HealthPlus™
The Right Plan for a Healthier You™

HealthPlus of Michigan Primary Care Physician and Primary Physician Group and HealthPlus Partners Primary Care Physician and Primary Physician Group Performance Reports for Year-End 2013

Instructional Guide

Purpose:

Primary Care Physician (PCP) and Primary Physician Group (PPG) reports compare individual practice patterns and patient case mix with that of other PCPs/PPGs in either their Specialty or the Plan by Line of Business. The content in these reports is intended to provide information regarding cost and utilization, as well as highlight the clinical complexity of the patient panel.

Reports Included:

Multiple reports are included in this packet. Specific content and methodology information is included with each report.

The reports being distributed to the PCP include:

- PPG/PCP Utilization Summary Report (Primary Care Physician Profile)

PPGs have been sent a PCP Ranking Report by specialty. PCPs have been sent blinded ranking reports that highlight their own performance relative to their PCP Peers. For the Ranking Reports, statistical significance flags indicate that the sample size was large enough at a physician level such that there is a high degree of statistical confidence that the measures are accurate and that differences are not due to chance.

Methodology:

- A PCP is defined as a Family Practice, Internal Medicine or Pediatric physician.
- Reports are based on a paid claims basis and come from HPM's data repository.
- Reports are based upon at least a 3-month lag for claims runout.
- Reports contain service events that include facility, professional, and pharmacy payments.
- Reports are for the HPM Commercial, the HPP Medicaid and Medicare Risk line of business, and do not include any TPA utilization.
- Services included/excluded: All medical and pharmacy services are included in the Performance Ranking Reports, the PCP Utilization Summary Reports and the Major Medical Category by PCP Reports **with the exception of**: behavioral health/psych, capitated lab and pharmacy prescriptions written by behavioral health providers. However, all reports exclude outlier total dollars in excess of the statistically determined truncation point.
- Claims data that are utilized in these reports are mapped to the same funds in the same manner as PCP/PPG HPM financial reports, and to a certain extent are modeled upon that methodology. Dollars would tie closely to the PPG financial reports if these profiles were run on paid dates through 12/31/2013. However, for the purposes of these reports HPM has utilized claims data paid through 3/31/2014 for the following reasons:

    1. To minimize the impact of IBNR (estimates of paid but not incurred claims).
    2. To present a more accurate view of the PCP utilization through year-end 2013.

Key Definitions:

Case Mix Acuity Measure – The Case Mix indicator is a measure derived from The Johns Hopkins ACG® (Adjusted Clinical Groups) System, which ascertains the difficulty, risks, knowledge, and resources required to diagnose and treat a patient's clinical conditions. A more serious clinical condition requires more resources, knowledge and effort than a less severe clinical condition. The ACG methodology uses medical claims to classify individuals into ACG categories based upon their clinical similarity. Case Mix utilizes both medical and pharmacy claims data to ascertain acuity, or 'risk' of the patients in the PCP's/PPG's panel.

Comparisons of acuity are made relative to the Specialty Peer group at the PCP level, or to the Commercial, Medicaid or Medicare Risk Plan at the PPG level. The relative complexity, or severity, of the population is still built around 1.00, such that a case mix score >1.00 indicates a 'sicker' group of patients than normal for the population of interest. There are essentially eight steps in the case mix methodology using one year's worth of diagnoses, and age and gender from claims data.

1. Classify patient diagnoses.
2. Search for comorbidities.
3. Find 'within-disease' severity of illness.
4. Combine with demographic and hospitalization indicators to assign a patient category (ACG Categories).
5. Calculate expected cost for each category (ACG Categories).
6. Compute a physician's expected cost based on patients' category (ACG Categories).
7. Compare expected to actual costs.
8. Determine the relative clinical case mix by comparing the physician's expected costs to the peer group's expected costs.

"**Expected" –** The case-mix adjusted expected amount paid for the patients of provider X is an estimate of the amount that would have been paid if a "typical" provider of the same specialty had treated provider X's patients. A "typical" provider is defined by the average experience across all patients and all providers of the specialty. A patient's sickness level/complexity/need for services is defined by the ACG category to which a patient is assigned.

Performance Index – The Performance Index is a ratio of Actual Expenses (total or PMPM) divided by 'Expected' Expenses (total or PMPM) for the measure of interest. The Performance Index is fully dependent upon the Peer Group being analyzed, and is centered around 1.00. This measure indicates variance from the average in terms of costs on a risk-adjusted basis, however, it is intended that this be evaluated in the context of all other supporting data. Additionally, the measure is not intended to be utilized as an indicator that assesses quality of care. Both the Performance Index and the case mix measures can be found in the Performance Ranking Reports, and PCP Utilization Summary Report.

Peer Avg PMPM Paid – Total PMPM paid for medical services rendered for members assigned to Primary Care Physicians within a Medical Specialty (Internal Medicine, Pediatrics, or Family Practice). PMPMs exclude Psych, SNF, Rehab, capitated lab payments and all pharmacy services.

PCP Utilization Summary

The PCP Utilization Summary reports are designed to provide an overall summary of a PCP's performance relative to others within their peer group (Specialty). The expected figures generated for each PCP take into account the PCP's case mix. These figures are then compared to what the "average" subject in their peer group would have generated in costs based upon the underlying case mix of the peer group population.

Descriptions are provided for each section indicating those line items where further explanations would be helpful.

Section 1: Member Statistics, Measures & Totals

Avg Panel Size – Average number of members per month; threshold for small panel size and care in report interpretation if panel size < 75.

Total Mbr Mnths – The total number of member months is the sum of the number of months within the reporting periods that each member was assigned to the PCP's panel.

Avg Months Enrolled – Member months divided by members.

Pct Panel w/o PCP visits – Percent of members that had no PCP office visit and/or no PCP preventive visit.

Case Mix – This is the acuity score derived for the PCP based upon the Johns Hopkins ACG® (Adjusted Clinical Grouper) methodology.

PI – The PI is calculated by dividing the Actual PMPM by the Expected (based upon the Population) PMPM. This is an indicator of the difference between "actual" utilization and "risk-adjusted" utilizations. ">1" indicates greater than average utilization on a risk-adjusted basis.

Actual PMPM – The Actual Per Month paid amount is derived by dividing the Total Dollars Paid by the Total Member Months.

Peer Avg. PMPM – The Peer Avg PMPM is based upon Peer selection (i.e. PPG/PCP). The PMPM represents the straight average of either the Plan PMPM or within each Specialty. Calculation is Total Actual Dollars Reported divided by the appropriate Member Months.

Total Dollars Paid – This is the sum of the Paid Dollars for all the PCP's assigned members during the time period that they were assigned to the PCP.

Total IP Days – Total Days (excluding Psych, SNF and Rehab services) associated with a member's inpatient stay where the admission/stay occurred at any hospital (PPG and Non-PPG).

Section 2: Professional Services

This section consists of two subsections. The first subsection (PCP services) reflects the professional services that were performed by the PCP or by a colleague serving as the PCP while the second subsection (Specialty services) reflects the professional services that were performed by the specialist.

PCP Actual – PCP actual is defined as the rate per 1000 annualized or PMPM for the services rendered in the service category (or measure) for the members assigned to the Primary Care Physicians during the reporting period and paid through a 90 day claims run out period.

Expected – See Key Definitions

Peer Avg – Peer average is defined as the rate per 1000 annualized or PMPM for the services rendered in the service category (or measure) for all PCP's in a Medical Specialty Peer group (Internal Medicine, Family Practice, Pediatrics).

Perf Index – See Key Definitions

PCP Office Visits/1000 – Office or Other Outpatient Services (CPT Codes 99201-99215), Office or Outpatient Consultations (CPT Codes 99241-99245), Confirmatory Consultations (CPT Codes 99271-99275) where the primary care physician performed the visit, and Newborn visits (99432).

PCP Preventive Visits/1000 – Preventive Medicine Services (CPT Codes 99381-99429) where the primary care physician performed the visit.

PCP Total Office Visits/1000 – Sum of office and preventive visits counts.

Specialist Office Visits/1000 – The number of specialist services per 1000 including consults and visits in the Specialist's Office.

Total Specialist Services PMPM Paid – All Primary services not defined as Office Visits or Preventive Visits. This includes, but is not limited to: hospital discharge visits, hospital inpatient visits, hospital observation visits, and non-capitated lab procedures.

Ratio of Specialist Office Visits to PCP Office Visits – The ratio of the number of specialist consults visits to the number of PCP visits. If the PCP ratio is greater than the Peer Average, the PCP is referring patients to specialists more often than the Specialty norm.

Section 3: Inpatient Hospital – Acute Care

This section reflects the inpatient facility services that were performed for the PCP's members. It excludes Psych, SNF, and Rehab services.

Total Discharges per 1000 – Combined medical, surgical, and OB/maternal pediatric-inpatient discharges per 1000 members annualized for the reporting period. Includes in- and out-of-network utilization. Excludes Psych, SNF, and Rehab.

Non-PPG % Discharges & Non-PPG % Days – Proportion of total inpatient days (excluding Psych, SNF, and Rehab) associated with the members' inpatient stay where the admission/stay was not at the primary care physician's affiliated hospital.

Section 4: Outpatient Services

Total ER Visits/1000 – Emergency room visits annualized per reporting period. Any ER visits with a Revenue Code of 450-459. Includes Outpatient facility dollars only and does not include any visit that results in an inpatient stay.

Urgent Care Visits/1000 – Office services provided on an emergency basis (CPT Code 99058) performed in a freestanding facility or performed by non-PCPs in an emergency office location.

Ambulatory Surgery /1000 – OR Room Services (Revenue Codes 0360-0369), Cardiology Services (Revenue Codes 0480-0481), Ambulatory Surgical Care (Revenue Codes 0490-0499), Gastro-Intestinal Services (Revenue Codes 0750-0759), Lithotripsy Services (Revenue Codes 0790-0799), and where there is NOT an ER Service (Revenue Codes 0450-0459). Includes outpatient facility and facility dollars associated on same date of service.

Section 5: Pharmacy

This section contains four pharmacy-based measures for the members assigned to the PCP and excludes prescriptions written by Behavioral Health providers.

PMPM – Total Paid (rebate adjusted) divided by Total Member Months.

Generic %: – The proportion of total prescriptions prescribed as generic.

Util PMPY – (Total Count of Prescriptions divided by Total Member Months) *12.

Avg Paid/Rx – The average paid amount per prescription is the Total Amount of Paid for the members' pharmacy claims divided by the count of pharmacy claims (aka number of scripts). Note: Claim count has been adjusted to account for mail order scripts: i.e., one script per 30 days.

Section 6: Case Mix Breakdown Within Peer Graph

The intent of the graph is to provide a quick visual as to where a PCP/PPG acuity level is distributed relative to the comparative population of interest. The range for the relative Case Mix will be:

<0.7
>=0.7 and <0.9
>=0.9 and <1.1
>=1.1 and <1.3
>=1.3

Section 7: Performance Index Breakdown Within Peer Graph

The intent of the graph is to provide a quick visual as to where a PCP/PPG performance index is distributed relative to the comparative population of interest. The range for the relative PI will be:

<0.7
>=0.7 and <0.9
>=0.9 and <1.1
>=1.1 and <1.3
>=1.3

Since these graphs reflect the experience of the comparative population they will remain the same for each PCP within a Specialty and PPG.

HealthPlus of Michigan
Utilization Summary

Peer Group	**COMMERCIAL - FP**
PPG	**105**
PCP	**010A2B4C80**
PCP Name	**KNEEDPHAM, TOBY**

SAMPLE

Member Statistics

Avg. Age	41
Avg. Panel Size	321
Total Member Months	3,855
Avg. Months Enrolled	10.31
Pct. Panel w/o PCP Visit	25 %

Measures

Case Mix	1.11
Performance Index	1.14
Actual PMPM	$ 345.49
Peer Avg. PMPM	$ 272.68

Totals

Total Dollars Paid	$ 1,331,959
Total Medical Paid	$ 1,056,946
Total Pharm Paid	$ 275,013
Total IP Days	52

Professional Services

	Actual	Expected	Peer Avg	Perf Index
PCP Office Visits/1000	1,964	2,382	2,202	0.82
PCP Preventive Visits/1000	514	375	356	1.37
PCP Total Office Visits/1000	2,478	2,758	2,558	0.90
PCP Primary Svcs PMPM	$ 12.63	$ 14.41	$ 13.43	0.88
Specialist Office Visits/1000	1,799	1,137	1,018	1.58
Total Specialist Svcs PMPM	$ 145.20	$ 99.74	$ 89.83	1.46
Ratio of Specialist OV to PCP	73 %	41 %	40 %	N/A

Inpatient Hospital - Acute Care

	Actual	Expected	Peer Avg	Perf Index
Total Discharges/1000	75	79	75	0.95
Total Days/1000	162	273	260	0.59
Avg. Length of Stay	2.17	3.47	3.45	0.62
Total Inpatient PMPM	$ 23.89	$ 61.13	$ 55.47	0.39
Non PPG % of Discharges	54 %	N/A	26 %	N/A
Non PPG % of Days	63 %	N/A	27 %	N/A

Note: excludes Psych, SNF, and Rehab services

Outpatient

	Actual	Expected	Peer Avg	Perf Index
Total ER Visits/1000	174	211	194	0.83
Urgent Care/1000	230	161	146	1.43
Amb Surg Procedures/1000	299	218	197	1.37
Total ER PMPM	$ 8.63	$ 11.28	$ 10.43	0.76
Urgent Care PMPM	$ 1.04	$ 0.76	$ 0.69	1.37
Amb Surg PMPM	$ 76.70	$ 43.77	$ 39.20	1.75

Pharmacy

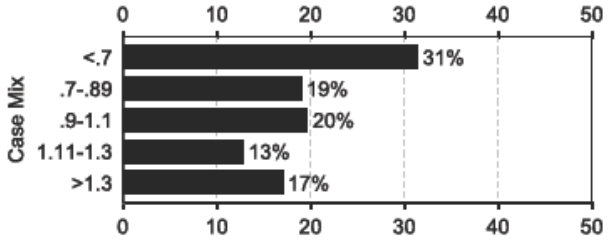
	Actual	Expected	Peer Avg	Perf Index
PMPM	$ 71.34	$ 65.53	$ 58.76	1.09
Generic %	63 %	70 %	71 %	N/A
Util PMPY	18	19	17	0.94
Avg Paid/Rx	$ 48.11	$ 41.35	$ 40.49	1.16

Note: Mail Order scripts represent a count of 1 script per 30 day supply

Note: Pharmacy paid metrics are derived from total member months

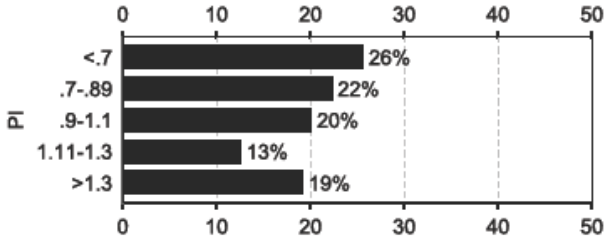
Case Mix Breakdown Within Peer

Bars represent % of peers in each case mix range



Performance Index Breakdown Within Peer

Bars represent % of peers in each PI range



Report Comments Report Period 01/01/2007 to 12/31/2007, Pd thru 03/31/2008

Run Date June 24, 2008

PCP by Specialty Ranking Reports

The Ranking reports are designed to provide an overall summary of a PCP's performance relative to others within their peer group (Specialty). PCPs are ranked based upon the difference between their actual costs and their case mix adjusted expected costs or Performance Index. The expected figures generated for each PCP take into account the PCP's case mix. These figures are then compared to what the "average" subject within their peer group would have generated in costs based upon the underlying case mix of the peer group population.

Before generating comparison figures, HPM identifies outlier patients and truncates their costs from this analysis. Elimination of outlier dollars is done to reduce the potential for making a PCP responsible for the rare, unusually expensive/inexpensive costs and, therefore, is an effort to avoid inappropriately biasing the physician performance statistics. All patients are included in the calculation of case mix adjustments. The outlier definition is based upon a truncate/trim point methodology with a total cost threshold.

At this time, HPM will only be making PCP/PPG peer group comparisons to internal benchmarks (Population).

SAMPLE REPORT

Peer Group COMMERCIAL - FP
Peer Group Count 377

		Actual			Peer Group				
Rank	PPG - PCP - PCP Name	Average Members Per Month	Total Member Months	Total Actual Paid	Total Expected Paid	Difference	SS	Perf Index	Case Mix
90	**********	1.00	12	$ 626	$ 885	-$ 259		0.71	0.30
134	101 - 0203040 - GILHOOLEY, SAR	10.10	121	12,657	$ 15,081	-$ 2,424		121	0 .49
205	**********	1.54	9	$ 3,080	$ 3,086	-$ 5		1.00	1.52
323	**********	1.00	3	$ 1,698	$ 1,187	$ 511		1.43	1.55
370	**********	1.00	8	$ 6,338	$ 1,735	$ 4,604		3.65	0.83
371	**********	1.88	23	$ 58,503	$ 14,811	$ 43,692	**	3.95	2.58
		Totals		$ 82,902	$ 36,784	$ 46,118			

Major Medical Category by PPG/PCP Reports

The Major Medical Category Reports can be used to compare the total cost of CPT procedure codes for a category to the expected cost for the Population and/or Benchmark group. A “major medical category” is a classification of the CPT or HCPCS codes for which a patient’s services are billed. Services that are billed to unknown codes are mapped to a default category of “Uncategorized”.