

Measuring Total Cost of Care

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Measuring and understanding the drivers of total cost of care are key steps to assist providers in moderating the upward trend in healthcare costs.

ABSTRACT: In response to affordability concerns, the California Pay for Performance (P4P) Program has developed a measure of Total Cost of Care (TCC) that captures the costs of care delivered to all commercial HMO/POS enrollees in each P4P-participating physician organization. The TCC measure includes all covered professional, pharmacy, hospital, and ancillary care, as well as administrative payments, and is risk-adjusted to capture differences in patient population characteristics across physician organizations. Measuring and understanding the drivers of total cost of care are key steps to assist providers in moderating the upward trend in healthcare costs.

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INTRODUCTION: AFFORDABILITY CONCERNS AND THE MOVE TOWARDS MEASURING “VALUE”

The Integrated Healthcare Association (IHA) manages the California Pay for Performance (P4P) Program, which is the largest non-governmental physician incentive program in the United States. Founded in 2001, this program represents the longest running U.S. example of data aggregation and standardized results reporting across diverse regions and multiple health plans. IHA runs the program on behalf of eight health plans representing 10 million insured persons, and is responsible for collecting data, deploying a common measure set, and reporting results for approximately 35,000 physicians in over 200 physician organizations (PO).

The P4P Program has created a successful statewide collaboration that encompasses uniform performance measures, aggregated data collection and validation, a trusted governance process, and a single public report card for POs in California. Over the life of the program, steady, incremental performance improvements have been achieved in the quality of healthcare delivered by P4P participants, however the dramatic increase in California’s healthcare costs over the past decade has overshadowed quality gains.

In response to these concerns, IHA’s P4P Program has begun a transition to Value Based P4P, which encompasses both cost and quality, as its overarching goal over the next five years. The foundation of this new strategic direction is a measure of Total Cost of Care (TCC) developed by the P4P Technical Efficiency Committee. This brief outlines TCC specifications, the process of risk adjustment, TCC implementation, and the implications of total cost of care measurement for the future of the California P4P Program.

WHAT DOES TCC MEASURE?

TCC measures actual payments associated with care for all commercial HMO/POS enrollees in a PO, including all covered professional, pharmacy, hospital, and ancillary care, as well as administrative payments and adjustments. Participating health plans report a single lump sum payment for each contracted PO to a data



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aggregator; the lump sum includes both capitation and fee-for-service payments, as well as member co-payments, paid to the PO or any providers caring for its members (e.g., hospitals, pharmacies, etc.). Per member costs above \$100,000 per year are truncated, and payments for mental health and chemical dependency services; acupuncture or chiropractic services; dental and vision services; and P4P quality incentive payments are excluded from the calculation. Two metrics are calculated with these data for each participating PO: risk-adjusted Total Cost of Care per member per year (PMPY)¹ by contracted health plan, and risk-adjusted Total Cost of Care PMPY across all contracted plans.

THE PROCESS OF RISK ADJUSTMENT

The TCC measure is risk-adjusted to account for the health status of the patient population. In order to do so, member-level relative risk scores (RRS) are calculated using Verisk's DxCG Relative Risk methodology. The RRS accounts for a member's age, gender, and health status, which is identified through the use of diagnosis codes appearing in claims and encounter data provided by a health plan. Once these calculations are completed, RRSs are normalized for the total P4P population (across all plans and POs) to a benchmark of 1.0, and members are assigned risk scores. As an example, a member with a RRS of 1.4 has expected costs that are 40% higher than the average cost for all HMO/POS enrollees covered by the P4P Program.

Once this is complete, average RRSs are calculated for each PO for both each contracted plan and the total enrolled population, and these scores are then used to determine expected costs for each PO. To assess performance, these expected costs are compared to the actual payments for care delivered. TCC results are reported by region to account for market-specific pricing differences.

IMPLEMENTING TCC MEASUREMENT

Preliminary testing has been completed using two years of data from three health plans, and further testing is underway with another year of data and two additional health plans. Preliminary testing results have exhibited face validity in terms of TCC amounts and

year-over-year trend. Similar to the quality measures that the P4P Program has collected since 2003, significant variation in TCC performance was found both across and within regions. Assuming continued testing proceeds smoothly, TCC will be part of the P4P 2011 Measurement Year measure set which will establish a baseline TCC amount for all P4P participating POs. Incentive payments are expected to begin in 2014, based on a PO's performance relative to peers or trend over last year's performance.

Underlying key drivers of total costs, including the percent of outpatient procedures done in a preferred facility, generic prescribing for seven therapeutic areas, and all-cause readmissions within thirty days, will continue to be provided so that POs can assess the underlying drivers of their performance relative to their peers and identify areas with opportunity for improvement.

THE VALUE OF MEASURING TOTAL COSTS OF CARE

Measuring total cost of care alongside quality gives stakeholders a better understanding of the value of care delivered, and robust data for the purpose of provider comparison. Aligning total cost of care measurement and incentives across P4P's participating health plans will maximize impact, and ideally incentivize POs to control their overall cost growth. Finally, in the future, publicly reporting total cost of care data for POs alongside quality metrics will allow healthcare purchasers and consumers to make informed decisions about providers based on quality and costs.

In the future, the California P4P Program will place an even greater emphasis on both cost and quality as it transitions to "Value Based P4P." Under this new paradigm, the TCC measure will be used to establish the base amount of incentive payment for which a PO is eligible, and quality performance will be used to adjust this amount. Similar programs, such as the Medicare Shared Savings Program, that allocate shared savings payments to organizations based on both the amount of money they save compared to benchmark and their quality scores, are becoming increasingly prevalent across the country as healthcare stakeholders acknowledge and take responsibility for the need to tame healthcare costs.

1. There is no continuous enrollment requirement for this measure; it includes all members who are enrolled in a PO and a health plan for one day or more during the measurement year. Member years for a particular

health plan are the sum of the number of days during the measurement year that each eligible member was enrolled with the health plan and PO, divided by 365.