nrhi
Network for Regional Healthcare Improvement

Getting to Affordability

Issue Brief

Medicare Total Cost of Care Reporting

True health care transformation requires access to clear and consistent data. Three regions are working together to develop reporting that is as consistent as possible, to support comparisons across regions in the future. Multi-payer data not only provides clinics valuable information that has largely been unavailable to them, but also provides policymakers the ability to see and address system and regional trends and inconsistencies.

In 2013, the Network for Regional Healthcare Improvement (NRHI) and five regional health care improvement collaboratives (RHICs)—Center for Improving Value in Health Care (CIVHC) in Colorado, Maine Health Management Coalition (MHMC), Oregon Health Care Quality Corporation (Q Corp), Midwest Health Initiative in St. Louis, and Minnesota Community Measurement—were funded by the Robert Wood Johnson Foundation (RWJF) to report Total Cost of Care (TCOC) to primary care practices for their commercially insured populations. A second phase was funded by RWJF to continue these efforts and specifically to explore reporting on the Medicaid and Medicare populations. In order to meet this need, NRHI launched a workgroup with three of the five original regions—CIVHC, MHMC and Q Corp—to develop Cost of Care reporting for the Medicare Fee-For-Service (FFS) population, using the National Quality Forum endorsed HealthPartners Total Cost of Care measure set.

Availability of Data

The first step to producing TCOC reports for the Medicare population is obtaining the Medicare FFS claims data. This data set is only available through the Centers for Medicare and Medicaid Services (CMS). Each region found a different avenue for gaining access to this data.

MHMC has access to the data through dual tracks. They received certification through CMS as a Qualified Entity (QE). A certified QE

is an organization that has met rigorous privacy and security requirements in order to receive, house and use identified Medicare data. MHMC also received approval to use the data through their State Innovation Model (SIM) program. The data use agreements for the two programs are different, and while the QE program requires public reporting, the SIM program does not. While piloting the Medicare TCOC measures, MHMC determined that publicly reporting would not be prudent as they work through data issues and gain providers' trust in the data. Therefore, MHMC chose to use the data through the SIM program for the Medicare reporting pilot.

CIVHC, a RHIC and also the administrator of Colorado's All Payer Claims Database, gained access to the data through the State Agency Request process. This process allows the Colorado Department of Health Care Policy and Financing, the state Medicaid agency, to request access to the Medicare FFS claims data on behalf of the Colorado APCD. The data use agreement under this program allows a broad range of research uses. CIVHC is able to process the data and store it in their data warehouse alongside their commercial and Medicaid data. CIVHC also completed CMS phase 1 QE certification, was designated a QE, and is now working with their data vendor to demonstrate compliance with CMS's security requirements and complete the process in order to receive data.

Q Corp is receiving data through the QE program. Q Corp has been a QE since 2012 and has reported quality measures using the Medicare FFS data since 2014. Through updated rules for using QE data implemented as part of MACRA in 2015, Q Corp's use of the data now allows custom analytic projects, including private reports to clinics. This enabled Q Corp to pilot Medicare TCOC clinic reporting using QE data.

Since Medicare FFS claims data is available through multiple avenues, regions should determine the best path for each specific proposal. Each avenue involves a thorough review of privacy and security standards to ensure the entity receiving the data will treat it with the requisite care. Each region has proven to CMS that they are capable of handling the data in a secure fashion and are working hard to produce valuable results for their communities.

Other Medicare FFS Cost Reporting

The Quality and Resource Use Report (QRUR) produced by CMS is one existing tool for medical groups to understand their performance for the Medicare FFS population. Currently, CMS uses these reports to calculate a group's value-based payment modifier for Medicare Physician Fee Schedule reimbursements, the results are aggregated at the Tax Identification Number (TIN) level. Benchmarking information is reported at a national level, making it hard for groups to make meaningful comparisons between themselves and their peers limiting the ability to understand regional variation and actionability. These reports reflect data for the Medicare FFS population only; similar reports do not exist for Medicare Advantage, commercial or Medicaid populations from CMS. Indeed, the TCOC reports and the QRUR reports are quite complementary, allowing for greater visibility into comparative reporting and trends.

"In the primary care world, there is a potential shortage of primary care providers and burnout is one factor...[we] have thrown a lot of quality issues in addition to patient care at providers, now cost of care will be thrown at them as well. Data must be very carefully reviewed to determine what is actionable and what can be done to not to burn out providers."

— Michael Whitbeck, Northwest Primary Care

TCOC Reports	*Quality and Resource Use Reports (QRUR)*
Compares performance to regional benchmark	Compares performance to national benchmark
Reporting level varies, but can be at clinic level	Reported at the Tax ID Number level
Focuses on identifying variation	Shows practice cost and quality assessments
Shows Total Cost Index and Resource Use Index	Neutralize some variation in price
Produced by local entities	Produced by CMS

Each of the workgroup regions has successfully produced TCOC reports on a multi-payer commercial population. While these reports are highly valuable to clinics, they only show one segment of their patient population. By using the same cost reporting methodology for Medicare as for commercial populations, the regions are able to show clinics consistent information across multiple patient segments. This information can be compared side-by-side to gain a broader understanding of the true costs associated with treating their patients. It is worth mentioning that some regions are also working to produce similar reports for the Medicaid population, but given the differences among states' Medicaid plans, standardization is difficult. The Medicare TCOC reports include regional benchmarks. These allow practices to compare themselves to their peers in the same geographic region. Together, the commercial and Medicare reports provide clinics with more information to make strategic practice improvement decisions.

Technical Considerations

While HealthPartners, the measure developer, does not make specific recommendations on adjustments to the TCOC methodology for the Medicare and Medicaid populations, they do recommend reviewing differences in cost, utilization, enrollment patterns, and provider networks to ensure reliability and validity of the results. Among the changes that may be needed are:

- Applying a different risk adjustment methodology
- Using a different attribution methodology
- Assessing inclusion of Pharmacy
- Evaluating populations

Risk Adjustment

It is important to consider risk adjustment methodologies carefully. Each region has decided to stay consistent with the risk adjuster used to produce their commercial TCOC reports. MHMC is using the Optum Symmetry Episode Risk Groups (ERGs) and CIVHC and Q Corp are both using the Johns Hopkins Adjusted Clinical Groups (ACGs). Different populations have different condition profiles that may affect a risk adjuster's effectiveness. An adjustment methodology that works well for a high illness burden population like Medicare may not work well for the commercial population. Additionally, no risk adjuster is able to account perfectly for the health status and other factors of a given population. Each risk adjustment methodology has trade-offs which need to be evaluated for acceptability within a region.

"The greatest health care cost incurred in a person's life is frequently in the last year of life; clinicians not having cost data are not seeing the whole picture. Should cost be part of those discussions? What are the constraints; the ethical best practices?"

— Dr. Richard Shonk, The Health Collaborative

Attribution

The methodology for attributing patients to providers is another key consideration. For the pilot, each region is closely following their standard attribution methodology. This approach allows more consistent patient attribution to clinics between the commercial and Medicare reports, which in turn supports consistent messaging as the reports are discussed with clinics. However, because Medicare and commercial claims are filed differently, using the same attribution methodology does introduce the risk of some inconsistencies.

These methodologies, while varying slightly among sites, all involve using a standard database of primary care providers, which may include MDs, DOs, PAs and NPs, and the clinics at which they work. These methodologies

do not take into account specific considerations for Federally Qualified Health Centers or Rural Health Centers. Both of these types of clinics have different billing practices, which can affect the way their visits are identified as primary care. CMS has developed an attribution methodology for the Medicare FFS population which takes these factors into consideration, and the pilot sites are assessing it for future Medicare TCOC reporting.

Pharmacy

One large area of difference between commercial reporting and Medicare reporting is pharmacy. The Medicare pharmacy benefit (Part D) is separate from medical benefits (Parts A & B). While CMS releases the Medicare Part A & B data with a three month claims lag plus six weeks of processing, the Part D data is released separately, and has an 11 month delay. In addition, the variation among Medicare Part D plan designs presents additional complexities to measuring Medicare pharmacy costs. As a result, each region determined that it would be prudent not to include pharmacy data in the initial Medicare TCOC reporting.

Population Considerations

For a variety of reasons including benefit design, payment structure, and population characteristics, it is extremely important to report TCOC separately for the commercial, Medicare and Medicaid populations. While providers and clinics may prefer to receive a report showing them cost information on their entire patient panel, due to the above noted differences, combined reporting would not be meaningful or valid. Each region decided to segment the Medicare population based on entitlement category and will only report on age-based Medicare enrollees (those over 65 who are not in other categories), excluding the dual-eligible, Disabled and End Stage Renal Disease populations. These excluded populations have very different demographics, spending and usage characteristics, making meaningful cost comparisons difficult.

Not all Data are Created Equal

CIVHC learned that it is imperative to ensure the data vendor is processing all data fields required for this work, and making those fields available. The Medicare data are quite different from commercial and Medicaid data, and some fields needed for the TCOC analysis of the Medicare population are not part of commercial data sets. Entitlement category, for example, is needed in order to exclude subpopulations (dual-eligible, disabled and End Stage Renal Disease) from the analysis. Reviewing all available data fields before data processing begins is essential to ensuring the delivery of viable results. Due to issues with inconsistent exclusion of data fields, CIVHC will not be able to report to clinics, but will be reviewing the data and ensuring accuracy while they prepare to produce reports in the future.

Feedback from the Field

Q Corp produced 45 reports and had informal interviews with three medical groups to get feedback. Here are some key takeaways that will be considered as the report is further refined:

- *There is value to using the report template/ format for both the commercial and Medicare FFS populations when reporting TCOC.*
- *Medicare patients are more likely to be attributed to specialists and therefore might be missing from the report. We need further understanding of this attribution issue.*
- *Clinics understood why exclusions were made for dual eligible and ESRD patients.*
- *There were mixed reactions from clinics about the validity of the risk adjustment and this is an area that should be delved into further.*
- *Not having pharmacy data was a gap but delayed pharmacy data would have limited value.*
- *There is limited experience and familiarity with the QRUR reports. However, clinics that participate in the CMS Comprehensive Primary Care program are much more familiar with the Medicare FFS data they receive, although these data lacks indices.*

Q Corp has learned a number of lessons through the pilot, most notably that working with a national data source vs. a local one can make it more difficult to identify the source of data problems, particularly if a region relies on a data vendor to process CMS data. This introduces further delays between receiving the data and being able to create clinic-level reports.

MHMC has learned similar lessons as the other regions regarding data processing and report generation. They also discovered that not including pharmacy data has a more significant impact than originally anticipated. While all regions were aware that the specific pharmacy measures would not be able to be included in these reports, MHMC discovered this missing data also affects chronic disease identification, causing an under identification of these diseases, and risk adjustment. The reports are slightly less robust without this information.

Resources

For information about the HealthPartners' Total Cost of Care framework visit their website at https://www.healthpartners.com/hp/about/tcoc/index.html.

The Research Data Assistance Center (ResDAC) is a CMS contractor (Contract Number HHSM-500-2013-00166C) that provides free assistance to academic, government and non-profit researchers interested in using Medicare and/or Medicaid data for their research. ResDAC is staffed by a consortium of epidemiologists, public health specialists, health services researchers, biostatisticians, and health informatics specialists from the University of Minnesota. For more information about ResDAC visit their website at http://www.resdac.org/.

The CMS Qualified Entity (QE) Program (also known as the Medicare Data Sharing for Performance Measurement Program) enables organizations to receive Medicare claims data under Parts A, B, and D for use in evaluating provider performance. Organizations approved as QEs are required to use the Medicare data to produce and publicly disseminate CMS-approved reports on provider performance. QEs are also permitted to create non-public analyses and provide or sell such analyses to authorized users. In addition, QEs may provide or sell combined data, or provide Medicare claims data alone at no cost, to certain authorized users. Under the Qualified Entity Certification Program (QECP), CMS certifies

QEs to receive these data and monitors certified QEs. To learn more about the CMS QE Program visit their website at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/QEMedicareData/index.html.

More information on state agency research Data Use Agreements can be found on the CMS website: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Privacy/States.html.

For more information about the NRHI Getting to Affordability initiative on Total Cost of Care, visit our website at http://www.nrhi.org/work/multi-region-innovation-pilots/tcoc/ or for a sample Clinic Medicare Fee for Service Report contact us at gettingtoaffordability@nrhi.org.

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PRIMARY AUTHORS

Oregon Health Care Quality Corporation (Q Corp)

Maine Health Management Coalition (MHMC)

Center for Improving Value in Health Care (CIVHC)

CONTRIBUTORS

Network for Regional Healthcare Improvement (NRHI)

Compass Health Analytics

Midwest Health Initiative (MHI)

Minnesota Community Measurement (MNCM)

HealthInsight Utah (HI) in partnership with the Utah Office of Healthcare Statistics

Maryland Health Care Commission (MHCC) in partnership with The Hilltop Institute

ABOUT THE NETWORK FOR REGIONAL HEALTHCARE IMPROVEMENT (NRHI)

The Network for Regional Healthcare Improvement is a national organization representing over 35 regional multi-stakeholder groups working toward achieving the Triple Aim of better health, better care, and reduced cost through continuous improvement. NRHI and all of its members are non-profit organizations, separate from state government, working directly with physicians, hospitals, health plans, purchasers, and patients using data to improve healthcare. For more information about NRHI, visit www.nrhi.org.

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