – 2019 performance period**

Metric Performance Summary

Services paid through 02/14/2019 for claims from 10/01/2017 to 09/30/2018

Pass Fail 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	# seen by PCP at least 2x in past 12 months / # 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)	# 15 month old beneficiaries with at least five wellness visits / # beneficiaries 0-15 months	
3. % of beneficiaries 3-6 years of age who had one or more well-child visits during the measurement year	# 3-6 year old beneficiaries with one or more wellness visits per year / # beneficiaries 3-6 years	
4. % of beneficiaries 12-20 years of age who had one or more well-care visits during the measurement year	# 12-20 year old beneficiaries with one or more wellness visits per year / # 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	# beneficiary events that were prescribed an antibiotic / # 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	# with HbA1C testing / # diabetic beneficiaries age 18–75 years	
7. % of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines	# beneficiaries that were prescribed two or more prescriptions / # of beneficiaries age 18 and older	
8. % of beneficiaries 1-18 years of age who received Tamiflu and respiratory antibiotics on the same day	# of beneficiaries who received Tamiflu antibiotic on the same day / # 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)	# patients with blood pressure reading <140/90mmHg / # 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)	# patients with HbA1C level greater than 9.0% or missing or not done / # 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)	# of patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention / # patients18 years of age and older seen for at least 2 visits or at least one preventive visit	
Core Metric Summary		**Status**
1. % 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)	# of beneficiaries with 0-1 wellness visits / # of beneficiaries who turned 15 months old	
2. % of patients 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who did have evidence of height/weight/BMI % documentation during the measurement period	# of patients who had a height, weight, and BMI % recorded during measurement year / # of patients 3–17 years of age with at least one outpatient visit	

4

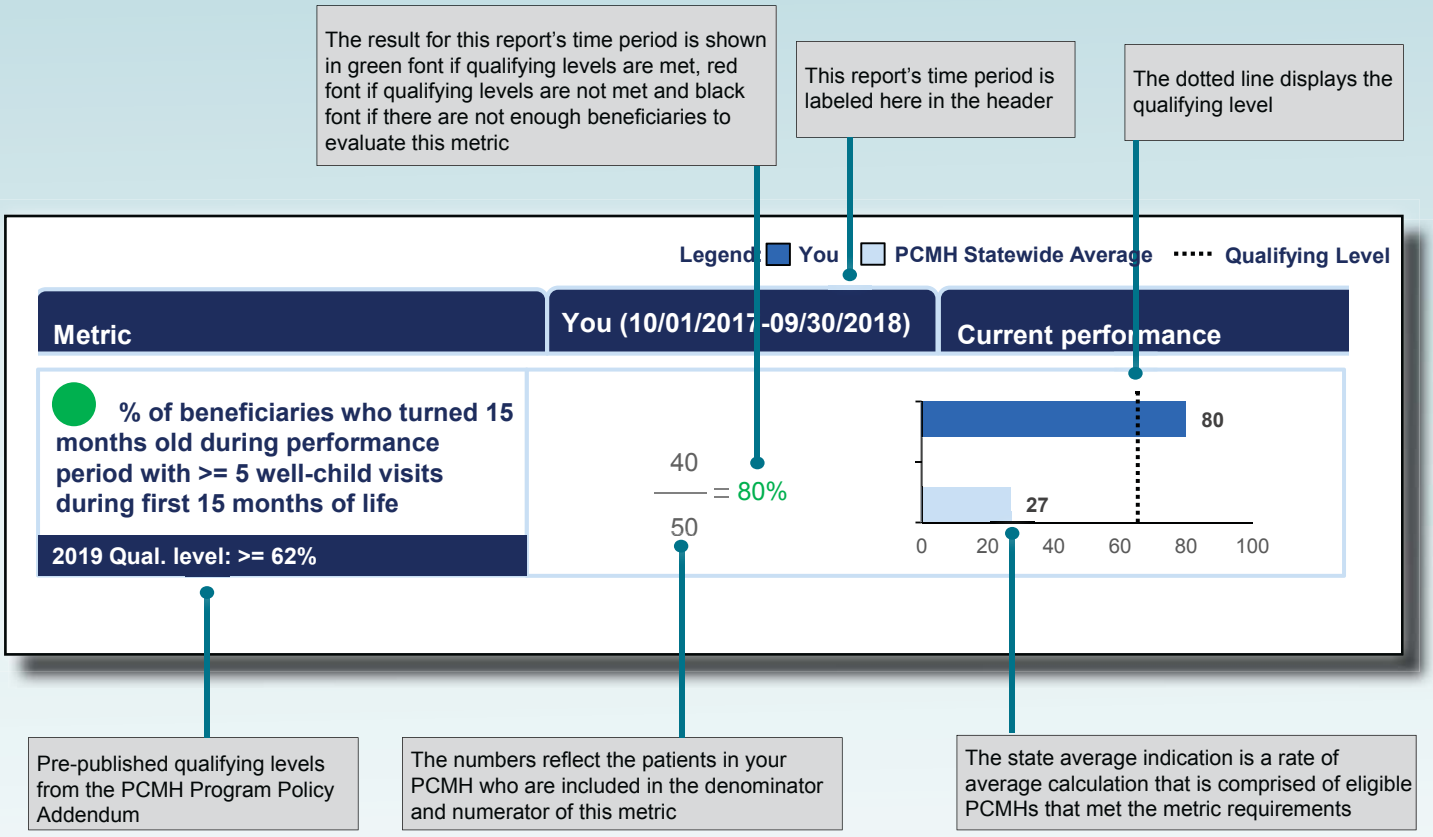
Additional metric specifications can be located in the PCMH Program Policy Addendum at: http://paymentinitiative.publishpath.com/pcmh-manual-and-additional-resources

How to read metrics charts[1]

Metrics charts

The format of metrics charts are consistent across shared performance metrics (pages 6 - 9), and additional informational metrics (pages 10 - 14)

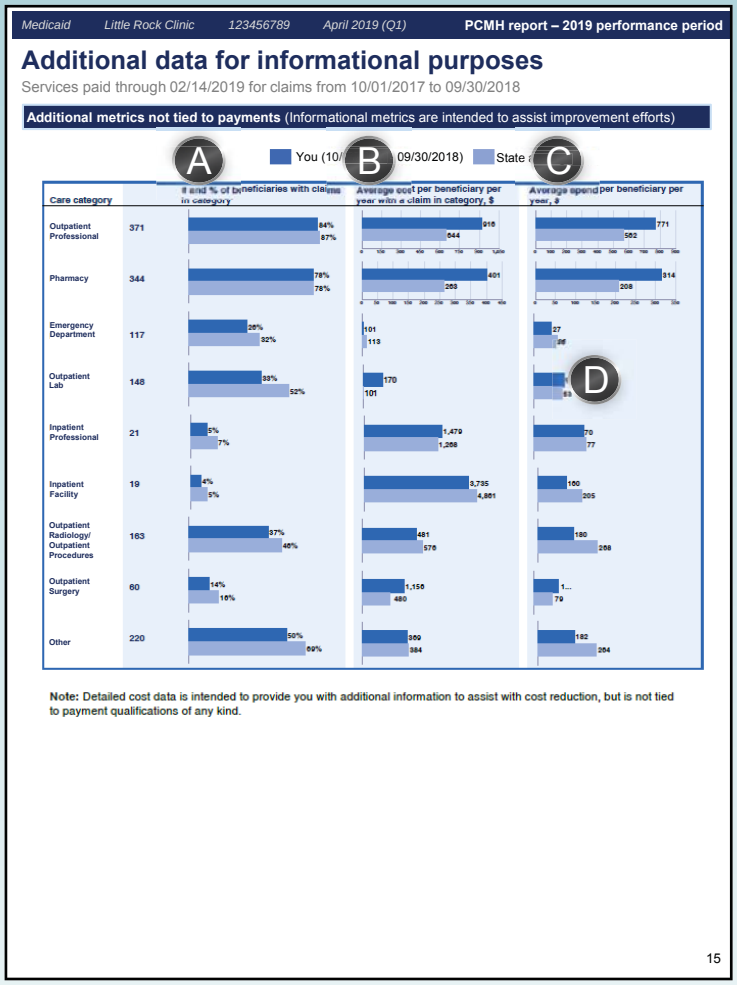
- Informational metrics do not show qualifying levels (known as 2019 targets) because they are not evaluated as part of the PCMH program requirements, but they do show the state average



1 Relevant to charts and metrics for shared performance (pages 5 - 9), and additional informational data (pages 10 - 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 15)

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 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 others
- 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.