Office of the Patient Advocate (OPA)
California Health Care Quality Medical Group - Commercial HMO Report Card, 2021-22 Edition[1]

Scoring Documentation for Public Reporting of *Total Cost of Care* (Reporting Year 2021)

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 to include ratings for HMO health plans, PPO health plans, commercial HMO Medical Groups, and medical groups serving Medicare Advantage members. The current version (2021-22 Edition) of the online Health Care Quality Report Cards is available at www.opa.ca.gov.

The Integrated Healthcare Association (IHA) collects performance results for more than 200 physician organizations that participate in its Align. Measure. Perform. (AMP) Commercial HMO program. IHA is a multi-stakeholder leadership group that promotes quality improvement, accountability, and affordability of health care. IHA collects quality data on the physician organizations that contract with commercial HMOs for AMP and provides the data to OPA for the Health Care Quality Report Card. The IHA physician organizations are referred to as medical groups in the Report Card and in the remainder of this document.

Sources of Data for California Health Care Quality Report Cards

The 2021-22 Edition of the Health Plan and Medical Group - Commercial Report Cards were published in Fall 2021 with clinical care and patient experience ratings data for performance in Measurement Year (MY) 2020. The *Total Cost of Care* measure and rating is added in Spring 2022, for the same Measurement Year, MY 2020.

The 2021-22 Edition of the Report Cards uses data reported in Reporting Year (RY) 2021 for performance in Measurement Year (MY) 2020. Data sources are:

1. The National Committee for Quality Assurance's (NCQA) publicly reported HMO and PPO Healthcare Effectiveness Data and Information Set (HEDIS®[2]) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®[3])

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[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

[2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). HEDIS is a source for data contained in the California Health Care Quality Report Cards obtained from Quality Compass®2021 and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass 2021 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA

[3] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)

commercial measure data. (HEDIS and CAHPS Methodology Descriptions in separate documents)

2. The Integrated Healthcare Association (IHA) AMP Commercial HMO program's medical group clinical performance data.
3. The Purchaser Business Group on Health (PBGH) Patient Assessment Survey's (PAS) patient experience data for medical groups. (Methodology Description in a separate document)
4. **The IHA AMP Commercial HMO program's medical group total cost of care data, called *Total Cost of Care*.**

Medical Group *Total Cost of Care* Methodology Process

1. Methodology Decision Making Process

OPA conducts a multi-stakeholder process to determine the scoring methodologies for each of the health care quality ratings displayed on the Report Card. Beginning with the 2013 Edition of the Report Cards, OPA enhanced its partnership with IHA's AMP programs. IHA's Technical Measurement Committee (TMC) serves as the primary advisory body to OPA regarding methodologies for the Health Plan and Medical Group Report Cards. 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. The *Total Cost of Care* ratings methodology is developed and owned by IHA with consultation from OPA.

TMC Roster (2021)

Chair: Christine Castano, MD, *Optum*
Alyson Spencer, *Blue Shield of California Promise Health Plan*
Cheryl Damberg, PhD, *RAND*
Chris Jioras, *Humboldt IPA*
Dave Schweppe, *Kaiser Foundation Health Plan*
Edward Yu, MD, *Sutter Palo Alto Medical Foundation*
Eric Garthwaite, *Health Net*
Kenneth Phenow, MD, *Cigna*
Leticia Schumann, *Anthem*
Marnie Baker, MD, MPH, *MemorialCare Medical Group*
Pegah Mehdizadeh*, DO, Aetna*
Rachel Brodie, *Pacific Business Group on Health*
Ralph Vogel, PhD, *Southern California Permanente Medical Group*
Ranyan Lu, PhD, *UnitedHealthcare*
Sherilyn Wheaton, MD, *Primary Medical*
Tory Robinson, *Blue Shield of California*
Alice Gunderson, *PFCC Partners, Patient Advisor Network*
Ting Pun, *PFCC Partners, Patient Advisor Network*

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

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, as such, welcomes questions and comments sent to OPAReportCard@ncqa.org.

2. Stakeholder Preview and Corrections Period

Each year, prior to the public release of the OPA Report Cards or with the addition of new measures, 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 identified within the given time period, it is corrected prior to the public release of the OPA Report Cards.

Medical Group *Total Cost of Care* Scoring Methodology

Measure Development

The *Total Cost of Care* measure uses measure specifications developed by HealthPartners in Minnesota. The specifications for the *Total Cost of Care* measure were endorsed by the National Quality Forum in 2012, and this measure 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, Onpoint Health Data (Onpoint), collected Commercial HMO/POS cost data from eleven California health plans: Aetna, Anthem Blue Cross, Blue Shield of California, Cigna Healthcare of California, Health Net, L.A. Care Health Plan, Kaiser Permanente, Sharp Health Plan, Sutter Health Plus, UnitedHealthcare, and Western Health Advantage. These plans represent 96% 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 *Total Cost of Care* results, which represents $35 billion in total care costs paid by both patients and their health insurance plans for care received during 2020.

2. Measure Description

The *Total Cost of Care* measure assesses actual payments associated with care provided to commercial HMO/POS members between ages 1 and 64 who belong to a medical group for at least nine months 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
- AMP 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 AMP Manual.

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 $250,000 per member per year are truncated (i.e., a member's costs up to $250,000 are retained).

3. **Adjustments for Fair Comparisons**
In order to facilitate fair comparisons of medical group performance, the *Total Cost of 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 risk adjustment is applied using the Johns Hopkins' Adjusted Clinical Grouper® (ACG)® System. The risk adjustment accounts for a member's age, gender, and health status, which are identified through diagnosis and procedure codes appearing in claims and encounter data submitted by medical groups and other healthcare providers to a health plan. The model used is concurrent in that the codes used to identify a member's health status are from the same period as the measurement year. More details are available on the HealthPartners website.

      Note: The methodology uses up to 13 diagnosis codes for professional and 13 for facility services. However, the number of available diagnosis codes varies across plans and providers. If diagnosis codes are incomplete, a medical group's Total Cost of 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) Reliability of Results – Minimum Number of Observations

In order for a medical group's performance to be considered reliable enough to be displayed in OPA public reporting, *Total Cost of Care* must be based on the equivalent experience of 2,400 member months enrolled for the measurement year (e.g., 200 members enrolled for 12 months each, 400 members enrolled for only 6 months each, etc.). Any medical group whose *Total Cost of Care* results are based on fewer member months will be identified as "Not enough data to score reliably."

b) Performance Categories

Each medical group's *Total Cost of Care* results are translated into a performance category. The category ranges are defined by the 10th, 35th, 65th, and 90th percentiles of medical group performance across participants for the same measurement year. The minimum number of observations required does not impact the performance category *Total Cost of Care* ranges.

Rating the Total Cost of Care	Performance Category	Range of Total Cost of Care per member per month*
Lowest Total Cost of Care (lowest 10% of costs)	5-star	$291 or lower cost
Lower Total Cost of Care	4-star	$342- $292
Medium Total Cost of Care	3-star	$383 - $343
Higher Total Cost of Care	2-star	$439 - $384
Highest Total Cost of Care (highest 10% of costs)	1-star	$440 or higher cost

* The performance rating is assigned per the cutpoint, which factors in a buffer zone. Any medical group whose score is in the buffer zone is assigned to the next higher stars rating category.

Legends to Explain Missing Scores

Two categories are used to explain instances in which a medical group is not rated for *Total Cost of 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 members enrolled for reliable measurement. This label is also used when a medical group's members are highly concentrated in one plan and the reported result may disclose proprietary information.

Additional Notes about Interpretation and Use of the *Total Cost of Care* Rating

1. *Total Cost of 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 *Total Cost of Care* alone assumes that the quality of care across providers is equivalent; there is substantial evidence that it is not. Therefore, the actual Total Cost of Care amount is not reported, only the star rating based on the range/performance category.

2. *Total Cost of 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 medical group 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. *Total Cost of 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 *Total Cost of 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 *Total Cost of Care* methodology and may be appropriate to consider when interpreting medical groups' results.

6. *Total Cost of Care* is used in the IHA Excellence in Health Care Awards, which recognize exceptional medical groups for achieving strong quality results while effectively managing costs. To earn this recognition, a medical group must have performance that ranks in the top 50% for each of the following: clinical quality, patient experience and T*otal Cost of Care*.