HealthPartners®

2025 Hospital and Surgery Center Cost Assessment

Methodology Overview Background:

The objective of HealthPartners' hospital and surgery center cost assessment is to compare the cost of a facility including the inpatient and outpatient services provided. The overall cost index is case mix adjusted (DRG, APC, RVUs) and place of service case mix adjusted (IP vs. OP). The cost index for each facility is indexed to the aggregate 13 county metro Total Cost Index.

Criteria Applied to Analysis

1. Dates of service: 1/2023 to 12/2023
2. Outliers excluded
3. Commercial product
4. COB admissions excluded

13 County benchmark

1. Minnesota counties included in the benchmark – Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington and Wright
2. Wisconsin counties included in the benchmark – Pierce and St. Croix

Cost Assessment Methodology

1. Facility case mix is adjusted by DRG for inpatient admissions and APC and RVUs for outpatient visits.
2. The inpatient/outpatient case mix is adjusted by facility. (the cost index from IP and OP will be weighted by the percent of business in each component by facility)

Cost Assessment Details

1. Hospital admission and outpatient encounter service dates between 1/2023 and 12/2023
2. Outliers excluded
    - All admissions and outpatient encounters with TCI's outside of the normal range are excluded
    - Admissions with a LOS outside the normal range for the same DRG are excluded
3. Commercial products included
    - Includes fully insured and self-insured
4. COB admissions and encounters excluded
    - Only admissions and encounters that are paid 100% by HealthPartners are evaluated
5. Facilities with a minimum of 30 inpatient admissions or 200 outpatient encounters are evaluated

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2024 Primary Care Cost Assessments

Cost Assessment Methodology Overview

Based on NQF endorsed Total Cost of Care Measure

1. Only providers that meet minimum number of attributed members are included.
2. Providers with less than minimum number of attributed members are excluded, and follow default rules.
3. Cost tier placement is based on the provider specific risk adjusted PMPM indexed against the overall risk adjusted PMPM for all 13-county metro primary care providers.

Criteria Applied to Analysis

1. Attributed Provider
2. Outlier members truncated
3. ACG Risk adjustment applied
4. Commercial product only
5. Claims dates between January 2022 and December 2022
6. Babies age less than one and members 65 and over are excluded
7. Members must be continuously enrolled for a minimum of 9 months to be included

13 County benchmark

1. Minnesota counties included in the benchmark – Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington and Wright
2. Wisconsin counties included in the benchmark – Pierce and St. Croix

Further explanations of the above criteria:

1. Attributed Provider
   A member is assigned to a medical group that provides the majority of the primary care office visits
   - Office visits are identified though the place of service code that indicates a clinic site (11, 50)
   - Primary care specialty is determined by the servicing physician
   - Primary care specialties include: family practice, internal medicine, pediatrics, geriatrics, nurse practitioner, physician assistant and OB/GYN
   - Individuals that do not have a primary care office visit are excluded

2. Outlier members truncated
   - A member's combined medical and pharmacy costs are truncated at $125,000

3. ACG Risk adjustment
   - Adjusted Clinical Groups (or ACGs) were developed by Johns Hopkins University and allow comparisons between populations with varying illness burdens.
   - A member's medical claims are ACG risk adjusted based on diagnoses, age, and gender

Dollar Ratings Description – For 2024, overall dollar sign ratings are calculated for Primary Care, and Hospitals and Surgery Centers. Dollar sign ratings are based on each provider's TCI compared to set thresholds as described below.

Thresholds – Dollar ratings are assigned as follows.

Total Cost Index (TCI)	Dollar Rating
TCI <0.90	$
0.90 <= TCI < 1.0	$$
1.0<= TCI < 1.1	$$$
TCI >= 1.10	$$$$

2025 Quality Assessments

Principles for Assessing Primary Care and Hospital Quality Performance

Quality assessments are conducted based upon the following over-arching principals:

- Performance assessment should represent a reasonable cross section of conditions or procedures within the usual scope of practice
- Performance assessment should sufficiently reflect the spectrum of care (e.g., prevention and health promotion, chronic illness, acute care and procedures (diagnostic and surgical).
- Performance assessment should be assessed using a sufficient combination of cost/efficiency, patient experience, process, structural, and risk-adjusted outcome measures
- Performance assessment set of metrics should reflect multiple available data sources to incorporate all perspectives and viewpoints (external, internal, chart, admin, hybrid, self-report, patient exp, etc).
- Quality domains should reflect the strength and breadth of the underlying measures and scope of practice of the provider.
- The significance and comparative performance benchmarks as calculated by external measurement organizations will be leveraged for determining performance. This means comparative groups will vary by measure.
- Performance assessments should be shared with the physicians or hospitals prior to public reporting with a reasonable comment period to address any provider concerns.
- Significant provider and member feedback & complaints should be addressed within a reasonable time period.
- Complete descriptions of all measures, criteria, algorithms, methodologies, and data sources should be made available to all stakeholders.
- Physicians and consumer's feedback and collaboration regarding the design, selection of measures, methodology, and display formats will be considered through appropriate advisory and collaboration forums.

Measure Inclusion in Quality Assessment scoring

Measures are selected for Quality Assessments based upon the following measurement selection principles:

- Measures selected should represent a reasonable cross section of conditions or procedures within the

usual scope of practice of a provider group or hospital.
- Measures selected should have followed HealthPartners' Measurement Development Policy reflecting reliable, valid based on sound scientific evidence, and accurate and timely as possible.
- Measures should be based on where there has been consensus among stakeholders and when possible, predictive of overall quality performance.
- Measures should be important and relevant to stakeholders, including physicians, consumers, health plans, and purchasers.
- Measures should reflect appropriateness and/or processes of care that provider groups or hospitals can influence or impact.
- As available, measures selected should be endorsed by nationally or locally recognized quality measurement organizations such as NQF, CMS, and MNCM, etc. HealthPartners will supplement with internally developed or provider self-reported measures as needed.
- Measures of appropriateness of care should be utilized whenever possible.

Provider Inclusion in Quality Assessment scoring

Providers are included in quality assessment scoring if they meet the following criteria:

- Members must have direct access to the provider
- Providers that primarily serve PMAP members are excluded
- Measurement results for the provider must represent the spectrum of quality measures reported by MNCM.
    - Providers must have at least 30% of available measures in order to be included in the overall quality assessment.

Provider Mergers and Definitions

- Due to the fact that measurement & system changes typically lag & require time to reflect merged providers, adjustments to cost and quality measures may need to be accommodated to provide the most accurate profiles.
    - When possible, quality results will be rolled up at the measure level, to reflect the current merged provider.
    - In some cases system limitations may only allow for the display of one set of cost/quality data for a merged provider. In this case, the larger entities information will be displayed.
- Due to the fact that two measure sources are used by MNCM – measures submitted directly by the providers and measures submitted by the health plans on behalf of the providers – there can be differences in provider definitions used by those sources.
    - In these cases, quality results may be rolled up at the measure level to create an overall quality result for the provider based on the highest level definition submitted.

Provider Individual Measures

Measures reported by providers:
- Adolescent Depression: Follow-up PHQ-9/9M at 12 Months
- Adolescent Depression: Remission at 12 Months
- Adolescent Mental Health and/or Depression Screening
- Adult Depression: Follow-up PHQ-9/9M at 12 Months
- Adult Depression: Remission at 12 Months
- Colorectal Cancer Screening
- Optimal Asthma Control - Adults

- Optimal Asthma Control - Children
- Optimal Diabetes Care
- Optimal Vascular Care

Measures reported by health plans:

- Avoidance of Antibiotic Treatment in Acute Bronchitis/Bronchiolitis
- Breast Cancer Screening
- Cervical Cancer Screening
- Childhood Immunization Status (Combo 10)
- Chlamydia Screening in Women
- Controlling High Blood Pressure
- Diabetes Eye Exam
- Follow-up Care for Children Prescribed ADHD Medication
- Immunizations for Adolescents (Combo 2)
- Osteoporosis Management in Women Who Had a Fracture
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD

Detailed results by provider are available on MNCM's website: https://mncm.org/reports/#community-reports. Results for measures submitted by providers (reflecting 2023 dates of service) were shared in April 2024 with providers including performance compared to the statewide average.

Results will also be published in MNCM's 2023 Health Care Quality Report anticipated to be released end of year 2024.

Provider Star Rating Methodology

Using MNCM reported measures, 21 individual quality measures are included in the assessment (see Individual Measures above) to determine overall quality performance. Providers must have measure results for at least 30% of measures to be included in the quality assessment. The star rating is based on the number of measures for which a provider is eligible and performance for each measure is compared to the statewide average. The rate and 95% confidence interval (lower and upper) are used to define 'above', 'average', and 'below' ratings.

- 4 stars - ≥50% of measures statistically above average
- 3 stars - 70% of measures statistically above average or average
- 2 stars - 51% of measures statistically above average or average
- 1 star - 50% of measures statistically below average

Hospital Quality Scoring Specifics

Hospital Measures sourced from:

- Centers for Medicare and Medicaid Services Outcomes Measures
- Centers for Medicare and Medicaid Services HCAHPS Patient Satisfaction (experience) Surveys

Overall Hospital Quality Star Ratings

The Overall Hospital Quality Star Rating measure groups are:

- Mortality
- Safety of Care

- Readmission
- Patient Experience
- Timely and Effective Care

Resource details of CMS's methodology, rating calculation, and individual reported measures included can be found here: https://qualitynet.cms.gov/inpatient/public-reporting/overall-ratings/resources

Detailed hospital results can be found here: https://www.medicare.gov/care-compare/?providerType=Hospital

Hospital quality assessments based on CMS calculated star ratings and reflected as: 4 stars (4-5 stars), 3 stars, 2 stars, 1 star performance.

Quality Tier Definitions

- The following tier definitions will be used to designate providers and hospitals as tier 1 or tier 2 for quality.
  - 2 Tier Model
    - Tier 1: Quality star rating = 3 or 4
    - Tier 2: Quality star rating = 1 or 2
  - 3 Tier Model
    - Tier 1: Quality star rating = 4
    - Tier 2: Quality star rating = 3
    - Tier 3: Quality star rating = 1 or 2

Principles for Determining Provider/Hospital Benefit Levels/Tiers

Final Tier placements are determined based upon the following over-arching principals:

- Cost and quality must be available at the comparative level (hospital or primary care) for tiering application.
- In general, better than average quality and cost performance is required to achieve tier 1 placement.
- Cost determines tier placement when provider volume in quality measures is not sufficient for comparative assessments.
- Tier placements may be adjusted due to access concerns related to geographic location and capacity. To avoid barriers to preventive services for Primary & OB/GYN care, a reasonable proportional split of historic episodes will help serve as a guide when considering tier adjustments.
- Public displays for will consumer transparency illustrate actual performance regardless of Tier placement.
- Primary care providers who do not submit to Minnesota Community Measurement will receive the lowest Tier placement.
- Employer groups may customize HealthPartner's standard Tier placements.
- Tier placements may be adjusted to recognize highly-specialized providers/facilities serving unique populations or conditions/procedures.

Final Tier Definitions

- 2 Tier Method- Primary care providers and hospital Tier 1 determined by average and better cost &

quality (index TCI <=1 for cost and quality star rating = 3 or 4 for quality)

- 3 Tier Methodology

  Primary Care Providers and Hospital
  - Tier 1 determined by TCI <= 1, Quality = 4 stars
  - Tier 2 determined by TCI <= 1.05, Quality =3 stars
  - Tier 3 determined by TCI > 1.05, Quality = 1 or 2 star

Geographic Assessment

The east/west geographic distribution of Tier 1 providers is assessed to ensure reasonable access to Tier 1 providers by specialty and hospital. If there is limited access to Tier 1 providers, additional providers may be moved into Tier 1 using the following process:

- Only providers that meet the quality requirements to be eligible for Tier 1 are considered
- Of these providers, identify the provider in the geographic area that has the next best TCI— this provider would be moved into Tier 1.
- Identify any providers outside of the geographic area that have a TCI better than the group moving into Tier 1 and meet the quality requirements to be eligible for Tier 1. These identified groups would be moved into Tier 1 as well.