Atlas Results for MY 2019

DMHC FSSB, August 11, 2021

Integrated Healthcare ASSOCIATION

Background

IHA- a unique 501(c)6 Not for Profit

Our work

Performance Measurement

We're championing standard ways to measure healthcare performance.

Align. Measure. Perform.   **Atlas**   **EDGE**

Provider Directory Management

We're bringing the industry together to improve the quality of provider directory data.

Symphony Provider Directory

IHA

IHA's Atlas

One of the nation's largest multi-payer <u>voluntary</u> claims database (MPCD)

- **Measures:** Over two dozen standardized measures of clinical quality, Total Cost of Care (TCoC), patient cost sharing, and utilization
- **Includes:** Nearly 20 million Californians including Commercial HMO, PPO, ACO, and Medicare Advantage
- **What's viewable:** Geography and product line (per business rules)
- **What's collected:** Member level detail
- **Years' measured:** Since 2015
- **What's improving:** Data is now coming to IHA quarterly; 2020 data will be Q1 2022

IHA
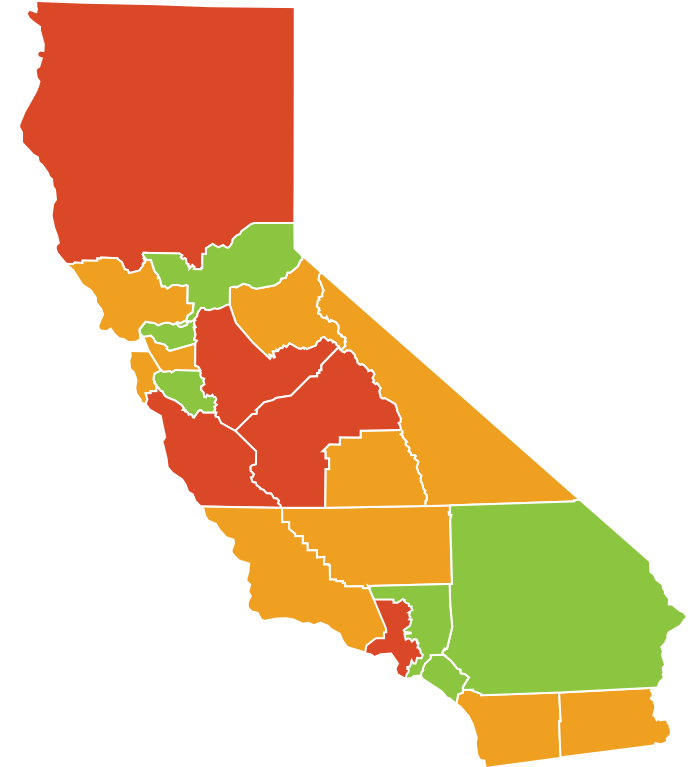
IHA Atlas analyses (selective)

- Quality and cost of care variation by risk type

- Quality and cost of care variation by geography

- Quality and cost of care variation adjusted for equity and clinical integration (in process)

- Quality and cost of care variation for Accountable Care Organizations (ACOs)

- Primary care spending as a percent of total spending by product type

- Quality and cost of care for providers in non-financial risk sharing referral networks

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Why do it?

Colorectal Cancer Screening Rates

Colorectal Cancer Screening Rate (%)

Physician Organization contracting with more than one health plan

IHA
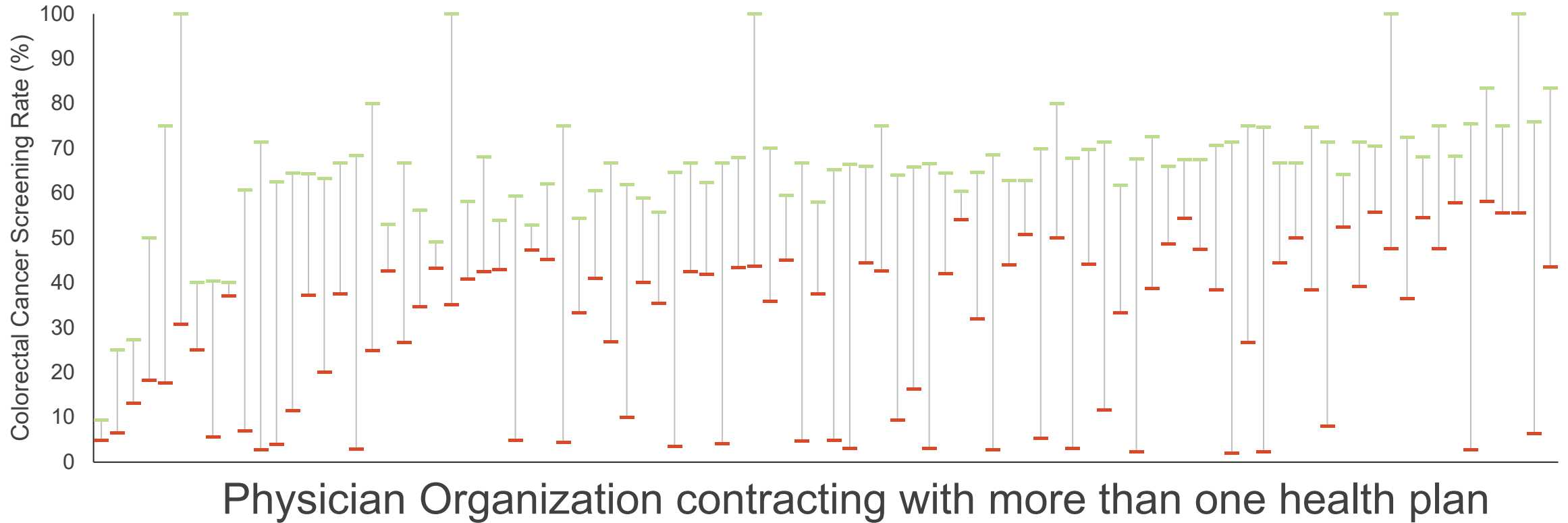
Colorectal Cancer Screening Rates

Min Plan Specific Rate — Max Plan Specific Rate — Aggregated Rate

Colorectal Cancer Screening Rate (%)

Physician Organization contracting with more than one health plan

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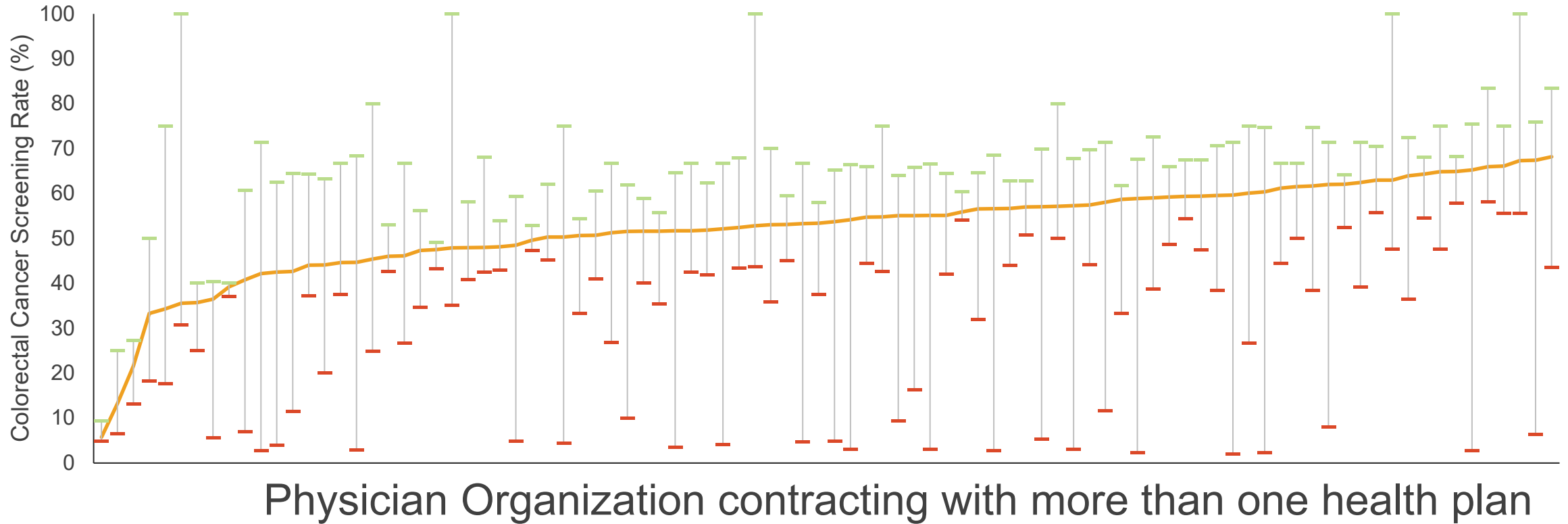
One analysis: How does financial risk sharing impact quality and total cost of care?

Behind this analysis

7.5 out of 12 million Californians*

Full Risk, 19%

Professional Risk Only, 22%
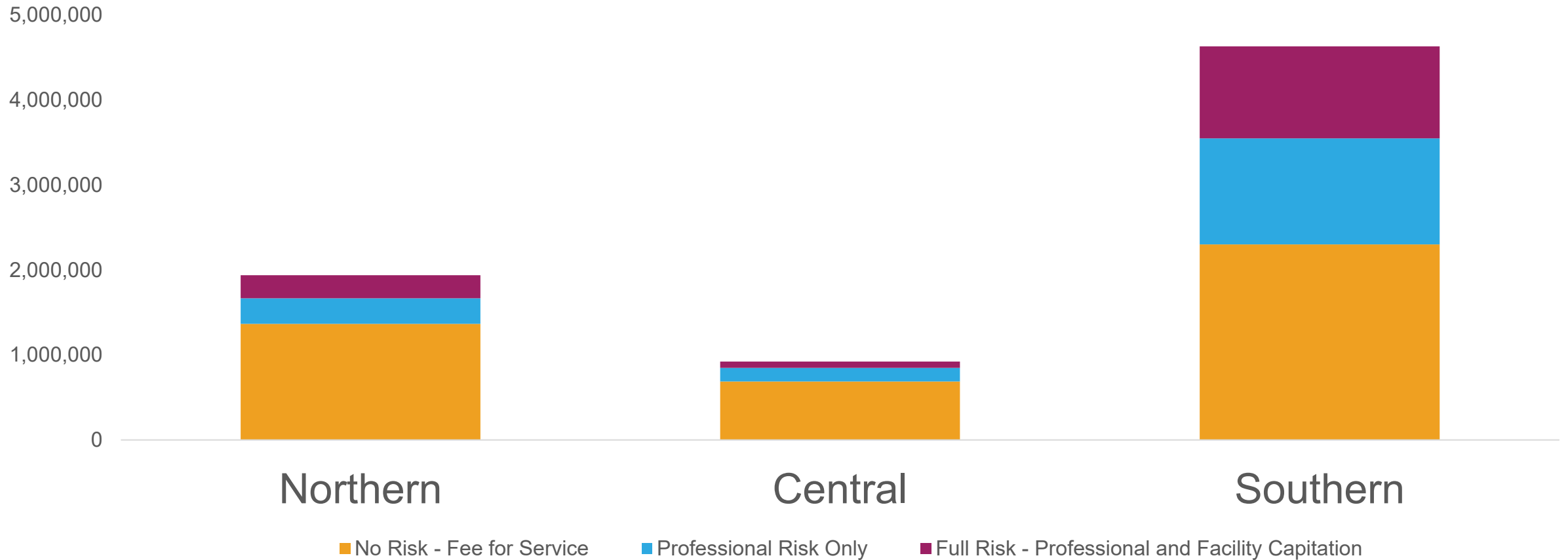
No Risk - Fee for Service, 59%

Quality scores from

- 12 clinical quality measures

- 5 resource use measures

- 8 cost measures

* MY 2019 Atlas covers 12 million lives, but this analysis excludes Kaiser data

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Geography determines level of risk sharing available

Risk sharing (Full+ Prof Only) covers 50% of lives in So. Cal, 30% in No. Cal, 25% in Central

Legend: No Risk - Fee for Service ■ Professional Risk Only ■ Full Risk - Professional and Facility Capitation

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Financial risk sharing associated with better quality in California

Clinical Quality Composite of 12 Measures

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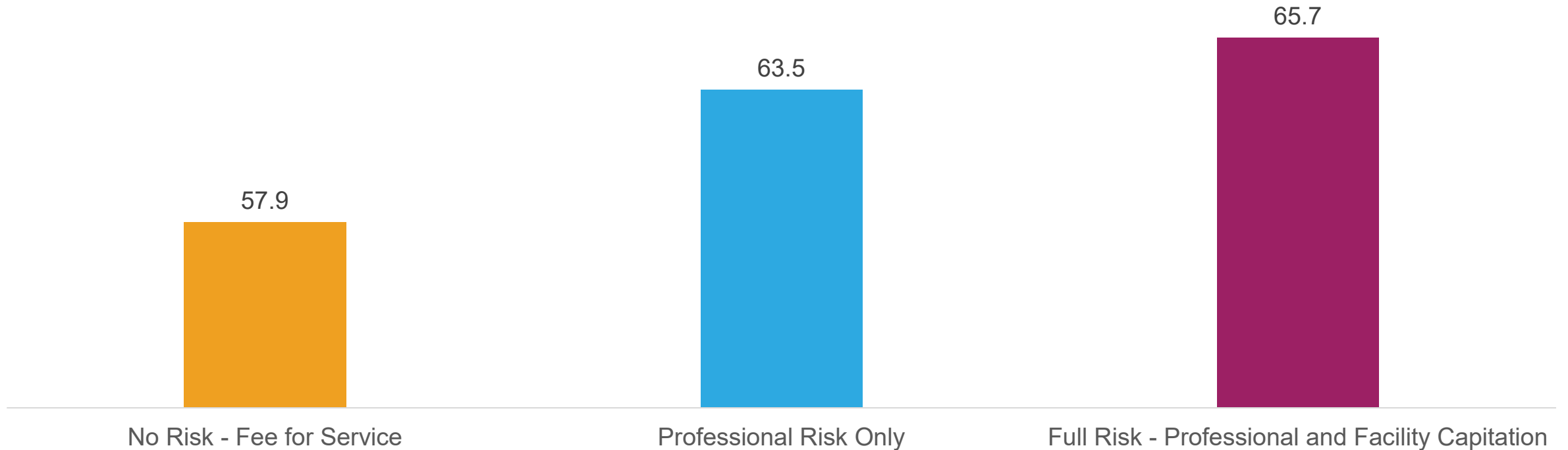
The most pronounced difference in quality occurs with chronic care management
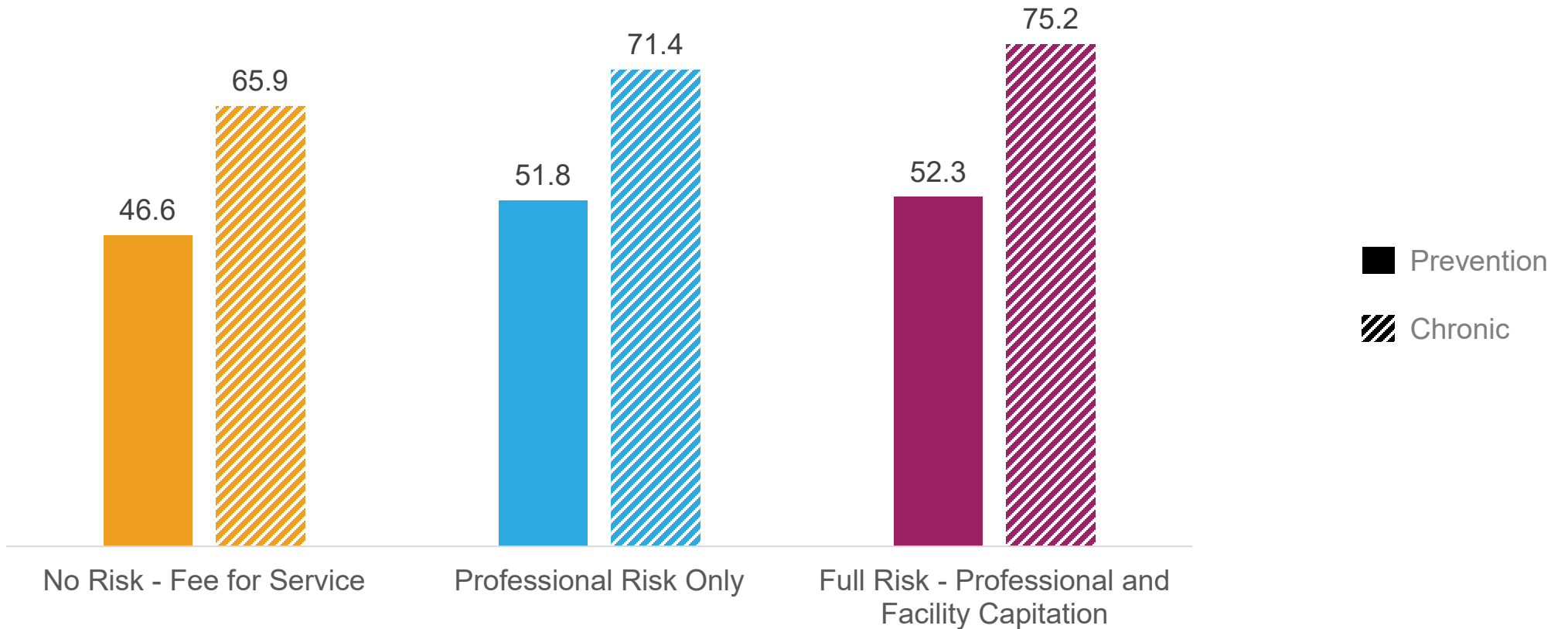
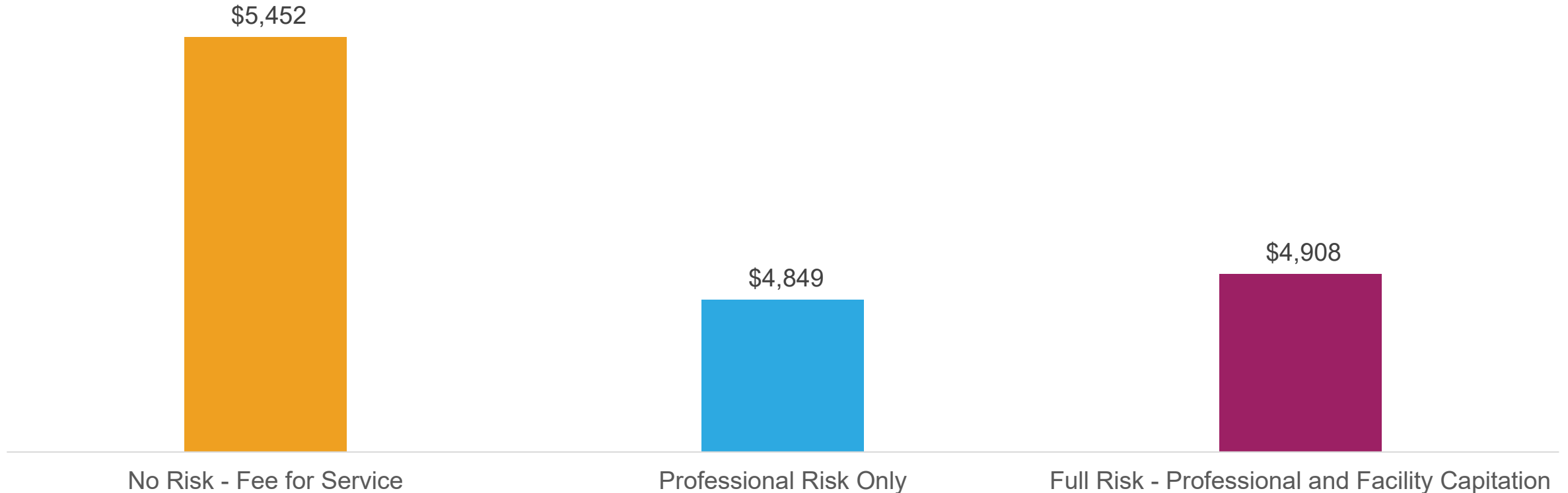

Immunizations for Adolescents: Combination 2 All Antigens (~20%) and Colorectal Cancer Screening (~40%) bringing down the prevention rates

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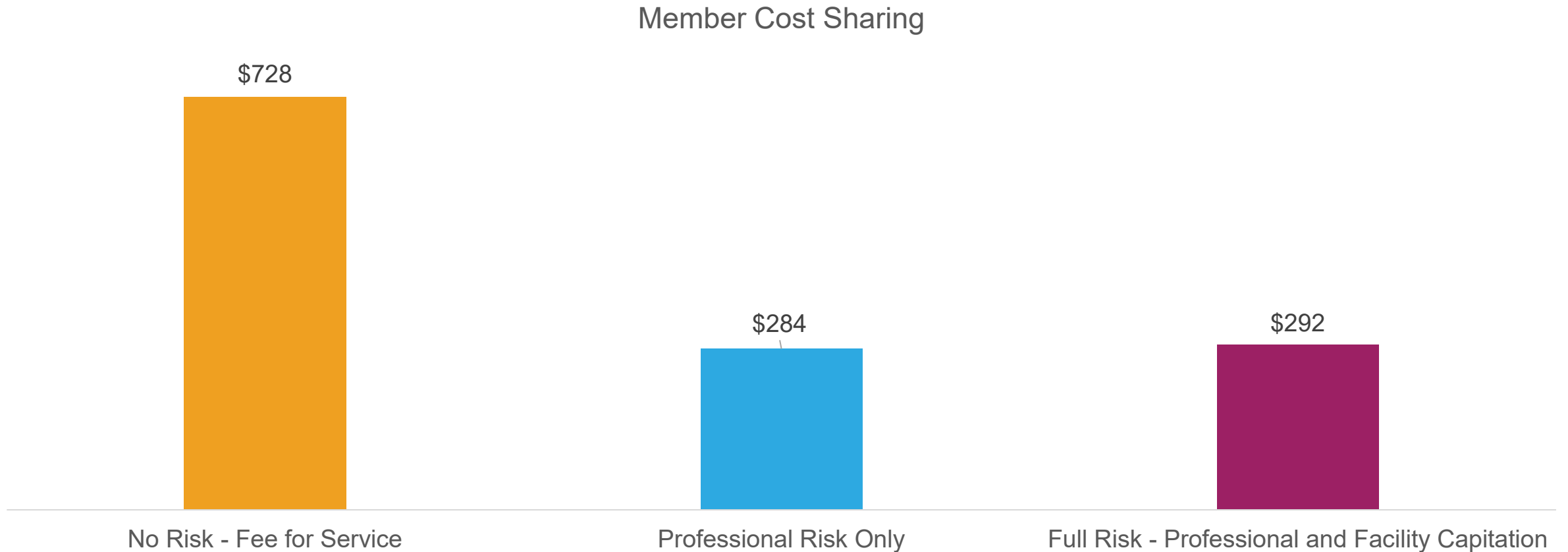# Financial risk sharing associated with lower TCoC in California

Integrated groups that accept any level of risk through capitation have at least 11% ($603) lower total cost of care than those that don't.

Geographic wage and Clinically Risk Adjusted Total Cost of Care (TCoC)

$5,452 — No Risk - Fee for Service

$4,849 — Professional Risk Only

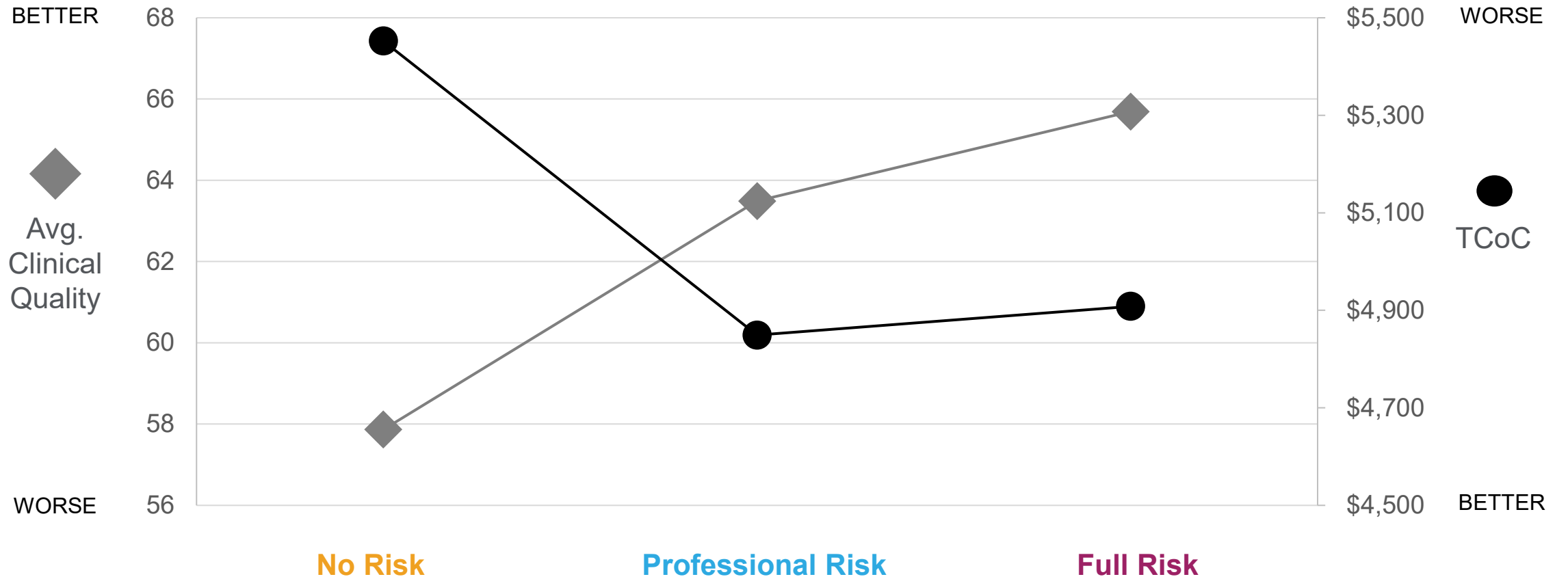$4,908 — Full Risk - Professional and Facility Capitation

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Financial risk sharing associated with lower member cost sharing

Patients who select providers that accept risk on average save $444 per year in out-of-pocket costs

Member Cost Sharing

$728	$284	$292
No Risk - Fee for Service	Professional Risk Only	Full Risk - Professional and Facility Capitation

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Financial risk sharing associated with higher value

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Risk sharing correlates with higher quality and lower cost across all geographies
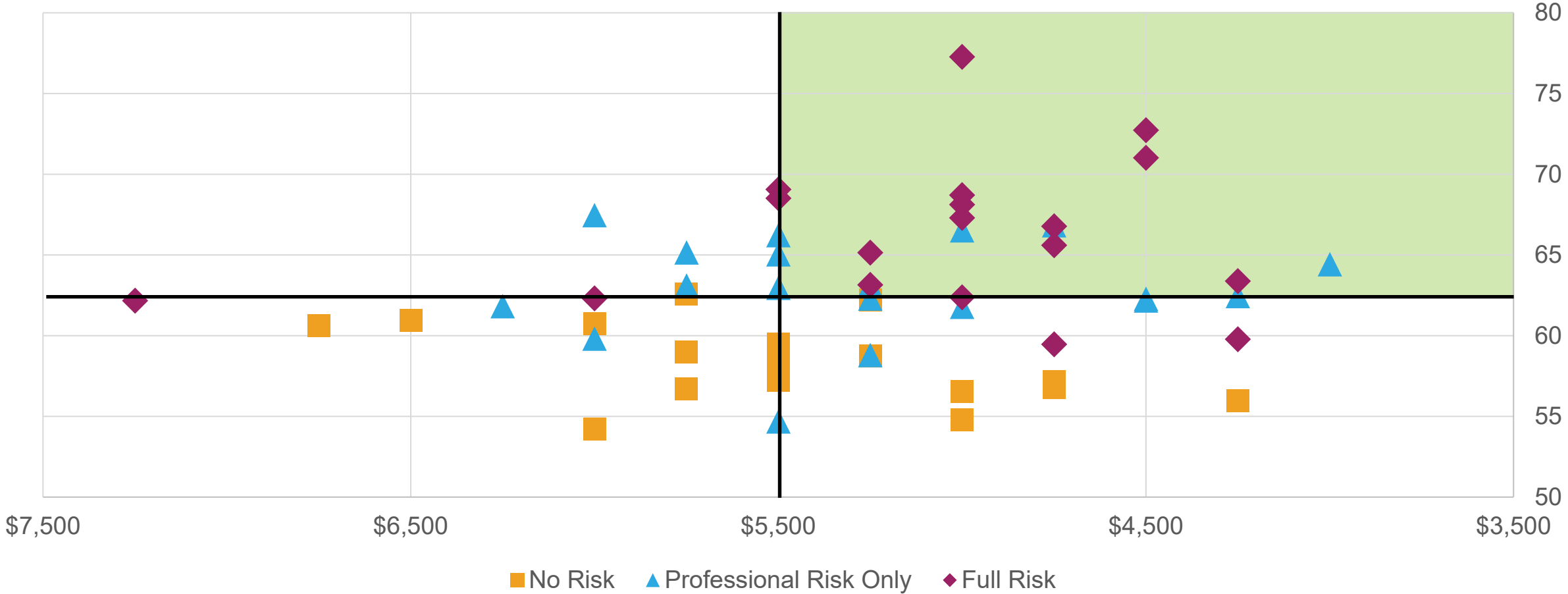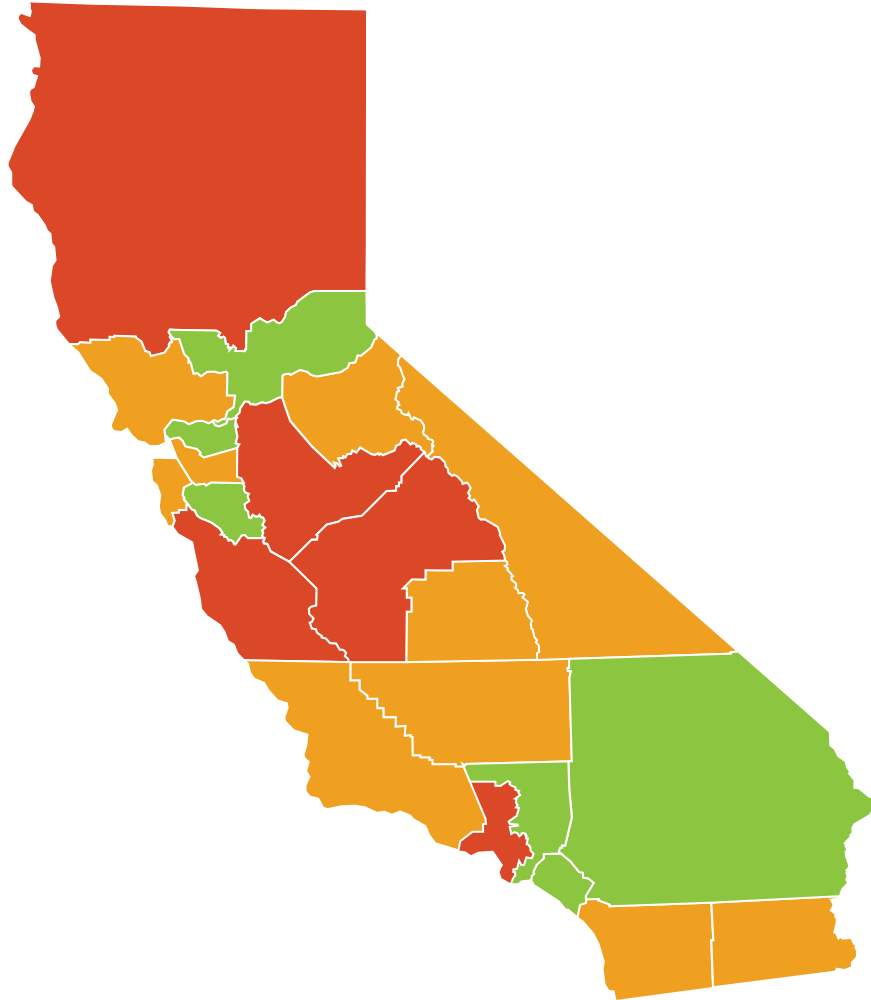

Average Geography and Risk Adjusted Total Cost of Care: $5,300

Average Clinical Quality (12 measures): 62.5%

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A second analysis: Geographic variation of quality and total cost of care

Geographic variation of quality and total cost of care

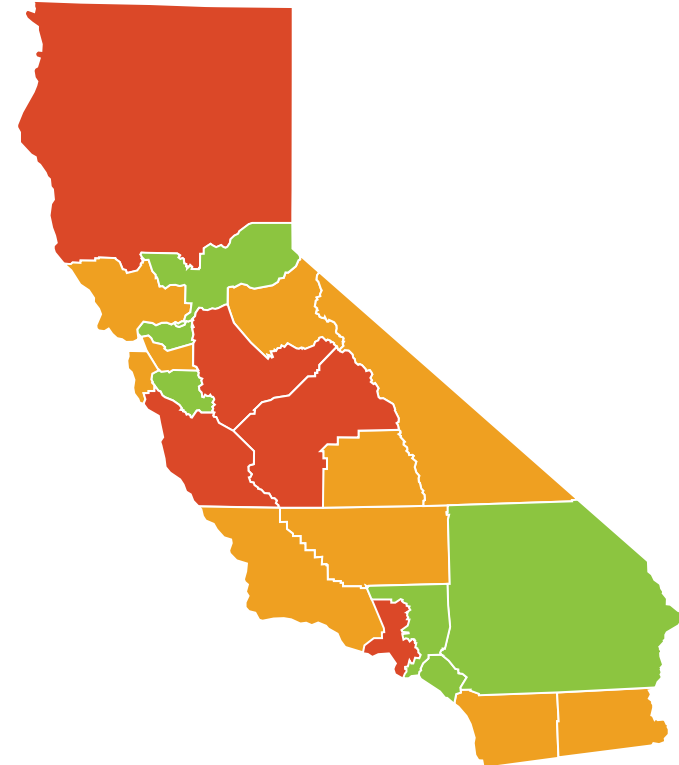**Northern Counties, Central Valley - North, LA West, Central Coast North**

Fresno, Central Coast - South, Eastern Region, Kern County, North Bay counties, San Francisco County, Alameda County, San Mateo County, San Diego County

Greater Sacramento, Contra Costa, Santa Clara, LA East, Inland Empire, Orange County

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RAND's Bayseian Improved Surname Geocoding (BISG) Method

- Most health plans and delivery systems lack complete race/ethnicity data, hindering efforts to track disparities in care quality and outcomes, and effectively target community-based interventions to improve health equity.

- RAND's indirect estimation method, BISG, uses a person's census surname and the racial/ethnic composition of their <u>neighborhood</u> to produce a set of probabilities that a given person belongs to one of a set of mutually exclusive racial/ethnic groups.

- BISG can measure race/ethnicity with 90-96% accuracy for the four largest racial/ethnic groups– Blacks, Asians/Pacific Islanders, Hispanics, and Whites.

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BISG Proof-of-Concept (Phase 1)

- Onpoint prepared a data set containing member information from IHA's Atlas using measurement year (MY) 2019 data containing ~20M members
  - Onpoint geocoded the data and applied the BISG model to a random subset containing ~5M members
  - Onpoint currently is running the model on the entire ~20M member data set
- The model uses surname and address, and performed well when both were available*
- The model can generate estimates for 98% of members with available surnames and addresses

Implication: when combined with self-reported race/ethnicity data, BISG model coefficients can be used to investigate equity-related performance on cost, quality, and access metrics (at the population level to start)

*Among members analyzed, 100% have surnames, 75% have addresses, and 98% have ZIP codes

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Potential Next Steps for IHA, Onpoint and RAND

- Enhance model parameters to align with IHA data characteristics

- Validate model performance against self-reported race/ethnicity data and additional external data sets

- Support DMHC efforts re: Equity and Quality measures as requested

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