Office of the Patient Advocate (OPA)
California Health Care Quality Medical Group - Commercial Report Card, 2016-17 Edition[1]

Scoring Documentation for Public Reporting of *Average Annual Payment for Care*
(Total Cost of Care) Methodology Summary
Measurement Year 2015

Background

Representing the interests of health plan and medical group members, the California Office of the Patient Advocate (OPA) publicly reports on health care quality. OPA published its first HMO Health Care Quality Report Card in 2001 and has since annually updated, enhanced and expanded the Report Cards on HMOs, PPOs and commercial Medical Groups. The current version (2016-17 Edition) of the online Health Care Quality Report Cards is available at: www.opa.ca.gov and via mobile apps.

Performance results are reported for 205 California physician organizations (hereinafter referred to as medical groups) that participate in the Integrated Healthcare Association (IHA) Pay for Performance (P4P) program (see details on this initiative at: http://www.iha.org/our-work/accountability/value-based-p4p). IHA is a statewide, multi-stakeholder leadership group that promotes quality improvement, accountability and affordability of health care.

Sources of Data for California Health Care Quality Report Cards

The 2016-17 Edition of the HMO, PPO, and Medical Group - Commercial Report Cards is published with clinical care and patient experience ratings data for performance in Measurement Year (MY) 2015:

1. The National Committee for Quality Assurance's (NCQA) publicly reported HMO and PPO Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) commercial measure data (HEDIS and CAHPS Methodology Descriptions in separate documents).
2. The Integrated Healthcare Association (IHA) Pay for Performance (P4P) program's commercial medical group clinical performance data (Methodology Description in a separate document).
3. **The Integrated Healthcare Association (IHA) Pay for Performance (P4P) program's commercial medical group total cost of care data, called *Average Annual Payment for Care*.**
4. The California Healthcare Performance Information System, Inc. (CHPI) Patient Assessment Survey's (PAS) commercial patient experience data for medical groups (Methodology Description in a separate document).

Medical Group Total Cost of Care Methodology Development Process:
Average Annual Payment for Care

[1] Also see the Scoring Methodology for the Medical Group Report Card clinical quality and patient experience ratings: http://reportcard.opa.ca.gov/rc/medicalgroupabout.aspx

1. **Methodology Decision Making Process**
   OPA conducts a multi-stakeholder process to determine the scoring methodology. Beginning with the 2013 Edition of the Report Cards, OPA enhanced its partnership with IHA's Pay for Performance Program. IHA's Technical Measurement Committee (TMC) now serves as the primary advisory body to OPA regarding methodologies for the HMO and PPO Report Cards for both HEDIS clinical and CAHPS patient experience data and the Medical Group Report Cards for commercial and Medicare Advantage clinical care data and total cost of care data. Comprised of representatives from health plans, medical groups, and health care purchaser organizations, TMC members are well-versed in issues of health care quality and patient experience measurement, data collection and public reporting. OPA's Health Care Quality Report Cards are a standing item at the TMC meetings.

   TMC Roster (2016)
   Chair: Mike Weiss, DO: *CHOC Health Alliance*
   Marnie Baker, MD: *MemorialCare Medical Group*
   Christine Castano, MD: *Healthcare Partners*
   Cheryl Damberg, PhD: *RAND*
   Ellen Fagan: *Cigna Healthcare of California*
   John Ford, MD: *Family Practice Physician*
   Peggy Haines: *Health Net*
   Marcus Lee: *Blue Shield of California*
   Chris Jioras: *Humboldt-Del Norte IPA*
   Ranyan Lu, PhD: *UnitedHealthcare*
   Leticia Schumann: *Anthem Blue Cross*
   Kristy Thornton: *Pacific Business Group on Health*
   Ralph Vogel, PhD: *SoCal Permanente Medical Group*

   Please note that the methodology and display decisions made by OPA do not necessarily reflect the views of each organization on the advisory committee.

   The Medical Group total cost of care, Average Annual Payment for Care methodology is based on the methodology developed by IHA staff in conjunction with feedback from the TMC.

   OPA also consults with Dr. Patrick Romano, who is a national expert in health care quality and public reporting, and a practicing physician and professor at the University of California, Davis Medical School.

   Additionally, OPA values the opinions and perspectives of other stakeholders with interest and expertise in the field of healthcare quality measurement, data collection and display, and consumer issues and, as such, began conducting regular annual Stakeholder Briefings in 2014. These briefings include industry representatives, professional associations, state agencies, purchasers, regulators, legislative staff and consumer advocacy organizations.

2. **Stakeholder Preview and Corrections Period**
   Each year, prior to the public release of the OPA Report Cards, all participating health plans and medical groups are invited to preview the Health Care Quality Report Cards. Health plans and medical groups are given access to a test web site with updated results and given several days to review their data and submit corrections and questions regarding the data and methodology to

OPA and its contractors. If an error in the data is discovered, it is corrected prior to the public release of the OPA Report Cards.

Medical Group Total Cost of Care Scoring Methodology: *Average Annual Payment for Care*

Measure Development

The Total Cost of Care (TCC) measure was developed between 2007 and 2010 by IHA through its Pay for Performance (P4P) committee structure, which included health plans, medical groups, health care purchasers, and technical experts. The IHA Total Cost of Care measure was tested for validity and reliability in 2010 and 2011 using three years of data from five health plans, and was vetted through the IHA P4P governing committee structure. Following this development and vetting, Total Cost of Care was officially added to the P4P measure set for Measurement Year 2011 and has been reported internally to medical groups and health plans since that time. In 2014, Total Cost of Care was used for the first time for value-based incentive payments and for public recognition awards (IHA Excellence in Healthcare Awards), and in early 2016, Total Cost of Care was publicly reported for the first time as the Medical Group Report Card rating: *Average Annual Payment for Care*.

The IHA Total Cost of Care measure and methodology is very similar to the total cost of care measure developed by HealthPartners in Minnesota, which was endorsed by the National Quality Forum in 2012, and is being used by several regional health improvement collaboratives across the country. Through the Network for Regional Healthcare Improvement and Center for Healthcare Transparency, IHA is part of a national effort to develop and report reliable and meaningful total cost of care performance along with quality to help drive value in healthcare.

Performance Grading

1. **Data Collection**
   IHA, through a contracted data aggregator, Truven Health Analytics, collected cost data for over nine million Commercial HMO/POS patients from eight California health plans: Anthem, Blue Shield of California, Cigna, Health Net, Kaiser Permanente, Sharp Health Plan, UnitedHealthcare, and Western Health Advantage. These plans represent approximately 94% of the Commercial HMO/POS population in California, which provides a strong foundation to measure and report on the cost of care. The cost data are used to calculate ***Average Annual Payment for Care*** results, which represents $39 billion in total care costs paid by both patients and their health insurance plans for care received during 2015.

2. **Measure Description**
   The ***Average Annual Payment for Care*** measure assesses actual payments associated with care provided to commercial HMO/POS members of any age who belong to a medical group for one day or more during the measurement year. Participating health plans annually report to IHA’s contracted data aggregator a single lump sum payment for each qualifying member for all contracted medical groups; the lump sum includes both capitation and fee-for-service payments, as well as member cost sharing, paid through the members plan benefit to the medical group or any providers caring for its members (e.g., hospitals, pharmacies, ancillary providers).

The lump sum costs include the cost of claims with dates of service during the measurement year (i.e., the previous calendar year) and dates of payment through March 31 of the following year. The following services and payments are excluded from the lump sum cost amount:

- Mental health
- Chemical dependency
- Dental
- Vision
- Acupuncture
- Chiropractic
- P4P quality incentive payments

If any of the above services are included in a medical group's capitation agreement, the plan uses its own actuarial method to adjust for them.

Payments made to a medical group, not directly related to the delivery of services to individuals, are included and attributed to members on a prorated basis. More details are available in the IHA P4P measure specifications (pages 172-174)..

The approach for allocating costs differs between health plans due to unique financial systems and contracts, and may include estimates based on utilization, members, and contracted fee schedules. The developed methodologies are intended to provide for the most comparable estimates possible for medical groups across health plans.

Costs above $100,000 per member are truncated (i.e., a member's costs up to $100,000 are retained).

3. **Adjustments for Fair Comparisons**

In order to facilitate fair comparisons of medical group performance, the Average Payment by Patient & Health Plan for Care measure is risk-adjusted to account for the differences in the health status of the patient population, and geography-adjusted to account for differences in wage costs.

a) Risk Adjustment: Member-level relative risk scores (RRS) are calculated using the Verisk DxCG Relative Risk methodology. The RRS accounts for a member's age, gender, and health status, which are identified through diagnosis codes appearing in claims and encounter data submitted by a medical group to a health plan. The model used is concurrent in that the diagnosis codes used to identify a member's health status are from the same period as the measurement year. More details are available in the IHA P4P measure specifications (pages 172-174).

Note: The methodology uses up to 7 diagnosis codes for professional services and 13 for facility services. However, the number of available diagnosis codes varies across plans and providers. If diagnosis codes are incomplete, a physician organization's Average Payment by Patient & Health Plan for Care will appear higher than expected.

b) Geography Adjustment: CMS's Hospital Wage Index Geographic Adjustment Factor is used to account for regional differences in cost.

Note: CMS' Hospital Wage Index Geographic Adjustment Factors were developed and calibrated based on Medicare data, and therefore may not always precisely reflect the geographic cost differences in the Commercial market.

4. Methodology for Public Reporting Displays

a) <u>Reliability of Results</u> – Minimum Number of Observations

In order for a medical group's performance to be considered reliable enough to be displayed in OPA public reporting, *Average Annual Payment for Care* must be based on the equivalent experience of 200 members enrolled for the full year (e.g., 200 members enrolled for 12 months each, 400 members enrolled for only 6 months each, etc.). Any medical group whose *Average Annual Payment for Care* results are based on fewer member years will be identified as "Not enough data to score reliably."

b) <u>Performance Categories</u>

Each medical group's *Average Annual Payment for Care* results are translated into a performance category. The category ranges are defined by the 10th, 50th, and 90th percentiles of medical group performance across participants for the same measurement year.

Rating the *Average Annual Payment for Care*	**Performance Category**	**Range of payment per member per year**
Highest payment (highest 10% of costs)	1-star	\$5,024 or more
Higher payment	2-star	\$4,062 - \$5,023
Lower payment	3-star	\$3,395 - \$4,061
Lowest payment (lowest 10% of costs)	4-star	\$3,394 or less

c) <u>Legends to Explain Missing Scores</u>

Two categories are used to explain instances in which a medical group is not rated for *Average Annual Payment for Care*:

- **Not Willing to Report:** Medical group declined to report its results.

- **Not Enough Data to Score Reliably**: Medical group score is not reported because there were not enough patients enrolled for reliable measurement. This label is also used when a medical group's members are highly concentrated in one plan and the reporting the result may disclose proprietary information.

Additional Notes about Interpretation and Use of the Total Cost of Care Rating: *Average Annual Payment for Care*

1. *Average Annual Payment for Care* by itself does not demonstrate value; value requires incorporating information about the quality of care delivered – such as clinical performance and patient experience. Making judgments about value on *Average Annual Payment for Care* alone assumes that the quality of care across providers is equivalent; there is substantial evidence that it is not.

2. *Average Annual Payment for Care* is intended to reflect resource stewardship from an overall perspective and does not necessarily indicate an individual consumer's cost responsibility or the medical group's internal costs. It reflects physician organization management of the amount and intensity of services its members are receiving; it is also affected by the characteristics and business practices of the hospitals available in the local geography, and other factors outside the medical group's control.

3. *Average Annual Payment for Care* is measured annually. Costs can change year-over-year, with small groups prone to larger year-over-year changes due to the greater impact of outlier member costs.

4. This *Average Annual Payment for Care* measurement only represents the members with a commercial HMO/POS plan, which may not indicate a medical group's performance on Total Cost of Care with other types of health insurance.

5. Differences in medical group's structures, policies, and practices – including, but not limited to payer mix, the extent of uncompensated care, graduate medical education, and other services that may be considered a community benefit – are not accounted for in the *Average Annual Payment for Care* methodology and may be appropriate to consider when interpreting medical groups' results.

6. The approach for allocating costs differs between health plans due to unique financial systems and contracts, and produces the most comparable physician organization estimates possible. Approaches include estimates based on utilization, members, and contracted fee schedules.

7. *Average Annual Payment for Care* is used in the IHA Excellence in Health Care Awards, which recognize exceptional physician organizations for achieving strong quality results while effectively managing costs. To earn this recognition, a physician organization must have performance that ranks in the top 50% for each of the following: clinical quality, patient experience and total cost of care.

Links to Additional Resources

- IHA Total Cost of Care Measure Specifications
- IHA Total Cost of Care Fact Sheet