VT Health Care Innovation Project
Episodes of Care Subgroup Meeting Agenda
Friday, March 6, 2015 9:00 AM – 11:00 AM.
109 State Street, Montpelier, EXE - 4th Floor Conf Room
Call in option: 1-877-273-4202
Conference Room: 2252454

Item #	Time Frame	Topic	Presenter	Decision Needed?	Relevant Attachments
1	9:00-9:05	Welcome and Introductions; Approval of 02/12/15 EOC Sub-Group Meeting Minutes	Alicia Cooper	Y- Minutes Approval	Attachment 1: 02/12/15 EOC Sub-Group Meeting Minutes
2	9:05-9:15	Updates	Alicia Cooper	N	
3	9:15-9:35	Arkansas Reports	Discussion	N	Attachment 3a: Arkansas Report Attachment 3b: 'How to Read' Document
4	9:35-10:35	Approach for Sharing Reports	Discussion	N	Attachment 4: PPT
5	10:35-10:55	Quality Measures	Discussion	N	
6	10:55-11:00	Public Comment and Next Steps		N	Next Meeting: March 26th, 9am-11am, AHS Training Room, 298 Hurricane Lane, Williston

Attachment 1

VT Health Care Innovation Project
Episodes of Care Subgroup Meeting Agenda
Thursday, February 12, 2015 9:00 AM – 11:00 AM.
Small Conference Rm, 312 Hurricane Lane, Williston, VT
Call in option: 1-877-273-4202
Conference Room: 2252454
Attendees: Cathy Fulton (VPQHC), Alicia Cooper (DVHA), Jim Westrich (DVHA), Amanda Ciecior (DVHA), Mike DelTrecco (VAHHS), Pat Jones (GMCB), Andrew Garland (MVP Health Care), Beth Tanzman (Blueprint for Health), Susan Aranoff (DAIL), Kelly Lange (BCBSVT), Amy Coonradt (DVHA), Sean Murphy (BCBSVT)

Topic	Notes	Next Steps
Welcome and Introductions	Alicia Cooper started the meeting at 9:05am. Those in attendance and on the phone introduced themselves, and for those unable to attend in person, a screen sharing option was available. Susan Aranoff moved to approve the minutes, Cathy Fulton seconded. The motion carried with one abstention.	
Updates and Follow Up	Beth Tanzman gave an overview of the Blueprint for Health HSA-level Profile (attachment 2). The following were key points of from the discussion and questions from workgroup members. • Reports are produced every 6 months; this is significantly faster than they were being produced at the start of this initiative. Currently, there are reports being done at both the HSA and practice level and for both adult and pediatric patients. Reports are also being distributed at an ACO level for internal analysis. • Beth noted that it is the long term goal of the Blueprint for profiles to be used to enhance collaboration among providers and ACOs and to improve clinical care and quality performance throughout the state. Results in these reports are normalized and the data does adjust for outliers, so it is easy to compare across HSAs throughout the State. • Susan Aranoff asked how inclusion in each HSA is determined. Beth responded that the HSA is made up of the residents that live there, not those who sought treatment in the HSA. This method allows for a better understanding of HSA residents and their particular patterns of care.	

- Comparing Medicaid to Commercial data is challenging as Medicaid covers more social services than commercial payers do; most analyses included in the profiles exclude these Special Medicaid Services (SMS) to allow for more uniform comparison.
- Mike DelTrecco asked if the 'cost' is what is paid to providers. Beth responded that the cost is what is actually being paid by insurance based on VHCURES claims data. Additionally, he asked how these reports are being distributed and how they are being used for accountability purposes. Beth replied that all practices in the Blueprint and the Blueprint leadership team were receiving the reports. She believes this information is helping to hold people accountable, especially in the primary care networks as well as throughout the HSA. As these reports go beyond just primary care services, there is potential to expand the audience as providers and ACOs see fit.
- Cathy asked about the poorly performing Randolph HSA and whether the data can be used to drill down into what is occurring in the HSA to provide such poor results. Beth responded that Randolph is working to improve, and that they are starting to do this by looking more closely at their data. However, equally important to driving improvement is looking into what high-performing HSAs are doing so well.
- Pat Jones clarified that this analysis is based on beneficiaries attributed to Blueprint practices, or roughly 300,000 Vermonters, so it is not quite representative of the full state population.
- Currently, available data does not reach down to the patient level, but can tell practices where to start looking for cost savings. Mike shared VAHHS' experience with sharing patient-level information with providers, noting that it can be more specifically actionable.
- Beth noted that the practice recipients are receptive to this information and find it to be actionable. The claims and clinical data sources and the analytics being done by the contractor tend to be credible
- Kelly Lange responded that presently, BCBSVT does not validate the data being used to generate the reports, and wondered if BCBSVT or other payers had done so previously. Beth responded that she was not sure – and would defer to other members of the Blueprint team for this information.

Alicia updated the sub-group on additional outstanding issues from the last

	meeting. She reported that a request has been made to follow up on alignment between this initiative and the all payer waiver. Finally, the nursing home bundled payment program will be presented at the larger PMWG meeting, and staff is currently working on adding this to the next month's agenda.	
MVP Episodes Analytics Presentation	Andrew Garland presented on MVP's Episodes of Care program. The following are key points and comments on the presentation • This data uses unique TINs to identify providers/practices. • Key terminology in this presentation: efficiency is in reference to resource use while effectiveness references quality • The vendor MVP selected has their own episode definitions, although there is some flexibility in how to define episodes. There are 527 episodes, while the top 15 account for majority of volume in costs. Episodes are often separated out by severity of illness, giving way to levels 1, 2 and 3 for most episodes. Severity level 3 is always removed from analysis as there is significant variation occurring around this level of illness. Other factors contributing to the assigned severity level is if it is an acute or chronic condition as well as the age of the patient. • The first set of MVP's reports was generated using 2012 data, and they are about to produce their 3rd annual installment of reports using data from 2014. Each episode analysis allows for a three month claims run-out, ensuring all services are included. MVP's vendor is already using ICD 10 coding. • Episodes exclude comorbidities, as it adds too much instability to fairly analyze and compare each case. In the end, about 50% of the available episodes are thrown out. • Episode assignment is achieved by preponderance of care on the provider side; to be assigned a patient the provider must bill for at least 20% of non-hospital charges. Often there will be multiple providers attributed to one patient which can be beneficial when trying to understand the care pattern of patients within a particular episode. • Mike asked about changing current attribution to the ACO attribution model, and if that would be possible with this vendor. Andrew responded	

	that yes, they could attribute to provider, and then attribute them to their respective ACOs. • MVP does not send providers these reports without having representatives there to explain what it all means. The information needs 'socializing' and therefore a group of experts who can effectively explain what the reports mean to providers accompany each release. Currently, MVP is only sending out reports to 10 of the 37 specialty types for which they produce episode analytics. • There were a few questions within the group about how to cut costs while still being preventive and providing necessary services. Andrew responded that this is where an expert physician can be leveraged to speak to other providers in their field. The data suggests that efficiency and effectiveness can go hand in hand, and the best way for providers to learn how to drive down utilization and costs is to learn from their peers. • When disseminating reports, MVP plans annual trips to practices to go over reports, choosing to focus on the highest utilizing practices first. Andrew reported that they do typically return back to the same practices every year. In addition, they have been adding roughly 3 specialty practices a year for report sharing and annual visits. There are currently 27 specialty types not receiving episode reports. Information is not shared with these specialty types due to a lack of resources and time; MVP does not want to provide reports without the accompanying effort to explain and socialize the information. Andrew reported that most have found this information very useful. In regard to concerns around reporting on so many types of episodes, it did not cost more to get analytic work done on all episodes versus just a few; and by running analytics on all episodes MVP could then prioritize and incrementally expand information sharing initiatives over time. • Susan Aranoff expressed concern around how to assure patients are still satisfied with their care if physicians are actively trying to cut costs. Andrew said they are still a long way from being able to measure outcomes associated with each episode. However, there is a patient satisfaction measure for all physicians, and generally, patients are reporting they are satisfied with their providers and their care.	

Episode Selection	Alicia Cooper started the conversation around choosing which episodes to prioritize for Vermont's planned episode analytics, and pros and cons were discussed around choosing a universe of episodes versus identifying specific episodes for analysis. • Pat Jones said she was leaning towards a broader approach, and then prioritizing which episodes to share. She thinks the cost for a larger set of episodes will not change much, and is therefore worth it. • Cathy Fulton would like to know more about the process to follow after we collect this information, and how we would deliver the reports and what resources we would have to educate report recipients on the information gathered. She also supported a broader approach, but would like to further discuss how we will then manage the distribution of this information once it is available. • Alicia commented if the group feels a broader approach might be best, then we can -shift our focus in the near-term to discussion about a dissemination plan instead of episode-specific methodology considerations. • Susan commented that there should be as much overlap as possible between any new reports and what is already produced by the ACOs and BP. Pat Jones mentioned that it is important to keep in mind that BP and ACO measures are focused on primary care. Additionally, BP reports are focused on the PCMH population, and ACOs on their own populations, and that there may be a unique opportunity for Episodes information to be used population-wide. • Kelly also identified some potential challenges for future discussion: Presentation of the data presents a challenge with sustainability, particularly when the SIM grant ends. She also whether this initiative might want to require any actions or improvement by providers. • Alicia asked the payers if there may be an alternative to using VHCURES to provide claims to a vendor. Andrew responded that MVP would be able to provide files in a common format; Kelly agreed that it could be done. While it would take time to generate and share extracts on an ongoing basis, there is no immediate barrier to pursuing such an alternative option VHCURES proves unsuitable for this type of analysis. • Pat noted that the ACOs have a lot of specialists in their networks, and are continuing to develop their specialist participation. It will be important to	Feasibility of using VHCURES for future episode analytics work

	leverage those networks when thinking about how to distribute this information to the appropriate people. • It was noted that the Northern New England Accountable Care Collaborative (NNEACC) might have something currently available to OneCare around Episodes and we need to make sure we identify what is already being done before potentially duplicating efforts. • Blueprint has had conversations around bringing in a specialist focus through an Episode lens before, but no current work is occurring on this front. It would seem like a natural next step. • The question of a small sample size in Vermont arose. Andrew responded that MVP has meaningful data for roughly 25 specialty types in VT – should not be a concern in going forward.	
Public Comment and Next Steps	• Next meeting will be focused on plans for disseminating analytics as well as long term sustainability beyond the life of the SIM grant. • Discussion of the group's VHCURES flag "wish list" will be postponed until a later meeting.	Next Meeting: March 6th, 9am-11am, EXE 4th Floor Conference Room, Montpelier, VT

Attachment 3a

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Health Care Payment Improvement Initiative

Building a healthier future for all Arkansans

Arkansas Health Care Payment Improvement Initiative Provider Report

Medicaid
Report Date: January 2015

Performance Period Report

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

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
HEALTH CARE INNOVATIONS
www.paymentinitiative.org

January 31, 2015

Dear Provider:

Through the Arkansas Healthcare Payment Improvement Initiative (AHCPII), the State is creating a multi-payer patient centered system that embraces improving population health, patients' experience of care and cost-effective care. We are accomplishing this by transforming payment to a model that rewards and supports providers who consistently deliver high quality, coordinated, and cost-effective care.

An episode is the care provided to treat a condition over a given time period. For each episode, the provider ensuring care is delivered at appropriate cost and quality will be designated as the Principal Accountable Provider (PAP). You have been identified as the PAP for one or more episodes. The performance period report reflects episodes eligible for risk and gain sharing as well as providers' details about quality and cost of care. Your average quality and cost were compared (after appropriate risk adjustment and exclusions) with established thresholds and performance of other providers to determine potential sharing of savings or excess cost indicated in your report. Figures in the performance report may be revised due to time required for final claim submission and processing.

PAPs for Perinatal and Upper Respiratory Infection will find payment information for the second performance period in this report. The Incentives Summary details reflect your gain or risk share for episodes that closed during this reporting period. The Incentive History reflects a cumulative balance of your gain or risk share for episodes in the current calendar year. If you are eligible for gain share, a remittance will be generated. If you are subject to risk share, a detailed letter explaining the process for recovery will be sent.

Data are cumulative within each episode's performance period. Each new performance period begins with episodes occurring in a single quarter; as the year progresses, additional quarterly data are added. Thus, at the beginning of each period, cases at extreme ends of the cost range (averaged over a small total) may influence results more strongly than the same data at a later point with additional cumulative data. Again, providers should be mindful that your overall performance, averaged over time, is the most important factor. After the first full performance/payment reports for each episode, PAPS will no longer receive historical reports; performance reports will be the only reports available.

You may receive similar reports from Arkansas Blue Cross Blue Shield and/or QualChoice covering their patients. In addition to viewing/downloading your reports, you may use the provider portal at www.paymentinitiative.org to enter selected quality metrics for patients within an episode, view episodes with quality metrics linked to gain sharing, FAQs, obtain training material and sign up for alerts. We have been soliciting feedback from providers and will continue to respond to questions, comments and concerns. Contact us at 1-866-322-4696, 501-301-8311 or via email at arkpii@hp.com.

Sincerely,

Dawn Stehle

Dawn Stehle
Medicaid Director

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Incentive (Gain/Risk Share) Summary

Box 1 includes:

- **All Episodes of Care (EOC) that completed their performance during this reporting period and that met the minimum case threshold**
- **Total Gain/Risk share for this reporting period**

Box 2 includes:

- **Incentive History for the current calendar year**
- **Completed EOC Gain/Risk share amounts**
- **Year to date Gain/Risk share balance**

1 Quality of services and cost summary

Episode of Care	Quality Metric	Average Episode Cost	Your Gain/Risk Share	Share Amount
Perinatal	Met	Commendable	Will receive gain sharing	$5,235.42
Your Total Gain/Risk Share for This Period:				$5,235.42

2 Incentive History

Quarter, Year: Q1 2015

Episode of Care	Gain/Risk Share Amount	Episode Timeframe
Perinatal	$5,235.42	10/01/13 - 09/30/14
Y-T-D Balance:	**$5,235.42**	

Note: In any calendar year, total EOC risk share is limited to 10% of a PAP's net Medicaid reimbursement during the year. A Stop Loss indicator appears on this page only when EOC risk share is limited by the 10% stop loss protection. If additional information is desired, see Provider Manual Section 181.00 (L)(2).

Performance summary

1 Quality of services and cost summary

Episode of Care	Close Date	Quality Metric	Average Episode Cost	Your Gain/Risk Share	Share Amount
Perinatal	September 2014	Met	Commendable	Will receive gain sharing	$5,235.42

The figures in this report are preliminary and are subject to revision.

Stop loss may be applied to all of your EOCs upon completion of the performance period for the current calendar year.

Summary - Perinatal

1 Overview

Total episodes: 223 | Total episodes included: 196 | Total episodes excluded: 27

2 Cost of care compared to other providers

Commendable	Acceptable	Not acceptable
< $3,394	$3,394 to $3,906	> $3,906

You

All Providers

Gain/Risk share

$5,235.42

You will receive gain sharing

-Selected quality metrics: Met

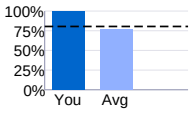
-Average episode cost: Commendable

3 Quality summary

You achieved selected quality metrics

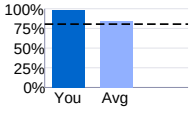
Linked to gain sharing

HIV screening



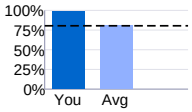
Std/Max for gain sharing

Group B Strep screening



Std/Max for gain sharing

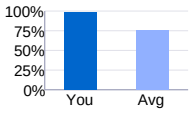
Chlamydia screening



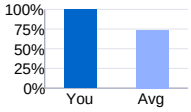
Std/Max for gain sharing

Not linked to gain sharing

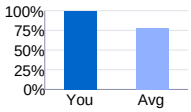
Gestational DM screening



Bacteriuria screening



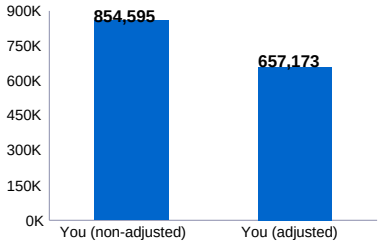
Hepatitis B screening



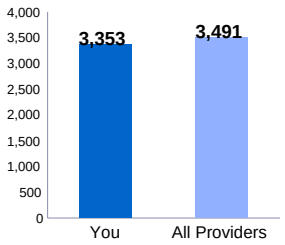
4 Cost summary

Your average cost is commendable

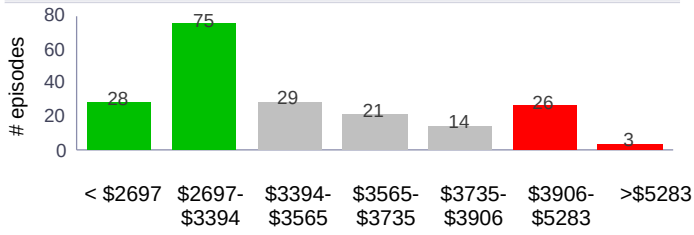
Your total cost overview, $



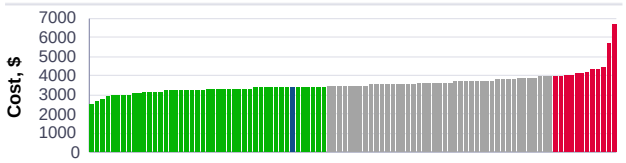
Average cost overview, $



Your episode cost distribution



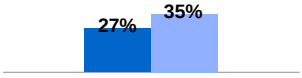
Distribution of provider average episode cost



You | Commendable | Acceptable | Not acceptable

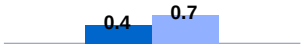
5 Key utilization metrics

C-section rate



Average number of ED visits per episode

You | All Providers

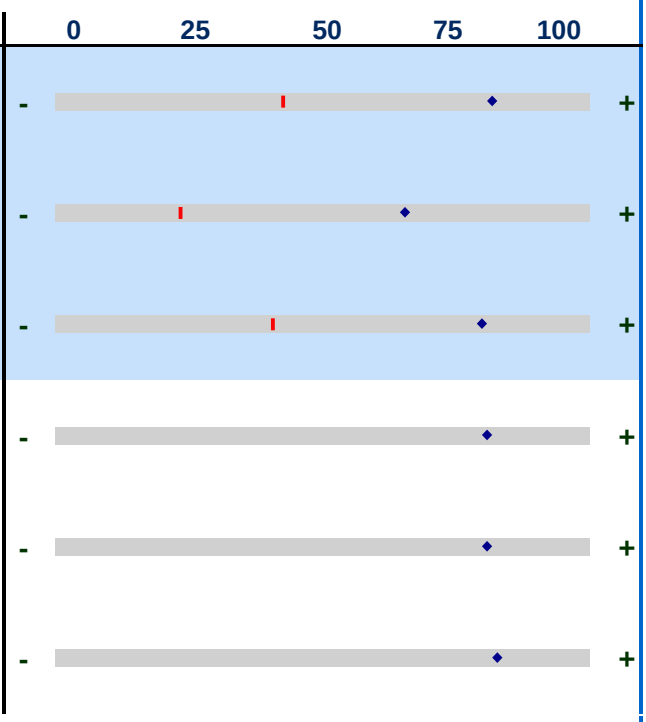


Quality and utilization detail - Perinatal

You | Metric linked to gain sharing | Minimum standard for gain sharing

1 Quality metrics: Performance compared to provider distribution

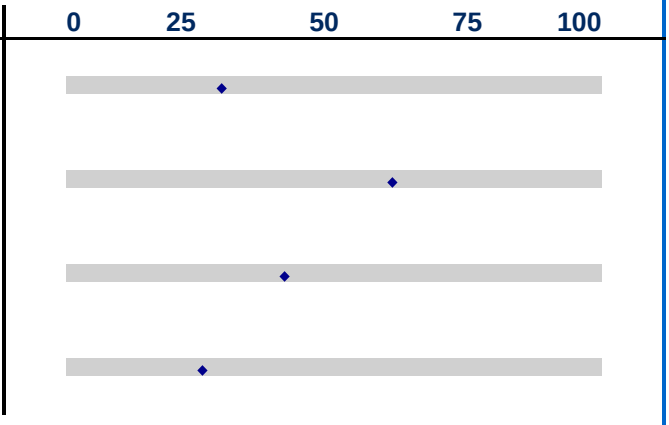
Metric	You	Percentile 25th	Percentile 50th	Percentile 75th
HIV screening rate	99%	67%	83%	94%
Group B strep screening rate	97%	85%	94%	100%
Chlamydia screening rate	98%	69%	86%	95%
Gestational diabetes screening rate	98%	65%	83%	94%
Asymptomatic bacteriuria screening rate	99%	59%	81%	94%
Hepatitis B screening rate	99%	67%	85%	92%



You achieved selected quality metrics

2 Utilization metrics: Performance compared to provider distribution

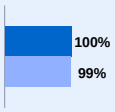
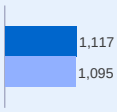
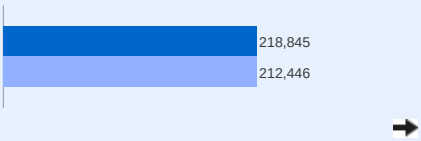
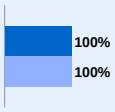
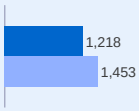
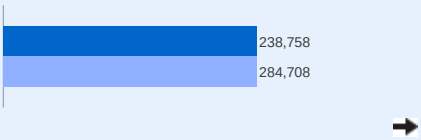
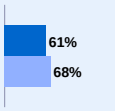
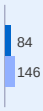
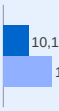
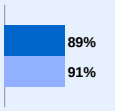
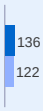
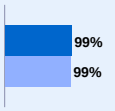
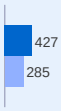
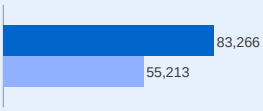
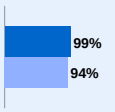
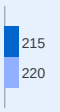
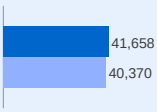
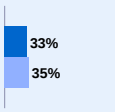
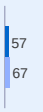
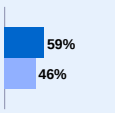
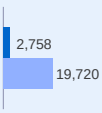
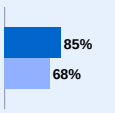
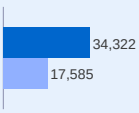
Metric	You	Percentile 25th	Percentile 50th	Percentile 75th
C-section rate	27%	25%	33%	43%
% of episodes with an ultrasound	99%	92%	97%	100%
Average number of ED visits per episode	0.4	0.4	0.5	0.8
Average length of stay for inpatient admissions	1.9	1.9	2.1	2.4



Cost detail - Perinatal

Total episodes included = 196

You All Providers

Care category	# and % of episodes with claims in care category	Average cost per episode when care category utilized, $	Total vs. expected cost in care category, $
Inpatient professional	196.0 		
Inpatient facility	196.0 		
Outpatient professional	120.0 		
Pharmacy	175.0 		
Outpatient lab	195.0 		
Outpatient radiology / procedures	194.0 		
Emergency department	64.0 		
Outpatient surgery	116.0 		
Other	166.0 		

NOTE: If displayed, the arrow (➔) indicates that the graph continues and is not to scale.

Perinatal - Detailed episode cost information for [redacted]

Episode ID	Patient name	Quality metric achieved	Episode start & end date	Non-adjusted cost	Cost	Care categories with costs: Ip fac Cost #claims	Ip prof Cost #claims	Op prof Cost #claims	Op surg Cost #claims	Op rad Cost #claims	Op labs Cost #claims	ED Cost #claims	Pharm Cost #claims	Other Cost #claims
[redacted]	[redacted]	Yes	04/01/2013 03/07/2014	$4,097	$2,912	$604 1	$983 2	$104 1	$4 2	$177 2	$461 33	$51 1	$302 10	$225 10
[redacted]	[redacted]	Yes	06/14/2013 05/20/2014	$3,997	$3,637	$1,547 1	$1,346 2	$0 0	$5 2	$227 2	$471 26	$0 0	$40 5	$0 0
[redacted]	[redacted]	Yes	01/22/2013 12/28/2013	$4,455	$3,366	$1,284 1	$1,030 2	$0 0	$2 1	$244 3	$494 30	$54 1	$103 12	$154 9
[redacted]	[redacted]	Yes	01/04/2013 12/10/2013	$4,798	$4,511	$1,598 1	$1,137 1	$113 1	$3 1	$235 2	$555 27	$41 1	$219 17	$610 13
[redacted]	[redacted]	Yes	08/21/2013 07/27/2014	$3,897	$3,546	$1,547 1	$1,329 2	$0 0	$0 0	$132 1	$461 25	$0 0	$78 5	$0 0
[redacted]	[redacted]	Yes	11/28/2012 11/03/2013	$4,760	$3,310	$1,182 1	$1,029 2	$25 1	$2 1	$174 2	$423 28	$0 0	$335 13	$140 10
[redacted]	[redacted]	Yes	11/29/2012 11/04/2013	$3,431	$3,191	$790 1	$1,428 2	$0 0	$3 1	$296 3	$438 26	$0 0	$82 5	$152 3
[redacted]	[redacted]	Yes	08/07/2013 07/13/2014	$4,099	$3,812	$790 1	$1,125 1	$141 1	$0 0	$270 2	$412 21	$0 0	$1,074 8	$0 0
[redacted]	[redacted]	Yes	07/20/2013 06/25/2014	$6,664	$4,320	$1,102 1	$871 2	$13 1	$0 0	$216 4	$554 38	$46 1	$1,312 29	$205 9
[redacted]	[redacted]	Yes	02/06/2013 01/12/2014	$3,357	$2,482	$629 1	$1,108 2	$0 0	$4 2	$185 2	$333 22	$0 0	$177 15	$47 2
[redacted]	[redacted]	Yes	08/12/2013 07/18/2014	$4,184	$3,041	$618 1	$977 2	$92 2	$4 1	$421 7	$528 36	$119 3	$100 9	$182 9
[redacted]	[redacted]	Yes	08/23/2013 07/29/2014	$5,398	$4,007	$1,893 1	$1,169 3	$109 4	$0 0	$216 2	$450 28	$40 1	$29 2	$101 4
[redacted]	[redacted]	Yes	12/26/2012 12/01/2013	$4,294	$2,586	$1,024 1	$741 1	$0 0	$4 2	$166 3	$157 17	$78 2	$98 9	$320 5
[redacted]	[redacted]	Yes	02/12/2013 01/18/2014	$4,386	$3,226	$1,251 1	$1,145 2	$88 3	$0 0	$214 2	$443 27	$0 0	$0 0	$86 5
[redacted]	[redacted]	Yes	10/30/2012 10/05/2013	$4,158	$3,526	$1,442 1	$1,336 3	$102 1	$5 2	$0 0	$532 28	$0 0	$109 2	$0 0
[redacted]	[redacted]	Yes	10/15/2013 09/20/2014	$4,330	$4,027	$1,581 1	$1,428 2	$0 0	$0 0	$270 2	$638 29	$0 0	$97 5	$12 1
[redacted]	[redacted]	Yes	02/18/2013 01/24/2014	$3,276	$2,611	$678 1	$1,071 2	$0 0	$5 2	$199 2	$436 29	$0 0	$80 4	$143 4
[redacted]	[redacted]	Yes	11/29/2012 11/04/2013	$3,127	$2,940	$799 1	$1,264 2	$0 0	$3 1	$235 2	$570 27	$0 0	$70 3	$0 0
[redacted]	[redacted]	Yes	02/27/2013 02/02/2014	$3,355	$2,933	$743 1	$1,343 2	$24 1	$3 1	$218 2	$399 22	$0 0	$91 8	$112 6

Episode ID	Patient name	Quality metric achieved	Episode start & end date	Non-adjusted cost	Cost	Care categories with costs									
						Ip fac Cost #claims	Ip prof Cost #claims	Op prof Cost #claims	Op surg Cost #claims	Op rad Cost #claims	Op labs Cost #claims	ED Cost #claims	Pharm Cost #claims	Other Cost #claims
[redacted]	[redacted]	Yes	08/05/2013 07/11/2014	$2,995	$2,905	$824 1	$1,174 1	$73 1	$0 0	$282 2	$478 25	$0 0	$73 8	$0 0
[redacted]	[redacted]	Yes	09/21/2013 08/27/2014	$4,413	$3,774	$1,454 1	$1,305 1	$31 1	$3 1	$168 2	$553 29	$0 0	$260 8	$0 0
[redacted]	[redacted]	Yes	06/14/2013 05/20/2014	$4,466	$3,904	$1,486 1	$703 2	$42 2	$3 1	$404 3	$768 38	$0 0	$180 22	$318 7
[redacted]	[redacted]	Yes	04/02/2013 03/08/2014	$4,762	$4,342	$1,550 1	$1,349 3	$84 2	$0 0	$228 2	$674 31	$0 0	$98 8	$360 9
[redacted]	[redacted]	Yes	05/04/2013 04/09/2014	$7,769	$5,193	$2,841 4	$976 2	$43 1	$4 2	$178 3	$449 33	$107 2	$46 6	$549 18
[redacted]	[redacted]	Yes	11/02/2012 10/08/2013	$4,622	$3,879	$713 1	$1,241 2	$12 1	$5 2	$1,357 9	$299 22	$0 0	$149 16	$103 3
[redacted]	[redacted]	Yes	06/05/2013 05/11/2014	$3,522	$2,031	$490 1	$735 2	$27 1	$0 0	$167 2	$239 44	$41 1	$71 8	$260 11
[redacted]	[redacted]	Yes	02/18/2013 01/24/2014	$5,443	$3,514	$1,097 1	$995 2	$120 2	$2 1	$161 2	$294 23	$0 0	$28 3	$816 25
[redacted]	[redacted]	Yes	06/28/2013 06/03/2014	$3,986	$3,628	$1,547 1	$1,329 3	$0 0	$0 0	$132 1	$549 26	$0 0	$71 10	$0 0
[redacted]	[redacted]	Yes	07/24/2013 06/29/2014	$5,230	$4,864	$1,581 1	$1,428 2	$0 0	$0 0	$270 2	$552 28	$0 0	$145 12	$888 17
[redacted]	[redacted]	Yes	04/16/2013 03/22/2014	$3,628	$3,014	$1,412 1	$827 2	$46 2	$0 0	$241 2	$327 17	$0 0	$0 0	$161 2
[redacted]	[redacted]	Yes	07/29/2013 07/04/2014	$5,420	$3,181	$998 1	$856 2	$50 2	$148 2	$170 2	$421 44	$126 4	$88 7	$323 15
[redacted]	[redacted]	Yes	11/27/2012 11/02/2013	$2,906	$2,702	$790 1	$1,125 1	$0 0	$6 2	$135 1	$390 20	$0 0	$256 5	$0 0
[redacted]	[redacted]	Yes	05/16/2013 04/21/2014	$4,470	$3,526	$1,341 1	$1,212 2	$73 2	$105 2	$82 1	$518 25	$0 0	$23 1	$173 11
[redacted]	[redacted]	Yes	11/03/2012 10/09/2013	$4,801	$3,112	$1,102 1	$645 2	$119 5	$0 0	$188 2	$304 25	$0 0	$142 11	$612 14
[redacted]	[redacted]	Yes	01/23/2013 12/29/2013	$2,957	$2,430	$698 1	$994 1	$0 0	$2 1	$119 1	$375 19	$0 0	$240 6	$0 0
[redacted]	[redacted]	Yes	07/16/2013 06/21/2014	$3,461	$2,929	$719 1	$1,567 2	$0 0	$0 0	$246 2	$311 22	$0 0	$0 0	$87 4
[redacted]	[redacted]	Yes	04/22/2013 03/28/2014	$7,268	$3,686	$1,293 1	$782 2	$67 4	$69 3	$155 6	$576 71	$88 3	$224 15	$433 23
[redacted]	[redacted]	No	01/11/2013 12/17/2013	$4,163	$3,913	$1,598 1	$1,137 1	$0 0	$6 2	$235 2	$13 2	$41 1	$616 2	$267 4
[redacted]	[redacted]	Yes	02/12/2013 01/18/2014	$5,595	$3,483	$1,588 1	$1,234 3	$50 2	$2 1	$148 2	$374 28	$0 0	$16 2	$72 5
[redacted]	[redacted]	Yes	04/24/2013 03/30/2014	$3,235	$3,235	$850 1	$1,536 2	$0 0	$3 1	$290 2	$451 22	$0 0	$105 2	$0 0
[redacted]	[redacted]	Yes	07/26/2013 07/01/2014	$5,412	$3,970	$1,247 1	$1,127 2	$48 1	$0 0	$151 4	$479 42	$0 0	$93 8	$826 24
[redacted]	[redacted]	Yes	01/06/2013 12/12/2013	$3,742	$3,108	$706 1	$1,005 1	$177 3	$0 0	$311 4	$455 30	$59 1	$255 6	$139 6
[redacted]	[redacted]	Yes	04/05/2013 03/11/2014	$6,519	$3,605	$1,410 1	$1,106 3	$15 1	$2 1	$161 2	$385 35	$0 0	$142 8	$384 17

Episode ID	Patient name	Quality metric achieved	Episode start & end date	Non-adjusted cost	Cost	Care categories with costs									
						Ip fac Cost #claims	Ip prof Cost #claims	Op prof Cost #claims	Op surg Cost #claims	Op rad Cost #claims	Op labs Cost #claims	ED Cost #claims	Pharm Cost #claims	Other Cost #claims
[redacted]	[redacted]	Yes	08/08/2013 07/14/2014	$4,011	$2,850	$604 1	$476 1	$872 9	$0 0	$206 2	$325 27	$0 0	$138 14	$229 8
[redacted]	[redacted]	Yes	07/18/2013 06/23/2014	$4,168	$3,572	$1,457 1	$1,316 2	$56 1	$0 0	$89 1	$607 32	$0 0	$25 2	$22 2
[redacted]	[redacted]	Yes	12/23/2012 11/28/2013	$3,239	$3,012	$790 1	$1,375 2	$0 0	$3 1	$270 2	$532 25	$0 0	$30 2	$12 1
[redacted]	[redacted]	Yes	11/21/2012 10/27/2013	$6,957	$3,522	$1,291 1	$749 2	$33 1	$0 0	$147 2	$259 30	$0 0	$94 9	$949 21
[redacted]	[redacted]	Yes	12/26/2012 12/01/2013	$4,024	$3,412	$721 1	$1,026 1	$0 0	$5 2	$212 2	$592 34	$0 0	$35 5	$821 10
[redacted]	[redacted]	Yes	02/06/2013 01/12/2014	$4,998	$3,984	$1,355 1	$1,224 2	$72 4	$2 1	$212 3	$349 27	$0 0	$248 13	$521 10
[redacted]	[redacted]	Yes	01/26/2013 01/01/2014	$5,718	$3,031	$1,352 1	$687 3	$93 3	$0 0	$308 3	$353 36	$0 0	$111 7	$126 5
[redacted]	[redacted]	Yes	11/18/2012 10/24/2013	$4,215	$3,152	$1,271 1	$1,106 3	$0 0	$2 1	$217 2	$362 25	$0 0	$97 11	$96 2
[redacted]	[redacted]	Yes	08/21/2013 07/27/2014	$4,040	$3,798	$1,598 1	$1,444 2	$0 0	$0 0	$273 2	$423 22	$0 0	$60 3	$0 0
[redacted]	[redacted]	Yes	04/09/2013 03/15/2014	$5,552	$3,492	$1,069 1	$833 2	$243 4	$0 0	$221 4	$554 49	$79 2	$41 7	$452 16
[redacted]	[redacted]	Yes	06/14/2013 05/20/2014	$3,154	$2,592	$698 1	$1,089 2	$90 4	$0 0	$141 2	$311 21	$0 0	$42 3	$220 9
[redacted]	[redacted]	Yes	12/09/2012 11/14/2013	$4,052	$3,543	$1,486 1	$1,175 2	$0 0	$3 1	$218 2	$536 28	$0 0	$56 4	$69 3
[redacted]	[redacted]	Yes	04/10/2013 03/16/2014	$4,247	$3,753	$1,502 1	$1,357 2	$106 3	$0 0	$257 2	$403 24	$0 0	$0 0	$128 7
[redacted]	[redacted]	Yes	08/12/2013 07/18/2014	$2,974	$2,974	$850 1	$1,325 2	$0 0	$0 0	$250 2	$549 22	$0 0	$0 0	$0 0
[redacted]	[redacted]	Yes	08/02/2013 07/08/2014	$3,699	$3,199	$735 1	$1,262 2	$5 1	$0 0	$216 2	$591 29	$0 0	$191 8	$199 6
[redacted]	[redacted]	Yes	08/16/2013 07/22/2014	$4,518	$3,601	$1,355 1	$1,256 3	$52 1	$0 0	$199 2	$567 31	$0 0	$102 6	$71 5
[redacted]	[redacted]	Yes	08/07/2013 07/13/2014	$2,833	$2,635	$790 1	$1,125 1	$0 0	$0 0	$270 2	$434 17	$0 0	$15 2	$0 0
[redacted]	[redacted]	Yes	01/07/2013 12/13/2013	$4,687	$3,044	$1,656 2	$643 1	$42 1	$2 1	$131 2	$278 18	$0 0	$158 8	$134 4
[redacted]	[redacted]	Yes	12/12/2012 11/17/2013	$3,667	$2,242	$520 1	$810 2	$33 1	$4 2	$209 3	$328 28	$0 0	$157 16	$181 8
[redacted]	[redacted]	Yes	03/11/2013 02/14/2014	$4,651	$3,338	$1,220 1	$1,175 2	$0 0	$4 2	$179 2	$417 30	$0 0	$75 7	$267 5
[redacted]	[redacted]	Yes	02/06/2013 01/12/2014	$3,731	$2,968	$676 1	$1,222 2	$98 4	$2 1	$116 1	$440 29	$0 0	$10 1	$405 11
[redacted]	[redacted]	Yes	04/29/2013 04/04/2014	$3,627	$2,660	$1,247 1	$887 1	$20 1	$0 0	$213 2	$215 19	$0 0	$21 4	$56 4
[redacted]	[redacted]	Yes	11/01/2012 10/07/2013	$4,877	$3,727	$1,299 1	$1,174 2	$113 4	$2 1	$222 2	$500 31	$0 0	$233 14	$185 10
[redacted]	[redacted]	Yes	02/06/2013 01/12/2014	$4,276	$3,738	$1,486 1	$1,343 2	$162 2	$3 1	$218 2	$360 22	$0 0	$64 2	$102 5

Episode ID	Patient name	Quality metric achieved	Episode start & end date	Non-adjusted cost	Cost	Care categories with costs									
						Ip fac Cost #claims	Ip prof Cost #claims	Op prof Cost #claims	Op surg Cost #claims	Op rad Cost #claims	Op labs Cost #claims	ED Cost #claims	Pharm Cost #claims	Other Cost #claims
[redacted]	[redacted]	Yes	06/03/2013 05/09/2014	$3,352	$2,411	$611 1	$1,105 2	$0 0	$2 1	$209 2	$105 8	$31 1	$155 6	$193 8
[redacted]	[redacted]	Yes	09/21/2013 08/27/2014	$5,125	$2,378	$1,183 1	$571 1	$30 1	$0 0	$135 2	$246 33	$66 2	$44 8	$102 7
[redacted]	[redacted]	Yes	12/11/2012 11/16/2013	$6,059	$3,817	$1,606 2	$762 1	$142 4	$2 1	$183 2	$468 43	$98 2	$123 5	$434 15
[redacted]	[redacted]	Yes	09/27/2013 09/02/2014	$5,070	$3,357	$1,125 1	$1,017 2	$61 2	$0 0	$248 4	$463 43	$92 2	$241 8	$109 6
[redacted]	[redacted]	Yes	02/13/2013 01/19/2014	$5,130	$2,769	$918 1	$1,111 3	$0 0	$0 0	$165 4	$366 31	$39 1	$33 7	$138 6
[redacted]	[redacted]	Yes	12/24/2012 11/29/2013	$4,133	$3,288	$1,352 1	$1,192 2	$0 0	$2 1	$231 2	$411 26	$0 0	$87 3	$12 1
[redacted]	[redacted]	Yes	12/24/2012 11/29/2013	$3,869	$3,636	$1,598 1	$1,264 2	$11 1	$3 1	$235 2	$467 22	$0 0	$59 4	$0 0
[redacted]	[redacted]	Yes	07/24/2013 06/29/2014	$4,198	$3,559	$1,442 1	$1,302 2	$0 0	$0 0	$123 1	$492 26	$0 0	$146 14	$54 2
[redacted]	[redacted]	Yes	02/18/2013 01/24/2014	$6,113	$5,401	$1,502 1	$1,188 2	$3 1	$3 1	$220 2	$732 34	$51 1	$1,449 10	$253 5
[redacted]	[redacted]	Yes	05/21/2013 04/26/2014	$5,711	$3,514	$523 1	$1,021 2	$191 6	$2 1	$366 10	$341 27	$33 1	$243 6	$794 13
[redacted]	[redacted]	Yes	09/28/2013 09/03/2014	$4,174	$3,501	$1,426 1	$1,224 2	$101 1	$0 0	$244 2	$435 26	$0 0	$71 6	$0 0
[redacted]	[redacted]	Yes	01/14/2013 12/20/2013	$5,333	$3,412	$1,087 2	$938 3	$23 1	$330 3	$109 5	$422 37	$46 1	$160 8	$296 7
[redacted]	[redacted]	Yes	05/04/2013 04/09/2014	$3,539	$2,907	$1,396 1	$1,104 2	$44 1	$0 0	$300 2	$6 1	$0 0	$37 5	$21 2
[redacted]	[redacted]	Yes	08/11/2013 07/17/2014	$3,305	$2,921	$751 1	$1,171 2	$0 0	$0 0	$257 2	$569 30	$51 1	$110 8	$13 1
[redacted]	[redacted]	Yes	04/29/2013 04/04/2014	$5,904	$3,473	$1,500 1	$933 4	$86 1	$0 0	$196 4	$371 35	$39 1	$242 23	$105 4
[redacted]	[redacted]	No	05/03/2013 04/08/2014	$3,175	$2,776	$743 1	$1,183 2	$79 1	$5 2	$91 1	$395 21	$38 1	$64 2	$177 8
[redacted]	[redacted]	Yes	11/07/2012 10/13/2013	$3,140	$2,952	$799 1	$1,444 2	$0 0	$3 1	$273 2	$426 22	$0 0	$8 1	$0 0
[redacted]	[redacted]	Yes	06/22/2013 05/28/2014	$5,505	$3,989	$1,848 1	$1,142 3	$87 1	$2 1	$181 2	$487 33	$52 1	$153 14	$37 1
[redacted]	[redacted]	Yes	05/20/2013 04/25/2014	$4,023	$3,701	$1,564 1	$1,413 2	$0 0	$3 1	$230 2	$421 20	$0 0	$0 0	$71 4
[redacted]	[redacted]	Yes	04/04/2013 03/10/2014	$4,644	$3,939	$1,442 1	$1,267 2	$180 4	$3 1	$276 3	$552 24	$0 0	$129 8	$89 5
[redacted]	[redacted]	Yes	12/05/2012 11/10/2013	$3,407	$2,799	$698 1	$1,262 2	$53 1	$2 1	$119 1	$488 30	$0 0	$80 6	$95 7
[redacted]	[redacted]	Yes	09/20/2013 08/26/2014	$4,247	$2,695	$1,079 1	$768 1	$0 0	$82 1	$184 2	$410 33	$62 2	$31 5	$80 5
[redacted]	[redacted]	Yes	12/25/2012 11/30/2013	$4,137	$2,547	$523 1	$745 1	$74 3	$82 2	$179 2	$449 43	$0 0	$163 10	$333 25
[redacted]	[redacted]	Yes	01/24/2013 12/30/2013	$3,882	$2,819	$617 1	$1,115 2	$0 0	$2 1	$181 2	$652 38	$42 1	$76 8	$133 7

						Care categories with costs									
Episode ID	Patient name	Quality metric achieved	Episode start & end date	Non-adjusted cost	Cost	Ip fac Cost #claims	Ip prof Cost #claims	Op prof Cost #claims	Op surg Cost #claims	Op rad Cost #claims	Op labs Cost #claims	ED Cost #claims	Pharm Cost #claims	Other Cost #claims
[redacted]	[redacted]	No	01/15/2013 12/21/2013	$7,184	$4,600	$2,721 2	$1,253 4	$4 1	$4 2	$147 3	$263 23	$37 1	$15 2	$156 6
[redacted]	[redacted]	Yes	05/16/2013 04/21/2014	$4,992	$3,907	$1,996 1	$1,218 2	$0 0	$0 0	$114 1	$471 25	$0 0	$109 10	$0 0
[redacted]	[redacted]	Yes	12/04/2012 11/09/2013	$5,927	$3,165	$908 1	$1,089 2	$55 2	$2 1	$91 2	$403 44	$62 1	$128 13	$427 22
[redacted]	[redacted]	Yes	03/18/2013 02/21/2014	$3,211	$2,639	$698 1	$818 2	$121 4	$0 0	$119 1	$496 28	$0 0	$83 3	$303 7
[redacted]	[redacted]	Yes	11/02/2012 10/08/2013	$3,661	$2,825	$656 1	$1,429 2	$50 1	$2 1	$224 2	$365 25	$0 0	$50 1	$49 3
[redacted]	[redacted]	Yes	12/11/2012 11/16/2013	$3,338	$2,347	$598 1	$851 1	$3 1	$2 1	$175 2	$461 32	$0 0	$123 7	$135 2
[redacted]	[redacted]	Yes	03/05/2013 02/08/2014	$5,488	$3,699	$1,719 1	$1,035 2	$0 0	$2 1	$196 2	$538 34	$73 2	$68 7	$69 3
[redacted]	[redacted]	Yes	09/07/2013 08/13/2014	$4,726	$3,688	$1,327 1	$1,124 2	$0 0	$0 0	$340 6	$523 35	$45 1	$166 9	$164 10
[redacted]	[redacted]	Yes	06/10/2013 05/16/2014	$3,025	$2,813	$790 1	$1,125 1	$0 0	$3 1	$191 3	$523 30	$0 0	$97 6	$83 4
[redacted]	[redacted]	Yes	03/04/2013 02/07/2014	$12,977	$6,476	$4,242 2	$1,056 4	$0 0	$4 3	$145 5	$250 28	$71 2	$542 21	$166 13
[redacted]	[redacted]	Yes	07/01/2013 06/06/2014	$3,592	$3,073	$727 1	$1,584 2	$79 2	$0 0	$248 2	$395 23	$0 0	$7 1	$33 1
[redacted]	[redacted]	Yes	11/14/2012 10/20/2013	$3,215	$2,926	$774 1	$1,563 2	$0 0	$3 1	$264 2	$319 20	$0 0	$4 1	$0 0
[redacted]	[redacted]	No	11/13/2012 10/19/2013	$2,910	$2,910	$1,700 1	$1,210 1	$0 0	$0 0	$0 0	$0 0	$0 0	$0 0	$0 0
[redacted]	[redacted]	Yes	11/27/2012 11/02/2013	$3,477	$2,605	$637 1	$1,007 2	$0 0	$2 1	$154 3	$429 30	$0 0	$186 7	$189 8
[redacted]	[redacted]	Yes	02/26/2013 02/01/2014	$3,321	$3,321	$850 1	$1,617 2	$121 1	$3 1	$290 2	$440 23	$0 0	$0 0	$0 0
[redacted]	[redacted]	Yes	12/31/2012 12/06/2013	$6,582	$3,530	$1,368 1	$752 2	$0 0	$3 2	$157 4	$346 36	$38 1	$97 10	$768 17
[redacted]	[redacted]	Yes	02/14/2013 01/20/2014	$3,130	$2,794	$759 1	$1,080 1	$0 0	$5 2	$246 3	$579 32	$64 1	$16 2	$46 1
[redacted]	[redacted]	Yes	10/26/2012 10/01/2013	$3,888	$3,067	$1,341 1	$867 4	$0 0	$2 1	$115 1	$325 22	$0 0	$12 2	$406 13
[redacted]	[redacted]	Yes	01/22/2013 12/28/2013	$3,328	$2,706	$691 1	$1,233 2	$0 0	$5 2	$203 2	$502 31	$0 0	$30 4	$42 2
[redacted]	[redacted]	Yes	09/27/2013 09/02/2014	$3,828	$3,483	$1,547 1	$1,120 1	$0 0	$0 0	$264 2	$526 29	$0 0	$26 2	$0 0
[redacted]	[redacted]	Yes	06/03/2013 05/09/2014	$6,189	$4,736	$2,602 2	$1,175 2	$69 2	$104 3	$191 2	$390 24	$0 0	$49 4	$157 6
[redacted]	[redacted]	Yes	08/02/2013 07/08/2014	$7,174	$5,659	$3,353 2	$1,298 5	$37 1	$0 0	$197 2	$479 28	$66 1	$209 14	$20 2
[redacted]	[redacted]	Yes	11/25/2012 10/31/2013	$4,680	$3,470	$1,261 2	$897 1	$0 0	$2 1	$341 4	$408 31	$95 2	$274 13	$191 10
[redacted]	[redacted]	Yes	12/20/2012 11/25/2013	$5,066	$3,757	$1,261 1	$1,139 2	$57 2	$0 0	$215 2	$404 35	$79 2	$17 1	$585 17

Episode ID	Patient name	Quality metric achieved	Episode start & end date	Non-adjusted cost	Cost	Care categories with costs									
						Ip fac Cost #claims	Ip prof Cost #claims	Op prof Cost #claims	Op surg Cost #claims	Op rad Cost #claims	Op labs Cost #claims	ED Cost #claims	Pharm Cost #claims	Other Cost #claims
[redacted]	[redacted]	Yes	11/17/2012 10/23/2013	$4,982	$4,056	$1,384 1	$1,094 2	$0 0	$2 1	$203 2	$663 33	$35 1	$229 10	$446 18
[redacted]	[redacted]	Yes	05/17/2013 04/22/2014	$4,286	$3,446	$1,367 1	$1,240 3	$149 2	$0 0	$234 2	$347 21	$0 0	$70 9	$40 2
[redacted]	[redacted]	Yes	05/29/2013 05/04/2014	$5,237	$3,846	$1,248 1	$987 2	$137 5	$379 4	$277 2	$503 36	$0 0	$121 7	$194 3
[redacted]	[redacted]	Yes	01/12/2013 12/18/2013	$4,420	$2,613	$1,005 1	$886 2	$55 2	$0 0	$172 2	$348 36	$0 0	$56 4	$92 7
[redacted]	[redacted]	Yes	01/19/2013 12/25/2013	$5,961	$3,234	$1,383 1	$656 1	$64 2	$2 1	$467 9	$373 32	$0 0	$146 14	$142 10
[redacted]	[redacted]	Yes	02/19/2013 01/25/2014	$5,443	$2,812	$1,317 2	$877 3	$0 0	$3 2	$129 2	$300 26	$0 0	$159 8	$26 1
[redacted]	[redacted]	Yes	12/30/2012 12/05/2013	$4,430	$3,562	$1,367 1	$1,334 2	$96 3	$2 1	$234 2	$432 26	$0 0	$0 0	$96 5
[redacted]	[redacted]	Yes	02/27/2013 02/02/2014	$4,380	$3,870	$1,502 1	$1,340 2	$106 3	$3 1	$221 2	$478 29	$0 0	$165 3	$56 3
[redacted]	[redacted]	Yes	12/03/2012 11/08/2013	$6,343	$4,848	$1,299 1	$1,174 2	$96 5	$5 2	$191 2	$552 42	$0 0	$233 11	$1,298 43
[redacted]	[redacted]	Yes	02/28/2013 02/03/2014	$3,925	$3,572	$1,547 1	$1,403 2	$0 0	$3 1	$95 1	$397 20	$0 0	$127 7	$0 0
[redacted]	[redacted]	Yes	01/30/2013 01/05/2014	$3,014	$2,833	$799 1	$1,137 1	$61 1	$3 1	$273 2	$500 24	$0 0	$0 0	$60 3
[redacted]	[redacted]	Yes	04/21/2013 03/27/2014	$3,968	$3,730	$1,598 1	$1,137 1	$52 2	$3 1	$273 2	$591 38	$0 0	$27 2	$50 2
[redacted]	[redacted]	Yes	04/04/2013 03/10/2014	$5,925	$3,989	$1,717 1	$1,444 3	$0 0	$91 3	$70 1	$388 26	$0 0	$63 7	$215 12
[redacted]	[redacted]	Yes	11/03/2012 10/09/2013	$4,767	$3,948	$2,112 1	$1,193 2	$0 0	$5 2	$207 2	$418 22	$0 0	$13 2	$0 0
[redacted]	[redacted]	Yes	12/04/2012 11/09/2013	$3,346	$3,020	$767 1	$1,213 2	$36 2	$3 1	$225 2	$394 24	$0 0	$82 1	$300 9
[redacted]	[redacted]	Yes	07/01/2013 06/06/2014	$7,513	$4,212	$2,382 2	$851 2	$0 0	$2 1	$140 2	$450 43	$38 1	$178 14	$171 5
[redacted]	[redacted]	No	06/09/2013 05/15/2014	$3,108	$2,922	$1,598 1	$629 1	$26 1	$0 0	$273 2	$244 8	$0 0	$17 2	$134 1
[redacted]	[redacted]	Yes	07/25/2013 06/30/2014	$3,450	$3,243	$1,598 1	$936 2	$113 3	$0 0	$136 1	$203 15	$0 0	$0 0	$257 5
[redacted]	[redacted]	Yes	07/25/2013 06/30/2014	$4,983	$2,919	$996 1	$923 3	$125 3	$0 0	$170 2	$476 44	$0 0	$19 4	$210 8
[redacted]	[redacted]	Yes	07/19/2013 06/24/2014	$5,775	$3,113	$1,375 1	$792 3	$50 2	$0 0	$171 3	$307 51	$36 1	$89 6	$294 23
[redacted]	[redacted]	Yes	04/01/2013 03/07/2014	$3,004	$2,598	$735 1	$1,047 1	$0 0	$5 2	$216 2	$444 23	$0 0	$40 2	$111 2
[redacted]	[redacted]	Yes	06/13/2013 05/19/2014	$2,702	$2,220	$698 1	$550 1	$145 5	$0 0	$207 2	$315 23	$0 0	$0 0	$305 8
[redacted]	[redacted]	No	04/06/2013 03/12/2014	$2,703	$2,268	$713 1	$1,160 2	$68 2	$3 1	$178 2	$103 6	$0 0	$0 0	$43 4
[redacted]	[redacted]	Yes	07/10/2013 06/15/2014	$3,407	$2,659	$663 1	$777 2	$96 4	$0 0	$227 2	$375 20	$0 0	$117 4	$404 13

Episode ID	Patient name	Quality metric achieved	Episode start & end date	Non-adjusted cost	Cost	Care categories with costs									
						Ip fac Cost #claims	Ip prof Cost #claims	Op prof Cost #claims	Op surg Cost #claims	Op rad Cost #claims	Op labs Cost #claims	ED Cost #claims	Pharm Cost #claims	Other Cost #claims
[redacted]	[redacted]	Yes	06/24/2013 05/30/2014	$4,430	$3,313	$1,271 1	$1,153 2	$49 1	$0 0	$217 2	$493 32	$32 1	$46 4	$51 3
[redacted]	[redacted]	Yes	02/15/2013 01/21/2014	$5,229	$2,568	$835 1	$1,001 2	$14 1	$1 1	$91 4	$180 24	$41 1	$84 4	$320 13
[redacted]	[redacted]	Yes	07/25/2013 06/30/2014	$3,352	$3,252	$824 1	$1,397 2	$52 1	$0 0	$365 2	$588 27	$0 0	$0 0	$25 2
[redacted]	[redacted]	Yes	11/13/2012 10/19/2013	$3,610	$2,931	$1,380 1	$982 1	$0 0	$336 2	$118 1	$22 4	$0 0	$20 1	$73 2
[redacted]	[redacted]	Yes	09/06/2013 08/12/2014	$4,076	$2,530	$1,055 1	$907 2	$0 0	$0 0	$142 3	$262 24	$44 1	$9 1	$111 5
[redacted]	[redacted]	Yes	08/11/2013 07/17/2014	$3,590	$2,389	$566 1	$907 2	$79 2	$0 0	$97 1	$486 36	$0 0	$204 5	$51 2
[redacted]	[redacted]	Yes	10/04/2013 09/09/2014	$2,237	$1,691	$643 1	$506 1	$0 0	$0 0	$220 2	$220 11	$0 0	$53 5	$51 2
[redacted]	[redacted]	Yes	08/20/2013 07/26/2014	$3,348	$3,147	$799 1	$1,246 2	$139 4	$0 0	$273 2	$610 25	$0 0	$9 1	$72 2
[redacted]	[redacted]	No	09/13/2013 08/19/2014	$4,032	$3,413	$1,439 1	$1,268 2	$38 1	$3 1	$211 2	$312 16	$0 0	$99 3	$43 1
[redacted]	[redacted]	Yes	07/30/2013 07/05/2014	$3,817	$3,474	$1,547 1	$1,398 2	$0 0	$0 0	$132 1	$288 13	$0 0	$109 5	$0 0
[redacted]	[redacted]	Yes	04/01/2013 03/07/2014	$3,889	$3,007	$1,314 1	$1,218 3	$21 1	$0 0	$195 2	$222 12	$0 0	$25 2	$12 1
[redacted]	[redacted]	Yes	07/16/2013 06/21/2014	$3,845	$3,614	$1,598 1	$1,246 2	$113 3	$0 0	$273 2	$371 24	$0 0	$0 0	$14 1
[redacted]	[redacted]	Yes	07/02/2013 06/07/2014	$4,240	$3,427	$1,374 1	$1,258 2	$0 0	$0 0	$235 2	$385 21	$0 0	$30 5	$145 4
[redacted]	[redacted]	Yes	06/18/2013 05/24/2014	$5,082	$2,974	$995 1	$1,126 2	$86 4	$0 0	$170 2	$422 32	$0 0	$93 9	$82 5
[redacted]	[redacted]	Yes	07/19/2013 06/24/2014	$4,005	$3,645	$1,547 1	$1,381 2	$110 1	$0 0	$264 2	$343 22	$0 0	$0 0	$0 0
[redacted]	[redacted]	Yes	07/17/2013 06/22/2014	$4,175	$3,766	$1,534 1	$1,110 1	$0 0	$0 0	$262 2	$625 29	$0 0	$236 9	$0 0
[redacted]	[redacted]	Yes	12/11/2012 11/16/2013	$5,119	$3,917	$1,301 1	$1,191 2	$0 0	$385 3	$80 1	$495 32	$55 1	$161 8	$251 5
[redacted]	[redacted]	Yes	10/28/2012 10/03/2013	$3,312	$2,633	$676 1	$1,221 2	$0 0	$2 1	$115 1	$394 24	$57 1	$127 7	$41 1
[redacted]	[redacted]	Yes	06/11/2013 05/17/2014	$5,070	$3,487	$1,169 1	$1,056 2	$125 3	$6 3	$242 3	$511 42	$30 1	$152 12	$195 5
[redacted]	[redacted]	Yes	04/17/2013 03/23/2014	$4,256	$3,562	$1,423 1	$1,286 2	$0 0	$3 1	$243 2	$456 23	$0 0	$99 5	$54 2
[redacted]	[redacted]	Yes	11/08/2012 10/14/2013	$2,760	$2,678	$824 1	$966 2	$0 0	$6 2	$242 2	$217 12	$0 0	$34 3	$388 2
[redacted]	[redacted]	Yes	05/28/2013 05/03/2014	$3,842	$3,359	$743 1	$1,259 2	$0 0	$5 2	$218 2	$450 31	$0 0	$334 9	$350 6
[redacted]	[redacted]	Yes	01/24/2013 12/30/2013	$3,620	$2,796	$657 1	$1,024 2	$56 3	$2 1	$224 2	$496 29	$0 0	$238 12	$99 4
[redacted]	[redacted]	Yes	02/13/2013 01/19/2014	$3,999	$3,719	$1,581 1	$1,232 2	$0 0	$6 2	$232 2	$517 25	$0 0	$104 6	$48 2

Episode ID	Patient name	Quality metric achieved	Episode start & end date	Non-adjusted cost	Cost	Care categories with costs									
						Ip fac Cost #claims	Ip prof Cost #claims	Op prof Cost #claims	Op surg Cost #claims	Op rad Cost #claims	Op labs Cost #claims	ED Cost #claims	Pharm Cost #claims	Other Cost #claims
[redacted]	[redacted]	Yes	11/21/2012 10/27/2013	$4,188	$3,937	$1,598 1	$1,444 2	$150 5	$0 0	$136 1	$489 21	$0 0	$33 1	$87 5
[redacted]	[redacted]	Yes	05/09/2013 04/14/2014	$4,239	$3,985	$1,598 1	$1,444 2	$50 1	$3 1	$223 2	$499 28	$0 0	$168 4	$0 0
[redacted]	[redacted]	Yes	01/23/2013 12/29/2013	$4,609	$3,675	$1,356 1	$1,225 2	$96 3	$2 1	$232 2	$444 28	$67 1	$91 5	$164 7
[redacted]	[redacted]	Yes	04/18/2013 03/24/2014	$4,627	$3,650	$1,341 1	$1,045 2	$71 1	$5 2	$263 4	$479 30	$0 0	$26 2	$419 10
[redacted]	[redacted]	Yes	05/14/2013 04/19/2014	$4,065	$3,311	$1,384 1	$1,079 2	$22 1	$2 1	$187 3	$401 26	$47 1	$96 3	$93 5
[redacted]	[redacted]	Yes	03/12/2013 02/15/2014	$3,536	$3,324	$799 1	$1,444 2	$226 4	$3 1	$273 2	$492 25	$0 0	$0 0	$87 5
[redacted]	[redacted]	Yes	02/27/2013 02/02/2014	$3,061	$2,970	$824 1	$1,490 2	$0 0	$0 0	$282 2	$374 22	$0 0	$0 0	$0 0
[redacted]	[redacted]	Yes	05/14/2013 04/19/2014	$3,750	$3,278	$1,486 1	$1,175 2	$0 0	$0 0	$127 1	$401 19	$0 0	$0 0	$90 2
[redacted]	[redacted]	Yes	08/13/2013 07/19/2014	$4,549	$3,104	$1,160 1	$924 2	$0 0	$0 0	$345 6	$390 34	$39 1	$40 4	$206 14
[redacted]	[redacted]	Yes	05/29/2013 05/04/2014	$3,936	$3,338	$1,442 1	$1,148 2	$78 2	$0 0	$123 1	$352 20	$0 0	$54 2	$141 4
[redacted]	[redacted]	Yes	05/15/2013 04/20/2014	$4,098	$3,476	$1,442 1	$1,303 2	$23 1	$5 2	$172 2	$279 16	$61 1	$158 6	$33 1
[redacted]	[redacted]	Yes	04/04/2013 03/10/2014	$4,257	$4,002	$1,598 1	$1,137 1	$174 2	$3 1	$235 2	$637 36	$0 0	$48 4	$170 6
[redacted]	[redacted]	Yes	02/13/2013 01/19/2014	$4,096	$3,734	$1,550 1	$1,208 2	$0 0	$3 1	$229 2	$472 26	$0 0	$144 8	$128 2
[redacted]	[redacted]	Yes	12/24/2012 11/29/2013	$3,222	$3,222	$1,700 1	$804 2	$28 1	$0 0	$145 1	$460 23	$0 0	$0 0	$86 1
[redacted]	[redacted]	Yes	07/06/2013 06/11/2014	$4,763	$3,053	$1,090 1	$849 2	$0 0	$2 1	$214 4	$450 36	$92 3	$25 3	$331 22
[redacted]	[redacted]	Yes	12/21/2012 11/26/2013	$5,061	$3,281	$1,102 1	$996 2	$167 8	$218 3	$94 1	$335 25	$65 2	$129 16	$175 12
[redacted]	[redacted]	Yes	05/20/2013 04/25/2014	$4,613	$3,601	$1,327 1	$1,199 2	$137 5	$2 1	$227 2	$514 31	$34 1	$69 4	$93 7
[redacted]	[redacted]	Yes	06/05/2013 05/11/2014	$4,509	$3,209	$605 1	$861 1	$124 2	$4 2	$196 3	$369 30	$60 1	$757 37	$233 10
[redacted]	[redacted]	Yes	04/16/2013 03/22/2014	$4,204	$3,381	$1,367 1	$1,235 2	$74 2	$0 0	$201 2	$391 24	$0 0	$20 1	$92 7
[redacted]	[redacted]	Yes	02/19/2013 01/25/2014	$4,642	$3,272	$599 1	$1,083 2	$46 1	$0 0	$401 6	$703 45	$59 1	$114 4	$268 11
[redacted]	[redacted]	Yes	08/13/2013 07/19/2014	$4,046	$3,804	$1,598 1	$1,246 2	$87 2	$0 0	$136 1	$615 33	$0 0	$94 3	$28 2
[redacted]	[redacted]	Yes	06/17/2013 05/23/2014	$3,886	$2,875	$629 1	$1,228 2	$89 1	$2 1	$354 4	$409 27	$62 1	$55 5	$47 2
[redacted]	[redacted]	Yes	12/17/2012 11/22/2013	$3,238	$2,527	$663 1	$1,049 2	$72 2	$0 0	$227 2	$274 21	$34 1	$27 2	$181 11
[redacted]	[redacted]	Yes	03/12/2013 02/15/2014	$4,534	$3,614	$1,355 1	$1,224 2	$3 1	$103 1	$252 4	$286 26	$91 2	$76 5	$224 14

Episode ID	Patient name	Quality metric achieved	Episode start & end date	Non-adjusted cost	Cost	Care categories with costs									
						Ip fac Cost #claims	Ip prof Cost #claims	Op prof Cost #claims	Op surg Cost #claims	Op rad Cost #claims	Op labs Cost #claims	ED Cost #claims	Pharm Cost #claims	Other Cost #claims
[redacted]	[redacted]	Yes	07/17/2013 06/22/2014	$4,379	$3,528	$685 1	$1,336 3	$0 0	$2 1	$297 8	$849 50	$67 1	$79 6	$213 5
[redacted]	[redacted]	Yes	02/21/2013 01/27/2014	$3,997	$3,532	$1,502 1	$1,069 1	$131 2	$5 2	$92 1	$573 31	$38 1	$121 8	$0 0
[redacted]	[redacted]	Yes	07/21/2013 06/26/2014	$5,002	$4,373	$1,486 1	$1,192 2	$0 0	$0 0	$254 2	$396 19	$0 0	$694 7	$351 3
[redacted]	[redacted]	Yes	01/18/2013 12/24/2013	$4,027	$3,521	$1,486 1	$1,158 2	$57 1	$0 0	$254 2	$466 25	$0 0	$55 5	$45 2
[redacted]	[redacted]	Yes	07/07/2013 06/12/2014	$3,815	$3,406	$759 1	$1,371 2	$0 0	$0 0	$243 3	$413 22	$60 1	$126 9	$433 8
[redacted]	[redacted]	Yes	05/13/2013 04/18/2014	$3,883	$3,766	$1,649 1	$1,522 2	$0 0	$3 1	$103 1	$464 21	$0 0	$0 0	$25 2
[redacted]	[redacted]	Yes	03/11/2013 02/14/2014	$5,244	$4,008	$1,949 1	$1,174 2	$49 2	$5 2	$222 2	$387 27	$0 0	$144 14	$79 6
[redacted]	[redacted]	Yes	02/19/2013 01/25/2014	$3,485	$2,720	$663 1	$1,184 2	$0 0	$2 1	$197 2	$497 29	$34 1	$111 10	$32 3
[redacted]	[redacted]	Yes	03/27/2013 03/02/2014	$4,180	$3,367	$1,369 1	$771 2	$56 1	$0 0	$244 4	$464 29	$58 1	$86 5	$319 8

Glossary

Term	Description
# and % of episodes with claims in care category	This column provides both the number of included episodes with a claim in each category as well as the percentage of episodes with a claim in each category.
# episodes initiated as open	Total number of episodes attributed to a PAP that open cholecystectomies from the onset of the procedure.
# of episodes converted lap to open	Total number of episodes attributed to a PAP that were converted from a laparoscopic cholecystectomy to an open cholecystectomy.
% episodes resulting in remission (based on episodes w/ 180 day run-out)	Total number of episodes attributed to a PAP where for which a patient had no additional episodes for ODD within the 180 days following the conclusion of each 90 day episode / Total number of included episodes attributed to a PAP. Note: this quality metric may reflect remission rates for some episodes ending in a different time period than the remainder of this report as it represents a lagging indicator.
% episodes that are shared episodes	Total number of shared episodes / # of episodes
% episodes with >9 visits	Total number of episodes of care attributed to a PAP that had >9 total claims for provider care (as recorded through claims data) / Total number of included episodes attributed to a PAP.
% episodes with antibiotics	Please see "% of episodes with at least one antibiotic filled" for further description.
% new episodes with medication	Total number of episodes for new ODD patients (as recorded through claims data) attributed to a PAP where the patient filled a prescription for behavioral health medications (recorded through claims data) / Total number of included episodes attributed to a PAP.
% non-guideline concordant	From the online continuing care certification, the total number of episodes attributed to a PAP where "No" was answered for the question "I am providing guideline concordant medication management" / Total continuing care certifications completed for PAP
% non-guideline concordant care with no rationale	From the online continuing care certification, the total number of episodes attributed to a PAP where "No" was answered for the question "I have documentd complete rationale for care outside of guidelines" / Total continuing care certifications completed for PAP
% of acute patients filling prescriptions for beta blockers within 30 days post-discharge	Count of valid episodes where patients filled prescriptions for antiplatlets from 60 days prior to trigger through end of episode over all valid episodes
% of episodes during which at least 1 "adverse outcome" occurs	Count of valid episodes where patients experienced at least 1 adverse outcome in the post procedure window over all valid episodes
% of episodes that are Level I	Total number of episodes attributed to a PAP that have not completed an online severity level II certification (on provider portal) / Total number of included episodes attributed to a PAP.
% of episodes that are Level II	Total number of episodes attributed to a PAP that have completed an online severity level II certification (on provider portal) / Total number of included episodes attributed to a PAP.
% of episodes that had a strep test when an antibiotic was filled	Total number of included episodes attributed to a PAP with a claim for both a strep test and a claim for an antibiotic / Total number of included episodes attributed to PAP with a claim for an antibiotic.
% of episodes with >7 family visits (this may be row = 146)	Total number of episodes with 8 or more family visits / # of episodes
% of episodes with >9 therapy sessions over a period of 30+ days and of which >7 are family therapy sessions (CPT 90846 OR CPT 90847)	Total number of episodes of care attributed to a PAP that had >9 total claims for provider care (as recorded through claims data) AND with at least 8 of those claims being linked to CPT code 90846 or 90847 / Total number of included episodes attributed to a PAP.

Term	Description
% of episodes with AV fistula in 30 days post procedure	Count of episodes where {AV_fistula} = 1 / Count of valid episodes
% of episodes with a documented quantitative ejection fraction value	Total number of included episodes attributed to a PAP where episode has a quantitative ejection fraction value (e.g., hyperdynamic, normal, mild dysfunction, moderate dysfunction, or severe dysfunction) documented through the provider portal. This metric does not influence eligibility to share savings or excess costs / Total number of included episodes attributed to a PAP.
% of episodes with an ultrasound	Total number of included episodes attributed to a PAP where episode has a claim for an ultrasound / Total number of included episodes attributed to a PAP.
% of episodes with at least one antibiotic filled	Total number of included episodes attributed to a PAP with at least one claim for an antibiotic / Total number of included episodes attributed to a PAP. Note, metric is calculated separately for each episode type.
% of episodes with medication	Total number of included episodes attributed to a PAP where with a claim for an ADHD medication / Total number of included episodes attributed to a PAP.
% of episodes with multiple courses of antibiotics filled	Total number of included episodes attributed to a PAP with more than one claim for an antibiotic / Total number of included episodes attributed to a PAP. Note, metric is calculated separately for each episode type.
% of episodes with myocardial infarction in 30 days post procedure	Count of episodes where {Myocardial_infarction} = 1 / Count of valid episodes
% of episodes with outpatient visits within 7-14 days	Total number of included episodes attributed to a PAP with at least one claim for an outpatient visit within 7-14 days after discharge from continuous inpatient care (based on claims data) / Total number of included episodes attributed to a PAP.
% of episodes with post-operative hemorrhage in 30 days post procedure	Count of episodes where {Hemorrhage} = 1 / Count of valid episodes
% of episodes with pulmonary embolism in 30 days post-procedure	Count of episodes where {Pulmonary_embolism} = 1 / Count of valid episodes
% of episodes with stent thrombosis in 30 days post procedure	Count of episodes where {Stent_thrombosis} = 1 / Count of valid episodes
% of non-acute patients receiving nuclear study in 30 days prior to PCI	Percent of valid PCIs for non-acute patients that received a nuclear study in the 30 days prior to the trigger
% of non-acute patients receiving stress echos and treadmill echos in 30 days prior to PCI	Percent of valid PCIs for non-acute patients that received a stress echo study in the 30 days prior to the trigger
% of patients admitted on day of surgery	Count of valid episodes which had no pre-procedure length of stay over all episodes
% of patients filling prescriptions for antiplatelets within 30 days post-discharge	Count of valid episodes where patients filled prescriptions for antiplatlets from 60 days prior to trigger through end of episode over all valid episodes
% of patients filling prescriptions for statins within 30 days post-discharge	Count of valid episodes where patients filled prescriptions for statins from 60 days prior to trigger through end of episode over all valid episodes
% of patients for whom an internal mammary artery is used	Count of valid episodes where an internal mamary artery was used for the procedure over all valid episodes
% of patients on a ventilator for longer than 24 hours after surgery	Count of valid episodes where patients were on a ventillator for longer than 24 hours over all valid episodes
% of patients receiving simultaneous interventions on multiple vessels	Percent of valid PCIs where multiple vessels were intervened on the same date of service

Term	Description
% of patients receiving staged interventions on multiple vessels	Percent of valid PCIs where multiple vessels were intervened on multiple dates of service within the episode window
% of patients with deep sternal wound in 30 days post-procedure	Count of valid episodes where patients experienced a deep sternal wound in the post procedure window over all valid episodes
% of patients with post-operative renal failure in 30 days post-procedure	Count of valid episodes where patients experienced post-operative renal failure in the post procedure window over all valid episodes
% of patients with stroke in 30 days post-procedure	Count of valid episodes where patients experienced a stroke in the post procedure window over all valid episodes
% of patients with surgical re-exploration in 24 hours post-procedure	Count of valid episodes where patients experienced a surgical re-exploration in the 24 hours post procedure over all valid episodes
% of stents placed that are drug-eluting	Percent of valid PCIs where a drug-eluting stent was placed over all PCIs where a stent was placed (does not including angioplasty only cases)
% repeat episodes w/ medication	Total number of episodes for repeat ODD patients (as recorded through the claims data) attributed to a PAP where the patient filled a prescription for behavioral health medications (recorded through claims data) / Total number of included episodes attributed to a PAP.
% with completed certification	Total number of episodes attributed to a PAP with completed online certification (on provider portal) / Total number of included episodes attributed to a PAP.
30-day all cause readmission rate	Total number of episodes attributed to a PAP with any inpatient claim within 30 days after discharge from continuous inpatient care / Total number of included episodes attributed to a PAP.
30-day heart failure readmission rate	Total number of episodes attributed to a PAP with any inpatient claim with primary diagnosis of heart failure, within 30 days after discharge from continuous inpatient care / Total number of included episodes attributed to a PAP.
30-day outpatient observation care rate	Total number of episodes attributed to a PAP with any observation care claim within 30 days after discharge from continuous inpatient care / Total number of included episodes attributed to a PAP.
30-day wound infection rate	Total number of included episodes attributed to a PAP with at least one claim indicated as a wound infection 30 days after the date of service (based on claims data) / Total number of included episodes attributed to a PAP.
ACE-Inhibitor / ARB prescription rate	Total number of included episodes for patients that were either prescribed an ACE-inhibitor or ARB therapy at time of discharge or were already taking these medications (documented in their current medication list) / Total number of included episodes attributed to a PAP.
Abdominal blood vessel injury rate	Total number of episodes attributed to a PAP with abdominal blood vessel injury (as recorded through claims data)/ Total number of included episodes attributed to a PAP.
Acceptable	Average adjusted episode cost above the commendable threshold and below the acceptable level. Providers whose average adjusted episode cost fall in this range will see no change in their total reimbursement. Please see "Acceptable threshold" for more information.
Acceptable threshold	Providers whose average adjusted cost per episode is greater than this threshold will be subject to cost sharing. The acceptable threshold is set separately for each episode.
All providers	Represents mean performance of Medicaid PAPs for Medicaid episodes.
Anesthesiologist Rate	(Count number of episodes where anesthesiology = 1) / # of valid episodes
Appropriate PCIs per ACC Appropriate Use Criteria	Percent of PCIs that are "Appropriate" according to American College of Cardiology
Asymptomatic bacteriuria screening rate	Total number of included episodes attributed to a PAP with a claim for bacteriauria screening / Total number of included episodes attributed to a PAP.
Average cost of behavioral visits per episodes	Total cost of behavioral visits / # of episodes

Term	Description
Average cost overview	Comparison of a PAP's average adjusted episode cost and the average adjusted episode cost of all providers. Please see "average episode cost" for more information.
Average cost per episode when care category utilized	This column provides the average cost of each category per episode. It calculates the average using only those episodes with services provided in the specific category.
Average episode cost	Mean cost of all included episodes (after all normalizations and risk adjustments) attributed to a PAP. This is calculated as: Total risk-adjusted cost of included episodes attributed to PAP / Total number of included episodes attributed to a PAP. For each PAP the average episode cost will be labeled as either "commendable," "acceptable," or "not acceptable" based on how their average episode cost compares to the established cost thresholds. Please see "commendable," "acceptable," and "not acceptable" for more information.
Average length of pre-operative inpatient stay	The average length of inpatient stay from admission to surgery (the costs for which are not included in the episode) for all valid episodes
Average length of stay	PAP's average length of stay for all valid episodes
Average length of stay for inpatient admissions (for episodes with inpatient stay)	PAP's average length of stay for inpatient admissions (for episodes which involve an inpatient admission)
Average medication fill rate per episode	Mean of all medication fill rates
Average number of ED visits per episode	Total number of ED claims within included episodes attributed to a PAP / Total number of included episodes attributed to a PAP.
Average number of behavioral therapy visits per episode	Total number of behavioral therapy claims for all episodes of care attributed to a PAP (as recorded through claims data) / Total number of included episodes attributed to a PAP.
Average number of family visits per episode	Total number of familiy visits / # of episodes
Average number of psychosocial visits per episode	Total number of psychosocial visits in the included episodes attributed to a PAP / Total number of included episodes attributed to a PAP.
Average number of visits per episode	Total number of physician, ED, or clinic visits in all included episodes attributed to a PAP / Total number of included episodes attributed to a PAP.
Average rate of inpatient admission	PAP's average rate of admitting patients into the inpatient
Avg. physician visits per episode	Total number of physician claims for all episodes of care attributed to a PAP (as recorded through claims data) / Total number of included episodes attributed to a PAP.
Bowel perforation or injury rate	Total number of episodes attributed to a PAP with Bowel perforation/injury (as recorded through claims data)/ Total number of included episodes attributed to a PAP.
C-section rate	Total number of included episodes attributed to a PAP where delivery was by cesarean section / Total number of included episodes attributed to a PAP.
CT scan within 30 day pre-op rate	Total number of episodes attributed to a PAP with any inpatient or outpatient claim for a CT scan within 30 days prior to surgery / Total number of included episodes attributed to a PAP.
Care categories with costs	For each episode detail line, number of claims and cost within each care category are provided.
Care category	Each care category is defined as a group of billed CPT and HCPC codes that correspond to broad categories of treatment provided to consumers. Please see care category definitions in glossary.
Cecal intubation rate	Average rate at which cecal visualization was achieved (as recorded through the provider portal).
Chlamydia screening rate	Total number of included episodes with a claim for an Chlamydia test / Total number of included episodes attributed to a PAP.

Term	Description
Closed Episode	All episodes, unless otherwise noted (e.g., with an "open" or "partial) are closed. See "open episode" and "partial episode" for more information
Commendable	Providers whose average adjusted episode cost is in this range may be eligible to receive gainsharing. Please see "Commendable threshold" for more information.
Commendable threshold	Providers whose average adjusted cost per episode is lower than this threshold will be eligible to receive gain sharing. The commendable threshold is set separately for each episode.
Common bile duct injury rate	Total number of episodes attributed to a PAP with injury to the common bile duct (as recorded through claims data)/ Total number of included episodes attributed to a PAP.
Completed episode	Episode that has met minimum requirements of duration and care provided within a performance period. Only completed episodes are included in the reports.
Cost	Total episode cost listed in episode detail after normalizations and risk adjustment.
Cost of care compared to other providers	Comparison of the report recipient's average adjusted cost per episode to the range of all Medicaid provider performance. There are three ranges: the green area depicts average episode costs in the "commendable" range; the gray area depicts average episode costs in the "acceptable" range; and the red area depicts average episode costs in the "not acceptable" range.
Cost summary	Overview of episode costs, including the total cost of a PAP's episodes (before and after adjustments), average episode cost, the distribution episodes according to cost, and average episode cost compared to all Medicaid PAPs.
Distribution of provider average episode cost	The average adjusted episode cost for each Medicaid PAP represented in percentiles. Bars marked green correspond to the percentiles that are "commendable"; bars marked gray correspond to the percentiles that are "acceptable"; bars marked red correspond to the percentiles that are "not acceptable". The blue bar represents the percentile of the report recipient.
Emergency department	Care category for professional and facility claims originating from the emergency department.
Episode	An episode is a collection of care provided to a patient to treat a particular condition over a given length of time.
Episode ID	The unique identification number assigned to each episode.
Episode exclusions	Each episode type identifies several reasons for excluding episodes from the model. For example, certain comorbidities or a lack of continuous insurance are potential exclusion factors. For a description of exclusions for each episode type please see www.paymentinitiative.org.
Episode start date	First date of service for the episode.
Episode type	Condition that is included in the Arkansas Health Care Payment Improvement Initiative. Criteria used to define each episode type can be found at www.paymentinitiative.org.
Expected cost in care category	This column provides the total expected cost of all claims in each category for the average provider, assuming the same total number of episodes included as the PAP. The exact calculation will be the 'Total episodes included' (for the PAP) x '% of episodes with claims in care category' (for 'All providers') x 'Average cost per episode when care category utilized' (for 'All providers').
Gain share	Supplemental incentive payment made at the end of a performance period to providers who meet quality of service requirements and whose average adjusted episode cost is below the commendable threshold. This represents the sharing of savings from efficient treatment of patients.
Gain sharing limit	Providers will not receive further gain sharing if their average adjusted cost per episode is below this threshold. Thus, the maximum gain share per episode is calculated as: Commendable threshold - Threshold for gain sharing.
Gestational diabetes screening rate	Total number of included episodes attributed to a PAP with a claim for an Gestational diabetes test / Total number of included episodes attributed to a PAP.

Term	Description
Group B strep screening rate	Total number of included episodes attributed to a PAP with a claim for an Group B strep test / Total number of included episodes attributed to a PAP.
HIV screening rate	HIV screening rate = Total number of included episodes with a claim for an HIV test / Total number of included episodes attributed to a PAP.
Hepatitis B screening rate	Total number of included episodes attributed to a PAP with a claim for an Hepatitis B test / Total number of included episodes attributed to a PAP.
Inappropriate PCIs per ACC Appropriate Use Criteria	Percent of PCIs that are "Inappropriate" according to American College of Cardiology
Informational Report	Historical claims data about the qulaity & cost of care
Inpatient facility	Care category for any facility claim billed in an inpatient setting.
Inpatient professional	Care category for any professional claim billed in an inpatient setting.
Intra-operative steroid Rx rate	Average rate of intra-operative steroids administration (as recorded through the provider portal) / Total number of included episodes attributed to a PAP.
Key utilization metrics	Metrics detailing the use of certain services and procedures in each episode. The key utilization metrics represent some drivers of episode cost. Please see definition of each metric for more information.
LVEF assessment	(Count number of episodes where LVEF flag 1 = yes + LVEF2 = yes) / # of episodes
Non-adjusted cost	Cost calculation that includes normalization of some claim costs but does not include patient-level risk adjustments.
Normalization	In order to calculate the adjusted cost, Medicaid applies several modifications to the actual allowed costs included in the episode to equalize by location of service or other factors.
Not acceptable	Average adjusted episode cost above the acceptable threshold. Providers in this range may be subject to sharing excess costs. Please see "Acceptable threshold" for more information.
Open Episode	Is an ADHD episode that has not closed (e.g., trigger occurred but the year has not passed)
Other	Care category for claims that do not fall into any of the other care categories.
Outlier	Episodes whose total adjusted cost is greater than an upper outlier limit will be excluded.
Outpatient lab	Care category for claims with procedure codes associated with labs and are not conducted in an inpatient facility.
Outpatient professional	Care category for professional claims from physician offices, clinics, RHCs, FQHCs, and behavioral health facilities. Also includes claims associated with facility claims for outpatient clinics.
Outpatient radiology / procedures	Care category for claims with procedure codes associated with radiology / procedures and are not conducted in an inpatient facility.
Outpatient surgery	Care category for professional and facility claims corresponding to surgical procedures that were not performed as an inpatient.
Partial Episode	For ADHD is an episode that closed, but is less than one year long. Occurs when there is a severity certification that is entered after four months into the episode but within the course of the one year.
Patient name	Name of patient associated with the episode.
Perforation rate	Total number of episodes attributed to a PAP in which a perforation occured (as recorded through claims data) / Total number of included episodes attributed to a PAP.
Performance period	A 12 or 15 month period for each episode type. Episodes that end during this time frame will be used to determine a PAP's average quality and cost performance.
Pharmacy	Care category for claims associated with point of service pharmacy claims.
Poor access adjustment	Medicaid may temporarily lower the stop-loss percentage for certain providers to preserve access to care. Providers will be notified if an access adjustment applies.

Term	Description
Post-op DVT/PE prophylaxis Rx rate	Total number of included episodes attributed to a PAP with documented use of prophylaxis against post-op DVT or PE (based on provider portal data entry) / Total number of included episodes attributed to a PAP.
Post-op DVT/PE rate	Total number of included episodes attributed to a PAP with a post-surgical DVT or PE (based on provider portal data entry) / Total number of included episodes attributed to a PAP.
Post-op complication rate	Total number of included episodes attributed to a PAP with at least one claim indicated as a post-op complication within 90 days after the date of service (based on claims data) / Total number of included episodes attributed to a PAP. This utilization metric does not influence eligibility to share savings or excess costs. For more information, please see www.paymentinitiative.org
Post-polypectomy bleed rate	Total number of episodes attributed to a PAP in which a post-polypectomy bleed occured (as recorded through claims data) / Total number of included episodes attributed to a PAP.
Post-proced. primary bleed rate (i.e. bleed within 24 hours post-surgery leading to post-procedure admission or unplanned return to OR)	Total number of episodes attributed to a PAP in which a post-procedural primary bleed occurred (as recorded through claims data) / Total number of included episodes attributed to a PAP.
Post-proced. secondary bleed rate (i.e. bleed within more than q day post-surgery leading to post-procedure admission)	Total number of episodes attributed to a PAP in which a post-procedural secondary bleed occurred (as recorded through claims data) / Total number of included episodes attributed to a PAP.
Post-procedure Abx Rx	Total number of episodes attributed to a PAP in which patients had claims for antibiotics during a post-procedural secondary bleed occurred (as recorded through claims data) / Total number of included episodes attributed to a PAP.
Preparatory Period	Period prior to the first performance reports
Principal accountable provider (PAP)	Provider identified by the payer from claims data as being the most responsible and accountable for the episode. This provider often makes key clinical decisions and coordinates the team of providers involved in an episode. A PAP can be an individual or group of providers that use the same billing ID for submitting claims to Medicaid. PAPs will share in the savings and excess costs of episodes and receive supplemental payments or recoupments at the end of each performance period. Please see www.paymentinitiative.org for more information on how a PAP is determined for each episode.
Provider billing ID	Medicaid billing ID used to submit claims to Medicaid. All reports contain information for the episodes attributed to the given provider billing ID.
Quality metrics linked to gainsharing	Quality metrics for which a provider must meet a minimum standard to be eligible for shared savings. These metrics are either tracked through claims data or provider portal entry.
Quality metrics not linked to gainsharing	Quality metrics for an episode tracked through either claims data or portal entry. These metrics do not influence eligibility to share savings or excess costs.
Quality metrics: Performance compared to provider distribution	This table lists all the quality metrics reported for the episode type, noting the performance of the report recipient as well as the 25th, 50th, and 75th percentile of all Medicaid PAPs
Quality requirements	Some episodes require PAPs to achieve a certain level of performance on certain quality metrics to be eligible to share savings. Quality of service requirements are either "Met," meaning the provider achieved adequate performance on all quality metrics linked to gainsharing, or "Not met," meaning the provider did not achieve adequate performance on one or more of the quality metrics linked to gainsharing. Please see "Quality metrics linked to gainsharing" for more information.

Term	Description
Quality summary	Overview of quality metrics identified for the episode type. For each metric, the red or blue bar represents the report recipient's performance. Black lines indicate performance required to be eligible for shared savings. The triangles represent the average performance of all Medicaid PAPs. Please see "Quality metrics linked to gainsharing" and "Quality metrics not linked to gainsharing" for more information.
Rate of follow-up visit with physician	Percent of episodes where patient visits a physician in the outpatient setting within 30 days of initial discharge
Rate of patient on appropriate medication	Rate of patient on appropriate medication determined by a filled prescription for oral corticosteroid and/or inhaled corticosteroids during episode window or (within 30 days prior to trigger)
Rendering provider	Name of performing provider on claim who delivered services. Episode level detail in reports is separated out for each rendering provider who practices with the same provider billing ID.
Repeat acute exacerbation within 30 days	% episodes with a repeat acute exacerbation (i.e. potential trigger event) during episode window
Risk adjustment	For some episode types, each episode is adjusted to account for severity differences in patients. The risk adjustment is the total adjustment of episode costs based on all the risk factors that apply to an episode. For more information, please see www.paymentinitiative.org.
Risk factor	A select diagnosis, demographic, procedure, or life event that complicates treatment for a condition and requires greater resources. Risk factors adjust the total episode cost. For a detailed listing of risk factors for each episode, please see www.paymentinitiative.org.
Risk share	Recoupment from providers whose average adjusted episode cost is above the acceptable threshold. Risk share is the sum to be withheld over the course of a year following the end of a performance period.
Stop-loss percentage	Maximum cost sharing a provider is allowed to bear in any given period. Stop-loss is calculated as a percentage of total Medicaid reimbursements for the year.
Stop-loss provision	The rule that Medicaid will apply stop-loss protection across all episodes for one year such that the net negative supplemental payment payable in a period is capped at 10% of Medicaid reimbursement in the period.
Surgical pathology utilization rate	Total number of episodes with surgical pathology test / # of episodes
Total cost in care category	This column provides the total cost of all claims in each category. Total cost occurs after normalization and risk adjustment.
Total episodes	Total number of episodes attributed to a provider, before any exclusions.
Total episodes included	Total number of episodes attributed to a provider after all episode exclusions. Please see "Episode exclusions" for further details.
Total excluded episodes	The number of episodes removed from cost and quality calculations due to episode exclusions. Please see "episode exclusions" for more detail.
Uncertain PCIs per ACC Appropriate Use Criteria	Percent of PCIs that are "Uncertain" according to American College of Cardiology
Unclassified PCIs per ACC Appropriate Use Criteria	Percent of PCIs that are "Unclassified" by the criteria specified by the American College of Cardiology
Utilization metrics: Performance compared to provider distribution	This table lists all the utilization metrics reported for the episode type, noting the performance of the report recipient as well as the 25th, 50th, and 75th percentile of all Medicaid PAPs.
Withdrawal time (min.)	Average withdrawal time for colonoscopy cases (as recorded through the provider portal).
You	Represents the performance of the recipient of the report.
Your episode cost distribution	The distribution of the adjusted cost of a PAP's included episodes. Red represents episodes with total cost above the acceptable threshold, gray represents episodes in the "acceptable" range, and green represents episodes in the "commendable" range.

Term	Description
▪ Your total cost overview	Total non-adjusted cost includes the actual cost of all included episodes attributed to the PAP. Adjusted cost represents the cost of included episodes after normalization and risk adjustments. Adjusted cost is used to calculate average episode cost to determine provider's shared savings or excess costs. For more details on normalizations and risk adjustments, please see www.paymentinitiative.org.

Attachment 3b

Guide to Reading Your PCMH Report

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

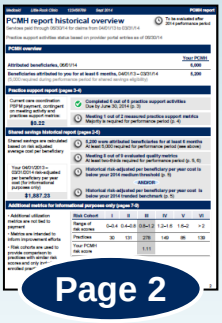
The website also has a link to the online portal. Use a secure username and password to:

- View your full report
- Submit required program data

Contact our knowledgeable provider support teams with questions and feedback

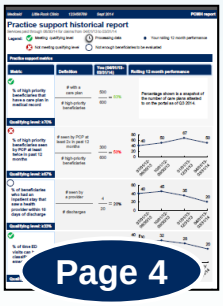
- Your Medicaid provider representative at Arkansas Foundation for Medical Care at 501-212-8600 or PCMH@afmc.org
- HP Enterprise Services Arkansas Health Care Payment Improvement Unit at 1-866-322-4696,locally at 1-501-301-8311, or via email at ARKPII@hp.com.

Your report provides information on four areas



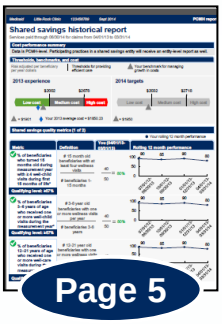
Summary data (page 2 of report)

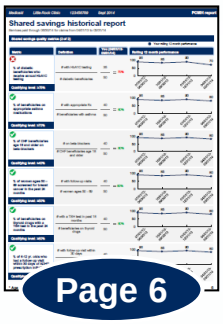
The summary page gives basic data for your PCMH, as well as a summary of the requirements for practice support and shared savings payments once the performance period begins.



Practice support data (page 3 and 4 of report)

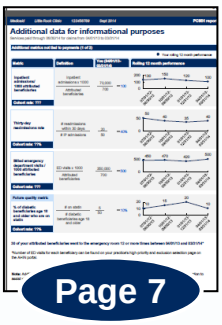
The practice support report includes both a progress report on activities and a historical view on practice support metrics. These two elements will be tied to practice support payments (PMPM) during the performance period.

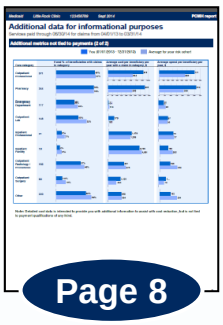




Shared savings data (page 5 and 6 of report)

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.



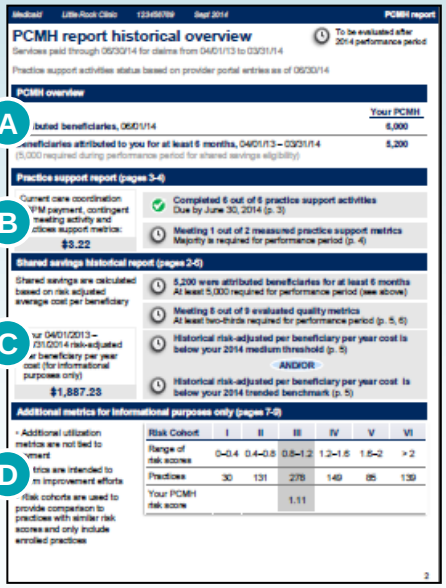


Additional data (page 7 and 8 of report)

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



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 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

B 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

Requirements to sustain practice support

- **Completed 6 out of 6 practice support activities** Due by June 30, 2014 (p. 3)
- **Meeting 1 out of 2 measured practice support metrics** Majority is required for performance period (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

- **5,200 were attributed beneficiaries for at least 6 months** At least 5,000 required for performance period (see above)
- **Meeting 8 out of 9 evaluated quality metrics** At least two-thirds required for performance period (p. 5, 6)
- **Historical risk-adjusted per beneficiary per year cost is below your 2014 medium threshold** (p. 5)

AND/OR

- **Historical risk-adjusted per beneficiary per year cost is below your 2014 trended benchmark** (p. 5)

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

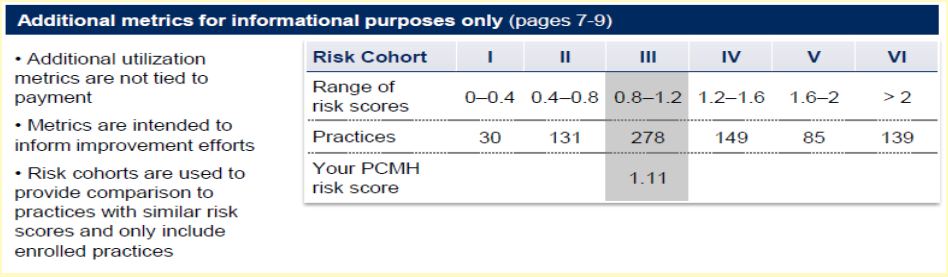
- The PCMH total cost of care is compared to both the medium cost threshold as well as the PCMH-specific benchmark; both of these parameters are pathways to shared savings

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

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

D

Additional utilization metrics summary for informational purposes only



Additional metrics for informational purposes only (pages 7-9)

- Additional utilization metrics are not tied to payment
- Metrics are intended to inform improvement efforts
- Risk cohorts are used to provide comparison to practices with similar risk scores and only include enrolled practices

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 PCMH risk score			1.11			

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

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

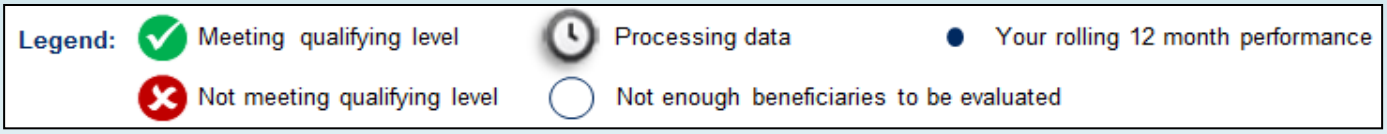
Practice support activity	Due date	Status
1. Identify top 10% of high priority beneficiaries (to be reviewed annually)	3/31/14	✓
2. Assess operations of practice and opportunities to improve	6/30/14	✓
3. Develop and record strategies to implement care coordination & practice transformation	6/30/14	✓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

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.
- 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[1]

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

Symbol	Legend description	Details
	Meeting qualifying level	The historical data in this report meets qualifying levels for the metric
	Not meeting qualifying level	The historical data in this report 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) and shared savings (pages 5 and 6)

How to read metrics charts[1]

Metrics charts

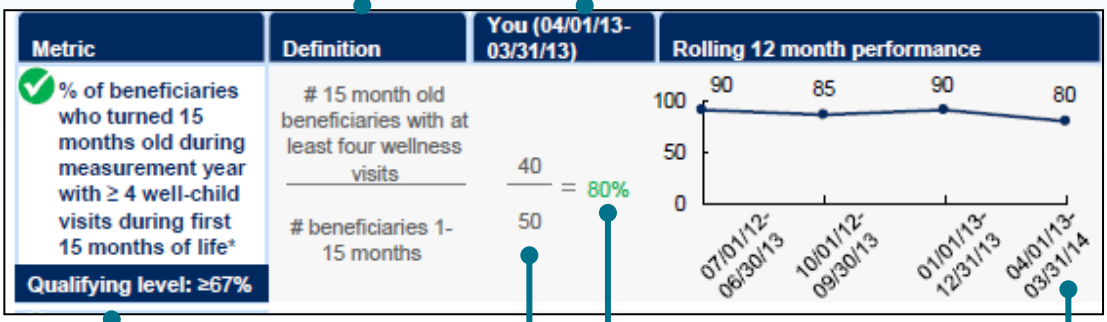
The format of metrics charts are consistent across practice support metrics (page 4), shared savings metrics (pages 5 and 6), and additional utilization metrics (page 7)

- Utilization metrics do not show qualifying levels because 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

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

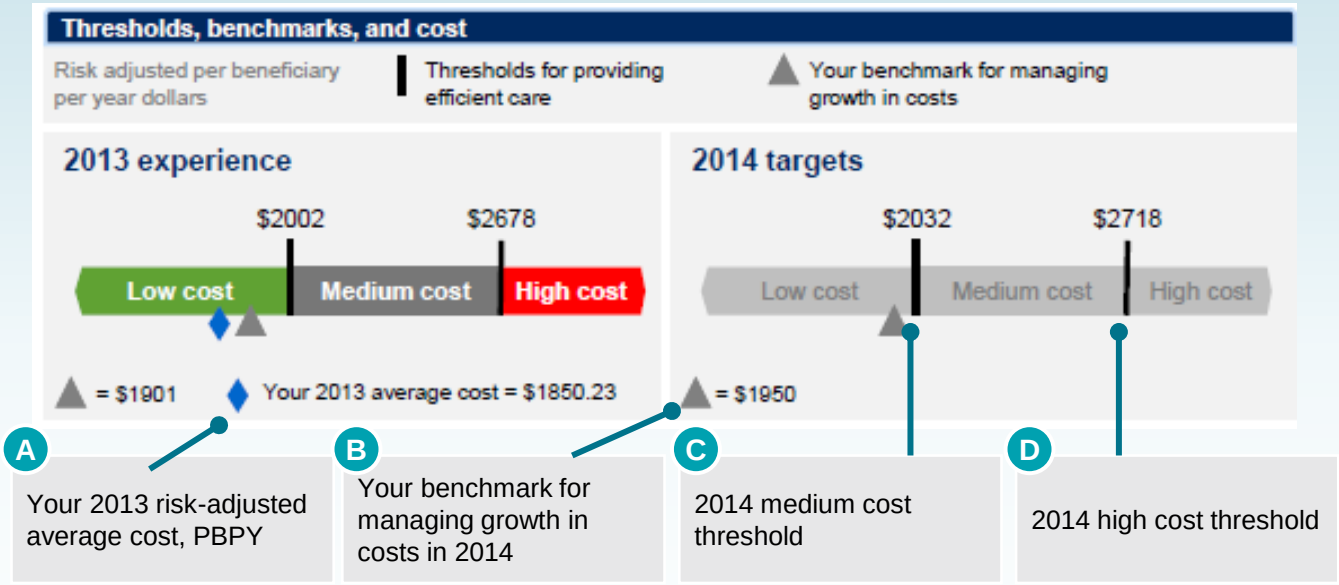
Each point on the chart represents a rolling 12 months' worth of data for the time period labeled on the x-axis

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 (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

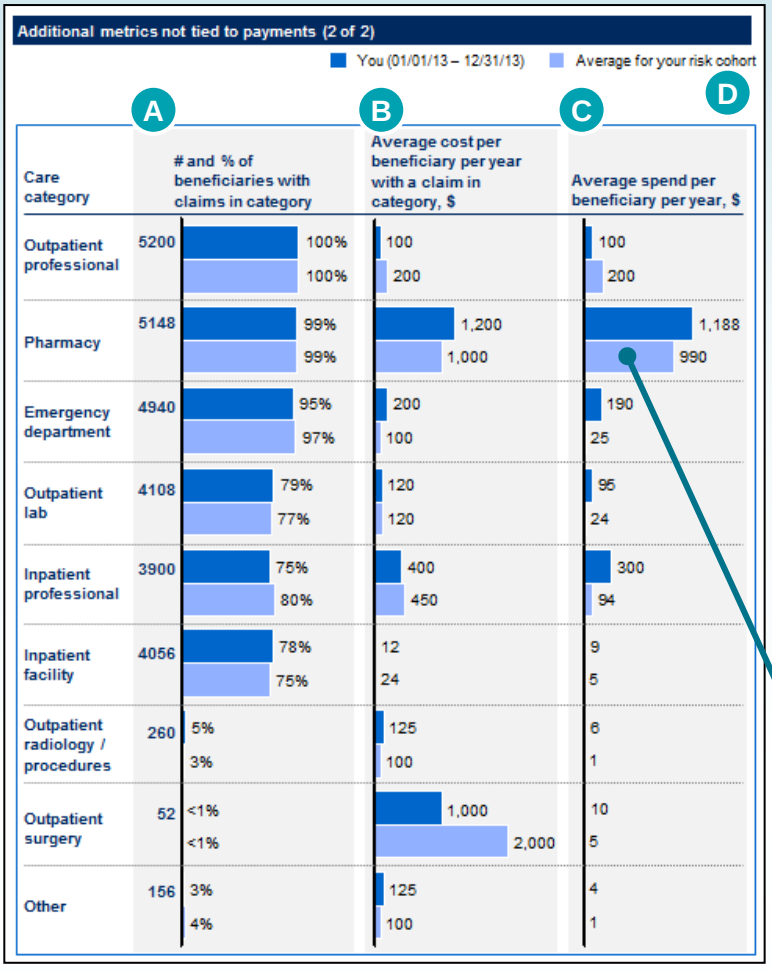
C $2,032 is the 2014 medium cost threshold. This threshold is used to calculate shared savings for providing efficient care as well as to establish your shared savings percentage for managing your growth in costs

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)

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