Arkansas Payment Improvement Initiative (APII)

Cholecystectomy Episode
Statewide Webinar
August 21, 2013
Building a healthier future for all Arkansans

Angela Littrell - Infrastructure Development and Implementation Manager - **Overview of the Healthcare Payment Improvement Initiative**

Shelley Tounzen, Medicaid Health Innovation Unit Public Information Coordinator – **Initiative Update**

Dr. William Golden, Medicaid Medical Director – **Cholecystectomy Episode of Care**

Detra Lovelace – HP APII Analyst - **Episode Reports**
Today, we face major health care challenges in Arkansas

- **The health status of Arkansans is poor**: the state is ranked at or near the bottom of all states on national health indicators, such as heart disease and diabetes

- **The health care system is hard for patients to navigate**, and it does not reward providers who work as a team to coordinate care for patients

- **Health care spending is growing unsustainably**:
  - Insurance premiums doubled for employers and families in past 10 years (adding to uninsured population)
Our vision to improve care for Arkansas is a comprehensive, patient-centered delivery system

<table>
<thead>
<tr>
<th>Objectives</th>
<th>For patients</th>
<th>For providers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>▪ Improve the health of the population</td>
<td>▪ Reward providers for high quality, efficient care</td>
</tr>
<tr>
<td></td>
<td>▪ Enhance the patient experience of care</td>
<td>▪ Reduce or control the cost of care</td>
</tr>
<tr>
<td></td>
<td>▪ Enable patients to take an active role in their care</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>How care is delivered</th>
<th>Population-based care</th>
<th>Episode-based care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>▪ Medical homes</td>
<td>▪ Acute, post-acute, or select chronic conditions</td>
</tr>
<tr>
<td></td>
<td>▪ Health homes</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Four aspects of broader program</th>
<th>Results-based payment and reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Health care workforce development</td>
</tr>
<tr>
<td></td>
<td>Health information technology (HIT) adoption</td>
</tr>
<tr>
<td></td>
<td>Consumer engagement and personal responsibility</td>
</tr>
</tbody>
</table>
Medicaid and private insurers believe paying for results, not just individual services, is the best option to improve quality and control costs.

**This initiative aims to...**

<table>
<thead>
<tr>
<th><strong>Transition to a payment system that rewards value and patient health outcomes</strong> by aligning financial incentives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reduce payment levels for all providers</strong> regardless of their quality of care or efficiency in managing costs</td>
</tr>
<tr>
<td><strong>Pass growing costs on to consumers</strong> through higher premiums, deductibles and co-pays (private payers), or higher taxes (Medicaid)</td>
</tr>
<tr>
<td><strong>Intensify payer intervention in decisions through managed care or elimination of</strong> expensive services (e.g. through prior authorizations) based on restrictive guidelines</td>
</tr>
<tr>
<td><strong>Eliminate coverage of</strong> expensive services or eligibility</td>
</tr>
</tbody>
</table>

**This initiative DOES NOT aim to**

- Transition to a payment system that rewards value and patient health outcomes by aligning financial incentives
- Reduce payment levels for all providers regardless of their quality of care or efficiency in managing costs
- Pass growing costs on to consumers through higher premiums, deductibles and co-pays (private payers), or higher taxes (Medicaid)
- Intensify payer intervention in decisions through managed care or elimination of expensive services (e.g. through prior authorizations) based on restrictive guidelines
- Eliminate coverage of expensive services or eligibility
## Principles of payment design for Arkansas

<table>
<thead>
<tr>
<th>Principle</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient-centered</td>
<td>Focus on improving quality, patient experience and cost efficiency</td>
</tr>
<tr>
<td>Clinically appropriate</td>
<td>Design based on evidence, with close input from Arkansas patients and providers</td>
</tr>
<tr>
<td>Practical</td>
<td>Consider scope and complexity of implementation</td>
</tr>
<tr>
<td>Data-based</td>
<td>Make design decisions based on facts and data</td>
</tr>
</tbody>
</table>
Angela Littrell - Infrastructure Development and Implementation Manager - **Overview of the Healthcare Payment Improvement Initiative**

Shelley Tounzen, Medicaid Health Innovation Unit Public Information Coordinator – **Initiative Update**

Dr. William Golden, Medicaid Medical Director – **Cholecystectomy Episode of Care**

Detra Lovelace – HP APII Analyst - **Episode Reports**
For Medicaid, work has occurred on 15 Episodes, with 8 having gone live.

<table>
<thead>
<tr>
<th>Episode</th>
<th>Legislative Review</th>
<th>Reporting Period Start Date</th>
<th>Multipayer Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Upper Respiratory Infection</td>
<td>Spring 2012</td>
<td>July 2012</td>
<td>QualChoice</td>
</tr>
<tr>
<td>2 Attention Deficit Hyperactivity Disorder (ADHD)</td>
<td>Spring 2012</td>
<td>July 2012</td>
<td>QualChoice</td>
</tr>
<tr>
<td>3 Perinatal</td>
<td>Spring 2012</td>
<td>July 2012</td>
<td>QualChoice</td>
</tr>
<tr>
<td>4 Congestive Heart Failure</td>
<td>November 2012</td>
<td>December 2012</td>
<td>QualChoice</td>
</tr>
<tr>
<td>5 Total Joint Replacement (Hip &amp; Knee)</td>
<td>November 2012</td>
<td>December 2012</td>
<td>QualChoice</td>
</tr>
<tr>
<td>6 Colonoscopy</td>
<td>June 2013</td>
<td>July 2013</td>
<td>QualChoice</td>
</tr>
<tr>
<td>7 Cholecystectomy (Gallbladder Removal)</td>
<td>June 2013</td>
<td>July 2013</td>
<td>QualChoice</td>
</tr>
<tr>
<td>8 Tonsillectomy</td>
<td>June 2013</td>
<td>July 2013</td>
<td>QualChoice</td>
</tr>
<tr>
<td>9 Oppositional Defiance Disorder (ODD)</td>
<td>August 2013</td>
<td>October 2013</td>
<td>QualChoice</td>
</tr>
<tr>
<td>10 Coronary Artery Bypass Grafting (CABG)</td>
<td>August 2013</td>
<td>October 2013</td>
<td>QualChoice</td>
</tr>
<tr>
<td>11 Percutaneous Coronary Intervention (PCI)</td>
<td>August 2013</td>
<td>October 2013</td>
<td>QualChoice</td>
</tr>
<tr>
<td>12 Asthma</td>
<td>August 2013</td>
<td>October 2013</td>
<td>QualChoice</td>
</tr>
<tr>
<td>13 Chronic Obstructive Pulmonary Disease (COPD)</td>
<td>August 2013</td>
<td>October 2013</td>
<td>QualChoice</td>
</tr>
<tr>
<td>14 ADHD/ODD Comorbidity</td>
<td>September 2013</td>
<td>January 2014</td>
<td>QualChoice</td>
</tr>
<tr>
<td>15 Neonatal</td>
<td>Q1 CY 2014</td>
<td>1st-half CY 2014</td>
<td>QualChoice</td>
</tr>
</tbody>
</table>

1 Participation includes development and rollout of episode
2 Subject to legislative approval. Wave 2b has been approved by Public Health Committee; further approvals expected during August 2013
3 Qualchoice is a Qualchoice of Arkansas; The cross and shield represent Blue Cross Blue Shield of Arkansas
Building a healthier future for all Arkansans

- Angela Littrell - Infrastructure Development and Implementation Manager - **Overview of the Healthcare Payment Improvement Initiative**

- Shelley Tounzen, Medicaid Health Innovation Unit Public Information Coordinator – **Initiative Update**

- Dr. William Golden, Medicaid Medical Director – **Cholecystectomy Providers, Patients & Quality**

- Detra Lovelace – HP APII Analyst - **Episode Reports**
## Cholecystectomy: key facts

### What is a cholecystectomy?
- Gall bladder removal surgery
- Performed laproscopically (i.e., minimally invasive surgery using a small camera as a guide)
- Patients typically go home on the same day as surgery if there are no complications

### Goals of episode
- Reduce complications and readmissions
- Reduce reliance of CT imaging prior to operation
- Reduce excess pre-op and post-op days in hospitals
Cholecystectomy: Patient journey

Pre-procedure entry into medical setting (30 days)

- Patient presents to ED
- Patient presents to non-acute setting

Emergency Department services
PCP office

Procedure

- Determine timing, type and setting of operation

Inpatient procedure
Outpatient procedure

Open cholecystectomy at hospital
Laparoscopic cholecystectomy

Post-procedure (90 days)

- Care and recovery (inpatient or outpatient)
- Follow-up clinician visits

Complications and post-procedure admissions

SOURCE: Society of American Gastrointestinal and Endoscopic Surgeons, expert/clinician interviews
Cholecystectomy episode design (1/2)

**Episode definition / scope of services**

- Episode is triggered by open or laparoscopic cholecystectomy procedure, including:
  - Laparoscopic or open cholecystectomy surgery and
  - Primary or second diagnosis (Dx_1 or Dx_2) indicating conditions related to cholecystectomy (e.g., cholelithiasis, cholecystitis)

- Episode time frame:
  - Cholecystectomy surgery and related services during procedure (i.e., inpatient and outpatient facility services, professional services, related medications, treatment for complications)
  - Related services within 90 days post procedure
  - Post-procedure admissions within 30 days post-procedure as defined by BPCI

**Exclusion criteria**

- Certain patients are excluded from this episode design:
  - Select co-morbid conditions or past procedures within 365 days or 90 days after cholecystectomy (e.g., HIV, cancer, sickle cell anemia, transplants)
  - Pregnancy 30 days prior to 90 days after cholecystectomy procedure
  - ICU care within 30 days prior to cholecystectomy procedure
  - Acute pancreatitis, cirrhosis, or cholangitis concurrent with procedure
  - Open cholecystectomy procedure (includes laparoscopic converted to open and surgeries initiated open)
  - Death in hospital during episode
  - Patient status of “left against medical advice” during episode
  - Age equal to or less than 1 or greater than or equal to 65
  - Dual coverage of primary medical services
  - Inconsistent enrollment (i.e., not continuously enrolled) during the episode

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1 Specific parameters of these design elements may vary by payer
2 Open cholecystectomies included as triggers since they should be captured for tracking purposes, although open episodes will be excluded
3 30 day all-cause post-procedure admission, excluding irrelevant procedures as determined by BPCI (Bundled Payments for Care Improvement, a CMS initiative)
4 Does not include ICU care during inpatient stay of cholecystectomy procedure
Cholecystectomy episode design (2/2)

- Episode cost is adjusted based on
  - Patient co-morbidities, including indirectly related health conditions (e.g. hypotension, ventilator dependence) and patient presentation prior to cholecystectomy surgery (e.g. acute cholecystitis, common bile duct stones)
  - ED admittance prior to procedure for episodes with inpatient cholecystectomy
  - High cost or low cost outliers, applied after other cost adjustments

- Only providers with at least 5 episodes per year will be eligible for gain sharing/risk sharing

- Quality metrics for reporting only:
  - Rate of major complications that occur in episode, either during procedure or in post-procedure window: common bile duct injury, abdominal blood vessel injury, bowel injury
  - Number of laparoscopic cholecystectomies converted to open surgeries
  - Number of cholecystectomies initiated via open surgery

- Quality metrics required for gain sharing payment:
  - Percent of episodes with CT scan prior to cholecystectomy (must be below threshold rate to qualify for gain sharing)

- For Medicaid, the Principal Accountable Provider (PAP) will be the primary surgeon performing the cholecystectomy. Other payers independently determine the PAP by considering the following factors:
  - Decision making responsibilities
  - Influence over other providers
  - Portion of episode cost

1 Specific parameters of these design elements may vary by payer
2 Risk adjustment methodology applied to determine whether and to what extent co-morbidities are associated with increased episode cost
3 Adjustment is for episodes with inpatient cholecystectomy and ED visit prior to surgery, and will adjust for the per diem cost of one inpatient day
4 High cost outlier defined statistically; low cost outlier defined by adding cost of minimum services possible for episode
5 Episode minimum determined by each payer separately and applied to volume for payers separately
## Design rationale: Episode definition / scope of services (1/2)

<table>
<thead>
<tr>
<th>Episode design decisions</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Trigger identification:</strong></td>
<td><strong>Although open cholecystectomies will be excluded, they can trigger an episode, which will be used for tracking purposes only</strong></td>
</tr>
<tr>
<td>– Laparoscopic or open cholecystectomies can be potential trigger</td>
<td><strong>Requiring an appropriate diagnosis code (Dx fields 1 and 2) excludes episodes with conditions that lead to highly variable patient conditions, outcomes, and costs (e.g. cancer)</strong></td>
</tr>
<tr>
<td>– Episode is triggered by cholecystectomy procedure and appropriate primary or secondary diagnosis</td>
<td><strong>A list of CPT and ICD-9 Px codes for laparoscopic cholecystectomies identified as triggers for an episode</strong></td>
</tr>
</tbody>
</table>

| Pre-procedure window: | Pre-procedure costs often due to behavior of upstream providers who surgeon may have little influence on (e.g. primary care physician, GI specialist) |
| – Pre-procedure cost excluded from episode cost | **Episode is triggered by cholecystectomy procedure and appropriate primary or secondary diagnosis** |

| Post-procedure window: | **90 day period for follow-up care related to cholecystectomy procedure because this care may occur over a long period of time, particularly in cases with complications** |
| – Related services within 90 days after procedure (i.e., inpatient and outpatient facility services, professional services, related medications, treatment for post-procedure complications) | **Related services defined by specific set of CPT and ICD-9 Px/Dx codes** |
| – Inpatient post-procedure admissions within 30 days after procedure as defined by BPCI | **Post procedure admissions due to complications, etc. are included in episode cost calculations since reducing complications and treating them effectively and efficiently is an identified value driver** |
| | **CMS BPCI provides a list of procedure codes which are not relevant to cholecystectomies or similar acute episodes; these procedures will not be included in episode costs (i.e., if a patient is treated for a condition that is not a complication or relevant to the cholecystectomy procedure within 30 days after the procedure, it will not be included in the episode cost calculation)** |
Episode definition:
- All related services during cholecystectomy procedure and 90 days after procedure, including inpatient and outpatient facility services, professional services, related medications
- Related complications and post-procedure admissions

The episode includes the following services:

- Labs, imaging, and diagnostic tests during procedure
- Professional claims
- Inpatient or outpatient facility care
- Medications
- 30-day post-procedure admissions

- All claims with a diagnosis or procedure code related to preparation, delivery, recovery, or complications of cholecystectomy
- All medications prescribed in outpatient setting related to preparation, recovery and complications from procedure
- Inpatient admissions within 30 days post-procedure as defined by BPCI, and admissions 31-90 days post-procedure if related to cholecystectomy
## Design rationale: Patient exclusions (1/2)

<table>
<thead>
<tr>
<th>Patient exclusion design decision</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select co-morbid conditions within 365 days prior to procedure or during episode</td>
<td>Patients with certain co-morbidities which may unfairly increase a PAP’s average episode cost due to their inherent medical condition(s) within a year prior to procedure or during the episode are excluded (i.e., co-morbidities are factors beyond the PAP’s control/influence)</td>
</tr>
<tr>
<td>Pregnant in episode window or 30 days prior</td>
<td>Cholecystectomies performed on women who are known to be pregnant during the episode window or 30 days prior are excluded due to their potentially complex condition</td>
</tr>
<tr>
<td>ICU care within 30 days prior to cholecystectomy procedure</td>
<td>These patients are likely to have severe co-morbidities that increase the complexity of the cholecystectomy episode</td>
</tr>
<tr>
<td>Acute pancreatitis, cirrhosis, or cholangitis concurrent with procedure</td>
<td>Cholecystectomies performed on people who present with these diagnoses are excluded due to the increased complexity of these cases</td>
</tr>
<tr>
<td>Open cholecystectomy performed</td>
<td>Open cholecystectomy surgeries often have patient conditions, outcomes, and costs which are often significantly variable (i.e., many factors beyond the control of the PAP), and are therefore excluded</td>
</tr>
<tr>
<td></td>
<td>Open cholecystectomy surgeries most often associated with concurrent open incision surgery (e.g., gastric bypass)</td>
</tr>
</tbody>
</table>
## Design rationale: Patient exclusions (2/2)

<table>
<thead>
<tr>
<th>Patient exclusion design decision</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death in hospital during episode</td>
<td>Patients with death in hospital likely to have complex co-morbidities</td>
</tr>
<tr>
<td>Patient status of “left AMA (against medical advice)” on any claim included in episode cost</td>
<td>A PAP cannot be held responsible for outcomes and resulting cost of care if patient leaves AMA</td>
</tr>
<tr>
<td>Age younger than 1 or older than 64</td>
<td>Patients under 1 and older than 64 tend to have more complicated procedures and are therefore excluded</td>
</tr>
<tr>
<td>Inconsistent enrollment with payer during episode</td>
<td>Consistent enrollment ensures that all costs associated with an episode are accurately and fully captured</td>
</tr>
<tr>
<td>Dual coverage of primary medical services</td>
<td>In order to reduce the possibility that costs within an episode are not accurately and fully captured (i.e., costs partially covered by another program), patients who have dual enrollment are excluded</td>
</tr>
</tbody>
</table>
Design rationale: Quality metrics

- Rate of major surgical complications that occur in episode, identified during procedure or post-procedure window:
  - Common bile duct injury
  - Abdominal blood vessel injury
  - GI tract perforation

- Number of laparoscopic cholecystectomies converted to open surgeries

- Number of cholecystectomies initiated via open surgery

- Percent of episodes with CT scan prior to cholecystectomy (below threshold rate to qualify for gain sharing)
Design rationale: Principal Accountable Provider (PAP)

PAP design decision

- Payers independently determine the PAP by considering the following factors:
  - Decision making responsibilities
  - Influence over other providers
  - Portion of episode cost

Rationale

- Medicaid has publicly announced that the Principal Accountable Provider (PAP) will be the primary surgeon performing the cholecystectomy since they are in the position to have most influence over decisions, other providers, and episode costs
Building a healthier future for all Arkansans

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- Dr. William Golden, Medicaid Medical Director – Cholecystectomy Episode of Care

- Detra Lovelace – HP APII Analyst - Episode Descriptions & Reports
Arkansas Health Care Payment Improvement Initiative
Provider Report

Medicaid
Report date: April 2013


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

This is an update on the Arkansas Health Care Payment Improvement Initiative (APII) – a payment system developed with input from hundreds of health care providers, patients and family members. Our goal is to support and reward providers who consistently deliver high-quality, coordinated, and cost-effective care.

As a reminder, a core component of this multi-payer initiative is episodes of care. An episode is the collection of care provided to treat a particular condition over a given length of time. Since July of 2012, Arkansas Medicaid has introduced new episodes, including Upper Respiratory Infection (URI), Perinatal (colloquially, called “pregnancy”), Attention Deficit/Hyperactivity Disorder (ADHD), and more. To see the most up to date list of episodes visit the APII website at www.paymentinitiative.org.

For each episode, the provider that holds the main responsibility for ensuring that care is delivered at appropriate cost and quality will be designated as the Principal Accountable Provider (PAPs). For some episodes in the period covered in the attached report, you were identified as the PAP. After appropriate risk-adjustments and exclusions, your average quality and cost was compared with previously announced thresholds. This determines any potential sharing of savings or excess cost indicated in the report. Note that all information described throughout your report is based on claims already submitted and all providers should continue to submit and receive reimbursement for claims as they do today.

This report contains episodes currently in the ‘preparatory phase’ and so the data and analyses for these reports are historical only (i.e. they are not data from the time period that you will be measured against). To see “performance” reports (i.e., containing episodes eligible for gain or risk sharing) for episodes launched earlier, log onto the provider portal at www.paymentinitiative.org to download a separate report.

To aid you in your role as a PAP for future episodes, we have been working hard with providers and other payers to design a set of reports that give you detailed data about the quality and cost of your care as well as how this compares with previously announced thresholds and the range of performance of other providers. As each payer will send a report covering their patients, you may receive similar reports from Arkansas Blue Cross Blue Shield and / or QualChoice.

We encourage you to log onto the provider portal to access your current and previous ‘preparatory period’ and ‘performance period’ reports. As a PAP for select episodes, you should begin using this portal to enter selected quality metrics for each patient with an episode of care starting. To see which episodes have quality metrics linked to gain sharing visit the APII website.

We have been working diligently to solicit feedback from the provider community and will continue in our efforts to respond to all questions, comments and concerns raised in a timely and consistent manner. For answers to frequently asked questions regarding the initiative and episodes, please refer to the payment initiative website (www.paymentinitiative.org) You can also call us at 1-866-322-4696 or locally at 501-301-8311 with questions or email ARKPII@hp.com. Additionally, be sure to check the website regularly for updates on upcoming informational WebEx sessions, other resources, or to sign up for alerts.

Sincerely,

Andy Allison, PhD
Medicaid Director

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Performance summary

Attention Deficit/Hyperactivity Disorder (ADHD) – Level I

Attention Deficit/Hyperactivity Disorder (ADHD) – Level II

Cholecystectomy

Colonoscopy

Congestive Heart Failure

Oppositional Defiance Disorder

Perinatal

Tonsillectomy

Total Joint Replacement

Upper Respiratory Infection – Non-specific URI

Upper Respiratory Infection – Pharyngitis

Upper Respiratory Infection – Sinusitis

Glossary

Appendix: Episode level detail
## Performance summary

### Quality of services and cost summary

<table>
<thead>
<tr>
<th>Episode of Care</th>
<th>Quality of Service</th>
<th>Average Episode Cost</th>
<th>Your Gain/Risk Share</th>
<th>Share Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attention Deficit / Hyperactivity Disorder (ADHD) – Level I</td>
<td>Not met</td>
<td>Acceptable</td>
<td>Not eligible for gain sharing</td>
<td>$0.00</td>
</tr>
<tr>
<td>Attention Deficit / Hyperactivity Disorder (ADHD) – Level II</td>
<td>Met</td>
<td>Acceptable</td>
<td>Not eligible for gain sharing</td>
<td>$0.00</td>
</tr>
<tr>
<td>Cholecystectomy</td>
<td>Met</td>
<td>Acceptable</td>
<td>Not eligible for gain sharing</td>
<td>$0.00</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>Met</td>
<td>Acceptable</td>
<td>Not eligible for gain sharing</td>
<td>$0.00</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>Not met</td>
<td>Acceptable</td>
<td>Not eligible for gain sharing</td>
<td>$0.00</td>
</tr>
<tr>
<td>Oppositional Defiance Disorder</td>
<td>Met</td>
<td>Acceptable</td>
<td>Not eligible for gain sharing</td>
<td>$0.00</td>
</tr>
<tr>
<td>Perinatal</td>
<td>Met</td>
<td>Acceptable</td>
<td>Not eligible for gain sharing</td>
<td>$0.00</td>
</tr>
<tr>
<td>Tonsillectomy</td>
<td>Met</td>
<td>Acceptable</td>
<td>Not eligible for gain sharing</td>
<td>$0.00</td>
</tr>
<tr>
<td>Total Joint Replacement</td>
<td>N/A</td>
<td>Acceptable</td>
<td>Not eligible for gain sharing</td>
<td>$0.00</td>
</tr>
<tr>
<td>Upper Respiratory Infection – Non-specific URI</td>
<td>N/A</td>
<td>Not acceptable</td>
<td>Subject to risk sharing</td>
<td>-$3,844.50</td>
</tr>
<tr>
<td>Upper Respiratory Infection – Pharyngitis</td>
<td>Not met</td>
<td>Acceptable</td>
<td>Not eligible for gain sharing</td>
<td>$0.00</td>
</tr>
<tr>
<td>Upper Respiratory Infection – Sinusitis</td>
<td>N/A</td>
<td>Commendable</td>
<td>Will receive gain sharing</td>
<td>$349.50</td>
</tr>
</tbody>
</table>

Across these Episodes of Care You are Subject to Risk Sharing: Stop-loss was applied

The figures in this report are preliminary and are subject to revision
# Summary – Cholecystectomy

## Overview

- **Total episodes:** 262
- **Total episodes included:** 233
- **Total episodes excluded:** 29

## Cost of care compared to other providers

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>You (adjusted)</th>
<th>You (non-adjusted)</th>
<th>All providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of care</td>
<td>$466,000</td>
<td>$512,000</td>
<td>$1,750</td>
</tr>
<tr>
<td>Cholecystectomy</td>
<td>Blue</td>
<td>Red</td>
<td>Blue</td>
</tr>
</tbody>
</table>

**Gain/Risk share:**

- **You:** $0

You will not receive gain or risk sharing.

- Selected quality metrics: N/A
- Average episode cost: Acceptable

## Quality summary

- **CT scan rate 30-day pre-op:**
  - **You:** 100%
  - **Avg:** 50%
  - **Maximum for gain sharing:** 100%
  - **Linked to gain sharing:**

- **Common bile duct injury rate:**
  - **You:** 0%
  - **Avg:** 0%

- **Bowel perforation/injury rate:**
  - **You:** 0%
  - **Avg:** 0%

- **Abd blood vessel injury rate:**
  - **You:** 0%
  - **Avg:** 0%

## Cost summary

### Your total cost overview, $

- **You:** $512,000
- **Adjusted:** $466,000

### Average cost overview, $

- **You:** $2,000
- **All providers:** $1,750

### Your episode cost distribution

- **# episodes:**
  - **<$1,581:** 100%
  - **$1,581 to $1,919:** 50%
  - **$1,919:** 0%

### Distribution of provider average episode cost

- **Percentile:**
  - **< $1,581:** 100%
  - **$1,581 to $1,919:** 50%
  - **$1,919 to $5,142:** 0%

## Key utilization metrics

- **# episodes converted from laparoscopic to open:**
  - **You:** 6
  - **All providers:** 4

- **# episodes initiated as open:**
  - **You:** 10
  - **All providers:** 8
# Quality and utilization detail – Cholecystectomy

## Quality metrics: Performance compared to provider distribution

<table>
<thead>
<tr>
<th>Metric</th>
<th>You</th>
<th>25th</th>
<th>50th</th>
<th>75th</th>
<th>Percentile 50</th>
<th>75</th>
<th>100</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT scan rate 30 day pre-op</td>
<td>40%</td>
<td>20%</td>
<td>44%</td>
<td>60%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Common bile duct injury rate</td>
<td>2%</td>
<td>1%</td>
<td>3%</td>
<td>5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bowel perforation / injury rate</td>
<td>1%</td>
<td>1%</td>
<td>5%</td>
<td>8%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdominal blood vessel injury rate</td>
<td>3%</td>
<td>1%</td>
<td>4%</td>
<td>7%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

You achieved selected quality metrics

## Utilization metrics: Performance compared to provider distribution

<table>
<thead>
<tr>
<th>Metric</th>
<th>You</th>
<th>25th</th>
<th>50th</th>
<th>75th</th>
<th>Percentile 50</th>
<th>75</th>
<th>100</th>
</tr>
</thead>
<tbody>
<tr>
<td># episodes converted from laparoscopic to open</td>
<td>6</td>
<td>2</td>
<td>4</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># episodes initiated as open</td>
<td>10</td>
<td>4</td>
<td>8</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Total episodes included = 233

Cost detail – Cholecystectomy

<table>
<thead>
<tr>
<th>Care category</th>
<th># and % of episodes with claims in care category</th>
<th>Average cost per episode when care category utilized, ($)</th>
<th>Total vs. expected cost in care category, ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient professional</td>
<td>233</td>
<td>100% 550</td>
<td>128,150</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>230</td>
<td>99% 2,415</td>
<td>555,450</td>
</tr>
<tr>
<td>Emergency department</td>
<td>221</td>
<td>95% 76</td>
<td>16,796</td>
</tr>
<tr>
<td>Outpatient lab</td>
<td>184</td>
<td>79% 81</td>
<td>14,904</td>
</tr>
<tr>
<td>Outpatient radiology / procedures</td>
<td>21</td>
<td>75% 117</td>
<td>2,457</td>
</tr>
<tr>
<td>Inpatient professional</td>
<td>16</td>
<td>78% 70</td>
<td>1,120</td>
</tr>
<tr>
<td>Inpatient facility</td>
<td>12</td>
<td>5% 69</td>
<td>828</td>
</tr>
<tr>
<td>Outpatient surgery</td>
<td>1</td>
<td>&lt;1% 97</td>
<td>97</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>3% 25</td>
<td>175</td>
</tr>
</tbody>
</table>

Outpatient professional: You 550, All provider average 500
Pharmacy: You 2,415, All provider average 2,400
Emergency department: You 76, All provider average 76
Outpatient lab: You 81, All provider average 81
Outpatient radiology / procedures: You 117, All provider average 95
Inpatient professional: You 70, All provider average 75
Inpatient facility: You 69, All provider average 62
Outpatient surgery: You 97, All provider average 84
Other: You 25, All provider average 189
For more information talk with provider support representatives…

**Online**
- More information on the Payment Improvement Initiative can be found at [www.paymentinitiative.org](http://www.paymentinitiative.org)
  - Further detail on the initiative, PAP and portal
  - Printable flyers for bulletin boards, staff offices, etc.
  - Specific details on all episodes
  - Contact information for each payer’s support staff
  - All previous workgroup materials

**Phone/ email**
- **Medicaid**: 1-866-322-4696 (in-state) or 1-501-301-8311 (local and out-of state) or [ARKPII@hp.com](mailto:ARKPII@hp.com)

- **Blue Cross Blue Shield**: Providers 1-800-827- 4814, direct to EBI 1-888-800-3283, [APIICustomerSupport@arkbluecross.com](mailto:APIICustomerSupport@arkbluecross.com)

- **QualChoice**: 1-501-228-7111, [providerrelations@qualchoice.com](mailto:providerrelations@qualchoice.com)