Q Corp Clinic Comparison Report FAQs

General FAQs

Why is Q Corp producing these reports?
Three 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 second year Q Corp is sending out these 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 bi-annually in private reports to clinics on our provider portal: http://q-corp.org/reports/provider-reports. The Clinic Comparison 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: Within the next few months, Q Corp will be sharing the Clinic Comparison Reports with the health plans (Bridgespan, Moda Health, Oregon's Health CO-OP, 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 has approved this important next step in testing the measures and working collaboratively to address health care costs in Oregon. Q Corp expects that the health plans will use 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 is still being validated, Q Corp is requesting that the data not be used for contracting purposes.
- Public Reporting: Q Corp currently reports quality and utilization metrics: http://q-corp.org/compare-your-care. Because this is a newer measure to Q Corp, we are testing and validating it, and will continue to do so until we are confident they reflect our mission to make accurate and reliable data available to the public. Q Corp will work directly with providers, consumers and other stakeholders to test the validity and utility of the measures in Oregon before any information is reported publicly. Clinic level public reporting will be reviewed by Q Corp's Measurement & Reporting Committee and Cost of Care Steering Committee before reporting.

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 Total Cost of Care measures, we want to make sure we understand what is driving year over year variation for a clinic as well as 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 April 2015?
These reports cover the period between January 2014 and December 2014, providing more up-to-date information. Also, Q Corp and its data vendor have made refinements to the calculations for the cost measures since the April 2015 pilot. Additionally, a new page showing 2012-2014 year over year changes has been added.

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 85% of the fully insured population and 23% of the self-insured population in Oregon, and uses a 12-month reporting period (January 2014-December 2014) 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 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 carrier 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 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 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 2014?
Multiple factors affect the timing and release of clinic reports.
- Claims Lag: The clinic reports released in spring 2016 reflect commercial claims data incurred January 2014 through December 2014 and paid through March 2015. 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 must be produced. The process from receiving the completed data set to producing final reports typically takes 60 to 90 days.

Why are my clinic's results different from the Clinic Comparison Report I received in April 2015?
For cost and 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 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 these 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® 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 commercial data?
The HealthPartners® Total Cost of Care methodology, which Q Corp is using for these reports, has only been endorsed by the NQF for use with commercial claims data. Q Corp is working with several regional and national partners to explore the feasibility of creating similar reports for the Medicare and/or Medicaid populations.

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 multiple chronic conditions categorized?

- Q Corp uses Milliman's proprietary Chronic Condition Hierarchical Groups (CCHGs) to identify patients with chronic conditions.

- Each patient is assigned to **one** CCHG according to a hierarchical algorithm developed by Milliman.
- Patients with comorbidities will be reported under the CCHG that falls highest in the hierarchy. For example, suppose you have a patient with hypertension and a GI disorder. Since hypertension falls higher in the hierarchy than GI disorders, that patient will fall in the hypertension category.
- This categorization method is reflected on pages 1 and 7 of the report.
- The "Chronic Condition Patient Summary" on page 7 of the report shows up to 10 Chronic Conditions with the average costs for each condition. Conditions are shown in same hierarchy order as page 1 and must have at least 30 patients to be shown.

Why is 2013 cost information on the Year over Year page different than what I received last year?
Since the Clinic Comparison Reports were released last April, Milliman has made changes to how the Total Cost of Care measures are calculated, and Q Corp has been working with Milliman to ensure all specifications are being followed. Milliman has rerun the 2013 data and due to the changes made, PMPMs and the Total Cost Indices have changed.

Are there other changes in how results are calculated?
There was a change in the specifications for calculating the Pharmacy Resource Use Index and Price Index. For 2012 and 2013, pharmacy utilization was based on days' supply. For 2014, the specification changed to pill count.

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 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

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@q-corp.org.

Technical Assistance FAQs

Will specific technical assistance about how to use the reports within a clinic be provided?
- Our current round of funding allows for limited development of training and technical assistance solutions to assist clinics with using the reports in meaningful ways. Through both regional and national collaborations, Q Corp 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 analysis and taking appropriate actions.
- We know there is a lot of work to do in this area, and we welcome and value ideas and suggestions about how to incorporate Oregon clinics in developing and testing these items. Q Corp has convened a workgroup to assist with these efforts. Potential solutions that have been prioritized include: group roll-up reports, webinars and newsletters, a Train the Trainer program, and customized reports on utilization. If you have suggestions, or are interested in receiving technical assistance related to analyzing or reducing costs, please email us at costofcare@q-corp.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?

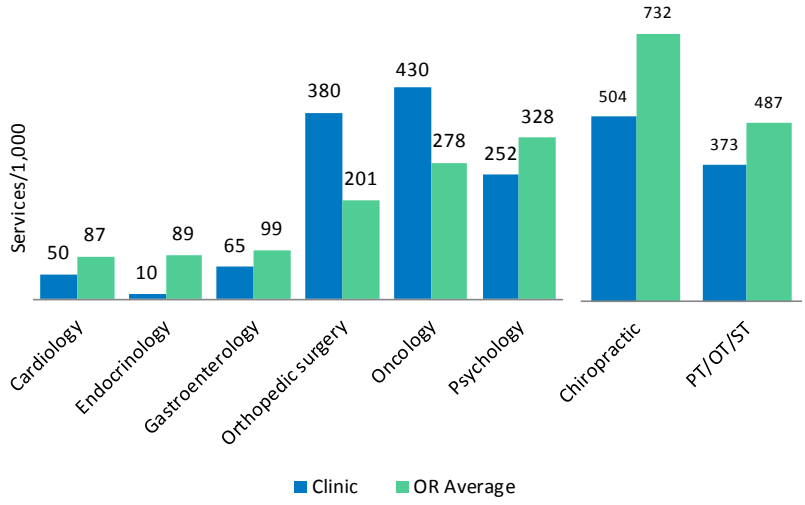
The goal of the Clinic Comparison Reports is to identify clinic variation in cost, quality and utilization. The measures are designed to give each clinic a detailed understanding of how the care their patients receives differs from the average, which enables practices to create action plans targeted 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. 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.

	Clinic Adj PMPM	OR Average PMPM	TCI	= RUI	Price x Index
PCP Office/Home Visits	**$25.82**	$24.91	**1.04**	1.13	0.92
Surgery/Anesthesia	**$24.55**	$23.41	**1.05**	1.09	0.96
Specialist Office/Home Visits	**$14.35**	$17.58	**0.82**	0.86	0.95
Office Administered Drugs	**$11.96**	$10.11	**1.18**	1.17	1.01
Office Radiology	**$7.04**	$9.65	**0.73**	0.77	0.95
Physical Therapy	**$9.51**	$9.26	**1.03**	1.06	0.97
Office Pathology/Lab	**$8.77**	$8.45	**1.04**	1.21	0.86
Office Surgery	**$9.71**	$8.33	**1.16**	1.19	0.98
DME & Home Health	**$6.29**	$6.45	**0.98**	0.89	1.10
Preventive Physical/Well Baby Ex	**$6.55**	$6.35	**1.03**	1.13	0.91
Preventive Labs & Tests	**$4.97**	$5.27	**0.94**	0.96	0.98
Behavioral Health	**$3.48**	$5.11	**0.68**	0.75	0.91
Maternity	**$8.49**	$4.23	**1.22**	1.00	1.22
IP/OP Radiology/Pathology/Lab	**$5.90**	$4.13	**1.43**	1.34	1.07
ER Visits and Observation Care	**$2.56**	$3.06	**0.84**	0.93	0.90
Chiropractor	**$3.81**	$2.54	**1.50**	1.44	1.04
Preventive Immunizations	**$1.45**	$1.79	**0.81**	0.96	0.84
Inpatient Visits	**$2.06**	$1.73	**1.19**	1.13	1.05
Cardiovascular	**$1.75**	$1.58	**1.11**	1.01	1.11
Urgent Care Visits	**$3.15**	$1.23	**2.57**	2.75	0.93
All Others	**$11.06**	$11.96	**0.93**	0.94	0.98
Total	**$173.24**	$167.12	**1.04**	1.09	0.95

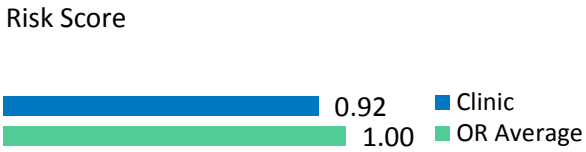


2. Specialty utilization (page 2) – are your patients using more or fewer specialist services than the state average? If they are using more, can you identify any specialty practices to which you often refer patients who might be treating patients more intensively than necessary?

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?

	Clinic Adj PMPM	OR Average PMPM	TCI	= RUI	Price x Index
Outpatient Surgery	**$46.99**	$48.68	**0.97**	1.30	0.74
Emergency Room	**$16.23**	$18.25	**0.89**	0.99	0.90
Radiology - CT/MRI/PET	**$7.73**	$7.96	**0.97**	1.11	0.87
Pathology/Lab	**$8.02**	$7.56	**1.06**	1.10	0.96
Radiology General	**$7.28**	$7.41	**0.98**	1.46	0.67
Preventive	**$5.07**	$6.72	**0.75**	0.96	0.79
Other	**$1.88**	$5.84	**0.32**	0.36	0.89
Pharmacy	**$1.00**	$5.56	**0.18**	0.22	0.82
PT/OT/ST	**$2.31**	$4.25	**0.54**	0.55	0.99
Cardiovascular	**$1.63**	$2.81	**0.58**	0.70	0.82
Behavioral Health	**$0.14**	$0.50	**0.27**	0.22	1.24
Total	**$98.27**	$115.53	**0.85**	1.07	0.79

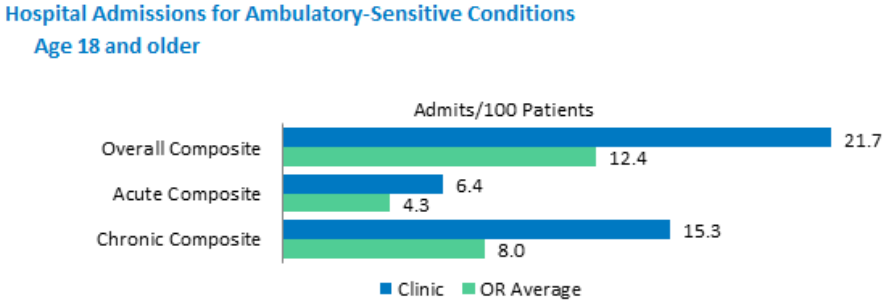
4. Your clinic's retrospective risk score is provided in the cover letter. Supposing this shows that your practice has a lower disease burden than the state average (see sample below), you might look at the rate of acute inpatient admits and days (see page 4 of the report). If your rate is higher than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

	Clinic Adj PMPM	OR Average PMPM	TCI	= RUI	Price x Index
Diagnostic	**$11.13**	$10.56	**1.05**	1.09	0.97
MRI	**$8.43**	$8.43	**1.00**	1.13	0.88
CT Scan	**$6.36**	$4.94	**1.29**	1.16	1.11
Therapeutic/Radiation Oncology	**$3.35**	$3.80	**0.88**	0.89	0.99
PET	**$0.50**	$0.48	**1.06**	0.98	1.08

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 musculoskeletal conditions 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

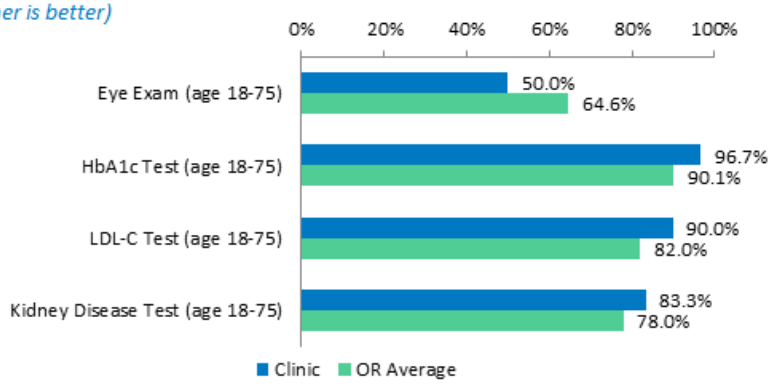
	Clinic				OR Average					
	Patients	Prevalence	Raw PMPM	Adj PMPM	Prevalence	Adj PMPM	TCI	= RUI	x	Price Index
Hypertension (Includes stroke & peripheral vascular disease)	**70**	**2.0%**	**$1,204.37**	**$1,108.02**	3.9%	$813.29	**1.36**	1.31		1.04
Diabetes without Coronary Artery Disease	**38**	**1.1%**	**$2,740.71**	**$2,521.45**	3.4%	$1,651.90	**1.53**	1.44		1.06
Chronic musculosketetal/osteo arthritis/osteporosis	**32**	**0.9%**	**$3,899.52**	**$3,587.56**	2.4%	$3,137.90	**1.14**	1.03		1.11
Other chronic conditions	**31**	**0.9%**	**$1,504.88**	**$1,384.49**	2.9%	$1,142.32	**1.21**	1.01		1.20

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

Comprehensive Diabetes Care
(higher is better)



9. 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?

10. Suppose page 8 shows that your clinic has a higher than average resource use for Multi-Source Brand 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