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
• 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 (see “Guide to Reading Your Pool 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 four areas

Summary Data (page 2 of report)
The summary page gives basic data for your PCMH historical overview 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 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.

Shared Savings Data (page 4 - 8 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 9 - 12 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 point in time beneficiaries” shows the number of beneficiaries that were attributed to your PCMH 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 your PCMH 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 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
- In order to continue receiving practice support, including payments, practices must meet all activities by the required due dates

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.
How to interpret your summary data (part 2 of 2)

Risk Cohort Breakdown

<table>
<thead>
<tr>
<th>Risk Cohort</th>
<th>I</th>
<th>II</th>
<th>III</th>
<th>IV</th>
<th>V</th>
<th>VI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Range of risk scores</td>
<td>0–0.4</td>
<td>0.4–0.8</td>
<td>0.8–1.2</td>
<td>1.2–1.6</td>
<td>1.6–2</td>
<td>&gt; 2</td>
</tr>
<tr>
<td>Practices</td>
<td>0</td>
<td>63</td>
<td>108</td>
<td>19</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Your entity risk score</td>
<td>0.613</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 9) and care categories (page 12). The comparison is for information only and not tied to payments.
Understanding the status of your practice support activities

Practice Support Report

<table>
<thead>
<tr>
<th>Practice support activity</th>
<th>Due date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Identify top 10% of high-priority patients (including BH clients)</td>
<td>03/31/2017</td>
<td>✓</td>
</tr>
<tr>
<td>B. Provide 24/7 access to care</td>
<td>06/30/2017</td>
<td>N/A</td>
</tr>
<tr>
<td>C. Document approach to expanding access to same day appointments</td>
<td>06/30/2017</td>
<td>N/A</td>
</tr>
<tr>
<td>D. Capacity to receive direct e-Messaging from the patients: Describe method of e-messaging used</td>
<td>06/30/2017</td>
<td>N/A</td>
</tr>
<tr>
<td>E. Enrollment in the Arkansas Prescription Monitoring Program (PMP): All PCPs must enroll in PMP. Report method(s) used to monitor controlled substance prescriptions using PMP</td>
<td>06/30/2017</td>
<td>N/A</td>
</tr>
<tr>
<td>F. Childhood/Adult Vaccination Practice Strategy</td>
<td>12/31/2017</td>
<td>N/A</td>
</tr>
<tr>
<td>G. Join SHARE or participate in a network that delivers hospital discharge information to practice within 48 hours</td>
<td>12/31/2017</td>
<td>N/A</td>
</tr>
<tr>
<td>H. Incorporate e-prescribing into practice workflows</td>
<td>12/31/2017</td>
<td>N/A</td>
</tr>
<tr>
<td>I. Care Plans for High Priority Beneficiaries: Create Care Plans</td>
<td>12/31/2017</td>
<td>N/A</td>
</tr>
<tr>
<td>J. Patient Literacy Assessment Tool: Choose any health literacy tool and administer the screening to at least 50 beneficiaries (enrolled in the PCMH program) or their caregivers</td>
<td>12/31/2017</td>
<td>N/A</td>
</tr>
<tr>
<td>K. Ability to receive Patient Feedback: Indicate method used to receive patient feedback and describe how feedback is used to make improvements</td>
<td>12/31/2017</td>
<td>N/A</td>
</tr>
<tr>
<td>L. Care Instructions for HPB: Create and share with the patient an after-visit-summary of visit. Include diagnosis, medication list, tests and results (if available), referrals (if applicable), and follow up instructions.</td>
<td>12/31/2017</td>
<td>N/A</td>
</tr>
<tr>
<td>M. Medication Management: Describe the practices EHR reconciliation process. Document updates to active medication list in EHR for HPB</td>
<td>12/31/2017</td>
<td>N/A</td>
</tr>
<tr>
<td>N. 10-day follow-up after an acute inpatient hospital stay</td>
<td>12/31/2017</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Legend: ✓ Submitted subject to verification ☠ Not Submitted or Under Validation N/A Not due yet

Pre-defined activities come from the PCMH Program Policy Addendum
- 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. A red X will be present if the activity was not submitted or if it is under validation. 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:
Shared savings Quality Metrics (pages 5 - 8)

• 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 fifteen quality metrics cannot be evaluated, the PCMH would have to meet two-thirds of the thirteen evaluated quality metrics

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Legend description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>✅</td>
<td>Meeting metric qualifications</td>
<td>The historical data in this report meets qualifying levels for the metric</td>
</tr>
<tr>
<td>❌</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>⏳</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>🔥</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 shared savings (pages 5 - 8)
How to read metrics charts

**Metrics charts**

The format of metrics charts are consistent across shared savings metrics (pages 5 - 8), and additional utilization metrics (pages 9 - 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.

<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 / # beneficiaries 0-15 months</td>
<td>40 / 50 = 80%</td>
<td>90 / 85 / 90 / 80</td>
</tr>
</tbody>
</table>

Pre-published qualifying levels from the PCMH Program Policy Addendum

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.

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 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.

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1 Relevant to charts and metrics for shared savings (pages 5 - 8), and additional utilization data (pages 9 - 11) sections of the report.
Understanding your cost data (part 1 of 2)

Cost data

Cost data are displayed in the shared savings section of the report (page 4).

- 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 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 12)

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.