This guide explains how to read your PCMH report and can help you:

- 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 historical data
  - Data is displayed in rolling one-year time periods; exact timeframes are noted on each page
  - Practice support metrics are only tied to practice support eligibility in Q2 of each year following a PCMH’s first full year in the program; these metrics in all other reports are meant as progress indicators only
- The report shows information about your PCMH practice
  - For pooled practices, the information for your shared savings entity will be provided in the Shared Savings Entity report
  - All PCMHs will receive a shared savings report, even though not all PCMHs are eligible for shared savings

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 Medicaid, Arkansas Blue Cross Blue Shield, and QualChoice of Arkansas.

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

Our website www.paymentinitiative.org has details on:

- PCMH program details including the provider manual and methodology used to calculate metrics
- Archived webinars on the PCMH program, interpreting reports and understanding shared savings
- 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 to:

- 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 at 501-212-8600 or PCMH@afmc.org
- HP Enterprise Services Arkansas Health Care Payment Improvement Unit at 1-866-322-4696, locally at 1-501-301-8311, or via email at ARKPII@hp.com.
Your report provides information on four areas:

**Summary data (page 2 of report)**

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

**Practice support data (page 3 and 4 of report)**

The practice support report includes both a progress report on activities and a historical view on practice support metrics. These two elements will be tied to practice support payments (PMPM) during the performance period.

**Shared savings data (page 5 and 6 of report)**

The shared savings report shows a historical view of costs and of the quality metrics that will be tied to shared savings incentive payments during the performance period.

**Additional data (page 7 and 8 of report)**

The additional data pages provide a historical view on utilization metrics and cost of care by care category as well as a comparison to practices in your risk cohort. This information will not be tied to either practice support or shared savings payments, and is only for your planning purposes.
How to interpret your summary data (part 1 of 2)

Summary page

PCMH overview

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

- “Attributed beneficiaries” shows the number of beneficiaries that were attributed to your PCMH as of the month prior to the reporting quarter (i.e. June 1 for Q3)
- “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

Practice support progress report summary

This section provides two main data points: estimated care coordination payments and requirements to continue receiving practice support, including payments

- Care coordination estimates are based on historical numbers and the risk profile of patients
- Practice support has two requirements, both of which must be met in order to continue receiving practice support, including payments

Shared savings eligibility summary

This section displays pre-defined requirements to receive shared savings incentive payments

- The PCMH total cost of care is compared to both the medium cost threshold as well as the PCMH-specific benchmark; both of these parameters are pathways to shared savings

Note: PCMHs must meet all practice support requirements in addition to the requirements listed above. CPC practices must achieve all CPC milestones and measures on time

Note: CPC practices will be held accountable to different requirements as outlined in the CPC program requirements
Additional utilization metrics summary for informational purposes only

This section introduces your practice risk score and risk cohort, which enable you to compare data against similar practices (for informational purposes only):

- Your PCMH risk score is based on an average across all beneficiaries attributed to your PCMH for at least 6 months.
- Risk cohorts are based on the PCMH’s average risk score.
- Only practices enrolled in Medicaid PCMH are included.
- A cohort of practices with similar risk scores is used in this report to allow comparisons to these practices on utilization metrics (page 7) and care categories (page 8). The comparison is for information only and not tied to payments.
### Understanding the status of your practice support activities

**Activities progress report**

<table>
<thead>
<tr>
<th>Practice support activity</th>
<th>Due date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Identify top 10% of high priority beneficiaries (to be reviewed annually)</td>
<td>3/31/14</td>
<td>✔</td>
</tr>
<tr>
<td>2. Assess operations of practice and opportunities to improve</td>
<td>6/30/14</td>
<td>✔</td>
</tr>
<tr>
<td>3. Develop and record strategies to implement care coordination &amp; practice transformation</td>
<td>6/30/14</td>
<td>✔</td>
</tr>
<tr>
<td>4. Identify and reduce medical neighborhood barriers to coordinated care at the practice level.</td>
<td>6/30/14</td>
<td>✔</td>
</tr>
<tr>
<td>5. Provide 24/7 access to care. Provide telephone access to a live voice or to an answering machine that immediately pages an on-call professional</td>
<td>6/30/14</td>
<td>✔</td>
</tr>
<tr>
<td>6. Document approach to tracking access to same-day appointments</td>
<td>6/30/14</td>
<td>✔</td>
</tr>
<tr>
<td>7. Document approach to contacting beneficiaries who have not received preventive care</td>
<td>12/31/14</td>
<td>N/A</td>
</tr>
<tr>
<td>8. Complete survey related to timeliness of patients' access to specialists</td>
<td>12/31/14</td>
<td>N/A</td>
</tr>
<tr>
<td>9. Document investment in healthcare technology or tools that support practice transformation</td>
<td>12/31/14</td>
<td>N/A</td>
</tr>
<tr>
<td>10. Join SHARE to get inpatient discharge information from hospitals. Document compliance.</td>
<td>12/31/14</td>
<td>N/A</td>
</tr>
<tr>
<td>11. Review/adjust top 10% of high priority beneficiaries</td>
<td>3/31/15</td>
<td>N/A</td>
</tr>
<tr>
<td>12. Incorporate e-prescribing into practice workflows</td>
<td>6/30/15</td>
<td>N/A</td>
</tr>
<tr>
<td>13. Integrate EHR into practice workflows</td>
<td>12/31/15</td>
<td>N/A</td>
</tr>
<tr>
<td>14. Re-assess operations of practice and opportunities to improve</td>
<td>12/31/15</td>
<td>N/A</td>
</tr>
<tr>
<td>15. Refine strategy to implement care coordination &amp; practice transformation improvements</td>
<td>12/31/15</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Pre-defined activities come from the provider manual**

- The provider portal at [https://secure.ahin-net.com/ahin/logon.jsp](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 check whenever the activity has been submitted, subject to verification. Activities which are required to be completed by a later date will be marked as “N/A”—not due yet.
How to interpret the legend for metrics charts

**Metrics legend**

Legend for metrics charts

The legend applies to the following sections of the report: practice support (page 4) and shared savings (pages 5 and 6)

- These symbols indicate whether historical 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 nine quality metrics cannot be evaluated, the PCMH would have to meet two-thirds of the seven evaluated quality metrics

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Legend description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔️</td>
<td>Meeting qualifying level</td>
<td>The historical data in this report meets qualifying levels for the metric</td>
</tr>
<tr>
<td>✗</td>
<td>Not meeting qualifying level</td>
<td>The historical data in this report does not meet qualifying levels for the metric</td>
</tr>
<tr>
<td>🕒</td>
<td>To be reported pending provider portal data</td>
<td>Metric data relies on data reported in the provider portal that is not yet due</td>
</tr>
<tr>
<td>🕒</td>
<td>Not enough beneficiaries to be evaluated</td>
<td>The data for the metric must be based on at least 25 applicable beneficiaries in order for the metric to be evaluated. Metrics not evaluated will be omitted for the purposes of meeting program requirements</td>
</tr>
</tbody>
</table>

1 Relevant to charts and metrics for practice support (page 4) and shared savings (pages 5 and 6)
How to read metrics charts

Metrics charts

The format of metrics charts are consistent across practice support metrics (page 4), shared savings metrics (pages 5 and 6), and additional utilization metrics (page 7)

- Utilization metrics do not show qualifying levels because they are not evaluated as part of the PCMH program requirements, but they do show the risk cohort or state average.
- Refer to the provider manual and provider manual attachments for details on exclusions for each metric.

metrics chart

The numbers reflect the patients in your PCMH who are included in this measure.

The result for this report’s time period is shown in green font if qualifying levels are met, red font if qualifying levels are not met and black font if there are not enough beneficiaries to evaluate this metric.

The methodology for calculating each metric is shown in the definition.

This report’s time period is labeled here in the header.

Each point on the chart represents a rolling 12 months’ worth of data for the time period labeled on the x-axis.

Pre-published qualifying levels from the provider manual.
Understanding your cost data (part 1 of 2)

Cost data

Cost data are displayed in the shared savings section of the report (page 5).

- Only PCMHs with at least 5,000 beneficiaries that are attributed for at least 6 months are shown their benchmarks and 2014 targets. Participating practices in a shared savings entity will receive an entity-level report in addition.

- All costs are in per beneficiary per year numbers that have been adjusted by both risk score and the number of months a beneficiary has been attributed to your patient panel.

A. Your 2013 average cost is used to give you an idea of how your cost performance has been recently. If your cost is below your benchmark, or below the medium or high cost threshold in 2014, you may be eligible for shared savings. This number should be used as a starting point for you to assess and prioritize opportunities for managing the growth in costs and providing efficient care.

B. Your 2014 benchmark is used for the purpose of managing growth in costs. If your 2014 average cost at the end of the performance period is at least 2% below your 2014 benchmark, indicating performance improvement, you may be eligible to receive shared savings payments.

C. $2,032 is the 2014 medium cost threshold. This threshold is used to calculate shared savings for providing efficient care as well as to establish your shared savings percentage for managing your growth in costs.

D. $2,718 is the high cost threshold. This threshold is used to establish your shared savings percentage for managing your growth in costs.

Note: See Section 237.000 of the provider manual for a detailed description of the shared savings incentive payment for providing efficient care and managing the growth in costs.
Understanding your cost data (part 2 of 2)

Cost data by care category

Cost data by care category is displayed in the additional data section of the report (page 8)

<table>
<thead>
<tr>
<th>Care category</th>
<th># and % of beneficiaries with claims in category</th>
<th>Average cost per beneficiary per year with a claim in category, $</th>
<th>Average spend per beneficiary per year, $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient professional</td>
<td>5200 100%</td>
<td>100 1,200</td>
<td>100 1,188</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>5145 98%</td>
<td>98 1,000</td>
<td>190 990</td>
</tr>
<tr>
<td>Emergency department</td>
<td>4340 95%</td>
<td>95 1,000</td>
<td>21 26</td>
</tr>
<tr>
<td>Outpatient lab</td>
<td>4100 79%</td>
<td>79 1,200</td>
<td>120 499</td>
</tr>
<tr>
<td>Inpatient professional</td>
<td>3900 75%</td>
<td>75 400</td>
<td>300 94</td>
</tr>
<tr>
<td>Inpatient facility</td>
<td>4055 78%</td>
<td>78 120</td>
<td>5 5</td>
</tr>
<tr>
<td>Outpatient radiology / procedures</td>
<td>230 3%</td>
<td>230 126</td>
<td>8 1</td>
</tr>
<tr>
<td>Outpatient surgery</td>
<td>52 &lt;1%</td>
<td>52 &lt;1%</td>
<td>5 5</td>
</tr>
<tr>
<td>Other</td>
<td>156 3%</td>
<td>156 125</td>
<td>4 4</td>
</tr>
</tbody>
</table>

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 pursuing improvement in a category

D. Average for your risk cohort – enables you to identify areas for improvement, i.e. where your performance is below that of your peers caring for similar types of patients

Cost information shows a comparison of your spend by care category to practices in your risk cohort

- The data is intended to provide insight around where your spend occurs compared to your peers caring for similar types of patient, enabling you to focus on areas for improvement
- The care categories are the same categories used in Arkansas Payment Improvement Initiative (APII) episode reports. Over time, these will be refined to highlight data particularly relevant to patient centered medical homes
- Care categories include: outpatient professional, pharmacy, outpatient lab, inpatient professional, inpatient facility, outpatient radiology / 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 “Supplemental information to the PCMH manual” on the APII website