Tennessee
Health Care Innovation Initiative

Provider Stakeholder Group Meeting

January 28, 2015

Agenda

Updates on the episode of care model

Wave 2 episode of care definitions

Improving provider communication on the episode of care model

State Innovation Model Testing Grant

Payment reform and Insure Tennessee

Updates on the Tennessee Health Care Innovation Initiative

- ***TennCare wave 1 episode of care performance period***
  - The performance period for wave 1 episodes, including total joint replacement, acute asthma exacerbation, and perinatal, began on January 1, 2015. The performance period will last 12 months.
  - Throughout the performance period, providers will continue to receive quarterly reports. Final episode risk and gain-sharing are expected to be paid in August 2016.

- ***Commercial participation in episode of care model***
  - The first performance period for episodes of care for most commercial payers will begin in January 2016. This will allow provider additional time to understand the model and evaluate their cost and quality outcomes. A staggered start for commercial insurance was a key request from some provider stakeholders.
  - BCBST began issuing preview reports for their commercial in May 2014, and will continue to send quarterly reports throughout 2015.
  - For 2015, Cigna will implement a voluntary episode of care program to a select group of providers across the state.

Updates on the Tennessee Health Care Innovation Initiative

- ***Wave 3 Technical Advisory Group (TAG)nominations***
  - Our wave 3 TAGs are scheduled to begin on March 18th. The state is requesting nominees to participate in three TAGs including, upper gastrointestinal endoscopy and gastrointestinal hemorrhage, upper respiratory infection and simple pneumonia, and office and hospital-based urinary tract infection.
  - The deadline to submit nominees to participate in the wave 3 TAG is this **Friday, January 30th.** The wave 3 TAGs will meet on the following days:

TAG topic	TAG member specialties	Proposed TAG schedule
Upper gastrointestinal endoscopy and Gastrointestinal hemorrhage	Gastroenterologists, hospitalists, and pediatric gastroenterologists	▪ Tuesday, March 31st (9AM-12PM CST) ▪ Wednesday, April 22nd (9AM-12PM CST) ▪ Tuesday, May 5th (9AM-12PM CST)
Upper respiratory infection and Simple pneumonia	PCPs, hospitalists, pulmonologists, and pediatricians	▪ Wednesday, March 18th (9AM-12PM CST) ▪ Wednesday, April 8th (9AM-12PM CST) ▪ Wednesday, April 29th (9AM-12PM CST)
Office-based urinary tract infection and Hospital-based urinary tract infection	PCPs, hospitalists, urologists, and pediatricians	▪ Wednesday, March 25th (9AM-12PM CST) ▪ Wednesday, April 15th (9AM-12PM CST) ▪ Tuesday, May 5th (1PM-4PM CST)

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Colonoscopy definition

Component	Revised episode base definition
1 Identifying episodes (trigger)	▪ A professional claim with a specific procedure code for colonoscopy and a specific diagnosis code for screening triggers the screening colonoscopy episode
2 Selecting Quarterbacks	▪ The physician who performs the colonoscopy is the Quarterback
3 Including services	▪ Only the cost of services and medications related to the episode are included in the calculation of episode spend ▪ **Colonoscopy and other specific scope procedures** (only during and after procedure) ▪ **Specific sedation procedures** (only during and after procedure) ▪ **Care related to specific complications** (only during and after procedure) ▪ **Specific lab tests** ▪ **Office visits to the Quarterback** ▪ **Specific medications e.g. bowel prep**
4 Setting duration	▪ The episode begins 30 days before procedure (or admission if inpatient) and ends 14 days after procedure (or discharge if inpatient). The episode timeframe is divided into three windows: ▪ Pre-trigger: The 30 days prior to procedure (or admission if inpatient) ▪ Trigger: Length of stay in facility for procedure ▪ Post-trigger: The 14 days after the triggering procedure stay

SOURCE: Clinical experts, team analysis

Colonoscopy definition

Component	Revised episode base definition
5 **Excluding episodes and risk adjustment**	Episodes affected by comorbidities that make them inherently more costly than others are **risk adjusted**. Episodes which are not comparable and cannot be risk-adjusted are excluded. There are three types of exclusions: ▪ **Business exclusions:** Episodes are excluded if the available information is not comparable or is incomplete (e.g. 3rd party liability, dual-eligibility) ▪ **Clinical exclusions:** Episodes are excluded if the patient's care pathway is different for clinical reasons or the patient's medical risk cannot be properly risk adjusted for due to low volume and high variability ▪ **High-cost outlier exclusions:** Episodes are excluded if they have abnormally high risk-adjusted episode spend (3 standard deviations above the mean)
6 **Quality metrics**	For screening colonoscopy ▪ Tied to gain sharing: — Percent of valid episodes performed in a facility participating in a QCDR (GIQuIC) ▪ For reporting only: — Performation rate — Post-polypectomy bleed rate — Prior colonoscopy (within 1 year) — Repeat colonoscopy (within 60 days) rate

SOURCE: Clinical experts, team analysis

Acute and non-acute PCI definitions

Component	Revised episode base definition
1 **Identifying episodes (trigger)**	▪ **A PCI episode is triggered by:** — A professional claim that has one of the defined procedure codes for PCI, AND — A facility claim that has a diagnosis code relevant to PCI, e.g. myocardial infarction, angina pectoris ▪ Acute and non-acute PCI episodes are distinguished from each other based on two **acute indicators** A **A PCI episode is acute if** there is one of two acute indicators present: 1. The facility claim has an **acute ischemic heart disease diagnosis code**, OR 2. The patient presents in the **emergency department** N **A PCI episode is non-acute if** there is no acute indicator
2 **Selecting Quarterbacks**	A For an **acute PCI episode**, the Quarterback of the episode is the **facility** where the procedure is performed N For a **non-acute PCI episode**, the Quarterback of the episode is the **cardiologist** who performed the procedure
3 **Including services**	▪ **Specific PCI procedures** (only included during and after procedure) ▪ **Care related to specific complications** (only included during and after procedure) ▪ **Specific diagnostics, pathology, and labs** ▪ **Office visits to the Quarterback** ▪ **Specific medications**

Acute and non-acute PCI definitions

Component	Revised episode base definition
4 Setting duration	A For **acute episodes**, the episode begins on the day of the procedure (or admission if inpatient) and ends 30 days after the procedure (or discharge if inpatient) N For **non-acute episodes**, the episode begins the lesser of 90 days prior to the procedure (or admission if inpatient) and the first visit to the Quarterback and ends 30 days after the procedure (or discharge if inpatient) ▪ The episode timeframe is divided into three windows: — Pre-trigger (non-acute episodes only): The lesser of 90 days prior to the procedure (or admission if inpatient) and the first visit to the Quarterback within those 90 days — Trigger: Length of stay in facility for the procedure — Post-trigger: 30 days after the procedure stay
5 Excluding episodes and risk adjustment	Episodes affected by comorbidities that make them inherently more costly than others are risk-adjusted. Episodes which are not comparable e.g. the available information is incomplete or the patient has a different care pathway due to a comorbidity are excluded. There are three types of exclusions: ▪ **Business exclusions:** 3rd party liability, dual-eligibility, non-continuous eligibility, incomplete episode, left against medical advice, out of network Quarterbacks ▪ **Clinical exclusions:** The patient's care pathway is different for clinical reasons or the patient's medical risk cannot be properly risk adjusted for ▪ **High-cost outliers:** Episodes with abnormally high risk-adjusted episode spend (3 standard deviations above the risk-adjusted mean)
6 Quality metrics	▪ **Tied to gain-sharing** — Hospitalization rate in the post trigger window, except for staged/multi-vessel PCI ▪ **For reporting only** — Percent of multiple-vessel PCIs — Percent of episodes with a repeat PCI in the post trigger window

Cholecystectomy definition

Component	Revised episode base definition
1 Identifying episodes (trigger)	▪ **A cholecystectomy episode is triggered by:** — A professional claim that has one of the defined procedure codes for cholecystectomy, AND — A facility claim that has a either one of the defined procedure codes for cholecystectomy OR a diagnosis code relevant to cholecystectomy, e.g. acute cholecystitis, abdominal pain ▪ Outpatient and non-acute inpatient cholecystectomy procedures, and acute inpatient cholecystectomy procedures, are distinguished from each other based on two factors A **A cholecystectomy procedure is acute inpatient** if there are two conditions indicators present: ▫ The facility claim has an **acute cholecystitis diagnosis code** N **A cholecystectomy procedure is outpatient and non-acute inpatient** if the above condition is not met
2 Selecting Quarterbacks	A For an **acute cholecystectomy episode**, the Quarterback of the episode is the **facility** where the procedure is performed N For an **outpatient and non-acute inpatient episode**, the Quarterback of the episode is the **surgeon** who performed the procedure
3 Including services	N **Before procedure stay** — Specific diagnostic imaging, ultrasound, and nuclear procedures — Specific labs and pathology — Office visits to the Quarterback — Gastroenterology tests — Specific medications A **During procedure stay** — All professional and facility services performed during the stay — Specific medications N **After procedure stay** — Repeat cholecystectomy procedures — Specific surgical procedures on the digestive system — Specific anesthesia — Specific diagnostic imaging, ultrasound, and nuclear procedures — Specific labs and pathology — Office visits to the Quarterback — Care related to specific complications — Specific medications

Cholecystectomy definition

Component	Revised episode base definition
4 Setting duration	A For acute inpatient episodes, the episode begins the day of the procedure (or admission if inpatient) and the first visit to the Quarterback and ends 30 days after the procedure (or discharge if inpatient) N For outpatient and non-acute inpatient episodes, the episode begins the lesser of 90 days prior to the procedure (or admission if inpatient) and the first visit to the Quarterback and ends 30 days after the procedure (or discharge if inpatient) ▪ The episode timeframe is divided into three windows: — Pre-trigger (non-acute episodes only): The lesser of 90 days prior to the procedure (or admission if inpatient) and the first visit to the Quarterback within those 90 days — Trigger: Length of stay in facility for the procedure — Post-trigger: 30 days after the procedure stay
5 Excluding episodes and risk adjustment	Episodes affected by comorbidities that make them inherently more costly than others are risk-adjusted. Episodes which are not comparable e.g. the available information is incomplete or the patient has a different care pathway due to a comorbidity are excluded. There are three types of exclusions: ▪ **Business exclusions:** 3rd party liability, dual-eligibility, non-continuous eligibility, incomplete episode, left against medical advice, out of network Quarterbacks ▪ **Clinical exclusions:** The patient's care pathway is different for clinical reasons or the patient's medical risk cannot be properly risk adjusted for ▪ **High-cost outliers:** Episodes with abnormally high risk-adjusted episode spend (3 standard deviations above the risk-adjusted mean)
6 Quality metrics	▪ **Tied to gain-sharing** — 30-day readmission rate (as a proxy for complications) ▪ **For reporting only** — Interoperative cholagiography rate — ERCP within 3-30 days after procedure rate — Average length of stay (trigger window)

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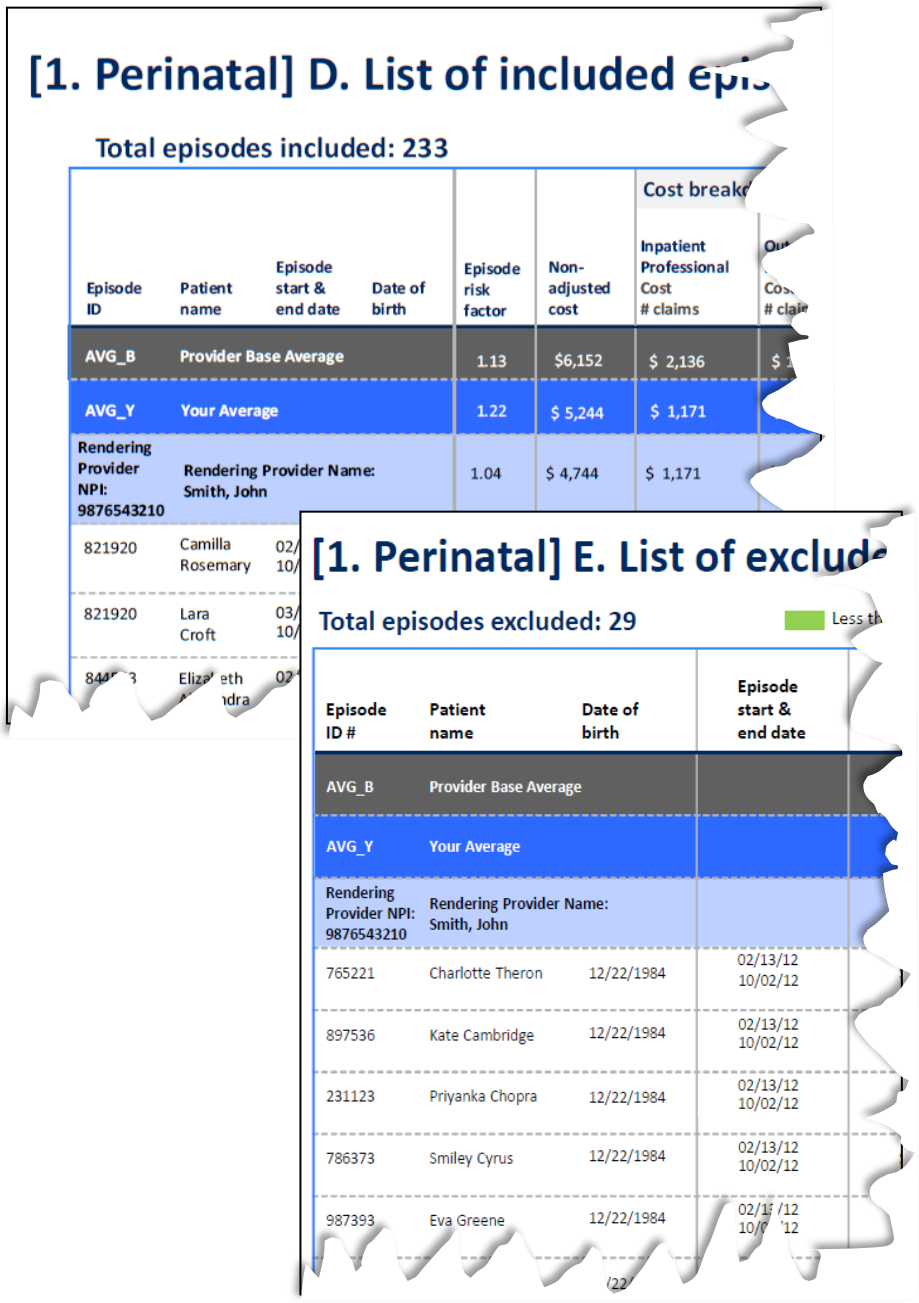
Enhanced reporting to providers

- Based on feedback from providers, the state will implement the following report changes:
  - Add patient date of birth
  - Add provider generated patient ID
  - Identify rending provider

- Theses changes would appear on included and excluded episode lists (PDF and excel files) beginning with the May 2015 reports. As sample report is included in the appendix.

- The state continues to look for ways to improve the episode of care reporting, and we encourage providers to continue to submit recommendations for future updates.



[1. Perinatal] D. List of included epi

Total episodes included: 233

Episode ID	Patient name	Episode start & end date	Date of birth	Episode risk factor	Non-adjusted cost	Cost breake... Inpatient Professional Cost # claims	Ou... Co... # clai...
AVG_B	Provider Base Average			1.13	$6,152	$ 2,136	$
AVG_Y	Your Average			1.22	$ 5,244	$ 1,171	
Rendering Provider NPI: 9876543210	Rendering Provider Name: Smith, John			1.04	$ 4,744	$ 1,171	
821920	Camilla Rosemary	02/ 10/					
821920	Lara Croft	03/ 10/					
844...	Eliza... eth ...dra	02/					

[1. Perinatal] E. List of exclud

Total episodes excluded: 29 Less th

Episode ID #	Patient name	Date of birth	Episode start & end date
AVG_B	Provider Base Average		
AVG_Y	Your Average		
Rendering Provider NPI: 9876543210	Rendering Provider Name: Smith, John		
765221	Charlotte Theron	12/22/1984	02/13/12 10/02/12
897536	Kate Cambridge	12/22/1984	02/13/12 10/02/12
231123	Priyanka Chopra	12/22/1984	02/13/12 10/02/12
786373	Smiley Cyrus	12/22/1984	02/13/12 10/02/12
987393	Eva Greene	12/22/1984	02/1... /12 10/... '12
		/22	

Episode of care outreach strategy

- The state is committed to improving the outreach strategy for future waves of episodes. In wave 1, the state and the MCOs contacted PAPs through:

Type of communication	Examples
Written communication	▪ Notifying stakeholders and providers of release of reports ▪ Providing written descriptions of episode definitions and episode of care program ▪ Updating providers on episodes in monthly provider newsletters
Online and in-person trainings	▪ Leading instructional webinars on the episode model and how to access reports ▪ Presenting to provider groups on episode model (e.g. TMA Provider workshops, one-on-one sessions)
Telephonic outreach	▪ Calling providers to confirm how they would like to receive reports ▪ Following up with providers who fail to access reports within 30 days

- Going forward, if you encounter providers who are unfamiliar with the episode of care model, you can refer that provider to the state or the MCOs. The contact information for all groups is below.
  - HCFA: Payment.reform@tn.gov
  - Amerigroup: 615-232-2160
  - BlueCare: 800-924-7141 (Option 4)
  - UnitedHealthcare: 615-372-3509

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State Innovation Model Testing Grant

- On December 16th, the state was awarded a $65M SIM testing grant. The grant period will last from February 2015 – January 2019. The grant supports:

  - *Primary Care transformation:*
    - TNAAP practice transformation and quality improvement training Pediatric PCMH
    - Consultant for multi-payer PCMH and SPMI Health Homes
    - Consultant for multi-payer PCMH and SPMI Health Homes practice transformation
    - HIT capabilities for SPMI Health Homes
  - *Episodes of care:*
    - McKinsey episode of care design and implementation
    - Supportive efforts from TMA and THA
  - *Long-term services and supports:*
    - Consultant for design and implementation of quality and acuity payment model
    - Consultant for LTSS provider training
  - *Provider portal:*
    - Cost and quality provider interface applications
  - *Evaluation:*
    - External evaluation consultant
  - *Population health:*
    - TN Department of Health lead project to develop a plan to improve population health in Tennessee

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Tennessee Health Care Innovation Initiative and Insure Tennessee

Tennessee Health Care Innovation Initiative and Insure Tennessee

- When Tennessee Health Care Innovation Initiative launched in March 2013, Governor Haslam stated that in order to consider expanding Medicaid coverage the underlying health care delivery system must be reformed. He noted that payment reform was a prerequisite for future coverage expansion, and would move forward even without future expansion.
- In December, with the announcement of Insure Tennessee, the governor further stated that payment reform is a prerequisite of Insure Tennessee.
  - *"The governor's delivery system reform initiative lays the foundation for reform by addressing the underlying quality and outcome deficiencies that contribute to growing health care costs and unaffordable insurance coverage. This initiative creates financial incentives for providers to provide high quality care in an efficient and appropriate manner so as to reduce costs and improve health outcomes."*

Appendix

Included:

- Sample episode of care report

State of Tennessee Health Care Innovation Initiative

Illustrative Provider Report

[Report Date]

[Report Period: Start/end dates of period]

Payer Name (TennCare/Commercial)

Provider Name

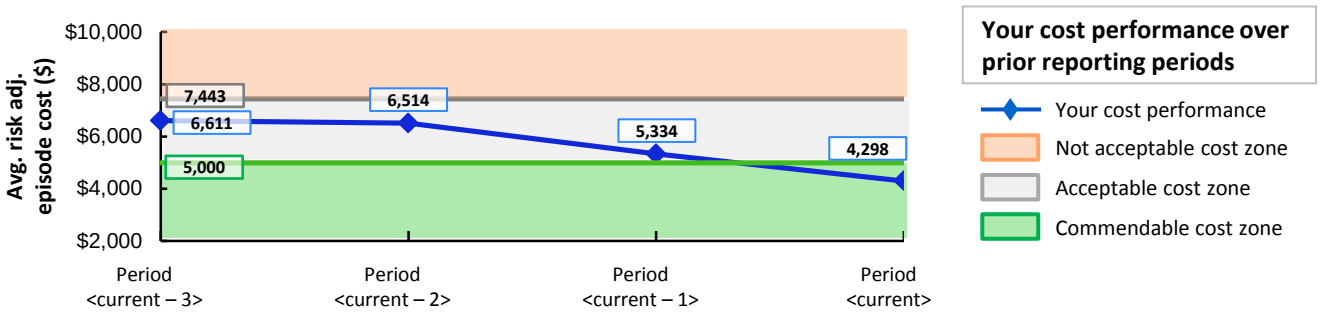
Provider Code

Preliminary draft of the provider report template for State of TN (for discussion only)
All content/ numbers included in this report are purely illustrative

[1. Perinatal] Overall Performance Summary

Payer Name (TennCare/Commercial) | Provider Name | Provider Code

Episode of care	Quality metrics	Average risk adj. episode cost ($)		Gain/risk share eligibility	Share Value ($)
1. Perinatal [Start/end dates of period]	Met	4,298	Commendable	Gain Sharing	**$81,783**



Description of gain / risk sharing	You	Description
1. Total cost across episodes	$1,221,749	Total of all associated claims submitted and paid during this cycle
2. Total # of included episodes	233	Net of episodes excluded for clinical or operational considerations
3. Avg. episode cost (non adj.)	$5,244	Raw claims average ; Equals line (1) divided by line (2)
4. Risk adjustment factor* (avg.)	1.22	Average adjustment to raw claims to account for clinical variability
5. Avg. episode cost (risk adj.)	$4,298 Commendable	Adjusted cost per episode; Equals line (3) divided by line (4)
6. Versus: commendable cost	$5,000	Commendable threshold
7. Total upside generated	$163,566	Total difference in adjusted cost vs. commendable cost; Equals difference between line (5) and line (6) multiplied by total included episodes i.e. line (2)
8. Risk sharing factor	50%	Portion of total upside to be shared with you
9. Total gain / risk share	**$81,783**	**Net proceeds to you above claims already paid**

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[1. Perinatal] A. Episode Summary

1 Overview

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

2 Cost of care (avg. adj. episode cost) comparison

Commendable	Acceptable	Not acceptable
Less than $5,000	$5,000 to $7,443	More than $7,443

◆ Your avg. cost: **$4,298** ★ Providers' base avg. cost: **$5,444**

YOUR GAIN/ RISK SHARE

You are eligible for gain sharing

+ $81,783

Commendable cost ($)	–	Your avg. cost ($)	x	Number of episodes	x	Share factor
5,000		4,298		233		50%

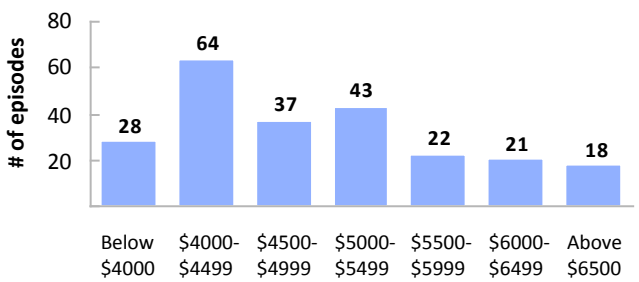
3 Episode cost summary

Your average episode cost is commendable

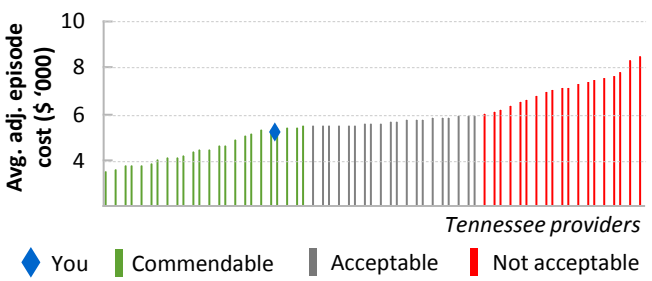
Parameters	You	Provider base average
1. Total cost across episodes	$1,221,749	$1,445,654
2. Total # of included episodes	233	235
3. Avg. episode cost (non adj.)	$5,244	$6,152
4. Risk adjustment factor* (avg.)	1.22	1.13
5. Avg. episode cost (risk adj.)	$4,298 Commendable	$5,444 Acceptable

** Risk adjustment factor calculated for select provider's patient base*

Your episode cost distribution (risk adj.)



Distribution of provider average episode cost (risk adj.)



4 Episode quality and utilization summary

You achieved selected quality metrics

Quality metrics linked to gain sharing	You	Gain share standard	Met standard
1. HIV screening	97%	85%	✓
2. Group B Strep screening	90%	85%	✓
3. C-section rate	20%	41%	✓

Quality metrics not linked to gain sharing	You	Provider base average
1. Gestational DM screening	56%	50%
2. Bacteriuria screening	90%	62%
3. Hepatitis B screening	58%	55%
4. Tdap vaccination rate	90%	62%

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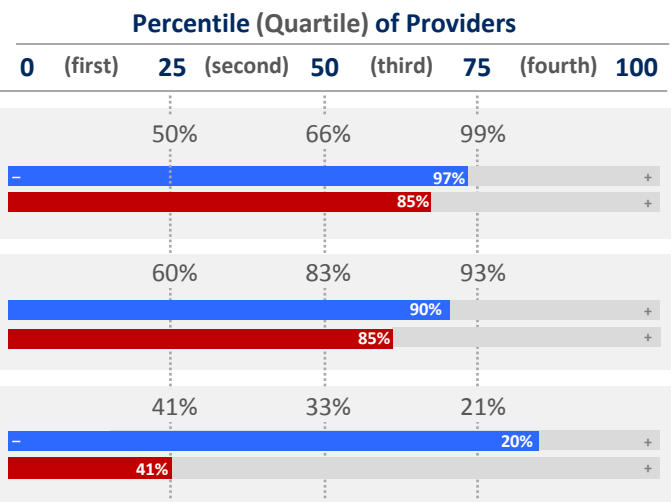
[1. Perinatal] B. Episode quality and utilization details

5 Quality and utilization (metrics) comparison with provider base

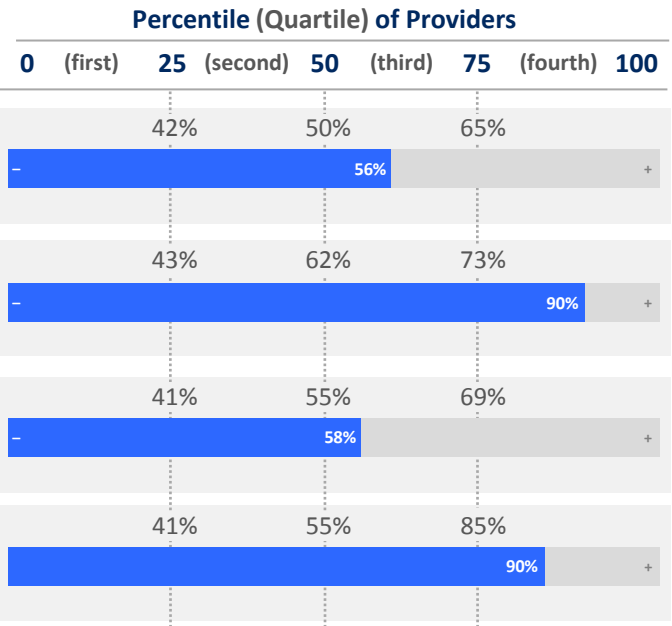
Your performance | Minimum standard for gain sharing

You achieved selected quality metrics linked to gain sharing

Quality metrics linked to gain sharing



Quality metrics not linked to gain sharing



[1. Perinatal] C. Episode cost details

6 Episode cost breakdown by care category (risk adj.)

Total episodes included: 233

Your performance | Provider base average

Care category	# of episodes with claims in care category	% of episodes with claims in care category	Avg. adj. cost per episode when care category utilized (Percentile (Quartile) of Providers: 0 (first) 25 (second) 50 (third) 75 (fourth) 100)
Outpatient Professional	195	84% 82%	< $100 < $125 < $150 $120 $120
Pharmacy	11	5% 5%	< $25 < $45 < $65 $50 $50
Emergency department or observation	90	39% 30%	< $200 < $230 < $260 $235 $230
Outpatient lab	220	96% 84%	< $145 < $195 < $245 $190 $200
Outpatient radiology/ procedures	215	94% 88%	< $275 < $325 < $375 $320 $330
Inpatient professional	220	96% 91%	< $950 < $1,000 < $1,200 $960 $1,000
Inpatient facility	233	100% 99%	< $1,200 < $1,300 < $1,650 $1,255 $1,315
Outpatient facility	0	0% 0%	$0 $0 $0 0% 0%
Other	210	90% 88%	< $165 < $190 < $210 $170 $180

[1. Perinatal] D. List of included episodes with cost and quality information

Total episodes included: 233

Less than provider base average cost | More than provider base average cost

Episode ID	Patient name	Episode start & end date	Date of birth	Episode risk factor	Non-adjusted cost	Cost breakdown by care category (non-risk adj.)								
						Inpatient Professional Cost # claims	Outpatient Professional Cost # claims	Pharmacy Cost # claims	Emergency Department or observation Cost # claims	Outpatient Lab Cost # claims	Outpatient Radiology Cost # claims	Inpatient Facility Cost # claims	Outpatient Facility Cost # claims	Other Cost # claims
AVG_B	Provider Base Average			1.13	$6,152	$ 2,136	$ 136	$ 57	$ 761	$ 727	$ 375	$ 1,494	$ 0	$ 4
AVG_Y	Your Average			1.22	$ 5,244	$ 1,171	$ 146	$ 61	$ 287	$ 232	$ 390	$ 1,030	$ 0	$ 207
Rendering Provider NPI: 9876543210	Rendering Provider Name: Smith, John			1.04	$ 4,744	$ 1,171	$ 146	$ 61	$ 287	$ 232	$ 390	$ 530	$ 0	$ 207
821920	Camilla Rosemary	02/13/12 10/02/12	07/13/83	1.03	$ 3,921	$ 1,196 # 14	$ 137 # 2	$ 0 # 0	$ 247 # 1	$ 259 # 19	$ 419 # 7	$ 1,479 # 13	$ 0 # 0	$ 185 # 4
821920	Lara Croft	03/07/12 10/02/12	07/13/83	1.00	$ 4,105	$ 1,375 # 12	$ 161 # 2	$ 0 # 0	$ 279 # 1	$ 272 # 17	$ 371 # 8	$ 1,399 # 11	$ 0 # 0	$ 248 # 4
844563	Elizabeth Alexandra	02/21/12 10/11/12	07/13/83	1.01	$ 3,605	$ 1,035 # 15	$ 125 # 2	$ 0 # 0	$ 0 # 0	$ 182 # 13	$ 205 # 5	$ 1,592 # 14	$ 0 # 0	$ 466 # 3
124445	Julia Robertz	02/14/12 10/03/12	07/13/83	0.98	$ 3,700	$ 943 # 13	$ 114 # 2	$ 0 # 0	$ 0 # 0	$ 373 # 18	$ 187 # 4	$ 1,658 # 16	$ 0 # 0	$ 425 # 4
100235	Catherine Middleton	02/15/12 11/04/12	07/13/83	1.01	$ 3,921	$ 1,196 # 14	$ 137 # 2	$ 0 # 0	$ 247 # 1	$ 259 # 19	$ 419 # 7	$ 1,479 # 13	$ 0 # 0	$ 185 # 4
832011	Saylor Swift	03/19/12 11/10/12	07/13/83	1.01	$ 4,105	$ 1,375 # 12	$ 161 # 2	$ 0 # 0	$ 279 # 1	$ 272 # 17	$ 371 # 8	$ 1,399 # 11	$ 0 # 0	$ 248 # 4
Rendering Provider NPI: 0123456789	Rendering Provider Name: Smith, Jane			1.45	$ 6,244	$ 1,671	$ 146	$ 61	$ 287	$ 232	$ 390	$ 1,530	$ 0	$ 207
115320	Kate Beckett	03/24/12 11/13/12	07/13/83	1.00	$ 3,700	$ 943 # 13	$ 114 # 2	$ 0 # 0	$ 0 # 0	$ 373 # 18	$ 187 # 4	$ 1,658 # 16	$ 0 # 0	$ 425 # 4
112447	Phillie Ivey	04/04/12 12/19/12	07/13/83	1.03	$ 3,921	$ 1,196 # 14	$ 137 # 2	$ 0 # 0	$ 247 # 1	$ 259 # 19	$ 419 # 7	$ 1,479 # 13	$ 0 # 0	$ 185 # 4
450021	Monica Gellar	04/14/12 01/03/13	07/13/83	1.01	$ 4,105	$ 1,375 # 12	$ 161 # 2	$ 0 # 0	$ 279 # 1	$ 272 # 17	$ 371 # 8	$ 1,399 # 11	$ 0 # 0	$ 248 # 4

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Sample representation wherein each episode is risk-adjusted individually; actual risk adjustment methodology for TN not decided and as such not represented here

[1. Perinatal] E. List of excluded episodes

Total episodes excluded: 29

Less than provider base average cost More than provider base average cost

Episode ID #	Patient name	Date of birth	Episode start & end date	Non-adjusted cost	Reason for exclusion
AVG_B	Provider Base Average			$ 6,152	
AVG_Y	Your Average			$ 5,244	
Rendering Provider NPI: 9876543210	**Rendering Provider Name: Smith, John**				
765221	Charlotte Theron	12/22/1984	02/13/12 10/02/12	$ 4,207	Risk factor/ co-morbidity reference found
897536	Kate Cambridge	12/22/1984	02/13/12 10/02/12	$ 5,905	Risk factor/ co-morbidity reference found
231123	Priyanka Chopra	12/22/1984	02/13/12 10/02/12	$ 3,715	Patient has a discharge status of “left against medical advice”
786373	Smiley Cyrus	12/22/1984	02/13/12 10/02/12	$ 4,207	Patient was not continuously enrolled during episode window
987393	Eva Greene	12/22/1984	02/13/12 10/02/12	$ 5,905	Patient has a discharge status of “left against medical advice”
387726	Giselle Berry	12/22/1984	02/13/12 10/02/12	$ 3,715	Patient was not continuously enrolled during episode window
138890	Megan Alba	12/22/1984	02/13/12 10/02/12	$ 4,207	Patient died in the hospital during the episode
987234	Marilyn Aniston	12/22/1984	02/13/12 10/02/12	$ 5,905	Risk factor/ co-morbidity reference found
234564	Baby Ruth	12/22/1984	02/13/12 10/02/12	$ 3,715	Patient has dual coverage of primary medical services
Rendering Provider NPI: 0123456789	**Rendering Provider Name: Smith, Jane**				
542132	Eva Greendale	12/22/1984	02/13/12 10/02/12	$ 5,905	Risk factor/ co-morbidity reference found
432233	Scarlet Hayek	12/22/1984	02/13/12 10/02/12	$ 3,715	Patient has dual coverage of primary medical services
542234	Salma Johansson	12/22/1984	02/13/12 10/02/12	$ 4,207	Patient has a discharge status of “left against medical advice”
554312	Jennifer Longoria	12/22/1984	02/13/12 10/02/12	$ 5,905	Risk factor/ co-morbidity reference found
231234	Eva Lopez	12/22/1984	02/13/12 10/02/12	$ 3,715	Patient was not continuously enrolled during episode window
546321	Kayden Monroe	12/22/1984	02/13/12 10/02/12	$ 4,207	Risk factor/ co-morbidity reference found
332234	Julia Cross	12/22/1984	02/13/12 10/02/12	$ 5,905	Risk factor/ co-morbidity reference found
212223	Ain Styles	12/22/1984	02/13/12 10/02/12	$ 5,905	Risk factor/ co-morbidity reference found