"DID YOU KNOW?"

Highlights from IHA's
Atlas and Align.Measure.Perform. (AMP) data

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DMHC FSSB presentation 02282024

About the Integrated Healthcare Association and our work

We're a non-profit IRS business league organized to provider trusted and unbiased health information.
Our board of directors includes leaders from across the healthcare industry

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Performance Measurement at IHA

Since 2003, our measure set has tracked **provider level data for quality, resource use, and cost measures** that have the biggest impact on care outcomes. **AMP**

In 2015, we added broader measurement of healthcare performance including plans, non-integrated provider networks and geographies to provide a statewide view of where healthcare is working well and where it's not. **Atlas**

Since 2017, we've consistently measured **cost of care, quality, and utilization** allowing us to provides insights and trends. **Atlas and AMP**

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

- 20M member claims under management
- 15 health plans submitting data regularly
- 200 physician organizations participating
- Pioneered the use of Onpoint in California
- Providing analytics for Covered CA and CalPERS

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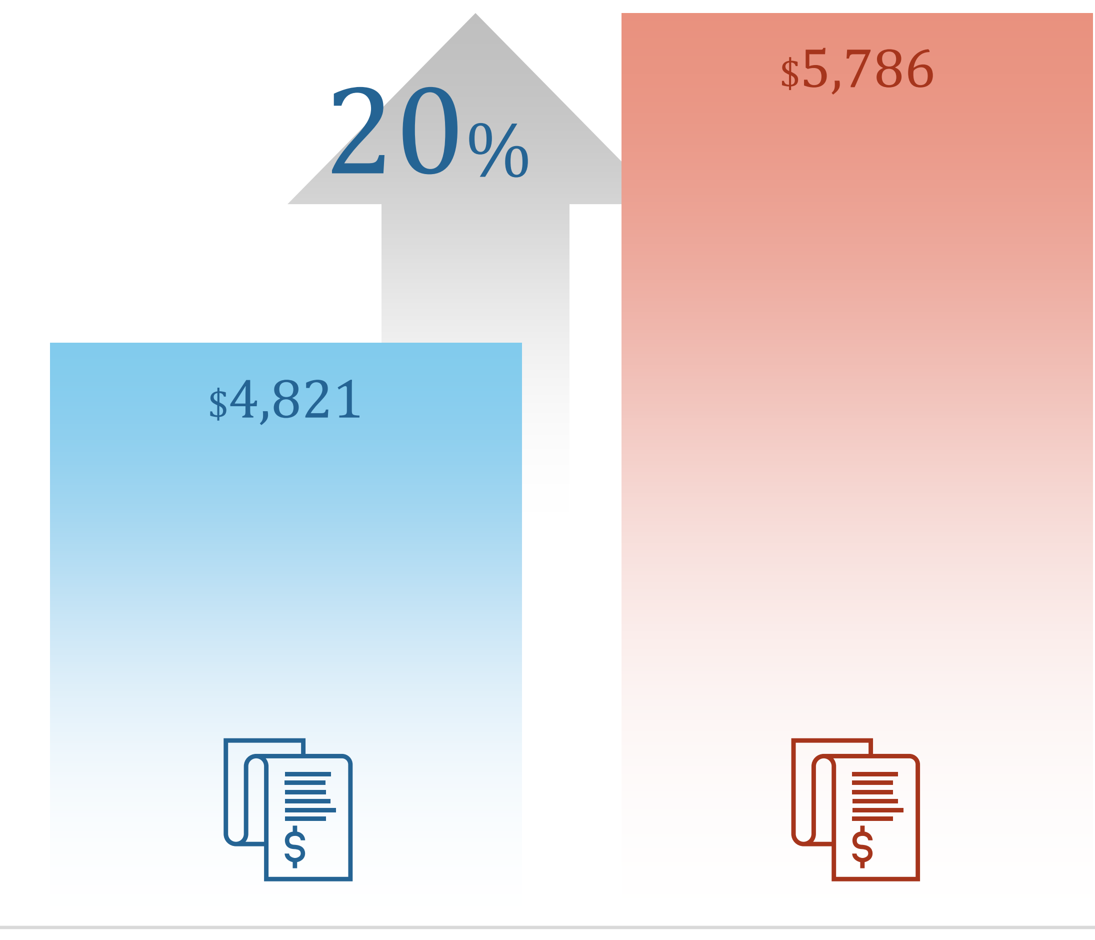
What does the Atlas data tell us about cost of care?

The Total Cost of Care has risen 20% over the last 5 years in California.

Commercial data only



Based on geographical and clinically risk adjusted TCOC

Risk adjusted and normalized to a Commercial California statewide population using Johns Hopkins ACG System

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Specialty pharmacy has been a big contributor with a 266% increase.

15%

$895

$776

266%

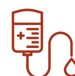
$322

$88

MY 2017

MY 2021

TOTAL PHARMACY


SPECIALTY PHARMACY

Costs shown are per member per year

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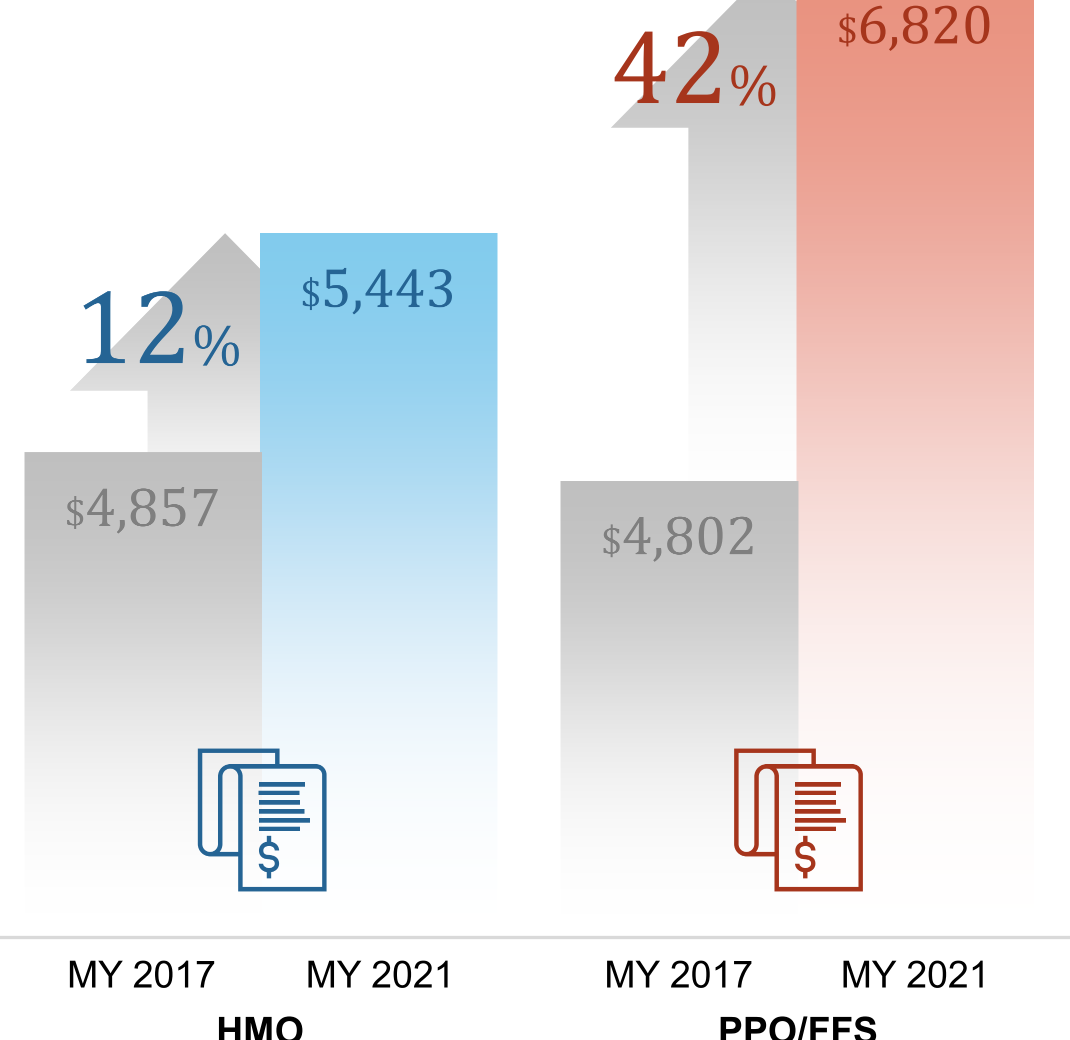
There are significant differences depending on the degree of integration at the provider level.

The majority of HMO product providers accept some level of risk



Based on geographical and clinically risk adjusted TCOC

Risk adjusted and normalized to a Commercial California statewide population using Johns Hopkins ACG System

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OHCA proposes a five-year, single fixed value statewide spending target of 3.0% for 2025-2029.

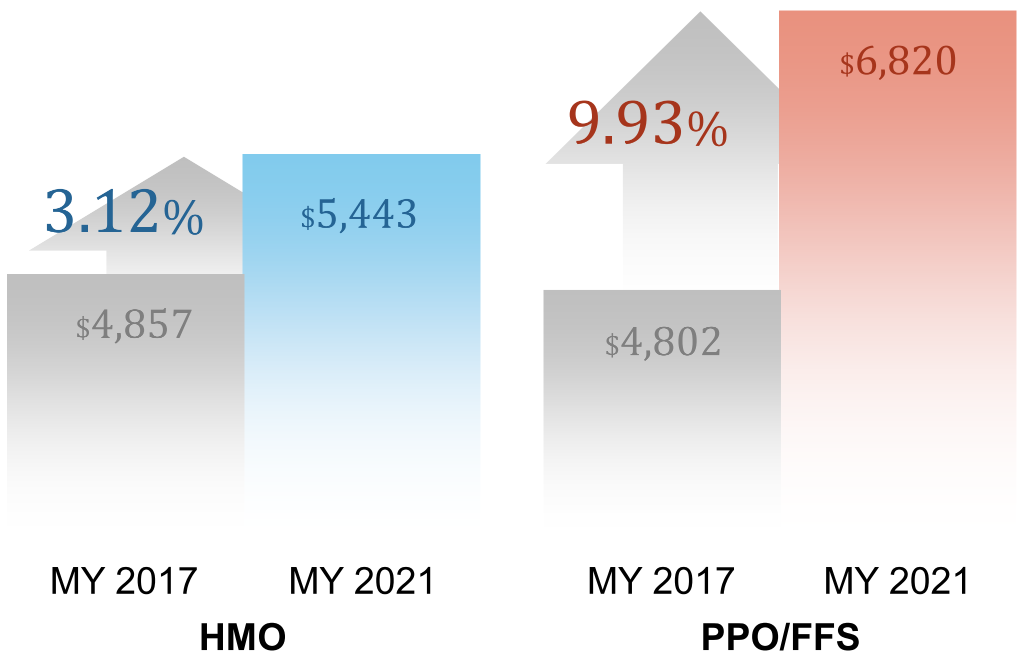
What does IHA Atlas information tell us regarding historical spending?

Atlas vs. OHCA historical cost information

4.98%
Atlas TCOC average annual increase
across all commercial plans in a five year "look back"

5.2%
OHCA average annual per capita healthcare spending
increase from 2015-2020

Atlas integrated vs. non-integrated average annual increase



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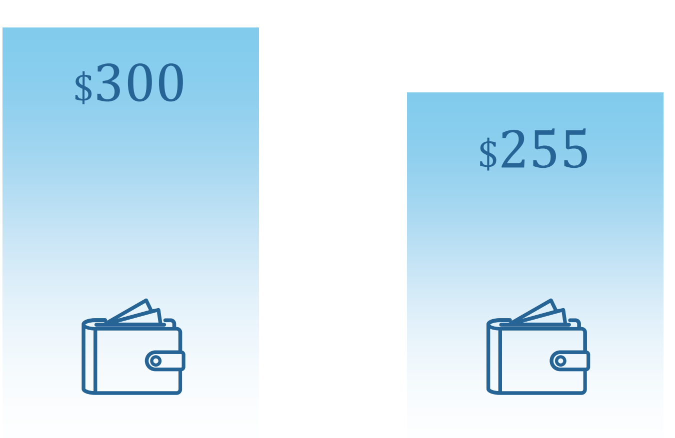
For patients, integrated care means lower out-of-pocket costs

Financial risk sharing associated with lower member out-of-pocket costs



$724

MY 2021 data

FULL RISK
Professional and Facility Capitation

PROFESSIONAL RISK ONLY

NO RISK
Fee for Service

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What do Atlas and AMP data tell us about quality of care- Focusing on the "Core 4"?

All risk types showed increases in Clinical Quality, but "No Risk" is still below the 2017 rate for integrated care.

NOTE of caution: claims only information which is incomplete

	MY 2017	MY 2021	Change
FULL RISK *Professional and Facility Capitation*	65	69	4 points
PROFESSIONAL RISK ONLY	63	66	3 points
NO RISK *Fee for Service*	55	60	5 points

Commercial data only; composite consists of 8 quality measures: 2 of 4 are Core 4

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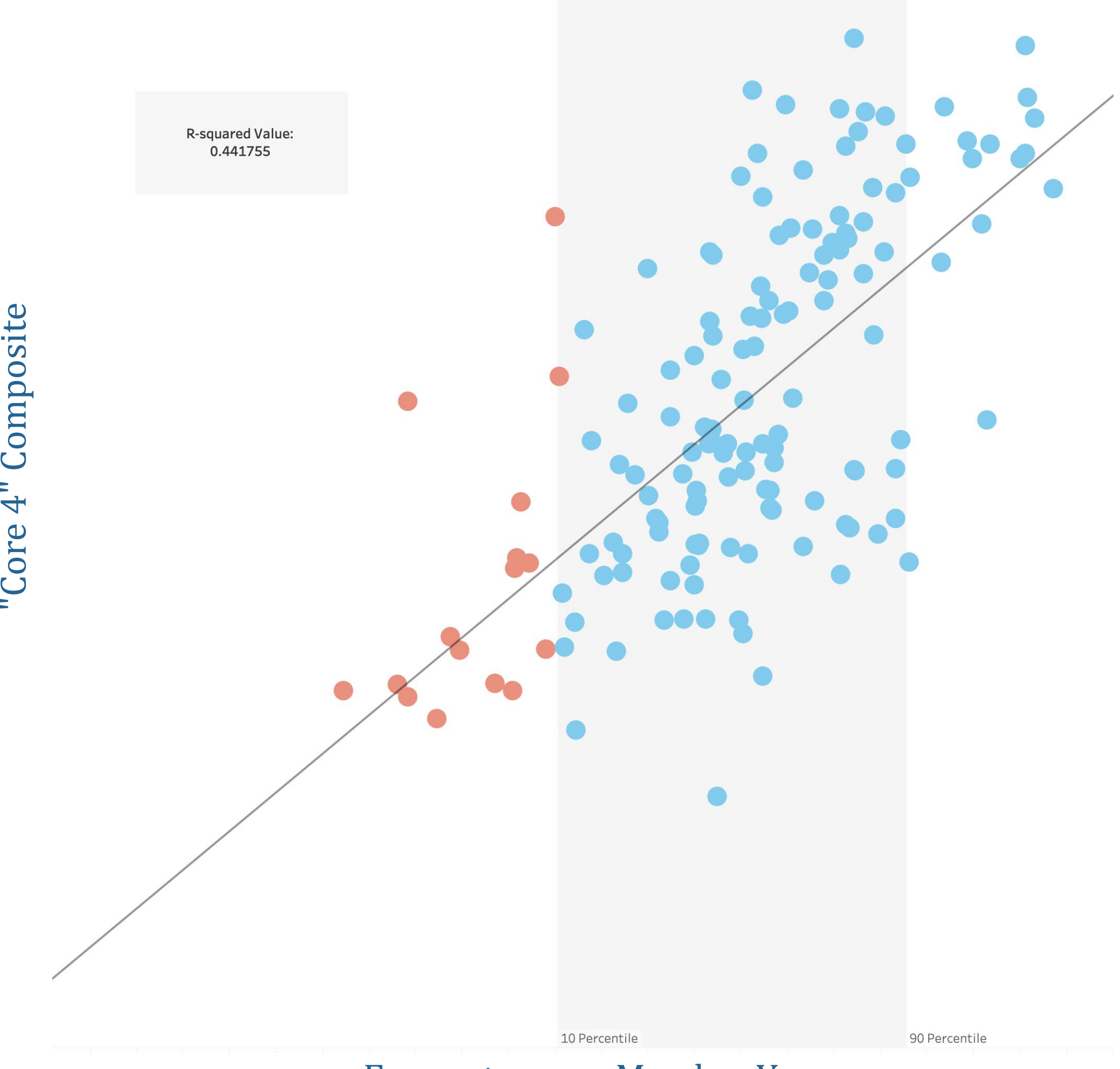
Data challenges: encounter performance highly correlated to quality scores

IHA has already identified those PO/IPAs that are most challenged



Data challenges: the critical contribution of clinical data to performance

Performance boost seen for "Core 4" measures

Measure	CLAIMS ONLY	CLAIMS + CLINICAL	Increase
Controlling High Blood Pressure	15%	47%	32%
Hemoglobin A1c (HbA1c) Control	51%*	57%	6%
Colorectal Cancer Screening	46%	61%	15%
Childhood Immunization Status	18%	46%	28%

*HbA1c Control (<8%) performance can be supplemented with lab data in the claims only rates

Rates averaged across health plan reported rates in MY 2021 for Commercial HMO

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The “boost” range also confirms the variability across plans

“Core 4” Measures	Range of difference across health plan reported rates (0%–100%)
Controlling High Blood Pressure (NQF #0018)	2% – 73%
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8%), (NQF #0575)	0% – 27%
Colorectal Cancer Screening (NQF #0034)	7% – 21%
Childhood Immunization Status (Combo 10) (NQF #0038)	12% – 55%

*HbA1c Control (<8%) performance can be supplemented with lab data in the claims only rates

Rates averaged across health plan reported rates in MY 2021 for Commercial HMO

Claims only rates provided by Onpoint and claims + clinical data rates provided by FinThrive

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Health plans have high rates of “known” race and ethnicity data, but a lot of variability re: information collected directly from members

81% of AMP health plan members have complete race and ethnicity data

Commercial, Medi-Cal, and Medicare data are included for each health plan.

13 million members are reflected in the data

Proportion of overall health plan race and ethnicity data by data source

	HP 1	HP 2	HP 3	HP 4	HP 5	HP 6	HP 7	HP 8	HP 9	HP 10	HP 11	HP 12	HP 13	HP 14	HP 15
Direct	89	37	93	7	64	35	99	26	97	11	14	96	21	50	100

Legend: Direct, Indirect

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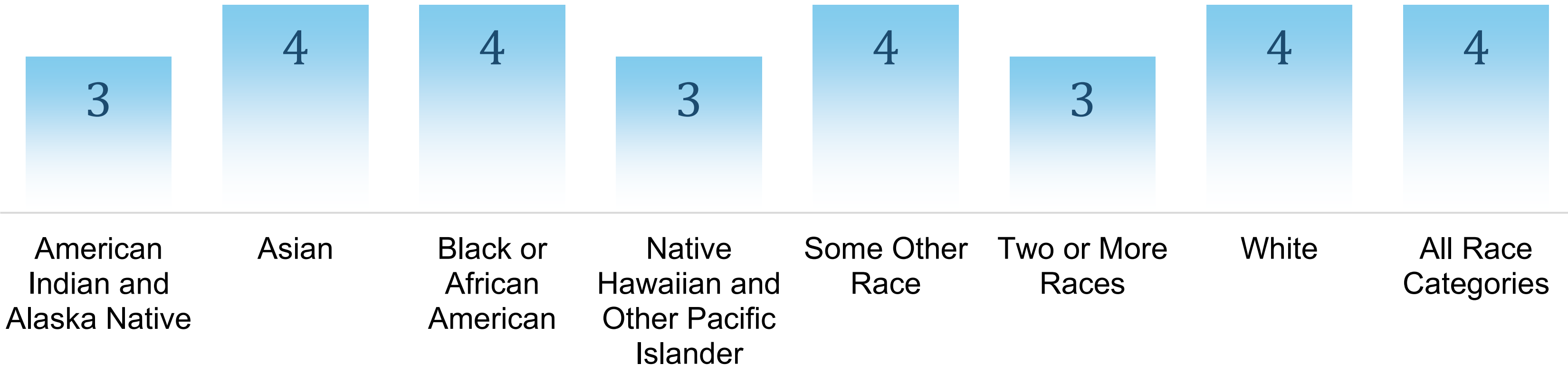
Using race and ethnicity data is critical in identifying low performance in care and health outcomes for all of California enrollees

Number of IHA affiliated commercial plans (out of 15) that meet Medicaid 50th percentile, by race, for controlling blood pressure



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This variability extends to critical spending categories like primary care

Results from IHA/CQC CAPCI program

2021 Primary Care spending percentage by commercial health plan product

EPO PPO HMO

Commercial Population Average, 8.7%

Product	Primary care spending %
EPO	3.8%
EPO	4.4%
PPO	5.8%
PPO	6.4%
HMO	6.5%
PPO	6.6%
PPO	6.6%
HMO	7.2%
HMO	7.4%
EPO	7.5%
HMO	7.7%
HMO	8.1%
HMO	9.2%
EPO	9.6%
HMO	10.1%
HMO	11.1%
HMO	11.3%
HMO	13.7%

Why it matters: A need for alignment

Purchaser and regulator programs – alignment and impact

DMHC Quality and Health Equity Program is just part of what is emerging statewide

	DMHC Quality and Health Equity Program	Covered CA Quality Transformation Initiative-2025	CalPERS Clinical Performance (QAMS)-2026	DHCS Managed Care Accountability Program-active	VOLUNTARY CA Advanced Primary Care Initiative
	13 measures 96 plans affected	6 measures 13 QHPs affected	8 measures 12-13 plans affected	18 measures 25 MCOs affected	12 measures 4 plans to date
FINANCIAL PENALTIES	$TBD	$49.4M	$TBD	$3.4M (2023, pre-appeal)	NONE- upside incentive only

Require clinical data for accuracy (all five programs)

Includes the "Core 4" (all five programs)

Includes race & ethnicity stratification *(method may vary)* (DMHC, Covered CA, CalPERS, DHCS)

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How does IHA's historic approach fit with OHCA activities?

- Total Healthcare Expenditure (THE) vs. Total Cost of Care (TCOC)
- Risk adjustment- age/sex only or also adjusted for clinical condition
- Sector specific analysis with capitated medical groups/IPAs as a sector ("RBO")-<u>accelerated by OHCA in regulations and DSG</u>
- Capitation data inclusion/exclusion-<u>accelerated by OHCA in regulations and DSG</u>
- Defining APMs consistently
- Primary care definitions re: spending, performance and practice level analysis
- Quality's role in the "affordability" discussion
- Health equity's role in the "affordability" discussion
- Sourcing information- central vs. organization specific