Guide to Reading Your Pool Report

This guide explains how to read your PCMH pool 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 pool 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
  — Data from all beneficiaries attributed to PCMHs in the pool is combined to determine performance on metrics, cost, 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 individual report should be used to assess the PCMH performance
  — The individual report may also be used to demonstrate each pooled PCMH’s contribution to the pool provided in the Shared Savings Entity report
  — All PCMHs, except standalone pools, will receive a shared savings 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 Medicaid, Arkansas Blue Cross Blue Shield, Ambetter, United Healthcare and QualChoice of Arkansas.

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

www.paymentinitiative.org

Our website has details on:
• PCMH program details including the PCMH Program Policy Addendum 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 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 slightly higher total cost of care thresholds and benchmarks and its own list of practice support activities, quality metrics, 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 2016 program will continue to receive reports for several quarters, and if that practice is also enrolled in the 2017 program, it will receive a separate report for that configuration.

Additionally, the Arkansas PCMH program requires at least 5,000 beneficiaries to be attributed to a PCMH for at least six months in order for that PCMH to be eligible for shared savings payments. To help more practices qualify for these payments, PCMHs below that threshold may voluntarily pool with other PCMHs to reach the 5,000-beneficiary threshold, and any small PCMH not enrolled in a pool will be placed in a statewide default pool for shared-savings purposes. Each PCMH enrolled in a voluntary pool or the statewide default pool will receive both an individual report that pertains only to that PCMH and a pool report (also called a Shared Saving Entity Report), which contains data from all PCMHs in the pool. Standalone PCMH practices that have at least 5,000 attributed beneficiaries will only receive an individual report.

Finally, though the Arkansas PCMH program runs on a calendar-year basis, cost-of-care figures and metrics are processed quarterly. Provider reports allow PCMHs to see how these measures are trending across sequential 12-month periods. 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 2017, for example, a PCMH that was enrolled in both the 2016 and 2017 versions of the program and was in a voluntary pool both years will receive a 2016 individual report and a 2016 pool report, which both will cover a period ranging from January 1, 2016, to December 31, 2016, and a 2017 individual report and a 2017 pool report, which both will cover a period ranging from April 1, 2016, to March 31, 2017.

<table>
<thead>
<tr>
<th>Report Run</th>
<th>Performance Period (2016*)</th>
<th>Performance Period (2017**)</th>
<th>Report Delivery (Month Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2 2017</td>
<td>1/1/16 - 12/31/16</td>
<td>1/1/16 - 12/31/16</td>
<td>June 2017</td>
</tr>
<tr>
<td>Q3 2017</td>
<td>1/1/16 - 12/31/16</td>
<td>4/1/16 - 3/31/17</td>
<td>September 2017</td>
</tr>
<tr>
<td>Q4 2017</td>
<td>N/A</td>
<td>7/1/16 - 6/30/17</td>
<td>December 2017</td>
</tr>
<tr>
<td>Q1 2018</td>
<td>1/1/16 - 12/31/16</td>
<td>10/1/16 - 9/30/17</td>
<td>April 2018</td>
</tr>
<tr>
<td>Q2 2018</td>
<td>N/A</td>
<td>1/1/17 - 12/31/17</td>
<td>June 2018</td>
</tr>
<tr>
<td>Q3 2018</td>
<td>N/A</td>
<td>1/1/17 - 12/31/17</td>
<td>September 2018</td>
</tr>
<tr>
<td>Q1 2019</td>
<td>N/A</td>
<td>1/1/17 - 12/31/17</td>
<td>April 2019</td>
</tr>
</tbody>
</table>

*Quality metrics – HPB PCP, Inpatient Follow Up, Infant Wellness, Child Wellness, Adolescent Wellness, HbA1c, Asthma, CHF, ADHD, Diabetics on Statin, URI, Xanax (HEDIS metrics run under 2013 HEDIS specifications)

**Quality metrics – HPB PCP, Inpatient Follow Up, Infant Wellness, Child Wellness, Adolescent Wellness, HbA1c, Asthma, CHF, ADHD, Diabetics on Statin, URI, Xanax (HEDIS metrics run under 2016 HEDIS specifications)
Your report provides information on three areas

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

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

**Shared Savings Data (pages 3 - 7 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 (pages 8 - 11 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.
Summary Page

**Shared Savings 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. March 1 for Q2)
- "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
- "Time Adjusted Member Attribution" shows the adjusted number of months a beneficiary has been attributed to your patient panel

**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

**Shared Savings Eligibility Summary**

- 5,200 were attributed beneficiaries for at least 6 months
- At least 5,000 required for performance period (see above)
- Meeting 6 out of 13 evaluated quality metrics
- At least two-thirds required for performance period (p. 4-7)
- Historical risk-adjusted per beneficiary per year cost is below your 2017 medium threshold (p. 3) AND/OR
- Historical risk-adjusted per beneficiary per year cost is below your 2017 trended benchmark (p. 3)

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

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

**Additional utilization metrics summary for informational purposes only**

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

- Your pool risk score is based on an average across all beneficiaries attributed to PCMHs in your pool for at least 6 months
- Risk cohorts are based on the pool’s average risk score
- Only practices enrolled in Medicaid PCMH are included
- A cohort of Pools with similar risk scores is used in this report to allow comparisons to these practices on utilization metrics (page 7) and care categories (page 11). The comparison is for information only and not tied to payments

Note: PCMHs must meet all practice support requirements in addition to the requirements listed above.
## How to interpret the legend for metrics charts

### Metrics legend

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Legend description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="https://example.com/image" alt="Meeting metric qualifications" /></td>
<td>Meeting metric qualifications</td>
<td>The historical data in this report meets qualifying levels for the metric</td>
</tr>
<tr>
<td><img src="https://example.com/image" alt="Not meeting metric qualifications" /></td>
<td>Not meeting metric qualifications</td>
<td>The historical data in this report does not meet qualifying levels for the metric</td>
</tr>
<tr>
<td><img src="https://example.com/image" alt="Processing data" /></td>
<td>Processing data</td>
<td>Metric data relies on data reported in the provider portal that is not yet due</td>
</tr>
<tr>
<td><img src="https://example.com/image" alt="Not enough beneficiaries to be evaluated" /></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>

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1 Relevant to charts and metrics for shared savings (pages 3-7)
How to read metrics charts

Metrics charts
The format of metrics charts are consistent across shared savings metrics (pages 3 - 7), and additional utilization metrics (pages 8 - 11)

- Utilization metrics do not show qualifying levels (known as 2017 targets) 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 PCMH Program Policy Addendum for details on specifications for quality and informational metrics

The methodology for calculating each metric is shown in the definition

This report's time period is labeled here in the header

The graphed trendline displays the rates

Metric

<table>
<thead>
<tr>
<th>Metric</th>
<th>Definition</th>
<th>You (01/01/2016 – 12/31/2016)</th>
<th>Rolling 12 month performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of beneficiaries who turned 15 months old during performance period with ≥ 5 well-child visits during first 15 months of life</td>
<td># 15 month old beneficiaries with at least five wellness visits [\frac{40}{50} = 80%]</td>
<td># beneficiaries 0-15 months</td>
<td>90 85 90 80</td>
</tr>
</tbody>
</table>

2017 Qual. level: >=43%

Pre-published qualifying levels from the PCMH Program Policy Addendum

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

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

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

1 Relevant to charts and metrics for shared savings (pages 3 - 7), and additional utilization data (pages 8 - 11) sections of the report
Cost data are displayed in the shared savings section of the report (page 3).

- Participating practices in a shared savings entity will receive an entity-level report in addition
- Standalone practices (6 month attributed beneficiaries of 5,000 or more) will only receive an entity-level report
- 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 2016 risk-adjusted average cost, PBPY 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 2016, 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 2017 benchmark is used for the purpose of managing growth in costs. If your 2017 average cost at the end of the performance period is at least 2% below your 2017 benchmark, indicating performance improvement, you may be eligible to receive shared savings payments

C. $2,124 is the 2017 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. $2,842 is the 2017 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 or 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 11)

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 improved 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, 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 APII website.