A commentary relating to *Measuring and Assigning Accountability for Healthcare Spending*

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HealthPartners®

Overview

The ongoing national conversation about measurement of total cost of care and resource use in health care is important. It is a critical issue and one that merits the full engagement of all involved parties to arrive at the best possible solutions.

In 2012, the National Quality Forum endorsed the Total Cost of Care (TCOC) and Total Care Relative Resource Value (TCRRV or resource use) measures developed by HealthPartners over an 18-year period. The measures have been released into the public domain and we have had many opportunities to discuss this methodology in detail with many physician and other groups, particularly with the nearly 100 licensees across the country who have or are adopting our measures free of charge for use in their own organizations. These discussions continue to expand understanding of the central, real-world, practical challenges we face in this arena, and they contribute to new approaches and practical solutions.

Harold D. Miller of the Center for Healthcare Quality and Payment Reform, in a recent paper published on his organization's website, offers observations on measuring cost. Among many contemporary commentaries on this topic, his paper presents a broad, theoretical overview of cost analysis methodologies and, although it is not an analysis of HealthPartners' NQF-endorsed methodology *per se,* he offers some comments on our methodology. Those familiar with both Mr. Miller's work and ours may have questions as to how our perspectives may or may not align. While the overall goals are similar, there are some areas of difference.

In this commentary we summarize three of these differences pertaining to 1) attribution, 2) a use of measures, and 3) measure construction. As always, we welcome direct inquiries from those who may wish to explore these or other matters.

Distinction #1. A patient-centered approach to attribution

We advocate and use a patient-centered attribution approach that focuses on care of the whole person, not as a subdivided patient with care attributed to multiple providers.

The patient-centered approach is in sync with reform-related structures such as accountable care organizations (ACOs), medical homes, health care homes and others, which have the aim of acting as a coordinated group on behalf of a patient. This viewpoint allows alignment of reforms and encourages latitude for innovation. A provider-centric approach to attribution – one that parcels care from the perspective of what a physician orders and or renders – runs counter to this alignment.

We've adopted a patient-centered approach for a number of reasons, specifically:

Provider acceptance: We have found that patient-centered attribution is accepted by providers as they understand and learn about it within the context of payment reforms and their involvement in the development of the model. Attribution is standardized and widely accepted by providers in our community because they helped to develop the method and can review results for accuracy when compared to medical records. In an environment of open-access products and consumer choice, claims-based attribution models are the link to understanding care-seeking behaviors and who is directing it.

Standardization: Attribution techniques are guidelines in our NQF-endorsed measure. Health care is local and the guideline approach allows a local community to collaborate on what makes sense for the market and what is acceptable to its providers and other stakeholders. We have done this in Minnesota. Our analysis (cited in Miller, citation #34) was generated to study and illustrate that while we had different attribution models among payers, they didn't yield substantially different results. The paper was a result of a working study to enable collaborative work to harmonize. We looked at this as a community opportunity to standardize, and we have achieved it working with providers, payers, consumers, purchasers and others in a collaborative manner.

Collaboration and transparency: Providers don't have full control but they can influence and develop solid partnership and processes with colleagues, specialists and hospitals to ensure care is well coordinated. This is the promise of medical homes, ACOs and other care redesigns. Providers are open to this when the process is collaborative and transparent and they understand and are a part of creating the method. Transparency drives acceptance because there is mutual interest in freeing the systems to redesign care in new ways that are not anchored to fee-for-service visit based payments. Again, we have seen success with this approach in Minnesota and believe it can be used similarly in other markets.

Coordination: Our attribution model technically assigns to primary care but groups we work with view it as their medical group, ACO or care group "collective performance". We find close to 70% of patients see primary care, and our practice premise is that primary care providers are the 'trusted guide' to help patients navigate the system. Patients and consumers want consistent messaging across providers, whether they practice in the same group or not. The ideals of the ACO and medical home concepts aspire to deliver this type of coordinated care, and the attribution models and TCOC and resource use measures support this approach. While it may be true some items are out of anyone's control, the large majority of health care spend does have the opportunity to be better coordinated and evidence-based.

Distinction #2. A Triple Aim-oriented approach to measurement use

The value of any measurement system lies not only on its rigor and reliability but also on its practical value and usability. In payment reform, benefit design, improvement, and transparency, we align all of our efforts around the Triple Aim and a measurement approach that complements it. Specifically:

Payment reform: The measures are designed to work well with complementary payment reforms such as bundled payments and primary pre-paid care. This frees primary care from today's issues related to fee-for-service payment, which limits the ability to financially support care redesign outside of relying on face-to-face office visits. Risk arrangements are derived collaboratively with providers to appropriately align incentives to improve care and experience while reducing costs. In order to earn shared savings for reducing the overall cost of care, quality and experience performance thresholds must be met.

Benefit design: Provider networks are designed using two bars – cost and quality. The measures offer a mechanism to evaluate value by considering total cost of care in addition to quality. Quality includes patient experience information and clinical quality. For example, when we define preferential networks or tiers for benefits, providers must perform better than average on quality *and* cost.

Improvement: The total cost of care suite of reports provides relative performance and benchmarking information in summary and detail for providers. It is risk-adjusted using Johns Hopkins' Adjusted Clinical Groups (ACG) software, which is our preferred cell-based approach to address patient characteristics. Improvement information includes concurrent (retrospective) benchmarked performance. All of this information is updated quarterly and is of use to providers in understanding comparative performance. We also provide prospective risk score information to assist providers with active care coordination. Improvement information is drillable to condition, episode and utilization measures. All use measures are risk-adjusted and benchmarked using the same cell-based method for comparability and benchmarking.

Transparency: Transparency of results and pricing information goes hand-in-hand with benefit design. Members and patients need information to make informed choices based on cost and quality. All this information drills to more details and are available on the website. TCOC starts at the cost to care for the population. The framework allows drilling to conditions or procedures of interest. We complement this information with service specific price transparency which is becoming increasingly important as consumers are paying greater out of pocket expenses.

Distinction #3. Measure construction

The HealthPartners measures were carefully created and evolved over time with input from multiple stakeholders. As an integrated care and financing organization, HealthPartners was in the unique position to develop the measures with active input from providers and place emphasis on practical usability to understand and improve performance.

The measurement approach includes two powerful, companion components -- total cost of care and resource use. When considered together, they facilitate a standardized price-comparison (as total cost is the product of resource use and price). When used separately, they are informative in understanding overall cost of care for a population, the price paid for overall care and the resource use generated for care. While it starts at the population view, the measures support multiple levels of analysis as previously mentioned.

Attribution: While close to 70% of patients are attributed, what happens to the remaining 30%? We find half do not use any services at all. The other half use ancillary or specialty or emergency department services only. The goal of the attribution model is to understand patient care-seeking behaviors in a way that informs construction of an approach that most closely approximates a "relationship" between the practice and the patient. The models are also designed in a manner that limits assigning patients who are using higher-cost facility based services exclusively. Of the 70% that are attributed, we find these patients account for more than 90% of the inpatient admissions, about 90% of the outpatient surgeries and about 80% of the emergency department visits. Also, nearly 90% of attributed patients only seek primary care at one provider group.

Risk Adjustment: HealthPartners uses Johns Hopkins Adjusted Clinical Groups software for risk adjustment. It is our preferred approach and is NQF-endorsed. It is a cell-based method, not a regression based method. Cell-based is preferred because it categorizes patients based on like characteristics and considers all the combinations of diagnoses. This is opposed to a regression based method which accounts for risk at the individual diagnosis level. Both approaches account for age and gender mix. We use two companion approaches to risk adjustment. First, retrospective or concurrent for historical benchmarking and analytical information provided to at risk groups to understand performance benchmarked to a peer group. Second, we augment this with prospective risk information to assist with active care coordination activities. The method appropriately truncates total expenditures at $100,000 to strengthen effectiveness. The Society of Actuaries (SOA) has a complete study on the topic of risk adjustment and has deemed it an acceptable approach.

Truncation: Claims associated with higher cost members are truncated at $100,000 in both the TCOC and resource use methodologies and impacts only approximately 0.3% of the population and 7% of the total health care spend. The claims for higher cost members are not removed to hold providers accountable for the full population and all the care that is provided. However, we know that all risk adjusters become less effective (lower R2) in explaining the risk of members when their costs surpass a certain threshold of spend. Since these two points are in conflict, we determine that truncation is an acceptable balance rather than removing them from the provider's panel.

N Size: HealthPartners has tested the TCOC measures at various n sizes; however, they are NQF-endorsed at the 600 panel size. We recommend a minimum panel size of 600 attributed members for reliable cost comparisons and sufficient data size for available quality and patient experience measurement. Availability of all measures allows for Triple Aim-based evaluation of results. Our reliability testing has determined that results are technically reliable at a minimum data size of 150 members. The n size chosen will depend on the intended use and level of scrutiny given to the measure (e.g. more reliability/larger n required to support TCOC contracts vs. less reliable/lower n required to support provider practice improvement efforts).

Pharmacy Carve Outs: The measures are designed to accommodate that fact that some members of a health plan may have their pharmacy benefit 'carved out' and offered through another vendor. For this reason, the measures are designed to calculate medical and pharmacy components separately. The results are then summed creating the Total Cost of Care and Total Resource Use measures. If a provider's percentage of members with a pharmacy carve out is too high (between 70% and 100%), they can be compared to a medical only benchmark. However, this is not desirable as the impact of pharmacy management within TCOC is lost.

Reliability and Validity Testing: The National Quality Forum review process required thorough reliability and validity testing. Results were externally reviewed by statistical experts and endorsed. We are confident of their reliability, validity and suitability for the tasks they were designed to perform.

Conclusion

Multiple methods are needed to fix the issue of health care affordability. TCOC is promising and has been acceptable to many provider organizations and others who have reviewed and are using this methodology. In development and continuous iteration for nearly two decades, our measures are tangible, transparent, and have been externally tested and reviewed for reliability and validity. Available in the public domain and free of charge, they have seen rapid uptake since their release and are now licensed by nearly 100 organizations.

They cannot and do not solve for all the issues in health care payment and affordability. They do not address all potential theoretical issues. No measurement approach does. But they do offer a welcome, positive, and sound approach as a basis for momentum to begin this important improvement work and as a bridge to desperately needed new payment methods. After field-testing for many years, they are already showing practical benefits in areas critical to Triple Aim advancement. While we appreciate the importance of ongoing theoretical exploration, our key focus is the urgent need for practical problem solving across the nation. We are grateful for the partnership of those from so many organizations who share our aims and are putting our measures to work to solve those problems every day.

Above all, we welcome continued commentary and dialogue. It is an important issue and one warranting new and evolving ideas and partnerships to continue our needed progress.

Other resources

Detailed white papers on attribution, total cost of care, resource use, reliability and validity results can be found at our public website: www.healthpartners.com/tcoc

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