Center for Data Insights and Innovation (CDII) California Health Care Quality Medical Group - Commercial HMO Report Card, 2023-24 Edition[1]

Scoring Documentation for Public Reporting of *Total Cost of Care* (Reporting Year 2024)

Background

Representing the interests of health plan and medical group members, the California Center for Data Insights and Innovation (CDII) publicly reports on health care quality. CDII's predecessor, the Office of the Patient Advocate (OPA), published its first HMO Health Care Quality Report Card in 2001. The Report Cards have since annually updated, enhanced and expanded to address a variety of ratings for HMO health plans, PPO health plans, Commercial HMO Medical Groups, and medical groups serving Medicare Advantage members. The current version (2023-24 Edition) of the online Health Care Quality Report Cards is available via the CDII Consumer Reports webpage.

The Integrated Healthcare Association (IHA) collects performance results for 188 provider 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 provider organizations that contract with Commercial HMOs for AMP and provides the data to CDII for the Health Care Quality Report Card. The IHA provider 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 2023-24 Edition of the Medical Group - Commercial Report Card and *Total Cost of Care* measure and rating are published in Spring 2024. This Report Card uses clinical care and patient experience ratings data reported in Reporting Year (RY) 2024 for performance in Measurement Year (MY) 2022. The data source for Total Cost of Care rating and measure addressed in this document is the IHA AMP Commercial HMO program's medical group total cost of care data, called Total Cost of Care.

The Medical Group Report Card also relies on additional sources for clinical quality and patient experience data:

1. The IHA AMP Commercial HMO program's medical group clinical performance data (Methodology Description in a separate document).

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[1] Also see the Scoring Methodology for the Medical Group Report Card clinical quality and patient experience ratings via the About the Medical Group Ratings page:

2. The Purchaser Business Group on Health (PBGH) Patient Assessment Survey's (PAS) patient experience data for medical groups (Methodology Description in a separate document).
3. The IHA AMP Medicare Advantage program's medical group clinical performance data (Methodology Description in a separate document).

Medical Group *Total Cost of Care* Methodology Process

1. Methodology Decision Making Process

CDII conducts a multi-stakeholder process to determine the best scoring methodology for capturing patient experience appropriately and accurately. Through OPA and now CDII's partnership with IHA's AMP programs, IHA's Technical Measurement Committee (TMC) serves as an advisory body for the Medical Group Report Cards clinical data, and the TMC provides insight and thought partnership on the Health Plan Report Cards. The TMC reviews industry changes, the AMP proposed measure set, and recommendations for public reporting options. 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.

TMC Roster (2023)

Chair: Edward Yu, MD, *Sutter Palo Alto Medical Foundation*
Christine Castano, MD, *Optum* (former chair, retired in 2023)

Alice Gunderson, *PFCC Partners, Patient Advisor Network*
Alyson Spencer, *Blue Shield of California Promise Health Plan*
Andy Dang, MD, *Sharp Rees-Stealy Medical Group*
Bihu Sandhir, MD, *AltaMed*
Cheryl Damberg, PhD, *RAND*
Eric Garthwaite, *Health Net*
Frederick Kuo, MD, *UnitedHealthcare*
Kenneth Phenow, MD, *Cigna*Leticia Schumann, *Anthem*
Marnie Baker, MD, MPH, *MemorialCare Medical Group*
Pegah Mehdizadeh, DO, *Aetna*
Peter Robertson, MPA, *Purchaser Business Group on Health*
Rachel Brodie, *Purchaser Business Group on Health*
Ralph Vogel, PhD, *Permanente Medical Groups*
Sara Frampton, *Kaiser Permanente*
Sherilyn Wheaton, MD, *Primary Medical*
Ting Pun, *PFCC Partners, Patient Advisor Network*
Tory Robinson, *Blue Shield of California*

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

Additionally, CDII 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 CDII 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 CDII 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 CDII 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.

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 MY 2022 AMP Technical Specifications.

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 CDII 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	$286 or lower cost
Lower Total Cost of Care	4-star	$333- $287
Medium Total Cost of Care	3-star	$383 - $334
Higher Total Cost of Care	2-star	$425 - $384
Highest Total Cost of Care (highest 10% of costs)	1-star	$426 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*.