# IT-5.3: Total Cost of Care

| **Measure Title** | **IT-5.3 Total Cost of Care** |
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| **Description** | Total Cost of Care reflects a mix of complicated factors such as patient illness burden, service utilization and negotiated prices. Total Cost Index (TCI) is a measure of a primary care provider’s risk adjusted cost effectiveness at managing the population they care for. TCI includes all costs associated with treating members including professional, facility inpatient and outpatient, pharmacy, lab, radiology, ancillary and behavioral health services. A Total Cost of Care Index when viewed together with a Resource Use measure provides a more complete picture of population based drivers of health care costs.**Type of Resource Use Measure:*** Per capita (population- or patient-based)

**Resource Use Service Categories:*** Inpatient services: Inpatient facility services
* Inpatient services: Evaluation and management
* Inpatient services: Procedures and surgeries
* Inpatient services: Imaging and diagnostic
* Inpatient services: Lab services
* Inpatient services: Admissions/discharges
* Inpatient services: Labor (hours, FTE, etc.)
* Ambulatory services: Outpatient facility services
* Ambulatory services: Emergency Department
* Ambulatory services: Pharmacy
* Ambulatory services: Evaluation and management
* Ambulatory services: Procedures and surgeries
* Ambulatory services: Imaging and diagnostic
* Ambulatory services: Lab services
* Ambulatory services: Labor (hours, FTE, etc.)
* Durable Medical Equipment (DME)
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| **NQF Number** | 1604 |
| **Measure Steward** | HealthPartners |
| **Link to measure citation** | <http://www.qualityforum.org>  |
| **Measure type** | SA for project area 2.5NSA for all other project areas |
| **Performance and Achievement Type**  | Pay for Performance (P4P) – Improvement Over Self (IOS): Prior Authorization

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|  | DY4 | DY5 |
| Achievement Level Calculation | Baseline - 5% \*(performance gap)=Baseline - 5% \*(0% – Baseline rate) | Baseline - 10% \*(performance gap)=Baseline - 10% \*(0% – Baseline rate) |

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| **DSRIP-specific modifications to Measure Steward’s specification** | The only modification is changing designation of “member” to “patient”, in order to be consistent throughout the document to avoid confusion between applicability of the measure to a (managed care) plan rather than an individual provider. However, this is a population-based measure that applies to all service categories, care settings and conditions. |
| **Denominator Description**  | None |
| **Denominator Inclusions** | None |
| **Denominator Exclusions** | None |
| **Denominator Size** | Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)* For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
* For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.
* For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
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| **Numerator Description**  | Total cost of care |
| **Numerator Inclusions** | None |
| **Numerator Exclusions** | None |
| **Setting** | Multiple |
| **Data Source** | Administrative Claims |
| **Allowable Denominator Sub-sets** | All denominator subsets are permissible for this outcome  |