

Total Cost of Care

Measuring and Using Total Cost of Care Data in California



As U.S. and California health care spending continues to grow faster than the overall economy and people's incomes, making care less affordable, alternative payment models are being developed to encourage physicians to be accountable for both the quality and cost—or overall value—of patient care. To help California physician organizations reduce unnecessary costs, the Integrated Healthcare Association (IHA) developed a total cost of care (TCC) measure to complement existing clinical quality and patient experience measures used in IHA's Pay for Performance (P4P) program. By merging quality, TCC, resource use, and patient experience measures into a single incentive program across multiple health plans, IHA's Value Based P4P is one of the largest advanced alternative payment models in the country. Today, participation includes 10 health plans and 200 physician organizations caring for 9 million Californians enrolled in commercial health maintenance organization (HMO) and point of service (POS) products. In March 2016, IHA partnered with the California Office of the Patient Advocate to publish the largest statewide multi-payer public report card to provide side-by-side assessments of physician organization performance on all three key aspects of value—clinical quality, patient experience, and costs.

TOTAL COST OF CARE MEASUREMENT

IHA has been measuring and tracking total cost of care since 2011 for physician organizations (POs) participating in Value Based P4P. The TCC measure is based on actual risk-adjusted annual payments to POs for each HMO/POS enrollee's care, including professional, pharmacy, hospital, and ancillary services and consumer cost-sharing amounts. For all contracted POs, participating health plans report a lump-sum payment for each member to a data aggregator. The lump sum includes both capitated—fixed per member, per month amounts—and fee-for-service payments for all care. Individual patient costs exceeding \$100,000 in a year are truncated, and payments for mental health, chemical dependency, acupuncture, chiropractic, dental, and vision services are excluded from the calculation.

RISK ADJUSTMENT

To ensure fair comparisons of PO performance, the TCC measure is risk adjusted to account for health status differences in the patient population and adjusted by geographic region to account for differences in the price of inputs, such as wages.

Relative Risk Scores: 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 in claims and encounter data submitted by POs to health plans. Diagnosis codes used to determine a member's health status are from the same period as the measurement year.

Geographic Adjustment: The Centers for Medicare and Medicaid Services Hospital Wage Index Geographic Adjustment Factor is used to account for regional differences in input costs.

REWARDING HIGH-VALUE CARE IN CALIFORNIA

Measuring TCC, alongside quality, resource use, and patient experience, aligns Value Based P4P incentives—payment, public recognition awards, and public reporting—to reward physician organizations delivering high-value care in California.

- Payment:** In 2014, the first health plan—Blue Shield of California—made incentive payments to POs using the new Value Based P4P design, which is based on a shared-savings model. Savings are generated by improvements in resource use: inpatient care, emergency department use, outpatient procedures, and generic prescribing. Any net savings are shared between the health plan and the PO. Without shared savings, there are no incentive payments. Further, to be eligible to earn any share of savings, physician organizations must first meet minimum quality standards, as well as demonstrate a total cost of care trend of no more than the consumer price index (CPI) plus 3 percentage points. Four more major health plans—Aetna, Cigna, Anthem Blue Cross, and UnitedHealthcare—have adopted value-based incentive payments or will do so within the next year. By merging quality, cost, resource

use, and patient experience measures into a single incentive program across multiple health plans, Value Based P4P can potentially help bend the cost curve while maintaining or increasing the quality of care.

- **Public Recognition Awards:** IHA publicly recognizes top performing and most improved physician organizations each year. In November 2014, IHA launched a new Excellence in Healthcare Award to recognize POs performing in the top half of all three measurement areas: clinical quality, patient experience, and cost. Only about 10 percent of participating physician organizations received the award in 2015. Already, development of the award methodology has advanced discussion and understanding of how to define value, and IHA expects discussion to continue as information increases about the characteristics and best practices of POs that deliver high-quality, affordable, patient-centered care.
- **Public Reporting:** IHA partners with the State Office of the Patient Advocate to publicly report Value Based P4P results each year. As with quality and patient experience, standardized measurement of total cost of care is essential to enable comparison across physician organizations. Starting in March 2016, public reporting of TCC performance at the physician organization level, alongside performance on clinical quality and patient experience measures, will allow purchasers and consumers to make more informed decisions about physician organizations based on value.

IMPLEMENTATION TESTING & CHALLENGES

Before the TCC measure was added to the P4P measure set, it was tested for reliability and validity to ensure both consistent and meaningful results. Testing took place in 2010 and 2011 using three years of data from five plans. IHA identified three key challenges with TCC implementation:

- **Capitation creates comparability challenges:** In California's commercial market, HMOs operate primarily through a delegated model and pay POs on a capitated basis. Capitation can benefit the overall accountability and coordination of care; however, it creates unique challenges when measuring TCC. Under capitation arrangements, dollars paid to providers represent the actuarial value of a package of

services delegated to the provider. To ensure TCC results are comparable across POs, capitated payments for all providers must represent the same services.

- **Lack of accurate encounter data creates risk-adjustment challenges:** In a capitated payment arrangement, encounter data is not tied to payment; there is no financial incentive to ensure an encounter is coded completely, transmitted, received, and processed. This creates challenges for risk adjustment needed for accurate comparisons of PO performance. For example, if a provider does not fully code a visit or if a PO's claims and encounters are not processed by the plan, diagnosis codes for that member will be missing. As a result, the risk adjustment will estimate a lower RRS for that member than if the diagnosis codes were present.
- **Cost data is sensitive:** Despite the push for greater transparency, the sharing of pricing information—even if aggregated and adjusted—is sensitive. To gain buy-in from plans and providers, IHA agreed to collect TCC data as a lump-sum amount at the member level. While this limits the ability to drill-down and understand underlying cost drivers, it was a necessary first step for implementation. With testing complete, the TCC measure was added to the P4P measure set in 2011, establishing an initial baseline TCC amount for all physician organizations participating in Value Based P4P.

Additional information

- www.ihc.org: Value Based P4P Fact Sheet, Issue Brief, Award Methodology, and Results
- JAMA: Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations
- Health Affairs Blog: Value-Based Pay for Performance
- Health Affairs Blog: Public Reporting by Physician Organizations of Costs Alongside Quality

ABOUT IHA

IHA is a statewide, multi-stakeholder, leadership group that promotes quality improvement, accountability, and affordability of health care in California.