Ohio Comprehensive Primary Care (CPC) Practice Webinar #6

Ohio CPC Referral Reports

August 8, 2017

Contents

- Welcome and Overview
  - Overview of the Ohio CPC Referral Reports
  - Update on activity requirement monitoring in 2017
  - Follow-up from last Ohio CPC webinar on quality metrics
  - FAQ and live Q&A
Overview and update on the Ohio CPC Program

• New Ohio CPC reports are available now on the MITS portal:
  – Ohio CPC Practice Reports for Q2, covering the reporting period January 1, 2016 to December 31, 2016
  – Ohio CPC Referral Reports for Q2 (for today’s discussion), covering the period January 1, 2016 to December 31, 2016
  – Ohio CPC Attribution and Payment Files for Q3, reflecting attribution as of March 1, 2017

• PMPM payments for Q3 2017 were issued to MCPs and CPC practices for FFS members in late July

• The next Ohio CPC Practice Webinar is scheduled for Tuesday, September 12th

• Slides from past webinars are available on the Ohio Department of Medicaid website under the ‘CPC Provider Webinar’ section: http://www.medicaid.ohio.gov/Providers/Paymentinnovation/CPC.aspx #1657177-cpc-provider-webinars
Overview of the Ohio CPC practice journey

**Attribution**
Determining the patients for which an Ohio CPC practice is responsible

**Payment**
Quarterly per-member-per-month (PMPM) payments

**Reporting**
Summary of performance at the Ohio CPC Practice level and detailed member level

**Key Dates:**

**Late July:** Q3 attribution and payment files shared on MITS

**October:** Q4 attribution and payment files shared on MITS

**Late July / August:**
Q3 PMPM payments issued to MCPs and CPC practices for FFS members

**July:** Q2 Ohio CPC Practice and Referral Reports released on MITS

**Late September:** Q3 CPC Practice and Referral Reports to be released on MITS

The practice journey through the Ohio CPC program is intended to transform care delivery and support primary care practices in effectively managing patients’ health needs.
How to Access your CPC Reports on the MITS Portal

CPC Reports are located in the MITS Provider Portal under the Reports section

- Your CPC Practice’s MITS Portal Administrator can access your CPC Reports
- Your MITS Portal Administrator can assign their designated Agent the **new** Role of **Reports**. Then any Agent assigned the Reports Role can access your CPC Reports.

For Assistance accessing your reports, identifying your MITS Portal Administrator, or with Agent set up:

- Call Medicaid Providers Services @ 1-800-686-1516 and speak with a representative
- Visit the Ohio Department of Medicaid website Provider tab, and click on the blue box in the right corner, “Access the MITS Portal”

http://medicaid.ohio.gov/PROVIDERS.aspx
## Reminder: Practice Webinar dates and topics for 2017

<table>
<thead>
<tr>
<th>Webinar topic</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ <strong>1.</strong> Attribution and payment</td>
<td>April 6, 2017</td>
</tr>
<tr>
<td>✓ <strong>2.</strong> Best practices in meeting activity requirements</td>
<td>April 25, 2017</td>
</tr>
<tr>
<td>✓ <strong>3.</strong> Ohio CPC Practice Reports</td>
<td>May 9, 2017</td>
</tr>
<tr>
<td>✓ <strong>4.</strong> Risk tiers and deep dive into attribution</td>
<td>June 13, 2017</td>
</tr>
<tr>
<td>✓ <strong>5.</strong> Ohio CPC’s approach to quality measurement</td>
<td>July 11, 2017</td>
</tr>
<tr>
<td>✓ <strong>6.</strong> CPC Referral Reports</td>
<td>August 8, 2017</td>
</tr>
<tr>
<td><strong>7.</strong> Feedback on payment and reporting in 2017</td>
<td>September 12, 2017</td>
</tr>
<tr>
<td><strong>8.</strong> Model design changes and supporting new enrollment for 2018</td>
<td>October 10, 2017</td>
</tr>
<tr>
<td><strong>9.</strong> Behavioral health integration</td>
<td>November 14, 2017</td>
</tr>
<tr>
<td><strong>10.</strong> Shared savings methodology</td>
<td>December 12, 2017</td>
</tr>
</tbody>
</table>

*Note: dates and topics are subject to change*

If there are other topics we should address in future webinars, please let us know
Contents

- Welcome and Overview
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Questions to be addressed in today’s webinar

A. What are CPC Referral Reports, and why were they created?

B. How can your practice use the information contained in the CPC Referral Report?

C. How should you interpret your CPC Referral Reports?
Referral Reports aim to expand the field of vision of Ohio CPC providers to member activity outside your practice.

**Primary care**

**Member**

**Episode-based care**

- Member has asthma exacerbation and presents in the ED
- Member has COPD exacerbation, but doesn’t receive adequate follow-up care
- Member receives prenatal and delivery care from an OBGYN
What are the Ohio CPC Referral Reports?

- CPC Referral Reports are designed to:
  - Highlight variation in the cost and quality of care for three episodes of care for your practice’s attributed CPC members
  - Identify potential areas for to collaborate with other PAPs
- CPC Referral Reports consist of two subcomponents:
  - PDF summaries of patient activity CPC Referral Reports
  - Detailed patient-level files (CSV format)
- PAPs also receive their own referral reports once a year, which are similar to the CPC referral reports but exclude practice specific details and exclude the detailed patient file
Your practice will receive three sets of reports each quarter:

1. **Attribution and payment file**
   - Contains attributed members and associated PMPM payments for each quarter
   - Latest report on MITS: Q3 Attribution files, shared July, 2017
   - 1 quarterly (.csv) file

2. **CPC Practice Reports**
   - Contains practice-level summary and a member-level detail of Ohio CPC performance over a rolling 12-month period
   - Latest report on MITS: Q2 CPC Practice Reports, shared July, 2017
   - 1 quarterly (PDF) file
   - 1 quarterly (.csv) file

3. **CPC Referral Reports**
   - Contains practice-level summary and member-level detail of asthma, COPD, and perinatal episodes over a rolling 12-month period
   - Latest report on MITS: Q2 CPC Referral Reports, shared July, 2017
   - 1 quarterly (PDF) file
   - 1 quarterly (.csv) file
Referral Reports are distributed to both Ohio CPC practices and episode PAPs

Materials were shared with ...

CPC practices in early July 2017...

CPC referral report (PDF file)
- Shows the number of patients receiving care from each PAP for a given CPC practice
- Displays PAP performance, with PAPs ordered by the current CPC practice’s patient volume

Detailed patient file (CSV file)
- One CPC practice-specific underlying data file to show the episodes and members that drive the member utilization fields in the pdf report (one episode per row)
- Enables practices to develop their own analyses or tools

...Peer PAPs in late June 2017

PAP referral report (PDF file)
- Shows zip codes and cost/quality performance for all PAPs in the state
- Appended to the quarterly episode reports
## How do the Ohio CPC and PAP Referral Reports differ?

<table>
<thead>
<tr>
<th>Question</th>
<th>CPC referral report</th>
<th>PAP referral report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who receives a report?</td>
<td>Enrolled Ohio CPC practices</td>
<td>PAPs for perinatal, asthma, and COPD episodes</td>
</tr>
<tr>
<td>What information is included?</td>
<td>By episode, PAP names, risk-adjusted cost indicator, quality indicator, number of attributed members, and associated payers, episode and quality metric summary and CSV file</td>
<td>By episode, all PAP names, risk-adjusted cost indicator, quality indicator, and zip code, episode and quality metric summary</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unlike CPC referral reports, PAP reports exclude:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>– Trend in risk-adjusted costs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>– List of relevant payers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>– Number of patients from PCPs</td>
</tr>
<tr>
<td>What is the data time-frame?</td>
<td>Number of attributed members, and includes PAPs within radius</td>
<td>All PAPs, alphabetical order</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Calendar year 2016</td>
</tr>
<tr>
<td>How is it sorted?</td>
<td>Number of attributed members, and includes PAPs within radius</td>
<td>All PAPs, alphabetical order</td>
</tr>
<tr>
<td></td>
<td>Rolling 12 months (July report CY16)</td>
<td>Calendar year 2016</td>
</tr>
<tr>
<td>How often will providers receive the report?</td>
<td>Quarterly (April, July, October, December, etc.)</td>
<td>Annually</td>
</tr>
<tr>
<td>When will practices receive the report?</td>
<td>First report: mid-July</td>
<td>Delivered to PAPs in late June</td>
</tr>
</tbody>
</table>
Provider performance data is currently shared across CPCs and PAPs for select episodes

Provider performance shared with ...  

For example ... 

Today:
- Episode reports go to PAPs and CPC reports go to practices
- PAP cost and quality information shared with peer PAPs for select episodes
- PAP cost and quality information shared with CPC practices for select episodes

Potential future application: For example, PAP performance could be used by Medicaid and other payers for network assessments

Potential future application: For example, PAP performance could be shared with patients via a mobile app to aid in healthcare decision-making

1. E.g. Identifiable PAP performance shared with other PAPs
2. E.g. Identifiable episode PAP performance shared with CPC Practices
3. E.g. Payer, software developers, academic researchers, etc.
How can you use the Ohio CPC Referral Reports to improve your practice?

<table>
<thead>
<tr>
<th>Key areas of interest</th>
<th>How the CPC Referral Report can help</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost</td>
<td>• Lower your practice’s overall costs by understanding and creating more efficient referrals, as episode-based spending is included into your practice’s total cost of care</td>
</tr>
<tr>
<td>Quality</td>
<td>• Identify and collaborate with low-cost and high-quality Principal Accountable Providers (PAPs) to help provide better care to your patients</td>
</tr>
<tr>
<td>Collaboration</td>
<td>• Recognize where your patients are receiving care, so you can help better coordinate care across different providers where appropriate</td>
</tr>
</tbody>
</table>
How to read your CPC Referral Report:
Overview of report components

Provider performance and patient activity PDF

- Data on your CPC practice’s attributed members
- Average cost per patient
- Percent of referrals to each PAP
- Details on other PAPs within a geographic radius

Detailed patient file

- Underlying episodes behind the patient activity shown on the report
- In-depth information on PAP performance by episode
How to read your Referral Report (1 of 4)

1. This section displays an overview of the data included in the report and describes the performance period used.

2. The date label corresponds to the reporting period used.

3. The number of “dollar signs” correspond to quintiles of PAP cost performance for a given episode. The dollar value ranges below represent the expected non-risk-adjusted cost for the average patient.

4. Names of Principal Accountable Providers (PAPs) will be shown, ordered in the report using the following logic: number of your patients with an episode attributed to the PAP, quality metric pass, and risk-adjusted cost category.
The “number of episodes from your patients” field shows the reported episodes triggered by CPC members with the given PAP. The “% of your episodes” metric shows this number as a proportion of all patient episodes for your attributed members.

Risk-adjusted cost categories correspond to the legend above (3). A trend indicator is shown next to the dollar signs to represent a change in cost category from the previous quarter’s report to this quarter’s report. An up arrow signifies movement to a more expensive cost category, a down arrow shows movement to a less expensive cost category, while no arrow means staying in the same cost category. No arrows will be present for the first quarter of reports.

Quality metrics linked to payment are represented with a single check mark or cross. All metrics linked to payment must be passed in order to receive a check mark. A full list of measures linked to payment is located on the last page of the report.
Relevant payers provides a list of MCPs for which each PAP has episodes. Historical claims data from the latest performance period is used to determine the links between PAPs and payers.

Explanatory footnotes for the report are displayed at the bottom of the page. Brief descriptions of the risk-adjusted cost per episode trend arrows, the quality metrics, and the relevant payer abbreviations are shown here.

A disclaimer is written at the very bottom of the page along with a link to the Medicaid website for further information.
A description of the episode is shown on the back page of the report. This text provides an overview of the key elements of the episode – the triggers, duration, inclusions and exclusions. The PAP is defined and the risk-adjustment process is briefly described along with a link to the Medicaid website for further information.

The quality metrics linked to payment are displayed along with current pass thresholds. All quality metrics shown here must be passed in order to receive a check mark on the provider performance and patient activity page.
How to read your detailed patient-level file (1 of 2)

Each PDF report made available to a CPC practice is accompanied by a (.csv) file that contains the underlying episodes behind the patient activity shown on the report. This episode level detail can be used to determine the following:

1. Physician or hospital PAP for the episode trigger event, along with the associated billing ID, service zip code, and efficient PAP as defined by passing quality measures tied to gain sharing and being in lowest quintile of cost.

2. Change in risk-adjusted cost category from previous quarter. Will be blank for the first quarter of reports.

3. PAP spend is calculated across all valid episodes. PAP spend will not correspond to the average of episode spend on the same the detailed patient-level file because the PAP spend columns shown here only correspond to only for members attributed to the CPC practice.

4. List of patients attributed to the CPC practice who received care from the episode PAPs.

5. Date that the patients’ episodes take place and the associated durations.

6. Reported cost of each episode in terms of both risk-adjusted cost and non-risk-adjusted cost.

7. Breakdown of quality measure performance for QMs tied to gain-sharing for each episode.
How to read your detailed patient-level file (2 of 2)

<table>
<thead>
<tr>
<th>Episode ID</th>
<th>Patient name</th>
<th>Patient Medicaid ID</th>
<th>Excluded episode</th>
<th>Episode start</th>
<th>Episode end</th>
<th>Episode risk-adjusted spend</th>
<th>Episode non-risk-adjusted spend</th>
<th>Payer</th>
<th>Asthma follow-up visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>E1</td>
<td></td>
<td>No</td>
<td>XX/YY/2016</td>
<td>XX/YY/2016</td>
<td>XX</td>
<td>YY</td>
<td></td>
<td>Payer1</td>
<td>1</td>
</tr>
<tr>
<td>E2</td>
<td></td>
<td>No</td>
<td>XX/YY/2016</td>
<td>XX/YY/2016</td>
<td>XX</td>
<td>YY</td>
<td></td>
<td>Payer2</td>
<td>0</td>
</tr>
<tr>
<td>E3</td>
<td></td>
<td>No</td>
<td>XX/YY/2016</td>
<td>XX/YY/2016</td>
<td>XX</td>
<td>YY</td>
<td></td>
<td>Payer1</td>
<td>0</td>
</tr>
<tr>
<td>E4</td>
<td></td>
<td>No</td>
<td>XX/YY/2016</td>
<td>XX/YY/2016</td>
<td>XX</td>
<td>YY</td>
<td></td>
<td>Payer3</td>
<td>NA</td>
</tr>
<tr>
<td>E5</td>
<td></td>
<td>No</td>
<td>XX/YY/2016</td>
<td>XX/YY/2016</td>
<td>XX</td>
<td>YY</td>
<td></td>
<td>Payer1</td>
<td>NA</td>
</tr>
<tr>
<td>E6</td>
<td></td>
<td>No</td>
<td>XX/YY/2016</td>
<td>XX/YY/2016</td>
<td>XX</td>
<td>YY</td>
<td></td>
<td>Payer1</td>
<td>NA</td>
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<tr>
<td>E7</td>
<td></td>
<td>No</td>
<td>XX/YY/2016</td>
<td>XX/YY/2016</td>
<td>XX</td>
<td>YY</td>
<td></td>
<td>Payer3</td>
<td>NA</td>
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<tr>
<td>E8</td>
<td></td>
<td>No</td>
<td>XX/YY/2016</td>
<td>XX/YY/2016</td>
<td>XX</td>
<td>YY</td>
<td></td>
<td>Payer4</td>
<td>NA</td>
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<tr>
<td>E9</td>
<td></td>
<td>No</td>
<td>XX/YY/2016</td>
<td>XX/YY/2016</td>
<td>XX</td>
<td>YY</td>
<td></td>
<td>Payer2</td>
<td>NA</td>
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<tr>
<td>E10</td>
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<td>No</td>
<td>XX/YY/2016</td>
<td>XX/YY/2016</td>
<td>XX</td>
<td>YY</td>
<td></td>
<td>Payer3</td>
<td>NA</td>
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<tr>
<td>E11</td>
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<td>No</td>
<td>XX/YY/2016</td>
<td>XX/YY/2016</td>
<td>XX</td>
<td>YY</td>
<td></td>
<td>Payer2</td>
<td>NA</td>
</tr>
<tr>
<td>E12</td>
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<td>No</td>
<td>XX/YY/2016</td>
<td>XX/YY/2016</td>
<td>XX</td>
<td>YY</td>
<td></td>
<td>Payer1</td>
<td>NA</td>
</tr>
</tbody>
</table>

Each PDF report made available to a CPC practice is accompanied by a (.csv) file that contains the underlying episodes behind the patient activity shown on the report. This episode level detail can be used to determine the following:

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Reminder: activity requirement monitoring will begin in Q3 2017

- Structured assessment questionnaire
- Phone discussion and review of relevant documents
- Practices not passing onsite reviews must submit a performance improvement plan
- Practices may contest the results of the monitoring reports through a reconsideration process

- Written report from each desk review
- Detailed discussion of how activity requirements are or are not being met
- Opportunity to observe and learn from innovative practices, or observe activities for practices where desk reviews indicate improvement is needed

1 Practices may be selected for an additional on-site review
## What to expect from activity requirement monitoring

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
</table>
| ▪ The Ohio Department of Medicaid (ODM) has contracted with the Health Services Advisory Group (HSAG) to conduct activity requirement reviews for the Ohio CPC program  
▪ HSAG will reach out to the **primary CPC point of contact for your practice** to schedule time for the initial desk review  
▪ HSAG will conduct an **initial desk review by phone** with your practice, which may last up to 3 hours  
▪ **Your practice may be selected for an additional on-site review**, based on the results of the desk reviews and other criteria to ensure reviews are conducted across a broad representation of Ohio CPC practices  
▪ The primary purpose of the reviews is to **understand how practices are meeting the eight Ohio CPC activity requirements**  
▪ These data will be used to **inform program design in future years** and to **highlight best practices across CPC practices** meeting the requirements in unique or innovative ways |
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Question from the last Ohio CPC Webinar on quality metrics: How do minimum denominator requirements work?

- Practices are scored only on quality metric where there are 30 or more members in the denominator of the given metric; for example:
  - If a pediatric practice serves members over the age of 18, those members may be included in the denominator for certain adult health quality metrics
  - These adult health quality metrics are scored, even for a pediatric practice, if at least 30 members are included in the denominator

- Practices are scored on all metrics for which they qualify; practices may not choose the quality metrics on which they are scored

- Due to the 30-member minimum denominator requirement, many practices will not be scored on all 20 quality metrics

- The 50% pass rate requirement for quality and efficiency metrics only applies to the metrics for which a practice is eligible
Example: CPC Practice scored on 14 quality metrics

Although this is a pediatric practice, enough members qualify for some of the adult, women’s health, and behavioral health quality metrics, which are scored in addition to the pediatric metrics.

Because this practice has 14 metrics with enough members to be evaluated, the practice must pass at least 7 of the 14 metrics to meet the overall 50% passing requirement.

<table>
<thead>
<tr>
<th>Quality measures tied to payment</th>
<th>Oct 2015 - Sep 2016 performance meeting threshold</th>
<th>Measure not tied to payment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pediatric Health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well-Child Visits in the First 15 Months of Life: Six or More Visits</td>
<td>100%</td>
<td>≥ 11%</td>
</tr>
<tr>
<td>Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life</td>
<td>100%</td>
<td>≥ 41%</td>
</tr>
<tr>
<td>Weight Assessment and Counseling for Children/Adolescents: BMI Percentile</td>
<td>100%</td>
<td>≥ 10%</td>
</tr>
<tr>
<td>Adolescent Well-Care Visits</td>
<td>100%</td>
<td>≥ 15%</td>
</tr>
<tr>
<td><strong>Women's Health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Timeliness of Prenatal Care</td>
<td>N/A</td>
<td>≥ 50%</td>
</tr>
<tr>
<td>Live Births Weighing Less than 2,500 Grams</td>
<td>N/A</td>
<td>≤ 11%</td>
</tr>
<tr>
<td>Postpartum Care</td>
<td>N/A</td>
<td>≥ 41%</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>100%</td>
<td>≥ 36%</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>100%</td>
<td>≥ 52%</td>
</tr>
<tr>
<td><strong>Adult Health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult BMI Assessment</td>
<td>100%</td>
<td>≥ 10%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care: HbA1c Testing</td>
<td>100%</td>
<td>≥ 75%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care: Poor Control (HbA1c &gt;9%)</td>
<td>100%</td>
<td>≥ 90%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care: Eye Exam</td>
<td>100%</td>
<td>≥ 35%</td>
</tr>
<tr>
<td>Controlling High Blood Pressure</td>
<td>100%</td>
<td>≥ 10%</td>
</tr>
<tr>
<td>Statin Therapy for Patients with Cardiovascular Disease; Received Statin Therapy</td>
<td>N/A</td>
<td>≥ 28%</td>
</tr>
<tr>
<td>Medication Management for People with Asthma: 75% Compliance</td>
<td>N/A</td>
<td>≥ 24%</td>
</tr>
<tr>
<td><strong>Behavioral Health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antidepressant Medication Management: Acute Phase</td>
<td>100%</td>
<td>≥ 47%</td>
</tr>
<tr>
<td>Follow-Up After Hospitalization for Mental Illness within 7 Days</td>
<td>N/A</td>
<td>≥ 32%</td>
</tr>
<tr>
<td>Initiation of Alcohol and Other Drug Dependence Treatment</td>
<td>100%</td>
<td>≥ 34%</td>
</tr>
<tr>
<td>Tobacco Use: Screening and Cessation Intervention</td>
<td>100%</td>
<td>≥ 10%</td>
</tr>
</tbody>
</table>
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- FAQ and live Q&A
FAQs asked during the last CPC Practice Webinar

Q: What does PAP stand for?
A: Principal Accountable Provider, which is defined as the person or entity who is held accountable for both the quality and cost of care delivered to the patient for an entire episode of care.

Q: Will each report (PAP Referral Report & CPC Referral Report) identify the provider that the patients are attributed to?
A: Your CPC Referral Report contains only members attributed to your CPC practice, but identifies the names of the PAPs for each of your members’ episodes.

Q: How would we go about changing our CPC contact person?
A: Please call Medicaid Providers Services @ 1-800-686-1516 to specify your CPC practice’s primary point of contact.

Q: Where can I find the Quality Metric User Guide?
A: The Quality Metric User Guide was emailed to your practice’s primary point of contact through secure e-mail in June, 2017. Due to licensing restrictions, the guide must be shared via secure e-mail, and cannot be posted online. If you did not receive the email, or the secure e-mail has expired and you are unable to access the guide, please contact Medicaid Providers Services at 1-800-686-1516.
Additional Questions?