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 Q1 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 Q1 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 timeframes in the Q1 report do not intersect with the performance period and thus are not tied to continuation of practice support
- The report shows information about your PCMH practice
  - For pooled practices, the information for your shared savings entity will be provided in the Q2 PCMH 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 details, methodology, and links to resources
- Where to direct your questions and how to share feedback
- Upcoming and archived events such as Town Halls
- Upcoming and archived WebEx informational sessions

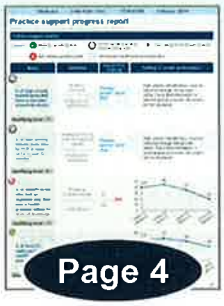
The website also has a link to the online portal. Use a secure username and password to:

- View your full report
- Submit required program data

Your report provides information on four areas

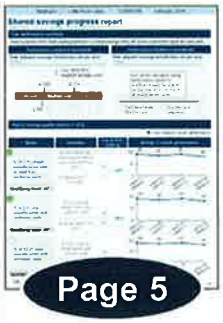
Summary data (page 2 of report)

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.



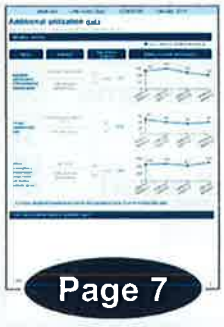
Practice support data (page 3 and 4 of report)

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.

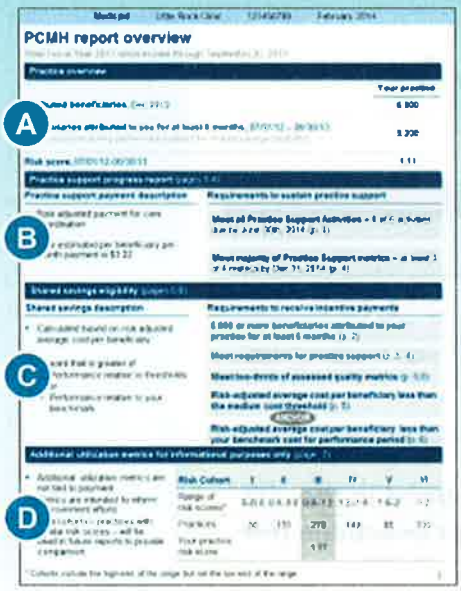


Additional data (page 7 of report)

The additional data page provides a historical view on utilization metrics. These metrics will not be tied to either practice support or shared savings payments, and they are only for your planning purposes.

How to interpret your summary data (part 1 of 2)

Summary page



A 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 December 1, 2013
- "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 "Risk score" is based on an average across all beneficiaries attributed to your PCMH for at least 6 months. Additional description of the risk score is available in section D on the next page of this guide.

B Practice support progress report summary

This section provides two main data points: estimated care coordination payments and requirements to sustain practice support

- 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 sustain practice support

Requirements to sustain practice support

Meet all Practice Support Activities – 6 of 6 activities due by June 30th, 2014 (p. 3)

Meet majority of Practice Support metrics – at least 3 of 4 metrics by Dec 31, 2014 (p. 4)

Note: CPC practices will be held accountable to different requirements as outlined in the CPC program requirements

C Shared savings eligibility summary

Requirements to receive incentive payments

5,000 or more beneficiaries attributed to your practice for at least 6 months (p. 2)

Meet requirements for practice support (p. 3, 4)

Meet two-thirds of assessed quality metrics (p. 5,6)

Risk-adjusted average cost per beneficiary less than the medium cost threshold (p. 5)

AND/OR

Risk-adjusted average cost per beneficiary less than your benchmark cost for performance period (p. 6)

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

- PCMH must meet all practice support requirements, as indicated by the second box
- 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

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

D

Additional utilization metrics summary for informational purposes only

Additional utilization metrics for informational purposes only (page 7)

- Additional utilization metrics are not tied to payment
- Metrics are intended to inform improvement efforts
- Risk cohorts – practices with similar risk scores – will be used in future reports to provide comparison

Risk Cohort	I	II	III	IV	V	VI
Range of risk scores*	0–0.4	0.4–0.8	0.8–1.2	1.2–1.6	1.6–2	> 2
Practices	30	131	278	149	85	139
Your practice risk score			1.11			

This section introduces risk cohorts, which will be used in the Q2 report to enable you to compare data against similar practices (for informational purposes only)

- Risk cohorts are based on the PCMH's average risk score
- Only practices enrolled in PCMH are included
- A cohort of practices with similar risk scores will be used in your Q2 report to allow comparisons to these practices. The comparison will be informational only and not tied to payments.
- Your Q1 report displays your utilization metrics, but not in comparison to other practices

Understanding the status of your practice support activities

Activities progress report

Practice support activities status based on provider portal entries as of 12/31/2013

Legend: ✓ Submitted subject to verification ✗ Not submitted N/A Not due yet

Enrollment effective: 1/1/14

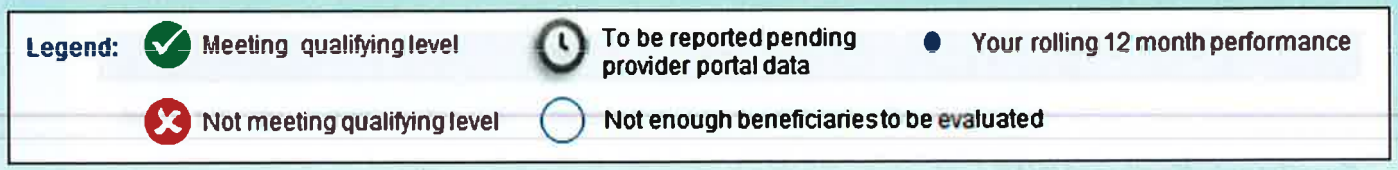
Practice support activity	Due date	Status
1. Identify top 10% of high priority beneficiaries (to be reviewed annually)	3/31/2014	N/A
2…	…	…

Pre-defined activities come from the provider manual

- 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.
- For the baseline report, the status of all activities will be marked as "N/A"—not due yet. For future reports, the status will show a green check whenever the activities have been completed.

How to interpret the legend for metrics charts[1]

Metrics legend



Legend for metrics charts

The legend applies to the following sections of the report: practice support (page 4), shared savings (pages 5 and 6), and additional utilization data (page 7)

- 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

Symbol	Legend description	Details
✓	Meeting qualifying level	The historical data in this report (7/1/2012 – 6/30/2013) meets qualifying levels for the metric
✗	Not meeting qualifying level	The historical data in this report (7/1/2012 – 6/30/2013) does not meet qualifying levels for the metric
🕒	To be reported pending provider portal data	Metric data relies on data reported in the provider portal that is not yet due
○	Not enough beneficiaries to be evaluated	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

1 Relevant to charts and metrics for practice support (page 4), shared savings (pages 5 and 6), and additional utilization data (page 7) sections of the report

How to read metrics charts[1]

Metrics charts

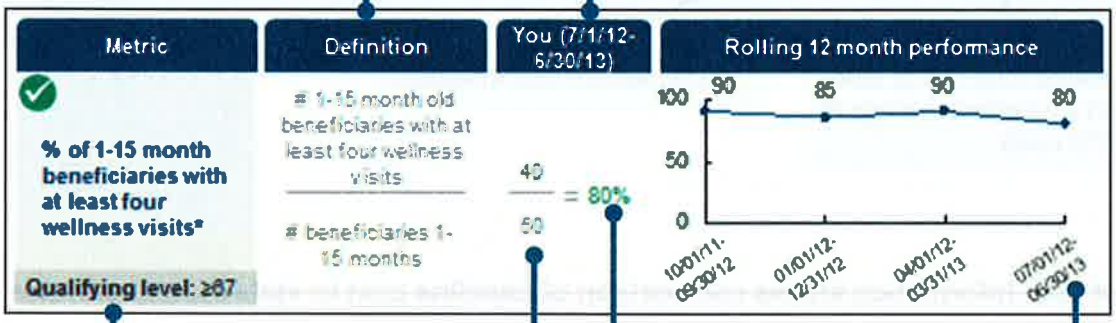
The format of metrics charts are consistent across practice support metrics (page 4), shared savings metrics (pages 5 and 6), and additional utilization metrics (page 7)

- Utilization metrics do not show qualifying levels because metrics are not evaluated as part of the PCMH program requirements
- Refer to the provider manual and provider manual attachments for details on exclusions for each metric

The methodology for calculating each metric is shown in the definition

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

Metrics chart



Pre-published qualifying levels from the provider manual

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 practice support (page 4), shared savings (pages 5 and 6), and additional utilization data (page 7) sections of the report

Understanding your cost data

Cost data

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

- Though costs are shown for every PCMH, only those with at least 5,000 beneficiaries that are attributed for at least 6 months will be eligible for shared savings incentive payments
- All costs are in per beneficiary per year numbers that have been adjusted by both risk score and member months of the patient

Current cost information shows comparison of baseline cost to statewide thresholds

A Your 2010-2012 weighted average cost is your baseline cost.

B $2,032 is the medium cost threshold. A total cost of care below the medium cost threshold is in the low cost range. This is the threshold you will be measured against in the 2014 performance period.

C $2,718 is the high cost threshold. A total cost of care between the medium and high cost thresholds is in the medium cost range, while a total cost of care above the high cost threshold is in the high cost range.

Note: See Section 237 of the provider manual for a detailed calculation of the shared savings incentive payment and how it relates to the medium and high cost thresholds shown here.

Note: Your Q2 reports will show a more recent historical total cost of care.

Contact our knowledgeable provider support teams with questions and feedback

- Arkansas Medicaid:1-866-322-4696 (in-state) or 1-501-301-8311 (local and out-of state) or ARKPII@hp.com.

PRELIMINARY

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Health Care Payment Improvement Initiative

Building a healthier future for all Arkansans

Arkansas Health Care Payment Improvement Initiative Your Practice Baseline Report

Medicaid
Little Rock Clinic
Report date: TBD
Historical performance: 07/01/12 – 06/30/13

DISCLAIMER: The information contained in these reports is intended solely for use in the administration of the Medicaid program. The data in the reports is neither intended nor suitable for other uses, including the selection of a health care provider. For more information, please visit www.paymentinitiative.org