

Frequently Asked Questions: Total Cost of Care

What is total cost of care?

Total cost of care measures all costs associated with treating commercially-insured patients. It is endorsed by the National Quality Forum, considered the gold standard of health care measurement. The costs are based on actual patient costs from 2014, including professional, facility inpatient and outpatient, pharmacy, lab, radiology, behavioral health and ancillary costs.

The total cost of care is the full cost – paid by both patients and health insurance companies. The amounts have been risk-adjusted and outlier costs have been removed to create a level playing field for all medical groups so true differences in cost can be evaluated.

How many medical groups are included?

The 2015 results include 132 medical groups that represent 954 clinics in Minnesota as well as neighboring communities in Wisconsin, Iowa, North Dakota and South Dakota.

Groups had to have at least 600 patients with claims across all four health plans to be included in the results, to ensure accuracy.

All patients are included in the statewide averages, including those who were seen at groups that were not reported by medical group due to having less than 600 patients.

Where are the costs from?

The information is based on 2014 claims data from the four health plans in Minnesota with the largest commercially insured populations: Blue Cross and Blue Shield of Minnesota, HealthPartners, Medica and PreferredOne.

It includes the actual costs of more than 1.5 million patients insured by the four Minnesota-based health plans. The costs accounted for in the claims evaluated for this report totaled \$8.3 billion.

What are the 2015 statewide averages and how do they compare to last year's averages?

The statewide, risk-adjusted averages per patient per month are:

	2015 Average	2014 Average	Change
Overall	\$449	\$435	+ 3.2%
Adult Patients	\$529	\$513	+ 3%
Pediatric Patients	\$225	\$216	+ 4.4%

Eighty-three percent of medical groups in Minnesota have an average range of costs. For overall cost, individual medical group results ranged from \$298 to \$823 per patient per month.

Adult patients are ages 18 to 64; child patients are ages 1 to 17.

How do you connect patients to medical groups?

Patients were attributed to medical groups based on the number of office-based primary care visits they had during the year. The medical group that the patient had visited the most frequently for Family Practice, Pediatric, Ob/Gyn and/or Internal Medicine services was considered the patient's primary care medical group. Patients could be by any type of provider that fell into one of those specialties (doctor, nurse practitioner, physician assistants, etc.). All patient costs throughout the year were assigned to that primary care group.

The measure relies on the accuracy of medical groups to code their claims properly and set up credentialing agreements with health plans that reflect the true specialty of their providers. Both of these are in the medical groups' hands to address if there are concerns.

In the event that two or more medical groups had an equal number of primary care visits with a patient during the year, an additional evaluation was done for the last three months of 2013. If a tie still existed, the patient was not attributed to any medical group and was removed from the measure.

This attribution method is one of the many aspects of this measure that required ongoing multi-stakeholder consensus to achieve.

How do you make sure all medical groups are treated fairly in this measure?

The methodology includes risk adjustment and outlier truncation to ensure that medical groups with the sickest, most complex patients do not skew the results. Utilizing the Johns Hopkins Adjusted Clinic Groups (ACG) Case-Mix System, the Total Cost of Care measure adjusts for the illness burden associated with sicker patients and complex cases that generally result in higher utilization of care. Additionally, patients incurring more than \$100,000 in health care costs during 2014 had their costs truncated to reduce the impact of those outliers on the overall measure. In other words, if a patient incurred \$500,000 in costs during 2014, the methodology adjusted that patient's costs to \$100,000.

Medical groups are risk adjusted to the median, so more-expensive clinics will be reduced slightly and less-expensive clinics will be increased slightly.

Once these calculations were completed and verified, medical groups were given the opportunity to review their own results. As is our normal process, MNMCM allows a review period and an appeal process for any groups with concerns about the validity of their results.

This process was agreed upon by the majority of medical groups in the community to get to a consistent definition of Total Cost of Care. The calculations have been endorsed by the National Quality Forum. And the execution of those calculations was externally validated by independent statisticians.

What are the limitations of the measure?

The underlying assumptions are that the claims coding by medical groups, the credentialing agreement between medical groups and plans, and the Tax Identification Numbers plans use to pay medical

groups are accurate. Agreement on these assumptions was part of the long and careful process MN Community Measurement followed to gain consensus in our community about the best way to measure the total cost of care.

- The measure looks at office-based primary care claims to determine where to attribute patients. Thus, non-primary care claims could be included if they were miscoded by the medical group.
- The measure defines primary care as Internal Medicine, Family Practice, Pediatric and Ob/Gyn providers. Medical groups that have nonstandard physician credentialing agreements with health plans could have specialty providers, and thus their patients, included in the measure.
- The measure separates medical groups based on the Tax Identification Numbers health plans used to pay claims to the medical groups. Medical groups that separate care groups or sites, but utilize the same Tax Identification Number, could have patients or claims attributed between sites within a single medical group.
- The measure's Johns Hopkins ACG risk adjustment calculation utilizes International Classification of Disease (ICD-9) codes which are included on claims submitted to the health plans. Risk adjustment calculations could be off if the diagnosis codes were miscoded by the medical group.

However, the considerable number of patients in this measure (1.5 million) means a small number of miscoded claims or misidentified providers would not change a medical group's result in a meaningful way. One of the many verification steps conducted by MNCM and external statisticians was to test for consistency in information across health plans, to ensure the results were not greatly influenced due to one health plan's information or process with any individual medical group.

All of the details in these assumptions can be controlled by the medical groups.

Are other states doing this?

Minnesota leads the nation with this first-ever, community-wide reporting of the variation in the cost of care by medical groups.

MN Community Measurement is participating in the Network for Regional Healthcare Improvement's Total Cost of Care pilot with four other communities. The goal of the project is to produce a common measurement standard of total cost and resource use to be able to compare costs nationally.

However, no other states have found the measure stability that Minnesota has with Total Cost of Care. This is the result of having cleaner data, because it comes directly from the health plans; having a larger sample size; and having created a thoroughly-vetted and well thought-out measure.

What are MNCM's future plans with Total Cost of Care?

Our Cost Technical Advisory Group is considering multiple options for future iterations of Total Cost of Care, such as the total cost of care for patient insured by Medicare or Medicaid.

Additionally, MNCM is in the process of developing a Relative Resource Use measure, a companion measure for Total Cost of Care that will evaluate utilization. There are two major inputs to total cost of care: average cost per procedure, or what medical groups are being paid for the services; and

utilization, or how much they're using the services. For medical groups, both pieces of information are important to understand how they can reduce their overall total cost of care.