Comagine Health
Formerly Qualis Health and HealthInsight

Clinic Comparison Report FAQs
Commercial

General FAQs

Who is Comagine Health?
In 2017, the Oregon Health Care Quality Corporation (Q Corp) merged with HealthInsight, leveraging our mutual strengths and broadening our geographic reach across a four-state region. HealthInsight merged with Qualis Health in 2018. As of 2019, we have rebranded as Comagine Health.

Comagine Health is a national, nonprofit, health care consulting firm. We work collaboratively with patients, providers, payers and other stakeholders to reimagine, redesign and implement sustainable improvements in the health care system. As a trusted, neutral party, we work in our communities to address key, complex health and health care delivery problems.

Comagine Health is the sponsoring organization for the Oregon Data Collaborative (ODC). The purpose of ODC is to improve the quality of health care and treatment of members and patients of the participating health plans and health care providers that are willing to merge, aggregate, and analyze their claims, encounter, and clinical data and other information.

The ODC collects, validates, analyzes, and aggregates data to generate performance measure results. The ODC supports health care providers including practices, medical groups, hospitals and other providers with consolidated information about their patients to facilitate treatment decisions and ODC performance measures to facilitate quality improvement activities. The ODC also provides public performance reports and custom analytics of health care quality, resource use, efficiency, effectiveness and cost for Oregon.

Comagine Health works with Oregon's largest health insurers plus the Oregon Health Authority and the Centers for Medicare & Medicaid Services to develop our comprehensive claims database, which includes claims from 2014 to present, representing data for over 3 million covered Oregonian lives. Our database includes 82 percent of the fully insured population, 24 percent of the self-insured population, 100 percent of the Medicaid population and 89 percent of the Medicare population in Oregon. The mission of the Oregon Data Collaborative has remained unchanged: to use data to improve the quality and affordability of health care for all Oregonians.

Why is Comagine Health producing these reports?
Seven 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. Now as Comagine Health, our shared goal continues to be 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 sixth time Comagine Health is sharing these reports with primary care clinics across Oregon.

Comagine Health continues to receive guidance and support for our cost reporting from two multi-stakeholder advisory groups: the Leadership Advisory and Analytics Advisory committees.

How are these reports different from Comagine Health'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 Comagine Health runs and reports to clinics on our Reporting 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?

Comagine Health believes that in order to reduce health care costs, all stakeholders must have access to more information about the cost of care. Comagine Health committed to sharing information with a broader audience after two rounds of private reporting.

- **Health Plans:** Comagine Health shares 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 former Q Corp 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.
- **Public Reporting:** Comagine Health reports quality, utilization, and cost metrics for primary care clinics on a public website once a year, available at http://q-corp.org/compare-your-care.

How are these reports different from the Clinic Comparison Reports I received in 2017?

These reports cover the period between January 2018 and December 2018, i.e. calendar year 2018, 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.

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Attribution FAQs

What information is included in the report?

Reports are based on commercial claims data from the Comagine Health claims database, which includes claims data on 82% of the fully insured population and 25% of the self-insured population in Oregon, and uses a 12-month reporting period (January–December 2018) with three months run-out.

Approximately what percentage of my clinic's population is covered by these reports?

For Oregon overall, Comagine Health 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 can review their lists of attributed patients upon request.
- Only patients assigned to PCPs in Comagine Health'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 Comagine Health'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 $125,000 for any individual patient are excluded.

Data FAQs

Why is the data from 2018?

Multiple factors affect the timing and release of clinic reports.

- **Claims Lag:** These clinic reports reflect commercial claims data incurred January 2018 through December 2018 and paid through March 2019. 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 previously?

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.

Why are my clinic's emergency department measure results so different from the Clinic Comparison Report I received previously?

We found an error in the way we were counting emergency department visits in previous cost of care reports, which overcounted ambulatory ED visit rates. The report now counts an ED visit as any outpatient hospital claim included in Total Cost of Care claims that includes 1 or more line items for ER department charge.

How are these reports different from performance reports clinics might be getting from health plans?

Data in the Comagine Health 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 use 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 Comagine Health has reviewed clinic risk adjuster scores and costs year over year, we see variation in some clinics. Comagine Health is actively investigating methods to mitigate some of this variation.

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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 $125,000. 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. Please note that due to the complexity of the calculations, results of a given measure may vary by a few cents in different contexts, for example, different pages of the report.

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.

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?

- Comagine Health 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.
- The "Chronic Condition Patient Summary" on page 6 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.

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://www.q-corp.org/sites/qcorp/files/TCOC%20Technical%20Appendix%20CY%202018.pdf

What is the Quality Composite score?

Comagine Health 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, Comagine Health 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/TCOC%20Technical%20Appendix%20CY%202018.pdf

What does the information on the Year over Year Summary page tell me?

The Year over Year Summary page presents the total cost index, price index, and resource use index each year from 2014-2018, overall and by professional, outpatient, inpatient, and hospice & home health. The year-over-year benchmark is always one, so trend lines show clinic performance relative to the benchmark. A delta indicator of change presents the magnitude in change of index score from 2014 to 2018.

The Cost of Care Steering Committee decided to use 0.95 and 1.05 as the thresholds for identifying clinics who performed lower than average cost, average cost, or higher than average cost. These thresholds are also indicated on the Year over Year summary page.

Can my clinic have access to more detailed data?

Upon request, Comagine Health 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 qcorpinfo@comagine.org.

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Technical Assistance FAQs

Is technical assistance available on how to use the reports within a clinic?

- Comagine Health 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 qcorpinfo@comagine.org.

Where can I find additional information about the Clinic Comparison Reports?

Additional information can be found on our website at 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?

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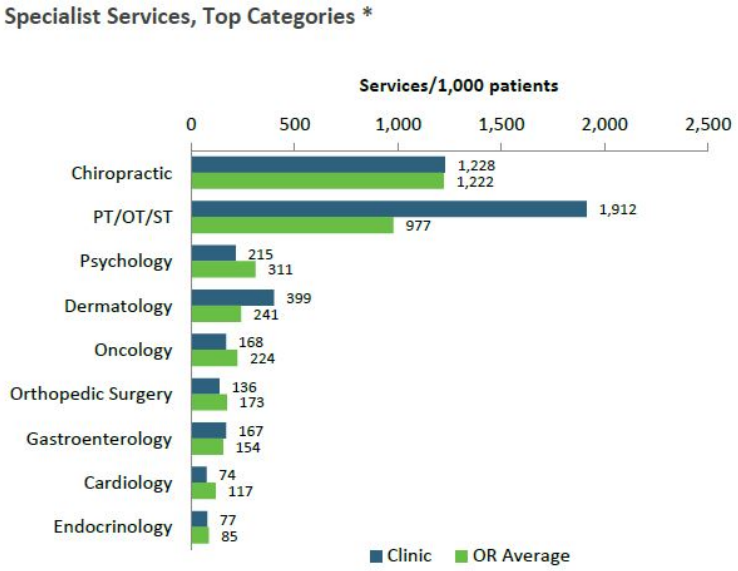
Examples of where and how clinics have used the clinic report information:

1. Suppose that, on page 2 (see sample results to the right), your clinic's Lab & Pathology 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 laboratory services.

Professional PMPM by Service Category

	Clinic Adj PMPM	OR Average PMPM	TCI	= RUI	Price x Index
Evaluation & Management	**$50.64**	$57.57	**0.88**	0.87	1.01
Surgery & Anesthesia	**$34.37**	$36.82	**0.93**	0.91	1.03
Preventive Screenings	**$11.93**	$12.47	**0.96**	1.07	0.89
Physical Therapy & Rehab	**$15.04**	$11.79	**1.28**	1.33	0.96
Lab & Pathology	**$11.34**	$10.13	**1.12**	1.17	0.96
Preventive Visits	**$9.60**	$9.59	**1.00**	1.04	0.96
Psychiatric Visits	**$9.24**	$9.23	**1.00**	0.88	1.13
Endoscopic Procedures	**$5.61**	$6.02	**0.93**	0.85	1.09
Advanced Imaging	**$8.12**	$5.11	**1.59**	1.67	0.95
Emergency Dept. Visits	**$6.60**	$4.63	**1.42**	0.90	1.58
Echography	**$4.33**	$4.01	**1.08**	1.18	0.92
Oncology & Chemotherapy	**$0.61**	$3.26	**0.19**	0.19	0.99
Standard Imaging	**$4.49**	$2.94	**1.53**	1.56	0.98
Durable Medical Equipment	**$1.30**	$2.58	**0.51**	0.60	0.84
Chiropractic Treatments	**$2.40**	$2.54	**0.94**	0.97	0.97
Preventive Vaccinations	**$1.42**	$1.87	**0.76**	0.74	1.03
Cardiac Imaging & Tests	**$1.30**	$1.02	**1.27**	1.24	1.02
Consultations	**$0.01**	$0.25	**0.04**	0.09	0.43
Dialysis	**$0.00**	$0.12	**-**	-	-
Other Professional Services	**$46.75**	$43.47	**1.08**	1.12	0.96
Total	**$225.09**	$225.42	**1.00**	1.01	0.99

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?



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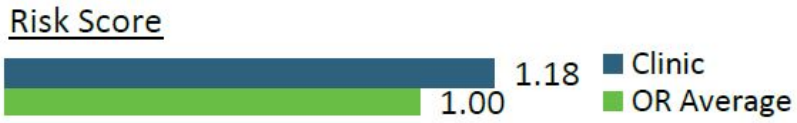
3. Are there any outpatient costs (page 3) that are surprising? If you are looking at reports across clinics owned by the same medical group, are there differences in the patient populations that are being treated?

Outpatient Facility PMPM by Service Category

	Clinic Adj PMPM	OR Average PMPM	TCI	= RUI	Price x Index
Operating Room	**$23.93**	$39.67	**0.60**	0.74	0.82
Emergency Dept. Visits	**$12.15**	$18.35	**0.66**	0.62	1.07
Lab & Pathology	**$4.51**	$9.55	**0.47**	0.50	0.95
Advanced Imaging	**$3.81**	$8.44	**0.45**	0.45	1.00
Surgery & Anesthesia	**$4.10**	$7.11	**0.58**	0.83	0.70
Preventive Screenings	**$0.89**	$6.82	**0.13**	0.18	0.74
Physical Therapy & Rehab	**$0.82**	$4.83	**0.17**	0.20	0.85
Oncology & Chemotherapy	**$1.40**	$4.82	**0.29**	0.31	0.93
Cardiac Imaging & Tests	**$2.17**	$3.92	**0.55**	0.61	0.91
Echography	**$1.08**	$3.20	**0.34**	0.31	1.10
Evaluation & Management	**$0.93**	$3.07	**0.30**	0.46	0.65
Standard Imaging	**$0.69**	$2.75	**0.25**	0.20	1.29
Dialysis	**$0.00**	$1.78	**-**	-	-
Endoscopic Procedures	**$0.25**	$1.64	**0.15**	0.15	1.04
Psychiatric Visits	**$0.58**	$0.53	**1.10**	1.01	1.10
Other Outpatient Facility	**$16.65**	$22.96	**0.73**	0.39	1.88
Total	**$73.97**	$139.44	**0.53**	0.53	1.01

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 to the right), 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
Advanced Imaging (e.g., MRI, CT, PET)	**$11.93**	$13.55	**0.88**	1.13	0.78
Echography	**$5.41**	$7.21	**0.75**	0.92	0.81
Standard Imaging	**$5.19**	$5.69	**0.91**	1.26	0.73
Cardiac Imaging & Tests	**$3.47**	$4.94	**0.70**	0.77	0.91

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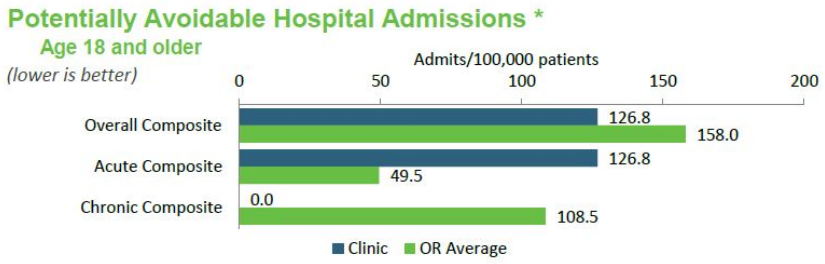
6. Is your practice's Hospital Admissions for Potentially Avoidable Conditions (page 5) admission rate higher than the average? There may be an opportunity to evaluate primary care protocols for these conditions and implement additional patient management strategies.



7. "The Chronic Condition Patient Summary" (page 6) 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 cancer 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

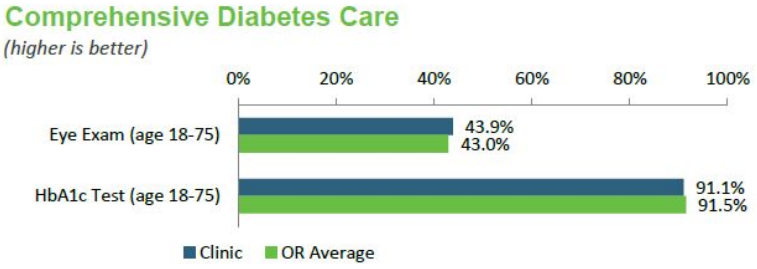
	Clinic		OR Average			
	Patients	Adj PMPM	PMPM	TCI	= RUI	Price x Index
Acute Myocardial Infarction	4	-	$4,429	-	-	-
Alzheimer's Disease and Related Disorders or Senile Dementia	8	-	$2,332	-	-	-
Asthma	69	$901	$1,478	0.61	1.07	0.57
Atrial Fibrillation	19	-	$2,203	-	-	-
Cancer	114	$953	$1,517	0.63	1.00	0.63
Chronic Kidney Disease	83	$966	$1,715	0.56	0.71	0.79
Chronic Obstructive Pulmonary Disease and Bronchiectasis	16	-	$1,980	-	-	-
Depression	408	$782	$907	0.86	1.26	0.68
Diabetes	114	$779	$1,238	0.63	0.63	1.00
Heart Failure	14	-	$2,946	-	-	-
Hyperlipidemia	443	$805	$902	0.89	1.31	0.68
Hypertension	411	$728	$1,006	0.72	1.10	0.66
Ischemic Heart Disease	109	$955	$1,870	0.51	0.83	0.62
Mental Illness	99	$771	$991	0.78	1.07	0.73
Osteoporosis	49	$1,040	$1,287	0.81	1.02	0.79
Rheumatoid Arthritis/ Osteoarthritis	284	$1,021	$1,451	0.70	1.06	0.66
Stroke / Transient Ischemic Attack	6	-	$3,341	-	-	-

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	OR Average
ED Visits/1000 patients	**111.4**	141.6

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?



10. Suppose page 7 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	Price x Index
Single-source Brand	**$64.83**	$78.41	**0.83**		0.80	1.03
Generic	**$22.03**	$19.52	**1.13**		0.97	1.17
Multi-source Brand	**$12.09**	$13.55	**0.89**		0.87	1.02
Total	**$98.95**	$111.48	**0.89**		0.86	1.03