Clinic Comparison Report FAQs
Commercial

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 Q Corp's 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 third year Q Corp is sending out these reports to primary care clinics across Oregon.

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/portal; however, the Clinic Comparison Reports show quality results for the specific line of business shown in the report (i.e., only Commercial). The reports allow clinics to review cost and utilization and make connections to the quality of care that patients are receiving.

What Clinic Comparison Report content will be reported to other audiences?
Q Corp believes that in order to reduce health care costs, all stakeholders must have access to more information about the cost of care. Q Corp has committed to sharing information with a broader audience after two rounds of private reporting.

- **Health Plans:** In 2016, Q Corp shared Clinic Comparison Reports with the health plans (Moda Health, PacificSource Health Plans, Providence Health Plans, Regence BlueCross BlueShield of Oregon, and Tuality Health Alliance) that voluntarily contributed their cost data to this effort. The Cost of Care Steering Committee approved this important step in testing the measures and working collaboratively to address health care costs in Oregon. The health plans are using this information to support their quality improvement efforts, and to better understand how clinics are performing across a wider population than the health plan's membership. While the methodology was still being validated, Q Corp requested that the data not be used for contracting purposes.
- **Public Reporting:** Q Corp currently reports quality and utilization metrics on a public website: http://q-corp.org/compare-your-care. For the newer cost measures, Q Corp has committed to two rounds of private reporting for testing and validating the measures. Once Q Corp and our stakeholders have determined that measures are valid for public reporting, we will release clinic level scores to the public. Clinic level results will be reviewed by Q Corp's Cost of Care Steering Committee prior to reporting.

How are these reports different from the Clinic Comparison Reports I received in 2016?
These reports cover the period between January 2016 and December 2016, i.e. calendar year 2016, providing more up-to-date information.

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 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 commercial claims data from the Q Corp claims database, which includes claims data on 83% of the fully insured population and 25% of the self-insured population in Oregon, and uses a 12-month reporting period (January–December 2016) with three months run-out.

Approximately what percentage of my clinic's population is covered by these reports?
For Oregon overall, Q Corp is calculating the Total Cost of Care measures for about 35% of the commercial population, excluding patients covered by Medicaid and Medicare. The cost measures are limited to patients between 1 and 64 years old, and some carriers are not allowing us to use their data for cost reporting. Your clinic may have a lower percentage of its total population represented in this report due to commercial payer mix or a higher percentage of Medicare and Medicaid patients.

How are patients and their costs attributed to my clinic?
- Clinic reports are limited to commercial 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 are able to review their lists of attributed patients upon request.
- Only patients assigned to PCPs in Q Corp's provider directory are included. If a patient received care solely from specialists, urgent care clinics or other providers not included in the provider directory, the patient is 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 commercially-insured patients ages 1–64 who were enrolled in coverage for at least nine months are included.
- There are separate reports for pediatric (ages 1–17) and adult (ages 18–64) populations.
- Annual costs over $100,000 for any individual patient are excluded.

Data FAQs

Why is the data from 2016?
Multiple factors affect the timing and release of clinic reports.
- **Claims Lag:** The 2017 clinic reports reflect commercial claims data incurred January 2016 through December 2016 and paid through March 2017. There is a lag (i.e., run-out) of three months beyond the completion of the reporting period.
- **Data Processing:** Following the completion of claims run-out, the data suppliers 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. Finally, the reports are produced.

Why are my clinic's results different from the Clinic Comparison Report I received in 2016?
For the cost indices (TCI, RUI), clinics will see changes from one reporting period to the next. The cost indices reduce variation by limiting to adult or pediatric populations, by capping costs for any individual and by limiting to a commercial population, but variation due to other factors still exists. Changes in the services patients use for a particular condition or the price of those services will cause changes in the costs reported. Risk adjustment accounts for much of the variation in expected costs, but not all of it.

How are these reports different from performance reports clinics might be getting from health plans?
Data in the Q Corp reports is aggregated across multiple commercial health plans, allowing a clinic to understand its data and identify practice patterns across a larger group of patients.

Why was a minimum panel size of 600 used for reporting?
HealthPartners®, the developer of the Total Cost of Care framework we are using to report cost, has tested the measures at various population sizes and determined that a minimum panel size of 600 attributed patients is necessary for reliable cost comparisons for process improvement. This is also the threshold at which the National Quality Forum (NQF) endorsed the measures.

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 commercial data?
The HealthPartners® Total Cost of Care methodology has only been endorsed by the NQF for the commercial population. Q Corp has been working with several regional and national partners to develop specifications for running the measures for the Medicare Fee for Service population and will release reports for that population in early 2018. We are also exploring the feasibility of creating similar reports for the Medicaid population.

How are the items ordered in the PMPM by service category charts?
Service categories are arranged in descending order based on the Oregon Average PMPM.

What is the "Oregon Average" that is shown in the report?
The Oregon Average is calculated based on the combination of all the clinic panels in the report release. Separate averages are calculated for the Adult and Pediatric reports.

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 and conditions are shown in order by highest cost.

Why are all the inpatient, outpatient, professional and pharmacy costs attributed to just PCPs?

- The HealthPartners® methodology uses a patient-centered attribution approach that includes all care given to a patient.
- While PCPs 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://q-corp.org/sites/qcorp/files/Total%20Cost%20of%20Care%20-%20Technical%20Appendix%20April%202016.pdf

What is the Quality Composite score?

Q Corp and the Cost of Care Steering Committee have determined that it is critical that any public reporting of cost information be accompanied by quality information. In order to make interpretation of information easier, Q Corp developed a Quality Composite measure that includes an equal number of adult and pediatric measures. More information on the Quality Composite methodology can be found online at: http://www.q-corp.org/sites/qcorp/files/Q%20Corp%20Composite%20Quality%20Measure%20Methodology%20Dec%202017.pdf

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 current round of funding allows for limited development of training and technical assistance for clinics with using the reports in meaningful ways. While these reports are specific to commercial payers, HealthInsight Oregon has some funding available to provide assistance to 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?

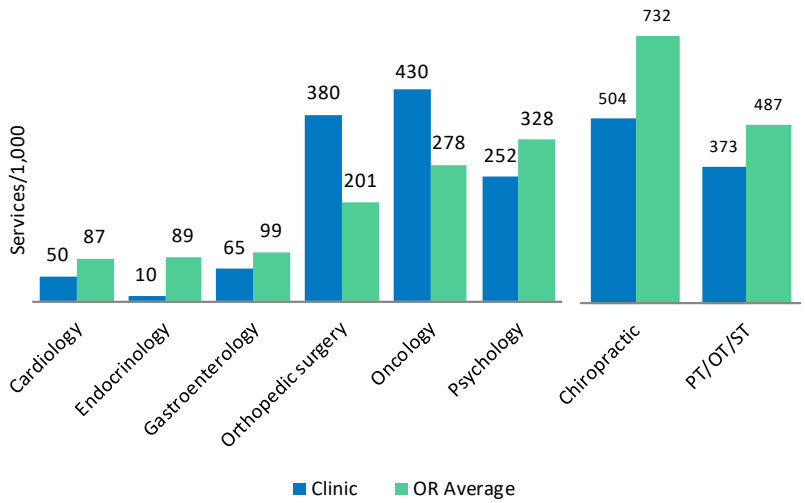
Examples of where and how clinics have used the clinic report information:

1. Suppose that, on page 2 (see sample results to the right), your clinic's maternity RUI indicates average resource use and the TCI indicates higher-than-average cost. This may lead you to seek out lower-cost, but still high-quality, facilities that your patients can use for maternity care.

Professional PMPM by Service Category

	Clinic Adj PMPM	OR Average PMPM	TCI	= RUI	x Price Index
Evaluation & Management	**$24.98**	$28.31	**0.88**	0.75	1.18
Surgery & Anesthesia	**$25.27**	$19.56	**1.29**	1.22	1.06
Preventive Screenings	**$22.40**	$14.39	**1.56**	1.38	1.13
Psychiatric Visits	**$14.94**	$11.45	**1.30**	1.37	0.95
Physical Therapy & Rehab	**$6.85**	$11.35	**0.60**	0.60	1.01
Lab & Pathology	**$14.62**	$10.59	**1.38**	1.11	1.24
Oncology & Chemotherapy	**$5.78**	$10.13	**0.57**	0.61	0.93
Preventive Visits	**$6.80**	$7.88	**0.86**	0.87	0.99
Endoscopic Procedures	**$7.73**	$7.77	**0.99**	0.92	1.08
Advanced Imaging	**$7.97**	$6.70	**1.19**	1.17	1.02
Emergency Department Visits	**$1.53**	$3.91	**0.39**	0.39	1.00
Echography	**$2.88**	$3.29	**0.88**	0.62	1.42
Chiropractic Treatments	**$2.92**	$2.75	**1.06**	1.19	0.89
Durable Medical Equipment	**$1.73**	$2.01	**0.86**	0.86	1.00
Standard Imaging	**$1.34**	$1.87	**0.72**	0.62	1.16
Cardiac Imaging & Tests	**$5.82**	$1.69	**3.44**	2.89	1.19
Preventive Vaccinations	**$2.43**	$1.69	**1.44**	1.23	1.17
Other Professional Services	**$37.99**	$34.57	**1.10**	1.03	1.07
Other Services	**$13.62**	$14.56	**0.94**	0.91	1.03
Total	**$207.60**	$194.45	**1.07**	0.97	1.10

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

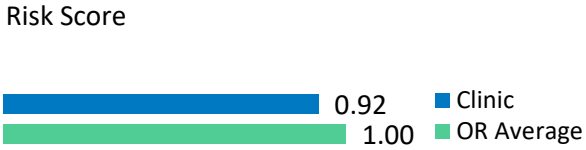


3. Are there any outpatient costs (page 3) that are surprising? If you are looking at reports across clinics owned by the same medical group, are there differences in the patient populations that are being treated?

Outpatient Facility PMPM by Service Category

	Clinic Adj PMPM	OR Average PMPM	TCI	= RUI	Price x Index
Operating Room	**$56.54**	$52.91	**1.07**	0.98	1.09
Emergency Department	**$13.73**	$19.53	**0.70**	0.60	1.18
Other Outpatient Facility	**$0.87**	$6.41	**0.14**	0.10	1.31
Lab & Pathology	**$2.76**	$6.67	**0.41**	0.33	1.26
Oncology & Chemotherapy	**$1.45**	$7.13	**0.20**	0.18	1.13
Advanced Imaging	**$4.12**	$7.96	**0.52**	0.67	0.77
Preventive Screenings	**$3.67**	$6.00	**0.61**	0.83	0.73
Surgery & Anesthesia	**$1.50**	$6.23	**0.24**	0.17	1.41
Physical Therapy & Rehab	**$0.59**	$4.14	**0.14**	0.16	0.91
Cardiac Imaging & Tests	**$1.03**	$3.07	**0.33**	0.33	1.02
Echography	**$0.13**	$0.78	**0.16**	0.01	26.61
Total	**$86.39**	$120.83	**0.71**	0.72	1.00

4. 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.

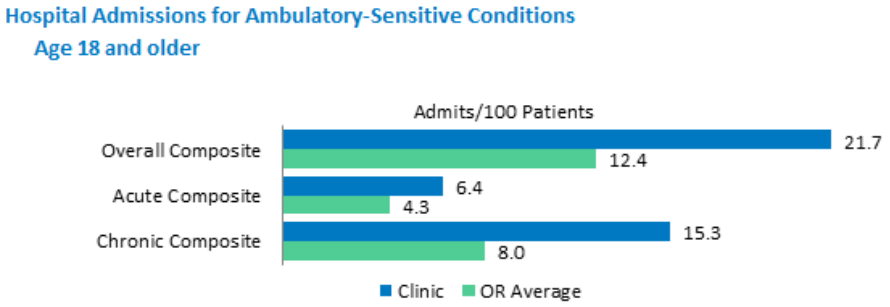


5. Suppose page 4 shows your clinic has high costs on imaging due to high CT utilization and a higher price, while MRI is lower price and has higher-than-average resource utilization. Are alternative locations for CT services available? It may be valuable to understand why more services are being delivered than the state average. Do you have a lot of patients with cancer? Are there any unnecessary or duplicative services you could avoid? Could the orthopedic surgeons to which your practice refers be using higher-cost facilities or requesting multiple images?

Radiology (Outpatient Facility and Professional Services)

	Clinic Adj PMPM	OR Average PMPM	TCI	= RUI	Price x Index
Standard Imaging	**$9.67**	$11.15	**0.87**	1.01	0.86
Advanced Imaging (e.g., MRI, CT, PET)	**$8.77**	$7.90	**1.11**	1.19	0.93
Cardiac Imaging & Tests	**$5.00**	$4.86	**1.03**	1.12	0.92
Echography	**$0.33**	$0.44	**0.75**	1.00	0.75

6. Is your practice's Hospital Admissions for Ambulatory-Sensitive Conditions (page 4) 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.



7. "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 heart failure in your practice? Are more or fewer resources being used than the state average? The sample clinic report below 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?

Chronic Condition Patient Summary

	Clinic		OR Average				
	Patients	Adj PMPM	PMPM	TCI	=	RUI	x Price Index
Cancer	151	**$1,228.56**	$1,834.11	**0.67**		**0.65**	1.02
Ischemic Heart Disease	75	**$619.30**	$1,659.26	**0.37**		**0.41**	0.90
Chronic obstructive pulmonary disease and bronchiectasis	130	**$1,379.57**	$1,534.82	**0.90**		**0.73**	1.23
Heart Failure	89	**$1,459.52**	$1,529.01	**0.95**		**0.92**	1.04
Diabetes	281	**$800.07**	$1,184.04	**0.68**		**0.70**	0.97

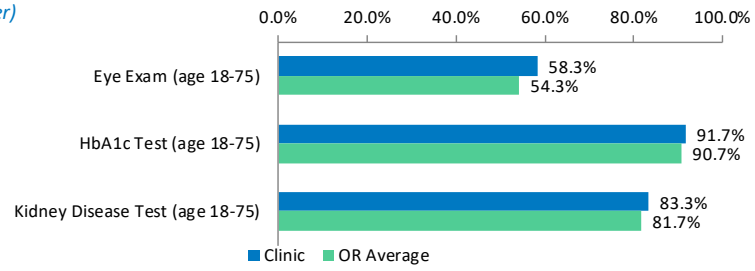
8. If your practice has higher-than-average ED rates (page 4), this may indicate an opportunity to educate patients on primary care access and appropriate emergency room use. Are there alternative primary care access points that could encourage improved primary care coordination?

Emergency Department Utilization *
(lower is better)

	Clinic	Benchmark
ED Visits/1000	**260.1**	131.8

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

Comprehensive Diabetes Care
(higher is better)



10. Suppose page 8 shows that your clinic has a higher-than-average resource use for brand name prescriptions. Are there opportunities to prescribe generic drugs in place of brand drugs?

Pharmacy by Category

	Clinic Adj PMPM	OR Average PMPM	TCI	=	RUI	x Price Index
Single Source Brand	**$43.40**	$41.34	**1.05**		1.07	0.98
Generic	**$19.17**	$21.23	**0.90**		0.94	0.96
Multi-Source Brand	**$5.02**	$4.82	**1.04**		1.03	1.01
Total	**$67.59**	$67.39	**1.00**		1.01	1.00