Arkansas Payment Improvement Initiative (APII)

Congestive Heart Failure
Total Joint Replacement Episodes
Statewide Webinar
February 11, 2013
Dawn Zekis, Medicaid Health Innovation Unit Director - Overview of the Healthcare Payment Improvement Initiative

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

Dr. William Golden, Medicaid Medical Director – CHF/TJR Providers, Patients & Quality

Wanda Colclough and Paula Miller – HP Enterprises Technical Consultant and HP APII Analyst - Episode Descriptions & Reports

Sheryl Hurt, Provider Relations Representative – Arkansas Foundation for Medical Care - Provider Portal
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)
  - Large projected budget shortfalls for Medicaid
Our vision to improve care for Arkansas is a comprehensive, patient-centered delivery system...

**Objectives**

- For patients
  - Improve the health of the population
  - Enhance the patient experience of care
  - Enable patients to take an active role in their care
  - Encourage patient engagement/accountability

- For providers
  - Reward providers for high quality, efficient care
  - Reduce or control the cost of care

**How care is delivered**

- **Population-based care**
  - Medical homes
  - Health homes

- **Episode-based care**
  - Acute, procedures or defined conditions

**Four aspects of broader program**

- Results-based **payment and reporting**
- Health care **workforce** development
- **Health information technology** (HIT) adoption
- **Expanded access** for health care services
Payers recognize the value of working together to improve our system, with close involvement from other stakeholders…

Coordinated multi-payer leadership…

- Creates **consistent incentives** and standardized reporting rules and tools
- Enables **change in practice** patterns as program applies to many patients
- Generates enough scale to justify investments in **new infrastructure** and operational models
- Helps **motivate patients** to play a larger role in their health and health care

1 Center for Medicare and Medicaid Services
We have worked closely with providers and patients across Arkansas to shape an approach and set of initiatives to achieve this goal.

| 500+ | ▪ **Providers, patients, family members**, and other stakeholders who helped shape the new model in public workgroups |
| 21   | ▪ **Public workgroup meetings** connected to 6-8 sites across the state through videoconference |
| 16   | ▪ **Months of research**, data analysis, expert interviews and infrastructure development to design and launch episode-based payments |
| Monthly | ▪ **Updates with many Arkansas provider associations** (e.g., AHA, AMS, Arkansas Waiver Association, Developmental Disabilities Provider Association) |
The episode-based model is designed to reward coordinated, team-based high quality care for specific conditions or procedures.

**The goal**
- **Coordinated, team based care** for all services related to a specific condition, procedure, or disability (e.g., pregnancy episode includes all care prenatal through delivery)

**Accountability**
- A provider ‘quarterback’, or **Principal Accountable Provider** (PAP) is designated as accountable for all pre-specified services across the episode (PAP is provider in best position to influence quality and cost of care)

**Incentives**
- **High-quality, cost efficient care** is rewarded beyond current reimbursement, based on the PAP’s average cost and total quality of care across each episode
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Wave 2 launch

- **February 27**th 10am-12pm: Behavioral Health Public Workgroup
- **February 27**th 4pm-6pm: Chronic Obstructive Pulmonary Disease (COPD) and Asthma
- **February 28**th 4pm-6pm: Percutaneous coronary intervention, commonly known as Coronary Angioplasty and Coronary Artery Bypass Grafting
- **March 4**th 3pm-5pm: Neonatal Care
- **March 7**th 3pm-5pm: Long term Services and Supports: Preview Initial Design Decisions
- [www.paymentinitiative.org](http://www.paymentinitiative.org)
Building a healthier future for all Arkansans

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The model rewards a Principal Accountable Provider (PAP) for leading and coordinating services and ensuring quality of care across providers.

<table>
<thead>
<tr>
<th>PAP role</th>
<th>What it means…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core provider for episode</td>
<td>▪ Physician, practice, hospital, or other provider in the best position to influence overall quality, cost of care for episode</td>
</tr>
<tr>
<td>Episode ‘Quarterback’</td>
<td>▪ Leads and coordinates the team of care providers</td>
</tr>
<tr>
<td></td>
<td>▪ Helps drive improvement across system (e.g., through care coordination, early intervention, patient education, etc.)</td>
</tr>
<tr>
<td>Performance management</td>
<td>▪ Rewarded for leading high-quality, cost-effective care</td>
</tr>
<tr>
<td></td>
<td>▪ Receives performance reports and data to support decision-making</td>
</tr>
</tbody>
</table>

PAP selection:
▪ Payers review claims to see which providers patients chose for episode related care
▪ Payers select PAP based main responsibility for the patient’s care

NOTE: Episode and health home model for adult DD population in development. Model will utilize lead provider and health home to drive coordination.
Ensuring high quality care for every Arkansan is at the heart of this initiative, and is a requirement to receive performance incentives

<table>
<thead>
<tr>
<th>Two types of quality metrics for providers</th>
<th>Description</th>
</tr>
</thead>
</table>
| **1** Quality metric(s) “to pass” are linked to payment | ➢ **Core measures** indicating basic standard of care was met  
➢ **Quality requirements** set for these metrics, a provider must meet required level to be eligible for incentive payments  
➢ In select instances, quality metrics must be entered in portal (heart failure, ADHD) |
| **2** Quality metric(s) “to track” are not linked to payment | ➢ Key to understand overall quality of care and quality improvement opportunities  
➢ Shared with providers but **not linked to payment** |
How episodes work for patients and providers (1/2)

Patients and providers deliver care as today (performance period)

1. Patients seek care and select providers as they do today
2. Providers submit claims as they do today
3. Payers reimburse for all services as they do today
How episodes work for patients and providers (2/2)

4. Review claims from the performance period to identify a ‘Principal Accountable Provider’ (PAP) for each episode

5. Payers calculate average cost per episode for each PAP

6. Based on results, providers will:
   - **Share savings:** if average costs below commendable levels and quality targets are met
   - **Pay part of excess cost:** if average costs are above acceptable level
   - **See no change in pay:** if average costs are between commendable and acceptable levels

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1. Outliers removed and adjusted for risk and hospital per diems
2. Appropriate cost and quality metrics based on latest and best clinical evidence, nationally recognized clinical guidelines and local considerations
PAPs that meet quality standards and have average costs below the commendable threshold will share in savings up to a limit.

**High**
- Pay portion of excess costs

**Acceptable**
- No change in payment to providers

**Commendable**
- Receive additional payment as share as savings

**Gain sharing limit**
- Shared savings
- Shared costs
- No change

**Individual providers**, in order from highest to lowest average cost.
Illustrative examples of risk and gain sharing

Risk sharing capped at 10% of total reimbursement from each payer (i.e., provider will always be guaranteed at least 90% reimbursement)

Illustrative example:
- Average episode cost $200 below commendable threshold
- 50% ($100) gain shared with provider per episode
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# Congestive Heart Failure Algorithm Summary (1/2)

## Triggers
Inpatient admission with a primary diagnosis code for heart failure

## PAP Assignment
For each episode, the Principal Accountable Provider (PAP) is the admitting hospital for the trigger hospitalization

## Exclusions
Episodes meeting one or more of the following criteria will be excluded:

A. Beneficiaries do not have continuous Medicaid enrollment for the duration of the episode
B. Beneficiaries under the age of 18 at the time of admission
C. Beneficiaries with any cause inpatient stay in the 30 days prior to the triggering admission
D. Beneficiaries with any of the following comorbidities diagnosed in the period beginning 365 days before the episode start date and concluding on the episode end date: 1) End-Stage Renal Disease, 2) organ transplants, 3) pregnancy, 4) mechanical or left ventricular assist device (LVAD) or 5) intra-aortic balloon pump (IABP)
E. Beneficiaries with diagnoses for malignant cancers in the period beginning 365 days before the episode start date and concluding on the episode end date. The following types of cancers will not be criteria for episode exclusion: colon, rectum, skin, female breast, cervix uteri, body of uterus, prostate, testes, bladder, lymph nodes, lymphoid leukemia, monocytic leukemia.
F. Beneficiaries who received a pacemaker or cardiac defibrillator in 6 months prior to the start of the episode or during the episode
G. Beneficiaries with any of the following statuses upon discharge: 1) transferred to acute care or inpatient psych facility, 2) left against medical advice or 3) expired

## Episode Time Window
Episodes begin at inpatient admission for heart failure. Episodes end at the latter of 30 days after the date of discharge for the triggering admission or the date of discharge for any inpatient readmission initiated within 30 days of the initial discharge. Episodes shall not exceed 45 days post-discharge from the triggering admission.

## Claims Included
1. Inpatient facility and professional fees for the initial hospitalization and for all cause readmissions
2. Emergency or observation care
3. Home health services
4. Skilled nursing facility care due to acute exacerbation of CHF (services not included in episode for patients with SNF care in 30 days prior to episode start)
5. Durable medical equipment

## Quality Measures
**Quality measures "to pass":**
1. Percent of patients with LVSD who are prescribed an ACEI or ARB at hospital discharge – must meet minimum threshold of 85%

**Quality measures "to track":**
1. Frequency of outpatient follow-ups within 7 and 14 days after discharge
2. For qualitative assessments of left ventricular ejection fraction (LVEF), proportion of patients matching: hyperdynamic, normal, mild dysfunction, moderate dysfunction, severe dysfunction
3. Average quantitative ejection fraction value
4. 30-day all-cause readmission rate
5. 30-day heart failure readmission rate
6. 30-day outpatient observation care rate – utilization metric

## Adjustments
No adjustments are included in this episode type
<table>
<thead>
<tr>
<th>Trigger codes</th>
<th>Each episode is triggered by an inpatient admission with a primary diagnosis code for heart failure. ICD-9 Heart failure primary diagnosis codes: 428.xx, 40201, 40211, 40291, 40401, 40411, 40491</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codes to assign PAP</td>
<td>Admission hospital is principal accountable provider (see trigger codes above)</td>
</tr>
<tr>
<td>Reporting codes</td>
<td><strong>Outpatient visit within 7 to 14 days:</strong> any outpatient professional claim within 7 to 14 days of date of discharge <strong>All-cause readmissions:</strong> any hospitalization in the 30 day period following the date of discharge <strong>Heart failure readmission:</strong> any hospitalization in the 30 day period following the date of discharge with a primary diagnosis of heart failure (see triggers above)</td>
</tr>
<tr>
<td>Included claim codes</td>
<td>List of ICD-9 and CPT codes that should be included in episode <strong>Acute inpatient heart failure primary diagnosis codes:</strong> ICD-9 codes 428.xx, 40201, 40211, 40291, 40401, 40411, 40491 <strong>Post-acute skilled nursing facility (SNF):</strong> CPT codes 99304-99310, 99318 <strong>Post-acute skilled nursing professional:</strong> Revenue codes 190-193 <strong>Health home serves:</strong> HCPCS codes T1021, T1021-TE (modifier), T1021-TD (modifier) <strong>Durable medical equipment:</strong> HCPCS codes 4030F, E0601, E0561, E0562, E0470, A7030-A7039, A7044, A7046, K0532</td>
</tr>
</tbody>
</table>
## 5 Total joint replacement algorithm summary (1/3)

<table>
<thead>
<tr>
<th>Triggers</th>
<th>A surgical procedure for total hip replacement or total knee replacement.</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAP assignment</td>
<td>For each episode, the Principal Accountable Provider (PAP) is the orthopedic surgeon performing the total joint replacement procedure.</td>
</tr>
<tr>
<td>Exclusions</td>
<td>Episodes meeting one or more of the following criteria will be excluded:</td>
</tr>
<tr>
<td></td>
<td>A. Beneficiaries who are under the age of 18 at the time of admission</td>
</tr>
<tr>
<td></td>
<td>B. Beneficiaries with the following comorbidities diagnosed in the period beginning 365 days before the episode start date and concluding on the date of admission for the joint replacement surgery: 1) select autoimmune diseases, 2) HIV, 3) End–Stage Renal Disease, 4) liver, kidney, heart, or lung transplants, 5) pregnancy, 6) sickle cell disease, 7) fractures, dislocations, open wounds and/or trauma</td>
</tr>
<tr>
<td></td>
<td>C. Beneficiaries with either of the following discharge statuses: 1) left against medical advice or 2) expired during hospital stay</td>
</tr>
<tr>
<td></td>
<td>D. Beneficiaries who do not have continuous Medicaid enrollment for the duration of the episode</td>
</tr>
<tr>
<td>Episode time window</td>
<td>Episode begins 30 days prior to date of admission for the inpatient hospitalization for the total joint replacement surgery and end 60 days after the date of discharge.</td>
</tr>
<tr>
<td>Claims included</td>
<td>1. From 30 days prior to the date of admission to the date of the surgery: All evaluation and management, hip- or knee-related radiology and all labs/imaging/other outpatient services</td>
</tr>
<tr>
<td></td>
<td>2. During the triggering procedure: all medical, inpatient and outpatient services</td>
</tr>
<tr>
<td></td>
<td>3. From the date of the surgery to 30 days after the date of discharge: All cause readmissions, non–traumatic revisions, complications, all follow-up evaluation &amp; management, all emergency services, all home health and therapy, hip/knee radiology and all labs/imaging/other outpatient procedures</td>
</tr>
<tr>
<td></td>
<td>4. From 31 days to 90 days after the date of discharge: Readmissions due to infections and complications as well as hip or knee–related follow–up evaluation and management, home health and therapy and labs/imaging/other outpatient procedures</td>
</tr>
<tr>
<td>Quality measures</td>
<td>Quality measures “to track”:</td>
</tr>
<tr>
<td></td>
<td>1. 30-day, all cause readmission rate</td>
</tr>
<tr>
<td></td>
<td>2. Frequency of use of prophylaxis against post–op Deep Venous Thrombosis (DVT) / Pulmonary Embolism (PE) (pharmacologic or mechanical compression)</td>
</tr>
<tr>
<td></td>
<td>3. Frequency of post–op DVT/PE</td>
</tr>
<tr>
<td></td>
<td>4. 30-day wound infection rate</td>
</tr>
<tr>
<td>Adjustments</td>
<td>For the purposes of determining a PAP’s performance, the total reimbursement attributable to the PAP is adjusted for total joint replacement episodes involving a knee replacement to reflect that knee replacements have higher average costs than hip replacements. Additionally, over time, Medicaid may add or subtract additional risk or severity factors in line with new research and/or empirical evidence.</td>
</tr>
</tbody>
</table>
| Trigger codes | Each episode is triggered by a surgical procedure for total hip replacement or total knee replacement. The procedure is identified by a claim with either of the following procedure codes and ICD–9 diagnosis codes.  
**Hip Replacement**: CPT codes 27130, 27447; ICD–9 codes 81.51, 81.54  
**Knee Replacement**: CPT code 27447; ICD–9 code 81.54  
**Exclusion from Hip or Knee Replacement (disqualifying triggers)**: ICD–9 codes 800.xx–829.xx, 860.0–869.1, 850.0–854.1, 925.x–929.x, 170.x, 996.xx, V52.xx |
| Exclusion codes | List of prior diagnoses and meds that would disqualify a patient from the episode  
**Comorbidity codes for exclusion**: ICD–9 codes 279, 042, 585.x, V45.1, V56.xx, 630–669.94, V22–V24.99, V27–V27.99, V42.0, V42.1, V42.6, V42.7, 718.35, 718.38, 820.00–920.9, 827.0–827.1, 835.0–835.13, 928.01, 928.11, 959.7, 282.6  
These codes represent the set of business and clinical exclusions described previously |
| Codes to assign PAP | PAP is the orthopedic surgeon performing the joint replacement surgery and is identified by the triggers outlined above |
| Reporting codes | **30-day wound Infection rate**: any claim in the 30 day period following the date of discharge with code for wound infection – CPT codes 10180; ICD–9 codes 998.59, 038.0–038.9  
**Revisions**: any claim following the date of discharge with a code for revision – CPT codes 27134, 27137, 27138, 27486, 27487, 27488  
**Complications**: any claim in the 90 day period following the date of discharge with code for complications – CPT codes 10180, 12020, 12021, 13160, 35860; ICD–9 codes 998.30–998.81, 998.83–998.9, 996.40–996.49, 997.32–997.39, 038.0–038.9  
**All-cause readmissions**: any hospitalization in the 30 day period following the date of discharge |
### List of ICD–9 and CPT codes that should be included in episode are as follows:

#### ICD–9 Codes

**Hip Replacement:** 81.51, 81.54  
**Knee Replacement:** 81.54  
**Osteoarthritis and joint degeneration after care:** 710–721, 725–733, 736, 738, 739, 755, V54.81, V58.31, V58.32, V58.78, V43.64, V43.65  
**Complications / Wound Infections / Sepsis:** 998.30–998.81, 998.83–998.9, 996.40–996.49, 997.32–997.39, 038.0–038.9  
**DVT and PE:** 451.0–451.2, 453.4–453.42, 454.0–454.9, 444.22

#### CPT Codes

**HIP Replacement:** 27130, 27447  
**Knee Replacement:** 27447  
**Hip / Knee Radiology:** 73500–73550, 73560–73580, 73700–73702, 73721–73723  
**Home Health:** T1021, T1021-TD (modifier), T1021-TE (modifier)  
**Personal Care:** T1019-U3 (modifier)  
**Physical Therapy:** 97001, 97110, 97150, 97110-UB (modifier), 97150-UB (modifier), S9131, S9131-UB (modifier)  
**Occupational Therapy:** 97003, 95530, 97150-U2 (modifier), 97530-UB (modifier), 97150-UB-U1 (modifiers 1,2)  
**Revisions:** 27134, 27137, 27138, 27486–27488  
**Complications / Wound Infections / Sepsis:** 10180, 12020, 12021, 13160, 35860
PAPs will be provided tools to help measure and improve patient care

Reports provide performance information for PAP’s episode(s):

- Overview of quality across a PAP’s episodes
- Overview of cost effectiveness (how a PAP is doing relative to cost thresholds and relative to other providers)
- Overview of utilization and drivers of a PAP’s average episode cost

Example of provider reports
PAP performance reports have summary results and detailed analysis of episode costs, quality and utilization

- First time PAPs receive detailed analysis on costs and quality for their patients increasing performance transparency

- Guide to Reading Your Reports available online and at this event
  - Valuable to both PAPs and non-PAPs to understand the reports

- Reports issued quarterly starting July 2012
  - July 2012 report is informational only
  - Gain/risk sharing results reflect claims data from Jan – Dec 2011

- Reports are available online via the provider portal

NOTE: Episode and health home model for adult DD population in development. Tools and reports still to be defined.
Arkansas Health Care Payment Improvement Initiative
Provider Report

Medicaid
Report Date: December 2012

Historical performance: July 1, 2011 – June 30, 2012

DISCLAIMER: The information contained in these reports is intended solely for use in the administration of the Medicaid program. The data in the reports is neither intended nor suitable for other uses, including the selection of a health care provider. For more information, please visit www.paymentinitiative.org
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<td>Upper Respiratory Infection – Sinusitis</td>
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<tr>
<td>Upper Respiratory Infection – Non-specific URI</td>
</tr>
<tr>
<td>Perinatal</td>
</tr>
<tr>
<td>Attention Deficit/Hyperactivity Disorder (ADHD)</td>
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<td>Total Joint Replacement</td>
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<td>Congestive Heart Failure</td>
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<td>Appendix: Episode level detail</td>
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### Performance summary (Informational)

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<tr>
<th>Congestive Heart Failure (CHF)</th>
<th>Total Joint Replacement (TJR)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality of service requirements:</strong> N/A</td>
<td><strong>Quality of service requirements:</strong> N/A</td>
</tr>
<tr>
<td><strong>Average episode cost:</strong> Acceptable</td>
<td><strong>Average episode cost:</strong> No eligible episodes</td>
</tr>
<tr>
<td><strong>Your gain/risk share</strong></td>
<td>$0</td>
</tr>
<tr>
<td>You will not receive gain or risk sharing</td>
<td>You are not subject to gain or risk sharing</td>
</tr>
</tbody>
</table>

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**Your Total Gain/Risk Share:**
Across these episodes of care you will not receive gain sharing:

$0.00
# Quality and utilization detail - Congestive Heart Failure

## 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>0</th>
<th>25</th>
<th>50</th>
<th>75</th>
<th>100</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of episodes with outpatient visits within 14 days</td>
<td>60%</td>
<td>22%</td>
<td>50%</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-day all cause readmission rate</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>25%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-day heart failure readmission rate</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>7%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

No quality metrics linked to gain sharing at this time

## 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>
</tr>
</thead>
<tbody>
<tr>
<td>30-day outpatient observation care rate</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>
# Cost detail - Congestive Heart Failure

Total episodes included = 5

<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>Inpatient professional</td>
<td>5 [87%]</td>
<td>1,107 [605]</td>
<td>5,533 [2,643]</td>
</tr>
<tr>
<td>Inpatient facility</td>
<td>5 [100%]</td>
<td>3,910 [3,688]</td>
<td>19,550 [18,441]</td>
</tr>
<tr>
<td>Outpatient professional</td>
<td>0 [0%]</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>0 [0%]</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Outpatient lab</td>
<td>0 [0%]</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Outpatient radiology / procedures</td>
<td>0 [0%]</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Emergency department</td>
<td>2 [40%]</td>
<td>84</td>
<td>168</td>
</tr>
<tr>
<td>Outpatient surgery</td>
<td>0 [0%]</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>1 [20%]</td>
<td>870</td>
<td>870</td>
</tr>
</tbody>
</table>

*Note: You vs. All providers*
Summary - Total Joint Replacement

Overview
Total episodes: 5  Total episodes included: 5  Total episodes excluded: 0

Average cost of care compared to other providers

<table>
<thead>
<tr>
<th>Commendable</th>
<th>Acceptable</th>
<th>Not acceptable</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;= $8098</td>
<td>$8098 to $12469</td>
<td>&gt; $12469</td>
</tr>
</tbody>
</table>

Gain/Risk share

You: $0
All providers: $0

You will not receive gain or risk sharing
- Quality requirements: N/A
- Average episode cost: Acceptable

Quality summary

No quality metrics linked to gain sharing at this time

Quality metrics - linked to gain sharing

Quality metrics - not linked to gain sharing

30-day all cause readmission rate: 3% (0% vs. 4%)
30-day wound infection rate: 3% (0% vs. 1%)

Cost summary

Your average cost is acceptable

Your total cost overview, $:
- You (non-adjusted): $45,909
- You (adjusted): $45,331
- Average cost (adjusted): $9,066
- All providers: $9,444

Your episode cost distribution

Distribution of provider average episode cost

Key utilization metrics

Post-op complication rate: 13%
### Quality and utilization detail - Total Joint Replacement

#### 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>0</th>
<th>25</th>
<th>50</th>
<th>75</th>
<th>100</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-day all cause readmission rate</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-day wound infection rate</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

No quality metrics linked to gain sharing at this time

#### 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>0</th>
<th>25</th>
<th>50</th>
<th>75</th>
<th>100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-op complication rate</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Cost detail - Total Joint Replacement

Total episodes included = 5

<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>Inpatient professional</td>
<td>5 [100%]</td>
<td>2,727</td>
<td>13,634</td>
</tr>
<tr>
<td>Inpatient facility</td>
<td>5 [100%]</td>
<td>3,543</td>
<td>17,714</td>
</tr>
<tr>
<td>Outpatient professional</td>
<td>5 [100%]</td>
<td>190</td>
<td>951</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Outpatient lab</td>
<td>5 [100%]</td>
<td>201</td>
<td>1,004</td>
</tr>
<tr>
<td>Outpatient radiology / procedures</td>
<td>5 [100%]</td>
<td>340</td>
<td>1,702</td>
</tr>
<tr>
<td>Emergency department</td>
<td>1 [20%]</td>
<td>66</td>
<td>66</td>
</tr>
<tr>
<td>Outpatient surgery</td>
<td>2 [40%, 34%]</td>
<td>76</td>
<td>152</td>
</tr>
<tr>
<td>Other</td>
<td>5 [100%, 95%]</td>
<td>2,022</td>
<td>10,109</td>
</tr>
</tbody>
</table>
Building a healthier future for all Arkansans

▪ Dawn Zekis, Medicaid Health Innovation Unit Director - Overview of the Healthcare Payment Improvement Initiative

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

▪ Dr. William Golden, Medicaid Medical Director – URI Providers, Patients & Quality

▪ Wanda Colclough and Paula Miller – HP Enterprises Technical Consultant and HP APII Analyst - Episode Descriptions & Reports

▪ Sheryl Hurt, Provider Relations Representative – Arkansas Foundation for Medical Care - Provider Portal
The provider portal is a multi-payer tool that allows providers to enter quality metrics for certain episodes and access their PAP reports.

- Accessible to all PAPs
  - Login with existing username/password
  - New users follow enrollment process detailed online
- Key components of the portal are to provide a way for providers to
  - Enter additional quality metrics for select episodes (Hip, Knee, CHF and ADHD with potential for other episodes in the future)
  - Access current and past performance reports for all payers where designated the PAP
Provider Portal

Want more details on changing Medicaid regulations? Click here.
Provider Portal

The goal of the initiative is to reward providers who deliver high-quality, coordinated and cost-effective care for certain certain medical episodes. The Provider Portal is a key component of the payment initiative approach. The portal is a HIPAA-compliant online tool that allows hospitals, physicians, mental health providers and other providers to submit a limited set of additional quality metrics data that will be tied to the initiative’s financial incentives. The portal also allows providers who are designated as PAP access to comprehensive reports of their average quality, costs, and utilization for episodes during a given time period. This is the first time that Medicaid and the state’s private insurance companies will make such detailed analytical information available to providers. To help providers navigate the reports, we have created an easy-to-understand guide that explains how to read the report using an illustrative example. For those needing assistance using the portal, here you will find step-by-step instructions.

During a three- to six-month preparatory period beginning in July, data submission of additional quality metrics beyond those captured by claims will be available through the portal. At the end of July, PAP performance reports will be posted to the portal for physician/hospital providers or available via secure messaging for non-physician providers. After the preparatory period, the payers will use some of the data entered into the portal for the ADHD, Congestive Heart Failure and Hip and knee replacement episodes to determine whether a provider is eligible to share in savings or excess costs across their episodes. No additional data will be required for Upper Respiratory Infection or Perinatal episodes. All future reports are expected to all be available online.

Physician practices, hospitals, RSPMI providers and other qualifying providers can click here: Advanced Health Information Network to access the portal using an existing Advanced Health Information Network (AHIN) username and password. If you do not have an active AHIN account and would like to register contact Customer Support (501) 378-2336 or email customersupport@ahin.net.

Arkansas Medicaid has opted to use the AHIN Provider Portal for RSPMI, psychologists and other mental health providers who are participating in the Attention Deficit/Hyper Activity Disorder episodes of care. Access is free. Beginning Oct. 1, 2012, provider portal data entry of quality metrics is required to be eligible for gain-sharing for selected episodes. If you have questions, please contact the Medicaid payment initiative customer service center at 501-301-0311 or at ARKPI@hp.com.
Provider Portal

AHIN
ADVANCED HEALTH INFORMATION NETWORK

Logon
User Id: 
Password: 
Logon

Questions
Reset/Forgot Your Password?
Learn More about AHIN?
How do I select AHIN as my clearinghouse?

Links
Arkansas Blue Cross and Blue Shield
Health Advantage
Health Advantage Customer Service
Arkansas Medicare
Arkansas Medicaid
Blue Advantage Administrators of Arkansas
Medi-Pak Advantage PFFS

Arkansas Payment Improvement Initiative
Click here to enroll for API access if not a current AHIN user
API Provider Portal Documentation
User Assignment for the API Portal

AHIN Alerts
Arkansas Blue Cross and Blue Shield is required by the Centers for Medicare & Medicaid Services (CMS) regulations to develop and maintain a compliance program and to provide annual training to all first-tier, downstream and related entities. Providers are considered first tier entities because there is a direct contract for Medicare Services between Arkansas Blue Cross and each provider. As a contractor with CMS to provide Medicare Advantage (MA) and Prescription Drug Program (PDP) plans, we are required to provide compliance and Code of Conduct training materials to you annually. This training and attestation is MANDATORY for all that provide services for Medi-Pak Advantage members. Click here to view the training materials and attestation form. If you have questions, contact the Arkansas Blue Cross Blue Shield Medicare C & D Compliance Office at 501-378-2525, or email us at medicarecdcompliance@arbluecross.com
Clinical Data Entry - CHF Episode

*Payer: [Choose One]
*Facility name:
*Provider:
*Patient first: Patient middle: *Patient last:
*Member ID: *Patient DOB: *Date of service:

Was there documentation in the hospital record of:
The results of an LVEF assessment - performed either before or during hospitalization?
LVEF assessment planned after discharge?
Medical reason for not documenting the results of an LVEF assessment or not able to perform test afterward (e.g., patient expired, patient left AMA)?

Was LVEF assessed only qualitatively? If so, what is the description?

What was the average quantitative ejection fraction value (e.g., 50%)?
Was an ACE inhibitor prescribed upon discharge OR was the patient already taking ACE inhibitor as documented in current medication list?
Was ARB therapy prescribed upon discharge OR was the patient already taking ARB therapy as documented in current medication list?
Were there medical, patient, or systematic reason(s) by physician, nurse practitioner, or physician assistant for not prescribing ACE inhibitor and ARB therapy?

Submit Episode Data ▶️ Submit Data and Add Another Episode ▶️
Clinical Data Entry - Hip Replacement Episode

*Payer: Choose One

*Facility name:

*Provider:

*Patient first: Patient middle: *Patient last:

*Member ID: *Patient DOB: *Date of service:

Did the patient develop a symptomatic post-op DVT/PE during the inpatient stay?  ○ Yes  ○ No

Was post-op DVT/PE prophylaxis (pharmacologic or mechanical compression) prescribed during the inpatient stay?  ○ Yes  ○ No

If yes, what type of prophylaxis was prescribed?

If no, why was prophylaxis not prescribed (please explain)?

Submit Episode Data  Submit Data and Add Another Episode
Clinical Data Entry - Knee Replacement Episode

*Payer:  
Choose One

*Facility name: 

*Provider: 

*Patient first: 

Patient middle: 

*Patient last: 

*Member ID: 

*Patient DOB: 

*Date of service: 

Did the patient develop a symptomatic post-op DVT/PE during the inpatient stay?  

- Yes  
- No

Was post-op DVT/PE prophylaxis (pharmacologic or mechanical compression) prescribed during the inpatient stay?  

- Yes  
- No

If yes, what type of prophylaxis was prescribed?  

Choose One

If no, why was prophylaxis not prescribed (please explain)?  

Submit Episode Data  
Submit Data and Add Another Episode
Questions
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

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

- **QualChoice**: 1-501-228-7111, providerrelations@qualchoice.com