Q Corp Medicare FFS Clinic Comparison Report FAQs

General FAQs

Who is HealthInsight Oregon?
HealthInsight Oregon is a private, nonprofit, community-based organization working to improve health and health care. HealthInsight Oregon is affiliated with Utah-based HealthInsight, a recognized leader in quality improvement; transparency and public reporting; health information technology; patient and community engagement; and redesign of delivery and payment systems. As of a mid-2017 merger, HealthInsight Oregon and Q Corp have joined operations and all former Q Corp employees are now HealthInsight employees.

Why is Q Corp producing these reports?
Four years ago, Q Corp's Board of Directors and committee members made a bold decision to move beyond quality and utilization to add cost of care to its measurement initiative. Our shared goal is to help multiple stakeholders achieve the Triple Aim of better health, better quality of care and lower costs. Based on strong support, we set out to develop cost of care reports. These reports reflect an initial step on this journey. This is the first year Q Corp is sending out Medicare Clinic Comparison Reports to primary care clinics across the state.

How are these reports different from Q Corp's other reports?
These reports contain information on cost, utilization and quality. The quality measures should be familiar to clinics as they are the same measures which Q Corp runs and reports to clinics on our reporting portal: http://q-corp.org/reports/portal. The Clinic Comparison reports allow clinics to review cost and utilization and make connections to the quality of care that patients are receiving. The cost information in these reports includes only Medicare FFS data. Other Clinic Comparison Reports that clinics have received included only commercial payer data.

What do the combined Commercial and Medicare FFS Overall Results show me?
The combined results present the Total Cost Index for the clinic population that is covered by Medicare FFS and a participating Commercial plan. However, because cost structures between the two payer types differ, the combined information has limited value. Reporting combined Commercial and Medicare FFS results is a CMS requirement.

What Clinic Comparison Report content will be reported to other audiences?
Q Corp believes that to reduce health care costs, all stakeholders, including the public, must have access to more information about the cost of care. These Medicare FFS Clinic Comparison reports will not be reported to other audiences at this point. Commercial Clinic Comparison reports information will be publicly reported on Q Corp's Compare Your Care website. This public reporting comes after two years of private reporting to clinics, during which clinics and providers have had opportunities to submit reconsiderations on their data.

Why is Q Corp testing the cost measures?
As with all measures Q Corp reports, Q Corp tests measures to ensure that they are performing as intended. For the Medicare FFS reporting of the Total Cost of Care measures, we want to make sure we understand what is driving variation between clinics. These measures are based on the intensity of services used and the prices for those services, which can be affected by changes in clinic practices, staffing or contracting rates, for example. The HealthPartners methodology attempts to reduce variation in cost due to other factors – such as the age, gender and illness burden of patients – by using risk-adjustment, capping costs and requiring a minimum number of patients. We want to understand how well the measures do at reducing variation due to these other factors.

How are these reports different from the Clinic Comparison Reports I received in January 2018?
These reports cover Medicare FFS patients who were attributed to your clinic between January 2015 and December 2015, and separately, January 2016 and December 2016. The commercial Clinic Comparison Reports shared in January 2018 included patients with commercial insurance who were attributed to your clinic between January 2014 and December 2014. The Commercial population's costs are significantly different from the Medicare population.

Why am I receiving reports for 2015 and 2016 at the same time?
Due to a data submission error with one of our participating health plans, Q Corp was not able to release the 2015 Clinic Comparison Reports as anticipated. As it turned out, the 2015 data was available at the same time as the 2016 data, so the reports are being delivered together.

How is "cost" defined?
For purposes of the Clinic Comparison Reports, "cost of care" refers to the cost for the purchaser of care- the individual and/or organization paying for health care services- not the cost to a provider to deliver the care. Costs in the report are based on total allowed amounts, all payments from the health plan and the patient for one year.

Attribution FAQs

What information is included in the report?
Reports are based on Medicare FFS claims data from the Q Corp claims database, which includes claims data on 100% of the Medicare FFS population in Oregon and uses a 12-month reporting period (January 2015 - December 2015 and January 2016 - December 2016) with three months run-out.

Approximately what is the percent of my clinic's population covered by these reports?
For Oregon overall, Q Corp is calculating the Total Cost of Care measures for 100% of the Medicare FFS population, excluding patients also covered by Medicaid and commercial insurers. The cost measures are limited to patients age 65 or older. Your clinic may have a lower percentage of its total population represented in this report due to carrier mix or a higher percentage of commercial and Medicaid patients.

How are patients and their costs attributed to my clinic?

- Clinic reports are limited to Medicare FFS patients.
- Patient panels are created using a claims-based attribution methodology. Patients are attributed to the Primary Care Provider (PCP) that they have had the most visits with over a 24-month period. In the event of a "tie," patients are attributed to the provider they have most recently seen. Clinics can review their lists of attributed patients upon request.
- Only patients assigned to PCPs in Q Corp's provider directory were included. If a patient received care solely from specialists, urgent care clinics or other providers not included in the provider directory, they were not assigned a PCP (unattributed).
- If there were no office visit claims for a PCP in Q Corp's provider directory, the patient is not attributed.
- Only Medicare FFS-insured patients aged 65+ who were enrolled in coverage for at least nine months are included.
- Patients who are Medicare/Medicaid Dual Eligible or enrolled with an ESRD (End Stage Renal Disease) network are excluded.
- Annual costs over $100,000 for any individual patient are excluded.

Data FAQs

Why is the data so old?
Multiple factors affect the timing and release of clinic reports.

- Claims Lag: These reports reflect Medicare FFS claims data incurred January 2015 through December 2015, and January 2016 through December 2016. There is a run-out of three months beyond the completion of the reporting period.
- Data Processing: Following the completion of claims run-out, CMS must extract the records from their database and send them to our data vendor. Records must be checked for consistency and plausibility, and anomalies must be investigated and corrected before the process of combining and cross-walking the data can begin. Measures must then be run on the data and validated.
- Analysis and Reporting: Once the data are ready we begin our analysis and reporting activities. This is followed by an extensive quality assurance process.

How are these reports different from performance reports clinics might be getting from CMS?
Data in these reports is reported at the clinic level, using a slightly different patient attribution methodology than CMS uses. CMS is just starting to report on their cost measures, so in conjunction with utilization and quality, these reports provide a more comprehensive view. Finally, CMS does not report an Oregon Average benchmark against which clinics can compare their own results.

Why was a minimum panel size of 600 used for reporting?
HealthPartners® has tested the TCOC measures at various *n* sizes; however, they are National Quality Forum (NQF) endorsed at the 600-patient panel size. HealthPartners® recommends a minimum panel size of 600 attributed patients for reliable cost comparisons.

Are the costs in these reports risk-adjusted?
Yes. Costs are risk-adjusted at the member level using the Johns Hopkins ACG system, which weights patients based on disease patterns, age and gender.

How does risk adjustment work?
Risk adjustment is a method of using characteristics of a patient population to estimate the population's illness burden. Diagnoses, age and gender are characteristics that are often used. Although risk adjustment can be a helpful tool, it does not account for all variation between populations. As Q Corp has reviewed clinic risk adjuster scores and costs year over year, we see variation in some clinics. Q Corp is actively investigating methods to mitigate some of this variation.

What is the difference between the risk adjusted PMPM and the raw PMPM?
The raw PMPM (Per Member Per Month) amount is the total allowed amount (payments from the health plan and the patient combined) paid in health care costs for all attributed patients, divided by the number of member months. Annual per member costs are capped at $100,000. The adjusted PMPM is calculated using the raw PMPM and risk adjustment. The adjusted PMPM for different populations can then be compared regardless of differences in the populations' characteristics.

Why are the reports based only on Medicare FFS data?
Due to differences in payer type and data submission, the Total Cost of Care measures are more meaningful when reported separately by payer. There is no methodology for reporting Medicaid or Medicare Advantage, so for now, Commercial and Medicare FFS patient quality, utilization, and cost are reported separately.

What is the "Oregon Average" that is shown in the report?
The Oregon Average is calculated based on the combination of all the Medicare FFS clinic panels (age 65+ only) in the report release.

Why are certain numbers highlighted?
The blue highlights indicate that the number is at least 10% above the Oregon Average. This is approximately one standard deviation above the mean.

How are patients with chronic conditions categorized?

- Q Corp has included patient information for chronic conditions that we have learned are of interest to providers. These conditions and the number of patients identified with each condition are shown on page 1 of the report.
- Patients with more than one condition appear in each category for which they have been identified as having the condition. (Note that this is a change from prior versions of the Clinic Comparison Report which used Milliman's proprietary Chronic Condition Hierarchical Groups to assign patients to only one category.)
- The "Chronic Condition Patient Summary" on page 7 of the report shows up to ten Chronic Conditions with the average costs for each condition. Conditions must have at least 30 patients to be shown.

Why are all the inpatient, outpatient, professional, and hospice and home health costs attributed to just PCPs?

- The HealthPartners® methodology uses a patient-centered attribution approach that includes all care given to a patient.
- While it is true that primary care providers may not have full control over total costs or resource use, they can influence and develop partnerships and processes with colleagues, specialists and hospitals to ensure care is coordinated.
- For more information regarding the method for attribution, please see the Cost of Care technical appendix online at http://www.q-corp.org/sites/qcorp/files/Total Cost of Care - Technical Appendix April 2016.pdf

Why isn't there a quality comparison on the cover letter?
The Quality Composite measure which Q Corp uses for the comparison with cost was designed for the commercial population. Quality measure results that are relevant to the Medicare FFS population are included in the Clinic Comparison Report where appropriate.

Can my clinic have access to more detailed data?
Upon request, Q Corp can provide a clinic with a list of its attributed patients. If you are a medical group, an IPA, or an ACO, and are interested in receiving a custom report that includes information from multiple clinics, please email costofcare.or@healthinsight.org.

Technical Assistance FAQs

Is technical assistance available on how to use the reports within a clinic?

- Our grant funding allowed for limited development of training and technical assistance for clinics with using the reports in meaningful ways. While these reports are specific to Medicare FFS (CMS), HealthInsight Oregon has some funding available to assist organizations eligible to report under the Quality Payment Program's Merit-based Incentive Payment System (MIPS) for 2018. To find out if you are eligible for MIPS, please check qpp.cms.gov, or contact HealthInsight at qpp@healthinsight.org. Additionally, through both regional and national collaborations, HealthInsight Oregon is exploring a variety of options to make this work understandable and informative to clinics. We are working with partners to develop solutions that will assist clinics in interpreting the results, conducting additional analyses and taking appropriate actions.
- Additionally, HealthInsight Oregon is working with clinics and systems on a custom basis to develop supplemental reports that they find useful. If you have suggestions or are interested in receiving technical assistance related to analyzing or reducing costs, please email us at costofcare.or@healthinsight.org.

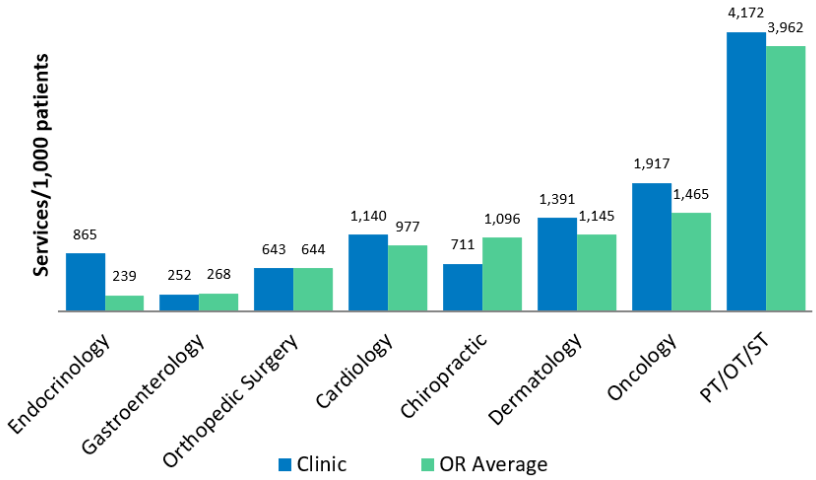
Where can I find additional information about the Clinic Comparison Reports?
Additional information can be found on our website: http://q-corp.org/our-work/costofcare.

Examples

What do I do with these clinic reports? Where do I look for opportunities?
The goal of the Clinic Comparison Reports is to identify clinic variation in cost, quality and utilization. The measures are designed to give each clinic a detailed understanding of how the care their patients receive differs from the average, which enables practices to create action plans targeted at improving specific aspects of their patients' care. Some suggested starting points and areas to consider:

- Where do your clinic's TCI, Price Index and RUI differ substantially from the Oregon average?
- Are there areas where your clinic has a substantially higher Price Index than RUI? Higher RUI than Price Index?
- Are there known or suspected service categories of high cost to your clinic? If so, does the report reflect this and provide more detailed information?

Examples of where and how clinics can and have used the clinic report information:

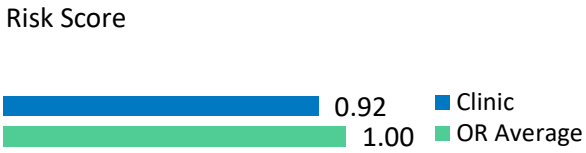


1. Specialty utilization (page 2) – are your patients using more or fewer specialist services than the state average? If they are using more, can you identify any specialty practices to which you often refer patients who might be treating patients more intensively than necessary?

2. Are there any outpatient costs (page 3) that are surprising? If you are looking at reports across clinics owned by the same medical group, are there differences in the patient populations that are being treated?

	Clinic Adj PMPM	OR Average PMPM	TCI	= RUI	Price x Index
Operating Room	**$13.60**	$16.48	**0.83**	0.97	0.85
Evaluation & Management	**$1.96**	$12.27	**0.16**	0.12	1.37
Lab & Pathology	**$5.19**	$10.75	**0.48**	0.45	1.07
Advanced Imaging	**$3.20**	$9.02	**0.35**	0.36	0.98
Emergency Dept. Visits	**$3.52**	$7.82	**0.45**	0.55	0.81
Oncology & Chemotherapy	**$7.48**	$7.62	**0.98**	0.93	1.06
Cardiac Imaging & Tests	**$2.68**	$6.75	**0.40**	0.39	1.01
Surgery & Anesthesia	**$2.73**	$6.68	**0.41**	0.43	0.95
Standard Imaging	**$0.97**	$4.71	**0.21**	0.19	1.06
Physical Therapy & Rehab	**$1.80**	$4.27	**0.42**	0.47	0.89
Preventive Screenings	**$0.39**	$3.75	**0.10**	0.10	1.01
Echography	**$0.29**	$1.49	**0.19**	0.20	0.95
Endoscopic Procedures	**$0.41**	$0.88	**0.47**	0.48	0.97
Dialysis	**$0.53**	$0.69	**0.76**	1.00	0.76
Preventive Vaccinations	**$0.03**	$0.54	**0.05**	0.05	1.08
Preventive Visits	**$0.00**	$0.20	**-**	-	-
Other Outpatient Facility	**$28.34**	$39.45	**0.72**	0.50	1.44
Total	**$73.11**	$133.40	**0.55**	0.56	0.97

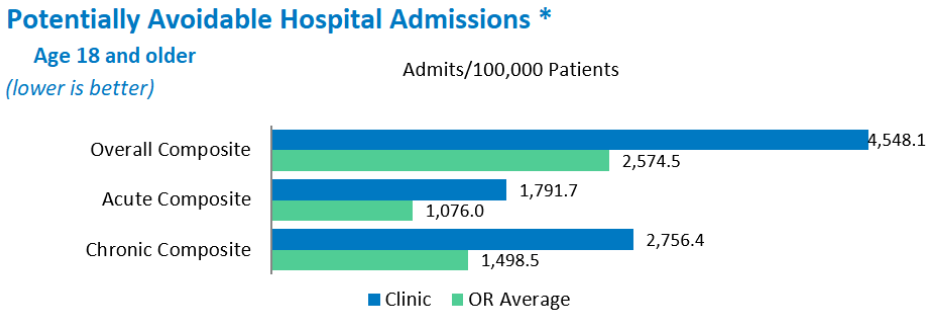
3. Your clinic's retrospective risk score is provided in the cover letter. Supposing this shows that your practice has a lower disease burden than the state average (see sample below), you might look at the rate of acute inpatient admits and days (see page 4 of the report). If your rate is higher than average, you might want to explore causes.



4. Suppose page 4 shows your clinic has high costs on imaging due to higher prices of advanced imaging, while standard imaging is lower price and has lower than average resource utilization. Are alternative locations for advanced imaging services available? It may be valuable to understand why services are higher priced than the state average. Are there any unnecessary or duplicative services you could avoid?

	Clinic	OR Average			
	Adj				Price
	PMPM	PMPM	**TCI**	= RUI	x Index
Advanced Imaging (e.g., MRI, CT, PET)	**$27.73**	$15.16	**1.83**	0.94	1.95
Cardiac Imaging & Tests	**$7.26**	$9.35	**0.78**	0.75	1.04
Standard Imaging	**$7.18**	$8.70	**0.82**	0.60	1.38
Echography	**$3.40**	$3.61	**0.94**	0.84	1.12

5. Is your practice's Hospital Admissions for Ambulatory-Sensitive Conditions (page 5) admission rate higher than the average? There may be an opportunity to evaluate primary care protocols for these conditions and implement additional patient management strategies.



6. "The Chronic Condition Patient Summary" (page 7) may indicate differences in cost and utilization between your practice and the average for a list of clinical conditions. Does it cost more or less to manage asthma in your practice? Are more or fewer resources being used than the state average? The sample clinic report shows higher cost and resource use than the benchmark. Consider the quality of care being delivered. Does it reflect the higher intensity of care shown in the cost and resource use?

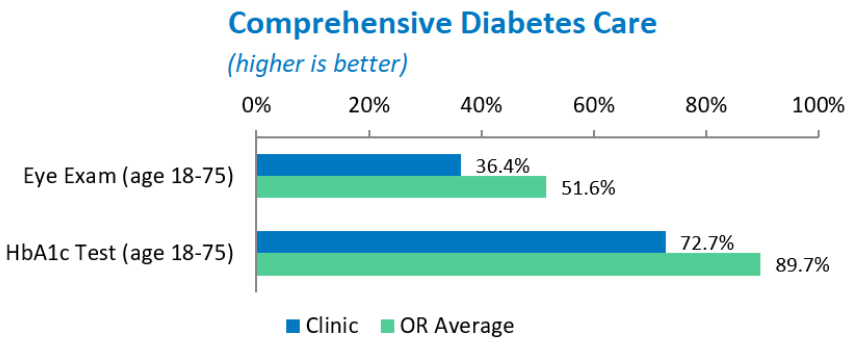
	Clinic		OR Average			
	Patients	Adj PMPM	PMPM	TCI	= RUI	Price x Index
Acute Myocardial Infarction	16	-	$2,988	-	-	-
Alzheimer's Disease and Related Disorders or Senile Dementia	67	$2,092	$1,500	1.39	1.44	0.97
Asthma	54	$2,204	$1,873	1.18	1.20	0.98
Atrial Fibrillation	98	$1,511	$1,402	1.08	1.12	0.97
Cancer	206	$995	$1,252	0.80	0.80	0.99
Chronic Kidney Disease	151	$1,439	$1,423	1.01	1.03	0.98
Chronic Obstructive Pulmonary Disease and Bronchiectasis	35	$2,404	$1,859	1.29	1.32	0.98
Depression	187	$1,129	$1,214	0.93	0.92	1.01
Diabetes	164	$1,130	$1,006	1.12	1.15	0.98
Heart Failure	101	$1,938	$1,847	1.05	1.08	0.97
Hyperlipidemia	596	$823	$833	0.99	0.99	1.00
Hypertension	669	$874	$862	1.01	1.02	0.99
Ischemic Heart Disease	213	$1,290	$1,226	1.05	1.06	1.00
Mental Illness	35	$973	$1,217	0.80	0.83	0.96
Osteoporosis	68	$1,675	$1,175	1.43	1.35	1.05
Rheumatoid Arthritis/ Osteoarthritis	280	$1,227	$1,097	1.12	1.12	1.00
Stroke / Transient Ischemic Attack	10	-	$2,035	-	-	-

7. If your practice has higher-than-average ED rates (page 4), this may indicate an opportunity to educate patients on primary care access and appropriate emergency room use. Are there alternative primary care access points that could encourage improved primary care coordination?

Emergency Department Utilization *

(lower is better)

	Clinic	Benchmark
ED Visits/1000 patients	**1,027.0**	961.5



8. Are there any quality measures in which your clinic looks significantly different than the state average? If so, does this present an opportunity to develop quality improvement initiatives around these areas?